DOCUMENT RESUME

ED 415 120 SO 025 072

TITLE	Art Therapy: Journal of the American Art Therapy Association, 1983-1996.
INSTITUTION	American Art Therapy Association, Towson, MD.
ISSN	ISSN-0742-1656
PUB DATE	1996-00-00
NOTE	2560p.; A complete run of this journal from its inception in 1983 through 1996 (43 issues). 1983-1990: three times a year; 1991: twice a year; 1992-1996: quarterly. Not available via UMI.
AVAILABLE FROM	American Art Therapy Association, 1202 Allanson Road, Mundelin, IL 60060.
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Art Therapy: Journal of the American Art Therapy Association; v1-13 1983-1996
EDRS PRICE	MF23/PC103 Plus Postage.
DESCRIPTORS	Art Expression; *Art Therapy; Artists; *Disabilities; Emotional Disturbances; Neurological Impairments; Psychological Evaluation; *Psychological Testing; Self Expression; *Visual Arts
IDENTIFIERS	Professional Concerns

ABSTRACT

This journal focuses on art therapy from research, clinical, and educational perspectives. Current issues arrange information under six categories: editorial; commentaries; articles; brief reports; viewpoints; and reviews of books and videotapes. While most articles are not education-related, each issue generally contains some material relevant to education, e.g., exceptional children; art therapy training; art therapy faculty; Diagnostic Drawing Series for children, etc. (AA)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 415 120

ART THERAPY

Journal of the American Art Therapy Association

Volume 1, Number 1, 1983 — Volume 13, Number 4, 1996

(Complete Set)

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

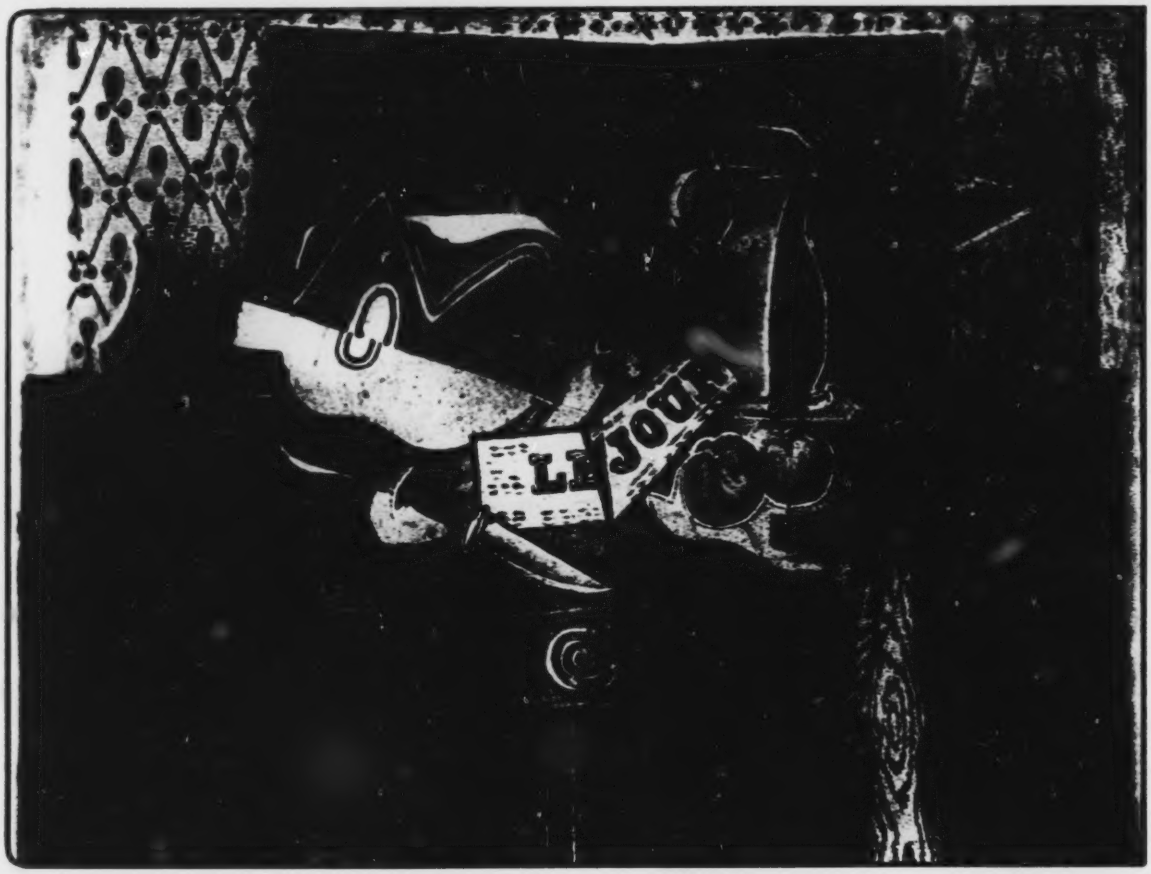
"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
CATHY A
MALCHIODI
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

SO 025 072

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association



Volume 1, Number 1 October, 1983

- **In Memoriam:** Margaret Naumburg (1890–1983)
- Paul-Max Simon: The Father of Art and Psychiatry
  John Monroe MacGregor, PhD
- An Art Therapist's Personal Record
  Don Jones, ATR
- A Critical Analysis of A Review of the Published Research Literature in Arts for the Handicapped: (1971–1981)
  Frances Anderson, EdD, ATR
- Identifying Gifted Handicapped Children Through Their Drawings
  Rawley Silver, EdD, ATR
- Making Verbal the Nonverbal
  Mildred Lachman-Chapin, MEd, ATR

BEST COPY AVAILABLE

ACKNOWLEDGMENTS

Much appreciation is expressed toward the members of the AATA Journal Planning Committee, who made this premier issue possible. We are grateful to Vija Lusebrink, ATR, Harriet Wadeson, PhD, ATR, Sandra Packard, EdD, ATR, and Anita DeVivo, who served on the selection committee for *ART THERAPY*. Ms. DeVivo was also a consultant for the new journal. Particular thanks is due to Steve Trigonoplos, Director of Press and Communications, American Association for Counseling and Development, who offered his guidance throughout the process, and Debra Bass, who served as production editor. Finally, we appreciate the hard work done by Scott Stoner, ATR, AATA Executive Director, and AATA staff, who supervised the production of our premier issue.

Barbara Katz Mandel, ATR
AATA Publications Chair
1981-1983

Coordinator, AATA Journal
Planning Committee

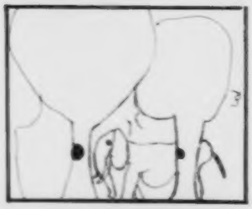
ART THERAPY is published quarterly by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates (includes 4 issues). Individuals: $18 (US); $22 (Foreign). Institutions: $30 (US). $34 (Foreign) A discount of 10% is available for 10 copy minimum orders. Single copies of the inaugural issue are available at $9 (Individuals) $15 (Institutions). Printed in the U.S.

Advertising: For information, write or call the AATA office, 5999 Stevenson Avenue, Alexandria, VA 22304, (703) 370-3223.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

ART THERAPY

Journal of the American Art Therapy Association



Editorial

Editorial, Linda Gantt, MA, ATR 2

Articles

Dayenu: A Tribute to Margaret Naumburg, Judith A. Rubin, PhD, ATR 4
The Legacy of Margaret Naumburg, Patricia Buoye Allen, MA, ATR 5
A Naumburg Bibliography 6
Paul-Max Simon: The Father of Art and Psychiatry, John Monroe MacGregor, PhD 8
An Art Therapist's Personal Record, Don L. Jones, ATR 22
A Critical Analysis of A Review of the Published Research Literature in Arts for the Handicapped: 1971-81, *with Special Attention to the Visual Arts*, Frances E. Anderson, EdD, ATR 26
Identifying Gifted Handicapped Children Through Their Drawings, Rawley A. Silver, EdD, ATR 40
Making Verbal the Nonverbal: A Commentary, Mildred Lachman-Chapin MEd, ATR 47

Viewpoints

The Art in Art Therapy, Harriet Wadeson, PhD, ATR 50
The Art Therapy Intensive, Shaun McNiff, PhD, ATR 51
Viewpoint, Evadne McNeil, MS, ATR 52
Reviews 53
Recent Literature of Interest to Art Therapists 62
Brief Communications 63

Copyright © 1983 American Art Therapy Association, Inc.

Cover illustration: Still Life Le Jour, by Georges Braque, National Gallery of Art, Washington, D.C.: Chester Dale Collection 1962 (French, 1882-1963, date: dated [19]29).

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in theory, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

Volume 1, Number 1 October, 1983

EDITORIAL BOARD

Interim Editor
Linda Gantt, MA, ATR
Interim Associate Editor
Mildred Lachman-Chapin, MA, ATR
Viewpoints
Hariett Wadeson, PhD, ATR
Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Production Editor
Debra Dulina Bass

Journal Planning Committee
Barbara Katz Mandel, MA, ATR, Chair
Frances Anderson, EdD, ATR
Linda Gantt, MA, ATR
Mildred Lachman-Chapin, MEd, ATR
Ruth Obernbreit, MA, ATR
Susan Michal, MA, ATR
Judith Rubin, PhD, HLM, ATR
Harriett Wadeson, PhD, ATR
Robert Wolf, MPS, ATR
Georgiana Jungels, MA, ATR (ex officio)
Scott Stoner, MS, ATR (ex officio)

American Art Therapy Association, Inc. 5999 Stevenson Avenue, Alexandria, VA 22304, (703) 370-3223

EDITORIAL

The inaugural issue of ART THERAPY provides us the opportunity, as do all new ventures, to take a Janusian look at our endeavors, to see where we have come from and to predict where we will go. It is therefore fitting that the focus of this issue may be broadly described as being on art therapy literature, past and present. Some of these articles remind us of our beginnings or acquaint us with forgotten or unknown predecessors; others look at contemporary problems and issues. Taken together, they help us to see the launching of this journal in suitable perspective.

It seems ironic that the woman whom most art therapists consider to be the founder of the field died as this issue was in the process of a hard labor and delivery. Through her courses and writings, Margaret Naumburg influenced virtually all art therapists practicing today. That she had an earlier career as an innovative and influential founder and Director of the Walden School is not known by many who read her books in art therapy, yet she considered the philosophy she developed as an educator to be the foundation of her later work.

It was the publication of Naumberg's detailed case studies that marked the 1940s as the beginning of art therapy as a distinct field. Yet, fully 60 years before, Paul-Max Simon, a French psychiatrist and an artist laid the groundwork for systematic studies in art and psychiatry. Dr. MacGregor's careful scholarship introduces us to this important historical figure whose work may serve as a model for present investigations.

Naumburg, although far and away the best known writer on our subject, was by no means the only one exploring the therapeutic possibilities of art in the 1940s. During that period, there was an almost simultaneous but separate development of the three principle branches of art therapy—in education, in rehabilitation, and in psychotherapy. Viktor Lowenfeld, an Austrian immigrant, brought to this country a heritage of European ideas about the importance of children's art. Apparently independent of Naumburg's work, was that of Adrian Hill, an Englishman who published two slim volumes on art therapy with tuberculosis patients. Hill was a professional artist whose own bout with that disease gave him the idea of "painting out illness." Hill, Lowenfeld, and Naumburg were relatively well-known, each one devoting considerable time to lecturing and teaching. The same forces that affected these writers must have influenced uncounted others who, without benefit of specialized training or particular theory, were already working in a variety of hospitals and institutions. A few such individuals did write about their programs and patients but those articles were generally of an introductory nature and were scattered in a variety of professional journals.

Undoubtedly, Don Jones's experience was similar to that of others who came to the notion of art therapy on their own and who practiced in isolation until the publication of the *Bulletin of Art Therapy* (as the *American Journal of Art Therapy* was first named) provided a rallying point. Mr. Jones's sensitive paintings give us a glimpse of that lonely existence in the institutional world of 40 years ago, a world about which most of us have only read. The art work provides a document in the broadest sense—a record of experience as permanent as that supplied by any written narrative.

The other papers in this issue deal with more current issues. The article by Dr. Anderson reviews a decade of published research literature on the visual arts and the handicapped. She discusses the flaws in the studies and suggests suitable remedies. Her article reflects a contemporary pressure placed on us from those outside art therapy and art education—to conduct empirical research that can back up our theoretical claims. Dr. Silver's article, like much of her previous published work, delves into a territory that is still rather new for art therapists. She gives us a model for future studies—to branch out and to investigate those areas in which the use of art is still relatively unexplored. The commentary by Associate Editor Mildred Lachman-Chapin raises some philosophical and methodological questions. How do we say what we do? Practicing a "nonverbal" craft in no way exempts us from having to talk and write about what we do and how we do it in clear and well-considered presentations.

Thirty years ago in an article on "The Arts as Applied Psychotherapy" Ernst Harms deplored the state of the literature and criticized the all-too-common "reports of individual experiences which are sometimes more sentimental than factual, outlets of needs and urgent demands, and even rather insincere and dubious journalistic elaborations and presentations with absolutely no meaning or possibility of application to the sphere of concrete work with mental abnormality" (Harms, 1944 p. 51). How would we answer Harms today? How far have we come in the intervening time? What is the state of art therapy literature? What accomplishments can we claim? Most importantly, what is our mandate for the immediate future?

Our intellectual and philosophical history is a longer one than many art therapists suspect. We must

6

chronicle that history, gather more information on our roots, evaluate our borrowings from neighboring fields. We must re-examine the ideas passed on to us from the early writers, test them, and, if necessary, discard them in favor of more cogent explanations. The case study, the staple of our literature to this point, needs to be buttressed by empirical research and more relevant theory. Now is the time to evaluate the art therapy literature with the clear objective of weeding out useless and simplistic ideas, developing a more precise vocabulary, and countering our critics' charges.

The 1980s will be a critical period in our profession's development. We will be forced to show how art therapy is both distinct from and similar to allied fields, for on such distinctions rests our future, our training programs, our positions, and our prestige.

Harms prescribed an antidote for the problems he perceived in the early literature: "The progress in any scientific endeavor depends upon the collection of data in its proper combination, thoughtfully coordinated and systematized. . . . All three activities have to go hand in hand and must be checked and double-checked and upon the advancement of one depends the advancement of the other" (Harms, p. 51–52). Application of the scientific method to human endeavors, however, is not without its own problems. With respect to empirical research our literature has lagged behind that of most therapeutic disciplines. We may make the most of this lag, however, by profiting from other's discoveries of the limits (as well as the benefits) of the scientific method.

Our Janusian look must not be reserved for the beginning of new projects but must be our customary stance as we take stock of our successes and failures, always with an eye to improving the published literature, the foundation of our field.

Linda Gantt, ATR
Interim Editor

References

Harms, E. (1944). The arts as applied psychotherapy. *Occupational Therapy and Rehabilitation, 23, 2*, April, 51–61.

GUIDELINES FOR AUTHORS: Please submit four (4) copies of manuscripts to: AATA Journal, 5999 Stevenson Ave., Alexandria, VA 22304. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ inch margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100–125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white, glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

Citations for journal articles should include author(s), journal name in full, date of publication, volume number, issue number and inclusive pages.

Example: Zeiger, B. L. (1976). Life review in art therapy with the aged. *American Journal of Art Therapy, 15*(2), 47–50.

Citations for books should include author(s), title, city of publication, publisher's name and publication date.

Example: Naumburg, M. (1966). *Dynamically oriented art therapy*. New York: Grune & Stratton.

For each reference, the surname of the author and the year of publication must be cited in the text. For quotations, include page numbers.

Examples: Smith (1980) made a study . . .
In a study on children's art (Smith, 1980) . . .
According to an article on children's art (Smith, 1980, pp. 107–118) . . .

Manuscripts are welcome at any time.

AATA EXECUTIVE BOARD
1981–1983

Board of Trustees
President
Georgiana Jungels, MA, ATR
President-Elect
Gladys Agell, MA, ATR
Secretary
Judith Gerberg, MA, ATR
Treasurer
Suzanne Silverstein, MA, ATR

Committee Chairs
Affiliate Societies
Irene Corbit, MA, LC, ATR
Bylaws
Bernard Levy, PhD, HLM, ATR
Education
Myra Levick, PhD, HLM, ATR
Governmental Affairs
Nancy Schoebel, MA, ATR
Membership
Robin Goodman, MA, ATR
Public Information
Bobbi Stoll, MA, MFCC, ATR
Publications
Barbara Mandel, MA, ATR
Research
Janie Rhyne, PhD, HLM, ATR
Standards
Karen Cadenhead, MS, ATR

Executive Director
Scott Stoner, MS, ATR

DAYENU: A Tribute to Margaret Naumburg

Judith A. Rubin, PhD, HLM, ATR
Past president
AATA

Judith A. Rubin, PhD, HLM, ATR, is an Assistant Professor in the Department of Psychiatry at the University of Pittsburgh, and is the Co-Director of the Creative and Expressive Arts Therapy Program, Western Psychiatric Institute and Clinic, Pittsburgh, PA.

There is a song usually sung during the Passover seder, in which Jews express their gratitude as a people for the many wonderful things done by the Lord on their behalf. After recounting each marvelous act, we chant "Dayenu!" ("It would have been enough!"). If God had done only this one thing, it would have been sufficient to merit our eternal praise and thanks. When I was asked to write something about Margaret Naumburg, the word *Dayenu* soon came to mind. The more I thought about it, the more I realized how very apt it was—as a description of the enormity of her contributions to the field of art therapy, and as a reminder of the gratitude and respect we shall always owe to her memory.

Had she done nothing more than to found the Walden School (1914), a place where freedom and discipline in all of the arts were fostered and were considered central to normal children's healthy development, that would have placed her among other significant educators who recognized and promoted the broadly therapeutic potential of the arts. *Dayenu!* She went on, however, building on her own broad study of psychoanalysis, psychology, education, philosophy, and other disciplines; she seized the opportunity offered by Dr. Nolan D. C. Lewis to try out the therapeutic potential of art with child patients at the New York State Psychiatric Institute. And she didn't just do that; she also wrote a series of descriptive ble, often providing food and drink

as well as support and direction. Because I now find myself receiving frequent requests for such guidance, I marvel even more at the willingness of Margaret Naumburg to play a nuturing role with so many aspiring art therapists. It is well known that she and thoughtful case studies, publishing them in a variety of journals, and finally collecting all in a single book (1947). *Dayenu!*

But that was only the beginning. She continued her research into the use of art in therapy with other populations, first with schizophrenics (1950), then with neurotics (1953). Each time, she published book-length case studies, along with her developing theories about art therapy. Being the scholar she was, she also included chapters that put her work into perspective against that of others, educating her readers about the multiple roots and manifold possibilities of art therapy. One such book would have made her a pioneer in our field; two would have been sufficient to establish her reputation; three would have been a most generous contribution. But Margaret Naumburg, at an age when most people start winding down, went on to write a fourth book, in which she tried to define for herself and for others the nature of what she called "dynamically-oriented art therapy" (1966). As in her earlier volumes, she included material on history and relationships with other disciplines, as well as beautifully written and vividly illustrated case studies. *Dayenu!*

Had she done nothing more than to write these four books (the first three for a while the only books on art therapy in this country), that would have been enough. But she was also extremely generous—nurturing individuals in the era before formal art therapy training programs, giving sound and supportive guidance about relevant readings, courses, supervision, and psychotherapy experience. She gave freely of her time, which I am sure was much in demand by the time I met her (1963); and was, in addition, most hospita- could be difficult, demanding, and temperamental; I hope it is equally well known that she could be warm, caring, and giving. *Dayenu!*

She went beyond training individuals, many of whom came to her for supervision from far as well as near. She also initiated what may have been the first formal university courses in art therapy, in the Psychology Department at New York University and later at the New School for Social Research. She was, in addition, a tireless crusader on behalf of this new discipline that she had helped to create. She gave lectures and short courses all over this country and across the seas, eager to spread the word about this idea in which she believed most passionately. It may never be possible to enumerate those individual art therapists whose careers were strongly shaped by her writings, courses, or personal contact. Similarly, it may not ever be possible to know how many institutions offering courses or training programs in art therapy were first alerted to its potential by this articulate traveling salesperson. *Dayenu!*

I am certain no one ever questioned that she should be the recipient of the first Honorary Life Membership Award of the American Art Therapy Association, presented at its first meeting. I remember her talk that year, a sharply reasoned and eloquent plea for art therapists to be trained, like other clinicians, in sound principles and techniques of interviewing. She always was concerned with improving the quality of work done in the field, never content to rest on her laurels. Through her writing and teaching Margaret Naumburg provided a model of excellence in a field that could easily be diluted by mediocrity and superficiality. Her own standards were very high, her thinking deep and complex, and her contributions to the "peoples" of art therapy worthy of many *Dayenus*. We should feel the deepest admiration, respect, and gratitude for a woman we can proudly call "the mother of us all."

The Legacy of Margaret Naumburg

Patricia Buoye Allen, MA, ATR

Patricia Buoye Allen, MA, ATR, is an Assistant Professor in the Art Therapy Graduate Program at the University of Illinois at Chicago and is in private practice.

There is an enormous temptation, upon the death of someone as venerable as Margaret Naumburg, to idealize her and to focus only on her tangible achievements and contributions. Such an idealization seems analogous to erecting a monument in stone: a certain aspect is caught and frozen, larger than life, to serve as a continuing inspiration for the survivors. Yet, when I reflect on my relationship with Margaret, I am intrigued less by her greatness than by the richly complex and contradictory aspects of her human nature.

I came to know Margaret in Boston where she lived in the early seventies, ostensibly in retirement. She became my teacher and a great deal more. I was her disciple, supplicant, and companion for several years. Traditional boundaries of student and teacher did not apply. We might drive to the ocean or shop for clothes as often as we discussed art therapy. The living room of Margaret's small Brookline apartment, stacked with books and papers that she never found room for, was as familiar to me as my own.

Margaret's interests were wide-ranging. She fostered in me the view that all disciplines, whether artistic or scientific, traditional or esoteric, have the potential to contribute to one's own discipline. Although we identify her as the original art psychotherapist, to her art therapy was not a narrow offshoot of psychoanalytic psychotherapy. Rather, it was the practice of understanding human nature by employing a fruitful conjunction of the psychological, historical, spiritual, cultural, and artistic aspects of human experience.

Although her name is synonymous with dynamically-oriented art therapy, Margaret's approach was actually quite eclectic. She underwent Jungian analysis in addition to psychoanalysis during her career and was most attuned to the universal archetypal layer of symbolism. Her knowledge of world culture, art history, and of religion, especially Eastern religion, was considerable. At a certain point, when I was undergoing considerable stress due to the concurrent demands of school and work, Margaret suggested that I attempt meditation at the Buddhist Temple in Cambridge. She correctly assessed my need for centering and greater inner focus that was answered by the discipline of meditation.

Margaret was also interested in the potential relationship between biofeedback studies and art therapy. It was a source of great pain and disappointment to her that, due to her age, research opportunities at the local universities were not available to her.

Another area in which Margaret was quite knowledgeable was psychic research. She believed implicitly in the existence of psychic phenomena. In fact once, when I left Boston somewhat suddenly to take a position assisting in a research project in Washington, D.C., Margaret consulted a psychic friend of hers about this development. She later told me that she knew I would return soon and indeed I did so in order to take my first job in art therapy in a summer program for disturbed children.

Margaret introduced me to a process of self-exploration that she considered vital to an art therapist's development. It involved a commitment to using one's own art for self-understanding, following a sequence of steps. After I had completed a free painting or scribble drawing, she instructed me to write in a looseleaf notebook any thoughts, feelings, or associations that came to mind. These included both the personal and the universal aspects of symbolism. The page was folded in half length-wise and the large margin reserved for later associations and insights. I have continued this process, although sporadically, for 10 years. It is an invaluable aid both to my art therapy work and to my personal growth.

Margaret was my mentor in the truest sense. Her participation in my life was the major influence at the formative time when I began my career. Her support and belief in me, as well as her teaching and emphasis on personal and professional discipline, have been the foundation of my development as an art therapist. Yet, as with any mentor, there are contradictions. For all of Margaret's vast knowledge and creativity, her serendipitous openness to ideas did not extend to people. She had few kind words for any other practitioners of art therapy. In fact, she advised me to focus my energies on my work rather than on personal relationships with others, which she felt would inevitably be disappointing.

It has always seemed highly paradoxical to me that a woman with the extraordinary insight into human behavior that Margaret showed in her clinical skills and writings would be so adamant about the dismal potential for human relationships. Perhaps this was the result of attitudes that she encountered in the era in which she herself lived as a determined, intelligent, professional woman struggling to create a new discipline and to gain recognition.

I shall never know with certainty the reasons for Margaret's advice to me not to bother with relationships, although I felt the echo of past pain in her words. For her and for all of us, the exclusive focus of her will and energy on her work produced the seminal writings and principles of art therapy. It seems a bittersweet legacy, containing within it not only the gift of art therapy but also the seeds for thought about the personal sacrifices women have often made in the process of contributing their knowledge and insight to society.

A Naumburg Bibliography

(1928). *The child and His world.* New York: Harcourt Brace.

(1943). Children's art expression and war. *The Nervous Child, 2*:4.

(1944). A study of the art expression of a behavior problem boy as an aid in diagnosis and therapy. *The Nervous Child, 3.*

(1944). The drawings of an adolescent girl suffering from conversion hysteria with amnesia. *Psychiatric Quarterly, 18.*

(1945). A study of the psychodynamics of the art work of a nine year old behavior problem boy. *Journal of Nervous and Mental Disease,* January.

(1945). Fantasy and reality in the art expression of behavior problem children. In N. D. C. Lewis & B. L. Pacella (Eds.), *Modern trends in child psychiatry.* New York: International Universities Press.

(1945). The psychodynamics of the art expression of a boy with tic syndrome. *The Nervous Child, 4*:4.

(1946). A study of the art work of a behavior problem boy as it relates to ego development and sexual enlightenment. *Psychiatric Quarterly, 20.*

(1946). *The art expression of a behavior problem boy and an adolescent schizophrenic girl.* (Annual meeting of American Psychiatric Association, Chicago.)

(1947). *Art therapy in diagnosis and treatment of behavior problem children* (Fifth Pediatrics Congress, New York).

(1947). Studies of the "free" art expression of behavior problem children and adolescents as a means of diagnosis and therapy. *Nervous and Mental Disease Monographs, 71.*

(1949). *The psychotherapeutic significance of the art productions of a college girl.* (Annual meeting of American Psychiatric Association, Montreal.)

(1950). *Schizophrenic art: Its meaning in psychotherapy.* New York: Grune & Stratton.

(1951). *The survival value of fantasy projection in art therapy.* (Annual meeting of American Psychiatric Association, Cincinnati.)

(1952). Spontaneous art in therapy and diagnosis. In D. Brower & L. E. Abt (Eds.), *Progress in clinical psychology.* New York: Grune & Stratton.

(1953). *Psychoneurotic art: Its use in psychotherapy.* New York: Grune & Stratton.

(1954). *The use of spontaneous art in psychotherapy.* (Annual meeting of American Orthopsychiatric Association, New York.)

(1955). Art as symbolic speech. *Journal of Aesthetics and Art Criticism*, July.

(1955). *Images and hallucinations of an alcoholic patient during art therapy.* (Annual meeting of American Psychiatric Association, Atlantic City.)

(1956). The relationship between Theo and Vincent Van Gogh, by G. Kraus (Amsterdam, The Kroller-Muller Foundation 1954). *Psychoanalytic Review. 25*:2. [Book Review]

(1956). *Stereotype and symbol in the art productions of an obsessive-compulsive boy.* (International Pediatrics Congress, Copenhagen.)

(1957). Art as symbolic speech. In R. N. Anshen (Ed.). *Language: An enquiry into its meaning and function.* New York: Harper Brothers.

(1957). *Art therapy in the treatment of a 17-year-old schizophrenic girl.* (Second International Congress of Psychiatry, Zurich.)

(1957). "Art therapy: Its scope and function" and "Art therapy with a 17-year-old schizophrenic girl." In E. Hammer (Ed.). *The clinical application of projective drawings.* Springfield, Ill.: Charles C Thomas.

(1957). Art therapy with a schizophrenic patient. (In collaboration with Kenneth E. Appel.) *Proceedings of International Congress of Psychiatry* (Zurich, Switzerland).

(1958). *Art therapy in the treatment of a depressed woman.* (Annual meeting of American Psychiatric Association, San Francisco.)

(1958). Religious symbols in the unconscious of man. *International Medical Record*, December.

(1959). *Art therapy in the treatment of a schizophrenic girl.* (Annual meeting of American Psychiatric Association, Philadelphia.)

(1959). The use of spontaneous art in analytically oriented group therapy of obese women. *Proceedings of International Group Therapy Association*, (Zurich, Switzerland).

(1960). *The power of the image: Symbolic projections in art therapy.* (Annual meeting of American Psychiatric Association, Atlantic City.)

(1961). Discussion of the findings. In E. F. Hammer (Ed.). *Creativity*. New York: Random House.

(1961). Expanding non-verbal aspects of art education on the university level. *Journal of Aesthetics and Art Criticism, 19*:4.

(1961). *La magie du dessin: Du griffonage automatique au dessin thérapeutique* (The magic of drawing: Concerning automatic scrawls in therapeutic drawing) by Jean Vichon (Bruges, Belgium: Desclee de Brouer, 1959). *Psychoanalytic Quarterly, 30*:1.

(1961). *Shapes of sanity*, by Ainslie Mears (Springfield, Ill.: Charles C Thomas, 1960). *International Journal of Group Therapy*, October. [Book Review]

(1961). The need of a more creative orientation in universities and colleges. *Bulletin of Art Therapy, 1*:2.

(1961). *The role of spontaneous art in education.* (New York: Loeb Student Center, New York University.)

(1962). Spontaneous art, creativity and psychotherapy. In L. E. Abt & B. F. Riess (Eds.). *Progress in clinical psychology.* New York: Grune & Stratton.

(1963). If this be madness: A study in psychotic art, by Jean Cocteau, Georg Schmidt, Hans Steck, and Alfred Bader (London: Thames & Hudson, 1961). *Bulletin of Art Therapy, 2*:3. [Book Review]

(1965). Spontaneous art in education and psychotherapy. *Bulletin of Art Therapy, 4*:2.

(1965). *The role of spontaneous art in psychotherapy and education.* (Annual meeting of American Psychiatric Association, New York).

(1966). Art from the mentally disturbed, by J. H. Plokker (Boston: Little, Brown & Co., 1965). *Bulletin of Art Therapy, 5*:3. [Book Review]

(1966). *Dynamically oriented art therapy: Its principles and practice.* New York: Grune & Stratton.

(1966). The nature and purpose of dynamically oriented art therapy. *Psychiatric Opinion, 7*, Spring.

(1967). Discussion (of "Recovery, Repression, and Art" by Stewart R. Smith, Lee B. Macht, and Carolyn C. Refsnes). *Bulletin of Art Therapy, 6*:3.

(1967). The artist in society: Problems and treatment of the creative personality, by Lawrence Hatterer (New York: Grove Press, 1965). *Bulletin of Art Therapy, 6*:3. [Book Review]

(1968). The psychology of children's art, by Rhoda Kellogg with Scott O'Dell (San Diego: CRM, Inc., 1967). *Bulletin of Art Therapy, 7*:3. [Book Review]

(1968). *The universality of sexual symbolism.* (Part of "Aspects of Art Therapy" exhibition, American Psychiatric Association, Boston.)

(1969) Studies in psychiatric art, by R. W. Pickford (Springfield, Ill.: Charles C Thomas, 1967). *Journal of Orthopsychiatry*, Spring. [Book Review]

Paul-Max Simon: The Father of Art and Psychiatry

John Monroe MacGregor, PhD

John Monroe MacGregor, PhD, is a lecturer in the psychology of art, Ontario College of Art, Toronto. This article will appear as a chapter in Dr. MacGregor's forthcoming book, The Discovery of the Art of the Insane.

The enormous productivity of Cesare Lombroso, the range of his interests and knowledge, as well his contribution to criminology and anthropology, have led to a temporary overestimation of his achievement in the investigation of the pictorial productions of the mentally ill. His fame and notoriety—even in his own day—have obscured the fact that the first psychiatrist to undertake a serious and extensive survey of the drawings and paintings of the insane was a little-known French alienist, Dr. Paul-Max Simon. Simon's contribution is to be found in two articles: "L'Imagination dans la folie" (1876), and "Les Ecrits et les dessins des aliénés" (1888).[1]

This article, devoted to Dr. Simon and his work, corrects the erroneous belief that Lombroso's investigations preceded those of Simon, and attempts to establish Simon's right to the title, Father of the Study of Psychiatry and Art.

An artist himself, Simon was less inclined to associate creativity with pathology.

It might have been preferable to examine Lombroso's work prior to a discussion of that of Simon, simply because the unusual nature of Simon's achievement is best understood against the background of the Romantic conception of genius and in contrast to the later and more simplistic views of Lombroso. The persistence of Lombroso's perverted conception of genius, as well as his generalizations about "insane art," continue to prejudice the reader of psychiatric and psychological investigations of art to this very day. It remains necessary to perpetually slay the Lombrosian dragon before beginning any serious discussion of the art of the mentally ill.

Simon's Contemporaries

The few existing references to the origins of this field of investigation have described Lombroso as the innovator who first studied the art of the insane. This error resulted from a failure to recognize the date of Lombroso's earliest publications dealing with the art of the hospitalized insane. For this article it is important to establish the year in which Lombroso first published the chapter on the art of the insane, entitled "L'arte nei pazzi," which forms part of his book *Man of Genius.*

Man of Genius first appeared in 1864 in a far shorter version and with a different title, *Genio e follia.* This essay appeared again in 1872 and 1877. Then, in 1882, a fourth edition appeared, much enlarged, and bearing the new title, *L'uomo di genio* (*Man of Genius*). The crucial chapter on art of the insane was a new addition to this revised edition. It was included because in 1880 Lombroso had published, with Maxime du Camp, an article entitled "L'arte nei pazzi" in the periodical, *Archivio di psichiatria e scienze penali* (Lombroso & du Camp, 1880). It was this article that was then added to the revised fourth edition of *L'uomo di genio.* As a result, Lombroso's work with the pictorial productions of psychotic patients, usually understood as beginning in 1864, actually began in or around 1880, some 4 years after the publication of Simon's pioneering article, "L'Imagination dans la folie" (1876).

Simon's only significant predecessor is now seen to be the physician, Ambroise-Auguste Tardieu (1818–1879), who had published a brief discussion of the work of two patients in 1872. The uniqueness of Tardieu's early contribution is established by the fact that a patient's drawing was reproduced in a psychiatric publication accompanied by the patient's explanation of its meaning, and, perhaps more importantly, by a detailed description of the forces that led to its creation.

---

[1] "L'Imagination dans la folie: Etude sur les dessins, plans, descriptions, et costumes des aliénés," was published in *Annales médico-psychologiques* in 1876. No reproductions of the works discussed accompanied the text. "Les Ecrits et les dessins des aliénés" was published 12 years later in *Archivio di antropologia criminelle, psichiatria e medicina legale* in 1888. This article included a lengthy discussion of the writings of the mentally ill, both in terms of graphological analysis and content. The discussion of drawings was essentially identical to that of 1876, except that several new cases had been added, a new section on "délire érotique" was included, as well as a discussion of a number of prominent artists who had become insane. The text was now illustrated. All quotations from Simon's writing are from the article of 1876 unless otherwise indicated.

Tardieu's book, *Etudes médico-légales sur la folie* (1872), was the work of a highly respected French psychiatrist who had devoted himself to the study of mental illness from the beginning of his career. He possessed unusually extensive firsthand knowledge of the behavior and mental processes of hospitalized patients. His particular concern, and the subject of a long series of publications, was the problematic "no-man's-land" between psychiatry and the law. As in our day, the possibility of utilizing a diagnosis of insanity as a means of removing individuals who were critical of, or hostile to, the reigning social order posed a serious threat to the liberty of many people, as well as a challenge to the integrity of the medical profession. Then as now, physicians could always be found to testify to the sanity, or lack of it, of accused individuals. Tardieu's intent in writing his *Etudes* was to establish objective criteria for a legally acceptable diagnosis of insanity. An examination of the complex relationship between the functions of the physician and the more mundane concerns of the legal profession, Tardieu's scholarly discussion of the problem had considerable influence and established him as one of the more prominent psychiatric authorities in France.

Tardieu's involvement with the pictorial productions of mentally disturbed individuals was minimal. He was only led to examine this material because in some instances drawings and paintings might be used in the courtroom as evidence of a person's mental condition. His book included a brief outline of what he felt to be the basic characteristics of the graphic productions of the insane. The minor importance of this aspect of patient behavior to the task of diagnosis as it was understood at the time did not lead Tardieu beyond the most superficial observations and, in fact, he was guilty of obvious oversimplification and exaggeration, which his direct experience with patients might have been expected to prevent.

> No matter how hard you may try to imagine fantastic and impossible things, or the most bizzare images, you will never succeed in conceiving of the type of insane image which presents itself on canvas at the hand of a madman, those nightmare creations which make you dizzy (Tardieu, 1872, p. 94).

Tardieu's interest in patient art and his overly dramatic view of the material was seemingly inspired by his encounter with a patient whose work he followed over a long period of time. His regrettably brief reference to the work of this individual is important because it represents the first effort to describe the style and subject matter of drawings and paintings in the context of a specific case. He wrote:

> For many years I have been able to observe a patient who though he had no talent whatever, spent all of his life in painting. I have seen more than five hundred of these pictures, some of quite large size. They reveal the wildest associations of color, green or scarlet faces, unusual proportions, yellow skies, extravagant effects of light, monstrous beings, fantastic animals, senseless landscapes, unrecognizable architecture, infernal flames; all expressing through unique forms, dreams of the most indescribable nature (Ibid).

It is evident that these powerful images produced in such large quantity by a single artist molded Tardieu's conception of the artistic productions of the mentally ill. What would we not give to have those 500 paintings today! His description of them seems to range over much of the art of the 20th century, calling to mind the creations of one major artist after another. The work of this anonymous patient inevitably awakens thoughts of the Fauves, of Gauguin, van Gogh, and of the Surrealists, all of whom were so soon to trouble the sleep of French art and to make the critics "dizzy." Was this patient who spent his life at the easel perhaps another Rousseau? We will never know; no reproduction of his work was provided in Tardieu's text and his name was never mentioned.

Before condemning Tardieu for lack of perception or sensitivity, it is essential to remember the prevailing aesthetic criterion of his day with its insistence on a rather restricted naturalism. The experience of the Impressionists, whose first exhibition was to open 2 years later in 1874, indicates how conservative even the most advanced critical opinion was. They too were labeled insane and their art degenerate. Tardieu lacked tolerance for distortion in the service of expression, a tolerance that we have only developed as a result of innovations in art that occurred at the beginning of the 20th century. It is not likely that a physician raised in the environment of the Salon and the French Academy, schooled to appreciate the realism of Meissonier (1815–1891), Gérôme (1824–1904), and Bouguereau (1825–1905), would be in any position to accept the radical expressive means utilized by this unknown painter. Nevertheless, the dramatic language that Tardieu employs, as well as the fact that he apparently followed the patient's work over several years, tends to suggest that on some level his interest had been caught and that he reacted with excitement to the imaginative world that unfolded in those 500 paintings. In terms of his stated goal, "to demonstrate the importance of the writings and drawings of the insane from the point of view of determining their mental state," it was not necessary that he understand his patients' efforts at communication, or that he react emotionally to the intensity of feeling that undoubtedly motivated the creation of the pictures. In his desire to provide the necessary evidence for a diagnosis of insanity, Tardieu tended to exaggerate the bizarre characteristics of drawings. He

The first report of the production of a drawing made "under the eyes" of a physician was made by Simon.

suggested, for example, that the majority of patients display a preference for erotic or obscene subject matter, a generalization that was later challenged by Paul-Max Simon.

It is Dr. Tardieu's second case that is of unique importance to us. He reproduced, without comment, a drawing made by one of his patients (Figure 1, Tardieu, 1872). Although he took the unusual step of including the patient's explanation of his own drawing, not because he felt the patient's description was of significance in understanding his behavior, but because the written description confirmed his own diagnosis. We are brought closer to the reality of the individual who produced the drawing, and we are able to sense the intensity of the needs that forced him to go on drawing to the point of total exhaustion. He describes his work as the result of divine guidance, an example of automatic drawing analogous to the more familiar phenomenon of automatic or mediumistic writing. The artist's description is presented below:

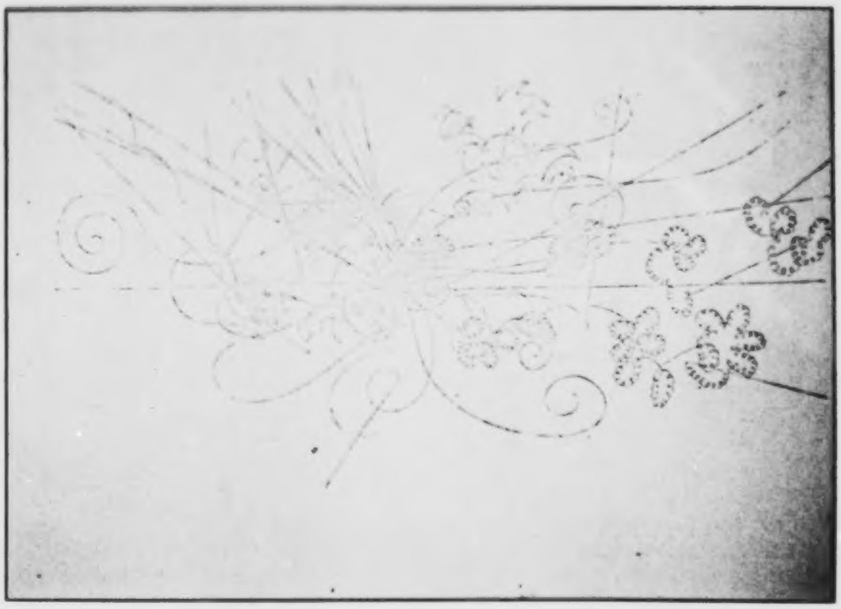


Figure 1

The Soul of The Earth[2]

> On several occasions during the last three weeks I have put pen to paper at God's disposal. He guided it in producing the drawing of which an example is here provided. It is in this way that I was able to perceive the aromas. Because the aromalized magnetism of Mrs. H. is a compound which does not occur on Earth, except in her organization and my own, the Soul of the Earth could not induce the fluids to leave her head, except by directing them towards me. Also, in order to deceive them, it was necessary to draw Octavie's head on the paper signaling them to approach. (These instruments of a super-human mentality are almost thinking beings.) In truth, this rough portrait sketch was completed on the left side by a sphere which quickly repelled them. The Soul of the Earth caused me to follow their movements with my pen on the paper, and the electricity of the ink absorbed the fluids which had already been more or less completely denatured. If you examine the drawing which our ray-god-of-souls himself traced upon the wood, you will see that the feminine aroma is still recognizable in the several jets which emerge from Octavie's head and breast. Each of these ring-like forms represents, more or less exactly, ten fingers of a ray-god-of-souls; this however, is no longer the superior feminine aroma, as it issued, all jagged, from our speaking trumpet. Those fluids which are neither utilized nor neutralized decompose. Almost all those which emanate from Octavie's head in the engraving, retain nothing of the aroma referred to as feminine, but the straight line corresponding to its sudden escape after six groups of tight convolutions, at which point it is functioning normally. The others obviously aspire to the coiling up of the neutral electricity. These latter were obscured in my drawing. As for the others, still alive, I was often obliged to follow their movements with my arm even beyond the edge of my table. I directed them, following the instructions of the Soul of the Earth, towards the fire in the chimney, a hearth of energy where they disappeared. The best preserved of all the aromas, among those which I have included in my drawing, is the aromalized magnetism, a shower of leaping crescent forms. They originate from the reduction to which my wife's spiral had to submit in order that the lid would remain on her head. This aroma, of exceptional strength, was the most tiring for me to follow. The engraving included in this book reproduces one of the least intense aromal therapy sessions. It has happened on occasion that in carrying out this exercise, the piece of paper has been entirely covered with ink, and has been torn to pieces beneath my pen, leaving my arm totally exhausted (Tardieu, 1872, pp. 101-103).

This lengthy and complicated description by a severely disturbed patient of the creative process involved in the making of his drawings is one of the most interesting documents in the study of spontaneous or automatic expression in the 19th century. Curiously, no later references to it occur in the literature of the period. The drawing consists of a variety of elegant curved, zig-zag, straight, and convoluted lines proceeding from the head and breast of a female figure designated by the patient as "Octavie." These calligraphic lines are explained as representations of different kinds of aroma, or possibly of magnetic currents; the term used is *magnétisme aromalisé*. Executed at the bidding of a super-human being, "the Soul of the Earth," the drawing seems to have had the function of influencing or attracting the magnetic odors. In this respect, the act of drawing can be seen to have had a magical purpose. Despite the occasional obscurity of the passage, one senses an effort on the patient's part to account for his activity in a coherent fashion. His experience of intensely felt external compulsion suggests the reality of the forces that prompted him to draw. His effort to describe what was happening to him may imply that he was concerned to make contact with the people around him.

---

[2] The translation presented considerable difficulty in determining which of a number of possible meanings the patient may have intended for many of the words.

Again and again these artists, dismissed as mindless, tried to explain the significance of their work and the inner promptings that led to the creations. The failure of physicians such as Tardieu to take these explanations into account explains the long delay in attaining even a minimal degree of insight into the relationship between the life experience of these individuals and the graphic productions they inspired. For much of the 19th century the most valuable writing about the image-making activity of the insane was that done by the patients themselves, although the importance of this readily available material went unrecognized and, for the most part, unpublished. The contribution of intelligent patients to the understanding of psychotic expression was to provide the most promising source of insight, once investigators found the courage to listen. But the psychiatric stance of physicians in the latter half of the 19th century stood in the way of understanding, or even of truly seeing or listening. Although burdened with this "scientific" point of view, Paul-Max Simon nevertheless was to achieve far more than his predecessor, Tardieu, in his systematic attempt to understand the art of the insane.

Simon's Background and Training

Paul-Max Simon, Médecin adjoint at the asylum of Blois, and later Director of the Asylum of Bron, is a figure about whom little is known. (A complete Simon bibliography can be found in the catalogue of the Bibliotheque Nationale Paris, 173:275–279.) His studies of the art and literature of the insane convey the impression of an original, highly organized and sensitive mind able to function in new and rather chaotic territory.

His involvement with the art and literature of his patients was the outcome of his curiously old-fashioned medical ideals, combined with a scientific orientation that was surprisingly forward-looking. Although it would be erroneous to assume that all 19th centûry alienists emerged from the same mold, it is important to obtain some insight into the self-image of a physician whose clinical interests were as unconventional as Simon's.

Simon's identity as a doctor was constructed around his idealized image of the physician as a "médecin-gentleman." Thoroughly trained in his chosen calling, this physician "worthy of the name" was to be an "homme du monde."

> A man of the world, and of the best society, a refined spirit, appreciative of things artistic and literary, whichever suits him. In sum, a person of superior nature, and of inherent distinction, subtle, but with the large heart and ardent faith of a true Christian (Simon, 1895, p. 202).

Simon's insistence that his ideal physician be "a man of letters" derived from his own extensive involvement with literature. An artist himself, Simon was less inclined to associate creativity with pathology.

Between 1864 and 1903, Simon published a series of novels, short stories, and literary investigations that drew upon his experience as a physician working with the mentally ill. One might almost speak of a second career, or, were his varied abilities not so well integrated, of a split personality. Unusual even among men of letters in France at this time, Simon had an extensive acquaintance with English and American literature, publishing a number of critical studies in this area. The most important of these, his book on Jonathan Swift, is subtitled "A psychological and literary study" (Simon, 1893). His discussion of Swift's life and work, based on a surprisingly detailed knowledge of the critical and biographical literature, is exceptional in presenting a generous and human picture of Swift, free from any of the weaknesses of pathographic investigation. Despite the fact that Swift died insane, Simon insists on the absolute sanity of his writings, and on the mental stability of the man until the final years of his life. Having arrived at a tentative diagnosis of Swift's condition as epilepsy, possibly complicated by Menière's Disease, Simon (1893) concluded:

> The intellectual value of such men is neither denied, nor even contested, and I repeat, the disease from which they suffer [epilepsy] in no way prevents them from accomplishing their work. None of them was as a result of it either less wise as a politician, less of a genius as a tactician, or a less great writer (p. 104).

The distance between this point of view and that expressed on every page of Lombroso is infinitely great. Simon's goal was "to portray the man as a living personality," and not in terms of a literary ideal or of a stereotyped and romanticized conception of artistic genius.

Simon's memoirs, Temps passe: journal sans date (1895), provide a detailed account of his friendships with prominent writers of the day. If Lombroso's contribution was marred by the distorted influence of Romanticism, Simon's was undoubtedly enhanced if not engendered by his involvement with Realism as a mode of perception. One of Simon's friends was the writer Gustave Flaubert (1821–1880). When as a young man Simon told Flaubert of his decision to become a doctor, Flaubert was furious. He was only reconciled to the idea when Simon explained that his

For much of the 19th century the most valuable writing about the image-making activity of the insane was that done by the patients themselves . . .

intention was "... to become physician to an asylum in order to have at my disposal the numerous scientific facts which are readily available in a vast institution for the insane ...." (Simon, 1895, p. 11). It is clear that Simon's style as a writer, as well as his clinical outlook, was influenced by Flaubert's obsession with objective observation. Writing of his friend many years later, Simon described his attitude toward the task of the writer:

> An essential characteristic of the writer, particularly of the novelist was, according to Flaubert, impersonality. The novelist must see things from afar, hovering above it all, espousing no cause as his own, affiliated with no theory or point of view: observation, artistic truth, and nothing more (p. 14).

This is precisely the attitude at work in Simon's case histories, in his objective descriptions of his patients' fantasies or artistic productions.

Simon's Philosophical Position

Simon's attitude toward genius is a further expression of the Realist position. His goal in writing his memoirs was to function as "a simple spectator." Describing his many encounters with men of unusual ability, at times approaching "genius," he never succumbed to destructiveness or petty gossip. He deliberately avoided psychological speculation about genius, and looked upon the activity of pathographers with distaste:

> I am always astonished by the relentless eagerness with which they pursue men of genius. It seems that they feel a personal hatred for them; the revenge of the mediocrity of the eternally envious crowd. This is still more odious and despicable because, although geniuses assuredly suffer from all the weaknesses of other men, most of them are kind, generous, and charitable, to the point of self injury (1895, p. 29).

Without mentioning the name of Lombroso he criticizes his approach. "In recent years, an effort has been made to see genius, and even talent, as a derivative of insanity. As proof of this position they refer to the originality of the majority of great men. Is this convincing? No" (p. 36). In opposition to the imaginative inventions of pathography, Simon was devoted to the scientific method, and to accurate observation. He speaks in his memoirs of the danger of:

> ... wanting to leave the circle of direct observation in order to throw oneself into the unbounded fields of speculation; of wanting to include everything in an overall view of the whole, and of thereby losing one's way; believing oneself to be standing on the solid ground of experimental philosophy so precisely defined by Newton, and of venturing, all unknowing, into the territory of pure metaphysics (1895, p. 29).

Simon's accomplishment resided in his ability to limit himself to the role of observer. It was not given to him to go further.

Simon had discovered that these random scrawls were in fact a language.

Although the existence of spontaneously produced drawings and paintings by mental patients had often been commented upon throughout the 19th century, it was Simon who recognized their unique importance, and who first developed systematic methods of studying them. The originality and difficulty of this step cannot be overemphasized. It is one thing for a physician to mention that his patient is indulging in a symptom of one sort or another, to characterize this form of behavior as bizarre or "insane," and then to pass on, unaware that this activity might possess a significance of its own, or that a closer examination of it might even provide a key to the deeper understanding of the human mind. To go further demands a tolerance of chaos, an ability to co-exist with deep and pervasive irrationality, and to "listen" attentively to words and images that by their very nature can at times inspire fear and even revulsion. It is no small matter to take as an object of study a subject traditionally seen as unworthy of attention, or as the insignificant and meaningless product of a sick mind. Simon's achievement lies in his decision to enter into this chaos and to begin the task of imposing order.

Two sources motivated him in his decision to proceed with such an undertaking, and provided him with his methodology. Studies of the literary productions of the mentally ill, and graphological investigation of the links between handwriting and personality had awakened his interest in the possibility of utilizing a similar approach to both the content and the formal aspects of so-called insane art.[3]

The primary task that Simon set for himself was to attempt to describe and classify the drawings in his collection in terms of the standard nosological groupings in use at the time, making extensive and careful use of case material to illustrate and confirm the observations. This preoccupation with classification and diagnosis can be seen as a logical extension of the systematic effort to describe and classify all types of symptomatic behavior and ideas that characterized much of 18th and 19th century French psychiatry. It should be remembered that our discussion of the origins of the psychiatric study of art in the 19th century is concerned, for the most part, with what Henri F. Ellenberger has termed *official* or *non-dynamic* psychiatry. In his brilliant book, Ellenberger (1970) traced the early development of a whole new school of French psychiatry that undeniably represented the path into the future. It is significant that the men who made the earliest contributions to the investigation of the psychopathology of art did not belong to this promising psychiatric underground. As we will see, the preoccupation of official or neurological psychiatry was less with the development of methods of therapy or cure, and more involved with the systematic description of disease entities. On the other hand, it is this attachment to objective description and classification that distinguishes Simon and separates him from scholars such as Lombroso, whose manipulation of facts betrays a deep fear and hatred of genius, as well as a need to keep the insane as far from himself as was necessary to avoid any possibility of contamination. This was the ultimate purpose of the concept of degeneracy. Lombroso's orientation was derived from the Romantic attitude to genius and to insanity. But his conception of genius as a form of psychosis interfered profoundly with his examination of the visual images produced by his patients.

---

[3] Well before Freud had made such studies acceptable, Simon published a book entitled *Le Monde de rêves* (1882). Having decided, as a result of his studies in art and psychiatry, that hallucinations were a significant factor motivating the artistic productions of his patients, he proceeded to investigations of both auditory and visual hallucinations: *Les Invisibles et les voix* (1880) and *Sur l'hallucination visualle* (1880).

Simon was surprisingly free of the Romantic preconceptions that were to hinder Lombroso. He was under no obligation to glorify the pictures that he collected in the hospitals in which he worked as the creations of genius. He never used the word *art* in referring to the drawings or paintings of the mentally ill that were available to him, and, in fact, he constantly refers to their lack of artistic significance. It is to his credit that he sought to investigate the expressive activity of his patients in the absence of any belief in their artistic ability. In this respect, as in so many others, he reveals the objectivity of the scientific observer. Although it is doubtful that his interest in the drawings of these people was motivated by any therapeutic considerations beyond diagnosis, his approach to the drawings represents the beginning of a method of investigation still utilized today. His conviction that drawings betray characteristic features that can be used as a means of psychiatric diagnosis remains one of the essential assumptions implicit in modern diagnostic techniques that utilize drawings—the Draw-A-Person Test, the House-Tree-Person Test, and the Draw-Your-Family Test.

One of the most extraordinary features of Simon's research was his insistence on discussing not only the paintings and drawings of the patients, but also the improvised costumes they wore. He even carried his study into the patients' inner world, collecting and describing imaginary visual experiences reported by his patients, visions and hallucinations that he understood as the basis for many of the pictures they produced. Simon was aware that there was a common source underlying all of the patient's imaginative creations. The lengthy presentation of "verbal descriptions," what he referred to as "artistic conceptions not embodied in drawings," indicates his belief that these purely mental images are the origin of the less complex, but more concrete, costumes and pictures. Simon was the first to convincingly establish a connection between the ideas and delusions of the patient and the graphic productions that attempted to serve as the externalized expression of those ideas. The patient was now seen as attempting to communicate, a discovery that gave a new significance to the "random scribbles" of the insane.

The recognition of the element of communication as an aspect of the patient's image-making activity may have come about as a result of Simon's involvement in the creative process as an observer. The first report of the production of a drawing made "under the eyes" of a physician was made by Simon! It survives in a note that accompanied a set of drawings sent by Simon to Lombroso. The drawings, which Simon refers to as "Arabesques," were done by a 26-year-old patient in the Asylum of Vaucluse suffering from what Simon describes as "folie circulaire" (manic-depressive psychosis). Simon describes how he watched the patient for 10 minutes, during which the two drawings were produced.

Simon's Findings

There is little to be gained today from an examination of Simon's various nosological classifications and the type of drawing he associated with each. Changes in psychiatric terminology and in the conception of the various disease entities have consigned the majority of Simon's conclusions to the realm of purely historical interest. Simon added nothing new in the way of diagnostic categories. Following the standard system of classification of his day, he discussed the drawings under the following headings: *Lypemania*, distinguishing four sub-varieties—*lypemania generaux, aigus, stupides, anxieu; manie chronique; megalomanie; paralysi generale; demense; les imbeciles;* and in 1888, *delire erotique*. His method of approach, however, and his general attitude to the drawings were eventually to influence later workers and are therefore of considerable importance in reconstructing the first efforts to explore the graphic productions of the mentally ill. For the purpose of discussing Simon's methodology, we will confine ourselves to an examination of his conclusions in regard to the drawings of patients suffering from delusions of persecution and *manie chronique*, a continuing psychotic state, in most cases to be equated with one form or another of schizophrenia. All discussions of the drawings of the mentally ill in the 19th century restrict themselves to the work of clearly psychotic patients, including under this classification the drawings of people suffering from organic brain diseases, particularly syphilis of the brain (*paralysie générale*), epilepsy, and mental retardation. The neurotic illnesses were not included in any discussion of patient art in this period.

To admit that a single patient was capable of a variety of styles was a unique, but at the same time disturbing discovery . . . .

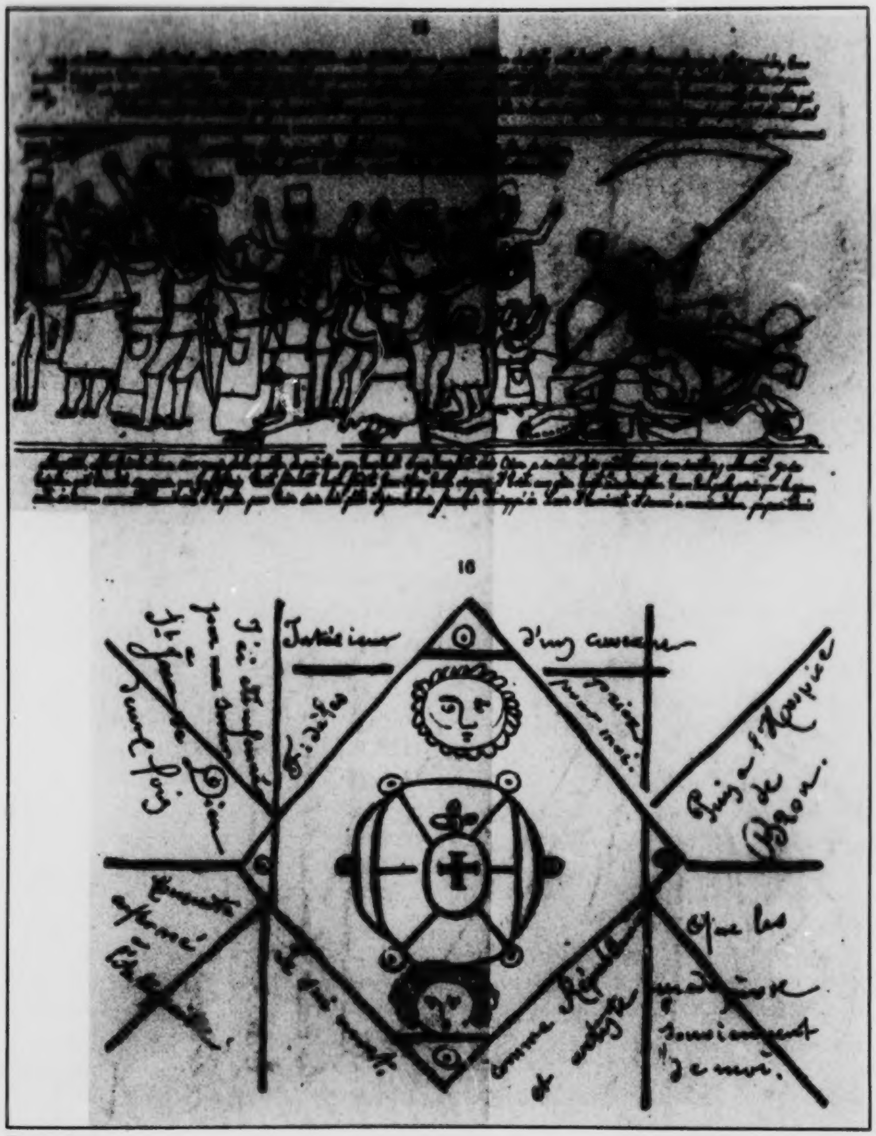


Figure 2

Les Persécutés

Simon was particularly interested in the production of patients who experienced delusions of persecution as an aspect of their illness. In his two articles he grouped these individuals together, classifying them as *les persécutés*. He distinguished these cases from those in which ideas of persecution were accompanied by megalomania, in the conviction that delusions of grandeur usually represented a later development in the course of the illness.

> Megalomania includes a whole series of forms of insanity among which the patients' delusions of grandeur are obvious to even the most inattentive observers. This form of delusion commonly follows upon the development of ideas of persecution; at times, however, ideas of persecution only become apparent as a secondary factor (Simon, 1876, p. 370).

From the case descriptions provided by Simon, it seems that the majority of his patients were suffering from some variety of paranoid schizophrenia.

In his discussion of the drawings of *les persécutés*, Simon was concerned primarily with subject matter. The only observation contributing to the analysis of form is the statement that the pictures are usually complete compositions or little dramatic scenes.

> The artistic productions of *Les persécutés* have a completely unique character, closely related to the ideas which this type of patient ordinarily displays. They are commonly pictures in the complete sense of the word, little compositions, of doubtful value of course when considered as drawings, but very interesting for the physician and the psychologist (Simon, 1876, p. 360).

Simon's major theoretical contribution was his recognition that the subject matter of many of the drawings could be related to the specific ideas that preoccupied the patients. He emphasized that the subject of the drawings is closely related to the patient's delusional system. "You can see that they are closely related to the delusions of the patient, that they are nothing but what one might call the images of his expression (*l'expression imagée*) (Simon, 1888, p. 337). His recognition that the drawings were an externalization of their delusional preoccupations was to attract the attention and interest of future students, including, of course, Lombroso.

The cases presented as characteristic examples of les persécutés are disappointing as depictions of the terrible persecution of which these patients believed themselves to be the object. They are of two kinds. In the first type the patients illustrate "their misfortunes, the torments which they have endured, and the persecutions of which they imagine themselves to have been the object" (Simon, 1876, p. 360). The case of Monsieur Dupont best represents this illustrative tendency. "Sometimes it is a court of law before which an accused man is pleading, who is no one else but the patient himself. At other times, a landscape surrounded by rocks among which one sees an injured lion, birds, and animals of bizarre form surrounding the composition which is surmonted by the scales of justice. Here too, the patient is to be found at the center of the picture" (Simon, 1876, p. 361). In the article of 1888, an extremely interesting picture by

BEST COPY AVAILABLE

Dupont was reproduced. It depicts the figure of Death, armed with a scythe, slaying the evil and perverse people of the world, presumably to be identified with the enemies of the patient (Figure 2, top; Simon, 1888, p 337). The picture is accompanied by an extensive written commentary which, unfortunately, is not clear enough to read. The subject, well known in the history of art, is the so-called triumph of death. In the famous fresco in the Camp Santo in Pisa, Death appears with a scythe cutting down wealthy citizens and wicked members of the clergy. In that version Death is depicted as a witch flying in the air, rather than as a skeleton. Death as a skeleton is typical of the "Dance of Death" engravings that could easily have been available to the patient.

The illustration of Dupont's work makes it clear that French patients were also influenced by visual material in their environment. Here too the historical style of the period is as evident in the work of psychiatric patients as it is in the work of recognized artists. We are reminded as well of Lombroso's speculations concerning a possible stylistic "regression," which he referred to as an "atavistic tendency" in the productions of some patients. Investigation of the sources of the patient's imagery, particularly of the religious images that formed a part of his home environment, might have suggested a simpler solution to the problem of this curious reversion to earlier styles.

A passage in Simon's memoirs makes it clear that his knowledge of the history of art was more than sufficient to enable him to recognize the contribution of religious art to his patients' imagery.

> Christianity, that great revelation of the quality of all men, had sculpted on the porches of its cathedrals, or painted on the walls of its cloisters, various scenes of that terrible myth in which one sees kings, potentates, popes, *manants*, and all the skeletons of those obsessed with hopeless desires. Physicians participate every day in the realization of this fiction in art (Simon, 1895, p. 116).

It is a tribute to his humanity that he was able to admit that he too saw in this scene an aspect of his own reality, although it was not that of the patient. It was this ability to use his own subjectivity to sense aspects of an inner reality within seemingly alien images that was to lead to the possibility of much deeper understanding.

Dupont's personal style is related to children's drawings of the period. This is to be seen in the choice of either full frontal views or profiles, the raised arms bent at the elbow in every case, as well as the emphasis on rows of buttons, aprons, and pockets, all of which appear in contemporary children's art. It is a style that in terms of its simple and direct narrative quality recalls the popular engravings of the period—inexpensive prints that were widely available.

All of the remaining cases displaying delusions of persecution exemplify a second feature that Simon felt was characteristic of this group of patients, the use of symbolism or allegory. Lombroso later associated this feature with all of the drawings of the insane. Simon distinguished two different types of symbol; those that possess a generally understood meaning—"Again, sometimes it is traditional emblems which they represent: the lion as a symbol of strength, the scales representing justice, symbols of salvation, etc."—and symbols whose meaning was known only to the patients (Simon, 1876, p. 360). The crucial point is that he realized that they did possess meaning at least to the individual who made them. The investigation of recurring symbols was to provide the first indication that the drawings of patients might possess a symbolic significance which, with effort, could be interpreted and understood. It was not possible for Simon to proceed very far in this direction; however, the majority of the images that he encountered belonged to the second type of symbol, those with a meaning known only to the patient, if even to him or her. For example, he described a case in which the patient produced writings interspersed with crosses, triangles, and signs of every sort to which their creator attached private meanings.

The use of diagrams as a means of representing symbolically one's experience was illustrated by Simon by the case of a musician confined in the asylum of Bron. He described the man as "representing the circumstances of his life by a sort of emblematic schema" (Figure 2, bottom; Simon, 1888, p. 337). Here again, he was aware that the patient's intention was to convey something about himself through the use of symbols.

Mégalomanie

In the discussion of cases characterized by delusions of grandeur—mégalomanie—Simon's formulations are of greater interest. He was aware that this symptom could occur in a number of different psychiatric illnesses. He shows an unusual awareness of the relationship between delusions of persecution and megalomania, and he attempted to formulate a principle that would indicate the influence of this relationship upon the drawings of patients.

> In that delusions of grandeur form the basis of the delusional ideas of the patients with whom we are concerned at the moment, it is natural to assume that their drawings would deal with ambitious schemes, designs for palaces, cathedrals, machines, and gardens, and these are in fact the ordinary subjects of their compositions (Simon, 1876, p. 371).

Simon suggested that the relative intensity of the delusions of persecution was closely related to the uniqueness and elaborateness of the patients' artistic conceptions, taking into account the imaginative powers prior to the onset of their illness, as well as their earlier experience and possible training in art.

Careful formulations such as these demonstrate Simon's superiority to Lombroso. Free of the assumptions relating insanity and genius, free of the necessity of demonstrating the emergence of genius in response to the onset of mental illness, he could examine the productions of his patients with far greater objectivity. He did not exaggerate the talent of these individuals. Rather, he indicated clearly the necessity of studying their work in an effort to obtain greater

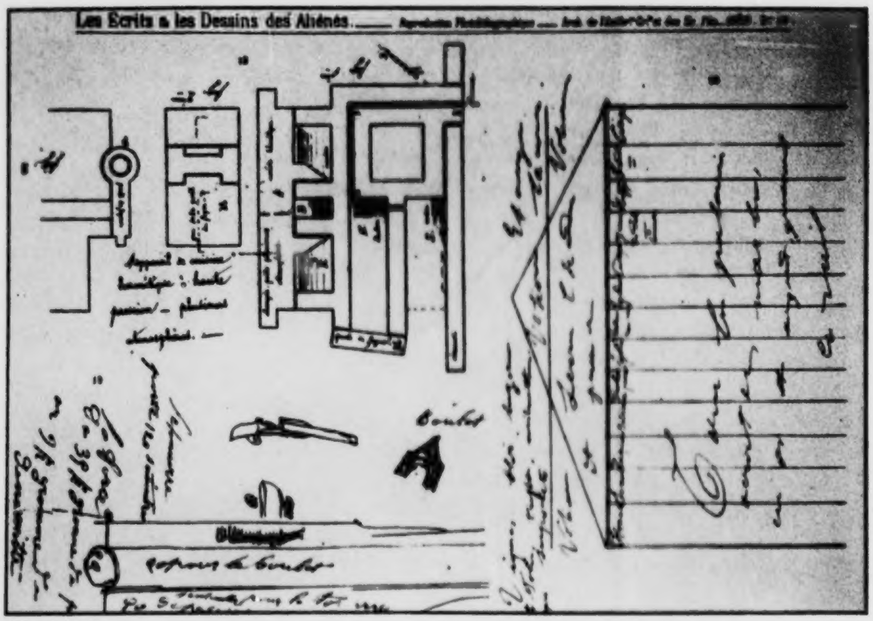

Les Ecrits & les Dessins des Aliénés

Figure 3

understanding of their illnesses and of their personalities prior to its commencement. He speaks of the "imagination of the patient which forms the subject of our investigation." In a very real way he had begun the task of exploring the relationship between the patient's inner experience, his or her ideas and internal images, and the drawings in which this inner reality found expression.

Les Ambitieux

The analysis of the drawings of *les ambitieux* concerns itself more specifically with formal problems. He postulated a relationship between the systematized, reasoned quality of their delusional ideas, and the clarity and precision of the drawings.

> We observe in all the drawings, as in the form of insanity which engenders them, a regularity, a logical character, and if I might risk saying it, of correctness, despite the fact that the conception which they reproduce is thoroughly mistaken and completely fantastic (Simon, 1888, p. 341).
>
> It would be easy for me to show by a greater number of examples the ambitious character of the drawing, its coordination, and if I might put it thus, the correctness of the lines from which it is formed, remain constant (p. 341).

An extremely interesting case displaying these features is presented in the article of 1888. The patient, resident in the asylum at Bron, had been trained as a draftsman prior to his illness.

> He is an inventor, and since he has been at the asylum of Bron, he has presented me with a number of designs, drawings of machines sufficient to compose a voluminous album. In that this patient was in earlier days a competent draftsman, his plates, characterized by the most complete insanity, are at the same time characterized by an absolute correctness of execution, offering to the eye a markedly harmonious effect (p. 340).

Simon was intrigued by the unusual functions implicit in these extraordinary designs, and explained in the inscriptions that accompanied them. He describes these plans in detail, reproducing one of the many drawings, "an hermetically sealed apparatus for cooking, at high pressure—of several atmospheres," a 19th-century pressure cooker (Figure 3, top left; Simon, 1888). The drawing is essentially architectural in conception, and the execution the work of an adequately trained draftsman of the period. Simon was always careful to distinguish between patients who had prior training and those whose fantasies surpassed their expressive ability. "The unaccustomed hand of our patient could not manage to trace the dreams which presented themselves to his imagination" (Simon, 1876, p. 375).

Manie chronique

Simon's scrupulous objectivity, so typical of the French neuro-psychiatry of the period, comes to the fore in his analysis of the drawings of patients diagnosed as suffering from *manie chronique*. The bizarre productions of these severely ill people so intrigued Tardieu that he was led to characterize the whole of the art of the mentally ill on the basis of the work of this group of patients. For such investigators, the element of the bizarre represented a barrier beyond which they could not go, nor did they realize that a possibility of further understanding would ever arise. They were content merely to describe or ridicule. Simon recognized that Tardieu's description referred exclusively to the work of chronic maniacs, and that even then it was a one-sided exaggeration. Simon's investigation represents the first effort to unravel these images and, by looking at them intensively and with real curiosity, to penetrate their meaning.

It is possible to observe him searching about for a means of access. His first move in this direction was the realization that disturbances of speech were related to disturbances in pictorial rendering. French psychiatry at this time excelled in precise descriptions of language dysfunctions. "In the same way that among these patients disorders of speech are at times extremely evident, the combinations of lines in their drawings can often be extremely complicated, or the colors which they use to illuminate their pictures can be absolutely untrue to nature" (Simon, 1876, p. 366). This insight is an example of Simon's inclination to look for common origins behind a number of symptoms, the same inclination that had led him to study costume, imaginative descriptions of things visual, as well as graphic productions, as related phenomena. He resisted the temptation, which confronts any investigator of such confusing and chaotic material, of simplifying the terrible complexity of the masses of drawings with which he or she must deal. For example, he admitted that some "maniacs" produce drawings that are unexceptional, displaying no obvious distortions of form. "It can occur that chronic maniacs produce drawings in which the correctness of the lines, and the neat and finished quality of the drawing is fully apparent, especially when they attempt no more than the depiction of a single object" (1876).

In the context of *manie chronique* Simon presented a single case, that of Monsieur H. His description and analysis of the case and the paintings related to it were unusually thorough. In this respect, therefore, the case represents the first investigation into the creative activity of a single patient. In the article of 1888 three drawings by Monsieur H. were reproduced. Simon's interest in the drawings of H., and his decision to reproduce several of his pictures, were motivated by the realization that the patient was able to produce drawings that differed from one another in style. To admit that a single patient was capable of a variety of styles was a unique, but at the same time disturbing, discovery, in that it brought into question the essential hypothesis motivating the study of the graphic production of the mentally ill, namely the conviction that specific syndromes exerted a consistent influence on both the form and the subject matter of the drawings.

Simon described the types of drawings produced by H. very clearly.

> He draws voluntarily. The drawings which he does and which he gives us quite punctually, consist sometimes of badly arranged geographical maps, crossed by lines of all sorts and mixed together with useless references and bits of verse (Figure 4, left side; Simon, 1876, p. 367).

His patient was also capable, however, of highly ordered and coherent drawings or plans. "At other times, the figures drawn by our patient represent some sort of design, for example the design of a machine which he has invented. These drawings are then more clear, correct, and complete, although the idea remains generally eccentric" (1876).

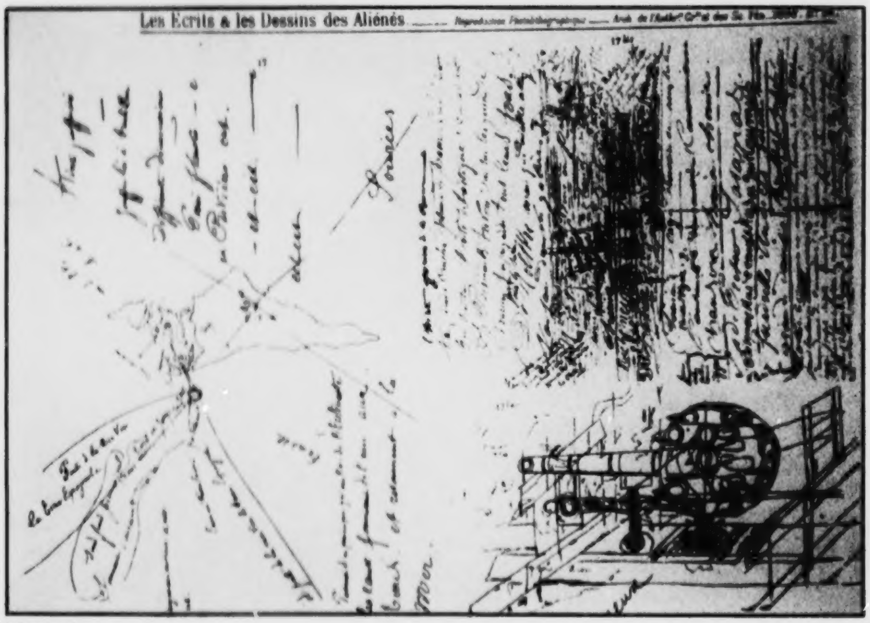

Les Ecrits & les Dessins des Aliénés

Figure 4

Simon's aesthetic, and his taste in drawing, were formed in an overtly academic mold. His drawing instructor at the Lycée in Rouen was a distinguished student of Ingres. He recounts how "not a week went by that he did not repeat a motto which Ingres had been in the habit of saying: 'Look after your line, make the contour correct, exact, irreproachable; and then . . . spit on it' " (Simon, 1895, p. 161).

Simon's attempt to account for the variations in formal coherence, although essentially speculative, is of great importance in that it reveals his awareness of the close tie between the structure of the patient's ideas and the form that the patient utilizes. The first hint of a theory of conflict of ideas as the source of a conflict of superimposed images within a single picture can be seen emerging here. The complexity of these drawings finds its explanation, according to Simon's hypothesis, in a "double series of ideas, mixed together, or separate," which at times overlap or fuse in the mind of the patient, producing the incoherent style of drawings. At other times a single conception will seek to find expression and the drawings that result are characterized by clarity and logic.

> In certain drawings of this patient whose work we are describing, one sees great incoherence, but this incoherence is not absolute. The lines, while often criss-crossing one another and confused, in the most incoherent of his compositions, reveal, in fact, in the spirit which has conceived them a double series of ideas: mystical ideas and scientific ideas. Moreover, in other drawings, these latter ideas are to be found without any admixture, at which time we encounter the inventor. A plow of special design drawn for us by H., or a model for a revolving cannon which is at the moment before our eyes, shows us very particularly this patient in this latter guise (Figure 4, lower right; Simon, 1876, p. 367).

How far we have come from Lombroso with his list of typical features of "insane art." Despite the simplicity of his theories, Simon's attempt to analyze even the most complex and seemingly meaningless images reveals a conviction that within these drawings, often no more than tangles of overlapping lines, there lay levels of meaning whose implications could be disentangled and un-

EST COPY AVAILABLE

derstood. His conclusion is stated as a general principle:

> However great the disorder and the confusion of the lines in the drawings of chronic maniacs, it will ordinarily correspond exactly with the extent of the insanity of the patient: the chronic maniac with multiple delusional ideas being more disordered in his productions than the chronic maniac with a single series of dominant delusional ideas. As for the patient suffering from acute mania, characterized by complete incoherence, excitation, and extreme restlessness, he is able to furnish us with very little in the way of drawings which can be studied (1876, p. 367–368).

It is amusing to note that the paintings of the Impressionists were considered suitable evidence for the critics to arrive at a diagnosis of insanity.

Evaluation of Simon's Contribution

Almost 100 years have passed since Simon published his pioneering study. His work has inevitably been superseded and, in the light of accumulated evidence and experience, it is not difficult to criticize some of his findings and failures. The difficulty for us lies in trying to reconstruct the confused situation that confronted him and in realizing the total originality of what he was attempting to do. In one sense, his research represented a logical continuation of the scientific preoccupation with accurate observation and description of symptoms, and the effort to classify them into systematized groupings that was characteristic of 19th-century French psychiatry. Simon's main theoretical contribution was unquestionably the recognition and the clear enunciation of the relatedness of inner idea and outer image, of delusional thinking and pictorial subject matter, of confused or limited thinking and confused or puerile form, of symptom and symbol. Both Lombroso and Simon recognized the symbolic quality of some of the pictures they were examining, but beyond that they did not, and could not, go. There seemed to be little possibility of penetrating the private language of the patient's personal symbolism, just as there was little recognition that symptoms might have meaning. One does not really discover in the studies of either Lombroso or Simon a concern with the patient's products as an effort to communicate with them, or as expressions of an organized self-image. Simon had discovered that these random scrawls were in fact a language. The task of translation was left to others.

Simon was one of the first psychiatrists to form a large collection of paintings and drawings by the insane. His intention was to impose order upon this mass of chaotic material, and to try to discover ways of linking this visual evidence with the systems of nosological classifications in use at the time. In this task it must be admitted that his success was limited. Using Simon's descriptive classifications it is quite impossible to divide a group of drawings made by a variety of patients into categories related to the syndromes identified by 19th century physicians. Undoubtedly, this is attributable at least in part to Simon's inability to reproduce a sufficient sample of drawings. His system suffered from the artificiality and over-simplication of the nosology of the period. The most we can assume is that it worked for him.

Simon might be criticized for his failure to deal openly and adequately with the overt sexual imagery that is not uncommon in the drawings of the insane. In both of his publications he revealed a rather prissy attitude to sexual matters, an accusation that could not be leveled against Lombroso, and which was not characteristic of the age. As Ellenberger (1970) in his discussion of the scientific milieu around 1880 pointed out, "contrary to present day assumptions, sexual matters were treated frankly in medical and anthropological literature. They also were discretely hinted at in literature" (p. 257). An incident in which Simon actively interferred in the production of obscene drawings might be held up as an example of his lack of scientific objectivity.

> I should also mention in connection with this repugnant subject a patient under my care obsessed with libidinous hallucinations. Incapable of drawing, he had drawings executed for him by another patient, drawings of the last word in obscenity. It is hardly necessary to add that, once informed of these very specialized works of art, I put an end to these licentious compositions (Simon, 1888, p. 351).

In 1876, however, he did indicate his conviction that sexual themes were especially prevalent in the drawings of *les persécutés, les déments* and *les imbéciles*. He challenged Tardieu's contention that such subject matter was extremely frequent. In fact, his decision to avoid discussion of the subject was based not on prudery but on his awareness that he had insufficient information. "I have not observed a sufficient number of examples to permit me to express an opinion on this point with any degree of certainty" (Simon, 1876, p. 390). He recommended that further study would be necessary. "It would be useful to investigate whether the characteristic of obscenity in drawing is more prevalent in specific forms of insanity" (1876). In his second publication he added a new diagnostic category, "erotic delirium," and he discussed sexual representation in much greater detail. It is probable that he was influenced in this direction by the publication of Lombroso and du Camp's article, "L'arte nei pazzi," in 1880. Following Lombroso's emphasis on hereditary degeneracy, Simon was led to state:

> Today, having been able to study the facts more closely, I am inclined to believe that this sort of patient generally reveals traces of an hereditary

> defect. I have collected information on several of these patients which permits me to put forward the opinion which I am presenting here; but concerning several others, I have not been able to obtain sufficient information (Simon, 1888, pp. 351–352).

In this passage we seem to encounter the seductive intensity of Lombroso's theories as Simon, the man of science, was about to succumb.

His sole concession to such subject matter was the inclusion of a single plate drawn by a lady whose preoccupations scarcely deserve the title "erotique," especially if one considers the vogue for Spanish fashions that swept France during the reign of the Empress Eugenie (1853–1871).

> Things Spanish enjoyed enormous popularity in France during the reign of the beautiful Empress Eugenie. Not only were Spanish dancers and bull-fighters welcomed in the French capital, but Spanish themes were common in novels and plays, the annual Salons were filled with paintings of Spanish subjects, and details of Spanish dress came and went in the changing world of fashions (Hanson, 1966, p. 71).

Small wonder then that the preoccupation with Spaniards had reached the hospital at Dijon, and that the art of the patients had begun to reflect the art of the Salon.

> Passionate preoccupations of a less condemnable type find expression at times among the insane, especially among the ladies, in drawings about which a word might here be said: I speak of the amorous preoccupations which frequently lead the insane, and hysterics too, to draw, or rather to copy, portraits of young men of more or less perfect beauty. At times it is the conviction which they have of a resemblance to a beloved person which leads them to choose them as their model; at other times it is merely the satisfaction to be derived from copying a beautiful face. I have encountered several cases of this type, and I am reminded, among others, of a patient at Dijon who drew, or copied, with some facility, a vignette representing an individual in Andalusian costume. Beneath it she had inscribed these lines which indicated the preoccupations of the author clearly enough: 'It's a pleasure to suffer for so beautiful an actor' (Figure 5, lower right; Simon, 1888, p. 352).

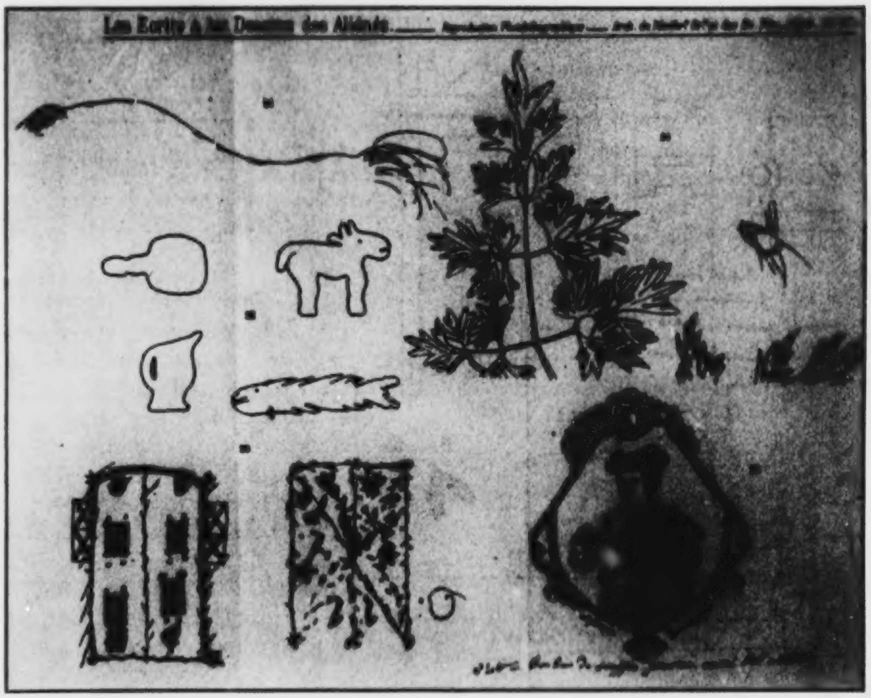


Figure 5

For the art historian Simon's work is of particular interest in that it represents an effort to come to grips with the difficult problems inherent in the analysis of nonverbal forms of expression. Simon's ability to write dispassionately and analytically about comparatively bizarre material could have served as an example to the art critics of his day who displayed far less objectivity and seriousness in their confrontation with the Impressionists. It is amusing to note that the paintings of the Impressionists were considered suitable evidence for the critics to arrive at a diagnosis of insanity. The passage that follows is taken from a review of a group show arranged by the painters in 1876:

> The rue Le Peletier has bad luck. After the opera fire, here is a new disaster overwhelming the district. At Durand-Ruel's there has just opened an exhibition of so-called painting. The inoffensive passerby, attracted by the flags that decorate the facade, goes in, and a ruthless spectacle is offered to his dismayed eyes: five or six lunatics, among them a woman, a group of unfortunate creatures stricken with the mania of ambition, have met there to exhibit their works. Some people burst out laughing in front of these things, my heart is oppressed by them. Those self-styled artists give themselves the title of non-compromisers, impressionists; they take up canvas, paint, and brush, throw on a few tones haphazardly and sign the whole thing . . .. It is a frightening spectacle of human vanity gone astray to the point of madness (Wolff, quoted in Rewald, 1973, pp. 368–369).

One can't help but wonder what Simon would have thought of all this.

Simon's lack of involvement in the genius-insanity controversy, and his almost total avoidance of any problems relating to aesthetic evaluation of the drawings he was studying, makes it difficult to arrive at a clear idea of the nature of his aesthetic standards, or of his involvement with the visual art of his day. A wide and clearly demarcated gulf separated the drawings of the mentally ill from the "fine arts," a division that is far less apparent today. As a result, Simon was able to dismiss the pictures as of no artistic importance. As pointed out earlier, he avoided altogether using the word *art*, although he did re-

BEST COPY AVAILABLE

fer to the non-pictorial descriptions of his patients as "les conceptions artistiques." He used evaluative terms rarely, referring occasionally to a drawing as badly drawn, or as executed "avec correction." We also find references to pictures being "very agreeably composed." One of his most interesting hypotheses, created in the context of a discussion of the improvised costumes worn by some severely disturbed patients, is the idea that there is "among maniacs a disturbance of taste, just as there is a disturbance in behavior" (Simon, 1876, p. 368). All of these evaluative judgments place Simon's aesthetic conceptions quite clearly within the academic and more conventional standards of taste of his period. He reveals an unquestioning acceptance of the belief that standards exist by which art can be judged and separated off from non-art. His 20th-century successors were not as fortunate in this respect.

Perhaps the best clue to Simon's personal preferences in art, and an indication of just how conservative they were, is provided by the one reference to a famous artistic personality that occurs in his article. Describing the work of a patient diagnosed as suffering from *paralysie générale* , Simon told the story of a young soldier who displayed a whole range of delusions that he was a painter, he intended to ornament the walls with frescoes.

> Ch . . . imagines himself, in fact, to have artistic talents equal at least to those of Horace Vernet. This belief led our patient to execute a drawing of a horse which was the most insignificant daub in the world; a child in his most imperfect attempt could not produce anything more insignificant. A curved line, with several strokes at either end of it representing the mane and the tail! There you see what the efforts and the pretentions of the poor paralytic resulted in, this man who, in his madness, sought to emulate one of our greatest painters of battle scenes (Simon, 1876, p. 380–381).

It is the last phrase that seems to suggest that one of Simon's artistic heroes may have been called to mind. Horace Vernet (1789–1863), like his father Carle, was indeed a specialist in the painting of horses, and might well have appealed to a conservative physician whose knowledge of painting may not have extended much beyond the doors of the Salon. The description of the drawing of "Ch." as "la chose la plus nulle du monde" could be mistaken as a vicious attack on the art of the mentally ill. What Simon is trying to do is not to attack the young soldier, whom he in fact referred to as having an open and sympathetic character, but rather, to differentiate as clearly as possible cases of psychologically induced delusions of grandeur from the organic diseases that resulted in a complete collapse of graphic control. Although this patient might display megalomanic delusional ideas, his ability to depict them had deteriorated to the point of utter puerility. It was this aspect of the drawings of patients diagnosed as suffering from *paralysie générale* and *imbécilitié* that led him to make comparisons between the drawings of these individuals and the art of children, thereby introducing yet another topic that would continue to stimulate discussion up to the present.

In this analysis of Paul-Max Simon's approach to the graphic production of the mentally ill, the intent was to remove him from the shadow of Cesare Lombroso, and to restore him to his rightful position as the creator of a significant new field of scientific investigation. Lombroso's influence was soon to make an impression upon a far wider public, overshadowing Simon's work completely with an endless series of pathographies of genius, biographies that displayed Lombroso's extraordinary gullibility, or carelessness, in regard to the facts. Simon's more modest undertaking, which owed less to Romantic conceptions of genius, and more to the descriptive psychiatry of his day, can be understood now as far superior to that of Lombroso, an achievement which in its seriousness and objectivity was to provide an admirable prototype for all later explorations into the psychology of psychotic pictorial expression.

References

Ellenberger, H. (1970). *The Discovery of the unconscious: The history and evolution of dynamic psychiatry*. New York.

Hanson, C.A. (1966). *Edouard Manet*. Chicago: Art Institute of Chicago.

Rewald, J. (1973). *The history of Impressionism*. New York: New York Graphic Society.

Simon, P. (1876). L'imagination dans la folie: Etude sur les dessins, plans, descriptions, et costumes des aliénés. *Annales médico-psychologiques, 16*, 358–390.

Simon, P. (1888). Les ecrits et les dessins des aliénés. *Archivio di antropologia criminelle, psichiatria e medicina legale, 3*, 318–355.

Simon, P. (1893). *Swift: Etude psychologique et litteraire*. Paris.

THE ARTS IN PSYCHOTHERAPY

AN INTERNATIONAL JOURNAL

GIVE YOURSELF A HEAD START! SUBSCRIBE NOW AND SAVE!

Subscribers to *Art Therapy* and Members of American Art Therapy Association
ENJOY REDUCED RATE!

A quarterly, international, multi-disciplinary journal for professionals and students in all areas of the arts in psychotherapy, mental health and education, THE ARTS IN PSYCHOTHERAPY publishes original articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologists which reflect advances in theory, research and practice with no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy, THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers to: Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583

TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA

Please enter my subscription for 1984. Enclosed is check for $20.
(Regular rate for individuals $40) Bill me ☐

Name ____________________
Address ____________________
City __________ State ______ Zip ______

american journal of ART THERAPY

Art in Education, Rehabilitation, and Psychotherapy

This independent quarterly, published since 1961, deals with the visual arts as they contribute to human understanding and mental health. Its contents include new theoretical formulations, bibliographical information, a job information exchange, and news of opportunities for training and of international developments in the field.

Topics treated in recent articles include:

- transference and countertransference in art therapy
- art therapy and cultural difference
- art as therapy in a public school
- art therapy with the severely physically disabled
- self-expression of a disturbed adolescent
- art in strategic family therapy
- the combination of art and play therapy
- the place of art in art therapy
- research into hospitalized children's self-images.

Name: ____________________ Address: ____________________
Street

City ____________________ State __________ Zip __________

Individual Subscribers: U.S. and Possessions, $15; foreign, $17.50 (Students and members of the American Art Therapy Association are eligible for discounted subscriptions as follows: U.S. and Possessions: $12; foreign, $14)
Institutional Subscribers (U.S. and Foreign): $25

AMERICAN JOURNAL OF ART THERAPY, P.O. Box 4918, Washington, DC 20008-0118

An Art Therapist's Personal Record

Don L. Jones, ATR

Don L. Jones, ATR, was one of the five members of the Ad Hoc Committee that formed the American Art Therapy Association and served as the organization's president from 1975 to 1977. He is the Director of Adjunctive Therapy as well as the Director of the Clinical Internship Program in Art Therapy at Harding Hospital, Worthington, Ohio.

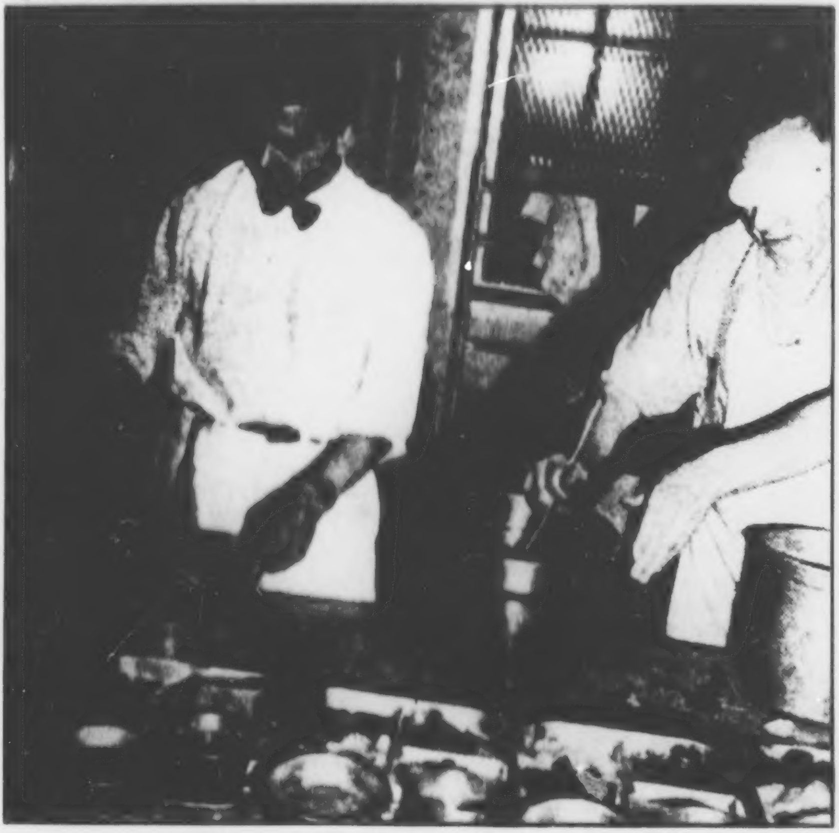
This article records the process of looking backward and looking inward for the roots of my interest in art therapy. I hope that such recollection and review will provide a perspective from which to look ahead. These reflections relate to the period between 1943 and 1946, during which I worked as an attendant in a state mental hospital. It was this experience and the paintings I did in response to it which were the origin of a compelling and continuing involvement in art and psychiatry.

Background

The economic crisis of the Great Depression of the 1930s wrought havoc on the state mental hospital system. Standards of care fell as budgets were cut, and overcrowding increased. Progressive ideas of treatment were forgotten; the patients were dehumanized and the staff demoralized. The low state into which those hospitals fell was documented by the U.S. Public Health Service. These detailed findings, first set down in confidential reports, then later published, revealed conditions of inhumanity and neglect of which the public continued to be unaware.

This depressing state of general deterioration of standards was accentuated by the advent of World War II. The Veterans Administration and state hospitals lost most of their professional staff, and lay personnel deserted for more lucrative wartime industries. Morale in the institutions and the level of care plummeted further.

Figure 1—The author serving meals on "Senile II."



Editor's Note: While Margaret Naumburg and other writers were beginning to lay down the theoretical foundations for art therapy, Don Jones was discovering for himself the therapeutic value of art through his experiences as an attendant in a state hospital where little more than custodial care was given the patients.

Mr. Jones's paintings provide a glimpse of a world many younger art therapists have never seen. Two major influences have dramatically altered mental health treatment since the 1940s: the development of effective psychotropic drugs that make patients more accessible and capable of participating in other types of therapy and the mental health movement whose members have led the way for more humane treatment.

It was at this time and under these circumstances that some 3,000 conscientious objectors, drafted by the Selective Service, volunteered to staff many of the state hospitals. Under the Selective Training and Service Act of 1940, the U.S. Congress had made provisions for conscientious objectors to perform work of national importance under the auspices of a Civilian Public Service program.

After being drafted out of college into a brief labor camp assignment and a 6-month stint as a human guinea pig for the Army Medical Corps, I volunteered for "detached" service and was assigned to the Civilian Public Service Unit No. 63 at the Marlboro State Hospital in New Jersey. It was there that I entered the world of psychiatry as a young artist with a 19-year-old's idealism.

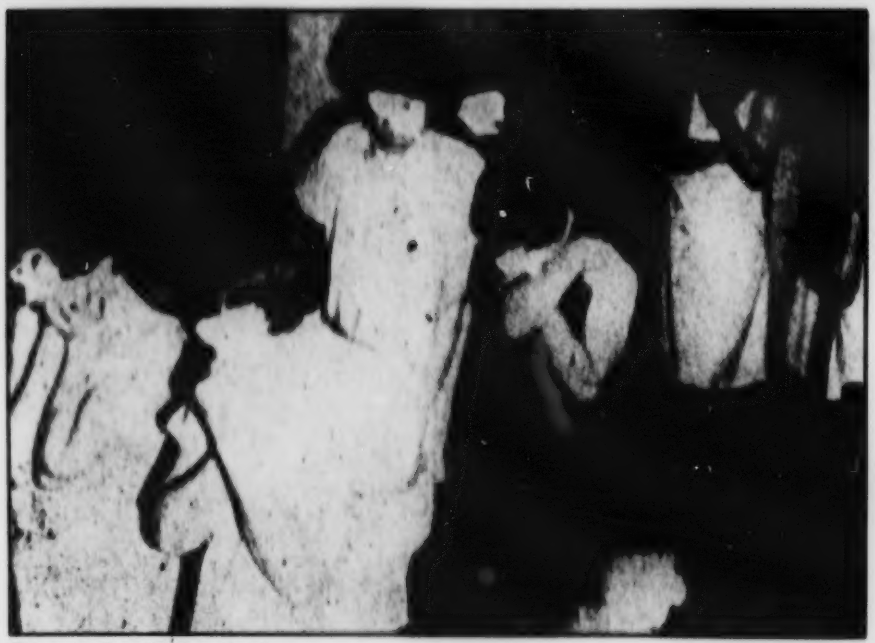


Figure 2—The "Rosegarden."

The Hospital Setting

The hospital housed 2,800 people in cottages of approximately 150 patients each. In addition, there were two buildings (one for males and one for females) for "disturbed" patients; about 90 patients lived on each of the three floors in these buildings. There also was a building for patients with tuberculosis and a small infirmary.

The attendants worked 12-hour shifts, 6 days a week. Being the only staff member on a ward, an attendant had to be a "jack-of-all-trades," serving meals (Figure 1) as well as providing some stimulation. Working the night shift (7p.m. to 7a.m.) usually entailed additional responsibility; I would cover three cottages and three floors of the "disturbed" building by myself. Figure 2 shows a typical scene from a ward euphemistically called the "Rosegarden." I used to move all the furniture to the middle of the day room and then sing and make noise to encourage these vegetating people to get up and move. We did not have the psychotropic medicines available now, let alone the luxury of time or materials for art therapy. The activity areas previously set aside for woodworking and crafts had all been closed.

Subjective Reactions Recorded in Art

A multitude of indelible images from that experience are imprinted on my psyche. There were:

> "sick people shackled, strapped, straight-jacketed and bound to their beds . . . curable cases sinking into chronicity . . . wards upon wards of patients sitting in idleness and stripped of human dignity. In some of the wards there were scenes that rivaled the horrors of the Nazi concentration camps" (Deutsch, 1949, p. 448–450).

It was these scenes, which Albert Deutsch described in words, that I described in my paintings. Some of those paintings accompany this article.

It was my previous experience with art that now provided me asylum and a means of survival. I developed a growing awareness that creative expression often serves those who are under severe stress. I found myself painting in the process of working out and living through the human misery that I shared with these patients. I discovered and collected the artwork of the patients, which they produced not only out of boredom or on demand but out of inner impulse and psychic necessity. The walls, the halls, and even the tunnels and passageways beneath the buildings were covered with elaborate, spontaneous scribblings, depicting pain, tumultuous anxiety, and abandoned hope. It was more than graffiti—it was soul language! I looked and learned and tried to interpret, and, ultimately, began to understand and to communicate with these deserted, desolate aliens. The vaguely conscious thought of using art as therapy began with me here in this singularly lonely situation.

The Paintings

- Communication with this regressed patient seemed impossible but I would sit beside him and talk. After a year, he answered (Figure 3).
- I discovered that some patients on the "disturbed" ward had been locked in security rooms for several years. I told them that their doors would be unlocked. Gradually, they risked coming out. I could not imagine that they would be afraid of *me* (Figure 4).
- Caring for the most severely impaired was a special problem, but even some of the most disturbed

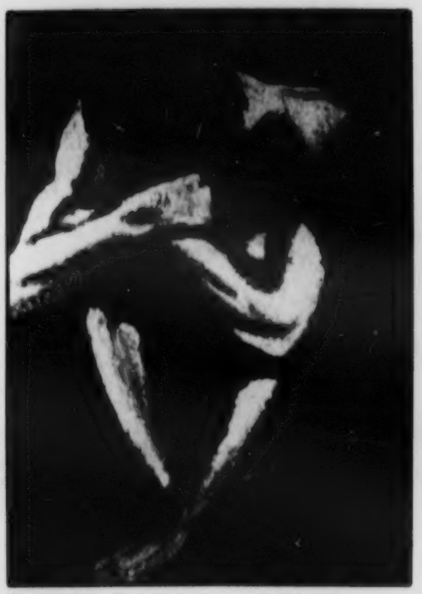


Figure 3—"Regressed" . . . naked and crouched in a corner . . . neither the comfort of a fetal position nor the hope of being reborn.

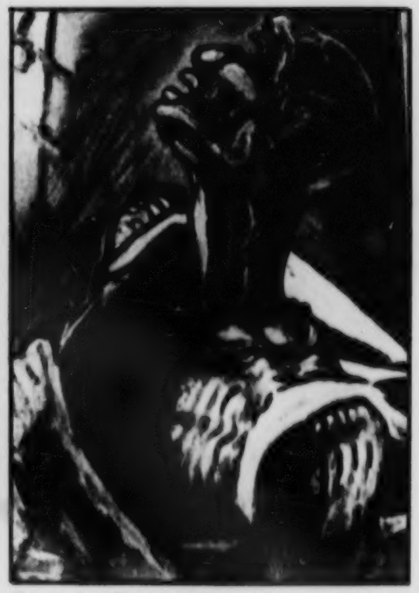


Figure 4—"Restrained" . . . in a straightjacket . . . struggling like a turtle turned on its back . . . feeling neither secure nor protected.

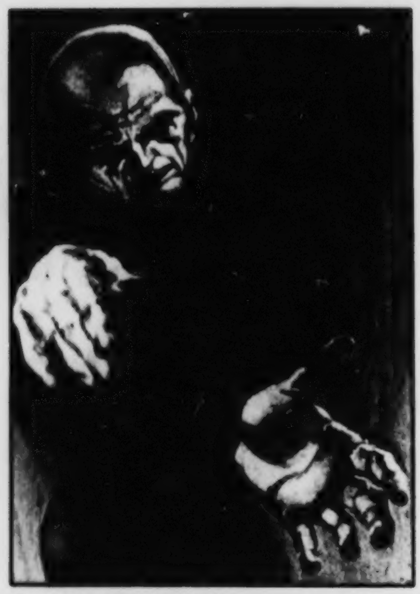


Figure 5—"Blind and deaf" . . . without sight and sound, with only hands to grope and buffer . . . to touch.

patients were compassionate and helpful to others in these difficult circumstances. It is a lesson I have remembered (Figure 5).

- This man ultimately escaped from the hospital by breaking through a brick wall. During the long night shift alone, I often wondered why he did not simply take the keys from me. But I trusted him and apparently, he felt something for me (Figure 6).
- The malaria treatments given in an attempt to arrest this man's syphilis were too late to prevent blindness and neurological impairment. I felt sad for this cultured gentleman and knew he would be forgotten. So, I asked him to sit for a portrait. I remember him well (Figure 7).
- This is a self-portrait at age 19. I also made many pencil portraits of patients as a device for getting them to sit still and talk with me (Figure 8).

The Beginnings of Reform

Out of this experience too, came a book about the work of the conscientious objectors called *P.R.N.* (*pro re nata*—in hospital parlance, a medicine that is given "for the emergency"). Its preface states:

> So, we became the "PRN's" of the hospital community, filling in wherever there were shortages. Three thousand men have volunteered for this role in over fifty hospitals. There, they have filled a variety of capacities . . . on the wards . . . the farms . . . in the labs, the kitchens, the offices. We came to Marlboro closing a gap, but our vision has broadened during the time spent here, so that we hope our concern for the welfare of the mentally sick will be lifelong rather than merely . . . PRN" (Civilian Public Service Unit No. 63, 1945).

P.R.N. was an educational monograph, designed both to train conscientious objectors who staffed the hospitals and to inform the general public about more enlightened methods of patient care. This book on the New Jersey State Hospital was illustrated with photographs and some of the patients' art work I had gathered. It portrayed the hospital in an objective light and reflected the impact of the conscientious objectors. Through study groups in psychology and mental health, we were able to formulate guidelines for attendants and to raise the level of care.

At the same time, we participated in documenting and reporting instances of hospital neglect and abuse. These constructive public exposés contributed to the beginnings of reform in the state hospital system. As Deutsch (1949) notes, "Scores of these conscientious objectors—sensitive to the suffering of the patients under their care—kept careful notes of incidents and observations in diaries and reports. These notes were later collected by a central group in Philadelphia and published in various forms by the National Mental Health Foundation, which was organized in 1945, primarily by idealistic ex-attendants" (p. 451).

An Invitation from the Menninger Foundation

An unpublished manuscript, *The Tunnel* (Jones, 1947), illustrated with my own cathartic paintings of the Marlboro Hospital, later came to the attention of Dr. Karl Menninger. As a result, I was invited to hang these paintings in the Menninger Foundation museum as well as to start an art therapy program at the Menninger Foundation Hospital. A sophisticated art therapy program had been

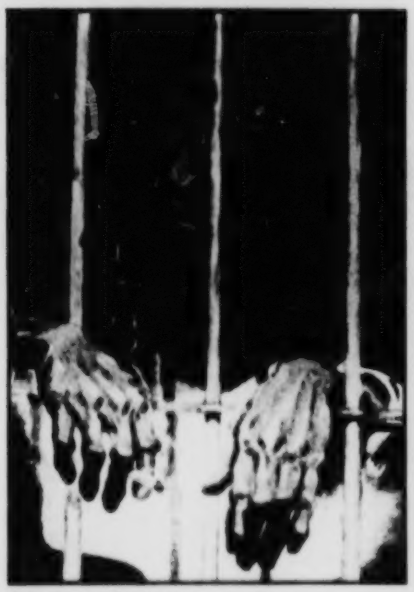


Figure 6—"Confined" . . . waiting . . . smoldering . . . waiting.

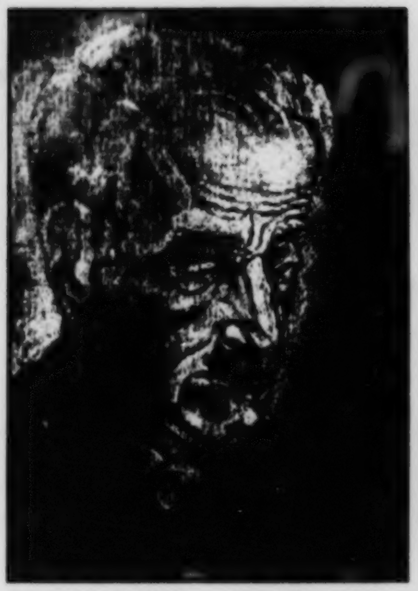


Figure 7—"Old Man" . . . How did you come here? How long will it be?

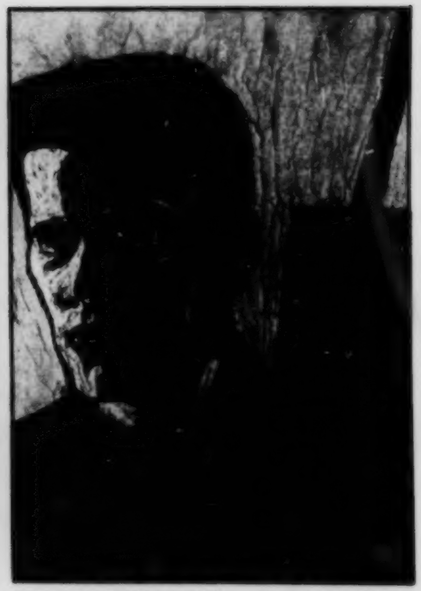


Figure 8—"Self-portrait" . . . Don Jones at age 19.

developed as early as 1934 in Topeka, Kansas, at the Winter Veterans Administration Hospital (Huntoon, 1949) under the leadership of Mary Huntoon and Ruth Shaw (who had initiated the use of finger painting as therapy). At the time I joined the Hospital in 1951, however, the VA art therapy program had been defunct for over a decade.

Art was a part of the milieu therapy at the hospital. An active art-and-activities program was developed with the helpful support of Drs. Karl and Will Menninger. "Dr. Will," influenced by his studies with Ernst Simmel in Berlin, used art as a cathartic activity. There were others who affected me during that period including Gunter Ammon, MD, a psychoanalyst now practicing in Berlin, who introduced me to German literature on the relationship of psychoanalysis and art and Ben Horlacher, a personal friend, mentor, gifted ceramist, and natural therapist who left his imprint on hundreds of patients at the Winter VA Hospital. Later, Robert Ault who was to serve with me on the Ad Hoc Committee that formed the American Art Therapy Association, joined me at the Menninger Hospital where we established a Creative Activities Program.

Epilogue

After 16 years at the Menninger Clinic, I was invited to become Director of Adjunctive Therapy at Harding Hospital in Worthington, Ohio. Art at Harding Hospital is an integral part of the therapeutic milieu that emphasizes group and individual psychotherapy as well as provides "art as therapy" in painting, ceramic, and sculpture studios.

One of my surprises in coming to Ohio in 1967 was discovering the first art therapy department and training program to be approved by the state Mental Hygiene Department. It was run by Bernard Stone, under the supervision of Dr. Pedro Corons, a psychiatrist, and Dr. Curt Boenheim, a psychoanalyst. Combining my interest and energies with them and others in the state we formed the Buckeye Art Therapy Association.

After years of working in relative isolation, practicing art therapists, invited by Myra Levick, met in Philadelphia to lay the groundwork for a national association. That first meeting in 1967 proved to be a turning point for me personally as well as for the field.

Today, I am an art therapist as well as a professional painter and sculptor. When I first entered the world of psychiatry as a young amateur artist, my eyes were opened to experiences I could barely absorb or understand. I painted from intuition and impulse. These pictures remain alive for me; they serve as a constant reminder of what must never be again. They are milestones measuring the distance we have come in the treatment of mental illness and stand in stark contrast to the contemporary practice of mental health and art therapy.

References

Civilian Public Service Unit No. 63, 1945. *P.R.N. in a Mental Hospital Community*. New Jersey: Author.

Deutsch, A. (1949). *The mentally ill in America* (2nd rev. ed.). New York: Columbia University Press.

Huntoon, M. (1949). The creative arts as therapy. *Bulletin of the Menninger Clinic, 13* (6), 198–203.

Jones, D. (1947). *The Tunnel*. Unpublished manuscript.

A Critical Analysis of *A Review of the Published Research Literature in Arts for the Handicapped: 1971–1981*, with Special Attention to the Visual Arts

Frances E. Anderson, EdD, ATR

Frances E. Anderson, EdD, ATR, professor of art at Illinois State University, Normal, Illinois, is a founding member of both the Illinois and American Art Therapy Associations. The author of a number of publications in art education and art therapy, she recently completed a curriculum, "Arts for the Handicapped," which will be published by Abbeyville Press, New York. Her co-author on that project is José D. Colchado of San Jose State University. This critical analysis was funded in part by Illinois State University's Summer Research Program in 1982. Other support, including library access and office space, was provided by the Mary Ingraham Bunting Institute of Radcliffe College where the author was a Visiting Scholar during the summer of 1982. The author wishes to express gratitude to both institutions for their support, without which the project could not have been undertaken.

Criteria for Inclusion of Research Studies

In May of 1981, the National Committee, Arts for the Handicapped (NCAH) requested the author to review the published research literature on arts and the handicapped. Because a similar project (Kalenius, 1978) had covered the research on arts and the handicapped up to 1975, the NCAH literature review originally was intended to cover the period from 1975 to the summer of 1981. As the author undertook the initial computer-assisted library searches, however, it became apparent that a more complete and representative literature review would result from a systematic search of the published research literature over the past decade. Therefore, the NCAH literature review was expanded to include the 10-year period from 1971–1981.

Careful criteria were established for the inclusion of research studies in the literature review. These were based on the criteria established by Kalenius (1978), which required that studies be "structured inquiries that utilized acceptable scientific problem-solving methodology and created new knowledge that could be generally applicable." The NCAH project, therefore, was limited to empirical research (Eisner, 1972) utilizing methods of investigation that were grounded in psychological and educational research methods and that yielded "hard data." Articles that dealt with philosophical, theoretical, or more "subjective" investigations were not included in the review.

These parameters were drawn because it had become apparent to NCAH that lay persons, researchers, and funding agents outside the arts were demanding systematic research. What was critically needed was evidence that could convince professionals and funding agencies outside of the arts of the value of the arts as treatment modalities and as means of reinforcing learning, modifying behaviors, and improving the lives of handicapped individuals. The external agencies and professionals who are not art therapists generally do not accept the case study as a valid research method upon which decisions and generalizations can be based. What is acceptable is empirical research based on scientific methodology that includes objective measurement, hypothesis testing, and replication. Therefore, only those research articles that used case studies employing time series strategies (Rush & Krathochwill, 1981) or an ABAB reversing experimental treatment research design (Walker, 1980) were included. As Dr. Ernest L. Boyer, Chair of the NCAH Board of Directors, stated in his introduction to the NCAH literature review:

> Some of the reasons for attention to applied research in the arts and the handicapped are practical. Today, when widespread and rapid changes are being made in governmental support, demands for strict budget

and programming accountability become imperative. Knowing more about what does and does not work can increase the relevance of our work.

Once the criteria for inclusion of research studies were established, the author, assisted by Linda Ash, then Director of the Special Education Instructional Materials Library at Illinois State University and James Gambach, a graduate student in special education at Illinois State University, made computer-assisted and manual searches of over 33,000 books, technical reports, and monographs, as well as over 50,000 educational documents that covered the 10-year span of the research.

The following art forms were included in the literature search: visual arts, drama, music, and dance/movement, as well as the following handicapping conditions: hearing, speech, and visual impairments; mental retardation; behavioral or emotional disorders; orthopedic handicaps; and learning disabilities.

Sources of Data

Two major data bases were covered in the computer searches: *Educational Resources Information Center* (ERIC) and *Psychological Abstracts Information Service* (Psychinfo). ERIC was initiated in 1966 and has two main files: *Research in Education* (RIE) and *Current Index of Journals in Education* (CIJE). Educational documents such as conference presentations, final grant reports, and educational research projects are covered in the 52,729 entries of the RIE. About 780 publications and journals in education and related fields are covered in CIJE. Psychinfo, started in 1967 by the American Psychological Association, includes 334,021 citations with monthly updates. It covers the world's literature in psychology and related disciplines in a data base that includes 1,500 books, technical reports, and monographs, as well as 940 periodicals.

In conducting the computerized searches the project staff identified all possible key descriptors and words for the handicapped and the arts from the Psychinfo and ERIC thesauruses. Over 90 different descriptors pertaining to the handicapped, research, and the arts were used in the automated searches. Next, manual searches were made of the *Education Index*, which includes 334 journals, and of *The Music Therapy Index* and the *Art Index*, which together cover 202 journals. Finally, bibliographies from identified articles also were checked for further possible research studies. The final part of the search process was personal contact with experts in the field of arts for the handicapped in an attempt to locate as many research studies as possible and to ensure that no important article was overlooked.

Despite these efforts, some studies were undoubtedly omitted. Also, because the project was conducted over only 2½ months (June 1 to August 15, 1981), other data bases, such as *Art Therapy in Mental Health* (U.S. Department of Health and Human Services, 1981), could not be tapped. One of the aims of the NCAH literature review was to stimulate further research and to identify other pertinent research. Since the publication of the NCAH project results, other studies have been (and are being) identified that meet the inclusion criteria, and it is hoped that it will be possible to update the literature review periodically.

Time constraints also did not permit the reading of dissertations on the arts and the handicapped. A list of 30 dissertations was compiled, however, using the *Comprehensive Dissertation Data Base*, which includes every dissertation completed at an American institution of higher education since 1861. The compiled list covers 10 studies in music, 9 in visual arts, 5 in dance movement, 5 in drama, and 1 study in creative thinking. Two universities (Illinois State University, Normal, Illinois, and Texas Women's University, Denton, Texas) are making efforts to purchase all dissertations that pertain to research in arts and the handicapped.

> **What was critically needed was evidence that could convince professionals and funding agencies . . . of the value of the arts as treatment modalities . . . .**

Results Produced by the Literature Search

The literature search produced 30 studies on music and the handicapped, 19 studies on the visual arts and the handicapped, 3 studies on dance/movement and the handicapped, and 1 on drama and the handicapped. One of the ongoing problems with research on handicapped individuals is the variation in descriptions of handicapping conditions. These descriptions change over time as various labels are revised and refined. Unfortunately, because many of the authors of the 52 identified research studies did not provide an operational definition of the handicapping condition under investigation, there is no uniformity in definition or description. This created problems in comparing research studies and in drawing conclusions about the effects of arts on the behavior of handicapped individuals. The project staff had to rely on each author's own description of the particular handicapping conditions. Thus, the NCAH literature search included the following studies:

- **Deaf**
  1-visual arts
  1-music
  1-dance/movement
- **Hearing Impaired**
  2-visual arts
- **Speech Impaired**
  1-music
- **Mentally Retarded**
  15-music
  4-visual arts
  1-dance/movement

- **Orthopedically Handicapped**
  1-visual arts
  1-music
- **Emotionally Maladjusted**
  7-music
  1-visual arts
  1-dance/movement
  1-drama
- **Learning Disabled**
  8-visual arts
  5-music
- **Two or More Handicaps**
  1-visual arts (Mentally Retarded, Emotionally Maladjusted, Learning Disabled)
  1-visual arts (Mentally Retarded, Multiply Handicapped)

The original literature review was to have two phases. The first phase consisted of identifying and abstracting the published research that met project criteria. Abstracts one to three pages long were written that included the following categories of information whenever possible: topic or hypotheses of the study, selection of subjects and description of handicaps, presence or absence of control groups, research design and methods used, assessment instruments used, including sources and dates, all experimental treatments and intervention methods, and results and conclusions (including statistical results). The second phase, which was to be a critical analysis of the 52 identified research studies, was never undertaken because of budget restrictions at NCAH. The results of the first phase (abstracts of the 52 identified studies and the list of 30 dissertations) was published by NCAH in the spring of 1982.

Despite this budget reduction, the author was able to obtain partial support to undertake a portion of the originally planned critical analysis. This critical analysis involved three parts. First, all studies in the NCAH literature review were reread by the author. Next, the authors were grouped according to topic areas. Once these areas were identified, it seemed helpful to "chart" each research study so that comparisons could be more easily drawn. This charting (see Table 1) included the following categories: author and date of study, handicapping condition, topic or research question under investigation, assessment instruments (tests) used in the research with the citations (i.e., sources and publication dates of tests if the original study included them), types of experimental treatments, research design, and results. (The table is at best a condensation of the research, therefore, the reader is urged to read the original published work for other relevant details.)

. . . These studies suggest that it may be possible to identify students with potential emotional problems, by assessing their figure drawings.

The published research studies on art from the NCAH literature review can be utilized in several ways. By examining the charts, the reader can quickly identify all studies concerning a particular handicapping condition. The reader can also look at all studies using a particular research design, or the same standardized assessment instruments. Themes and issues addressed in each study can be compared. Finally, it is possible to group the studies around themes, such as the use of the art product to identify personality traits and problems, as well as the use of art as a means of reinforcing other behaviors or academic concepts.

Analysis of Visual Arts Studies Included in the Review

In the NCAH literature review, 19 studies on the handicapped and the visual arts were identified. Of these, eight concern the learning disabled, four the mentally retarded, and three the hearing impaired. Two dealt with several handicapping conditions (one with mentally retarded, learning disabled, and emotionally maladjusted persons; one with mentally retarded and multiply handicapped); one with emotionally maladjusted; and one with poliomyelitis patients.

Studies of Figure Drawing Assessment as a Diagnostic Tool

One group of research studies investigated the art products of various types of handicapped individuals to determine in what ways various handicapping conditions influence the ways human figures were drawn. This group of studies further attempted to determine if a type of problem, such as emotional maladjustment, including low self-esteem or other personality traits, could be predicted from an assessment of the figure drawings themselves.

Johnson and Greenberg (1978) found no significant difference between the figure drawings of polio patients and non-impaired subjects who were matched on geographic locality, age, sex, educational level, and marital status. Raskin and Bloom (1979) examined the Kinetic Family Drawings of two groups of learning disabled children. The 33 males and 17 females in the study, all of whom had significant academic delays were divided into two groups according to chronological age. When their drawings were evaluated for indicators of emotional problems, no statistically significant differences between the two age groups were found.

Calhoun and Whitley (1978) did find, however, a statistically significant relationship between a measure of self-esteem (Coopersmith Self-Esteem Inventory, 1967) and the self-drawings of eight secondary school age students who were considered educable mentally retarded. Ireton, Quast, and Gantcher (1971) also found that the Draw-A-Man Test (DAM) was an effective means of indicating a need for further, more sensitive testing for behavior and learning problems. These three researchers screened all children 4 to 6 years old who entered a pediatric clinic over a 9-month period. All subjects who scored below 85 on the DAM Test (Harris, 1963) were identified and screened for other possible learning problems, speech problems, visual and motor problems, and retardation. Of the 38

Table 1. Summary Charts

Study	Handicap	Topic	Sample selection/ description	Sample size	Tests	Treatment	Research design	Results
Gair, 1975	Learning disabled	Can art remediate visual problems of the learning disabled?	20 subjects, 7 to 12 years old with a mean IQ of 102 (no control group or randomization indicated)	20 subjects	Five visual subtests of the Illinois Test of Psycholinguistic Abilities (ITPA) (Kirk, 1968, and two drawings—a design and a self-portrait—as pre- and posttest measures	Subjects had a slide tape design curriculum covering 28 art tasks, lasting 1 hour a day, 5 days a week for 7 weeks	Quasi-experimental (pretest, treatment, posttest; no control group or randomization indicated)	Drawings rated on a scale developed by the researcher showed a statistically significant increase after the treatment. There also was a statistically significant increase in ITPA scores on visual reception, visual closure, visual association, visual memory, manual expression, and receptive-expressive tasks. Gair concludes that art as presented in this program can remediate learning disabled subjects
Miller, Sabatino, & Miller, 1977	Learning disabled (visual perceptual dysfunction)	How does traditional remediation for learning disabilities affect the art work of students?	34 females, 78 males, 6 to 10 years old of whom 56 had no visual dysfunction. Fifty-six did have visual perceptual problems, were underachievers, and had word recognition problems. The subjects were randomly assigned to four groups	112 subjects	Pre- and posttest crayon drawings of children based on a story theme. Drawings evaluated by 5 graduate art education students on 7 variables	Each of three experimental groups received a different one of the following three traditional remediation programs: Merrill Linguistic Reader; Frostig Program for the Development of Visual Perception; and Early Childhood: Form Constancy Program. One control group did standard remedial work without any special visual perceptual remediation. Treatment was over a 12-week period with 30 minutes of daily treatment	Experimental (pretest, three treatments and one control group, posttest)	Subjects who received specific visual perceptual remediation program did not experience any disruption in their drawings
Silver & Lavin, 1977	Learning disabled	Can an art program remediate subjects who have visual spatial handicaps?	Four females and seven males, ages 7 to 11 years, all having visual spatial handicaps (no control group or randomization indicated)	11 subjects	Drawing to a story as both pre- and posttest. All 22 drawings rated on seven factors (Bruner & Kenney, 1966; Piaget, no date)	Three tasks were given: forming groups, establishing spatial relationships, and or[illegible]ng (all remediated with art materials in 10 one-hour Saturday art sessions by 11 graduate students in a one-to-one situation). No detailed description of art activities provided	Quasi-experimental (pretest, treatment, posttest); no control group indicated	Judges rated pre- and posttreatment drawings; their comparisons indicated a statistically significant improvement in the three task treatment areas

BEST COPY AVAILABLE

Table 1. (continued)

Walker, 1980	Learning disabled	Can painting and/or gross motor activities program decrease the hyperkinetic activity of learning disabled children?	Four elementary school age learning disabled children randomly selected from a group of 12 children who had been matched for attention to task behavior	Four subjects	Observation by judges to establish baseline behavior for attention to task (Frostig, no date)	Two treatments: one consisting of 30 minutes of painting a day, the other of 30 minutes of running, skipping rope, and tossing balls for 5 days	ABAB reversal design (time series strategy)	For three of the four subjects, art activities were most effective in increasing attention to task behavior. For one subject, it was the gross motor activity that significantly increased attention to task behavior. For three of the four, the attention to task behavior increased by at least 20%
Wood, 1977	Learning disabled	Can directed art activities increase visual perception in learning disabled subjects?	Eight subjects having a mean chronological age of 9.3 years, 7 of whom scored 90 or below on the Frostig Developmental Test of Visual Perception. No report of sex or socio-economic status; no reported random selection	Eight subjects	Frostig Development Test of Visual Perception; Wide Range Achievement Test (Jastak, 1976); and Peabody Picture Vocabulary Test (Dunn, 1965)	Draw-A-Person Test (Urban, 1963). Eight weeks of directed art activities (no details specified as to type)	Quasi-experimental (pretest, treatment, posttest; no control group or randomization indicated)	All subjects increased 11.62 on the Frostig Developmental Test of Visual Perception, which was statistically significant. Visual motor functioning improved for all subjects when pre- and posttest "learning quotients" for subjects were compared
Bachara, Zaba, & Raskins, 1975	Learning disabled	Do figure drawings of learning disabled children differ on emotional indicators from the drawings of non-impaired children?	Two groups: an experimental group of 35 children matched in age (5 to 13 years) and sex (40 males and 30 females) with a control group of 35 children	70 subjects	Human Figure Drawings scored according to Koppitz for 30 emotional indicators	Subjects asked to draw a human figure	Ex post facto	The drawings of the experimental group showed omissions of hands and feet, excessive attention to eyes. The experimental group demonstrated a statistically significant occurrence of two of the Koppitz emotional indicators: feelings of inadequacy and sense of insecurity and helplessness
Netley, 1973	Learning disabled	How do subjects with drawing disorders differ from non-impaired subjects on other tests?	15 males, each of whom was referred to the hospital because of academic achievement problems. This group was matched for age and IQ (Wechsler Intelligence Scale of Children) with a control group of 15 males. The experimental group scored one standard deviation above the norm on the Bender Gestalt Test	30 males	Guessing Games Test, Motor Skills Test, and Prismatic Distortion Tests (Netley, 1973)	All tests were individually administered	Ex post facto	The experimental group made statistically significantly more guesses on the Guessing Game Test, and had more difficulty in analyzing sequentially a visual array and solving problems with visual-motor integration than did the control group

Table 1. (continued)

Raskin & Bloom, 1978	Learning disabled	What indicators of emotional problems occur in Kinetic Family Drawings?	50 children from a clinic (33 males and 17 females), divided into two groups by a chronological age median split (mean score on Wechsler Intelligence Scale of Children was 94.2 and mean age was 10 years 4 months)	50 subjects	Kinetic Family Drawing (Burns & Kaufman, 1970), judged with Koppitz (1968) criteria for emotional indicators	Subjects were asked to "draw you and your family doing something"	Ex post facto	No statistical difference between age groups. The emotional indicators did not show up with a statistically significant frequency
Arem & Zimmerman, 1976	Educable mentally retarded	How does modelling affect the creative drawing of the educable mentally retarded?	34 male and 34 female non-retarded 5th and 6th graders with a chronological mean age of 11.3 years and an IQ range of 89 to 111 (Lorge Thorndike Intelligence Test); 30 male and 24 female educable mentally retarded subjects with IQ scores ranging from 48 to 79 (Wechsler Intelligence Scale of Children or Stanford-Binet Intelligence Test); randomly assigned to the treatment and control groups	122 subjects	Used a modification of the Torrance Test of Creative Thinking, Figural Form B (Torrance, 1966)	Four treatments: 1) modeling only, 2) verbal description only, 3) a combination of 1) and 2), and 4) an unrelated art task	Experimental (randomly assigned groups with the inclusion of a control group (pretest, three experimental treatments, and posttest)	There was a statistically significant effect in favor of the modeling treatment on task performance for the educable mental retarded groups. The modeling treatment did not help the nonretarded group learn the task. There was only a 5% occurrence of copying from the model by the educable mentally retarded group. The higher the IQ, the less helpful was the modeling treatment in learning the task
Bryant & Schwan, 1971	Mentally retarded	What are appropriate instructional methods for use with the mentally retarded?	Self-contained class of 13 subjects ranging in chronological age from 8 years 6 months to 12 years 9 months and having IQ scores from 59 to 108; type of IQ test not specified; no control group or randomization indicated	13 subjects	Bryant Schwan Design Test (BSDT) (test of art information and terms based on the five design elements developed by the authors for this study); Peabody Picture Vocabulary Test (Dunn, 1965).	Fifteen half-hour weekly art classes that focused on a structured approach using drill and repetition of topics directly related to the BSDT	Quasi-experimental (pretest, treatment, posttest; no control group)	Subjects made significant gains on four of the five subtests of the BSDT. There was no statistically significant relationship between subjects' scores on the BSDT and the PPVT
Calhoun & Whitley, 1978	Educable mentally retarded	Is low self-esteem indicated in drawings of the self produced by educable mentally retarded subjects?	Eight primary and eight secondary school age educable mentally retarded subjects	16 subjects	Goodenough-Harris Drawing Test (Harris, 1966b); Coopersmith Self-Esteem Inventory (Coopersmith, 1967).	Subjects were asked to draw themselves. The Self-Esteem Inventory was administered individually to the subjects	Ex post facto	There was a statistically significant correlation between scores on the Self-Esteem Inventory and the Drawing Test scores for secondary school age educable mentally retarded students, indicating low self-esteem in these drawings

BEST COPY AVAILABLE

Table 1. (continued)

Carter, Richmond, & Bundschuk, 1973	Mentally retarded	Can art or movement or both be effective means of fostering creative thinking?	16 males and 10 females, ages 7 to 16 years, IQ range from 40 to 85. Subjects randomly placed in three groups (two experimental and one control)	26 subjects	Torrance Test of Creative Thinking (TTCT, Figural Form A, Torrance, 1966)	Three types of training: 1) visual/motor training (drawing, finger painting, clay, and bead work); 2) kinesthetic/motor training (dancing, tumbling, and jumping rope); and 3) control group (free play)	Experimental (Pretest, two training groups, two training groups, and one control group, posttest)	Scores on the TTCT indicated a statistically significant increase in flexibility scores for the visual/motor training (art) group. No statistically significant score increase on this test was reported for the control or the kinesthetic/motor group
Ireton, Quast, & Gantcher, 1971	Mentally retarded, behaviorally disordered, and learning disabled	Can the Draw-A-Man Test (DAM) be used as means of screening children for these handicaps?	All children in a pediatric clinic ages 4 to 6 years; 38 of these children were identified as scoring below 85 on the DAM	38 subjects	DAM (Goodenough, 1926; Harris, 1963). Nurses were used as judges after only one training session.	DAM scores were compared with other clinical evaluations of the handicapping conditions being investigated	Ex post facto	36 of the 38 children identified as scoring below 85 on the DAM had statistically significantly higher occurrence of mental retardation, behavioral disorders, and learning disabilities
Musick, 1977	Mentally retarded and multiply handicapped	What are the effects of a creative arts program in increasing subjects' visual perceptual skills beyond their expected curriculum levels?	Five female and three male mentally retarded and multiply handicapped preschoolers, termed *convenience sample*; no control or randomization indicated	Eight subjects	Eight behaviors necessary for public school admission were charted and compared to typical behaviors of subjects who were the same chronological age as the eight subjects. Drawings were collected during weekly art sessions over one semester and evaluated on criteria developed by Lowenfeld and Brittain (no date) and a baseline established. Post-treatment drawings/paintings rated on 1 to 5 point scale by three judges and videotapes of baseline and treatment behaviors judged	Two 20-minute art sessions each week for the whole semester were conducted by adults on a one-to-one basis	Quasi-experimental (pretest, baseline, treatment, posttest); no control group or randomization indicated	The level of subjects' "creativity" increased from a zero advance to an advance of 33 months. Results suggest art can supplement remediation programs and can help subjects attain visual perceptual skills

Table 1. (continued)

Greene & Hasselbring, 1981	Hearing impaired	Can a correlated art and language curriculum increase the language development of hearing impaired subjects?	21 subjects of normal intelligence, ages 5 years 6 months to 7 years 9 months from two classrooms of two state schools for the deaf. All randomly assigned to four groups	21 subjects	Form A and B of Boehm Test of Basic Concepts (BTBC, no date)	After Form A of BTBC was administered two treatments were given: 1) 5 weeks of traditional curriculum without art (control), or 2) 5 weeks of correlated art and language curriculum. Both treatments focused on language concepts that the pretest identified as unmastered ones. At the end of 5 weeks, treatments were reversed (and only after Form B of BTBC administered). At the end of 10 weeks, Form A of BTBC was re-administered to all subjects.	ABAB reversal design (time series strategy) (where each group receives both control and experimental treatment)	Every subject made statistically significant improvement in language concept development when the art curriculum was the treatment method
Davis & Hoopes, 1975	Hearing impaired	What differences exist between the House-Tree-Person drawings of hearing impaired and hearing children? Can emotional disturbance be predicted from these same drawings?	40 subjects, 7 to 9 years old (20 of whom were hearing impaired, 20 hearing), with equal number of females and males 44 subjects, 10 years old, half hearing impaired and half hearing; 22 males and 18 females	84 subjects	Behavior Rating of Pupils Scale (Lambert & Bower, 1961); Draw-A-House, Tree, Person Test (Rappaport, 1960; Koppitz, 1968)	Subjects asked to make three separate drawings (a whole person, house, and tree)	Ex post facto	Judges were unable to distinguish emotional disturbance from the drawings (that is, judges were unable to match drawing of a specific subject with teachers' ratings of the same subject on the Behavior Rating of Pupils Scale)
Silver, 1975	Deaf	Can art activities be used to develop cognitive skills (spatial concepts, classification, and sequential ordering)?	18 subjects in a control and 18 subjects in an experimental group randomly selected from three classes in a special deaf school (no IQ scores or ages reported)	36 subjects	14 cognitive skills (from Piaget)	11 art periods	Quasi-experimental design (pretest, treatment, posttest); no control group or randomization indicated	18 subjects in the experimental group scored statistically higher on the 4 cognitive skills test than the other subjects
Arkkell, 1976	Emotionally maladjusted	Can emotional maladjustment be predicted from figure drawings?	20 subjects (10 were judged as emotionally maladjusted and 10 judged as "adjusted" by clinicians). Ages ranged from 7 to 9 years old	20 subjects	Five groups of judges (10 teachers, 10 students, 10 administrators, 10 secretaries, and 10 clinicians) evaluate human figure drawings of the subjects	Subjects asked to draw a complete picture of a person	Ex post facto	There was no statistically significant difference between groups of judges. All judges predicted emotional maladjustment 79% to 83% of the time
Johnson & Greenberg, 1978	Orthopedically handicapped (polio)	How do figure drawings of polio subjects differ from drawings of non-impaired subjects?	32 subjects who had had polio were matched on age, sex, education, marital status, and locality with subjects who had not had polio; randomization not indicated	64 subjects	Four judges evaluated figure drawings of all subjects on 17 factors including movement, size, completeness, and "quality."	Subjects were asked to draw a person in a bathing suit	Ex post facto	Judges found no statistically significant difference between the drawings of the experimental and control groups

children thus screened, 36 did indeed have a higher occurrence of mental retardation or cognitive and behavioral problems.

Bachara, Zaba, and Raskin (1975) also discovered a significant difference in the emotional indicators (feelings of inadequacy and a general sense of insecurity and helplessness indicated by over-attention to the eyes and omission of hand and feet in the drawings) of the figure drawings of two groups of children, ages 5 to 13 years who were matched for sex, age, and intellectual functioning, but differed in terms of learning problems. One group had learning problems including eye/hand coordination problems, difficulty with tracking, and difficulty with visualization. The control group had no visual or academic difficulties. The figure drawings of the learning-disabled group displayed two of Koppitz's indicators of emotional problems.

Arkkell (1976) found that it was possible to predict emotional maladjustment from the figure drawings of children. This researcher took the drawings of 20 children, half of whom had been diagnosed as emotionally maladjusted by means of clinical evaluations. These drawings were shown to five groups of judges: one group each of teachers, students, clinicians, administrators, and secretaries. All judges were able to predict those children who had emotional disturbances from their drawings, 79% to 83% of the time.

Davis and Hoopes (1975), however, found that judges could not predict emotional disturbances from the House-Tree-Person drawings of hearing impaired and hearing children. Judgments of these drawings did not match teacher evaluations of the children. Although there were some differences in the ways the hearing impaired children drew trees and mouths, those children who had been identified as emotionally disturbed produced drawings that judges did not identify as the work of emotionally disturbed persons.

Taking a somewhat different approach, Netley (1973) investigated how children who had demonstrated drawing problems differed on other types of tests from children who were matched with a control group of 15 males. The experimental group had error scores that were one standard deviation above the norm on the Bender Gestalt Test (Koppitz, 1964). The experimental group had more difficulty in sequentially analyzing a visual array, more difficulty with visual-motor integration, and made more guesses on the Guessing Game Test (a test developed by Netley for the study).

Although the evidence is not conclusive, these studies suggest that it may be possible to identify students with potential emotional problems by assessing their figure drawings. The contradictory results in this area of study suggest the need for a larger, more comprehensive study of the House-Tree-Person and Kinetic Family Drawings of matched groups of the six major handicapping conditions (learning disabled, mentally retarded, emotionally maladjusted, hearing impaired, visually impaired, and orthopedically handicapped) matched with non-impaired groups of children, so that a set of norms can be established against which future research studies in the area might be compared. In addition, these same groups of matched subjects could be given the other standardized assessment instruments that have been used in the research studies mentioned above. Specifically, these six studies utilized the following assessment instruments: Coopersmith Self-Esteem Inventory (1967); Behavior Rating of Pupils Scale (Lambert & Bower, 1961); and Guessing Game, Motor Skills Test, and Prismatic Distortion Test (Netley, 1973).

Norms, once established, might be helpful in predicting emotional and visual-motor problems. Without such norms, prediction of any type of problem based on only one or two drawings from one subject can be tenuous at best. Moreover, such a research project might help to clarify the issue Rubin (1982) addressed—that standardized measures of personality traits and self-concepts are not sensitive enough to assess the deficits or progress of a specific handicapped individual.

Studies of the Learning Disabled

If the research studies are grouped by type of handicapping conditions, the largest single group of studies included in the NCAH literature review concerned the learning disabled. In addition to the five studies of the art products of the learning disabled already discussed (two of which were studies of learning disabilities and other handicaps), five other studies focusing on art and the learning disabled student were identified (Gair, 1975; Miller, Sabatino, & Miller, 1977; Silver & Lavin, 1977; Walker, 1980; Wood, 1977). This research suggests that use of traditional remediation techniques does not inhibit the artistic expression of the learning disabled student (Miller, Sabatino, & Miller, 1977) and that art activities can be effective remediation tools (Gair, 1975; Silver & Lavin, 1977; Walker, 1980; Wood, 1977).

Some of the traditional types of visual-perceptual mediation have been identified as potentially inhibitory to other artistic work. Miller, Sabatino, and Miller (1977) investigated how much remediation could affect the art work of learning disabled students. Tested were 35 female and 78 male students ages 6 to 10. Of these, 56 had no visual perceptual dysfunction and the rest had visual-perceptual problems, were underachievers, and had word recognition problems. All children tested were randomly assigned to three experimental groups and one control group. Each of the three experimental groups was given one standard type of visual-perceptual remediation (Merrill Linguistic Reader, the Frostig Program for the Development of Visual Perception, and the Early Childhood: Form Constancy Program). The control group received standard remediation work without any special visual-perceptual remediation. All children were asked to make pre- and posttest drawings illustrating a story they had been told. These drawings were rated by art education graduate students on seven independent variables. The results of these evaluations indicated that children who received specific visual-perceptual remediation techniques did not experience a disruption in their drawing abilities.

Silver and Lavin (1977) studied the potential of art for remediation with learning disabled students. They used three types of tasks (forming groups, spatial relationships, and ordering and conserving) incorporating art materials to remediate 11 children who had visual-spatial handicaps. All children made 22 pre-treatment drawings and were then involved in 10 Saturday art sessions, each an hour long, organized so that each child received individual instruction. Instruction was provided on a one-to-one basis by 11 art therapy graduate students. Post-treatment drawings of all children were evaluated and compared with the pre-treatment drawings and indicated a statistically significant improvement in the three task areas. The authors concluded that art can be an effective remediation tool for learners with visual-spatial handicaps.

Wood (1977) also found that art activities improved visual-perceptual functioning for eight children with a mean age of 9.3 years,seven of whom scored 90 or below on the Perceptual Quotient of the Frostig Developmental Test of Visual Perception (FDTVP). After 8 weeks of art activities, all children increased 11.62 points on the FDTVP, which was a statistically significant gain.

Gair (1975) also studied the potential of art in remediation of visual problems of students. She tested 20 children ranging in age from 7 to 12 years and having average IQ scores of 102. All children were given the five visual subtests of the Illinois Test of Psycholinguistic Abilities (ITPA) and all were asked to draw a design and a self-portrait prior to any experimental treatment. The treatment consisted of a slide/tape design curriculum that required 29 art tasks, and ran 1 hour a day, 5 days a week, for 7 weeks. After the treatment program, the children were again given the ITPA subtests and asked to draw a design and self-portrait. Pre- and posttest treatment drawings were rated on an author-developed scale and indicated a statistically significant increase in ratings. There were also statistically significant increases in ITPA scores in visual reception, visual association, visual closure, visual memory, manual expression, and receptive-expressive tasks. Gair concluded that art-based learning can help children learn other tasks and can improve visual skills as measured by the ITPA.

Some of the traditional types of visual-perceptual mediation have been identified as potentially inhibitory to other artistic work.

The effectiveness of art as compared to movement as a remediation and training vehicle was investigated by Walker (1980). She found that art was more effective than movement for remediation and training in working with hyperkinetic subjects. Using a time series ABAB reversal research design, she investigated the effects of painting and physical exercise on the level of hyperkinesis of four elementary school, learning disabled students. The students had been randomly selected from a group of 12 who were matched for attention to task behavior. Treatment A consisted of painting half an hour a day for 5 days. Treatment B included running, skipping rope, and tossing beanbags half an hour for 5 days. For three of the four children the art activities were the most effective in increasing attention to task behavior. The three increased their attention spans by at least 20%. For the fourth child, it was the gross motor activity that significantly increased the attention to task behavior.

Mention should also be made of those studies already cited that deal with art products of learning disabled subjects. Raskin and Bloom (1979) found no statistical difference between two age groups of learning disabled students and their indicators of emotional problems as illustrated in Kinetic Family Drawings. Bachara, Zaba, and Raskin (1975) did find a statistically significant occurrence of two of the Koppitz emotional indicators in a group of 36 learning disabled students. Ireton, Quast, and Gantcher (1971) discovered that the Draw-A-Man Test could be used as a means of screening 4- to 6-year-old children and identifying those who have learning problems and need to be tested further. Finally, Netley (1973) found that children with learning disabilities that were manifested as drawing disorders also scored differently on three other tests, had more difficulty in analyzing sequentially a visual array, and had problems with visual-motor integration. These research results suggest that drawings can be used as a means of identifying learning problems.

Studies of the Mentally Retarded

The next largest group of studies identified were four investigations of visual arts programs for the mentally retarded. Two of these four studies were with the mentally retarded and the multiply handicapped, and one with mentally retarded, behaviorally disturbed, and learning disabled children). Like Walker (1980), Carter, Richmond, and Bundschuk (1973) found that visual arts activities were more effective than gross motor activities in achieving a particular result. In the latter study, the result being measured was an increase in the creative thinking of the mentally retarded subjects.

As noted above, two studies dealt with the art products of mentally retarded persons. Calhoun and Whitley (1978) found that the self-drawings of mentally retarded, secondary school students correlated with a measure of low self-esteem. Ireton, Quast, and Gantcher (1971) found that the Draw-A-Man Test could be used to identify retardation as well as learning problems and could serve as an indicator of the need to further test children ages 4 to 6 in a pediatric clinic.

Both Bryant and Schwan (1971) and Arem and Zimmerman (1976) investigated different instructional methods that might be appropriate for use with the mentally retarded child. Bryant and Schwan found that a structured approach using drill and repetition was helpful in teaching art information and design terms to 13 students with chronological ages ranging from 8 years 6 months to 12 years 9 months, and IQ scores that ranged from 59 to 108.

Arem and Zimmerman (1976) found that a group of 54 educable mentally retarded children learned best when a modeling treatment was used. The control group of 68 nonretarded children were not helped in learning a task when the same strategy was used. It is interesting to note that when the researchers checked for instances of copying in conjunction with the modeling treatment, there was less than a 5% incidence of copying from the model presented in the educable mentally retarded group. This result is thought-provoking because "copying" is often one of the main criticisms that professionals make when a modeling methodology is used with children. The results of this study suggest that that criticism is not a valid one.

. . . if art activities can enhance the acquisition of language concepts, can they also enhance the acquisition of . . . other concepts from the school curriculum?

The final study of art with the mentally retarded was a report of the results of a special creative arts program to increase both the mentally retarded and multiply handicapped subjects' visual-perceptual skills beyond expected levels for this population (Musick, 1977). The program, which ran twice a week for 20 weeks, was evaluated by rating pre- and posttest drawings of the eight children who participated. Three judges evaluated the drawings and videotapes of the baseline and treatment phases and reported an increase of "creativity" (which was not operationally defined in the study but was based on the work of Lowenfeld and Brittain (1970) that ranged from no increase to an increase of 33 months.

On the basis of these investigations it seems that visual arts programs can enhance the creative thinking and perceptual skills of mentally retarded and that a more structured methodology is more effective with the educable mentally retarded and mentally retarded student. Research also suggested that by studying the art products of the children it is possible to identify retardation and learning problems that require additional testing on the part of clinicians. Finally, the low self-esteem of the mentally retarded child is reflected in his or her self-portrait.

Studies of the Hearing Impaired

In addition to the study of the drawings of hearing-impaired children discussed above (Davis & Hoopes, 1975), there were two studies of hearing impaired children and the effects of art activities on the development of their cognitive skills and language development. Silver (1975) studied the effects of an experimental art curriculum on the cognitive skills of 36 children from a school for the deaf. Half the children were randomly placed in an experimental group and half in a control group. The experimental group was exposed to a variety of art tasks over 11 periods. All subjects were evaluated on 14 cognitive skills before and after the experimental treatment. The experimental group made statistically significant gains on the 14 cognitive skills.

One of the few studies that investigated the effects of an integrated art and language curriculum on the language development of hearing impaired students was one by Greene and Hasselbring (1981). Using an ABAB research design, they tested 21 hearing impaired children of normal intelligence, ages 5 years 6 months to 7 years 9 months. The 21 children were taken from the population of two classrooms of two state schools for the deaf. These subjects were randomly assigned to four groups and all groups were given both the control and experimental treatments. As a pretest, Form A of the Boehm Test of Basic Concepts was administered. Two groups were taught the unmastered concepts from the BTBC using an art curriculum and the other two groups were taught the same language concepts using a traditional (non-art) curriculum. After 5 weeks, Form B of the BTBC was administered to all children and then the treatments for each group were reversed. Then, after 5 additional weeks, Form A of the BTBC was readministered to all the children. Every child made statistically significant improvement in concept development when the art curriculum was the treatment method.

Research Problems Occurring in the Studies

When one examines the summary charts for all these studies, it becomes apparent that many of the studies included in the NCAH literature review reflect a certain naivete regarding experimental design. Quite often, for example, studies failed to include information on how subjects were chosen. Many studies did not use a control group, without which it is impossible to draw conclusions about the effect any special treatment might have on any particular group of individuals (Ary, Jacabs, & Razavieh, 1972). Many of the studies do not even indicate whether there was a control group. Other studies do not state how the experimental and control groups were selected. (The best method of selection is randomization. If randomization is not possible, intact groups can be used and appropriate statistical methods applied to the data analysis.) Matching of subjects was another neglected aspect of experimental design. It is best to match subjects in terms of age, intelligence, sex, amount of prior art experience, and handicapping condition. Without matched subjects, one cannot make any conclusive statement as to whether a particular treatment was the cause of subjects' behavior changes (Kerlinger, 1973).

In addition to these inadequacies in experimental design, there were failures in defining the handicapping conditions being examined or the population being tested. For example, one study might state that mentally retarded, primary school children were tested, without providing any information as to what was meant by the term *retarded* and without specifying the subjects' ages. It would be more helpful to indicate that subjects ranged in chronological age from 10 years 5 months to 12 years 4 months and scored 45 to 55 on the same standardized test (such as the Stanford Binet Intelligence Test) and had no handicapping condition other than mental retardation.

Another problem that arose was the failure of many researchers to describe adequately the instruments they used to assess abilities or personality traits. At times a researcher would refer to the Draw-A-Man Test or to the Draw-A-Person Test or the Human Figure Drawing Test without specifying the originator of this instrument. Without this information about the assessment tools used, no researcher would be able to replicate the study. Moreover, in many studies, researchers discussed their own assessment tools and evaluative instruments or art product rating scales without clear explanations as to how these self-developed tests and scales were originated, refined, validated, and made reliable. Researchers also often failed to describe sufficiently the experimental treatments used.

Exemplary Studies and Recommendations for Meeting Research Needs

Perhaps two of the best studies reported in the NCAH literature review were the Walker (1980) study and the Greene and Hasselbring (1981) study. Both provide enough information about methods of selecting subjects and about pre- and post-treatment assessment tools so that it is possible to replicate these studies. Also, the Walker study explains how a time series strategy can be used in research with a very small number of subjects (in this case only four). The Greene and Hasselbring study (1981) provides a useful explanation of what is meant by an ABAB reversal research design. Because of clear reporting of their method of subject selection and assessment of pre-experimental behaviors and because of thorough attention to systematic research methods and appropriate statistical treatment, these studies are examples of good research in the visual arts with handicapped children. Moreover, their findings are credible and impressive; these two studies do document with hard evidence that carefully planned art activities can have positive effects on the development of language concepts and increased attention spans. Also, these studies are cast in terms that even the most skeptical scholars from disciplines outside of art therapy readily understand and respect.

Not only does a critical analysis of existing research studies in art for the handicapped underscore the need for better, more systematic study, but such an analysis also points out that there are many knowledge gaps in the field. There is a pressing need for more sensitive testing and evaluation in order to pinpoint more precisely the kinds of art tasks most helpful in the remediation of learning problems. For example, is one art medium better than another in remediating visual sequencing? Is a structured sequence of marker drawings more effective than a "free choice" drawing? Motor control is another area in which knowledge is inadequate. The research discussed in this review tells nothing of the effects of art activities on the improvement of motor control for orthopedically handicapped or mentally retarded persons. There is also a need for more systematic study of visually impaired and behaviorally disordered persons. If art is effective in the remediation of learning problems, can it also remediate problems that accompany other such handicapping conditions?

. . . the most widely used form of research reporting, the case study, has no generally accepted, systematic format . . . .

An integrated art and language curriculum can significantly enhance the language development of hearing impaired students (Greene & Hasselbring, 1981). What would be the results of similar studies with other handicapping conditions, especially mental retardation? Moreover, if art activities can enhance the acquisition of language concepts, can they also enhance the acquisition of reading, social studies, mathematics concepts, and other concepts from the school curriculum? In the treatment of emotionally disturbed individuals, what is the unique therapeutic effect that one art activity or a series of art activities can produce?

Finally, as noted above, there is an urgent need to examine existing assessment instruments and determine if they are suitable for subjects with handicapping conditions. If existing tools are suitable, then norms need to be established for these tools with various ages and types of handicapping conditions. If, as Rubin (1982) suggested, the existing tools are not sensitive enough for this purpose, then there is a pressing need to develop more appropriate assessment tools for use in research with individuals with handicapping conditions.

Art therapists believe strongly that art is a major means of treatment. The profession must document this belief in terms that laypersons and scholars from other disciplines can understand and accept. If art therapists lack the research skills and training to do this kind of investigation, then it is important that they acquire this expertise or interest scholars and researchers from other disciplines in collaborating with them to do the needed research (Anderson, 1981).

There is also a gap in systematic research in most studies being undertaken in art therapy. This research is necessary to provide standardized information for building the knowledge base of art therapy and for replication of important studies. With this need in mind it is interesting to note that the most widely used form of research reporting, the case study, has no generally accepted, systematic format for conveying information. Without this standardized format, researchers from outside the art therapy field are not as willing to accept the case study as appropriate research methodology. In fact, case studies are important research strategies; they help in developing hypotheses that, in turn, can form the basic questions for planning and implementing research strategies. What is needed is a generally accepted format and the systematic inclusion of certain kinds of information for all case studies. Moreover, a case study approach can increase its potential for generating data if time series strategies and ABAB reversing treatment research strategies are utilized.

If art has value as a treatment modality, and if this value is supported by evidence obtained from case studies, then the use of art as a treatment and assessment tool will stand the test of other types of research methods. Art therapists must begin to use other research methodologies, in addition to the traditional case study, if they are to expand knowledge and justify the discipline to scholars and policymakers outside the field.

References

American Association of Mental Deficiency. (1973). *Manual on terminology and classification in mental retardation* (Rev ed.). Baltimore: Garamond Pridemark Press.

Anderson, F. E. (1981). Research and issues in art for exceptional populations. *Studies in Art Education, 22*(2), 5–6.

Anderson, F. E., Ash, L., and Gambach, J. (1982). *A review of the published research literature in arts for the handicapped: 1971–1981.* Washington, D.C.: National Committee Arts for the Handicapped.

Arem, C. A., & Zimmerman, B. J. (1976). Vicarious effects on the creative behavior of retarded and non-retarded children. *Journal of Mental Deficiency, 81*(3), 289–296.

Arkkell, R. N. (1976). Naive prediction of pathology from human figure drawings. *Journal of School Psychology, 14*(2), 114–117.

Ary, D., Jacabs, L. C., and Razavieh, A. (1972). *Introduction to research in education.* New York: Holt, Rinehart and Winston, Inc.

Bachara, G. H., Zaba, N., and Raskin, L. M. (1975–76). Human figure drawings and LD children. *Academic Therapy, 11*(2), 217–222.

Boehm, A. *Boehm Test of Basic Concepts, 1969–71.* New York: Psychological Corporation.

Bruner, J., & Kenney, H. (1966). On relational concepts. In J. Brunner et al. (Eds.). *Studies in cognitive growth.* New York: John Wiley & Sons.

Bryant, A., & Schwan, L. B. (1971). Art and the mentally retarded child. *Studies in Art Education, 12*(3), 50–63.

Burns, R. & Kaufman, S. (1970). Kinetic family drawings. New York: Brunner/Mazel.

Calhoun, G., Jr., & Whitley, J. D. (1978). An investigation of the Goodenough-Harris drawing test and the (Coopersmith) self-esteem inventory. *Educational and Psychological Measurement, 38*(4), 1229–1232.

Carter, K. R., Richmond, B. O., & Bundschuk, E. A. (1973). The effect of kinesthetic and visual-motor experiences in the creative development of mentally retarded students. *Education and Training of the Mentally Retarded, 8*(1), 24–28.

Coopersmith, S. (1967). *The antecedents of self-esteem.* San Francisco: W. H. Freeman.

Current index to journals in education (1980–81). (Vol. 13, Nos. 1–6). Phoenix, AZ: Oryx Press.

Davis, C. F., & Hoopes, J. H. (1975). Comparison of house-tree-person drawings of young deaf and hearing children. *Journal of Personality Assessment, 39*(1), 28–33.

Dunn, L. (1965). *Peabody Picture Vocabulary Test.* Circle Pines, MN: American Guidance Services.

Eagle, C. T. (Ed.). *The music therapy index* (Vol. 1). (1976). Lawrence, KS: National Association for Music Therapy.

Eisner, E. W. (1972). *Educating artistic vision.* New York: Macmillan Co.

ERIC document reproduction service (EDRS). (1975–78). Arlington, VA: Computer Microfilm International Corp.

Frostig, M. *Marianne Frostig Development Test of Visual Perception*, 3rd Ed., 1961–66. M. Frostig, D. Lefever, J. Whittlesey, P. Maslow. Palo Alto, CA: Consulting Psychologists Press.

Gair, S. B. (1975). An art-based remediation program for children with learning disabilities. *Studies in Art Education, 17*(1), 55–67.

Goodenough, F. (1926). *Measurement of intelligence by drawings.* New York: Harcourt, Brace and World.

Granick, L. (Ed.) (1980–81). *Psychological abstracts* (Vols. 64, 65). Arlington, VA: American Psychological Association.

Greene, J. C., & Hasselbring, T. S. (1981). The acquisition of language concepts by hearing impaired children through selected aspects of an experimental core art curriculum. *Studies in Art Education, 22*(2), 32–37.

Harris, D. (1963). *Children's drawings as measures of intellectual maturity.* New York: Harcourt, Brace and World.

Harris, D. (1966). *Goodenough-Harris Drawing Test, 1926–63.* (Revision and extension of the Goodenough Intelligence Test, F. Goodenough and D. Harris). New York: Harcourt Brace Jovanovich.

Hewitt, M. L. (Ed.) (1977–81). *Education index* (Vol. 22–52). New York: H. W. Wilson Co.

Ireton, H., Quast, W., & Gantcher, P. (1971). The draw-a-man test as an index of developmental disorders in a pediatric outpatient population. *Child Psychiatry and Human Development, 2*(1), 42–49.

Jastak, J. (1976). *Wide Range Achievement Test (WRAT)*, 1940–65. J. Jastak, S. Jastak, and S. Bijou. Wilmington, DE: Guidance Associates of Delaware.

Johnson, F. A., & Greenberg, R. P. (1978). Quality of drawing as a factor in the interpretation of figure drawings. *Journal of Personality Assessment, 42*(5), 489–495.

Kalenius, W. G. (1978). The state of the research. In *Arts and the handicapped: Defining the national direction.* Proceedings from a conference, April 28–29, 1977. Washington, D.C.: Bureau of Education for the Handicapped, Division of Innovation and Development and the National Committee, Arts for the Handicapped.

Kerlinger, F. N. *Foundations of behavioral research* (2nd Ed.). (1973). New York: Holt, Rinehart and Winston, Inc.

Kirk, S. (1968). *Illinois Test of Psycholinguistic Abilities (ITPA)*, 1961–69. Samuel A. Kirk, James J. McCarthy, and Winifred D. Kirk. Urbana, IL: University of Illinois Press.

Koppitz, E. (1968). ***Psychological evaluation*** *of children's human figure drawings*. New York: Grune and Stratton.

Lambert, N., & Bower, E. (1961). *Behavior Rating of Pupils Scale: A Process for In-School Screening of Children with Emotional Handicaps*. Atlanta: Educational Testing Service.

Miller, S. R., Sabatino, D. A., & Miller, T. L. (1977). Influence of training in visual perceptual discrimination on drawings by children. *Perceptual and Motor Skills, 44*(2), 479–487.

Musick, P. L. (1977). Interdisciplinary study of creativity and behavior: Special child development. Houston, TX: University of Houston at Clear Lake City. ERIC Document Reproduction Service, ED 146 750.

Netley, C. (1973). Prismatic adaptation and visual-motor skills in children with language disabilities. *Journal of Learning Disabilities, 6*(6), 377–382.

Patten, D. S. (Ed.). (1971–81). *The art index* (Vol. 50–51). New York: The H. Whitxen Co.

Raskin, L. M., & Bloom, A. S. (1979). Kinetic family drawings by children with learning disabilities. *Journal of Pediatric Psychology, 4*(3), 247–251.

Rubin, J. A. (1982). Research in art with the handicapped: Problems and promises. *Studies in Art Education, 23*(1), 4–12.

Rush, J.C., and Krathochwill, T. (1981). Time-series strategies for studying behavior change: Implications for research in visual arts education. *Studies in Art Education, 22*(2), 59-67.

Silver, R. A. (1975). Using art to evaluate and develop cognitive skills. New Rochelle, NY: College of New Rochelle. ERIC Document Reproduction Service, ED 116 401.

Silver, R. A., & Lavin, C. (1977). The role of art in developing and evaluating cognitive skills. *Journal of Learning Disabilities, 17*(7), 416–424.

Torrance, E. (1966). *Torrance Tests of Creative Thinking*, Research Edition. Columbus, OH: Personnel Press.

Urban, W. (1963). The Draw-A-Person Test. Los Angeles: Western Psychological Services.

U.S. Department of Health and Human Services. (1981). *Art therapy in mental health literature survey series No. 3*. Rockville, MD: National Institute of Mental Health.

Walker, B. C. (1980). The relative effects of painting and gross-motor activities on the intrinsic locus of control of hyperactivity in learning disabled elementary school pupils. *Studies in Art Education, 21*(2), 13–21.

Wood, N. C. (1977). Directed art, visual perception, and learning disabilities. *Academic Therapy, 12*(4), 455–462.

The publication, A Review of the Published Research Literature in Arts for the Handicapped: 1971-1981, *is available from The National Committee, Arts for the Handicapped, 1825 Connecticut Avenue, N.W., Suite 409, Washington, D.C. 20003. Send $5.00 with your request.*

Identifying Gifted Handicapped Children Through Their Drawings

Rawley A. Silver, EdD, ATR

Rawley A. Silver, EdD, ATR has conducted three research projects on art and the handicapped, supported by the U.S. Department of Education, the National Institute of Education, and the New York State Department of Education. Parts of the following article are excerpted with permission from the manual of Silver Drawing Test of Cognitive and Creative Skills, *published by Special Child Publications, Seattle, Wash., Copyright © 1983.*

This study explores the question whether a drawing test can be useful in identifying children who have intellectual abilities that escape detection on traditional tests of intelligence or achievement. Two such children are considered: Joey, 8, learning disabled; and Alan, 14, an "average" student.

In the test under consideration,[1] drawing takes the place of language as the primary channel for receiving and expressing ideas. Stimulus drawings prompt response drawings that solve problems and represent concepts.

There are three tasks, designed to assess levels of ability in conceptual, spatial, and sequential thinking—the three areas of cognition said to be fundamental in mathematics (Piaget, 1970) and in reading (Bannatyne, 1971; Rugel, 1974; Smith, Coleman, Dokecki, & Davis, 1977).

The Drawing from Imagination task assesses ability to associate and form concepts. When appropriate, drawing responses are also scored for projection of feelings and for language skills. The Drawing from Observation task assesses concepts of space, and the Predictive Drawing task assesses ability to sequence.

In previous studies, the test was used to assess the abilities of children and adults who were language-impaired, hearing-impaired, learning disabled, or emotionally disturbed. Norms were developed, and in a pilot study, gifted children showed unusually high scores for their grade levels (Silver, 1973, 1976, 1978, 1982, 1983; Silver et al., 1980; Silver & Lavin, 1977).

Although the drawing test showed significant correlations with 10 traditional tests, a few children with high scores on the drawing test had low scores on the traditional tests. How can this be explained? Did these children have intellectual abilities untapped by the traditional tests? Were their low scores caused by subtle cognitive disabilities? Were they handicapped by emotional problems?

Whitmore (1980) found evidence that gifted underachievers had been confused with learning disabled children when, in fact, their major deficits were feelings of inadequacy. She cited special characteristics that cause the gifted children to be vulnerable: perfectionism (feelings of inadequacy and unrealistic expectations of performance), supersensitivity, deficit social skills, and social isolation.

These characteristics seem to fit one of the children, "Joey."

Joey

In the 2nd grade, Joey was not succeeding in the classroom. He had particular difficulty with reading and was on a behavior modification program. According to his teacher, "Only for that, I'm afraid he would not have progressed at all."

As measured by the Canadian Cognitive Abilities Test (CCAT), Joey's IQ was 91, below average. Only two of the 24 other children in his class had lower scores.

As measured by the Drawing from Imagination subtest, however, Joey had the highest score in his class, higher than the mean score of 103 2nd graders in the test's normative sample, higher than the eight gifted 4th graders in the pilot study, even higher than the adult sample. Joey scored in the 99th percentile.

To determine the relationship of the drawing test to the CCAT, the scores of the 25 children tested were correlated. On the Drawing from Imagination subtest, significant correlations were found at the .01 level ($r = .50$). On the other two subtests, Drawing from Observation and Predictive Drawing, no significant correlations were found.

Except for Joey, most of the children in his class were approximately as successful in Drawing from Imagination as they were on the CCAT.

---

[1] *Silver Test of Cognitive and Creative Skills*, published by Special Child Publications, P.O. Box 33548, Seattle, WA 98133.

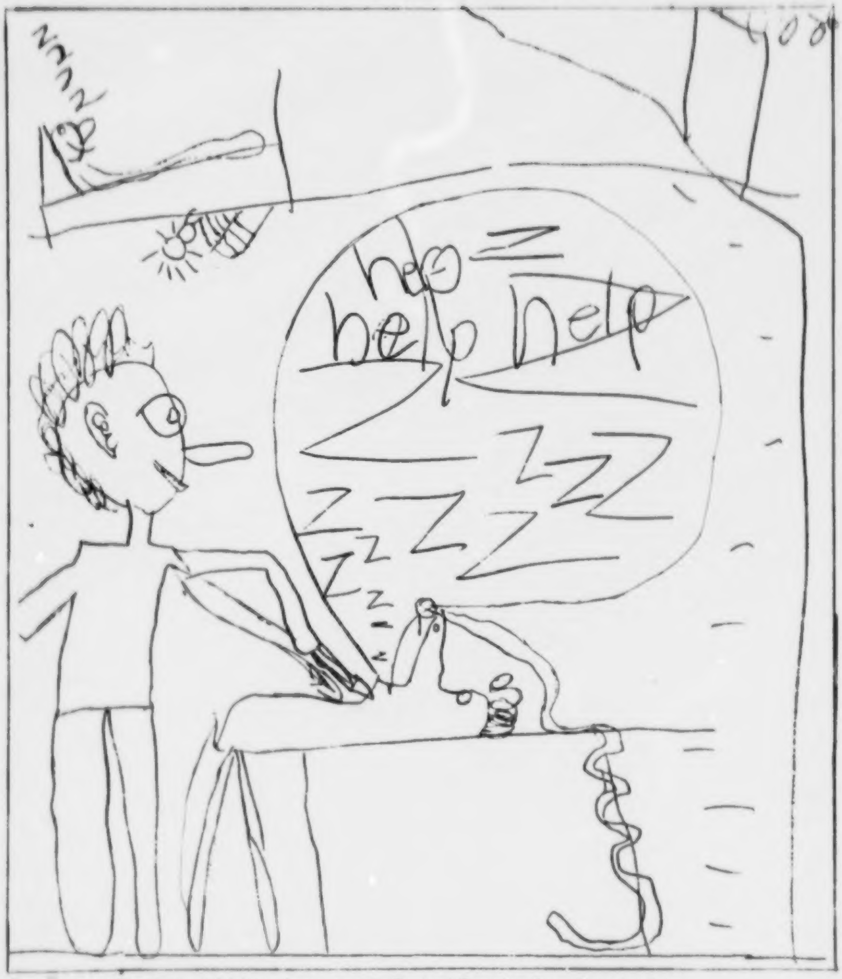


Figure 1.—"The Killier" (sic) by Joey, age 8, Pretest Drawing from Imagination.

The three children with the next highest scores in Drawing from Imagination had IQs ranging between 123 and 150 on the CCAT.

In the Drawing from Observation subtest, however, Joey had the lowest score in his class, well below the 2nd grade norm, placing him in the 14th percentile.

Joey's remediation teacher had offered to help develop norms for the drawing test by giving it to pupils in her school. Then, because she was interested in acquiring new remediation techniques, it was arranged that she would follow the art program of our research project (Silver et al., 1980). Supervised via correspondence and telephone, she worked with Joey individually once a week for 12 weeks.

While the art program with Joey was in progress, the CCAT was again administered, as it was once a year in his school. Joey's score increased 8 points, from 91 to 99.

Joey's Drawings

Joey's pretest Drawing from Imagination, Figure 1, entitled, "The Killier," (sic) seems to represent a doctor operating on a patient who calls for help even though anaesthetized. Upstairs, someone lies in bed, snoring.

Although Joey did not explain his drawing, it nevertheless provides considerable information about his ability to form concepts. It is recognized that impairment of this ability underlies maladjustment and language disorders. Forming concepts involves making selections, associating them with past experiences, and combining them into a context, such as selecting words and combining them into sentences. Selecting and combining are the two fundamental operations underlying verbal behavior, according to the linguist, Ramon Jakobson (1964). They are also fundamental in drawing—selecting subjects and combining them into images.

In the Drawing from Imagination subtest, the task is to select two subjects, one from each page of the test booklet, combine them into a narrative drawings, and give the drawing a title. Children are encouraged to change the stimulus drawings and to add other images of their own.

Joey's response drawing does more than simply show what his subjects do, the functional level typical of 8-year olds. It indicates that he selected subjects at the conceptual level, on the basis of an imaginative, well-organized idea that implies more than is visible.

His drawing shows that his ability to combine goes beyond the base line level, also typical of children his age (someone is upstairs). Furthermore, his ability to represent goes beyond imitating or restructuring the stimulus drawings of the test booklet. His drawing is original and expressive, representing feelings of intense distress and suggesting that he identified himself with either the victim, the sleeper, or the "Killier."

Joey's pretest Drawing from Observation, Figure 2, provides consid-

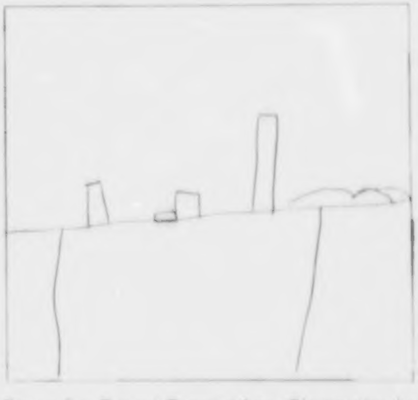


Figure 2.—Pretest Drawing from Observation by Joey.

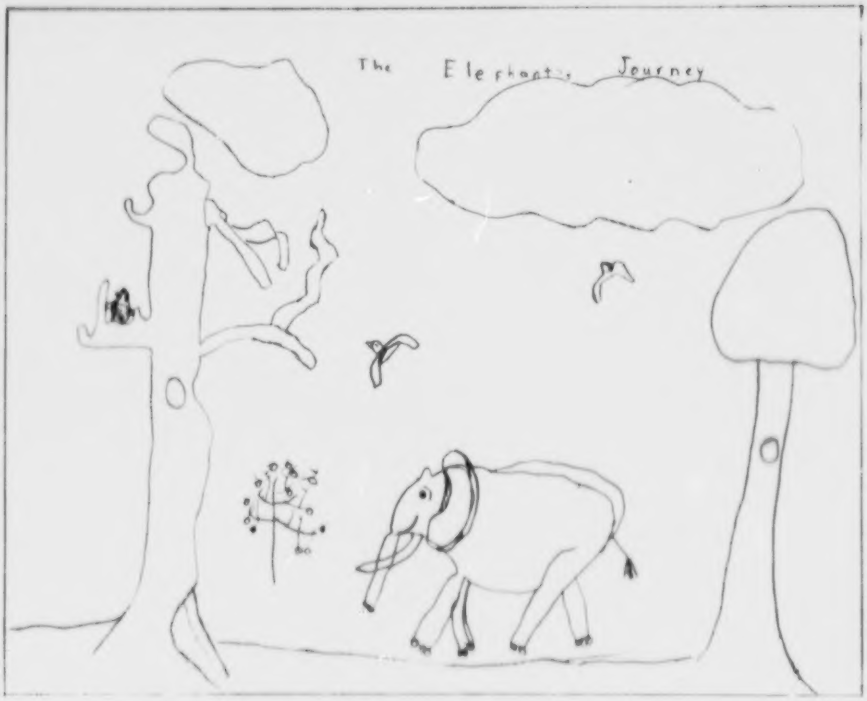


Figure 3.—"The Elephant's Journey," by Joey.

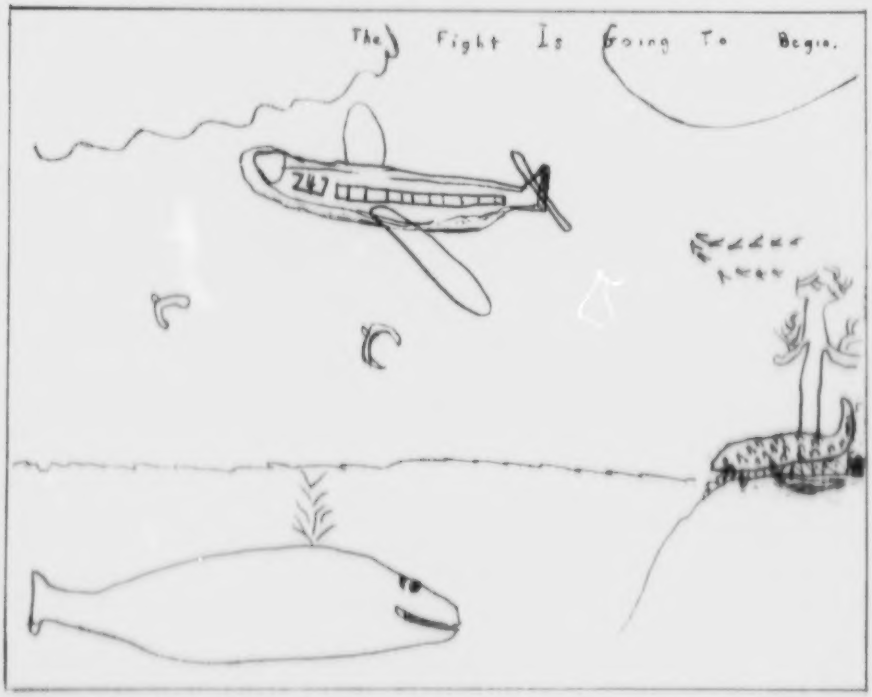

The Fight Is Going To Begin.
747

Figure 4.—"The Fight is Going to Begin," by Joey.

erable information about his spatial thinking. In this subtest, the task is to draw an arrangement of three cylinders differing in height and width, and a stone. Joey's response shows only one of the objects in the correct position—the tallest cylinder on the right. He confused all the left-right and above-below relationships, and failed to show any depth in his drawing although two objects in the arrangement were, in fact, in the foreground and two, in the background. Most 8-year olds can perceive and represent accurately these left-right (horizontal) and above-below (vertical) relationships although they often miss front-back (depth) relationships, drawing all objects in a row. Consequently, Joey's score in the 14th percentile, in Drawing from Observation, strongly suggests that something is wrong.

The art program begins with drawing from imagination, selecting stimulus drawings (different from those in the test booklet and now presented in groups according to category).

Joey selected an elephant and a tree—an old gnarled tree with a small young tree at its side, then drew "The Elephant's Journey," Figure 3. Although the elephant is under a cloud, it smiles. Birds are nesting or on the wing, and the feeling projected suggests hope for pleasant things to come, perhaps a metaphor for the new art class.

With time for another drawing in his first art session, Joey selected a whale and an alligator, then drew, "The Fight is Going to Begin," Figure 4. The whale and alligator confront one another, the alligator (and another old tree) on land, the whale (smiling) at sea, with birds and a 747 in the air. This drawing suggests that Joey was having second thoughts about the art program.

The following week, Joey drew "The Bear Chased them Amay" (sic), Figure 5. An unsmiling bear stands between two trees, one behind him, the other in front. The trees seem to hold back the sun as they hold back the bear. Facing the bear on the other side of the tree is a red car with a yellow flag, black wheels, and blue roof lamp, suggesting a military or police car, and above the car is a dark blue cloud. Only the car, cloud and sun (yellow) have colors, and they are colored in heavily with many strokes of a fine point, indicating that they were of much concern. Joey's title suggests a wish, contradicted by a drawing that projects feelings of isolation and frustration.

The next session of the art program called for painting (mixing tints

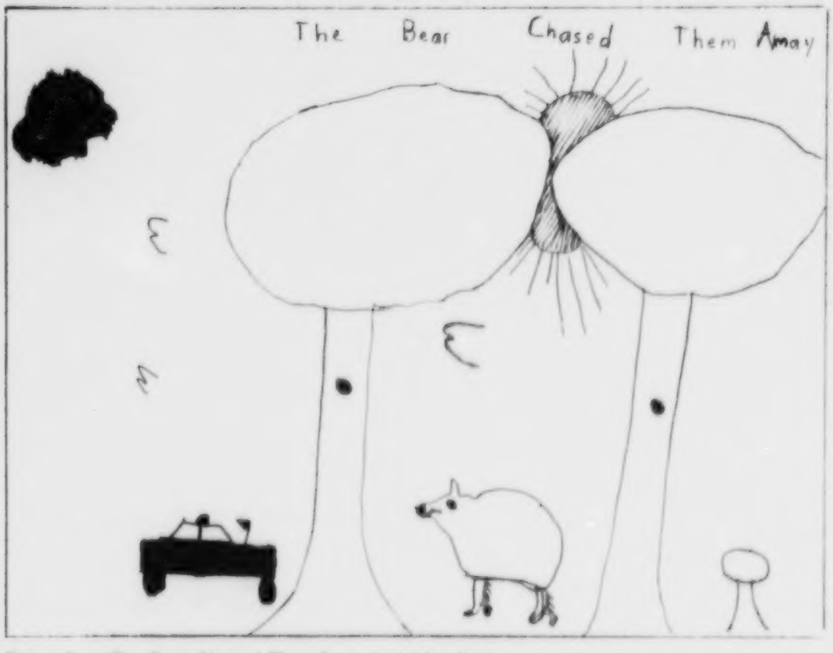

The Bear Chased Them Amay

Figure 5.—"The Bear Chased Then Amay," (sic) by Joey.

and secondary colors, then painting from imagination). Painting was followed by drawing from observation (an orange and a roll of construction paper at first, an apple was added, then a toy landscape). The following sessions included clay modeling, family portraits, and self-portraits[2] (Joey drew himself smiling.)

Joey's remediation teacher, Miss A, reported that even though he was "still struggling with objects in space," his classroom teacher had said, " 'You have Joe all turned on these days,' 'so he is thoroughly enjoying his experiences'." She felt that he had "improved almost 100%." Previously she had described him as "lashing out at his peers, sometimes justified but often uncalled for." As seen from an adult's point of view:

> Deep within, I believe Joe is hostile because he cannot express his very average abilities in our educational system. As I recall, his performance on the WISC-R was one in which the Performance IQ was superior to the verbal, thus Joey's dilemma, to exist in a school system which depends highly on the verbal component of the WISC-R.

Before a week had passed, however, a series of unhappy events began to unfold. Miss A, reporting on his ninth art session, wrote that she was not pleased with the results, "perhaps the answer lies in the fact that his regular teacher threatened him with missing the art lessons because of some misbehavior on his part." Joey's teacher carried out her threat, cancelling two lessons. Then Miss A became ill, postponing their 10th meeting for 5 weeks. With only 2 weeks before the end of the school year, she provided a final session in drawing from imagination, then administered the posttest.

After the summer recess, two letters addressed to Miss A went unanswered. Then, on learning that her telephone number had been assigned to someone else, I wrote to the school's principal who replied that Miss A had died.

Since then, inquiries about Joey's progress in school have produced meager results: when the CCAT was administered the following year, Joey's score dropped to 90 from 99 the previous year (during the art program), and 91 the year before the art program. Thus there is some evidence (the 9-point gain) that the art program was beneficial to Joey.

More substantial evidence is provided by Joey's posttest drawings. His Drawing from Observation shows the objects in the arrangement in the correct positions, horizontally, vertically, and in depth, even though discriminations are crude, Figure 6. This drawing scored in the 85th percentile, a dramatic gain from the 14th percentile score of his pretest response.

His pretest Drawing from Observation suggests that Joey may be suffering from deficits in visual perception or memory. These could also explain why he confused "m" and "w" in his title for Figure 5, reversals characteristic of learning disabled children. Although Joey's posttest drawing shows considerable improvement, there is no way to know if there was any carry over to other school learning, particularly reading and writing.

In his posttest Drawing from Imagination, "The Dog Chasing the Cat," Figure 7, there are several noteworthy changes. The pain (inflicted and suffered) in his pretest drawing, is gone. Although the cat is

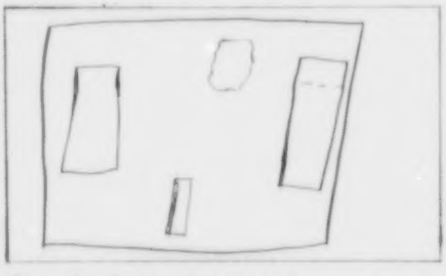


Figure 6.—Posttest Drawing from Observation, by Joey.

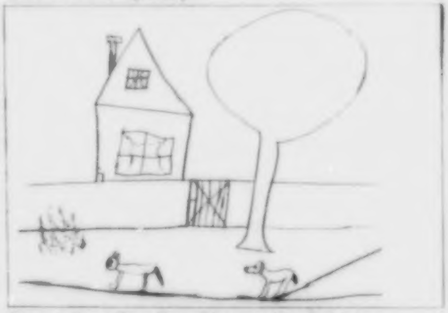


Figure 7.—"The Dog Chasing the Cat," by Joey, Posttest Drawing from Imagination.

---

[2] Further information about the art program may be obtained from the author at 1600 Harrison Avenue, Suite 105A, Mamaroneck, NY 10543.

being chased, it does not seem very unhappy compared with the man on the operating table in Figure 1. Thus one change is in Joey's Projection score, no longer the expression of intense feelings of distress.

Another change is in the form of the posttest drawing: a house is in the background, a wall in front of the house, a tree in front of the wall, and the chase carried on in front of the tree—spatial concepts that are unusual in drawings by 8-year olds. Thus Joey's score in Ability to Combine improved.

A third change reduced his score in Ability to Select. In this drawing, Joey seems to have selected the dog and cat on the functional rather than conceptual level, simply showing what they do. Furthermore they seem static compared to his dynamic pretest drawing. Thus Joey's gains in spatial concepts were offset by losses in content and creativity. He scored in the 91st percentile in his posttest Drawing from Imagination, down from the 99th percentile in his pretest Drawing from Imagination.

Was a decrease in spontaneity and expressiveness the price that was paid for gains in spatial skills? The only further evidence available is in Joey's last drawing from imagination, produced the week before the posttest was administered.

"Seeing an Elephant in the Woods!" Figure 8, was produced in the 10th and final session of his art program. Joey had selected the stimulus drawing of a young mountain climber wearing a backpack. In his drawing, however, the climber is elderly. He climbs a tree looking for the elephant in the wrong direction and wearing dark glasses. This drawing resembles Figure 5: the bear is now an elephant and the cloud extends across the sky. Once again, Joey's title contradicts his drawing: the man could *not* see the elephant, and as though to reinforce the contradiction, the elephant would be hidden from the airplane as well. The trees would hide it from view even if the plane had windows.

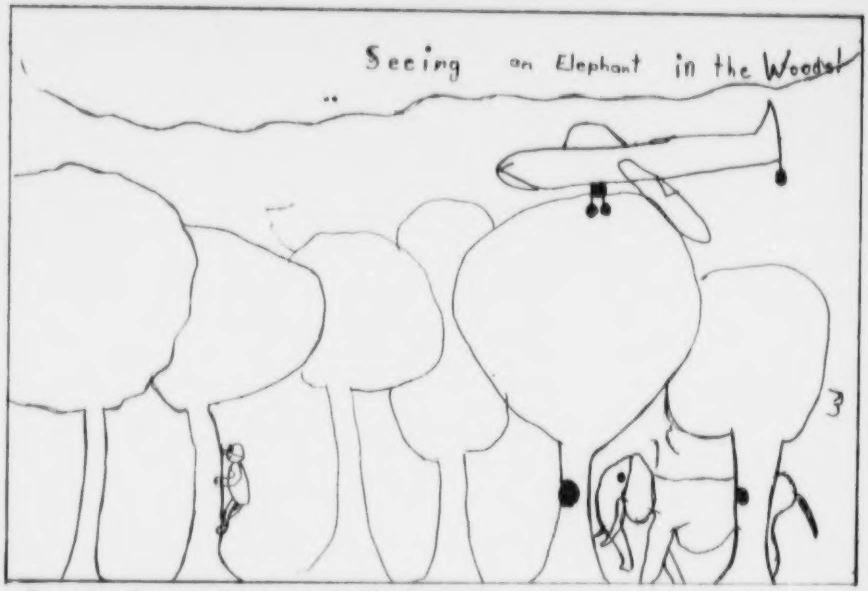

Seeing an Elephant in the Woods!
3

Figure 8.—"Seeing an Elephant in the Woods," by Joey.

Scored in the 99th percentile, this drawing received the same score as his pretest Drawing from Imagination, suggesting that Joey's spontaneity and expressiveness were still intact, and that he was still burdened with feelings of frustration, isolation, and inadequacy. Even Miss A had low expectations, referring to Joey's "very äverage abilities." These expectations may have blinded her to his true potential and blocked her kind intentions as the trees in his drawings blocked the sun and hid him from view.

Alan

Alan, 14, took the drawing test when it was administered to his class in order to develop 8th grade norms. The 21 children in his class were the total number of 8th graders in his school, a small public school in an urban, low to middle socioeconomic neighborhood. Scores on the test were then compared with scores on the two achievement tests used by this school, the Iowa Test of Basic Skills (reading and math) and the California Achievement Test (CAT) (reading only). These tests had been administered by school personnel at the beginning of the school year. On the Iowa, Alan scored at the 8th grade 7th month level (8.7); on the CAT, at the 10th grade level (10.0).

Compared to the scores of his classmates, Alan's scores were just below the mean for his class on the Iowa, and somewhat above those on the CAT. Thus he seemed about average in intelligence for an 8th grader.

On the drawing test, however, Alan had the highest possible score, and so far he is the only person tested to have the highest possible score.

The drawing entitled "Possessed," Figure 9, is Alan's response to the Drawing from Imagination subtest. He selected a man and a knife, then made a sequence of drawings. In the first, a devil speaks to someone lying in bed, saying, "Come." Then, the person in bed becomes possessed by the devil, saying, "Get out" as he faces a man who calls him "son," repeating "get out" as he wields the knife. Next, he looms over the man who lies stabbed, and finally vanishes as the words, "Be gone" issue from a cross.

This drawing, highly imaginative in both form and content, also represents violence, injury, and danger, which are scored for Projection, like Joey's pretest Drawing from Imagination. A single such drawing may represent only a passing mood. Repetition, however, suggests a need for clinical follow-up and verification by other methods. Alan did produce another such drawing, but consider, first, drawings by the two students with the highest scores on the CAT and Iowa tests, Max and Sarah.

Max

Max scored at the 11th and 12th grade levels on the Iowa (11.0) and the CAT (12.9). He also had a high score in Drawing from Imagination. Selecting a bride and a mouse as his subjects, he produced, "Panic in a Church" (Figure 10). Like Alan's, his drawing is imaginative and represents intense feelings of unhappiness but there is a crucial difference: Max does not seem to identify himself with the suffering bride (groom?). He seems to be enjoying her embarrassment. Alan, on the other hand, seems to identify himself with the person possessed.

Sarah

Sara scored at the 11th grade level on the Iowa (11.0) and on the CAT (11.7). In Drawing from Imagination, however, she did not have a high score, and her total score on the three subtests was slightly below the mean score for the class.

Sarah's drawing from imagination, entitled, "Going to the Malt Shop," Figure 11, is descriptive rather than imaginative. She seems to have selected her subjects (a girl and an ice cream soda) at the functional level—what they do or what one does with them—and represented an event that lacks the creativity and expressiveness of the drawings by Max and Alan. In projection, her associations were with a happy situation. She seems to identify with the girl to whom good things happen.

Why was Sarah's score low in the drawing test and high on the Iowa and CAT? Why did Max have high scores on all three tests? Why did Alan have high scores on the drawing test but moderate scores on the other two tests?

One possible explanation is that Max is strong in both visual and verbal thinking, the so-called left and right hemisphere skills; Sarah is strong in verbal thinking (high scores on the CAT and Iowa tests), weak in visual thinking (in the 44th percentile in the Drawing from Imagination subtest); Alan, is strong enough in verbal thinking to score at and above grade level on the CAT and Iowa tests, but his unusual skills in visual thinking are overlooked by these traditional, language-oriented measures.

Another possible explanation is that Alan is handicapped by emotional conflicts while Max and Sarah are well-adjusted. Reports in Alan's school file indicate that his mother had remarried when he was in the 4th grade, and that Alan had difficulty adjusting to his new family situation. His mother felt that this was the reason for his poor progress in the 4th grade, and in the years since, his progress remained poor. One teacher reported that he worked in spurts. Another reported conferences with his parents to discuss his work habits.

A week or so after taking the drawing test, Alan was asked to make another drawing from imagination,

Figure 9.—"Possessed," by Alan, age 14.

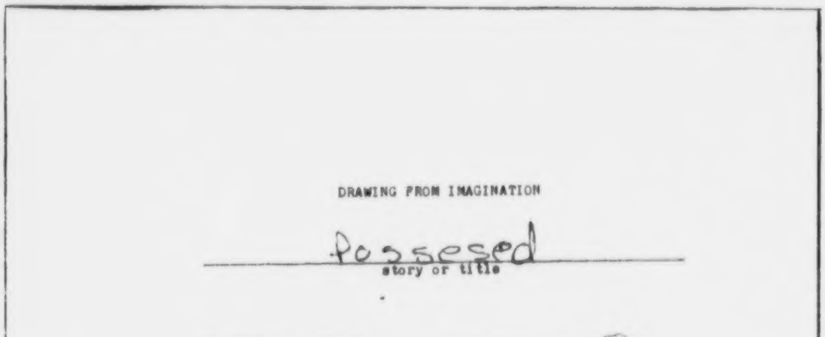
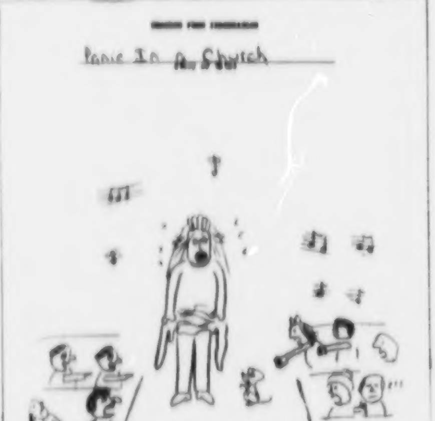


Figure 10.—"Panic in a Church," by Max, age 13.



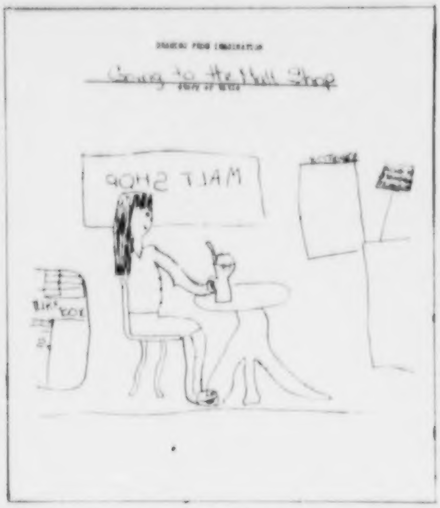

Going to the Malt Shop
MALT SHOP

Figure 11.—"Going to the Malt Shop," by Sarah, age 14.

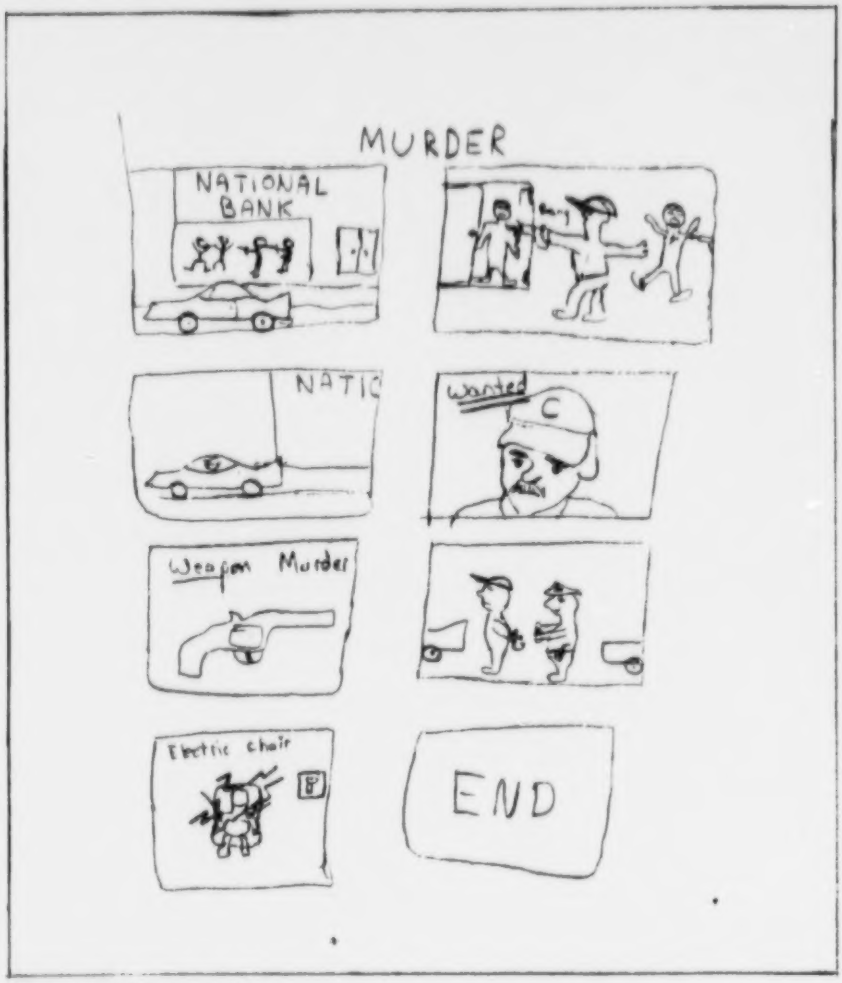


Figure 12.—"Murder," by Alan.

using the stimulus drawings rather than the test booklet. Again he drew a series of events, entitled, "Murder," Figure 12. It starts with a bank hold-up, two people are shot, a robber escapes, is wanted for murder, is caught, handcuffed, and electrocuted. Alan's repeated fantasies about murder and punishment suggest preoccupation with emotional problems, which could explain, in part, why Alan may be a gifted underachiever. There was no opportunity for follow-up.

Conclusion

In order to function well in school, a child must be free from debilitating emotional problems. It is difficult for teachers, administrators, and parents to recognize that a youth like Alan may be gifted but handicapped by maladjustment, or that a child like Joey may be gifted as well as learning disabled. There may be many like Alan, masquerading as an average student, or Joey whose disability masks his true potential, their gifts hidden even from themselves, but manifest in their drawings. Identifying such children could be a useful first step in art therapy.

References

Bannatyne, A. (1971). *Language, reading, and learning disabilities.* Springfield, IL: Charles C Thomas.

Jakobson, R. (1964). Linguistic typology of aphasic impairment. In A. de Reuck and M. O'Connor (Eds.). *Disorder of language.* Boston: Little Brown.

Piaget, J. (1970). *Genetic epistemology.* New York: Columbia University Press.

Rugel, R.P. (1974) WISC subtest scores of disabled readers. *Journal of Learning Disabilities, 10(7),* 57-64.

Silver, R. A. (1973). *Cognitive skills development through art activities.* N.Y. State Urban Education Project Report # 147 232 101.

Silver, R.A. (1976). Using art to evaluate and Develop Cognitive Skills: children with communication disorders and children with learning disabilities. *American Journal of Art Therapy, 16*(1), 11-19.

Silver, R. A., & Lavin, C. (1977). The role of art in developing and evaluating cognitive skills. *Journal of Learning-Disabilities, 10*(7), 416–424.

Silver, R. A. (1978). *Developing cognitive and creative skills through art.* Baltimore: University Park Press.

Silver, R. A., Lavin, C., Boeve E., Hayes, K., Itzler, J., O'Brien, J., Terner, N., & Wohlberg, P. (1980). *Assessing and developing cognitive skills in handicapped children through art.* National Institute of Education Project Report #G 79 0081.

Silver, R. (1982). *Developing Cognitive Skills Through Art.* In L. Katz (Ed.). *Current topics in early childhood education, Vol. 4,* Norwood, NJ: Ablex Publishing Corp. Also in ERIC (National Institute of Education Project Report) ED # 207 674, 1981.

Silver, R. *Drawing test of cognitive and creative skills.* Seattle: Special Child Publications. In press.

Smith, M. D., Coleman, J. Dokecki, P. R., & Davis, E. E. (1977), Intellectual characteristics of school labeled learning disabled children. *Exceptional Children, 43*(6), 352–357.

Whitmore, J. (1980). *Giftedness, conflict, and underachievement.* Boston: Allyn and Bacon.

Making Verbal the Nonverbal: A Commentary

Mildred Lachman-Chapin, MEd, ATR

Mildred Lachman-Chapin, MEd, ATR, interim associate editor of Art Therapy, *is acting director of the Graduate Art Therapy Program at Vermont College of Norwich University, Montpelier, Vermont. She taught art therapy courses in Washington, DC, and in Chicago where she had been the director of the Adjunctive Therapies Department at the Barclay Hospital for the past 4½ years.*

Let us take a look at words. Here we are, putting together a journal, a collection of writings about our profession. In our work, we pride ourselves on being able to make verbal the nonverbal, to help our clients make, through their art, a visual expression of the truth about their lives. As we encourage and foster this process, watch it unfold, and respond to the client-in-process as well as to the final product, we are in touch with the client's truth, we say, in a way that would not be possible if he or she were trying verbally to *tell* it to us. For most clients we also try at some point to translate something of what we see into words so that they can begin to be conscious about it, to find words for it. This is our specialty. We are trained to be directly in touch with what Spence (*Narrative Truth and Historical Truth,* 1982) refers to as the "historical." This, as he describes it, is the vivid experience as lived, as opposed to the telling of the experience. In the telling, he says we weave a tale, we try to "make sense," we distort by putting into "discursive" thought what is essentially "presentational" thought [(as Langer (1957) calls it).]

Malcolm (1983), reviewing Spence's book describes succinctly what Spence terms the "conflict between what is true and what is describable." Malcolm says, "The true memory or dream or thought is often so unformed and murky and inchoate that it cannot be expressed except by resort to narrative description, which somehow falsifies it. For it is the very nature of speech to form, rather than to express thought."

Like Malcolm, I was intrigued by Spence's book. Spence is a psychoanalyst who criticizes most severely what he considers the essential experience of psychoanalysis: the patient free associates in words as the analyst listens and responds in words with interpretive meanings. In this exchange, Spence writes, there are many avenues for distortion and error. Malcolm puts it this way:

> Like the patient, the analyst, caught in the conflict between what is true and what can be described, opts for the describable. Inevitably, Spence writes, "in making a formal interpretation we exchange one kind of truth—historical truth—for the truth of being coherent and sayable—narrative truth." In other words, if you can say it you are not being truthful, since the truth is unsayable, like the word of God.

Malcolm, coming to the defense of psychoanalysis, refutes Spence's argument. She claims that he has missed the point by focusing on the "truth" of words, both as they are uttered by the patient and as they are interpreted and responded to by the psychoanalyst. The "truth," she writes, is in the acting out of the transference between the two. She argues that the present, the here-and-now of the analytic encounter, not the past, is the true focus of psychoanalysis.

In a way, Malcolm's argument brings us back to the nonverbal. In her view it is not what the patient is telling, but how the patient is behaving (which includes *how* he or she uses his telling, and how this use reenacts past expectations and demands), that holds the kernel of "truth" that is available for examination and change. Malcolm adds that in the end, if the analysis is successful, the patient is enabled to live with the "story" that he or she believed to be the story of his or her life. The patient has a new understanding, achieved after many hours of using words, but not directly attributable to the verbal exchange. The patient may not even be able to put into words what this new understanding is. Rather it is by the new feeling of self, the new way of relating to the world, that he or she "tells" people of the change.

As I was pondering our own professional dilemma, shared with verbal therapists and their clients, of how to use words to tell the "truth" of what we, as art therapists, encounter nonverbally, I came across a book on neurolinguistic programming. It is called *Frogs into Princes* and is written by Richard Bandler and John Grinder (1979), who don't beat around the bush.

According to them, we use words to *trigger* unconscious and sensory responses. For it is at those levels, the authors claim, that we respond "truly" and where real change can occur. We react to the world, they say, through our three primary sensory systems: auditory, visual, and kinaesthetic. Each of us has a preferred response mode. Some individuals are predominantly auditory (responding to what they hear or are told); others are visual (responding to what they can see or can visualize); and others are kinaesthetic (responding to what they can feel in their bodies). If you address a visual person with visual words ("Do you see what I mean?"), an auditory person with auditory words ("I hear what you are saying"), and a kinaesthetic person with feeling words ("What is your gut feeling about this?") you, as therapist, will be more directly in touch with the client who is consequently more ready to work for change.

Then, through words, you lead the client to approach directly his or her own sensory responses, which become messengers of unconscious "parts"—those conflicting elements of his or her inner life that cannot be controlled through cognitive awareness. As a therapist you first use words to trigger the sensory gatekeepers of the unconscious into action. You then address the unconscious directly, as the gate-keepers allow it, coaxing, bargaining, wheeling, and dealing. Change comes, then, through successful bargaining with the unconscious. The conscious, the awareness that the client can express verbally, is bypassed. The therapist's words are used to bypass the client's cognition as a controlling element of change. The authors were led to work out this theory by observing and studying the work of Virginia Satir (1964, 1972) and Milton Erikson (Haley, 1967; 1973); they attempted to understand and duplicate the ways these therapists were able to effect quick and dramatic patient change through certain indirect verbal approaches to the patient's unconscious.

What do art therapists do with words? Do we use them to heighten awareness, to bring cognitive control, to further insight? Do we use them to bypass the conscious system in our own way—perhaps poetically? Do we use them to further transference, as do the psychoanalysts? Do we do all of these, none of these, or something else? I continue to examine these questions.

In our work, we pride ourselves on being able to make verbal the nonverbal . . .

What I can answer at this moment is that even if we are not sure how we use words with clients, we do need to use them as we relate to and learn from each other and our professional colleagues. This brings me back to our difficulty in writing, talking, and thinking about what we do. Those of us charged with training students to reach their client's "truth" through nonverbal images, find the process full of traps. One trap is the too-easy translation of images into words—"this means this; that means that"—which so often not only distorts, but also inhibits the unfolding of the living "historical" truth.

In the encounter with our client who makes pictures or art objects in order to convey some truth about himself or herself, we wonder how to complete the dialogue. Like verbal therapists, we wonder what words to use that will not distort the "truth" of the client's tale without words. If we try to translate it into words, we do an injustice to all that is unworded in their visual images. Instead, we can construct a response in kind, a poetic response reflecting, reverberating, replaying what we know of the client through the images made explicit in art work. Verbal metaphors can do this, if words are what we must use. A special kind of language is needed as we watch and register our client's images. (What is the visual counterpart of "listen," a word about receiving? "See," "watch," "look" are too active.) Once this contact is made, we, like other therapists, must choose the guiding theoretical framework we will use to effect change for our client—psychoanalytical psychotherapy, neurolinguistic, or any other. Or maybe sometimes giving the right response to the unsayable becomes in itself a step out of life's dilemmas for the patient, something like being understood and supported at the right time. In any case, we have learned that we must use words in a special way in referring to visual meaning. I think our special way with words should be similar to that of the poet or novelist who makes an image tale or paints a word-picture.

Once we are reasonably well versed in this new way of using words, we are faced with having to use them in still another way, to describe for other professionals what we have done. In our collaborative work in institutions, should we use the lingo of the milieu in which we work—medical, educational, social work, and so on? Or should we try to offer, through words, something of what "really" was being experienced by the client in the making of art? Pragmatism and the pay check may point the way more than a little here. In writing about our work in professional journals such as this, we must also be able to use language as scientists do, with precision and clarity. For here we are trying to write in a way that will enable others to understand and duplicate our work. Logical analysis, organized thinking, clear sequences of thought are our ways of making certain the reader can do again what we have done, or think what we have thought. That means that we must dig as hard, articulate as clearly, question as profoundly, and analyze as logically as possible.

Those who have already done this in art therapy have created a theoretical foundation for us. They have helped us know what we are doing and how to share this with each other. In particular, I refer to Elinor Ulman, who founded the *American Journal of Art Therapy* 20 years ago, before the American Art Therapy Association began. Through her writings she clarified some of our basic concepts. She has been a relentlessly demanding editor of that journal, insisting on the highest standards of clarity in thinking and writing. Not only did she require that you have something meaningful and relevant to say, but she also insisted that you say it well, which, I think, comes down to combining the word-language of the scientist on the one hand with the poet's reconstruction of reality on the other.

References

Bandler, R., & Grinder, J. (1979). *Frogs into princes.* Moab, utah: Real People Press.

Haley J. (Ed.), (1967). *Advanced techniques of hypnosis and therapy: The selected papers of Milton H. Erickson, M.D.* New York: Grune & Stratton.

Haley, J. (1973). *Uncommon therapy: The psychiatric techniques of Milton H. Erickson, M.D.* New York: W. W. Norton & Company.

Langer, S. (1957). *Philosophy in a new key.* Cambridge, MA.: Harvard University Press.

Satir, V. M. (1964). *Conjoint family therapy: A guide to theory and technique.* Palo Alto, CA: Science and Behavior Books.

Satir, V. M. (1972). *People making.* Cupertino CA: Science and Behavior Books.

Spence, D. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis.* New York: W. W. Norton.

The American Art Therapy Association, Inc.
(AATA)

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, The AATA Journal, discounts on publications, discount on admission to the annual convention, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (A.T.R.). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA office

MEMBERSHIP CATEGORIES:

Initial application for membership in the Association shall be accepted in one of the following classes: ASSOCIATE, STUDENT, or CONTRIBUTION. Applications for PROFESSIONAL membership shall be reviewed following one year of association membership in good standing.

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the Annual Meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee

Annual Dues: $25.00

Applications for student membership must be accompanied by a copy of current ID.

Associate Membership shall be open to individuals interested in the therapeutic use of art, and who wish to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the and to attend the Annual Meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $40.00

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $80.00

Professional Membership is subject to approval by the Membership Committee, individuals who have been associate or student members of the Association for at least one year and who have completed professional training in art therapy and who are or have been engaged in the therapeutic use of art are eligible. Professional membership shall provide for their participation in all activities of the Association and receipt of all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA office for an application.*

Annual Dues: $65.00

Credentialed Professional Membership shall be open to individuals who have met the qualifications and been approved for Professional membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in *Documents and Procedures Relevant to Professional Registration.*

Annual Dues: $70.00

MEMBERSHIP APPLICATION

☐ Associate ☐ Student ☐ Contributing

Name ______________________________
Last First Middle

Preferred Mailing Address ______________________________

____

____
City State Zip Code

Phone ______________________________

Title ______________________________
Occupation or Profession

____
Employer or Educational Institution

Make checks payable to AATA and return with application to:
American Art Therapy Association, 5999 Stevenson Avenue Alexandria, VA 22304

VIEWPOINTS

***VIEWPOINTS** provides a forum for sharing ideas and graphics about issues facing art therapists. The following selections are related in their emphasis on art.*

The Art in Art Therapy

Harriet Wadeson, PhD, ATR
Chicago, Illinois

As one who has been clothed in the garments of "art psychotherapy," it is unusual for me to be recognized in my "importance of art" garb. Perhaps these are my undergarments, which I presume others know I wear even if they do not show. It is about that aspect of our work that I wish to address, as well as the extension of creativity into the therapeutic relationship. Is art, therapy? Is therapy, art? That both are possible is obvious, because as art therapists we know that this combination is the power and purpose of our work. And yet subtle pressures often lead us astray from the very heart of our unique philosophy: art as therapy and therapy as art.

A particularly strong pressure is one that I call "institutional." As a director of an art therapy graduate program, I have witnessed the experience of students and graduates as they enter the field. Often, they work in isolation from other art therapists, being the sole art therapy member of a treatment team. The hierarchical ladders they begin to ascend, usually from the bottom rungs, are seldom art oriented. More often these hierarchies are developed along a medical, social service, or educational model. I refer to these institutions as hierarchies (rather than as hospitals, agencies, or schools) because it is their hierarchical structure that has an impact on the art therapist in terms of power. Entering this sort of structure not only at the bottom, but also as an anomaly, beginning art therapists often feel pressured to conform to the modus operandi of the facility. I have seen art therapists trying to assess patients in the manner of the facility, to chart the same sort of material, to transmit information to other staff in the way in which they communicate with one another, and finally to relate to patients and clients in the manner of other therapists. They become junior psychologists, social workers, or psychiatrists in looking for the way up the ladder. Often they have few other models. The art becomes a mere activity or excuse for contact.

What gets lost is art's powerful potential for catharsis, immersion in feeling, synthesis, and integration. Lost is a fuller communication through imagery, spatial relationships, color, and texture. Lost is art's great ladle for dipping into the unconscious soup. When art therapists forget the mysterious therapeutic possibilities of art-making, they lose their unique source of power.

But that is not all. If there are any therapists whom one would expect to bring creativity to the therapeutic relationship, it would be therapists whose métier is art. It has long been recognized that creativity requires some degree of spontaneity. And yet there are art therapists who plan activities in advance and do not deviate from them, who eagerly seek out "techniques" that others have used. Art therapy in this sense becomes a resort to gimmicks. Therapy cannot be a lesson plan or a series of exercises. What gets lost is the art therapist's sensitivity and responsiveness to the client's ongoing process, and often to the relationship as well. And the art expression also may be diminished because it comes from the therapist's agenda rather than the client's expressive potential. This sort of over-structure is often a response to the art therapist's own anxiety at the expense of creative spontaneity in relating to clients.

I believe we must look for solutions to the all-too-understandable pressures that cause a beginning art therapist to feel anxious, isolated, and powerless. I believe we must provide art therapy models in addition to those provided by other professionals in the beginning art therapist's development of professional identity. Art therapists may need to be encouraged to recognize what we already know. We need to remind ourselves and our colleagues that our area of expertise is *different* from that of other professionals. If we remember the power of art for self-expression, communication, understanding, and integration, and approach the therapeutic relationship with creativity, we will recognize that ours is a unique way in which to work with others. If we perceive ourselves as providing treatment through art, as experts in an area in which co-workers are less familiar, rather than as experiencing ourselves as junior members of a treatment team, then we will relate to patients, other staff, and the institution out of a sense of confidence in the power of our work. Particularly in relating to other staff we will find ourselves communicating out of the richness of our special source of data. And of course, our clients will benefit from our creative relationship to the therapeutic process. In our hands, art can truly be therapy and therapy can be art.

The Art Therapy Intensive

Shaun McNiff, PhD, ATR
Cambridge, Massachusetts

For the past 5 years I have been conducting training programs in the United States, Europe, and Israel. Because of time constraints the groups are structured as "intensives," meeting for 8 to 12 hours a day for 3 to 5 days. The intensive takes on the qualities of a spiritual retreat, a prolonged shamanic healing ceremony, or a seasonal celebration in a tribal community. The immediate goal of the training group is to provide an opportunity for participants to experience the ways in which art heals; the long term goal is to become a master of that healing process.

I am discovering that the therapeutic and creative value of the intensive is usually determined by the extent to which it allows for the creation of *a studio of expression* for all group members. My job seems to be one of always initiating the sanctification of the group place, inspiring expression and encouraging the creation of helping relationships between group members. Time, even more than the quality of the physical space, is the basic element needed to create the studio environment. We will often work individually for 3 to 4 hours on art works before coming together as a group for "sharing."

Within the time structure of the intensive we are given the opportunity to work thematically through multiple creations, allowing personal process to emerge with depth and variety. We might need as much as 2 hours of preparatory work to truly relax and open feelings and find the form of our expression.

The extended *time* that we spend together creating and sharing our work allows for the full expression of conflict and frustration. Many people resist the freedom of the process, desiring more "structure" and guidance. The groups deal with and embrace conflict, using it as fuel for ongoing transformation. I tell the training groups that conflict is our subject matter, the material we work with as therapists, the energy that we must master and help others transform into art. Through conflict, groups grow closer and become a community. The group enactment of inner dissatisfaction releases blocked energy and acknowledges the dark side of our personal and collective souls. Art's healing power lies in its ability to provide exaltation through the expression of pain and conflict. Within the intensive, time spent in personal creation can be viewed as a pilgrimage into the self, demanding sustained concentration. Sharing with the group as a whole complements the individual process and results in the creation of a collective energy that supports continuous personal creation.

Art and healing are the same energy. They transform one form of life into another, giving healthy expression to pain and illness. My personal interests are in the depth psychology of art, the primal spiritual elements from where all creation and healing emerge. In my experience it is art that reveals the depths. Art can be an ambitious and sophisticated therapy. Within the intensive, therapy takes the form of ART, rather than art trying to squeeze itself into and justify itself within the structures of conventional psychotherapy. Therapy becomes united with the creative transformation and sensitivity of art.

I am returning more each year to work in the art studio of therapy. It is a place where there are no dichotomies between art and therapy; where a psychology of personal depths can emerge in the form of art expressing profound personal feeling. An environment of this kind might beckon artists reluctant to accept "art therapy" because of their fears that serious art values are being violated through subordination to, or over-identification with, conventional therapeutic systems of thought and action. Within the studio environment of the intensive, art is the primary therapeutic process. The artist becomes part of a community committed to the revelation of self and group through shared creativity. In the intensive, I personally experience the "lost unity" of art, spirituality, community, and individual mystery. These primary elements will emerge if simply given the proper Time, Space, and Support.

The art therapy intensive becomes a microcosm of nature's ecological interdependence where creations and people are linked to one another. Everything emerges and takes shape in its own time.

The poem below is a response to the title of this section as well as reflection on the similarities between portraiture and therapy.

VIEWPOINT

Only I can stand here;
Only my eye can view you;
Only my I can take you in from here.

When I touch you with my eyes
You touch me with your presence.

Eye invites you to my soul

I wander over your face.
I feel you in my fingers.
Pen in hand, I know your
  framed bones
  wrapped softly
  up and over here
  there down and back
  shadowed deeply here
  there caught in light

In my onliness you give to me for taking.

Evadne McNeil, ATR
Glen Ellyn, Illinois

REVIEWS

A Review of

Michelangelo: A Psychoanalytic Study of His Life and Images

Robert S. Liebert, MD, New Haven and London: Yale University Press, 1983, (435 pages; $29.95).

Ellen Handler Spitz, PhD, *is with the Center for Psychoanalytic Training and Research, Columbia University.*

Since the publication of Freud's now classic and much discussed, disputed, and imitated monograph on Leonardo da Vinci (1910), numerous psychoanalysts have entered the domain of the arts in an attempt to illuminate issues such as the relation between an artist's life and work, the nature of artistic creativity, and the origins of specific and recurrent symbols. This year, Robert S. Liebert, MD, wrote *Michelangelo: A Psychoanalytic Study of His Life and Images*, which both partakes of this Freudian tradition and, in refreshing ways, departs from it. His study has relevance not only for scholars in Renaissance art history and psychoanalysts with a penchant for art, but also for all who share his passion for probing the complexities of created visual images—images that have the power to arrest, to evoke, and to endure.

In the 70-odd years since Freud wrote his *Leonardo*, significant changes have occurred both in the cultural milieu where such writing on art takes place and within psychoanalytic theory itself. Such change is reflected in Liebert's book in terms of both methodology and goals. Although, like Freud, he is principally concerned with relating the internal and external events of Michelangelo's life to his works, especially to the major sculptures, Liebert shifted his focus from the presumed pathology of the artist to the works themselves. He regards these works taken together not as evidence to support a tentative diagnosis of Michelangelo *qua* patient, but rather as the major datum for whose interpretation all other facts (e.g., historical records) and hypotheses (e.g., psychoanalytic reconstructions) must be mustered. In other words, Liebert gives primary weight and emphasis to the visual imagery itself. Hence, his is genuinely a book about art. It discusses the shift that has taken place in this century from the Romantic, expressive, artist-centered mode of interpretation still in vogue in Freud's time to the critical approach of this era in which the primacy and autonomy of works of art are stressed and in which the artist's manifest and latent intentions become important only insofar as they illuminate particular aspects of given works.

As even Freud's staunchest apologists now agree, his data on Leonardo were often selected arbitrarily, misinterpreted, and distorted. By contrast, Liebert's book reflects meticulous scholarship, grounding its psychoanalytic hypotheses on a foundation of data amassed from a rich variety of sources. These sources include contemporary biographies, Michelangelo's letters, poems, personal documents, and drawings, a thorough acquaintance with the artist's oeuvre and that of contemporary Florentine masters, as well as aspects of the relevant iconographic tradition (both mythological and religious). Thus, Liebert utilizes what I have called elsewhere a "documentary" approach within the psychoanalytic tradition, an approach that leads him to his most remarkable contribution.

That contribution is the tracing through Michelangelo's works of themes and motifs borrowed from the works of earlier artists. Of course, such tracing of figure-types, poses, and other stylistic idiosyncrasies to their sources in antiquity has, since Panofsky, been the staple of research in art history. But Liebert's uniqueness lies in the questioning of such artistic choices from a psychodynamic perspective. Thus, in subjecting these sorts of decisions to psychoanalytic inquiry, Liebert, using Michelangelo as a special case of a more general principle, demonstrates that an artist's particular problems and visual solutions (both in terms of form and content) make sense not only culturally and intellectually but also in terms of his own persistent intrapsychic themes. Liebert points out that Michelangelo, operating in the Renaissance tradition, which sponsored the adaptation and re-working of classical visual material for religious purposes, was able to put this tradition to work for himself psychically by appropriating, for the expression of forbidden unconscious wishes, a series of acceptable symbolic forms. In so doing, Liebert offers us a richer understanding of the imagery than previously was possible.

In the course of his chronological and well-illustrated book, Liebert presents the series of Michelangelo's madonnas, his sculptures for the tomb of Julius II, the pietàs, and so on, tracing with the author as many interrelationships as possible among formal, thematic, affective, and iconographic elements. These form the broad-based substructure of evidence on which Liebert has built and from which he has elicited his psychoanalytic hypotheses.

Rather than offer a condensed example of his approach which, as is the case with all psychoanalytic interpretations, derives plausibility from the repetition of its general trends over a series of examples, this reviewer suggests that the major value of this book lies in its paradigmatic quality. Its power to enhance experience with works of art and to offer insights into the psychic life of that conflicted and enigmatic titan known as Michelangelo, emanates from Liebert's unique admixture of psychoanalytic narrative with ingredients drawn from relevant nonpsychoanalytic systems of interpretation. This rich merging of disciplines enables him to hold out the promise of telling a story that is not only internally consistent but that also tallies with the facts as they are known. Such an ambitious promise, with all the as yet unresolved methodological and philosophical difficulties it entails, lies at the heart of this book and sets it apart from others of its genre.

This book's implications for clinical practice warrant discussion as well. In reading it and experiencing the intellectual excitement and aesthetic value of integrating knowledge from multiple contexts, readers will become increasingly aware of the poverty of any approach to art that would omit either a cultural-historical or a psychoanalytic dimension. In clinical work, where therapist and patient share the same time and place, cultural contexts are perhaps too often taken for granted and full therapeutic reliance is placed on transference phenomena, the ad hoc application of general theory, or both. Liebert's book, with its profuse documentation and respect for the contextual aspects of human data of all kinds, with its commitment to a species of truth that can withstand the rigors of scrutiny under the lights of various disciplines, may well serve to inspire practicing clinicians with a renewed sensitivity to the irreducibility of art.

Liebert states in his conclusion that "We cannot account for Michelangelo's extraordinary endowments as a sculptor, architect, painter and poet" (p. 416). In applying a mind trained in psychoanalytic theory, an eye trained in art history, and the disciplined will of the patient scholar to works of genius, Liebert has provided a paradigm, however incomplete, for further exploration in the arts. Michelangelo is no more "accounted for" or "explained" in these pages than is any work of art by any critic, or the mind of any patient by any therapist. Rather (and perhaps this is all that can and should be hoped for at the present), this book enriches the context for experiencing specific imagery and, in equal measure, expands interpretative horizons in general.

References

Freud, S. [1910]. Leonardo da Vinci and a memory of his childhood. *Standard Edition*, 1953, *11*, 63–137.

A Review of
Art and Disabilities

Florence Ludins-Katz and Elias Katz. Berkeley, California, Institute of Art and Disabilities, 1983, 235 pages with black and white illustrations, limited photocopy edition, $15.00.

Carole Kunkle-Miller *ATR, is an art therapist at the Western Pennsylvania School for the Deaf and Coordinator of the Art Therapy Preparation Program, Carlow College, Pittsburgh, Pennsylvania. She chairs the AATA Special Committee on Art Therapy with the Disabled.*

In 1973, Florence Ludins Katz, an artist and educator, and Elias Katz, a clinical psychologist, began a project based on a unique and exciting concept. Their dream was to establish a creative arts center that would be a stimulating and noncompetitive environment designed to assist disabled artists and nonartists to reach their highest level of artistic ability. They believed that the disabled should be active members of the community and that this goal could best be accomplished through such a center.

Their program, Creative Growth, is now well established, offering art studio facilities to handicapped persons, ranging from those with severe physical limitations to severe mental impairments, including individuals with varying levels of artistic skill and experience. Creative Growth is a place where people come to *create art*; the authors emphatically state that creating art is not therapy, nor is it recreation or prevocational training. The creative experience is valued in and of itself, as a worthwhile personal endeavor; it represents "work" to many of the individuals. The basic premise is that, given the right opportunities, the disabled can be creative.

> The Creative Art Center sees each person, no matter how disabled, mentally, physically or emotionally, as a potential artist and seeks to develop his ability to create and to grow through rich and varying art experiences within a supportive environment (p. 11).

Based upon their extensive experience in establishing and directing programs and centers for the disabled, Ludins-Katz and Katz have compiled a limited edition, photocopied publication that focuses upon the philosophy, conceptualization, and implementation involved in establishing a creative art center for people with disabilities. Their work reflects considerable brainstorming about the components of a successful program. This publication, a compilation of pre-tested ideas, is directed toward professionals interested in replicating such a program.

The uniqueness of the program is its focus on a topic that has only recently received national attention. Considering that Public Law 94-142 (Education for All Handicapped) was implemented in 1978, the concept of art for the disabled child is still fairly new. The notion of providing studio art experiences to disabled *adults*, with the primary goal being to stimulate their development as artists, is both novel and noteworthy. The authors' steadfast belief in the potential for creative growth in the disabled adult serves as an additional model to other professionals.

Art and Disabilities begins with a brief discussion on creativity in general, as well as an exposition on the creativity of people with disabilities. This is an essential starting point. In designing an art program for the disabled, one needs to examine the nature of creativity and its application to the disabled. Misconceptions about the disabled's impaired creative ability are frequently the stumbling block preventing many art educators and art therapists from considering work with this population.

The specific intent of the book is to provide information about initiating a creative art center. In many respects, the book is similar to a "how-to" manual, describing the details of program implementation. The authors freely share the wealth of their experience, giving their thoughts on stimulating community involvement and support, choosing and acquiring a site, rehabilitating a building (including floor plans), drafting a budget for the first year of operation, obtaining a license, establishing a non-profit tax exempt corporation, writing job descriptions for the staff, and obtaining continuing financial support. The authors' energy and commitment to their dream is nothing short of amazing. Every aspect of the essentials has been covered in detail; consequently, the development of other art centers will be much more feasible.

One specific section deserves special mention for the application of creative and effective programming ideas. The authors devote one entire chapter to public relations, including numerous useful strategies. They discuss the purpose and organization of exhibits, broadcasts, publications, workshops and conferences, open houses, and exchange visits with other programs. One particularly intriguing idea is the organization of "Disabled Artists Month," where a specific month is set aside to publicize the accomplishments of these special artists. During this month, stores and museums are encouraged to display work; radio and television broadcasts featuring the art and artists are presented. At the Creative Growth Gallery, disabled artists exhibit their work alone, in groups, and sometimes with nondisabled artists. The purpose of these events is to involve broader segments of the community and enhance their understanding of the disabled and their art. The more people from the community who are involved and the more personal interest they develop, the greater the chance that an arts center will become a permanent part of the community. This effort to integrate the disabled with the nondisabled is recognized as an essential component of normalization.

A materials section describes art materials, including characteristics of expressive media and useful techniques. Seasoned art therapists or art educators will not find much that is new, but the book will be informative to those in special education or rehabilitation currently working in art programs for the disabled. This section is brief, yet practical and useful. Detailed descriptions and illustrations suggest methods of adapting materials and tools. Illustrations of designs for adaptive mechanisms, such as head-gear, foot aides, or mouth pieces are precisely drawn with specified dimensions, and can be created from easily obtainable materials.

One particularly significant aspect of this publication is the definition of terms and roles related to the practice of art with the disabled. Ludins-Katz and Katz point out the similarities and differences among the creative art center concept, art therapy, art recreation, and art education. Several goals of the creative art center are therapeutic, yet they are not perceived as therapy. This is an important clarification, because art with the handicapped is frequently perceived as art therapy. Although all art professions employ art materials, art language, and personnel trained in art, each one has goals, methods, and expectations that distinguish it from the others.

The authors' philosophy of art teaching is clearly stated throughout the text. They view the art teacher's role as providing creative stimulation for the students; the teachers are to be available, but not to direct student work or become the dominant force in the creative process.

This philosophy seems akin to Lowenfeld's. Unfortunately, no theoretical perspective is provided as a background from which the reader may better understand the development of the art center concept. This book defines a new and important direction in art that deserves recognition, but it does not address the past or present status of the field of art and the disabled. The authors state that they are currently conducting research on art with the disabled, yet they list topics that are under investigation, with no report of results. For the field of art with the disabled to progress and thrive, it needs more attention to theoretical background and development of research, in addition to the detailed program development described by the authors.

Art and Disabilities is a comprehensive and creative instruction manual that describes the essential information required to initiate a successful art program. Clearly, the authors' intent is to demonstrate a need and to stimulate seeds of interest; this, the book fully accomplishes. Ludins-Katz and Katz are to be commended for their progress in an uncharted field, their commitment to an important concept and their willingness to share the benefits of their immeasurable knowledge about program implementation. In essence, this is a book about establishing art programs for the disabled, rather than a descriptive publication on art and disabilities. It is highly recommended as a resource book for anyone who wishes to establish an art program for the disabled.

A Review of *Clinical Work with Children*

Judith Mishne. New York: The Free Press, 1983.

Eleanor C. Irwin, PhD, *is a drama therapist who works with children at the Western Psychiatric Institute and Clinic in Pittsburgh, Pennsylvania. She is Assistant Professor of Child Psychiatry at the University of Pittsburgh and a research candidate at the Pittsburgh Psychoanalytic Institute.*

As though to correct a famine, a number of books on child therapy have been published lately, whetting the appetite of clinicians who work with children. In the main, these offerings reflect a variety of current eclectic approaches to theory and practice, serving to stimulate interest in individual as well as group work. For hungry practitioners who are working to make sense of the "play" of children, such publications are welcome fare. Child therapy, it seems, is one of those fields where good teachers are rare, and good books, rarer still.

Not surprisingly, there is a ready market for practice and technique books, reflecting, perhaps, the ubiquitous eternal wish to find *the* answer that will tell all, *the* approach that will cure all. On the other hand, theory books generally stimulate less interest, possibly because they are harder to digest. Such has seemed the case with books on psychoanalytic theory. Despite the fact that psychoanalysis has dominated the field in child work, making enormous contributions to theory and practice, many clinicians remain unaware of core concepts, or have a strong emotional bias against it. The more's the pity, because psychoanalysis continues to provide a clinical heritage that can enrich our understanding of troubled children and their families. One of the difficulties has been the dearth of good material that can translate theory in understandable terms into practice. A good text could help remedy the situation, serving to illuminate past contributions and providing a framework for current clinical work.

Such a text may be at hand in Judith Mishne's new book. Trained in the Child Therapy Program at the Chicago Institute of Psychoanalysis, Mishne holds a doctorate in social work from Hunter. Her experience as a psychotherapist, teacher, and supervisor is evident as is her ease, tact, and empathy for children and their caregivers as well as for clinicians and the systems they serve. In a straightforward style, with little mysterious jargon, she presents current, albeit complex, ego psychology. She then demonstrates, through detailed case histories, just how theory shapes and guides practice. The goals of her book, stated in Chapter I, are:

> to lessen . . . therapeutic nihilism and bias, to kindle or rekindle enthusiasm for work with children, and to provide a comprehensive view of diagnosis and treatment planning for children and their parents . . . to convey the spirit of the diagnostic process, and to focus on the problems and issues specific to child therapy and general childcare services. The hope is to avoid a cookbook of recipes and instead to present a survey of the literature that deliberately omits some of the highly abstract and controversial aspects of the theory (p. 4).

The book is, indeed, a "clear and comprehensive presentation of the fundamentals of child psychotherapy" (p. 3). In addition to a presentation of the facts and perhaps ultimately more important, however, is the attitude the author conveys. She teaches, supports, inspires. Without apology, she makes clear the complexity of the work and demonstrates the imperative need for a firm theoretical base on which to anchor one's practice. Along the way, the reader senses a growing identification with the author's attitude, an awareness of the long-term commitment needed, and increased tolerance for the inevitable anxiety that is aroused in work with troubled children and their families. The naive reader may have some difficulty with the theory, but there is much to be learned from a thorough reading of the case studies alone. Because of content as well as style, however, this book surely will be used as a text in clinical work in a variety of settings by professionals from many backgrounds.

From the overall presentation of the material to the finely culled reference list, there are many admirable aspects to the book. Lucid sections on theory are woven throughout the book, their implications echoed and articulated in case presentations. Also throughout, the psychoanalytic developmental approach leads the way. Thus, for example, Anna Freud's diagnostic profile is used in a general way to provide a comprehensive understanding of assessment; Mahler's stages of separation-individuation and the achievement of self and object constancy are used to delineate psychotic from neurotic functioning, as well as that of the "borderline" in between.

Beginning with a brief overview of psychoanalytic theory, the author outlines the multiple ways in which the ego acquires an organizing function in the process of development. Perceiving, evaluating, coordinating, and integrating, the ego mediates between the agencies of the id and superego, Mishne states. Following this overview, the spectrum of child psychopathology is covered, with case examples of autism and psychosis, mental retardation, pre-Oedipal disorders, and psychoneurosis. This is followed by sections on translating the assessment material into a treatment plan, the treatment process itself. Throughout, there is an emphasis on the child and parents' psychological structure—or lack thereof—and the implications of this for clinical work.

One of the most valuable contributions is the discussion of pre-Oedipal disorders: the borderline, narcissistic, and character disorders.

Individuals with such disorders present a bewildering array of difficulties—developmental arrests and fixations, a poorly defined sense of self and object, severe defects in ego functioning, and little capacity to invest in treatment. Mishne's intelligible presentation of controversies, along with discussions of etiology and treatment interventions will be welcomed by most clinicians. She stresses that for the borderline individual as well as the psychotic, supportive—not insight-oriented—work is needed. Goals for these individuals include achieving some measure of separation-individuation and moving toward fusing the split-off good and bad aspects of self and object, along with developing a more tolerant and flexible superego. The treatment approach should be "slow, indirect, lengthy, supportive and empathic, with the emphasis on building identification and introjection, and more mature defensive and adaptive mechanisms" (p. 180). As with adults, interpretation should be directed toward the reflection of feelings, affects, and defenses, rather than interpretation of the id material. She agrees with Ekstein who suggests that clinicians adjust to the "special modes of relating and communicating, e.g., their play with metaphor and simile, their indirect way of talking, and their different stage of language and play development" (p. 180). Always linking theory to practice, she comments that it is erroneous to seek a unitary concept of the borderline child. . . . In general, the less inner structure the child possess, the more outer structure he or she will need" (p. 107).

An emphasis is placed on need for a family perspective in considering child treatment. The author stresses the child's dependence on home and family, and includes a sensitive discussion on the multiple (and maddening) issues inherent in placement of children. Parents and caregivers are presented in a humane way, their strengths as well as weaknesses highlighted. A diagnostic picture is drawn of the parents as well as the child, with an examination of environmental and constitutional factors. Clinicians are admonished to be aware of unconscious racism and stereotyping. She quotes Cooper in detailing the "errors made by clinicians who not infrequently impose their own highly emotional attitudes on clients" (p. 158).

Mishne both quotes and follows Josselyn's advice to not rely on any one mode of intervention to the neglect of others. Accordingly, many kinds of treatment are discussed, from child analysis to child psychotherapy, from family to group work. Material on the latter, although brief, is helpful, covering group composition, types of therapy, setting, and goals. Current issues in family therapy also are presented, including an overview of the family systems approach vis-a-vis a psychodynamic one. Here, as elsewhere, she gives practical advice. To wit, "The general rule is that the therapist must guard against criticizing the parents or endorsing the child's indignation over something the parents have done." But understanding human nature (not to mention countertransference), she adds tactfully, "One can say that the child's indignation is understandable—adding that perhaps the parents did not fully understand the situation, or maybe that their action was their way of showing love and concern" (p. 205), a suggestion she attributes to Kessler.

The chapters on resistance, defense, regression, and working through are useful. The case study of Arleen is presented, a child who "unquestionably" was the most difficult the author ever treated. Recounting the tribulations in treatment, she adds, "This case underscores the need for the therapist's absolute respect of the child without becoming retaliatory in the face of unpleasant forms of resistance" (p. 304). It is this attitude of awareness and control of countertransference, coupled with empathy and intelligent use of theory that informs and inspires the reader.

Arts therapists looking for special mention of their fields will be disappointed. Drawings are mentioned in passing as serving as projective tools; paper and crayons are stock materials in the play room. Children are depicted as drawing, dramatizing, roleplaying. The arts are mentioned specifically, however, in a sensitive section on the needs of those with severe narcissistic pathology. Treatment interventions with this population should include greater opportunities for sublimation, for "transformations of narcissism" (Kohut) via creative outlets. She quotes Green and Clark as saying it is "imperative that 'leisure activities' be taken seriously" with such populations (p. 217). Similarly, the chapter on play therapy presents little that is new to experienced art therapists. These, however, are minor disappointments, given the general richness of the material.

Overall, what *is* new is a comprehensive text in which theory forms and informs practice, coupled with an attitude of patience, respect, and empathy for disturbed children. In a fine chapter on transference and countertransference, Mishne quotes Marcus as saying that it is "untenable" to view interest in the patient and pleasure in the therapeutic work as unconscious over-identification. "Such an all-inclusive concept denies appropriate human and professional feelings toward patients and the therapeutic work. Warmth, affection, and respect for patients are not overemotional responses and therefore are not countertransference" (p. 217). This intelligently written book, based on theory, filled with such sentiments, garnished with practical advice, and flavored with contributions from the current literature should go a long way toward satiating clinicians, including art therapists who work with children.

A Review of

They Could Not Talk and So They Drew: Children's Styles of Coping and Thinking

Myra F. Levick, PhD, HLM, ATR. Springfield, IL: Charles C Thomas, 1983 (210 pages; $34.50).

Nancy E. Curry, PhD, *a research candidate at the Pittsburgh Psychoanalytic Institute, heads the Child Development Program at the University of Pittsburgh.*

The author of this book has undertaken an ambitious project, which, in her words ". . . represents the culmination of my educational and professional experience as a clinician art therapist and educator in the field of creative arts in therapy" (p. xv). This explains why there is an enormously complicated body of material in this book. Its purpose is to present a developmental perspective on the mechanisms of defense as explicated by Anna Freud and to propose that art therapists can elucidate these mechanisms of defense in art productions, specifically drawings. The author uses both psychoanalytic theory and cognitive-developmental theory to undergird her theoretical perspectives as well as her considerable experiences as an art therapist.

In perusing the chapter titles one is impressed with the intended scope of the book: from an overview of the field of art therapy to an explication of the mechanisms of defense, to an integration of psychosexual and cognitive development as related to children's drawings. The second half of the book presents clinical data to illustrate the author's viewpoint that the mechanisms of defense are hierarchical, show a developmental progression in the normally developing child, and serve as a diagnostic tool to pinpoint developmental regressions, fixations, and progressions in the art products of disturbed children and adults. Finally, the author presents her raw data for examination and to demonstrate the care she took in establishing the data validity and reliability.

With this awesome body of work that could hold much promise for clinicians, the author has indeed shared her theoretical background and her clinical experience. Undaunted, she has undertaken at least three major areas—each of which could be a book in and of itself (the value of art as a therapeutic and diagnostic tool; the use of drawings to illustrate the developmental hierarchy of defenses; the integration and synthesis of psychosexual and cognitive-developmental theories).

Unfortunately, her attempts to deal with all of these areas in some depth leaves the reader gasping, especially in the theoretical section (Section I). Here readers will find less of the author herself; most of the material is derivative and readily available and readable in the sources she cites, many of which already are secondary. For example, in attempting to integrate psychoanalytic and cognitive theories, she depends heavily on Greenspan. Rothgeb is her secondary source for Sigmund Freud, who needs no intermediary, given his skill and clarity of writing. Even the explanation of the chronological development of defenses relies heavily on Greenspan and Kestenberg. Because these secondary sources are available to the reader interested in these areas, they add little to this work, which becomes labored and very difficult to read. In contrast, the summary tables pull together many concepts with a clarity that is missing in the text.

Section I may tempt the reader to neglect Section II, which is enlivened by clinical examples in which the author shares her clinical expertise. Here, too, however, the lack of clarity persists both in the theoretical use of the mechanisms of defense and in the photographs, which unfortunately, are in black and white and occasionally difficult to see, especially those with small details. The tables in Section II are valuable in charting out the author's definitions of mechanism of defense and the criteria she uses to label them in drawings. Some of her definitions and criteria are open to question. For example, in the table the author defines *isolation* as "A process in which ideas are split off from feelings which were originally associated. Used to avoid guilt, carry through a logical train of thought without contamination and distraction." Following this somewhat confused definition are her criteria: "Manifested in the representation of objects drawn singly on a page; unconnected inappropriately to other forms on a page; ungrounded; separate in or from environment" (p. 130). Although I am not an art therapist, I am wary of diagnosis based on such a criterion as "objects drawn singly on a page," yet the author clearly used this criterion to diagnose *isolation* on a number of her subjects' drawings. There is danger in labeling too precisely what an art symbol may represent, for it could lead to a quick and easy method of diagnosis on the part of less sophisticated therapists. Some readers might be tempted to use the author's interpretation as recipes that very well could be incorrect.

In the field of art therapy as is true of most therapies utilizing projective techniques, therapists need to be cautious about interpreting from limited data or about projecting their own ideas and feelings into a patient's production. Those of us in the fields of psychotherapy and education often have been accused of being unscientific. We have learned to teach ourselves and our students the importance of developing hypotheses, finding the data either to support or reject these hypotheses, and only *then* making generalizations with sufficient evidence to support them. Although the author supplies us with ample amounts of raw data from which she drew her conclusions, both the validity and reliability checks are questionable. She honestly acknowledges that this is a first attempt to propose "criteria for identifying adaptive and maladaptive defense mechanisms in drawings" (p. 182), but she should have supplied some caveats to her readers early on. Careful defense analysis takes time, a strong working alliance between patient and therapist, and enough evidence from both patient and therapist to provide the sense of conviction when a correct interpretation is made. Although the heart of this book does not deal with therapy, but with diagnosis, and although the author warns of the pitfalls in labeling and interpreting from too little data, this book lends itself to that pitfall by the author's own tendency to interpret from data that seem to be limited.

In general, then, I would recommend this book only for advanced graduate students or practitioners who already have a very solid understanding of psychoanalytic and cognitive-developmental theory. Without such a background, readers could flounder in Section I, which paradoxically, is too complex in contrast to Section II, which errs on the side of being too simplistic.

Although the title utilizes the author's poetic license, it must be recognized that those who draw also *can* communicate in other ways, verbally and nonverbally, to other people. Art productions indeed make a vital contribution, but cannot be the only data base from which those in the field diagnose, plan treatment programs, and evaluate the effectiveness of treatment plans. Only from this wider data base can and should an individual's defensive structure be determined with some degree of accuracy and conviction. The author acknowledges that this is a pilot study; her continued efforts to supply validity and reliability to her measures for identifying defenses in drawings will strengthen this promising project.

Dr. Levick's Reply

Myra F. Levick, PhD, HLM, ATR
Philadelphia, Pennsylvania

I want to thank Dr. Curry for her comprehensive and sensitive review of my book and the editors of this journal for the opportunity to respond.

Dr. Curry credits me with attempting to do more than I in fact did. The value of art as a therapeutic and diagnostic tool has been demonstrated by many art therapists in the field dating back to the 1940s; their books and articles are listed in an extensive bibliography at the end of my book. The integration and synthesis of psychosexual and cognitive-developmental theories also has been addressed by many investigators in the last 4 decades, but a literature search revealed that only Greenspan (1979) had produced a comprehensive work on this topic. To redo what he had done so well, and so recently, seemed presumptuous and so the reader is referred, frequently to Greenspan's work for further elaboration, hence, the secondary source in this instance.

Part of the motivation for this work was based on the fact that there is little in the literature that points to a *hierarchical* development of defenses. Anna Freud only began to suggest a hierarchical development in 1967 and this work is cited extensively in Chapter Two. Dr. Curry refers to Rothgeb as a "secondary" source for Sigmund Freud, but it should be noted that Rothgeb is the editor for *Abstracts of the Standard Edition of Freud* (1971–1972), which contains original passages of Sigmund Freud's work. It is a particularly useful source for anyone wishing to review Freud's conclusions from his original writings as they evolved.

I appreciate Dr. Curry's concern that the theoretical sections are "labored and difficult to read." I struggled a long time on how much of this material to include. It should be remembered, however, that many art therapists, developmental psychologists, and other practitioners have very limited training in psychoanalytic theory.

I certainly recognize that black and white reproductions of the drawings leave much to be desired, but with over 140 illustrations it was impossible to reproduce any in color, because of the prohibitive costs.

I would reiterate here (and did so repeatedly in the book) that "one needs to be cautious about interpreting from limited data." Dr. Curry's concerns about this are mine as well. And because, as Dr. Curry points out "Those of us in the fields of psychotherapy and education have often been accused of being unscientific," the book contains a first and limited effort to demonstrate reliability and validity. Dr. Curry, of course, could not know this, but since the manuscript was completed 2 years ago, several of my own advanced students have utilized these criteria for their thesis research projects and have further supported the reliability and validity of these data.

The definition of *isolation* that Dr. Curry finds "somewhat confused" is a direct quote from *A Glossary of Psychoanalytic Terms and Concepts* published by the American Psychoanalytic Association (Moore & Fine, 1968). This reference is cited at the top of Table 2 (p. 129). My criteria for identifying defenses in drawings, as we both agree, needs further validation.

I would be as distressed as Dr. Curry if some readers looked to this work as "recipes." The book was written as a text for "advanced graduate students and practitioners," but not necessarily for those with an extensive background in psychoanalytic and cognitive-developmental theory. I hope that art therapy educators who chose to use this book will pay as close attention to the caveats (Dr. Curry's and mine) as well as the interpretations I have made and keep in mind that they reflect 20 years of experience as an art therapist and educator. I also hope that students and practitioners not trained extensively in these theories would be stimulated to pursue further study. I believe the theories are critical for understanding human development.

Dr. Curry suggests I used poetic license for the title and in some measure she is correct. The idea for the title came from a poem written as a gift for me by a psychiatric nurse whose first exposure to art therapy was at our mutual place of employment 18 years ago. The first four lines read as follows:

> I could not talk
> and so I drew
> on the floor, with chalk,
> when I was small. . . .

The poem is reprinted in its entirety on page 133.

It is not, however, and never has been my intent to imply that people who draw cannot communicate in other ways. In fact, it has been my position (in contrast to that of some of my collegues) that verbal comments are necessary before interpretations can be reached by patient and therapist. I further maintain that even the best trained art therapist can only make "inferences" and "educated guesses"—"especially in the absence of direct observation, associations from the artist and/or historical data" (pp. 64–65).

Finally, I concur completely with Dr. Curry that art productions "cannot be the only data base from which we make diagnosis, plan treatment programs, and evaluate the effectiveness of our treatments."

I support this further with the belief that "members of education and mental health disciplines, other than art therapists, can use graphic productions to discern whether a child or an adult has age-appropriate capabilities. In the absence of some or all of those criteria [which identify these capabilities], a mental flag should be raised to call for further evaluation by qualified art and other psychodiagnosticians" (p. 165).

References

Greenspan, S. (1979). Intelligence and adaptation. In H. Schlesinger (Ed.), *Psychological issues*. New York: International Universities Press.

Moore, B., & Fine, B. (Eds.). (1968). *A glossary of psychoanalytic terms and concepts* (2nd Ed.). New York: The American Psychoanalytic Association.

Rothgeb, C. (Ed.). (1971–1972). *Abstracts of the standard edition of Freud*. Washington, DC: Department of Health, Education, and Welfare.

Expressive
Arts
Therapy

The Department of Expressive Arts Therapy at Goucher College offers Master of Arts degrees in Dance-Movement Therapy and in Art Therapy.

Combining academic study with extensive supervised field work, the co-educational graduate programs prepare students to become specialists in the treatment of psycho-social problems.

For more information, contact the Department of Expressive Arts Therapy:

Dance-Movement Therapy—
(301) 337-6373
Arlynne Stark, M.A., D.T.R., director
Art Therapy—(301) 337-6376
Christine W. Wang, M.A., A.T.R., director

The Dance-Movement Therapy program is an approved A.D.T.A. program.

Masters Degree Programs
Goucher College
Towson, MD 21204

Recent Literature of Interest to Art Therapists

Books:

Alland, A., Jr. (1983). *Playing with form: Children draw in six cultures.* Irvington, NY: Columbia University Press.

Becker, H. (1982). *Art worlds.* Berkeley, CA: University of California Press.

Benenzon, R. (1982). *Music therapy in child psychosis.* Springfield, IL: Charles C Thomas.

Deinhardt, C. (1983). *Personality assessment and psychological interpretation.* Springfield, IL: Charles C Thomas.

Furrer, P. (1982). *Art therapy activities and lesson plans for individuals and groups: A practical guide for teachers, therapists, parents and those interested in promoting personal growth in themselves and others.* Springfield, IL: Charles C Thomas.

Gardner, H. (1982). *Art, mind and brain: A cognitive approach to creativity.* New York: Basic Books.

Krauss, D., & Fryrear, J. (1983). *Phototherapy in mental health.* Springfield, IL: Charles C Thomas.

Landreth, G. (Ed.). (1982). *Play therapy: Dynamics of the process of counseling with children.* Springfield, IL: Charles C Thomas.

Sandblom, P. (1982). *Creativity and disease: How illness affects literature, art, and music.* Philadelphia: Geo. F. Stickley.

Schaeffer, C. E., & O'Connor, K. J. (Eds.). (1983). *Handbook of play therapy.* Somerset, NJ: John Wiley & Sons.

Schulman, J., & Irwin, M. (Eds.). (1982). *Psychiatric hospitalization of children.* Springfield, IL: Charles C Thomas. (Contains a section on art therapy.)

Articles:

Arieti, J. (1983). Bibliography—Silvano Arieti, MD. *Journal of the American Academy of Psychoanalysis, 11*(1), 173–180

Burgess, A., et al. (1981). Children's drawings as indicators of sexual trauma. *Perspectives in Psychiatric Care, 19*(2), 50–58.

Charman, D. (1981). The cerebral hemispheres appear to function differently in artists and scientists. *Cortex, 17*(3), 453–458.

Clarke, L. (1982). Art therapy: A learning experience for students in nursing. *Journal of Nursing Education, 21*(9), 24–27.

Fleming, M., et al. (1982). The use of an animal drawing test in the assessment and disposition of transsexualism. *Journal of Clinical Psychology, 38*(2), 420–424.

French, C., et al. (1981). Mood judgments in black and white pictures as a function of tonality and polarity. *Ophthalmic and Physiological Optics, 10*(2), 115–122.

Impey, L. (1981). Art media: A means to therapeutic communication with families. *Perspectives in Psychiatric Care, 19*(2), 70–77.

Kaufman, G. (1981). Art therapy with the addicted. *Journal of Psychoactive Drugs, 13*(4) 353–360.

Lerner, L. (1981). Discussion of imagery and the self in artistic creativity and psychoanalytic literary criticism. *Psychoanalytic Review, 68*(3), 421–424.

Liebert, R. (1982). Methodological issues in the psychoanalytic study of an artist. *Psychoanalysis and Contemporary Thought, 5*(3), 439–466.

Light, P., et al. (1981). Internal spatial relationships in young children's drawings. *Journal of Experimental Child Psychology, 31*(3), 521–530.

Maloney, M., et al. (1982). An evaluation of the clinical utility of the DAP test. *Journal of Clinical Psychology, 38*(1), 183–190.

Myers, J. (1983). The creative imagination scale: group norms for children and adolescents. *International Journal of Clinical and Experimental Hypnosis, 31*(1), 28–36.

Naglieri, J., et al. (1981). Inter-rater reliability and concurrent validity of the Goodenough-Harris and McCarthy Draw-A-Child scoring systems. *Perceptual and Motor Skills, 53*(2), 343–348.

Nasser, P., et al. (1981). Inpatient art therapy: Implications and applications for training. *Schizophrenia Bulletin, 7*(2), 308–315.

Petchkovsky, L. (1982). Images of madness in Australian aborigines. *Journal of Analytical Psychology, 27*(1), 21–39.

Piersal, W., et al. (1982). Comparison of McCarthy and Goodenough-Harris scoring systems for kindergarten children's human figure drawings. *Perceptual and Motor Skills, 55*(2), 633–634.

Rae, W. (1982). Body image of children and adolescents during physical illness and hospitalization. *Psychiatric Annals, 12*(12), 1065–1073.

Ravin, J. (1981). Van Gogh's illness. *Ohio State Medical Journal, 77*(21), 699–702.

Roland, A. (1981). Imagery and the self in artistic creativity and psychoanalytic literary criticism. *Psychoanalytic Review, 68*(3), 409–420.

Sarrel, P., et al. (1981). Using the Draw-A-Person (DAP) Test in sex therapy. *Journal of Sex and Martial Therapy, 7*(3), 163–183.

Shaw, J. (1981). Adolescence, mourning, and creativity. *Adolescent Psychiatry, 9*, 60–77.

Sheskin, R., et al. (1982). Assessment of children's anxiety throughout dental treatment by their drawings. *ASDC Journal of Dentistry for Children, 49*(2), 99–106.

Spitz, E. (1982). Reflections on form and content in modern art. *Psychoanalytic Study of the Child, 37*, 547–568.

Taylor, M., et al. (1982). Constraints on the visual accuracy of drawings produced by young children. *Journal of Experimental Child Psychology, 34*(2), 311–329.

Toburen, J., et al. (1982). Art as a rehabilitation counseling tool for use with persons who are mentally retarded. *Journal of Rehabilitation, 48*(2), 53–57.

Topper, D., et al. (1981). Depth perception in linear and inverse perspective pictures. *Perception, 10*(3), 305–312.

Tucker, P., et al. (1982). Creativity, divergent and allusive thinking in students and visual artists. *Psychological Medicine, 12*(4), 835–841.

Wright, J., & McIntyre, M. (1982). The family drawing depression scale. *Journal of Clinical Psychology, 38*(4), 853–861.

BRIEF COMMUNICATIONS

This column provides a forum for information exhange among clinicians. Items relevant to research and to programmatic, historical, or clinical developments may be submitted. Contributions should be sent to Brief Communications, ART THERAPY, AATA, 5999 Stevenson Avenue, Alexandria Virginia 22304. Submissions are subject to acceptance and editorial revision.

Professional Treat

The 27th Annual Meeting of the American Association of Psychoanalysis was held from April 28 to May 1, 1983, in New York City. The topic: *Psychoanalysis and the Arts.*

The link between art and psychoanalysis was made through a broad series of stimulating presentations. There were the expected papers devoted to psychoanalytic understanding of artists and writers: Could Hyronimus Bosch's ego make distinctions between id, ego, and super-ego? Why did Edvard Munch create? What are some of the psychological themes of Henry Moore's work? In a lively discussion, participants and listeners were warned of trivializing the art with clinical interpretations. This was indicative of the healthy intellectual climate evident throughout the conference.

A number of challenging presentations grappled with the nature of creativity and its relationship to the psychoanalytic process: Are creative endeavors enhanced or impaired by psychoanalytic exploration? How much can psychoanalytic treatment be considered a science? Or is it basically an art that requires the practitioner's creativity as much as his or her scientific training and discipline? One presenter shared her own paintings in looking at chaos and control within the creative process. Such concerns, familiar to art therapists, led to a rich inquiry when addressed by the psychoanalytic community. Art therapists have a great deal to offer to this realm and were represented by participators Myra Levick, PhD, ATR, and Lynne Flexner Berger, ATR.

Included in the program were presentations dealing with psychoanalytic treatment of the artist-patient, as well as the use of art with non-artist patients. The creative aspect of the psychoanalytic treatment process itself was addressed in a number of ways. One such presentation saw transference as drama, and therapy as the play, with the therapist and analyst directing and producing. The keystone of this fascinating paper was how play, illusion, and transitional phenomena take place in the drama of therapy.

The 4-day program, with its focus on creativity and its relationship to the human psyche, was richly rewarding. The complete program is listed below.

PROGRAM OF 27TH ANNUAL MEETING OF THE AMERICAN ASSOCIATION OF PSYCHOANALYSIS

"Arthur Miller's Insights on Aggression," *H. Krystal, MD*; "Marcel Proust and His Mother," *D. Lipshutz, MD*; "Graham Greene—His Fiction and Autiobiography: Reflections on the Writer as Private Person," *R. Spiegel, MD; J. Lefer, MD*

• •

"Does Psychoanalysis Enhance or Diminish Creativity," *M. Glucksman, MD; K. Ecker; D. Marland; B. Primus; M. Rydell; M. Travers*

"The Incorporation of the Arts into the Theory and Practice of Psychoanalysis," *N. Tabachnick, MD, PhD; J. Martin, PhD; D. Safan-Gerard, PhD; R. Gould, MD; G. Rose, MD*

"Varied Uses of Art Therapy as a Facilitative Tool in Psychoanalysis," *M. Berger, MD; L. Flexner Berger, ATR; P. Fink, MD; M. Zukmann, ATR*

"The Future of Psychoanalysis," *J. Spiegel, MD*

"Three Stages of Dreaming: A Clinical Study of Henry Miller's 'Dream Book,' " *J. Martin, PhD; R. Gottesman, MD*; "Michelangelo: Early Childhood and Maternal Imagery—The Sculptor's Relation to Stone," *R. Liebert, MD; S. Grolnick, MD*

"The Creative Process and the Addictive Process," *L. Hatterer, MD; M. Stone, MD*; "Psychotherapy as Creative Process," *A. Kagan, MD; N. Levy, MD*

"Relationship between Role Playing of Love Themes, Operatic Training and Psychotherapy," *C. Diaz de Chumaceiro*; "Alienation as Expressed in 20th Century Opera," *J. O'Brien, MD; S. Keill, MD*

"Timon of Athens: The Progress from Naivete to Cynicism," *N. Shainess, MD*; "Shylock in 'The Merchant of Venice,' " *S. Greenberg, MD; N. Holland, PhD*

"Creativity and the Adolescent Artist," *D. Halperin, MD; L. Canepa, MD*; "Rimbaud and Lautreamont: Adolescence and the Birth of Surrealism," *D. Halperin, MD*; "Poetry, Adolescence and Death," *L. Hancoff, MD*; "Arthur Rubinstein, the Adolescent Artist Reborn," *Z. Lothane, MD; H. Greenberg, MD*

"Control and Chaos in the Creative Process," *D. Safan-Gerard, PhD*; "The Art in Analysis," *D. Forrest, MD; I. Bieber, MD*;

BEST COPY AVAILABLE

" 'Thou Shalt Kill' Abraham and Isaac, 2000 Years of Visual Interpretation." *F. Terna, L. Hatterer, MD*

"Psychoanalytic Speculations about the Influence of the Devil on Some of the Creations of Hyronimus Bosch." *L. Weyl, MA*; "Caravaggio: Themes of Defiance and Despair." *L. Norsa, MD*; "Transitional Process and Creativity: The Borderline Life and Art of Edvard Munch." *L. Warick, MD; E. Warick, BA, AT; G. **Pollack, MD**.*

"Special Issues in Psychoanalytic Work with Cinema and Television Directors, Producers, and Writers." *R. Anshin, MD; L. Greenleigh, MD, PhD; A. Rogawski, MD; A. Schrut, MD; B. Conn, MD*

"Expressive Movement in Children and Mothers: Focus on Individuation." *D. Dulicai, MA, DTR; S. Silberstein, PhD, DTR*; "The Mother-Child Relationship in Modern Art: Henry Moore and the Separation-Individuation Process." *L. Schneider; C. Sarnoff, MD*

"Psychiatry Looks at Myth, Dreams, and Art Forms." *G. Chrzanowski, MD; L. Davidson, MD*; "Dream and Legend in Native American Art." *R. Gold, MD*; "Identity Conflict in Art of Russian Jews." *E. Goldstein, MD*; "Psychoanalysis and Art in Iceland." *E. Petursson, MD; E. Hegeman, PhD; W. Tardy, MD*

Special Presentation Of The Historical Committee—"An Historical Portrait of Sandor Rado"

"Freud, Physics, and Literature." *N. Holland, PhD*

"Psychoanalytic Treatment of the Performing Musician: Superego Aspects." *H. Babikian, MD; M. Cantor, MD*; "Considerations in Analyzing the Highly Creative Patient." *L. Greenleigh, MD, PhD; S. Slipp, MD*; "Transference as Drama." *N. Tabachnick, MD, PhD; I. Alger, MD*

"Resistance: Developmental Image of Ego Defenses." *M. Levick, PhD, ATR*; "The Legend of the Unicorn: An Illumination of the Complexity of the Oedipal Stage." *I. Mohacsy, MD*; "A Psychoanalytic Study of the Appreciation of Art." *C. Rotenberg, MD; P. J. Fink, MD*

"The Role of the Double in the Creative Process and Psychoanalysis." *J. Simon, MD; C. Goldberg, PhD*; "Mastering Metaphor and Self." *M. Schneider, MD; D. Schneider, MD*; "Psychoanalysis of an Artist: Utilizing the Medium of Her 'Automatic Drawings.' " *M. Olds Strahl, MD; S. Warner, MD*

Editor's Note: Please let us know if publication of entire programs such as the one above is useful.

Journals of Interest to Art Therapists

Visual Arts Research is a journal concerned with discussing key issues that shape our understanding of the visual arts and for critical analysis of research now being conducted in the field. It is published twice a year by the University of Illinois Press. Individual subscriptions are $10 per year. Mail to: Visual Arts Research, University of Illinois Press, 54 E. Gregory Drive, Champaign, IL 61820.

Journal of Multi-Cultural and Cross-Cultural Research in Art Education is a new journal that will appear once a year, beginning in November, 1983. It is published by USSEA (United States Society for Education through Art). It seeks to confirm cultural and social commitment to a greater understanding of diverse cultures and the role of art in multi-cultural education. Send manuscripts to the editor, Dr. Larry A. Kantner, A202 Fine Arts Bldg., University of Missouri, Columbia, MO 65211. Send subscription orders ($8 per year) to Dr. Maryl Fletcher DeJong, USSEA Treasurer, 5052 Collinwood Place, Cincinnati, OH 45227.

Empirical Studies of the Arts is also a new journal appearing this year. For information regarding its editorial policy and subscription rates, contact: Frederick R. Gardner, Promotion Dept., Baywood Publishing Co., 120 Marine St., Farmingdale, NY 11735.

New Testing Material Available

The *Silver Drawing Test of Cognitive and Creative Skills* is now available. It is the work of Rawley A. Silver, EdD, ATR. Write to: Special Child Publications, J. B. Preston, Editor and Publisher, P.O. Box 33548, Seattle, WA 98133.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Volume 1, Number 2 May, 1984

- Art Work of Cystic Fibrosis Patients
  Marilyn D. Leonhart
  Richard M. Rothberg
  Don Seiden
- Holistic Healing Through Creative Expression
  Josef E. Garai
- Ten-Year Follow-up Survey on Art Therapy in Los Angeles
  Helen B. Landgarten

BEST COPY AVAILABLE

ART THERAPY is published by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Nonmembers may subscribe at the following annual rates. Individuals: $18 (US); $22 (Foreign). Institutions: $30 (US); $34 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies of the inaugural issue are available at $99 (Individuals) $15 (Institutions). Printed in the U.S.

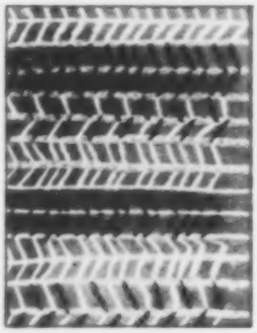
Advertising: For information, write or call the AATA office, 5999 Stevenson Avenue, Alexandria, VA 22304, (703) 370-3223.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association



Editorial

Editorial, Gary C. Barlow, EdD, ATR 66

Letters to the Editor 67

Editor's Notes 67

Articles

Art Work of Cystic Fibrosis Patients, Marilyn D. Leonhart BFA, Richard M. Rothberg, MD, Don Seiden, ATR 68

New Horizons of Holistic Healing through Creative Expression Joseph E. Garai, PhD, ATR 76

Ten Year Follow-Up Survey on the Status of Art Therapy in the Greater Los Angeles Area Helen B. Landgarten, MA, HLM, ATR 84

Viewpoints

Some Views About the New Art Therapist, Ursula Goebels, MA 89

Art Therapy: An Educator's Response Virginia Niswander, MEd, ATR 89

Reviews

Book Reviews

The Lowenfeld Lectures: Viktor Lowenfeld on Art Education and Therapy 90

Invented Worlds: The Psychology of the Arts 91

Film Reviews

The Color Bunch 92

Brief Communications 95

Volume 1, Number 2 May, 1984

Copyright © 1984
American Art Therapy Association, Inc.

The cover is a painting done in 1982 by an adult male in art therapy at Wright State University, Dayton, Ohio.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in theory, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
  Gary Barlow, EdD, ATR
Viewpoints
  Harriet Wadeson, PhD, ATR
Book Reviews
  Judith Rubin, PhD, HLM, ATR
Brief Communications
  Ruth Obernbreit, MA, ATR
Film/Video Reviews
  Georgiana Jungels, MA, ATR
Production Editor
  Debra Dulina Bass

Contributing Editors
  Frances E. Anderson, EdD, ATR
  Robert Ault, MFA, ATR
  Lynn Cashell, MCAT
  Dana N. Christensen, PhD, ATR
  Linda Gantt, MA, ATR
  Anthony Kowalski, MD
  Susan LaMantia O'Connor, MA, ATR
  Ellen A. Roth, PhD, ATR
  Lewis K. Shupe, PhD, ATR
  Suzanne Silverstein, MA, ATR
  Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 5999 Stevenson Avenue, Alexandria, VA 22304, (703) 370-3223

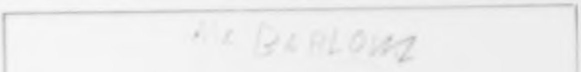
BEST COPY AVAILABLE

EDITORIAL

With this issue of *Art Therapy* our profession has reached an important milestone. Following an impressive inaugural issue, with members of the American Art Therapy Association serving on the planning and editorial committees (plaudits to Linda Gantt, ATR, the interim editor and her committees for the first issue!) we now have a bona fide journal, an editor and an editorial board. The 1981-83 and the (current) 1983-85 AATA Executive Boards have supported this publishing venture, and Scott Stoner, ATR, past Executive Director of AATA was also instrumental in helping to bring this publication into existence. We are all indebted to these persons for their interest, support, and encouragement.

It seems fitting that, as our profession grows, we take this significant step into a new phase of professional publication. Our sister journal, *The American Journal of Art Therapy* (formerly the *Bulletin of Art Therapy*) has been an important voice for nearly 23 years, and has done much to bring art therapy to the forefront. In more recent years, another sister publication, *The Arts in Psychotherapy*, was established for professionals in the fields of mental health, education, and creative arts therapies and, also, is an invaluable contribution to the professional literature. As editor of *Art Therapy*, it is my wish to join with these two important predecessors in building additional strength, integrity, vitality, service, and awareness to current and potential readership.

The American Art Therapy Association is 15 years old — perhaps the "crisis of adolescence" is an appropriate term in describing our developmental stage. From the early 1930s and the work of Margaret Naumburg, art therapy was taking its first steps toward becoming a major field of study and practice. Pioneering efforts of Naumburg and others began to give credence to this voice in the wilderness, and the voice soon grew loud and clear. Over the next few decades the field rapidly gained prominence, and a new awareness of art therapy developed.



Drawing by a 9-year-old boy, learning disabled

We do have an impressive, albeit relatively short, history as our written documentation attests; however, we have by no means been exhaustive in our historical search of our "roots" with focus on implications for mental health training and service through the visual modality of art therapy.

In addition to our rich history, throughout the most recent years we have had to quickly reassess our professional strategies relative to the job market, legislation regarding funding and support of programs, related human service modalities, foundation and outcome research, economics, and the budget "crunch." The results of our appraisals have often been discouraging; however, in a larger perspective, by focusing on the potential of art therapy, and our sound educational training and professional practices, we seem to be alive and well.

For the future we should give strong consideration to the building of an even greater body of knowledge through our research efforts in art therapy. We must continue to have dialogue with professionals in related therapies and plan strategies to share efforts in human service delivery. We should educate others about the excitement of, and the need for, the visual arts as an expressive and therapeutic modality. We need to identify and understand legislative issues and move forward with concerted efforts to give even greater credence and strength to art therapy. Let us come to know our profession, and ourselves, with greater depth and understanding. Perhaps the theme of the 1983 AATA Conference can give us an obvious direction for future action: "Working Together: Sharing Efforts."

Art Therapy, as a professional journal, should be representative of all of us. It can "speak to" many professional areas through clinical and theoretical articles, reported outcome research, letters to the editor, and personal viewpoints. I encourage your participation, suggestions and views; diversity of thought within articles, open letters, general opinions, and about content, format and theme is encouraged. Your contributions will help to make the journal grow and develop into a major voice in art therapy. I look forward with great anticipation to our combined efforts in this vital and exciting venture.

Gary C. Barlow, EdD, ATR
Editor

Letter to the Editor

To the Editor:

In the October, 1983 issue, there is an error in the article, "A Critical Analysis of *A Review of the Published Research Literature in Arts for the Handicapped, 1971-1981.*" Referring to my 1975 publication, the review states:

> Quasi-experimental design (pretest, treatment, posttest); no control group or randomization indicated. (p. 33)

The fact is that both randomization and a control group were described in the 1975 publication, as follows:

> There were 18 children in Burt's experimental group. Eighteen other children, who did not attend the art classes, served as controls. They were a randomly selected 50% sample of all pupils in three classes in a school for children with language and hearing impairments. On the posttest, the difference between groups in favor of the experimental group was found to be highly significant, at the $p < .001$ level, as measured by the 14 key items. (ERIC ED # 116 401, p 15/17)

At the end of this quotation, the footnote referred to the *original* study, a 110-page 1973 project report having an ERIC Ed number (084 745) and an EC number (060 575).

The project results were also described in a 1978 book (ERIC ED # 157 252) and in a 1981 document (ED # 207 674) which is also a chapter in Vol. 4 of *Current Topics in Early Childhood Education*, published by the ERIC Clearinghouse at the University of Illinois at Urbana-Champaign. None of these publications are mentioned in the review which relied on computer searches of the ERIC data system.

I am under the impression that many ERIC documents fall between the cracks, and therefore do not blame the researchers who contributed to the review.

Rawley A. Silver, EdD, HLM, ATR

Editor's Notes

- Letters to the editor are welcome. Send correspondence to the office of the editor:

  Art Therapy
  228 Creative Art Center
  Wright State University
  Dayton, Ohio 45435

- Major articles submitted for consideration should follow the "Guidelines for Authors" published in each issue, and should be sent to the AATA Office.

- Other content for consideration, or suggestions for particular sections, should be sent to the AATA Office, 5999 Stevenson Avenue, Alexandria, Virginia 22304, c/o the Editorial Board representative as noted below:

Viewpoints: (personal statements; graphics; other relevant material for this section) c/o Harriet Wadeson, PhD, ATR.

Book Reviews: c/o Judith Rubin, PhD, HLM, ATR

Film/Video Reviews: c/o Georgiana Jungels, MA, ATR.

Brief Communications: (including information relevant to research and to programmatic, historical, or clinical developments; this column provides a forum for information exchange among clinicians and educators): c/o Ruth Obernbreit, MA, ATR.

CORRECTION

In the first issue of *Art Therapy* (Vol. 1, No. 1, 1983) the following error occurred in the Summary Charts accompanying "A Critical Analysis of A Review of the Published Research Literature in Arts for the Handicapped: 1971-1981, with Special Attention to the Visual Arts" by Frances E. Anderson (pp. 26-39): the Silver, 1975 research study that is identified on page 33 was listed as a quasi-experimental study. The correct designation is "Experimental (two randomly assigned groups: one experimental and one control, with pre- and post-treatment testing)."

NOTICE

AATA has adopted a policy for the purchase of advertising space in *Art Therapy*. Universities, institutes, clinical programs, companies, publishers, and commercial exhibitors are encouraged to consider the opportunity to purchase advertising space in the journal. Additionally, programs or persons wishing to place ads in *Art Therapy* relative to workshops, institutes, and other clinical or educational offerings should write to the AATA Office for information on format and costs.

AATA EXECUTIVE BOARD
1983-1985

Board of Trustees

President
Gladys Agell, MA, ATR
President-Elect
Sandra L. Graves, PhD, ATR
Secretary
Nina Holtzman, MA, ATR
Treasurer
Helen Landgarten, MA, HLM, ATR

Committee Chairs

Affiliate Societies
Irene Corbit, MA, LC, ATR
Bylaws
Donald L. Cutcher, MA, ATR
Education
Gary C. Barlow, EdD, ATR
Governmental Affairs
Nancy Schoebel, MA, ATR
Membership
Robin F. Goodman, MA, ATR
Public Information
Bobbi Stoll, MS, MFCC, ATR
Publications
Harriet Wadeson, PhD, ATR
Research
Janie L. Rhyne, PhD, HLM, ATR
Standards
Ronald E. Hays, MS, ATR

Acting Executive Secretary (ex officio)

Maggie Rheinstein

Art Work of Cystic Fibrosis Patients

Marilyn D. Leonhart, BFA
Richard M. Rothberg, MD
Don Seiden, ATR

Marilyn D. Leonhart, BFA, an art therapist at the University of Chicago, Departments of Pediatrics and Psychiatry, initiated an ongoing comparative study of medical patient art work there in 1980. She earned a Graduate Certificate in Art Therapy from The School of the Art Institute of Chicago in 1981. Richard M. Rothberg, MD, is a professor of pediatrics, head of the Section of Allergy, Immunology and Pulmonology and director of the Cystic Fibrosis Center, University of Chicago. Don Seiden, ATR, is an associate professor, chairman of the Department of Art Education and Art Therapy, The School of the Art Institute of Chicago and senior art therapist at Rush-Presbyterian St. Luke's Hospital, Chicago. A practicing artist and lecturer, he was the founding president of the Illinois Art Therapy Association.

Spontaneous drawings by 30 patients with cystic fibrosis (CF) and 24 controls with pulmonary disease were obtained at health maintenance clinic visits between December, 1981 and April, 1983. The initial correlations were made in a prospective blind manner. The drawings were analyzed for art content, psychosocial content, and possible pathophysiologic implication. After 12 months, the pathophysiologic speculations were evaluated by direct comparison of drawings with the medical information routinely collected for health maintenance care. This retrospective analysis demonstrated some consistent relationships between drawing content and physiologic symptomatology. In addition, many interesting psychosocial correlations with the patients' life cycle events and disease severity became evident. The CF drawings exhibited a high degree of sublimation. The latter possibly was an indication of the development of survival attitudes associated with inherited, potentially fatal illness.

The regularity with which somatic metaphors (pictorial imagery symbolic of body parts affected by illness) showed up in art work of patients[1] led to formal studies of the significance of such somatic metaphors and physiologic manifestations in drawings by patients with specific pathophysiologic problems. Since psychological (Kramer, 1971; Naumberg, 1966) and developmental (Kellogg, 1970; Lowenfeld & Brittain, 1964) correlations with art work have been established, it was speculated that the expression of physiological correlations should be found in the drawings of patients with a chronic life threatening disease.

Cystic fibrosis (CF) was chosen as a condition to study because it is a progressive chronic disease of young patients and it has multiple system involvement. At present, this disorder is the most common, potentially lethal genetic disorder in the white population of the United States (1 in 2,000 live births). The main pathophysiologic abnormality is the production of thick viscid mucus that blocks the mucus epithelial-lined ducts to the outside of the body. This blockage has two major effects. The first is to block secretions of exocrine glands, such as the pancreas, resulting in glandular destruction. The major manifestation of destruction of glands of the gastrointestinal tract, such as the pancreas, is malabsorption of food secondary to the loss of the digestive enzymes. This results in malnutrition, diarrhea, and polyphagia (excessive appetite). A second common manifestation of this type of obstruction occurs in the tracheobronchial tree. This results in chronic airway obstruction and pulmonary infection leading to tissue destruction and eventually respiratory insufficiency. Despite ignorance of the etiology of the mucus alteration, specific preventive medical procedures have resulted in a remarkable prolongation of these patients' lives and many are now young adults (Doershuk & Boat, 1983).

The mainstay of the program discussed here is routine health maintenance visits. During these visits the patients learn to care for themselves and adjust their lives to integrate this care into their daily routine.

The primary purpose of this study was to gain insight concerning specific CF psychologic/physiologic correlations while enhancing physician evaluation of individual CF patient status as to self-image, compliance, disease-related emotions, and family dynamics. In these studies a report is given on the emergence of patterns of color usage, composition, affect, linear configuration, and use of materials in specific pathophysiologic conditions.

This study was supported in part by the Cystic Fibrosis Foundation and The School of the Art Institute of Chicago. The authors gratefully acknowledge the contributions of C.P. Kimball, MD, L.A. Lester, MD, Zenaida Corpuz, RN, Margaret Moelenkamp, Glenn Leonhart, Nancy Muller, and Anne Grigg.

[1] Somatic metaphors were noted by the author during field work in Spring, 1980 at West Suburban Hospital, Oak Park, Illinois.

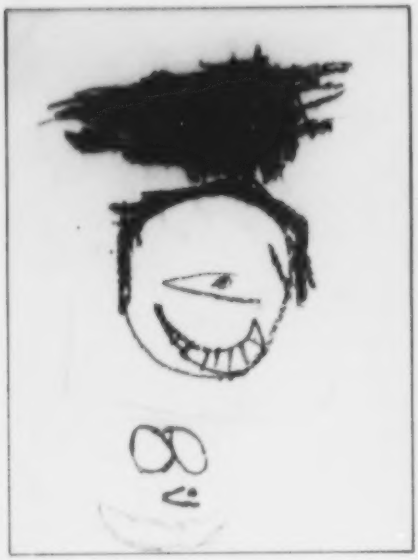


Figure 1—Disturbed affect, smeared pastels, filled-in shape at top. (Female, age 5, CF)

Materials and Methods

Population

Thirty CF patients, ages 3 to 22, and 24 control patients with other pulmonary diseases (PUL), ages 3 to 15 were studied. Because CF also involves the gastrointestinal tract and this illness can be fatal, concurrent studies of drawings by hospitalized adult gastrointestinal (GI) and oncology patients provided additional controls for substantiating correlations.

Settings

Of the 215 CF- and PUL-patient drawings, 203 were done in outpatient clinic examining rooms. The remaining 12 drawings were done by hospitalized patients. Both of these settings provided heightened patient awareness of illness and attitudes toward it.

As the patient enters the examining room, a whole change in orientation may be occurring, but the nature of this change varies, depending on age. The main concern of the younger patients is how the visit will affect their day-to-day living. For the adolescent or adult, it is time to focus on the disease process. Thoughts and feelings are concentrated not only on illness and its manifestations, but on a very personal sense of self and a desire for well-being.

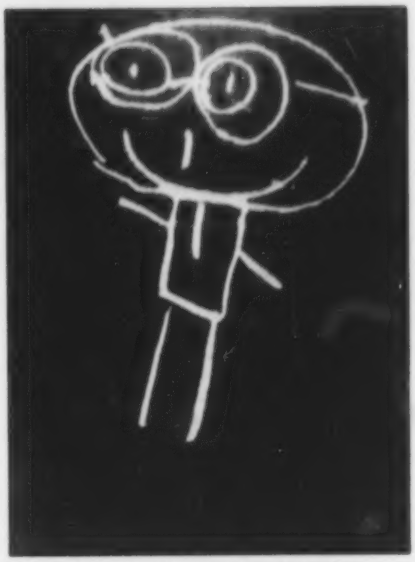


Figure 2—Patient A, several weeks before agitated lines appeared, as shown in Figures 3 and 4. Complete figures returned to drawings following acute episodes. (Female, age 4, CF)

This awareness on the part of the patient and the concentration of the health-care team on the patient possibly had a strong effect on the emotional and physiologic components manifested in the drawings.

Procedures

The purpose of the study was explained briefly to the patient and parents. The patient was offered 9 x 12 construction paper and drawing media consisting of pastels, oil pastels, watercolor markers, and pencils. Paper and media were in full representative color range. Brief descriptions of media qualities, such as softness and blendability of pastels, were given in order to encourage spontaneous emergence of patient inner structure, rather than imposing preconceived structure through specific directions on what to draw. The approach was non-intrusive—questions concerning feelings were not asked.

During the drawing process, pertinent data were noted, such as media and color choices, placement of paper, progression of drawing, gender, and age. To avoid initial therapist bias, diagnosis and general degree of illness were not noted until analysis of the first drawing of each patient began, along with other follow-up drawings, after the completion of clinic for the day. Clinical findings based on history and physical examinations on the particular day of any drawing were not considered in these analyses during the first year. In drawing analyses done during the same period (at The School of the Art Institute of Chicago), however, pathophysiologic speculations were made. These results were then compared with data from the patient charts at the end of the first 12 months of the study.

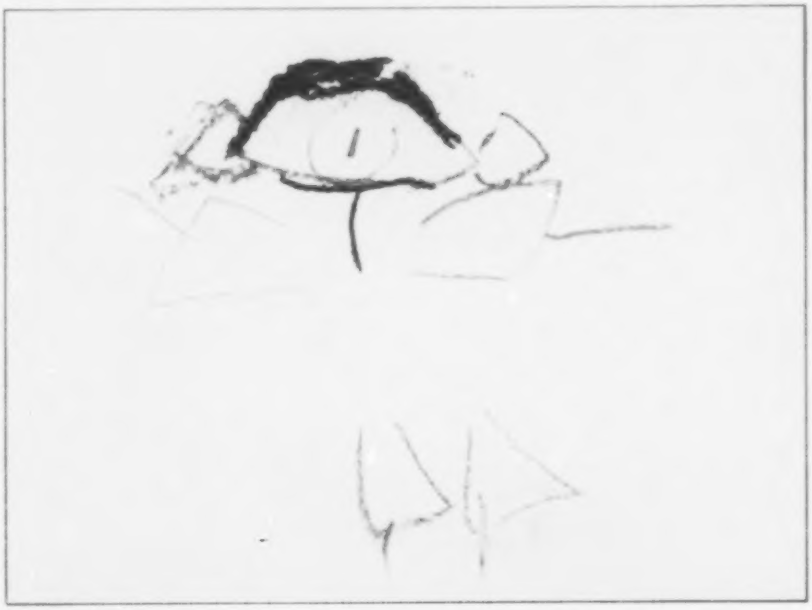


Figure 3—Patient A. Disturbed affect, disintegrating figure, smeared pastels, implied triangles. (Pink eyes, body and feet are not evident in black and white photo.) (Female, age 4, CF)

Results

In viewing the collection of drawings by CF patients as a whole, the most significant observation was that of sublimation. Sublimation is defined in this context as the ability to transform deficits of chronic illness into a focus for corrective and adaptive ego responses. It translates into aesthetic refinement of the art product (Kramer, 1971). This transformation is exemplified in the drawings by serene affect (affect is defined here as emotional content or mood of the drawing as perceived by the viewer), combined with compositional balance and full-page orientation. Prior to comparisons of individual patient drawings (with information from medical charts) at the end of the first 12 months, drawings that showed disturbed affect, compositional imbalance and/or incomplete use of space, were singled out. They were usually found to be indicative of acute phases of disease. Disturbed affect was associated with anxiety over bodily conditions (see Figure 1, Figure 2, Figure 3, Figure 4), and was manifested as agitated line quality and excessive overlaying of media. Compositional imbalance and incomplete use of space (areas left empty) suggested avoidance of (see Figure 5, Figure 6, Figure 7, and Figure 8), or exaggerated awareness of an affected part of the body (see Figure 1 and Figure 9).

Other drawings, while maintaining the serenity of composition (see Figure 10), showed linear configurations, such as triangles, and metaphors, such as filled-in clouds representing upper respiratory congestion, similar to those found in acute drawings. These were reflective of underlying pathophysiologic symptomatology. Physiologic involvement in drawings by both CF and PUL patients appeared in mirror image, according to affected body parts. For example: A PUL-patient with a left lung lesion drew a "mouse hole" on the left side of the page (Figure 9).

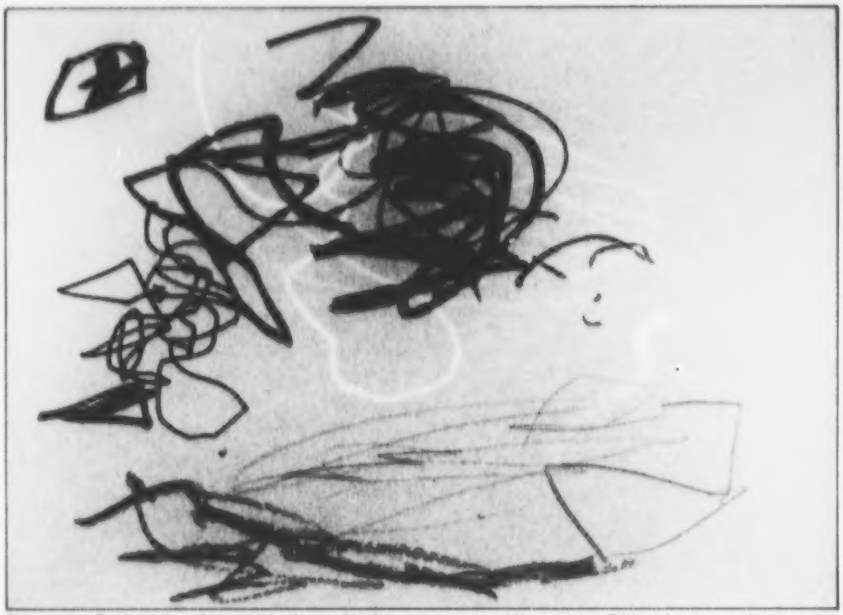


Figure 4—Patient A, a few weeks later. No figures appear. Worsening GI involvement. Approach/escape maneuver with angles. (Female, age 4, CF)

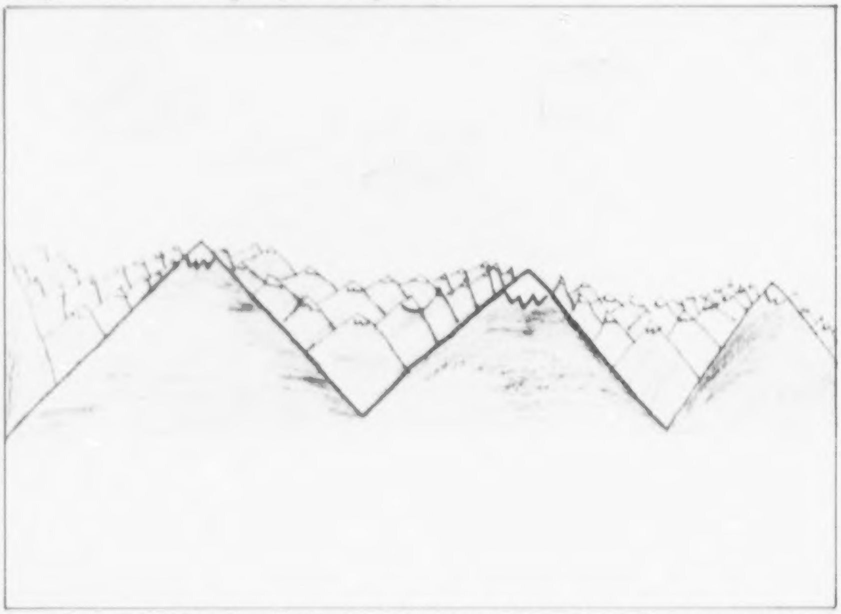


Figure 5—Patient B. Triangles, filled-in clouds, horizon sun. Completed in four separate sessions; bottom of page left empty until last session. (Female, age 13, CF)

An example of linear configurations (regardless of pictorial content) correlating with symptomatology would be triangles, or implied triangles (Figure 5), which were identified with GI pain, and occasionally with pulmonary pain. This was substantiated in drawings by adult GI patients. In addition, CF patients with GI involvement, and adult GI patients frequently drew compartmentalized shapes (see Figure 11 and Figure 12), which may be associated with constriction. Triangles and compartments also appeared in drawings by pediatric GI patients in earlier studies.[2]

The triangles, which showed up during acute phases of GI involvement and as underlying symptomatology in some CF patients, were universally present in the drawings by hospitalized adult GI patients in acute care units. Compartmentalized shapes commonly accompanied the triangles. In both CF- and adult GI-patient drawings, the triangles and compartments

---

[2] Completed in Fall, 1980, at Westlake Community Hospital, Melrose Park, Illinois, and Wyler Childrens' Hospital, the University of Chicago.

Figure 6—Patient B, a few weeks later. Relief from acute GI symptoms; bottom of page is used, triangles are gone. (Female, age 13, CF)

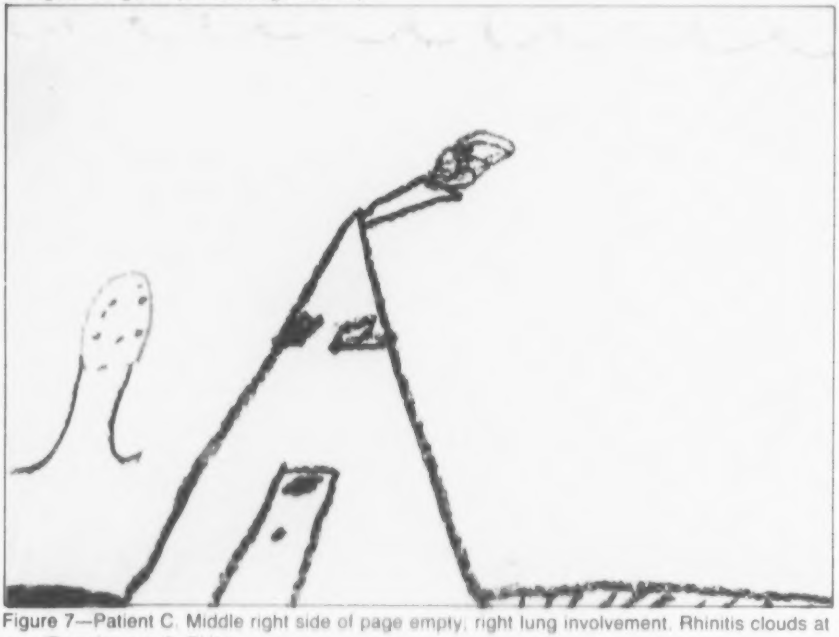


Figure 7—Patient C. Middle right side of page empty; right lung involvement. Rhinitis clouds at top. (Female, age 8, PUL)

were generally incorporated in the drawings as integral parts of the composition. They become apparent when drawing is viewed in a linear flat pattern. Examples of incorporated triangles are : pine trees, sails, and high-pitched roofs. Examples of incorporated compartments are: multi-paned windows, picket fences, and clothing decorations. Rarely (and only in adult patient drawings) were these configurations attributed verbally to pain and constriction by the patient.

Untidy use of materials—smeared pastels and excessive overdrawing of watercolor markers inconsistent with recognized developmental drawing stages—was sometimes present when mucus plugging in CF patients significantly increased (Figures 1 and 3). Filled-in shapes, often clouds (Figures 1, 5, 6, and 10), were associated with respiratory congestion in drawings by both CF and PUL patients, as well as in drawings done by pediatric respiratory patients from earlier studies.[3] Filled-in shapes, again usually clouds, at the very top of the page appeared in drawings made by patients suffering from rhinitis, an inflammation of the mucus membrane of the nose Figure 7).

Large *horizon suns*, showing partially above horizon lines, occurred only in drawings done by CF patients, and were often associated with increasing lung hyperexpansion (Figures 5, 6, and 13).

A phenomenon peculiar to drawings done by patients with respiratory involvement was designated *initial monochromatic color scheme* (IMCS). The first drawing color used matches the paper color chosen—blue on blue, yellow on yellow, white on white, and so on (Figure 9). IMCS was found in some drawings by patients with lung disease (with or without CF), once among the drawing of adult GI patients but not in oncology patient drawings, nor in drawings done by other pediatric patients without lung disease.

Although not a consistent finding, a few seriously ill CF patients drew prominent horizon lines combined with the theme of hidden treasures symbolizing things to come. An example of this would be a Halloween farm scene (Figure 14) of a closed barn next to an empty, fenced-in field with an open gate. The CF patient-artist explained that inside the barn (unseen) was "a horse of the most beautiful color you have ever seen." She said that there would be a path leading to the field, (it was not in the picture), and that the gate was open, waiting for the horse.

Discussion

Cystic fibrosis is a potentially fatal inherited autosomal recessive disease. Thus, both parents are heterozygotes (carriers) with no phenotypic expression of the disorder, and the severe illness in the child is often unexpected. The parents often are greatly disturbed and this feeling influences the

---

[3] Completed in Fall, 1980, at Westlake Community Hospital, Melrose Park, Illinois, and Wyler Children's Hospital, the University of Chicago.

BEST COPY AVAILABLE

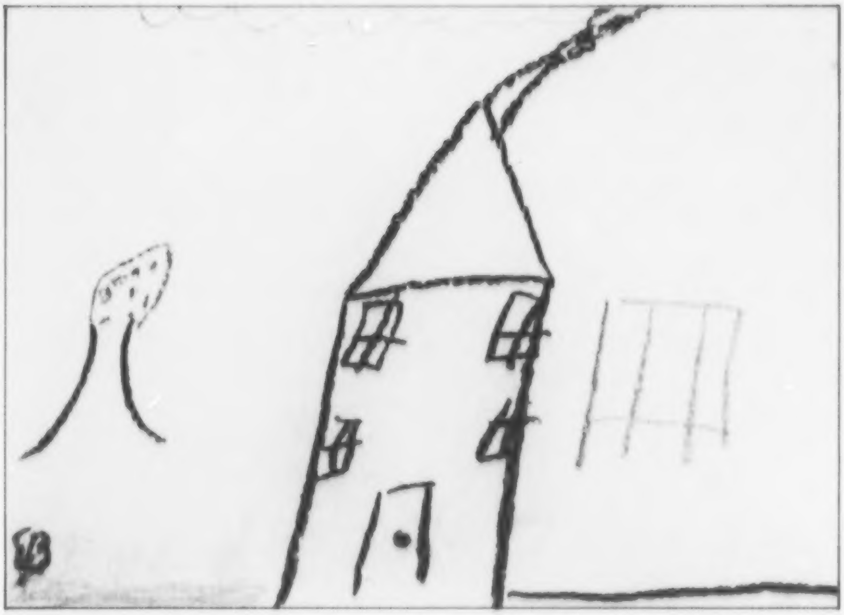


Figure 8—Patient C, 1 month later. Improvement in right lung. (Female, age 8, PUL)

child's outlook and the ability of the family to comply with the preventive medical program. Although the degree of compliance cannot be directly correlated with the patient's present health, there is an overall correlation between compliance and long-term survival.

Considering the existing knowledge about CF and the care available to those who have it, evaluation of the drawings must take into account concerns of these patients and their families. The extensive health maintenance emphasis given the families is directed at the pulmonary and gastrointestinal manifestations, the two processes most seriously affected by CF. This results in a greater conscious awareness and monitoring of these functions by the patient and physician than is usually the case.

Maintaining physical functions and thus survival is not the only motivational goal. A desire to preserve a sense of well-being and a semblance of normality in spite of difficulties, is also prevalent. Given that a cure is not available, it becomes a matter of living life as well as possible in light of the circumstances. The sublimation found in the drawings could be interpreted as confirmation of this. The patients develop this strength as they learn to cope with the disease. Without the aid of health care professionals and family in developing this attitude, these coping strengths falter. The drawings help illuminate patient response to illness, providing assessment of stability, concerns, and attitudes.

A balanced composition with full-page orientation may indicate a harmonious global approach by the patient. (In this study, the paper was identified with patient perception of environment, and the use of drawing media was identified with the patient's way of dealing with the perceived environment.) This would be compatible with sublimation—in this case incorporating health care regimens as a regular part of activities of daily living while monitoring and adjusting to the whole of one's world, and upgrading the quality of living.

Figure 9—Possible subconscious awareness of left lung lesion. Dotted line indicates IMCS figure—orange on orange. (Male, age 5, PUL)

The majority of drawings was obtained during health maintenance visits; therefore, the predominance of serene affect, balance, and full-page use can be attributed to the general approach to CF by the patients. Deviance from these three given qualities usually occurred during acute activation of the disease process. When this happened it was difficult, in the interpretations, to separate physical distress from emotional distress as exemplified in art form. They seemed to be closely intertwined.

The association of sharp-angled triangels with sharp pain was not difficult to make. Further speculations can be made based on the drawing processes of a 4-year-old CF patient with severe GI disease. In one drawing session (Figure 4) she used extra pressure in executing the approach line of each angle. She eased up at the end, then very deliberately changed the direction of the line to form the apex. This could represent the cyclic wave-like pattern of the gastrointestinal pain. The therapist, who had seen similar strong reactions during adult GI therapy sessions, also had the impression of a sudden turning away, of relief from the inevitable. This specific maneuver may warrant more intensive study.

Compartmentalized shapes, often drawn in a ritualistic, attention-to-detail way (occasionally in a compulsive manner) provide many ideas for discussion. Only once during the studies did a GI patient, an adult with Crohn's Disease, specifically identify compartmentalizing with constriction. She explained while drawing part of her intestinal tract (Figure 12) that she knew the constriction (which her lines represented) would always be there, but that she was ready to deal with it. When the usually self-regulating and orderly mechanics of digestion become abnormal, the drawings suggest a psychological attempt to impose regulation. For example, when diarrhea secondary to malabsorption occurs,

The drawings help illuminate patient response to illness, providing assessment of stability, concerns, attitudes. ... The association of sharp-angled triangles with sharp pain was not difficult to make.

the drawings suggest an instinctive desire to regulate them, to compartmentalize the process as with the locks of a canal.

Other suggestions of a correlation between drawings and patient problems were: untidy use of materials, which was reflective of mucus plugging; and the filling-in of shapes, especially clouds, representing respiratory congestion.

The horizon suns come closer to pictorial metaphors than those previously discussed, with the exception of compartmentalized shapes. They appear in concrete structural forms, symbolic of the bodily structures they represent.

The use of IMCS, beginning a drawing with a media color to match the paper chosen is the most unusual finding to date. It was first noticed[4] in 1980 and has been described during speculative analyses by therapists and attending physician as "fading into the wallpaper," "brittleness" (not wanting to change; staying the same), "soaking in," and "tentative beginning." Occasional conscious awareness of this phenomenon on the part of patient or family does occur: "You can't use that, Joey. It won't show up" and "I'd better use green. Red won't show up." A hospitalized 4-year-old turned the process around by picking the marker color first, then the same paper color. After three such drawings, his mother handed him a contrasting color marker. He turned it down, saying, "But *this* matches!"

The process of breathing, unlike eating, sleeping, or exercising, cannot be suspended for hours, or even minutes at a time. It establishes a direct dependency on environmental air. The same air that is part of our world metaphorically becomes a part of us. The IMCS might be symbolic of the establishment of this sameness, and once the relationship is functioning (air is being exchanged) then the other processes can be attended to.

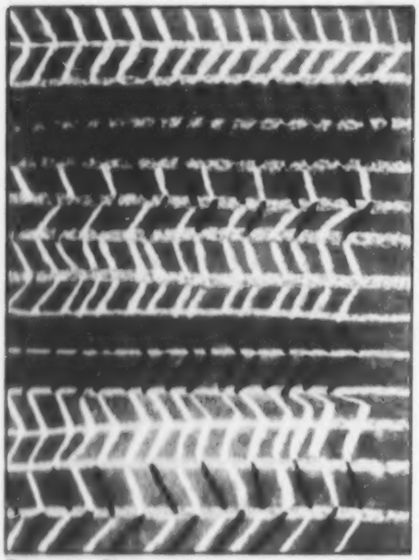


Figure 11—Sharp angles and compartmentalized shapes correlate with severe GI involvement. (Female, age 15, CF)

Finally, the hidden treasures symbolize things to come and imply hope for the future, a spiritual strength that is consistent with the composed balance noted in so many CF patient drawings.

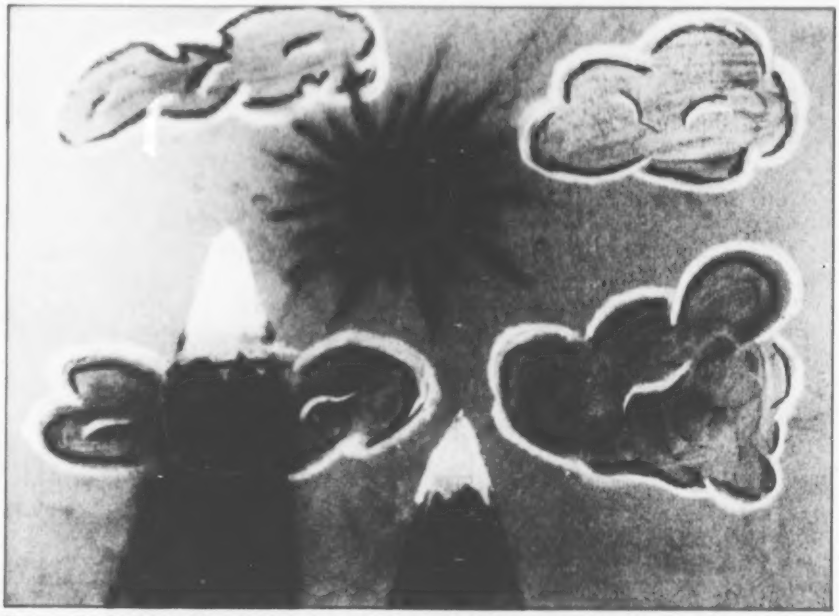


Figure 10—Feeling better, despite cold (filled-in clouds), family more hopeful. Triangle mountains suggest underlying chronic GI symptomatology. (Male, age 12, CF)

References

Boyle, I.R., DiSant'Agnese, P.A., Sack, S., Millican, F., & Kulezycki, L.L. (1976). Emotional adjustment of adolescents and young adults with cystic fibrosis. *The Journal of Pediatrics, 88,* 318-326.

Cohen, S. (1983). Social service on a gastrointestinal unit. In E. Kenney (Chair), *Proceedings of the First Midwestern Colloquium in Art Therapy* (pp. 21-23). Chicago: Illinois Art Therapy Association and Loyola University of Chicago.

DiSant'Agnese, P.A. (1973). Cystic fibrosis (mucoviscidosis). *American Family Physician), 7,* 102-110.

Doershuk, C.F., & Boat, T.F. (1983). Cystic fibrosis. In R.E. Behrman & V.C. Vaughan (Ed.), *Nelson Textbook of Pediatrics* (12th ed.) (pp. 1086-1099). Philadelphia: W.B. Saunders.

Kellogg, R. (1970). *Analyzing children's art.* Palo Alto, CA: Mayfield.

Kellogg, R. (1979). *Children's drawing/Children's minds.* New York: Avon.

---

[4] Observed by the author in drawings by pulmonary patients at Wyler Children's Hospital, the University of Chicago.

BEST COPY AVAILABLE

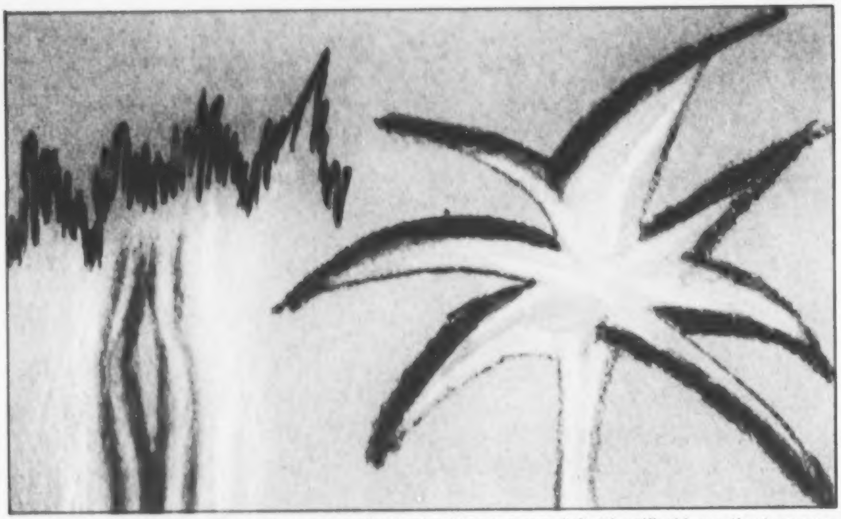


Figure 12—Compartmentalized drawing of intestinal tract, lower left, identified by patient as constriction. (Female, age 30, Crohn's disease)

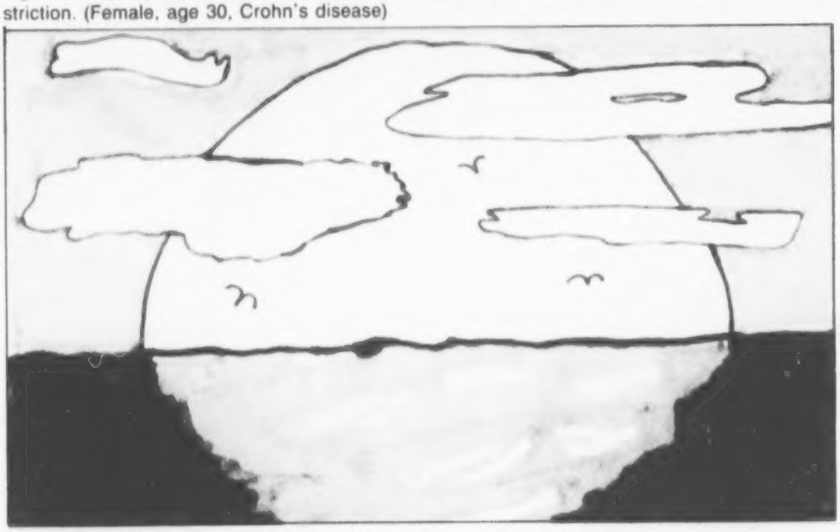


Figure 13—Horizon sun; lung hyperexpansion. (Male, age 12, CF)

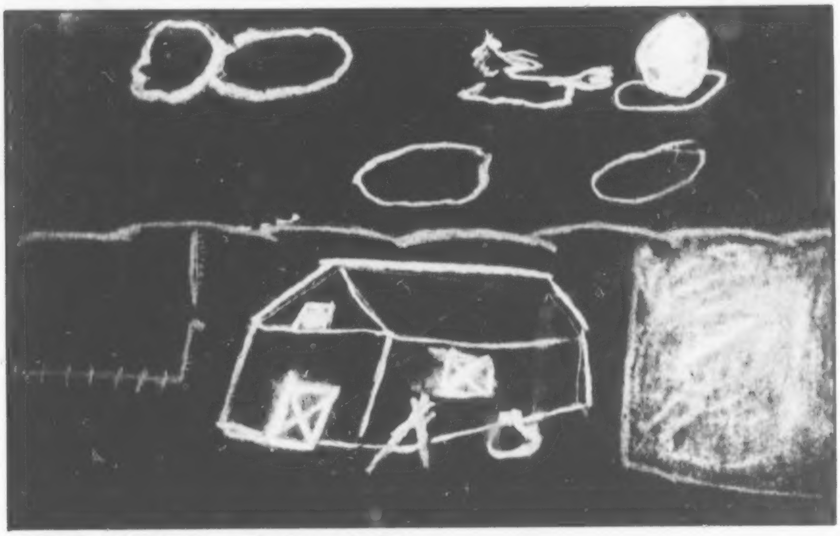


Figure 14—Hidden treasure. (Female, age 12, CF)

Kellogg, R., & O'Dell, S. (1967). *The psychology of children's art.* New York: CRM-Random House.

Kimball, C.P. (1981). *The biopsychosocial approach to the patient.* Baltimore: Williams & Wilkens.

Kimball, C.P. (1982). The concept of behavioral specificity: Three concepts. *Psychotherapy and Psychosomatics, 38,* 32-38.

Kramer, E. (1971). *Art as therapy with children.* New York: Schocken Books, Inc.

Leonhart, M.D. (1982). Comparative attitudinal study of pulmonary patient art work. In L. Herman (Ed.), *Proceedings of the Third Annual Illinois Art Therapy Association Symposium* (pp. 23-28). Chicago: Northwestern University.

Leonhart, M.D. (1983). Art therapy with gastrointestinal patients. In E. Kenney (Chair), *Proceedings of the First Midwestern Colloquium in Art Therapy* (pp. 19-21). Chicago: Illinois Art Therapy Association and Loyola University of Chicago.

Lewis, B.L., & Khaw, K. (1982). Family functioning as a mediating variable affecting psychosocial adjustment of children with cystic fibrosis. *The Journal of Pediatrics, 101,* 636-640.

Lowenfeld, V., & Brittain, W.L. (1964). *Creative and mental growth* (4th ed.). New York: MacMillan.

Naumburg, M. (1966). *Dynamically oriented art therapy: Its principles and practice.* New York: Grune and Stratton.

Whybrow, P.C., & Ferrell, R. (1973). Psychic factors and Crohn's disease: an overview. In A.E. Lindner (Ed.), *Emotional factors in gastrointestinal illness* (pp. 82-98). New York: American Elsevier.

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.
(AATA)

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, The AATA Journal, discounts on publications, discount on admission to the annual Conference as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (A.T.R.). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA office.

MEMBERSHIP CATEGORIES:

Initial application for membership in the Association shall be accepted in one of the following classes: ASSOCIATE, STUDENT, or CONTRIBUTING. Contact the AATA Office for applications for Professional and Credentialed Professional Membership.

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the Annual Meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee.

Annual Dues: $25.00

Applications for student membership must be accompanied by a copy of current ID.

Associate Membership shall be open to individuals interested in the therapeutic use of art, and who wish to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the AATA and to attend the Annual Meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $40.00

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $80.00

Professional Membership is subject to approval by the Membership Committee. Individuals who have completed professional training in art therapy and who are or have engaged in the therapeutic use of art are eligible. Professional membership shall provide for their participation in all activities of the Association and receipt of all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA office for an application.*

Annual Dues: $65.00

Credentialed Professional Membership shall be open to individuals who have met the qualifications and been approved for Professional membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in *Documents and Procedures Relevant to Professional Registration.*

Annual Dues: $70.00

The American Art Therapy Association serves as a clearinghouse for information about the field of art therapy. The following Proceedings are available from the AATA Office. Contact the AATA Office for a Resource Order Form.

PROCEEDINGS	**Members**	**Non-Members**
Creativity and the Art Therapists' Identity (1976) 118 pages	$ 3.00	$ 5.00
Art Therapy: Expanding Horizons (1978) 142 pages	$ 5.00	$ 7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) 124 pages	$ 7.00	$ 9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$ 7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00

MEMBERSHIP APPLICATION

☐ Associate ☐ Student ☐ Contributing

Name ______________________________
Last First Middle

Preferred Mailing Address ______________________________

____

____
City State Zip Code

Phone ______________________________

Title ______________________________
Occupation or Profession

____
Employer or Educational Institution

Make checks payable to AATA and return with application to:
American Art Therapy Association, 5999 Stevenson Avenue Alexandria, VA 22304

New Horizons of Holistic Healing through Creative Expression

Josef E. Garai, PhD, ATR

Josef E. Garai, PhD, ATR, is professor emeritus at Pratt Institute, New York. Dr. Garai is a creative expressive therapist in private practice, and is the founder and former chairperson of the Graduate Art, Dance and Movement Therapy Department at Pratt Institute. A consultant to many community mental health associations, Dr. Garai has authored many articles in psychology, art therapy, and social issues. He received the Adolf Meyer Award, from the Association for Improvement of Mental Health for leadership in community mental health organization and education.

Feelings of fragmentation and alienation are characteristic of the spirit of our times. In recent years holistic health movements have sprung up all over the world. They tend to counteract splitting and fragmenting tendencies by placing the emphasis on the harmonious integration of body, mind, and spirit and creating a mutually satisfying interaction between the individual and his natural ecological environment.

Ferguson (1980) described the transformations that our society is experiencing as creating a climate in which each individual considers his or her own personal transformation as the basis for the transformation of society as a whole. **The Aquarian Conspiracy: Personal and Social Transformations in the 1980s** ***consists of an informal network of people from all walks of life who have joined in this endeavor to achieve a change in the surrounding society based on personal experiences of change. Roszak (1979) in*** **Person/Planet: The Creative Disintegration of Industrial Society** ***introduces us to the "Age of the Person," which, for the first time in human history, makes the personal self-fulfillment of each individual person the avowed goal of society.***

Garai (1979) outlined the seven specific steps that must be taken to educate each individual toward the conscious assertion of these five principles. This article defines each of these seven steps, and presents specific exercises in art therapy and other expressive modalities that the author has developed during the past 10 years to assist students to gain holistic personality integration. The purpose of the detailed descriptions of these methodologies is to provide the holistically oriented student of expressive therapies with a basic holistic healing training manual that can be used both for personal holistic personality integration and for holistic healing with clients.

On the threshold of the third millennium, the future of mankind offers unprecedented opportunities for transformation and change, while it simultaneously sees itself confronted by unfathomable risks of global self-destruction. No wonder that feelings of fragmentation, loss of identity, disintegration of personhood, a sense of being cut off from nature and rootedness altogether, feelings of helplessness, despondency, and lack of control over one's own life reflect the zeitgeist or the characteristic spirit or ethos of our times. Mankind seems to have become fragmented in its own inherent structure. Instead of cooperating and reinforcing mutual functions, body, mind, and spirit are deeply at odds with one another. This internal process of fragmentation has increasingly led to an alienation of one from the natural environment. In efforts to fragment the natural habitat, humankind has further compounded the effects of one's internal splitting. In *Person/Planet: The Creative Disintegration of Industrial Society*, Roszak eloquently analyzes the repercussions of this process of disintegration and their revolutionary implications.

Mankind seems to have become fragmented in its own inherent structure.

We are fortunate to witness the emergence of powerful trends that recently have begun to move away from this process of schizophrenic fragmentation. They seek to make the person whole again both within oneself and within one's bond to the planetary environment. Holistic health movements are spontaneously springing up all over the world. The time is ripe for innovative approaches to achieve basic changes and transformations that are intended to counteract splitting, alienation, hopelessness, despair, and cynical aloofness.

The Aquarian Conspiracy

In her groundbreaking book, *The Aquarian Conspiracy: Personal and Social Transformation in the 1980s*, Ferguson (1980) described this new movement as an informal network of people from all walks of life, all income levels, and all status categories, from the humblest to the highest. Ferguson pointed out the specific characteristics of the Aquarian Conspiracy:

> A leaderless but powerful network is working to bring about a radical change in the United States . . .
>
> This network is the Aquarian Conspiracy. It is a conspiracy without a political doctrine. . . .

> Broader than reform, deeper than revolution, this benign conspiracy for a new human agenda has triggered the most rapid cultural realignment in history.... It is a new mind—the ascendance of a startling world view that gathers into its framework breakthrough science and insights from earliest recorded thought. ....
>
> You can break through old limits, past inertia and fear, to levels of fulfillment that once seemed impossible ... to richness of choice, freedom, human closeness. You can be more productive, confident, comfortable with insecurity. Problems can be experienced as challenges, a chance for renewal rather than stress. Habitual defensiveness and worry can fall away. *It can all be otherwise.* ...
>
> [People] found themselves rethinking everything, examining old assumptions, looking anew, at their work and relationships, health, political power and "experts," goals, and values ....
>
> The poets and philosophers were right in their intimations of an open, creative universe. Transformation, innovation, evolution — these are the natural responses to crisis.
>
> The crises of our time, it becomes increasingly clear, are the necessary impetus for the revolution now under way. And once we understand nature's transformative powers, we see that it is our powerful ally, not a force to be feared or subdued. *Our pathology is our opportunity.* (pp. 23-25).

The Aquarian conspirators have profited from the lessons of the past. All the mass movements that have ever tried to evolve the "new" person by changing society first have proved ineffective in the long run. Neither socialism nor democracy has produced the new ideal "socialistic" or "democratic" person. In order to be lasting, transformation and change must first be experienced by individual persons as profound redefinitions of their own lives to provide the basis for a total transformation of society and its harmonious compassionate reintegration.

Roszak (1979) pointed out that we are entering the *Age of the Person.* This means that for the first time in the history of humankind the assertion of each individual's right to the fullest development of his or her unique personhood and identity becomes the sacred trust and shared goal of society. This new principle is bound to change profoundly the role of all of our institutions and agencies, whether they relate to government, education, the professions, trade unions, science, physical and mental health, industry, or business. All these organizational frameworks will henceforth be evaluated in accordance with their ability to respond effectively to and provide opportunities for the personal growth, self-fulfillment, and life enrichment of their individual members. They can no longer claim that their members must pay allegiance to their norms, values, and organizational structure rather than seek self-actualization, growth, and new challenges.

We are today witnessing the emergence of support groups and self help networks that provide a communal basis for individuals who share problems, disabilities, and handicaps that are frequently ridiculed, disregarded or even violently rejected and attacked by other people.

A second Aquarian principle implies that this search for the assertion of a unique identity, personhood, and self-fulfillment remains no longer restricted to a privileged minority or elite; it is now claimed by all individuals. Adherents demand full respect for their dignity, integrity, individuality, and choice of belief or lifestyle. We are today witnessing the emergence of support groups and self help networks that provide a communal basis for individuals who share problems, disabilities, and handicaps that are frequently ridiculed, disregarded or even violently rejected and attacked by other people.

There are groups of childless couples, homosexual artists, abused wives, former mental patients, senior citizens, mistresses anonymous, and many others whose main purpose consists in strengthening the pride of their members in their common experiences and sharing a unique identity and personhood. They want to confront a discompassionate competitive society with living examples of compassionate support and sympathetic cooperation. "No matter how different I may be from you and many others, I have the same right to assert my own dignity, self-respect, uniqueness, identity, and inviolability as you do," say the members of these support networks. Society must be flexible enough to accommodate diversity and even nonconformity.

Basic Principles of the Holistic Approach

From the confluence of ideas expressed by Ferguson (1980), Garai (1979), and Roszak (1979), one can formulate the following five principles: (a) Each individual has the inalienable right to the fullest development of unique personhood, identity, and lifestyle; (b) each individual has the right to expect respect for unique personhood, identity, and integrity or wholeness from all other people; (c) each individual is encouraged to associate oneself with other individuals on the basis of sharing common goals, ideas, interests, handicaps, or lifestyles; (d) each individual has the right to challenge any authority or institution to respond positively to one's own need for recognition of unique identity and personhood; and (e) each individual is encouraged to seek internal wholeness, that is, a harmonious balance between body, mind, and spirit, as well as external wholeness, that is, a wholesome connectedness with other people and the ecological environment on this planet.

These five principles must be adhered to to ensure the transformation needed to initiate the Age of the Person as defined by Roszak (1979). The specific steps that must be taken to educate each individual toward the conscious assertion of these five principles of unique personhood, are outlined by Garai (1979) as follows: (I) The Holistic Approach; (II) Achievement of Genuine Individuation; (III) Movement from Autonomy to Intimacy; (IV) Formulation of Meaningful Life Goals; (V) The Holistic Perspective of the Life Cycle; (VI) Fluidity and Stability of Individual Identity; and (VII) Empathy and Intuition in Symbolic Communication.

Each of these seven steps suggests practical exercises to provide therapeutic tools for the promotion of holistic personality integration in education and mental health.

The Holistic Approach

> The holistic approach is based on a field theory of intrasystemic and intersystemic interactions of body, mind and spiritual functions with special emphasis on their integration through harmonious combinations of the effects of both brain hemispheres. All the disciplines and professions must cooperate in the process of achieving holistic integration." (Garai, 1979, p. 178)

Exercises

The first exercise is designed to achieve holistic personality integration. Each subject is given two pieces of plasticine modeling clay with which to model figures (preferably the nontoxic nonhardening Swiss Caran d'Ache clay), two sheets of sketching paper (preferably 17 x 14 inches) and assortments of multicolored crayons. Instructions are: "Take a piece of clay, close your eyes, and model the clay with your eyes closed. Imagine how you are fragmenting and splitting yourself, how you engage in activities or thoughts that cut off your body from your mind, your mind from your spirit, and yourself from your natural environment. Try to impart these splitting tendencies to the piece of clay in your hand." Then wait 10 or 12 minutes before adding the following instructions: "Now soon I will count from one to three. When you hear the number three, open your eyes, place the clay figure of your self-fragmentation next to the first sheet of paper, mark this sheet with number one in the lefthand upper corner, and proceed to draw with crayons the experience of your self-splitting in any way you desire." After waiting for 3 more minutes, the count to three is made.

The second exercise is initiated with the following instructions: "Now take another piece of clay, close your eyes, and model it with your eyes closed. Let images flow depicting how you attempt to integrate your body, mind, and spirit harmoniously so as to satisfy your basic needs and feel whole within yourself." Then after a delay of 10 or 12 minutes the following instructions are added. "Soon I will count from one to three. When you hear the number three called out, open your eyes, place the clay figure of your self-integration next to the second sheet of paper, mark this sheet with the number two in the lefthand upper corner and proceed to draw with crayons the experience of your self-integration in any way you desire." After an additional delay of 3 more minutes, the count to three is made.

A comparison of the clay models and the crayon drawings is then made, first in dyads, then in groups of four, and finally by the whole group with the assistance of the facilitator in order to clarify movements from fragmentation to integration as revealed by interpretations of the symbolic meanings of the clay models and the crayon drawings. It is a simple yet powerful method of demonstrating holistic personality integration.

Achievement of Genuine Individuation

> This process can best be described as attainment of authenticity, autonomy, and actualization of self (the three A's) through creative expression. The most important step leading to individuation consists in the accomplishment of the developmental task of learning to be a separate person able to take full charge of one's own life. It requires completion of the process of separation from significant other persons, especially from the mother and the father. This separation leads to genuine individuation providing the basis for true autonomy. The autonomous person is able to control his life effectively. He can enjoy the state of aloneness without experiencing feelings of loneliness and despair. He has the courage to stand alone without feeling lost or abandoned. (Garai, 1979, p. 178)

The autonomous person is therefore able to appreciate the state of being alone as an opportunity to enjoy the utmost freedom of choice with regard to goals, ideas, interests, and activities that can be pursued without fear of disapproval, ridicule, objection, or intrusion. The dependent non-autonomous person seems to experience all aloneness as "loneliness," that is, a state of deficiency, the absence of an important companion or lover, and consequently, exposure to frightening feelings of abandonment and rejection. One can focus on this state of deprivation to such an extent that he or she feels paralyzed, immobilized, and unable to envisage any activity that would replace the absent partner.

Exercises

The first exercise is designed to assist participants to move from the type of loneliness that is perceived as a lack, a state of deficiency, or an incapacitating experience to enjoyable aloneness providing optimal freedom of choice and relaxation encouraging creative expression. Subjects are provided with two pieces of plasticine modeling clay, two sheets of sketching paper, and assortments of multicolored crayons. The first instructions are: "Take a piece of modeling clay in your hand, close your eyes, and model it with your eyes closed. Imagine yourself feeling lonely because you are missing the companionship of the person closest to you. You cannot concentrate on anything you would like to do alone bcause of the painful absence of your partner. You feel as if you were nonexistent and are unable to engage in any meaningful activities."

After 10 or 12 minutes the following instructions are added: "I will soon count from one to three. When you hear the number three, open your eyes, place the clay model next to the first sheet of paper, mark this sheet with number one in the upper left hand corner, and proceed to draw the experience of your painful loneliness with crayons." After 3 more minutes the count is made from one to three.

This first exercise is followed by a second exercise for which the initial instructions are: "Take a piece of modeling clay, close your eyes, and model the clay. Imagine yourself all alone and eagerly looking forward to the opportunity to be able to do whatever comes to your mind and whatever you enjoy doing most without having to bother about the needs, likes, preferences, or objections of any other person in the world. You experience a tremendous surge of vital energy and a feeling of complete freedom of choice. Impart these feelings upon the piece of clay in your hand."

Then after 10 or 12 minutes the final instructions are given: "I will soon count from one to three. When you hear the number three, open your eyes, place the clay model of your enjoyable aloneness next to the second sheet of paper, mark this sheet with number two in the upper lefthand corner, and proceed to draw the experience of your positive aloneness with crayons." After 3 more minutes the count to three is made.

Participants get together first in dyads, then in groups of four to compare drawings and clay models of both exercises to draw conclusions about movement from dependency to genuine individuation reflected in the symbolic meanings of the artwork. This is followed by analyses of the artwork and interpretation of symbolic meanings by the group facilitator with individual group members to deepen the understanding of symbolic interpretations of dependency versus autonomy and individuation.

Movement from Autonomy to Intimacy

> Once a person has achieved genuine individuation and autonomy, he is ready to seek out other similarly individuated and autonomous persons for the purpose of satisfying relationships. One must first be a person in one's own right to get ready for the encounter with another person. This is most eloquently expressed in the treatise 'I and Thou' by Martin Buber. The expressive therapist realizes the importance of balancing the needs for intimacy and privacy in close dyadic relationships. (Garai, 1979, p. 178)

Exercises

To explore the movement from autonomy to intimacy, the following exercise is suggested. First have each participant depict with clay and crayons the following: "I feel whole in body, mind, and spirit, and at ease with the world around me." Then each participant depicts the scenario: "My friend feels whole in body, mind, and spirit and at ease with the world around him or her." The third exercise deals with the theme: "I feel whole within myself and at ease with the world, my friend feels whole within himself or herself and at ease with the world, and we both feel whole within our relationship." In each of these exercises similar instructions to those used in the previous exercises on achievement of individuation with similar time sequences can be used with relevant adoption of the scenarios. The clay models and crayon drawings from the three scenarios are then interpreted by the group, first in dyads, then in groups of four, and finally by the whole group with the facilitator using his experience in the interpretation of the symbolic meanings of the artwork as a valuable asset for further clarification of movement from autonomy to intimacy.

Formulation of Meaningful Life Goals

> Man cannot live by bread alone. He must find some meaning in his existence. . . . Life thus becomes a series of metamorphoses . . . life goals must involve self-actualization through engagement in some meaningful and personally satisfying occupation. But it must also go beyond mere self-fulfillment to reach other people in the search for self-transcendence. One's personal life must move toward transcendence of the mere personal interest and strive toward transpersonal experiences. A meaningful life goal must open up avenues that hold out the promise of some kind of transformation characterized by growth and change in other people's lives. A profound concern for social justice and change, alleviation of social and economic discrimination, elimination of racial, ethnic, national, religious, and sexual prejudices, and the improvement of the microcosm of the family and the immediate neighborhood as well as of the macrocosm of the nation and the world community as a whole reflects the value system of self-transcendence. It appears to create a firm basis for a genuinely meaningful existence. (Garai, 1979, p. 178-179)

Exercises

The following exercises have been developed to explore meaningful life goals. Using plasticine clay, sketching paper, and multicolored crayons, each subject first models and draws the theme: "I am doing something I really like; and follows it with an exercise depicting the theme: "I am doing something I dislike very much." Drawings and clay models are then compared first in dyads, then in groups of four, and finally by the group as a whole with the facilitator deepening the analytic interpretations of the symbolic meanings reflected in the clay models and crayon drawings.

Another exercise might use the same materials to explore first the theme: "I am doing something I dislike because it makes a lot of money" (or "because others make me do it, although I hate doing it") followed by the theme: "I am doing something I really like because it is my own *special* thing or because it really makes me feel fulfilled and happy." Again similar comparisons and procedures are followed as in the previous exercises to derive a more profound comprehension of the dynamics involved in the establishment of meaningful life goals.

In the "real" world we must learn to live with a variety of people whose identities and life styles are often quite different from ours.

Another relevant exercise requires participants to focus on their most meaningful life goals, making clay models, crayon drawings or collages depicting these goals, and following this exercise with artwork depicting: "Obstacles in the way to achievement of this goal created by myself and others and ways of overcoming these obstacles."

The Holistic Perspective of the Life Cycle

> The individual person must develop the perception of the life cycle as an integrated process rather than a se-

> quence of disconnected crises and experiences. Birth, death, and rebirth, health and disease, pleasure and pain, success and failure, hope and despair are integral parts of the total life cycle. The goal of holistic humanistic therapy is not to eliminate pain but to assimilate it like all other experiences for the purpose of deriving meaning and creative energy from it. Jung and Rank were most aware of the necessity to deal with life and death as cosmic processes reflected in the individual experience. Freud's conception of Eros and Thanatos indicates how deeply he struggled with the problem of reconciling these forces. His dualistic approach induced him to define Eros as the sexual instinctive drive, whereas Thanatos was perceived as the aggressive instinctual drive. Eros thus became the creator of life and Thanatos the destroyer of life. It is a basically pessimistic view which permits death to triumph with no ultimate redemption.
>
> Jung's system of polarities reflects his view that each individual must seek to integrate such polarities as the persona and the shadow, the animus and the anima, and others. It lays the groundwork for the integration of the life force and the death force. Of course, Jung was influenced by his knowledge of Eastern philosophies which avoided the dualistic split of Western thought systems. Capra in *The Tao of Physics* explains how the findings of modern physics vindicate the views of Eastern philosophical thought. They reveal surprising parallels between the behavior of particles of matter and the behavioral interactions of human beings. (Garai, 1979, p. 179)

To summarize these views, the holistic perspective of the life cycle emphasizes the continuity and fluidity of life as a cyclic phenomenon characterized by birth, death, and rebirth of cosmic matter. Living and dying are intricately intertwined processes. We are living and dying throughout our lifetime, while old cells of the body and outdated ideas of the mind are continuously discarded and replaced by new cells and novel ideas to get us ready for the next states of growth.

The holistic perspective of the life cycle reinforces attitudes that reject any type of segregation on the basis of race, religion, socioeconomic status, ethnic or national affiliation, type of handicap, sex, marital status or age. In the "real" world we must learn to live with a variety of people whose identities and life styles are often quite different from ours. This can lead to the development of attitudes of acceptance, compassion, and respect, which will create a microcosmic society of justice and cooperation serving as a model for the society as a whole. How the aged and the very young can benefit from mutual interaction was recently demonstrated in a national television program that showed young handicapped children visiting a nursing home and becoming instant friends and playmates of the elderly residents. It is quite clear that our society needs more such efforts to loosen age barriers.

. . . the holistic perspective of the life cycle emphasizes the continuity and fluidity of life as a cyclic phenomenon characterized by birth, death, and rebirth of cosmic matter. Living and dying are intricately intertwined processes.

Exercises

During the past few years I have developed a new method that has proved to be most effective in assisting participants to gain an integrated view of the total life cycle. I have described this method as *rebirthing through creative expression in art* or *rebirthing through art.* Participants are induced to go through the four stages of being in the womb, being born, facing death, and *willed* rebirth with the help of imagery. Autogenic induction of guided imagery precedes each stage as follows: (a) "Imagine yourself being in your mother's womb and floating in the amniotic fluid"; (b) "Imagine yourself going through the birth canal and emerging in the outside world"; (c) "Imagine yourself facing the last hour of your life"; and (d) "Imagine yourself going through the birth canal again, but this time you are able to determine the outcome of your birth, choosing whoever and whatever you will be in this reborn existence."

During the exercises, each participant models the experience (with eyes closed) with a piece of plasticine clay, and following this experience draws it with multicolored crayons. This advanced and difficult exercise should be presented only by highly qualified registered art therapists who have undergone advanced training. Experience has shown that this method leads to an unusual unfolding of creative energies in the rebirth state in which colorful mandalas, flowers with scintillating petals, mountains, rainbows, landscapes, scenes from the bottom of the sea, birds and stars appear as symbolic representations of rebirth.

After developing this method of *rebirthing through art,* I attempted several times to administer it, while omitting the death stage. I discovered that the rebirth experience (immediately following the original birth experience) brought forth drawings and clay figures that were stiff, poor in detail, and unexciting. This was in contrast to the artwork following the death state, which was striking, colorful, expansive, and innovative, and reflected bursts of vital energy. Once a person faced the fear of death, he or she seemed to release a strong reservoir of vital energy that was waiting for creative expression. This result furnishes convincing evidence for the holistic integration of the life cycle.

Fluidity and Stability of Individual Identity

> This was stated in Buhler's eighth principle of the humanistic approach as follows: 'Identity is fluid and yet stable throughout a person's life requiring continued attempts to reintegrate and reconcile polar tendencies and different needs.' Erikson's brilliant analysis of 'The Eight Ages of Man' in *Childhood and Society* focuses in depth on the first five stage of life until adulthood which is described as the stage of 'Intimacy versus Isolation.' But his later stages fail to reflect the significant transitional stages of growth, change, redefinitions of identity, and challenges which people in modern societies go through in early childhood, midlife,

> midlife, early old age, and old age. Erikson allocates the lifespan from age thirty-five until seventy, the expected average age of death in modern industrial societies .... only the two stages of 'Generativity versus Stagnation and Ego Integrity versus Despair.' There is no doubt that we need a greater awareness and comprehension of the numerous transitional stages, the challenges, crises, changes, redefinitions of identity and life goals, and the creative resources needed to negotiate the adult and later stages of life.
>
> The humanistic expressive therapist considers the total life-span as a continuous series of challenges and crises which require the constant learning of new adaptive strategies in order to cope with them. Each individual must acquire a sense of trust and confidence in his ability to survive and derive satisfaction from life. We must learn to cope with transitions from one stage to another, with change, choices, and the creation of our specific lifestyles. The humanistic expressive therapist assists his clients in the mobilization of latent creative resources to meet these challenges with authenticity, autonomy and actualization of their creative potential. The benefits accruing from working with older clients stem from the frequent discovery of potent creative energies which a youth-centered society does not want to acknowledge or discover. (Garai, 1979, p. 180-181)

It is clear from this description that the process of identity formation is not finally completed by the end of adolescence. Transitional periods, turning points, and new life experiences provoke identity crises in early childhood, middle childhood around age 8, early adolescence, adolescence, midlife around age 40, early old age around age 60, and old age between the ages of 70 and 80. Change is inherent in the experience of life in the modern era. The person who has a firm and stable core identity is most likely to successfully adapt one to the required changes, and modify identity without losing basic anchoring points. Expressive therapies can be most effectively used to assist clients in the resolution of subsequent identity crises.

Exercises

A danger that may frustrate efforts to resolve an identity crisis consists in confusing the role one plays with one's basic identity. An exercise intended to explore and clarify this confusion of role-playing with identity might suggest to participants (using crayons, clay, or collages, or through movement improvisation or poetry therapy) various roles each of them may be required to play such as teacher, husband, wife, accountant, psychologist, or policeman. Then each participant depicts (a) how one is able to maintain identity while enacting this specific role, and (b) what might happen, if the role took over to such an extent as to replace one's identity. Finally, each participant depicts how he or she plans to maintain this unique identity, no matter how overriding any specific roles might become. A comparison of the artwork, movement improvisations, or poetic passages produced under these three different conditions can be used to explore ways of resolution of identity conflicts devised by the participants.

Imagery and fantasy are acknowledged as powerful healing forces.

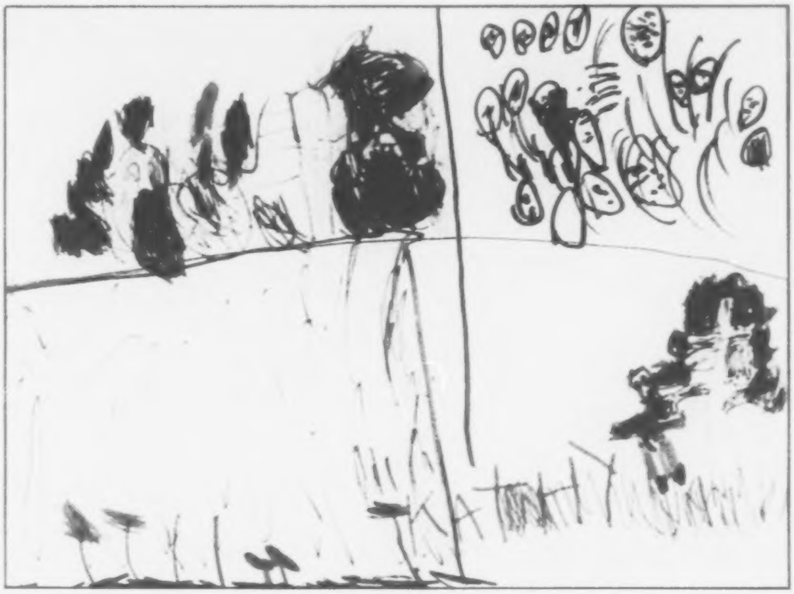
Another exercise would require participants first to depict "the stable me" and then "the fluid me" and follow up with a third exercise centering around the theme: "I am integrating the 'stable me' with 'the fluid me' harmoniously."

Empathy and Intuition in Symbolic Communication

> The special skill of the expressive therapist consists in his training in methods of symbolic communication. His preference for this modality stems from the realization that symbolic communication can become a more direct, genuine, honest, and sincere way of expression of feelings than verbal communication. Words can conceal, hide, and lie as well as reveal, expose, and tell the truth. Using empathy and intuition in his interpretation of symbolic communication and the meanings of symbolic messages, the sensitive art therapist is able to get in touch with his client's feelings more directly. The art therapist prefers means of graphic, sculpted, pictorial, and collage expression, the music therapist, musical instruments and the singing voice, the dance and movement therapist, various forms of individual and group dance, movement improvisation, and breathing techniques. We ought to include also poetry therapy among the expressive therapies, because it is characterized by the use of verbal communication on a deeper symbolic level.
>
> Symbolic communication requires an empathetic and intuitive grasp of what Jung has defined as the collective unconscious and its relationship to the personal unconscious of the client. The explorations of myths, fairy tales, religious stories, dreams, great tribal, national, and supernatural epics, traditions of good and evil spirits, God and the Devil, folklore, etc., involve an understanding of the archetypes, images, and symbolic messages which frequently assume a strong powerful role in the unconscious of the individual. They affect our conscious behavior as well. (Garai, 1979, p. 181)

Dreams focus on unfulfilled wishes or unresolved problems.

Imagery and fantasy are acknowledged as powerful healing forces. Many of the innovative techniques in imagery and fantasy have been described by Singer and Pope (1978). Asking individuals to depict with crayons, plasticine clay, collages, or movement improvisation a recent or recurrent dream can provide insights into the imagery and fantasy of participants. Dreams focus on unfulfilled wishes or unresolved problems. They may even resolve deep-seated personal crises or point out solutions to everyday problems as Jung has demonstrated. Simonton (1980) and his coworkers have used imagery to assist cancer patients in their recovery from cancer. Using chemotherapy, he instructs his patients to visualize the laser beam as directly attacking the cancerous cells with invading armies of immunogenic or "health-bringing" cells, while imagining that his own body mobilizes auxiliary armies of immunogenic cells which help the invading health-bringing cells to defeat the "enemies," that is, the diseased cancer cells.



"Fall, then winter, and spring . . . and then summer." When words are not available, the visual image allows for K. to sequence her ideas logically and to share a communication with others. The success of the visual arts is demonstrated repeatedly in clinical settings throughout the nation. It is important that this value is shared with colleagues in all disciplines of the human services.

A healthy mind in a healthy body in a healthy spirit in a healthy world.

Exercises

Garai developed a method that can be used to replace drug therapy based on the use of tranquilizers. Whenever a client claims that he or she cannot survive without the use of tranquilizers, Garai suggests: "Imagine the pain as vividly as possible. Try to focus on the specific part of the body it attacks, picture how it squeezes, tears, cuts, hurts, nags, etc., how heavy it feels, and try to draw with crayons and model with plasticine clay the pain and all its effects." After discussion of the symbolic meanings of the drawings and the clay models, the following instructions are presented: "Now imagine how the pain is receding and leaving your body. Try to picture how your muscles are relaxing, how your body feels more at ease, and how you can breathe more freely and easily. You feel your energy slowly coming back and the pain no longer interfering with your activities. You can breathe freely." After interpreting the artwork of the pain leaving the client's body, the surprising effect of freedom from it is frequently more relaxing and longer lasting than that which might be derived from a tranquilizing pill.

Summary

To summarize the basic position of holistic expressive therapy, it may be stated that it follows the principle: *Mens sans in corpore sano in spiritu sano in mundo sano.* It reflects the holistic approach whose ideal is: *A healthy mind in a healthy body in a healthy spirit in a healthy world.* Its purpose consists in assisting the individual in the development of a holistic and integrative rather than a fragmented and alienated life style. The person who genuinely experiences wholeness respects the Integrity, Indentity, Individuation, and Idealism (the four I's) of both oneself and every other human being. This holistic philosophy leads the way of life of Care, Compassion, and Concern (the three C's) which flows organically from the integration of Authenticity, Autonomy, and Actualization of Self (the three A's).

The truly educated healer is a healed or whole individual

The holistic expressive therapist believes that the attainment of this way of living constitutes a goal that is within the reach of every single human being. Therefore the therapist is engaged in a lifelong journey toward this goal together with his or her clients. This basic credo will inspire the therapist with the courage to create; it will also inspire with *the courage to heal* as the original meaning of the word "healing" conveys the sense of "making whole." The truly educated healer is a healed or whole individual; in healing others, one heals oneself, and in healing oneself, the individual is healing others.

References

Ferguson, M. (1980). *The Aquarian conspiracy: Personal and social transformation in the 1980s.* Los Angeles: J.P. Tarcher, Inc.

Garai, J.E. (1979). New horizons of the humanistic approach to expressive therapies and creativity development. *Art Psychotherapy, 6,* 177–183.

Roszak, T. (1979). Person/planet: *The creative disintegration of industrial society.* New York: Doubleday Anchor Press.

Simonton, O. (1980). *Getting well again. New York: Bantam.*

Singer, J.L., & Pope, K.S. (1978). *The power of human imagination: New methods in psychotherapy.* New York and London: Plenum Press.

THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

GIVE YOURSELF A HEAD START! SUBSCRIBE NOW AND SAVE!
Subscribers to *Art Therapy* and Members of American Art Therapy Association
ENJOY REDUCED RATE!

A quarterly, international, multi-disciplinary journal for professionals and students in all areas of the arts in psychotherapy, mental health and education, THE ARTS IN PSYCHOTHERAPY publishes original articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologists which reflect advances in theory, research and practice with no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy, THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers to: Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583

TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA

Please enter my subscription for 1984. Enclosed is check for $20.
(Regular rate for individuals $40) Bill me ☐

Name
Address
City State Zip

american journal of ART THERAPY
Art in Education, Rehabilitation, and Psychotherapy

This independent quarterly, published since 1961, deals with the visual arts as they contribute to human understanding and mental health. Its contents include new theoretical formulations, bibliographical information, a job information exchange, and news of opportunities for training and of international developments in the field.

Topics treated in recent articles include:

- transference and countertransference in art therapy
- art therapy and cultural difference
- art as therapy in a public school
- art therapy with the severely physically disabled
- self-expression of a disturbed adolescent
- art in strategic family therapy
- the combination of art and play therapy
- the place of art in art therapy
- research into hospitalized children's self-images.

Name: Address:
Street

City State Zip

Individual Subscribers: U.S. and Possessions, $15; foreign, $17.50 (Students and members of the American Art Therapy Association are eligible for discounted subscriptions as follows: U.S. and Possessions: $12; foreign, $14) Institutional Subscribers (U.S. and Foreign): $25

AMERICAN JOURNAL OF ART THERAPY, P.O. Box 4918, Washington, DC 20008-0118

BEST COPY AVAILABLE

Ten Year Follow-Up Survey on the Status of Art Therapy in the Greater Los Angeles Area

Helen B. Landgarten, MA, HLM, ATR

Helen B. Landgarten, MA, HLM, ATR, is director of the Graduate Department of Clinical Art Therapy of Loyola Marymount University in Los Angeles. She is also coordinator of the Art Psychotherapy Program of the Family and Child Department of Psychiatry of the Thalians Community Mental Health Center at Cedars-Sinai Medical Center, Los Angeles. An Honorary Lifetime Member of the American Art Therapy Association, she has lectured and conducted workshops on clinical art therapy throughout the U.S. and in the U.S.S.R., Germany, South Africa, Sweden, Israel, Brazil, France, Yugoslavia, and England. She is the author of Clinical Art Therapy, A Comprehensive Guide, *and is a member of the Executive Board of A.A.T.A.*

This article presents a format for, and information from a regional questionnaire about art therapy in the mental health field, and could serve as a model for other surveys. Collection of regional data at different time periods would be useful in yielding information from both regional and national perspectives. The survey, therefore, provides both a model for a survey format that could be used by art therapists in different geographical areas, and presents data that can be cross-referenced to build a greater body of knowledge regarding the status of art therapy.

In 1982, a survey was conducted to ascertain the status and future for art therapy in the mental health field in the Greater Los Angeles area. This survey was a follow-up to similar surveys taken in 1972 (Anderson & Landgarten, 1973, 1974, Landgarten, 1972, 1974a, 1974b). In addition, three later surveys, utilizing similar questionnaires, were conducted by Immaculate Heart graduate students (Hoseman, 1976; Siegel, 1979). Each of these latter surveys conveyed and recorded the mental health institutional attitudes and perceptions of the field of art therapy in the Greater Los Angeles area. The information from the survey discussed here provides both comparative data regarding the growth of art therapy in the Greater Los Angeles area and information that can be compared with that from other regional or national surveys.

The questionnaire provided important information about the current employment and status of art therapists, the training background and credentials of both art therapists and supervisors, and a listing of agencies that expressed an interest in an art therapy presentation or being available for use as a practicum site for training.

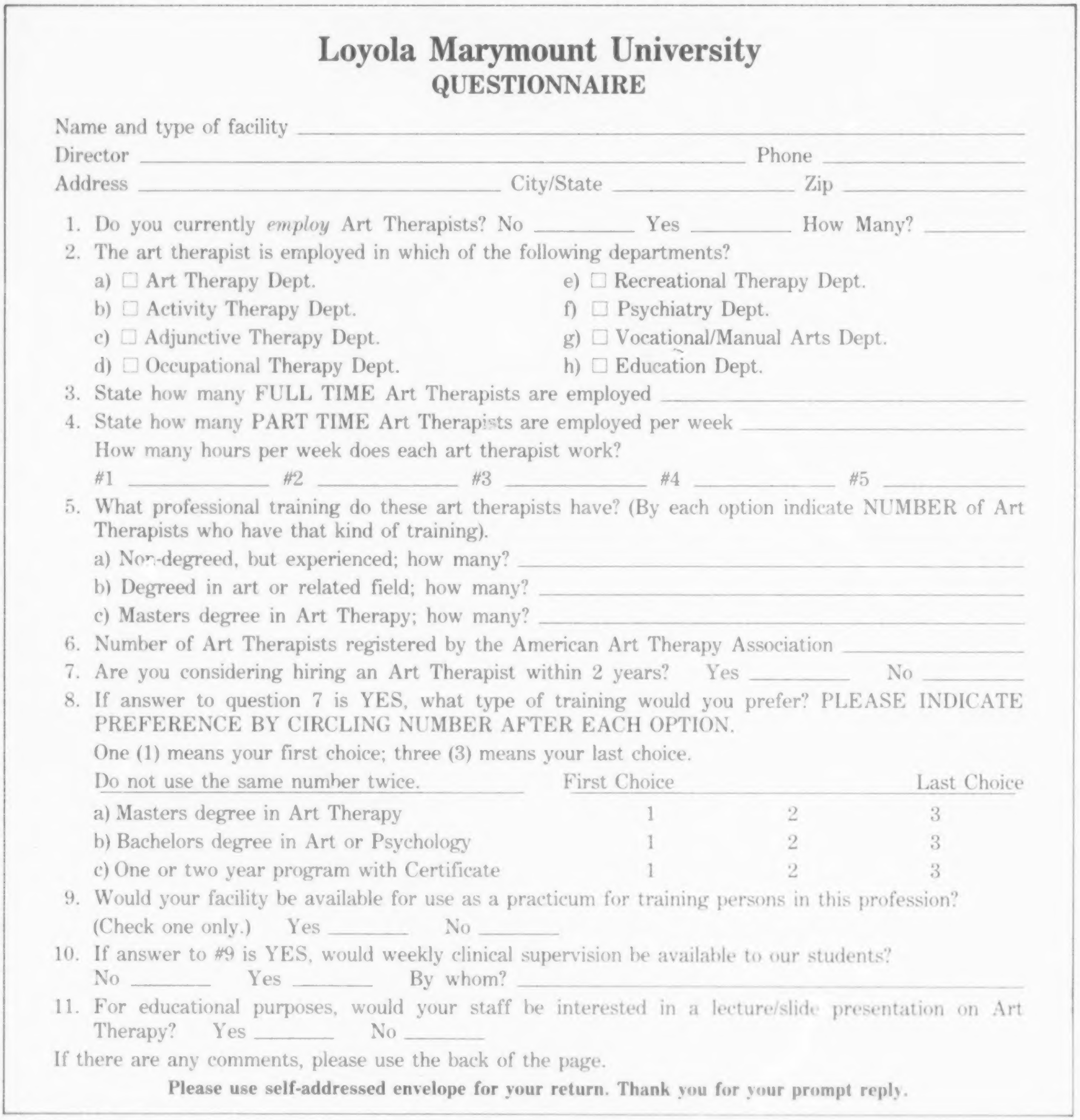
A cover letter and questionnaire (Figure 1) were sent to 245 mental health institutions in the Greater Los Angeles area. The mailing was based on information from *The Directory of Health, Welfare, Vocational, and Recreational Services in Los Angeles County* and the Loyola Marymount University's Field Placement lists. Of the 245 questionnaires that were mailed, 137 were returned, for a response rate of 56%.

A total of 96 questionnaires (39%) were not returned, and 12 questionnaires (5%) were returned by the Post Office as undeliverable. Sixteen (12%) of the returned questionnaires were not applicable to the study. The survey analysis is based on 121 responses, (49% of the total number of questionnaires mailed), and 88% of the total number of responses returned.

For the purpose of making numbers and percentages clear, the following procedure is used in this article: when segments of the sampling are discussed, percentages are given in terms of the number in the segment, which is represented by the small letter "n." Findings are reported in terms of numbers and percentages of the completed answers. Table data are referred to in the discussion where both the number and percentages of responses bear an importance to the questions.

Responses were compiled from the following types of institutions: community mental health/family counseling; out-patient and in-patient units; schools; developmentally disabled centers; residential treatment (child, adolescent, adult); rehabilitation; day care (adult, geriatric); day treatment (child, adolescent, adult); out-patient (drug abuse, alcohol); geriatric; residential treatment (child, adolescent). The facilities were listed according to various service categories to determine what type of institution showed the greatest amount of interest in the art therapy field. The response rates are listed in Table 1.

It would have been wise to combine community mental health with outpatient facilities because they serve the same function. In situations where in-patient units are within a community mental health center, they were cited under the "in-patient" heading. Table 1 may be utilized to study comparisons between the 1982 survey and the past surveys of 1972, 1974, 1976, and 1979.



Loyola Marymount University
QUESTIONNAIRE

Name and type of facility ____________________
Director ____________________ Phone __________
Address ____________________ City/State __________ Zip __________

1. Do you currently *employ* Art Therapists? No ________ Yes ________ How Many? ________
2. The art therapist is employed in which of the following departments?

a) ☐ Art Therapy Dept.	e) ☐ Recreational Therapy Dept.
b) ☐ Activity Therapy Dept.	f) ☐ Psychiatry Dept.
c) ☐ Adjunctive Therapy Dept.	g) ☐ Vocational/Manual Arts Dept.
d) ☐ Occupational Therapy Dept.	h) ☐ Education Dept.

3. State how many FULL TIME Art Therapists are employed ____________________
4. State how many PART TIME Art Therapists are employed per week ____________________
   How many hours per week does each art therapist work?
   #1 ________ #2 ________ #3 ________ #4 ________ #5 ________
5. What professional training do these art therapists have? (By each option indicate NUMBER of Art Therapists who have that kind of training).
   a) Non-degreed, but experienced; how many? ____________________
   b) Degreed in art or related field; how many? ____________________
   c) Masters degree in Art Therapy; how many? ____________________
6. Number of Art Therapists registered by the American Art Therapy Association ________
7. Are you considering hiring an Art Therapist within 2 years? Yes ________ No ________
8. If answer to question 7 is YES, what type of training would you prefer? PLEASE INDICATE PREFERENCE BY CIRCLING NUMBER AFTER EACH OPTION.
   One (1) means your first choice; three (3) means your last choice.

Do not use the same number twice.	First Choice		Last Choice
a) Masters degree in Art Therapy	1	2	3
b) Bachelors degree in Art or Psychology	1	2	3
c) One or two year program with Certificate	1	2	3

9. Would your facility be available for use as a practicum for training persons in this profession?
   (Check one only.) Yes ________ No ________
10. If answer to #9 is YES, would weekly clinical supervision be available to our students?
    No ________ Yes ________ By whom? ____________________
11. For educational purposes, would your staff be interested in a lecture/slide presentation on Art Therapy? Yes ________ No ________

If there are any comments, please use the back of the page.

Please use self-addressed envelope for your return. Thank you for your prompt reply.

Figure 1.—Art therapy questionnaire sent to 245 mental health institutions in Greater Los Angeles

Questions 1, 3, and 4 (See Figure 1) were directed toward discovering the number of facilities who hire full-time and part-time art therapists. This survey represents a total of 81 art therapists. Twenty-eight (45%) facilities hire art therapists on a full-time basis, and 35 (55%) facilities hire on a part-time basis.

The 45% rate of full-time employed Art therapists is extremely high in Los Angeles, for a profession which graduated its first seven master's degree students in 1975.

The questionnaire provided information on institutional hiring practices. The number of art therapists that are employed ranges from one to five in a a single institution. Of the total number of 63 institutions, 24 (38%) facilities hire one art therapist on a full-time basis. This full-time statistic is low because a number of art therapists *prefer* not to have one full-time job.

The number of art therapists that are employed part-time ranges from one to five in a single institution. Of the 63 total number of institutions, 29 (46%) facilities hire one art therapist on a part-time basis.

Written comments on the questionnaire and discussion with personnel indicated that many art therapists chose to hold several part-time institutional positions. This preference has been cited as: a deterrent to burnout, extra time needed for private practice, a desire to combine their work as an art therapy instructor or supervisor. In addition, some art therapists have part-time group work as a means to higher earnings.

Because the role of the art therapist may be revealed through the department in which he or she functions, question 2 (see Figure 1) referred to an identification of specific departments within which the art therapist worked. Departments were listed as: art therapy; activity therapy; adjunctive therapy; occupational therapy; recreational therapy; psychiatry; vocational/manual arts; and education. It is gratifying to find that 27% of the art therapists are located in art therapy departments (see Table 2).

Psychiatry (23%) is almost equal in number to art therapy, with psychology and social work receiving the third and fourth highest number. Because clinicians in these disciplines are frequently the primary and/or only workers to offer treatment to the client, it is assumed that art therapy is also viewed as a primary or parallel therapeutic intervention.

In the original 1972 survey, Art Therapy as a department was nonexistent. The departments with the lowest number of art therapists are equally important. The survey shows departments of education, activity, adjunctive, occupational, and recreational therapies with low scores of 8 to 1 percent (see Table 2).

The survey provided data on the educational background of employed art therapists. A master's degree in art therapy received a high response of 76 (94%) (see Table 3).

This indicates that the master's degree in art therapy is highly recommended for the professional art therapist in order to be integrated into the paid mental health system in Greater Los Angeles. Institutions are viewing art therapists as equal to social workers in view of educational background, duties, and salaries.

Fifty (62%) of the employed art therapists hold an ATR (Registered

Table 1. Type of Facilities Responding to Questionnaire

Type of facility	Number sent	Number returned	Percent returned
Inpatient	34	31	91
Day treatment: Adult	8	7	88
Schools	29	22	76
Community Mental Health; Family Counseling	40	30	75
Day treatment: Child/Adolescent	7	4	57
Outpatient Drug Abuse/Alcohol	42	22	52
Developmentally Disabled: Residential/Training	9	4	44
Rehabilitation	10	4	40
Geriatric	12	4	33
Residential Treatment: Child/Adolescent	54	9	17
n = 137 Totals:	245	137	

Table 2. Departmental Location

Department	Art therapists	Percent
Art Therapy	22	27
Psychiatry	19	23
Psychology	9	11
Social Service	8	10
Education	6	8
Activity Therapy	6	8
Adjunctive Therapy	5	6
Occupational Therapy	3	4
Undefined	2	2
Recreational Therapy	1	1
Totals:	81	100

n = 81 (more than one art therapist; each in a different department)

Table 3. Employed Art Therapists' Education and Registration

	Number	Percent
Non-degreed, with experience	1	1
Degreed in art or related field	4	5
Master Degree in Art Therapy	76	94
Totals:	81	100
Registered by the American Art Therapy Association	50	62
Non-registered	31	38
Totals:	81	100

n = 81

Art Therapist, awarded by the American Art Therapy Association). A number of respondents filled in information stating that their employees' registrations were in progress (see Table 3).

Art therapy registration (ATR) currently fulfills a dual purpose: it is a symbol of professional qualifications and is also a necessary requirement for agencies who desire a Loyola Marymount University Clinical Art Therapy Intern. In addition, it seems that the increased number of professional art therapists is certainly a boon to the public relations aspects of art therapy as the therapeutic agent.

The 121 questionnaires showed that 42 (35%) respondents planned on employing art therapists within the next 2 years: 33 (27%) answered with a "yes," while 9 (7%) wrote in a "possible" response (see Table 4).

In Table 4, institutions are listed according to their services in order to gain a clearer picture of the type of facility where job offers will be available. The responding institutions that offer the largest *number* of hiring considerations are: Community Mental Health and Family Counseling with nine (21%); Inpatient units with eight (19%); and Outpatient/Drug/Alcohol with five (12%).

The 35 percent of prospective employment returns is considered to be especially high and surprising during these depressed times, with federal, state, and county mental health funding cutbacks, and the author wondered about the optimistic responses regarding the future hiring practices within agencies. In discussions with institutional directors and art therapists who have been recently employed, it was discovered that art therapists are filling jobs that were formerly held by social workers or psychologists with a master's degree, or by other degreed counselors. Mental health facilities have mentioned the impressive gains that the Loyola Marymount University interns have been able to accomplish through their competent use of the clinical art therapy modality.

Institutions that stated they will, or might, hire an art therapist were requested to answer the question referring to the preferred educational

Table 4. Future Employment for Art Therapists

Facilities	Number returned	Number responding		Yes		Possible	
		#	%	#	%	#	%
Community Mental Health/ Family Counseling	30	10	24	9	21	1	2
Inpatient	28	10	24	8	19	2	5
Outpatient/Drug/Alcohol	23	7	17	5	12	2	5
School	15	5	12	3	7	2	5
Day Treatment-Child/Adolescent	2	2	5	2	5	0	0
Day Treatment-Adult	6	3	7	2	5	1	2
Residential RX-Child/Adolescent	7	2	5	2	5	0	0
Developmentally Disabled- Residential and Day RX	3	1	2	1	2	0	0
Rehabilitation	4	2	5	1	2	1	2
Geriatric	3	0	0	0	0	0	0
Totals:	121	42	35	33	27	9	7%

Totals n = 121
Facilities Responding n = 42

Table 5. Choices for Training of Art Therapists

	M.A.		B.A.		Certificate		Total
	#	%	#	%	#	%	
First choice	38	90	3	7	1	2	42
Second choice	1	5	13	69	5	26	19
Third choice	2	7	7	26	18	67	27

n = 42

Table 6. Clinical Supervisors' Profession

Yes response		Number	Percentage
Psychology		21	17
Art Therapy		16	13
Clinical Social Work		14	12
Marriage Family Child Counselor		14	12
Psychiatry		12	10
Director (degree unknown)		9	7
Consultant (degree unknown)		3	2
Occupational Therapy		1	1
Recreation Therapy		1	1
	Total:	91	75
"No Response		30	25
n = 121	Totals:	121	100

background. Eleven additional respondents also chose to answer this question. This may be due to the institutions' desire to obtain a Loyola Marymount University intern. Some facilities that listed choices for the training of art therapists did not answer second or third choices. The large number of first choices for preferred educational background indicated 38 (90%) of the institutions wanted a master's degree in art therapy (see Table 5).

This indicates the acceptance of art therapy as a viable mental health modality equal to the master's degree in both social work and school psychology.

The question concerning the institution's availability for practicum training purposes yielded a high score of 91 (75%) "yes" answers. (This score includes three respondents who wrote "possibly.") From the 30 (25%) respondents who marked "no" replies, six declared that supervision was a problem.

The high number of "yes" answers may have been affected by institutional motivation to answer the questionnaire with a desire to receive an intern from Loyola Marymount University.

Institutional clinical supervision with the highest percentages were as follows: 21 (17%) by psychologists; 16 (13%) by art therapists; 14 (12%) by clinical social workers; 14 (12%) by marriage family child counselors; 12 (10%) by psychiatrists; and nine (7%) were to be supplied by directors whose degree was unknown (see Table 6).

Clinical supervision revealed the institution's perception of art therapy. This question is not as important as it was in the original survey due to the large number of current master's degreed art therapists. It reveals a trend, however, toward clinical supervisors who have an equal or higher degree than the one the student is completing.

Related to Number 11 on the Questionnaire, seventy-nine (65%) of the responses indicated an interest in receiving art therapy education through a slide/lecture presentation. Forty-two (35%) answered with a "no." Some of the "no" responses stated art therapists were already employed with no need for further education.

A number of institutions who employed art therapists also expressed a desire to receive a slide presentation. The desire for presentations in the original 1972 survey stemmed directly from the institution's curiosity and willingness to learn about an innovative and pioneering mental health modality. In this survey, however, the majority of respondents were well aware of the field of art therapy, and their current motivation tended toward staff meetings where various therapeutic approaches formulated a base for discussion. This fact is validated by the institutions that have taken advantage of Immaculate Heart College and Loyola Marymount University's graduate presentations in the past.

Conclusions

In comparison to previous surveys, clinical art therapy has made tremendous gains in the field of mental health. Agencies have been educated to the value of the dynamically oriented art therapy approach. A master's degree in art therapy has become a requirement for persons seeking employment. The mental health community recognizes the value of hiring an art therapist who is certified by the American Art Therapy Association, or who offers documentation of working toward that goal. In spite of funding cutbacks for institutions, future hiring plans are positive.

This survey indicates the art therapy profession has forged its way to an acceptable position in the field of mental health in Greater Los Angeles.

References

Anderson, F. & Landgarten, H. (1973-74). Art in mental health: a survey on the utilization of art therapy, *Studies in Art Education, 15*, 3, 44-48.

Anderson, F., & Landgarten, H. (1974). Survey on the status of art therapy in the Midwest and Southern California. *American Journal of Art Therapy, 13*, 2.

Hoseman, T. (1976). *Status of art therapy in Greater Los Angeles, 1976: A four year follow-up study.* Los Angeles: Immaculate Heart College, Unpublished paper.

Landgarten, H. (1972). *Art therapy in mental health: a survey on the utilization of art therapy,* Unpublished.

Landgarten, H. (1974a). *Survey of art therapy in 1974: Greater Los Angeles.* Unpublished.

Landgarten, H. (1974b). The state of art therapy in Greater Los Angeles, 1974: A two year follow-up study, *Art Psychotherapy International Journal, 5*, 4.

Siegel, B. (1979). *Status of art therapy in Greater Los Angeles: a seven year follow-up study,* Los Angeles: Immaculate Heart College, Unpublished paper.

Ed. Note: A copy of the complete research paper may be obtained from the author at: c/o Loyola Marymount University, Loyola Blvd. at 80th Street, Los Angeles, CA 90045.

GUIDELINES FOR AUTHORS: Please submit four (4) copies of manuscripts to: AATA Journal, 5999 Stevenson Ave., Alexandria, VA 22304. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ x 11 inch bond paper, with at least 1½ inch margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degrees(s) of the authors(s), professional affiliations, and the return mailing adress of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" x 7" black-and-white, glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure froma copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

VIEWPOINTS

VIEWPOINTS provides a forum for sharing ideas and graphics about issues facing art therapists. The following selections are related in their emphasis on art.

Some Views About the New Art Therapist

Ursula Goebels, MA
Westmont, Illinois

I was pleased to find an article in the first issue of *Art Therapy* touching upon a subject matter that has been of interest to me for quite some time. As a neophyte in the profession, still vividly remembering the anxieties, doubts, and frustrations experienced during the first couple of months on the job, I would like to share some thoughts and concerns about my search for a solution to the "all too understandable pressures that cause a beginning art therapist to feel anxious, isolated, and powerless" (Wadeson, 1983).

I am not so sure that we need to remind graduate students entering the field that our area of expertise is different; after all, that's why most of us chose this field. Providing additional models may not be extremely helpful since students entering the field seldom have the luxury of working in an established setting with an experienced art therapist to model. Instead, it seems to me it is important to recognize that everyday realities of clinical practice often do not mesh with the projected ideal needs (which is the first step in the never-ending search for an art therapist's unique and flexible concept in art therapy).

Much needs to be learned through experience, but I think most of us acknowledge that students entering our profession face an especially difficult task. Often students are on their own in creating new jobs which means fighting lonely battles for facilities, materials, recognition, self-assurance, and professional identity all at once. Indeed, they might have to fit into well-established systems and have to adjust to treatment approaches that are quite different from the new with which they are familiar, and it is hard — maybe even impossible — to determine the effectiveness and usefulness of different techniques without trying them.

Little wonder, then, that under all of this pressure beginning art therapists struggle and stumble in an attempt to learn from other distinguished colleagues by selecting the right amount of tools needed to enhance art therapy without succumbing to the modus operandi of the facility, the therapeutic team. Yes, many might go overboard in an attempt to survive or "fit in" or both. Nevertheless, it is from the experience that eventually causes the pendulum to swing into the right position; namely, the position in which the individual's personality, his or her expectations, and aspirations as humanist and artist determines the first primitive framework utilized to effect change in the clientele.

It takes maturity, tolerance, and sensitivity to accept different ideologies and treatment approaches working in conjunction with each other, and time to develop solid cornerstones on which clearly enunciated principles and tenets can be built. The young professional must be helped and guided (by teachers, supervisors, and other clinicians) in his or her relentless effort to establish the first workable relationships among the desires of an art therapist, the demands of an institution, and the needs of the population served.

An ideological framework in which the best of all theoretical approaches is combined with "art's powerful potential for catharsis, immersion in feeling, synthesis and integration" (Wadeson, 1983) will emerge as the result of experience in clinical practice. I think that all art therapists (both new and the experienced) must be patient and gentle with themselves and with each other.

Reference

Wadeson, H. (1983). The art in art therapy. *Art Therapy*, 1 (1), pp. 50-51.

Art Therapy: An Educator's Response

Virginia Niswander, MEd, ATR
Dayton, Ohio

The issue of the status of lone art therapists working in institutions, addressed by Harriet Wadeson (1983) in *Art Therapy*, is a very real one to art therapy educators whose concern for their graduated students extends to students' continuing growth and future registration. The lack of understanding of the role of art therapy that may greet the new art therapist stems from the relative-

Continued on page 93.

REVIEWS

A Review of

The Lowenfeld Lectures: Viktor Lowenfeld on Art Education and Therapy

John A. Michael (Editor). State College, PA: The
Pennsylvania State University Press, 1982.
(420 pages, $24.50)

Reviewer ***Rawley Silver,*** *EdD, HLM, ATR, is an art therapist who has done teaching, research, and consultation with special emphasis on art with the deaf.*

If you are in your twenties or thirties, it may come as a surprise that Viktor Lowenfeld's famous book, *Creative and Mental Growth*, once included a chapter titled, "Therapeutic Aspects of Art Education." This 74-page chapter appeared until the fifth printing of the third edition. After his death in 1960, his book was revised and his chapter on art therapy disappeared without a trace.

In the early 1960s, art education was uncomfortable with art therapy. Art teachers were under the thumb of abstract expressionism, figurative art was taboo, and the time-honored occupation of working your way through college by posing for the life-drawing classes had disappeared. Many art schools had discontinued representation in any art form.

An art therapist works with a child, age 10, on a tree weaving. The setting was at the CHAP (Children Have a Potential) Camp summer program at the Wright Patterson Air Force Base, Dayton, Ohio. With this autistic boy, initial assessment was focusing on repetition, sequence and motor patterning through the use of fibers.

It is not surprising, therefore, that the chapter on the therapeutic aspects of art education was eliminated from Lowenfeld's book in subsequent editions, or that students in art education and art therapy never knew what they were missing.

Now they can know, thanks to two of Lowenfeld's former students. One had taped his lectures and the other has edited the tapes into the book that is the subject of this review. The first student, Ellen Abell, inspired by his lectures, had obtained his permission to tape them at Pennsylvania State University in 1958, just 2 years before his death.

She wanted to publish the tapes but after years of inactivity and in failing health, she turned to a fellow-student, John H. Michael, now professor of art education at Miami University. He edited the lectures with the help of others who transcribed the tapes in longhand, and then typed them. The 31 lectures have now been published by The Pennsylvania State University Press.

Section III of this work, titled, "Art Education Therapy," includes four lectures on the therapeutic aspects of art education. These are, "Psychotic-Neurotic Considerations"; "A Case Study of Virginia, a Neurotic Child"; "A Case Study of Aggie, a Mongoloid Individual"; and "A Case Study of Camilla, a Deaf-Blind Child."

From my point of view, this book should be required reading not only for art therapy students but also for art education students so that they can judge for themselves the work of a pioneer in both fields.

Viktor Lowenfeld is another of the refugees from Nazism who have made valuable and lasting contributions not only to us but also to the world at large. His books have been translated into Arabic, Chinese, Danish, German, Hebrew, Italian, Japanese, Norwegian, Spanish, and Swedish. One can only wonder whether his chapter on art therapy is missing from the foreign editions. If so, it is hoped that these *Lectures* will follow them, even if they can never catch up.

A Review of

Invented Worlds: The Psychology of the Arts

by Ellen Winner. Cambridge: Harvard University Press, 1982 (431 pages, $25.00).

*Reviewer **Nancy A. Cusack, ATR,** is assistant professor, Department of Art Education, at the Massachusetts College of Art in Boston. She is also an independent consultant to clinical and educational programs.*

That there has not been a current reference/resource to serve as an introduction to the psychology of the arts has made the task of teaching in this area all the more challenging. Ellen Winner's response to that challenge was to formulate such a work, *Invented Worlds: The Psychology of the Arts.*

We are early advised that the "book has both a theoretical and a methodological basis" (p.12). We know that we will be considering the *cognitive* psychology of the arts. Goodman (1983), one of the mentors Winner credits with influencing her theoretical orientation, recently commented that the cognitive movement "is often decried by behavioristically oriented theorists as nonempirical and unscientific, and widely thought by writers on art to be bent on analyzing the arts to death" (p. 34). Such decriers may find considerable fuel in this work. In Goodman's view, however, cognition is *not* in contrast to perceptual, emotive, and nonlinguistic modes but is incorporative in the sense of "gaining insight and understanding by all available means." This distinction seems essential here because the book is designed to be approached from this later perspective.

The format in which all of this material is considered is impressive. Within a framework of investigating the "why" and "how" of aesthetic response, Winner is arbiter. She selects views considered significant to this investigation and presents them against her theoretical/methodological base. A careful selection of three art areas (painting, music, and literature) furthers the manageability of the author's task. The rationale for this selection is the different manner of symbolizing, which characterizes each as well as the wealth of resources available.

The most characteristic strength of this work might be seen as its tight organization and clarity of intent. The latter may largely derive from the author's style throughout as "agent provocateur." Winner presents a view, states it plainly and briefly. The reader, free from lengthy presentation of arguments and limitations of the view, is thus urged to allow, argue, or further pursue. To illustrate: "The average five-year-old can paint a picture that is strikingly similar to works by contemporary painters" (p. 306). No discussion of contrary ideas concerning qualitative characteristics of adult/child/ work is offered. Readers who question this notion will want to read varying views elsewhere.

Where this book will be a handbook is not in the expected traditional sense of compendium but largely in the provocative style and presentation of key and often controversial views through which the author opens the door to further investigation.

The final section of the text is entitled "Art and Abnormality" and might immediately attract readers of *Art Therapy.* It opens with an enticing discussion of "The Damaged Brain." Following this is a chapter devoted to mental illness, which may be considered the weakest portion of this commendable work. Here, the focus has been narrowed to the degree that two themes dominate. One is the author's interest in the anomaly of the artist — a theme that appears early and emerges throughout the text. The other is that mental illness is considered almost entirely through pieces of information about schizophrenia. Emphasis is given to the artist's link with madness, schizophrenia in particular. Winner's rationale is that artists exhibit behavior symptomatic of schizophrenia but to a lesser degree. She cites the similarity of artists' "unusual insights" to schizophrenic hallucinations and schizophrenic loss of contact with reality to artists as "often deviant, isolated members of society" (p. 355).

In suggesting a relation between art and schizophrenia, Winner accepts as a parallel the idea that "schizophrenics fail to screen out 'irrelevant' details from their perceptual field, just as artists notice important details that ordinary people ignore as trivial" (p. 355). Here she confuses schizophrenic diffusion and lack of differentiation with a refined, highly differentiated process.

It is in this section also that the therapeutic application of art is addressed. Winner discusses art as a reflection of mental state emphasizing the value as a diagnostic tool more than as a measurable therapeutic process.

Readers may find this final section, "Art and Abnormality," generally lacking in balance. The paucity of the chapter on mental illness lies in its lack of reference to a breadth of ideas that might have brought it to a more useful end.

As a whole, however, the book is useful and welcome. Alone in its effort, it is extremely polished and highly courageous. It will be used and, no doubt, quoted for many years.

References

Goodman, N. (1983). Notes from the underground. *Art Education, 36,* (2), 34.

BEST COPY AVAILABLE

Film Review

The Color Bunch

Reviewers ***Kate Hartman, ATR*** *and* ***Georgiana Jungels, ATR*** *are in Art Therapy Studies, Art Education Department, State University College at Buffalo.*

The use of film animation for therapeutic purposes was first documented in the mid-sixties at the Lausanne University Psychiatric Clinic. Bader (1972) of the Center for the Study of Psychopathology of Expression, described the film production work of the inpatients as "a new form of group therapy." Since then, three of the films made by the patients at Lausanne have been widely distributed ("The Poet and the Unicorn," "Good Morning My Eye," and "Seven Nights in Siberia").

"The Color Bunch," made by art therapist Judith Rothschild, MS, presents film "animation as a therapeutic tool." (The film was partially funded by the Illinois Arts Council, an Illinois state agency.) The film demonstrates the use of several different film animation techniques within a group therapy setting. "The Color Bunch" is the name the clients gave themselves as participants in this creative group process.

The viewer is introduced to the film's focus by a series of well-organized interviews with mental health professionals: "I thought it was exciting because often when clients first come in here they are very much into themselves and kinda in their own world and the fact that they would be willing to come together collaboratively is exciting."

Film animation lends itself to a narrative life review process, and one client says, "I always said that I wished the time would come so that I could retire; I wished I didn't have to get up in the morning; I was feeling very tired every morning . . . they told me I would get nervous . . . it came out true." The animation process involved the clients—individually and as a group—in active self-exploration and self-expression.

Clinical issues such as self-identity and self-esteem are addressed by the clients and presented in case vignettes. The selected case material provides the film viewer with an understanding of the clients' concerns and use of filmmaking as a therapeutic tool and "how animation aided therapy goals." For example, one client who was identified as learning disabled found that he could "do" film animation and then began to "tackle some other activities that he was always afraid to do."

Treatment goals of goal setting, problem solving, decision-making, socialization, and peer interaction are accomplished through the use of film animation as an artistic and therapeutic process. The film illustrates some of the parallels between some film animation techniques and art therapy techniques (eg., the use of the story board and the sequential pictorial narrative) and there are obvious similarities between the combination of sequential verbal and visual information in a film animation and a client's images and comments in art therapy. In "The Color Bunch" a client tells a "story" through film animation. This process is similar to the use of theatrical performance in drama therapy (eg., Emunah and Johnson, 1983).

The "The Color Bunch" gives a good introductory overview of the technique of film animation. Although there is enough information to interest the viewer in using film animation as a therapeutic technique, the art therapist who has no previous film training would need to learn more about "how" to do film animation prior to beginning to use film animation as a therapeutic technique. (There are currently many excellent publications on the technique of film animation.) In addition to reading supplementary material on film and film animation, the viewer should analyze the safety considerations of the tools used to apply and/or scratch the painted film and the photochemicals used to develop the film. (An excellent reference on the safe use of a variety of art materials is *Safe Practices in the Arts and Crafts: A Studio Guide* published by the College Art Association.

The film contains a considerable amount of information about the potential of film animation as a therapeutic technique and is edited to share the filmmaker's enthusiasm about the process. The therapist who is considering the use of film animation as a therapeutic technique would need to consider the appropriateness of this technique to individual and group needs.

Some questions might be: What functioning level is necessary before a client is able to successfully participate in film animation? (The clients in "The Color Bunch" are described as "chronic" and "isolated" and seem to be relatively articulate, high functioning, and able to use a variety of art materials and to learn to animate pictures and combine these narrative images with personal statements.) Is the technique of film animation applicable to a wide variety of client populations? Are adaptions necessary for some special needs? How does film animation fit into an ongoing art therapy program? (Some of the case material in "The Color Bunch" is developed enough for the viewer to understand both the client's treatment issues and the use of film animation as a therapeutic intervention. Other vignettes present only basic information—sex, age, diagnosis—and leave the viewer to wonder how the film animation group provided a therapeutic experience.) Is film animation a specialization within an art therapy program or group therapy of a special activity program?

Is this technique appropriate for individual therapy and/or group therapy? What are the roles of the group leaders? Is the therapist skilled in both film animation and art therapy or are a therapist and a filmmaker/artist acting as co-leaders?

Film animation has many therapeutic possibilities and "The Color Bunch" is a good introduction to several techniques in film animation. This film offers the viewer a visually exciting introduction to the use of film animation as a group therapy technique. Although the film has some technical limitations, it has been edited to include relevant information as efficiently as possible on a low-budget with respect for the decision-making of the group members. One of the strongest testimonials to the therapeutic benefit of film animation was made by one of the client's participating in "The Color Bunch," who said: "I think I got something done . . . seeing my film makes me feel like a star."

"The Color Bunch" (16mm, color/sound, 17 minutes, 1982) is a film by Judith Rothschild, MS, and is distributed by Judith Rothschild, JKR Productions, 650 Midfield Lane, Northbrook, Illinois, 60062 for rental or purchase.

References

Bader, A. (1972). Therapeutic Art Programs Around the World—IX: Filmmaking in a Swiss Psychiatric Hospital. *The American Journal of Art Therapy, II* (4), 185-188.

Emunah, R., & Johnson, D. (1983). The impact of theatrical performance on the self-images of psychiatric patients. *The Arts in Psychotherapy, 10*, 233-239.

Continued from page 89.

ly recent advent of art therapy into areas of therapy and rehabilitation already served by professionals from long established human service fields.

It is no wonder that newly employed art therapists may feel isolated practicing their "art" within this structure. Much like the artist or art teacher, the graduating art therapist is removed from the nurturing environment of an educational program where faculty and students share a philosophy based upon confidence in their individual experiences of the power of art. They quite likely will be thrust among those to whom art may be a frill, a mystique, a hobby — certainly not a serious contender as a mode of treatment. Until communication, understanding, and respect can be established, the new art therapists are in a vulnerable position, and are required to practice and defend their skills to maintain the identity of art therapy.

Although each one must prove competent as an art therapist, he or she must also be prepared to serve as an advocate for art therapy, demonstrating its unique value and its credibility. Unfortunately, the right-brain attributes of artists frequently are countered by a lack of verbal skills so necessary to communicate with colleagues whose dedication is evidenced by their left-brained verbal interactions and written reports. It is imperative that each student, at the very least, develops a basic description of art therapy and delivers it with conviction in preparation for job-seeking. Clinical sites of internships or practica may be urged to give the student the opportunity to give art therapy presentations to the staff, and it is a wise student who seeks appropriate ways to promote art therapy and develop his or her advocacy skills even before employment. The contribution of art therapy to the multidisciplinary team can become apparent during the sharing of information and participation in treatment planning. Slide presentations are very effective in illustrating the process, products, and progress of art therapy sessions to the clinical or administrative staffs. As always, most effective learning results from actual experience. Providing the staff with direct art therapy experiences will bring them greater personal understanding of the potentials of art therapy.

Exhibits of clients' or patients' art work not only enhance an area visually, but also attest to the presence and vitality of the art therapy program As these bridges of professional acceptance develop, ripples of information flow out to other institutions, clients, families, and friends creating interest and demand. It is from such slow, but substantial experiential efforts of art therapists that our field has grown, and will continue to grow.

Although there is increased awareness of the role of art therapists in geographic areas where their service has been available, numbers have been few in relation to those already long entrenched in the delivery of human services. There is a tremendous "information gap" about art therapy not only among the general public, but also among the populations and service-givers of those we strive to serve. As a developing profession it has been — and continues to be — important to share our experiences, techniques, and research among ourselves in our meetings and conferences, and in our books and journals. Now, we need a broader base of public awareness of the benefits of art therapy. There is a need for media coverage of factual accounts of what art therapy is, what it does and whom it serves. This would not only extend the opportunities for employment, but also would ease the entry of graduates into a therapeutic milieu that already is beginning to understand and value what art therapy has to offer.

ART THERAPY

Journal of the American Art Therapy Association

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in theory, practice and research. An emphasis will be placed on the visual arts, but articles in related disciplines that have relevance to art therapists will also be published.

ART THERAPY is published quarterly by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates.

Individuals: $18 (US); $22 (Foreign). Institutions: $30 (US); $34 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies of the premiere issue are available at $9 (Individual), $15 (Institutions). Printed in the U.S.

Subscribers to THE ARTS IN PSYCHOTHERAPY enjoy reduced rate! Individual: $15.

To subscribe, fill in coupon below and mail now. Enclose proof of subscription to THE ARTS IN PSYCHOTHERAPY.

American Art Therapy Association, Inc.
5999 Stevenson Avenue, Alexandria, VA 22304

Please enter my subscription for 1984. Enclosed is my check, payable to AATA, for $15. (Regular rate for individuals is $18)

Name ____________________

Address ____________________

City ____________________ State __________ Zip __________

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

CLASSIFIED

ART THERAPIST — Western Psychiatric Institute & Clinic, a division of the University of Pittsburgh, is currently seeking an Art Therapist. Responsibilities include diagnostics and therapeutic use of art with individuals, families, and groups. Evening and weekend hours included on a regular basis. Significant experience with acutely disturbed and psychotic individuals in a psychiatric hospital required. Experience in neuropsychological testing a plus. Masters degree preferred. Salary range $15K - $16K including a competitive benefits package. Please submit resume by May 30, 1984 including salary requirements to:

Allied Health Recruiter,
WESTERN PSYCHIATRIC
INSTITUTE & CLINIC,
3811 O'Hara Street
Pittsburgh, PA 15213

An Equal Opportunity Employer M/F.

BEST COPY AVAILABLE

BRIEF COMMUNICATIONS

This column provides a forum for information exchange among clinicians and educators. Items relevant to research and to programmatic, historical, or clinical developments may be submitted. Contributions should be sent to Brief Communications, ART THERAPY, AATA, 5999 Stevenson Avenue, Alexandria, Virginia 22304. Submissions are subject to acceptance and editorial revision.

Hahnemann Symposium Set

The Creative Arts in Therapy Program at Hahnemann University will host a symposium "The Creative Arts in Therapies As An Integral Part of Treatment for the 90's: Looking Ahead – Planning Together," June 22-24, 1984. Distinguished professionals from the fields of psychiatry, psychology, medicine, and the creative arts therapies will participate in presentations, discussions, and panels. Panel moderators will include Israel Zwerling, PhD, MD, Bertram S. Brown, MD, and Paul J. Fink, MD. For information write: Hahnemann University, Mail Stop 424, Creative Arts in Therapy Department, Philadelphia, PA 19102.

AATA Film Festival Coming

The first AATA Film Festival will be presented at the 1984 AATA Conference in Washington, D.C. on October 31-November 4. The Film Festival will provide exposure for professional, amateur, and student filmmakers. A goal is to identify quality films or videotapes that explore the field of art therapy through educational and creative media presentations. A panel of experts in areas of content, technical quality, and utilization will select winning entries. Entries will receive wide recognition and exposure during the festival competition and, following the Conference, will be published in the AATA Media List that is available to all members, schools, institutes, and others who may wish to purchase or rent the pieces. Certificates of merit will be presented to films and video entries of exceptional merit. A trophy will be awarded to the overall winner of the festival. Filmmakers, producers, art therapists, and students are invited to submit original 16mm films or ¾" or ½" videotapes pertaining to the use of art as therapy, art psychotherapy, or related subjects. For information and an official entry form, write to the AATA Office or to the Film Festival Coordinator, Cathy Malchiodi, 45 Kilgore Avenue, Medford, MA 02155.

Kaleidoscope Publishes International Edition

The second International Edition of *Kaleidoscope* magazine has been published. The unique publication provides a forum for the works of published and unpublished writers and artists who manifest various physical, mental, and emotional handicaps. The eighth issue, also the second international edition, features many contributors including a profile and art of photorealist Charles Wildbank, who is deaf; photography and an interview with Flo Fox, a legally blind photographer who will have her life story made into a television movie; poetry and fiction winners from the United Kindgom's Spastic Society Contest; selections from Vassar Miller's anthology *Whispered in the Chambers: Shout it from the Housetops;* a posthumous tribute to Susan Dunn, featuring excerpts from her play *The Drummer I Must March To;* and *Kaleidoscope's* 1983 International poetry, fiction, and art award winners.

What people are saying about *Kaleidoscope:*

> . . . honest and powerful portrayal by disabled artists and writers of the experience of disability, devoid of the common triteness and pat answer quality of so much that is produced on disability. *Disability Rag,* December, 1983.

> Highly recommended for any type or size of library because it reaches not only the disabled, but others who can learn much from the fine material in each issue. *Library Journal,* March 1, 1983.

> Kaleidoscope is bringing the disparate parts of a unique creative perspective together in a beautiful way . . . and succeeding in giving artist and reader alike a new vision. *Art Space,* The Ohio Arts Council, January/February, 1984.

For information on *Kaleidoscope,* write to: United Cerebral Palsy and Services for the Handicapped (UCPSH), Kaleidoscope, 326 Locust Street, Akron, Ohio 44302.

"Lori" Film Available

Helen Landgarten, HLM, ATR has generously donated three copies of the film, "Lori, Art Therapy and Self Discovery," to AATA. The 32-minute film focuses on a emotionally disturbed 14-year old girl who struggles to break out of her inner world with the help of art therapy. "Lori" is a 16 mm, color/sound film and is available for rental to AATA members for $30.

Address Correction

Please note in your Membership Directory that the address of the President-Elect, Sandra L. Graves, ATR, is incorrect. Her correct address is: Sandra L. Graves, ATR, Department of Expressive Therapies, Robbins Hall, University of Louisville, Louisville, KY 40292, 502/588-5265.

Report on Standards Ballot

The Professional membership voted into place Adopted Revised Standards and Procedures for Registration, December, 1983. Contact the AATA office for copies of the newly revised Standards. Anyone involved in a program or in accumulating hours to apply for AATA registration under previous Standards should send a Readiness Checklist and letter of intent to Ron Hays, Standards Chair. The standard due date for filing these requests is 6 months from the date (February 10, 1984) when information on the newly revised Standards was distributed.

Fee Structure for Training Program Evaluation Adopted

The Executive Board of AATA has adopted a fee structure for the processing of new program applications and yearly review of approved programs. The fees are in effect as of February 1, 1984.

Programs applying for initial approval must submit a fee of $300 to begin the program evaluation process. Programs that are approved must submit a renewal fee of $150. Programs already approved and applying for continuation of approval of programs will indicate that original standards are being maintained.

This fee structure falls within a format consistent with other associations and professions. Once the evaluation process is underway, the fees are not refundable.

For further information, contact the national AATA Office, or Dr. Gary Barlow, Chairperson, Education Committee, AATA.

Pratt Summmer Institute Offered

The Pratt Creative Arts Therapy annual summer Institute will be held in Jefferson, New Hampshire, from June 25 to July 31, 1984. Graduate workshops and courses will be offered from object relations, Gestalt, and Jungian perspectives. Opportunities will be offered through the Institute to complete a master's degree. For further information please contact: Art Therapy Department, Pratt Institute, Brooklyn, NY 11205, or call (212) 636-3428.

Government Affairs Conference Sponsored

A Creative Arts Therapy Governmental Affairs Working Conference will be sponsored by the Legislative Alliance of Creative Arts Therapies in Washington, D.C., July 21 and 22, 1984. The Conference will provide a forum for creative arts therapists to explore licensure and reimbursement strategies with policy makers, insurance representatives, and related health professionals. For registration information write: C.A.T. Governmental Affairs Conference, 1438 Duke Street, Alexandria, VA 22314.

LOYOLA MARYMOUNT UNIVERSITY

Approved by American Art Therapy Association

CLINICAL ART THERAPY

MASTER'S DEGREE

Helen Landgarten, Director and
Textbook Author: *Clinical Art
Therapy: A Comprehensive Guide*

Information:
☐ 2 Year Master's Degree Program
☐ Part-time Program

For Information Call:
Art Therapy Office (213) 642-4562
Graduate Office (213) 642-2721

LMU

**Loyola Marymount University
Clinical Art Therapy Department
Loyola Blvd. at West 80th Street
Westchester, CA 90045**

ART THERAPY

Journal of the American Art Therapy Association

Volume 1, Number 3 October 1984

- Art Therapy Supervision
  Laurie Wilson • Shirley Riley • Harriet Wadeson
- The Struggle for Self-Cohesion
  Arthur Robbins
- Imagery as a Style of Thinking
  Myra F. Levick
- Cross-Cultural Psychotherapy and Art
  Shaun McNiff
- The Stimulus Drawing Technique with Adult Psychiatric Patients, Stroke Patients, and in Adolescent Art Therapy
  Louise Sandburg • Rawley Silver • Kristen K. Vilstrup

BEST COPY AVAILABLE

ART THERAPY is published biannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $15 (US); $20 (Foreign). Institutions: $18 (US); $24 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA office, 11800 Sunrise Valley Drive, Suite 808, Reston, VA 22091 (703) 476-5437.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1983-1985

Board of Trustees

President
Gladys Agell, MA, ATR

President-Elect
Sandra L. Graves, PhD, ATR

Secretary
Nina Holtzman, MA, ATR

Treasurer
Helen Landgarten, MA, HLM, ATR

Committee Chairs

Affiliate Societies
Irene Corbit, MA, LC, ATR

Bylaws
Donald L. Cutcher, MA, ATR

Education
Gary C. Barlow, EdD, ATR

Governmental Affairs
Nancy Schoebel, MA, ATR

Membership
Robin F. Goodman, MA, ATR

Public Information
Bobbi Stoll, MS, MFCC, ATR

Publications
Harriet Wadeson, PhD, ATR

Research
Janie L. Rhyne, PhD, HLM, ATR

Standards
Ronald E. Hays, MS, ATR

Executive Director (ex officio)

Richelle Grapsy

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Editorial, Gary C. Barlow, EdD, ATR 98
Letters to the Editor 99

Articles

Art Therapy Supervision
Part I: The Beginning Phase of Supervision in Art Therapy,
Laurie Wilson, PhD, ATR 100
Part II: The Middle Phase of Therapy and Supervision,
Shirley Riley, MA, ATR 102
Part III: The Termination Phase of Supervision,
Harriet Wadeson, PhD, ATR 104
The Struggle for Self-Cohesion: An Analytically Oriented Art Therapy Case Study
Arthur Robbins, PhD, ATR 107
Imagery as a Style of Thinking,
Myra F. Levick, PhD, ATR, HLM 119
Cross-Cultural Psychotherapy and Art,
Shaun McNiff, PhD, ATR 125
The Stimulus Drawing Technique with Adult Psychiatric Patients, Stroke Patients, and in Adolescent Art Therapy
Part I: The Use of Stimulus Drawings with Adult Psychiatric Patients in a Day-Care Setting,
Louise Sandburg, MSc, ATR 132
Part II: The Use of Stimulus Drawings with Stoke Patients in a Rehabilitation Center,
Rawley Silver, EdD, ATR, HLM 135
Part III: The Stimulus Drawing Technique as Metaphor in Adolescent Art Therapy,
Kristen K. Vilstrup, MA 137

Viewpoints

Journey Through Hell,
Yolande Porter 141

Reviews

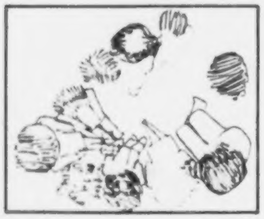
Book Reviews

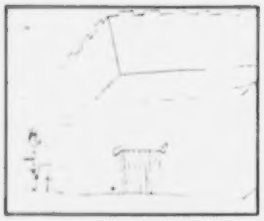
Psychotherapy Through Imagery 143
Spontaneous Painting and Modelling: A Practical Approach in Therapy 144
To Be Remembered: Art and the Older Adult in Therapeutic Settings 147

Film/Video Review

Suicide: The Ultimate Rejection and *The Maze* 148

Brief Communications 152





Cover: This painting was done by an 83 year old woman in a nursing home. The activity was supervised by an art therapy graduate student at Wright State University, Dayton, Ohio.

Volume 1, Number 3 October, 1984

Copyright © 1984
American Art Therapy Association, Inc.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Production Editor
Shirley N. Nuhn

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Anthony Kowalski, MD
Susan LaMantia O'Connor, MA, ATR
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

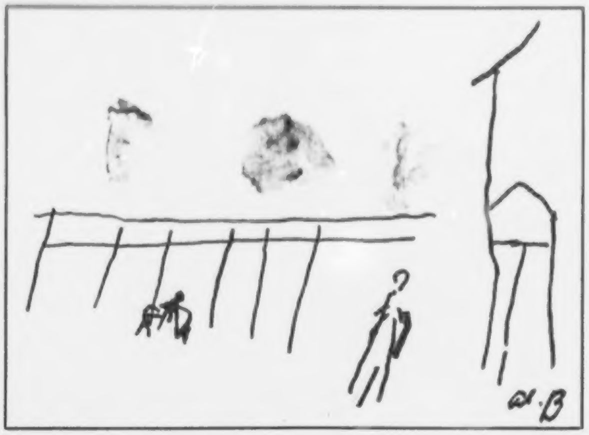
American Art Therapy Association, Inc. 11800 Sunrise Valley Drive, Suite 808, Reston, VA 22091 (703) 476-5437

BEST COPY AVAILABLE

EDITORIAL

This issue of *Art Therapy* offers a potpourri of articles with important content relative to awareness, practice, training and research. The topic of supervision, that has been prevalent in the past two AATA conference programs, is given emphasis at the initial, middle and termination stages by Laurie Wilson, Shirley Riley and Harriet Wadeson. Myra Levick's article on imagery offers information on creativity, image and language formation, approaches and research. A three-part article on the Stimulus Drawings and their use with psychiatric and stroke patients and with adolescents in therapy, is presented by Louise Sandburg, Rawley Silver and Kristen Vilstrup. An extensive case study illustrates Arthur Robbins' work with a 29 year old male in long-term therapy, and gives information on the "mirroring" aspect of therapy. Shaun McNiff's article on cross-cultural art psychotherapy emphasizes an area in which there has been little art therapy research; he reiterates the need for the art therapist to be aware of the increasing interest in cross-cultural modalities. In addition to the regular features contained in the issue, I believe that the art therapist, and other readers, will find much to ponder and discover.

The readership is encouraged to submit articles to *Art Therapy* for publication consideration. Procedures for submission of articles are found elsewhere in this issue. A brief abstract must be included that will serve as the "lead-in" for each article. In addition to main articles, submissions for "Viewpoints," "Reviews" and "Brief Communications" are also welcome. If photographs accompany articles, they must be of good quality, crisp and clear and documented on the back. For readers who want to submit individual photographs of art work that might be included in an issue, or used in various issues, the same high quality standards apply. Color photographs may also be submitted for possible use on the cover.



"Lottie and Me Chasing the Sheep." Drawing by an 80 year old man, resident of a nursing home.

With the recent, and hopefully temporary, cutback on allocations at various levels within the American Art Therapy Association, the Executive Board has approved a change in the publishing schedule of *Art Therapy*. The journal will be published on a biannual rather than a quarterly basis. For the present time, therefore, *Art Therapy* will be published as a pre-conference issue, with the remaining issue scheduled for March or April.

You are encouraged to correspond with the editor, and to offer comments on the content, format and special features. Suggestions for future content, for special issues and for noteworthy material, are welcome. It is *your* journal and your input is important. It is my hope that, by our working together, *Art Therapy* will not only be an important voice in our own professional field, but in the other human services professions as well.

Finally, it doesn't seem as if a year has gone by since our last AATA conference, and that we are ready for our next annual meeting. Sandra Graves, 1984 conference chairperson, Richelle Grapsy, AATA Executive Director, Pat Allen, program chairperson, Bonnie Smith, local arrangements chairperson, and the many committees have worked long and hard to organize the numerous details that are necessary for a successful conference. I hope that the conference will be well-attended, and I know that each person will come away from it with information, insight and inspiration. I look forward to seeing you in Washington!

Gary C. Barlow, EdD, ATR
Editor

Letters to the Editor

To the Editor:

Just got the second issue of ***Art Therapy***. It looks good. Congratulations! In your editorial you give "plaudits to Linda Gantt, ATR, the interim editor and her committees for the first issue!" As you know I was the interim associate editor and was very much responsible for helping Linda with this first issue. So, since clearly I was not on one of Linda's committees, you have left me out in your plaudits.

Mildred Lachman-Chapin, M.Ed., ATR
Montpelier, VT

Ed: There was no intention to overlook anyone who played a role in planning and bringing to fruition the first issue of ***Art Therapy****. Certainly Millie Lachman-Chapin, who served as the interim associate editor, deserves much of the credit for the first issue and I, therefore, also send plaudits her way.*

* * *

To the Editor:

"Congratulations on the latest edition of the new journal! Just the right combination of professionalism and panache. It is a pleasure to be associated with the effort. Best wishes . . ."

Dana N. Christensen
Louisville, KY

To the Editor:

". . . my congratulations to you on this effort! (***Art Therapy***, Vol. 1, No. 2, May, 1984) The articles are interesting and the layout is a good mix between visuals and verbal word content. I also like the use of the bulletin headlines which helps to set off the straight copy. I think it is a real excellent job."

J. Theodore Anderson
Assistant Executive Director
The National Art Education Association
Reston, VA

* * *

Ed: My thanks to everyone who sent comments on the second issue of ***Art Therapy****. Letters on future issues are welcome and encouraged.*

Guidelines for Authors

Please submit four (4) copies of manuscripts to: AATA Journal, 11800 Sunrise Valley Drive, Suite 808, Reston, VA 22091. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ x 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" x 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must by typed, double-spaced, in alphabetical order, on a separate sheet.

Art Therapy Supervision

·Part I: The Beginning Phase of Supervision in Art Therapy
Laurie Wilson, PhD, ATR

Part II: The Middle Phase of Therapy and Supervision
Shirley Riley, MA, ATR

Part III: The Termination Phase of Supervision
Harriet Wadeson, PhD, ATR

Laurie Wilson, PhD, ATR, *is Director of the Graduate Art Therapy Department at New York University, New York, New York.* **Shirley Riley, MA, ATR,** *is Field Placement Coordinator Graduate Art Therapy Department, Loyola Marymount University, Los Angeles, California.* **Harriet Wadeson, PhD, ATR,** *is Director of the Graduate Art Therapy Department, University of Illinois, Chicago, Illinois.*

This three-part article addresses specific phases of art therapy supervision: beginning, middle and termination. The authors (Wilson, Riley and Wadeson) identify special skills needed to successfully supervise graduate art therapy interns. They emphasize the integration of theory and art expression, the effective use of the art therapy or psychotherapy modalities and the supervisory relationship. The authors suggest that the articles be read as three brief chapters in a manual focused on art therapy supervision.

Each of the authors is an art psychotherapist or an art therapist/educator, who guides master's level art therapy students in practicum experiences. An art therapy internship is arranged by each university and clinical supervisors meet a level of professionalism that is set by the graduate program.

In addition, each author has administrative duties, teaching obligations and extensive clinical experience. This combination of skills provides the practical and theoretical knowledge necessary for the successful selection, continuing support and education of good supervisors.

To supervise graduate master's level-students, the American Art Therapy Association recommends that the art therapist/supervisor be Registered. The authors agree that in addition to registration, the supervisor should have additional training in the special skills of supervision.

The initial motivation for exploring these issues of supervision was stimulated by the interest expressed by educators, supervisors, and supervisees at recent conferences of the American Art Therapy Association (Riley, 1982, 1983 and 1984). Panel discussions were offered and participants became aware that very little material was available to guide the art therapy supervisor. This three-part article is the result of the authors' collaborations and continuing interest in providing some guidelines to answer this need.

In these writings, supervision is referred to in the context of a relationship between an experienced art therapy supervisor and a graduate art therapy student/intern who is training as a therapist in an approved practicum setting. This supervision process requires at least one hour per week, over a prescribed time; it is usually an individual session, but it also can be supplemented by small group supervision.

Additional information is available in the guidelines for master's level programs published by the American Art Therapy Association.

Part I: The Beginning Phase of Supervision in Art Therapy

The beginning of any formal relationship such as that of supervision or clinical work is marked by the expectations of the individuals entering the relationship. It is important to specify with clarity the nature of these expectations. In order for this to occur, the introduction to both relationships needs to include two ingredients: an introduction of the individuals involved, including a direct or indirect statement of their roles in the relationship, and some sort of contract setting out the "rules of the game."

In introducing oneself as a supervisor to students it is helpful to briefly describe one's professional experience as an art therapist (i.e., populations with whom one has worked), and the type of institutions in which one has worked or trained. It is also important to indicate the nature of one's approach to art therapy if that is not already known to the students. This will later help them to place the comments and advice in context. There should be a minimum of "how to" advice from "on high" and an understanding that the supervisor will help the students learn how to identify and solve their clinical dilemmas. The supervisor serves as a model of the reflective, thoughtful art therapist who continually examines and questions his/her work and its results. The supervisor's role is one of teaching students how to ask questions. "Why did the patient paint that then?" "Why did I say what I said?" and so on. This essential self-examination on the part of the student in supervision needs to be clearly separate from the self-examination of

BEST COPY AVAILABLE

personal therapy. It is the supervisor's role to identify personal difficulties which interfere with a student's clinical work, but I believe it is not appropriate to work therapeutically with those difficulties in the educational setting of supervision. Instead, the students should come to realize that the supervisor is there to help them with the specifics of their clinical work and not with their personal problems no matter how much these two areas may become intertwined.

The student's or supervisee's role is more difficult and fraught with anxiety than that of the supervisor. Normally as a student one is judged upon one's grasp of the material taught in a course, as evidenced by an exam or paper. In clinical supervision, however, one is judged by the reporting of one's own and the client's behavior in exquisite detail. To be useful to a student the supervisor must know a great deal about the student's work; the student reveals both successes and "mistakes" in as frank a way as possible, and it is probably true that more can be learned from mistakes and problems than from successes. A supervisor, particularly with new students, needs to create an atmosphere in which revelation of ignorance and error is gently received, carefully supported and non-judgmentally welcomed. I frequently thank students for helping the class by their willingness to reveal problems which usually turn out to be common for all in the group. It often occurs, subsequently, that another student in the group has found a solution to the problem presented and can pass on his/her expertise. Through the supervision process students should come to feel accepted at their own level and know that their capacity to grow and learn from mistakes is a factor being assessed by supervisors.

The supervisor should explicitly state, in the first meeting, expectations both for himself/herself and for the students. General expectations would likely include the idea that the students are there to learn how to do art therapy and, in addition, to learn how to report clinical work both orally and in written form.

The ways in which students will be assessed should be made clear to the students from the beginning. Likewise, the ways used to help students should be outlined early. There may be considerable variety on supervisory styles as some supervisors will write copious notes on individual student's process notes, and others will lecture to the group on specific issues they find in the course of reading the process notes, and so on.

"The supervisor serves as a model of the reflective, thoughtful art therapist who continually examines and questions his/her work and its results."

Students need to learn that just as they have made an informal contract with the supervisor they must also make some kind of contract with their patients. Fruitful classes early in supervision will cover details of how such a contract is best established addressing management issues, such as length of stay in art therapy, meeting times and use of materials, as well as more subtle questions. The student needs to be aware that unspoken but important questions may be lurking in the minds of patients. "How will this art therapist compare to the last one I had?" "How is the evaluation different from art therapy per se?" "What will this person expect from me?" "How will I be judged?" Central to these questions is the issue of anxiety. Both the new student and the patient are almost certain to feel anxious at the beginning of their work together. A discussion of this anxiety in supervision sessions can help allay some of the worst pangs, and students can be helped to sensitively tune in to the fears of patients while not acting upon their own jitters. A discussion of the initial intense desire to do something to help patients can lead to the awareness of the value of passivity in the therapist. This discussion might include mention of the students' probable feelings of incompetence and worthlessness and how frequently these feelings impel new students to activity that may be intrusive and obstructive. I have found that the first and most difficult problem for new students is learning how to tactfully and productively "do nothing" and feel comfortable about it. This topic always touches on issues of timing, clinical tact, and the inherent value of a receptive non-judgmental apparently passive stance. By placing a focus on observation, students may come to be actively and constructively involved without moving a muscle or opening their mouths.

A parallel issue is the new student's desire to know *the* meaning of the patient's art work *immediately*. This is manifested in several ways. Some students barely allow the patient the opportunity to finish the work on his/her picture or sculpture before asking questions about the work or asking the patient to "tell me something about your picture." The patient soon gets the idea that the meaning behind the work is much more important than the work itself, and I believe this reduces the therapeutic value of the process. Furthermore, the interruption of art making at a moment when the patient is hesitant, unsure of how or whether to proceed may abort the unfolding of expression via art and short-circuit a process which has its natural pauses and rhythms.

The other facet of the urgent wish to decipher meaning in a patient's work is seen in the quick leap to interpretation from one or two pieces of data: big ears mean paranoia, black means depression, etc. Satisfying as these fast answers may be, they also short-circuit a more profound and probably more accurate assessment of meaning.

New students need to be encouraged to look at the patient's behavior as well as the work, and to contemplate all the features before them: both formal and narrative, size, color, pressure of drawing tool, part of the page used, relation of the parts to the whole, and so on.

The fine art of asking questions leading from the most neutral "Oh!" to the more specific "What's going to happen to that boy?" must be taught and students need to carefully reflect on the effect of their own interventions. In short, students need to learn to tolerate their own ignorance with equanimity and humility. They need to hear from supervisors that they will in time understand more of what is happening before their eyes and know more quickly what to do. For the moment, they must learn to suspend judgment and pause before acting.

A final perspective has to do with the larger goals of supervision, and what I believe are effective ways of reaching them. I once heard a psychiatrist describe two alternative ways of supervising. The first involved the supervisor functioning as the therapist, by directing the case with the student functioning as a vessel or vassal. The second approach emphasized the student developing his or her own initiative with the supervisor serving to draw out the student's ideas and observation.

I expect you feel as I do that the latter is the preferred mode, and I would go even a bit further. I believe if the student has a good grasp of the theoretical issues lying behind the clinical work he/she will be able to find his or her own solutions to any clinical dilemma. I believe in fostering this approach by encouraging the group to find alternative solutions to the clinical problems that arise. Students, especially new ones, need to be convinced and coaxed into the realization that there is no one right way to "do" art therapy. Rather, students need to learn how to observe what actually happens in sessions and how to develop sufficient distance so that they can analyze why it happened. Finally, they need to have the flexibility to seek alternative solutions.

Bibliography

Arlow, Jacob A. "The Supervisory Situation." *Journal of the American Psychoanalytic Association.* 11: 576-594, 1963.

Ekstein, Rudolf, and Wallerstein, Robert. *The Teaching and Learning of Psychotherapy.* New York: International Universities Press, 1958.

Tarachow, Sidney. *An Introduction to Psychotherapy.* New York: International Universities Press, 1970.

Part II: The Middle Phase of Therapy and Supervision

An introduction to the concept of middle phase of therapy might perhaps begin by asking the question: "Is there a clearly defined middle phase in the therapeutic process?"

If the answer is "Yes, there does seem to be a recognizable shift in both the content and process of the supervisory relationship and the client/therapist relationship," we can then ask a second question: "How do the participants (supervisor/supervisee/client) recognize that the treatment has arrived at this phase?" The third aspect of this concept is a concern about how, or if, the supervisory sessions and relationship should be modified at this point in treatment. The answers to these questions are, as expected, more conditional than most of us would prefer; however, we can consider some of the following points to help us better understand some of these issues.

When the middle phase of therapy is achieved, it can be looked at in various ways depending upon the theoretical approach and the demands of the agency where the therapy is being offered. Some examples of the modifying factors are: therapists who work on a brief therapy model, six to ten sessions, and would move as quickly as possible into the process of defining the problem; other models would use the beginning relationship to more slowly unbalance the family system sufficiently than the intense working phase might be relatively short; long term therapy would expect this period to emerge at a slower pace. There are many variations on this theme, but there is always the need to be flexible and responsive to the case dynamics.

In addition, since the supervisor must guide the students in the theoretical model preferred by the agency in which they train, they must teach them specific techniques which will enhance the art therapy treatment within this framework. The art psychotherapist can work within a variety of theoretical models. The appropriate use of art will enrich any systemic or psychodynamic approach. During this central portion of the therapeutic alliance with the client, reflected in the supervisory relationship with the trainee, it should become apparent that *theory and art expression have fused.*

The type of work done in the middle phase in therapy, as in the middle phase of the supervisory relationship, is built on other strengths that have been established during the earlier joining period. The task is to be sure that all involved recognize that they have entered into a new phase of a relationship which will call for unique techniques, techniques which are reflective and responsive to this change.

In treatment, one can expect that at this time, after the more superficial matters have been cleared away, the basic problem may be revealed. This core may be multi-faceted and the possibility of finding resolution offers challenge to therapist, client and supervisor.

One can look at some examples of how casework and supervision display parallel growth and change. The trainee may feel anxious about attempting more adventuresome interventions with the client and may also lack confidence to utilize these interventions in the therapeutic process. If a student-therapist decides to take these chances he or she may fear that a result might be the loss of a comfortable dependent position on the supervisor. The persons in treatment may also reflect this timidity by remaining dependent and anxious about change. The student-therapist may demonstrate an unwillingness to move the usual pace of therapy into a new gear that will match the readiness of the client(s) to deal with issues. This hesitation may affect the clients and inhibit them from making a move toward problem resolution. The timing and force of the student's interventions often reflect their perception of how their supervisor has affirmed the students' competence and thus timed reinforcement of their progress. Often the therapeutic relationship and the supervisory relationship progress, stand still, or regress in a remarkably parallel pace.

Client resistence differs at this middle period. It is often a more covert, powerful defense used to protect against dealing with the deeper, more painful issue in the therapy. Corrective interventions usually demand a greater sophistication on the part of the therapist and these moves cannot be learned unless there is a minimum amount of resistance in the education/supervisory relationship. Freedom to examine counter-transference feeling and to accept criticism, and not feel it as blame, are all signs that supervisor and supervisee can handle the resistance that may occur at this point in the process.

An experienced supervisor sometimes has to lead the trainee into an awareness that some major systemic changes have occurred in the treatment. The new therapist often will sense the shift in attitudes and resistances, but not having been exposed to this level of dynamic interactions before, be unable to identify the signs that a modified method of punctuation and reframing is appropriate. The support given at this time from the supervisor usually will be directly reflected through the intern into the therapeutic session—support which gives encouragement to the family or individual to try new solutions and tolerate unaccustomed stress or relief.

A major training opportunity can be offered the intern if the supervisor is able to share a sense of excitement when he/she observes that there is a positive shift in the therapeutic relationship. This heightened awareness indicates that all involved have entered into a more intense working period. This is evidenced by the greater sense of trust felt from the client and it gives permission for the therapist to encourage change in a more vigorous manner. A vigor is needed that does not translate as mere interpretations by the clinician, but rather recognizing that the client is conscious of the process and more in control; thus the therapist can be either passive or aggressive as is appropriate. This does not diminish the work done earlier in the relationship, and in fact, cannot occur unless sufficient trust has been established.

> ***"An experienced supervisor sometimes has to lead the trainee into an awareness that some major systemic changes have occurred in the treatment."***

The art component becomes expressive in a new way. This is demonstrated by the clients' awareness of how much their graphic work adds to the verbal process and by a more acute ability to self-interpret the art product and initiate goals. Often the client feels greater comfort with the art modality.

A change may also be exhibited in the supervisory relationship. The student may venture more risky questions, try more creative interventions and challenge the supervisor's interpretations. The supervisor can be receptive to the way the case material is offered and take more chances in creative criticism. These modifications indicate confidence built on the strength of the past sessions and underlines trust in the trainee's ability. The student shows greater insight into the covert messages revealed in the art—and builds future expressive/therapeutic opportunities on the material gained through the art.

The middle phase of therapy and the middle phase of a supervisory relationship is a time when the supervisor can also gain the most for his/her own learning enrichment. The synergistic process between supervisor/trainee/client aids in the possibility that a unique solution for the treatment being considered may be created. It is my conviction that the parallel process is highly apparent in this middle-central part of the student's relationship with a client or family and with his/her supervisor.

It cannot be taken for granted that this middle phase of the therapeutic experience is an ordinary occurrence for the student and supervisor. In many instances the relationship does not achieve this satisfactory and challenging level. Often circumstances inhibit the success implied in the above descriptions. Some of the roadblocks encountered are: limitations on the length of time needed to implement and carry through a treatment plan; the system in which the trainee works may ask for unreasonable goals; the necessary skill may be lacking to establish the groundwork of a working relationship; and in particular, a lack of willingness to risk and test the creativity which must be tapped in the forming of both a treatment plan and fostering unique expression through the art products.

Resistance to these more creatively adventuresome and yet theoretically profound interventions will cheat the therapist, supervisor and client of the satisfaction that can be derived from achieving goals that profit each person involved in this multi-leveled relationship.

The gift of supervision is the permission for the trainee to hypothesize, experiment, and fantasize creative moves both with the therapeutic plan and the art expression. At the same time, the protection of the supervisor exists to inhibit the use of these techniques if they seem inappropriate. The dialogue in supervision about theory and practice, the implementation of the client's use of art expression and verbal interpretations is the core of this middle phase of supervision and leads toward anticipation and recognition of the time for termination.

Bibliography

Ekstein, Rudolf, Ph.D., and Wallerstein, Robert S., M.D. *The Teaching and Learning of Psychotherapy.* New York: International Universities Press, Inc., 1972.

Hess, Allen K. *Psychotherapy Supervision.* New York: John Wiley and Sons, 1980.

Langs, Robert, M.D. *The Supervisory Experience.* New York: Jason Aronsen, 1979.

Whiffer, Rosemary, Byng-Hall, John. *Family Therapy Supervision.* New York: Grune and Stratton, 1982.

The Clinical Supervisor, A Journal of Supervision in Psychotherapy and Mental Health. Vol. 1, No. 3, 1983 and Vol. 1, No. 4, 1983, Haworth Press, Inc.

Part III: The Termination Phase of Supervision

Separation is one of life's central experiences. Seldom is it possible to move to a plateau of greater growth without leaving a previous one. Termination is the ultimate separation and perhaps life's most difficult experience, leading as it does to the realization for each of us of our own death. That most of us do not handle separations well is reflected in the dearth of writing on termination in the psychiatric literature.

Because of the universality of strong feeling associated with separation, nowhere in supervision is the parallel process of student and patient etched in as sharp relief as in the experience of termination. Therefore, it is essential that the supervisor be particularly sensitive to the student's actions, reactions and feelings at this time. But even more difficult, the supervisor must be aware of his/her own process that parallels that student's: the difficulty in separating from the student may be similar to the student's painful issues in separating from patients.

There are other difficulties as well that require particular attention to termination issues. Successful therapy can reverse itself in the struggles to terminate, and what might have become a positive outcome may eventuate in a therapeutic miscarriage if termination is handled poorly: "The manner in which the therapeutic relationship is brought to a close is crucial to the outcome of treatment; it has a major influence on the degree to which the gains that occurred are maintained . . . Failure to adequately explore and work out these feelings during the ending period may result in a weakening or undoing of the completed therapeutic work." (Levinson, 1977, p. 491)

To make matters even more problematic, it is characteristic that patients who have progressed well will begin to regress as the ending approaches, and many of the symptoms that characterized the patient's presenting picture will re-emerge (Levinson, 1977, p. 485; Dewald, 1971, p. 280). Therefore, in addition to facing the difficulty of separation from the patient, the student must deal with the disappointment in seeing what had appeared to be fruitful therapeutic work seem to go up in smoke.

The parallel, of course, is that the student may exhibit a similar regression. I have seen a resurgence of students' anger at supervisors and other students around issues that had surfaced earlier in training and had seemingly been resolved.

Specific points of focus must be considered. First, it is important that the student recognize different conditions of termination, each imposing its various implications for the termination process. For example, the termination of short-term therapy where there has been less engagement is likely to be considerably less consequential than termination from long-term therapy for both patient and student-therapist (Levinson, 1977, p. 481). Termination may occur because the patient has completed therapy, is being transferred to another facility, or because the student is leaving after having completed the practicum assignment. Each of these situations differs from the other with regard to the feelings evoked.

Termination from group therapy has further ramifications. The group may continue after the student's departure, and the student may need to help the group adjust to the trainsition as well as come to terms with his/her own feelings about not being indispensable to its life. The group, as a whole, may be ending and may have to deal with its dissolution. One member may be terminating, and the student-therapist will not only have to help that member come to closure, but also help the other members to deal with the loss of that participant (McGee, Schuman, Racusen, 1972). In the parallel process, students may be coming to the end of their own supervision group's life.

Because of the complexities and difficulties of termination, supervisors should encourage their trainees to prepare for it well in advance. Similarly, the student should prepare the patient. This is done by bringing up the issue, focusing on its importance, and interpreting behaviors and feelings in the light of the pending ending (Dewald, 1971, p. 280). How far in advance this process begins depends upon the conditions of the treatment. In some instances, such as brief, time-limited therapy, it may be appropriate to point toward termination in the first session.

A further consideration in termination is the transferrence to an institution. It is both place and people. For students and patients alike it is often a home and a way of life. Termination requires leave-taking of that structure for support. A patient leaves the hospital; a student leaves school. Both usually will be entering a world where they are expected to take on more responsibility, in a sense to become more adult. Although there may have been anger at the infantilization that both patient and student status often encourage, there may be fear in having to become more responsible. (I have heard students, who did excellent work with patients, express fears that they would be unable to function in a professional capacity.) Therefore, both termination from therapy and graduation from training often necessitate attention to the institution's importance and what its loss means.

The understanding that termination regressions are expectable and not necessarily indications of major set-backs is another aspect of the process in which the supervisor supports the trainee and the therapist-in-training supports the clients. Much discouragement can be avoided in this way.

Just as elderly persons are encouraged to review their lives as it is approaching its end, so should the therapeutic endeavor be reviewed as it enters the home stretch. This review would include all those who are involved: patient, student-therapist, supervisor. The student helps the patient to see what has been accomplished, what needs to be done, and points the way toward the future. If the nature of the therapeutic relationship has been mainly supportive, then the focus may be on how much the patient and student-therapist have meant to each other. There must be acknowledgement of feelings of loss in any case, but also an emphasis that what has been gained has been a capacity to relate or engage, and that is not lost but can be utilized further.

Naturally in some cases there is bound to be disappointment and frustration at what has not been accomplished, which ending makes no longer possible. These feelings must be acknowledged to efficiently produce a successful termination. If the termination process is painless, then probably little engagement has occurred.

For the student-therapist the feelings of loss may be especially strong. The zeal to practice what one has invested so much effort to learn makes one's initial patients particularly important, meaningful and memorable. Students, unaccustomed to the comings and goings of client and patients often find their initial leave-taking especially poignant.

> ***"Because of the complexities and difficulties of termination, supervisors should encourage their trainees to prepare for it well in advance."***

It is obvious that the same forces operate in the supervisory relationship. If it has been especially fruitful there may be feelings of loss on both sides. Both may believe that more work needs to be done and could be done, but an arbitrary ending intervenes. If the supervisor is new to supervision, the student may have special significance, and parting may be difficult. Just as in therapy, it is necessary for the supervisor to encourage a review of the process and a transition to the next step, whether it be a new placement or professional status.

Even with adequate preparation, the unknown is usually frightening, and the wish to remain in the present, known situation is often preferable to a future uncertainty. Thus, patients are afraid to leave the support of the therapist and the student may be reluctant to leave the guidance of the supervisor. As stated previously, the more helpful the therapy or the supervision, the more painful the leave-taking may be. The supervisor may need to aid the student in both the awareness of the feelings and the courage to take the next step. Patients' regression toward termination time often conveys the message that they can't get along without the therapy. Similarly, at this time students often express fears that they won't be able to do therapy on their own, that the transition from student to the professional is more than they can manage. In this regard, the fantasy-tapping process of art therapy can be useful in supervision as well. Students can be encouraged to make pictures of their images of being a professional and in this way confront some of their fears.

Because of its inherent painfulness, separation is often avoided, so there may be collusion at all levels (supervisor, student and patient) to avoid the processing. In this respect, denial often takes a strong hold. For example, in the parallel process one student denied imminent separation from her supervisor by citing that they would continue to see one another at professional meetings. The supervisor had to insist that the student recognize the ending of their supervisory relationship and their regular weekly meetings. As is evident, diligence is necessary at all levels, beginning with the supervisor who must stay on track and encourage the student's awareness of termination issues. This, then, becomes translated to the therapeutic relationship.

Finally, it seems to me that just as a life process is seldom rounded out with a sense of completion—there is more left to be done—so it is with termination. There is always more to be done in therapy, more that can be learned in supervision. But there comes a time to end and to acknowledge ending.

Bibliography

Dewald, Paul. *Psychotherapy: A Dynamic Approach.* New York: Basic Books, 1971.

Levinson, Hilliard L. "Termination of Psychotherapy: Some Salient Issues," *Social Casework,* 58:8, October, 1977, pp 480-489.

McGee, Thomas F., Schuman, Benjamin N., Racusen, Frances. "Termination in Group Psychotherapy," *American Journal of Psychotherapy,* 26:4, October, 1972, pp 521-32.

IN MEMORIUM

Bernard I. Levy, PhD, ATR, HLM
April 3, 1924 - August 18, 1984

The world of art therapy has experienced a great loss in the sudden death of Bernie Levy, who suffered a heart attack caused by an embolism following orthopedic surgery.

Dr. Levy was a major force in the development of art therapy as a profession, and in the growth of AATA. He served the organization in many capacities: including eight years on the Executive Board as Chairman of Public Relations (1971-1973), Research (1973-1977), and Bylaws (1981-1983). He was instrumental in founding the first journal in the field (*Bulletin of Art Therapy*), and one of the first graduate training programs (at George Washington University) of which he was the Director.

Born and raised in New York, his study of art at Pratt (1941-43) was interrupted for military service in W.W. II (1943-45). While in service he was awarded the Purple Heart. He then turned to psychology, earning a BA at New York University (1948), an MA at Princeton (1950), and a PhD at the University of Rochester. He became a member of the Psychology Department at George Washington University, a licensed psychologist, and a Fellow of the American Psychological Association.

He remained an artist as well, turning from early work in pottery and sculpture, to teaching and creating watercolor, and creating paintings, for which he won local and national awards. His "vision" was not limited to art; Bernie was also able to provide leadership to AATA in the development of professional standards for both practitioners and educators. He was a passionate man, with deeply held convictions and profound affection for the people he loved. He was a demanding, inspiring and popular teacher, a gifted and lyrical painter, and the possessor of a witty way with words. He will be missed not only by his wife Claire and his children, Amy and Adam; he will also be sorely missed by all of us.

By Judy Rubin, with the gracious assistance of Claire Levy, Elinor Ulman, and Millie Chapin.

american journal of ART THERAPY
Art in Education, Rehabilitation, and Psychotherapy

This independent quarterly, published since 1961, deals with the visual arts as they contribute to human understanding and mental health. Its contents include new theoretical formulations, bibliographical information, a job information exchange, and news of opportunities for training and of international developments in the field.

Topics treated in recent articles include:

- transference and countertransference in art therapy
- art therapy and cultural difference
- art as therapy in a public school
- art therapy with the severely physically disabled
- self-expression of a disturbed adolescent
- art in strategic family therapy
- the combination of art and play therapy
- the place of art in art therapy
- research into hospitalized children's self-images.

Name: ______________________ Address: ______________________ Street

City ______________________ State __________ Zip __________

Individual Subscribers: U.S. and Possessions, $15; foreign, $17.50 (Students and members of the American Art Therapy Association are eligible for discounted subscriptions as follows: U.S. and Possessions: $12; foreign, $14)
Institutional Subscribers (U.S. and Foreign): $25

AMERICAN JOURNAL OF ART THERAPY, P.O. Box 4918, Washington, DC 20008-0118

BEST COPY AVAILABLE

The Struggle for Self-Cohesion: An Analytically Oriented Art Therapy Case Study

Arthur Robbins, PhD, ATR

Arthur Robbins, PhD, ATR, is Chairman of the Graduate Creative Arts Therapy Department of Pratt Institute, New York, and Director of the Institute of Expressive Analysis.

This article describes a long-term therapy of Bob, a 29 year old male who was imprisoned by a restrictive ego ideal preoccupied with conforming and achieving. In the therapy sessions there was a focus on helping the patient to find self-cohesion through the discovery of a "unique self," and the concept of mirroring was utilized. In the context of a real relationship, a mirror transference evolves; the therapeutic work encourages the patient's sense of self that has not been nurtured during critical periods of development.

Six principles are identified that summarize the mirroring process. These principles were instrumental in the work with Bob over four years of art psychotherapy. The patient moved from harbored pain and low affect to an active participant in a group, with evidence of self-cohesion, successful human contact and successful integration.

Introduction

Much has been written in recent years concerning the "false self" personality and the difficulties in treating such a patient. This article explores the subtle interplay between art and psychoanalytic psychology in the long-term therapy of one patient's grappling for self-cohesion. Critical in this process is the development of a mirror transference which, in this particular case, did not emerge until art media were introduced. Several factors were obvious with this patient in therapy. On the one hand was the patient's attempt to reconcile the drab reality of everyday existence with the rich libidinal life forming the core of his deep inner self (the struggle of the slow tempering of his rigidly strict ego ideal by an emerging idealized image). On the other, was the therapist's use of psychoanalytic and psychological theory and methodology along with aesthetic perceptions and sensitivities to promote a dialogue on a non-verbal level as well as on a more conventional verbal one.

In the study of the self, artists and psychologists have written on its origins and evolution, and on its relationships to mother, father, family, society and the cosmos. Each of these perspectives illuminates a different dimension and deepens one's understanding. One such facet is represented by self psychologist Heinz Kohut who defines the self as the basis of our sense of being and the independent center of initiative and perception. The self is integrated with our most central ambitions and ideals as well as with our sense that our body and mind form a unit in space and a continuum in time. This psychic configuration exists in connection with an individual set of talents and skills responsive to both the demands placed upon it and the ideals living within the nuclear self (1). As Kohut is quick to point out, the self falls into the realm of psychical reality phenomena which are unknowable in their essences. We may each have an intuitive grasp of what "self" means in its broad sense as the center of the individual psychological universe, but it would be difficult to be more specific in a way that was acceptable to everyone.

Paradoxically, the artist's preoccupation with the self is essentially with this elusive essence. In one's work, the artist attempts to organize dimensions of form, color, space, depth and shading. Since the gestalt principle that the whole is more meaningful than its independent components is inherent in all visual organization, a work of art can capture the dimensions of the self and transcend the limitation of words. Therepeutically, this is important, in that patient and therapist alike can view the complex and unique self as it is mirrored in the patient's art.

Mirroring means more, in art psychotherapy as I practice it, than merely the creation of a visual frame in which to externalize and explore internal images. This alone, does not accomplish the therapeutic task of repairing an unattended or neglected self. In my work, mirroring connotes a mirroring transference. This embodies many of the characteristics associated with an early mother-infant relationship, that special multi-sensory experience that exists on kinesthetic, auditory, tactile, visual levels. The importance of the real relationship, which modifies the traditional therapeutic approach of neutrality, cannot be overstated.

In the context of this real relationship, a mirror transference evolves that has as its cornerstone empathy from therapist to patient. Within this frame of reference, there are far fewer direct interpretations and a greater degree of reflection of the process. Essentially, the therapeutic work is directed toward the encouragement and development of the patient's sense of self that has not been adequately nurtured during critical periods of development. Consequently, the curative power of treatment comes via transmuting internalizations rather than from insight or the release of unconscious material alone.

The following principles summarize the mirroring process:

1. The patient's artwork is a part of the total therapeutic matrix, both stimulating and reflecting the patient/therapist interaction.
2. Within this matrix, two minds touch and play as they create a transitional space. Transitional space becomes a therapeutic space of empathy and connection. When I speak of this "space," noted by Winnicott as being neither inside nor outside but somewhere in between (2), I am describing the mutual process of non-verbal communication between patient and therapist in which they are wholely connected while paradoxically maintaining their own separateness.
3. The artistic mirroring used in building this mirroring transitional space reflects the multi-sensory mirroring of early childhood development. In the artwork, this is seen in such dimensions as space, rhythm, rate and energy.
4. Similarly, associated mental structure phenomena such as ego ideal, idealized image, internalizations and libidinal manifestations all have parallels in the artwork. Necessarily, these are very personal in expression.
5. The mirror transference does not preclude the development of competition, rivalry, jealousy or other traditional issues within the therapeutic matrix.
6. The job of the therapist is to facilitate the patient's quest to integrate the various components of the self through exploration, questioning, enthusiasm, interest and response. Mirroring, then, becomes a joint process in which the affects, perceptions and attitudes of the therapist are of major importance in giving validation to the development of the patient's self.

> ***"The self is integrated with our most central ambitions and ideals as well as with our sense that our body and mind form a unit in space and a continuum in time."***

Background and Initial Therapy

The following case material on Bob, a 29 year old engineer, represents a self, imprisoned by a restrictive ego ideal preoccupied with conforming, being "good" and achieving. Like so many of the cases Alice Miller writes about in *Prisoners of Childhood* (3), this case is one in which the patient's love for—and wish to—please his parents caused him to internalize aspirations and ideals which choked off other significant portions of himself from expression. Each individual must find a balance between childlike primitive urges and the values and aspirations handed down by one's family. This process, however, which could have served to shape Bob's life with richness and vitality worked, instead, to deaden his responses and leave him consumed by emptiness. Our work together was aimed at bringing his cut-off inner and outer worlds into congruence and putting vitality back into his life.

Four years earlier, Bob walked into my office; he was hunched over and stiff, and his upper torso was locked as though it was in an iron corset. He spoke in a low, flat voice to which I had to strain to hear and attend. Suddenly he blurted out that his past therapist had jumped out of a window and was now hospitalized. It was due to this experience that Bob had been referred to me for verbal therapy.

Bob was agitated; he simply didn't know what to do. His desperation, lonliness and isolation were encapsulated in his query "If this is what happens to supposedly healthy people, is there any help for me?" He mumbled that he was particularly frightened of homosexuality which was manifested in vague, lingering thoughts of being penetrated from the rear. What was remarkable was that all of this was said with so little affect that I could hardly sense this man's presence.

In the subsequent weekly therapy sessions, my attention often wandered, and I felt removed and disconnected in spite of my efforts to encourage Bob to address himself to his real thoughts and feelings. At times, I confronted and, at other times, mirrored or reflected, but all of my efforts were met by the patient with a sense of puzzlement. The excitement, the release of affect, the subtle connection with non-verbal cues that mark empathy in the therapeutic process evaded us. Only rarely did Bob break down in pain and tears to voice a deep sense of lonliness and isolation; he had been shrunken and truncated to the point where all one could hear and see was a hollow robot performing his duties. All of the energy and passions of life lay buried in body armor. In his weekly group sessions, Bob was viewed as a nice, quiet, sweet man, although he personally felt absent from the interactions.

Although sessions continued in this dull, plodding vein, Bob's life improved immeasurably over the next three years. After a number of brief affairs, he met a woman to whom he became engaged and married in the third year of treatment. The relationship was a good one, though Bob often had difficulties in either being sexually involved or excited by his wife. Work relationships also seemingly improved.

The Third Year in Therapy

In the third year of treatment it became clear that inspite of Bob's gains, his essence (the self) had re-

BEST COPY AVAILABLE

mained unchanged. The first session followed a long summer break in which Bob described the miserable summer he had suffered. In a flat, disconnected tone Bob related how he had thought he was going to die from a heart attack as short breathing, cold sweats and nausea washed over him. He went to many doctors and was assured nothing was wrong. He stayed home from work for a number of days and felt as if he were fighting for his life, even though he had been told that there was no physical problem.

As the monotonously delivered recitation continued, I knew that something had to be done to break this unbearable isolation that words only seemed to accentuate. I asked Bob if he would like to draw how he was feeling in the session, in the hope that this would help us to connect on a pre-logical, symbolic and feeling level. He looked at me somewhat curiously, but was pleased with the idea.

He began to draw circles and then made big sharp points on top of the circles. "That's you. You are God, and I am one of your supplicants," he lamented. Then, with a display of affect as he made sharp points up and down in a green magic marker, he continued "I'm angry! We patients have to wait for you therapists and we can do nothing about it until you decide to return." (4) As he started to fill in the rest of the picture, there was a shift in our relationship. I became engaged and intrigued as the face developed (see Figure 1).

As Bob worked on his drawing (while becoming quite pleased with himself) it began to take on qualities that seemed to emerge into a combined clown and king. I could see myself reflected in Bob's image as the God he was entertaining: the clown/king who opened up the surreal world of Bob's unconscious. This stimulated further associations on my part. On one level, I could see Bob's grandiose self searching for a safe harbor in the therapeutic relationship, just as a slightly irreverent subject might look to his king. Underneath this grandiosity, I could see the "good little boy" wearing forks on his crown, striving for the sky. This mask was woven with a richness of color that had a surreal integration. Although it would have been premature to make interpretations on these newfound impressions until further exploration was made and groundwork laid, they did suggest some basic personal content and pointed toward new directions to pursue, new material from which to build a bridge between us. The importance of such images as these which bubble up from the therapist's unconscious in response to something not quite tangible in a patient would not be underestimated as they so often turn out to resonate with emerging issues in the patient.

Here were the true beginnings of the mirroring process in more than just one way. Most tangibly, Bob's pictorial representation became a meeting ground where we made contact; we both looked into the same mirror, so to speak. With the gazing I found myself transfixed by the penetrating look of Bob's clown/king, and therefore, by Bob. So many nuances never seen before appeared in this face: fear, sadness, loneliness, sensuousness, sadism, cosmic consciousness and some depersonalization.

Parallels between mirroring in therapy and in early childhood de-

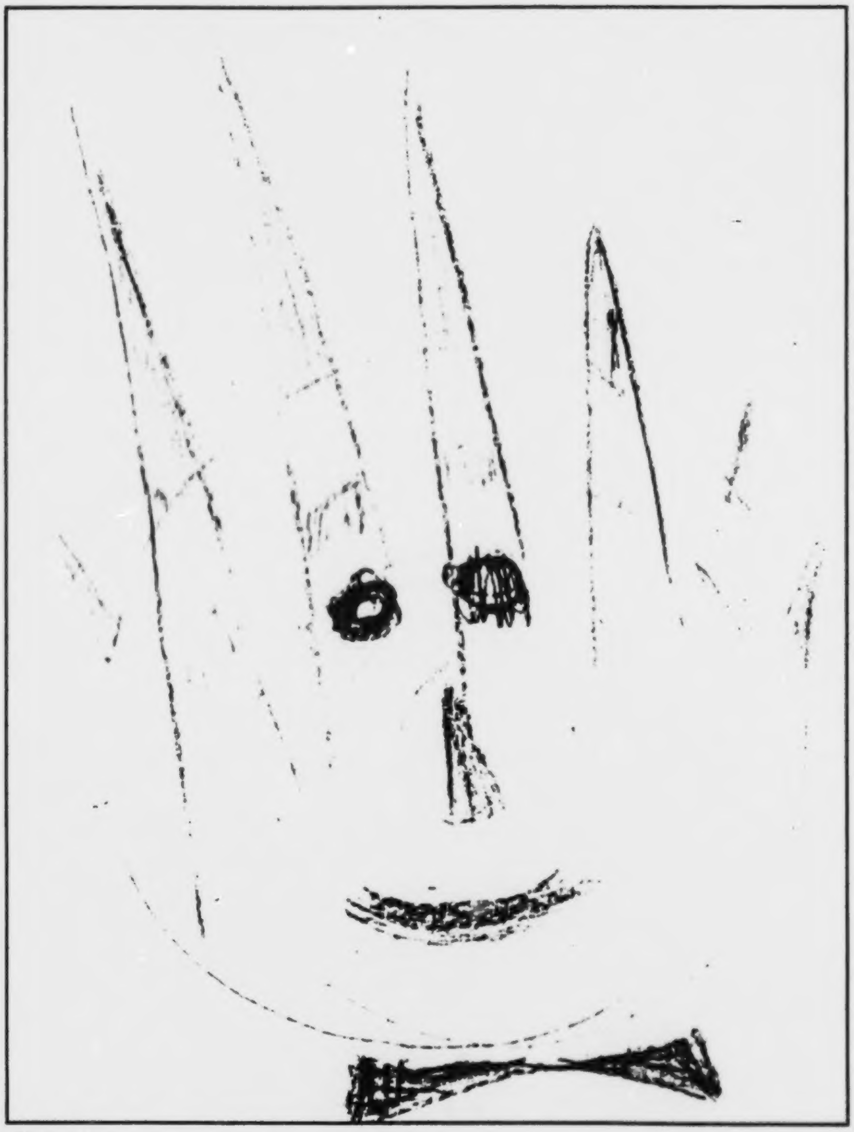


Figure 1

velopment became obvious. Threads from such theorists and clinicians as Greenacre, Eigen and Winnicott are woven together here. Eigen and Greenacre speak of the face as a focal point of contact between mother and child which strongly influences later patterns of behavior (5, 6), while Winnicott describes the significance of mother and infant transfixed in one another's gaze. The infant sees himself/herself reflected in the mother's look and thereby comes to formulate a sense of oneself. Furthermore, this ongoing interaction helps the baby to feel good about oneself and consequently one's world. In Winnicott's terminology, mother and child (or therapist and patient) create a transitional space via primary creativity (7).

When this mirroring does not occur, it is not uncommon for the psyche to embed itself within stout walls, refusing communication with the soma, and making the expression of emotional richness and vitality impossible. This description paralleled Bob's behavior when he first walked into my office. The continued lack of direct facial contact up to the time of the clown/king drawing further added evidence to suggest a lack of adequate early mirroring.

Here, with the two of us riveted to Bob's clown/king with its richness of nuance, I re-experienced Winnicott's primary creativity, and felt that we were creating that critically important transitional space. I commented to Bob that we had a clown and a king rolled into one, but I did not elaborate further (not wanting to push him inappropriately). As he laughed at the drawing of the clown/king, I interpreted his response as indicative of some vague awareness of this image, but he certainly was by no means ready to explore more deeply.

In the next session, Bob came back to the image he had drawn. He started out this session by telling of a dream in which he was attracted to a woman in his office, but he was afraid that his wife would discover his secret. His associations brought him to the recognition that he was actually sexually attracted to a woman in the therapy group. After a pause he said "You know, I've been thinking about that drawing, and in many respects it reminds me of the Statue of Liberty." The clown/king had metamorphosed into a symbol of freedom, one that has always indicated liberty and opportunity. Bob's symbol was encased in cold concrete, and I wondered why the symbol of freedom was represented in such a massive, cold form. (Were women in general, or his mother in particular, experienced by Bob as being hard, cold or unyielding?)

Bob could go no further with this dream as he wondered whether he could ever share his interest in the group member with others in the group. This man's need for encouragement and support was so strong it was almost palpable, but I managed to contain my wish to tell him to get with it and take the risk when I realized that I would be acting out the omnipotent God or clown/king of his symbolic inner world. I said little and listened. Bob's stance continued to be alternately despairing and resigned in the therapy group.

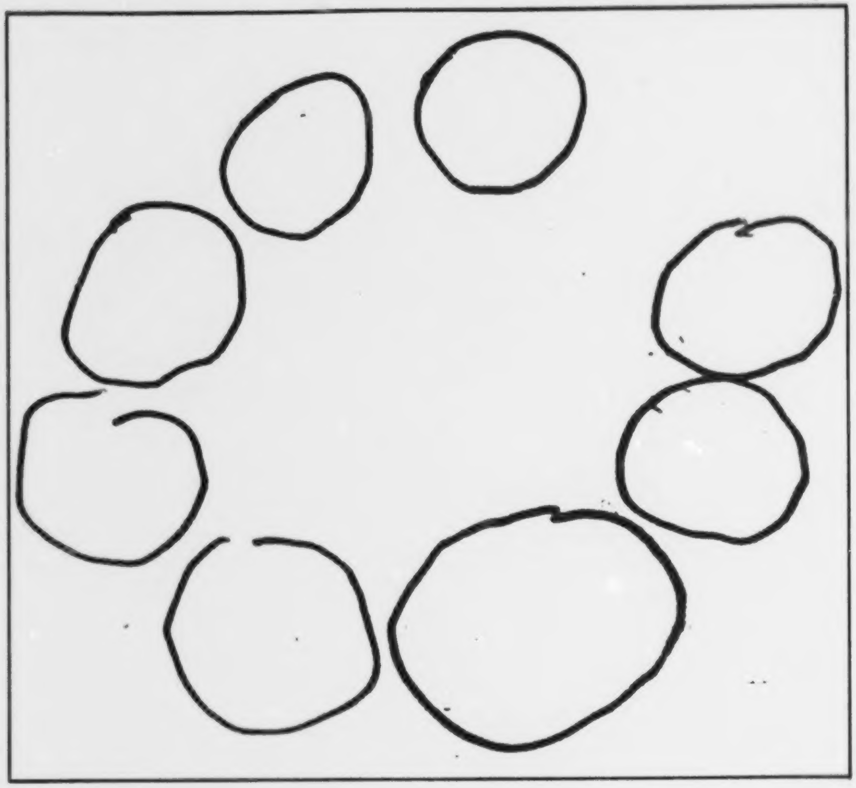


Figure 2

The Fourth Year in Therapy

It was again the first session following a long summer break. Bob reported that the summer hadn't been bad. He and his wife had rented a place on Fire Island and were part of a small cooperative living situation. Bob missed the therapy sessions, but there were none of the frightening symptoms of the previous year. As happy as he was to return to individual sessions, Bob was not looking forward to returning to the therapy group. He never had made much of a connection there, and nothing seemed to be happening. In spite of how disconnected he felt from the group, the people were still quite important to him.

When I asked him to draw a picture of the group, the resulting nine empty circles made quite a statement (Figure 2). I was differentiated as the big circle (located at the bottom center) and he was a small yellow circle directly opposite me. The rest of the circle/group members had very little individuality. At this point I decided to take a more

BEST COPY AVAILABLE

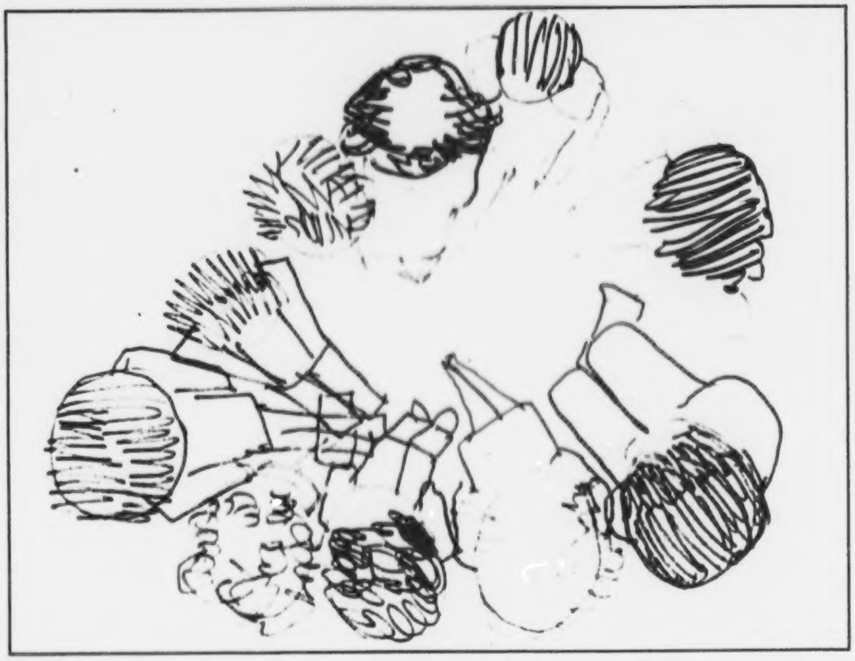


Figure 3

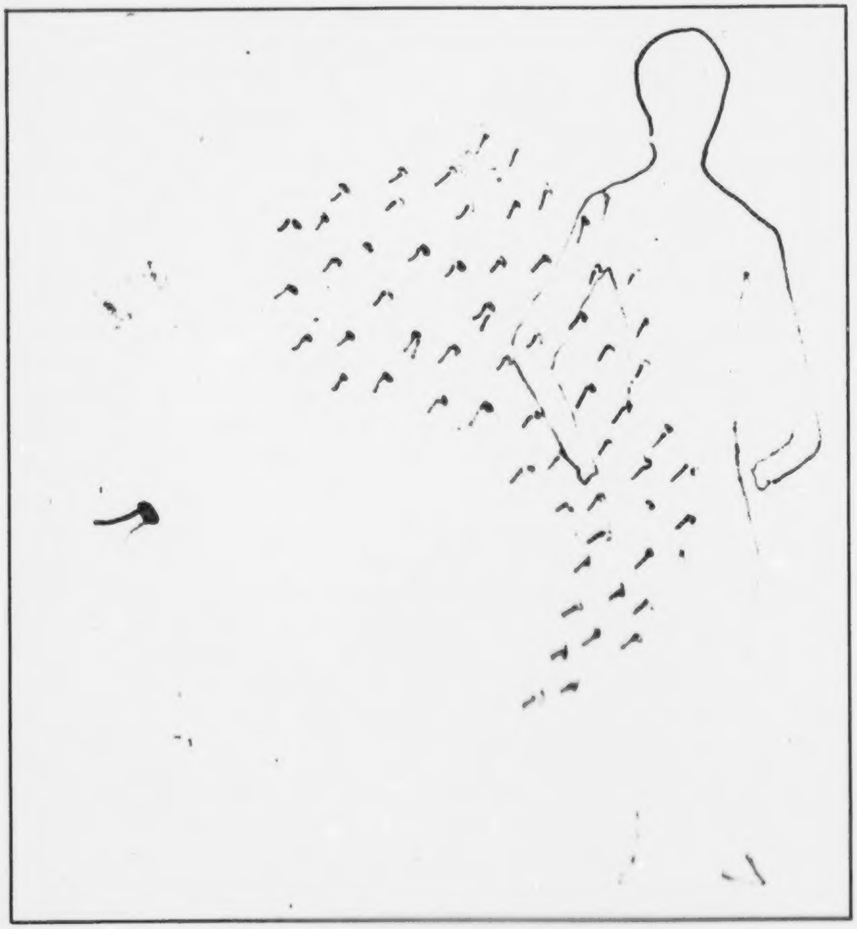


Figure 4

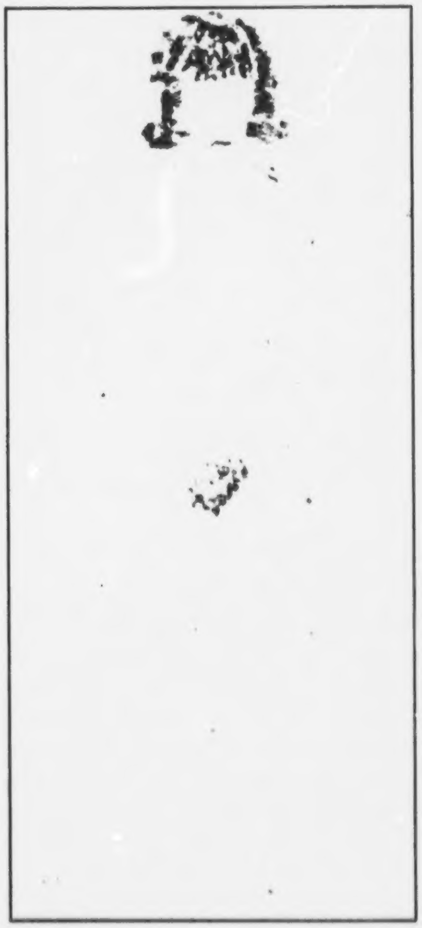


Figure 5

active role. I commented that the group members were more than empty shells. (Could he, I wondered, put some life and substance into them?) Through a more active role, I realized that I could become an extension of Bob's ego and, in turn, he could feel supported enough to venture into the frightening realm of his feelings. Because of the degree of his disconnectedness, most feelings were frightening to this man, be they positively or negatively charged. I said to Bob "You can do better than that. Let's see the people in the circles."

The resulting second picture of the group (Figure 3) had the same riveting power as had his clown/king drawing. It was like an aerial view of the group, faces absent, but essences captured with a few quick strokes. The hair, in particular, conveyed the sensuality of each individual. Bob placed himself at one end (in the right corner) with short stubby hands reaching out in the attempt to make contact, while the remaining group members collected around me at the far end.

The aerial quality of the drawing commanded my attention; this might reflect Bob's detachment, or it could also represent the distance we both had to negotiate if we were to form a closer and more emotionally empathic relationship. Bob looked as if he had things to say about his drawing so, for the moment, I kept personal observations to myself. Bob verbalized that he was attracted to some members and repelled by others. He commented about one man who reminded him of his father (a "hard working drudge who was full of duties and busyness and very little life"). Bob's comments about his father continued and he mentioned "He's alright and a nice guy, but I would never want to be like him. He just drones on and on, and everything just seems so boring and uninteresting."

Bob detested Diane, the woman sitting next to him. He saw her as loud, boisterous, and unble to hear anybody but herself. Next, he described the two men sitting side by side who were particularly close to him. They were his good friends, and his allies.

Again, a drawing provided access to the inner life Bob could not spontaneously have put into words. The artwork offered a framework within which we could jointly play with the symbols of Bob's inner reality and together observe the feelings, sensations and attitudes which emerged. With this mirroring process, the empty first representation of the group was transformed into a multifaceted vision.

> ***"Mirroring means more, in art psychotherapy as I practice it, than merely the creation of a visual frame in which to externalize and explore internal images."***

With this drawing another piece of Bob's being suffered for the first time. The man who seemed like a lost, lonely soul due to his lack of manifest and energy, revealed himself to be an intensely libidinal person who kept his "treasures" tucked away in secret corners of himself.

That night in the group session, Bob made a passing reference to his picture. Everyone's interest was piqued, so Bob repeated his observations from the morning session, leaving out some of the more sensuous or angry details. With this sharing, Bob's hidden self found a port of entry into the world. I mused on his earlier drawings and wondered if he could now carry his own torch and find his own liberty. For the moment, though, it was more appropriate to support Bob's newfound mastery in art and his ability to let himself go in order to share and have some fun with his creation than to make interpretations.

Again, Greenacre's statements regarding the importance of the face and genitals in facilitating self-differentiation and identity came to my mind. In the earlier clown/king drawing Bob became more interested in the face. Now, the therapy group had been transformed from a faceless crowd into several unique individuals. Bob was differentiating others from one another and from himself with greater clarity and richness. A full spectrum of bright colors from browns and reds to oranges and blues were used along with the description of organizing forbidden strivings and permitting partial expression through visual play. The good, conforming, achieving boy with his facade of an empty shell had changed enough to recognize and display affect and sensual nuances.

Soon thereafter in a following session, Bob discussed a dream. He told of bugs flying around him—bugs that were harmless enough, but annoying. I asked if he wished to draw the dream and he readily agreed. The picture showed the outline of a man whose insides were missing, an empty faceless shell (Figure 4). He then drew one of the bugs in a larger scale (center left), and said that it reminded him of pubic hair and a naked woman. My response was to ask Bob to draw this naked woman. While I questioned my being too seductive or directive, I recognized the importance of this intervention on various levels. Most immediately, Bob needed me to be a real object, to provide tangible support for him to explore his sensuality or sexuality. Empathy and attunement are essences of this [mirroring] process that should occur naturally in infancy. Self psychologists (e.g., Kohut) maintain that the ability to connect feeling states and words emerge from the pre-verbal period when the budding self in an infant is nourished by the verbal and nonverbal ministrations of the mother (8). Bob clearly had lacked adequate mirroring judging from his disconnectedness from his sensual self and his difficulty in recognizing and naming his own feeling states. My attunement and genuine responses were important therapeutically to him now.

Within the therapeutic relationship, Bob's drawings allowed us to make connection with one another and with Bob's pre-verbal self. The mirroring process went on with his vital energies making contact with his own as well as my source of symbols, which either resonated with, or were reactions to, his representations. The art work offered a safe framework within which Bob could see his innermost reflections organized and mirrored back in an empathic way.

This interplay reflects Winnicott's definition of therapy as play, or a moving of the patient towards play (2). Play is not aimless. It involves the meeting of psyches on a deep, symbolic, tactile and non-verbal level. It is through this kind of relatedness that the patient is helped to create and define self, other, and their interrelationships.

Bob's first attempt to draw a woman was a pale one, the outline barely perceptible. The genital region could vaguely be seen, but there was no torso or legs. I urged him to elaborate and knew that I was risking asking him to do something for which psychically he might not be ready. I also knew that the authenticity of his response would provide information as to where he really was.

He took a deep breath and went on to do another drawing. The resulting figure was a primitive earth woman: powerful, genital and with implied feet firmly planted on the ground (Figure 5). When I asked Bob where this woman had come from, he was unable to supply further information. What he did associate with the drawing was the recollection of seeing his mother naked in the bathroom when he was young. He could remember thinking that if only he didn't have a penis, he could stay forever to gaze at her. The verbal association connected the drawing to infantile issues and clearly stirred up Bob's libidinal energy as he proceeded to knock his knees back and forth in a masturbatory fashion. This way his way of ridding himself of his free-floating sexual excitement. The drawing and discussion of the primitive earth mother gave grounding to the energy as Bob found and defined its source.

The theme shifted slightly in our next meeting. Bob drew another dream (Figure 6). In this one, he was in his parents' house. The women were sitting in the kitchen; they consisted of his grandmother, mother, and some local women (located in the upper right). He stood outside the room looking in. He felt excluded and wanted to be part of the group. He drew his brother and placed him alone in one corner (lower right). He then placed his father at the other end of the house (upper left). All figures were faceless as the house was filled with empty circles and boxes. The hallway led to an elevator (Figure 7) which was going up and down while two men inside embraced (center right). He stated that the dots on the left were "bums" that were outside in the street.

Issues of isolation, strictness of ego ideal, and lack of idealized image came to the fore as Bob associated to his dream/drawing. He had always felt excluded from the family inner circle which was comprised of women and headed by grandma, the matriarch. Bob's sense of isolation and lack of warm attachments were reflected in the empty circles and boxes in the house, as well as in the faceless figures.

This wish for warmth, an erotic need for male contact, and a need for a strong man with whom to identify led Bob to draw the men embracing in the elevator. Unaware of his deep rooted needs, Bob associated his wish for closeness to men with homosexuality. He was unaware that his search for the real male/hero was a normal stage in development. Bob needed this transitional adoration in order to help define his sense of maleness, strength and identity.

Both his father and brother were devalued and distanced from him in the drawing and, in fact, he so rarely mentioned his brother that I sometimes thought of Bob as an only child. As he elaborated on the lack of respect and relatedness he felt toward his father, Bob described an accountant so busy with the figures and numbers of his profession that nothing else seemed to exist for him. The warmth, hero worship and male contact Bob craved was not to be found in his relationship with the father. Bob recalled how his father had repeatedly warned that if he did not work hard and get good grades, he would turn out to be a "bum."

Bob's only ideal of manliness within his childhood home was to be a super-

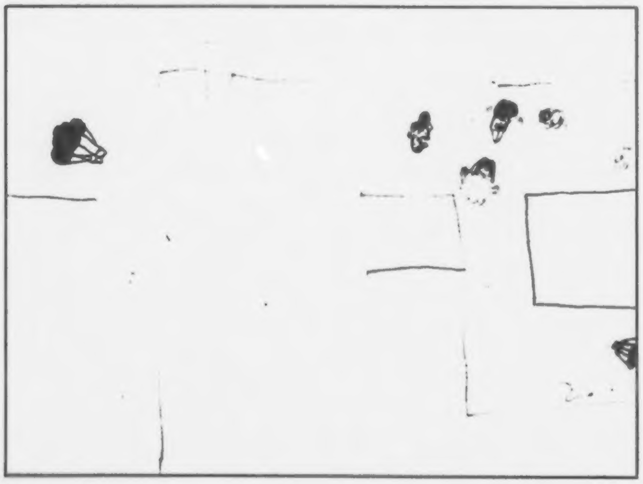


Figure 6

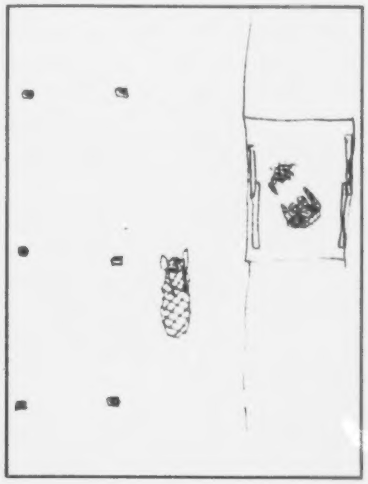


Figure 7

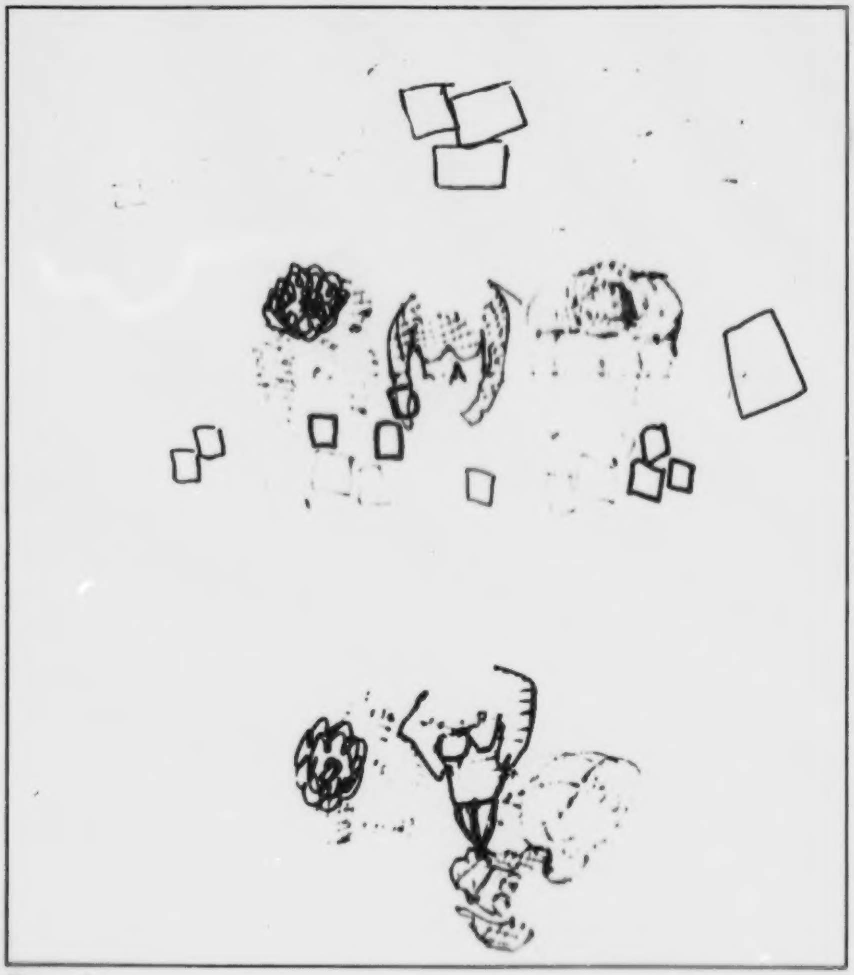


Figure 8

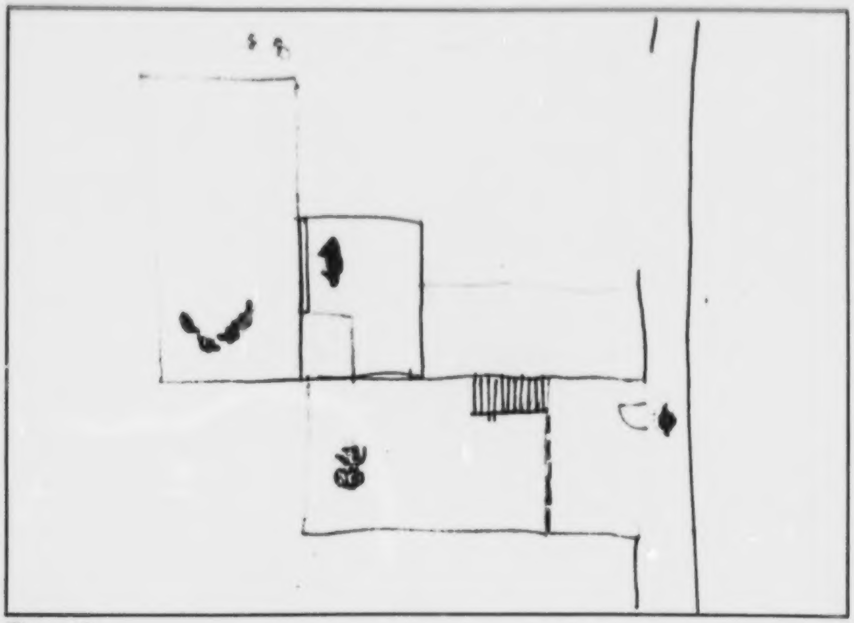


Figure 9

worker and achiever. Bob was frightened to risk becoming like one of the outcast bums in his drawing, so he adopted the ego ideal he was given. To feel loved, he became a well-behaved, conforming boy who received high grades and achieved. This ego ideal gave him a value system, organization and direction, but at a tremendous cost. Bob not only curtailed his autonomy, but also kept all of his sexual drives in secret masturbatory check while maintaining an anti-libidinal existence for the eyes of the world.

Bob's childhood was devoid of an idealized image, or hero, except in his homosexual fears. Although the more primitive ego ideal allowed Bob to function in the world, he never went through the transitional state of development where the early "should" system was modified through emulation of an idealized hero. He, therefore, never gained a sense of identity based upon the "picking and choosing" among many models.

Bob's figures of the isolated self, brother, and father, of the embracing men in the elevator and bums in the street, poignantly depicted the conflicting desires and fears of Bob as a small boy. The support and real relationship in therapy allowed painful and frightening memories and images to emerge for recognition and feedback. Bob could talk about the drawings and was able to make conscious connections concerning issues regarding family structure. Homosexual fears and wishes became less threatening as they were explored via visual representations and were fitted into a cognitive structure. In two successive sessions, Bob's erotic interest in women and men revealed itself and was verbalized as his emerging self gained further cohesiveness.

In the next session another dream was offered. Bob was sitting in the office with a co-worker. There were many papers around them. As he drew the dream, I was aware of the reappearance of numerous boxes and circles (Figure 8). Bob spoke about the other man with whom he felt somewhat competitive. He first drew himself in gray outline and then wondered why he picked such a drab

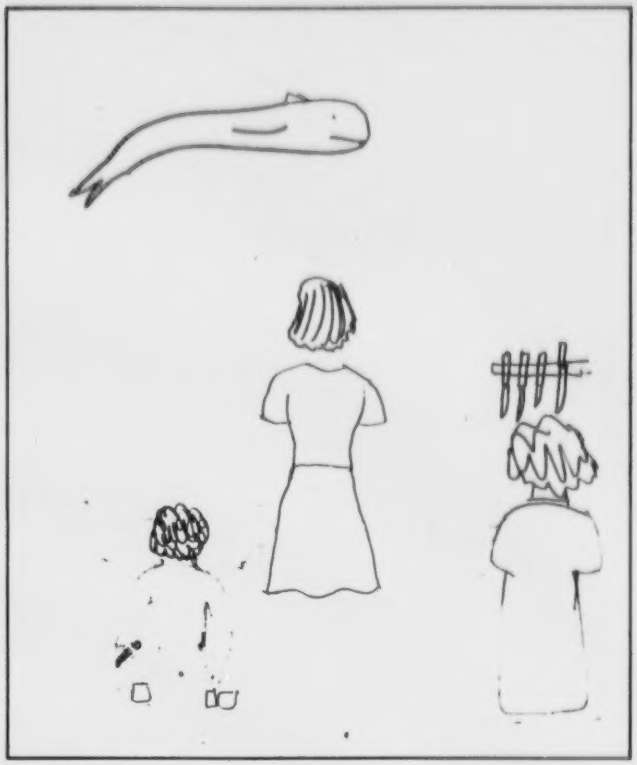


Figure 10

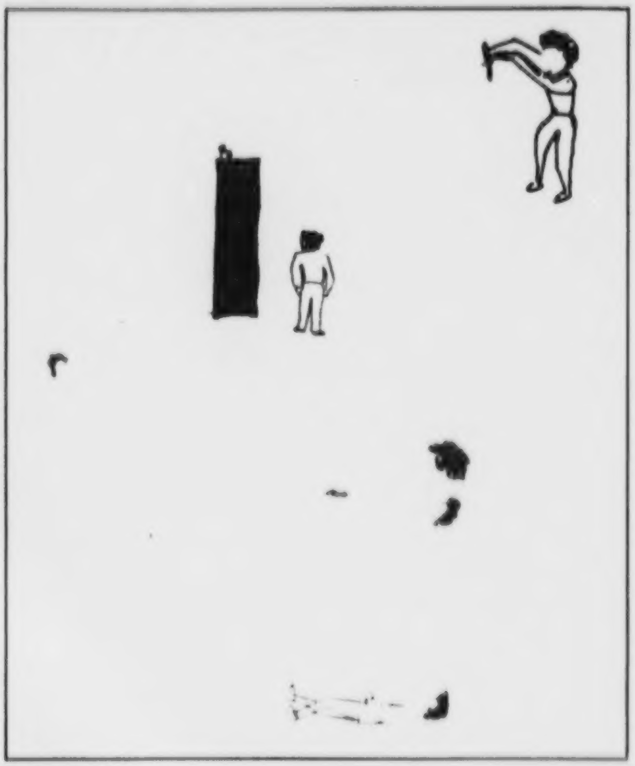


Figure 11

color. He proceeded to fill himself in with a red marker. There was a woman drawn between them (middle of the drawing). Smiling at this drawing, he then stopped to complain: "Why do we have to share one woman?" He proceeded to draw a circle of two men and two women (center bottom) and smiled with satisfaction as he said "Now we each have a woman."

Through this image, Bob shared with me his need for communion and closeness: a wish to break out of the rigid squares of his existence, a world of achievement and work. This highly structured world had always been Bob's anchor, supporting ego mastery and giving purpose and direction. It wouldn't be easy to modify this structure, yet this battle for self-cohesion now faced him with the challenge of bringing his needs for intimacy and relatedness into the sphere of his work. Bob discussed how "fed up" he was with overtime work and how much he wanted to enjoy himself with his wife and friends. The specific symbolism of circles and squares was not mentioned, but Bob verbally connected his drawing with his very real wish for closeness and intimacy. The conflict was still evident, however, by the fact that there were no faces in these pictures.

In a subsequent session Bob brought in another dream. He no longer asked if he could draw, but proceeded to do so on his own initiative. The dream centered around moving into a new apartment. The drawing (Figure 9) showed a man from his office whom he described as a "schmegegi" (far left) standing outside the apartment. In the dream, he and his wife were investigating all the new space in the apartment. The inner house had a barren look with no furniture moved in, with his wife (lower center) in one room and he (top center) in another. Bob's compartmentalization and isolation were again apparent in the separate, doorless rooms and faceless figures. Bob needed some way to connect with others. He and his wife were in distinct worlds, as were the men and women previously depicted in his family drawing. I reflected that he needed to find a connection between past and present to really touch and be touched by others.

Bob had often complained of his wife's demanding and dependent nature. This session his complaints specifically focused on her "sloppy approach to job hunting." I hoped that the vehemence of his complaints might form the basis of an opening to reach out to one another.

A few more weeks into treatment, and Bob presented another dream. As a small boy Bob was seated under the sink in the kitchen looking at his mother's and grandmother's legs (Figure 10). He was playing with a fish, but the women took it away and cooked it. The fish reminded him of a penis, and Bob remarked that the women in his house were man-eaters. "Men just didn't have a place or a say in anything."

The dream in the next session might well have been a reaction to this protest. The dream took place in his parents' house. His mother and father were having sex, and he heard them

> ***"Each individual must find a balance between childlike primitive urges and the values and aspirations handed down by one's family."***

from his bedroom next door. As Bob began to depict the dream (Figure 11), he first drew a large and erect water cooler, and placed himself next to it. Then he drew his parents having sex. Bob was quite impressed with himself for being able to draw his parents so graphically (center of picture). As Bob admired the visual expression of his dream, he commented "Oh yes, in the corner of the house is my baby brother." Bob's face now took on a twisted and upset look. The warm sexual feeling he expressed in the drawing disappered. "My picture is ruined by the entrance of my baby brother," he said. I encouraged him to draw his anger, so in the corner of the paper he drew himself standing with a knife (upper right). For the first time, Bob directly depicted evidence of aggressive and sexual natures. Predominant in previous sessions were impotence and lonliness; he diluted the sexual and aggressive content of his group portrait when he described it to the members. In his family drawing he was searching for male support while he felt frozen out of the inner female circle. After his last dream he produced a symbolic visual expression of castration with a verbal commentary on impotence. In this latest drawing of a dream, the flatness of expression diminished and a furiously angry boy was depicted expressing feelings towards a new brother for intruding into a secret world. After expressing his castration ("they took away my fish") Bob was able to take the next step to recognize a piece of his aggressive, sexual self within the framework of a supportive therapeutic environment. The appearance of a more frontal, direct view of the face now occurs.

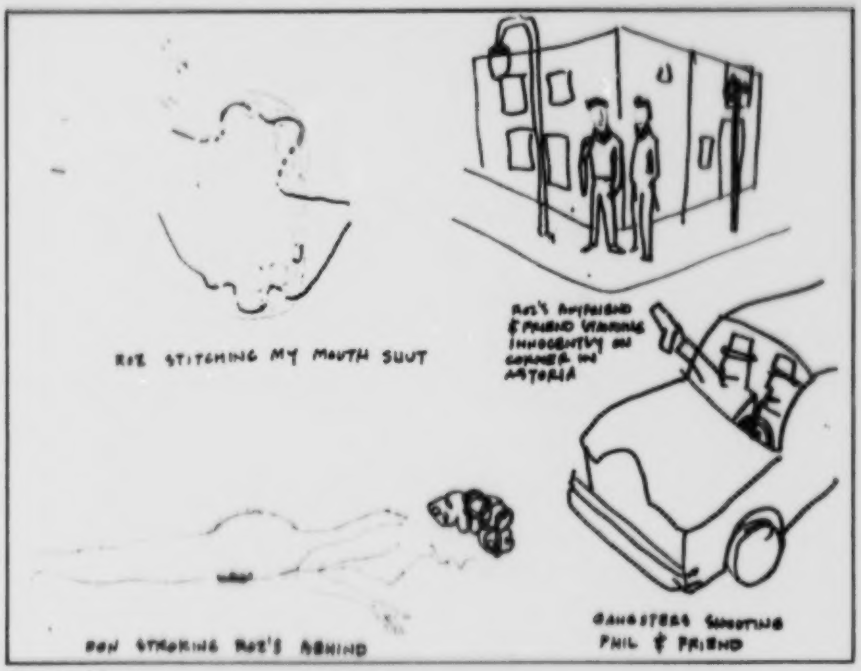

ROZ STITCHING MY MOUTH SHUT
ROZ'S BOYFRIEND & FRIEND WAITING INNOCENTLY ON CORNER IN ASTORIA
BOB STROKING ROZ'S BEHIND
GANGSTERS SHOOTING PHIL & FRIEND

Figure 12

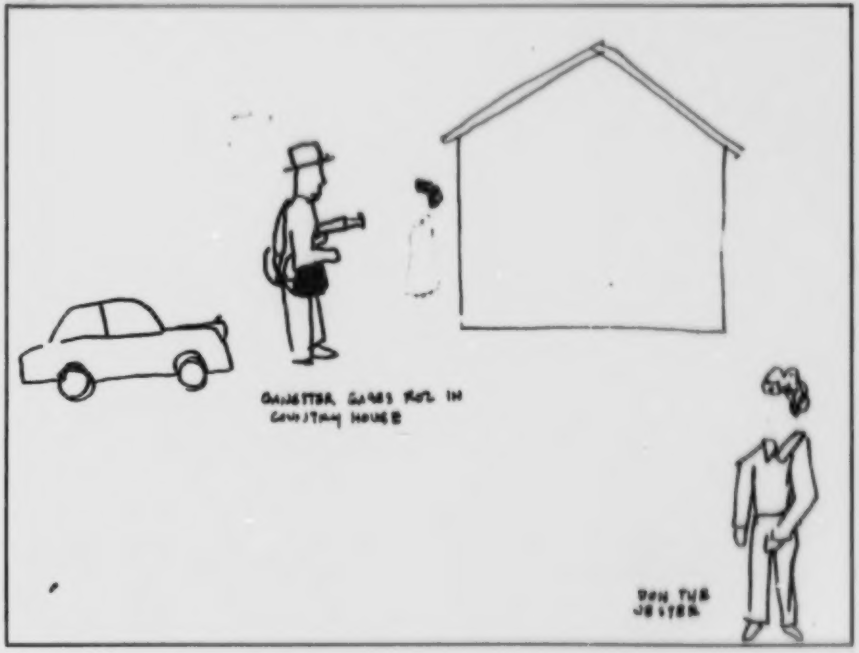

GANGSTER GUARDS ROZ IN COUNTRY HOUSE
BOB THE JESTER

Figure 13

This final picture presented here elaborates upon some of the issues regarding Bob's self-cohesion (Figures 12 and 13). Bob reported that he had an interesting dream about a member of the group. In the dream, Diane was stitching his mouth shut, and he proceeded to draw a picture of his mouth stitched (Figure 12, upper left). In the next part of the dream, Diane's boyfriend and a friend were standing on a corner (upper right). In the following sequence, two gangsters in a car shot at her boyfriend (lower right). In the next frame, Bob saw Diane in miniature and stroked her behind (lower left). When Bob drew this part, he drew her larger than she had appeared in the dream. The presence of therapeutic support plus felt markers allowed Bob to give a sharp,

BEST COPY AVAILABLE

visual focus to the drawing of the body. Finally, in the last section of the dream (Figure 13), a gangster went to Diane's summer house and gassed her. In the corner, the patient was observing the action.

Bob labeled himself the jester, then proceeded to identify all the parts of the dream. His title "Bob the Jester" was reminiscent of the first clown/king image he drew a year and a half before, but now we had a much better notion of what was behind the clown's face. Bob connected the clown/king image to the jester, and commented that, in the drawing, he looked as if he were masturbating. The front view did capture a certain physical likeness and essence of his true self standing in a masturbatory-like trance day-dreaming about the "loudmouthed group member, Diane."

From Bob's first picture of the group, Diane was the one person he could not tolerate. He was turned off by this woman whom he saw as attention seeking and crude. Diane's sewing of his mouth in the latest dream gave the clear message to keep his mouth shut and his erotic interest to himself. In the course of the dream, Bob managed to open his mouth, freeing murderous impulses toward Diane's boyfriend.

When Bob brought the dream drawing to the group, everyone was interested in it, but especially Diane, who was joyous. "You mean you dreamed about me?" she asked as he described himself stroking her behind. He continued to tell Diane that he had seen her living a wild, exciting life. When Diane reported that she did not care in the least that, in the dream, Bob shot her boyfriend, Bob was astonished. "You mean you are not mad at me for shooting up your boyfriend?" "No," she responded, "who cares about him? You found me wild and exciting and that's what counts." Bob couldn't believe that he received approbation.

The picture of the good little boy searching for an omnipotent ideal while keeping his wild, erotic, playful self under wraps, now had evolved. Drive content had been recognized within the self structure to take its place next to the ego ideal of hard work and achievement. I didn't verbally share these insights with Bob because, from an empathic mirroring point of view, Bob's wonderment at being appreciated for expressing murderous fantasies was far more important than making historical connections.

> ***". . . I knew that something had to be done to break this unbearable isolation that words only seemed to accentuate."***

Bob responded to all of this in a dream brought in during the next session. In the dream he was having sex with his wife in his parents' room. His mother opened the door to intrude. Suddenly the dream switched and his father wanted to meet one of his dull, dreary friends, but oddly enough, this dull friend turned out to be a football hero. Bob had a flashback and commented "You know that picture where I was standing in the corner as the jester with my mouth sewn up by Diane? Well, I always thought that there was something secretive going on between me and my mother. We were always intimate and close when my father wasn't around. It really was like my lips were sealed." It was suddenly clear why our strictly verbal therapy had originally had so little meaning. His lips also had been sealed in the sessions. I joked to him that it would no longer be necessary to keep his lips sealed since his secret was now out in the open. His response was one of a shy grin and cold sweat.

Next Bob started to talk about his father. He hated his father's friends because they were so dull and nondescript. I reminded him of the image of the football hero in his dream. "Well," he said, "my father did play ball with me and that was fun. One good thing about my father, he was always there to help me with my television repair hobby. My brother and I ran a small service and we could repair everything. My father would help get the supplies."

As his sexual and aggressive feelings erupted into consciousness we began to see the emergence of an idealized self image. In contrast to the overpowering ego ideal composed of the "shoulds" and "should nots" reflected in his earlier dreams, another dimension of Bob's self was emerging. Here, the hero so sorely longed for in his youth, surfaced. Bob's transitional identification could help tame his raw erotic and aggressive drives and would serve as the basis for future mature identifications. His need for warmth and control, freedom and expression were slowly becoming integrated with a more realistic sense of the work ethic. In remembering incidents like playing ball and working on his hobby with his father, Bob was permitting himself to see some of the better aspects of their relationship, but he still was far from coming to terms with his feelings of vengeance toward women for putting him to sleep and making secrect his erotic strivings.

Summary and Discussion

A crucial aspect of this case related to the use of transitional space. Bob's symbol of the lips being sealed represented the complete cutting off of libidinal and aggressive energy in verbal communication. Through non-verbal play, we discovered a bridge by which to make symbolic therapeutic contact. Bob could not be explicit regarding this issue, but there was little question in his mind that he now could be more forceful and aggressive with others than he had been able to be before this series of drawings.

The use of art for patients is neither magic nor the answer for everyone in creating the bridge. In each case, we must find the appropriate container that allows the metaphor and image to find its own expression.

Bob had received support from his father for his mechanical endeavors. The family also supported Bob in such artistic and musical pursuits as piano lessons. Both areas lent themselves to freer expression so that art, in therapy, became an additional means to connect image and libidinal

> ***"When this mirroring does not occur, it is not uncommon for the psyche to embed itself within stout walls, refusing communication with the soma, and making the expression of emotional richness and vitality impossible."***

expression where words, at first, were hollow representations of the self.

Before Bob and I started using art in the therapy sessions we had made superficial contact on the level of his ego ideal. In many respects he seemed to have made progress. This progress, however, is not uncommon in "false self" personalities. This kind of patient will often try hard to make progress in order to please the therapist. It is simply one more means to conform and be successful (2). Unfortunately, this success may come at the cost of total integration of the self, as it did for Bob.

Bob had kept his "guts and soul" in hiding cloaked by a false self, but with the introduction of a non-verbal medium, it no longer was possible for patient and therapist to delude themselves into thinking that there had been as much progress as originally assumed. Bob's original ego ideal was based on fear and pressure. There was little joy in, nor room for, the release or flow of energies. Within this very restricted self, oedipal material was a dark secret beneath layers of masturbatory fantasies and, in turn, encased within rigid body armor. The gap between libidinal body self and work-oriented ego was enormous as seen in the polarity between boxes and circles, each representing unintegrated parts of the self. This choice of symbols had always seemed apt to me. Although the connected issues were verbalized, the specific symbolism was not.

Bob worked hard in his quest for self-cohesion. His need for more human contact and community relatedness was consistenty represented by the symbol of the circle, as he openly discussed his wish for intimacy and closeness. His striving for achievement and success was first viewed in the sharp points of the clown/king reaching for the sky and was later more clearly verbalized and responded to with empathy. In treatment, the lifting of repression permitted the release of an idealized image and allowed Bob's libidinal life to become better integrated in his identity. Bob's joy, good humor, and sharing ultimately became part of his group participation.

Crucial in the facilitation of Bob's inner life finding expression in his outside behavior was the development of the mirror transference through art. Where words alone seemed to encourage repetition of Bob's sterile early childhood experience, the non-verbal medium of art permitted a profound connection necessary to transform stagnant sessions into exciting and magical worlds where the discovery of new paths was possible. The patient and therapist rediscovered the lost parts of the self through a mutual psychic adventure. A mirroring transference must have the dimensionality and vision of a good work of art so that this rediscovery can take place.

Author's Note:

I am indebted to Trudie Loubet for her editorial help and guidance.

References

[1] Kohut, H. *The Restoration of the Self.* New York: International University Press, 1976.

[2] Winnicott, D.W. *Playing and Reality.* New York: Basic Books, Inc., 1921.

[3] Miller, Alice. *Prisoners of Childhood: The Drama of the Gifted Child and the Search for the True Self.* New York: Basic Books, Inc., 1981.

[4] This first session was reported in a different context in the *American Journal of Art Therapy,* Vol. 21, October, 1971.

[5] Eigen, Michael. "The Significance of the Face," *Psychoanalytical Review,* 67 (4), pp 427-491, 1980.

[6] Greenacre, Phyllis. "Early Physical Determenance in the Development in the Sense of Identity," *International Journal of Psychoanalysis,* 1958.

[7] Winnicott, D.W. *Playing and Reality.* New York: Basic Books, Inc., 1921.

[8] Kohut, H. *The Restoration of the Self.* New York: International University Press, 1971.

Imagery as a Style of Thinking

Myra F. Levick, PhD, ATR, HLM

Myra F. Levick, PhD, ATR, HLM *is professor and director, Master of Creative Arts in Therapy Program, Hahnemann University, Philadelphia, Pennsylvania.*
She is the author of ***They Could Not Talk and So They Drew,*** *and is Editor-in-Chief of* ***The Arts in Psychotherapy.***

This article reflects the author's efforts to synthesize image formation and its relationship to development and role in learning. References include material on the creative process with a specific focus on "image formation as a style of thinking and learning."

Read (1960) and Horowitz (1970) are discussed at length—the former for his interest in art and education and the latter for his interest in the process of image formation in the treatment of psychotic patients. Horowitz's work also includes a historical review of the literature pertaining to thought and perception and the role of environment in producing a style of thinking.

Some attention is given to recent right brain/left brain research and the author offers some of her own clinical case material to illustrate these phenomena. A major developmental issue regarding the sequential emergence of words versus image is discussed and significant investigators including Segal (1971), Paivio (1971), Haber (1971) and Chall and Mirsky (1978) are cited.

In the summary and conclusion the author suggests some ways in which specialists from different disciplines may pool their resources, utilize what scientific knowledge is available, current and timely, in the area of child development and begin to apply it to prevent emotional problems and intervene early for emotional problems and/or learning disabilities. In addition to some examples from the author, the recent work in this direction by Silver (1978) is discussed.

Introduction

As a child and adolescent, I drew everything that appealed to me, and many things that did not. Image formation, in one form or another, has been a way of doing and learning for me as far back as I can remember. Therefore, after graduation from art school (trained as a painter) it seemed perfectly logical to me to respond to an advertisement for an artist to work with mentally disabled patients. I had never heard of art therapy, did have a knowledge of psychology on an undergraduate college level, but knew very little about psychiatry. The sensitive, intuitive psychiatrists and psychoanalysts who trained me knew the power of non-verbal communication with disturbed populations. As they struggled to articulate this, I struggled with such questions as: If it works so well for severely neurotic and psychotic patients as a means of communication, how can it be employed for children with language problems? What were the implications when children with borderline or below average I.Q's drew in a manner that indicated they were clearly using higher level mental functions such as reality oriented perceptions, organization, sequencing and appropriate spatial relations in their images?

A number of learned, articulate psychiatrists have written extensively on the creative process and its role in mental illness in an effort to synthesize for themselves, and for the field, this complex relationship. A review of this literature and examples from professional experience reflects my efforts to synthesize image formation and its relationship to development in the area of learning.

> ***"As a child and adolescent, I drew everything that appealed to me, and many things that did not."***

The Creative Process

The last four decades have produced a voluminous amount of literature on the creative process in the fields of psychology, psychiatry and education. Its role in education is often undefined and inconclusive. Because the scope of this paper is limited, I will review only a number of publications that address the focus of "image formation as a style of thinking and learning."

Read (1960) cites Fiedler (1949) who describes the artistic process as "a holding on to perceptual experiences in spite of both sensation and abstraction" (p 61). Read compares this statement to the words of Cezanne (in Rewald, 1941, p 235) who said that "an artistic production which represents and at the same time expresses a feeling is a form of cognition which is separate from scientific and philosophical cognition and for the arts suffices as a principle of reality." According to Fiedler (in Read, 1960) art does not start from abstract thought in order to arrive at forms; rather, it moves up from the formless to the formed, and in the process is found its entire mental meaning.

Read (1960) sees education exclusively as a system for developing a capacity for forming concepts with little attention paid to developing a capacity for concrete perceiving. The earliest cave drawings date back to 40,000 B.C. and demonstrate that early man used images to comprehend his word and record those images on the walls of his dwellings. Throughout history man has continued to find need for comprehension and expression through the visual arts. Great works of visual art are honored side by side with philosophical teachings and Read purports that we do not give recognition to the results of perceptual experience, or ability to conceptualize forms, in ordinary people when we assess capabilities in our educational and social systems (Read, 1960).

Image Formation

Sir Herbert Read felt compelled to address educational reforms in England, and ten years later Dr. Mardi Horowitz, a psychoanalyst using art as a means of communication with psychotic patients, saw image formation connected to the issues of thinking, emotion and perception. He was confronted with the questions of the usefulness of images in cognition and differentiation of internal images from perceptions. Working with a number of patients who hallucinated, he wondered how to control image formation (Horowitz, 1970).

Historically, image formation was a major topic for research in academic, psychological and psychoanalytical study around 1900. After World War II, this was replaced by experimental cognitive research and interest in the functions of the ego with emphasis on the "defensive aspects of thought processes, perception and regulation of emotion" (Horowitz, 1970). Along with the increased interest in cognitive research there was a need to know more about nonlexical thought and its relationship to other aspects of cognition. Horowitz, as a psychiatrist, needed to communicate with withdrawn, psychotic patients and was impressed with spontaneous images emerging during a patient's free associations. He defined these images as representations of thought with a sensory quality, and the underlying process of image formation as being unconscious. He further defined images as "memory fragments, reconstructions, reinterpretations and symbols" (Horowitz, 1970). Within this definition, an image can represent objects, feelings or ideas.

> ***"Image formation, in one form or another, has been a way of doing and learning for me as far back as I can remember."***

In order to pursue the study of image formation, Horowitz suggests a phenomenological categorization which would serve as a basis of his theory that images are stimulated by a specific experience. His categories are: 1) Hallucinations—images associated with a psychotic state in which internal thoughts and images seem real; 2) Hypnogogic—images appearing in the twilight state between wakefulness and sleep which move from logic to fantasy; 3) Hypnopompic—similar to hypnogogic but occurring in the process of awakening, when thoughts move from fantasy to logic; 4) Dream—images which are usually visual; 5) Nightmares—unpleasant images usually accompanied by a physical sensation; 6) Psychedelic—images like a hallucination, but drug induced; 7) Dream Scintillations—a rapid succession of images intruding upon awareness and not easily remembered, and are often induced by physical stress; 8) Illusion—a transformation of [illegible]nal stimulus into a different object (common in everyday life); 9) Perceptual distortions—changes in line direction, shape, size, color; 10) Synethesias—blends of images which are produced by an auditory stimuli and imagined both auditorily and visually (Example: I was so inspired by a concert performance that I "heard in yellow" and then, subsequently, I painted in yellow); 11) Images in a collection of forgotten details; 12) Imaginary images—when past images and perceptions are combined to form new concepts and fantasies; 13) Entopic images—intrapsychic images that relate to perception (Example: After a blow to the head, one might "see stars"); 14) Body image—experiences which have a constant, transactional relationship and contain current perceptions, memory and emotions, along with drives, thoughts and actions. (Some body image experiences may be on a preconscious level and can be raised volitionally, while others are unconscious and cannot be raised easily. Common examples include reported cases of people who experience their body as it was before a physical injury. A specific example is of a student when asked to make a clay mask of her own face with her eyes closed, made her nose as it was prior to plastic surgery.); 15) Para-Normal Hallucinations or visions—these are usually mystical and/or religious visions; 16) Imaginary companions—frequently described by children who usually know the 'companion' is not real; and 17) Number and Diagram Forms—used by some people for arithmetic problems. (This last kind of vision certainly suggests some form of right and left brain synthesized organization).

Horowitz (1970) cites Aristotle who saw image formation as a basic element of thought, connected by relevant associations and a motivating force for the expression of emotion and effort. Lock (1690, in Horowitz, 1970) described complex ideas as the result of the recombination of simple images which are recalled as part of thought. Hume (1739) saw images as separate from and copies of perceptions; however, he maintained that perceptions are more vivid, have more force and liveliness than images (in Horowitz, 1970). Hartley (1834) defined two systems for representing thought: words without sensory quality; and various sensory type words (in Horowitz, 1970). In the early 19th century, psychologists categorized words by their image quality. These were visual (quality of being articulated). Images were assembled according to various laws of association, and one image led to another: "Thought proceeded by selecting the image highest in a hierarchy of activation" (Horowitz, 1970, p 57). In the early 1900's, members of the Wurzberg School concluded that thought was imageless. This was disputed by Wundt and Titchner, and the questioning continued when, in 1905, Arch attempted to unite both ideas by suggesting that conscious sensations or memory image is an image representation in consciousness of imageless knowledge. In 1927, Selz concluded that thought can be understood, but investigation of introspective reports of conscious awareness was necessary to understand thought processes beyond information (Horowitz, 1970).

The Gestalt School concluded that thought (as well as perception) was assembled holistically from less clear to more distinct versions, and conceived two image types: people who formed concepts pictorially, and others who had no picture in their mind's eye and conceived thought as a series of words (Horowitz, 1970). Angeli, in 1910, (in Horowitz, 1970) reviewed methods used to study determination of mental imagery and made recommendations that Horowitz suggests would still be worth following. Angeli thought investigators should examine all forms of images any individual could command such as forms used in daily life and, therefore, define the functions of the image.

Language and Image Formation

Horowitz (1970) concludes that environment must play a role in producing a style of thinking. He sees the environment as a kind of perceptual stimulation particularly to the extent that the infant uses internal images as a substitute for perceptions. He suggests that the ability to acquire symbolism and language substitutes for image formation. He also believes that infantile experiences play an important role in image formation and a significant influence on eventual cognitive style may be the separation-individuation phase of development.

> ***"Art does not start from abstract thought in order to arrive at forms; rather, it moves up from the formless to the formed, and in the process is found its entire meaning."***

In the last two decades there have been a number of other theorists who have suggested different ideas about the relationship of language and image formation. In addition to those cited by Horowitz (1970), others are briefly discussed. Piaget, 1930 (in Horowitz, 1970) said the pre-verbal child uses an image to transform or to gratify a desire. Werner (1957) and Lukianwica (1960) contend that children, primitive men and psychotic persons fuse inner images with perceptions of external reality through the use of magical constructions (in Horowitz, 1970). Children progress naturally from images to words, and for adults thinking has lexical signification. Horowitz cites Humphrey (1951) who believed that thinking is not the same as word usage, and that images either serve as distractions or enrichment of thinking. Vernon (1967, in Horowitz, 1970) studied 8000 subjects and concluded there was no relationship between concept formation and level of verbal language development. Bruner, 1964 (in Horowitz, 1970) sees thought representation as the end product of information processing. Bruner identifies three forms of processing as enactive, iconic, symbolic, and the process moves from concrete to abstract. Horowitz agrees with Bruner's concept of information processing, but he believes the three forms are enactive, image and lexical. Horowitz' focus is on the subjective quality and he concludes that thought is represented by images and words. In ordinary thought, modes interact; modes are less integrated in organic pathology and psychic trauma.

Horowitz sees perception as an active process and maintains that there is an interaction between internal and external processing. This results in a schemata that the cognitive process needs to organize in order to identify and label (1970). From his clinical experience, Horowitz has concluded that image formation (in hallucinations) is elaborated from elementary sensations. He further raised the questions of psychological motives versus physiological structures. He identified permanent or transient changes in structure or function of the brain. Briefly, he points out that nondominant hemisphere pathology impairs visual and spatial tasks that require image formation, while dominant hemisphere pathology will more likely impair lexical thinking.

> A number of years ago a twenty-two year old man was referred to me for art therapy after an attempted suicide. I was told he had suffered a cerebral hemorrhage, had been a science major in college and as a result of the trauma could no longer focus on that curriculum. He found himself painting to fill the time during his recovery, but became more frustrated and consequently very depressed. Little was known at that time about right brain/left brain studies, other than one side of the brain could take over some functions of a damaged part. His course of therapy, with art being used as a rehabilitative modality was dramatic. Within two years he was enrolled in an art school and finding a new way to be a productive human being. The results of this case, while exciting, left many questions unanswered for me and the neurologist and psychiatrist who supervised this patient's progress. Our conclusions at that time were certainly consistent with Horowitz's conclusion that there is a connection between art therapy and learning, and that the creative process can serve as a new form of communication for the mute, withdrawn or blocked patient. The implications of this in the field of learning disabilities are enormous, particularly in light of recent brain research.

Imagery and Cognitive Approaches

Segal (1971) invited several psychologists to contribute to his book on

> ***"Children progress naturally from images to words, and for adults thinking has lexical signification."***

imagery and the relationship to cognitive approaches. Paivio (in Segal, 1971) sees the aspect of meaning in an image related to verbalization and an aid in developing comprehension and retention. Language competence and language performance are initially dependent on the substrate of images. It follows that an image approach would enhance language acquisition. Infants develop a storehouse of images upon which language is built. Infants can indicate by behavior that they recognize objects before they respond to names of those objects. This suggests that some kind of representation is stored which matches perceptual information which later produces a word/image relationship (Paivio, in Segal, 1971).

> My own child was born with a partial cleft palate and we were advised not to encourage language development until after surgery was performed at eighteen months. Consequently she and I developed a very satisfactory pantomime relationship. After surgery, when it was even more difficult for her to gesture (because her arms were bound for two weeks), she nevertheless discovered very quickly where the baby food was kept and when she was hungry she would start towards the kitchen, communicating with her head that I was to follow and feed her. She learned words rapidly in the year that followed and I think the word image relationship was enhanced by the image-response relationship. For example, when she wanted a cookie, she would lead me to the cookie jar where she had perceived the cookies to be. When I perceived what she wanted, the fantasied image became real. This is also an example of the idea that image formation, according to Horowitz, connects to the real and fantasied past and produces emotional responses and cognitive process associated with real experiences.

Infants are exposed to objects in relation to other objects. This produces events which repeat themselves and from observed events a syntax is evolved. This becomes incorporated into representational images. Syntax is elaborated and enriched by the action component derived from the child's own actions. Names are learned for events, relations and objects, with a developing association forming between or among them. The child begins to acquire function words, develops an intraverbal network which expands through usage. Eventually abstract verbal skills are learned, verbal behavior and verbal understanding are possible at a relatively autonomous level. Paivio (in Segal, 1971) maintains these verbal skills—to some extent—are free from a situational context and image. Haber (in Segal, 1971) states that "the perceiver may see the world before he knows it—at the early state of processing he does not know what he sees. Thus in the beginning there is the image before the word" (p 47).

Brain Research

Right brain and left brain research will be reviewed briefly in relation to the creative process and its implications for education. Environmental stimulation and experience appear to be the most important influence on the growth of the brain (Chall and Mirsky, 1978). These are specifically important in overcoming inherited deficiencies or acquired injuries. The concept of plasticity of the brain is most important in understanding how damaged brain function may recover over time in the child. Mastery of sequences/stages can be accomplished by going back to simple known forms to build upon, recognize and to elaborate (Rudel, in Chall and Mirsky, 1978). The importance of timing in learning is discussed by MacLean and Epstein. For example, the emotion of empathy must start early because the region of the brain that is responsible for this emotion develops early. Also, if proper timing is observed more effective cognitive development can be achieved (in Chall and Mirsky, 1978).

Wittrock suggests that in the future educators should match instructional methods to right brain and left brain functions (see examples in the conclusion). Wittrock points out the importance of cerebral lateralization in the development of human cognition. The implications direct educators to plan curriculum based on different cognitive strengths and weaknesses in individuals, by sex, social class and cultural background. He sees a weakness in the left brain as genetic and would therefore give such children success experiences in music and construction for right brain performance (Chall and Mirsky, 1978).

Chall and Mirsky report their fantasy for the future: collaboration between educators and neuroscientists in the 21st century. This will produce a new specialist—an educational neurophysiologist—who will have a knowledge of effective methods of teaching and neurophysiology and neuropsychology (1978).

> ***"The concept of plasticity of the brain is most important in understanding how damaged brain function may recover over time in the child."***

Edwards (1979) was searching for new methods to teach art and during a lecture discovered that she could not talk and draw at the same time. She embarked on a study of split-brain research and concluded that drawing requires a shift from verbal analytic processing (left brain function) to spatial global processing (right brain function). Subsequently, Edwards developed a "new way of seeing" to teach art. Her technique focuses the students on the space around the form, instead of on the form directly. She demonstrated considerable success with this method, working with college students and other normal populations. Her work may help us find

BEST COPY AVAILABLE

new ways to guide the non-verbal child to clarify images first in the process of learning self expression.

Silver (1978) is an art therapist who teaches handicapped children. She hypothesized that brain damaged children could acquire concepts of space, order and class by means of art procedures. She set up an experimental design, with art classes as the independent variable. There were thirty-four children in each group. Significant results supporting her hypotheses were obtained. In addition her study indicated that drawing procedures can serve as an instrument for assessing and developing cognitive growth abilities of children or adults who cannot communicate well verbally. These abilities are to associate and represent concepts, order sequentially, and perceive and represent spatial relationships. These abilities are relatively independent of language (Silver, 1978).

Summary and Conclusion

Art is an integral part of everyday living. It was-and is-a part of mine, stimulated and supported first by my parents, and throughout my growth and development by other people and situations in my environment. Compelled to "follow my nose" and use my art to work with the mentally disabled, I have now come full circle. How can the creative process be used to prevent emotional problems, serve as early intervention in emotional and/or learning disabilities?

Chall and Mirsky's (1978) fantasy is the ideal solution. However, the educational system is resistant to change and creative innovations, and we cannot afford to wait to train a new specialist. We must pool our resources, utilize whatever knowledge we have about development, and begin to apply it.'

There are numerous authors who have described the development of children's art. Kellogg (1970) has done the most comprehensive and descriptive analysis demonstrating that all children, regardless of ethnic background or geographic location move through the same sequences pictorially. This process experienced by all children is the same and is not noticeably influenced by culture or socioeconomic factors or sex until around the ages of five to seven years. Graphic image formation is inherent and moves from the formless to the formed in the child who has no genetic abnormalities. Children often master their environment, their fears and their anxieties through drawing and, in this process, learn. At this early level of development it appears to be much more a function of the right brain. As images are connected, and as organizations and reorganizations take place, one can see the beginning of left brain function.

"We must pool our resources, utilize whatever knowledge we have about development, and begin to apply it."

This is consistent with the literature reported above. Unfortunately, it is also true that our educational system inhibits creative expression and the child that cannot master language and reading is too often identified as learning disabled. Horowitz, (1970) suggests that the ability to acquire language and symbolism is a learned substitute for image formation. But, what is "wrong"? Or is it possible that some children may have a different style for thinking and learning? Silver's study (1978) proved the value of using art to develop certain cognitive skills with handicapped, non-verbal children, and there are many case studies supporting her hypothesis.

Intelligence tests have played havoc with our perceptions and conclusions regarding individuals' cognitive performance; in many instances these tests have been used indiscriminately to label a child or adult as below average intelligence. Over the years, acting as a consultant to schools where art therapy students have been interns, I found I could not reconcile reported I.Q. scores of some children with their drawings that clearly indicated their ability to conceptualize, organize and sequence. In other situations I could not reconile diagnosis of minimal brain damage for some children whose drawings showed they had the ability to identify boundaries, and with structured direction make appropriate spatial relationships (not unlike Edwards' teaching program). Paradoxically, my experience and training enabled me to recognize that some children diagnosed as having behavioral problems did, in fact, have minimal brain damage that had not been detected by standardized testing. In some cases the conclusion was based solely on observable behavior.

Edwards (1979) describes an incident about a child of a friend of hers. The child came home from school excited about a new word he had learned in school and wrote on his little blackboard. The word was "house," and when asked what it meant he had no idea. He had simply visualized it, and the teacher satisfied that he could write it assumed that the child knew what it meant.

> During my graduate work I had the opportunity to test a sixteen year old girl. After one mistake in the verbal subtests she immediately became discouraged and would not continue. Her performance scores, Bender Gestalt and Beery results were almost perfect and her figure drawing was age appropriate for developmental indicators. In addition, her strategies were highly sophisticated. What was not apparent on the test scores was her depression and poor self-concept.
>
> One of my students recently completed her thesis for the master's degree using cartoon drawing to develop comprehension (Hado, 1980). She told the children in her study (all diagnosed as learning disabled with no organic signs) a story and had them recall it in three conditions: recall it verbally; recall it in the cartoon format; and recall it verbally following the drawing of the cartoon. Recall in the second and third conditions was far more successful than in the first.

The vignettes above reflect a small sample of problems we face in meeting the individual needs of children to help them learn. The first child "saw" the word, but did not know what it meant; the sixteen year old girl "knows" many things on a superior level, but cannot communicate it verbally and has experienced so many failures that she sees herself as worthless; my student effectively demonstrated a technique for improving comprehension, but the children in her study are still expected to learn to read by traditional methods.

Cultural and social influences were also mentioned earlier (Horowitz, 1970). When I first entered the field of art therapy in 1962, I learned that most children begin to draw stick figures around the age of seven. The reasons for this seemed to be attributed to the fact that children at that age are preoccupied with school, peers or their own sex and "learned" this stick-figure image in school. Figures with sexual indicators did not appear until around nine or ten years, which is pre-adolescent and was considered an age appropriate addition. Over the years, the stick figure has disappeared and the pre-adolescent form appears much earlier. In discussing this with my colleagues we have concluded that exposure to television has had a tremendous influence on making children much more aware of sexual differences at an earlier age and I now view this as "normal" in today's world. Another example is the marked difference in the drawings of lower socioeconomic black children of the same age and class. The black children's drawings show a slower maturation and appear to be one-to-three years behind. In my experience, and the experiences of my colleagues, the gap closed in adolescence. To my knowledge, there is no statistical evidence to support this—only case studies and anecdotal reports.

Kubie (1958) believed neurotic and creative energy emerged from the same psychic force. In the practice of art therapy it is the creative process that leads the patient back through the psychoneurotic process and eventually to conscious awareness of self and the tools to reorganize and restructure behavior. This therapeutic exploration of the creative process is a learning experience for patient and therapist. With what we already know, and are learning everyday, it seems critical that we continue to explore the creative process to better understand the relationship between image formation and learning, and identify styles of thinking to develop minds that are curious and unrestricted.

I believe that we already have specialists in the fields that Chall and Mirsky would "blend" together to produce a "super" educator. Our specialists need to learn to communicate first with each other verbally and nonverbally and with the creative arts therapists to help individuals utilize whatever learning capacities they have.

Bibliography

Chall, Jeanne S. and Mirsky, Allan F., Eds., *Eduction and the Brain*, University of Chicago Press, Chicago, Ill., 1978.

Edwards, Betty, *Drawing on the Right Side of the Brain*, J. B. Tarcher, Inc. L.A., St. Martin's Press, New York, 1979.

Goldstein, Nathan, *The Act of Responsive Drawing*, Prentice-Hall, Englewood Calif., N.J., 1973.

Hado, Lisa. *A Study of Sequential Cartooning With the Reading Disabled Child*, An Unpublished Thesis, Hahnemann Medical College and Graduate School, Philadelphia, Pa. 1980.

Horowitz, Mardi Jon, *Image Formation and Cognition*. Appleton-Century Crofts, Education Division, Meredith Corporation, New York, 1970.

Kubie, L.S. *Neurotic Distortions of the Creative Process*. University of Kansas Press, Lawrence, Kansas, 1958.

Read, Sir Herbert, *The Forms of Things Unknown*, Horizon Press, New York, 1960.

Segal, Sidney Joelson, Ed., *Imagery-Current Cognitive Approaches*, Academic Press, New York and London, 1971.

Silver, Rawley, A., Ed. D., ATR, *Developing Cognitive and Creative Skills Through Art*, University Park Press, Baltimore, MD., 1978.

Cross-Cultural Psychotherapy and Art

Shaun McNiff, PhD, ATR

Shaun McNiff, PhD, ATR, is Professor of Expressive Therapy, and Dean, Institute for the Arts and Human Development Lesley College Graduate School, Cambridge, Massachusetts.

This article presents an introduction to cross-cultural psychotherapy, with reference to historical theories of art, symbols and myth, and to the therapist working with the client—both individual and groups. Cross-cultural dimensions of art therapy are delineated with a support for further research and cooperation between cultures, with attention given to outcomes relative to art therapy practice and training. An art therapy perspective is presented by the author from his work over a ten-year span with cultural groups from numerous countries. A review of literature is presented which focuses on cross-cultural psychology, defining issues applicable to art therapy. The literature discussed includes psychotherapy practice and training, cultural differences in therapeutic methods, research on cross-cultural mental health, as well as universal and personal symbols. A section on cross-cultural art therapy training brings together the author's observations of training in various countries, art therapy principles, and symbolic focus and transformation.

Introduction

Cross-cultural psychotherapy is a vehicle for the study of the therapeutic process in relation to the many variables of human behavior and universal phenomena. Clarification of transcultural therapeutic elements does not contradict the need for sensitivity to, and knowledge of, the specific qualities of different *cultural* and clinical situations. Throughout history theories of art, symbols and myth have conceptualized universal structural forms to human expression. In the twentieth century C. G. Jung has been the most influential theorist articulating the presence of universal symbolic forms and the existence of motivational forces of a "collective" character. Rank (1959, 1968) and Campbell (1949, 1959, 1972) have documented universal myth structures in varied cultural groups. James George Frazier's *The Golden Bough* (1951), in describing how fundamental principles of similarity and contagion underlie healing rituals in indigenous cultures throughout the world, has been one of the formative influences on twentieth century thought on the subject of universal forms of healing. In his studies of world religions and his research on Shamanism, Mircea Eliade (1964) documented the presence of universal religious forms. Artists responsible for major movements in twentieth century culture (Picasso, Dubuffet, Gauguin, Van Gogh and others) received inspiration from artistic traditions and forms of Africa, the Far East and the South Pacific. D. H. Lawrence and numerous writers have immersed themselves in the mythology of native cultures and ancient civilizations, making applications to contemporary life. Darwin's theories were formulated through world travel and comparative observations of nature. His concepts of evolution influenced Freud who saw both the individual and the human race as developing according to universal principles. Freud's position was that basic psychic processes are universally present in all human experience and there is a fundamental "psychic unity" to behavior in the present and past.

Freud's work helps to guide the process of cross-cultural psychotherapeutic research since his theories of universal psychological dynamics have been criticized for overlooking the particulars of regional cultures and gender. *Totem and Taboo* (Freud, 1955), although making contributions to understanding cross-cultural manifestations of taboo, projection and other phenomena investigated by Freud, also reveals the problems that are created by interpreting all human behavior in terms of personally created theory. The value and brilliance of Freud's research can be better appreciated if viewed from a phenomenological and creative perspective, whereby the researcher engages the universal by investigating private experience. When evaluating the ongoing controversy that his theories have generated together with their lasting power and influence, Freud can be regarded as one of the greatest phenomenologists of the twentieth century.

In cross-cultural research a fundamental taboo is the projection of a personal theory of behavior and values onto other cultural groups. This principle can also be applied to interpersonal relations within a culture. Historically, cultural stereotyping, prejudice and misunderstanding have resulted from these practices. It, therefore, seems important to understand universal elements of the therapeutic process together with variables of culture, personality and individual style with specific reference to cross-cultural art therapy practice and training. A review of literature is necessary to raise issues relevant to art therapy. Cross-cultural dimensions of art therapy need to be delineated to encourage further research and cooperation between cultures. Future outcomes may include both increased attention given to cross-cultural art therapy practice, training and research and the involvement of the arts in cross-cultural studies.

An Art Therapy Perspective

My work as an art therapist has in the past ten years engaged me in world travel and practice with many cultural groups. I have worked with students and faculty from over thirty countries and have taught regularly in Israel, West Germany, Scandinavia, The Netherlands, Switzerland and various regions of the United States. My students and clients have included people from European countries, South and Central America, Africa, the South Pacific and the Far East. As a result of these varied cultural experiences I find that people commonly ask how my work with them compares with groups in other countries. Experience has revealed that cross-cultural commonalities are much more apparent than differences. These characteristics have been apparent not only in my training groups, but also in the clinical practice of art therapy. Common qualities consistently present themselves in imagery and in the process of making art. Cultural groups tend to similarly correspond in approaches to sharing feeling and discussing their group process. It would appear that art therapy as it is being developed in the United States, exhibits definite characteristics of cross-cultural interchangeability. There is a distinct universality to the art therapy process which also applies to other art modalities of dance, drama, music and poetry.

Research and treatment methods developed in the United States tend to be easily adapted to other countries so long as they respect cultural differences. The same applies to application within the United States of art therapy approaches developed outside the country. This is not necessarily true of more language based treatment practices which express the particular values of a culture. Of all expressive modes, language most clearly presents cultural differences whereas the visual arts, music and dance are more interchangeable and universal.

> ***"Cross-cultural dimensions of art therapy need to be delineated to encourage further research and cooperation between cultures."***

The principles of cross-cultural practice can be perceived as applying not only to different countries and cultural groups within a nation or community, but also to different psychological systems of thought and therapy that may be operating within a single clinic. If culture is defined as a systematic mode for interpreting life, the principles of cross-cultural psychology can serve as a guide to relations between individuals. This is particularly true in a pluralistic society. One-sided emphasis on differences makes cooperation difficult. Contemporary cross-cultural psychology, perhaps in response to earlier tendencies to perceive all cultures in terms of "psychic unity," seems to deal extensively with differences. Recent editions of *Psychological Abstracts* list numerous references comparing differences between cultural groups—Anglo versus Chicano, Dane versus Swede, Israeli versus Arab and American Indian versus White. The image of one group versus another is the dominant theme of many of the studies listed. This trend in research is essentially positive in that it satisfies the need to differentiate cultural attributes while creating a complementary need for the study of commonalities. The articulation of differences helps to form individual, community and national identity. Psychologically, it can be said that identity is a necessary individual and collective creation. Heelas and Lock (1981) describe how "No one indigenous psychology is the same as another . . ." and that these native psychological systems are "necessary." In addition to defining identity, indigenous and personal psychologies serve as sources of empowerment and organization.

In my personal experience in cross-cultural art therapy and practice, there has been an interdependence between universal and particular forms of communication. Creativity is the drive toward the particular, providing a specific definition of the self which allows access to universal forces of transformation.

Dr. Kuang Chung Ho, a noted authority on acupuncture, Chinese herbal medicine, Tai Chi and I Ching, told me that methods of healing can be viewed hierarchically in terms of the extent to which they stimulate natural healing functions.[1] In his perception surgery is the lowest form of healing together with the use of synthetic medications. Herbs are higher on his scale because they introduce natural elements to the body. Acupuncture, massage and other related therapies activate natural chemical reactions which promote healing. The highest form of healing—according to Dr. Ho—is the self directed creative process in which a person, without external manipulations by others or the introduction of materials into the body, activates healing energies through action and contemplation. The continuities of Chinese medicine demonstrate how the mind can direct healing transformations within the body.

The energies of art and healing are closely related and often identical. Art therapy has historically taken its philosophical foundations from the "cultures" of western psychiatry and psychology. Art therapy, as a profession, can benefit from theoretical expansion and interdisciplinary studies with fields such as anthropology, religion, the philosophy of art and the practice of art. Respect can be given to the necessary interdependence with the dominant medical and psychological cultures of the mental health field while also engaging art as a primary source of identity. Art therapy and the other creative arts therapies have a unique potential to construct a

---

[1] From a private conversation, November, 1982, Cambridge, Massachusetts.

"Experience has revealed that cross-cultural commonalities are much more apparent than differences."

cross-cultural theory of psychotherapy based on universal properties of the creative process. If this opportunity is to be grasped, it will be necessary to view the art experience as a primary, rather than as an adjunctive mode of therapy.

Review of Literature

The literature on cross-cultural psychology helps to define many issues applicable to art therapy. Leonard Doob, in evaluating recent trends in cross-cultural psychology, notes how the extensive documentation of cultural differences has produced positive outcomes in human understanding but that further investigations of how people differ will be of little value. What is needed according to Doob is validation of the fundamental similarities between people in all parts of the world (Doob, 1980). In the Netherlands, Ype Poortinga also encourages the investigation of cultural similarities (Poortinga, 1982). Art therapy research can be particularly useful in providing visual data.

A. O. Odejide from Nigeria, in a review of literature on cross-cultural psychiatric disorders, maintains that there are few differences between Western and non-Western cultures (Odejide, 1979). Murphy and Leighton through their studies of Melanesian and Eskimo concepts of illness, found that western psychiatric observers experience little difficulty in determining "genuine pathology." Acknowledging clear differences between western psychiatry and the native conceptions studied, Murphy and Leighton found "underlying parallels which strongly suggest that cross-cultural comparisons can be reasonably made." (Murphy and Leighton, 1965).

Although there are universal elements of both sickness and healing, the literature on cross-cultural mental health consistently recognizes the need for sensitivity, respect and understanding of local beliefs. Culture and values often make therapeutic systems and attitudes irrelevant to particular groups of people within the same nation or community (Ahn Toupin, 1980; Sue, 1981; Lager and Zwerling, 1980). It might be helpful for therapists to constantly evaluate their work in terms of its cultural orientation and the extent to which their viewpoints and operational systems are adaptable to the needs of clients and students.

Psychotherapy practice and training have been criticized for imposing stereotypic psychological values onto clients from different cultural groups. Treatment approaches are more likely to succeed if they avoid "ethnic chauvinism" (Patterson, 1977) and have meaning to the client groups by engaging culture in a positive way (Casas, 1976; Kareem, 1978). It has been suggested that therapists working with groups where folk medicine is practiced should familiarize themselves with these methods (Ness and Wintrob, 1981).

Cross-cultural and historical studies of psychotherapy at first glance will present significant differences and varieties ranging from the spiritual and magical enactment of the shaman to the more analytic and scientifically based methods of clinicians today. It is generally believed that the formal principles of therapy are culturally determined and some would suggest that positive outcomes are not likely if there are major cultural differences between therapist and client (Neki, 1977).

Laosebikan (1980) documents how American mental health workers tend to be more permissive and openminded than their more authoritarian and restrictive Nigerian counterparts. According to Nüssner (1980) the Japanese have maintained far more traditional and culturally specific forms of therapy within technological society than the Germans. In a cross-cultural study of creativity Mar'i (1976) reveals how social and economic factors influence creative thinking and expression. Social status as well as sex role stereotypes can affect opportunities for the development of creativity (Raina, 1969). Mar'i's research documents how specific forms of creativity are evaluated in accordance with social values and thus culture can have a dominant influence on creative outcomes of individual behavior. Obvious examples of cultural influences on creativity include the differences in artistic forms produced in societies that value collective participation versus those which emphasize individual autonomy (Rank, 1968).

"It might be helpful for therapists to constantly evaluate their work in terms of its cultural orientation . . ."

While giving full respect to cultural differences in both the formation of personality and therapeutic methods, the continuation of studies which focus *only* on differences will result in a diffusion and separation of human energy. The challenge to an increasingly global society is the integration of universality and regionalism. With the possible exception of Jungian analysis, the major western psychotherapeutic methods of the twentieth century have not been conceived within a universalist theoretical context. However, the international appeal of certain therapeutic methods, such as the theatre inspired techniques of psychodrama and gestalt therapy can be attributed to their engagement of universal forms of expression. Perhaps the clearest contemporary example of universality in psychotherapeutic practice is the recognition of the value of meditation and relaxation techniques inspired by eastern spiritual disciplines. These practices have not only been widely integrated into psychotherapy but also into western approaches to the treatment of cancer, heart disease and other ailments. Meditation practices have similarly affected western religious disciplines. New opportunities for the expansion of art therapy have been suggested by these transformations of health care principles due to the prominent role of "visual imagery" in focusing healing energy.

Research on cross-cultural mental health has been primarily concerned with manifestations of psychopathology and relative standards of deviance in both universal and culturally specific forms (Murphy and Leighton, 1965). There has been less emphasis on cross-cultural methods of treatment. In related fields of religion and anthropology the methods of healers and the structures of symbols across cultures have been studied. Jerome Frank (1974) and E. F. Torrey (1972) have attempted to reveal universal elements of the therapeutic process which characterize all forms of treatment, regardless of theoretical orientation, culture and methodology. Frank stresses that the core element of all therapeutic practices is the belief in the process, while Torrey emphasizes the universal therapeutic abilities to name and explain (diagnose); to fulfill client needs for acceptance (also described by Rogers in terms of empathy and a totally positive feeling for the client on the part of the therapist); and to generate respect from clients. R. H. Prince (1976) believes that all forms of psychotherapy utilize endogenous resources.

Draguns presents the view that "culture pervades the conduct and experience of psychotherapy, and change in one's behavior and well being takes place in relation to cultural referents." (Draguns, 1981, p. 6). He maintains that therapeutic techniques must be "adapted" if they are to be applied beyond the culture of their origin. Although Draguns recognizes universal elements of therapy, he believes that culture ". . . contributes more than just the external and visible trappings . . ." and ". . . is embedded in the subjective experience of therapy . . ." (Ibid., p. 23). This experience of cultural orientation characterizes every therapeutic relationship.

> ***"Artistic energy in all cultures engages and transforms pain, conflict and disorder."***

In a pluralistic contemporary society cultural differences are present within age groups, genders, races, people of different sexual preferences, and political and religious values. If therapy is approached with sensitivity to differences, then all relationships between therapists and clients can be viewed as meetings between cultures. If every therapeutic relationship does involve dimensions of cross-cultural communication, then there is reason to seriously consider the underlying theory of psychotherapy in relation to this fact. I believe that in practice therapists are typically sensitive and adaptive to client needs. However, the more general presentation of psychotherapeutic theory, with the exception of people like Frank and Torrey, has tended to be far more concerned with the projection of the values of therapists.

Because the individual personality can be perceived as a culture and world view unto itself, especially in relation to the intricacies of emotional structures investigated in psychotherapy, it is perhaps unrealistic to make ethnic or cultural matching between therapist and client a priority when conceptualizing optimum conditions for the therapeutic process. However, race, culture, language, values and other factors that I have described are important variables to be carefully considered in evaluating the therapeutic relationship. Cultural similarity will have positive effects in some cases and negative implications in others.

In my personal work I have consistently found that cultural differences have had beneficial effects on the therapeutic process. In all of its forms I find psychotherapy to be a process of sharing subjective perceptions of experience. Quentin Lauer described phenomonological philosophy in terms of "intersubjectivity." In reviewing the history of rationalism in the west since ancient times Lauer maintains that particular "forms" of thought have consistently been considered invalid by those that succeed them, while what Husserl described as the "essences," or "invariants," of experience maintain continuity (Lauer, 1967). The particular therapeutic experience and on a larger scale, all systems of psychotherapeutic thought comprise a vast ecological structure of intersubjectivity. All parts make contributions to the advancement, decline and general validity of the whole.

The process of intersubjectivity characterizes all human relations. Cross-cultural communications simply make the perception of differences more explicit. Within cross-cultural therapeutic relationships and art therapy training groups differences tend to increase curiosity and interest. Barring serious depression and thought disorder, people generally want to learn about others and themselves. The increase of cultural variables tends to stimulate rather than impede the process. This fundamental human motivation to learn about different forms of experience, together with the realities of contemporary accessibility, guarantee increasing developments in the field of cross-cultural psychotherapy.

Cross-Cultural Art Therapy Training

In training sessions I tell participants that the strongest groups and interpersonal relationships encourage and support the revelation of differences. This theory of small group process has been useful in clarifying my more general cross-cultural experience. Whether working with training groups in Israel and Finland, or Cambridge, Massachusetts, I have consistently found that only through respect for differences can we establish strong and trusting relationships. The issues generated by cross-cultural situations serve to highlight this principle which provides an example of how a "universal essence" (respect for differences) works together with variables (the existence of differences) in psychotherapy. There is an interdependence between the universal and the particular.

In practicing cross-cultural psychotherapy and art I have observed universal elements which manifest themselves in every training experience. My historical and anthropological investigations have suggested that there is an "eternal recurrence" (Nietzsche) of these core elements which include the principle of correspondence, creative transformation, symbolic and ceremonial focus, rhythm, catharsis, purposeful action, contagious energy, the emergence of personal form, group validation, opening to others and giving. In the practice of art therapy principles of correspondence, symbolic focus and transformation have particular significance. Symbolic correspondence involves a relationship between inner and outer experience, between the self and the image. The art work not only serves as an expression of inner feelings but its external structure also stimulates internal transformations. These qualities of art are universal and cross-cultural. In *The Golden Bough* Frazer (1951) describes how native healing practices throughout the world are based on correspondence and the principle that "like produces like." In the sixteenth century Paracelsus said that "the outer reveals the inner" and "the similar is cured by the similar." Correspondence serves as the underlying psychodynamic principle of therapeutic practices which establish reciprocal relationships with nature and of symbols which act as focal points for transformative energy. The symbol stimulates and channels healing energy, acting as an external form for inner feelings. The process of symbolic transformation indicates how the psychology of art suggests a universal psychology of healing in that both creativity and therapeutic change involve changes in physical and psychic structure. Artistic energy in all cultures engages and transforms pain, conflict and disorder. What is most bothersome can potentially fuel the creative will. No matter what the content of their theories may be, virtually all systems of psychotherapy involve a fundamental transformation process.

> ***"The value and brilliance of Freud's research can be better appreciated if viewed from a phenomenological and creative perspective. . . ."***

Symbols may change across cultures but the underlying dynamics that I have summarized are consistent. I have often observed that although a specific symbolic form, like the mandala or the cross, may appear in different cultures, varied interpretations may be attached to the image as a result of experience and history. Yet, Gestalt psychologists like Rudolf Arnheim (1954) present the view that on a structural and perceptual level there is a continuity across cultures in terms of how formal configurations affect consciousness. In music and dance, rhythm serves as an example of this process. There are thus universal patterns to the relationship between form, thought and feelings. These sensory qualities of vision, sound, touch and movement are rarely influenced by culture. They are, rather, examples of the universal physiological and psychological qualities of human experience.

In her cross-cultural research on childrens' drawings Rhoda Kellogg (1969) documents universal formal elements. Art historians have observed similar continuities across cultures. There are undisputed universals of line, color, form, shape, texture, material, composition, movement, touch, etc., which produce these similarities. Because of this shared and universal language, art therapy has potential for indepth exploration on a cross-cultural basis that is not possible within more language limited therapies. The art object becomes a bridge between cultures and languages and a common focal point that provides access to universal qualities of feeling. I have found that—even when working exclusively with translators—art objects, materials from nature, rhythmic music and dance, gesture and dramatic enactment have enabled shared communication to take place on a level of mutuality that parallels comparable experiences in situations where a common language exists. The absence of verbal language can actually have positive results, focusing even more energy on the significance of the art object. Body movement, facial expression and the tone of voice are similarly influenced when there is not a shared verbal language. Other forms of communication by necessity begin to compensate for the loss. Art therapists are potentially capable of working successfully with these challenges because in their clinical practice, clients have been referred because of inabilities to communicate verbally. By clinical definition art therapy thus lends itself to cross-cultural practice, providing the beginnings of a universal language and an alternative to verbal communication.

In cross-cultural training sessions I have observed major differences in groups as a result of external conditions within the society such as war versus peacetime; poverty versus affluence; climate; and regional ritual traditions. These culturally specific experiences manifest themselves in both art and group process. It is also interesting how training groups in European countries involve many more men than groups in the United States and Israel. Psychiatrists, psychologists and professional artists in European countries have been more eager to involve themselves in art therapy work than their American and Israeli counterparts.

Cross-cultural differences are often most pronounced between individual group members within the same country. In art therapy intensive training sessions which meet communally for periods of three-to-five days, I have observed how the universality of the artistic process and attitudes of

BEST COPY AVAILA

respect for differences have enabled groups of people from distinctly different personal, political, religious and cultural backgrounds, to cooperate in the most intimate ways. Artistic expression and group responsibility can become vehicles for sharing.

Cross-cultural work is not only a constant source of new stimulation for me but also an ongoing opportunity for learning. Because English is rarely the first language of most of the people with whom I work, I have learned to speak slowly, simply and with increased clarity. My psychotherapeutic vocabulary has also been enriched by terms and concepts from other languages. I have developed an increased sensitivity and respect for the process of translation as it applies to all levels of experience. A graduate student from Switzerland, involved in translating my writings into German, worked with me in exploring the fundamental psychodynamics of the translation process. The good translation not only brings about a transformation of a statement from one language to another, but penetrates to the "universal idea" which relates to the source of the original statement. The translation process can also be applied to therapy where the therapist and client working in the same language translate the emotional expressions of one another and give them back transformed and with additional meaning (Ursprung, 1984). All of psychotherapy and human relations can be perceived as the exchange of personal creations motivated by universal sources.

Summary

Both art therapy and cross-cultural psychotherapy are relatively new areas of study and they have much to contribute to one another. Cross-cultural research and the history of the arts as ways of healing provide a conceptual framework for investigating how contemporary therapeutic processes relate to ancient and worldwide continuities in human experience. Because they share universal languages, creative arts therapists will find many opportunities for international and cross-cultural communication. The specific art object is a tangible meeting point. "Art" can take many forms and may include psychotherapy itself, which has much to gain by expanding its conceptual and creative boundaries.

Bibliography

Ahn Toupin, Elisabeth. Counseling Asians: Psychotherapy in the Context of Racism and Asian American History. *American Journal of Orthopsychiatry*, 50:1, 1980.

Arnheim, Rudolf. *Art and Visual Perception*. Berkeley and Los Angeles: Univ. of California Press, 1954.

______. *Visual Thinking*. Berkeley and Los Angeles: Univ. of California Press, 1971.

Campbell, Joseph. *The Hero With A Thousand Faces*. New York: Patheon, 1949.

______. *The Masks of Gods*. New York: Viking, 1959.

______. *Myths to Live By*. New York: Viking, 1972.

Casas, Jesus. Applicability of a Behavioral Model in Serving the Mental Health Needs of the Mexican American. *Spanish Speaking Mental Health Research Center Monograph Series*, 3, 1976.

Doob, Leonard. The Inconclusive Struggles of Cross-Cultural Psychology. *Journal of Cross-Cultural Psychology*, 11:1, 1980.

Draguns, Juris. Cross-Cultural Counseling and Psychotherapy: History, Issues, Current Status, in *Cross-Cultural Counseling and Psychotherapy*, ed. by Marsella, A. and Pedersen, P. New York: Pergamon Press, 1981.

Eliade, Mircea. *Shamanism: Archaic Techniques of Ecstasy*. New York: Pantheon, 1964.

Frank, Jerome. *Persuasion and Healing*. New York: Schocken, 1974.

Frazer, James George. *The Golden Bough: A Study in Magic and Religion*. New York: Macmillan, 1951.

Freud, Sigmund. *Totem and Taboo*. London: Hogarth Press, 1955.

Heelas, Paul and Lock, Andrew, eds. *Indigenous Psychologies: The Anthropology of the Self*. London: Academic Press, 1981.

Kareem, Jafar. Conflicting Concepts of Mental Health in a Multi-Cultural Society. *Psychiatrica Clinica*, 11:2, 1978.

Kellogg, Rhoda. *Analyzing Children's Art*. Palo Alto: National Press Books, 1969.

Lager, Eric and Zwerling, Israel. Time Orientation and Psychotherapy in the Ghetto. *American Journal of Psychiatry*, 137:3, 1980.

Laosebikan, Supo. Attitudes of Nigerian and American Psychiatric Professionals Towards the Mentally Ill. *Journal of Social Psychology*, 110:2, 1980.

Lauer, Quentin. Intersubjectivity, in *Phenomenology: The Philosophy of Edmund Husserl and Its Interpretation*, ed. by Kockelmans, Joseph. New York: Doubleday, 1967.

Mar'i, Sami. Toward a Cross Cultural Theory of Creativity. *Journal of Creative Behavior*, 10:2, 1976.

McNiff, Shaun. *The Arts and Psychotherapy*. Springfield, Illinois: Charles C. Thomas, 1981.

______. Motivation in Art. *Art Psychotherapy*, 4:3-4, 1977.

______. From Shamanism to Art Therapy. *Art Psychotherapy*, 6:3, 1979.

Murphy, J. M. and Leighton, A. H., editors. *Approaches to Cross-Cultural Psychiatry*. Ithaca: Cornell University Press, 1965.

__________. Native Concepts of Psychiatric Disorder, in *Approaches to Cross-Cultural Psychiatry*, ed. by Murphy and Leighton. Ithaca: 1965.

Neki, J. S. Culture-Conflict and Psychotherapeutic Approach. *Mental Health and Society*, 4:5-6, 1977.

Ness, Robert and Wintrob, Ronald. Folk Healing: A Description and Synthesis. *American Journal of Psychiatry*, 138:11, 1981.

Nüssner, J. The Role of the Psychiatrist Under Different Cultural Conditions: A Comparison Between Germany and Japan. *Confinia Psychiatrica*, 23:1, 1980.

Odejide, A. O. Cross-Cultural Psychiatry: A Myth or Reality. *Comprehensive Psychiatry*, 20:2, 1979.

Patterson, Orlando. *Ethnic Chauvinism: The Reactionary Impulse*. New York: Stein and Day, 1977.

Prince, R. H. Psychotherapy as the Manipulation of Endogenus Healing Mechanisms: A Transcultural Survey. *Transcultural Psychiatric Research Review*, 13: 115-134, 1976.

Poortinga, Ype. Cross Cultural Psychology and the Study of Minorities. *Psycholoog*, 17:11, 1982.

Raina, M. K. A Study of Sex Differences in India. *Journal of Creative Behavior*, 3:2, 1969.

Rank, Otto. *Art and Artist*. New York: Agathon, 1968.

__________. *The Myth of the Birth of the Hero*. New York: Vintage, 1959.

Sue, Derald Wing. *Counseling the Culturally Different: Theory and Practice*. New York: Wiley, 1981.

Torrey, E. F. *The Mind Game: Witchdoctors and Psychiatrists*. New York: Emerson Hall, 1972.

Ursprung, Regula. *Roots of Understanding and Translation*. Unpublished Masters Thesis, Lesley College Graduate School, Cambridge, MA, 1984.

Wallace, Edwin. *Freud and Anthropology: A History and Reappraisal*. New York: International Universities Press, 1983.

Expressive Arts Therapy

The Department of Expressive Arts Therapy at Goucher College offers Master of Arts degrees in Dance-Movement Therapy and in Art Therapy.

Combining academic study with extensive supervised field work, the co-educational graduate programs prepare students to become specialists in the treatment of psycho-social problems.

For more information, contact the Department of Expressive Arts Therapy.

Dance-Movement Therapy—(301) 337-6373
Arlynne Stark, M.A., D.T.R., director

Art Therapy—(301) 337-6376
Christine W. Wang, M.A., A.T.R., director

The Dance-Movement Therapy program is an approved A.D.T.A. program.

Masters Degree Programs
Goucher College
Towson, MD 21204

The Stimulus Drawing Technique with Adult Psychiatric Patients, Stroke Patients, and in Adolescent Art Therapy

Part I: The Use of Stimulus Drawings with Adult Psychiatric Patients in a Day-Care Setting

Louise Sandburg, MSc, ATR

Part II: The Use of Stimulus Drawings with Stroke Patients in a Rehabilitation Center

Rawley Silver, EdD, ATR, HLM

Part III: The Stimulus Drawing Technique as Metaphor in Adolescent Art Therapy

Kristen K. Vilstrup, MA

Louise Sandburg, MSc, ATR, *is Art Therapist at St. Vincent's Hospital, Harrison, New York.* ***Rawley Silver, EdD, ATR, HLM,*** *is author of* ***Developing Cognitive and Creative Skills Through Art,*** *and has additionally authored more than 30 research reports and articles. Other of her works include a drawing test and two exhibitions on art and disabled children and adults (circulated by the Smithsonian Institution).* ***Kristen K. Vilstrup, MA,*** *is Clinical Art Therapist at Shadow Mountain Institute, Tulsa, Oklahoma.*

The stimulus drawings used in these studies consist of a set of 50 line drawings of people, animals, places and things (Silver, 1982). The drawings are designed to be ambiguous or suggestive in order to facilitate their use in diagnostic or treatment, or both. The technique consists of presenting the stimulus drawings (individually or to groups), asking the patients to choose some drawings, imagine something happening to the subjects chosen, then show what is happening in drawings of their own. When response drawings are finished, they are discussed. The authors (Sandburg, Silver and Vilstrup) adapted this basic technique to the needs of the patients with whom each worked. Stimulus drawings with adult psychiatric patients in a day-care setting, with adult stroke patients in a rehabilitation center, and the technique as metaphor in adolescent art therapy comprise this three-part article.

Part I: The Use of Stimulus Drawings with Adult Psychiatric Patients in a Day-Care Setting

Overview

This section presents the use of stimulus drawings over a one year period, with chronic schizophrenic patients at the Preventive Treatment Unit of St. Vincent's Hospital in Harrison, New York. An "Artworks Group" was designed to meet the needs of the lower-functioning patients in the program. The stimulus drawings provided a structured format which offered safe choices while, at the same time, provided enrichment and encouraged socialization.

The stimulus drawings were presented to the patients as a working tool, and the meaning of stimulus was discussed with them. The drawings were displayed and discussed before each of the sessions with the patients; the instructions directed the patients to choose two or three of the stimulus drawings and to think of a story that could include these images. These simple images provided models and also served as a starting point. The instructions remained identical from week to week for the purpose of establishing consistency. Following the instructions, the patients drew a picture from the story that was created (using the stimulus drawing as a motivation). The patients were encouraged to create their own imagery, although they were allowed to copy a stimulus drawing if they felt it was necessary. Copying was most often an issue when a patient first joined the group, and also if a patient was in periods of regression under stress; however, the stimulus drawings helped to overcome fear and resistance, and they helped to decrease comments such as "I can't draw."

The art work was done in a closed room, at a large table that seated eight. 12" x 18" white paper was used, with craypas as the drawing medium. This size of paper, as well as the vivid

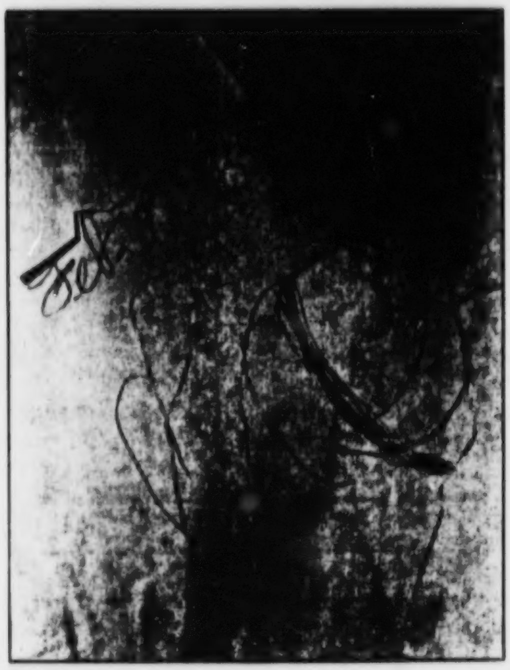


Figure 1

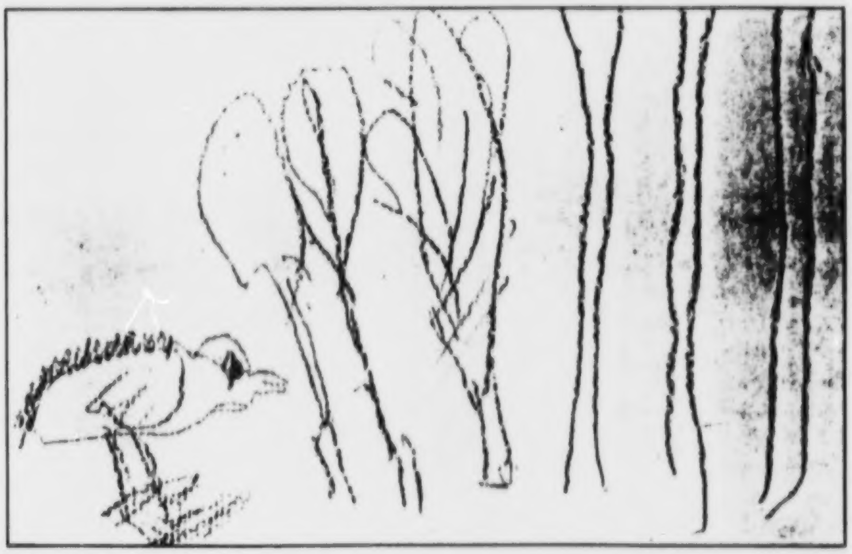


Figure 2

colors, were chosen to stimulate the patients and to counteract any rigidity that might be present. After completion of the drawing, the art work was displayed on the wall, and in some cases the patients chose to display the cue stimulus drawings with their drawings.

The chairs were moved into a semicircle in order to arrange the patients comfortably in preparation for viewing the completed and collected art work. The therapist encouraged interaction with questions such as "Is there anything you would like to know about one of these pictures?" Each patient was given ample time and encouragement to verbally present his or her own art work.

The structuring of the sessions around the stimulus drawings helped to focus on specific ideas, and it helped to stem the flow of loose associations; it was previously noticed that at time the loose associations overwhelmed the patient and made working in art a threatening process. This group served as an introduction to the creative process for patients who had never before explored art. The art experience was presented as a problem-solving task, thereby making the process more accessible and enticing to those with poor self-concepts. Group cohesiveness was built by encouraging even the most minimal participation. When a patient was feeling particularly stressed and too agitated to draw, he or she would often choose a stimulus drawing and participate in the verbal processing, rejoining the group the following week as a full participant.

The direct involvement in developing one's own art work from the drawings and processing it within the group often brought up therapeutic issues. The processing often moved from the art work itself into aspects of the patient's own life experiences. At times, patients shared these past experiences, discovered peer identification and received peer support. Uncharacteristic affect flexibility and spontaneous humor were periodically observed.

The art work was often cathartic, it served as a source of pride and pleasure, and it provided accomplishments for patients who seldom experienced these positive feelings in their daily lives. The group served as a model for interpersonal interactions and the stimulus drawings, in turn, often served as the focal point. The drawings also promoted common shared experiences; patients often remembered who had used a particular drawing and they reminded each other of previously chosen stories.

After one year of work with the standardized stimulus drawings, the patients decided to construct their own set of story cards using the collage technique to construct these cards. They took this initiative after having gained much self-confidence in this long-term process, and they used the stimulus drawings as their working models to move (although somewhat tentatively) in more personal directions.

BEST COPY AVAILABLE

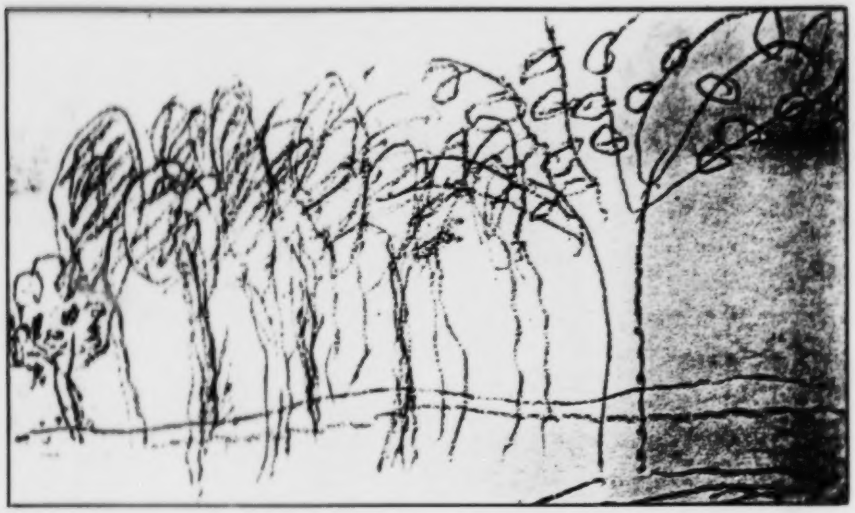


Figure 3

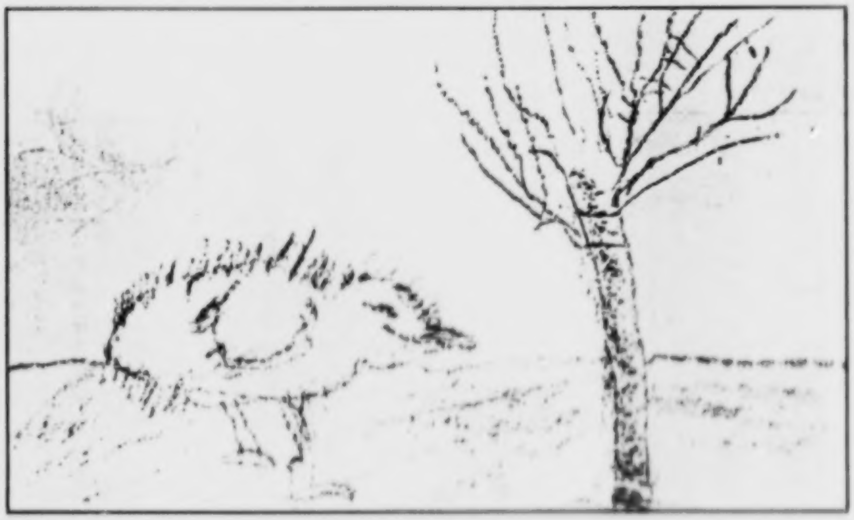


Figure 4

Case Example

Ms. A is a 69 year old single, white female diagnosed as hebephrenic schizophrenic, who (despite constant delusions and hallucinations) was usually smiling and cooperative. She had trained as a classical pianist but refused to play the piano anymore. The group served to introduce her to a less conflicted creative outlet. Although her artistic "style" was basic, and limited by the organicity of tardive dyskinesia, her art work reflected her vigor. She took great pride in her work and was pleased when she learned how to use a horizon line to ground her imagery.

The style of Ms. A's first image of a "Queen" (Figure 1) revealed her hesitancy in the new group setting. She was quite involved in the drawing process, physically isolating herself from the group which she later rejoined to proudly discuss her art work. The elaborate hat corresponded to a tumor on her head. Her next picture (Figure 2) was a "Curious Chicken in the Forest" and at this point she used the group to explore her self-experiences. Ms. A's third image (Figure 3) portrayed fall trees, and included a horizon line and multicolors. The chicken, looking smug, reappears in the last drawing (Figure 4) and this image is more complete than in previous work. As she moved through this series of drawings, Ms. A received positive feedback on her progress from her peers as well as support from the therapist. These drawings were done over a one year period where progress in the group helped to promote progress that was noted in other aspects of her treatment.

"...The stimulus drawings helped to overcome fear and resistance, and they helped to decrease comments such as 'I can't draw.'"

Conclusion

Richard Lamb states that:

> ...many long term severely disabled psychiatric patients find only emptiness. A positive sense of meaning in life is usually associated with membership in groups...as these persons with limited capabilities become older, they have experienced repeated failures in dealing with life's demands and in achieving their earlier goals. (Lamb, 1982)

A need for success within a group counteracts the "common sense of defeat" that Arthur Robbins sees as a trait of schizophrenia (Robbins, 1976). A highly structured group, built around the stimulus drawings, correlates with Sylvia Honig and Kathleen Haynes' findings that identify the need for consistency within the treatment regime when working with chronic patients in long-term settings (Honig, et al, 1982). Helen Landgarten writes about "cooperative task orientation," wherein the sheltered group setting serves as a trial area for interactions that develop socialization skills to be used and further developed elsewhere (Landgarten, 1981). The "stilted styles," also mentioned by Landgarten, are often seen in the art work of patients in day treatment settings. Many of these

"The structuring of the sessions around the stimulus drawings helped to focus on specific ideas, and it helped to stem the flow of loose associations. . . ."

points were directly applicable to the Artworks Group and to the art produced by the patients within the group. The stimulus drawings within this one year period served as concrete tools for focusing fragmented thinking patterns, and allowed risk-taking in a safe setting.

The Preventive Treatment Unit enriches the quality of life for these chronic patients in treatment. The Artworks Group is only one of thirty different activities available within this structured milieu. The stimulus drawings were the core of this group, serving as communication tools to evoke images from past history, allowing risk taking, and forming the basis for development of social and artistic skills. They served as a stimulus for change for these patients who live with daily deprivation.

Part II: The Use of Stimulus Drawings with Stroke Psychiatric Patients in a Rehabilitation Center

In this study, the stimulus drawings were used for diagnostic and therapeutic purposes with patients who had language impairments as a result of cerebral accidents.

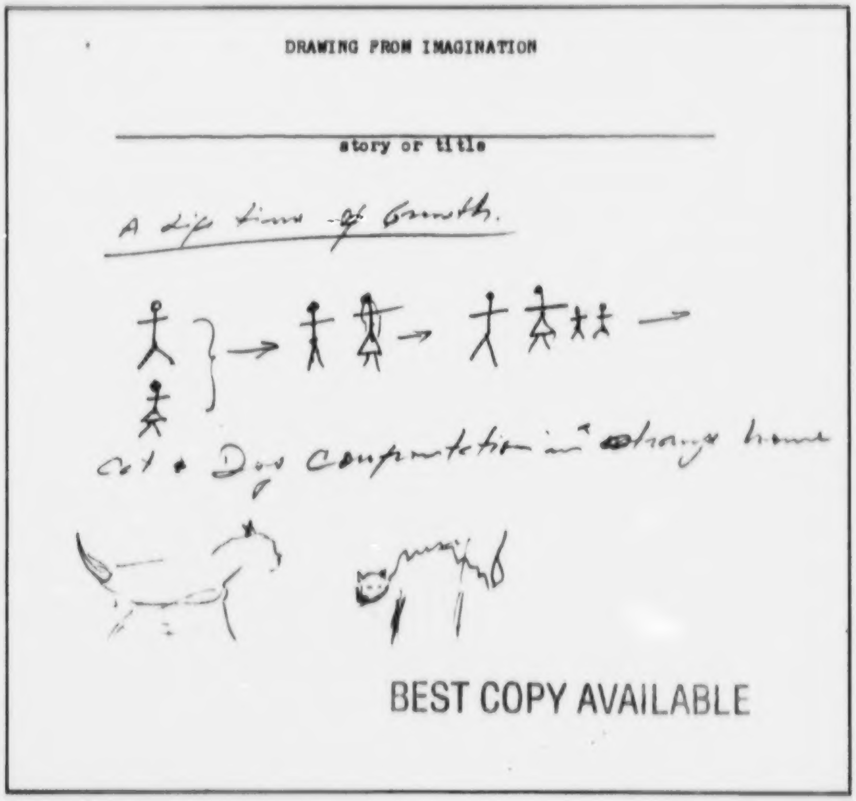
To illustrate, Mr. O, age 56, had a cerebral hemorrhage. Although he spoke fluently, his vocal responses did not always make sense. He could not read aloud and tended to confuse grammar and verb tenses. He also had difficulty following a series of commands, such as "Put the book on the table, and put the pencil in your pocket." His greatest difficulty, according to the medical report, lay in expressing concepts. Although he was discharged from the hospital, Mr. O returned once a week for speech therapy.

As an art therapist, my goals were: 1) to determine whether Mr. O's impairments were cognitive as well as linguistic; and 2) to help Mr. O overcome his difficulties in expressing concepts.

Diagnostic Information

The stimulus drawings (SDs) were used in conjunction with the Silver Drawing Test (1983) which was administered as a pre-post instrument in the first and last sessions. The objective was to obtain information about his ability to perceive, form and represent concepts nonverbally as well as verbally.

In the pretest Mr. O had no difficulty with two of the three subtests, scoring the maximum 15 points in Drawing from Observation (spatial concepts) and Predictive Drawing (the ability to deal with hypothetical situations). In the third subtest, however, Drawing from Imagination (the ability to select, combine and represent), Mr. O's graphic response was somewhat garbled. This corresponded to, and resembled, his expressive language. This response included two drawings (see Figure 5). The first, titled "A Life Time of Growth," shows stick figures of men, women and children. Although the figures are related by arrows, their meaning is unclear. His second drawing (also in Figure 5) is more meaningful: titled "Cat and Dog Confrontation in a Strange Home," it may reflect his feelings about his hospital experience, or perhaps his feelings about taking the test. His first drawing was scored 5 points; his second, 8 points (from a maximum possible 15 points). Comparing these scores with our norms for children in the second grade, Mr. O's scores were in the 7th and 40th percentiles respectively. In other words, he seemed to be performing at a level that was low for 8 year old children.


DRAWING FROM IMAGINATION
story or title
A Life time of Growth.
Cat + Dog confrontation in strange home

BEST COPY AVAILABLE

Figure 5

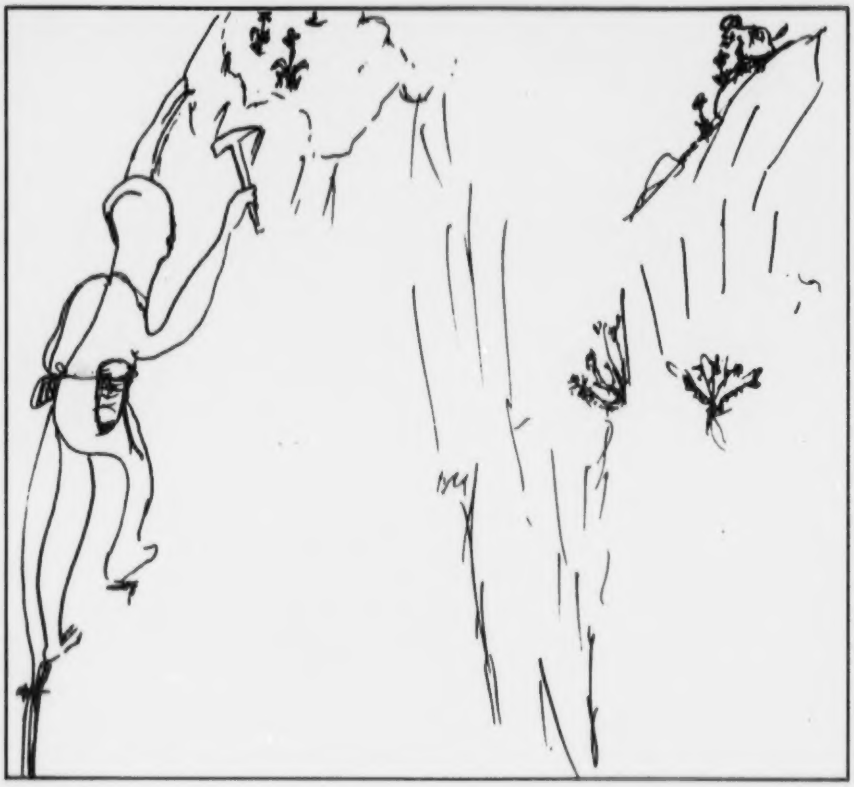


Figure 6

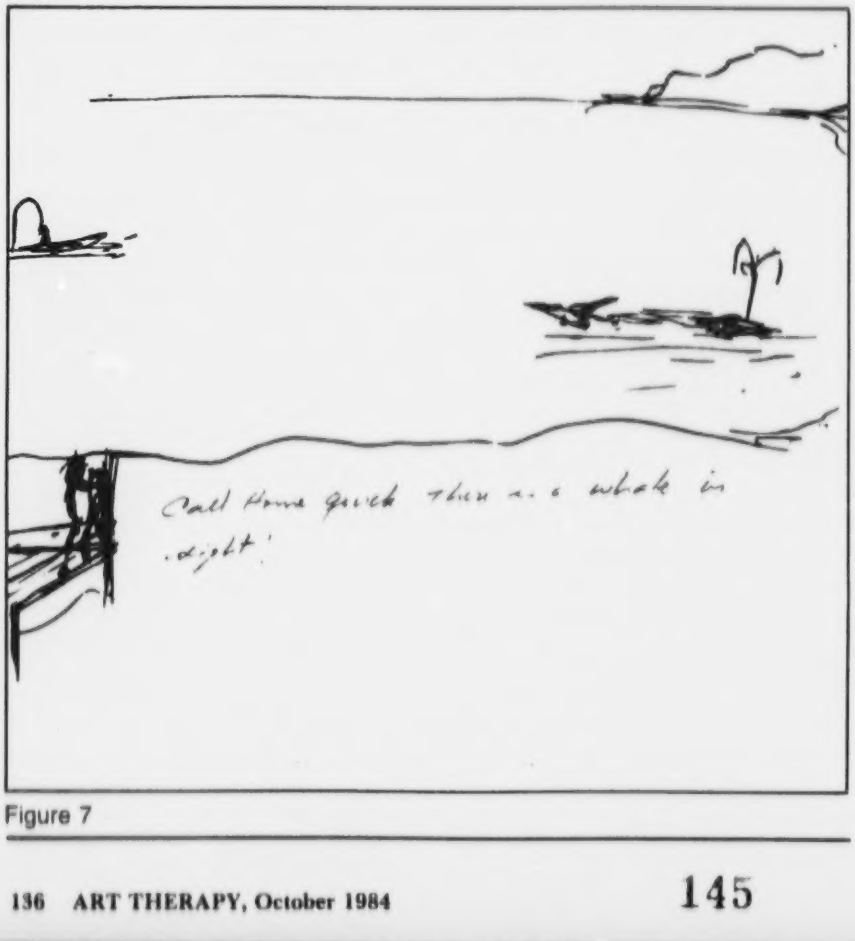

Call Home Quick Ther a a whale in
sight!

Figure 7

Did this low score reflect cognitive impairment or language impairment, or both? To obtain further information, the stimulus drawings were used.

Therapy

The therapeutic objectives were to encourage Mr. O to express concepts through drawings followed by talk, as well as to provide him with opportunities to ventilate feelings which he could not verbalize. We met in four weekly hour-long sessions.

In the first session the stimulus drawings (SDs) were spread out on the table between us, clustered into two groups: people and animals in one group, places and things in the other. Mr. O chose a mountain climber, then drew Figure 6, which he titled "Gathering Magic Herbs." In Mr. O's drawing the mountain climber was changed from a child into an apparently masculine, faceless adult. Mr. O added the climbing equipment and mountain scenery, showing the climber higher than an airplane and the tree line just below the herbs on the peak. On a neighboring peak, a mountain goat has reached the top and is savoring the rewards. The theme of this drawing seems to be striving to overcome obstacles, with the likelihood of success. Climbing mountains is an appropriate metaphor for trying to regain one's health. This drawing shows no difficulty with forming and expressing concepts, and its upbeat character presumably reflects a need or wish to overcome the dangers and difficulties of his illness. The drawing, scored as though it had been a response to the test, received the highest possible score of 15 points.

Returning to the stimulus drawings, Mr. O selected a whale and a seascape, then drew Figure 7 titled "Call Home Quick. There is a Whale in Sight." In trying to explain his drawing, Mr. O pointed to the person on the dock and said "sing walk walk." I asked if he meant telephoning. He replied "yes," adding that his words "do not come out right." Mr. O then talked about the onset of his stroke.

He had been having lunch with a friend when suddenly he found that he was unable to talk or write. Even so, he said that he was fully aware of what was happening at the time as well as later, when he was in the hospital. His choice of a whale with water spraying from its spout is an interesting metaphor for a cerebral hemorrhage.

The following week Mr. O chose the stimulus drawing of a city street, then he made two drawings: people with crutches and canes (titled "Handicapped People That Can be Trained to New Aspects of Machine Maintenance"), and a drawing of someone walking along dotted lines across city streets (titled "Paths to Learning Machine Maintenance"). Mr. O then talked about his work as an executive in a large company, and he noted that he was planning to return to work soon. Although the subjects of his drawings were handicapped in walking rather than talking, and their work involved maintaining machines rather than communications, they seemed to represent Mr. O in disguise. Like the mountain climber in Figure 6, the figure symbols are overcoming obstacles: they can be trained, they can find the paths through a maze of city streets, and perhaps they can also help him to conquer fears and fulfill wishes indirectly by projecting them onto his surrogates.

At the last therapy meeting the Test was administered again. This time Mr. O's score on the Drawing from Imagination subtest yielded the maximum possible score. This subtest resembles the SD technique in that the examinee is asked to look over a different group of 15 SDs, choose two, think of something happening to the subjects selected, draw what is happening, and add a title. (Directions: "Don't just copy these pictures. You can change them and draw other things, too"). Mr. O chose the snake and the cat, then drew Figure 8, titled "Hedges May Hide Surprises." His snake (in the hedge) faces away from the cat, apparently in retreat. The cat, facing toward the snake, partly resembles the "test booklet cat" in that its back is arched and its tail is raised. Unlike the test drawing, however, Mr. O's cat smiles and its eyes are open. Like the mountain climber and the handicapped people in previous drawings, his cat seems about to achieve success—in this case, mastering an unpleasant surprise.

It may be that Mr. O was preoccupied with his return to work the next day and that the cat represented himself (Mr. O), courageously facing up to and dominating a threatening situation. On the other hand, it may be that Mr. O identified the snake with himself. There was no way to know, and Mr. O offered no explanation; he spent the remaining time saying goodbye.

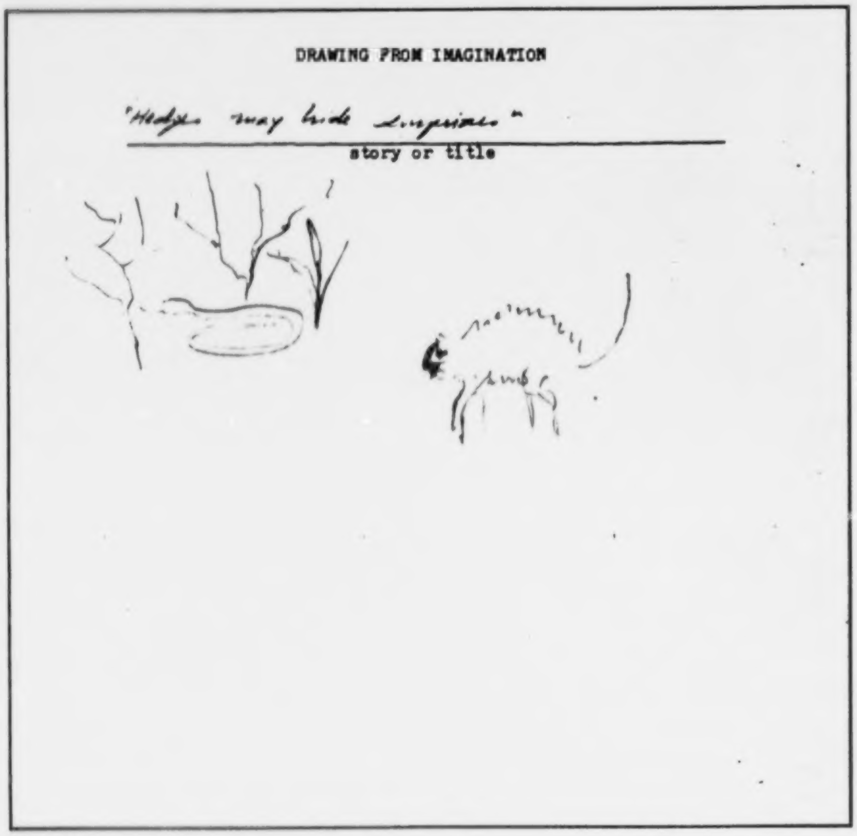


Figure 8

It seems evident from Mr. O's response drawings and explanatins that his impairments were not cognitive, but linguistic. His drawings also suggest that art experiences provided him with opportunities to express some of the fears, needs and wishes that he was unable to put into words.

Part III: The Stimulus Drawing Technique as Metaphor in Adolescent Art Therapy

The stimulus drawings by Rawley Silver (hereafter referred to as stimulus drawings), provide a valuable resource for art psychotherapy with children and adolescents. Although these drawings were originally developed for assessment purposes, this section will focus on the stimulus drawings as a projective technique with adolescents in an inpatient psychiatric setting. The drawings stimulate symbol formation and provide insight into strengths, conflicts, and maladaptive defenses of even highly resistive clients. The metaphoric level of material is less emotionally charged, and can often serve as a bridge to the child's life situation. Furthermore, the therapist has a better chance of effectively being understood while speaking within the child's own symbolic language (Ekstein and Wallerstein, 1957).

Directives and Technique

The child is provided with paper and pencils or other suitable media. The four stimulus card groupings of People, Animals, Places and Things are placed in front of them and the following directions are given:

> Choose 2 or 3 cards which can be combined together to illustrate a story. You may choose cards from any category, but do not take more than one card from a single category.

After the cards are chosen, continue with the following:

> Draw a picture using the *ideas* from the cards you have chosen. Try not to copy the cards directly, but use them as a starting point for your picture.

Upon completion of the drawing, the child is asked to explain it by telling a story which contains a beginning, a middle and an end. Finally, the therapist asks the child to provide a moral or title for the story.

The child's personal symbols and metaphors are presented through the selection of stimulus cards and the storytelling process. A varied choice of mood and setting are available within the combinations of the 50 possible stimulus card selections. Drawings may range from creative fantasy to tragedy, depending upon the life experience and current affect of each individual.

As in any art work, no single stimulus drawing should be interpreted to represent overall functioning of that individual. These projective responses, as reflections of internal states, will vary from day to day. Common characters and themes surfacing over time, however, offer the therapist a more genuine understanding of the child's inner process (Silver, 1983).

Schematic deviation from the original stimulus cards is a creative variable, and by no means should be perceived as being abnormal. In the author's experience, however, major alterations in form or subject often punctuate a critical theme for that individual. Figure 9 illustrates the stimulus cards selected by a 14 year old boy with a history of repeated abuse and abandonment. During the drawing process the whale, often selected by adolescents to symbolize venting or "blowing off steam," was transformed to a shark moving toward a frightened man (as seen in Figure 10). When asked if this change was significant, the young man discussed the fear he felt when his mother used to "take her anger out" on him.

When the child presents a story which contains a great deal of unresolved conflict, it is important for the therapist to assist that child in sealing over raw affect and achieving closure. The stimulus drawings often enhance the primary process orientation of the art media, evoking powerful affect-laden material relating to family, home and interpersonal relationships. Keeping interpretation within the metaphor at these times may prove less threatening to a frightened child. The metaphor can be used to manipulate toxic primary-process material without prematurely lifting its meaning into the language of the secondary process (Caruth and Ekstein, 1966).

One method very helpful in facilitating this process is the "Mutual Storytelling Technique" developed by Dr. Richard Gardner. This technique provides the therapist with the opportunity to create a second story containing the same characters and theme, but presents the child with

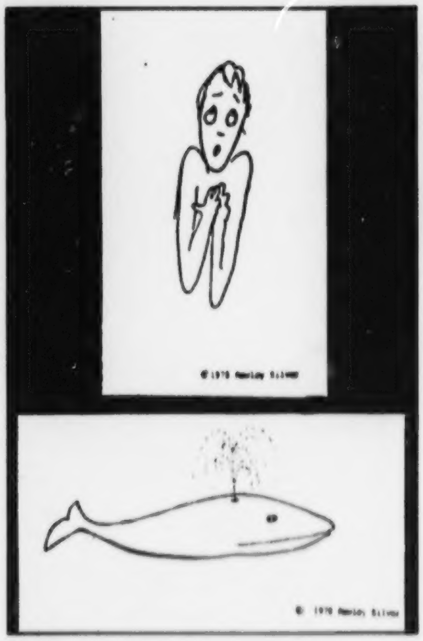


Figure 9

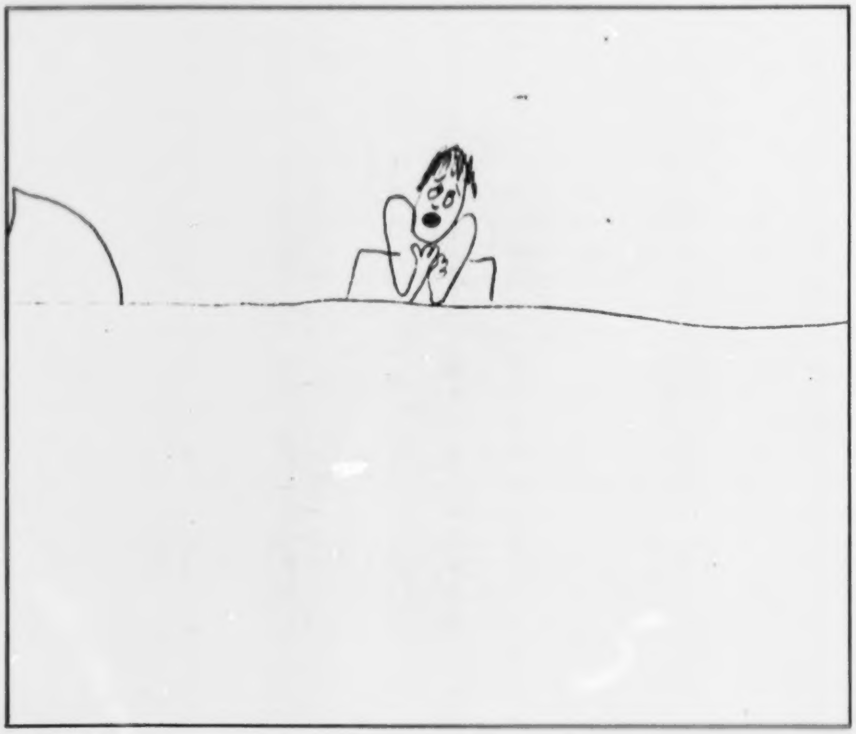


Figure 10

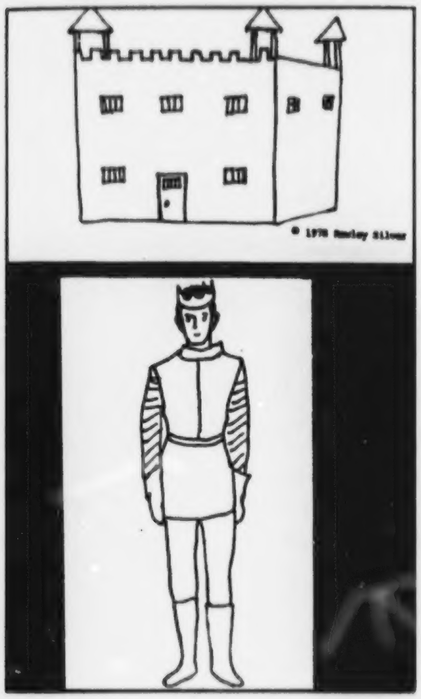


Figure 11

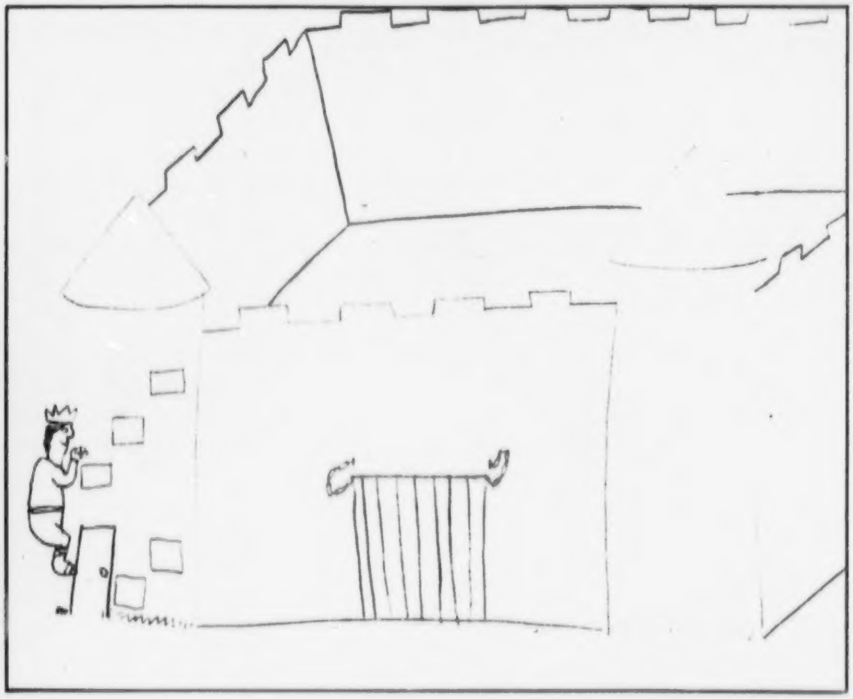


Figure 12

healthier adaptations and coping choices. Gardner (1982) explain his technique as follows:

> After asking myself, "What would be a healthier resolution . . . than the one used by the child?," I create a story of my own. My story involves the same characters, setting, and initial situation as the child's story, but it has a more appropriate or salutary resolution of the most important conflicts. In creating my story, I attempt to provide the child with more alternatives . . . Therapy must open new avenues not considered in the child's scheme of things. (page 69)

Readers interested in this technique are referred directly to the source for a more comprehensive explanation of story analysis (Gardner, 1971).

A corrective drawing has similar potential, and can be used separately or in conjunction with the storytelling technique. This process allows the child and/or therapist to make changes on the original drawing which helps to alleviate a threatening situation. For example, a dragon in pursuit of a helpless victim can be "contained" with an added fence to help that child set healthy limits.

Case Example

Frequently, the situation arises in which clients recognize their personal metaphors and choose to process them directly. This was the case with Michael, a withdrawn 16 year old with a history of withholding anger until he blew up in violent acting-out episodes. The last of these incidents culminated with Michael kicking down a door because he felt his father "wasn't listening" to him. Michael's natural parents divorced seven years ago. Feelings of rejection developed as he was traded back and forth between parents. He felt especially rejected by women, a position which was continually reinforced by the covert actions of his step-mother. Due to non-verbal tendencies and past therapeutic failures, art psychotherapy was determined to be the treatment of choice for this young man. Despite psychological tests indicating little capacity for insight, Michael worked actively through metaphor. Choosing the stimulus drawings of a king and a castle (Figure 11) Michael illustrated his feelings of isolation (Figure 12). His story went as follows:

Michael: "One day the king forgot his keys and had to climb the wall. So he went to climb the wall and just as he got to the top he fell."

Therapist: "What happened next?"

Michael: "He went to the hospital, and found out he had a spare set of keys to get back in, but he also realized that this door (pointing to the small door below the king) was open all along."

Therapist: "Does any of this story fit for you? Did you ever feel a time when you felt locked out and tried to climb in, but kept falling?"

Michael: "In a way I feel like that with my family. I feel like they're on the inside and they lock me out."

Therapist: "But you have a spare set of keys. Do you have any ideas what those keys may be that you already possess?"

Michael: "I don't know, I'm so confused. I just can't talk to my step-mother. She's the one that really locks me out."

Therapist: "I think we need to work on what keys are there for you, and for you to remember that, somewhere in that fortress is an unlocked door. Can you think of who or what the door might be?"

Michael: "The door might be my father, but its a small door. It has to be a lot bigger before I could fit through."

Michael's story not only demonstrated that he had capacity for in-

> ***"As in any art work, no single stimulus drawing should be interpreted to represent overall functioning of that individual."***

sight, but it also provided a valuable therapeutic focus underscoring the need for a stronger alliance between father and son. Weekly family therapy sessions were temporarily revised to meet this goal. Father and son were seen in a dyad for several weeks to increase communication and strengthen assertive skills. With his father's support, Michael was able to overcome the fear of expressing himself to his step-mother, and was able to relinquish his role as the "identified patient" in the family.

Conclusions

In summary, the Rawley Silver Stimulus Drawings are a valuable projective tool for clinicians working with adolescents and children. These drawings provide a wonderful opportunity to enter into a child's own symbolic language. The storytelling process offers further insight into the child's strengths and weaknesses, and allows the therapist a vehicle to facilitate conflict resolution.

Bibliography

Caruth, E. and Ekstein, R. "Interpretation Within the Metaphor—Further Considerations." *American Academy of Child Psychiatry Journal*, 1966, Vol. 5 (1), 35-45.

Ekstein, R. and Wallerstein, J. "Choice of Interpretation in the Treatment of Borderline and Psychotic Children." *Bulletin of the Menninger Clinic*, 1957, Vol. 21, 199-207.

Gardner, R. *Therapeutic Communication with Children: The Mutual Storytelling Technique*. New York: Science House, 1971.

Gardner, R. "The Mutual Storytelling Technique in the Treatment of Anger Inhibition Problems." In: *Helping Through Action: Action Oriented Therapies*. Edited by Nickerson, E. and O'Laughlin, K., Amhearst, Mass: Human Resource Development Press, 1982, 66-86.

Honig, S. and Haynes, K.M. "Structured Art Therapy with the Chronic Patient in Long Term Residential Treatment." *Arts in Psychotherapy*, 9, 4, 269-292 (Winter, 1982).

Lamb, H. Richard. "Young Adult Chronic Patients: the New Drifters." Hospital and Community Psychiatry, *33*, 465-468 (June, 1982).

Landgarten, H. *Clinical Art Therapy*. New York: Brunner Mazel, 1981.

Robbins, A. and Sibley, L.B. *Creative Art Therapy*. New York: Brunner Mazel, 1976.

Silver, R. *Stimulus Drawings and Techniques in Therapy, Development, and Assessment*, 1982. (Available from the American Art Therapy Association, 11800 Sunrise Valley Dr., Suite 808, Reston, VA 22091)

________ *Silver Drawing Test of Cognitive and Creative Skills*. Seattle: Special Child Publications, 1983.

Plan to Attend

Myths, Visions, Realities

15th Annual Conference

of the

American Art

Therapy Association

October 31 - November 4, 1984

J. W. Marriott Hotel

Washington, D.C.

VIEWPOINTS

***VIEWPOINTS** provides a forum for sharing ideas and graphics about issues facing art therapists. The following selections are related in their emphasis on art.*

Editor's Preface

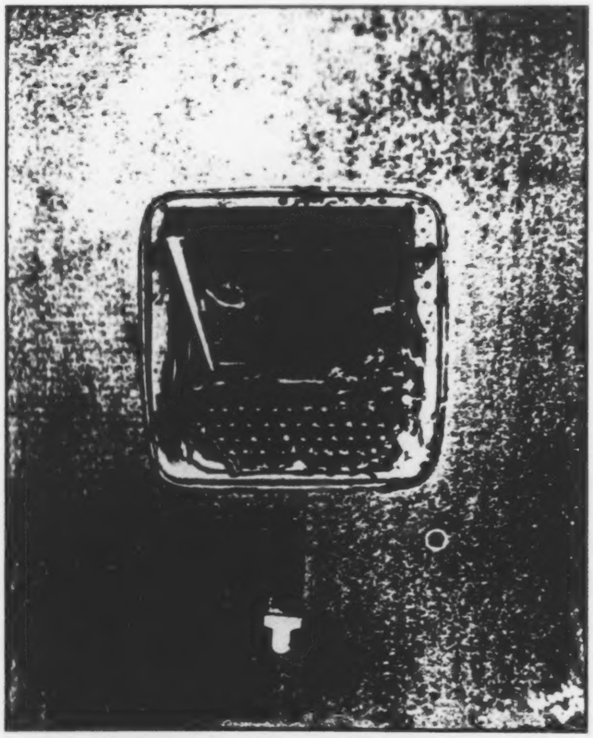
*Yolande Porter, from Toronto, Canada, shared a series of slides, written documentation (including poetry) and narration of personal tragedy (i.e., the burning of her home, the death of her husband, and economic trouble within a relatively short time) and subsequent healing and rebirth experiences through art therapy. The photographs of her paintings were categorized into three series headings: Series I, **"Journey Through Hell"**; Series II, **"Uncertain Journey"**; and Series III, **"The Sun Series."** Through this personal testament and reaffirmation of the power of art therapy, Mrs. Porter shares with readers a few personal statements, together with selected photographs from each of the series. The complete collection of paintings will be exhibited at the Robarts Library, University of Toronto in 1985.*

Artist's Statement

[In the ***"Journey Through Hell"*** series, the pieces of debris, charred fragments, toys and broken machines]- ". . . bears no likeness to anything I previously painted . . . I did not realize what I was actually creating. The story itself is literal. The material used to create the pieces are authentic and survived by mere chance . . . After (its) completion, I spent months reviewing my own work realizing, to my amazement, that everything had stemmed from my subconscious and that it encompassed my entire life. It took months for me to allow anyone to see what is in reality a private part of me."

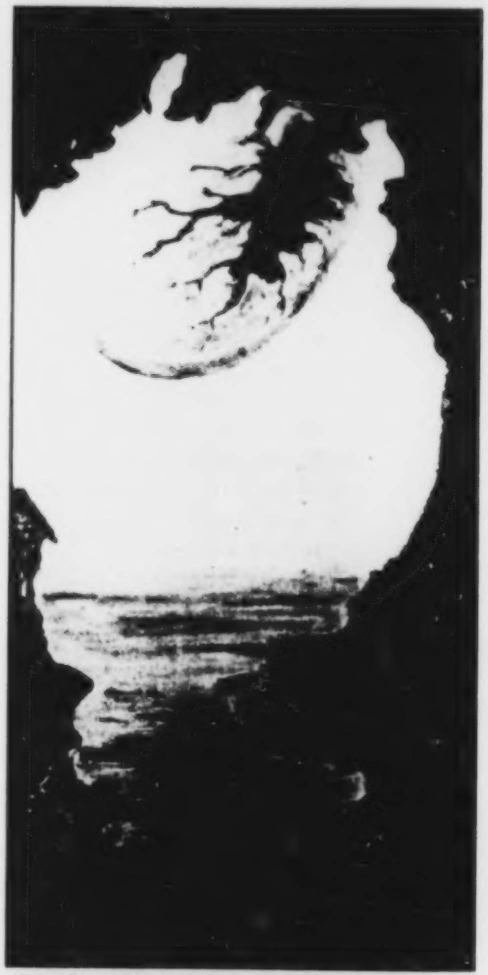
"The healing series ***"Uncertain Journey"*** started in a strange way . . . This was how I saw myself—an empty shell, black inside . . . over a black, bottomless ocean . . . The lowest ebb in my life, and what more could I hope for than a green valley . . ." For ten months I was like a possessed person, and if my life depended on it I could not have stopped the outflow. I now realize that it was as though something has festered and burst—all the poison drained away." [As the "Uncertain Journey" series evolved, the primary focus was on healing, implemented by the therapeutic process of painting.]

[Finally, the ***"Sun Series"*** was created to celebrate the reentering life with special focus on the sun, birds, blossoms, the spirit and the dance.] "After a decade . . . when I left the darkness and broke the last bonds that confined me, there was the Sun—at last . . . Morning and evening I watched the sun bird and gazed upon spectrums appearing in many hues . . . it was time to return to earth . . . These complete the cycle and are intrinsic to it. Though the wound is now healed, the scar remains."

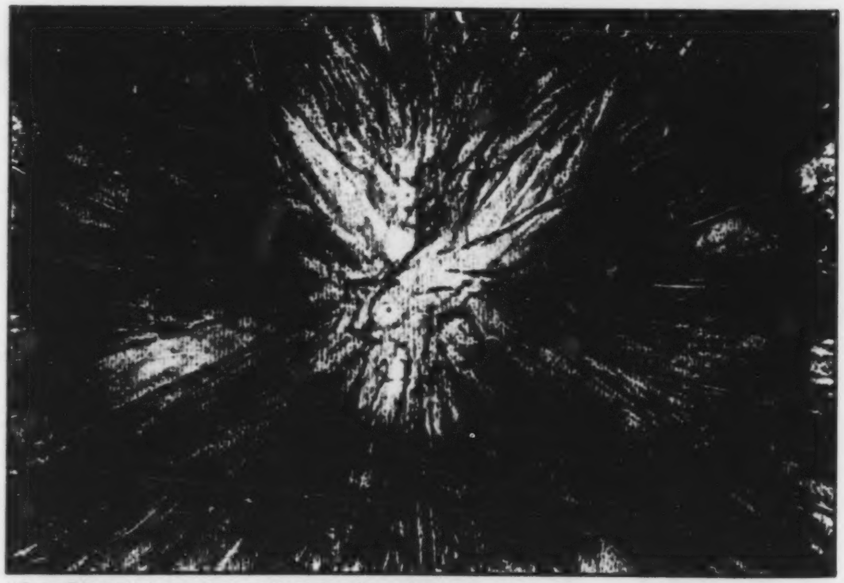


"Charred Machine" from Series I: "Journey Through Hell"

BEST COPY AVAILABLE



"Egg Over Black Bottomless Ocean" from Series II: **"Uncertain Journey"**



"Sun Bird 1" from Series III: **"The Sun Series"**

BEST COPY AVAILABLE

REVIEWS

Book Reviews

Psychotherapy Through Imagery

Joseph Shorr. New York: Thieme-Stratton, 1983
(476 pages) $19.95

Reviewer ***Evelyn Virshup, PhD, ATR*** *is an author, an art therapist in private practice, and an active member of the American Association for the Study of Mental Imagery.*

It is interesting to remember that less than 10 years ago imagery was just beginning to emerge as a respectable clinical tool and experimental science. One of a handful of pioneers, Joseph Shorr wrote two of the landmark books in this field, *Psycho-Imagination Therapy* and *Psychotherapy Through Imagery*, in 1972 and 1974. Now, in a more receptive environment, these two classics have been expanded, brought up to date, and combined in one book, *Psychotherapy Through Imagery*.

This is a biased review. I have been a fan and admirer of Joseph Shorr since I attended one of his seminars ten years ago, and was first exposed to his ingenious and powerful methods for evoking personal imagery. I have been using many of his techniques successfully since. I am in good company in my enthusiasm. Eric Klinger (University of Minnesota) says in the Introduction to the book, that Joseph Shorr is among the most fertile contemporary creators of psychotherapeutic techniques. Jerome Singer of Yale writes, "Few people I know are as ingenious and imaginative as Dr. Shorr in generating situations that can evoke from patients powerful and meaningful imagery."

Psychotherapy Through Imagery is an encyclopedia of various directed imagery methods that Shorr has developed in the course of direct patient care. They have been validated through his extensive clinical experience, and are organized and categorized to make them useful and available for every conceivable clinical situation. The book is bursting with suggestions which, as we know, have to be experienced to be fully understood. Individually, his imaginative questions are invaluable. When combined, they act synergistically, helping the client bring to awareness his conflicts, the traumas behind them, and his feelings about those experiences.

Dr. Shorr is a clinical psychologist, not an art therapist; his book is directed to talking psychologists, and does not mention art or art therapy. But not to worry: as an art therapist, I have tested his theories and used his techniques. Not only do they translate to our language, but art gives them a dimension of which even Shorr may not be aware. Drawing provides his images with a range and variety of information hardly possible with linear verbal discourse.

What is Dr. Shorr's conceptual framework? Go directly to the chapter called "Imagination and Psychotherapy." After a fascinating historical overview of imagery in psychology, you will find that he has been influenced by Freud, Sullivan, Horney, Laing, Jung, May, Desoille, Leuner, Rogers, symbolic interactionism, various existential therapists, and the empirical tradition of general psychology. Shorr brings all of these elements into relationship with one another within his orientation to imagery and his well developed techniques.

Shorr quotes R.D. Laing frequently . . . "One is in the first instance the person that other people say one is. As one grows older one either endorses or tries to discard ways in which others have defined one." Shorr uses imagery to help strip away false identities. The psycho-imagination approach used in this framework is specifically geared to help people become strong enough to define themselves accurately. He believes that one of the principle functions of imagination is the resolution of conflicts between outer reality and inner fantasy. Imagination is the "modus operandi" which harmonizes these opposing components. The active and conscious use of imagination helps to distinguish the difference between one's world and that of others.

He defines the therapeutic relationship as one of basic equality between two people whose roles are different. He found that as patients became "accustomed to this kind of therapy, it was less and less necessary to make any interpretations for them . . . It would be possible to help focus the patients to greater awareness, where they would be forced to face the truth for themselves." Shorr advises that we interpret sparingly; that instead, by using imagery appropriately, we lead the patients to understand their phenomenological ways of seeing the world for themselves. He abhors formulas and recommends that these specific approaches not be used in any set order, but flexibly and responsively to reflect the individual client's needs. He encourages the therapist to adapt and to improvise. The following examples will help give the flavor of his approach.

In "The Imaginary Situation," to assess how a person feels about his situation, he says to the client, "Imagine you are on top of a mountain and on a ledge below, you are also there. Now the *top you* lowers a line to the *bottom you.* What will happen?" The response allows him to get a picture of the client's attitudes about help, self help, and resistance to therapy. He also describes variations, such as "Imagine one you in a boat and the other you in the ocean. The you in the boat throws the you in the ocean a line." He suggests using variations in later sessions to assess change.

In "Self-and-Other" questions, clients will disclose how they view themselves, and how they feel others have defined them. One such question is "How would you drive someone crazy?" You will probably hear the dark side of the patient's memory of his/her childhood. Or, "Look into a mirror and see another person. Whom do you see? What would you say?" People are generally quite surprised by their responses to this powerful question. Used as the last of a series of completion sentences, the "Finish-the-Sentence" item "Never refer to me as. . . . ." quickly evokes the patient's despised image.

One of my favorites elicits information about specific internal conflicts: "Imagine two fantasy animals. Describe them. Imagine them walking down a road together. How would they behave? What would they say to each other?" When I ask patients to draw these two animals, I have them write three adjectives for each animal, and then their conversation. For evoking an image of the trauma behind a conflict, he asks, "What was the day of shame in your life? What was the guiltiest feeling in your life?" For sexual imagery, Shorr has varying degrees of evocative instructions, depending upon the tolerance of the client. "Look into a hole in the floor. What do you see?" There are more explicit imaginary situations, as the client becomes willing to deal with such conflicts. And, for the exploration of self-esteem: "Imagine yourself sitting on a throne." Or, for exploring relationships with a parent: "Imagine you are holding your father's face in your hands. What do you see? Say something to him. What does he say to you?

Two of the chapters are transcripts of audio-taped interviews, and are helpful for those who would learn by following Dr. Shorr's thinking as he interacts verbally with his patients. Shorr suggests that clients listen to their audio-tapes after a period of time for a "picture" of where they have been, where they are now, and where they want to go. This is undoubtedly useful. Personally, I find that reviewing a patient's actual drawings is even more effective and, of course, more succinct.

Where the manuscripts of the two original books join together, the book becomes a little repetitious. Some skillful editing might have made the transition more graceful. However, repetition does help ideas stick. These are minor cavils. Taken as a whole, the book is a classic; it is a landmark in our understanding of the uses of imagery and psychotherapy. I highly recommend *Psychotherapy Through Imagery*, not only as a source book for stimulating imagery, but for its conceptual framework. If you take the time to digest and experience these "Psycho-Imagination" techniques for yourself and adapt them to your own art therapy practice, I predict that you and your clients will be richly rewarded.

A Review of

Spontaneous Painting and Modelling: A Practical Approach in Therapy

E.M. Lyddiatt. New York: St. Martin's Press, 1971
(Out of Print)

Reviewer **Edith Wallace, MD, PhD,** is a Jungian Analyst who trained with C.G. Jung and has taught at the Jung Foundation and Institute in New York. She is also a prize-winning painter who conducts art workshops on "Opening Channels to the Creative."

> "You love the earth and the earth loves you.
> And therefore the earth brings forth."
> C.G. Jung, *Two Essays in Analytical Psychology*
> (quoted by Lyddiatt, it could well be the
> motto for her book)

BEST COPY AVAILABLE

There are all too few books that describe a Jungian approach to art therapy. Jolande Jacobi's *Vom Bilderreich der Seele (Imagery from the Depth of the Soul)* has been translated but not published; the richness of the illustrations presumably make the publishing too expensive. *Irene Champernowne's* excellent articles have not been collected in a book, although they could and should be. Seonaid Robertson's *Rosegarden and Labyrinth* is once again available, a fine example of how a process for training and therapy can be started, carried out, researched, and applied—often via mythology. Margaret Frings-Keyes' *Inward Journey* is also valuable, but only touches on the Jungian approach and is more outward than inward. This is not a very big collection, so I was delighted when my attention was drawn to a book that was not familiar to me: E.M. Lyddiatt's *Spontaneous Painting and Modelling: A Practical Approach to Therapy*. However, the book is out of print, available in libraries only.

E.M. Lyddiatt is an English art therapist who, according to her testimony, worked in mental hospitals, mainly with inpatients. She carefully stays within the realm of allowing art to be the therapeutic medium, with as little interpretation or "interference" on her part as possible. She also works with the doctors, apparently in harmony, though there is at times little tolerance or understanding on their part. As one patient expressed it: "No, you and the doctor have different points of view; he clips my wings, you make me feel there is magic in the air, that anything might happen," to which Lyddiatt's comment was: "The roles might have been reversed: the aim is to make sure the different points of view blend."

I find that there can be not only magic in the air, but also poetry. Lyddiatt is aware of it and gives it space. She says, "Often what is desirable for an art department is reminiscent of the quiet pondering of adults who in solitude play in streams and wander on the seashore." (p. 14) When L. describes her intent, she states: "We need an immediate practical method of helping those who are ill, or whose lives are unsatisfying, to get in touch with their own unconscious background, and painting can do this." (p. 10) We know how important it is to live one's creative potential; and this is not mere self-expression, nor is it sublimation. Lyddiatt makes clear and succinct statements on this subject, never losing her enthusiasm and astonishment about results achieved via the use of art media—she gives many examples from her own practice.

I read recently in the diary of a woman-writer and psychologist some words with which I believe Lyddiatt would agree: "I think people can't be reduced to psychological formulae, that only the artist can render human beings down to their last irrational elements." The writer also says: "And then there is that ridiculous unease that I still can't quite place, but that one day, I should think, might help me to write, if only I learn how to channel it properly." This description of what goes on inside the artist-writer confirms the art therapist's endeavour to use malaise or even deeper disturbances as a starting point in this form of therapy. As the author says, "This is how the inner life of ordinary people can show itself." (p. 45)

I once studied with a Chinese woman painter who said to her students: "Don't go to the canvas when you are happy—go when you are troubled, even desperate; but don't go when you are tired, either." In the patients' terminology "spontaneous painting" as Lyddiatt calls it, is: "practical imagination" or "immediate thinking."

> "Even if it is an over-simplification it may sometimes be a useful plan to describe spontaneous painting in three stages: firstly, imaginative material is given form; secondly, it 'works back' on the maker and is experienced; and thirdly, one feels more alive. Often these stages blend." (p. 6)

In another place she describes the creative process:

> "People put on paint; paintings make themselves and these in their turn work back on their makers—if the paintings are given the chance. It is a perpetual surprise to see how quickly scribbles grow and change when valued by the painter as well as by the therapist . . . This 'thing' moves and changes us, provided we feel and value it and cease to demand reasons. It is a spark of something greater than ourselves that can lead us on so long as we do not seek to cage it." (p. 13)

This non-interpretative approach appeals greatly to me: I use art myself in this manner. We learned it from Jung and from his method which he called "Active Imagination." Lyddiatt tried it out on herself and speaks of it as "something one can live by, and it can be developed until it can be trusted as something to depend upon." (p. 139) Lyddiatt describes; she does not interpret. I found it fascinating how 12 inmates, who made a collective mural, produced something chaotic and not always intelligible to the "sane" mind that was, however, profoundly moving and meaningful to the patients. While, when Lyddiatt herself added something to the painting to tie things together, it was rejected. How little we know about this world of the so-called "insane." Another observation of Lyddiatt's concerning an Exhibition also reflects her humility:

> "Work I had deliberately included to demonstrate 'this is not art' was pointed out as excellent art. One painting was particularly chosen to show how extremely ill and shattered the person was at the time of painting it; but artists particularly hailed this as an excellent and desirable picture. It seemed that the unconscious material set the onlookers talking. More than one critic said, 'Are all these people artists or are all modern artists crazy?' . . . Curiously enough, one of the first visitors said, 'It is as if you have taken up the paving stones and shown what lies in the raw ground underneath.' " (p. 130)

One is reminded of the compensatory function of the unconscious, compensatory that is to conscious knowledge, attitude, and behavior with these mental patients, compensatory even to their so-called insanity. This in turn gave a validation to the irrational in the eyes of the patients which Lyddiatt sometimes could not see (she was maybe too close to it), while the visitors to the exhibit, without foreknowledge, saw it with unconditioned eyes.

Lyddiatt describes several aspects of the process of art therapy, for instance, working in and with a group in various ways: 1) individually—just everyone being together in the art room; 2) doing a collective mural; 3) having an exhibit and the working on putting it

BEST COPY AVAILABLE

together, done by the patients under supervision. I am very much in sympathy with what the author describes. Trust in the constructive, creative aspect of the unconscious is the basis of her work, so that her intention can be to allow that which is below appearances to surface. According to her repeated joyful statements, the art medium brings it out without its being threatening. It is a gentle opener as well.

Lyddiatt leaves interpretation to the doctors, but she also takes a strong stand against all interpretation. If interpretation means analyzing and labelling, I am with her. However, she leaves out one step here: all articulation is consciousness. If this articulation means putting preconceived general notions on the image, then it is not only wrong but destructive. This would not be working in the spirit of Jung's approach to the unconscious. However, what has been produced needs to be looked at thoughtfully; and that means putting into words what we see, not only an emotional reaction. Both levels can meet here. It is true some paintings or other works of art say so much that they say enough. But as we live with them, and as more and more recognition occurs, we need to put such recognitions—which are revelations about ourselves and sometimes beyond ourselves—into words. If it is subtle enough, it may even come out in poetry. I do not forget that most of the time she works with mentally ill people where verbal articulation may not always be available, while articulation through images may be of the highest value. In such instances one cannot look for more. An illustration from my own hospital experience comes to mind: a young hebephrenic girl who would hardly ever talk drew a tree for me (I used the House—Tree—Person test at the time) from which she could not part, it meant so much to her, even though the tree was a dead tree and—interestingly enough—when I tried to make a copy for my records, my tree always came out alive!

I can also corroborate another observation of Lyddiatt's with an experience of my own. Lyddiatt says:

> "In the acute stage of a psychotic illness, sometimes—not always—patients produce in their paintings a remarkable clarity and conviction. These pictures have a definite wholeness about them and from an artistic point of view they are not broken up. Whichever way the illness goes the ability to produce in this manner fades. When they have recovered, some patients value these pictures and others detroy them." (p. 131)

Once a young girl was admitted to a mental hospital (in which I worked) in a severely disturbed state. She had done lifeless paintings of a photographic nature which her parents proudly showed; they had no artistic value. During her stay in the hospital, in her disturbed condition she produced fine, somewhat abstract paintings full of life and beauty. There seems to be a place in the depth of the unconscious which is the source of creativity or total chaos. Lombroso knew about it: note the title of his major work—"Genius and Madness"—note many an artist's life story. Jung spoke of this place as one of greatest reward and greatest danger.

Since the book I am reviewing here is out of print, I have allowed more quotes than I would ordinarily use. I want to end with a longer quote, in order to present the flavor of Lyddiatt's spirit, her writing, and her basic philosophy.

> "Art can work in the same way as active imagination, that is, the unconscious and the conscious come together in the creation of a symbol, and this is health giving and restoring. This is easy to say but a mystery when it occurs...
>
> Often it is external facts and problems that people discuss with regard to spontaneous painting; but its essence concerns the inner, unknown domain of life. This is difficult to talk about in whatever strain and from whatever point of view. The feelings, the wonderings, the gleams of hope that get expressed when we start to paint or write, the moods of hopelessness, the unknown stuff of ourselves. These are expressions of the elements of our nature that have forever been cared for by ritual and religion. To allow them life and form, however simple, seems to be vitalizing. This is a fact I know when I do it and I do not know when I do not do it. How foolish we are to neglect our own source of well being." (p. 138)
>
> "We all see things in different way and I was astonished to hear a psychiatrist tell the hospital staff that spontaneous painting was a modern form of prayer...
>
> This activity is deep and mysterious because one is contacting something unknown and realizing something new that is both constant and changing. It is of immediate practical value and seems to be never-ending." (p. 139)

BEST COPY AVAILABLE

A Review of

To Be Remembered: Art and the Older Adult in Therapeutic Settings

Georgiana Jungels. Buffalo, NY: Potentials Development, 1982. (37 pages, $4.95)

Reviewer ***Ann Strosser, RN, MA,*** *is Art Therapist, Geriatric Module, Creative and Expressive Arts Therapy Program, Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine. She is also a consultant with an emphasis on work with women and the elderly.*

I have a scene in my memory that I mentally view when I need to remember a touch of beauty . . . On a warm summer day I walk through a wooded area, and see a large, flat rock covered with hundreds of pale blue butterflies. After the initial moment of surprise and delight, I begin to wonder about them. Why are they gathered here? Where did they come from?

I had a similar feeling after reading *To Be Remembered* by Georgiana Jungels. I was delighted with it, and then began to wonder about the population represented. It is a small book which makes sensitive statements about the author-therapist, by telling about her interactions with some elderly people.

Examples are given of various materials, how they may be used, and specific responses that are elicited in the therapy process. Approximately half of the text is devoted to a description of the experiences of one patient.

These glimpses that are offered make me wonder why the book is written for those working with older persons, without defining approaches more specifically in terms of different segments of that population. Some of the advice about using adult language and techniques, for example, seems to make the assumption that all elderly people associate art with kindergarten, or that they need specific directions to enable them to use materials. With geriatrics, like any other identified population, there is a wide range of ages and abilities. There is perhaps a wider range in this group than in younger populations.

In spite of this small irritation, it is a small book to be remembered, especially if you are interested in working in art therapy with the elderly.

BEST COPY AVAILABLE

Film/Video Review

SUICIDE: THE ULTIMATE REJECTION

Videotape (¾", color, 58:52, 1982) Gregory Bernhardt, PhD and Susan Praeger, PhD, produced by Wright State University, Dayton, OH.

THE MAZE

Film (16mm, color/sound, 1970, 30 minutes), produced by Houghton Mifflin, Boston, MA.

Reviewer ***Georgiana Jungels, ATR,*** *is in Art Therapy Studies, Art Education Department, State University College at Buffalo, New York.*

There are approximately 22,000 to 27,000 suicides reported in the United States each year and suicidologists suggest that the actual number may be twice as high (Patterson, 1983 and Johnson, et al, 1980). The videotape *SUICIDE: THE ULTIMATE REJECTION* documents a group therapy session for the "survivors" of a suicide—the victim's parents, children, or friends. As a silent member of this group session for 58 minutes, the viewer learns about the feelings of guilt, anger, grieving, confusion, isolation, and rejection commonly felt by the people close to someone who commits suicide. The message of a common pain is explained by each person: a "life defined by loss"... "a blow to ego... person preferred death over you." As the members of the group talk about their own experiences, the viewer simultaneously learns about the members of the group and learns more about suicide prevention, the stages of grieving and support services for survivors. The viewer is also able to observe the clinical expertise of Drs. Bernhardt and Praeger as role model facilitators.

As we watch the members of the suicide survivors group discussing their experiences and feelings with each other, we begin to wonder about the person who committed suicide: what did they look like? how would they describe their feelings? what led to their decision to commit suicide? We begin to share the question that all of the survivors have asked over and over: Why?

In the classic film *THE MAZE*, we learn from the well-known Canadian artist William Kurelek more about one person's imagery of depression and suicidal ideation as we see the graphic pictures of "himself as a lizard pinned to the ground with black crows waiting to make him their prey" and "cutting self right down to the bone." In his autobiography (Kurelek, 1980) describes how he became discouraged by his lack of progress in treatment and "began for the first time to consider suicide." In the film Kurelek recalls that he "just let things take their course" and decided "logically that suicide was the right thing to do" and that he had "this feeling of utter abandonment... complete and utter abandonment."

The film *THE MAZE* tells the story of William Kurelek's years of depression and depersonalization through the images he included in a large painting entitled "The Maze" that he made while he was hospitalized in England in the 50's. In one of the film scenes, Kurelek says that the painting "The Maze" is "a story of my life in the sense that people tell stories to entertain their guests and trying to make them accept you ... in this case I wanted to be accepted." In his autobiography, *Someone With Me* (1980), Kurelek says:

> *The Maze* was conceived as a kind of pictorial package of all my emotional problems in a single painting. This I contrived to do by fitting the various problems as little vignettes into the compartments of a maze inside my skull, which was cloven in half and lying open on the ground. The group is a wheat field in Manitoba. It was my firm belief that my problems stemmed in the main from my father's farm failures, his habit of taking his frustrations out on me because I was so useless at farming. My helpless dependence on the doctors was represented symbolically by a white rat knotted up in the middle of the maze. I had picked up that idea from the two-unit course in psychology I took at the University of Manitoba... The anatomy of the middle of the skull I found in a detailed medical book in a Charing Cross Road bookstore during one of my leaves from the hospital. I had to use my imagination and memory for the rest of the pictures. An example is the dung heap seen through the nose of the skull. The implication of this Swiftian image is that the world is a dung heap and the human race a cloud of flies crawling over it to suck out a living."

Dr. Morris Carstairs, who treated Kurelek during his hospitalization, wrote that in "The Maze", the artist drew "his skull open to reveal a maze, enclosed with no escape" and revealing his preoccupied feelings with "his own tortured ruminations, his own nightmarish fantasies and his sense of being trapped and helpless." (Kurelek, 1980)

Painting was an important part of Kurelek's communication during treatment and in the early years of hospitalization he designed a self-help experiment to establish the image of what "the public often imagines a temperamental artist to be." However, "no matter how intensely I painted out my accumulated store of fears, hates and disillusionments, they still remained with me as an immense psychological burden. (Kurelek, 1980). When he was transferred to the Netherne Psychiatric Hospital, Kurelek painted a picture entitled "Help Me Please Help Me Please Help Me—Please Help." This picture "showed me symbolically as a bird flying across the Atlantic with a bag around my head, the bag representing my depersonalization. Instead of untying it, a figure in a clinically white smock, resembling Dr. Carstairs, clips my wings, put me in a cage and hangs it by a hook on the White Cliffs of Dover." (Kurelek, 1980) A later painting, "I Spit on Life" was given to one of his psychiatrists as a going-away gift before a suicide attempt. The artist/therapist, Edward Adamson reports:

> "When I first saw William he was extremely withdrawn. His body was huddled up and he was nursing a small doll which he had made. He could hardly speak and it soon became obvious that he would not be able to mix with the others in the studio. He did try, but it was quite impossible. What he needed was to be entirely alone with his paints. Finally, I managed to find a small room for him which had previously been used as a linen store. I provided him with paint and materials and he began to work entirely on his own. I came and sat with him each day. He would not speak; he just pushed his latest painting in front of me. One of the first works he completed was entitled, 'Where am I? Who am I? Why am I?' It told me with an eloquence greater than words exactly how he felt: blind and lost on a windswept barren plain. The only vital aspects of the picture are the hands. They helped him paint his way to recovery . . . I am convinced that it was through painting that William found his own way back to health." (Adamson, 1984)

The imagery in Kurelek's paintings focuses on his personal symbols and the painting "The Maze" contains many of his memories of his childhood and early family life. The film *"THE MAZE"* intercuts scenes from Kurelek's painting of "The Maze" with real life interviews and family discussions. The footage is edited to illustrate the complexity of what Whitaker (1982) calls the family system.

Kurelek's sister Winnie remembers how "Mother and Dad were terribly worried about him" and his father remembers finding the drawings and paintings that were on the walls of his son's room:

> "I saw so many pictures on the walls . . . all kind of snakes and devils and priests and nurses and everything and so I was afraid to go there; so I say, 'Who draw all that? Who paint all that?' William started looking down because he was afraid. William says 'I do that' and I say 'don't do that anymore because you're wasting time and you wouldn't be able to study.' After that it was worse because he was still doing that and he had to hide from me."

His mother recalls that "he was quiet . . . that what I think of him . . . that I should have looked at him more closely but I guess I didn't understand much. I think when a child is quiet you have to be with him more and talk to him more; well I didn't have the time; I had to work; oh, I don't know what to say . . . I just feel bad about it all . . . . when I look back I feel bad that I didn't have the money then to take better care of him . . . . . and now our children . . . they would just listen to what the child said and I didn't do that . . . I felt that that work had to be done . . . so for those things I feel sorry." His father asks, "was that a good thing or a bad thing?" and his mother replies "I think they're overdoing it and we were underdoing it."

Over and over we see recorded in the sections of *THE MAZE* Kurelek's memories of his childhood fears and adult terrors. We can observe the efforts of his whole family to understand his pain and illness. We can further understand his father's own struggle as he "left the Old Country with hard feelings against his parents . . ." and his mother's attempts to elicit sympathy for her husband by saying to her children "You mustn't be annoyed with him. He's trying so hard and things aren't working out." (Kurelek, 1980)

Things did eventually work out for William Kurelek and he wanted the film *THE MAZE* to be made so that his story could be told and he could "bear witness to the fact that people do recover from mental depression." (Kurelek, 1973) When he rewrote his autobiography *SOMEONE WITH ME* in 1980, he said:

> "I believe those who suffer mentally, both in hospital and out, will take hope from the fact that someone like themselves—a real person with a real name—did eventually recover. Not only is it possible for them to recover, it is possible to take advantage of and put to work the suffering they are going through." (Kurelek, 1980)

The videotape *SUICIDE: THE ULTIMATE REJECTION* and the film *THE MAZE* are excellent references for increasing our understanding of the knowledge about suicide. This information is essential to Art Therapists because "frequently graphic representation of suicidal feelings led to greater insight than did words alone, particularly among depressed patients with difficulty in verbalizing feelings. On occasion, the first indication of a death-wish appeared in a picture." (Wadeson, 1975). Additional information abut the pictorial clues to suicidal ideation/intent may be found in the writings of Wadeson (1975, 1980), Landgarten (1981), Ogdon (1982) and Hammer (1978). Information about procedures for assessing suicidal ideation or intent may be found in the guidelines for the suicide assessment form (Johnson, et al, 1980), the SAD PERSONS Scale (Patterson, 1983), and the suicidal death prediction scales (Beck, Resnik, Lettieri, 1974).

The videotape, *SUICIDE: THE ULTIMATE REJECTION*, presents the work of Drs. Bernhardt and Praeger. It was produced and directed by James Craig and Annette Scarazzo in cooperation with the Wright State University College of Education and

Human Services, the School of Nursing, and the Suicide Prevention Center in Dayton, Ohio. This videotape of a suicide survivors group illustrates one community's services and can serve as both an educational program and a model for programs in other communities because "The surviving experience can be an emotionally and physically difficult one. This is natural, but survivors have the right to feel and to have their feeling respected. Groups such as this one can be found in many suicide prevention centers . . . remember you don't have to go it alone."

The film *THE MAZE* is a classic film that was made in 1970 by Dr. James B. Maas, Robert Young and David Gruben and won the Red Ribbon Award for outstanding educational documentary in the 1972 American Film Festival. In an introduction to the 1973 edition of Kurelek's autobiography, Dr. Maas says that he "wished to document the life story of a person my students could easily relate to; and, to make a film wherein the student is forced to think, being confronted with the realities of modern day psychiatry."

The videotape *SUICIDE: THE ULTIMATE REJECTION* and the film *THE MAZE* make us think by presenting both the view of an individual who has been suicidal and the surviving family and friends of a suicide victim. One pain is more focused on depression and hopelessness; the other pain is dominated by hurt and rejection. The members of the suicide survivors group and the Kurelek family have shared their feelings of fear and guilt and confusion, and support through the media of a film and a videotape so that we can all understand more about depression and suicide and illness and the power of therapeutic communication in images and words.

Bibliography

Adamson, Edward. *Art as Healing*. London: Coventure Ltd., 1984.: York Beach, Maine: Nicolas Hays, Inc., 1984.

Beck, Aaron T., Resnik, Harvey L. P., and Lettieri, Dan J. *The Prediction of Suicide*. Bowie, Md: The Charles Press Publishers, Inc., 1974. (Reprinted in Keller, Peter A., Ritt, Lawrence G. *Innovations in Clinical Practice: A Source Book*. Sarasota, FL: professional Resource Exchange Inc., 1982.

Hammer, Emmanuel F. *The Clinical Application of Projective Drawings, 2nd edition*. Springfield, IL: Charles C. Thomas, 1978.

Johnson, C. Warner, Snibbe, John R., Evans, Leonard A. *Basic Psychotherapeutics: A Programmed Text*. New York: SP Medical and Scientific Books, Spectrum Publications, 1980.

Kurelek, William. *Someone With Me*. Ithaca, NY: Center for Improvement of Undergraduate Education, Cornell University, 1973.

Kurelek, William. *Someone With Me*. Toronto: McClelland and Stewart Ltd., 1980.

Landgarten, Helen. *Clinical Art Therapy*. New York: Bruner/Mazel, 1981.

Neill, John R. and Kniskern, David P., (eds.) *Psyche to System, the Evolving Therapy of Carl Whitaker*. New York: The Guilford Press, 1982.

Ogdon, Donald P. *Psychodiagnostics and Personality Assessment: A Handbook, 2nd edition*. Los Angeles, CA: Western Psychological Services, 1982.

Patterson, William J., Dohn, Henry H., Bird, Patterson, Gary A. "Evaluation of Suicidal Patients: *The SAD PERSONS Scale*." Psychomatics, Vol. 24 #4, April, 1983.

Wadeson, Harriet. *Art Psychotherapy*. New York: Wiley, 1980.

Wadeson, Harriet. *"Suicide: Expression in Images."* American Journal of Art Therapy 14:75-82, 1975.

Notes

1) The imagery in William Kurelek's painting "The Maze" and his other paintings made during his periods of depression and suicidal states include many of the pictorial indicators identified by Art Therapists as possible early clues of suicidal ideation—the spiral, the loop, the slash, the blackbirds, the dead tree, the path going nowhere. His paintings also contain many other pictorial elements and are pictures made by a skilled artist. Further study is needed in the area of suicidal pictorial indicators.
2) Slides of William Kurelek's imagery in "The Maze" can be obtained from McGraw Hill; several of the paintings he made during his hospitalization in England are included in the Adamson Collection/England; his paintings are handled by The Isaacs Gallery Ltd. in Toronto.
3) The film *THE MAZE* can be rented from film libraries; the videotape, *SUICIDE: THE ULTIMATE REJECTION* is available from Wright State University, Dayton, Ohio.
4) I am grateful to Patricia Brown for her assistance in researching material on William Kurelek and to Jill Fondiller for her assistance in researching material on suicide.

BEST COPY AVAILABLE

"Highly recommended."
—American Journal of Art Therapy

NEW EDITION!

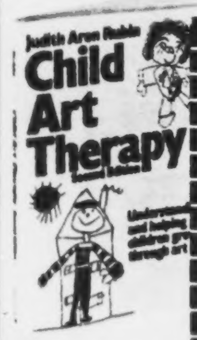
By Judith A. Rubin

Child Art Therapy

Second Edition

Expert therapist Judith Rubin shows you how to help your students use art to achieve important goals—self-expression, increased awareness, and emotional control. She offers sound advice on how to interpret children's needs from their art, when to intervene in the creative process, how to get your students to respond more easily, and more. "A welcome addition to the literature of art therapy."—*American Journal of Art Therapy. 304 pages, 151 photographs, $18.50 paper*

Mail FREE – EXAMINATION coupon alone or attach to school purchase order



VAN NOSTRAND REINHOLD

VAN NOSTRAND REINHOLD
Mail Order Service
7625 Empire Drive, Florence, KY 41042

YES. Please send me **CHILD ART THERAPY** for 15 days' **FREE EXAMINATION.** At the end of that time, I will send $18.50 plus local sales tax and a small shipping handling charge or simply return the book and **OWE NOTHING.**

Name ______________________

Address ______________________
(No shipment to PO box addresses without prepayment)

City ______________________

State ______________ Zip ______________

☐ VISA ☐ MasterCard ☐ American Express—Please charge my credit card. Publisher pays for shipping handling. If I return the book at the end of 15 days, charges will be cancelled.

Card # ______________ Exp ______

Signature ______________________

Offer good in U.S.A. only and subject to credit department approval

27767-9 A8386

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

BEST COPY AVAILABLE

BRIEF COMMUNICATIONS

This column provides a forum for information exchange among clinicians and educators. Items relevant to research and to programmatic, historical, or clinical developments may be submitted. Contributions should be sent to Brief Communications, ART THERAPY, AATA, 11800 Sunrise Valley Drive, Suite 808, Reston, VA 22091.

AATA'S New Executive Director

As of May 1984, the American Art Therapy Association, Inc. transferred management of association business from the National Office in Alexandria, Virginia to The Cate Corporation, an association management firm in Reston, Virginia. With the change in management, AATA underwent both a staff change and an office move.

Richelle Grapsy is an employee of The Cate Corporation and serves as AATA's newly appointed Executive Director. She graduated from The Catholic University of America with a degree in Music Therapy and Piano. While working in the creative arts therapy field, she worked with geriatric patients and handicapped children.

Before joining The Cate Corporation, Ms. Grapsy was awarded an Arts Management Fellowship with the National Endowment for the Arts where she conducted a study of the effectiveness of education programs administered by symphony orchestras throughout the United States. At the close of the Fellowship, Ms. Grapsy continued with the NEA Music Program performing special assignments which included service as Interim Chorus Program Specialist and coordination of a joint Special Constituencies/Orchestra review panel. This panel awarded grants to orchestras conducting model education and outreach programs aimed at special constituencies.

Ms. Grapsy has also held positions in public relations and meeting planning with the Maryland Summer Institute for the Creative and Performing Arts and the American Symphony Orchestra League. She is currently an MBA candidate at George Mason University, and is specializing in non-profit organizations.

You can contact Ms. Grapsy at AATA's new National Office:

AATA
Suite 808
11800 Sunrise Valley Drive
Reston, VA 22091
(703) 476-5437

Rawley Silver, EdD, ATR, HLM, has donated 200 copies of the *Stimulus Drawings* to the American Art Therapy Association. Her request specifies that the proceeds will be utilized by AATA to help offset some of the current deficits. To order a copy of the *Stimulus Drawings* send $9.95 per copy plus $1.00 for postage and handling to:

Stimulus Drawings
The American Art Therapy Association
Suite 808
11800 Sunrise Valley Drive
Reston, VA 22091

* * *

Rawley Silver, EdD, ATR, HLM, has donated to the New York State Museum the two exhibitions that have been circulated by the Smithsonian Institution. The Museum plans to exhibit and circulate them within New York State and to develop additional materials based on them. Anyone interested in further information contact:

Martin E. Sullivan, Assistant Commissioner
New York State Museum
Empire State Plaza
Albany, NY 12230

These exhibitions are titled "Art As Language" and "Shout in Silence, Visual Arts and the Deaf."

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published biannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $15 (US); $20 (Foreign). Institutions: $18 (US); $24 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 11800 Sunrise Valley Drive, Suite 808, Reston, VA 22091.

Please enter my subscription for 1985. Enclosed is my check, payable to AATA, for $15. (Regular rate for individuals is $18)

Name ____________________

Address ____________________

City ____________________ State __________ Zip __________

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

TAKE ADVANTAGE OF THIS SPECIAL OFFER!

Subscribers to *Art Therapy* and Members of American Art Therapy Association
ENJOY REDUCED RATE!

SUBSCRIBE NOW—AND SAVE 50% OR MORE! *The Arts in Psychotherapy* is a quarterly journal in its 11th successful year of serving practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologists which reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy. THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers to: Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583
TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA

Please enter my subscription for Vol. 11, 1984 ☐ (Prepayment required) Check enclosed ☐
Please enter my subscription for Vol. 12, 1985 ☐
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume
2 Vol. subscriptions subject to additional 10% discount Individuals $36 Students $27

Name ____________________

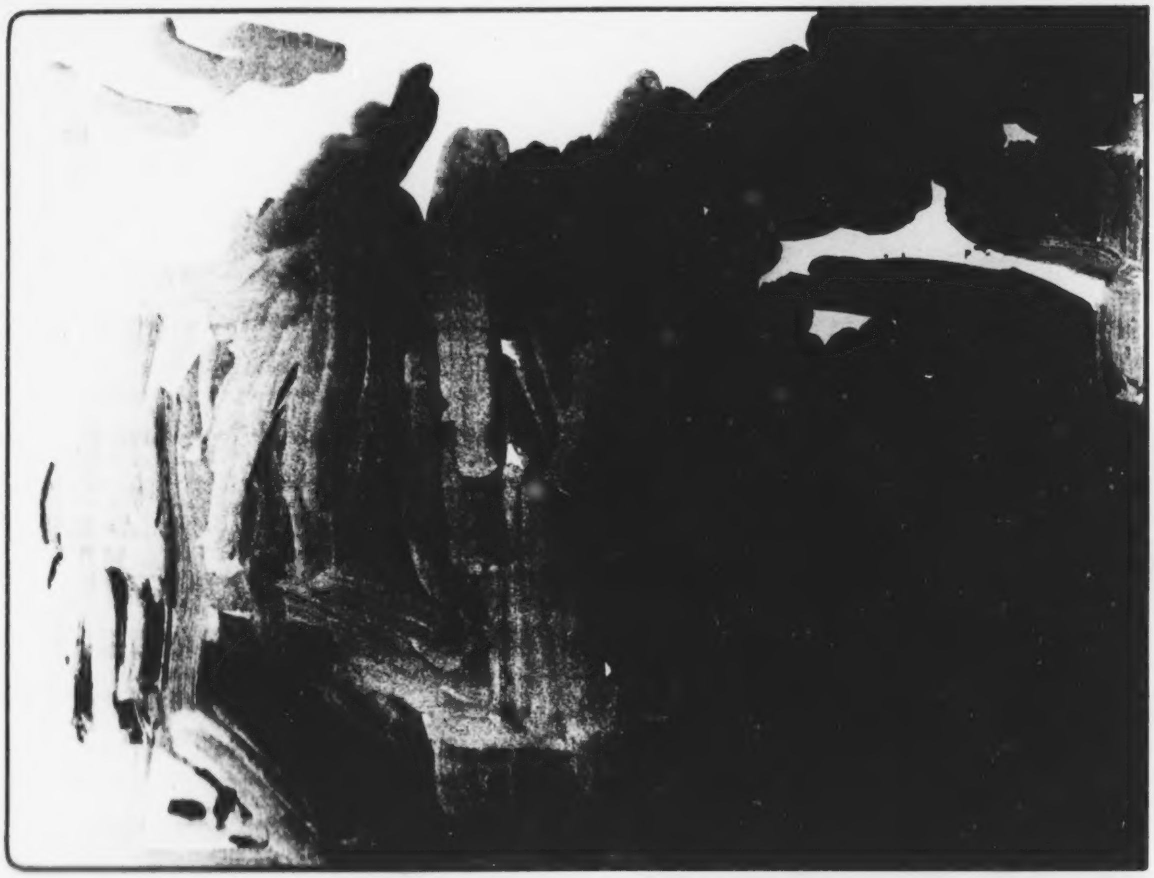
Address ____________________

City ____________________ State __________ Zip __________

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association



Volume 2, Number 1 March 1985

- The Book about Daddy Dying: A Preventive Art Therapy Technique to Help Families Deal with the Death of a Family Member
  Maxine Junge
- Object Relations Theory and the Language of Art: Tools for Treatment of the Borderline Patient
  Ruth Obernbreit
- 1984 Conference Overview
- AATA Position Paper

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA office, 1980 Isaac Newton Square South, Reston, VA 22090 (703) 476-5437.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1983-1985

Board of Trustees

President
Gladys Agell, MA, ATR

President-Elect
Sandra L. Graves, PhD, ATR

Secretary
Nina Holtzman, MA, ATR

Treasurer
Helen Landgarten, MA, HLM, ATR

Committee Chairs

Affiliate Societies
Nancy Steinberg, MA, ATR

Bylaws
Donald L. Cutcher, MA, ATR

Education
Gary C. Barlow, EdD, ATR

Governmental Affairs
Nancy Schoebel, MA, ATR

Membership
Robin F. Goodman, MA, ATR

Public Information
Bobbi Stoll, MS, MFCC, ATR

Publications
Harriet Wadeson, PhD, ATR

Research
Janie L. Rhyne, PhD, HLM, ATR

Standards
Ronald E. Hays, MS, ATR

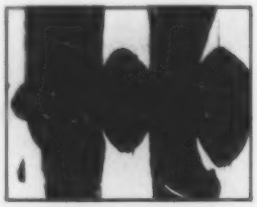
Executive Director (ex officio)

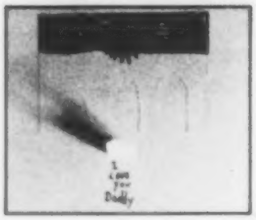
Richelle Grapsy

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association





Cover illustration: This untitled painting was done by an 8 year old girl with severe behavior problems. (Art therapy clinic, Wright State University, Dayton, Ohio)

Editorial

Editorial, Gary C. Barlow, EdD, ATR 2

Articles

"The Book About Daddy Dying:" A Preventive Art Therapy Technique to Help Families Deal With the Death of a Family Member
Maxine Junge, MSW, LCSW, ATR 4
Object Relations Theory and the Language of Art: Tools for Treatment of the Borderline Patient
Ruth Obernbreit, MPS, ATR 11
"Art Therapy in the Schools:" A Position Paper of the American Art Therapy Association 19
AATA Conference Overview 22

Viewpoints

A Question of Creativity: Paradigms: Facilitators or Inhibitors?
Harriet Wadeson, PhD, ATR 39

Reviews

Book Reviews

Phototherapy in Mental Health 40
Portraits of the Artists: Psychoanalysis of Creativity and Its Vicissitudes 41
Picasso: Art as Autobiography 41
Psychoanalytic Theory of Art: A Philosophy of Art on Developmental Principles 41
The Mind's Best Work 43
Silver Drawing Test of Cognitive and Creative Skills 44

Film Reviews

Stevie's Light Bulb: Graphic Art in Child Psychiatry 45
With Eyes Wide Open 46

Brief Communications 48

Volume 2, Number 1 March, 1985

Copyright © 1985
American Art Therapy Association, Inc.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Production Editor
Shirley N. Nuhn
Advertising Manager
Beth Nord

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Anthony Kowalski, MD
Susan LaMantia O'Connor, MA, ATR
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 1980 Isaac Newton Square South, Reston, VA 22090 (703) 476-5437

3EST COPY AVAILABLE

EDITORIAL

The current issue of *Art Therapy* brings to the reader diverse facets of art therapy: articles, a position paper, a conference overview and a major artist's work (reproduction), as well as regular features—book and film reviews, Viewpoints and Brief Communications. Our pertinent and timely articles are on "Object Relations Theory and the Language of Art," including case overviews, and "The Book About Daddy Dying" that illustrates a preventive art therapy technique appropriate for working with families in trauma following the loss of a family member.

The Governmental Affairs Committee of A.A.T.A. has a subcommittee whose purpose is to focus on art therapy in schools. This subcommittee, for the past number of years, has dealt with issues emphasizing art therapy and education, and during the past two years has brought to fruition a position statement. This statement was presented to the Executive Board of A.A.T.A. for its consideration, and it was subsequently adopted by the Board in October, 1984. The position paper, "Art Therapy in the Schools," is presented in this issue for your consideration and comments. Many thanks must be given to the committee members for their long and arduous work in preparing this position statement.

The recent A.A.T.A. Conference was an exciting and productive one. Plaudits are given to the many personnel and committees responsible for organizing the Conference, and for the continued work that was completed during the full run of the Conference. Because the proceedings from A.A.T.A. Conferences are currently not being published, the Editorial Board of *Art Therapy*, together with consultants to the Journal, suggested that the Conference overview might be of interest to the readers, and to persons who did not attend the Conference as well as those who did. Therefore, in this issue you will find an overview of the pre- and post-Conference courses, papers, panels, workshops, open forums, general sessions, exhibits, special meetings and events, the film festival (including the grand prize and merit awards), and other highlights. The descriptions appear as each was printed in the Conference program; no attempt was made to edit or change any of the written information submitted by the presenters. However, addresses are included so that readers may contact the presenter(s) for additional information regarding the particular content, method or format. It should be noted that *Art Therapy* will continue to publish a Conference overview in each yearly post-Conference issue.

One of the highlights of the recent Conference in Washington, D.C., was a museum tour to the Corcoran Gallery of Art where members were treated to a sensitive and powerful retrospective exhibit of the work of Robert Motherwell, a dominant figure in American art. With consent of the Corcoran Gallery, we are pleased to present in this issue a reproduction of a Robert Motherwell work.

At the Executive Board meeting of the American Art Therapy Association, October, 1984, approval was given to publish *Art Therapy* three times (instead of two) for the coming year. As of now, we are moving ahead with this plan, and a timeline is being formulated that will permit a changeover to March, June and October issues.

A suggestion was made recently by an A.A.T.A. member that the membership should be encouraged to submit statements about our profession for the purpose of collecting thoughts, sharing the information by making definitive statements for deliberation and discussion. Questions to consider are: What is art therapy now as compared to ten or twenty years ago? Where do we want to be ten or twenty years from now? Where do we see drastic changes currently occurring? What changes might be projected in the near and distant future? We invite you to communicate with us on these issues. Your statements might be submitted in an article format, or perhaps be specifically planned for the "Viewpoints" section. I encourage each of you to share your thoughts and ideas on these and other issues that have importance for our profession.

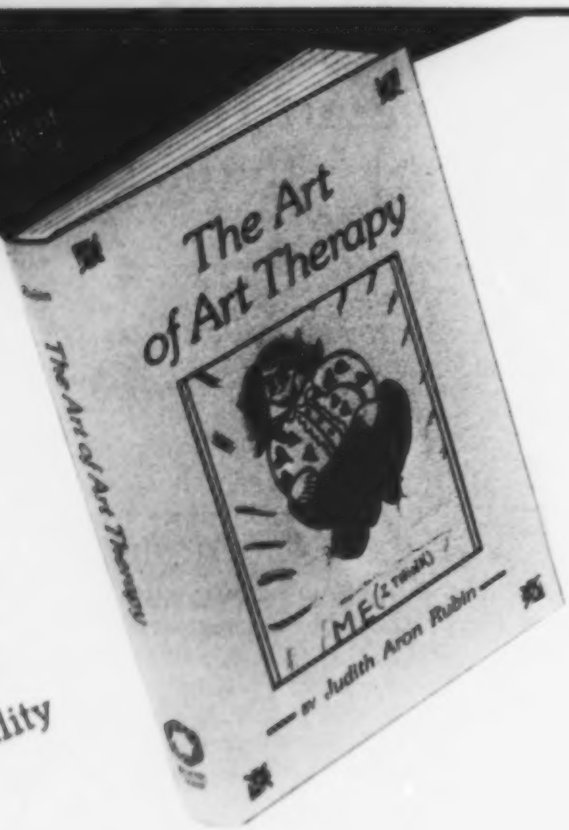
Gary C. Barlow, EdD, ATR
Editor

Just Published

"A penetrating exposition of those elements that produce professional excellence, a welcome addition to the literature." GLADYS AGELL, ATR
Associate Professor, Director, Graduate Art Therapy Program, Vermont College of Norwich University

An Innovative Overview of the Essential Components in the Delivery of Services through Art Therapy

- in any setting
- with all ages
- in any modality



In THE ART OF ART THERAPY, Dr. Judith Rubin shows "how to think about doing" art therapy, rather than "how to do" art therapy. She presents the general "understandings" necessary for effective art therapy with any age level, in any setting, and in any modality, as well as the specific knowledge essential for work with particular populations in different contexts. It will be useful not only to art therapists but also to any mental health professional incorporating art into clinical work. *"I expect this book to be an excellent addition to public libraries and private collections as a resource to practitioners of art therapy."*
—IRENE JAKAB, M.D., PH.D., Professor of Psychiatry,
U. of Pittsburgh, School of Medicine

224 pages LCN 84-9344 $25.00 list Special *only* $22.50

Send to: BRUNNER/MAZEL Publishers 19 Union Square, New York, N.Y. 10003 atr

☐ Yes, please send me copy/copies of THE ART OF ART THERAPY (Rubin) at the special saving of $22.50 ($25.00 list). *I understand any book(s) may be returned within 30 days for a full refund.*

Name ____________
Address ____________
City ________ State ________ Zip ________
$ ________ enclosed (Please add $1.50 postage and shipping for one book, 50¢ for each additional book) *(N.Y.C. residents please add 8¼%. N.Y. State 4% plus applicable local tax)*
(or) Charge my ☐ American Express ☐ MasterCard ☐ Visa
Account No. ____________
Expires ________ Signature ____________

BEST COPY AVAILABLE

"The Book About Daddy Dying": A Preventive Art Therapy Technique to Help Families Deal with the Death of a Family Member

Maxine Junge, MSW, LCSW, ATR

Maxine Junge, MSW, LCSW, ATR is Assistant Professor and Associate Director, Graduate Department of Clinical Art Therapy, Loyola Marymount University, Loyola Blvd. at 80th Street, Los Angeles, CA 90045. *Parts of this paper in a different form were presented at the 1983 Conference of the American Art Therapy Association.*

This paper presents a clinical art therapy technique to help a family cope with the death of one of its members. It describes the making of a book in which all the family participates. A theoretical rationale about bereavement is proposed and two case examples described. The approach of the "Book About Dying" is presented as a technique and model for dealing with the attendant feelings of a death in the family, with perhaps its most important benefit to the family being its preventive mental health function. Also, the book's potential as a vehicle for family ritual to aid in the transition from one life stage to another is discussed.

Introduction and Theoretical Rationale

In the last ten years or so, we have experienced a virtual cultural revolution in our attitudes toward death and its vicissitudes with a resulting proliferation of thought and literature on death and dying. Out of the pioneering work of Kubler-Ross (1969) and others we have gained important new insights in many of these areas including that of the impact of death on those left behind.

The importance of the expression of a mourning process and its role in the successful adaptation in later life to separations and losses, has been emphasized in the psychological literature starting with Freud's seminal work, "Mourning and Melancholia," (1917). Further, it is well-known that failure to mourn or inadequate mourning by a parent may result in various, possible pathological problems in parent-child relationships. Clearly, problems may not arise in all cases of death in a family nor may there be resultant pathology or symptomotology, as a reaction to any crisis is strongly influenced by past and present life experiences, ego strengths and coping mechanisms.

However, over the years, the consistent and increasing presence in my clinical practice of families who need help in dealing with and communicating about the death of a family member leads me to the notion that a reconsideration of the issues involved, as well as the development of new effective interventions and strategies to deal with loss, are in order.

Studies on the level of stress' effect on the development of illness have found that the "death of a spouse is the life event associated with the greatest degree of stress" (Holmes and Masuda, 1973). The parent whose spouse had died suddenly needs to cope with changed financial, emotional and domestic roles and responsibilities and an uncertain future at a time when she or he is most unable. Questions from children may not be welcome nor answered as to the facts of the death, cremation or burial, etc.

Sometimes the circumstances of death, such as a violent one or a suicide, may be cause for shame and may make the subject of the death taboo. Or a surviving parent may want to spare the children the pain of loss and may not share their own feelings with them. A parent overwhelmed with his or her own feelings of sadness, abandonment and confusion, finds it difficult at best to help the children effectively grieve. In any case, the surviving parent's silence conveys to the children that the death is secret and frightening and cannot be openly discussed. After the intense reaction of the first few days or weeks, the loss may be covered over and becomes for the family a taboo subject, a hidden and uncommunicated reservoir of pain and secrecy which can lead to the development of grave family dysfunction and psychopathology.

The reaction of the child, or children, to a death in the family depends on many factors including age, emotional and cognitive development and the emotional closeness to the dead family member. The death may result in loss of residence or change in schools. The child may not only have to cope with the primary loss, but also with his or her feelings of distance from and abandonment by the surviving parent who, because of the situations noted above, or others, cannot be emotionally available and withdraws from the child. Thus the child experiences a second, perhaps even more devastating, loss and has no avenue of communication with which to question or understand. Family therapist Murray Bowen (1976) and others have found that "the most influential factor in the child's reaction to the loss of the parent appears to be the ability of the remaining parent to not allow his or her emotions to create distance from the child."

Herz in Carter and McGoldrick (1980) cites four factors which she feels affect a family's reactions and adjustments to a death. These are: (1) the timing of the death in the life cycle of the family; (2) the nature of the death (is it expected or unexpected? Was there a long term of caring for the dying family member or was it a sudden death?); (3) the family position of the dying or dead family member and the emotional signifance to the family; and (4) the openness of the family system.

Herz feels that difficulties arise from a lack of openness in the family system and goes on to define openness as the "ability of each family member to stay nonreactive to the emotional intensity in the system and to be able to communicate thoughts and feelings to others without expecting others to act on them."

The book described in this paper is seen as a technique to permit family expression and communication and to prevent the premature closing down of the family system.

Case Examples

The following two case examples show the process of making a book with two families. The first example describes the development of the book idea because of the clinical needs of a particular family. It describes an intact family with two young children undergoing the death of the father by suicide. The second case example concerns a divorced family, in which the 32-year-old father died of a melanoma and is intended to underscore the flexibility of the book technique in its adaptability to use with various family constellations.

Case 1: The F. Family

Ms. F. came to the mental health clinic with her two young sons, Jimmy, age four and Mark, age seven, two months after the suicide of her husband, Mr. F., a 37-year-old engineer, who had a history of depression. One month before his death he had been a patient in a psychiatric hospital where he was thought to be improved and no longer suicidal. Ms. F. had disagreed with her husband's psychiatrist's assessment and asked that he be kept for a longer time at the hospital. This was refused. Three days after his release, Mr. F. ingested an overdose of medication and died.

As presenting problems at the clinic, Ms. F. cited intense and ongoing depression in herself. She felt overcome with guilt that she had been unable to convince her husband's doctors of the seriousness of the situation, as well as intense anger at the mental health system. Both sons had been noted by their teachers as being pervasively sad and unable to concentrate on their school work.

> ***". . . it is well-known that failure to mourn or inadequate mourning by a parent may result in various, possibly pathological problems in parent-child relationships."***

The F. family was assigned for therapy to a staff psychologist who saw them for four sessions, which she felt were of little help. Mother could do little other than cry through the sessions, and said she also cried at home whenever she thought of her husband. She was preoccupied with the loss of her husband and seemed unable to disconnect from her constant ruminations in order to focus on her two sons and their grief. In the sessions, the psychologist observed that the boys made occasional attempts to gain their mother's attention, but seemed to grow increasingly detached and withdrawn at her lack of response. The psychologist contacted me in her hope that a family art therapy task might serve to focus the family in a more productive way.

As I thought about the F. family system, it seemed to me that something more than the usual art therapy techniques were needed to symbolically contain all the overwhelming thoughts and feelings evoked by the father's suicide. Although there was clearly an overriding need for catharsis to allow for acceptance and support, Ms. F.'s inability to control her feelings in any way had caused her to withdraw from her sons and they from her. Using a structural theoretical framework, it seemed necessary to help Ms. F., if possible, to reconnect with her sons, so that she could begin to help them with their loss, as well as perhaps gain some sustenance from them. Appropriate defenses would be supported and confrontation of fragile ones would be avoided. As I look back, however, the book idea may have emerged because I knew education was highly valued in this family and Mr. F. had read nightly to his sons.

The psychologist and I met with the family, to suggest that they make a book together about Mr. F. This would include their memories of him, both good and bad, and events together as a family before his death, their questions (and answers) about the death and, of course, all their feelings. I asked the family to bring in photographs of Mr. F. to include.

We met weekly for six weeks and worked together in the sessions on the book. During our work together Ms. F. became increasingly capable of concentrating and helping her sons to do so. Thus her nurturance of them resumed. The distancing device of making the book and the focus on its pages seemed to cause a damming up of the previous spilling-over of feelings in mother, giving her more control and more comfort, thus allowing more room for her sons' feelings. Sometimes the family worked individually and sometimes together on one piece of paper around a central theme. The separate pages remained in a folder with the therapists each week and we told the F. family that when we finished the book, we would get it bound for them to take home.

In the sessions, family communication was emphasized and questions were asked and answered and re-asked and answered again. This was my first experience in working with a very young child undergoing the experience of the death of a parent, and although many developmentalists tend to emphasize the young child's lack of conceptual ability and thus the inability to understand, I found that Jimmy was *trying* to understand. His repeated questions, as well as his on-going involvement in the work of the book, convinced me of this. With Jimmy I came to believe that the young child must find some way to make sense out of his dramatically changed world in order to be able to go on.

At the end of the six weeks, family and therapists agreed that the book seemed finished. (The six weeks were not preplanned, and we would have continued with the many chapters as long as this seemed useful.) The therapists agreed to "get the book put together" and we arranged a last meeting. We mounted the newsprint pages on sturdier paper and put four notebook rings through the pages to keep them firmly together. At the last meeting, the family talked about its feelings of doing the book and both family and therapists expressed that they had shared a difficult but special experience together. We recommended that the book be kept in a safe place at home where any family member could read it at will, but that the book be read together by all three at least one time a week.

One year later, Ms. F. called at the insistence of Jimmy who had told her "the book is falling apart and needs to go back to the clinic." We asked Ms. F. to bring the boys and the book in for a re-evaluation (what I like to call "a 2,000 mile check-up").

Indeed, the book *was* falling apart literally. We wondered was the family also? The family told us that they had read the book together almost every night for the year. Ms. F. stated that the book had given the family an avenue for communicating about Mr. F. and a vehicle whereby they could continue the expression of feelings of all kinds. Each family member had individually read the book as needed in her or his own way and it was the only thing in the house consistently returned to its "safe place" on the shelf.

In our re-evaluation sessions, we created some new pages for the book as to what had been happening to the family in the year since Mr. F.'s death. Ms. F. was now attending a widows' group. She had started graduate school with a goal of a career as a mathematics teacher. She had very recently had a few dates and in the month before the call to the clinic, had spent a weekend away skiing with friends. The boys had remained with a baby sitter for the weekend. Jimmy and Mark had settled down in school and were doing well except for occasional spells of "moodiness." Mark still tended to be overaggressive at times and Jimmy had occasional nights when he wet his bed. But generally all family members seemed to be progressing appropriately in their mourning process. Jimmy's urging that the F.'s come to the clinic was seen as an anniversary reaction to Mr. F.'s death, probably exacerbated by Ms. F.'s trip away.

"Sometimes the circumstances of death, such as a violent one or a suicide, may be cause for shame and may make the subject of the death taboo."

We took the book and reinforced the binding with notebook "reinforcers" and sent the book and family home with the recommendation that they call us as needed.

At the two-year point, we received no phone call, so we decided to follow up ourselves. Ms. F. reported that all was well. She was still having trouble adjusting to her role change as a single mother and felt overwhelmed and harried at times. She had finished her graduate work, acquired a teaching position which was very rewarding to her, was still attending the widows' group, and had recently begun a relationship that she said, "might become very important." Both boys were doing well at school and with friends. Mark, the older, had begun to successfully stay overnight at the houses of his friends. Jimmy, though invited, was not ready for this yet, but his incidences of bed wetting were down to practically nothing. Both boys had big brothers through the Big Brother's organization.

Ms. F. said that in the second year, they had continued to read the book together though not as often, and that she would sometimes find one or the other of the boys, usually Mark, engrossed in it. She said that they sometimes still cried when they read the book, but that the pain had diminished. The book stayed in its safe place on the shelf for whichever family member who might need it. Ms. F. expressed her gratitude for the book and later wrote the Director of the Clinic a letter expressing her thanks.

Case 2: The H. Family

The family was being seen in treatment for problems of stress and family disruption at the time of the divorced 32-year-old father's death from a malignant melanoma after a three-year illness. The family consisted of Ms. H., a single mother, with two daughters, Ruthie age five, and Sharon age seven. Also attending meetings periodically was Sam, Ms. H's live-in boyfriend. Because of the divorce (which had occurred four years previously), this book was viewed as "belonging to the two children." However, mother was included with Ruthie and Sharon in almost every session as a "therapeutic ally" in an attempt to help her help her children with their feelings of loss, and in an effort to increase family cohesiveness.

Ms. H., as a self-supporting single mother with two young children, typically experienced role overload and the family style tended toward chaos. However, Mr. and Ms. H., after the divorce, when their daughters were very young, had managed to remain on good terms and the girls had regular contact with their father. Ms. H. had contributed financially to help her ex-husband with medical bills and Mr. H. had been included in several therapy sessions with his daughters. Mr. H.'s death was unexpected in spite of his long illness and there had been little anticipatory grieving.

We met in the therapy room to begin the book soon after the family's brief memorial service, and the making of it continued for slightly more than three months. Ruthie and Sharon were invited to bring in photographs to include and simple materials such as markers, crayons, and collage pictures were offered. At times the therapist suggested specific directives. At other times free drawing was encouraged, as themes emerged indirectly. Verbal exploration, discussion and writing on the artwork were encouraged to extend communication. At times, Ruthie and Sharon directed me or their mother what to put on the picture and we wrote it for them.

The weekly therapy sessions were often attended by Ms. H.; occasionally the two girls met alone with the therapist to allow freedom for information and feelings that might be difficult for the children to say in front of their mother. Communication was enhanced when the girls shared these pages with their mother.

The artwork centered around typical issues of grieving, separation and loss.

The following are chronological, though not consecutive, examples of artwork from beginning, middle and ending phases of the book.

Figure 1 shows the front cover of the book finished and bound by the therapist upon completion. Then the book began with a page of Sharon's (age 7) writing:

> Daddy died Sunday. He was lying sick in bed when all of a sudden the door sprang open and two little girls came in. The nurse had to wake him up becuase (sic) right before they came, daddy had just had a shot. And right after they left he died.

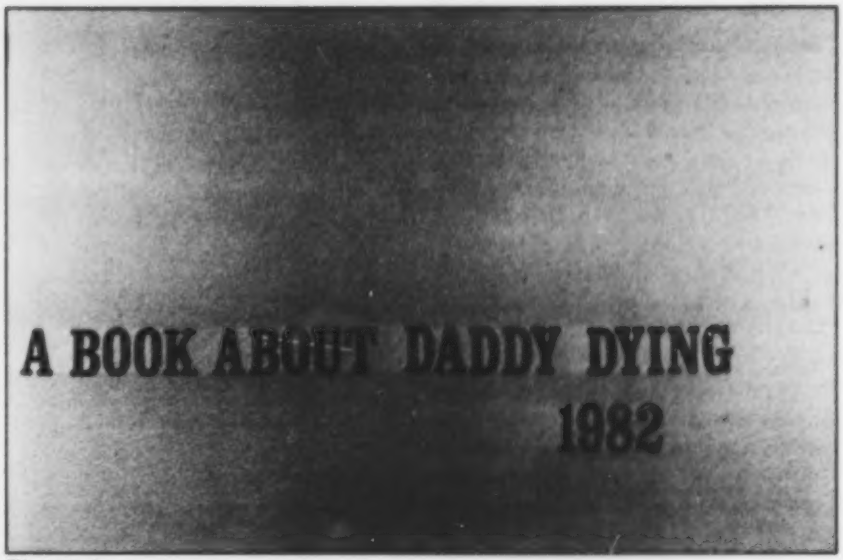
Figures 2 and 3 by Sharon, show the visit to the funeral home and the cremation. Pages in the first section of the book, along with feelings of grief, were often informational in tone. In the middle phase of the book more ambivalent expressions prevailed. Figure 4 shows pleasant memories of past times, together with loss. Also in this section appropriate underlying anger surfaced.

In Figure 5 "Daddy Lying Sick in Bed," a spontaneous drawing, Ruthie showed her vivid and mixed feelings. She told me about the picture and I wrote the words on another sheet of paper for her:

> Daddy's in pain. He feels sad and all Daddy said when we went to visit him was "Hi L," cause L's my Grandpa and he is very tall. I wished he would say "Hi" to me. I felt mad that he didn't say "Hi" to me because I wasn't tall enough. I held his hand. My grandmother kissed him. I wanted to kiss him but right after she kissed him it was time to go because he fell back to sleep. I felt mad that I didn't get to kiss him. But there was another reason I didn't get to kiss him. I was scared cause he looked scarey. He had his mouth open and he was breathing hard and he was moaning.

Sharon's drawing of the aggressive "Packman (sic) Eating Daddy's Dreams" (Figure 6) depicted her normal rage metaphorically. In the last month of making the book, Ruthie expressed a reunion fantasy and a wish to have a tangible part of her father (an ash) in Figure 7. Figure 8, done by Sharon in a last session, "Daddy is as nice as a butterfly" shows Daddy floating away, smaller than the butterflies and in the distant top corner.

In her drawing from the end of the book, Sharon pictures one of her Father's



A BOOK ABOUT DADDY DYING
1982

Figure 1

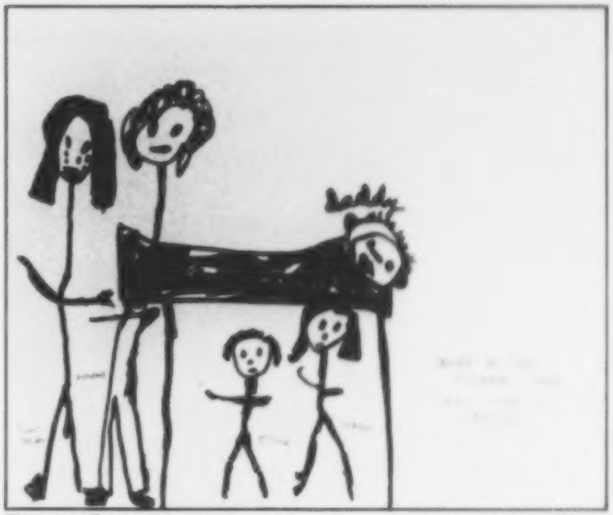


Figure 2

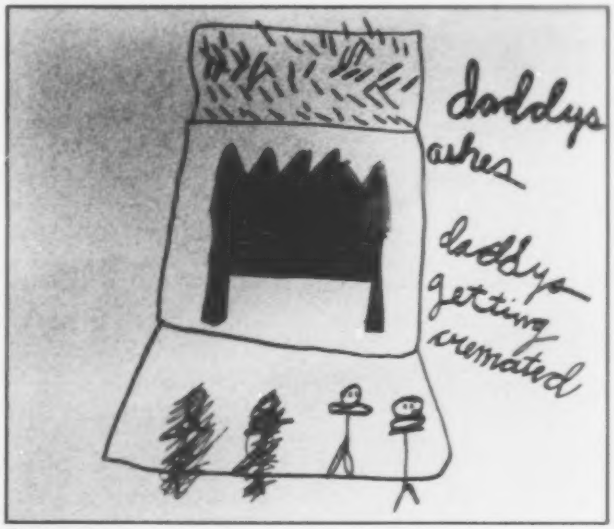


Figure 3

BEST COPY AVAILABLE

drawings. During his illness, Mr. H. had been involved in a holistic cancer program which utilized techniques of guided imagery and drawing. After his death, the girls had asked to have his drawings and were given them. Both children often mentioned his drawings during the course of our therapy time, as if their father's imagery on paper, now in their possession, had provided some tangible evidence of his presence in their lives. They often drew "his pictures" in their book.

For the last page of "The Book About Daddy Dying" Ruthie and Sharon each chose to render one of their father's drawings. Sharon illustrated three arches (Figure 9) with a hand-written "I love you Daddy" covered by a paper flap (perhaps representing their lost father, the shape resembled a tombstone). Over the arches is a vibrant red sun setting into dark blue clouds. The sun has a few spikey points on the bottom reminiscent of the spikes of hair, typical of the girls' portrayals of their father's head, bald from chemotherapy. It is my speculation that the three arches represent the remaining family group with Mr. H. as the setting sun in the distance.

In the last session, we took the calendar and counted up how long it had been since the day of Mr. H.'s death. The girls wrote: "Daddy died May 3, 1982, on Sunday, 14 weeks and two days, three months and a week, 100 days ago today," and the book was finished.

Approximately a year later, I met Sharon and Ruthie in the waiting room where they were waiting for their mother, who was now participating in a group with a colleague in the office. Sharon's first words to me were "We still have the book."

Conclusion

Each life transition in the developmental phases of a family requires more or less drastic changes by all family members and death demands a uniquely difficult adjustment. The art therapy technique described, based on a family systems approach, has as its goal the openness and flexibility of the system at a time of great family crisis and change. The book is seen as preventive as well as ameliorating in that if grief is incompletely

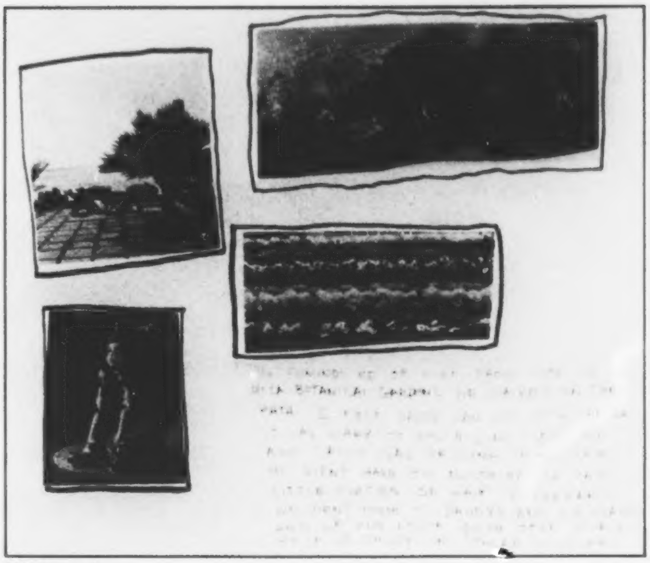


Figure 4

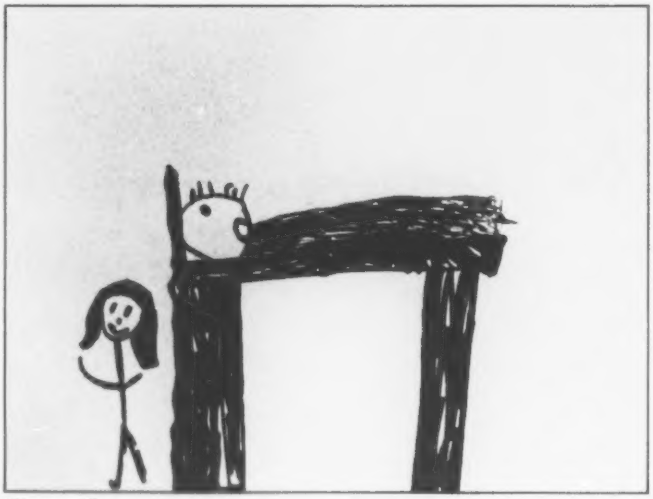


Figure 5

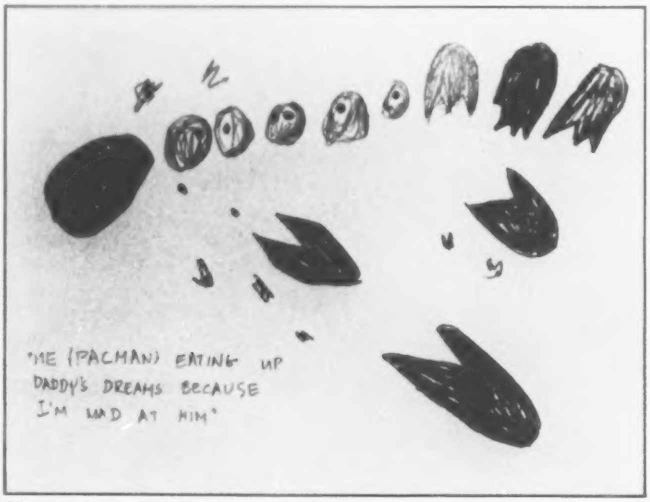


Figure 6

resolved by the premature closure of the system, family dysfunction and the development of psychopathology can result. This therapist believes that a book such as this can be an instrument of important family ritual to aid in a successful transition.

Grief rituals such as traditional funerals require the expression of different emotional reactions within a context and thereby can help stimulation of both the mourning process and the restoration of normal life. In making the book, family members are given permission to express, communicate and work on the many feelings of grief within the safety of the therapeutic milieu.

Rituals consist of symbolic acts and often objects with symbolic value may be used. Being able to work with the symbolic act or object implies both a focus and a certain amount of distance and can free up the investment of psychic energy for real life activities. A book such as that described is a permanent, stable container of memories, feelings and of a history. Like a life it has a beginning and an end and thus can provide a symbolic way of working on the sense of loss caused by a death. This may be particularly important in helping young children gain some level of understanding and comfort.

"Each life transition in the developmental phases of a family requires more or less drastic changes by all family members and death demands a uniquely difficult adjustment."

We began and ended our sessions. We began to make and finished making the book's pages. We began and ended reading the book and we began and ended the first year and continued on to the next. And throughout, the book remains in a "safe place" on the shelf to remind us of our beginnings and our endings and our constancy in the face of

continued on page 10

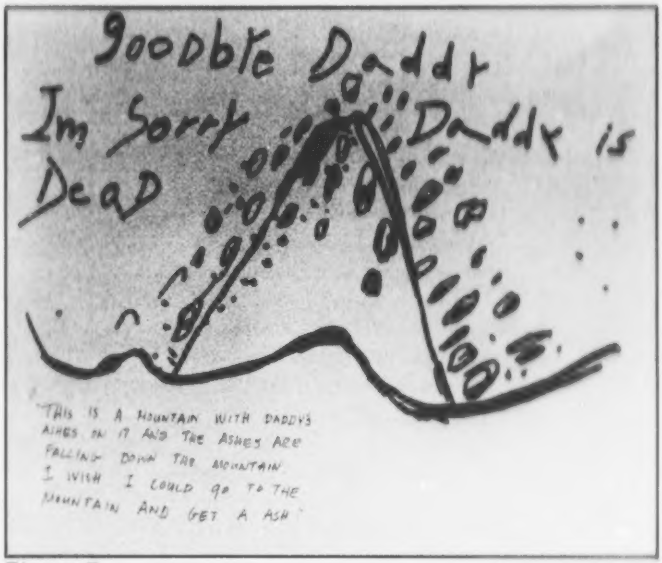

9ooDbYe Daddy
Im Sorry Daddy is Dead
"THIS IS A MOUNTAIN WITH DADDYS ASHES IN IT AND THE ASHES ARE FALLING DOWN THE MOUNTAIN I WISH I COULD GO TO THE MOUNTAIN AND GET A ASH"

Figure 7

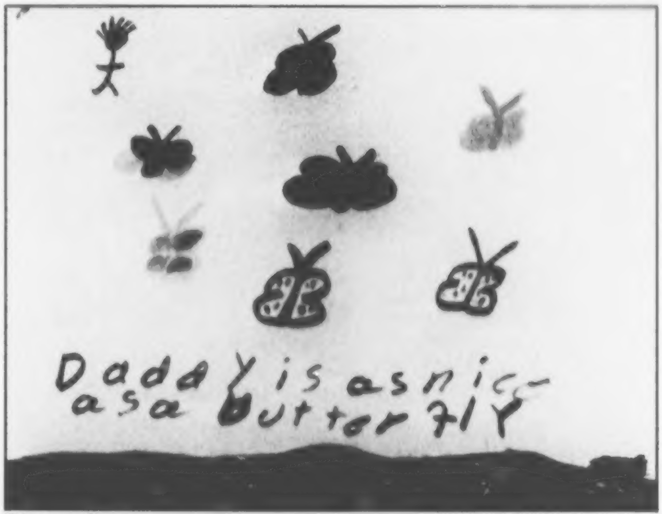

DaddYisasnic-
asa butterflY

Figure 8

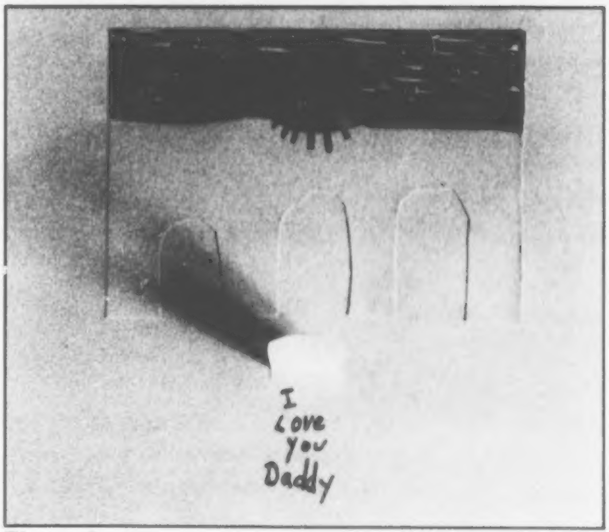

I Love You Daddy

Figure 9

MANDALA ASSESSMENT SEMINAR SCHEDULED JUNE 1985

The CLINIC FOR HUMAN DEVELOPMENT, Clearwater, Florida, will sponsor a 30-hour course in MANDALA ASSESSMENT. The instructor will be Joan Kellogg, MA, ATR. A Certificate of Completion will be awarded by MARI, Mandala Assessment and Research Institute, to participants. Part #1 and Part #2 will be held on two consecutive weekends in June; attendees may elect to take one or both parts. **Dates:** June 21, 22, 23 and June 28, 29, 30. Course will be repeated in September, 1985.

For information write to Clinic for Human Development, 925 Lakeview Rd., Clearwater, FL 33516, Attention Ms. Sally Meadows. Phone numbers: (813) 447-7606 or (813) 581-0786.

Certificate course fee: $300

For information on on-going evening courses write MARI, P.O. Box 14009, Clearwater, FL 34279-4009, or call (813) 796-1341.

American Art Therapy Association, Inc.

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, Art Therapy, discounts on publications, discount on admission to the annual convention, as well as pertinent information about research, insurance, and other matters of interest.

MEMBERSHIP APPLICATION

☐ $40 Associate ☐ $25 Student ☐ $80 Contributing
(copy of student ID req'd)

Name ______________________
Last First Middle

Preferred Mailing Address ______________________

____

____
City State Zip Code

Phone ______________________

Title ______________________
Occupation or Profession

____
Employer or Educational Institution

Make checks payable to AATA and return with application to:

American Art Therapy Association
1980 Isaac Newton Square South
Reston, VA 22090

A Landmark Publication for Every Therapist

The Psychosocial Therapies: Part II of The Psychiatric Therapies
The American Psychiatric Association Commission on Psychiatric Therapies
Chaired by Toksoz Byram Karasu, M.D.

Five years in the making, this landmark reference objectively examines the major psychosocial therapies and places them in perspective. Under the careful guidance and scrutiny of the Commission, the presentation of each therapy includes historical background, basic theoretical issues, strategies and techniques, indications and limitations, and developmental age-related issues. This book will be a guide and classical textbook for all clinicians for years to come.

Contents of The Psychosocial Therapies:
• Psychoanalysis and Individual Psychotherapy • Disorder Specific-Manual Based Psychotherapies • Group Therapy • Family Therapy • Behavior Therapy • Experiential, Inspirational, Cognitive/Emotive, and Other Therapies • Biofeedback • Milieu Therapy – Nursery Schools, Children and Adolescents • Therapies for Psychosexual Dysfunction • Hypnosis • Narcosynthesis • Creative Therapies • Psychodrama • Occupational Therapy • Self-Help Groups • Psychotherapy Outcome Research.

The Psychiatric Therapies:
#42-102-1, $49.95, 932 pages, index, casebound, May 1984.
The Somatic Therapies:
Part I of The Psychiatric Therapies
#42-104-8, $17.50, 366 pages, softcover, September 1984.
The Psychosocial Therapies:
Part II of The Psychiatric Therapies
#42-103-X, $25.00, 617 pages, softcover, September 1984.

Send a check or money order in the amount of the cover price, plus $2.00 (shipping/handling) to Department **894**, 1400 K Street, N.W., Suite 505, Washington, D.C. 20005.
Or MasterCard or Visa holders **call 1-800-368-5777** to place your order by phone (9-5 EST, in Washington, D.C. call 682-6262)

American Psychiatric Press, Inc.

"The Book About Daddy Dying"

continued from page 9

them. It is a book made by those still living and is representative of the acknowledgement and permanancy of important feelings and memories and that those we love live on in our memories and feelings. This acknowledgement can be crucial in the process of saying goodbye, for it is the beginning of letting go and of going on.

Bibliography

Beecher, D. and Margolin, F. "How Surviving Parents Handled Their Young Children's Adaptation to the Crisis of Loss," *American Journal of Orthopsychiatry*, 1967. 37, 753-757.

Bowen, M. "Family Reaction to Death" in *Family Therapy: Theory and Practice* ed. by Guerin, P., New York Gardiner Press, 1976.

Bowlby, J., "Processes of Mourning," *The International Journal of Psychiatry*, XLII: 317-40, 1961.

Freud, S. (1917 [1915]) *The Standard Edition of the Complete Psychological works of Sigmund Freud* Vol. XIV (1914-1916). London: The Hogarth Press. 1957, 237-260.

Herz, F., "The Impact of Death and Serious Illness in the Family Life Cycle," in *The Family Life Cycle*, Eds. Carter, E. and McGoldrick, M., New York Gardiner Press, 1980.

Holmes, T. and Masuda, M. "Life Change and Illness Susceptibility" in *Separation and Depression Clinical and Research Aspects*, Pub. 94, Washington, D.C., American Association for the Advancement of Science, 1973.

Kübler-Ross, Elisabeth, *On Death and Dying*, New York, McMillan Publishing Co., Inc., 1969.

Shneidman, Edwin S., Death: *Current Perspectives*, New York, Jason Aronson, Inc., 1976.

Solomon, M. and Hersch, L. B. "Death in the Family, Implications for Family Development," *Journal of Marital and Family Therapy*, 5/2, April, 1979.

BEST COPY AVAILABLE

Object Relations Theory and the Language of Art

Tools for Treatment of the Borderline Patient

Ruth Obernbreit, MPS, ATR

Ruth Obernbreit, MPS, ATR *is Assistant Professor, Adjunct Faculty, Graduate Art Department, College of New Rochelle, New Rochelle, New York, and Art Therapist, Long Island Jewish/Hillside Medical Center, New Hyde Park, New York.*

With the advent of Object Relations Theory, art therapists have a new framework relevant to their work. This approach is particularly useful in understanding the patient whose unresolved issues involving separation and individuation result in borderline pathology. Borderline patients are often drawn to creative endeavors, and in clinical situations are referred to art therapy so that this strength can be tapped and used to expedite treatment. The art process as experienced by the borderline individuals parallels their internal dilemmas. D.W. Winnicott's concept of the transitional object phenomena is of importance for understanding this type of patient. The borderline's inclinations toward the creative process can be correlated with developmental arrest, pointing to the stage when transitional experiences did not lead to separation. The art provides a vehicle to remaster this deficit. The language of art, and the many methods through which art is taught can address these intrapsychic phenomena. The art therapist can transpose (object relations oriented) clinical understanding into elements crucial to the making of art and prescribe them as borderline patients experience their disabling condition in art therapy treatment. These elements are claimed to be restorative to the patients fragmented ego. The paper supports specific art therapy techniques correlated with theory from the school of object relations.

Introduction

"It's an excellent shoulder," remarked the instructor to the art student, "but it's *not* what is out there." The artist's interpretation of the form had lacked contact with the model being drawn. The instructor witnessed this falseness and confronted the student in terms of the art. "Look at the shoulder," he suggested, "and find a line that is true."

I was a student in a life drawing class when I overheard these words. At that time, as an art therapist I worked with hospitalized patients who were diagnosed as borderline. They were a group that mystified me. Bright, engaging, verbal, and displaying no psychotic features, these patients were initially responsive to art therapy. These individuals seemed to like art and more often than not expressed themselves with great intensity and insight. (Figures 1 & 2) These attributes alone would not prove to be the basis of a working therapeutic relationship. I was perplexed by this group that was drawn to the arts but seemed unable to use the art experience as a restorative tool.

To enhance my clinical understanding, I read works by leading object relations theorists. I found the works of Winnicott,

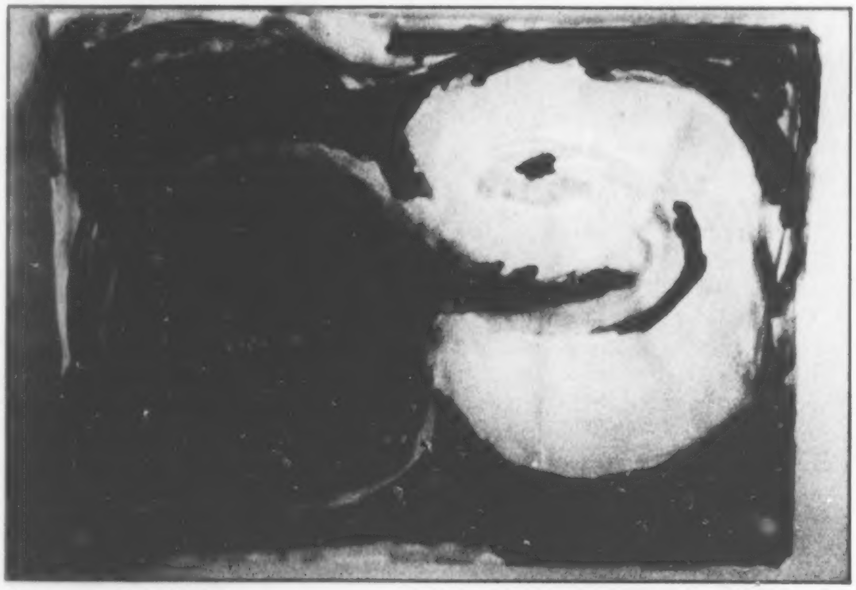


Figure 1—"Rebirth"

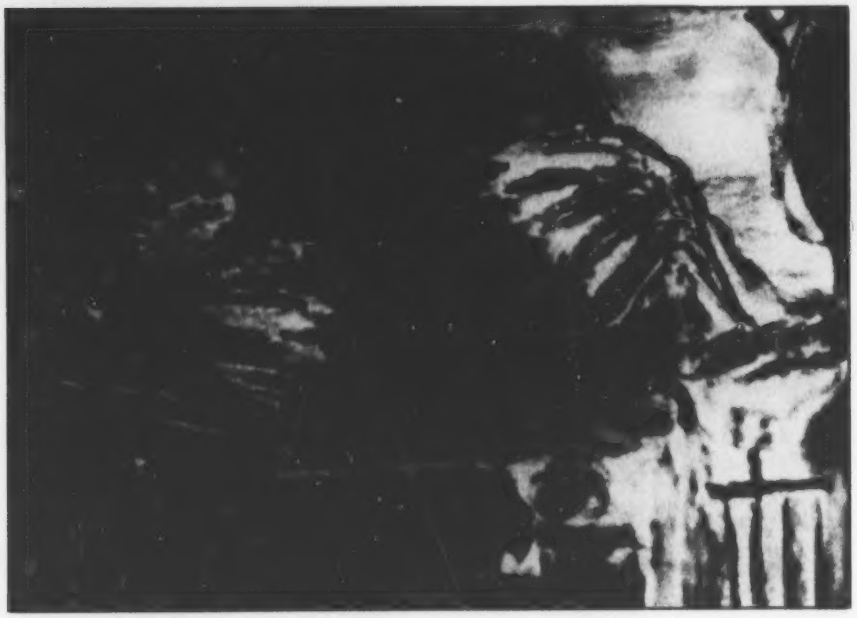


Figure 2—"About Trying to Touch"

"*It became clear that artistic perception and the ability to carry it out had much to do with one's internalized relations to objects.*"

Guntrip, Kernberg and Horner to be diverse and interesting, but techniques regarding the application of the theory within a framework of art therapy still eluded me.

The drawing instructor spoke to us using speech that was a type of shorthand. Things "worked" or they "didn't work." There was a great deal of discussion about form and space. Talking to the woman beside me, the instructor spoke about *how her narcissism was causing her to distort her perceptions, and as a result, her picture was out of control.* He did not use these words, of course; he spoke to her in the language of art but being influenced by recent studies I found myself translating his comments in a therapeutic context. In being able to translate problems into another "language," one could understand that what was addressed was crucial to both the artist and the clinician. For example, elements of projection, internalization, narcissism: how much of the model can one let in, and how much of one really "reaches out" to grasp the essence of something outside oneself? (Figures 3 & 4) It became clear that artistic perception and the ability to carry it out had much to do with one's internalized relations to objects. I began to eavesdrop on discussions that were basically concerned with the self and reality and the intricate process whereby they meet on paper.

What this meant in terms of my patients was that I found a way to transform the problems patients were having with their work into concepts germane to object relations, and conversely could easily see how problems with the self were manifested in terms of the creative process. Being able to understand art vis-a-vis an object relations framework led to therapeutic techniques particularly applicable to the borderline patient.

The Borderline Dilemma

Borderline patients represent a unique clinical picture because they exhibit characteristics similar to both neurotics and psychotics. Unlike psychotics, they maintain reality testing, but have not achieved the neurotic's integrated self identity (Kernberg, 1975). The adult borderline is psychologically arrested in the developmental realm of toddlerhood. One can say that they have one foot in the world and one foot in the womb, thus explaining their capacity to function on disparate levels. In an attempt to maintain the balance between symbiosis and separation, the borderline's relationships are marked by ambivalence. On becoming close to someone they fear

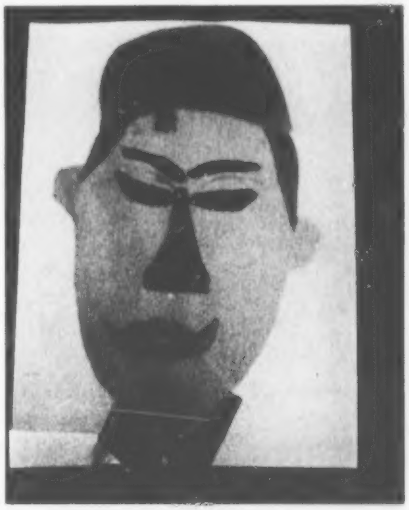


Figure 3—"How much of one really reaches out to grasp the essence of something outside oneself?"

This portrait done by a patient of another member of the art therapy group resembles the creator far more than the subject. The portrait was made with construction paper cutouts.

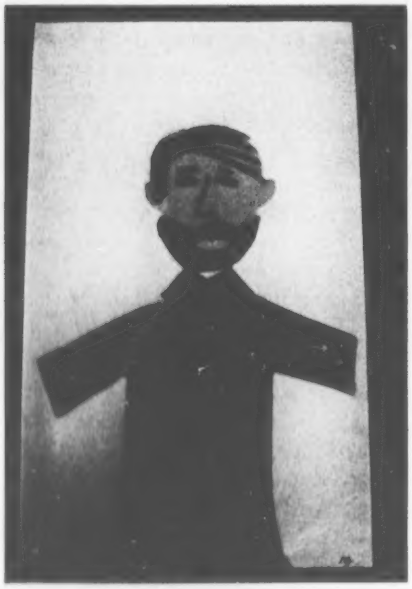


Figure 4—In this portrait the creator was able to capture something of the subject.

merging, but when there is too much distance, they will experience a sense of abandonment. Because their object consistency and self identity are not developed, the self oscillates back and forth and their ambivalence about separation becomes part of a life pattern. This life position is confronted when borderline individuals become involved in making art.

The borderline individual is seemingly receptive to art media but often approaches the task with a grandiosity which only feebly covers their extreme vulnerability. A better appreciation of the nuances of this psychic state might be had by reviewing the basic tenets of Object Relations Theory.

Object Relations Theory

- The term "object" in object relations theory is borrowed from philosophy and when used philosophically refers to the "other," that which is not the self.
- Objects relations theorists uphold the principle that human beings are epigenetically programmed to respond to other human beings. The psyche internally organizes because of this emotional contact. This theory differs from the classical Freudian position which postulates character development as deriving from the regulation of instinctual drives.
- Object relations theorists see human development occurring as a result of internalized early mother-child relationships. At birth, the infant is in a state of normal autism; he/she is unrelated (Mahler, 1968). In infancy, he/she forms an attachment to the mother, thereby contributing to a mutually satisfying symbiosis. The infant is dependent on the mother to organize his/her environment and takes in sufficient emotional supplies in order to reduce frustration and achieve a sense of security. The mother cannot always be physically and emotionally available to meet the infant's needs, and thus emerges the inevitability of object loss.
- In response to the lost object the baby invents a substitute force to fill its needs and creates an affectual and abstract replacement. With a need to replace the mothering figure, the child turns to actual objects. A blanket, a stuffed teddy bear or a piece of mother's clothing is imbued with emotional significance. The object does not have to be of particular substance. It can be a crack in the ceiling or a familiar corner in the room where the eyes can comfortably rest (Grolnick et al. 1978). An emotional exchange ensues and the baby receives the comfort from a relationship that he/she initiates. This activity is an example of projection.
- These new cognitive experiences and the attachment to an object are said to be "transitional" because they serve as mediators between the inner psyche and the outside world. The infant negotiates these two realities by adapting to loss through creation (Winnicott, 1953).
- The infant, in being able to play in this way, now has some flexible control between fact and fantasy, being alone and not being alone. Because of this new cognitive capacity, the baby can safely practice separating from mother. In doing so, the development of an emotionally independent self is initiated.
- The emergent self is elaborated in terms of the concepts of the true self and the false self (Winnicott, 1960). The true self is the basic core of our being. It forms the nucleus for an organized self-identity. The false self is the part of the personality that develops when the core being is not accepted by the environment, i.e. the mother may respond to the baby in accordance with her own needs and not those expressed by the infant. Consequently, the false self organizes to conform to mother's desire and if successful, hides the true self.

> ". . . At the earliest stage the True Self is the theoretical position from which come the spontaneous gesture and the personal idea. The spontaneous gesture is the True Self in action. Only the True Self can be creative and only the True Self can feel real . . ." (Winnicott, 1965 p. 148)

The Borderline and the Art Therapy Milieu

In the formative early years, emotional independence for the borderline was not fostered; a "true" self was not supported. Instead, symbiotic yearnings were rewarded sufficiently to thwart the completion of the transitional phase of development normally leading to a separate self-identity. The borderline thus has a chronic need to create a transitional object, a substitute for attachment. Due to a vague and shifting constellation of a self, borderlines experience difficulty obtaining the relief and creative satisfaction that transitional phenomena have to offer, yet this sphere holds attraction for such a population. Unlike the artist who, as it will be later explained, makes use of the transitional arena to refurbish, the borderline has never left this transitional arena. The borderline thus has easy access to creative realms, but enters them largely as a result of psychological necessity. These individuals find themselves acutely sensitive to transitional experiences but lack the ego strengths necessary to do anything with these very perceptions.

Issues pertaining to the true and false selves come into play when the borderline embarks on a creative task. The frustration oftentimes expressed is the result of the person creating from an inauthentic (false) position. The "true" representation, when not hidden, flounders without an organizing ego to support it. This explains, in part, why so many attempts at art work by the borderline patients wind up crinkled in a ball or torn to shreds.

Skills needed by the artist are unavailable to this individual: the ability to tolerate frustration; the ability to withstand the anxiety of something unfinished or undeveloped; the capacity to maintain a sense of control over the self while experiencing closeness to the work; the capacity to retain distance and objectivity; the ability to perceive positive and negative attributes in the same work; the capacity to take a point of view; and the capacity to experience pleasure and love what one is doing. These attributes, all functions of the ego, are not always available to the borderline.

When involved in creative efforts, the borderlines' relationship with their artistic productions mirror their inner

"There is a wish that the creative tools will magically produce the image intended. When this does not occur the borderline experiences inordinate frustration."

object relations. They will treat their work in a way similar to how they relate to themselves and others. For example, their expectations that the "other" should symbiotically gratify needs gets projected onto the art materials. There is a wish that the creative tools will magically produce the image intended. When this does not occur the borderline experiences inordinate frustration. The medium is perceived as an obstacle rather a challenge. This position taken by the borderline is in contrast to that of the artist, who might find the process of making art an exciting struggle.

Due to the borderline's fragmented sense of self he or she will be terrified by the chaos that is inherent in the artistic process, and frustrated by the lack of immediate resolution. This individual will experience the work in parts, each part perceived as either very good or very bad. This splitting makes it impossible to experience the work as part of a whole. Because the borderline exists psychologically in two places, a consistent point of view with regard to the work is also unobtainable. Without a stable core self within, external and internal stimuli are confused. Associations, projections, and distortions easily overwhelm the psyche. The frustration experienced is typified by one of my first borderline patients, a young woman named Leah:

> Leah G., a 23 year old woman diagnosed as borderline, was referred to the art therapy studio in a long term psychiatric facility. She came in totally delighted to have the opportunity to do some art work. Leah told the therapist at length about her past endeavors in art, which included working for a commercial art studio. She had an idea for a painting based on a dream she recently had, and proceeded to describe it in full, including an interpretation. She was asked if she would like to do a sketch of the image. "No," Leah replied. "I would like to paint it because it is very important." Insisting that she could handle the oil paints available because of all her experience, she walked towards a large stretched canvas and said, "I've got to get started." She spent the first session getting set up and then became annoyed when told it was time to clean up.
>
> The subsequent session found Leah frustrated in her attempts to "get it right." She started over a number of times, always obliterating with turpentine all that she had painted. Leah did not attend the third session. During the fourth session, she tried a new approach. Rather than paint with a loose medium she employed a palette knife and used thick globs of paint. Exasperated, she said, "Ugh, I hate it!" and taking the palette knife attacked the painting as if to rip it open. Frustrated and angry, tears came to her eyes.

The Artist's Experience

The intrinsic nature of making art requires the artist to be able to move freely through various developmental stages and to experience a sense of object relatedness with the work itself. For example, the artist goes back to the transitional arena in order to create, and can also move out of this state with freedom. The artist may, in fact, re-experience the continuum from unrelatedness to attachment to separation and individuation in the creative act itself (Rose, 1980). The capacity to substitute, invent, and re-create, rooted in early development, lays the foundation for future creative endeavors (Rosen, 1964).

The artist, cognitively comfortable in transitional realms, depends on transitional phenomena to help him/her perceive a more multidimensional view of things. He sees things as both fact and illusion.[1] This capacity for multiple perception relates to early experiences with transitional phenomena; for example, the baby's perception of the teddy bear. The teddy bear as transitional object is teddy bear is fact. It is a piece of objective reality; it is brown; it is fuzzy; it has two plastic eyes. But it is also teddy bear as illusion. It simultaneously represents a subjective inner reality; it has soul, a personality that is projected from the introject of good mother.

The artist masters this paradox of fact and illusion by calling upon his artistic sensibilities to reconstruct reality through form (Rose, 1980). In the midst of this fluid process, the artist strives to project a particular point of view towards his/her subject. The artist directs the work so it accurately expresses perceptions stemming from within. The creator aspires to be true to the emergent image. The work goes through many stages, as does the artist's relationship to the work, but that which is considered to be a successful piece feels "true." If the finished work resonates with the psychic structure of the self it is experienced as legitimate. (Figures 5 & 6) The finished successful work is one that is ego-syntonic.

The working artist knows that perhaps twenty studies may be necessary until one will yield an image that feels right, that is ego-syntonic. Each attempt is neither discounted or devalued as worthless in its rough and imperfect state. Each was necessary because it contained bits and pieces of the creative process essential for the development of an idea. The way the arm was depicted in one study, the spirit was captured in another, the use of space in yet another are all consciously or unconsciously remembered and used in the future. The studies are part of a continuum in which no one aspect is good or bad, but represents necessary components of the creative process.

The artist experiences a dialogue, not always an easy one, between his or her medium and ideas. Materials are respected, and the artist needs to be aware of their limitations. The artist struggles to work within the bounds inherent in the materials. He/she must experiment, must do and undo, and has to tolerate the work being unfinished. He/she must

"The intrinsic nature of making art requires the artist to be able to move freely through various developmental stages and to experience a sense of object relatedness with the work itself."

return to the place where one might be at an impasse. He/she must be able to get very close to the primary source of inspiration within, so one can "feed" the work as well as move away from it so as to objectively critique it.

The way in which the artist speaks about his/her work offers clues as to how these issues can be addressed in treatment. It is the art therapists' own experiences with these aspects of the artistic process that perhaps make us uniquely empathic toward the borderline individual who has been unsuccessful in developing skills necessary for artistic differentiation.

Treatment: The Language of Art

Language belonging to the art world speaks of elements crucial for persons struggling with self identity and object relations. Common art phraseology is replete with notions about form or lack of it, structure, or lack of it, and being true to the mind's eye. In talking and writing about art, the language used by artists borrows heavily from emotionally laden words describing relationships and the manner of relating to the work. Elements of the work can be spoken about in this dynamic way:

"The shapes are aggressive."

"These are lines that scream NO!"

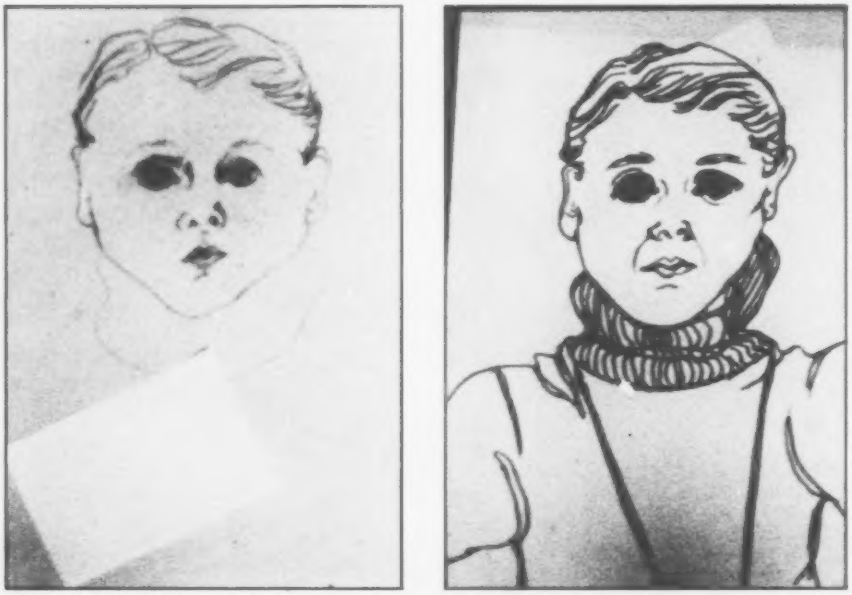
"The picture cannot decide what it is about."

Words from the art critic's page reflect this way of speaking about art:

> " painting is a synonym for truth where all mistakes are visible."[2]
>
> "The forms are locked in their struggle for dominance."[3]
>
> "The painting gives an impression of color so totally enveloping the viewer that other factors are initially obscured Color was restricted in what appeared to be a conscious effort to deal with structure"[4]

The art-critic author is implying that affect takes over so that organization is obscured, and then affect is limited, so structure emerges. Language belonging to the art world makes it possible to label unconscious dynamics in a non-judgmental way. Use of non-pejorative phraseology from the art milieu is restorative to the punitive part object within one that harshly judges this individual.

This way of speaking about oneself and one's work could be internalized through learning a new "language." The terms become metaphor and shorthand for the patient to assess aspects of the self. He/she can discuss what intrinsically feels true , and can perceive those parts of the self as reflected in the art process: parts that are genuine, contrived, impulsive, rigid, spontaneous, whimsical, etc. By immersing treatment into the realm of art, yet understanding what is being experienced in terms of the patient's object relations, the art therapist has the opportunity to communicate to the individual an understanding of what he is feeling in a non-toxic way.



Figures 5 & 6—These self portraits were done as part of a series executed in front of a mirror by an adult borderline patient. She depicts herself as very young. As treatment progressed, the self image drawn began to take on greater maturity. The portraits were ego syntanic with her then psychic states.

The clinician addresses the issues by translating them into the language of art. "What parts of the piece work? What parts don't work?" Speaking about the art as working or not working allows for exploration of inner dynamics with a minimum of anxiety. "What does the picture need?" The work can be spoken about in terms of needs that can be met. In approaching the art as an object that had needs that can be met, the patient is forced to separate from the picture and respond to it as a distinct other with its own requirements. He/she can find creative ways to highlight aspects that are ego-syntonic and true to the self.

The art therapy milieu affords such an individual the opportunity to remaster problems concerning the self. Recall that it is the baby's capacity to invent his own imagery which is the first step towards establishing a self and moving away from the symbiotic orbit. In a therapeutic situation, the individual has a chance to recreate something that will help him/her to respond to the object world in a healthier way. The art is a suitable vehicle in which something pathological (i.e. arrest in the transitional sphere), can be maximized and transformed into something positive—art that is connected to the true self. In redirecting the creative process, stimuli are untangled and new concepts about the relation of self and others can be internalized. "Self and work create and transform each other."[5]

The borderline presents special treatment concerns with regard to the internalization of such new experiences. It is profoundly difficult for this type of person to internalize what the art has to offer because the necessary curative processes inherent in the making of art are experienced as **ego-dystonic**. For example, the borderline may devalue praise because "hating" the work is more comfortable. The work often remains unfinished, similarly because that state resonates with the psyche. Their introjects are negative.

In responding to this, the art therapist is aided not only by a clinical understanding but by the language of art and the lessons learned from artistic training. It is the language and milieu of art which provide the necessary boundaries which enable the borderlines to digest new experiences at their own pace. It is the art therapist's familiarity with the artist's creative process which needs to be further examined and related to difficulties in the borderline's object world.

The art therapist calls upon a wide repertoire of art exercises and prescribes selected ones as the dynamics call for them. For example, in the art therapy studio, it may become apparent that the borderline has great difficulty in organizing time in accordance with a given task. In a life drawing class, the typical short post exercise is very useful to the artist. It helps him/her to warm up to the process and reminds one that the first stroke is not the final one. It also helps the artist to "see" differently as dictated somewhat by time. The "two minute," "five minute," or "ten minute" pose exercise could be very helpful to the borderline who has difficulty in working within the realm of time constraints.

This type of directive not only helps the individual to be more spontaneous, but the boundaries imposed break down the drawing process into manageable segments. (Figures 7 & 8) Such an assignment helps to structure the process of a developing work, a conflictual sphere for the borderline. A live model may be not feasible in a clinical situation, but any object of interest would accomplish the same task. The plant on the windowsill can be depicted taking only two minutes, taking five minutes, and taking ten minutes. This helps the patient adapt to time restraints and also generates a more spontaneous and hopefully "real" response to the subject.

Another example of therapeutically structuring the art process would be to have particular patients work with watercolors, doing studies that would gradually increase in intensity from very watery to opaque. The art materials serve as "the other" with whom this individual needs to learn how to negotiate.

The patient is helped to approach his/her deficits in a controlled and safe way, with a therapist available to intervene as problems with the task are expressed. The therapist, with an understanding of how the individual's object relations will be reflected in this arena, can communicate with the patient about these issues as they are represented in the art. Problems with the self will emerge as drawing problems, painting problems, perceptual difficulties, etc. The picture or piece will scream for help vis-a-vis aesthetic problems. The individual will need help in trying new options. This flexibility is not often possible for the borderline whose rigidity hinders seeing the work through. Assessing the aesthetics of the art is conflictual for the borderline individual who splits the experience into good and bad and cannot handle processes.

"Speaking about the art as working or not working allows for exploration of inner dynamics with a minimum of anxiety."

Art exercises provide a rich resource for interventions with a theoretical base. The creative experience must be modulated in a manageable way and the patient acquainted with gradual change. Different directives parallel different aspects of internal object relatedness. The focus of intervention with borderlines lies not in responding to the content of their work, but in addressing its structure (i.e. what "it needs") and

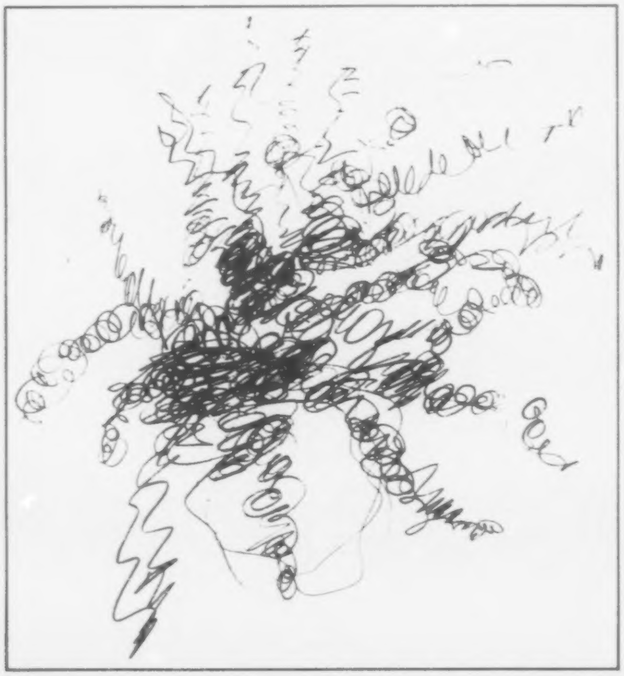


Figure 7—Directive: "Draw the plant in two minutes"

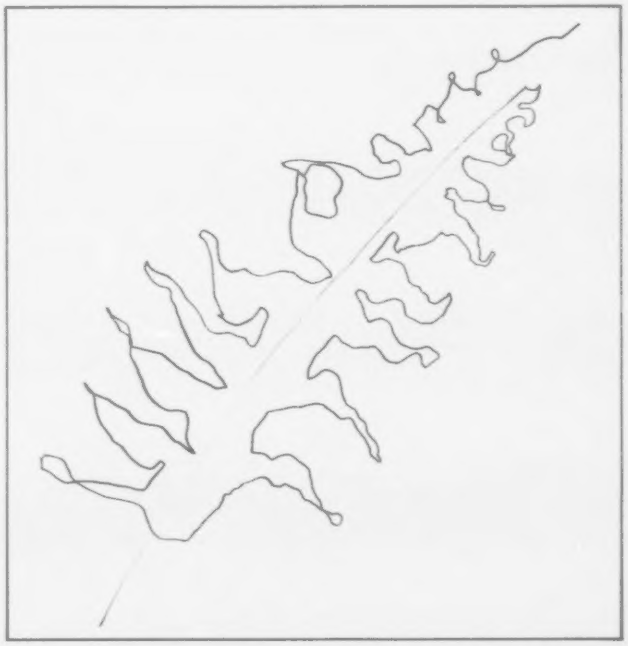


Figure 8: Directive: "Draw the leaf without looking at the page" (contour drawing)

the subtlety of their relationship with it.

Another use of the plant as a model could be used to help foster a sense of the creative paradox. "Draw the plant as if it's tired (slowly) or using only dots or . . ." Such directives have their psychodynamic correlates and moderate the multidimensional ways in which the environment can be perceived. (Figures 9 & 10)

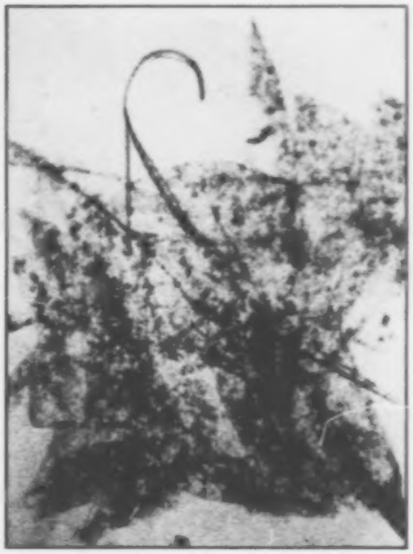


Figure 9—Directive: "Draw the plant as a mass"

Interventions suggesting 'doing a study' could help the individual foster a balance between fact and illusion. Art always requires a negotiation between fact and illusion. If the borderline is too steeped in illusion, no art can be made. This can be seen in the case of Penny, who was referred to the art therapy studio while undergoing long-term hospitalization:

> Penny M., a borderline woman of 33 was working on a pastel portrait of another patient who was sitting across the room. She was having great difficulty with the picture, letting out deep sighs every few seconds. "It's no good," she said. The therapist saw a very anxious person with a very overworked picture. The colors had turned muddy and the form was indistinguishable from the background. Seemingly overrun with associations, the therapist suggested to the patient that she make three "studies" to help the picture. The first was to be about how she herself was feeling. Penny picked several colors and smeared them all together. The second was to be a study of the main characteristic of her subject. She drew a determined looking face. Third was a picture about what she thought her subject was feeling. She drew a face and wrote "embarrassment" over it. Her present picture was having difficulties because she was flooded with her own associations, projections and distortions and was not able to "see." When it was pointed out by the therapist that she was drawing her own discomfort and not the external object, Penny started again and this time was much more able to work on her art.

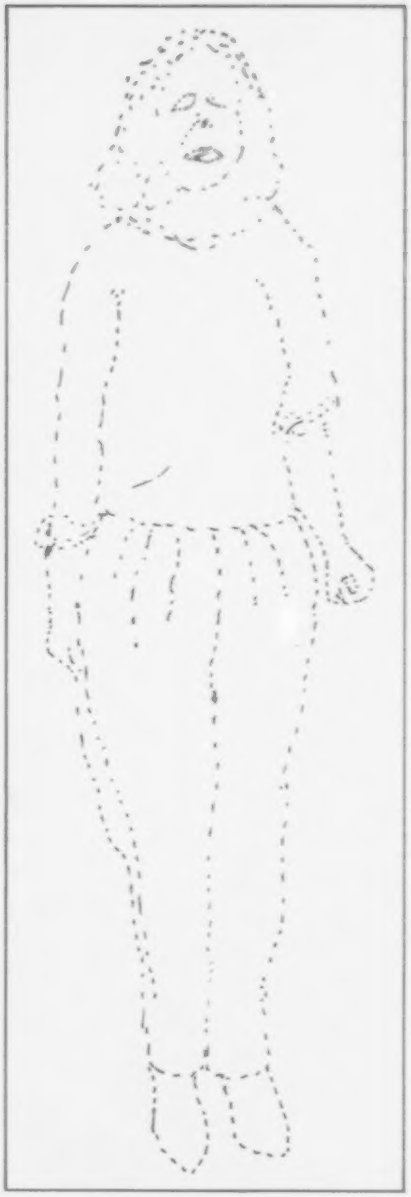


Figure 10—Directive: "Draw the model only using dots"

A problem for the artist, and one in greater extreme for the borderline, is upholding a point of view with regard to the art. Without having one, without having an essential focus from which to work, determining what the art work needs is impossible. The borderline often sets out with a very diffused idea, one without a "point of view," and may struggle to conform to a pre-set notion of how the picture should be. This problem relates to the true self versus false self dilemma. The false self that conformed to mother's desires is reflected in the patient's difficulty in developing parts of the work that come from an organized center within.

"When awareness is visually identified, the patients have a graphic clue as to how to have some control over their projections."

The emergence of the dormant true self can be supported by specific exercises that encourage one's own point of view. At the time that the work or patient is in trouble due to this deficit, the art therapist could suggest a series of studies. These could be brief sketches of things that the patient finds truly appealing such as a color, a shape, or parts of an object. (Figures 11 & 12) The studies are in an incomplete state and the patient is encouraged to capture the essence of something that strikes a chord within and not be concerned with details. This exercise mirrors the task of separating from the introject of mother and being true to one's own point of view.

When awareness is visually identified, the patients have a graphic clue as to how to have some control over their projections. Distance is provided, so the artistic process can be reversed, slowed down and unmangled, separating out internal versus external stimulations. The art therapist calls upon training in art and a style of communication to convey to the borderline patient important and curative concepts. The therapist helps the individual to integrate continuity of experience and the search for authentic representation.

Summary

The "language" of art, and the many methods whereby art is taught, can address intrapsychic phenomenon. The art therapist can work effectively with the borderline patient by being able to conceptually translate back and forth from an Object Relations framework to the "language" of art. An understanding of how object relations are manifested through the art problems that emerge in the work guides the art therapist. While engaged in the creative process, the borderline's difficulty regarding impulse control, reality testing, and authenticity are exposed. In response to specific interventions which utilize lessons from the art milieu, the patient can begin to resolve various developmental crises. The symbiosis with the work slowly breaks down, and the borderline can learn to individuate around the creative work. Art therapists are encouraged to go back to their experiences as artists to recall mechanisms from the art process that draw upon intrapsychic strengths. In doing so, clinical theory of how to treat the borderline in art therapy is enhanced.

References

[1] Credit for concepts relating to art go to my art instructors, Elaine Galen and Fay Spahn of New York City who used many of the constructs (fact and illusion, point of view) in their teachings.

[2] Shnabel, Julian as quoted in *Arts Magazine*, Nov., 1979, p. 86.

[3] "Jonathen Santlofer" by Michiko Miyanoto, *Arts Magazine*, Nov., 1979, p. 3.

[4] Ibid.

[5] Robbins, A., ed., *Expressive Therapy: A Creative Arts Approach to Depth Oriented Treatment*. Eiger, M. and Robbins, A. "Object Relations and Expressive Symbolism" p. 84, New York, Human Sciences Press, 1980.

Bibliography

Grolnick, S., Barkin, L., Muensterberger, W., eds. *Between Reality and Fantasy*. New York: Jason Aronson, 1978.

Guntrip, Henry J.S., *Schizoid Phenomena, Object-Relations, and the Self*. New York: International Universities Press, 1968.

Horner, A. *Object Relations and the Developing Ego in Therapy*. New York: Jason Aronson, 1979.

Kernberg, A. *Borderline Conditions and Pathological Narcissism*. New York: Jason Aronson, 1975.

Kohut, H. *The Analysis of Self*. New York: International Universities Press, Inc., 1971.

Mahler, M. *On Human Symbiosis and the Vicissitudes of Individuation*. New York: International Universities Press, 1968.

Miyamoto, M. "Jonathen Santlofer." *Arts Magazine*, Nov. 1979, p. 3.

Reed, D.W. Julian Schnabel: The Truth of the Moment. *Arts Magazine*, Nov. 1979, p. 86.

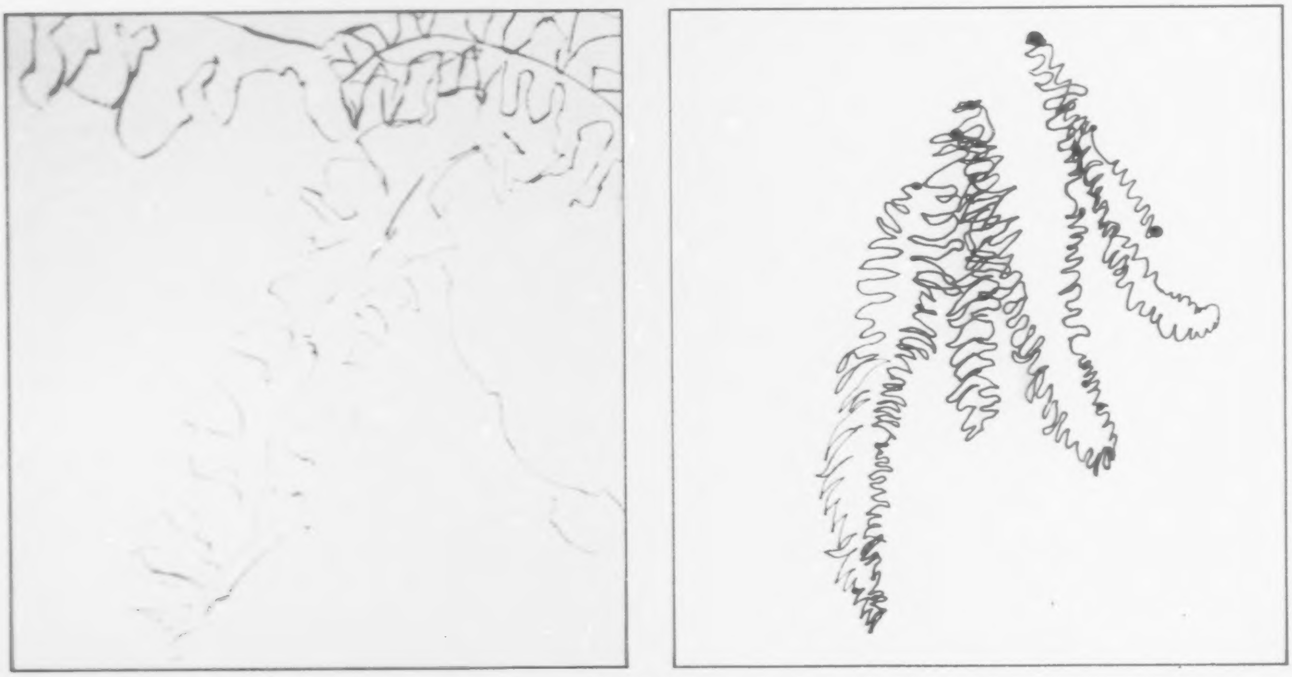
Robbins, A., ed. *Expressive Therapy: A Creative Arts Approach to Depth Oriented Treatment*. New York: Human Sciences Press, 1980.

Rose, G. *The Power of Form*. New York: International Universities Press, 1980.

Rosen, J. Some Effects of Artistic Talent on Character Style, Psychoanalytic Quarterly, 33:1-24.

Winnicott, D.W. Transitional Objects and Transitional Phenomenon. *International Journal of Psychoanalysis*, 34: 89-97.

________. *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press, 1965.



Figures 11 & 12—Contour drawing(s) of the "part of the plant found to be most intriguing."

BEST COPY AVAILABLE

"Art Therapy in the Schools"

A Position Paper of the American Art Therapy Association

This position paper was prepared as a project of the "Art Therapy in Schools" subcommittee of the Governmental Affairs Committee of the American Art Therapy Association. The paper was written by **Barbara Shostak, ATR,** *subcommittee chair, with help of the contributors:* **Audrey DiMaria, ATR** *and* **Edna Salant, ATR** *who initiated the project;* **Nancy Schoebel, ATR,** *Chair, AATA Governmental Affairs Committee, who served as a project consultant; and a review panel of art therapists working in schools. This review panel included:* **Janet Bush, ATR; Virginia Minar, ATR;** *and* **Leslee Pollakoff, ATR.** *The "Art Therapy in Schools" subcommittee is now working on an accompanying resource packet that will include sample job descriptions, goals and objectives, referral forms, and other useful guidelines for art therapists working in schools.*

Art therapy is a psychoeducational therapeutic intervention that focuses upon art media as primary expressive and communicative channels. The art therapy process allows one to explore personal problems and potentials through nonverbal and verbal expression and to develop physical, emotional and/or learning skills through therapeutic art experiences. In art therapy the child can directly manipulate materials and the environment, symbolically exploring, organizing and assimilating meaning from a complex world of ideas and experiences. This process may facilitate order, reduce confusion and uncertainty and promote the integration of experiences. This integrative process is important for children as they experience, communicate and negotiate through developmental levels.

For children with special needs, art therapy in a school setting can offer opportunities to work through obstacles that impede educational success. Art therapy can facilitate appropriate social behavior and promote healthy affective development so that children can become more receptive to learning, realizing their social and academic potential. Therefore, art therapy in a school—whether public or private—can be relevant to a child's education and social-emotional maturation.

In recent years there has been a growing awareness of the value art therapy may have in a child's educational program. There has been slow but steady progress in distinguishing art therapy services from art education, thereby giving opportunity for the inclusion of art therapy services in the schools. Art therapy positions have been created where none have previously existed.

Administrators, parents and professional colleagues need to know the effectiveness of the diagnostic assessment and treatment of children that is possible in art therapy. This knowledge will help to facilitate the continuing development of more art therapy programs in schools.

Target Population

Art therapy can be a treatment of choice for children who have emotional, social, cognitive or physical adjustment difficulties that require specialized remediation within a school setting. Such children are usually identified as having special needs under Public Law 94-142, The Education For All Handicapped Children Act (1975). The term "handicapped" refers to those individuals who are learning disabled, emotionally disturbed (including autistic), hearing impaired, speech impaired, visually handicapped, mentally retarded, orthopedically impaired, or those who have other health impairments (PL 94-142, Section 121a.5). The pressing needs of these youngsters call for unique educational and related services applications.

> ***"For children with special needs, art therapy in a school setting can offer opportunities to work through obstacles that impede educational success."***

Additionally, there are children who are not identified as handicapped, but who may experience difficulty in school as a result of social or emotional problems. Art therapy assists them in achieving an appropriate level of social and academic performance. Difficulties associated with the nonschool environment may be related to a crisis in the home, such as the death of a significant person, parental separation or divorce, physical or mental ailment, physical or psychological abuse, and other disruptive circumstances. The supportive service and direct involvement of an art therapist in the school can help to address, assess and remediate those specific issues.

Behavior problems not visible at home but exhibited at school may be caused by academic-related difficulties, transferring to a new school, peer pressure, problems in socialization and difficulties with authority figures. The resolution of conflicts during a child's educational career may result in more successful school adjustment and more productive adult experiences.

Art therapy is applicable to, and appropriate for, students at all age levels, from pre-school through senior high school and it offers a therapeutic diagnostic and prescriptive approach. Continued efforts should be made to strengthen the program for those students identified as handicapped, and also to develop programs for students who, although not identified as handicapped, would profit from the art therapy treatment.

> ***"Art therapy is applicable for students at all age levels, from preschool through senior high school and it offers a therapeutic diagnostic and prescriptive approach."***

Rationale

Individuals recognized as handicapped qualify for special education and related services. The Senate Report on the Code of Regulations for Public Law 94-142 clearly defines art therapy as a related service that can assist a handicapped child to benefit from education (PL 94-142, Section 121a.305). Art therapy helps the child to resolve the conflicts that can often impede learning.

The distinction between art education and art therapy was clarified by a joint statement developed by the National Art Education Association and the American Art Therapy Association (in a conference sponsored by the National Committee, Arts for the Handicapped). These organizations recognize that art education could contain specially designed instruction to meet the unique needs of a handicapped child. They recognize art therapy as a supportive service designed to assist a child in benefitting from education.

While art therapy and art education are by no means mutually exclusive, their primary goals are quite different. It is possible for a child to need both specialized art instruction and art therapy as part of the requirements for one's education program.

One aspect of interpreting Public Law 94-142 is determining a child's eligibility for art therapy. Some children are more accessible by nonverbal, graphic means of communication. For example, a language impaired child who has difficulty with verbal expression may profit more from art therapy than from a therapy focusing on verbal intervention. It is important that these children become eligible for art therapy services.

Documentation

1) The Rockefeller Task Panel (1977) was composed of twenty-five members who focused on the significance of the arts for American education. In the book *Coming to Our Senses,* that resulted from the panel's study, referral was given to "convincing statistics" that demonstrated how meaningful artistic activities promoted clear gains in performance; for example, the influence of art programming on discipline and motivation was included.

2) The Senate and House Report (No. 96-712, May 15, 1980) on the Mental Health Systems Act of 1980 paid special attention to the creative arts therapies in the treatment of persons who require mental health services but do not respond to traditional therapeutic modalities. This report also acknowledged that these persons are quite often "unserved or underserved," because obstacles exist in the establishment and broader utilization of the arts therapies within mental health settings.

3) Through the Governmental Liaison representative, the American Art Therapy Association submitted testimony (September, 1982) to the U.S. Department of Education regarding PL 94-142; this testimony cited exemplary programs in both public and private schools.

Funding

Within the school there may be obstacles to providing art therapy services for many children who need these services. Obstacles may relate to a lack of awareness of art therapy and its benefits, to an unclear plan for the utilization of art therapy services within the school, and to a lack of a mechanism for hiring art therapists in schools. Funds can be designated for art therapy through Public Law 94-142, as long as eligible candidates for treatment are identified and there is a qualified staff art therapist to provide the art therapy services.

Federal funds are not available for children not identified as handicapped. It therefore remains under the jurisdiction of local county school systems or private school organizations to budget funds for art therapy. A number of programs have succeeded in securing and maintaining the funds necessary to provide art therapy services.[1]

Credentials

The American Art Therapy Association, Inc., (A.A.T.A.) establishes professional standards for the awarding of credentials to qualified art therapists through its registration process. Criteria for art therapy registration (ATR) include a graduate degree (master's) from an accredited academic institution, or graduate level clinical training in art therapy, or graduate level institute training in art therapy. Also included are extensive hours of supervised clinical work and experience as an art therapist. In addition, the A.A.T.A. has established "Guidelines for Academic, Clinical and Institute Art Therapy Training" that delineate standards for training in the field.[2] Included in these standards are requirements for supervised graduate level clinical experiences. The A.A.T.A. recommends that state teacher certification boards and school administrators use these guidelines as a model when developing position descriptions and recruiting for art therapists.

Some states additionally require that art therapists secure teaching credentials or teacher education credits in order to work in schools. Administrators should consider employing qualified art therapists as related service providers who may not possess teaching credentials, since the art therapist's role is one of assessment and treatment, requiring specialized clinical experiences rather

---

[1] For five years, the Dade County public school system in Miami, Florida has recognized the need for art therapists, and has integrated them into the exceptional student education programs. The Niles Township (Illinois) has also included art therapy in its Federally funded, public therapeutic day school program for the past five years.

[2] For particular details, copies of the "Adopted Revised Standards and Procedures for Registration" and "Guidelines for Academic, Clinical and Institute Art Therapy Training" may be obtained from the national office of the American Art Therapy Association.

"The art therapist works primarily outside of the traditional classroom setting with individuals or small groups, engaging in long or short term treatment, and using basic art materials."

than teaching experience. The A.A.T.A. encourages each state to establish criteria for art therapists in the schools that align with current A.A.T.A. standards.[3]

Role of Art Therapists in Schools

The art therapist works primarily outside of the traditional classroom setting with individuals or small groups, engaging in long or short term treatment, and using basic art materials. Services include the diagnostic evaluation and assessment of the child's needs, and implementation of a treatment program designed to address those needs. The art therapist has close consultation with the child's classroom teacher, staff psychologist, and other service providers as well as with the child's parents or guardian. Parental consent should be required for a child to receive therapeutic services, such as art therapy, within an educational milieu.

Working in a school, an art therapist would design and implement an individualized treatment plan for each student with whom the art therapist works; this should include working with appropriate personnel in the development of an IEP (individualized educational plan), rather than following a traditional instructional teaching curriculum. Periodic progress reports[4] are prepared. Such reports are considered confidential, as are all evaluations and documented records pertaining to each child.

An art therapist also acts as a liaison or consultant to other supportive programs within the school; for example, the art therapist supplements the verbal efforts of guidance counselors or school psychologists, and is considered a member of the human services team. With younger children the use of art media as an aid in counseling is one of the few and most appropriate means of intervention. The art therapist acts as a resource person and consultant to designated school staff regarding the assessment and treatment of individual students.

The Necessity of Research

Art therapy is gaining recognition in the public and private sector of psychoeducational care. This recognition has favorably influenced art therapy service delivery in educational settings. The clinical use of art therapy enjoys growing recognition and respect. The field of art therapy encourages continued controlled research regarding its application to, and outcome in, educational settings. Publication of accounts of the effectiveness of using art therapy in educational settings, and of the development of innovative strategies for the most beneficial utilization and dissemination, are also encouraged.

Summary

Art therapy fosters and facilitates cognitive and emotional development by providing experiences conducive to psychoeducational growth. For children with special needs, this process will undoubtedly play a vital role in their education. The role of art therapy in the schools is important for consideration by both teachers and therapists, as well as for administrators, parents and human services personnel.

References

Art in the Lives of Persons with Special Needs. (Proceedings of a joint conference of the National Art Education Association, Inc., and the American Art Therapy Association, Inc., through support of the National Committee Arts for the Handicapped, August 7-8, 1980). NCAH, J. F. Kennedy Center for the Performing Arts, Education Office, Washington, D.C. 20566.

Code of Federal Regulations, Parts 100-149 (Revised as of October 1, 1978). Published by the Office of the Federal Register, National Archives and Records Service.

Goodman, Robin. Statement of the New York Creative Arts Therapies Coalition with respect to proposed revisions in PL 94-142, 1983.

Guidelines for Academic, Clinical and Institute Art Therapy Training. American Art Therapy Association, 11800 Sunrise Valley Dr., Suite 808, Reston, VA 22091.

Legislative Alliance of Creative Arts Therapies. Testimony regarding PL 94-142 Proposed Regulatory Changes, 1982. Washington, D.C.: U.S. Department of Education.

Mental Health Systems Act, S. 1177 (May, 1980). Report of the Committee on Labor and Human Resources.

Minar, Virginia. School Art Therapist Rationale for DPI Certification. The New York State Art Therapy Association *Bulletin*, Vol. 28, No. 3, (May, 1978), pp 8-9.

National Alliance of Pupil Service Organizations. Testimony regarding PL 94-142 Proposed Regulatory Changes, September 9, 1982. Washington, D.C.: U.S. Department of Education.

Professional Standards and Procedures for Registration (Adopted Revised 1983). American Art Therapy Association, Inc., 11800 Sunrise Valley Drive, Reston, VA 22091.

Public Law 94-142 (1975). United States Statutes at Large, Volume 89.

Rockefeller, David, Jr. (Chairman). *Coming to Our Senses, The Significance of the Arts for American Education* (a panel report). New York: McGraw-Hill Book Company, 1977.

---

[3] At this time (1985) Wisconsin has a proposal for certification of creative-expressive therapists in the public school system.

[4] Reports may include narrative, descriptive progress notes on academic work, social behaviors, psychological or emotional behaviors, and similar annotation, as well as recommendations and strategies for continued therapy if it is needed. Objectives would be adjusted accordingly during systematic periodic reviews.

BEST COPY AVAILABLE

AATA Conference Overview

The 15th annual Conference of the American Art Therapy Association was held in Washington, D.C. from Wednesday, October 31 through Sunday, November 4, 1984. Based on numbers of attendees and on enthusiasm and interest, the Conference was a success. The Conference and committee chairpersons and the presenters and participants are to be congratulated for their involvement and support in helping to make the Washington Conference a good one.

Beginning here and on the following pages is a listing of the presenters with a brief overview of the presentations, workshops, papers, pre- and post-conference courses and other highlights of the Conference. Following the presenters' names are addresses. When more than one presenter is listed, the complete address of only the first presenter is given. In lieu of the AATA *Proceedings*, this information is offered so that readers can communicate directly with the presenter(s) for any additional information desired. It should be noted that the information and descriptions have not been edited and are printed as they appeared in the Conference program.

—Editor

15th Annual Conference Committee

Program Committee

Program Chair: Patricia Buoye Allen, MA, ATR
Program Committee: Nancy Hall, ATR
Don Jones, ATR
Lou King, ATR
Virginia Niswander, ATR
Kathy Neely, MA
Leslee Pollakoff, ATR
Shirley Riley, ATR
Nancy Sidun, ATR
Ellen Sontag, MA
Terri Sweig, ATR
Dee Spring, ATR
Marianne Thomas
Sandra Thomas, ATR
Cheryl Treiber
Shelley Whitman, ATR
Gail Wirtz, ATR
Program Committee Consultants: Gary Barlow, EdD, ATR
Sandra Graves, PhD, ATR
Judy Rubin, PhD, ATR, HLM
Harriet Wadeson, PhD, ATR

Arrangements Committee

Arrangements Committee Chair: Bonnie Smith, MA, ATR
AATA Publication Sales: Jackie Linard
Art Supplies: Carol Cos
AV Equipment: Margie Eife
Exhibits: Sirkku Hiltunen, EdD
General Information: Deborah Broffman Schroeder
Open Studio: Alma Tolins
Publicity: Gwen McPhaul
Registration: Marie Therese Endrés
Special Events: Sondra Geller, ATR
Students: Adrienne Kwopen
Theme: Barry Cohen, ATR
Volunteers: Francesco Creo

PRE- AND POST-CONFERENCE COURSES

The Association is again pleased to offer special courses of study prior to and following the Conference. The courses include didactic/experiential instruction at the graduate level, and are taught by art therapy educators.

PRE-CONFERENCE COURSES

I. The Rainbow Phenomenon: Toward a Psychology of Color
Roberta Shoemaker, MFA, ATR, Assistant Professor, Art Therapy, Emporia State College, Emporia, KS 66081.
The main problem with studying color has been the contradictory information. This course will attempt to bring together divergent opinions into a cohesive overview of color theory, as reflected in the rainbow symbol. Certain colors reflect physical stress; these will be presented with experiential work and with case studies from recent research.

II. The Full Rainbow: Symbol of Individuation
Lillian Rhinehart, MA, MFCC, ATR, Director, Eagle Rock Trail Art Therapy Institute, P.O. 2885, Santa Rosa, CA 95405. Paula Engelhorn, MA, ATR, Coordinator, Eagle Rock Trail Art Therapy Institute
The workshop will focus on color as a natural source of individuation by exploring three principles: 1) color as an objective reality; 2) the symbol of the circle as the greatest representation of wholeness; and 3) the theory of opposites as expressed in Jung's psychological system. Because we have found these principles expressed in the Native American path of life, we have based much of our work on color as an individuation process in this heritage.

III. Art as Therapy with the Handicapped Child
Frances E. Anderson, EdD, ATR, Professor of Art, Illinois State University, Normal, IL 61761
This session includes lecture, discussion and hands-on arts activities focusing on children with a range of disabilities. The course content will include implications of the IEP (Individualized Education Plan) process and "mainstreaming" of special needs students. A major focus will be on *adaptations* of the art activities to fit children with specific handicapping conditions on *task analysis*. (The course is planned as a introduction to the topic and is for beginning professionals.)

IV. Use of Art Therapy in a Phase-Specific Approach to Treatment of Borderline Patients
Molly Hardy, MA, Art Therapist, The Brown Schools, San Marcos Treatment Center, San Marcos, TX 78666
L.G. Hornsby, MD, Medical Director, San Marcos Treatment Center
An art therapist and a child psychiatrist will present Mahlerian phases of development shown in artwork of their borderline patients and discuss utilization of these therapeutic tools in team treatment of borderlines (DSM-III 301.83 and 313.82). Participants are requested to bring borderlines' artwork for consultation/discussion period. Extensive illustrations, handouts, bibliography are included.

V. Art Therapy with Children in Trauma
Cathy A. Malchiodi, MA, ATR, Instructor of Art Therapy, University of Utah, Salt Lake City, Utah 84112; Art Therapist/Program Coordinator, Women in Jeopardy Program
Valerie E. Appleton, MA, MFCC, ATR, Art and Play Therapist, St. Francis Memorial Hospital
This course focuses on the use of art therapy with children in crisis because of physical/emotional abuse, incest, physical illness and hospitalization. Specific art therapy interventions to facilitate transition from trauma to resolution will be demonstrated through case material and experiential work. Symbols and recurring themes in the art productions of young burn patients, abused children and incest victims as well as indicators of psychic return to "pre-crisis" life will be presented through slides.

VI. Theory and Practice of Transpersonal Art Therapy
Josef E. Garai, PhD, ATR, Professor Emeritus, Pratt Institute, 155 West 68th St., New York, NY 10023
This one-day pre-conference course introduces participants into theories of transpersonal psychology and their potential for application in art therapy work with clients of different population samples. Transpersonal art therapy requires profound self-knowledge, holistic integration of body, mind, and spirit, and transcendence of self. These attitudes lead the individual toward profound self-transformation and the ability to merge with the cosmos transcending the limited boundaries of the self to get ready for community enrichment and the solution of global problems.

VII. Life Review of the Stages of Development Through Art Therapy: Gardening in the Great Forest
Doris Arrington, MAT, ATR, Director, Assistant Professor, Master of Art Therapy Program, College of Notre Dame, Belmont, CA 94002
This course focuses on adult development in a cyclical mode rather than a linear mechanical one, with emphasis on reminiscence and life review. The life cycle of death, threshold, and renewal will be presented metaphorically through slides and creative expression. Drawing on contemporary research, evidence will be presented from traditional societies that consciously and unconsciously investigate tasks of midlife individuation. Visual concepts used as instruments to assess aspects of development and their clinical application will be shared. Life prints will be explored.

VIII. Theory and Techniques of Adolescent Art Therapy
Shirley S. Riley, MA, ATR, MFCC, Instructor, Clincial Art Therapy, Loyola Marymount University, Los Angeles, CA 90045
This one-day course on the effective use of clinical art therapy with an adolescent population will include a focus on the major developmental tasks of adolescence and the differentiation of goals concerning the pre-adolescent, early adolescent, mid-adolescent, and late adolescent. Emphasis will be on the particular techniques that a therapist must be aware of in establishing and continuing a therapeutic relationship with this age group. There will be a discussion of the problems parents face when their child becomes an adolescent and the stress factors that most commonly arise in families with adolescents will be explored. A brief discussion of the more disturbed adolescent as well as role-play will be included.

POST-CONFERENCE COURSES

IX. Fundamentals of Depth-Oriented Psychodynamic Group Art Therapy
Ralph Levinson, PhD, ATR, Clinical Psychologist, Doyle Center of Loyola University, 2306 Ridge Avenue, Evanston, IL 60201
This course will concentrate on the fundamental aspects of depth-oriented group art psychotherapy. Through lecture, discussion, and experiential activities, participants will explore underlying group process issues, group development, the role of the group leader, transference and countertransference phenomena and contrasting intervention techniques. Special attention will focus on how the participants' artwork symbolically represents personal, often unconscious communications about the group, its individual members and the group therapist.

BEST COPY AVAILABLE

X. The Practice of Jungian Art Therapy: Introduction to Jung's Principles of the Therapeutic Relationship

Ethne J. Gray, MA, ATR, Clinical Social Worker, Jungian Art Therapist, 112 Chestnut Street, West Newton, MA 02165

The course will explore Jung's theories about the interactional resources in therapy as practiced by analytical psychologists ("Jungians"), from empathy and interpretation to amplification and active imagination. It will examine Jung's theories of transference and countertransference reactions, and will compare and contrast Freudian theories for working with such reactions with those of Jung. In particular, an attempt will be made to show that the Jungian model for the therapeutic interaction between art therapist and patient offers particularly rich possibilities for healing and integration in view of Jung's unique and effective manner of working with patients' symbolic language.

SPECIAL MEETINGS AND EVENTS

Opening Reception

Come and join your fellow colleagues for refreshments and a special "Welcome!" to the 15th Annual AATA Conference. The exhibits in the Capitol Ballroom will be open for preview.

Washington Highlights Tour

Tour Washington by moonlight when its major monuments and buildings are beautifully illuminated and provide a spectacular view of the Capitol City. A three-hour tour by motor coach, with a professional guide from the National Fine Arts Associates, Inc. is offered.

Dancers of the Third Age

A well-known senior citizen dance group will perform (audience participation invited). The concert will be held at the "Pavillion" in the Old Post Office Building, the location of many shops and restaurants and home of the National Endowment for the Arts and Humanities. The "Pavillion" is less than a five-minute walk from the J.W. Marriott Hotel. Stop at the Ticket Sales Desk for directions. Plan to arrive early to get a table. This event is sponsored by AATA and is open to the public.

"Kaleidoscope"
Annual Masquerade Ball

Come create a kaleidoscope . Don your favorite colors. Be a painting, a flower, a rainbow. Whatever! Color is the theme. Do with it what you will. A cash bar and light snacks will be provided.

Annual Business Meeting
Bring your lunch!

Art Therapy Educators Meeting

Student Meeting
Come and share your lunch hour with your fellow students! Bring your lunch, if you wish.

"Fireside Chat" with Executive Board
Bring your lunch!

Regional Lunches
"Networking: Art Therapy in the Marketplace"
Join your regional colleagues for a luncheon treat!

Eastern Region
Robin F. Goodman, MA, ATR, speaker

Midwestern Region
Donald J. Cutcher, MA, ATR, speaker

Western Region
Cay Drachnik, ATR, speaker

EXHIBITS

OPEN STUDIO

For those who wish to indulge their creative needs during the Conference, an Open Studio is again available to delegates throughout the day on Friday and Saturday, 10:30 a.m.-5:00 p.m., in the Exhibit area of the Capitol Ballroom. It will be well-stocked with basic art supplies/materials and facilitated by art therapists. Don't forget, this is a good opportunity to create your special mask for the Masquerade Ball!

EXHIBITS

As part of efforts to expand educational opportunities available to delegates during AATA's Annual Conference, coordinators have designed an Exhibit Area that includes the latest in professional resources and supplies. The Exhibit Area is located in the Capitol Ballroom. Please take advantage of this excellent opportunity to learn more about the tools, processes and products of your profession!

15th Annual AATA Conference Exhibitors

American Journal of Art Therapy
Brunner/Mazel, Inc.
Chaselle, Inc.
Chroma-Vision
College of St. Theresa
Color Research/George Washington University
Davis Publications, Inc./School Arts
Goucher College—Graduate Art Therapy Program
Missouri Art Therapy Association
Nasco
Sax Arts & Crafts
S & S Arts & Crafts
Stemmer House Publishers, Inc.
Stern's Book Service
Vermont College of Norwich University
J. Weston Walch, Publisher
Wright State University

"ART AND DESIGN IN ACTION"

Through a cooperative effort between AATA and the National Art Materials Trade Association, you are invited to "Art and Design in Action," the largest art materials exposition ever held on the East Coast. Visit over 1,400 booths displaying, demonstrating and offering hands-on experiences with artists' materials. The exposition will be held November 1-3, 1984 at the Washington Convention Center.

"ART BY ART THERAPISTS"

An exhibit of artwork by art therapists at the Firebird Gallery in Olde Town Alexandria is planned. The Firebird specializes in artwork done by the disabled or by therapists, so Dennis Roach, the gallery director, is anxious to meet all of you. Take advantage of this opportunity to view the work of your peers. The Gallery is located at 814 N. Saint Asaph Street in Alexandria, Va. and is within walking distance from the King Street Metro Station (but wear your walking shoes!)

Firebird Gallery	"Therapeutic Masks for Play and Display" Sirkku Hiltunen, EdD This art exhibit of masks by Sky can be viewed at the Firebird Gallery in Olde Town Alexandria
Arts Club of Washington	"Paintings, Collages, and Drawings by Edith Kramer"
Corcoran Gallery Of Art	Museum Tour The Corcoran Gallery of Art, featuring a Robert Motherwell retrospective, will be open for all who wish to tour. The Corcoran is within walking distance from the J.W. Marriott Hotel, but buses are available for those who prefer to ride.
Tapestry Room Corcoran Gallery of Art	Reception After the Gallery tour, you may wish to relax at a special wine and cheese reception in the Tapestry Room.
Ainilian Gallery	"Watercolors by Bernard Levy"

FILM FESTIVAL

AATA proudly presents its First Annual Film Festival this year with eighteen films and videos for viewing. All entries will be judged by Eddie Cockrell, a Washington film critic who regularly reviews films for WGMS-FM radio and *The Washington Post*. The winning entrant will be presented with a trophy which has been designed and executed by New England Sculptor James Wright. Certificates of merit will also be presented to media of exceptional quality. Please see the program for Festival viewing times. The films and videos entered in the Festival are:

The Angel That Stands By Me
Allie Light and Irving Saraf, producers

Art and Therapy
Hugues Lavergne, producer

Art Therapy: What Is It?
Mary Lou Weber, producer

Children and the Arts
Judith A. Rubin, PhD, ATR, HLM, producer

Creative Art Therapy with Children
Kim Pawley, MA and Terry Conheady, producers

Draw From Within: An Introduction to Art Therapy
Don L. Jones, ATR, producer

Expressive Art With the TMR
Kay Hometachko, producer

Gestalt Art Experiences with Janie Rhyne
Janet Greenwood, producer

Glad to Be Alive
Hans Klostermann, producer

The Green Creature Within
Judith A. Rubin, PhD, ATR, HLM and Eleanor C. Irwin, PhD, RDT, producers

Lonny: A Case Study in Clinical Art Therapy
Jane Schulman, producer

The Monument of Chief Rolling Mountain Thunder
Allie Light and Irving Saraf, producers

Stevie's Light Bulb: Graphic Art in Child Psychiatry
Ralph D. Rabinovitch, MD, producer

A Study of Lights and Sound (Parts 1 and 2)
Charles Anderson, ATR, producer

A Very Special Arts Festival
Robert Hart, director and Norman Bassett, editor

We'll Show You What We're Gonna Do!
Judith A. Rubin, PhD, ATR, HLM, producer

With Eyes Wide Open
Laurence A. Becker, PhD, producer

Working Together
Eric Marano, Bruce Birnbaum and Ray Levine, producers

Grand Prize Trophy Winner
Stevie's Light Bulb:
Graphic Art in Child Psychiatry
(This film is reviewed on page 00)

Certificate of Merit
(Professional Category)

Gestalt Art Experiences with Janie Rhyne

The Monument of Chief Rolling Mountain Thunder

With Eyes Wide Open

Certificate of Merit
(Amateur Category)

Creative Art Therapy with Children

The Green Creature Within

Certificate of Merit
(Student Category)

Lonny: A Case Study in Clinical Art Therapy

OPEN FORUMS

Computer Literacy and Application in Art Therapy

Virginia Niswander, MEd, ATR, Assistant Professor, Art Therapy, Wright State University, Dayton, Ohio 45435

This is a continuation of last year's presentation of computer literacy which was requested by members wanting to initiate an interest group discussion. Those who listed their names last are urged to attend and anyone else with an interest in the subject is invited to the discussion.

How to Do a Presentation Proposal

Pat B. Allen, MA, ATR, Program Chair Program Committee, Art Therapy Program, University of Illinois, P.O. Box 4348, Chicago, IL 60680

Jung's Active Imagination in Art Therapy

Ethne J. Gray, MA, ATR, Jungian Art Therapist, Clinical Social Worker, 112 Chestnut Street, West Newton, MA 02165 Painting, modeling, dancing and music, as a means to releasing unconscious fantasies in an awakened state of consciousness may be seen as salutory forms of what Jung described as "passive imagination." *Active imagination*, which is done alone, is not so well understood, although Jung saw it as the most powerful tool for achieving wholeness. A case study illustrating its use with art therapy, is presented in this open forum.

The Significance of Color in Art Therapy

Sandy Geller, ATR, Coordinator of Art Therapy Services, George Washington University, 5 Primrose St., Chevy Chase, MD 20015

Selling Skills for Art Therapists

Judith Gerberg, MA, ATR, 35 West 82nd Street, #8B, New York, NY 10024

Selling skills are necessary to confidently pursue your career. Learn techniques to market your unique skills and talents. Recognize and overcome the common barriers that prevent you from achieving the job, the promotion and the income you deserve. Discover methods to create opportunities for new jobs and clients. Leave with an action plan for Monday.

The Pregnant Art Therapist. Images of Pregnancy: Role Integration, Identity and Transference Issues in Art Therapy

Julia Byers, MA, ATR, Assistant Professor, Art Therapist, Concordia University, 4382 Melrose Avenue, Montreal Quebec, H4A 2S6 Canada

The symbolic and metaphoric "pregnancy" is a unique time limited event with profound implications for the therapeutic relationship. This forum intends to discuss the relevance of an art therapist's actual pregnancy to the therapeutic interaction in art therapy.

Student Forums

Governmental Affairs

GENERAL SESSIONS

GENERAL SESSION: Keynote Speaker

Archetypal Images and Art

Dean L. Frantz, Analyst in the Psychology of C. G. Jung, 3831 Evergreen Lane, Fort Wayne, IN 46815

Jung said "Whenever the archetype clothes itself with adequate symbols, it takes hold of the individual in a startling way, creating a condition of 'being deeply moved,' the consequences of which may be immeasurable." The creative power of archetypes to move us at the deepest levels of our being is manifested in dreams, fairy tales, great music, literature, and art. The paintings of Peter Birkhauser are the medium through which archetypal powers have found expression in a most unique way. These paintings have been characterized as "medicine for the soul."

Frantz will examine the relationship between archetypes and art, and remarkable life of Birkhauser himself, and experience some of the same forces which moved Birkhauser to paint. Slides of Birkhauser paintings will be shown.

With Eyes Wide Open

Laurence A. Becker, PhD, producer, 507 Park Blvd., Austin, TX 78751

This general session offers a viewing and discussion of *With Eyes Wide Open*, a documentary film about the Scottish artist Richard Wawro. Don't miss this inspiring film about a handicapped artist whose art has earned him four international awards in 1984 alone!

This film is reviewed on page 40.

Lisa Montag Brotman and Sarah Tuft: Slide Presentation and Discussion of Their Work

7910 Springer Road, Bethesda, MD 20817

Lisa Montag Brotman and Sarah Tuft, artists and mothers, will present a visual history of the evolution of their work. Their art is figurative and rich in psychological content. Sarah, a painter, photographer and filmmaker, uses images of mothers and daughters as symbols for all relationships. Lisa, a painter, deals with all relationships though images of women. In her work, the viewer is incorporated as part of the relationship. Both artists will discuss the creative process utilized in their work. Slides will be shown.

PAPERS

Art Therapy With Spinal Cord Injury, Stroke, and Head Injury Patients in a Rehabilitation Setting

Margaret Ann Cotton, MA, ATR, Art Therapist, Rehabilitation Institute of Chicago, 1625 Sheridan Rd. 204, Chicago, IL 60611

This paper concentrates on the correlation and progression of art work in three major diagnostic groups: spinal cord injury, stroke, and head injury. Background information of each disability group will be summarized, and the therapist's approach to each group will be discussed. Slides, the major portion of this presentation, will verify information given.

Art Therapy Used to Enhance Patients' Ability to Utilize a Vocational Rehabilitation Program

Jane Schroeder DeSouza, MPS, ATR, Therapeutic Activities and Vocational Rehabilitation Service Coordinator, St. Vincent's Hospital, 7 Sterling Forest Lane, Suffern, NY 10901

This paper discusses the development of an art therapy group designed to complement a time-limited vocational rehabilitation program. It has provided therapeutic intervention that is recognized by both patients and the multi-disciplinary team as both beneficial and integral in promoting involvement, participation, and commitment to treatment.

Women Healing Women: Group Treatment of Childhood Sexual Abuse

Terri L. Sweig, MA, ATR, Art Therapist/Art Psychotherapist, Department of Psychology, Highland Park Hospital, 364 Roger Williams Avenue, Highland Park, IL 60035

Unhealed emotional scars of traumatic childhood sexual abuse resurface and painfully disrupt adult womens' lives. A therapeutic partnership between art therapy and psychiatric nursing established a structured group therapy model for treating unresolved feelings of rage, shame, guilt, isolation, betrayal, mistrust and focused on ending victimization and healing the wounded-child-self.

BEST COPY AVAILABLE

A Day in the Life: The Story of Q, An Autistic Man
Nancy Hall, MA, ATR, Recreation Therapist (Art), Buffalo Psychiatric Center, P.O. Box 203, Bidwell Station, Buffalo, NY 14222
This paper is a case study documenting the work of Q, a young man who appears to perceive, synthesize, and communicate information and experience through images rather than words.

Loss and Mourning: Art Therapy with a Child Cancer Patient and his Family
Mari M. Fleming, MA, ATR, Art Therapist, ADJ Assistant Professor, George Washington University, 1711 McGee Ave., Berkeley, CA 94703
Discussant: Pat Davis, ACSW, Director of Social Work, Child and Adolescent Services, Department of Psychiatry, Walter Reed Army Medical Center
An 11 year old boy with inoperable cancer and his family were seen in time-limited art therapy. Expression of feelings of loss and depression through art and the metaphors of danger and the hero were utilized to rebuild the love and support previously known. Treatment issues in working with the medically ill child and his family are discussed and illustrated.

Coping with Loss and the Art of Pediatric Oncology Patients
Robin F. Goodman, MA, ATR, Art Therapist, Mount Sinai Hospital, 77 East 12th St. #3B, New York, NY 10003.
Presentation of the concerns of pediatric cancer patients. Focus is on three major types of loss: loss of identity, control, and relationships. Art work is used to illustrate how these themes are depicted, how the patients cope, and what can be done in treatment.

Art Therapy and the Homeless
Patricia Prugh, MA, Art Therapist, Sarah House, 1305 Rhode Island Avenue, NW, Washington, DC 20005
This presentation provides an overview of the problems surrounding homeless women in the United States. The results of an art therapy group comprised largely of "bag-ladies" is equally explored. In addition, the role of art therapy with this neglected population is explored.

Animals in Dreams and Spontaneous Drawings
Elizabeth Caspari, Art Therapist, 30 Lincoln Plaza, 30 N, New York, NY 10023
The role of animals in fantasies, dreams and spontaneous pictures has often been discussed as "instinct." Through actual dreams, slides and audience participation, I intend to show that the significance of the animal, with its own distinctive biological and natural qualities, can give us valuable clues and greater insight into the unconscious.

Co-Treatment by an Art-Psychotherapist and a Clinical Psychologist of a Suicidal, Sexually Abused Adolescent Elizabeth Goll, MA, ATR, Art Therapist, CharterBarclay Hospital, 6101 No. Sheridan Rd. 8H, Chicago, IL 60660
David Kenis, PhD, Director, Sexual Abuse Program, Charter-Barclay Hospital, 6101 No. Sheridan Rd. 811, Chicago, IL 60660
Noted will be the sexual abuse component of this case intertwined with the girl's suicidal ideation and the different treatment methods used to teach a common goal. Special attention will be given to parallel evolution of the patient's process and the collaborative relationship, transference and countertransference issues and the advantage of opposite sex co-therapists.

Treatment Metaphors from Adolescent and Adult Psychiatric Patients: Watermelon Saviors and Pilgrims
Bruce L. Moon, MA, ATR, Art Psychotherapist, Supervisor of Adolescent Adjunctive Therapy Program, Harding Hospital, 1697 Bunty Station Road, Delaware, OH 43015
This presentation explores the recurring and dominant metaphors expressed by hospitalized adult and adolescent patients engaged in intensive long-term inpatient psychiatric treatment. Attention is also given to the metaphoric responses of the art psychotherapist and adjunctive therapist member of the treatment team.

Fear of Fat: The Use of Art Therapy in an Interdisciplinary Approach to the Treatment of Anorexia Nervosa
Tally Tripp, ATR, Art Therapist, Psychiatric Institute of Washington, 4121 W St., NW #303, Washington, DC 20007
Peter Coe, ACSW, Social Worker, Washington,
This presentation describes the collaboration in treatment efforts between an art therapist and a social worker with an adolescent anorexic girl and her family. Slides of her art work produced in art therapy and guided imagery groups will be discussed in relation to psychological issues and family dynamics.

Art Therapy with Only-Child Early Adolescent Boys of Divorce
Gregory L. Wolfe, MA, Clinical Art Therapist, Kendall & Associates, 8920 Ashcroft Avenue, Los Angeles, CA 90048
This clinical paper and slide presentation presents three case studies in which art therapy was used as a primary treatment modality with only-child early adolescent boys of divorce in an outpatient clinic. The case studies demonstrate how art therapy facilitated the exploration of five divorce-related issues and brought about change and growth in the lives of these boys and their families.

Portrait of an Adolescent Obsessive Personality: A Case Study
Barbara Sprayregen, MEd, ATR, Art Therapist, McLean Hospital, Old Sudbury Rd., Lincoln, MA 01773
This paper will describe the case of a seventeen-year-old youth participating in an adolescent art therapy group, who experienced more than usual developmental difficulties. His major presenting issues were very vividly and dramatically depicted in his artwork and will be shown in a series of slides. The patient has been considered to show a profile of an alienated obsessive personality similar to the type given notoriety by the John Hinckley, Jr. case.

Using Art Therapy with Chemically Dependent Adolescents
Erica L. Thompson, MA, Substance Abuse Prevention Counselor, Council on Prevention and Education: Substances, 3525 Ramona Ave., Louisville, KY 40220
Pat Grajkowski, Student
This presentation focuses on art therapy techniques in an adolescent treatment program. Slides are used to increase awareness of the effectiveness of art therapy and chemically dependent adolescents. Theory, media and techniques are emphasized in this presentation.

Group Art Therapy With the Abused Adolescent
Josie Abbenante, MA, ATR, Counselor, Art Therapist, UNM/BCMHMRC Drug Counseling, 917 Amherst SE #5, Albuquerque, NM 87106
This paper will explore an approach to treatment of the abused adolescent utilizing group art therapy. Techniques and client response will be demonstrated with slides. The group is of mixed sex and the clients are in residential treatment. Art therapy is the vehicle by which the evocative imagery is allowed expression and through which the healing occurs.

Assertiveness Training through Art Therapy with Handicapped Adolescents
Denise Gatti, MCAT, Art Therapist, Children's Heart Hospital, 3955 Conshohocken Ave., Philadelphia, PA 19131
Handicapped individuals often have limited opportunities for social interactions and therefore often interact in a passive manner. This presentation will focus on a unique use of art therapy to develop assertive social skills. Slides of artwork and discussion of weekly group art therapy sessions with adolescents with spina bifida will be used to illustrate this process which would be applicable to many other populations.

BEST COPY AVAILABLE

Assessment, the Learning Disabled Child and Art Therapy

Patricia A. St. John, EdD, Assistant Professor of Art, University of Massachusetts, Art Dept. FAC 365, Amherst, MA 01003

Careful assessment is the basis of effective treatment. Treating the LD child through art therapy demands a thorough appreciation of the relationships among perceptual processing, learning, and psychological characteristics. These relationships are explored through general and specific tests which tap grahic-constructional abilities. Two cases illustrate the diverse abilities, psychological factors and treatment strategies used with learning disabled children.

The Process of Art Therapy: A Case of a Preadolescent Boy

Pamela Madden, MS, Art Therapist, Western Psychiatric Institute and Clinic, 6633 Wilkins Avenue, Pittsburgh, PA 15217

This project is an empirical study exploring how art therapy works as a technique of psychotherapy. A systematic analysis of a pre-adolescent boy's course in treatment is formulated. Discussed will be techniques of analysis and implications the findings suggest for theory and practice of art therapy.

Intervention Following a Sniper's Attack Which Traumatized an Elementary School

Suzanne Silverstein, MCAT, ATR, Art Psychotherapist, Center for the Study of Psychological Trauma, 2336½ So. Beverly Glen, Los Angeles, CA 90065

This presentation describes an intensive elementary school intervention following a sniper attack in which one child was killed and eleven other children and two adults were wounded. The following issues will be explored: the intrusion of violence and death, the threat to personal safety, and the consequences of the sniper attack on the school students, teachers, administrative staff and parents.

From Psychotherapy to Recreation to Breakdancing: Art and Dance with Children and Adolescents

Kate Hartman, MA, ATR, Art Therapist, Art Therapy Educator, State University College at Buffalo, 763 Bird Avenue, Buffalo, NY 14290

Ulrike Chamberlain, ATR, Field Supervisor, Art Therapy Studies; Georgiana Jungels, ATR, Program Director, Art Therapy Studies; Tracy Gevirtzman, MA, Art Therapy Intern, Graduate Assistant; Sandy Ticen, MA, Art Therapy Intern, Graduate Assistant

Art and dance therapy with emotionally disturbed and delinquent children and adolescents in a residential treatment setting is the subject of this presentation.

Words and Pictures: Developmental Relationships in Preschool Children

Judith A. Rubin, PhD, ATR, HLM, Assistant Professor, Child Psychiatry, Western Psychiatric Institute & Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213; Herbert Rubin, PhD, Professor, Department of Communications.

Twelve normal preschool children were presented individually with five drawing and five oral verbal tasks to explore relationships between the two parallel modes of expression. Following semantic, morphological and syntactic analyses of both kinds of data, each matched pair of tasks was examined phenomenologically. Results suggest that the same mechanism(s) may underlie both skills.

Primary and Secondary Intervention in Infancy and Toddlerhood Through Art Therapy: A Theoretical Rational

Donna I. Bassin, MPS, ATR, Faculty, Creative Arts Therapy Department, Pratt Institute, 7 Great Jones Street, New York, NY 10012

Art therapists have an opportunity to devise optimal therapeutic intervention in infancy and toddlerhood through the use of art. This paper will provide a theoretical rationale for "why do we use art for prevention" and "how do art experiences in the earliest years facilitate the construction of self and other."

Art Therapy Through a Museum-Based Program for Children and Adults of Special Need

Lucy Andrus, MS, ATR, Art Therapist, Coordinator, Matter at Hand Program, Albright-Knox Art Gallery, 799 Potomac Ave., Buffalo, NY 14209

This presentation will focus on an innovative art therapy program called "The Matter At Hand", sponsored by the Albright-Knox Art Gallery, Buffalo, N.Y. MAH serves children and adults of three distinct art therapy approaches. This presentation will demonstrate how the use of original works of art can enhance art therapy treatment by serving as a stimulus for client participation, motivation, and heightened creative self-expression.

Is the Parakeet Dead? And Other Vignettes from Lives of Children from Alcoholic Homes

Debra DeBrular, BFA, Art Therapist, Harding Hospital, 445 E. Dublin-Granville Rd., Worthington, OH 43085

The purpose of this paper is to illustrate the uses of art therapy in an educational and therapeutic treatment program for children from alcoholic homes. Objectives include: 1) to develop understanding of problems these children experience; 2) to delineate a treatment paradigm; and 3) to suggest techniques and processes for the art therapist.

The Art of the Sexually Abused Child

Cynthia A. Wolf, MS, ATR, Director, Art Therapy Master's Program, Eastern Virginia Medical School, CMHC, P.O. Box 1980, Norfolk, VA 23501

This presentation will touch upon some of the history of the use of art with the sexually abused child and give an overview of the psychological problems most commonly experienced by these children. It will, through the use of victim artwork, illuminate how these problems are revealed in the work of these children and how the art therapist functions as an integral part of the sexual trauma team.

Incest Markers of Children's Art Work

Felice W. Cohen, ATR, Chief, Art Psychotherapy, Texas Research Institute of Mental Sciences, 1300 Moursund Avenue, Houston, TX 77030

Co-researchers:

Randy Phelps, PhD, Research Consultant, Child and Family Clinic, Texas Research Institute of Mental Services; Sara Simon, MSW, Child Sexual Abust Team, Harris County Child Welfare Program

Consultant: Lauretta Bender, MD, Child Psychiatrist

Discussants: Gary C. Barlow, EdD, ATR, Myra Levick, PhD, ATR, Lewis K. Shupe, PhD, ATR

A comprehensive study of the analysis of eighty children's drawings, with experimental and control groups, to determine markers of incest will be presented. Drawing protocol includes: free drawing, a House-Tree-Person and the family in some activity. Blind ratings were obtained from naive and sophisticated judges. Results of this study are reported with projections for further collaborative research and implications are presented for training helping relationships professionals in detection and referral procedures.

Multiple Family Group Art Therapy

Debra B. Greenspoon, MA, ATR, Clinical Art Therapist, Vista Del Mar Child Care Services, 664 Kelton Avenue, Los Angeles, CA 90024

Discussant: Helen Landgarten, MA, HLM, ATR, Director, Clinical Art Therapy, Loyola Marymount University, 664 Kelton Avenue, Los Angeles, CA 90024

This paper will explore multiple family group art therapy through the development of a theoretical framework and the exploration of case material. Pertinent literature will be examined briefly in order to establish a treatment model and rationale. The remainder of the paper will discuss examples of artwork in an ongoing multiple family art therapy group, focusing on the utilization of this process for both assessment and intervention.

The Family Art Evaluation as an Intake Tool at a Community Mental Health Center

Audrey Di Maria, MA, ATR, Art Therapist, North Community Mental Health Center, 1711 Mass. Ave., NW #301, Washington, DC 20036

Mary D. Durrum, MA, Clinical Psychologist; Trudy Summers, MSW, Social Worker

Although the family art evaluation procedure was developed by Kwiatkowska in the 1960's, few facilities make consistent, ongoing use of it. This presentation demonstrates the important role of the family art evaluation as a major component of the intake process in an adolescent outpatient program and a children's day treatment program.

Draw Me a Paradox

Shirley Riley, MA, ATR, MFCC, Art Psychotherapist, Loyola Marymount University and Didi Hirsch Community Health Center, 960 Roscomare Rd., Los Angeles, CA 90077

This paper will first review the basic systemic and Milan techniques of conducting family therapy, touching upon the premises of joining, reframing, and positive connotation, etc., and their function in producing change. Discussion will then move toward the feasibility of incorporating art therapy expression with the systemic theories. The argument presented will focus on what appears to be a reluctance of some art therapists to consider a creative accommodation of their abilities and special skills with the more current and also creative approaches to family therapy. In conclusion, the paper will attempt to weigh the gains or losses that might occur if these two techniques were unified in family sessions.

The Symbolic Meaning of Early Childhood Imagery in the Art Work of a Brain Injured Man

Susan R. Dwight, MA, Art Therapist, Trevilla of Robbinsdale, 4815 Queen Avenue So., Minneapolis, MN 55410

This paper presents a case study of a 29-year-old brain injured man with whom the author worked as an art therapist over a two-year period at a nursing home for physically disabled young adults. Early childhood imagery is used to symbolize aspects of his personality and his feelings about his present condition.

Utilization of Art Therapy in the Diagnosis of Organic Mental Disorder

Toby Michaels, MA, ATR, Art Therapist, Department of Psychiatry, Norwalk Hospital, 248 North Avenue, Westport, CT 06880

This paper summarizes the case of a 71-year-old woman and describes how the use of art material assisted the medical team to further evaluate and test for organic mental disorder in an otherwise organized personality.

Healing Images: The Use of Art Therapy in Traumatic Head Injury

Phyllis Cohen, MA, ATR, Clinical Art Therapist, Center for Creative Art Therapies, 1778 Commonwealth Ave., Brighton, MA 02135

Severe head trauma can leave its victim with a variety of psychological and physical difficulties. This presentation will explore the treatment needs of the head injured and how art therapy helped one woman deal with these impairments. The paper will also describe broader implications for the use of art therapy with other neurologically impaired clients.

Art Therapy and the Dually Diagnosed Client: The Mentally Retarded and Emotionally Disturbed Adult

Ellen Sontag, MSW, MA, Art Therapist, 1021 Ridge Court, Evanston, IL 60202

Gilda Moreno, MA, Art Therapist

This presentation will focus on the concerns that have been expressed in the art work of the dually diagnosed, developmentally disabled and emotionally disturbed adult. This presentation will help others to more accurately identify the particular needs of this population.

A Comprehensive Treatment Approach to Geriatrics: A Creative Arts Partial Hospitalization Program

Marianne Thomas, MCAT, Art Therapist, Bristol-Bensalem Human Services Center, 4424 Wingate St., Apt. C-22, Philadelphia, PA 19136

The innovative program design of the Creative Arts Partial Hospitalization Program for geriatric, chronically mentally ill individuals is introduced. The myths and stereotypes accompanying the elderly are addressed and stripped away enabling the clinician to maximize the potential of each individual. Art therapy tasks are presented through a slide presentation to address problem areas of attention, memory, visuo-spatial ability and cognitive flexibility.

The Importance and Integration of a Sequential Art Therapy Program for the Developmentally Disabled Adult in a Day Treatment Setting

Elizabeth Spear Rogers, MS, Art Therapist, Self-Direction Coordinator, Niagra County Association for Retarded Children, 1256 Colvin Blvd., Kenmore, NY 14223

Beth Farr, MS, Art Therapist; Glenna Gleason, MEd, Training Coordinator

One of the most challenging problems facing the field of art therapy today is that of providing effective programs for the developmentally disabled adult. The Niagra County Association for Retarded Children's Adult Day Treatment Program, based on a principle of normalization, offers individualized, integrated programs in a multitude of environments and opportunities for client growth. Sequential art therapy has been incorporated into the program using multi-sensory, highly structured, success-oriented experiences, within the framework of the developmental mode. This paper will show how, with the continued coordination of art therapists and other specialists, the development of cohesive programs will lessen the distance between the developmentally disabled adult and the rest of society.

Uncovering Buried Treasure: A Look at a Successful Art Program for Elders in Long Term Care

Mary Lou Coles, MA, Art Therapist/Activity Director, Hillhaven Convalescent Hospital, 477 30th Ave., San Francisco, CA 94121

The "Art for Elders Program" at Hillhaven Convalescent Hospital (Oakland, CA) has successfully created an environment where its elderly residents can use "art as a vehicle for basic human expression" (Merker-Benton, 1983). This paper examines the success of using art with the frail elderly as a means of self expression and discovery; a means of connecting with others, with environment and with the community.

A Study of Human Figure Drawings of Rheumatoid Arthritis Patients

Vija B. Lusebrink, PhD, ATR, Associate Professor, University of Louisville, 255 Lauire Vallee Rd., Louisville, KY 40223

Bruce Scott, Louisville, KY; Josephine Rhodes, New Albany, IN

Human figure drawing scale (HFD) and visual pain chart (VPC) were developed to evaluate the changes in the body image and pain experience for patients with a physical illness. Both HFD and VPC were used to evaluate the body concept of rheumatoid arthritis patients as compared to a control group, and the changes present in drawings of the rheumatoid arthritis patients after twenty weeks of peer group counseling.

BEST COPY AVAILABLE

Group Art Therapy with the Institutionalized Aged: A Restorative, Reparative and Reengagement Agent

Vicky Youngman-Yazdi, Activities Worker, Florence Nightingale Nursing Home, 420 Clinton Ave., Apt. 6D, Brooklyn, Ny 11238

"Total institutionalization" inflicts heavy damage upon the ego. Aspects in which nursing homes constitute total institutions and the incurred adverse effects upon the aged's cognitive, social and psychological abilities will be explored. Group art therapy combats the "institutionalization syndrome" and attempts to restore capacities for relatedness, self-determination and self-respect. A slide review of art work, which illustrates the group's growth process, is included.

An Art Assessment Study of Schizophrenic Subjects On and Off Haloperidol

Elaine S. Kramer, MA, ATR, Chief, Art Therapy Section, St. Elizabeth's Hospital, United States Department of Health and Human Services, 6621 Wakefield Dr., #213A, Alexandria, VA 22307

Andrei-Claudian Iager, MD, Clinical Research Associate, National Institutes of Mental Health

Ambivalance: Art Therapy With a Chronic Paranoid Schizophrenic Patient in a Psychiatric Setting

Rachel Garber, MA, Art Therapist, Douglas Hospital, Mental Hygiene Institute, 3839 Clark Street, Montreal Quebec, H2W 1W4 Canada

A case study spanning eight months of art therapy, this paper focuses on the problems of splitting and ambivalence in the context of contradictory and inconsistent interventions on the part of the treatment team. The relation of staff conflicts to the art therapeutic approach and the patient's conflicts will be explored with the aid of slides.

Graphic Images of Going Crazy and Being Sane

Janie Rhyne, PhD, ATR, HLM, Gestalt Counselor/Art Therapist, 1031 E. College, Iowa City, IA 52240

Drawings representing real and fantasized images of psychosis and sanity have been collected along with descriptions of these mind-states as verbalized by their creators. Drawings by clients in therapy with the presenter will be shown to demonstrate how constructs of "craziness" are reflected in therapeutic process and benefits.

Drawing Toward Wellness: Art Therapy with the Hospitalized Medically Ill

Barry M. Cohen, MA, ATR, Director of Expressive Therapies, Mount Vernon Hospital, 855 Richmond Hwy. #302, Alexandria, VA 22309

The theoretical basis for art therapy's unique role in treating the hospitalized medically ill patient is presented. A model which delineates the concepts of illness and disease is discussed. The psychological impact of medical hospitalization on the patient is clarified.

Separateness and Relatedness: The Structured Use of the Mural with a Psychiatric Population

Laura V. Loumeau, MPS, Activities Therapist, Mount Sinai Medical Center, 79-04 149th Street, #3-I, Flushing, NY 11367

This modality is discussed in terms of its implications for a schizophrenic population where issues of merging can make the use of a common space an anxiety-provoking experience. Various structured uses of the mural which were developed specifically to address the issue of individual identity within a common space, to act as an organizer for chaotic stimuli, and to develop symbolic thinking will be presented.

Pictures in a Methadone Clinic Lobby

Evelyn Virshup, PhD, ATR, Art Therapy Consultant, Suicide Prevention Center, 4900 Dunman Avenue, Woodland Hills, CA 91364

This paper presents a methadone clinic client's graphic experience over a year's time, using the process of art in an informal group in the waiting room of the clinic. Drug abusers have considerable difficulty articulating their feelings. The "public" art process proved effective in helping the clients become more aware and able to relate to each other and their counselors, and find common bonds with both groups.

The Peter Pan Dilemma: Treatment of Psychiatric Patients with Emancipation Problems

Catherine Moon, BFA, ATR, Art and Activity Therapist, Harding Psychiatric Hospital, 1697 Bunty Station Rd., Delaware, OH 43015

This presentation employs the use of allegory, imagery and didactic modalities to explore the treatment of psychiatric patients who are in the process of emancipating from their families. A clinical description of the three phases of treatment will be given, as well as a delineation of the role of the art therapist.

The Role of Creative-Expressive Arts Therapies in the Third Millennium

Josef E. Garai, PhD, ATR, Professor Emeritus, Pratt Institute, 155 West 68th St., New York, NY 10023

This paper visualizes the role of creative-expressive arts therapies in the "Age of the Person" which we enter in the third millennium. Artists as therapists will use imagination, intuition, and empathy.

The Full Rainbow: Symbol of Individuation

Lillian Rhinehart, MA, MFCC, ATR, Director, Eagle Rock Trail Art Therapy Institute, P.O. Box 2885, Santa Rosa, CA 95405

Paula Engelhorn, MA, ATR, Coordinator

The paper will investigate color as a natural source of individuation by exploring three principles: 1) color as an objective reality; 2) the symbol of the circle as the greatest representation of wholeness; and 3) the theory of opposites as expressed in Jung's psychological system. Because we have found these three principles expressed in the Native American Path of Life, we have based much of our work concerning the Full Rainbow on this heritage.

The Psycho-Cybernetic Model of Art Therapy

Aina O. Nucho, PhD, ATR, ACSW, Associate Professor, University of Maryland at Baltimore, 2124 Cedar Circle Drive, Baltimore, MD 21228

The concept of cybernetics (derived from the Greek word for "helmsman" or "navigator") is utilized to develop a model of art therapy process consisting of three phases. The specific tasks of the therapist in each phase are described and illustrated with brief excerpts from video taped art therapy sessions with several clients.

Milton Erikson's Theories and Techniques of Hypnotic Induction as they Refer to Art Therapy

Mildred Lachman-Chapin, MEd, ATR, Assistant Professor of Art Therapy, Graduate Art Therapy Program, Vermont College of Norwich University, 25 Foster Street, Montpelier, VT 05602

Discussant: Linda Gantt, ATR

Dr. Erikson's hypnotic techniques achieve a direct accessing of the client's unconscious material, finding language cues and metaphors to tap the private language of the client. This process, and the trance induction it occasions, is compared to the process of art therapy.

Non-Structured Art Therapy for Diagnostic Purpose

Ikuko Acosta, MA, Art Therapist, Essex County Hospital Center, 122 No. Mountain Avenue, Montclair, NJ 07042

Discussant: Harriet Power, MA, ATR, Art Therapist

This presentation focuses on the values and advantages of non-structured art therapy format for diagnostic purpose. A wide variety of drawings (slides) are shown in order to illustrate how they could be utilized for depicting various mental disorders in a categorical manner.

BEST COPY AVAILABLE 194

The Diagnostic Drawing Series: A Systematic Approach to Art Therapy Evaluation and Research

Barry M. Cohen, MA, ATR, Director of Expressive Therapies, Mount Vernon Hospital, 8559 Richmond Hwy, #302, Alexandria, VA 22309

Anna Reyner, MA, ATR, Art Therapist; Shira Singer, MA, ATR, Art Therapist

The Diagnostic Drawing Series is presented and discussed. Designed by art therapists for use by art therapists in the clinical setting, this tool is being systematically studied in psychiatric settings nationwide. The series was the winner of the 1984 AATA Research Assistance Grant.

To Interpret or Not to Interpret? That Is Often the Question

Roberta Shoemaker, MFA, ATR, Assistant Professor, Art Therapy, Emporia State College, Emporia, KS 66081

Bonnie Smith, MA, MFA, ATR, Psychiatry Unit, Prince George's County General Hospital

An approach to verbal interpretation of the visual content of art work done in art therapy sessions will be discussed. Since there are difference of opinions about the value, timing and need for verbal interpretation, the presenters will give a conceptual theory and the pro's and con's of interpretation.

Advanced Clinical Seminar: An Approach to Training and Education

Christine W. Wang, MA, ATR, Assistant Professor and Director, Graduate Art Therapy Program, Goucher College; Assistant Clinical Professor, University of Maryland; Clinical Supervisor and Instructor, Sheppard and Enoch Pratt Hospital; Praecept in Psychiatry, Sinai Hospital

This paper considers the use of students' drawings as part of a formal course on transference and counter-transference. We will present material on issues of empathy, intuition, introjection, and projection. The resultant benefits are: for the student, clarification of the therapeutic relationship, integration of theoretical and clinical learning, growth and change; for the instructors, clarification of group process, identification of weaknesses in supervision.

The Clinical Application of Art Therapy: Its Contribution to a Short Term Psychiatric Setting

Mary Anne Blank, MA, Art Psychotherapist/Activities Therapist, Mental Health Management, Inc., 211 Jackson Avenue, Ridgway, PA 15853

The major objective of the session is to identify the various treatment, cathartic, and diagnostic uses of art psychotherapy a short-term psychiatric setting. The eleven therapeutic (curative) factors will be identified and expounded upon as well as those antitherapeutic elements involved in an acute inpatient setting. The multi-disciplinary team approach and the specific role the art psychotherapist plays in this overall domain will be discussed. Finally, various techniques that are most beneficial to this clientele will be discussed and explained.

How Patients Evoke Therapists' Shadows: Subtle Dangers of Unacknowledged Counter-Transference

Don L. Jones, ATR, Director, Adjunctive Therapy, Harding Hospital, 490 Mid Drive, Worthington, OH 43085

The patient who fails to improve, who is resistant or who disagrees with one's treatment approaches, perhaps threatening that subtle sense of omnipotence, is always in danger of being confronted with primitive behavior barely disguised as therapeutic.

Art Therapy Evaluation: A Standardized System Based on the Use of Computer Scoring and Video

Georgiana Jungels, MA, ATR, Program Director, Art Therapy Studies, State University College at Buffalo, 745 West Delavan Avenue, Buffalo, NY 14222

Kate Hartman, ATR, Art Therapy Studies Faculty, Art Therapy Graduate Research Assistant

Discussant: Lewis K. Shupe, PhD, ATR, Professor, Art Therapy/Speech Pathology, Wright State University

Report on a recently developed system and standardized procedure for collecting, recording, and analyzing visual and verbal information in drawings through the use of a computer-scorable evaluation form and video.

The Concept of Space: The Circle and the Square. An Art Therapy Protocol to Address Cognitive Disturbance

Marilyn La Monica, MPS, Art Therapist, Clinical Supervisor, Pratt Institute, 454 14th St., Brooklyn, NY 11245

Maria Belfiore, MPS, Art Therapist

This presentation describes an art therapy protocol designed to address the cognitive disturbance of the concept of space. The underlying psychological, aesthetic and clinical assumptions of such a protocol will be developed through (a) a clinical description of cognitive disturbance in schizophrenia, with particular emphasis on distortions of the concept of space (b) developmental considerations using various theories to describe the cognitive, psychological and affective stages in the achievement of organized space and ego boundaries (c) an overview of geometrical shapes and their intrinsic meaning, with particular emphasis on the characteristics of the square as it represents, organizes and defines space and (d) a protocol of a structured art therapy group which suggests the clinical application of the previous work.

Progress Through Art Therapy With a Thirty-Nine Year Old Inmate of a County Prison

Denise Asteneh, BA, 123 East Vaughn St., Apt. A, Kingston, PA 18704

Irene Mclaughlin, BA

A slide presentation depicting progress made through two art therapy students, working consecutively over a seven month period with a low functioning male inmate. The progress includes: 1) going from extreme low self-esteem to presently exhibiting self-confidence; 2) from a determination of pre-school level to now learning to read and write; 3) from having no goals to originating future goals upon release from prison.

Exploratory Literature Study of Self-Mutilators' Characteristics and Their Reflection in Art Work

Nancy Knapp, MA, ATR, Assistant Behavioral Science Consultant, Director of Art Therapy Program, Harbor-UCLA Medical Center, 16081 St. Croix Cir., Huntington Beach, CA 92649

Isolde Martin, Art Therapy Intern

This presentation consists of the findings of a literature search of self-multilating behavior which was tabulated with the presenting behavior, case histories and art from twenty psychiatric patients. The results of the exploratory study and slides of the art will be shown.

continued

See page 38 for the preliminary announcement of AATA's 16th Annual Conference.

BEST COPY AVAILABLE

BEST COPY AVAILABLE

Functional Art Therapy with Handicapped Clients who Exhibit Self-Injurious Behaviors

Connie Livingston-Dunn, MA, ATR, Activity Therapist III, Dixon Developmental Center, 107 E. Oregon St., Polo, IL 61064

The utilization of functional art therapy is presented through case studies as an alternate behavior for clients who exhibit self-injurious behaviors. This will assist personnel who will be working with this special population in a multi-disciplinary approach as they become mainstreamed from larger institutions to smaller community facilites.

Art Therapy Group With Artists

Patricia Gould, MA, ATR, Art Therapist, Community Counseling Center, Inc., P.O. Box 33, Flintstone, MD 21530

This paper will present an overview of a research group of artists in art therapy. Literature and slides will be reviewed. In addition, attention will be paid to the special problems and responses the artist has in art therapy, their ways of interacting, personality traits and function of the art production.

Jackson Pollock: Art Without Therapy

Evelyn Virshup, PhD, ATR, Art Therapy Consultant, Suicide Prevention Center, 4900 Dunman Ave., Woodland Hills, CA 91364

Jackson Pollock's work, including early paintings, gives us an opportunity to see the progression of a troubled alcoholic's emotional development, through his images. In his retreat into abstract work, his "mature" style, constantly veiling his images, it appears that he denied himself tools which could have helped him be creative longer.

The Mask and the Medicine Wheel: An American Indian Art and Movement Ritual

Susanne Pitak Davis, MPS, Art Therapist, Carrier Foundation, The Laceworks, Rt. 29, Lambertville, NJ 08530

The American Indians used the Medicine Wheel ceremony to promote unity within the tribe and harmony with nature. This modern day version incorporating art and movement attempts to do the same. Slides of the actual ceremony plus art work illustrate the effectiveness of this workshop which was given out of doors.

Innovative Therapy Programs for Communication Disorders: Integration of Art, Drama and Group Therapy

Carole Kunkle-Miller, MEd, ATR, Art Therapist, Western Pennsylvania School for Deaf, Carlow College, 3117 Dobson Street, Pittsburgh, PA 15219
Judith Rubin, PhD, ATR, HLM, Art Therapist and Assistant Professor, Department of Psychiatry
Paul A. Loera, MS, Counselor

This presentation will include an overview of the use of expressive arts modalities with children and adolescents demonstrating communications disorders. The need for such mental health programs will be defined, and a model program which was developed at the Western Pennsylvania School for the Deaf to help meet this need will be described. Suggestions will be offered for setting up similar programs in other facilities. Slides of clients' art work and a videotape of the therapeutic group process will also be presented, with discussion of treatment issues and implications for development of treatment plans.

Drawing Them Out: Art Therapy with Deaf/Hearing Impaired Psychiatric In-Patients

Sally Brucker, MA, ATR, Art Therapist, St. Elizabeth's Hospital, 1732 Q Street, NW, Washington, DC 20009

Art therapy, in conjunction with sign language, is used to break through the communication barrier between a hearing therapist and a group of deaf/hearing impaired psychiatric in-patients. Using object relations theory as a framework, the focus will be on the use of art as a means of communication and working through the various stages of therapy. Illustrative case material is included.

The Use of Art Therapy in a Multi-Disciplinary Approach to English as a Second Language

Virginia Minar, MS, ATR, Art-Exceptional Education Teacher/Therapist for the School District of West Allis-West Milwaukee; Art Therapy Instructor, Alverno College, 308 East Dean Road, Milwaukee, WI 53217

An overview of team procedures used in developing a program for teaching English to an eight-year-old from Thailand will be presented. Art therapy sessions will be detailed showing that the creative experience allowed for non-threatening visual communication which then served as the catalyst for verbal communication.

PANELS

Healing and Psychotherapeutic Process in Art Therapeutic Practice

Arthur Robbins, EdD, ATR, Chairperson, Art Therapy Department, Pratt Institute, 325 West End Avenue, New York, NY 10027
Elaine Rapp, ATR, Faculty
Edith Wallace, MD, Jungian Analyst, Faculty, Institute for Expressive Analysis
Shaun A. McNiff, PhD, ATR, Chairperson, Creative Arts Therapy Department, Lesley College

Through open-ended questions and discussion, this panel will discuss specific issues pertinent to this area: 1) What do we mean by healing energy? 2) The interrelationship of the healing agent of art and the therapist. 3) Are there different levels of healing and can it be misused or abused? How so? 4) What kind of patients are ready for a healing? 5) Where and how can healing orientation be counterproductive to treatment? 6) Can all therapists utilize a healing approach to art therapy? 7) Specific case examples may be discussed regarding the interface of an psychotherapeutic and healing approach.

Dialogue with Editors of Publications in Art Therapy

Gary C. Barlow, EdD, ATR, Editor, *Art Therapy* and Professor of Art Therapy, Wright State University, 228 Creative Arts Center, Wright State University, Dayton, OH 45435
Myra Levick, PhD, ATR, Editor-in-Chief, *Arts in Psychotherapy*
Barbara Sobel, MA, ATR, *American Journal of Art Therapy*

A presentation by editorial personnel of the primary publications in our field and related fields is planned. Emphasis will be given to editorial policies and procedures, suggestions for prospective authors, ideas on manuscript preparation, and other suggestions for publication. Following the panel, the session will be open to the audience for questions.

The Quiet Trauma: Symbolic Language of the Sexually Abused Gives Predictive Clues

Dee Spring, MA, ATR, Consultant/Therapist, Consulting Services in Victimology, 361 Arapaho St., Ventura, CA 93001
Josie Abbenante, MA, ATR, Beth Silvercloud, MEd, CSW, Dianne L. Meixner, MA, ATR, and Nana Zizzis, OT

Private Practice: Ethical, Personal, Professional and State Considerations

Bobbi Stoll, MA, MFCC, ATR, Marriage, Family, Child Therapist, 8020 Briar Summit Drive, Los Angeles, CA 90046
Robert Wolf, MPS, ATR
Nancy Schoebel, MA, ATR, Director, Expressive Therapies, Psychiatric Institute of Washington
Irene E. Corbit, MA, ATR, Art Psychotherapist, Center for Creative Resources

Basic guidelines for private practice in art therapy including educational, ethical, financial and entreprenurial demands, variations in states' laws and licensing regulations with special focus on NY, CA, TX and overview of the status of private

BEST COPY AVAILABLE

practitioners in other popular states. Attention will be given to art therapists' efforts to effect state legislation granting private practice privileges.

What is the Impact of PhD Studies on the Career of an Art Therapist?

Ellen A. Roth, PhD, ATR, Art Therapist/Research Consultant, Western Psychiatric Institute and Clinic, 114 Yorkshire Drive, Pittsburgh, PA 15208
Sandra L. Graves, PhD, ATR, Chair, Expressive Therapies Department, University of Louisville
Myra Levick, PhD, ATR, Director, Creative Arts Therapy Program, Hahnemann Medical College
Janie Rhyne, PhD, ATR, Psychotherapist in Private Practice
Laurie Wilson, PhD, ATR, Director, Art Therapy Program, New York University

There is a growing trend among registered art therapists to seek advanced education and training leading to a PhD degree in a related field. This panel brings together a distinguished group of art therapists to share their experiences and impressions related to PhD study. The presentation will be of interest to students planning their future academic goals as well as to seasoned practitioners who may be contemplating PhD study.

Art Education vs. Art Therapy with the Disabled: Where Do You Draw the Line?

Carole Kunkle-Miller, MEd, ATR, Art Therapist, Western Pennsylvania School for Deaf, Carlow College, 3117 Dobson Street, Pittsburgh, PA 15219
Gary C. Barlow, EdD, ATR, Professor of Art Therapy, Wright State University
Judith Rubin, PhD, ATR, HLM, Western Psychiatric Institute and Clinic

This session will feature a discussion of the divergent points of view regarding the roles and responsibilities of art therapists and art educators working with the disabled. Implications for training and practical applications will also be emphasized.

The Status of Men in Art Therapy: Yesterday, Today and Tomorrow

Herbert Rosenberg, MFA, ATR, Director, Art Therapy Studies, Jersey City State College, 408 Ogden Avenue, Jersey City, NJ 07007
Robert Ault, ATR, Menninger Foundation
Gary C. Barlow, EdD, ATR, Professor of Art Therapy, Wright State University
Ronald E. Hays, MS, ATR, Hahnemann University
Cliff Joseph, ATR, Elizabeth General Hospital
Arthur Robbins, EdD, ATR, Chairperson, Art Therapy Department, Pratt Institute

Is art therapy a female profession? We don't think so but a look at the history of our field challenges a good look at the underlying issues that have kept men in disproportionate numbers. Leading men in the field discuss the issues.

The Interface of Object Relations Theory and Art Therapeutic Practice

Arthur Robbins, EdD, ATR, Chairperson, Art Therapy Department, Pratt Institute, 325 West End Avenue, New York, NY 10027
Judith A. Rubin, PhD, ATR, HLM, Western Psychiatric Institute and Clinic, 3811 O'Hara St., Pittsburgh, PA 15213
Marilyn LaMonica, MPS, Art Therapist, Clinical Supervisor, Pratt Institute
Donna Bassin, MPS, ATR, Faculty, Creative Arts Therapy Department, Pratt Institute

hat is object relations theory and how does it apply to art therapeutic practice? Specific issues will be raised regarding the therapeutic management of anxiety, etc. Principles of aesthetic form will be discussed in terms of transitional process.

WORKSHOPS

How the Arts Affect Learning: Research and Use of Arts Interventions in the Public Schools

Dottie H. Oatman, MA, Art Therapist, 959½ Arapahoe, Boulder, CO 80302
Eric Goodwin, RMT, Music Therapist
Steve Harvey, PhD, Educational Psychologist/Dance Therapist, 959½ Arapahoe, Boulder, CO 80302

Classroom interventions using activities designed from the art, music and dance therapies were used in a research project to increase students' self-esteem and positively affect their achievement in reading. Drawing on our most successful experience, in this workshop we will draw, dance and sing in order to explore creative arts programming in the public schools.

The Memory Suitcase: A Paper and Workshop on a Technique for Facilitating the Termination Phase of Hospitalization

Diane L. Tumblin, MS, ATR, Assistant Director, Art Therapy Master's Program, Eastern Virginia Medical School, 150 Broad Street, Portsmouth, VA 23707

This is a paper and workshop presentation of a technique used with latency-aged children. The technique, "The Memory Suitcase," is designed to aid in the termination phase of the child's hospitalization. It is designed to help the child express symbolically his ideas and concerns about leaving the hospital. The Memory Suitcase can function as a transitional object for this purpose; it is only done with the child around the time of discharge. The technique will be presented in full during the presentation.

The Stimulus Drawing Technique in Therapy, Development and Assessment

Rawley A. Silver, EdD, ATR, HLM, Art Therapist/Consultant, 1600 Harrison Avenue, Mamaroneck, NY 10543

This workshop will provide experiences in using the stimulus drawings, interpreting and scoring response drawings, and in self-exploration. This technique has served as an educational tool in identifying and developing cognitive and creative skills, as well as in the diagnosis and treatment of emotionally disturbed patients.

Art Therapy in Hospice Settings

Grace Cocuzza Zambelli, ATR, Art Therapist, Consultant, 41 Coolidge Rd., Maplewood, NJ 07040
Gail Shamberg Davidson, MEd, Psychotherapist, Delaware Valley Psychological Clinics
Discussant: Susan Lennon, ATR, Mt. Sinai Hospital

Many children have found art to be a useful tool when working through feelings about impending or recent loss. This paper will outline some guidelines for implementing art therapy programs in Hospice settings. Experiential training will be provided and actual case examples will be discussed.

Intraactional Drama With Masks

Irene E. Corbit, MA, ATR, Art Psychotherapist, Center for Creative Resources, 7722 Braesview Lane, Houston, TX 77071
Jerry Fryrear, PhD, Psychologist, University of Houston at Clear Lake

Fryrear and Corbit have developed a technique in which players create their own masks, then interact with aspects of themselves personified in the masks. Based upon Jungian theory of the persona, these interactions provide players the opportunity for expanded awareness and integration of the shadow side of the personality.

"Step into our Environment . . .": Exploring the Senses through Art with Developmentally Disabled Adults

Elizabeth Spear Rogers, MS, Art Therapist, Self-Direction Coordinator, Niagara County Association for Retarded Children, 29 Minnesota Avenue, Buffalo, NY 14222

Lucy Andrus, MS, ATR, Art Therapist, Coordinator, Matter at Hand Program, Albright-Knox Art Gallery

Participants will have the opportunity to view slides of a sensory environment structure created by developmentally disabled adult clients followed by an experiential workshop exploring sensory capabilities with a variety of art materials.

Sensory Tactileness: Use of Media with Moderately, Severely and Profoundly Disabled Individuals

Jacquelyn Martin, ATR, Art Consultant, County of Summit Board of MR/DD, 214 No. Portage Path, Akron, OH

This workshop will focus on the utilization of sensory-tactile media for clients who are moderate, severe or profoundly disabled individuals. Areas of discussion and demonstration will include increasing attention span and visual attention to task, improving fine motor skills and decreasing tactile defensiveness.

That Magnificent Metaphor: Art Therapy's Unique Tool

Don L. Jones, ATR, Director of Adjunctive Therapy, Harding Hospital, 490 Mid Drive, Worthington, OH 43085

Karen Rush Jones, ATR, Art Therapist/Lecturer, Capital University

A combination paper, case dramatization and workshop to explore metaphor and its unique role in evoking feeling and revealing insight into unconscious conflicts. Presentation illustrates the use of metaphorical dialogue, an "interpretation within the metaphor" rather than a direct verbal intervention or analysis.

Combined Art and Movement Therapy Group: Paper and Workshop

Barry M. Cohen, MA, ATR, Director of Expressive Therapies, Mount Vernon Hospital, 8559 Richmond Hwy, #302, Alexandria, VA 22309

Beth Kaplan, DTR, Movement Therapist

An art and movement therapy group is discussed in this paper and demonstrated with audience volunteers in a workshop format. Designed for use with psychiatric inpatients, this structure may be employed with many populations. Aspects of the Expressive Therapies continuum will be correlated with constructs from Effort Shape Analysis. Slides will be shown.

Exploring Dimensions of Stimulation and Structure as a Means of Facilitating a Holding Environment

Leslie Abrams, MPS, ATR, Assistant to the Chairperson, Pratt Institute, 1 Bank Street, #5N, New York, NY 10014

Participants will explore some of the problems inherent in the breakdown of stimulus barriers that are connected with ego disintegration and how the expressive group art therapist facilitates reintegration and synthesis.

Grants: Creating Job Connections

Doris Arrington, MAT, ATR, Director, Assistant Professor, Master in Art Therapy Program, College of Notre Dame, 30 Knollcrest, Hillsborough, CA 94010

Valerie E. Appleton, MA, MFCC, ATR, Art and Play Therapist, St. Francis Memorial Hospital

Cathy A. Malchiodi, MA, ATR, Instructor of Art Therapy, University of Utah

David Anderson, San Francisco, CA

Pat Keefe, ATR, Hillsborough, CA

Art Therapy graduates, educators and professionals will share experiences in the creation and realization of grants as job sources. The "how to's" and the consideration of the broad creative options available to professional art therapists in this hi-tech age will be shared.

How to Create an Effective Experiential Inservice

Barbara Fish, MA, Art Therapist, Allendale School, 1635 W. Touhy Ave., #1N, Chicago, IL 60626

An experiential art therapy inservice can be helpful in the development of a productive working relationship between the art therapist and the staff at any facility. This workshop will demonstrate an experiential art therapy inservice. Following the example media exercise, practical considerations of setting up an inservice will be discussed.

Picture Making for Peer Group Supervision

Harriet Wadeson, PhD, ATR, Director, Art Therapy, Graduate Program, University of Illinois at Chicago, 1020 W. Oakdale, Chicago, IL 60657

The power of the image can be utilized for reflection and communication in supervision. This workshop will present a model for art therapy peer group supervision using picture making for feedback. The process can also be adapted for group supervision from a supervisor.

Discovering the Creative Self in Later Life: Being Creative at Any Age

Helen Weil, MA, ATR, Art Therapist, Educator, Artist, Marble Hill Senior Citizens Center, 40 West 86th St., New York, NY 10024

The session will be experiential and didactic for those working with the elderly and interested in creativity as relating to longevity and the quality of life. Methods of stimulating the client/patient will be demonstrated by participants through role-playing, involving art materials and several other creative expressive modalities.

Burnout: What Is It and How to Get Rid of It

T. Thorne Wiggers, EdD, Coordinator of Outreach and Consultation, George Washington University, 718 21st St., NW, Washington, DC 20052

Sandy Geller, ATR, Coordinator of Art Therapy Services, George Washington University

This workshop will define burnout and provide information about its causes and symptoms. Using cognitive-behavioral and art therapy experiences participants will identify aspects of themselves and their jobs that contribute to burnout and will learn how to gain more control as a way of inoculating themselves.

BEST COPY AVAILABLE

A New Hawthorn Center Teaching Film

Stevie's Light Bulb: Graphic Art in Child Psychiatry

Awarded Blue Ribbon as Best-in-Category
American Film Festival, New York, 1984

Awarded Grand Prize
American Art Therapy Association Film Festival, 1984

Written by Ralph D. Rabinovitch, M.D. and Sara Dubo, M.D.

Produced by Ralph D. Rabinovitch, M.D. and Francis C. Pasley, M.D.

"...the theory and application of the art therapy modality is beautifully portrayed in a well-organized manner. I highly recommend this film for educational purposes"

Art Therapy
by Helen Landgarten, M.A. A.T.R., H.L.M.
Author of "Clinical Art Therapy: A Comprehensive Guide"

"This film has a warm, present quality it does a fine job technically and comprehensively of documenting the value of art therapy with children"

From a review in Journal of Child Psychiatry
by D. Scott May, M.D.
UCLA Medical School

"STEVIE'S LIGHT BULB is a stunningly effective example of both thematic organization and an innate understanding of film's relentlessly honest power. Without sacrificing the responsibility of contributing to the field, STEVIE'S LIGHT BULB has a clinical effectiveness that won't soon be forgotten by anyone who watches it"

From a review in Art Therapy
by Eddie Cockrell
American Film Institute Theater
The Kennedy Center, Washington, D.C.
Writer of "Film Talk" in
The Washington *Post*

STEVIE'S LIGHT BULB illustrates the uses of graphic art in child psychiatry through applications in diagnosis and treatment. The film covers 35 years of involvement by the authors. Numerous case studies demonstrate the elements of graphic art that are crucial in work with disturbed children. Eight young artists appear; the work of sixty others is shown. The film is directed to the interests of workers in mental health, art therapy, education and related fields, as well as to an interested general public.

76 minutes in two parts: PART I—41 minutes; Part II—35 minutes

Available in FILM 16 mm, color and VIDEO CASSETTE VHS, Beta and 3/4"

PURCHASE PRICE: Film—$695
Video—$225

RENTAL FEE: Film—$50 for three days
Video—$40 for three days

FOR ORDERING OR INFORMATION CONTACT
Hawthorn Center Films
Hawthorn Center
Northville, MI 48167
Telephone: (313) 349-3000

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

1980 Isaac Newton Square South Reston, VA 22090 (703) 476-5437

RESOURCES

The American Art Therapy Association serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapists' Identity (1976) 118 pages	$3.00	$5.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy Journal of the American Art Therapy Association	.00	$23.00
American Psychiatric Association Special Conference Proceedings Use of the Creative Arts on Therapy (1979)	$3.00	$4.00
National Art Education Association Journal: Special Issue Art Education, Vol 33, No. 4 (1980)	$3.00	$4.00
AATA Newsletter Subscription	.00	$9.00
Full Color Poster (16 x 20)	$1.00	$2.00
Stimulus Drawings and Techniques in Therapy, Development, and Assessment by Rawley A. Silver, EdD, ATR, HLM	$10.00	$14.00
Developing Cognitive and Creative Skills through Art by Rawley A. Silver, EdD, ATR, HLM	$14.00	$20.00

FILMS (Rental/Purchase)

		Members	Non-Members
Art Therapy: Beginnings (1977) 16 mm, color/sound, 45 minutes	Rental:	$30.00	$40.00
	Purchase:	$300.00	$400.00
Michael (1977) 16mm, color/sound, 12 minutes	Rental:	$20.00	$25.00
Art Therapy (1981) 16mm. color/sound. 12 minutes	Rental:	$25.00	$35.00
	Purchase:	$250.00	$325.00
Lori, Art Therapy and Self Discovery (1978) 16mm, color/sound, 32 minutes	Rental:	$30.00	$40.00
	Purchase:	$300.00	$400.00

ORDER FORM Make checks payable to AATA, and mail to the above address.

Indicate Quantity of Unit Items Below		Cost/Unit		Total
______	( ) ×	______	=	______
______	( ) ×	______	=	______
______	( ) ×	______	=	______
______	( ) ×	______	=	______
______	( ) ×	______	=	______
		______	=	______

Total Unit Costs = ______

*Postage/Handling = ______

Note: for postage/handling, add $1.50 for the first unit item, $.50 each additional unit. VA Residents add 4% Sales Tax.

Total Enclosed = ______

Proceedings Index (1976-1982)
$1.00 Members $2.00 Non-Members

Set of five Proceedings (consecutive years): 25% discount on total cost (Index:Free)

10 or more copies of any single issue: 15% discount on total cost

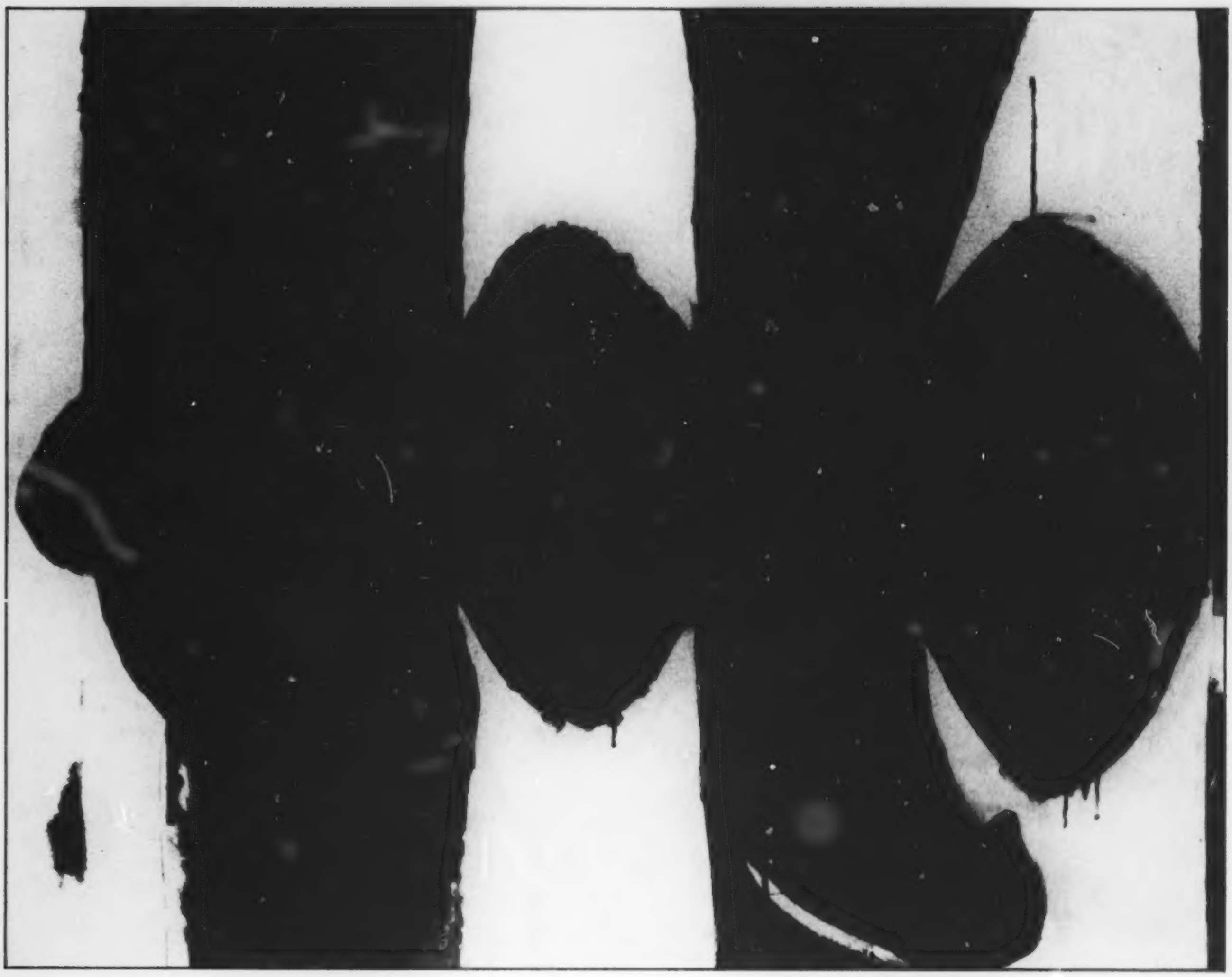
Discounts are available when purchasing quantities, as follows:
Set of four Proceedings (consecutive years): 20% discount on total cost (Index: Free)

Send To: ______

______

______
city state zip code

BEST COPY AVAILABLE



Elegy to the Spanish Republic, No. 34, Robert Motherwell, 1953-54. Oil on canvas, 80 × 100 inches.

This is one of over 80 Motherwell paintings that composed the retrospective exhibit at The Corcoran Gallery of Art, Washington, D.C., September 15-November 4, 1984. (Photo courtesy of The Corcoran Gallery of Art)

"Messages in Art"

16th Annual Conference
American Art Therapy Association, Inc.

October 24-27, 1985

Hyatt Regency
New Orleans, Louisiana

Wednesday October 23	**Pre-Conference Courses**
Sunday October 27	**Post-Conference Courses**

The Conference will feature general sessions, hands-on workshops, commercial and educational exhibits, research papers and discussion forums.

For more information, please complete this form and return to the AATA National Office, 1980 Isaac Newton Square South, Reston, VA 22090.

Please send more information about the 16th Annual AATA Conference:

____ Pre-Registration
____ Exhibits
____ Call for Papers

Name ____________________
Address ____________________
City, State, Zip ____________________

VIEWPOINTS

VIEWPOINTS provides a forum for sharing ideas and graphics about issues facing art therapists.

A Question of Creativity: Paradigms—Facilitators or Inhibitors?

Harriet Wadeson, PhD, ATR

C. G. Jung wrote: "I can only hope and wish that no one becomes 'Jungian'. . .I proclaim no cut-and-dried doctrine and I abhor 'blind adherents.' I leave everyone free to deal with the facts in his own way, since I also claim this freedom for myself."[1] The special genius of Jung or Freud enabled each to transform his own unique experience into a new way of viewing human life. In his own conceptual structuring, Jung did not remain a "blind adherent" to another's ideology, but in fact parted company from Freud.

Although those of us engaged in developing and refining the profession of art therapy may never reach the stature or the impact of a Jung or a Freud, nevertheless we work in a field fertile with opportunity for creative exploration. Furthermore, the very nature of our work is the encouragement of the creative. It seems ironic to me, therefore, that often we become the "blind adherents" Jung abhorred. We become "Jungians" or "Freudians" or whatever.

I am not suggesting that we discard the teachings of Jung, Freud and the many others who have informed our work. But I would like to see art therapists gain greater respect for and confidence in our creativity. Just as we have much to learn, we also have much to teach. Who is better prepared than art therapists to encourage and to understand the use of image-making for personal human development?

As a young field, we have struggled for our place in the sun among the older sturdier professions of psychiatry, psychology, social work, education and others. Often working in a setting as the lone art therapist among other more established professionals, lacking the presence of art therapy role models, some of us may be intimidated; some of us may model ourselves on seemingly more successful professionals from other disciplines. Needing a theory or an approach to support our efforts, we may look to a Jung or a Freud for guidance.

In so doing, we may neglect the very heart of our work: creativity. We encourage it in our clients, but sometimes forget its place in our own work. We recognize that in conducting art therapy, the practitioner must be creative in working with clients rather than depending on prescribed formulas. But do we consider that in a larger sense art therapists have the creative potential to become who we are—art therapists, rather than Jungians or Freudians using art? Most of us would agree that art therapy is more than a technique. But is seems to me that sometimes we operate otherwise. Such was my impression from attending the last A.A.T.A. Conference. For some of us, art is merely a method used in the context of a larger theoretical framework.

A narrow adherence to another's doctrine limits our vision. To use Jung as an example, his concepts provide a useful paradigm for many art therapists. As a creative thinker, he is an exemplary model. It is in this light that I believe he is an illuminating guide. His vision encourages us to take from him what we can use and to create our own vision. It is time for our young profession to grow beyond our parents, to go forth from the houses of our fathers and mothers (such as Jung and Freud), and to articulate the centrality of art and imagery in self development and in the therapeutic relationship.

Reference

[1] Goldenberg, Naomi. *Changing of the Gods.* Boston: Beacan Press, 1979. (No source given for quote)

Request for Graphic Submissions

"Viewpoints" encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit a black and white glossy photograph and four copies of the written material to: Viewpoints, ART THERAPY, 1980 Isaac Newton Square South, Reston, VA 22090.

BEST COPY AVAILABLE

REVIEWS

Book Reviews

Phototherapy in Mental Health

Edited by David Krauss and Jerry Fryrear. Springfield, IL: Charles C. Thomas, 1983

Reviewer **Shaun McNiff, PhD, ATR** *is Professor of Expressive Therapy and Dean of the Institute for the Arts and Human Development, Lesley College Graduate School, Cambridge, MA. He is also the author of* **The Arts and Psychotherapy** *(Springfield, IL: Charles C. Thomas, 1981).*

Phototherapy in Mental Health follows the previous books co-authored and co-edited by Jerry Fryrear (*Videotherapy in Mental Health* and *The Arts in Therapy*) in defining the field addressed in a manner which respects varied points of view and advances the interests of the whole. The Introduction, written with co-editor David Krauss, discusses eleven dimensions of phototherapy: "The evocation of emotional states; the elicitation of verbal behavior; modeling; mastery of a skill; facilitation of socialization; creativity/expression; diagnostic adjunct to verbal therapies; a form of nonverbal communication between client and therapist; documentation of change; prolongation of certain experiences; and self-confrontation."

The book includes twelve chapters on various phototherapy themes written by the editors and contributing authors. Fryrear's chapter, "photographic Self-Confrontation as Therapy" presents a practical overview of the literature and process of self-confrontation, which can be considered an essential element of both photo and video therapy. Fryrear's well-documented presentation offers an effective integration between clinical work and theory.

Alan Entin's chapter, "The Family Photo Album as Icon: Photographs in Family Psychotherapy" presents many provocative ideas for the creative use of photographic imagery in psychotherapy. The author explores possibilities for the "visual" analysis of family systems through family albums which offer information about earlier generations; relationships between family members; the identification of "favorite" and "hated" photographs; the photographing of one family member more than others; etc. The author describes how, during periods of stress or conflict, photographic patterns often change with a certain family member being absent. The author tries to connect his interesting personal ideas and experiences with family photographs in therapy to Bowen's family systems theory, which unfortunately tends to weaken rather than strengthen this creative and original chapter.

Judy Weiser's "Using Photographs in Therapy With People Who Are Different" offers an excellent and detailed case study of the role of photographs in a long-term relationship with a Native American girl who began working with the author at the age of nine. This case study helps to personalize the book, adding emotional and artistic depth through the story and the author's photographs of the child. Other chapters include Robert Wolf's presentation of the medium of instant photography combined with children's drawings. The Wolf chapter is thorough and comprehensive in its treatment of the visual medium and its place within the psychodynamics of the more general therapeutic relationship. Illustrative case materials are also presented.

Joel Walker's discussion of "The Photograph as a Catalyst in Psychotherapy" offers a series of stimulating and attractive photographic images which "though basically abstract, are representational enough to imply either singular thoughts or actions, or relationships between individuals." Walker's chapter suggests possibilities for artistic, personalized and more therapeutically oriented transformations of the standardized and more rigid TAT and Rorschach tests. The photos are described as "ambiguous images of suffused color and shadowy form that attempt to leave everything to the imagination."

There is a humanistic tone to Walker's chapter. The photographs used in the therapeutic work were taken by the author himself, and they seemed to serve the purpose of engaging him in a process of shared creativity with clients. He is engaged as both an artist and a therapist, utilizing projective qualities of the visual image adapted by both art therapy and psychology. This chapter demonstrates how the personal interests of therapists and clients can shape methodology, and how ultimately it is the person who is the therapeutic vehicle. Walker stresses how "the visual impact overshadows the verbal defensive repertoire," and how "The photograph as a catalyst in psychotherapy should not be viewed as a strategy in and of itself, but rather should be utilized as an integral part of the psychotherapeutic process."

"The Psychological Niche: The Auto-Photographic Study of Self-Environment Interaction" by Ziller, Rorer, Combs and Lewis, presents an overview of the principles of self-concept and self-presentation within a more general cognitive orientation theory. As a result of being cited by a number of authors, the work of Dr. Hugh Diamond of

England in the 1850's in photographing the "insane" is marked in the memory of the reader. This historical information and other nineteenth century precedents cited in the book give a sense of continuity to the therapeutic use of photos. Historical information could have been furthered through the inclusion of historical photographs. David Krauss ("Reality, Photographs and Phototherapy" and "The Visual Metaphor: Some Underlying Assumptions of Phototherapy") contributes reflections on the "underlying" themes of symbol and metaphor, the psychodynamics of perception, reality, culture, visual imagery, etc. From a practical perspective the message comes through that photography supplies "a vast amount of information" to the therapeutic relationship, both in terms of communication and client projections, often presenting material that people avoid or of which they are unaware.

Krauss, like all of the contributing authors, approaches photography as one of many modes of communication available to therapists and clients, and as a means through which "visual" imagery can be introduced. Krauss' discussion of image and metaphor reflects the book's more general lack of attention to photography as an artistic process, and the many parallels between photography and art therapy. A chapter dealing with these issues would have increased the depth and scope of the book. Art, however, has a way of always manifesting itself in works of quality, and in this book it is in the form of Krauss' personal photographs, included between the chapters and introductory pages. The sensitivity, technical quality and visual appeal of these images increased my desire for a discussion of "imagery," and a serious analysis of how phototherapy relates to other "visual" art therapies.

Although certain art therapists may declare that phototherapists are members of a distinct discipline, and vice versa, it is an undisputed fact that both are united in the primary attention focused on the visual image. It is also generally accepted that photography, together with painting, drawing, sculpture and other media, is a visual art. Additional attention and inquiry directed toward the imagistic and informal qualities of photographs could benefit both phototherapy and art therapy. The image as a reality unto itself deserves additional attention.

The scholarly and professional tone of *Phototherapy in Mental health* will give a big boost to the practice of phototherapy. The attractive layout and high quality materials used by Charles C. Thomas to produce the book will similarly contribute to the "image" of the work, and result in yet another contribution to the literature of the creative arts in therapy.

Psychoanalytic Perspectives on Art . . . A Review of Three Books

Portraits of the Artist: Psychoanalysis of Creativity and its Vicissitudes

John E. Gedo. New York: The Guilford Press, 1983
(303 pages, $20.00)

Picasso: Art as Autobiography

Mary Mathews Gedo. Chicago: University of Chicago Press, 1980
(304 pages, $10.95 paperback)

Psychoanalytic Theory of Art: A Philosophy of Art on Developmental Principles

Richard Kuhns. New York: Columbia University Press, 1983
(169 pages, $11.50 paperback).

Reviewer **Judith A. Rubin, PhD, ATR** *is Assistant Professor, Department of Psychiatry, University of Pittsburgh School of Medicine; and Co-Director, Creative and Expressive Arts Therapy Program, Western Psychiatric Institute & Clinic, Pittsburgh, Pennsylvania. She is also a graduate and member of the Faculty-by-Invitation of the Pittsburgh Psychoanalytic Institute.*

Three exciting new books—one by a psychiatrist, one by an art historian, and one by a philosopher—offer distinct and stimulating psychoanalytic perspectives on art and the artist. As an undergraduate art history major, this reviewer was quite intrigued by the light shed on that discipline by all three volumes. As an art therapist and psychoanalyst, the most exciting aspect of all three books was their ability to illuminate aspects of the creative process and the art product heretofore either shadowy or not visible.

One reason for the quality of all three books is the genuine interdisciplinary understanding of their authors. It is not uncommon for books on art by analysts or on analytic approaches by aestheticians, to be flawed by the writer's incomplete comprehension and presentation of concepts foreign to his/her primary field of expertise. This is equally true of much writing on art therapy by non-artists or non-clinicians. It is also regrettably valid for some publications by art therapists, which attempt to deal with ideas from related — but incompletely digested —

disciplines. Each of these books, however, provides a welcome model of how two or more perspectives can be fruitfully integrated by a serous investigator.

Dr. Kuhns, in a most original synthesis of early and recent psychoanalytic thought, develops and describes his own "enactment" theory of art, applying it both to the creative product and to the cultural tradition of which it is a part. His reliance on classical literature, particularly some relevant works by Freud, does not inhibit him from selectively integrating those later ideas and concepts which allow him to expand and explicate his ideas. He draws creatively on the work of Hartman, Kris, Winnicott, and Kernberg in a way which indicates his deep understanding of each man's contribution.

While this reviewer is tempted to share with the reader some of the specific notions espoused by Kuhns, it seems unfair to deprive anyone of the immense pleasure of following the author, step by step, in his careful exposition of his clever and provocative thesis. I can recommend the journey to anyone with even a slightly philosophical bent. An especially appealing aspect of this guide is his ability to put complex ideas into clear and simple language, rendering the book accessible to even the less-sophisticated reader.

John and Mary Gedo are not only authors of two related books; they are also husband and wife. He is a psychiatrist and psychoanalyst, with an impressive list of publications to his credit, including *Advances in Clinical Psychoanalysis* (1981), *Beyond Interpretation* (1979), and *Models of the Mind* (1973, co-authored with Arnold Goldberg). She is an art historian who has shared and developed her ideas not only within that community, but also in the lively milieu provided by Institute for Psychoanalysis in Chicago.

Mary Gedo's book on Picasso is subtitled "Art as Autobiography," which is an apt description not only of her hypothesis, but also of her research method. In essence, she studied the artist's life by studying his creations, paying close "attention to how, when, where, and why he created each of them." As she describes in her Introduction, she "carefully noted alterations in his medium or mode of production and correlated such changes with events in his life." Assuring the reader that she approached this study without preconceptions about Picasso's personality conflicts, Dr. Gedo states that "the evidence shaped her conclusions." This is a simple but profound statement of diagnostic integrity. I think the author's subsequent words bear repeating, since they apply equally well to work in assessment by art therapists: "... the hypotheses I developed fit the visual evidence, providing internally consistent reconstructions of the relationship between the artist's character and his creativity."

Dr. Gedo's most intriguing conclusion is that "Picasso's art, like his life, depended on partnerships." Her detailed rendition of his history of partners, from mother and father through mistresses, wives, and colleagues, is a fascinating and well-documented tale. Picasso's inner life, like his art, never fails to intrigue the reader with its complexity and many levels of meaning. This reader was also stimulated to reflect on the "partnership" of therapist and patient in art therapy. The natural liaisons described by Mary Gedo are similar to that between Freud and Fliess, who served as transference-object for the former's pioneering self-analysis. Since then, the analyst or therapist has served in a variety of ways as "partner" to the patient undergoing the exciting but frightening process of change. In *art therapy*, there is the additional component of the creative process of art-making, within a matrix provided and protected by another person. It seems to me that the art therapist plays a kind of "partnership" role in the creative work on both art and self of the patient in treatment. Mary Gedo's analysis of the function of his "partners" in Picasso's creative work helps us to think more deeply about our own roles as "partners" in art therapy.

While many ideas were stimulated by Mary Gedo's "arto-biography" of Pablo Picasso; even more were evoked by John Gedo's wide-ranging book, *Portraits of the Artist*. Most exciting was Dr. Gedo's integration of insights derived from seeing creative patients in analysis, with ideas drawn from the psychoanalytic study of famous artists and theorists. His subtitle, Psychoanalysis of Creativity and its Vicissitudes," while appropriate to the content, does not begin to describe the richness of this book. While it may sometimes be necessary, to make a choice between a "depth" and a "breadth" mode of inquiry or presentation; Dr. Gedo has impressively accomplished both depth and breadth throughout this stimulating volume.

The first two chapters, in a section entitled: "Psychoanalytic Studies of Creativity: A Retrospect," offer the finest review and discussion of that literature this reviewer has read. The four chapters of clinical studies which follow are written in a novelistic narrative form, and are fascinating to read on a human level. On a conceptual level, Dr. Gedo leads the reader through the "material" via his own psychoanalytic perspective, to a number of prescient hypotheses about the nature of creativity.

One chapter which is sure to interest the predominantly female members of the field of art therapy is entitled "Barefoot and Pregnant: The Dilemma of the Woman Artist." The third section includes psychoanalytic considerations of creative individuals in the arts; offering new perspectives on even the much-studied painters Van Gogh, Gauguin, and Picasso, along with provocative analyses of Caravaggio and Nietzsche.

A series of chapters are devoted to the creative work of the two great psychoanalysts, Sigmund Freud and Carl Jung, including the role played by each in the life of the other. A final chapter discusses the dilemma of our time: "The Artist and the Age of Mass Culture: Prophet in the Wilderness." Into what has too often been a jungle of heated, tangled conjecture, Dr. Gedo brings a welcome breath of clear, fresh air.

The book is an aesthetic as well as a scholarly delight to read, and is highly recommended.

The Mind's Best Work

D. N. Perkins. Cambridge: Harvard University Press, 1983 (314 pages) $18.50

Reviewer **Dr. Jack Matthews** *is Professor of Speech and Theatre Arts, and also has an appointment in the School of Dental Medicine, University of Pittsburgh, Pittsburgh, Pennsylvania. He was awarded his PhD from the Ohio State University. He has a lifelong interest and experience in the crafts, and has devoted much professional work toward studies of creativity.*

This is more than just another attempt to describe or explain the creative process. It does present explanations others have given but it goes far beyond. This is a book which brings together many explanations of creativity that have been advanced over several centuries. The explanations are examined both from the standpoint of their logical consistency as well as the empirical data available to support or to question the explanations. Perkins allows us to observe him as he goes through the process of stating some preliminary propositions about the creative process and of revising those propositions as he carries out experiments and thinks about his findings.

In a sense he "walks us through" the laboratory of his own mind. It's a pleasant journey because his is an alert and creative mind and because it's the mind of a scientist-artist who is interested in both poetry and science. In addition he writes good prose. He has produced a book which students of creativity—artists and scientists—should read to gain additional insights into the creative process.

Writers on creativity have described how in one night as Mozart was hardly able to keep awake he composed the overture to Don Giovanni; we have been led to believe that in Beethoven we had a composer who improvised with great ease but labored over every note in the process of composition.

Coleridge would have us believe that he conceived Kubla Khan and his wonderous palace in a dream brought on by opium. The actual writing supposedly was accomplished in a single sitting.

Poe, on the other hand claimed that the "Raven" was worked out with the precision and rigid consequence of a mathematical problem.

Perkins has examined numerous examples of the creative process as carried out by both artists and scientists—Picasso, Darwin, Marie Curie as well as numerous published poets. He provides us with their descriptions of what happens as they create. The descriptions are derived in part from what the artists and scientists wrote about the creative process. These explanations are supplemented by a series of more controlled observations in which the creative individual is asked to talk about the creative process immediately following the creative act. Perkins argues that such controlled observations do not unduly impede the creative process and result in more accurate information about what goes on in the process of creating. Perkins' goal is to get a better picture of what the mind is doing during the process of creating—a time when the mind "is working at its very best."

Perkins examines a number of propositions which have been used or which might be used to explain the process of creating. He musters evidence to support and to question each of the propositions and moves on to reject or revise propositions. In this process he offers propositions about mental leaps, introspection, insight, directed memory, etc.

In the end we are led to believe that we should not oversimplify creativity nor treat it as some mysterious entity. He argues instead that creativity should be viewed as the extension and orchestration of perception, understanding and memory—all ordinary everyday abilities about which we have much information and which can be investigated by widely accepted methodologies developed by psychologists working in many areas of the discipline.

If I were forced to give shelf space to only one book on creativity I believe that today the book would be D. N. Perkins *The Mind's Best Work*.

Guidelines for Authors

Please submit four (4) copies of manuscripts to: AATA Journal, 1980 Isaac Newton Square South, Reston, VA 22090. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5″ × 7″ black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

BEST COPY AVAILABLE

Silver Drawing Test of Cognitive and Creative Skills

Rawley A. Silver, EdD, ATR, Seattle: Special Child Publications, 1983
(96 pages with black and white illustrations)

Reviewer: **Ellen G. Horovitz, MA, ATR**, *is an art therapist at Hillside Children's Center, teaches art therapy at Nazareth College in Rochester, NY, and is in private practice. She is also on the national advisory board of Substance Abuse Intervention Services for the Deaf (SAISD), and is on the membership committee of AATA.*

Finally someone has introduced a non-verbal test that can be used for screening cognitive abilities and measuring developmental gains over time through pretest-posttest administration. That person is Dr. Rawley Silver.

The objectives in designing the Silver Test for children and adults were: a) to create a tool capable of identifying skills which often elude detection on language-oriented intelligence/achievement tests; and b) to provide a pretest-posttest measure proposed to test the efficacy of educational/ therapeutic programs.

Dr. Silver's premise is that "art can be a language of cognition paralleling the spoken word." (p. 5) Her aim is to bypass language and graphically assess conceptual problems basic to the "fundamentals in mathematics and possibly reading." (p. 11)

The body of the manual is 33 pages long and consists of an introductory chapter and sections on research and administration of the test. The remaining chapters offer extensive scoring samples (with illustrations and short case histories), tables of statistics and a reference section.

The battery is divided into three subtests: 1) Predictive Drawing—which evaluates the subject's understanding of sequential concepts and principles of conservation; 2) Drawing from Observation—which measures the subject's ability to perceive and represent spatial relationships; and 3) Drawing from Imagination—which determines the subject's capacity to form concepts, particularly that of class inclusion.

Performance in each area is rated on a scale of 0-5, (5 being highest), with a maximum of 15 points per subtest and a total score of 45 points. The test is succinct and can be administered to individuals or groups by teachers, therapists or psychologists.

Nevertheless, its concise quality has both positive and negative aspects. On the negative side, it offers the administrant less data for purposes of correlation and test reliability. When comparing the correlations of the Silver Test to intelligence/achievement tests, such as the WISC-Performance, WAIS-Performance, Metropolitan Achievement Test (MAT), Otis Lennon, and the Canadian Cognitive Abilities Test (CCAT), the Silver Test falls short of the mark. Yet it is difficult to fault the Silver Test for this shortcoming given the opinion of noted authorities such as MacCay Vernon, who states "neither the methods of diagnosis nor the appropriate therapies are completely known" when dealing with non-verbal populations. (p. 220)[1] Dr. Vernon looked at several verbal instruments including the WISC-Performance and WAIS-Performance. Although he found the WISC-Performance and WAIS-Performance adequate, he repeatedly stated their limitations when working with a non-verbal population. (p. 208-211) One wonders how he would have viewed the Silver Test.

The Silver Test indicates great promise. Its brevity is useful for subjects with histories of limited attention span. In addition, the subtest, Drawing from Observation, measures areas untapped in many of the language—oriented instruments. As a pretest-posttest, the Silver Test is an excellent gauge for charting educational/therapeutic programs. The Silver Test's ability to measure art therapy (treatment) over time, fills a previous void and creates the potential for impacting related clinicians and commanding greater respect for the field. It could very well become an invaluable assessment tool offering the art therapist an avenue to monitor theoretical findings. For the theorist seriously interested in validating art therapy (treatment) through pretest-posttest administration, the Silver Test is a must.

Reference

[1] Vernon, MacCay's Psychologic Evaluation of Hearing-Impaired Children, Chapter 5, in Lyle E. Lloyd's *Communication Assessment and Intervention Strategies*, University Park Press, Baltimore, Maryland (1976).

The Honesty of the Image

Stevie's Light Bulb: Graphic Art in Child Psychiatry

Best-of-Festival Award, American Art Therapy Association 1984 Film Festival

Film (16m, color, 76 minute in two parts: 41 minutes and 35 minutes; also available on VHS, Beta or 3/4" videocassette). Produced by Ralph D. Rabinovitch, M.D. and Francis C. Pasley, M.D.

Reviewer **Eddie Cockrell** *is a film consultant and teacher based in Washington, D.C. Currently, his "Film Talk" column appears in the* **Washington Post**. *He is also programming The American Film Institute Theater at The Kennedy Center.*

The non-fiction film is a difficult genre in which to work. Effectiveness and responsibility are rarely in evidence simultaneously; filming real life in real time rarely yields significant drama. To hold the interest of an audience (be they professionals or laypersons), it is often necessary to jazz up the flow of events through editing or other film techniques, thereby violating the purity of the documentary form. If observation alters the event observed, as many film theoreticians feel, then how on earth, especially in this media-conscious age, is it possible to use the documentary film as a teaching tool—particularly in such an arbitrary, mysterious world as child psychiatry?

Ralph D. Rabinovitch, M.D., Director of Clinical Research for Michigan's Hawthorn Center, has assembled a clinical film team that has, to date, produced six teaching films in child psychiatry. Their most recent effort, *Stevie's Light Bulb: Graphic Art in Child Psychiatry,* is a stunningly effective example of both thematic organization and an innate understanding of film's relentlessly honest power. Through clarity, organization, and a simplicity born of care, the team has made a movie that reveals a methodology of discovering the fantasy life of disturbed children with words and pictures that are of interest to all. Without sacrificing the responsibility of contributing to the field, *Stevie's Light Bulb* has a clinical and emotional effectiveness that won't soon be forgotten by anyone who watches it.

"While this is a teaching film," says "Dr. R." (as he is familiarly known to his patients) near the beginning of the film, "it is hopefully not too didactic. To identify with children's creativity, one really should relax, kind of lose oneself, and just enjoy the experience. For the next hour, we are the guests of Stevie and his fellow artists." A little later on, he opines "Free expression often can and should be fun, enjoyed by child, teacher, and therapist. A too didactic or interpretive approach may well take the joy out of art, and may also lead to unwarranted conclusions. Is Stevie's light bulb really only a light bulb? Only Stevie knows, and he won't tell. If we plague him with our conjectures, he may well come to exclude us from his fantasies. He loves to create, and that's good enough. Most important, through his creating and sharing in therapy, he is beginning to find language for communication."

Accepted clinical doctrine aside, here is a man who knows how to communicate. While it is far beyond this reviewer's scope of experience to critique the methodology employed, as a full-time film critic with a special interest in the documentary format, rest assured that films like *Stevie's Light Bulb* don't come along very often. The majority of films in this genre tend to be dry, serious pieces that do very little more than attach pictures to a thesis. In this film, Dr. Rabinovitch and his team have had the good sense to do what any filmmakers should do when confronted with such a visual subject: point the camera at it and wait.

Mostly a series of static interviews intercut with examples of artwork, *Stevie's Light Bulb* succeeds primarily because it doesn't rush or manipulate its subjects. If you've ever been near a film set, you know that the bizarre-looking equipment and hot lights can be terribly intrusive in a real-life situation. Film consultant and editor Christa Kindt and cinematographer Lawrence W. Trinkaus have somehow managed to create an on-screen environment that doesn't appear to intrude on the therapeutic process—without sacrificing technical quality. Similarly, the original music of Dana Newhouse avoids the irritating cliches so often used in films of this sort (plaintive pianos, busy reeds), choosing instead to complement the mood of the art without making a direct comment on it.

Working in tandem with fellow psychiatrists Dr. Francis Pasley and Dr. Sara Dubo (Mrs. "Dr. R."), Rabinovitch has filtered 35 years worth of work into the film's existing format, which features eight young artists on-screen and representative works by 60 others. Using the title patient, and his cardboard construction of a light bulb, and drawing of an alphabet as the central metaphors of the film, the doctors have arranged the content into an exploration of elements of drawing and painting. This is followed by a variety of clinical applications. Subdividing the elements of drawing and painting into form, affect, content, defenses, and symbols, the art is examined economically, yet completely.

As important as the individual team contributions are to the success of the film, it is Rabinovitch's vision and presence that makes the movie move. Sort of the Marlin Perkins of child psychiatry, Rabinovitch has a folksy, sing-song tenor that relates the voluminous narration with unflagging enthusiasm. While most of his on-camera involvement is secondary to the main action (and rightly so), he appears to be a natural—relaxed and photogenic. This kind of figure acts as a conduit to the viewer, making even the most clinical passages of the film understandable.

The five other films in the team's series cover reading disabilities, early infantile autism, and inpatient psychiatric treatment for deaf children. If these works are as cogently organized and technically polished as *Stevie's Light Bulb*, they deserve to be in any film library that needs information on these subjects.

Incidentally, *Stevie's Light Bulb* also was awarded the Blue Ribbon at the highly-regarded American Film Festival in New York City last year as the best film in its category. The film or videocassette is available for rental or purchase through Hawthorn Center Films, Hawthorn Center, Northville, MI, 48167. Orders may be phoned in at (313) 349-3000.

With Eyes Wide Open

Documentary film (16mm, color/sound, 1983, 58 minutes) by Laurence Becker and Ron Zimmerman

Reviewer **Georgiana Jungels, ATR**, *is in Art Therapy Studies, Art Education Department, State University College at Buffalo, New York.*

The film *With Eyes Wide Open* documents the life of Richard Wawro and includes over 200 of the 3,000 pictures he has made in his lifetime. The film focuses on his life and art from his early years and first drawings to his current pictures, daily activities, travels, and exhibits. Who is Richard Wawro? He is an artist and his preferred medium is oil-crayon. His drawings have been shown in London, Paris, Krakow, and the United States and his "pictures are filled with trains, boats, cars, buses, space ships, and airplanes."

Through interviews and comments we learn that Richard was born in Scotland in 1952 with cataracts in both eyes, was diagnosed as deaf, displayed autstic behaviors and appeared "hopelessly retarded." Although Richard began drawing before he was 4, "he didn't speak out-loud until he was eleven." At home he was "constantly moving and slept only infrequently." When Richard was 12, a Polish art professor, Marian Bohusz-Szyzko, said he was "thunderstruck" by Richard's drawings and urged his parents "to do everything they could possibly do to develop Richard's talent."

In the film we see Richard's pictures are "everywhere" in his parents' home; "in the bedrooms, in the living room, in the dining room. There are stacks of newly completed pictures waiting to be matted, catalogued and exhibited. Even the stairway leading to the attic is lined with early pictures, each one displaying a consistent, developing style." Throughout the film Richard's drawings are constantly present. It is obvious that "drawing takes up most of Richard's time" whether he is at home, or at the adult occupation center he attends every day, or visiting his brother in Glasgow, or traveling through Europe with his father, or in the United States with Laurence Becker (the film producer). He is "almost totally aware of everything around him" and "with his binoculars, Richard seems to be constantly searching for new images. He's like a blotter soaking up every detail, visual elements that might show up even years later in one of his paintings."

The footage in the film *With Eyes Wide Open* is almost equally balanced between the PEOPLE who are significant in Richard's life (his mother, father, brother, teachers, neighbors, the filmmaker/producer) and the PICTURES that Richard has made throughout his life. The film documents Richard Wawro's past and present through real-time contemporary scenes from his daily life, through a review of his collected pictures, and through interviews and commentaries with the people who know Richard.

The most significant footage in this film is the retrospective review of Richard's pictures and the scenes of Richard working on his pictures. "He works close to the surface with his eyes just inches away . . . . and drawings may have half a dozen layers of color . . . the colors blend and then reflect light together." The film narrator observes that Richard "has a phenomenal memory for places, dates and pictures. He can remember when and where he finished most of his drawings and can calculate the years since that time." Although his pictures reflect his daily life, his travels, or the images he sees in magazines or on television, "he never looks directly at anything while he is drawing" and his pictures "are not simply literal images of what he's seen. He adds and subtracts, rearranges and organizes." His brother Michael has noticed that "the content of his pictures is determined by the size paper given him." These observations are well-illustrated in the making of the picture *Mountains of New Zealand at 30,000 Feet*.

With Eyes Wide Open presents an excellent collection of Richard Wawro's pictures and provides the viewer with an "inside" view of both the art work and the artist. The film includes some very special events in Richard's life and there are the "important" moments that every documentary filmmaker hopes for (e.g., the first time that Richard signs a picture). The viewer is frequently reminded that there is a contrast between Richard's artistic abilities and his physical disabilities. "Richard is an artist with a special vision responding through his pictures with strong feelings to world events. He continues to express himself most articulately through the medium he knows best: the color crayon . . . when Richard talks about his own pictures, he's active and articulate."

The film *With Eyes Wide Open* has been edited to present the "successful" development of Richard Wawro from a profoundly handicapped child to an internationally exhibited artist. The strength of the film is in the documentation of Richard Wawro's pictures and their relationship to his life. It is very clear that Richard Wawro's life and art work have been nurtured by many dedicated people: his parents who refused to follow one doctor's advice to "put Richard in a home and forget him"; the neighbor in whose kitchen Richard "first discovered a piece of chalk"; the teacher who provided him with paper and crayons and reflected that "it is difficult to describe the emergence of his first picture: so unexpected it was . . what I saw was magic"; his brother Michael who "has continued to encourage Richard to take new and even bolder steps toward selfhood"; and the film producer who has spent years on this film to prepare a "personal view of a disturbed and disabled little boy who, through his art, is becoming a young man with joy and confidence in his work, in his world, and in himself."

The film *With Eyes Wide Open* is well-photographed and includes many memorable scenes from Richard Wawro's adult life and hundreds of examples of his first drawings to his current pictures. However, the overall impact of the film would have been stronger if the film had been edited to focus more on the documentary footage of Richard Wawro and his family and less on the people who were involved in the making of the film. The beginning and ending film sequences could have been eliminated and some of the factual information (eg. the fact that Richard eyes had been misdiagnosed for more than 25 years) incorporated into the voice-over comments.

The strength of the film is not in the interpretive comments about Richard Wawro's art work and life but rather in the fact that the film provides the artist with a broader forum and makes a significant statement about the potential of art.

I would recommend that the viewer approach this film in the spirit suggested at the beginning of the film and "try not to have too many preconceptions about Richard. Keep your mind open; watch Richard yourself."

For further information about the film, contact the producer, Dr. Laurence Becker (Creative Learning Environments, 507 Park Boulevard, Austin, Texas 78751) or the filmmaker, Ron Zimmerman (Zimmerman & Associates, 411 Bonham, San Antonio, Texas 78215).

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

Kutztown University presents

ART EDUCATION STUDY INSTITUTE

Art in Action for Exceptional Learners

JUNE 23-28, 1985

The institute will offer an opportunity for teachers and other professionals who work with atypical persons to interact with nationally known experts in the field. A concentrated program will provide instruction and inspiration for professional development.

INSTRUCTIONAL STAFF

- Dr. Gary C. Barlow, Wright State University, Dayton, OH
- Dr. Shaun McNiff, Leslie College, Cambridge, MA
- Dr. Sondra Gair, Educational Management Services, Washington, DC
- Ms. Ellen Granetz, Academy School, West Bratleboro, VT
- Mr. Theodore Salazar, Gallaudet College, Washington, DC
- Ms. Susan Aach, school for Blind Children, Pittsburgh, PA

For further information write to: Dr. John R. Sawyer,
School of the Visual and Performing Arts,
Kutztown University, Kutztown, PA 19530.

BEST COPY AVAILABLE

BRIEF COMMUNICATIONS

The Canadian Art Therapy Association *Journal* has recently begun publication (Fall & Winter, 1984-85, Volume I, Number 1). As stated in the information for contributors, "The Journal is dedicated to publish scientific papers dealing with all aspects of Art Therapy." For information, contact: Editor, Canadian Art Therapy Association, 216 St. Clair Ave. W., Toronto, Canada M4V 1R2. The Editor and Editorial Board of *Art Therapy*, the Journal of the American Art Therapy Association, offer our congratulations for the establishment of this new Journal in our professional field.

* * *

The British artist and art therapist, Edward Adamson, and psychologist, John Timlin, will give a lecture on "Art as Healing" at the State University College at Buffalo on April 19, 1985 at 4:00 p.m. in the Communication Center. This public lecture will be the first lecture in the United States for these well-known pioneers in the field of Art Therapy in Britain.

Edward Adamson is an artist, art therapist who developed the Art Therapy program at Netherne Hospital in England and founded the British Association of Art Therapists. During the past 37 years, he has supported and guided many people who were going through critical periods of stress in their lives and he has collected over 60,000 images that illustrate how art can help to communicate feelings about illness and healing. Selections from the world famous Edward Adamson Collection have been exhibited throughout the world and Edward Adamson is a Council Member of the Societe Internationale de Psychopathologie de l'Expression.

John Timlin is a member of the British Psychological Society and taught emotionally disturbed children in London's East End before becoming Principal Lecturer in Remedial Education at a London University teacher's college. He was a founder member of the British Association of Art Therapists and is the Honorary Chairman of the "Adamson Collection" charity.

For further information, contact Georgiana Jungels, ATR, Art Therapy Studies, Art Education Department, State University College at Buffalo, 1300 Elmwood Avenue, Buffalo, NY 14222, (716) 878-5721 or (716) 878-4106.

**THIS SUMMER,
ART THERAPISTS CAN GO JUMP IN THE LAKE...**

**at the Summer Art Therapy Institute
Lake Geneva, Wisconsin**

The University of Illinois at Chicago Art Therapy Program and the Office of Continuing Education announce a two week institute for practicing art therapists and those studying art therapy. Four courses are offered during the two week period, allowing students to earn up to 13 hours of graduate credit if all courses are taken. Instructors for the courses are: Harriet Wadeson, Ph.D.,ATR, Robert Ault, MFA, ATR, Pat Buoye Allen, M.A.,ATR, and Evadne McNeil, Ph.D.,ATR.

The setting for these courses is George Williams College, located on the shores of beautiful Lake Geneva. It provides a relaxing and creative ambiance for study, sports, and socializing in our summer art therapy community.

For more information or to obtain a registration form, contact:

The University of Illinois at Chicago
Office of Continuing Education
Box 4348, Mail Code 165
Chicago, IL 60680
(312) 996-4650

The University of Illinois at Chicago also announces Intensive Art Therapy Workshops on April 26 and 27 featuring Edith Wallace on Active Imagination. For more information call (312) 996-5728.

Calendar

12-13 April, 1985. **Art and Medicine 1985: Diagnosing the Canvas.** Sponsored by the University of Connecticut, Office of Continuing Education. Fifteen speakers from the worlds of art and science will discuss topics such as medical illustration, children's art, the art of the mentally ill, and Navajo art and curing. Contact Cecile Volpi, Continuing Education Coordinator, University of Connecticut Health Center, Farmington, CT 06032.

20-24 April, 1985. **American Orthopsychiatric Association's 62nd Annual Meeting.** Institutes, courses, sessions, panels, and workshops highlighting the theme of "Government's Responsibility to Promote Mental Health." New York City Hilton. Contact: American Orthopsychiatric Association, 19 W. 44th St., Suite 1616, New York, NY 10036, (212) 354-5770.

22-24 March, 1985. **8th Annual Invitational Convocation of Art Therapy Educators.** Sponsored by the St. Louis Institute of Art Psychotherapy. The conference, open to all art therapy educators, will be held at the Chase Park Plaza Hotel, St. Louis, Missouri. Contact: Mary St. Clair, 8407 Glen Echo Dr., Belle Nor, MO 63121. (314) 381-5447.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1980 Isaac Newton Square South, Reston, VA 22090.

Please enter my subscription for 1985. Enclosed is my check, payable to AATA, for $23

Name ______

Address ______

City ______ State ______ Zip ______

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

TAKE ADVANTAGE OF THIS SPECIAL OFFER!

Subscribers to *Art Therapy* and Members of American Art Therapy Association
ENJOY REDUCED RATE!

SUBSCRIBE NOW – AND SAVE 50% OR MORE! *The Arts in Psychotherapy* is a quarterly journal in its 12th successful year of serving practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologists which reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy, THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers to: Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583
TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA

Please enter my subscription for Vol. 12, 1985 ☐ (Prepayment required) Check enclosed ☐
Please enter my subscription for Vol. 13, 1986 ☐
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume
2 Vol. subscriptions subject to additional 10% discount Individuals $36 Students $27

Name ______

Address ______

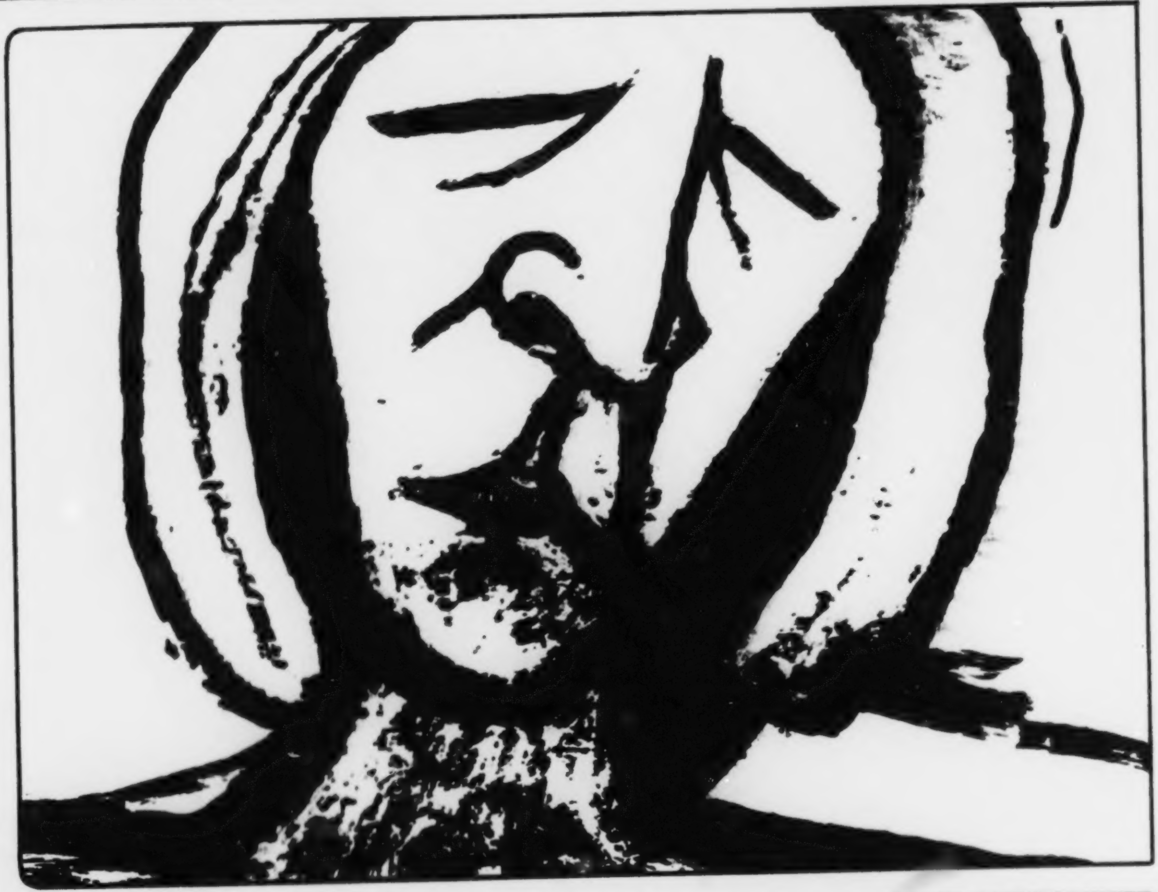
City ______ State ______ Zip ______

BEST COPY AVAILABLE

BEST COPY AVAILABLE

ART THERAPY

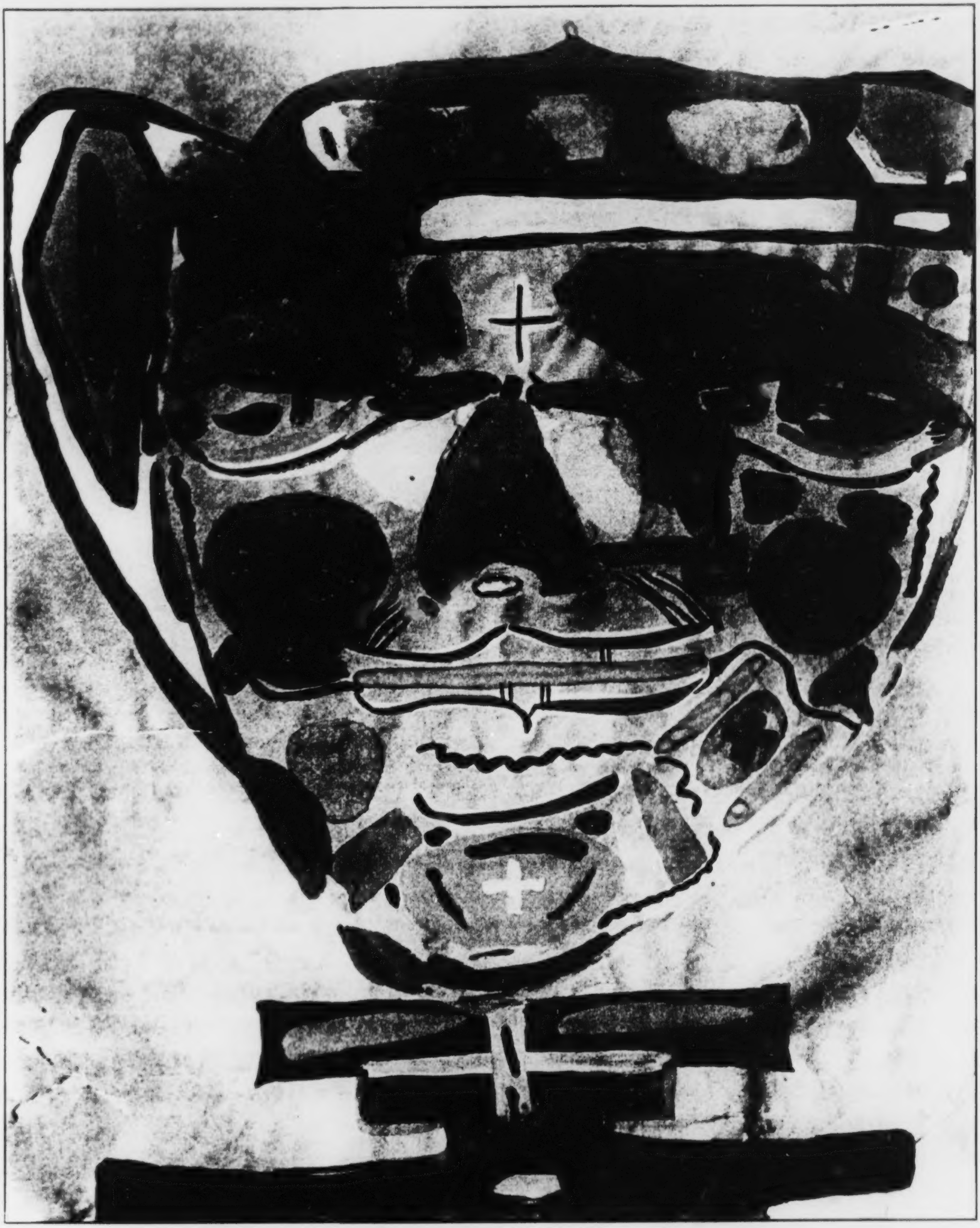
Journal of the American Art Therapy Association



Volume 2, Number 2

June 1985

- Creative Art Expression from a Leukemic Child
  Margaret A. Cotton
- The Potential of Rehabilitative Computer Art Therapy for the Quadriplegic, Cerebral Vascular Accident and Brain Trauma Patient
  Diane J. Weinberg
- The Art of Healing: The Work of Edward Adamson
  Georgiana Jungels



BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, EdD, ATR 49

Articles

Creative Art Expression from a Leukemic Child
Margaret A. Cotton, MA, ATR 55
The Potential of Rehabilitative Computer Art Therapy for the Quadriplegic, Cerebral Vascular Accident and Brain Trauma Patient
Diane J. Weinberg, MA, ATR 66
The Art of Healing: The Work of Edward Adamson
Georgiana Jungels, ATR 73

Viewpoints

Our Search for Excellence
Gary C. Barlow, EdD, ATR 83
Multiple Intelligences
Janie Rhyne, PhD, HLM, ATR 84

Brief Communications 85

Reviews

Book Reviews

Art and Mainstreaming (Art Instruction for Exceptional Children in Regular School Classes 88
Obtaining Funds for Therapeutic Recreation and the Creative Arts Therapies 90
The Artist in Each of Us 91
Inpatient Group Therapy 92
Self-Growth in Families, Kinetic Drawings (K-F-D): Research and Application 94
Normal and Anomalous Representational Drawing Ability in Children 96

Film/Video Review

Art and Therapy; Lila 98

About Our Covers:

All four covers in this issue feature paintings from the Adamson Collection. Titles and/or numbers follow: Front Cover—#29 "Face of Suffering;" Inside Front Cover—#18 "Self Portrait;" Inside Back Cover (clockwise from upper left)—#83, #17 "Self Portrait," #21 "Self Portrait;" Back Cover—#92. Additional photographs and background begin on page 75.

Volume 2, Number 2 June 1985

Copyright © 1985
American Art Therapy Association, Inc.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Production Editor
Shirley N. Nuhn
Advertising Manager
Beth Nord

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Anthony Kowalski, MD
Susan LaMantia O'Connor, MA, ATR
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Sivlerstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 1980 Isaac Newton Square South, Reston, VA 22090 (703) 437-6012

BEST COPY AVAILABLE

CHARLES C THOMAS • PUBLISHER

ART AND MAINSTREAMING: Art Instruction for Exceptional Children in Regular School Classes *by* **Claire B. Clements** *and* **Robert D. Clements.** The authors discuss and illustrate the ways in which art can enhance the lives of handicapped children, and they include methods for involving nonhandicapped students in the mainstreaming process. Individual chapters present art strategies and curricula for working with behaviorally disordered, mentally retarded, hyperactive, learning disabled, perceptually impaired, and neurologically and orthopedically handicapped students. The final chapter provides challenging art projects for gifted students. Necessary classroom modifications are fully described. Over 100 photographs and illustrations enhance the text. *'84, $17.50*

New! **MUSIC THERAPY: An Introduction, Including Music in Special Education (2nd Ed.)** *by* **Donald E. Michel.** The new edition of this text continues to provide an excellent introduction to the use of music in therapy and in special education. Highlighting this edition are recent changes in the definition of music therapy, new approaches to the handicapped and to persons with substance abuse problems, discussions of the international growth of music therapy practice, and the latest academic and clinical changes in music therapy education. *'85, $14.75*

New! **DRAMA WITH THE ELDERLY: Acting at Eighty** *by* **Fred S. Greenblatt.** Activity directors and therapeutic recreation specialists will find the information they need to successfully establish and conduct a drama group for the elderly. The author outlines various dramatic forms, itemizes the essential steps in forming and operating a drama group, and explodes myths about the older adult's inability to act and memorize lines. Suggestions for integrating drama into the total activity program are included. *'85, $19.75*

ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS *by* **P. J. Furrer.** This elementary school art education workbook presents activities and lesson plans that encourage, stimulate and facilitate creative expression. The author shows how to use art in a more meaningful way than is usual in the elementary school setting. Rejecting the product-oriented approach, she details instead a method that helps the child explore who he or she really is, to accept that person, and to change and grow. While the book is light-hearted — not at all the ponderous tome its purpose may suggest — it does indeed show how to promote therapeutic expression and how to use art to deal with problems and meet psychological needs. The lessons themselves — tested and proven successful — include information on materials, procedures, directions, goals, target populations, evaluation, resources and notes. *'82, $12.75*

PERSONALITY PROJECTION IN THE DRAWING OF THE HUMAN FIGURE: A Method of Personality Investigation (11th Ptg.) *by* **Karen Machover.** An original technique for human figure drawing analysis receives total coverage in this classic text. The author details the method's background, explains administration and interpretation, identifies specific elements and their import, and provides many illustrative examples. *'80, $16.75*

New! **A MANUAL OF SEQUENTIAL ART ACTIVITIES FOR CLASSIFIED CHILDREN AND ADOLESCENTS** *by* **Rocco A. L. Fugaro.** This practical manual details art activities that are designed to remediate deficiencies and encourage self-actualization in children and adolescents. For each classification — neurologically/perceptually impaired, emotionally disturbed/socially maladjusted, depressed — the author develops a therapeutic format that details specific goals to be achieved, abilities to be measured, assessment procedures, and treatment plans. Each of numerous art activities lists motivational materials, specific activities, necessary supplies and expected performance. Normal cognitive and affective art development is illustrated to help in determining at what level appropriate treatment should begin. An important discussion on developing motivation in handicapped children concludes the text. *'85, $25.75*

PHOTOTHERAPY IN MENTAL HEALTH *edited by* **David A. Krauss** *and* **Jerry L. Fryrear.** In their examination of the therapeutic uses of photography in mental health, professionals from all involved disciplines discuss current concepts of phototherapy and explain the techniques used in the process. They delineate photographic self-confrontation, the auto-photographic study of self-environment interactions, instant phototherapy with children and adolescents, and phototherapy in family psychotherapy. Numerous photographs from actual sessions accompany the text. The result is, as Rudolf Arnheim said in his review for *The Arts and Psychotherapy,* "one of the liveliest books on art therapy this reviewer has seen in years. It overflows with fresh ideas of how to apply the medium of photography to diagnosis and therapy." *'83, $29.75*

THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking *by* **Myra F. Levick.** In this book, a pioneer and leader in art therapy describes and illustrates normal and abnormal development of cognitive skills and defense mechanisms through the graphic productions of children between two and ten years old. The range of topics thus examined includes art therapy, defense mechanisms of the ego, psychosexual and cognitive development, and manifestations of defense mechanisms in children's drawings. *'83, $34.50*

THE ARTS AND PSYCHOTHERAPY *by* **Shaun McNiff.** An integrated approach to all of the arts in psychotherapy is presented in this insightful book. The author examines the distinctive and common qualities of the various expressive arts in relation to psychotherapy. He also draws on the statements of artists to develop a psychology of art that views artistic exploration as psychological research of the highest order. "Though this approach may be controversial, the book will be interesting, provocative, and valuable to clinicians who use any of the arts in a therapeutic context." *—Contemporary Psychology. '81, $19.75*

THE CLINICAL APPLICATION OF PROJECTIVE DRAWINGS (6th Ptg.) *edited by* **Emanuel F. Hammer.** This classic guide to projective drawings grounds the reader in the fundamentals and goes on to consider differential diagnosis, appraisal of psychodynamics, conflict and defense, and projective drawing usage in therapy. *'80, $34.75*

Order direct for fastest results • Write or call (217) 789-8980 • Books sent on approval
Postage paid on MasterCard, Visa & prepaid orders • Catalog sent on request

2600 South First Street • Springfield • Illinois • 62717

EDITORIAL

Bits and Pieces

The American Art Therapy Association Conference is not too far away (October 24-27, 1985) and each of us should begin now to make our plans for attending. It promises to be an exciting and productive one (Theme: "Messages in Art") not only in content, but also in the traditional yearly meeting of old friends, the sharing of ideas, the motivating of one another to "get back to the easel or the clay," and the partaking of those extra benefits of belonging to an active professional association. New Orleans is an "energetic" city, and for everyone who attends, the Southern hospitality and unique food should be especially attractive. Another conference that will be of interest to you is the NCATA (National Coalition of Arts Therapy Associations) meeting, to be held in New York City on November 23-27, 1985. The theme is "Creative Arts Therapies: Interaction/Interplay."

* * *

This issue of *Art Therapy* offers a stimulating mixture of articles, reviews, photographs, viewpoints and other features. Edward Adamson, artist/therapist and a pioneer in art therapy, is featured in an article, with photographs and an interview. We are pleased to include, on all four covers of this issue, full color pages that show some of the patients' work collected by Edward Adamson. His collection of over 60,000 pieces of graphic imagery relating to art as healing has been collected from patients since 1946. Many of these are from his patients in Netherne Psychiatric Hospital in England. This collection—or parts of it—has been exhibited in England, the United States, France, Spain, Sweden, Finland and Egypt.

An article on "Creative Art Expression from a Leukemic Child" offers support for the power of art therapy as an important modality when working with a dying child. "The Potential of Rehabilitative Computer Art Therapy for the Quadriplegic, Cerebral Vascular Accident and Brain Trauma Patient" presents the importance of looking beyond the paper and pencil to other forms of media and adaptive devices appropriate for handicapped and disabled clients in art therapy.

The Viewpoints section offers two [seemingly] disparate areas of content: the search for excellence, with references to corporate management, and multiple intelligences, as identified by Howard Gardner. The two authors (Barlow and Rhyne) present views, then offer responses to the other's content. A final comment is shared by Harriet Wadeson, **VIEWPOINTS** editor.

A thought: In re-reading *Creativity, The Magic Synthesis* by Silvano Arieti (1976), this section emerged once again:

> The person who appreciates a great work of art has the feeling that the work grows in him as he becomes involved in a prolonged capturing of emerging marginal meanings. He feels that he, too, is creative, that he himself is adding to his experience and understanding. Moreover, he wants to confront the work of art many times. He is not easily tired of it, as he would be had he read a purely logical statement. He realizes that the work of art does not merely transmit information; it produces pleasure. He also experiences each element of it as essential and unique: nothing is redundant. By reading the poem again, the reader adds further to his aesthetic understanding and again experiences pleasure. Indeed, many people enjoy and even prefer going back to well-known poems and music many times, rather than experiencing new works (Arieti, 1976, p 141).

As art therapists, we should continue to "go back to the work." We should reexperience those paintings and sculptures not merely as information givers, but also as pleasure givers. At a recent university exhibition of collected works from individuals and corporations, paintings and sculptures were shown. Many past and present artists were represented such as Stuart, Corot, Millet, Gainsborough, Reynolds, Arp, Dali, Christo, Hofmann, Kline, Motherwell, Oldenberg, Pollock, Poons, Rothko, Warhol and others. My art therapy graduate students spent much time experiencing and enjoying, and came away being revitalized. They revisited, reexplored and added further to their aesthetic understandings. As art therapists, we need to continue to visit galleries, attend concerts and poetry readings, attend plays and opera and dance performances. We need to *be* creative, *feel* creative, and gain from the pleasure and the understandings that work offers. This can be revitalizing for each of us.

* * *

There have been some questions regarding the proper way to submit articles for publication in *Art Therapy*. Each issue of the journal includes "Guidelines for Authors." You will find them in this issue as well. However, it might be pertinent to identify here some specific points that may answer questions that authors have posed.

Articles submitted to *Art Therapy* must include four copies of the manuscript, and must be typed (double-spaced). If original photographs are included, photocopies of them should be included with the remaining three copies of the manuscripts. A detachable cover page should include information about the author (name, title, place of work, address, and telephone number). Three of these copies are sent by the Editor to reviewers for "blind" evaluation. The article may be accepted, accepted pending major or minor revisions, or rejected. The Editor then communicates with the author regarding acceptance, revisions or rejection. The Editor will work closely with any author in the revisions, or in the case of an article that is rejected, will offer suggestions for revamping the article for possible future submission.

An abstract must accompany the manuscript. This condensed, comprehensive version of the entire article provides the reader with a quick survey of the material. It is also used by abstracting and information services to index the article, and to formulate a retrieval system for it. An abstract generally consists of approximately 100-125 words, although it may be slightly more or less, depending upon the nature of the article.

For particular questions on style or format, refer to the *Publication Manual of the American Psychological Association* (1983). Often called the "APA Manual," this book offers rules for the preparation of manuscripts and is an invaluable reference for content and organization, writing style, referencing and much more.

Many authors have asked about the proper way to reference, and to formulate a bibliography that has consistency. Some specific questions are as follows:

Q. How does one reference an unpublished paper?

A. To reference an unpublished paper presented at a meeting, the correct style would be:

> Jones, D. (1983, October). *Art psychotherapy in a private psychiatric hospital: A psychodynamic approach to group and individual treatment.* Paper presented at the American Art Therapy Association Conference, Chicago, IL.

Q. How should one reference proceedings of meetings and symposia?

A. To give specific references to proceedings, the correct style would be:

> Ault, R. (1977). Are you an artist or therapist—a professional dilemma of art therapists. *Creativity and the Art Therapist's Identity: Proceedings of the Seventh Annual Conference of the American Art Therapy Association* (pp 53-56). Baltimore, MD: The American Art Therapy Association.

Q. How should an unpublished master's thesis be referenced?

A. An unpublished master's thesis would appear as follows:

> Feen, H.R. (1982). *The Role of art therapy in the expression of self-concept in adults with adventitious disabilities.* Unpublished master's thesis, Wright State University, Dayton, OH.

For additional guidelines on manuscript preparation, or for the sharing of ideas on writing in art therapy, you may wish to attend the session on "Writing for Publication" that is to be offered at the AATA Conference in New Orleans.

Happy writing!

—Gary C. Barlow, EdD, ATR
Editor
Art Therapy

References

American Psychological Association. (1983). *Publication manual of the American Psychological Association* (3rd ed.). Washington, DC: Author.

Arieti, S. (1976). *Creativity, the magic synthesis.* New York: Basic Books, Inc., Publishers.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:
Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, *ART THERAPY, Journal of the American Art Therapy Association,* discounts on publications, discount on admission to the annual conference, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (ATR). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA National Office.

Associate Membership shall be open to individuals interested in the therapeutic use of art wishing to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $50

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee. **Applications for student membership must be accompanied by a copy of current ID.**

Annual Dues: $35

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $100

Professional Membership is by application only and is open to individuals who have completed professional training in art therapy and who are or have been engaged in the therapeutic use of art. Professional members are eligible to participate in all activities of the Association and receive all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $75

Credentialed Professional Membership is by application only and is open to individuals who have met the qualifications and been approved for Professional Membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in Standards and Procedures for Registration. Professional members are eligible to participate in all activities of the Association and receive all official publications. A Credentialed Professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $80

Make checks payable to AATA

American Art Therapy Association, Inc.
1980 Isaac Newton Square South
Reston, VA 22090
(703) 437-6012

NAME ______________________________
LAST FIRST MIDDLE

PREFERRED MAILING ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________________

OTHER ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________________

TITLE ______________________________

EMPLOYER ______________________________
INDIVIDUAL OR INSTITUTION

HIGHEST EDUCATIONAL DEGREE ______________

☐ $ 50 **Associate Membership**

☐ $ 35 **Student Membership**
(copy of current ID required)

☐ $100 **Contributing Membership**

☐ $ 75 **Professional Membership**
(by application only)

☐ $ 80 **Credentialed Professional Membership**
(by application only)

Payable in U.S. Dollars

Dues and expenses related to participation in AATA may be tax deductible as a business expense.

BEST COPY AVAILABLE

RETURN THIS APPLICATION WITH YOUR REMITTANCE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA office, 1980 Isaac Newton Square South, Reston, VA 22090 (703) 437-6012.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1983-1985

Board of Trustees

President
Gladys Agell, MA, ATR

President-Elect
Sandra L. Graves, PhD, ATR

Secretary
Nina Holtzman, MA, ATR

Treasurer
Helen Landgarten, MA, HLM, ATR

Committee Chairs

Affiliate Societies
Nancy Steinberg, MA, ATR

Bylaws
Donald L. Cutcher, MA, ATR

Education
Gary C. Barlow, EdD, ATR

Governmental Affairs
Nancy Schoebel, MA, ATR

Membership
Robin F. Goodman, MA, ATR

Public Information
Bobbi Stoll, MS, MFCC, ATR

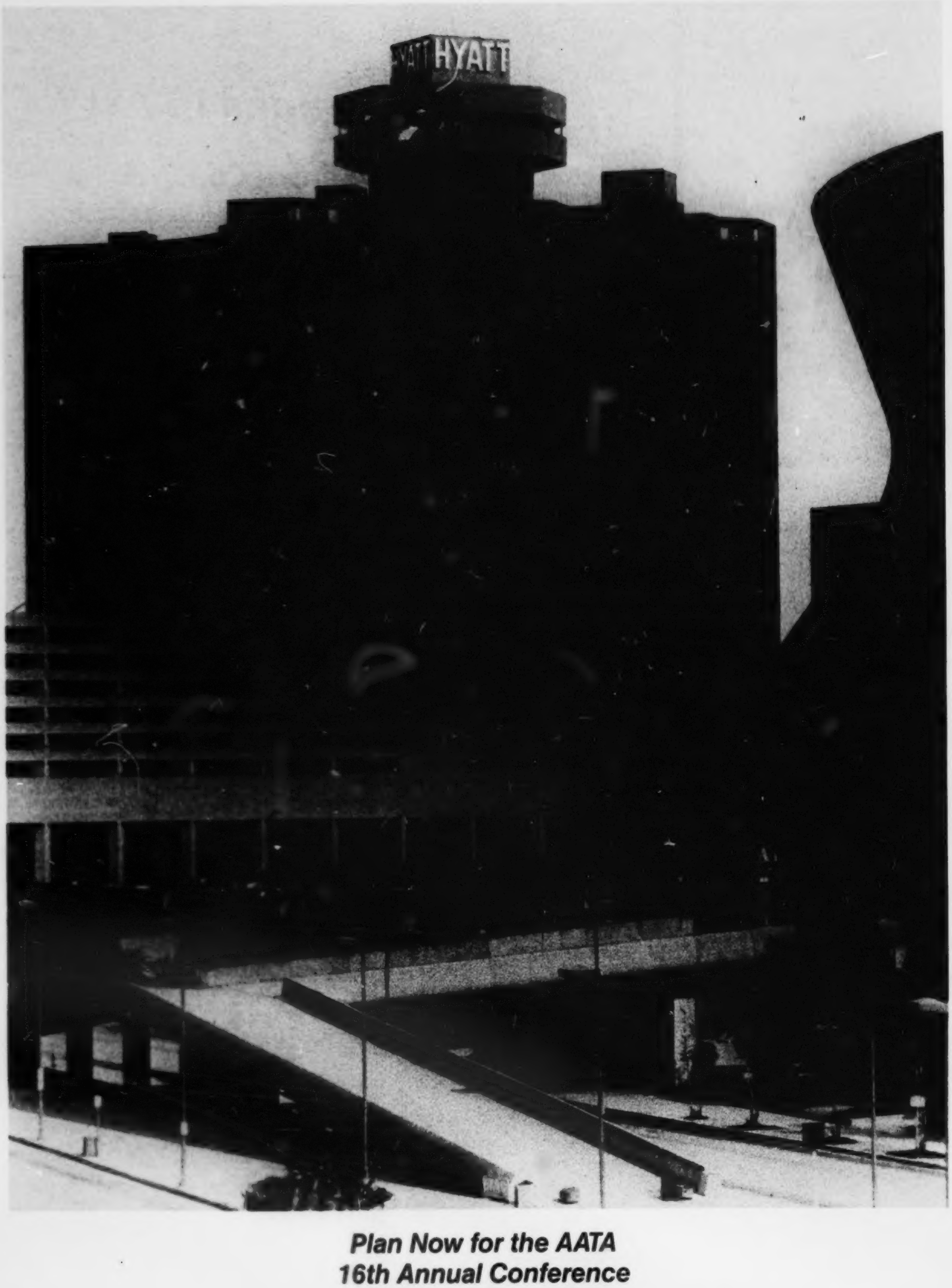
Publications
Harriet Wadeson, PhD, ATR

Research
Janie L. Rhyne, PhD, HLM, ATR

Standards
Ronald E. Hays, MS, ATR

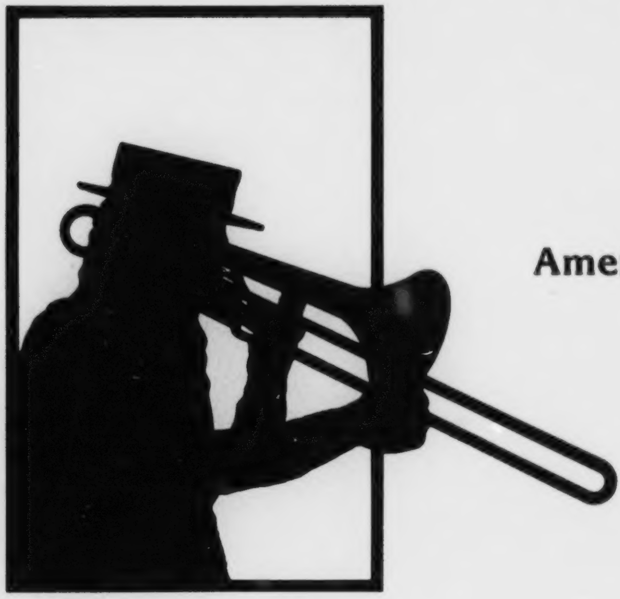
Executive Director (ex officio)

Richelle Grapsy



Plan Now for the AATA
16th Annual Conference
October 24-27, 1985
Hyatt Regency, New Orleans

BEST COPY AVAILABLE



"Messages in Art"

16th Annual Conference
American Art Therapy Association, Inc.

October 24-27, 1985
Hyatt Regency
New Orleans, Louisiana

Wednesday October 23	**Pre-Conference Courses**
Thursday - Sunday October 24-27	**Conference Sessions and Exhibits**
Saturday October 26	**Keynote Address: Christine Sizemore** *(The Three Faces of Eve)*
Sunday October 27	**Post-Conference Courses**

The Conference will feature general sessions, hands-on workshops, commercial and educational exhibits, research papers and discussion forums.

For more information, please complete this form and return to the AATA National Office, 1980 Isaac Newton Square South, Reston, VA 22090. (703) 437-6012.

Please send more information about the 16th Annual AATA Conference:

_______ Pre-Registration
_______ Exhibits

Name ______________________________
Address ______________________________
City, State, Zip ______________________________

Creative Art Expression from a Leukemic Child

Margaret A. Cotton, MA, ATR

Margaret A. Cotton, MA, ATR *is Art Therapist at the Rehabilitation Institute of Chicago.*

A primary purpose in studying the creative art expression of a leukemic child was to observe the progress of the disease as it might appear in a child's art work. In this case study the author was interested in discovering whether the healing process through art could alleviate the mental and physical traumas of leukemia in its more acute and advanced stages. By working with the child, an atmosphere of mutual trust was encouraged whereby some of these feelings could emerge through pictorial expression. Further study with children who have leukemia must be done in order to expand our knowledge through research; however, some of the present evaluations might provide insight into the problem of leukemia—both diagnostically and therapeutically.

Following an introduction and examples from literature, a section is included on leukemia. Then a description illustrates the author's work with Sabrina for approximately six months. The author ends the descriptive case study with a section on personal experience, conclusion, and a list of references.

Introduction

In this study I was interested in discovering whether or not the healing process through art could alleviate the mental and physcial traumas of leukemia in its more acute and advanced stages. Through the child's art, possible implications of death awareness might be seen. (My own observations would be strengthened by research in the general concept of the process of dying, all of this hopefully evolving into a fuller realization of the power of art to reveal the progression of death awareness through art.)

In my work with Sabrina, a six year old girl with whom I worked, some of the practical problems occurred; these problems could be expected, and were: the physical limitations of the critically ill child; the emotional stress of the patient, family and therapist; and the constant coming-and-going of a hospital routine. Nevertheless, the art therapy continued over a period of time. A variety of materials were chosen for the therapy; this was done to màximize the art expression through the art experience. Because of the nature of the illness and the obvious limitations of the child, my plans would have to be flexible and perhaps spontaneous whenever possible.

Literature References

Little research material was available on the specific study of art and the leukemic child. In the concept of dying, literature was more comprehensive and this helped me to assess, observe and evaluate my work with Sabrina. Focus was given to art as a dynamic medium to further therapeutic communication (Naumburg, 1966) and to art as a means of sublimation, a process through which the ego comes to master unconscious drives and impulses (Kramer, 1971).

Information relating to the dying child was important. Regarding the overall stress that occurs in the process of dying, Kübler-Ross explained five stages that usually emerge. The first is *denial,* "no not me," followed by *anger,* "why me." Succeeding in order are *bargaining* with the Superior Power as the patient and family hope for more time, *depression* as the actuality of the prognosis is realized, and *acceptance* of dying either positively or negatively. As the patient and family hold onto the expectation of a cure or the like, hope may be experienced (Kübler-Ross, 1975). The way that a child is told about the prognosis depends upon his/her age and maturity, and the parents, in most cases, make the final decision on how much a child is actually told about the disease and its outcome.

The family of a child who is terminally ill is of a major importance in the process of dying. They often have to make decisions about time to be spent with the child in the hospital, interim home visits during the child's remission, and communication with the siblings. The duration of the disease may be from diagnosis to five years. Emotions may be displayed in dealing with all of these facets. Sometimes anger, irritation, and worry about financial investments and assessments evolve. The anger can be directed at physicians, research programs, and treatment teams (Sherman, 1976). In the final analysis the parents work with the medical team. Important for both staff and parents is not to mourn the child too early and too completely. "He has been mourned and put to rest before he is dead." (Easson, 1970, p 79). This is important as the child needs active support day to day.

A review of literature specifically relating to the art expression of leukemic children would be significant and relevant. Carol Perkins (1977), in "The Art of Life-Threatened Children, A Preliminary Study" wrote on the anxiety of life-threatened children as it appeared in the art expression. In her study the drawings of life-threatening children contained large quantities of black. The children's response was a negative one—faceless nightmare creatures, shadows and

"...an integral part of an art therapist's working with a person with leukemia is an understanding of the disease and the treatment protocol."

dark houses. Although red was consistently used by many children, exceptionally large quantities of red were found in the drawings of life-threatened children. Their verbal correlation was usually in the concept of blood. Perkins also indicated that at least one other author had signified this red as "burning" or "tumor" red.

With regard to space positioning and specific correlations in her group, Perkins placed the division of a picture into four quadrants: the lower left, the darkest downhill trend; the upper right, a positive sign, the here and now; the upper left, following the setting sun, or if a path, then a going out of life; the fourth, located in the lower right, a potential future or recent past (Perkins, 1977). Most of the life-threatened children, according to Perkins, drew the sun in the upper left part of the page.

The leukemic children in Perkins' study seldom drew pictures of persons, perhaps because of a sense of isolation from the outside world. Their houses often projected a diseased state, and small, often round windows were drawn under the eaves of their houses. Other symbols noted by Perkins were snakes, threatening representations to the children, cave-like structures, rainbows, and fruit trees, possible maternal or nurturing symbols. One leukemic child in Perkins' study said she wanted to draw a happy face, but instead drew a small black ball. She then started to work on a larger face, but the face was still not a happy one. She added black spots over the face and called them chicken pox. The picture was overall "burning" red, purple and black.

Her last picture, painted two weeks before her death, had a blotch of red in the center, with red coming from the lower left quadrant. She also painted a white, almost closed, circle—possibly symbolizing an uncontrolled production of white blood cells. Another leukemic child in Perkins' study painted a picture of a sailboat sailing on a calm and peaceful sea. After a fourth central nervous system relapse when the white cell count had increased, the sailboat was on a "storm tossed sea."

Leukemia

Because of the nature of the disease, medical treatment may be required at any time—occasionally, some treatment may be administered during an art therapy session. Therefore, an integral part of an art therapist's working with a person with leukemia is an understanding of the disease and the treatment protocol.

Leukemia is defined as cancer of the blood, a condition in which there is an uncontrolled proliferation of white cells (leukocytes). In acute leukemia immature white cells are discharged into the blood. In one type of acute leukemia the blood produces oversized white cells that crowd out and destroy essential cells. In chronic lymphocytic, also called lymphoblastic, leukemia there is a tremendous increase in lymphocytes, which are produced in the nodes and responsible for antibody production. Thus, the body's disease fighting mechanism is completely destroyed (Fishbein, 1979).

Anemia, hemorrhage, fever, sweating, enlarged liver and spleen, swollen glands, and aches and pains in the joints are some of the different indications of the disease. Bleeding disturbances correlate to the number of blood clotting platelets. In almost all instances the bleeding correlates with a platelet count of 70,000 cu. mm. or less, and serious life-threatening hemorrhage has occurred in levels below 20,000 cu. mm. (Lascari, 1973). Whereas normal blood contains from 5,000 to 10,000 cu. mm. white cells, the leukemic child may have as many as 500,000 white cells (Fishbein, 1979).

Platelets are defined as tiny or circular discs in the blood, concerned with the physiological process of coagulation and contraction of the clot. Petechiae, small red dots, and bruises are some of the symptons of leukemia, and these develop from a low platelet count. The presence of leukemia may be suspected from any of these symptoms, but the final diagnosis is made from the white cell count and platelet count, blood tests, and bone marrow examinations (Fishbein, 1979).

The goal of chemotherapy is to achieve a decrease or eradication of leukemic cells. A remission occurs when symptoms are gone. Blood and platelet transfusions correct anemia and restore clotting functions. Hydrocortisone is part of long term therapy for combating the overproduction of white cells, and anti-metabolites help to restore normal blood cell manufacture. One development in treatment is the transplanting of healthy bone marrow (Fishbein, 1979). Drugs can be administered as pills, intravenously, or as intra-muscular injections. All of these are capable of producing side effects. Prednisone causes mood changes and weight gain, whereas vincristine causes hair loss and affects the nervous system. Drugs may cause bone marrow depression and gastrointestinal disturbances. Despite serious side effects, drugs can be tolerated for months or indefinitely (Sherman, 1976).

The use of these therapies has resulted in 50% remissions in young children for as long as five years, and in adults for as long as fifteen years. If the child survives for five years, his/her chances for remission and survival increase (Sherman, 1976). The cure for all types of cancer is a goal for which the medical society constantly strives. Hope for a complete eradication of leukemia continues.

Case Study: Associations with the Child

This particular study was specifically designed for a six week period;

"Sabrina was encouraged to draw whatever she wished, and I drew with her to make her feel comfortable."

however, work with the child continued for approximately six months. The first six weeks were documented in more detail and the remaining months in less detail as times together were dependent upon the availability of the child and therapist. During the first six weeks, the child and I met three times a week for approximately one-to-two hours although schedules varied according to her illness. The child was in isolation most of the time (isolation referring to room isolation to keep the child free from cold viruses and other infections the body in its weakened state could not tolerate). The child was quiet although she often spoke to her mother, sometimes in Italian, as the family was of Italian origin. The immediate family consisted of her mother, father, younger brother, and older sister.

Description of the Child

Sabrina was a six year old girl, on the pediatrics unit of a midwestern medical center. Her cheeks were full, her skin pale and her lips delicate. Adding to her soft appearance were big brown eyes, and short wavy hair of light brown. A slight space separated two front teeth that were small and baby-like. Sabrina was always clean, wearing a newly laundered nightgown each day while in the hospital. Her toenails and fingernails were painted, and sometimes she wore a small piece of jewelry. Quiet, reserved, and intelligent, she appeared to accept the inevitable routine of the hospital.

Description of the Mother

Sabrina's mother was young and pretty with dark hair and dark eyes. She stayed in the hospital room around the clock, and was often with Sabrina during our sessions. Much time and attention was devoted to her child, and the mother and child became as one. She was especially friendly toward people who were helping and working with her daughter, and "thank you" was often said. At times, the mother appeared depressed, sometimes she was angry at the medical staff, and at God; however, these times were few and her mood was generally uplifted and she was very considerate and kind to others. The mother and father chose not to tell their child that she might die. Leukemia was discussed with Sabrina, but the possible outcome of the disease was never mentioned to her. The mother noted that everyone had ideas as to why and how Sabrina should be told about the disease but to this she would like to reply "Wait until this situation happens to you—then let's see about your advice." Sabrina did not directly ask her mother and father if she would die although, once, she asked her mother if children die. Her mother answered "yes" and continued to tell her a story about a beautiful heaven where children go after they die. Sabrina did not ask again.

Patient History

Sabrina's condition was first diagnosed as acute lymphoblastic leukemia in 1975. Before diagnosis she had complained of acute pain in one leg and her symptoms were similar to those of influenza. She began chemotherapy treatments after the diagnosis. She was admitted to the hospital in early 1978 because of a low platelet count and overall swelling, and it was during her admittance that I started working with her.

First Session

(I will relay in some detail a general atmosphere of our times together, and provide an overall description of Sabrina and her art work when she was feeling well.) Although the picture described in this session is unavailable (as are the pictures done in the next few weeks), it is important to compare this drawing with the others later seen. For this first session I chose chalk as an expressive medium. Sabrina was encouraged to draw whatever she wished, and I drew with her to make her feel comfortable.

> When I entered the room, I saw a little girl sitting on the edge of the bed, her back toward the door. Her mother was standing near the bed. The room was filled with stuffed animals, pictures and crafts. Her art work suggested the schematic stage (7-9 years) of development and gang age (9-11) of development (Lowenfeld, 1979). Sabrina turned around as I entered the room, and upon a closer look, I noticed a red ring around the iris of her right eye—this was possibly due to a hemorrhage as a result of the disease. Her mother left the room, and we started to work.
>
> On a large sheet of newsprint Sabrina drew a farm. In order, she colored green grass along the bottom

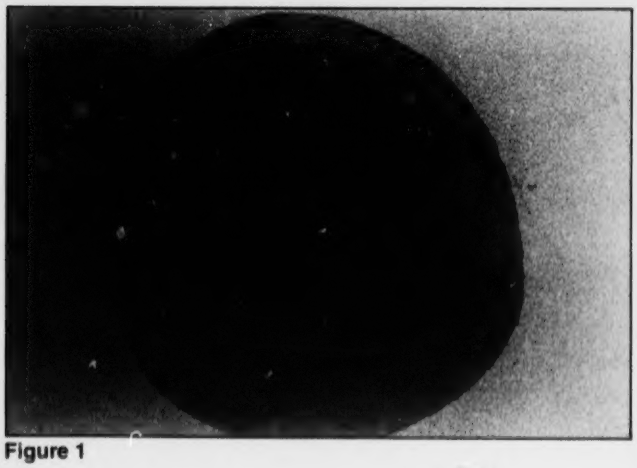


Figure 1

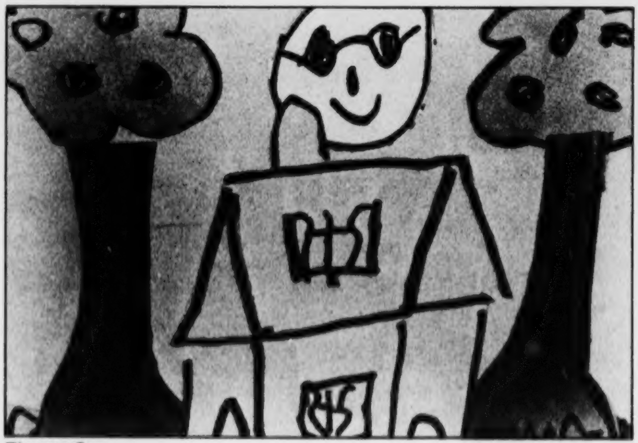


Figure 2

> edge of the paper, a farmer with a hat and pipe, a horse, a dog, a kitten, two chickens, two ducks in a pond of water, two cows, and in the upper right corner, a large yellow sun outlined in red with a happy face outlined in red. Last, she drew a blue sky at the top of the page.
>
> After her picture was completed, it was displayed on the wall. I asked her a few questions about the drawing to which she replied "I don't know." Sabrina had previously been in isolation and was not in isolation on this day. I could see that she wanted to leave the room so I said goodbye and she went down the hall in a very determined fashion.

In this particular session Sabrina was feeling well, and I believe, her picture was indicative of her feelings. The page was filled with many colors, all appropriate to the content. She included animals in the first drawing and animals became a part of many pictures during the progression of the disease. During the first sessions, appropriate colors, animals and typical scenes drawn by children her age appeared. In this first picture, the red ring around the sun could correlate with the red ring around her iris.

Continued Art Work and Analysis

The sun was prevalent in many of Sabrina's pictures, and continued to illustrate the progression of her disease. Many times she would draw a sun to ease her pain. According to the Jungian theory, the sun as a circle represents total life and a source of all energy. Machover (1978), Hammer (1958) and Jolles (1971) represent the sun as an authority figure of high positive or negative regard. The sun, in Sabrina's second drawing, was also outlined in red; however, this time the sun wore glasses outlined in red. When the red ring disappeared from the iris of her right eye, the glasses were more often outlined in black (Figure 1) or filled in with black (Figure 2). I asked Sabrina many questions about the sun's glasses to which she replied "I don't know." When I asked who the sun might be if it were a person, she said "The sun does not want to be a person." Typically, small children draw suns; however, I believed that the sun represented a special kind of warmth light and energy to Sabrina. She did not wear glasses nor did any member of her family. Because Sabrina's eyes were especially sensitive to light—often painful—and occasionally red and bruised, possibly glasses or sun glasses represented an awareness of these symptoms.

"When I asked who the sun might be if it were a person, she said, 'The sun does not want to be a person.' "

Sabrina drew a mural in red and black (Figure 3) during the weekend in mid-March. Four self-portraits (she identified these as being herself) were drawn left to right at the bottom of the page; the last one had her name above it. The portrait next to the last looked very much like her mother. Sabrina drew herself with a downturned mouth, matted hair and glasses. The eyes were mere dots in the last portrait; this was in contrast to the more elaborate eyes previously seen. This picture was the first in red and black and the first with a downturned mouth. A few days later Sabrina was not feeling well, the area around her right eye was bruised, and intermittently she cried out in pain. At this time, she made a turtle out of a paper plate (Figure 4) with a downturned mouth and thick red glasses—this, again, suggesting her discomfort and pain.

On a weekend late in March, Sabrina made three people (father, mother and herself) out of yarn and placed them in a basket (Figure 5). The child again displayed dots for the eyes, matted hair and glasses. Red dots were on the child's cheeks, and would be seen in later pictures. These dots could correlate with petechiae, tiny pin point sized hemorrhages underneath the skin. (Perkins, 1977, described a child who drew black dots on a face and called them chicken pox). In late March the doctor tested Sabrina's vision, and although no conclusive results warranted serious visual problems, he indicated that her eyes would continue to be sensitive as a result of the disease. Sabrina rarely drew glasses after this time, and her room was often kept dark.

Black swing sets and playground sets were drawn in many pictures at this time (Figures 6 and 7), possibly indicating a wish to play and a focus on the disease which thwarted her play. Also seen in pictures were paths leading to the upper left quadrant of the page (Figures 6 and 7). In Figure

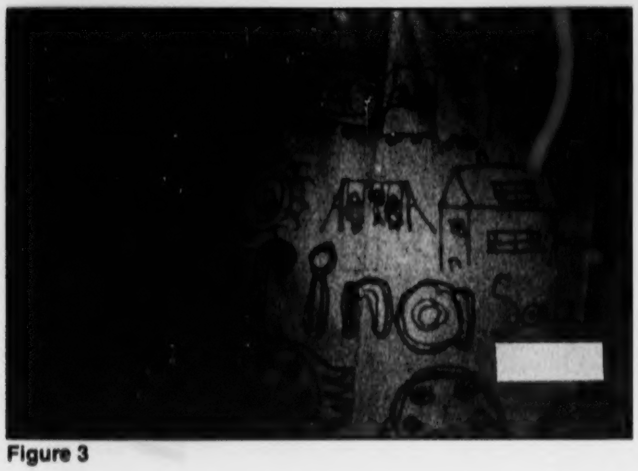


Figure 3

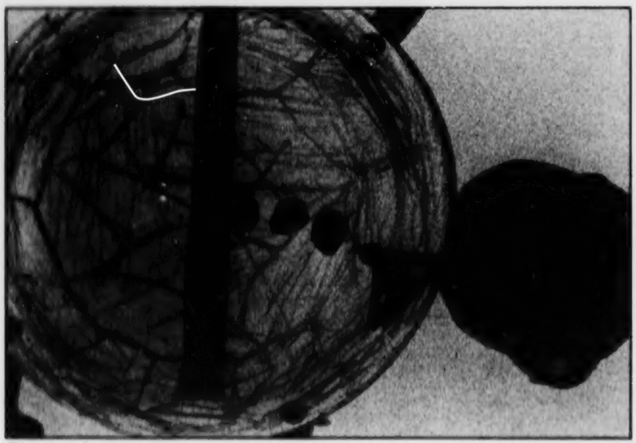


Figure 4

7, a path leading to a house (possible self-symbol) could suggest a bleeding through the mouth or nose area, as the child was susceptible to nose bleeds and vomiting of blood. (A path leading to the upper left quadrant might mean a going out of life). In her pictures Sabrina drew many fruit trees, commonly drawn by children, and specifically drawn by leukemic children (as noted in Perkins' group, 1977). When she was not feeling well, Sabrina focused on drawing clouds in her pictures.

Leukemia has it ups-and-downs as the disease takes its course. Therefore, Sabrina's art work did not consistently take a downward trend. Happy pictures were drawn when she was feeling well and many of these pictures were drawn at home while on interim home visits (Figures 8, 9 and 10). In these drawings smiles were big, cheeks were large and red—although the red might correlate with blood, as noted earlier. In Figure 9, a happy child is depicted, with dots on the face as a possible remainder of the disease. Sabrina was discharged from the hospital in mid-April, as she seemed to be feeling better. At this time, she made a happy girl (Figure 10).

One week after leaving the hospital she was re-admitted. Her platelet count was low, and an infection had developed in the spinal area. The day following this admittance, Sabrina's condition was crucial and life-threatening. Sabrina did not die at this time; however, her condition was considerably weakened. During the following week, Sabrina worked in art. Her pictures contained excessive quantities of red and black—particularly black—colors that Perkins (1977) had observed as appearing often. Other colors had been available to Sabrina at the time.

One picture in red and black (Figure 11) illustrated a row of houses, a walkway and two cars facing toward the upper left quadrant. Again, a path slanted toward the upper left section of the page. Black windows and doors could suggest a black within, a probable projection of the child. Another picture in red and black (Figure 12) illustrated a boat on

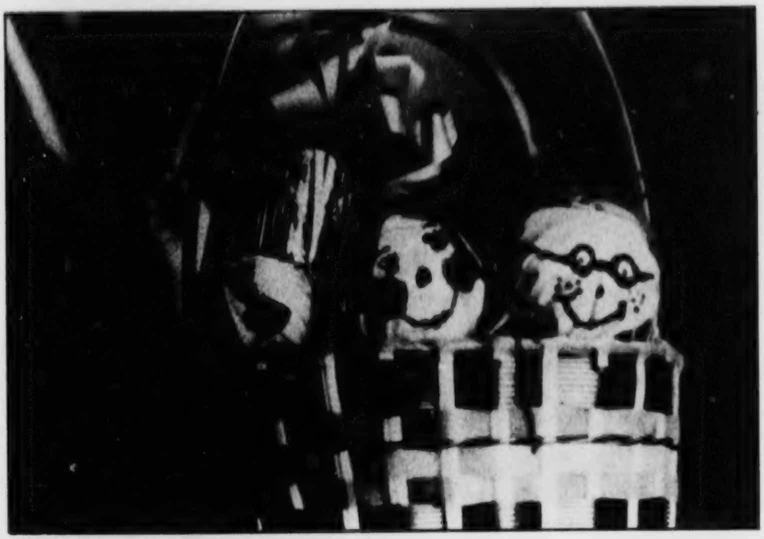


Figure 5

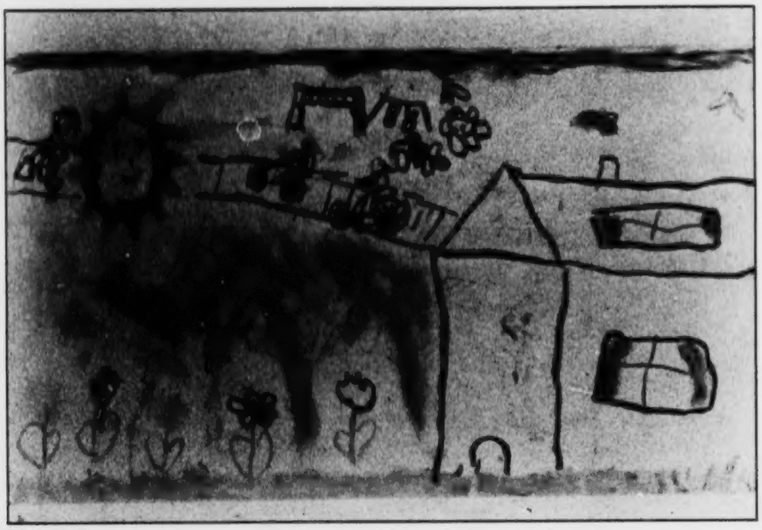


Figure 6

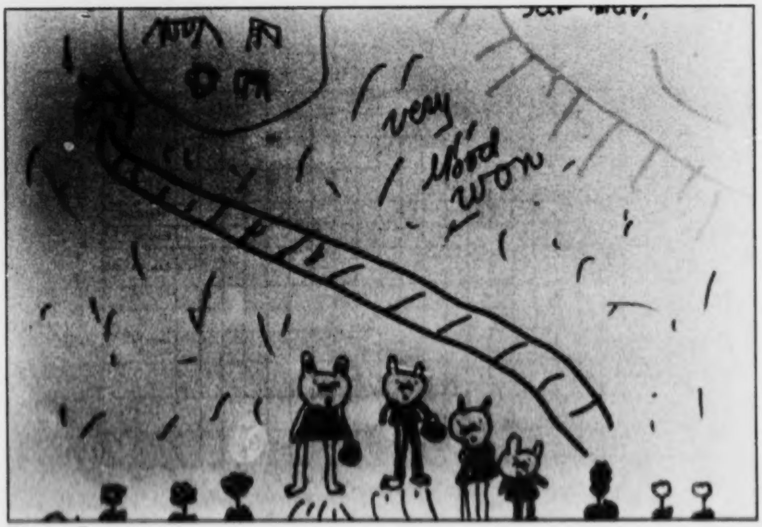


Figure 7

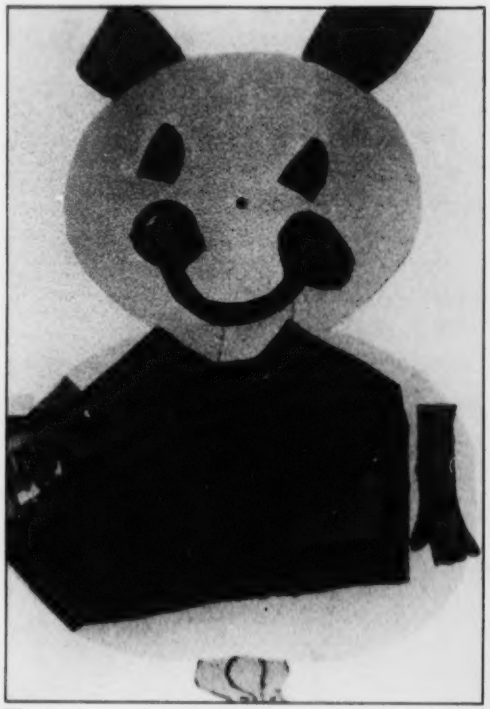


Figure 8

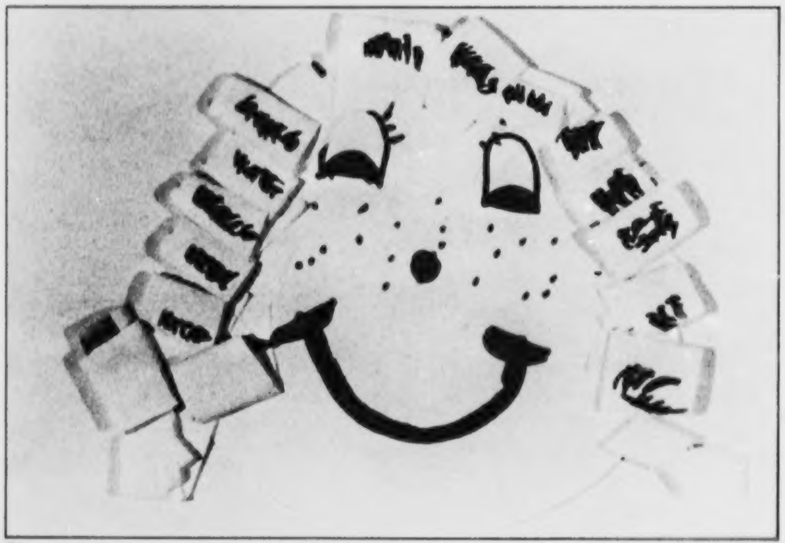


Figure 9

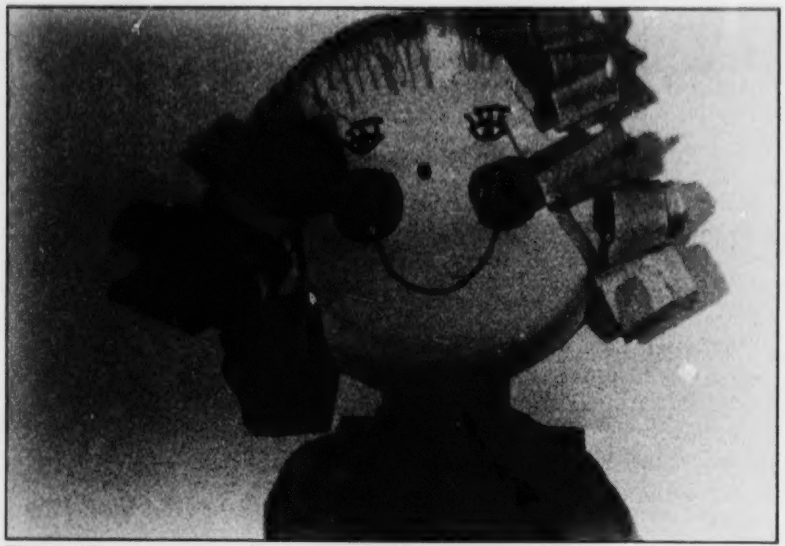


Figure 10

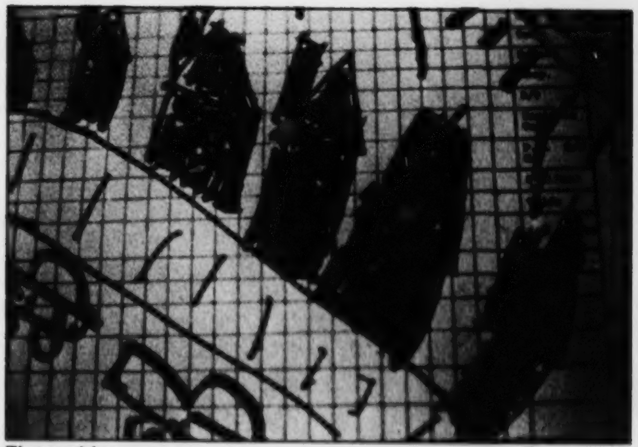


Figure 11

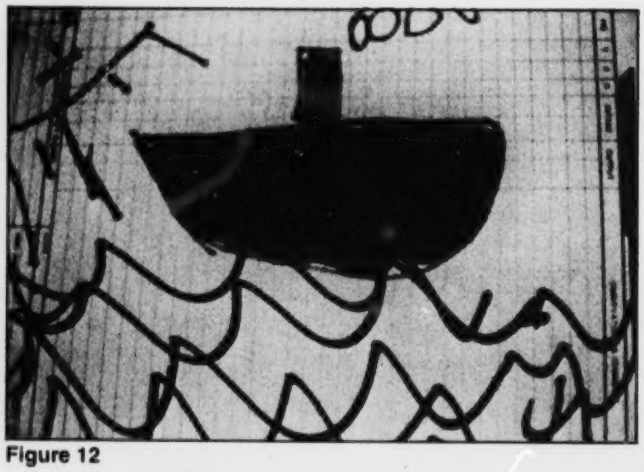


Figure 12

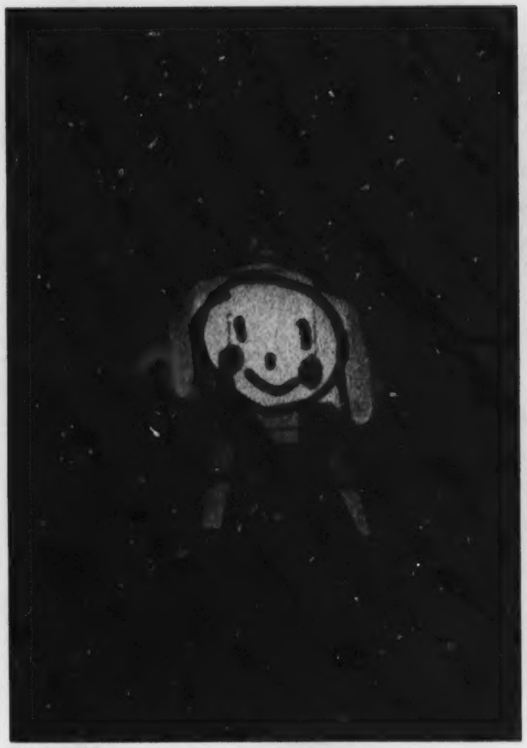


Figure 13

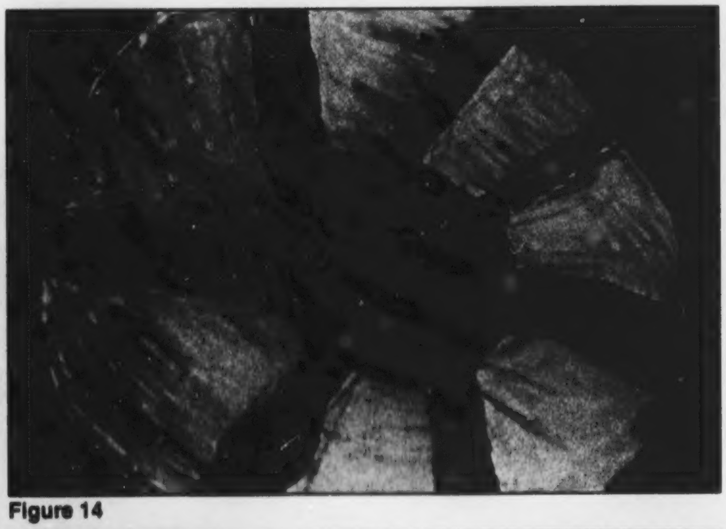


Figure 14

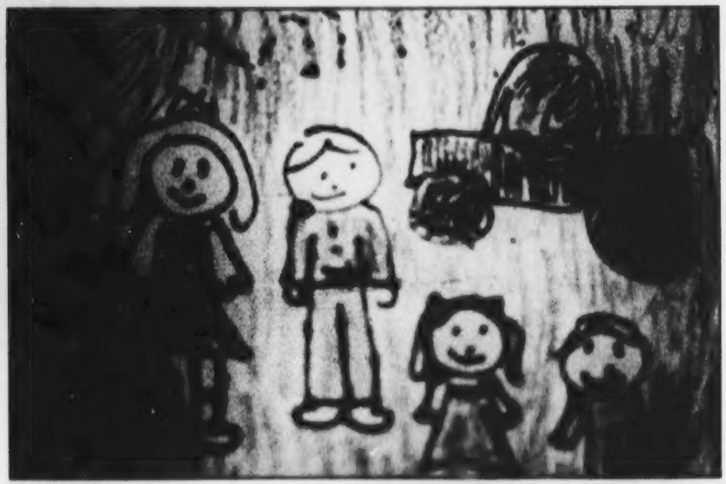


Figure 15

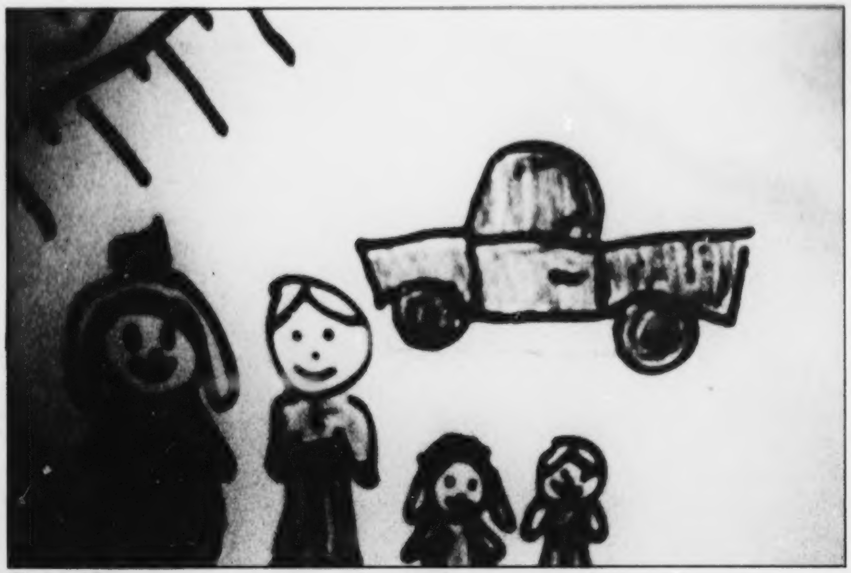


Figure 16

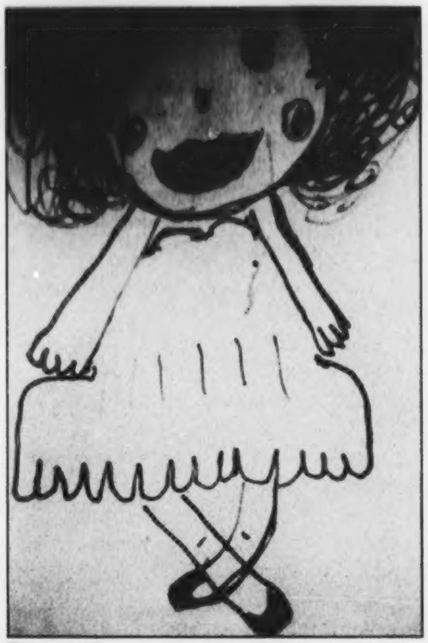


Figure 17

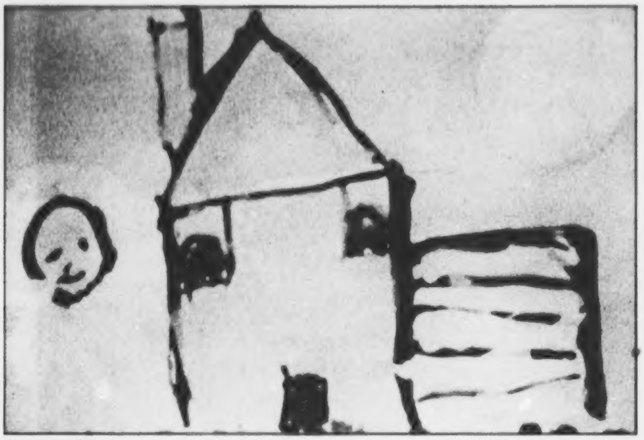


Figure 18

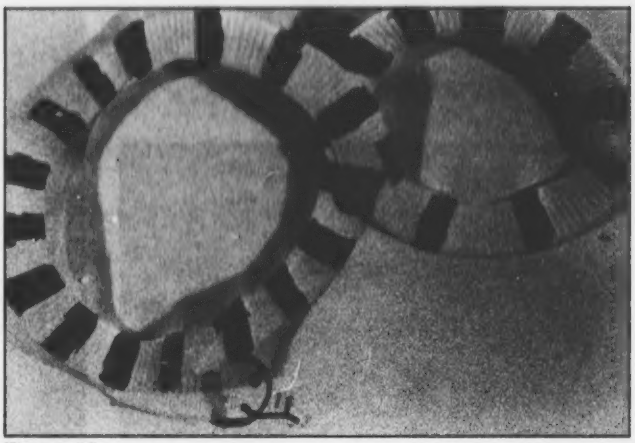


Figure 19

"storm tossed" water, a striking correlation to a picture drawn by a leukemic child in Perkins' study group. The sun appeared to be drawn quickly with dots for the eyes and a slash for the mouth. Suns at this time appeared more often in the upper left corner of the page. Black completely surrounded a little girl (Figure 13). Many pictures followed this pattern at the time. Mandalas were drawn in red and black (Figure 14), and in one picture black covered the entire page. In Figures 15 and 16, Sabrina drew what appeared to be a family: man, woman, boy and girl. One picture was outlined in red and the other in black. This particular picture could represent Sabrina's family, Sabrina not visible.

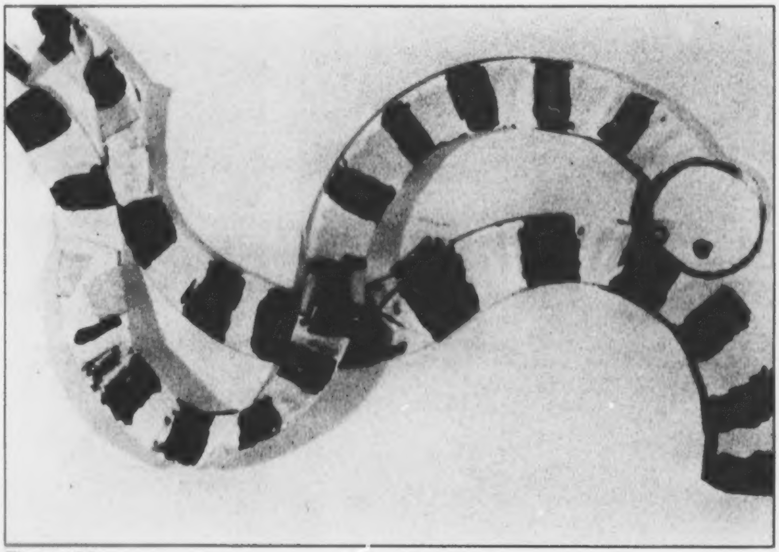


Figure 20

One week following her critical period she began to feel better. She drew a girl (Figure 17) with legs that appeared limp, possibly suggesting her inability to walk at the time. She drew a house (Figure 18) and a person to the left of the house. The body was completed blurred in white "as if the white cells had taken charge" (Perkins, 1977). The front of the house was face-like with blue in the windows for eyes and red in the doorway for the mouth. Sabrina was again discharged in early May as she was feeling better. I met with her once at her home. She made snakes (Figures 19 and 20), representations described as threatening by leukemic children in Perkins' group. Sabrina's art work at this time was more often only outlined, and appeared to be done more quickly. Single items on the page replaced more complicated and filled-in pictures. Sad faces, glasses, dots on the faces, roof top windows in black...all continued to be apparent in her work (Figures 21, 22, 23 and 24).

Sabrina was re-admitted to the hospital in mid-May (her home stays were usually about one week in duration). As a last resort, Sabrina was put on experimental medication—this medication followed a pattern of remission and relapses after three months. After receiving this medication, Sabrina appeared more stable although nose bleeds and infections continued. At this time, hand control became more difficult as the disease took its course (Figure 25). Sabrina was in remission until August. Although I did not work with her at this time, I saw pictures completed by her during the remission period. She drew butterflies (Figures 26, 27 and 28)—possibly symbolizing a kind of rebirth. Black centers of the butterflies might be a reminder/symbol of the disease (as a correlation, I have recently worked with a cancer patient in remission who drew butterflies with black centers). While she was in remission Sabrina drew a night scene (Figure 29).

Sabrina was re-admitted in mid-August, and I brought to her room canvas paper and acrylic paints. Because her hands were so weakened from the deterioration of the disease and the continuous intravenous injections in her hands, Sabrina could

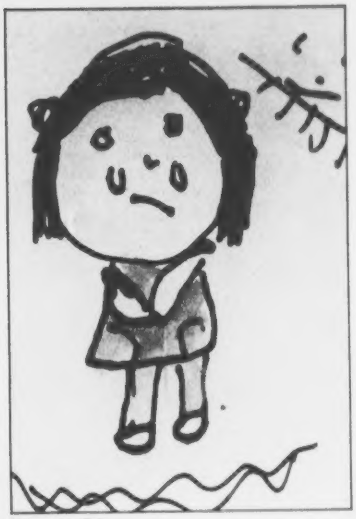


Figure 21

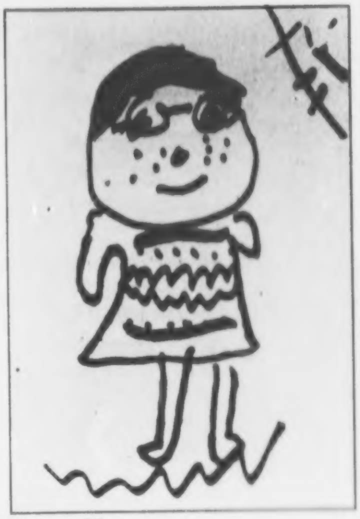


Figure 22

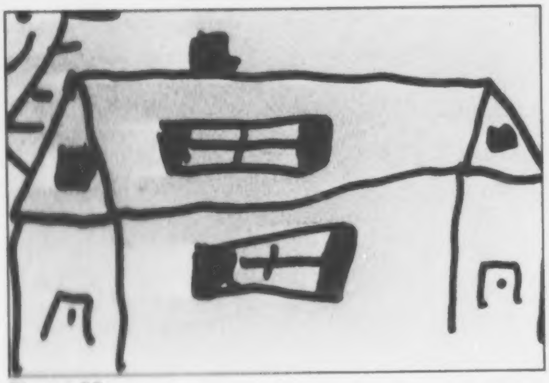


Figure 23

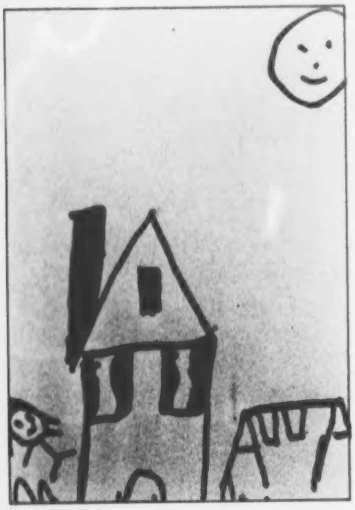


Figure 24

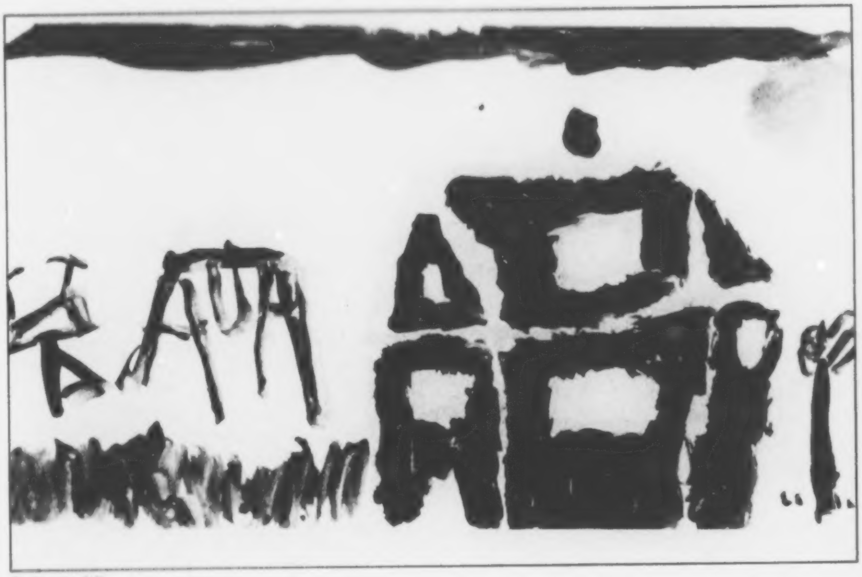


Figure 25

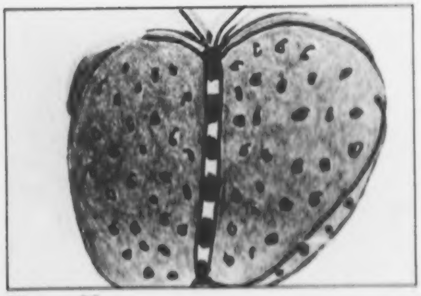


Figure 26

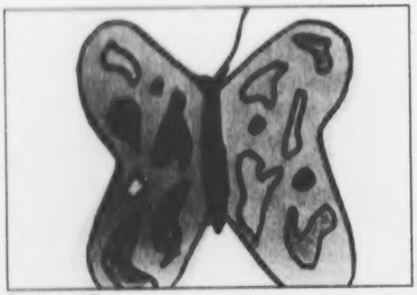


Figure 27

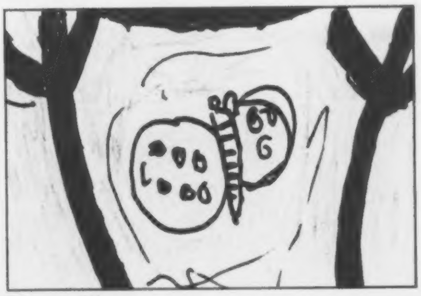


Figure 28

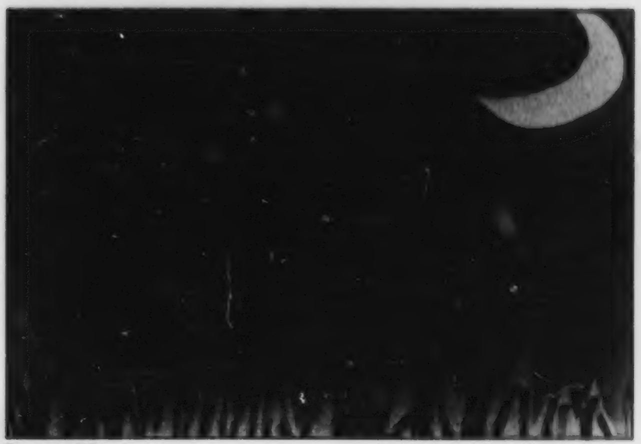


Figure 29

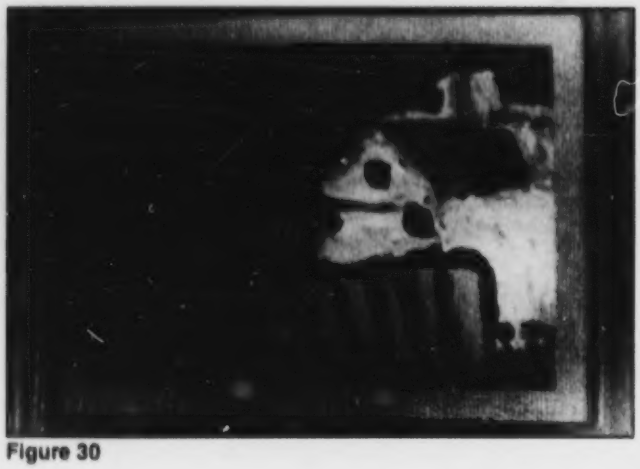


Figure 30

not use a brush. Instead, she applied paint to the paper with a small plastic knife placed in the palm of her hand; her fingers were unable to wrap around the handle. She painted a picture (Figure 30) that would be special, a picture that would be well-remembered by those who knew her. On the right side of the page, she painted a large three quarters view of a house with a large black opening in the attic area. A fence separated the house and tree filled with red fruit. Three flowers grew along one side of the house. The sky was filled with blue, turquoise and white paint. Black stars were scattered across the sky, and a half moon shone in the upper left quadrant of the page.

Sabrina drew another night scene. The house, a possible self-symbol, was cut off on the right side of the page (the future side, according to Machover and Hammer). A large black opening was under the eaves of the house, a remarkable correlation to a "soul" window drawn by leukemic children in Perkins' group. A fence separated the house (self-symbol) and fruit tree (maternal, nurturing symbol). This was Sabrina's last picture. She died in August.

Personal Experience

Sabrina, her mother and I spent many hours together and we became friends, relying on each other for support. Thus the therapist is part of this picture—my past experiences and emotions play a part in the ongoing experience. I recall one earlier experience with Sabrina which might illustrate the emotional impact of working with a dying child.

When I opened Sabrina's door that morning with art supplies under one arm, I noticed her mother crying. I saw Sabrina with the back of her head, hair wet, against the pillow, and her face gray. Her breathing was short and raspy. Sabrina's mother mentioned for me to come inside the room, and I laid the materials on the floor outside the door, donned a gown and mask, and entered the room. I sat on a chair on the opposite side of the bed. I felt my heart pounding. I felt that Sabrina would die soon. My thoughts flashed back to my own father lying in a hospital bed, looking pale, and breathing in much the same manner as Sabrina. The doctors said that my father had two hours to live. I thought that Sabrina had no longer to live than he.

Her mother and I said little. If we talked, we talked about her anger toward God, and her questions as to why this was happening to her child. Although I could not answer "why," I was there to listen, and to support. Intermittently, Sabrina would open her eyes, roll them to one side, and look at me, then slowly close them again. I wondered what she was thinking about when she looked at me. I stayed all morning, not wanting to leave. At noon, I left and until late afternoon I worked with my scheduled patients. I thought about Sabrina the entire time. I returned to Sabrina's room at 4:00. Her skin appeared extremely gray, and she was vomiting blood. I stayed with her mother until 6:00. I thought that Sabrina would die during the night. I heard doctors ordering blood and platelet transfusions "stat" (immediately) as I was leaving the room. On the way home I cried. The emotional experience for me was a staggering one.

Conclusion

Throughout many of Sabrina's experiences, when we worked together and when she worked alone, some definite patterns emerged in the progression of her art work. These patterns became more apparent when she was not feeling well as she possibly tried to communicate her pain and discomfort (examples: in clouds, tightened figures and downturned mouths). In comparing her work with other leukemic children, some death awareness could be assumed. These correlations could be observed in the use of color and page placement. Some of her pictures seemingly did not relate to her illness and were "typical" pictures of a happy child drawn especially when she was feeling well.

Her experiences in doing the work provided her with an interest, a mutual continuing relationship with me, and an incentive to reveal her feelings. Her art experiences were perceived to be valuable in alleviating the trauma of her disease and in the meaningfulness of expressing feelings through art. Although Sabrina was often verbally unresponsive, especially toward the end of our sessions, we did communicate through her art experience.

I observed correlations between Sabrina's drawings and those described by Perkins (1977). Red and black were evident in many pictures, especially after her life-threatening experience. Paths leading toward the upper left quadrant could mean a

"When she was not feeling well, Sabrina focused on drawing clouds in her pictures."

"going out of life," and suns more often moving toward the upper left corner could suggest similar meanings. Other correlations were fruit trees as nurturing symbols, and dots on the faces as representatives of petechiae, commonly seen in the disease.

After her life-threatening experience, specific implications of Sabrina's pictures correlated with those of Perkins' study. Excessive quantities of red and black, boats on "storm tossed seas," black windows under the eaves of houses, bodies blurred in white as if the "white cells had taken charge," and snakes as threatening representations…all were seen in Sabrina's pictures and those described by Perkins.

Happy pictures were drawn when Sabrina was feeling well; clouds were prevalent when she was not. The glasses appearing on the suns, animals and little girls (self-portraits) were rarely seen after the doctor tested Sarbina's eyes and clarified the sensitivity of her eyes. The elaborate faces on the suns turned to mere dots for the eyes and a slash for the mouth. Black playground sets possibly expressed her wish to play as well as an expression of the disease which was a denial of this wish. Butterflies possibly symbolized a rebirth while Sabrina was on experimental medication and in remission.

Sabrina was left-handed, although during the progression of the disease she became proficient in the use of both hands. Toward the end of our sessions, her hand/motor functioning decreased as a result of the disease and excessive intravenous injections. She could not control a brush in her last picture and she used a white plastic knife to apply the paint. Her eagerness to "do art" was apparent as she released her feelings and communicated her thoughts onto the paper. Sabrina was special, she had much to say, and she said it through her art. The value for me was through the learning experiences, both in the field of art therapy and in my interpersonal relationship with her. The intrinsic value of my own experiences with Sabrina will always be remembered.

References

Burns, Robert C. and Kaufman, Harvard S. (1973). *Kinetic family drawings.* New York: Brunner/Mazel Publishers.

Di Leo, Joseph H. (1973). *Children's drawings as diagnostic aids.* New York: Brunner/Mazel Publishers.

Di Leo, Joseph H. (1970). *Young children and their drawings.* New York: Brunner/Mazel Publishers.

Easson, William. (1970). *The dying child.* Springfield, IL: Charles C. Thomas, Publisher.

Fishbein, Morris, M.S., Dr. (1979). *Fishbein's popular illustrated medical encyclopedia.* Garden City, New York: Doubleday and Company, Inc.

Golomb, C. (1974). *Young children's sculpture and drawing.* Cambridge, Mass: Harvard University Press.

Hammer, E. (ed). (1958). *Clinical application of projective drawings.* Springfield, IL: Charles C. Thomas, Publisher.

Harris, Dale B. (1963). *Children's drawings as measures of intellectual maturity.* New York: Harcourt, Brace and World, Inc.

Jolles, Isaac. (1971). *A catalog for the qualitative interpretation of the house-tree-person (H-T-P).* Los Angeles, CA: Western Psychological Services.

Jung, Carl G. (1974). *Man and his symbols.* New York: Dell Publishing Company, Inc.

Kellogg, Rhoda. (1969; 1970). *Analyzing children's art.* Palo Alto, CA: Mayfield Publishing Company.

Kramer, Edith. (1971). *Art as therapy with children.* New York: Schocken Books.

Kübler-Ross, Elisabeth. (1975). *Death, the final stage of growth.* Englewood Cliffs, NJ: Prentice Hall, Inc.

Kübler-Ross, Elisabeth. (1969). *On death and dying.* New York: Macmillan Publishing Company, Inc.

Kübler-Ross, Elisabeth. (1974). *Questions and answers on death and dying.* New York: Collier Books.

Kübler-Ross, Elisabeth. (1973). "Facing up to death." Annual editions: Readings in human development '73-'74. Sluice Dock, Guilford, CT: The Duskin Publishing Group, Inc.

Lascari, Andre D. (1973). *Leukemia in childhood.* Springfield, IL: Charles C. Thomas, Publisher.

Lowenfeld, Viktor and Brittain, W.L. (1979). *Creative and mental growth.* New York: Macmillian Publishing Company, Inc.

Machover, Karen. (1978). *Personality projection in the drawing of the human figure: A method of personality investigation.* Springfield, IL: Charles C. Thomas, Publisher.

Naumburg, Margaret. (1966). *Dynamically oriented art therapy.* New York: Grune and Stratton.

Perkins, Carol Francisco. (1977). "The art of life-threatened children: A preliminary study." *Creativity and the art therapist's identity, proceedings of the American Art Therapy Association,* pp 9-12. The American Art Therapy Association, Publisher.

Pritchard, Elizabeth R. and others (eds.). (1977). *Social work with the dying patient and the family.* New York: Columbia University Press.

Sherman, Mikie. (1976). "The leukemic child." Drew Publication C. (NIH), *3,* pp 76-86.

"Her experiences in doing the work provided her with an interest, a mutual continuing relationship with me, and an incentive to reveal her feelings."

The Potential of Rehabilitative Computer Art Therapy for the Quadriplegic, Cerebral Vascular Accident and Brain Trauma Patient

Diane J. Weinberg, MA

Diane J. Weinberg, MA is Art Therapist at Chicago City-Wide Colleges, and a Board Member of the Illinois Art Therapy Association and the Westwood Center for the Arts of California. Ms. Weinberg is also an artist. Parts of this paper were presented at the 1983 meeting of the American Art Therapy Association.

Certain frustrations physically and mentally disabled patients and the art therapist encounter during art therapy sessions, prompted an investigation of computer art therapy as a potential support to conventional rehabilitative art therapy.

Artistry, which is an inherent quality in computer art, increases the possibility for successful art experiences. Patients' autonomy and control are challenged when their minds, in substitution for their hands, make the decisions that direct the metamorphosis of a computer design.

Both rehabilitative computer art therapy and conventional art therapy, in attempting to foster the ability to adapt and cope, provide the suddenly disabled patient with a non-threatening method to express anger and frustration. Both therapies test patients' cognitive abilities, reflect their affect and encourage their psychosocial skills. For patients who need specialized adaptations, rehabilitative computer art therapy offers an unusually novel and rapid approach to successful art experiences, and it has the unique power and advantage to elicit disabled patients' curiosity and motivation to build upon their residual strengths.

The credibility of rehabilitative computer art therapy rests in its potential to offer the disabled accessibility and advantages beyond what has previously been confirmed by conventional rehabilitative art therapy.

Following an introduction to the potential of rehabilitative computer art therapy, conventional art therapy is discussed with specific reference to quadriplegic and stroke patients (patients who experienced cerebral vascular accidents), and brain trauma patients. Examples of computer art are shared followed by a summary.

Introduction

There is a pervasive demand for rehabilitation and the necessity to understand and to utilize the scientific implements of any and every discipline to achieve its objectives. This article explores the premise that the computer provides a powerful instrument for rehabilitative art therapy for physically and mentally disabled patients.

The primary goal of rehabilitation is to return the diseased and injured, as much as possible, to their former healthy state of activity. Patients suffering a sudden physical disability also experience a psychological loss with regard to their personal wholeness and identity. Depression and difficulties, associated with the basic pathologic process, are apt to increase impairment unless an attempt is made to improve the disabled patient's independent functioning.

It is crucial for the art therapist to attempt to understand the thoughts of those who are suddenly disabled to discern their varying degrees of risk for physical and psychological deterioration. Many severely handicapped individuals are sensory deprived and lack exploration experiences due to low levels of expectation and self-confidence. Expectations that others will reject them are unfortunately too often realized. Problems such as incontinence promote fear of embarrassment and often prevent patients from attending therapy and other [activity or therapy] functions. As a result, the physically impaired individual may experience the paradox of greatly needing acceptance while withdrawing from most social situations to avoid rejection. It would appear that the ability to psychologically adapt is a critical element in influencing successful rehabilitation. Prolonged depression, low self-esteem and fear of rejection must be dealt with promptly.

Conventional rehabilitative art therapy was conducted with three populations: quadriplegia, cerebral vascular accident (cva or stroke) and brain trauma. Recurring problems of resistance, lack of self-control, short attention span, distortion of reality, emotional liability, depression, distractibility, irregular attendance and my difficulties in making the art experience possible prompted an investigation of rehabilitative computer art therapy as a potential support to conventional rehabilitative art therapy.

Conventional Rehabilitative Art Therapy

In a rehabilitative setting, often only the patient's mental functioning is intact. The desire to make the art experience possible for the disabled

"The primary goal of rehabilitation is to return the diseased and injured, as much as possible, to their former healthy state of activity."

may stretch an art therapist's creativity, imagination and patience further than for any other population. The rehabilitative art therapist has the responsibility to monitor progress in range of motion and cognition. Therefore, the therapist must be aware of the physical as well as the mental state of the patient. Some knowledge of adaptive devices and their application is mandatory. The art therapist, by improvising with the adaptive devices and art materials, discovers how these devices and materials can best serve to support and compensate for a disability. Such innovations help to promote a positive environment that will stimulate and challenge a patient's self-expression, creative growth, and exploration.

Unconscious information revealed by the art work of quadriplegic and stroke patients, in particular, often shows recurring concerns regarding body image; disabled body parts are often exaggerated or omitted. Such drawing phenomena appear to be manifestations of natural anxiety rather than illness, because most patients were productive and well-adjusted individuals prior to their physical impairment. In my experience, deep psychological illness in the suddenly physically disabled patients was so rare that dependence upon psychotherapy or patients' explanations of the intention of their art work did not appear to offer maximum benefit. Psychoeducational art therapy or art as therapy were more appropriate because they focus upon patients' current problems of coping, adapting and building self-esteem through accomplishment.

The Quadriplegic, Cerebral Vascular Accident and Brain Trauma Patient

Quadriplegia is caused by an injury or disease to a particular area of the spinal cord; the location of the spinal cord damage determines the degree of consequential paralysis. Paraplegia involves a paralysis that affects the body only from below the waist. Quadriplegia, however, manifests in a paralysis that begins at the shoulder line and affects the whole body.

Minimal gross and fine motor activity necessitates the use of adaptive devices. The flexi-splint, pneumatic puff-sip control, mouth-stick, braces and other orthopedic appliances provide some support to the muscles of disabled limbs. The adaptive device, by ensuring some measure of activity, prevents disfigurement and psychological alienation of the impaired limb from the patient's body image. Practice with adaptive devices may promote gradual improvement in hand/motor functioning.

Automobile, motorcycle and swimming accidents account for the large number of quadriplegic patients who are young males barely into their teens. A preoccupation with their healthy past often produces a type of depression that has intense anger at its core. Considering the circumstances of a suddenly disabled person, depression is experienced so often that its absence might suggest a denial of reality.

It is important for the art therapist, in attempting to determine quadriplegics' reactions to their disability, to ask the following questions: (1) How are patients perceiving their body image? (2) How are they adapting to and coping with their situation? (3) Do they have a locus of control? (4) Are they grieving? (5) Do they need to be coaxed to resocialize?

Patients who were accomplished artists prior to their quadriplegia are most difficult to engage in art therapy. The scratch marks they produce are unacceptable to them. The inability to maintain their artistic standard creates anger and frustration which often manifests in some antisocial behavior and, perhaps, withdrawal. They often refuse to return to art therapy sessions despite their realization that practice with adaptive devices could gradually improve their hand/motor functioning enough to possibly regain the ability to produce satisfying art work.

A male quadriplegic's manhood may be extremely vulnerable, and he may refuse to use adaptive devices because he believes that art activities are unmasculine, or even an assault to his masculinity. It is not uncommon for male patients to use manipulative behavior or outright refusal to avoid art therapy sessions. Male paraplegics will attend art therapy sessions more readily, but they often request photographs of powerful or ferocious animals to copy. Their art work often depicts monsters and sharp teeth which appear to be symbols of anger.

Cerebral vascular accident (cva or stroke), is an injury to the brain and may be caused by a blood clot, a rupture to a blood vessel, a tumor, an infection or a trauma to the head. Patients often experience varying degrees of weakness or paralysis (hemiplegia), which usually affects the one side of the body that is opposite to the affected side of the brain. A left hemiplegic suffers stroke damage on the right side of the brain but the paralysis manifests on the left side of the body. The reverse is true for the right hemiplegic.

Aphasia usually appears in right hemiplegics and refers to varying degrees of loss of speech, language comprehension, reading and calculating abilities. Frequently the mental functioning of aphasic patients is intact; however, I worked with Betty, aged 75, whose aphasia was quite severe. She was given the task of drawing a picture of a tree and she responded by producing symbols, numbers and random writing that

"It is crucial for the art therapist to attempt to understand the thoughts of those who are suddenly disabled to discern their varying degrees of risk for physical and psychological deterioration."

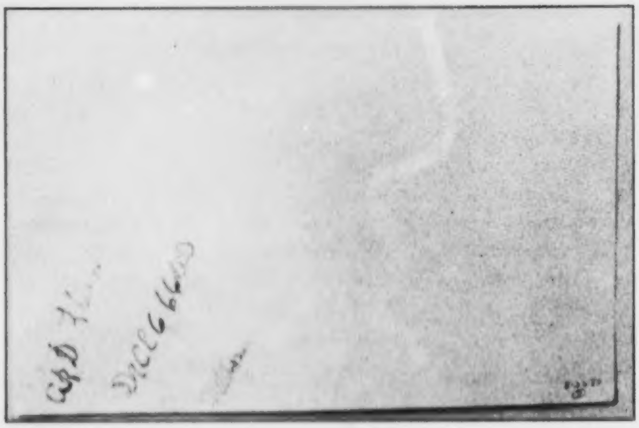


Figure 1

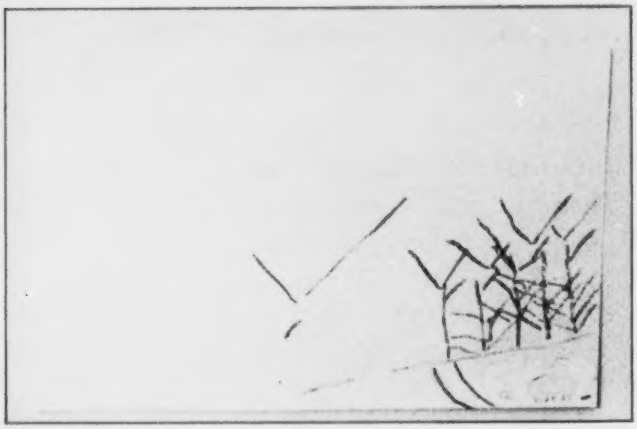


Figure 2

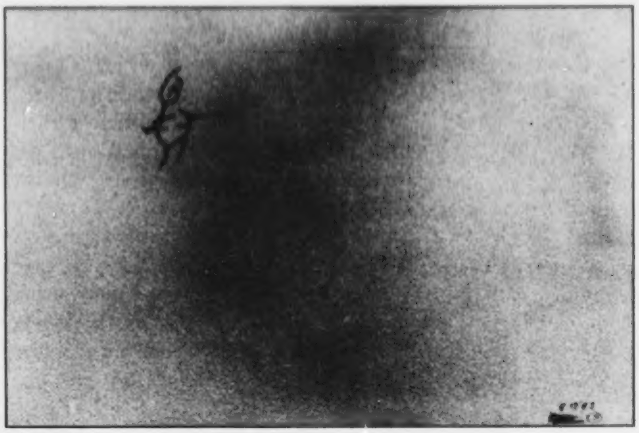


Figure 3

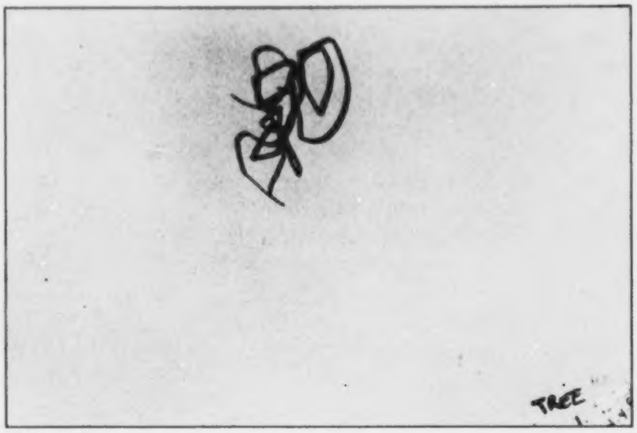


Figure 4

she was unable to decipher (Figure 1).

Often stroke patients are conscious of their environment and sadly frustrated by their deficits, which include confusion due to memory and perceptual problems. Although psychological distress is expressed in anger, shock, anxiety, depression and in denial of the permanence of the stroke condition, feelings and the overt expression of emotion are not always connected. Stroke patients' emotional lability often has little relationship to what they are experiencing in their environment. Unlike true emotional response, emotional lability can be easily interrupted by diverting the patient's attention.

Stroke patients can frequently be motivated to work from their imaginations if given concrete instructions. The art therapist watches the stroke patient for improvement in cognition, range of motion and hand/eye coordination. Due to residual eye problems, one-side neglect of the drawing paper is a common occurrence. Although patients think that they are drawing on the whole sheet of paper, only one side—depending upon whether they are right or left hemiplegics—will be used. William, aged 72, was continually reminded of the neglected side and prompted to keep his unimpaired side toward the action (Figure 2). In some cases patients can be taught to compensate by turning their heads to the neglected side. Over a period of time, as the conditions of stroke patients improve, their drawings gradually begin to move across the paper to the neglected area and eventually may fill the entire sheet of paper. A collection of consecutive drawings provides the art therapist with a remarkable documentation of the stroke recovery process.

It is important for the art therapist to attempt to make use of patients' paralyzed upper extremities. A paralyzed arm can be situated to hold the drawing paper in place; however, as part of the medical treatment the disabled arm is sometimes elevated and placed in a splint. In the latter case, the paper is taped down to the table surface and the patient has to adjust to the awkwardness of using the non-dominant hand.

Depending upon the severity of the impairment, brain trauma (caused by an outside injury to the head) produces difficulties that are very similar to those of stroke patients. Deficits and frustrations that both populations share are often revealed in their art work: drawings are placed high on the paper, essential parts and color mass are omitted, the line is disconnected, one side of the paper is often neglected, perseveration is experienced. David's drawing (Figure 3) illustrates several of these examples that are indicative of per-

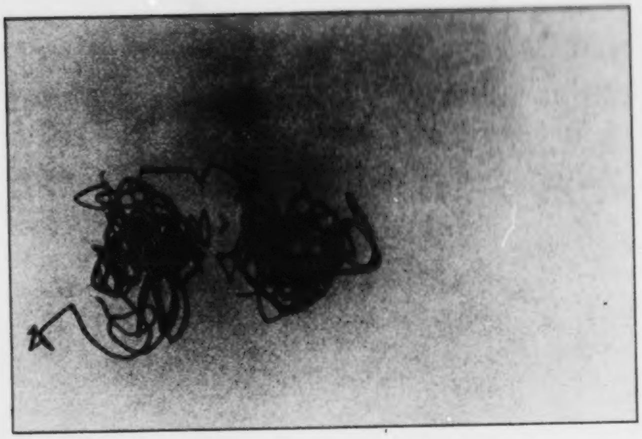


Figure 5

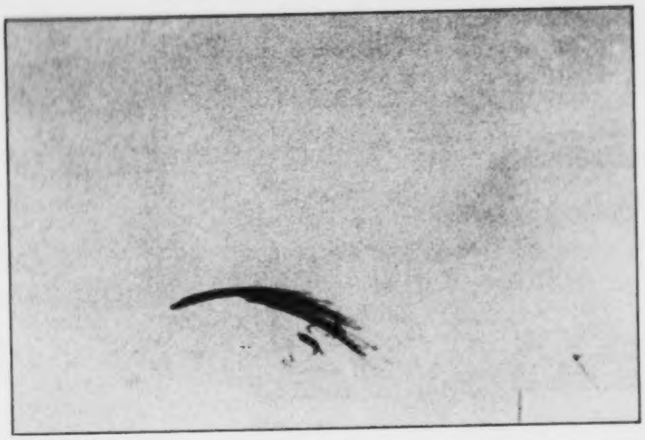


Figure 6

ceptual deficits, misperceptions of spatial relationships or spatial neglect, body image disorders, disorganization of thought, or visual-motor disorders.

Due to their memory deficits, brain trauma patients are often indifferent to their surroundings and are therefore unmotivated. It is necessary for the art therapist to continually structure and direct them throughout the art therapy session. A brain trauma patient's attention span can be as short as only a few seconds. Often they exhibit poor judgment and are capable of behaving and talking impulsively. The art therapist should be prepared to deal with this impulsivity, sexual comments, gestures and overtures.

Brain trauma patients' levels of regression are evident in their art work. Depending upon the severity of the trauma, the patient's developmental level may be reduced to the scribble representation. A felt tip pen scribble, by 35 year old Tim, is placed high on the paper (Figure 4). Progress is noted (Figure 5) with the scribble moving closer to the center of the paper, increasing in size and having more than one color. Tim titled his drawing "Toys with Wheels" which indicated that he was finally making mental [image] connections to his art work. The art work of brain trauma patients will gradually progress to each developmental stage and become more age appropriate as the patient begins to recover.

Occasionally brain trauma and stroke patients will perseverate during the art process as shown in a drawing by Dan, aged 24 (Figure 6). A gentle attempt should be made to interrupt the perseveration and alert the patient to his/her repetitious movements. Claude, aged 26, traced a large stencil (Figure 7) which appeared to bring some control to his perseveration and was due, perhaps, to the stencil serving as a concrete guide.

Rehabilitative Computer Art Therapy for the Quadriplegic, Cerebral Vascular Accident and Brain Trauma Patient

One of the greatest powers of the computer is its ability to easily change a simple design into one of striking complexity. A different orientation or visual effect may become instantly visible to the artist by rotating the angle of the design. The artist theoretically has the opportunity to infinitely vary and alter the size and position of programmed images, lines and colors. Therefore, the computer art process has the potential to provide an education in symmetry, aesthetics and creativity.

Previous computer experience is no longer necessary because today's computer programs provide simple step-by-step instructions. I experimented with the Atari 800™ graphic art program titled Video Easel, and produced free line, abstract and representational drawings (for an example, see Figure 8). Drawings were made by manipulating the keyboard and joystick, a handle that can be moved in any position to give the computer directional information. Symmetrical designs were made by slowing down the speed of the computer and activating four lines to converge simultaneously (Figure 9). The painting segment of the program consists of six preprogrammed designs in transition that continually change in shape while moving across the computer's TV monitor. Termination of this metamorphic activity provides a finished design. This design was used as an overlay for my computer line drawings, and a wide selection of background colors allowed me to easily change the "mood" of the art work.

The light pen is a photosensitive pen-like device. It is used to trace objects or images that are placed on the graphics tablet. The graphics tablet is a prescribed surface on which each point, located under the tip of the light pen, may be accurately sensed by the computer. As I used the light pen to trace the shape of a frog, the frog's image began to appear on the TV monitor. The plotter, an instrument that prints felt tip pen drawings of what is featured on the TV monitor, produced a printout of the frog that I had traced (Figure 10). The computer was then programmed to sense all the movements and pauses I experienced while tracing the frog. The plotter duplicated my movements and pauses while it simultaneously repeated the image, diminished its size and rotated its angle (Figures 11 and 12).

Physically and mentally disabled patients' autonomy and control are challenged when their minds, in substitution for their hands, make the decisions about composition, color and size that will control the metamorphosis of a computer design. Rehabilitative computer art therapy has the potential capability to monitor stroke patients' cognitive abilities, spontaneity, creativity, perception and expression in carrying out and elaborating upon personal ideas for problem solving.

Artistry is an inherent quality in computer art. The increased possibility for successful computer art experiences could mitigate patients' frustration, anger, tension and depression. Frustrated artistic quadriplegics may find a creative outlet by using the preprogrammed continual motion designs to produce satisfying work. Their decisions in directing the computer might provide the experience of feeling some control in their lives and increase their motivation to explore and create.

For those with little or no upper extremity fine or gross motor activity, the light pen—which does not have to make direct contact with the graphics tablet—eliminates the need for hand pressure and cumbersome adaptive equipment. The voice command, which uses the sound of the voice to activate the computer program, offers another alternative.

Physical lack of control and manipulative limitations result in fatigue and frustration and cause those with quadriplegia to work at a slower rate. The speed of the computer may be slowed down to meet the needs of a patient and offers a less taxing method of creating art. The spontaneous and rapid action of shapes and colors might stimulate those who are sensory deprived by sharpening their perceptions, and the bright colors and rapid activity of the shapes might help to hold and increase the patient's attention span. Swift computer activity has the potential to shorten the length of therapy sessions which might encourage the attendance of those suffering from incontinence. Computer capability to store work in progress until activity is resumed could provide a consistent reminder and basis for reality orienta-

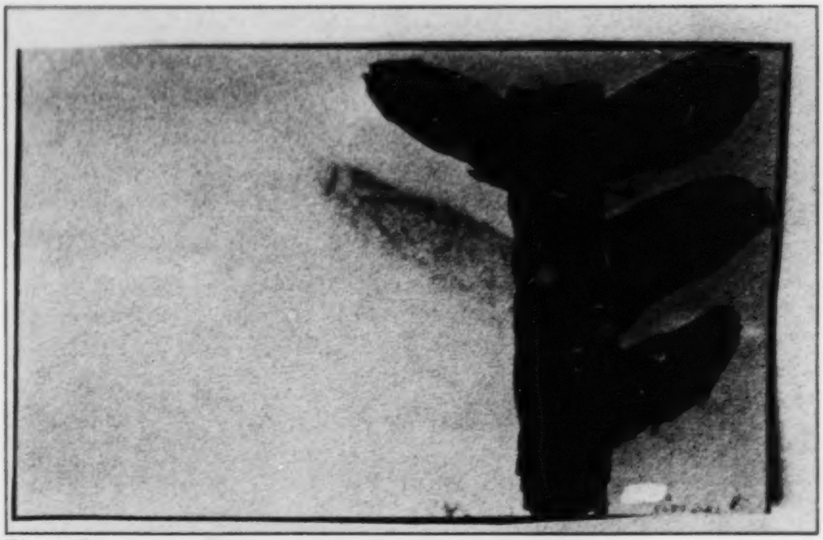


Figure 7

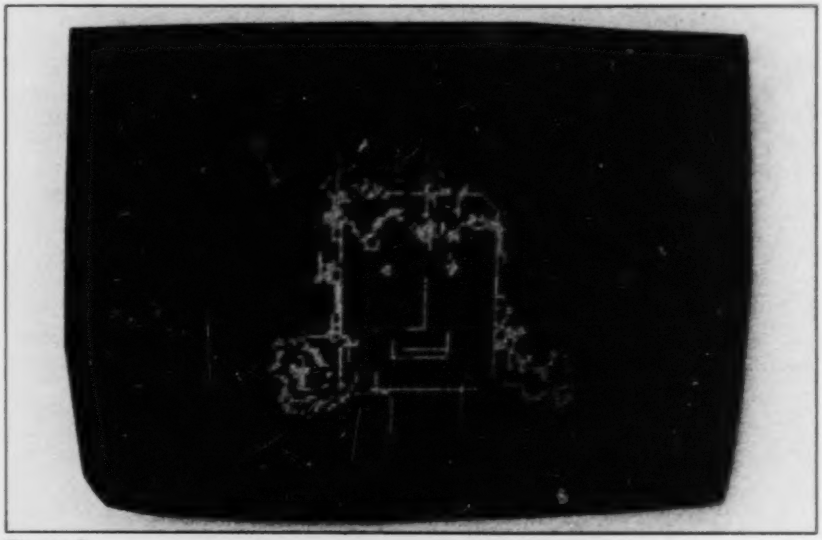


Figure 8

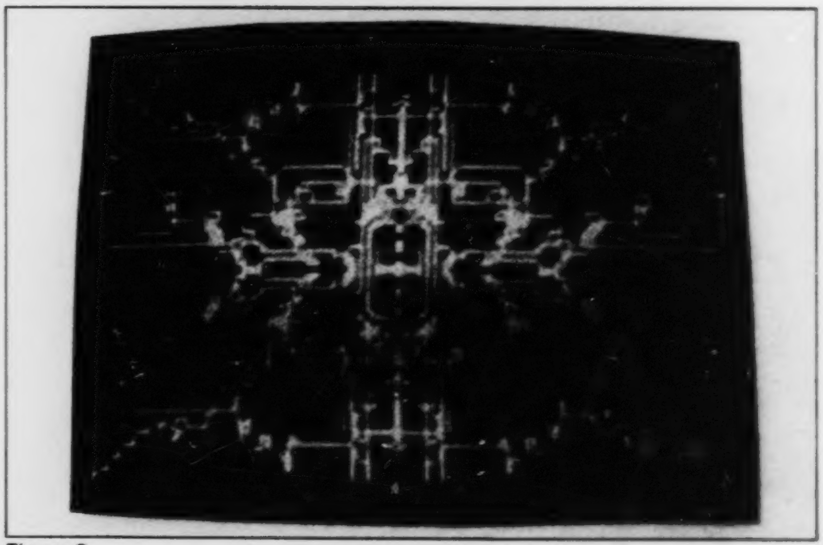


Figure 9

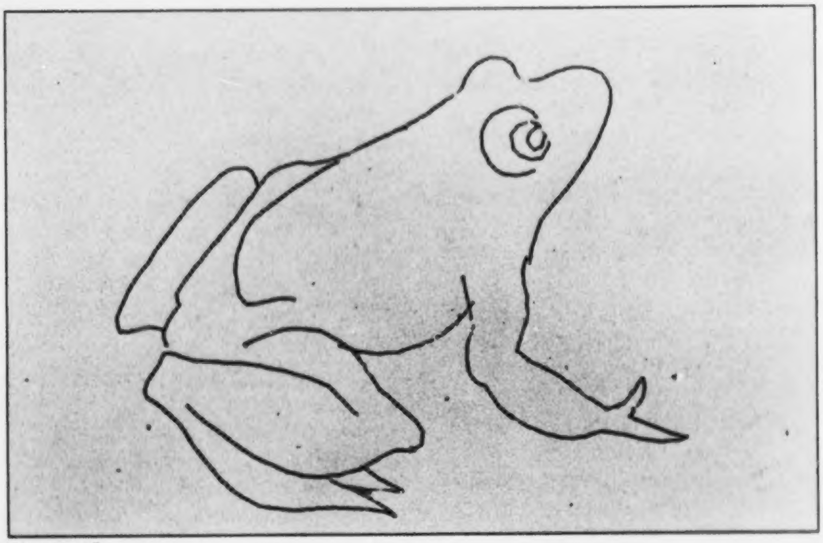


Figure 10

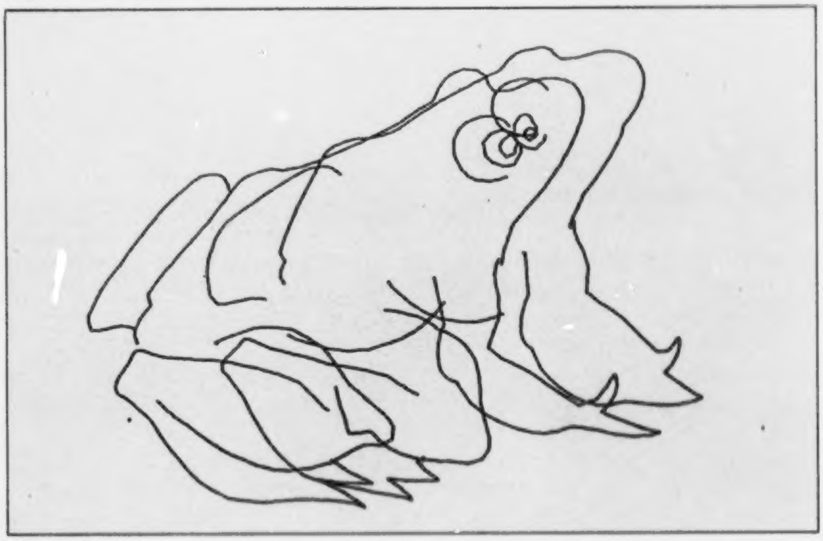


Figure 11

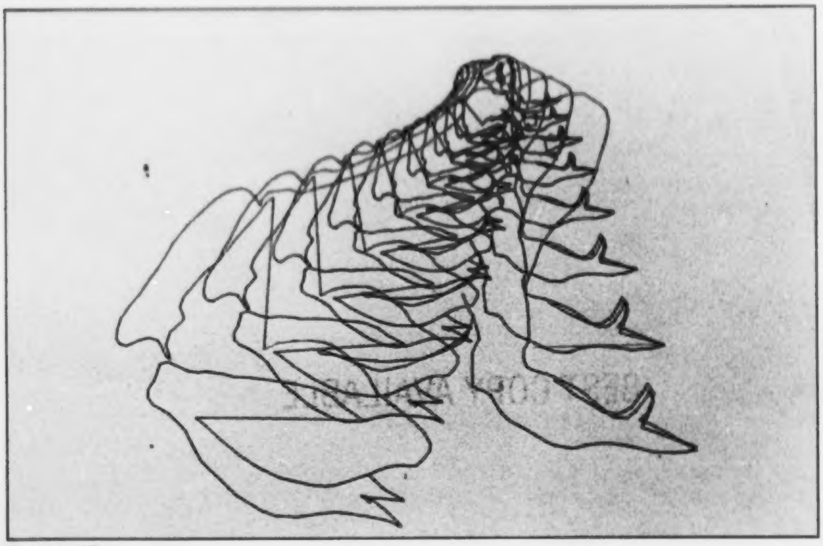


Figure 12

tion for brain trauma and stroke patients with memory deficits.

The computer's ability to accept a wide range of inputs vastly increases its potential to accommodate to various physical disabilities. Technologists, however, are continually developing new strategies to modify computers and their adaptive devices to enable the physically handicapped to perform increasing numbers of tasks otherwise denied to them.

Summary

Fear and frustration are just two of the emotions that may undermine a disabled patient's self-worth. Productivity and energy needed to maintain mental and physical activity become depleted by long-term hospitalization. The patient's personality changes from passive to unmotivated and withdrawn. Bodily disability shifts to the main focus of attention for the withdrawn patient who no longer feels hope for the future.

The use of computers for the handicapped is significant because computers do not demand manual skill for the creation of art. What the computer does require is that the artist [patient] make aesthetic judgments. The computer's unusually novel method of creating art stimulates observation, reflection, discrimination and recall. Computer art opens the way to communication by arousing curiosity which encourages patients' psychosocial skills. Sharing art work is a natural method of gaining the esteem and acceptance of others, and overcoming feelings of isolation and fear of rejection.

The spontaneity of the computer lends itself to the process of art therapy. Computer art therapy provides opportunities for the manipulation and processing of spatial information and can serve as an instrument for assessing and developing the cognitive abilities of patients who cannot communicate well verbally, or comprehend and illustrate spatial relationships, organize sequentially, or associate and depict concepts. Graphic information can be stored, regenerated to another form, or viewed purely for its aesthetic value. These multiple computer art experi-

"One of the greatest powers of the computer is its ability to easily change a simple design into one of striking complexity."

ences can pique a patient's awareness of aesthetic qualities.

Computer art therapy fosters the disabled patients' ability to adapt and cope by providing the opportunity to release tensions and express inner experiences and emotions in a constructive way. The patient is provided with a method to use his/her autonomy by making the decisions that control the metamorphosis of the computer art work. Computer art is instantly visible and easily altered so that the patient can manipulate and reorder programmed information to achieve new or unfamiliar abstract or representational patterns. This procedure, often revealing new insights about basic aspects of form, composition, space and color, could promote unexpected innovations and creativity—a technological creative synthesis. The computer process could also provide a momentary, mesmerizing and meditative escape from the awareness of physical and mental pain.

The computer has the potential to supply crucial rehabilitative information. Its special capability to sense all the artist's movements and pauses provides the art therapist with an opportunity to witness the actual execution of disabled patients' graphic tablet drawings. A comparison of a collection of consecutive individual patients' plotter printouts could offer a concrete basis on which to measure progress in their range of motion.

Rehabilitative computer art therapy for quadriplegic, stroke and brain trauma patients has the potential to meet the following therapeutic goals: (1) To help patients to adapt, cope and value remaining functions by having successful art experiences; (2) To encourage patients to build upon their remaining strengths; (3) To increase patients' self-esteem; (4) To increase patient motivation; (5) To stimulate patient exploration and creativity; (6) To provide patients with a less threatening method to express anger and frustration; (7) To provide sensory stimulation to counteract lack of exploratory experiences due to low levels of expectation; (8) To allow patients to gain autonomy and control; (9) To prevent isolation by providing socialization through non-verbal communication; (10) To help maintain orientation and memory; and (11) To provide patients with a temporary escape from the awareness of physical and mental pain by channeling attention into creative activity.

Disabled people will take responsibility for their health and well-being only if they are able to adapt and cope with their remaining function(s) enough to avoid preventable complications. Rehabilitative computer art therapy, by offering an unusually novel and rapid approach to successful art experiences, has the unique power and advantage to elicit disabled patients' curiosity and motivation to build upon their residual strengths.

The credibility of rehabilitative computer art therapy rests in its potential to offer the disabled accessibility and advantages beyond what has previously been confirmed by conventional rehabilitative art therapy.

References

Brubeck, Thomas. (1974). *A great resource for disabled people.* New York: Art Digest, Inc., *48.*

Katzan, Harry Jr. (1982). *Microcomputer graphics and programming techniques.* New York: Van Nostrand Reinhold Company.

Lindsay, Zaidee. (1972). *Art and the handicapped child.* New York: Van Nostrand Reinhold Company.

Lynch, W.J. (1981). *A guide to Atari Videocomputer Programs for rehabilitative settings.* Indianapolis, IN: Presented at a conference on models and techniques—cognitive rehabilitation.

Malina, Frank J. (1979). *Visual art, mathematics and computers.* Selections from the Journal of Leonardo. New York: Pergamon Press, Inc.

Rubin, Judith. (1978. 2nd ed: 1984). *Child art therapy.* New York: Van Nostrand Reinhold Company.

Schontz, Franklin C. (1969). *Perceptual and cognitive aspects of body experience.* New York: Academic Press.

Silver, Rawley A. (1978). *Developing cognitive and creative skills through art.* Baltimore: University Park Press.

Treischmann, Roberta B. (1980). *Spinal cord injuries.* New York: Pergamon Press, Inc.

Video Easel, graphic art program for the Atari 800™, Atari Computers.

Weinberg, Diane J. (1983). *Computer art for the quadriplegic, the physically and mentally disabled: Its implications for rehabilitative art therapy.* Chicago: University of Illinois at Chicago.

Williams, Greg. (1982). *The graphics primer.* Byte, 7, November, Byte Publications, Inc.

BEST COPY AVAILABLE

The Art of Healing: The Work of Edward Adamson

Georgiana Jungels, ATR

***Georgiana Jungels, ATR** is an Associate Professor in Art Therapy Studies, State University College at Buffalo, New York, and Art Therapist, Private Practice, Counseling Services, University Center for Human Services, Amherst, New York.*

Introduction to Edward Adamson

Art has been an essential part of human existence for as long as civilizations have been recorded (Brookes, 1983) and people have expressed their understanding of the mysteries of life and death through art expression (Jones, 1978).

The search for some sense of well being through art is very old (Levy, 1976) and art has been part of therapy throughout all of recorded history (Lommel, 1967). Over and over people have created configurations that are equivalent to life processes (Kramer, 1958) and art is basic to psychotherapeutic treatment (Naumburg, 1966). Both the artist and the analyst search to recognize the inner and outer reality of life and the universal in people (Hammer, 1975).

In the 19th century, psychiatrists studied the spontaneous art of psychotic and neurotic patients in Europe (Naumburg, 1950) and in the 20th century, Margaret Naumburg defined Art Therapy as a profession in America (Levick, 1973). All of the individual artists, therapists, and art therapists who pioneered art therapy in the United States (Ulman, 1977, APA, 1984) and Europe (Gantt and Schmal, 1974) synthesized the histories of artistic expression and therapeutic intervention into a recognized interdisciplinary profession in contemporary times.

In recent years the field of Art Therapy has grown rapidly in the United States and the work of art therapists who have contributed to the growth of the field has been documented by publications, films, exhibits, and the American Art Therapy Association (AATA 1976-82). Much less, however, is known in the United States about the art therapists who are the pioneers in other countries. In England, one of these pioneers is Edward Adamson.

Edward Adamson has worked as an artist, therapist, and art therapist for over 40 years in England. He developed the Art Therapy program at Netherne Hospital, founded the British Association of Art Therapists, and is a member of the Societe Internationale de Psychopathologie de l'Expression. He is an artist, therapist, cotherapist, facilitator, lecturer, and author.

In the recent book, *Art as Healing* (Adamson, 1984), Edward Adamson and John Timlin document how Adamson has used art to facilitate healing and health. The National Association for Mental Health (MIND) in England selected the book, *Art as Healing*, for the 1984 MIND Book of the Year Award. When the Chairman of the judges, Professor Derek Russell Davis, announced the award, he said:

> Edward Adamson's approach has been educative. He has put the emphasis on self-healing, the release of creative resources latent within every patient, and reintegration....he has given people, with great respect for them as individuals, the courage and the space to express themselves.[1]

This space to express has been described by Anthony Stevens as an "enabling space":

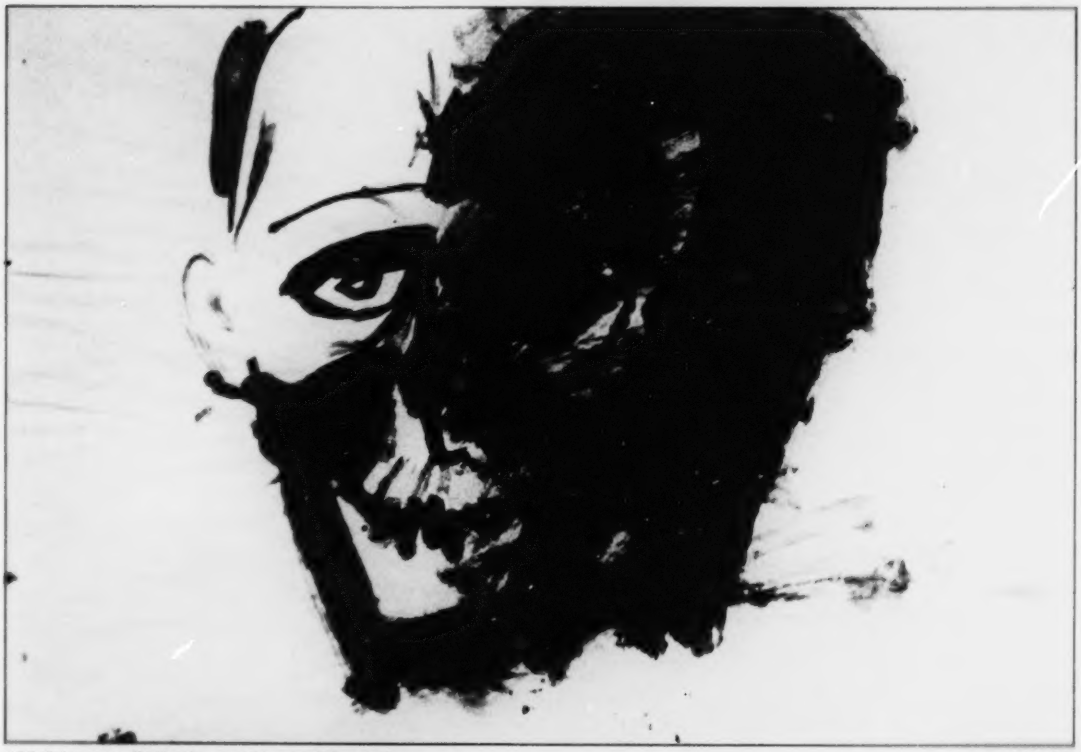
> Edward Adamson possessed not only vision, but the talent and charisma needed to bring his vision to birth in reality. Intuitively he knew there to be a connection between creativity and healing, and he understood the importance of providing a sanctuary—a space, a temenos—in which this connection could be made. His genius lies in his ability to create the enabling space.[2]

When Adamson chronicles his involvement in art as a form of treatment, he prefers to rely "on the pictures to speak for themselves, and to provide a more eloquent testimony to the extraordinary efficacy of Art as healing" (Adamson, 1984).

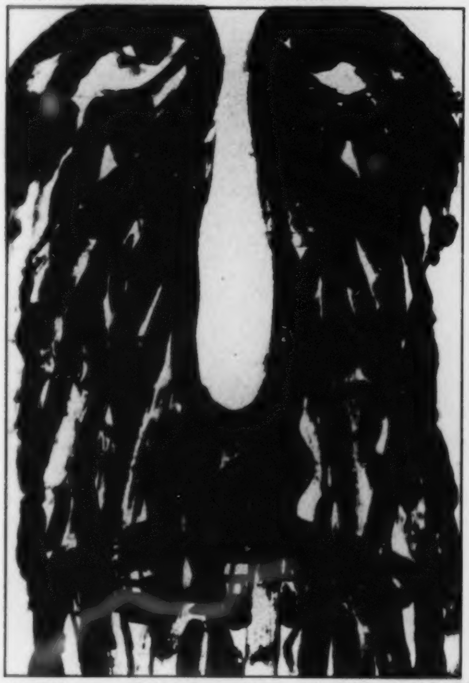
In order to understand more about Adamson's work and his approach, I have reviewed hundreds of images from the Adamson Collection[3] and recorded Adamson's comments and observations about his work[4]. I think that the best way to begin to understand the art of healing illustrated in Adamson's work is to study the images that have been made by the people with whom he has worked. To further our understanding of how these images were related to the healing process, I have included an accompanying text based on recorded comments and observations by Edward Adamson. These visual and verbal statements will be followed by a review of the past and present work of Edward Adamson, a discussion of the Adamson Collection, and some of the relationships between Adamson's Art Therapy work and current Art Therapy services in the United States.

The Images With Observations Based on Comments By Edward Adamson

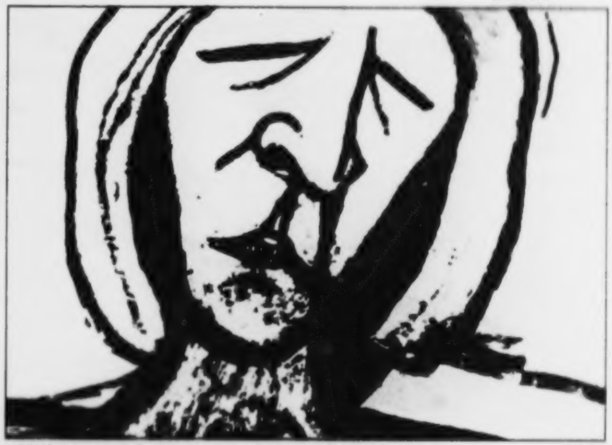
Pictures #22, #37, #25, and #29 were made by a young man who is an artist and whose mother was dying of cancer. He was in great distress and unable to express his feelings in words. When he first came, he just couldn't use any other color but black. All of his paintings were black and this distressed him even more. He felt completely depersonalized, depressed, and empty. Through his



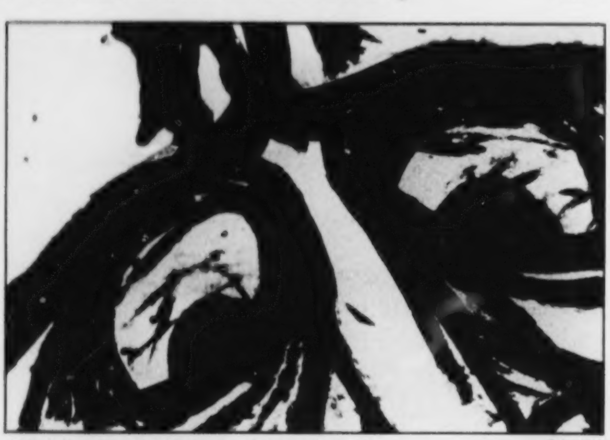
#22 Adamson Collection—"Face of Death" 23x33



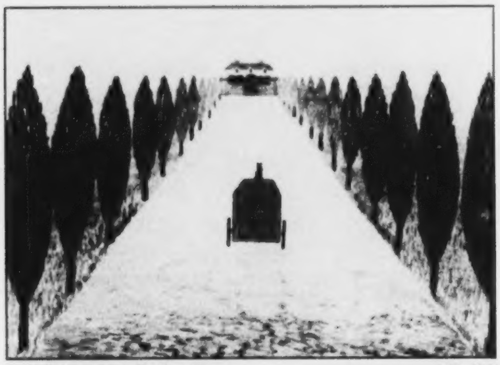
#37 Adamson Collection—"Anguished Face" 23x23



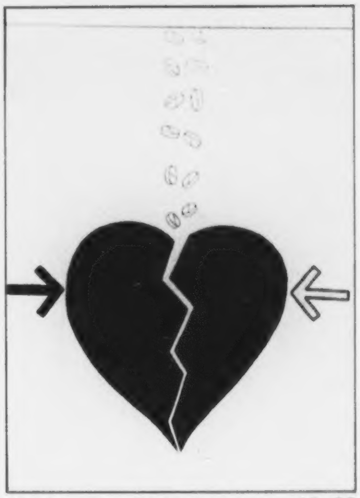
#29 Adamson Collection—"Face of Suffering" 23x23



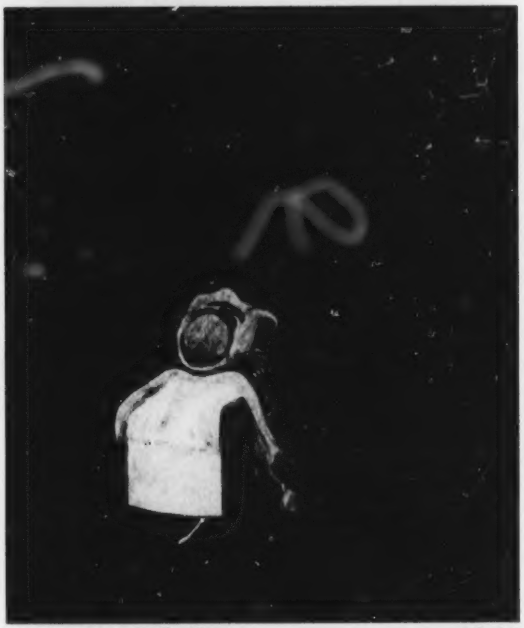
#25 Adamson Collection—"Eyes of Pain" 23x23



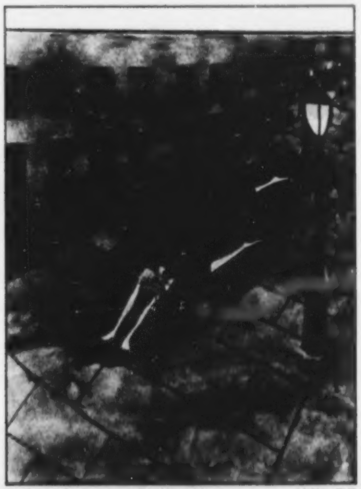
#92 Adamson Collection 18x23



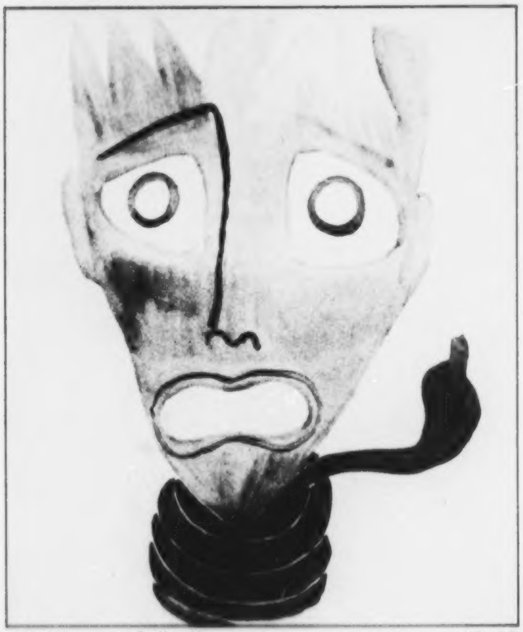
#93 Adamson Collection 18x23



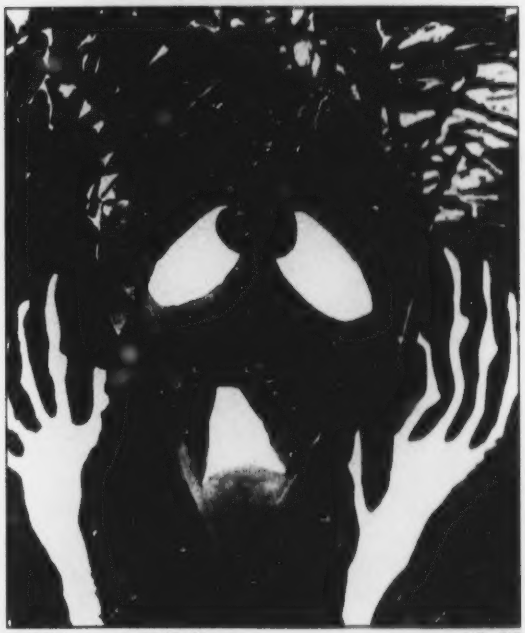
#82 Adamson Collection 18x22



#83 Adamson Collection 18x22



#85 Adamson Collection 18x22



#86 Adamson Collection 18x22

painting he pulled himself out of his depression, began to use color, and faced up to the fact that he was going to lose his mother. He did get better after about a year and he did it himself...through his painting.

These pictures illustrate the pain and suffering of illness; but they are only part of a process...the healing process. When it is no longer necessary to make any more images of illness, the healthier person can emerge. This young man was helped by Edward Adamson because he was allowed to express all of his painful feelings graphically. However the pictures were not the end product. As John Timlin (1985) has observed:

> "The end product was that he no longer needed to express his grief...it was something that he got over...it is an example of someone who came when they felt an imminent breakdown...expressed everything in the most eloquent way possible and then...got over the trauma in the shorter and best possible way."

Pictures #92 and #93 were made by a young man—about 25—who was under the impression that he killed somebody. He said he knocked a child over in his car and knocked both his eyes out. This became an obsession with him and he had to go to report it every day to the police. They were very tolerant and tried to help him in every possible way. They used to take him back to the scene of the accident—or supposed accident—just to point out to him that there was nothing wrong. However, this went on for about 18 months and they got rather tired of this every day appearance and suggested that he should have psychiatric treatment. When he didn't progress very favorably with his psychiatrist, she suggested that he should come to the studio and try to paint out his troubles.

When he first came to the studio, he didn't want to produce at all and all he would do is doodle. (Although artists are usually sustained by their creativity, when they are overcome by illness their sensitivity may make the experience very painful; and it may take some time before art can begin to assist in the healing process.) Later he portrayed himself as a tree that was fenced in or a tree that was cut down and completely infertile. Over and over he recalled and painted the recurring nightmare about the child he thought he killed. This dream had originally occurred when his mother died and he used his graphic skills to go over the evidence again and again.

"Where problems of the mind are concerned, the solution must be found where they originated, that is, from WITHIN. It is only here that we have the source of real change."

When he painted the picture of the carriage going toward the gate in front of a large house (#92), he said that he was longing.to get into other people's houses but was barred from everybody's home because of the crime that he committed. He painted the gate at the end of the avenue completely shut and he said he would never be allowed in.

He wished that he could knock some sense into himself and felt that there was no love for him because he had a broken heart and had to be fed on tranquilizers. (#93) After about two years he was discharged from the hospital. He relapsed and had to come back to the hospital.

At this stage, Edward Adamson suggested that he should buy a new car...which he did...and...he "took me for a ride in it...I was terrified." (Adamson, 1985)

He was discharged again and went back to his job as a graphic designer which he has held on to the present day and is doing quite well again. In his own creative way—through his painting—he managed to face up to his difficulty.

• In *Art as Healing* (1984), Adamson recommends that:

> "Where problems of the mind are concerned, the solution must be found where they originated, that is, from WITHIN. It is only here that we have the source of real change. Art obliges us to communicate with the inner self, and in so doing, to engage in a dialogue with both our destructive and creative forces. The destructive powers have precipitated the problem, so that the symptoms of illness we observe are merely the acting out of an unresolved, inward struggle...Art places the central responsibility for change upon the individual, rather than making him rely exclusively upon imposed treatment from outside."

Pictures #82, #83, #85, #86 are four examples from the thousands of paintings that M.S. made during her hospitalization for over 30 years. Her pictures describe some of her intensely painful feelings of fear, rejection, isolation, depression, anger, persecution, and despair (#82) and "her existence was only made bearable by the fact that she could come and paint whenever she liked." (Adamson, 1985)

She thought the hospital was like a prison. If anyone said anything that she didn't like, she would stop and scream. One time she was demonstrated to the medical students when they came to the hospital. She disliked it intensely and made the medical students look stupid in her painting about this experience and then she would not paint again for almost six months.

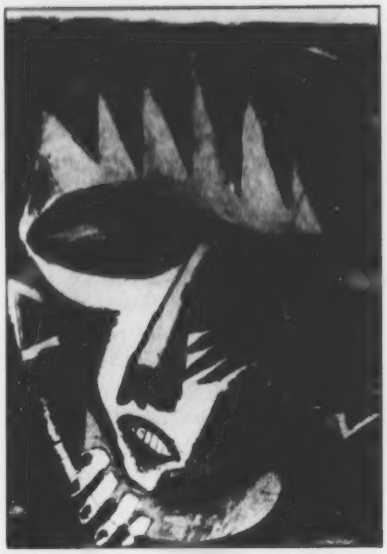
She traveled all over the world in her paintings...bowing down to the elements. (#83) She would become trapped, tied up, part of the elements, the witches would catch her, and she would be left alone crying in the desert. She identified with the crucifixion and would die in her paintings and then have to be reborn. Occasionally she would paint a slightly happier picture, but disaster was always lurking.

She identified with suffering in most of her images and would discuss these feelings with her doctor. In the picture of the face with the snake around her neck (#85), she is controlled by a being in her body which she calls George which sometimes comes out like a snake-like creature and strangles her.

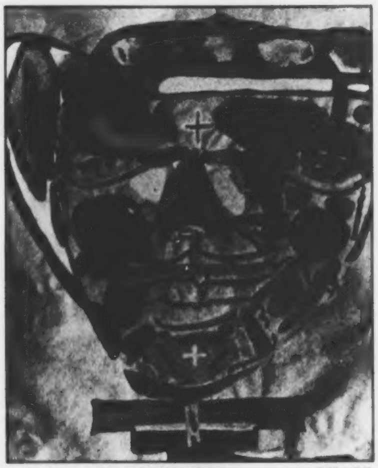
Over and over she requested help, and she frequently said "If you can't help me, I'll kill myself". Picture #86 is a powerful example of her pleading. Picture after picture was titled "Help me." Sometimes she painted the same picture every day for two weeks. "You may see the same imag-

BEST COPY AVAILABLE

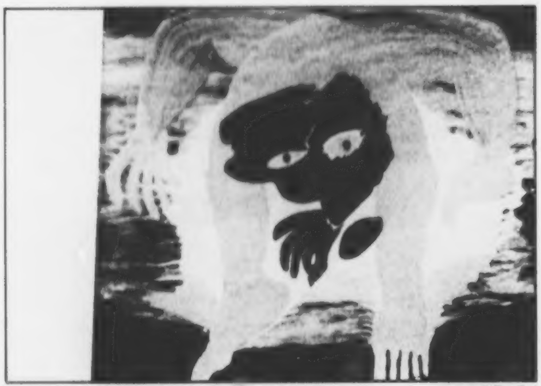
#9 Adamson Collection— 15x20
"The Mystical Eye"
The eye is a frequently depicted sign or symbol in the art of the severely disturbed, and will often appear spontaneously in a variety of ways in many different cultures.



#17 Adamson Collection 15x20
"Self Portrait"
This picture was made by a 32 year old man who "had been so hurt by his unsuccessful attempts to form relationships in his childhood that he had finally ended up by turning his love inwards towards himself. He told me that he would like to paint a self-portrait. I managed to find him a mirror from which he could copy his image; it was in a heavy oak frame. He tried several times, but without success. Then he covered the whole mirror with the black paint of despair. Then, as I watched him, his index-finger sought out his buried reflection amid the wet paint on the glass. He first of all traced the outline of his head, then his eyes. Then he drew his hands, but this time on the heavy frame of the mirror, as if he were physically struggling to get out. Slowly he was climbing out of the imprisonment of his narcissism. This painting marked a turning point in his development. He subsequently learned to relate healthily to the outside world and never looked back." (Adamson, 1984)



#18 Adamson Collection— 17x20
"Self Portrait"
This picture was made by a woman who believed her head was a teacup.



#21 Adamson Collection—"Self Portrait" 18x21
This picture was made by a young man to show how he saw himself.

ery coming out day after day but this must be accepted" and "you must be there to help....all the time." (Adamson, 1985)

She was recently discharged and is living in a hostel and managing for herself; but she is still desperately lonely and now there is nowhere for her to paint.

The images collected by Edward Adamson range in size, media, symbols, themes, subject matter, skill, and style. Some are very simple statements that mean a great deal only to the person who makes the image. Other pictures dramatically illustrate very clear graphic statements about feelings of anxiety, depression, loneliness, fear, anger, abandonment, or grief. Some pictures include personal or universal symbols (#9). Other pictures are self-portraits that reveal a distorted self image or great distress (#17, #18, #21). Other pictures are conventional landscapes or illustrate a view of the hospital grounds (#73, #74).

Who is Edward Adamson and How Does He Work?

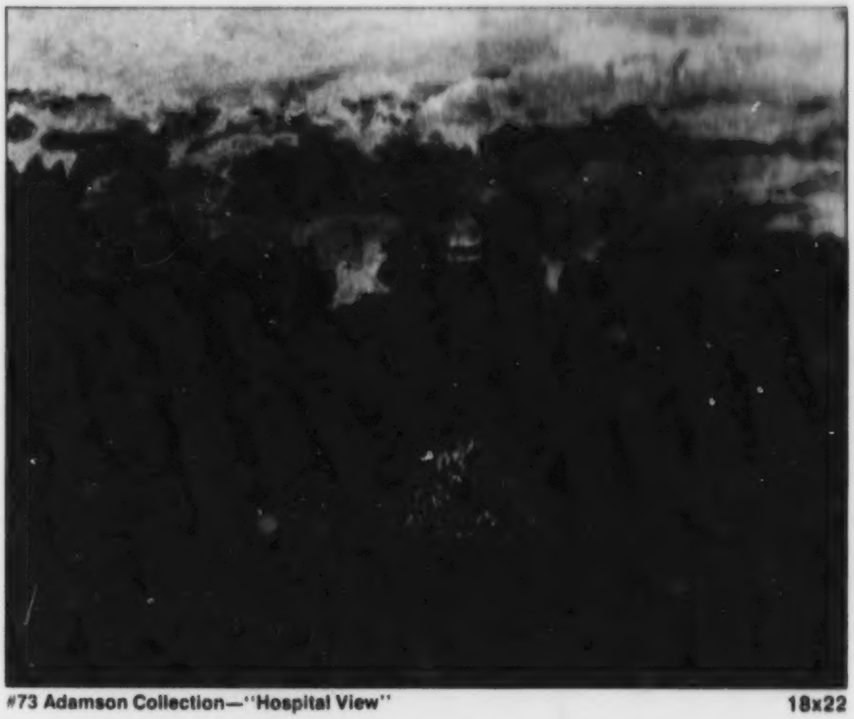
After seeing the images made by the people with whom Edward Adamson has worked, the viewer may have many questions about the artists: Who made the pictures? How? When? Why? Where? What about the therapist, Edward Adamson? How does he work with people? What does he say? What does he do? Where does he work? When? How did he begin?

Edward Adamson was trained as an artist and worked with the artist Adrian Hill in a T.B. sanitoria in the early 40s. As artists, their role was to assist people "who needed an occupation and a diversion during their long months of recuperation...we practiced a form of occupational therapy through Art...the main concern was to acquire a good technique." (Adamson, 1984)

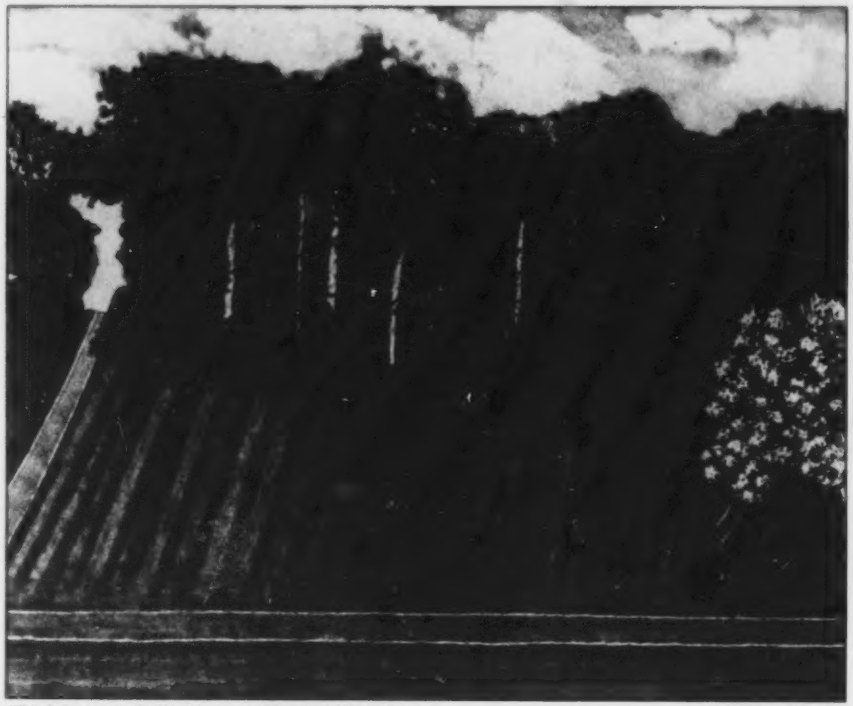
When Edward Adamson began to work at Netherne Hospital in Hertfordshire in 1946, he found that psychiatric patients exhibited a wider range of personalities than the people with whom he had worked in the sanitoria. He remembers that "we were all working very much in the dark in those early days." (Adamson, 1984). He began by creating a stimulating environment, painting the ceilings and walls in sunshine yellow and shocking pink. He worked with patients that nobody else would take. When people were incontinent, he worked with them on their paintings in the hospital showers. He frequently observed the spontaneous need to draw... on scraps of paper, on toilet paper and on library books. He offered people paints, brushes, paper, and a place. Every day about 40 people came to his makeshift studio.

Later he made a studio on the hospital grounds—away from the hospital buildings—so the patients could make the effort to get there...and leave the hospital atmosphere behind. In the studio, Adamson provided the materials for drawing, painting, sculpting, and pottery and created an atmosphere of quiet encouragement. Everyone had their own space—a "little island"—where each person could feel that privacy was respected. The studio became an oasis...people appreciated the natural silence and quiet concentration and looked forward to their time in the studio...and artistic expression became a form of treatment. In this studio, Adamson saw his role as a facilitator and cotherapist:

> In the studio, I considered it my role to facilitate, rather than direct. I never suggested what anyone ought to paint, because it seemed essential that the idea should be entirely theirs. If someone wished to discuss a possible topic for a painting, I would merely try to explore what he wanted to do. Invariably, when we had finished talking, he would go away and paint something entirely different. I never criticised, and I never praised the paintings. I just welcomed them. I certainly never tried to interpret them. I did pass them



#73 Adamson Collection—"Hospital View" **18x22**



#74 Adamson Collection—"Hospital View" **18x22**

> on to the individual's doctor, whom I hoped would use them to get a little closer to his patient.

Sometimes people came to the studio on their own; sometimes at the request of their doctor. John Timlin (1984) reports that "art became the medium through which they could collaborate with their doctors and assume some personal responsibility for their return to mental health. The people who came to the studio were allowed to rediscover a rich vein of creativity which made their predicament more accessible and coherent to themselves and to others."

Adamson (1984) noticed that even though the majority of people had little or no art training,

> "many of the paintings possessed an extraordinary degree of intensity…the reason that the paintings are so positive in their statement is that they express the powerful creative energy that we all possess but may not have released."

Sometimes people confused Adamson's role with that of an occupational therapist or an art teacher. He was neither. He was an artist and a therapist, a facilitator, a catalyst who "allowed the healing art to emerge." He "never imposed the use of a particular medium, but might suggest one to facilitate the expression of someone's idea." In the studio, people would "be reborn," "ventilate," "dream," "fantasize," "recollect," "reintegrate," and discover how art could rescue and heal. He worked with individuals and groups and offered people who could not talk about their pain and hopes the vocabulary of imagery. He found that the "act of painting is a magical moment" that creates a "subtle dialogue…between the painter and the slowly unfolding symbolic drama of the inner mind." Sometimes he was the object of "deeply felt hatred"; other times he was the symbolic groom or "buried in the bed of the sea and taunted by a lobster." He knew that there "are many parallels between the dynamics of spontaneous painting, and the therapeutic process." (Adamson, 1984)

How does Edward Adamson work with people? In the forward to *Art as Healing* (Adamson, 1984), the British psychiatrist Anthony Stevens suggests that "the key to Adamson's success is the absolute respect—one might say reverence—he has for the individual" and reminds the reader that "success in art therapy, like success in analysis, depends as much on the relationship between patient and therapist as on the symbol-forming potential of the unconscious psyche."

"The silence is very important…you know in stillness there is great activity."

John Timlin (1984) has observed that Edward Adamson goes about "his extraordinary work with a Zen-like simplicity" and Edward Adamson emphasizes the relationship between time and healing in his work:

> There seems to be a natural, 'fullness of time' which occurs in both Art and healing. Just as a painting cannot be forced, healing must proceed at its own pace. One is obliged to co-operate with this rhythm to avoid any precipitous insult which could abort the process. Because of this, when a person comes to the studio, I never suggest what he should draw; it is essential that the idea should be entirely his own. This particular approach demands a considerable amount of patience. Sometimes it is often weeks, months, or even years that we are both obliged to wait for the birth of someone's creativity. All I can do is to try and create a permissive atmosphere and have the necessary paint and paper on hand. If the person is prepared to come and spend his time with me, then I must be prepared to join in the vigil. (Adamson, 1984)

Gordon (1973) suggests that the creative process depends upon a capacity to be active as well as passive and to give as well as receive.

In a recent interview (Jungels, 1985), Edward Adamson talked about working "quietly active in a passive way" and stressed the importance of silence and time in his method; and John Timlin described Adamson's ability to wait—to be simultaneously active and passive:

Edward Adamson:

"The silence is very important. Inactivity on the part of the therapist, being passive as possible and withdrawing the whole time and encouraging the individual to produce things in his own way. You know in stillness there is great activity. That is the thing they sense. As long as I'm there—they know I'm there—and they appeal to me for that reason. When I'm with them, I never sit down because once I relax, they will relax too and it will not be necessary for them to paint. So it is quietly active in a passive way, if that is possible. You must tune in to the individual you are going to work with. And that takes a little while. You try to get behind their eyes to see what they are trying to envision, paint, and I encourage it from their angle the whole time…if they're prepared to share it with you…then you must be prepared to wait for it."

John Timlin:

"Edward waits and he does not know for what he waits but when it comes he knows it has arrived. Because then people are willing to do something. The person is nervous at first. They go through a whole lot of stages; they know, then they think—

> 'well, perhaps I better please…but no, we haven't even got to do that—…perhaps I better do something small'—

they're going through this process of development. They can externalize how they are feeling and can face up to it because on the paper there is something concrete and they can talk about that thing on the paper rather than talk about themselves. If one waits, then one is waiting for the patient—the person themselves—to make a statement. One just has to wait and wait. I've seen Edward wait and wait for many years in some cases. In Edward's method, anything that the person produces is right; they don't have to please Edward. The studio in the hospital was one of the happiest places in the hospital…it was one place where people could be themselves and act—but not act up—really do something for themselves…in the studio they were trying to heal themselves."

During his many years of therapeutic work, Edward Adamson guided many people through critical periods of stress and collected over 60,000 images that illustrate how art can help to communicate feelings about illness and facilitate healing. Currently he is continuing his work in private practice in his studio in Chelsea and working on the development of a stress center "where people can come and paint when they feel under stress." (Adamson, 1985)

When Adamson retired from his position as Art Director at Netherne Hospital, the gallery that he had built with great care was turned into a physiotherapy department and some of the art work was destroyed. The hospital was ambivalent about the pictures and a charitable trust—the Adamson Collection—was set up to preserve and augment the collection. John Timlin, (Adamson Foundation, 1984) Honorary Chairman of the Adamson Collection, reports:

> "The Adamson Collection is not static but continues to evolve, encompassing the work of prisoners and children for whom art therapy is used as a preventative tool."

The purpose of the collection is multiple: to witness the efficacy of Adamson's work; to stimulate members of the medical and helping professions to gain deeper insights into the situation of the mentally ill; to educate the general public; to study the graphic representations of psychopathology; to show how people can communicate their difficulties through art, prevent long hospitalizations, and be responsible for their own cure. (Timlin, 1985)

The Adamson Foundation for Creative Therapy in Canada was formed in 1982 to further study and research into the application of creative therapy in the diagnosis, treatment, and prevention of mental illness. In a recent presentation, the foundation summarized the purposes of the Adamson Collection:

> to illustrate the process of art therapy;
>
> to provide the patient's own illustrations of his psychiatric, social, and environmental experience;
>
> to illustrate the great creative potential of some patients work;
>
> to furnish visual aids for specialized groups of visitors who study aspects of psychiatric work, such as doctors, nurses, health visitors, social workers, counsellors, psychologists, psychiatrists, teachers, and clergymen;
>
> to provide visual material for art exhibitions, the mass media, and specialized text books.

"You must tune in to the individual you are going to work with. And that takes a little while. You try to get behind their eyes to see what they are trying to envision, paint..."

Currently, selections from the permanent collection of the Adamson Collection are exhibited in the public gallery on Ashton estate (near Cambridge) of one of the Adamson Foundation trustees, Dr. Miriam Rothschild. In 1984 selections from the Adamson Collection were exhibited in Canada (Art Gallery of Ontario) and the United States (Albright-Knox Art Gallery, Buffalo NY). In the exhibit catalog, David Burnett, Curator of Contemporary Canadian Art at the Art Gallery of Ontario observed that these art works have "a rare, literalness in the relationship between visual signs and the verbal language those signs elicit." (Burnett, 1984)

David Sax, a contributing reviewer for the BUFFALO NEWS observed that the work from Adamson's collection conveys a sense of "therapy at work while also conveying a feeling for the creative process that underlies an artist's work" and offers "insights into both the human condition and the artistic process." (Sax, 1984)

When work is selected from the Adamson Collection for public exhibits, people frequently select certain pictures because they are graphically dramatic and illustrate something that is frequently much more difficult to describe in words. Adamson (1984) points out that "these pictures may be superficially regarded as the stereotype of mental illness" and it is important to recognize that they simply illustrate feelings that we have all experienced to one degree or another.

In any exhibit, it is important to include the images of hope and healing to balance the images of pleading and pain. Timlin (1984) has found that some visitors may be shocked at the uninhibited display of feeling, and question the intrusion into the confidential relationship between therapist and patient. Adamson always requests permission to publish or exhibit art work made by the people with whom he has worked and has found that many people who have experienced mental disturbance are very willing to contribute their work to educate the public about mental illness and share their experience in using art as healing.

Visitors to exhibits of the art work from the Adamson Collection comment that the work is "remarkable," "powerful," "beautiful," "frightening," "revealing," "fantastic," "touching," and "moving." Some people find the images "almost depressing but impressive"; or "an eye opener"; or "very human, very real"; others wonder why this art "seems more true to the events that shape us all."[5]

Edward Adamson is one of the pioneers in Art Therapy. Through the thousands of images made by people with whom Edward Adamson worked, we are able to understand more about the many different kinds of visual statements that can be made about feelings of anger, depression, pain, confusion, hurt, or other feelings associated with stress, crises or illness.

These images of illness are complemented by each person's journey toward health. The pioneering work of Edward Adamson in England, Margaret Naumburg in the United States, and many other art therapists throughout the world established the foundations for the growth and development of the profession. Currently art therapists work in different countries with children and adults in a variety of health and educational settings.

In the United States, art therapy is a recognized professional field providing assessment, treatment, evaluation and discharge planning services in rehabilitation, counseling, psychiatric, habilitation, substance abuse, and other health related or educational programs. In 1985 art therapists are credentialed specialists in counseling, psychotherapy, and rehabilitation (Goldenson, 1984) and provide services ranging from physical rehabilitation to psychosocial therapy. (APA, 1984.) Art Therapists monitor, evaluate, and record patients' progress toward treatment goals, functional or behavioral objectives, and criteria for discharge; and participate in multidisciplinary or interdisciplinary case reviews and rehabilitation team meetings.

From the pioneering work of many people throughout the world, art therapy services have expanded to include:

1. assessment of physical, cognitive, psychological, and social functioning;

2. treatment and discharge planning based on initial and ongoing assessments of strengths, limitations, and needs;

3. evaluation of self-care, daily living, and coping skills, mental status, stress level, adjustment to disability, family support, interpersonal skills, functioning level, and other physical, social, or psychosocial areas;

4. rehabilitation plan of care using art experiences to develop skills, restore functioning, prevent or reduce disability complications, assist communication, increase coping and adaptive living skills, facilitate optimal level of functioning, increase ability to express feelings about illness or disability and identify realistic goals, and/or provide counseling for individuals, families, or groups to attain or maintain health.

In these different roles and responsibilities, each therapist's day-to-day experiences may vary considerably. Whether we wait for a few minutes or years and emphasize the artistic or the therapeutic process, we all work to reduce the pain of illness and facilitate health. The images and words may vary but quality of care is a common goal. We can all identify with what Edward Adamson calls "Art as Healing."

References

Adamson, E. (1984) *Art as healing*, London: Conventure, Ltd. and York Beach, ME: Nicolas-Hays, Inc.

Adamson, E. (1985), unpublished observations and comments in lecture on "Art as Healing" at the State University College at Buffalo on April 19, 1985 and interview on April 18, 1985.

Adamson, E. and Langford, R. (December 14, 1983), The patient as artist. *Nursing Times* (London), pp. 8-10.

Adamson Foundation for Creative Therapy, catalog for the exhibit "Selections From the Edward Adamson Collection." (1984) Toronto: Adamson Foundation for Creative Therapy (Canada).

AATA, American Art Therapy Association Publications Committee. Annual Conference Proceedings (1976, 1977, 1978, 1979, 1980, 1981, and 1982), Reston, VA: American Art Therapy Association.

APA, The American Psychiatric Association Commission on Psychiatric Therapies (Toksoz B. Karasu, M.D., Chair). (1984) *The psychosocial therapies, part II of the psychiatric therapies*. Washington, D.C.: American Psychiatric Association.

Brooks, C. E., (1983) "Psychoanalysis as art—art as psychoanalysis" Academy Forum (American Academy of Psychoanalysis) 27:10-12.

Gantt, L. and Schmal, M. (1974) *Art therapy: A bibliography*. Washington, D.C.: National Institute of Mental Health.

Goldenson, Robert M., Editor (1984) Longman Dictionary of Psychology and Psychiatry. New York: Longman, Inc.

Gordon, R. (1978) Reflections on creation, therapy, and communication. *Art Psychotherapy* 5:25-30.

Hammer, E. (1975) Imagery: The Artistic style in the artist's communications. *Art Psychotherapy* 2:225-231.

Jones, D. (1978) Art Therapy. *Art Psychotherapy* 5:11-12.

Jungels, G., unpublished recorded and transcribed lecture comments by Edward Adamson (4/19/85) and interview/discussion with Edward Adamson, John Timlin and Dianne Shelton (4/18/85).

Kramer, E. (1958) Art therapy at Wiltwyck School. *School Arts* 58:5-8.

Levick, M. F. (1973) Family art therapy in the community, *Philadelphia Medicine* 69:257-261.

Levy, B. I. (1976) in AATA Public Information document. American Art Therapy Association.

Lommel, A. (1967) *Shamanism: the beginnings of art*. New York: McGraw Hill Book Co.

MIND, National Association for Mental Health, (1984) Healing Through Art—*MIND* Book of the Year Award" (press release, 22 October 1984.) London: National Association for Mental Health.

Naumburg, M. (1950) *Schizophrenic art: Its meaning in psychotherapy.* New York: Grune & Stratton, Inc.

Naumburg, M. (1966) *Dynamically oriented art therapy: Its principles and practice.* New York: Grune and Stratton.

Sax, G. (1984, August 24) review of Adamson Exhibit, *Buffalo News*.

Timlin, J. (1984) Art Therapy and Beyond in *OPEN MIND*, No. 11, October/November, London: MIND. (National Association for Mental Health).

Timlin, J. (1984) in Adamson, London: Conventure, Ltd. and York Beach, ME: Nicolas-Hays, Inc.

Timlin, J., unpublished recorded comments April 18, 19, 1985.

Ulman, E., Kramer, E. Kwiatkowska, H. (1977) *Art therapy in the United States*. Craftsbury Common: Art Therapy Publications.

NOTES

1. Davis, Derek Russell in MIND Press Release 22 October 1984; National Association for Mental Health, 22 Harley Street, London W1N2ED, Great Britain.
2. Stevens, Anthony, DM, MA, DPM in the forward to the book, ART AS HEALING (Adamson, 1984).
3. Jungels, 1985, photographs of original art work selected from the Adamson Collection.
4. Jungels, 1985, recorded interview with Edward Adamson and John Timlin on April 18, 1985 and re-

corded observations in lecture "Art as Healing" at the State University College at Buffalo, April 19, 1985.

5. Comments by visitors to the exhibit, "Selections from the Edward Adamson Collection" at the Art Gallery of Ontario (Toronto, Ontario, Canada), March 16—April 15, 1984 and at the Albright-Knox Art Gallery (Buffalo, New York, USA), August 21-September 30, 1984.

Further information about the Adamson Collection may be obtained from the secretary, 16 Hollywood Road, London SW10 9HY. The Adamson Collection is housed at The Gallery, Ashton, near Oundle, Northamptonshire and is open to visitors.

I am grateful to several groups and individuals for their assistance in preparing the material for this article: to Edward Adamson for granting permission to photograph the original art work; to the trustees of the Adamson Foundation; to John Timlin for his observations about the work of Adamson; to Dianne Shelton for her assistance in making the arrangements for the exhibit and lecture; to Kate Hartman, Lucy Andrus, and Ulrike Chamberlain for their observations and suggestions; to Rena Reisman for references on the collaborative work of artists and therapists; to Sandy Ticen, Dianne Seger, and Jody Benton for their assistance in photographing the Adamson Collection; to Applied Media Associates, Campos Photography, the University Center for Human Services, and the SUNY State University College at Buffalo for technical advice and assistance; and to the Faculty Student Association and the Creative Arts Therapy Association at the State University College at Buffalo for funding Edward Adamson's visit and lecture at Buffalo.

Rehabfilm
Rental
Catalogue

REHABFILM

Films and video
on every aspect
of disability
that can help you train
professionals, deliver services,
advocate for the disabled, or
educate the public

Rehabfilm, a division of Rehabilitation International, USA, (RIUSA) rents high quality films and videotapes to organizations in North America. These materials have been carefully selected for you from thousands of titles in an evaluation process which began in 1975.

SEND FOR YOUR
CATALOGUE TODAY

Catalogues are available free to RIUSA members and for $5.00 each to nonmembers (deductible from first film order). Write today to: Rehabfilm Catalogue, RIUSA, Box RW, 1123 Broadway, New York, NY 10010.

VIEWPOINTS

__VIEWPOINTS__ provides a forum for sharing ideas and graphics about issues facing art therapists. It also encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit a black and white glossy photograph and four copies of the written material to **Viewpoints**, *ART THERAPY, 1980 Isaac Newton Square, Reston, VA 22090.*

Editor's Note: On October 5-6, 1984, **Janie Rhyne, ATR** *and* **Gary Barlow, ATR**, *were participants in the Michigan Art Therapy Association Conference at Michigan State University, East Lansing, Michigan. Dr. Barlow presented the keynote address "Art Therapy: Assuming a Professional Role," and Dr. Rhyne gave a major presentation on a theory of multiple intelligences. Each spoke to a general theme of "excellence." Both Rhyne and Barlow collaborated to present this information, in condensed form, for* **VIEWPOINTS**.

Our Search for Excellence

Gary C. Barlow, EdD, ATR

All of us are, and should be, concerned with excellence in our profession—as art therapists, in the delivery of services, and at our places of work. In pursuing readings on excellence, with the emphasis aimed specifically toward art therapy and expressive arts therapy, I discovered a "best seller" on excellence in corporate research titled *In Search of Excellence, Lessons from America's Best-Run Companies* by Thomas J. Peters and Robert H. Waterman, Jr. (1982). The authors posed many questions that, although related to large American companies, seemed pertinent for consideration for those of us in art therapy and the expressive arts therapies.

The corporate styles and content were not necessarily easy to translate into art therapy terminology or method, or even style, but many of the strategies posed interesting questions for us. The art of American management was the focus of this book—the authors, for a number of years had been studying corporate excellence—and these large commercial companies were those familiar to all of us: McDonald's, Texas Instruments, International Business Machines, Hewlett-Packard, Xerox, Procter & Gamble, and numerous others. In the study of these corporations the authors focused on what conditions encourage success and what approaches and methods seemed to be key factors in innovation, productivity and goodwill among workers, as well as many other factors.

Data were collected and the standards of excellence were condensed into eight basic principles. Each of these may seem a platitude, but when actually put into practice all together they make for excellence in performance. These basic guiding principles are: 1) A bias for action (a preference for doing something—anything—rather than sending a question through cycles and cycles of analyses and committee reports; 2) [Staying] Close to the customer (learning his/her preferences and catering to them); 3) Autonomy and entrepreneurship (breaking the corporation into small companies and encouraging them to think independently and competitively); 4) Productivity through people (creating in all employees the awareness that their best efforts are essential and that they will share in the rewards of the company's success); 5) Hands-on, value driven [modes] (insisting that executives keep in touch with the firm's essential business); 6) Stick to the knitting (remaining with the business the company knows best); 7) Simple form, lean staff (few administrative layers, few people at the upper levels); and 8) Simultaneous loose-tight properties (fostering a climate where there is dedication to the central values of the company combined with tolerance for all employees who accept those values) (1982, pages 119 ff).

The study of excellent corporations shows that these companies were "brilliant on the basics." As examples, tools didn't substitute for thinking, intellect didn't overpower wisdom, and analysis didn't impede action. Rather, these companies worked to keep things simple in a complex world. They insisted on top quality, and listened to their customers. (1982, page 13)

The basic principles of excellence in business and corporate management might seem simplistic and obvious. In our technological age, we sometimes need reminding that platitudes exist for so long because they sometimes state pragmatic truisms. Nevertheless, as professionals in art therapy and in the expressive therapies, what might we learn from this thought-provoking research on corporate activity and management? "To understand why the excellent companies are so effective in engendering both commitment and regular innovation...we have to take into account the way they deal with...constrictions that are built into human nature." (1982, page 55)

As art therapists we may not often have the luxury of revamping, for example, aspects of facilities where we work, nor do we always have the means to operate in smaller units as is identified in the overall structure of some excellent companies. We might, however, have possibilities presented to us for change in the future. For example, buildings—or parts of buildings—may be restructured in a way that would affect the spatial units within which the art therapy sessions would function. With some reference to space use, and to those effective measures adopted by successful corporations, might the art therapist be able to make some pertinent decisions regarding newer innovative ways that build and enhance excellence, both in process and product?

We should not adopt step-by-step strategies from corporations, because the dissimilarity is too great. However, in our "search for excellence" in all of the intricate aspects of service delivery, art expression, healing potential, communication and the physical structures within which we work, the art therapist *must* play a role in helping to foster a climate for excellence—a climate of productive, creative experiencing and communicating, of learning and sharing.

Reference

Peters, Thomas J. and Waterman, Robert H., Jr. (1982). *In search of excellence, lessons from America's best-run companies.* New York: Warner Books, Inc.

Rhynes's Response

As I admired Gary's presentation, I realized that his ideas and mine might be interactive in pointing out some mundane truths which "everybody knows" but which we lose sight of when we get too far away from our daily people-with-people learning. How would we like to see these principles applied by the people in our organization? As Gary defined each principle, questions were formulated and he suggested that we think about these applications. And think I did! As the slides of art work flashed by, I found that I was making a quick scan of each and wondering if I could recognize what "frame of mind" its creator had represented. I realized that my mind was running on three tracks at once: I was listening to Gary's words, seeing qualities in the visual images, and at the same time, I was making connections between how we can best foster "excellence" in art expression by encouraging each individual both to find and use his or her most naturally given kind of intelligence. It is intriguing, but difficult, to compose a logical treatise synthesizing research from two such supposedly disparate fields as "business management" and "cognitive psychology." But I am working on it, using the kinds of intelligence that seem most natural to me.

Multiple Intelligences

Janie Rhyne, PhD, HLM, ATR

My presentation was planned around ideas from *Frames of Mind: The Theory of Multiple Intelligences* (1983), and I am excited by how relevant Howard Gardner's observations and studies seem to be to the practice of art therapy. The relevance has to do with what we all know when we work directly with our clients, but which we seem to forget when we get all involved in esoteric dialogues that take us away from our more prosaic job of helping people find out what they can do best. We are, I think, in the business of promoting excellence in our clients' functioning. In doing so we must deal with the role of intelligence as a factor in successful performance. Art therapists tend to shy away from open admission that levels of intelligence are of any concern to us. A good reason for our denial is that we recognize that conventional intelligence scoring is, at best, inadequate and, at worst, discriminatory. Along with many others in human services, we know that testing for verbal, mathematical, and analytical abilities does not tap into other kinds of capacities which people use in making sense of experience. A not-so-good reason for art therapists' denial of any interest in intelligence levels is a sort of reverse elitism which discriminates against the kind of thinking that people with high scores in verbal, mathematical and analytical skills are likely to use in their own therapy.

Gardner's ideas of multiple intelligences provide us with a nondiscriminatory way of recognizing and respecting a wide range of intelligences. When we do that, we can bring together in our work an acceptance of the kinds of capacities that are not available to our clients, while we delve into their resources—and our own—for those faculties that can be developed and honed into maximum functioning. For that way of searching for excellence, we are being honest and realistic in admitting that we all live in a competitive world and that our clients want to succeed in it as surely as do those who engage in organizational management.

Gardner's data are gathered from observation and studies of children's play, prodigies, brain-damaged patients, and professional experts in action. He suggests that the multiple forms of intelligence can be mobilized by society to achieve a greater diversity of ends and to fulfill a wider range of social goals. In addition to the linguistic and mathematical intelligences, scored and esteemed as indicants of academic excellence, Gardner proposes five other intelligences: musical, spatial, bodily, and two personal intelli-

AVAILABLE

Continued, page 101

The American Art Therapy Association, Inc.

1980 Isaac Newton Square South   Reston, VA 22090   (703) 476-5437

RESOURCES

The American Art Therapy Association serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA Office.

PUBLICATIONS	Members	Non-Members
Creativity and the Art Therapists' Identity (1976) 118 pages	$3.00	$5.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy Journal of the American Art Therapy Association	.00	$23.00
American Psychiatric Association Special Conference Proceedings Use of the Creative Arts on Therapy (1979)	$3.00	$4.00
National Art Education Association Journal: Special Issue Art Education, Vol 33, No. 4 (1980)	$3.00	$4.00
AATA Newsletter Subscription	.00	$9.00
Full Color Poster (16 x 20)	$1.00	$2.00
Stimulus Drawings and Techniques in Therapy, Development, and Assessment by Rawley A. Silver, EdD, ATR, HLM	$10.00	$14.00
Developing Cognitive and Creative Skills through Art by Rawley A. Silver, EdD, ATR, HLM	$14.00	$20.00

FILMS (Rental/Purchase)			
Art Therapy: Beginnings (1977) 16 mm, color/sound, 45 minutes	Rental:	$30.00	$40.00
	Purchase:	$300.00	$400.00
Michael (1977) 16mm, color/sound, 12 minutes	Rental:	$20.00	$25.00
Art Therapy (1981) 16mm. color/sound. 12 minutes	Rental:	$25.00	$35.00
	Purchase:	$250.00	$325.00
Lori, Art Therapy and Self Discovery (1978) 16mm, color/sound, 32 minutes	Rental:	$30.00	$40.00
	Purchase:	$300.00	$400.00

ORDER FORM Make checks payable to AATA, and mail to the above address.

Indicate Quantity of Unit Items Below   Cost/Unit   Total

______ ( ) × ______ = ______

______ ( ) × ______ = ______

______ ( ) × ______ = ______

______ ( ) × ______ = ______

______ ( ) × ______ = ______

______ = ______

Total Unit Costs = ______

*Postage/Handling = ______

Note: for postage/handling, add $1.50 for the first unit item, $.50 each additional unit. VA Residents add 4% Sales Tax.

Total Enclosed = ______

Proceedings Index (1976-1982)
$1.00 Members $2.00 Non-Members
Set of five Proceedings (consecutive years):
25% discount on total cost (Index:Free)
10 or more copies of any single issue: 15% discount on total cost
Discounts are available when purchasing quantities, as follows:
Set of four Proceedings (consecutive years): 20% discount on total cost (Index: Free)

Send To: ______

______

______

city   state   zip code

BEST COPY AVAILABLE

BRIEF COMMUNICATIONS

This column provides a forum for information exchange among clinicians and educators. Items relevant to research and to programmatic, historical, or clinical developments may be submitted. Contributions should be sent to Brief Communications, ART THERAPY AATA, 1980 Isaac Newton Square, Reston, VA 22090.

Developing Cognitive and Creative Skills Through Art by Rawley Silver, ATR, is no longer in print. However, it may be obtained through The American Art Therapy Association National Office. See "Resources" order form in this issue, p. 86.

The Silver Drawing Test of Cognitive and Creative Skills (reviewed in the March, 1985 issue of ART THERAPY) can be purchased through Slossom Educational Publications, PO Box 280, East Aurora, NY 14052.

* * *

Have you recently seen an exciting new product that you would like to share with other art therapists? Invite the manufacturer to exhibit at the 1985 AATA national conference in New Orleans, October 24-27. Write or call the AATA national office for a brochure for exhibitors: 1980 Isaac Newton Square South, Reston, VA 22090 (703) 437-6012.

* * *

The American Art Therapy Association announces its Second Annual Film Festival under the chair of Cathy Malchiodi, ATR. The AATA Film Festival provides exposure for commercial, amateur and student filmmakers. The goal is to identify and honor quality films and video tapes which explore the field of art therapy through educational, entertaining and creative media presentations. The competition is open to AATA members and nonmembers, and students are particularly encouraged to enter.

Films and videos of exceptional merit will be awarded AATA Certificates; the best overall entry will be awarded a trophy. For more information on the Second Annual AATA Film Festival please contact: Cathy Malchiodi, ATR, AATA Film Festival Chairperson, 45 Kilgore Avenue, Medford, MA 02155 (617) 483-5058.

* * *

Call for Manuscripts

Dr. Shawn McNiff, ATR, and Dr. Gary Barlow, ATR, Editor, are planning an issue of *Art Therapy* focusing on multi-cultural issues and the sharing of international concerns in art therapy. People working in the cross-cultural modalities are invited to send manuscripts, or to submit special features or photographs. For more information, write to the Editor, or to Dr. McNiff, Dean of the Arts Institute, Lesley College, Cambridge, MA 02138.

* * *

The Art Therapy Educators Conference, scheduled for March 22-24, 1985, was postponed. However, it is being planned for 1986. Watch for details.

Guidelines for Authors

Please submit four (4) copies of manuscripts to: AATA Journal, 1980 Isaac Newton Square South, Reston, VA 22090. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

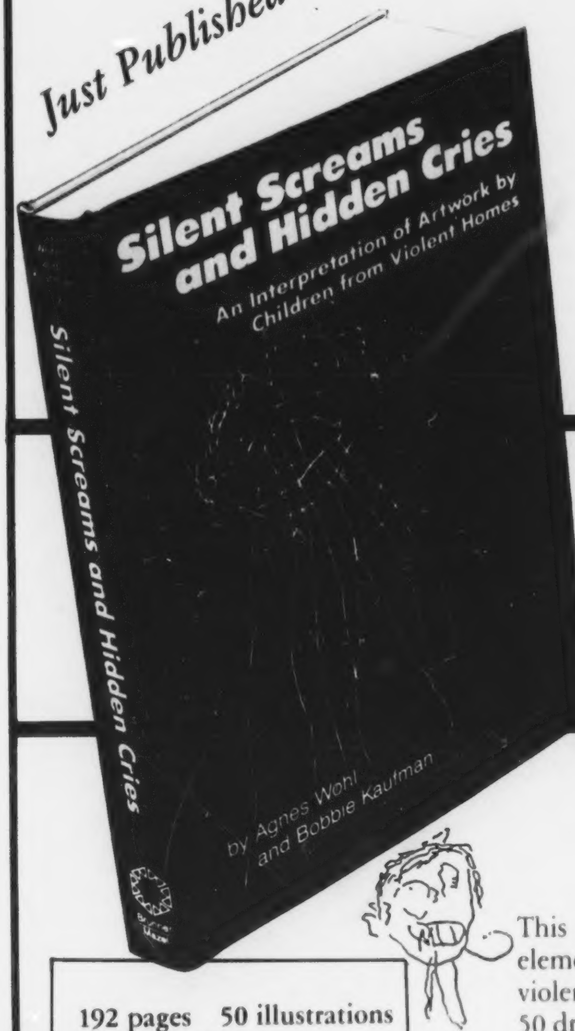
FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

Just Published


Silent Screams and Hidden Cries
An Interpretation of Artwork by Children from Violent Homes
by Agnes Wohl and Bobbie Kaufman
Silent Screams and Hidden Cries

"The authors have performed a most valuable service in showing how the drawings reflect the damage to the child's developing personality and in indicating measures to heal and restore, and to break the cycle that tends to perpetuate destructive, barbaric behavior."

—JOSEPH H. DI LEO, M.D.

SILENT SCREAMS AND HIDDEN CRIES: An Interpretation of Artwork by Children from Violent Homes

By Agnes Wohl, C.S.W., A.C.S.W., &
Bobbie Kaufman, M.P.S., A.T.R.
(under the auspices of the Coalition for Abused Women, Inc.)

This poignant volume is the first study of drawings of elementary school children who have witnessed domestic violence or have been themselves victims of violence. The 50 drawings project the children's emotional disturbances and alert the therapist to their feelings of helplessness, fragmentation, depression, anger, and anxiety. As a result, the helping professional is better able to define the therapeutic task and to "heal and restore."

192 pages 50 illustrations
LCN 85-6652
$25.00 list
First Press only $21.95

Send to: **BRUNNER/MAZEL Publishers 19 Union Square, New York, New York 10003**
ATW

☐ Yes, please send me __________ copy/copies of SILENT SCREAMS AND HIDDEN CRIES (Wohl) at the First Press saving of $21.95 ($25.00 list). *I understand that any book may be returned within 30 days for a full refund.*

Name ______________________________

Address ______________________________

City ______________ State __________ Zip __________

$____________ enclosed (Please add $1.75 postage and shipping for one book, 50¢ for each additional book. *(N.Y.C. residents please add 8¼%; N.Y. State 4% plus applicable local tax.)*

(or) Charge my
☐ American Express ☐ Mastercard ☐ Visa

Account No. ______________________________

Expires __________ Signature ______________________________

REVIEWS

Book Reviews

Art and Mainstreaming (Art Instruction for Exceptional Children in Regular School Classes)

Claire B. Clements and Robert D. Clements, Springfield, IL: Charles C. Thomas, 1984
(171 pages with over 70 black and white photographs ad illustrations) $17.50.

Reviewer **Virginia Minar, ATR** *is an art exceptional education teacher/therapist with the School District of West Allis-West Milwaukee, West Allis, Wisconsin, and an art therapy instructor at Alverno College, Milwaukee, Wisconsin. She is also a member of the Education Committee of the American Art Therapy Association.*

Early in 1975, a National Art Education Association Mini-Conference on "Art Education and Special Education" was held in Chicago. The Reports of that conference were published in a special issue of *Art Education* (1975, 28(8)). Although most of the presenters and participants were providing art experiences to handicapped children, there was at that time very little published material on the subject. Since then, numerous articles and books have appeared in print.

Because so many school districts use the art class for mainstreaming, the subject needed to be addressed. I therefore looked forward to reviewing *Art and Mainstreaming by Claire B. Clements, Associate Professor of Education of Exceptional Children, Georgia Retardation Center, a University Affiliated Program, University of Georgia; and Robert D. Clements, Professor of Art Education, Department of Art, University of Georgia.*

The issue of mainstreaming in art should deal with: 1) the exceptionalities of those students being mainstreamed; 2) the other students in the art class; 3) the art educator receiving those students; and 4) the purpose of the mainstreaming. In regard to the first item, the authors present individual chapters on all of the handicapping conditions defined in P.L. 94-142 except "speech impaired," with an additional chapter on art for gifted children. These chapters serve as an introduction to the various kinds of handicapping conditions that an art teacher might need to be familiar with. It should be understood that each child is unique and that all descriptors do not necessarily fit. Art teachers interested in learning more about specific exceptionalities would need to read other in-depth coverage.

The first chapter, "Art for the Behavior-Disordered," is the most extensive coverage of a handicapping condition. The authors describe a behavior management program, using art terms and art-related contingencies. The material presented is well-written and would be useful to the art educator serving this population. It would be advisable, however, to discuss any system one wishes to use with the classroom teacher, to see if it is consistent with the one he/she is using. Also, in the years I have been serving emotionally disturbed children, I have used some of the techniques the authors describe, but not always with the same results. One needs to remember that what works for one student, may not work for another; and that what works well one time may "bomb" the next. The readers need to take the Clements' detailed and knowledgeable suggestions, and then adapt them to their own situations.

The second issue that needs to be addressed pertains to the attitudes and feelings of the other students in the class. The authors do not discuss preparation of the regular students prior to mainstreaming. Mary E. Scott, in her article, "The Real Issue of Mainstreaming: The Education of the Nonhandicapped" (1982) touches on some of the problems and gives a number of suggested activities. These authors, however, do not deal with questions like: 1) How does a regular student become a "buddy?"; 2) Does he volunteer? Does the teacher interview people or does he/she just assign those he/she thinks would do a good job?; 3) If the students are helping others, when do they do their own work?; 4) Do they resent the disproportionate time the teacher spends with the exceptional students?; and 5) How do you handle negativism?

The authors have covered the various disabilities well enough to give art teachers some understanding of the handicapped student's special needs and how to meet them. They do not, however, adequately address the third issue: the needs of the art educator receiving the mainstreamed students. How does the art educator—who may be teaching 5 to 6 classes per day, 25 to 30 classes per week—find the time to institute these services, which include preparing lesson plans for the mainstreamed students as well as for the regular students?

The authors repeatedly advise different projects for and different handling of the exceptional children. They do not suggest, however, how many children could comfortably be mainstreamed into one class. If mainstreaming does occur, shouldn't some kind of "weighting" be followed to make it workable? For example, in a class of 25, one might suggest that no more than two or three studets, depending upon the disability, should be mainstreamed. The authors also do not address the extra time needed for staffings, or for the art teacher's written contributions to each handicapped child's Individualized Education Program as required under P.L. 94-142.

The fourth issue is the purpose of the mainstreaming. If it is mainly socialization, then mainstreaming in art might accomplish that purpose, if the regular students are properly prepared. When a handicapped student is academically at grade level, then mainstreaming should certainly occur, except where behavior is so disruptive that the entire class is adversely affected. If the exceptional education student would learn better in a self-contained art class, however, then mainstreaming should not occur. In the school district where I am employed, students are mainstreamed into regular art class only after staffings, and/or on the recommendation of one of the two art/exceptional education teacher/therapists. P.L. 94-142 mandates that education take place in the "least restrictive environment." A key word is "education." If mainstreaming does not enable the exceptional education student to show academic, motoric, or emotional growth, then "education" is not occurring.

After reading the book, it is apparent that the authors are concerned with providing meaningful art experiences for all handicapped children. In combining their knowledge and experience, they have sensitively produced a usable beginning work. Readers should be aware that the material they have developed was used successfully at the Georgia Retardation Center, and by student teachers under their supervision working in mainstreamed art classes.

There are two instances, however, where the authors give suggestions for eliciting verbal responses from the students about their art work, which seem to me to be closer to art therapy than to art education. The first one is in the chapter dealing with the emotionally-disturbed student:

> The teacher can encourage the withdrawn student to express his thoughts and feelings through art, by saying to him, "I'm interested in how you feel about this picture." By talking about what he sees in art reproductions and his feelings toward those subjects depicted, the student learns that his feelings are okay. Sometimes it is easier for him to draw his ideas than to talk about them; the teacher might say, "Some things happen that are so important that it's hard to talk about them. Can you show me kind of what it's like in a picture?" In developing this student's ability to talk about his art to his classmates, it is most important that first the teacher, then the more verbal students, demonstrate the kind of verbal response considered acceptable. (p. 23)

There are several problems with using this approach in a regular classroom. The first is that the material seen or depicted in a picture may be very personal, and perhaps inappropriate for a classroom setting. The second is that the material may trigger emotional responses in that child or others that the art teacher, who is not trained in therapeutic techniques, might not be able to handle.

The second instance occurs in the chapter dealing with trainable mentally retarded students:

> Children for whom night toilet training is a problem could, with a little water poured on their clay creation, act out the sorrow and parental scoldings of bed-wetting and the praise of getting up in the night to go to the bathroom. Thus, for the TMR child, art can provide a way to work through some of the problems connected with daily living. (p. 55)

One concern about using this approach with mainstreamed TMRs is that the other children might make fun of the activity or the discussion. It is, however, a rather clever technique which could be used by an art therapist easily in a one-to-one relationship, and possibly with a group, if all members are experiencing the same problem.

A joint conference of the National Art Education Association and the American Art Therapy Association, through the support of the National Committee Arts for the Handicapped, took place in August of 1980. At that conference some of these same issues and many others were considered by the participants. Recommendations were made for future directions and further dialogue. Through cntinued effort by all parties, art for the disabled should finally be recognized as an important element of their lives. Not only art for all the children, but art for all the people, is beginning to become a reality. There has been considerable progress since the NAEA Mini-Conference of 1975.

Although I have raised a number of points for consideration, I do feel *Art and Mainstreaming* would be a worthwhile addition to any library on art in exceptional education. The Clements"s work reflects expertise in their areas of specialization. The procedures they detail are certainly workable in self-contained groups, and are worth trying with exceptional children who are mainstreamed in the regular art class. It is one thing to develop methods and techniques that work in a controlled setting like the Georgia Retardation Center, or in supervising student teachers who utilize the procedures during their short-term practicums; but quite another to carry them out day-after-day, year-after-year, in mainstreamed art classes in public schools. The authors are to be commended for their dedication and their work with exceptional children, and for writing a usable methods book on art in exceptional education.

References

Mahlmann, J. J. and others (1980). *Art in the lives of persons with special needs,* Proceedings of a joint conference of NAEA and AATA. Washington, DC: The National Committee, Arts for the Handicapped.

Scott, M. E. (1982). "The real issue of mainstreaming: The education of the non-handicapped." *Kappa Delta Pi RECORD,* 19(1): 17-20.

Obtaining Funds for Therapeutic Recreation and the Creative Arts Therapies

Peter J. Verhoven and Donald E. Hawkins, Washington, D.C.: Hawkins and Associates, Inc., 1981

Reviewer ***Harriet Wadeson, PhD, ATR*** *is Director of the Graduate Art Therapy Department, University of Illinois, Chicago, Illinois, and is VIEWPOINTS Editor for* **Art Therapy**.

The cover of this handbook states that it is "a manual for therapeutic recreation personnel, and music, art, psychodrama and dance therapies." As an art therapist myself I am all too aware that my skills and interests, and those of many of my colleagues, reside in clinical realms, and that few of us would consider ourselves "business people." And yet in these days of shrinking (or already shrunken) budgets, we find ourselves needing to attract and administer funding from external sources.

This "workbook" describes itself as "designed for individuals involved in planning and directing programs of recreation or creative arts for special populations" and "faculty...involved in research or... professional preparation curricula or in service and continuous education in...recreation for special populations or the creative arts therapies." It promises to "help you learn...about writing a proposal for funding,...evaluating your potential for getting grants and contracts, open your eyes to...types of grant assistance available,...types of agencies in the 'funding business,' and hone your skills in the 'positive politics' of grantsmanship." As I am getting ready to look into grant support for art therapy training, service and research, I figured the book was written for me. It was with eager anticipation, therefore, that I opened its cover.

The Introduction presented me with a confusion of definitions about types of federal assistance, differences between grants and contracts and types of proposals. This section seems misplaced. A more appropriate beginning would be the first steps in seeking funding. Hard on the heels of this section are sample forms and instructions that are difficult to read because of the poor quality of their reproductions. The clearer ones, however, do give a sense of the amount of effort required to write a grant proposal.

If the reader is able to get past these initial obstacles, there is useful information sprinkled throughout the rest of the book. This includes references to funding sources, tips about proposal writing, a checklist of information to obtain about the funding agency to which one is applying, a timetable for proposal development, milestone charts, budget estimating pointers, criteria employed by grant reviewing boards, and sample forms they use for evaluation of proposals.

These are the areas where the book is most helpful. For example, under "Tips on How to Write Grant Proposals," there are concrete suggestions, such as "Keep your paragraphs short, and only present one thought per paragraph." "If you have trouble getting started, begin with the budget. Money has a strange way of defining our methods and objectives." An example of the 15 items on the checklist of information to obtain about the funding agency before writing the proposal is: "What is the length of time over which a project may run? Is it fiscal year to fiscal year?"

On the other hand, the book is less useful in its presentation of the obvious, for example, the several places where it emphasizes following the funding agency's directions in writing the proposal. Also, its myriad reproductions of forms, regulations, and directions are redundant.

Upon completion of the book I found myself puzzled as to why it is directed toward recreation and arts therapists. Except for some initial examples of relevant grants awarded, some sample application forms and regulations for grants in this general area, and an appendix of foundations that support the handicapped, the book focused on "grantsmanship" in general. On the other hand, the authors limited themselves primarily to public monies with a disclaimer that grant-writing is the same regardless of the funding source. In my limited experience, I have learned of private sources that request little more than a budget and a descriptive letter, compared to the elaborate documentation required by NIH, for example.

It seems to me that *Obtaining Funds* is most useful as a reference, rather than as an instrument for learning "grantsmanship" as it purports to be. A grant-seeker might refer to it initially for references to directories of funding sources and utilize its pointers and checklists for evaluating a project's "fundability," for obtaining information to help gear a proposal toward an agency's manner of funding, for estimating a budget, and for tips on proposal writing and criteria on which proposals are reviewed. Though hardly the solution to the recreation and art therapist's funding needs, *Obtaining Funds* provides some helpful hints.

Reprinted with permission from *Residential Group care and Treatment, 2* (3). New York, the Hayworth Press, Inc., Spring 1984.

The Artist in Each of Us

Florence Cane, Craftsbury Common, VT: Art Therapy Publications, 1983
(370 pages)

Reviewer ***Helen B. Landgarten, MA, HLM, ATR*** *is Professor and Director of the Clinical Art Therapy Master's Degree program at Loyola Marymount University in Los Angeles. She is also the Coordinator of Art Psychotherapy at the Cedar-Sinai Medical Center, in the Thalians Mental Health Out-Patient Division. Landgarten authored the book,* **Clinical Art Therapy: A Comprehensive Guide** *(Brunner/Mazel, 1981).*

The readers of this review will fall into two categories: those who are reacquainting themselves with *The Artist in Each of Us*, and persons new to art therapy, who will be experiencing this book for the first time.

To fully appreciate Florence Cane's book one must view it in a historical perspective. In 1951, the author's contribution to art education was, and still is, innovative, sensitive and therapeutic. Many art therapists who work within the art-as-therapy framework claim Florence Cane as the founding mother of their approach. The last segment of this book is devoted to describing "The Healing Quality of Art."

The Artist in Each of Us was a pioneering and fascinating publication for art educators and therapists in the fifties and sixties. Now, some thirty years after the book first appeared, the approach is no longer innovative; but more importantly, it does present itself as a *tried and true current piece of literature*, a reflection of the lasting value of Florence Cane's work. She was certainly an influential person who helped to lay the foundations of our profession.

The newly revised paperback edition of *The Artist in Each of Us* is beautifully presented, with 23 color plates and 166 illustrations in black and white. The book is divided into four parts: Theory, Method, Practice, and the Healing Quality of Art. The theoretical segment addresses the creative process, the conditions which stimulate creativity, and the integration of the person through the art experience. This particular section of the book may prove to hold the least amount of interest for art therapist, whereas the later chapters may prove to be progressively more interesting and involving.

Part II is devoted to Cane's METHOD. In it she tells about what she called the "Release of Creative Faculty Through Basic Experience of the Body." She describes techniques for developing the kinesthetic sense, and offers specific movements to liberate expression. The author expresses her belief that large movements in drawings release images from the mind, and thereby stimulate the creative process. In addition, she offers the reader step-by-step exercises which include the purpose for each activity. A segment on the "scribble" is especially worthwhile. Although many art therapists have integrated this particular technique into their own repertoires, they may be unaware that Florence Cane was its originator.

Methods also include "Release of the Creative Faculty Through Basic Experiences of Feeling" as well as what she calls the "Psychological Approach." The vignettes included illustrate the ways in which Cane solved specific problems with a variety of individual students. Here one begins to get a sense of the beauty in Florence Cane, as well as the inventive and energetic aspects of her personality.

"Awakening of the Imagination" is additionally related to Cane's methodology. A parallel to the Jungian approach to "active imagination" is seen. The history of a depressed girl whose unconscious drawings dealt with her inner struggles and conflicts is described. The art enabled the student to gain insight, which furthered her developmental growth. In contrast, the chapter on "The Training of Observation, Recollection, and Perception," depicts a process which is automatically created by any artist. However, Cane is to be commended for putting it into a cognitive perspective.

This reviewer found the chapter on "The Growth of Form and Design" to be of greatest interest. It presented the normal progression of a child's pictorial development through form and design. Cane also delineates ways in which the teacher can bring out the child's intuitive potential.

Part Three, which refers to PRACTICE, is divided into two segments, the Child and the Adult. Five case histories are delineated; they were gathered while the author acted as a consultant to the Counseling Centre for Gifted Children at New York University. One value of these cases lies in the extensive longitudinal data presented. One child's pictures are recorded from the ages of four through twelve; another example includes work created from age six through sixteen; and a third person's work is from the twelfth through the twentieth year. In the last account, where the girl goes through her adolescence, the issues of this stage of development are addressed and pictorial interpretations are made. The author strives to bridge the gap of feeling and expression, in order to help the adolescent through the insecurities indigenous to the particular phase of her life.

These chapters are lightly sprinkled with additional techniques for helping her students achieve a freer and more productive approach to art. Cane also introduces a spiritual element, reading the Old Testament to her students to stimulate creative ideas. The Jungian approach, which evidently influenced Florence Cane, also integrates the spiritual side of the individual.

In spite of the brevity of the "adult" section of the book, this segment deals with four students whose ages range from late adolescence to early adulthood. One case involves overcoming a creative block. Another portrays Cane's success in helping an older woman bring art into her life. Yet another individual demonstrates the integration of art as a symbol for beginning a new life style. In addition, there is an illustration of a male student, who was directed into utilizing his creativity for professional purposes.

The last sixty pages of the book deal with "The Healing Quality of Art." This fourth part of the book is dedicated to "A Modern Psychotherapy." It contains a vignette on the way in which art, creativity, and increased self-esteem helped a shy child to interact with peers. Cane offers the reader fresh and updated interpretations of the drawings throughout the child's development. Her inventiveness brings a new dimension to the therapeutic aspects of art.

Patients were sent to Florence Cane for the purpose of drawing from the unconscious, for the presumed healing effects of this approach. Referrals came from physicians and analysts. This was a collaborative effort, with Cane as the creative teacher who perceived the meaning of her pupil's work, yet left the analysis to the psychiatrist. She claimed the only difference between the referred individuals and other students was "that the emphasis is placed on their expression of fantasy with a minimum of time spent on technical proficiency." The book has several examples which are described lesson by lesson. One reads about the persons, who delved into their past. The author writes about the working process and the outcome which held a brighter future.

Cane's last chapter is entitled: "Mario—Renewal through New Use of Breath and Sound." She claimed "it offers the most dramatic illustration of the value and influence of art in the development of the child." It describes a very talented boy who creates art for a period of nine years. The reader sees the initial sketches which were drawn at the age of nine, accompanied by a series of pictures created in different years. The last sketch shows the student's physical and artistic maturity. In this final case, the point the author makes is that Mario did not use his art to escape from life. Rather, he created art in which he "found new health in body, soul, and mind." I found statements such as this one rather grandiose. Nevertheless, many readers may find them consonant with their own therapeutic beliefs.

The Artist in Each of Us holds historical value. This book, that was out of print for many years, deserves to be read. Art educators and art therapists who seek an understanding of the key contributors to their professions will be pleased to acquaint themselves with Florence Cane and her innovative work.

Inpatient Group Therapy

Irvin Yalom, New York: Basic Books, 1983
(350 pages, $16.95)

Reviewer ***Kathleen Mileski Hanes, ATR*** *is Clinical Instructor in Art Therapy at Trenton State College, Art Therapist at St. Francis Medical Center, Dept. of Psychiatry, and the author of* **Art Therapy and Group Work: An Annotated Bibliography,** Greenwood Press, Westport, CT, 1982.

Irvin Yalom, psychiatrist and author of the landmark text on long-term groups (*The Theory and Practice of Group Psychotherapy,* 1976), now offers a much-needed book about short-term, inpatient group therapy. His audience is "the front line clinician—the harried mental health professional who leads groups amidst the tumult often found on the acute psychiatric ward" (p. x.). One senses that Yalom knows the unit only too well, with its frantic pace, problems with turnover, conflicts among disciplines, and misunderstandings about the value and goals of group work. Yalom, in fact, visited 25 training units, each with 15 to 35 beds, interviewing the staff and observing group therapy sessions. He draws from these visits, as well as from his personal clinical experience and vast knowledge of the research literature. The creative arts therapist may take issue with the lack of attention Yalom gives to expressive groups, or to page 311 where he refers to "activities that call for *indirect expression* [italics mine] such as art, writing, or movement." Yalom, however, delimits his task in the Preface: "I focus exclusively...upon the central, indispensible ingredient of the inpatient group therapy program: the daily 'talking' group" (p. xiii). He does not discuss groups for patients with special programs or diagnosis. Rather, he describes the *generic verbal therapy group,* and carefully delineates how to operate such a group in order to implement goals he believes to be germane to this special setting.

Yalom is careful to point out that his goals for group practice are not identical to those for inpatient hospitalization. He believes it is important (1) to engage the patient in the therapy process and obtain a commitment to outpatient follow-up; (2) to encourage patients in the belief that "talking helps," and that life experience and feelings are often shared by others; (3) to assist patients in identifying their personal problems in relating to others; and (4) to alleviate anxieties about hospitalization. In discussing this last goal, the psycho-ecology of the milieu itself is addressed, with stresses on the staff understood as potential sources of disruption to the patient group (and vice-versa). Art therapists will probably recall the writings on moral groups by Harris & Joseph (1973) or Brown (1976) that document such interactions.

Strategies for assigning patients to groups are described, with advantages and disadvantages of various approaches carefully spelled out. Yalom favors the "levels" approach, with the "focus" group designed for patients who are the most disorganized. Such groups have mandatory attendance and meet for about 45 minutes. Leaders are responsible for the judicious selection of themes and methods, and are urged to offer "support, support, support." Among the techniques mentioned are several graphic tasks; many others are readily adaptable to graphic or plastic media. The "curative factors" of catharsis, universality, altruism, and cohesiveness (Yalom, 1976) are said to be especially salient in a focus group. In higher level groups, meeting for up to 75 minutes, interpersonal learning and self-understanding are most relevant. For all groups, Yalom stresses the importance of boundaries and of operating sessions with a firm sense of beginning, middle, and end.

Strategies and techniques of leadership are covered in chapters three and four, describing how the group leader can deal with common issues such as the expression of anger, leader transparency, giving and encouraging feedback, focusing on the here-and-now, etc. The final two chapters outline specific procedures for both the higher and lower level groups. Clinical vignettes are employed to exemplify and amplify premises and techniques, and deserve careful reading. Yalom focuses on the single session and does so in detail, devoting less attention to the flow of affect and of "basic assumptions" throughout the week or month. These, too, need attention when describing group work on an inpatient unit.

It is important to step back from the text long enough to ponder the theoretical base from which this particular helping model emanates. Yalom identifies himself with the "existential" school of psychology (Corsini, 1984). Hence, he would operate from a "compensatory model," according to the four generic helping/coping paradigms defined by Brickman et al. (1983). In this model, patients are felt to suffer from conditions imposed by their environments (they are "thrown into the world" so to speak), and must assert themselves in order to create their own futures. In subscribing to the compensatory model a helper says, in effect, "I am your temporary servant. How may I help you?"

In the "medical model," in contrast, a helper says in effect, "Do what I suggest." Patients are not felt to be responsible for their condition or their cure. In the other two models, patients *are* seen as responsible for their presenting condition, but the locus of responsibility for cure differs in each instance. In the "Moral model" (associated with Albert Ellis' RET and est groups), the *patient* is held accountable for future actions or "cure." In the "enlightenment model" (associated with therapeutic communities and Alcoholics Anonymous), the helping group or individual *practitioner* is the locus of responsibility.

One would like to hear more from Yalom himself on the theoretical framework he offers, its inherent values and its ramifications. For example, what are some of the problems in using the compensatory model he seems to describe? Is it differentially effective with various social classes, ethnic groups or diagnostic categories? What are the possibilities of potential staff burnout using the Yalom model? If patients are seen as responsible for their futures, would staff be willing to view the continually readmitted patient as somehow not responsible for his/her condition? What is Yalom's understanding of how his model contrasts with other models? While the text is primarily a manual of practice, this does not eliminate responsibility for framing the work within theory and value systems.

Finally, how might the art therapist benefit from this highly recommended book? First, the therapist might present the text to his/her staff for consideration. Secondly, the generic principles of leadership delineated in the text translate readily to the expressive therapies. Problems discussed range from basic gatekeeping functions to the timing and "dosage" of interventions. Certainly, these are problems faced by every art therapist (cf. Shoemaker & Smith, 1984). Yalom offers a clear "agenda"—even a "prescription"—for operating verbal groups. While the gestalt or phenomenological art therapist might be at home with some of these practices, the analytic or nondirective art therapist would probably be less comfortable with Yalom's active here-and-now style. Also, the therapist committed to art-as-therapy or the evolution of personal symbol systems may have difficulty working within Yalom's frame, or even adapting to the contemporary short-term treatment setting. These matters bear further discussion within the field of art therapy.

Carol Beighley Paraskevas (1979) is one of the few art therapists who has published on combining art with verbal therapy on a short-term unit. In addition, Linda Gantt (1979) has designed special projects for short-term remediation of ego diffusions, and Pat Allen (1983) has described the evolution of her treatment approaches in short-term hospital settings. Cohn and Tuder (1978) reported on a specially designed group problem-solving approach at an early AATA conference, and Francis F. Kaplan (1984) spoke recently on the benefits of combined verbal and art therapy. Mary Ann Blank (1984) spoke at the last AATA conference on utilizing Yalom's approach, but did not deal with how the art group related to other groups on the unit. This is essential if Yalom's latest work is to be utilized within the field of art therapy.

It will be the task of all art therapists to develop short-term strategies and goals, as well as to define viable complementary services. Short-term hospitalization is here to stay, and Yalom offers a humane method for coping with this situation. His is a voice of experience and authority, and one hopes that his approach will be adopted by many enlightened units. Finding ways to "go with the flow" on such units will be essential.

References

Allen, P.B. (1983). Group art therapy in short-term hospital settings. *American Journal of Art Therapy, 22*, 93-95.

Blank, M.A. (1984). The clinical application of art therapy: Its contribution to a short-term psychiatric setting. Paper, American Art Therapy Conference, Washington, D.C.

Brickman, P., Rabinowitz, V., Karuza, J., Coates, D. & Kidder, L. (1983). Models of helping and coping. *American Psychologist, 37*, 368-384.

Brown, J.J. (1976). The closing of a day care center: Conflict resolution through the group mural. *Art Psychotherapy, 3*, 11-16.

Cohn, L. & Tuder, E. (1978). Individual problem solving: A group art therapy technique. In B. Mandel, R. Shoemaker, & R. Hayes (Eds.), *Dynamics of Creativity*. Baltimore, MD: American Art Therapy Association.

Corsini, R. (1984). *Current psychotherapies*. Itasca,IL: F.E. Peacock Publishers, Inc., 3rd ed.

Gantt, L. (1979). The other side of art therapy. *American Journal of Art Therapy, 19*, 11-18.

Harris, J. & Joseph, C. (1973). *Murals of the mind*. New York: International Universities Press.

Kaplan, F.F. (1984). Combining art and verbal therapy. Paper, Trenton State College Art Therapy Conference, Trenton, NJ.

Paraskevas, C.B. (1979). *A structural approach to art therapy methods*. New York: Collegium Book Publishers, Inc.

Shoemaker, R. & Smith, B. (1984). To interpret or not to interpret? That is the question. Presentation, American Art Therapy Association Conference, Washington, D.C.

Yalom, I. (1976). *The theory and practice of group psychotherapy*. New York: Basic Books.

Self-Growth in Families, Kinetic Drawings (K-F-D): Research and Application

Robert C. Burns, New York: Brunner/Mazel, 1982

Reviewer ***Mari Fleming, ATR, MFCC****, is an art therapist currently working in the eating disorders unit at Marshall Hale Hospital in San Francisco, and teaching at both the College of Notre Dame and Sacramento State University, in California.*

"Aside from studies by Reznikoff (1956) and Shearn and Russell (1969) no other reports of the D-A-F (Draw-a-Family test) could be found in the literature. Hammer (1958), Koppitz (1968), and Di Leo (1974) discuss the use of D-A-F." (1982, p. 63)

So writes Burns, an author who, with Kaufman, is referred to by many art therapists and used by them as a valuable resource. Yet he seems not to have heard of art therapy as a field, nor to be aware of those who have worked with families using art. True, art therapists do not write of the "Draw-A-Family *test*," but it is regrettable that a researcher who uses family drawings is unfamiliar with the work of Kwiatkowska (1962, 1967, 1978), Rubin (1974, 1978), and Wadeson (1973). When Burns and Kaufman first published their work on Kinetic Family Drawings (K-F-D) in 1970 and 1972, such an omission was understandable.

The current volume, however, published in an era of computer access and library search, has less of an excuse. In fact, what seems extraordinary is the inclusion of a reference to Betty Edwards, art educator/author of *Drawing on the Right Side of the Brain*. Although Dr. Edwards' work does not deal with children, families, family drawings, or assessment, she and/or her publisher are apparently possessed of enviable merchandising skills!

Putting my frustration and parochialism aside, however, I recommend this as a useful and thought-provoking book for art therapists. In their first text (1970) Burns and Kaufman described their Kinetic Family Drawing Test (K-F-D), presenting the thesis that "in drawing every member of his family doing something, the subject reveals a great deal more about himself than in the simpler and more conventional task of drawing a family." (1982, p. 7). The second volume (1972) provided the authors' interpretations at a symbolic level for commonly-depicted objects, different styles, and common themes in K-F-Ds.

The current volume summarizes the use of the K-F-D, and seeks to demonstrate its use as a scientific tool, including a research manual, scoring criteria and instructions for judging, with a projection of computer quantification and handling of data. This section offers stimulating ideas about how to accomplish the very difficult task of objectively evaluating drawings. The suggestion of a superimposed grid, for example, is a direction researchers in art therapy might well consider. I also found myself thinking of the ways in which children compose color, line, and form on computers, as they learn to manipulate this new technology. Could the *process* be tabulated and quantified as well as the final form?

Yet this is the kind of question only the art therapist seems to ask. The protocol for the K-F-D requires the examiner to state the instructions, and then to leave the room and check back periodically. "The situation is terminated when the subject indicates verbally or by gesture that he/she is finished." (1982,

p. 68) If the child is not observed drawing, is the process inferred from the work itself? The criteria for scoring include actions, figure characteristics, position, distance, barriers, styles, etc. "Style" is related to "compartmentalization, edging, encapsulation, folding, underlining, and bird's eye view." (p. 72) In none of these are line quality, degree of pressure, order of drawing, or the child's affect considered. Color is mentioned only briefly, in one case history, with no discussion of the possible meanings of color usage in drawings.

This way of looking at art contrasts sharply with that of Rubin, who suggests that "the process is as revealing as the decision-making that preceded it." (1978, p.65) It is also different from that of Kwiatkowska (1978), who emphasizes the value of observing the process, and of having the drawing take place within the family group. As an art therapist who has used both the Kwiatkowska and Rubin family evaluations, and taught and supervised their use, I believe my evaluation and treatment would suffer by omission of the data on art process and family interaction. My training in making art and using art in therapy, as well as my training as a family therapist in viewing the family as a system, insist that I observe context as well as content.

Burns states the K-F-D is significant for its reflection of the self within the family context. He conjectures that the K-F-D is the *nuclear self*, "the self shaped in the early years of family life." (p. 17) He contrasts this with D-A-P (Draw-A-Person), "an expression of the self in the environment" (p. 17), i.e. the *environmental self* which he states is similar to the person obtained by the House-Tree-Person technique. The material contrasting a child's D-A-P self and the self in the K-F-D is among the most interesting in the book. In the troubled families shown, the K-F-D-S (Kinetic Family Drawing Self) is markedly less mature or more disturbed, fragmented or incomplete than the D-A-P self or the D-A-F self. Burns provides a useful way of looking at this contrast: seeing the drawings as reflecting the child as he is inside the family, vs. his reflection in the context of the outside world.

This is a fertile area for further inquiry, and Burns presents material demonstrating how such contrasting data can be used to help determine custody and foster placement. Others have also sought contrasting methods of picturing the family as a way to obtain fuller information. Kwiatkowska, for example, contrasts the picture of the family with an abstract family portrait. Rubin describes having the family draw the main problem in the family.

Burns also focuses on the process of identification, the internalization of the feelings and values of parental figures, and the role of pictured identification in evaluating the child. This material can provide validation of a change in the K-F-D self following treatment or more appropriate placement. Art therapists have observed similar changes in drawings, and can learn from this sustained and systematic procedure another means of evaluating the efficacy of treatment.

The book also includes an Appendix, which brings together and summarizes general hypotheses regarding the variables used in human figure drawings. Burns adds an additional "style"—the "bird's eye view"—and discusses the moon as a symbol. Burns states the moon is "almost always masculine" (p. 174), and all his examples stress the "high frequency of morbid moon fascination in children with unrequited love for a parent, usually the father." (p. 174) His examples are not totally convincing to this reviewer, since two pictures reflect loss of a mother's nurturing equally well.

In viewing and evaluating pictures and symbols according to Burns, the art therapist needs to keep in mind that this is a research procedure. The novice may be seduced by a dramatic procedure and readily available interpretations, without annoying and confusing variables like "How" and "In what order" and "What was said." Most art therapists are aware of the necessity for viewing symbols within a cultural and personal context, emphasizing the artist as the authority for the meaning of his own work.

In his Introduction, Burns states the theory: "K-F-Ds have a special language telling us a great deal about family interactions, if we speak the language. Most of us are visually illiterate, however..." (p. 3) He suggests that all those interested in human figure drawing analysis should learn to draw people. That is, in order to truly see, we must have experienced the processes of drawing. The art therapist's contribution to the use of art in measurement and evaluation can be a major one, insisting that such evaluation consider process as well as product. Perhaps this text and its careful methodology will inspire productive investigation of this additional factor.

References

Burns, R.C. and Kaufman, S.H. (1970). *Kinetic Family Drawings (KFD): An introduction to understanding children through kinetic drawings.* New York: Brunner/Mazel.

Burns, R.C. and Kaufman, S.H. (1972). *Actions, styles and symbols in Kinetic Family Drawings (K-F-D): an interpretative manual.* New York: Brunner/Mazel.

Di Leo, J.H. (1974). *Children's drawings as diagnostic aids.* New York: Brunner/Mazel.

Hammer, E.F. (Ed.). (1958). *The clinical application of projective drawings.* Springfield, IL: Charles C. Thomas.

Koppitz, E.M. (1968). *Psychological evaluation of children's human figure drawings.* New York: Grune and Stratton.

Kwiatkowska, H.Y. (1962). Family art therapy: Experiments with a new technique. *Bulletin of Art Therapy, 1,* 3-15.

Kwiatkowska, H.Y. (1967). Family art therapy. *Family Process, 6,* 37-55.

Kwiatkowska, H.Y. (1978). *Family therapy and evaluation through art.* Springfield, IL: Charles C. Thomas.

Reznikoff, M., and Reznikoff, H.R. (1956). The family drawing test: A comparative study of children's drawings. *Journal of Clinical Psychology, 12,* 167-169.

Rubin, J.A. (1978). *Child art therapy: Understanding and helping children grow through art.* New York: Van Nostrand Reinhold.

Rubin, J.A. and Magnussen, M.G. (1974). A family art evaluation. *Family Process, 12,* 185-200.

Shearn, P.R. and Russell, K.R. (1969). Use of the family drawing as a technique for studying parent-child interaction. *Journal of Projective Techniques, 33,* 35-44.

Wadeson, H.S. (1973). Art techniques used in conjoint marital therapy. *American Journal of Art Therapy, 12,* 147-164. .

Normal and Anomalous Representational Drawing Ability in Children

Lorna Selfe. London, England: Academic Press, 1983 (251 pages).

Reviewer ***Vivian T. Harway, PhD*** *is a Child Psychologist with many years of experience in consultation, teaching, research and clinical work (both diagnosis and therapy). She is Director of Psychological Consultation Associates, and she is also Clinical Associate Professor of Child Psychiatry at the University of Pittsburgh.*

This is a fascinating and important book. The author is unnecessarily modest when she implies on the dust jacket that the studies on which her book is based would be of interest to "educational psychologists, and psychologists from student to professional level...(and) to those concerned with art education."

Normal and Anomalous Representational Drawing Ability in Children makes a valuable contribution to the literature on cognitive and conceptual development in children, and on the all important relationships between non-verbal (spatial and imaginal) and verbal (symbolic) intellectual functioning. As such, it should be read by developmental psychologists, clinical child psychologists, and all other professionals interested in normal and impaired cognitive growth.

The author, Dr. Lorna Selfe, a teacher and educational psychologist, from Hereford, United Kingdom, published in 1977 *Nadia—A Case of Extraordinary Drawing Ability in an Autistic Child.* This is a case study of a severely autistic and language-impaired child who, between three-and-a-half and adolescence (she is now 17), produced a series of drawings which showed, from the first, a remarkable understanding of proportion and perspective. Dr. Selfe used her continuing work with this unusual child as a springboard for the study of the special nature of anomalous drawing skills in autistic children with severe expressive and receptive language retardation. She also conducted an intensive study of the development of realistic representation in normal children between the ages of five and ten.

The author reviews the international literature on theoretical approaches to understanding children's drawings developmentally, and the assumptions made by proponents of different approaches about the course of conceptual and cognitive growth. In terms of the relationship of drawing to intelligence, the prevailing view seems to be that of Goodenough (1926). The child is seen as attempting to approximate photographic reality in the representative of the human form. His or her relative success is considered to be a reflection of the intellectual maturity of the child.

This conceptualization is rather narrow, ignoring the fact—emphasized especially by the Gestalt psychologists (cf. Arnheim, 1974) that children see more than they draw, and that the representation of objects is usually not as well differentiated as the perception of objects. Thus, drawing may represent not only what an object looks like, but also how the child has experienced the object.

Dr. Selfe's theoretical approach to understanding children's drawing derives from the interactionist model proposed by Gibson (1979). Children's drawings represent the perceptual experience of the child; they need not be photographic, since the child's perceptions may include experiences of color, speed, motion, etc. The child learns to use certain invariant representational structures, such as the human head as a graphic circular structure. The child draws those aspects of the enivronment which are salient or relevant for him/her, and may neglect other features. The young child will not usually draw in perspective, because he/she is not interested in those aspects of the optic array which determine perspective (such as edges, contours, occlusions, etc.). The child will represent those features which are significant to him/her at the time. Only later will the child begin to manifest an interest in fixed-position perspective. Thus, to Gibson, "visual realism" may not be the primary aim of the drawings of normal young children. Rather, the drawings represent a symbolic representation of meanings to the individual child.

It is of particular interest that in the language-impaired and autistic children in Dr. Selfe's population, the anomalous drawing ability is seen in a facility for expressing perspective from a single fixed viewpoint. It is as if the drawings of the autistic children are meant less to communicate, or to symbolize, or to express meaning; but rather manifest excessive concentration on non-symbolic aspects of the visual field.

The author also reviews the literature on the development of the representation of depth and linear perspective in children's drawings. Mastery of this problem comes with the child's gradual realization, generally at adolescence, that with distance comes change in the perception of proportion, dimensionality, and diminishing size.

This comprehensive theoretical overview, clearly and economically written, comprises the first quarter of this book. The author then describes her systematic studies of the development of skills in representation of photographic realism in normal children's drawings between the ages of 5 and 10. She also provides an in-depth analysis of the drawings and the histories of six children with exceptional graphic competence (including Nadia). These children also manifested severe learning difficulties and "retarded language development."

The author investigated separate elements of representation of photographic realism in children's drawings. These included the ability to portray realistic proportions in the human figures; the ability to depict three dimensions in single objects; the ability to represent depth by drawing diminishing size; and the ability to represent two objects, one partially occluded by the other. The author devised several unique and ingenious tasks to assess the child's skill in each of these areas. A scale for the natural progression of the representation of photographic realism was then devised, based on the results of these studies.

In all of these areas there was an age-related trend toward more accurate depiction of realism through representation of accurate proportions, dimensions, diminishing size with distance, and occlusion. However, even by ten years of age, most normal children have not accurately solved the problem.

In contrast, drawings of the anomalous groups (ages six to eight), when compared to the drawings of the normal children (using the 12 point scale of photographic realism) show that the autistic children were able, at a very early age, to achieve realistic proportions in a single figure; to depict three-dimensionality; to depict realistic proportions between objects with distance; and to depict overlap or occlusion in drawings with relative ease.

The author speculates that normal children, even when presented with specific experimental tasks, tend to represent features of the optic array that have significance or meaning to them at different age levels. Also, with increasing socialization there is gradually increasing similarity in the process of attending to and organizing features of the visual field. The drawing of the normal child represents the interaction of the dynamic visual experience of the child with properties of the object he/she is trying to represent.

The autistic children, on the other hand, attend to such features as the lines, edges, contours, and angles of the optic array. The focus on non-symbolic, and non-linguistic aspects of their visual field. The space between and around objects is given equal consideration with the object. For the normal child, the depiction of the object itself is paramount. For the normal child, the development of photographic realism is a "late blooming" accomplishment. For the anomalous children with language deficits and idiosyncratic symbolic abilities, the early development of photographic realism is symptomatic of their disturbance. The author states that this trait is symtomatic of the depth of these children's cognitive deficits. However, it also could be viewed as symptomatic of their extreme inability to communicate with the world in terms of language and verbal symbolism. With their anomalous skills they "mirror" visual experience, without incorporating any intermediary symbolization or personalization, as the normal child does.

The author considers the literature on the art of talented children and mentally retarded children, and demonstrates that her "anomalous" group is indeed unique. All six of these subjects had IQs in the lowest 2% of the population on whom the tests were standardized. All showed a wide range of variability in skill levels. They had "peaks" in perceptual matching, spatial imagery and visual memory for abstract symbols; and "troughs" in performance on verbal reasoning tasks, speed of information processing, retrieval and application of knowledge. All of the children began spontaneously producing accurate representations of animals, buildings, architectural details, and human figures, usually in three-dimensional settings, at very early ages. The 40 pages of this book which are devoted to reproductions of these drawings are worth intensive study.

In her conclusions, Dr. Selfe presents a fascinating discourse on the relationship of art and language, and how the ability to depict space in drawings may vary from child to child as a function of the degree to which the child uses verbal mediation in the approach to the task. The autistic children's drawings represent the comprehension of spatial relationships at a very early age, in the absence of a commensurate level of language expression and comprehension. Artistic expression is enriched as the artist acquires skills in integrating imaginal information with the ability to express insights into human nature. The drawings of normal children have charm as they reveal the child's attempts to organize and express his experience, under the domination of his symbolic and conceptual thinking. Dr. Selfe concludes that "realism" in artistic development is a less advanced stage than that seen in the drawings of normal young children who are struggling to create a symbolic representation of their experience.

Why, however, is this anomalous drawing ability limited to only a few of the autistic, language-impaired children? Severe infantile autism is a very rare disorder (approximately two to four cases per 10,000). Although performance is generally worse for this group on tasks demanding symbolic thought and sequential logic, and many show better performance levels on manipulative or visual-spatial skills (DSM III, p. 14); only a small percentage of autistic youngsters show the type of anomalous skill that Dr. Selfe's group manifested. Might it be that her group, and children like them, represent the extreme end of a continuum that extends at the other extreme to the excessively symbolic and highly internalized representations of the drawings produced by severely disturbed and acutely schizophrenic individuals? Dr. Selfe does not make this point, but it is a logical extension of her reasoning. There is a rich literature in the area of the art of severely disturbed individuals, and this comparison begs to be made.

This excellent and very important book should be widely read, and should stimulate much further research on children's art, children's cognitive development, the artistic expression of a typical and disturbed individuals, and on the nature of art itself.

References

Arnheim, R. (1974). *Art and visual perception*. Berkeley: University of California Press.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders*, DSM III (3rd ed.). Washington, D.C.: Author.

Gibson, J.J. (1979). *The ecological approach to visual perception*. Boston: Houghton Mifflin Co.

Harris, D.B. (1963). *Children's drawings as measures of intellectual maturity, a revision and extension of the Goodenough-Draw-A-Man Test*. New York: Harcourt Brace and World, Inc.

Selfe, L. (1977). *Nadia—A case of extraordinary drawing ability in an autistic child*. London and New York: Academic Press.

Film/Video Review

Art and Therapy

Videotape (3/4", color, 21:45, June, 1983) Hughes Lavergne, 67 East 4th Street, #14, New York, NY 10003, Tel: (212) 777-7789.

Lila

Film (16 mm, color/sound, 28:30, 1980) Ideas and Images, Inc., P.O. Box 5354, Atlanta, GA 30307, Tel: (404) 523-8023.

Reviewer ***Lewis K. Shupe, PhD, ATR*** *is Professor of Art Therapy and Communication, Wright State University, Dayton, Ohio.*

The videotape of *Art and Therapy* and the 16mm color film of *Lila* are two productions that are recommended for the experienced clinician, the neophyte therapist, and all personnel working in the human services to view as honest sharings of the clinical process in action. These are not presentations that are staged strictly for the purpose of demonstrating process, but are a sharing of the rationales, experiences, and insights of two practicing clinicians who are able to demonstrate the translation of theory into practice.

In the videotape *Art and Therapy*, art therapist Vera Zilzer effectively demonstrates a range of techniques in working with both individuals, and individuals within a group setting, in the South Bronx Community Mental Health Center. The tape also serves as a testimony for the value of art therapy in working with clients who are being seen for treatment in a mental health agency.

The beginning of the tape introduces the therapist and her direct work with individual clients in the Community Mental Health Center. Ms. Zilzer is clear in presenting her rationale for working as an art therapist. This presentation of rationale is evident by observing the rapport she has established with her clients, and also may be one of the factors in the results that are reported, and evidenced in the sharing of the art of the members of her therapy group. The tape demonstrates a confidence of the therapist in the work being done, and within the videotape it is evident that art therapy is a viable discipline.

Individual clients are interviewed and verbalize the values of their experiences in the therapeutic process as they share their art work with the viewer. Motivated to complete drawings of "every tree in the Bronx," a client experienced the rebirth process and responded that it was like "bringing new life to me." He added that working in art "helps me to relearn how to express my own feelings." These specific responses from the clients are not insertions into the videotape as solicited testimonies but are genuine extensions of their involvement in the process. Ms. Zilzer demonstrates a range of responses by the therapist: a verbal therapist, to the comfort of being there as a support to the clients and allowing them to work in the art without intrusion. "She meets him in his silence" is an important message to all therapists that the client needs time to work without verbal interruptions. The meeting in silence is presented as a level of comfort for both the client and the therapist.

In addition to the traditional procedures for working in art therapy, Ms. Zilzer shares two of her techniques that may not be in the repertoire of the majority of art therapists. In one scene of *Art and Therapy* she sketches directly onto the work of a client in helping this client to recreate an earlier experience. Another technique refers to the therapist drawing a series of portraits of the client in therapy as a procedure to enhance self esteem. This is also used to set the mood in the art therapy room where the clients then sketch themselves and other members of the group. The therapist interprets, for the client, the changes in affect that have occurred; the client appears comfortable with this procedure. These two approaches may stimulate some questions as appropriate procedures; however, Ms. Zilzer demonstrates the procedures through experience and as a therapist who can articulate the rationale for use. They also demonstrate the uniqueness in the diversity of art therapy as not being a recipe-type intervention process.

The last part of the videotape demonstrates the individual members working in a group setting, and focuses primarily on two members interacting on an interpersonal level through their art. The interaction between the two members is illustrated as a specific description of how the art work served as the introduction to the establishment of communication. The symbols in the art work depict how weapons and missiles were used as barriers and probes in the interactive process, and the two clients are able to share their emerging insights as they progress to a higher level of comfortable dialogue. The interaction of these two clients, with the appropriate interpretations by Ms. Zilzer, reflects group process for both content style and work style as presented in the Hill Interaction Matrix (Dinkmeyer and Muro, 1971). The other members of the therapy group do not interact within the dialogue of the two members. The viewer can infer that they are comfortable members of the group as they continue to work on their art and listen to the assertive, speculative, and confrontive interaction of their two group members. In the midst of an "argument" they appear to be comfortable "in their silence."

The therapist states that in the group process the members are being gently "pushed and pulled through small changes." Ms. Zilzer explains that "art therapy is not group therapy although it takes elements of group therapy. We go as fast as possible into group cohesiveness, which is the third stage of group therapy. Working gives them a sense of calmness that is like relaxation." This sense of calmness is apparent among members of the group.

The medium selected for the work is drawing, and the product appears to be emphasized as an important element of the process. The art work and the process of creating the drawings are well photographed for the videotape, and are presented as a well crafted, completed video production. This is complemented by an excellent musical background and an audio narration that is clear and articulate.

The average length of day-treatment therapy for the clients shown in the videotape is six months. It is difficult to encapsulate a six month time period into a twenty minute presentation; however, with the viewer being able to infer early motivations with the clients and interim therapy, there is a feeling of completeness. The ending of the videotape is abrupt, but does not diminish the effectiveness of this excellent presentation of an art therapist who is willing to share the clinical process in a comfortable and positive manner.

The videotape is sponsored by the Bronx Mental Health Council, Inc., and consultant for the project was Laurie Wilson, PhD, ATR.

* * *

Lila is a sensitive, beautifully reminiscent film introducing us to Lila Bonner-Miller, M.D. Dr. Bonner-Miller is an active, practicing psychiatrist who, at eighty years of age, informs us that "I'm not going to talk about senility because I'm not going to fool with it." This declaration establishes the primary impact of the film that "life can be exciting but we need to put forth the effort." Specifically, the film is recommended for those persons working with geriatric and/or gerontological populations, but it is also a film that should be seen by all persons who believe in the human condition—in sensitivity, awareness and the joy of living.

In 1920 Dr. Bonner-Miller was enrolled into the first medical school class (at the University of Virginia) to accept females as students. She became a successful practicing physician while at the same time maintaining a marriage and raising a family. An interesting transition occurred in her medical career (in 1949) when she returned to medical school to study psychiatry because it was apparent to her that in working with her patients there were questions that could not be explained by their physical symptoms. This motivation for learning is characteristic throughout the entire film where we come to know Dr. Bonner-Miller as a life-long student.

The film does not emphasize the creative process as the primary influence in Dr. Bonner-Miller's philosophy, but it is apparent that creativity permeates all that she attempts and accomplishes. As an artist, she shares with the viewer that art has been an important part of her life and it helped her gain insights into her own self. She continues to practice her art and also encourages those with whom she works to "do something creative." The specific media incorporated throughout the film are painting, drawing, and clay, and they are used integrally as motivations for the group members to "do something" and to work toward independence.

In addition to the dictum of "doing something creative," we are also told that we "need to be with people." Dr. Bonner-Miller is a strong advocate of the group process; and she is shown in diverse interactions from working with after-care patients following release from a mental hospital, to a group of persons who are coping with being alone as a result of divorce, separation or death of a spouse or family member. The discussion of group process is not presented in an academic sense because we see Dr. Bonner-Miller with friends and family members and the same respect for others is evident in these interactions also. As a keen observer of others, the establishment of the groups presented in the film emerged from her recognition of lonely people needing to have experiences in learning to relate to each other. An interesting commentary from Dr. Bonner-Miller is that she learned a lot about group therapy and group interaction from working with the Girl Scouts at a time when she assumed the leadership role when no one else could be found to be their leader.

The film is presented in a comfortable manner where the viewer can identify as being a member of the group and is drawn into the "community fellowship" that Dr. Bonner-Miller believes to be so important. The film is able to create the atmosphere of being a participant in the clinical process and life experiences, and the camera does not intrude into the clinical environment. (This is in contrast to some films or videotapes where group process interaction appears to have been staged or simulated.) The producers, Fran Burst-Terranella and Cheryl Gosa, have constructed a nostalgic, retrospective narrative with Dr. Bonner-Miller reflecting back to previous experiences, interacting at the present time, and sharing early black and white photographs in an effective manner. There are times when the camera work becomes imprecise, and there is some narrative that may be difficult to hear—suggesting similarities to a home movie. This in no way detracts from the overall effect of this excellent film, but enhances the personal quality of it. Dr. Bonner-Miller is an inspiring individual who serves as a role model for all clinical persons. She is able to demonstrate in a simplistic manner one of the intrinsic values of group therapy, that of treating the patient with dignity and respect (Yalom, 1983). This film is recommended because it presents Dr. Bonner-Miller, but one gets to know Lila.

References

Dinkmeyer, D.C. and Muro, J.J. (1971). *Group counseling: theory and practice.* Itasca, IL: F.E. Peacock Publishers.

Yalom, I.D. (1983). *Inpatient group psychotherapy.* New York: Basic Books, Inc.

MANDALA ASSESSMENT SEMINAR SCHEDULED SEPTEMBER 1985

The CLINIC FOR HUMAN DEVELOPMENT, Clearwater, Florida, will sponsor a 30-hour course in MANDALA ASSESSMENT. The instructor will be Joan Kellogg, MA, ATR. A Certificate awarded by MARI, Mandala Assessment and Research Institute, to participants after completion of the 30 hour course. Part #1 and Part #2 will be held on two consecutive weekends in September; attendees may elect to take one or both parts. **Dates:** September 13, 14, 15, September 20, 21, 22.

For information write to Clinic for Human Development, 925 Lakeview Rd., Clearwater, FL 33516, Attention Ms. Sally Meadows. Phone numbers: (813) 447-7606 or (813) 581-0786.

Certificate course fee: $300

For information on on-going evening courses write MARI, P.O. Box 14009, Clearwater, FL 34279-4009, or call (813) 796-1341.

Viewpoints

Continued from page 84

gences (one turns inward for access to one's sense of self, and the other turns outward in understanding others as individuals). There is evidence that all intelligences are, in part, biologically based since they show up in infancy and early childhood. Gardner makes no claims for this—or any other listing—as demonstrably a "truth" about the nature of intelligence.[1] I take his thesis as a proposition: if we assume such entities as these multiple intelligences, then how can we educate and apply them?

In my own thinking, I make many applications of these ideas in my way of working with clients. I question my thinking, too, and wonder how other art therapists, with viewpoints differing from mine, might feel and think about this focus on "frames of mind" and its importance in their therapeutic approach. It seems to me we already know through personal contact with clients that each person is individually endowed: does it help or hinder to consider these endowments as latent intelligences?

Reference

Gardner, Howard. (1983). *Frames of mind, the theory of multiple intelligences*. New York: Basic Books, Inc., Publishers

Barlow's Response

As Gardner states, what is missing from an analysis through "anthropological lenses" are ways that individuals within a culture can still differ significantly from one another—in intellectual strengths, in ability to learn, in ultimate use of their faculties, in originality and creativity (1983, pp 325-6).

The multiple intelligences framework may help us to understand better educational methods and strategies, as well as defining a more comprehensive clinical focus, for our future work with clients. Gardner's proposal for five other senses (musical, spatial, bodily and the inward/outward personal intelligences) offers us limitless possibilities for methods, assessment, and a more definitive understanding of the persons with whom we work. His mention of the possibility that multiple forms of intelligence may serve to expand and broaden social participation and goal setting is important for our consideration.

Janie's plea that we consider the "help or hinder" aspects seems appropriate, and should serve as a starting point for our discussion and thinking relative to clinical concerns—and to the topics of excellence and intelligence posed in these Viewpoints articles.

* * *

VIEWPOINTS Editor's Note: *Gary Barlow's discussion on* **In Search of Excellence, Lessons from America's Best-Run Companies**, *and Janie Rhyne's discussion on* **Frames of Mind: The Theory of Multiple Intelligences** *pose interesting questions for art therapists. In viewing the organizations with which we are connected, including our places of employment as well as our professional societies, are we in positions to influence their positive functioning along the lines suggested by Barlow? As art people we are particularly sensitive to other than analytic, linear, scientific intelligences. How might we apply the understandings suggested by Rhyne to clinical work?...to training art therapists?*

Perhaps you see possibilities for greater excellence in the aspects of our profession in which you are involved. "Viewpoints" invites your responses.

—Harriet Wadeson, PhD, ATR
Viewpoints Editor

---

[1] For a conversation with Howard Gardner, "The Seven Frames of Mind: Unconventional Measures of Intelligence," see *Psychology Today*, June, 1984, *V*, Number 6, pp 20-26.

BEST COPY AVAILABLE

BEST COPY AVAILABLE

ART
THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1980 Isaac Newton Square South, Reston, VA 22090.

Please enter my subscription for 1985. Enclosed is my check, payable to AATA, for $23
Name ______
Address ______
City ______ State ______ Zip ______

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

TAKE ADVANTAGE OF THIS SPECIAL OFFER!

Subscribers to *Art Therapy* and Members of American Art Therapy Association
ENJOY REDUCED RATE!

SUBSCRIBE NOW – AND SAVE 50% OR MORE! *The Arts in Psychotherapy* is a quarterly journal in its 12th successful year of serving practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologists which reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

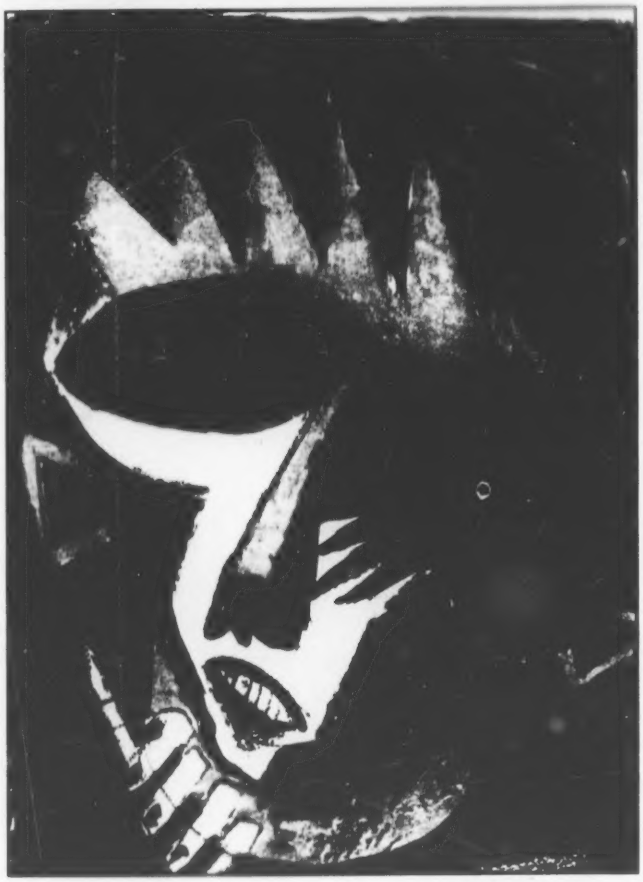
AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy. THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

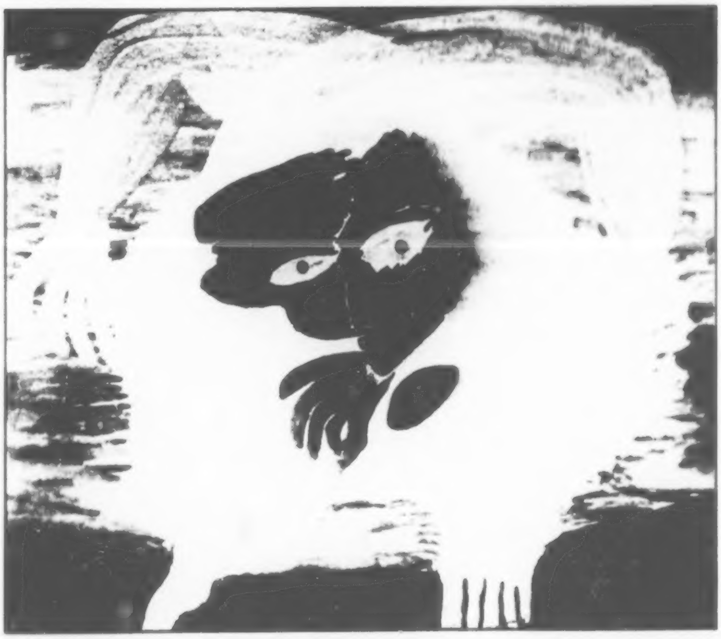
THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers to: Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583
TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA

Please enter my subscription for Vol. 12, 1985 ☐ (Prepayment required) Check enclosed ☐
Please enter my subscription for Vol. 13, 1986 ☐
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume
2 Vol. subscriptions subject to additional 10% discount Individuals $36 Students $27
Name ______
Address ______
City ______ State ______ Zip ______

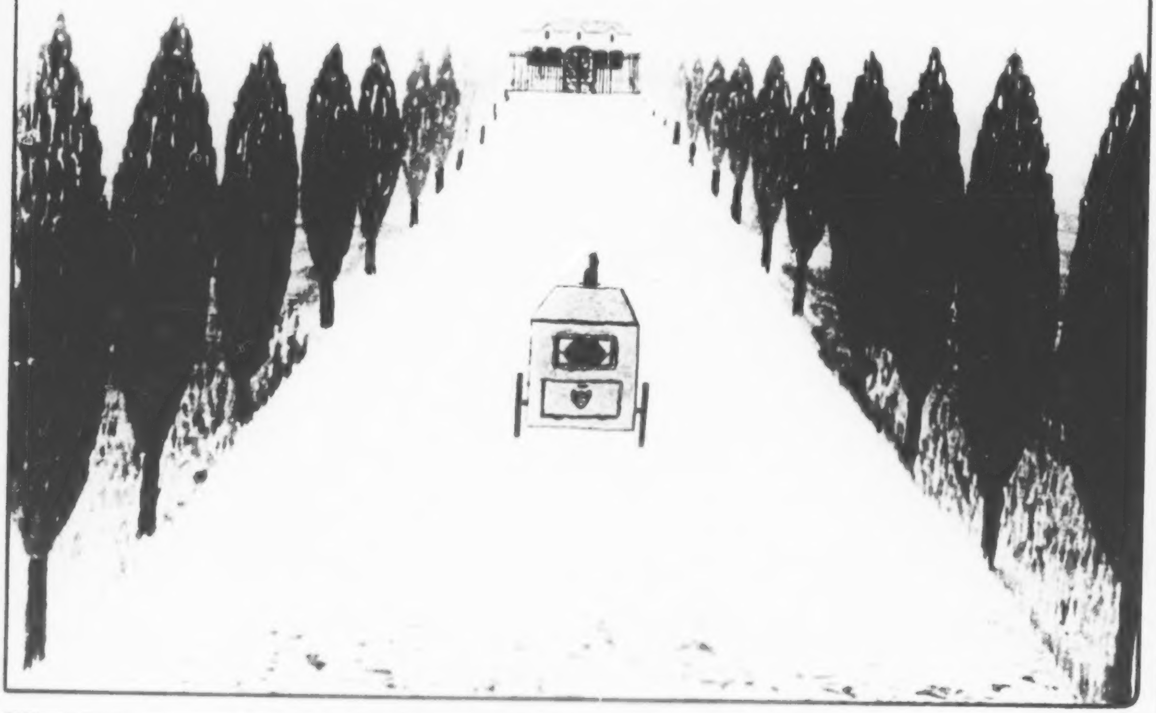
BEST COPY AVAILABLE





BEST COPY AVAILABLE

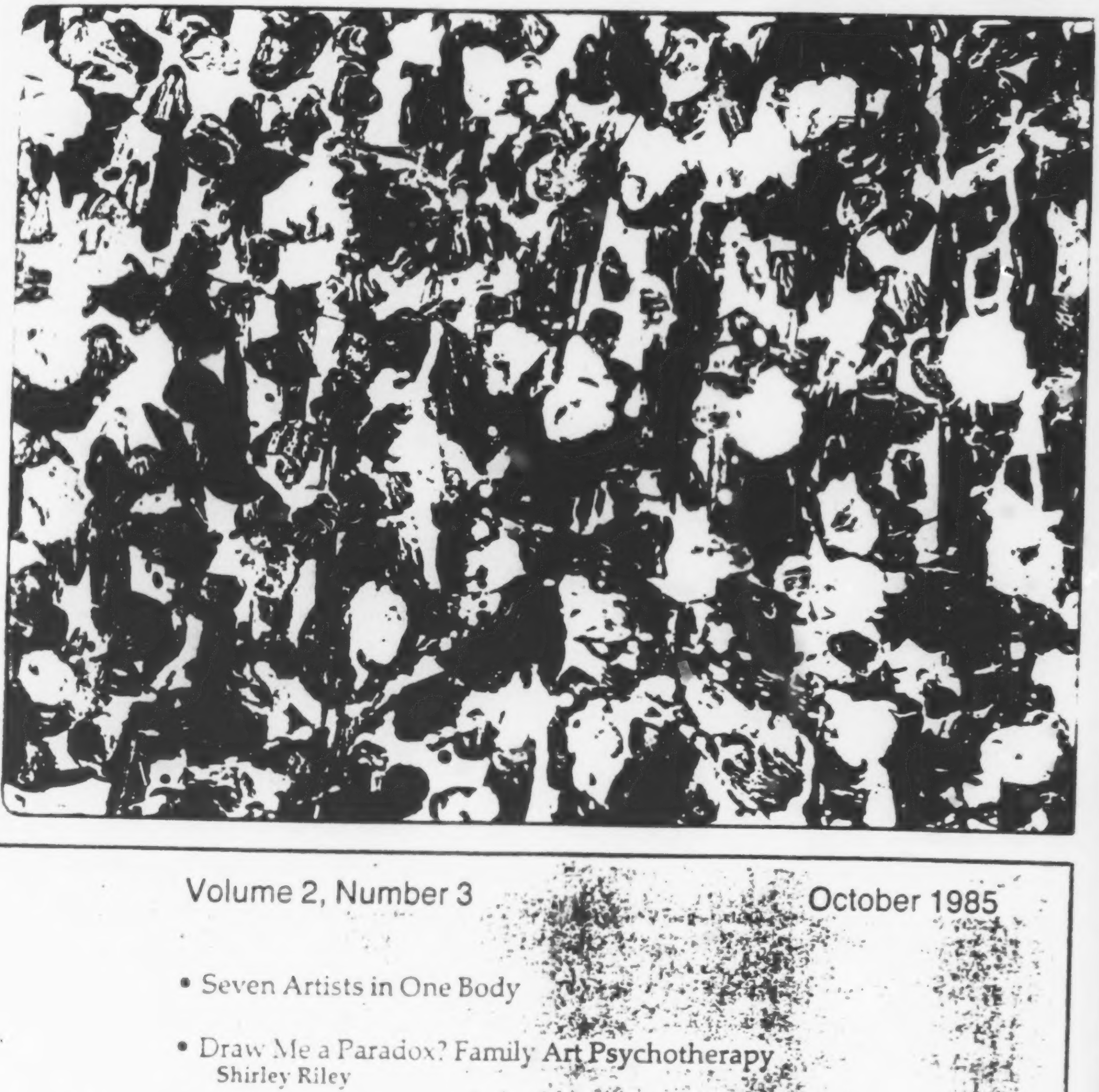
Art Therapy
1980 Isaac Newton Square South
Reston, VA 22090



BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association



Volume 2, Number 3 October 1985

- Seven Artists in One Body
- Draw Me a Paradox? Family Art Psychotherapy
  Shirley Riley
- Image Induction in the Countertransference
  Robert Wolf

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA office, 1980 Isaac Newton Square South, Reston, VA 22090 (703) 437-6012.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1983-1985

Board of Trustees

President
Gladys Agell, MA, ATR

President-Elect
Sandra L. Graves, PhD, ATR

Treasurer
Helen Landgarten, MA, HLM, ATR

Committee Chairs

Affiliate Societies
Nancy Steinberg, MA, ATR

Bylaws
Donald L. Cutcher, MA, ATR

Education
Gary C. Barlow, EdD, ATR

Governmental Affairs
Nancy Schoebel, MA, ATR

Membership
Robin F. Goodman, MA, ATR

Public Information
Bobbi Stoll, MS, MFCC, ATR

Publications
Harriet Wadeson, PhD, ATR

Research
Janie L. Rhyne, PhD, HLM, ATR

Standards
Ronald E. Hays, MS, ATR

Executive Director (ex officio)

Richelle Grapsy

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, EdD, ATR 105

Art Therapy Education 1985-86 110

Articles

Draw Me a Paradox?...Family Art Psychotherapy Utilizing a Systemic Approach to Change
Shirley Riley, MA, ATR, MFCC 116

Seven Artists in One Body: Highlight of Chris Costner Sizemore 125

Image Induction in the Countertransference: A Revision of the Totalistic View
Robert Wolf, MPS, ATR 129

Reviews

Book Reviews

Expressive Therapy with Elders and the Disabled: Touching the Heart of Life 135

Playing with Form: Children Draw in Six Cultures 136

The Art of Art Therapy 138

Using the Creative Arts in Therapy 139

Film/Video Reviews: Twenty-two Productions about Art Therapy
Georgiana Jungels, MA, ATR 141

Viewpoints

Young Peoples' Portfolio 147

Brief Communications 149

About Our Cover
This painting, entitled "Flowers," was done by a young adolescent girl in the art therapy clinic, Wright State University, Dayton Ohio.

Volume 2, Number 3 October 1985

Copyright © 1985
American Art Therapy Association, Inc.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Production Editor
Shirley N. Nuhn
Advertising Manager
Beth Nord

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Anthony Kowalski, MD
Susan LaMantia O'Connor, MA, ATR
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Sivlerstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 1980 Isaac Newton Square South, Reston, VA 22090 (703) 437-6012

THREE EXCITING GUIDES TO BETTER TEACHING AND THERAPY

1

NEW

Silent Screams and Hidden Cries

SILENT SCREAMS AND HIDDEN CRIES: An Interpretation of Artwork by Children from Violent Homes

By **Agnes Wohl, C.S.W., A.C.S.W.**, and **Bobbie Kaufman, M.P.S., A.T.R.**

(under the auspices of the Coalition for Abused Women, Inc.)

> *"The authors have performed a most valuable service in showing how the drawings reflect the damage to the child's developing personality and in indicating measures to heal and restore, and to break the cycle that tends to perpetuate destructive, barbaric behavior."*
> – Joseph H. DiLeo, M.D.

Here is the first study of drawings by elementary schoolchildren who have actually witnessed domestic violence or have been victims of violence themselves. Fifty drawings of human figures, families, trees, and houses were produced by 18 children over a two-year period during their stay at The Safe Home for Abused Families (a service of the Coalition for Abused Women, Inc., Nassau County, N.Y.). The drawings which project the children's emotional disturbances and feelings and the authors' intrepretations prepare the helping professional to define the therapeutic task and "heal and restore."

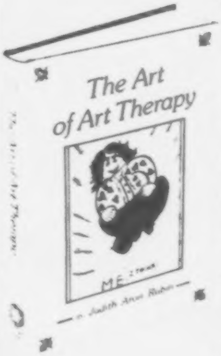
192 pp. 50 illus. LCN 85-6652 Cloth $20.00 SPECIAL ONLY $18.00

2

THE ART OF ART THERAPY

By Judith Aron Rubin, A.T.R.

"A penetrating exposition of those elements that produce professional excellence, a welcome addition to the literature."
– **Gladys Agell**, A.T.R., Associate Professor, Director, Graduate Art Therapy Program, Vermont College of Norwich University



THE ART OF ART THERAPY is a "how to think about doing," rather than "how to do" art therapy book. Ms. Rubin provides the specific know-how essential for working with populations of any particular age level, setting, and modality. The problems encountered by both patient and therapist as artists are closely examined to enhance the art therapist's clinical skills and increase the effectiveness of treatment for every patient.

224 pp. LCN 84-9344 Cloth $25.00
SPECIAL ONLY $22.50

3

CLINICAL ART THERAPY: A Comprehensive Guide

By Helen B. Landgarten, M.P.A., A.P.R.

"A remarkable and practical book. It is written creatively and its many detailed descriptions of the art therapy process are nicely organized. [E]normously useful to psychotherapists and mental health workers."
–American Journal of Orthopsychiatry

Clinical Art Therapy

This integrated guide to the entire spectrum of clinical art therapy covers every age range in various settings – from school and outpatient clinics to psychiatric hospitals and private treatment. Included are detailed instructions for use of numerous clinical procedures for assessment and treatment, and extensive case studies.

410 pp. 148 illus. LCN 80-22564
Cloth $27.50 SPECIAL ONLY $24.75

Send to: **BRUNNER/MAZEL Publishers**
19 Union Square, New York, N.Y. 10003

YES! Please send me:

- ☐ **SILENT SCREAMS AND HIDDEN CRIES** (Wohl) at the Special Price of only $18.00 ($20.00 list)
- ☐ **THE ART OF ART THERAPY** (Rubin) at the Special Price of only $22.50 ($25.00 list)
- ☐ **CLINICAL ART THERAPY** (Landgarten) at the Special Price of only $24.75 ($27.50 list)

I understand that any book may be returned within 30 days for a full refund.

Name __________

Address __________

City __________ State ______ Zip ______

$______ enclosed. *Please add $1.75 postage and handling for one book, 50¢ for each additional. (N.Y.C. residents must add 8¼ % sales tax; N.Y. State residents 4% plus applicable local tax.)*

(or) Charge ($20.00 minimum) my
☐ American Express ☐ MasterCard ☐ VISA

Account # __________ Expires ______

Signature __________

ATJ1085

BEST COPY AVAILABLE

EDITORIAL

In his article "Image Induction in the Countertransference: A Revision of the Totalistic View," Robert Wolf, MPS, ATR, presents an integration of psychoanalytic and creative art therapy concepts as related to the totalistic view of countertransference. The author states that the writing is "an attempt to expand the parameters of what psychoanalysts call 'totalistic' countertransference." Also, in his alluding to the possibility (or probably *fact*, by inference) that psychoanalysis and creative art have certain commonalities and "complement each other," the author supports the belief that art materials should be available to both the patient and the analyst during the session. This article gives the reader much insight, offers many points for personal consideration, and I urge you to devote time to this highly important content.

Similarly, Shirley Riley, MA, ATR, MFCC, presents an article titled "Draw Me A Paradox?...Family Art Psychotherapy Utilizing a Systemic Approach to Change." Riley offers to the reader procedures for integrating art therapy into the systemic theoretical approach to family therapy. She believes that the use of creativity produces positive interaction within the family unit. Theoretical principles are included in the article, such as metaphoric utilization, ritual, and paradoxical interventions. A major insight for all art therapists to be aware of is the "therapeutic double bind," which the author illustrates prior to leading into "Case III."

Contained within this issue is the newly revised Education and Training List of the American Art Therapy Association. Categories include: 1) Approved programs; 2) U.S. and Canadian institutions, graduate degree programs; 3) Graduate level certificate/diploma programs; 4) Clinical training programs; 5) Institute programs; 6) Undergraduate degree programs offering art therapy prerequisites; and 7) Institutions offering courses in art therapy or closely related subjects. This is an important listing for our profession, and it is as comprehensive and accurate as could be done with the information sent in to the Education Committee. It is necessary, however, for the designated contact person (or his/her representative) of each of the listed entries to continue to update this information whenever the occasion demands. We must keep the listings as current and as accurate as possible.

* * *

The color plates for the outside and inside covers in the last issue of *Art Therapy* (Volume 2, Number 2, June 1985) were made possible through private donations to the journal. Many thanks to the contributors.

* * *

We are most fortunate to have Chris Sizemore for our keynote speaker at the October AATA Conference. Through the publication of *The Three Faces of Eve* (1957) as well as the movie of the same title, worldwide audiences were spellbound when observing the personal experiences of a person with multiple personalities. A professor of clinical psychology, W. Scott Gehman, Jr., Ph.D., in *I'm Eve* (1977) states:

> I remember...my vicarious meeting with Eve White and Eve Black. What a fascinating account of her neurosis—dissociative reaction, multiple personality type. Then came the professional film "A Case of Multiple Personality," which allowed one to be present at a few moments of therapy with the real Eve...one could see the dissociative state in action...Dissociative hysterical amnesia, the blotting out of important, sometimes traumatic experiences is a precondition to both fugue states and multiple personalities. This is beautifully illustrated in Chris's early life, when she denied doing things (repressed them) and as a result received punishment for acts she could no longer remember doing. (pp vii-viii).

In the Author's Note, Chris Costner Sizemore (1977) writes:

> This book was born because of my conviction that the true facts of my life were not known, and that I had a story to tell; because the world had the impression that I had recovered from my dissociative problem, multiple personality. I have known twenty-two personalities and have lived to tell of their demise. I have attempted to present my story openly, freely, and with dignity and feeling...It is my life as I have lived it. These are my memories and impressions; and my emotions. (p x)

Continued

Chris Sizemore further elaborates on her reasons for writing *I'm Eve* —as personal therapy and documentation, and to open a door through which the reader may journey, as well as to help the general public better understand and accept the mentally disturbed.

It is a book of hope, and it is a pleasure to be able to hear from a most courageous and sensitive woman.

* * *

A line to ponder:
Discovery consists of looking at the same thing as everyone else and thinking something different. (von Oech, 1983, p 7)

Gary C. Barlow, EdD, ATR
Editor
Art Therapy

References

Sizemore, C.C. and Pittillo, E.S. (1977). *I'm Eve*. Garden City, New York: Doubleday & Company, Inc.

Thigpen, C.H. and Cleckley, H.M. (1957). *The three faces of Eve*. New York: McGraw-Hill.

von Oech, R., Ph.D. (1983). *A whack on the side of the head, how to unlock your mind for innovation*. Menlo Park, CA: Creative Think, publishers.

CHARLES C THOMAS • PUBLISHER

New! **A MANUAL OF SEQUENTIAL ART ACTIVITIES FOR CLASSIFIED CHILDREN AND ADOLESCENTS** *by* **Rocco A. L. Fugaro.** The author details the therapeutic use of art activities with children who have been classified as neurologically-perceptually impaired, emotionally disturbed-socially maladjusted, or depressed. He includes treatment plans, objectives, motivational techniques and evaluation procedures. *'85, $25.75*

PHOTOTHERAPY IN MENTAL HEALTH *edited by* **David A. Krauss** *and* **Jerry L. Fryrear.** The contributors to this book explain the uses of photographs in self-confrontation, in the study of self-environment interactions, in the treatment of children and adolescents, in family psychotherapy, and in other situations. Rudolf Arnheim, writing in *The Arts and Psychotherapy,* called this "one of the liveliest books on art therapy . . . in years. It overflows with fresh ideas of how to apply the medium of photography to diagnosis and therapy." *'83, $29.75*

THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking *by* **Myra F. Levick.** In this book, a pioneer and leader in art therapy describes and illustrates normal and abnormal development of cognitive skills and defense mechanisms through the graphic productions of children from two to ten years old. *'83, $34.50*

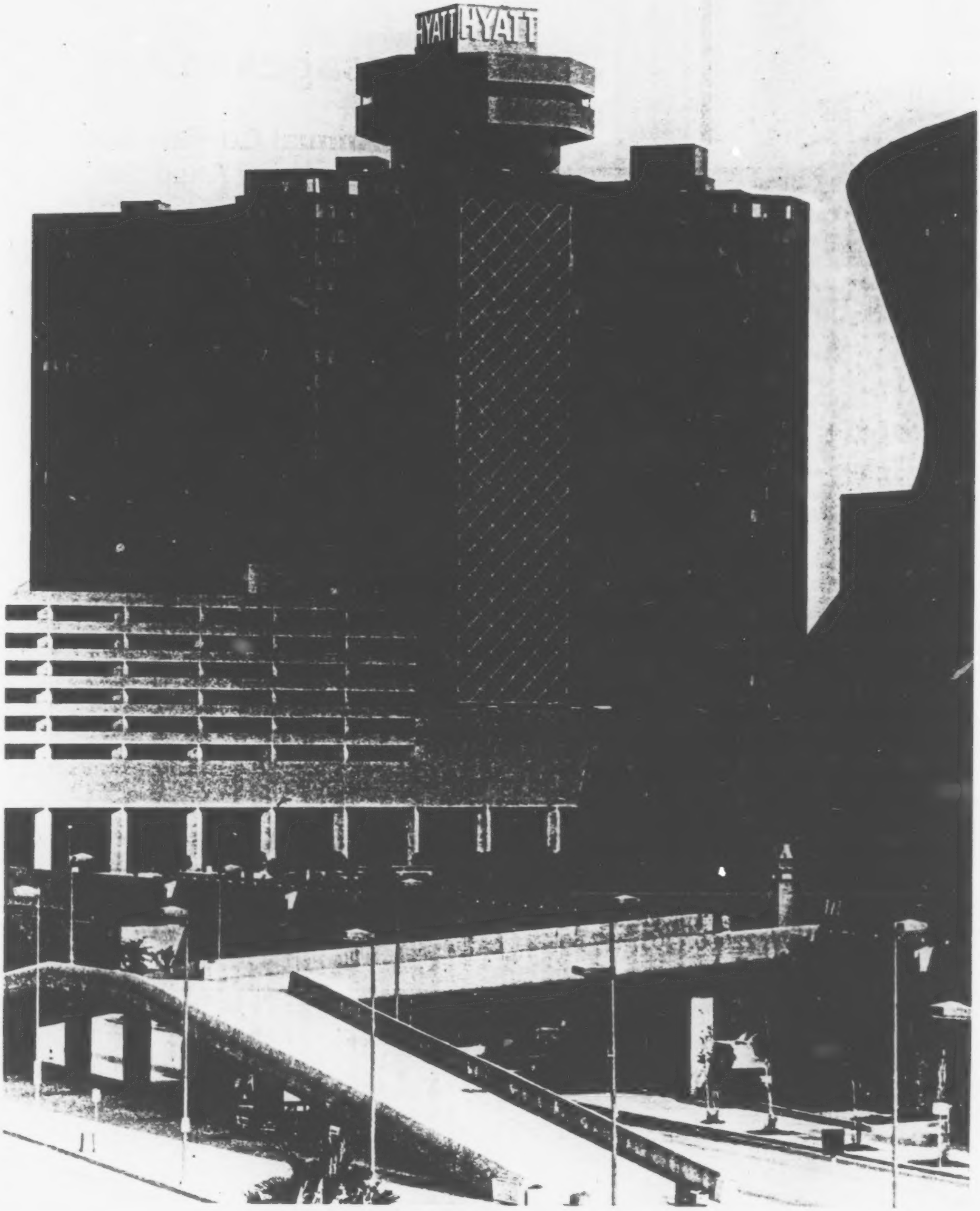
New! **EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession** *by* **Shaun McNiff.** This is the first comprehensive study of higher education in the growing arts therapy profession. It explores the interdependence of diverse training traditions, and it reviews the various areas of concentration, such as art therapy, music therapy, and others. Specific competencies and diverse philosophies are examined, but their commonalities are emphasized. The author includes chapters on historic trends, defining the profession through education, training program characteristics, and educational elements common to all arts therapies. He also discusses specific media competencies, supervision and evaluation, an artistic theory of mental health, student and faculty characteristics, and key issues in creative arts therapy education. *Dec. '85, about $32.50*

THE ARTS AND PSYCHOTHERAPY *by* **Shaun McNiff.** An integrated approach to all of the arts in psychotherapy is presented in this insightful book. The author examines the distinctive and common qualities of the various expressive arts in relation to psychotherapy. He also draws on the statements of artists to develop a psychology of art that views artistic exploration as psychological research of the highest order. " . . . interesting, provocative, and valuable to clinicians who use any of the arts in a therapeutic context." – *Contemporary Psychology. '81, $19.75*

Order direct for fastest results • Write or call (217) 789-8980 • Books sent on approval
Postage paid on MasterCard, Visa & prepaid orders • Catalog sent on request

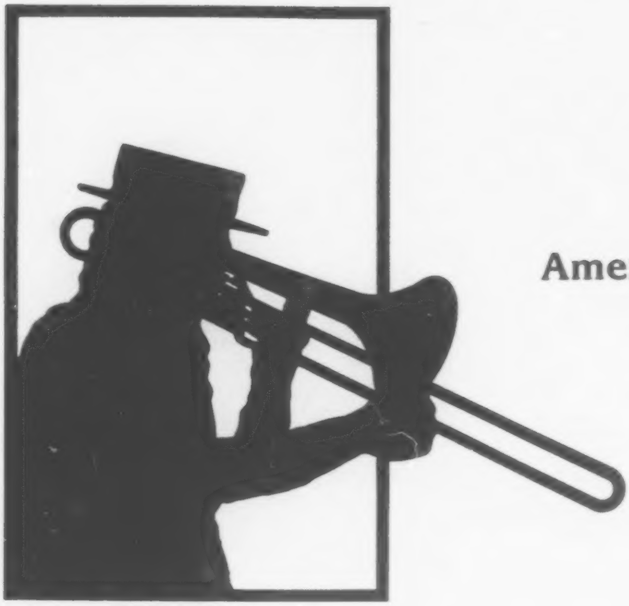
2600 S. First St. • P.O. Box 4709 • Springfield • Illinois • 62708-4709

BEST COPY AVAILABLE



Plan Now for the AATA
16th Annual Conference
October 24-27, 1985
Hyatt Regency, New Orleans

BEST COPY AVAILABLE



"Messages in Art"

16th Annual Conference
American Art Therapy Association, Inc.

October 24-27, 1985
Hyatt Regency
New Orleans, Louisiana

Wednesday October 23	**Pre-Conference Courses**
Thursday - Sunday October 24-27	**Conference Sessions and Exhibits**
Saturday October 26	**Keynote Address: Christine Sizemore** *(The Three Faces of Eve)*
Sunday October 27	**Post-Conference Courses**

The Conference will feature general sessions, hands-on workshops, commercial and educational exhibits, research papers and discussion forums.

For more information, please complete this form and return to the AATA National Office, 1980 Isaac Newton Square South, Reston, VA 22090. (703) 437-6012.

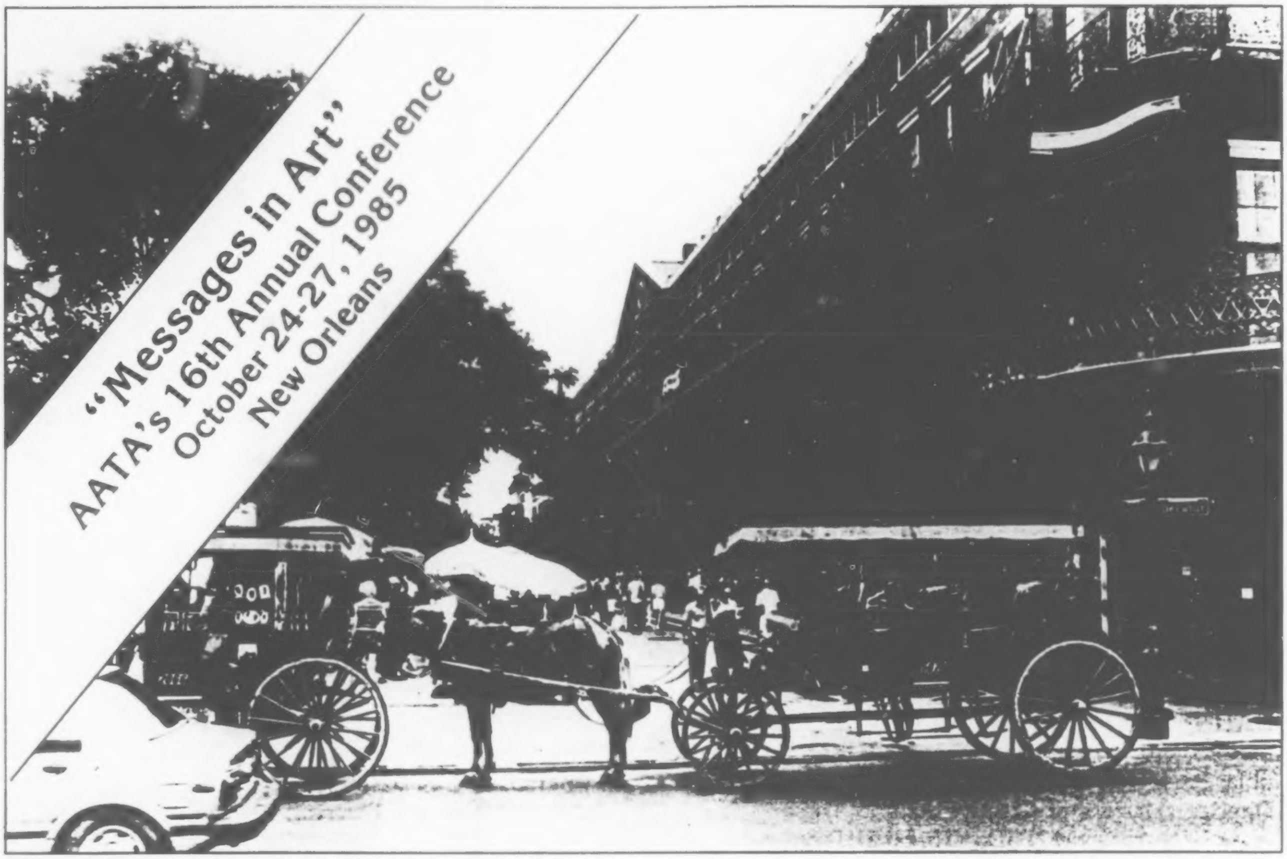
Please send more information about the 16th Annual AATA Conference:

_____ Pre-Registration
_____ Exhibits

Name ______________________________

Address ______________________________

City, State, Zip ______________________________


"Messages in Art"
AATA's 16th Annual Conference
October 24-27, 1985
New Orleans

A flair for tradition and color mark New Orleans. A horse and buggy ride is but one of numerous attractions for new and returning visitors. Photo courtesy of the Greater New Orleans Tourist & Convention Commission.

BEST COPY AVAILABLE

ART THERAPY EDUCATION 1985-86

The following entries compose the "Art Therapy Education List, 1985-86" for the American Art Therapy Association, Inc. Categories of the entries include: 1) Approved Programs; 2) U.S. and Canadian Institutions, Graduate Degree Programs; 3) Graduate Level Certificate/Diploma Programs; 4) Clinical Training Programs; 5) Institute Programs; 6) Undergraduate Degree Programs Offering Art Therapy Prerequisites; and 7) Institutions Offering Courses in Art Therapy or Closely Related Subjects.

This collection and editing of the listing is a project of the Education Committee, AATA. Members of this Committee are: Gary C. Barlow, ATR (Chair); Myra Levick, ATR; Virginia Minar, ATR; Bruce Moon, ATR; Arthur Robbins, ATR; and Mary St. Clair, ATR.

Approved Programs

The following constitutes a list of those degree granting graduate training programs that have received the approval of the Association. Approved programs, in meeting the standards set forth in *Guidelines for Art Therapy Training*, have assured their graduates of the award of credit toward Registration (ATR).

COLLEGE OF NEW ROCHELLE, New Rochelle, NY 10801 (Contact: Caryl Horwitz, MA, ATR, Director, Graduate Art Programs) Master of Science (MS) in Art Therapy.

EASTERN VIRGINIA MEDICAL SCHOOL, PO Box 1980, Norfolk, VA 23501 (Contact: Cynthia A. Wolf, MA, MS, ATR) Master of Science (MS) in Art Therapy.

HAHNEMANN UNIVERSITY OF HEALTH SCIENCES, Broad and Vine Streets, M.S. 424, Philadelphia, PA 19102 (Contact: Ronald E. Hays, MS, ATR, Director, Masters of Creative Arts in Therapy Program, or Myra Levick, PhD, ATR, HLM, Professor and Consultant to Art Therapy Education) Master of Creative Arts in Therapy (MCAT)—Art Therapy.

HOFSTRA UNIVERSITY, Department of Counseling, Psychology and Research in Education, Hempstead,NY 11550 (Contact: Lillian C. Resnick, ATR, Coordinator) Master of Arts (MA) in Creative Arts Therapy.

LESLEY COLLEGE, Institute for the Arts and Human Development, 29 Everett Street, Cambridge, MA 02238 (Contact: Shaun McNiff, PhD, ATR, Professor and Dean of the Arts Institute) Master of Arts (MA)—Art Therapy and other Creative Therapies, and Certificate of Advanced Graduate Study (CAGS) in Creative Arts Therapies.

LOYOLA MARYMOUNT UNIVERSITY, Loyola Boulevard at West 80th Street, Los Angeles, CA 90045 (Contact: Helen Landgarten, ATR, HLM, Director, Graduate Department of Clinical Art Therapy) Master of Arts (MA) in Clinical Art Therapy.

NEW YORK UNIVERSITY, 735 East Building, 239 Greene Street, New York, NY 10003 (Contact: Laurie Wilson, PhD, ATR, Director, Art Therapy Program) Master of Arts (MA)—Art Therapy.

PRATT INSTITUTE, Creative Arts Therapy Department, East Building, Third Floor, Brooklyn, NY 11205 (Contact: Leslie Abrams, MPS, ATR, Acting Chairperson) Master of Professional Studies (MPS) in Art Therapy.

STATE UNIVERSITY COLLEGE AT BUFFALO, 1300 Elmwood Avenue, Buffalo, NY 14222 (Contact: John R. Rogers, MA) Master of Arts (MA) or Master of Science (MS)—Multidisciplinary Studies.

THE GEORGE WASHINGTON UNIVERSITY, Department of Art Therapy, 2129 G Street, NW, Washington, DC 20052 (Contact: Katherine J. Williams, MA, ATR, Acting Director, Graduate Program in Art Therapy) Master of Arts (MA) in Art Therapy.

UNIVERSITY OF ILLINOIS AT CHICAGO, Art Therapy Department, School of Art and Design, Box 4348, Chicago, IL 60608 (Contact: Harriet Wadeson, PhD, ATR, Director) MA in Art Therapy.

UNIVERSITY OF LOUISVILLE, Department of Expressive Therapies, Belknap Campus, Louisville, KY 40292 (Contact: Dana N. Christensen, PhD, Director) Master of Arts (MA)—Art Therapy.

VERMONT COLLEGE OF NORWICH UNIVERSITY, Montpelier, VT 05602 (Contact: Gladys Agell, ATR, Director) Master of Arts (MA) in Art Therapy.

WRIGHT STATE UNIVERSITY, 228 Creative Arts Center, Dayton, OH 45435 (Contact: Gary C. Barlow, EdD, ATR, Coordinator of Art Therapy) Master of Art Therapy (MAT).

BEST COPY AVAILABLE

Other Educational Opportunities

The following programs submitted information to AATA indicating their coursework offerings in art therapy. Although the Association cannot endorse other than the preceding Approved Programs, the entries below are listed for informational purposes. It is recommended that interested persons contact program personnel directly for further information and, in addition, review AATA's *Guidelines for Academic, Clinical and Institute Art Therapy Training.*

U.S. and Canadian Institutions, Graduate Degree Programs

ANTIOCH UNIVERSITY SEATTLE, 1165 Eastlake Ave. E., Seattle, WA 98109 (Contact: Lea Camero, MFA, ATR or Dean Elias, Regional Director) MA Psychology/Area of Concentration: Art Therapy or other creative arts modalities.

CALIFORNIA STATE UNIVERSITY AT LOS ANGELES, 5151 State University Drive, Los Angeles, CA 90032 (Contact: Ed Forde, Chair, Art Department) MA in Art Specialization—Art Therapy.

CALIFORNIA STATE UNIVERSITY AT SACRAMENTO, 6000 J Street, Sacramento, CA 95819 (Contact: Dr. Lita Whitesel) MA in Art with Emphasis in Art Education.

COLLEGE OF NOTRE DAME, Belmont, CA 94002 (Contact: Doris Arrington, MA, ATR, Director) Master of Art Therapy.

CONCORDIA UNIVERSITY, 1455 de Maisonneuve Bldg. West, Montréal, Quebec, CANADA H3G 1M8 (Contact: Graduate Programs Coordinator, VA-201) MA in Art Education (Option: Art in Therapy); and Diploma (in Art Therapy).

EMPORIA STATE UNIVERSITY, 1200 Commercial Street, Emporia, KS 66801 (Contact: Robert E. Ault, ATR) MS in Art Therapy.

GOUCHER COLLEGE, Dulaney Valley Road, Towson, MD 21204 (Contact: Christine W. Wang, MA, ATR, Director) MA in Art Therapy.

ILLINOIS STATE UNIVERSITY, Normal, IL 61761 (Contact: Dr. Marilyn Newby, Art Department) MS in Art Education, MRA and MA in Art, EdD in Art.

INDIANA UNIVERSITY OF PENNSYLVANIA, Indiana, PA 15705 (Contact: Dr. Robert J. Vislosky, EdD, ATR) MA in Art Therapy.

INTERNATIONAL COLLEGE, Los Angeles, CA (Contact: M.A. Fischer, MD, D. Psych., Executive Director, Toronto Art Therapy Institute, 216 St. Clair Avenue West, Toronto, Ontario, CANADA M4V 1R2).

LINDENWOOD COLLEGE FOR INDIVIDUALIZED EDUCATION, St. Charles, MO 63301 (Contact: Dr. Rebecca Glenn, Program Coordinator) MA in Counseling Psychology—Art Therapy Emphasis.

MARYLHURST COLLEGE, PO Box 261, Marylhurst, OR 97036 (Contact: Kay Slusarenko, BA, Chairperson, Art Department) MA in Art Therapy.

MARYWOOD COLLEGE, Scranton, PA 18509 (Contact: Sister Dorothy McLaughlin, RSM, EdD, ATR) MA in Art Therapy.

NEW YORK UNIVERSITY, 735 East Building, 239 Greene Street, New York, NY 10003 (Contact: Laurie Wilson, PhD, ATR) DA—Art Therapy; PhD—Art and Art Education.

NORTHERN ILLINOIS UNIVERSITY, Department of Art, DeKalb, IL 60115 (Contact: Terri Sweig, MA, ATR, Department of Art) MS in Education, Major in Art with Specialization in Art Therapy.

SCHOOL OF THE ART INSTITUTE OF CHICAGO, Jackson and Columbus Drive, Chicago, IL 60603 (Contact: Don Seiden, ATR) MA in Art Therapy.

SOUTHERN ILLINOIS UNIVERSITY AT EDWARDSVILLE, School of Fine Arts and Communications, Dept. of Art and Design, PO Box 64, Edwardsville, IL 62026 (Contact: Dr. Joseph A. Weber, Head, Art Education) MFA—Art Therapy Specialization.

STATE UNIVERSITY COLLEGE AT BUFFALO, 1300 Elmwood Avenue, Buffalo, NY 14222 (Contact: John Rogers, MA) MS—Art Education.

UNIVERSITY OF BRIDGEPORT, University Avenue, Bridgeport, CT 06602 (Contact: Robert Brennan, Chairman, Art Department or Carol Paraskevas, ATR, Coordinator, Art Therapy Program), MS in Counseling, Art Therapy Specialty.

UNIVERSITY OF NEW MEXICO, Department of Art Education, College of Education, Albuquerque, NM 87131 (Contact: Dr. Howard McConeghey, Professor) MA in Art Education with Emphasis in Art Therapy.

UNIVERSITY OF TEXAS AT ARLINGTON, Graduate School of Social Work, Arlington, TX 76019 (Contact: Dr. Mary Lee Hodnett, ATR) MA in Interdisciplinary Studies.

UNIVERSITY OF WISCONSIN—SUPERIOR, Superior, WI 54880 (Contact: Dr. Marjorie Whitsitt, ATR, PhD) MA; MA in Art Therapy.

URSULINE COLLEGE, 2550 Lander Road, Cleveland, OH 44124 (Contact: Sr. Kathleen Burke, MA, ATR, Associate Professor and Coordinator, Art Therapy) MA in Art Therapy.

Graduate Level Certificate/Diploma Programs

ATLANTA ART THERAPY INSTITUTE, 1083 Austin Ave., Room 204, Atlanta, GA 30307 (Contact: Suzanne F. Fincher, MA, ATR, Director) Certificate of Completion.

MONTCLAIR CENTER FOR PSYCHODRAMA AND PSYCHOTHERAPY, 6 South Fullerton Avenue, Montclair, NJ 07042 (Contact: Harriet Power, MA, ATR, Director of Art Therapy) Graduate Level Certificate.

MOUNT MARY COLLEGE, 2900 North Menomonee River Parkway, Milwaukee, WI 53222 (Contact: Lori Vance, ATR) Graduate Level Certificate.

PHOENIX ART THERAPY INSTITUTE, 1814 East Granada Road, Phoenix, AZ 85006 (Contact: Krista Raudzens, ATR, Director) Diploma (DPATI) upon completion.

SCHOOL OF THE ART INSTITUTE OF CHICAGO, Jackson and Columbus Drive, Chicago, IL 60603 (Contact: Don Seiden, ATR) Professional Certificate in Art Therapy.

STATE UNIVERSITY COLLEGE AT BUFFALO, 1300 Elmwood Avenue, Buffalo, NY 14222 (Contact: John Rogers, MA).

TORONTO ART THERAPY INSTITUTE, 216 St. Clair Avenue West, Toronto, Ontario, CANADA M4V 1R2 (Contact: Martin A. Fischer, MD, D. Psych., Executive Director) Diploma upon completion.

UNIVERSITY OF LONDON, GOLDSMITHS' COLLEGE, Art Therapy Department, 27 Albury Street, DEPTFORD, London, SE 8, ENGLAND (Contact: Diane Waller, Head of Unit) Diploma in Art Therapy, Mode 1 Clinical; Mode 11 Education, M. Phil. (Research A/T).

Clinical Training Programs

ART STUDIO, INCORPORATED, Cleveland Metropolitan General/Highland View Hospital, 3395 Scranton Road, Cleveland, OH 44109 (Contact: M.K. McGraw, ATR) Academic credit. Clinical experience through accredited colleges.

BETHESDA HOSPITAL, Art Psychotherapy Department, 2951 Maple Avenue, Zanesville, OH 43701 (Contact: Bernard Stone, MFA, ATR) Clinical Interims: 8-20 weeks; Graduate students or post-grads only. Certificate.

CARRIER FOUNDATION, Adjunctive Therapies Department, Belle Meade, NJ 08502 (Contact: Frances F. Kaplan, MPS, ATR, Supervisor, Creative Arts Therapies) sixteen-week full-time or thirty-two week part-time internship. Certificate of completion.

HARDING HOSPITAL, 445 East Granville Road, Worthington, OH 43085 (Contact: Don L. Jones, ATR, LM, Director of Adjunctive Therapy) Graduate Level one year full-time Clinical Internship, Individually ATR Supervised, 2000 hours. Certificate in Art Psychotherapy. Collaboration with Master's programs possible.

MILWAUKEE PSYCHIATRIC HOSPITAL, 1220 Dewey Avenue, Wauwatosa, WI 53213 (Contact: Rose Washington, Supervisor of Activities) Certificate of Completion—600 hours, six months.

Institute Programs

EAGLE ROCK TRAIL ART THERAPY INSTITUTE, PO Box 2885, Santa Rosa, CA 94905 (Contact: Lillian Rhinehart, MA, ATR) Certificate.

INSTITUTE FOR EXPRESSIVE ANALYSIS, 325 West End Avenue, New York, NY 10023 (Contact: Dr. Arthur Robbins) Certificate Expressive Analyses.

MATRIX ART THERAPY INSTITUTE, 7447 Holmes Road, Kansas City, MO 64131 (Contact: JoEl Vogt, MA, ATR) Certificate.

NEW SCHOOL FOR SOCIAL RESEARCH, 66 West 12th Street, New York, NY 10011 (Contact: Erika Steinberger, ATR) Training Certificate.

PITTSBURG STATE UNIVERSITY, Art Department, 1701 South Broadway, Pittsburg, KS 66762 (Contact: Harry Krug, Chairperson).

ST. LOUIS INSTITUTE OF ART PSYCHOTHERAPY, 8407 Glen Echo Drive, St. Louis, MO 63121 (Contact: Mary St. Clair, ATR) Certificate.

THOMAS MERTON INSTITUTE, PO Box 11931, Shorewood, WI 53211 (Contact: Deirdre L. Kozlowski, MS, ATR) Certificate. (For information on TMI Minnesota Branch, contact: Virginia Shaver, MA).

Undergraduate Degree Programs Offering Art Therapy Prerequisites

ALBERTUS MAGNUS COLLEGE, New Haven, CT 06511 (Contact: Dr. William M. Sherman, Chairperson, Department of Psychology) BA in Art or Psychology—Art Therapy Concentration.

ALVERNO COLLEGE, 3401 South 39th Street, Milwaukee, WI 53215 (Contact: Sister Julie Knotek, ATR, Art Therapy Director) BA—Concentration in Art Therapy.

ANNA MARIA COLLEGE, Paxton, MA 01612 (Contact: Ralph A. Parente, Jr.) BFA.

BOWLING GREEN STATE UNIVERSITY, School of Art, Bowling Green, OH 43403 (Contact: Registrar) BS—Art Therapy.

CAPITAL UNIVERSITY, 2199 East Main Street, Columbus, OH 43209 (Contact: Richard Phipps) BA—Major in Art Therapy.

CARLOW COLLEGE, 3333 Fifth Avenue, Pittsburgh, PA 15213 (Contact: Carole Kunkle-Miller, MEd, ATR, Coordinator) BA in Art, with a Concentration in Art Therapy Preparation.

COLLEGE OF NEW ROCHELLE, New Rochelle, NY 10801 (Contact: Jo-Ann O'Brien, MA, ATR, Chairperson, School of Arts and Sciences Art Department) BFA and BS, Art Therapy.

COLLEGE OF SAINT TERESA, Winona, MN 55987 (Contact: John DeFrancisco, ATR) BA—Art Therapy.

DRAKE UNIVERSITY, Des Moines, IA 50311 (Contact: Jeanette Wright, ATR, Associate Professor and Director of Art Therapy) BFA or BA, Major in Art Therapy; MS—Concentration in Art Therapy.

EMMANUEL COLLEGE, 400 The Fenway, Boston, MA 02115 (Contact: Sister Susan Thornell, MA, Department of Art) BA in Art with Specialization in Art Therapy.

EMPORIA STATE UNIVERSITY, 1200 Commercial Street, Emporia, KS 66801 (Contact: Roberta Shoemaker, ATR) BS in Art Therapy.

ILLINOIS STATE UNIVERSITY, Normal, IL 61761 (Contact: Dr. Marilyn Newby, Art Department) BS, BA, BFA in Art.

INDIANA CENTRAL UNIVERSITY, 1400 East Hanna Ave., Indianapolis, IN 46227 (Contact: Chairman of Art Department) BS and BA in Art—Minor in Psychology.

JERSEY CITY STATE COLLEGE, 2039 Kennedy Boulevard, Jersey City, NJ 07307 (Contact: Herb Rosenberg, ATR, Chairman, Art Therapy Studies), BA, GFA.

MARIAN COLLEGE, 3200 Cold Springs Road, Indianapolis, IN 46222 (Contact: Sr. Sandra Schweitzer, OSF, Chairperson, Art Department) BA in Art—Concentration in Art Therapy.

MARYVILLE COLLEGE, 13550 Conway Road, St. Louis, MO 63141 (Contact: Muriel Eulich, MEd, ATR) BA—Therapeutic Art.

MARYWOOD COLLEGE, Scranton, PA 18509 (Contact: Sister Dorothy McLaughlin, RSM, EdD, ATR) BA in Art Education; BFA.

MERCYHURST COLLEGE, Glenwood Hills, Erie, PA 16546 (Contact: Joseph Pizzat, Professor of Art) BA—Art Therapy.

MOUNT MARY COLLEGE, 2900 North Menomonee River Parkway, Milwaukee, WI 53222 (Contact: Lori Vance, ATR) BA—Art Therapy.

NORTHERN ILLINOIS UNIVERSITY, Department of Art, DeKalb, IL 60115 (Contact: Dr. Caroline Allrutz, Department of Art) Bachelor of General Studies Program Contract Major—Emphasis in Pre-Art Therapy.

OHIO UNIVERSITY, School of Art, College of Fine Arts, Athens, OH 45701 (Contact: Geraldine H. Williams, ATR) BFA—Art Therapy.

PHILADELPHIA COLLEGE OF ART, Broad and Spruce Streets, Philadelphia, PA 19102 (Contact: Sherry Lyons, ATR, Director, Art Therapy) BFA in Studio Major with Concentration in Art Therapy.

PITTSBURG STATE UNIVERSITY, Art Department 1701 South Broadway, Pittsburg, KS 66762 (Contact: Harry Krug, Chairperson) BS in Education, Art Therapy Major.

SALEM COLLEGE, Salem, WV 26426 (Contact: Harold Reed, Arts Department Chair) BA.

SPRINGFIELD COLLEGE, Dana Fine Arts Center, 263 Alden Street, Springfield, MA 01109 (Contact: William Blizard, Chairman, Art Department) BS, BA.

STATE UNIVERSITY COLLEGE AT BUFFALO, 1300 Elmwood Avenue, Buffalo, NY 14222 (Contact: John Rogers, MA) BS—Preprofessional Studies in Art Therapy.

THE SCHOOL OF VISUAL ARTS, 209 East 23rd Street, New York, NY 10010 (Contact: Estelle Bellomo, ATR, Coordinator, Art Therapy Department) BFA—Concentration in Art Therapy.

TRENTON STATE COLLEGE, Hillwood Lakes, Department of Art, CN 550, Trenton, NJ 08625 (Contact: Marcia F. Taylor, PhD, ATR) BA—Art Therapy.

UNIVERSITY OF MIAMI, School of Education and Allied Professions, PO Box 248025, Coral Gables, FL 33124 (Contact: Dr. Marion F. Jefferson, Coordinator of Art Education) BA, BFA.

UNIVERSITY OF WISCONSIN—SUPERIOR, Superior, WI 54880 (Contact: Dr. Marjorie Whitsitt, PhD, ATR, Art Therapy Program Coordinator) BA.

URSULINE COLLEGE, 2550 Lander Road, Cleveland, OH 44124 (Contact: Sr. Kathleen Burke, MA, ATR, Associate Professor and Coordinator, Art Therapy) Certificate—Adjunctive Art Therapy Program.

WRIGHT STATE UNIVERSITY, 228 Creative Arts Center, Dayton, OH 45435 (Contact: Gary C. Barlow, EdD, ATR, Coordinator, Art Therapy) BFA, BA, BS in Art Education—with Coursework in Art Therapy.

Institutions Offering Courses in Art Therapy or Closely Related Subjects

ALFRED ADLER INSTITUTE OF CHICAGO, 159 North Dearborn Street, Chicago, IL 60601 (Contact: Evelyn Wachman, Registrar) MA—Counseling Psychology.

COLUMBUS COLLEGE OF ART AND DESIGN, 47 North Washington Avenue, Columbus, OH 43136 (Contact: Edward Lathy, Dean of General Studies) BFA in Art Therapy/General Studies.

MONTCLAIR STATE COLLEGE, Fine Arts Department, Upper Montclair, NJ 07043 (Contact: Dr. Susan E. Gonick-Barris, ATR).

PARSONS SCHOOL OF DESIGN, Department of Continuing Education, 2 West 13th Street, New York, NY 10011 (Contact: Judith Gerberg, MA, ATR) ASA, BFA.

S.P.O. MIDDELOO, Creative Therapies, 140 Hooglandseweg, 3813 AS Amersfoort (Contact: Dr. Arie Stuijt, Director).

UNIVERSITY OF CALIFORNIA EXTENSION—SANTA CRUZ, UC Extension, Carriage House, Santa Cruz, CA 95064 (Contact: Patty Barron, Continuing Education Specialist).

UNIVERSITY OF EVANSVILLE, Art Department, PO Box 329, Evansville, IN 47702 (Contact: Les Miley or Larry Barnfield) BS Art Therapy.

UNIVERSITY OF MISSOURI AT KANSAS CITY, School of Education, 5100 Rockville Road, Kansas City, MO 64110 (Contact: JoEl Vogt, MA, ATR).

The American Art Therapy Association, Inc.

1980 Isaac Newton Square South   Reston, VA 22090   (703) 476-5437

RESOURCES

The American Art Therapy Association serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA Office.

PUBLICATIONS

		Members	Non-Members
Creativity and the Art Therapists' Identity (1976) 118 pages		$3.00	$5.00
Art Therapy: Expanding Horizons (1978) 142 pages		$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages		$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages		$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages		$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages		$10.00	$14.00
Art Therapy Journal of the American Art Therapy Association		.00	$23.00
American Psychiatric Association Special Conference Proceedings Use of the Creative Arts on Therapy (1979)		$3.00	$4.00
National Art Education Association Journal: Special Issue Art Education, Vol 33, No. 4 (1980)		$3.00	$4.00
AATA Newsletter Subscription		.00	$9.00
Full Color Poster (16 x 20)		$1.00	$2.00
Stimulus Drawings and Techniques in Therapy, Development, and Assessment by Rawley A. Silver, EdD, ATR, HLM		$10.00	$14.00
Developing Cognitive and Creative Skills through Art by Rawley A. Silver, EdD, ATR, HLM		$14.00	$20.00

FILMS (Rental/Purchase)

		Members	Non-Members
Art Therapy: Beginnings (1977) 16 mm, color/sound, 45 minutes	Rental:	$30.00	$40.00
	Purchase:	$300.00	$400.00
Michael (1977) 16mm, color/sound, 12 minutes	Rental:	$20.00	$25.00
Art Therapy (1981) 16mm, color/sound, 12 minutes	Rental:	$25.00	$35.00
	Purchase:	$250.00	$325.00
Lori, Art Therapy and Self Discovery (1978) 16mm, color/sound, 32 minutes	Rental:	$30.00	$40.00
	Purchase:	$300.00	$400.00

ORDER FORM Make checks payable to AATA, and mail to the above address.

Indicate Quantity of Unit Items Below		Cost/Unit		Total
____________	( ) ×	____________	=	____________
____________	( ) ×	____________	=	____________
____________	( ) ×	____________	=	____________
____________	( ) ×	____________	=	____________
____________	( ) ×	____________	=	____________
		____________	=	____________

Proceedings Index (1976-1982)
$1.00 Members $2.00 Non-Members
Set of five Proceedings (consecutive years):
25% discount on total cost (Index:Free)
10 or more copies of any single issue: 15% discount on total cost
Discounts are available when purchasing quantities, as follows:
Set of four Proceedings (consecutive years): 20% discount on total cost (Index: Free)

Total Unit Costs = ____________
*Postage/Handling = ____________

Note: for postage/handling, add $1.50 for the first unit item, $.50 each additional unit. VA Residents add 4% Sales Tax.

Total Enclosed = ____________

Send To: ______________________________

____

____
city   state   zip code

BEST COPY AVAILABLE

Draw Me a Paradox? ... Family Art Psychotherapy Utilizing a Systemic Approach to Change

Shirley Riley, MA, ATR, MFCC

***Shirley Riley, MA, ATR, MFCC** is a faculty member of Loyola Marymount University, Graduate Program in Clinical Art Therapy, and an Art Psychotherapist, Didi Hirsch Community Mental Health Center, Family and Child Division.*

The author points out how family art therapy can be integrated into the systemic theoretical approach to family therapy, and supports the thesis that the use of creativity produces positive interactions in family therapy. Key theoretical principles of systemic family work described by the author are: the family as a system; positive connotation through art process; prescribing the symptom; utilizing the metaphor; family ritual; paradoxical interventions; the therapeutic double bind; homeostasis; and the termination of treatment. Three condensed case studies are presented in which techniques are highlighted, such as circular causality versus linear causality, forming a hypothesis, assessment of compliancy, and recursive patterned behavior and interventions.

Introduction

This article supports the notion that family art therapy can be successfully integrated into the systemic theoretical approach to family therapy. Moreover, the use of creativity—basic to both theories—produces a positive interaction resulting in a process that enhances family art therapy treatment.

In a paper delivered as a keynote address at the Family Therapy Network Symposium held in Washington, D.C., March 1984, Peggy Papp of the Ackerman Family Institute, New York, discussed "The Links Between Clinical and Artistic Creativity." Papp stated:

> The major goal of therapy, as of art, is to change a basic perception so that one 'sees differently.' Through the introduction of the novel or unexpected, a frame of reference is broken and the structure of reality is arranged." (Papp, 1984).

This remark (in my view) seems to be addressed to the family art therapist and leads one to question why family art psychotherapy plays a minor role in the growing field of family therapy.

Other family therapists have referred to the need for the therapist to bring to the work of psychotherapy a creative and innovative view, and this certainly could be one of the family art therapist's contributions. In an article in *Family Process* (June, 1984, Vol. 23, page 159) Stanton offers a theory of systemic change which includes several hypotheses. From his "Hypothesis 2" Stanton says:

> The extent to which a change is total will depend upon the similarity between the intervention and the actual interactive process addressed by the intervention. The more elements or dimensions—visual, auditory, kinaesthetic —attending or composing the intervention, the more effective that intervention will be in bringing about change.

The interactive process mentioned by Stanton can effectively incorporate these elements by the use of a variety of visual and kinaesthetic art media that are natural tools of the art therapist. This hypothesis reinforces the importance of the use of concrete imagery which has been an integral part of art psychotherapy from its beginning.

With this thought in mind, I have taken some of the key theoretical principles of systemic family work and have attempted to demonstrate how these techniques have been utilized by this art therapist. These principles are: 1) The family as a system; 2) Positive connotation through art; 3) Prescribing the symptom; 4) Utilizing metaphors; 5) Understanding family ritual; 6) Using paradoxical interventions; 7) Understanding a therapeutic double bind; 8) Maintaining homeostatic properties; and 9) Terminating treatment. This procedure of looking at the principles and demonstrating how certain techniques have been used by the author may help to focus on the "addition of art" and to study whether it enhances the effectiveness of the interventions made by the therapist. We can also gauge whether the art was an aid to the family in achieving relief from symptoms they have connotated as undesirable.

BEST COPY AVAILABLE

The Family as a System

The most basic concept of a systemic approach to change is based on seeing the family as operating within a system. The family as a system has often been defined as two or more people in a relationship interacting with each other in a recursive manner over a period of time, despite changes in environment. Within a systems approach, causality is seen as a process of *circular causality,* and it is judged anti-productive to see one member's behavior as separate or disassociated from the other members of the family system. The circular view of cause and effect in transactions is a radically different stance from the historically accepted *linear view* of events.

Another aspect of this definition lies in the concept that the family members are usually unaware of the redundant interactional sequences that make up the bulk of their patterned responses. It follows that family behavior can be understood when *seen* in the context of family rules and to observe how their rules serve to maintain the family stability or guard against its dissolution. Here "seeing" is a key word, since we can "see" in a unique manner many aspects of the system in the art product. The therapist's task is to discover how the dysfunction has taken a particular form and what patterns maintain what Minuchin calls "the family dance;" therefore the early assessment should speculate on the processes which appear to maintain the problem.

In the assessment phase this basic concept of causality and the other aspects of family systems (not mentioned in this brief definition) present a difficult challenge for the family therapist to understand and then decide which interventions to put into practice. It follows that at the beginning of treatment, an overview of the system and observation of the interactions between the members are the first steps that must be considered.

One of the more common and effective techniques utilized by family art therapists when they start treatment is to have the family do a *family drawing/mural.* Observation of the results of this task, which is left up to the family members to accomplish in any way they feel most natural, is an immediate opportunity for the therapist to form a hypothesis about the family system and to think about interventions that will redirect the family's interactions.

> ***"The most basic concept to a systemic approach to change is based on seeing the family as operating within a system."***

The task of a family drawing together enables the therapist to introduce these concepts: *definition of the problem, pose the dilemma of change,* and *formulate the treatment* in a manner best accepted by this particular family.

Let's look at some of the technical underpinnings of this family mural task:

a) The therapist has *taken control* early by persuading the family to use a media (art) which, for most families, is unfamiliar and, sometimes, even adverse to their idea of what therapy should be. The thought of doing art as a therapy seems to many families a "ridiculous way" to solve serious problems since it includes offering pleasurable experiences such as use of media, color, etc. How paradoxical (they feel) to expect pleasure to relieve pain! Based on their acceptance or rejection of the new experience, the therapist can begin to speculate whether the family falls into the *compliant* or *non-compliant* mode of family systems. The next move is to decide how it would be appropriate to further test their high/low resistance to change (or new ideas) and then decide on an approach to treatment.

Interventions, interpretations, and homework are tailored to these considerations. A family that is compliant and ready for change may need only suggestions, feedback, and a new way of looking at their problems. At the other end of the scale, a non-compliant family with a system rigidly resistant to change requires a different set of techniques.

In returning to the task of the family mural, we can examine how the therapist's utilization of the task can facilitate appropriate interpretations.

b) The family members reveal their family system in the mural drawing. All family members are represented; spatial, dominant and sub-dominant positions are noted; verbal and non-verbal messages are sent and received, they are either rejected or acted upon. In short, so much can be observed by the therapist in the mural, and in the way the family created the drawing, that he/she can proceed to use some of the following techniques if they serve the goals.

In Minuchin's book, *Families and Family Therapy,* 1976, he refers to the family structure as an "invisible set of rules that govern transactions...Family structure becomes visible in the behavioral transactions between family members." Family art therapy provides tasks which serve to make the invisible visible and which simultaneously supplies a process to observe the family behavior.

Positive Connotation Through Art

A *positive connotation* of the family's motivation and behavior can be introduced in an explicit and concrete manner through the art. If the therapist observes how each member has, for example, demonstrated that they "have worked with the others on the paper and have risked expressing their place in the family," or, "families who take a chance to draw together are families who demonstrate they are able to risk new experiences," the therapist may then define other behaviors within a positive frame. This supports the fact that indeed this family *has* been able to engage in doing a task together that is unfamiliar to them. The implications that can be made from the family drawing can begin to *reframe* the family behavior in a manner that shifts the emphasis from "a family group who is at the clinic because of an inability to solve problems," to "a family which has strength that will serve them in solving problems that they no longer wish to have as part of their interactions."

Positive connotation of behavior or *redefining* behavior is not a simple positive support of the family or an individual in the family, (i.e. "you are good people.") The redefinition is based on the therapist's assessment of the family system and how each piece of behavior can be seen to be a gesture to preserve the family stabil-

"... at the beginning of treatment an overview of the system and observation of the interactions between the members are the first steps that must be considered."

ity. Not all redefining is presented in the same way; certainly with violent, illegal, or suicidal acts the therapist *avoids* positive connotation of the acts themselves and deals with the motivation behind the behavior. This aspect of when to avoid the use of positive connotation must be clearly defined and emphasized for the therapist new to this approach.

Any assumptions and interpretations made by the art therapist must be based on an honest appraisal and an empathetic feeling toward the family. In addition, it is necessary to have an attitude of respect and attentive focus on the family's display of behavior and emotions and do a great deal of theoretical thinking about how the family system works. This is a responsibility that supersedes any choice of approach or manner of working. However, the expressive product that is a result of the family's group or individual effort gives the art therapists additional avenues for appreciating underlying messages and covert alliances within the system. The *therapeutic plan* or tentative, first *hypothesis for treatment* is then based on a body of information that is enriched by the material the family has provided through verbal and non-verbal levels of communication.

Case I

A family of seven children, ranging from the age of 7 years to 19 years, and their mother, came into art psychotherapy five months after the untimely death of the father. Before his death the family had functioned in a "normal" manner; all of the children were well-cared for and wanted by the parents. They had regarded themselves as a "happy family." After Father's death, (which followed a stroke and five months of life support treatment) the family began to fight violently and the children demanded an outrageous and unrealistic amount of material goods as well as emotional support from the mother. At the first session the family promptly revealed that they had not talked with each other about the loss of their father and, in addition, they couldn't understand why the mother, who had always been the disciplinarian and limit setter, had become so withdrawn and lacking in forcefulness. The family spent the first hour drawing a "good bye" drawing to Father and, with the therapist's support, sharing their feelings about the loss. They had been afraid to burden each other with additional sorrow and had therefore turned away from each other in their pain. The symptom of "fighting" seemed to be a projection outward of anger around the father's death.

After a coffee break they did a *family mural*. Each worked with an individual color. They elected to draw their last fishing trip on a boat with Father. Among the multiple issues that were explored during the review of the family mural, one major focus was on the fact that the oldest son, of fourteen, had drawn himself steering the boat, and then drawn his father up in the sky. This was quickly seen by the family as a parallel to his attempt to take over a father role in the family. This effort to be Father had caused a major part of the verbal fighting in the sibling sub-system since he was not only very inept in this role, but in addition, he was preceded in age by three older sisters who also were vying for some part of the parental position.

At the end of the session the art therapist gave the mother this *prescription* to be read at home to the family every evening. First, the family, and particularly the oldest son, were congratulated on their sensitivity to the family's needs. The boy was further supported for his willingness to sacrifice his youth to perform a role that turned him into a 47-year-old man and forced him to give up the adolescent pleasures enjoyed by most 14 year-old males. The therapist recommended that he continue to act as father, and to further improve his skills to lead and parent the family by isolating himself from his older sisters and his friends and by studying bookkeeping and household management. Second, the sisters were to be respectful, make him his favorite foods and not be rude or sassy to such a dedicated member of the family. Third, the mother as head of the family was to monitor these actions and to point out to the family how their fighting and rudeness to one another had helped her become more perceptive and able to structure some resolution for their problems. She had the power to modify any of the therapist's suggestions and report these changes at the next session, because as head of the household she was the final authority.

This *prescription* or "prescribing the symptom" seemed to be necessary to push the family interaction pattern off balance and would hopefully result in a new configuration of the field.

Paradoxical prescriptions serve as a means of isolating behaviors, requiring that behaviors occur artificially (Agell, 1982). Ritualized prescriptions must be carried out at specific and regular times. This method forces the clients to think about their situation or act it out in a prescribed fashion. (Weeks and L'Abate, 1982, pg. 92).

Needless to say, the recommendation failed. When this was re-

"The thought of doing art as a therapy seems to many families a 'ridiculous way' to solve serious problems since it includes offering pleasurable experiences such as the use of media, color, etc."

ported at the next session, the therapist remained "puzzled," the mother took over and delegated family tasks and demanded some improved manners, the son refused to be a responsible adult-figure and wanted time to be "14," and everyone reflected that no one could "father" the family the way their beloved father had when he was alive. They agreed to work on a new way of living together "without father" in future sessions.

This method had raised their awareness and had increased the intensity of the symptomatic behavior. The family then chose to find a "better" solution to their problem. The therapist had successfully *"lost"* and *the family was the real winner*.

Prescribing the Symptom

Prescribing the symptom is defined in this manner: "Having been defined positively as serving one another, both the symptom and system are prescribed. The wording of the prescription is extremely important. It should be brief, concise, and unacceptable to the family. If it is acceptable there will be no recoil" (Papp, 1983).

Utilizing Metaphors

To be able to communicate and *join* with a family, the therapist is best understood if he/she enters into the family's world view by utilizing *metaphors* particular to the family. It is here that the creative artist in the art therapist can be so successfully utilized. In the family's art products we have a greater opportunity to move into the metaphoric language by observing the product and being attentive to how the family speaks and interprets the artwork. Creatively using their metaphors strengthens the therapeutic relationship since it is a language tailored to "fit" this particular family and no other. After the joining process begins to succeed, we can next evaluate how the family sustains the problematic situation. Through the use of art therapy tasks which provide visual as well as verbal material we may begin the process of change.

> ***"Family art therapy provides tasks which serve to make the invisible visible and which simultaneously supplies a process to observe the family behavior."***

Case II

A family of four came for treatment: a mother, father, daughter (15 years) and son (13 years). Their system was sustained by a "blaming" technique that allowed each member to recognize the unhappiness in the family but expect the solution to be achieved when another member changed in some way. This was reinterpreted as "each member loving the other more than they loved themselves and therefore always being attentive to another rather than themselves." Following this reframing the family said, "this was the first time any therapist had really understood how they felt." They agreed that the son was the person that needed to change the most and the son also supported this view. The family was judged *to be highly resistant to change but compliant to task performance*. (This assessment was based on the beginning sessions.) It included a long past history of unsuccessful individual therapeutic treatment, a marriage that was endured by the couple as a formality; numerous diagnoses of the boy had been made as "learning disordered, oppositional behavior, high I.Q., not using his potential;" and in addition, there was the fact that both children were adopted and had multiple unresolved feelings around this issue.

The family decided they would be willing to *build their home together from construction paper*, since most of the complaints were focused on the activities and unfulfilled tasks performed in the home. They made every attempt to represent the home in a realistic manner. The process revealed: Father and Mother aided the construction to a minor degree while constantly correcting and criticizing each other; the daughter refrained from helping except for a mark or two on the walls; the son competently solved most of the building tasks and persisted until the home was completed. Paradoxically, the way the family observed this process was to deny that the son had really contributed much effort, that the daughter had "meant to cooperate" and that Mother and Father alone had provided the basic structural support for the paper house. The art therapist did not modify this perception but just puzzled about "who did what, when?" It became apparent that because of the way the process was experienced by the family they were unable to appreciate how involved and concerned the "bad" son was in building the home, how minimally cooperative the "good" girl was in this same task, and how the parents failed in providing structure for completion of the task.

Understanding Family Ritual

At this junction in art therapy with the family described above, the therapist was faced with a decision as to how to proceed with the treatment. Based on the conviction that the family was highly resistant to change, the therapist decided to prescribe a *family ritual*. Therefore, the following suggestion was made to the family near the end of the session.

"The family was congratulated for completing such a difficult art task and sharing their home with the therapist by creating it during their session. It was the therapist's recommendation that every evening after dinner they place the little house on the dining table and each person point out what part they had built. They were not to refer to the house or the process of creating it at any other time until they brought it back into the art therapy session the next week. They were under no circumstances to attempt to generalize the involvement of the family construction of the house to the emotional and behavioral involvement of the family members and the actual functioning of the family.''

> *''My belief is that a positive-synergistic action takes place when family art therapy is based on this epistomology.''*

These instructions were written, given to the father and read aloud by him each evening before they talked about the paper construction.

The family came in the following week and made little reference to the house. However, they were concerned that ''the daughter had become so uncooperative'' and surprised that ''the son appeared to be much more attached to the family,'' even though nothing had changed with the household tasks which were performed in the same manner during the week. No further mention of the ''homework'' (i.e. ritual) was made except to verify that they had followed through on the directions given them for the daily review.

From this session on, the boy was no longer referred to as the ''problem-child.'' The focus shifted to the daughter and, in due time, to the marital relationship.

This non-critical approach aided in modifying a firmly entrenched interaction and recurrent patterned response in this family. It succeeded in achieving the desired results by replacing an old perception of how the family members performed with a more realistic and workable view. When the family was released from the stereotypes they had assigned and accepted to and from each other, they were able to move on from an outmoded stage to a new level of development.

Using Paradoxical Interventions

Webster's International Dictionary defines *paradox* as ''an assertion or sentiment seemingly contradictory or opposed to common sense, but that may be true in fact...''

According to Papp (1983, page 33), ''Designing a systemic paradox, the therapist connects the symptom with the function it serves in the system and prescribes each in relation to the other. The consequences of eliminating the symptom are enumerated and the therapist recommends that the family continue to resolve their dilemma through the symptom.''

''The therapist must be convinced that the paradoxical messages only appear to be contradictory. It contains a double message to the family—one implies it would be good for them to change, the other implies it would not be so good—and the messages are delivered simultaneously.''

This message must be delivered with conviction and sincerity and believed to be a true interpretation of the observed family transaction.

Paradoxical interventions used by the art therapist are no different than if this technique became the treatment of choice by a therapist of another discipline. Usually, the art therapist sees in the art product more of the covert interactions than the clients have been willing to discuss. Since the art therapist is aware (through the messages surfacing in the art) of the second level (covert) stress points, he/she can better tailor the paradoxical intervention to address both available and less available material. These interventions vary from a simple directive, for example, to a resistant adolescent (''Don't draw today, we want you to remain silent as your blank page, while the family talks about your problems'') to a more complicated directive which involves the family doing a task in a structured way that reinforces and highlights the problem-maintaining interactional pattern.

Understanding a Therapeutic Double Bind

Therapist resistance to utilizing *paradoxical interventions* or *double bind messages* is based on a fear that these techniques could be destructive, overmanipulative, and bordering on unethical practice. If the therapist understands the difference between the double bind that produces toxic behavior and the *therapeutic double bind*, chances are that his/her anxiety will be alleviated.

The original double bind theory described by Bateson is referred to in Lynn Hoffman's book, *Foundations of Family Therapy*, (1981, page 20). ''The basic ingredients that create this kind of impasse are: 1) A primary negative injunction, 'Don't do that,' 2) A secondary negative injunction at another level which conflicts with the first, 'Don't listen to anything I say,' 3) An injunction forbidding comment (usually non-verbal cues reinforcing rules that no longer need to be made explicit), and another forbidding person to leave the field (often delivered by context, as when the person is a child), 4) A situation that seems to be of survival significance, so that it is vitally important for the person to discriminate correctly among the messages, and 5) After a pattern of communication containing these elements has become established, only a small reminder of the original sequence is needed to produce a reaction of rage and panic.''

In contrast, the authors of *Pragmatics of Human Communication*, Watzlawick, Beavin, and Jackson (1967), describe how the *therapeutic double bind*, works by pointing out that in a pathogenic double bind the patient is ''damned if he does and damned if he doesn't.'' In a *therapeutic double bind*, since he/she is told not to change, he/she is in a similar trap, but with a different outcome. If one

> *''...the expressive product that is a result of the family's group or individual effort gives the art therapists additional avenues for appreciating underlying messages and covert alliances within the system.''*

BEST COPY AVAILABLE

resists the injunction, he/she changes; if one doesn't change, he/she is "choosing" not to change. Since a symptom is something, which by definition, one *"can't help"* he/she is then no longer behaving symptomatically. Thus he/she is "changed if he does and changed if he doesn't." It is a bind where a positive reward is provided upon completion rather than a negative impasse.

A mild form of therapeutic bind which we art therapists, even in our student days, were comfortable giving to clients was structured in this manner, "being able to draw your feeling is important, but difficult, so why don't you make it easier for yourself by choosing either a good feeling or a bad feeling to draw today." This is an example of an *allusion of alternatives.*

Considering, in the above example, that no one has ever "seen a feeling" and considering that the options for choice were constructed to gain the desired end result, it follows that when the art therapist recognizes and reinforces the value of the client performing this "impossible" task he/she provides a reward that modifies this bind into a therapeutic experience. At this point perhaps one can see that the use of paradox and art therapy have been bed-fellows for a long time!

Case III

An intact family of five, a mother, father, 11 year old son, 13 year old daughter and 11 month old son, requested treatment at the clinic because the teen-age girl had refused to attend school for the last one and a half years. She displayed violent behavior when the parents attempted to force her to return to school, i.e. kicking a hole in the door, screaming and threatening to harm herself. The presenting problem was that they felt they needed therapeutic help to get the girl back to school.

> *"To be able to communicate and* **join** *with a family, the therapist is best understood if he/she enters into the family's world view by utilizing* **metaphors** *particular to the family."*

The following observations were made in the initial assessment period. The mother and father were strongly attached to one another and both perceived the other in a positive manner. This was a Latino family and the male/female roles of dominance and sub-dominance were complimentary and functional at this time. The father became rather overassertive and loud when drinking beer on the weekends but more importantly he provided well for the family and did not distance himself. The mother was pleased with her new baby, liked her marriage, enjoyed the children (until recently) but was now ready to pick up a more active social life since the little boy was no longer an infant. The pre-adolescent son was perceived by the family as a "good" child. He was socially adjusted, a poor student (which was ignored) and often absent from school. He was, in fact, home about half of the school days but this pattern was also overlooked by all. The toddler son seemed to be a happy, healthy baby that was thriving. The daughter described her position in the family as one of being unloved and undervalued. She resented her father's loud yelling at her mother (even though the mother did not perceive it as "yelling"), she was "afraid" to go to school because of the noise and she "hated" her younger brother and her father.

The pattern of the family was to allow daughter to sleep late every morning. During this time, Mother went to the school and picked up her daughter's homework, which the girl accomplished during the day and thus kept her grades adequate. When school was over the daughter's friends came by. They either swam in their pool or picked up Tina (a pseudonym) and went out cruising. They used street drugs and alcohol and returned home very late. Tina denied that she participated in the substance abuse in a heavy manner. This recursive behavior pattern evolved and had been maintained since the mother announced her pregnancy with the last child one and a half years ago.

The group drawings made by the family and the art expression done in individual sessions revealed that each member, with the exception of the pre-adolescent son, was very anxious to make a change. However, every attempt at solving the problem seemed only to maintain the problem. The family was so locked into this system that it needed something to help the family members move to a new and more satisfying set of interactional patterns.

The artwork was essential in making this assessment because each member saw the dilemma and was able to illustrate the components. But even though they were able to verbally and visually lay it all out they were "stuck" in their interrelational system. They projected a feeling of hopelessness.

At the end of one unhappy session this paradoxical prescription was given to the family.

The daughter was acknowledged as the mainstay of the family who was attempting to keep the family "in balance" by sacrificing her normal youthful patterns of school/play. To this end it was advised that Mother should respect her position and wait on her and bring her meals to her room and make every effort to make her life even more agreeable. The father should come home early every day and check that the mother had pleased the daughter, but *not* talk directly to the girl. The brother was to bring his school progress record home every day and read it to his parents without Sister being present in the room. Daughter was advised that "although she was giving her mother so much support she needed to increase it and therefore no longer go out with her friends *at all*. She must spend more time in her room and increase her efforts to maintain the family. The more she stayed home the more the family would stay in this stable system."

The family looked startled with this "advice" but promised, in their desperation, to give it a try.

The following week the family came in very angry. Within two days of living by the new rules, the mother and father demanded that the daughter go back to school. The daughter countered by agreeing to go to school if she could go to the therapeutic school the therapist had suggested. The next day she and her mother enrolled her in this new school. The son had "forgotten" to bring his school report home but had attended school every day.

The family was very defiant in mood and aggressively told the therapist that "her plan was not workable and they simply had to take the decision in their own hands." The therapist then accepted her failure and congratulated them on their success.

This paradoxical prescription seemed to be successful since the family achieved its desired ends of returning the girl to school and did it on the family members' own terms. The system was clarified when the connection the symptom had with the system emerged. This enabled them to modify the system and move to a new level of functioning even without "insight."

Maintaining Homeostatic Properties

Each family system varies according to the amount of fluctuation and degree of internal variation it will tolerate. To maintain stability families exhibit *homeostatic properties*, such as responding adaptively to new circumstances that impact the family from within and without. However, if the homeostatic process is maintained inappropriately and resists acknowledging changing circumstance then this persistence produces maladaptive, symptomatic reactions. An expansion of this notion with the concept of heterostasis or morphogenesis, which is based on processes of positive or negative feedback loops, is a concept that could be pursued in future articles.

> *"If the therapist understands the difference between the double bind that produces toxic behavior and the* **therapeutic double bind**, *chances are that his/her anxiety will be alleviated."*

Terminating Treatment

The time when the family is ready to *terminate treatment* can be anticipated when the therapeutic process reaches a point where the patterns, both verbal and visual, that were the target of discomfort have changed and become more adaptive. A successful outcome of therapy is evaluated when behavior and meaning are changed on both first and second levels of reality. Benjamin and Bross (page 92, 1984) describe change: "Evaluation of change should depend neither on the therapist's subjective judgment nor on the client's subjective report; rather, it should be a matter of empirical evidence, that is, behavioral sequences and ways of attributing meaning that were observed regularly prior to intervention no longer occur following intervention."

If we are fortunate, and termination is a result of success, the ending is done with attention to these final goals: 1) Gains are solidified by giving the family full credit for all changes; 2) Success is maintained by speculating on possible failure which will mobilize the family to resist this prediction; and 3) Follow up sessions are offered in the future (six months) to allow for the ongoing process of change to take place and therapeutic reinforcement be available if needed.

Again a technique which has been a bedrock of the termination process in family art psychotherapy, namely, a *review of the family's art products*, can be of great use to accomplish the above goals.

How better can the family members "own" their own struggles and resolution with problems, than to *see* what they accomplished over a period of time? If the therapist has used the strengths of the family and consistently resisted taking credit for change, and has, in fact, been "worried" at the rapid changes and has been "troubled" that the consequences might lead too quickly to problem resolution, then the therapist has helped the family members to become familiar with the idea that they are capable of "doing things that they could not previously do." Often the family will terminate rather quickly, because the members feel they have been able to solve the problem better than the therapist. The "failure" of the therapist to predict the exact outcome and which results in success for a family is often most clearly *seen* when the entire course of therapy is reviewed through the art work at the close of therapy. As the family members point out the sessions where they moved from a patterned response to a new combination of more gratifying interactions, in the visual as well as verbal process, both family and therapist can appreciate the successful results achieved by the combination of a systemic theory and a synthesis of these techniques with art psychotherapy.

Conclusion

In this article an attempt has been made to demonstrate how some of the basic theories of systemic-strategic therapy are compatible with the theory and techniques of family art psychotherapy. The art tasks which reflect the attempts of the family to solve its problems also enrich the ability of the family to be expressive. Through the graphic and verbal process displayed in family art therapy the therapist is, in this author's view, almost forced to view the family as a system.

> *"The art tasks which reflect the attempts of the family to solve their problems also enrich the ability of the family to be expressive."*

BEST COPY AVAILABLE

With the conviction of the worth of the systemic approach as a base, some of the techniques of how to work with that system were reviewed: the notions of circular causality vs. linear causality, forming a hypothesis, assessment of compliancy, positive connotation, recursive patterned behavior and paradoxical interventions, etc. Although the information offered is limited, the hope is that the family art therapist will be stimulated to pursue learning the theories of this methodology more extensively and to test if it stimulates a more creative approach to family work which will result in more successful outcomes. My belief is that a positive-synergistic action takes place when family art psychotherapy is based on this epistomology.* I also feel that the creative potential which exists in this combination can enhance the position of the clinical art therapist in the field of family therapy.

References

Ackerman, N.W. (1958). *The psychodynamics of family life.* N.Y.: Basic Books.

Bateson, G. (1978). "The birth of a matrix of double bind epistemology." In M.M. Berger, Ed. *Beyond the double bind.* N.Y.: Brunner/Mazel.

Bowen, M. (1978). *Family therapy in clinical practice.* N.Y.: Jason Aronson.

Bross, A., and Benjamin, M. (1982). "Family therapy: A recursive model of strategic practice." In A. Bross, ed. *Family therapy: A recursive model of strategic practice.* Toronto: Methuen.

Dell, P.F. (1980). "Researching the family theories of schizophrenia: An exercise in epistemological confusion." *Family process.* (pp 321-325).

Fisher, L., Anderson, A., and Jones, J.E. (1980). "Types of paradoxical intervention and indications/contraindications for use in clinical practice." *Family process.*

Haley, J. (1963). *Strategies of psychotherapy.* N.Y.: Grune & Stratton.

Haley, J. (1973). *Uncommon therapy.* N.Y.: Ballantine.

Haley, J. (1976). *Problem-solving therapy.* San Francisco: Jossey-Bass.

Haley, J. (1980). *Leaving home: The therapy of disturbed young people.* N.Y.: McGraw-Hill.

Hoffman, L. (1981). *Foundations of family therapy: A conceptual framework for systems change.* N.Y.: Basic Books.

Landgarten, H. (1981). *Clinical art therapy.* New York, NY. Brunner/Mazel

Madanes, C. (1981). *Strategic family therapy.* San Francisco: Jossey-Bass.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, Mass.: Harvard University Press.

Minuchin, S., and Fishman, H.C., (1981). *Family therapy techniques.* Cambridge, Mass.: Harvard University Press.

Palazzoli, M.S., Cecchin, G., Prata, G., and Boscola, L. ((1978). *Paradox and counter-paradox: A new model in the therapy of the family in schizophrenic transaction.* (Trans. E.V. Burt), N.Y.: Aronson.

Papp, P., ACSW. (1983). *The process of change.* N.Y.: Guilford Press.

Stanton, M. D., Ph.D., (1984). "Fusion, compression, diversion, and the workings of paradox: A theory of therapeutic/systemic change." *Family process,* Vol. 23, No. 2, June.

Watzlawick, P. (1978). *The language of change: Elements of therapeutic communication.* N.Y.: Basic Books.

Watzlawick, P., Beavin, J.H., and Jackson, D.C. (no date). *Pragmatics of human communication.*

Watzlawick, P., Weakland, J., and Fisch, R. (1974). *Change: Problem formulation and problem resolution.* N.Y.: Norton.

Weeks, G. and L'Abate, Luciano. (1982). *Paradoxical psychotherapy.* N.Y.: Brunner/Mazel, Inc.

**Epistomology*

Epistomological:
"The study of the method and grounds of knowledge, esp. with reference to its limits and validity; the theory and knowledge."—Webster International Dictionary.

"The rules one uses for making sense out of the world." Bateson; *Hoffman,* p. 342 (1981).

"This new epistomology would influence profoundly not only the way one thought about therapy, but how one practiced it." *Hoffman,* p. 345 (1981).

Guidelines for Authors

Please submit four (4) copies of manuscripts to: AATA Journal, 1980 Isaac Newton Square South, Reston, VA 22090. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½×11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5"×7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

Nasco
ARTS & CRAFTS

Nasco
ARTS &
CRAFTS
FORT ATKINSON, WI OR MODESTO, CA
STOP AND SEE US AT OUR BOOTH
300

WRIGHT
STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:
Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

BEST COPY AVAILABLE

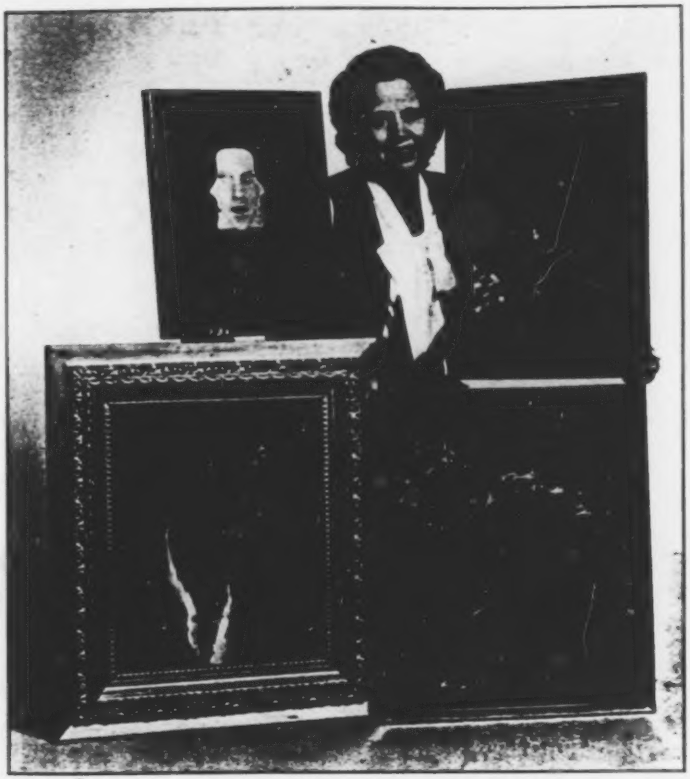
Seven Artists in One Body

Seven different artists, each with distinctive styles and techniques, along with 15 mother personalities, emerged within Chris Costner Sizemore. She had begun painting as therapy toward recovery from the multiple personality disorder diagnosed in 1952.

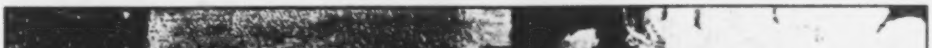
Her story of courage, recounted in the film "The Three Faces of Eve," and her autobiography, *I'm Eve,* has fascinated the world.

The American Art Therapy Association welcomes Chris as its Special guest at the Annual Conference. She will deliver the keynote address on October 27. A reception for her and an exhibit of her art work is scheduled for that evening.

Featured here and on the next three pages are photographs of several of the paintings she will exhibit. (Photographs by Betsy Perdue)

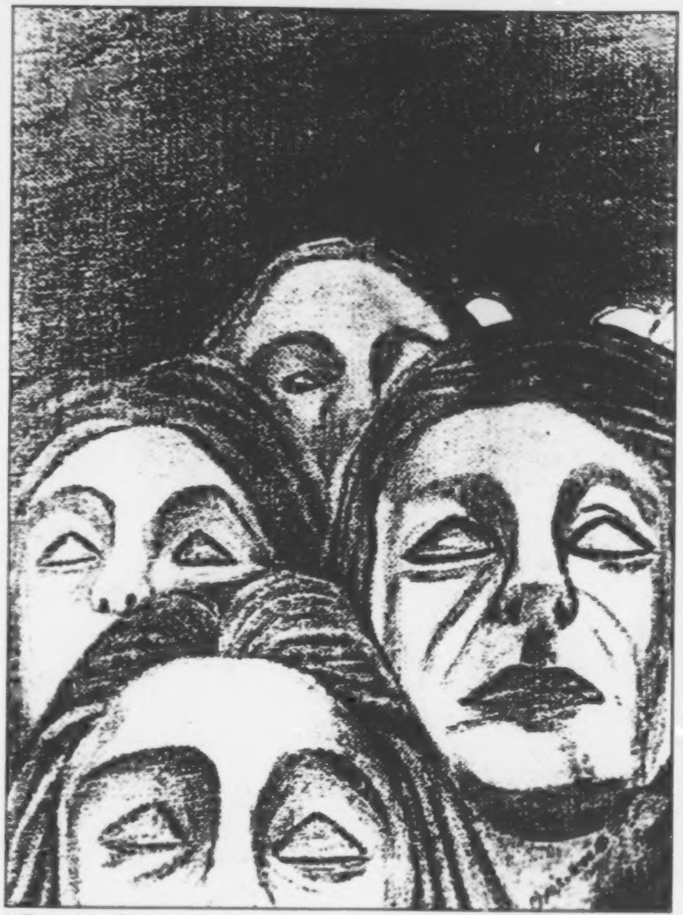


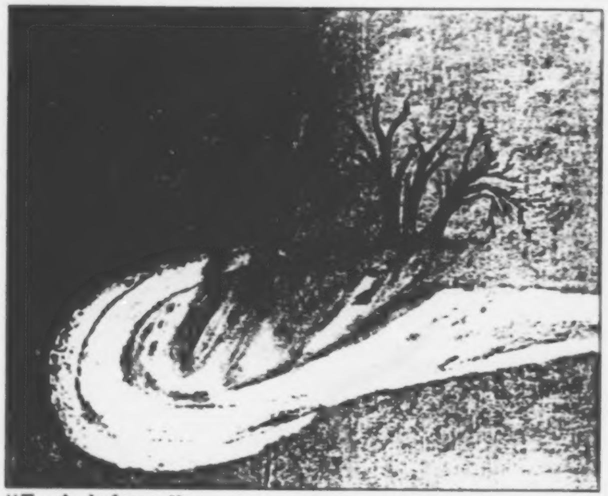
Chris Sizemore at right with four of her paintings. Their titles, clockwise are: "The Attic Child," "Three Faces in One," "Journey into Darkness," and "Taffy—a Portrait of a Daughter." (The latter will not be exhibited at the Conference.)

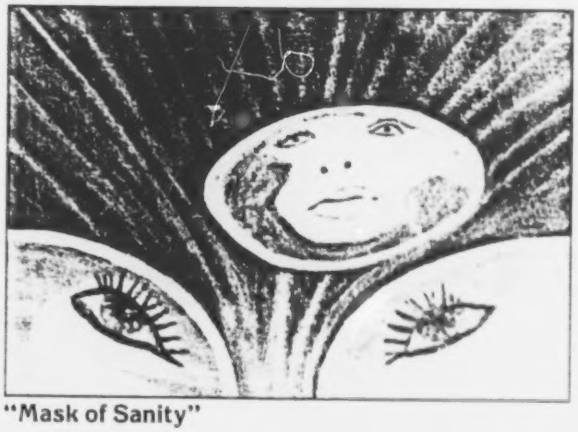


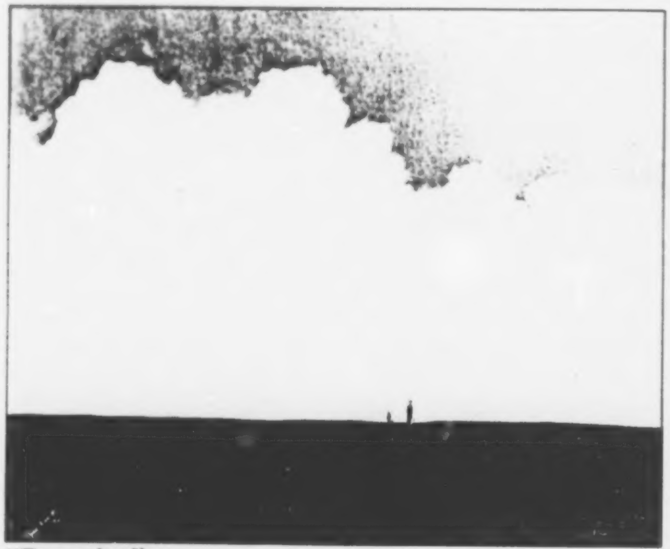
"Free Art"

BEST COPY AVAILABLE

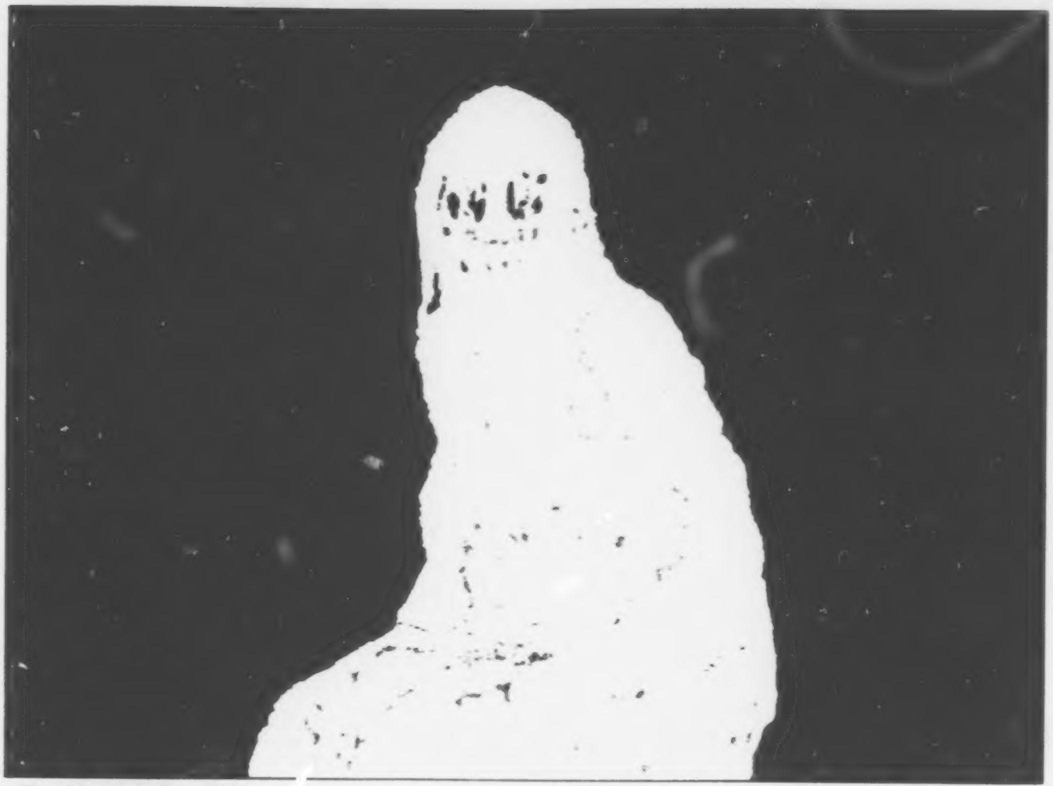

"Psychic Sisters"


"Eve's Inferno"

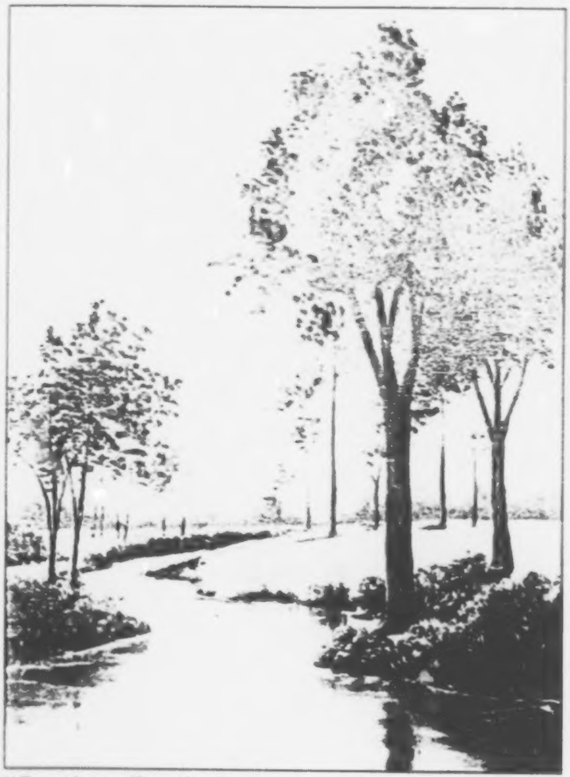

"Mask of Sanity"


"Emerging"

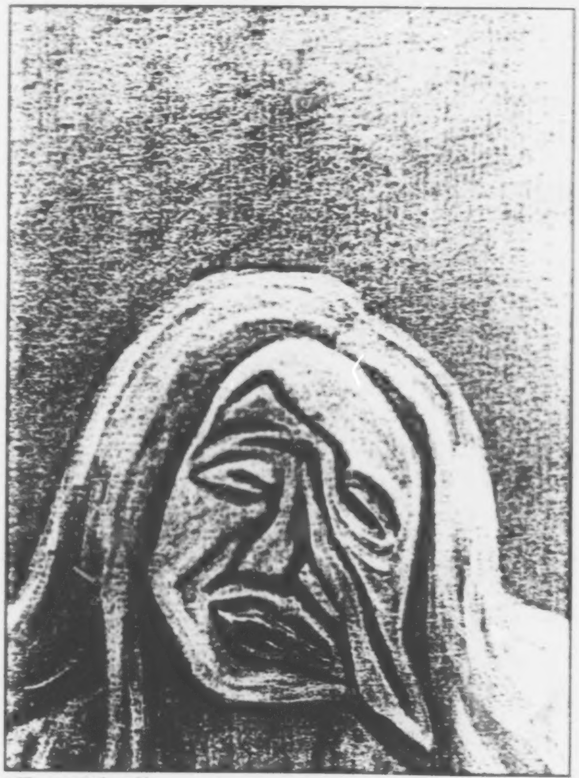
BEST COPY AVAILABLE



"The Human Candle"

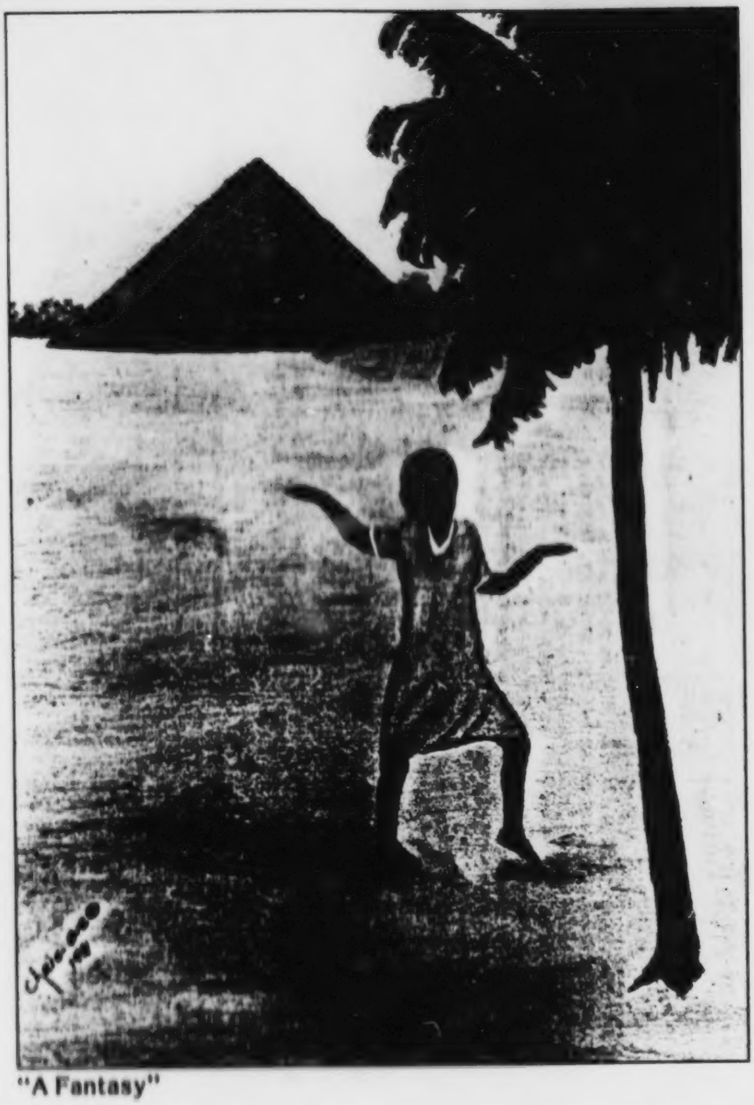


"Southern Sunrise"

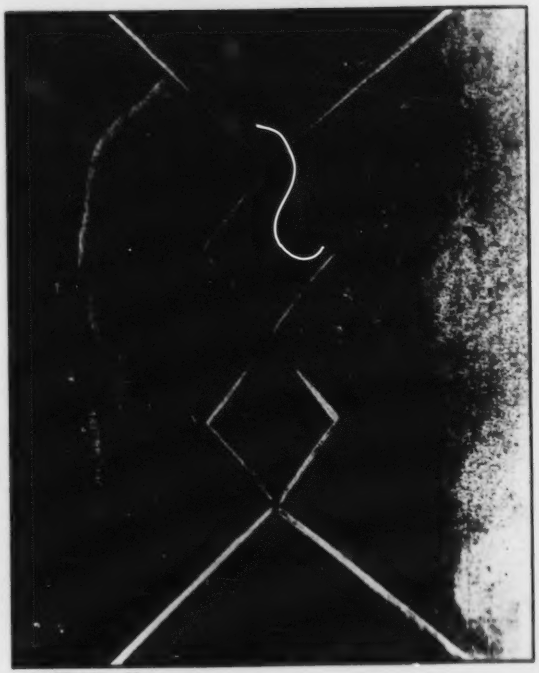


"Transition"

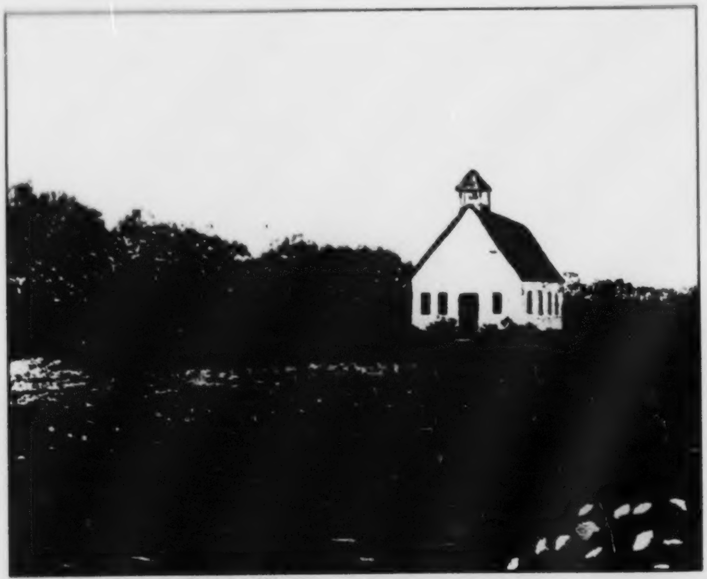
BEST COPY AVAILABLE



"A Fantasy"



"Splitting"



"Pleasant Lane School"

BEST COPY AVAILABLE

Image Induction in the Countertransference: A Revision of the Totalistic View

Robert Wolf, MPS, ATR

***Robert Wolf, MPS, ATR** is a full-time faculty member of the Graduate School of the College of New Rochelle where he teaches art therapy and studio art courses. He is a practicing psychoanalyst, art therapist and sculptor. He is a senior member of the National Psychological Association for Psychoanalysis, a member of the faculty of their Training Institute and the Institute for Expressive Analysis. He is the author of many articles on art therapy and phototherapy, and is a contributing editor to **Art Therapy**.*

This article presents an integration of psychoanalytic and creative art therapy concepts in an attempt to expand the parameters of what psychoanalysts call "totalistic" countertransference. The totalistic view of countertransference, regression and empathy, and projective identification are described and discussed, followed by a brief section on visual reception in which the author supports the belief of the necessity for making creative art materials available to both the patient and the analyst during the session. When art materials are used, identification and understanding the significance of images can take place. A clinical example (Miss A.) is presented; the patient is a 33 year old artist who began psychoanalytic psychotherapy two years previously, and currently is better able to understand some of the aspects of attachments to a boyfriend and to a clinging mother. Intellectual, disconnected experiences were evident from the patient's past experiences, and the author points out the need—and some procedures—for resolving this disconnectedness. A brief discussion of the case is presented, followed by a summary statement regarding a technique, with appropriate cautions given.

Introduction

A focus of this article is on an integration of psychoanalytic and creative art therapy concepts in an attempt to expand the parameters of what psychoanalysts call "totalistic" countertransference. Although psychoanalysis and creative art may at first seem quite different from each other, they may indeed have much in common and, in fact, complement each other. Freud himself, in his paper *On The Question of Lay Analysis*, comes to the conclusion that psychoanalysis is, in fact, an "art" rather than a science, and people who are themselves especially creative may be the most particularly well disposed to become psychoanalysts (Freud, 1927). Before I present the major theme of this paper, I would like to define several terms which are often found in psychoanalytic literature, but may be used by various authors in different ways. To ensure that the reader understands my particular usage of these terms, and will, therefore, be better able to follow the reasoning set forth here, I offer the following three definitions.

1. The Totalistic View of Countertransference

When Freud first used the term countertransference (Freud), he spoke of the analyst's unconscious reaction to his patient, based upon the analyst's early object internalizations. This was, for many years, considered to be a detriment to the psychoanalytic work and such reactions within the analyst would be understood to indicate a need for the analyst to analyze and work through the personal conflicts which stimulated such reactions, as it was believed they would inevitably interfere with the progress of his patient's treatment. This specific point of view is today called the "classical" definition of countertransference.

However, during the years since this original conceptualization, other authors have written extensively about other types of countertransference reactions which commonly occur in the analyst as he/she works with various types of patients (Kernberg, Masterson, Racker, Robbins, Roland, Searles, Winnicott). These reactions, because of the inevitability of their presence, have led clinicians to believe that less emphasis should be placed upon viewing this phenomenon as the analyst's deficiency, but should be seen instead as a new and unique tool with which we can better understand the patient's transference projections and early object, or self-object experiences.

Some authors point out the necessity for the analyst to be open and receptive to these feeling "inductions," as they inevitably arise in treatment, in order to keep them conscious and not repressed (Masterson, Winnicott, Racker, Bion). It is precisely the repression of such feelings which most often leads to countertransference acting-out, and ultimately to interference with the progress of the patient. This new emphasis then shifts the analyst's attention onto these "inductions," rather than away from them, and encourages the analyst to use them to better understand what is happening within his/her patient and therefore plan more effective treatment strategies.

The term "totalistic countertransference" is utilized to include under one term all of the various kinds of affective reactions which are found within the analyst—induced reactions and classical countertransference.

While analysts are advised by these authors to constantly examine their affective responses to patients and utilize these feelings in their clinical work, it is beyond the scope of this article to examine how these authors recommend using these feelings. The reader is, therefore, referred to the bibliography for further exploration of specific techniques. My intent here is to add to the currently accepted range of "totalistic" responses one more kind of response within the analyst. This new additional response is in the form of visual images which spontaneously occur within the analyst in response to his/her patient.

2. Regression and Empathy

Regression in the service of the Ego has been commonly cited as a paradigm for both creative experience and the phenomenon which takes place within the analyst as he/she tries to maintain an affective or empathic connection with a regressed or primitively organized patient (Robbins, Kris).

The analyst needs to maintain this affective tie in order for the patient to feel understood, and for new object relationships to develop which can then modify the earlier, pathogenic internalizations. The analyst needs to become a container for, or receptive to, the split-off and projected aspects of self and object which must be externalized by the patient through the transference. The most critical challenge to the analyst is to receive these projections and not allow himself/herself to be transformed or "changed" by them. For further clarification of this process I offer this last definition, projective identification.

3. Projective Identification

"Projective Identification is the mental mechanism whereby the self experiences the unconscious fantasy of translocation of itself, or parts of itself, onto or into an object for exploratory or defensive purposes." (Grotstein, p. 123)

To simplify matters, we will focus upon the exploratory or nondefensive aspect of this phenomenon.

> ***"My intent here is to add to the currently accepted range of 'totalistic' responses one more kind of response within the analyst."***

Within this context, projective identification is best understood as a communication. It is a device through which a patient may externalize the self or parts of the self onto the analyst, with the hope that these projections will be received and experienced by the analyst (so the patient can identify with the analyst) but that they will not damage, change or otherwise transform the analyst into either a victim or persecutor (Grotstein, p. 126).

The key here is that the analyst must receive this projection and in some way acknowledge this receipt. It must then be demonstrated, through behavior, that he/she has not been pathologically transformed by it. In other words, the analyst must allow himself/herself to feel the affective component of whatever the patient has projected onto him or her but the analyst must discipline himself or herself to feel it without acting it out in any way. This process then becomes a model for the patient to internalize. It clarifies for the patient the difference between feeling and acting-out a feeling. The analyst must use his/her expanded ego capacity to facilitate this process. In essence the analyst is receiving, transforming, and ultimately neutralizing the pathogenic energy which the patient needs to externalize if treatment is to be successful.

This leads the patient to a point where the projection is now somewhat neutralized and more readily available for interpretation and subsequent working through. If any step in this delicate sequence is missed, the patient and analyst may never reach this unconscious material in a way which makes it available for analysis, but instead they would either recreate pathological conflicts through unconscious transference and countertransference acting-out, or find themselves bogged down in a didactic, intellectualized discussion "about" feelings. In either case, this would certainly bring the analytic process to a halt.

Visual Reception

Several authors speak of the necessity for the analyst to assume a position of "passive reception" and become a "container" for these projections (Bion, Robbins, Meltzer). It is my belief that, if the analyst utilizes his/her own inner creative resources by making creative art materials available to both the patient and the analyst during the analytic session, he/she may significantly widen the range of reception of these projections to include visual images. These images must then be used within the session and explored in an open and often playful way in order for the patient and analyst to more fully identify and understand their significance. These images may be treated in much the same way as we treat dream images. The patient must be encouraged to associate to not only the image but, also, the affective experience stimulated by such a powerful phenomenon.

The following clinical vignette is offered to illustrate this process.

Clinical Example

Miss A. is a 33 year old artist. She is extremely creative and often uses visual images and metaphors in her treatment to describe feelings which, for her, are difficult to put into words. She began once-a-week psychoanalytic psychotherapy two years ago and, as a result of this treatment has been able to better understand how her current attachment to a boyfriend has been, to some degree, a pathological displacement of split-off aspects of her symbiotic, clinging mother. This material has been coming through in the treatment as an intellectual, disconnected experience and as a result, the patient has not been able to effectively work it through in a meaningful way. She has, therefore, remained cautious and guarded and has had difficulty experiencing trust with her (male) analyst.

During the following session the analyst feels this disconnection, but instead of simply confronting it as a

BEST COPY AVAILABLE

"... the analyst is receiving, transforming and ultimately neutralizing the pathogenic energy which the patient needs to externalize if treatment is to be successful."

defense (a position taken on many past occasions which inevitably led to a stalemate), he decides to explore it by sketching spontaneous images on his note pad, as the patient drones on. His mental state is one of free-floating awareness as he begins to let his mind roam through the procession of affectless words and piece together visual forms. This mental state begins to feel like a form of meditation as the content of the patient's statements is left behind and his aimless sketches begin to take on a form of their own.

Without any cue from the analyst, the patient, who cannot yet see what the analyst is doing, reaches for a piece of clay and also begins to make three-dimensional sketches as she continues her monologue. The analyst is now engrossed in his sketch which has taken on the form of a fish with an open gaping mouth. (See illustration) Once again he becomes aware of the patient who has suddenly stopped talking and is now staring at the clay fish which she has unconsciously created! In startled amazement the analyst flips his pad around to show the patient his sketch. She gasps in surprise.

There follows a special moment of silent astonishment where both the analyst and patient share a deeply moving feeling of empathic connection. There is a feeling of excitement in the air. Something profound has just happened.

Miss A. says: "This is a clear case of being connected." What follows is quite dramatic. As if floodgates had been opened, Miss A. began to pour out highly charged associations.

She says: "Fish, water, unconscious, symbiotically connected...to you! I'm connected to you. That large gaping mouth, dependency...it felt so good when you shared your drawing with me, like we shared the feeling of being connected. I'd get a lot more out of this treatment if I'd trust you more. I need to feel that connection in order to trust you."

The analyst interprets how her mother's need for symbiotic attachment to the patient made it frightening for her as a child to feel comfortable with her own developmentally natural need for closeness and intimacy with her mother. He further points out she had been reliving that experience in the transference, being afraid of her dependent feelings as they evolved in treatment.

To this Miss A. responds: "Yes, mother's sign was Pisces, the fish...the gaping mouth is her need to take me in, in order to feel whole. I can sometimes feel this inside me, too. I'm afraid I would need you too much if I ever let this part of me out. Maybe this is why I've kept my distance from you."

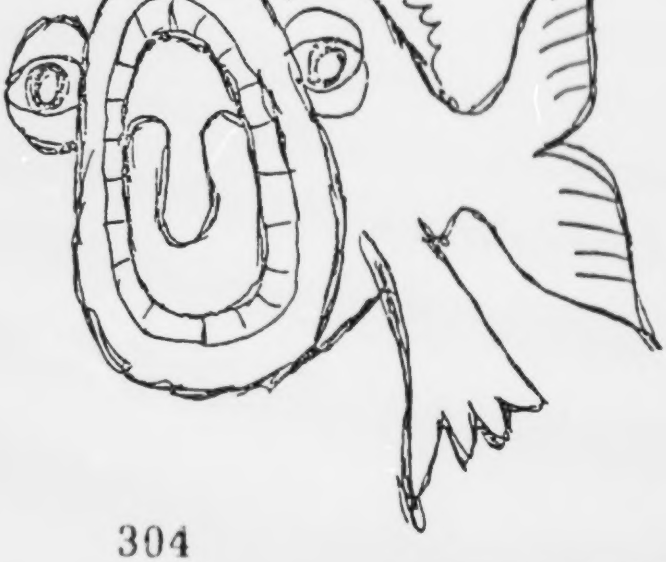
In the weeks that follow, this image and experience is often referred to as having changed her in some way.

Discussion

We see here an example of how an analyst fostered an externalization of pathologically internalized aspects of both self and object, by adopting a passive-receptive position in order to transform the patient's projections in a creative way. Any confrontation of the patient's affective withdrawal as purely defensive would have closed off the possibility of this important material emerging. It is both the analyst's acceptance of this position as the receptor and container (Bion, Robbins, Meltzer), along with his own creative ability to synthesize the projection into a visual image, which leads to this most unusual and productive psychoanalytic experience. Of critical importance here is the analyst's understanding of the projective identification process as being a creative, unconscious communication which is offered by the patient to the analyst, in the service of helping the analyst to better understand her.

"It was also important in this situation for the analyst to show the patient his drawing."

It was also important in this situation for the analyst to show the patient his drawing. This demonstrated to the patient that the analyst did indeed receive the projection, and was not pathologically transformed by it. It is interesting to speculate whether ongoing reception of such projections would eventually cause the analyst to



"The analyst needs to maintain this affective tie in order for the patient to feel understood, and for new object relationships to develop which can then modify the earlier, pathogenic internalizations."

mobilize some defense mechanism, if he were not able to neutralize the projection through his own process of creative externalization, in this case drawing. We wonder if, without this vehicle of externalization, the analyst might eventually act out this projection or his affective reaction to the projection in some way. This might be in the form of either playing out the clinging, devouring mother or the patient's unconscious, split-off and projected sense of clinging dependency, the former being the internalized object representation, the latter being the internalized self representation.

It is clear that in this particular case it was important for the analyst to show his drawing to the patient. However, it must also be made clear that acknowledgment of receipt of such projections may sometimes take less direct forms. In fact, the direct sharing of the analyst's art may be far too threatening for many patients. Patients who have had traumatic experiences with early objects that were intrusive and didn't promote a healthy sense of personal boundaries may become quite threatened by the analyst's direct sharing of such material. The experience may become too similar to the feeling that the object is inside of them, and may cause the patient to reinternalize the original traumatic situation.

The challenge here is for the analyst to use these images to put himself/herself on track and become sensitized to subtle shifts in the transference. The analyst may not choose to show the patient *how* he/she understands; what is most important is the demonstration *that* he/she understands, and this the analyst may accomplish in many different ways. He/she may design a variety of interventions, from calmly receiving the projection, containing it and using the knowledge to reaffirm in one's own mind that the overall approach is working, to (on the other end of the spectrum) sharing the image as described above. In fact, for many patients, the analyst's ability to "not respond" may be the most important therapeutic response of all!

One may ask why, in the case above, the sharing was not experienced as intrusive. It is my belief that this kind of intervention will always be, to some degree, a form of acting-out of a symbiotic transference. However, in this type of situation, it led to more cohesion of her sense of self. Why? The reason is based on a paradox. That is, the patient is best able to relate on a symbiotic level and, therefore, needs to be met on this level. To try to reach the patient in an object related way on a higher level would be, and often was in this case, a hollow intellectualized experience. We needed first to meet in a way in which she could connect and then, through the mirroring of the split-off projection, foster a feeling of cohesion for her fragmented self.

From an Ego Psychological perspective, the use of drawing and clay engages secondary process elaboration and fosters a structure within the ego, which binds instinctual energy, making these images less threatening for both analyst and patient. This "ego mastery" experience takes the primary process energy which until now has had a disintegrating effect on the ego, and transforms it into a structure which can now become internalized, thereby strengthening the ego (Horner).

We must also note the possibility that the analyst's image may spring forth more from his own unresolved personal conflicts than from the patient's own psychic material. In this case we may treat it more as a classical countertransference reaction and deal with it as such. However, we must also consider the probability that even in such a situation, there is often some aspect of the patient's conflict which sets off the reaction in the analyst, and if we can understand it and not act-out our personal conflicts, we may still salvage the situation to the patient's advantage.

A true demonstration of effectiveness of any technique must be judged by the patient's behavior and growth.

Summary

I present to you this material which demonstrates such growth in the hope of expanding analysts' awareness of how they can use creative parts of themselves in a new way to help patients grow. It is not my intention to promote this technique as one which should be widely used without careful consideration of its potential dangers. Like any good clinical intervention, it must be woven into a solid treatment structure which reflects both the analyst's personal and professional skills, along with a healthy regard for and understanding of where the patient is and what he/she can use. It is always essential for us to assess what a person is or isn't ready to use in the service of personal growth. In the case described above, the image induction experience became the "keystone" of a phase of treatment. The patient's progress was fueled by the power of the experience. Her profound sense of being understood led to a deepening ability to trust, which had a dramatic effect on her ability to form healthier object relationships.

The importance of the analyst's willingness to utilize creative assets to help decipher split-off projections should be reemphasized. Often it is the limitations of the analyst in receiving deciphering, understanding and creatively using these projections that may lead to an interminable analysis (Robbins). Because of the primitive, nonverbal nature of these projections, an analyst who is most comfortable with his/her own nonverbal, creative processes is perhaps best suited for this kind of intervention.

"The patient must be encouraged to associate to not only the image but, also, the affective experience stimulated by such a powerful phenomenon."

BEST COPY AVAILABLE

Bibliography

Bion, W.R. (1971). *The seven servants.* New York: Aronson.

Freud, S. (1950; originally in German, 1927). *The question of lay analysis.* New York: Norton and Co.

_______ "The dynamics of transference," *Standard Edition* (Vol. XII), pp 89-96.

Grotstein, J.S. (1981). *Splitting and projective identification.* New York: Aronson.

Horner, A.J. (1979). *Object relations and the developing ego in therapy.* New York: Aronson.

Kernberg, O. (1975). *Countertransference,* (Chapter 2), *Borderline conditions and pathological narcissism.* New York: Aronson.

Kris, E. (1952). *Psychoanalytic explorations in art.* New York: Schoken.

Mastersom, J.F. (1983). *Countertransference and therapeutic technique.* New York: Brunner Mazel.

Meltzer, D. (1975). Adhesive identification, *Contemporary psychoanalysis,* 11: 289-310.

Racker, H. (1968). "The meaning and uses of countertransference," (Chapter 6), *Transference and countertransference.* New York: IUP.

Robbins, A. (1980). "Creative exploration of countertransference experiences," (Chapter 3), *Expressive therapy.* New York: Human Sciences Press.

Roland, A. (1981). Induced emotional reactions and attitudes in the analyst as transference in actuality, *The psychoanalytic review,* Vol. 68, No. 1, Spring.

Searles, H.F. (undated). Oedipal love in the countertransference, *Collected papers on schizophrenia and related subjects.* New York: IUP.

Winnicott, D.W. (1975). Countertransference, *Through paediatrics to psychoanalysis.* New York: Basic books.

_______ (1975), Hate in the countertransference, *Through paediatrics to psycho-analysis.* New York: Basic Books.

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, *ART THERAPY, Journal of the American Art Therapy Association*, discounts on publications, discount on admission to the annual conference, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (ATR). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA National Office.

Associate Membership shall be open to individuals interested in the therapeutic use of art wishing to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $50

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee. **Applications for student membership must be accompanied by a copy of current ID.**

Annual Dues: $35

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $100

Professional Membership is by application only and is open to individuals who have completed professional training in art therapy and who are or have been engaged in the therapeutic use of art. Professional members are eligible to participate in all activities of the Association and receive all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $75

Credentialed Professional Membership is by application only and is open to individuals who have met the qualifications and been approved for Professional Membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in Standards and Procedures for Registration. Professional members are eligible to participate in all activities of the Association and receive all official publications. A Credentialed Professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $80

Make checks payable to AATA

American Art Therapy Association, Inc.
1980 Isaac Newton Square South
Reston, VA 22090
(703) 437-6012

NAME ______________________________
LAST FIRST MIDDLE

PREFERRED MAILING ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________________

OTHER ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________________

TITLE ______________________________

EMPLOYER ______________________________
INDIVIDUAL OR INSTITUTION

HIGHEST EDUCATIONAL DEGREE ______________

☐ $ 50 **Associate Membership**

☐ $ 35 **Student Membership**
(copy of current ID required)

☐ $100 **Contributing Membership**

☐ $ 75 **Professional Membership**
(by application only)

☐ $ 80 **Credentialed Professional Membership**
(by application only)

Payable in U.S. Dollars

Dues and expenses related to participation in AATA may be tax deductible as a business expense.

BEST COPY AVAILABLE

RETURN THIS APPLICATION WITH YOUR REMITTANCE

REVIEWS

Book Reviews

Expressive Therapy with Elders and the Disabled: Touching the Heart of Life

Jules C. Weiss, New York: The Haworth Press, 1984
213 pages, $19.95

*Reviewer **Doris Arrington, MA, ATR** is Director of the Masters' degree program in Art Therapy at the College of Notre Dame in Belmont, California.*

The rising number of frail and infirm elderly citizens represents a profound shift in our national social and economic structure. Projections indicate that by the year 2020, one in every five Americans will be 65 or older. In this light, Mr. Weiss' book is both timely and provocative.

While creative arts therapies have been a part of programs for the elderly for some time, only in the last ten years has their importance in the overall health of the institution and the individual resident been recognized. Through the practice of creative arts therapy as communication, the book addresses a new model, a new concept, and a new paradigm of the psychology of aging.

The book is a conversational essay, suggesting concrete ways to help the elderly adjust to physical changes, and to the emotional difficulties stemming from changes in life style and/or loss of abilities. Mr. Weiss is insightful regarding both institutional issues and client patterns of regression and dependency. The case studies he presents, as well as the theory he proposes, provide the reader with an opportunity to understand the elderly as persons.

When long-time members of social communities are uprooted and placed in institutions, because of a need for health care or economic support or both, there is still a craving for real human contact. In this new phase of existence there remains a need for the sharing of life experiences. Mr. Weiss sees a caring professional staff as meeting needs of the extended family as well as the client. His understanding of this area indicates that if appropriate and satisfactory changes are not made, and attitudes are not addressed by the family and the institutional staff, then depression and illness will set in, causing further social and economic distress. While his primary focus is on psychological support of the institutionalized individual, the implications are clear. He feels that in order to prevent expensive, ineffective, guilt-ridden warehousing or intensive professional or medical intervention, a caring and involved staff is necessary.

The book's strength is also its weakness: Jules Weiss' personal participation in the lives of his elderly clients, and the emotionality of his writing about these experiences. At times he sounds rather self-indulgent, almost overstating his care and concern, even causing the reader to question his motives. Does he think his "case" needs a "hard sell"? If so, he is speaking to the wrong audience. The audience that reads this book will be interested in his subject. Is he, however, overidentified with his clients?

Mr. Weiss' chapter on "Dying, A Meaningful Experience: Encountering the Process through Art Therapy" could have been explored more thoroughly. A great deal has been written on death and dying; this literature generally relates to the ill and diseased, and not specifically to helping the elderly and their families face the next phase of their lives—accepting aging, infirmity and death. Mr. Weiss piqued my interest in this subject, but too quickly moved on to the next chapter. Perhaps this will be a subject that he will address in the future.

Mr. Weiss' first publication—*Creative Arts Therapy with Elders: A Pictorial Essay*—was a lovely presentation of elderly and disabled individuals involved in the creative process: "the dynamics of self-encounter-awareness, reflection, re-orientation, and assertion" (p. 15). This second volume, however, is not as well-integrated, leaving the reader somewhat confused. In this format, the pictures and story lose much of their original poignancy and power.

Mr. Weiss has a rich background of experiences with the elderly. Although at an early age himself, he is something of an expert in the field of creative arts with the aging. He has much to say and much to tell. He needs, however, to learn to say it succinctly, without either apology or oversell. Any professional who works with the elderly will find in the work of Jules Weiss an illustration of the ethics of commitment—a commitment to joining others in shaping the tasks and the shared meaning of all our time together.

Playing with Form: Children Draw in Six Cultures

Alexander Alland, Jr. New York, NY: Columbia University Press, 1983
220 pages, 100 black and white illustrations. Paperback.

***Reviewer Linda Gantt, ATR** a graduate of the art therapy program at the George Washington University, is currently working on a doctorate in Interdisciplinary Studies at the University of Pittsburgh in the departments of Anthropology and Communication. She teaches art therapy courses at Vermont College of Norwich University and Carlow College.*

A statement which invariably closes written accounts of research projects or doctoral dissertations is "More investigation is needed." Surely, few art therapists will succeed in reading this book and reflecting on its implications without having the same phrase come to mind as it did to me. I hope at least a few will also share my excitement about Alland's work and will be spurred on to become part of those further investigations.

Playing with Form is not Alland's first venture into anthropology and art (see Alland, 1977). The chair of the anthropology department at Columbia University, Alland takes as the focus for his latest book such questions as: What part does culture play in children's art? What rules for art making are followed in particular cultures? Do "formal aesthetic universals" (similar to the universal grammar postulated by the linguist Noam Chomsky) exist? What are the similarities and differences in children's drawings when compared within or between various cultures? To begin answering these questions Alland set up an empirical study under controlled conditions in which he observed and videotaped children drawing in two Western and four non-Western countries.

The subtitle "Children Draw in Six Cultures" recalls the ambitious work on cultural differences in child rearing practices done by the Whitings (Whiting, 1963; Whiting and Whiting, 1975), both part of the multivolume Six Cultures Series. These carefully designed studies are landmarks in anthropological research; no doubt, Alland wished to invoke the spirit of these earlier works by this subtle reference to the famed Six Cultures Project even though he does not cite these books and articles in his bibliography. Nor is his sample precisely identical to that of the Whitings. However, the cultures he did choose (Bali, Ponape, Taiwan, the United States, France, and Japan) make for a well-balanced and culturally diverse group.

Like the Whitings' work, Alland's book provides an excellent model for empirical research. The standardized procedures are outlined at the beginning of the book along with a list of the terms and definitions Alland has selected to describe the drawing process *(fill, build,* and *kinetic scribble)* as well as the finished picture *(aggregate, thread,* and *tadpole figure).*

Each child drew one picture of his or her choosing (some were asked for a second one) while the drawing process was filmed. Research assistants translated the child's spontaneous comments and, after the drawing was completed, inquired what the picture and its parts meant. Felt-tip markers (red, blue, yellow, green, brown, and black) and rather small paper (9 by 11 inches) were the only materials offered. With few exceptions (which Alland carefully notes) the children worked alone and did not see the work of those who preceded them.

The bulk of the book presents each of the subsamples in turn, along with a brief ethnographic sketch (including the artistic climate) and a table of the data on each child's sex, age, schooling, and the time spent on the drawing. Almost half of the children and their pictures are discussed in detail. These discussions include the child's comments about the pictures but there is no systematic reporting, tabulating, or analyzing of the verbal material *per se.*

One hundred of the drawings are reproduced. The publication of this much primary material (Alland wished that all the drawings could have been printed) illustrates the absolute necessity of providing as much of it as possible for only then can the reader get a sense of the scope of the children's responses. Publishing the pictures serves as a check on overly enthusiastic, poorly done, or misguided verbal descriptions. However, the technical problems of reproducing the art work are also apparent. In the black and white versions of the drawings the colors are difficult to identify and the yellow fades into oblivion. Being able to turn to a copy of the actual picture is absolutely crucial when reading the section on "unusual" pictures; as Alland states, one of the criteria for judging a picture to fit this category was that it was "generally aesthetically successful according to [Alland's] own evaluation." Further, he leaves it to the reader "to judge with what success" this had been accomplished (page 190). Such judgment is possible only with recourse to the pictures.

The data presented in this rather modestly appearing book provide a startling challenge to a principle art therapists all but take for granted—that healthy children, regardless of environment, proceed through predictable stages in drawing. After collecting and analyzing 240 drawings Alland concludes that:

> "It is quite clear...that cultural influences appear early and have a strong effect on the overall style of

> children's drawing. Leaving aside similarities in the development of human figure drawing (there appear to be real cross-cultural regularities in this domain) *generalizations about particular stages of development in children's drawing appear to be false.* My data also strongly suggest that development from scribbling toward representation is not an automatic result of maturation, or even of experience with drawing" (page 211, emphasis added).

Thus, Alland scores a dead hit on the generalizations made by Viktor Lowenfeld (among others) and accepted without doubt or further investigation.

Alland's questioning of the universality of specific stages in children's drawings must give pause to those art therapists who are called on to evaluate non-English speaking children (particularly recent immigrants). If subsequent studies duplicate Alland's results one of the basic tools we use in determining age-appropriate drawings may be invalid except under specific conditions (i.e., with children from certain cultural backgrounds, from the United States and Western Europe). As important as this finding is, we cannot accept the conclusions uncritically for, as Alland points out, he could not get a "completely matched sample by age and sex in each culture" (page 21). Nor did he get a truly representative sampling of the drawing *process* in each culture. He cautions that "this study is developmental *only* in the sense that it samples the art work of children in six cultures from a range of ages....but the size of the samples provide little reliable comparable data on how specific types of design are drawn at different ages in the six cultures" (page 22).

I found it surprising that Alland did not attempt to collect data on other variables with which he could correlate the drawing skills. Admittedly, IQ tests are difficult to administer and even more difficult to interpret when given to members of different cultures. In fact, many anthropologists refuse to use such tests, given the past abuse of the results. However, it seems that a simple task for testing hand-eye coordination, manual dexterity, or color-naming might have been included without great trouble. A test of manual dexterity would have been particularly useful in comparing older scribblers with those children who made small, discrete units or marks. With one exception (a French child whose teacher said she was mentally retarded) all children were presumably "normal." The need for correlative psychological testing was especially evident to Alland as he was "struck by the degree of aggression displayed" by children in the United States sample who, in the process of doing a kinetic scribble, "literally attacked the page" (page 159). A good study for an art therapist with access to only one cultural group would be the testing of the hypothesis that there is a positive correlation between "this particularly violent type of scribbling" and aggressive feelings.

Alland's detailed description of the entire data collection process invites, in fact, *demands*, replication. No doubt, many art therapists will react initially with disbelief at his conclusions but few will find major faults with his general methods or basic research design. This is not to say, however, that there could not be some modifications in both the methods of obtaining the drawings and of analyzing the results. Of course, such *post hoc* changes are far easier for a dispassionate observer to suggest than for the researcher to think of *de novo*.

It may be possible that some of Alland's results are artifacts of asking for a single drawing. Requesting two or three pictures in one session or collecting several over a specified period might have yielded quite different results. Of course, the ideal cross-cultural study on this subject would follow a large sample of children from infancy to adolescence so that the entire drawing process could be documented. In working with adult psychiatric patients I have observed an example of how asking for only one picture can produce misleading results. Like the shy Ponapean school children who drew stereotyped designs of a school house and a flower my adult patients frequently produced well-practiced formula drawings (of four-pointed stars, profiles of pretty girls, and endless knots). I think that Alland is right in concluding that such pictures reflected the children's "general unwillingness to experiment in the face of an unfamiliar situation" (page 216); that certainly seemed to be the case with my patients. But, more importantly, the second picture done by these same individuals was stylistically unrelated to the first. If Alland is going to find more generative rules of art-making it will require looking beyond the first drawings.

In trying to describe specific cultural rules, one might ponder which are specific to art and which may apply to larger contexts. For example, it is well-known that various cultures handle time in different ways. The kindergarteners in the American sample had the shortest mean time for drawing (3.6 minutes) (page 156) and, overall, the U.S. children spent less time drawing. Alland postulates that this may have been an artifact of the testing procedures. However, it may be that these children were conforming to a cultural rule which supersedes the art-making rules, that is, a rule regarding spending a minimum of time on one activity before changing to another. (American television with its emphasis on quickly changing plots and scenes and fast-paced commercials certainly exemplifies this rule.)

Alland's writing is generally clear and straightforward but there were two slips in his thinking that struck me as curious. One was a beginner's mistake in separating one variable from another. In the Taiwanese sample he reasoned that the use of colors was correlated with schooling, that is, preschool children tended to use only one color while the school children used several colors. Alland states, "Clearly schooling has an effect on color use" (page 102). But the preschool sample was heavily weighted with four-year-olds while the school sample had a preponderance of six-year-olds. On the basis of this data alone one cannot say that schooling was the determining factor. (Neither, for that matter, could one say that *age* was.) In this case, the two variables are impossible to separate.

A more serious slip, perhaps, was contained in his proposition that "Art, like language, is specific to humans. It occurs in no other species. This suggests immediately that aesthetic behavior is biological in origin. This in turn raises the possibility that pre-coded principles of aesthetics exist as well" (page 8). One might just as well turn the argument around and conclude that since art does not occur in other species it is *not* biological. Unfortunately, Alland offers no convincing proofs for his position on this issue. In the main though, Alland's generalizations are suitably restrained and he does not try to extend his conclusions beyond the limits of his data. When he does insert his own opinions or speculations they are carefully labelled as such.

Alland's emphasis on teasing out rule-based behavior in art will help to balance what has been for art therapy an almost exclusive emphasis on psychological factors in children's drawings. Once art therapists and art educators get over the shock of having a challenge mustered to some of their basic assumptions I am certain they will see the importance of this book both as a model for research and for future theory building.

References

Alland, A., Jr., (1977) *The artistic animal: An inquiry into the biological roots of art.* New York, NY: Doubleday-Anchor.

Whiting, B., Ed., (1963). *Six cultures: Studies of child rearing.* New York, NY: John Wiley and Sons.

Whiting, B., & Whiting, J., (1975). *Children of six cultures: A psycho-cultural analysis.* Cambridge, MA: Harvard University Press.

The Art of Art Therapy

Judith Aron Rubin. New York, NY: Brunner/Mazel, Inc., 1984
(224 pages, 25.00)

Reviewer Don L. Jones, ATR, HLM is *Director of Adjunctive Therapy, Harding Hospital, Worthington, Ohio*

I bought Dr. Rubin's new book *The Art of Art Therapy* "sight unseen," having appreciated her thoughtful and specialized approach to child art therapy in her first book. The comprehensiveness of the title was intriguing. The content is clearly a systematic and encompassing outline divided into five major sections each with relevant subsections. The major sections include The Art Part, The Therapy Part, The Interface, Indirect Service, and Applications.

The book more than accomplishes its purpose if it is aimed at a readership of art educators, undergraduate art therapy students or student advisors. It is also a relatively complete and useful outline to guide art therapy educators. Viewing the book and its contents through the eyes of a practiced clinician, specializing in the field of adolescent and adult psychiatry, will account for the flagging of some specific issues which appear to have been given more critical attention. Among the very few items left out but which deserve mention is the necessity for art therapists to know something about somatic treatments, psychopharmacology and biological factors all of which play a major adjunctive role in treatment planning. The constant referring to the art therapist as "she" and the patient as "he" is an interesting sign of the times, emphasizing that the art therapy field is dominated by women and (implying incorrectly) that the patient population is dominated by men.

The Art of Art Therapy, however, is not a manual of practice. It may be of limited use to practicing clinicians who, from experience, certainly should be "knowing materials," "knowing processes," "knowing products" and "knowing therapy." (These are subsection titles.) The title promises everything you always wanted to know about art therapy and, perhaps, can find out by reading the extensive and useful bibliography. But, in the preface, Dr. Rubin states her own reservations about the title, thinking that it may be presumptious.

Much of the content seems to speak from and to an art education point of view. The continuous emphasis on "spontaneous expression" and "creativity" suggests the kind of approach that is used in the classroom or in play therapy with children, but which may not necessarily apply in clinical settings or to adult patients. Dr. Rubin is not alone in the art therapy field in overemphasizing the creative and spontaneous approaches. Seldom, however, by classical definition is the patient able to be creative or spontaneous. Much of what is produced is not free, but is more often than not stereotyped crude communication stifled by neurosis and the influence of disabilities. Dr. Rubin, while emphasizing that "the end is not art but therapy," must decide if seeking to evoke "authentic art work" in a "least restrictive environment" (a concept that has failed many patients in the mental health system) is applying art therapy in the most therapeutic manner with the efficient interventions necessary in such serious and urgent circumstances.

Although the concept is important, the more technical and extensive discussion of transference and counter-transference may be out of keeping with the more simplified discussion in other areas of the book, but it does reflect Dr. Rubin's interest in sharing her special background and training. Perhaps a discussion using simpler language describing the "involuntary participation" of the art therapist in the treatment process would set an example for eliminating some of the "jargoneze" so often lifted from other disciplines and used by art therapists.

No one can take issue with the philosophical and political notion that every person has "a right to be creative" and "a right to do art." As Dr. Rubin suggests, to find the "song in the soul" and the "poetry in the person" is an ideal humanistic goal, but a clinician might focus more on symptoms and syndromes, bipolars and borderlines and be concerned with the depth of depression. Certainly the general purposes of art and art therapy include providing growth sublimation and narcissistic gratification. But therapy's primary focus is to treat specific symptoms, to do therapy. Of course everyone has a right to be creative if only it were possible to interrupt the repetition compulsion quality of behavior that would allow freedom for spontaneity and creativity. More often than not, the art therapy clinician is attempting to understand and correct behavior, to identify character defenses, and to differentiate the ways in which the patient is using the art materials, the process and the personal interaction. The purpose is not usually to explore the level of creativity, but rather the degree of inhibition, the reflections of reaction formation and to assess the potential for impulsive or chaotic acting-out.

On page 95, Dr. Rubin refers critically to some of the structured approaches to art therapy as "clever and probably harmless which may deprive the patient of the essence of a genuine art experience." She is correct in worrying about the "cookbook" use of techniques, but should not ignore the important role of guided imagery and the designing of isomorphic metaphors which have specific prescriptive functions. I don't understand how using art therapy in a prescriptive fashion is a perversion of the medical model as Dr. Rubin suggests. Is the purpose of the art therapist to provide a genuine art experience, or to be a clinician who engages the patient in the act of self-healing? If art therapists are not working in a prescriptive fashion, are they then merely working in a surgical cut and search exploration?

I appreciate what Dr. Rubin has provided in this book, for the stimulation to look at the field with a broader perspective. Most of all, I appreciate Dr. Rubin's challenge to the art therapy field to find its own identity, not as practitioners of other health disciplines who use art. It is a challenge that is given brief emphasis in the book but ultimately may be the most important item in it.

Using the Creative Arts in Therapy

Edited by Bernie Warren. London and Canberra: Croom Helm; Cambridge, MA: Brookline Books, 1984, 173 pp.

Reviewer ***Vija Lusebrink, PhD, ATR*** *is Associate Professor Expressive Therapies, University of Louisville, Louisville, KY.*

This small volume, described in its preface as a "practical introduction to the therapeutic arts" (p. vii), covers the following areas: folklore, movement, visual arts, music, and drama. The contributors all have an English educational background in their respective fields except for Roberta Nadeau, the editor's wife who obtained her undergraduate training in the United States.

The exercises discussed in the book are group-oriented, inasmuch as the first part briefly covers such topics as where and when to meet and the composition of the group. It also suggests that, in order to learn the role of a group leader, it is necessary to work with other leaders. The hints for creative therapy sessions include the suggestion for the leader to enjoy him or herself, but to be careful not to be the only one who does so. The teacher is also advised to turn off the lights and water after the session, which is seen as critical because "janitors and cleaners are possibly the most important professionals we come in contact with" (p. 19). The book also mentions the importance of record-keeping, but does not address the sharing of observations with other mental health professionals. Apparently in the setting where the authors are working (England and Canada), this aspect of professional work is not often necessary for creative arts therapists. Warren states that only a small percentage of those who are employed have been trained in the therapeutic application of the arts.

This raises a question about the purpose of this book, and the validity of addressing the practitioners in this volume as "therapists." Warren states that "it is the act of making a mark—not its effect on an outside professional—that is of value in reintegrating mind, body and soul" (p. 6). The goal of the book is to develop socially acceptable "human creative expression," enabling all people to be themselves, so that "the improvement in the quality of human life will make arts therapy, and books like this redundant" (p. viii). This is a tall order indeed, especially for therapists working in the field of mental health, who are frequently forced to accept in their work the imperfections of human nature.

Maybe the book is addressed to artists, who possess a certain degree of naivete which allows them to group all individuals with different presenting problems and pathology as "special populations" and "handicapped," as does Nadeau in her chapter on the visual arts. Nadeau does admit, however, that the individuals in a group may keep their distance and their involvement at a minimum—possibly because "at times unknown to us, cruelties have occurred that are too inhuman for us to deal with in creative arts sessions" (p. 81). This statement best defines the line between a therapist and a facilitator for creative expression. Under these terms, the book is useful in providing some exercises in facilitating creative expression, but should not be confused with doing "therapy."

There are some other contradictions, too, in the material presented, especially in regard to using the visual arts. Nadeau, like Warren, admonishes the reader using arts with "special populations" to know his or her art medium well. Her chapter then presents an introduction of the characteristics of basic art media like pencil, charcoal, pastel, paint, etc. Most individuals who have done some work in the visual arts would know these basic media, even if they do not call themselves artists. This leaves this reviewer with some apprehension as to whom this book addresses, and who shall use the material presented therein and in which circumstances. It appears that group leadership skills are not required, nor is any other knowledge about the therapeutic interaction and process. Similarly, even knowledge of the creative experience and the basics of using art materials are not assumed as present.

None of the authors make any direct reference in the text to the existing disciplines of art, music, dance or drama therapy in the United States. This lack of acknowledgment may explain the minimal reference to any work published in the above disciplines. Both Warren and Nadeau refer to Feder and Feder's survey (1981) of the expressive arts therapies, which contains brief summaries of art, music, dance, and movement therapies with some examples of applications. This source is too general and too brief to be, for all practical purposes, a primary reference for the therapeutic use of arts.

On the positive side, individual contributors to the present volume give some examples of their work which appear "track tested," as claimed in the introduction. Professional therapists with knowledge and training in their fields will find some of the exercises in the expressive modalities discussed here useful as a warm-up for further group work.

In his chapter on folklore and ritual, Watling gives a very brief overview on the use of folklore in groups. He also presents several examples of traditional games and narratives, and includes a useful list of references.

Stebbing's approach to the physical roots of movement is based on the use of the weight of a body part and the force of gravity to stretch another part of the body. Stebbing defines his approach as a creative and self-educational body and exercise therapy. He does not give any references in his chapter, but his work appears to be based on Feldenkreis' (1982) awareness through movement exercises and yoga. I am not a movement or physical theapist, but I would be reluctant to try most of the exercises with disabled clients, as suggested by Stebbing.

Yon's chapter on expanding human potential through music is one of the more thorough ones in the present book. He uses sound and rhythm for communicating with others. In his work he also incorporates movement, space, textures, and play. Drawbacks are the many references in the text to notes at the end, and the lack of a bibliography.

Warren covers the areas of dance and drama to develop self-expression and as stepping stones to personal growth. According to Warren, the use of the material discussed under dance requires little formal training in dance or dance therapy. His goals are to gain control over isolated body parts, improve body image, achieve controlled emotional release, and become more socially adept. As a step towards this goal he introduces ten simple games, and a suggestion for a free-form movement to follow wherever the music takes the participants. In the chapter on drama, Warren presents fifteen easy games, including group story-telling and acting out a guided fantasy. Both of Warren's chapters also have the handicap of numerous references to notes at the end; but he does include suggested reading for both chapters.

The present book concludes with a table listing in alphabetical order all the exercises discussed in the book, regardless of the modality or discipline involved. This work is cross-referenced with the possible benefits in ten different areas: body awareness, flexibility, communication, attention span, emotional release, creativity, self-esteem, social skills, motor skills, and perception. This table is an example of one of the basic shortcomings of the book: the emphasis is on specific activities, rather than on the areas of possible change. Thus, despite the use of the term "therapy," this little volume really contains suggestions for a variety of arts activities. In the hands of a trained therapist familiar with a particular creative modality—be it dance, music, art or drama—these activities can become a creative means of facilitating change, and thus being "therapeutic."

Film/Video Reviews

*Reviewer **Georgiana Jungels, MA, ATR** is an Associate Professor in Art Therapy Studies, State University College at Buffalo, New York, and Art Therapist, Private Practice, Counseling Services, University Center for Human Services, Amherst, New York.*

What is an "Art Therapy" film or videotape? One criterion for a film or videotape about art therapy is that the production illustrates what is defined as "Art Therapy." Although art has been part of therapy throughout all of recorded history (Lommel, 1967), the term "Art Therapy" was first used in the 20th century (APA, 1984). The *Longman Dictionary of Psychology and Psychiatry* (Goldenson, 1984) defines art therapy as "the use of artistic activities such as painting and clay modeling in psychotherapy and rehabilitation." Art therapy is also defined as a mental health discipline (Ulman, 1976), a rehabilitation treatment service (JCAH, 1983), a mental health speciality (APA, 1983) a psychosocial therapy (APA, 1984), a counseling service (AACD, 1984), an allied health service for handicapped students (P.L. 94-142), and a human service profession (AATA, 1979). The American Art Therapy Association has defined two major approaches in the field of art therapy:

> The use of art as therapy implies that the creative process can be means both of reconciling emotional conflicts and of fostering self-awareness and personal growth. When using art as a vehicle for psychotherapy, both the product and the associative references may be used in an effort to help the individual find a more compatible relationship between his or her inner and outer worlds.

Each of these definitions provide a framework for identifying a film or videotape about "Art Therapy." Because art therapists work with people of all ages, with individuals and groups in clinical, educational, and rehabilitative settings, an art therapy film or videotape may focus on an overview of the field *(Art Therapy,* 1981) or a specific population *(Stevie's Light Bulb,* 1984) or an individual client (LORI, 1978).

Although a single distributor's catalog may list only one or two "Art Therapy" films/tapes, a review of several major catalogs, the *AATA Media List* (Jungels, 1977), an Art Therapy bibliography including film and videotapes (Niswander, 1980), and the 1984 AATA Film Festival entries (Malchiodi, 1985) identified over 100 films and videotapes about art therapy. (Note: a number of "media" productions have been made by art therapists to illustrate their work in art therapy and have been presented at conferences or workshops but are not available through commercial distributors or film libraries.)

Each art therapy film/videotape offers different information about the theory, practice, and experience of art therapy. Just as one book or article on art therapy cannot present a comprehensive view of the field, one film or videotape on art therapy cannot make a definitive statement about art therapy. Therefore, for this review, I have selected several films and videotapes on art therapy that present a variety of views about art therapy theory and practice. Some of the productions were made years ago and have become "classics." The strengths of these films and videotapes is that they have withstood the test of time and have been selected frequently enough that commercial clinical, and/or university libraries continue to distribute these productions. Other films and videotapes are recent and were included in the *1984 AATA Media Festival* (Malchiodi, 1985).

The following films and videotapes represent a basic "library" of films and videotapes on art therapy.

Art Therapy (16mm, color/sound, 10 minutes, 1981) Produced by the American Art Therapy Association, Inc. and available from the AATA association office, 1980 Isaac Newton Square South, Reston, VA 22090 (703) 437-6012.

This film is an overview of the field of art therapy and includes hundreds of images selected from the art of children and adults working with art therapists in a variety of human service settings in the United States. The film was produced by the American Art Therapy Association and is appropriate for introducing the field of art therapy to students, educators, clinicians, administrators, legislators, and the general public. This film was selected for the John Muir Medical Film Festival in 1982 and has been shown frequently in colleges/universities, workshops, and conferences and provides the viewer with a basic introduction to the field of art therapy in the United States.

Art Therapy: Beginnings (16mm, color/sound, 45 minutes, 1977) Produced by the American Art Therapy Association and available from the AATA association office, 1980 Isaac Newton Square South Reston, VA 22090 (703) 437-6012.

This film presents four pioneers in art therapy: Margaret Naumburg, Elinor Ulman, Hanna Yaxa Kwiatkowska, and Edith Kramer. The film has four parts and includes a 1976 interview with Margaret Naumburg by Judith Rubin and three clinical sessions (filmed in a studio) led by Elinor Ulman, Hanna Yaxa Kwiatkowska, and Edith Kramer. Ulman, Kwiatkowska, and Kramer demonstrate their individually designed procedures for assessing new clients in a single art therapy session: the "Diagnostic Drawing Series" by Elinor Ulman; the "Family Art Evaluation" by Hanna Yaxa Kwiatkowska; and the "Diagnostic Procedures in Art Therapy with Children" by Edith Kramer.

The three assessment procedures documented in this film provide the viewer with some "real time" footage and complement the written descriptions about the single session assessment procedures developed by Ulman, Kwiatkowska, and Kramer. Because the three assessment procedures are presented sequentially in the film, the viewer is able to observe the similar and the unique procedures used by these three therapists in their assessment procedures. The value of the filmed sessions is that we can SEE how a real person in a REAL time situation responds to a request to make a "free picture," a "scribble," or an "abstract family portrait."

In many ways, these filmed sessions offer an example of the strengths and the limits of a film or videotape on art therapy. The strengths are that the viewer can see the development of each visual statement and observe the verbal statements and the hesitancies, the pauses, the glances, and other non-verbal communications. The limits are that the cost of filming a *documentary* defines very real limitations on the number of people and sessions that can be filmed and the final film may or may not represent the overall approach, technique, therapist style, and/or the most significant clinical issues.

Ideally, a documentary film will be made over a period of time with the subject matter filmed and filmed until the filmmaking is simply part of the experience and the resulting footage represents the variety of experience and responses that occur in more than a single filmed session. This is often very costly and difficult to do. The minimum goal for a documentary is to collect information over a period of time.

Three examples of this documentary style are:

Stevie's Light Bulb: Graphic Art in Child Psychiatry (16mm, color/sound; also available on VHS, Beta and ¾" videocassette, 1984). Produced by Ralph D. Rabinovitch, M.D. and Francis C. Pasley, M.D. and available from Hawthorne Center, Northville, MI 48167 (313) 349-3000.

This film features eight young artists on-screen and the art work of 60 other children who are or have been patients of the child psychiatrists, Dr. Ralph Rabinovitch, Dr. Francis Pasley, and Dr. Sara Dubo. The film presents the use of graphic art in child psychiatry and focuses on the development of communication through the language of art. These case studies illustrate the use of graphic art in diagnosis and treatment. This film won the "Best-of-Festival Award" at the 1984 American Art Therapy Association Film Festival and has been described by the film reviewer Eddie Cockrell as "a movie that reveals a methodology of discovering the fantasy life of disturbed children with words and pictures that are of interest to all." (*Art Therapy*, Volume 2, Number 1, March 1985).

The Green Creature Within (¾" videotape, color/sound, 24 minutes, 1979). Produced by Judith Rubin, Ph.D., ATR, and Eleanor Irwin, PhD, RDT, and available from the Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213 (412) 624-2378.

This documentary film is a record of a two-year outpatient therapy group for male female adolescents using the expressive modalities of art and drama. The narration summarizes the necessary conditions in the therapeutic environment, two case studies, and some of the specific therapist behaviors that seem to facilitate therapeutic growth. This tape is one of the few productions available on the creative arts with adolescents and documenting the interdisciplinary work of an art therapist and a drama therapist. The strength of the production is that the footage was collected over a period of time and edited to represent a clear and concise statement for educational purposes. This film was awarded a Certificate of Merit (Amateur Category) at the 1984 AATA Film Festival.

Gestalt Art Experience With Janie Rhyne (16mm, color/sound, 27 minutes, 1976). Produced by Janet Greenwood and available from the University of California Extension Media Center, 2223 Fulton Street, Berkeley, CA 94720 (415) 642-0460.

This film presents a group art experience led by Janie Rhyne, HLM, ATR. She explains the principles and key terminology of gestalt art experience. Working with a diverse group of healthy adults, she presents three therapeutic art experiences: "Finding Your Own Rhythm Vocabulary," "Creating Your World with Clay," and "Building a World Together." This film is a good example of both the broadset definition of art therapy ("fostering self-awareness and personal growth") and the distinction between art therapy and art experiences. The film was awarded a Certificate of Merit (Professional Category) at the 1984 AATA Film Festival.

* * *

There are several art therapy case studies available in film or video. The strength of these productions is that they present a detailed accounting of a single person's imagery and clinical issues. The limitations of a case study in film or videotape share the same limitations as a case study in written form; that is, the information is specific to a given person and set of unique situations and cannot be generalized to the population as a whole. The following three films represent very different clinical populations and production styles. Each production uses a retrospective approach; however, one case history is reported by the art therapist (*Lori*, 1978); one is reported by a physician (*The Magic Mirror of Aloyse*, 1967); and one is reported by the artist/former patient (*The Maze*, 1970).

Lori: Art Therapy and Self Discovery

(16mm, color/sound, 32 minutes, 1978). Produced by Helen Landgarten, MA, ATR and available from the AATA association office, 1980 Isaac Newton Square South, Reston, VA 22090 (703) 437-6012.

This film is a recreated case study of a 14-year-old girl who was in art psychotherapy for a period of 34 months. The film depicts a sequential history of Lori's progression from a withdrawn, isolated and depressed girl to a maturing person who has learned how to find the good things in herself and "stand up and be myself." The strength of this film is the careful and clear reporting of the therapeutic growth of one person working with one art therapist (Helen Landgarten) over a period of almost three years and the transition from admission to treatment to discharge and subsequent continued health.

The Magic Mirror of Aloyse

(16mm, color/sound, 27 minutes, 1967). Produced by Alfred Bader, M.D. and the Center for the Study of Plastic Expression, Switzerland and available in the U.S.A. from New York University Film Library, 26 Washington Place, New York, NY 10003 (212) 598-1212.

This film is about the art and life of a woman named Aloyse, diagnosed as a chronic schizophrenic and who lived more than half of her life in a Swiss mental hospital. Her pictures document the onset of her illness and romanticized relationships. Although the viewer can see many of the pictures that Aloyse has made and a scene of her working (alone, rapidly and silently) on a new picture, the film does not integrate the art content or experiences with any art therapy treatment. It appears that making pictures is simply part of Aloyse's daily living activities. The focus of the film is primarily a documentation of the art expression of the art of the mentally ill or the story of an artist who was schizophrenic.

The Maze

(16mm, color/sound, 30 minutes, 1970). Produced by Dr. James B. Maas, Cornell University and Houghton Mifflin and available from Audio Visual Services, the Pennsylvania State University, University Park, PA 16802 (814) 865-6314

In this film, the well-known Canadian artist, William Kurelek, presents his own case study by reviewing his life and examining his years of depression. He focuses his recall on the images and symbols he included in a large painting entitled "The Maze" that he made while he was hospitalized in England in the 1950s. Although Kurelek worked with the British art therapist Edward Adamson at Netherne Hospital, the film does not include this information and the case study is presented primarily by Kurelek himself. The film footage focuses on his painting "The Maze," his symbols for his emotional problems and suicidal ideation, and his memories of his childhood and early family life. By intercutting scenes from Kurelek's painting of "The Maze" with real life interviews with three generations of the Kurelek family, the film successfully illustrates the complexity of a family system and the life review process from several different perspectives. (Note: A more detailed review of this film is in *Art Therapy*, Volume 1, Number 3, October 1984.)

* * *

The use of film animation for therapeutic purposes was first documented in the mid-1960s at the Lausanne University Psychiatric Clinic. Bader (1972) of the Center for the Study of Psychopathology of Expression, described the film production work of inpatients as "a new form of group therapy." Since then three of the films made by the patients at Lausanne have been distributed internationally. Although the prints of these films are old and no longer distributed by several previous distributors, it is still possible to rent copies of these films in the U.S.A. from the Embassy of Switzerland in Washington, D.C., Cultural and Information Office, 2900 Cathedral Avenue, N.W. Washington, D.C. (202) 745-7925. The following films are available:

Good Morning, My Eye

(16mm, color/sound, 16 minutes, 1965)

This film presents scenes from the daily life in a psychiatric hospital with an imaginative approach. The potato, for instance, which appears frequently in the hospital menu, was used in many symbolic and humorous ways to express the importance of food and the attitude of the patient's confinement, delirium and inability to recognize external reality.

Seven Nights in Siberia

(16mm, color/sound, 13 minutes, 1967)

This film presents animated sequences of jokes about psychiatrists and a patient's view of the problems of mental illness.

The Poet and the Unicorn

(16mm, color/sound, 17 minutes, 1969)

This film was written, drawn, and animated by the patients of the Psychiatric Clinic of the University of Lausanne. The story focuses on the experiences of admission, treatment and discharge from a psychiatric hospital. Several scenes show the patients working on the film production.

Two contemporary films that present the use of art and film animation as a therapeutic technique are:

The Color Bunch (16mm color/sound, 17 minutes, 1982). Produced by Judith Rothschild and distributed by JKR Productions, 650 Midfield Lane, Northbrook, IL 60062.

This film demonstrates the use of several different film animation techniques within a group therapy setting. "The Color Bunch" is the name the clients gave themselves as participants in this group process. This film offers the viewer a basic introduction to the potential of film animation as a therapeutic technique. Although the film has some technical limitation, it has been edited to include relevant information as efficiently as possible on a low-budget with respect for the decision-making of the group members. (Note: a more detailed review of this film is in *Art Therapy*, Volume 1, No.2, May 1984)

Dreams So Real (16mm color/sound, 28 minutes, 1981). Produced by Warren Rudavsky with the W.G. Nord Center, Lorain, Ohio and available from Filmmakers Library, 133 East 58th Street, New York, NY 10022 (212) 355-6545.

This film includes both the process of making animated films and several final animated films made by three clients in a community mental health center. The film (and the films within the film) focus on the dreams and realities of three men who present their story through interviews, discussions, and their animated films.

Although there is enough information in the above films to interest the viewer in using film animation as a therapeutic technique, the art therapist who has no previous film training would need to learn more about "how to do" film animation prior to beginning to use film animation as a therapeutic technique. The therapist who is considering the use of film animation as a therapeutic technique would need to consider the appropriateness of this technique to individual and group needs. Some questions might be: How does film animation fit into an ongoing art therapy program and an agency's range of treatment services? What are the benefits of film animation to an individual? a group? What functioning level is necessary before a client is able to successfully participate in film animation? What are the roles of the group leaders? Is the therapist skilled in both film animation and art therapy or are a therapist and a filmmaker/artist acting as coleaders?

* * *

There are several films and/or videotapes that focus on therapeutic art experiences or art therapy with specific populations. Some examples are:

Art and Therapy (¾" videotape, color, 21:45, 1983). Produced by the Bronx Mental Health Council, Inc. and available from Hughes Lavergne, 67 East 4th Street, #14, New York, NY 10003.

This videotape documents an art therapy program in the South Bronx Community Mental Health Center and the work of the art therapist, Vera Zilzer. The videotape demonstrates a range of techniques in working with both individuals alone and in a group setting. (A more detailed review of this videotape is in *Art Therapy*, Volume 2, Number 2, June 1985)

Creative Art Therapy with Children (¾" videotape, 8 minutes, 1984). Produced by Kim Pawley and available from her c/o 80 Berkeley Street, Rochester, NY 14607.

This videotape presents an overview of art therapy with children and is a good example of a brief and succinct introduction to the range of art therapy services in a specific agency. This videotape was awarded a Certificate of Merit (Amateur Category) at the 1984 AATA Film Festival.

Creative Growth (16mm film, color/sound, 25 minutes, 1978). Produced and distributed by James Stanfield Film Associates, Santa Monica, CA 90406 (213) 395-7466

This film documents a community-based art program for developmentally disabled adults in which many "people can't express themselves in words, but they can do it with their paints." The strength of this film is the documentation of both the studio experiences and art work of participants in the Creative Growth center. This film provides the information for a good discussion about the art in art therapy, the therapy in art therapy, therapeutic art experiences, art therapy, and the making of art.

Lonny: A Case Study in Clinical Art Therapy (¾" videotape, 30 minutes, 1984). Produced by Jane Schulman and available from her c/o 942 Embury Street, Pacific, Palisades, CA 90272.

This videotape tells the story of Lonny, a six-year old emotionally disturbed boy, and his treatment through art psychotherapy. This case study is recreated by combining slides of the child's art work and a soundtrack of the client-therapist dialogue and therapist's narration. This videotape was awarded a Certificate of Merit (Student Category) at the 1984 AATA Film Festival.

The Shape of a Leaf (16mm film, color/sound, 29 minutes, 1967). Produced by Campbell Films and available from The National Committee*Arts with the Handicapped, John F. Kennedy Center, Education Office, Washington, D.C. 20566 (202) 332-6960

This film documents an art and educational program for mentally retarded/developmentally delayed children at the Perkins School. The children are encouraged by the art teacher (Mary Perkins) to relate their academic work to their art experiences in painting, stitchery, weaving, batiking, ceramics, mask-making, and puppetry. The theme of the "shape of a leaf" is basic to all of the art experiences. Although this film focuses on art and learning experiences in a self-contained special education residential program and was made eight years before Public Law 94-142 was passed, many of the ideas will be useful to current teachers, art educators, and art therapists working in a studio based program in a school setting.

We'll Show You What We're Gonna Do (16mm, black/white, 28 minutes, 1974). Produced by Judith Rubin and available from Western Psychiatric Institute, 3811 O'Hara Street, Pittsburgh, PA 15213. (412) 624-2378.

This film documents an exploratory art program with 18 blind, partially sighted and multiply-handicapped children from ages 4-14. Each child demonstrates his/her individual rhythms, styles, media preferences, and strengths and needs. The narration summarizes some of the basic principles of an initial program for handicapped children and the importance of adult helpers observing behaviors carefully with respect in order to learn what each child is "gonna do." Many of the ideas in this film have been documented in subsequent articles and books and this information will complement and update the overview presented in this film. the soundtrack is especially notable because it was made by the well-known jazz musician Eric Kloss who, as a child, had attended the school for the blind.

* * *

Finally there are films and videotapes that may be seen as "Art Therapy" productions within the broadset definition of art therapy or related to art therapy because they provide models for artists with disabilities. One of the strong messages from the 1977 White House Conference on the Handicapped was that the word *therapy* should not be applied to everything a person does simply because the person has a handicapping condition. The artist who is handicapped is an artist and art is a vocation, not a therapy. Dalley (1984) suggests that art cannot be therapy without a therapist. All of the preceding films and videotapes involved a therapeutic relationship between client and therapist. The following films document the artistic work of people who are artists. Some began their art experiences as part of therapy after a disabling accident. All are now practicing artists.

Could You? (16mm, color/sound, 28 minutes, 1976). Produced and distributed by the International Association of Handicapped Artists, Inc. in the U.S.A. by the Association of Handicapped Artists, Inc. 503 Brisbane Building, Buffalo, NY 14203 (716) 842-1010.

This film features several international artists at work in their home or studio. All of the artists work without the use of their hands or arms and their paintings, drawings, and sculptures are completed by the skillful use of a brush or tool held between the teeth or toes.

Gravity Is My Enemy (16mm, color/sound, 26 minutes, 1977). Produced and distributed by Churchill Films, 662 North Robertson Boulevard, Los Angeles, CA 90069 (213) 657-5110.

This film is about the artist Mark Hicks who is without nerve or muscle function below the neck. He demonstrates his artistic skill and techniques and discusses his images, his life, and others' perceptions of him. This film was an Academy Award winner for Documentary, Short Subjects, in 1977.

With Eyes Wide Open (16mm film, color/sound, 58 minutes, 1983). Produced by Laurence Becker and Ron Zimmerman and available from Creative Learning Environments, 507 Park Boulevard, Austin, TX 78751 (512) 454-4489.

This film documents the life and art of the Scottish artist Richard Wawro, who has made over 3,000 pictures since he first began to draw as a child. Although Richard began drawing before he was four, he didn't speak out loud until he was 11 and was initially diagnosed as deaf, autistic, and retarded. The strength of this film is that it provides this artist with a broader forum. The overall impact of this film would have been stronger if the film had been edited to focus more on the documentary footage of Richard Wawro and his family and less on the people who were involved in the making of the film. (Note: a more detailed review of this film is in *Art Therapy,* Volume 2, Number 1, March 1985).

* * *

The above films and videotapes represent thousands of hours of filming and editing and present different views of art therapy for educational and informational purposes.

References

AACD (1984) National Academy of Certified Clinical Mental Health Counselors. Alexandria, VA: American Association of Counseling and Development.

AATA (1979) American Art Therapy Association, Public Information Committee (Georgiana Jungels, Chair). Alexandria, VA: AATA.

Continued

APA (1983) Committee on Mental Health Specialties in Psychology Washington DC: American Psychological Association.

APA (1984) The American Psychiatric Association Commission on Psychiatric Therapies (Toksoz B. Karasu, M.D., Chair) *The Psychosocial Therapies, Part II of the Psychiatric Therapies*. Washington, DC: American Psychiatric Association.

Bader, A. (1972) Therapeutic art programs around the world—IX Filmmaking in a Swiss psychiatric hospital in *The American Journal of Art Therapy*, II, (4), 185-188.

Dalley, T., ed. (1984) *Art as therapy*. London and New York: Tavistock Publications Inc. in association with Methuen, Inc.

Goldenson, R. M., ed. (1984) *Longman dictionary of psychology and psychiatry*. New York: Longman, Inc.

Joint Commission on Accreditation of Hospitals (JCAH) (1983) *Consolidated standards manual/83*. Chicago: JCAH.

Jungels, G. (1977) *AATA media list*, Baltimore MD: The American Art Therapy Association.

Lommel, A. (1967) *Shamanism: The beginnings of art*. New York: McGraw Hill Book Co.

Malchiodi, C. (1985) *AATA film festival media list (1984)*. Reston, VA: The American Art Therapy Association.

Niswander, V. (1980) Art therapy bibliography in *Art education*. Reston, VA: National Art Education Association.

Public Law 94-142 (1975). United States Statutes at Large, VOL. 89

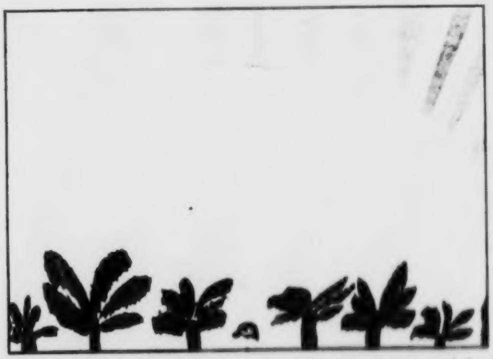
Ulman, E. (1976) Art therapy in the mental health disciplines in *Hospital and community psychiatry*, Vol. 27, No. 7, July, pp. 502-503.

VIEWPOINTS

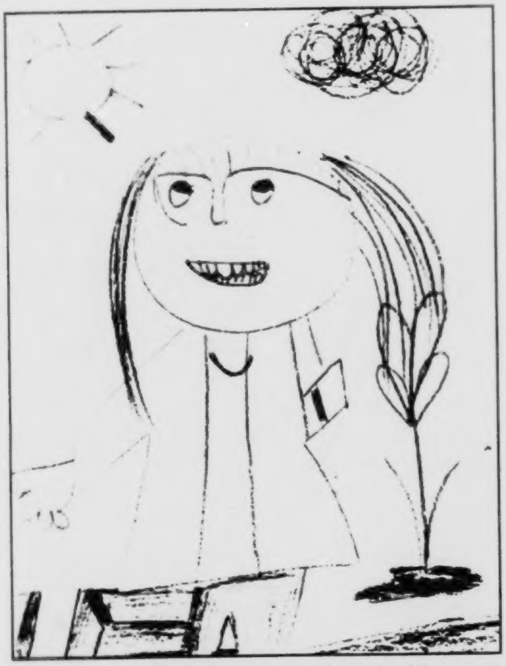
***VIEWPOINTS** provides a forum for sharing ideas and graphics about issues facing art therapists. It also encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit a black and white glossy photograph and four copies of the written material to:* ***Viewpoints**, ART THERAPY, 1980 Isaac Newton Square, Reston, VA 22090.*

Young Peoples' Portfolio

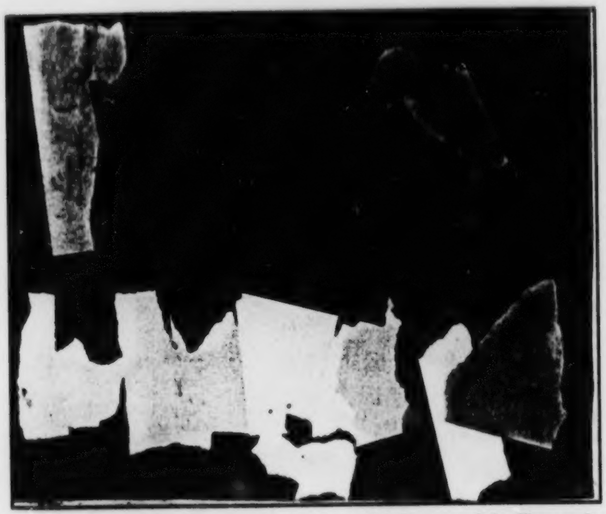
This issue offers a gallery of work by young people in art therapy.



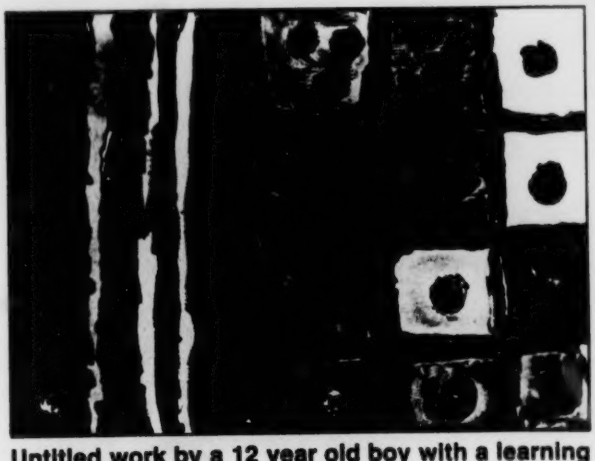
"Hawaiian Sunset" by a 12 year old hemiplegic girl



Untitled work by a 15 year old girl with mental retardation and psychological problems. Motivation was a drawing of the therapist, leading to a drawing of herself.



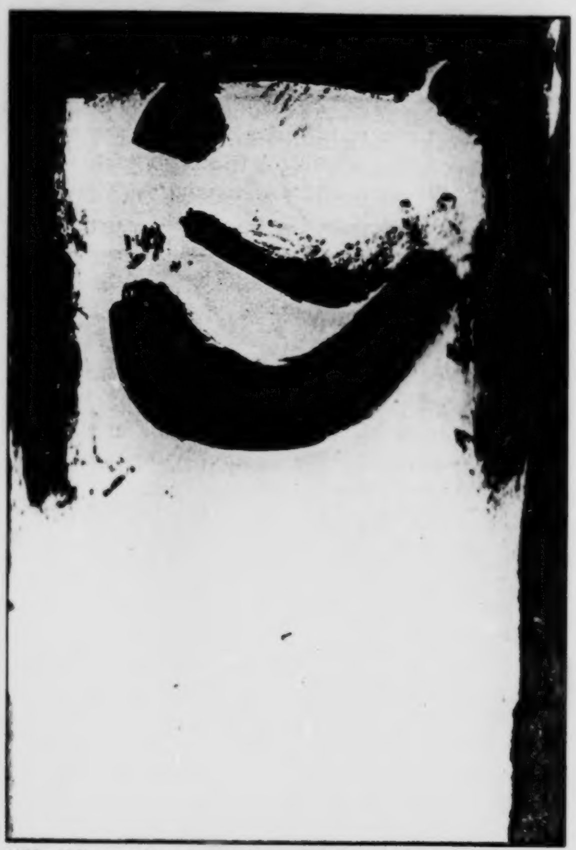
Untitled work by a 10 year old boy with Down's Syndrome



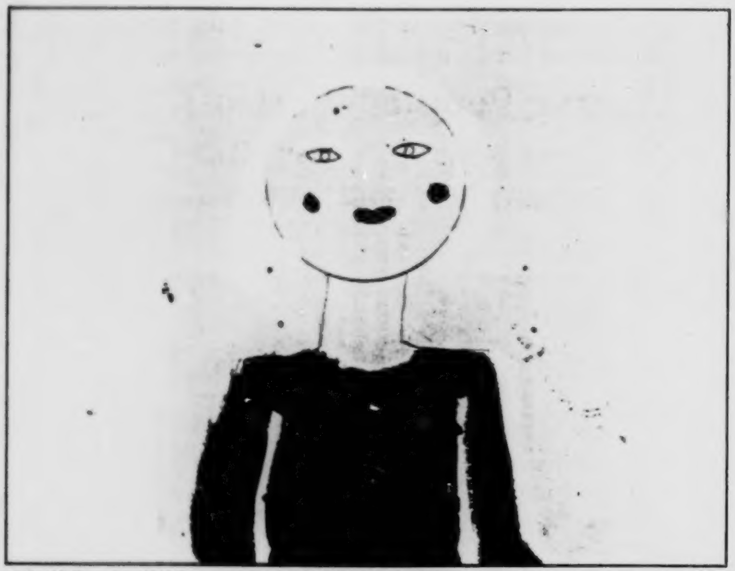
Untitled work by a 12 year old boy with a learning disability and behavioral disorder.

BEST COPY AVAILABLE

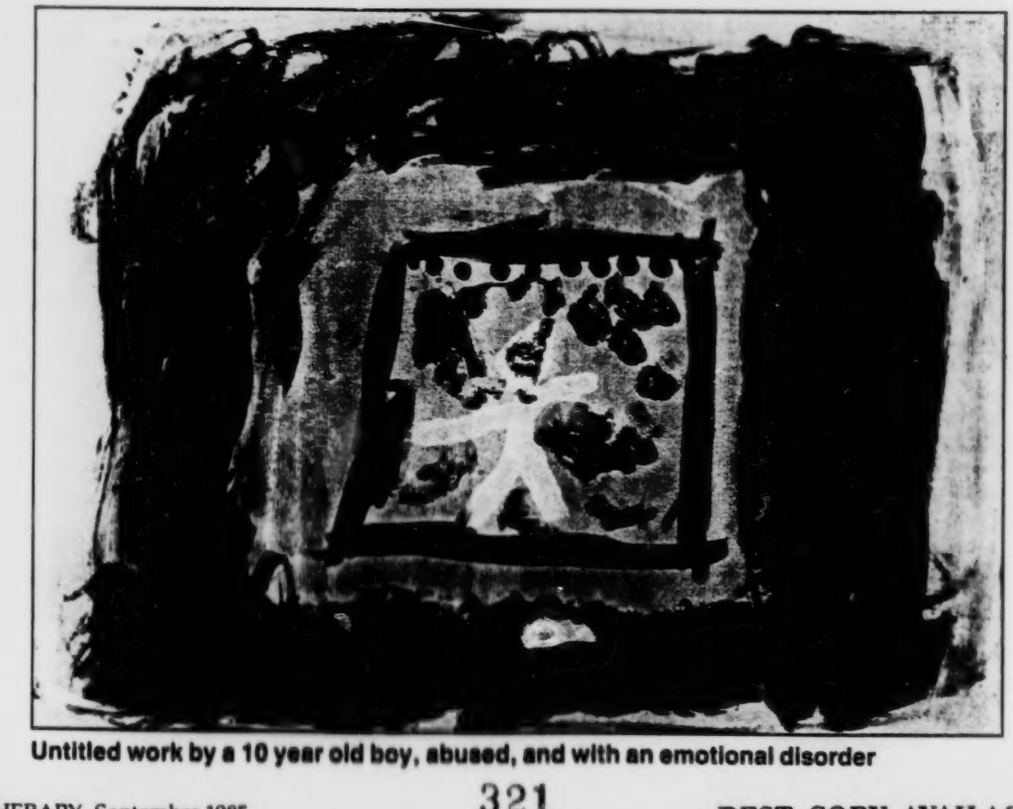
Continued



"Me" by an 8 year old mentally retarded boy



"Self Portrait" by a 13 year old girl with a hearing impairment



Untitled work by a 10 year old boy, abused, and with an emotional disorder

BEST COPY AVAILABLE

BRIEF COMMUNICATIONS

This column provides a forum for information exchange among clinicians and educators. Items relevant to research and to programmatic, historical, or clinical developments may be submitted. Contributions should be sent to Brief Communications, ART THERAPY AATA, 1980 Isaac Newton Square South, Reston, VA 22090.

Call for Manuscripts

Dr. Shawn McNiff, ATR, and Dr. Gary Barlow, ATR, Editor, are planning an issue of *Art Therapy* focusing on multi-cultural issues and the sharing of international concerns in art therapy. People working in the cross-cultural modalities are invited to send manuscripts, or to submit special features or photographs. For more information, write to the Editor, or to Dr. McNiff, Dean of the Arts Institute, Lesley College, Cambridge, MA 02138.

* * *

The AATA's Executive Board has approved the appointment of Patricia Gould as Secretary of the Education and Training Board.

Call for Manuscripts

Do you have photographs (black and white, glossy) that you would like to submit for review and possible publication in *Art Therapy*? Also, why not send in that 'perfect' color photo that might be a good cover of the journal? You are invited to submit them for consideration. Simply identify on the back with your name, title, and other pertinent information and mail to the AATA Office. If the work is from a patient or client, a release form must be signed and on file.

Connect your creativity to a changing world

at the Institute for Arts and Human Development.

Our Master's of Arts Degree Program (including practicum) offers:

- **Expressive Therapies**—Art, Music, Movement, Poetry, Psychodrama
- **Creative Arts in Learning**—Integrating Arts in Education and Human Services
- **Holistic Studies and Healing Arts**—Application of body/mind theories

Call or Write Joanna Fabris, 868-9600, ext. 480, 29 Everett Street, Cambridge, MA 02238.

LESLEY COLLEGE GRADUATE SCHOOL

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1980 Isaac Newton Square South, Reston, VA 22090.

Please enter my subscription for 1985. Enclosed is my check, payable to AATA, for $23.
Name ____________________
Address ____________________
City __________ State ______ Zip ______

WHAT EVERY THERAPIST SHOULD KNOW

Appears in **THE ARTS IN PSYCHOTHERAPY**
AN INTERNATIONAL JOURNAL

TAKE ADVANTAGE OF THIS SPECIAL OFFER!

Subscribers to *Art Therapy* and Members of American Art Therapy Association
ENJOY REDUCED RATE!

SUBSCRIBE NOW—AND SAVE 50% OR MORE! *The Arts in Psychotherapy* is a quarterly journal in its 13th successful year of serving practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologists which reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy, THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers to: Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583
TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA

Please enter my subscription for Vol. 12, 1985 ☐ (Prepayment required) Check enclosed ☐
Please enter my subscription for Vol. 13, 1986 ☐
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume
2 Vol. subscriptions subject to additional 10% discount Individuals $36 Students $27
Name ____________________
Address ____________________
City __________ State ______ Zip ______

BEST COPY AVAILABLE

ART THERAPY

will be back in March, June and October 1986.

For details on obtaining copies of back issues, and for advertising rates and closings, contact:

American Art Therapy Association
1980 Isaac Newton Square South
Reston, VA 22090
(703) 437-6012

ART THERAPY

Journal of the American Art Therapy Association

Volume 3, Number 1

March 1986

- Expanded Work Settings for Art Therapy
  Margaret L. Smart
- From Psychopathology to Psychotherapy Through Art Expression: A Focus on Hans Prinzhorn and Others
  Judith A. Rubin
- Grants—Demystifying the Mystique and Creating Job Connections
  Frances E. Anderson
  Doris B. Arrington
- 1985 AATA Annual Conference Overview and a Conversation with Chris Costner Sizemore

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA office, 1980 Isaac Newton Square South, Reston, VA 22090 (703) 437-6012.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1985-1987

Board of Trustees

President
Sandra L. Graves, PhD, ATR

President-Elect
Cay Drachnik, MA, ATR, MFCC

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, MA, ATR

Committee Chairs

Affiliate Societies
Nancy Steinberg, MA, ATR

Bylaws
Roberta J.H. Shoemaker, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Bobbi Stoll, MS, MFCC, ATR

Publications
Harriet Wadeson, PhD, ATR

Research
Linda Gantt, MA, ATR

Standards
Ronald E. Hays, MS, ATR

Executive Director (ex officio)

Richelle Grapsy

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, EdD, ATR 2

Articles

Overview of 1985 Annual Conference of the American Art Therapy Association . . . 3

Conversation with Chris Costner Sizemore 17

Expanded Work Settings for Art Therapy
Margaret L. Smart, BA, MSW 21

From Psychopathology to Psychotherapy Through Art Expression: A Focus on Hans Prinzhorn and Others
Judith A. Rubin, PhD, ATR, HLM 27

Grants—Demystifying the Mystique and Creating Job Connections
Frances E. Anderson, EdD, ATR and Doris B. Arrington, MA, ATR . . 34

Viewpoints

The Fantasy of Art Therapy Enters the Mainstream
Harriet Wadeson, PhD, ATR 39

Reviews

Book Reviews

Handbook on Adolescence 40

Sandplay: A Psychotherapeutic Approach to the Psyche 41

Images of the Self: The Sandplay Therapy Process 41

Rosegarden and Labyrinth: A Study in Art Education 42

Brief Communications 46

About Our Cover

"Free Art," from *Child in the Attic Series*, by Chris Costner Sizemore

Volume 3, Number 1 March 1986

Copyright © 1986
American Art Therapy Association, Inc.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Shirley N. Nuhn
Advertising Manager
Beth Nord

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Anthony Kowalski, MD
Susan LaMantia O'Connor, MA, ATR
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Sivierstein, MA, ATR
Robert Wolf, MPS, ATR

BEST COPY AVAILABLE

American Art Therapy Association, Inc. 1980 Isaac Newton Square South, Reston, VA 22090 (703) 437-6012

EDITORIAL

In the fall of 1985, two major professional conferences were held that served to bring together art therapists and creative arts therapists, to enlighten them about professional concerns and to promote positive social interaction. The first of these—The American Art Therapy Association Annual Conference—was held in New Orleans, Louisiana, in October. The second—The National Coalition of Arts Therapy Associations (NCATA)—occurred in November in New York City.

Each of these conferences was well attended, sparked much professional dialogue, and identified issues and concerns. Each served to bring our professional status to the forefront of human services/health related professions. In this issue of *Art Therapy* the reader will find a comprehensive overview of the American Art Therapy Association Conference. For those readers who wish to obtain more specific information about a paper, workshop, open forum, panel, pre- and post-conference course, or any of the other highlights of the conference, he/she may write directly to the presenter (an address is given in each category to help direct the correspondence to the appropriate person). The A.A.T.A. Conference Committees are listed elsewhere in this issue. Many people should be thanked for a highly successful Conference: the Conference and Program Chairpersons; the Program Committee members and consultants; the Arrangements Committee Chairperson and committee members; the presenters, exhibitors, "behind-the-scene workers," and everyone who devoted long and hard hours for the profession.

Although a comprehensive listing of the NCATA Conference is not printed in this issue, the program ("Creative Arts Therapies: Interaction/Interplay") was filled with insightful papers, panel presentations, forums and special events. Dr. Kenneth L. Bruscia, Conference Chairperson, and the many committees are to be congratulated for presenting the first NCATA Conference, and one that was highly successful and popular. The new NCATA Chair is David Read Johnson, PhD, RDT, Department of Psychiatry, Yale University, New Haven, CT 06520. I am certain that he would enjoy hearing from members of A.A.T.A. relative to our future professional relationships with NCATA.

In this issue Margaret L. Smart's article, "Expanded Work Settings for Art Therapy," illustrates the need for the art therapist to explore alternate job possibilities (i.e., varied and unique settings) as well as to continue with our more "traditional" settings. She implores the reader to broaden definitions of the uses of art therapy and the settings "in which it might profitably be practiced."

Judith A. Rubin's article, "From Psychopathology to Psychotherapy Through Art Expression: A Focus on Hans Prinzhorn and Others," is an important one for its historical relevance, with particular focus on one of our major predecessors ("...though he cannot be called the Grandfather of Art Therapy, Prinzhorn probably functioned as kind of Uncle, almost as important as his fellow Viennese, Sigmund Freud.") as well as other people who contributed to our professional development, growth and understanding of art and mental illness and mental health.

Frances E. Anderson and Doris B. Arrington offer a timely—and welcome—article on grant writing, "Grants—Demystifying the Mystique and Creating Job Connections." Included are some key pointers for the person intending to write a grant (establishing goals and objectives, writing a capability statement, detailed program description, etc.) and the authors have inserted humorous aspects into what is often considered a "dry" topic.

As a follow-up to the most recent A.A.T.A. Conference (Louisiana), Chris Costner Sizemore was invited to submit a statement that could be published in *Art Therapy*. With references to her keynote address, Mrs. Sizemore not only supplied photographs, newspaper clippings and an audiotape (on which most of her comments in the article are based), but we have had numerous telephone conversations as well. During the preliminary and continued work relative to this article, it has been my pleasure to be associated with this kind and gracious lady. She is currently at work on a collection of artwork and poetry, titled *The Attic Child*, as well as a follow-up book to *I'm Eve*, recording the richness of life she has experienced since becoming one integrated personality and offering advice and insight that only someone who has emerged from mental illness could. To illustrate her positive outlook, Mrs. Sizemore emphasizes the importance of good psychiatric treatment, family support, a personal desire to be well, and faith in God, in a total view of her road to recovery.

One reminder: don't forget to select those photographs that might be appropriate for publication in *Art Therapy*. Black and white glossy photos are considered for publication, and color prints are considered for the cover. Clearance statements must be submitted with the photograph, and documentation should be included. Why not take time right now to gather together some photographs that you have been intending to submit?

—*Gary C. Barlow, EdD, ATR*
Editor

AATA Conference Overview

The 16th annual Conference of the American Art Therapy Association was held in New Orleans, Louisiana, from October 24-27, 1985. The Conference and committee chairpersons and the presenters and participants are to be congratulated for their involvement and support in making the New Orleans Conference a highly successful one.

Beginning here and continuing on the following pages is a listing of the presenters with a brief overview of the presentations, workshops, papers, pre- and post-conference courses and other highlights of the Conference. Following the presenters' names is an address of the primary presenter, or the address of the first person listed in the event that more than one presenter is listed for a session. In lieu of the AATA *Proceedings*, this information is offered so that readers may communicate directly with the presenter(s) for any additional information desired. This listing is printed as it appeared in the Conference program and, therefore, has not been edited for this journal.

—*Editor*

16th ANNUAL CONFERENCE COMMITTEE

Conference Chair: Sandra L. Graves, PhD, ATR

Program Committee

Program Chair: Dee Spring, MA, ATR
Student Liaison: Josie Abbenante, MA, ATR
Small Groups and Open Forum Liaison: Dianne Meixner, MA, ATR
Student Representative: Mary Lane
Program Committee: Paula Englehorn, MA, ATR, MFCC
Sondra Geller, MA, ATR
Nancy Hall, MA, ATR
Don Jones, ATR, LM
Lou King, PhD
Ruby Koppelman, MA, ATR
Leslee Pollakof, ATR
Lillian Rhinehart, MA, ATR
Nancy Sidun, MS, ATR
Ellen Sontag, MA
Bobbi Stoll, MS, MFCC, ATR
Terri Sweig, MA, ATR
Joan Unger, MA, ATR
Nana Zissis, OTR
Alternates: Kay Stovall, MA
Gail Wirtz, ATR
Consultants: Pat Buoye Allen, MA, ATR
Gary C. Barlow, EdD, ATR
Sandra L. Graves, PhD, ATR
Janie L. Rhyne, PhH, HLM, ATR

Pre/Post-Conference Courses

Chair: Pat Buoye Allen, MA, ATR

On-Site Committee

Art Supplies: Margie Elfa
Local Committee Chair: Michael Marshall, MA, ATR
Local Committee: Gay Bahlinger
Denise DeSelle, ATR
Daryl Hlavsa, ATR
Betsy Kimbrell
Al Kirsch
Cynthia Levy, ATR
Rosemary Loumiet
Becky Olivera, MA, ATR
Jules Weiss, MA, ATR
Linda McMahon, ATR
Claudia Trevithick

Film Festival

Chair: Cathy A. Malchiodi, MA, ATR
Pre Screening Panel: Mariagnese K. Cattaneo, ATR
Karen Frostig, ATR
Barbara Sprayregan, MEd, ATR
Patricia St. John, EdD
Festival Panel: Frances Anderson, EdD, ATR
Robert Ault, MFA, ATR
John D. Francisco, ATR
Mari Fleming, MA, MFCC, ATR
Vija Lusebrink, PhD, ATR
Irene Rosner, ATR
Judith Rubin, PhD, ATR, HLM

PRE- AND POST-CONFERENCE COURSES

The Association is again pleased to offer special courses of study prior to and following the Conference. The courses include didactic/experiential instruction at the graduate level, and are taught by art therapy educators. There is a fee for each course, which covers the instructor's honorarium, equipment/supplies and administrative costs. Each course is available for one college credit at an advanced undergraduate or graduate level from the University of Illinois through the office of Continuing Education.

PRE-CONFERENCE COURSES

I. Phenomenology: A New Approach to Art Therapy

Mala Betensky, PhD, ATR, 7037 31st St. NW, Washington, DC 20015

Theoretically based on philosophical phenomenology and applied to art therapy, this approach synthesized phenomenological concepts of consciousness, intentionality, and meaning with relevant elements of psychology of art, principles of Gestalt psychology of art, and some concepts from clinical psychology. This is followed by the phenomenological method of art therapy, carefully tested over a span of fifteen years in practice, supervision, and teaching. Workshops, demonstrations, displays, role-playing, and hand-outs. **Open to art therapists and graduate art therapy students only.**

II. Mandala and Art Therapy

Phyllis Frame, MA, ATR, Educator, Piedmont College; Consultant, Private Practice, Demorest, GA 30535

This is a workshop to deepen understanding of the mandala as a powerful diagnostic and therapeutic tool in art therapy. It will be particularly valuable for the art therapist interested in the meaning of archetypal imagery in clients' work and will include an introduction to Joan Kellogg's theory of color and the archetypal stages found in the great round of the mandala. The workshop includes illustrative slides and a mandala art experience.

III. Theory and Practice of Verbal and Non-Verbal Responses to Clients and Their Art Work

Mildred Lachman-Chapin, MEd, ATR, Assistant Professor of Art Therapy, Graduate Art Therapy Program, Vermont College of Norwich University, Montpelier, VT 05602

This course for experienced clinicians will examine clients' needs for closeness and distancing and the kinds of responses the art therapist can make in words, body language and art. Attention is given to levels of clients' needs. Appropriate therapist reaction to these needs in terms of works and/or art is examined. Attendees will study their uses of language and art work as ways to diminish or accentuate the psychic distance between clients and themselves. Theoretical material will include Winnicott, Kohut, Erickson, and Carini. Case materials will be presented. Attendees will participate in workshop explorations. **Open to practicing, trained art therapists only.**

IV. Imagery in Biofeedback and Art Therapy

Roberta Shoemaker, MFA, ATR, Associate Professor, Art Therapy, Emporia State College, Peter Parks, MS, Emporia, KS 66801

This course is designed to explore the healing potential of imagery through a presentation of the latest research in the field of biofeedback, the companion neurological observations of how and why biofeedback works, and a presentation of a surprisingly parallel conceptualization of the neurological observation of how and why art therapy works effectively as a healing process. Experiential biofeedback-assisted relaxation, guided imagery sessions, and discussion will then be incorporated into therapeutic art activities with a parallel discussion. The goal of this course is to assist clinical art therapists in broadening and reinforcing their skills in using imagery within the framework of wholistic growth. This will be done via the presentation of the Evolutionary Developmental Continuum (a neurological conceptualization for pre-verbal therapies) and through the presentation of established biofeedback experiences utilizing imagery and a synthesis and comparison of the valuable aspects of these approaches.

V. The Diagnostic Drawing Series: Its Use in Clinical Practice

Barry M. Cohen, MA, ATR, Director of Expressive Therapies, The Mount Vernon Hospital, 855 Richmond Hwy. #302, Alexandria, VA 22309
Adrienne Kwapien, MA, Art Therapist, Fairfax Hospital
Anne Mills, Art Therapist, Fairfax Hospital
Maryellen Smolenski, ATR, Art Psychotherapist, St. Elizabeth Medical Center

The Diagnostic Drawing Series (DDS), winner of the 1983 AATA Research Assistance Grant, is presented as a tool for use in the clinical setting in a lecture and workshop format. The series, designed for use in a psychiatric setting, is also utilized as a training tool for art therapy interns. Pre-registrants will be sent the DDS protocol in advance and are invited to bring a single series for group discussion. This course is designed with both the student and practicing professional in mind.

(NOTE: This is a half-day course and is offered twice: VI-A 8:30 a.m.-12:30 p.m. and VI-B 1:30 p.m.-5:30 p.m.)

POST-CONFERENCE COURSES

VI. Art as Therapy in Mid-Life: Changing Images of Women

Sally Brucker, MA, ATR, Art Therapist, St. Elizabeth's Hospital, Washington, DC 20037
Jane Gilbert, ATR

Presentation of theoretical and case material will lead to an understanding of salient clinical issues regarding mid-life women seeking treatment. Depression in mid-life will be addressed. Art therapy techniques will be explored as a means of drawing upon resources and working on issues related to emotional and physical changes as well as cultural biases.

VII. Problem Oriented Art Therapy

Abby Calisch, MS, ATR, Professor of Art Therapy, School of the Art Institute of Chicago, Chicago, IL 60603
Therapy, School of the Art Institute of Chicago

This course will teach the participants the structure, application, and principles of short-term, task-centered art therapy. The process will be elucidated through both experiential participation and didactic supplementation and exploration. After choosing the problem, each member will follow the step-by-step exploration through the combined use of individual art-work and the verbal feedback from other participants.

VIII. New Dimensions of Interpreting Archetypes Complexes, and Symbolic Imagery in Creative Art Therapy

Joseph Garai, PhD, ATR, Professor Emeritus, Pratt Institute, Brooklyn, NY 11205

Jungian archetypes, including animus/anima, birth/rebirth, fool/wise man, nurturant mother/evil witch, stem from the collective unconscious. Through experiential exercises students learn to interpret dreams, fantasies, and art work as revelations of intrapsychic and interpersonal conflicts, and as a means to achieve authenticity, autonomy, individuation, and self-actualization.

IX. Helping Children Master Stress Through Art Therapy

Evadne McNeil, PhD, ATR, 646 Park Blvd., Glen Ellyn, IL 60137

Through lecture, slides, and case histories, course participants will learn to identify the stresses attendant to traumatic events in children's lives. Art therapy interventions will be designed in relationship to a child's chronological and developmental needs, to the event, and to the context.

SPECIAL MEETINGS AND EVENTS

Opening Reception

Come and meet your fellow Conference attendees and the Conference exhibitors at a special opening reception sponsored by AATA. The exhibit hall will be open for a special preview during the reception and a cash bar with complimentary hors d'oeuvres will be available to all Conference attendees. Attendance is free.

Walking Tour Royal Street Art Galleries

Join your colleagues for a guided walking tour through the many and varied art galleries located on Royal Street in the French Quarter of New Orleans. The tour will begin at the hotel and end in the French Quarter. After the tour, plan to spend some time experiencing the French Quarter night life or take a short taxi ride back to the hotel. The walking tour is free.

Keynote Luncheon "Seven Artists in One Body"
Chris Coster Sizemore

Chris Sizemore's keynote address will be open to all Conference attendees and a buffet luncheon will be available to those wishing to take advantage of it. Buffet luncheon tickets can be purchased for $15.00. Combine your special keynote experience with an authentic New Orleans-style luncheon for a real treat.

"A Special Time with Christine Sizemore"
Reception/Art Exhibit

Take advantage of this special time to meet Christine Sizemore, have her autograph her books, and view her art work. Cash bar and complimentary hors d'oeuvres will be available for all Conference attendees. Come and greet our special guest at this reception to be held in her honor.

"Meet the Ole Timers" Conversation and Reception

Come and spend some time with the founders and honorary life members of AATA who have made art therapy history. This special reception, planned with students in mind, is open to all who wish to meet those who have built our profession. Cash bar and complimentary hors d'oeuvres will be available for all Conference attendees.

New Orleans Museum of Art
Private Tour and Reception

Join your fellow Conference attendees for a private tour and reception in New Orleans' only fine art museum. Cocktails and hors d'oeuvres will be served throughout the reception and the entire museum will be open especially for AATA Conference attendees. Shuttle buses will run from the hotel to the museum and back throughout the entire two-hour reception to allow attendance at all Saturday evening functions, both inside the hotel and out. Tickets for the tour and reception are $12.00 and include a free round trip shuttle bus ride.

Masquerade Ball

Celebrate art therapy in New Orleans at the Annual Masquerade Ball, New Orleans style! A Dixieland band, New Orleans special cocktails, and tempting snacks are on tap and, when combined with the creative costumes of the attendees, will result in a festive, unforgettable evening for all. Masquerade Ball tickets are $10.00. Make your reservations and plan for a rousing final Conference evening.

"Fireside Chat" with Executive Board

Annual Business Meeting

Student Mini-Conference

Alumni Gatherings

Closing Luncheon

The 16th Annual Conference will close with a special screening of the Second Annual Film Festival winning entry, presentation of awards, and installation of 1985–87 AATA officers. The festivities are open to all Conference attendees and a buffet brunch will be available to all those who wish to partake of the delicious New Orleans-style cuisine—for the last time during their current visit! Brunch tickets will be $15.00. Join your colleagues for one "last hurrah!"

Riverboat Cruise

For those who wish to spend their final afternoon in New Orleans on a unique sightseeing trip, a special cruise on the Mississippi River has been arranged. The cruise tickets include a round-trip shuttle between the hotel and the boat dock and a two-hour riverboat cruise. Come and view the city of New Orleans from a quite different vantage point. Cruise tickets are $8.00.

EXHIBITS

OPEN STUDIO

For those who wish to indulge their creative needs during the Conference, an Open Studio is again available to delegates on Thursday and Friday, 10:00 a.m.–5:00 p.m. and Saturday, 10:00 a.m.–7:00 p.m. in the Rosedown Room. The Open Studio will be well-stocked with basic art supplies/materials and facilitated by art therapists. Don't forget, this is a good opportunity to create your special mask for the Masquerade Ball!

EXHIBITS

As part of efforts to expand educational opportunities available to delegates during AATA's Annual Conference, coordinators have designed an Exhibit Area that includes the latest in professional resources, brochures, and educational information. The Exhibit Area is located in the French Market. Please take advantage of this excellent opportunity to learn more about the tools, processes, and products of your profession!

16th Annual AATA Conference Exhibitors

AATA Placement Office
Anti Coloring Book Corporation
CRDL Incorporated
Davis Publications
Evans Publishing
George Washington University
Hahnemann University
Institute for Expressive Analysis
Lesley College
Maginnis and Associates
Martin F. Weber Company
Missouri Art Therapy Association
Morilla Incorporated
Nasco
New York University
Ohio University
S & S Arts and Crafts
School of the Art Institute of Chicago
State University College at Buffalo
Stern's Book Service
Strathmore Paper Company
The Arts in Psychotherapy
University of Illinois at Chicago
University of New Mexico
Vermont College of Norwich University
Wright State University

"SEVEN ARTISTS IN ONE BODY"

An exhibit of artwork done by Keynote Speaker Christine Sizemore ("The Three Faces of Eve") will be on display in Ballroom C throughout the Conference. Stop by, view the exhibit, and Chris' Keynote Address will hold more meaning.

"THE ART OF THE ALCOHOLIC"

In this display, approximately 50 works of art will be presented. The work exhibited was completed in two art therapy programs of inpatient treatment programs for alcoholics. The artwork is both skillful and sensitive and shows the inner feelings of the alcoholic, struggling to reach sobriety. This display will show how adult and adolescent alcoholics have worked through the recovery process to deal with: (1) feelings of denial, loss, and unmanageability; (2) treatment and positive future goals; (3) issues of forgiveness, anger, guilt, low self-esteem, resentments, self-pity, and self-centeredness; and (4) the final stage of the progression, "HOPE."

SECOND ANNUAL FILM FESTIVAL

AATA proudly presents its Second Annual Film Festival this year in conjunction with the 16th Annual Conference. Festival films in the professional, amateur, and student categories will be screened and reviewed throughout the Conference. Please consult the program schedule for screening times. (For last minute changes and information on entrants, please see the Film Festival display outside the Royale Room.)

Special showings of the winning entries from the First Annual Film Festival are also scheduled throughout the Conference. The films and videos entered in the Festival are:

"Art As Language" Rawley A. Silver, EdD, HLM, ATR, Producer
"Art Therapy with Children with Cancer" Audio-Visual Department, Memorial Medical Center, Producer; Sandy Gurewitz, MA
"Art With Elders in Long-Term Care: A Visual Legacy" Mary Ann Merker-Benton, Producer; Mary Lou Coles, MA
"Because It's There" Frank Muriel and David P. Wohl, Producers; Susan LaMantia O'Connor, ATR
"Draw Me A Picture" Jill Grey and Janise Finn, Producers
"Expressions" Richard Wieske, Producer
"Grandma's Bottle Village" Allie Light and Irving Saraf, Producers, Light-Saraf Films
"Hundred and Two Mature" Allie Light and Irving Saraf, Producers, Light-Saraf Films
"Joey: Expressions of Loss" Ann Dillhoefer Bussard, Producer
"Kaleidoscopic Meditation" Cheryl Finn, Producer
"Lori: Art Therapy and Self Discovery" Helen Landgarten, MA, HLM, ATR, Executive Producer
"Possum Trot" Allie Light and Irving Saraf, Producers, Light-Saraf Films
"Quilts in Women's Lives" Pat Ferrero, Producer

Grand Prize Trophy Winner

"Joey: Expressions of Loss"

BEST COPY AVAILABLE

Certificate of Merit
(Professional Category)

"Grandma's Bottle Village"
"Hundred and Two Mature"
"Lori: Art Therapy and Self Discovery"

Certificate of Merit
(Amateur Category)

"Art with Elders in Long-Term Care: A Visual Legacy"

OPEN FORUMS

Discussion of the Future of Pre- and Post-Conference Courses for AATA

Pat Buoye Allen, MA, ATR, Assistant Professor of Art Therapy, University of Illinois, P.O. Box 4348, Chicago, IL 60680

Discussion will center around the results of a survey recently completed regarding the views of art therapy training program directors toward Pre- and Post-Conference Courses. In an effort to move toward greater standardization in the planning and offering of Pre- and Post-Conference Courses, responses will be examined and discussed.

Art Therapy: What Now?

Moderator: Robin F. Goodman, MA, ATR, Art Therapist, Mount Sinai Hospital and New York University, 77 East 12th St. #3B, New York, NY 10003.

Susan Anand, Art Therapist, Consultant, Willowood Developmental Center; University of Mississippi Medical Center, Department of Psychiatry

Nancy Knapp, MA, ATR, Art Psychotherapist and Assistant Behavioral Scientist, Harbor UCLA Medical Center

A presentation by a panel of art therapists who have taken different directions in their art therapy careers will be followed by a discussion of issues in professional development.

Art Therapy Registration (ATR): How To...

Ronald E. Hays, MA, ATR, Chair, Standards Committee, American Art Therapy Association, Hahnemann Medical College, 230 North Broad St., New College Bldg, Philadelphia, PA 19102

Questions and Answers About the Assembly of Affiliate Societies

Nancy Steinberg, MA, ATR, Speaker, Assembly of Affiliate Societies, American Art Therapy Association, Inc., 306 Park Ridge Circle, Marietta, GA 30067

Non-Affiliate and Affiliate Societies alike are invited to this informal gathering. The value, purpose, and importance of having an Assembly of Affiliate Societies will be discussed. Information on affiliation procedures (application) will be available.

Group Assessment Tools

Alan J. Miller, MA, Psychiatric Institute of Houston, West Oaks Hospital, 6500 Hornwood, Houston, TX 77074

Sun Wheel: Color and Healing

Paula Englehorn, MA, ATR, MFCC, Educator/ Practitioner, Eagle Rock Trail Art Therapy Institute, P.O. 2885, Santa Rosa, CA 95405

Lillian Rhinehart, MA, ATR, Educator/Practitioner, Eagle Rock Trail Art Therapy Institute

This is the first part of a two-part presentation. Part 2 will be presented during the Saturday Open Forum session from 7:30 a.m. to 8:45 a.m.

Writing for Publication in *Art Therapy*

Gary C. Barlow, EdD, ATR, Editor, *Art Therapy: Journal of the American Therapy Association*, 228 Creative Arts Center, Wright State University, Dayton, OH 45435

Harriet Wadeson, PhD, ATR, Chair, Publications Committee, American Art Therapy Association, Inc.

Writing for publication in art therapy will focus on the AATA journal, *Art Therapy*, and other publications. Presenters will discuss selection of topics, preparing manuscripts, and steps prior to submitting an article. Requirements for the journal will be discussed. Questions/answers will be included and sharing of ideas for publications encouraged.

Art Therapy in a Large Urban School System: Strategies for Implementation

Chairpersons:

Janet Bush, MCAT, Coordinator, Art Therapy Program, Dade County Public Schools, 1450 NE 2nd Ave. Rm. 929, Miami, FL 33132

Patricia Isis, MEd, ATR, Art Therapist, Day Treatment Program, Bertha Abess Childrens Center

Panelists:

Audrey Elkinson, Art Therapist, Dade County Public Schools

Enid Garber, Art Therapist, Dade County Public Schools

Maryann Hamilton, Art Therapist, Dade County Public Schools

Susan Webb, Art Therapist, Dade County Public Schools

This presentation will concentrate on art therapy as a current approach to the education and treatment of emotionally handicapped and severely emotionally disturbed students. The Dade County Public Schools, Miami, Florida, which has embarked on this educational frontier, believes that the gains to be realized from art therapy services are considerable.

Art Therapy with the Disabled: Clarifying Roles in Multiple Settings

Carole Kunkle-Miller, PhD, ATR, Art Therapist/ Coordinator, Western Pennsylvania School for

the Deaf, Carlow College, 3117 Dobson St.,
Pittsburgh, PA 15219
Virginia Minar, ATR, Art and Exceptional Education Teacher/Therapist, School District of West Allis/West Milwaukee
John DeFrancisco, ATR, Art Therapist

The changing roles of art therapists working with individuals with disabilities in educational and therapeutic settings will be examined. This open forum will allow time for discussion of common problems and collective brainstorming of solutions. Time will be allotted for networking by art therapists working within specific settings.

Introducing the 'Getting to Know You' Book

Dorothy Webman, 1820 Comm Avenue,
Brighton, MA 02135

Open Forum on Undergraduate Programs Preparing Students for Graduate Art Therapy Studies

Geraldine H. Williams, ATR, Art Therapy Program, College of Fine Arts, Ohio University, Athens, OH 45701

Art Therapy Research: How to...

Janie Rhyne, PhD, ATR, HLM, Chair, Research Committee, American Art Therapy Association, Inc., 1031 E. College St., Iowa City, IA 52240

How to Answer a Call for Papers

Dee Spring, MA, ATR, MFCC, 1985 Program Chair, Conference Committee, American Art Therapy Association, Inc., 361 Arapaho St., Ventura, CA 93001
Pat Buoye Allen, MA, ATR, 1984 Program Chair, Conference Committee, American Art Therapy Association, Inc.

Art Therapy in Employee Assistance Programs

Dianne Meixner, MA, ATR, P.O. Box 8153,
Minneapolis, MN 55408

GENERAL SESSIONS

Opening Address
"Welcome to the 16th Annual Conference"
Gladys Agell, MA, ATR, President, American Art Therapy Association, Inc.

KEYNOTE LUNCHEON

Seven Artists in One Body

Chris Costner Sizemore

The 1985 American Art Therapy Association Conference is proud to present Christine Sizemore, "The Three Faces of Eve," and her original art work for the Keynote Address.

Art therapists work with varied populations, but seldom, if ever, encounter a multiple personality. The artwork and story of Christine Sizemore is unique and has been described as both primitive and classic, fantasy and realism. Chris, like other multiples, had several artists who resided in one body, each exhibiting a particular style, theme, content, form, and composition in the art work produced.

Chris Sizemore is not only "a legend of psychiatric phenomenon" as described by the *Reston Times,* but a gifted artist who produced works of art which will not only enlighten art therapists about the once thought to be "rare" dissociative disorder, but also teach the art therapist about the seven artists who created with the same hands. Her mystifying experience included a collection of artists who respected each other and would not touch each other's work, although personalities fought for recognition and attention within one body and wanted to "outdo" each other. Although the artists competed with each other, they had a special respect for each other's work. Her paintings are done by artists who knew not how to paint, but created as a defense against the oblivion of insanity.

PAPERS

Art Therapy and Disability: Do We Need Special Competencies to Be Effective?

Carol Kunkle-Miller, PhD, ATR, Art Therapist/Coordinator, Western Pennsylvania School for the Deaf, Carlow College, 3117 Dobson St., Pittsburgh, PA 15219

The development and results of a national survey conducted with 300 art therapists practicing with individuals with disabilities will be described. In this study, a list of special competencies generated from the literature, art therapy experts and field tested by practitioners will be identified. Implications for future training of these specialists will be discussed.

Functional Art Therapy and Developmentally Disabled Adults: Self-Concept and Behavior

Connie Livingston-Dunn, MA, ATR, Activity Therapist III, Dixon Developmental Center; Director, Art Therapy Clinical Program, Mount Mary College, 107 E. Oregon St., Polo, IL 61064

An overview of functional art therapy is presented and applied to development of self-concept with developmentally disabled adults with severe behavioral problems. Physical and/or mental handicaps contribute to the development of a poor self-concept which may be manifested in behavioral problems that preclude placement from institutions to less restrictive environments.

Fusion of Symbols, Confusion of Boundaries: Percept Contamination in Alzheimer's Disease Patients

Judith Wald, MA, ATR, Art Therapist, Activity Therapy Suprvisor, Burke Rehabilitation Center, 186 Lakeview Ave., Apt. J4, New Canaan, CT 06840

The art work of patients in an advanced stage of Alzheimer's disease is related to neurological and psychological theories of memory and perception. Fused symbols and boundary confusion are examined in terms of Rorschach, Freudian, and Ego psychologies, discussing the unconscious processes revealed by the physical and emotional regression.

Child Abuse: A Longitudinal Study of Change in Abusive Families

Judi Levy-Monolias, MA, Art Therapist, Department of Children's Services, Los Angeles County; Art Therapist, Family Counseling Agency of West San Gabriel Valley, 6000 Canterbury Dr., #D316, Culver City, CA 90230

This study is based on the psychological and emotional impact of child abuse. It is psychodynamic/psychosocial in its approach and is presented in three parts. Four families were asked to do drawings related to categories of 1) discipline, 2) anger, and 3) love. The directives were duplicated from a previous study done one year earlier with the same families. The drawings depict various changes (i.e., positive, negative, none at all) in abusive families.

Thou Shalt Not Be Aware: Alice Miller's Ideas Applied to Art Therapy

JoEl M. Vogt, MA, Art Therapist/Staff Therapist, Matrix, 4627 W. 62, Fairway, KS 66205

This overview of Alice Miller's ideas is based on her books and applied to the art therapy program at Matrix, a long-term outpatient mental health facility where clients work through early childhood developmental stages and memories which often include images of abuse, neglect and abandonment. Slides of artwork are included.

Comparative Group Art Therapy Research

Marcia L. Rosal, PhD, ATR, Research Scholar, University of Queensland, 412 Allegheny Ave., Pittsburgh, PA 15239

This paper focuses on group art therapy outcome research comparing two forms of art therapy. Each form of art therapy will be thoroughly outlined and illustrated. Similarities and differences of the two art therapy groups will be discussed in terms of the two outcome measures evaluating the efficacy of the group art therapy interventions.

A Jungian Study of Selected Visual Constructs by Mainstream Community-Minded Women

Doris Arrington, MA, ATR, NCC, Director, Master in Art Therapy Program, College of Notre Dame, 30 Knollcrest, Hillsborough, CA 94010

The presentation will focus on the Visual Preference Test (VPT) researched spring 1985 seeking to measure selected visual constructs (graphic signs and symbols) based on Jungian archetypal symbols of Feminine, Masculine, Self, and Transformation. Participants will have an opportunity to take the VPT and the Bem Inventory and to correlate their results with previous research.

The Use of Personal Construct Drawings as an Art Therapeutic Outcome Measure

Marcia L. Rosal, PhD, ATR, Research Scholar, University of Queensland, 412 Allegheny Ave., Pittsburgh, PA 15239

This paper will focus on uses of personal construct drawings as an evaluative tool in art therapy practice and research. This information is based on research using a personal construct activity with behavior disordered students involved in an art therapy intervention. The discussion of the paper will be on the adaptability of the instrument and its use in the evaluation of art therapy treatment programs and research.

Body Image Therapy: The Art of Change with Eating Disorder Patients

Mari M. Fleming, MA, MFCC, ATR, Art Therapist, Consultant, Marshall Hale Hospital; Assistant Professor, California State University, George Washington University, 1431 Glendale Ave., Berkeley, CA 94708

Body Image Therapy is a major treatment component of the eating disorder unit in this inpatient setting. Art, movement, and imagery are used to explore distortions in body image, sources in individual and family dynamics and cultural influences. Art messages convey the individual's reality; the art process allows exploration of new possibilities.

The Use of Art Psychotherapy in the Treatment of Anorexia Nervosa

Renée Kreisher, MS, Coordinator/Therapist, Partial Hospitalization Program, North Penn Mental Health/Mental Retardation, 502 Ruah St., Blossburg, PA 16912

Anorexia nervosa has become a type of epidemic that is sweeping the country. It is an extremely complex psychosomatic illness that has often been resistant to the more traditional forms of treatment. It is felt that the use of art therapy can provide these individuals with a sense of control and a realistic projection of their body image, allowing them to develop more constructive coping strategies.

Communication and Self-Expression Through Creative Arts Experience: Art, Music, Movement

Elizabeth Spear Rogers, MA, ATR, Art Therapist, Coordinator, Matter-At-Hand, Albright-Knox Art Gallery, 1256 Colvin Blvd., Kenmore, NY 14223

Charlotte L. Lee, MA, Recreation Therapist, People, Inc.

This presentation documents the collaborative efforts of two art therapists working in an art gallery and a day treatment center for the adult developmentally disabled. Program goals addressed two areas of personal development: awareness of self and awareness of others. Art, music, and movement experiences will be illustrated by videotape.

Art Therapy with the Learning Disabled: Self-Esteem, Sublimation, or Insight

Laurie Wilson, PhD, ATR, Art Therapist, Art Therapy Educator, New York University, 321 Hartford Rd., South Orange, NJ 07079

Art therapy with the learning disabled is usually performed in either educational or mental health settings. Pressures for work focusing on rehabilitation compete with the need to address emotional and psychological issues. Case material and clinical observations will deal with issues of appropriate goals and modes of treatment.

Damsels, Dragons, and Rusty Armor: The Borderline Pilgrimage Through Art

Bruce L. Moon, MA, MDiv, ATR, Art Psychotherapist, Supervisor, Activity Program, Harding Hospital, 1697 Bunty Station Rd., Delaware, OH 43015

This paper explores the metaphoric journey of adolescent borderline personality patients as they participate in intensive group art psychotherapy in the milieu at the Harding Hospital. Emphasis is placed on three areas: 1) theory of borderline personality development, 2) treatment methodology, and 3) recurring metaphoric themes of the borderline struggle.

Which Way to Success in Art Therapy?

Aina O. Nucho, PhD, ATR, ACSW, Associate Professor, University of Maryland, 2124 Cedar Circle Dr., Baltimore, MD 21228

Two types of obstacles to forming a successful therapeutic alliance with adults who have no art background are discussed: a) obstacles arising within the client and b) obstacles that arise within the therapist. Specific strategies for circumventing both types of obstacles are suggested and illustrated with drawings made by art therapists.

The Death of a Parent: A Child's View

Audrey Di Maria, MA, ATR, Adjunct Assistant Professor, Graduate Training Program in Art Therapy, George Washington University; Art Therapist, North Community Mental Health Center, 1711 Mass. Ave. N.W., Washington, DC 20036

Losing a parent is difficult at any age. For a child—whose degree of dependency is great and whose understanding of death is small—the loss can be traumatic. This presentation illustrates how, through art therapy, children at three different stages of development (ages 6, 8, and 10) addressed the death of their parents.

Family Art Therapy With the Deaf

Ellen G. Horovitz, MA, ATR, Art Therapist/Psychotherapist, Hillside Children's Center, 1183 Monroe Ave., Rochester, NY 14620

This presentation covers an in-depth look at family art therapy spanning one and one half years with two deaf/hearing impaired children placed in Hillside Children's Center's Residential Treatment Facility for deaf children. This treatment center is the only one of its kind in New York State and is a joint venture between both Rochester School for the Deaf (RSD) (the educational component) and Hillside Children's Center (HCC) (the clinical component). This paper purports the efficacy of coupling family art therapy with individual and group art therapy to expedite mental health recovery in these youngsters.

Level of Ego Development as Reflected in Patients' Drawings

Frances Fisher Kaplan, MPS, ATR, Supervisor, Creative Art Therapies, Carrier Foundation, 20 Exeter St., Morris Plains, NJ 07950

This paper presents the results of a research project investigating the relationship between level of ego development and degree of sophistication of family drawings. Some attention is given to related research, as well as to the possible implications for drawing analysis and for the practice of art therapy.

Children of War: The Use of Art Therapy in Working with Southeast Asian Refugee Children

Ronna McC-Hammond, MPS, Social Worker/Art Therapist, St. Dominic's Home, 29 Dickinson Ave., Nyack, NY 10960

The presenter will describe the use of art therapy in working with Cambodian and Vietnamese children during their internment in Southeast Asian refugee camps. Slides of children's artwork will be shown to illustrate the use of the arts in response to war. The presenter strongly recommends the viewing of recent film release, "The Killing Fields," as prerequisite to this presentation.

Nightmares, Dreams, and Art Therapy in a Vietnam Veterans Group

Irene E. Corbit, MA, ATR, Art Psychotherapist, Private Practice, Center for Creative Resources, 7722 Braesview Lane, Houston, TX 77071
Irene E. Corbit, MA, ATR, Art Psychotherapist, Private Practice, Center for Creative Resources

This presentation explores the nightmares, the dreams, and the art work of Vietnam veterans participating in a hospital dream group. We will discuss how the nature and severity of these nightmares can change as a result of the veterans' participation in the group.

Commonalities in Symbolic Language: Survivors of Traumatic Events

Moderator: Nana Zissis, OTR, Occupational Therapist, Adult Psychiatric Hospital, University of Michigan Medical Center, Ann Arbor, MI 48109
Dee Spring, MA, ATR, MFCC, Consultant/Therapist/Diplomate, American Institute for Counseling and Psychotherapy; Private Practice; Ventura Health Care Services
Deborah Golub, EdD, ATR, Co-Author

Sexual abuse, war, catastrophic events, violent crime and physical abuse are traumatic events which are characterized by inescapability and uncontrollability. These events create a trauma which has a companion defined as Post Traumatic Stress Disorder (PTSD) with resultant symbolic language. This language is exhibited in a visual dialogue through a unique communication system. The commonalities of this symbolic language, attached to the "Quiet Trauma," will be explored and discussed in this state of the art presentation.

Covert Messages in Art: The Therapist as Artist

Don Jones, ATR, LM, Director, Adjunctive Therapy, Harding Hospital, 490 Mid Drive, Worthington, OH 43085

Society has always been curious about what manner of creature the creative artist is and what makes him or her tick. Plato implies, "an inspired neurotic," Aristotle, "an exquisitely introspective psychologist." An ATR artist-therapist shares a dialogue between himself as "artist" and "therapist" while viewing his art retrospectively.

Two Sides of the Mirror: The Therapeutic Significance of Portraiture

Laura V. Loumeau, MPS, Art Therapist, Mount Sinai Hospital, 79-04 149th St., Apt. 3-I, Flushing, NY 11367

Iris L. Schlossberg, MPS, Art Therapist, Carrier Foundation

The psychological and theoretical aspects of mirror symbolism as well as mirror as a tool for examining the inner self will be explored using the diverse theories of object relations and Jungian psychology. Attention is also given to aesthetic applications of mirror symbolism. Specifically, we will discuss the use of portrait drawing as a means of fostering insight, integration and recognition of one's authentic self. Participants will view patients' portraits of each other as well as examples of self-portraits.

The Heart as a Key Symbol in Art Psychotherapy Treatment and Diagnosis

Bernard O. Stone, MFA, ATR, Director, Art Psychotherapy Department, Bethesda Hospital, 445 Walnut Hills Dr., Zanesville, OH 43701

The author's color slides and lecture will clearly illustrate conscious and unconscious meanings associated with graphic heart projections. Spontaneous paintings collected from four psychiatric hospitals form the data base for planning, psychodynamics, research, and the individuality of affect and metaphors.

U.S. Study Group on Symbolic Language of Sexually Abused Individuals

Dee Spring, MS, ATR, Consultant/Therapist, Private Practice, Ventura County, 361 Arapaho St., Ventura, CA 93001

The purpose of this group is to provide a communication system by means of a national network to study the relationship between sexual abuse, its companion post-traumatic stress, and the resultant symbolic language. This involves data collection and investigation of a treatment model for determining levels of PTSD which appears to correlate with the symbolic language produced by this population. This group would further embrace the investigation of what appears to be a natural phenomenological detection system for silent victims of sexual abuse (those who have never told a soul and may have been hospitalized or institutionalized for years without the "real problem" being discovered).

Feminist Art Therapy in the Eighties

Status of Women Committee, "Introduction"
Jane Gilbert, MEd, ATR, PO Box 137, Orland, ME 04472

Women and Work: Where Are We Today?

Jane Gilbert, MEd, ATR, PO Box 137, Orland, ME 04472

An overview of the situation of women in our society will make clear why we need to be feminists in the eighties. There will be an update on the advances and setbacks of women's economic and sociocultural status with some inferences drawn and suggestions for the future both in society and within this organization.

In a Different Image: Are 'Male' Pressures Shaping a 'Female' Art Therapy Profession?

Harriet Wadeson, PhD, ATR, 1020 West Oakdale, Chicago, IL 60657

In its headlong thrust to be accepted and respected, art therapy strives to play the mental health game according to established rules. These are rules developed by primarily male patriarchal mental health and academic establishments. This presentation will attempt to bring to awareness some of the prevailing "male" pressures which often go unnoticed and unrecognized, in order to assist our predominantly "female" profession to develop in a congruent and self-consistent way.

The Integration of Power and Compassion

Judith Gerberg, MA, ATR, LM, 35 West 82nd St. #8B, New York, NY 10024

What images must we create in order to achieve the integration of power and compassion? What are our potentialities as women, artists, and therapists? What is the unique contribution we can make to the spaceship Earth, as the strong women we already are?

The Place of Politics in the Art Therapy Process

Lou King, PhD, 205 Richmond SE, Albuquerque, NM 87106

The majority of hospital patients will eventually reenter a world that initially overwhelmed them, and they will need to have the most comprehensive understanding possible of that world if they are to function well in it. As women, they will need to understand not only the obvious aspects of their oppression, but the subtle ones as well. Our approach to therapy will be one-sided if we only give our attention to the personal, inner life of the psyche and ignore the realities of the environment in which the person lives. Attending to the environment necessarily entails not only a consideration of the home and work life of the patient/client, but a consideration of the institutions influencing or governing the realities of their lives as well, especially the lives of women. What does the inclusion of these political realities mean, in terms of how we approach treatment issues such as passivity, depression, abuse, manipulation, seduction, lack of self-esteem, self-worth, etc? How will a consideration of politics affect the way we process

BEST COPY AVAILABLE

the images and verbalizations of women patients/clients? Are there times when it is inappropriate to include the political in the treatment process? These questions and others will be examined and addressed.

The Homeless and Art Therapy: An Exploratory Study

Kay Stovall, MA, 3732-B Seventh Ave., San Diego, CA 92103

Do the drawings of the homeless reflect their radically different lifestyle? Preliminary research using art therapy techniques in collecting and analyzing spontaneous drawings of homeless individuals is examined. Background information on homelessness, characteristics of the population, and their response to art materials is presented. Slides of drawings by the homeless illustrate the presentation.

Art Therapy with Adolescents in a Crisis Intervention Facility

Jean Spates, BA, 407 Columbia SE,
Albuquerque, NM 87106
Amy Sehr, BA

The purpose of this paper is to introduce the use of art therapy with adolescents in a short term facility. The visual presentation is accompanied by actual casework showing the effectiveness of art therapy when used in this setting. It will also show the importance of utilizing visualization to accelerate the art therapy process.

An Art Support Group for Bereaved Children and Adolescents

Barbara Betker McIntyre, BA, Art Therapist, Grand Traverse Area Hospice, Route #1, Williamsburg, MI 49690

Mary Raymer, ACSW, Director, Grand Travis Area Hospice

The pilot arts program at our area hospice involves an art support group for bereaved children and adolescents. The group uses art expression to express and resolve feelings and experiences associated with grief. Four exhibiting artists and an art therapist facilitate the group. The grief process for children and adolescents, accompanying art work, group dynamics, and program implementation will be presented by the hospice director and art therapist.

The Visual Language of Multiplicity (MPD Disorder)

Dee Spring, MA, ATR, Specialist in Victim Recovery, Ventura Health Care Services, Private Practice, 361 Arapaho St., Ventura, CA 93001

This presentation with slides will focus on artistic visual dialogues created by MPD patients before and after diagnosis. The primary purpose will be to introduce the use of visual language as an artistic identifier for multiple personalities and their alternates through styles of drawing which can be used both as a tool for therapy and a tool for integration.

"I Have Never Lived In This World Before"

Ellen David, RN, ATR, 2610 April Drive, Birmingham, AL 35243

This visual/verbal presentation shares experiences, observations, and techniques used by an RN/art therapist to detect information and promote therapeutic alliance between therapist/alters and alter/alters aiming toward awareness or integration. The audiences preparedness concerning creativity, intuition, spontaneity, emotional maturity, knowledge, and compassion will be challenged. Handouts provided.

"The Case of Billy Milligan"

Don Jones, ATR, LM, Director, Adjunctive Therapy, Harding Hospital, 490 Mid Drive, Worthington, OH 43085

This paper considers the dynamics of multiple personality development and illustrates the use of art therapy treatment in one such case. The book, *The Minds of Billy Milligan,* by Daniel Keyes is based on a landmark legal decision which declared "Billy" not guilty by reason of multiplicity.

A World View of Art Therapy

Bobbi Stoll, MA, ATR, MFCC, Marriage, Family, and Child Therapist, Art Therapist, Private Practice, 8020 Briar Summit Dr., Los Angeles, CA 90046

This session will detail the results of a 1985 survey of art therapists and institutions of art therapy from 20 countries. It will shed light on the question of "What's happening with art therapy in . . .?" by providing a world view of the direction and development of our profession and discussion of the major similarities and differences in practice and theory.

New Horizons: Interfacing of the Art Therapy Movement with the Art Establishment

Robert E. Ault, MFA, ATR, Art Therapist, The Menninger Foundation, 1506 Boswell, Topeka, KS 66604

Art therapy conceptualized as a movement of ideas rather than as a client-centered professional can be integrated into governmental and/or operational arts agencies. Specific strategies and political moves as utilized successfully in one state arts commission are outlined. These resulted in official guidelines for funding of arts therapies projects.

Short-Term Inpatient Art Therapy: An Eclectic Approach

Michael J. Swiderski, MS, ATR, Art Therapist, Mansfield General Hospital, 432 Shepard Rd., Mansfield, OH 44907

This paper discusses frustrations and difficulties which are inherent in the practice of short-term, inpatient art therapy in general hospital psychiatric units. It points out the need for art therapists to develop an eclectic approach, and it outlines three different models of short-term group art therapy.

Expanding Concepts of Visual Images Through Increased Understanding of Artistic Development

Betty Jo Troeger, PhD, Assistant Professor,
Florida State University, 123 Ed. Bldg.,
Tallahassee, FL 32306

This presentation will focus on helping art therapists assimilate current information related to art growth and development into existing concepts of interpreting visual images of clients. Cultural influences on art learning and individual learning styles will be linked to applications in art therapy practices with children, adolescents, and adults.

Addressing Countertransference Through Image Making

Barbara Fish, MA, Art Therapist, Institute for
Therapy Through the Arts, Ravenswood
Hospital, 1635 W. Touhy Ave. #1N, Chicago, IL
60626

This paper is an examination of countertransference issues through images. My own art work is used to clarify dynamics within therapeutic relationships that occured on an inpatient psychiatric unit, with an acute adult population. It is my hope that this paper will encourage art therapists to use their own images in therapeutic work.

Themes of Self-Destruction: Indicators of Suicidal Ideation in Art Therapy

Carol Thayer Cox, MA, ATR, Art Therapist,
Accotink Academy, 1024 Plymouth Dr., Stafford,
VA 22554

The primary objective of this paper is to establish the value of art therapy in the expression and communication of suicidal ideation. Ten themes of self-destruction, extracted from a theoretical review of motives and characteristics of suicide, will be used as guidelines for graphic indicators in several case presentations involving self-destructive behavior.

Creative Process and Psychopathology: Some Neurocognitive Considerations

Patricia A. St. John, EdD, Assistant Professor of
Art, University of Massachusetts, Fine Arts
Center 460, Amherst, MA 01003

Creative process has been studied from a neurocognitive perspective. Exploration of the relationships among perceptual style, creative process, and psychopathology suggests a dichotomous model. This model is presented and discussed within the context of the well-functioning artist and under the stress of psychopathology. Usefulness of the model within art therapy assessment and treatment is considered.

The Use of Art Therapy in the Treatment of Premenstrual Syndrome

Therese M. Halas, MA, ATR, Adjunct Professor,
Arizona State University: Art Therapist, Private
Practice, 4541 N. 7th St., Phoenix, AZ 85014

Art therapy has been used as an aid in the diagnosis and treatment for premenstrual syndrome sufferers at a comprehensive treatment center for PMS. The paper includes a detailed description of the physical and psychological symptoms of PMS and the techniques of art therapy used with individuals, families, and groups. Case studies will be presented.

The Art of the Alcoholic

Sherry Kreitman, BFA, Art and Recreational
Therapist, Center for Comprehensive
Alcoholism Treatment, 2334 Wheeler,
Cincinnati, OH 45219

This slide presentation will illustrate the use of art therapy with adult and adolescent alcoholics in two residential, chemical dependency/inpatient treatment programs. Art therapy will be demonstrated as a component of the inpatient treatment program: understanding the disease, exploring feelings and working towards sobriety. Case studies of adolescent alcoholics, treatment processes, and art work will be presented along with a multi-media presentation of an original production by the alcoholics.

DX-RX-TX: Creative Uses of Art Therapy Assessment Probes

Don Jones, ATR, LM, Director, Adjunctive
Therapy, Harding Hospital, 490 Mid Dr.,
Worthington, OH 43085

Of prime importance to the clinician is creating and administering flexible protocol that give *immediate* clues to an individual patient's preoccupations, anxieties, defenses, coping style, and (often neglected) assets. A senior art therapist presents a package of assessment techniques illustrating individualized creative arts interviews versus general psychological testing approaches.

Recognizing and Activating Multiple Intelligences: Professionals/Patients Meeting of Minds

Janie Rhyne, PhD, ATR, HLM, Psychotherapist,
Private Practice, 1031 E. College St., Iowa City,
IA 52240

Psychotherapy allies both therapists and clients in finding ways of making sense out of actual experiences: when patients and professionals are of different minds, how can the alliance work? Systematic study of drawings made by persons from both groups shows various ideas about sense and nonsense. Paper and slide presentation.

From Art to Science: The Formal Analysis of an Artist's Symbolic Universe

Albert J. Levis, MD, Director, Center for the
Study of Normative Behavior, 2750 Whitney
Avenue, Hamden, CT 06518

The presenter will introduce the ten levels of scientific analysis of the Formal Analysis Profile and then apply them in organizing information about the artist's symbolic universe. Formal analysis regards sequences of symbolic constructs as proceeding dialectically in the resolution of conflict. Formal methodology demonstrates how each one of his canvases fits in this perspective and how we can attribute to each graphic vectorial a quantitative and qualitative score.

From Confusion to Clarity with the Elderly: A Creative Process

Jules C. Weiss, MA, ATR, Director, Community Center, New Orleans Recreation Department; Art Therapist, Private Practice, Longevity Therapy, Inc., 1527 Lowerline Street, New Orleans, LA 70118

The paper will examine the psychological, social, and physical influences on elderly people who become confused and disoriented and what we as art therapists can do to slow down or reverse that process. Art therapy techniques and processes which help confused people become clearer in thought and expression and aid elders in the life review process will be examined.

PANELS

The Significance of Color in Art Therapy

Moderator: Sondra K. Geller, MA, ATR, Coordinator of Art Therapy Services, George Washington University Counseling Center, 5 Primrose St., Chevy Chase, MD 20015
Paula Englehorn, MA, ATR, MFCC, Educator/Practitioner, Eagle Rock Trail Art Therapy Institute
Lillian Rhinehart, MA, ATR, Educator/Practitioner, Eagle Rock Trail Art Therapy Institute
Jeanette Fino, MA, ATR, Art Therapist, Spring Grove Hospital Center
Vija Lusebrink, PhD, ATR, Associate Professor, Expressive Therapies, University of Louisville
Phyllis Frame, ATR, Educator, Piedmont College; Consultant, Private Practice
Roberta Shoemaker, MFA, ATR, Associate Professor, Emporia State University
Edith Wallace, PhD, Jungian Analyst, Private Practice; Faculty, Institute of Expressive Analysis

The understanding of color and its many applications in the clinical process is a fundamental tool for the art therapist. A panel of experienced art therapists and a Jungian analyst will discuss aspects of color application in art therapy ranging from color and healing to research and theory. Attendees will participate in discussions. There will also be a brief group experiential.

A Feminine Paradigm: The Goddesses in Everywoman

Pat Buoye Allen, MA, ATR, Assistant Professor of Art Therapy, University of Illinois, 300 S. Wesley, Oak Park, IL 60302

Archetypal patterns as personified by the goddesses will be explored as the foundation of a paradigm of feminine psychology. Through music, poetry, and slides, participants will enrich their understanding of the goddesses with the goal of making images of the goddess within.

Art in Motion: Integrating Art and Dance Therapies as a Treatment Modality with Adult Psychiatric Patients

Stewart Ault, MA, ATR, Art Therapist, Maimonides Medical Center, 423 Hicks St., #4E, Brooklyn, NY 11201
Patricia Capello, MA, ADTR, Dance Therapist, Maimonides Medical Center

Through lecture and workshop experience, the presenters will discuss and demonstrate their specific technique combining the expressive and creative potentials of art therapy and dance therapy processes. Using slides and videotape, we will share examples of works created by adult, psychiatric patients in a partial hospitalization setting.

Learning to Use the Therapist's Visual Inductions: An Innovation in Clinical Supervision

Robert Wolf, MPS, ATR, Psychoanalyst/Art Therapist, Private Practice, College of New Rochelle, 148-16 85th Ave., Briarwood, NY 11435

This workshop will demonstrate how an art therapist can use his own visual inductions, spontaneous images which occur in response to patients seen in clinical practice, to explore and more effectively understand the patient's inner object world. Emphasis will be placed on uncovering transference and countertransference dynamics and developing treatment strategies.

Uncovering Our Outer Mask...

Elizabeth Spear Rogers, MA, ATR, Art Therapist, Coordinator, Matter-At-Hand, Albright-Knox Gallery, 1256 Colvin Blvd, Kenmore, NY 14223
Elizabeth Cunningham, Student

The workshop will cover the collaborative efforts of an art therapist and a graduate student working with children who had difficulties identifying and expressing their emotions. A brief presentation with visual documentation will provide workshop participants with techniques to view how students' learning problems in academic areas and various developmental needs were addressed. Workshop participants will then explore first-hand many of these original techniques.

A Visual Exploration of the Interface Between the Art Psychotherapeutic Process of Healing and Insight

Arthur Robbins, EdD, ATR, Professor, Pratt Institute, 325 West End Ave., New York, NY 10023

This workshop will explore a variety of interventions associated with the treatment of psychosomatic illness. Participants will first observe how personal conflicts can be converted into disguised somatic expressions. Then alternate methods of healing will be introduced as a means of resolving conflict. Discussion will follow regarding such issues as the integration of uncovering techniques within the context of a positive healing experience.

Telephone Supervision: Working with the Visual Through Non-Visual Communication

Beth Gonzalez-Dolginko, MPS, ATR, Art Therapy Faculty and Supervisor, Pratt Institute, 700 Washington Dr., Centerport, NY 11721

The study of a unique form of supervision will be shared by means of viewing and hearing creative expression of those who have been a part of it. Creative use of technology for the purposes of advancing the field of art therapy will be explored. Workshop participants are asked to bring a piece of art done by their supervisor or a supervisee which will be used to understand feelings brought up by the supervisory experience.

A Training Workshop on Art Therapy and PMS

Therese M. Halas, MA, ATR, Adjunct Professor, Arizona State University; Art Therapist, Private Practice, 4541 N. 7th St., Phoenix, AZ 85014

(Prerequisite: "The Use of Art Therapy in the Treatment of Premenstrual Syndrome" presented 10:15 a.m. to 12:30 p.m. Saturday, October 26)
This experiential workshop is designed to further train art therapists in the techniques developed especially for use with the PMS population. It will include advanced methods of diagnosis and the use of art therapy with the PMS patient and significant others.

Dali and Magritte: Naturalists of the Imaginary, Stimulate Creative Expression

Virginia Minar, MS, ATR, Art and Exceptional Education Teacher/Therapist, School District of West Allis/West Milwaukee, 308 East Dean Road, Milwaukee, WI 53217

Many emotionally disturbed adolescents have difficulty understanding real/unreal concepts. The workshop will follow a procedure that motivates them to work with their imagination by selecting and organizing imagery into a creative collage. Group discussion clarifies the difference between fact and fantasy, concrete and abstract reality.

The Integration of Aesthetic Form Within the Treatment of Borderline Conditions

Arthur Robbins, EdD, ATR, Professor, Pratt Institute, 325 West End Ave., New York, NY 10023

Participants will explore a variety of ego states commonly associated with a borderline condition. They will then confront problems of self cohesion in the context of altering moods and defensive patterns. Participants will have the opportunity to explore different methods of confrontation that promote an aesthetic integration of content and form associated with self-cohesion. Discussion will follow after the experiential section.

1985 Conference

ANOTHER GLANCE

Shown here is AATA's 1983-85 Board of Directors. Back row, left to right: Don Cutcher, Gary Barlow, Nancy Schoebel, Ron Hays, Nancy Steinberg. Front row, left to right: Bobbi Stoll, Harriet Wadeson, Janie Rhyne, Gladys Agell, Robin Goodman, and Sandra Graves.

At right, conference participants created masks to wear at the popular Masquerade Ball. The annual conference offers many opportunities for informal exchange. Below left are Don Jones and Rawley Silver. Below right are Shaun McNiff and Robert Ault.

Photographs by Beth Nord

BEST COPY AVAILABLE

Conversation with Chris Costner Sizemore

Editor's Comments:

The publication of *The Three Faces of Eve* in 1957 literally turned the psychiatric community upside down, as two doctors used Chris Costner Sizemore's case history to present this rare disorder of multiple personality to the public. In 1977 Mrs. Sizemore revealed her identity as "Eve" as well as the story of the emergence of 22 personalities in over 40 years. Her autobiography titled *I'm Eve* was published in 1977.

It is an intense journey that the reader takes as he/she becomes acquainted with the various personalities—the Bell Lady, the Strawberry Girl, the Retrace Lady, the Freckle Lady, the Card Girl, Jane, and Eve, to name just a few. Also, a powerful experience follows the final integration of personalities as Mrs. Sizemore tells of her feelings of emptiness, and how she thought they (the various personalities) would return. She had to have grief therapy for the death(s) after it was over ("I had died so many times!") She, occasionally, wished that they would come back because "I didn't know how to deal with my life."

Chris Costner Sizemore's story continues to intrigue the world. Medical and law enforcement communities look to her for the wisdom and knowledge based on her experiences. Persons with mental illness, their families and friends, seek her advice and see her as a symbol of hope for recovery. She has dedicated much time and energy to helping others, primarily through various state mental health associations. For her efforts in trying to dispel the needless stigma of mental illness, the National Mental Health Association honored her with its prestigious Clifford W. Beers Award in 1982.

In addition to our numerous telephone conversations, the audiotape dialogue that she so thoughtfully provided, articles and newspaper clippings that were submitted, some references are taken from publicity materials listing background information, biographical data, and her campaign for mental health issues.

The last sentence of her comments ("...I have just *begun* to live.") is prophetic, and it demonstrates the tremendous positive energy and direction that is a part of Chris Costner Sizemore's life.

—Gary C. Barlow, EdD, ATR
Editor

"On My Life with Multiple Personalities"

Comments by Chris Costner Sizemore

First of all, I wish to express my appreciation for the pleasure of participating in the A.A.T.A. Conference. I am grateful for the warm welcome and for the camaraderie that all of you afforded my husband and me. A great honor was bestowed on me by the A.A.T.A. when they chose to hang my art exhibit at the Conference in New Orleans.

When we arrived I knew little about art therapy, but I left feeling excited about your work, totally energized, and determined to try and do more to help my fellow man. Therefore, I will give you a little background material on my case history.

For a period of over forty years, I was a mental patient. I had the disorder known as multiple personality—the existence of two or more personalities in one body at the same time. It is classified as a defense mechanism—a unique coping mechanism where the personality actually creates satellites to face the realities that appear unbearable. I coexisted with two or more personalities from the age of two. I'm not sure exactly what caused this disorder, but I do believe that it may have been hurtful events that occurred before I was old enough to deal with them. In my research with other therapists and with other multiples, I have discovered that this neurosis begins before the age of five and that it is caused by childhood trauma; in my own case, it was a violent death experience at the age of two.

My case was diagnosed in 1952 by Dr. Corbet H. Thigpen and Dr. Hervey M.Cleckley in Augusta, Georgia. I was under their care for two and a half years, and it was from my case history that they wrote the book *The Three Faces of Eve* (1957) from which that motion picture was made. During the last 17 years of this illness I was under the care of two Northern Virginia doctors; it was in the office of Dr. Tony A. Tsitos that the final three personalities integrated. It was a violent integration, when one personality announced hysterically that she had killed another one. Dr. Tsitos recognized the importance of this breakthrough.

You might be interested to know that my personalities followed a definite pattern. There were always three at a time. Three would manifest themselves. Then they would die and then three more would emerge. They actually thought of themselves as dying, and this certainly is reflected in their art work. They experienced death so much that they actually wrote wills, packed away their memorabilia—and some of them even shrouded themselves for death and just did not come back anymore.

In each group of my personalities there was an amnesiac. The dominant personality was *never* aware of the action of the other two personalities and sometimes when she was surfaced in the body, the other personalities could talk to her from a recessive space. In each group of personalities as a little girl, I had a bad little girl, and a good little girl, and one of an indifferent personality.

"There were always three [personalities] at a time. Three would manifest themselves. Then they would die and then three more would emerge."

As I grew into womanhood, it became a wife/mother image, then a fun-loving, life-loving party girl—and the third personality in each group was the intellect of the three.

As a small child, I was not aware that everyone else was not just like me. It was only after I started school and entered the real world that I recognized that I was indeed different from other people. I began to have severe headaches, a feeling of weakness and inertia, and then long periods of amnesia. That's how my case was originally diagnosed—as a strange kind of amnesia. I think this is true of the diagnosis of many multiples; they are misdiagnosed.

I will share with you my last three personalities. Because of the complexity, I won't attempt to get into all of the 22 personalities that I exhibited over a period of 40 years.I was integrated at the age of 46 (11 years ago) and it has been eight years since I've had any therapy at all.

In existence at that time was the "Purple Lady," who thought that she was 58 years old. She sprayed her hair gray, she wore purple garments, she painted purple pictures, and she was just obsessed with the color purple. Coexisting with her was the "Strawberry Girl" who thought that she was 21 years old. She wore long dresses, went barefoot, wore long red wigs, and ate only strawberries.* At that time I weighed 179 pounds, and the "Strawberry Girl" thought she was thin! When she looked in the mirror, she saw a thin image rather than the obese person that I really was.

Coexisting with those two personalities was the "Retrace Lady," and her hang-up was that she simply would not retrace her tracks no matter where she went. If she was only a block away from home, she would drive a mile around to return from another direction. She thought, "If I just don't repeat anything, then I cannot make the mistakes the others have made, and then I will be the survivor." And that's what it was all about—it *was* a battle for survival.

"With a mixture of clay and water I designed murals on the sides of the outside of the buildings wherever we happened to live."

I think it is important for people to know that there are physical aspects involved in multiplicity, as well as the emotional ones. I had left-handed and right-handed personalities, those who were deaf, those who were blind, and some who were mute. Also, one of my personalities "The Purple Lady," (who thought she was 58) required bifocals to read. At the same time, "The Strawberry Girl," (who thought she was 21) could read form the telephone directory without glasses. "The Retrace Lady," who was 46 (my own actual chrondlogical age) was already using reading glasses. There are some things we simply cannot explain about multiple personality.

Unfortunately, art therapy was never introduced as a part of my formal therapy; however, painting and writing became therapy for me without my knowing it. My creative efforts seemed to be the only *acceptable* accomplishments in my life. The few family members who saw my art thought it was academically good, but very strange and very weird. *No one* realized that my very soul was imprinted on that canvas. Nor was there a professional to observe from a psychological point of view and help determine the path I was struggling to follow out of this wilderness of pain.

My first attempts at art I call "Sand Art," because I drew in the sand with sticks. This was during the great depression, and there was no money for paints and canvas or crayons. And from the "Sand Art" I went into what I refer to as "Barn Art." With a mixture of clay and water I designed murals on the outside of the buildings wherever we happened to live. Memories of these experiences and these days have developed into a series that I call "The Attic Child."

It was not until 1963 that I actually painted a picture—it is called "The Three Faces of Eve," and the artist was "The Bell Lady." Seven of my personalities were artists, and their styles and techniques were totally different from each other. I continue to paint today, and I have a style that is my very own and different from theirs—even though, at times, some of their knowledge will appear on my canvas, and I realize that I can draw on the expertise of seven other artists!

I have discovered in my travels and in my research that *all* multiples are creative and therefore need the assistance available to them through art therapy. I am honored to share with you a part of my life experiences as a multiple personality patient, and I thank you as art therapists for the important, the necessary, and the greatly needed work that you are doing. You are not only providing for the psychiatric community another valuable tool with which to diagnose, to better understand and to provide proper treatment for the mentally disturbed—but I believe that art therapy, within itself, is a healing modality.

Since the services of an art therapist were not available to me, I am certainly in a position to recognize the *absence* of that assistance and the importance of your work to others. On behalf of those who cannot help themselves, and will never have the opportunity to voice their gratitude, I thank you for caring and may God bless you in your efforts to heal.

At the Conference I shared a couple of poems with the members. The first one I wrote right after the integration, and was still feeling the pain of the departure of the other personalities. It is titled "Why Me, God?"

Sometimes my soul is torn by the sound
　　of soundless mirth
And my thoughts are often pressed to
　　justify its worth.
I'm urged to ever strive to loose
　　the great facade
As shadows from my past come back,
　　I whisper "Why me, God?"

Ed. Note: Many of the personalities were named by Chris Sizemore's daughter, for things that they liked or collected.

> **"...*all* multiples are creative [and] therefore need the assistance available to them through art therapy."**

This last poem I recently wrote (about six months ago). It is titled "Wholeness."

How present I become, as though there were
no more yesterdays.
Sudden silences separate the moments, while
I walk that crooked mile
That only faith can make straight.
Star shine encircles me with grace,
Butterfly wings sing a lullaby and reveal
pink fragrant rosebeams.
My trembling soul reaches for the hand of God—
beyond the realm of angels—
And a soft "Amen" gently brushes the edge
of my face.

In any interview, I tell people that there are four things that have brought me successfully to the present time. They are:

1. **Good psychiatric treatment.** It is vitally important for the multiple to have good therapy.
2. **Family support.** I had a fine family support system, and I think that love can do wonders for any of us.
3. **My desire to be a well person.** I feel that the patient must help himself or herself.
4. Last, but not least, **my faith in God**.

It took all four of these things to bring me to where I presently am. Although it is probably needless to tell you, I feel as though I have just *begun* to live.

References

Sizemore, C.C. and Pittillo, E.S. (1977). *I'm Eve.* Garden City, New York: Doubleday & Company, Inc.

Thigpen, C.H. and Cleckley, H.M. (1957). *The three faces of Eve.* New York: McGraw-Hill.

Guidelines for Authors

Please submit four (4) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed, ATR, Wright State University, Creative Arts Center, 228 Creative Arts Center, Dayton, OH 45435. Send manuscripts and illustrations certified mail, with return receipt requested. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½×11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5"×7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

BEST COPY AVAILABLE

Expanded Work Settings for Art Therapy

Margaret L. Smart, BA, MSW

Margaret L. Smart, BA, MSW is in private practice in Palo Alto, California. She is a member of the American Art Therapy Association, Inc. and the Northern California Art Therapy Association.

This paper identifies expanded work settings for art therapy, such as Employee Assistance Programs, as a potential employment resource for art therapists. The nature, number and scope of services of these programs is discussed, as well as the prejudice against art therapy that might exist within firms that provide the services. Examples of the value of art therapy in such settings are provided. Art therapists are challenged to broaden their own definition of the uses of art therapy and the settings in which it might be profitably practiced.

> To be shaken out of the ruts of ordinary perception, to be shown for a few timeless hours the outer and the inner world, not as they appear to an animal obsessed with words and notions but as they are apprehended, directly and unconditionally, by Mind at Large—this is an experience of inestimable value to everyone.
>
> Aldous Huxley (1954)

In the summer of 1984, I was in the process of leaving long-time, full-time employment to start a private practice. To facilitate this transition, I looked for a part time position with a mental health or other counseling agency. The search led me to a firm that was identified as an Employee Assistance Program. They were looking for experienced therapists to provide short term counseling in one of their several offices. I was hired for twenty hours per week.

Employee Assistance Program

Employee Assistance Program is the term used to identify certain health benefits for employees in both the public and private sector. The term is usually used by employers to designate a program of limited counseling services that employees can obtain as part of their health management benefit package. The term is also used as a general label for those counseling firms that contract with employers to provide the counseling service. Presently, there are over 5000 such firms in the United States. It is estimated that these firms serve a potential client population in excess of one million people.*

Employee Assistance Programs first came into being in the 1930s at the time alcoholism was beginning to be defined as a disease rather than the result of personal moral weakness. Originally the initials "EAP" stood for Employee Alcoholism Program and the services were limited to those workers who were having work problems because of alcohol addiction. The availability of counseling and related services was considered to be a more appropriate response to disease than were reprimand and firing. Additionally, the cost of such a service was usually small in comparison to that of hiring and training new employees. The programs were designed to provide crisis intervention, assessment of employee need, and a referral to community resources for ongoing service. The programs were staffed by human services professionals, primarily psychologists and social workers, and were normally situated at the work site.

As the programs grew, employers began to contract out the work to counseling firms and they were moved off-site. At the same time, personnel officers became aware that it was not only alcoholism or other addictions that interfered with employee productivity, but that employee output also suffered when employees were under the emotional stress that might come from personal or family problems. For this reason, although the main thrust is still to provide treatment for substance abuse problems, many employers have extended the benefits of employees whose job functioning was impaired because of any emotional, family or work-related problem.

The value of employee assistance programs to industry has been buoyed by research from a variety of sources. The National Institute on Alcohol Abuse and Alcoholism estimates that one worker in 10 has an alcohol abuse problem, and that two workers in 10 suffers from either a drug or alcohol abuse or mental illness difficulty. In dollars and cents, according to 1983 figures from Research Triangle Institute, the total cost to society in lost productivity from the three causes exceeds $102.9 billion per year. A study of 500 employees at one division of AT&T found that providing early treatment for troubled workers, particularly those with alcohol problems, reduced their absenteeism rate from an average of 18 to 7 days a year. (Foreman, 1985)

---

*From an interview with an EAP office manager, April 1985

"[An] Employee Assistance Program [identifies] certain health benefits for employees in both the public and private sector."

Silicon Valley EAP Program

The EAP in which I worked is located in Santa Clara County, California—otherwise known as Silicon Valley. The firm has contracts with approximately 40 different companies, with a total employee population among those companies at around 70,000. Since all contracts also provide services to dependents, the potential client population for the firm exceeds 225,000 people.* The contracts usually provide between three to five counseling sessions per "personal crisis." In some cases the therapist is to do only an assessment and referral, and in others the employee is free to remain with the EAP firm for ongoing, longer term therapy. Usually, however, the counseling is expected to be of a short-term nature, with referrals elsewhere if long-term psychotherapeutic or psychiatric services are deemed necessary.

Upon beginning employment, I was advised that the therapeutic approach was traditional and that the firm was not "into" enhancement, enrichment, or encounter. The directions focused on assessment, short-term problem-solving and/or referral. The firm's clientele was defined as individuals who would profit mainly from a rational, "reality-focused" form of counseling rather than any therapeutic interventions that might be construed as "mind expanding."

My own style of therapy, developed over a period of 15 years, is a combination of the traditional and experiential modes of psychotherapy. I had studied Gestalt therapy in the early 1970s and found it to be an especially potent therapeutic tool. About five years ago, I began to use drawings in conjunction with Gestalt therapy and dream work. At about that same time, I took a position as a family counselor in a child abuse prevention program. I found myself turning more and more to the use of art in my work. Art became an important vehicle to facilitate communication between myself and my clients as well as between family members themselves. Because of my education and experience, I hold a firm belief in the value of experiential and non-verbal methods of intervention in on-going as well as diagnostic work with both adults and children, I asked for, and received, permission to do limited Gestalt work and to use art therapy in diagnostic work with children.

The viewpoint of the EAP management that experiential and art therapy had limited value in their firm seemed to be saying that traditional "talk therapy" was real therapy whereas experiential or expressive "non-verbal" therapies were esoteric in nature and were not quite as useful as the "real stuff." Personal experience has led me to conclude that this viewpoint may be professionally widespread. For example, the *Civilian Health and Medical Program of the Uniformed Services (Champus) Handbook* (January, 1983) specifically excludes "mind expansion," such as Gestalt therapy and meditation, from coverage. The main criticism of the experiential, expressive modes of therapy is that the proponents of such therapies are selling "quick cures" and tend to delude their clients into believing that a "cure" can be effected quickly without the years of painful "work" that is the accepted part and parcel of traditional therapy. This attitude is not only quite narrow in its bias against non-verbal forms of therapy, but seriously limits the scope of interventions that a therapist might consider appropriate for any given client.

Nonverbal Therapy and Brain Research

The prejudice against, or perhaps a misunderstanding of, non-verbal, non-rational forms of therapy is not new to art therapists. Books on art therapy usually devote a few paragraphs to the concern that art therapy is seen as merely "messing around" or having only limited benefit in the world of psychotherapy. (Landgarten, 1981; Wadeson, 1980) Art therapists, employed in various hospitals, are not only required to give their attention to their clientele but are often faced with the additional task of continuing to prove their worth to administrators and other clinical staff. (Wadeson, 1980)

In recent years, more research has been done to increase our knowledge of how the brain works. This research has led to a clearer understanding of the different functions of the right and left sides of the brain. It is understood that each hemisphere serves a specific and important function. To briefly summarize a tremendous body of work, the left hemisphere is inclined to be intellectual, analytical and rational, whereas the right hemisphere is described as intuitive, subjective, non-linear and holistic. Researchers have also noted that science and our educational system neglect and discriminate against the right or non-verbal hemisphere. (Sperry, 1973) However, even in light of this research, the worlds of psychology, education and business, among others, have been slow to recognize the value of the non-verbal, non-rational approach to learning and problem-solving.

Others have deplored our tendency to exhalt the rational and demean the intuitive. Samples (1983) has written of the creativity of the metaphoric mind and the application of intuitive, non-rational thought in the areas of education, business and psychology. An extremely popular book has been Edwards' *Drawing on the Right Side of the Brain*. (1979) Although slanted toward improving one's ability to draw, the message is clearly that we limit ourselves via our reluctance to utilize both hemispheres of the brain.

"...many employers have extended the benefits of employees whose job functioning was impaired because of any emotional, family or work-related problem."

BEST COPY AVAILABLE

In his book *How to Tap into Your Own Genius,* Thomas Cowan (1984) suggests that one revert to childlike ways to tap creative processes. Dr. Cowan recognizes the second class position of imagery and meditation as problem solving methods. In his book, he offers a series of exercises that are designed to open ourselves to the use of the symbols and images generated by the brain's right hemisphere as a problem-solving method.

Art Therapy and the Business World

In the 1960s there was some integration of humanistic and encounter methods into the business world in an attempt to improve productivity, upgrade communication between staff, and enhance employee morale. This human relations theory of management (McGregor, 1960) fell into disrepute because of the excessive attention given to communication and insufficient attention paid to producing the product.

In the 1980s there has been a continuing emphasis on the value of the rational and technical approaches in business to the exclusion of the humanistic approach. This would seem to be a further move away from the intuitive; and yet some of the most popular management textbooks have tended to include a more nonrational approach as appropriate for achieving improved employee morale and productivity. (Peters and Waterman, 1982)

This is not to say that firms are sponsoring encounter or problem-solving through art groups. But there has been a move toward encouraging open and creative thinking among all their employees. Along with this trend has been the continued support of short-term personal counseling as an appropriate benefit for employees. The benefit is available at firms that are considered forward-thinking and concerned with the human needs as well as the production capacity of their employees.

In the EAP firm where I worked, the client population was like other counseling agencies in the nature of the presenting problems. However, in Silicon Valley, most clients were engineers, computer programmers, technical writers and other support staff whose work was concerned with the creation and production of computer-oriented products. They were career oriented people, and at least one third were men. They were all working in an environment that demanded high productivity, job excellence, attention to detail and adherence to deadlines.

What many also had in common was a knowledge that they had a problem that was interfering with work, and that their company was providing a means to deal in some way with resolving that problem. Although discouraged from using mind expanding type interventions with these clients, I found myself leaning more and more toward the inclusion of drawings in diagnostic and on-going work. I considered appropriate all interventions that would facilitate client understanding and problem resolutions regardless of any management prejudice that might exist. I had no art supplies except paper and crayons; however,

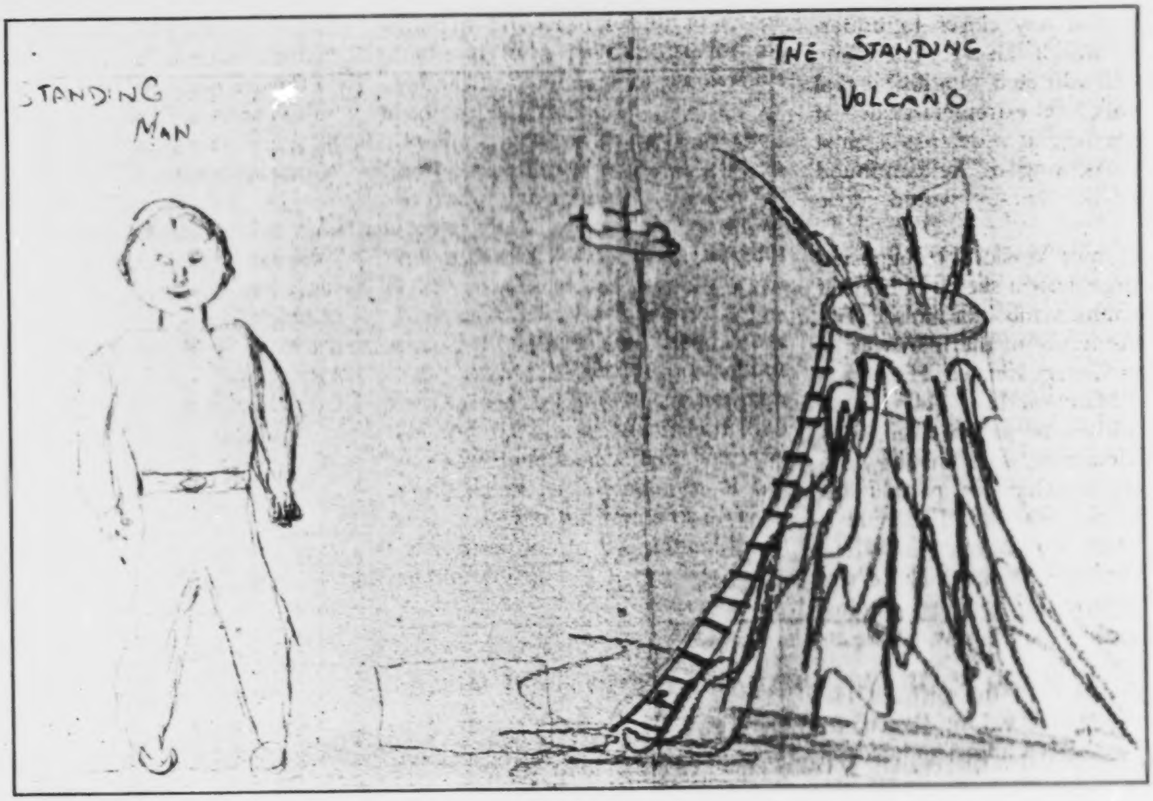


Figure 1

the use of these in many situations proved to be valuable to the client in basic art therapy sessions.

Case Example #1: George

George (pseudonym), one of my first clients, was a 44-year-old engineer. He was divorced and the father of two young sons. He had been living with a woman for over three years, but she had recently left his home, suggesting that he "get into therapy." George said he was depressed over the breakup. He did not know why she had left him. He was seeking some understanding of this plus some help in adjusting to being "single" again. George's eyes were dull in appearance. He spoke quietly and without emotion. He said he was not aware of feeling angry. He felt empty. George had very effectively cut himself off from his feelings and self.

It seemed important to use a technique to "connect him to himself," yet I was wary of introducing experiential techniques into the therapy. However, it was apparent that simply talking about his difficulties was not bringing him any closer to understanding himself. George, like many other well-educated, highly verbal individuals, was extremely skilled at using language as a defense against feelings. As long as he continued only to talk, therapy would move slowly.

In the third session, I suggested that George draw a sketch of himself plus a graphic symbol for himself (Figure 1); the figure of the man was as lifeless as George himself. He gave it the title "Man Standing." As he studied the picture he saw himself, as if for the first time, as someone who was going nowhere in neither his work nor personal life. The symbol George drew was a volcano. When first drawn, it did not include the ladder, helicopter nor fire coming from the cone that is now visible in the picture.

We worked with the picture. He described himself, via the sketch, as inactive and forbidding. The helicopter and ladder were added as he entertained the idea of how someone might get close to him, and how difficult that might be. The wispy, somewhat reddened fumes emanating from the cone were added to signify that there was perhaps more feeling inside than he would allow to be expressed.

> ***"The prejudice against, or perhaps a misunderstanding of, non-verbal, non-rational forms of therapy is not new to art therapists."***

The use of the art therapy technique served to increase George's awareness about himself and how he might be acting in ways that were truly self-defeating. As a result of the art exercise and his interaction with his art production, George did organize himself to pursue some work goals with fresh vigor. Also, his therapy took a new direction because he now understood that he needed to develop his capacity for intimacy before he could expect that someone would want to share her life with him.

Case Example #2: Anne

Another client was Anne (pseudonym), who held a technical writing position in a large company. She was twenty-eight-years of age and married. She liked her work and felt she was good at it, and yet often felt overwhelmed by the pressures of deadlines and other job demands. She had previously worked in more low key service work that left time for personally rewarding activities. But she had left that in order to earn the higher salaries available in the computer industry. At the time she came for counseling, she was beginning to doubt her competency. She was feeling fragmented, unable to concentrate, and obsessed with thoughts of failure. In the first interview we dealt with the realities of the job and how that fit with her personal goals, which were to be successful financially and personally.

In the second interview, I suggested that she complete a realistic sketch as well as a symbolic drawing of herself (Figure 2). The realistic drawing came as no surprise to Anne. She related immediately to the

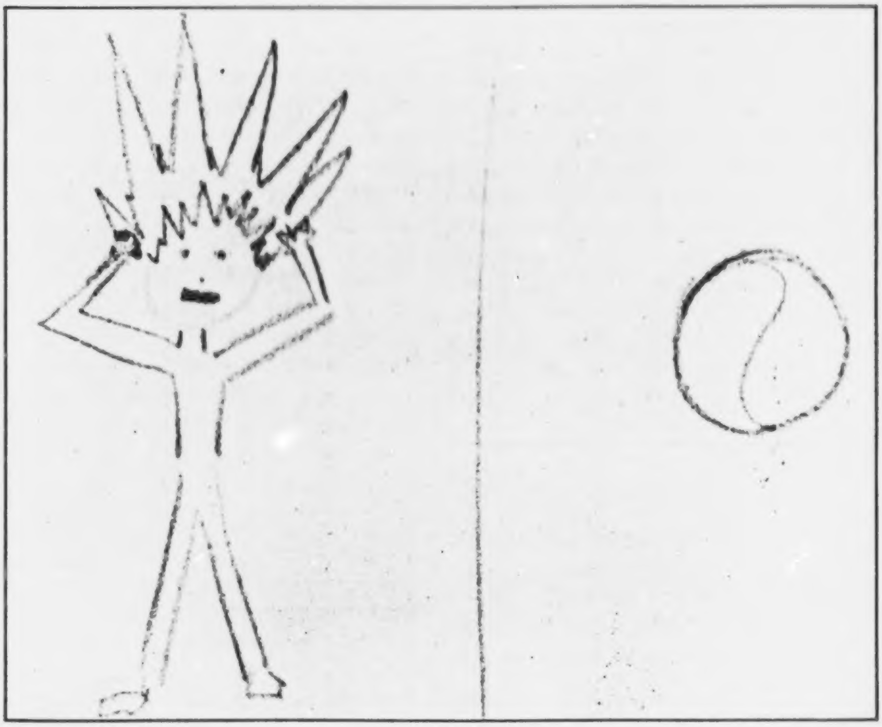


Figure 2

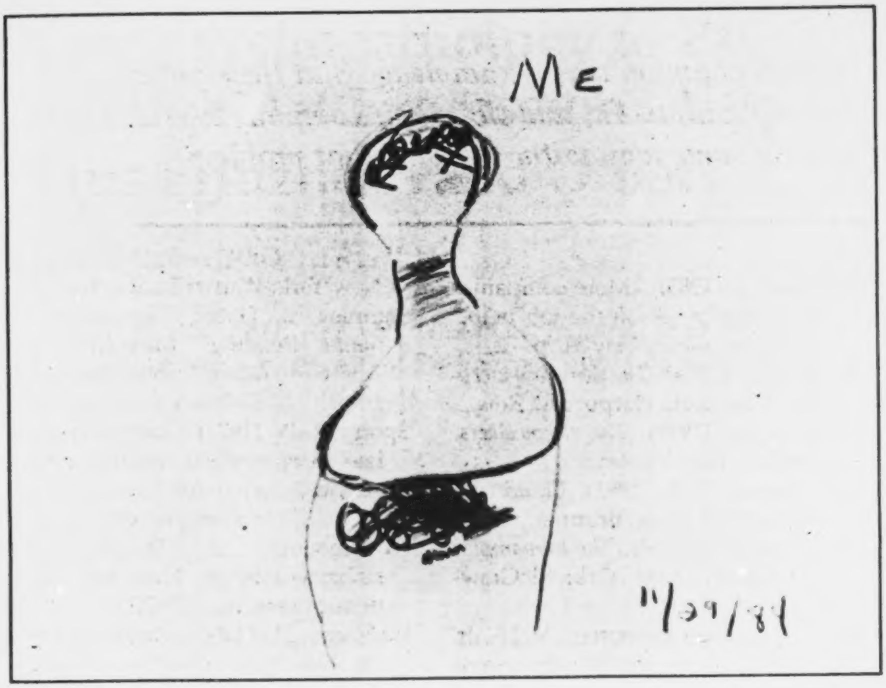


Figure 3

frantic, chaotic feeling depicted. The yin-yang symbol was used to express the idea that she had both a rational and a creative side to her personality. More important, however, was her observation that a serious conflict existed between those two aspects of herself. She said, with a sense of discovery, that she had been putting all her energy into rational expression to the detriment of her creative needs.

Anne shared that she felt this imbalance was at the root of her anxiety. She was able to act on this insight and initiate a plan to provide time to recreate herself in her off-work hours. She also began long-range plans to seek work that would allow for expression of both parts of herself.

Case Example #3: Shirley

A third case was that of a 31-year-old woman who came in because she was not doing well on the job; neither was her marriage going well. Her husband was talking of a trial separation and her company was attempting to relocate her to a job in which she might do better. Shirley (pseudonym) looked depressed. Her speech was slow. She sometimes paused so long between words I feared she had lost touch with the present. Her history included prior episodes which she described as being depressed. She admitted to contemplating suicide as an answer to her hopeless situation. She was reluctant to accept a referral to a psychiatrist for an assessment of the use of medication to control depression.

In the course of an early session, Shirley mentioned physical pain in her body. She refused a referral for medical examination. She agreed to draw a picture of her "pain" (Figure #3). She stared at this representation of herself and the black and red coloration that she felt in her head, neck and stomach. She finally spoke about her awareness of how severe her pain was and that she was worse off than she had imagined. This was the beginning of her acceptance of her need to seek a full range of services for her reaction to the difficulties in her life.

Art Therapy as a Viable Method

Koestler (1959) stated that every creative act involves a new innocence of perception, liberated from the cataract of accepted belief. Surely, in each of these cases, the creative act constituted a turning point for the client. Not only did each gain an increased awareness of the self-defeating behavior, but each was able to mobilize his or her energy to move away from that behavior to take action to correct the situation.

Art therapy was a key part of a short-term, assessment type therapeutic approach for these clients. Not all the clients whom I saw were either open to (or appropriate candidates for) the expressive approach to connecting with their behavior. However, for those who were, and these were many, it provided a valuable avenue to cut through defenses redirecting energy from non-productive to productive behavior. In each case, the client effectively used a nonrational, art oriented approach to solve a real problem.

There is a place for art therapy in short-term, evaluative therapy. The question appears to be whether or not there is a place for art therapists in organizations such as EAP firms. The burden for opening up this employment resource to art therapists rests with the therapists themselves. It will be necessary, of course, to demonstrate the value of art therapy to those who are in a position to hire therapists. Beyond that, however, I believe it will be necessary for art therapists to begin to view their skills as applicable in a broader range of settings. This will demand that art therapists be willing to become generalists as well as having a specialized focus.

There may be objections to this proposal on the part of art therapists; however, it would appear that inte-

---

"In the 1960s there was some integration of humanistic and encounter methods into the business world in an attempt to improve productivity, upgrade communication between staff and enhance employee morale."

"What many [people] had in common was a knowledge that they had a problem that was interfering with work, and that their company was providing a means to deal in some way with resolving that problem."

gration into the mainstream of psychotherapists is a necessary step toward giving art therapy the recognition it deserves as an important part of the world of psychotherapy.

References

Champus handbook. (1983). Aurora, CO., January.

Cowan, T.D. (1984). *How to tap your own genius.* New York: Simon and Shuster.

Edwards, B. (1979). *Drawing on the right side of the brain.* Los Angeles: J. P. Tarcher, Inc.

Foreman, J. (1985). "More companies offer employees off-the-job help," *The Boston Globe,* May 31, p. 72.

Huxley, A. (1954). *The doors of perception.* New York: Harper and Row.

Koestler, A. (1959). *The sleepwalkers.* London: Hutchinson.

Landgarten, H.B. (1981). *Clinical art therapy.* New York: Brunner/Mazel.

McGregor, D. (1960). *The human side of enterprise.* New York: McGraw-Hill.

Peters, T. J. and Waterman, R. H., Jr. (1982). *In search of excellence: Lessons from America's best-run companies.* New York: Warner Books, Inc.

Samples, B. (1983). *The metaphoric mind.* Reading, Massachusetts: Addison-Wesley Publishing Company.

Sperry, R. W. (1973). "Lateral specialization of cerebral function in the surgically separated hemispheres," in F. J. McGuigan and R. A. Schoonover (eds), *The psychophysiology of thinking.* New York: Academic Press, pp. 209-229.

Wadeson, H. (1980). *Art psychotherapy.* New York: John Wiley & Sons.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

From Psychopathology to Psychotherapy Through Art Expression: A Focus on Hans Prinzhorn and Others

Judith A. Rubin, PhD, ATR, HLM

***Judith A. Rubin, PhD, ATR, HLM** is an art therapist in private practice. She is also Clinical Assistant Professor, Department of Psychiatry, University of Pittsburgh and Faculty-by-Invitation, Pittsburgh Psychoanalytic Institute.*

This article is condensed from a paper presented in connection with the Prinzhorn Exhibit, University of Miami, Miami, Florida, February 1985. Reference is made to the "magic power of the image" (Kris, 1952) and to modern healers as they practice art therapy. Major writers in art therapy, psychiatry and psychology from the 1800s and 1900s are identified, with reference to their contributions to mental health and the healing process. Focus is given to the contribution of Hans Prinzhorn, whose monograph published in 1922 (translated: **The Pictorial Works of a Mental Patient: A Contribution to the Psychology and Psychopathology of the "Gestaltung"**) *is considered a hallmark in art therapy and mental health literature. Several hundred items from his collection of art by mental patients were included in the exhibit; these works serve as a testimony to the wisdom—although considered revolutionary at the time—of the creative Viennese art historian and psychiatrist, Hans Prinzhorn.*

Although the use of art for healing and for mastery is at least as old as the paintings on cave walls, only recently has the "magic power of the image" (Kris, 1952) been harnessed by modern healers in the form of Art Therapy. There are ancient precursors, like fertility figures or voodoo effigies—both thought to have magical powers. Sand painting is only one of many rituals involving the creation of visual imagery for the purpose of healing physical or psychic pain. While all of these are practiced by the medicine man or shaman—the healer—sometimes art is used by the individual in an attempt at self-healing or to signal to others his or her need for help.

Similarly, individuals caught in the turmoil of serious mental illness—threatened by loss of contact with reality—have sometimes found themselves compelled to create art. Such productions, found as often on scraps of paper or walls as on canvas, began to intrigue mental health professionals toward the end of the 19th century. At that time, a few psychiatrists began to collect the drawings, paintings, sculptures and needlework made spontaneously by their patients. Although most doctors "regarded them only as curiousities" (Plokker, 1965, p. 83), there were a few notable exceptions. Paul-Max Simon, a French psychiatrist, was actually the first to publish serious studies of the drawings of the mentally ill (1876, 1888). He was followed by Cesare Lombroso (1887), whose equation of genius with insanity is less common today, but still apparent in the attitudes of many who consider creativity synonymous with a kind of madness.

In any case, both of these early workers appreciated, even before the advent of depth psychology, that patients' products were related to their conflicts; that as confusing as they often were, they made a kind of **psycho - logical** sense (MacGregor, 1983). In 1906 Fritz Mohr, a German psychiatrist, described the first "drawing tests." Although these involved the copying of figures, like the present-day Bender Gestalt Test (Bender, 1938), his work led to the more freely expressive use of figure drawings, family drawings, and free drawings in both clinical psychology and art therapy. And, in a study of the art of the mentally ill, a French psychiatrist named Réja (1901) described three types—infantile, ornamental, and symbolic—and noted similarities between the art work of patients and that of both children and primitive people.

In 1918 Paul Schilder, the psychiatrist who originated the concept of the "body image," published a monograph *(Wahn und Erkenntnis)* in which he compared art by one of his patients to the avant-garde works of the time; suggesting that while both seemed "mad" to the layman, there was indeed sense in both. Another individual case study by Swiss psychiatrist Walter Morgenthaler on the art of Adolph Wölfli, a paranoid schizophrenic, appeared in 1921 with a title *(Ein Geistestranker als Kunstler)* variously translated as: *A Mental Patient as Artist* or *Psychopathology and Pictorial Expression.* Wölfli's considerable technical skill and visually pleasing pictures have been appreciated by many art-lovers over the years, and it is interesting to note that although he died in 1930, he is featured in two fairly recent publications on art by the untrained: *Outsider Art* (Cardinal, 1972) and *Art Brut* (Thévoz, 1976).

But the publication that is still cited by all scholars as "standard," and is often commended for its timely insights over half a century since it appeared, was Prinzhorn's mongraph, *Bildnerei de Geisteskranken* (1922). The full title is usually translated as: *"The Pictorial Works of a Mental Patient: A Contribution to the Psychology and Psychopathology of the "Gestaltung"" (Ein Beitrag zur Psychologie und Psychopathology der Gestaltung).* That publication was based on the largest collection of art by mental patients ever assembled, several hundred items of which are on display in this traveling exhibit. Prinzhorn, a highly creative Viennese art historian and psychiatrist, while familiar with the early discoveries of both Freud and Jung about the symbolic meanings of visual imagery, chose to focus his attention on the formal qualities of the art works rather than on their content or subject matter. As those familiar with the concept of "Gestalt" might imagine, he was interested in holistic, configurational—and largely asethetic—aspects of the work he studied. His approach was essentially phenomenological, as he attempted to discover through a close look at the art of schizophrenics, the basic creative strivings which he assumed were present in all human beings. In his exploration of universal motivations, he talked about "urges" to express, to play, to ornament, to order, and to imitate; he spoke too of the need for symbols and for significance. He described the art work of his schizophrenic patients as objectively as he could. In a similarly phenomenological fashion, he explored relationships among that work and the art of children and of primitive, pre-logical cultures.

As James Foy, a Washington psychiatrist, states so clearly in his Introduction to the 1972 English translation of Prinzhorn's book: "The questions probed by Prinzhorn are the same questions that have fascinated several generations of psychiatrists and art scholars. Although much has been accomplished in the study of symbolism and its structures over the past 50 years, the creative process, its psychic substrate, and its unique formation or deformation under the influence of schizophrenia remain as puzzling to us today as they were to Prinzhorn..." (1972, p. xiv)

"...individuals caught in the turmoil of serious mental illness—threatened by loss of contact with reality—have often found themselves compelled to create art."

"The paths opened up by Prinzhorn have been followed by others into many sectors." (1972, pp. xiv-xv) One of these is Art Therapy. As Foy explains, however: "It must be understood that the Heidelberg collection with which the author worked consisted of productions by untrained, and unpracticed persons for the most part, who lacked artistic indoctrination. These persons were often long-term residents of mental hospitals, confused and frightened people who lived in uninspirational, isolated and isolating institutions. Between the years 1890 and 1920 when these works were made, there was no formal occupational therapy provided for hospitalized mental patients. The patients who made these images were driven to do so by strong inner needs, often in the face of frustrating circumstances. Paper for drawing was rescued from wastebaskets. Some drawings were made on the insides of unfolded envelopes or on toilet paper. Prinzhorn remarks about the small sculptures made from bread in evidence at the institutions he visited. The works of the patients were not included in any therapeutically conceived program, certainly no art therapy as we understand it today. One must remember that the works discussed and illustrated in this book are spontaneous in the fullest sense of the word." (1972, p. xiii)

Prinzhorn himself does not discuss Art Therapy, a term which had not yet been coined, though it is intriguing that he does describe an approach to artistic invention first noted by Leonardo DaVinci, which anticipated the development of what is probably the most common stimulus used by art therapists today: the scribble drawing. Prinzhorn quotes Leonardo abut how artists can be stimulated by ambiguous visual phenomena like spots on the wall, ashes in the fire, or clouds in the sky. He then goes on to describe an approach strikingly similar to the scribble technique later elaborated by Florence Cane (1951) and by her sister, art therapy pioneer Margaret Naumburg (1966): "Suppose that one scribbles aimlessly on a sheet of paper while averting his eyes, and covers as much of the sheet as possible with a confusion of lines of variously strong and variously projecting curves and only then, looking for the first time, lets himself be inspired to some composition or other, whether figure or landscape." (Prinzhorn, 1922, p. 19)

As those who have used it can attest, the technique is indeed a powerful one in eliciting meaningful imagery.

In a similarly modern-sounding statement, Prinzhorn declares at the outset of his study that he will not fall into the trap he thinks captured earlier students of psychiatric art of looking for "diagnostically useful signs in the pictures by various patients." Although there may be exceptions, this author would agree for the most part with his statement that "crude characteristics can be found, but anyone unable to make a diagnosis without the drawings will certainly not have an easier time with them." (1922, p. 3) Prinzhorn wisely renounced the temptation to conduct a "blind analysis" of the artists on the basis of their creations: "We believe, in other words, that even the best psychiatric and psychopathological methods will not protect us from drawing nonsensical conclusions about our heterogeneous material." (1922, p. 4)

In my own earliest work, which was with hospitalized schizophrenic children, this issue was still very

"Although trained psychologists, psychiatrists, and art therapists are taught to see certain "signs" in patient art as clues to organicity or particular pathology, sophisticated clinicians are conservative about making either diagnostic or predictive judgments on the basis of art products alone, especially with only a limited sample of productions."

much alive, although it had been over 40 years since the publication of Prinzhorn's book. The chairman of my department asked how the art of the schizophrenic youngsters was different from that of the normal children, who I also saw weekly in an after-school recreation program.

Despite a literature suggesting consistent signs or characteristics, it was difficult to pinpoint specific differences in the art work of the two groups. However, direct observation of the children's behavior with the therapist and the art materials enabled one to easily distinguish between the two populations, since the schizophrenic children appeared and acted quiet differently.

In order to look more systematically at the question of whether their art work differed, a study was designed in which a group of normal youngsters, matched for age and sex, was seen for a series of individual art interviews. They were given a free choice of media and topic, as were the hospitalized children. Products were then randomly selected from work by both populations, and presented as slides to 40 judges varying in experience with children, art, and psychopathology.

When the judges were asked if they thought they could discriminate the work of schizophrenic from that of normal youngsters, most of them replied in the affirmative. They were then asked to identify each of 40 items (half from each population, presented in random order) as schizophrenic or non-schizophrenic, and to note their degree of certainty as well as the reasons for their decision. In an effort to achieve greater accuracy with a larger sample of art work, groups of products from a single session were also presented in the order in which they had been done, with the same judgments requested.

Only three of the 40 judges were able to judge correctly beyond chance expectation on both single items and groups of products. It was found that two of the three were in the group of ten judges with no experience in child art or psychopathology. When given information on chronological age or sex, their accuracy was no greater. What did emerge, which enables us to understand the historic impact of Prinzhorn's book, was a significant correlation between judged normality and judgments of aesthetic value (which were made at the end on the forty single products)—suggesting that what looks "good" also looks "normal" to most judges (Rubin & Schachter, 1972).

Although trained psychologists, psychiatrists, and art therapists are taught to see certain "signs" in patient art as clues to organicity or particular pathology, sophisticated clinicians are conservative about making either diagnostic or predictive judgments on the basis of art products alone, especially with only a limited sample of productions. As the author has written elsewhere:

"Of course, there are meanings in products, in formal qualities and in content; but they are not to be found in neat formulas or simple recipes, much as we might crave easy answers. Those generalizations which are in current usage are useful as an indication of possibilities, sometimes probabilities, but never certainties. Human beings, after all, are complex creatures, and so is their expressive behavior and the products that arise therefrom." (Rubin, 1984)

Anyone who works with people in art is familiar with the phenomenon of intra-individual variability—that, as Dewdney noted in his work with adult patients: "An individual can produce so wide a range of subject matter, mood, and style, that frequently two drawings done within an hour by the same person have no noticeable common feature of style or content." (1967, p. 16) And, as Kellogg (1969, p. 191) has so graphically illustrated, normal children can vary widely in their drawing of even the same subject under standardized conditions in the course of a single week.

Because of this phenomenon, and the contradictory research findings on the diagnostic use of patient art, the author and her colleagues conducted a normative study, using 180 boys and girls from ages 4 to 12. Each child did four "person" drawings in pencil with the same instructions on a Monday, Tuesday, and on the following Monday and Tuesday. After the coded drawings were scored, using the Goodenough-Harris scale—a developmental measure correlating significantly with I.Q. tests (Harris, 1963)—the variability in each child and each age group (20 Ss) was assessed using a standard deviation among the four scores. *Content* and *visual variability* were also scored, and both correlated significantly with each other and with *score variability*. This suggests that all were facets of the same phenomenon. (Rubin, Schachter & Ragins, 1983)

The developmental "line" that emerged was, however, a surprise, since it was not a straight line of gradually decreasing variability with age as had been expected, but rather a cyclical picture with lows at ages 5 and 10, and peaks at ages 4 and 8, as well as an upswing at 12. The results of this study, like that of the early one, should serve as a caution. How consistent are people at different developmental levels? And how does consistency/variability relate to other correlates, like *creativity* (if variability is viewed as flexibility) or *emotional disturbance* (if variability is seen as instability)? Are the artists represented in the Prinzhorn exhibit more or less variable or consistent in their work? Or is what we see simply a reflection of someone's selection process? In any case, although we are now often able to observe the act of creation, and we do know a good deal more about our patients than did Prinzhorn about the artists whose work he collected, we can still admire and approve of the caution he exercised in making diagnostic generalizations from the products themselves.

Prinzhorn was also skeptical of another approach to the use of art in mental health, one which was just beginning and which formed one of the roots of the field of Art Therapy. Although very little had been published at the time he wrote, Freud had printed a drawing by the father of Little Hans, the first case of child analysis, in 1905 (Freud, 1905, p. 13, Figure 1). After his father drew a picture of a giraffe, Hans made "a short stroke, and then added a bit more to it, remarking 'Its widdler's longer!'" And in 1918, the founder of psychoanalysis had published the famous case of the Wolf Man, describing how the patient did a drawing of his dream, though it isn't clear from the text whether it was done spontaneously or at Freud's request: "He added a drawing of the tree with the wolves, which confirmed his description." (Freud, 1918, p. 30)

Although Prinzhorn doesn't refer to Freud specifically, he does state that "Psychoanalysts have made repeated attempts to use pictures by persons under analysis as aids in the analysis, i.e. to interpret them symbolically. It has even become fashionable for patients to try to express their conflict symbolically in pictures, regardless of whether they have had previous training or not." (1922, p. 262) In a footnote, he refers specifically to material published by two analysts, some of which has since been translated into English (Pfister, 1913). Prinzhorn also notes that "nothing has so far been published of the very fascinating and problematic pictorial work which originated in the course of C.G. Jung's work as objective manifestation of psychic developmental phases." Although he notes that "comparative material from this quarter [presumably Jung] would be especially welcome in answering the questions as they have been formulated here" (1922, p. 262), he does not seem to value the therapeutic potential of work in art.

"Prinzhorn quotes Leonardo about how artists can be stimulated by ambiguous visual phenomena like spots on the wall, ashes in the fire, or clouds in the sky."

In fact, Prinzhorn's aesthetic bias seems to color his usual objectivity, when he remarks about the art that analysts have received from patients: "The pictures which have resulted have so far unfortunately been interesting only for their contents and have been inconsequential as configurations. In our opinion it is most improbable that they will lead to any insights into the problems of configuration, and we feel compelled to emphasize by a few basic remarks what separates our approach from the symbolic analysis which is purely concerned with content."

Later in the same paragraph he makes clear his preference for a visual, formal, aesthetic approach to patient creations as works of art, seeing such an approach as having the potential to answer larger and more important questions. He also makes a provocative statement which all art therapists would do well to heed: "Anybody unable to experience a picture visually without feeling a compulsive desire to explain or unmask may be a good psychologist, but he necessarily bypasses the essence of the creation."

He goes on: "We acknowledge every psychological insight as such, but at the same time we are certain that it leads away from the work to a knowledge of intimate facts. We put the accent on the universal components and subordinate everything else to them, fully conscious that we thereby go counter to the inescapable temper of the times to which we must all make obeisance." (p. 262)

One wonders what Prinzhorn would have said today, had he witnessed the development of the use of art in mental health for assessment as well as for treatment. It is likely that he would have respected Clinical Psychologists like Dale Harris (1963), Elizabeth Koppitz (1968) and Emanuel Hammer (1958), whose sophisticated use of drawings for the evaluation of both developmental and dynamic pathology has contributed much to differential diagnosis and decision-making. He probably would have also respected Play Therapists like Virginia Axline (1947) and Clark Moustakas (1953), or Child Analysts like Melanie Klein (1932) and Anna Freud (1946), all of whom found it necessary to provide young children with a wide range of nonverbal modes of communication, including art materials. Further, he would have approved of the development of Occupational Therapy, which in its earliest days, and still in many places, occupies institutionalized patients with constructive activities using art and craft materials.

What is puzzling is that Prinzhorn clearly recognized the intensity of the creative "urge" in these patients, who produced art in spite of the lack of easily available supplies or support systems. He even proposed the rather modern notion, later suggested by Freud and most recently by British psychiatrist R. D. Laing, that people may sometimes get sick in order to get well—that there is a creative *purpose* in mental illness. Laing's patient, Mary Barnes, is a case in point. Mary, in her most severely regressed state, did what only infants sometimes do—smeared her feces to make pictures on the wall. Her therapist therefore decided to offer her paints when she began to improve. She engaged in a veritable frenzy of creative activity, eventually recovering from her psychotic illness and even becoming a fairly successful painter. (Barnes & Berke, 1971)

Given his recognition of the urgency behind spontaneous art and the potential creative self-healing involved, one would think Prinzhorn would have been especially delighted by the development of the field of Art Therapy, where the practitioners are *artists* as well as *therapists*. It is hard to imagine an art therapist "unable to experience pictures visually without feeling a compulsive desire to explain or to unmask;" and there is no question that art therapists promote what he also valued: "the essence of creation." One also wonders why it never occured to him to suggest that creative activities be provided as therapy. The only plausible explanation is that he was offended, as are many contemporary clinicians, by reductionistic approaches which threaten to destroy creative work in the process of explaining it away.

Nevertheless, though he cannot be called the *Grandfather* of Art Therapy, Prinzhorn probably functioned as a kind of *Uncle*, almost as important as his fellow Viennese, Sigmund Freud. Freud developed the notion that the symbolism in visual imagery was dynamically significant, primarily through his psycho-analytic work with dreams. (1900) Moreover, at the time that Art Therapy was being "born," with Margaret Naumburg—probably the truest *Mother* of the field—beginning her work at the New York State Psychiatric Institute in the early 1940s, she and others were reacting strongly to the impact of Prinzhorn's fascinating book. Perhaps most important, its beautiful color reproductions and intriguing illustrations familiarized the average psychiatrist—perhaps for the first time—with the expressive potential of the art of the mentally ill.

Since then, there has been a good deal of growth in both Europe and the United States in the activities provided for psychiatric patients, sometimes under the rubric of Occupational Therapy, sometimes Recreational Therapy or Therapeutic Recreation. In Western Europe, art activities in mental hospitals are often called "Cultural" or "Creative" Therapy. Plokker, a Dutch psychiatrist, writing in 1962, contrasted Prinzhorn's era with the situation then in Holland, where "an attempt has been made to stimulate patients in this direction...There are now charmingly furnished and well-equipped studios in many institutions where work is carried out under the direction of specialists." (p. 4) He went on to state that the "so-called 'cultural therapy' (painting, drawing, modeling, music-making, singing, dancing, etc.) now plays an important part both with

Personal Experiences

When I was 17 years old, a high school friend died in an accident. Feeling numb, I went to the funeral, then returned to the camp at which I was working as an arts and crafts counselor. I succumbed to a high fever which lasted several days. Upon recovery, I felt a strong need to go into the woods and paint, which I did on my first day off. The painting was not of my friend Peter, but someone playing the piano—making music—and it was in dark reds, purples and blacks. It was a cry of anguish, a scream of pain caught and therefore tamed. It was also a new object in the world, perhaps a replacement for the person who was gone, as well as a tangible testament. The doing of it afforded tremendous relief. It did not take away the hurt and the ache, but it did help in releasing some of the rage, and in giving form to the confused feelings which threatened to overwhelm me.

Similarly, on a walk through the woods I once came across another self-initiated use of art to cope with an overwhelming event. A rural man had carved a powerful totem-like sculpture from a tree trunk, in part to mourn the untimely death of his young wife. His explanation was that he "just had to do something," and the activity of creating the larger-than-life carving seemed to fit his need—also filling the void left by his dreadful, personal loss.

Yet another person comes to mind—a seven-year-old boy—whose mother had committed suicide, and who was having a difficult time talking about it. Visiting his home shortly before the event, I had seen a "message" he had made (for himself and others) on the mantlepiece. On one side it said "Trouble," and inside were cutout cardboard weapons with which he hoped to "help" his mom (who had already made an unsuccessful suicide attempt). Following his mother's suicide and funeral, the boy came to me for an art session. He worried about getting messy with chalk and fingerpaint because "My mommy would yell at me." He tried hard to "keep in the lines," but eventually relaxed and let himself enjoy the regressive tactile pleasure of the fingerpaints, saying they were "good and smudgy." He saw a dog in his abstract painting, and told me that it must have been the dog he had wanted so very badly, but could not have because of his mother's depressive illness.

He then made a much messier, darker finger-painting, and commented anxiously on how angry his mother would be if she could see him. He wondered aloud whether she was angry at him, and if his being bad or wanting the wrong things (i.e. dog) had anything to do with her leaving him. His story about the finger-painting was that it was a road, but "You'll never find your way out...No one can stop me...They'll never find their way out. They'll feel so sad...they'll be stuck there forever." He placed his hand in the black paint, lifted it up to show me, and then smashed it aggressively down onto the paper, expressing nonverbally his rage at his mother for abandoning him. One year later he came again for a visit, and in this session he symbolically represented his mother's suicide in a drawing. In this story, a pink person falls off a road (his mother had jumped off a bridge). Later, he dramatized with clay and tools; his dramatizations were of a crash, an emergency, and an operation in which he (the doctor) unsuccessfully tried to restore the injured clay patient. He was productive, and his art work represented not only an opportunity to release his anger and frustration, but also to clarify and to cope in fantasy with the painful reality he had to accept.

sufferers from psychoses and also in the case of *neurotic* patients." (Ibid., p. 5)

Plokker, in his book *Art from the Mentally Disturbed*, discussed "Painting as Therapy," noting how it is sometimes used in one or more of the following ways: as occupational therapy, for purposes of diagnosis, to follow the course of the illness, and for catharsis. Somewhat critically he asked what remains a vital question for art therapists: "Does the patient improve because he has released his tension in drawings and the like, or is the fact that he can express these tensions in pictures already proof his mental condition is improving?" (p. 120)

Plokker ends with the following ambivalent caveat: "Summarising, it must be recognized that there can scarcely yet be any question of purposeful art therapy, since it is still in its initial stages. For the present, we can only work descriptively, collect and exchange data. It is impossible to draw far-reaching conclusions. It is certainly expected that this form of therapy *can* exert a favourable influence on the mental condition of the patient, on his mood, his attitude towards reality and his own self, perhaps even to his illness and that it will, as a part of general more active therapy, consequently be able to make its contribution to the treatment of those who are mentally disturbed." (p. 128)

Otto Billig, a psychiatrist sharing Prinzhorn's interest in psychopathological art, has made a major contribution to the cross-cultural understanding of the phenomenon of schizophrenic creations through a recent study in collaboration with B. G. Burton-Bradley, a New Guinea psychiatrist. *The Painted Message*, published in 1978, compares the art of patients from different cultures who have the same disease. This work, like that of many other investigators, represents a logical extension of what Prinzhorn so ably began: his attempt to relate the art and thought of the mentally ill to the art and thought of others—such as children and primitives—and to better grasp the one through comprehending the other.

> *"...though he cannot be called the* **Grandfather** *of Art Therapy, Prinzhorn probably functioned as a kind of* **Uncle,** *almost as important as his fellow Viennese, Sigmund Freud."*

But perhaps the most direct modern-day descendants of Hans Prinzhorn are those psychiatrists (mostly European) who founded the International Society of Psychopathology of Expression (I.S.P.E.) in Verona, Italy in 1959. In 1966, Dr. Irene Jakab, an active member of that group who had recently come to the United States, founded the American Society of Psychopathology of Expression (A.S.P.E.). (cf. Jakab, 1968) This interdisciplinary group, in existence for several years prior to the American Art Therapy Association, served as a gathering point and communication center for art therapists from all over the country. Physicians like Irene Jakab in A.S.P.E. and I.S.P.E., not only helped art therapists to meet each other and those from related disciplines; they also served as mentors, trainers, and promoters of this field all over the world.

Psychiatrists interested in the psychopathology of expression tend to be art-lovers themselves. Often they are artists, having tasted the deep and satisfying pleasures of the creative process. The physician has usually been in the leadership, decision-making, and hiring role in most mental health settings. Such a person has often been the impetus for the development of an art therapy program.

Margaret Naumberg, for instance, would never have had the chance to try out her theories had it not been for the facilitating role of psychiatrist Nolan D.C. Lewis, Director of the New York State Psychiatric Institute. (Naumburg, 1947, 1950, 1953) Similarly, Don Jones, a past President and founding member of the American Art Therapy Association (AATA), recently (1983) told how his own "cathartic paintings" of a psychiatric hospital where he worked during World War II came to the attention of psychiatrist Karl Menninger, and led to an invitation to start an art therapy program at the Menninger Foundation Hospital in Topeka, Kansas. Psychoanalyst Paul Fink provided Myra Levick, the first President of AATA and founder of the first graduate training program in art therapy at Hahnemann Medical College, important support and guidance. Nor would the author have had the opportunity to develop and grow as a art therapist, had there not been a similarly nurturing psychiatrist, Marvin I. Shapiro, who invited her to come and work at the Pittsburgh Child Guidance Center in 1969.

In other words, although Prinzhorn himself was less impressed with early psychoanalytic uses of patient art than he was with a purely aesthetic approach, his psychiatric descendants have not only studied the work of the mentally ill, but have also supported the work of an emerging group of art therapists.

Although Art Therapy as such did not exist at the time that Prinzhorn made his collection of spontaneous patient art, there is no question that the impact of his monograph on the psychiatric community helped to fertilize the soil in which Art Therapy was later able to take root and grow. The very fact that patients so often chose to express themselves through art, helped psychiatrists to value such modes for their communicative as well as their aesthetic potential. The growing number of books and articles about Art Therapy today reflects the rapid expansion of the field.

In state hospitals, like the institutions in which Prinzhorn's artists worked, and in many other kinds of psychiatric, medical, rehabilitative and educational settings, art therapists today do both diagnosis and therapy—with individuals, families and groups. We have come a long way from the days when mental patients had to rescue paper from wastebaskets in order to express themselves pictorially. We owe a debt of thanks to Hans Prinzhorn, for opening the eyes of the worlds of

> ***"Although Art Therapy as such did not exist at the time that Prinzhorn made his collection of spontaneous patient art, there is no question that the impact of his monograph on the psychiatric community helped to fertilize the soil in which Art Therapy was later able to take root and grow."***

both Psychiatry and Art to the creative urge that sometimes bursts forth in the mentally ill. And we are indebted, too, to his modern-day descendants, the art-loving psychiatrists, for enabling us to help many people in treatment settings to enjoy the benefits of creative activity through Art Therapy.

References

Axline, V. M. (1947). *Play therapy.* New York: Ballantine Books.

Barnes, M. & Berke, J. (1971). *Two accounts of a journey through madness.* New York: Ballantine Books.

Bender, L. Y. (1938). A visual-motor Gestalt test and its clinical use. *Research Monographs, American Orthopsychiatric Association,* No. 3, 176 pp.

Billig, O. & Burton-Bradley, B. G. (1978). *The painted message.* New York: Schenkman Publishing Co.

Cane, F. (1951). *The artist in each of us* New York: Pantheon.

Cardinal, R. (1972). *Outsider art.* New York: Prager.

Dewdney, S., Dewdney, I. & Metcalfe, E. (1967). The art-oriented interview as a tool in psychotherapy. *Bulletin of Art Therapy, 7,* 4-19.

Foy, J. (1972). Introduction to the English translation of Prinzhorn, H. *Artistry of the mentally ill.* New York: Springer-Verlag, ix-xvi.

Freud, A. (1946). *The psychoanalytical treatment of children.* New York: Schocken Books.

Freud, S. (1900). *The interpretation of dreams,* Stand. Ed., Vols. 4-5. London: Hogarth. (1955.)

Freud, S. (1905). *Analysis of a phobia in a five-year-old boy,* Stand. Ed., Vol. 10, London: Hogarth, (1955) pp. 3-149.

Freud, S. (1918). *From the history of an infantile neurosis,* Stand Ed., Vol. 17. London: Hogarth, (1955) pp. 3-149.

Hammer, E. F. (ed.) (1958). *The clinical application of projective drawings.* Springfield, IL: Charles C. Thomas.

Harris, D. B. (1963). *Children's drawings as measures of intellectual maturity.* New York: Harcourt, Brace & World.

Jakab, I. (Ed.) (1968). *Psychiatry and art* (Proceedings, 1st Colloquium, American Society of Psychopathology of Expression). New York: S. Karger.

Jones, D. L. (1983). An art therapist's personal record. *Art Therapy,* (1) 22-25.

Kellogg, R. (1969). *Analyzing children's art.* Palo Alto, CA: National Press Books.

Klein, M. (1932). *The Psychoanalysis of children.* London: Hogarth.

Koppitz, E. M. (1968). *Psychological evaluation of children's human figure drawings.* New York: Grune & Stratton.

Kris, E. (1952). *Psychoanalytic explorations in art.* New York: Schocken.

Lombroso, C. (1887). *Genius and insanity.* Leipzig: Reclam.

Mac Gregor, J. M. (1982). Paul-Max Simon: The father of art and psychiatry. *Art Therapy,* 1(1), 8-21.

Mohr, F. (1906-07). Uber zeichnungen von geisteskrankan und ihre diagnostische verwertbarkert. *J. für Psychologie und Neurologie, 8,* 99-140.

Morgenthaler, W. (1921). *A mentally ill artist.* Bern-Leipsig: Bircher.

Moustakas, C. (1953). *Children in play therapy.* New York: Ballantine Books.

Naumburg, M. (1947). Studies of the "free" art expression of behavior problem children and adolescents as a means of diagnosis and therapy. *Nervous and Mental Disease Monograph.* No 71. (Reprinted as, *An introduction to art therapy.* New York: Teachers College Press, 1973)

Naumburg, M. (1950). *Schizophrenic art: Its meaning in psychotherapy.* New York: Grune & Stratton.

Naumburg, M. (1953). *Psychoneurotic art: Its function in psychotherapy.* New York: Grune & Stratton.

Naumburg, M. (1966). *Dynamically oriented art therapy: Its principles and practices.* New York: Grune & Stratton.

Pfister, O. (1917). Analysis of artistic production (1913). In *The psychoanalytic method.* New York: Moffat, Yard.

Plokker, J. H. (1965). *Art from the mentally disturbed: The shattered vision of schizophrenics.* (1962). Boston: Little, Brown & Co.

Prinzhorn, H. (1922). *Artistry of the mentally ill.* New York: Springer-Verlag. (1972)

Réja, M. (1901). L'art malade: Dessins de fous. *Revue Universelle, 1,* 912-915; 940-944.

Rubin, J. A. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Rubin, J. A. & Schachter, J. (1972). Judgments of psychopathology from art productions of children. *Confinia Psychiatrica, 15,* 237-252.

Rubin, J. A., Schachter, J. & Ragins, N. (1983). Intra-individual variability in human figure drawings: A developmental study. *American Journal of Orthopsychiatry, 53,* 654-667.

Simon, P. (1876). L'imagination dans la folie? *Annales Medico-psychologiques, 16,* 358-390.

Simon, P. (1888). Les écrits et les dessins des alienés. *Archivo di Antropologia Psychiatrica e Medicina Legale, 3,* 318-355.

Thévoz, M. (1976). *Art Brut.* New York: Rizzoli/Skira.

BEST COPY AVAILABLE

Grants—Demystifying the Mystique and Creating Job Connections

Frances E. Anderson, EdD, ATR
Doris B. Arrington, MA, ATR

***Frances E. Anderson, EdD, ATR** is Professor of Art, College of Fine Arts, Illinois State University, Normal, Illinois. **Doris B. Arrington, MA, ATR**, is Director, Master in Art Therapy Program, College of Notre Dame, Belmont, California.*

Since 1980, graduate students at the College of Notre Dame have had the option of writing a grant in lieu of a thesis. Some of these successful projects are detailed by the program's Director to demonstrate that grants can be viable avenues toward creating jobs. Then, the senior author shares some of her insights and specific guidelines (based on more than 15 years of successfully obtaining grants resulting in funding in excess of $250,000) to assist readers in writing their own grant proposals.

GRANT WRITING CAN BE:

1. **Grants can be Financially Beneficial!**

*2. "Grant" is a five letter word that should be a four letter word!

3. **Grants are Political!**

*4. PROMISES, PROMISES, PROMISES!

5. **Grants can be Unbelievably Easy!**

*6. You've heard about the Oldest Profession...and the Second Oldest Profession...Well, Grants are a combination of both. You prostitute your mind, your body and your soul.

7. **Grant Writing can be Simple!**

*8. If you don't do it, it doesn't get done!

9. **Grant Writing can be Painfully Disappointing!**

*10. The submission date is THE DAY AFTER you receive the guidelines and the forms.

11. **Grant writing is knowing your Buzz Words!**

*12. From the time you submit your grant until the time it's reviewed, the buzz words have changed!

13. **Grant writing can be Rewarding!**

*14. Nightmares at 3 o'clock in the morning.

15. **Grant writing can be Uncomplicated!**

*16. What if I get it? How am I going to do it?!

17. **Doing a grant can be a wonderful Group Experience!**

*18. It's not WHAT you do, but WHOM you KNOW!

19. **Getting you first grant is like applying for a job without any Prior Experience.**

*20. Getting grants is like being rich...Those who HAVE, GET.

21. **Getting a grant is Ego Building!**

*22. After the first month, you realize that you really need five times as much money to do half as much as you promised!

23. **Getting a grant can be Tough and Competitive!**

*24. Things your Mother NEVER told you!

25. **A successful grant can give you High Visibility and Professional Integrity!**

*26. Three quarters of the way through the grant you KNOW you should have lied about your budget... YOU'RE OUT OF MONEY!

27. **Grant writing and getting it funded can be a heady Professional Experience!**

*28. The funding agency GIVETH and the funding agency TAKETH away!

29. **Grant writing can be a good way to Create a Job.**

*30. Grants are like puppy love...they don't last.

31. **Doing a grant is a wonderful Professional Experience.**

*32. Implementing a grant is like jogging—IT FEELS SO GOOD WHEN YOU STOP!

33. **A grant can be a Life Long Professional Journey!**

*34. Having a grant is like having a fish in your icebox...it smells after three days!

Grantspersonship and the Job Market

While the above list of statements are all true, there is an important point to make about grants and the art therapy profession. As we all know, most art therapists must often create their own jobs. No agency, hospital or special school is "rolling out the red carpet" or clamoring for art therapy or eagerly trying to hire art therapists. As art therapists, we must assume the responsibility for carving out our own niches in the "real world." One relatively unexplored means to do this is by writing and obtaining grants.

In fact, this is one option open to graduate students at the College of Notre Dame. Since 1980, over 40 percent of the college's art therapy students have opted to write a grant in lieu of a thesis. One quarter of these grants have been funded and another quarter are still pending. Of those that were not funded, one half resulted in either full or part-time art therapy jobs due to the students' efforts.

Perhaps it might be helpful to briefly describe some of the funded projects and some of those proposals that led to an art therapy job. One of the first grants funded to do art therapy as counseling in public schools, was written in 1980 by one of the first graduates of the College of Notre Dame program. D. Anderson was facing layoff from his regular job as an art teacher in an alternative high school. He submitted a proposal for an art therapy program to the city of San Francisco. In 1981 that grant was funded, and since then has been refunded.

Mr. G. Loughlin, a teacher of learning disabled children, worked with the Cupertino, California School District to write a grant to establish a classroom for seriously emotionally disturbed children; both verbal and art therapy were to be a part of the regular classroom structure. While the grant was not funded, Mr. Loughlin, working with the same school district, has since established just such a program with supplemental funding from Santa Clara County in California.

V. Appleton, in 1981, wrote a grant to work as an art and play therapist with another art therapist in the St. Francis Bothin Burn Unit in San Francisco County. This grant was funded, and she has continued to work as full-time staff in the hospital's burn unit. She has had ongoing grant funding for her work since then.

C. Malchiodi, another student who moved out of California, used a grant to introduce herself to her new location. She wrote a proposal for using art therapy with battered children. The YWCA funded this project and Ms. Malchiodi has continued to submit grants since 1981. To date she has been funded in amounts of approximately $100,000.

Often just going through the process of writing a grant for a private or public agency has helped the student to clarify his/her own role as an art therapist. This process has helped to clearly communicate to the potential funding source the merits of art therapy with a particular clientele.

In 1981, P. Keefe, a graduate and a volunteer at the Crystal Springs Rehabilitation Center in San Mateo County, California, wrote a grant to the state for a Visiting Artist Program. While the specific grant was not funded, Ms. Keefe generated such agency support that the rehabilitation facility hired her. Since then she has continued to bring the center positive public acclaim through organizing ongoing art exhibits of her handicapped clientele.

In another case, T. Moskin wrote a grant in 1982 to fund an art therapist to work in a halfway house for schizophrenics. While the grant was not funded, within a year that very facility, Hawthorn House in San Mateo County, hired an art therapist. A similar situation occurred for yet another student, C. Volberg. Although a grant for enhancing self-esteem through creative expression at a short term residential crisis shelter for adolescents was not funded, she was later hired by the facility.

Another student, V. Crittenden, wrote a grant for an art therapy program within the San Mateo County Women's Correctional Center. Again, the grant was not funded, but from a church group she received alternate funding for this program.

In 1982, B. Stevenson wrote a grant for work with deaf and hard of hearing children. While the grant was not funded, Ms. Stevenson was no longer "mystified" by the grant writing process. Based on her prior experience in grant writing, she was instrumental in successfully obtaining a $20,000 seed grant for Touchstone, a support group for hospitalized children in Santa Clara County.

In 1983, P. Farver wrote an art therapy component for inclusion in the ongoing program in residential homes for disabled adults. Art therapy was used as a communication component in the Individualized Living Skills Grant which the facility received. This funded project was a model program in living skills in Shasta County, California.

That same year M. Anderson wrote a grant (an art-as-therapy focus) to run 10 hours weekly as a part of a residential drug treatment program in East Palo Alto. Although the grant was not funded, the drug treatment center staff was so impressed by the work being done by two art therapy volunteers that both were hired by the facility.

In a similar case in 1984, S. Gleeson submitted a grant for an art therapy program for children who were victims of violence in their own homes. She did not get the grant—but she was later hired by Santa Clara County to work with those battered children.

In 1984, D. Landes wrote a grant for art therapy services for sexually abused children. This was not funded, but the Family Services Agency of San Mateo County wants to consider the proposal again, and will do so when Ms. Landes returns to work after maternity leave.

Recently two students, D. Perry and M. Hunter, who were interning at the Creative Living Center, a day care facility for emotionally disturbed adults, submitted a grant to Marin County, California to cover the salaries of two art therapists for three years. Interestingly, the proposal was returned to the facility with the notation that the amount of monies requested WAS TOO SMALL TO COVER A THREE YEAR PROGRAM. The students were asked to increase the budget and resubmit the proposal. They have done that, and the project is pending.

Thus, we can see from these examples that when people go through the rigors of preparing and submitting a grant, jobs have often resulted, even when the particular grant proposal was not successful. Many art therapists may be extremely overwhelmed by the prospect of undertaking the task of writing a grant. For this reason we have included some suggestions that might help in "demystifying" the grantwriting process.

Some Key Pointers on Grant Writing

First, the agency or foundation is in the business of giving out money. You are helping someone do his/her job. IF YOU DO NOT ASK, YOU DO NOT GET. It will be important to remember that most major corporations have one person in charge of corporate giving. This can be a boring job—and the arts are interesting areas. Thus you have an "in." Also, it is important to realize that large corporations want good public relations—a good image. Art therapy and art for the handicapped are areas that have a "real" mission and an intrinsically good image. Therefore, the program will often sell itself.

Second, if you are approaching a corporation or agency, do research on that funding source. Find out what the funding priorities are of the agency—or find out what sorts of projects the corporation tends to fund. (Most corporations tend to have a pet project or area they like to fund.) You will want to make a visit to that corporation and bring your written grant proposal. Give out ONLY the first page, which should be a summary of your proposed project. This is probably all you should give out. (But have the rest in your pocket, just in case the agency or corporation wants to see it.)

Third, find out what language the corporation or agency speaks. Use that language. If you do not use THEIR language, they will NOT understand what your proposal is about.

> ***"A successful grant can give you high visibility and professional integrity!"***

Fourth, find out what funding limits the corporation or agency uses as a guideline. If an agency only gives out five thousand dollar grants, then it would be silly to submit a grant for thirty thousand.

Fifth, find out what forms and formats are used and USE those specific forms and formats. In other words, tailor your grant to fit the specific agency or corporation. DO NOT SEND OUT A STANDARD GRANT PROPOSAL FORM TO EVERYONE.

Now comes the hard part—the proposal itself. You should remember two key points:

KISS!

Keep It Short
and Simple!
If you cannot
scan it, can it.

Most grants should be no longer than 10 pages. No one wants to wade through pages and pages of text.

All grant proposals include the following general categories. Some may be called by another title. But, A ROSE IS A ROSE IS A ROSE!

1. INTRODUCTION/ABSTRACT. Limit this to one page and use LARGE type. It will be helpful to begin with the following statement as an INTRODUCTION. (You fill in the blanks!).

YOU ______________________ (your hospital or institution) seek $ _____ from ______________________ Corporation for ____________________ (Specify what: a program, an evaluation, an arts festival, etc.); for the time period _____ to _____. Matching funds will come from __________ (Examples: Board contributions, NCAH, California Arts Council). This project follows _____ number of years of successful festival programs, etc.

2. PROBLEM STATEMENT. (This is sometimes called the "Rationale" or "Needs Assessment.") You are solving some societal problem. It is even better if you have several. You may want to establish the problem via citing research that relates to the issue. Or you may want to clearly document a specific need. If you intend to establish a specific NEED, then you may have to conduct a survey or poll (i.e. a needs assessment) of agencies or clientele. Then you can say: "A survey of all the art teachers in the Bay Area reveals that none have received special training to work with emotionally disturbed children." Or, "A poll of the museums in the area reveals no programs for handicapped visitors." Or, "A preliminary art therapy program in the womens' correctional facility revealed that clients were better able to make decisions and to take responsibility for their own actions as a result of participation in the art therapy program. NO other service had the same results; thus, this proposal is being submitted to provide funds to continue this program."

3. GOALS/OBJECTIVES. It will be important to state goals in quantifiable terms. This means that you will need to translate statements like "A greater appreciation for the artistic/therapeutic process will result" as: "The goal is a 10 percent increase in persons served by the program in two months." It will be essential to use objectives that are *easy to measure*.

4. CAPABILITY STATEMENT. (Sometimes this section is combined with the "Problem Statement" described earlier.) This statement is essentially why you should get money. Show how your project will be cost effective. It also will be important to indicate how long you have been doing this sort of activity. Evidence, such as demand for the program and your services and other testimonials, would be appropriate here. Also, if you are submitting a proposal for your institution, corporations are extremely concerned about your institution's management structure. Is it a good structure, i.e. one which can carry out the programs for which you are requesting funds? THE

"...by going through the rigors of preparing and submitting a grant, jobs have often resulted, even when the particular grant proposal was not successful."

STRENGTH OF THE ORGANIZATION IS VERY IMPORTANT.

5. DETAILED PROGRAM DESCRIPTION. (Sometimes this section is called "Methods.") In this section you would include: Plan of Action, Treatment Plans, and Time Line for accomplishing the project. It would be very important to briefly describe week by week what you intend to do. For example, "Week One: Interview potential clientele, meet with project staff, select clientele for project, get legal clearance forms signed. Week Two: Program begins, baseline measured, observations recorded, art work photographed."

6. EVALUATION. Justification for your project is essential—not just because ART IS ART, OR ART THERAPY IS GOOD—but because you have to be accountable for the effectiveness of your project to laypersons who are not convinced that art therapy has value. It will be important to provide some pre/post measures such as: paper and pencil tests of self-concept; house-tree-person drawings; observational checklists of client behaviors; third party measures of social interactions; video tapes of sessions; visual documentations of work being done; unsolicited comments from clientele; and reports of progress from other staff members who have the same clientele in other programs.

You also should include how you will disseminate information about the program. This would include some outcome such as: an art exhibit, a videotape, a slide/tape package, a presentation at a regional or national conference, an article in a newspaper or professional journal. You should remember that the funding agency wants to see some tangible outcome of its funding of your program. You want to provide good public relations for art therapy, your specific program and the funding agency or corporation.

7. FUTURE FUNDING. It also will be important to include plans for future funding of this kind of program. Future funding might be via clientele fees, grants from other agencies, or corporation grants.

8. BUDGET. Give a detailed accounting of all items. Be sure that you check on actual costs of items and briefly explain why you have included the items in your budget. It will also be important to list the value of "in-kind" contributions (any support other than actual dollars such as provision of space, use of office equipment, secretarial help) after the rest of the budget. Do not hesitate to include ALL possible in-kind contributions. This accounting makes your project look better—that is, the agency knows that you are really giving them something.

9. FINANCIAL STATEMENTS. This section is important only if you represent a nonprofit institution asking for a grant. If you are submitting your proposal through some agency, you should include that agency's Internal Revenue Service Tax exempt statement. It will be important to establish the "financial soundness" of the agency through which you are submitting your grant proposal. No agency or corporation will give monies to an institution that is not financially sound. NO ONE WANTS TO GIVE MONEY TO A SINKING SHIP!

10. REFERENCES. You should include FULL bibliographic citations for All studies and/or experts cited in each and every part of your proposal narrative. You should find out what style manual (i.e. Turabian, American Psychological Association Manual, etc.) is preferred by the funding agency and use that format.

11. LETTER OF APPROVAL FROM AGENCY. This is necessary only if you are submitting your grant via an agency. Your grant proposal should then include a letter from the agency saying they approve of your proposed project.

12. PROMOTIONAL MATERIALS. Again, this would be important if you are submitting your grant through an agency.

13. RESUMES OF ALL STAFF INVOLVED. Some Federal agencies have a special one page form that you must use for each staff person involved. It will be important that you include only current and pertinent information in the staff vitae. The funding agency is not interested if you were president of your high school cheerleaders or a halfback on the soccer team. Do not forget *KISS*!

14. LETTERS OF SUPPORT. Get testimonials from "neutral," highly visible persons. It will be very important to find out what impresses the agency/corporation to which you are submitting the proposal. If this is a Federal agency, try to get congresspersons to send letters. If the project is an individual submission, get letters from state arts councils, the American Art Therapy Association, or other related professional organizations such as the American Association of Mental Difficiency, Easter Seals or the local chapter of the Muscular Dystrophy Association. Another potentially strong source of support could be letters from parents in local associations for handicapped children.

"Often just going through the process of writing a grant for a private or public agency has helped the student to clarify his/her own role as an art therapist."

"Art therapy and art for the handicapped are areas that have a 'real' mission and an intrinsically good image."

Other Helpful Hints

In writing a grant proposal, should you ask for more funding than you think you can get? Do not hesitate to be as realistic and honest as you can in your proposal. It is usually a wise idea to plan a program that will cost a little more than you think the agency might fund. Often projects are approved, but for 10 to 20 percent less monies than are requested. If you have to cut your budget, be sure you also eliminate a part of your proposed program. Generally most Federal agencies cut budgets as a usual practice.

If you are a little unsure in writing a grant, team up with someone who may know the jargon of the corporation or agency and work with that person. This was how the senior author got her first major Federal grant.

It may also be helpful to get a highly visible expert or professional who is already known in the field to serve as the Project Director—purely as an honorary title with no actual time spent on the project. This may mean that your name does not appear as the initiator of the project or as the person who will run the project (even though you will be implementing the grant). This means that your ego will not get the strokes for writing and doing the grant—but it COULD mean the project will get funded. You may have to make the tough decision to give up "kudos" in order to get the grant. This was how one major grant was obtained by the senior author. She had to list two highly visible professionals as the Project Directors. She did not get the top billing for the project—nor credit for running the project. However, this was the only way that the proposal could be funded AND IMPLEMENTED at her facility.

Most universities have a grants office with lists and books of corporations' foundations and agencies that give out funds. These books are divided by geographic location and by topics/areas in which they award funds. A rule of thumb is that the closer you or your agency is to the funding source geographically, the easier it is to get your project funded. Sometimes it is easier to go for a smaller grant that is funded by a local group or business than to go for a huge project that would be funded by a Federal agency.

It also is very helpful to peruse a funded grant or two written for the same type of corporation or agency for which you are planning a proposal. It is always easier to follow someone else's successful model.

If you fail, try, try again. The competition for grant funds is tough and one out of 10 or 20 might get funded. Also, know that, at least for Federal grants, the funding agency will send you the reviewers' comments on your proposal so you can "clean up your act." We know of one person who applied 10 times to a private agency before she scored. PERSISTENCE PAYS. IF YOU DON'T ASK, YOU DON'T GET.

We hope that this information has been helpful to you. We feel that writing grants is never easy—but rewarding. Even if you are not funded, the process may well lead to a job and, at the very least, you will be spreading the good news about art therapy to the uninitiated.

Resources

(Listed in priority order, not in alphabetical order)

1. Someone with grant writing experience.
2. Tenbrunsel, T.W. (1982). *The fund raising resource manual.* New Jersey: Prentice-Hall.
3. Flanagan, J. (1982). *The grass roots fundraising book: How to raise money in your community.* Chicago: Contemporary Books.

Editor's Note:

Excellent references that may be found in any library are: *The Foundation Directory* (specializing in foundations), the *Catalogue of Federal Domestic Assistance* (listings of governmental funding programs), and the *Annual Register of Grant Support* (a comprehensive register).

For information on periodical literature, newspapers, library materials, institutional grants offices, and subscription information services, an excellent source is as follows:

White, V.P. (1975). *Grants, how to find out about them and what to do next.* New York: Plenum Press.

"You want to provide good public relations for art therapy, your specific program and the funding agency or corporation."

Note: The authors have compiled a Grants Manual to assist professionals in their grant writing. For more information about this booklet, contact F.E. Anderson, EdD, ATR, Art Department, Illinois State University, Normal, IL 61761.

The Fantasy of Art Therapy Enters the Mainstream

Harriet Wadeson, PhD, ATR

Well Gang, we've made it! Some say it was Margaret Naumburg who put art therapy on the map. Others look back to Prinzhorn. But at this moment, I would like to credit Andrea Freud Loewenstein. (Freud?) Yes, Andrea Freud Loewenstein, for introducing art therapy into our culture's fantasy life through her creation of Sonya, art therapist at Redburn Prison for Women in her novel, *This Place* (Pandora Press, Routledge & Kegan Paul, Boston, 1984). Although art therapists have expounded in the written word prolifically over the years, our audience has consisted mainly of other professionals. But now we have captured the imagination of at least one contributor to our current culture. As members of a profession with creative expression at the core of its efficacy, art therapists readily recognize the import of a novel's main character created as an art therapist. Her appearance in this form for our society is comparable to such a creation in a dream or portrait created by an individual. What this means is that art therapy is no longer simply understood rationally as an extant mode of treatment. Now it is also imbued with the power of fantasy as it strikes sparks in the imaginations of those who create our culture and shape our ideas and images. In other words, art therapy has entered the world of art in the forceful and influential appearance of Sonya.

Andrea Freud Loewenstein's novel is told in the four voices of its central characters, two prison inmates, a social worker, and the art therapist. Sonya is new to the prison system and is at first a breath of fresh air and courage in a world of oppression and intimidation. Loewenstein is particularly vivid in her wonderful word-pictures of the inmates' first ventures into art and Sonya's own sculptures inspired by prison life. Sonya is portrayed as a warm, open, sensuous free spirit—a sympathetic character among the tough, crazy, or self-destructive prisoners and the rigid or non-caring staff. Alas, however, her rosy glow fades, and to the credit of the novel's complexity, those who initially appeared weaker are those we truly care about at the end. So, how does art therapy fare? Sonya lets us down, as she does everyone with whom she is involved. Interestingly, one of her gravest mistakes is to underestimate the power of art for a psychotic inmate whom she appeared to be helping. As one of the four "voices" of the story, this inmate's thoughts are available to us so that we can see the power her art and her art therapist held for her. Although this power and Sonya's lack of comprehension of it lead to the tragic denoument of the central characters' lives, we are nonetheless left with the impression that it is the system and its insensitive administrators that are at fault, as well as our society, rather than the central characters of the book.

This Place is a compelling novel that moves swiftly through the intricate relationships in the world of a women's prison. We come to know and care about its unheroic heroines and learn about a world we seldom see. I am not attempting a book review here, but rather noting art therapy's place in this particular novel. Its central position emphasizes its significance to the author and by extension to those who are influenced by her writing. That the person of the art therapist is ultimately selfish and disconnected from those to whom she has been important appears to be her personal failure rather than an attribute of her profession. The major detrimental reflection on art therapy is that Sonya apparently is not very well trained, particularly in her disastrous handling of termination.

Sonya is but one art therapist. As we capture the imaginations of other culture creators, more of us will be created. Just as we read of good and evil doctors, priests, nurses, artists, so art therapists will probably come in all sizes, shapes and colors. What puts us on the imaginative map is that the power of our work is such that dreams are made of.

Book Reviews

Handbook on Adolescence

Carl P. Malmquist, MD, New York, New York: Jason Aronson, 1985
877 pages

*Reviewer **Shirley Riley, MA, ATR, MFCC,** is Senior Staff Family and Child Division of Didi Hirsch Community Mental Health Center; and a member of the faculty of Loyola Marymount University Master's program in Clinical Art Therapy. She is also Field Placement Coordinator, Supervisor, and Instructor with a major focus on work with adolescents.*

For those of us who deal with adolescents or with adults having residual problems of adolescence, it is a joyful occasion to find Carl Malmquist's book again available. This second edition was recently republished, and we hope will remain on the market for an extended period of time.

The art therapist becomes a more valuable member of assessment and treatment planning for the adolescent when she compares her observations of material in the artwork with the "norms" of pubertal and adolescent development. The youth in treatment is often the youth with some discord between chronological and maturational growth. Either physical or emotional pacing is out of phase with how society, family or self expects the young person to perform.

Art therapists cannot look to a great deal of material in their own literature for help in adolescent treatment. However, they can be effective if they have a broad understanding of adolescent development and of the psychological problems that arise when this development malfunctions.

For this reason, I recommend *Handbook of Adolescence*. I have not found any other text to contain this amount of valuable information under one cover. Malmquist devotes the first chapters to defining the stages of adolescent development, from preadolescence through early, middle and late adolescence. He then is concerned with biographical growth and sex-role standards. These sections are basic to all books on this age period; Malmquist not only informs us about what to look for, but also how the adolescent himself/herself sees the importance of these issues.

The author then moves on to the problems that we see in the mental health setting: antisocial behaviors, neurotic and character disorders, and finally the psychotic. He ends with a look at the judicial system.

The last chapter is a valuable contribution for beginning therapists, as well as for those of us who need some refreshing concerning the *particular* therapeutic approach that is necessary in the treatment of adolescents.

This extensive text (877 pages) is worth the time and effort required to take in that amount of material. Carl Malmquist is a recognized authority on the treatment of adolescence, and his thoughts on masked depression and on suicide, hysteria and youth's view of death are most helpful. Adolescence is a period of life where the person often acts in such a disturbed manner that assessment and planning of therapy goals are very demanding. Avoiding the pitfalls of unwarranted labels, premature hospitalization, or neglected therapeutic support when needed is of the greatest concern to the therapist responsible for this age group.

The clinical art therapist who is familiar with the theoretical material can use the art product and related verbalizations offered by the adolescent client to responsibly make better treatment decisions. The art work often reveals the incongruence between chronological age and developmental age, which cannot be seen as clearly in the youth's behavior. However, without the knowledge of what to expect from the adolescent in terms of normality or pathology (the material available in this text); all the art work produced may not be useful in helping the therapist find a way to solve the problems that bring the youngster into treatment.

The book is written with the thought that the adolescent lives in a family and in a society, and is acted upon by schools, mental health institutions and judicial institutions. This approach, which confirms that the youth is embedded in a system and not a "psychological entity" unto himself, is an additional strength of this excellent volume.

I recommend that individual practitioners of art therapy and educators of art therapy students review this text and utilize it both for their treatment of adolescents and for their teaching of that specialized skill.

Sandplay: A Psychotherapeutic Approach to the Psyche

Dora A. Kalff, Boston, MA: Sigo Press, 1980
169 pages. $11.50.

Images of the Self: The Sandplay Therapy Process

Estelle L. Weinrib, Boston, MA: Sigo Press, 1983
172 pages. $11.95.

Reviewer ***John Allan, PhD*** *is Associate Professor in the Department of Counselling Psychology, Faculty of Education, University of British Columbia.*

These two books describe the process of sandplay therapy with children and adults, from a Jungian perspective. Dora Kalff's book provides a brief theoretical introduction, based mainly on the work of Carl Jung, Erich Neumann, and Eastern thought. She then presents the case histories of seven children and two young adults. Estelle Weinrib gives us a much longer introduction to various aspects of sandplay (88 pages), and a detailed account of the treatment of a young man, in his late twenties, over an 18-month period. Both writers make extensive use of black and white and colored photographs of their clients' sand trays. Weinrib also offers a useful glossary of some key Jungian concepts. Both sets of bibliographies, unfortunately, leave out major references cited in the text.

What is sandplay therapy and how successful are these writers in conveying the practice of sandplay? Both rightly inform us that the experience involves much more than sandplay. The practitioner needs to be grounded in theory, to have a knowledge of the language of symbols, and to be aware of and know how to use transference and countertransference phenomena. Both therapists use many other approaches— play, painting, story writing, dream analysis, etc.—depending on the needs of their clients.

Children, of course, have played in sand, earth, dirt and mud since time immemorial. There is something very freeing about the tactile experience of sinking your hands and arms in wet sand, tunneling, burrowing and playing in it with small toys. The use of sandplay in therapy can be traced back to the English pediatrician, Margaret Lowenfeld, who established the Institute of Child Psychology in London in the 1930s. In her youth, Lowenfeld read H.G. Wells' book, *Floor Games* (1912), where he described the many invigorating hours he spent on the floor playing with his children. Lowenfeld had sand and water trays built for her clinic, and gathered many small toys together in a box. The children came to refer to this box as "the world" and Lowenfeld called her approach the "World Technique." The method was brought to the United States by Charlotte Buhler, who used it primarily for diagnostic purposes.

Dora Kalff, a gifted pianist, was encouraged by Jung to become a child psychotherapist. She met Lowenfeld in London at an international conference in the late 1950s and studied with her for a while, before returning to Switzerland to use the method from a Jungian perspective. Kalff worked first with children and then adults. She noticed that through play, conflicts were expressed and healing occurred. Weinrib, a Jungian analyst and a former student of Kalff's, gives a good description of the basic components of sandplay. The basic equipment is a rectangular tray, 28 x 19 x 3 inches, half-filled with sand, and lined with sheet metal or heavy plastic painted light blue. Sand can thus be moved around to create an image of sea, lake, pond, or river. Many miniature toys are arranged on open shelves, so the client can choose as he or she wishes. The toys should represent a wide range of symbolic objects sufficient to create a miniature "world." The clients are encouraged to play or create as they wish. The therapist sits quietly at a little distance observing, listening, empathizing, experiencing and thinking, but verbalizing only a little. After the session is over, the therapist may request comments and associations, or may ask the client to tell a story about the sand picture or to explain a particular area. The therapist does not offer interpretations, nor does she press or confront the client at this time. After the client has left, the sandtray is photographed, and is then dismantled. Later, towards the end of therapy, the slides or prints might be shown to the client, and used as a basis for deeper understanding.

In many ways the two books are quite similar. Indeed Weinrib quotes Kalff liberally throughout her volume. In both the theoretical and practical areas, Weinrib expands on Kalff's work. She hypothesizes that a healthy mother-child relationship constellates, between the ages of two and three, the archetype of the Self. This constellation is manifested in mandala images, and reflects a unity of the conscious (in Jungian terms the "ego") and unconscious mind. This experience of "wholeness" becomes internalized, and greatly facilitates the next stage of psychological life which is the various aspects of ego development.

Often clients come to therapy impaired in ego functions, due to primary damage to this mother-child unity, and to the lack of an internalized image of wholeness. Sandplay, because it operates on a matriarchal level of consciousness (i.e., on a preverbal symbolic level), offers a "free and protected space" where instinctual struggles can be expressed, reenacted and resolved through play. The miniature figures become "containers of feeling," which help to externalize conflicting emotions and to give rise to new healing symbols. At this stage, interpretations do not have to be made by the therapist because they are "known" and experienced by the client on the "felt" level. Mrs. Kalff's case histories give many examples of symbolic resolutions and the freeing of libido, passion and energy for new growth.

There is a depth and an integrity to Mrs. Kalff's book that is somehow missing in Weinrib's work. The experience, sensitivity and wisdom of a highly skilled psychotherapist emerges clearly in Kalff's writing. The success of her work reminds me of Jung's observation that much of the outcome of psychotherapy depends on the relationship the therapist has to his or her unconscious.

In contrast, I found the theory and practice sections of *Images of the Self* disjointed and repetitious. The book did not flow or evolve coherently for me. Likewise, the case study was replete with so many archetypal symbolic amplifications, that I found myself losing touch with the immediacy of the client himself, his struggles and resistances. I see this as a potential danger in the Jungian approach—that the therapist's fascination with the meaning of symbols and their historical and cultural evolution, can detract from empathizing with the present psychological experiences of the client.

Reference

Wells, H.G. (1012) *Floor games*. Boston: Small, Maynard and Company

Rosegarden and Labyrinth: A Study in Art Education

Seonaid Robertson, Dallas, TX: Spring Publications, 1982.

Reviewer ***Judith Snider*** *is a graduate student in the Department of Counselling Psychology, Faculty of Education, University of British Columbia.*

In *Rosegarden and Labyrinth*, Robertson takes the reader on a journey following much the same course she herself travelled in search of answers to questions about art and art education. How can art be a vehicle in the process of finding a way to one's center, to one's core? How can art teachers develop the awareness and sensitivity to facilitate that process? The answers to these questions becomes clearer as Robertson discusses the concrete, practical details of her work with eleven and twelve-year-old English school children, with fourteen and fifteen-year-old working class boys in a coal mining town, and with a group of teachers. Woven into these discussions is an exploration of symbols and of two archetypal images—the *Rosegarden* and the *Labyrinth*.

Robertson's interest in archetypal themes and their place in the teaching of art eventually led to a more formal research project. She had the assistance of twelve teachers, who volunteered to use selected evocative themes in their work with 11- to 17-year-old youngsters. In testing her hypothesis that relevant topics were what inspired the creation of haunting art work, Robertson learned that there were some themes which produced, in the artist, an intense state of concentration, a deep satisfaction with the product and a feeling of being more "centered." These archetypal themes, which root the artist in the traditions of the past, and at the same time have a revitalizing effect, are at the core of Robertson's concept of art education.

Rosegarden and Labyrinth offers an excellent critique of what often passes for art education—and puts forward an alternative approach that is much broader than that expressed in much of the current literature.

Robertson views art and the teaching of art in the context of a world in turmoil, one in which the development of the human soul has not been a priority. In art lessons with children and adults, Robertson takes into account their life experience and their current situations and aspirations. In so doing, she is able to educate on many levels. For example, she might even include in a clay session with miners' sons, whose fathers have a lot of power in their homes, a discussion of early matriarchal communities.

Unlike some art educators, whose focus might be on the achievement of a quality product—often as a result of learning a series of techniques—Robertson's focus is on the process. She does not try to make her students artists, but rather gives them an opportunity to become "utterly absorbed in an activity which will take them down through the layers of their own personalities, extending their limits of experience." (p. 90).

Robertson also offers many practical suggestions. while she describes the ideal art lesson as one in which each student works on his or her own project, receiving individual help from the teacher, she is also aware of the realities of the system. If it is necessary to teach a large group together, Robertson recommends that children have the right to opt out of the activity until the creative urge strikes. Specific techniques used in her work with adolescents and adults are also described in detail, and useful tips, such as how to assist a student locked into stereotyped images, are presented. She also has included in her book the list of painting themes used in her research.

An important question for art educators and art therapists is the relationship between technique and spontaneous self-expression; this issue is addressed several times in this book. According to Robertson, techniques should not be learned for their own sake, only insofar as they contribute to the creative act. The art lesson, in her opinion, should alternate between the expression of spontaneous feeling, and more deliberate exercises exploring different media and techniques.

For those art teachers and art therapists who view art as more than mere self-expression or the study of techniques, and like Seonaid Robertson, see it as a process of spiritual searching, *Rosegarden and Labyrinth* can be a valuable tool in helping others to carry out that search.

CHARLES C THOMAS • PUBLISHER

New! **EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession** *by* **Shaun McNiff.** This is the first comprehensive study of higher education in the growing arts therapy profession. It explores the interdependence of diverse training traditions, and it reviews the various areas of concentration, such as art therapy, music therapy, and others. Specific competencies and diverse philosophies are examined, but their commonalities are emphasized. The author includes chapters on historic trends, defining the profession through education, training program characteristics, and educational elements common to all arts therapies. He also discusses specific media competencies, supervision and evaluation, an artistic theory of mental health, student and faculty characteristics, and key issues in creative arts therapy education. *Jan. '86, about $29.75*

New! **DRAMA THERAPY: Concepts and Practices** *by* **Robert J. Landy.** This pioneering text deals not with drama *in* therapy, but with drama therapy itself, documenting its legitimacy as a distinct field. Its disciplinary context and conceptual bases, its psychodramatic and projective techniques, its settings and intended populations, and its body of research all are detailed. *'86, $28.50*

We fill all orders promptly • Books sent on approval
MasterCard, Visa & prepaid orders sent postpaid
Catalog sent on request • Write or call (217) 789-8980

2600 S. First St. • P.O. Box 4709
Springfield • Illinois • 62708-4709

Study Within a Tradition of Innovation and Creativity

• •

at the Institute for the Arts and Human Development.

Our Master of Arts Degree and Certificate of Advanced Graduate Study Programs offer:

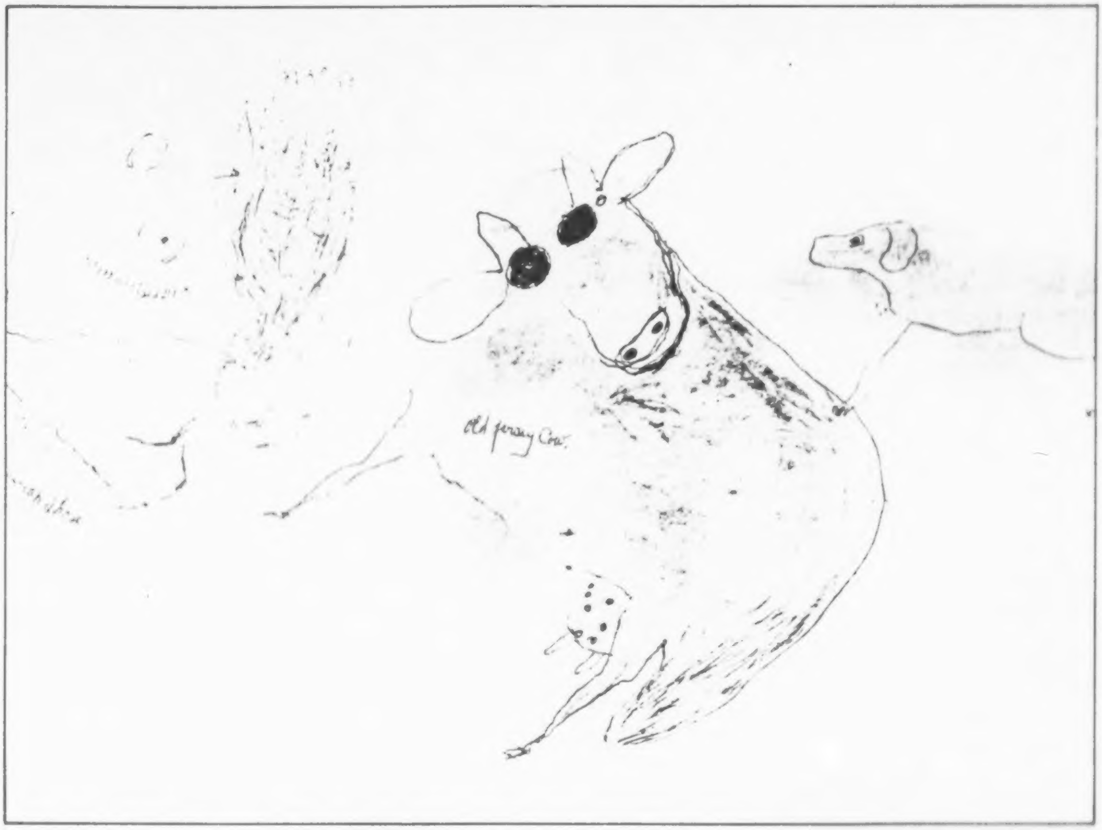
- **Expressive Therapies**—concentrating in Art, Music, Dance/Movement, and Psychodrama. Application of body/mind/spirit theories. Program approved by AATA.
- **Creative Arts in Learning**—integrating arts in education and cultural institutions.
- **Summer intensive degree programs**—are available for working professionals and advanced undergraduates.

Call or write Joanna Fabris, (617) 868-9600, ext., 480, 29 Everett Street, Cambridge, MA 02238

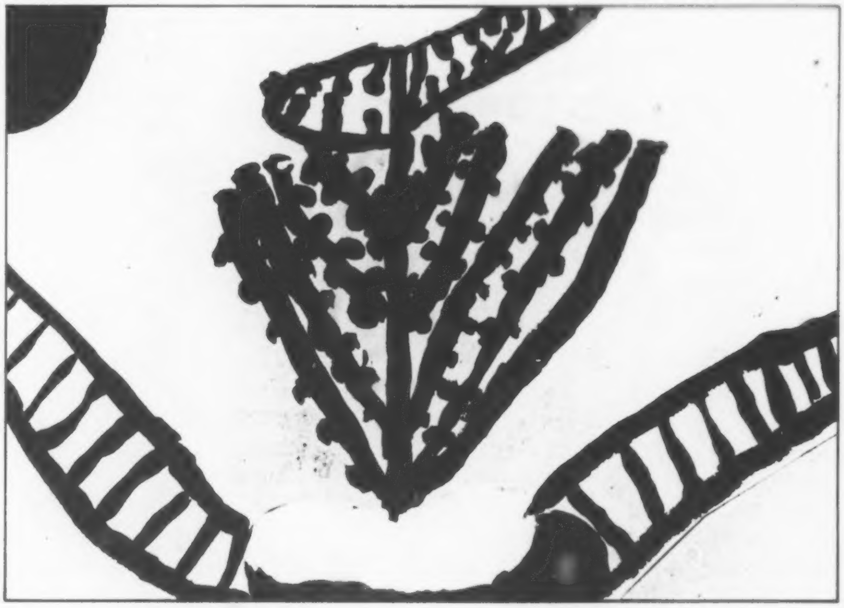
LESLEY COLLEGE GRADUATE SCHOOL

PORTFOLIO

Artwork by Nursing Home Clients

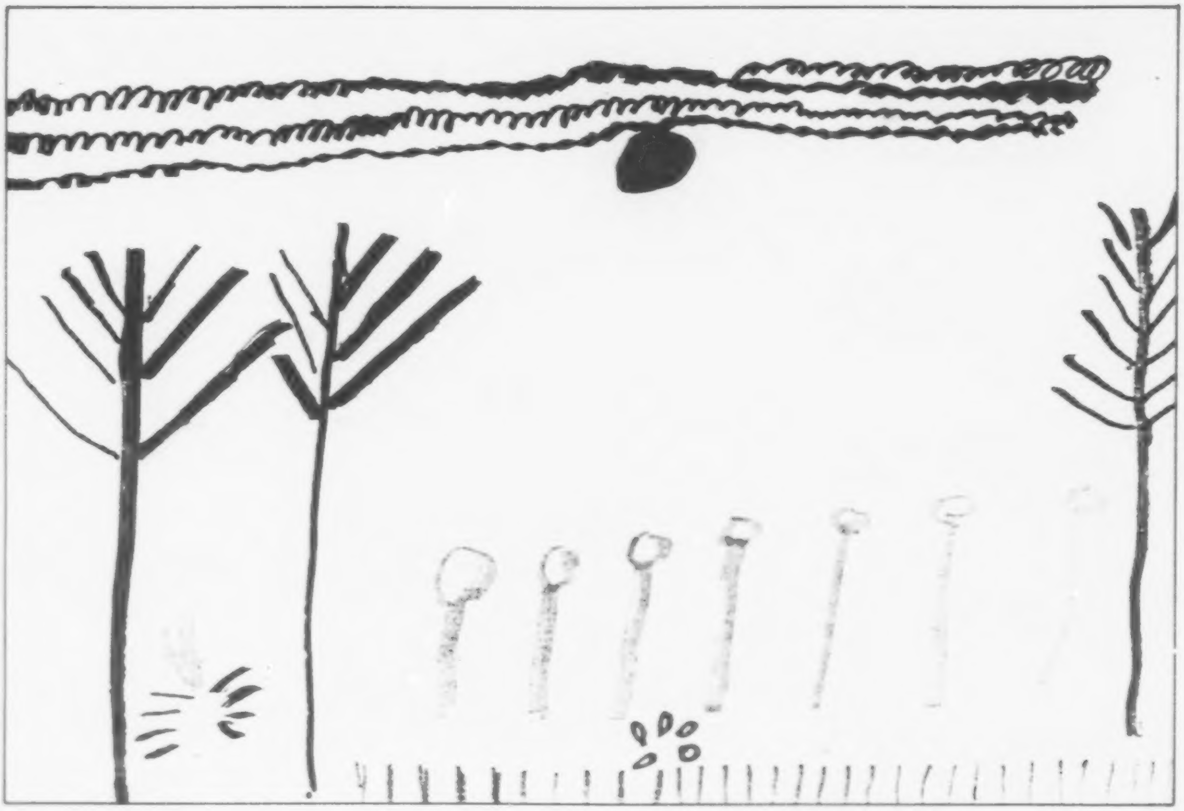


"Old Jersey Cow"
by an 83-year-old man

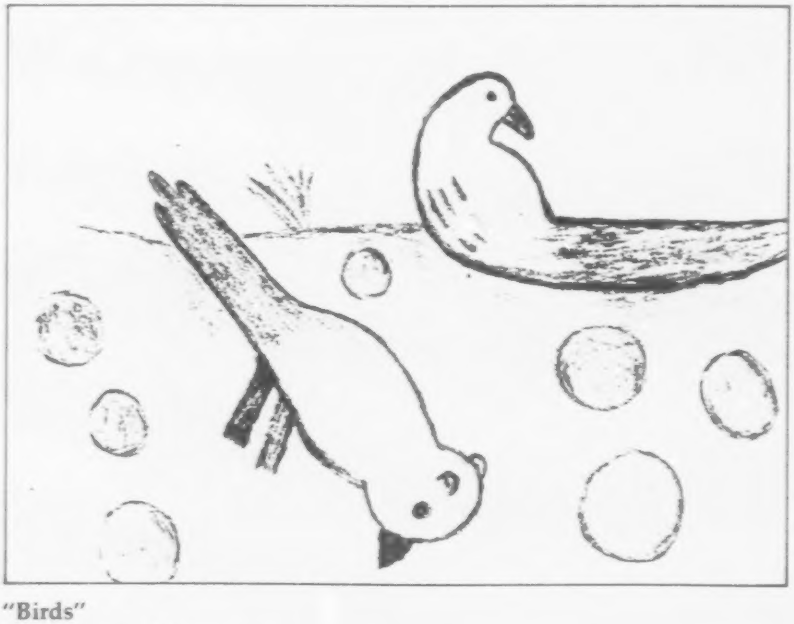


Untitled work
by an 86-year-old man

BEST COPY AVAILABLE



"My Garden"
by an 80-year-old woman



"Birds"
by a 78-year-old woman

BEST COPY AVAILABLE

Photographs provided by Wright State University, Dayton, Ohio

BRIEF COMMUNICATIONS

This column provides a forum for information exchange among clinicians and educators. Items relevant to research and to programmatic, historical, or clinical developments may be submitted. Contributions should be sent to Brief Communications, ***Art Therapy****, Gary Barlow, EdD, ATR, Wright State University, 228 Creative Arts Center, Dayton, Ohio 45435.*

Journal Multi-cultural Theme... Papers Still Accepted

Dr. Shaun McNiff, ATR, and Dr. Gary Barlow, ATR, continue to plan an issue of *Art Therapy* focusing on multi-cultural issues and the sharing of international concerns in art therapy. People working in the cross-cultural modalities are invited to send manuscripts, or to submit special features or photographs. For more information, write to the Editor, or to Dr. McNiff, Dean of the Arts Institute, Lesley College, Cambridge, MA 02138.

* * *

Call for Photographs

Do you have photographs (black and white, glossy) that you would like to submit for review and possible publication in *Art Therapy?* Or maybe you have that ideal color photo that might be a good cover for the journal. You are invited to submit them for consideration. Simply identify, on the back of the photo, the title, something about the artist, and other pertinent information. If the work is from a patient or client, a release form must be signed and on file. Please send photographs to Gary Barlow, *Art Therapy* editor, at the above address.

* * *

Projective Drawings Workshops Planned

The American Projective Drawing Institute will offer two Summer Workshops this year in New York City: Basic July 21, 22, 23; Advanced and Cases Seminar July 23, 24, 25. *The Clinical Application of Projective Drawings,* Hammer, E.F. (Ed.), Charles Thomas, Publisher, 2600 South First St., Springfield, Illinois 62717, is suggested as preparation for the workshops. For information write to Dr. Emanuel Hammer, 381 West End Avenue, New York, New York 10024

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, *ART THERAPY, Journal of the American Art Therapy Association*, discounts on publications, discount on admission to the annual conference, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (ATR). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA National Office.

Associate Membership shall be open to individuals interested in the therapeutic use of art wishing to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $50

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee. **Applications for student membership must be accompanied by a copy of current ID.**

Annual Dues: $35

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $100

Professional Membership is by application only and is open to individuals who have completed professional training in art therapy and who are or have been engaged in the therapeutic

NAME ______________________________
LAST FIRST MIDDLE

PREFERRED MAILING ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________________

OTHER ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________________

TITLE ______________________________

EMPLOYER ______________________________
INDIVIDUAL OR INSTITUTION

HIGHEST EDUCATIONAL DEGREE ______________________________

---

practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologists which reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy. THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers to: Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583
TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA

Please enter my subscription for Vol. 13, 1986 ☐ (Prepayment required) Check enclosed ☐
Please enter my subscription for Vol. 14, 1987 ☐
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume
2 Vol. subscriptions subject to additional 10% discount Individuals $36 Students $27

Name ______________________________
Address ______________________________
City ______________ State ________ Zip ________

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Volume 3, Number 2 July 1986

- Multiple Family Group Art Therapy
  Debra B. Greenspoon, MA, ATR
- Identification of Child Abuse in the Art and Play Products of the Pediatric Burn Patients
  Pat Levinson, ATR, MFCC
- Approaching Artistic Sublimation in Low-Functioning Individuals
  David R. Henley, ATR
- Fusion of Symbols, Confusion of Boundaries: Percept Contamination in the Art Work of Alzheimer's Disease Patients
  Judith Wald, MS, ATR
- The Influence of Art-Making on the Transference Relationship
  Harriet Wadeson, Ph.D., ATR

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1985-1987

Board of Trustees

President
Sandra L. Graves, PhD, ATR

President-Elect
Cay Drachnik, MA, ATR, MFCC

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, MA, ATR

Committee Chairs

Affiliate Societies
Nancy Steinberg, MA, ATR

Bylaws
Roberta J.H. Shoemaker, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Bobbi Stoll, MS, MFCC, ATR

Publications
Harriet Wadeson, PhD, ATR

Research
Linda Gantt, MA, ATR

Standards
Ronald E. Hays, MS, ATR

Executive Director

Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Annual Conference 50

Editorial

Gary C. Barlow, EdD, ATR 52

Articles

Multiple Family Group Art Therapy
Debra B. Greenspoon, MA, ATR 53

Identification of Child Abuse in the Art and Play Products of the Pediatric Burn Patients
Pat Levinson, ATR, MFCC 61

Approaching Artistic Sublimation in Low-Functioning Individuals
David R. Henley, ATR 67

Fusion of Symbols, Confusion of Boundaries: Percept Contamination in the Art Work of Alzheimer's Disease Patients
Judith Wald, MS, ATR 74

The Influence of Art-Making on the Transference Relationship
Harriet Wadeson, PhD, ATR 81

Viewpoints

Writing for Publication in Art Therapy
Cynthia Levy, ATR 89

Art Therapist's Portfolio
Patricia Ann Tindall 90

Reviews

The Lowenfeld Lectures: Viktor Lowenfeld on Art Education and Therapy
John A. Michael, EdD
Rawley Silver, EdD, ATR 91

About Our Cover

"Rainbow," a painting by a 9-year-old hyperactive girl with learning disabilities, and enrolled in the Art Therapy Clinic at Wright State University, Dayton, Ohio.

Volume 3, Number 2 July 1986

Copyright © 1986
American Art Therapy Association, Inc.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Shirley N. Nuhn
Advertising Manager
Beth Nord

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Anthony Kowalski, MD
Susan LaMantia O'Connor, MA, ATR
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Sivlerstein, MA, ATR
Robert Wolf, MPS, ATR

BEST COPY AVAILABLE

American Art Therapy Association, Inc. 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064

“COMING OF AGE”

AMERICAN ART THERAPY ASSOCIATION, INC.

NOVEMBER 12–16, 1986

WEDNESDAY/NOVEMBER 12 .... *PRE-CONFERENCE COURSES*

THURSDAY–SUNDAY/NOVEMBER 13–16 .... *CONFERENCE SESSIONS*

SATURDAY/NOVEMBER 15 .... *KEYNOTE ADDRESS:* JEAN BOLEN

PLAN NOW FOR THE AATA 17th ANNUAL CONFERENCE/WESTIN BONAVENTURE, LOS ANGELES

For more information, please complete this form and return to the

AATA NATIONAL OFFICE, 505 E. HAWLEY ST., MUNDELEIN, IL 60060

(312) 949-6064

AATA '86 • "COMING OF AGE"
17TH ANNUAL CONFERENCE REGISTRATION FORM

WESTIN BONAVENTURE / LOS ANGELES, CA 90071

NOVEMBER 12-16, 1986

REGISTRATION FEES	Before OCT 10	After OCT 10
Member Registration	$125	$140
Non-Member Registration	160	175
Student Member Registration*	55	65
One-Day Registration*	65	75
Pre-Conference Courses		
1. The Ulman Assessment Series	85	95
2. Footprints of our minds, Mirrors of our Lives, Photos as Therapy Tools	85	95
3. The Sand Tray Dialogue	85	95
4. Family Art Assessment	85	95
5. Systematic Study of Visual Languaging in Drawings of Primary Emotional Experiences	85	95
6. Art Therapy with Children from Violent Homes	85	95
7. Dream Interpretation through Archetypes and Eidetic Imagery for Art Therapists	85	95

	Before OCT 10	After OCT 10
8. Grants: Creating Job Connections	$ 50	$ 60
9. The Rainbow Phenomenon: Toward a Psychology of Color	50	60
10. Bitter Roots: Child Abuse and Multiple Personality	85	95
Course Credits	53	53
Extra Wine & Cheese Reception Tickets	20	20
Extra Closing Reception Tickets	20	20

**Does Not Include Receptions*

Tours Available at Tour Desk

Check payable to AATA enclosed ☐

Please charge to my: VISA MASTERCARD (Circle One)

CARD NUMBER ____________________ EXP. DATE ____________

SIGNATURE ______________________________

• *Badge Limitation for Name and Degree is 21 characters*

NAME: ______________________________ DEGREE ____________

ADDRESS ______________________________

____

CITY ______________ STATE ______________ ZIP CODE ____________

TELEPHONE (DAY) ______________________ EVENINGS ____________

WORKSHOP REGISTRATION *CHOOSE ONLY ONE IN EACH SESSION.*

Workshops are filled on a first-come, first-served basis. Please check first choice and second choice.

SESSION I

____ 100 Art Therapy as an AA Treatment Component: A Six Task Series

____ 200 Behaviorally Oriented Art Therapy

____ 300 The Study of Aesthetics and Toxicity in Understanding One's Relationship to the Institutional Process

SESSION II

____ 400 Mandala Meditations

____ 500 Butterfly Life-Cycle: Creative Arts Modality with Children from Violent Homes

____ 600 Drawing and Meditation for Assessing, and Realizing Life Goals

SESSION III

____ 700 Me and My Shadow: An Adventure into Photo and Art Therapy

____ 800 Footprints of Our Minds, Mirrors of Our Lives — Photos as Therapy Tools

SESSION VI

____ 900 Unthinkable Anxieties: Images for Understanding Early Object Relations

____ 1000 Sunwheel and Individuation

SESSION VII

____ 1100 Inner Tool Box — New Perceptions for Art Therapists in Short-Term Settings

____ 1200 Imaginaction — Action Methods in Group Art Therapy

NOTE: Cancellations received prior to: Oct 29, 1986 — 90% refund
Cancellations received on Oct 29, 1986 — 50%
Cancellations Nov 12, 1986 — No Refunds

• RETURN TO: AATA NATIONAL OFFICE
505 E. HAWLEY ST./MUNDELEIN, IL 60060

EDITORIAL

Bits and Pieces

With this issue, the American Art Therapy Association begins its journal publication with a new management firm, Stygar and Willis—(Edward Stygar, Executive Director of A.A.T.A., and Robert Willis, Assistant Executive Director)—located in Mundelein, Illinois. As Editor, I have been working with Sharon Purtell who will be closely associated with the publication responsibilities of A.A.T.A. Assembling an issue of *Art Therapy* requires the balancing of a myriad of details, and I have been helped immensely by the thoughtfulness and insight Sharon has exhibited. Her work on this issue is much appreciated, and I look forward to our work together on the future issues of the journal. Welcome to our new Executive Director, Assistant Executive Director, and to the office staff and personnel!

Occasionally, one who is entrusted with a job such as Editor of a professional publication must step back (translation: maintaining a distance) and take an objective look at the product and the people responsible for it. In the day-to-day and month-to-month work on a publication, one can become so enmeshed with the product that it is sometimes difficult to maintain this "objective separateness." Nevertheless, now that eight issues of *Art Therapy* have been published, I am attempting this objective evaluation for purposes of looking to the future and to the publication in the years ahead. At this time it is important to publicly give heartfelt and sincere thanks to the many persons who are committed in helping this journal to continue to increase its professional significance. Thanks go to the Editorial Board members for their devoted work toward making the journal a major publication in our field, and for their responsibilities for the various sections within each issue . . . and certainly I value highly the skill and contagious enthusiasm of the dedicated Contributing Editors (their names are listed in each issue) who read the manuscripts, offer suggestions to the Editor, and serve as a creative force behind the journal. Appreciation is offered to the many others (readers; professionals in art therapy and other related fields; designers, printers, publishers and technicians; academicians) who have offered advice and direction . . . and to those of you who have jotted a note or telephoned regarding your support and constructive comments about the format, design, articles or other points relative to an issue. All comments are welcome, and since the journal is *your* journal, I am pleased that you are helping to let it "speak" for you.

Some readers have been concerned that their articles are not processed as quickly as they would hope. My apologies go to you for what has been, occasionally, unnecessary delays. Part of this, of course, has been due to the change from the previous management firm location in Reston, Virginia, to our National Office located in Illinois. Also, during the past few months, the submission of articles has increased. Please keep in mind that each article is sent to Editorial Board members for review and recommendations; these are then sent back to the Editor for final decisions that are then passed on to the authors. Please be patient—but keep those articles coming! It is gratifying to realize that in our profession we do have great numbers of people who are writing and documenting for publication.

Contained within this issue are thought-provoking articles covering a variety of subjects. Debra B. Greenspoon presents "Multiple Family Group Art Therapy," as a treatment modality with, as she points out, "little recognition in the literature." The cases presented offer the A, B, C, and D families as productive individual units, then becoming increasingly intertwined and mixed in a more complex pattern as the families move into multiple processes.

Pat Levinson offers an article titled "Identification of Child Abuse in the Art and Play Products of the Pediatric Burn Patients." Art and play therapy are utilized as projective modalities in the Bothin Burn Center, San Francisco. With the intensive focus on child abuse, the author states that "this article is based upon nine years of looking at art and play products and extrapolating recurring, pervasive themes that are often used as legal, admissible evidence in child abuse cases."

David R. Henley's article "Approaching Artistic Sublimation in Low-Functioning Individuals" presents a thoughtful view of art and process with special populations. He states, "It is now known that the retarded, the autistic, and the severely multiply handicapped child is capable of creating highly unusual and provocative works of art." The reader is introduced to Robert, a young man with Down's Syndrome, and with severe mental retardation. Henley's discussion of artistic sublimation in low-functioning persons tenders much content for thought and discussion.

In the article "The Influence of Art-Making on the Transference Relationship," Harriet Wadeson presents foci on the art therapist, the art-making process, transference portraits, transference to the institution, and countertransference issues for our understanding and deliberation. Examples (words and pictures) within each of these categories are given, illustrating brief vignettes as they have occurred when the author served as an art therapist with clients.

Finally, make plans now to attend the American Art Therapy Association's 17th Annual Conference, to be held in Los Angeles, California in November. Details are included in this issue. The theme of Conference is "Coming of Age," and it promises to be a good one. I look forward to seeing you there.

Gary C. Barlow, EdD, ATR
Editor, Art Therapy

Multiple-Family Group Art Therapy

Debra B. Greenspoon, MA, ATR, has a private practice in Los Angeles and is a part-time faculty member in the Graduate Department of Clinical Art Therapy at Loyola Marymount University.

This article explores multiple-family group art therapy through the development of a theoretical framework and the exploration of case material. Pertinent literature is briefly examined in order to establish a treatment model and rationale. The remainder of the article presents examples of artwork in an ongoing multiple-family art therapy group, focusing on the utilization of this process for both assessment and intervention.

Multiple-family art therapy is a new treatment modality with little recognition in the literature. It is based on integrating family art therapy with multiple-family group therapy, a combination that enhances the benefits of each and provides a unique opportunity for the families involved. This article presents an overview of a year and one-half long multiple family art therapy group, with focus given to its particular benefits.

Review of Multiple-Family Therapy Literature

A survey of the literature on multiple-family group therapy suggests that the core benefits of this modality can be divided into three categories. Since all the authors examined (Blinder, Colman, and Kessler, 1965; Cunningham and Matthews, 1982; Davies, Ellenson and Young, 1966; Donner and Gamson, 1968; Leichter and Schulman, 1972; and Leichter and Schulman, 1974) articulate similar viewpoints about these groups, their writings are assimilated and divided into the three categories perceived by this writer.

The first benefit addressed by the researchers was the exposure to different systems experienced by the families involved in a multiple-family group. There was unilateral agreement that the interfamily interactions impacted on the intrafamily behaviors and insights. Blinder, Colman, Curry and Kessler (1965) explain how "the scrutiny of all the other families present acts as a powerful counterforce against the system remaining closed." (p. 564) Leichter and Schulman (1974) reinforce this idea of the potential impact of one family on another when they say "the exposure to different systems may be the only way to shake up their own." (p. 96) Davis, Ellenson and Young (1966) discuss the process involved in the way one family can affect another: "In conjoint family group therapy, the members of a family increase their awareness of other families' processes and apply this knowledge to understanding their own family process." (p. 145)

In addition to the potential for exposure between different family systems, multiple-family therapy also provides access to parental substitutes for the children in the group. Leichter and Schulman (1974) discuss the way in which the collective resources of the parents make available diverse strengths to meet the children's needs. When they claim that "Multi-family group therapy can be very helpful for the family with a missing parent—usually the father" (p. 96), they are referring to the way in which these groups can help supplement the often depleted resources of the single parent. On a more dynamic level, Leichter and Schulman (1972) point out how the provision of parental substitutes offers opportunities for the family members to experiment with new behaviors: "In multi-family therapy group, each individual has a chance, in the presence of his actual family, to transfer onto other group members as well as to try himself out in ways which his own family is not yet able to tolerate." (p. 176)

The third category of benefits involves the concept of intergenerational communication. Leichter and Schulman (1974) address the value of facilitating interaction between children and parents of different families. They express an understanding of how such interaction can enrich the intergenerational rapport in the original family. "While it is very difficult for children and parents to change the image they have of each other, in the multi-family group, adults and young people have a chance to experience the universality of human needs and emotions across family boundaries." (p. 101)

This division into benefit categories (*i.e.* system impact, parental substitution and intergenerational empathy) provides a framework to understand the value of multiple-family groups and ultimately to explore the multiple-family art therapy modality. It is important, however, to first review the literature that discusses the value of art therapy techniques in work with families.

Review of Family Art Therapy Literature

Several authors (Kwiatowska, 1978; Landgarten, 1981; Rubin, 1978; and Wadeson, 1980) have articulated the value of utilizing art expression to facilitate family therapy goals. The benefits of family art therapy seem to emerge into two main categories: diagnostic clarification through evaluation of the art process, and facilitation of change through the art tasks themselves.

The concept of using art as a diagnostic tool for individual psychopathology is supported by authors of many disciplines, but it seems to be the art therapists who have contributed most to the exploration of its use in family assessment. Landgarten (1981) articulates the unique role graphic expression can play. She states, "The artwork is concrete evidence of the family's interactional performance. Where verbal dynamics reveal the family's manifest style of communication, nonverbal visual elements provide a dimension for displaying the subtle mechanisms which are in operation." (p. 21) Because the art process is an activity that minimizes the generational differences in communication abilities, it can involve all family members simultaneously and record the dynamics, the roles and the defense mechanisms at play in the whole system. In addition the graphic expression remains a concrete record for the ongoing assessment of change over the treatment period.

Art expression utilized in family therapy can have a second important function, that of aiding the therapeutic goals themselves. Wadeson (1980) suggests how the art process can release blocked communications and rigidified roles: "Although role relationships are often inflexible or assumed initially, the introduction of this new mode of expression can supply leverage so that a family may provide more space within itself for the movement of its members, both in family roles and position." (p. 281) Landgarten (1981) points out the way a directed art process can facilitate the goals of a systems approach to family work, "Within the art therapy approach, a large portion of the intrusion is accomplished through the dynamically oriented method of requesting families to create mutual art tasks with a variety of themes, art media and at times, role designations, which are therapeutically based." (p. 23)

The few authors who do discuss multiple-family group art therapy (Landgarten, 1981; Rubin, 1978; Wadeson, 1980) list a variety of benefits that echo the previously cited literature. They discuss how the art process offers a variety of communication experiences that can be utilized by all family members simultaneously, and how the multiple-family process offers unique opportunities for recognition and exploration of the communications.

Mrs. A. **(age 36)**		**Mrs. B.** **(age 39)**	**Mrs. C.** **(age 43)**	**Mrs. D.** **(age 40)**
BOBBY A.	BILLY A.	MARLA B.	NATALIE C.	AARON D.
(age 12)	(age 9)	(age 12)	(age 12)	(age 10)

Diagram No. 1

Introduction to Multiple-Family Art Therapy Group

The multiple-family art therapy group, identified in following sections, was an outgrowth of a multimodality day treatment department in a large residential facility for children. Three families were initially selected for participation and a fourth was added after one of the original families left the group. Each of the families was composed of a single mother and a latency age child enrolled in the day treatment program with only one of the families having a second sibling. (See Diagram No. 1.)

Issues of separation and autonomy pervaded the difficulties in all these families as the overwhelmed, depleted mothers struggled with responses to the special needs of their ego-damaged children.

Beginning Stages of Group

In the early weeks of this group, emphasis was placed on helping the families gain familiarity with this modality of self-expression and become acquainted with one another. Consequently, very little initial direction was given and most of the products from this stage grew out of "free choice" experimentation with the materials. Several examples have been selected to illustrate the way in which the artwork provided not only a diagnostic picture of these families but also a vehicle for them to connect and find support through the acknowledgement of mutual struggles.

Figures 1 and 2 were created by the A. family. Both the marker drawing and the clay sculpture depict the affective state (depressed) and the core difficulty (isolation) of this family. The drawing, created by Mrs. A. and Billy A., is not only impoverished but also separated into two unintegrated parts. Mrs. A. (using a blue marker) drew about her frustrated response to her sons bickering while Billy A. (with a green marker) concentrated on the home, identifying mother's bedroom and symbolizing the sibling rivalry for her attentions with the two-sided ascending stairway. Mrs. A. and Billy A. spoke about this drawing sadly, recognizing its representation of their relationship but concerned about the group's reception of this depiction of a family crisis. The clay sculpture, created two sessions later by Mrs. A. and her two sons, represents a much more invested participation in the art process for the

". . . multiple-family therapy . . . provides access to parental substitutes for the children in the group."

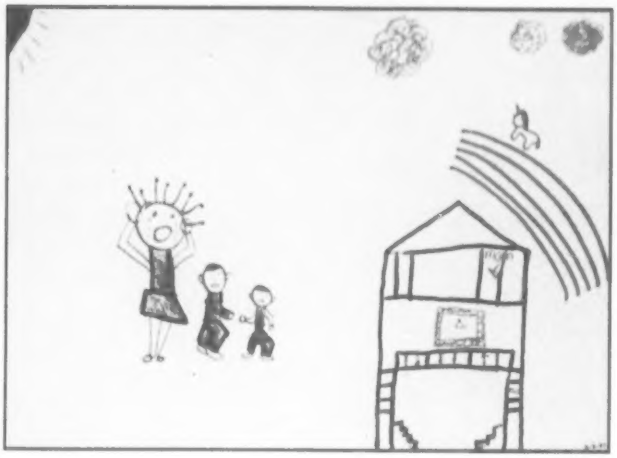


Fig. 1

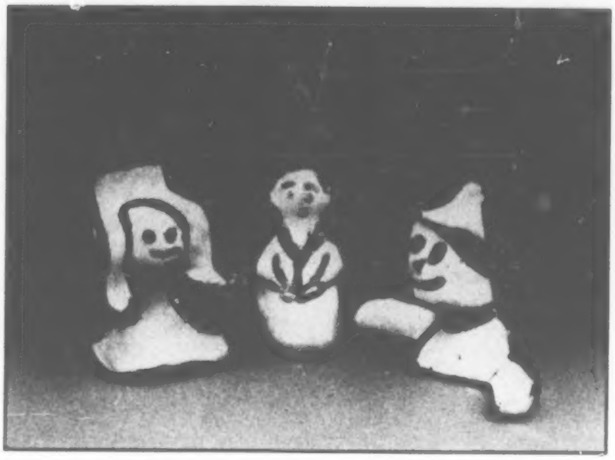


Fig. 2

entire A. family. Although Mrs. A. portrays herself as passive, self-enclosed and unavailable, the self-satisfied peaceful quality of her figure stimulated Mrs. A. to comment on her conflicts between her own needs and the demands of her sons. Both Billy A.'s and Bobby A.'s self-representations suggest the idiosyncratic manners in which they respond to their mother's struggles: Billy A. with efforts at compensation (his small arms try to embrace the family) and Bobby A. with acting out behaviors (the legs of a trouble causing wizard perch on his head). This sculpture and the drawing which preceded it combine to accurately reflect the manner in which the A. family presented itself in the beginning stage of this multiple-family art therapy group. Beginning to risk self-disclosure, the A. family found safety in this group which provided for them as individuals and encouraged them to interact as a family.

The B. family responded differently to the beginning stages of this group. More skeptical about the benevolent nature of this modality, Mrs. B. and Marla B. maintained an ironic attitude toward their art projects. Nevertheless, Figures 3 and 4 illustrate the manner in which the art process provided this highly defended family with a way to share its pain. The B. family members began Figure 3 by tracing and designing outlines of their hands on separate pieces of paper. In the process Marla B. duplicated her mother's color selection and flamboyant style of embellishment, signifying her attempts to connect and identify with her parent. Mrs. B.'s bandaged self-representation, followed by her admonishment to Marla B. that her daughter's hand must "only lightly touch hers," served, however, to thwart Marla B.'s enthusiasm. In apparent reaction Marla B. stated that the project was unfinished and drew in the cat, explaining how it had eaten the missing half of the heart she hastily sketched above Mrs. B.'s hand. It seems likely that Marla B.'s spontaneous additions represent a regressive reaction (*i.e.* the age-appropriate effort to identify, once frustrated, became an aggressive effort to incorporate). This symptomatic solution to the interactive conflicts in the family reflected the coping patterns the B. family characteristically utilized. Graphically illustrated in the artwork, this interaction became available for observation by the therapists, by the family itself and no less importantly, by the other group members. Thus began the first step in this family's evolution towards mutually shared self-expression. In the plasticene sculpture of Figure 4, Marla B. repeated her self-representational symbol of the cat, this time even more clearly

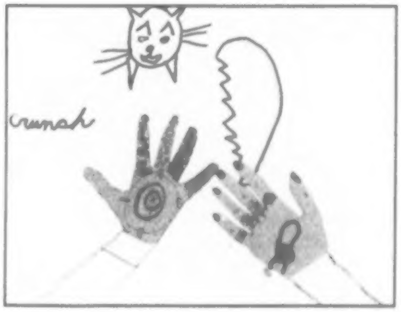


Fig. 3

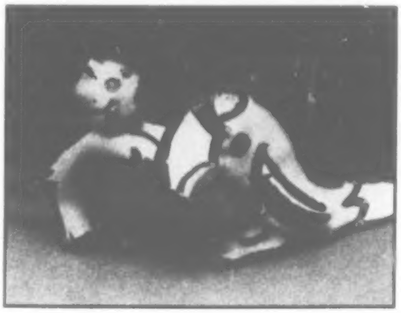


Fig. 4

". . . the art process offers a variety of communication experiences that can be utilized by all family members simultaneously."

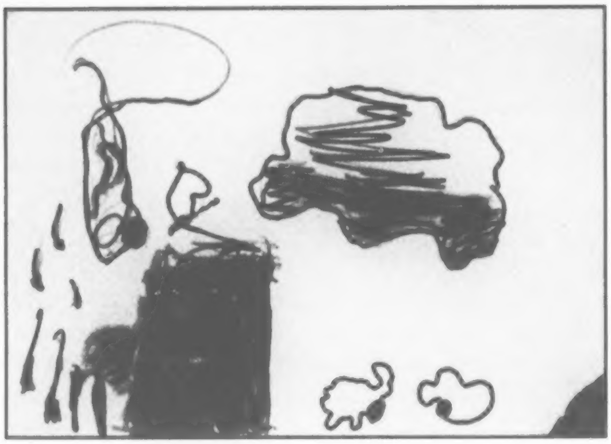


Fig. 5

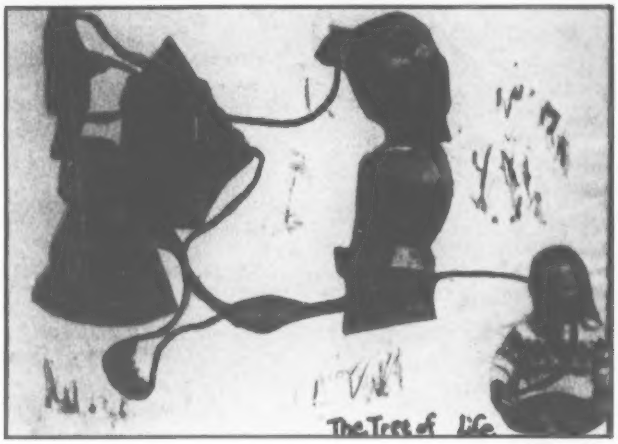


Fig. 6

releasing her aggression in the cat's direct attack on her mother's equally self-representational parrot. Like Mrs. A.'s self-contained clay sculpture, Mrs. B.'s self-representation suggests self-absorption and unavailability. The children's artwork appears to be a reaction to this dynamic.

The C. family's first attempts at family art projects were less successful, and its failures evoked strong responses in the other group members. Figure 5, a marker drawing that quickly disintegrated into hostile chaos, accurately portrayed the state of the relationship between Mrs. C. and Natalie C. The group's reaction to this depiction of the interaction between emerging adolescent anger and a parent's impoverished ability to contain it, was strong. The severity of the disturbance evident in the drawing shocked the families into acknowledgement of a system other than their own, but more importantly, it provoked the members to express empathy. Figure 6 represents an equally unsuccessful attempt for the C. family to work together on the same piece of paper, but this time observation of the process helped the group members gain understanding of the interaction. Mrs. C. and Natalie C. began work on this collage by individually choosing pictures that interested them but making no conjoint decisions about theme or topic. Each then glued their selections on the page in a relatively integrated manner. Without any discussion, Mrs. C. drew a line that linked all the pictures together with the title, "The Tree of Life." This addition appeared to agitate Natalie C. and she impulsively removed the pictures she had selected, thus leaving the collage in the disintegrated state it appears in Figure 6. Mrs. C.'s tendency to merge with her daughter provoked Natalie's brutal attempts at separation and resulted in this graphic representation of the family's pain. This was the first art project to stimulate an interactive group discussion in which the other mothers shared their perceptions that things might have worked out better had Mrs. C. conferred with her daughter about linking the pictures. This discussion served to mark the transition from the beginning stage of the group where emphasis was on facilitating self-expression to the middle stage of the group which would encourage group responses to each family's art productions.

Initially, the three families in this group responded very differently to the self-expressive potential in the art materials. The materials they selected, the way they worked together, the degree of self-exposure they could tolerate and the manner in which they discussed their projects all combined to present a rich picture of each family to the group as a whole. The art process was invaluable in providing these families with a nonthreatening expressive modality and the multiple-family aspect provided relief from isolation, a sense of universality in their struggles and a glimmer of hope for these conflicted families.

Middle Stages of Group

As the group members felt more familiar and comfortable with each other, they moved into a middle stage of development by identifying issues and exploring problem-solving methods. In order to increase discussion and interaction among group members, directed art tasks were employed that focused on exploring their symptomatic interactions. The next four figures illustrate the ways in which directed art tasks helped to shift the focus of the group from conflict to solution.

The collage in Figure 7 was produced by Mrs. A. and Billy A. on an evening when Bobby A. was not in attendance. In response to the therapist's suggestion that the family select pictures of people expressing feelings, the A. family created this work portraying an empathic exchange. Billy A. and Mrs. A. took such delight in this process that they went on to produce several more collages, using the pictures to develop dialogues of care between the characters. It appears that the collage process provided the family

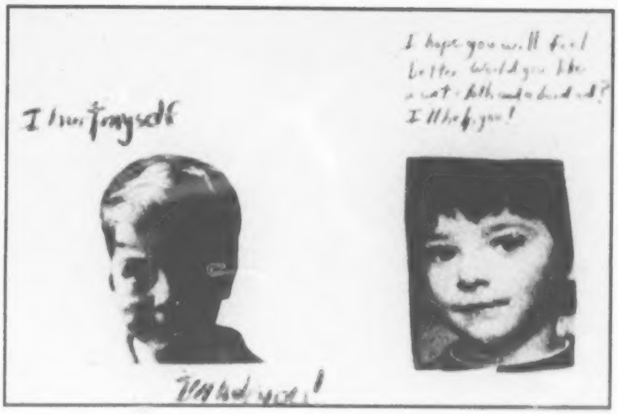

I hurt myself
I hope you will feel better. Would you like [illegible]? I'll help you!

Fig. 7

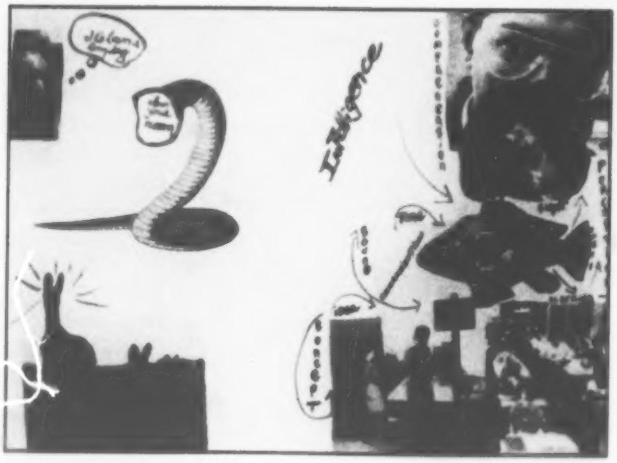


Fig. 8

with the distance required for them to express the positive feelings between them that were difficult for them to acknowledge in more direct ways. The other families in the group were touched by these poignant expressions and Mrs. C.'s verbalized response included her observation of Billy A.'s contained behavior as an apparent consequence of the expression. Mrs. C.'s comments reflected the fact that she was utilizing her observation of the A. family to augment her understanding of her own interactions with her daughter. This is a clear example of how the art process (providing opportunities for projected self-expression) combined with the multiple-family process (providing exposure to different family systems) to offer the families a unique experience.

The task assigned for Figure 8 was also focused on augmenting system self-expression in order to explore the families' solutions to problematic interactions. Each family was encouraged to divide the page into individual sections and develop each section to represent the family members. In the verbal explanation of this project, Mrs. B. explained her section (on the right side) as a depiction of the learning process. This overly intellectualized and convoluted expression suggests the defenses Mrs. B. uses to avoid recognition of her daughter's needs and her own affective state. Marla B.'s section (on the left side) suggests her dependent struggles (baby kangaroos follow their mother and the open-mouthed snake has incorporated in its oral cavity the nagging maternal command, "Clean your room.") As the B. family members discussed their work, they recognized the lack of connectedness but did not explore their reactions to each other. However, Mrs. A. insightfully pointed out that disconnectedness was simply the "other side" of this family's usually aggressive interaction. The art process had provided for a safe expression of family issues which became available for discussion as universal concerns in the multiple-family group.

Figures 9 and 10 also grew out of an assigned task, requesting that each individual use the art materials to create a statement he/she wanted to make to the rest of his/her family. The collages in Figures 9 and 10, done respectively by Mrs. C. and Natalie C., are remarkably complementary. Mrs. C.'s collage focuses on the theme of maternal caretaking while Natalie's presents images of children, several of whom appear to be requesting or receiving nourishment. Although it was difficult for this family to discuss these projects, the group was quick to notice the similarities of theme. The group members acknowledged that some families required separation onto two different sheets of paper to create complementary communications (*i.e.* C. family in Figures 9 and 10) while other families did not (*i.e.* A. family in Figure 7).

Figures 7 through 10 illustrate how, as the families began to risk increased self-disclosure, art discoveries were used to help facilitate expanded expressions. These directives were presented with guidance in the use of art materials, and to understand the ways in which members responded to each other.

"... to increase discussion and interaction among group members, directed art tasks were employed that focused on exploring their symptomatic interactions."

Working Stages of Group

The group evolved into a third and working stage of development as the interfamilial interactions intensified and as the members began to initiate whole group projects.

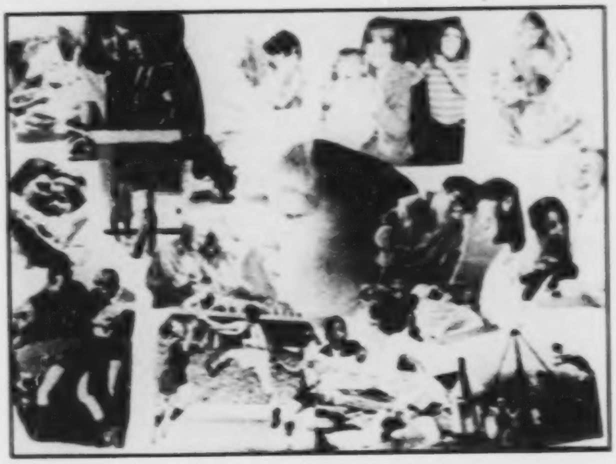


Fig. 9

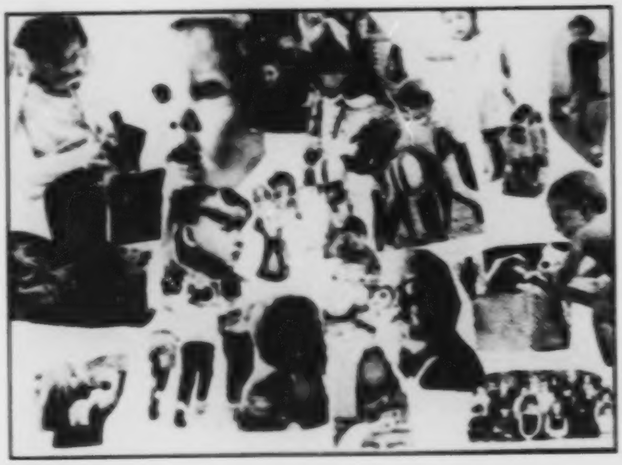


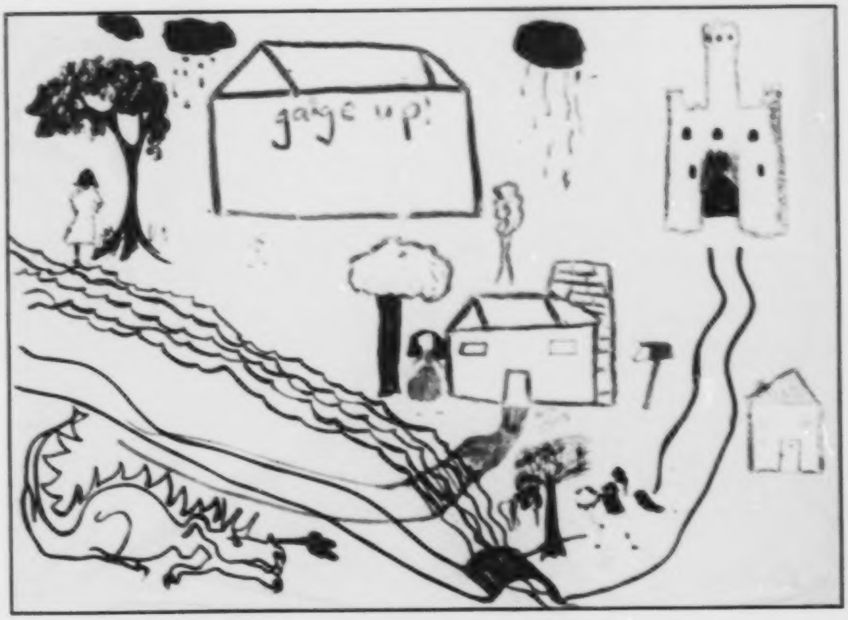
Fig. 10

With this shift in emphasis from individual and family self-expression toward large group communication, the therapeutic goals evolved as well, moving on to encourage each family to seek alternatives to the problematic interactive patterns that had already emerged in their art projects. The large group focus provided these depleted families with the additional resources to augment their problem-solving skills and their affective repertoire.

Figure 11 is a large mural created conjointly by the B. and C. families. To begin, Mrs. B., Marla B., Mrs. C., and Natalie C. were each requested to draw individual representations of a house, a tree and a person. Once completed, the images were cut out and pasted onto the large mural paper and each person in turn added more details to the picture as a whole. Selected details from this mural illustrate the way the symbolic expression facilitated experimentation with intergenerational and interfamilial communications. The first interaction example is the one between the two mothers, symbolized in the juxtaposition of the tree and figure in the upper left corner. Mrs. C. inquired whether she might place her small black girl adjacent to Mrs. B.'s apparently strong and nurturing tree. Mrs. C. seemed to be asking for support from this other single mother who was perceived as more capable. From earlier art projects one can remember that the parenting skills of both mothers are limited but in this union, the first interaction completed in the mural, the two seemed to bolster each other with their strengths. In response Mrs. B. placed her "princess on a horse" figure adjacent to Mrs. C.'s tree in the lower right.

With an understanding of the connection between the two mothers in this mural, one can examine the ways both daughters responded to this pooling of maternal resources. The first response involves the rivers and bridges drawn on this mural. Mrs. C.'s river was the first addition to the mural and it runs from her cut out girl figure to the opposite corner of the paper. After its completion, Mrs. B. drew a path from her isolated castle and a bridge which crossed Mrs. C.'s river, again suggesting the two mothers' union. Most significant, however, is Natalie C.'s apparent response; her drawing (in red) duplicated Mrs. B.'s path and bridge but runs from her own house, across her mother's river and merges with Mrs. B.'s own path. It

Fig. 11



BEST COPY AVAILABLE

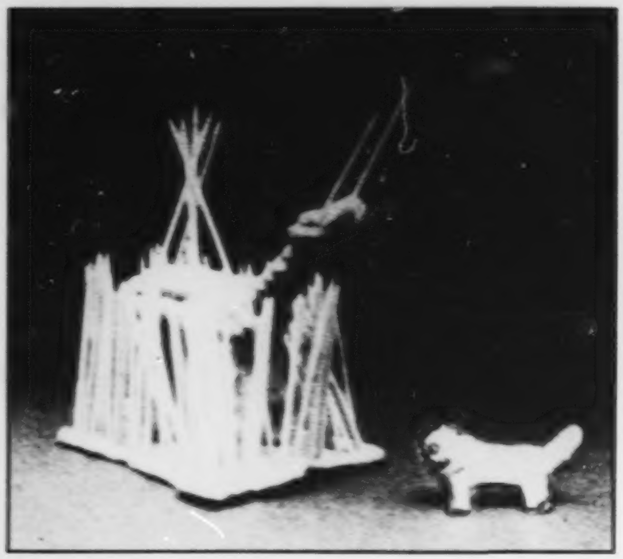


Fig. 12

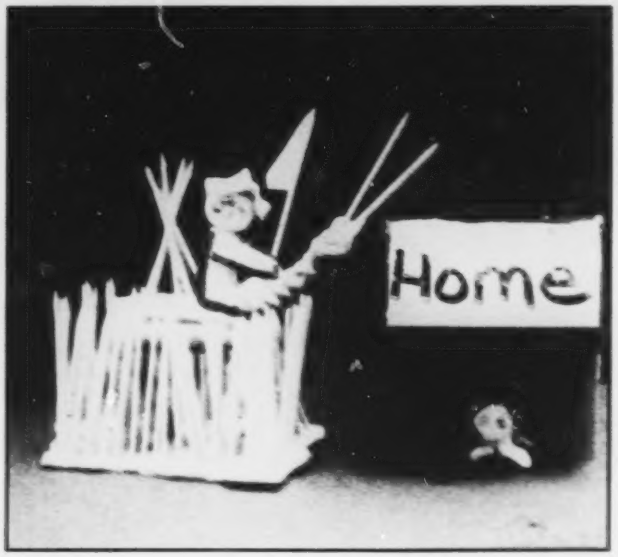


Fig. 13

can be speculated that the combined maternal strength allowed this angry girl to alter her brutal, provocative dynamic with her mother and interact positively with the maternal symbols. Less available to play the victim, Mrs. C.'s strength, supported by Mrs. B., provoked an alternative kind of reaction in her generally hostile daughter.

Marla B., unlike Natalie C., did not respond to the maternal union, by moderating her usual aggression. On the contrary, she utilized the opportunity to directly express the anger that had previously been discharged in her artwork. After her mother placed the "horseback princess" near Mrs. C.'s tree, Marla B. drew the sword carrying murderer hanging upside down from the tree, stealthily awaiting the princess's proximity. This symbolic expression provoked Marla B.'s mother into drawing the equally aggressive dragon in the bottom left corner which in turn provoked Marla B. to verbally express her feelings of being "ganged up on." As she wrote these words on her house, she was taking a big step in her developing capacity to communicate affectively within her family. Within the process of this mural, old behavior patterns were challenged; as mothers found mutual support, children responded to bolstered parental strength and risked behavior previously not tolerated by their family system.

Figures 12 and 13 further exemplify the therapeutic potential in multiple-family art expression. Figure 12 is a plasticene sculpture created by the D. family during its first group meeting, a year after the group had begun. Mrs. D. and Aaron D. had been asked to introduce themselves to the other group members by making animal self-representations. This juxtaposition of Aaron D.'s wild beast, barely contained by a rickety cage, with Mrs. D.'s overwhelmed looking French poodle, accurately reflects the dynamics in this family. As new members in a group which had achieved a high degree of intimacy, the D. family members became quite anxious as they discussed their project, becoming aware of its undeniable disclosures. Their anxiety triggered an empathic response in the A. family members who inquired if they could assist Aaron D. and Mrs. D. Figure 13 illustrates the way the A. family modified the D. family's original work. Interestingly, this was done across generational as well as familial boundaries as Bobby A. built a protective shelter for Mrs. D.'s dog and Mrs. A. created a controlling rider for Aaron D.'s "out of control" monster. As the A. family offered support for the newer and more anxious D. family they were, of course, addressing their own needs, experimenting with different kinds of responses to family patterns that troubled all the families in this group.

The working stage of this multiple-family art therapy group, illustrated by Figures 11 through 13, continued for many months as all four families deepened their involvement with each other. Prior to Thanksgiving, after the group had met for over

---

"The working stage of this multiple-family art therapy group . . . continued for many months as all four families deepened their involvement with each other."

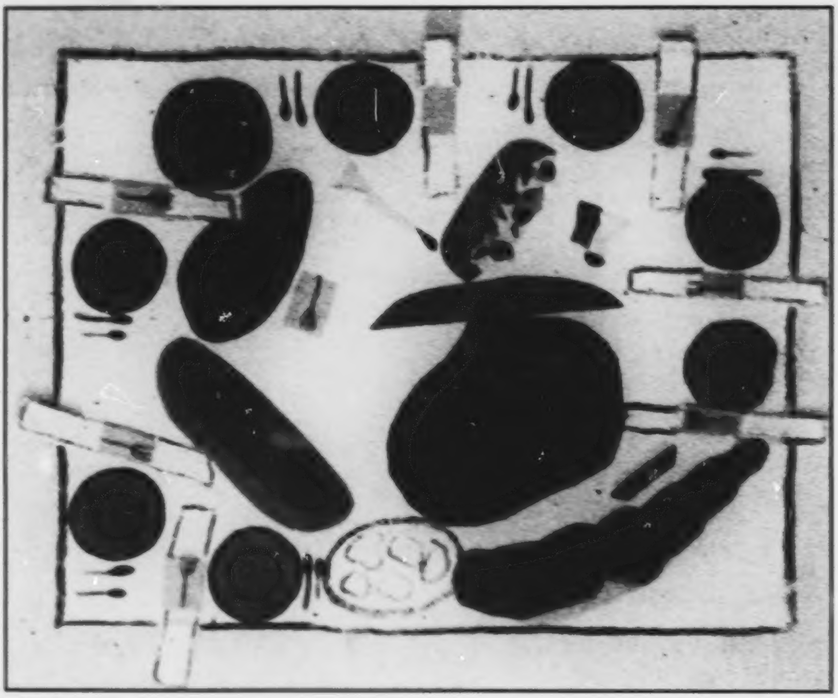


Fig. 14

one year, the participants suggested ways of celebrating holidays together. The suggestion, met with eager enthusiasm, was the catalyst for the work illustrated in Figure 14.

This Thanksgiving meal was produced cooperatively by the A., C., and D. families. The creation of this nurturing and festive project was a valuable experience for these isolated and resource-limited families. The symbolic celebration reflected the manner in which this group had become an extended family experience with a pooling of emotional strengths and resources. A look at two details from this symbolic process illustrates this project's value. The salad in the lower center of the table was begun by Mrs. A. and added to by the other mothers. All spoke of their concerns for their children's nutritional needs as they cut and pasted representations of fresh vegetables. The bowl of salad can be understood as a collaboration of maternal resources, providing more for the children than any of the mothers could have done as individuals.

After adding to the salad, Mrs. D. retreated from the group to carefully create tissue paper napkins, apparently somewhat disconcerted by the intimacy of the project and needing to distance herself from this shared provision of food. The art process allowed Mrs. D. to find her own level of participation (making napkins was perhaps ego-syntonic with her need to tidy spilled, *i.e.* shared, material) while still remaining involved with the group. All four families were delighted with Figure 14 and continued to initiate similar kinds of projects each time a holiday occurred.

Figures 11 through 14 have illustrated the working stage of this group, which has become a very valuable experience for all the families involved. The artwork has taken on an interactive and exploratory quality where the participants are beginning to make attempts, both consciously and unconsciously, to alter the behavioral/communication patterns that had been made obvious in the artwork produced in the earlier stages of this group.

The combination of these fourteen art projects provides an overview of how multiple-family group art therapy can be of value for a particular population. These single parent families, isolated and shattered, were able to find relief in the process of communication and self-expression, inherent in this modality.

References

Blinder, M., Colman, A., Curry, A., and Kessler, D. (1965). "MFCT: Simultaneous treatment of several families." *American Journal of Psychotherapy* Vol. 19: 559-569.

Cunningham, J., and Matthews, K. (1982). "Impact of multiple family therapy approach on a parallel latency-age/parent group." *International Journal of Group Psychotherapy*. Vol. 32: 91-102.

Davies, I., Ellenson, G., and Young, R. (1966). "Therapy with a group of families in a psychiatric day center." *American Journal of Orthopsychiatry*. Vol. 36: 134-146.

Donner, J., and Gamson, A. (1968). "Experience with multi-family, time limited outpatient groups at a community psychiatric clinic." *Psychiatry*. Vol. 31: 126-137.

Kwiatkowska, H. Y. (1978). *Family therapy and evaluation through art*. Springfield: Charles C. Thomas.

Landgarten, H. (1981). *Clinical art therapy*. New York: Brunner/Mazel.

Leichter, E., and Schulman, G. (1972). "Interplay of group and family treatment: Techniques in multi-family group therapy." *International Journal of Group Psychotherapy*. Vol. 22: 167-176.

Leichter, E., and Schulman, G. (1974). "Multi-family group therapy: A multi-dimensional approach." *Family Process*. Vol. 13: 95-110.

Rubin, J. (1978). *Child art therapy*. New York: Van Nostrand Reinhold.

Wadeson, H. (1976). "The fluid family in multi-family art therapy." *American Journal of Art Therapy*. Vol. 15: 115-118.

Wadeson, H. (1980). *Art psychotherapy*. New York: John Wiley & Sons.

Identification of Child Abuse in the Art and Play Products of the Pediatric Burn Patients

***Pat Levinson, ATR, MFCC,** is a member of the Dominican College Graduate School in Counseling Psychology, California. She is a Fellow, the Menninger Foundation, and a member of the American Burn Association, the Association for the Care of Children in Hospitals, A.A.T.A. member, and Director of Art and Play Psychotherapy, St. Francis Memorial Hospital Burn Unit.*

This article deals with the identification of child abuse and neglect in a burn center setting utilizing art and play therapy (APT) as a projective base, a diagnostic and investigative tool, and a treatment modality. APT is a blend of the psychotherapeutic technique and creative process. Providing developmentally appropriate materials and techniques facilitates the communication necessary for the child to tell how he/she was burned. Consistent and repetitive themes of hurting and sadism in the play are combined with observations from the medical team, and give indications as to how the child had been abused. Conflicting versions of how the injury was sustained provoke suspicion, and often inappropriate family interaction may be observed. When a pervasive play theme indicating abuse emerges, appropriate steps are taken to notify the attending physician, the medical social worker, and child protective services. The therapist, after locating the problem area, moves from nondirective play to a structured play (release therapy) modality. This article is based upon nine years of looking at art and play products and extrapolating recurring, pervasive themes that are often used as legal, admissable evidence in child abuse cases.

Introduction

Play is the work of childhood and is a serious business for the child in crisis. Play imitates life. It is the primary autotherapeutic tool the child naturally possesses for self-healing, communicating problem areas, and defusing traumatic experiences. APT gives form to feeling and facilitates self-expression. The child will reveal in play what he cannot express outright.

APT as a treatment modality provides a safety valve for explosive feelings. By providing a forum for self-expression, the therapist, nonjudgmentally, gives the child a variety of opportunities to tell his/her personal story.

Being hurt by one's parents is always a dilemma for the child, who, of course, needs his/her parents. It is frightening for the child to indict his/her parents, and he/she will not explicitly do so. It is only with the protective qualities play affords that the child will dare to express a story of child abuse. The microcosm of the play world is much less threatening than the macrocosm of the real world and is without retribution.

Patients and Methods

During a five-year period 122 children between the ages of one and thirteen years were admitted to the Bothin Burn Center of Saint Francis Memorial Hospital. Four were cases of child abuse; sixteen involved suspected abuse or neglect; and ten were cases of lack of supervision. All children participated in the Art and Play (APT) program. Each child received three sessions per week.

Extent of burn injury ranged from 10% to 62% of total body surface, the average being approximately 20% total body surface. Sessions began as soon as the child became sufficiently alert to participate, provided they did not interfere with primary medical care.

The therapist recorded each session in the patient's chart, highlighting the following: the patient's affect (mood); interaction with the therapist, medical staff, parents, and product; what the child produced in the session—*i.e.*, painting, story, grafted or intubated Surgi-Doll, or hospital miniatures; and what was said by the child about each product. The therapist also noted recurring play themes.

These records were subpoenaed and used as evidence if the abuse case went to court. The therapist was deposed on a number of occasions and testified in court as an expert witness in therapeutic play.

The therapist charted all of the evaluations. Assessments of contents of play were discussed on a daily or weekly basis in Psychosocial Pediatric Rounds attended by the medical social worker, the child psychiatrist, the child art and play therapist, the adolescent art therapist, resident physicians and interested members of the burn team.

The psychotherapeutic technique initially used was nondirective. This modality is permissive, nonjudgmental, supportive, reflective and helps to establish an atmosphere of flexibility and creative spontaneity. Trust and empathy are achieved in this first phase of cooperative effort in a safety zone.

As the play continued, problem areas began to emerge and the thera-

Fig. 1
Sexually abused child paints genital burns on Surgi-Doll in exactly the same area of the body where she was burned.

pist encouraged the child to "play through" a significant trauma. In this second phase of play, the therapist used release therapy designed for children who have had a significant traumatic event. The major principle of release therapy is in the use of the acting-out principle in play to the highest degree. Release therapy is structured play.

When the therapist became absolutely sure of the pervasive play theme, her role was much less passive; she encouraged play in problem areas. The therapist set up situations similar to the event. An example is as follows:

1. *Set-up:* Two doll house figures (boys) were put into the garage of the doll house by the therapist.
2. *Narrative:* Two little boys were playing. One had matches, the other a lighter. What happened?

The psychotherapist had a specific identified goal when she used this approach: a cathartic re-experience of the burn injury. It seemed to be in the child's best interest to share the specifics of the burn injury, including: confessions, feelings of guilt, blame, fear and anger—all highly charged feelings. The child could act them out, with support in the hospital setting.

Results

When the child used art and play to tell stories of burn experiences over and over again, he/she ventilated feelings. Moods elevated and cooperation increased. The children formed close attachments to Burn Center staff and felt protected in the setting. These transference issues were dealt with in appropriate ways during the course of treatment.

Case 1.

C. was admitted for reconstructive surgery, and APT was done some years after the initial acute injury. She was a six-year-old female who, four years previously, had suffered 45% total body surface area burn injuries of the lower abdomen and legs. C. was in the first grade in school and was a slow learner requiring special tutoring in reading. She lived with her mother and grandmother, who were significant family members in her life. Her father visited regularly and contributed to her care financially.

C. had been held in scalding water at the age of two by the babysitter who was prosecuted for this act of abuse. The mother was at the movies during the time of the burn injury.

C. first worked on the Surgi-Doll. She painted genital burns on it in exactly the same area of the body where she had been burned (Fig. 1). C. was extremely creative and became quite absorbed in this project. She once looked up and declared, "This really happened, to me!"

Two of her paintings were sexual in nature depicting large, black penises that scared children, who ran away. C.'s affect while talking about her pictures was embarrassed and giggling. She was self-conscious when talking about sex.

C.'s mother told us that the child had been taking money from the boys at school in return for showing them her genital scars. This occurred after school in a park on the way home.

Child sex abuse became a clear play theme. The medical social worker, the psychiatrist and the clinical psychotherapist referred this child to a local family mental health clinic upon discharge from the Burn Center.

In this case child abuse was well established. APT confirmed the sexual nature of the abuse.

In other cases there was a strong suspicion of abuse or neglect, but no consistent story surfaced in the play due to parental interference. The child told many versions of the burn injury, was clearly coached by the parents, and changed the story to accommodate the parents. The following case is illustrative:

Case 2.

L. was a three-year-old male who sustained 20% mixed partial and full thickness burns due to scalding nine days prior to admission. The mother had been hospitalized at the time, and the father treated the burn injury at home. Because the child became febrile, the mother insisted upon medical evaluation.

The injury occurred while father went to empty garbage. When father returned, the child was screaming because of the water being too hot. Apparently L. had turned on the hot water and tried to get out of the tub but fell back in. The attending physician was alerted in this case that child abuse was a possibility.

L. had been attending pre-school for the prior ten months. He enjoyed painting and playing with his puppy. He played in an age appropriate manner, demonstrating normal skills and interests: trucks, trains, space men, and animals.

L. was clearly attached to his mother and she to him. They were affectionate towards each other. L.'s behavior towards father was guarded. A parent was always present during play therapy sessions, which was not unusual in families with hospitalized pre-schoolers. The father was quiet.

L. played in the doll house each session. He especially wanted to play with the miniature bathtub. All of the figures received multiple baths in hot water. One key figure became the theme—a miniature boy who received many baths that were "too hot." The therapist became suspicious when the doll house boy was splashed with hot water from a bucket and "got burned." The boy in the doll house then turned off the hot water. At one point the doll house father turned on the hot water himself and burned the boy. The play became confused. The mother began to correct L.

After sharing the contents of the play sessions in weekly psychosocial pediatric rounds attended by the medical social worker, the child psychiatrist, the pediatrician and interested medical personnel, the decision was made to report the case to Child Protective Services (CPS) as suspected child abuse.

Discharge planning included the following: (1) CPS was to monitor the home; (2) The family was to participate in ongoing psychotherapy; (3) The family was not to change residences; (4) The child was to attend burn clinic on a regular basis; and (5) The child was to receive follow-up care from the visiting nurse and the play therapist in the home. The family agreed to these conditions because they did not want to lose L. to foster care. Compliance was mandatory.

At the last minute, before discharge, L. changed the story once again, telling us he had lied. "Daddy didn't do it," he said.

Case 3.

D. was a four-year-old male who suffered a 70% first and second degree injury reportedly from scald burns sustained in hot bath water. The parents reported drawing his bath. The patient stated he got in, and "jumped right out." Parents reported that he complained of the water being too hot, but that he was lying on his back with water up to his chin. Neither parent felt that the water was too hot. D. began to complain that his feet hurt, and the mother noted blisters. He was put to bed but continued to fuss. Mother was aware of blisters on his chest, heels, elbows and back. He was taken to the Emergency Room of the hospital.

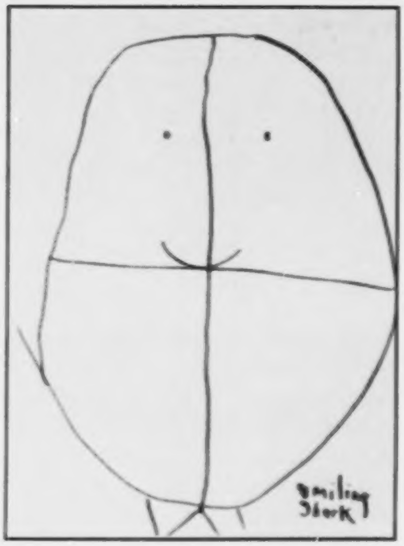


Fig. 2
Drawing titled "The Smiling Shark" expressed a child's ambiguous feelings about caregivers.

D.'s affect was angry. He rolled around the burn unit on his hot wheels, hitting other children. His play was hostile—giving shots to Surgi-Dolls in the eyes, fingertips, or genitalia. His drawing "The Smiling Shark" (Fig. 2) expressed ambiguous feelings about his caregivers. His house drawings were all bright red, indicating intense feelings about his home. One day he drew a huge, evil-looking man, and called it "Daddy."

> ***"As the play continued, problem areas began to emerge and the therapist encouraged the child to 'play through' a significant trauma."***

In a play session, he took all of the figures and furniture out of the doll house, then threw them up in the air and let them crash saying, "It's all bad." Three weeks before discharge D. drowned both parents in doll house bathtub and shot them with the squirt gun (Fig. 3). D. enjoyed this activity, taking great satisfaction in symbolically punishing his parents. This child was discharged into the care of foster parents.

Case 4.

Sometimes a picture of neglect surfaced in the play. Children were not adequately supervised.

O., a six-year-old male, and two other children were playing with gasoline when an explosion occurred, resulting in burn injury. O.

Fig. 3
Abused child drowns parents in doll house bathtub and shoots them with squirt gun.

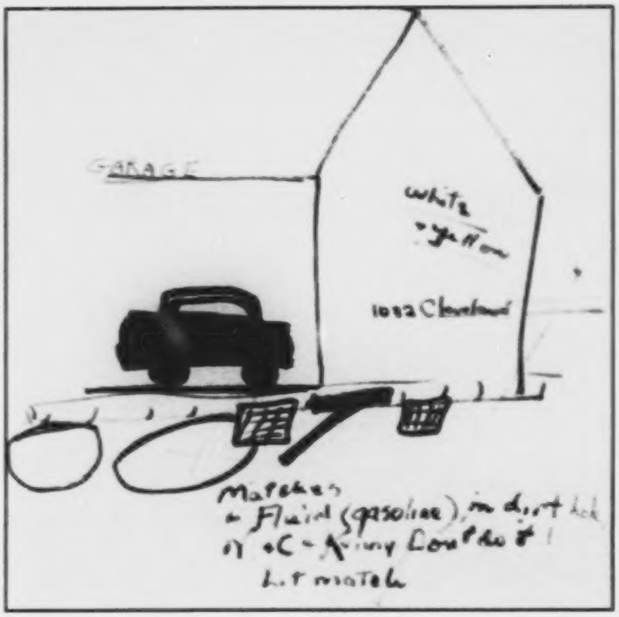


Fig. 4
Drawing: Three young boys take screen out of neighbor's garage, pick up open can of gasoline, crawl into construction tunnel and light a match.

sustained 22% total body surface area full thickness injury to face, hands and arms. His eight-year-old brother was also burned, and a third child died. O's mother was angry at the babysitter. Mother became increasingly depressed and nervous.

O.'s first drawings were all of jail bars. He was frightened and asked repeatedly in detail if the police had come out. The three boys had taken two screens out of a neighbor's garage, entered the garage, picked up an open can of gasoline, crawled into a construction tunnel, and (because it was dark) lit a match (Fig. 4).

Discharge planning included referring the family for psychotherapy, play therapy in the home, and the services of the visiting nurse.

Case 5.

An example of unsupervised play was the case of A., a ten-year-old boy who sat on a generator and sustained a 6% electrical burn injury to his right foot. A. was thrown twenty feet into the air as he was shocked by the generator.

"The psychotherapist had a specific identified goal: a cathartic re-experience of the burn injury."

In his drawing A. expressed his feelings about the accident and the impending loss of his toe (Fig. 5) saying, "I'm lucky to be alive."

Case 6.

Another case of unsupervised play and possible neglect was J., an eight-year-old male who suffered an electrical burn injury from contacting a live wire in a large tree. The patient was climbing the tree when the branch suddenly broke. He grabbed onto a power line which was conducting electricity at 7200 volts. The patient became stuck in the tree. His brother went to assist him, and both fell several feet down. J. was immediately brought to a neighbor's house. An ambulance was called, and the paramedic team started an IV at the home. They then transported J. to the Burn Center. The calculated extent of the injury was 80% of total body surface area.

The surgeon recommended waiting sufficiently to allow demarcation of the injury to the extremities to occur prior to any definitive therapy or surgery. On his thirteenth day of hospitalization, J.'s fingers (2 through 5) on his left hand were amputated to the metacarpophalangeal joints. The hospital course was fifty days. The patient underwent multiple debridement and grafting procedures.

J. lived with his mother and four siblings. He was accident prone. There was suspicion of sexual abuse of the female sibling by the father. The parents were divorced. The younger brother was also accident prone and was admitted to the Emergency Room twice during J.'s hospitalization. The family was considered at high risk.

J.'s play was age appropriate; he preferred "Star Wars" miniatures, transformers and toys of a mechanical nature. He also enjoyed dramatic play with dinosaur miniatures, and there was a tendency to always lose at checkers.

J.'s first drawing depicted the accident (Fig. 6). He told the story as he drew the picture. He said he felt

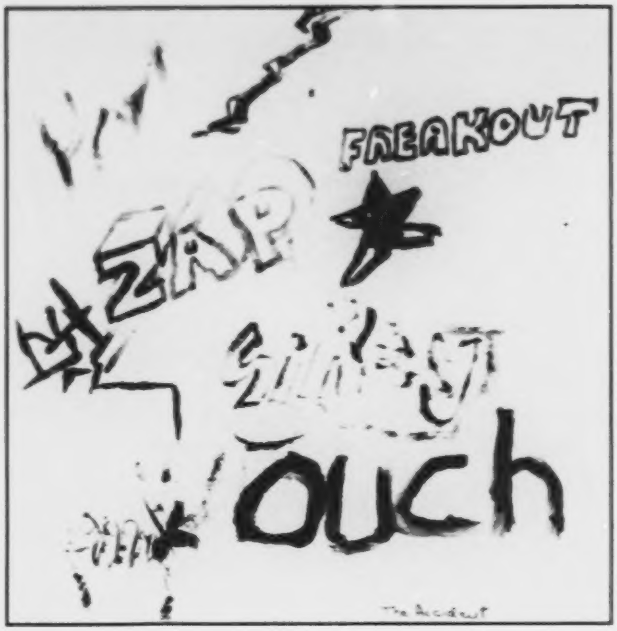


Fig. 5
Drawing: Child thrown off generator expresses his feelings.

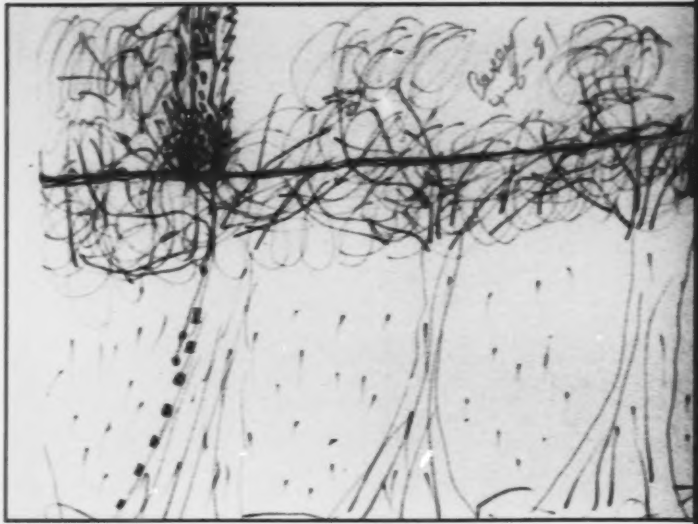


Fig. 6
Child draws his accidental fall from tree onto power line where he sustained electrical injury with 7,200 volts.

guilty about "doing such a dumb thing" and blamed the electric company for "hiding the wire in the branches of the tree."

Possibly due to the long healing period inherent in his injury, J. began to feel that he was possessed by the devil. He spoke in a raspy and frightened voice of his demon. This subject became a play theme which was explored with dramatic play techniques.

In the story-making the demon was finally destroyed after nearly taking over the child's psyche. It was destroyed in a church by a priest using holy water. The story was tape recorded and played back to J., further divesting the demon of its powers over the child. At that point the play theme ceased, as did "the voice."

On the fiftieth day J. was discharged with a referral for follow-up psychiatric care for the entire family. The discharge plan included a recommendation that the mother enroll in Parent Effectiveness Training. Home visits by the visiting nurse, the art and play therapists were scheduled.

When there was physical evidence of child abuse (*e.g.*, an immersion line or police report), corroboration often surfaced in play activity. In this way, cases of suspected abuse were sometimes confirmed as children recreated the details of their situations in the doll house, on the Surgi-Dolls, in miniature play, or with the graphic arts materials.

Frequently, the abuser became the abused in the play world. This was a safe way for the child to gain a sense of mastery and a degree of control over an untenable situation at home or school.

APT defused potentially overwhelming situations and helped the child cope with feelings about the burn injury, the hospital, and the family. Problems were examined, and solutions were explored.

Family systems were closely observed on the burn unit and in private or group counseling sessions. Interaction between parents and children was closely observed by the therapist. Some children did not trust specific adults, and seemed to prefer members of the medical staff. Many demonstrated avoidant behavior toward their parents and were calmer when the parents left the unit.

APT was made available for selected children in the home. This allowed check-ups on the children's emotional adjustment post-discharge. APT was a nonthreatening way to observe the home situation.

Summary

During a five-year period, children treated at Saint Francis Memorial Hospital's Bothin Burn Center received individual APT sessions designed to meet their special needs and to detect child abuse when present.

The play focused upon recurring play themes. Nondirective therapy

> ***"When there was physical evidence of child abuse, corroboration often surfaced in play activity."***

BEST COPY AVAILABLE

was used until the problem area was identified. Release therapy was then used in a structured play format for more focused play.

Children responded to this approach and revealed the story of the burn injury symbolically with toys and art materials, miniatures and puppets. The process confirmed that play is an imitation of life.

Often the child's affect improved in the Burn Center and became more relaxed, open and age appropriate. Children felt safe and well cared for in the hospital setting.

In a patient population of 122 children, 4.9% were cases of abuse, 19.5% were cases of suspected abuse or neglect, and 12.2% were cases of lack of supervision. The clinical observations indicated that APT was demonstrated as an effective tool for the detection and confirmation of suspected child abuse in pediatric burn patients.

Notes:
Information in this article refers to work at the Division of Plastic and Reconstructive Surgery and the Bothin Burn Center, Saint Francis Memorial Hospital, San Francisco, California.

Reprint requests to Cathy Nichol, RN, Bothin Burn Center, Saint Francis Memorial Hospital, 900 Hyde St., San Francisco, CA 94109.

Acknowledgment:
The author wishes to acknowledge the continued support of Robert Hines, M.D.; J. W. Stubblebine, M.D.; Edward Falces, M.D.; and Cathy Nichol, RN.

References

Axline, R. M. (1955). "Play therapy procedures and results." *American Journal of Orthopsychiatry*, Vol. 25: 618-626.

Axline, V. (1956). "Play interviews as described by child participants." *Journal of Consulting Psychology*, Vol. 74: 53-63. Copyright © 1950 by the American Psychological Association.

Azarnoff, P., and Flegal, S. (1975). *A pediatric play program*. Springfield, Ill.: Charles C. Thomas.

Erickson, E. H. (1963). *Childhood and Society*. N.Y.: W. W. Norton and Company.

Hambridge, G. (1955). "Structured play therapy." *American Journal of Orthopsychiatry*, Vol. 24: 601-617.

Kramer, E. (1974). *Art as therapy with children*. N.Y.: Schocken Books.

Levinson, P., and Ousterhout, D. K. (1979). "Art and play therapy with pediatric burn patients." *Journal of Burn Care and Rehabilitation*, Vol. 1: 42-46.

Plank, E. (1977). *Working with children in hospital*. Chicago: Yearbook University Press.

Robertson, J. (1975). *Young children in hospital*. London: Tawistock Publications, Ltd.

Rubin, S. (1978). *Child art therapy*. N.Y.: Van Nostrand Reinhold Company.

Schaefer, C. (1981). *Therapeutic use of child's play*. N.Y.: Jason Aronson, Inc.

Shore, M. (1967). *Red is the color of hurting*. Bethesda: National Institute of Mental Health.

State of California, Department of Social Services Bureau. (1982). Statistical Series, CPS 2, Vol. 1.

"[Following nondirective therapy to identify the problem area] release therapy was then used in a structured play format for more focused play."

Approaching Artistic Sublimation in Low-Functioning Individuals

David R. Henley, ATR is art therapist at the Katzenbach School for the Deaf, West Trenton, New Jersey, and the Jewish Guild for the Blind, New York, New York. Mr. Henley is certified as both teacher of the handicapped and as an art teacher.

The treatment of low-functioning individuals in an adaptive art therapy program was conducted using the "art as therapy" approach. Both the theoretical formulations of Edith Kramer and Viktor Lowenfeld were used to devise practical strategies that addressed the clients intellectual and emotional handicaps. Emphasis upon the pursuit of both aesthetic and therapeutic goals is illustrated in a case treatment study that involved a severely retarded client with Down's syndrome. The author's contention is that in exceptional instances, these clients are capable of approaching artistic sublimation, and deriving the quoted benefits from such a process.

Overview

It has been almost four decades since Viktor Lowenfeld first expressed his conviction that it is our therapeutic and educational responsibility to bring to fruition the full creative potential of all individuals regardless of the severity of their disabilities. The seminal chapter "Therapeutic Aspects of Art Education," that last appeared in the third edition of *Creative and Mental Growth*, (Lowenfeld, 1957) implied that we must recognize the need for making available meaningful art experiences specifically adapted for the handicapped person. Lowenfeld further asserted that the professionals working with low-functioning populations must possess an understanding of not only the disabilities under review, but also the psychological implications that arise from being subjected to a disability. The idea of a profoundly retarded or cerebral palsied child having complex psychodynamic issues addressed effectively by an art specialist is still an idea alien to many in the mental health and educational field.

Lowenfeld's remarkable insight has since paved the way for other art therapy–art education theoreticians and practitioners, particularly Edith Kramer, who is recognized as a leading exponent of integrating the skills of artist, therapist and teacher, in her work with exceptional children. Throughout Kramer's writings, there is a continued emphasis upon the inherent and evocative powers of the visual art process as a restorative measure of emotional health. Kramer's belief in the integrative properties of the art experience has laid the foundation for many other practitioners who utilize the concept of "art as therapy." (Kramer, 1977) It has been only in recent years that this approach has been seriously applied to those low-functioning clients, who had previously been relegated to kit/craft art and poured-mold ceramic workshops. It is now recognized that the retarded, autistic, or the severely multiply handicapped child is capable of creating highly unusual and provocative works of art. This artistic giftedness in many instances, seems to be inextricably tied to the very congenital conditions that comprise the individuals handicap. (Selfe, 1983) Yet to foster the expression of this special potential, the art therapist must be prepared to function as both an artist and teacher, as well as a therapist.

To guide and give creative form to this potential, one must rely upon the skills, insights and aesthetic sensitivity that we ourselves have developed as seasoned, practicing artists. Only then can we empathize with the client's frustration in the face of creative stagnation or intimidation, or share their exhilaration upon successfully giving aesthetic form to their innervision.

Art therapists structure, adapt and continually compensate for the client's disabilities. They also develop strategies and adaptive equipment that attempts to ease or surmount any orthopedic involvement or sensory impairment, thus insuring full participation and an opportunity for a successful art experience.

The art therapist promotes the therapeutic process, and relies upon an understanding of individual and group dynamics, constantly assessing emotional need and intervening according to insight and professional intuition. Ultimately, it is the quality of these therapeutic interventions that is the measure of worth of a program.

The diversity of these dual-capacities implies that there must be a shifting of emphasis in response to

---

> ***". . . the art therapist must be prepared to function as both an artist and teacher, as well as a therapist."***

---

meeting the individual need of the child. Those interventions that foster aesthetic sensitivity, cognitive problem solving or therapeutic growth, should not be viewed as conflicting nor should they be dichotomized. The therapist must strive to engage the client's intellectual, manual and imaginative faculties toward an "effort of supreme integration." (Kramer, 1971, p. 68)

The resulting art product may or may not reflect a greater degree of autonomy, or reflect the inner unity of such an integration. By encouraging the child to mobilize his or her resources, regardless of how meager, the art therapist should strive to promote and set the stage for such achievements. The initial art productions or precursor attempts will then constitute a graphic expression of the individual self: a reference point which reflects the child's sensory impressions, developmental readiness and potential for projecting ideas and concerns through the art medium. One respects these aspects of even the most developmentally arrested child and utilizes them as points of departure from which to plan strategies and formulate treatment goals that promote the growth process.

Concept of Kramer's Artistic Sublimation

Throughout the writings of Edith Kramer, there is constant reference to the concept of sublimation as an ultimate goal in art and therapy. (Kramer, 1971, pp. 67-71; 1979, pp. 75-131) Kramer has formulated the theory of drive neutralization through the process of artistic sublimation, with regard to clients whose level of functioning is relatively within the normal range. Kramer asserts that the individual must possess sufficient ego, so that a symbolic linkage is achieved between the instinctual drives and those of more complex ideation. This concept presupposes the mental capacity to evoke ideas and perceive analogies which involve both the primary and secondary processes. In accordance with this thinking, the severely retarded, autistic or multiply handicapped, low-functioning individuals would be capable of only the precursors of sublimation, since the ego is arrested at such a formative stage of development. (Kramer, 1979, p. 104)

". . . we structure, adapt and continually compensate for the client's disabilities."

One can attempt however, to expand upon Kramer's definition of sublimation by identifying instances where low-functioning individuals have successfully benefited from the struggle with intrapsychic conflict during the art process and, as Kramer's theory requires, "effected some fundamental change in the balance of inner forces." (Kramer, 1979, p. 104)

The following case history traces the artistic development of one severely retarded young man, who was treated by focusing on "art as therapy." The approach in this treatment summary reflects the author's commitment to and pursuit of both aesthetic and therapeutic goals with a client previously considered too low-functioning to benefit from either.

Despite a protracted period of artistic stagnation and resistance to change, this individual eventually expanded his limited repertoire of self-expressive avenues, and approached a form of artistic sublimation.

Case History

Robert is a young man born with Down's syndrome resulting in severe mental retardation. With an IQ of 24 and a mental age of 3.2 years, Robert had limited receptive language and very little expressive language other than several responses that communicated his most basic needs and concerns. At the time of this study, Robert resided in a large residential institution for the severe and profoundly retarded. His current placement is a residential group home that offers a more normalized and stimulating home environment.

After participating in a recreational art program for many years, Robert's level of art expression and skill development had plateaued at a rudimentary yet eccentric style. This eccentric style reflects the years of accumulated personal experiences, sensory impressions and established set of personal preferences. The resulting idiosyncracies combined with a certain giftedness in the graphic arts and contributed, in this case, to a highly evolved form of self-expression that cannot be accurately correlated to a normal child at a comparable stage of mental development.

After several months of art education/therapy, Robert's art work took a dramatic turn, developing in an expansive direction at a rapid pace. This progression was prompted by several interventions that evidently engaged and stimulated both cognitive and emotional faculties, resulting in sweeping structural changes in artistic style, affective expression and elaboration of ideas.

Art Productions

For the past six years, Robert had been leaving his lines of ink unchanged—they appeared woven in a grid format, relying upon the shape of the paper for form and support. Figure 1 illustrates a detailed look at this formula that is worked out in a highly perseverative style based upon repetition in the stereotypical sense. The artwork is virtually imprisoned in endless combinations of linear grids. The coils, spirals and

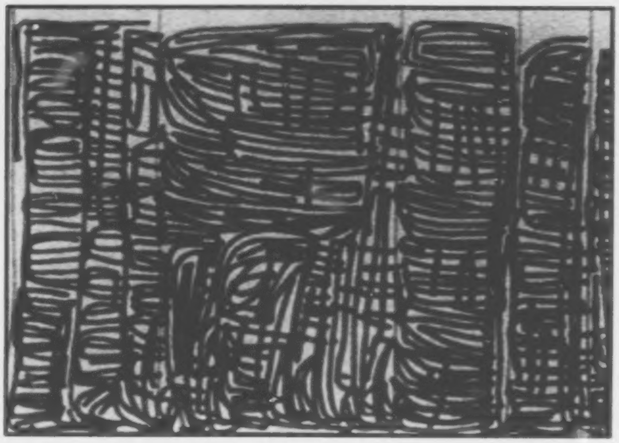


Fig. 1

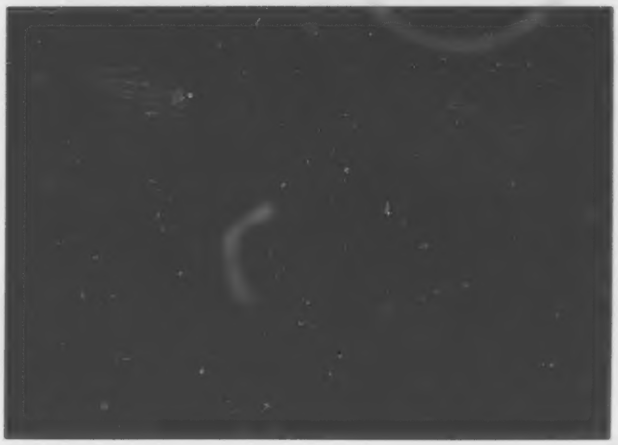


Fig. 2

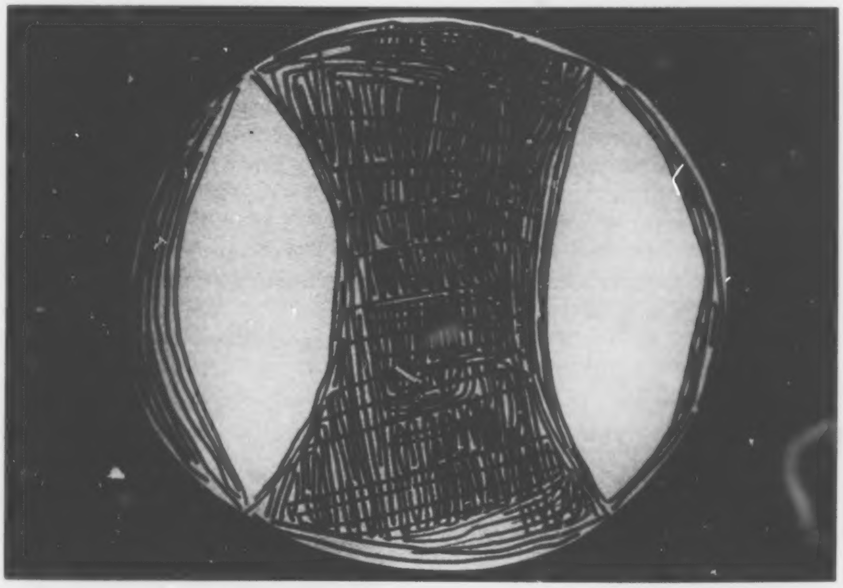
helixes that are sometimes crossected by a single or series of lines, create an interesting yet suffocating design. Figure 2 attests to this obsession of filling every crevice with tightly compressed line work. In this piece Robert had completed the drawing and then assisted in its matting. Not satisfied with the clean white mat surrounding the piece, he retrieved the picture off the wall and continued to work the mat until it too was covered with a dense black grid. Although there is overriding compulsivity in these pieces, further study reveals in especially the photographic enlargement (Figure 1) that there is a certain complexity and diversity in the line work; these gave an indication to the author that a degree of artistic potential awaited to be developed.

The intervention that aimed at fostering an initial artistic breakthrough, lay in the author's changing the shape of the standard rectangular drawing paper that Robert habitually relied upon. Knowing that Robert had a consuming interest in baseball memorabilia, the author precut an 8" white paper shape in the form of a circle and presented it as a "baseball." Robert shyly accepted this gift and then slipped it under his rectangular work already in progress. The author did not suggest or direct the use of this new shape, but gave it as a gift with no strings attached.

After a week, Robert returned to the art session with his familiar pad of grids in varying stages of completion, and again, began drawing according to his formula. At one point he seemed distracted with his current effort, eventually interrupting the piece altogether. Much to the author's amazement, Robert then retrieved the paper circle which evidently had been smuggled into the session safely buried within his stack of papers. Robert seemed somewhat embarrassed, as he contemplated this alien form. After intermittently looking around and over his shoulder, he further deliberated for a few moments, chose a blue marker, then commenced drawing his lines following the new and unfamiliar boundaries of the circle.

The resulting piece (Figure 3) represents a first departure from the endless works of repetition, toward a new variation of stylistic change. While the composition is still highly dependent upon the periphery for support, it has not dictated its content. Whereas in the previous productions there was an intense need to fill the entire pictorial space, there are now two bold white forms or

Fig. 3



". . . we rely upon our understanding of individual and group dynamics, constantly assessing emotional need and intervening according to our insight and professional intuition."

voids, which symmetrically offset the involved interplay of the central line work. While there is still a sense of tension and compression, there is also a respite from the habitual rigidity toward increasing resilience and elasticity. There is now a balanced integration created by the intense core and the cushioning white forms, giving the piece a heightened sense of compositional awareness. There is a new affective element in evidence (as the addition of red color had been deeply positioned within the central core). Robert's previous pieces were predominantly monochromatic, with color used on occasion in a fragmentary and arbitrary way. Color in this drawing may have been manipulated consciously as an element of design, imparting the suggestion of new emotional content to the self-expression. The choice and positioning of color is possibly reflective of the affective stirrings over the internal struggles and changes beginning to take place. The two white forms tend to insulate the inner "fire red," which seems to be actively spreading within the piece.

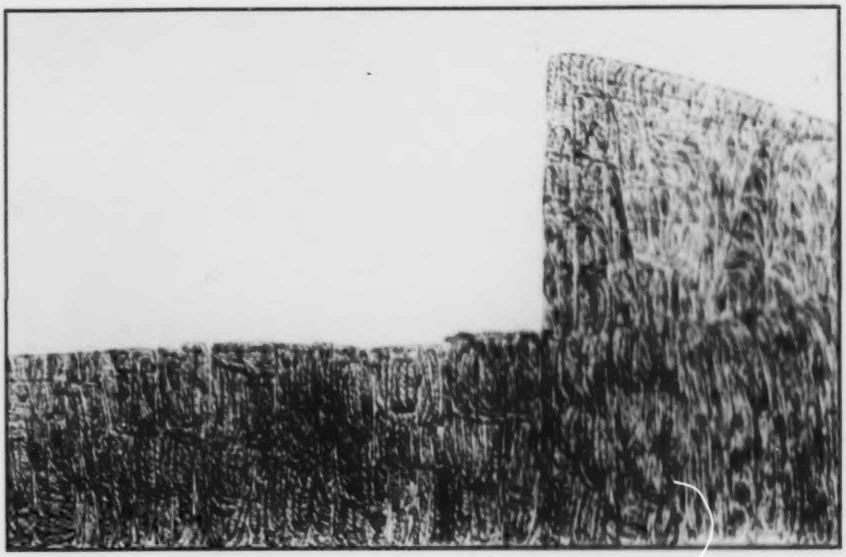


Fig. 4

In the follow-up sessions, Robert was presented with a choice between another precut circle, a square and several sizes of rectangular white drawing paper. He chose the all-familiar rectangle and black ball-point pen, then reverted back to the usual style of weaving countless lines into a mass. The author did not intervene or attempt to prevent this apparent regression. Under the therapist's supervision, Robert was allowed to retreat, to effectively mobilize his defenses and withdraw to a more tenable position. By supporting and accommodating this apparent regression, Robert was afforded a pressure-free atmosphere that allowed him to digest the formidable risks he had taken in the previous piece. The unparalleled intensity and fineness of the linework in this new piece, seemed to graphically portray an attempt to sew and bind up any errant loose ends that threatened to unravel, and thus leave him exposed or vulnerable.

As this drawing evolved however, it became clear that this piece was yet another interesting departure from the norm. The expectation was that Robert would defer further experimentation in favor of reverting back to the security of his static style of compulsivity. This presumption proved wrong as Robert had finally given form to the linework by creating a horizon line which partitions the piece bi-laterally. (Figure 4) The lower half appears as a tightly threaded landmass, which almost shimmers in its intensity. In direct contrast, is the untouched whiteness which is suggestive of an atmosphere. The white expanse seems to offer an insulating, buffering respite from the compulsivity of the grid. The horizon forms a solidly grounded profile which is boldly designed with a strong sense of scale and composition. The profile, read from left to right, presents a straight line which is really composed of many segmented sections, running horizontally until it encounters a sheer cliff face, ascends vertically, reaches a gently curved peak, then descends off the paper. This landscape makes use of several unusual grades and directions, creating a

"After participating [in recreational art] for many years, Robert's level of art expression and skill development had plateaued at a rudimentary yet eccentric style."

fairly sophisticated interplay of positive/negative form, movement, rhythm and contrast. While there is still overriding compulsivity in this place, it has been given a more expansive form that imparts a degree of increasing resilience and strength.

In the author's view, there is an air of victory in this piece; the peak seems to stand in silent repose, restful and almost contemplative after its waging of inner struggle. The previous period of stagnation, the lack of experimentation and weakened boundaries have all been symbolically expressed in a powerful work of graphic art.

After creating this culminating piece, Robert's art work alternated between weaving more lines and leaving open space, allowing for more dynamic use of the pictorial field. Among the significant later works, were a number of fully threaded pictures which seemed to be evolving in an equally static and compulsive style as the very first drawings. The author felt inclined to intervene more forcefully in these instances, by asking Robert if he may draw a line on the work in progress. Robert nodded in agreement, allowing the author to draw a diagonal line stretching from corner to corner, in contrast to the strictly square format underway. The rationale for this intervention, was to foster a continuation of improvisational technique and discourage further lapsing into perseveration and stagnation. The author was confident that Robert could withstand such a transgression and possibly make creative use of its concept. Robert did indeed profit from this diagonal, by utilizing its structure from which to experiment with new combinations and patterns of linework.

In the following session, Robert displayed further influence from this intervention, as he independently began with two purple diagonals which formed opposing triangles. (Figure 5) He then turned to a green marker and blocked in the supportive structure around these newly emerged forms. This piece is additionally striking in that the entire form floats independent of the borders of the paper. This represented yet another breakthrough for this client, who for years had sought the protection of the paper's perimeter. The contrast in color again invests the piece with affective sensitivity, thus highlighting the newly emphasized dynamic treatment of form.

The last work in this series illustrates a further relaxation of defenses and continued graphic experimentation. Six weeks after working the original precut circle, Robert chose (for the first time) the circle shape from among his preferred rectangles and squares.

He began this piece (Figure 6) by drawing in pen, two elliptical forms that are situated bilaterally and indirectly utilize the form of the paper for support. After arranging these elements, Robert unexpectedly resisted the compulsion to continue in his linear mode, instead choosing oil crayon to block in the color. The red which had previously been placed in the interior of the first composition, has now migrated and surfaced to the outer borders. Replacing the fierylike core are several soft gradations of blue which are in turn, encased in a jacket of cool grey. While this piece does not rival Figure 4 for aesthetic strength and emotional intensity, it does reflect an important step in therapeutic progress.

Discussion

In treating cases where there is severe cognitive and developmental arrest, the clinician must often address the client's limited modes of expression that habitually rely upon primitive mechanisms of defense.

Perseveration is a pervasive form of defense for the retarded person, rooted in the early rocking movements during infancy, then carried on indefinitely as a self-stimulatory mannerism into adulthood. These self-stimulatory movements (i.e., rocking, hand flashing, head weaving, teeth grinding) serve an adaptive function especially for the institutionalized person who is retarded, by dispelling the buildup of libidinal and aggressive energy.

Fig. 5

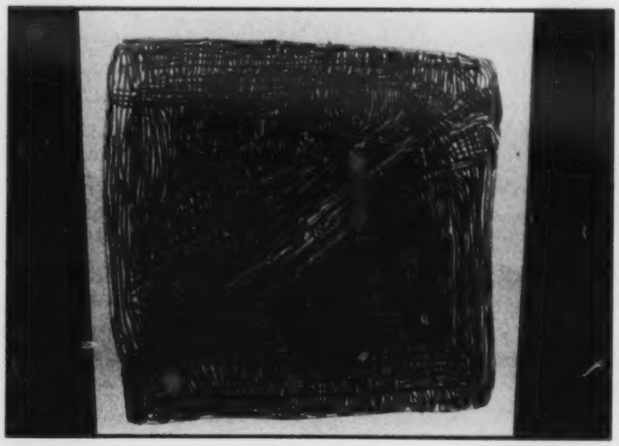
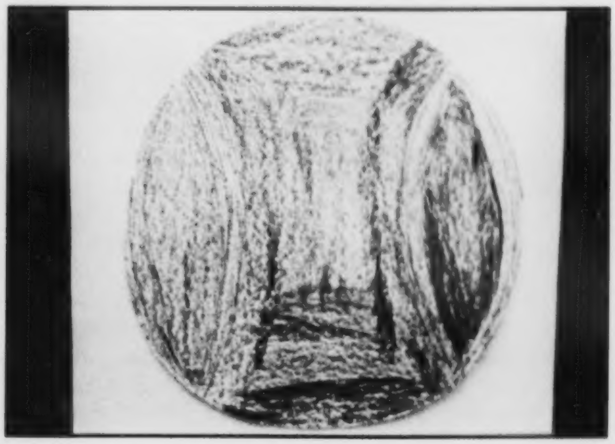


Fig. 6



This discharge is considerably more benign and pleasurable than the more aberrant self-stimulatory behaviors (i.e., head-banging, pica, rumination). The static qualities of self-stimulation can be traced to a sensorially deprived environment, where normalized modes of expression and nurturing and interactive role models are not available. This creates a bind, where the retarded individual is left to his own limited resources to express feelings such as frustration, anxiety and anger.

It is this varied form of rhythmic motion which is repeatedly exercised and translated in graphic terms, throughout this client's many art productions. One suspects that the compulsivity evident in these delicate grids, spun with equal care and precision, reflects the need for the same unyielding repetition present in his institutional lifestyle. On the few occasions that Robert's daily activity schedule was interrupted or changed, the author observed an increase in agitated and sometimes tantrum behavior. This observation then raises the question as to whether Robert's reconvening the motif over the course of many years, contributed to the preservation of autonomy, by binding the anxiety that resulted from any threatening irregularity. The rigidity of both his lifestyle and art style additionally posed the question as to where to initially intervene with respect to the client's evidently fragile defenses. The immediate goals were to develop a sufficient bond of therapist/client trust; this allowed for the cautious loosening of rigid defenses, leading toward the expansion of the graphic vocabulary, with the aesthetic progress being ideally reflected in the client's overall functioning.

To help accomplish this goal, the author referred to Kramer's concept of "auxiliary ego." (Kramer, 1971) This concept is the use of the art therapist's own autonomy as a support system that facilitates the client's art expression and emotional growth. As facilitators, we rely upon our own maturity as artists and on our psychotherapeutic skills to guide and instruct—especially the low-functioning client—through the art process. One can set the stage for this process by creating a stimulating yet secure environment, by clearly demonstrating the art techniques and by encouraging experimentation with the medium in anyway that is appropriate and pleasurable. It may be additionally useful for the art therapist to participate in the art making, so long as this does not work in opposition to the therapeutic goals, and does not intimidate or infringe upon the client's work time. Parallel drawing or painting may assist in easing the client's anxiety over having to "draw on command" or be a reluctant center of attention particularly if it is an individual session. Having the art therapist engaged in the art process may also create a studio atmosphere, where everyone has mobilized his or her creative energies and is taking stimulation and inspiration from others in the art room. As previously stated, low-functioning clients who are institutionalized, and are often without intact families or friends, are often in dire need of individuals who serve in this context—as normal behaving, productive and creatively functioning role models. As our sense of values and commitment to the visual arts are communicated, we encourage the client to identify and emulate us as practicing artists. As the art process becomes more familiar, as technical and aesthetic problems begin to be addressed, the client may eventually develop a highly individual style of artwork. At this point the art therapist may decide to empathically comment upon the artwork in a manner similar to a studio critic. Without becoming overly abstract or ethereal, the art therapist can point out strengths, interesting elements and emerging directions that can be comprehended in some capacity by the client/artist who has reached this level of sophistication. In this way one creates a sense of camaraderie and parity, accepting the client efforts as work that is worthy of serious study and appreciation.

"In treating cases where there is severe cognitive and developmental arrest, the clinician must often address the client's limited modes of expression that habitually rely upon primitive mechanisms of defense."

Before achieving such long term objectives for low-functioning art therapy clients, the art therapist must stand ready to accept protracted periods of resistance, stagnation or regression. The rate and nature of the creative growth sometimes occur in the smallest of increments. Every effort must be made to preserve a relaxed atmosphere in which the art process can unfold without regard to overly rigid preset expectation. The especially fragile, rigid defenses employed by low-functioning clients make them especially liable to withdraw or act out if threatened. As art therapists, it is important to aid in the reducing of this threat by intervening cautiously, intuiting when to exhort the

"It may be . . . useful for the art therapist to participate in the art making, so long as this does not intimidate or infringe upon the client's work time."

client to extend himself/herself, or when to allow the client a respite from this potentially anxiety provoking process.

With the establishing of these therapeutic prerequisites, we may then begin to structure the art experience so as to encourage the development of more adaptive defenses and the taking of more creative risks. With the lessening of client resistance may come the advent of artistic exploration and the opportunity to release previously repressed affect. Despite the incapacity of low-functioning clients to depict this material in realistic representational terms, they can nonetheless make potential use of this liberated energy. (Naumburg, 1966) Since the majority of these clients have poor expressive language, they may better articulate their concerns through the non-verbal means of graphic expression. However, as shown in the illustrated case study, and in innumerable other clinical instances, this phenomenon can also precipitate regression in varying degrees of severity. Yet regression can be viewed as being a vital element for the mobilization of creative energies (Kramer, 1978; Kris, 1952). Kramer points out that, for this process to be beneficial rather than destructive, the activation of primary process material must occur only when the ego can resist the pull toward permanent regression. If the client is unable to withstand such pressures, a pathological regression can ensue, thus hindering any previous maturational gains.

The regression undergone in the presented case study may be that rare instance when a low-functioning client successfully regressed in the "service of the ego," (Kramer, 1978; Kris, 1952) thus allowing for new insights to emerge and the opportunity for artistic sublimation to possibly occur. Inherent within this progression and temporary regression was a subtle yet clearly discernable upward spiraling movement. Although the client carried the graphic repetitions through to each piece, they were developed in an expansive direction. However, Kramer has regarded repetitions such as these as simply pleasureful and benign exercises that do not signify the presence of intrapsychic conflict. Kramer has viewed the dynamics of this change as a relinguishing of one fixation for a more variegated one, with little benefit to ego maturation. Thus, it is the lack of perceptible reconciliation with the inner turmoil which prohibits Kramer from designating the process (such as in the case of Robert) as true artistic sublimation.

It is certainly impossible to prove whether Robert actually bound and discharged his anxieties by recreating countless grid drawings. It is also conjective to say that he consciously confronted his pain and then took pleasure in mastering such feelings through his art. Yet the dramatic evolution of these art productions attests to the increase in creative energies as well as a shift toward greater aesthetic diversity. Regardless of whether Robert actually attained a form of sublimation, each work constituted a new beginning that enhanced this client's previously limited powers of creative self-expression.

Summary

The use of anecdotal case history material that essentially describes a particularly intriguing client, is by its very nature, a limited vehicle for sophisticated study. Without the systematic collection of data from a large and representative sampling of clients with similar deficits, we cannot begin to measure the full creative potential of this population. This account may be instructive however, since it describes in detail the course of a highly idiosyncratic art process and how such dynamics are affected by the therapists interventions. The low functioning client may never be able to verbalize his or her intentions, express his or her reactions or realistically depict ideas or concerns through the art imagery. The art therapist must then adjust interventions using the subtleties of body movement, gesture, patterns of behavior or forms of self-stimulation to discern the appropriate point of departure from which to begin treatment.

References

Kramer, E. (1977). *Art therapy in a childrens community.* N.Y.: Shocken Books.

Kramer, E. (1971). *Art as therapy with children.* N.Y.: Shocken Books.

Kramer, E. (1979). *Childhood and art therapy.* N.Y.: Shocken Books.

Kris, E. (1955). "Neutralization and sublimation." *The psychoanalytic study of the child,* 10; 30-46.

Lowenfeld, V. (1957). *Creative and mental growth.* N.Y.: MacMillan.

Naumburg, M. (1966). *Dynamically oriented art therapy: Its principles and practice.* N.Y. and London: Grune and Stratton.

Selfe, L. (1983). *Normal and anamalous representational drawing ability in children.* London: Academic Press.

Fusion of Symbols, Confusion of Boundaries: Percept Contamination in the Art Work of Alzheimer's Disease Patients

Judith Wald, MS, ATR, the Burke Rehabilitation Center, White Plains, New York.

Art work consisting of fused images and hybrid organisms is representational of the perceptual, conceptual, and psychological confusion resulting from Alzheimer's disease. As this dementing illness progresses to an advanced stage, boundaries become confused and visual symbols merge to form bizarre amalgamations. As the patient regresses in psychological defense against the neuroperceptual breakdown, unconscious aspects often surface in the drawings. These phenomena are researched in terms of neurological theories of memory and perception, interrelated with Rorschach psychology, Freudian psychology, and the ego psychology of Spitz and Jacobson.

The emotional regression as viewed through art productions parallels the physiological regression in the Alzheimer patient.

Introduction

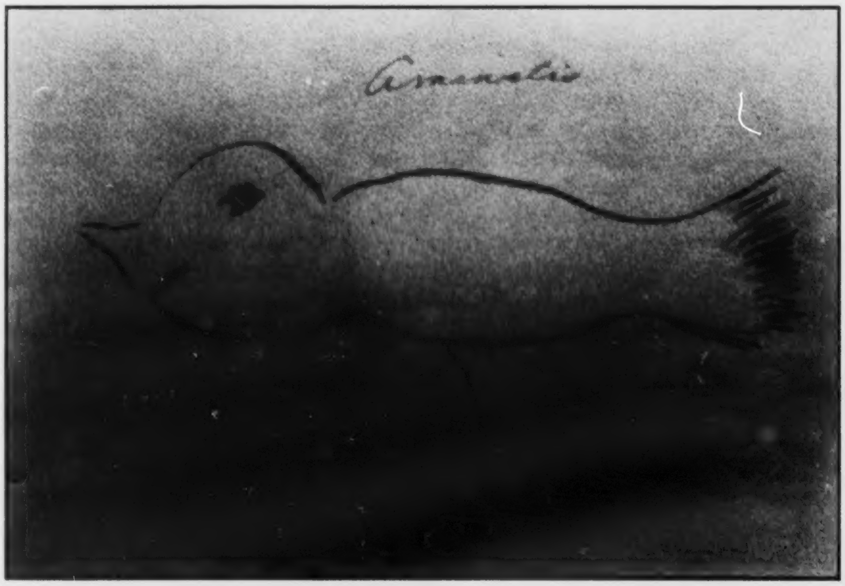
A bird with a feminine eye, skirt, legs, and shoes, entitled "aminalis" (Figure 1). A house with a mouth, chin, and arms (Figure 2). A face within a face (Figure 3).

Neologisms? Graphic flights of fantasy evoking half-humans, half-animals of mythical origin, like the centaur and the mermaid? Pictorial personifications? No, these are not Chagall-like dreams of childhood memories merged with the mundane, nor are they Picasso-like attempts to evolve new visual concepts through artistic creativity. They are, in fact, reflections of the perceptual, conceptual, and psychological confusion resulting from Alzheimer's disease. This art work was done by patients in an advanced stage of this dementing illness.

As an art therapist working with these patients when they were higher functioning, I have seen them make more coherent art work. Originally, each of these patients drew, when given a free-subject choice, what I would call "personal symbols." Their visual vocabulary had some personal significance to them. Patient A drew houses, people, and a flower or tree with round blossoms (Figure 4). Patient B drew people, cats, flowers, and curlicue lines. Patient C drew triangular trees, houses, circles, stripes, and wrote "Merry Christmas" and "Happy New Year" (Figure 5). Patient D drew people, houses, animals, and wavy lines. As their disease progressed, these symbols merged to form bizarre amalgamations.

These striking fused and confused images are "mirrors to the mind" (The Chronicle, 1984, p. 7) of the Alzheimer's disease patient. What do they tell us about the perceptual, neurological breakdown occurring in the brain? What do they tell us about their psychological regression? How are the physical and emotional declines interrelated? Does the emotional regression, viewed through art productions, parallel the physiological regression? Like a pathologist studies disease through microscopic examination of pathological tissue, the art therapist can examine conscious and unconscious personality structure through art work. These questions are explored within this article.

Fig. 1



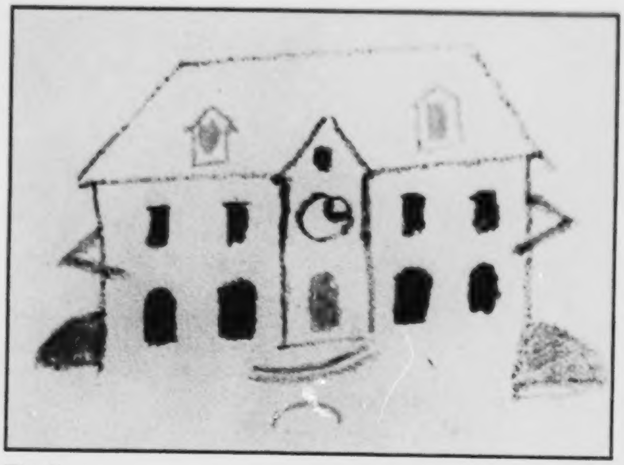


Fig. 2

Fig. 3

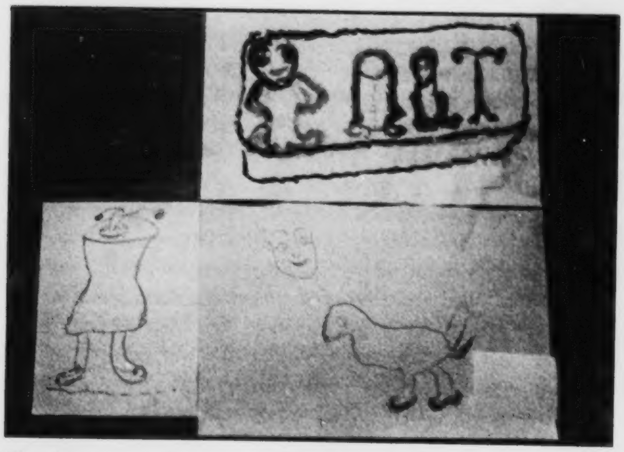


Fig. 4

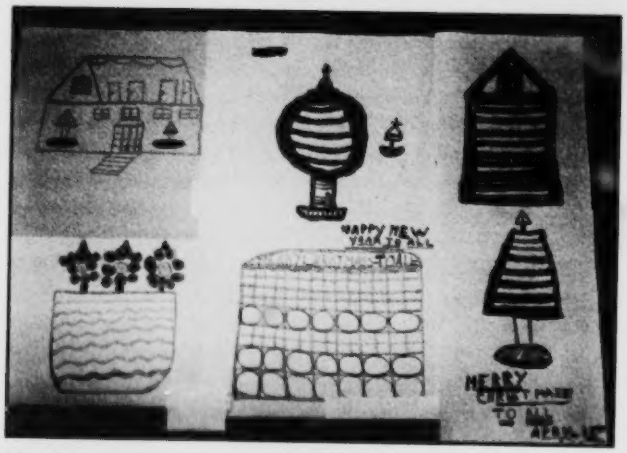


Fig. 5

Neurologic and Perceptual Aspects of Alzheimer's Disease

Alzheimer's disease is a neuropathological organic brain disease, characterized clinically by memory loss, perceptual confusion, intellectual deterioration, and pathologically by specific patterns of specific lesions. Unable to learn new material, unable to organize old concepts, the patient progressively degenerates to a helpless condition. Some patients develop delusions, personality disorders, and hallucinations. Motor deficiencies may occur at a later stage.

These symptoms of Alzheimer's disease are expressed graphically and described verbally in art therapy sessions. Characteristics of their art work range from regression, perseveration, simplification, fragmentation, disorganization, distortions, to perceptual rotation, overlapping configurations, confused perspective, and incomprehensible work (Wald, 1983). In order to better understand the misperceptions evident in patients' art work, focus should be given to the loss of memory and perceptual confusion that is so central to the Alzheimer patient.

Memory and perception are closely related, for one must perceive before one can remember. Perception is "a mental representation of an object, while the memory image is a mental representation of a perception" (Hall, 1954, pp. 24-25). Psychologists and neurologists describe perception as cognitive processes involving the sensory system, the motor system, the perceptual system, and the memory system. Sensory stimuli send messages through neural pathways to the principle organ of the nervous system, the brain, which in turn processes and acts upon nerve signals. Since our perception of reality is based primarily on our interpretation of the information our senses provide, any deficiency or distortion in the sensory mechanism or any change in the perceptual apparatus can cause us to experience a distorted reality (Wolanin, 1981). Some theories of memory describe three types of neu-

BEST COPY AVAILABLE

rons: the afferent, or sensory neurons; the efferent, or motor cells; and the internunciatory, or associative cells. Memory seems to rely on billions of the associative cells (Halacy, 1970). Researchers report evidence of changes in the neuron structure and the connections between them (the synapses) as the basis of learning and memory. Neurotransmitters carry messages from the axon of one neuron to the dendrite of the next neuron—researchers note an increase in the number of synapses in the dendrite shafts and a swelling of the heads of the dendrite spine as memory is stored (Bloom, Lazerson, & Hofstadter, 1985). Theorizing that memory is the actual growth of new connections between neurons, memory loss with age can be understood as stemming from degeneration of these connections (Halacy, 1970). The pathophysiology of Alzheimer's disease includes neurotransmitter loss and imbalance, notably of the forebrain cholinergic system. Neurofibrillary tangles, granulovascular plaques, and cortical atrophy characterize the Alzheimer brain upon autopsy.

Fused Images

Having reviewed the perceptual, neurological deterioration of Alzheimer's disease, let us return to the "fused images" initially described in patients' art works. This occurrence, that I have encountered in about 5% of my patients, is a phenomenon similar to Freud's concept of "condensation" in his theory of dreams and what Rorschach defined as "contamination"—the illogical combination of two or more ideas (Meili-Dworetzki, 1956). Rorschach psychologists further define contamination as "two incompatible percepts combined into one without the perceiver being aware of their incompatibility" (Alcock, 1963, p. 165). This mode of perception is even rare in the response of psychotic patients, and occurs more often with chronic or deteriorated paranoids, in schizoid children, schizophrenic adults, and adults with organic brain syndromes.

"Like a pathologist studies disease through microscopic examination of pathological tissue, the art therapist can examine conscious and unconscious personality structure through art work."

What do these fused images tell us about the psychological regression of these Alzheimer's disease patients? Have they become psychotic? Rorschach literature describes the similarities and differences between the psychotic and the adult organic, and notes that mixed conditions can occur:

> The psychotic shows little or no concern for the "goodness of fit" between his percept and the reality. He is quick to distort reality to suit his inner needs . . . and may be quite bland about the gross bizarreness of his response. The adult organic by contrast reveals an impairment in perception of which he may be painfully aware but unable to effect a change. . . . The adult organic will generally indicate some effort at reality testing and some discontent or uneasiness about his responses. . . . The adult organic also tends to be quite concrete and suffers in the capacity to use abstractions. By contrast, the psychotic may or may not show impairment in ability to abstract (DeCato & Piotrowki, 1977, pp. 14-15).

Klopfer and Spiegelman also differentiate that "the organically-impaired subject is genuinely confused; the schizophrenic patient only appears confused—he is just 'not there.' The organic psychotic, however, tends to show both kinds of confusion and often resolves his difficulty by responding with whatever pops into his head, regardless of stimulus" (1956, p. 287).

Of the four Alzheimer patients whose fused images revealed percept contamination, two showed other definite signs of psychosis in their art work. Both Patient B and Patient D drew x-ray-vision bodies, that is, drew the skeletal structure within a body, simultaneously portraying the internal and the external. Patient A and Patient B both manifested paranoid tendencies: Patient A drew people's eyes looking suspiciously to one side (Figure 6); Patient B drew multiple eyes and monsters (Figure 7).[1] Patient C expressed a complex delusional system in an attempt to cover up incongruities with confabulations and a proper social facade. Four other patients with psychotic ideations did not draw such overt fused images, but their verbal descriptions of their art productions—descriptions of snakes in a face, bizarre stories—revealed percept contamination. This artistic fusion of personal symbols or the bizarre verbal descriptions of their art work therefore alerts one to the possibility of psychosis. In another sense, it points to a perceptual problem manifesting itself in what could be called "boundary confusion."

Boundary Confusion

Boundary confusion is evident in various ways in the Alzheimer patient's art work. Figure collisions is an example. Some patients draw off the edge of their paper, on another's drawing, onto the table cloth, even onto the vertical flap of the table cloth. Other patients use their neighbor's paintbox, or paint their own paintbox rather than the paper. Perceptual confusion of boundaries also occurs in the perseverative drawing of a person within a person: a face within a body (Figure 8), a face with-

---

[1] Patient B was described extensively by the author, Judith Wald (1984), in "The graphic representation of regression in an Alzheimer's disease patient," *The Arts in Psychotherapy*, Vol. II, pp. 165-175.

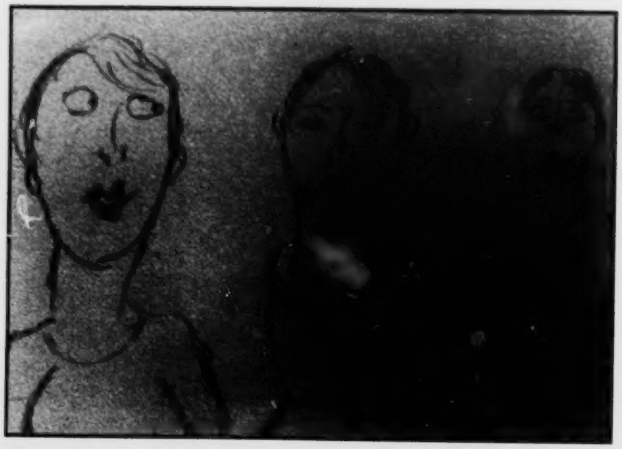


Fig. 6

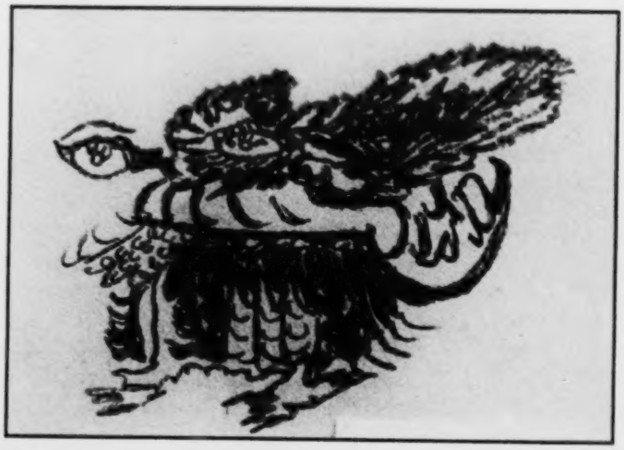


Fig. 7

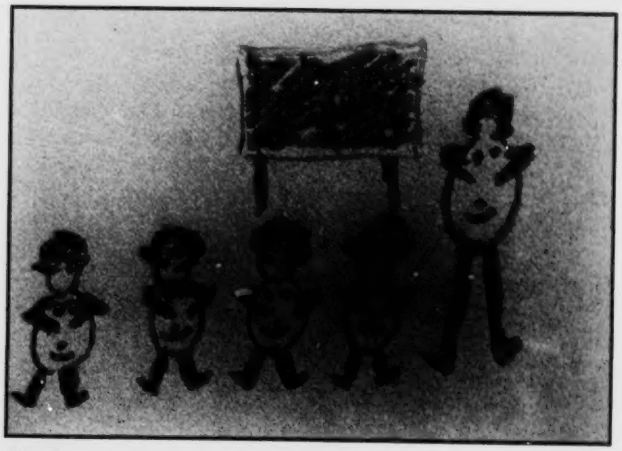


Fig. 8

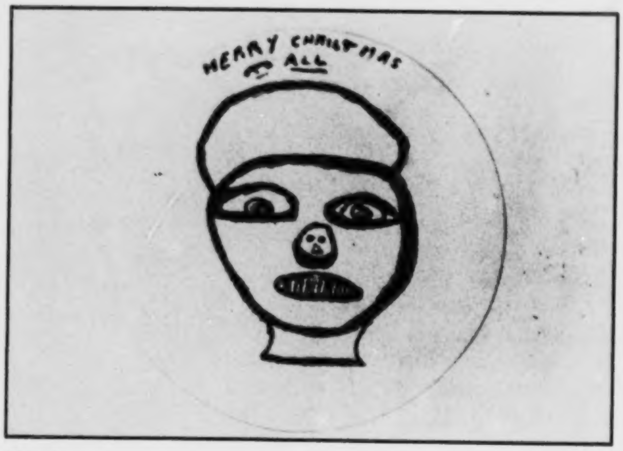


Fig. 9

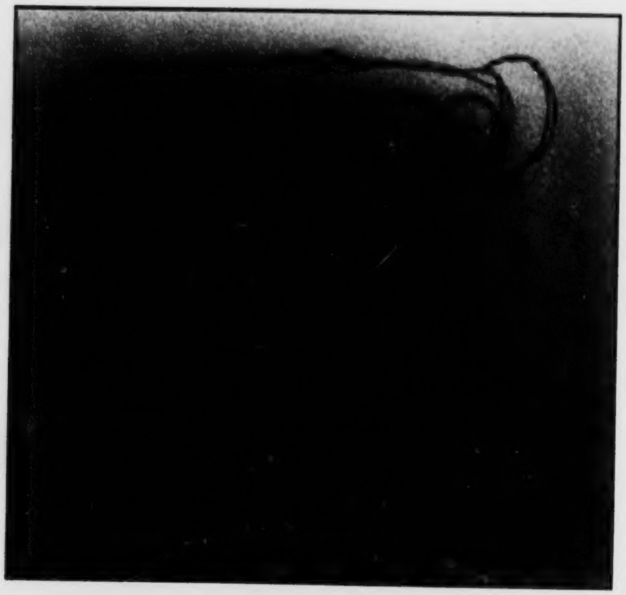


Fig. 10

in a face (Figure 3), a face within an eye or nose (Figure 9, 10). For example, the patient seems to view the circle he drew for the eye as the outline for another face, which he proceeds to draw in turn within its boundaries; Patients B, C, and D, as well as five other patients, manifested this interesting phenomenon. Patient A would focus on one part, such as a shoe, rather than on the whole entity. Loss of boundaries is seen in drawing facial parts without a circle to enclose them. Logical parts (an arm, an ear, legs) are omitted, repeated, or misplaced on people, animals, and inanimate objects (Figure 11, 12). Behaviorally, boundary confusion is displayed by a patient taking food from his neighbor's plate, following another around,

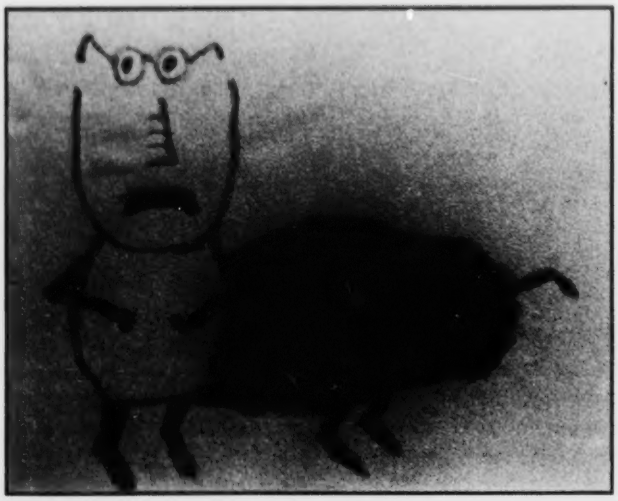


Fig. 11

Fig. 12

mistaking another's pocketbook or coat for his own.

Unconscious Processes

A face within an eye draws one visually, symbolically, and psychologically deeper into the unconscious. Delving further into the study of the unconscious processes revealed in these patients' art work brings one to descriptions of condensation, contamination, interpenetration, and fusions as primary process manifestations (Holt, 1977). In terms of Freudian psychology, this art work mirrors the primary process mode of thinking to which these patients have regressed. Primary process thinking originates from the id portion of the personality. In its earliest form, the id is a reflex apparatus that discharges sensory excitations through motor pathways, releasing tension by impulsive motor activity and image formation. Primary process develops in the id as a result of frustration in an attempt:

> to discharge tension by establishing what Freud called "an identity of perception" [i.e.] . . . the id considers the memory image to be identical with the perception itself. For the id, the memory of food [for example] is exactly the same as having the food itself. The id fails to distinguish between a subjective memory image and an objective perception of the real object (Hall, 1954, p. 25).

Indeed, these patients have largely regressed to id-level functioning, acting impulsively, irrationally, and asocially. Secondary process, that is, problem solving and realistic thinking, the main function of the ego, is defective in the Alzheimer patient.

The fusion of subjective memory image and objective perception of the real object is described in psychoanalytic literature by the ego psychologists in the early stages of personality development preceding ego formation in the young infant. The ego psychologists, in particular Hartman, Spitz, Jacobson, Blanck and Blanck, describe an "undifferentiated matrix" before birth containing potential ego, id, drive, affect, psyche, and soma (Blanck & Blanck, 1979). Development is viewed as interrelated, proceeding through numerous grades of differentiation and organization:

> Before differentiation, the human infant is a psycho-physiological organism. Soon after birth, . . . differentiation begins. Still living "in the body," the child also lives in the immediacy of the interaction in the dyadic experience as self and object images remain merged. The separation-individuation process whereby major aspects of psychic structuring take place, coincides with the gradual sorting out of self from object images and of gradual selective identification, the process by which attributes of the object become transformed into parts of the self-images (Blanck & Blanck, 1979, p. 73).

According to Mahler, the differentiation of the self-images from object images is vital to the process of ego organization (in Blanck & Blanck, 1979).

Similarly, Spitz defines the establishment of the rudimentary ego and the structuring of perception by the three-month old infants "smiling response to a percept with Gestalt attributes" (1959, p. 16). In Freudian terms, it establishes that something that is present in the ego as an image can also be perceived in reality. According to Spitz, at this milestone of development, the infant has progressed from the primary narcissistic stage of non-differentiation, turning from inner sensation to outer perception. As memory traces are laid down and become available, reality testing can begin, directed object relations originate and can be observed. Psychoanalytically, the psychic apparatus divides into conscious and unconscious parts and

". . . artistic fusion of personal symbols or the bizarre verbal descriptions of their art work therefore alerts one to the possibility of psychosis."

the differentiation of an ego and an id establish a psychic structure and the first example of the functioning of thought processes.

Having defined the first organizer of the psyche as the appearance of the smiling response, Spitz describes the second organizer of the psyche occurring during eighth-month anxiety, when the infant is able to distinguish familiar persons from unfamiliar ones. The third organizer occurs after 18 months of age with the acquisition of speech, marking the inception of complex mental operations.

The recognition of a facial Gestalt, the ability to differentiate between different facial Gestalts, and the acquisition of language point to markation of boundaries—psychological, physical, and perceptual boundaries between the self and object representations. The late stage Alzheimer patient can no longer recognize loved ones, nor differentiate between different people, nor make a coherent sentence. When structuralization and self-identity break down due to organic brain disease or psychosis, the psychological apparatus reacts with the defense of regression to protect itself; "considering the nature of developmental processes and their profound dependency upon the process of separation-individuation, it is little wonder that the human being is prone to regress to the 'safety' of oneness" (Blanck & Blanck, 1979, p. 145).

Pathological indications in art work, seen in confusion, merging, and loss of boundaries, reflect the malformation occurring in the organizing process, which is a main function of the ego. The Alzheimer patient's personal visual symbols merge in a similar way that a child's first object images and perceptions of different objects merge into varying image composites. According to Jacobson, "at the first, our image of the self is, like the primitive object image, not a firm unit. Emerging from sensations hardly distinguishable from perceptions of the gratifying part object, it is fused and confused at first with the object images which reflect mainly the incessant fluctuations of the primitive mental state" (1973, p. 20).

The capacity for perception, discrimination, and evaluation, all which are malfunctioning in the Alzheimer patient, are necessary for a clear self-image and object images. The first primitive type of identification in the infant is "achieved by refusion of self and object images, . . . accompanied by a temporary weakening of perceptive functions, and hence a return from the level of beginning ego formation to an earlier, less differentiated state" (Jacobson, 1973, p. 40). At this time, object relations and self-identity return to the earliest wishful fantasies of merging and being one with the mother. Therefore, as the infant fantasizes of fusion with his love object (mother), borrowing from the mother's ego for his own need fulfillments, the demented or psychotic adult is compelled to lean heavily on his caretaker's ego for need gratification, support, or control. Regressed Alzheimer patients frequently ask for their mothers, who they say is waiting at home for them. In art therapy, the patient looks to the therapist as his/her ego organizer, asking for directions, compliments, encouragement, and validation. As patients deteriorate, they characteristically copy another patient's drawing; they may borrow the other's name, go over another's line in a group picture, or fuse images.

Jacobson further expounds that:

> the processes of aging and physical decline . . . might involve a decrease in the cathexes of the periphery, of perceptive and motor functions, resulting in a rise of the cathexis of the body organs, with concomitant regressive drive defusion to the point of prevalence of destructive drive energy, which must again be discharged through physiological channels in the body (1973, p. 17).

With progressive organic changes leading to deterioration occurring at all levels—physical, perceptual, intellectual, psychological—particularly with a psychotic component, the patient regresses to this early primary process stage. Caretakers often acknowledge that they best manage to deal with their regressed spouse or parent by regarding him or her as a helpless child.

Conclusion

The bizarre fused images and the hybrid organisms created by some Alzheimer patients in their art work led this author to an inquiry of their deeper meanings. Similar phenomena were defined by Freud as condensation in dreams and by Rorschach as percept contamination. The neuro-perceptual pathology of Alzheimer's disease can be related to theories of memory and perception. A clear perception requires intact memory, perceptual, sensory, and

"The Alzheimer patient's personal visual symbols merge in a similar way that a child's first object images and perceptions of different objects merge into varying image composites."

motor systems and their healthy interrelationships. As the patients described in this article, regressed in psychological defense against the neuro-perceptual breakdown, unconscious aspects surfaced in their drawings. Comparing the psychotic and the organic patient indicated that fused visual images can signal a psychotic component in the Alzheimer patient.

The patients appeared to be reacting on a primary process, id-directed level. The fusion of self and object images, and other manifestations of boundary confusion, can be regarded as problems in the separation-individuation process. Ego psychologists described the fusion of memory image and objective perception in early stages of personality development preceding ego formation in the young infant; a reverse comparison can be made between the merging self and object images in the young child and the regressed, late stage Alzheimer patient. Indeed, Spitz's schema of psychological and perceptual formation leading to ego formation, which is dependent upon the ability to distinguish one percept from another (i.e., at seeing a boundary between self and object images), also helps to clarify this process. Defects in a patient's art work, seen in confusion, merging, and loss of boundaries can be viewed in terms of malfunctioning of the organizing process of the ego. The patient regresses, needing to fuse once again self and object images. The patient remerges with mother or caretaker, who can take over the patient's ego's failing ability to organize and coordinate sensory, instinctual, and emotional experiences with ideational process, perceptive, and executive functions. The emotional regression as viewed through art productions parallels the physiological regression in the Alzheimer patient.

References

Alcock, T. (1963). *The Rorschach in practice.* Philadelphia: J. P. Lippincott Co.

Blanck, G. & Blanck, R. (1979). *Ego psychology II.* New York: Columbia University Press.

Bloom, F., Lazerson, A., & Hofstadter, L. (1985). *Brain, mind, and behavior.* New York: W. H. Freeman & Company.

The Chronicle. (1984). "Mirror to the mind." Burke Rehabilitation Center, White Plains, N.Y.

DeCato, C. & Piotrowski, Z. (1977). *A concise manual for Rorschach interpretation.* Cherry Hill, N.J.: Postgraduate International Inc.

Halacy, D. S., Jr. (1970). *Man and memory.* New York: Harper & Row.

Hall, C. S. (1954). *A primer of Freudian psychology.* New York: The World Publishing Company.

Holt, R. (1977). "Method for assessing primary process manifestations and their control in Rorschach response." In Rickers-Ovsiankina, M. (Ed.) *Rorschach psychology.* Huntington, New York: Robert E. Krieger Publishing Company.

Jacobson, E. (1973). *The self and the object world.* New York: International Universities Press.

Klopfer, B. & Spiegelman, M. (1956). "Differential diagnosis." In Klopfer, B. (Ed.) *Developments in the Rorschach technique.* Vol. II. New York: Harcourt, Brace, Jovanovich, Inc.

Korchin, S. & Larson, D. (1977). "Form perception and ego functioning." In Rickers-Ovsiankina, M. (Ed.) op. cit.

Meili-Dworetski, G. (1956). "The development of perception in the Rorschach." In Klopfer, B. (Ed.) op. cit.

Spitz, R. A. (1959). *A genetic field theory of ego formation.* New York: International University Press.

Wald, J. (1984). "The graphic representation of regression in an Alzheimer's disease patient," *The arts in psychotherapy,* Vol. II.

Wald, J. (1983). "Alzheimer's disease and the role of art therapy in its treatment." *American journal of art therapy* 22:2.

Wolanin, M. O. (1981). *Confusion.* St. Louis, MO: C. V. Mosby, Co.

The Influence of Art-Making on the Transference Relationship

Harriet Wadeson, PhD, ATR. *Director of the Graduate Art Therapy Department, University of Illinois, Chicago, Illinois.*

The art produced in art therapy cannot be fully understood without appreciation of the transference relationship which forms its context. In both client and art therapist there is the awareness that the art will be used to further the therapeutic process, that its purpose is therapy. To a large extent, the art becomes the meeting place of client and art therapist. These conditions exert a powerful influence on the nature of the art product's development. I'm not suggesting that clients and patients set about to make art that is therapeutic (whatever they may believe that to be), but rather that their expectations around the sort of processing to which it will be subjected and their expectations of the way it will be received by the art therapist are significant determiners of the nature of the art expression.

Against this background are further considerations of how art-making may influence transference phenomena. These include both the person of the art therapist and the process of making art in art therapy. It is also important to consider art therapy's important potential to hold a mirror up to the transference relationship in the form of transference portraits. These portraits may picture transference to the treatment facility and to other staff members, as well as to the art therapist. Finally, art-making may induce some unique counter-transference phenomena as well.

The Art Therapist

In considering the "person" of the art therapist, it is important to recognize that transference is not a random occurrence. Although transference is an unconscious process that may be a part of any human relationship,[1] there are some situations that encourage its development more than others. Those involving authority figures evoking a "child-to-parent" sort of transference are the most obvious. In fact, the major thrust of a psychoanalysis is the facilitation and resolution of the "transference neurosis."[2]

When I think of the selectivity involved in transference reactions, the image of a coat hook comes to mind. Certain personal characteristics in particular situations provide convenient hooks on which to hang a transference. The art therapist, by the very nature of his or her work, furnishes some very accommodating hooks for some heavy transference garments.

An art therapist is a *provider*. Other therapists certainly provide as well, but in addition to all the intangibles a therapist may give (such as interest, care, attention, insight), we also provide *tangible supplies*. I recall the exclamation of an adolescent upon seeing the art materials on her initial visit to my office at the National Institutes of Health: "All this for *free?*" She had been making art for a long time, and to her my office looked like heaven. She hadn't even interacted with me yet, and already I was perceived as the all-giving mother. (Naturally, meager supplies could evoke feelings toward a withholding parent.)

Because the patient or client is called upon to make a product in art therapy and because art-making is not an activity in which most people feel very skilled, the art therapist may readily be experienced as a critical parent, a harsh judge whose approval, the patient believes, will not be forthcoming. Figure 1 is an expression of such feelings. In this case, a young woman in a private practice art therapy group wrote the following about her picture:[3]

> The first thing that came to my mind was a finger pointed at me. I appear small, weak, helpless—I'm looking at the ground. The feelings that the smaller figure evoke in me are helplessness, worthlessness, rejection and depression. The small figure is also angry but can't express it to the overbearing larger figure. The larger figure represents my mother, but it also represents the many older authoritarian females in my life that I have feared. The older female figure is chewing me out, demanding that I be perfect and refusing to listen to me. I still cringe when an older woman has authority over me. I feel that I am reliving a scene with my mother (whose approval I constantly strove for) when she would

"To a large extent, the art becomes the meeting place of client and art therapist."

---

[1] Moore, B. and Fine, B. (1968). *A glossary of psychoanalytic terms and concepts*. New York: American Psychoanalytic Ass'n.

[2] Ibid. p. 92.

[3] Some of the examples here appeared in Wadeson, H. (1980). *Art psychotherapy*. New York: John Wiley and Sons.

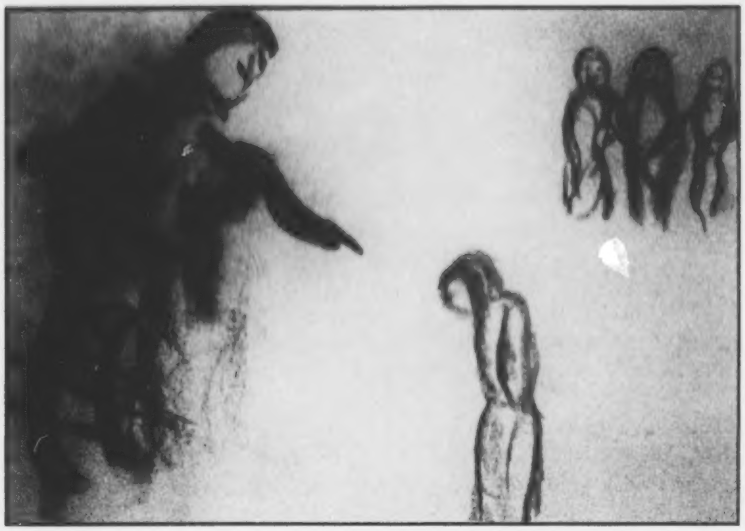


Fig. 1

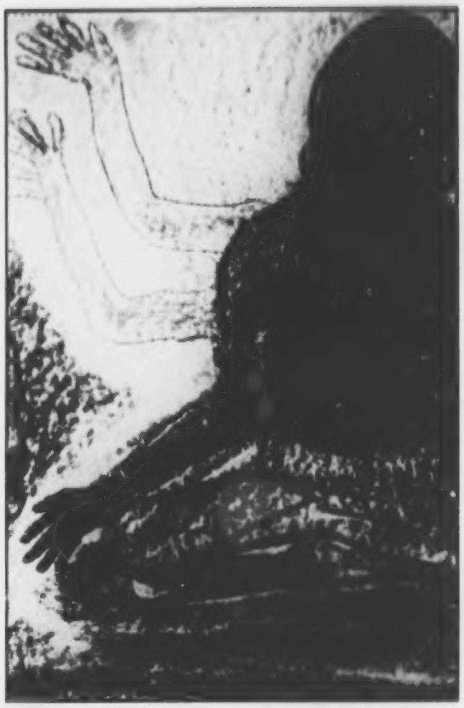
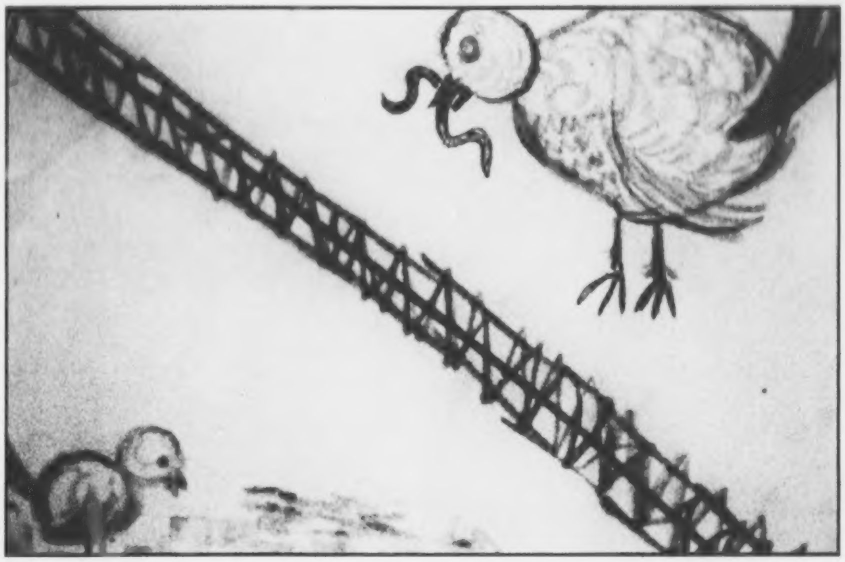


Fig. 2

Fig. 3



> reprove me or criticize me. Disapproval seems to mean worthlessness, but this only occurs with older women.

The client acknowledged an approach/avoidance feeling towards me which was partially based in her early experience of being judged unworthy by her mother. For example, she gave me these written comments almost immediately after I requested them (to please me), and then was certain I wouldn't use them (disapproval). In this case the critical parent perception spread well beyond the art-making activity. It even included writing about the picture.

Another "parental hook" is one-who-knows-the-meaning-of-things. Young children turn to their parents (especially their mothers) to explain things and to make the world comprehensible to them. Art expression often has about it an element of mystery. Patients may suspect that their art has hidden meaning that the art therapist can read to which they themselves are blind. We have all probably had clients request us to tell them what their pictures mean. This dependency on an all-knowing mother (or father) at times even conveys the perception of a sorcerer or god-like being. Figure 2 is an example. A young woman in another private practice art therapy group wrote the following about her idealized image of me:

> I see Harriet as a goddess. I want her to be a goddess, for how else can she help me out of my dungeon. If I am so low down in the ground, she must be high in the sky to pull me up. Then we can both be on earth, human. I know Harriet is not a goddess. She is human and earthy, the earth mother. She too has a shield against the pain radiating inside, like me. But she glows. She carries a goddess behind her—a many-armed Hindu goddess. This is how I relate to her, as a goddess, loved and feared. I cannot get near—I can barely put myself in the picture so close.

"Certain personal characteristics in particular situations provide convenient hooks on which to hang a transference."

Expectedly, the power given the art therapist as one who is nurturing and all-knowing evokes negative feelings as dependency needs are frustrated. An art therapy student (not in a program in which I taught) had seen me at a professional meeting and felt unbalanced in the brevity and superficiality of our relating there, as compared with the therapy sessions. These feelings gave rise to her picture of her relationship with me (Figure 3). She wrote the following about it:

> I picture myself as a hungry little blue bird looking kind of helpless, cut off, pathetic. I have to wait to be fed by Mother bird. The red diagonal is my anger. I am angry about being kept dependent. The little bird would like more nurturing without having to ask.

Figure 4, also an example of negative transference, was drawn by another private practice group member. She was able to make good use of it in examining issues of power and control. She wrote the following about it:

> Originally, I had in mind as I began to depict the therapist, an all-loving, all-caring figure. As the picture evolved, it developed into something quite different. I saw myself as the doll-like figure arching back rigidly from this all-too-sweet woman. The blue surrounding me indicated my way of distancing myself and the red in the figure expressed my anger and fear of being possessed and of being deceived by her. The woman's expression appears very sadistic and her grasp almost a squeezing-to-death action. The green around the woman figure was used to denote growth which she wanted and could help foster in the child. As I flipped the drawing and became the woman, I was able to identify with her as the way I keep people at a distance and how I feel the need to be all-controlling and powerful.

Occasionally a patient treated by a variety of staff in a treatment facility may find in the art therapist a "messenger-type transference hook." This might be particularly likely for people who have communicated through one parent to another. The art therapist readily becomes a "messenger" because the art product is such a tangible message.

Figure 5 is an example of such a transference reaction to her psychiatrist by a hospitalized manic-depressive woman who was very angry at her psychiatrist because she felt he underestimated her abilities. Underneath the anger were painful feelings associated with his confirmation of her own self doubts. She had been militantly religious, but at this time felt extremely disappointed about not being "saved." She drew Jesus crucified with bullet-holes in the shape of a cross in his heart. Beside him is herself, smiling and holding a salt shaker. She said she would like to crucify him again, shoot bullets through his heart and pour salt in the wounds. She joked about "twisting off Jesus' penis." Then, amidst sobs, angry outbursts and sarcastic glee, she said her revenge on her psychiatrist would be "to twist off his peter, but I really don't think he has one." There is a clear connection in her rage at her doctor, Jesus, the neglectful husband she divorced and her alcoholic father—all men whom she felt cared for her inadequately.

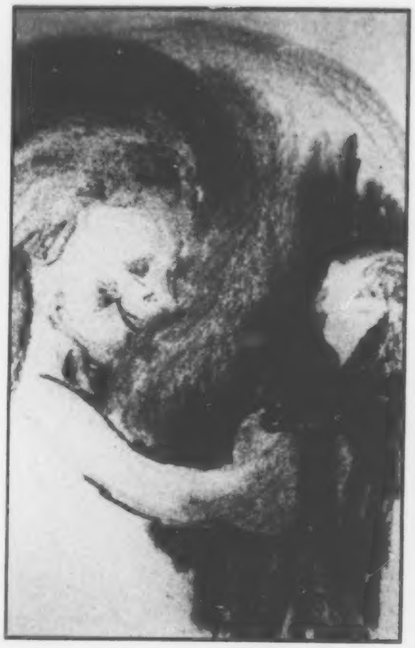


Fig. 4

In this example the art therapist was probably used as a messenger to convey the patient's anger to her psychiatrist. But to consider this picture as serving only that purpose is to miss its obvious facilitation of ventilation of feeling with the concomitant opportunity for exploring those feelings through imagistic metaphor and sharing them with another (the art therapist). In this case, such communication was probably easier than dealing directly with the psychiatrist.

The Art-Making Process

As noted earlier, the "person" of the art therapist, by the nature of his or her work, may readily evoke certain transference projections. But be-

"Patients may suspect that their art has hidden meaning that the art therapist can read to which they themselves are blind."

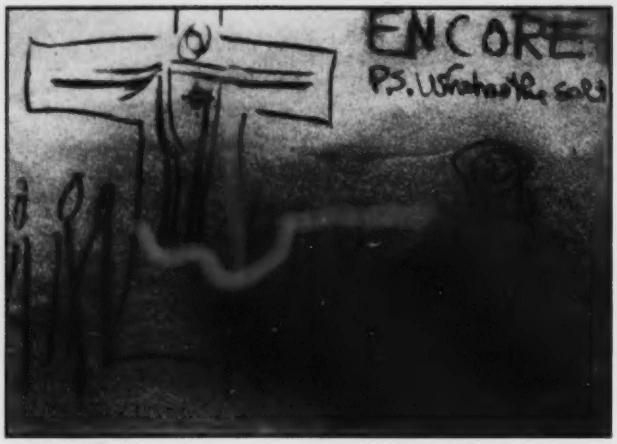


Fig. 5

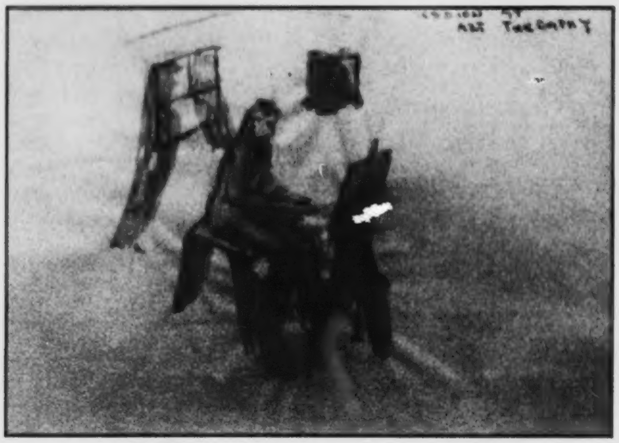


Fig. 6

yond that, the process of art-making in art therapy sessions may also stir up old familiar feelings or patterns of behavior in the way a client relates to the art therapist.

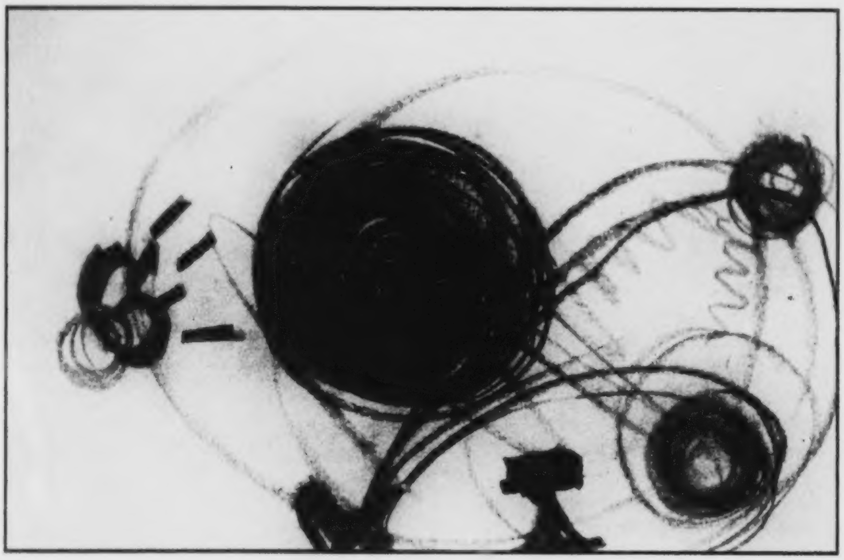
Although people undergoing any sort of psychotherapy often feel exposed, they may feel particularly vulnerable around the unexpected aspects of themselves that are sometimes revealed in their art. Figure 6 is an especially clear representation of these feelings accompanied by sexual overtones. A middle-aged man hospitalized for anxiety and depression had intended to depict "The Thinker" but instead produced a picture of himself nude, working at an easel with my head gazing at him from a framed picture on the wall. He titled the painting "Session at Art Therapy." In the picture, he is revealed naked to me, while I am "safely ensconced in a frame" and have no body. He explained that this way I could not be "active." The lack of mutuality and balance in this situation is one in which the patient may feel exposed, evaluated and judged in producing a product which may be self-revealing in ways the patient feels unable to control.

Many of those who come to art therapy have not participated in art activities since childhood. Often they feel thrown back to school days. Some enjoy the regressive feelings stimulated by the art materials, but many are embarrassed by what they consider the child-like appearance of their work. The regressive nature of artwork for those unaccustomed to it sometimes leaves art therapy clients feeling deskilled and ineffectual. This aspect of transference to the process is usually readily overcome with the help of a sensitive art therapist.

In group therapy there is an expectable sibling-like rivalry for the attention of the therapist, but in group art therapy it may take on the added dimension of producing art that will interest the therapist and help to establish a position among peers. Figure 7 is a depiction of the art therapy group in which the art therapist is the largest central "dark sun" with the group members orbiting around her.

When I have encouraged patients to try out the art materials, they have sometimes responded initially by indicating that they were making a picture *for* me. They saw the art as an activity and product *I* wanted rather than as something they were doing for themselves. They behaved like cooperative, obedient children trying to please mommie or teacher.

Fig. 7



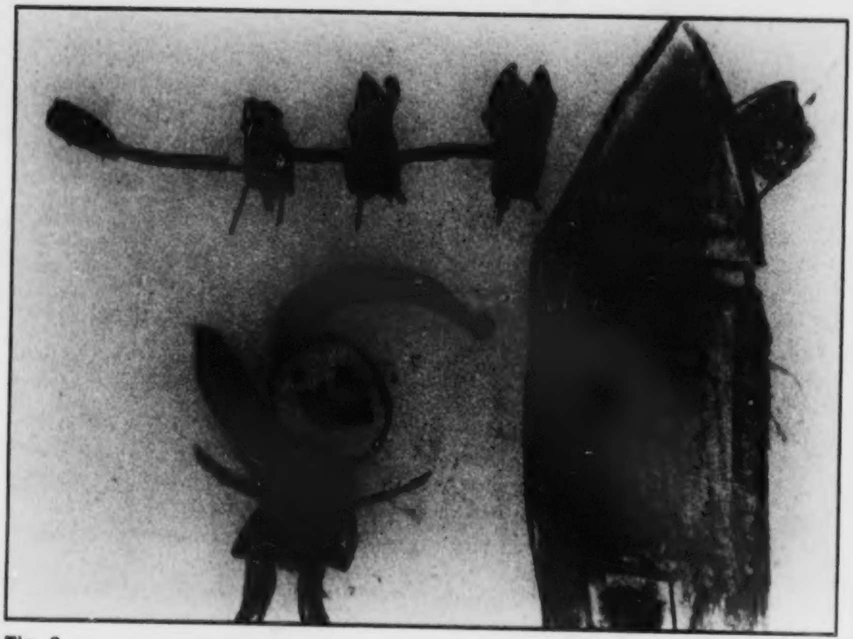


Fig. 8

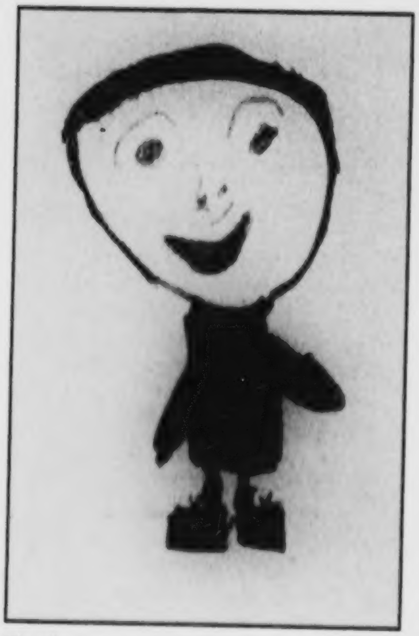


Fig. 9

Shortly before a Christmas holiday, a six-year old child diagnosed as minimally brain damaged, in treatment for disruptive behavior in school and at home, drew a picture of Santa Claus, Figure 8. He said that Santa would give his first present to me. In contrast to reports of his problematic behavior elsewhere, he liked art therapy and tried to please me. His next picture, Figure 9, was a picture of me. This was produced spontaneously and was very much in the nature of a gift for me. Although he reacted to frustration or over-stimulation with disruptive behavior in peer situations, in a one-to-one relationship he was a "good little boy" trying to please mommie or teacher.

Transference Portraits

Like this child's picture of me, many of the examples presented here are portraits conveying various aspects of the nature of the transference relationship. Perhaps most difficult to articulate is that aspect of art therapy that resembles the early relationship between mother and child in which the mother looks on attentively and lovingly as the young child plays. The mother's witnessing the activity and viewing the final product, whether it be a picture, mud pie, a house of blocks, or some other creation, is often an essential component of the experience for the child. Seldom in our subsequent lives do any of us receive this sort of loving delight in what we do. (And many, of course, never experienced this kind of devotion even in early childhood.) At times the art therapy relationship has a feeling of loving devotion as the art therapist watches and encourages the patient's progress, giving full attention to whatever the patient produces.

A depressed young woman who was hospitalized at the National Institutes of Health following a suicide attempt, drew Figure 10 shortly before discharge. In art therapy she had explored family relationships and her reaction to the death of her mother (when the patient was eleven) following a long illness during which the patient cared for her. In the drawing she has depicted NIH as a ghost-like figure (possibly her mother) watching her as a young child building. The title she gave it, "Parental Vigilance," further expresses her transference to the institution as a whole, in addition to her art therapy experience. Seldom is this aspect of the transference expressed so explicitly.

> *". . . the 'person' of the art therapist, by the nature of his or her work, may readily evoke certain transference projections."*

Transference to the Institution

The art products provide an especially clear, dramatic, and revealing reflection of transference phenomena. As such, they may refract various facets of the transference. Transference to the treatment facility is one such important aspect as evidenced in Figure 10.

Often particular experiences of institutionalization evoke transference reactions, sometimes of even delusional proportions. Figure 11 is an example. In it a young man hospitalized for acute schizophrenia at the

"The art products provide an especially clear, dramatic, and revealing reflection of transference phenomena."

National Institutes of Health portrayed an experience in the unit dayroom. He has drawn himself seated on the sofa, and watching a TV program involving a theft. He believed that the three people in the picture—himself, an aide in the chair, and a female patient—had committed the crime. These three were the only black members of the unit's population at the time. He thought the female patient's pocketbook was filled with the money they had stolen, as was the suitcase beside the sofa. When the aide moved the suitcase to the nursing station, the male patient was convinced that the other two were attempting to cut him out of his share of the stolen money. The formation of this delusion appeared based in the patient's general sense of guilt, his transference reaction to the institution and to the triangular nature of the relationship among the three blacks on an otherwise white ward.[4]

Figure 12, a depiction of life on the same ward drawn by another schizophrenic patient, illustrates aspects of transference to the institution in the eye looking through the seclusion room window, the barred window of the seclusion room, the rushing doctor, pharmacological mood determinants, as well as the anger and sadness she was feeling.

The seclusion room represented in Figure 12 appeared spontaneously in many of the pictures of patients on this ward.[5] The young woman who drew herself there in Figure 13 believed that she was in a gas chamber watched by a "silent guard" outside the door. The incarcerating aspect of institutionalization clearly provoked some transference reactions of delusional proportions to the institution itself. Note the contrast in these experiences of NIH compared with "Parental Vigilance," Figure 10.

Countertransference

It is easier for therapists to discuss and illustrate transference than it is to look at countertransference. Nevertheless, art therapy may evoke some unique countertransference phenomena as well. We may enter the mode of art teacher or achievement-oriented parent and encourage clients and patients to produce "good art," sometimes at the expense of a larger acceptance of whatever they do or their own self-determination. In this way, our needs may collude with the helpless quality of a patient's transference. Seldom do we do this overtly. It is much more likely to be a subtle influence through which the patient comes to see where our interests lie.

Because we treasure the art-making process and delight in our own accomplishments in this activity, it is

Fig. 11

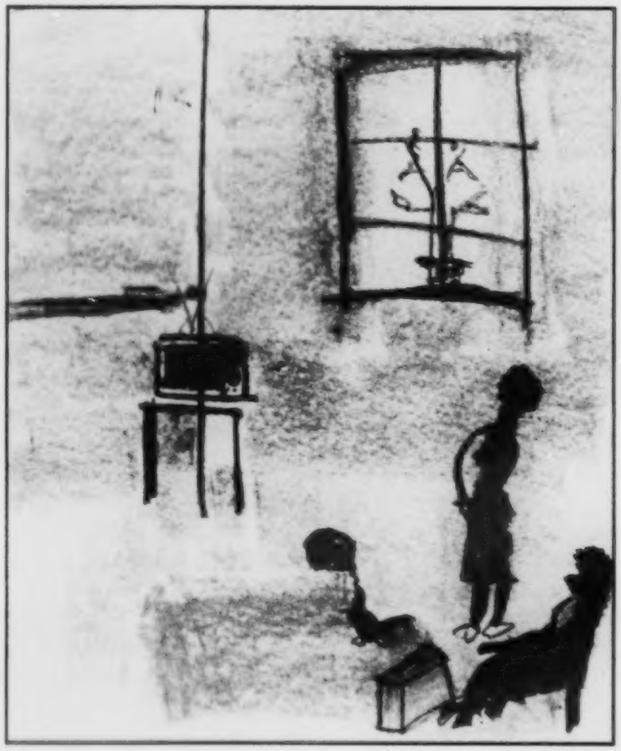
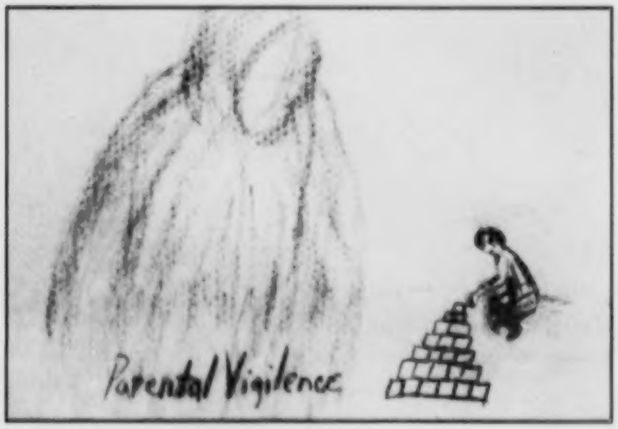


Fig. 10



---

[4] The influence of TV on delusion formation is reported in Wadeson, H. and Carpenter, W. "TV in the hospital: Programming delusions." *American Journal of Orthopsychiatry.* 46: 434-438.

[5] See Wadeson, H. and Carpenter, W., "Impact of the seclusion room experience," *Journal of Nervous and Mental Disorders.* 163: 318-328.

not unlikely that at times we may envy our skillful patients both their artistic talent and the excitement of their imagery.

Along the same lines we may envy their patienthood in art therapy. There have been many occasions when I have seen patients immerse themselves in the art materials that I personally find so inviting. The tender mother-child relationship that art therapy may evoke (discussed previously and exemplified by Figure 10) may arouse longing in the therapist for the child position. The loving acceptance the art therapy patient receives may appear very appealing to those of us who love making art, especially when compared with what may have been the harsher reception our art might have received in traditional art training. Envy of our patients, along these and other lines, most often arises from feelings of inadequacy usually rooted in the imperfect nurturing that most of us experienced in early childhood.

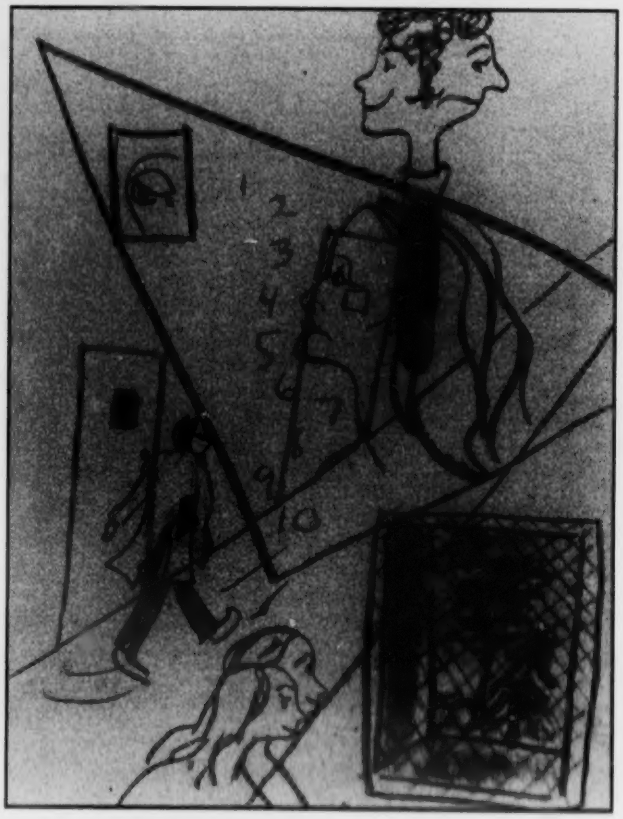
Countertransference manifests itself in innumerable ways, but there are a few to which art therapy is especially subject. A defensive maneuver on the part of the therapist may be to set himself/herself above the patient. In art therapy, judgment of patient art is a readily accessible vehicle for such positioning. The art therapist can judge the art, interpret it, use it for assessment and diagnosis. Obviously, there are expectable aspects of the art therapist's work and not simply countertransference maneuvers. The point is that the ambiguity and sometimes mystery of art expression makes it a ready sphere for the enactment of power ploys on the part of the art therapist. Since on most treatment teams the art therapist is the expert on art expression, he/she is not likely to be challenged by other staff on such judgments.

> ***"Often particular experiences of institutionalization evoke transference reactions, sometimes of even delusional proportions."***

Communication through art made by the art therapist may also become a countertransference vehicle. For example, a young female student established an art therapy group composed of men with chronic disorders. She made an abstract picture of each man conveying her impressions of him at the group's onset and then at its ending some months later. These pictures were gifts for the men, and the group's dynamics appeared to center around competition

Fig. 12

Fig. 13



BEST COPY AVAILABLE

for the female art therapist's affection. Without awareness, she was directing the group in such a way as to satisfy her own needs.

The anxiety generated by countertransference issues around the need for control may be manifested in art therapy in an over-structuring of sessions. Rather than being responsive to clients' needs, the art therapist may plan activities in advance without being sufficiently flexible to adapt to immediate conditions and needs. This is especially likely to occur in group art therapy where the session may feel more difficult to control. It is sometimes in this way that art therapy becomes "gimmicky."

Conclusion

Art therapy is more than just art or just therapy. The combination forms a special sort of synthesis. As a form of therapy, as opposed to art expression alone, the process of art therapy cannot be fully understood without accounting for the matrix of the patient-therapist relationship in which it evolves. The unique synthesis of art and therapy gives rise to a special sort of transference relationship. The art therapist is readily seen as nurturer, judge, sorcerer, or messenger; and the art-making process can readily lead to feelings of regression and exposure as well as mastery under the care of loving guidance.

In addition to the many facets of transference which the "person" of the art therapist and the art therapy activity may evoke, is the significant potential the art expression carries for revealing the nature of the transference experience. As such, the substance of art therapy itself (art-making in relationship to another) furnishes its own means of understanding.

It not only becomes the meeting place of art therapist and client, but advances the therapy by reflecting images of the therapeutic relationship, thereby clarifying dimensions of transference phenomena. These images then become further grist for the therapeutic mill.

Finally, working with patients and clients through art may also stimulate some unique countertransference reactions. It is important for art therapists and the staff with whom they work to be aware of the forms of transference and countertransference that art therapy may evoke.

> ***"It is easier for therapists to discuss and illustrate transference than it is to look at countertransference."***

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

"Writing for Publication in Art Therapy"

Cynthia Levy, ATR, author, (pen name of Levee*).*

This is in response to the open forum "Writing for Publication in Art Therapy" I attended at the 1985 American Art Therapy Association Conference. I am a registered Art Therapist, and a published poet, fiction writer and book reviewer who studied in the Masters of Creative Writing program at San Francisco State University.

After hearing the discussion on writing for publication in art therapy, I want to comment that two reasons I write are: (1) to share, and (2) because I have something to say. When my writing is because of my art therapy work, it is crucial for me to remember that my identity as a Healer comes before my identity as an Author. Gladys Agell, outgoing president of A.A.T.A., spoke about art therapists needing to hold on to their identities (*i.e.*, in her opening address at the Conference). I agree I don't want to become molded into a corporate structure of attaché cases and silk shirts, even though my job depends on surviving in a corporate structure.

The work of the arts and the Creative Arts Therapies is not created in the image of the Medical Model. Though art therapists may desire to publish, we have the freedom to turn to the arts as a model for sharing our work and being heard and seen. Private viewings and sharings of a picture or poem with one or two friends can be extremely valuable for an individual's growth and development. The actual picture or poem may best not be viewed by the public because of the artist's own vulnerability at being in process and not having enough objectivity or distance with his/her work to have the strength to share publicly at that time. Sharing work publicly can be an entirely different process than sharing work with a small group of friends. Private sharing can be a special experience to be treasured. Robert Bly, a better-known-than-most poet, wrote an article in *Coda, Poets & Writers Newsletter*, about the mad rush in these times for young writers to publish early. I have been warned of the dangers of being public before the work or the person need be.

Since our professional ethics are that the patient's healing comes first, then the patient is most important. Our publishing articles using our patient's work is next. Our greatest strength and contribution towards healing ourselves, our patients, our systems, and our planet, lies in art therapists retaining our own authentic identities and remembering to look to the artistic process, going inside and doing what we must because we must, and sharing with the world when to share is part of the healing creative process.

Art Therapist's Portfolio

VIEWPOINTS provides a forum for sharing ideas and graphics about issues facing art therapists. It also encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit black and white glossy photographs and four copies of the written material to: ***Viewpoints,*** ART THERAPY, *505 E. Hawley St., Mundelein, IL 60060.*

The artwork was submitted by Patricia Ann Tindall from Memphis, Tennessee. She was a founder of the Tennessee Regional Art Therapy Association, and has over ten years of experience in art therapy. Ms. Tindall was instrumental in designing and implementing an art therapy program in a school system in Tennessee that served as a pilot program using art therapy with learning disabled children in an open space classroom.

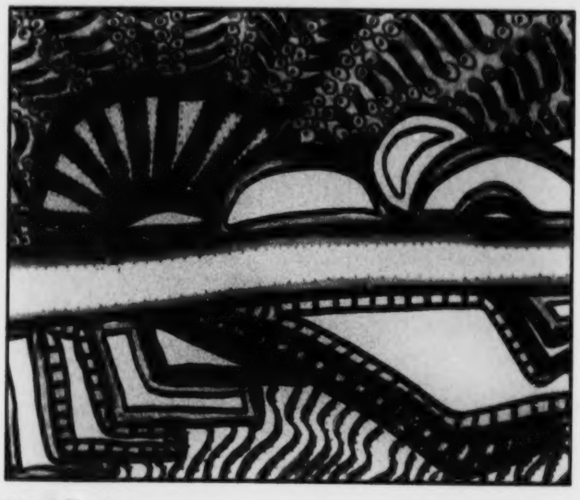


Fig. 1 Fusion

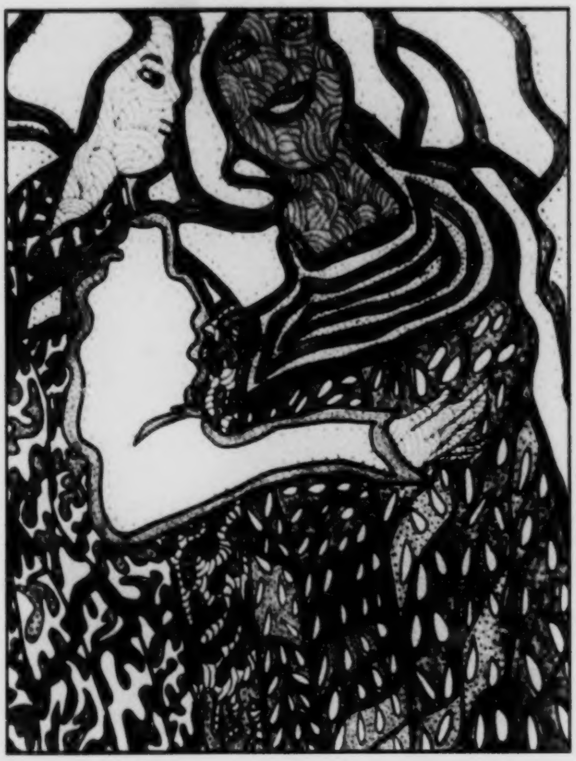


Fig. 2 The Sisters

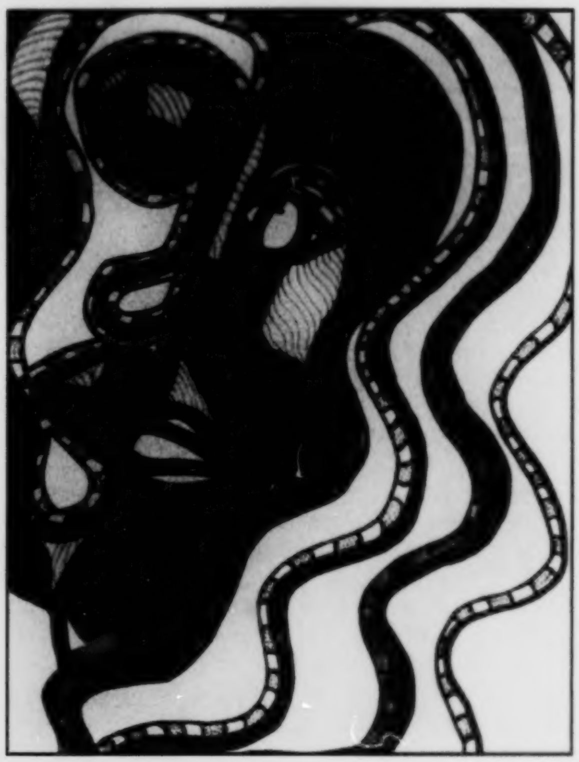


Fig. 3 The Other Person Inside

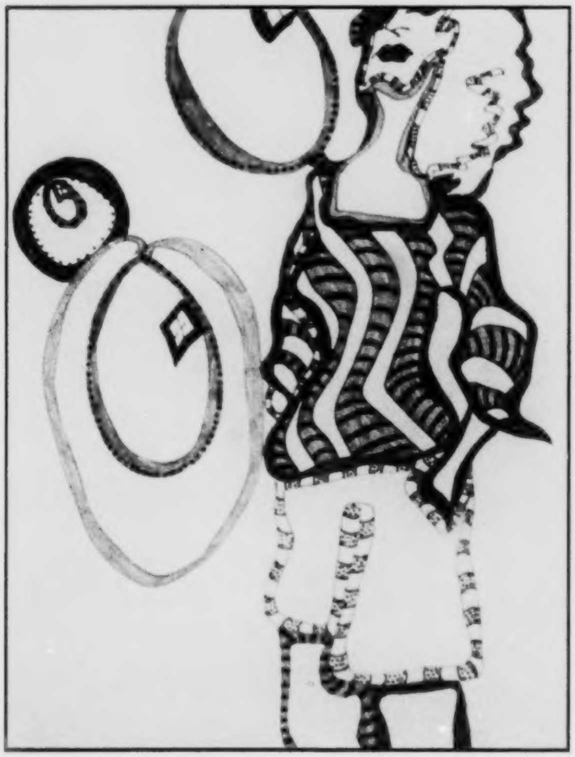


Fig. 4 Encapsulated Secrets

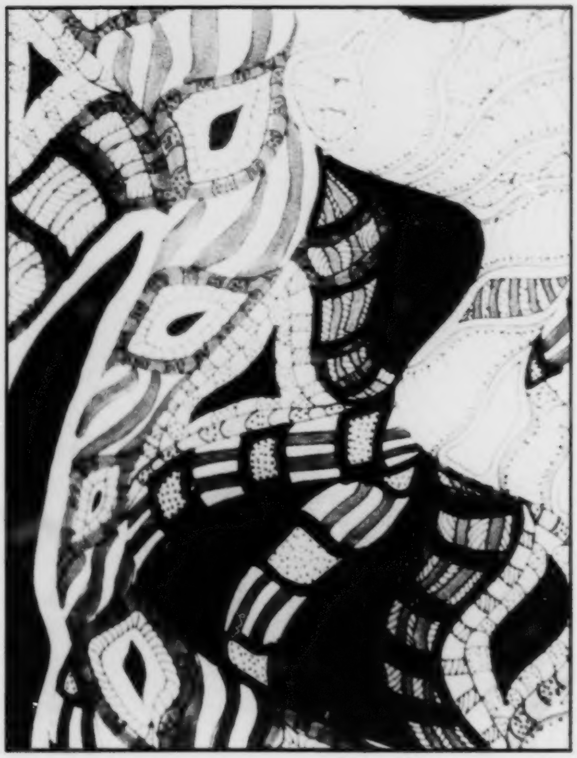


Fig. 5 Labyrinth

REVIEWS

The Lowenfeld Lectures: Viktor Lowenfeld on Art Education and Therapy

John A. Michael, Editor, EdD, Professor Emeritus, Art Education, Miami University, Oxford, Ohio.

Reviewed by **Rawley Silver,** *EdD, ATR, HLM. Silver is author of the Silver Drawing Test, Stimulus Drawing and Techniques, and Developing Cognitive and Creative Skills Through Art.*

If you are in your twenties or thirties, it may come as a surprise that Viktor Lowenfeld's famous book, CREATIVE AND MENTAL GROWTH, once included a chapter titled, "Therapeutic Aspects of Art Education." This 74-page chapter appeared until the fifth printing of the third edition. After his death in 1960, his book was revised and his chapter on art therapy disappeared without a trace.

In the early 1960s, art education was uncomfortable with art therapy. Art teachers were under the thumb of abstract expressionism, figurative art was taboo, and the time-honored occupation of working your way through college by posing for the life-drawing classes had disappeared. Many art schools had discontinued representation in any art form.

It is not surprising, therefore, that the chapter on art therapy was eliminated from Lowenfeld's book in subsequent editions, or that students in art education and art therapy never knew what they were missing.

Now they can know, thanks to two of Lowenfeld's former students. One had taped his lectures and the other has edited the tapes into the book that is the subject of this review. The first student, Ellen Abell, inspired by his lectures, had obtained his permission to tape them at Pennsylvania State University in 1958, just two years before his death. She had wanted to publish the tapes but after years of inactivity and in failing health, she turned to a fellow-student, John H. Michael, now Professor of Art Education at Miami University. He edited the lectures with the help of others who transcribed the tapes into longhand, and typed them. The 31 lectures have now been published by The Pennsylvania State University Press, 1982.

Section III of this work, titled, "Art Education Therapy," includes four lectures on the therapeutic aspects of art education. These are: "Psychotic-Neurotic Considerations; A Case Study of Virginia, a Neurotic Child; A Case Study of Aggie, a Mongoloid Individual; and A Case Study of Camilla, a Deaf-Blind Child."

From my point of view, this book should be required reading not only for art therapy students but also for art education students so that they can judge for themselves the work of a pioneer in both fields.

Viktor Lowenfeld is another of the refugees from Nazism who has made valuable and lasting contributions not only to us but also to the world at large. His books have been translated into Arabic, Chinese, Danish, German, Hebrew, Italian, Japanese, Norwegian, Spanish, and Swedish. One can only wonder whether his chapter on art therapy is missing from the foreign editions. If so, it is hoped that these *Lectures* will follow them, even if they can never catch up.

BEST COPY AVAILABLE

CHARLES C THOMAS • PUBLISHER

Just Published!

EDUCATING THE CREATIVE ARTS THERAPIST

By Shaun McNiff

Lesley College, Cambridge, Massachusetts

This is the first comprehensive study of higher education in the burgeoning arts therapies. It is a timely, valuable book for everyone involved at the more than 200 schools now offering related courses and programs.

After introducing the context for the creative arts therapies, the text reviews pertinent historic trends in higher education, particularly disciplinary interdependence. Discussions of early training programs, academic milieus and current educational approaches are used to define the profession through education. Music, dance, art, poetry and drama therapies are brought into play, as are artist/therapists and psychodrama.

The author delineates characteristics of academic training programs: types of schools, undergraduate and graduate programs, degrees, prerequisites, coursework, the thesis, and related topics. He explicates the elements common to all the creative arts therapies, specific media competencies, supervision and evaluation, an artistic theory of mental health, and student and faculty characteristics. A dialogue among leading educators on key issues in the education of the creative arts therapist concludes the book.

'86, 296 pp., $29.75

THE ARTS AND PSYCHOTHERAPY *by* **Shaun McNiff.** "Though [its] approach may be controversial, the book will be interesting, provocative, and valuable to clinicians who use any of the arts in a therapeutic context." *—Contemporary Psychology. '81, $19.75*

A MANUAL OF SEQUENTIAL ART ACTIVITIES FOR CLASSIFIED CHILDREN AND ADOLESCENTS *by* **Rocco A. L. Fugaro.** This book shows how to apply art activities with children who are classified as impaired, maladjusted or depressed. *'85, $25.75*

ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS *by* **P. J. Fürrer.** The author cleverly details activities and lessons that promote awareness, foster acceptance, and encourage experimentation and exploration. *'82, $12.75*

ART AND MAINSTREAMING: Art Instruction for Exceptional Children in Regular School Classes *by* **Claire B. Clements** *and* **Robert D. Clements.** ". . . a worthwhile addition to any library on art in exceptional education." *—Art Therapy. '84, $17.50*

We fill all orders promptly • Books sent on approval
MasterCard, Visa & prepaid orders sent postpaid
Catalog sent on request • Write or call (217) 789-8980

2600 S. First St. • P.O. Box 4709
Springfield • Illinois • 62708-4709

HOFSTRA
UNIVERSITY
HEMPSTEAD, NEW YORK 11550

Hofstra University is pleased to announce a new interdisciplinary graduate program:

M.S. in Special Education and Art Therapy

This interdisciplinary program is designed to prepare candidates with competencies both in Art Therapy and in Special Education. Graduates will be qualified to work with handicapped individuals as teachers in Special Education and as Art Therapists who can work as therapeutic team members in a variety of hospital and rehabilitative settings. Professional preparation will provide candidates with experiences in the use of art therapy in the treatment of persons with emotional, mental, physical disabilities, other handicapping conditions and those with special learning needs.

FOR FURTHER INFORMATION, PLEASE CONTACT:

Lillian C. Resnick, ATR
Coordinator, Creative Arts
Therapy Program

HOFSTRA UNIVERSITY
Mason Hall 212
Hempstead, New York 11550
(516) 560-5752

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, *ART THERAPY, Journal of the American Art Therapy Association*, discounts on publications, discount on admission to the annual conference, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (ATR). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA National Office.

Associate Membership shall be open to individuals interested in the therapeutic use of art wishing to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $50

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee. **Applications for student membership must be accompanied by a copy of current ID.**

Annual Dues: $35

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $100

Professional Membership is by application only and is open to individuals who have completed professional training in art therapy and who are or have been engaged in the therapeutic use of art. Professional members are eligible to participate in all activities of the Association and receive all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $75

Credentialed Professional Membership is by application only and is open to individuals who have met the qualifications and been approved for Professional Membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in Standards and Procedures for Registration. Professional members are eligible to participate in all activities of the Association and receive all official publications. A Credentialed Professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $80

Make checks payable to AATA

American Art Therapy Association, Inc.
505 E. Hawley Street
Mundelein, IL 60060
(312) 949-6064

NAME ______________________
LAST FIRST MIDDLE

PREFERRED MAILING ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________

OTHER ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________

TITLE ______________________

EMPLOYER ______________________
INDIVIDUAL OR INSTITUTION

HIGHEST EDUCATIONAL DEGREE ______________________

☐ $ 50 **Associate Membership**

☐ $ 35 **Student Membership**
(copy of current ID required)

☐ $100 **Contributing Membership**

☐ $ 75 **Professional Membership**
(by application only)

☐ $ 80 **Credentialed Professional Membership**
(by application only)

Payable in U.S. Dollars

Dues and expenses related to participation in AATA may be tax deductible as a business expense.

RETURN THIS APPLICATION WITH YOUR REMITTANCE

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

505 E. Hawley Street   Mundelein, IL 60060   (312) 949-6064

RESOURCES

The American Art Therapy Association serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA Office. This form may be photocopied.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapists' Identity (1976) 118 pages	$3.00	$5.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy Journal of the American Art Therapy Association	.00	$23.00
American Psychiatric Association Special Conference Proceedings Use of the Creative Arts on Therapy (1979)	$3.00	$4.00
National Art Education Association Journal: Special Issue Art Education, Vol 33, No. 4 (1980)	$3.00	$4.00
AATA Newsletter Subscription	.00	$9.00
Full Color Poster (16 x 20)	$1.00	$2.00
Stimulus Drawings and Techniques in Therapy, Development, and Assessment by Rawley A. Silver, EdD, ATR, HLM	$10.00	$14.00
Developing Cognitive and Creative Skills through Art by Rawley A. Silver, EdD, ATR, HLM	$14.00	$20.00

FILMS (Rental/Purchase)

Art Therapy: Beginnings (1977) 16 mm, color/sound, 45 minutes	Rental:	$30.00	$40.00
	Purchase:	$300.00	$400.00
Michael (1977) 16mm, color/sound, 12 minutes	Rental:	$20.00	$25.00
Art Therapy (1981) 16mm, color/sound, 12 minutes	Rental:	$25.00	$35.00
	Purchase:	$250.00	$325.00
Lori, Art Therapy and Self Discovery (1978) 16mm, color/sound, 32 minutes	Rental:	$30.00	$40.00
	Purchase:	$300.00	$400.00

ORDER FORM Make checks payable to AATA, and mail to the above address.

Indicate Quantity of Unit Items Below		Cost/Unit		Total
________	( ) ×	________	=	________
________	( ) ×	________	=	________
________	( ) ×	________	=	________
________	( ) ×	________	=	________
________	( ) ×	________	=	________
		________	=	________

Total Unit Costs = ________

*Postage/Handling = ________

Note: for postage/handling, add $1.50 for the first unit item, $.50 each additional unit. VA Residents add 4% Sales Tax.

Total Enclosed = ________

Proceedings Index (1976-1982)
$1.00 Members $2.00 Non-Members

Set of five Proceedings (consecutive years):
25% discount on total cost (Index Free)

10 or more copies of any single issue: 15% discount on total cost

Discounts are available when purchasing quantities, as follows:
Set of four Proceedings (consecutive years): 20% discount on total cost (Index: Free)

Send To: ________

____

____

city   state   zip code

BEST COPY AVAILABLE

ART THERAPY
Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 505 E. Hawley St., Mundelein, IL 60060

Please enter my subscription for 1985. Enclosed is my check, payable to AATA, for $23
Name ______
Address ______
City ______ State ______ Zip ______

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

TAKE ADVANTAGE OF THIS SPECIAL OFFER!

Subscribers to *Art Therapy* and Members of American Art Therapy Association
ENJOY REDUCED RATE!

SUBSCRIBE NOW – AND SAVE 50% OR MORE! *The Arts in Psychotherapy* is a quarterly journal in its 12th successful year of serving practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologists which reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy, THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers to: Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583
TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA

Please enter my subscription for Vol. 12, 1985 ☐ (Prepayment required) Check enclosed ☐
Please enter my subscription for Vol. 13, 1986 ☐
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume
2 Vol. subscriptions subject to additional 10% discount Individuals $36 Students $27
Name ______
Address ______
City ______ State ______ Zip ______

BEST COPY AVAILABLE

Art Therapy
505 E. Hawley Street
Mundelein, IL 60060

ART THERAPY

Journal of the American Art Therapy Association

Volume 3, Number 3

November 1986

- A Dialogue with James Hillman
  Shaun McNiff, PhD, ATR
- Archetypal Art Therapy Is Cross-Cultural Art Therapy
  Howard McConeghey, EdD
- Art Therapy in Israel
  Lenore Steinhardt, MA, ATR
- Art Therapy for Acculturation Problems of Hispanic Clients
  Gilda Prieto Moreno, MA and Harriet Wadeson, PhD, ATR

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1985-1987

Board of Trustees

President
Sandra L. Graves, PhD, ATR

President-Elect
Cay Drachnik, MA, ATR, MFCC

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, MA, ATR

Committee Chairs

Affiliate Societies
Nancy Steinberg, MA, ATR

Bylaws
Roberta J.H. Shoemaker, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Bobbi Stoll, MS, MFCC, ATR

Publications
Harriet Wadeson, PhD, ATR

Research
Linda Gantt, MA, ATR

Standards
Ronald E. Hays, MS, ATR

Executive Director

Edward J. Stygar, Jr.

ART THERAPY

Journal of the American Art Therapy Association

Volume 3, Number 3
November 1986

Editorial

Gary C. Barlow, EdD, ATR 98

Articles

A Dialogue with James Hillman
Shaun McNiff, PhD, ATR 99
Archetypal Art Therapy is Cross-Cultural Art Therapy
Howard McConeghey, EdD 111
Art Therapy in Israel
Lenore Steinhardt, MA, ATR 115
Art Therapy for Acculturation Problems of Hispanic Clients
Gilda Prieto Moreno, MA, ATR and Harriet Wadeson, PhD, ATR .. 122

Reviews

Art and the Wish to Die
Fred Cutter 131
The Special Artist's Handbook (Art Activities and Adaptive Aids for Handicapped Students)
Susan Rodriguez 132
Mommy, Daddy, Look What I'm Saying: What Children Are Telling You Through Their Art
Myra Levick 133
Child Art Therapy, 2nd Edition
Judith Aron Rubin 134

Viewpoints

Wasted Wealth: Thoughts on the Discontinuation of AATA Conference Proceedings
Pat Buoye Allen, MA, ATR 136
My Stars, We Need Art Therapy
Harriet Wadeson, PhD, ATR 136
Portfolio
Art Work by Japanese Children 137
Brief Communications 140

About Our Cover

"Wishes to be a Spring Goddess," a painting by a 9 year old girl from Hiroshima, Japan. The artwork depicts the child's desire whether real or imagined.

Copyright © 1986
American Art Therapy Association, Inc.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Sharon Purtell

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Anthony Kowalski, MD
Susan LaMantia O'Connor, MA, ATR
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064

BEST COPY AVAILABLE

EDITORIAL

The guest Contributing Co-Editor for this issue of *Art Therapy* is Shaun McNiff. Shaun is Professor of Expressive Therapy and Dean of the Institute for the Arts and Human Development at Lesley College, Cambridge, Massachusetts. He was a pioneer and is a major figure in education, theory and practice of the creative arts therapies. His experience as a consultant and teacher in other countries, as well as the United States, is well-known and highly respected. Dr. McNiff has written two landmark books in our professional field. *The Arts and Psychotherapy* was widely received and acclaimed, and his most recent book, *Educating the Creative Arts Therapist*, is the first comprehensive study of higher education and art therapy.

Dr. McNiff and I have worked for over a year on groundwork plans for the development of a multicultural, international issue in art therapy. Because of the growing interest—and positive responses—to this idea from persons in the United States, and in other countries, we have decided to introduce some of the "international flavor" in this issue, but to continue with the idea in succeeding issues (over the next few years) incorporating articles from various cultures and countries, as they become available and are ready for publication. Certainly Dr. McNiff has set the stage for the encouragement to international authors to submit articles, and I am happy to announce that we are receiving requests for information as well as some initial draft articles from authors in Holland, France, Germany, and other countries. I believe that this added dimension will help each of us with our global understanding of the nature of our profession.

Within this issue is a major article introduced by Dr. McNiff, followed by an interview/dialogue with James Hillman. This insightful, thought-provoking dialogue serves to illuminate aspects of art therapy and therapy in general. As McNiff points out in his introduction to the dialogue, "Hillman does have immediate relevance to all art therapists if we approach his writings as one of many important viewpoints on the nature of the image. What he can unquestionably do for our profession, whether we all agree with what he says or not, is introduce an essential perspective, respecting the integrity of the image and providing cautions as to how we approach it." James Hillman is one of the major writers in the psychological field, and his ideas are dynamic and provoking. We are indeed fortunate to be able to include this dialogue/interview in this issue, and his contribution is greatly appreciated.

A second article is by Howard McConeghey, titled "Archetypal Art Therapy Is Cross-Cultural Art Therapy." With reference to the cross-cultural aspects, McConeghey states that "It is this collective or archetypal aspect in art therapy which by its very nature is cross-cultural." The article offers much to consider, and is presented by a major thinker, writer, philosopher, and humanitarian in art therapy and education.

The third article focuses on art therapy in Israel, and is authored by Lenore Steinhardt. Steinhardt's article is one of our first ones on art therapy as it is organized and practiced in another country, and we present this excellent contribution as one of the first "international" entries into what we know will be an important part of our professional literature in art therapy.

The fourth article is titled "Art Therapy for Acculturation Problems of Hispanic Clients," by Gilda Prieto Moreno and Harriet Wadeson. The authors discuss roles in Hispanic families, acculturation problems and art therapy practice in a mental health center. Photographs of individual art work, and recommendations for therapy with people who have been relocated are presented in an insightful way. Directions and/or suggestions are given for the art therapist who may work with clients from various cultural backgrounds.

Because much content in this issue is either directly or indirectly related to "dialogue," it seems appropriate to issue an invitation to the readers to extend this dialogue. Let us hear your thoughts and ideas on content, relevance of issues, and send in your suggestions for consideration. Perhaps you have an idea for "Viewpoints," or you might need some help in expanding that article that you are writing. Perhaps a letter to the editor might be relevant, or a telephone call to discuss the possibility of a future article. Let's keep this dialogue going.

Thanks to all of you who are submitting articles to *Art Therapy*. We have recently been inundated with articles, and they are being sent for review as quickly as possible. During the first few months of publication, there seemed to be an "easy flow" of articles and, therefore, the pace was slower. However, with the recent increase of submissions, we are re-grouping and reassessing our procedures so that we can better serve the authors who are submitting articles. Please bear with us. It is gratifying to observe the tremendously growing interest in *Art Therapy*, and the desire to be a part of the profession through our journal. Thanks to all of you, and for the constructive ideas and suggestions.

The 1987 A.A.T.A. Conference is nearly upon us. An exciting program has been planned for the Los Angeles meeting, and congratulations are sent to all of the planners and coordinators of this massive undertaking. See you at the Conference!

Gary C. Barlow, Ed.D., ATR
Editor, Art Therapy

A Dialogue with James Hillman

Shaun McNiff is a Professor of Expressive Therapy and Dean, Institute for the Arts and Human Development at Lesley College, Cambridge, Massachusetts.

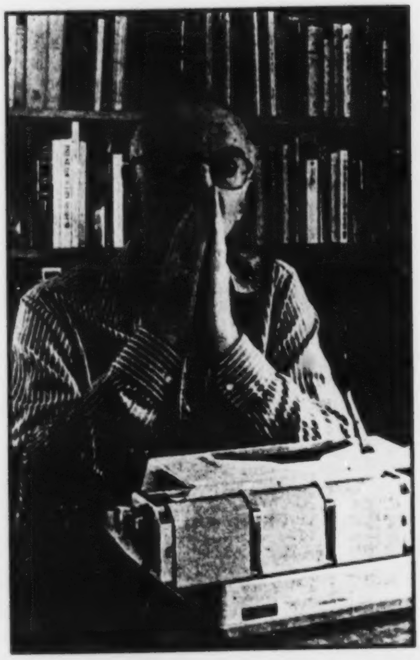
Introduction

James Hillman stands out among psychological writers of the twentieth century as an inspirational and useful ally to the art therapy profession. Howard McConeghey, Professor and Director of the art therapy graduate program at the University of New Mexico, has been suggesting this for many years. Hillman's value to art therapy lies in his demonstration of how to reverse the most fundamental theoretical presuppositions and habitual behaviors of psychotherapy. Rather than analyzing art through the methods of psychology, he urges psychology and psychotherapy to engage art. In the tradition of Friedrich Nietzsche, one of the most influential philosophers of the late nineteenth century, Hillman calls for the breaking of the containers of professions that limit vitality. He urges us to create new metaphors for what we do, or better yet, resurrect ancient continuities of culture.

The psychological writings of James Hillman are particularly useful to art therapy because of the primacy of the image in his thought and his practice of psychoanalysis and therapy. Rather than approaching images as clinical data serving rational systems of analysis, Hillman approaches the image as the embodiment of the psyche. The image lives; is treated with respect; is distinct from the person of the client and the therapist; is to be interpreted and understood, phenomenologically, on its own terms; is sacred, and a manifestation of "the gods" themselves. This psychology of the image presents an extraordinary challenge to art therapy. Are we capable of understanding and heightening the wisdom, complexities and gifts of images? Are we capable of allowing images to speak for themselves, and hearing, or seeing, what they communicate to us?

"Rather than approaching images as clinical data serving rational systems of analysis, Hillman approaches the image as the embodiment of the psyche."

Prerequisite knowledge is needed for our profession to fully engage the image. This guidance cannot be gained exclusively through contemporary systems of psychological analysis and psychotherapeutic practice. The image can be fully understood only through cooperative studies of culture, the fine arts, literature, history, religion, philosophy, and myth. Where the appeal of many popular contemporary psychologies lies in their ability to contain experience, and place it within conceptual boundaries, Hillman does the reverse. He challenges our ability to open and embrace diversity, and readily acknowledges what he does not know. Describing himself as polemical, he questions dogmatism and the unconscious acceptance of psychological principles simply on the basis of their position within the mainstream. Like Socrates, Hillman serves as a gadfly, stinging the anaesthetized mentality within us, and stimulating an awakening of critical judgment.



Dr. James Hillman © M. RINALDINI, 1986

What is perhaps most unusual about James Hillman is his ability to complement philosophical inquiry with an exemplary respect for the animal, as revealed in the statements made here to the readers of *Art Therapy*. He is as committed to the act, as to the idea, and minimizes distinctions between the two. Hillman goes beyond Dionysian/Apollonian dualites and introduces us to polymorphic modes of understanding. It is from the perspective of polytheism, constantly evoked by Hillman, that his work can be best understood. The image can say different things, some of which may contradict one another. Our response to the image will predictably change. There is no single, correct interpretation of an artwork or dream, although there will be some that suit the image better than others. There is no single human ego responsible for the creation of the image. The images have a live force unto themselves, and do not belong to individual people. "The dreamer is in the image rather than the image in the dreamer" (*Archetypal Psychology*, p. 6).

Hillman is sharply critical of the "creative ego" which he sees as usurping a "godlike capacity." He not only helps to respect the rights of images, dreams and artworks that we too often approach with interpretations that are more likely to reveal our internal preoccupations, but he suggests how we might lighten the loads of our clients who feel the unspoken burden, of being "creative," within the art context. Hillman perceives the world as continuous creation. If we approach our clients with attitudes of helping images to emerge naturally, we might just help to further the "quality" of what comes forth. It is the single ego function that most restricts the vitality of the many faceted person. Not only does the "ego personality" limit our ability to discover "other persons" within ourselves but it subjects non-human entities to inferior status. Hillman reverses the most accepted tenets of psychiatry and psychology: he believes that the multiple rather than the single personality is an expression of well-being and that the idea of a single ego oppresses the many forms of the psyche; he and his patients talk to animals, stones and pictures and they believe that these things talk to them. According to orthodox psychiatry, Hillman's work must be a manifestation of madness and he would not disagree, having said that within the context of how the psychological establishment defines health, "my books can be used to increase your sickness." He speaks of the soul, rather than the unconscious; imagination and poetics rather than technology; and so forth. He encourages art therapy to find its metaphors for healing within art. Hillman challenges the very essence of technological belief systems when he describes "the poetic basis of mind."

In his essay on "psychological language" Hillman expresses his distrust of psychological terminology, and especially its concepts of psychopathology where "the language of the field and the speech of the soul seem to go most at cross-purposes. . . . The language of psychology insults the soul. It would sterilize metaphors into abstractions. We are made ill because it is ill" (*The Myth of Analysis*, p. 121). However, a principal focus of his writings is pathology. His complaint is with how it has been "viewed, treated and condemned."

James Hillman wants psychotherapy and psychology "to move towards art." He supports art therapists who desire to speak, and act, as artists, without abandoning respect for the context within which we work, and the many other disciplines and points of view that are embodied by the present mental health field. Hillman is not suggesting a new artistic monotheism or dominance, but speaks against those beliefs and traditions that suppress the artistic, the sacred, the poetic, variety, soul and imagination. He speaks to us as an artist. His polytheistic psychological thought can be particularly useful to those in our profession, artists, psychotherapists and teachers, who are uncomfortable with a single identity.

Every psychology is for James Hillman a confession, a religious activity. He discourages us from following the great psychologists in being "Freudian," "Jungian," etc. Instead, he urges us to "be psychological," with the inspiration and guidance of their work. I believe that the same applies to his own writings. It would be a mistake to consider Hillman's ideas about the nature of images, for example, as either being right or wrong, acceptable or unacceptable. That is precisely the type of dualistic and dogmatic response that he questions. Hillman does have immediate relevance to all art therapists if we approach his writings as one of many important viewpoints on the nature of the image. What he can unquestionably do for our profession, whether we all agree with what he says or not, is introduce an essential perspective, respecting the integrity of the image and providing cautions as to how we approach it. He demonstrates the need for learning and cultural knowledge combined in his case with a lifetime of clinical and artistic experience. Hillman's involvement with ideas does not suggest separation from the commonplace, what is practical and useful. He draws from Blake and Keats in describing his "work" in the world as "soul-making." He is also critical of idealistic and spiritual ascent, preferring descent into the world, what he calls "insearch." Hillman cites Wallace Stevens to support this mission: "The way through the world is more difficult to find than the way beyond it."

James Hillman now lives in Thompson, Connecticut near the Massachusetts border and works as a Jungian analyst, author and lecturer. He grew up in New Jersey, attended Georgetown University, earned his Bachelors and Masters degrees at Trinity College, Dublin, and his Ph.D. at the University of Zurich (summa cum laude). Dr. Hillman lived in Europe for thirty-two years and served for ten of them as director of studies at the Jung Institute in Zurich. He returned to the United States in 1978 to accept an appointment as Professor of Psychology and Senior Fellow in the Institute of Philosophic Studies at the University of Dallas where he was later Dean of the Graduate School. Since the 1960's Dr. Hillman has regularly been a main speaker at the Eranos lectures in Ascona, Switzerland. In 1972 he was invited to give the Dwight Harrington Terry lectures at Yale University on the topic of archetypal psychology and he has also taught semesters at Syracuse University in the Department of Religion and at the University of Chicago.

In 1986 Dr. Hillman was a guest professor at the Institute for the Arts and Human Development at Lesley College where the dialogue presented here took place. Written notes rather than electronic recording equipment were used. The text was expanded afterwards through correspondence.

The writings of James Hillman have been translated into nine languages and his books include:

Emotion: A Comprehensive Phenomenology of Theories and Their Meanings for Therapy. Evanston, Illinois: Northwestern University Press, 1960.

Suicide and the Soul (1964). Dallas: Spring Publications, 1976.

Insearch: Psychology and Religion (1967). Dallas: Spring Publications, 1979.

The Myth of Analysis: Three Essays in Archetypal Psychology (1972). NY: Harper and Row, 1978.

Loose Ends: Primary Papers in Archetypal Psychology. NY/Zurich: Spring Publications, 1975.

Re-Visioning Psychology. NY: Harper and Row, 1975. *Nominated for a Pulitzer Prize.*

The Dream and the Underworld. NY: Harper and Row, 1979.

Healing Fiction. Barrytown, NY: Station Hill Press, 1983.

Archetypal Psychology: A Brief Account. Dallas: Spring Publications, 1983.

Inter Views. NY: Harper and Row, 1983.

Thought of the Heart (1979). Dallas: Spring Publications, 1984.

Freud's Own Cookbook (with Charles Boer). NY: Harper and Row, 1985.

Anima: An Anatomy of a Personified Notion. Dallas: Spring Publications, 1985.

Shaun McNiff: Do you ever think about where images come from?

James Hillman: I try to never think about origins, neither about myself nor about the universe. These things lead into the past and away from phenomena. In practice it is an escape from what is. I live to speculate, but I am appalled by the money that is spent on determining where the universe came from. I am interested in the *fantasy* of origins, why it grips people. You catch cold and you want to know where it came from: how, who, when, etc. . . . causal thinking; into the past—away from the sneezing. We are so baffled and perplexed by symptoms, images, poems and dreams. The image can be baffling. I begin with Jung's idea that psyche is image. The image is the unmediated. It just appears. If that is the case, the image does not originate elsewhere. Going to the past for an explanation is the reduction of the image to something already known. We want to place it somewhere familiar, avoid its perplexity. Traditional psychotherapy is a system of avoidance. Jung said, start with what is, there, now. Do not interrupt it.

"*I am interested in the* fantasy *of origins, why it grips people.*"

In our culture we are historical materialists. We favor the past in a literalistic way. We are stuck with the efficient and immediate cause. We have lost the formal cause (Aristotle and Thomas Aquinas), the way the dream or thing is put together, that which forms it in a certain way. The psyche takes the residues of yesterday and forms it today. Aristotle and St. Thomas also had the final cause, that for the sake of which something happens. The final cause, the intention or purpose in each event is crucial to looking at life psychologically.

S.M.: Is there an existential terror or simple reluctance to look at the situations before us for what they are, in themselves? I feel that within an art therapy context, analytic interpretation according to a particular psychological system stops the process of dialogue, it establishes a distance between people, and between the person and the phenomena. A participant in one of my art therapy training groups said that this kind of interpretation can be likened to talking *about* a person or an image, as opposed to talking *with* them.

J.H.: Much of what I write is intensely polemic and against what I see an excess of. One of these excesses is an addiction to meaning. We attach ourselves to meaning and lose the image or dream. Abstract interpretations take us away from the image. I try not to reduce big trucks to power drives and little dogs to feelings. Our psychological language is conceptual. It does not have images. We need metaphoric interpretations, rather than symbolic ones. Putting meaning onto something is often an avoidance. Another avoidance is identifying your feelings with the image.

I do not say, become the truck, or the little dog. That is the "I," the ego, swallowing the dream. *You are not the dog, the truck.* They are independent psychic events. It is important to feel what you feel vis a vis the truck and the dog; not what they feel.

There is also the problem of ownership. People will soon be owning the Gods, by feeling what they feel. Very pretentious! If a fox comes to you in a dream, it is not yours, anymore than a fox that comes to you in the forest. You are one figure in the dream. What comes to you is not yours. The ego is not the owner.

S.M.: You are suggesting that the drawing, the art work, is distinct from the person. It has a life of its own.

J.H.: When Plotinus said, about the Gods, "It is for them to come to me, not for me to go to them," he was probably talking against magic and theurgy: attempts to make the Gods do things you want them to do. Like Prayer. "For them to come to me" as a visitation. Now, take this in terms of images: images, whether in dreams, in poems, in dayfantasies, or in art. If they come to you, then you respond as best you can; you record the dream, you enter the fantasy, question it, talk about it, and if it is a painting under your hand, you shape it as best you can. All along, you could have in the back of your mind the idea that what comes to me may be a visitor, a "God." That was the moral of the old tale of Baucis and Philemon: they let some broken down vagrants into their little house, who turned out to be Gods. Mercury and Apollo, I think. This notion of the image as a visitor, a visitation—rather than some thing creative, created by "me"—also helps account for why it's so damned hard to make a poem or a picture. If, as Jung says, a God is what crosses your path, what comes in you and is against your conscious intention, the image forces you to receive it, and even serve it with your hands, with your words, with your movements.

S.M.: What do you think of approaches to therapy that stress role play, becoming the image, the fox?

J.H.: By becoming the fox, I lose the religiosity of the other, which carries something different and moves on its own. Is it acceptable to the fox for me to act like a fox. Isn't it insulting to be imitated? Any theory of animals has to be acceptable to the animals. I don't think they would vote for Descartes or St. Thomas. You see, I will not make a distinction in my respect, in my regard for the animal, between an outer gorilla in the Congo and a gorilla in my fantasy or dream. I am like a very archaic caveman: what comes to me is the animal and I have to be in good shape not to offend it. When an indigenous healer puts on a leopard mask, the leopard is there. He has the leopard's permission. It's not my ego playing a role. It is bringing the Gods onto the stage. The God's, the animals, do the healing through the masked man. They know what's what. Instinct is the word we use in psychology for the knowing of the Gods and the animals.

S.M.: You pay less attention to the ego in a dream or artwork and more attention to the animals, or other figures. They are as you say "the forces or powers which were once called Gods."

J.H.: A rule of thumb might be: everything is right in the dream except for the ego. I do not question the other things in a dream as much as I question the behavior and attitudes of the dream ego. It is usually defensive, or hysterical, or anxious, or just plain dumb. By "dream ego" I mean the "I" that is walking around in the dream and with whom the dreamer feels identified in the morning. Often what feels right is merely "right" because it fits the ego attitude. Feeling is not the only cue. People are awfully identified with what they feel. We are overly reacting to the rationalism of Descartes, the Victorian age. Psychic value might lie where our feelings most rebel, where the defense is hiding. Analytic work goes against nature, against the naive. Rather than judge your work by the feeling you have about it, judge your feeling by the image you are having. By working on images in art therapy we sophisticate the feeling.

S.M.: Is this a guide to the interpretation of art?

J.H.: Well, I'm afraid I'll get caught in presenting an opinion and taking it literally, so let's move warily. Art gives a feeling—some feeling—maybe rich and sweet, or even repulsion, or most likely upset and bafflement. You have first to feel what you feel, and then disengage from it, and look into it. The best way to disengage from the immediacy of the feeling is to look to the image. I ask what is the feeling like: describe it. That rich and sweet feeling, makes me see a woman, swoon, or makes me think of pastry, or I want to touch it. I never stay with the feeling as it is, good or bad. Put the words "good" and "bad" back on the shelf. Get images.

S.M.: For example?

J.H.: A man dreams he is flying at incredible speed in and around stars seeing wonderful lights in a vehicle piloted by James Dean. He wakes up happy and feeling good, he says. In another dream, he meets a girl from childhood who looked down on him for being puny, and in this dream, in her kitchen, she says "don't go away." He wakes up happy and feeling good. Now, there are two kinds of feeling good. "Good" doesn't say anything by itself: we need to see the images that make him feel good and these are very, very different "places to be." The first has the puer prospects of crashing, of being spacey, of being spiritually dazzled by "stardom." The second feeling good refers to refinding and brings with it the rejected puny feelings of himself which are now accepted, even wanted, by this early love. It's pretty evident that feeling good says very little while the difference between the girl and James Dean, between the high space and the common kitchen, between speed and cooking, between the power and the puniness—these say a lot. Of course, it helps to have a symbolic, archetypal, mythical background against which the images can be placed, which give the images depth and cultural resonance. I mean knowing something about anima helps give that girl more value, as knowing something about the puer helps you see the attraction in flying, and so on.

S.M.: Psychotherapy training has historically placed more emphasis on

"Rather than judge your work by the feeling you have about it, judge your feeling by the image you are having."

analysis within a tightly circumscribed context that reinforces the therapist's knowledge of the particular system. Your approach to "knowledge" is more ambitious, broader and expressive of the multiplicities of culture. It is many dimensional rather than one-dimensional. Knowing is complemented by imagining. This makes for a lively cooperation.

J.H.: My work is the revitalization of the imagination, the ability to live imaginatively in many ways. In recent years I enjoy therapy enormously, probably because I am not concerned with the feeling. I have let it go. I am not busily concerned with transference, the relationship. In the past I was working at it too hard. I was overly concerned. Therapy is never a one-to-one relationship. There are many more persons in the room than the two people who think that they are the only ones there. I do not think that the one-to-one relationship with the analyst is enough. There has to be a relationship to the world. What was wrong for me before, was that my feeling was under a director. Another was the attempt to do therapy "very well." But I can't explain a thing with biography. These are just stories.

S.M.: You certainly do reverse the most fundamental beliefs of the psychotherapeutic community. You have described therapy as a work of love.

J.H.: It is a love of the psyche; not the other person. We have to be very careful of locating love in the personal relationship. Isn't it the same with art? You love the dance, the music—not your dance partner or the other person playing in the quartet. Of course, your common engagement brings love into the personal field, but it starts in the love that is at the same time the work.

S.M.: How does this apply to a painting? Do you love the painting itself or the psyche that it emerges from?

"I do not think that the one-to-one relationship with the analyst is enough. There has to be a relationship to the world."

J.H.: It's probably more like a tremendous captivating interest in what's going on in the painting that you are working on. You can't leave it, you keep finding new things to touch, you're exploring and bothered and preoccupied—but it isn't love of the painting as a thing—you know: "I just love that one!" Now, the other person brings the possibility with him or her into the consulting room, a possibility "to paint," or "to make love." You see what I mean here? It's not the other person, it's the psyche that constellates an erotic response. But our culture, our Christian culture especially, because of its repression of eros and sexuality, because of its deifying "the person," because of its commandment to love confuses us and we believe we love, or must love, the other person.

It gets horrifying. Therapists become Christian Pygmalions: we not only fall in love with what we are working on, the other person, but believe that this love will bring the other person to life. Meanwhile we aren't making anything, no painting, no psyche, no nothing. Just indulging feelings under the self-deception that this is therapeutic.

S.M.: I am sure that your orientation to "love of psyche" rather than to "love of the other" has provoked passionate criticism. It can be said that "you do not seem concerned with the patient or client as a person in difficulties"; that you are more concerned with "art" and "imagination" than with the person's life; that your work "separates art from life and becomes aestheticism or 'l'art pour l'art' images for their own sake and not for the person's life."

J.H.: You are right. It does sound as if this were my attitude. But in actual cases this is not the way it is. In actual cases life and imagination are not at all that separated. The way a person imagines his life is the way he lives it. We live imagination, not just life, for even "life" with its problems and troubles is a specifically organized narrative of experience, a way of styling or imagining, that sees and feels things in terms of "problems and troubles." What I try to do with actual cases is discover the imagination shaping and informing the problems and troubles and then work them out on the level of images.

Most problems and troubles have been worried over by the patient for years. I can't add much there. They know far more about their lives and how they cope that I can advise or inquire into. But what they usually don't have are images that can take them right out of the Catch 22 situations that have them trapped. "Should I stay with my drunken husband: should I leave and be on welfare and the kids without a father?" Back and forth, in the stew. Until one day a black crow comes into a dream, or a painting, a talking crow. I encourage the patient to talk with the old crow, and that bird turns out to be very savvy and very tough, and begins to take her (the patient) under her wing. And its not just the figure of the crow, its the whole opening of imagination that gets her out of her trappedness—not out of the trappedness of the marriage, but of the narrow confines of her mind in which she has trapped her marriage, her mind that could not imagine beyond that Catch 22 puzzle. She begins to fantasize and not just worry, to speculate and not just think it all through one more time. A little bit of freedom, and a little less guilt. It is amazing how people's lives loosen up when they gain better footing in fantasy and how much more self-confident they become.

S.M.: The "attempt to do therapy very well" is where the profession reaches toward art, where the professional becomes an artist working independently.

J.H.: I enjoy being professional.

S.M.: What does "professional" mean to you?

J.H.: I enjoy my knowledge and my skill. I enjoy the ability to form a vision of what's going on, to give form to what is presented, to be right there with reactions, and to sense the blunders as I make them, or soon after. I enjoy my trained nose for psychotherapy. I enjoy being baited and not getting caught . . . all sorts of things. I even enjoy being founded on the fathers of the profession, Freud and Jung, being a member of a school. But, and there is a huge "but" here: I disassociate myself from any professional model, or what Jungians call "persona." That is, I don't look at myself in terms of a model, from the outside in terms of rules, or standards, or procedures. I don't think of myself as a therapist while I'm in the act of doing therapy. That keeps me from literalizing what I do as "therapy." I think of myself as anything but a professional when I am actually practicing my profession. Then I maybe am a cook or an alchemist or a teacher or a bullfighter or a schemer—undercover spy . . . anything. Because therapy is so tied into feeling professional and professional feeling, I try to keep clear of a model that would bind my actual feelings. I don't know whether the patients are happier. I don't know.

S.M.: You have been asked, "Are the images happier?"

J.H.: In some situations they are. The voices that the patients bring, that they speak with, are definitely in better shape. They are relieved. They have come out of the closet. There is a release of the demons from hell, an opening of the gates of hell. They can move into a closer relationship to the person they are associated with.

We are so indoctrinated to think that the repressed are unhappy. We cannot imagine that the images love us. Let's not look at love as a feeling but rather think about it as a repetition . . . it keeps visiting us, wanting to be a guest, there when we need it, entering into a conversation with us. We can lose our images by ignoring them. If we see the images as demons, then they are things that we do not want to lose contact with. We are afraid of the image appearing in the form of spiders. We diagnose them as crazy when they can be friends, or at least partners, advisors, coaches, etc. Spiders are beings who drop in on us, spin, and catch noisome, buzzing distractions. They are very purposive.

Some people interrogate images. The images clam up and do not want to say anything about their personal lives, who else they might be seeing. Sometimes the image gets hurt. We think that we will have dreams and ideas forever. One ought to be grateful to have a dream. It is worth respecting, spending time with. It is not just a fountain. Artists are afraid of losing contact. They relate to Mercurius and have more respect for the inexplicable spontaneity of the image.

S.M.: How do we relate to the polytheism of an image?

J.H.: In our culture we tend to take voices and figures as commands. We receive contradictory commands which do not cause the same kind of confusion in a polytheistic culture. They hear things differently. Their language structures are different. For instance, other cultures are not so hung-up with the logic of contradiction, or on differences between past, present or future, or between the intention or fantasy to do something and the actual deed.

"Because therapy is so tied into feeling professional and professional feeling, I try to keep clear of a model that would bind my actual feelings."

S.M.: How do we learn to let the image speak to us?

J.H.: Abstain from declaring the meaning. Polytheism cannot appear until the feeling judgment of good/bad, like/dislike is bracketed out. Painting tries like crazy to break us from the feeling that we know what it means. Then the many possibilities begin to appear.

There is always a list of possible interpretations. Multiple narratives emerge from the complexity of the image. If we say that the meaning is none of these, and just describe the physical characteristics of the image, then we place it back into the genre of social realism, another interpretation.

The first step is to withhold meaning.

The second is to realize that every one of the tales reveal the polytheism of the image.

Third, it is a matter of determining which is the better tale; which one sticks to the image, is authentic, is the fecund way of talking about it. Does the tale release other things? Fecundity is important. Does it spark an image in the observer? The response that is as imaginative as the image is an adequate response. The longer it lasts has something to do with the fecundity of the image.

"A posteriori" judgment tries to fit the image into the case. I am more interested in the material than the case. At Yale in 1973 my wife and I did interpretations of dreams in seminars without personal information. The structure of the dream then told the person who submitted the dream anonymously a great deal.

Stories change. People tell themselves in and out of stories. Usually the ego is served by the narrative. Generally, a story tends to be about a single figure and this is why I am cautious of narrative: it serves the speaker, the ego, making him or making her the hero or the victim or the superior observer or the loyal servant—but I want to know more about the *other* figures. "The images speak because they want to speak" as Mary Watkins says, and not because they represent some aspect of the ego. They are not representatives, they are ambassadors, full plenipotentaries with lots to say. Unfortunately, we don't have an adequate philosophical context for these voices other than magic or madness. Our secular humanism, rationalism and doctrinal religiosity do not work for them. It only supports the solitary ego. We desperately need a cosmology that allows the image to speak. So of course there is so much loneliness and neediness because our psychology does not allow us to talk to our selves, our elves. We aren't ever actually alone, even if our secular cosmology and transcendent theology have left us there.

S.M.: Art therapy needs theory and methods, a cosmology, indigenous to art.

J.H.: Part of the job of the art therapist is to be superior. You need something that can hold what you are doing. You need a philosophy; a religious understanding . . . not techniques. But beware of the new.

S.M.: Art can be distinguished from "creative expression" because of the discipline involved. It may take years to perfect a particular gesture. Art also involves decision making, a critical moment, determining when to stop and what needs to be omitted.

J.H.: I am concerned with the place of the critic in imaginative work. When an image appears, a critic appears. Puritanism begins with the smashing of the image, as with Cromwell. That is not criticism. The wrong critic completely negates artistic expression, and says that we should not be doing it at all. There has to be a ghost trap for catching these wrong critics.

With the idea of the critic comes the suggestion that there is an "other" that we have to communicate with. The image wants itself to be articulated as well as possible. It lays a claim on the hand to be rightly and deeply presented. The critic is within the image. There is some urge within the image to be realized. The critic compels us to listen well. Why are we so responsible for getting it right, as with writing down a dream correctly? Getting to the dream involves an aesthetic precision. I am trying to get to the phenomenology of the experience. I critically evaluate whether or not the person is listening to the dream, image or figure. My job is to sensitize people to what they are actually doing.

The hand helps us to get through things. A basic metaphor of the arts therapies is the hand, and this is why they can do so much. The hand is tremendously important for resolving things. There is an animal sense to this. The hand is thinking about what it does. When I write, I have to get the thought down and through my hand in order to express it. With the animal, consciousness is in the doing of the act.

At the University of New Mexico a number of years ago I was working with Howard McConeghey in an art therapy seminar. We were dealing with the issue of what to do if a patient was having difficulty making a perfectly round image. A student said that she would give the patient technical advice on how to make the image round. I asked her: "Do you trust the hand that cannot make it round?" Howard said: "If he cannot make it round, he does not have an image of roundness." The image is what the hand is capable of.

S.M.: How do you see the image within the context of art therapy? Do we create images?

J.H.: Paintings can help us to find images "inside" ourselves, rather than psychological concepts, that can be helpful when we meet new situations. Psychology and clinical language do not use images. I try not to read a painting in terms of the artist. I see it as psyche presenting itself in images through the hand of the artist. Images appear before us. I do not want to say that we make images. Paintings can be perceived as images of the psychic condition. Imagination manifests itself in the painting. I am not as interested in the biography of the artist. Jung spoke of how we must regain resources beyond the personal, and that this is where healing begins.

S.M.: You are presenting art therapy with the task of looking at paintings to find a resource of healing images that we can take inside us, to be used instead of clinical language. You suggest using the physical phenomenon rather than the conceptual abstraction.

J.H.: Art therapy should consider having a whole range of physical metaphors for the work. For example, alchemy has boiling, cooking, freezing, fire, etc. You need to introduce artistic metaphors as distinguished from technological ones. Medical *metaphors,* such as "suturing," "closing," "splinting," can be more useful to us than the medical *model*. Metaphors from sport are helpful in therapy . . . "Go for the daylight; find the hole." The tacit knowledge of the running back in football contrasts to the technical drawings of the television analyst. The running back is in tune with the interference, the blocker he is running with; it is intuitive, a body sense. Therapy is packed with situations of this kind, where people dance together. We need to find metaphors for what takes place in art therapy.

S.M.: In art therapy we do use

language. It is often essential for dialogue, for depth and the engagement of the image.

J.H.: Language is so conceptual, so dead in the academic world. It's not much better in the media or business or science. Just think of the robotic language of the men who landed on the moon. Why send people into space if they talk like machines. Language has become so stiff and creaky and just plain dull that many psychologists believe now that wordlessness is better than speaking. They think the grunt and the omm take us where words cannot. I think just the contrary. Rhetoric is our animal nature: speech is phylogenetically built into our throats, lips and tongue structure. We are the only species to talk: it's as much part of our animal nature as the leopard's spots. We don't have tails to wave about and show off like sleek fur. We display ourselves in words. And people have been storytelling since the beginning, using words to evoke, to inspire, or remember, or just to enhance and dramatize, what's going on. And those descriptions are not a recounting of what happened, second level and removed. The stories are themselves an event, a show, that is aesthetic right from the start. It's essential not to abandon language. Let's treasure it. Psyche needs logos; it needs psychology. The soul enjoys words and ideas.

S.M.: You have worked for many years in the Jungian tradition. Do the conceptual abstractions of Jungian psychology get in the way of the image speaking for itself?

J.H.: If the word evokes only doctrine, then it is not useful. The concept gets in the way of the image. My own intellectualism can hurt the presentation of the image and distance me from it. What is being suggested here is the inherent intelligence in the image. *To talk about the world in terms of the imagination implies that everything has intelligence and does not require the imposition of structure by a meaning giving mind.* Rather than an abstract order, the world is a text, or a work of art, that can be read, or understood. Our aesthetic sense is necessary for living sensibly in the world. We just need to pay closer attention to it, and less to ourselves and how we feel about it.

S.M.: The perception of aesthetic sensibility as a fundamental element of well-being may help art therapy to see itself as a primary mode of therapy, rather than attaching itself in a secondary role to the medical and behavioral science models. I have often felt that the stronger the aesthetic experience is, the more comprehensive the healing is.

J.H.: We all feel this, yet it is so hard to legitimize. We all know that powerful aesthetic experiences are healing: whether in a concert hall, a museum, by the ocean . . . even the people who decide about grants and allocate funds know the importance of the aesthetic in their lives, yet when it comes to justifying money spent on art, let alone art therapy, they have a terrible time. Why is this? What is wrong with our formulations that at once vitiate our experiences?

S.M.: In the popular mind the arts are perceived as recreation and entertainment. They have been disassociated from their historic philosophical functions. Can you give an example of an aesthetic experience in therapy as contrasted to an analytic one?

J.H.: In Korean ceramics, there is no question of symmetry or asymmetry. No "opposites." There is a bowl or a jar. That bowl or jar can be classified as asymmetrical: it tilts, it has more thickness on one side, or a crack. But to think of asymmetry, immediately raises "symmetry" in the mind: that is, the mind walks away from what is here, the jar, into a pair of opposites: symmetry/asymmetry. Immediately we have moved from the image to a concept. Now, the making of this bowl or jar, as such, "overcomes" the mental process of self-division. The bowl experienced aesthetically (not conceptually) either by the hand and eye in the making, or the hand and eye in the appreciating, heals the oppositional tendency, the problem-making tendency.

S.M.: The unity of opposites is a tidy abstraction, especially when we are perceived as progressing toward integration.

J.H.: The evolutionary model has to do with towardness. Why is unity so important? There is not a single philosopher in the history of the West who will condemn unity. The Neo-Platonists suggested that unity is a quality of any event. There are any number of unities. There is not any over-all unity. There is a phenomenal unity.

S.M.: How does this apply to the image?

J.H.: An image is not going anywhere. One of the problems of therapy is that it is so damn goal directed. A painting cannot go anywhere. It is what it is. Picasso said of himself: "I do not develop. I am." Unfortunately therapy does not think this way but approaches things in terms of where they are going. The painting can be a manifestation rather than a development. In the language of the psychotherapeutic genre, people come to therapy in January and want to get to summer.

S.M.: James Joyce spoke of art works as "epiphanies," manifestations that reveal the divine.

J.H.: Is there any relationship between the different works, the epiphanies? Is there a development, a Darwinian evolution? We are caught in the narrative of development. Another model would be a chain of epiphanies, separate events, strung on a necklace, maybe interchangeable beads for other necklaces.

S.M.: Are developmental psychologies, and humanistic approaches to "becoming a person," future oriented distractions from "being"?

J.H.: I go with a "via negativa"

which for me means not letting the mind get ahead of itself. We get in the way of the animal by preknowing things. Western philosophy always gives the animal a low place. The restoration of the animal in our psyche is primary and for that reason alone. The contemporary animal rights movement is significant. There is something revolutionary in restoring animal consciousness. We have the black movement, the women's movement and now the animal movement.

The most important dreams for me are those with animals. I am not as interested in parents as in animals. I go after the animal. The animal knows what it wants; it has a nose, modes of protection; it is ecologically in the world . . . the ego in the form of Hercules slays the animal. "Ego" is the classic mechanism of defense.

Before getting involved with concepts of ego, consciousness, specific pathologies, etc., I want to know what the person is doing. In therapy I look for a figure to talk to, an animal, a rock, an image that the person can relate to. It might be useful to make a circle to sit in, or a person can go to a stone and sit there with his or her back to it . . . or a tree. We are trying to find ritualized acts. Breathing is another way. There are ways to get out of crazy states. A person that I worked with got out by just breathing. These modes offer imaginal containers. Belief in the larger strength, the more important value of an animal, stone, or tree is what matters. This is animism.

S.M.: You bring mind back to the physical world.

J.H.: I do not try to define consciousness. I would never try. I attempt to find the metaphor that is being used to define consciousness.

S.M.: The arts engage the soul, and its conflicts, directly, through the language of the soul, rather than always feeling the need to translate the image into psychological concepts for analysis.

J.H.: Yes. That's exactly right! Through art therapy, we meet disorders of imagination with imagination. Other therapies use foreign systems. But still ideas belong. Ideas are vitally important. Rather than rejecting ideas, can we envision an *imagining intellect*? Intellect is one of the places of the spirit. It is an art, a theatre. Intellect can dance too.

S.M.: With others?

J.H.: We tend to be herd animals. We are socialized. Suffering on the animal level is caused by separation from the herd. Let's bring the pathology into the fantasy of the animal. Human communities have periods when the person is separated for the purpose of initiation, but the isolation is still within a context. The patient needs a context, or ritual, within the community for the psychosis rather than being opposed to the community. Jung does us damage in separating the individual from the collective, in romanticizing the individual.

S.M.: In our language we use animal and herd metaphors disparagingly. Pathologogy is conceived in terms of animals—eating like a hog, bull headed, stubborn as a mule. . . . "Dog, pig, rat, snake, beast!" The American College Dictionary defines animal as "an inhuman person; brutish or beastlike person . . . pertaining to the physical or carnal nature of man, rather than his spiritual or intellectual nature." You reverse these values and emphasize the virtues of animals. Humans have a tendency to elevate themselves at the expense of animals. Our fears of sensuousness and of our animal nature are revealed in how we form the image of the devil with animal and serpentine features. D. H. Lawrence does the reverse too in perceiving "the plumed serpent" as a manifestation of divinity.

J.H.: We have prejudiced animals by referring to them as "brutal" and "beastial." It is the Cartesian dualism that has turned peaceful beings into brutes, pigs, bitches, lizards, monkeys, apes . . . derogatory things. In dreams animals can appear as saviours, as teachers. The main problem is the dreamer's fear of the animal. The dream, or the image, is to be connected to an animal rather than be interpreted. If you call the cow in a patient's painting, "your mother," then you lose it. You insult both the cow and the mother. It may be a hurt cow, or a nasty cow with horns. It is important to keep using the word cow. Where is your cow? Is it a hurt cow?

People get upset when an animal is dying in a dream. A small bird is dying. Rather than referring to the bird as your dying spirit, you can say that this little bird is in dire straits, and has come into *your* dream. Now what?

We can learn from fairy tales. The person who gets through, is the one who speaks to the animals, as opposed to those who ignore the animal or see it as inferior. We have to work our way through the brutal aspect of our reactions to animals, and not project the brutality onto them. What you do to the animal, it does to you.

There is a specificity about animals. It is very different when an eagle comes to you in a dream than when a pig comes. Wherever Islam went in the 7th and 8th centuries, the pigs got it. They were killed as unclean. Pigs have been our companions for thousands of years, yet even Christ cast demons into swine. They are so rejected! When we talk about animals generically in terms of

---

"Through art therapy, we meet disorders of imagination with imagination."

"instinct," this simply groups them all together. The Irish saint is the one who can talk to the animals. Sainthood involves living in connection with the animals, and knowing the language of each kind.

S.M.: And appreciating their differences?

J.H.: Different birds have different meanings in dreams and imagery. It is important to distinguish the birds from one another. Even 100 years ago people sat for hours in carts, reins in their hands, staring at the moving butts of horses. They lived the life and smell of horses. Animals were close to daily life. People knew how to live with them. We can read our cats and dogs, but do you realize how they can read us? This has to do with external animals, but probably our internal animals are watching us, and watching over us, too.

As we get farther away from the animals in daily life, it worries me. What good is it to be in the ecology movement and still beat the animal in your dreams. Animals have a natural piety; they don't get out of hand. The human being is not first in all cultures. With the bushman we are ranked fourth.

S.M.: You are resurrecting an aboriginal respect for all forms of life.

J.H.: If a bug appears in a dream, we stamp our feet on it. We want to immediately get the insecticide. Going "bugs" is going crazy. The pesticide industry is psychologically based. In California they realized that the total cost of pesticides and herbicides is greater per year than the loss of the crops would be if left untreated. If the Carlos Castenada series were about bugs and worms instead of eagles, I might like it.

People who have never been with animals still have intense animal familiars. They do establish a living connection with them. I even think it is necessary to go look at animals. Ask your patient to take a day in the aquarium or zoo. The sacred quality of animals is what I try to get at in therapy, the numinosity, respect, fear, the eternal. The American Indians believed that the buffalo disappeared in the fall and came up through the earth in the spring, the same buffalo, eternal.

S.M.: How do you relate to the killing of animals?

J.H.: In a dream the pet dog may have to be put away because the sweet, domesticated spirit has to go. The butcher is an important figure in dreams because he knows the art of dismembering the animal. Slaying can be getting to the essence, penetrating, not running from it.

With the butcher, the dismembering is to get through the sentimentality of the animal. Some of the old sentimentality says never hurt an animal. This relates to Dionysian mythology and his being torn apart, and dismembered by the maenades, and then put back together again. It is not merely hurtful and ugly—like Yankees feel at the bullfight who turn away their eyes. It is an opening. It is a ritual, and a different motif than talking with the animal or flying with the animal. The butcher knows how not to damage the soul of the animal. It is hard for us to find the right way to deal with the animal because it is either so worthless or sentimentalized within our society.

If an animal comes to an American Indian during a dream, it might be the beginning of a vision quest. If a particular animal comes to us, we need to spend a great deal of time thinking about it and looking at it. We might study its natural history and the distinctive features of its way of being. Why does the animal come to you? What does it want from you?

S.M.: This animism and your respect for art as a primary therapeutic metaphor are in sharp contrast to the technological values of contemporary mental health systems?

J.H.: The early psychoanalytic community was totally untechnological. It was an artistic community with Rank coming in from high school, Freud analyzing his daughter . . . what a marvelous, crazy bunch! Our minds have become technological. "Figure" has become number rather than shape. "It doesn't figure." The technological approach assumes that things can be "figured out" and "fixed."

"Therapy is caught in the literary genre of social realism . . . not the genre of lyric or epic."

Therapy is caught in the literary genre of social realism . . . not the genre of lyric or epic. Life work is perceived as struggle and dense. Therapeutic work is directed at those who are oppressed. It is a depressive genre. The concept of social realism is closely associated with depression, working with "hard reality." But social realism is a genre, a form of art. When social realism is combined with developmentalism and the notion that everybody is supposed to grow, it is exhausting. The model produces burn-out. We might consider other models to work in, a totally different context.

S.M.: It is difficult for art therapists to go all the way with the artistic metaphor, to stand alone with it. There is a fear of losing something, the relationship to the mainstream of the mental health tradition.

J.H.: O my goodness! "The mainstream of the mental health tradition." Pardon me; but that sounds like the KGB! What mainstream? You mean case management and workups and files and supervision tricks . . . I am being nasty because I don't believe that there can be a mainstream unless there is a spring, a deep source—and now I am contradicting myself regarding "origins." But rivers rise from a deep clear riverhead: and what is the riverhead of the mainstream in mental health? It's not Freud, or Jung or even Alfred Adler, or William James—it's something vapid as "the ethics of good works" or simply bureaucracy, "agency," KGB, keeping people in line, getting them back to work, and so on. The mainstream works for the government. I see therapy as subversive: it is *intensely anarchic* and *intensely communal:* both; but it is not mainstream in that collective sense that I am insulted by: paperwork, tinkering, disguised churchiness.

S.M.: And drugs! The mainstream has swallowed the revolutionary origins. The most influential teachers in history have been those who have most radically reversed what we take most for granted, that help us to see that what we value the most may in fact be limiting us. The creation of a different context for the practice of therapy, an artistic context perhaps, is not easy for the art therapist. You are referring to a *political* aspect of art therapy. The art therapist in a hospital setting, or working with children in a school or in an agency will not prosper by going against the system. We have worked very hard to make favorable impressions.

J.H.: This is an important question. I don't believe much attention has been paid to the politics of art therapy—except for the politics of therapy in general (Laing and Cooper or the Marxists and the feminists).

S.M.: Minority and cultural groups.

J.H.: I see an inherent conflict between artistry and art therapy. They require different politics. Let's take Blake as the model for artistry: he was a nut working alone, almost antisocial. The Romantic Artist. Art therapy, however, is paid for by insurance companies, state funds, taxpayers finally. Of course, its aims will bend toward conformism, conservatism. How does the individual art therapist work through this dilemma?

S.M.: Art therapists are interested in being *useful* within a context of artistic liberation.

J.H.: To do something very well, with dedication—even if one has no great talent, is artisanship. Its like making things for the village that are useful: pots, woodwork, weavings. This can be intensely communal, because these are functional objects serving communal needs. At the same time, the intensity of expression, the personal shape given by the hands, the "individuality" of the piece as a formed image is intensely anarchic: it isn't intended to conform to anything but to itself, fully. That last is very important: because if you lose the individuality-side of the dilemma, your focus is not on the thing and the hands and the image (while working) but on a societal product. Only indirectly is what one makes a societal product. Of course, all along the struggle with invisible community values, the battle against collective stupidities, is going on in the shaping of the product. It's the old problem of how to keep the moral and social aspect of art from taking over, and yet not losing it altogether in *l'art pour l'art.* When I write something, for instance, I am intensely communal, out to break up cliches, trying to get my ideas readable, wanting them to have effect on therapists and be helpful to souls in their messes. But—and this "but" is crucial—I never write directly in that direction: my main concern as I write is the careful formation of the work itself and this tends again and again to be intensely anarchic (individualized), forgetting the actual community. I am often at the point of not caring at all if it is ever read by anyone.

S.M.: You caution against evangelical attitudes toward creativity.

J.H.: Archetypal theory helps us to understand that there is always another side of the coin. When you are being positive always keep in mind that there is the negative somewhere. When the negative feeling is repressed it will appear. Wherever you find disturbance, that is where the psyche will be working. I emphasize the importance of destruction, and hatred. They are the acids that motivate. Certain art therapists may be obsessed with the notion that we are all creative. Creativity becomes a one-sided model, having lost its shadow of destruction, and becomes a dangerous word. There is an inflation of creativity today. People do not read poetry, they just write it. Our notion of creativity dispenses with learning. Creativity has become a shibboleth to art therapists and an awful, impossible burden is placed on people "to be creative." Belief in the endless flow of creativity is problematic. We need more than just expression; we need to give form. The classic alchemical formula is "dissolve and coagulate." In addition to flow there must also be coagulation.

S.M.: Can you describe how the artist or the art therapist might engage destruction?

J.H.: Your question is really a very good one. Or should I say *bad* one. . . . Let me first make clear that to engage in the patient's destruction is not to release the devil, or abreact the emotion. Get it out, get it down on paper in big red blotches, or dig your nails into the clay. We are not in the business of exorcism. Devils are resources, and very difficult to distinguish from angels, who once had beating animal-wings and were fiery and huge. So, if you are working with destruction you are *interested in it* and not trying to get rid of it. Second, you are not even trying to improve it so it is less destructive. Rather, you may be trying to get its expression more formed, more verbal or dimensional, less hulky say, and more articulated, where articulated means both more verbalized and more jointed and connected and differentiated. Then third, you have to have some joy in *your own* destructiveness: I think Swift must have loved writing his hatred into stories and essays. Or Bosch and Goya. Therapists are often goody-goodies, or do-gooders,

Dr. Howard McConeghey (left) and Dr. James Hillman

and awfully ashamed of their hatred for the patient, or the hatred and anger that the patient evokes in them. What do you hate? What precisely? Picture it yourself, and get into it with the patient: maybe both of you together can work on this hateful quality.

S.M.: Is there any truth to art being a projection of the person?

J.H.: Sure there is, though I prefer not to see art that way. I think it's this view of art that art therapy most uses, which overvalues the "person" and undervalues the "art." Certainly tribal art and medieval art were not projection of the person. No artists, but plenty of art. I think this view is the ego-artist view; just not interesting and it leads to all the psycho-biography stuff, of dirty-minded gossip about people and explaining their writings or paintings in terms of their impotency, or mistresses, or drinking, or their poor old mothers. But—if you were to imagine "person" differently, then I'd say, yes, it's a projection of the person: it's a "pro-jection," a throwing forward and outward of the impersonal elements that make up personality. The maker's soul is in the work, thrown out there (projected) into visibility. But what this soul is, that can't be defined with the usual notion of person that psychology employs. Too limited. Soul has historical and cultural and archaic levels that are most un-biographical and impersonal.

S.M.: At the beginning of this dialogue, you mentioned that each teaching situation, or engagement, is an opportunity to learn something new. Has this discussion of your work in relation to art therapy been of use?

J.H.: I learned how quick I shoot off at the mouth! You know questions like this bring out my opinions. I leap for the bait. An old fish like me ought to be more wily. I also learned that I have tremendous sympathy for the plight of art therapists . . . they could really be the carriers of imagination into the culture at the grassroots level. They have access that artists themselves don't have, and that psychologists have wasted. I really do want to encourage them with all my heart.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:
Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

Archetypal Art Therapy Is Cross-Cultural Art Therapy

Howard McConeghey, Ed.D., is a Professor of Art Education, Department of Art Education, College of Education at the University of New Mexico, Albuquerque.

This paper uses the term "Archetypal" following C. G. Jung who took this term from St. Augustine because it means a typos ***(imprint), an archaic or primal pattern. It is considered to be a universal aspect which crosses cultural barriers and is thus valid for all cultures and individuals.***

Such cross-cultural or archetypal elements are presumed to reach the deepest layers of the unconscious and therefore to be of primary importance in therapy.

Citing Navajo and Tibetan sand paintings, the Mandala is used as an example of archetypal symbols. Its use is mentioned in addition, in Medieval European alchemy, in prehistoric drawings and pictographs, in circular activities in space and time and in the art of children and dreams of modern persons.

Finally the role of modern art and artists in expressing unconscious, thus cross-cultural, feelings is discussed. From the post-Impressionists the expressive focus in modern art has been on inner and psychological concerns. This concern preceded that of depth psychology of Freud and Jung and art therapists. The contrast between materialistic science and Vico's **New Science** ***based on myth and human beginnings, is related to Jung's "objective or transpersonal" psyche which is therefore considered cross-cultural.***

In the end it is suggested that the title of the essay could be turned around to read, "Cross-Cultural Art Therapy Is Archetypal Art Therapy."

Archetypal Art Therapy
Is Cross-Cultural Art Therapy

> Cross-cultural psychotherapy is a vehicle for the study of the therapeutic process in relation to the many variables of human behavior and universal phenomena. Clarification of transcendental therapeutic elements does not contradict the need for sensitivity to, and knowledge of, the specific qualities of different cultural and clinical situations.
>
> **Shaun McNiff**

The title of this essay is in itself an important statement. Art therapy which crosses cultural barriers will be more than personal, will be collective and therefore will be archetypal. When the therapist can see the collective significance in a patient's image, he or she is seeing the cross-cultural, archetypal situation in the pathology of the patient. The image extends beyond the merely personal layer of the unconscious. The patient's problem is not then entirely a personal affair, but something which crosses individual boundaries and those of any single culture, to touch upon the problems of mankind in general. The pathology of the individual may be a reflection of the pathology of the culture. The poet, Theodore Roethke asks:

> What's madness but nobility of
> soul
> At odds with circumstance . . .

Although the ability to apply a cross-cultural point of view is of great therapeutic importance, modern psychotherapy is not always alert to this fact. In ancient times it was well known that the raising of the personal disease to a higher and more impersonal level had a curative effect. Often contemporary psychotherapy takes into account only our rational psychology—thus missing the collective and thereby the cross-cultural depth where much therapy first becomes possible.

In earlier traditions a great deal of practical therapy was built upon this principle of raising the merely personal ailment to the universal. Ancient Greek medicine also worked with personal problems in the same way. Myth or image arises from the archetypal material which is constellated by the disease, and the therapeutic effect consists in connecting the patient with this archetypal meaning. The therapist's task is to express the archetypal situation—to show the patient that a particular ailment is not solely his or hers, but is a universal ailment. The patient is in the company of humankind and the Gods. This knowledge produces a healing effect.

Psychological suffering always isolates the patient from the so-called normal masses, and to understand that the conflict is cross-cultural and not just a personal failure is of great significance. This archetypal—and cross-cultural—point of view lifts the individual out of himself and connects him with humanity. C. G. Jung said,

> That outlook is very important, because a neurotic feels tremendously isolated and ashamed of his neurosis. But if he knows his problem to be general and not merely personal, it makes all the difference. (Jung, 1968)

The image extends beyond the merely personal layer of the unconscious.

Although the ability to apply a cross-cultural point of view is of great therapeutic importance, modern psychotherapy is not always alert to this fact.

Art therapy which is at all therapeutic goes beyond the personal and conscious to the collective and unconscious. Because it is collective, it is therefore cross-cultural. The term "archetypal" was taken by Jung from St. Augustine because it means a *typos* (imprint), an archaic or primal pattern. He tells us that:

> the deepest we can reach in our exploration of the unconscious mind is the layer where man is no longer a distinct individual. . . . On this collective level we are no longer separate individuals. . . . Because the basic structure of the mind is the same in everybody we cannot make distinctions when we experience on that level. On the deepest level of the psyche the therapist experiences the same archetypal situation as the patient and can help the patient to relate to that deeper level of himself or herself. There we do not know if something has happened to you or to me. (ibid.)

On the personal level the therapist cannot know what the figures in the art work mean to the patient. The therapist must ask, "What is your context, what is the psychological context in which each figure is embedded?" A conscientious therapist will begin by saying to himself or herself, "I do not understand this work." Can the therapist know what the figure of a woman, for example, conveys to a particular patient's mind? Of course not; how could he/she? Only when patients have given their associations can the therapist know in what mental tissue the personal image is embedded. In Jungian terms that is called amplification. Amplification can help the therapist find the personal context—discover what complexes form the patient's personality. However, merely to discover the complexes is not enough. The therapeutic purpose is to learn what patients are doing with their complexes; that is the practical question that really matters in therapy.

In dealing with the personal unconscious the therapist must rely upon the patient's associations. The therapist cannot know the personal meaning of any figure in the patient's art work. Jung said, "I always welcome that feeling of incompetence because then I know I shall put some good work into my attempt to understand the image." (1968) This is the infirmity of the therapist and it cannot be overcome. According to Jung "Only through our feebleness and incapacity are we linked up with the unconscious, with the lower world of instincts and with our fellow beings . . . in our inferiority we are linked up with mankind as well as with the world of our instincts." Again, the poet says,

> In a dark time the eye begins to see. . . .

Art therapy is always dependent upon the patient for the context of the personal image. The patient has a life of his/her own. The therapist cannot add something to the personality of the patient. On the other hand, the therapist can help the patient to realize the underlying archetypal reality which forms or unlocks a complex. When we come to an archetypal image, a good therapist will know more than the average patient. Here the therapist can begin to think. In dealing with the personal unconscious the therapist is wise not to think too much or to add anything to the associations of the patient. But the archetypal or collective is no longer personal. We all have the same basic structure of mind and at the archetypal level the therapist can associate for the patient, and even provide the necessary context because, presumably, the therapist will have greater knowledge of myth, legend and image, just as the shaman in primitive healing knows the lore of the tribe or the collective culture, the therapist must provide the material from the collective in order to help the patient understand the archetypal nature of the complex. Mircea Eliade said that myths reveal the structure of reality, and the multiple modalities of being in the world. (Eliade, 1963) That is why they are the exemplary models of human behavior; they disclose the true stories, they are realities. The Navajo healing chants, for example, consist of "a complex of songs, prayers, rituals and sand paintings centering around myths of heroes and heroines who have made journeys to the land of the Gods (Yei) to acquire supernatural power." (Sandner, 1972) "Essential in Navajo healing is the placement of the patient in profound and intimate relationship to the past, his physical surroundings and his social group." (ibid.) "The medicine man draws the individual into the great cosmic network of which he is an integral part in body and mind, back to the beginnings of life and consciousness. Through the myths and paintings he became part of the symbolic history of the Navajo people. He has a place in the unity of the whole." (ibid.) The medicine man must undergo a long period of training and appren-

Only when patients have given their associations can the therapist know in what mental tissue the personal image is embedded.

ticeship after he has been chosen to become the healer. He must know the cultural myths, images and rites. Just so, the art therapist must have a rich background in myth and legend in order to help the patient connect with the structure of reality and multiple realities of being in the world as Eliade suggests, and to place the patient "in profound and intimate relationship to the past, his physical surroundings and his social group" as Sandner tells us the Navajo medicine man seeks to do.

These sand paintings are made in the form of a circle or mandala, the symbol or archetype of wholeness. The mandala may serve as an example of a cross-cultural symbol as will be seen in the following paragraphs.

In Sandscrit the word "mandala" means circle or magic circle. The circular sun wheel is an exceedingly archaic idea, perhaps the oldest religious idea there is. It can be traced to the Mesolithic or Paleolithic ages. This sun-wheel image is a circle divided into 4 or 8 portions—a divided circle which appears throughout the whole history of humankind as well as in the dreams of modern individuals. Jung suggests that "We might assume that the invention of the wheel started from this vision. Many of our modern inventions came from mythological anticipations and primordial images. . . . Our conscious scientific mind started in the matrix of the unconscious mind." (Jung, 1968)

The Tibetans, too, make mandala-like sand paintings on the temple floor. Like Navajo sand paintings, these are oriented to the four directions bringing the powers of these ruling directions into relationship around the center. They are made for certain initiation rites. Both the Tibetan and Navajo mandalas are expected to bring about important transformation in the participants.

In medieval European alchemy, the form of the *quadrata circuli* represents the synthesis of the four elements—air, earth, fire and water—which are metaphorically continually falling apart and must be brought together through alchemical processes. The mandala also appears as dance patterns in Dervish monasteries. These Dervish orders perform ecstatic dancing ceremonies which include spinning and whirling patterns—a magic circle.

As psychological phenomena mandala patterns may appear spontaneously in the dreams and drawings of modern patients. They seem to function as an inner order and wholeness which may serve to counter-balance the confusion and disorder of certain psychic states. The mandala is a manifestation of the archetype of wholeness. It is a cross-cultural or collective unconscious manifestation of what Levi-Brhul has called *participation mystique*.

Cross-cultural correspondences are only possible because of this underlying collective structure of the human psyche. Fundamentally, we are identical with everybody and everything on this primitive or primordial level.

Black Elk, the Ogalala Sioux Indian, describes the power of the mandala circle projected into space and time.

> Everything the Power of the world does is done in a circle. The sky is round, and I have heard that the earth is round like a ball, and so are all the stars. The wind, in its greatest power, whirls. Birds make their nests in circle, for theirs is the same religion as ours. The sun comes forth and goes down in a circle. The moon does the same, and both are round. Even the seasons form a great circle in their changing, and always come back again to where they were. The life of man is a circle from childhood to childhood, and so it is in everything where power moves. Our tepees were round like the nests of birds, and these were always set in a circle, the nation's hoop, a nest of many nests, where the Great Spirit meant for us to hatch our children. (Neihardt, 1979)

In dealing with the personal unconscious the therapist is wise not to think too much or to add anything to the associations of the patient.

Cross-cultural correspondences are only possible because of this underlying collective structure of the human psyche.

As Shaun McNiff points out, "healing, creativity and spirituality have been closely associated in all cultures since ancient times." (McNiff, 1984) He tells us that the early depth psychologist, C. J. Jung, has been "the most influential theorist articulating the presence of universal symbolic forms and the existence of motivational forces of a "collective character." (unpublished paper) McNiff is certainly the most important voice at present speaking for recognition of cross-cultural art therapy.

Modern artists have spoken of art as "reflecting our state of mind." (Gauguin) In fact, artists recognized the depth of expression as coming from the unconscious mind before Freud "discovered" the importance of unconscious motivations in psychotherapy. Behind the optical reality of impressionistic surface in Van Gogh's works he beheld and portrayed a reality "that extended deep into the soul." The depth psychologists who were to follow began to look to things as the mirror of the soul. Werner Haftmann (1960), the art historian, says:

> One thing Cezanne knew above all else, namely, that rigorous inexorable construction of form does not result in formalism but rather enables the work to clasp its hands, as it were, in prayer and paint the way to a realm which more religious epochs called "revelation"—and Cezanne said "Nature is more depth than surface, the colors are the expression of the surface of this depth; they rise up from the roots of the world.

James Hillman, the first to name his depth psychology archetypal psychology—"because it reflected the deepened theory of Jung's later work to solve psychological problems beyond scientific models"—echoes Cezanne's thought when he says, "I think the only way we can get at the soul of an object is to think of it as a form or a shape or a face, an image, and it displays its own image, its imagination." (Hillman, 1983)

Modern art transforms the world, which appears to the eye, into a world that takes on reality in the human mind. It recreates the outside world in a metaphor of colored forms, whose symbolic character can at the same time make visible the real response of the artist's inner world—the totality of self and world. With Gauguin, Van Gogh, and Cezanne and their followers, art reached a frontier "where nature dissolves and recedes into the shadow, where the contours of our inner world loom more distinctly in the twilight, where nature and the mind become curiously indistinguishable." (Haftmann, 1960)

This, it seems to me, must be recognized as the beginning of the idea of art as therapeutic and the beginning of concerns similar to the depth psychology of Freud and Jung which followed. Art therapists are not always aware that this idea came first in art and only later in psychotherapy through Jung, followed by art therapy itself. However, since archetypal is primordial we may say that these ideas have existed since the beginning of time.

The impressive achievements of modern science are based on foundations resting in Bacon, Galileo and Descartes; but Vico's *New Science* already in 1730 proclaimed that myth, correctly understood, could yield the science of humankind. Vico's science of humankind may be called psychology because in it, as in archetypal psychology, the human realm becomes unusually autonomous—with its own principles of development which are more directly reflected in mythology than in natural science as such. Modern science is of necessity limited to the actual. It does not speculate about things that do not appear in physical form. However, Vico insisted that science "must begin where its subject begins," with human beings. Myth is the key here as Eliade has indicated. It is a wakening to the divine, the poetic and the mythological. Roberts Avens points out that . . .

> In Jungian psychology 'soul' has an objective or collective aspect which shows itself in our capacity to conceive, imagine, behave, and be moved according to fundamental patterns called 'archetypes.' The empirical knowledge of archetypes is derived mainly from philosophy, ethnology, the arts, religion and mythology. Jung believes that these fields contain the most adequate formulations of the objective or transpersonal psyche. (Avens, 1980)

It is this collective or archetypal aspect in art therapy which by its very nature is cross-cultural. It is also this universal aspect which is most profoundly healing.

Thus we might not only say that archetypal art therapy is cross-cultural art therapy, but also the other way around, cross-cultural art therapy is archetypal art therapy.

References

Avens, R. (1980). *Imagination is reality*. Dallas: Spring Publications Inc.

Eliade, M. (1963). *Myth and reality*. New York: Harper Torch Book.

Haftmann, W. (1960). *Painting in the twentieth century*. New York: Frederick A. Praeger Publishers.

Hillman, J. (1981). *Archetypal psychology, A brief account*. Dallas: Spring Publications.

Jung, C. G. (1968). *Analytical psychology: Its theory and practice*. New York: Pantheon.

McNiff, S. (1984). "Art and Religion in Psychotherapy." *The bulletin of the national guild of catholic psychiatrists*, Vol. 30.

Neihardt, J. G. (1979). *Black elk speaks*. Lincoln: University of Nebraska Press.

Roethke, T. (1966). *Collected Poems*. Garden City, N.Y.: Doubleday.

Sandner, D. F. (1972). "Healing symbolism in navajo religion," *Spring 1972*. New York: Spring Publications.

"Art Therapy in Israel"

Lenore Steinhardt, MA, ATR, *BA in Fine Arts, the University of California, Berkeley, MA in Expressive Therapy, Lesley College, Cambridge, Massachusetts.* ***Ms. Steinhardt*** *is a registered art therapist (A.T.R.) with the American Art Therapy Association, and a member of I.C.E.T.—the Israeli Creative Expressive Therapy Association.*

The socio-cultural composition of Israel is identified, with focus on the cultural diversity flourishing in the backgrounds of basic Jewish identity. The art therapist in Israel, often practicing within the volunteer status, must maintain acceptance of a variety of origins as a norm, and understanding these culturally diverse populations while respecting the contributions of all people. Within this setting, art therapy can offer an experience of direct unimpeded creative self-expression and can give people opportunities to cut through divisive mental barriers. The history of the development of art therapy in Israel is included with identification of various types of settings in which the art therapist may practice. Illustrations are included from children, prisoners, soldiers, and veterans.

The multi-ethnic modern day state of Israel is one of the true melting pots of the world. Images of rich cultural diversity flourish on the background of a basic Jewish identity, reflecting the myriad of socio-cultural systems in which Jews lived in the Diaspora. Israel today is a cross-cultural fact, a fluid society constantly adapting to conditions in the modern world, and constantly absorbing new immigrants from vastly different social systems such as South America, Ethiopia and the Far East. In the daily press, news about Israel is often extreme, charged with exaltation or tension, rejoicing or disaster. The images are often polarized, pitting secular against religious, war against peace, Arab against Jew, or workers against bureaucracy. And in accordance with the national character, the public is usually vociferously involved.

The very socio-cultural composition of the country could also be seen as encompassing a variety of extremes. The first waves of immigration from Eastern Europe in the early 1900's were ardently Zionist and democratic in outlook. Social institutions such as the Kibbutz were formed and developed with an eye to building a society for future generations. Independence of men and women in personal expression, self-development and choosing one's own mate (rather than a pre-arranged marriage), as well as the individual's responsibility to a group other than the immediate family, set the tone of the new society. With the establishment of the State of Israel in 1948, great waves of people arrived, some as refugees of the Holocaust, some in mass airlifts such as from Yemen, or total evacuation from Iraq, Libya, Kurdistan, and Tripolitania in which whole families immigrated. From Morocco, Persia and Turkey, immigrants arrived alone or with part-families. Each individual ethnic or cultural group had specific traditions governing religious and social practices, education of children, the position of women, and the individual's responsibility for him/herself in the wider society. Immigrants of European or American origin and Holocaust survivors were able by and large to adjust to Israeli society and integrate themselves into daily life.

Immigrants from Middle Eastern countries, with their close and interdependent family ties, headed by an all-powerful father, believing in magic and supernatural phenomena as life-controlling forces, had a more difficult adjustment to this society, which did not resemble their expectations of it. Israeli society received all these different immigrants simultaneously, and not having yet established an identity of it's own, also had difficulty in absorbing these various groups with efficiency and understanding. (Palgi, 1966)

Tolerance of diversity of this kind and acceptance of diversity as a social norm are not general characteristics of individual ethnic groups, who frequently maintain themselves by closing their system to foreign values and ostracizing outsiders. Today, almost 40 years after the founding of the State, this diversity remains evident in disagreements and antagonisms between groups of different origins and religious persuasions, often paralleled by economic disparity between them.

The difficulties of adjustment in such a complex, fluid society may cause stress and emotional imbalance on parents and children. Other areas of stress can be connected to the region's political situation, the demands of the educational system, the position of women in religious or secular society, the continuing effect of the Holocaust on children and grandchildren of the survivors, a difficult economic situation, and divorce.

However, there is also a steady and definitely rising trend towards interethnic marriage, from 13.6% in 1966 to 19% in 1974. Phyllis Palgi, an anthropologist specializing in the Israeli family, predicts a more uniform type of family life in the future. ". . . One can identify a trend towards convergence and homogeneity rather than cultural pluralism or more diversity." (Palgi, 1977)

Israeli art therapists, in contrast to ethnic groups who have their own stereotypes about each other, must maintain acceptance of a wide variety of origins as a norm, and accept variety in human society as an enrichment rather than a threat. They must fit into the spaces between culturally diverse populations, aware that clients may regard cultural differences as dividers among people. They must work to enable clients to maintain self-respect and dignity while trying to arrive at the human essence of each, the universal factors relevant to every person's emotional health.

Within this confluence of Eastern and Western culture, of ancient and modern, of secular and religious lifestyles, art therapy can offer an experience of direct unimpeded creative self-expression. The opportunity to interact spontaneously with art materials also gives people an opportunity to cut through divisive mental barriers and reveal their commonality.

Art Therapy in Israel

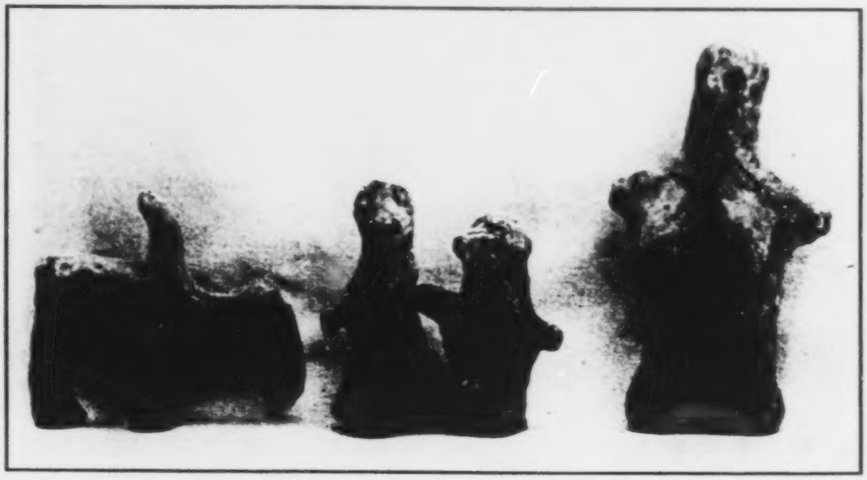
In contrast to the longer history of Dance and Music therapy in Israel, Art therapy as a distinct profession had very few people actively practicing prior to 1980, although artists and art teachers had long worked with emotionally disturbed people in hospitals and clinical centers. In 1980, new immigrants and Israelis trained professionally as art therapists in other countries began working in mental health settings. In addition, professional art therapy training programs became available for the first time in Israel, attracting people from the arts, education, social work and psychology. The advent of professional training with a student body composed mainly of mature people, many of whom had attained professional status in other fields, gave impetus to the practice of art therapy, and filtered it increasingly into the awareness of mental health institutions and into the Board of Education.

Increased numbers of professionally trained people also generated a host of practicum sites where none had existed before. Trainees began to work in mental hospitals, day-treatment centers, community centers, schools, organizations for children with various handicaps, orphanages and old-age homes. Thus, many ethnic groups were reached and people with different levels of physical and emotional disability benefited from art therapy. Indeed, one striking aspect of the spread of art therapy in Israel, is the demand for it and its applicability to different populations. The success of a five-day intensive workshop given in an Arab village to local school teachers and educators resulted in Arab teachers regularly participating in similar workshops given to Jewish school teachers in Tel Aviv, resulting in true non-verbal *and* verbal communication in a crucially important area.

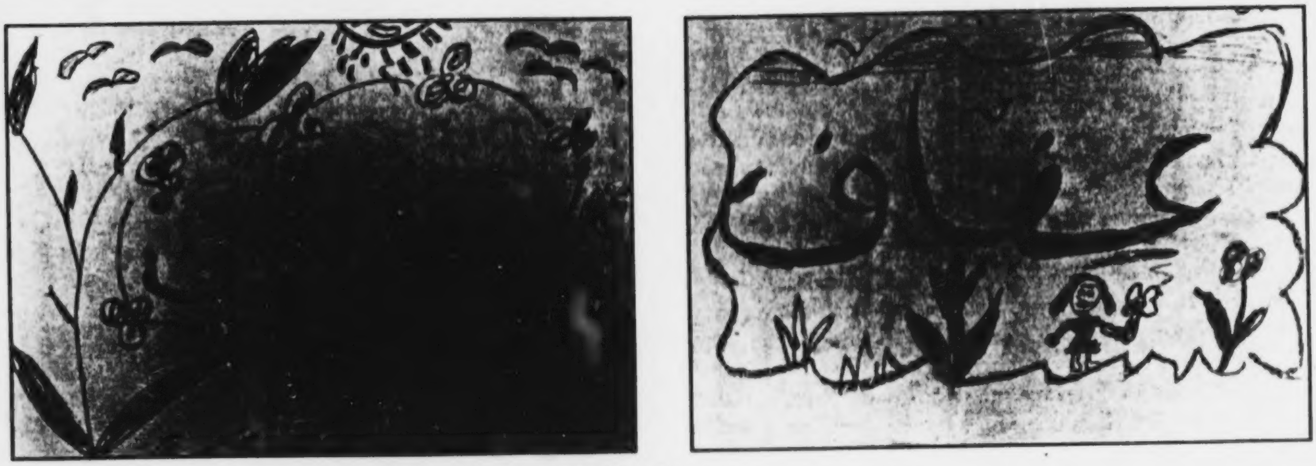
An art therapist working with Ethiopian children just a week after their arrival in Israel was impressed by the naturally direct, spontaneously done clay figurines (Figure 1). A few sessions later, the children's clay work expressed their schooling and "retraining" in adjusting to a new society, with sculptures of airplanes, cars and transistor radios. General enrichment courses for speech therapists, occupational therapists and special education teachers in the school system include art therapy as an additional tool in their work. These groups also provide a common ground for social interaction and integration between Israeli born educators and new immigrant teachers, and art therapy becomes here a means of self-expression leading to increased group cohesion.

The Israeli art therapist, working as a matter of course within such varied settings becomes aware that this is a profession that can answer the specific needs of specific populations, with flexibility. In beginning art therapy groups, the often used exercise of drawing and decorating one's name as a presentation of self demonstrates the variety of approaches of different groups. A ten-year-old girl living in the Galilee drew a lovely field of flowers to decorate her name which she wrote in acrostic fashion. Her name—Maya—spelled out in Hebrew the first letters of "Yom Kippur War," (*M*ilchemet *Y*om *H*akipurim). She explained her bright flower picture by saying that at the moment there was no war. Drawing and decorating one's name became a serious opportunity for the participants of the workshop given in an Arab village. (Shlonsky, 1985) The group leader

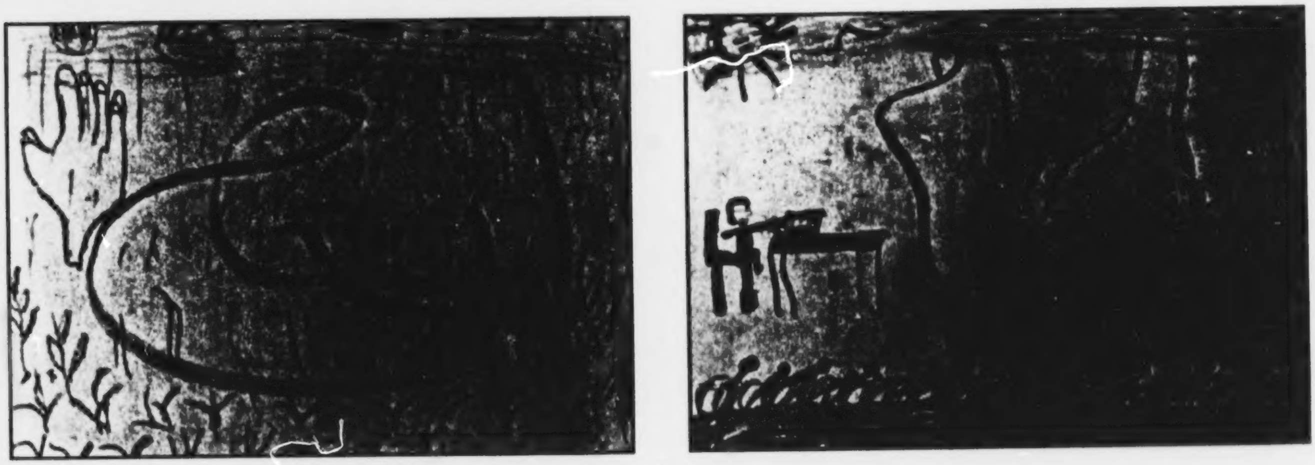
Fig. 1 Clay figurines done by Ethiopian new immigrant child in Israel.



BEST COPY AVAILABLE



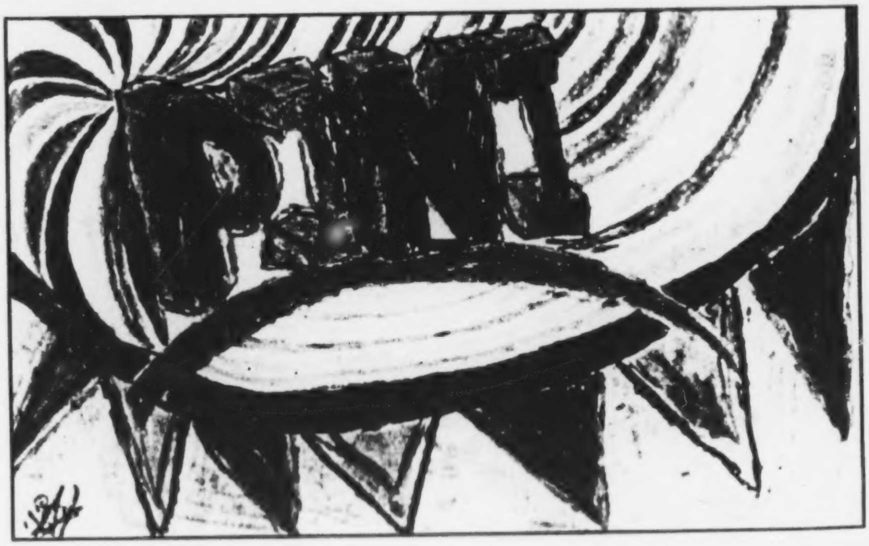
Figs. 2A & 2B Name drawings in Arabic done by Arab schoolteachers.



Figs. 3A & 3B Name drawings in Arabic done by Arab schoolteachers.

spoke in Hebrew but asked that all interpersonal conversation, and poetry written in conjunction with the name drawings be in the mother tongue. She was able to sense their communication and did not often avail herself of the translator. Name drawings of both men and women here show an unhurried taking of time to present one's name with respect, together with a noticeable decorative sense, a softness of execution, and a feeling of contact with nature (Figures 2A, 2B, 3A, 3B). This writer has used name-drawing in regular and special education art classes in a Junior High School. The results are often beautiful and dynamic works of art, as well as more satisfying personal and peer group awareness (Figure 4).

Fig. 4 Name drawing in many shades of blue, yellow and orange, done by 13-year-old J.H.S. boy.



BEST COPY AVAILABLE

Finding budgets to pay for art therapy services in a country usually in a state of economic crisis is fairly difficult. Many public institutions cannot provide paying jobs, and if they do salaries may be relatively symbolic. However, the fact that art therapists are welcome volunteers where not long ago their profession was unknown, indicates acceptance and a newly created demand. Paying jobs for art therapists seem to exist mainly in special education work with children in Therapy Centers run by the Board of Education. Mental hospitals, outpatient facilities, and evening post-hospitalization clubs also use art therapy as a regular form of treatment, but more often than not on a volunteer basis. Some art therapy work done in prisons has been paid for by special financial arrangements, as have occasional workshops done with army personnel (Figures 5A, 5B, 5C).

Art therapy as an additional tool for other professions is much in demand, and in general, art therapy courses are well attended by those seeking personal enrichment and new tools and directions in their own work. The Board of Education has recently created a position of Coordinator of Creative Arts Therapy in response to this demand. The coordinator organizes workshops throughout the country and trains local group leaders who will continue work in their areas. Thus teachers, counselors, speech and occupational therapists, and others in the educational system can widen their repertoire with basic art therapy methods.

Art Therapy with Children in Public Facilities

Children receive art therapy scheduled in the afternoon at Therapy Centers for children from normal schools. There are Therapy Centers for organically impaired children, schools designated for special education, schools in children's wards of mental hospitals, and in children's outpatient clinics. The largest employer seems to be the Children's Therapy Centers, of which there are about thirty throughout Israel, and about half of these are located in the greater Tel Aviv area. Each Center is attached to a local Educational Psychological Service, often located in the same building. The Centers may be in areas of economic deprivation, or areas integrating many of the major ethnic groups and encompassing many socio-economic levels (Figure 6).

Remedial instruction, speech therapy, occupational therapy, and often movement, dance and music therapy in addition to art therapy are

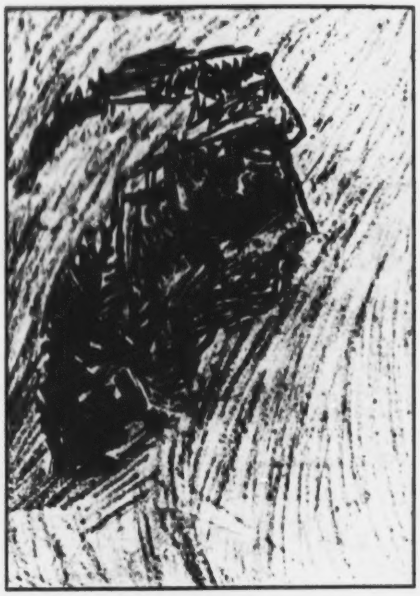
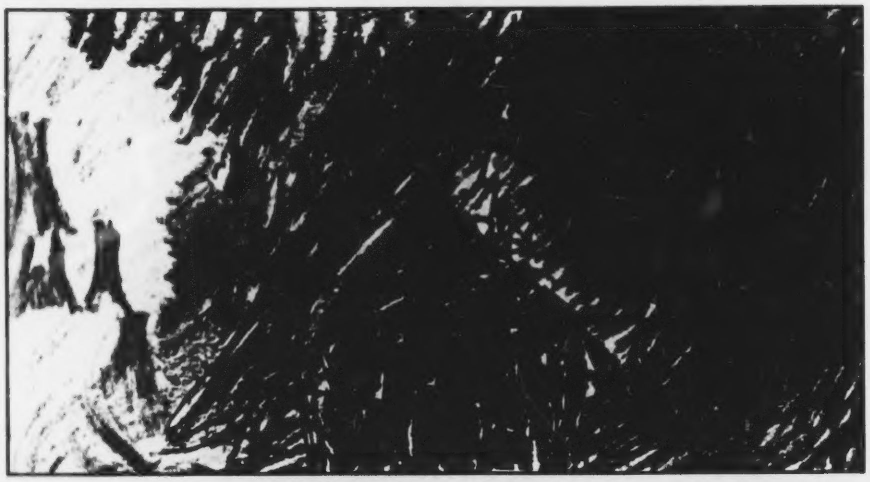
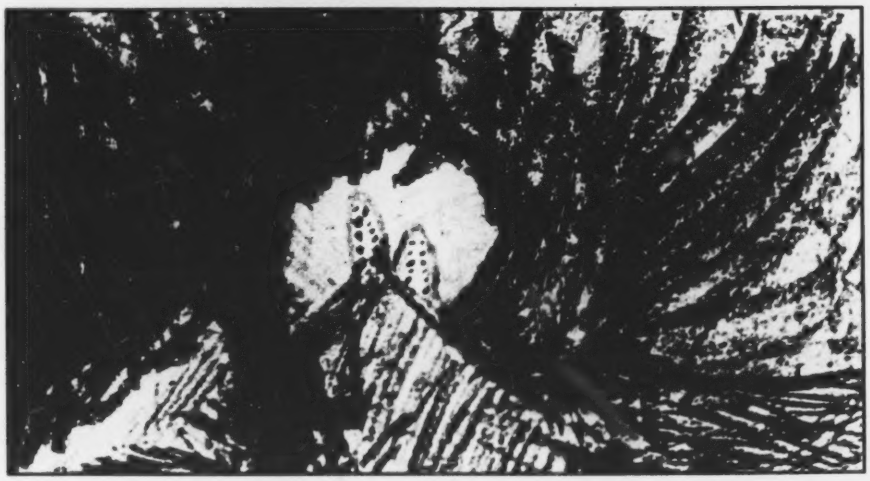


Fig. 5A Portrait done by prisoner in solitary confinement.

Figs. 5B & 5C Landscapes drawn by prisoner in solitary confinement.





BEST COPY AVAILABLE

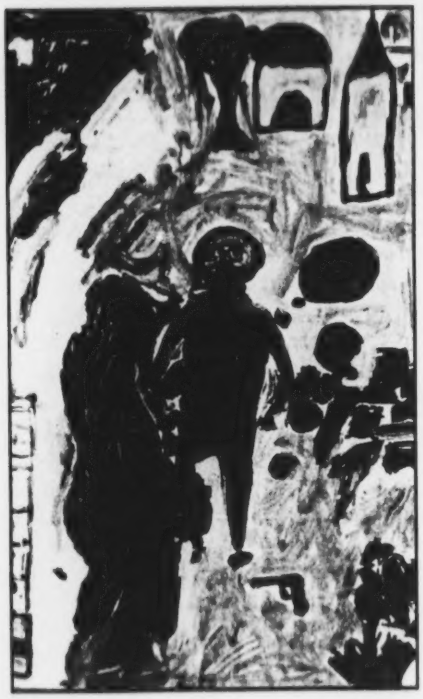


Fig. 6 "Jewish settler stabbed and shot in Hebron," done by a 14-year-old girl in a special education class for organically impaired children. The dark shadow to the left of the body and the spots on the right are painted red, for pools of blood.

provided, usually free of charge, to children referred by school psychologists. The children may be first and second generation Israeli's whose parent's and grandparent's ethnic and cultural values remain active in the family network. As an example, this writer works as an art therapist in an area populated by many of the major groups of origin: North African, Yemenite, Iraqui, Parsi, American, English, South African, Polish, German, and Rumanian. In most of these groups, extended family relationships are usually important and close. Thus children are directly in touch with their Diaspora heritage and also observe how their families cope on the socio-economic ladder of contemporary Israeli society. Israeli children, through the media and computers are also very much a part of international youth culture, music and fashion, and the space age. Within their own peer group, their changing slang and dances or pop heroes do not resemble their parent's choices.

The first of these Centers was founded in Tel Aviv in 1967, followed two years later by another based on the same model. Growth of these Centers continued, with art recognized from the start as an effective non-verbal tool of treatment. In comparison to the recent availability of professionally trained art therapists, early groups were usually staffed by artists or art teachers with a background in special education. Children attend their groups once or twice weekly, according to their individual therapeutic program. Because creative arts therapy groups are usually of no more than six or seven children and run as afternoon extracurricular arts activities (more intimate and personally geared than ordinary art classes), children feel as though they are participating in a regular, albeit special group, and the stigma of being "singled out" and referred for therapy is considerably lessened. Parents' groups may also be part of the services offered in the Therapy Center. Together with the Center psychologist, this writer has co-led parents' groups which represent the usual wide distribution of ethnic groups in the area. The sessions utilized a combined directive psychological approach and art therapy. In reviewing work done in art therapy with parents, or with their children, I find that ethnic difference does not diminish a client's ability to trust in the therapist, nor affect his/her own abilities to use art and personal symbols creatively.

Art Therapy with Adults in Public Facilities

Psychiatric hospitals, and post-hospitalization hostels and evening clubs encompass much of the art therapy work being done today with the emotionally disturbed adult population. Acknowledgement of art therapy as a valuable therapeutic resource compatible to hospital and post-hospitalization treatment is confirmed by requests for as many volunteers and practicum students as possible. It is hoped that cooperation between mental health facilities, and schools offering professional art therapy training will eventually lead to more, permanent and officially paying jobs for art therapists in these settings. Meanwhile, in addition to the definite call for volunteers, several art therapists have become regular staff members of a mental hospital, and an outpatient day clinic.

In speaking with art therapists working in facilities for the adult mentally ill, I found that patient groups comprise cross sections of both Sephardic and Ashkenazi populations, may include Israeli Arabs, other minority groups, and new immigrants of different origins, and are generally representative of middle to lower middle class economic levels. Patients may suffer from the stresses which ordinary life, or life in Israel can create. The effects of battle shock on soldiers, the culture shock of some new immigrants, the shock of terrorism, are some examples of stress specific to Israel (Figures 7A, 7B). In using art therapy as treatment, the degree of mental illness, rather than ethnic or cultural background is the determinant of effectiveness, response to art, and ability to be creative.

The kibbutz network has it's own therapeutic clinics, and the policy is to keep mentally ill kibbutz members in their own kibbutzim while receiving treatment. Several kibbutz members who have studied art therapy in professional training programs have been given facilities to practice art therapy on their own kibbutz with kibbutz members, and they receive supervision from a psychologist attached to the kibbutz clinic.

Summary

Art therapy as a distinct profession has been acknowledged within the last five years as a valuable resource and contribution to the therapeutic professions in Israel. In addi-

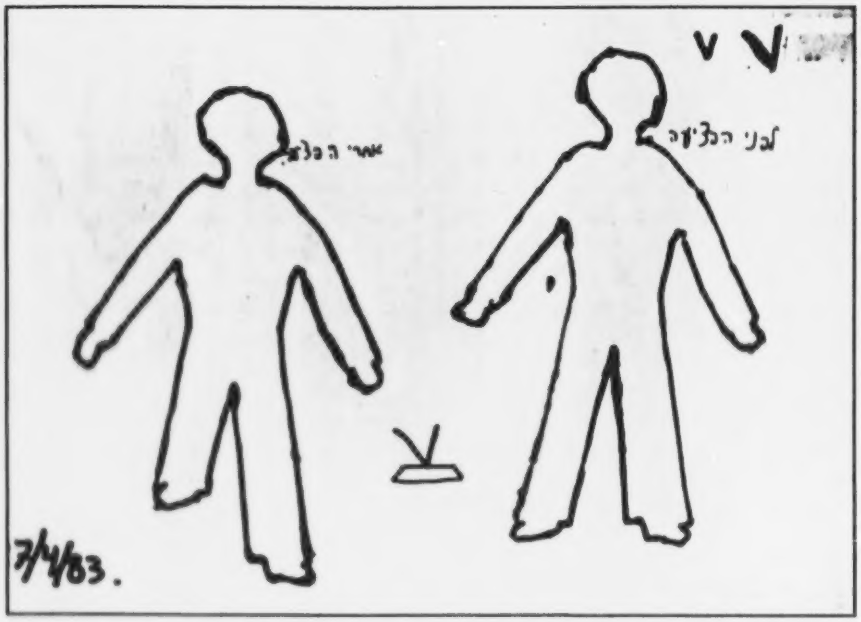


Fig. 7A Self image of soldier with head wound and disabled foot, drawn after several years in therapy. The right-hand figure is labeled "before injury," and the left-hand figure labeled "after injury." Figure 7B shows the continued state of depression of the patient and the desire to die, rather than live in a state of uselessness. Here, train tracks lead to a graveyard. On a tombstone is written "guilty." (Patient's name has been deleted.)

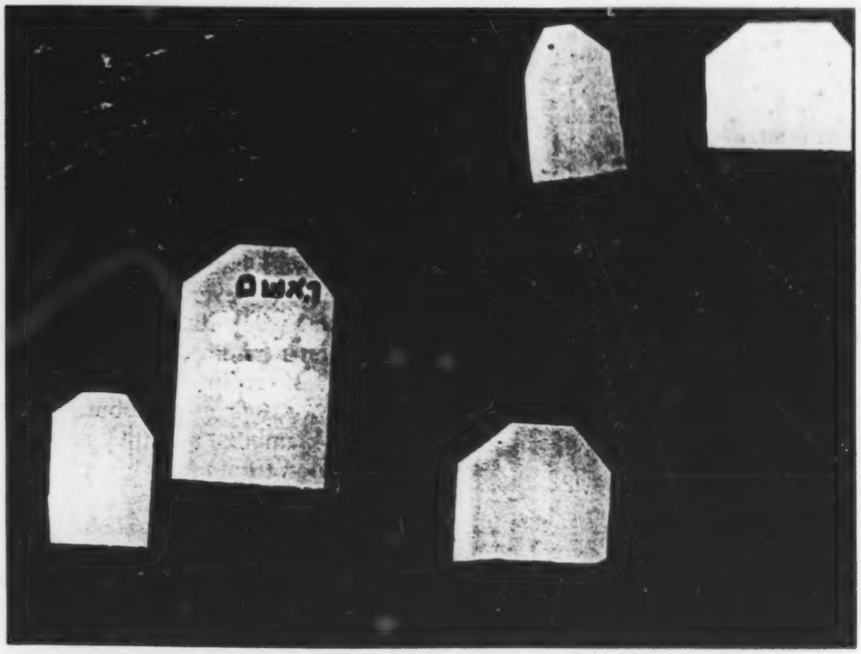


Fig. 7B War-disabled patient depicts depression and desire to die rather than live in a state of uselessness. Train tracks lead to graveyard; on tombstone is written "guilty" (of not having died). Patient's name has been deleted under the word "guilty."

tion to trained art therapists, psychologists, social workers, educators and others in helping professions increasingly study art therapy to stimulate their own creativity and widen their repertoire as therapists. Art therapy is now differentiated from art education with special populations, and the professionally trained art therapist works in specific capacities related directly to therapy. With increased numbers of people entering the field, working conditions can begin to be improved. These conditions include the basic requirements of a closed and intimate room, adequate space, materials and time, and staff consultations, access to case material and professional supervision. In work with children, for example, misunderstanding of art therapy as an educational tool may account for inadequate working conditions or supervisional deficits. The art therapists, frequently alone in their profession among the many others in a facility, may experience a sense of isolation. Thus there is a need of forming support groups in lieu of adequate personal support in work settings.

In view of continuing budget cuts in public spending, art therapists in many facilities may continue on a volunteer basis, repaid only by personal satisfaction and the reward of accompanying their clients' creative search and growth. However, as the trend of acceptance continues, it is likely that an increase of official positions will result.

As an art therapist, I have been fortunate in experiencing acceptance and cooperation from the Board of Education, and also in being rewarded in the trust of my clients. When accompanying others in their personal process, in centering themselves creatively, and using art materials as extensions and mirrors of themselves, the differences between us, whether cultural or personal in origin, are far less important than what we have and feel in common. Here the socialization process inherent in group work truly begins. Both

BEST COPY AVAILABLE

children and adults may be referred for art therapy for similar reasons. They may not be able or willing to express their needs verbally. They may be uncooperative to other forms of therapy which they feel as more threatening. They may be unable to communicate with others, and the small-group creative experience provides an ideal initial experience of support and contact with peers, for them.

Channeling energy into creative expression rather than conflict becomes a powerful tool for self-revelation and group cohesion, and clears a path through the complicated array of values such as one experiences in Israel. Attaining a center of personal clarity, balance and awareness provides a more effective and spontaneous method of coping with the conflicts of everyday life. I have heard young children express their feeling about their own completed creative effort as "doing my own thing," or "doing what I had to do." The art therapist can be a valuable participant in this rich tapestry of people, who with all their diversity, may yet come to see themselves as one people, one nation.

References

Palgi, P. (1966). "Cultural components of immigrants' adjustment," (Chapter 8). *Migration, mental health and community services.* Washington, D.C.: International Research Institute.

Palgi, P. (1971; Revised Edition, 1977). "The emerging Israeli family." *Children and their families in Israel.* New York: Breach and Gordon.

Shlonsky, O. (1985). "Burn-out syndrome and the use of intermodal expressive therapies." Unpublished masters thesis. Cambridge, MA: Lesley College.

CHARLES C THOMAS • PUBLISHER

New! **EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession** *by* **Shaun McNiff.** This is the first comprehensive study of higher education in the growing arts therapy profession. It explores the interdependence of diverse training traditions, and it reviews the various areas of concentration, such as art or music therapy. Specific competencies and different philosophies are examined, but their commonalities are emphasized. Chapters are also included on an artistic theory of mental health and on supervision and evaluation. *'86, $29.75*

THE ARTS AND PSYCHOTHERAPY *by* **Shaun McNiff.** A unique, innovative perspective of the expressive arts in psychotherapy is presented in this book. The author stresses the unity of the diverse arts therapies in a theoretical and operational approach that is firmly rooted in the historical continuities and essential meaning of art. Chapters deal with important therapeutic considerations common to all of the arts therapies, obstacles to artistic expression, and preparation for the arts therapies. *'81, $19.75*

New! **DRAMA THERAPY: Concepts and Practices** *by* **Robert J. Landy.** Emerging from the first degree-granting program in drama therapy, this pioneering text covers this nascent field with clarity and comprehensiveness. The text is divided into five sections that parallel the major concepts and practices of drama therapy: the context of drama therapy; conceptual bases and interdisciplinary resources; specific practices and techniques; appropriate populations and settings; and research. *'86, $28.50*

New! **VISUAL ARTS AND OLDER PEOPLE: Developing Quality Programs** *by* **Pearl Greenberg.** This lucid text provides the background and knowledge necessary to understand and appreciate older adults as artists and to develop quality visual art programs. Chapters explore retirement, gallery and museum programs, adult learning, working with disabled older people, art appreciation, and diverse art mediums. *Jan. '87, about $27.50*

A MANUAL OF SEQUENTIAL ART ACTIVITIES FOR CLASSIFIED CHILDREN AND ADOLESCENTS *by* **Rocco A. L. Fugaro.** This manual details activities designed to remediate deficiencies and encourage self-actualization. For each classification—neurologically/perceptually impaired, emotionally disturbed/socially maladjusted, and depressed—the author details goals, assessment and treatment. Each of numerous art activities lists motivational materials, specific activities, supplies, and expected performance. *'85, $25.75*

THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking *by* **Myra F. Levick.** In this book, a pioneer and leader in art therapy describes and illustrates normal and abnormal development of cognitive skills and defense mechanisms through the graphic productions of children from two to ten years old. *'83, $34.50*

Sent on approval • Write or call (217) 789-8980
MC/Visa & prepaid orders shipped postpaid • Catalog sent on request

2600 South First Street
Springfield • Illinois • 62794-9265

BEST COPY AVAILABLE

Art Therapy for Acculturation Problems of Hispanic Clients

Gilda Prieto Moreno, M.A., ATR, Art Therapist at Casa Central, Community Agency, Chicago and Harriet Wadeson, Ph.D., ATR, Director, Art Therapy Graduate Program, The University of Illinois at Chicago, and author of Art Psychotherapy *(John Wiley, 1980)*

This article focuses on art therapy for acculturation problems evidenced by Hispanic clients. Hispanics represent the second largest minority group in the United States, but there are insufficient mental health providers. An encouraging factor is that centers around the country are studying culturally sensitive therapeutic modalities, and this should help in the delivery of services in future years. In this article discussion is given to roles in Hispanic families, and to acculturation issues. Art therapy for Hispanics at a Chicago mental health center is described, including art therapy assessments and results, accompanied by photographs of clients' art work. The article concludes with an art therapy group, including processes and media, a case example from the group, and reference to other Hispanics and immigrants.

Introduction

For years, the mental health needs of the marginal sectors of our society have been avoided or neglected. Although the community health centers developed in 1963 were intended to serve groups unable to afford mental health care in private institutions (Lang and Muñoz, 1982), and have in fact provided a significant service to the population at large, for ethnic minorities the challenge of community health remains essentially unmet (Arce, 1976).

Hispanics represent the second largest minority group in the United States; there are estimated to be from 11 to 16.6 million Hispanics in the country. Yet this population is often neglected by mental health service providers:

> The delivery of psychotherapeutic and other forms of mental health treatment has historically been aimed at white, non-Hispanic middle upper classes. The Hispanic has too often received insufficient or inappropriate mental health care—a fact well documented in the literature (Becerra, Karno, Escobar, 1982).

Studies indicate that the Spanish-speaking, Spanish-surnamed patients who do seek mental health services typically receive less, and briefer forms of therapy than Anglo-American patients (Santisteban, 1980).

Lack of bicultural therapists who are sensitive to the needs of a particular group poses a significant impediment in providing appropriate treatment. Even if the therapist speaks Spanish, but is unable to relate to the client's issues because she or he lacks knowledge about the cultural idiosyncracies that might be involved in the presenting problems, the client is unlikely to engage with confidence in a therapeutic relationship.

In addition, the availability of a mental health center in a "barrio" (neighborhood) is an important factor. Often, immigrants are limited to public transportation. The location of a center almost predestines which population it will serve (Acosta et al., 1982).

One encouraging factor is that there are centers around the country studying culturally sensitive therapeutic modalities, although the need for trained professionals is so great that the Hispanic community will not be served adequately for many years.

Given these circumstances, one of the authors (Moreno) was highly motivated to work with an Hispanic population. She has written:

> My experience in working with Hispanics has brought me closer to my culture of origin. I was born in Cuba, and at the age of two moved to the U.S. We lived in a primarily Hispanic neighborhood, and my mother never worked, so until the age of five I did not interact within the Anglo community. Kindergarten was my first true encounter with English and the beginning of my own process of acculturation. In working with the Hispanic population, I have understood more fully how this process has molded my personality and idiosyncratic characteristics. In a need to understand more fully my Hispanic clients, I relate to my own migratory experience in recognizing the feelings of loss, isolation, and helplessness that my clients stressed over and over again.

Roles in Hispanic Families

In addition to needs for help created or exacerbated by the stress im-

---

Lack of bicultural therapists who are sensitive to the needs of a particular group poses a significant impediment in providing appropriate treatment.

---

posed by the change in cultural habitat, difficulties are increased by characteristics of the Hispanic culture that mitigate against seeking psychotherapy initially and progressing in it subsequently. In order to be of assistance to this population, it is necessary to comprehend these structural aspects of its social dynamics.

"The key to the understanding of any cultural group is knowledge of its family structure and ideology" (Carillo, 1982). In the Hispanic culture, the family is a source of support and acceptance. For this reason, it is not uncommon for an Hispanic individual faced with a problem first to seek help or advice from a family member, and only in extreme cases turn to a mental health professional.

It is not unusual for Hispanic groups to be characterized by the tradition of an extended family system (Carillo, 1982). This system can include grandparents, parents, children, cousins, aunts, uncles, and "compadres," (a Spanish word which can signify godparents or close friends). In many instances these individuals have specific roles or areas of expertise within the family. Because of this family network, Hispanic family members may appear to be over-dependent on each other, when in reality they are acting appropriately within their cultural context.

Most characteristic of Hispanic families is the rigidity which characterizes the sex roles and the adherence to gender-appropriate behavior. Researchers note that sex roles among these groups tend to be more clearly defined than in other cultures (Santisteban, 1980). This stereotypic behavior can fluctuate according to the amount of acculturation an individual has experienced. As a father, a man is seen as the breadwinner and authoritarian figure of the household; no major decisions are made without him. Parenting and household chores are not perceived as his responsibility. Since most of his duties deal with activities outside of the home, it is not surprising to find that Hispanic men enjoy a great deal more freedom than the women.

The Hispanic woman is described as being submissive, unable to take care of herself and expected to be sexually "pure." Generally in Latin cultures the weight of preservation of the family falls on the mother (Padilla, and Ruiz, 1973); she is expected to deny all her needs and pursue the satisfaction of her family.

Aunts, uncles, cousins, grandparents and "compadres" share a very important role in the Hispanic family. In cases where the mother needs to go out of the home, the grandmother or aunt may serve as an auxiliary parent. For migrating or exiled families, this has been a significant factor in their economic survival. It has allowed the mother to go out and work and still feel that her children are well cared for. This approach does call for flexibility within the traditional roles, however, and can present an imbalance in the family system.

Acculturation

When Hispanic families arrive in this country both parents may need to work because of economic pressures. The father, who had traditionally held the role of breadwinner, must now share this position with his wife. The mother who had perceived herself as being the primary caretaker of the family must share this role with an aunt or grandmother who will now look after the children. Even the children are challenged by their peers about their seemingly dependent behaviors. Almost like a domino effect, everyone in the family must readjust and assimilate a new role.

Because of this family network, Hispanic family members may appear to be overdependent on each other, when in reality they are acting appropriately within their cultural context.

Often the degree to which a family as a unit can acculturate correlates with the emotional stability of its individual members (Carillo, 1982). A study of 110 Cuban mothers (Szapocznik, 1976) indicated that the number of years in the U.S. had little to do with successful acculturation, but that personality and behavioral attitudes were much more significant in determining an individual's adaptability.

The most widely accepted analysis of acculturation is that of Gordon, written in 1964 (Santisteban, 1980). He delineates seven stages which an individual must undergo in order to become acculturated. He explains how a person can assimilate a new culture, first behaviorally and later, as he or she resolves internal conflicts, structurally. Structural assimilation is the more difficult task since it involves such aspects as change in patterns of dress, manner and language.

Current research has shown that acculturation in and of itself can produce an imbalance in the family structure. Studies conducted by Scoppetta, Szapocznik, and King (1977), have revealed that acculturation rate has a great deal to do with age. They found that young people acculturate more rapidly than older members of a cultural system.

Another significant variable in acculturation rate is sex. Because of the roles which Hispanic women have held traditionally, it is not unusual to find that men acculturate faster than women (Santisteban, 1980). Traditionally in Hispanic cultures, men have been better educated and more mobile within their communities than women. This has allowed them to be more receptive and flexible when arriving in a new culture.

Due to the extreme stress experienced by many Hispanic women as they assimilate into a new culture, they may present such symptoms as depression, extreme anxiety, and excessive drug taking (in the form of sedatives and tranquilizers) and increasing alcohol abuse (Szapocznik, 1978). Some of the symptoms which males may present because the homeostasis of the family has been altered are alcohol abuse, unemployment, involvement with illegal activity, and child and spouse abuse (Rodriquez, 1980).

As previously mentioned, younger people acculturate more successfully than older people. Children who migrate to the U.S. and receive education here are found to acculturate much more rapidly than their parents. There appear to be two main factors involved in this process. First, children are not as rigid as adults in accepting and trying out new ideas. Therefore, they do not feel as stressed by new experiences. Further, as children go to school they learn to interact in their host culture, while at the same time they have the assurance that they can return to their families and continue to function within their original context. This allows the children to grow within the new culture while at the same time feeling supported by their families. Unfortunately, adults do not often find themselves in such supportive situations.

The Use of Art Therapy for Hispanics in a Mental Health Center

The day treatment program at Chicago's Northwest Community Center services approximately forty people every day. It is composed of bicultural and bilingual staff who work primarily with a chronic population. Some of the clients have been coming to the center for the past ten years. The purpose of the day treatment center is to give people who are chronically mentally ill a place where they can socialize and be functional. In addition to psychotherapy, various daily activities that constitute its program include: discussion of current events, arts and crafts, community affairs, parties, job training, exercise, trips, discussion of public services, and games. Added to these regular activities, art therapy was introduced for both treatment and assessment. All art therapy sessions were conducted in Spanish.

Current research has shown that acculturation in and of itself can produce an imbalance in the family structure.

Art Therapy Assessment

The goal of the art therapy assessment was to aid the therapist in becoming more aware of the acculturation issues that might be relevant to the client's presenting problem. This assessment was designed to be used primarily at the time of intake or as an appropriate intervention in the course of therapy.

Since the male clientele at the Center were resistant to art therapy (see Art Therapy Group below), those who participated in the assessment study consisted of fifteen women. They shared many common characteristics: limited education, depression, and withdrawal. Many of the women were not very articulate. Because of these characteristics, it appeared that art expression might be facilitating. It would provide a less stressful form of communication because the clients would not be pressured to speak at length.

All assessments were administered individually and lasted approximately one hour. Pastels and 18" × 24" paper were used. At the beginning of the session, an explanation was given of how the assessment would be used to enhance communication between the client and the therapist. It was also explained that the assessment was part of a study being conducted to develop more culturally sensitive therapeutic approaches which might be used with the Hispanic population in the future.

Criteria for inclusion in the study were as follows: the participants had to have lived in the U.S. for at least five years and must have lived in their country of origin for at least the first twelve years of their life. They had to have been born in an Hispanic country, and must still speak fluent Spanish. Although there was some resistance, for the most part the women were cooperative and willing to experience something which they had not done since they were very young—drawing. The opportunity of taking part in a project that could help other immigrants was very appealing to most of the women.

Of the fifteen women referred for assessment, a questionnaire administered prior to the art tasks determined the following: the majority were Catholic, more than half had reached only the sixth grade or less, more than half were divorced and only two spoke English. Only two of the fifteen women had ever worked in the U.S., and all of them stated their primary reason for coming to the U.S. was either economic difficulty or that they had been brought by other family members.

The possibility of some of these characteristics prompting these women's presenting problems is very strong. Low socioeconomic status and educational levels add to helplessness and hinder upward mobility.

The Art Assessment consisted of four drawings as follows:

1. Draw anything which comes to your mind.
    - A. What can you tell me about your drawing?

   - **B.** Is there anything that made you think of these images?
     (Rationale: Warm-up and production of spontaneous images.)
2. Draw a memory from your life in your country of origin.
   - **A.** What can you tell me about your drawing?
   - **B.** What else can you tell me about your life in your country of origin?
     (Rationale: Relationship to the culture of origin.)
3. Draw something significant from your life in Chicago.
   - **A.** What can you tell me about your drawing?
   - **B.** Is there something else you can tell me about your life in Chicago?
     (Rationale: Assessment of current functioning.)
4. Draw something or someone from your country of origin you would like to have in the U.S.
   - **A.** Can you tell me more about your drawing?
   - **B.** Why is this important for you?
     (Rationale: Comparison of past and present life situations and relationship to present adjustment.)

Assessment Results

One prominent theme in almost all the assessments was unresolved feelings over a loss of some kind, such as family members left behind or the family home. When talking about these images a great deal of pain was usually expressed.

Free Picture:
Figure 1 is the first picture drawn by a single parent who has five children, three of whom are retarded. She has no family in Chicago and feels that she cannot go back to Mexico because she would have no means of supporting her family. Her husband left, she claims, because he could no longer deal with the family situation. She said that her drawing depicted how she felt on the day of the assessment. She said she felt as if she was going around in circles and could not get out. The colors were intended to signify her many problems and her inability to solve them,

Memory from Country of Origin:
The importance of family, friends, and homelife appear as a predominant motif in all the pictures. Many of these themes were emphasized in the literature. Through the images of their former homes, the women were able to tell stories about their childhood or early adolescence. These were often memories that they had not thought about for a long time. (Figure 2)

Fig. 1 "How I Feel Today"

Fig. 2 "My House in Puerto Rico"

When discussing their pictures, the women talked about their childhood and how they had lived most of their lives deprived of many things, but at least they felt they had a house they could call their own and they were free to visit friends and family. They compared this to their lives in Chicago. Here they feel enclosed and isolated from other people. They complained about living in overcrowded buildings where people do not want to be bothered by each other. Many expressed feelings of helplessness because they believe they can do nothing to change the course their lives have taken.

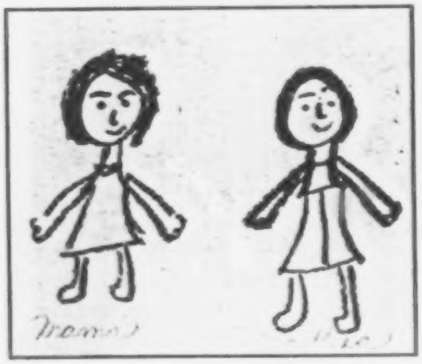


Fig. 3. "My Mother and Father"

When these women left their homeland, they left behind many people and places they cherished. After many years, they still have not come to terms with these losses. Figure 3 was drawn by a

BEST COPY AVAILABLE

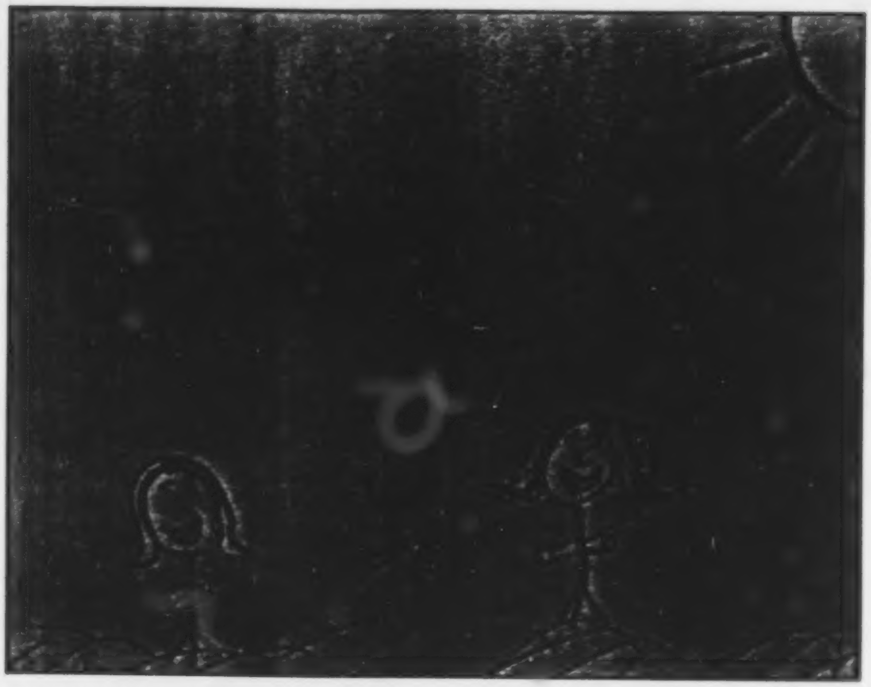


Fig. 4 "My Mom, My Daughter, and Myself"

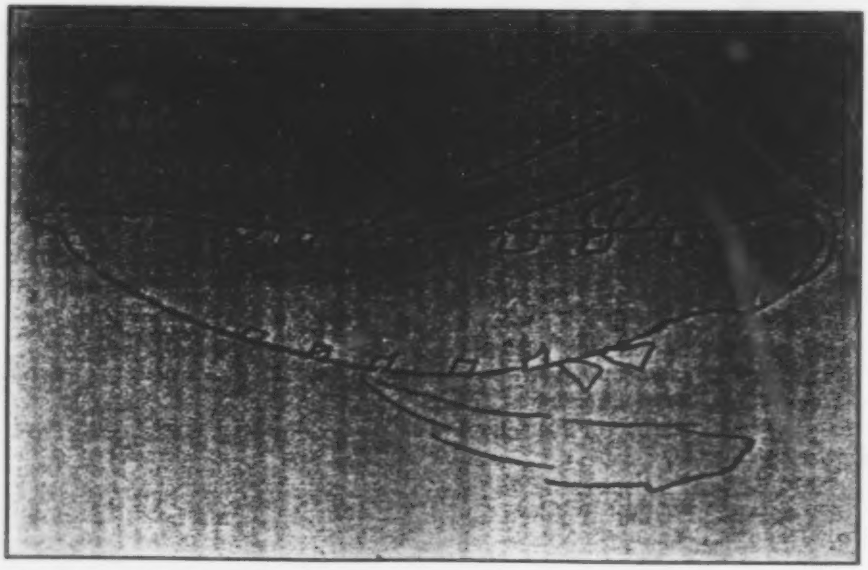


Fig. 5 "Plane Leaving O'Hare"

43-year-old woman who portrayed her parents, mentioning that it was very difficult for her to accept the fact that she may never see them again. She said that they were now getting old and that she feared they would die before she could see them.

Figure 4 represents the client's presenting problem of having ambivalent or guilt feelings about her daughter living in Puerto Rico while she is in the U.S. She drew a picture of herself, her daughter and her mother. She said that this is how she wished it could be, but, because of financial difficulties, she has to remain in the U.S. Her daughter is being raised by the maternal grandmother.

Life in Chicago:

Several of the drawings exemplify how uninvested these women are in developing their own lives in Chicago. One woman said that when she thought of Chicago, she thought about a plane leaving O'Hare Airport for Puerto Rico. (Figure 5)

Several depicted their children as representative of their lives in Chicago, and one said her children were the only reason she stayed in the U.S., that without them she would have nothing. The emptiness found in most of the pictures possibly reflects these women's present life situations. Most of them have few or no interests or activities outside of their families. Their investment in life in Chicago appears limited.

Something from Country of Origin You Would Like to Have Here:

In the final group of drawings, there were three basic themes which the women drew consistently. These were images that represented palm trees, houses or family life, or a member of the extended family. The women appeared to be missing both significant people and a place that was familiar. Complementing the lack of investment in their lives in Chicago was an often poignant longing expressed in this last drawing, such as Figure 6, titled "My Family in Puerto Rico."

The assessment provided information about life in the origin country compared to present life to assess the acculturation process. According to Carballo (1970), the acculturation process has two major variables: the antecedent, or those having to do with the level of the individual's functioning in his or her country of origin, and the intervening variables of how well the individual can integrate his or her previous level of functioning into the host culture. The art therapy assessment utilized images and associations to them to explore these variables.

When the assessment was used as part of the intake procedure, its sensitivity to the acculturation process became a very useful tool. It enabled a more accurate diagnosis, identification of significant issues, and appropriate treatment planning and therapist assignment. One of the results was to facilitate communication be-

BEST COPY AVAILABLE

tween the client and art therapist. Through the use of art and themes related to the process of acculturation, many relevant feelings and memories were disclosed that could be explored in ongoing art therapy.

An interesting aftermath of the assessment was that one group of women dedicated one of their meetings to discuss it. In the group setting, they explored and shared what their feelings and experience had been while doing these drawings. The group agreed that the memory of their country of origin always provoked unresolved feelings around the losses they have sustained.

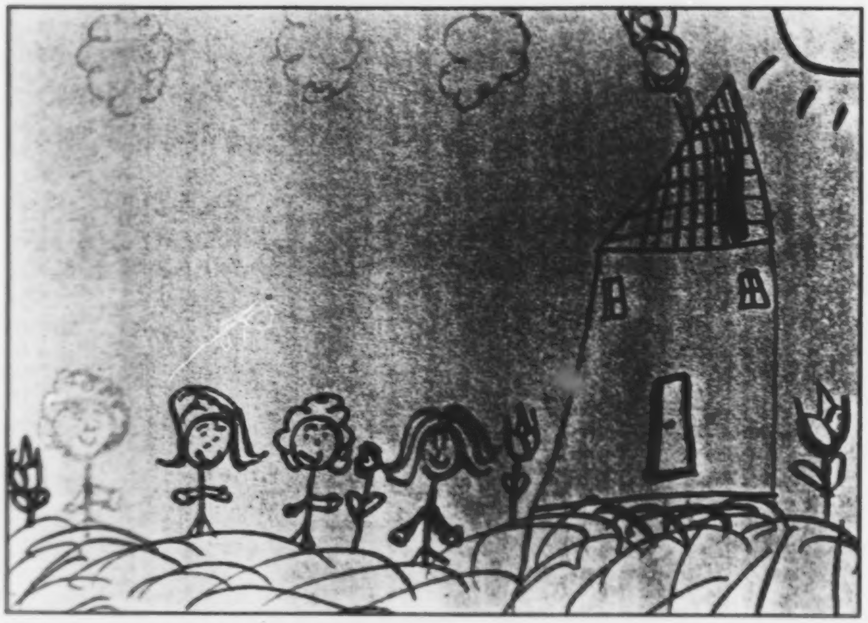


Fig. 6 "My Family in Puerto Rico"

Art Therapy Group

Little has been written or studied on specifically what the treatment of choice for Hispanics might be. What the literature does suggest is that traditional modalities have not been successful and that research should continue to provide more appropriate models for the Hispanic populations. With these factors in mind, art therapy was introduced at Northwest Community Mental Health Center in an effort to add to the therapeutic resources.

The group was to be an open one so that new members could enter as they joined the day treatment center. Because the population was a chronic one, the atmosphere of the group was to be as relaxed as possible, and only those people who wished to discuss their art work did so. No tasks were assigned. The size of the group fluctuated from four to six members. The group met for approximately twenty sessions over a five month period.

Through the use of art and themes related to the process of acculturation, many relevant feelings and memories were disclosed that could be explored in ongoing art therapy.

Early on, the men in the group dropped out. They said that they could not draw and they would not. This was not the case; some of them drew very well. It appears that they felt threatened by the art work since it was something over which they did not have full control.

The media available to the group were craypas, crayons, magic markers, tempera, and collåge materials. Participants were especially comfortable with collåge-making because it involved a series of steps that seem very appropriate to the Hispanic way of socializing. The group would begin to look at magazines and share the pictures with other members. Their own issues would be presented, but in a way that felt nonthreatening. During the session the group members spontaneously discussed their own work or commented on the work of others. This appeared to facilitate communication and set a very relaxed atmosphere where a variety of topics were discussed. As they drew and verbalized some of their conflicts, group members were able to interrelate and support each other. The group provided a safe atmosphere where they could discuss the hardships of their present life circumstances while at the same time they reminisced about their lives in their country of origin.

One topic that came up very often was how difficult it had been to adjust to the cold. All of the women in the group were born and raised in Puerto Rico, where the temperature is warm all year round. The drawings often depicted palm trees, fruit and the sun, and the discussion of them centered on the difficulties of adjusting to a new culture.

Most of the people whose pictures are presented here have lived in the U.S. from ten to fifteen years, yet their pictures related minimally to their current life situations. Nora's drawings depicted palm trees, flowers, the sun, a chicken and herself (Figure 7). Nora's verbal com-

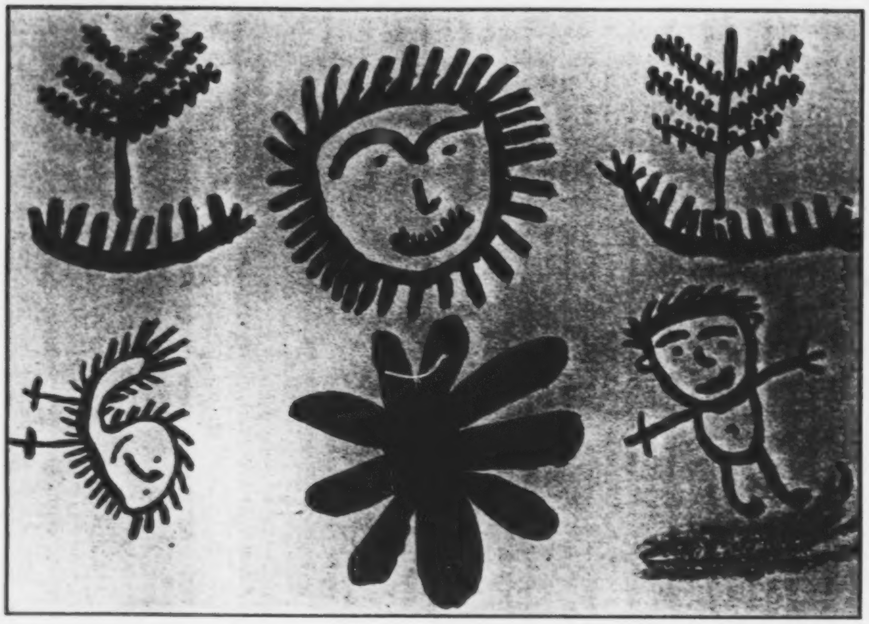


Fig. 7 "Palm Trees and Me"

Fig. 8 "My House in Puerto Rico"

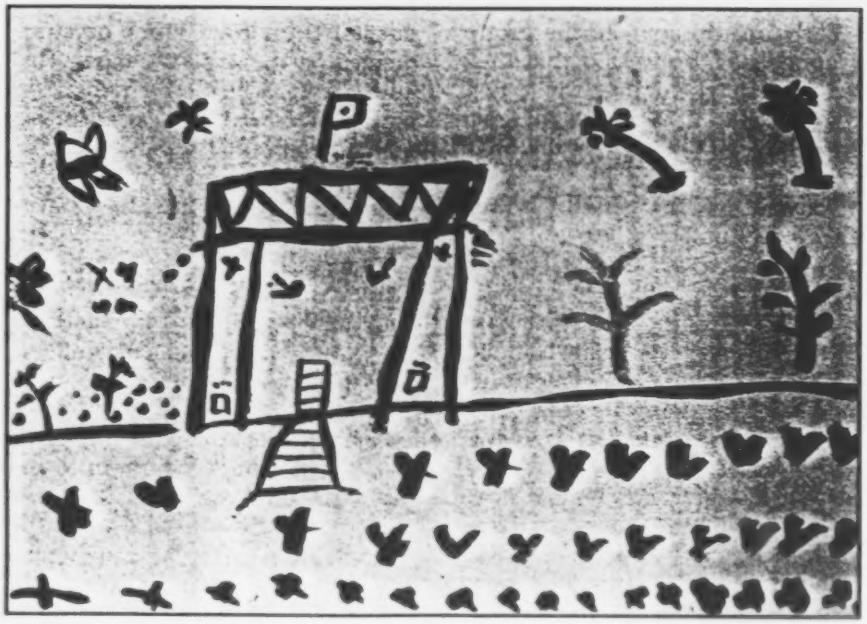


Fig. 9 "My House in Chicago"

munications were very minimal. She was withdrawn, does not know how to read or write, and has never attended school. When she first came to the group, her drawings were light and small. As the group developed, so did Nora's ability to communicate through her art. She expressed her concerns and found joy in her own accomplishments.

It was very common for people from the rural areas to live in a house such as the one drawn by Maria in Figure 8. In Figure 9, another group member's house looks like an apartment building in Chicago, but it is still surrounded by palm trees. Most of the houses drawn, however, did not have the appearance of northern homes, but resembled the airy, thatch-like homes on stilts still seen in the Caribbean islands. For these women it appeared that home was a place far away in a very different kind of land.

The group members gained a great deal of satisfaction from their finished drawings. They were very proud to show their pictures, and they made sure that anyone who wanted could discuss her picture. There women rarely do anything just for themselves, but in this group they were able to dedicate time to their own issues and feelings. Here was a place where they could explore themselves without feeling guilty. It was important for them to

Although most of the images were simple, they were familiar and evoked poignant feelings shared by all the group members.

BEST COPY AVAILABLE

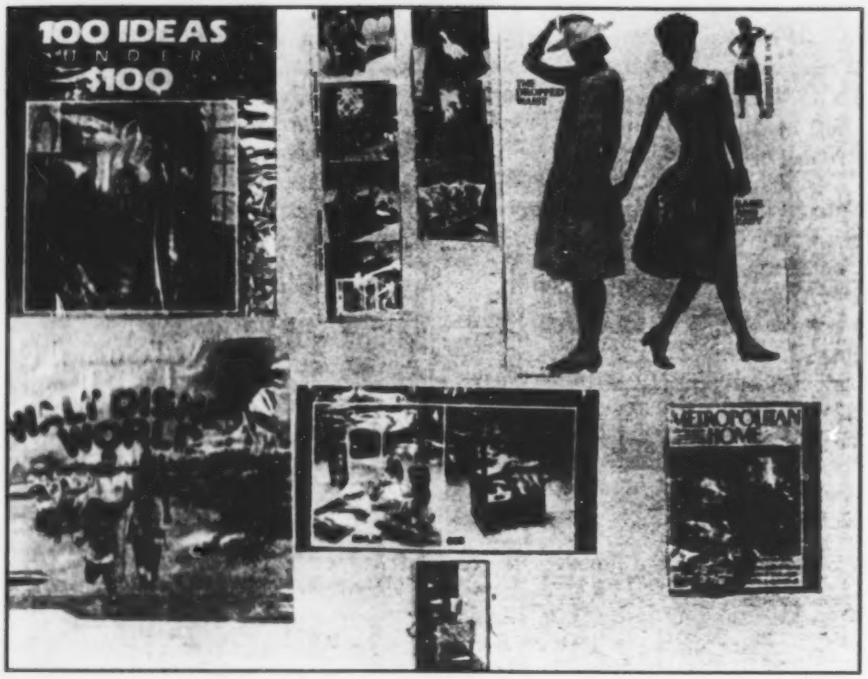


Fig. 10 "Dreams of Clothes, Toys and Other Things"

have a place where they could share the many aspects of their present life situation.

The communication that was achieved was brought about through the expression in images. Although most of the images were simple, they were familiar and evoked poignant feelings shared by all the group members. Through these images the women were able to look at hardships in their present situation and reminisce about the homes they had left in their country of origin. Having an Hispanic therapist who was bilingual, bicultural and an immigrant herself, facilitated communication and trust in the group. For this chronically ill population of isolated individuals, the group's main thrust was supportive in nature. The familiar shared images that resulted from spontaneous art expression promoted experiences of universality, one of the significant curative factors in group psychotherapy (Yalom, 1975).

Case Example

One group member who appeared to benefit greatly from the group's input was Ileana. Ileana is a 27-year-old Hispanic female who has been in the U.S. for approximately eight years. She was referred to the center because she was physically abusive toward her child. The child was eventually removed from the home and placed with the maternal grandmother for protective custody.

During the course of the group, Ileana explored the responsibility and pressures of being a single parent. In her art work one can see both adult and child-like images (Figure 10). In this collage she depicted clothes of which she is very conscious, accessories for her home, which she described as one of her "dreams," and toys for her little girl.

The reunification with her child and her extended family remained a clear goal throughout her therapy. In Figure 11 she depicted herself in Puerto Rico, enjoying her family. Through the use of art, Ileana was able to visualize and later verbalize her hopes and what steps she would need to take in order to attain them.

Other Hispanics

Not all Hispanics in therapy need specially designed therapeutic programs. There are, and will continue

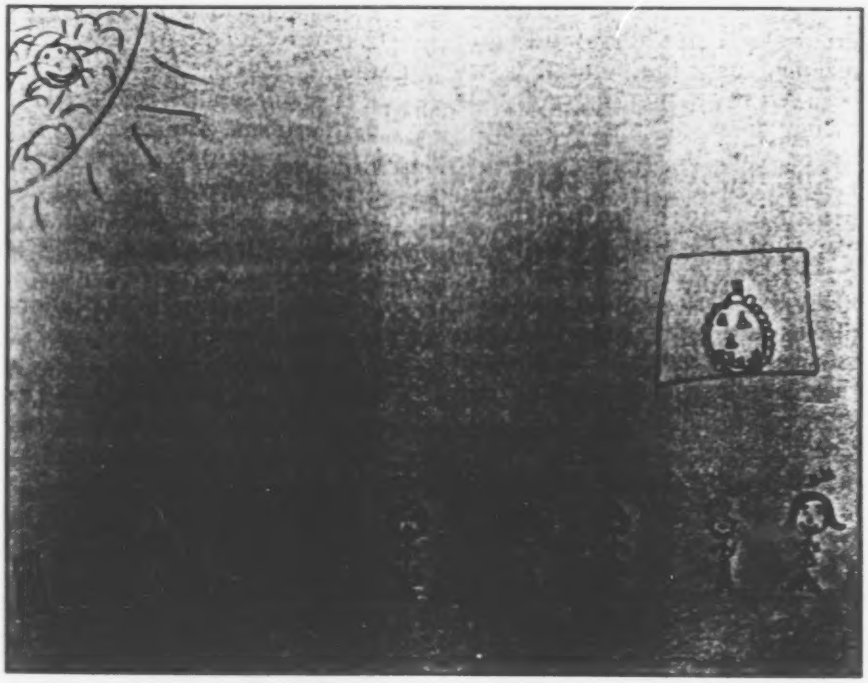


Fig. 11 "In Puerto Rico with My Family"

to be, clients who have a middle-class orientation and who seek agency services in the same manner as non-immigrant clients (Mezio, 1979). These people will be able to adjust to the present system. The less educated, unskilled poor, monolingual Hispanic clients represent a group of people who are particularly vulnerable in our society and who often need new, flexible and innovative models for the delivery of mental health services.

Other Immigrants

Many of the issues that surfaced in the Hispanic art therapy group are not unique to the Hispanic community, such as inadequate housing, being a single parent, and the handicaps of being mentally ill. On the other hand, patterns of family organization, socialization, resources, and approaches to seeking help bear particular cultural characteristics.

Applicable to other immigrant populations would be the understanding of these factors necessary for the Hispanic immigrants as well as such definitive factors as the use of bilingual and bicultural therapists. The awareness of the idiosyncracies of the immigrant's cultural background and an understanding of feelings about the home that has been left in relation to present life circumstances will enhance the effectiveness of the therapy. Art expression can be a useful tool in tapping the images and feelings associated with these conditions. For these populations, it is particularly likely that verbalization may pose problems, thereby reinforcing communication through art as an especially useful modality.

Conclusion

In this article we have specifically dealt with the plight of Hispanic immigrants or refugees. Their experiences of loss and isolation can also be seen in other migratory groups who have left familiar places and loved ones behind.

Today the United States is faced with an influx of migrants who bring with them a variety of needs and expectations. This article presents a beginning in the use of art expression and shared images in helping the many people whose lives have been disrupted through relocation and who feel like strangers in our country.

References

Acosta, F., Yamato, J., and Evans, L. (1982). *Effective psychotherapy for low income and minority patients.* (pp. 51-81). New York: Plenum Press.

Arce, M. D., A. (1976). *Mental health policy and the Hispanic community,* Proceedings of the First National Conference on Health & Human Services.

Becerra, R., Karno, M., and Escobar, J. (eds.). (1982). *Mental health and Hispanic American minorities.* Second edition, Dubuque, Iowa: Wm. C. Brown Co., (pp. 181-213).

Carillo, C. (1982). Changing norms of Hispanic families: Implications and treatment. (Enrice Jone, Ed.), *Minority Mental Health,* (pp. 250-263), Praeger, New York.

Carballo, M. A. (1970). *Socio-psychological study of acculturation/assimilation: Cubans in New Orleans.* Unpublished doctoral dissertation, Tulane University.

Lang, J., Muñoz, R. (1982). *Quality of life & psychological well being in a bicultural Latino community,* (pp. 433-450). Hispanic Journal of Behavioral Sciences, V. 4., Dec.

Padilla, and Ruiz (1979). *Counseling Latinos,* Chapter 14, (Atkinson Donald, Mortin, George, Sue derald Wing, Eds). Counseling American Minorities, A Cross Cultural Perspective, Dubuque, Iowa: Wm. C. Brown Company Publishers.

Rodriquez, A. (1980). *The emergence of Dade County's Hispanic woman: Past, present, and future implications.* Presented at the Second Annual Women in Crisis Conference, Washington, D.C., June.

Santisteban, D. (1980). *Acculturation/assimilation and psychological stress: A review of the literature.* Manuscript in preparation for publication.

Scopetta, M., King, O., and Szapocznik, J. (1977). *Relationship of acculturation, incidence of drug abuse, and effective treatment for Cuban Americans.* National Institute on Drug Abuse. Final Report of Research Contract No. 271-75-4136.

Szapocznik, J. (Ed.). (1976). *Hispanic mental health, drugs and alcohol policy issues: Views from the field.* Washington, D.C.: COSSMHO.

Szapocznik, J., Scopetta, M., & King, O. (1977). *Factors contributing to the brevity of brief strategic family therapy.* (Technical report for the Spanish Drug Rehabilitation Research Project.) University of Miami Spanish Family Guidance Center.

Szapocznik, J., and Truss, C. (1978). Intergenerational sources of role conflict in Cuban mothers. In: M. Montiel (Ed.), *Hispanic Families.* Washington, D.C.: COSSMHO.

Yalom, I. (1975). *The theory and practice of group psychotherapy.* New York: Basic Books.

REVIEWS

Art and the Wish To Die

***Fred Cutter,** Chicago: Nelson-Hall, Inc., 1983. xiv + 294 pages, 183 unnumbered figures, $26.95.*

*Reviewer **Aaron Sheon** is Professor of Art History at the University of Pittsburgh in Pittsburgh, Pennsylvania.*

The author explained in the preface that the idea for this book came from his background as a psychologist studying "unpredicted death." Dr. Cutter and his wife Dorothy, a professional artist, began to thumb through books about art and found in eighteen months of browsing "more than two hundred fifty artists who had painted suicide themes and a smaller number who had themselves committed suicide." Armed with this information they prepared a small exhibit of "suicidal art work arranged historically from the Renaissance to the present." Eventually they felt that such exhibitions might aid in the prevention of self-injury behavior. Their idea was that any person contemplating suicide might look at their exhibition and be dissuaded. Even though Dr. Cutter admitted that specialists in health fields doubted the efficacy of this notion, and that there was "much resistance to my ideas," he felt that he should persist. This book is the result of his efforts.

There are several problems that severely weaken the author's premise. He believed that the book's examples of "suicidal art" have "far more impact on the public than do 'scientific words.'" There has been no testing of this belief, but the author feels that when, at meetings, he showed the slides of these images and some colored commercial reproductions, "the viewer has an experience not unlike going to a museum or concert. . . . Being exposed to a one- or two-hour concentration of self-injury themes in visual art is an emotional experience. . . . No one has ever committed suicide or attempted self-injury because of viewing this art." He feels that somehow the viewers of this image collection have been changed emotionally, and that they will in some way never again think of self-injury or suicide.

Since there is no evidence that this imagery does indeed change attitudes, and no attempt was made to test his theory, he makes analogies with how advertising affects people. His book, with its messages about the need to stop suicide and self-injury, will work wonders, he feels, when combined with his "suicidal art" collection.

The images are strewn throughout the book with little explanation of their original intent. There can be no doubt that in the Renaissance and Baroque periods images of Cleopatra and Dido committing suicide were favorites of artists, but their relevance to his theory or the likelihood of using them to prevent suicides or self-injury seems quite dim.

Dr. Cutter's approach seems to be that if there is a knife or a dead body in a painting, he will use it in his collection. Works of art with no relevance to suicide or self-injury are included on some pages, and we are left to guess why they are there. There are even some curious tables that give a gloss of scientific statistical support for his efforts, but which in reality are worthless, because his random sampling of imagery can hardly be called complete.

Another weakness is the naive attempt to explain the artist's intention in creating a particular image. Instead of seeking information about the artist or the work, the author has given his pronouncement and makes it sound as if he had been at the artist's side as he or she painted. Discussions of works are frequently filled with incorrect interpretations. His comments about prints by the Pop Artists Andy Warhol and Roy Lichtenstein, for example, seem sophomoric. Surprisingly little attention has been given to the art history meanings of specific themes and the context of their use in an historic situation.

The Special Artist's Handbook (Art Activities and Adaptive Aids for Handicapped Students)

***Susan Rodriguez,** with photographs by Paul Blumenthal. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1984. 278 pages. 235 black & white photographs & illustrations. $24.95.*

*Reviewed by **Virginia Minar,** MS, ATR, Art Therapy Instructor at Alverno College, Milwaukee, Wisconsin, and a former Art-Exceptional Education Teacher/Therapist with the West Allis-West Milwaukee School District in Wisconsin.*

Because of this reviewer's area of concentration in art therapy for exceptional children, special interest was given to this book since Ms. Rodriguez has had the experience of teaching art in both regular and special classrooms for over 15 years in the Philadelphia Public Schools. She has also supervised training experiences for Art Education and Art Therapy students from several universities.

The book is divided into four sections, with Part II "Art Activities" comprising two-thirds of the material presented. Each student-centered activity lists materials needed, pre-session preparation, directions, and suggestions for further development. Adaptations of the activity are then written for each of the handicapping conditions described in Part I, "The Handicaps." It is with the adaptations that the strength of the book is evident.

Ms. Rodriguez exhibits her experience and knowledge in the sensitive way in which she addresses the students' particular needs for individual creative growth. These adaptations are valuable, in that they break down steps for the less able student and expand the activity to challenge the more capable student. Although she refers to Public Law 94-142, she does not deal with writing goals and objectives for the required IEP (Individualized Educational Plan). It would have been helpful to show some remedial objectives for each activity.

I appreciated the interesting suggestions made for motivating the gifted [student], since there is so little attention given to providing stimulating art experiences for these students. The adaptations written for the socially and emotionally disturbed children are particularly interesting and useful for art therapists working with those populations. The suggestions are open-ended enough to allow for insightful personalization. Since many emotionally disturbed children exhibit gifted and talented characteristics, the adaptations for that category might also be utilized.

In Part I, the author sensitively handles "Myths, Prejudices, and Misconceptions." Definitions and characteristics of major handicapping conditions and exceptionalities are presented in a concise and usable format that describes the major skills they *may lack* and the remediation they *may require.* The categories covered are: Severely and Profoundly Impaired; Mentally Retarded; Trainable Mentally Retarded; Educable Mentally Retarded; Socially and Emotionally Disturbed; Learning Disabled; Physically Handicapped; Sensory Losses (Hearing Impaired and Visually Handicapped/Blind); and Gifted.

At the end of this section, Ms. Rodriguez pictorially shows sign language for the most important words used in the art classroom. While this limited sign vocabulary would not be sufficient for an individual working exclusively with the hearing impaired, it is a way to make mainstreamed students feel that you are interested in communicating directly with them.

Part III, "Adaptive Aids and Materials," deals with suggestions of simple ways to adapt tools and materials to enable students to participate, as independently as possible, in the art activities. Part IV, "The Art Classroom," addresses environmental concerns for the special student including furniture, equipment, lighting, storage and display. Safety considerations are presented, including a list of art materials not recommended and some safer alternatives.

The *Special Artist's Handbook* is one of the best resource books available on this subject. It is well done, because Ms. Rodriguez writes from practical experience describing tested methods and activities, rather than limiting herself to only a theoretical point of view. While the material covered is written for elementary school children, it is certainly adaptable for the secondary level. I highly recommend this work for art educators and art therapists working in public schools, or in other settings where art experiences are provided for children/students with handicapping conditions.

Mommy, Daddy, Look What I'm Saying: What Children Are Telling You Through Their Art

***Dr. Myra Levick,** with Diana S. Wheeler. New York: M. Evans and Company, Inc., 1986. 191 pages. $17.95.*

*Reviewed by **Libba Jetter Spiegel,** M.S., Child Development Specialist and Play Therapist in Private Practice, Pittsburgh, Pa.*

The inner world of children is communicated through their art work. Consequently art productions represent a nonverbal behavioral key to assessing developmental well-being. In *Mommy, Daddy, Look What I'm Saying,* Dr. Myra Levick asserts that art is a key that parents as well as art therapists can use, if they only understand how. Generously, this is just what Dr. Levick proposes to teach. By sharing some of the art psychotherapist's "tools of the trade," the author informs parents how to use art as a way of deciphering what their children are saying.

The three most essential tools shared are: (1) how to read danger signals in art productions; (2) how to provide the kind of environment in which children will feel safe and free to communicate through art; and, most importantly, (3) how to use an understanding of normal artistic development as a standard from which abnormal development can be differentiated.

The first step in this last process is to acquire a knowledge of normal developmental sequences; to this end, the last half of the book is devoted. Much of the information is imparted through the dramatic device of two fictional children, whose growth from birth to 12 years illustrates the stages of psychological and artistic development. One of the book's central concepts is that artistic development is related to, and is an expression of, emotional, intellectual and verbal development, and that it, therefore, reveals the latter. This is given visible proof through the presentation of children's drawings and paintings that are impressively utilized throughout the book. These communicate more clearly than words the interrelatedness of developmental capacities.

There are some pertinent questions for us to consider: Is it really helpful for parents to look at their children's art from a diagnostic perspective? Is there a danger that parents will relate to their child's art like sleuths, anxiously alert to discover warning signals? Might not the child be robbed of something as a result?

Most likely, the answers [to the above questions] lie in the individual parent's way of using this information, and of the art therapist's help to parents in furthering the understanding of the ingredients, methods, approaches, forms and intricacies of child art. I suspect that *Mommy, Daddy, Look What I'm Saying* will be an informative and educative reference book that will be used by many parents as well as art therapy professionals. Having acquired knowledge about artistic as well as other areas of development, parents can hopefully approach their child's creations with enhanced sensitivity and appreciation.

Guidelines for Authors

Please submit four (4) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed, ATR, Wright State University, Creative Arts Center, 228 Creative Arts Center, Dayton, OH 45435. Send manuscripts and illustrations certified mail, with return receipt requested. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5″ × 7″ black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

BEST COPY AVAILABLE

Child Art Therapy (2nd edition)

Judith Aron Rubin, *New York: Van Nostrand Reinhold Company 1984. 320 pages, $19.95, paperback*

Reviewed by ***Lewis K. Shupe, Ph.D., ATR,*** *Professor of Art Therapy and Communication, Wright State University, Dayton, Ohio 45435*

The first edition of *Child Art Therapy* was a major contribution to the field of art therapy and to any field focusing on the study of children and their art. This revised edition updates the information contained in the first edition, and "explores the author's recent experiences in the field, including work with deaf children and multimodal therapy involving the closely related activities of art therapy and play therapy." The book is profusely illustrated with children's paintings and drawings and clay work as well as spontaneous photographs of children at work and play. The organization seems clear and concise: Part I presents "The context" within which subsequent information is presented. Within this first part is "Framework for Freedom," and "Conditions for Creative Growth." In this first part author Rubin presents most comfortably her theoretical base, personal experiences, and discusses methodology and materials— ". . . thinking about appropriate facilitating conditions for growth, something I assume necessary in order to help human beings to actualize their inner creative potential." Materials, space, time, order, safety, respect, interest, pleasure, and support are amplified as necessary conditions for growth and for the development of creative potential.

Subsequent sections include "The Individual," "The Family and the Group," and "The Community" followed by a section that is most enlightening and important for the art therapist; this final section—one that could be inadvertently overlooked because of its low-key title, "General Issues,"—is a cornerstone of the entire book. To take this last section first, the titles of the chapters give the reader most important content: "Why and How the Art Therapist Helps," "How the Art Therapist Learns Through Research," and "What Child Art Therapy Is and Who Can Do It."

There are 10½ pages of references, with over 30 entries on each page. To peruse these references is to go through a "history" of literature directly related to our field; it is a wealth of references that should not be overlooked. For example, when Rubin discusses developmental aspects of art and the child (Chapter 3), the references pertaining to this content are abundant (Lowenfeld, Piaget, Cole, Kellogg, Silver, Levick, Uhlin, Viola, Wilson and Wilson, Wolff, and others). Of particular interest to the art therapist will be Chapter 5, "Decoding Symbolic Messages." Rubin says "In order to utilize the unstructured art interview effectively, it is important to know how to look, what to look at, what to look for, and how to make sense out of what has been observed." She identifies various areas of vital concern: verbal and non-verbal behaviors, the interaction process, process and product, common themes, attitudes and roles, among others. In discussing the therapeutic process, brief discussions are presented on testing, trusting, risking, communicating, facing, understanding, accepting, coping and separating. Case studies are presented in Chapter 7, as well as vignettes and examples scattered throughout the book. Separate focus is given to art therapy with the handicapped child, family art therapy and evaluation, the mother-child art therapy group, group art therapy, and multimodal group therapy. Helping the "normal" child through art and helping parents through art and play offer much information related to mastering media and expressing feelings in ways that are constructive and supportive. Expecially worthwhile are brief descriptive units on core issues for the infant, toddler, preschooler, school-age child and the adolescent.

One senses the importance of art therapy by listening carefully to the author as she—at times quite conversationally—presents her rationale for this modality. As an example, in the introduction to the first edition, also included in this edition, Rubin says:

> My own understanding of "art therapy" is that it refers broadly to understanding and helping a person through art, and that it encompasses a wide variety of dimensions. These include the integrative aspects of the creative process itself, as well as the use of art as a tool in the service of discharge, uncovering, defense, or communication . . . it seems that for anyone, the art activity over time ranges from being central and integrative to peripheral and adjunctive and back again, serving many different possible functions. What is important is to know what is occurring when it is happening, and to have some sense of its meaning and function for that person at that moment in time. What seems equally vital to me, is that the worker have the flexibility and openness to permit the individual to flow in different di-

> rections over time, and the wisdom and creativity to stimulate, unblock, or redirect the flow when necessary. (pp 17-18)

This is an excellent edition, and a book that every art therapist and human services professional should have for reading, reference and research. The interdisciplinary theoretical emphases are presented clearly, and speak directly to the issue of the art therapist having a working knowledge of interrelated modalities. In addition to providing a valuable resource for the art therapist, *Child Art Therapy* can amplify the art therapy discipline for our colleagues in other professions. The coverage of content is appropriate and it entices the reader to want to know more and delve further. It is a "comfortable" book to read, and the author presents many personal glimpses that enhance the other content being presented.

The Master of Arts in Expressive Therapies. Certificate of Advanced Graduate Study in Expressive Therapies.

Offered by the Institute for the Arts and Human Development, Lesley College Graduate School.
For students interested in the creative modalities of art, music, dance/movement, drama, and holistic studies and healing arts presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning.
For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theatre studies.

Lesley College Graduate School is pleased to announce a new Ph.D. Program in Expressive Therapies with a focus on higher education and professional leadership.
For more information call or write to: Joanne Fabris, (617) 868-9600, ext. 480. Institute for the Arts and Human Development. Lesley College Graduate School, 29 Everett St., Cambridge, MA 02238

LESLEY COLLEGE GRADUATE SCHOOL

BEST COPY AVAILABLE

VIEWPOINTS

Wasted Wealth: Thoughts on the Discontinuation of AATA Conference Proceedings

Pat Buoye Allen, M.A., ATR

In 1982 a decision was made to discontinue the publication of the proceedings of the AATA National Conference. Recently I have had occasion to delve into the proceedings of past conferences as I review art therapy literature for my doctoral work. These publications form an invaluable resource to chart the development of trends and ideas in the field. Frequently, art therapists present material at conferences that is new, in ferment, experimental. It may not be as formal as an article in one of the professional journals but often it is as valuable. There is a breadth of topics covered during our Conferences including workshops, accounts of which are unlikely to reach publication any other way.

Until faced with my current task of seeking views of art therapists on art therapy, I had not, I admit, fully appreciated the Conference proceedings. Using them so thoroughly has given me cause to reflect on the abolition of this publication.

Simply put, I believe it was a major error in judgment to discontinue Conference proceedings. It seems to be another way of disregarding our own valuable contributions to one another. We have silenced the most potent voice for the development of art therapy: our own. Our combined professional journals give us at most 30 or so scholarly articles on art therapy per year. A typical Conference may have over 100 presentations. Some of those who make presentations will not prepare their material to meet the more formal demands of the journals. Sometimes re-reading a selection from the proceeding can catalyze a nascent idea, having a ripple effect. The Conference draws from a far broader, more representative sample of our AATA membership. It is a more realistic compendium than our journals of what is taking place nationally, simply because the standards and aim of a Conference are different. It is to inform and report as well as to challenge in a scholarly way.

The recent innovation of selling tapes of Conference proceedings is, in my opinion, an inadequate substitute for a publication. As another option, tapes are fine. I am a visual person, I need to see text written down, to read it and re-read it, especially when I am writing something myself.

In addition, I remember a student whose presentation was published in a Conference proceeding. She was so proud to see her name in print and feel she was contributing to the field. What better way to stimulate more writing and publishing than to use the proceedings as an initial place to present ideas?

Cost has been cited as a factor. I propose adding a proceedings charge to the Conference registration fee. In addition, graduate programs ought to order these publications as texts in literature survey courses.

We are throwing away a resource of value by neglecting to publish our Conference proceedings. Our history and evolution are something to be proud of and to be preserved.

My Stars, We Need Art Therapy

As mentioned in Viewpoints previously ("The Fantasy of Art Therapy Enters the Mainstream," Vol. 3, #1), art therapy is surfacing in the fantasy life of our culture. Whether you consider it fact or fancy, astrology's celestial rhythms are also encompassing our profession these days.

The Chicago Tribune newspaper edition for March 12, 1986 ran the following in its Horoscope by Joyce Jillson:

> CAPRICORN *(Dec. 22 - Jan. 19)*: Wild dreams continue to haunt you at night. You can figure out their message if you think about them. Art therapy may loosen you up.

Discovered by Evadne McNeil, Ph.D., ATR
Submitted by Harriet Wadeson, Ph.D., ATR
(a Capricorn)

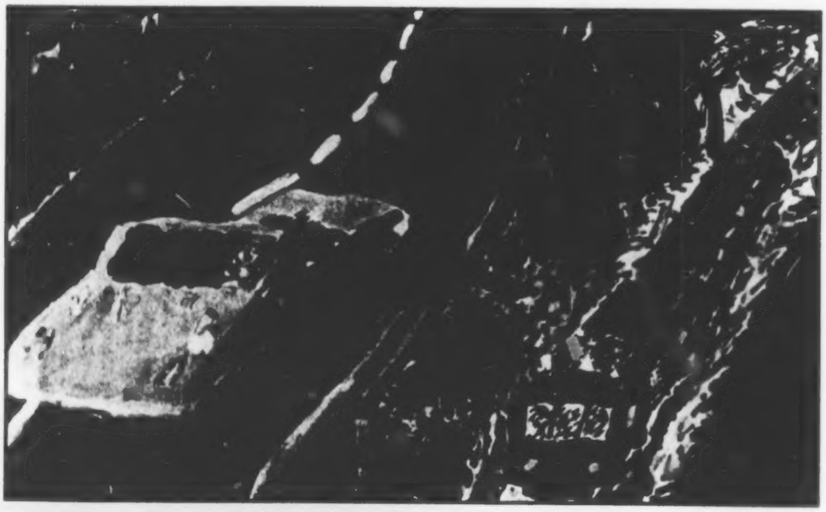
Art Therapist's Portfolio

VIEWPOINTS provides a forum for sharing ideas and graphics about issues facing art therapists. It also encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit black and white glossy photographs and four copies of the written material to: ***Viewpoints,*** *ART THERAPY, 505 E. Hawley St., Mundelein, IL 60060.*

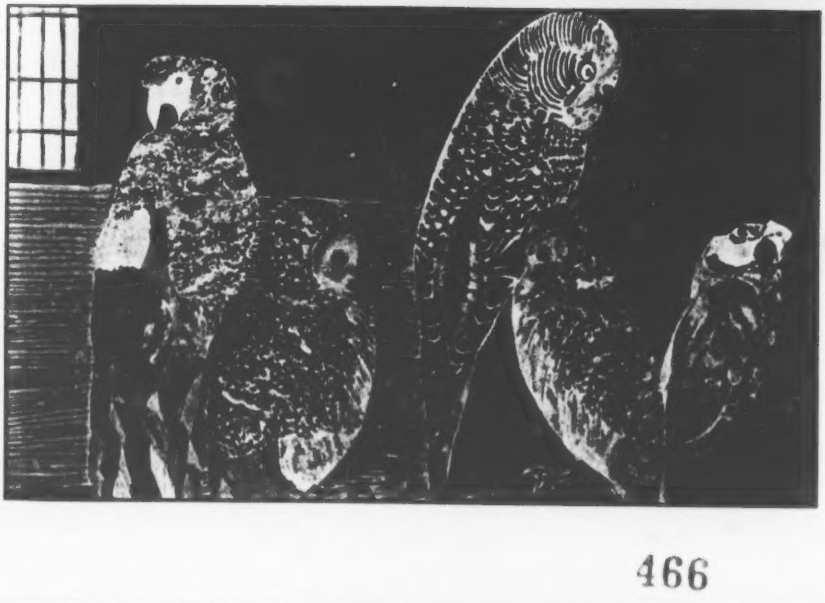
The portfolio of children's art work has been collected from various exchange programs between Cincinnati, Ohio and Japan. These exchange exhibits occurred during the 1970's. Reproductions of the work from Japanese children have been made from various exhibitions. Each year there was a different theme; for example, the color reproduction on the cover of this issue is from a painting titled "Wishes to be a Spring Goddess," and occurred in the early 1970's from an exhibit that emphasized what each child wanted to be—either real or imaginary. In each exhibit, there was work that included a variety of media: drawings, paintings, mixed media, and other similar materials that could be found in a classroom or art room.

Mr. Isao Takasugi was the Secretary General of the Japanese Children's Art Association. The Association was comprised of over 60 elementary and junior high schools throughout Japan, and the Center for the Association had its headquarters in Tokyo where each year's exhibit was held.

For the use of these reproductions, appreciation is given to the children who participated in the exhibits. Grateful recognition and thanks are also given to Mr. Takasugi and to the Children's Art Association. A special "thank you" goes to Lane V. McCombs of Cincinnati, Ohio, who was instrumental in organizing the exchange of children's art work over the years.

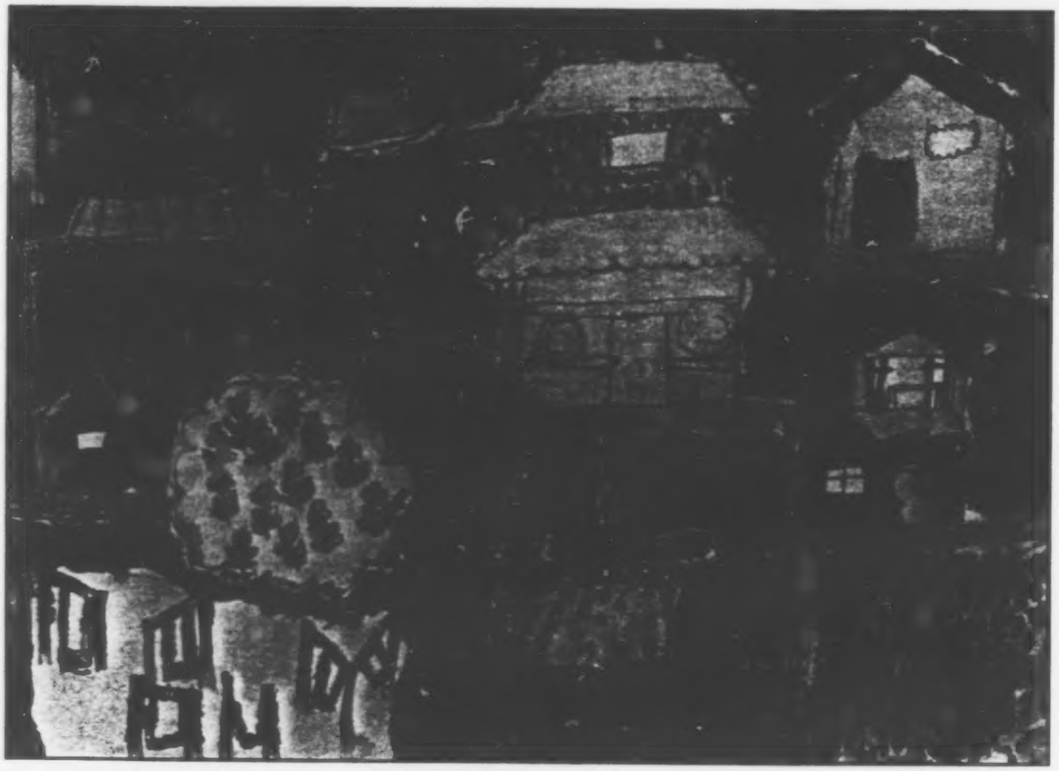


Highway in the Night
Jyunichi Yonese, Tokyo
Elem. (5), Age 10

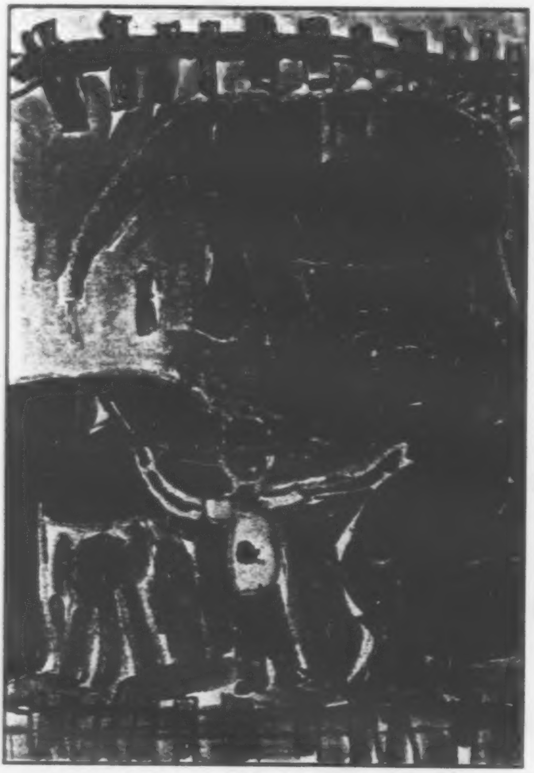


Wishes to be a Bird
Ikuko Masuda, Tokyo
Elem. (5), Age 10½

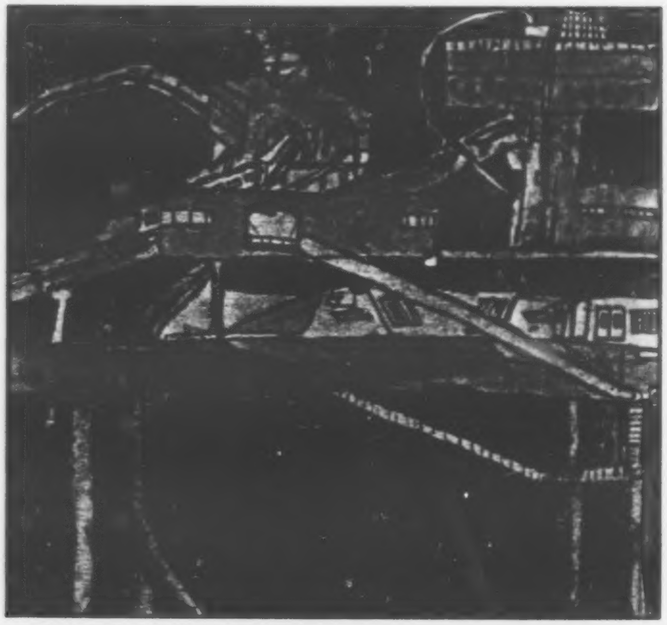
BEST COPY AVAILABLE



Candy Village Seiko Takahashi, Tokyo Elem. (3), Age 8-9

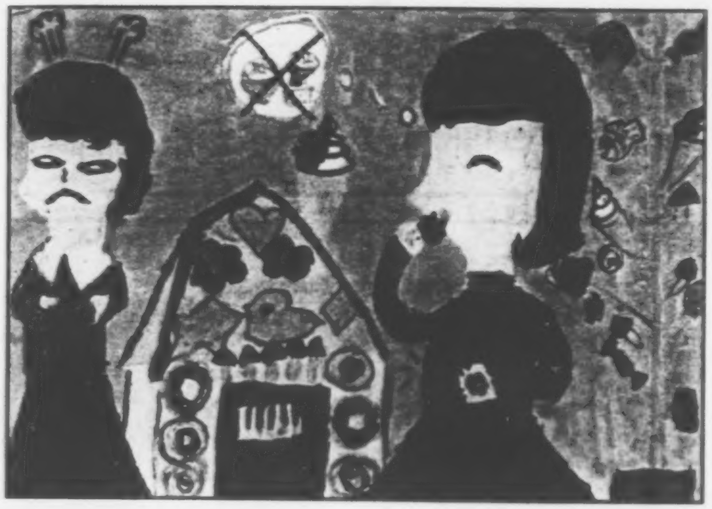


Teaching a Trick to the Elephants Naohioko Uematsu, Shizuoka Elem. (3), Age 8½

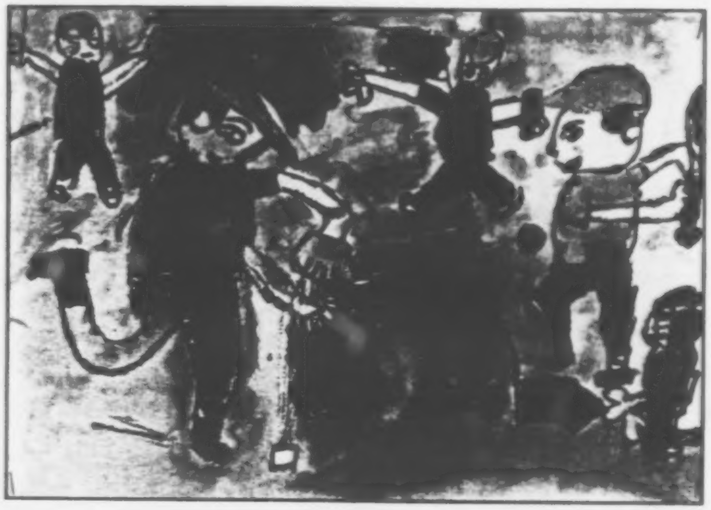


Wishes to be a Future Station Master
Hiroyuki Kashima, Tokyo
Elem. (4), Age 9½

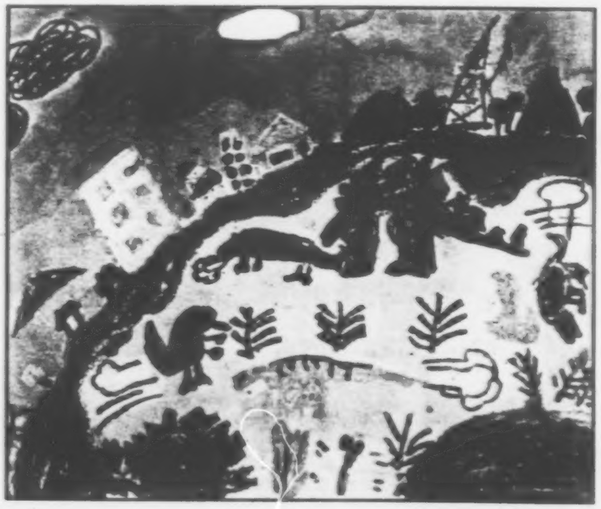
BEST COPY AVAILABLE



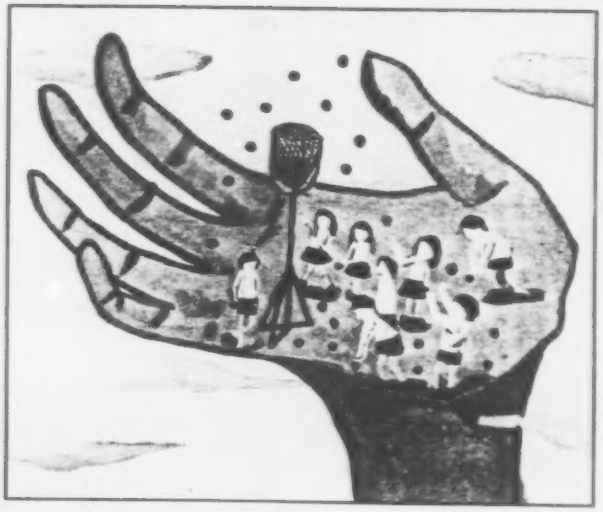
Mom Worries Weak, Tiny Yukiko
(Mom: Eat! Not junk food.
Yukiko: I want a candy!)
Yukiko Takaoka, Tokyo
Elem. (1), Age 6½



Wishes to be a Baseball Player
Koichi Hrada, Shizuoka
Elem. (4), Age 9



Why Does Earthquake Happen?
Yasuko Matsuura, Tokyo Elem. (2), Age 7



Peace for Children
Mari Kawamoto, Tokyo Jr. High (3), Age 14½

BEST COPY AVAILABLE

BRIEF COMMUNICATIONS

This column provides a forum for information exchange among clinicians and educators. Items relevant to research and to programmatic, historical, or clinical developments may be submitted. Contributions should be sent to Brief Communications, ART THERAPY AATA, 505 East Hawley Street, Mundelein, IL 60060

The National Academy of Television Arts and Sciences presented a Community Service Emmy Award on August 26, 1986, for the film "Child at Risk." This award is the first one ever given to a Public Broadcasting Service station (Channel 8, Houston, Texas). This documentary was chosen as the winner from over 187 entries from across the United States. Felice Cohen, ATR, serves as the art therapist in this film that focuses on child abuse and incest. It is now being used as a training film for police departments throughout the country, and it has also won a silver award for Community Service Documentary at the Houston International Film Festival as well as a gold medal at the New York Film Festival. The film will be aired nationally this year.

Congratulations to Felice Cohen for a job superbly done in an area that is receiving focused attention by all human service personnel professionals.

NEW BOOK REVIEW JOURNAL ISSUED BY AMERICAN ORTHOPSYCHIATRIC ASSOCIATION

A different kind of mental health journal is being introduced in March 1986 by the publisher of the *American Journal of Orthopsychiatry*.

READINGS: A Journal of Reviews and Commentary in Mental Health will be the field's only interdisciplinary journal to focus exclusively on book reviews. Featuring essay-reviews by the outstanding thinkers in the behavioral sciences, *READINGS* will be an essential forum for the debate of both new ideas and traditional concepts. *READINGS'* Overview section of one-paragraph reviews will cover the new literature quickly and comprehensively. All will be contained in a handsome professional journal, highlighted by black-and-white photography.

Issued quarterly, *READINGS* will be an easy and interesting way to keep current on all book publishing relevant to mental health and human behavior.

For more information about *READINGS*, contact: Ernest Herman, Editor, 212/354-5770.

The American Art Therapy Association, Inc.

505 E. HAWLEY STREET
MUNDELEIN, ILLINOIS 60060
(312) 949-6064

RESOURCES

The American Art Therapy Association serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapists' Identity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: Journal of the American Art Therapy Association **Rates: Individuals - U.S. $23.00; Foreign $30.00; Institutions - U.S. $27.00; Foreign $36.00**		
Art Therapy: Journal - Back Issues	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings Use of the Creative Arts on Therapy (1979)	$5.00	$7.00
National Art Education Association Journal: Special Issue Art Education, Vol 33, No. 4 (1980)	$3.00	$4.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 × 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

FILMS (Rental/Purchase)

		Members	Non-Members
Art Therapy: Beginnings (1977) 16mm. color/sound, 45 minutes	Rental:	$40.00	$50.00
	Purchase:	$300.00	$400.00
Michael (1977) 16mm. color/sound, 12 minutes	Rental:	$30.00	$35.00
Art Therapy (1981) 16mm. color/sound, 12 minutes	Rental:	$35.00	$45.00
	Purchase:	$250.00	$325.00
Lori, Art Therapy and Self Discovery (1978) 16mm. color/sound, 32 minutes	Rental:	$40.00	$50.00

ORDER FORM Make checks payable in U.S. funds to AATA, and mail to the above address

Indicate Quantity of Unit Items Below		Cost/Unit		Total
________	( ) ×	________	=	________
________	( ) ×	________	=	________
________	( ) ×	________	=	________
________	( ) ×	________	=	________
________	( ) ×	________	=	________
		________	=	________
		Total Unit Costs	=	________
		*Postage/Handling	=	________

10 or more copies of any single issue: 15% discount on total cost.
Discounts are available when purchasing quantities.
Set of four Proceedings (consecutive years): 20% discount on total cost.

Note: for postage/handling, add $1.50 for the first unit item. $ .50 each additional unit.

Total Enclosed = ________

Send To: ________________ MBR ID#: ________

____

City State Zip Code 8/86

Marylhurst College
Marylhurst, Oregon
Master of Arts
in Art Therapy

A two year program offering a balance of academic study and clinical internship. Part time study is possible. Program begins in September of each year. Apply in March for September admission.

For information:
Christine Turner, ATR
Director, Art Therapy Program
Marylhurst College
Marylhurst, OR 97036
(503) 636-8141

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, *ART THERAPY, Journal of the American Art Therapy Association*, discounts on publications, discount on admission to the annual conference, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (ATR). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA National Office.

Associate Membership shall be open to individuals interested in the therapeutic use of art wishing to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $50

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee. **Applications for student membership must be accompanied by a copy of current ID.**

Annual Dues: $35

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $100

Professional Membership is by application only and is open to individuals who have completed professional training in art therapy and who are or have been engaged in the therapeutic use of art. Professional members are eligible to participate in all activities of the Association and receive all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $75

Credentialed Professional Membership is by application only and is open to individuals who have met the qualifications and been approved for Professional Membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in Standards and Procedures for Registration. Professional members are eligible to participate in all activities of the Association and receive all official publications. A Credentialed Professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $80

Make checks payable to AATA

American Art Therapy Association, Inc.
505 E. Hawley Street
Mundelein, IL 60060
(312) 949-6064

NAME ______________________
LAST FIRST MIDDLE

PREFERRED MAILING ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________

OTHER ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________

TITLE ______________________

EMPLOYER ______________________
INDIVIDUAL OR INSTITUTION

HIGHEST EDUCATIONAL DEGREE ______________________

☐ $ 50 **Associate Membership**

☐ $ 35 **Student Membership**
(copy of current ID required)

☐ $100 **Contributing Membership**

☐ $ 75 **Professional Membership**
(by application only)

☐ $ 80 **Credentialed Professional Membership**
(by application only)

Payable in U.S. Dollars

Dues and expenses related to participation in AATA may be tax deductible as a business expense.

BEST COPY AVAILABLE

RETURN THIS APPLICATION WITH YOUR REMITTANCE

ART
THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 505 E. Hawley St., Mundelein, IL 60060

Please enter my subscription for 1985. Enclosed is my check, payable to AATA, for $23.
Name
Address
City State Zip

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

SPECIAL ISSUE — VOL. 14 NO. 1 1987

The USE of the CREATIVE ARTS THERAPIES in TREATMENT of SEXUALLY ABUSED CHILDREN and ADOLESCENTS

SUBSCRIBE NOW—AND SAVE 50% OR MORE!
SUBSCRIBERS OF *ART THERAPY* AND MEMBERS OF
THE AMERICAN ART THERAPY ASSOCIATION ENJOY REDUCED RATE! (See Coupon)
THE EDITORS WELCOME ORIGINAL MANUSCRIPTS
Submit papers in triplicate to: The Managing Editor, Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583
TO SUBSCRIBE, fill in coupon and mail now with proof of membership in AATA.

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA
Enter subscription for 1987 (Vol. 14) ☐; 1988 (Vol. 15) ☐.
Reduced rate $20 each volume (Regular rate for individuals $40) Students $15
Two volume subscriptions (Vol. 14, 1987 and Vol. 15, 1988) subject to additional discount: $36; Students $27.
Single copies special issue $10 each.
Prepayment required. Enclosed is check ☐
Name
Address
City State Zip

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Volume 4, Number 1

March 1987

- 17th Annual AATA Conference Overview
- Honorary Life Membership Acceptance Speech
  Robert E. Ault, MFA, ATR
- The Therapeutic Effects of Combining Apple Macintosh Computers and Creativity Software in Art Therapy Sessions
  Devorah Samet Canter
- An Art Support Group for Bereaved Children and Adolescents
  Mary Raymer, ACSW and Barbara McIntyre
- Utilizing Imagery and the Unconscious to Explore and Resolve the Trauma of Sexual Abuse
  Marsha Yates, BS and Kim Pawley, MA, ATR

474

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1985-1987

Board of Trustees

President
Sandra L. Graves, PhD, ATR

President-Elect
Cay Drachnik, MA, ATR, MFCC

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, MA, ATR

Committee Chairs

Affiliate Societies
Virgil Matheny, ATR

Bylaws
Roberta J.H. Shoemaker, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Bobbi Stoll, MS, MFCC, ATR

Publications
Harriet Wadeson, PhD, ATR

Research
Linda Gantt, MA, ATR

Standards
Ronald E. Hays, MS, ATR

Executive Director

Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, EdD, ATR 2

Articles

17th Annual AATA Conference Overview 3
Honorary Life Membership Acceptance Speech
Robert E. Ault, MFA, ATR 15
The Therapeutic Effects of Combining Apple McIntosh Computers and Creativity Software in Art Therapy Sessions
Devorah Samet Canter 17
An Art Support Group for Bereaved Children and Adolescents
Mary Raymer, ACSW and Barbara McIntyre 27
Utilizing Imagery and the Unconscious to Explore and Resolve the Trauma of Sexual Abuse
Marsha Yates, BS and Kim Pawley, MA, ATR 36

Viewpoints

Portfolio 42

About Our Cover

This painting was done by an adult with emotional and organic disorders.

Volume 4, Number 1 March 1987

Copyright © 1987
American Art Therapy Association

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Sharon Purtell

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Anthony Kowalski, MD
Susan LaMantia O'Connor, MA, ATR
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064

EDITORIAL

As in previous post-conference issues of *Art Therapy*, we are publishing a program overview of the most recent conference of the American Art Therapy Association (Los Angeles). We are pleased to offer to the readers this listing (reassembled here in specific categories) with the name and address of the primary presenter. This is done for the art therapist who wishes additional information on any particular topic; he or she may write directly to the presenter pertaining to summaries, additional information, reading lists, or other presentation materials.

Congratulations to Robert Ault, the most recent recipient of the Honorary Life Member distinction, awarded by the American Art Therapy Association. Bob is worthy of this honor, and he joins the ranks of other worthy individuals who have been presented this most prestigious award. As newer members of A.A.T.A. may not know, he was an original founder of our Association. It seems important, as we expand our communication and dialogue with other professionals and groups, that our Association continues with this process—that of selecting recipients for this designation. It is important to honor members who have shown their commitment to the field, who have shared their dedication, knowledge and leadership. The act of honoring members with an award of this caliber "speaks well" for our profession. We are pleased to present Bob Ault's acceptance speech as it was delivered at the Los Angeles A.A.T.A. Conference.

One of our articles in this issue, titled "An Art Support Group for Bereaved Children and Adolescents," by Mary Raymer and Barbara Betker McIntyre, speaks to an issue that the authors say is often overlooked and frequently misdiagnosed as pathology. The article bears serious consideration, and offers three condensed cases from a support group begun in Michigan. For additional information on the particulars of how the authors began the group with Council for the Arts funding, the reader may wish to communicate directly with Raymer and McIntyre.

A second article is "Utilizing Imagery and the Unconscious to Explore and Resolve the Trauma of Sexual Abuse." Author Marsha Yates, in collaboration with Kim Pawley, follows Martha Williams (pseudonym) through her history of child abuse, reexperiencing the past and coming to a realization of fears, integrating and accepting these feelings, exploring methods of control, redefining relationships and moving toward personal integration. It is an intense journey that we take with Martha as we begin to sense the history, the "now," and the processes that help to bring to fruition some of these intense feelings, understandings, confrontations and resolutions. The format is somewhat unusual, as the narrative was supplied, in large part, by the client and woven into the entire fabric of the article, along with the overall organization supplied by authors Yates and Pawley. We are introduced to Martha, and to the gradual step-by-step process, obviously presented here in a condensed version.

"The Therapeutic Effects of Combining Apple Macintosh Computers and Creativity Software in Art Therapy Sessions" is an article that is both timely—relative to current technological equipment in use—and appropriate for the art therapist who needs to be introduced to perhaps an unfamiliar "territory." Following an introduction and background, the reader is presented with information on the computer, hardware and software with details that simplify the total operation (such as using the "mouse") and graphic packages (i.e., MacPaint™, VideoWorks™ and MusicWorks™). Case study 1 illustrates extensive work with E.M.C., a 12-year-old child with behavioral and emotional problems, and Case study 2 describes work with D.C., a 17-year-old female adolescent. In each case, the computer was an important aspect of the therapy program. In the concluding section, author Canter lists six areas that are important results of a three month study on computers and creativity software used by children and adolescents with learning disabilities. The author says that further research in using computers and software with children, adolescents, adults and older populations is needed; this article is an important step in helping to make the reader more aware of computers and their use in therapy.

Once again, keep the articles coming. I am pleased with the response to *Art Therapy*, and your suggestions and comments have been—and will continue to be—valued and appreciated. If you have suggestions for future "theme issues," send along your ideas.

Believe it or not, it is not too early to begin thinking about the next A.A.T.A. Conference. It will be held in Miami, Florida, and the theme is "New Directions in the 80's." Watch the A.A.T.A. publications for more information as Conference time draws nearer.

Have a pleasant spring!

Gary C. Barlow, Ed.D., ATR
Editor, Art Therapy

AATA Conference Overview

The 17th annual Conference of the American Art Therapy Association was held in Los Angeles, California, from November 12-16, 1986. The committees and their chairpersons, and the presenters and participants, are to be congratulated for their participation in helping to make the California meeting a most successful and professionally rewarding one. Special thanks must be given to Cay Drachnik, Conference Chair, and Joan Ungar, Program Chair, for their dedication and professionalism in the initial stages of planning and throughout the Conference to the completion of the meeting.

Beginning here and continuing on the following pages is a listing of the presentations, workshops, papers, forums, meetings, symposia, pre- and post-conference courses, and other highlights of the Conference. Included with the presentations is the name and address of the single presenter, or the address of the first person listed in the case of multiple presenters for a session. In lieu of the past AATA *Proceedings,* the information is offered in this format so that readers may communicate directly with the primary presenter for any additional information desired on the specific topic listed. Each entry is printed as it appeared in the Conference program, although categories (such as "Papers") have been grouped together for the reader's convenience. The information has not been edited relative to any changes that may have occurred at the Conference.

—EDITOR

17TH ANNUAL CONFERENCE COMMITTEE

CONFERENCE CHAIR:
Cay Drachnik, ATR, MFCC

PROGRAM CHAIRMAN:
Joan Ungar, LP, ATR

PROGRAM COMMITTEE:
Josephine Abbenante, MA, ATR
Sally Brucker-Cohen, ATR
Kay Conlon, MA
Loris Damerow, MA, ATR
John De Francisco, MA, ATR
Susan Dwight, MA
Paula Engelhorn, MA, ATR, MFCC
Lois Gelbmann, ATR
Marge Geegaard, ATR
Ruby Koppelman, MA, ATR
Deirdre Kozlowski, MA, ATR
Dianne Meixner, MA, ATR
Susan Orr, MA, ATR
Lillian Rhinehart, MA, ATR
Virginia Shaver, MA, ATR
Barbara Sprayregen, MA, ATR
Kay B. Stovall, MA
Joel Vogt, MA, ATR
Patty Volner, MA, ATR

LOS ANGELES LIAISON:
Greg Wolfe, ATR, MFCC

CONSULTANTS:
Don Jones, ATR, LM
Janie L. Rhyne, PhD, HLM, ATR
Dee Spring, MA, ATR, MFCC

PRE-CONFERENCE COURSES CHAIRMAN:
Cathy A. Malchiodi, MA, ATR

PRE-CONFERENCE COURSES CO-CHAIRMAN:
Pat Buoye Allen, MA, ATR

PRE-CONFERENCE COURSES

COURSE #1–The Ulman Assessment Series

Gladys Agell, ATR, Associate Professor; Director, Art Therapy Program, Vermont College of Norwich University, Montpelier, VT 05602.
Elinor Ulman, HLM, DAT, ATR, Associate Professor, George Washington University, Washington, DC 20052.

This is an experiential course covering an art therapy projective personality assessment, the Ulman Assessment Series (UAS). Enrollees are expected to participate in the drawing procedure and should be attired for studio work. The course is an eight-hour course; assigned readings should be completed in advance. On receipt of notice of enrollment, a bibliography will be sent to the student.

COURSE #2–Footprints of Our Minds, Mirrors of Our Lives–Photos as Therapy Tools

Judy Weiser, MS Ed, MSW, RSW, Director, PhotoTherapy Centre, 1107 Homer St., Suite #304, Vancouver, BC Canada V6B 2Y1.

Photos by themselves have no meaning, yet all those we take or choose to respond to are in some way 'self-portraits.' Shooting, responding to, or interacting with them can stimulate thoughts, memories, and feelings not otherwise accessible. Using client snapshots and interactions or dialogues with them as tools in counseling allows connection with those more emotional, intuitive, and less-defended parts of people. Prior knowledge about, or contact with cameras or photography is **not** necessary for workshop. Participants are asked, however, to **bring along to the workshop** a couple dozen various snapshots taken or collected (even if torn from magazines!) that are meaningful.

COURSE #3–The Sand Tray Dialogue

Lillian Rhinehart, MA, MFCC, ATR, Educator, Eagle Rock Trail Art Therapy Institute, 1475 Los Alamos Rd., Santa Rosa, CA 95405.
Paula Englehorn, MA, MFCC, ATR, Educator, Eagle Rock Trail Art Therapy Institute.

The focus of this course will be to demonstrate to professionals the Sand Tray Dialogue process as an adjunctive tool. Jungian Psychology, Gestalt Therapy and the elements of the sand tray experience form the foundation of the Sand Tray Dialogue experience. The course is open to professionals. Those who intend to take the course would find it helpful to read Dora Kalff's **Sandplay** or Evelyn Dundas' **Symbols Come Alive in the Sand.**

COURSE #4–Family Art Assessment

Joan Phillips, MA, MS, ATR, Private Practitioner/Consultant, 430 S. Lahoma, Norman, OK 73069.

This course is designed to introduce the field of family art therapy and art assessment as well as offer additional theoretical/methodological considerations in assessing families. Major family therapy approaches of Bowen, Whitaker and Minochin will be discussed and interfaced with family art assessment. Specific methodology will be demonstrated experientially and through case materials. Various styles of observational records and the importance of family art therapy/assessment as part of multidisciplinary treatment will also be shared.

COURSE #5–Systematic Study of Visual Languaging in Drawings of Primary Emotional Experiences

Marcia Rosal, Univ. of Louisville, Expressive Therapies, Louisville, KY 40292.

Balancing learning through both instruction and experience, this course offers a way of using simple drawings to develop more understanding of how people use visual language in expressing and communicating thoughts and feelings. Theoretical approaches are from study of configurations as perceptions of personal realities and are adapted to providing a method for recognizing and recording how form in itself can be understood as a conveyor of messages in visual language. Applicable both to basic research and in working with clients. Illustrative slides will be shown. Required reading: two articles in Proceedings of AATA Conferences (1979 & 1980): Rhyne, J. "Expanding Our Comprehension of Visual Imagery" (1979) and "Personal Dramas of Transition" (1980).

COURSE #6–Therapy with Children From Violent Homes

Cathy A. Malchiodi, MA, ATR, Assistant Professor, University of Utah, AAC 161 Dept. PF Art, Salt Lake City, UT 84112.
Ivo R. Peterson, MFA, Drama Therapist, Assistant Professor, Cardinal Stritch College, Milwaukee, WI.

This course is designed to teach therapeutic art modalities to professionals who work with child populations in domestic violence shelters and other situations involving children traumatized by abuse or domestic violence. Through discussion, participation and visuals, attendees will learn how to utilize a variety of creative art therapy interventions with client populations and to understand diagnostic implications, symbols and reoccurring themes in the expressions of abused children and incest victims. Required reading: **Creative Art Modalities with Children From Violent Homes** by the authors.

COURSE #7–Dream Interpretation Through Archetypes and Eidetic Imagery for Art Therapists

Joseph Garai, PhD, ATR, Professor Emeritus, Pratt Institute, 155 W. 68th St., Apt. 26-A, New York, NY 10023.

The theoretical part of this course will familiarize students with the basic principles of dream theories developed by Freud, Jung, Erikson, and Perls. The didactic-experiential part requires participants to draw with multicolored crayons or craypas and model with plasticine clay a recent or a recurrent dream. These dreams are then interpreted through archetypes and eidetic imagery. The course instructor will assist students in interpreting dreams in the framework of Freud, Jung, Erikson, and Perls. The purpose is to provide the students with basic skills in dream interpretation and to increase their work with clients of many different patient populations.

COURSE #8–Grants: Creating Job Connections

Frances E. Anderson, EdD, ATR, Professor of Art, University of Illinois, 311 Orlando Ave., Normal, IL 61761.
Doris Arrington, EdD, ATR, Director, Art Therapy Program, College of Notre Dame, Belmont, CA 94002.

A hands-on grant writing workshop that includes: identifying finding sources for art therapy jobs and programs, "do's" and "don'ts" of grant writing, why proposals fail, how to locate and approach funding agencies, critiques of selected grant proposals. Participants are asked to bring 15 copies of a brief (no more than 5 typed pages) **preliminary** grant proposal to the workshop (this is required if they want credit for the course, or, is strongly recommended if participants want to get the most out of the workshop experience). This workshop is open to all levels of participants but will be orientated to those with little or no grant writing experience. Required reading: "Grants: Demystifying the Mystique" and "Creating Job Connections" by the instructors, which appear in **Art Therapy,** March 1986.

COURSE #9—The Rainbow Phenomenon: Toward a Psychology of Color

Roberta J. H. Shoemaker, MFA, ATR, Emporia State University, Art Therapy Art Dept., Emporia, KS 66801.

A difficulty in studying the psychology of color usage in art work has been conflicting writings and research. This course will present a cohesive psychology based on the rainbow phenomenon as an organizational frame of reference that is reflective of color in physiology and levels of psychological coping styles. Current research findings and experiential work will be included.

COURSE #10–Bitter Roots: Child Abuse and Multiple Personality

Dee Spring, MA, ATR, MFCC, Art Therapist, Vista Del Mar Hospital, 5159 Teton Lane, Ventura, CA 93003.

This workshop is designed to teach the fundamental treatment approaches to multiple personality through the use of art work and hypnosis. The combination of these two techniques produces an interpretation of symbolic language which may lead to bringing repressed memories to consciousness through hyposymbolism. The use of clay in exploring normal ego states will be used as a method of understanding Multiple Personality Disorder.

OPENING CEREMONY

President's Address–"Identity in the 90's"
Sandra Graves, PhD, ATR

OPENING RECEPTION

Start the conference by renewing old friendships and making new acquaintances at the Wine and Cheese reception, Thursday, November 13, 1986.

CLOSING RECEPTION

A closing reception for all attendees will be held on Saturday, November 15, 1986 to provide an enjoyable time period for social interaction with your peers prior to leaving the conference.

STERN'S BOOK FAIR

Stern's Book Fair will be set up in the San Bernardino Room, Thursday, November 13 through Saturday, November 15.

OPEN STUDIO

For those who wish to indulge their creative needs during the Conference, an Open Studio is again available to delegates in the La Brea Room from 9:00 A.M.–5:00 P.M., Thursday, Nov. 13, 1986 through Saturday, Nov. 15, 1986. The Open Studio will be well stocked with basic art supplies/materials and facilitated by Art Therapists.

AATA NATIONAL OFFICE

The AATA National Office will be set up in the La Cienega Room for the entire conference.

MEETINGS

ANNUAL BUSINESS MEETING

The AATA Annual Meeting will be conducted Friday, Nov. 14, 1986, 3:15 P.M.–6:15 P.M. in the San Diego and San Jose Rooms. Individuals who are Professional and Credentialled Professional (voting) members are requested to attend. The Association also welcomes all conference delegates to attend this important meeting.

STUDENT SUB-COMMITTEE
Bobbi Stoll, ATR

ART THERAPY EDUCATION COMMITTEE
Shirley Riley, ATR, Education Chairperson, AATA

GOVERNMENT AFFAIRS OPEN FORUM
Nancy Hall, ATR

ART THERAPY EDUCATORS
Myra Levick

WOMEN'S COMMITTEE
Lou King

BY-LAWS OPEN FORUM
Roberta Shoemaker, ATR

OPEN FORUM FOR EDUCATORS
(Questions and Answer Period)
Shirley Riley, Education Chairperson, ETB, and Education Committee

GOVERNMENT AFFAIRS COMMITTEE
STATEWIDE NETWORK
Gwen McPhaul

AFFILIATED SOCIETY MEETING
Nancy Steinberg, MA, ATR

CONTINUING EDUCATION
Laurie Wilson, PhD, ATR;
Katherine Williams, MA, ATR

NOMINATING COMMITTEE
Bobbi Stoll, ATR

CLINICAL CHAIR IN AATA
Maxine Junge, MSW, LCSW, ATR

GENERAL SESSION

The Alchemy of Creativity

Jean Shinoda Bolen, MD, 2021 Webster St., San Francisco, CA 94115

The alchemical influence of Aphrodite, Goddess (archetype) of Love and Beauty can be found in creative work and in therapy. Whenever a therapist is en-

BEST COPY AVAILABLE

gaged in bringing forth the potential in another person or an artist is deeply absorbed in his or her work, a quality of consciousness is present that is similar to being in love. To become aware of Aphrodite's influence on creative process and be knowledgeable about the Pygmalion effect in therapy, is to become conscious of the power of Aphrodite and the risks and rewards of alchemy.

SYMPOSIA

SYMPOSIUM A: ARCHETYPAL

Alchemy, Myth, Metaphor: Matters of the Imagination

Janet Osborn, 500 11th St. NW, Albuquerque, NM 87102

(All Levels)

A descent into the bizarre and fascinating visual world of Hieronymous Bosch (15c. painter) from an alchemical, mythological, and metaphorical perspective. Images from his 'Garden of Earthly Delights' are explored within the imaginal realm expanding our understanding and awareness beyond literal interpretations.

Theoretical

Inner Guide as the Wise Helper and Healer

Vija B. Lusebrink, PhD, ATR, Expressive Therapies, University of Louisville, Louisville, KY 40292

(All Levels)

The concept of inner guide is considered from the perspective of Jungian thought and Jung's experience, with examples of its representation in folklore and art. Discussion includes spontaneous manifestations of inner guide in therapy, and the benefits and difficulties encountered of introducing the concept of inner guide in art therapy.

Clinical
Conceptual

Art Therapy with a Hemodialysis Patient

Cathy Schueler, 708 Hermosa NE, Albuquerque, NM 87110

(All Levels)

The hemodialysis patient faces up to 24 hours weekly in semi-isolation with limited mobility and shares many of the same issues as medical hospital inpatients. They are not inpatients however, and life in and outside of the hospital must somehow be bridged. Through a young Navajo man's imagework, this case study emphasizes the need and untapped potential for art therapy within the hemodialysis population using an imaginal approach.

Theoretical
Clinical
Educational

SYMPOSIUM B: ADOLESCENCE

Stages of Social Development Indicated in Drawings by Adolescents

Mary Francey, PhD, Assistant Professor, University of Utah, Department of Art, 161 AAC, Salt Lake City, UT 84112

(All Levels)

This paper is an exploration of how visual images produced by adolescents can reveal level of social development at which the person is functioning. Determination of stage of social development makes it possible for the teacher or therapist to design appropriate remedial or clinical interventions, and to avoid unrealistic expectations of performance or behavior.

Theoretical

Art Therapy in Drug Abuse Treatment Programs for the Adolescent

Kristina Sly-Linton, MA, ATR, Art Therapists II, University of New Mexico Hospital, Drug Abuse Division, 119 Walter St. SE, Albuquerque, NM 87102

(Intermediate)

Slide presentation illustrating art therapy techniques used in conjunction with drug counseling in the treatment of both outpatient and institutionalized substance abusing teenagers. Methods of confrontation and alternative problem solving incorporating the art process will be discussed. Minority issues and youth gang involvement will also be addressed.

Clinical

Art Therapy with the Delinquent Adolescent

Kathryn A. Webb, MA, Clinical Art Therapist, Catholic Social Services, 1611 Victory Blvd #307, Van Nuys, CA 91406

(All Levels)

This paper is designed to promote an understanding of the clinical art therapy approach with delinquent adolescents. A brief review of the literature will provide a definition of delinquency while it will explicate some generalized etiological theories and typology. The focus of this presentation will be on case examples which will demonstrate the advantages of the art psychotherapeutic approach with this population and how depressive components may be detected through the production of artwork. Special considerations and particular factors beneficial to the therapist's development of a successful treatment plan will also be discussed.

Clinical
Educational

SYMPOSIUM C: ASSESSMENT

Sex Differences in the Emotional Content of Drawings

Rawley A. Silver, EdD, HLM, ATR, Consultant, 1600 Harrison Ave. #105A, Mamaroneck, NY 10543

(All Levels)

Slide presentation of a projective drawing technique and research findings. The study included 326 subjects, their drawings rated for negative or positive emotional content on a 7 point scale. Significant differences were found in drawings by males and females in four age groups: third graders, high school seniors, adults and the elderly.

Educational
Research

The Diagnostic Drawing Series: Phase II–Research Findings

Barry M. Cohen, MA, ATR, Director, Expressive Therapies, Mt. Vernon Hospital, 8559 Richmond Highway #302, Alexandria, VA 22309

(All Levels)

The AATA research assistance grant facilitated expansion of this seminal study to a national level. Three years of clinical use and refinements to research instruments have resulted in the statistical data to be presented. Clinicians and students are encouraged to join the first integrative database of art therapy assessments.

Research

BEST COPY AVAILABLE

The Rating of Personal Construct Drawings to Measure Behavior Change

Marcia Rosal, PhD, ATR, Assistant Professor,
University of Louisville, Expressive Therapies,
Louisville, KY 40204

(All Levels)

Thirty-six behavior disordered students involved in group art therapy evaluation research completed eight personal construct drawings as a pre- and post-test measure. This paper will focus on the ratings of these drawings as a measure of behavior change and as a tool to discriminate between students involved in art therapy and students in the control group.

Research

SYMPOSIUM D: ELDERLY

Art with Elderly in Long-Term Care: Restoring Confidence, Pride and Life

Mary Lou Coles, MA, ATR, Activity Director, Hillhaven
Convalescent Home, 477 30th Ave., San Francisco,
CA 94121

(All Levels)

The "Art with Elders" program, in Oakland, CA, has been recognized, internationally, as a successful model art program which improves the quality of life of the institutionalized elderly through the creative process and life-long learning. Art becomes the avenue to connect with others, the environment, and the community at large.

Educational

Alzheimer's Disease: The Effects on the Individual and the Family System

Gretchen Jaenike, BA, Work-Study, University of
Louisville, Expressive Therapies, Louisville, KY 40292

(All Levels)

The intent of this paper is to explain the role of art therapy with the Alzheimer's Disease victim. This information was collected from research done directly with Alzheimer's victims, the geriatric population and interventions with the involved family. The discussion will include the use of art therapy to aid in the family capability of coping with the effects brought on by this disease.

Clinical

Art Therapy Group Work with Aphasic Stroke Victims in a Residential Geriatric Facility

Diane L. Tumblin, MS, ATR, Associate Director,
Adjunctive Therapies, Easter VA Medical Authority,
Community Mental Health Center, P.O. Box 1980,
Norfolk, VA 23501

(Basic)

The art therapy group described in this paper was specifically designed for work with the aphasic geriatric patient. The group is based upon twelve highly structured art tasks involving a variety of media. The techniques and materials used in this group were devised to address the problems with cognition, comprehension, and performance of skills that exist with aphasic stroke victims. The presentation of the techniques and media used are contained in the paper, as well as slides of the residents' work. A discussion of the group and the need for art therapists to be involved in geriatric health care is also included.

Clinical

SYMPOSIUM E: PSYCHODYNAMIC

Creativity and Psychopathology: Introducing Two Contemporary Women in Paris

Ellen Handler Spitz, PhD, Assistant Professor, New
York University, 37 Iselin Terrace, Larchmont, NY
10538

(All Levels)

The language barrier and institutional parochialism have kept Americans innocent of fascinating recent developments in French psychoanalytic thought. Janice Chasseguet-Smirgel and Joyce McDougall, both training analysts at the Paris Psychoanalytical Society, are writing currently on issues of import to art therapists and drawing directly upon their analysis of artists. Their interests include psychosomatic symptomatology, sexual perversions and fantasies, and the theoretical difficulties of differentiating symptom from symbol, psychological destruction from construction, and psychopathology from creativity.

Theoretical

Censorship or Intervention: "But You Said We Could Draw Whatever We Wanted"

Martha P. Haeseler, BA, ATR, Art Therapist, Private
Practice, Director of Recreations Therapy, Yale-
Haven Hospital, 54 Water St., Guilford, CT 06437

(All Levels)

When self-destructive or aggressive images come up in artwork what interventions does the art therapist make and why? Discussion includes theoretical considerations and case material illustrating how the art therapist helps the client move from artwork as reenactment of violence to artwork as metaphor for more complex internal states.

Theoretical
Clinical

SYMPOSIUM F: COLOR

Significance of Color in Art Therapy: Focus on Therapy and Clinical Application

PANEL

Sondra Geller, MA, ATR; 718 21st St. NW Bldg H,
George Washington Univ., Washington, DC 20052;
Mala Betensky, PhD, ATR; Paula Engelhorn, MA,
ATR, MFCC; Joan Kellog, MA, ATR; Lillian Rhinehart,
MA, ATR, MFCC; Roberta Shoemaker, MFA, ATR;
Edith Wallace, MD, PhD

(All Levels)

A panel of art therapy practitioners, educators/researchers and a Jungian analyst will talk about the significance of color in art therapy. Focus will be on in-depth discussions of existing theoretical perspectives and their clinical application in art therapy. There will be time for questions and answers.

Theoretical

SYMPOSIUM G: CREATIVITY

Conflict and Creativity: Reflections on the Contributions of Otto Rank

Ellen Handler Spitz, PhD, Adj. Assistant Professor,
New York University, 37 Iselin Terrace, Larchmont,
NY 10538

(All Levels)

Unlike psychoanalysts who merely reduce the conflicts of the artist to special cases of more general phenomena, Otto Rank (1884-1939), saw the artist and his struggles as fundamental and worthy of study in their own right. His pages, often overlooked today, speak with passion and empathy of the uniqueness of the artist's experience. This presentation seeks to introduce his major ideas to art therapists—many of whom are also practicing artists.

Theoretical

Creative Process/Therapeutic Process: Parallels and Interfaces

PANEL

Cathy Malchiodi, MA, ATR, University of Utah, AAC 161 Dept. PF Art, Salt Lake City, UT 84112; Mariagnese Cattaneo-Knill, PhD, ATR; Jane Gilbert, ATR; Moderator: Harriet Wadeson, PhD, ACSW, ATR

(All Levels)

A panel of art therapists/practicing artists will discuss their personal creative processes as visual artists. How each creates and produces art will be related and paralleled to the role creativity plays in art therapy and the therapeutic process.

Theoretical

Facilitating the Creative Process with Art Therapy

Evadne McNeil, RN, PhD, ATR, Assistant Professor, University of Illinois at Chicago, 646 Park Blvd., Glen Ellyn, IL 60137

(All Levels)

The bonding model of creativity will be used to illustrate the path by which art therapy facilitates the creative life process. Case material will be presented to exemplify how art therapy can be followed and how art therapy interventions can be designed by using the creativity model.

Theoretical
Clinical

SYMPOSIUM H: FAMILY

Family Art Psychotherapy: A Systemic Approach to Change, Theory and Demonstrations Through Role Play

Shirley Riley, MA, ATR, MFCC, 960 Roscomare Rd., Los Angeles, CA 90077

(All Levels)

This presentation will be concerned with discussing and then demonstrating some of the techniques a clinical art therapist might use early in treatment to facilitate change within the family system. Some reading on systems approach is recommended for the audience: Lyn Hoffman, **Foundations of Family Therapy;** Peggy Papp, **The Process of Change;** Shirley Riley, "Draw Me a Paradox" **Art Therapy Journal,** Vol. 2, No. 3, 1985; Helen Landgarten, **Family Art Psychotherapy** (to be published).

Combating "Holiday Stress": A Series of Art Therapy Groups for Families with Multiple Problems

Kathleen Ball, MA, Counselor, Peanut Butter and Jelly Therapeutic School, 19 Hacienda Ct., Los Lunas, NM 87031

(All Levels)

Art therapy was used in a series of parent group discussions to deal with holiday related issues. These low income families often lacked social support systems and felt financial pressure, especially from their children. The art work also helped deeper issues to surface, such as drug use and sexual abuse.

Clinical

The Use of Art Therapy in Strategic Family Therapy

Virginia Fry Shaver, MA, ATR, Director of Counseling, St. Stephens Church, 3448 Rum River Dr., Anoka, MN 55303

(Intermediate)

This presentation will emphasize the use of art therapy in Strategic Family Therapy. Previous knowledge of art therapy and family therapy will be expected. Lecture, demonstration, and slides will be used to show how the non-verbal approach of art therapy can be combined with Strategic Family Therapy to give effective treatment to dysfunctional families.

Clinical

SYMPOSIUM I: ADOLESCENTS

Group Art Therapy with Adolescents: Theory and Application

Debra B. Greenspoon, MA, ATR, Lecturer, Loyola Marymount University, 664 Kelton Ave., Los Angeles, CA 90024

(All Levels)

This paper will attempt to provide a theoretical framework for the use of group art therapy with severely disturbed adolescents. It will begin with a brief review of the literature supporting the use of group therapy in general and group art therapy in particular with this population. It will then discuss the details of a long-term art therapy group with four adolescent girls, exploring the art work produced by the youngsters to illustrate a variety of issues involving group process.

Art Therapy and the Developmental Tasks of Adolescence

Kay Stovall, MA, Art Therapist, Mercy Hospital and Medical Center, 3732 B Seventh Ave., San Diego, CA 92103

(Intermediate)

Using Peter Blos' description of the tasks of adolescent development from a psychoanalytic perspective, the presentation integrates art therapy techniques to provide a practical and theoretical model. Illustrated with slides of adolescent artwork and clinical material.

Theoretical

SYMPOSIUM J: MENTAL HEALTH

Short-Term Inpatient Group Art Psychotherapy: New Directions

Barbara Sprayregen, MA, ATR, Art Therapist, McLean Hospital, 6 Colonial Village Drive #11, Arlington, MA 02174

(All Levels)

This presentation will consider effects on art psychotherapy groups of the present shift to shorter lengths of inpatient psychiatric hospitalization. Using actual vignettes, it will closely view brief group art psychotherapy formats that attempt to integrate a directive structured, here and now approach with art therapy techniques.

Clinical

The Art Therapist and the Anti-Psychiatry Movement

Anne Mills, MA Candidate, Art Therapist, The Fairfax Hospital, 8559 Richmond Hwy., #302, Alexandria, VA 22309

(All Levels)

What is a figure without a ground? In day-to-day work, we often adopt strategies or perceptions that neglect the broader socio-political context of our therapy work. The ideas of "anti-psychiatry" will allow us to consider one way to reunite ground and figure.

Theoretical

A Thoroughly Processed Product—Art Therapy in a Prevocational Setting

Pat Young, Founder, Director, Bristol Place Corp., 2600 Grand Ave. S., Minneapolis, MN 55408

(Basic)

Those who have experienced chronic mental illness face bleak prospects when they attempt to re-enter the mainstream. This presentation will introduce participants to an innovative prevocational program, using art therapy. A process and product orientation can be creatively combined to help the mentally ill in taking charge of their lives.

Conceptual

SYMPOSIUM K: COLOR

Current Research on Color by Art Therapists

PANEL

Barry M. Cohen, MA, ATR, 8559 Richmond Hwy. #302, Alexandria, VA 22309; Carol T. Cox, MA, ATR; Cheryl S. Earwood, MA, ATR; Jeannettee K. Fino, MAT, ATR; Mari Fleming, MA, ATR, MFCC; Phyllis Frame, MA, ATR; Sondra Geller, MA, ATR; Vija B. Lusebrink, PhD, ATR; Bonnie Smith May, MA, ATR; Lucy Sollers Wood, MFA, ATR; Moderator: Linda M. Gantt, MA, ATR.

(All Levels)

Art therapists will present their most recent work in the area of color research. This panel represents a continuation of the strong interest regarding color research generated at the 1985 AATA Symposium on Color. It will focus on the need for documented information about color to help validate systems for assessment and treatment in art therapy.

Research

SYMPOSIUM L: TRAUMA/ABUSE

Gaining Mastery Over Victimization

Dee Spring, MA, ATR, NCC, MFCC, Art Therapist, Vista Del Mar Hospital and Private Practice, 5159 Teton Lane, Ventura, CA 93003

(Intermediate)

Art work created by sexually abused individuals reflects a pattern of compulsion-repetition which is congruent with an accommodation syndrome. Components of accommodation syndromes and compulsive-repetitive patterns will be presented as a means of fostering understanding of the lifelong effects of sexual abuse and the individual's need to gain mastery over the victimization.

Theoretical
Clinical

Effects of Psychological Trauma on Children

Suzanne Silverstein, MA, ATR, President, Center for the Study of Psychological Trauma, 3143 So. Barrington #E, West Los Angeles, CA 90066

(All Levels)

This panel will describe a non-profit organization which addresses the needs of children who have experienced psychological trauma directly and indirectly. Developmental aspects of psychic trauma in children will be addressed. Central American children who suffer trauma due to warfare in their homeland will be explored plus the culture shock they experience with immigrating to the United States. Examples of art work will be given throughout each presentation.

Theoretical
Clinical

SYMPOSIUM M: ARCHETYPE

Myth, Metaphor and Imagination in Art Therapy: A Case Study

Josie Abbenante, MA, ATR, Lecturer II/Art Therapist, University of New Mexico, 303½ 12th NW, Albuquerque, NM 87102

(All Levels)

The dramatic panel presentation during which the panelists will review the art therapy process of a client, incorporating the tenets of archetypal psychology. Demonstration of the transformation of literal to imaginal and back to the therapy session. We will "articulate a psychology that reflects the passionate importance of the individual soul." (Hillman)

Theoretical
Clinical
Educational

The Sensibility of the Sensuous: Imagination and the Reality in Art Therapy

Howard McConeghey, PhD, EdD, Professor, University of New Mexico, Dept. of Art Education, College of Education, Albuquerque, NM 87131

(All Levels)

Art therapy is image therapy. Art work is imagined image. "We get more sense (significance) from the image the more we note its sense (data)." A retraining of the senses is suggested to help the therapist grasp the image metaphorically. Image and interpretation are presented in non-personal, archetypal perspective.

Theoretical

SYMPOSIUM N: PROFESSIONAL

An Inclusive History of Art Therapy in the United States

Maxine Junge, MSW, LCSW, ATR, Assistant Director and Assistant Professor, Loyola Marymount University, 3451 Greenfield Ave., Los Angeles, CA 90034

(All Levels)

This paper charts the course of the development of the profession of art therapy in the United States during the last fifty-five years. Thus far, what little history has been written has tended to concentrate on events and personalities from the East Coast. With a more comprehensive framework, this paper traces developments across the country and within the vicissitudes of our sometimes tumultuous and divergent history attempts to suggest the richness and potential of our discipline. Art therapy is viewed against the larger background of the history of mental health during these times. The question of the future of the profession is also addressed.

Theoretical
Educational
Conceptual

Three Tracks of Art Therapy: Similarities and Differences

Bobbi Stoll, MA, ATR, MFCC, 8020 Briar Summit Dr., Los Angeles, CA 90046; Virginia M. Minar, MS, ATR; Lewis Shupe, PhD, ATR; Carol Kunkle-Miller, ATR; Jules Weiss, MA, ATR

(Basic)

The panelists will present material for a comparative analysis of art therapy along three tracks: Clinical Art Therapy, Art Therapy in Schools and Rehabilitative Art Therapy. The areas to be discussed along all three tracks are: competencies/standards of practice; appropriate theoretical base and education to supplement art therapy; specific areas of legislative interest; colleagues and related professional alliances; required/desired certification, license or registration; appropriate settings and population. Occupational

SYMPOSIUM O: ARCHETYPAL

Jungian Sandtray as a Modality of Art Therapy (Lecture with Question and Answer Period)

Donna Hanna-Chase, MA, ATR, MFCC, Co-Coordinator Early Childhood Program, Child Guidance Center, Inc., 710 E. Palmdale, Orange, CA 92665

(Basic)

This paper presents the practical aspects of the Jungian Sandtray technique as a modality of Art Therapy. It assumes the reader's knowledge of Art Therapy, Jungian Psychology, and psychodynamic process. Focus is on the Sandtray creation process as a means of personal expression with emphasis on materials, procedures, and evaluation. Clinical

A Method of Visualization Applied to the Treatment of Chronic Illness

Elsa LaFlamme, PhD, ATR, Psychotherapist, Comprehensive Psychological, 101 Hospital Loop Suite 214, Albuquerque, NM 87109

(Intermediate)

Research case study demonstrating the use of imagery in the treatment of chronic illness, methods for visualization and centering, analysis of subjects' unique metaphorical language, the interactive relationship between illness and the process of individuation and the significant role of transformational imagery in health and ego functioning. Research

SYMPOSIUM P: DEATH/LOSS

Art Making as an Aid in Bereavement

Pat Buoye Allen, MA, ATR, Assistant Professor, University of Illinois, 300 S. Wesley Ave., Oak Park, IL 60302

(All Levels)

This paper will describe art therapy as a component of hospice services for bereaved children and families. Art making can play an important role in preventing mental health problems that are sometimes a complication of normal grieving. Case examples will be included as well as an overview of hospice philosophy and theories on bereavement. Theoretical Clinical

Death in the Media Age: Children Picture the Shuttle Explosion

Audrey Di Maria, MA, ATR, Adj. Assistant Professor, George Washington University, 1711 Massachusetts Ave. NW, Apt #301, Washington, DC 20036

(All Levels)

In the weeks following the explosion of the Challenger, "experts" described the impact of the event on the children who had witnessed it. Pictures by 25 emotionally disturbed children (ages 6-13) will be presented, with reference to the children's conceptual understanding of death and in light of their experiences of trauma, separation, and loss. Clinical

The Utilization of Art Therapy in Helping Children Deal with Loss

Sister Mary Duffy, MA, Social Worker/Art Therapist, Maryvale, 122 South Ramona Ave., Monterey Park, CA 91754

(Basic & All Levels)

This paper presents ways art therapy can help children deal with feelings of loss. The breaking up of family life and helping children deal with it have lead to a development of art processes presented here. Attention was given to the Kinetic Family Drawing and the House, Tree, Person Test, as a measure of growth. Also included are common symbols and themes these children seem to use in their art. It shows that art can be used to increase children's feelings of worth and help them to function better in their families suffering from losses through death and divorce. Research

SYMPOSIUM Q: EATING DISORDERS

The Use of Art Therapy in an In-Patient Eating Disorder Unit

Nancy Mayhew, MA, Art Therapist, Private Practice, 494 S. Marengo Ave., Pasadena, CA 91101

(Intermediate)

This presentation will discuss the use of art therapy in group treatment with hospitalized anorexic and bulimic patients over a three year period. The major issues and dynamics of this population will be illustrated by slides of patients' art. Several case histories will be shown. Emphasis will be on psychodynamically oriented treatment and presentation of unconscious material in the art. Thirty-five slides will be shown from patients ranging in age from twelve to forty. Clinical

Hungry Love—An Art Therapy Treatment Approach with the Eating Disorder Patient

Iris Schlossberg, MPS, ATR, Art Therapist, Carrier Foundation, 80 Garrison Pl., East Windsor, NY 08520

(Intermediate)

The clinical use of art correlated with object relations theory in the treatment of eating-disordered patients will be explored as well as therapeutic interventions related to particular dynamics of bulimics and anorexics. Attention will be given to various group art therapy techniques that may help our patients to renegotiate conflicted areas of development in order to move ahead towards autonomy and self-regulating behavior. Theoretical Clinical

PAPERS

Characteristics of the Art of the Endogenously and Exogenously Depressed

Janice Musante, MA, ATR, Art Therapist, Box 306F RD3, Moscow, PA 18444; Cydney Savage, BFA, Student

(All Levels)

The purpose of this paper is to examine similarities and differences in drawing style, placement and symbolism of the art of the endogenously and exogenously depressed through a series of six drawings. Subjects were limited to 35 patients on a psychiatric unit admitted with the diagnosis of "Major Depression" who received biological marker testing.

Research

Footprints of Our Minds, Mirrors of Our Lives—Photos as Therapy Tools

Judy Weiser, MS Ed., MSW, RSW, Director, Photo-Therapy Centre, 1107 Homer St. Suite #304,
Vancouver, BC Canada V6B 2Y1

(All Levels)

Photos by themselves have no meaning, yet all those we take or choose to respond to are in some ways 'self-portraits.' Shooting, responding to, or interacting with them can stimulate thoughts, memories, and feelings not otherwise accessable. Learn about Photo-Therapy—adjunctive tools using ordinary snapshots as catalysts for exploring nonverbal/buried information and emotions.

Art as Depth Psychology

Shaun McNiff, PhD, ATR, Professor & Dean, Lesley College Graduate School, 29 Everett St., Cambridge, MA 02238

(All Levels)

Art therapy will serve society's needs for in-depth psychological investigation if it defines itself with theory and methods indigenous to art. Images of sexuality, destruction, aggression and spiritual contemplation will be discussed with the goal of heightening sensibility and imagination, rather than restricting their power through inappropriate interpretation and labeling.

Theoretical
Clinical
Educational
Conceptual

Art Therapy Program Development: Grant Application to Implementation

Nancy Greene, MA, Special Ed Teacher/Chemical Dep Counselor, Hopevale School/Bry-Lin Hospital, 25 Ludwig Ave., West Seneca, NY 14224

(All Levels)

The nature of this presentation involves the step-by-step process in obtaining a grant to initiate an art therapy program in the residential school for emotionally disturbed female adolescents; and the actual implementation of that art therapy program through the use of case material.

Educational

The Artist Against Art Therapy—Resistance in the Creative Personality

Laura V. Loumeau, MPS, Art Therapist, Mt. Sinai Medical Center, 79-04 149th Street Apt 3-I, Flushing, NY 11367

(All Levels)

Resistances in art therapy treatment associated with the artist/patient will be examined. One of these is the Narcissistic threat to the Persona imposed by this modality. Another is an underlying belief in the myth of "Mad Genius"; to be cured may mean to be stripped of the creative core of self. Facile use of the art product as a defensive shield will also be discussed.

Theoretical

Art Therapy—Coming of Age: A Personal/Profession/Psychodynamic Perspective

Judith Rubin, PhD, HLM, ATR, 128 N. Craig St., Pittsburgh, PA 15213

(All Levels)

The author—who has experienced a variety of art therapist roles over the years—reflects on her own and the profession's journey—from periods characterized by the acquisition of skills, knowledge, and identity—to those involving their use in the service of others; patients, students, fellow professionals, and the public.

The Ecology of Human Development: Implications for Art Therapy

Barbara Bickett, MA, University of Louisville, 1967 Goldsmith Ln. Apt D-3, Louisville, KY 40218

(All Levels)

The theory of ecology of human development proposed by Bronfenbrenner may hold possible implications for group art therapy specifically within the family setting. Bascue's Conceptual Model of group therapy will be used to chart the ecological model. Application to the group art therapy process will be demonstrated within the networking of the family system.

Theoretical

Mothers of Incest Victims in Group Therapy

Maralynn Hagood-Slegelis, MS, Art Therapist, Counseling Inter, Passageways Counseling Center, 36163 Fremont Blvd. #92, Fremont, CA 94536

(Intermediate & Advanced)

Art Therapy was used with a group of mothers of incest victims. A variety of therapeutic issues typical of these mothers is discussed as well as a description of art therapy techniques used in addressing these issues. The group focussed on the mother's individual needs as well as her family role in the tragedy of incest.

Clinical
Educational

Clinical Art Therapy in an Outpatient Clinic

Shirley Riley, ATR, MFCC, Art Psychotherapist, Loyola Marymount University, 960 Roscomare Rd., Los Angeles, CA 90077

(All Levels)

This paper attempts to demonstrate that an outpatient clinic will profit both in the sense of improved services for its clients and greater cost efficiency if it engages a clinical art therapist as a staff member. The problematic areas of treatment that respond best to intervention with art therapy are illustrated; family therapy, adoption issues, child abuse, suicide, and adolescent groups. An emphasis on systems approach correlated with evaluation of developmental status of the family members is a central theme of this paper. Discussion period, slides/illustrations.

Clinical
Occupational

Case Studies in Multiple Personality

Dee Spring, MA, ATR, NCC, MFCC, Vista Del Mar Hospital and Private Practice, 5159 Teton Lane, Ventura, CA 93003

The complex and mystifying psychopathology of multiple personality will be explored through the artistic productions of three patients diagnosed with Multiple Personality Disorder. The use of art therapy with this population lends itself to a particular dimension in the fight for integration and unity of the alters and different drawing styles provides a specialized dimension for exploring individual constructs, systems, attachments, behaviors and functions.

Theoretical
Clinical

Georgia O'Keefe, Themes and Resonances: An Art Therapist's Viewpoint

Maxine Junge, MSW, LCSW, ATR, Associate Director & Assistant Professor, Loyola Marymount University, 3451 Greenfield Ave., Los Angeles, CA 90034

(All Levels)

This paper explores repetitive themes reflected in Georgia O'Keefe's life and art. In particular, from a feminist developmental perspective, it focuses on the psychological implications of separation and individuation and postulates a midlife crisis revolving around these issues, predicted, reflected, and resolved in O'Keefe's artwork.

Conceptual

Art Therapy as Primary Treatment for Co-Dependents: Alcoholism Outpatient Treatment

Dianne Seger, MA, Art Therapist/Consultant, Horizon Human Services, Corp. II, 115 Claremont Ave., Buffalo, NY 14222

(All Levels)

This presentation will review the use of art therapy as the primary treatment modality with co-dependents in an outpatient alcoholism treatment program. The problems of integrating art therapy into such an agency from its inception will also be discussed. Case material will be presented.

Clinical

Privacy and Confidentiality in Art Therapy: An Ethical Dilemma

Laurie Wilson, PhD, ATR, Director AT, New York University, 321 Hartford Road, South Orange, NJ 07079

(All Levels)

The problem of confidentiality in art therapy centers upon the use of patient artwork in presentations and publications. Though patients' identities may be disguised in discussion of their personal histories, their artwork usually remains uniquely identifiable even when signatures have been concealed. Questions, issues and recommendations will be presented.

Theoretical
Educational
Occupational

Making Art Therapy Available to the General Public Through College Extension Classes

Sue Anne Foster, MA, ATR, Extension Instructor, American River College, 6965 Auburn Blvd., Citrus Heights, CA 95621

(All Levels)

Art therapy processes may be adapted for college extension classes. The results of five years of teaching such courses will be shared including how to establish such a course, guidelines and precautions in facilitating the experiences, and the employment and professional benefits of working with motivated, self-selected adults.

Occupational

People with AIDS: An Exploratory Study Employing the Art Therapy Modality

Susan Kleinman, MA, 3143 S. Barrington #E, West Los Angeles, CA 90066

(Basic & All Levels)

This presentation will be based on information and findings from my research paper written for the Masters Degree in Art Therapy at Loyola Marymount University, Los Angeles, CA. Final results of the paper are in progress. Slides of the participants' artwork will be incorporated into the presentation.

Research

The Homeless and Art Therapy: Facilitating Communication Through Art

Kay Stovall, MA, Art Therapist, Mercy Hospital and Medical Center, 3732 B Seventh Ave., San Diego, CA 92103

(All Levels)

Report on an art therapy group for the downtown homeless and community members. Art materials were used to create an environment for expressing opinions, sharing experiences and gaining insight despite radically different lifestyles. Background information on homelessness. Slides of artwork illustrate the presentation.

Clinical

WORKSHOPS

Art Therapy as an AA Treatment Component: A Six Task Series

Diane K. McElligott, ATR, Art Therapist, Brawner Psychiatric Institute, 1599 Piedmont Ave., Atlanta, GA 30324

(Intermediate & Advanced)

This workshop presents a six-task series of techniques structured to meet the needs of a four to six week AA/NA treatment program. Topics include the etiology and symptomatology of the disease, use of art therapy as a component in achieving current addiction treatment goals and development of a collaborative team approach.

Clinical
Hands-on Exp

Behaviorally Orientated Art Therapy

Michael J. Swiderski, ATR, Art Therapist, Mansfield General Hospital, 432 Shapard Rd., Mansfield, OH 44907

(All Levels)

While the intent of this workshop is for therapists to experience how a behaviorally sequenced art therapy group can be used to help patients gain insight into the process of therapy, participants might become aware of repressed thoughts and feelings represented in their artwork. When unconscious material comes to light during the preliminary stages of this group process, it is usually not too far removed from consciousness and to some degree congruent to the participants' sense of self.

Clinical
Hands-on Exp

The Study of Aesthetics and Toxicity in Understanding One's Relationship to the Institutional Process

Beth Gonzalez-Dolginko, MPS, ATR, Faculty, Pratt Institute, 19 Eaton's Neck Rd., Northport, NY 11768

(All Levels)

We are surrounded by institutions. Our family, our community, our jobs, our political, social, or religious affiliations all bring us in contact with institutions. However, how we deal with and survive in these institutions may affect us either positively or negatively. This workshop addresses how we can handle the toxic effects of institutions on us as humans and professionals in order to optimize our working environment.

Hands-on Exp

Mandala Meditations

Phyllis Frame, MA, ATR, Art Therapist & Art Therapy Consultant, 3410 Ridge Rd., Charlottesville, VA 22901

(All Levels)

This workshop gives participants a chance to experience for themselves the mandala as an integrative and healing meditation. It will include guided imagery, selected music and vibrational patterns as well as mandala drawing and related written expression. The purpose is to present the mandala holistically through a variety of integrated modalities.

Hands-on Exp.

Butterfly Life-Cycle: Creative Arts Modality with Children from Violent Homes

Cathy A. Malchiodi, MA, ATR, Assistant Professor, University of Utah, AAC 161 Dept. PF Art, Salt Lake City, UT 84112

(Advanced)

This workshop is designed to teach a creative arts experiential to practitioners who work with children traumatized by family violence. Participants will learn to use the actual experiential and to understand its role in diagnosis and treatment of abused children.

Clinical
Hands-on Exp.

Me and My Shadow: An Adventure into Photo and Art Therapy

Irene E. Corbit, PhD, LPC, ATR, Art Psychotherapist, Private Practice, 7722 Braesview Lane, Houston, TX 77071

(All Levels)

This workshop will begin with a visual and didactic explanation of the Jungian concept of the shadow, the darker side of our personality which we normally repress or deny. Still photography and art will be used to express our shadow aspects as well as some psychodramatic techniques.

Hands-on Exp.

Footprints of Our Minds, Mirrors of our Lives—Photos as Therapy Tools

Judy Weiser, MS Ed, MSW, RSW, Self-Employed, PhotoTherapy Centre, 1107 Homer St. Suite #304, Vancouver, BC Canada V6B 2Y1

(All Levels)

Photos by themselves have no meaning, yet all those we take or choose to respond to, or interact with can stimulate thoughts, memories, and feelings not otherwise accessible. Learn about PhotoTherapy—adjunctive tools using ordinary snapshots as catalysts for exploring nonverbal/buried information and emotions.

Hands-on Exp.

Unthinkable Anxieties: Images for Understanding Early Object Relations

Lynn Kapitan, MPS, ATR, Assistant Professor, Director of the Art Therapy Institute, Mount Mary College, 3061 N. Newhall St., Milwaukee, WI 53211

(Intermediate)

Object relations theory, useful to the creative art therapist will be validated by personal imagery in this workshop. Using a creative focus on universal anxieties associated with each stage of development, participants will learn to recognize within their own experience, the anxiety of their clients, developing empathy essential to the art therapy relationship.

Theoretical
Educational

The Sun Wheel and Individuation

Lillian Rhinehart, MA, ATR, MFCC, 1475 Los Alamos Road, Santa Rosa, CA 95405; Paula Engelhorn, MA, ATR, MFCC, Consultants Rainbow Bridges, Inc.

(All Levels)

Jungian psychology, Gestalt Therapy concepts, color and the wisdom of Ancient American truths are integrated in our work. We find these concepts best demonstrated through the Sun Wheel, which is an ancient medicine wheel and a Rainbow Wheel of color. The Sun Wheel provides a way for people to explore their own wholemaking and individuation.

Inner Tool Box: New Perceptions for Art Therapists in Short-Term Settings

Lynn Kapitan, MPS, ATR, Assistant Professor, Director of Art Therapy Institute, Mount Mary College, 3061 N. Newhall St., Milwaukee. WI 53211

(Intermediate)

The key to turning short-term art therapy into a more dynamic, effective approach lies in shifting the focus from the often painfully felt limitations of the setting to the therapist's use of him or herself. This workshop will help the therapist activate creative inner "tools" necessary to develop a dynamic therapeutic style needed in the short-term setting.

Imaginaction: Action Methods in Group Art Therapy

Leigh Files, MED, MA, ATR, Executive Director, NW Institute for the Creative Art Therapies, 1430 Pearl St., Eugene, OR 97401

(All Levels)

This experiential workshop successfully blends visual imagery with action-methods to provide the environment and tools for participants to develop their innate spontaneity and creativity, and effect change in their lives. Art therapy media and psychodramatic techniques will be utilized to explore individual and group themes. No previous experience necessary.

Hands-on Exp.

FORUMS

US Study Group on the Symbolic Language of Sexually Abused Individuals—2nd Annual Meeting

Dee Spring, MA, ATR, NCC, MFCC, Art Therapist, CPC Vista Del Mar Hospital and Private Practice, 5159 Teton Lane, Ventura, CA 93003

Educational
Research

Writing for Publication in Art Therapy

Gary C. Barlow, EdD, ATR, Professor and Coordinator Art Therapy, Wright State University, 222 Creative Arts Center, Dayton, OH 45435

(All Levels)

Ethics and the Art of Art Therapy

Nancy Mayer Knapp, MA, ATR, Assistant Sci Consultant/Art Therapist, Harbor, UCLA, Department of Psychiatry, 16081 St. Croix Circle, Huntington Beach, CA 92649

(All Levels)

The potency of the art process and the impact of having concrete products from therapeutic interactions present unique clinical issues for our profession. This forum will address these issues with theoretical precedents from literature as well as participants' practice and opinions. Ethical guidelines related to art itself will be formulated.

Theoretical
Conceptual
Occupational

Art Therapy: Marketing to the Community

Susan Boeshart, MA, ATR, Community Relations,
Harbor View Medical Center, P.O. Box 1686, La Jolla,
CA 92038

(All Levels)

This open forum discussion will overview the recent trends in Mental Health Services and the resulting impact upon art therapists. A social model of the cooperative efforts of the San Diego Art Therapy Association will be presented, along with the introduction of basic marketing principles applied to this competitive market.

Educational

Meet the Author—Art and Psyche: A Study in Psychoanalysis and Aesthetics

Ellen Handler Spitz, PhD, Adj. Assistant Professor,
New York University, 37 Iselin Terrace, Larchmont,
NY 10538

(All Levels)

This open forum provides an opportunity to discuss issues raised in a new book which scrutinizes the way in which psychoanalysis has been applied to the work of artists. Three major problems are addressed: (1) the complex relationships between an artist's life experience and his/her work, (2) whether and how it is possible to use knowledge about the human mind to interpret works of art, and (3) what goes on in the interaction between works of art and their audiences (spectators).

Theoretical

What Do You Want from Membership in the AATA?

Bobbie Stoll, MA, ATR, MFCC, AATA Membership
Chairman, Self-employed, Private Practice and
Consultant, 8020 Briar Summit Drive, Los Angeles,
CA 90046

(Basic)

The membership committee of the AATA will provide an opportunity for informal discussion, problem-solving and brainstorming related to membership issues. New directions, membership benefits and expansion of student membership are topics inviting input. What do you expect from a professional association? How does the AATA stack up?

Occupational

Undergraduate Art Therapy Programs—Forum II

Geraldine H. Williams, MA, ATR, Director, Art
Therapy Program, School of Art, Ohio University,
Athens, OH 45701

(All Levels)

This open discussion will continue the dialogue begun at the 1985 AATA Conference. Focusing on issues of establishing guidelines for the 32 undergraduate programs currently offering art therapy studies, for establishing a new "A.T." designation for graduates of such programs, for encouraging AATA to bring more student participation into the conference planning for each year's major meetings as well as include student and faculty representatives of undergraduate programs on Educational and Standard Committee.

Educational

IND

Family Art Psychotherapy—A Review of the Book

Helen Landgarten, MA, HLM, ATR, Art Therapy/
Loyola Marymount University, Loyola Boulevard at
80th St., Los Angeles, CA 90045

The family systems theory is utilized within the art psychotherapy approach. The following chapter examples will be demonstrated: crisis intervention for a molested child; family treatment for an encopretic boy; a failure case of a family's flight into health; and separation and individuation for an adolescent.

Clinical

The Art Therapist's Third Hand (Pictorial Communication and Intervention in Art Therapy)

Edith Kramer, HLM, MA, ATR, 80 Delancey Street
#23, New York, NY 10002

The metaphor concerns those realms wherein the art therapist's artistic competence and imagination functions in the emphatic service of others. Clinical examples of success and failure are given. Social forces which interfere with the capacity for emphatic pictorial communication are discussed and ideas on the systematic training of the third hand are presented.

WRIGHT
STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information: Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

HONORARY LIFE MEMBERSHIP ACCEPTANCE SPEECH

by

Robert E. Ault, MFA, ATR

Delivered November 15, 1986, at the AATA Conference—Los Angeles, CA

Madam President, Members of the Executive Board, Members of the Honors Committee, Colleagues and Friends. I am very touched by your actions and do thank you from the bottom of my heart. I can think of nothing more meaningful than to be so honored by one's peers. You have allowed me to join a group of very special people, and for that privilege I will always be grateful.

To Roberta Shoemaker, my colleague and friend at Emporia State, I do thank you for submitting my nomination to the Honors Committee. I am most appreciative.

There are so many people in this organization that I would like to thank for having helped make my professional life so rich through the years. The list is too long to thank individually from this podium but you do know of your place in my heart. Judy, Sandy, Maxine, Mari, Trish, Julie, Myra, Helen, Shirley, Charles, Gary, Jane, Lew, Lori, Shawn, Harriet, etc., etc.—thank you.

I also wanted to have recognized and to say thanks publicly to my best friend and wife Marilynn. She more than anyone else knows of, and has shared the personal struggles and sacrifices, as well as the great pleasures of being an art therapist. I am delighted to have her here today.

There are three other people that I would like to share this moment with for they have all given generously of their life energies to this organization. First, my dear friend, mentor, and teacher Don Jones. Don has always promoted the best in all of us by his word and example. Second, I'd like to recognize Joe Garai, who I believe history will be kind to, for his scholarship and pleas for all of us to humanize.

Last I'd like to share this with someone who promised she would be sitting on my shoulder today. I have greatly appreciated her counsel, her courage, and her love. She is my Houston friend Felice Cohen, and I do thank her for the phone calls.

As I pondered what I wanted to say to you today I reminisced in my mind of the old days, filled with the energy and highs of shared creativity as we put together and gave birth to our infant AATA. I also remember well the pain and the sleepless nights as we struggled to care for and nurture our beloved child. There was also the adolescent years complete with the intense swings of dependence and independence as we collectively attempted to individuate, secure, and internalize our identity as art therapists. There were moments of self involvement, of intense contacts and struggle, as well as moments of great satisfaction. Remember, none of us at that time had a professional history as we do today. We did survive those years and moved into young adulthood where we continued to define and mold the values and ideas that bound us together. For many of us it was something like a second chance at growing up or like a shared successful analysis.

Now we are at the threshold of another stage of development, that of adults, complete with the responsibility of adulthood that calls for our attention. For some of us, it is like the time of life when you reverse roles with your parents and you become the caretaker and nurturer. I believe AATA needs that from us at this time.

John Kennedy so elequently spoke of this by asking not what your country could do for you, but rather what you could do for your country. So it is with the idea of art therapy.

Like most of you, I have shared over the past few years the concerns about AATA, in particular its financial status. The executive board and officers have struggled so hard to maintain services when there simply was not enough money available. It has been a big problem but this challenge is no different from others we've faced except that it clearly tests our commitment to the vision. We are experts at problem solving—that is what we are all about, so let's get on with it. I understand Sandy has already taken some actions in this direction and I'm delighted. We are simply beyond the stage of supporting our mission through fees and the sale of services. Universities, hospitals, schools, and churches do it by means of fund

BEST COPY AVAILABLE

raising and I also believe we can, and are able, to do it. I believe we should immediately develop materials soliciting not only from our membership but from others the means to set up an endowment fund. We need to nurture ourselves. Most of us already do this for other causes—why not for AATA? I believe the problem is not in resistance to the idea, but simply in the need to develop the proper mechanisms for this activity. It is the responsibility that goes with our development but we have to believe in our guts that it is worth it, or it will become an obligation and resentment rather than an opportunity to take claim of the adventure. The key is for us to understand what art therapy, as we call it, is all about and to identify it as a movement of ideas, not as a profession. It is a set of ideas that have merged into a new relationship that can have, I believe, enormous impact on our lives and on the lives of our children and their children. The time is ripe, the history is correct, the ideas are solid, and on the side of what is the best of our character. We've only scratched the surface of knowing about art and its relationship to healing and growth of all our citizens, not just those that are sick. We must boldly move into new arenas of what I call the "Great American Wasteland," the vacuum created by too much emphasis on materialism, shallow values, and planned obsolescence. There is a world of individuals and organizations that need our help and we have the technology to do something about it and I hope shortly, the means. The use of visualization in thinking and problem solving, the language of images which incorporate both the affective as well as the cognitive, the understanding and development of creativity, the promotion of respect and reverence of all forms of life, and the resolution of differences between people, is our arena and challenge for the next decade. We have no choice for we're running out of time. Our national priorities demand we become more active and enter the social struggles more directly. Currently we spend as a nation more money on a single B-1 Bomber than we do for all the arts in America. The line item in the defense budget for military bands is greater than the entire National Endowment for the Arts, and we simply have to help enlighten others to the fact we have alternatives other than through the continued use of power. Power never resolves problems between people, it only delays expression and makes it worse. Art has served as a major civilizing agent since the beginning of time and we are now in a key position with our expertise in both art and human relations to help reinstitute this age old process.

I recently interviewed Dr. Karl Menninger for the Journal and at one point he asked how many art therapists there were. I answered we had a membership of about 3000. He rather emphatically said, "there should be 30,000 by now as they are so badly needed." I asked what he saw as a major problem facing mankind at this time and he spontaneously answered—"the bomb, the bomb, and the bomb!"

Well—I don't want to sound like doomsday—but we are being pressured in a way that will make all our good work irrelevant if something isn't changed.

I've had the experience now of seeing how art therapy can successfully be used in these social–nonpatient arenas and it is very exciting. It is not a time for remorse, it is a time of renewed commitment. It is also a time to broaden our view of art therapy—or creative living, or art enlightenment—whatever we want to call it, but let's get on with the responsibilities of our adult lives and help create on a much broader scale, a safer and more caring society.

Again, I thank you for this honor today. I love this organization, I love its ideas, and I love the people that it attracts. It is worthy of our energies and means and I invite you into the dream.

The Therapeutic Effects of Combining Apple Macintosh Computers and Creativity Software in Art Therapy Sessions

Devorah Samet Canter, M.A., School of the Art Institute of Chicago, Associate Member of the American Art Therapy Association

The Apple Macintosh computer and existing "creativity software" can have a positive effect on learning disabilities in children and adolescents with behavioral and emotional disabilities.

The purpose of this paper is to address the potentials of integrating computers and creativity software in art therapy settings, and discuss how these new media can be used to facilitate insight for the therapist and client. Case studies will illustrate how the Macintosh and specially designed software can bring out creative expression in clients with emotional and learning disabilities.

The art therapist based the paper on a study held at an inpatient children and adolescent psychiatric hospital funded by the state of Illinois.

Continual use of the Macintosh computer and creativity software by clients with learning and emotional disabilities exemplified positive changes in their behavior. The results of the study included increased attention span, the development of visual and musical expression, self-confidence, creativity, and communicative skills.

Introduction

With the advent of personal computers, non-computer professionals are now able to afford and use them for work and entertainment. As an art therapist one can begin exploring the benefits of integrating paper, pencils, markers and pastels with computers, drawing, animation and music programs.

Art critic, Anthony Reveaux, (1985) stated that every aspect of every art form is now affected and mediated by technology. Assuming this, art therapists are challenged to use state-of-the-art technology to positively reinforce art therapy techniques.

Purpose

The Apple® Macintosh™ computer and existing creativity software can have positive effects on learning disabilities in children and adolescents with behavioral and emotional problems. The effects of art therapy techniques on children and adolescents with behavioral and emotional problems have been documented. What has not been fully studied, with this population however, is the power of the personal computer and creativity software as therapeutic tools.

There is much potential in the integration of Apple Macintosh computers and creativity software in therapeutic settings, and these new media can be used to facilitate insight for the therapist and client. Case studies will illustrate how the Macintosh and specially designed software can bring out creative expression in clients with emotional and learning disabilities. These clients may have difficulties expressing themselves through the use of common art materials, because of problems with fine motor coordination and/or impulsive or destructive personalities. Thus, clients with these problems may find computers to be a constructive and beneficial tool for them to use because of the calming effects, and the creative and intellectual challenges they offer.

Background

The art therapist (author) worked as a part-time consultant, at a state psychiatric facility, using computers and creativity software with children and adolescents. Clients were referred by their primary therapist and/or teacher to participate in an art therapy program that utilized computers and creativity software. The art therapist worked in small groups and individually with these clients over a five month period.

The art therapist's approach provided an environment for children and adolescents, much like an artist's studio. Tools were available for the clients which included a variety of tactile art media, both two and three dimensional, (paint, paper, crayons, markers, clay, wire, canvas, cardboard etc.). Apple Macintosh ('Mac') computers, drawing, music and animation software were also available for children and adolescents to work with and explore. The art therapist was available to discuss personal issues when they came up in or through the clients' art, or critique work if it was apparent that one could benefit from this type of discussion.

> ***"What has not been fully studied . . . is the power of the personal computer and creativity software as therapeutic tools."***

> ***". . . children or adolescents who have never used a computer before can easily learn and adapt to new skills such as drawing and animating objects on a computer screen or composing Melody lines."***

In group and individual art therapy sessions, children and adolescent clients were asked to choose media with which they wanted to work. Some worked on long-term projects, while others created new art work each session. Some clients worked primarily on the computer, others chose to work with a variety of art materials.

The child and adolescent involved in this study were diagnosed as having learning and developmental disabilities and anti-social personality disorders. They were living and going to school in an inpatient psychiatric hospital funded by the state of Illinois. Children and adolescents residing at the center were from low to middle class families and many were from single parent homes. Child abuse, drug related problems, suicidal attempts and depression were commonly observed problems.

The Macintosh Computer, Hardware and Software

The Macintosh computer is a pixel-based graphics (computer graphics) computer. It has many capabilities, but it's high-contrast, black and white computer graphics generation is what makes the 'Mac' really unique. The Macintosh computer's screen is small (nine inches diagonally), but its square pixels (pixel is a single dot on the screen or a single bit) make the images seem sharp.

The 'mouse' of the 'Mac' is a moveable cursor or pointer. As you move the mouse around on a flat surface it moves the cursor on the screen. The user clicks the button on the mouse to control the computer.

On the top of the screen of the Macintosh is a row of words called the 'menu bar.' Each word is the name of a menu, under which is seen another set of words which represents the choices that are available to the user. Each menu is accessed by placing the mouse cursor on the menu name itself. When the menu is opened, the user pulls the mouse cursor down the menu to select the particular command desired, thus the term 'pull down menu' is used.

On the screen of the Macintosh are windows. Each program that runs on the Macintosh runs inside a window. Each window can be resized or overlayed.

This combination of 'pull down menus,' 'windows,' and a 'mouse,' are called a graphics based user-interface as opposed to a text based user-interface. All the information needed to control the computer is on the computer screen. Nothing is hidden with a graphic interface. This kind of interface is called "WYSIWYG" (what you see is what you get).

The software used in this study are all graphics based and are designed to be used on the Apple Macintosh computer. MacPaint™, VideoWorks™, and MusicWorks™ were the 'creativity software' programs used by the therapist. The software and hardware work together like a record and record player. Although, with the computer and creativity software you can transform the Macintosh into a paint canvas, or drawing pad, an animation stand or a composer's sheaf of music.

MacPaint is a drawing program that uses the mouse to 'draw' on the screen of the Macintosh. *MusicWorks* is a music program that enables the user to place notes on a music staff and hear the results instantly. *VideoWorks* is an animation program, that also lets the user draw his or her own artwork and control the movements of the characters created. The program incorporates sounds and has talking capabilities. Together these three programs provided a comprehensive set of creativity tools, that clients could use to make art and express their feelings. Because of the unique 'User Interface' of the Macintosh, children or adolescents who have never used a computer before, can easily learn and adapt to new skills such as drawing and animating objects on a computer screen or composing melody lines.

Case Study I

The first case study is a 12-year-old, white, middle-class, male child with behavioral and emotional problems. Computer drawings, taken from animation sequences, created by the client, are included. For confidentiality purposes he will be referred to as E.M.C.

E.M.C. has had a long history of prior therapeutic services and has been in and out psychiatric hospitals and special schools since the age of 3½. In April 1980, a psychiatric examination was completed on E.M.C., at a major psychiatric hospital. It was reported that on the Wisc-R he achieved a score in the high average level; with a Full Scale IQ—112. On the Performance subtests, he scored consistently above average level. It was felt at this time that his visual channel for learning was much stronger than his auditory channel and that his verbal abilities may have lagged behind due to inadequate verbal stimulation in his social environment.

E.M.C. was first admitted to the hospital in April, 1981, by his mother, because of his increased aggression and defiance in the home, increasingly poor impulse control and poor judgment, hyperactivity and fire-setting. His mother was frightened by his aggression in the home, and did not know how to help him. She stated that his mood had been "weird" for several months prior to this admission.

E.M.C.'s mother felt the main precipitating factor to the problem, at that time, was his father's inconsistency in visiting the son. His visits were sporadic and infrequent a few months following their separation and divorce. E.M.C.'s mood disturbances began to slowly build up and his whining soon turned to aggression when he realized his father was not going to come home. E.M.C. also had a difficult time relating to his older sister, and his mother felt that he was jealous of any attention given by her to others.

E.M.C.'s therapist felt that his hyperactivity-like aggressive behavior was a type of depressive equivalent since he was not likely to verbalize his concerns directly, but was more apt to act out his concerns. His therapist saw him as a very needy child experiencing considerable anxiety and preoccupation with sexual matters and dealing with an underlying depression.

Since E.M.C.'s initial two-to-three month admittance, in April, 1981, he was readmitted three other times to the psychiatric unit. Each time behavioral problems at home and at school were presented as the cause for his return. He had continued to be hyperactive and violent towards friends, teachers and family.

During E.M.C.'s third admission to the hospital (May, 1985) he was introduced to the art therapist and was asked if he would like to be in art therapy. He said he wanted to come. He was told he could do whatever he liked and could choose any art materials to work with.

E.M.C. came to art therapy twice a week for an hour each session. He participated in individual and group therapy sessions. It was immediately evident that he was visually oriented and could utilize his innate visual channels for learning if he was motivated. Each session he explored using different media and was excited about making things. He was good with his hands and could draw, paint or sculpt, with ease.

E.M.C., at first, enjoyed making objects that he could give away: a necklace for his mother or a toy to play with on the unit. This was not an unusual act for a child who is taken from his environment and placed in one that is unfamiliar and strange. The need to make up for the loss of personal objects can be worked through by making another object.

Through the art process E.M.C. was able to sublimate his hyperactive behavior into working with the art materials. His behavior was good in individual sessions, although in group therapy he had some difficulty working with other students. If he was not occupied at all times, he would become irritable and begin acting out.

His teachers, from the psychiatric center, were surprised, at this time, that he could spend more than 10 minutes working at anything. In his classroom and on the unit, where he lived with other children, he was noted as being impulsive, immature, rude, and hyperactive. This was in direct contrast to what was observed in the art therapy setting. There E.M.C. usually behaved well.

During this admission (May, 1985), E.M.C. was introduced to a Macintosh computer in art therapy. He immediately was drawn to it, stating his familiarity with other kinds of computers used at home to play games. He learned quickly how to set up the computer, turn it on, and start up the software programs. Working with a computer, drawing, music, and animation software enabled him to use his visual and intellectual abilities simultaneously. The software programs were challenging and interesting, so they held his attention.

In school, students and teachers tended to be negative and unfriendly towards E.M.C. because of his acting out behavior. He was unable to achieve successfully there, because he was emotionally insecure. In art therapy the computer created an environment which was creative, smart, and friendly. The computer was like a friendly teacher, it didn't get mad about mistakes, gave individual attention, and let E.M.C. work at his own pace. Working with the computer enhanced his self-esteem because he was in control working with this media and could achieve intellectually and creatively with this tool.

On the computer E.M.C. was very articulate about the work he created and was insistent in always getting the final product perfect. He would draw on the computer in 'fat bits' mode. This feature allowed him to draw an image pixel by pixel (dot by dot, like an etch-a-sketch). Fat bits magnified the area in which he was drawing, so he could work in detail. After E.M.C. learned how to draw in MacPaint he began experimenting with the animation program VideoWorks. The possibility of drawing pictures and making them move around the computer screen fascinated him. The following suggests why E.M.C. responded so positively to animation.

> "Animation is the art of ideas in motion. It is the construction of images, frame by frame, bit by bit. For the creative artist, it is a medium almost limitless in the concepts it can explore and display. Independent of physical reality, it can choreograph the actions of recognizable, everyday objects or zoom off into abstract spaces of fantasy. Even more special is its ability to change from one domain to another, to combine the real and the unreal, all breathing with the rhythm of thought. It can be audio-visual poetry of mixed metaphors and transformations, logical comparisons and impossible puns. Animation is a syntheses of the design of painting articulated with the tempo of music and, like the dance it's most alive when in motion." (Reveaux, 1977 p. 1)

The animation software, VideoWorks, provided E.M.C. an opportunity to express what was going on in his mind visually and in motion.

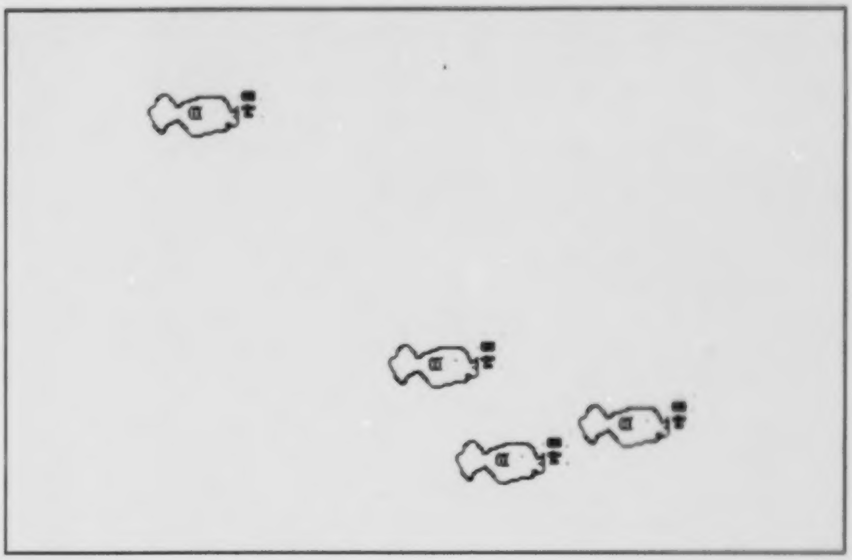


Fig. 1

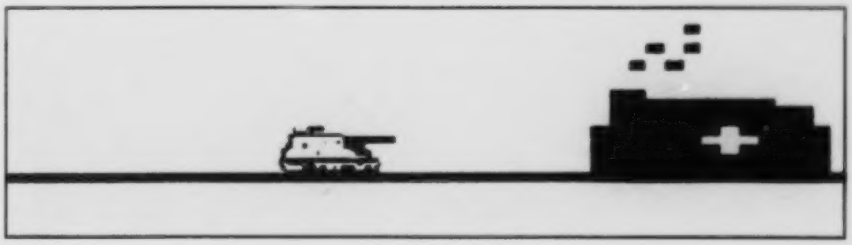


Fig. 2

Unlike static images, the animation sequences could be played back on the computer and viewed like a cartoon. Like dream sequences they told a story in pictures, and dealt with many layers of consciousness.

Therapy consisted of E.M.C. mastering the computer and talking about his drawings and animations. Having the ability to instantly play back an animation was also an important step in the therapeutic process. Looking at work on the computer, session to session, allowed him to review personal issues in a pleasant and fun way. E.M.C. enjoyed talking about his animations, because he produced them himself, and he felt good about mastering the computer.

E.M.C. was able to conceptualize and produce what he wanted to express via this media. He commented how 'neat' it was to be able to make his own cartoons, and that no one else could make it except him. He also said that on the computer he could make things 'real special,' unlike what he could make with a pencil and paper. His enthusiasm in understanding this new tool allowed him to learn, listen and think about his problems in a more positive environment.

One of the first animation sequences he produced, on the Macintosh, was reflective of his thoughts about making new friends at the hospital. The animation was of a group of fish swimming (see Figure 1). When E.M.C. was asked about it, he said that one fish came into the water to find friends, so he could play. The fish were just having fun and swimming together, he said. E.M.C. used the bubbling sound from VideoWorks sound file to represent the fish talking. Drawing the fish and making them swim and talk helped E.M.C. begin thinking about and discussing how it felt for him to deal with his new relationships at the hospital.

Another animation E.M.C. created was named *In Drive* (see Figure 2). When asked what this animation was about, he said that the tank was driving into the Medic Building and having a battle. He commented that this was a difficult animation to do because he had to draw a landing, smoke, house, and a tank. E.M.C. did not make a personal reference to this sequence, though one might interpret the medic center as the psychiatric hospital and the tank in battle as himself. E.M.C. worked for many hours designing this animation. He was especially proud of his work and showed it off to the other clients.

Although at this time E.M.C. was still having some difficulty controlling his behavior, on the unit and in school, it was decided by his therapist that he was ready to return home. Outpatient treatment was recommended for him and his mother. Upon discharge, E.M.C. expressed interest in trying to find a computer in his community to continue creating art.

A few months later E.M.C. was readmitted to the hospital. In school and at home, he was having the same behavioral and emotional problems as before. In addition, he was soon to be 12 years old and his mother was finding him more difficult to control.

When the art therapist heard that E.M.C. had been readmitted she went to the unit where he was living and asked if he was interested in coming back to art therapy. E.M.C. greeted her warmly and immediately asked if she had the Macintosh computer.

The first animation he did upon returning to art therapy was called *Alien* (see Figure 3). When he was later asked to talk about it he said the animation was about aliens. Two

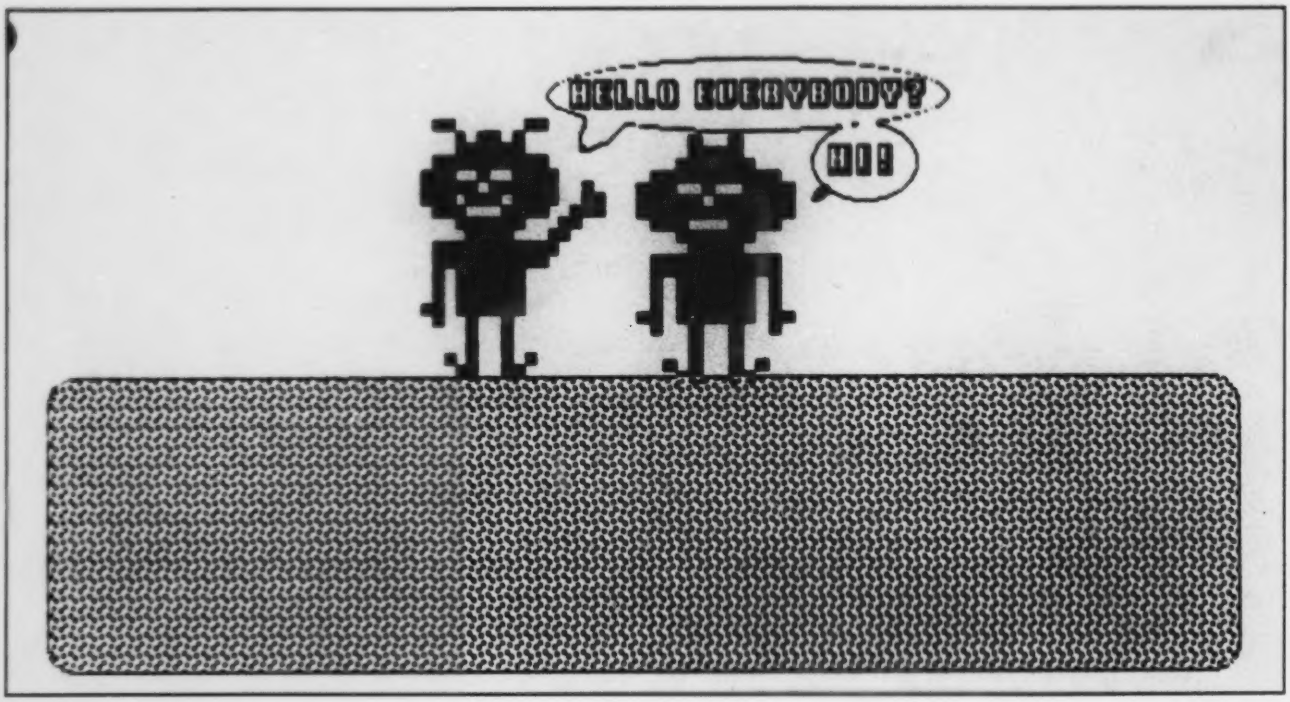


Fig. 3

aliens come together and one says hello everybody. E.M.C. said, when he first came to the hospital, he made that. It talks and says *hello everybody*. Using the computer and animation software, E.M.C. was able to conceptualize an idea and produce what he needed to express. Having an alien say *hello everybody* was his way of greeting his new peers at the hospital. The fact that he said the animation sequence *Alien* was done when he first came back to the center, exemplified his ability to associate an image to a time period. Here again, we see E.M.C. discussing an issue through another subject matter. He visually expressed what he wanted to talk about. After finishing his animation, he could begin discussing with the art therapist, what it was like to be back at the hospital.

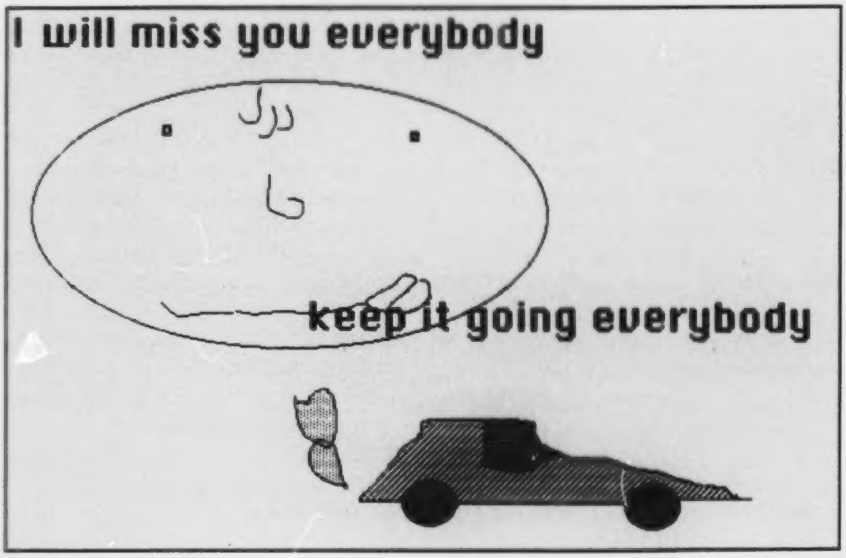

I will miss you everybody
keep it going everybody

Fig. 4

Keep Going (Figure 4), was one of the last animation sequences E.M.C. produced before he left the hospital for residential placement. He said it was about leaving. First it says *keep it going everybody* and then it says *I will miss you everybody*. In the animation you hear beeping sounds and you see a car, and a smiling face that he made. When E.M.C. was asked how he felt about this animation he said he felt mad and sad. He said he was sad he was leaving the hospital and mad he was leaving. Talking about the animation enabled us to begin talking about his feelings about leaving his friends, his fears toward going to live in a residential home, and his plans for the future. E.M.C.'s ability to visualize these issues allowed positive interpersonal discussions as well as a means for him to express his feelings verbally.

BEST COPY AVAILABLE

E.M.C.'s behavior had changed by this time. In art therapy he was able to work with other children, communicate to them how to make the computer work and have discussions in a personal and expressive manner. He showed increased attention span, positive development of visual expression, creativity, and self-esteem. E.M.C.'s teachers, therapist and staff were also noticing a change in his behavior. He was not as disruptive or hyperactive as before. His therapist felt that he still showed an underlying depressive behavior although he was not acting-out to express these feelings.

In one of E.M.C.'s final staffings, (before he was placed in a residential home for one year), his teachers and staff commented that they felt he had matured since the last time he was at the hospital. Because of this maturation he was beginning to express feelings, instead of acting them out. Since it was apparent that visual stimulators could modify E.M.C.'s behavior it was made known to his therapist and mother that he showed talent in the area of art and he was capable of visually expressing himself when given the freedom and encouragement. Art therapy and/or art classes were suggested as being part of his outpatient treatment plan. In addition having access to a computer and graphics program in his school and/or home environment were strongly recommended.

Case Study II

This case study is about a 17-year-old, white, lower to middle class, female adolescent. She was placed at the psychiatric center because of her poor impulse control and aggressive behavior toward peers and adults. She had a history of suicide attempts, depression, alcohol and polydrug abuse, truancy, verbal and physical aggression, running away, and a chaotic family environment. Drawings, taken from animation sequences she produced on the Macintosh computer, are included. For confidentiality purposes the client will be referred to as D.C.

D.C. was admitted to the psychiatric facility in the middle of November 1984 as a voluntary patient. She was 17½ when she began attending art therapy sessions. Less than a year before, she had had a baby. Her baby was placed under temporary custody of the Department of Children and Family Services (DCFS). D.C. had behavioral problems in her school and community. She had been under guardianship of DCFS since June 1964.

D.C. was bossy and her personality appeared to be cold and callous. She was known to start fights on the unit with other girls, and would lie to the milieu staff. After two weeks at the hospital, D.C.'s anger and inordinate neediness became acute and open. She verbally attacked peers and when advised that she could not touch peers she became self-abusive, hitting her head.

D.C. was a sexually aggressive adolescent, and she constantly talked about boys. It was not unusual for D.C. to have a different boyfriend each week. Besides talking about boys, D.C. would take pride in discussing her role as a gang member. She had difficulty trusting peers and adults and had very few positive role models. Manipulating others was D.C.'s way of feeling in control.

D.C.'s relationships to male peers at school remained problematic. She continued to be sexually provocative, such as touching boys inappropriately or asking questions in school such as how to spell 'masturbation.' On the unit as well as school, she viewed herself as a 'social butterfly.'

D.C. began participating in art therapy sessions in her third month at the psychiatric facility. From the very beginning D.C. enjoyed working with the art materials. She initially drew and painted 'pretty' flowers and still lifes. Eventually she engaged in a long-term, abstract sculpture project, that involved using chicken wire, wheat-paste, plaster and paint.

During the first month in art therapy, D.C.'s art work did not reflect what was going on in her life. Rather, it masked the difficulties she was going through. Her art work did not mirror her problems. She was concerned in completing a 'beautiful' piece of art. Creating art that aesthetically pleased D.C. allowed her to feel good about being productive. Once this was achieved she could build self-esteem and trust in the art therapist. The initial goals, in art therapy, at this time were building D.C.'s good feelings about working, and providing her with a positive environment for growth. Other therapeutic goals focused on dealing with her anger and impulse control.

After six weeks of working in art therapy with D.C., she stated that she was interested in coordinating art projects on her unit. This request was fulfilled by allowing her to borrow art supplies from the art therapist and having her plan art projects for the girls on her unit. D.C. enjoyed taking the responsibility of borrowing materials and returning them to the art therapy room. She asked if she could help teach art classes to other children at the hospital. She also expressed the need for additional schooling, training her to be an art teacher. This was a noteworthy shift in her behavior from being negative, to D.C. talking about wanting to take some positive control over her life and being interested in her future.

During the second month of art therapy sessions D.C. was introduced to the Apple Macintosh computer. She had worked with computers in school but never used one to create music or make art. D.C. first chose to work with the software program MusicWorks. She had experience playing the piano and quickly learned how to control the program. D.C. worked on her composition for weeks and named it *D.'s Tune.* She took delight in playing her song on the computer for other children and adolescent clients.

For the remaining month, in art therapy, D.C. concentrated her ef-

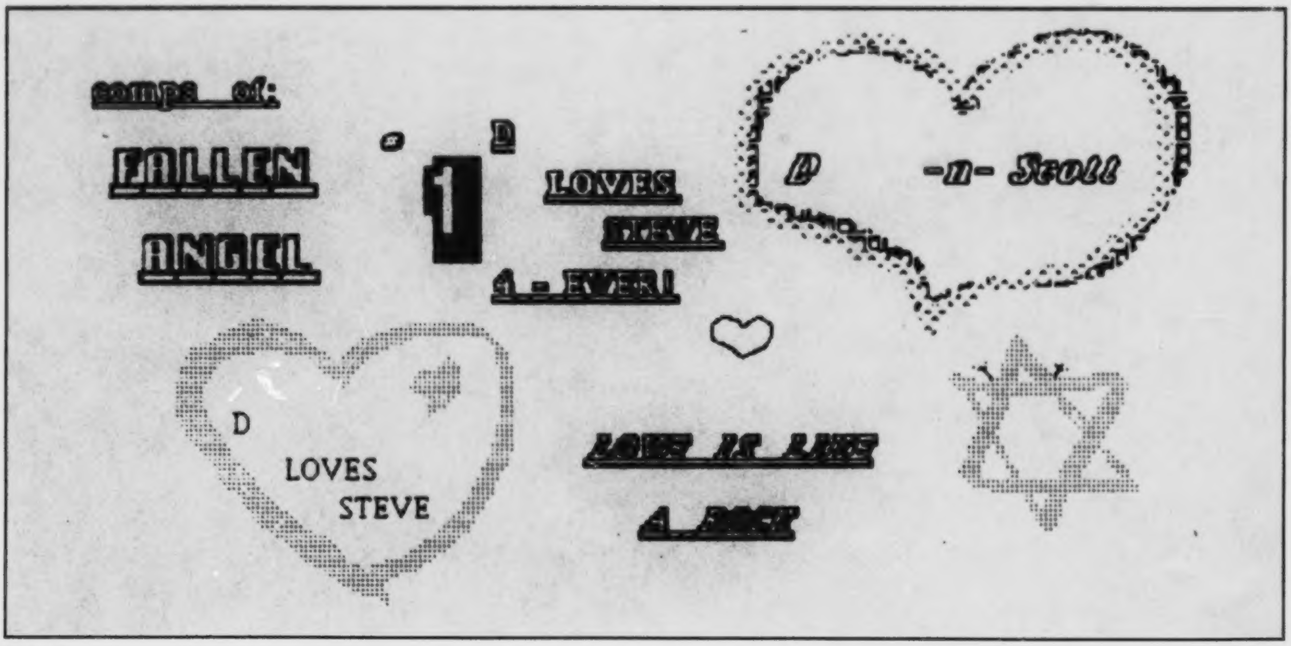


Fig. 5

forts on working with the animation software, VideoWorks. She found this tool ideal for expressing her feelings about boyfriends and love. She used the program to create audio-visual love poems. It was very interesting to watch D.C. work with VideoWorks. She was quite articulate about the timing and placement of images on the screen. She chose many different sound effects for an animation, and worked on the 'Score' to edit, cut, and paste in frames. D.C.'s concentration while working with this program was focused. Her determination to finish what she started exemplified that she cared about what she was doing. This behavior was different from school and on her unit, where she would often start fights and be disrespectful to teachers and staff.

D.'s Boys was the name of the first animated film D.C. produced. It began with the sounds of heart beats. At first, a large heart, with the words *D.-n-Scott* inside of it, moved across the screen. The words *D. loves Steve* appeared on the screen next, and slowly moved to the side. Following this, *love is like a rock* moved from one side to the other. The film ended with a six-sided star (gang sign) and the words *Comps of fallen angel* (see Figure 5).

This animation represented some of the issues D.C. felt were important to her. Discussing the content brought up questions about her ambivalence towards men and her affiliation with gang members. She had made the first step to begin looking at her problems. D.C. never asked for a copy of the disc, or print-out of individual drawings; creating the animation was what was important to her. She had found a productive and creative media in which she could focus her energy and thoughts. The control she normally exerted in manipulating others was sublimated into mastering the computer.

The second animation D.C. produced was called *Old Boyfriends of Mine*. In this film she starts off with the words, *Boys, Boys, Who Needs em. I Do. John and D.* appear in the middle of the screen and move out. You then see the words *Fun in the Summertime,* next to falling rain drops and a heart with an arrow in it. Afterwards *Robert and D.* appear, and it ends with *Boys, Boys, Boys Who Needs Em I Do.* D.C. implemented a variety of sound effects throughout the animation. She also used the program's 'Special Effects' feature and picture fonts (type faces) to create illusions and designs (see Figure 6).

The computer provided a world in which D.C. could build a new set of learning skills in which she could use to transfer her way of thinking about herself and others. Her animated poems represented important aspects of her life. In an honest and straightforward way she was able to present her feelings and conflicts. With this new tool came a new way for her to think about some of the difficult issues she faced. The computer gave categories more useful than good or bad and allowed D.C. to make her own decisions. In creating her world, D.C. built an environment in which she could be successful and feel positive about her accomplishments.

Unfortunately, at this time, art therapy sessions were terminated because of financial reasons. Two months later D.C. was transferred to an adult psychiatric facility for outpatient treatment. It was felt by D.C.'s therapists that she had attained maximum benefits of the hos-

BEST COPY AVAILABLE

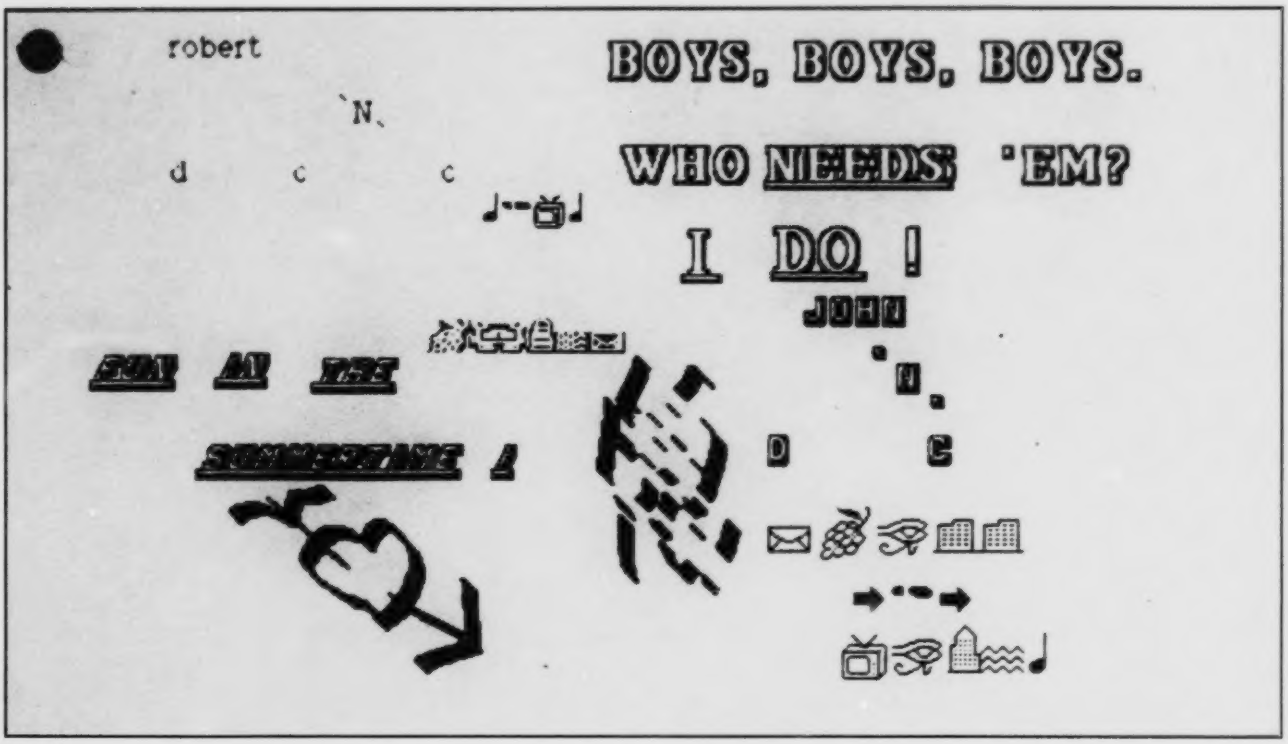


Fig. 6

pitalization, and that she was not in need of inpatient psychiatric care. Her prognosis was fair-to-good providing she made good use of the new outpatient treatment.

Discussion

MacPaint, MusicWorks and VideoWorks were incorporated in art therapy sessions to see if creativity software and the Macintosh computer could have positive effects on children and adolescents with learning disabilities as well as behavioral and emotional problems. The two case studies exemplified how these tools could be a therapeutic procedure that provided the right level of success, mastery and control for these clients.

Veljkov (1985) stated that creative and developmental growth in visual motor skills, eye-hand coordination, logical reasoning processes, and creative decision making could be enhanced through continual use of the Macintosh computer. Clients, in this study, who used the computer and creativity software did excel in creative and intellectual learning processes. Their ability to manipulate and control the hardware and software not only gave them a sense of self-satisfaction but allowed them to participate in a unique, stimulating, educational, and creative learning process.

Glenn, Humphrey and Kleiman (1984) found that some educators believed that computers were too complex for students with learning problems, and therefore would lead to frustration. This study found that clients with learning disabilities were able to concentrate and work longer on drawings while working at the computer because there were a variety of creative possibilities to be explored and because the Macintosh computer was easy and fun to use. Clients were enthusiastic towards using the computer and creativity software. Their art work and behavior reflected that this was a positive and rewarding experience.

Favaro (1983) found that children who were overly dependent on their teachers' attention were likely to become distracted easily from computer tasks. He also felt that children who were apt to respond to frustration with impulsive or destructive outbursts were not yet ready to use computers. These findings were not noticed in this study. Clients that were overly dependent on the thera-

"Clients, in this study, who used the computer and creativity software did excell in creative and intellectual learning processes."

"Slow learners had very little difficulty learning how to control the computer and were intrigued by the limitless possibilities."

pists' attention while using other media, did not need extra attention while working with the computer, and did not become frustrated by having to learn the necessary procedures to make the computer work. Clients with low attention spans and/or poor behavior were able to focus on creative problems, while feeling safe in an environment they could control.

The Macintosh icon oriented system allowed easy access into computer programs. Slow learners had very little difficulty learning how to control the computer and were intrigued by the limitless possibilities. The results were also aesthetically pleasing to them.

One of the key elements in these particular creativity programs was that any actions done on the computer could be 'undone' by the user. That is to say, if clients drew a line, or placed a note down on the staff they didn't like, they could undo it, and take the line or note away without any other consequences. This feature gave clients the security to experiment and try things that they might not do on paper or canvas, because they were afraid to make mistakes.

Another key element to this software was that it worked in real-time. This means, as users placed notes down on the staff, they heard them instantly. As users recorded the movement of an image on the screen, with their mouse, they saw the recording play back instantly. Users could even change the drawing being animated while it was animating. These sorts of features let clients see exactly what they just did, so if they don't like it, they could instantly change it. These kinds of features allow children and adolescents with emotional and behavioral problems to easily make quick changes without conflict, embarrassment or frustration.

Turkle's (1984) research revealed that computers can change the way people think about themselves and that personal issues are worked out by what clients were doing on the computer screen. In her study with children and computers she found that some children are able to see computers as a mirror of their mind. These children made explicit use of computational metaphors to think about themselves. She states, "By looking at the detail of how they provide a vantage point for understanding something, helps us understand how computer metaphors can turn into a new popular psychology for the culture at large" (p. 155).

In this study, the drawings and animated sequences produced on the Macintosh expressed the users' thoughts and concerns. Through drawings, animated poems and pictorial metaphors the clients disclosed personal information. These visual images produced were used in and throughout the therapeutic process. Clients were able to build self-esteem and trust in the art therapist because they felt good that they had the opportunity to successfully learn new tools and creative art processes. A combination of these results proved that using a computer and creativity software was a positive therapeutic approach.

Implementing creativity software and a Macintosh computer in art therapy sessions, at the psychiatric inpatient hospital, provided children and adolescents, with behavioral and emotional problems, new kinds of creative learning experiences, positive interpersonal communication, and state-of-the-art technological tools. Science Desk (1985) quotes Davidman as saying, "The most crucial struggle for institutionalized children is keeping up with the mainstream youths in some way. . . . That's Goal No. 1, giving the kids what they'd normally have if they were not locked away."

Conclusion

Continual use of computers and creativity software by children and adolescents with learning disabilities exemplified positive changes in their behavior. The results of a three-month study included:

1. *Increased Attention Span.* Clients who normally were unable to sit or concentrate for more than 10 minutes in a classroom, would work for an hour or more at the Macintosh Computer.
2. *Development of Visual Expression.* Clients who normally could not express themselves verbally, found drawing and animation programs ideal tools to visually express their feelings.
3. *Development of Musical Expression.* Clients who were unfamiliar with music, and music composition, found themselves writing their own songs with computerized music programs on the Macintosh.
4. *Development of Self-Confidence.* Clients felt more in control of their environment and felt better about themselves, once they became familiar with the technology of a Macintosh and its software.
5. *Development of Creativity.* Creative problem solving was further developed by clients, and the output from their experiences provided positive rewards.
6. *Development of Communicative Skills.* Clients developed communicative skills in an atmosphere without conflict, with a relationship of friendly "user" in an atmosphere created by a friendly "teacher."

Art therapists using traditional art therapy techniques may find implementing computers and creativity software in their sessions to be both educational and therapeutic.

Nathan (1985) has written and lectured on the creative and educational applications for computers. He believes that the most advanced and effective use of computers requires rethinking attitudes, providing opportunities for creative experimentation and changing traditional patterns and practices. He says that, "Computers can do much more, but they cannot do these tasks for us—we must be open, thoughtful and brave enough to do them ourselves" (p. 231).

Further research in using computers and creativity software, with children, adolescents, adults, and older populations with emotional and physical problems need to be explored. As computers become more accepted as therapeutic tools other kinds of software can be developed for working with specific kinds of problems. Solving problems is a basic process in both computer "packages" and art therapy. The combination of the two provides a powerful environment for therapy.

References

Favaro, P. (1983, April). My five year old knows basic. *Creative Computing*, 158.

Glenn, M., Humphrey, M. and Kleiman, M. (1984, October). Computers make special education more effective and fun. *Creative Computing*, 96.

Nathan, J. (1985). *Micro-Myths*. Minneapolis, MN: Winston Press, p. 231.

Reveaux, A. (1985, Fall). Art and technology. *Expo-See*, 1.

Reveaux, A. (1977, July). The art of animation, Chevron Gallery, San Francisco, *Catalog Essay*.

Science Desk. (1985, September 3). Computer is a new tool in psychiatric ward. *New York Times*, 24.

Turkle, S. (1984). The second self. *Computer and the Human Spirit*. New York: Simon & Schuster, p. 155.

Veljkov, M. (1985). The Mac and preschoolers. *The MACazine*, 80.

CHARLES C THOMAS • PUBLISHER

New! **VISUAL ARTS AND OLDER PEOPLE: Developing Quality Programs** *by* **Pearl Greenberg.** This lucid text provides the background and knowledge necessary to understand and appreciate older adults as artists and to develop quality visual art programs. Chapters explore retirement, gallery and museum programs, art for disabled older people, adult learning, art hazards, and art appreciation. Diverse art mediums are covered including collage, drawing and painting, clay and construction, fabric printing, and weaving. *'87, $30.25*

New! **IMPROVISATIONAL MODELS OF MUSIC THERAPY** *by* **Kenneth E. Bruscia.** This comprehensive guide identifies over 25 models of therapy, including: creative music therapy, free improvisation therapy, analytical music therapy, experimental improvisation therapy, Orff improvisation models, and paraverbal therapy. For ease of comparison, each model is uniformly described according to goals, clinical uses, assessment and evaluation, and treatment procedures. *Apr. '87, about $67.50*

New! **MUSIC THERAPY: An Introduction** *by* **Jacqueline Schmidt Peters.** This succinct compilation of basic information explores the development of music therapy; skills, knowledge, and attitudes important to the music therapist; major areas in practice and research; and theoretical concepts underlying various practices. This book will be of great value to professionals in related disciplines who desire a basic knowledge of the scope of music therapy. *Feb. '87, about $27.25*

EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession *by* **Shaun McNiff.** This is the first comprehensive study of higher education in the growing arts therapy profession. It explores the interdependence of diverse training traditions, and it reviews the various areas of concentration, such as art or music therapy. Specific competencies and different philosophies are examined, but their commonalities are emphasized. Chapters are also included on an artistic theory of mental health and on supervision and evaluation. *'86, $32.75*

THE ARTS AND PSYCHOTHERAPY *by* **Shaun McNiff.** An integrated approach to all of the arts in psychotherapy is presented in this insightful book. The author examines the distinctive and common qualities of the various expressive arts in relation to psychotherapy. He also draws on the statements of artists to develop a psychology of art that views artistic exploration as psychological research of the highest order. *'81, $21.75*

THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking *by* **Myra F. Levick.** In this book, a pioneer and leader in art therapy describes and illustrates normal and abnormal development of cognitive skills and defense mechanisms through the graphic productions of children between two and ten years old. The range of topics thus examined includes art therapy, defense mechanisms of the ego, psychosexual and cognitive development, and manifestations of defense mechanisms in children's drawings. *'83, $38.00*

We fill all orders promptly • Books sent on approval
MasterCard, Visa & prepaid orders sent postpaid
Catalog sent on request • Write or call (217) 789-8980

2600 South First Street
Springfield • Illinois • 62794-9265

"An Art Support Group for Bereaved Children and Adolescents"

Mary Raymer, A.C.S.W., M.S.W., is a Clinical Specialist: The Mental Health of Aging and Gerontology, Certified Gerontologist/Thanatologist, Wayne State University, Detroit, Michigan. ***Barbara Betker McIntyre*** *is a Ph.D. Candidate, Union Graduate School, Cincinnati, Ohio; Associate Member, American Art Therapy Association; Member of Michigan Association of Art Therapy.*

"An Art Support Group for Bereaved Children and Adolescents" provides an overview of the grieving process for children and adolescents and the utilization of creative art therapy in facilitating the process.

A hospice program in a rural area began a pilot program involving art and music therapy for bereaved youth through state arts council funds. The important goals of the art support group, as well as the dynamics and methods used to accomplish these goals are described. The overwhelming need and community support are addressed as factors for the program's successful development and continued growth. Three case studies provide further insight into the program. The creative art therapies used to facilitate grief are noted as a preventive measure. Finally, both authors address the importance of recognizing and understanding the grief process.

Introduction

The grief process is probably the least talked about and the least understood process in the field of mental health today. It is a painful, albeit critical, time of rebuilding and reordering one's world. It takes a long time to reach a state of emotional equilibrium; each person experiences grief differently, but it is always a time of powerful and often overwhelming emotion. Unfortunately, there is no set time frame for healing to take place. Some people recover in a little over a year, other people may take three years and some people never fully recover. While there are not easily definable "stages," the period of bereavement is usually characterized by three general "phases" which can include a variety of symptoms.

Three Phases and Assumptions

As with any trauma, the first of these phases is shock. People frequently report numbness, the inability to feel, or feeling as if they are robots just going through the motions of every day life. The task for bereaved persons at this point is to protect themselves from feeling the full impact of the loss. This is a sort of psychological "respite" and may last for several weeks or months.

The second phase can be described as a phase of intense disorganization. Symptoms may include inability to concentrate, sleep, or eat, frequent and often uncontrollable crying, numerous somatic symptoms, rage, depression, guilt and preoccupation with the deceased. Repressing the symptoms of this phase creates a serious block to healing. The task for the bereaved person at this point is to acknowledge and feel the full impact of the loss. Feelings need to be expressed and worked through. This phase may last many months.

With proper support, the person moves to the reorganization phase which is characterized by occasional peacefulness, more pleasant and bittersweet memories of the deceased, and less intensity of feelings. The goal is not to forget the deceased, but to complete the intensely emotional relationship and to choose to reenter life with enjoyment again.

This tumultuous time of healing is exhausting, demanding and difficult for any adult to cope with. It is little wonder that children are often lost in the shuffle of the struggle. Consider your first experience with death as a child. Was it with the death of a grandparent, parent or pet? How were you told about it? How did you feel? If you are like most people, chances are that you felt confused, guilty, curious, isolated, fearful and/or angry.

An unhealthy assumption is often made by well-meaning adults that children don't understand or are incapable of handling the truth. Generally, children take longer than adults to exhibit the symptoms of mourning and this adds to the assumption that children don't really need any intervention. Children require the same opportunities to vent and work through their feelings as adults do; intervention for children is even more critical because this period will shape their lives for many years to come. After the death of a loved one, a child may present a

---

"An unhealthy assumption is often made by well-meaning adults that children don't understand or are incapable of handling the truth."

---

somewhat pensive attitude often mixed with sadness and anger. After a short time, often to the consternation of adults, he/she may return to play with his/her toys, watch television or play with companions. This short sadness span is not a matter of unawareness of the loss, nor is it disrespectful. It is a simple matter of denial that allows the child to postpone having to deal with the tragic loss until he or she is ready. It is comparable to a bereaved adult's disbelief of a tragic loss, a normal reaction in the initial phase of grief. Children may make numerous demands of the living family members. This is the way they check out their relationships with those who are living in their family constellation.

A well-informed child, even after attending the funeral, may still believe that the loved one will return. One three-year-old, whose mother died of lung cancer, was sure that his mother would return. He stated that "my mother is dead but once doctors figure out a cure for cancer, she will be back when I'm big, but we have to wait until then." Another child, age five, whose sister died at age three months, stated "my sister called and said she'd go to the zoo with us on Saturday." It is at moments such as these that trusted adults have the awesome task of helping a child deal with the realities of the death. The easiest reaction for an adult is to ignore the child's comments; this is an unfair and unhealthy reaction. It is difficult, but important, to utilize these moments constructively as did the five-year-old's father. "I think you wish your sister would go to the zoo with us. When we miss your sister very much, we like to think that she's not really dead. I guess we will all be sad when we go to the zoo today."

In conversations with adults who have suffered a loss of a loved one in their own childhood, one of the saddest experiences is the frequency with which they tell of their memories of crying alone at night in a closet or in bed. This loneliness and isolation surrounding their expression of grief can be overwhelming and frightening. It is important that a child has a loved one to comfort him/her at these moments, as well as having the necessary art tools to work through the feelings.

Prolonged longing and wishing for the return of the deceased are normal in childhood, just as they are in adulthood. Knowing and understanding that a loved one has gone forever is only the initial phase of accepting reality and the permanence of the loss. A child, as an adult, must grapple for a long time to adapt to an important loss.

What happens all too often, however, is that the adult, finding the child's poignant struggle painful, turns away and avoids dealing with his/her anguish. When parents cannot deal with the struggle, it is crucial that other supports be provided.

Bereaved Children and Adolescents

Bereaved children often become anxious when family members are away, fearing that they too might fail to return. It is common for a child to exhibit regressive behavior during this period of bereavement. The child may become anxious at bedtime and be fearful of leaving home. He/she may lose urine and bowel control, or may generally be restless and out of sorts. Poor school attendance, due to bodily complaints, and a decrease in ability to meet educational challenges are common symptoms.

A bereaved child commonly dreads illness, even minor ones such as colds. The child may imagine that he/she may be about to die. Bereaved children who present behavior symptoms as they grapple with the loss, may be far healthier than children who deny the loss and are unable to deal with it in any manner whatsoever.

The death of a parent during adolescence has unique effects because of this particular developmental phase of life. At one moment, a healthy adolescent is extremely independent, setting off with great determination to make his/her own way in the world. The adolescent discontinues many old associations and seeks new relationships. At other times, particularly after a stressful period, an adolescent often reverts to a less mature state, seeking considerable parental care, sympathy and advice, quite in contrast to his/her behavior during the independent phase. Such fluctuations between independence and dependence would be considered highly abnormal at any other time in life. During adolescence, vascillation and restlessness are expressions of the normal process of maturation. The normal family constellation with two parents allows the adolescent to break away gradually on a trial basis, and to thrive at activity outside of his/her immediate family setting. During these phases of intense independence, the adolescent is often critical and, at times, openly hostile to parents. The fact that the option exists to "return to home base" and be taken care of as in former years can be a comfort during this time.

The alternating ways in which a young person relates to parents must be considered as an adolescent copes with the tragic loss of a parent. It is one experience to be struggling to become independent, knowing that both parents are available when needed. It is quite a different experience when death removes a parent or significant other in the midst of this struggle for emancipation.

A bereaved adolescent, even more than young children, may dread any illness, even of minor nature. At this developmental phase adolescents are deeply concerned about their bodies and life-threatening illness. Unresolved or ignored grief in children leads to serious problems with self-concept and intimacy in adulthood. Substance abuse, hostile and criminal behavior, promiscuity and phobic reactions are frequently the end result of unresolved childhood loss.

A Program in Action

The Grand Traverse Area Hospice of Munson Medical Center in Traverse City, Michigan is a program designed to provide supportive services for the terminally ill patient and his/her family. A main goal is to help persons live as fully as possible by providing medical, emotional and spiritual supports for them and their families. After death, the goal is to help the family heal and re-enter life's mainstream. The bereavement program provides one-on-one and group therapy as well as crisis intervention.

In 1982, an art therapist volunteered her services to the program. Art therapy allows for the expression and communication of nonverbal images. The creative process is utilized as a means to transform pain and conflict and fosters self-awareness and growth. The person, process and product are equal in the art experience.

Art is a balance for feelings, thoughts and experiences. Art work, made spontaneously, can communicate feelings, experiences, fantasies and behavior and coping patterns through medium viewed as safer than verbal communication. In this art therapy program, usually one half of the time is spent in drawing, painting, making collages, etc., and the other half is spent sharing the actual art and feelings with the therapist and/or others. It quickly became apparent that, through art, children responded especially well. It appeared as if they responded much more quickly than through traditional verbal therapy.

Art provided a tool which improved self-esteem, was non-threatening and could be used by the child as a healthy release. It also facilitated communication in the home with the other family members. The grief process seems to be hastened by drawing on the individual's creative skills. Problem solving and coping skills are increased, thus the youth has more ability to cope with future trauma.

> ***"Art provided a tool which improved self-esteem, was non-threatening and could be used by the child as a healthy release."***

Our experience with art therapy for children and adolescents with hospice families has been consistently positive. Families have reported consistent improvement in communication, sleeping patterns, appetite and decreased withdrawal and aggression. A group for bereaved children and adolescents helped with the realization that others are in the "same boat."

In 1984 a survey of all mental health agencies in our four county area indicated that there were no existing support systems for the bereaved child or adolescent. This same survey indicated that only one professional in the entire area had expertise in the field of bereavement. There seemed to be such an urgent need in our community that we decided to take action. We received many requests for help from the schools, court systems and non-hospice families.

We applied for funding with the Michigan Council for the Arts, to begin the Bereaved Children and Adolescent Support Group. The Council's purpose is to promote the arts and Michigan artists to special populations. The arts became a tool for bereaved youth to work through; i.e. they could develop an understanding and give form to the many conflicting emotions in grief as well as enable the visiting artists to grow with the experience of facilitating such a group.

As the program developed, criteria were set for referral of children/adolescents; goals were identified for art therapy in bereavement and for methods to accomplish the goals. The group was open to children/adolescents ages four-to-nineteen who experienced a loss of a parent, sibling or significant other or was a member of a hospice family or family currently suffering an imminent loss. Youth were identified who had trouble expressing grief feelings, who were easily frustrated with verbal expression, and who were using verbal expression to deny or mask feelings. It was reiterated that previous art talent was not a prerequisite, although some children/adolescents demonstrated these skills.

The overwhelming need for a bereaved child/adolescent art support group brought initial referrals of over forty youths within a two week time span. The ideal ratio of artists/therapists to children is one-to-four, although one-to-six can still be quite effective. Artists were carefully screened for qualifications in understanding children and adolescents, previous teaching and proficient use of their media. Six artists were selected with expertise in a variety of media, and all six artists had experienced an early loss. (It is interesting to note that Fleming (1983) in a study of artists, revealed that the majority had an early loss.)

A registered music therapist was recruited to work with the group to enhance the sense of community in the group and provide music as another creative mode of expression. A hospice volunteer with expertise in child growth and development also worked with the group. With a team of expressive art therapists and artists, the possibilities for expression seemed to broaden. This unique wide range of expression enhances the bereaved youth's choices and allows for synthesis of expression moving toward resolution and rebirth holistically. Intensive training in grief and art therapies preceded the beginning of the program.

The obtainable goals for a bereaved children and adolescents group using art therapy include:

1. encouraging self expression in art process and product with self and group reflection.
2. catharsis in art process and product; creative and constructive expression of feelings.
3. development of flexible but firm inner control.
4. group cohesiveness.
5. individual growth and increased self-esteem in art process and product.

Methods to accomplish these goals vary in visual art media, music, movement and dance and group discussion. During our group's training, artists were provided with experimental art therapy. A chance for artists to initiate their own methods to accomplish the goals was also afforded prior to beginning the group.

Art therapy sessions are held on a weekly basis and meet for two hour duration. We meet as a whole group at the beginning of each session for music therapy and for sharing our feelings and thoughts. Many times stories about life and death are read to stimulate discussions. Music therapy helps to provide socializing (Knill 1982). Music therapy stimulates discussion and provides a natural transition to expression in visual arts. Sometimes children write songs about pictures they draw as in these examples:

BIRTHDAY DOG *by L.A.*, age 6
When I was five my father gave
me Birthday Dog.
He is cute, he has tan and white
ears and a hat up on top.
It was only one year ago (or maybe
it was three) . . . and
I'm sad when I hold him, but it
just happened!
Now he's in Heaven and he wants
me to be happy.
So I come to art and draw
Birthday Dog.

THE COAT *by V.P.*, age 19
The coat was his
He wore it often
It was part of him
Now he's gone.
The coat is mine
I wear it often
It is part of me.
Sometimes I feel sad when I wear
it;
Sometimes the feeling is happy.
But either way
I feel close to my Dad
Through this special coat.

With a variety of media (i.e. clay, fiber, wood, paint, finger paint, crayons, pastels, craypas and charcoal) youths create art. The process and product provide a means for self and group reflection and increase awareness. Jonathon (4) drew a picture of his grandmother who died a month ago; his mom is now dying of terminal lung cancer. Amy (6) drew Daddy's chair and said she misses him. Jeff (4) made a puppet and a self-discovery that his hand could control it. Laura (6) drew a picture of herself under a rainbow after she drew when Daddy died. Monsters appeared from clay. Six adolescent boys made wooden marionettes and staged a puppet show about heaven for the group. Discussion about the art always provides for self-reflection and increased awareness. Our sessions close with sharing art as a whole group. It is often easier for a child to discuss in a group when there is an art product to share.

Some of the common themes found in bereaved children and adolescent art include monsters, a symbol for children to express the many elements in nature that are out of their control (McNiff 1978). Rainbows are commonly found to create order. Various groupings of colors in rainbows show different stages in grief, such as separation from the nurturer, red and blue, and death and rebirth, purple and yellow (Shoemaker 1981). Balloons and birds expressing an upward transition of the dying appear as natural additions to a scenery. Roads and time (search of), dead trees (damaged self) and anger themes of fire, lightening, explosive sun and storms have been noted by Fleming, 1983, as common themes in early loss and have appeared in the art from the bereavement group. A lack of hands and feet in a drawing about death or feelings of an imminent loss reflect the helplessness in the traumatic experience. The sadness, pain, helplessness, rage, guilt, anger and preoccupation with the deceased that may have been repressed in other kinds of communication formats are freely expressed in a protective environment utilizing the arts.

After just 10 sessions, art staff reported that 95 percent of the youths showed consistent and documentable behavior changes as observed in peer and school relationships, and as reported by parents. With the success of art therapy for grief expression, a monthly parent/child art session was added to the program. This special session gives parents the opportunity to work creatively with their children while observing them in action. A Hospice goal is to help the bereaved family readjust as a whole to its loss. The parent/child art night serves to do just that. Interaction and communication between parent and child become greatly enhanced during the creative process. Parents involved in the parent/child night reported a valuable experience of supporting each other's creative work. The art process encourages the rebuilding of the family's world.

Art therapy as an important process in grief expression is illustrated in the following case studies.

Case Study A

After the death of her father, a nine-year-old girl was referred to our group by her mother. She reported difficulty with sleeping and eating. She came to the group while simultaneously seeing a Hospice social

> ***"The art process encourages the rebuilding of the family's world."***

worker. This young girl energetically expressed herself in media of paint and crayons during the first session. Her work seemed creative and very colorful. After completing her work, she tore up everything she accomplished saying, "I don't like it: I can't do anything right." This seemed to be her way to show that "good things can't happen to me now; I don't want to progress past the time my daddy died." Her behavior suggested that she was stuck in her grief work. When asked by the Hospice social worker, "What do you want to be when you grow up?" she wept and could not answer. One of the artists worked with A. in a dyad on several projects. When A. saw the work the two of them had accomplished, she was eager to do more by herself and with the artist. In a matter of a few weeks A. was pleased with her work, wanting everything to be matted. She told the Hospice social worker that "remember when you asked me what I wanted to be when I grow up? Well now I want to grow up." Gradually her symptoms of sleeping and eating disorders disappeared. The art process when encouraged and supported in a therapeutic relationship can move an individual past his/her current limits and towards new growth. In this case, A. needed to see that she could successfully advance in her life. After a significant loss, the ability to take risks is often hindered. The art process and products help teach one to take risks which can slowly be incorporated into other life activities.

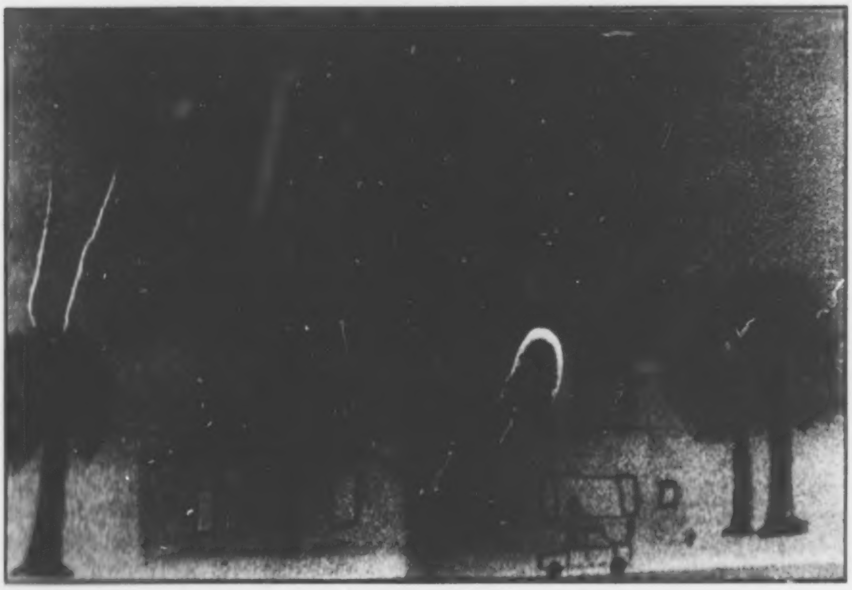


Fig. 1

A family picture when mom was alive included mom and the youth with a focus on the house structure.

Case Study B

After the death of his mother, B., a 15-year-old boy, was referred to the Art Therapist by his older brother who reported withdrawal and somatic symptoms within the past few weeks. I called B. and talked with him about the Art Support Group. B. explained that he had no energy, spent much of his time sleeping during the day and stayed awake at night, couldn't keep food down and was generally disinterested with life. He did agree to come to the Art Support Group. We talked about his Mom and he described a very close, dependent relationship with her. B. came early to the Art Support Group so we had time to talk together. He stated that he was not an artist. I encouraged him to paint and told him art is a way to express his feelings, experiences and thoughts towards his loss, hence it is not necessary to be an artist. He made a tree. The tree seemed to be healthy with a trunk, branches and a lot of green leaves. The drawing of a tree in a depression, however, is an expression of depressive and inadequate feelings (Buck 1950a). When others came to the group, I introduced B. to four adolescents who had been with the group for some time. B. stayed separate for a while. We began as a whole group with stories from Jill Krementz' book *How It Feels When a Parent Dies*. Two stories were read, one of which was quite close to B.'s situation (i.e. an adolescent boy whose mother died of cancer). One issue presented was the boy wished he would have helped his mother more, but didn't believe she would die. Our group talked about those feelings and most children and adolescents expressed feeling the guilt of not helping enough. We talked about believing we did all we could at the time. After our general discussion, small group work began. B. went with the adolescents who were finishing puppets and making props for the play. He interacted mostly with the artist facilitator and remained to himself while building a chair. Towards the end of the session, I spoke with B. and noticed a little more enthusiasm in his expression. He asked if he could see me alone the following day. We set a time for him to come in to the Hospice office. The next day, through discussion, I learned that B. began feeling chest pains, exhibited bulimia, and began feeling disinterested just two weeks prior when his family took a vacation. He told me at this time he "realized his mom was not coming back." (Before, he felt that she was just away on vacation.) He also expressed a great deal of anger towards his new stepmother; particularly, he noticed she and his dad were having fun to-

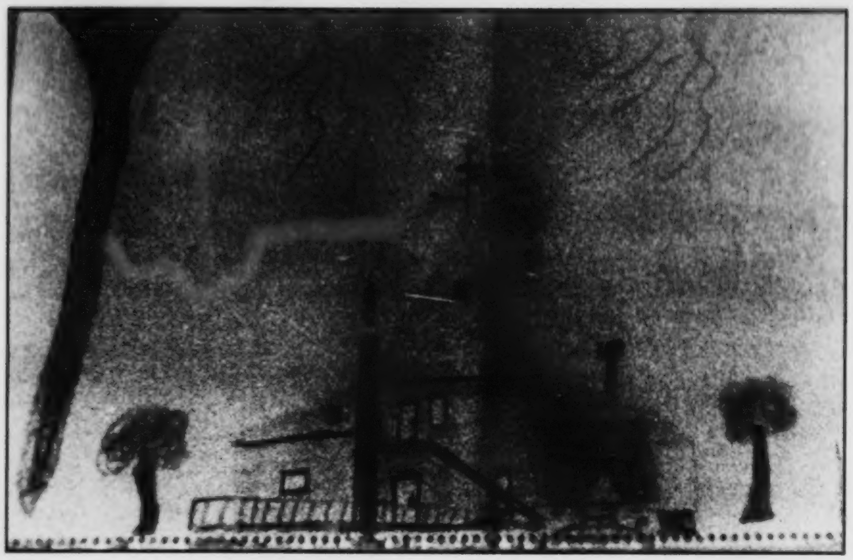


Fig. 2
A family picture of now, focusing on the house structure. The youth was able to discover through art, his conflict and fears were related to changes in the structure made by his father and stepmother.

gether. He then talked about his mom. His mom was a protector and strong nurturer for him. Her absence left him with a helpless feeling as he moved from protest to despair in the grief process. I suggested that he draw a family picture, when his mom was alive. He worked hard on this (Figure 1). This picture, he explained, is when "Mom got her new car and I was watching her through the window." I wondered why he chose the house and yard as a family picture and put only himself and Mom in the picture. It seemed to show his dependence on her. I asked him to draw a family picture of *now* (Figure 2). There are several themes in this picture that we discussed. B. stated the storm was his anger and fear about the way his stepmother and father were changing the house. "They are remodeling and none of Mom's things are staying." We talked about his fear of everyone "forgetting Mom." We also talked about ways he could be involved in remembering Mom and decided to work on a book about her using photographs and drawings (Maxine Junge, 1985). The trees in the picture are notably smaller than Figure 1 which suggests "feelings of isolation often associated with a need for maternal protection" (Buck 1948 & 1950a: Jolles 1952a). Indeed, his mother provided protection as he reported the comfort of having Mom call school and straighten things out when he was in trouble. Also, he was kept home from school an extra year and depended on his mother's comfort when he was sick (which occurred quite often). He told me he received an award for missing the most days of school.

One issue B. was considering was going in the hospital. I asked him how this would change things when he came home. He thought and said, "Maybe this is not the answer." He told me he felt better but not 100 percent better. He said it made him feel good to draw the storm (a release of anger). He then talked about a course he wanted to take at the College Observatory this summer. He said he's always been interested in astronomy and his mother encouraged his development. He also said he would attend our Monday evening sessions. B.'s father reported satisfaction with our art group and said B. sat out on the deck after his first session with us and talked with his stepmom and dad about things he wanted to do.

Loss of a loved one, especially one maternal, is also a loss of self-esteem. When B. experienced art and ability to build and create, this gave him a boost to become interested in life. He still will be grieving over the loss of his Mom for some time. The intervention with art, however, can be perceived as a preventive measure for further withdrawal and increased somatic symptoms which could occur.

I saw B. again the following Tuesday. He said he was sorry he missed last evening but did not have a ride. I asked how he was—his appearance and expression in his face and voice showed great improvement. He said "much better." He told me he is eating more often and stated that he used his telescope, went over to a friends, saw a parade and movie since last week. He attributed this to being involved in the art support group and our art therapy session the prior week. He brought a picture that he drew of his Mom, and we discussed it. B. chose to draw another picture, and proceeded to draw one of his Mom and family on the beach. This time he included all family members. He said he wants this as part of a book to make about memories of his Mom. We talked about the possibility of his doing this during the Art Support Group session. B. continues to attend the Art Group.

"Loss of a loved one, especially one maternal, is also a loss of self-esteem."

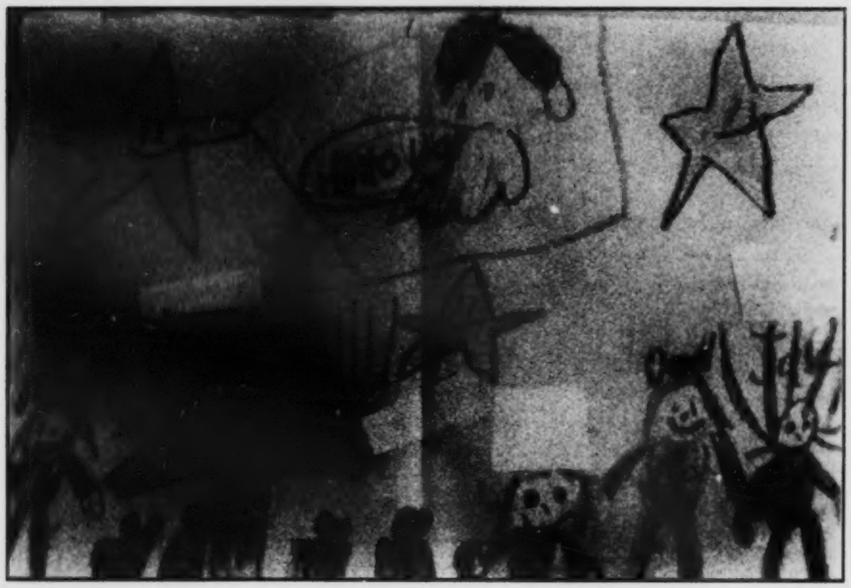


Fig. 3
K. drew dad-smiling and said, "This is dad but he's never happy."

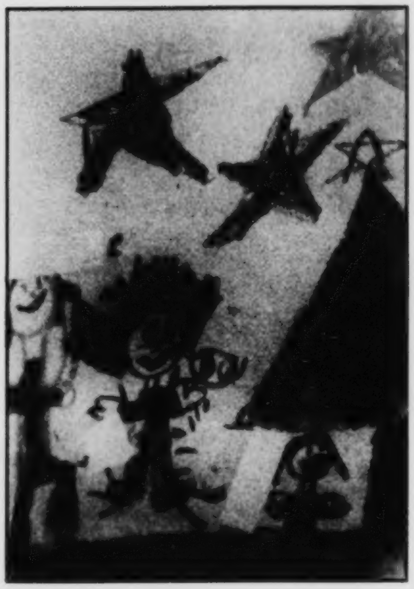


Fig. 4
J.'s family drawing "All they do is fight, fight, fight."

As with any other population in Art Therapy, each case is unique as is the person or family. Results are not always as dramatic when family dynamics are more complex as reported in the following on-going case study.

Case Study C

Mrs. C., a 38-year-old woman with a diagnosis of terminal brain cancer was referred to hospice by her physician. She resided at home with her husband and caregiver, Mr. C. and four daughters, H. (19), I. (18), J. (9), and K. (7). Mrs. C. needed constant supervision and the family hired a full-time caretaker while Mr. C. worked at a factory. The two oldest daughters were away at college. Their home was in a rural setting with limited resources for professional help. The home environment appeared chaotic and full of tension. The patient, having impaired mental capacity, was unable to participate in problem solving or conflict resolution. She often struck out in an aggressive and threatening manner as a result of her frustration. The two younger daughters played outside or in their rooms, thus avoiding interaction with the family.

The first art therapy session began with a group picture of "drawing things that you like." It took a long time for J. and K. to get started. They required a great deal of encouragement, which led to a drawing of sunshine, a river, rainbows, rainbow fish, people and flowers. The composition appeared to be a struggle to find order among their chaotic home environment exemplified by the multiple rainbows. At the end of the session, they appeared less inhibited and expressed enjoyment.

Family pictures were common themes (Figures 3 and 4). K. would say, "This is dad but he's never happy." J. would say, "All they do is fight, fight, fight," and draw her face in white. She felt she was not noticed in the family. Houses were drawn spontaneously by both children (Figures 5 and 6). J. always had very small doors on her houses, suggesting psychological inaccessability. In other discussions, they were asked to remember their mom before she was sick. Both would reply, "I only remember her being sick." This would lead them to regress to scribbling in drawing. Coupled with the small doors on houses, there seemed to be something repressed from the past.

Individual art therapy centered on discussing and expressing feelings. The family had trouble expressing and identifying feelings. Anger and "being mad" became the focus for one session. The therapist stated that angry feelings could be safely expressed through art. This statement gave permission to unleash the anger that was obviously repressed. Heavy black and red marks filled their paper. Several drawings of this nature were made in their one hour session. The energy to draw and release anger was vibrant and ended with exhaustion.

As the children drew many rainbows dedicated to mom, dad, friends, the hospice social worker and art therapist, one picture drawn by K. led to a dramatic enactment. This was a rainbow, a pot of gold and a man. She stated "He's mad and do you know why? Because someone else got to the pot of gold first and took all but two pieces, now some birds are taking those too." She laughed and repeated the story, using red, coloring over with black to make an Easter egg for mom and dad. This seemed to express anger directly related to the previous drama.

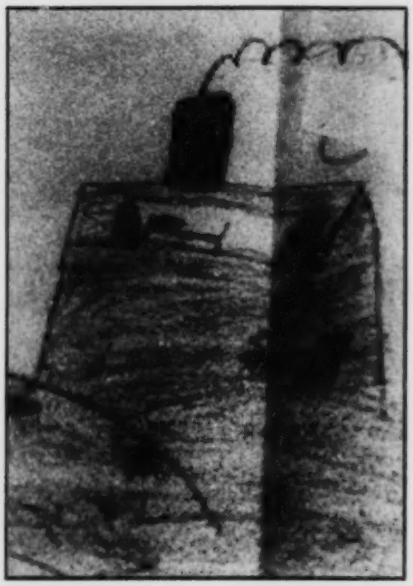


Fig. 5
K.'s drawing of a house shows mom in bed.

Fig. 6
J.'s houses were always drawn with small doors, suggesting psychological inaccessibility.

When Mrs. C. was present, she was encouraged to join art therapy. She spent an hour drawing a small sunset which could be perceived as a symbol of her life coming to an end. The children showed frustration with her debilitating ability to focus on a task. Tolerance was encouraged though the anger towards mom was quite evident from the children.

During the course of therapy, it was revealed that Mrs. C. had a relation with another man two years prior to her onset of cancer. The children were aware of this and were persuaded by Mrs. C. to keep it a secret from dad. It is evident that this situation brought about many repressed emotions, particularly anger. They exhibited decreasing respect for dad as they felt he was partially responsible. (Mr. C. learned of the relationship, and was also faced with a depleting savings account.) K.'s enactment with the empty pot of gold and the angry man related to this situation and was a cathartic experience through the vehicle of art.

When Mrs. C. was diagnosed with cancer, her relationship with the other man ceased. Mr. C. became her primary caregiver. The onset of cancer left many family conflicts unresolved. These conflicts were vividly expressed in the art of the younger children. (Substantial maturity has often been noted in the younger children's ability to cope and deal with frustrations as opposed to the older children who have not experienced art therapy.)

Mrs. C. was placed in a nursing home as continued care at home became too difficult. Home art therapy sessions were held immediately following her placement. The children were eager to draw. As J. saw a previous drawing she made, she said, "I'm going to draw that girl again." She drew her with more balloons going up in the air. This seemed to show the lighter feeling that now existed in the home. K. drew a picture of herself, her sister and a friend going down the river in innertubes. The moments of healthy expression expressed the relief of not having constant care for mom as well as the ability to utilize a safe way to express such feelings.

"Unfortunately, grief is often overlooked and pathology is diagnosed."

On parent/child night of the art therapy group, Mr. C. worked creatively with J. and K. The children exhibited respect toward dad for his creativity and help. It was also an important milestone for Mr. C. to attend art therapy group with other parents and children as historically he was not involved in social activities. Mr. C. seemed to gain self-esteem while working with his children and received support from them and the art therapist.

The children continue to attend group sessions accompanied by Mr. C. and are seen at home twice per month.

Summary

In life, everyone inevitably confronts loss. When mourning and grief work are successfully completed, the individual will grow and find increased strength. As professionals, it is important that we understand and facilitate the normal manifestations of grief. Unfortunately, grief is often overlooked and pathology is diagnosed. Helping an individual through grief work eliminates many of the serious psychological, physiological, sociological and behavioral problems that occur in unresolved grief. Art expression supported in a therapeutic relationship assists the bereaved child, adolescent or adult in working through the painful process of healing. Art touches feelings, experience and thoughts. Arnheim (1967, p. 41) states that art is ". . . an indispensable tool in dealing with the tasks of life."

References

Anderson, F. (1978). *Art for all the children*. Springfield, IL: Charles C. Thomas.

Arnheim, R. (1967). *Toward a psychology of art*. University of California Press.

Buck (1948) and (1950a) and Jolles (1952a). *Clinical Application of Projective Drawings*. Springfield, IL: Charles C Thomas, 1958.

Campbell, J. (1968). *The hero with a thousand faces*. Princeton, NJ: Princeton University Press.

Cane, F. (1983). *The artist in each of us*. Craftsbury Common, VT: Art Therapy Publications.

Cirlot, J. (1971). *A dictionary of symbols*. New York: Philosophical Library.

Cocuzza-Zambelli, G. and Riegelman, H. (1983). "The use of art therapy with children in the bereavement process," *Proceedings, 13th annual American Art Therapy conference*. A.A.T.A., Inc.

Cohn, R. (1984). "Resolving issues of separation through art," *The arts in psychotherapy* (Vol. 11, No. 1). Syracuse, NY.

Fleming, M. (1983). "Early object loss and its relations to creativity as expressed through art therapy," *Proceedings, 13th annual American Art Therapy conference*. A.A.T.A., Inc.

Fuchel, J. (1985). "Writing poetry can enhance the psychotherapeutic process: Observations and examples," *The arts in psychotherapy* (Vol. 12, No. 2). Syracuse, NY.

Fry, V. (1981). *Arts in hospice, hospice of the Good Shepherd*. Waban, MA.

Furman, E. (1974). *A child's parent dies*. Yale University Press.

Grollman, E. (1967). *Explaining death to children*. Boston, MA: Beacon Press.

Grollman, E. (1970). *Talking about death . . . a dialogue between parent and child*. Boston, MA: Beacon Press.

Junge, M. (1985). "The book about daddy dying: A technique to help families deal with the death of a family member," *Art therapy*, journal of the American Art Therapy Association (Vol. 2, No. 1). A.A.T.A., Inc.

Kellogg, R. (1970). *Analyzing children's art*. Mayfield Publishing Co.

Knill, P. (1981). "Intermodal use of arts' therapies," *Art therapy: A bridge between worlds, the proceedings of the 12th annual conference of the American Art Therapy Association*. A.A.T.A. Publications.

Krementz, J. (1981). *How it feels when a parent dies*. NY: Krapf.

Kries, B. and Pattie, A. (1969). *Up from grief: Patterns of recovery*. NY: Seabury Press.

Kubler-Ross, E. (1974). *Questions and answers on death and dying*. NY: MacMillan Publishing Co.

Kubler-Ross, E. (1969). *On death and dying*. NY: MacMillan Publishing Co.

Kubler-Ross, E. (1981). *Living with death and dying*. NY: MacMillan Publishing Co.

McNiff, S. (1981). *The arts and psychotherapy*. Springfield, IL: Charles Thomas Publishing Co.

Rando, T. (1984). *Grief, dying and death*. Champaign, IL: Research Press Co.

Rubin, J. (1978). *Child art therapy*. NY: Van Nostrand Reinhold Co.

Shoemaker, R. (1984). *The rainbow booklet*. Baltimore, MD: Renewing Visions Press.

Simon, R. (1981). "Bereavement art," *American journal of art therapy* (Vol. 20, July).

Stein, S. (1974). *About dying—for children and parents together*. NY: Walker and Company.

Temes, R. (1977). *Living with an empty chair*. NJ: Irvington Publishers.

The Master of Arts in Expressive Therapies.

Certificate of Advanced Graduate Study in Expressive Therapies.

. . . .

Offered by the Institute for the Arts and Human Development
Lesley College Graduate School.

For students interested in the creative modalities of art, music, dance/movement, drama, and holistic studies and healing arts presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning.

For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theater studies.

Lesley College Graduate School is pleased to announce a new Ph.D. Program in Expressive Therapies with a focus on higher education and professional leadership.

For more information call or write:
(617) 868-9600, ext. 480. Institute for the Arts and Human Development. Lesley College Graduate School, 29 Everett St., Cambridge, MA 02238

Lesley College
GRADUATE SCHOOL

Lesley College is accredited by the New England Association of Schools and Colleges and is an Equal Opportunity Employer.

BEST COPY AVAILABLE

"Utilizing Imagery and the Unconscious to Explore and Resolve the Trauma of Sexual Abuse"

Marsha Yates, B.S., *Art Education. Art Teacher at Convalescent Hospital for Children, a mental health center for emotionally disturbed children, adolescents and their families, Rochester, New York. Ms. Yates is also in the graduate art therapy program at Vermont College at Norwich University.* ***Kim Pawley, M.A., A.T.R.,*** *is a collaborator on this article. Ms. Pawley was previously an art therapist and coordinator of the Creative Art Therapy Department at Convalescent Hospital for Children in Rochester, New York, and currently is an art therapist at the Psychiatric Institute of Washington, D.C.*

This paper explores the process of eight months in which Martha was involved in psychotherapy. Several days following the sixth psychotherapy session, Martha created this book entitled "Spontaneous." It consisted of ten line drawings done with marker. This book was created without any conscious direction or thought, and the meaning was obscure to the client. However, the meaning became clearer as the psychotherapy process unfolded. "Spontaneous" was like a map, outlining the process which Martha needed to complete in order to resolve the issues of being sexually abused.

The author and collaborator have written the narrative as they have followed Martha Williams through an extended course of therapy. (Ed. Note: The name is a pseudonym for purposes of confidentiality, and the client is referred to as Martha in the article.) The client herself contributed most of the descriptive narrative that was reformatted by author Yates and collaborator Pawley. They worked with Martha using the book of personal drawings as the basic graphic image communication. The content was documented exactly as it was described by the client.

Prelude

This article explores the process covering eight months in which Martha was involved in psychotherapy. The artwork that was depicted early in the treatment process enabled her to directly deal with and eventually resolve feelings related to a history of sexual abuse. However, this was not the reason for the client's initial involvement in psychotherapy. For many years, the family could not or would not answer persistent questions regarding the mother or her death.

Martha was three and a half years old when her mother died of an embolism. The client hoped to recall unconscious visual and sensory memories of her through hypnosis and the process of psychotherapy.[1] During this process, Martha unexpectedly discovered that she had been sexually abused by a brother. Martha was first victimized at approximately age four, when the brother was twelve, and these sexual incidents continued until Martha was thirteen.

Within several days following the sixth psychotherapy session Martha created this book entitled "Spontaneous." This book was created spontaneously and without any conscious direction or thought. When the book was complete, the images, composition, and word placement were perfect, but the meaning was obscure. Through the process of psychotherapy, Martha felt certain she would understand the meaning of this book.

Martha now understands that "Spontaneous" was like a map, outlining the process which she needed to complete in order to resolve the issues of being sexually abused. She was unable to regain visual memories of her mother because the memories of sexual abuse strongly blocked access to them. Once Martha was able to acknowledge those horrifying memories, she was able to use hypnosis to recall the relationship with her mother and the emotional bond between them.

The following is a description of the client's visual images and process involved in creating "Spontaneous." Also included is her understanding of the meaning of the content of the book, which became clearer to her much later as the psychotherapy process unfolded.

Ambivalence about Exploring the Unconscious

Figure 1 spontaneously became the cover of the book. These are Martha's hands. Each hand reflects the different feelings that she had at the beginning of this process. One hand is opening and grasping, one hand is closed, and the other hand appears frightening. During the

---

[1] John Connolly, M.A. in Clinical Psychology. Psychotherapist in private practice in Rochester, New York.

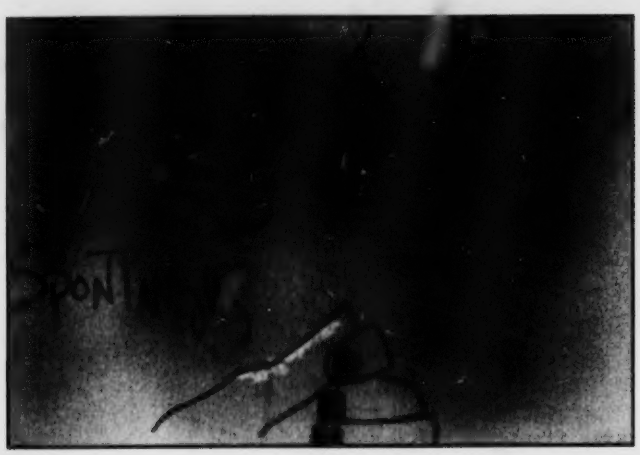


Fig. 1

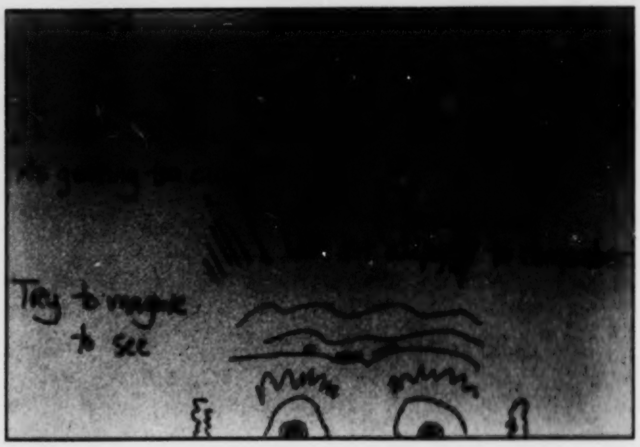


Fig. 2

Fig. 3

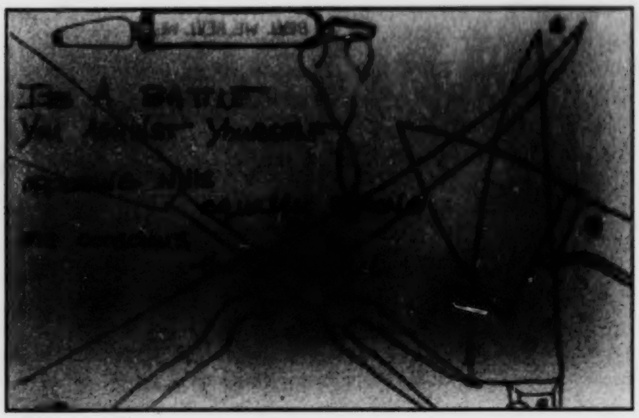


Fig. 4

early stages of psychotherapy, Martha simultaneously experienced the desire to know and understand, the need to withhold information from her conscious awareness, and the fear of knowing what she had repressed in her unconscious.

Figure 2 reflects the fear of remembering something sordid that was hidden in her unconscious. In this picture Martha was so terrified that her hair stands on end and she said "I can't look" at what is causing the fear. This image was cartoon-like and funny to Martha and she later realized that humor was an unconscious defense which reduced the intensity of feelings. Other images created in this book also appeared cartoon-like and humorous, which enabled her to tolerate the repressed rage.

Figure 3, the closed hand, represented a part of her that needed to restrain the memories and feelings with forceful determination. This was also frustrating, as Martha was also equally determined to know the truth about her past. During the first several weeks of psychotherapy, she experienced an intense need to restrain and constrict her feelings.

Reexperiencing the Past and Understanding the Source of Her Fears

Figure 4 continues to graphically exemplify her internal conflict: the will to remember against the terror of remembering. To illustrate the conflict Martha consciously chose conflicting colors of orange and blue,

"During the early states of psychotherapy, Martha simultaneously experienced the desire to know and understand, the need to withhold information from her conscious awareness, and the fear of knowing what she had repressed in her unconscious."

BEST COPY AVAILABLE

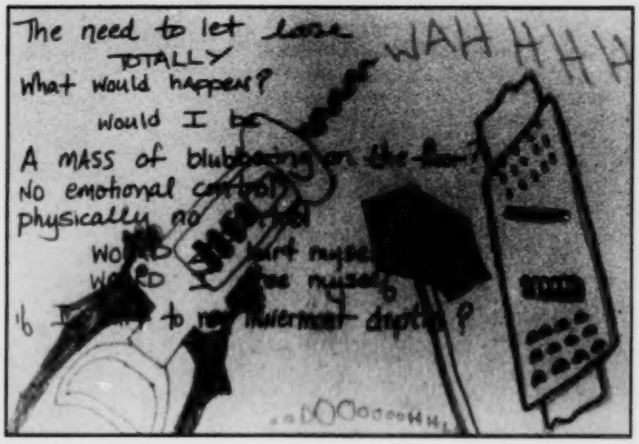


Fig. 5

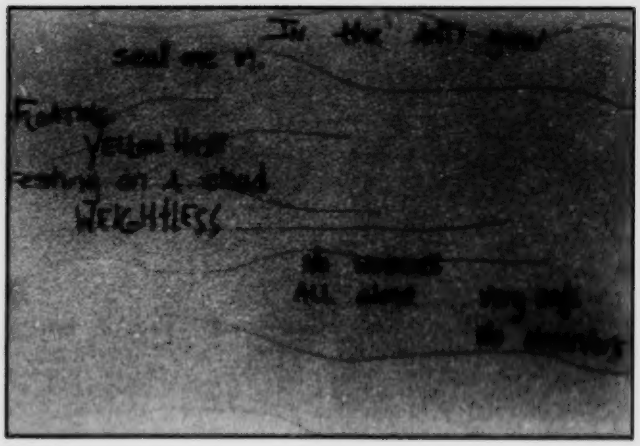


Fig. 6

as well as kitchen utensils and knives crossing each other. Martha had fears and fantasies that she would lose control if she allowed herself to explore the intensity of the feelings within. She imagined herself losing control on a linoleum floor in a kitchen as this would be the most painful and unsafe place.

Figure 4 also illustrates Martha's unconscious awareness of the sexual relationship between her brother and herself. However, Martha was not aware of the phallic content of the imagery until much later in the treatment process. After fourteen weeks of psychotherapy she began to wonder if she had been sexually abused during her childhood. Approximately three weeks later, Martha realized that she had definitely had a long-term sexual relationship with the brother. Upon later reflection of the imagery, Martha wondered if the words "beat me beat me" on the rolling pin reflected an unconscious perception that the sexual relationship with the brother may have been a form of punishment.

Author's Note:

I am uncertain of the meaning of the black hearts. The black heart on the handle of the knife may have reflected Martha's desire for a closeness with the brother. However, the history of incest would seem to have made that type of relationship impossible. Perhaps the other black heart on the outside of the images is a symbol for her dissociation which occurred during the sexual encounters. During these instances Martha would retreat to imaginary places in her mind in an attempt to distance herself. As the incest occurred consistently at night while she was sleeping, Martha often believed that she was experiencing a nightmare. Furthermore, when Martha attempted to tell her father about the incest he repeatedly stated: "It was a bad dream." In this new context the fear of night during her childhood and adolescence made sense.

Figure 5 illustrates Martha's fear of losing control and fear that the anger would overwhelm and engulf her. She was unaware of the phallic content of this imagery for many weeks. Later Martha realized that the imagery graphically exemplified the emotional trauma and suffering caused by the sexual abuse. Martha knew that she was afraid of experiencing rage at her brother. By the eighteenth psychotherapy session, Martha sensed that she must allow herself to feel the intensity of the rage within. She had denied the ongoing abuse as a child, consequently she reasoned that she must resolve this as an adult by allowing herself to feel what she had denied in the past. As Martha began to recall each of the sexual incidents in detail, she realized that she had a right to be angry, but continued to feel emotionally numb. At this point Martha was not able to experience the intensity of her own anger, for fear of losing control of it.

Integrating the Understanding

Figure 6 illustrated Martha's need to withdraw. The important phrases are "all alone," "no windows," and "no observers." The "anti-grav" meant antigravity chamber. This was an imaginary place in which her body could float. In the "anti-grav" Martha was safe to experience the intensity of her feelings. At approximately twenty-seven weeks of psychotherapy, Martha began an intense period of withdrawal from her close friends. She needed time to process the memories and experiences which had surfaced in psychotherapy. This period lasted about four weeks.

> ***"As Martha began to recall each of the sexual incidents in detail, she realized that she had a right to be angry, but continued to feel emotionally numb."***

BEST COPY AVAILABLE

"She sensed that she now was at liberty to explore and "discover" the depths of her unconscious, and that she had a greater capacity to reach her own creative potential."

Accepting Feelings

Figure 7 illustrated several different aspects of these feelings. This page answered the question "What would happen if I lost total self-control?" This image portrayed the feeling of being like a tightly wound coil. If the tension was released, the coil would unwind and spin uncontrollably.

This page also illustrated Martha's unconscious awareness of the confusion, emotional conflict, and physical twisting during the struggle of each sexual incident. Each time Martha recalled new memories of the sexual abuse during psychotherapy, she experienced the sensation of spinning, and relived the intense emotional conflict illustrated in this image.

Later Martha recalled that during each of the sexual encounters, she was aware that she could not cry out and must deny the reality of what was happening to her, despite the urge to struggle. Furthermore, she blamed herself, not only for not fighting back against the brother, but also because she had enjoyed the physical closeness to a certain extent. The crucial issue in therapy was to overcome her self-blame and guilt.

As a result of the incestuous relationship with the brother, Martha had learned that she must constantly repress, constrict, and constrain her emotions. In fact, no one had believed her when she shared the concerns about this relationship. Martha had learned to hide the secret, even from herself. She stored this enormous burden within herself, and it felt like a tightly wound coil, waiting to explode within her. This conflict greatly affected Martha's capacity for expressing herself completely, and resulted in the fear of losing control of her feelings.

Exploring New Methods of Control

Figure 8 illustrates the "dreamlike, happy, silly" mood that Martha imagined would be possible if she were able to let her emotions free. Martha realized after thirty weeks of psychotherapy that the full head figure with wings was herself, soaring. She felt that she could now transcend the denial of her feelings and perceptions as she had been taught at home. Having fully realized that the worst imaginable events were behind her, Martha felt as if she could handle anything, and that nothing would hold her back again. She sensed that she now was at liberty to explore and "discover" the depths of her unconscious, and that she had a greater capacity to reach her own creative potential.

Figure 9 illustrates a figure with movable limbs that are capable of twisting and turning full circle by the use of the reader's finger. This figure seemed to be the most humorous to her, yet she lacked any understanding about the entire page at the time of its completion, and for weeks afterward. Between the twentieth and thirtieth psychotherapy sessions, Martha no longer felt emotionally numb and began to feel the rage towards her brother. Martha was also angry at her father for not protecting her and denying the reality of the situation. Martha then realized that this figure represented that her body was manipulated and used for someone else's satisfaction.

Later in the psychotherapy process, other words on this page began to make sense to her. The phrase "backwards and up" is a reference to looking "backwards" in time at

Fig. 7

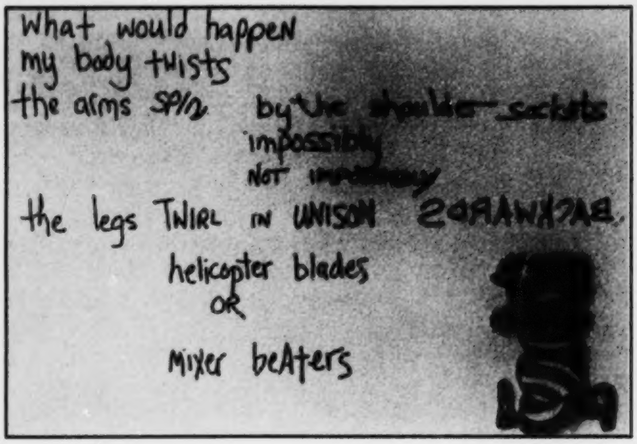
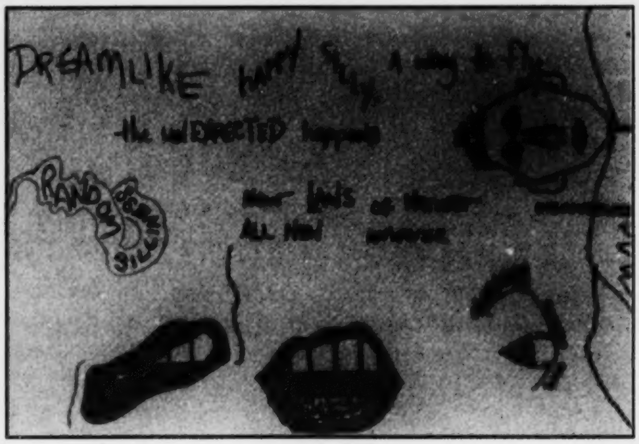


Fig. 8



BEST COPY AVAILABLE

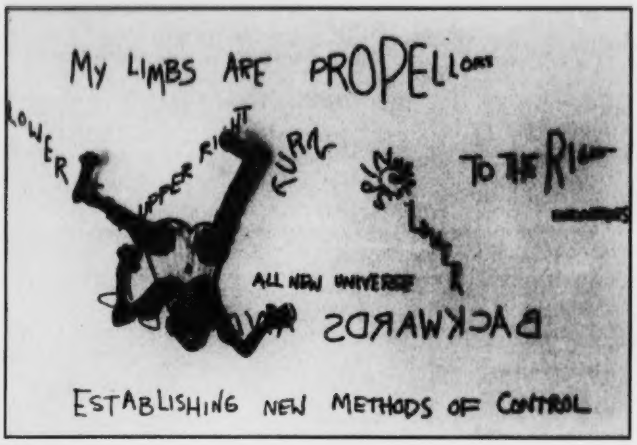


Fig. 9

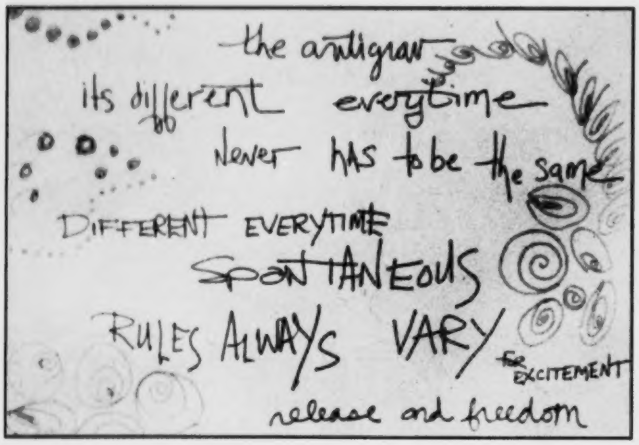


Fig. 10

her development and bringing "up" from her unconscious these new memories. "Establishing new methods of control" is a statement which expresses the directness and honesty with which Martha could now respond to her feelings, as opposed to the denial of them as the family taught. "To the right" is a response to a question that a co-therapist had asked in the sixth session—the one just prior to the completion of this book. He had asked: "On which side would you place the fear in your mind, and on which side would the memories of your mother belong?" It wasn't until the twenty-eighth session that Martha connected that her response to that question was also indicated on this page. Martha had stated that "the fear was on the left, and 'to the right' were 'discoveries' and memories of my mother." During the sixth session, Martha had indicated a need to explore separately and resolve the fears in her mind before she could explore the memories she sought of the mother. In fact, this was the progression of the subsequent psychotherapy sessions.

Redefining Relationships

Figure 10 was unclear to Martha at the time of rendering. At approximately the thirty-third psychotherapy session, Martha realized that the doodles represented changing patterns of responses to anger. At this time, Martha was able to overcome her fear of losing control of feelings and felt rage at both the brother and father in its totality. Martha now deals with anger more directly, rather than unconsciously denying it or using humor to suppress the anger. Martha feels more in control of her feelings.

Gradually Martha realized that she must choose between allowing herself to be furious with the brother and father, or continue to feel depressed and victimized. She realized that she needed to confront both the brother and the father and make them responsible, despite Martha's reluctance to do so.

Martha's brother was totally honest with her; he expressed his feelings of guilt, and a desire to undo the past between them. Martha was able to forgive him, her anger dissipated, and she felt that their relationship was strengthened.

Martha's father responded by acknowledging that there had been an incestuous relationship between the brother and her, but he said that he was not responsible for the brother's actions. The father did not remember Martha's attempts to tell him about the incest during the childhood years. Martha's feelings of intense unresolved anger resulted from his inability to listen to these concerns and protect her as a child. His constant reinforcement of a false reality, denial, and unwillingness to hear the truth seemed to be more psychologically damaging than the actual incest activity. Despite Martha's attempts to explain to her father about the suffering caused by his lack of response, he was unable to comprehend this, or acknowledge her resulting anger towards him. Martha grieved the death of the "good father" image that enabled her to survive for so many years. With great difficulty Martha has had to accept the inadequacies of her father, and his inability to understand her emotional needs. Throughout Martha's childhood, she had attributed this to the grief he was experiencing due to the death of Martha's mother.

Toward Resolution

The process described in "Spontaneous" began to unfold when Martha looked more deeply at her fears, questioned them, and remembered that she had been sexually abused throughout her childhood. Midway through the psychotherapy process, Martha also became involved in an adult therapy group for women who had been sexually abused as children.[2] Hearing other group members share their experiences enabled Martha to understand that her feelings and process towards resolution were common with the other group members. In addition, by reading on the topic of sexual abuse Martha had a greater understanding of the process of victimization.[3] Martha realized that she was not alone.

---

[2] *T.A.S.A.* Therapeutic Alternatives For Sexual Abuse. "Survivors Group" is a thirteen week program offered by Family Services of Rochester Inc.

By creating art and being involved in psychotherapy Martha learned about the healing process. She could not achieve new insights until she had completed each phase of the process. However, it was painful for her to scrutinize her thoughts and feelings during each phase and frustrating as she was anxious to complete the entire process.

During phase one Martha began to allow herself to use her unconscious to explore the feelings of her past. During phase two she began to reexperience the circumstances and trauma of the sexual abuse. During phase three she acknowledged the fears of losing control of feelings and understood the origin of these fears. During phase four Martha explored new methods of control and gained an increased capacity to express feelings. During phase five Martha acknowledged her rage and confronted those who had victimized her.

Through psychotherapy Martha learned how to gain access to her unconscious by using imagery during hypnosis and creating art. Rather than fear and repressing her unconscious, Martha learned that her unconscious is a reservoir of feelings and thoughts that she can use as a source for new imagery. Through this imagery, psychotherapy, and perseverence Martha has worked toward resolution of difficult emotional issues. As Martha states: "I have a new enthusiasm for creating art, and I will continue to explore the relationship between my unconscious and creative selves. It is through the knowledge of my unconscious and through expression in imagery that I have been healed."

Postscript

By collaborating with Martha on constructing this article, I achieved great insights into the power of art to reflect the unconscious. The artwork Martha created helped to clarify many conflicting feelings and helped her to more fully participate in the psychotherapy process. The artwork made in the early stages of psychotherapy and her description of the process helped me to be more sensitive to the client's struggle to overcome intense fears of the unconscious as they worked toward self understanding and emotional resolution.

I have learned to let the client lead the direction in treatment. I realize now how important it is to allow imagery to emerge spontaneously rather than pursue or persuade images to surface in an art form. It is also extremely important for the clients to find their own personal meaning for their art work at their own pace as they move through the treatment process. For Martha, the pages of her drawing book were not clear to her until the latter stages of her psychotherapy. Yet the meaning of her images will no doubt take on even more fuller meanings as she continues in her life. I now have great respect for the emotional defenses that impede on the treatment process, yet I have even more faith in the client's efforts to seek emotional growth.

Through our discussion and by observing the intensity of the art work she created, I better understand how the trauma of sexual abuse effects the individual's capacity to express him/herself freely and the ability to relate to others due to distorted self-perceptions. I now understand the feelings of self-guilt and blame which are, in part, due to the confliction desires for physical affection and feelings of repulsion and anger in the incestuous relationship. The client in treatment needs to have reality affirmed and conflicting feelings fully accepted and acknowledged.

The greatest gift I gained in collaborating on this article was to experience the emotional strength, courage and determination of this woman as she worked to overcome enormous obstacles and share her story with those who may learn from it.

KIM PAWLEY, MA, ATR
Collaborator

---

[3] Summit, Roland. (1982). *Women's sexual experience: Explorations of the dark continent.* (Martha Kirkpatrick, Ed.). New York: Plenum Press.

VIEWPOINTS

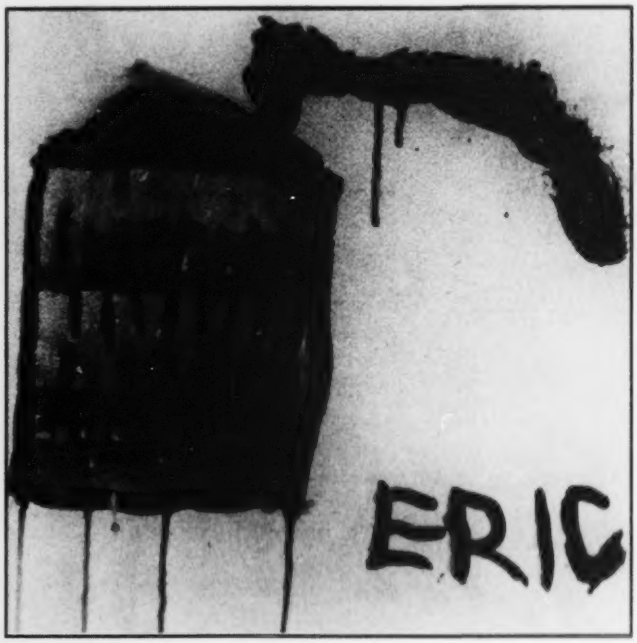


Fig. 1 Painting of "Where I Live." by 8 year old learning disabled boy

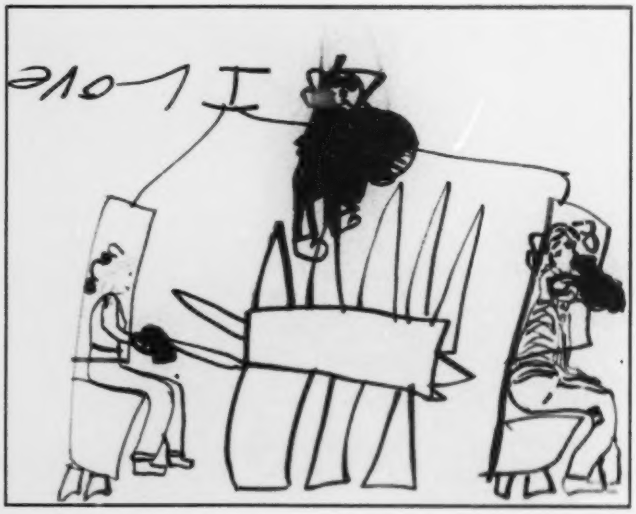


Fig. 2 Drawing of "My Family" by 10 year old girl severe behavior disorder

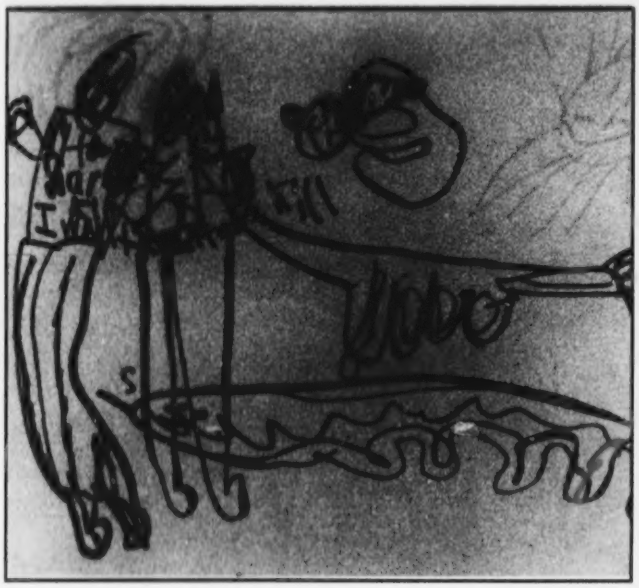


Fig. 3 Drawing of "Playing with My Friends" by 10 year old girl severe behavior disorder

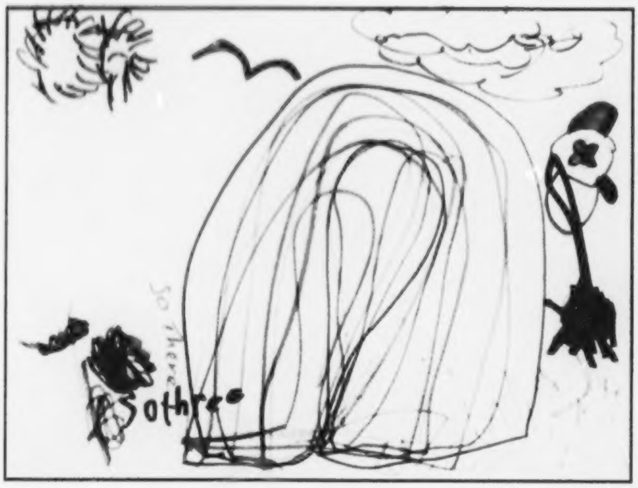


Fig. 4 Drawing of "What I Want to Draw" by 10 year old girl severe behavior disorder

Art Therapist's Portfolio

VIEWPOINTS** provides a forum for sharing ideas and graphics about issues facing art therapists. It also encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit black and white glossy photographs and four copies of the written material to:* ***Viewpoints, *ART THERAPY, 505 E. Hawley St., Mundelein, IL 60060.*

BEST COPY AVAILABLE

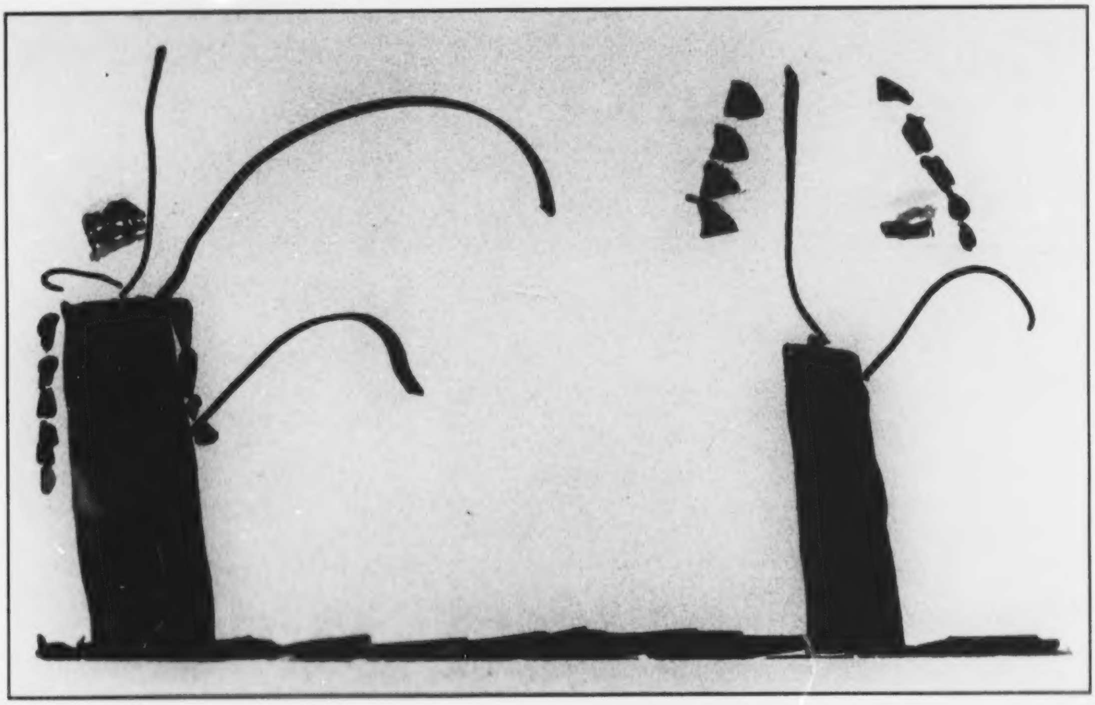


Fig. 5 Drawing of "Tree" by 13 year old male with an attention deficit disorder

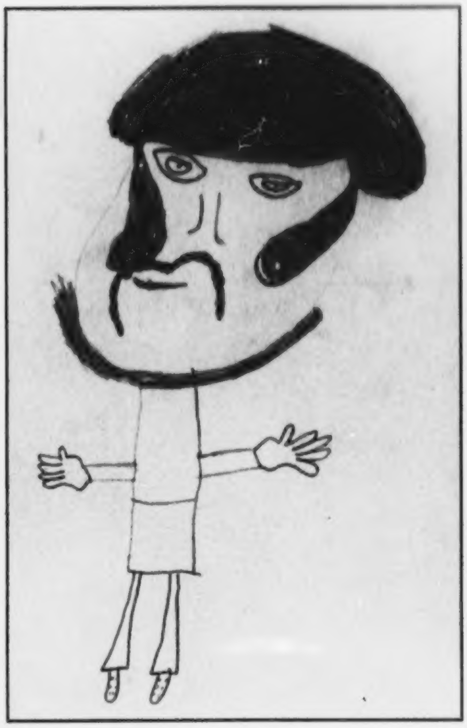


Fig. 6 Drawing of "Self-Portrait" by an adolescent male with self concept difficulties

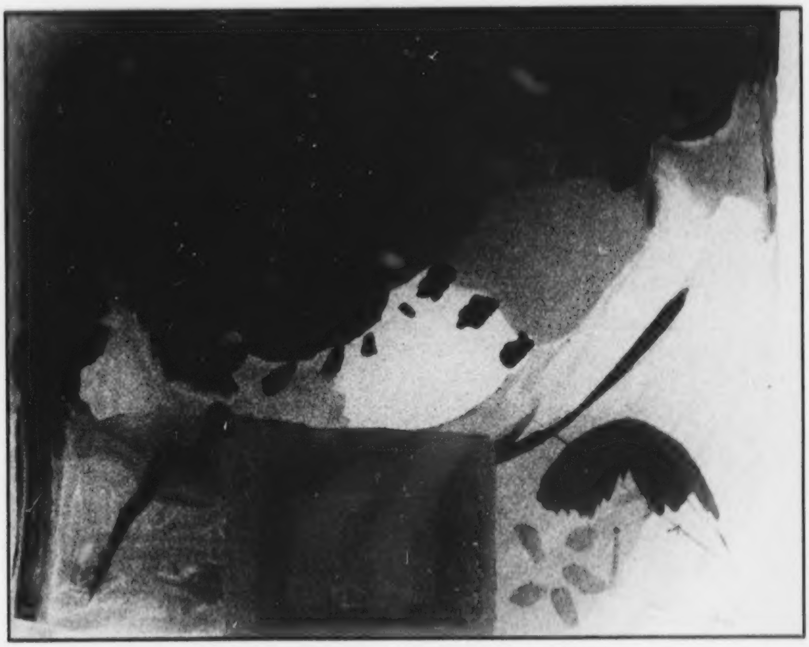


Fig. 7 A relaxation painting by an 11 year old female with a severe communication disorder

BEST COPY AVAILABLE

American Art Therapy Association, Inc.

"Coming of Age"

Los Angeles, California

November 12-16, 1986

ON AUDIOCASSETTES

Coming of Age was recorded by **InfoMedix**. The following is a list of the best selling audiocassettes. For a complete list contact **InfoMedix**. Please ✓ the box by the sessions you wish to order.

PROGRAM AS303

☐ **S303-1**	$9.00	**Presidents Address: Identity in the 90's,** S. Graves
☐ **S303-3**	$9.00	**Art Therapy in Drug Abuse Treatment Programs for the Adolescent,** K. Sly-Linton
☐ **S303-12AB**	$18.00 (2 tapes)	**PAPER: Art as Depth Psychology,** S. McNiff
☐ **S303-17**	$9.00	**Family Art Psychotherapy: A Systemic Approach to Change. Theory and Demonstrations Through Role Play,** S. Riley
☐ **S303-19**	$9.00	**The Use of Art Therapy in Strategic Family Therapy,** V. Fry Shaver
☐ **S303-21**	$9.00	**Short Term Inpatient Group Art Psychotherapy: New Directions,** B. Sprayregen
☐ **S303-30**	$9.00	**IND: The Art Therapist's Third Hand (Pictorial Communication and Intervention in Art Therapy),** E. Kramer
☐ **S303-32**	$9.00	**PAPER: Georgia O'Keefe, Themes and Resonances: An Art Therapist's Viewpoint,** M. Junge
☐ **S303-33AB**	$18.00 (2 tapes)	**GENERAL SESSION: The Alchemy of Creativity,** J. Shinoda Bolen
☐ **S303-35**	$9.00	**Gaining Mastery Over Victimization,** D. Spring
☐ **S303-36AB**	$18.00 (2 tapes)	**Effects of Psychological Trauma on Children,** S. Silverstein
☐ **S303-38**	$9.00	**The Sensibility of the Sensuous: Imagination and the Reality in Art Therapy,** H. McConeghey
☐ **S303-42**	$9.00	**A Method of Visualization Applied to the Treatment of Chronic Illness,** E. LaFlamme
☐ **S303-43**	$9.00	**Art Making as an Aid in Bereavement,** P. Buoye Allen
☐ **S303-46**	$9.00	**Hungry Love - An Art Therapy Treatment Approach with the Eating Disorder Patient,** I. Schlossberg
☐ **S303-47**	$9.00	**PAPER: Art Therapy as Primary Treatment for Co-Dependents: Alcoholism Outpatient Treatment,** D. Seger

Buy 6 Tapes
Get 1 Free!

☎ FOR FASTER SERVICE
Please have your credit card number ready and call
TOLL FREE 1 800 367-9286 (In California) 1 800 992-9286

☐ **Special Complete Set Price AS303: $136.00 Save 20%**

Total No. of Cassettes Ordered ________

Purchase orders accepted for purchases of $100.00 or more.

Orders outside U.S.: Add 10% surcharge of subtotal for additional shipping & handling

TOTAL PRICE: $ ________
SUB TOTAL: $ ________
SHIPPING & HANDLING: $ ________
Please enclose $1.00 for the 1st tape and $.50 for each additional tape for shipping and handling (maximum $7.00)
TOTAL AMOUNT ENCLOSED: $ ________

SHIP TO: NAME ________
ADDRESS ________
CITY ________ STATE ________ ZIP ________
Please Charge This To My Credit Card: VISA ☐ M.C. ☐ or A/E ☐ (minimum credit card order $25.00)
ACCT. NO. ________ CARD EXPIRATION DATE ________
Daytime phone ________
Signature ________

Please Allow 4 to 5 weeks for delivery

Make Checks Payable
and Mail Orders To

InfoMedix
EDUCATIONAL RESOURCES AND SERVICES

12800 Garden Grove Boulevard • Suite F • Garden Grove, California 92643

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

505 E. HAWLEY STREET
MUNDELEIN, ILLINOIS 60060
(312) 949-6064

RESOURCES

The American Art Therapy Association serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapists' Identity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: Journal of the American Art Therapy Association		

Rates: Individuals - U.S. $23.00; Foreign $30.00; Institutions - U.S. $27.00; Foreign $36.00

	Members	Non-Members
Art Therapy: Journal - Back Issues	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings Use of the Creative Arts on Therapy (1979)	$5.00	$7.00
National Art Education Association Journal: Special Issue Art Education, Vol 33, No. 4 (1980)	$3.00	$4.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 × 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

FILMS (Rental/Purchase)

		Members	Non-Members
Art Therapy: Beginnings (1977) 16mm. color/sound, 45 minutes	Rental:	$40.00	$50.00
	Purchase:	$300.00	$400.00
Michael (1977) 16mm. color/sound, 12 minutes	Rental:	$30.00	$35.00
Art Therapy (1981) 16mm. color/sound, 12 minutes	Rental:	$35.00	$45.00
	Purchase:	$250.00	$325.00
Lori, Art Therapy and Self Discovery (1978) 16mm. color/sound, 32 minutes	Rental:	$40.00	$50.00

ORDER FORM Make checks payable in U.S. funds to AATA, and mail to the above address

Indicate Quantity of Unit Items Below		Cost/Unit		Total
______________	( ) ×	______________	=	______________
______________	( ) ×	______________	=	______________
______________	( ) ×	______________	=	______________
______________	( ) ×	______________	=	______________
______________	( ) ×	______________	=	______________
		______________	=	______________
		Total Unit Costs	=	______________
		*Postage/Handling	=	______________

10 or more copies of any single issue: 15% discount on total cost.
Discounts are available when purchasing quantities.
Set of four Proceedings (consecutive years): 20% discount on total cost.

Note: for postage/handling, add $1.50 for the first unit item. $ .50 each additional unit.

Total Enclosed = ______________

Send To: ______________________________ MBR ID#: ________

____

City State Zip Code

8/86

ART + PSYCHOLOGY = ART THERAPY

Creative Counseling
Humanistic Orientation
Clinical, Educational
and Community Jobs

- The only Master of Art Therapy program in N. CA approved by AATA
- New Art Therapy Institute for professionals with Master's or Doctorate's
- Evening Classes—Convenient location

COLLEGE OF NOTRE DAME
GRADUATE SCHOOL
1500 Ralston Ave., Belmont, CA 94002

For further information
Call (415) 593-1606 or send for brochure

Name ______________________________ (s)

Address ______________________________

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, *ART THERAPY, Journal of the American Art Therapy Association*, discounts on publications, discount on admission to the annual conference, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (ATR). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA National Office.

Associate Membership shall be open to individuals interested in the therapeutic use of art wishing to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $50

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee. **Applications for student membership must be accompanied by a copy of current ID.**

Annual Dues: $35

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $100

Professional Membership is by application only and is open to individuals who have completed professional training in art therapy and who are or have been engaged in the therapeutic use of art. Professional members are eligible to participate in all activities of the Association and receive all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $75

Credentialed Professional Membership is by application only and is open to individuals who have met the qualifications and been approved for Professional Membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in Standards and Procedures for Registration. Professional members are eligible to participate in all activities of the Association and receive all official publications. A Credentialed Professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $80

Make checks payable to AATA

American Art Therapy Association, Inc.
505 E. Hawley Street
Mundelein, IL 60060
(312) 949-6064

NAME ____________________
LAST FIRST MIDDLE

PREFERRED MAILING ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ____________________

OTHER ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ____________________

TITLE ____________________

EMPLOYER ____________________
INDIVIDUAL OR INSTITUTION

HIGHEST EDUCATIONAL DEGREE ____________________

☐ $ 50 **Associate Membership**

☐ $ 35 **Student Membership**
(copy of current ID required)

☐ $100 **Contributing Membership**

☐ $ 75 **Professional Membership**
(by application only)

☐ $ 80 **Credentialed Professional Membership**
(by application only)

Payable in U.S. Dollars

Dues and expenses related to participation in AATA may be tax deductible as a business expense.

BEST COPY AVAILABLE

RETURN THIS APPLICATION WITH YOUR REMITTANCE

Guidelines for Authors

Please submit four (4) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed, ATR, Wright State University, Creative Arts Center, 228 Creative Arts Center, Dayton, OH 45435. Send manuscripts and illustrations certified mail, with return receipt requested. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 505 E. Hawley St., Mundelein, IL 60060

Please enter my subscription for 1987. Enclosed is my check, payable to AATA, for $23.
Name ______
Address ______
City ______ State ______ Zip ______

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

SPECIAL ISSUE — VOL. 14 NO. 1 1987

The USE of the CREATIVE ARTS THERAPIES in TREATMENT of SEXUALLY ABUSED CHILDREN and ADOLESCENTS

SUBSCRIBE NOW—AND SAVE 50% OR MORE!
SUBSCRIBERS OF *ART THERAPY* AND MEMBERS OF
THE AMERICAN ART THERAPY ASSOCIATION ENJOY REDUCED RATE! (See Coupon)

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS
Submit papers in triplicate to: The Managing Editor, Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583

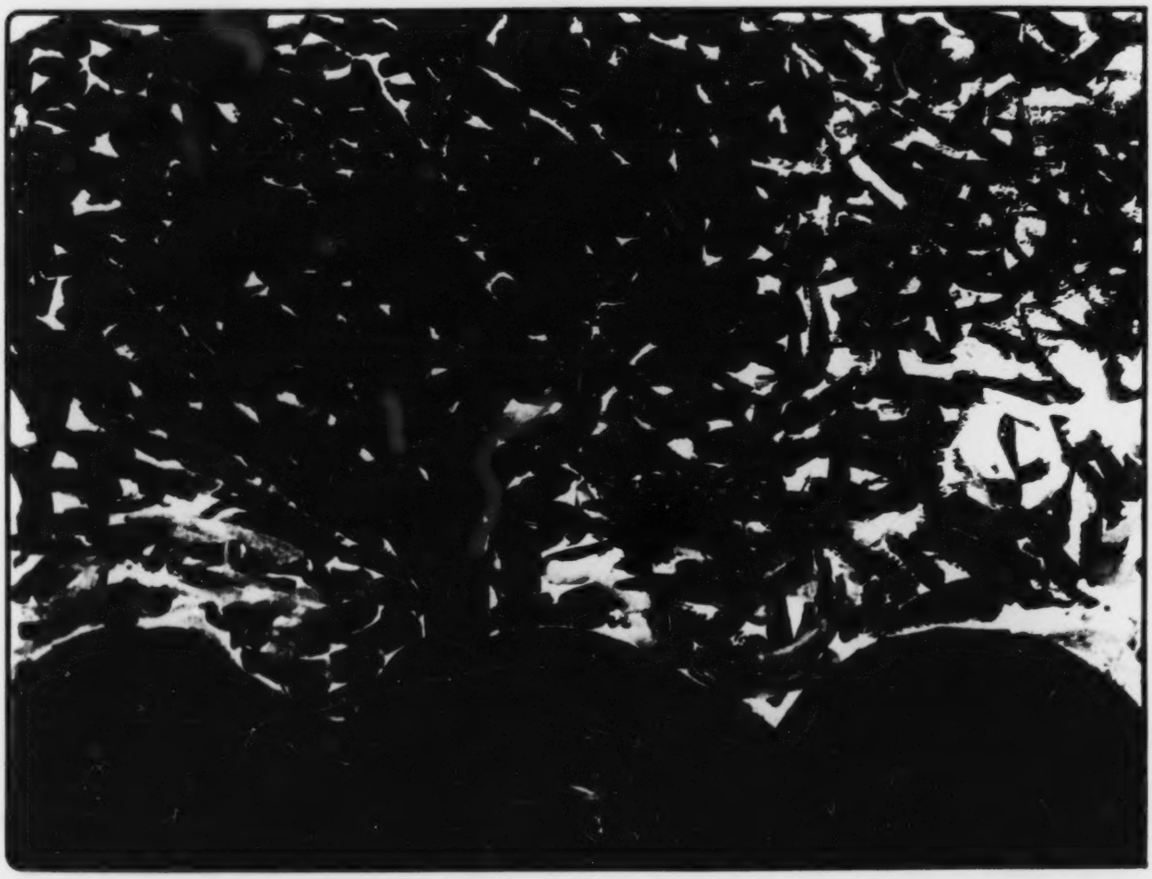
TO SUBSCRIBE, fill in coupon and mail now with proof of membership in AATA.

ANKHO International Inc., P.O. Box 426, Fayetteville, N.Y. 13066 AATA

Enter subscription for 1987 (Vol. 14) ☐; 1988 (Vol. 15) ☐.
Reduced rate $20 each volume (Regular rate for individuals $40) Students $15
Two volume subscriptions (Vol. 14, 1987 and Vol. 15, 1988) subject to additional discount: $36; Students $27.
Single copies special issue $10 each.
Prepayment required. Enclosed is check ☐
Name ______
Address ______
City ______ State ______ Zip ______

ART THERAPY

Journal of the American Art Therapy Association



Volume 4, Number 2 July 1987

- Art Therapy Education Program Listing, 1987
- Art Assessment with the Handicapped: Clinical, Aesthetic, and Ethical Considerations
  David R. Henley, MA, ATR
- Sex Differences in the Emotional Content of Drawings
  Rawley Silver, EdD, ATR, HLM
- Graphic Characteristics on the Draw-A-Person Test for Identification of Physical Abuse
  Frances M. Culbertson and Anna C. Revel

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1985-1987

Board of Trustees

President
Sandra L. Graves, PhD, ATR

President-Elect
Cay Drachnik, MA, ATR, MFCC

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, MA, ATR

Committee Chairs

Affiliate Societies
Virgil Matheny, ATR

Bylaws
Roberta J.H. Shoemaker, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Bobbi Stoll, MS, MFCC, ATR

Publications
Harriet Wadeson, PhD, ATR

Research
Linda Gantt, MA, ATR

Standards
Ronald E. Hays, MS, ATR

Executive Director

Edward J. Stygar, Jr.

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, EdD, ATR 50

Articles

Art Therapy Education Program Listing, 1987 52
Art Assessment with the Handicapped: Clinical, Aesthetic, and Ethical Considerations
David R. Henley, MA, ATR 57
Sex Differences in the Emotional Content of Drawings
Rawley Silver, EdD, ATR, HLM 67
Graphic Characteristics on the Draw-A-Person Test for Identification of Physical Abuse
Frances M. Culbertson and Anna C. Revel 78

Reviews

Educating the Creative Arts Therapist: A Profile of the Profession
Shaun McNiff, PhD, ATR
Irene Corbit, PhD, ATR 84
The Artist As Therapist
Arthur Robbins, EdD, ATR
Gary C. Barlow, EdD, ATR 85

Viewpoints

Art Therapist's Portfolio
Sarah Cannon 88

About Our Cover

"Summer Tree," a painting by an adult male in a mental health center.

Volume 4, Number 2 July 1987

Copyright © 1987
American Art Therapy Association

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Sharon Purtell

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Anthony Kowalski, MD
Susan LaMantia O'Connor, MA, ATR
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064

BEST COPY AVAILABLE

EDITORIAL

Welcome to summer! Many of you are looking forward to the long-awaited vacation, even though it goes much too quickly. A book that you might want to take with you is one that has once again come to my attention. It is a short paperback (only 80 pages) but it is a sensitive, moving description about a summer camp for handicapped children—a true story of how dying youngsters became kings, pirates, mountain climbers, and anything their imaginations could let them become. Ron Jones true story is a moving, haunting story that will stay with you for a long time. *The Acorn People,* by Ron Jones, (1985) is published by Bantam Books, Inc., 666 Fifth Avenue, New York, N.Y. 10103. The cost if $2.50 plus postage.

Articles in this issue focus on research, specific assessments, and work with different populations with varying emotional or physical conditions. "Graphic Characteristics on the Draw-A-Person Test for Identification of Physical Abuse," by Frances M. Culbertson and Anna C. Revel, uses the DAP and the Wechsler Intelligence for Children to identify characteristics of physically abused children. As the authors state, "The utility of psychological assessment data providing probability statements or inferences of physical abuse in children has been minimally researched" (see Introduction to the article). Their study utilizes three groups of students: physically abused children who are learning disabled or emotionally disturbed; non-abused learning disabled children; and non-abused emotionally disturbed children. All children were given complete assessment batteries, and standard scores were obtained. Readers should find the results, in various categorical classifications, interesting and stimulating for further research and study, as well as focusing on some of the intricacies of the content.

Rawley Silver presents an article titled "Sex Differences in the Emotional Content of Drawings." Her study focused on the possible differences that may exist relative to sex or age in the expression of emotions in particular drawings completed by the subjects. As Silver states, "This study was an attempt to verify and/or amplify preliminary findings . . . by using larger and more diverse populations coupled with a more controlled research design" (see Introduction to the article). Drawings were completed by boys and girls, women and men, from the Stimulus Drawings (previously published by Silver). Significant differences were found, and from an overview of the findings, the author presents a composite male description and a composite female description. The author asks some very important questions at the close of the article that might "spur us on" to continued important research using Silver's study as a foundation on which to continue. Silver, in fact, states that "These questions suggest that further research with larger and more diverse populations is worthwhile and necessary in order to build up on the knowledge already obtained" (see Discussion section).

David R. Henley's article, "Art Assessment with the Handicapped: Clinical, Aesthetic, and Ethical considerations," asks the reader to take a close, intense look at assessment methods in non-traditional settings (such as schools and agencies that provide services for the handicapped person). He explores problems of interpretive assessment as it is used with the physically and mentally handicapped person, and offers ". . . case studies . . . chosen for their enigmatic and contradictory content. . . ." (see Abstract). The author raises questions, identifies possible areas of controversy, and asks some hard questions. The historical importance of Viktor Lowenfeld (who raised the issue of the distinction between the diagnosed handicap and the emotional response to the disabling condition) serves as a foundation for the author's premises, and specific reference is given to a case as described by Emanual Hammer. Case descriptions are presented, followed by a discussion and concluding remarks. David Henley, throughout his article, supports the premise that we should adopt a restrained, cautious approach when interpreting client or patient art work; this approach seems to be important for any art therapist to consider, but especially those who are—or will be—working with the populations described by the author.

The reader of *Art Therapy* may wish to re-read previous book reviews that pertain specifically to content contained in articles in this issue. For example, a review of *The Lowenfeld Lectures: Viktor Lowenfeld on Art Education and Therapy* was published in the July, 1986 issue (Volume 3, Number 2), and the *Silver Drawing Test of Cognitive and Creative Skills* appeared as a review in the March, 1985 issue (Volume 2, Number 1). An article, "The Stimulus Drawing Technique with Adult Psychiatric Patients, Stroke Patients, and in Adolescent Art Therapy," by Sandburg, Silver and Vilstrup is included in the October, 1984 issue (Volume 1, Number 3).

Congratulations are in order for our illustrious professional "Art Therapist/Authors" who have had new books published within the last year or two. Their contributions serve to build knowledge and give insight in our field of professional work, and their books are certainly welcome additions to our literature. Myra Levick's book *Mommy, Daddy, Look What I'm Saying: What Children Are Telling You Through Their Art* was reviewed in the November, 1986 (Volume 3, Number 3) issue of *Art Therapy*, and Shaun McNiff's book *Educating the Creative Arts Therapist, A Profile of the Profession* (1986) is reviewed in this issue. Helen Landgarten has a new book titled *Family Art Therapy*, published by Brunner/Mazel, and will be on the market this summer. *The Artist As Therapist* (1987) by Arthur Robbins is reviewed in this issue of *Art Therapy*. Two additional books have just arrived on my desk, and will be reviewed in a future issue of *Art Therapy*. One is by Harriet Wadeson, and is titled *The Dynamics of Art Psychotherapy* (1987), published by John Wiley & Sons, and the other is *Approaches to Art Therapy, Theory and Technique* (1987, Brunner/Mazel) by Judith Rubin. These are just a few of the writers in art therapy who are active in publishing and, although it may sound meager or insufficient, my "thanks" to all of you is sincere and appreciative for the contribution that you are making.

Let's all plan to attend the National Conference in Miami, Florida. The theme is "New Directions in the '80's," and it should not only be a good series of meetings, but the locale is also inviting. Look for information elsewhere in this issue, as well as in our *Newsletter* and other special mailings.

Let me hear from you. Are there any potential authors of articles out there who need help in finalizing the draft of an article prior to submission for review? Do you need advice, or specific information? I'll be happy to talk with you by telephone, or drop a note to me requesting the information.

Gary C. Barlow, Ed.D., ATR
Editor, Art Therapy

Journal Associate Editor Sought

The Executive Board at its fall meeting determined that an Associate Editor of **Art Therapy,** AATA's journal, be sought. The responsibilities of the Associate Editor will be to assist Editor Gary Barlow. Since the Journal has not had an Associate Editor previously, the new Associate Editor will work with the Editor in current editorial practices, as well as further defining the duties of the position. Gary Barlow has been reappointed as Editor for a second term of four years beginning November 1987. It is anticipated that the Associate Editor may assume the Editor position in 1991.

If you are interested in applying for the Associate Editor position, please send a copy of the following to Harriet Wadeson, Publications Chair, and to Gary Barlow, Editor:

1. Resume
2. Writing sample
3. Statement of interest, including relevant background and qualifications as well as ideas for development of the Journal.

Contact Gary Barlow if you have questions regarding the editorial responsibilities in producing the Journal.

WRIGHT
STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

The American Art Therapy Association, Inc.

ART THERAPY EDUCATION PROGRAM LISTINGS
1987

Guidelines for Art Therapy Training are available from the AATA National Office

AATA APPROVED PROGRAMS*

The following constitute a list of graduate level training programs that have applied and received approval of the Association. Approved programs have met the standards set forth in the Guidelines for Academic, Clinical, and Institute Art Therapy Training. Approval of Programs must be renewed annually.

*Approved as of 5/87

GRADUATE DEGREE PROGRAMS:

COLLEGE OF NEW ROCHELLE, initial approval 10/84; Contact: Patricia A. St. John, EdD, ATR, Director, Graduate Art Programs, New Rochelle, NY 10805, (914) 654-5279. MS in Art Therapy.

COLLEGE OF NOTRE DAME, initial approval 10/85; Contact: Doris Arrington, EdD, ATR, Graduate Dept. of Art Therapy, Belmont, CA 94002, (415) 593-1601. ATM in Art Therapy.

EASTERN VIRGINIA MEDICAL SCHOOL, initial approval 10/84; Contact: Masters Program in Art Therapy, P.O. Box 1980, Norfolk, VA 23501, (804) 446-5157. MS in Art Therapy.

GEORGE WASHINGTON UNIVERSITY, initial approval 10/79; Contact: Katherine J. Williams, MA, ATR, Director, 2129 G Street, Building L, Washington, DC 20052, (202) 994-6285. MA in Art Therapy.

HAHNEMANN UNIVERSITY, initial approval 10/79; Contact: Ronald E. Hays, MS, ATR, Director, or Myra Levick, PhD, ATR, HLM, Creative Arts In Therapy Program, Broad & Vine, M.S. 424, Philadelphia, PA 19102-1192, (215) 448-8076. Masters of Creative Arts in Therapy – Art Therapy (MCAT).

HOFSTRA UNIVERSITY, initial approval 10/84; Contact: Lillian C. Resnick, ATR, Coordinator, Creative Arts Therapy Program, Department of Counseling, Psychology & Research in Education, Hempstead, NY 11550, (516) 560-5755. MA in Creative Arts Therapy.

LESLEY COLLEGE, initial approval 5/82; Contact: Shaun McNiff, PhD, ATR, Director, Lesley College Graduate School Arts Institute, 29 Everett Street, Cambridge, MA 02238, (617) 868-9600. MA in Expressive Therapies.

LOYOLA MARYMOUNT UNIVERSITY, initial approval 10/79 at Immaculate Heart College; Contact: Helen Landgarten, ATR, HLM, MFCC, Director, Graduate Department of Clinical Art Therapy, 7101 West 80th Street, Los Angeles, CA 90045, (213) 642-4562. MA in Clinical Art Therapy.

MARYWOOD COLLEGE, initial approval 11/86; Contact: Sr. Dorothy McLaughlin, RSM, EdD, ATR, Art Department, Scranton, PA 18509, (717) 348-6211. MA in Art Therapy.

NEW YORK UNIVERSITY, initial approval 10/79; Contact: Laurie Wilson, PhD, ATR, Art Department, 735 East Building, 239 Greene Street, New York, NY 10003, (212) 598-3481. MA in Art Therapy.

PRATT INSTITUTE, initial approval 10/80; Contact: Leslie Abrams, MPS, ATR, 200 Willoughby Ave., 3rd Floor East Building, Brooklyn, NY 11205-3897, (718) 636-3428. Master of Professional Studies in Art Therapy (MPS).

STATE UNIVERSITY COLLEGE AT BUFFALO, initial approval 4/82; Contact: Lucy Andrus, MS, ATR, Coordinator, Art Therapy Studies, Art Education Department, BI 108, 1300 Elmwood Avenue, Buffalo, NY 14222, (716) 878-5721. MA or MS in Multidisciplinary Studies (Art Therapy).

UNIVERSITY OF ILLINOIS AT CHICAGO, initial approval 2/85; Contact: Harriet Wadeson, PhD, ATR, Art Therapy Department, School of Art and Design, Box 4348, Chicago, IL 60608, (312) 413-2328. MA in Art Therapy.

UNIVERSITY OF LOUISVILLE, initial approval 5/81; Contact: Vija B. Lusebrink, PhD, ATR, Director, Department of Expressive Therapies, Belknap Campus, Louisville, KY 40292, (502) 588-5265. MA in Art Therapy.

"ATR®" is defined as an Active Registered Art Therapist with the American Art Therapy Association, Inc.

VERMONT COLLEGE OF NORWICH UNIVERSITY, initial approval 10/79 at Goddard College; Contact: Gladys Agell, PhD, ATR, Director. M.A. Program in Art Therapy, Montpelier, VT 05602, (802) 223-8810. MA in Art Therapy.

WRIGHT STATE UNIVERSITY, initial approval 11/81; Contact: Gary C. Barlow, EdD, ATR, Director of Art Therapy, 228 Creative Arts Center, Dayton, OH 45435, (513) 873-2758. Master of Art Therapy (MAT).

CLINICAL TRAINING PROGRAM:

HARDING HOSPITAL, initial approval 11/86; Contact: Don Jones, ATR, LM, Director, Adjunctive Therapy, 445 East Granville Road, Worthington, OH 43085, (614) 885-5381. Certificate in Art Psychotherapy.

OTHER EDUCATIONAL OPPORTUNITIES

The following programs submitted information to AATA indicating their coursework offerings in art therapy. The Association does not endorse programs other than Approved Programs and the entries below are listed **for informational purposes only.**

It is recommended that interested persons contact program personnel directly for further information and, in addition, review AATA's Guidelines for Academic, Clinical and Institute Art Therapy Training.

DOCTORATE PROGRAMS:

HAHNEMANN UNIVERSITY, Contact: Ronald E. Hays, MS, ATR, Creative Arts In Therapy Program, Broad & Vine Street, M.S. 424, Philadelphia, PA 19102-1192, (215) 448-8076. PsyD or PhD in Clinical Psychology with specialization in Creative Arts In Therapy.

ILLINOIS STATE UNIVERSITY, Contact: Dr. Marilyn Newby, Art Department, Normal, IL 61761, (309) 438-5621. EdD with emphasis in Art Therapy.

LESLEY COLLEGE, Contact: Shaun McNiff, PhD, ATR, Dean, Institute for the Arts and Human Development, 29 Everett Street, Cambridge, MA 02238, (618) 868-9600. PhD in Expressive Therapies.

NEW YORK UNIVERSITY, Contact: Laurie Wilson, PhD, ATR, Art Department, 735 East Building, 239 Greene Street, New York, NY 10003, (212) 598-3481. DA and PhD in Art Therapy.

GRADUATE DEGREE PROGRAMS:

ANTIOCH UNIVERSITY–SEATTLE, Contact: Prof. Lea Camero, ATR, 1165 Eastlake East, Seattle, WA 98109, (206) 343-9150 ext. 13. MA in Psychology with a concentration in Art Therapy or Creative Arts Therapies.

CALIFORNIA STATE UNIVERSITY–LOS ANGELES, Contact: Dr. Robert D. Reeser, Art Department, 5151 State University Drive, Los Angeles, CA 90032, (213) 224-3521. MA in Art with a specialization in Art Therapy.

CALIFORNIA STATE UNIVERSITY–SACRAMENTO, Contact: Counselor Education Program Coordinator, EDCAPS, 6000 J Street, Sacramento, CA 95819, (916) 278-6310. MS in Counseling with an Art Therapy Study Area.

CONCORDIA UNIVERSITY, Contact: Julia Byers, MA, ATR, Department of Art Education and Art Therapy, 1455 de Maisonneuve Blvd. West, Montreal, Quebec, Canada, H3G 1M8, (514) 848-4641. MA in Art Education with an emphasis of Art in Therapy and Diploma program in Art Therapy.

DRAKE UNIVERSITY, Contact: Jeanette Wright, MST, ATR, College of Arts and Sciences, Des Moines, IA 50311, (515) 271-2863. MS in Professional Studies with a concentration in Art Therapy.

EMPORIA STATE UNIVERSITY, Contact: Robert E. Ault, ATR, HLM, Division of Psychology and Special Education, 1200 Commercial, Emporia, KS 66801-5087, (316) 343-1200. MS in Art Therapy.

HOFSTRA UNIVERSITY, Contact: Lillian C. Resnick, ATR, Coordinator, Department of Counseling, Psychology and Research in Education, Mason Hall 212, Hempstead, NY 11550, (516) 560-5752. MS in Special Education and Art Therapy.

ILLINOIS STATE UNIVERSITY, Contact: Dr. Marilyn Newby, Art Department, Normal, IL 61761, (309) 438-5621. MA in Art Education with an emphasis in Art Therapy.

LONG ISLAND UNIVERSITY, Contact: Jacqueline Stern-Einzig, ATR, CRT, C. W. Post Campus, Art Department, Greenvale, NY 11548, (516) 299-2464. MA in Clinical Art Therapy.

MARYLHURST COLLEGE, Contact: Christine Turner, ATR, P.O. Box 261, Marylhurst, OR 97036, (503) 636-8141. MA in Art Therapy.

NORTHERN ILLINOIS UNIVERSITY, Contact: Terri L. Sweig, MA, ATR, Department of Art, Visual Arts Building Room 216, DeKalb, IL 60115-2883, (815) 753-1473. MS in Education, Major in Art with a specialization in Art Therapy.

NOTRE DAME COLLEGE, Contact: Judith Gerber, EdD, ATR, Codirector, Graduate Division Office, 2321 Elm Street, Manchester, NH 03104, (603) 669-4298. MEd in Counseling with a specialization in Art Therapy.

"ATR®" is defined as an Active Registered Art Therapist with the American Art Therapy Association, Inc.

BEST COPY AVAILABLE

The following programs submitted information to AATA indicating their coursework offerings in art therapy. The Association does not endorse programs other than Approved Programs and the entries below are listed **for informational purposes only.**

It is recommended that interested persons contact program personnel directly for further information and, in addition, review AATA's Guidelines for Academic, Clinical and Institute Art Therapy Training.

SCHOOL OF THE ART INSTITUTE OF CHICAGO, Contact: Don Seiden, ATR, Columbus and Jackson, Chicago, IL 60603, (312) 443-3775. MA in Art Therapy (MAAT).

SOUTHERN ILLINOIS UNIVERSITY AT EDWARDSVILLE, Contact: Dr. Joseph A. Weber, Art Therapy Area, Department of Art and Design, Campus Box 1764, Edwardsville, IL 62026-1764, (618) 692-3183. MFA with a specialization in Art Therapy.

UNIVERSITY OF NEW MEXICO, Contact: Howard McConeghey, EdD, Department of Art Education, Albuquerque, NM 87131, (505) 277-4112. MA in Art Education with an emphasis in Art Therapy.

UNIVERSITY OF UTAH, Contact: Cathy A. Malchiodi, ATR, AAC 161, Salt Lake City, UT 84112, (801) 581-8677. MA in Art Therapy.

UNIVERSITY OF WISCONSIN–SUPERIOR, Contact: Susan Elizabeth Loonsk, ATR, Superior, WI 54880, (715) 394-8391. MA in Art Therapy.

URSULINE COLLEGE, Contact: Sr. Kathleen Burke, PhD, ATR, or Richard Rule-Hoffman, MA, ATR, 2550 Lander Road, Cleveland, OH 44124, (216) 449-4200, ext. 273, 275. MA in Art Therapy.

CLINICAL TRAINING PROGRAMS:

HILLSIDE CHILDREN'S CENTER, Contact: Ellen G. Horovitz, MA, ATR, Coordinator of Art Therapy, 1183 Monroe Avenue, Rochester, NY 14620-1699, (716) 473-5150.

MILWAUKEE PSYCHIATRIC HOSPITAL, Contact: Rose Washington, 1220 Dewey Avenue, Wauwatosa, WI 53213, (414) 258-2600.

INSTITUTE TRAINING PROGRAMS:

INSTITUTE FOR EXPRESSIVE ANALYSIS, Contact: Dr. Arthur Robbins, 325 West End Avenue, New York, NY 10023, (212) 877-7384.

MATRIX, Contact: JoEl Vogt, MA, ATR, Art Therapy Institute Program, 7447 Holmes Road, Kansas City, MO 64131, (816) 363-3313. Certificate.

MONTCLAIR CENTER FOR PSYCHODRAMA AND PSYCHOTHERAPY, Contact: Harriet Power, MA, ATR, Director of Art Therapy, 6 South Fullerton Avenue, Montclair, NJ 07042, (201) 746-6928.

MOUNT MARY COLLEGE–ART THERAPY INSTITUTE, Contact: Lynn Kapitan, MPS, ATR, 2900 Menomonee River Parkway, Milwaukee, WI 53222, (414) 258-4810. Certificate of Professional Training.

PHOENIX ART THERAPY INSTITUTE, Contact: Krista Raudzens, MA, ATR, or Eugenia Sutcliffe, ATR, 225 West University #103, Tempe, AZ 85006, (602) 968-1567. Diploma.

ST. LOUIS INSTITUTE OF ART PSYCHOTHERAPY, Contact: Mary N. St. Clair, MAT, ATR, 16 Columbus Square Drive, St. Louis, MO 63101, (314) 621-4234. Certificate in Art Psychotherapy.

THE NEW ENGLAND ART THERAPY INSTITUTE, Contact: Dale Robin Schwarz, MEd, ATR, 216 South Silver Lane, Sunderland, MA 01375, (413) 665-3288. Certificate.

THE NORTHWEST INSTITUTE FOR THE CREATIVE ARTS THERAPIES, Contact: Leigh Files, MEd, MA, ATR, 1430 Pearl Street, Eugene, OR 97401, (503) 683-4483. Graduate Level Certificate.

THOMAS MERTON INSTITUTE, Contact: Deirdre Lee Kozlowski, MS, ATR, P.O. Box 11931, Shorewood, WI 53211, (414) 963-8028; or Virginia Shaver, MA, St. Stephen's Center, 516 School Street, Anoka, MN 55303, (612) 427-7678. Diploma.

TORONTO ART THERAPY INSTITUTE, 216 St. Clair Avenue W., Toronto, Ontario, Canada, M4V 1R2, (416) 921-4374. Diploma.

VANCOUVER ART THERAPY INSTITUTE, Contact: Lois Woolf, B.Arch., DTATI, ATR, 1410 B Clyde Avenue, West Vancouver, British Columbia, Canada, V7T 1B9, (604) 926-9381. Certificate.

GRADUATE LEVEL CERTIFICATE/ DIPLOMA PROGRAMS:

ATIRA ART THERAPY PROGRAM, Contact: Evadne McNeil, PhD, ATR, Oasis Center, 7463 North Sheridan Road, Chicago, IL 60626, (312) 274-6777. Post-Graduate Certificate. Independent Study.

BETHESDA HOSPITAL, Contact: John Barger, ATR, Art Psychotherapy Department, 2951 Maple Avenue, Zanesville, OH 43701, (614) 454-4000. Certificate.

BRITISH COLUMBIA SCHOOL OF ART THERAPY, Contact: Kathleen G. Collis, MA, ATR, 1931 Lee Avenue, Victoria, British Columbia, Canada, V8R 4W9, (604) 598-6434. Diploma.

CALIFORNIA COLLEGE OF ARTS AND CRAFTS, Contact: Kenneth Davids, Director of General Education, or Janet K. Long, MA, MFCC, 5212 Broadway at College, Oakland, CA 94618, (415) 653-8118. Certificate.

"ATR®" is defined as an Active Registered Art Therapist with the American Art Therapy Association, Inc.

The following programs submitted information to AATA indicating their coursework offerings in art therapy. The Association does not endorse programs other than Approved Programs and the entries below are listed **for informational purposes only.**

It is recommended that interested persons contact program personnel directly for further information and, in addition, review AATA's Guidelines for Academic, Clinical and Institute Art Therapy Training.

CARRIER FOUNDATION, Contact: Iris Schlossberg, MPS, ATR, Allied Clinical Therapies Department, Belle Meade, NJ 08502, (201) 874-4000.

PRATT INSTITUTE, Summer Institute, Contact: Leslie Abrams, MPS, ATR, 200 Willoughby Ave., 3rd Floor East Building, Brooklyn, NY 11205, (718) 636-3428. Certificate.

UNIVERSITY OF LONDON–GOLDSMITHS COLLEGE, Contact: Diane Waller, MA, RATh, Art Therapy Unit, 27 Albury Street, London, England, SE8 3PT, 01-692-1424. Diploma: Educational or Clinical.

UNIVERSITY OF WESTERN ONTARIO, Contact: Sarie E. Mai, RN, RMid, ATR, Department of Continuing Education, 1561 Gloucester Road, London, Ontario, Canada, N6G 2S5, (519) 672-9005.

WAYNE STATE UNIVERSITY, Contact: Dr. Arthur Park, 163 Community Arts Building, Detroit, MI 48202. Certificate.

UNDERGRADUATE DEGREE PROGRAMS OFFERING ART THERAPY PREREQUISITES:

See Guidelines Regarding Undergraduate Training

ALVERNO COLLEGE, Contact: S. Julie Knotek, ATR, 3401 S. 39th Street, Milwaukee, WI 53215, (414) 382-6146. BA in Art Ed/Art Therapy.

ANNA MARIA COLLEGE, Contact: Ralph A. Parente, Paxton, MA 01612, (617) 757-4586. BFA in Art Therapy.

BOWLING GREEN STATE UNIVERSITY, Contact: Michael Franklin, MA, ATR, School of Art, Bowling Green, OH 43403, (419) 372-2786. BS in Art Therapy.

CALIFORNIA COLLEGE OF ARTS AND CRAFTS, Contact: Janet K. Long, MA, MFCC, 5212 Broadway at College, Oakland, CA 94618, (415) 653-8118. BA.

CAPITAL UNIVERSITY, Contact: Richard J. Phipps, Chairman of the Art Department, or Karen Rush Jones, ATR, Coordinator of the Art Therapy Program, 2199 E. Main Street, Columbus, OH 43209, (614) 236-6330. BA with major in Art Therapy.

COLLEGE OF ST. TERESA, Contact: Haine Crown, ATR, Winona, MN 55987, (507) 454-2930, ext. 207. BA with emphasis in Art Therapy.

DRAKE UNIVERSITY, Contact: Jeanette Wright, MST, ATR, College of Arts & Sciences, Des Moines, IA 50311, (515) 271-2863.

EMMANUEL COLLEGE, Contact: Carol Andrews, MEd, ATR, 400 The Fenway, Boston, MA 02115, (617) 277-9340. BA in Art with a concentration in Art Therapy.

EMPORIA STATE UNIVERSITY, Contact: Roberta J. H. Shoemaker, MFA, ATR, Art Division, Emporia, KS 66801, (316) 343-1200, ext. 5246. BS with a major in Art Therapy.

ILLINOIS STATE UNIVERSITY, Contact: Dr. Marilyn Newby, Art Department, Normal, IL 61761, (309) 438-2355. BA with emphasis in Art Therapy.

JERSEY CITY STATE COLLEGE, Contact: Herb Rosenberg, MFA, ATR, Art Therapy Studies, 2039 Kennedy Blvd., Jersey City, NJ 07305, (201) 547-3214. BA in Art Therapy.

LONG ISLAND UNIVERSITY, Contact: Jacqueline Stern-Einzig, ATR, CRT, C. W. Post Campus, Art Department, Greenvale, NY 11548, (516) 299-2464. BS in Art with major in Art Therapy.

MARIAN COLLEGE, Contact: Megan M. Rohn, Art Department, 3200 Cold Spring Road, Indianapolis, IN 46222, (317) 929-0123. BA.

MERCYHURST COLLEGE, Contact: Joseph Pizzat, Coordinator of Arts Therapy Program, Glenwood Hills, Erie, PA 16546, (814) 825-0393. BA with an Art Therapy major.

MOUNT MARY COLLEGE, Contact: Lynn Kapitan, MPS, ATR, 2900 Menomonee River Parkway, Milwaukee, WI 53222, (414) 258-4810. BA in Art Therapy.

NORTHERN ILLINOIS UNIVERSITY Contact: Dr. Carolyn Allrutz, Department of Art, DeKalb, IL 60115, (815) 753-1473. BA with a contract major in Pre-Art Therapy.

OHIO UNIVERSITY, Contact: Geraldine Williams, ATR, School of Art, Athens, OH 45701-2979, (614) 593-4281. BFA in Art Therapy.

PHILADELPHIA COLLEGE OF THE ARTS, Contact: Sherry Lyons, ATR, Broad and Pine Streets, Philadelphia, PA 19102, (215) 875-1104. BFA with a concentration in Art Therapy.

PITTSBURGH STATE UNIVERSITY, Contact: Harry Krug, Art Department, 1701 South Broadway, Pittsburg, KS 66762, (316) 231-7000, ext. 4302. BS in Art Education with an emphasis in Art Therapy.

SALEM COLLEGE, Contact: Harold Reed, Arts Department Chairman, Salem, WV 26426, (304) 782-5233. BA with a major in Art Therapy.

SCHOOL OF VISUAL ARTS, Contact: Estelle Bellomo, MPS, ATR, 209 East 23 Street, New York, NY 10010, (212) 679-7350. BFA with a concentration in Art Therapy, Certificate.

"ATR®" is defined as an Active Registered Art Therapist with the American Art Therapy Association, Inc.

The following programs submitted information to AATA indicating their coursework offerings in art therapy. The Association does not endorse programs other than Approved Programs and the entries below are listed **for informational purposes only.**

It is recommended that interested persons contact program personnel directly for further information and, in addition, review AATA's Guidelines for Academic, Clinical and Institute Art Therapy Training.

SPRINGFIELD COLLEGE, Contact: Prof. William Blizard, Dana Fine Arts Center, 263 Alden Street, Springfield, MA 01109, (413) 788-3300. BS, BA.

TRENTON STATE COLLEGE, Contact: Marcia F. Taylor, PhD, ATR, Art Department, Holman Hall, Hillwood Lakes, CN 550, Ewing Township, NJ 08625-0550, (609) 771-2652. BA in Art Therapy.

UNIVERSITY OF EVANSVILLE, Contact: Larry S. Barnfield, MS, ATR, Art Department, Evansville, IN 47722, (812) 479-2043. BS in Art Therapy.

UNIVERSITY OF INDIANAPOLIS, Contact: Dee Schaad, 1400 E. Hanna Avenue, Indianapolis, IN 46227, (317) 788-3253. BS in Art Therapy.

UNIVERSITY OF WISCONSIN–SUPERIOR, Contact: Art Therapy Coordinator, Superior, WI 54880, (715) 394-8391. BA.

WRIGHT STATE UNIVERSITY, Contact: Gary C. Barlow, EdD, ATR, 228 Creative Arts Center, Dayton, OH 45435, (513) 873-2758. BFA, BA, BS in Art Education with concentration in Art Therapy.

XAVIER UNIVERSITY, Contact: Cynthia Van Niman, MA, ATR, Department of Art, 3800 Victoria Parkway, Cincinnati, OH 45207, (513) 745-3000. BA in Art with a concentration in Art Therapy.

INSTITUTIONS OFFERING COURSES IN ART THERAPY:

GRADUATE LEVEL:

ARIZONA STATE UNIVERSITY, Contact: Therese M. Halas, ATR, Art Department, Tempe, AZ 85281.

ATLANTA ART THERAPY INSTITUTE, Contact: Elizabeth R. Weathersby, ATR, 925 Virginia Avenue, Atlanta, GA 30306, (404) 876-0633.

JERSEY CITY STATE COLLEGE, Contact: Herb Rosenberg, MFA, ATR, Art Therapy Studies, 2039 Kennedy Blvd., Jersey City, NJ 07305, (201) 547-3214.

LINDENWOOD COLLEGE, Contact: Nancy C. Higgins, PhD, St. Charles, MO 63301, (314) 946-6912, ext. 228.

MONTCLAIR STATE COLLEGE, Contact: Dr. Susan Barris, Fine Arts Department, Montclair, NJ 07043, (201) 893-4307.

SALEM STATE COLLEGE, Contact: Maggie Bishop, Division of Graduate and Continuing Education, Room 103, Sullivan Building, Salem, MA 01970, (617) 745-0556, ext. 2315.

THE WASHINGTON INSTITUTE OF EXPRESSIVE THERAPIES, Contact: Christine Wang, MA, ATR, 4600 Connecticut Avenue NW, Washington, DC 20008, (202) 363-5761.

UNIVERSITY OF GEORGIA, Contact: Dr. Robert B. Kent, Department of Art, Visual Arts Building, Jackson Street, Athens, GA 30602, (404) 542-1598.

UNIVERSITY OF MISSOURI–KANSAS CITY, Contact: JoEl Vogt, MA, ATR, Continuing Education Services, Room 24, School of Education, 5100 Rockhill Road, Kansas City, MO 64110, (816) 276-1188.

UNIVERSITY OF OREGON, Contact: Leigh Files, MEd, ATR, Continuation Center, 333 Oregon Hall, Eugene, OR 97403-1217, (503) 686-3537.

UNDERGRADUATE LEVEL:

ARIZONA STATE UNIVERSITY, Contact: Therese M. Halas, ATR, Art Department, Tempe, AZ 85281.

ATLANTA ART THERAPY INSTITUTE, Contact: Elizabeth R. Weathersby, ATR, 925 Virginia Avenue, Atlanta, GA 30306, (404) 876-0633.

CARLOW COLLEGE, Contact: Suzanne M. Steiner, 3333 Fifth Avenue, Pittsburgh, PA 15213, (412) 578-6208.

FLORIDA INTERNATIONAL UNIVERSITY, Contact: Dr. Clem Pennington, Art Education Department, DM 295, Tamiami Campus, Miami, FL 33199, (305) 554-2562.

MONTCLAIR STATE COLLEGE, Contact: Dr. Susan Barris, Fine Arts Department, Montclair, NJ 07043, (201) 893-4307.

SOUTHEASTERN MASSACHUSETTS UNIVERSITY, Contact: Dr. Dante Vena, Art Education Department, North Dartmouth, MA 02747, (617) 999-8550.

THE NEW SCHOOL FOR SOCIAL RESEARCH, Contact: Erika Steinberger, PhD, ATR, 66 West 12th Street, New York, NY 10011, (212) 431-6845.

UNIVERSITY OF GEORGIA, Contact: Dr. Robert B. Kent, Department of Art, Visual Arts Building, Jackson Street, Athens, GA 30602, (404) 542-1598.

UNIVERSITY OF MIAMI, Contact: Dr. Marion Jefferson, Art Education Department, P.O. Box 8065, Coral Gables, FL 33124.

URSULINE COLLEGE, Contact: Sr. Kathleen Burke, PhD, ATR, Art Therapy, 2550 Lander Road, Cleveland, OH 44124, (216) 449-4200, ext. 273.

This brochure was compiled by Shirley Riley, MA, ATR, MFCC, Education Committee Chair, with Mary St. Clair, MAT, ATR, Education Committee Member.

5/87

"ATR®" is defined as an Active Registered Art Therapist with the American Art Therapy Association, Inc.

Art Assessment with the Handicapped: Clinical, Aesthetic and Ethical Considerations

David R. Henley MA, ATR, Associate Professor and Chair, Department of Art Education and Art Therapy. The School of the Art Institute of Chicago, Chicago, Illinois. Private Practice.

Art therapists who practice in nontraditional settings such as in schools, and other agencies that provide services for the handicapped populations, are frequently challenged to defend their assessment methods. In contrast to the clinical setting, those in the educational or behavioral sphere appear to remain skeptical of the validity of interpreting client artwork.

In this article, the author explores the problems of interpretive assessment as applied to the physically and mentally handicapped person. The case studies under discussion were chosen for their enigmatic and contradictory content, thus illustrating the clinical, aesthetic and ethical problems of relying upon interpretive assessments as a major art therapeutic resource.

Overview

As an art therapist who practices in predominantly educational settings, I am often aware of a frequent topic of controversy concerning our profession—that of diagnosis; diagnosis in this context refers to the interpretive assessments of children's artwork. Many professionals within the fields of special education and art education remain dubious of art therapists who rely heavily upon projective techniques in attempting to explain a child's inner dynamics or predict future behaviors. They continually voice their concern to the author about how such interpretations can be overly subjective, leading to questions of validity. They consider projective assessments (especially among the handicapped populations) to be based upon stereotyping rather than empirical data, which can lead to easy rationalizations and self-fulfilling prophecies.

Psychologists from a cognitive orientation may be especially critical of clinically based-affective interpretation. Their concern is that many formulations of child artwork reflect not the child's perceptions but are based upon adult symbolization. An example is the clinician who assesses a drawing according to it's psychodynamic symbolism when in fact, the child had created a narrative piece almost verbatum from his/her favorite television show.

Psychologists such as Winner and Gardner (1980) call attention to the environmental factors that may affect the outcome of the child's art production. The child whose drawn figures are positioned at the bottom of the picture—are these expressions of powerlessness and insufficiency, or is the easel positioned out of the child's reach?

Hammer raises the question whether "a given drawing response reflects overt conscious trends or unconscious latent tendencies" (1959, p. 640). Hammer concedes that not all graphic elements necessarily reflect deep dynamic tendencies.

> ***"The child whose drawn figures are positioned at the bottom of the picture—are these expressions of powerlessness and insufficiency, or is the easel positioned out of the child's reach?"***

It is this controversy over interpretation of artwork as especially applied to children in special education programs that is the focus of this article. Exploration of the dynamics of interpretive assessments is done by drawing upon case studies that were selected because of their enigmatic and contradictory contents. Using an assessment approach developed by Lowenfeld (1957) the author explores the relationship between the child's objective and subjective handicap as applied to his/her concept of body-image.

The discussion of diagnostic assessment is limited to two populations: the physically handicapped and the mentally handicapped. The former group includes individuals who have sustained traumatic or congenital damage to their sensory and/or bodily systems. The latter group includes those with traumatic or congenital brain damage that has resulted in mental retardation and other related neurological disorders. These two populations have been chosen because they are frequently encountered in art education therapy settings where it is applicable to use Lowenfeld's theory and practice of client assessment.

The Lowenfeld Approach

In 1957 Lowenfeld first raised the issue as to the subtle yet important distinction between the diagnosed

BEST COPY AVAILABLE

". . . Lowenfeld first raised the issue as to the subtle yet important distinction between the diagnosed handicap and the subsequent emotional response to the disabling condition."

handicap and the subsequent emotional response to the disabling condition. Lowenfeld contended that two individuals may share identical mental or physical defects, but their attitude toward their disability and their capacity to emotionally adjust to it may greatly differ. Lowenfeld further asserted that the successful outcome of art education-therapy hinges upon the clinician's ability to discriminate between the diagnosed and the subjective response to the handicap. Once a base line is established which measures the objective extent of the diagnosed disability and the subjective response, it is possible then to appraise how far the therapeutic process must proceed until both are brought into a harmonious balance.

This concept implies that the art therapist may work with a wide range of disabled populations without necessarily encountering psychopathology. For instance, a child with a congenital birth defect may function normally within his/her limitations, effectively compensating for the loss without ever thinking twice about the "problem." Indeed, he/she may not be able to imagine life any other way, thus the handicap becomes a normal part of everyday life. In this case, the focus of the child's art programming would be educationally or recreationally based without any cause or need for therapeutic interventions beyond an empathic and supportive environment. However, this same child may at some time enter into a new social, familial or physical situation that adversely effects his/her capacity to cope. In this case, the handicapping condition may now aggravate or precipitate increased anxiety and stress, resulting in possible emotional maladjustment. Such a predicament would then warrant art therapeutic interventions that would address these issues and attempt to neutralize them before serious emotional trauma is sustained.

The artwork produced in these circumstances may reflect the child's situation and thus becomes a useful tool and resource of the art therapist. In this instance, the artwork can assist the clinician in identifying the onset of emotional disturbance and then follow the effects of the art therapy process during the child's treatment.

However, in the author's treatment approach the question of pronouncing the content in a child's artwork as being pathological is an exceedingly cautious one. In most cases, a child within the author's program will not be considered in need of treatment because his/her physical or mentally handicapping condition is revealed or confirmed through the artwork. The author maintains that each child should be considered to be adapting and fully adjusted until the presence of behavioral symptoms convinces us otherwise. In this way the author resists being tempted by the "hazards of gratuitous interpretations that amount to preconceived, self-fulfilling prophecies" (Hammer, 1958, p. 642).

Researchers have documented the extent to which a child's psychomotor activities are preserved and projected through the art medium. Such psychomotor patterns will reflect, to some extent, the child's developmental level and his/her sense of self-image. Few art therapists, art educators or critics would quarrel with the hypothesis that the artist, including the physically and mentally handicapped, projects facets of his/her personality through the art productions. Problems arise however, when the attempt is made to assign significance to these interpretations, especially in regard to diagnosing pathological material. The tendency among many is to become preoccupied with imagery that displays any form of distortion, emphasis or immaturity, and then pronounce the artist emotionally at risk on the strength of these deviations from the norm.

Hammer's Case History

Emanual Hammer (1958) begins his seminal study on the application of projective techniques with a House-Tree-Person Test, drawn by a young man who was born without his left arm. In the figurative component of the test, the missing arm is represented, while the hand is depicted as atrophied and nonfunctional; otherwise the figure is competently drawn without any other psychomotor conflict. This issue surfaces again in the tree drawing by the presence of a broken tree limb depicted on the exact side and relative placement of the missing limb. With further documentation from the chromatic figure drawing, Hammer supports the thesis that this individual has unconsciously projected feelings of 'insufficiency' through the presence of the distortion. Such an interpretation would be shared by many art therapists. But in fact, the withered hand offers little real evidence suggestive of emotional

". . . the art therapist may work with a wide range of disabled populations without necessarily encountering psychopathology."

maladjustment. The drawing does graphically reflect concern or even consternation over this severe congenital defect. Yet such a concern should not support the automatic correlation between the man's *acknowledgement* of his handicap and the presence of the slightest emotional liability.

In this author's clinical experience, handicapped individuals routinely allude to the emotional pain, the embarrassment, the inconvenience and other affective expressions that come with living with an adventitious or congenital defect.

Such reactions, to this author's thinking, are perfectly natural and understandable. Indeed, alluding to these emotional reactions suggests a healthy test of appropriate sensory affect. The author would become concerned however, had this man drawn his limbs perfectly intact, thus suggesting that far more primitive and delusional defense mechanisms were at work.

Thus, it is Hammer's 'speculative leap' from acknowledging the handicap and his subsequent confusion over the man's emotional response, that the author finds unsupported. However, had this man elaborated his figures with other more symptomatic symbolism, the assessment would be then reconsidered. The following case account from the author's clinical experience illustrates such a situation.

Case Account: A Physically Handicapped Individual

Ronny was a nineteen-year-old black student participating in a studio art program at a school for hearing impaired children. Although profoundly deaf and legally blind, Ronny's self-portrait figurative drawings were rendered anatomically intact with a somewhat rigid but firm line. Yet, as is the case of many physically handicapped individuals, Ronny's sense of body image included an acknowledgement of being visually impaired; he always depicted the eyes as untouched whiteness of the paper surrounded by thick, black-framed glasses. Perhaps Ronny saw the thick lenses as preventing the clear image of the eye to shine forth, or maybe by omitting the eyes, Ronny was expressing some inner truth about organs that have failed and do not warrant acknowledgement or embellishment. In any case, such an omission is routine among the partially sighted who are capable of rendering their likenesses.

Ronny's drawings were dynamic for a sensory deprived individual coping within a sheltered environment. His figures were always exploring and sometimes transcending their limitations by engaging in all kinds of action. Ronny particularly enjoyed creating scenes involving travel and modes of transportation. It seemed that by creating these scenes, Ronny would be allowed some measure of vicarious enjoyment of the pleasures that come with barrier-free movement. Such images served an adaptive and compensatory purpose for Ronny and were encouraged during his art education programming.*

> *". . . handicapped individuals routinely allude to the emotional pain, the embarrassment, the inconvenience and other affective expressions that come with living with an adventitious or congenital defect."*

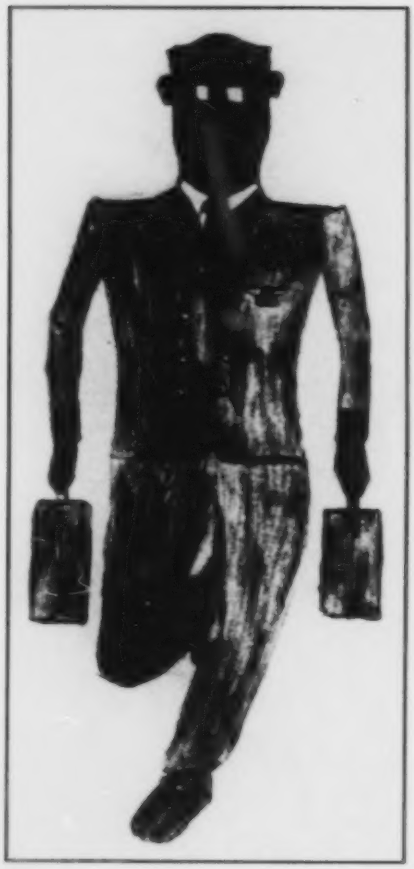


Fig. 1

However, as Ronny's graduation from the school for deaf children drew near, his art productions began to change. He began to depict himself in positions of power and adventure such as a wealthy executive being chauffered about in a Rolls Royce. Next a prolonged series of himself as an airline pilot emerged as evidenced by Figure 1. The change in Ronny's characterizations might have been played down by the author, had Ronny occasionally returned to his more dynamic and reality based imagery. However this disturbing element in his work soon manifested itself in his overt behavior. He began to attend his studio sessions in three-piece suits complete with briefcase. He carried with him photographs of luxury cars, playboy executives and airline promotional materials. Eventually, Ronny's behavior and artwork became bound together in fantasy, with each new acting role constituting ever more unattainable ego ideals. It was apparent that the issue of graduation had precipitated this identity crisis. Ronny was facing a stressful transition from the security of the residential school setting to a uncertain future back in the urban ghetto. Instead of being challenged by academic work, he was facing a worklife in a sheltered workshop which he vehemently regarded as being menial and "beneath his ability." He accused his vocational counselors as being racially biased, for steered him toward "slave labor with the retards."* To combat such stress, Ronny began to ignore his teachers and counselors, preferring instead to take refuge in his delusions. Despite the sincere and sensitive reality-based interventions of all his support staff, Ronny firmly asserted that his salient goal was to pilot a 'Lockheed L-1011' after high school graduation.

---

*Returning to the author's tenet that until symptomatic behavior is unequivocally demonstrated, the handicapped child should be able to create art in a nonclinical atmosphere conducive to solving aesthetic and art educational problems.

During this stormy period in Ronny's life, he created several drawings that reflected the denial of his sensory and cognitive limitations. Because this mechanism of defense is potentially dangerous to confront, the author's art therapeutic interventions remained low-key. Ronny was encouraged to explore avocational and vocational alternatives in his artwork. He was shown illustrations of men working in trades that were within his abilities. With consistent and empathic support, Ronny eventually displayed a willingness to abandon this mode of wish fulfillment. After several transitional pieces, Ronny began to demonstrate a relaxation of his denial defenses. As illustrated in Figure 2, Ronny began to confront his delusions as evidenced by his replacing himself as the pilot of the aircraft with a sighted individual. This picture suggests that Ronny had been able to renounce his unrealizable dreams and once again acknowledge his limitations of being deaf/blind. What is interesting is that Ronny is still depicted in the role of a co-pilot and in doing so, reaffirmed his need for vicarious pleasure and stimulation. This addition to the picture powerfully argues for his need of sensory stimulation and control. While Ronny had successfully again acknowledged his handicap, he had no intention of renouncing his hopes for a "better life that is usually due a deaf/blind child."*

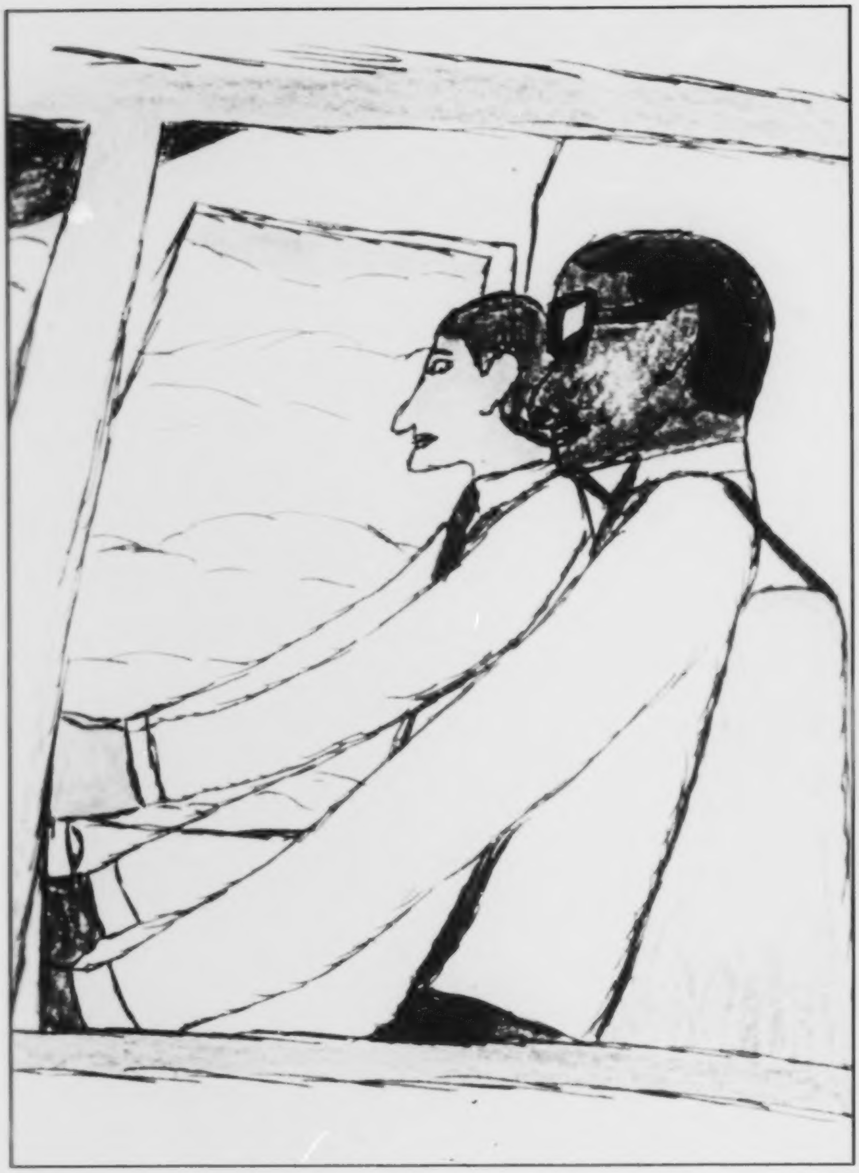


Fig. 2

The artworks that emerged during this period give testament to the compelling resolution of an emotional conflict. The assessing of the artwork in this case took on an active, functional role of confirming and elaborating upon the nature of the conflicts that arose. In studying such a sequence of artworks, one can clearly discern the cyclical progression, regression and reintegration during the art therapy process. Thus, Lowenfeld's goal of maintaining an even balance between handicapping condition and emotional adaptation were fully realized.

---

*There is often a preconceived hierarchy among those with handicaps, with those with severe/profound retardation being lowest in the pecking order.

*Ronny's quote interpreted from Signed English.

The Mentally Handicapped

In continuing our discussion, the focus remains upon assessing client artwork from the perspective of Lowenfeld's objective/subjective handicap theory and practice. In addressing the needs of the mentally handicapped, an expansion is made on an emphasis from the issues of body ego and self-concept to also encompass the developmental concerns of this population.

In studying the art of the mentally retarded person, the salient issue is for the clinician to develop the capacity to view each art production beyond the obvious predictions of developmental arrest and ideational impoverishment. While it is important for the clinician to be able to discriminate the stage at which the mentally retarded is functioning, it is more crucial that our assessments resist being encumbered by normative comparisons and other preconceptions. Although the art of mentally retarded people often is limited in representational ability, use of perspective and technical sophistication, their work can be unexpectedly fresh and expressive. As is the case with the normal populace, the incidence of artistic ability as well as the presence of psychopathology will be distributed throughout the population. Just as there may be a normal child who is gifted in a particular art form, there will be a mentally retarded counterpart who displays uncommon artistic ability within the scope of the characteristic population. The art of the retarded person in many cases, cannot be duplicated by the intact child; such art seems to integrate the deficits associated with mental retardation along with some capacity for graphic expression that results in highly idiosyncratic, original art productions (Henley, 1986).

Thus, it serves little diagnostic purpose to pronounce a child mentally retarded or developmentally disabled via the art assessments. What is of greater concern is whether this mentally retarded child is holding up under the stresses and difficulties that come with being severely sensory, physically and cognitively affected. It has been only in recent years that the mental health professions have addressed themselves to assisting the retarded child in realizing his/her potential. They have only recently been given an opportunity for normal sensory and cognitive stimulation in their educational programs. Thus it is the 'nurturance' issue that stands before the 'nature' issue, when assessing the art and art process of the mentally handicapped.

Case Account: A Mentally Retarded Individual

Our first case involves a young man of twenty-one who was a nonverbal, Down's syndrome individual with severe mental retardation. John was a productive and avid recreational artist, working in the art studio in the large residential institution where he resided. Like many of his peers, John had a rigid sense of routine and a firm set of preferences. These needs were reflected in his art process, where he would only work on white paper with a black felt-tip or roller-tip pen, with his themes being exclusively figurative.

Although this procedure affected the scope of the subject matter and medium, John's treatment of the human figure was something special. Figure 3 attests to John's ability to take developmentally arrested figures and make them aesthetically interesting. It is apparent that John had remained in a schematic-dawning realism stage of development (Lowenfeld)—like most of his Down's syndrome peers. What was atypical was his ability to modulate his lines and forms using design devices that are reminiscent of Abstract Expressionism, African Primitivism, the L'Art Brut of Jean Dubuffet and even Post-Modern styles of art seen today in New York's East Village. There is a dramatic discrepancy between the seemingly regressed distorted body imagery and the sophisticated, dynamic treatment of the figurative form.

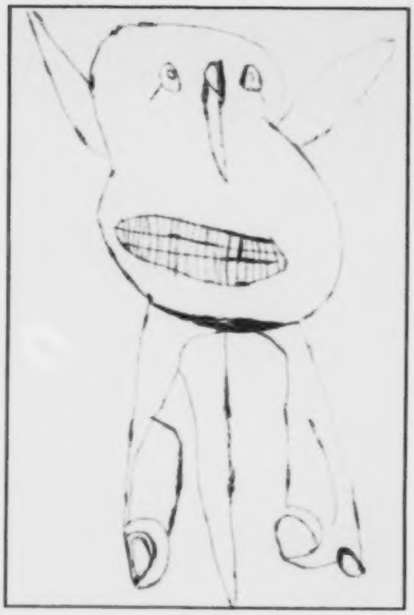


Fig. 3

Upon assessing this piece, the art therapist would ordinarily point to the overt sexual and aggressive forms that are repeated throughout the schema. The ears (horns) or the nose, and even the elongated phallus itself, impart a sexually charged figure of substantial pathology. The gnashing teeth and confused eyes contribute further to a sense of tension. Yet in direct contradiction to this interpretation, John's behavior was relaxed, outgoingly friendly and sexually/aggressively appropriate. Nothing in his manifest behavior suggested the slightest emotional disturbance. Figure 4 portrays the figure as being split from itself. Such disassociative features Machover (1949, p. 118) concludes, are visually suggestive of schizophrenia. The eyes and nose (?) in this piece have detached and migrated to the edge

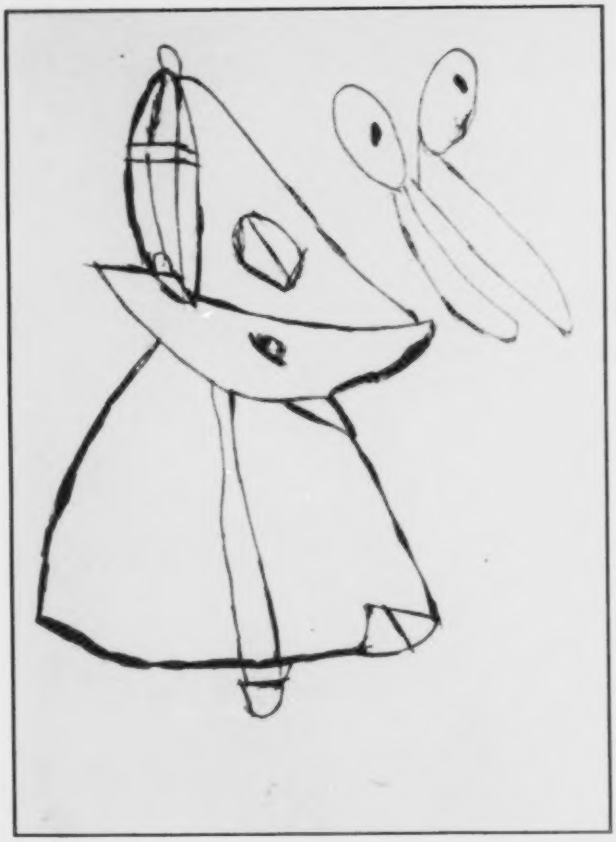


Fig. 4

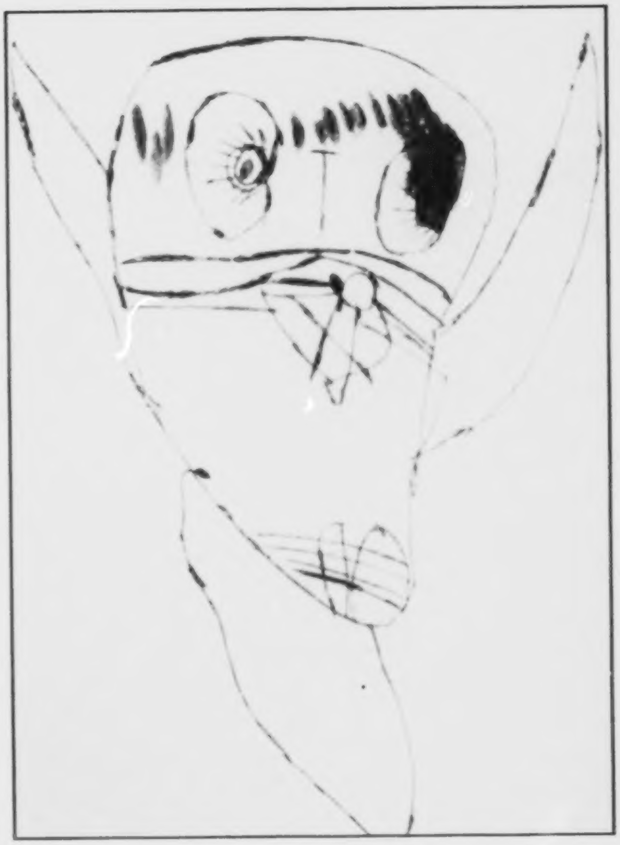


Fig. 5

of the paper. The body is virtually an abstraction of considerable inventiveness and graphic power. Figure 5, a portrait rendering, makes use of distortions, omissions and simplifications that are handled with verve and skill. The composition is at once developmentally regressed and graphically sophisticated. The furtive glance of the eyes which Machover (1949, p. 48) sees as an aggressive method of social control, contributes to the enigmatic effect of the piece. The expression of dislocation and isolation make the work more powerful and disturbing. The elaboration across the midline of the face and at the chin are extraordinary cosmetic design devices.

Case Account: A Teenager with Down's Syndrome

Another Down's syndrome young man of sixteen (referred to as Chris) delighted in lifedrawing, especially models in costume. In this piece, Figure 6, the model (another Down's syndrome teenager) had painted his face, donned an electric orange wig and broad outlandish smile. These expressions are captured with a wit and humor that essentially transcends developmental criteria. The drawing possesses none of the glib, self-conscious preciousness one finds in the art of contemporary "primitives."

The work of both John and Chris emphasizes that normative comparisons between different artist populations is fraught with contradictions, misleads and limitations. In each case, the client combines material that is developmentally arrested, and psychodynamically at risk, with an innate sense of graphic design. In contrast to the psychomotor patterns, each client lived fully adjusted and creative lives, virtually untouched by pathological behaviors. These two cases are not atypical; there are numerous accounts of cases whose artists remain richly enigmatic, defying our empirical formulations and assessment skills.

Case Account: Two Mentally Retarded Individuals

In contrast, Figures 7 and 8 represent the work of two mentally retarded individuals who succumbed to pressures and stresses resulting in severe emotional disturbances. Figure 7 represents a house, figure and other fragmented forms. The house floats around the midline of the paper and is built like a fortress or prison with a ring of confining windows in the upper stories. The figure is a dribbled line which trails off into the surrounding environment. The effect is disturbing, its form and substance are tenuous, as is it's

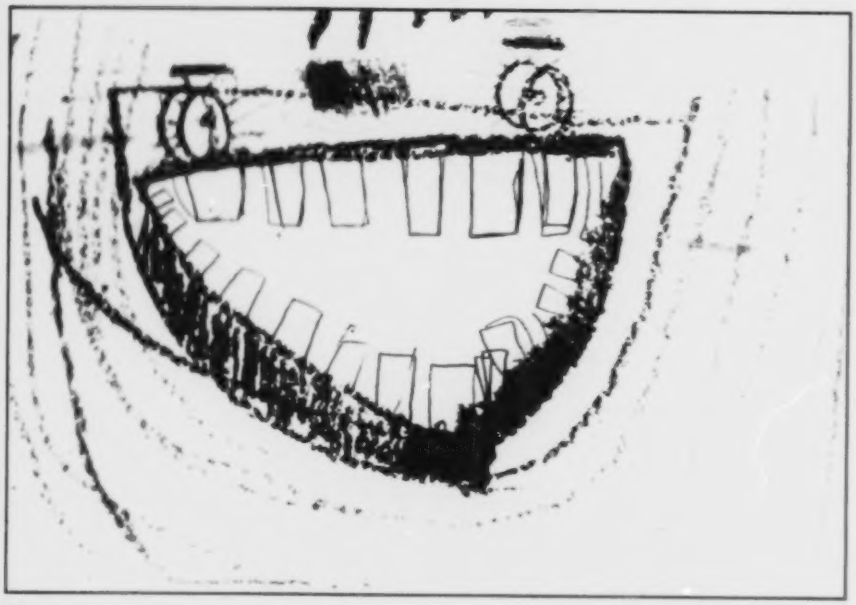


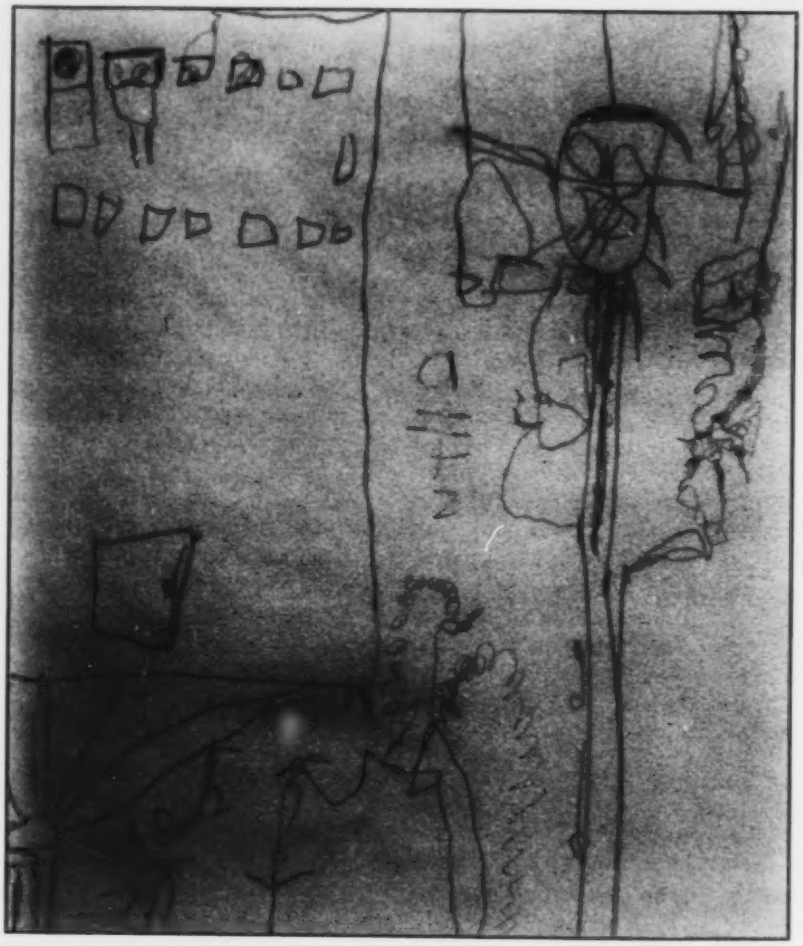
Fig. 6

sense of relatedness. The smaller scale forms lay scattered and fragmented at the lower end of the drawing. In this case the child's manifest behavior was accurately reflected by the disassociated content of the artwork. Self-abusive, poorly connected to either people or common objects, this child's severe emotional and developmental disabilities are clearly in evidence. Yet, without the empirical data derived from his case history, the author's assessment might have been reconsidered.

In our last illustration, Figure 8 depicts a nightmarish figure laying disembodied with his "head on the block." This piece is both instructive and inspirational because it represents an instance where a child with both emotional and developmental deficits was able to powerfully convey his feelings through his art. This child was severely mentally retarded with secondary autistic behaviors. His affect was normally flat, his behavior withdrawn and his sense of body-ego impoverished. Usually he would neither draw nor sculpt in the studio sessions, but sit and slowly rock facing the window, his arms folded beneath his waist. On this particular day he had just been informed that his mother, who usually visited him each Friday, would not be keeping their appointment. Once his rage had subsided over this disappointment, he became quite active within the studio—pacing, handling objects, checking the hallway. In an attempt to displace some of his agitation, and to harness his newly found energy, the author provided him with a white marker and glossy black illustration board. After several moments of hesitation and more pacing, he grasped the marker and began to draw.

The resulting portrait seems to howl in the blackened void, isolated and abandoned. The piece appears to convey the breadth of this child's inner pain and anxiety in a way that a mentally retarded child could

Fig. 7



BEST COPY AVAILABLE 541

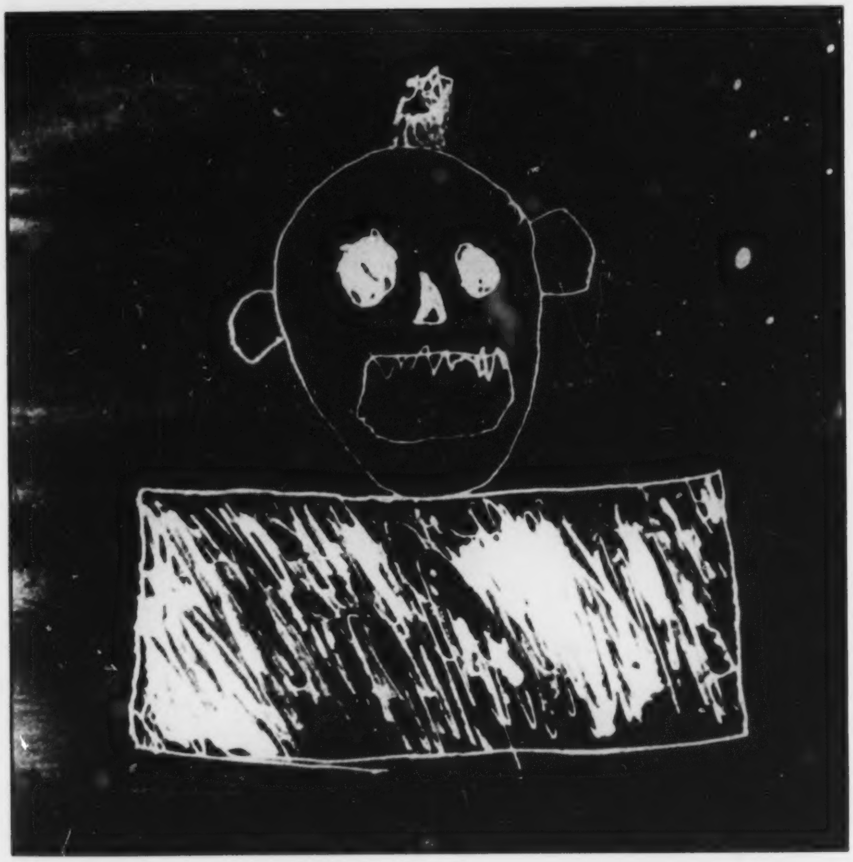


Fig. 8

never express through words. Yet despite his great distress, he was able to somehow muster the concentration, and the self-control to manipulate the medium in a powerful and poignant way. This process points to the integrative powers of the art experience that essentially transcends any question or concern over functioning level. Thus, the issue of the diagnosed handicap, which in this case is mental retardation, as applied to our assessments becomes the secondary concern. Ultimately the child's emotional response concerns us as art therapists as this is now the focus of our assessments and our subsequent interventions.

Discussion

Throughout the case discussions, the author has proposed a restrained, cautious approach to interpreting client art work. This approach stems from clinical, aesthetic and ethical considerations that have grown out of the author's practice with these populations.

From a clinical perspective, attention was given to the "speculative leaps" that can misguide even the most seasoned art therapist. In the first case, the author voiced concern over viewing the child's artwork with preconceived ideas that can hinder one's ability to effectively learn from the child and his/her art. Without integrating other empirical evidence, such as overt and covert behaviors, the art therapist cannot expect to derive maximum insight from the artwork.

For instance, in the case of Ronny, the deaf/blind child, the author accepted the idiosyncratic aspects of the artwork as being indigenous to the population. The emphasis upon deriving vicarious pleasures and stimulation through the use of fantasy was also accepted as a necessary avenue for expression in this child. The author resisted treating any of Ronny's initial expressions as symptomatic, deeming them instead, sublimative mechanisms that aided in compensation. However, this assessment was amended once a concomitant regression of art and behavior became clear. At this point, art therapeutic interventions were instituted to support the child through this time of crisis. As the crisis was resolved, Ronny's emotional responses to his handicap became effectively neutralized and thus ceased to remain a prevalent issue.

In the last case, the author described the art of a child who had just sustained a traumatic emotional upset. The artwork possessed many of the distortions, omissions and affect that art therapists would normally associate with emotional disturbance. While the author would ordinarily concur with this thesis, he maintains that there is more at issue here than discerning the presence of emotional lability.

Consider this autistic, brain-damaged child who at an early age, is separated from his mother and is abandoned to a residential institution. Here he competes with scores of other retarded children for the attention of a few attendants in a sensory deprived environment. He is incapable of comprehending or communicating his sense of loss, fear

---

"Without integrating other empirical evidence, such as overt and covert behaviors, the art therapist cannot expect to derive maximum insight from the artwork."

---

and anger through verbal or any other modalities.

The drawing in Figure 8 powerfully conveys this child's overwhelming anxiety and anger over his disappointment at not seeing his mother. To this author's thinking, such a depiction of horror points less to emotional *lability* than to this boy's power of resilience and fortitude. Faced with impossible circumstances he was able to reintegrate sufficiently so as to communicate a very powerful and accurate truth. In such a statement, the author finds an unequivocally sane and natural reaction to an unbearable situation. Kramer considers this to be the sum and purpose of the art therapy process; to allow such inner conflicts to "become agents of extraordinary effort at integration culminating in unusually powerful artistic statements" (1979, p. 14).

It is these powerful artistic statements that bring us to the next area of concern: assessing the content and aesthetic properties of artwork in relation to the presence of emotional lability.

In the case of John, the reader was introduced to an artistic style, whereby the elements of design were once again based upon distortion disembodiment and sexual aggressive content. John's innate sense of graphic sophistication and the presence of severe developmental arrest contributed to the highly disturbing and enigmatic quality in his artwork. Yet, despite the obvious sexual/aggressive content and the regressed or distorted sense of body-ego, John was a picture of psychic health. He remained personable, socially appropriate and well grounded to his environment despite the most vigorously distorted art productions.

John was a seasoned, practicing artist in every sense of the word. He worked constantly, he was intense in his concentration, and he preferred to work alone. His images were created in series, with a highly discernible progression regarding newly emerging directions and experimentation. His work was endowed with a high degree of originality, consistency and economy.

Thus, John's case is instructive, since it reminds us to look beyond the artist's "obvious sexual preoccupations," "aggressive tendencies" and other diagnoses; these labels permeate our mainstream culture in many guises of which the sensitive art therapist always must be aware.

As any student of art history can attest, both primitive and "high art" through the ages have celebrated with a virtual obsession the issue of human sexuality. At the very center of the art process is the unconscious need to evoke imagery that elicits a dramatic visual impact.

The human figure has particularly remained the artist's preferred object of experimentation, constantly altered and distorted in a full range of styles that provoke intense reactions from critics and the viewing public. Contemporary artists such as Francis Bacon celebrate the figure by ruthlessly inviscerating it into endless combinations. Even Andrew Wyeth, the champion of subdued figurative realism, can invoke a brooding, disturbing element in his work. (The Kuerner paintings in particular are charged with an almost uncomfortable intensity, as the subjects stare blankly at cracked walls beneath iron meat hooks. The newly emerged 'Helga' paintings are rendered with a caustic edge, as the model winces in some dark cellar or sits glumly in the depressed winter light. The Helga figures are invested with a coldly inanimate, clinical quality suggesting an almost autistic detachment from the subject.)

In practice with the handicapped population, the art therapist will indeed encounter artworks that are developmentally delayed, stereotypical, distorted or will display some other atypical qualities. Yet the presence of such qualities do not automatically imply emotional maladaption on the part of the artist. What one can infer is that the artist views the world shaped by the severity of his or her defects, the enrichment of one's environment and the support one receives by family and professional staff.

The complex interplay between these factors not only contribute to a disabling condition, but also can serve as a catalyst in forging unusually original, sometimes extraordinary styles of art.

Writing of this style of naive or eccentric art, Cardinal (1973) not only deemphasizes pathology in art, but to the contrary, asserts that there can be no "pure" art unless the artist is virtually isolated culturally and aesthetically. Only then can he or she follow an artistic vision uncontaminated by cultural norms, economic factors and aesthetic styles based upon fads and contemporary sensationalism. In some instances the art of the handicapped child meets these criteria, whereas the originality and idiosyncratic nature of the artistic vision is inextricably tied to the disabling condition (Selfe, 1983; Becker, 1982). Thus, the clinician who attempts to interpret such material cannot hope to isolate the elements of congenital disability, environmental deprivation and personal idiosyncracy. The artwork of such an individual stands as a statement of wholeness, of who he or she is, without bowing to clinical analysis and dissection that essentially reduces one to a group of symptoms.

Concluding Remarks

The discussion of the case histories was intended to demonstrate that the intellectual dissection of visual art is essentially a contradiction in terms. The artwork presented aptly conveys the limitations, the enigmas and the possibilities of interpreting what is considered to be heavily influenced by primary process material. As primary process-based material, art remains a visual language that transcends spoken words. Such is the challenge faced by the most skilled art critic: to do justice to an image of such depth and mystery, so as to not degrade it to a mere intellectual exercise. Even

BEST COPY AVAILABLE

Hammer in his championing of projective techniques marvels at the "elusive flame-like spirits of his subjects who defy neat and orderly logic with their flame-like dances that flicker beyond order" (p. 639-40).

We can equate this idea with the challenges posed by our early American Indians who objected to being photographed by the white settlers. They maintained that such a contrivance would seize their spirit; in other words, the cold mechanical eye of the camera would essentially strip them of their animateness, the vibrancy of their soul. As they reasoned that such a device could never approximate what they were, we can never expect to encapsulate the depth and meaning of the client's visual image.

Yet despite our ambivalence, we continue to delve into the mysteries of artistic creation. We attempt to confirm, moderate and predict the outcome of our treatment process through the fervent study of client artwork. Yet we must do so cautiously and in reverence to the artwork, which tells us so much more than we can describe.

References

Becker, L. and Zimmerman, R. (1983). *With eyes wide open.* Documentary film (16mm, color/sound, 58 minutes). Austin, TX: Creative Learning Environments.

Cardinal, R. (1973). *Outsider art.* New York: Praeger Publishers.

Hammer, E. (1958). *The clinical application of projective drawings.* Springfield, IL: Charles C Thomas, Publisher.

Henley, D. (1986). Approaching artistic sublimation in low functioning individuals. *American Journal of Art Therapy,* Vol. 3, No. 2.

Kramer, E. (1979). *Childhood and art therapy.* New York: Shocken Books.

Lowenfeld, V. (1957, 3rd ed.; with Brittain, W. 1987, 8th ed.). *Creative and mental growth.* New York: The Macmillan Publishing Co., Inc.

Machover, K. (1949). *Personality projection in the drawing of the human figure.* Springfield, IL: Charles C Thomas, Publisher.

Selfe, L. (1983). *Normal and anamalous representational drawing ability in children.* London: Academic Press.

Winner, E. and Gardner, H. (1982). *The art in children's drawings.* Boston: Harvard Project Zero.

Guidelines for Authors

Please submit four (4) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed, ATR, Wright State University, Creative Arts Center, 228 Creative Arts Center, Dayton, OH 45435. Send manuscripts and illustrations certified mail, with return receipt requested. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

BEST COPY AVAILABLE

"Sex Differences in the Emotional Content of Drawings"

Rawley Silver, Ed.D., ATR, HLM, is the author of Developing Cognitive and Creative Skills Through Art. *This is her 38th publication in the field of art therapy. The paper was presented at the 1986 Annual Conference of the American Art Therapy Association, held in Los Angeles, California. She is also a painter, having had her 10th one-person exhibition in October, 1986.*

This study was completed with a focus on possible differences relative to sex or age in the expression of emotions through drawings. This study was an attempt to verify and/or amplify preliminary findings by the author, by using larger and more diverse populations coupled with a more controlled research design. Questions asked referred to differences between men, women, boys and girls, in their concepts of self and environment as expressed through particular drawings. The drawings were from Stimulus Drawings (Stimulus Drawings and Techniques, by Silver), followed by discussion and clarification of meanings. A 7-point scale (on a continuum) was used in evaluation, and for each drawing two scores were obtained: one for Principal Subject (i.e., a main participant, person) and one for the Environment (including people, objects or events portrayed). A determination of reliability was made through a process of interscorer agreement. Significant differences were found between males and females across all age groups (girls, boys, women and men in four age groups: third graders, high school seniors, adults and the elderly). Emerging from the findings a composite male and a composite female are portrayed. In a closing discussion, the author offers suggestions and/or questions that can lead to further research in specific areas related to sex differences in the emotional content of drawings.

Introduction

In this study we asked if there were differences in sex or age in expressing emotions through drawings. The questions arose after examining drawings by art therapy students who had participated in a workshop on the use of Stimulus Drawings and had responded to the drawing task themselves. Their response drawings were predominantly negative—drawings about unhappy people in unpleasant situations.

Was this typical of adults? Or did these adults have unusually negative associations? In search of answers, the stimulus drawings were presented to groups of other adults and to children, and their response drawings evaluated on the 5-point Projection Scale of the Silver Drawing Test (Silver, 1983, p. 33). Results indicated that some groups tended to respond with predominantly negative themes while others responded with positive themes—happy associations and fortunate subjects.

The study reported here, was an attempt to verify and amplify the preliminary findings by using larger and more diverse populations and a more controlled research design.

One of the questions asked was whether there were differences between men and women, boys and girls, in their concepts of self and environment as expressed through drawings.

Witkin and his associates found significant differences between the sexes in laboratory tests involving perception (1954). In one test, their subjects were asked to adjust a luminous rod, surrounded by a tilted luminous frame, to the true upright position. In some trials, the subject's body was upright, in other trials, tilted. Results showed a wide range of differences in perception. At one extreme, some individuals determined the perceived upright almost exclusively in reference to the visual field. At the other extreme, some located the upright almost entirely on the basis of bodily position, uninfluenced by the field.

They also found that women tended to be more dependent on the visual field than men, while men tended to rely more on the positions of their own bodies in perceiving the rod independently of its background. Similarly, in their tilting-room-tilting-chair test, women relied less on the position of their bodies in determining the position of the room, and were more strongly influenced by the visual field.

With children, the differences in dependence on the visual field observed at the adult level occurred at all the ages tested, down to the 8-year-old level. Not until the 17-year level, however, did the differences in scores between girls and boys tend to be statistically significant, and only at the adult level were they consistently significant.

Since perception plays an essential role in the choice of stimulus draw-

> ***"[Are] there differences between men and women, boys and girls, in their concepts of self and environment as expressed through drawings?"***

ings, we asked whether gender differences would be found in the scores of response drawings, whether males and females differ in their differentiation of self from environment. And since some groups in our preliminary study tended to respond with negative themes and others with positive themes, it was also questioned whether there were age or sex differences in the degree of negativity in response drawings.

PROCEDURES

The Stimulus Drawing Task

In this task (Silver, 1986a), participants are asked to choose two Stimulus Drawings (SDs) from among the group of 50 presented, imagine something happening between the subjects selected, then show what is happening in drawings of their own. When drawings are finished, they are given titles and then discussed, whenever possible, so that meanings can be clarified.

Copying is discouraged. Emphasis is on expressiveness rather than skill. The SDs are intended to be ambiguous in order to stimulate a flow of associations and to invite expression through visual symbols and metaphors.

Vilstrup (1983) has written a review of the Stimulus Drawing techniques. Sandburg, Silver and Vilstrup (1984) have reported on the use of Stimulus Drawings with three populations, adapting the basic technique to the needs of the patients with whom each worked: Sandburg with adult psychiatric patients in a day-care setting; Silver with stroke patients in a rehabilitation center; and Vilstrup with adolescents in an inpatient psychiatric setting. Response drawings may be evaluated either for emotional content or for levels of cognitive and creative skill.

"Emphasis is on expressiveness rather than skill."

The Evaluation Instrument

To obtain greater precision in evaluating emotional content, the 5-point scale for evaluating response drawings was expanded into a 7-point continuum ranging from strongly negative content, such as drawings about suicide (1 point), to strongly positive content, such as drawings about honeymoons (7 points). The median score (4 points) is used for drawings that are ambivalent, unclear, or neither negative nor positive (Silver, 1986a).

For each drawing, two scores are obtained, one for the Principal Subject and one for the Environment—including the people, objects or events portrayed. This scale and scoring examples are shown in Figures 1 through 6.

To determine the reliability of the scale, a study of interscorer agreement was undertaken. Three judges independently scored 24 response drawings: four drawings selected at random from each of six populations of children and adults. The three judges, all women, were registered art therapists.

Before scoring, the art therapists met for one hour to discuss the scale and to score and discuss practice drawings. Then the 24 response drawings were presented individually at random to the art therapists who scored them without further discussion.

In the five analyses performed, agreement coefficients ranged between .924 and .549 as measured by Finn's r (Whitehurst, G. 1984). To illustrate, an r = .80 denotes 80% agreement beyond chance agreement (Silver, 1986a, 1986b). Thus the scale appears to be a reliable measure for evaluating emotional content projected into response drawings by children and adults.

Subjects

The stimulus drawing task was presented to 326 girls, boys, women and men in four age groups: third graders, high school seniors, adults and the elderly.

"The stimulus drawing task was presented to . . . girls, boys, women and men in four age groups."

The elderly population consisted of 19 men and 34 women in two Senior Centers in New York, one in a suburban neighborhood, the other in New York City. These Centers provided activities, hot lunches and opportunities to socialize.

The remaining adult population consisted of 11 men and 114 women, between the ages of 20 and 30, in three groups: artists and teachers in a suburb of New York City; Special Education teachers in Albany; and art therapists from various parts of the country.

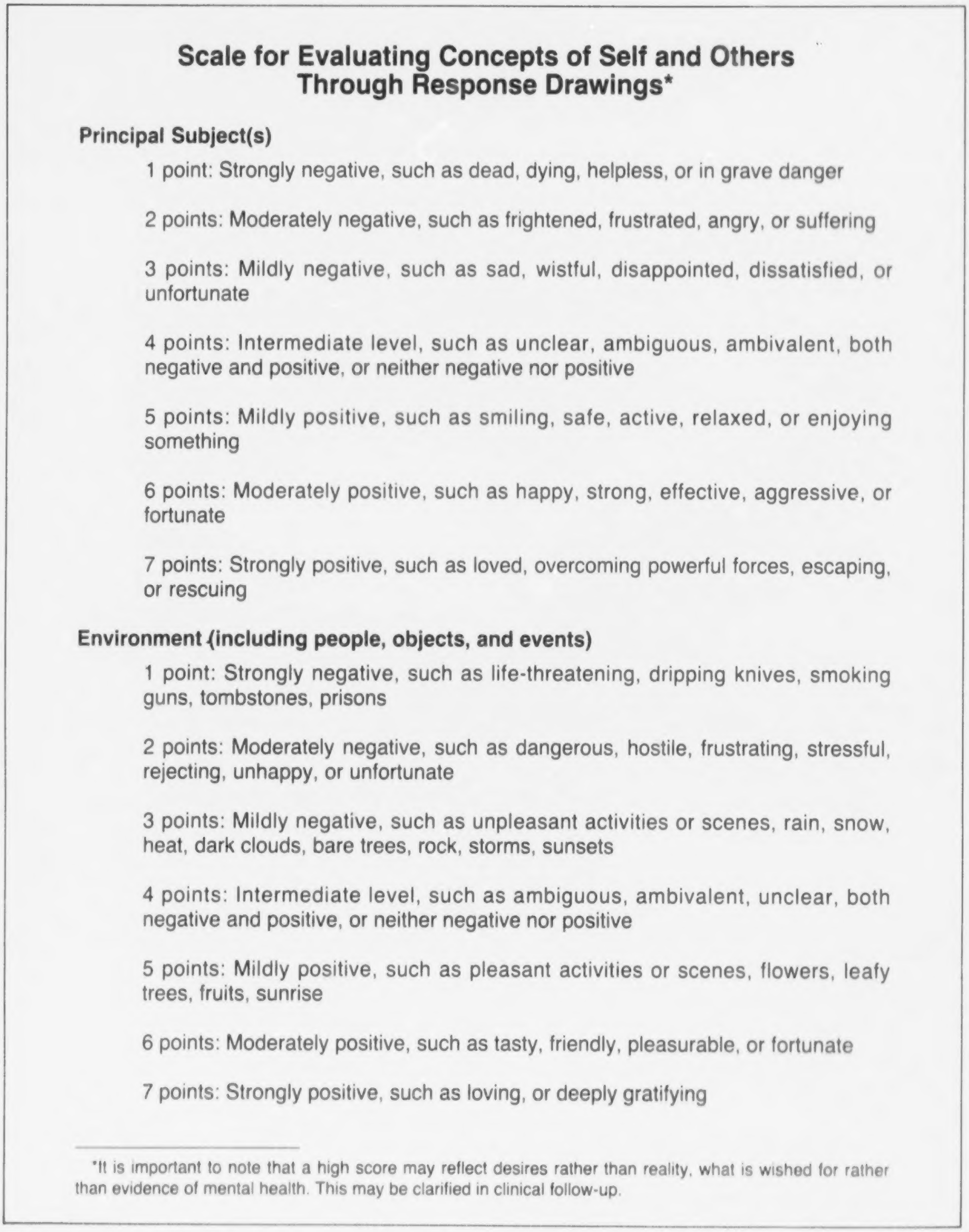
The third graders consisted of 55 boys and 58 girls in two elementary schools in a middle class socio-economic community in New Jersey.

The high school seniors consisted of 10 young men and 25 young women, the total number of students in an English class in a New York City high school.

Statistical Analyses

Response drawing scores were analyzed by means of a 2 × 4 × 2 Factorial Analysis of Variance with repeated measures on the last variable. The first variable, gender, had two levels (male and female). The second variable, age group, had four levels (third graders, high school seniors, adults and the elderly). The third variable, type of score, was the repeated variable, since for each drawing two scores were obtained (Principal Subject and Environment). From each age group, for each gender, ten subjects were randomly selected.

It was hypothesized that sex and age differences would be found in



Scale for Evaluating Concepts of Self and Others Through Response Drawings*

Principal Subject(s)

1 point: Strongly negative, such as dead, dying, helpless, or in grave danger

2 points: Moderately negative, such as frightened, frustrated, angry, or suffering

3 points: Mildly negative, such as sad, wistful, disappointed, dissatisfied, or unfortunate

4 points: Intermediate level, such as unclear, ambiguous, ambivalent, both negative and positive, or neither negative nor positive

5 points: Mildly positive, such as smiling, safe, active, relaxed, or enjoying something

6 points: Moderately positive, such as happy, strong, effective, aggressive, or fortunate

7 points: Strongly positive, such as loved, overcoming powerful forces, escaping, or rescuing

Environment (including people, objects, and events)

1 point: Strongly negative, such as life-threatening, dripping knives, smoking guns, tombstones, prisons

2 points: Moderately negative, such as dangerous, hostile, frustrating, stressful, rejecting, unhappy, or unfortunate

3 points: Mildly negative, such as unpleasant activities or scenes, rain, snow, heat, dark clouds, bare trees, rock, storms, sunsets

4 points: Intermediate level, such as ambiguous, ambivalent, unclear, both negative and positive, or neither negative nor positive

5 points: Mildly positive, such as pleasant activities or scenes, flowers, leafy trees, fruits, sunrise

6 points: Moderately positive, such as tasty, friendly, pleasurable, or fortunate

7 points: Strongly positive, such as loving, or deeply gratifying

---

*It is important to note that a high score may reflect desires rather than reality, what is wished for rather than evidence of mental health. This may be clarified in clinical follow-up.

Fig. 1

This scale appears on page 5 of *Stimulus Drawings and Techniques* by Rawley A. Silver (Trillium Books, 1986a) and is reproduced by permission.

Figures 2 through 5 are reproduced with permission from STIMULUS DRAWINGS AND TECHNIQUES, *1986a*

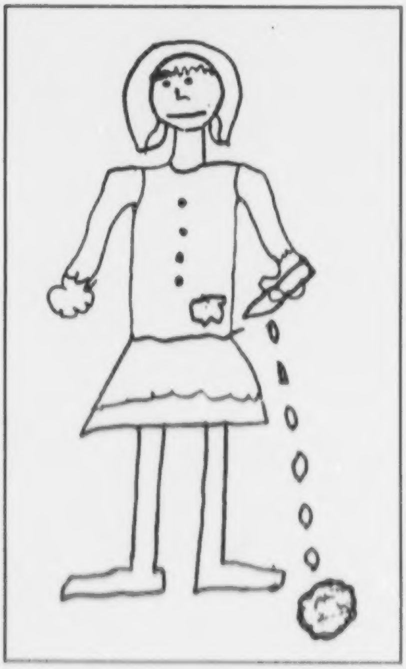


Fig. 2
"The Girl Who Killed Herself," Norbert, 12, 7th grade, Subject 1, Environment 1.

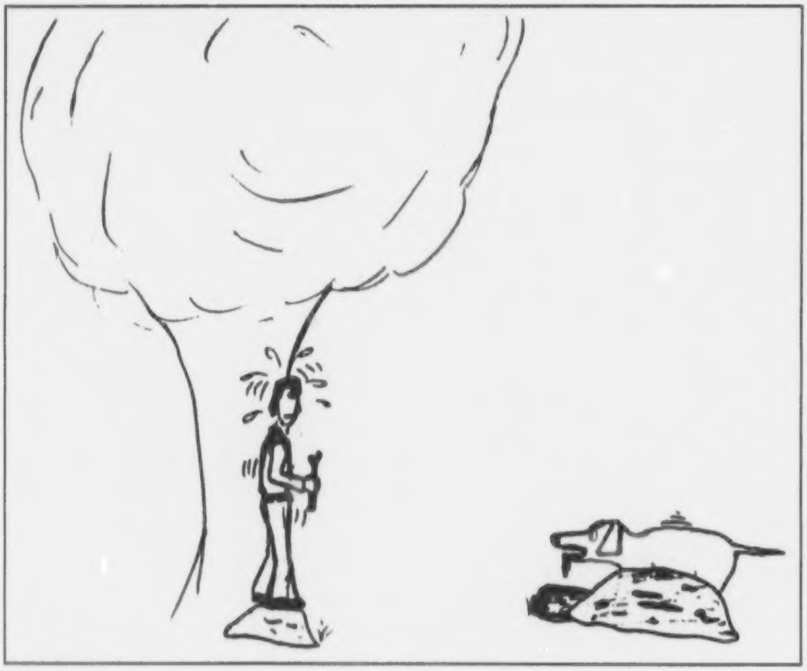


Fig. 3
"N-n-n-nice Doggie," Billy, 15, 10th grade, Subject 2, Environment 2.

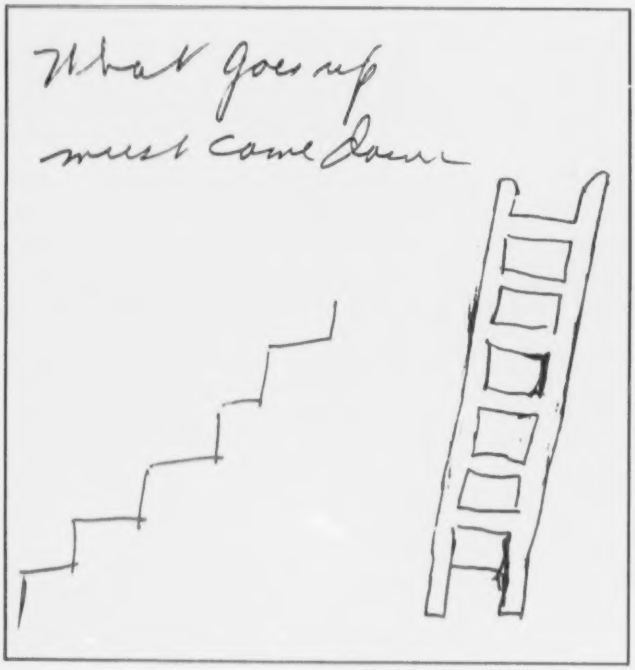


Fig. 4
"What goes up must come down," Elderly female, Subject 4, Environment 4.

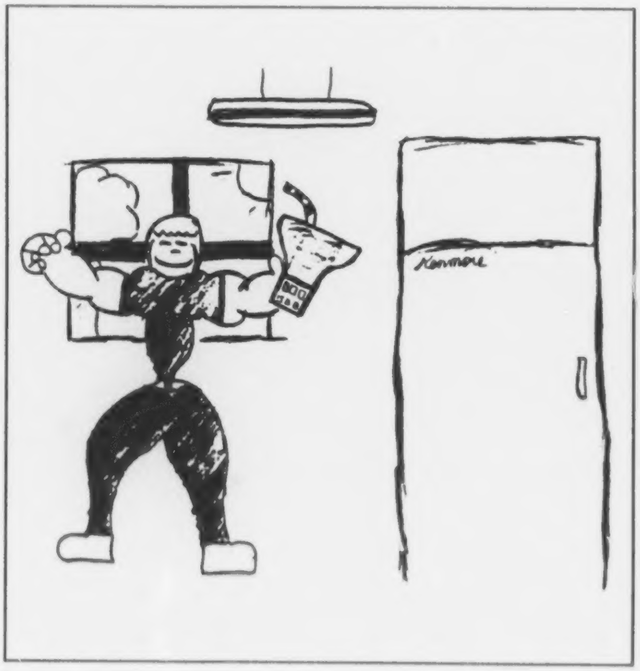


Fig. 5
"Muscleboy having a snack," Bruce, 12, 7th grade, Subject 6, Environment 6.

BEST COPY AVAILABLE

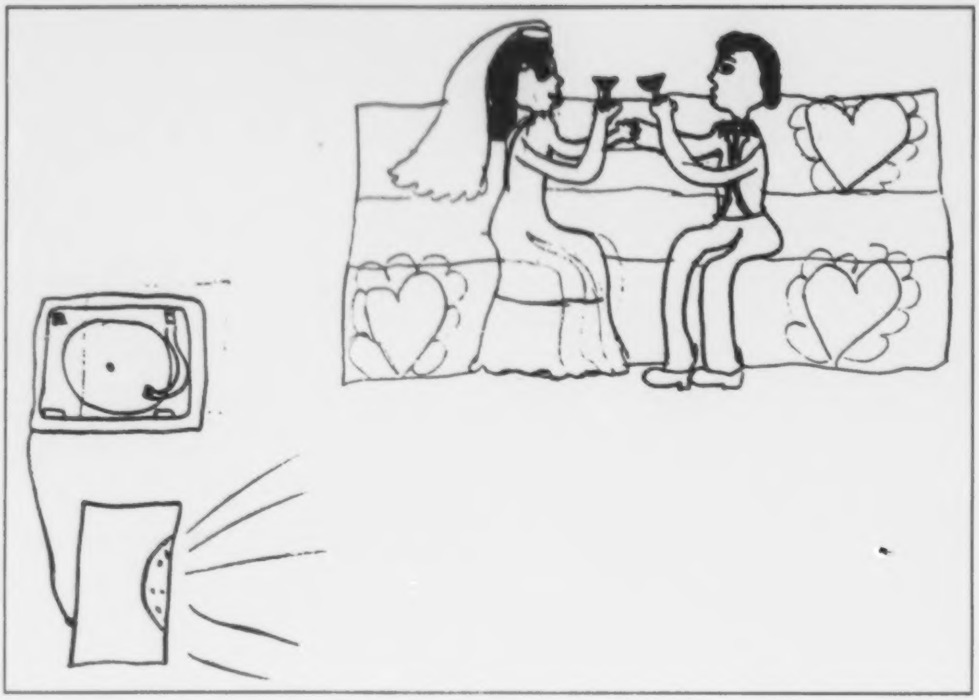


Fig. 6
"Honeymoon Suite," Darlene, 18, 12th grade, Subject 7, Environment 7.

the emotional content of response drawings as measured by the 7-point scale.

RESULTS

Significant differences were found between males and females across all age groups. Females received nearly identical scores for Principal Subject and Environment; males received higher scores for Principal Subject, lower scores for Environment.

In other words, if the rating scale is an accurate reflection of the drawings, males consistently portrayed more negative surroundings inhabited by more positively seen subjects. These differences were statistically significant, exceeding the .05 level of probability, as shown in Tables 1 and 2, and the graph, Figure 7.

These findings were supported by a Newman-Keuls Multiple Range Test of the significance of score type by sex interaction. Results were significant at the .05 level, showing that males tended to give higher ratings to Principal Subjects than to their surroundings. Female ratings showed no significant differences.

In an analysis of the entire sample of each age group, female ratings for Principal Subject and Environment were found to be significantly correlated; that is, as the ratings for Principal Subject increased, the ratings for Environment also increased.

Among Third Graders, for males, the correlation between Principal Subject and Environment scores were $r = .48$ ($p < .005$); for females, $r = .76$ ($p < .005$). Therefore, for both sexes, as Principal Subject ratings increase, Environment ratings increase.

Among High School Seniors, for males, the correlations were $r = .34$ (not significant), for females, $r = .76$ ($p < .005$).

Among Adults, for males, the correlations were $r = .18$ (n.s.), for females, $r = .67$ ($p < .005$).

Among the Elderly, for males, the correlations were $r = .19$ (n.s.), for females, $r = .60$ ($p < .005$).

Thus for every age group, female Principal Subject and Environment scores are significantly related.

Both males and females portrayed Principal Subjects more positively than they portrayed Environments. These differences also exceeded the .05 level of probability.

It is also interesting that women portrayed more negative views than men in both Principal Subject and Environment, but that they came together in old age in rating their Principal Subjects positively.

Age differences approached but did not achieve significance ($p < .10$). Nevertheless, it should be noted that of all groups, the high school girls received the highest ratings for both Principal Subject and Environment while the third grade

---

"Significant differences were found between males and females across all age groups."

Table 1 Analysis of Variance

Source	df	Sums of Squares	Mean Square	f	p
Sex	1	.10	.10	.03	n.s.
Age Group	3	25.32	8.44	2.57	n.s.
Sex by Age Group	3	21.05	7.01	2.14	n.s.
Subjects within Sex, Age	72	236.50	3.28		
Score Type	1	10.00	10.00	5.75	.05
Score Type by Sex	1	7.22	7.22	4.15	.05
Score Type by Age	3	5.75	1.91	1.10	n.s.
Score Type by Sex by Age	3	5.52	1.84	1.06	n.s.
Score by Subjects w.i. Sex, Age	72	125.50	1.74		

Table 2 Table of Means for 80 Randomly Selected Subjects

	Principal Subject		Environment		Total
	Males	Females	Males	Females	
Third Graders	4.1	2.8	2.9	2.9	3.2
High School Students	4.4	4.7	3.3	4.6	4.3
Adults	3.8	3.3	4.1	3.2	3.6
Senior Citizens	4.4	4.4	2.7	4.2	3.9
Total	4.2	3.8	3.3	3.7	3.7
	3.99		3.49		

Statistical Analyses were prepared by Beatrice Krauss, Ph.D.

girls received the lowest ratings, and that the most negative perceptions of the Environment were portrayed by the elderly men.

A closer look at these findings, even though they are not statistically significant, seems worthwhile.

The Composite Male

The 8-year-old boy who emerges from the statistical findings, portrays a threatening world, as threatening as the world of the 8-year-old girl, but unlike her, his Principal Subject tends to escape the dangers (mean scores 2.9 for Environment, 4.1 for Principal Subject). An example is shown in Figure 8.

The male adolescent, age 17 or 18, tends to perceive his Principal Subject as more powerful and his surroundings less threatening than the 8-year-old boy (Figure 9), but his Principal Subject is not quite as powerful as the Principal Subject of his female counterpart (mean scores 4.4 and 4.7 respectively), and his environment remains on the negative side while hers is on the positive side (3.3 and 4.6 respectively).

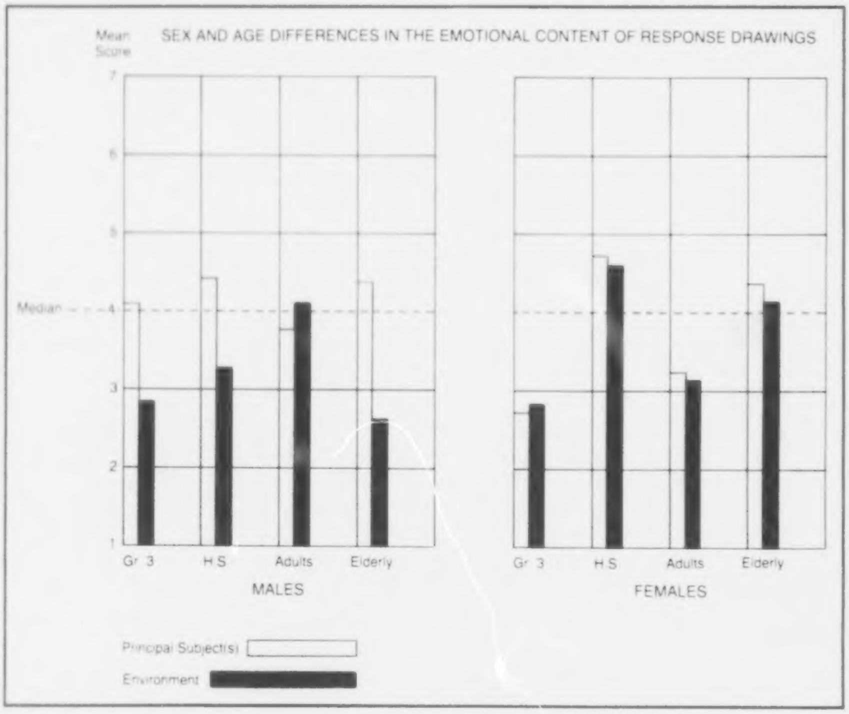
The man, age 20 to 30, reverses the negative environment-positive subject syndrome characteristic of the male groups as a whole, but the differences in mean score are slight and close to the median (Environment 4.1, Principal Subject 3.8, Figure 10).

The elderly man portrays the most negative environment of all eight groups (mean score 2.7) combined with a positively seen Principal Subject (mean score 4.4), matching the score of the elderly woman and the high school male, and exceeded only by the high school female (Figure 11).

The Composite Female

The 8-year-old girl seems to feel the most vulnerable and distressed of all the groups, with a mean score for Principal Subject, 2.8 (frightened,

Fig. 7



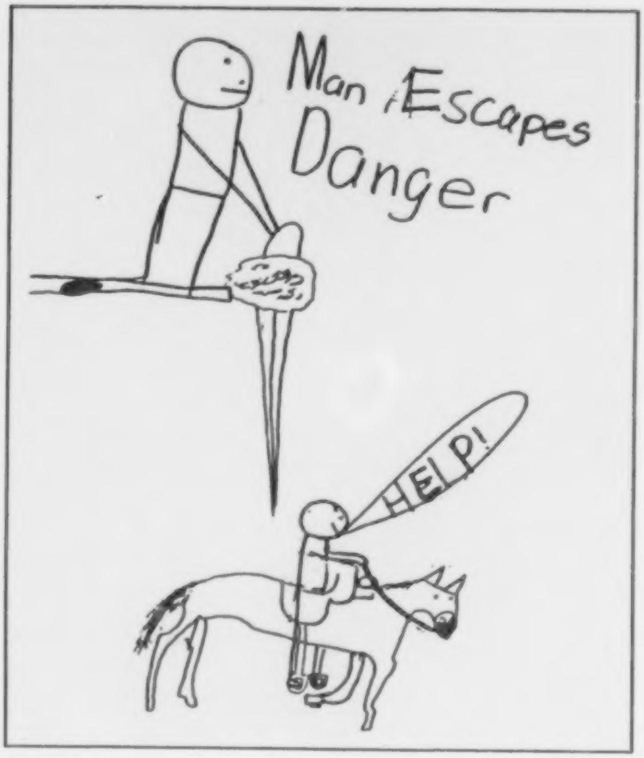

Man Escapes Danger
HELP!

Fig. 8
Response by an 8-year-old boy.

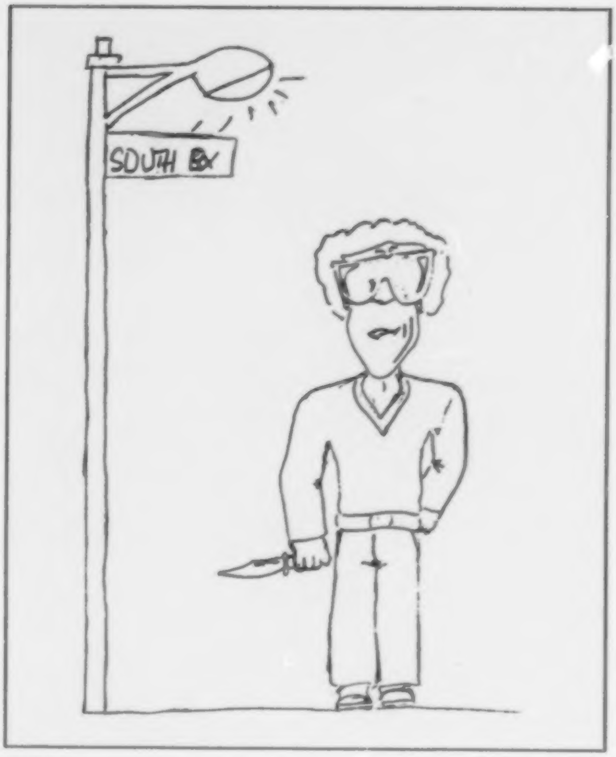


Fig. 9
Response by a male adolescent.

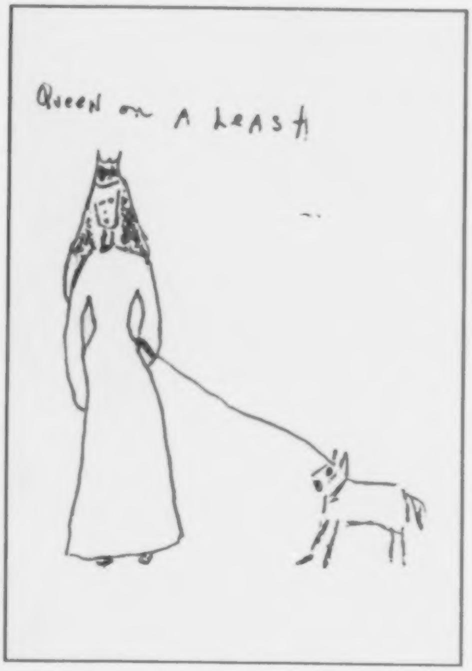

Queen on a Least

Fig. 10
Response by a young man (presumably unaware that he drew a dog, not the queen, on a leash).

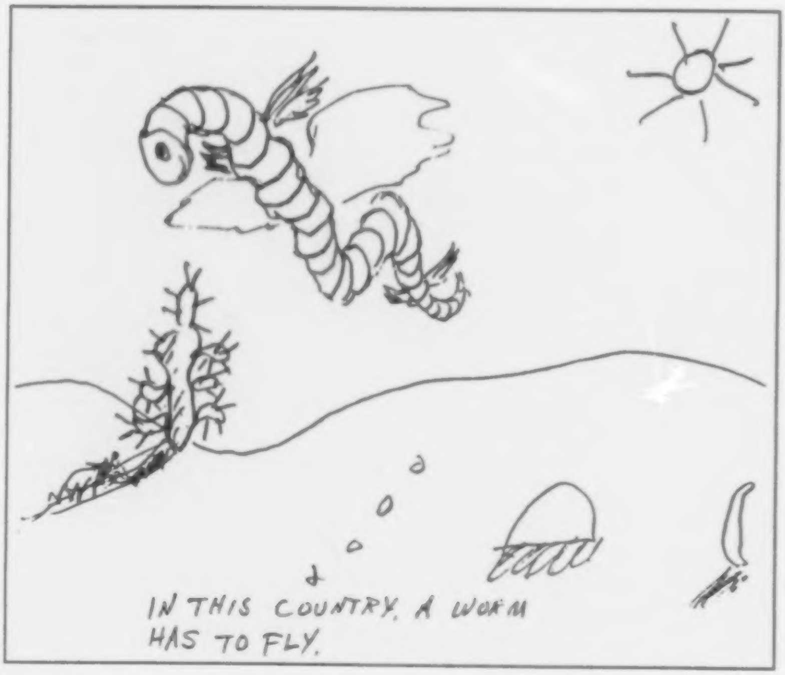

IN THIS COUNTRY, A WORM HAS TO FLY.

Fig. 11
Response by an elderly man.

BEST COPY AVAILABLE

frustrated, suffering, etc.) and for Environment, 2.9 (dangerous, stressful, etc., Figure 12).

By the age of 17 or 18, she sees her environment as positive, her mean score about as much above the median as the score of her male counterpart is below (4.4 and 3.3 respectively, Figure 6). Apparently she feels the most positive of all the groups in both Principal Subject and Environment, suggesting that girls of this age have a stronger sense of well-being and self-confidence than at the other times of their lives (mean score for Principal Subject, 4.7; for Environment, 4.6).

As she becomes a woman of 20 to 30, this confidence seems to fade. Her mean scores drop back below the median (Principal Subject, 3.3; Environment, 3.2) a greater decline than that of her male counterpart (Figure 13).

As she ages, she seems to grow stronger again, crossing the median line onto the positive side in both categories (mean score 4.4 for Principal Subject; 4.2 for Environment, Figure 14).

Discussion

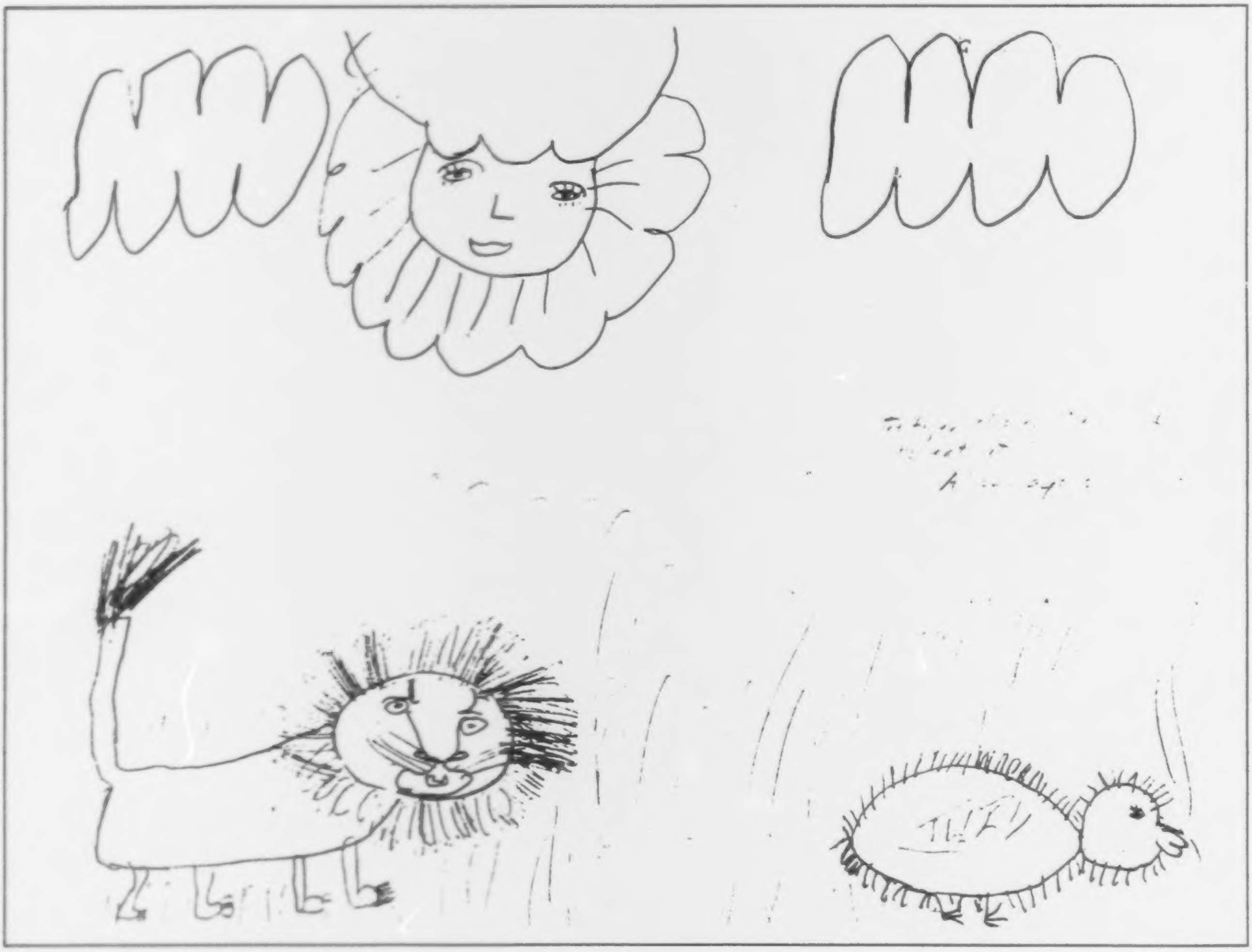
To the extent that the Principal Subject of a response drawing represents the self-image of the person who draws it, and the Environment represents the way that person perceives the world, the findings of this study suggest that males, from boyhood through old age, have more self-confidence and stronger self-images than women and girls. Even though males tend to see the world as more threatening, they see themselves as overcoming the dangers.

On the other hand, women and girls tend to relate themselves to the world. When they portray unfortunate subjects, their subjects tend to inhabit unpleasant worlds while their fortunate subjects inhabit pleasant worlds.

How can these differences be explained? What leads men and boys to see themselves fighting back in a hostile world, while women and

Fig. 12

Response by an 8-year-old girl "The tiger chases the chick to eat it."



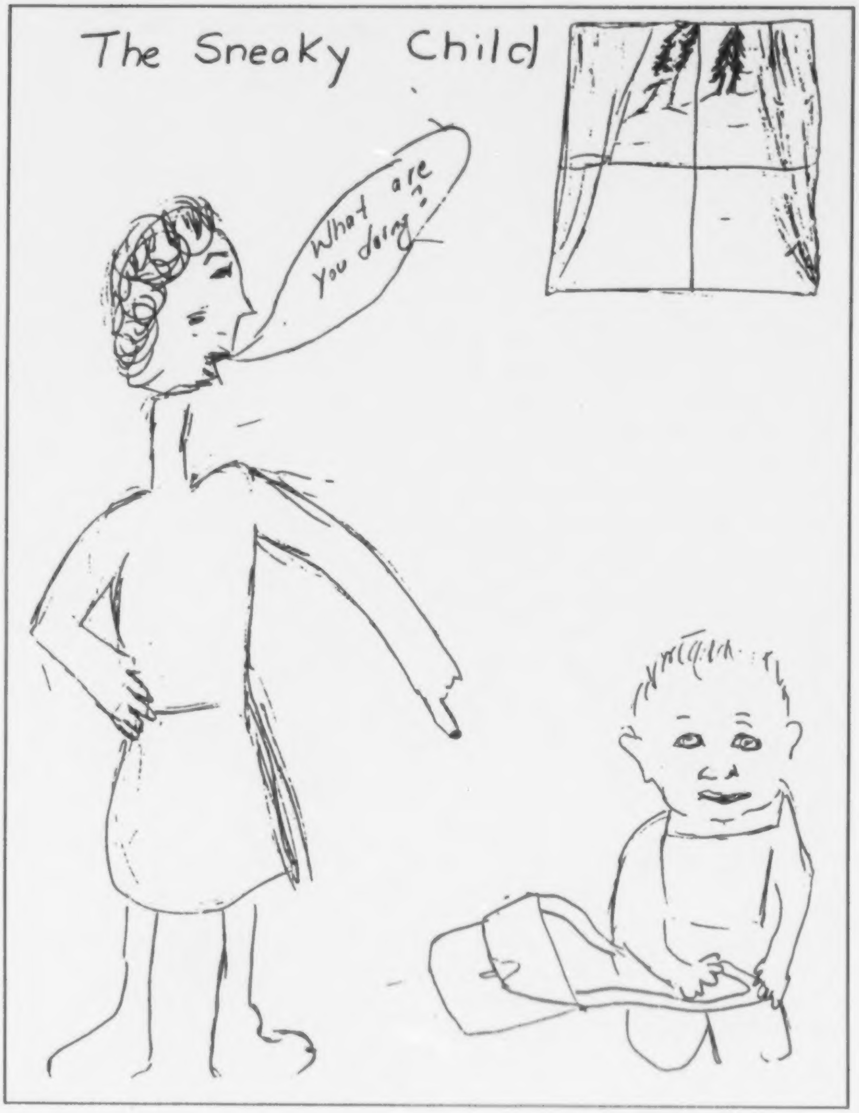


Fig. 13
Response by a young woman.

girls see themselves as part of the world, not opposing it?

Can these differences be attributed to cultural influences? biological factors? neither or both? Do they reflect strengths and weaknesses or maturity and immaturity, and if so, which sex is stronger or more mature?

Some observers seem to see gender differences like these as the result of cultural pressures, indicating a feminine weakness, lack of trust in one's self. Erica Jong, for instance, writes that women find it hard to achieve an authentic sense of self because they "are always encouraged to see themselves as role players and helpers . . . rather than as separate beings" (Jong, 1972).

Witkin and his associates also seem to view these differences as unfavorable to women, a matter of development, indicating feminine immaturity. They found women "less able to utilize the position of their own bodies" in perceiving the rod independently of its background or in determining the position of the room, more strongly influenced by the prevailing visual field (p. 155). Their assumption of correlations between maturity and field independence seems contradicted by another of their findings: that a number of hospitalized mental patients gave extremely high independent performances (p. 470), suggesting that independence is not necessarily correlated with maturity. Furthermore, they acknowledge that perception is influenced "in a basic and probably primary way" by the nature of the field in which it takes place, and that differences in task structure make for important differences in perception (p. 467). The perceptual situations provided by their experiments represent only one kind of perception, and in this kind of perception, males and females seem to respond differently.

When Witkin and his associates extended their experiments beyond spatial perception, testing groups of normal men and women with Figure Drawing, TAT, and Rorschach tests as well as interviews, they found no significant differences in mean personality scores that would parallel the differences in perceptual performances (p. 488). What they found were certain personality characteristics relevant to performance in perceptual tasks. These included self concepts, ways of managing impulses and strivings, and the nature of their subjects in relation to their environments (including other people). Field-dependence was found to be associated with passivity and low self-esteem.

Thus the field dependency associated with females may reflect the development of greater sensitivity to the environment, caused perhaps by adapting to environments that make harsher ego demands on females than on males, social environments that discourage girls from being narcissistic and aggressive, and encourage boys to want what they want when they want it.

Lewis Thomas seems to attribute gender differences, such as these, to biology, and to see them as favor-

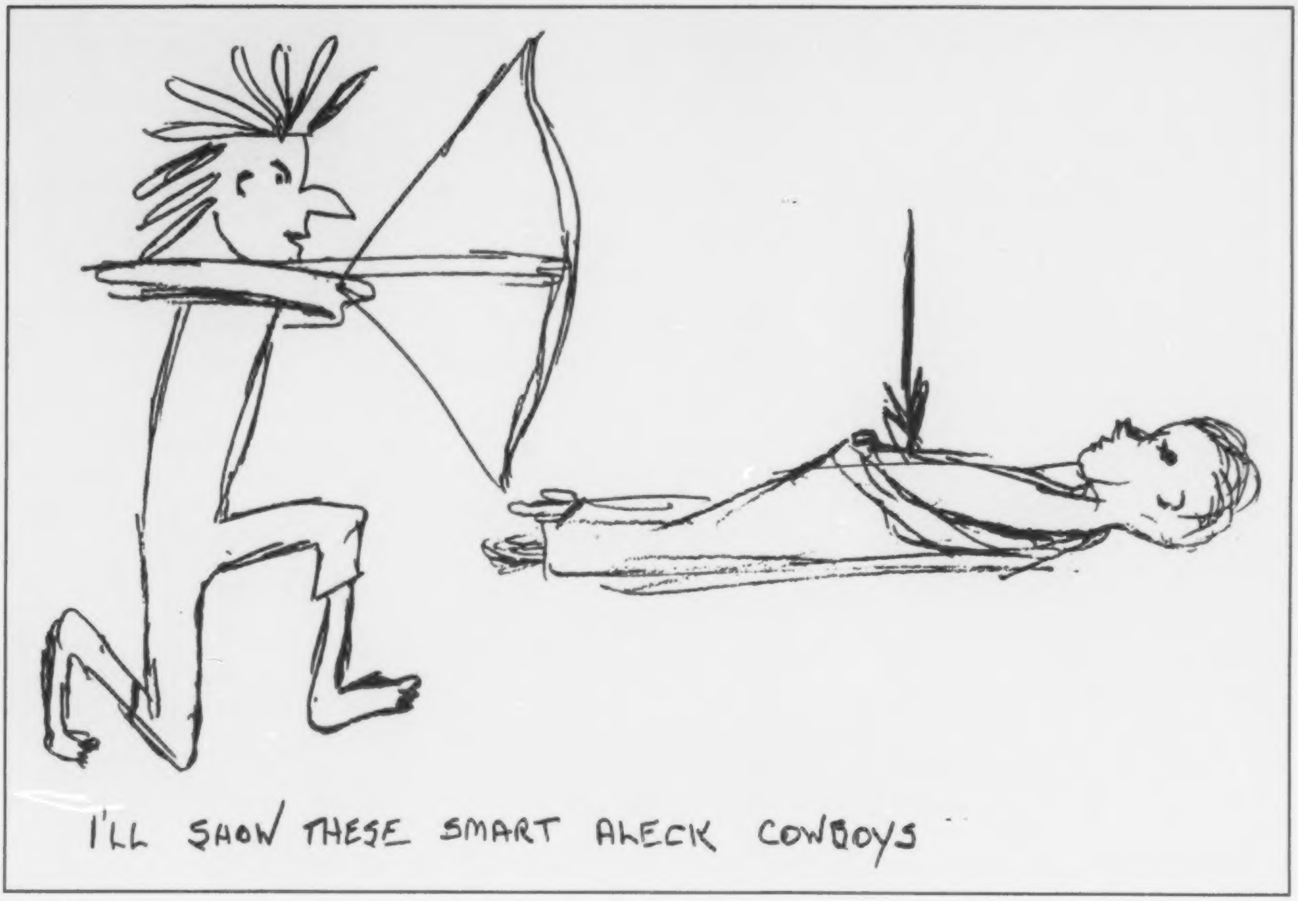

I'LL SHOW THESE SMART ALECK COWBOYS

Fig. 14
Response by an elderly woman.

able to females. As he observes, childhood lasts considerably longer in the human male than in the female. "There is somewhere a deep center of immaturity built into the male brain, always needing steadying and redirection" (Thomas, p. 236). He suggests that in the X chromosome (female) there is information for a qualitatively different sort of behavior than the instructions in the Y (male) chromosome, and that this difference benefits the long-term needs of the species. On "occasions when the survival of human beings is in question, I would trust that X chromosome and worry about the Y," and place the use of thermonuclear weapons "squarely in the laps of the world's women . . . I do not trust men in this matter" (p. 237).

It is important to note that the findings of gender differences reported here did not hold true for all members of the gender groups. In Witkin's studies, some men showed marked dependence on the visual field while some women showed very little dependence. In our study, many individuals, male and female, produced drawings that differed from their groups as a whole.

Although a comprehensive review of individual responses is beyond the scope of this study, the fact that some response drawings scored 1 or 2 points while others scored 6 or 7 points suggests that therapists will find individual responses useful for evaluating the emotional needs of the individuals who draw them, particularly those who may be depressed.

This study has found that response drawings by men and boys differ from drawings by women and girls to a degree that is statistically significant. These findings raise questions for further research: will

". . . response drawings by men and boys differ from drawings by women and girls to a degree that is statistically significant."

additional studies support the finding that men and boys tend to represent their Principal Subjects more positively, and Environments more negatively, than women and girls? Do males and females of other cultures or subcultures respond differently? Do male raters score response drawings differently? Is the 7-point scale useful in identifying and assisting those individuals, male or female, who are depressed or at risk for suicide?

These questions suggest that further research with larger and more diverse populations is worthwhile in order to build on the knowledge obtained.

References

Jong, E. M. (1967). The artist as housewife. *Reading for rhetoric* (C. Schrode, et. al.). New York: The Macmillan Company.

Sandburg, L., Silver, R., and Vilstrup, K. (1984). The stimulus drawing technique. *Art Therapy*, Vol. 1, #3, October. The Journal of the American Art Therapy Association.

Silver, R. (1986a, 1982, 1981). *Stimulus drawings and techniques*. New York: Trillium Press.

Silver, R. (1986b, 1978). *Developing cognitive and creative skills through art*. New York: Trillium Press.

Silver, R. (1983). *Silver test of cognitive and creative skills*. Seattle, WA: Special Child Publications.

Thomas, L. (1983). *The youngest science*. New York: The Viking Press.

Vilstrup, K. (1983). Book review. *American Journal of Art Therapy*, Vol. 22, #2, January.

Whitehurst, G. (1984). Interrater agreement for journal manuscript reviews. *American Psychologist*, Vol. 39, p. 22.

Witkin, H., Lewis, H., Hertzman, M., Machover, K., Meissner, P., and Wapner, S. (1958). *Personality through perception*. Westport, CT: Greenwood Press.

Graphic Characteristics on the Draw-A-Person Test for Identification of Physical Abuse

Frances M. Culbertson, *Coordinator of the School Psychology Program, University of Wisconsin–Whitewater.* **Anna C. Revel,** *School Psychologist, Public Schools of Janesville, Wisconsin, Deacon in the Episcopal Church.*

This study utilizes two common assessment procedures of school-aged children, the Draw-a-Person test (DAP) and the Wechsler Intelligence for Children-Revised (WISC-R) to identify characteristics of physically abused children. Sixty developmentally disabled children are included in the sample of children studied. Twenty of the children are in learning disability (LD) classes; twenty are in classes for emotionally disturbed (ED); and twenty are known physically abused (PA) children who are either in classes for learning disabled or for emotionally disturbed children. All children are of average intelligence. In the cognitive domain, difference scores of the DAP and WISC-R tests are compared across the three groups of special education children. In the emotional domain, two separate DAP graphic scoring systems assessing emotional functioning of children are analyzed for significant graphic elements in the drawings. Results of the statistical analyses of the WISC-R and the DAP intellectual differences indicate that the physically abused students in special education have significantly greater minus difference scores between the WISC-R and the DAP than other developmentally disabled children. Analyses of the emotional indicators of the DAP test result in 9 graphic items that are significantly associated with physical abuse. A decision tree model is presented for identifying physical abuse in school-aged children of average intelligence.

Key Words: WISC-R, DAP, Exceptional Educational Needs.

Introduction

Psychologists who are involved in the evaluation and assessment procedures of referred children have much to offer in identifying the possibility of physical abuse. Psychological instruments can be exquisitely tuned instruments in obtaining data on self-concept, conflicts, social-emotional delays and problems of children. Delays in motor development, learning problems, hyperactive behaviors, aggressive behaviors, sudden changes in academic performance are some of the early identified characteristics associated with abused and neglected children (Martin, Conway, Kempe, 1974; Reidy, 1977; Perry, Doran, Wells, 1983). Just as teachers are being alerted to academic failures and other changes in behaviors of children in the classroom as indicators of possible child abuse, so psychologists, working with children and adolescents, must be sensitized to the instruments they use and the possibility that these instruments may provide clues to the hypothesis or identification of children who are or have been abused.

The utility of psychological assessment data providing probability statements or inferences of physical abuse in children has been minimally researched.

One study that has attempted to examine psychological assessment procedures for some diagnostic indicators of physical abuse is the study of Blain, Bergner, Lewis, and Goldstein (1981). The authors in this study employed the House-Tree-Person test (HTP) to establish factors that could identify or at least hypothesize the presence of child abuse. As they noted, the HTP test may be highly relevant in identifying child abuse as this measure has "minimal intellectual demand characteristics," is an "unobtrusive measure," and "can establish empirical correlations between cues and a criterion," for detection of the abused child. Their findings proved to be useful, in differentiating physically abused children from normal and mental health, clinic children. Their findings in regard to the human figure of the HTP test pointed to the following items as possible child abuse indicators: "figure is comprised of geometric figures"; "absence of feet"; and "head is over ¼ the total size of figure." All factors were significant at the $p < .01$ level.

Another study is the exploratory research of physically abused children's Draw-a-Person test by the authors which has provided 17 graphic

"Psychological instruments can be exquisitely tuned instruments in obtaining data on self-concept, conflicts, social-emotional delays and problems of children."

"The utility of psychological assessment data providing probability statements or inferences of physical abuse in children has been minimally researched."

items characteristic of children's drawings in the DAP test (see Table 4).

Two instruments that are very frequently employed in a diagnostic workup of children referred for special education evaluation are the Wechsler Intelligence Scale for Children-Revised (WISC-R) and the Draw-a-Person test (DAP). The WISC-R is used primarily for intellectual evaluations of school-aged children from ages 6 through 16. The DAP test is used as both an intellectual assessment instrument (Harris, 1963) and as an assessment instrument for the evaluation of emotional functioning (Koppitz, 1968) for the same age range as the WISC-R. The DAP test, like the HTP test, is an unobtrusive measure, having minimal demand characteristics. However, the DAP test score is more likely than the WISC-R test score to be significantly lowered by emotional factors in the subject (Koppitz, 1968).

The present study is concerned with examining graphic differences on the DAP test as they relate to intellectual and emotional functioning of developmentally delayed, physically abused children compared to other developmentally delayed children (learning disabled, emotionally disturbed) in a school setting.

METHOD

Subjects

To clearly separate physical abuse influences on the DAP from the influences of learning-disabilities and/or emotional disabilities, the study includes three groups of students. They are known and reported physically abused children who have an LD or ED placement (PA); learning disabled children not known to be physically abused (LD); and emotionally disturbed children not known to be physically abused (ED). Students (20 in each group) were matched for sex and age. There were 13 males and 7 females; ages ranged from 6–15.10 years of age. Since intellectual functioning is considered to be an important variable of the DAP test, only those students whose WISC-R scores place them in the average or above range of intellectual functioning were considered for inclusion in the study.

Procedure

All children in this study were administered the WISC-R and DAP test as part of a more complete assessment battery to determine their eligibility for exceptional educational (special education) placement. For each child in the sample, the total standard scale scores of the WISC-R and DAP were obtained. In addition, each of the DAP test drawings were scored for emotional factors utilizing the Koppitz scoring system (Koppitz, 1968) as well as the scoring system for physical abuse factors developed by the authors. All DAP tests were scored by two psychology students not associated with the study. Inter-rater agreements were $r = .89$ for the Koppitz system, and $r = .85$ for the Culbertson-Revel system.

RESULTS

An ANOVA, 2 × 3, between and within design, yields the following findings: the between variables of the diagnostic category effect is significant, $F\ (2,57) = 5.937$, $p = .004$; the within subject variable test effect is significant, $F\ (1,57) = 4.088$, $p = .004$. This indicates that these subjects scored higher on the WISC-R than on the DAP. Interaction between diagnostic category and test is also significant, $F\ (2,57) = 8.26$, $p = .001$. For the WISC-R test, there is no difference between the three groups, however, for the DAP test, the PA group score is significantly lower than for the LD or ED groups (see Figure 1).

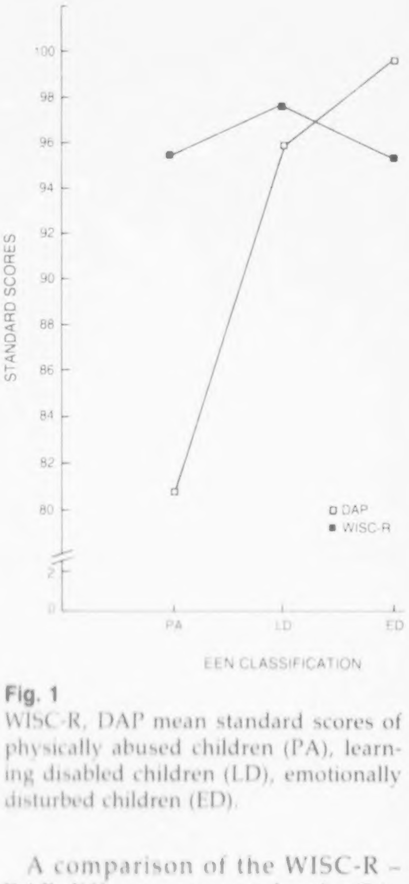


Fig. 1
WISC-R, DAP mean standard scores of physically abused children (PA), learning disabled children (LD), emotionally disturbed children (ED).

A comparison of the WISC-R – DAP difference scores for the PA, LD, ED students, using a 2 × 3 chi square analysis based on frequencies falling into plus or minus WISC-R – DAP differences, yields a X^2 $(2, N = 60) = 8.69$, $p < .05$ (see Table 1). Eighty percent of the PA children have DAP scores that are less than their WISC-R scores; fifty percent of the LD children have WISC-R – DAP minus scores, and thirty percent of the ED children have such a configuration. In considering the size of the differences, there are 14 out of the

BEST COPY AVAILABLE

20 PA students (70%) that have score differences of minus 15 or more points, while in the learning disabled group, only 5 out of 20 (25%) have such a difference. In the emotionally disturbed group of students, only one student out of the 20 (5%) has a negative difference score this large. For both the WISC-R and the DAP tests, −15 points equals −1 S.D. from the mean score of the test. The significance difference here is $X^2(2,N=60) = 19.95, p<.001$ (see Table 2.)

Table 1 WISC-R – DAP Difference Scores

	Difference Score +	Difference Score −	Row Total
PA	4	16	20
LD	10	10	20
ED	14	6	20

$X^2(2,N=60) = 8.69, p<.05$

Table 2 WISC-R – DAP Difference Scores (−15 or higher)

	Difference Score + −	Difference Score + −	Row Total
	−14 or less	−15 or higher	
PA	6	14	20
LD	15	5	20
ED	19	1	20

$X^2(2,N=60) = 19.95, p<.001$

Table 3 Koppitz Emotional Indicators on the DAP Test

Indicators	Physical Abuse N (%)	Learning Disturbance N (%)	Emotional Disturbance N (%)
A. Quality Signs			
1. Poor integration of parts	0 (0)	2 (10)	3 (15)
2. Shading of face	0 (0)	1 (5)	0 (0)
3. Shading body neck	0 (0)	1 (5)	4 (20)
4. Shading hands neck	0 (0)	1 (5)	0 (0)
5. Gross asymmetry of limbs	15 (75)	15 (75)	13 (65)
6. Slanting figure	1 (5)	0 (0)	0 (0)
7. Tiny figure	7 (35)	3 (15)	2 (10)
8. Big figure	6 (30)	6 (30)	5 (25)
9. Transparencies absent	20 (100)	12 (60)	15 (75)**
10. Tiny head	1 (5)	1 (5)	2 (10)
11. Crossed eyes	0 (0)	1 (5)	1 (5)
12. Teeth	4 (20)	3 (15)	2 (10)
13. Short arms	3 (15)	3 (15)	3 (15)
14. Long arms	0 (0)	0 (0)	5 (25)
15. Big hands	0 (0)	0 (0)	0 (0)
16. Arms clinging to body	0 (0)	2 (10)	4 (20)
17. Hands cut off	11 (55)	6 (30)	9 (45)
18. Legs pressed together	0 (0)	0 (0)	0 (0)
19. Genitals	0 (0)	0 (0)	0 (0)
20. Monster or grotesque figure	0 (0)	0 (0)	0 (0)
21. Three or more figures	0 (0)	0 (0)	0 (0)
22. Clouds, rain or snow	0 (0)	0 (0)	0 (0)
B. Omissions			
23. No eyes	0 (0)	0 (0)	0 (0)
24. No nose	3 (15)	1 (5)	1 (5)
25. No mouth	0 (0)	0 (0)	0 (0)
26. No arms	3 (15)	0 (0)	0 (0)*
27. No legs	0 (0)	0 (0)	0 (0)
28. No feet	5 (25)	1 (5)	0 (0)*
28. No body	0 (0)	0 (0)	0 (0)
30. No neck	0 (0)	0 (0)	0 (0)

*p<.05, **p<.01.

Consideration of emotional indicators as described by Koppitz, as predictive indicators of abuse, yields the following findings in the three groups as shown in Table 3.

Out of 30 items listed in the Koppitz scale, 3 items attain levels of significance of $p<.05$. These items are absence of transparencies, $X^2(2,N=60) = 9.6, p<.01$; no arms, $X^2(2,N=60) = 6.32, p<.04$; and no feet, $X^2(2,N=60) = 7.8, p<.02$ (see Table 3). All other Koppitz items do not reach significance levels to differentiate these items as characteristic of PA children as compared to LD or ED children.

The Culbertson-Revel scoring system consists of 17 characteristics (see Table 4). There are eight items (over 47%) that reach significance levels of $<.05$. The significance items are as follows:

1. Complexity of head, $X^2(2,N=60) = 34, p<.001$;
2. Pressured lines, $X^2(2,N=60) = 17.4, p<.001$;
3. No clothing, $X^2(2,N=60) = 7.1, p<.028$;
4. Vacant eyes (no pupils), $X^2(2,N=60) = 6.7, p<.035$;
5. Absence of figure in center of page, $X^2(2,N=60) = 10, p<.01$;
6. Absence of feet, $X^2(2,N=60) = 7.8, p<.02$;
7. Absence of arms, $X^2(2,N=60) = 6.32, p<.043$;
8. Head over ⅓, $X^2(2,N=60) = 6.2, p<.046$;

Combining all significance items for physically abused children on the DAP test, including the findings of Blain et al. (B), Koppitz (K), and

BEST COPY AVAILABLE

Table 4 Culbertson-Revel Emotional Indicators on DAP Test

Indicators	Physical Abuse N (%)	Learning Disturbance N (%)	Emotional Disturbance N (%)
1. Complexity of head over rest of figure	20 (100)	4 (20)	4 (20)***
2. Pressured lines—straight, hard lines	20 (100)	9 (45)	9 (45)***
3. Less than four items of clothing	16 (80)	16 (80)	15 (75)
4. No clothing	13 (65)	13 (65)	5 (25)*
5. Vacant eyes—no pupils	13 (65)	6 (30)	6 (30)*
6. Body distortions	15 (75)	11 (55)	7 (35)
7. Hands cut off	11 (55)	6 (30)	9 (45)
8. Forced congeniality of mouth	15 (75)	15 (75)	10 (50)
9. Petal fingers	6 (30)	10 (50)	8 (40)
10. Teeth	4 (20)	2 (10)	2 (10)
11. Overemphasis of eyes	3 (15)	4 (20)	1 (5)
12. Talon fingers	3 (15)	1 (15)	1 (5)
13. Absence of figure in center of page	20 (100)	16 (80)	12 (60)**
14. Large figure (50% or more of page)	6 (30)	5 (25)	6 (30)
15. Absence of feet	5 (25)	0 (0)	0 (0)*
16. Absence of arms	3 (15)	0 (0)	0 (0)*
17. Head over ¼ of total figure size	17 (85)	9 (45)	11 (55)*

N = 60 (20 in each column)
*p<.05, **p<.01, ***p<.001

Culbertson-Revel (C-R) yields the following results:

1. Absence of feet (C-R, B, K);
2. Head over ¼ of total size of the figure (C-R, B);
3. Absence of arms (C-R, K);
4. Complexity of head over body (C-R);
5. Pressured lines (C-R);
6. No clothing (C-R);
7. Vacant eyes (C-R);
8. Absence of figure in center of page (C-R);
9. Transparency absent (K).

The graphic significance test findings (from the three scoring systems of the DAP) and the WISC-R – DAP difference scores are combined to form a decision-tree model for identification of physical abuse in children with average intelligence. This decision-tree model is as follows:

Decision-Tree Model of Child Abuse

1. *Is there a difference of −15 points or more between the WISC-R and the DAP with the DAP score lower than the WISC-R?*

YES	NO
Suspect child abuse, continue on:	End of inquiry regarding child abuse.

2. *Are feet missing (C-R, B, K) (.02)?*
3. *Is head size ¼ or more of total size of figure (C-R, B) (.046)?*
4. *Are arms missing (C-R, K) (.043)?*
(Significance findings in two or more studies; significance levels from <.01 – <.05).

YES	NO
Suspect abuse if 2 out of 3 items are present, higher level of confirmation, continue on:	End of inquiry regarding child abuse.

5. *Is the head more complex than the body (C-R) (.001)?*
6. *Are pressured lines present (C-R) (.001)?*
7. *Is figure placed elsewhere but in center of page (C-R) (.01)?*
8. *Is transparency of figure absent (K) (.01)?*
(Significance findings in one study, and significance levels from <.001 – <.01).

YES	NO
Suspect abuse if 3 out of 4 items are present, and additional higher level of confirmation, continue on:	Question of physical abuse less likely but further inquiry recommended.

9. *Is clothing absent (C-R) (.028)?*
10. *Are eyes vacant (pupils missing) (C-R) (.035)?*
(Significance findings in one study, and significance levels from <.02 – <.03).

YES	NO
Physical abuse indicated when 1 out of 2 items is present. Gather additional validating data from other areas for definite confirmation.	Question of physical abuse is less likely but further inquiry is recommended.

The drawing in Figure 2 of a physically abused child, referred for special education placement is analyzed using the above proposed decision-tree model. This male child's age is 9 - 1 years. His IQ score on the Wechsler Intelligence Scale for Children - Revised is 99. His DAP IQ score is 75, resulting in a 24-point difference in the cognitive domain. Applying the decision-tree model, the following steps ensue: **1.** Is there a difference of −15 points or more between the WISC-R and the DAP with the DAP score lower than the WISC-R? YES, suspect physical abuse, continue on. **2.** Are feet missing? YES. **3.** Is head size ¼ or more of total size of figure? YES. **4.** Are arms missing? NO. Two out of three

BEST COPY AVAILABLE

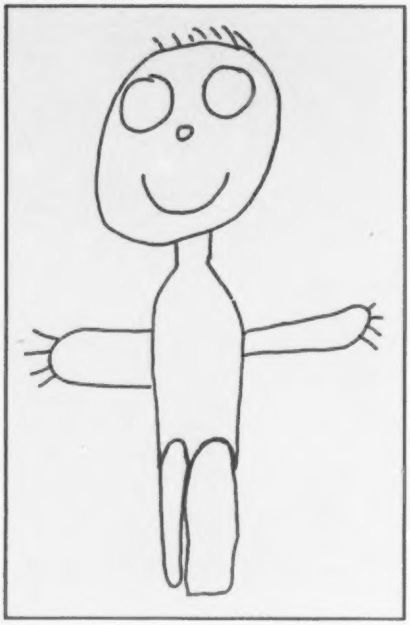


Fig. 2
The Draw-a-Person sample of a suspected physically abused child referred for special education placement (age 9-1, WISC-R – 95, DAP – 70).

items are present, suspect higher level of physical abuse. **5.** Is head more complex than body? YES. **6.** Are pressured lines present? YES. **7.** Is figure placed elsewhere but in center of page? NO. **8.** Are transparencies in figure absent? YES. Three out of four items present, suspect an additional higher level of physical abuse, continue on. **9.** Is clothing absent? YES. **10.** Are eyes vacant (pupils missing)? YES. Two out of two items are present. The conclusion is that physical abuse is present in this case. However, additional data from other sources are necessary to definitely establish physical abuse.

> ***". . . psychologists need to become more aware of the value of psychological data in generating clues or hypotheses regarding child abuse."***

Discussion

It is common knowledge that children are often the last to report that they have been abused. They tend to be reticent, protective and/or fearful regarding their experiences and the impact on parents and family. Therefore, psychologists need to become more aware of the value of psychological data in generating clues or hypotheses regarding child abuse. This study has attempted to show the utility of two very commonly used tests for detection of child abuse in developmentally disabled children.

It explores graphic characteristics of physically abused, developmentally disabled children compared to other developmentally disabled children on the Draw-a-Person test (DAP) as well as the intellectual status of these children as measured by the Wechsler Intelligence Scale for Children Revised (WISC-R) and the DAP test. Findings reflect significant differences in both cognitive areas of functioning and in emotional areas of functioning of developmentally disabled, physically abused children on these commonly used psychological instruments. The differences scores of the WISC-R and the DAP appear to yield a significant clue in the identification of suspected physical abuse. Differences of – 15 points or more between WISC-R – DAP scaled scores appear to be important indicators of physical abuse in children. In addition, the study's findings of nine graphic elements, common in the DAP figures of physically abused children, provide further confirmatory data for assessing physical abuse. A decision-tree model incorporating the significant findings of this study is proposed and needs further validation. Replications of the above findings are welcome and the necessity to include data on family functioning, medical history, behavioral and observational indices in suspected physical abuse cases before a conclusion of physical abuse is reached is recognized.

> ***". . . the study's findings of nine graphic elements, common in the DAP figures of physically abused children, provide further confirmatory data for assessing physical abuse."***

References

Baron, M. A., Bejar, R. I., and Sheaff, P. J. (1971). Neurological manifestations of the battered child syndrome. *Pediatrics*, 46(6): 1003-1007.

Blain, G. H., Bergner, R. M., Lewis, M. L., and Goldstein, M. A. (1981). The use of objectively scorable House-Tree-Person indicators to establish child abuse. *Journal of Clinical Psychology*, Vol. 37, #3.

Brandwein, H. (1973). The battered child: A definite and significant factor in mental retardation. *Mental Retardation*, 11: 50-51.

Cushna, B. (1979). A true perversion. In U.S. DHEW. *Child abuse and developmental disabilities: Essays*. Washington, D.C., 10-13.

Friedman, S. B. (1972). The need for intensive follow-up of abused children. In Kempe, C. H., and Helfer, R. E. (eds.). *Helping the battered child and his family*. Philadelphia, PA: J. B. Lippincott, 79-92.

Friedrich, N., and Boriskin, J. A. (1976). The role of the child in abuse: A review of the literature. *American Journal of Orthopsychiatry*, 46: 580-590.

Gelles, J. (1975). Violence and pregnancy: A note on the extent of the problem and needed services. *The Family Coordinator,* 24: 81-86.

Gil, G. (1970). *Violence against children: Physical child abuse in the United States.* Cambridge, MA: Harvard University Press.

Harris, D. B. (1963). *Children's drawings as measures of intellectual maturity.* New York: Harcourt, Brace & World, Inc.

Koppitz, E. M. (1968). *Psychological evaluation of children's human figure drawings.* New York: Grune & Stratton.

Martin, H. P. (1972). The child and his development. In Kempe, C. H., and Helfer, R. E. (eds.). *Helping the battered child and his family.* Philadelphia, PA: J. P. Lippincott, 93-114.

Martin, H. P., Conway, F. F., and Kempe, C. H. (1974). The development of abused children. *Advances in Pediatrics,* 21: 25-73.

Morse, C., Sahler, O., and Friedman, S. (1970). A three-year follow-up of abused and neglected children. *American Journal of Disabilities in Childhood,* 120: 493-496.

Perry, M. A., Doran, L. D., and Wells, E. A. (1983). Developmental and behavioral characteristics of the physically abused child. *Journal of Clinical Child Psychology,* 12(3): 320-324.

Reidy, T. J. (1977). The aggressive characteristics of abused and neglected children. *Journal of Clinical Psychology,* 33: 1140-1145.

U.S. Department of Health, Education and Welfare. (1979). *Child abuse and developmental disabilities: Essays.* DHEW Publications No. (OHDS) 79-30226, Washington, D.C.

Acknowledgments

The authors are indebted to Amy Culbertson and Joanne Jeske for their assistance in scoring of the DAP tests.

Educating the Creative Arts Therapist: A Profile of the Profession

***Dr. Shaun McNiff,** Charles C Thomas Publisher, 1986, x + 286 pages, $32.00.*

*Reviewer **Irene Corbit, PhD, ATR,** is an art psychotherapist in private practice in Houston, Texas, and part-time faculty, The University of Houston–Clear Lake.*

Long overdue, Shaun McNiff's new book fills a void on the educational scene for creative arts therapists, educators and supervisors in the field. Although McNiff's book is ostensibly directed towards a select audience, namely creative arts therapy educators, its peripheral audience is much broader. Clinical art therapists, dance therapists, music therapists, psychodramatists, and other arts therapy specialists can gain a clearer view of their own and other's respective professions. McNiff, incidentally, in his book, views all of the creative arts therapies as a single profession "which like any other complex discipline is composed of varied areas of specialization." He sees the various creative arts therapies to be far more similar than different.

With this theme carried throughout the book, McNiff discusses trends in American higher education, definition of the profession, academic training programs, media competencies, supervision and evaluation. The statistics incorporated into the book, which will unfortunately date the book in years to come, present a current picture of the field, including universities offering programs in the arts therapies.

McNiff, it appears to me, has a purpose in his book which goes beyond describing the creative arts therapies as they have been and as they are: namely, that of projecting an image of how he feels they ideally can be. McNiff presents his "pantheon" image, an umbrella encompassing the creative arts therapies field, which would allow for separate identities and training, but which would give arts therapists power in numbers. This power in numbers would be similar to that of physicians who practice their various specializations, yet have the advantage of their "physician" umbrella which gives them tremendous legislative strength. "The more established professions of law and medicine," says McNiff, "demonstrate how variety and specialization can be achieved while maintaining an integrated professional identity."

In line with this projected, idealized consortium of creative arts therapists, McNiff looks at similarities and differences in education and training between the various arts therapies. Were these therapies to join into one association with its component parts, consistent standards in education would be necessary. Except for music therapy, the requirement for all creative arts therapies is a master's degree. The educational criterion for music therapy is a bachelor's degree. McNiff sees this lower music therapy educational standard as the most serious deterrent to any prospective unification.

McNiff looks to the future in his proposal. "Current studies of higher education and the professions," he says, "indicate that there are endless possibilities for future specializations." He names drama therapy as a developing new specialization, distinct from psychodrama, poetry therapy, phototherapy, video therapy, bibliotherapy, and, in addition, other possible art forms that may in the future develop their own therapeutic systems. McNiff feels that "the continuing practice of creating a multiplicity of association fiefdoms is not appropriate to contemporary professional education."

"Cooperation should not interfere with the creative vitality of the profession," McNiff says, "but only eliminate unreasonable, inefficient and restrictive practices." He does not foresee a system of rigid standardization, but rather that "future coalition efforts be directed toward the coordination of variety and the definition of universal elements of clinical practice and training." Other possible problems in unifying the arts therapies include "differences as to when specialization should take place, the value of liberal education on the undergraduate level, and the need for requiring graduate training for professional practice." McNiff makes clear that he would like to see requirements for registration in the various creative arts therapies as equal, or at least equivalent. I might add here that there would be a large number of arts therapists in their respective fields who would strongly resist any attempts at unifying the professions.

Although *Educating the Creative Arts Therapist* might be viewed as a forum for McNiff's thoughts on coalition, it also has invaluable information for all of the disciplines. The part that I most welcomed, and wished had been expanded upon, maybe with some specific examples, is the section on supervising the creative arts therapist. Just as the arts therapies differ from verbal therapy, so supervision of the creative arts therapist differs from that of a verbal therapist. Should academic programs treat supervision as therapy? Should it be required that students experience personal therapy? Should a creative arts therapy student in training go into therapy with another creative arts therapist or a conventional therapist? McNiff debates these issues in his chapter on supervision and evaluation.

My favorite chapter is "An Artistic Theory of Mental Health and Therapy." In this section McNiff differentiates between traditional therapies and the creative arts therapies. Although major advances in psychology and psychiatry have been achieved "by people with highly developed thought and practice," McNiff feels that "the primary relationship of the artistic process to psychological thinking and psychotherapy has not been adequately investigated."

McNiff contends that the creative arts therapist needs to re-think his/her role. "The psychiatric and medical dominance of the mental health profession is coming to an end," he says, "and this is creating opportunities for re-thinking the basic elements of health, psychological inquiry and therapeutic transformation." Although different, the arts therapies can be as powerful, and often more so, than traditional therapies. In this context, McNiff would like to see the creative arts therapist assume the role of primary therapist, rather than a secondary or adjunctive role. Unique in the healing arts professions, the creative arts therapist is able to revitalize ancient practices through the use of storytelling, drama, art, dance, and music, facilitating healing as it has been done throughout cultures, throughout time.

The Artist As Therapist

Arthur Robbins, EdD, ATR, *Professor of Art Therapy, Pratt Institute; Director of the Institute of Expressive Analysis; Faculty, National Psychological Association for Psychoanalysis. Human Sciences Press, Inc., 1987, 226 pages, $29.95.*

Reviewed by ***Gary C. Barlow, EdD, ATR,*** *Professor and Coordinator, Art Therapy, Wright State University, Dayton, Ohio, and Editor,* Art Therapy.

In the preface, Robbins gives a personal example of an early sculpture made following the death of a family member. With a working through of the experience, coupled with comments from an analyst, he says "From that very personal perspective I came to see how working with art materials could promote the healing that comes from playing with one's personal symbols and also protect one's defense system from excessive pressure" (p. 13). The author states that he is now particularly aware of how his past issues with aesthetics have been reflected in his development of understandings, theories, techniques and skills of art therapy. He states, however, that "What that notion of art's role in therapy had done . . . is to create professional identity problems for my students and colleagues because it blurs the differentiations between art therapy and other psychotherapies. It does a real disservice to downplay the importance of aesthetic sensibility as fundamental to the role and function of an art therapist" (p. 15). Robbins says that this book attempts to ". . . mend the split by weaving object relations theory and principles of art and creativity into a cohesive conceptualization. The basis for that attempt is the premise that principles of aesthetics and psychodynamics used together are invaluable aids in facilitating the therapeutic process. . . . It is desirable for the student to explore, through artistic expression, personal experiences associated with significant self—object internalizations, facets of therapeutic process, and aesthetic equivalents of psychological issues" (pp. 15-16).

For these reasons, Robbins has included in this book aspects of theoretical bases, exercises that illustrate aesthetic, artistic expression and theory blending together to formulate learning and understanding, and the translation of this learning into the practice of art therapy. Because the sections and chapters (some written by two or more authors) can "stand alone"—even though there is an obvious sequential flow that is apparent from the first to the last page—a brief mention is given here to the individual parts. The book covers many issues, with didactic information coupled with personal testimony and case study examples, and although the author(s) have woven these parts into a fabric, section and chapter reviews may help to give the reader a sense of the "parts" that ultimately solidify into a "whole."

Chapter 1 offers "A Theoretical Overview." The interrelationships are explored (i.e., aesthetics and therapy) with a distinction between primary and secondary processes, aesthetic integration of symbolic form (and forming) in the identity process. Subsequent headings help to lay a foundation and give a clear overview: (1) Object Relations Theory and its Classical Roots; (2) Creation of a Holding Environment Via Empathy, Transitional Space and Play; (3) Use of Aesthetics of Therapeutic Communication in the Case of Bob (a condensed case study illustrating the struggle for synthesis of life experiences); and (4) Interrelationship Between Images and Words in the Therapeutic Relationship.

In the chapter titled "Technique as a Mirror of Theory," Robbins illustrates principles for the therapist to be aware of and to follow, such as interventions (". . . any input, whether verbal or nonverbal, on the part of the therapist" [p. 40]), holding, facilitating, active/inactive principles, using one's own artistry and expertise, and he points to discrepancies between the verbal and nonverbal modalities. Brief paragraphs are devoted to (1) Ongoing Interplay of Diagnosis, Developmental Issues, Aesthetic Reorganization and Technique; (2) Guiding Principles for Introducing Verbal or Nonverbal Interventions; (3) Therapist as Educator; (4) Self-Disclosure and Physical Contact by Therapist; (5) States that Cross Developmental Lines (depression, obsessional compulsiveness, passive aggressiveness and substance abuse); (6) Special Considerations in Working with Children; (7) Adolescence and the Adolescent; and (8) Terminal Patients and Their Families. More extensive focus is given to "Developmental Diagnosis and Technical Considerations" contained within the chapter. In the too-brief conclusion to this part, the author notes that a number of issues related to technique have been left untouched; however "the principles . . . remain the same. A therapist's role is to keep the therapeutic process moving, and he(she) therefore introduces elements of technique, of structures, to create holding environments that will facilitate symbolic play and differentiation of self and object" (p. 60).

Chapters 3 through 7 are written by Robbins in partnership with other authors. These chapters elaborate on the theory and methods already set in place in earlier parts of the book. The chapter on "Holding Environment as Frame for Theory and Technique" (Robbins, Costa, Mitchel and Rowan) describes the space between the client/patient and the therapist "in which we complement or mirror our patient's inner representational world" (p. 61). Work by three students in an advanced therapy seminar exemplify theoretical components of experience, representations and psychic structures. Illustrated with pictures of drawings, the three are intertwined in pair relationships and in triad, showing holding environments for the "patients" exhibited in each other's drawings. This is effective in its presentation, helping the reader to understand better the intricacies of patient/therapist relationship and the importance of understanding the holding environment.

"Aesthetics of Healing Within the Inner Representational World" is by Robbins and Rogers, and "presents the exploration of one advanced student as she grapples with the artist within the therapist in search of a synthesis of aesthetic and psychodynamic forms" (p. 89). A six-part thematic structure is presented, utilizing drawing of self, experiences of deprivation, unresolved conflict, somatization, fusion and symbiosis, to personal conceptions of healing energy. Working (i.e., moving with, experiencing, sharing with distance) with the student through the various "stages" is effective here, since it clarifies the process through a systematic plan.

Robbins and Goffia-Girasek present "Materials as an Extension of the Holding Environment," with focus on the importance of having a wide range of clinical art materials at hand, as well as appropriate utilization of these materials. Sections on form, texture, color, volume, space, movement, balance and abstraction are included. The content of this chapter is a welcome addition to the media literature for the art therapist. Although the sections are brief, they offer insight into media and media usage that encourages the reader to delve deeper into content, structure, flexibility, complexity, freedom and use of materials. Much research needs to be done relative to media and/in therapy, and the authors allude to "point[ing] the way for further exploration of the psychodynamic use of materials" (p. 115) in the final statements of this chapter.

"The Institution as a Holding Environment for the Therapist" is by Dolginko and Robbins. Discussions on personal identity as a creative arts therapist, the intern in the institution, the treatment team and supervisors, and countertransference are covered in this chapter. It is hoped that some of these areas (such as the intern in the institution) might be covered in more depth in future writing, although Dolginko and Robbins do introduce issues that are current and worthy of our consideration (for example, one is aware of the possibilities for discussion, insight and also for the education of others on administrative pressures of an agency, and the individual needs of the patients coupled with the art therapist's goals, understandings and needs).

Part II illustrates clinical applications issues, such as transference and countertransference, with focus on three case studies (Jan, Rebecca and Bob). The summary highlights eight principles "implicit in my treatment of those three patients that are intimately intertwined with the transference/countertransference relationships" (pp. 172-174). These points are especially valuable in obtaining a clear understanding of Robbins' process of therapeutic treatment as it relates to the therapist's organizational energy system, the holding environment, aesthetic issues and therapeutic interventions, the back-and-forth movement from the art form to the therapist/client relationship, and other postulates.

"Regeneration of the Potential Life Space of the Antitherapeutic Patient" presents three cases, and "A Study in the Aesthetics of Pain, Rage, Loss and Reintegration" offers a 25-page case description of John ("John has leukemia and very much wants to live," [p. 187] is the opening sentence of this very compelling case study).

This book is filled with insight, direction, focus, illustrations, tantalizing statements for consideration, brief hints at what needs to be pursued, and warm, personal insights. Some parts or sections seem too brief, although within the entire context of the book, they *do* serve as very important introductions for further consideration, and certainly they do serve as effective transitional elements. In the author's "final word," Robbins states "Ultimately, if we are to grow as professionals, we must develop concepts and formulations to match the complexities and depths of our therapeutic experiences. This text has been an attempt to make a small contribution in that area" (p. 214). In this reviewer's view, he has succeeded admirably in this attempt.

The Master of Arts in Expressive Therapies.

Certificate of Advanced Graduate Study in Expressive Therapies.

Offered by the Institute for the Arts and Human Development Lesley College Graduate School.

For students interested in the creative modalities of art, music, dance movement, drama, and holistic studies and healing arts presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning.

For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theater studies.

Lesley College Graduate School is pleased to announce a new Ph.D. Program in Expressive Therapies with a focus on higher education and professional leadership.

For more information call or write:
(617) 868-9600, ext. 480. Institute for the Arts and Human Development. Lesley College Graduate School, 29 Everett St., Cambridge, MA 02238

Lesley College
GRADUATE SCHOOL

Lesley College is accredited by the New England Association of Schools and Colleges and is an Equal Opportunity Employer

BEST COPY AVAILABLE

VIEWPOINTS

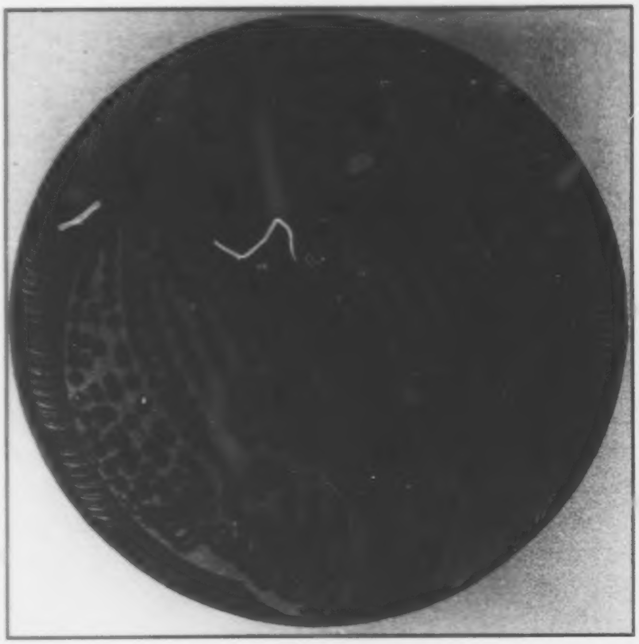


Fig. 1 The anima and animus of self.

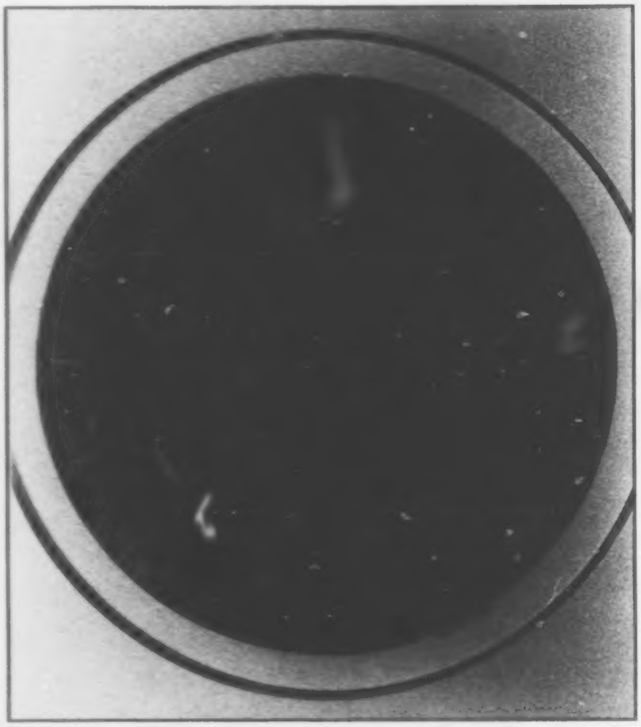


Fig. 2 The great wheel of life.

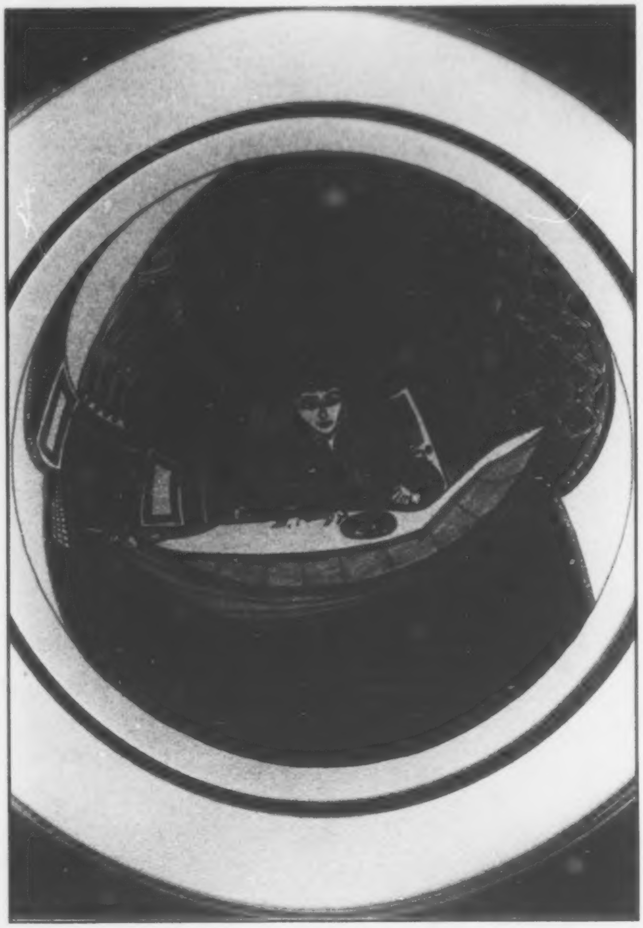


Fig. 3 Self-portrait: A distortion drawing from a Christmas tree ornament.

Art Therapist's Portfolio

The mandalas were submitted by Sarah Cannon, a member of the American Art Therapy Association. She holds the B.F.A. in Art Education and Fine Arts from the University of Illinois, Chicago Circle Campus. This art work represents personal statements by the use of the mandala image.

VIEWPOINTS** provides a forum for sharing ideas and graphics about issues facing art therapists. It also encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit black and white glossy photographs and four copies of the written material to:* ***Viewpoints, ART THERAPY, *505 E. Hawley St., Mundelein, IL 60060.*

BEST COPY AVAILABLE

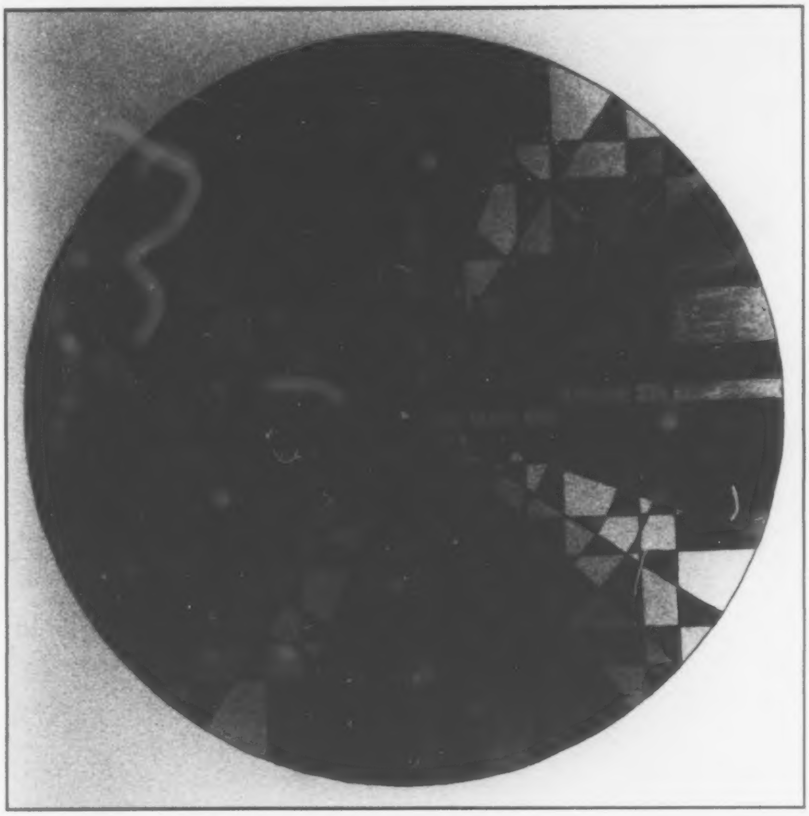


Fig. 4 Spiral III: Finding the axis.

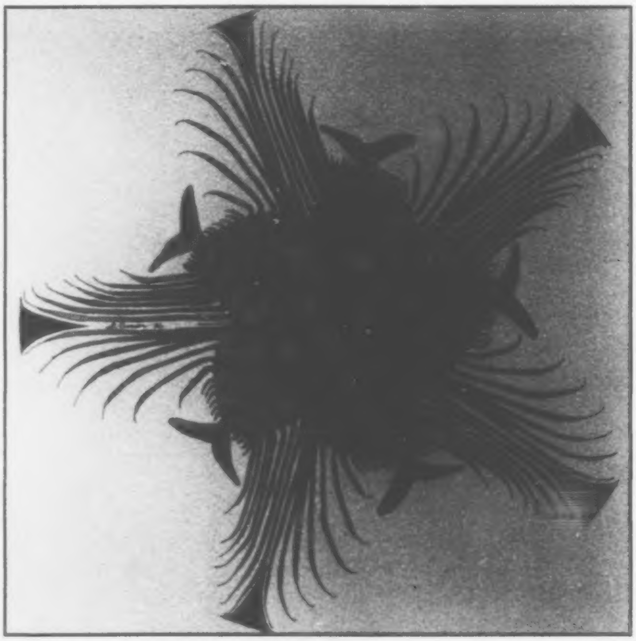


Fig. 5 African Pompano: Family of five.

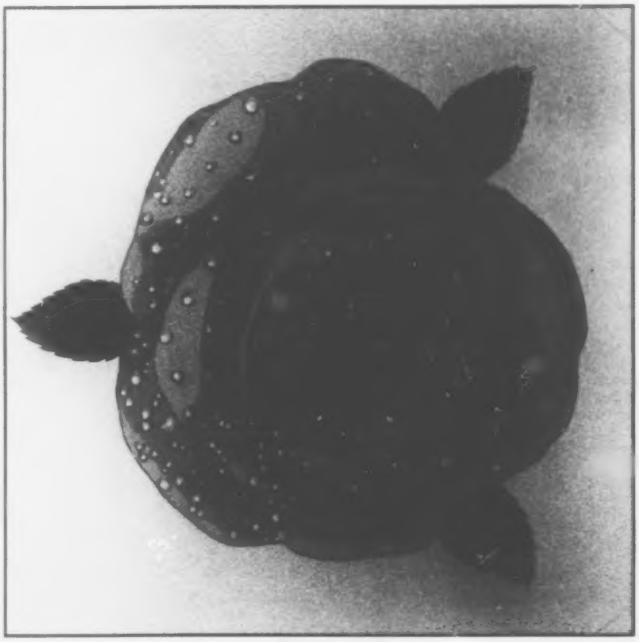


Fig. 6 The rose: Me.

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, *ART THERAPY, Journal of the American Art Therapy Association*, discounts on publications, discount on admission to the annual conference, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (ATR). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA National Office.

Associate Membership shall be open to individuals interested in the therapeutic use of art wishing to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $50

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee. **Applications for student membership must be accompanied by a copy of current ID.**

Annual Dues: $35

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $100

Professional Membership is by application only and is open to individuals who have completed professional training in art therapy and who are or have been engaged in the therapeutic use of art. Professional members are eligible to participate in all activities of the Association and receive all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $75

Credentialed Professional Membership is by application only and is open to individuals who have met the qualifications and been approved for Professional Membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in Standards and Procedures for Registration. Professional members are eligible to participate in all activities of the Association and receive all official publications. A Credentialed Professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $80

Make checks payable to AATA

American Art Therapy Association, Inc.
505 E. Hawley Street
Mundelein, IL 60060
(312) 949-6064

NAME ______________________
LAST FIRST MIDDLE

PREFERRED MAILING ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________

OTHER ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________

TITLE ______________________

EMPLOYER ______________________
INDIVIDUAL OR INSTITUTION

HIGHEST EDUCATIONAL DEGREE ______________________

☐ $ 50 **Associate Membership**

☐ $ 35 **Student Membership**
(copy of current ID required)

☐ $100 **Contributing Membership**

☐ $ 75 **Professional Membership**
(by application only)

☐ $ 80 **Credentialed Professional Membership**
(by application only)

Payable in U.S. Dollars

Dues and expenses related to participation in AATA may be tax deductible as a business expense.

RETURN THIS APPLICATION WITH YOUR REMITTANCE

The American Art Therapy Association, Inc.
505 E. HAWLEY STREET
MUNDELEIN, ILLINOIS 60060
(312) 949-6064

RESOURCES

The American Art Therapy Association serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapists' Identity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: Journal of the American Art Therapy Association		

Rates: Individuals - U.S. $23.00; Foreign $30.00; Institutions - U.S. $27.00; Foreign $36.00

	Members	Non-Members
Art Therapy: Journal - Back Issues	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings Use of the Creative Arts on Therapy (1979)	$5.00	$7.00
National Art Education Association Journal: Special Issue Art Education, Vol 33, No. 4 (1980)	$3.00	$4.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 × 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

FILMS (Rental/Purchase)

		Members	Non-Members
Art Therapy: Beginnings (1977) 16mm. color/sound, 45 minutes	Rental:	$40.00	$50.00
	Purchase:	$300.00	$400.00
Michael (1977) 16mm. color/sound, 12 minutes	Rental:	$30.00	$35.00
Art Therapy (1981) 16mm. color/sound, 12 minutes	Rental:	$35.00	$45.00
	Purchase:	$250.00	$325.00
Lori, Art Therapy and Self Discovery (1978) 16mm. color/sound, 32 minutes	Rental:	$40.00	$50.00

ORDER FORM Make checks payable in U.S. funds to AATA, and mail to the above address

Indicate Quantity of Unit Items Below — Cost/Unit — Total

______ ( ) × ______ = ______
______ ( ) × ______ = ______
______ ( ) × ______ = ______
______ ( ) × ______ = ______
______ ( ) × ______ = ______
______ = ______

Total Unit Costs = ______
*Postage/Handling = ______

10 or more copies of any single issue: 15% discount on total cost.
Discounts are available when purchasing quantities.
Set of four Proceedings (consecutive years): 20% discount on total cost.

Note: for postage/handling, add $1.50 for the first unit item. $ .50 each additional unit.

Total Enclosed = ______

Send To: ______ MBR ID#: ______

______

City ______ State ______ Zip Code ______

8/86

BEST COPY AVAILABLE

American Art Therapy Association, Inc.

"Coming of Age"

Los Angeles, California

November 12-16, 1986

ON AUDIOCASSETTES

Coming of Age was recorded by **InfoMedix**. The following is a list of the best selling audiocassettes. For a complete list contact **InfoMedix**. Please ✓ the box by the sessions you wish to order.

PROGRAM AS303

☐ **S303-1** $9.00	**Presidents Address: Identity in the 90's**, S. Graves
☐ **S303-3** $9.00	**Art Therapy in Drug Abuse Treatment Programs for the Adolescent**, K. Sly-Linton
☐ **S303-12AB** $18.00 (2 tapes)	**PAPER: Art as Depth Psychology**, S. McNiff
☐ **S303-17** $9.00	**Family Art Psychotherapy: A Systemic Approach to Change. Theory and Demonstrations Through Role Play**, S. Riley
☐ **S303-19** $9.00	**The Use of Art Therapy in Strategic Family Therapy**, V. Fry Shaver
☐ **S303-21** $9.00	**Short Term Inpatient Group Art Psychotherapy: New Directions**, B. Sprayregen
☐ **S303-30** $9.00	**IND: The Art Therapist's Third Hand (Pictorial Communication and Intervention in Art Therapy)**, E. Kramer
☐ **S303-32** $9.00	**PAPER: Georgia O'Keefe, Themes and Resonances: An Art Therapist's Viewpoint**, M. Junge
☐ **S303-33AB** $18.00 (2 tapes)	**GENERAL SESSION: The Alchemy of Creativity**, J. Shinoda Bolen
☐ **S303-35** $9.00	**Gaining Mastery Over Victimization**, D. Spring
☐ **S303-36AB** $18.00 (2 tapes)	**Effects of Psychological Trauma on Children**, S. Silverstein
☐ **S303-38** $9.00	**The Sensibility of the Sensuous: Imagination and the Reality in Art Therapy**, H. McConeghey
☐ **S303-42** $9.00	**A Method of Visualization Applied to the Treatment of Chronic Illness**, E. LaFlamme
☐ **S303-43** $9.00	**Art Making as an Aid in Bereavement**, P. Buoye Allen
☐ **S303-46** $9.00	**Hungry Love - An Art Therapy Treatment Approach with the Eating Disorder Patient**, I. Schlossberg
☐ **S303-47** $9.00	**PAPER: Art Therapy as Primary Treatment for Co-Dependents: Alcoholism Outpatient Treatment**, D. Seger

Buy 6 Tapes
Get 1 Free!

☎ **FOR FASTER SERVICE**
Please have your credit card number ready and call
TOLL FREE 1 800 367-9286 (In California) **1 800 992-9286**

☐ **Special Complete Set Price AS303: $136.00 Save 20%**

Total No. of Cassettes Ordered ____________

Purchase orders accepted for purchases of $100.00 or more

Orders outside U.S.: Add 10% surcharge of subtotal for additional shipping & handling

TOTAL PRICE $ ____________
SUB TOTAL $ ____________
SHIPPING & HANDLING $ ____________
Please enclose $1.00 for the 1st tape and $.50 for each additional tape for shipping and handling (maximum $7.00)
TOTAL AMOUNT ENCLOSED $ ____________

SHIP TO: NAME ____________
ADDRESS ____________
CITY ____________ STATE ____________ ZIP ____________
Please Charge This To My Credit Card: VISA ☐ M.C. ☐ or A/E ☐ (minimum credit card order $25.00)
ACCT. NO. ____________ CARD EXPIRATION DATE ____________
Daytime phone ____________
Signature ____________

Please Allow 4 to 5 weeks for delivery

Make Checks Payable
and Mail Orders To:

InfoMedix
EDUCATIONAL RESOURCES AND SERVICES
12800 Garden Grove Boulevard • Suite F • Garden Grove, California 92643

BEST COPY AVAILABLE

Plan To Attend

The

AATA '87 Annual Conference

"New Direction In The '80's"

November 4-8, 1987

Pre-Conference - November 4, 1987
Conference - November 5-8, 1987

Sheraton Bal Harbour
Bal Harbour, Florida

Program and Application for Registration will be mailed to all AATA members.

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 505 E. Hawley St., Mundelein, IL 60060

Please enter my subscription for 1987. Enclosed is my check, payable to AATA, for $23.
Name ______________________________
Address ______________________________
City ______________________ State ____________ Zip ____________

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

TAKE ADVANTAGE OF THIS SPECIAL OFFER!

SUBSCRIBERS TO *Art Therapy* and Members of American Art Therapy Association
ENJOY REDUCED RATE!

SUBSCRIBE NOW—AND SAVE 50% OR MORE! *The Arts in Psychotherapy* is a quarterly journal in its 14th successful year of serving practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologist that reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy, THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers in triplicate to Managing Editor, Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583
TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

Pergamon Journals, Inc., Maxwell House, Fairview Park, Elmsford, N.Y. 10523 AATA
Please enter my subscription for Vol. 14, 1987 ☐
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume

For subscriptions outside U.S. (except Canada) add $2.25 annual postage. Payment must be in U.S. funds.
Name ______________________________
Address ______________________________
City ______________________ State ____________ Zip ____________

ART THERAPY

Journal of the American Art Therapy Association

Volume 4, Number 3 October 1987

- The Use of Art Therapy with Juvenile Delinquents to Enhance Self-Image
  Mary Elizabeth Larose, ACSW, ATR
- The Sun Wheel: Bridge to the Unconscious
  Lillian Rhinehart, MA, ATR, MFCC and Paula Englehorn, MA, ATR
- Creative Analysis Involving Multidisciplinary Evaluations of a Case Study
  Edith Zierer, ATR
- Diagnosis and Assessment: Impact on Art Therapy
  Ellen G. Horovitz-Darby, MA, ATR

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA EXECUTIVE BOARD
1985-1987

Board of Trustees

President
Sandra L. Graves, PhD, ATR
President-Elect
Cay Drachnik, MA, ATR, MFCC
Secretary
Elaine Laskey, MA, ATR
Treasurer
Dee Spring, MA, ATR

Committee Chairs

Affiliate Societies
Virgil Matheny, ATR
Bylaws
Roberta J.H. Shoemaker, MFA, ATR
Education
Shirley Riley, MA, ATR, MFCC
Governmental Affairs
Nancy Hall, MA, ATR
Membership
Bobbi Stoll, MS, MFCC, ATR
Publications
Harriet Wadeson, PhD, ATR
Research
Linda Gantt, MA, ATR
Standards
Ronald E. Hays, MS, ATR
Clinical
Maxine Jung, ACSW, ATR

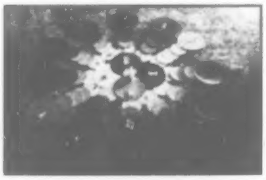
Executive Director

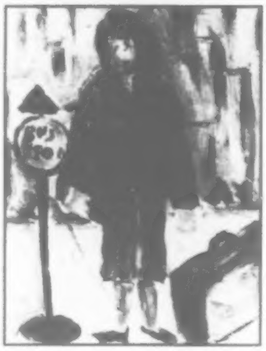
Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association





Editorial

Gary C. Barlow, EdD, ATR 98

Articles

The use of Art Therapy with Juvenile Delinquents to Enhance Self-Image
Mary Elizabeth Larose, ACSW, ATR 99
The Sun Wheel: Bridge to the Unconscious
Lillian Rhinehart, MA, ATR, MFCC and
Paula Englehorn, MA, ATR 105
Creative Analysis Involving Multidisciplinary Evaluations of a Case Study
Edith Zierer, ATR 113
Diagnosis and Assessment: Impact on Art Therapy
Ellen G. Horovitz-Darby, MA, ATR 127

Reviews

Art Therapy: The Healing Vision (videotape)
The Menninger Foundation
Lewis K. Shupe, PhD, ATR 138
Poetry as Therapy
Morris R. Morrison, Ed
Josef E. Garai, PhD, ATR 139
Ten Paintings
D. H. Lawrence
Shaun McNiff, PhD, ATR 141

Viewpoints

Rewriting a Myth
Frances Fisher Kaplan, DA, ATR 143

About Our Cover

"Picking Flowers" is the title of a painting done by a developmentally handicapped young adult in the "Arts for Transition" federallyfunded program in Dayton, Ohio. Winnie Ferguson, ATR, Director of the Program submitted the photo.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

Volume 4, Number 3 October 1987

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Judith Rubin, PhD, HLM, ATR
Brief Communications
Ruth Obernbreit, MA, ATR
Film Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Kathy Sargent

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Susan LaMantia O'Connor, MA, ATR
Paul Rodenhauser, MD
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064

Copyright © 1987 American Art Therapy Association

EDITORIAL

The following was found in Old Saint Paul's Church in Baltimore, and the date inscribed is 1692. Many of you may be familiar with the words, but upon recent reading, I thought they might have relevance for all of us. The advice and recommendations are worthy of our consideration and somehow seem as pertinent and timely today as they must have been in the 17th century.

GO PLACIDLY AMID THE NOISE & HASTE, & REMEMBER WHAT PEACE THERE MAY BE IN SILENCE. AS FAR AS POSSIBLE WITHOUT surrender be on good terms with all persons. Speak your truth quietly & clearly; and listen to others, even the dull & ignorant; they too have their story. ❧ Avoid loud & aggressive persons, they are vexations to the spirit. If you compare yourself with others, you may become vain & bitter; for always there will be greater & lesser persons than yourself. Enjoy your achievements as well as your plans. ❧ Keep interested in your own career, however humble; it is a real possession in the changing fortunes of time. Exercise caution in your business affairs; for the world is full of trickery. But let this not blind you to what virtue there is; many persons strive for high ideals; and everywhere life is full of heroism. ❧ Be yourself. Especially, do not feign affection. Neither be cynical about love; for in the face of all aridity & disenchantment it is perennial as the grass. ❧ Take kindly the counsel of the years, gracefully surrendering the things of youth. Nurture strength of spirit to shield you in sudden misfortune. But do not distress yourself with imaginings. Many fears are born of fatigue & loneliness. Beyond a wholesome discipline, be gentle with yourself. ❧ You are a child of the universe, no less than the trees & the stars; you have a right to be here. And whether or not it is clear to you, no doubt the universe is unfolding as it should. ❧ Therefore be at peace with God, whatever you conceive Him to be, and whatever your labors & aspirations, in the noisy confusion of life keep peace with your soul. ❧ With all its sham, drudgery & broken dreams, it is still a beautiful world. Be careful. Strive to be happy. ❧ ❧

This issue of *Art Therapy* contains articles with important and current content. Mary Elizabeth Larose's article on "The Use of Art Therapy with Juvenile Delinquents to Enhance Self-Image" gives an overview of art therapy work with a specific population, and the methods identified that are integral to the building of self-image and concept strength. Ellen Horovitz-Darby, in her article "Diagnosis and Assessment: Impact on Art Therapy," points out the need for familiarity with specific diagnostic assessments and illustrates her premise by using the H-T-P, the K-F-D, the Bender Gestalt, a Cognitive Art Therapy Assessment and the Silver Drawing Test. Lillian Rhinehart and Paula Englehorn, coauthors of "The Sun Wheel: Bridge to the Unconscious," discuss the individuation concepts of the Sun Wheel and the application to art therapy practice. As they so aptly state, "It offers art therapists a focal point for the growth inherent in the art process." The article "Creative Analysis Involving Multidisciplinary Evaluations of a Case Study" is presented by Edith Zierer. Recorded statements about a patient, described in this article, come from four professionals who worked on the case: the treating psychiatrist, the staff psychologist, Dr. Ernest Zierer and Edith Zierer. The emphases are on Creative Analysis in individual treatment, the testing instruments and procedures used and a brief history of the development of the method. All of these articles, collectively, offer much content for the art therapist to think about and to take necessary steps to expand upon one's modes of assessments, delivery of services and new populations to be served.

Gary C. Barlow, Ed.D., ATR
Editor, Art Therapy

The Use of Art Therapy with Juvenile Delinquents to Enhance Self-Image

Mary Elizabeth Larose, ACSW, ATR, member AATA, Lafourche Parish Juvenile Justice Facility, Thibodaux, LA.

The mental pictures we hold of ourselves tend to externalize and impact our relationships and life experiences. As humans we grow up accruing an image of ourselves based on feedback from relevant others. We live out our self-images often without questioning their present suitability to our lives and goals. This paper illustrates specific art techniques used with the population of a locked detention unit for adolescent offenders in an attempt to nurture the growth of a positive self-image and thereby influence behavior. Development and projection of body images are discussed as is the potential for transformation through the therapeutic use of art. Case examples from two residents of the facility are used.

I am employed as a therapist at a juvenile detention center that serves boys from ages 12 to 18 on charges that vary from truancy to murder. Art is an invaluable tool for therapy with these boys who are often low in verbal and socialization skills.

Generally, those who populate the detention unit have a shrunken ego sense, a lack of ambition and little social adaptation. They are dependent and depressed with inadequate impulse control.

As a matter of routine I have each inmate draw a picture of a person, a picture of his family, another of himself as he sees himself in the moment and then again as he would like to be in 10 years from now. Last, I have him draw his ideal situation in life.

This sequence of drawings gives me excellent clues into the child's self-concept and background. It also compels the child to examine his possibilities and desires and to shape them into life goals at the same time conceiving a more positive self image from which to operate.

Self-Projection

When an individual draws a human figure he is compelled to draw from some source. In the following statement Karen Machover (1949) elucidates this point:

> Some process of selection involving identification through projection and introjection enters at some point. The individual must draw consciously upon his whole system of psychic values. The body is the most intimate point of reference in any activity. We have in the course of growth come to associate various sensations, perceptions and emotions with certain body organs. This investment in body organs or the perception of the body image as it has developed out of personal experience must somehow guide the individual who is drawing in the specific structure and content which constitutes his offering of a "person." Consequently, the drawing of a person in involving a projection of the body image provides a natural vehicle for the expression of one's body needs and conflicts. (p. 5)

Self psychologist Henry Kohut (1971) describes the self as being integrated with our most central ambitions and ideals and also with the sense we have that our body and mind form a unit in space and a continuum in time. The self is the basis of our sense of being and the independent center of initiative and perception.

Body Image Acquisition

The child learns ways of seeing the world from other people's expressions. By the age of one children are learning large amounts about rules for the expression of emotion. Children learn first how not to show emotion especially anger and learn to put on expressions, for example smiles. The tight bond between facial expressions and the feeling itself begins to stretch and yet is never totally severed. If the physical action (smiling) triggers the emotional sensation (happiness) it is possible that one could feel happy by smiling or angry by feigning an angry expression (McDermott, 1986). If one can feel happy by smiling, it is probable that one could feel more whole by tapping the source of imagination and drawing an improved self.

Michael Eigen (1980) speaks of the significance of the face in the formation of the "self-feeling." He posits that certain basic ego defects may have their origins in the facial expressions or lack of them of the primary object or the mother figure of the individual. The infant by large builds his self-image in terms of how he sees himself reflected through his parents' eyes.

"Generally, those who populate the detention unit have a shrunken ego sense, a lack of ambition and little social adaptation."

The body image is built up as a maturation process by an integration of all sensory, motor and social experiences of the child having a center of localization in the brain. The body image runs parallel with sensory motor development according to child psychiatrist Laura Bender (1976). Paul Schilder (1935) says that the child's self-image and the ability to draw a person develop in a parallel fashion. He points out that since the child is satisfied with his drawing it must represent his knowledge and sensory experience of his body. Misrepresentation of the body on paper does not represent a difficulty in a child's technical ability to draw since he or she can successfully render other objects. It represents an imperception arising form perceptual and emotional difficulties in relation to his or her own body image. This is probably because the ability to draw the human figure is not related to a simple visual gestalt so much as it is to a more complicated gestalt based on sensory impressions of all types originating from the physical and psychic life of the child, both from the past and from the present.

Transformation of Body Image

Contrary to the dogma of many behaviorists man is more than the sum of his reflexes, instincts and immediate reactions. He is all these plus his creative potential for the future. The real measure of the individual must include the element of growth as a creative power. G. E. Coghill (1929) has said:

> Man is, indeed a mechanism, but he is a mechanism which within his limitations of life, sensitivity and growth is creating and operating himself. (p. 110)

P. Schilder (1939) developed a comprehensive concept of body image based on early studies in physics, neuropathology and psychoanalysis. He sees the body image as plastic, being built from earliest sensory and psychic experiences as well as by possible pathology in the brain, psyche or body and is unique for each individual.

> ***"The creative process can serve as a means for going beyond the blockages of a learned self-image."***

We tend to treat people of certain physical attributes and psychological temperaments in certain ways. Thus a person's self-image is sculpted by his interactions with others. Our desires, conflicts, compensations and social attitudes are somatically entrenched and influence self-projection through drawing the human figure as well as through ways of relating to others and the environment.

The creative process can serve as a means for going beyond the blockages of a learned self-image. In tapping the source of creativity one can simultaneously become in touch with the true self and at least briefly have an expanded idea of what is potential.

In the Realm of Possibilities

Patanjali, the Indian author of the *Yoga Sutras* describes the four bodies of man: the physical, the subtle, the causal and the supracausal. Ideas generated on the subtle level become manifest on the gross or physical level (Muktananda, 1980).

Quantum physicist D. Bohm postulated four orders of being: the explicate, implicate, potential and the fourth order of infinite energy (in Pearce, 1985). He says that what is now manifest had its origin as potentiality.

If existence is then the effect of conscious and unconscious thoughts on subtle levels it follows that by shaping the cause one can be active in influencing the effect. The therapist can function as a mediator between the material and immaterial dimensions of existence and can facilitate healthier interactions between these two spheres.

The task of repairing a neglected self-image can be achieved by encouraging and developing a patient's sense of self which may have been inadequately nurtured during critical periods of development. Graphically expressing internalizations of blockages buried in body armour can be curative. Awareness is curative and formulating an improved self-image must also be. My work at the detention center has been with that aim.

Case Example No. 1

Jesus was a 13 year old boy whose Mexican father had abandonded at birth. Jesus had an unhealthy attachment to his mother who often physically abused him. He was in the detention center for many months. I asked him to draw a picture of a person which he titled "The Ugly Boy????" and admitted was a picture of himself (Figure 1).

The picture had a proportionally large head, four large arms and hands, four very small legs and feet and was dressed in black. The boy was crying. In the picture of his family his mother and stepfather are on one side of the paper, bald figures with square abdomens and gro-

> ***"The task of repairing a neglected self-image can be achieved by encouraging and developing a patient's sense of self which may have been inadequately nurtured during critical periods of development."***

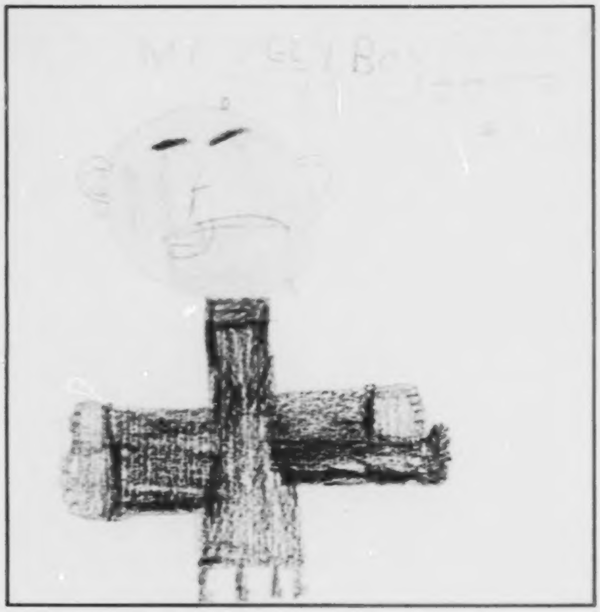


Fig. 1 The Ugly Boy

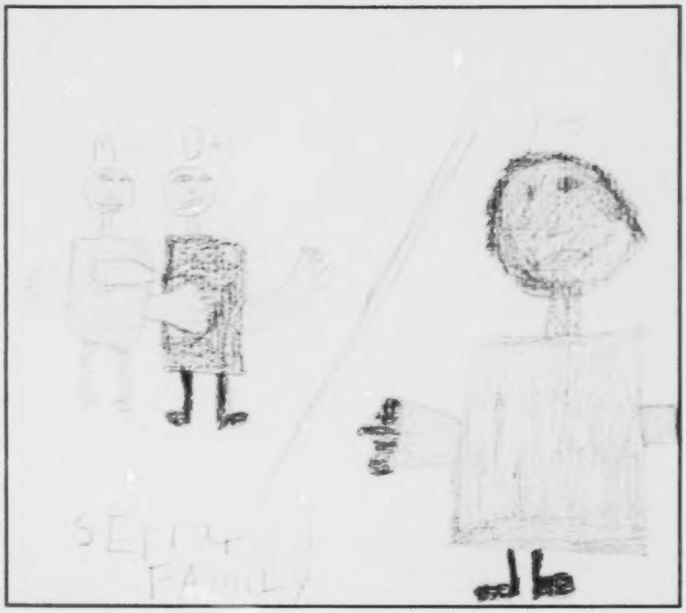


Fig. 2 The Separated Family

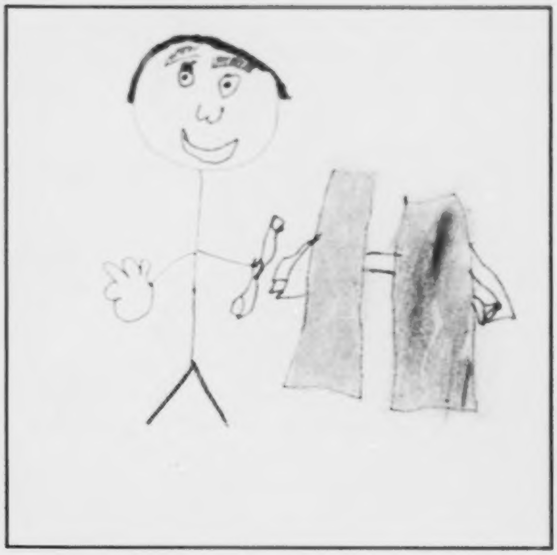


Fig. 3 Gas Man

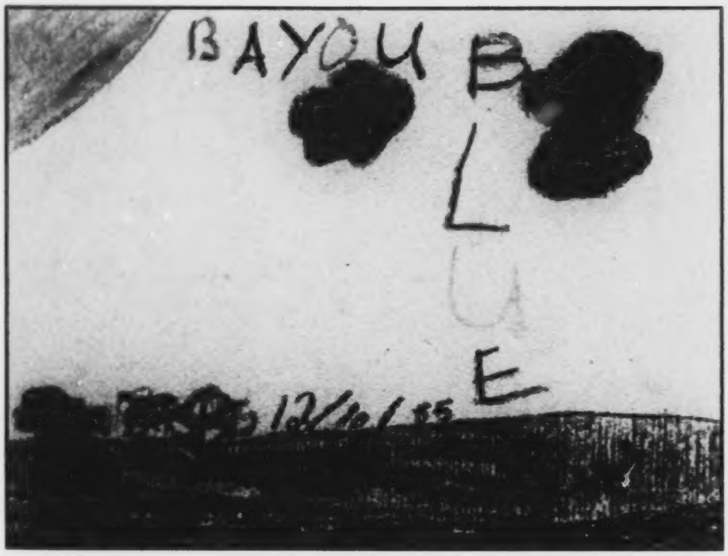


Fig. 4 Bayou Blue

tesquely large arms and hands. They are separated from a crying Jesus by a diagonal line in the center of the page. It is titled "The Separated Family" (Figure 2).

Three months later Jesus drew a picture of himself in 10 years from the present time as a service station attendant pumping gas (Figure 3). This Jesus has a happy face and although he is a stick figure his body parts are now in proportion.

When asked to draw his ideal situation in life Jesus drew a blue band of color on top of a sandy band with clouds floating above. It was entitled "Bayou Blue," which is a body of water used for hunting, fishing and recreation and is situated not far from the facility (Figure 4).

Jesus entered the unit as an aggressive, confused and angry child. By the time he did his fourth drawing Jesus was expressing a building enthusiasm for life. His aggressive actions had greatly subsided. I believe that drawing helped him to see his current situation as temporary and inspired a hope for his future.

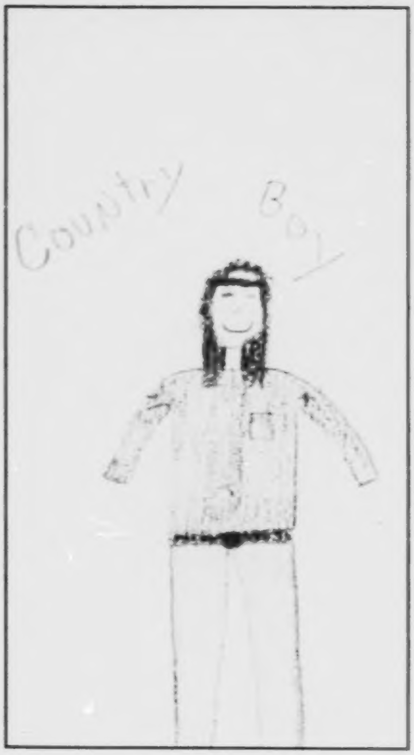


Fig. 5 Country Boy

Case Example No. 2

Jonathan was a 16 year old boy whose parents were divorced. His mother was a concerned parent.

Jonathan was depressed and overweight upon admittance. His first drawing of himself was of a heavy set boy with no hands or feet and very short arms (Figure 5). It was called "Country Boy." The picture of his family showed both parents, his two brothers and himself. None of the family members possessed hands or feet (Figure 6). Jonathan took a long time to draw himself as he would like to be in 10 years. After much thought he drew himself in a uniform as a member of the armed forces, still without hands or feet (Figure 7).

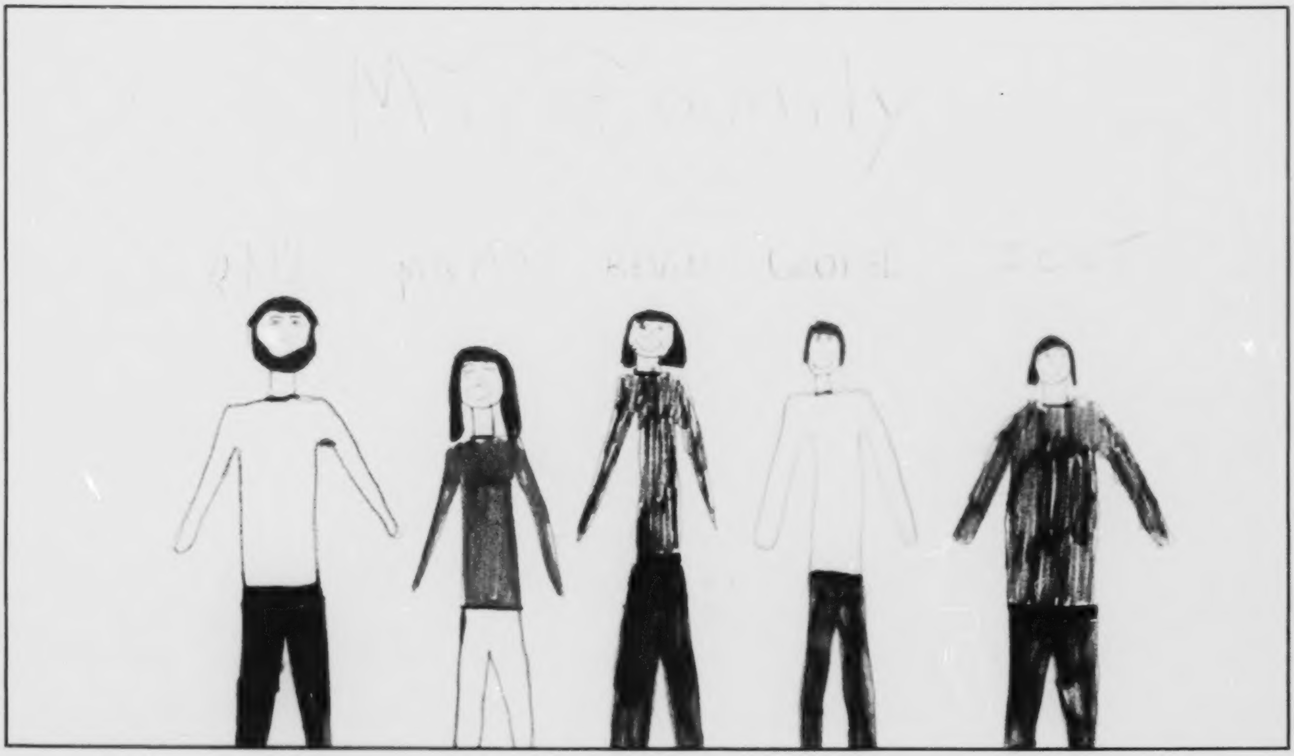
During the session Jonathan spoke at length about his feelings of hopelessness and his trouble with alcohol and substance abuse. He said he felt he had no way to do anything about himself. During the session he began to see a little light at the end of the tunnel. His last drawing was of his ideal situation. He called it "Living Easy" and was composed of a house, tree, swing and rising sun (Figure 8). He told me it portrayed the house he would like to have when he had a job and a family. Jonathan was beginning to believe in a life after detention. He began to express an interest in getting help for his alcohol problem.

Before he left to be incarcerated at another facility I asked him to draw himself again. This time he drew a nicely built boy (Jonathan had lost weight since his entry at our unit) Figure 9. This figure still had no arms but he did have feet well portrayed in detailed sneakers, symbols perhaps of a new feeling of capability inside himself.

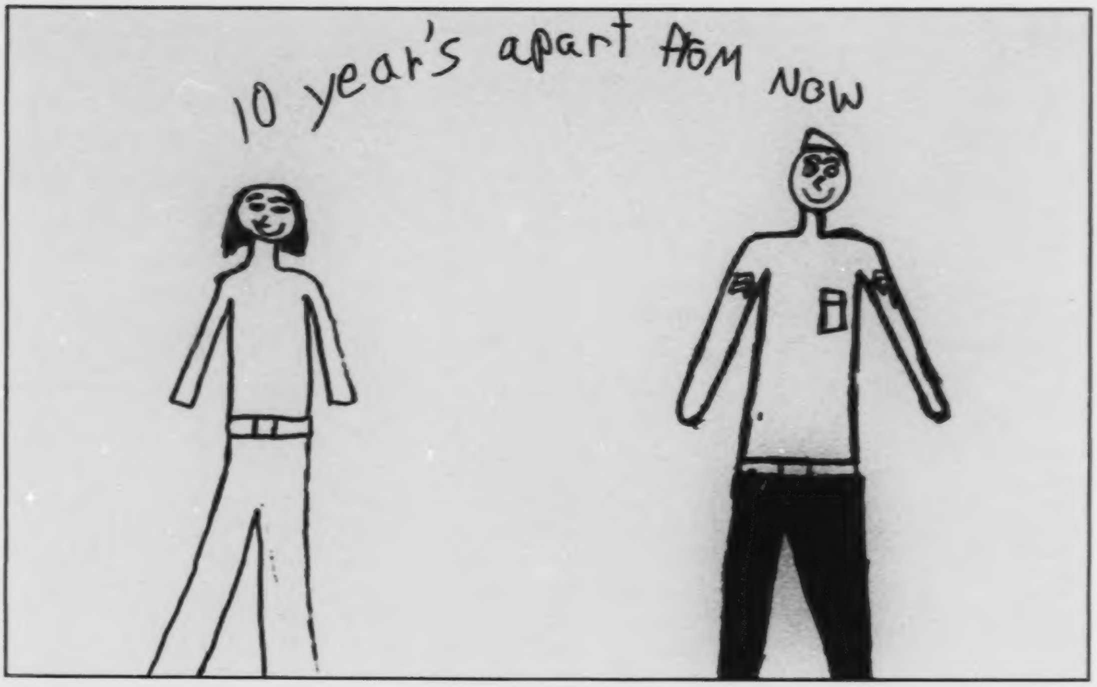
Summary

For both of these boys artwork was a catalyst for positive attitudinal changes, a means of breaking out

Fig. 6 My Family

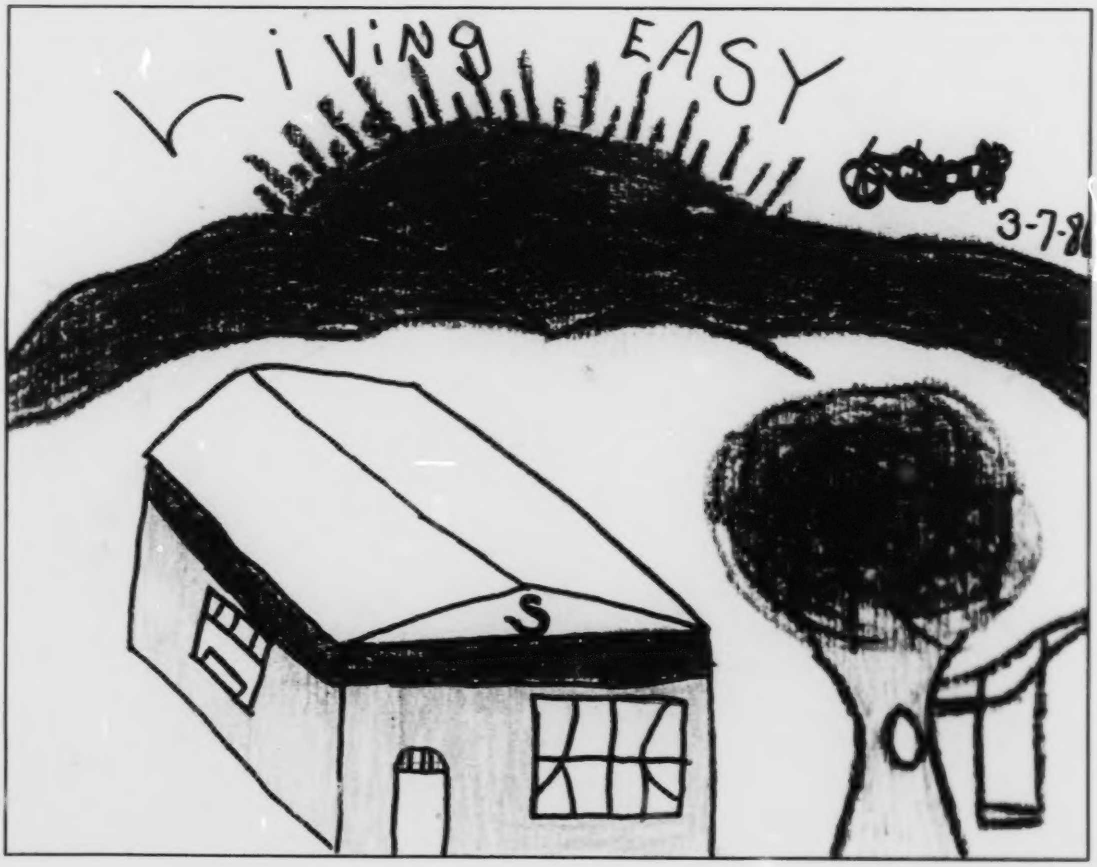


BEST COPY AVAILABLE


10 year's apart from NOW

▲ **Fig. 7** Ten Years from Now

▼ **Fig. 8** Easy Living


Living EASY
3-7-8
S

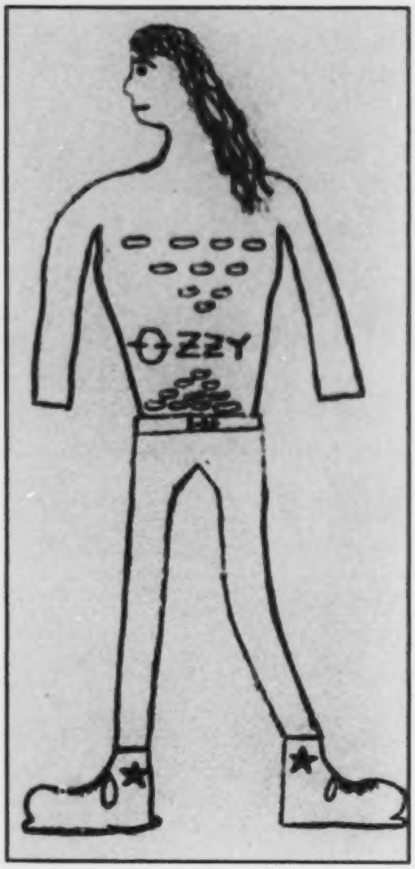


Fig. 9 Self Portrait II

from an imprisoning way of seeing themselves and their circumstances. They drew symbols of themselves that pointed beyond the lives they knew to something better. In the words of J. Rhyne (1973):

> The configuration of the world is seen selectively and idiosyncratically by individuals. Yet it must be that the whole exists within each man, immanent in all his parts and seeks material expression. (p. 84)

> ***"For both of these boys artwork was a catalyst for positive attitudinal changes, a means of breaking out from an imprisoning way of seeing themselves and their circumstances."***

References

Bender, L. Y. (1952). *Child psychiatric techniques*. Springfield, IL: Charles C. Thomas.

Bender, L. Y. (1976). The creative process in psychopathological art. *The Proceedings of the Seventh Annual Conference of the American Art Therapy Association*. Baltimore, MD: American Art Therapy Association.

Cavan, R. S., & Ferdinand, T. N. (1981). *Juvenile delinquency*. New York: Harper & Row.

Coghill, G. E. (1929). *Anatomy and the problems of behavior*. New York: Hafner Publishing Company.

Eigne, M. (1980). On the significance of the face. *Psychoanalytic Review, 67(4)* 427-441.

Goodenough, F. (1936). *The measurement of intelligence by drawings*. Yonkers, New York: World Book Company.

Kohut, H. (1971). *The analysis of the self*. New York: International University Press.

Machover, K. (1986). *Personality projection in the drawing of the human figure*. Springfield, IL: Charles C. Thomas.

McDermott, J. (1986). Face to face, it's the expression that bears the message. *Smithsonian. 16,* 113-123.

Muktananda, S. (1980). *The mystery of the mind*. Ganeshpuri, India: Gurudev Siddha Peeth.

Pearce, J. C. (1985). *The magical child matures*. New York: E. P. Dutton.

Rhyne, J. (1973). *The gestalt art experience*. CA: Brooks & Cole Publishers.

Robbins, A. (1984). The struggle for self cohesion: An analytically oriented art therapy case study. *Art Therapy 1(3),* 107-118.

Schilder, P. (1935). *The images and appearance of the human body*. New York: International University Press.

NOTICE OF CORRECTION

In the last issue, July 1987 an error appeared in the picture caption, Page 82. Should read: WISC-R 99, DAP-75.

"The Sun Wheel: Bridge to the Unconscious"

***Lillian Rhinehart, MA, ATR, MFCC** and **Paula Engelhorn, MA, ATR,** art therapists in private practice and founders of the Eagle Rock Trail Art Therapy Institute and Rainbow Clan, in California.*

This article introduces art therapists to the individuation concepts of the Sun Wheel and the application to the practice of art therapy. The concepts of the Sun Wheel encompass: 1) the circle or mandala as the greatest representation of wholeness; 2) the Rainbow color spectrum; and 3) a numerical system of one, four and twelve. These basic elements of the Sun Wheel are ancient archetypes, and in combination they become a powerful base for personal growth. The Sun Wheel Individuation process depends upon the art experience to help people find their own inner wisdom and balance. It offers art therapists a focal point for the growth inherent in the art process.

Introduction

Jungian Psychology, Gestalt Therapy concepts, color and the wisdom of Ancient American truths are integrated in our work. We find these concepts best demonstrated through the Sun Wheel, which is an ancient medicine wheel—a Rainbow wheel of color. A medicine wheel is a circle of stones which is placed on the earth to honor all life. These ancient forms used to cover the earth. Stonehenge is but one example of this form.

This article introduces art therapists to the individuation concepts of the Sun Wheel and how to apply these to the practice of art therapy. Just as the ancient wheels of the past provided ways for people to seek balance (Storm, 1972), the return of the Sun Wheel in a time when the earth and its occupants are in need of balance is providing a way for individuals to explore the quest for wholeness.

The concepts of the Sun Wheel encompass the following elements: 1) the circle or mandala as the greatest representation of wholeness; 2) the Rainbow color spectrum; and 3) a number system of one, four, twelve. The circle, the Rainbow and the numerical formation of the Sun Wheel are all ancient archetypes. Archetypes (Jung, Vol. 9, 1950), are synonymous with the word prototype, and means original model after which other similar behaviors, feelings, ideas or images are patterned. Jung said, "Archetypes were and still are, living psychic forces that demand to be taken seriously . . . always they were the bringers of protection and salvation. . . ." In combination the three archetypes of the Sun Wheel become a powerful base for individuation and collective growth.

The Three Major Archetypes of the Sun Wheel

The Circle

There are many legends in our Native American heritage of the circle as a path to wholeness. The journey of the Hopi (Waters, 1963), is spoken of in a circle metaphor. The Hopi is born and his journey begins with the rising sun. His death is like the setting of the sun. He then travels back through the underworld toward the rising of the sun, back to another birth. Within this cycle the circle is never broken. Black Elk (Neihardt, 1961), the great holy man of the Sioux, spoke eloquently of the circle: "You have noticed that everything an Indian does is in a circle, and that is because the Power of the World always works in circles, and everything tries to be round . . . even the seasons form a great circle in their changing, and always come back again to where they were. The life of a man is a circle, from childhood to childhood and so it is in everything where power moves." Carl Jung often referred to the circle, or the mandala, as a representation or symbol of wholeness. In *Memories, Dreams, Reflections,* he spoke of mandala drawings and the goal of the development of the psyche. He said, "I know that in finding the Mandala as an expression of the Self, I have attained what was for me the ultimate." (Jung, 1961). The Sun Wheel too is such a symbol. Like the mandala and like the medicine wheel, it is a statement of wholeness which represents a pathway to individuation.

The Rainbow Color Spectrum

The Sun Wheel is based on the Rainbow color spectrum. The process of individuation as expressed in Seven Arrows (Storm, 1972), is reflected in this wheel of color. Storm's book describes how we each enter the world on a particular part of the medicine wheel; the Sun Wheel is based on a similar premise. The premise of the Sun Wheel is that we each enter the world with a

"This article introduces art therapists to the individuation concepts of the Sun Wheel and how to apply these in the practice of art therapy."

predominant color identification. This premise is also parallel to the Jungian typology system in which a way of perceiving objective reality is given at birth (Jacobi, 1943). Jung's system also implied a color relationship to topology. In the Sun Wheel process toward individuation, people can identify color as possibly relating to their primary function.

Color is an important reality for the path of the Sun Wheel. Its importance to many Native American tribes as a way to healing and growth has been expressed over the centuries. The Navajo sand paintings have the figure of Rainbow Girl (Reichard, 1963), a healing image encircling the sand painting in protection. Each color in the painting done for healing has a specific, symbolic meaning (Villasenor, 1963). The four directions of the world, a major force for healing in Native American belief systems, are designated by specific colors (Sandner, 1979). To the Egyptian the Rainbow was more important than the spoken word (Birren, 1972). The Rainbow color spectrum plays an intricate part in the individuation process of the Sun Wheel.

The Number System

The Sun Wheel structure is based on a number system of one, four, twelve. The stone in the center represents the Light, consciousness, the Self, whatever word suits the person who is seeking wholeness. The next four stones around the central stone represent the Four Directions, the guardians of the Four Quarters of the Universe. The twelve stones forming the circumference represent groups of people, or color tribes. Nature and history give us many examples of this numerical pattern. In *one* year there are *four* seasons and *twelve* months. There is *one* God, *four* archangels, *twelve* signs of the zodiac and *twelve* basic types of people (Heline, 1965). Christ had *twelve* disciples and *four* apostles who wrote of his life. This particular numerical order is no mere coincidence, but rather a re-emerging archetype of consciousness. (See Figure 1).

Fig. 1 An Earth Sun Wheel

In-Depth Description of the Sun Wheel

Earth and Sky Tribes

The twelve stones marking the circumference of the Sun Wheel are divided into two distinct groups, six Earth Tribes and six Sky Tribes. The six colors of Earth and Sky echo one another. A Red Earth Tribe stone in the East, a Red Sky Tribe stone in the West; next to them an Orange Earth Tribe stone and an Orange Sky Tribe stone, and so on, with the six major colors of the Rainbow. The two halves of the Sun Wheel form a full circle of wholeness.

The union of Earth and Sky Tribes in the center of the wheel echoes the psychological truth that opposites must be reconciled for integration or individuation to occur. Individuation is defined as a quest for wholeness. The Gestaltist speaks of polarities and uniting the opposites through awareness and integration (Perls, 1969). Jungian psychology speaks of uniting opposites through the ownership of shadow elements and the integration of anima, animus energies within the individual (Jung, 1950). Many opposites can be united within the circle of the Sun Wheel. Stones in each of the two separate halves of the Sun Wheel can represent any polarity. Masculine and feminine, light and dark, man and spirit, opposites are integrated within the Sun Wheel's Circle of Wholeness. (See Figure 2).

The Central Stone

In the Sun Wheel, the central stone represents the Light of Consciousness or the Self archetype. The Self (Jung, 1950), is the central archetype in the collective unconscious much as the Sun in the center of the solar system. It is the archetype of order and unification, harmonizing all the archetypes. It unites the personality giving it a sense of

---

"There are many legends in our Native American heritage of the circle as a path to wholeness."

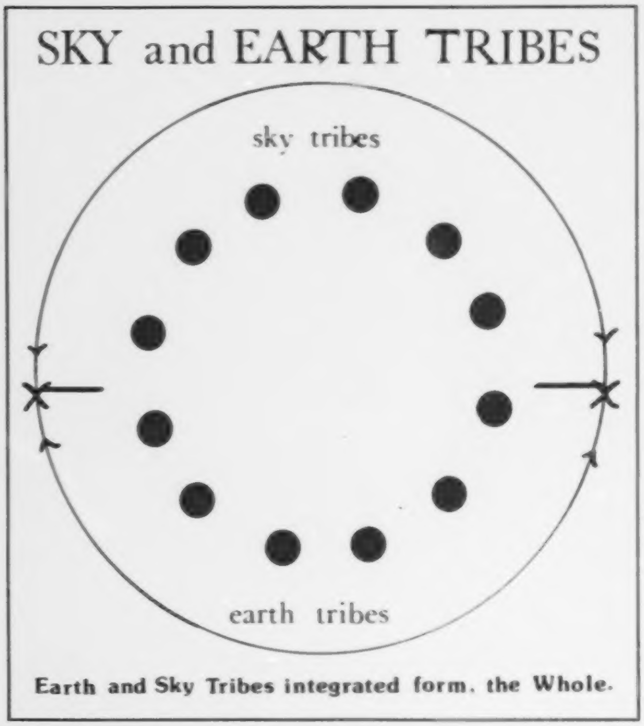

SKY and EARTH TRIBES
sky tribes
earth tribes
Earth and Sky Tribes integrated form, the Whole.

Fig. 2 Diagram: Sky and Earth Tribes

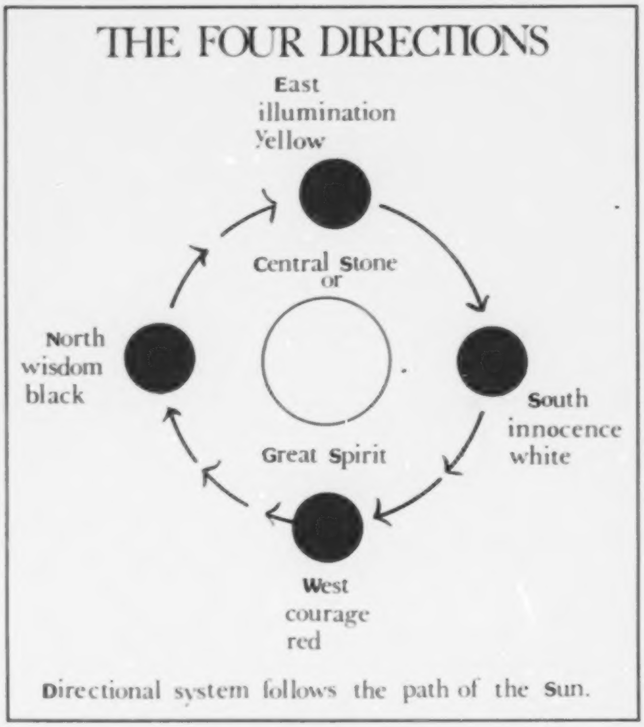

THE FOUR DIRECTIONS
East
illumination
Yellow
Central Stone
or
Great Spirit
North
wisdom
black
South
innocence
white
West
courage
red
Directional system follows the path of the Sun.

Fig. 3 Diagram: The Four Directions

"oneness." The purpose of the Sun Wheel is to provide a way of working toward that sense of "oneness" or individuation. It is a work of the development of consciousness.

The Sun Wheel system equates consciousness with light and lack of consciousness with dark; the movement of light and dark gradations equating with movement toward or away from greater consciousness. An underlying premise of the Sun Wheel is that all individuals are addressed to continually evolve toward an even greater state of consciousness.

The Four Directional Stones

The four stones surrounding the central stone represent the Four Cardinal Directions. Native and Ancient Americans among others, have recognized, experienced and named the powers of the Four Directions, and have assigned them four colors, usually yellow, white, red, and black. The Four Directions are powerful because they have been identified over many centuries as holding great properties. They are important resources for archetypal information. In our work with people we often ask them to identify the direction they are in right now. Through an art activity, based on the direction the person has identified, much information is added to their search for meaning. (See Figure 3.)

The Twelve Major Stones

The twelve major stones in the circumference of the Sun Wheel represent twelve tribes or twelve different stages of growth. These stones are each a Rainbow color. We come into the world as a member of a particular color tribe. The Color Tribe or home place on the Sun Wheel is easily identified by the individual. The individual is born into a color place. Jung makes a similar statement when he speaks of individuation and function types (Jung, 1971). We have found by doing an empirical research with 200 students that personality function through color preference could be identified more than 50 percent of the time (Rinehart/Engelhorn, 1984). This was clearly evident at the 1983 AATA Conference where a color preference and the Myers-Briggs Type Indicator, as a checkpoint, were administered to a group of art therapists. Though the numbers were small (30) the percentage of those identifying primary or auxilliary functions was 70 percent. Based on this strong implication of color identification and meaning, in our continuing work

---

"In the Sun Wheel, the central stone represents the Light of Consciousness or the Self archetype."

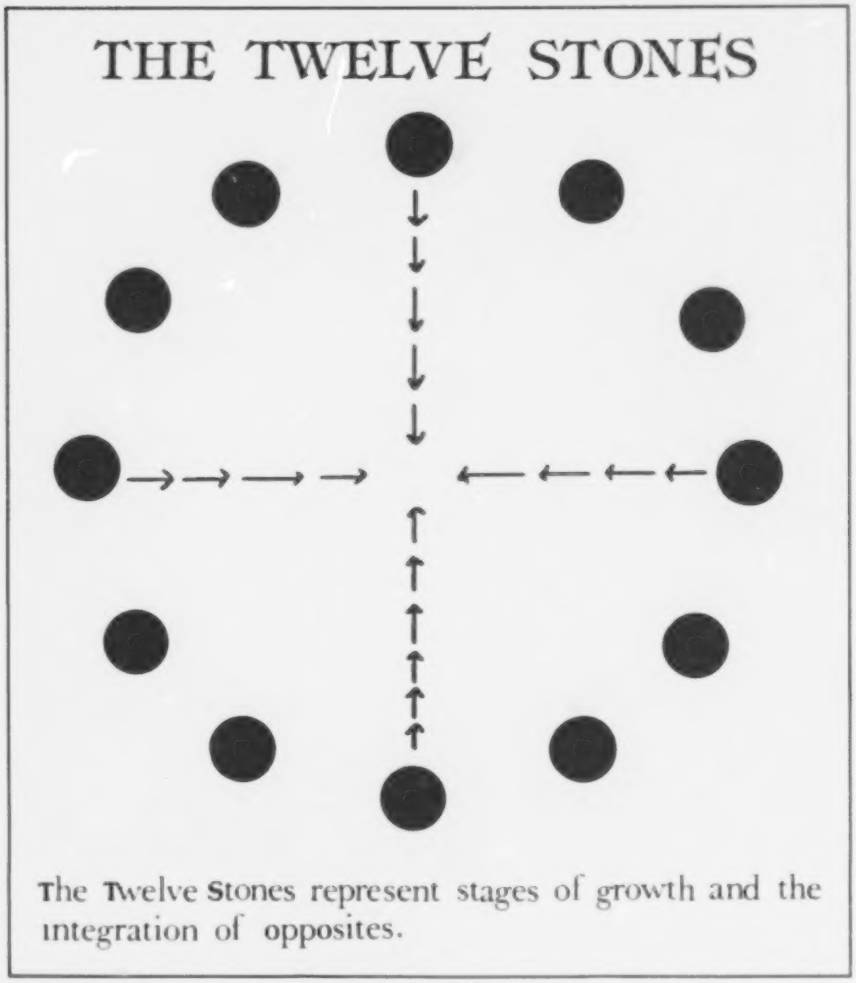

THE TWELVE STONES
The Twelve Stones represent stages of growth and the integration of opposites.

Fig. 4 Diagram: The Twelve Stones

with the Sun Wheel Individuation process we have found it to be rare that an individual has difficulty finding his/her color position on the Sun Wheel. As in astrology where meanings are associated with each sign of the zodiac, so different meanings are associated with each of the twelve color tribes. Yet the personal meanings are those we try and foster for clients and groups. It isn't so much what the color red or blue means to the collective, but what the colors mean to each of us as unique individuals with personal histories. Likewise, it isn't as helpful for personal growth to know the collective meanings of Earth or Sky Tribes. What is important and growth producing is the individual's own understanding. As we travel around the Sun Wheel, each of the twelve major color stones has a message for us which can be integrated into our consciousness. (See Figure 4.)

The Four Stepping Stones

We come to the final formation in the Sun Wheel. Wheels must have spokes to give them strength. Four smaller stones from each color tribe form the spokes of the Sun Wheel. They are the stepping stones which in sequence from the circumference to the Center represent the four kingdoms: mineral, vegetable, animal and human. At each of the stepping stones there is a guide from one of the kingdoms to help a psychological process in ego development on our journey toward the center, toward consciousness. The guides most often represent personal psychological stages of development. They help to bring to consciousness more self knowledge, thus allowing a movement along the path of individuation.

Introduction to the Art of the Sun Wheel

As we work around the Sun Wheel, we have found it an essential step to concretize the various parts of the Sun Wheel experience. We do this by having available a large variety of art materials and inviting groups to explore through the art process. The process of creating the forms and images offered through the stages of the Sun Wheel is essential to psychological development. The making of symbols as an integrative process is a very familiar one to the Native Americans who continue today to practice this art, much as they always have. Carl Jung was an early advocate of creating symbols in art form. He knew it helped unlock the mystery of their meaning (Jung, 1960). Throughout his lifetime he constantly produced drawings, paintings and stone carvings of symbols which came out of his own lifetime process of individuation. In the Sun Wheel way, the unlocking process begins with the creating, in art form, of one of the aspects of the Wheel. In a meditative process of creating the form, often its meaning and messages begin to be understood. Jung's written dialogue can further be used as a progressive step toward a deeper understanding of the symbols that emerge (Jung, 1960).

The Sun Wheel and Art Therapy

We have been working with the process form with many groups over the past five years. During that time we have come to know the importance of the three archetypes: circle, Rainbow and number. We have realized the power these archetypes add to the art experience. Other art therapists have told us there is a keen, alive, creative energy which comes forth in the art productions of people who work around the Sun Wheel. We have seen this and been awed by the level of the art work and by the excitement of the participants. In our own search we have come to know that in working with the Sun Wheel we have tapped into an ancient way of wholemaking which helps lead individuals to their own inner source of balance and growth. The creative force released through working with the Sun Wheel is the Self archetype. Our conviction is that only these clients, patients or groups who touch and experience the central archetype can begin to find healing. Reflecting upon a dream on the center of a mandala, Jung said, "The center is the goal, and everything is directed toward the center. Through this dream I understood that the Self is the principle archetype of orientation and meaning. Therein lies its healing function." (Jung, 1961) (See Figure 5.)

Fig. 5 A working Sun Wheel form is the center for Sun Wheel workshops.

Fig. 6 A group creating symbols which come out of the experience of the Sun Wheel.

How We Work With the Sun Wheel

We work with groups of creative, educated and searching people who want to grow. When we do a group, we see ourselves as facilitators who help individuals in the group to discover their own inner wisdom. Our focus is always on soliciting personal meanings from the individual. Our belief is that self knowledge is the most growth producing. Our objective is to allow this kind of knowledge to come forth through calling on the major archetypes of the Sun Wheel; meditations based on particular sections of the Sun Wheel such as the Four Directions, and asking participants to create in art form the experience the Sun Wheel has offered them. We have found it vital to offer groups a large variety of art materials—everything from paints, clay and pastels, to leather scraps, feathers and beads. We display these art materials in a lavish way and know that the rich variety of materials adds to the creative process of each participant. (See Figure 6.)

Our suggestions for the art experience always come from the Sun Wheel. We have led groups of over a hundred people walking around a Sun Wheel and finding their home or tribe color. People never seem to have any difficulty establishing their home color. Imagine a large wheel with six Rainbow colors each repeated across the wheel and then imagine 100 people walking around that wheel until they find their color. It always amazes us how quickly groups are able to do this. We have come to the conclusion that deep within each of us is the knowledge or archetype of the twelve color tribes.

Once individuals in a group have found their home color, we suggest an art activity to explore the color. We never limit how this exploration is to be done. People can explore their color in any possible way imaginable. The results of such an exploration lead to a high energy level, easily observable, as groups discover that color is a reality (Merry, 1958), and that it is a tremendous resource for personal growth.

After participants have discovered a richer relationship with one color, we often ask them to see which of the Four Directions their color is near. We have already mentioned that the Four Directions hold a great deal of archetypal meaning, and through an in depth art exploration, individuals find personal meanings associated with one of the Four Cardinal Directions.

The four guides offer a variety of possible art expressions. Once the individual has discovered the home color, we can lead him or her on a guided meditation to find one of the four guides from the mineral, vegetable, animal or human kingdoms. The meditation is designed to help individuals find their guide and to ask that guide the questions which concern them. We are evoking an inner dialogue process, knowing that active imagination is a powerful tool for bringing information and insight into consciousness (Jung, 1960). An art activity follows the meditation and again people are free to express themselves in whatever art media suits their unique experience.

All of the art experiences are processed in the group after each activity. The excitement and energy are always high. We facilitate each person's awareness and often make suggestions for a progressive step that could be taken in another art expression to further develop insights.

The Sun Wheel's depth allows many art experiences which lead toward balance and individuation. Opposites, polarities, can be explored through the dimension of the Earth and Sky Tribes. Individuals can begin by exploring in an art expression their personal associations with the Earth or Sky tribe. They can explore what the opposite position of Earth or Sky tribes might hold for them.

There are four guides with each of the twelve color positions around the circumference of the Wheel. Once the guides of the home color have been explored through meditation and art experiences, another color position on the Wheel offers four more guides and the possibility for growth through further self exploration.

The Sun Wheel Individuation concept is similar to the one described in Seven Arrows (Storm, 1972). Storm speaks of the need to travel around the medicine wheel, to sit at each of the four direction positions and to perceive the specific qualities represented by each direction. (See Figure 7.) Jung speaks of individuation in a similar way. Most especially Jung's typology parallels the medicine wheel (Jung, 1971). The individuation process of the Sun Wheel is to travel the twelve color positions and to learn what each position has to teach through meditation and art experiences. When the dimension of the four guides and the rich information available through the Four Directions are added to the color positions, the depth work available through the Sun Wheel has endless possibilities.

Our work is based with a segment of society consciously oriented to personal growth; however, we feel that the Sun Wheel Individuation possibilities can be adapted for use with many different populations, in a variety of settings. A young woman who attended one of our presentations said she was going to have the elders she worked with make a round quilt incorporating some of the principles of the Sun Wheel Individuation process. She envisioned each elder making a personal round color statement and then putting all the individual statements into a round format. The same activity could easily be done with paper and paint. The creativity of the individual art therapist will enhance such adaptations of the Sun Wheel process.

We are suggesting that whenever any of the major archetypes of the Sun Wheel are activated, the art therapy process is enhanced. Therefore, even a simple act of placing groups of people in a circle to talk about their art experiences activates the archetype of the circle and all the circle holds for growth. When we work with groups we place a representation of the Sun Wheel in the middle of the room. We have made this representation out of round cir-

Fig. 7 Gathering the participants for a closing ceremony.

"Once individuals in a group have found their home color, we suggest an art activity to explore the color."

cles of colored paper. This simple representation becomes the focal point for the group experience. We ask people to bring their art expressions back to the wheel and we discuss these expressions in a circle around the Rainbow color wheel. By this seemingly simple act we have activated the Circle, Rainbow, and numerical formation held within the structure of the Sun Wheel, and the creative process of each individual in the group is enriched.

We begin with a circle of Rainbow color and we end with that circle of color. Ritual and ceremony around the circle become a natural next step and a closure to the experience. We close a workshop with a ceremony in which all participants honor each individual and the living symbol represented in the artwork, acknowledging the presence of the Self archetype of healing.

Conclusion

The Sun Wheel Individuation process is a way to work toward consciousness and balance. Through the activation of three archetypes (circle, Rainbow and numerical formation), it offers an opportunity to help groups of people discover and claim individual unconscious parts of themselves and to integrate opposites within. The Sun Wheel Individuation process depends on the art experience to help people find their own wisdom and their own inner balance. The principles of the Sun Wheel are based in the belief that the Self archetype must be activated in each individual if growth is to occur. The Sun Wheel is based in the knowledge that once the Self archetype has been activated, a cocreativity between man and Spirit is achieved and the individuation process moves forward. The Sun Wheel is a bridge to the unconscious of endless depth and variety, which offers art therapists a focal point for the growth inherent in the art experience.

References

Birren, F. (1972). *Color psychology and color therapy*. Hyde Park, New York: University Books.

Helene, C. (1965). *Star gates*. California: New Age Press, Inc.

Jacobi, J. (1943). *The psychology of C. G. Jung*. New Haven, CT: Yale University Press.

Jung, C. G. (1950). *Collected Works*, vol. 9 part 1, 2d ed. Princeton: Princeton University Press (1968).

Jung, C. G. (1960). *The structure and dynamics of the psyche*, vol. 8 of collected works. New Jersey: Princeton University Press.

Jung, C. G. (1961). *Memories, dreams, reflections*. New York: Pantheon Books.

Jung, C. G. (1971). *Psychological types*, vol. 6 of collected works. Princeton, NJ: Princeton University Press.

Merry, E. (1958). *Gothe's approach to color* (extracts). California: Health Research.

Neihardt, J. G. (1961). *Black Elk speaks*. Nebraska: University of Nebraska Press.

Perls, F. S. (1969). *Gestalt therapy verbatim*. Lafayette, California: Real People Press.

Reichard, G. (1963). *Navaho religion*. New Jersey: Bolligen Series XVIII, Princeton University Press.

Rhinehart, L. and Engelhorn, P. (1984). *The full rainbow symbol of individuation. The Arts In Psychotherapy*, vol. 11, pp. 37-43.

Sandner, D. (1972). *Navaho symbols of healing*. New York and London: Harcourt Brace Jovanovich.

Storm, H. (1972). *Seven arrows*. New York: Ballantine Books.

Villasenor, D. (1963). *Tapistries in sand*. California: Naturegraph Publishers, Inc.

Waters, F. (1963). *Book of the Hopi*. New York: Viking Press.

Wiley . . . for Professional Excellence in ART THERAPY

From the most respected authority in the field . . .

Now available in paper!

Harriet Wadeson's

ART PSYCHOTHERAPY

Illustrated with 172 works of art from the author, other therapists and patients, here is a comprehensive account of this creative therapy. Provides information on art therapy fundamentals, including philosophy, creativity, application, training, advantages and the therapeutic relationship. Offers applications for a broad spectrum of psychiatric patients including children, adults and family groups. Loaded with case materials and clinical examples. *"It is rich in content and provocative in its framing of ideas."* ***-American Journal of Art Therapy***

352 pp. 1-62904-9 $14.95

About the Author

Harriet Wadeson, PhD, is Associate Professor and Director of the Art Therapy Graduate Program at the University of Illinois at Chicago. She serves as Publications Chair and Newsletter Editor of the American Art Therapy Association, as well as a member of the organization's Executive Board.

Harriet Wadeson's

THE DYNAMICS OF ART PSYCHOTHERAPY

Building upon the foundation laid in the groundbreaking work, *Art Psychotherapy,* this definitive work explores the rationale, methods, and objectives of art therapy and extends the coverage of the first volume into advanced issues. Applications with various patient populations are discussed as well as social and professional issues. Features over 140 illustrations of both client and patient art.

332 pp. 1-83137-9 $29.95

Available through your local bookstore or order directly from the publisher with the attached coupon. (Prices subject to change and higher in Canada.)

WILEY

JOHN WILEY & SONS
605 Third Avenue
New York, NY 10158-0012
In Canada: 22 Worcester Road
Rexdale, Ontario M9W 1L1

Mail to: JOHN WILEY & SONS, Attn.: R. Lazrus, 605 Third Avenue, New York, NY 10158-0012

Please send me ___copy(ies) of the following book(s):

___Wadeson: ART PSYCHOTHERAPY
1-62904-9 @ $14.95

___Wadeson: DYNAMICS OF ART PSYCHOTHERAPY
1-83137-9 @ $29.95

Payment enclosed, plus sales tax. Wiley pays postage/handling. We normally ship within 10 days. If shipment cannot be made within 90 days, payment will be refunded.

___Bill me. ___Bill my firm/institution
___Bill my: ___VISA ___MasterCard ___American Express

Card # ____________ Exp. ________

Signature ____________________
(Order invalid unless signed.)

Name ____________________

Address ____________________

City ____________________

State/Zip ____________________

#8-0677

Creative Analysis Involving Multidisciplinary Evaluations of a Case Study

Edith Zierer, ATR, *together with her husband, Dr. Ernest Zierer, the originator of Creative Analysis, to whose memory this article is dedicated. Edith Zierer developed and augmented the method of Creative Analysis during more than 40 years of collaboration and application at various hospitals in New York and Connecticut.*

After five years of intermittent psychiatric intervention, the patient described in this article was admitted to Hillside Hospital, Glen Oaks, New York, with a diagnosis of psychoneurotic hysteria, phobic type, with a paranoid component. The patient was treated in the hospital for one year after which she was released as she was much improved. The reports of the various treatment team members are juxtaposed with comments by the patient in order to facilitate an evaluation of the collaborative effectiveness of Creative Analysis as a treatment approach. The recorded statements of the treating psychiatrist, staff psychologist and those of Dr. Ernest Zierer and his associate, Edith Zierer, are included. The examples of the patient's work in Creative Analysis demonstrate the flexibility inherent in these testing instruments to accommodate individual treatment goals as well as their validity as corroborative diagnostic and evaluative implements. A brief history of the development of Creative Analysis, its precepts and methodology, is also included.

Introduction

This article presents a case study from the perspectives of the patient as well as of various treatment members who saw this patient. The documented statements of the physician of record, a psychiatrist, the staff psychologists and those of Dr. Ernest Zierer and his associate, Edith Zierer, are included. Decisive for the selection of this particular study for Creative Analysis correlation was the fact that it was one of the few supervised continuous case seminars lasting an entire year. The seminar met once a week for one and one half hours and was under the preceptorship of the Hillside Hospital Associate Medical Director.

This seminar had the obvious advantage of providing continuous communications between members of the therapeutic team and the entire psychiatric resident staff. As is often the case in research conducted in a therapeutic setting, important methodological questions can be raised concerning collaborative efforts, for example, the question of the possible influences of independent observations and interpretations by the various team members one upon another. Although the question cannot be resolved here, it is important to note that each of the professional observations and interpretations were recorded *prior* to each of the conferences. It is from these preconference, independently written reports that this presentation is drawn.

This paper is dedicated to the memory of Ernest Zierer, PhD, the originator of the basic concepts of Creative Analysis pioneering more than 50 years ago. These concepts were subsequently developed and augmented by his collaborator, co-author and often co-therapist, Edith Zierer, ATR. The method has been covered extensively by publications and teaching seminars in this country and abroad. The method was first explored in Europe (The "Zierer School") and in 1943, Hillside Hospital, Glen Oaks, NY was the first mental institution to introduce our diagnostic and therapeutic tool on a hospital-wide basis.

A brief review of the salient features of Creative Analysis precedes the case presentation.

Creative Analysis

Creative Analysis is a specialized psychodiagnostic and therapeutic treatment procedure devised as an aid in treating emotional disorders. In this procedure, painting activity is used to tap conscious, preconscious and unconscious motivations. The theory postulates that colors are not only related to the content of the work, but from an unconsciously created interrelationship described as color "integration" and color "disintegration." The ratio and relative intensity of "integrated" and disintegrated" paintings are considered reliable indicators of degree of ego integration. The theory also suggests that, via Creative Analysis, integrative deficiencies can be traced

> ***"In this procedure, painting activity is used to tap conscious, preconscious and unconscious motivations."***

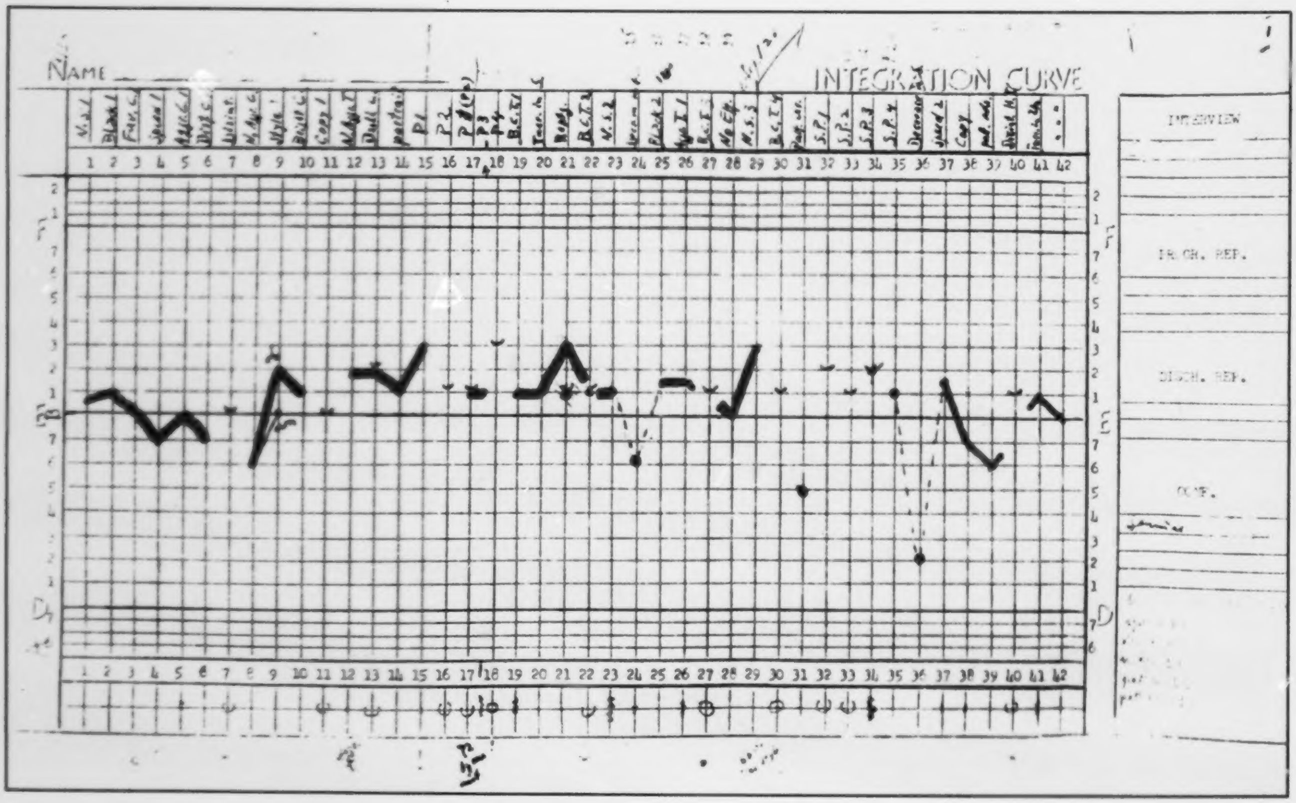
and color tension control (the equivalent of affect balance control) can be promoted.*

Creative Analysis procedures involve a battery of therapeutic painting tests which are structured but not explicitly directive of the patient's painting activity. The patient may choose to copy his or her own previous work or the work of another, make selections as to motif, color and application, form, style and brushwork. Where the patient is restricted to achromatic rendition, the choice as to motif, style, etc. remains with the patient. The battery of painting tests serves multiple purposes since the experimental conditions replicate past developmental vicissitudes as well as activate current stressful situations. Results of the selective assignment of appropriate tests serve as indices of normal and pathological responses and are, therefore, diagnostic. Similarly, these test constellations offer the patient the opportunity to comprehend these affective reactions and effect change through the development of color tension control which is consistent with his or her intent. This color tension control is equated with affect control and the test instruments simulate everyday situations in which conflict between external demands and internal needs of the individual can occur. For example, in the Reactivation tests, the test structure may simulate developmental obstacles impacting on infantile experiences. The intensity, quality and quantity of integration or disintegration in the finished painting testify to the successful or unsuccessful integration and resolution of conflicts raised by these obstacles. Interferences, which may be the introduction of foreign color particles into the patient's work by the therapist, may be painted out, repaired, isolated or ignored by the patient. This in turn provides clues to the patient's habitual defense and coping mechanisms.

The sequence of test administration is flexible and is determined by the therapeutic goals and the patient's immediate needs. Initial diagnosis and later evaluation of the patient's progress are facilitated by an objective record of specific elements in the artwork. This record is called the "Psychogram" (Figure 1). The

Fig. 1

Psychogram: This graph charts 42 test results (out of 168) and covers the first two months of the patient's Creative Analysis participation.



---

*Since all statements in this paper regarding the patient's painting activity are based on Creative Analysis findings, and are explored in numerous books, brochures and reviews, and since footnoting them would be too time consuming and cover too much space, it is hoped the enclosed bibliography will serve as a source of information.

BEST COPY AVAILABLE

"Initial diagnosis and later evaluation of the patient's progress are facilitated by an objective record of specific elements in the art work."

diagram permits the charting of an "integration graph" which represents the quality and quantity of color integration and disintegration in each painting assignment. The reader is reminded that the integration-disintegration continuum is not based upon content, form, color scheme, style or technique. It is based upon the total particular relationship of colors that is generated by the quality and quantity of personality integration or ego function. Changes induced in color responses in turn promote personality changes. It is only *after* the integrative-disintegrative discharge has been inferred from the interrelationship or interaction of color particles that deductions concerning subject matter, form, themes, individual patterns and style are included in the diagnostic considerations.

The psychograms permit the charting of fluctuations from test to test and the determination of borderline areas of general and specific levels of functioning. While reflecting essential criteria for differential diagnosis, a personality profile also suggests an appropriate course of therapy.

Case Study

The patient in this case was referred for Creative Analysis two months after her hospitalization. The quotes were taken directly from the records and were selected and edited to demonstrate both correlation and conflictual evidence of the independent Creative Analysis findings.

On admission, a psychological profile corroborated the findings of a prehospital psychological evaluation. The treating therapist, a psychiatrist, made the following entries in the record.

"This is the first and only hospitalization of a 25 year old, single Jewish, college graduate and former advertising manager. She was admitted to Hillside Hospital complaining of a series of phobic symptoms with a tendency towards somatic conversion symptoms, commencing at age 15. Family background revealed that the patient is the elder of two sisters. The younger sister is 18 years old and single. The father is a 52 year old postal clerk. The patient's mother had rheumatic fever and had several heart attacks and a number of strokes during the patient's puberty. The mother's long illness began when the patient was fourteen and the mother was almost constantly invalided until she died when the patient was 22½ years of age. Despite these difficulties, she was able to graduate from college, to work successfully in the advertising business in responsible positions, to date, and have a fairly active social life (though tremendously inhibited, frightened and guilty about any sexual activity)."

In the hospital, the patient was treated almost entirely by psychotherapy (including Creative Analysis) and mild sedatives. No tranquilizers or other somatic therapy was required or used. The first month of the patient's hospital stay seems to have been devoted to the accumulation of the developmental history and the history of the patient's illness. This period was used to deal with her adjustments to hospitalization and defining the psychological profile. It was determined from the psychological report that, "there was nothing in the patient's history that could be considered . . . pathognomic of any more severe psychiatric illness (than psychoneurosis hysteria). However, with a difficulty of such long standing object relationships, the type of depersonalization which she describes, the pervasive anxiety that at times seems to dominate her completely, the possibility of an underlying schizophrenic reaction must, at least for the time being, be kept in mind."

The psychiatrist seeing the patient recorded that their early visits included "vague, hurried references to her fears of homosexuality, her feelings of unworthiness and her confusion of her aggressive, passive conflict with masculine/feminine issues," as well as discussions of dream content and expressed resentment over residential duties such as mopping floors. Early in the third month of hospitalization, the patient was recommended for Creative Analysis.

The patient's attendance in Creative Analysis sessions was regular, but "her daily schedule was erratic or, rather geared to the number and presence of specific participants. Initally, as soon as the painting room became crowded, the patient left unobtrusively. There were no difficulties in the initial test administration; the paintings were made in average time and did not show undue concern regarding tests results. From the outset, the patient worked intensively, completing an average of two projects per day. Her pictures are quite striking, she experiments freely with colors, although much less with shape and form. She seems to feel free to ask questions and to make objections whenever the cor-

"From the outset, the patient worked intensively, completing an average of two projects per day."

relation between a specific test structure and the corresponding "reality situation" is not quite clear to her. Her questioning is never aggressive or negativistic and eventually she succeeds in finding a formulation acceptable to her."

The patient occasionally challenged the therapists' statements concerning unconscious test results, particularly when these results did not correspond to her conscious convictions. Repetitions of such tests at a later date seemed to indicate greater insight. It is a basic premise of Creative Analysis that consistency of integration in a patient's painting cannot occur without personality integration and vice versa. Therefore, such insight or awareness must be internalized before it can be made ego-syntonic. Repetition of such tests serves both educative and therapeutic purposes.

During the first month of Creative Analysis, the patient completed thirty projects. The personality diagram derived from these projects "differed in several important points from the patient's stated self-concept, but corroborated others. The level of the curve does not leave any doubt that we are confronted with a neurotic process. The general impression is that of a severely constricted personality. The single reaction points indicate that many of the patient's problems are rooted in her poor self-esteem. She does not dare to lower her integrative investment even when the project calls for an economy of energy output, for fear of never recovering her energy or else because of a sense of guilt for not functioning at her optimum level."

Other adjustment conflicts occurred. In an example of tests which demonstrate a patient's preparedness to accept a given pattern, inconsistencies arose when she was confronted with the "Copy Project." In this project, the patient is requested to select a reproduction or work of another person which symbolizes an ego-syntonic behavior pattern and to make a copy of that work as best she can. In this instance, the patient's painting showed marked disintegration, indicating a conflict with her selected model and consciously chosen behavioral preferences.

Again, when asked to select "non-aggressive" colors and techniques for a project, she chose previously designated "aggressive" colors and her brush strokes are bold, almost slashing in force, evidencing marked conflict with the assignment. "Hence, on an unconscious level, she rebels against a non-militant approach and, by disintegrating, offers a double repudiation." Integration shows the subsequent resolution of the problem (Figure 2). In a similar assignment, the patient was asked to select and paint with "dull" colors, an assignment which tests the patient's ability to perform adequately under unexciting or dull circumstances. Part of this project was integrated on a low level while the remainder of the painting shows fragmentation. Moreover, the picture gives the impression that she had, at first, succeeded in integrating it, indicating that potentially she could cope with the conflictual situation, but then had rebelliously gone over it with impatient brushstrokes, demonstrating "boring routine is not her forte."

Commenting further, the Zierers' note, "The responses to the reactivation of early developmental vicissitudes are indicative of traumatic experiences on an anal level and during the oedipal period. Initially they showed a predominance of oral character traits, but then anal traits appeared to be more prominent. The superego appears to be stable. Her manner of handling the push colors (those imposed on the patient's work by the therapist in Interference tests) indicates a mechanism of defense, which she calls 'undoing,' as a second rank rationalization. . . . The patient's advocacy of women's sexual emancipation and her repudiation of a double sex standard seems genuine enough. She integrates her concept well in work on this subject of equal rights, her acceptance of marriage, however, is conditional. She disintegrates the family unit depiction with

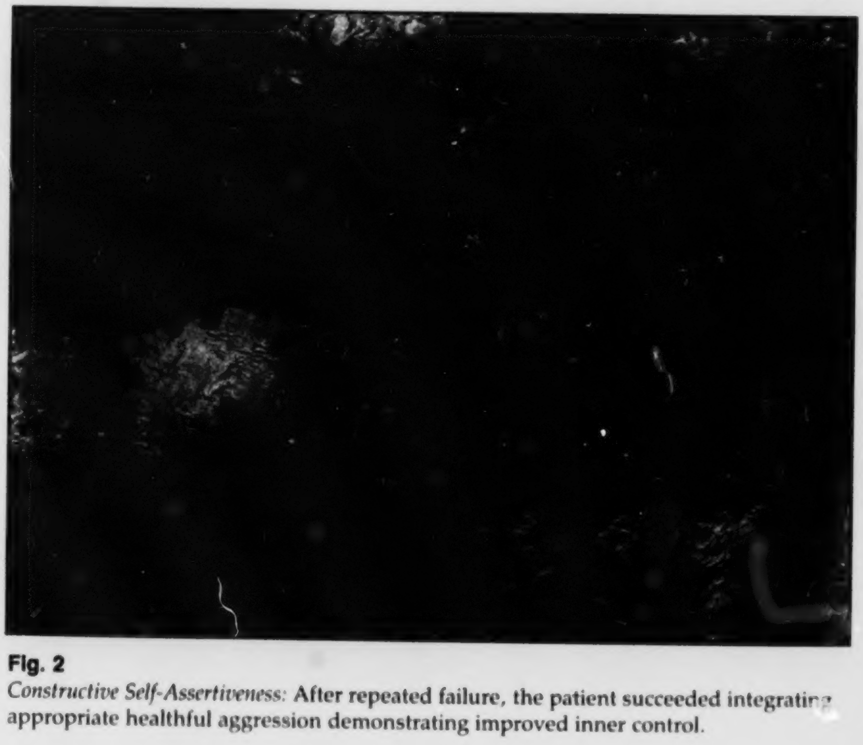


Fig. 2
Constructive Self-Assertiveness: After repeated failure, the patient succeeded integrating appropriate healthful aggression demonstrating improved inner control.

which she had intended to symbolize marriage (Figure 3).

The immediate therapeutic goal will be to strengthen the patient's self-esteem, to help regulate demands upon herself which may, in turn, facilitate a resolution of her conflicts, and take into consideration projects which facilitate constructive channelization of aggression and specific adjustment difficulties."

A subsequent psychological examination specifically mentions an IQ score of 129 in the Picture Arrangement subtest which also revealed, "very superior social intelligence, enabling her to sense other people's feelings toward her and react to them easily and appropriately. Her reactions to the unstructured stimuli disclose a constricted, narcissistic, hysterical woman whose emotional development has not kept pace with her intellectual growth. She is extremely immature, is impatient with delay in immediate gratification and has a low threshold for frustration. Her thinking shows only the slightest trace of disorganization, but her affects are extremely regressed, uncontrolled and disclose a potential for anal destructiveness. On the one hand, she evidences a great need to be conforming and conventional, while on the other hand, she discloses rebelliousness and hostility towards authority. Basically, an extremely orally dependent woman, she resists vehemently the role of passivity and submission and strives for an assertive, domineering position in her interpersonal relations."

Perhaps because of the mounting consistencies in reported findings of staff team members, it was decided to present the patient herself at one of the early case seminars. She was quite surprised at the number of staff present and felt that she had not been adequately prepared for so large a group. "That was a dirty trick," she told her doctor later. "It was sneaky. I feel as if I can't trust you. I've always felt afraid to trust anyone. I couldn't trust my other two doctors and I can't trust you." Two days later, she told her psychiatrist, "I get scared, afraid of exposing myself, like a kid afraid of masturbation, afraid of father . . . always upset about him. He looked so young when we walked together, we looked like boyfriend and girlfriend. I would get a queasy feeling when we walked together. It reminds me of a superstition that I can't remember all of, something about going crazy, something about incest, perhaps that's why I'm always sick like mother, I wanted to be her." She recalled that after her sister was born, "I used to get sick to get attention."

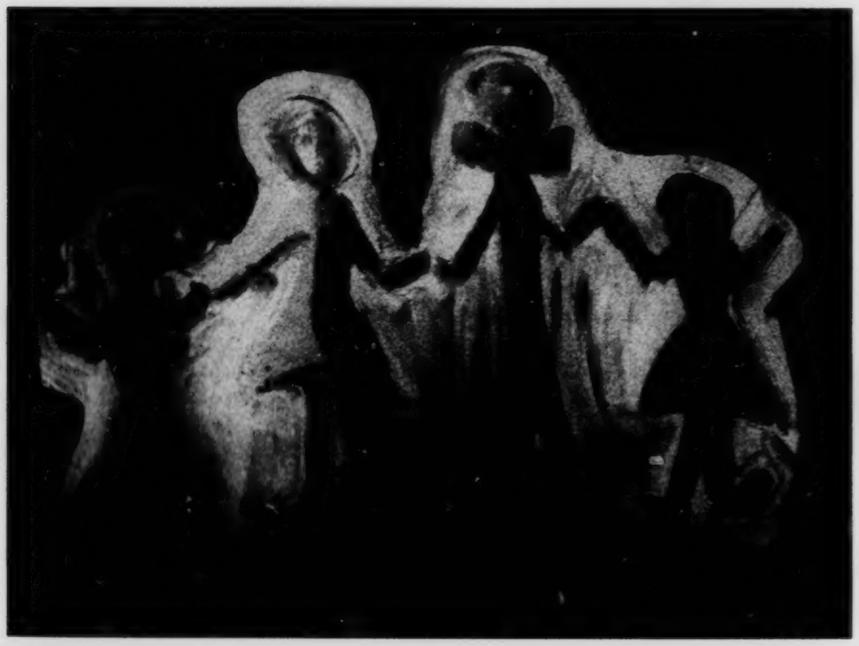


Fig. 3
Disintegrated Family: Large fragmented areas isolate rather than integrate the family members.

In the Creative Analysis reports, the patient's work pattern showed signs of disruption. She asked for an assignment and then could not find her folder of paintings although it was in plain sight. She began demanding more attention from "the Doctor Professor" (Dr. Zierer). She found her art sessions to be "encouraging and pleasurable," but described her behaviors as protective. "I usually feel the threat of doom of failure about anything that I've attempted, especially if it appears to be successful . . . the example of this would be my reaction to Creative Analysis. My anxiety becomes so strong that I run out in panic. I feel the need to run away though I realize that the anxiety and fear is coming from within rather than from an outside source. It's much easier not to attempt anything. I must be on my guard in situations where I might succeed. There is the apparent need to feel that I must punish myself for success."

At her request, a compromise solution to an arrangement was agreed upon whereby she might come to the art room early on the condition that she stay at least half an hour after the scheduled group session ended. The patient ended up not taking advantage of the arrangement. She did not start before the scheduled hour and continued to work no matter how crowded the place became. The Zierers commented, "It seemed that receiving this special privilege was more important than the actual use of it."

The patient's response to some of the Creative Analysis assignments

BEST COPY AVAILABLE

brought forth usual conflict statements but with unusual vehemence integration-wise, e.g. regarding flexibility versus habitual commitment patterns. To quote the patient, "I find no stimulus in too much responsibility and, I find it also difficult to modify my behavior or my environment."

It is a basic premise of Creative Analysis that the test instruments themselves facilitate behavioral awareness and offer an opportunity to explore change in ego-syntonic attitudes. Several projects involve the expression of dichotomies such as painting, side-by-side on the same canvas, in self-determined aggressive and non-aggressive favorite and disliked colors or in the patient's "own style" and alien self expression. (The test responses were inconsistent, but stabilized subsequently reflecting a more integrated self-concept.) In this patient's case, those tests which called for an increase or decrease of effort she found to be "the most important and most difficult of all the Creative Analysis projects." Indeed, regulation of demands on self-discipline seemed to be her most insurmountable challenge.

Nonetheless, during the second month of Creative Analysis, a gradual shift began to take place in the integration within the patient's art work. At the same time grotesque depictions were replaced by representational forms and the earlier aggressive brush stroke techniques were changed to a less aggressive painting style. The patient repudiated what she had previously called her "non-aggressive abstract style," initially presented as her own natural style, and created instead what the record describes as "a rather subdued realistic painting as representative of her personality" but with only moderate success on an integrative scale (Figure 4). This implied to the team that the patient was going through a transitional or leveling out process. Definite improvement was demonstrated in several areas, e.g., her ability to function in situations which she regarded as dull, monotonous or routine; her willingness and ability to conform to a given social structure and her tolerance for pressure and frustration.

"... during the second month of Creative Analysis, a gradual shift began to take place in the integration within the patient's art work."

Stylistic changes are not necessarily indicative of progress, as it was in this case; nor are representation depictions necessarily more indicative of adjustment than are abstract expressions.

In Creative Analysis, the quality and quantity of integration and effective control are the indicators of progress. As the patient began to explore and increase her integrative consistency in alternative styles and techniques of expression, a definite change could be charted.

An example of art therapy indicating behavioral changes contemplated by the patient is demonstrated in the patient's depictions of marriage and the family unit. In her first version mentioned earlier (Figure 3), the family is isolated and fragmented. In contrast, the integrative responses in subsequent matrimony paintings show a successful working-through process. The patient's declared color symbols changed also during this period in keeping with her less rigid passive-active feminine-masculine preconceptions.

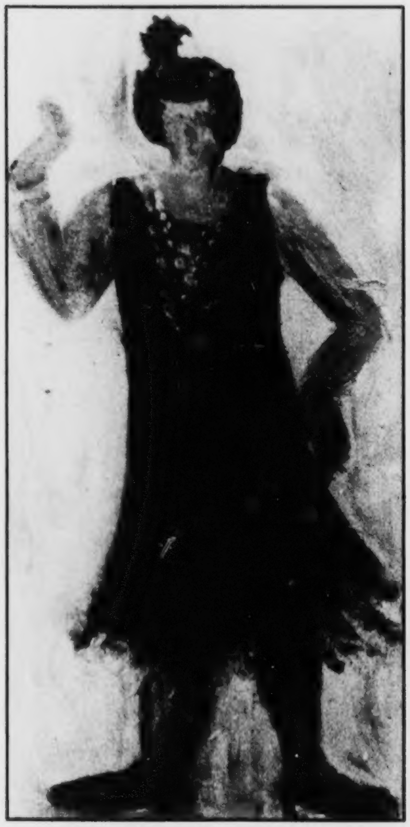


Fig. 4
Own Style: This depiction of the patient's current "own style" differs significantly from her earlier abstract and/or "clown" self representations.

Shortly thereafter, the patient began to make use of her "off-grounds pass" to get out on weekends. Somatic complaints increased after each of these events. She started a relationship with a male patient who also had an off-grounds pass and they went out together. She began to express some anger with her psychiatrist "over his passive, more silent approach to therapy . . . also angry at restrictions over hand holding in the hospital." In another psychiatric session, the patient reported a dream in which she "loses all of her teeth." She had no associations with that dream except the fact of an actual pending dental appointment. This was followed by an association to her in-hospital boyfriend and her father. Her father had come to visit her at the hospital and she repeatedly expressed a desire to have him see the psychiatrist. She mentioned being very angry with her father for losing a coat of hers. The psychiatrist pointed out to her how both of these men are weak and how she seems to be attracted to this type of man.

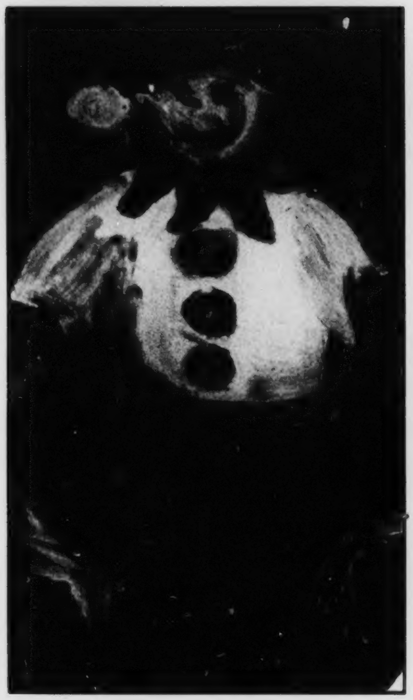


Fig. 5
Clown: A recurrent theme it symbolizes to the patient her demeaned mother self identification.

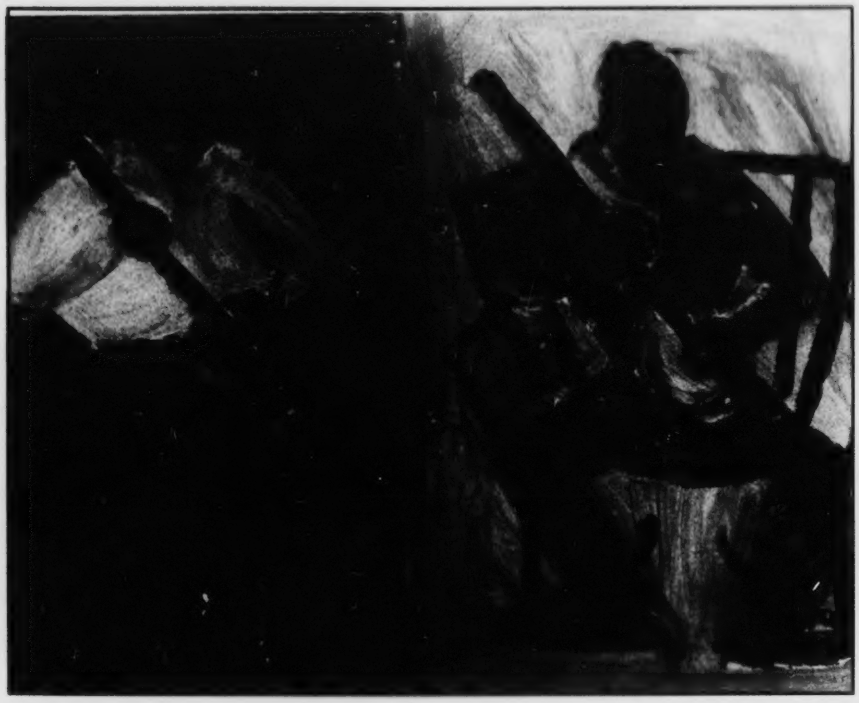


Fig. 6
Black Musicians: Another repeated theme. The musicians' stance pretorealizes the patient's own struggle against her self-imposed emotion immobilization.

The team reported increasing ambivalence towards male authority figures. Within the Creative Analysis setting, she showed marked hostility towards Dr. Zierer whom she accused of bias, while assuming, for the first time, a generally more positive attitude towards Mrs. Zierer.

Over the next three months, the patient completed 27 more projects. Her integrative results reflected a dramatic struggle to find and accept her own ego-syntonic style, technique and color scheme. "The total diagram (168 projects) reflects chronologically and in numerical terms the patient's struggle for an individual style and the recognition and expression of ego-syntonic attitudes and standards of conduct." With this resolution emerged certain motifs. The figures assumed a characteristic posture, seated or standing, of widespread legs. Seated figures were hunched over and the symbol of the clown began to reappear. "It seems significant that the clown (Figure 5) could make its reappearance as it stands for early oedipal disappointments. This does not seem to be a mere coincidence or an artistic whim. The patient's comments indicate that she connected the clown with her memories of when her mother had a stroke. She did not elaborate on this association, but it confirmed our theory that every recurrent theme is the pictorial or symbolic representation of a strongly cathected idea of an ambivalent nature."

In the originals, the apparently stationary figures of black musicians, another recurrent motif, give the impression of arrested or impending motion. The Zierers' records note that, "the movement, or perhaps rather rhythm, becomes, later on, the most striking element in her paintings; so much so that we were surprised to hear the patient refer to her recurrent subject matter as 'my sitting, still figures' (Figure 6). These often seated, individual or group depictions seem to fairly dance off the page. The sexual implications of the presence of [black] men in dreams has often been emphasized in the literature and patient's recurrent motif of [black] musicians and would bear investigation."

Although the color scheme

> ***"Her integrative results reflected a dramatic struggle to find and accept her own ego-syntonic style, technique and color scheme."***

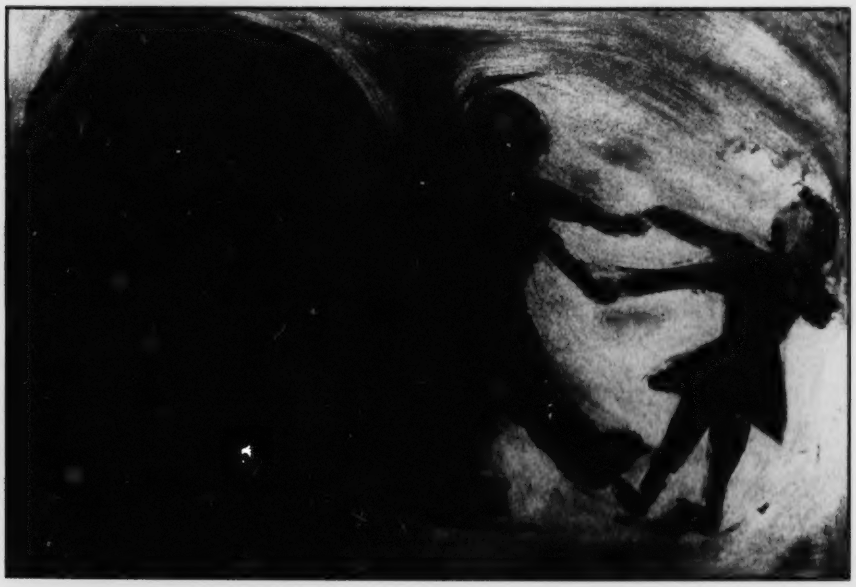
doesn't vary much, the patient finally finds in dancing an ego-syntonic and socially acceptable motif for the previously implied impending action. In one painting, two couples were depicted in a jitterbugging stance although the patient had an Apache dance in mind. The record notes that "in an Apache dance, the man pursues the woman, while in jitterbugging — according to an article we read and with which we agree — the man is totally disinterested in wooing, often even indicating that his partner should withdraw, so that he can give himself up more completely to the narcissistic pleasure of his own dance movements. Our theory is that the pictorial representation of a couple dancing may stand for the sexual act. For the patient this may previously have had a negative connotation resulting from a breakdown under the impact of oedipal traumata, for which she sought resolution in moral masochism. Now it has become permissible because she is more ready to admit to the active aggressive forces which she equates with masculine strivings."

The patient's association of professional success with masculine strivings seemed to inhibit her ability to accept herself as an active sexual partner. "To use the patient's own words, if she could stop forcing herself to sit still and start 'doing the doing,' i.e., by permitting her constructive aggressive tendencies to come to the fore, she could function adequately. In terms of painting, she has overcome whatever the clown motif stands for, and needs to work through the [black] musician theme."

These concerns are borne out in the patient's depictions and comments concerning childhood frustration. In several of the Social Conflict projects, the patient depicted children at play. She commented that she had added, "an ostracized child(who) is outside the integrated group and not part of it. In her last Social Conflict project, the patient repeated this motif which she described as (Figure 7) "a child sitting alone in darkness as opposed to the enlightened children playing in the light." The stated intent here was to depict a group of children in "free discussion about sex, at early ages . . . if sex were discussed more in the home and less in the gutter, there would be fewer frustrations and fewer problems." Concerning this last painting, the Zierers' record notes that "it may be significant that in this painting of the subject, she combines her two most recent modes of representation: the hunched over figure (this time the child in darkness) and the dance (performed by children playing in the light)."

Fig. 7

Isolated Child: (one of many representations) "The Child in Darkness" is not completely disintegrated nor "The Enlightened Children" completely integrated: Evidence of residues of conflict.



Other projects confirm the patient's ambivalence concerning biological impulses. When asked to depict something representative of her own individuality, the patient painted a woman similar to the one in Figure 4. When asked to paint in an alien style, the patient returned to the abstract style using a forceful, aggressive technique, consistent with her earlier statement of her own personal style. On the basis of this experimental evidence and a number of other experiential exercises, the Zierers speculated, "We feel justified in believing that at one point or another in this patient's infantile development, the gratification of primitive motor impulses became guilt laden and pleasure in body movement something forbidden. Motor expression, though, remained an active force. Fortunately for the patient, she was able to integrate it and eventually, with successful therapy, she should be capable of using it as a propelling force for optimum integrative investment."

The patient had become active in her residential cottage administration and involved in the development of a skit to be produced by the residents of the cottage. The patient complained of being an unworthy role model for one of the female patients and also of being misrepresented as a leader, when she was "bending over backwards" not to be one.

The series of reactivation tests were repeated at this stage and showed, for the first time, a beginning acceptance of oedipal frustration and with it a beginning reconciliation with the female role. The violin picture (Figure 8), an instrument placed in its own living space, represents to the patient the "acceptable self." Thereafter, progress was noted in specific problem areas, e.g., integration in projects dealing with self-determination and decision making. However, there was also evidence of still existing unresolved conflicts.

The patient related her difficulties around the issue of her sister's marriage to homosexuality. "Says she always felt disgusted whenever her mother and sister would kiss her." The patient began exercising and dancing, things she had not done previously. She practiced for her performance in the drama project in which she planned to dance the "Blackbottom." She began to explore sexual foreplay with the boyfriend who was a fellow patient. She also brought more of her pictures done during Creative Analysis sessions to her psychiatrist more often. She was beginning to become more insightful of the psychodynamics underlying her reactions to such things as her boyfriend becoming sick, a new arrival at her residential unit and the possibility of her getting well in the foreseeable future. The psychiatrist notes she "finally says that she thinks she has three more main problems: **a)** she's afraid of marriage, **b)** is still jealous of her sister, and **c)** has guilt over her mother's death. Somehow these all seem related. She is afraid that if she gets married and has a child, the child will alienate her from her husband."

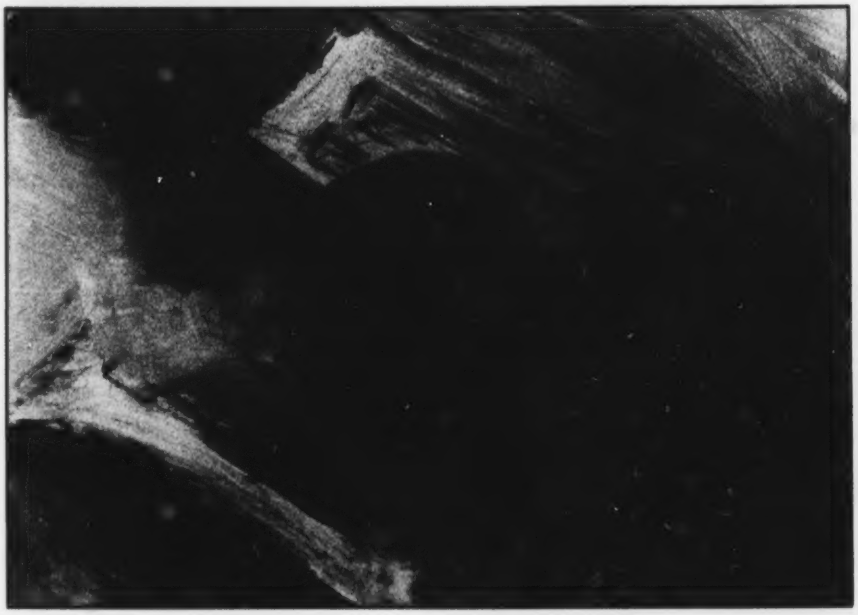
The patient made genuine efforts at reconciliation with her sister, for whom she began expressing sincere warmth. Although full of trepidation about leaving the hospital at the termination of therapy, or, alternately, being committed to a state hospital or having to live with her father, the patient related an incident of accidentally getting on a bus by herself and finding that she was unconcerned. She was later met and took a bus back to the hospital with her boyfriend. She was quite elated over her own lack of panic and ability to cope with the situation.

> ***"The patient made genuine efforts at reconciliation with her sister, for whom she began expressing sincere warmth."***

The Zierers' notes confirm this progress. "The results of [another test series] point to stronger self-motivation and an increased sense of responsibility for her achievements. We may assume, therefore, that her self-esteem is no longer dependent exclusively on external supplies precisely because it had ceased to be contingent upon aggressive motor behavior. The concept of success is, therefore, no longer unacceptable to her. What she represents in her paintings is ego-syntonic, i.e., her own style of painting integrates successfully. Similarly, there is no longer the need to express restrained motility. The ego-dystonic style is, as often before, an abstraction in aggressive colors and technique. Within the given context, this is indicative of a continued re-integration process in terms of further stabilization of performance."

Progress continued to be evident in the patient's increased ability to shop comfortably in a crowded department store, to enthusiastically enjoy her sister's wedding as well as the fact that she was able to investigate three residential opportunities outside the hospital (one of which was to her liking). Fluctuations evident in Creative Analysis could be correlated to other behavioral areas. For example, the Creative Analysis reports note "an inability to conform successfully with some accepted social patterns." When the patient was

Fig. 8:
Violin: Image of the patient's accepted self. Within the given text and context (the text structure and the patient's comments) the integrated instrument symbolizes a beginning resolution of oedipal conflicts.



BEST COPY AVAILABLE

refused off-grounds passes for the expressed purpose of sleeping over at her boyfriend's house (such leaves were granted for purposes of discharge planning only), the patient became irate and deliberately flaunted the regulations. The Creative Analysis reports note "an inadequate performance in situations necessitating more radical behavior change." When the patient was scheduled to go home, she could not bring herself to do so and called her father to come and get her. She became angry with herself for calling him and angry at him for coming. Her intention had been to be more independent.

On the other hand, she began painting precisely what constituted her "real" life difficulties. These were pictures of girls standing at bus stops (Figure 9), traveling by train and bus, staying in hotels, walking on the beach, etc. (Figure 10). At this point, a second figure joined the girl in the paintings. A male figure joined the girl in grocery shopping, traveling and staying in a hotel room. Churches (symbolizing intermarriage, according to the patient), theatres and modes of transportation recur as themes. These motifs were all integrated on her current functional level. The Creative Analysis record notes "the shift in defense mechanism seems significant: undoing is almost completely abandoned in favor of identification with the aggressor and rationalization. In summary, judging from the integrative results evident on the graph (168 projects), she should be able to confront independence and what this term symbolizes for her."

At this time, the patient underwent psychological reexamination. "Significant changes were noted. The Rorschach, HTP drawings and Bender-Gestalt were administered at this time. It is speculated that her imminent discharge from the hospital is arousing enormous anxiety. A response (to one of the cards not previously given) suggests her wish to lose conscious control over her body impulses so that her instinctual cravings may be released from intellectual surveillance. The utilization of space in the Rorschach suggest that a strong stubborn and negative feeling has been stirred up which has a dual implication. On the one hand, it represents ego strength in the sense that the patient can demonstrate assertiveness. On the other hand, it represents a tendency to restructure the environment on highly irrational grounds as well as reflecting a highly oppositional attitude in therapy. In summary, the patient appears to possess sources of ego strength which are keeping her from manifesting any flagrant psychotic behavior."

On the discharge record, the psychiatrist noted that, "In the course of therapy, it was felt that she had worked through fairly successfully the death of her mother, her strong hysterial identification with her, some of her sibling rivalry and some of her dependence-independence conflicts. She was felt to have been unable to work through or under-

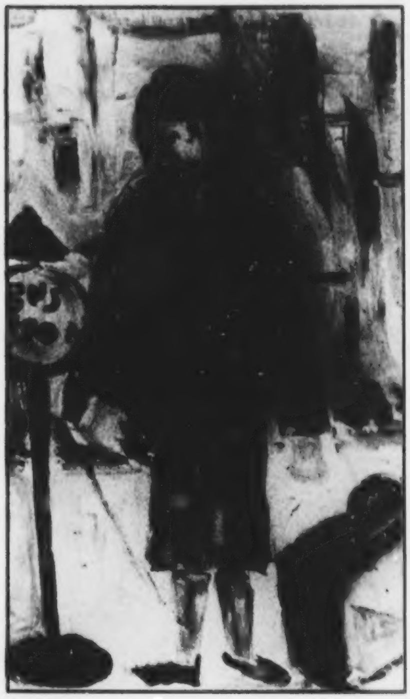
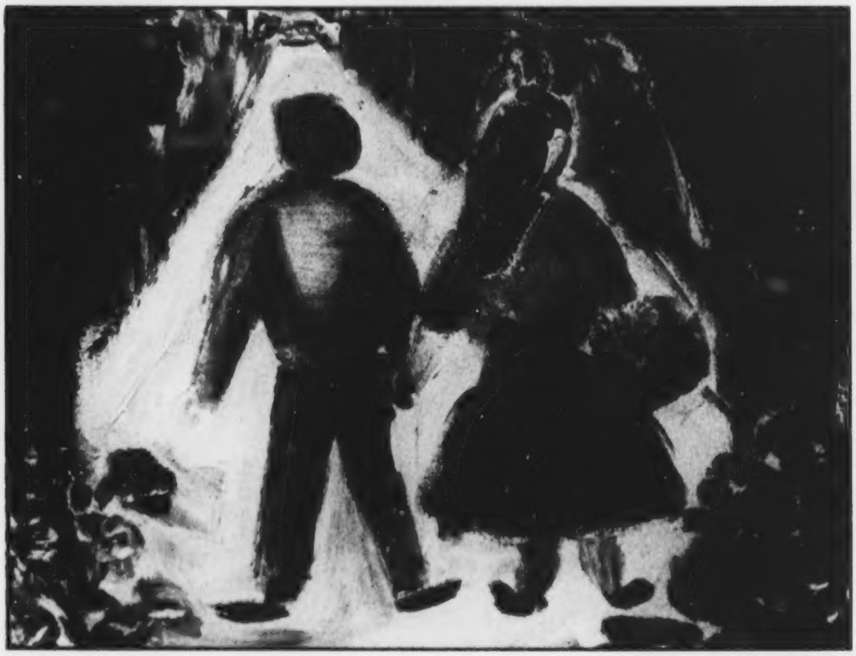


Fig. 9
Independence: The girl at a bus stop and similar motifs (all integrated) stand for increased self-reliance.

Fig. 10
Girl Togetherness: The integrated series of boy-girl pictures joined in everyday activities indicates a strong potential for meaningful heterosexual relations.



stand her oedipal strivings and her fears concerning them with their relationship to their displacement into other symptoms. She also has not been more than superficially able to explore some of her strong masculine strivings.

Response to Creative Analysis therapeutic testing reveals a strong conflicted individual. However, it also discloses sufficient ego strength enabling her to face her difficulties. The key to her identity crises was seen in her unresolved passive-active male-female confusion. This also accounts for her initial repudiation of motor expression which she associates with aggression perceived as a masculine attribute.

Summary

The key to this patient's initial repudiation of motor expression documented in her responses to Creative Analysis therapeutic testing was based upon an association with aggression which was perceived as masculine. Her recurrent motifs and reactivation test results were indicative of: **a)** an over-indulgence on an oral level; **b)** severe discipline during the anal period of development (which made gratification of primitive motor impulses unacceptable); and **c)** traumatic experiences on an oedipal level, the resolution of which had been sought in moral masochism. The patient was able to integrate, to some extent, the reconciliation of feelings of aggression and sexuality through her sessions with her psychiatrist and the Creative Analysis. The socialization with a male as well as her performance in the Blackbottom dance in her cottage facilitated emotional and intellectual insight. The patient's need to be recognized as a leader even though she resists it (bending over backwards to remain passive), is because leadership, like success, is still threatening to her. There remains an "apparent need to feel that I must punish myself for success. . . . that I must be on guard in situations where I might succeed."

From the outset, the patient worked very intensively on her recovery, but never admitted to any pleasure in that work. Her fear of success is seen as a fear of loss: the loss of her mother and her father's favor, as well as a punishment. By punishing herself, by denying herself success, she averts betrayal by an authority figure. She magically avoids the loss of her mother.

Objectively, the patient's course was marked by a lessening of her anxiety attacks, a widening ability to participate in extramural activities, becoming involved in a heterosexual relationship with greater ease than she had previously known and, finally, to making realistic discharge plans concerning living arrangement, seeking employment and continuing her therapy through a local out-patient facility. On discharge, one year after admission, the prognosis was judged to be good. It was felt that she would be able to maintain herself in her community and continue to reduce her symptomatology while enhancing her adjustments to social and professional demands and personal needs.

References

Foreign Language Publications by Dr. Ernest Zierer

Zierer, E., Ph.D. (1924). Kunst and Weltgesetze, Neue Wege Ihrer Erforschuung (Artistic and Universal Principles). Nordiska Boktryckeriet, Stockholm.

Zierer, E., Ph.D. (1924). Erdbuch. Ein Abwicklungsgesetz (Evolution). Nordiska Boltryckeriet, Stockholm.

Zierer, E., Ph.D. (1924). Ursprung der Barocken Kuppel (Origin of the Baroque Cupola). Research University, Stockholm.

Zierer, E., Ph.D. (1927). An die Kunstler (To the Artists). Nordiska Boltryckeriet, Stockholm.

Zierer, E., Ph.D. (1927). Intuitive Kunst (Intuitive Art). Nordiska Boktryckeriet, Stockholm.

Zierer, E., Ph.D. (1930). Objective Wertgruppierung (Classification of Art Values). J. J. Ottens Verlag, Berlin.

Zierer, E., Ph.D. (1931). Erziehung auf Grundlage der Absoluten Tiefenanschauung (Art Education on the Basis of Depth Evaluation). Kunst und Jugend, Berlin.

Zierer, E., Ph.D. (1931). Kinderzeichnungen und Kunstunterricht (Children's Drawings and Art Teaching). Kunst und Jugend, Berlin.

Zierer, E., Ph.D. (1931). Neuaufbau der Kunstkritik durch die Absolute Tiefananschauung (Reorientation of Art Evaluation, An Introduction to the Depth Psychology of Art). Verlag Seebote, Uberlingen.

Zierer, E., Ph.D. (undated). Das Ende Der Kunstritik Ihr Neuaufbau Durch Die Absolute Tiefenanschauung.

Zierer, E., Ph.D. (undated). Objective Wertgrupierung. Kunstmonographische Ubersicht uber das Werk des Walter Kurau. (Depth Evaluation of the work of Walter Kurau). J. J. Ottens Verlag, Berlin.

Zierer, E., Ph.D. (1948). Bipolaridad En La Esquizofrenia (Schizophrenic Bipolarity). Translated by Gabriel de la Vega, M.D., Revista de Psiquiatria del Uruguay. Montevideo, Uruguay.

Foreign Language Publications on Dr. Ernest Zierer's Theory

Wetzenstein, E. (1928). Kritische Betrachtungen der Zierer'schen Kunstkritik (Critical Thoughts on Zierer's Art Criticism). J. J. Ottens Verlag, Berlin.

Merwart, F. (1928). Zierer's Tiefenanschauung und Ihre Erzieherische Bedeutung (Zierer's Art Evaluation and Its Value for Art Education). Kunst und Jugend, Berlin.

Folke, M. (1933). Zierer's Tiefenanschuung. Drei Essays (Zierer's Art Evaluation. Three Essays). Stockholm.

Donath, A. (1931). Der Neue Hoffer Ausstellung bei Fleethteim.

Fechner, P. (undated). Erde die Zun Kunstwerk Wachst.

Wall, B. (1952). Gunnar Loberg. Astockholm.

English Publications

Zierer, Ernest, Ph.D. (1950). "Dynamics and diagnostic value of creative therapy, 1. The Body-Space Test," *Acta Medica Orientalia*, Jerusalem, Vol. IX, No. 2., February, 1-9.

Zierer, Ernest, Ph.D. (1950). "Bipolarity in diagnosis through art," *American Journal of Psychotherapy*. Vol. IV, No. 3., July, 448-499.

Zierer, Ernest, Ph.D. (1951). "Dynamics and diagnostic value of creative therapy, 2. Element Integration," *Acta Medica Orientalia*, Jerusalem, Vol. X, No. 2., Februrary, 41-48.

Zierer, Ernest, Ph.D. and Edith Zierer, ATR. (1951). "Body-space test for adolescents and adults," Scoring, New York.

Zierer, Ernest, Ph.D. (1952). "Transference in creative therapy," *Journal of the Hillside Hospital*, New York, Vol. I, No. 2., April, 93-102.

Zierer, Ernest, Ph.D. and H. J. Kleinschmidt, M.D. (1952). "Dynamics and diagnostic value of creative therapy, 3. Clinical Application," *Acta Medica Orientalia*. Jerusalem, Vol. XI, No. 5., May, 91-102.

Zierer, Ernest, Ph.D. (1952). "The total personality in creative therapy," *American Imago*, Vol. 9, No. 2, June, 3-16.

Zierer, Edith, ATR. (1953). "The function of occupational therapy in psychiatric hospital," *Journal of the Hillside Hospital*, New York, Vol. II, No. 3, July, 152-163.

Zierer, Ernest, Ph.D. and Edith Zierer, ATR. (1955). "Development aspects of the body-space concept," *Acta Medica Orientalia*, Jerusalem, Vol. XIV, No. 9, September, 232-241.

Zierer, Ernest, Ph.D. and Edith Zierer, ATR. (1956). "Structure and therapeutic utilization of creative activity," *American Journal of Psychotherapy*, Vol. X, No. 3, July, 481-519.

Zierer, Ernest, Ph.D. and Edith Zierer, ATR. (1957). "Leonardo da Vinci's artistic productivity and creative sterility," *American Imago*, Vol. 14, No. 4, Winter, 345-369.

Zierer, Ernest, Ph.D. and Edith Zierer, ATR. (1960). "The integration quotient in creative therapy," *Journal of the Hillside Hospital*, Vol. IX, No. 3, July 156-170.

Zierer, Ernest, ATR, and D. Sternberg. (1966). "Family creative analysis: It's role in treatment," *Part I and II, Bulletin of Art Therapy*, Vol. 5, January-April, 47-63, 87-104.

Zierer, Edith, ATR, (1966). "Creative analysis: Color integration as a diagnostic and therapeutic tool in individual and family treatment," *Psychiatry and Art*, Washington, D.C., 200-207. (Karger, Basel 1968).

Zierer, Edith, ATR, (1967). "Creative analysis: A method of reality confrontation,: Proceedings of the Fifth Congress of the International Society of Art and Psychopathology, Paris, Ser. No. 196, June, 65-82.

Zierer, Edith, ATR, (1970). "Creative analysis: Relationship of color integration to personality reintegration. Changes in the pathology of a schizophrenic patient," Proceedings of the Third International Congress of Social Psychiatry, Zagreb, Vol. 4, September, 289-203.

Zierer, Edith, ATR, (1970). "Reintegration of the self-image of an LSD patient," Proceedings of the Third International Congress of Social Psychiatry, Zagreb, Vol. 2, September, 91-100.

Zierer, Edith, ATR, (1971). "Reintegration of an LSD patient," *Psychiatry and Art*, Basel, Vol. 3, 184-205.

Zierer, Edith, ATR, (1973). "Creative analysis: A projective technique and structured therapeutic method," *Art Psychotherapy*, Vol. 1, No. 2, 101-108.

Zierer, Edith, ATR, (1975). "Case study: Creative analysis of a family," *American Journal of Art Therapy*, Vol. 14, No. 2, 49-53.

Zierer, Edith, ATR, (1975). "Methods of communication and levels of objectives in creative analysis," *Psychiatry and Art*, Basel, Vol. 4, 270-276.

Zierer, Edith, ATR, (1975). "Kreative analyse im rahmen einer familientherapie," *Handbuch der Psychiatrie*, 271-274. German Translation.

Zierer, Edith, ATR, (1976). "Creative analysis: A nonverbal and verbal psychotherapy technique," *Art Psychotherapy*, Vol. 3, 27-41.

Zierer, Edith, ATR, J. Jacobs, B.A., and M. Moore, B.C. (1976). "Identification of an art therapist through creative analysis," Proceedings of the Seventh Annual Conference of the AATA, Baltimore, Md., October, 66-69.

Zierer, Edith, ATR, (1976). "Family art therapy study session," Proceedings of the Seventh Conference of the AATA, Baltimore, Md., October, 26-27.

Zierer, Edith, ATR, (1978). "The use of painting in family creative analysis," *Japanese Bulletin of Art Therapy*, Vol. 9, 137-144.

Zierer, Edith, ATR, (1978). "Getting older in a changing society: Problems and problem solving," Proceedings of the Ninth Annual Conference of the AATA. (Published Art Therapy: Expanding Horizons; American Art Therapy Associated 1978-1979, pp. 66-69).

Zierer, Edith, ATR, (1979). "Another reaction to therapeutic doctrine and the artist-client." *American Journal of Art Therapy*. Vol. 18, Number 3, April.

Zierer, Edith, ATR, (1981). "Creative therapy: Gerontology & geriatrics." Bulletin of Expressive Art Therapy for Elderly. Spring-Summer, Vol. 1.

English Publications on Dr. Ernest Zierer's Theory

Silberman, I., Dr. Bulletin of the American Psychoanalytic Association of New York, Vol. 4, No. 3, "Art in Diagnosis." 1948 Annual Meeting in Washington, D.C.

Kleinschmidt, H., M.D. Organization and Management of a Progressive Psychiatric Institution, *Acta Medica Orientalia*, Jerusalem, Vol. 7, No. 7-8, 1948.

Kleinschmidt, H., M.D. and Miller, J., M.D. An Early Diagnosis of Schizophrenia, *Acta Medica Orientalia*, Jerusalem, Vol. 8, No. 5-6, 1949.

The author wishes to acknowledge the assistance and cooperation of Connie E. Naitove, ATR, literary editor and compiler for the article; A. Russell Lee, M.D.; Fred Brown, Ph.D.; Sylvia Markham, M.A.; and the administration of Hillside Hospital at Glen Oaks, New York, in making the records available for this purpose. Reprints of this article and bibliography of other publications by the Zierers may be obtained by writing to: Edith Zierer, ATR, 14 Acre Drive, Danbury, CT 06811. All photography courtesy of David Finn.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:
Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

BEST COPY AVAILABLE

CHARLES C THOMAS • PUBLISHER

New! **THE PSYCHOCYBERNETIC MODEL OF ART THERAPY** *by* **Aina O. Nucho.** This book begins with a detailed account of the origins and rationale of art therapy, and then focuses on the implementation of the psychocybernetic model which combines the verbal/analytic and the visual/imagistic symbol systems. The author describes ways to introduce clients to visual forms of expression, the actual "doing" phase, decoding the visual imagery, termination of treatment, and the scope and effectiveness of the model. *'87, $34.50*

New! **VISUAL ARTS AND OLDER PEOPLE: Developing Quality Programs** *by* **Pearl Greenberg.** This lucid text provides the background and knowledge necessary to understand and appreciate older adults as artists and to develop quality visual art programs. Chapters explore retirement, gallery and museum programs, art for disabled older people, adult learning, art hazards, and art appreciation. Diverse art mediums are covered including collage, drawing and painting, clay and construction, fabric printing, and weaving. *'87, $30.25*

New! **FUNDAMENTALS OF MARKETING THE PRIVATE PSYCHOTHERAPY PRACTICE** *by* **Bruce D. Forman** *and* **Kadette S. Forman.** Devoted solely to concerns of private mental health services, this book discusses the marketing concept; marketing strategies; techniques for analyzing, monitoring, and auditing a private practice; and the marketing mix (place, price, product, and promotion). An entire chapter explores the topic of promotion including copywriting, layout design, and direct mail advertising. *'87, $27.25*

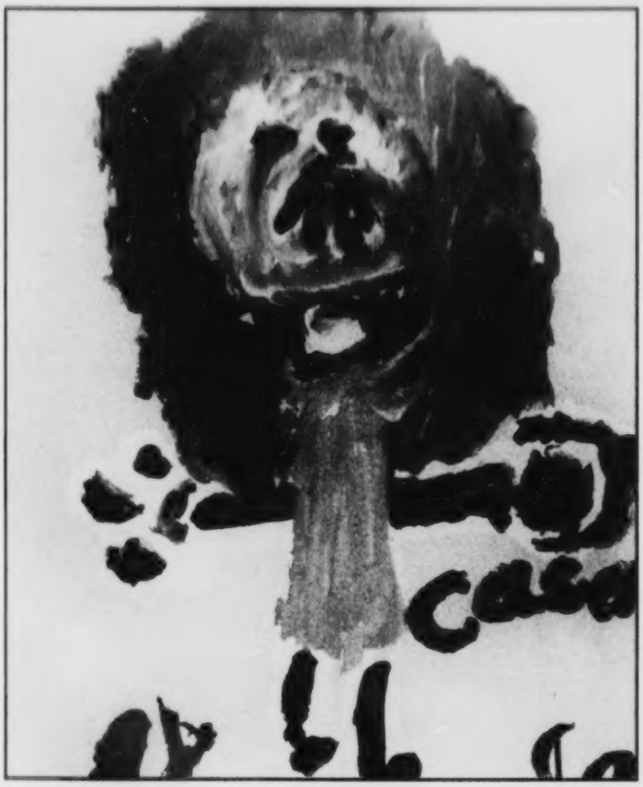
EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession *by* **Shaun McNiff.** This comprehensive study explores the interdependence of diverse training traditions, and it reviews the various areas of concentration, such as art or music therapy. Specific competencies and different philosophies are examined, but their commonalities are emphasized. Chapters are also included on an artistic theory of mental health and on supervision and evaluation. *'86, $32.75*

THE ARTS AND PSYCHOTHERAPY *by* **Shaun McNiff.** An integrated approach to all of the arts in psychotherapy is presented in this insightful book. The author examines the distinctive and common qualities of the various expressive arts in relation to psychotherapy. He also draws on the statements of artists to develop a psychology of art that views artistic exploration as psychological research of the highest order. *'81, $21.75*

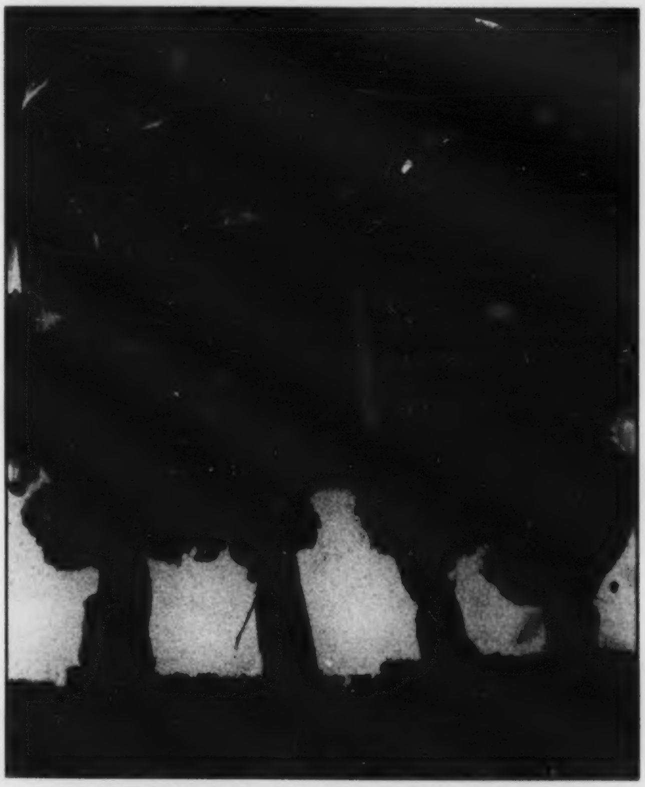
THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking *by* **Myra F. Levick.** In this book, a pioneer and leader in art therapy describes and illustrates normal and abnormal development of cognitive skills and defense mechanisms through the graphic productions of children between two and ten years old. The range of topics thus examined includes art therapy, defense mechanisms of the ego, psychosexual and cognitive development, and manifestations of defense mechanisms in children's drawings. *'83, $38.00*

We fill all orders promptly • Books sent on approval
Postage paid on MasterCard, Visa & prepaid orders
Write or call (217) 789-8980 • Catalog sent on request

2600 South First Street
Springfield • Illinois • 62794-9265



"SELF PORTRAIT" Painting by a young girl in art therapy at Wright State University, Dayton, Ohio



"TREES AND STORM" Painting by a pre-adolescent girl in art therapy at Wright State University, Dayton, Ohio

"Diagnosis and Assessment: Impact on Art Therapy"

Ellen G. Horovitz-Darby, MA, ATR, *Coordinator of Creative Art Therapies, Hillside Children's Center, Rochester, New York.*

This article underscores the need for the art therapist to become familiar with and use specific diagnostic assessments particularly "in an age where new legislative law and decreases in federal funding have impacted not only the mental health field but the future of Art Therapy itself. . . ." The format included is based on observations from social workers reports and from psychological assessments, as well as tests that have been refined over the years by Horovitz. Included in this article are references to the H-T-P, the K-F-D, the D-A-P, the Bender Gestalt, the Cognitive Art Therapy Assessment and the Silver Drawing Test. Some examples of completed evaluations are presented to give the reader an idea of the "look" of a completed diagnostic assessment.

Introduction

In 1978, I became active in the New York Art Therapy Association. Part of my work consisted of pouring over new legislative bills and conferring with our legislative assistant. One of the bills that I rewrote was a subsection of Public Law 94-142 entitled "Recreation Therapist (Art, Dance, and Music)." This support amendment was accepted and ratified into law and thus created a civil service line for creative art therapists in New York State. Creative Art therapists could benefit from that law if they were named as a "support service" for a handicapped child.

After eight years a Committee on the Handicapped (C.O.H.) meeting was held in a nearby town (Gananda, N.Y.) and a psychologist who was familiar with my work, referred a child for art therapy services. This referral was made directly on his Individualized Education Plan (I.E.P.). By law, since the "support service" had been recommended, the committee had to provide the services. I was contacted for consultation and assessment purposes. The C.O.H. agreed to transport the child (and family if necessary) for art therapy and to *pay* for this service.

After completing my diagnostic assessment, the child began treatment. Soon after, I received another referral from the same committee. The school psychologist called and exclaimed that he was not only impressed with the work on the first case but more importantly was astounded by the evaluation process and information which these tests revealed.

In an age where new legislative law and decreases in federal funding have impacted not only the mental health field but the future of Art Therapy itself, it is imperative for Art Therapy to be recognized as a professional field. It is for this very reason that I designed an Art Therapy Diagnostic format described herein.

The Format

Part of the format is based on observations of both social workers' intake reports and psychological assessments. The format is easy to read both in terms of finding specific data (test results) and determining whether or not the referral is an appropriate modality (Table A).

My agency, Hillside Children's Center in Rochester, New York, developed a Support Service Referral form (Table B) which is now a precursor to the Art Therapy Diagnostic Assessment. The Quality Assurance Department developed the Support Service Referral form as a manner of expediting not only this service but also other modalities (e.g., psychiatric, psychological). The inclusion of the creative art therapies on this form clearly underscores this agency's commitment to creative art therapy assessments as professional, clinical tools.

The Tests

In the last few years, I have been refining this procedure, adding and deleting tests when indicated. Originally, the assessment consisted of the House Tree Person (HTP) (both achromatic and chromatic); 2) the Kinetic Family Drawing (KFD): 3) the Draw a Person (DAP): 4) Bender Gestalt Visual Motor Test (B-G); 5) the Cognitive Art Therapy Assessment (CATA); and 6) the Silver Drawing Test of Cognitive and Creative Skills (ST).

(Author's Note: The CATA was a name I gave to an art therapy evaluation procedure described by Kramer, E. and Schehr, J., 1983. Because I scored the results according to the developmental stages of Lowenfeld and Brittain (1975), I felt the name befitted the procedures).

My review of Rawley Silver's test

> ***"Part of the format is based on observations of both social workers' intake reports and psychological assessments."***

(Horovitz, 1985) prompted me to include her battery and measure it against standardized tests (such as the WISC-R) and projective instruments (such as the HTP and KFD). The Silver Test not only yielded similar information but also uncovered invaluable information that was heretofore unknown with both our emotionally-disturbed hearing and deaf population.

Presently, all of the tests are included with two exceptions: 1) the Bender Gestalt (B-G) is scored developmentally and used only on children up to age 10; and 2) the Draw a Person is implemented if more information is required to determine sexual orientation or clarify cognitive and developmental functioning.

Projective analysis of test results (e.g., HTP, KFD, CATA) are stated succinctly and without elaborate descriptors of the work produced. It became clear that a respected clinician need not justify his or her interpretations but rather state them clinically in order to gain acceptance and credence.

A few examples of completed evaluations (minus identifying information such as real names and addresses) are presented at the end to give an idea of a completed diagnostic assessment.

This evaluation is one of many forms designed for our Creative Art Therapies Department. It is hoped that art therapists will continue to develop evaluative tools such as the Silver Test (ST) for inclusion in diagnostic assessments. Perhaps such contributions will convince other mental health professionals of the significance and impact of art therapy not only for treatment but also for diagnostic and assessment purposes.

Author's Note: Since submitting this article for publication, the author now scores the silver Drawing Test (ST) developmentally as well as emotively when applicable. Also the Bender Gestalt (B-G) is scored for emotional indicators as well as developmentally (again according to the Koppitz system - see reference section). Since this article was accepted for publication, another change has occurred at our agency. Since the Art Therapy Diagnostic Assessment highlilghts so much information, all deaf/hearing-impaired clients which enter residential treatment are now evaluated for the purpose of yielding information which might not otherwise be available.

References

Buck, J. N. (1950). *"Administration and interpretation of H-T-P Test,"* Proceedings of the H-T-P workshop held at Veterans Administration Hospital, Richmond, Virginia, March 31 - April 2.

Burns, R. and Kaufman, S. H. (1972). *Actions, styles, and symbols in kinetic family drawings (KFD).* New York: Bruner/Mazel.

Hammer, E. F. (1975). *The clinical application of projective drawings* (4th ed.). Springfield, Illinois: Charles C. Thomas.

Horovitz-Darby, E. G. (1985). "Review of the Silver Drawing Test of Cognitive and Creative Skills." *Art Therapy 2* (1), p. 44.

Koppitz, E. M. (1963). *The Bender Gestalt Test for Young Children.* New York: Grune and Stratton.

Koppitz, E. M. (1968). *Psychological evaluation of children's human figure drawings.* New York: Grune and Stratton.

Kramer, E. and Scheher, J. (1983). "An art therapy evaluation session for children." *American Journal of Art Therapy, 23* (1), pp. 3-12.

Lowenfeld, V. and Brittain, W. L. (1975). *Creative and mental growth* (6th ed.). New York: MacMillan.

Public Law 94-142, *The Federal Register,* Volume 42, No. 163, pp. 42299-42676, August 23, 1977.

Silver, R. A. (1983). *Silver Drawing Test of Cognitive and Creative Skills.* Seattle: Special Child Publication.

Wilson, L. and Goodman. R., Establishing Civil Service Job Classifications for Creative Arts Therapists in New York State, *American Journal of Art Therapy,* October 1980, Volume 20, Number 1, pp 13-17.

"It is hoped that art therapists will continue to develop evaluative tools . . . for inclusion in diagnostic assessments."

"It became clear that a respected clinician need not justify his or her interpretations but rather state them clinically in order to gain acceptance and credence."

Table A

ART THERAPY DIAGNOSTIC ASSESSMENT

NAME: ____________________

ADDRESS: ____________________

DOB: ____________________

PARENTS: ____________________

REFERRED BY: ____________________

TESTING DATES: ____________________

ADMINISTERED BY: ____________________

REASON FOR REFERRAL:

TEST ADMINISTERED:

BEHAVIORAL OBSERVATIONS AND IMPRESSIONS:

TEST RESULTS:

COGNITIVE ART THERAPY ASSESSMENT

TWO DIMENSIONAL	DEVELOPMENTAL STAGE
Painting Response	
Drawing Response	

THREE DIMENSIONAL	DEVELOPMENTAL STAGE
Clay Response	

OVERALL PERFORMANCE

SILVER DRAWING TEST	SUB TEST SCORES
Predictive Drawing	
Drawing from Observation	
Drawing from Imagination	

Total Score ; %; T Conversion Score:

BENDER GESTALT TEST

SCORE	DEVELOPMENTAL AGE

HOUSE TREE PERSON (Projective Results): ____________________

KINETIC FAMILY DRAWING (Projective Results): ____________________

COGNITIVE ART THERAPY ASSESSMENT (Projective Results): ____________________

SUMMARY AND RECOMMENDATIONS: ____________________

____

Title

607

Table B

HILLSIDE CHILDREN'S CENTER
SUPPORTIVE SERVICES REFERRAL
(instructions on reverse)

URGENT!
needed by:

client name	date of birth	program/unit	date of referral

REFERRAL TO: (name of practitioner)

REFERRAL FOR: ( ) CONSULTATIONS
( ) EVALUATION/ASSESSMENT
( ) TIMELIMITED SERVICES
proposed frequency ______
duration ______

EVALUATION/ASSESSMENT/SERVICE: (see reverse for listing of additional services & attachments

( ) psychiatric diagnosis ( ) physical ( ) medication ( ) personality functioning ( ) vocational

( ) psychoeducational ( ) psychotherapy ( ) art therapy ( ) dance therapy ( ) recreation therapy

( ) other ______ ( ) non-HCC service ______

REASON FOR REFERRAL:

( ) initial baseline assessment ( ) periodic update ( ) clinical reason described below

( ) required by funding/regulatory authority only (specify who requested: ______)

CURRENT FUNCTIONING: Describe client's current functioning or provide other information relevant to service requested (i.e. treatment goals) and state specific questions or problems this evaluation or service will help resolve. Continue on reverse for psychiatric evaluations, or if more space is needed.

referred by (signature)	extension	supervisor's signature	remittance date

****

TO BE COMPLETED BY SUPPORTIVE SERVICE PROVIDER:
( ) unable to accommodate referral at this time. Re-refer after (date): ______
( ) inappropriate referral on basis of material provided

EVALUATIONS/ASSESSMENTS/CONSULTATIONS: completed on (date): ______

PSYCHIATRIC DIAGNOSTIC INTERVIEW:
( ) unable to diagnose ( ) preliminary only ( ) final diagnosis ( ) revised final diagnosis

List diagnoses & codes:

MEDICATION REVIEW: Current medication: ______

( ) renewed as is ( ) discontinue ( ) dose/frequency changed to: ______

( ) new medication: ______

OTHER: Preliminary findings & recommendations (attach full report or mail promptly - not required for consultations)

TIMELIMITED SERVICES: client seen on (date): ______
( ) not appropriate for timelimited services.
REASON:

( ) accepted for services. Planned frequency & duration: ______
Preliminary objective & modality:

Continued on next page.

FOR FURTHER REPORT SEE: ( ) progress notes ( ) full report to follow ( ) medication order sheet

supportive service provider's signature	date

OA-14 (1 85) (rev 6 85)

THIS FORM IS USED TO REQUEST AND MONITOR THE UTILIZATION OF ALL SUPPORT ANCILLARY SERVICES. REQUESTS ARE INITIATED BY THE SOCIAL WORKER EXCEPT FOR THOSE INDICATED.

INSTRUCTIONS:

1. *TOP PORTION:* Top half of the Referral form is completed by the worker making the referral for the service.
2. *ATTACHMENTS:* Any additional information needed by the supportive service provider to process the referral must be attached to the Referral form.

	SERVICES NEEDING REFERRAL	ATTACHMENT
	art therapy	
	audiological evaluation	
	dance therapy	
(by nurse)	dietary nutritional evaluation	
	drug alcohol assessment	
	family life education	
	medication review evaluation	
	occupational therapy	
	one-to-one supervision	
	permanence	
	personality functioning	
	physical examination	
	psychiatric evaluation	
	psychodrama	
(by teacher)	psychoeducational evaluation	
	recreation therapy	
	resource volunteer	
	speech remediation	
	supplemental psychotherapy	
	vocational assessment	
(by nurse)	non-HCC medical service	

3. *BOTTOM PORTION:* Bottom half of the Referral form is completed by the supportive service provider upon receipt and processing of the referral.

COPIES: Three (3) copies are made of the completed Referral form.

DISTRIBUTION: The copies and original are distributed as follows:

(a) Original is returned to the worker who made the referral ASAP and then filed in the record.
(b) One copy is maintained by the supportive service provider.
(c) One copy is forwarded to the supportive service provider's supervisor.
(d) One copy is forwarded to the Quality Assurance Unit.

COMPLETE THIS SECTION FOR PSYCHIATRIC EVALUATIONS giving more detailed data for each area.

CURRENT FUNCTIONING AND CHANGES SINCE LAST INTERVIEW:

COTTAGE: ______

SCHOOL: ______

CASEWORK: ______

FAMILY: ______

BEST COPY AVAILABLE

Hillside Children's Center

150 Floventon Street
Rochester, New York 14610
(716) 482-3992

James W. Cotter ACSW
Executive Director

ART THERAPY DIAGNOSTIC ASSESSMENT

NAME: Adam

ADDRESS:

DOB: 7/12/73 CA: 12.4

PARENTS:

REFERRED BY:

TESTING DATES: 10/10/85, 10/18/85, 10/25/85, 11/15/85
11/22/85, 11/25/85, 12/6/85, 12/13/85

ADMINISTERED BY: M.E. Keef, AT Intern

Reason for Referral:

Difficulty verbalizing feelings and discussing relevant issues; attention deficit and hyperactivity leading to difficulty focusing on any one activity for more than 3-5 minutes.

Tests Administered:

- House-Tree-Person (Achromatic and Chromatic) (HTP)
- Kinetic Family Drawing (KFD)
- Silver Drawing Test of Cognitive & Creative Skills (ST)
- Bender Gestalt Test of Visual-Motor Perception (BG)
- Cognitive Art Therapy Assessment (CATA)

Behavioral Observations and Impressions:

Although a boy of twelve, Adam appears younger. During the initial testing session Adam was quite curious, asking many questions, and wishing to examine the contents of the cabinet as well as the room next door. Once sitting down to work, he was highly distractible during the testing process. Also, as he was given each new task, he moved first a chair away from myself, then repeatedly further until by the end of the session he was at the opposite end of the room. Upon my asking, he verbalized a difficulty in trusting new people. His manner remained friendly, however, and he stated in a teasing way that he was "testing" me. In the ensuing testing sessions Adam still evidenced curiousity and distractability, but was able to focus quite well on the artwork and necessary clean-up.

Test Results:

- Cognitive Art Therapy Assessment (CATA):

Two-Dimensional	Developmental Stage
Drawing Response -	Schematic, age 7-9 years (Lowenfeld & Brittain)
Painting Response -	(same as above)
Three-Dimensional	
Clay Response -	(same as above)

Overall Performance- Lower end of spectrum for schematic stage of development, age 7-9 years, Lowenfeld & Brittain.

Silver Drawing Test (SDT):	Sub-Test Score
Predictive Drawing -	8
Drawing from Observation -	10
Drawing from Imagination -	6

Total Score: 24; 9th % for grade 7
T-Score Conversion: 36.32

- Bender Gestalt Test of Visual-Motor Perception (BG):

Adam scored a 12, which indicates his visual-motor perception to be functioning at about age 5½. Werner Halpern, M.D. believes this to indicate integration as problematic for Adam, rather than perceptual impairment.

- House-Tree-Person (HTP):

Adam's overall response indicates instability and low self-esteem, especially the final two drawings of the tree and person, chromatic: given a selection of colors, Adam chose a pale flesh color, which all but disappears into the manila-color of the paper. These two drawings are the most minimal of the set, using only the essential elements to indicate "tree" and "person". Adam was unduly quiet during this session, appearing depressed. Upon my inquiring, Adam stated sadly: "Things at home are bad."

- Kinetic Family Drawing (KFD):

Upon being presented with this task, Adam declared that he could not draw his family. To my question of why he replied: "There's no paper big enough." He then chose the smallest paper available, drawing his mother on one and his sister on another, both as large faces (no bodies), which overwhelm the page. Adam refused to include himself. These drawings were also done during the session previously mentioned, when Adam verbalized his depression of the state of affairs at home. His use of separate pieces of paper to depict his mother and his sister, indicates he perceives divisions in the family. The size of the drawings on the page suggests feelings of being overwhelmed by them, and of their importance to him. Finally, his refusal to include himself indicates feelings of isolation from the family, coupled with low self-esteem.

- Cognitive Art Therapy Assessment (CATA):

It is interesting to note that in being given the freedom to create anything desired, Adam's artwork in all three areas of this task are strongly related to home. His comments also centered around creating the art work for his mother, and were indicative of anxiety that it be "good enough".

Especially of interest is Adam's response to the three-dimensional portion of the CATA. He created a house for his mother out of clay, then painted it with tempra paints. The finished piece projects an impression of home being a bleak, unstable place to be.

Summary and Recommendations:

Adam appears to be functioning at the low end of the schematic stage of development, age 7-9 years, Lowenfeld & Brittain. Associations to the tests revealed depression regarding his home life, low self-esteem, and need for acceptance. Since he is able to attend to the art materials, it is recommended that Adam be seen bi-weekly for individual art therapy. It is hoped that eventually Adam's family will become involved in family art therapy to extend the therapeutic process to the family constellation.

M.E. Keef,
Art Therapy Intern

Ellen G. Horovitz-Darby,
M.A., ATR
Coordinator of
Creative Art Therapy

MEK/jsl

Hillside Children's Center

150 Floventon Street
Rochester, New York 14610
(716) 482-3992

James W. Cotter ACSW
Executive Director

ART THERAPY DIAGNOSTIC ASSESSMENT

NAME: Michael

ADDRESS:

DOB: 5/20/77 CA: 8.6

PARENTS:

REFERRED BY: Paula Gianforti, MSW

TESTING DATES: 10/14/85, 10/21/85, 10/30/85

ADMINISTERED BY: Ellen G. Horovitz-Darby, M.A., ATR, Coordinator of Creative Art Therapies

REASON FOR REFERRAL: Michael was referred by his social worker, Paula Gianforti, MSW, for a variety of reasons including:
(a) functioning below grade level
(b) unsuccessful in traditional verbal psychotherapies
(c) difficulty accepting change
(d) separation anxiety regarding divorce trauma at age 5 years
(e) low frustration tolerance
(f) limited attention span

TESTS ADMINISTERED:
House Tree Person (chromatic and achromatic) (HTP)
Kinetic Family Drawing (KFD)
Cognitive Art Therapy Assessment (CATA)
Silver Drawing Test of Cognitive and Creative Skills (ST)

BEHAVIORAL OBSERVATIONS AND IMPRESSIONS:

Initially, Michael was extremely anxious during the testing situation. In the first interview, Michael stated his reasons for attending Art Therapy - "because I don't want them (mother and father) to be divorced." The testing situation revealed Michael as highly distractible, avoidant in posture, excitable and bordering on hyperactive behavior. For example, a few times during the testing sessions, Michael fell off his chair. Later, he purposely bumped into walls. When this worker addressed these actions, his response was, "Do you think they're lonely out there without me?" (Referring to his parents in the waiting room area). It was clear that he felt protective and very responsible for their well-being.

As the testing continued, Michael became more comfortable with this worker (buying her a gift on his second session) and was able to easily verbalize his conflicts.

TESTS RESULTS:

COGNITIVE ART THERAPY ASSESSMENT (CATA)

Two Dimensional	Developmental Stage
Drawing Response	Pre-schematic, age 4-7 years (Lowenfeld and Brittain)
Painting Response	Schematic, age 7-9 years (Lowenfeld and Brittain)
Three Dimensional	**Developmental Stage**
Clay Response	Schematic, age 7-9 years (Lowenfeld and Brittain)

Overall Performance - lower end of spectrum for schematic stage of development age 7-9 years, Lowenfeld and Brittain

SILVER DRAWING TEST (SDT)	SUB-TEST SCORE
Predictive Drawing	10
Drawing from Observation	3
Drawing from Imagination	8

Total Score 21 26% for grade 3 T Conversion Score = 43.68

HOUSE TREE PERSON (HTP)

Michael's response on both the achromatic and chromatic subtests of the House Tree Person were not highly differentiated. Of interest was his response to the house. He created just a shell which may be indicative of the lack of substance he feels exists within his home environment. With some prompting, he was able to create a door. Nevertheless it was overly large, often reflective of dependent personalities. His difficulty with the Person subtest revealed poor self-image, feelings of inadequacy, and avoidance of interaction with others. The Tree subtest reflected inner turmoil and conflict.

KINETIC FAMILY DRAWING (KFD)

Projective analysis of the Kinetic Family Drawing (KFD) revealed Michael's clear avoidance of family-related issues. His initial response was to spend much time articulating a house (his father's) yet he added no people. When this was pointed out, he then added his paternal grandparents and his father working in the garden, a workman repairing the chimney, his cousin, Patty outside the home by herself and last added himself looking out on this activity from inside the house. His need to isolate himself from family interaction was evident as well as his view of his grandparents and father as authoritative parental figures. Mother's absence was obvious and when the worker pointed this out, he placed her inside the kitchen rather than create another family system. Of particular interest is the chimney repairman; perhaps Michael views this worker as someone who can reconstruct the original family constellation and enact his fantasy of a parental reconciliation.

COGNITIVE ART THERAPY ASSESSMENT (CATA) (Projective)

Projective analysis of the CATA was of interest. His drawing revealed scrawling chaotic lines. His emotional response to this graphic association of inner conflict led him to fall off his seat.

The painting, two pieces of paper taped together has a circular rainbow which was later sub-divided to give to each of his parents so neither would feel "hurt". The art therapist's interpretation of the divorce issue followed the completion of the subtest as Michael frantically decided to cut the painting in half.

The clay response yielded similar verbal remarks - Michael became upset when only one creation had been made, again feeling torn between whom he should give the project.

Interpretation of his feelings allowed Michael to reflect his need to save his parents, burden himself with responsibility, and please others. Moreover, Michael was able to verbalize his loyalty conflict around mother's fiance', Paul, versus his father.

RECOMMENDATIONS AND SUMMARY:

Michael appears to be functioning at the low end of the schematic stage of development, age 7 years, Lowenfeld and Brittain. It is clear that he is cognitively arrested due to emotional turmoil, conflict, and unresolved feelings regarding his family constellation.

Since he obviously responds to the Art media and couples the art process with verbal associations to the work produced, individual weekly art therapy is highly recommended. In addition, bi-monthly family art therapy with separate sessions for Mrs. B and her fiance' Paul, and Mr. B is recommended to expedite resolve of Michael's inner conflict regarding placement within these family systems.

The testing seems to have revealed Michael's need for a self-contained classroom with highly individualized instruction in order to offer him the emotional support which he needs to make cognitive and academic gains.

Ellen G. Horovitz-Darby, M.A., ATR
Coordinator of Creative Art Therapies

EGH/jsl

REVIEWS

"Art Therapy: The Healing Vision,"

(Videotape Formats: ¾" U-matic, ½" VHS, ½" Beta, Color, 49 minutes, 1986), produced by Menninger Video Productions, Box 829, The Menninger Foundation, Topeka, KS 66601. Information on rental or purchase may be obtained by calling the toll-free number: 1-800-345-6036.

Reviewed by ***Lewis K. Shupe, Ph.D., ATR,*** *Professor of Art Therapy, Wright State University, Dayton, Ohio.*

Advanced publicity on this videotape mentions that the culmination of this production involved a team of art therapists, media designers and video professionals at The Menninger Clinic in over a year's work. Robert Ault, HLM, ATR, Art Therapist at The Menninger Foundation mentions that he has "long felt the need for a video program that would offer a comprehensive view of the entire art therapy discipline . . . and that [this tape] is intended to fill this gap."

The video film reviews history and methodology in art therapy and presents a conceptual framework for building techniques that would be appropriate for many levels of therapy work. Using clinical case materials (and, in some cases, the client or patient), this videotape demonstrates how art therapy is applied in at least three treatment settings and with a variety of populations. The tape includes: 1) an interview with Grandma Layton, the by-now-famous Kansas woman whose work documents her recovery from over 40 years of depression; 2) a brief historical review of the relationship of art and healing (including some clinical footage of art therapy in the 1930's, taken from The Menninger Foundation Archives; 3) the development of a conceptual model of art therapy; and 4) case examples (adult patient, child, group and older persons).

The photography is excellent, the computerized visual graphics are intriguing and an attractive complement to this video providing the viewer with a well organized visual presentation of the content. This includes over-images, unique blending of colors (in some cases, similar to exciting psychedelic-like color changes seen in specialized films) and unique perspectives of people, paintings, media and equipment. Close-ups of paint being daubed on canvas or the child's fingers manipulating clay are effectively done and photographed with understanding and care.

In the introductory statements by Ault, he points out that art is more than just for amusement or simply as an adjunct for psychotherapy, but that the very nature of art therapy has a life of its own. In reviewing the Layton sequence, he points out some background of the client ("shock treatments, drugs were ineffective [and with the] death of her son, she decided that she had to change her life. She started with contour drawing."). The paintings are powerful. Layton projects the self-drawing into different situations, and the images evoke a new situational experience. Ault mentions that her depression had vanished after she began drawing, and one can easily see how the art "took over," and helped to mold and shape meaning into her life. "Her experience illustrates what art therapy is all about" proclaims Ault, and it seems to be clearly delineated in this video by use of rapid image, close-up shots and client comments.

To the question "How did art therapy develop?" the video illustrates the use of art in healing (through images, rites, ceremonies, symbols, signs, events, "the whims of gods and the dreams of men"). This seems to be a short course in art history, as it moves rapidly from early representational symbols to Baroque, Romanticism, the 1800's, Impressionism, Abstraction and Expressionism. The examples (i.e., paintings) are well-chosen and photographed impressively. In answering the primary question of this section, Ault points out that psychiatrists in the 19th century began looking at art of disturbed patients and alludes to Prinzhorn, Freud, Jung and to symbolism, sublimation, dreams, images, sub-cultures, with a follow-up of Naumburg and dynamically oriented art therapy. Art education therapy (Lowenfeld) is briefly mentioned, as well as references to rehabilitation, special education and art with the aged person. Kramer ("sublimation") and Kwiatkowska ("family art therapy") are included, with a lead-in to the human potential movement with references to art, music, poetry, drama as expressive arts areas with direct relationships to art therapy. Paul W. Pruyser, Ph.D., asks questions (and dialogues with the viewer) about interactions, art as therapy, relationships, etc., and implies that we all struggle for answers, that art therapy is an important field for this struggle, and that we should continue in our search for the answers.

The section titled "How is it used?" is the core of the video. It points out the three elements that are central, according to Ault, to the entire understanding of art therapy: 1) the person; 2) the process; and 3) the product. In his introduction to these three parts, we see a child and adults working in art therapy (examples: a depressed person; a manic person; family pictures). "Information," says Ault, "must be analyzed within the context of the patient's life," and the ensuing sequences attempt to show us the contexts within which the work was done. In the "Person" section (i.e., "Person-Centered Art Therapy") Ault is shown working with Carrie, a young adult. As she draws, verbalizes and communicates, we have insights of the art therapy process as she moves through the course of treatment. There is appropriate interchange between the patient and therapist relative to the drawings, their meanings to the patient (i.e., in context) and to projections to other content.

In the "Process" section, the viewer is shown examples of art therapists working in different situations. One art therapist works with a deaf child ("acting out behaviors resulting from the death of mother"), and another works with a group on "Bridge Building" with clay, illustrating interaction with the therapist, media and each other. As is stated, this "Process Oriented Therapy" is one of the core foundations in the total view of what art therapy is and how it works.

The "Product" section ("Product-Centered Approach") emphasizes skill-building, and the importance of a focus on the product with certain approaches, with specific populations, in some sites, and for a particular purpose that is compatible with the goals and objectives that have been identified. An activities director mentions the important social, occupational and recreational aspects of crafts, for example, in a church home for older residents. Brief interviews of residents, and shots of a bazaar where some of the products are for sale, highlight this section.

The summary of the video recalls the "Person, Product, Process" core, and Ault states that "art therapy works because it involves the creative, integrative forces within the psyche." This video attempts to do a lot within the 49 minutes, and overall, it does it well. Perhaps in an hour tape some aspects (for example, the psycho-educational and developmental content) could have been more fully developed, as they were too lightly touched upon in this tape. However, the producers—and particularly Robert Ault and his colleagues at The Menninger Foundation—have done an excellent job in bringing a "visual" to the art therapist, and to the profession, that is long overdue. Along with the congratulations to all who were involved in the making of this videotape, it is recommended for the viewer who will find it fascinating, aesthetically pleasing and most significantly, of educational importance.

Poetry as Therapy.

Morrison, Morris R. (Ed.) *(1987). New York: Human Sciences Press. 229 pages, including numerous examples of therapeutic poetry.*

Reviewed by ***Josef E. Garai, Ph.D., ATR,*** *the former founder and chairperson of the Master of Professional Studies degree program in Creative Expressive Arts Therapy at Pratt Institute, from 1968 to 1980. He retired as Professor Emeritus from Pratt Institute in June, 1980. Currently Dr. Garai is an art psychotherapist in private practice in New York City. He has also been a member of the faculty of the New School for Social Research since 1968.*

This anthology of poetry therapy proceeds from the assumption that poetry therapy in conjunction with music, rhythm, rhyme and metaphors has been one of the oldest therapeutic means beginning with the Egyptian Book of the Dead through the allegories, fables, and Psalms of the Bible, the Sufi story-tellers, and Milton Erickson's story-inventing method. Morrison points out that the poet heals not only himself or herself, but also his or her readers through identification with the intrapsychic and interpersonal conflicts similar to those described in the poem. Like the expression in drawing, painting, sculpting, imagery, dreams and collages, poetry seeks to restore wholeness to the individual seeking integration of body, mind and spirit.

Poetry provides a spiritual dimension to life and

BEST COPY AVAILABLE

assists the individual in reconciling inherent polarities such as love and hate, fear and courage, life and death, power and powerlessness, loneliness and connectedness with the world at large. Morrison, as past president of the American Poetry Association and the founder of the American Academy of Poetry Therapy (sponsored by the University of Texas in San Antonio), is eminently qualified to discuss the ramifications of applications of poetry therapy in a variety of clinical and rehabilitative settings. These include prisons, with physically and emotionally handicapped persons, drug and alcohol addicts, prison inmates, holocaust survivors and others.

Particularly valuable for the creative expressive arts therapist are Morris Morrison's chapter on "Poetry and Therapy," Frances Louise Henry's and Phyllis Luckenbach Sawyers' chapter on "The Arts and Healing," William Sutherland's chapter on "Where do images come from?," Marc Kaminsky's chapter on "Voices from within the process: of writing and reminiscences in old age," Theresa G. Morrison's chapter on "Poetry as Therapy with Adolescents," Gene Bard's chapter on "Prison Therapy," and John Whittaker's chapter on "The Use of Poetry in Psychiatry."

Art therapists will find in this book a wealth of creative ideas enabling them to combine art therapy with poetry therapy. In my own practice, I have long since combined art and poetry therapy. When I ask individuals to draw with multicolored crayons and model with plasticine clay a recent or a recurrent dream, I also ask them to write a poem related to the dream. In family art therapy I require individuals to draw with crayons portraits of themselves and all the other family members. The poems frequently reveal the innermost thoughts of the family members including misconceptions about one another. The poem one identical twin wrote about his twin brother stated:

> I am Johnny and he is Jeff. We are twins and people mistake John for Jeff and Jeff for John. I, Johnny, am always on fire, while I Jeff's coolness greatly admire. I like playing hockey and baseball and making a mess, while Jeff prefers a quiet game of chess.

The metaphors in the poems are powerful incentives toward self-understanding, personal growth, individuation, autonomy and self-actualization. As Morrison points out, when Robert Graves wrote his first book of criticism "On English Poetry," he stated that poetry was his way of serving his Muse, while looking after his neurosis. Graves advertised poetry as a "form of psychotherapy" for the neuroses of poets and the culture they express and address. Graves assured his readers that a well-chosen anthology of poetry puts the reader in a hypnotic trance; the reader is confronted with an allegorical solution of the problem that has been troubling him or her; one's unconscious accepts the allegory as applicable to one's own condition; the emotional crisis is relieved. Graves concludes that such an anthology is a complete dispenser for the more common mental disorders and may be used as much for prevention as for cure.

The book *Poetry as Therapy* presents an excellent anthology of poems written by people from all walks of life seeking to resolve their problems creatively. The ultimate goal of poetry therapy consists in helping people to live more joyful and creatively productive lives. It is the same goal which we as art therapists share with our fellow professionals.

Some examples of the power of poetry therapy will illustrate further its usefulness. Working with aging people, Martha Rosenfelder wrote:

> Growing old to me is a new experience like any other phase of life. Growing old is like visiting a museum; one admires things of the past. Being old is like an evening after a day of work. It is like a beautiful sunset on a winter day or a vacation without responsibility. Being old is like fall time. Being old is like taking inventory. Being old is preparing for a long trip to the unknown.

Bea Lipsett wrote:

> Early morning I sit on my terrace upon the canal. The sun is rising from the East, spreading its iridescent rays upon the calm water. A boat with its churning motor passes slowly by, making the water swirl around. It kicks up the frightened fleeing fish. They find a place of refuge, far from harm. Why, then, can't I?

In Theresa Morrison's workshop with handicapped adolescents, Anne, a black girl, who had for years been subject to attacks of asthma and who has also suffered from a severe eczema which she aggravated by compulsive scratching, submitted the following poem:

"Prejudice"

Prejudice is love one bears
His own people
That causes him to spit
On beautiful innocent victims
Of another race.

Prejudice is a force
That prevents people from saying
"Hey, I love you!"

Prejudice is an ache
Surrounding my heart,
Making it feel
About to drop
Into the pit of hell

In the chapter by Nene Sims Glenn on "Reflections of Those Who Survived [the Bataan Death March]," the men found themselves joking at their situation to make it bearable, as in the verses contributed by one survivor:

When they git to talking medals,
And the battle souvenir,
Like the Silver Star and Purple Heart,
And this here "Croy de Gear" —

I ain't got no fancy ribbons
So I feel a little queer;
But there sure ought to be a medal
For guys with diarrhea.

My guts is shot all full o' holes,
Like a bullet drilled me clear
And blood! I've lost a bucketful
From this here diarrhea.

But after you lose your innards,
There ain't nothing else to fear;
And I bet God has got a medal
For guys with diarrhea.

Poetry therapy has genuinely brought insights and has come into its own in Morrison's thoughtfully collected anthology.

Ten Paintings

D. H. Lawrence: *Redding Ridge, CT, Black Swan Books, 1982 ($20.00), 31 pp.*

Reviewed by ***Shaun McNiff, Ph.D., ATR.*** *Dr. McNiff is a Professor of Expressive Therapy and Dean, Institute for the Arts and Human Development at Lesley College, Cambridge, Massachusetts.*

I carried D. H. Lawrence's *Ten Paintings* with me to Switzerland and Sweden where I give training groups in art therapy and dreams each year. The book was intimately connected to the work that we were doing. People in my training groups who looked at *Ten Paintings* all agreed that D. H. Lawrence could have been a member of the group. His pictures embody many of the archetypal themes that group members were dealing with in their art. There were similarities of both content and expressive style. Lawrence's images are manifestations of what he calls "the great sympathetic centres" in *Fantasia of the Unconscious* and *Psychoanalysis and the Unconscious* (NY, Penguin, 1986).

The art therapy profession has given little attention to what soul art looks like. The profession has been preoccupied with pseudo-scientific standards of graphic analysis which result in the creation of stiff, lifeless and unimaginative images which correspond completely to the psychological values of the environment in which they were produced. I have found that images which emerge from a soul oriented art therapy environment will express the inner vitality of the psyche. Pictures sometimes come from the "surface" of artistic consciousness as opposed to deeper and yet to be accessed realms of soul. This "deeper" way of working places more emphasis on the feeling to be expressed than the stylistic continuity of forms. Although forms and feelings cannot exist without one another in the arts, soul art focuses on the emergence of emotion and views formal construction as a supportive process. I have personally discovered how the re-engagement of themes from my previous pictures and the formal continuities of my art can be an avoidance to making something "fresh" and related to the immediate context.

Ten Paintings is an excellent resource for art therapists who desire to make contact with soul art. It is an elegantly produced, limited edition of thirty-one pages with 10 color plates of the paintings. The presentation of the book does justice to Lawrence's assertion in the accompanying essay, "Making Paintings," that "art is a form of delight." The 10 paintings are so magnificent and expressive of archetypal artistic forms that they merit treatment in a book-length study.

The book makes two important contributions to art therapy:

1. *Lawrence's paintings offer a vivid example, beautifully reproduced by Black Swan Books, of what soul art looks like.*
2. *The essay "Making Pictures" gives guidance on how to access this type of artistic expression.*

D. H. Lawrence started painting at the age of 40 in 1926. He died in 1930.

"A Holy Family," Lawrence's first painting, is a contemporary representation of an Italian Renaissance motif. It is a successful picture that must have spurred the artist on. This painting like all of the others in the book is a visual expansion upon the interplay between religion and sexuality that runs throughout all of Lawrence's writings. He perceived sexuality as both an expression of, and a mode of access to, a deeper, more essential religious purpose.

"Fight with an Amazon" is a direct portrayal of Lawrence's sexual subject matter. A nude man and woman in close physical contact are surrounded by vicious dogs, one of which is biting the man's thigh. The woman's hand is also digging into the same thigh. The picture expresses the inseparable themes of sexuality and aggression and Lawrence's preoccupation with darkness and light. The composition is visually forceful. Like other paintings in the book, it gives a sense of fullness because of the way the figures are not completely contained within the borders of the picture. It has strong suggestions of self-portraiture. I am beginning to realize that every artwork is a self-portrait. The extent to which the image succeeds as both a self-portrait and as an embodiment of transpersonal elements will determine its expressive powers. All of the 10 paintings satisfy these criteria.

In "Dancing Sketch" a woman, man and goat dance together. I experience all three figures as part of Lawrence's self-portrait. As in "Fight with an Amazon" he expresses the triad of woman, man and animal. The woman is in the foreground in "Dancing Sketch" as she is within his work as a whole. This picture offers a visual expression of the primal and rhythmic, religious consciousness that he describes in *The Plumed Serpent*.

"Red Willow Trees" is an illustration of nature as eros and life as passionate fire. "Flight Back into Paradise" has a nude woman pulling away from a firey industrial complex that she seems tied to with a black cord. Two men in the picture appear to be fighting. This image also corresponds to the novels where woman is connected more to soul and passion whereas man is responsbile for the evils of the merchantile world. "Boccacio Story" is a delightful picture of a field worker who is lying on his back and sleeping. He is naked below what appears to be a flowing shirt. A group of nuns are walking through the field painted in pastel colors and they are all staring at him in amazement. The innocent appearance of this image and the other pictures included in this collection show how social attitudes have changed since the 1920's when an exhibition of Lawrence's pictures caused a scandalous uproar in London. He responded to the controversy by saying: "There is something sacred to me about my pictures, and I will not have them burnt, for all the liberty of England."

In a letter to Earl Brewster he wrote:

> I stick to what I told you, and put a phallus, a lingam you call it, in each one of my pictures somewhere. And I paint no picture that won't shock people's castrated social spirituality. I do this out of positive belief, that the phallus is a great sacred image: it represents a deep, deep life which is denied in us, and still is denied.

The essay "Making Pictures" and excerpts from Lawrence's letters which are included in the book, present the Laurentian method of painting from the soul. He describes how "the picture happens" and "the struggling comes later" to bring it "to completion."

> The knowing eye watches sharp as a needle; but the picture comes clean out of instinct, intuition and sheer physical action.

This philosophy of painting corresponds to what Lawrence said about writing in *Fantasia of the Unconscious:* "The novels and poems come unwatched out of one's pen." He referred to his writing as "pure passionate experience" that he reflected upon "afterwards."

In "Making Pictures" Lawrence talks about the necessity of putting life into pictures; and painting as delight, exaltation, visual discovery, intense concentration and visionary awareness. As stated again later in *Apocalypse*, he writes that: "Art is a form of religion, minus the Ten Commandment business, which is sociological. Art is a form of supremely delicate awareness and atonement—meaning at-oneness, the state of being at one with the object." He criticizes those who treat art "as if it were a science, which it is not."

He tells us how to draw from the soul in the essay:

> The picture must all come out of the artist's inside, awareness of forms and figures. We can call it memory, but it is more than memory. It is the image as it lives in the consciousness, alive like a vision, but unknown. I believe many people have, in their consciousness, living images that would give them the greatest joy to bring out. But they don't know how to go about it. And teaching only hinders them.

And again in an excerpt from a letter to Alfred Stieglitz:

> If a picture is to hit deep into the senses, which is its business, it must hit down to the soul and up into the mind—that is, it has to mean something to the co-ordinating soul and the co-ordinating spirit which are central in man's consciousness: and the meaning has to come through direct sense impression.

Anais Nin, an admirer of Lawrence, said that "one art nourishes the other." This is what happens in *Ten Paintings*. Black Swan Books is providing an important service in publishing this volume. They are also producing a book on the paintings of Lawrence Durrell who together with D. H. Lawrence is one of my greatest sources of artistic and psychological inspiration. These books can help to take art therapy closer to the soul of art.

VIEWPOINTS

Statement concerning "Rewriting a Myth"

Frances Fisher Kaplan, DA, ATR, *private practice, Morris Plains, New Jersey*

The poem entitled "Rewriting a Myth" was catalyzed by a spontaneous drawing that I produced while leading an art therapy group. It holds a twofold significance for me. Creating it helped me more fully appreciate the productive interaction that can exist between words and images—both through the process that brought this particular poem into being and through using the modality of poetry with its almost exclusive reliance on imagery-eliciting words. And it helped me consolidate a more realistic conception of heterosexual relations—one that does not idealize, romanticize, or dehumanize the opposite sex.

REWRITING A MYTH

On a sunlite afternoon in May,
sitting under the dogwood tree
with blossoms like large white butterflies
poised for flight,
I go searching for the one I call the Dreamer
and find her in her rainbow-webbed cave
busy with her paints and chalks.
Slyly she unwinds for me
her latest scroll. . .
I kneel beside a sun-flecked pool
my hand outstretched
beckoning the shy creature with a silver horn
that drinks from the other side.

Come, I plead, lay your head in my lap.
I am no longer a maiden
but surely I am still entitled
to an enchanted moment.
Come, I will weave you a crown of roses
and not care if I prick my fingers on the thorns.
Come, I will plait your silken mane with daisies
and feed you honey made from orange blossoms.

Slowly the unicorn raises his head
and looks at me with pool-blue eyes.
He hesitates, puts forth a silver hoof.
I hold my breathe, and then—
reflected in my eyes he sees
a crouching hunter, sunlight glinting
on sharpened steel;
and with a leap and the flick of a tasseled tail
he is gone.

I plunge after him, murmuring,
Sweet unicorn, cruel unicorn, sad unicorn,
who is tormentor? Who is victim?
The woman snares you and betrays you, you say.
She says, I receive you only to be forced
to give you up.

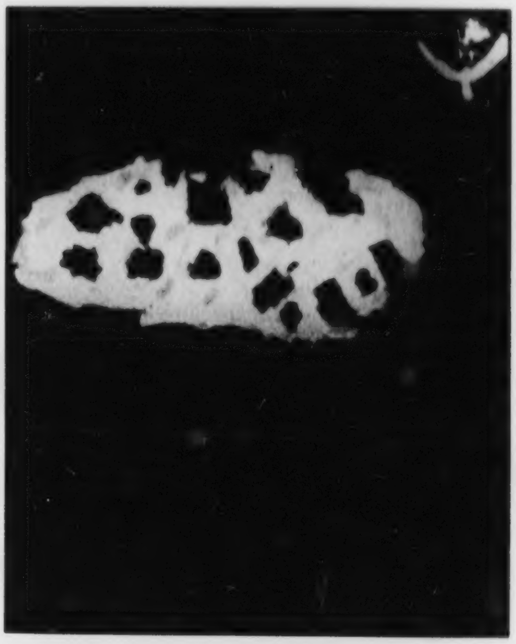
Pursuer and pursued,
we crash through the forest dimness.
Past rock and stump and broken branch.
Past secret cave and mossy ancients
thrusting high their leafy heads.
Until, suddenly, blocking our path
is the Old Wise One
holding up a much-lined palm.
We dare not pass
and deprived of patterned purpose, we allow
the miracle to happen.

Before me stands, not unicorn, but man,
a creature like me—yet not.
Across a small emptiness
we eye each other warily,
afraid of the power we perceive
disdainful of the weakness.
Then, recognizing a companion traveler on a journey
of uncertain course, of unknown destination,
we extend our arms
until our finger tips brush.

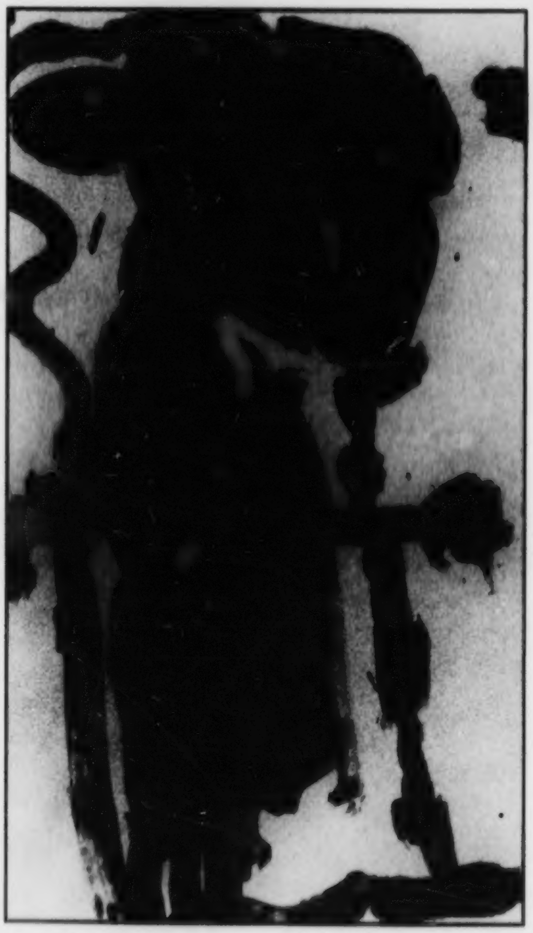
The scroll is rewound.
The sunshine warms the dogwood butterflies
who have not yet flown away.
There is still time
to rewrite the myth
to heal the breach between male and female
to learn what love is not.

Art Therapist's Portfolio

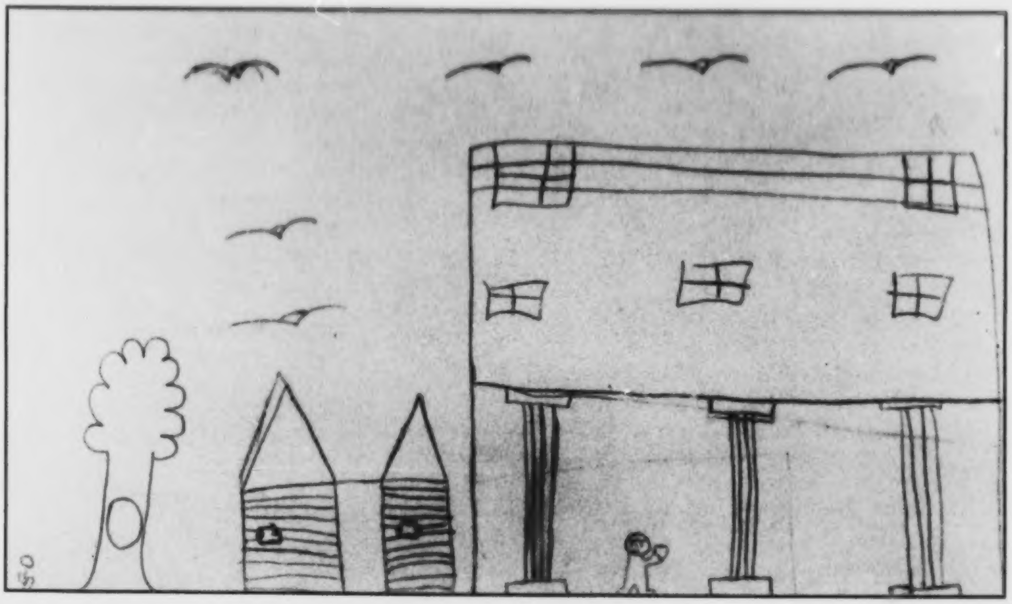
__VIEWPOINTS__ provides a forum for sharing ideas and graphics about issues facing art therapists. It also encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit black and white glossy photographs and four copies of the written material to: **Viewpoints,** ART THERAPY, *505 E. Hawley St., Mundelein, IL 60060.*



1. "TREE AT NIGHT" Painting by a young girl in art therapy at Wright State University, Dayton, Ohio



2. "SCARY FIGURE" Painting by a young boy in art therapy at Wright State University, Dayton, Ohio



3. "ME AND MY HOUSE" Drawing by a young boy in art therapy at Wright State University, Dayton, Ohio

BEST COPY AVAILABLE

Plan To Attend

The AATA '87 Annual Conference

"New Direction In The '80's"

November 4-8, 1987

Pre-Conference - November 4, 1987
Conference - November 5-8, 1987

Sheraton Bal Harbour
Bal Harbour, Florida

Program and Application for Registration will be mailed to all AATA members.

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, *ART THERAPY, Journal of the American Art Therapy Association*, discounts on publications, discount on admission to the annual conference, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (ATR). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA National Office.

Associate Membership shall be open to individuals interested in the therapeutic use of art wishing to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office or serve on a committee.
Annual Dues: $50

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee. **Applications for student membership must be accompanied by a copy of current ID.**
Annual Dues: $35

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.
Annual Dues: $100

Professional Membership is by application only and is open to individuals who have completed professional training in art therapy and who are or have been engaged in the therapeutic use of art. Professional members are eligible to participate in all activities of the Association and receive all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*
Annual Dues: $75

Credentialed Professional Membership is by application only and is open to individuals who have met the qualifications and have been approved for Professional Membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in Standards and Procedures for Registration. Professional members are eligible to participate in all activities of the Association and receive all official publications. A Credentialed Professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*
Annual Dues: $80

Make checks payable to AATA

American Art Therapy Association, Inc.
505 E. Hawley Street
Mundelein, IL 60060
(312) 949-6064

NAME ______________________________
LAST FIRST MIDDLE

PREFERRED MAILING ADDRESS

____
STREET

____
CITY - STATE ZIP CODE

PHONE ______________________________

OTHER ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________________

TITLE ______________________________

EMPLOYER ______________________________
INDIVIDUAL OR INSTITUTION

HIGHEST EDUCATIONAL DEGREE ______________

☐ $ 50 **Associate Membership**

☐ $ 35 **Student Membership**
(copy of current ID required)

☐ $100 **Contributing Membership**

☐ $ 75 **Professional Membership**
(by application only)

☐ $ 80 **Credentialed Professional Membership**
(by application only)

Payable in U.S. Dollars

Dues and expenses related to participation in AATA may be tax deductible as a business expense.

RETURN THIS APPLICATION WITH YOUR REMITTANCE

The American Art Therapy Association, Inc.

505 E. HAWLEY STREET
MUNDELEIN, ILLINOIS 60060
(312) 949-6064

RESOURCES

The American Art Therapy Association serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapists' Identity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: Journal of the American Art Therapy Association		

Rates: Individuals - U.S. $23.00; Foreign $30.00; Institutions - U.S. $27.00; Foreign $36.00

	Members	Non-Members
Art Therapy: Journal - Back Issues	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings Use of the Creative Arts on Therapy (1979)	$5.00	$7.00
National Art Education Association Journal: Special Issue Art Education, Vol 33, No. 4 (1980)	$3.00	$4.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 × 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

FILMS (Rental/Purchase)

		Members	Non-Members
Art Therapy: Beginnings (1977) 16mm. color/sound, 45 minutes	Rental:	$40.00	$50.00
	Purchase:	$300.00	$400.00
Michael (1977) 16mm. color/sound, 12 minutes	Rental:	$30.00	$35.00
Art Therapy (1981) 16mm. color/sound, 12 minutes	Rental:	$35.00	$45.00
	Purchase:	$250.00	$325.00
Lori, Art Therapy and Self Discovery (1978) 16mm. color/sound, 32 minutes	Rental:	$40.00	$50.00

ORDER FORM Make checks payable in U.S. funds to AATA, and mail to the above address

Indicate Quantity of Unit Items Below		Cost/Unit		Total
______________	( ) ×	______________	=	______________
______________	( ) ×	______________	=	______________
______________	( ) ×	______________	=	______________
______________	( ) ×	______________	=	______________
______________	( ) ×	______________	=	______________
		______________	=	______________
		Total Unit Costs	=	______________
		*Postage/Handling	=	______________

10 or more copies of any single issue: 15% discount on total cost.
Discounts are available when purchasing quantities.
Set of four Proceedings (consecutive years): 20% discount on total cost.

Note: for postage/handling, add $1.50 for the first unit item. $ .50 each additional unit.

Total Enclosed = ______________

Send To: ______________________________ MBR ID#: __________

____

____

City State Zip Code

8/86

American Art Therapy Association, Inc.

"Coming of Age"

Los Angeles, California

November 12-16, 1986

ON AUDIOCASSETTES

Coming of Age was recorded by **InfoMedix**. The following is a list of the best selling audiocassettes. For a complete list contact **InfoMedix**. Please ✓ the box by the sessions you wish to order.

PROGRAM AS303

☐ **S303-1**	$9.00	**Presidents Address: Identity in the 90's,** S. Graves
☐ **S303-3**	$9.00	**Art Therapy in Drug Abuse Treatment Programs for the Adolescent,** K. Sly-Linton
☐ **S303-12AB**	$18.00 (2 tapes)	**PAPER: Art as Depth Psychology,** S. McNiff
☐ **S303-17**	$9.00	**Family Art Psychotherapy: A Systemic Approach to Change. Theory and Demonstrations Through Role Play,** S. Riley
☐ **S303-19**	$9.00	**The Use of Art Therapy in Strategic Family Therapy,** V. Fry Shaver
☐ **S303-21**	$9.00	**Short Term Inpatient Group Art Psychotherapy: New Directions,** B. Sprayregen
☐ **S303-30**	$9.00	**IND: The Art Therapist's Third Hand (Pictorial Communication and Intervention in Art Therapy),** E. Kramer
☐ **S303-32**	$9.00	**PAPER: Georgia O'Keefe, Themes and Resonances: An Art Therapist's Viewpoint,** M. Junge
☐ **S303-33AB**	$18.00 (2 tapes)	**GENERAL SESSION: The Alchemy of Creativity,** J. Shinoda Bolen
☐ **S303-35**	$9.00	**Gaining Mastery Over Victimization,** D. Spring
☐ **S303-36AB**	$18.00 (2 tapes)	**Effects of Psychological Trauma on Children,** S. Silverstein
☐ **S303-38**	$9.00	**The Sensibility of the Sensuous: Imagination and the Reality in Art Therapy,** H. McConeghey
☐ **S303-42**	$9.00	**A Method of Visualization Applied to the Treatment of Chronic Illness,** E. LaFlamme
☐ **S303-43**	$9.00	**Art Making as an Aid in Bereavement,** P. Buoye Allen
☐ **S303-46**	$9.00	**Hungry Love - An Art Therapy Treatment Approach with the Eating Disorder Patient,** I. Schlossberg
☐ **S303-47**	$9.00	**PAPER: Art Therapy as Primary Treatment for Co-Dependents: Alcoholism Outpatient Treatment,** D. Seger

Buy 6 Tapes
Get 1 Free!

FOR FASTER SERVICE

Please have your credit card number ready, and call

TOLL FREE 1 800 367 9286 In California 1 800 992 9286

☐ Special Complete Set Price AS303: $136.00 Save 20%

Total No. of Cassettes Ordered ________

Purchase orders accepted for purchases of $100.00 or more.

Orders outside U.S.: Add 10% surcharge of subtotal for additional shipping & handling

TOTAL PRICE: $ ________

SUB TOTAL: $ ________

SHIPPING & HANDLING: $ ________

Please enclose $1.00 for the 1st tape and $.50 for each additional tape for shipping and handling (maximum $7.00)

TOTAL AMOUNT ENCLOSED: $ ________

SHIP TO: NAME ________

ADDRESS ________

CITY ________ STATE ________ ZIP ________

Please Charge This To My Credit Card: VISA ☐ M.C. ☐ or A/E ☐ (minimum credit card order $25.00)

ACCT. NO. ________ CARD EXPIRATION DATE ________

Daytime phone ________

____
Signature

Please Allow 4 to 5 weeks for delivery

Make Checks Payable
and Mail Orders To:

InfoMedix
EDUCATIONAL RESOURCES AND SERVICES

12800 Garden Grove Boulevard • Suite F • Garden Grove, California 92643

BEST COPY AVAILABLE

ART
THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 505 E. Hawley St., Mundelein, IL 60060

Please enter my subscription for 1987. Enclosed is my check, payable to AATA, for $23.
Name ______________________
Address ______________________
City ______________ State ________ Zip ________

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

TAKE ADVANTAGE OF THIS SPECIAL OFFER!

SUBSCRIBERS TO *Art Therapy* and Members of American Art Therapy Association ENJOY REDUCED RATE!

SUBSCRIBE NOW—AND SAVE 50% OR MORE! *The Arts in Psychotherapy* is a quarterly journal in its 14th successful year of serving practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologist that reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy, THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.
Submit papers in triplicate to Managing Editor, Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583
TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

Pergamon Journals, Inc., Maxwell House, Fairview Park, Elmsford, N.Y. 10523 AATA
Please enter my subscription for Vol. 14, 1987 ☐
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume

For subscriptions outside U.S. (except Canada) add $2.25 annual postage. Payment must be in U.S. funds.
Name ______________________
Address ______________________
City ______________ State ________ Zip ________

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Volume 5, Number 1 March 1988

- 18th Annual AATA Conference Overview
- Social Applications of the Arts
  Robert E. Ault, MFA, ATR, HLM, Gary C. Barlow, EdD, ATR, Maxine Junge, MSW, LCSW, ATR, Bruce Moon, BS, MACE, ATR
- Coming of Age: A Subjective Perspective
  Judith A. Rubin, PhD, HLM, ATR

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1988-1989

Board of Directors

President
Cay Drachnik, MA, ATR, MFCC

President-Elect
Linda Gantt, MA, ATR

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, PhD, ATR, MFCC

Committee Chairs

Affiliate Chapters
Virgil Matheny, ATR

Bylaws
Roberta J.H. Shoemaker-Beal, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Cathy A. Malchiodi, MA, ATR

Publications
Pat B. Allen, PhD, ATR

Research
Harriet Wadeson, PhD, ATR

Standards
Doris Arrington, EdD, ATR, NCC

Clinical
Paula Howie, ATR

Executive Director

Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, EdD, ATR 2

Articles

18th Annual AATA Conference Overview 3

Social Applications of the Arts
Robert E. Ault, MFA, ATR, HLM
Gary C. Barlow, EdD, ATR
Maxine Junge, MSW, LCSW, ATR
Bruce Moon, BS, MACE, ATR 10

Coming of Age: A Subjective Perspective
Judith A. Rubin, PhD, ATR, HLM 22

Reviews

Family Art Psychotherapy: A Clinical Guide and Casebook
Helen B. Landgarten
Shaun McNiff, PhD, ATR 30

Approaches to Art Therapy: Theory and Technique
Judith A. Rubin PhD, ATR, HLM
Michael Campanelli, EdD, ATR 31

Perpetual Arts Relaxation Tape #2 (videotape)
Perpetual Arts
Michael Campanelli, EdD, ATR
Judith Millman, CRC 33

Viewpoints

Door at Abiquiu-November 25, 1986
Maxine Junge, MSW, LCSW, ATR 35

Volume 5, Number 1 March 1988

About Our Cover

A landscape (by memory) of "My House Under Construction" by a deaf/legally blind autistic child of 13 years of age. Drawing with Prismacolor pencils (Art Therapy Program, New Jersey School for the Deaf; submitted by David R. Henley and Cynthia Orsini, Art Therapists).

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Aina O. Nucho, PhD., ATR, ACSW
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Kathy Sargent

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Susan LaMantia O'Connor, MA, ATR
Paul Rodenhauser, MD
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064

Copyright © 1988 American Art Therapy Association

EDITORIAL

As we have done in past post-Conference issues of *Art Therapy*, this issue contains an overview of the recent 18th Annual Conference of the American Art Therapy Association. We have reassembled the entries so that the papers are together, with a similar arrangement for workshops, pre-Conference courses, and the other categories contained in the Conference program. For those of you who did not attend the Conference—and for those of you who did, and would like additional information—a name and address is provided with each Conference overview entry, so that communication can be made easily by the reader who wishes the information.

This issue contains an article by Judith A. Rubin, an honorary life member of the American Art Therapy Association, and an author, teacher and therapist. Her article "Coming of Age: A Subjective Perspective," is taken from a presentation given at the 1986 (Los Angeles) A.A.T.A. Conference. Rubin moves us through her young childhood ("My love of art . . . had given my life meaning since early childhood. . . .") to adolescence and middle adulthood ("[My] clinical work [is] a source of stimulation, challenge, and pleasure in helping folks to get better."). She discusses the ordering of stated priorities and offers suggestions, through her own experience, and for the reader as well as briefly mentioning our own internal struggles and growth as an Association.

At the recent A.A.T.A. Conference in Miami, Florida, one of the general sessions was devoted to the topic "Social Applications of the Arts." Robert Ault organized and chaired the panel, and the other members were Maxine Junge, Bruce Moon (replacing Patricia Gould) and Gary Barlow. We were asked to "dream about the future," and be realistic about the present as well as "cite important statistics if necessary, think of a utopian concept, relate to experiences, and, in general, take the content in any direction" —relating, of course, to the overall theme of social applications and/or awareness of the arts. Bob focused on the great American wasteland, business and industry, and the economic structures within our society—and how art therapy "fits into" the present, and the future, and aspects of mental health work. Maxine cited some statistics about the American family that were thought-provoking and disturbing, and discussed the urgency of art therapists taking a political role relative to mental health and the family (". . . for the family in America today is in grave danger of dying."). Bruce shared an audio-visual presentation ("Images of Our Culture and the Effects of Events on Our History") that was direct, forceful in content and presented with a soft-glove "power punch." For my part of the panel, I discussed art therapy and education, and focused on three areas—teaching and self expression; attitudes; and concerns about the future. Many persons suggested that the panel members share the content of the presentation with the readers of *Art Therapy*, so in a very short turn-around time, we have prepared this four-part article for you. Keep in mind that it has not been completely edited out of the verbal presentation format; therefore, some of the narrative may carry with it the oral presentation flavor. The panel members (authors), however, felt that this direct approach to the article might enhance rather than detract from the basic message and content.

I am pleased to welcome a new "Book Reviews" editor—Aina O. Nucho, Ph.D., ATR, ACSW, associate professor at the University of Maryland School of Social Work and Community Planning. Aina has been an active member for many years in the American Art Therapy Association, and many of you have been "old friends" with her during this time. I am happy to welcome her to this new position, and look forward to working with her in the future. In the meantime, if any of you have a suggestion for a particular book to review, please send your ideas to Aina.

Articles are being received for review fairly regularly now, as well as some submissions for "Viewpoints," photographs for the cover, and photos of art work that might be used in various places in the journal. Thanks to all of you . . . your submission will be processed in a timely manner. Keep the articles and other materials coming.

Since Spring is on the distant horizon, my thoughts seemed to have turned to poetry. Maybe these bleak wintery days are causing Spring-like thoughts to crop up with regularity [Note: This editorial is being written in late January] although it does seem unusual, perhaps, that as I look out the window to the snow-covered ground, springtime can seem near. Very possibly the motivations came from glancing through the book *An Exceptional View of Life, The Easter Seal Story*, written and illustrated by handicapped children and edited by Bob Krauss (Norfolk Island, Australia: Island Heritage Limited, 1977). One child wrote the following (taken from a full poem titled "I Like"):

> *I like writing poems—making them up.*
> *It's a real neat feeling. I enjoy*
> *taking the time to think of them.*
> *Some are love poems, and some are*
> *just everyday, nice ones. (p. 15)*

Also, from an earlier part of the poem:

> *I like to horseback ride. When the*
> *horse is galloping, I can float*
> *away in my dreams.*

The poem included in this issue's "Viewpoints" was written by Maxine Junge, ATR. Maybe it is *your* turn to write a poem—to think of Spring, to be thankful, to anticipate, to enjoy, to sense discovery, to "float away in some dreams," to write some love poems or just everyday ones!

Gary C. Barlow, Ed.D., ATR
Editor, Art Therapy

A.A.T.A. Conference Overview

The 18th annual Conference of the American Art Therapy Association was held in Bal Harbour, Florida, from November 4-8, 1987. The theme was "New Directions in the 80's" and the entire meeting, from the pre-Conference sessions to the closing ceremonies, was a most successful and professionally satisfying one. Special thanks must be given to the Conference Chair, Cay Drachnik, and to the Program Chair, Barbara Sprayregen, and to the many committees that devoted time and energies toward the fruition of this Conference. The persons who were responsible are listed below.

On the following pages is a listing of the presentations, workshops, pre-Conference courses, symposia, and other highlights of the Conference. Included with the presentations are the name and address of a single presenter, or the address of the first person listed in the case of multiple presenters for a session. Information is offered in this format (similar to previous years) so that readers may communicate directly with the primary presenter for any additional information desired on a specific topic. It should be noted that each entry is printed as it appeared in the Conference program, although categories have been grouped together for the reader's convenience. The basic information has not been edited and, therefore, does not reflect any changes that may have occurred at the Conference.

—EDITOR

18TH ANNUAL CONFERENCE COMMITTEE

CONFERENCE CHAIR:
Cay Drachnik, MA, ATR, MFCC

PROGRAM CHAIR:
Barbara Sprayregen, MEd, ATR

PROGRAM CO-CHAIR:
Patricia Isis, MEd, ATR

PRE-CONFERENCE COURSES CHAIR:
Cathy A. Malchiodi, MA, ATR

MIAMI LIAISON:
Janet Bush, MS, ATR

CONSULTANT:
Joan Ungar, LP, ATR

PROGRAM COMMITTEE:
Joan Bloomgarden, MA, ATR
Mariagnese Cattaneo, PhD, ATR
Kay Conlon, MA
Loris Damerow, MA, ATR
John DeFrancisco, MS, MA, ATR
Paula Englehorn, MA, ATR
Linda Gantt, MA, ATR
Sondra Geller, MA, ATR
Ruby Koppelman, MA, ATR
Diane McElligott, MA, ATR
Susan Orr, MA
Tih Penfil, MAT
Linda Jo Pfeiffer, MA
Lillian Rhinehart, MA, ATR, MFCC
Julie Bry Schwab, MA
Patricia St. John, EdD, ATR
Eva Szego, MA, ATR
Jules Weiss, MA, ATR

MIAMI LIAISON COMMITTEE:
Jennifer Blackmore, MA, ATR
Diana Lynn Burchett, MEd, MA
Penny Dachinger, MA, ATR
Enid Shayna Garber, MS, ATR
Maryann Hamilton, MA
Patricia Isis, MEd, ATR
Karen Knuth, MS
Linda Jo Pfeiffer, MA
Barbara Phillips
Irene Platz, MA
Andrea Siassipour, MA, ATR
Helen Sweet
Rebecca Taulbee, MAT, ATR

OPENING CEREMONY

"New Directions in the 80's"
Sandra Graves, PhD, ATR
Mayor Alex Daoud, Miami Beach
Mrs. Martha A. Boden, Executive
Director, Dade County Public Schools

PRE-CONFERENCE COURSES

COURSE #1-The Ulman Assessment Series
Gladys Agell, PhD, ATR, HLM, Director,
Art Therapy Program, Vermont College of
Norwich University, Montpelier, VT 05602
Elinor Ulman, HLM, DAT, ATR Associate Professor,
George Washington University, Washington, DC 20052

COURSE #2-Art Therapy Diagnostics for Adolescents
Mala Betensky, PhD, ATR
4200 Cathedral Ave. NW
Washington, DC 20016

COURSE #3-Self-Psychology and Art Therapy
Mildred Lachman-Chapin, ATR
903A Waukegan Road, Deerfield, IL 60015

COURSE #4-Systematic Study of Visual Languaging in Drawings of Primarily Emotional Experiences
Janie Rhyne, PhD, ATR, HLM
1031 E. College, Iowa City, IA 52240

COURSE #5-Theories and Practice of Creativity Development for Creative/Expressive Arts Therapists
Josef E. Garai, PhD, ATR, Professor Emeritus, Pratt Institute
155 W. 68th Street, Apt. 26-A
New York, NY 10023

COURSE #6-Group Art Therapy for Sexually Abused Children
Joan E. Phillips, MA, MS, ATR, 430 S. Lahoma,
Norman, OK 73069
Debbie Sims, MS, ATR

COURSE #7-Diagnostic-Prescriptive Approach to Art Therapy: Focus on Chemical Dependence
Diane K. McElligott, MA, ATR
1599 Piedmont Avenue, Atlanta, GA 30324

COURSE #8-Phenomenal and Non-Phenomenal Body Image Tasks in the Treatment of Eating Disorders
Mury Rabin, PhD, ATR
75 Edgars Lane, Hasting on Hudson, NY 10706

COURSE #9-Art Therapy and the Therapeutic Relationship with Elders
Jules C. Weiss, MA, ATR, 1527 Lowerline St.
New Orleans, LA 70118

COURSE #10-The Circle and the Art Therapist
Sandy Geller, MA, ATR, 5 Primrose St., Chevy Chase, MD 20815
Lillian Rhinehart, MA, ATR, MFCC
Paula Englehorn, MA, ATR

OPENING RECEPTION—WINE & CHEESE

Wednesday, November 4, 1987 7:30 PM — 9:00 PM

The Opening Reception will be held in the Grand Ballroom with the Opening of the New Expanded Exhibit Hall. Meet the new ATRs, renew old friendships and make new friends.

CLOSING RECEPTION

Saturday, November 7, 1987 7:00 PM — 9:00 PM

A Closing Reception of all attendees will be held to meet the departing and newly elected board members and to provide social interaction with your peers prior to leaving the conference.

SPECIAL PROGRAMS

EXERCISE PROGRAM—FEELING GREAT

Jules Weiss, MA, ATR, 1527 Lowerline St., New Orleans, LA 70118

FILM PREMIERE—CREATIVE EXPRESSION

Continuous Viewing

Nancy Steinberg, MA, ATR, 103 Park Ridge Circle, Marietta, GA 30068

OPEN STUDIO—

Available to attendees daily

TOURS—

A. Bayside Marketplace
B. South Florida Art Center
C. Vizcaya Tour

EXHIBITING COMPANIES—

A. Brunner Mazel, Inc.
B. Pergamon Journals, Inc.
C. Stern's Book Service

Art Supplies for Art Studio were partially supported by: PYRAMID of Urbana.

MEETINGS

EXECUTIVE BOARD MEETING

EDUCATION AND TRAINING BOARD MEETING

TRANSITIONAL MEETING OF NEW BOARD MEMBERS

EDUCATION MEETING

ASSEMBLY OF AFFILIATE SOCIETIES

MEETING-CONTINUING EDUCATION

GENERAL BUSINESS MEETING

UNDERGRADUATE STUDY MEETING

SYMPOSIA

CLINICAL TRACK—SYMPOSIUM: Dreams and Art Therapy

From Inside Out: A Method of Working with Dreams in Art Therapy

Aina O. Nucho, PhD, ATR, 2124 Cedar Circle Dr., Baltimore, MD 21228

Joseph Mancini, MSW, PhD

Cognitive Integration of Dream Sequences and Affect

Vija B. Lusebrink, PhD, ATR, 255 Laurie Vallee Road, Louisville, KY 40223

CLINICAL TRACK—SYMPOSIUM: Substance Abuse in Art Therapy

Art Therapy and Long-Term Adolescent Substance Abuse Treatment

Barbara Fish, MA, ATR, 26198 Spring Grove Road #5, Antioch, IL 60002

Beyond the 1st Step: Images of Power During Inpatient Alcohol/Drug Treatment

Kristina Sly-Linton, MA, ATR, 119 Walter Street, NE, Albuquerque, NM 87102

CLINICAL TRACK—SYMPOSIUM Art Therapy and Family Treatment

The Use of Art Therapy in a Multiple Family Therapy Group

T. Tripp, MA, MSW, ATR, 4121 W. Street, NW, Apt. 303, Washington, DC 20007

The West Indian Immigrant Family; Integration of Art Therapy and Social Work

Evelyn Yee, MPS, ATR, 165 Park Row, Apt. 4F, New York, NY 10038

Shirley Thrasher, MSW

Sara Zahnstecher, MPS

BUSINESS OF ART THERAPY TRACK—SYMPOSIUM: New Arenas for the Development of Art Therapy Programs

Building an Art Therapy Program in Hospice Care

Barbara McIntyre, PhD, R.R. #1, Williamsburg, MI 49690

Mary Raymer, ACSW

Ladies of the Eighties: Outreach to Homeless Women

Patricia Prugh, MA, 1305 Rhode Island Ave. NW, Washington, DC 20005

CLINICAL TRACK—SYMPOSIUM: Structured Art Therapy Programs

Pathway Toward Spontaneity and Autonomy for the Deinstitutionalized Client

Ruby Koppelman, MA, ATR, Rt. 45, Pomona, NY 10970

Structured Inpatient Art Therapy: Framing Goals and Groups

Drew Conger, MA, ATR, 3614 Boat Dock Drive, Falls Church, VA 22041

CLINICAL TRACK—SYMPOSIUM: Art Therapy with Children

Cognitive Approaches in Art Therapy for Children

Marcia Rosal, PhD, ATR, University of Louisville, Expressive Therapies, Louisville, KY 40292

Ghosts in the Attic

Wendy Maiorana, MA, 4318 Fessenden St. NW, Washington, DC 20016

First and Final Pictures: Long-Term Art Therapy with Children

Audrey Di Maria, MA, ATR, 1711 Massachusetts Ave. NW, Washington, DC 20036

RESEARCH TRACK—SYMPOSIUM: Assessment Through Art Therapy

Evaluation of Family Structure Through Kinetic Family Drawings—Children from Alcoholic Families

Barbara Sobol, ATR, 8003 Mandan Road, #101, Greenbelt, MD 20770

Ana C. Gardano, MA

Comparative Study of D-A-P and Life Size Body Drawings in Assessment of Child Abuse

Cathy A. Malchiodi, MA, ATR, University of Utah, AAC 161-Dept. of Art, Salt Lake City, UT 84112

THEORETICAL TRACK—SYMPOSIUM: Art Health and Self Esteem

A Health Based Theory of Art as Therapy

Pat B. Allen, PhD, ATR, 1331 Ashland Ave., River Forest, IL 60305

Art, Process and Self Esteem

Michael Franklin, MA, ATR, Bowling Green State University, Bowling Green, OH 43403

CLINICAL TRACK—SYMPOSIUM: Art Therapy and Defense Mechanisms

Art Therapy with the Defensive Client: A Case Study

Kathryn A. Webb, MA, 903 Hayes Ave., San Diego, CA 92103

Symptom Formation of Psychosis Reflected in Art Productions by Psychotic Patients

M. Levick, PhD, ATR, HLM, 1901 J.F.K. Blvd., #2623, Philadelphia, PA 19103

K.S. Levick

GENERAL SESSIONS

GENERAL SESSION

Private Practice and Creative Self-Promotion (Panel)

Judith Rubin, PhD,ATR, HLM, 128 N. Craig Street, Pittsburgh, PA 15213

Sandra Graves, PhD, ATR

Helen Landgarten, ATR, HLM

Harriett Wadeson, PhD, ATR

Laurie Wilson, PhD, ATR

Judith Gerberg, MA, ATR

GENERAL SESSION—KEYNOTE SPEAKER

The Prediction of Acting Out Eruptions Via Projective Drawings: Assaults, Suicide, Homicide, Rape, and Exhibitionism, etc.

Emanuel F. Hammer, PhD, 381 West End Ave. New York, NY 10024

GENERAL SESSION

Social Applications of the Arts

Robert Ault, ATR, HLM, 1506 Boswell, Topeka, KS 66604

Gary Barlow, EdD, ATR

Maxine Junge, MSW, LCSW, ATR

Patricia Gould, MA, ATR

PAPERS

CLINICAL TRACK—PAPERS

Adolescence and Family Art Therapy

Shirley Riley, ATR, MFCC, 960 Roscomare Road, Los Angeles, CA 90077

Expressive Group Psychotherapy with Adolescent Boys: I am Bad. Explosive, Abandoned!

Don L. Jones, HLM, ATR, 490 Mid Drive, Worthington, OH 43085

The Art of Interpretation

Shaun McNiff, PhD, ATR, Lesley College, 29 Everett Street, Cambridge, MA 02238

RESEARCH TRACK—PAPERS

A Jungian-Based Study of Selected Visual Constructs Preferred by Women

Doris Arrington, EdD, ATR, 30 Knollcrest, Hillsborough, CA 94010

Phenomenal and Nonphenomenal Body Image Tasks in the Treatment of Eating Disorders

Mury Rabin, PhD, ATR, 75 Edgars Lane, Hasting on Hudson, NY 10706

Symbolic Language of the Sexually Abused

Dee Spring, PhD, ATR, MFCC, 5159 Teton Lane, Ventura, CA 93003

PROFESSIONAL ISSUES TRACK—PAPER

Art Therapists as Expert Witnesses: A Judge Delivers a Precedent Setting Opinion

Myra F. Levick, PhD, ATR, HLM, 1901 J.F.K. Blvd #2623, Philadelphia, PA 19103

D. Safran, MS, ATR

EDUCATIONAL TRACK—PAPER

Pragmatic Blending of Theory in the Supervision of Art Psychotherapists

Abby Calisch, MS, ATR, 445 Wellington #6F, Chicago, IL 60657

THEORETICAL TRACK—PAPER

An Inquiry Into Women and Creativity Including Case Studies of Frieda Kahlo and Diane Arbus

Maxine Junge, MSW, LCSW, ATR, 13900 Old Harbor Lane #204, Marina Del Rey, CA 90292

REHABILITATION TRACK—PAPERS

Art Therapy with Blind and Visually Impaired Adults

Rosalyn Benjet, ATM, BFA, MFCC, 1449 Washington Street #11, San Francisco, CA 94109

Arts for Transition: A Community Approach to Art Therapy

Winnie J. Ferguson, MEd, MAT, 6563 Millhoff Drive, Dayton, OH 45424

PICTORIAL COMMUNICATIONS TRACK—PAPERS

From Palais Ideal to Watts Towers with Parellels in Clinical Therapy

Nancy Mayer Knapp, MA, ATR, 16081 St. Croix Circle, Huntington Beach, CA 92649

Rene Magritte: Psychoanalytic and Other Perspectives

Ellen Handler Spitz, PhD, 37 Iselin Terrace, Larchmont, NY 10538

WORKSHOPS

100. **Exploring Blackness**

Arthur Robbins, EdD, ATR, 325 West End Ave., New York, NY 10023

200. **A Brief Moment in Time**

Beth Gonzales-Dolginko, MPS, ATR, 19 Eaton's Neck Road, Northport, NY 11768

300. **Art Therapy Supervision; Modeling the Aesthetic Response**

Leslie Abrams, MPS, ATR, 1 Bank Street, New York, NY 10014

400. **Unimaginable Images—Art Therapy and Sandplay**

Terri Sweig, MA, ATR, 1553 Knollwood Lane, Highland Park, IL 60035

500. **Increasing the Range of Self-Expression: Combining Poetry with Art Therapy**

Virginia Minar, MS, ATR, 308 E. Dean Road, Milwaukee, WI 53217

600. **Functional Art Therapy; Self-Concept**

Connie Livingston Dunn, MA, ATR, 107 E. Oregon, Polo, IL 61064

700. **Integrating Verbal and Visual Metaphors to Promote Change**

Molly Guzzino, MA, ATR, 902 Theresa Avenue, Austin, TX 78703

800. **Me and My Shadow—Photo and Art Therapy**

Irene Corbitt, PhD, ATR, LPC, 7722 Braesview, Houston, TX 77071

Jerry Fryrear, PhD, ATR

900. **Art Therapy as a Preventative Intervention: Use in Nuclear Age Education**

Ellen Speert, MEd, ATR, 1905 Crest Drive, Encinitas, CA 92024

1000. **Movement Intervention: Interfacing Visual Art & Dance Therapy**

Cathy Malchiodi, MA, ATR, University of Utah, AAC 161-Dept. of Art, Salt Lake City, UT 84112

Anne Riordan, BA

1100. **Marketing Workshop for Art Therapists**

Susan Boeshart, ATR, P.O. Box 1686, La Jolla, CA 92038

1200. **Beyond the Band-Aid: Effective Short-Term Group Art Therapy with Adult Psychiatric Patients**

Patricia D. Isis, MEd, ATR, 15413 SW 105th Ave., Miami, FL 33157

1300. **A Sensory Integration Approach to Creative Arts Therapy with Mentally Retarded Individuals**

Debra A. Winter, MPS, ATR, 22 Thistle Lane, Kings Park, NY 11754

1400. **Guided Imagery and Art Therapy: Self Help Tools for the Cancer Patient**

Penny Baron, MPS, 417 E. Lincoln Street, Ithaca, NY 14850

1500. **The Underside: Fascination/Revulsion**

Harriet Wadeson, PhD, ATR, 2119 N. Humboldt Blvd., Chicago, IL 60647

Rose Marano Geiser, ATR

1600. **Images of Wellness: Chronic Pain and Art Therapy**

Terri Halperin-Eaton, MEd, CAGS, ATR, 26 Pond Street, Winchester, MA 01890

1700. **Art Therapy in Transactional Analysis**

Connie Naitove, ATR, 20 Rip Road, Hanover, NH 03755

1800. An Art Therapy Approach to Apple/Macintosh Computers

Devorah Samet Canter, MA, BFA, 1028 W. Wolfram, Chicago, IL 60657

1900. Pictorial Awareness

Ikuko Acosta, MA, ATR, 471 Centre Street, South Orange, NJ 07079

2000. People Types and Tiger Stripes

Sherrie Lonker, MA, ATR, 7460 Devon Street, Philadelphia, PA 19119

2100. Guided Imagery and Art Therapy: Self Help Tools for the Cancer Patient

Penny Baron, MPS, 417 E. Lincoln Street, Ithaca, NY 14850

2200. Mime—A Healing Dance

Mary Raymer, MSW, ACSW, 815 W. Seventh, Traverse City, MI 49684

2300. Transparency, Transformation, and Transcendence as Gateways to Transpersonal Experiences

Josef E. Garai, PhD, ATR, 155 W. 68th Street Apt. 26-A, New York, NY 10023

FORUMS

OPEN FORUMS

Long Range Planning/Strategic Planning

Cay Drachnik, MA, ATR, MFCC, 4124 American River Road, Sacramento, CA 95864

Linda Gantt, MA, ATR

Chemical Dependence

Sherry Kreitman-Dansky, ATR, 1398 Sanzon, Fairborn, OH 45324

Diane McElligott, MA, ATR

For Educators

Shirley Riley, MA, ATR, MFCC, Loyola Marymount University, Loyola & 80th, Los Angeles, CA 90045

Diagnostic Drawing Series

Barry Cohen, ATR, 3307 Beechcraft Drive, Alexandria, VA 22306

U.S. Study Group on the Symbolic Language of Sexually Abused Individuals—3rd Annual Meeting

Dee Spring, PhD, ATR, MFCC, 5159 Teton Lane, Ventura, CA 93003

Student Forum

Geraldine Williams, ATR, Tate Center University of Georgia, 60 Old Barn Way, Casselberry, FL 32707

Writing for Publication

Gary Barlow, EdD, ATR, Wright State University, 228 Creative Arts Center, Dayton, OH 45435

RESEARCH TRACK—PANELS

Individual Inquiries: Single Case Research in Addiction, Autism, and Multiplicity

Marcia Rosal, PhD, ATR, University of Louisville, Expressive Therapies, Louisville, KY 40292

Rebecca Phillips, MA

Kristen Meene, MA

Helen Kling, MA

Contemporary Issues in Art Therapy Research

Linda Gantt, MA, ATR, Lake O'Woods, Bruceton Mills, WV 26525

Gladys Agell, MA, ATR

Rawley Silver, EdD, ATR, HLM

Harriet Wadeson, PhD, ACSW, ATR

PROFESSIONAL ISSUES TRACK—PANELS

Confidentiality in Art Therapy

Laurie Wilson, PhD, ATR, New York University, 735 East Building, New York, NY 10003

Gladys Agell, MA, ATR, HLM

Susan Alumbaugh, MA, ATR

Don Jones, ATR, HLM

Judith Rubin, PhD, ATR, HLM

Katherine Williams, MA, ATR

Governmental Affairs

Nancy Hall, MA, ATR, P.O. Box 203, Westside Station, Buffalo, NY 14213

Cay Drachnik, MA, ATR, MFCC

Paula Howie, MA, ATR

Maxine Junge, MSW, LCSW, ATR

Gwen McPhaul Short, MA, ATR

The Other Art Room: Art Therapy in the Schools

Janet Bush, MS, ATR, 1450 NE 2nd Avenue, Suite 750, Miami, FL 33132

Diana Lynn Burchett, MA, MEd

Enid Shayna Garber, MS, ATR

Patricia Isis, MEd, ATR

Maryann Hamilton, MS

Karen Knuth, MA

Linda Jo Pfeifer, MA

Irene Platz, MA

Rebecca Taulbee, MAT, ATR

REHABILITATION TRACK—PANEL

Using the Creative Arts for the Older Adult to Meet Individual Needs

Millie Bunnell, ATR, P.O. Box 8006, Vero Beach, FL 32963
Donald Hoffman, PhD
Georgiana Jungels, ATR
Geraldine Williams, ATR

EDUCATION TRACK—PANEL

The Role of Creativity in Art Therapy Education; Transference to Clinical Work

Cathy Malchiodi, MA, ATR, University of Utah, AAC 161-Dept. of Art, Salt Lake City, UT 84112
Mariagnese Cattaneo, PhD, ATR
Pat Allen, PhD, ATR
Evadne McNeil, PhD, ATR

POSTER SESSIONS

A. The Apple Macintosh Computer, a New Therapeutic Tool for Art Therapists

Devorah Samet Canter, MA, BFA, 1028 W. Wolfram, Chicago, IL 60657

B. Screening Depressed Children and Adolescents

Rawley Silver, MA, EdD, ATR, #5 Woodland Dr., Rye, KY 10580

C. To Be at the Beginning-Art Therapy in Germany

Karin Dannecker, MA, Bittel Schiesser St., West Germany

D. Art Therapy for Mentally Retarded Adults in an ICF/MR Facility

Donna Rose Testa, MsEd, 1515 NW 29th Rd., Apt. B4, Gainesville, FL 32605

E. Between Generations; Combined Creative Art Therapies with Older Adults and Children

Erika Cleveland, MA, 155 Riverside Dr., New York, NY 10024

F. The Spiritual Dimension of Art Therapy with Chemically Dependent Adolescents

Sister Kathleen Burke, PhD, ATR, Ursuline College, 2550 Lander Road, Cleveland, OH 44124

G. Reflections on Intensive Art Therapy Treatment with a Borderline Personality Organization In-Patient

Patti Wallace, MA, ATR, 3844 E. Casselle, Orange, CA 92669

H. New Directions in Caregiving; the Art Therapists Identity in Adult Day Care

Debra A. Rauman, BFA, 629 Hayes Ave., Racine, WI 53405

I. Visualizing Self Awareness in Group Art Therapy with Adults Affected by Incest

Jacqueline Theobald, MAT, ATR, 134 W. Dixon Ave., Dayton, OH 45419

J. *Cancelled*

K. The Use of Art Therapy with Dual Diagnosed Adolescents

Pamela Bertaud Klier, MA, ATR, 10705 Lake Ave., #304, Cleveland, OH 44102
Barbara Di Scenna, MA, ATR

L. Rainbow Phenomenon Research: Problems, Solutions, Rewards, An Update

Roberta J.H. Shoemaker-Beal, MFA, ATR, 306 Morgan Ct., Slidell, LA 70458

M. A New Beginning: Art Therapy with a Rehabilitated Chronic Schizophrenic Patient

Alma J. Tolins, MA, ATR, 4309 Olley Lane, Fairfax, VA 22032

N. The Necessity of Medical Knowledge in Working with Geriatric Clients

Victoria Chick, MFA, ATR, Rt. 3, Box 311, Excelsior Spring, MN 64024

O. Should We Do Art Work Alongside Our Clients? We Missed Your Beautiful Art Work

Marth P. Haeseler, BA, ATR, 54 Water Street, Guilford, CT 06437

P. The Effect of Brain Injury on Visual Perception and Art Production

Susan Cheyne-King, ATR, 4940 Scandia Road, Sandston, VA 23150

Q. Art Therapy with a Multiple Personality on a Short-Term Unit

F. Lori Greenfeld, MA, ATR, 3422 Vargas Circle, Baltimore, MD 21207

R. Organizing the Moment: Expressive Therapy with the Demented Elderly

Annette Shore, MA, 87 Barre-Paxton Road, Rutland, MA 01543

S. Diagnostic Drawing Series

Barry Cohen, ATR, 3307 Beechcraft Drive, Alexandria, VA 22306

T. Access Aesthetics! A Private Practice Model for Creative Arts Therapy Studio

Henry Gates, D'MIN, ATR, 3 Middlesex Road, Watertown, MA 02172

"Social Applications of the Arts"

Panel Moderator: ***Robert E. Ault, MFA, ATR, HLM,*** *Panel Members:* ***Gary C. Barlow, EdD, ATR, Maxine Junge, MSW, LCSW, ATR, Bruce Moon, BS, MACE, ATR.***

"Introduction" by Robert E. Ault

Last year I had a discussion with Ed Stygar and others during which I suggested we bring to our annual meetings speakers from outside of our own field. I felt it would help us all to grow to hear a Carl Sagan or a Lee Iacocca, or other scholars or leaders in the fields of anthropology, physics or international relations. I was beginning to grow weary of hearing art therapy hashed and rehashed. I've learned a lot from these speakers over the years but a part of me would like to engage more in the larger arena and explore the connections. For instance wouldn't it be exciting to have a panel to include a creative artist, an arts administrator, a secretary of health or education, and maybe someone from the military or defense department? Maybe a Harvard lawyer could be on the program. I had always found "over dinner" discussions with interesting people very stimulating and growth producing. One exciting thing for me this year has been to have a son enter a microgenetics graduate program and to share his interest and enthusiasm. It has also helped me look at art therapy a little differently. Well, as you know we don't have the budget yet for this, so maybe as a start we have set aside a time to think together about our field and how it relates to non-client populations and contemporary social issues.

It is our hope to stimulate your thinking about a broad view of art therapy and its possible applications to societal needs. Our intent is to share our thoughts and questions, not to attempt a definitive solution. I have asked three distinguished colleagues and friends to participate in this discussion and want to thank each of them for so generously agreeing to do so.

The session will be structured in the following manner. First, I will introduce the topic and how it came to be, then introduce each of our speakers. I will then make some comments, followed by presentations from Gary Barlow, Maxine Junge and Bruce Moon. Patricia Gould was to be a presenter but had to decline for health reasons; Bruce graciously and courageously agreed to step into her place with very short notice.

After the completion of all of our formal remarks, I would like for the panel to each have a brief time to respond to the ideas or thoughts stimulated by the other presentations if they wish. We will then open it up to the floor as time permits for any comments or dialogue that any of you would like to make. Again, we all thank you for being here and allowing us to participate with you.

In this introduction let me introduce myself and the topic together as I believe the two are intertwined and will help to illustrate the reason for, and direction of, this panel. Ten or more years ago at another A.A.T.A. Conference, Shaun McNiff made a presentation on the topic of art therapists that had remained active as producing artists. He included in his presentation art works by himself, Janie Rhyne and myself. It was an issue that many of us in art therapy had struggled with - namely, how do we balance our own creative art-making needs with the demands of clinical and academic life. At Shaun's presentation that day, I made a comment that I was thinking of leaving the field of art therapy and resigning my position at Menningers (one that I'd held at that time for 16 years). I'd just completed two years of being a primary therapist for seven hospitalized schizophrenic patients and felt completely burned out. Following that meeting, several friends suggested that I read the book *Passages*, as I'd just passed my 40th birthday.

Maybe it was a midlife crisis, or maybe it was a deeper need to reorder my priorities and the directions of my professional life. I had experienced the process of participating in the creation of the A.A.T.A. and had served in several leadership capacities over the years. This exposure to the larger national issues certainly impacted on my contentment of being a clinical specialist at one hospital with a handful of difficult patients.

I did reorder my professional life and cut my time in half at the Menniger Foundation, began directing a Master of Science in Art Therapy program at Emporia State University, and opened a private art school. Three other involvements concurrent to this time also altered my view of the field of art therapy. One was to become active in the political arena including the feminist movement, and getting a better understanding of how as a society we govern ourselves. The second was my appointment by our Governor to the Kansas Arts Commission. Finally, I would include my involvement with Ronald Goodman and Associates, a business communications consulting firm in Des Moines, Iowa.

What I began to discover was that there were great social issues, needs, and opportunities for people like you and me to address, bringing to each arena a specialized type of orientation that combines the therapeutic issues of imagery, the creative process and the understanding of

BEST COPY AVAILABLE

human behavior. I have deeply felt for some years that the arts can have a major role in the salvaging of a world that at times seems to have gone astray and that we as art therapists had a moral responsibility to participate in that process.

Last year I interviewed Dr. Karl Menninger, who at age 93 still works as actively as he did sixty years ago. During the course of that discussion I asked him what he saw as the most pressing problem we were facing today. Without hesitation he answered "The bomb, the bomb, and the bomb. Why would anyone want to incendiarate these books and paintings and these people?" He went on to explain his real fear of nuclear holocaust that would render all our works, regardless of how good we thought they were, as irrelevant.

As we talked that day it reminded me of another answer to the same question I'd heard years before when the (then) President of the American Psychiatric Association was presenting at the Menninger Foundation. Someone asked him what he saw as the greatest danger facing mankind and he answered, "It's not overpopulation, or world famine, or the threat of the nuclear bomb, —it's the giving up the Christian virtue of work." How could people maintain a sense of meaningful identity when they no longer did so through their work experience? How do we as a species expend our aggressive energies and keep from doing each other in? Viktor Frankl says "Life is a struggle—living is finding meaning in that struggle." How do we or our children or their children find meaning when we eliminate the struggle? It's a question that has already impacted our society, especially many of our youth that have been so protected from hardships and struggles. It does indeed become the "I" generation complete with the narcissistic demands for stimulation and validation and the pain of insecurity and boredom when these are not present.

The art therapy organization as a whole as well as many of its individual members, such as Dr. Joe Garai, Don Jones, and others, have had a particular sensitivity to these large social issues and have spoken out in their presentations and writings. Our speakers today want to accelerate that process. We are not social scientists, or futurists, but we do share a uniquely humane profession that can, and simply *must*, assist in the resolution of social conflict and dilemma. I have asked our speakers to present not only their observations of what is now possible, but to include their speculations, their dreams and their fantasies of the directions we could go in the future. I would like to introduce each of them to you, first, and then I will address more specifically my own topic. .

The second speaker today is Dr. Gary Barlow, professor and coordinator of the graduate program in Art Therapy at Wright State University in Dayton, Ohio. Two years ago, this program received the prestigious "Academic Challenge" award given by the University and the Ohio Board of Regents. Gary was also the recipient of the Outstanding Faculty Member Award in 1986, and in 1987 was inducted as an "Honorary Advocate" to the National Hall of Fame for Persons with Disabilities. You might know him best as the Editor of our professional journal, *Art Therapy*. He has also served the A.A.T.A. for many years in a variety of positions, such as the Education Chair and the Research Chair. Gary will be speaking on the relationship of art therapy and education.

The third speaker is Maxine Junge, an art therapist from Los Angeles. Maxine wears several professional hats in her busy life. She is the Associate Director of the Masters program at Loyola Marymount University, is a family therapist, does private practice, and is a good water colorist. She has served the A.A.T.A. in many capacities including her long work on the Education and Training Board, her service as the first clinical representative on the A.A.T.A. Board, etc. Much of her professional life, though, has been focused on art therapy and the family and I've asked her to speak to this.

The final speaker is Bruce Moon, an art therapist at the Harding Hospital in Worthington, Ohio. He is Chief of Adjunctive Therapy for the Child and Adolescent Divisions, and Co-Director of the clinical internship program. Bruce's first education and involvement was with the Methodist Church and he is a minister as well as a good art psychotherapist. He is a frequent speaker and writer, and I appreciate his joining the panel at such short notice.

BEST COPY AVAILABLE

Part I

"Art Therapy in the Great American Wasteland; Implications for Business and Industry and the Economic Structures of Society"

Robert E. Ault, MFA, ATR, HLM, *Director of Art Therapy, Emporia State University, Emporia, Kansas, and Art Therapist at the Menninger Foundation, Topeka, Kansas.*

Nine years ago I opened the Ault's Academy of Art, a small school in Topeka, that provides drawing and painting instruction for both children and adults. There are six classes per week of eight to ten students per class that I teach. About two-thirds of the students are children ages 8 to 15, and one-third are adults ages 16 to 80. Most of my clients are from the middle to upper socioeconomic population in our community. When I began this adventure I actively attempted to make the school a non-therapy oriented business as I was seeking relief from the demands of clinical life. In spite of my wishes to move away from therapy oriented relationships I found it quite impossible to move away from the tremendous therapeutic impact the classes seemed to have on the students. I observed about 25 to 30 percent of my clients who came to the school for mental health reasons under the guise of art lessons. What I had stumbled into was what I began to refer to as the "Great American Wasteland," middle class suburban America. When I use the metaphorical term wasteland, I don't mean land that is polluted and toxic. I mean land that has not been cultivated properly. These are people that carry tremendous social, political and economic clout, but who personally were suffering greatly from the emptiness of materialism, values of convenience, and a basic narcissistic orientation to life. They worked hard, they paid their taxes, they always voted, and they went through the motions of life without really questioning. Parents were distressed in their lack of understanding why so many of their children experienced school failures, and other forms of acting out such as drug use, drinking, etc., in spite of their favored social position. I was reminded of Frankl's comments about needing to find meaning in struggle. These were children or adult age children that had been overly indulged and protected.

By using very basic principles of art therapy such as providing a caring, stimulating environment, a structured process of involvement, some counseling, a strong sense of identity with the group and the place, the maximizing of responsibility by the students, the insistence on the proper use of materials, etc., many of these people began to make major changes in their lives. The inherent therapeutic value in the making of art and the ownership of the process came into play. Parents would come to me after a few weeks and say "I don't know what has happened, but my child is doing better in school than he ever has." Adults began to report that they had also made significant changes in relationships or in other areas of their lives and were generally feeling better than they had in years. It wasn't just the taking of art lessons, as many had tried that many times; it was, I believe, the provision of an educational and therapeutic involvement based on solid clinical understandings. It is a potential arena for the professional services of ten thousand art therapists. Topeka is not the only community in America with these needs. I am not recommending art therapy for middle class America, for they would reject it if it was presented as therapy. That term implies the unacceptable label of pathology. These people do not wish to be treated but they are starved for a type of involvement that is both meaningful and therapeutic. The arts have from the beginning of time helped individuals and societies define their being, their relationships, and their perception of reality, and it can continue to do so in our times.

"By using very basic principles of art therapy . . . many of these people began to make major changes in their lives."

Serving as an Arts Commissioner I was astonished by the lack of public understanding of the arts and their enormous value. The number of people served through the structure of the National Endowment for the Arts and its state agencies is still rather small compared to the total population. Basically, the same people attend the concerts, go to the galleries, or become art consumers. The arts remain essentially, with some exceptions, the goods of upper class America. I believe that by the way it is structured, these class distinctions are maintained. But what

"There are many . . . ways for art therapists to interact with business organizations other than treating the system."

has that really got to do with art as we as art therapists understand it? The competitive structuring of the arts and the commercial vice it finds itself in has separated it from the mainstream of our population. These folks are, instead, fed a diet of sit-coms, cop shows and Rambos. It distresses me to know the line item in our country's defense budget for military bands is larger than the National Endowment for the Arts, and that we as a nation will continue to spend more this year on a single B-1 bomber than we will spend on our collective creative, artistic and cultural needs. Art changes people's perceptions and opens the door to connecting—and it lasts forever. Weapon systems become obsolete almost before they are employed. They also cannot be recycled back into the economy in the form of useful goods.

The past few years, several of us in the A.A.T.A. have been exploring the relationship of art therapy to the world of business. It is another arena for our professional involvement, and is in need of further exploration and research. Social scientists or others who study organizations and organizational behavior have known for years that clinical concepts can be applied to these structures. Businesses or other institutions can, and do, become ill. They sometimes recover and sometimes expire. These ills are often caused not by market problems but by failures of the human relationships working within systems. These breakdowns are often attributed to bad judgment or bad leadership and are most often treated by purging those responsible. You solve the problem by firing people. But what if you look at these structures as family systems, and use family art therapy methods as defined by Kwiatkowska, and others? It can be powerful magic. My experience, to date, with doing this type of work with executives has also been astonishing to me. I have found them often enmeshed in extreme amounts of information and analysis of business factors, yet completely blinded to the role of their own emotions and the impact of these feelings on their judgments. To have someone who uses a less familiar visual mode of communicating and problem solving cut through years of inability to resolve by traditional talking interactions. We know that it works with our patients, and we are now beginning to know that it can work with other non-patient groups. Whether we like it or not, we do have a better mousetrap, but the world is not going to beat a path to our door until we market it.

If one looks at art therapy and business from an economic point of view the figures are staggering. Once Ronald Goodman, the business consultant I mentioned earlier, and myself worked with a group of executives from a company that was about to "go under." As part of the work, over a day and a half, I had several of the people do a mural together on the theme of reorganizing the company, and gave them 30 minutes to complete the task. That afternoon they did reorganize, shifted several positions, and reordered its structure. When the task was complete, Mr. Goodman stood and said "Congratulations gentlemen, you have just earned a million dollars." With the changes that followed over the next few months, the company began to dig itself out of a hole and, indeed, his words came true.

There are many other ways for art therapists to interact with business organizations other than treating the system. Dealing with stress reduction, employee burnout, bettering internal communication systems, developing a healthy and aesthetic work environment, developing better methods for evaluations of employees or, in general, working with employee wellness are only a few of the ways that art therapists can work with business. It's another arena in which art therapists can play a significant role. There are countless other systems throughout our society that this model can also find application to, such as governmental agencies, educational or service agencies, or others. What do we do with all of these possibilities? Joseph Campbell answered it best, I believe, when he said "Go with the bliss." Trust and follow your instincts in that which is most meaningful and pleasure-giving to you. Let me suggest a few ideas and fantasies.

First, accept a broad concept of art therapy. It is a powerful set of ideas rather than a method, task, or profession. I believe these ideas about imagery and its relationship to thought and feeling are as revolutionary as any put forth by science, religion or political interactions, and they will have their day. I know of no other professional group whose particular expertise is more on target to facilitate these ideas than our own, so scan the whole horizon of possibilities rather than the narrow trail of pathology and treatment.

Second, get involved in non-treatment arenas such as with political activities, local or state arts agencies, or with each other. As my friend Dr. Garai dreams: "Network with each other and get where the action is." A small number of people can have tremendous impact on governmental agencies if they define their goals and are assertive.

Exploit the visibility of our media. People can understand this much better when they can see it. Demand that all school systems in America require a credit in the arts for graduation from high school. Pressure your local or state arts agency to support non-competitive arts festivals rather than using exclusively a competitive model. In competition the vast majority loses. It may be alright for football, but not for the arts for it continues to breed elitism and separation for most of our population. We must help with this reintegration of the arts into daily life.

Finally, insist that our government put more of its resources into cultural exchanges with other countries, especially those we have hostile relations with. I believe people are basically the same everywhere. They love their children, are concerned for their future, and would rather live in peace than in conflict. As art therapists our business is to make peace in our clients and ourselves and these methods do have deep social implications.

Sigmund Freud said it best in 1939, in a letter to Albert Einstein. He states "Anything that creates emotional ties between human beings must inevitably counteract war. . . . Everything that leads to important shared action creates such common feelings. On them the structure of human society in good measure rests."

Part 2

"Art Therapy and Education"

Gary C. Barlow, EdD, ATR, *Professor and Coordinator of Art Therapy, Wright State University, Dayton, Ohio, and Editor,* ***Art Therapy.***

In my preparation for this panel, I was asked to give attention to art therapy and education. "How can we impact on concepts and the practice of teaching?" or "Is there a utopic educational process as well as concrete art therapy techniques for the classroom" were initial questions that were considered. In thinking about education and therapy, much content emerged; within this mass of information I chose to be selective not only in specific areas but also in my interpretation of these areas. I hope that this approach and focus will promote even more thought and deliberation among you. The three headings under which my comments are addressed are: 1) Teaching and concerns about self-expression, and what we can do; 2) A focus on attitudes, and what we can do; and 3) Concerns in the future, and what we can do.

Teaching and Concerns About Self-Expression—and what we can do

Education has traditionally focused on linear thinking—the step-by-step cause and effect line that has permeated the school experience with concrete thinking processes. Learning the ABCs, writing the poem in correct grammatical usage and formal constructs, and even in the art class: "To get this, you need to do this." Through this mode of inquiry and solution, though, the child *is* able to relate one fact to another or to grasp logical sequences, and he/she shares this world with others.

As skilled as we are, however, in the development of concrete thinking modes, we have been remiss in our affective, global experiencing and in our teaching strategies that proffer effective ways of helping the child or adult to fully partake of this affective learning, experiencing, internalizing and communicating. According to Robert W. Witkin, (1974) speaking of the affective experience in his book *The Intelligence of Feeling:*

> There is a world that exists beyond the individual. . . . The child needs to know about this world, to move in it and manage himself in it. . . . [Part of the world] exists only because the individual exists. It is the world of [one's] own sensations and feelings. . . . [Part of] the world [is] of private space and of the solitary object. . . . It implies. . . that the individual is able to relate personally to the world in which he moves. If his existence in the world disturbs his being in ways that fragment him and render his relationships in the world emotionally confused or even meaningless, the he is ill-adapted, and no amount of intellectual grasp of logical or factual relationships will change that. (p. 1)

The "intelligence of feeling" to which Witkin refers is an organized process of subject-reflexive action. (pp. 11 f.f.) The creative arts can provide instances of highly developed uses of subject-reflexive action. They relate to the intelligence of feeling as the sciences relate to logical reasoning. Witkin says that the common element in all expressive acts that the teacher is able to detect is the fact that all such acts release sensate impulse. In abstracting what appears to be the common element in a highly disparate range of activities, the teacher easily alights upon the notion of "catharsis." Self-ex-

BEST COPY AVAILABLE

pression is said to have a cathartic effect in that it is a means for releasing sensate impulse, for discharging tensions, for getting one's feelings into some sort of external form. This identifying of the common element of self-expressive acts as being the cathartic release engenders a wholly ambivalent attitude, according to Witkin, in teachers with respect to self-expression.

The art therapist and the art teacher (or the elementary teacher, the music, drama and English teacher) can come to some agreement, I suppose, on the first part; that is, that self-expression relates to sensate impulses. The second part—that of creative self-expression as being cathartic—can be a disturbing threat to the teacher. The teacher may view it as both creative, constructive and necessary, on one hand, and as possibly destructive, too independent and anarchical on the other. The teacher is moved by two conflicting impulses, as illustrated by Witkin, when he says "on the one hand to encourage self-expression, and on the other to stifle it." (p. 34)

The art therapist, then, can be a tremendous resource to the teacher in aspects of: (1) understanding the nature of self-expression, catharsis and abreaction; (2) processing the material; (3) knowing and understanding appropriate modalities and methods for processing; and (4) overall, allaying the fears that might underlie the delivery of self-expression through some forms of media. In this capacity in working with the teacher, the art therapist becomes the teacher or sharer, and the teacher becomes the student or recipient. I believe that we, as art therapists, have a primary responsibility to teach; to share awarenesses; to deliver meanings as we understand them; to educate about the human being and personal processes involving emotional, perceptual, intellectual and integrative experiencing; and to talk about and demonstrate our skills relative to the therapeutic process in ways that are unique and important to us. Providing that we have "set the stage" for this, and we move ahead with sensitivity and common sense, we will be able to take a prominant role in the education of educators and other human service and mental health professionals.

> ***". . . I do not believe that the art therapist delves enough . . . into what 'attitude' means."***

The Importance of Attitude—and what we can do

If we were developing a course for the training of art therapists, I should hope that we would consider the purpose(s), then list the understandings, skills and attitudes. The understandings would relate to the cognitive aspects (theories, techniques, perhaps some focus on crisis intervention or family systems, or maybe on different mental health systems and stress management—whatever the purpose of the course was). The skills would refer to the demonstration of strategies, perhaps demonstrated abilities with media or skill in referral techniques. And, in my opinion, the attitudes would be a key factor here, since I do not believe that the art therapist delves enough (i.e., thinks about; processes; practices *how* to positively support; understands the psychology of attitudinal change; etc.) into what "attitude" means.

Shaun McNiff (1986) states that "If we approach our clients with attitudes of helping images to emerge naturally, we might just help to further the 'quality' of what comes forth." (p. 100) Long, Morse and Newman (1980) devote a section of their book to the teacher and his/her mental health, and to the attitudes of the teacher based on personal history.

> One of the most important and least understood aspects of therapeutic management is that it is based on the relationship between the teacher and the pupil as much as on the specific strategies a teacher may use. This is why we say that all significant learning evolves and revolves around the teacher. This relationship is extremely complex because each teacher must struggle with his or her history to get in touch with feelings and conditions that will allow him or her to experience empathy with certain pupils, tolerance toward others, and disgust, anger and rejection toward still others. No teacher has a symptom-free history or the capacity and the skills to work therapeutically with all the pupils assigned to the classroom. The 'great teacher syndrome' is an educational fantasy. All teachers carry their history with them, including some unfinished psychological problems, attitudes and prejudices. (pp. 206-207)

Viktor Lowenfeld (1987) alluded to the teacher's attitude as being vitally important when he discussed personality traits of teachers. Elisabeth Kübler-Ross (1969) writes on attitudes toward the dying process and termination in death. Countless authors imply that attitudinal change is important for improvement in health to occur, and they point out how one's attitude can influence others, can shape behavior, can promote self-expression, can thwart freedom, can encourage, discourage, provoke fear, illuminate, enhance and mystify. And yet, considering all of these possible conditions or parameters, many of the indexes of books written in our field and other fields do not list "attitude" as a topic specifically addressed—usually only inferentially.

What is it about the creative process—and Witkin's "intelligence of feeling"—that is important for the art teacher in working with students or the art therapist in working with clients, and what does attitude have to do with it? How do we think, feel, intuit and project our attitudes and, ultimately, our insights about creative, productive personal activity? What we think and feel, we *show* and *exhibit* to others. Graham Greene said "Writing is a form of therapy; sometimes I wonder how all those who do not write, compose or paint can manage to escape the madness, the melancholia, the panic fear which is inherent in the human condition." (1982)

What are *our* attitudes . . . how do we, as individuals, "get into" the creative process, and what do we feel about unbridled, inventive, personal statements that are unhindered by extraneous trivia, and what do we think of this in others . . . and how can we begin to take part in this process of another's "intelligence of feeling"? I believe that the art therapist holds the unique position of not only fostering creative self-expression within individuals, but also of getting deeper into the understanding of what this creative process is and can be. I am not talking about the issues in the content here, but about the nature of the creative process itself. It is important, however, for the art therapist to understand one's *own* "intelligence of feeling," and I suggest that the art therapist *must* continue to be involved in the hard-work aspects of creative production as well as the intellectual stimulation and benefit from the intrinsic qualities within the dialogue of self/media. We must paint, draw, sculpt, weave, write, move, dance or make music. We must not only educate others to the integral values necessary for us to live fully, but *we* must also learn how to live fully through thoughtful and felt experiences, immersed in media, and with an attitudinal "set" that is conducive to learning, producing and sharing.

Concerns in the Future—and what we can do

Perhaps it was Nietzsche who said that the future can—and does—influence the present just as much as the past has influenced the present. What will happen in the future that will affect us as art therapists? What are trends that are already underway? What can we do in educational preparation that will help to "ease us into the future?" With this in mind, I referred to ideas from authors Baruth and Robinson (1987) and their book that included a section on counseling in the 21st century. I believe that their points are important for our consideration as art therapists, and that we should be cognizant of them as we move ahead in our educational planning. I have selected a few from their listing (pp. 375-382), but have edited and combined where necessary. Each, however, reflects content that the authors think will occur in the years just ahead.

1. There will be an increase in gerontological counseling as a professional specialty area, and on career counseling through the life span as well as an emphasis on life span work.
2. There will be emphases on continuing and in-service education and professional development will receive greater emphasis and will be mandated to receive or retain certification and licensure.
3. There will be an increase in the use of computers and other technological advances in the human services.
4. Another emphasis will be on special groups (minorities, women, one-parent families, intercultural groups, etc.).
5. There will be a focus on preventive activities, accountability, and on the counselor's role as a consultant to parents, teachers and others.
6. An emphasis will be placed on post-masters degree training in specialty areas (such as marriage and family, chemical dependency, and others) and on doctoral level training for persons wishing to enter private practice, work in non-school settings, or for focused research.
7. Counseling will be provided to a greater extent within business and industry, and will become increasingly multidisciplinary, as well as shifting to more private practice, clinics and home delivery. There will not, however, be a shift from services provided by school counselors.
8. There will be an increased emphasis on Holistic models of counseling—approaches that focus on all aspects of the individual (affective, behavioral, cognitive).
9. Group counseling will be utilized to a greater extent because of time-effectiveness and for social considerations.
10. Professional organizations will organize task forces to improve research, and professional alliances will form, more networking will occur, and some specialty groups may consider merging.

Based on these projections for the 21st century in the counseling profession, I would like to raise these "what if" questions for the art therapist and the art therapy profession:

1. What would happen if an art therapist, and an art teacher and a counselor, were considered as an integral and necessary team that was hired in a public school system?
2. What would happen if art therapists moved into more proactive roles in issues of mental health delivery of services, and served as a model to which other professionals referred? An example might be art therapy in home delivery services, with a focus on the education, knowledge, skills and attitudes relative to this mode of delivery.

3. What would happen if art therapists moved into reactive roles in certain areas, such as research, and focused on work that has been done, then took a proactive stance in the establishment and continuation of a strong national network of research in the human services?

4. What would happen if, through the Education Committee of A.A.T.A. or with other appropriate committees, we identified persons to help us in the increase of the use of computers and other technological advances in art therapy, and came to terms with planning, sharing and communicating about these systems?

5. What should we be doing relative to a greater emphasis on multicultural education and training?

6. What would happen if we moved forward with task forces to share research and educational strategies, and utilized these task forces to build professional alliances with others that could, ultimately, increase our professional and political strength?

7. What would happen if we would consider certain areas of professional preparation that seem to be looming large on the near horizon, such as gerontology, life-span work, and business and industry, and if we would move ahead with concerted educational efforts in these areas?

8. What would happen if we would be able to offer some basic coursework in art therapy to *all* teachers being trained in diverse fields? This might include fields such as elementary and secondary, music and theatre, but also in other areas of study such as social work, psychology, counseling, rehabilitation, speech pathology and communication, and nursing.

9. Since many institutions (such as mental health centers or nursing home facilities) have educational components, what if we would offer our services in these units—not just with art therapy services, but in various ways that would help in awareness building and with purposeful ventures, such as general arts activities for patients or families, or trips to the art museum or to a performance of a play?

10. In our profession we are subject to accountability and outcomes. What would happen if we would give concerted focus to accountability concerns in art therapy, to a study of how we can build strengths in areas, but also to how we can communicate about our strengths? Could this be an important focus for scheduled professional seminars over the next five years?

Summary

Three areas have been highlighted: 1) Teaching and concerns about self-expression; 2) A focus on attitudes; and 3) Concerns in the future. The philosophical concern dealt with education and linear thinking, the realization that many teachers may consider self-expression as both a blessing and a blight, and that the art therapist can help to break down the fear of self-expression while focusing on the true nature of the "intelligence of feeling." The second topic, that of attitudes, centered on attitudes in conjunction with understandings and skills. Special emphasis was given to understanding our own attitudes in art therapy while working with children, adolescents and adults, and their formulation of the expression of creative energies within a therapeutic environment. And, finally, the concerns of the future identified many projections as noted by our professional friends, the counselors, who have given us much to think about as we plan for the future.

Whatever we do in training and education for others, as well as continued education for each of us, depends on our commitment to art therapy, on our honest and deep belief that art therapy can be beneficial, on the understanding that we are not the only ones concerned about the human condition, and a realization that we do indeed have something to offer that is long-lasting. But, all-in-all, it depends on each of us individually, and how we view the profession, the process of working with people, and understanding our own levels of comfort as we work with people, media, ideas, concerns and issues.

References

Baruth, L.G. and Robinson, E.H. III (1987). *An introduction to the counseling profession.* Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

Greene, G. (1982). In E. Winner, *Invented worlds, the psychology of the arts* (p. 15). Cambridge, Massachusetts: Harvard University Press.

Kübler-Ross, E. (1969). *On death and dying.* New York: Macmillan Publishing Co., Inc.

Long, N.J., Morse, W.C., and Newman, R.G. (1980). *Conflict in the classroom, the education of emotionally disturbed children.* Belmont, California: Wadsworth Publishing Company.

Lowenfeld, V. and Brittain, W.L. (1987). *Creative and mental growth* (8th. ed.). New York: Macmillan Publishing Company.

McNiff, S. (1986). A dialogue with James Hillman. *Art Therapy*, 3(3), November, 1986, 100-110.

Witkin, R.W. (1974). *The intelligence of feeling.* London: Heinemann Educational Books.

Part 3

"Arts with Families"

Maxine Junge, MSW, LCSW, ATR, *Associate Director and Assistant Professor of Clinical Art Therapy, Loyola Marymount University, Los Angeles, CA.*

I'm pleased that we are thinking together today about this important area of concern.

Many of us in this field, particularly those of my generation, have our roots in the relationship of the arts and social activism. And I would like to suggest to you that the time is now to renew and intensify our commitment to social responsibility as individual art therapists and as a profession.

I like to remember that my first "serious" paper in high school was on Goya, Daumier and Ben Shahn as painters of social protest. In the late 60's and early 70's I ran arts programs in ghetto and barrio areas of San Diego and Los Angeles that were aimed at impacting the educational system and racism and that used the arts for community organizing and empowerment. I believe very strongly in the power of the arts for social change.

My topic today is the family and in preparing for the panel, we were invited to dream a little, to even envision a utopian application of the arts with families. I have been a family art psychotherapist for more than fifteen years and I am convinced about what I do and the effectiveness of using art as diagnosis and treatment. I am particularly interested in art's potential for enhancing family ritual, in a society that is increasingly losing its traditions while still retaining remnants of many that have come to be meaningless. I am fascinated with the relationship between art and playfulness for families that do not know how to play and consider the whole area of humor in its visual forms and uses as providing exciting potential new avenues for exploration. I want to focus with a family on the making of art as genuinely exhilarating and I view creativity and the creative metaphor as an important transforming medium toward new growth and new forms for families. I am interested in art for empowerment of individuals, families, communities, and nations. I *could* talk to you about those ideas. . . .

But I have a problem with this so I am going to take a different slant. I spent a lot of time thinking about this talk and a lot of time attempting to dream. And I found a certain image appearing repeatedly. It became all but inescapable until finally I had to pay attention. The image was of Van Gogh's painting of "The Potato Eaters." I'm sure I don't have to remind you of this dark painting of poverty and isolation. It is so strongly evocative that most of you can probably see it in your mind's eye as I speak.

And "The Potato Eaters" and Van Gogh convinced me that I have to tell you the truth as I see it.

That I don't think talking about art therapy with dysfunctional or normal families, and dreaming about a utopian future is where its at. It's time and time NOW to talk about the urgency of art therapists and the art therapy profession taking an expanded, active role, a *political role* toward the family, for the family in America today is in grave danger of dying.

In 1985, in his State of the Union address, President Reagan spoke for an "America of wisdom that honors the family, knowing that as the family goes, so goes our civilization."

The reality is much different.

There is a shocking lack of government interest in families. In fact the U.S. remains the only major industrialized nation without family policy. There are no programs of national provision for family allowances, day care for working parents or for health services.

The emphasis in this country is on armaments and defense.

There is a shrinking middle class and the indicators are that more are moving down.

There are 33 million poor and for a family of four the poverty level is now only a little above $10,000. The number of poor Latinos hit an historic high in 1985.

The facts are:

Major changes and evidence of breakdown in the American family are well documented:

1. Rates of unemployment have intensified especially for young adults and adult black males and Latinos.
2. There has been rapid increase in

> ***"Many of us in this field . . . have our roots in the relationship of the arts and social activism."***

female-headed households along with massive cuts in government programs of financial aid.

3. Families below the poverty line have grown in numbers as resources have diminished.

4. The revolution of the women's movement has caused major shifts in women's role with an absence of necessary societal supports, such as effective child care programs.

The family continues to be taken for granted and is almost a cliche in our society as the essential unit for growth and socialization of children—but it is expected to follow its path with no support in a time of tremendous change.

Some statistics:*

1. Only 15% of all American families are headed by two parents. The number of children living with one parent has nearly doubled since 1970.
2. The divorce rate is now stabilizing after twenty years of increase to more than 50% of all marriages. But it is now anticipated that *most* children will experience the departure and replacement of a parent.
3. Nine out of 10 children in single-parent homes lived with their mothers in 1985. More black children lived with just one parent.
4. Of non-white female-headed households, 70-80% live below the poverty line. More than three times the number of black, single female-headed families lived in poverty in 1984 in comparison with 1981.
5. Almost 40% of all Americans living in poverty are children.
6. Half of the labor force is women and 50% are single and independent of male economic support. Thus we see increasingly the feminization of poverty.
7. As women's involvement in the work force has increased, men's has decreased, particularly minority men. Rates of unemployment have intensified. This is particularly true for young adult, black males and Latinos. For each 1% increase in unemployment, suicides increase by 320 a year.
8. Half of all mothers with infants under one year old and more than two-thirds of working women with preschool children are working full time. Child care remains woefully inadequate.
9. Child abuse correlates with unemployment, with social isolation, with feelings of worthlessness and powerlessness. Even allowing for more attention paid to abuse these days and more accountability for reporting, in California, for instance, child abuse reports between 1974 and 1983 increased 900%.
10. The homeless, many of whom are families with children, are endemic in our cities and on the increase. One third of the homeless are families.

I don't think I have to say more. You all have personally encountered these problems yourselves in the increasingly horrendous cases we have seen for treatment in clinics and hospitals in the last five years.

The picture is bleak and the plight of families in this country is a systemic problem that requires a major commitment on the part of everyone and at all levels of government to effect systemic change.

All art therapists have had to be social pioneers in our young and striving and innovative field, as we have gone about our business of inventing our profession, of proving our capabilities to others, of creating jobs where none existed before and of working in exciting and creative new endeavors of assessment and treatment and with ever-expanding client populations.

I suggest to you that art therapists can no longer afford to remain in our safe offices dealing with the symptoms and results of such an increasingly destructive system. I urge that we take those skills we have gained as social pioneers into the larger arena.

We are about to enter an election year during which we will choose a President. I challenge you, if you believe in the on-going life of the family, to take your social concern into the political arena, to play an action role to implement and activate the social systems which must offer the necessary support to sustain the family as a social institution or we may watch it die.

And I challenge the American Art Therapy Association to focus on the family as a priority. I propose that it begin by devoting a major part of next year's conference to the family. I suggest that papers be invited and programs created that not only deal with assessment and treatment of pathological family systems, but with prevention and innovative community and larger systems approaches. And I suggest that a section be devoted to debating the art therapist's role as advocate and as social activist within the mental health community and the larger society.

My dream is that in empowering ourselves we can empower others.

And my dream is that sometime in the future as members of families and communities and of this nation—as members of the mental health community and of the art therapy community we will be truly free to dream: to dream of the transformative nature of the creative process and of the sweeping power of expression and social change that lies within the arts themselves. But right now we have much work to do first.

Thank you.

---

*I gratefully acknowledge the 1987 conference program of the American Orthopsychiatric Association for many of these statistics.

Part 4

"Images of Our Culture and the Effects of Events on Our History"

Bruce Moon, BS, MACE, ATR, *Co-Director of Art Therapy at the Harding Hospital, Worthington, Ohio.*

For my segment of this presentation, I want to focus on images of our culture and the effects of significant events from our communal history. I hope that this will be thought-provoking, maybe a little scary, and some fun as well. Additionally, I want to comment on the implications that these images may have for us art therapists.

To frame this, I need to tell you that I am a product of the post-World War II baby boom. I suspect that many of you are too. So, when I talk of our culture, and of art, my experience of both has been colored by the intriguing twists and turns that the world has taken these last three or four decades. [In preparation for showing slides] I'd like to set the stage for what I'm going to say through images and sounds. The intent is to stimulate your memories, feelings and ideas about the world we live in. [Ed. Note: At this point slides were begun, accompanied by an audio tape. This presentation of imagery and sound continued, with some of the following serving as interspersed narrative.]

To continue our looking together I'd like to share with you a brief passage from Dr. Erich Fromm's prophetic social commentary *The Sane Society* (1955).

> Man today is confronted with the most fundamental choice . . . between robotism (of both the capitalist and communist variety), or Humanistic Communitarian Socialism. Most facts seem to indicate that he is choosing robotism, and that means, in the long run, insanity and destruction. But all these facts are not strong enough to destroy faith in man's reason, good will and sanity. As long as we can think of alternatives, we are not lost; as long as we can consult together and plan together, we can hope. But, indeed, the shadows are lengthening; the voices . . . are becoming louder (p. 315)

Thirty odd years have passed since Dr. Fromm issued his warning and his call for transformation. I agree with him . . . that the shadows have lengthened and the voices continue to rise. Let's listen to a few of the social sounds from the last three or four decades . . . remembering that these are the whispers and screams that we baby boomers have grown up with.

The war to end all wars came to a close
Closely followed by the Korean War
Closely followed by the Vietnam War
A voice cried in the wilderness
I have a dream
Another voice screamed
America, love it or leave it
Shots echoed in the streets of Dallas
Shots echoed in the streets of Memphis
Shots echoed in Los Angeles
Richard Nixon proclaimed that he's seen
the light at the end of the tunnel
Four guys from England sang, all you need is love
Mayor Daley demanded order in Chicago
Governor Rhodes ordered National Guard troops
onto the Kent State Campus
Draft cards burned
Gloria Steinem gave the world a new
image of women
Bra's burned
Jimmy Carter announced
There is a malaise upon the people
If it felt good, we did it
Yuppy became a popular term
We learned to drink Perrier
Ron Reagan gave us the verbal image
of 'That Evil Empire'
The bull thundered and the Bears roared
and on, and on, and on.

"I [am focusing] on images of our culture and the effects of significant events from our communal history . . . [and on] implications that these images may have for us art therapists."

We baby boomers have all grown up now. And we have heard these voices. And we have gone to see The Big Chill and walked out of the theater depressed or denying. The Big Chill was recently on network television. The Morning After was a Rorschach of sorts for my colleagues and me. All of us had our notions of which character in the movie most reminded us of ourselves. The truly disturbing, denial provoking thing about The Big Chill is its ability to remind us of our naiveté from once upon a time. You know, in 1972 I really did believe that flowers could be more powerful than bullets. I believed that we could change the world. I was not alone. Let me share with you a segment of a recent letter from David Gallegos, the founder of the Art for Peace Organization, as he reflects on his own journey. "The most frustrating thing that happened was that I was so naive. I was so sure that as an artist I could do something but soon found out that I would face the peace *Business*. Of all the organizations I approached, not one was interested in working with Art for Peace. This left me shattered. . . ."

Those of us who were active, be it in the civil rights movement or the anti-war movement no doubt understand this shatteredness. And so we have gone to other things in our lives, to professions, and marriages, and baby making, and divorces. We have turned our energies and attentions to the more practical matters of daily life. We haven't forgotten the spector of nuclear war, we haven't forgotten the injustices that exist around the globe, we just sort of ran out of gas. The voices were just too loud, too confusing or too quiet; we couldn't listen anymore.

Some have chosen Fromm's 'Robotism,' while others have immersed themselves in the joys of upward mobility. Perhaps Bob Dylan says it best. . . "some are mathmeticians, some are carpenters' wives, I don't know how all this got started, I don't know what they're doin' with their lives."

One of the hallmarks of our society today is that we don't value pain very much. A case in point: the new aspirin commercials which feature an irate parent running to the medicine cabinet in a desperate attempt to tolerate her children. We like things to be easy; we like disposable things because they are so easy to live with, easy to use and easy to throw away. We like easy relationships, easy sex, easy fast food, easy abortion, easy divorce, easy entertainment, easy work. We like to take life easy, and we all hope for an easy death.

If you enjoy dark comedy you can't help but smile at underarm deodorant commercials—particularly the recent ad campaign whose slogan is "never let them see you sweat." It takes no great psychoanalytical thinking to interpret the common message of both the pain reliever and the deodorant commercials. "Don't put up with discomfort, and at all costs, don't let anyone know how you really feel."

As an art therapist I believe that all things we create are fragments of our own self-portrait. I suspect that this is true for the culture as a whole as well as for the individual. I am not so sure that I like the cultural self-portrait I see being painted around me.

The first sentence in Dr. Scott Peck's *The Road Less Traveled* (1978) is straightforward and clear. He says "Life is difficult." (p.15) When I read it the first time I felt an odd sense of relief. I'd had a vague feeling that something was wrong for a long time. The older I got, the more overwhelming the task of changing the world became and the harder life was. In 1972 it was easy to talk about peace for the whole world—I had no one else to feed and clothe and house back then—and life was much less difficult.

An inevitable consequence of growing up is realizing our own limitations. The Big Chill reminded us that life was not as easy as we thought it would be. By this point, you may be thinking that I am pessimistic or somehow bitter over my (our) innocence lost. On the contrary, I have much hope despite all the evidence of Frommian Robotism I encounter. Regardless of all the aspirin, Tylenol, Advil, Mennen Old Spice, Right Guard, ad infinitum, commercials—there is reason to hope.

In the clinical setting—or laboratory, if you will—I have seen the terribly disturbed and lost find themselves again. I have seen those in excruciating emotional pain cease their running and turn around to face and tame their monsters. I have seen some who once lived only for the pleasures of the moment learn the deep joy of struggle. How? By doing art. The studio, whether it be a music practice room, a dance floor, a stage, or a room filled with empty canvasses, is a sanctuary . . . protecting the virtue of struggle and the value of pain. It is here that attempts are made, failures allowed, mastery accomplished through repetition of process, gratification delayed and occasional successes celebrated. It is in the studio that the present-day artist ties himself or herself to the collective past of all artists before him/her. It is from the sum of all works of art, the tradition, that the artist makes his or her creative leap, thus taking one's place in the vast chain of art history. This history of art, as you all well know, is a saga of struggle. For the process of making art is much like that of giving birth—an act of love and labor and pain, replete with surprises.

Some of you may still want to save the world. I applaud you and wish you well. Others may have come to terms with your own limitations and are content to change little pieces of the world, one patient at a time. Still others, perhaps, just gave up thinking about it. In any case, let me propose that we, as art therapists, can have impact on life and culture by taking every opportunity that we can to remind people that it is okay to hurt, that it is good to struggle and that, indeed, life is difficult. That's what I believe art is. It's what I *think* therapy is. It's what I *feel* art therapy is.

References

Fromm, E. (1955). *The sane society*. New York: A Fawcett Premier Book, Holt Rinehart & Winston, Inc.

Peck, M.S., MD. (1978). *The road less traveled, a new psychology of love, traditional values and spiritual growth*. New York: A Touchstone Book, published by Simon and Schuster.

Coming of Age: A Subjective Perspective

Judith A. Rubin, PhD, HLM, ATR, *Clinical Assistant Professor, Dept. of Psychiatry - University of Pittsburg; Faculty, Pittsburg Psychoanalytic Institute*

From a presentation given at the 1986 American Art Therapy Association Conference, the author discusses, with personal insights, the "Coming of Age" of art therapy as a profession. From the author's early "typecasting" as a child therapist to her present art therapy work in private practice as well as the publication of books and articles in art therapy, she discusses the ordering of priorities, suggestions for the young art therapist (such as years of supervision), the sophistication and expertise needed in order to become a truly mature therapist, as well as the need to be involved with the professional association. Much focus is given to the "Coming of Age" of the association (as well as the therapist) with references to the (understandably expected) struggles associated with growth and development.

The talk on which this paper is based was given at the conference of the American Art Therapy Association, held in November of 1986 in Los Angeles, California. At the time, I shared with the audience my ambivalence about accepting the chairperson's invitation to talk to the group. The time and energy required to write a paper loomed as large and probably draining, despite the ever-potential narcissistic, exhibitionistic, and otherwise-gratifying pleasures of public presentation. But the primary reason, I think, that I said "Yes" to the chairperson's invitation to present, and to a friend's suggestion that I submit a version for publication, is that I feel great affection for and considerable responsibility to the field of art therapy, and to the organization which represents its interests in the world.

Although that may sound a bit pompous, even arrogant, it is quite sincere. And I think it is a sense of responsibility shared by many others who, like me, feel ourselves to be an integral part of this still-young professional family. Perhaps it is analogous to that bond among relatives so familiar to anthropologists and sociologists, who compare the respective thickness of blood and water. But, in addition to genuine feelings of loyalty and a sense of commitment to the members of an association, I believe that my own motives and those of many others are not only personal but even idealistic. For I think many of us feel a sense of responsibility not only to the group, but even more to the discipline—largely because we believe so deeply in what they are both about—because art therapy offers something of true value to the world, something that because of its intrinsic worth deserves to be nurtured and developed. Sharing with the next generation of workers thoughts about my own maturation process and that of the profession seems to me to be part of that responsibility to the field, fueled not so much by dutiful obligation as by passionate commitment.

These rather old-fashioned notions about ideals and values and commitment are as valid and central now as they were in my own "coming-of-age" as an adolescent, that crucial period usually marked as a time of passage into adulthood through pubertal rites and rituals. The idealism of fifty is more temperate than that of fifteen, but no less genuine. In the field of art therapy I found a way of integrating my love of art, which had given my life meaning since early childhood, and my desire to help people in a substantive way. Even though years of classical analysis have helped me to better understand the roots of both areas of interest, this awareness has not—as I once feared—diminished the pleasure derived from continuing work as a clinician who tries to synthesize art and therapy in creative ways, in order to help people to get better and to achieve their potential.

If I were to answer the question of why I feel so disinterested in writing papers these days, I would say that my energies are fully absorbed in the never-diminishing challenge of clinical work. So absorbed, in fact, that I find I have to monitor my tendency to say "Yes" to too many referrals, since they all sound so fascinating. My biggest problem, since leaving the university psychiatric hospital two years ago for full-time private practice, has been learning how to set limits on my apparently-insatiable appetite for challenging cases. Fortunately, my aging body has provided the best braking system, teaching me that, while I might get away with omitting a lunch hour and snacking intermittently, I cannot stretch my alertness beyond a certain number of hours without feeling sleepy and uneasy about my ability to respond to those patients who come at the end of the day. Similarly, my advancing years force me to admit that I can work with only so many preschoolers, and then not too many in a row!

". . . art therapy offers something of true value to the world, something that because of its intrinsic worth deserves to be nurtured and developed."

Fortunately, though originally "typecast" as a child therapist due to my early work at a guidance center, later experience with adults in analytic training and at a psychiatric hospital prepared me to deal with patients of all ages, providing a really delightful balance in my practice. In a recent piece of "mini-research" I discovered that my hypothesized sense of working with all ages was an accurate reflection of the facts. When I sat down and made a list and counted, roughly one-third of my patients turned out to be young children (between 3 and 12), one-third adolescents and young adults, and one-third grownups, at least chronologically. This variety in age level is paralleled by a similar range of diagnostic classifications and degrees of disability, so that the daily contacts are always varied and stimulating.

Beyond the investment of energy in this new enterprise, it is also clear to me that my early need to share with colleagues seems to have gradually modified over time, though it is not entirely absent. At the time of writing this paper (in the Fall of 1986), I had just sent off the chapters of an edited book on various *APPROACHES TO ART THERAPY* to a publisher. This recent project was stimulated by a felt need for clarification of different theoretical viewpoints and their application to art therapy, in response to publications, presentations, professionals, and students in learning situations like courses or supervision. The book just before this one, *THE ART OF ART THERAPY*, was also written in response to what seemed to be confusion about art and/or therapy on the part of many in our field. Like my first book, *CHILD ART THERAPY*, the second was an attempt to clarify and organize my own thinking about what constitutes good clinical work. All three of these, like most of the papers I have presented and the articles I have written, have been attempts to communicate to other art therapists . . . to share ideas which seemed useful, so that others could try them out and assist in the task of evaluation, modification, and elaboration.

But now, despite having vowed never to proof-read another book-length set of galleys, and despite being happily absorbed in a busy practice and continuing to teach and supervise on a voluntary basis in the Department of Psychiatry (University of Pittsburgh), the Creative & Expressive Arts Therapy Program (Western Psychiatric Institute & Clinic), and the Pittsburgh Psychoanalytic Institute. . . and, despite having recently formed a nonprofit corporation with my friend and colleague, Ellie Irwin, a drama therapist, called EXPRESSIVE MEDIA, INC., which owns and will some day distribute the films and videotapes we have made. . . and despite having a half dozen half-finished films and videotapes I am eager to work on, and at least one major research study I am eager to finish writing up. . . despite all of this, which should be enough (and is really more than enough), as soon as I sent the galleys back to the publisher last Fall, ideas for another book started to intrude persistently and insistently on my mind; and I think I may soon succumb to the internal desire to write it.

Whether or not I give in to this impulse now or ever, what is probably significant is that this book would not be for other art therapists or even for other mental health professionals, but for the lay reader, for the educated public. It would have something to do with art and creativity and therapy, and would be an attempt to make all of these less frightening and more accessible to the average person. When I first began to think along these lines, it seemed to have been stimulated largely by my recently intensified activities as a clinician. Though I have always done therapy, and was allowed to practice privately as part of my work in a psychiatry department, I have never done it on such an extensive basis, for so many hours a week, or with such a broad range of patients at any one time. This work, in addition to being fascinating, has impressed upon me the great confusion and fear among most people about psychotherapy; and, when a person is over a certain age, about plunging into the visual arts as an expressive mode, especially when the individual is comfortable and competent with words. But, as noted earlier, I feel almost evangelical about the value of both art and therapy, and my present persistent wish is to present this information in a digestible and appealing way to those who are the consumers of our services—the public.

Actually, the process of forming a non-profit corporation to own my old films reminded me of an earlier investment in reaching parents and teachers through such vehicles, of "selling" them on the broadly therapeutic values of the arts. So it's not a new idea to want to reach the public, but it does represent a shift in my thinking about a target audience for a book, and I am sure, another step in the personal process of "coming of age." And, although I will probably want to share my current experiments in technique and associated notions about theory with both psychoanalysts and art therapists, at some point in time when I feel more clear and certain; there are some things, like presenting at conferences, which used to interest me tremendously, and which have currently lost their luster. I think this phenomenon has to do with other facets of the process of COMING OF AGE, middle age as described by Simone de Beauvoir in her book of that name, not the blooming of adolescence.

It is true that I used to love to think up and, when possible, to conduct research studies. While I still value such work, I know that I have been dragging my feet for almost two years on writing up the already-completed data analysis of a study on family drawings, and wonder why it has fallen so low on my priority list. Similarly, I have been talking for several years with others about doing a study on the effectiveness of art therapy in cases of aphasia. The possibilities of helping people if our hypothesis is correct are substantial, so the interest and potential of this study are more than academic. Still, I have to confess that, while I think it is a fine study which really truly ought to be implemented, I'm really not motivated to spend my energies on anything other than the design, though I know that to get funding more time would be required. And maybe the key word here is the four-letter one that seems limitless when you are young, and all of a sudden appears in all its finiteness as the years go by . . . TIME. Because there is indeed a limit, and because there is never enough of it, and so one must choose how it is to be spent. And the truth is that at this point in my life, what is most rewarding at the deepest level is doing art therapy and psychoanalysis with a variety of patients, and possibly also writing a book for the layman and finishing some of those old films and tapes . . . in that order.

In other words, one facet of coming of age is a reordering of priorities—like discovering that activities which used to "turn me on," like research, just don't excite me as much, despite my continuing conviction of their value. I confess that both teaching and supervision are in that category too, despite the fact that I still do quite a bit of both. This year I find myself more interested in the supervision of general residents doing child therapy and teaching courses in psychoanalytic theory to candidates at the institute than in the supervision or teaching of art therapy. But the truth is becoming increasingly apparent to me, that I often feel fatigued and bored in each of these roles; whereas I hardly ever feel bored as a therapist, and fatigued less and less as I learn how to set realistic limits on my time. Doing psychotherapy excites me consistently as no other activity has ever done, and it seems to have become even more challenging the more I have learned and grown as a clinician.

". . . one facet of coming of age is a reordering of priorities. . . ."

What does all this personal reflection mean for our field? I think that the most startling lesson I seem to be learning is that learning to do effective art therapy is a lifelong task. So, lest my enthusiasm about private practice has stimulated the reader to envision herself in her own studio/office complete with clay and paint and good lighting, let me now add some sobering words of restraint, First, I happen to have had the good fortune to have gotten a PhD in a field which enabled me to qualify to take the nationally administered licensing exam in psychology. Those familiar with it know that the requirements for eligibility to take it are becoming increasingly stringent, and that the examination itself is getting progressively more difficult, as the profession of psychology struggles to keep its hard-won territory for itself in this age of tightening budgets. Even if it were an easy exam to pass—which it is not—it will never be one that those with art therapy training alone could take. Moreover, the likelihood of art therapists becoming licensed providers seems slim at present in most states; though the possibility of credentialling in related fields exists and should be pursued. The reader may well be wondering, since we have registration, why a license matters. In the real world of fees and payment for private practice it matters very much, since it generally makes the difference between insurance coverage and no third-party payment for most carriers. There are, of course, other possible arrangements. Many practitioners—social workers and others as well as art therapists—work under the supervision of a licensed professional who does the billing. But these arrangements are under increasingly close scrutiny and are often challenged. Although you can practice legally *without* a license, the patient carries the entire burden of payment, which means that you either treat only rich people, or you are forced to accept a relatively low fee.

But being paid for what you do in the private sector is only a small part of the problem. What is really critical is that you are taking on a very large and serious responsibility when you treat anyone without the protective umbrella of an institution. It is not the cost of the necessary malpractice insurance which poses a serious problem at this point in time for art therapists; that is minor and manageable. What is major and potentially unmanageable is being sufficiently knowledgeable to know: (a) what you are doing, and (b) when you don't know what you are doing. That may sound simple, but it is not. Simply getting regular supervision from a more experienced professional is not enough, though it is probably essential for most people with less than 20 years of supervised experience.

In case you wondered about a misprint, there wasn't one, and I wasn't being humorous, I really meant twenty (20) years. At least, that was true for me. I received supervision on a weekly basis from a professional with more experience than myself from the time I first did art therapy in 1963 through the completion of my psychoanalytic training in 1983, and most often had more than one supervisor at a time(!). Since that time, I have frequently sought consultation with one or more colleagues when I was puzzled about how to handle a case. I also attend two regular study groups, one of which involves ongoing case presentations. In other words, by the time I went into private practice "on my own" I had received thousands of hours of individual supervision on my clinical work. Moreover, I had, by 1985, worked in clinical settings for 22 years—16 of them full-time—with a wide variety of patients individually, in families, and in groups, and had had considerable vicarious clinical experience through hundreds of hours spent supervising others, usually individually and intensively. I would agree that I was probably "over-ripe" and actually "ready" for independent practice somewhat earlier, perhaps even at the time that I took and passed the licensing exam in 1979, and was legally entitled to hang out my shingle in the state of Pennsylvania.

My point is, however, that I believe that private practice in art therapy—as in any other serious form of psychotherapy—should not be undertaken until the practitioner has reached a rather high level of sophistication and expertise. Why? Primarily because of the responsibility for the patient and family which such a role requires, and secondarily, I believe that one also has a responsibility to the profession. For going into independent practice usually means losing the opportunity for your work to be regularly scrutinized and critiqued by those with more experience. And, even if you pay for supervision and attend study groups, you are in a position of greater responsibility—sometimes total—for whatever transpires for patient and family. Insofar as you risk making mistakes due to lack of expertise, you risk hurting not only your client, but also the profession of art therapy, which suffers as much as you from your potentially tarnished reputation. Conversely, if you have the patience and wisdom to work under supervision until your skills and understandings are really well-honed, then you will carry with you into the more public arena of independent practice a sound reputation and the opportunity to enhance the lives of those you treat, as well as the image of the discipline you practice.

That is, in brief, my very subjective perspective on the mid-life "coming of age" in which I am currently absorbed. My first, more adolescent "coming of age" had to do with professional identity, with finding the other swans—as in THE UGLY DUCKLING—with discovering a life's work that suited so well, that fit my innate capacities and met my deepest longings. Since I happened upon art therapy in my mid-twenties, already married and well into mothering, I remember the intensity of the conflict between fulfilling my maternal/nesting needs and responsibilities, and the pull of this all-absorbing and full-filling work. I "solved" the conflict by working part-time until I could resist the pull of the work no longer, and rationalized that my children were still getting enough of me. In retrospect, I am sorry that I didn't postpone that shift a few more years, since I now feel that I didn't get enough of *them*.

Continuing to use my own experience as a guide, I should like now to look more closely at some possibly common elements in the development and coming of age of an individual art therapist, and then at some developmental themes in the coming of age of both the professional association (AATA) and the discipline itself.

Like many art therapists in pre-association days, I began my work in a state of something akin to professional AUTISM, or at least isolation. Actually, I had discovered the possibility of such work at the invitation of one of my dearest mentors, a child psychologist named Margaret McFarland. She encouraged me to use art with hospitalized schizophrenic children, to share my work with sympathetic colleagues like Fred Rogers and Erik Erikson, and to explore in all my naiveté how to reach these lonely youngsters through the creative process. Like Winnicott's "good enough mother," Dr. McFarland provided a warm and supportive "holding environment." She was available for symbiotic nurturance in the early stages, and later for all of Mahler's stages of separation-individuation: for hatching and practicing and rapprochement, and the achievement of a kind of libidinal object constancy. I have often turned to her at critical times in my life, grateful for that gleam in her mother-mentor's eye, so vital to the developing human's sense of self. I was fortunate to have a father-mentor as well at a later stage of professional growth, a psychoanalyst and child psychiatrist named Marvin Shapiro, who guided my development as a clinician with a loving but always-firm hand, and who helped to point me in the direction of psychoanalytic training, which has been incredibily helpful.

Early on, in these and other relationships, I—like most neophytes—was predominantly ORAL, taking in hungrily and insatiably information, ideas, and experiences in the therapeutic use of art. At a certain point, I had reached a kind of ANAL phase, in that I needed not only to become

". . . private practice in art therapy . . . should not be undertaken until the practitioner has reached a rather high level of sophistication and expertise."

more separate and independent of my mentors, but also to both hold on to and let go of ideas. And it was then that I think that I got the most pleasure out of the making of creative products, and presenting them to others. This led into a phase of PHALLIC exhibitionism and delight in what I could produce, which I did in profusion: talks, papers, films, presentations, research projects, service programs, and the like. In the middle of writing this paper I had to proof a recently revised curriculum vitae, which has gotten embarrassingly long. I confess that I felt fatigued just reading it, and remembering those years of hyperactivity bordering on mania. I suppose that much of that "INDUSTRY" (á la Erikson) took place during what I might term my professional LATENCY. It was certainly a time of intense involvement in learning and training, including the study of adult and child psychoanalysis at an analytic institute, a doctoral degree at a university, and the writing of my first book.

Engaging with my peer group, I became very involved in work with this association, first as a member of the Nominating Committee, then as Bylaws Chair, then as President-Elect and then as President. Six years on the Board; six very busy years of work for AATA, two of them requiring that I officially represent art therapy to the outside world: consulting to the Task Panel on the Arts & Environment of the President's Commission on Mental Health, serving on the Board of the National Committee, Arts for the Handicapped, and planning for a conference hosted by the American Psychiatric Association which led to the birth, eventually, of the coalition of all creative arts therapy associations of which we are now a part—NCATA. These were years of great activity, much of it in relation to AATA and art therapy. While demanding, it was also exciting and exhilarating to participate in and help to guide the maturation of our association and our discipline. I like to think of the latter years of this phase as my professional ADOLESCENCE, not only a time of redefining and refining my personal identity, but also of doing so as a part of the field with which I so strongly identified.

And now I find myself in MIDDLE ADULTHOOD, turning more and more toward clinical work as a source of stimulation, challenge, and pleasure in helping folks to get better. And, for the first time in my professional life, I'm actually getting paid well for what I do. Although money never mattered much to me, not enough to demand an appropriate salary, being a full-time practitioner has required me to charge for my time in a new and more explicit way. I still feel a bit uncomfortable about the whole billing-fee-collecting process, and I wish my math and record-keeping skills were better. But, despite all the discomfort, I also feel excited at being able to do work which is such fun, and so thrilling, and which feels so good when people improve, which they do most of the time, and—on top of that—to be so financially richly rewarded as well. That is like icing on the cake of the pleasure provided by the work itself.

I don't know if I have yet "come of age" in any finished sense. Rather, it feels like my professional development has been a series of "comings" at different ages and stages. I'm even thinking now about the possibility of retiring when my husband does, perhaps in only five years, so that we can do some of the travelling I so enjoy without worrying about leaving patients. When I think of retirement, I think of ending the practice part of my work, and having free time to do lots of other things—like working on films and tapes and books, or accepting the tempting invitations I've had to refuse to teach in some lovely part of the world. I also love doing those other things, and now I don't really have the time. And maybe I would even return to my own painting, the one thing that has felt like a sacrifice during all this professional hyperactivity. I don't honestly know what direction I'll be going in five years from now. But I do suspect that, just as this time of the empty nest at home has stimulated changes for me, so my husband's retirement will do so as well. And, of course, there will be yet another coming of age, this time OLD AGE.

But there, the parallels with art therapy end, because only part of my own journey holds true. Unlike an individual life, the life of a discipline is potentially limitless. It will, I hope, continue to increase in sophistication and depth, as well as in application and scope. It is such a good thing—art therapy—that it deserves to grow. But even good things need good nourishment and care, and practitioners who know what they're doing and what they're talking about in order to make it in this competitive world. Happily, many of the young people I have met, the art therapists of the future, have impressed me with their sincerity and with their "smarts." I think you need both to be a good art therapist, along with a healthy capacity to play and to create—to be in that illusionistic, transitional sphere of patient and therapist, of artist and lover alike.

Thoughts on the Development So Far of Art Therapy and of AATA

In trying to take a wider perspective and reflect on the development so far of our field and our organization, I first came to the conclusion that as a profession, art therapy has grown with impressive speed since it was first born through the pioneering work of such individuals as Mary Huntoon in the Midwest at the Menninger Foundation, and Margaret Naumburg in the East at the New York State Psychiatric Institute. The literature, quite meager when I first encountered it as a graduate student in 1957, has literally mushroomed, and has gone from sparse to substantial in the three intervening decades. Training programs, standards of education and of practice, a code of ethics, all of the necessary components of professionalism—have been developed and mechanisms for their enforcement put in place.

Art therapy is now more often known than unheard of, the reverse of the situation just 23 years ago when I began to do it. And, not only has the field become increasingly more sophisticated, expanding in depth as well as in breadth, it is increasingly well-regarded and respected, also in contrast to the situation a short time ago. I well remember discussions with intelligent people like Joan Erikson, in which it became clear that her opposition to art therapy was based only partly on her concern about losing the healing quality of art by over-analyzing product or process; but also on her experiences of seeing shoddy clinical work done by people who called themselves "art therapists." While this is still possible, the situation has improved significantly, through the work of this association in developing and enforcing increasingly rigorous standards.

Ironically, while the discipline has traversed its "adolescent passage" fairly smoothly, its disciples—the people who have worked hard to create and sustain the professional association—have often been collectively vulnerable to an adolescent kind of turmoil, with rumblings of unresolved issues at earlier developmental levels. True to what is well known about the dynamics of groups, most people in the association, even those involved in some of the "sturm und drang," are quite sensible and mature individually.

In our growth and development we have, at times, encountered "tumultuous" events. It seems that we had a hard time giving up splitting as a defense under stress, and were all too ready to label people or groups as all-good or all-bad when tension was high. Perhaps we had not fully resolved what Mahler called the "RAPPROCHEMENT CRISIS." Maybe that happened because some of our impressive professional parents had a hard time letting our toddler-selves separate when we were ready; or maybe it was because we were unable to handle the overwhelming ambivalence which seems to be an essential part of that process. We also seemed vulnerable to OEDIPAL concerns, in the sense that issues of Inclusion and Exclusion were a frequent source of tension in the group from the inception of the organization. The greatest pain seemed to come from people or groups feeling left out and/or unappreciated. Egos were often bruised or wounded.

Yet somehow, in spite of all this turmoil, we managed to negotiate an organizational LATENCY, a time of intense learning and of hard work on important tasks, both within the group and in relation to the outside world; learning how to deal with political and economic realities, as well as how to better run our household. But, as with those latency-age children needing treatment, we did so at some cost, because of the fixations and regressions born of unresolved conflict. Perhaps the most painful time was the period through which we passed some years ago, which often made me think of Freud's hypothesis in TOTEM AND TABOO about the need of the children to rebel against the parents, and even—in primitive fashion—to attack them.

When Margaret Mead went to Samoa at age 23 to do her famous fieldwork, she wanted to prove that her mentor, Ruth Benedict, was correct about what was then called "cultural determinism." She found, in *COMING OF AGE IN SAMOA*, that adolescence there was not turbulent as in the West, but relatively smooth and peaceful, and triumphantly announced that she had proved the theory of those anthropologists who saw development as determined more by nurture than by nature. In 1983, an anthropologist named Derek Freeman from Australia shocked the academic world by publishing a reassessment of Mead's work, her findings, and her conclusions, titled: *MARGARET MEAD IN SAMOA: THE MAKING AND UNMAKING OF AN ANTHROPOLOGICAL MYTH*. Some have seen the book as an attack on the Great Mother of cultural anthropology. Freeman, however, did not view Mead as consciously distorting her data, but merely as a victim of her attachments, her biases, and the teasing reports of her young Samoan informants. These adolescent girls told her what she wanted to hear, which she then reported to her teacher, Franz Boas. He also wanted to hear about a "negative instance" of adolescent upheaval, in order to support cultural determinism, in which he and Benedict believed most deeply.

There is an interesting connection, it seems to me, between our painful coming of age in AATA and the Mead-Freeman findings. Because, thank heavens, even during some of the most confusing times, there is also—in Samoan adolescents and in AATA—growth and development. And there have been substantial periods of considerable group cohesion and task-oriented behavior, like the present one. To use Bion's terms, there were times when we behaved more like a "BASIC ASSUMPTION GROUP" than as a "WORK GROUP," but at other times we worked together well. Just as there were both genuine harmony and hidden tensions in Mead's Samoa, our occasional eruptions of passion have represented only a small part of the actual functioning of AATA over the years.

Having spent six years on the AATA Board, I can truthfully state that the energy spent in constructive work was much greater than that spent in destructive rivalries. I speak not only for myself, but for most of the colleagues who served with me during that period and, as far as I can tell, the same overall state of affairs has existed before and since

". . . our internal "coming of age" will help us to clarify our identity as a discipline, and will facilitate our ability to be effective in the outside world."

that time. However, while some may argue that conflict is both inevitable and even healthy, I found it frustrating that any of our energy should have been drained in unproductive directions; we really do need all of it, in order to work effectively on the many tasks required for the continued development of both the field and the organization. I confess I have felt especially sad that, because these tensions have so often surfaced at public meetings (at least in the first ten years), the image presented to our professional children—the students and budding practitioners who are the future of the field—has sometimes been a distorted and disturbing one. A significant sign of our organizational "coming of age" has been an increased ability to control and contain our passions in public, to behave with the respect and dignity we owe each other.

There was a time when we would have been good candidates for "association family therapy," had there been such a treatment. Since there did not exist a family therapist who would have wanted to take on a group like ours, we simply had to do it ourselves. So far, the improvement seems to be fairly stable. One of our continuing challenges as an association is to use the discipline we exercise with patients and with colleagues in other fields as we deal with each other. The goal is not to become identical or in any way to deny our differences, but to air them freely, to be secure enough to allow disagreement, debate, and the open exchange of ideas. In this way differences, tensions, and conflicts can be not only expressed but also resolved, as we struggle to integrate and synthesize the rich diversity of individuals who make up the AATA. Hopefully our internal "coming of age" will help us to clarify our identity as a discipline, and will facilitate our ability to be effective in the outside world. Fortunately, like many a family that squabbles at home, we have always been able to behave with greater dignity in public.

On reflection, several psychodynamically flavored thoughts occurred to me about why our coming of age may have been at times so stormy. First, it may be related to who we are. For we are artists as well as therapists, and share with other creative people that peculiar "flexibility of repression" (Freud) which allows us to "regress in the service of the ego" (Kris). Perhaps that is one of the reasons why we have been more vulnerable to group regressions than seems to be the case with other associations. And maybe it has been more apparent among us for similar reasons: that we, as artists, are freer to express our deepest passions, freer to let them show (while other groups both need and are able to hide them better). For, though it may be true that some of our internal struggles had to do with people and power, they also had to do with passionately held convictions about art therapy. This openness to both regression and expression, while it may be one source of our vulnerability to stress, is also a major source of strength in us as individual therapists, and as joint creators of a professional identity.

We do seem to have passed from an earlier stage of the wholistic incorporation or introjection of mentors to one of more mature, selective identifications. As our own identity as art therapists has developed and become more secure, our earlier chameleon-like need to be the same as more established groups has diminished. We are clearer about who we are, how we are similar to and different from other disciplines. We are becoming more comfortable about what we can contribute, and are less often either grandiose or overly modest. We are more comfortable, in other words, with our potential effectiveness, as well as with our very real limitations.

Similarly, we do seem less prone to seeing issues in black-and-white terms, and more able to view them in shades of gray, to integrate good and bad in regard to ourselves and others and, secondarily, in relation to our varied ideologies and methodologies. And, like the growing child, we have moved from early tendencies to view competition as dangerous and potentially annihilating, to seeing it as stimulating and fruitful, leading to new syntheses and integrations in our thinking and in our work.

Perhaps our rapid expansion has also been a source of vulnerability, as in a youngster whose social and emotional maturity has lagged behind physical and intellectual growth. Some of our awkward periods may have been accentuated by our need, coming as much from outside reality pressures as from internal strivings, to grow up too fast. Though we felt ready, for example, like some adolescents who leave home prematurely, to leave the nest of a management firm, we discovered that we were not really ready for setting up housekeeping quite that independently. We did, of course, as with all crises, learn a great deal from that experience.

As then President Sandra Graves pointed out in her opening remarks for the conference at which this paper was delivered, we know how to be therapists, but we don't know much at all about being managers or business-persons. Part of our recent maturation as an organization has come from having to painfully acknowledge our limitations in that area, and to accept the fact that we need to depend on and work with others who know more about such affairs than we do. Perhaps it is akin to my own distaste and incompetence in housekeeping, which long ago led me to work at what I love and pay someone else to do the cleaning. I feel no need or desire to acquire Mrs. Lee's expertise as a scrubber and duster, any more than I can imagine wanting to be an expert statistician or computer programmer. I much prefer to rely on the expertise of others I can trust in such realms. Perhaps such a model may represent an appropriate state of organizational housekeeping for AATA as well; only time will tell.

Periods of transition in normal development are marked by some degree of upheaval and disorganization, which seem to be necessary components of growth. Similarly, I'm convinced that if there is no resistance (in the unconscious sense) at some point in therapy with a patient of any age, there is also probably not much change going on. It *does* often get worse before it gets better. So maybe what we've been through is expectable and even necessary, and maybe it was an index of some unresolved issues, as I've suggested. In either case, there's no question that it has helped us to "Come of Age."

One reason I know we are coming of age is that we have experienced some of what Judith Viorst calls *NECESSARY LOSSES*, like those members who can no longer be with us, whose wisdom and inspiration and guidance we miss mightily. I think of wonderful people like Hanna Kwiatkowska, who, though gone, lives on through her book, *FAMILY ART THERAPY AND EVALUATION* . . . or Elsie Mueller, who has been unable to attend our annual reunions for a number of years, but whose sensibility, fairness and balance are also remembered as a model of mature behavior. We have also lost much of our youthful naiveté, as well as some of our earlier grandiosity. People and places and ideas are less often idealized and are viewed more realistically. We no longer need to be rebelliously different from other mental health professionals or slavishly imitative.

But we have not lost our belief in the power of art to speak the language of the soul, or in our ability to "work playfully and play seriously," as Edith Wallace has urged. Just as I felt rather self-indulgent in so much self-focus at the beginning of this paper, so I now feel equally self-indulgent in being able to share these personal hypotheses with you all. Like many in our field, I feel immensely fortunate to have found in art therapy such a wonderful way to do work which is so rewarding. Thank you very much for inviting me to indulge myself in sharing this highly subjective perspective on Coming of Age. I am very excited, as I hope you are, about the years to come. For, if my analysis is at all close to the truth, we should, in the near future, be entering upon our professional PRIME OF LIFE.

MARYLHURST COLLEGE

Graduate Program in ART THERAPY

A two-year clinical training program leading to a Master of Arts degree in Art Therapy. Flexible scheduling including part-time study is available. Applications for admission in September, 1988 are due in March, 1988.

Learning opportunities are also available for non-admitted students.

Art Therapy Program
Marylhurst College*
Marylhurst, OR 97036
(503) 636-8141, ext. 379

*Marylhurst College is twenty minutes from mid-town Portland, Oregon.

Master's Degree Programs in Expressive Therapies and in Creative Arts in Learning

**Offered by the Institute for the Arts and Human Development
Lesley College Graduate School**

Master of Arts in Expressive Therapies

For students interested in the creative modalities of art, music, dance/movement, and drama, presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning

For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theater studies.

For more information call or write the Institute for the Arts and Human Development, Lesley College Graduate School, 29 Everett Street, Cambridge, MA 02138-2790. (617) 868-9600, ext. 480.

Lesley College
GRADUATE SCHOOL

Lesley College is an Equal Opportunity Affirmative Action institution.

BEST COPY AVAILABLE

REVIEWS

Family Art Psychotherapy: A Clinical Guide and Casebook

***Helen B. Landgarten,** Brunner/Mazel, 1987, 299 pages, $27.50*

*Reviewer: **Shaun McNiff, PhD ATR.** Dr. McNiff is a Professor of Expressive Therapy and Dean, Institute for the Arts and Human Development at Lesley College, Cambridge, Massachusetts.*

Helen Landgarten has written a book which makes the most important single contribution to advancing the practice of art therapy with families. The author, grounded in both the practice of art therapy and family therapy, integrates the two naturally. Family art psychotherapy is described so effectively, and with such depth, that it appears to be a discipline unto itself rather than a combination of art and family therapies. Family therapists who read this book will see how art expands the therapeutic process and constantly surprises clients and therapists with its manifestations. Perhaps they will begin to imagine how they might begin to introduce art to their practice. The book will also inspire more art therapists to work with families and expand their psychotherapeutic identities.

Family Art Psychotherapy follows Helen Landgarten's highly regarded *Clinical Art Therapy* (1981) in its vivid descriptiveness of a varied collection of therapeutic experiences. What impresses me most about the book is the absence of personal and theoretical bias. Landgarten is pre-eminent in her pragmaticism and commitment to a straight-forward practice of art psychotherapy.

After a brief theoretical overview of family therapy models and a demonstration of how to conduct a "family evaluation," the author begins her presentation of comprehensive case materials. The book is essentially composed of seven studies of families which are described with a refreshing absence of jargon. An art assignment, or task-oriented approach, is used in all of the cases. I found that the activities were designed in a way that moved the families into serious dialogue within what appeared to be a limited amount of time. The use of art consistently circumvented the avoidances and resistances that can obstruct the therapeutic process. The range of experiences embodied by the cases gives an illuminating description of the problems which confront the contemporary American family together with an indication of the author's professional breadth. Each case is a chapter unto itself: Family Crisis Intervention for a Molested Child; The Family in the Midst of Divorce; Therapy for a Family with an Encopretic Child: Long-Term Treatment; A Single-Parent Household: Issues of Abandonment and Masked Depression; Intact Family with an Acting-Out Adolescent; Three Generation Treatment for a Terminally Ill Grandparent.

The extensive nature of the case materials suggests how art therapists can conduct descriptive research. The chapter reviewing the author's work with an "Intact Family with an Acting-Out Adolescent" chronicles a total of twenty-eight family sessions with two adolescent girls and their parents. Therapy was mandated by a court order resulting from the older daughter's motor vehicle violations. After many disparaging statements expressing his discomfort with, and distrust of, art therapy, the father began to realize that he was "getting his 'money's worth.'" After the seventh session, he said: "Who would think that art therapy would help people?" As the therapy progressed, the father and the entire family became serious in their respect for both the therapist and the art therapy process. At the end of the therapy, and as a vehicle of termination, they do successful role plays as art therapists.

The author also presents what she considers to be one of her treatment "failures" in another family's "flight to health." The tone of the book is modest and the value of art therapy with families is established through the continuity of the author's work through a variety of situations.

The theme of "separation and loss" runs throughout each case study while the identification and transformation of these feelings are the subtle, and quietly stated, philosophy of *Family Art Psychotherapy*. Children in the family scenarios are separating from parents in order to become themselves and this process is accompanied by emotional confusion because our society is without passage rites which clarify, express, and validate these changes. In other situations parents and children are separated from one another through divorce and abandonment and in the book's last chapter, death is imminent.

In art therapy there is creation in response to loss and this corresponds to the dynamics of healing. The pain of separation motivates the intimacy of the psychotherapeutic process. Separation and loss are close to the essence of artistic action and perhaps this can help us to understand why it is so therapeutically helpful. Art plays out the opposition between connection and independence. The emergence of the self requires isolation and the destruction of old dependencies. The ache of separation and loss deepens awareness. In *Psychoanalysis and the Unconscious,* D.H. Lawrence described the emergence of individual creativity as a "revolt from connection. . .the sharp clash of opposition." He felt that creative transformation cannot take place without "this dual circuit of direct, spontaneous, honest interchange."

In addition to the book's articulate commitment to individual families in crisis there is also an unspoken dedication to the institution of the family in what we now see as an epoch of radical change. The family, in a collective sense, suffers from the separation from, and the loss of, its historic continuities. From this destruction and opposition a new culture is emerging. For twenty years at Cedar-Sinai Medical Center in Los Angeles Helen Landgarten has helped families to adjust. Her inspirational practice of family art psychotherapy, documented vividly in this volume, provides us with the clarity and sustenance that will be needed to renew the eternities of family life.

Approaches to Art Therapy: Theory and Technique

***Judith Aron Rubin, Ph.D., ATR, HLM,** New York: Brunner/Mazel, 1987, $30.00.*

*Reviewed by **Michael Campanelli, Ed D, ATR,** Assistant Professor of Art Therapy, Wright State University, Dayton, Ohio 45435.*

This book is just what many art therapists have been waiting for. It is a notable effort to collect and describe theories that have been promulgated by distinguished experts in the art therapy field. The text highlights various ways in which art therapy has been conceived and presents each unique art therapy approach as equally feasible for conducting therapy. Each theory is described using its own theoretical terminology, and procedures are delineated with all the specificity that the most pragmatic art therapist might need.

The range of theoretical and clinical information presented in this volume makes it a useful tool for art therapists planning treatment programs, for mental health professionals using art in their work, and for instructors of art therapy. A theory is presented, its concepts examined, and a case example using the specific approach for illustration is given. Because of the skillful integration of illustrated case material into the presentation of each theory, the conceptual underpinnings of the various approaches are persuasively outlined. Therapists with varying amounts of experience will find the book's format valuable for handbook and reference purposes.

This text is important not only because it provides guidance for using a variety of models for clinical application, but also for its contribution to the continued development of the profession. Diverse orientations are well documented, and the concluding section successfully unifies rather than fragments ideas and practices. The result is the creation of a gestalt of the art therapy field where each theoretical framework is a component of equal merit.

The book is separated into four sections; each contains a series of chapters devoted to broadly defined areas of psychotherapeutic treatment. The first section deals with psychodynamic approaches that include Freudian Psychoanalytic Theory, Jungian Analytical Psychotherapy, and the more contemporary developments in psychoanalytic theory. Each of these is presented as having a direct impact on art therapy theories and practices.

In the first chapter, Rubin gives us some historical perspective on art therapy's roots, starting with Freud's insights regarding unconscious communication through dream imagery. The early growth of art therapy as a profession is then traced to Margaret Naumburg's incorporation of Freudian concepts into the first formal theory of art therapy. This chapter illustrates how the practice of art therapy can serve to bring unconscious conflicts to the surface through spontaneous art expression and free association to the images that emerge.

The next chapter is written by Edith Kramer, who elaborates upon her specific perspective on the value of art therapy (i.e., art as a healing act adjunctive to the therapeutic process). Featured in this discussion is an in-depth exploration of the role of sublimation in the treatment process, valued for its capacity to reduce instinctual tension and to enhance a sense of social position. Although Kramer has published previously on this topic, it is still fascinating to reread her ideas, particularly the discussion of the processes in lower species that are analogous to sublimation in human behavior. In concert with Kramer's view is Laurie Wilson's chapter on the importance of the symbolic process. In Wilson's view, symbolization is an ability that is fundamental to almost all civilized activity.

The chapters by Arthur Robbins and Mildred Lachman-Chapin are based upon theories emerging from more recent studies of early psychological development. Robbins deals with interpreting art therapy treatment within an object relations frame of reference, recommending the utilization of this framework for specific client populations such as the borderline personality. In Robbins' view, art serves as a mirror of early internal deficits in relatedness, and art therapy offers a unique way of providing the missing link to complete unfinished object relations.

Self-psychology as promoted by Lachman-Chapin is recommended for the art therapist working with the client who has a narcissistic personality disorder. Lachman-Chapin believes self-psychology to be congruent with an art therapy approach since art can satisfy narcissistic needs and relies on empathy for its appreciation. It should be noted that the chapters of Robbins and Lachman-Chapin, although informative and stimulating, might be ponderous for beginning art therapy students and practitioners not already familiar with the formulae on which the approaches of Robbins and Lachman-Chapin are based.

Espousing the importance of the image as a central focus of treatment are Edith Wallace and Michael Edwards. Both use a Jungian frame of reference in their practice of art therapy. The image in art therapy is viewed by these authors as having a life of its own. This allows the client to have an imaginative dialogue with images where both the therapist and the client link the imagery to archetypical structures inherent within them. Wallace's discussion of the process of active imagination is particularly helpful in understanding how the art therapist can assist the client in drawing out images from the unconscious.

The section on humanistic approaches to art therapy (as presented by Rose Garlock, Mala Betensky, Janie Rhyne and Joseph Garai is a striking contrast to the psychodynamic theories in the previous chapters that emphasize the deterministic view of human behavior. The authors in the later chapters focus on the "whole person" and believe that our psychological makeup consists of more than just past experiences. These contributors contend that each of us plays an active part in creating who we are. The emphasis here is on enhancing optimal functioning rather than simply alleviating distress. Each of the authors identifies with a different trend in the human potential movement. Rose Garlock developed a program predicated on the theories of Alfred Adler. Garlock uses Adler's ideas of a therapeutic social club, with art therapy having a major place in the program structure. She expands the creative potential of each client while simultaneously creating a sense of community. Her model incorporating Adlerian theory into an art therapy prescription for treatment is innovative and useful for application by other art therapists. The Phenomenological Approach (Betensky), the Gestalt Approach (Rhyne), the Humanistic Approach (Garai), have been detailed in other more extensive works. However, Rubin's linkage of these specific theories has enabled us to see the commonality of thought among them. Drawing upon these approaches, the art therapist helps the client experience himself or herself fully in the here-and-now. As with previous chapters, the case study material assists the reader in visualizing the procedures of each therapeutic model and in understanding its application.

Chapters 12, 13 and 14 are organized around more directive art therapy approaches. Presented in this section is a compilation of many of the concepts emanating from theories that concentrate on the objective assessment of overt behavior. These chapters broaden the range of the art therapy application in addressing the needs of the severely disabled person. In institutional settings, these approaches might be the art therapy treatment of choice, since they are in harmony with the prevailing methodology applied (i.e., the focus on specific behavioral change through the manipulation of a therapeutic situation).

The first chapter in this section (Chapter 12) is by Ellen Roth who combines traditional art therapy techniques with behavior modification principles. Her unique contribution in the implementation of behavior modification through art therapy involves "reality shaping." Rawley Silver, a second contributor, uses a cognitive approach to art therapy to assess cognitive and creative skills. Silver's vast experience using assessment techniques that she developed has enabled children with perceptual and learning difficulties to advance beyond a dysfunctional stage. Susan Aach-Feldman and Carol Kunkle-Miller utilize an approach in working with the multiply handicapped, stemming from perspectives that are grounded in developmental principles.

They present specific directions for the adoption of a developmental assessment protocol. Procedurally, their method is well defined and can be easily adapted to a variety of settings. These authors highlight the importance of the art therapist setting goals and evaluating movement towards these goals while considering a wider set of treatable conditions than would ordinarily be taken into account.

The last section of the book is of exceptional value. It presents models of art therapy synthesized from distinctly different styles of thinking and working. This section opens with a chapter by Elinor Ulman who has integrated the orientation of Kramer and that of Naumburg into her own theory of art therapy. Ulman's candor is impressive in discussing her struggles to discover an art therapy perspective that is in tune with her own "authentic self." Echoing Ulman's view is Harriet Wadeson who, in her chapter, offers us a model for devising an eclectic style of working. Believing that personal and professional growth depend upon a creative selection and synthesis of approaches, Wadeson discourages the art therapist from adhering to any single theory. Her case examples guide the reader in intelligent use of a variety of theoretical concepts when employing an eclectic strategy.

In the concluding chapter Rubin leads us further into a consideration of the designing of one's own style of work through theory selection. She covers such important issues as recognizing when a bias towards a theory might be self-serving, concealing the art therapist's own unconscious conflicts, and the pros and cons of mastering one single model and using it well versus the mastery of a variety of models. Also included in this chapter is a survey of the views of many notable art therapists on the nature of theory. The conception of theory that evolves from this survey is one that appears to perceive available styles of therapy as a collective wisdom upon which to build one's own personal theory, combining and transforming concepts from major approaches to create new ones. This chapter is penetrating in helping the reader realize that the principles of theory are not static, but are dynamically interactive with the art therapist's personal characteristic and the variety of clinical circumstances that the art therapist encounters.

Approaches to Art Therapy: Theory and Technique is an impressive body of work reminding us that the art therapy field is a pluralistic one providing a range of art therapy models. Rubin helps us to realize that although each art therapy approach necessarily has its own unique quality, they can be complementary and there can be convergence among these many methods. No doubt, as the art therapy field matures, new methods will be discovered and we will watch the expansion of the synthesis germinated in this book.

"Perpetual Arts Relaxation Tape #2"

This videotape (VHS, 30 minute) is available for purchase or rental. For additional information please write to: Perpetual Arts c/o Mr. Alma Bulkley, 9848 Wimbleton Drive, Sandy, Utah 84092, Telephone: (801) 942-8459.

Reviewed by ***Michael Campanelli, EdD, ATR,*** *Assistant Professor, Art Therapy, Wright State University, Dayton, Ohio 45435.* ***Judith Millman, CRC,*** *Manager, Office of Vocational Rehabilitation, 1139 Hylan Blvd., Staten Island, New York 10305.*

Watching this video is like gazing at fish in a tank. There is movement in a fluid fashion with an added component of filtered light to give it an illusory effect. There is no clear static definition of space or form, just frame upon frame of dramatic changes in color—very saturated reds, greens and yellows progressing to softer blends of pastel oranges, pinks and blues.

To accompany the color changes there is electronic music that echoes the fluidity and movement in the visual forms. The music is devoid of traditional harmonic structure, melody and counterpoint. These ambiguous sounds and forms have a calming effect on the viewer. The colors and sounds blend in a pace suitable to contemplation.

The video is 30 minutes long. The text is four quadrants with a continuing variety of color themes. The themes are abstractions containing no narrative or recognizable beginning, middle or end. The "new" structure can be disorienting at first because we are conditioned to expect a linear progression of logical sequences. Once we get past this expectation we are drawn into the moods created by intriguing sights and sounds.

The colors are vivid often resembling a watercolor being painted. The highlights of the images presented are frames that mirror brilliant tones. These tones then fade into soothing reflections that may then be perceived as (perhaps) a sunset, or a seascape, or other content.

There are many possible therapeutic applications for this video. Clearly it could be used as a relaxation technique prior to a session to help clients acclimate themselves to the therapy setting. As a motivational device it could be used by those who have their creativity blocked. Art therapy clients are sometimes unable to allow imagery to naturally emerge in a session; because of the "fluid nature" of the video, forms and shapes one wants to recall may be more accessible. This tape could facilitate the kind of communication the client must engage in to have dialogue with himself or herself and one's art therapist. In addition, individual segments could be used as part of a projective technique stimulating associations with visual content.

The video could also complement a movement therapy session. For example, the client could be asked to focus on one square of color and physically respond to the variations. The therapist and client could then explore the client's responses to determine how the color changes parallel the client's inner world. Using this video with movement would be ideal if projected onto a large screen where the shapes and forms would not only be a stimulus but would create an environmental effect.

Two populations that come to mind in considering clients who could benefit from this video: the child who is autistic, and the child with learning disabilities. An autistic child attracted to visual stimuli might be easily engaged by this video's content. Exposure to the variety of colors and their changes could serve as a non-threatening introduction to a hands-on art experience. While noticing which segments gather the child's attention, the therapist could elaborate upon these segments in a selected art activity. Since the video is relaxing, one could use it as a subliminal conditioning tool with the learning disabled child who is hyperactive. With each session, the therapist might gradually slow down the pace, attempting to acclimate the child to a calmer setting.

It is recommended that this video be used judiciously with certain populations. Because of its potential hypnotic effect, therapists should use caution when showing it to severely disturbed clients. The video might also not be appropriate for individuals with seizure disorders. The changes in light and color could stimulate a convulsive attack. Nor would it be suitable for individuals who are visually impaired. One should have visual acuity to benefit wholly from the nature of this video.

This video tape is both stimulating and useful in the form in which it is presented. It serves its purpose as a relaxation device and easily lends itself to adaptations for individualized art therapy treatment programs. The art therapist is encouraged to view the tape and to experience the forms, colors and sounds as they move in-and-out of the immediate space, and to think creatively of the many possible uses of this tape in clinical sessions with individuals and groups. It is a valuable resource for the therapist, both personally and professionally.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:
Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

VIEWPOINTS

"Door at Abiquiu-November 25, 1986"

Maxine Junge MSW, LCSW, ATR, *Associate Director and Assistant Professor, Graduate Department of Clinical Art Therapy, Loyola Marymount University, Los Angeles*

She thought sometimes
She no longer lived within the confines
of her own skin
But in some never-never land of betwixt
and between.
Permeable boundaries
Of yes/no, where/why
Being born and dying.

Lately: upon approaching the ends
Of sidewalks, she noticed she could not
Step forward into the street
To cross with the light
Without a palpable wave of panic.

Edges of paper or of feeling
Newly attracted her
And she found herself leaving broad white margins,
Watching
the lines and forms and colors of the evolving image
huddle together in an immaculate
Safe space bounded on all sides by emptiness.

She remembered Georgia O'Keefe's
Obsession with the black door
In the house at Abiquiu
Which she painted again and again for thirty years.
And she thought O'Keefe had also
struggled with the
Beckoning paradox of threshold as
The invisible line between before and after
The knife edge between
relationship and isolation, fullness in the void,
symbol and mystery, known and unknown,
attachment within individuation,
sanity and insanity.

In the prolonged act of noncompletion
there is the promise.
In the prolonged act of noncompletion
there is the beginning.
In the prolonged act of noncompletion
there is the constancy.
In the prolonged act of noncompletion
there is the going on.

Though bound to that doorway,
O'Keefe would not cross over until the
day at age 98 in the warm spring of 1986
When she died.

In November, she awoke one night
After a dreamless, fitful sleep
And came downstairs at two a.m.
To sit at her littered desk amidst
the house's luminous silences and watched
As the black-felt-tip penned words flowed avidly
from her fingers like blood from a secret wound,
They sliced onto the yellow-lined pad.
Were crossed out to start again.
And lines accumulated, one onto the next and the
next until
Moving slowly, slowly, finally, they filled the space
to its ends.
And she found no comfort in the act.

She took two valiums
Round like yellow moons and
Lapsed, into black sleep.

Clarification

In the last issue of *Art Therapy*, Vol. 4, No. 3, October, 1987, an article was published titled "Diagnosis and Assessment: Impact on Art Therapy," by Ellen G. Horovitz-Darby, MA, ATR. In this article there were references to the Bender Gestalt Test and the House-Tree-Person Test, among others. It has been called to my attention that a clarification should be made relative to the formal tests of each of these (both the Bender Gestalt and the House-Tree-Person)—the formal tests can be administered only by an art therapist who is also licensed in clinical psychology.

Editor

BEST COPY AVAILABLE

New from HUMAN SCIENCES PRESS

Blatner, Adam, M.D., and Allee Blatner

THE ART OF PLAY

An Adult's Guide to Reclaiming Imagination and Spontaneity

Third Edition

This book is about playfulness, that particular point in play when imagination and spontaneity begin to add some degree of elaboration, style and originality. Readers will gain a sense of mastery over relaxing, enjoyable and exploratory forms of play, making the enacting of roles with others an especially rewarding and important occupation. An extension of informal, creative dramatics—or what child development specialists call sociodramatic play—adapted for adults, *The Art of Play* demonstrates how this kind of imaginative, improvised enactment can be a potential source of artistic recreation.

"You have written a fine, original, and important book in ***The Art of Play****. It is, indeed, the best book of its kind principally because it not only makes sense, is clearly and understandably written, but above all is literally a practical handbook in the science and art of play. It is a book that will be immediately helpful to all who read it because at every step of the way you give the underpinning for the practice of play in its many various applications. It is bound to have a wide audience, and will establish itself as a fundamental contribution to the practice of everyday life."*

—Ashley Montague

"...most valuable as a broadly based look at theory, benefits and potential uses of sociodramatic play in promoting the growth of both individuals and society." —Dramascope

1987 **176 pp. (approx.)**
0-89885-355-9 **hard $26.95**
0-89885-359-1 **paper $12.95**

JOURNAL OF POETRY THERAPY

The Interdisciplinary Journal of Practice, Theory, Research, and Education

Sponsored by the National Association for Poetry Therapy

Editor: Nicholas Mazza, Ph.D.

Emerging from the tradition of the arts and psychotherapy, this interdisciplinary journal is devoted to the use of poetics in health, mental health, education and other human service settings. The *Journal* welcomes a wide variety of scholarly articles that focus on (1) an appreciation and strategic use of language in therapy, (2) poetic approaches involving metaphor and imagery, (3) the use of published poems and lyrics, (4) creative writing, and (5) the incorporation of various literary forms, audiovisual aids, and other bibliotherapeutic materials. Theoretical, historical, clinical, descriptive and evaluative studies will be emphasized.

The scope and special features of this journal include original articles, a research and clincial exchange column, news and notes, a column compiling a list of poetic resources to use in practice, book reviews, abstracts of current literature, and original poetry. The *Journal of Poetry Therapy* is the first periodical designed to meet the needs of the clinician, researcher, educator and professionals concerned with the therapeutic value of poetry, literature, and other related creative arts.

Quarterly Vol. 1, 1987-88 **ISSN 0889-3675**
Order JPTH-D **personal $30.00***
Order JPTH-F **institutions $70.00**

* If paid by personal funds for personal use.

20% discount to members of the National Association for Poetry Therapy

Robbins, Arthur, Ed.D., A.T.R.

THE ARTIST AS THERAPIST

Based on the author's thirty-four years as a sculptor, art therapist, psychologist and psychoanalyst, this informative text explores the role of the art therapist in integrating aesthetics and psychodynamics into the therapeutic process. Areas covered include: the use of materials; varying developmental issues in different diagnostic categories; actual clinical cases; the importance of therapists' utilization of their own inner experiences in the development of theories; and the principles of art therapy.

1987 **266 pp.**
0-89885-322-2 **$29.95**

Morrison, Morris R., Ph.D., editor

POETRY AS THERAPY

Foreword by Roger J. Williams, Ph.D.

"A superb collection of papers dealing with a special dimension in psychotherapy, poetry, proving once again that fine therapy and fine poetry have a remarkable affinity. A book to gladden the heart, the senses and the mind."

—Harold Greenwald, Ph.D.
President
Division of Humanistic Psychology
American Psychological Association

1987 **229pp.**
0-89885-312-5 **$29.95**

HUMAN SCIENCES PRESS, INC.
72 FIFTH AVENUE
NEW YORK, N.Y. 10011-8004 (212) 243-6000

Books sent on 30 day approval
No postage & handling on prepayment
Payment with U.S. Funds only.

Orders: 1-800-44-**HUMAN**
(have credit card information ready)

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

All classes of membership receive the following: Bylaws, Code of Ethics, Membership Directory, Newsletter, *ART THERAPY, Journal of the American Art Therapy Association*, discounts on publications, discount on admission to the annual conference, as well as pertinent information about research, insurance, and other matters of interest.

Membership should not be confused with Registration (ATR). Registration is bestowed only by the Professional Standards Committee. For application procedures and information about Professional Membership and Registration, contact the AATA National Office.

Associate Membership shall be open to individuals interested in the therapeutic use of art wishing to support the purposes and objectives of the Association. Associate members shall be entitled to receive all official and affiliated publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office or serve on a committee.

Annual Dues: $50

Student Membership shall be open to students taking courses in art therapy, art, psychology or who are interested in the field. Student members shall be entitled to receive all official and affiliate publications of the Association and to attend the annual meeting, but shall not have the right to vote or hold office. Student members shall be eligible to serve on the Student Affairs Subcommittee of the Membership Committee. **Applications for student membership must be accompanied by a copy of current ID.**

Annual Dues: $35

Contributing Membership is open to individuals, organizations, institutions, or foundations which contribute annually to the Association.

Annual Dues: $100

Professional Membership is by application only and is open to individuals who have completed professional training in art therapy and who are or have been engaged in the therapeutic use of art. Professional members are eligible to participate in all activities of the Association and receive all official publications. A professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $75

Credentialed Professional Membership is by application only and is open to individuals who have met the qualifications and been approved for Professional Membership and have been granted Registration (ATR) by the American Art Therapy Association, as set forth in Standards and Procedures for Registration. Professional members are eligible to participate in all activities of the Association and receive all official publications. A Credentialed Professional member shall be eligible to vote and hold office. *Contact the AATA National Office for an application.*

Annual Dues: $80

Make checks payable to AATA

American Art Therapy Association, Inc.
505 E. Hawley Street
Mundelein, IL 60060
(312) 949-6064

NAME ______________________________
LAST FIRST MIDDLE

PREFERRED MAILING ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________________

OTHER ADDRESS

____
STREET

____
CITY STATE ZIP CODE

PHONE ______________________________

TITLE ______________________________

EMPLOYER ______________________________
INDIVIDUAL OR INSTITUTION

HIGHEST EDUCATIONAL DEGREE ______________

☐ $ 50 **Associate Membership**

☐ $ 35 **Student Membership**
(copy of current ID required)

☐ $100 **Contributing Membership**

☐ $ 75 **Professional Membership**
(by application only)

☐ $ 80 **Credentialed Professional Membership**
(by application only)

Payable in U.S. Dollars

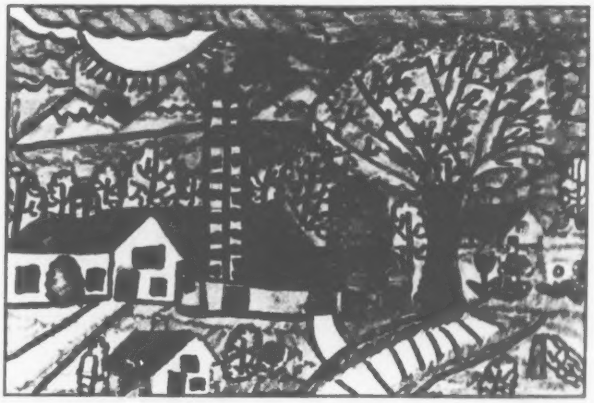
Dues and expenses related to participation in AATA may be tax deductible as a business expense.

RETURN THIS APPLICATION WITH YOUR REMITTANCE

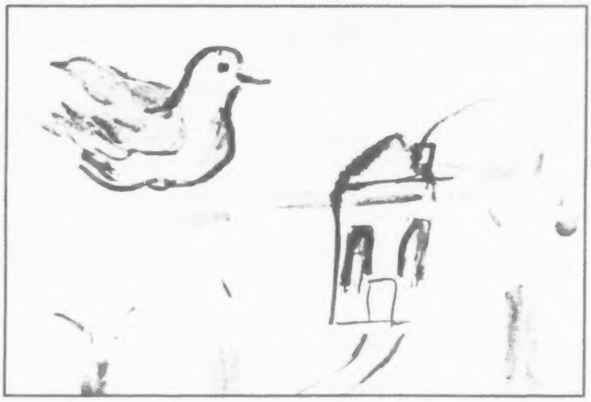
BEST COPY AVAILABLE

Art Therapist's Portfolio

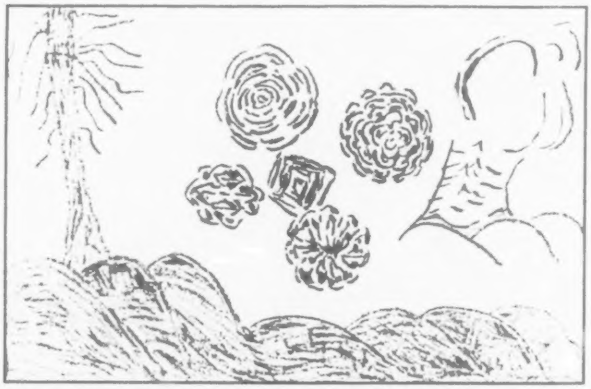
VIEWPOINTS provides a forum for sharing ideas and graphics about issues facing art therapists. It also encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit black and white glossy photographs and four copies of the written material to: ***Viewpoints,*** ART THERAPY, *505 E. Hawley St., Mundelein, IL 60060.*



"THE FARM"—drawing by a 14 year old gifted child (*Wright State University Art Therapy Clinic*)



Painting by an adult woman in art therapy. (*Wright State University*)



Painting by a 57 year old schizophrenic man. (*Wright State University*)

CHARLES C THOMAS • PUBLISHER

New! **FUNDAMENTALS OF ART THERAPY** *by* **Shaun McNiff.** Written in a dialogue format, a major portion of this text discusses questions raised by an art therapist in training. Topics examined include the nature of art, animism and art, archetypal imagery in children's art, theory as creation, diagnostic labels, killing and resurrecting the father, art as dreaming, and eros and image. Throughout the presentation, the author maintains that interpretation is not only fundamental to art therapy but that therapy is itself a process of interpretation. *'88, $34.75*

New! **THE PSYCHOCYBERNETIC MODEL OF ART THERAPY** *by* **Aina O. Nucho.** The first half of this book presents a detailed account of the origins and rationale of art therapy. Then it focuses on the actual therapeutic process of the psychocybernetic model which combines the verbal/analytic and the visual/imagistic symbol systems. The author describes ways to introduce clients to visual forms of expression, the actual "doing" phase, decoding the visual imagery, termination of treatment, and the scope and effectiveness of the model. *'87, $34.50*

VISUAL ARTS AND OLDER PEOPLE: Developing Quality Programs *by* **Pearl Greenberg.** This lucid text provides the background and knowledge necessary to understand and appreciate older adults as artists and to develop quality visual art programs. Chapters explore retirement, gallery and museum programs, art for disabled older people, adult learning, art hazards, and art appreciation. Diverse art mediums are covered including collage, drawing and painting, clay and construction, fabric printing, and weaving. *'87, $30.25*

ACTIVITIES FOR CHILDREN IN THERAPY: A Guide for Planning and Facilitating Therapy with Troubled Children *by* **Susan T. Dennison** *and* **Connie K. Glassman.** More than 200 fun and creative activities are presented for professional use with children between the ages of five and twelve. These ideas cover relationship building and self-disclosure, affective awareness and communication, social skills, school, termination, and follow-up. *'87, $32.75*

EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession *by* **Shaun McNiff.** This comprehensive study explores the interdependence of diverse training traditions, and it reviews the various areas of concentration, such as art or music therapy. Specific competencies and different philosophies are examined, but their commonalities are emphasized. Chapters are also included on an artistic theory of mental health and on supervision and evaluation. *'86, $32.75*

THE ARTS AND PSYCHOTHERAPY *by* **Shaun McNiff.** An integrated approach to all of the arts in psychotherapy is presented in this insightful book. The author examines the distinctive and common qualities of the various expressive arts in relation to psychotherapy. He also draws on the statements of artists to develop a psychology of art that views artistic exploration as psychological research of the highest order. *'81, $21.75*

We fill all orders promptly • Books sent on approval
Postage paid on MasterCard, Visa & prepaid orders
Write or call (217) 789-8980 • Catalog sent on request

2600 South First Street
Springfield • Illinois • 62794-9265

MIAMI®

NEW DIRECTIONS IN THE 80's

AMERICAN ART THERAPY ASSOCIATION, INC.

18th ANNUAL CONFERENCE

ON AUDIOCASSETTE TAPES

NOVEMBER 4-8, 1987 BAL HARBOUR, FLORIDA

AMERICAN ART THERAPY ASSOCIATION, INC. 18TH ANNUAL CONFERENCE WAS PROFESSIONALLY RECORDED BY **INFOMEDIX**. AUDIOTAPE COPIES OF THE PRESENTATIONS ARE AVAILABLE BY MAIL ORDER. **PLEASE CHECK THE BOX BY THE TAPES YOU WISH TO ORDER.**

PROGRAM No. AT 292

- ☐ **AT292-1AB** $18.00 (2 tapes) — **A Brief Moment in Time,** B. Gonzales-Dolginko
- ☐ **AT292-9** $9.00 — **CLINICAL TRACK - PAPER: Adolescence and Family Art Therapy,** S. Riley
- ☐ **AT292-12** $9.00 — **WORKSHOP: Art Therapy as a Preventative Intervention: Use in Nuclear Age Education,** E. Speert
- ☐ **AT292-14** $9.00 — **RESEARCH TRACK - PAPER: A Jungian-Based Study of Selected Visual Constructs Preferred by Women,** D. Arrington
- ☐ **AT292-16** $9.00 — **REHABILITATION TRACK - PANEL: Using the Creative Arts for the Older Adult to Meet Individual Needs,** M. Bunnell, D. Hoffman, G. Jungels, G. Williams
- ☐ **AT292-19** $9.00 — **WORKSHOP: Beyond the Band-Aid: Effective Short Term Group Art Therapy with Adult Psychiatric Patients,** P. Isis
- ☐ **AT292-22** $9.00 — **EDUCATIONAL TRACK - PANEL: The Role of Creativity in Art Therapy Education; Transference to Clinical Work,** C. Malchiodi, M. Cattaneo, P. Allen, E. McNeil
- ☐ **AT292-25** $9.00 — **CLINICAL TRACK - PAPER: Expressive Group Psychotherapy with Adolescent Boys: I am Bad, Explosive, Abandoned!** D. Jones
- ☐ **AT292-28** $9.00 — **WORKSHOP: The Underside: Fascination/Revulsion,** H. Wadeson, R. Marano Geiser
- ☐ **AT292-29AB** $18.00 (2 tapes) — **GENERAL SESSION - KEYNOTE SPEAKER: The Prediction of Acting Out Eruptions Via Projective Drawings: Assaults, Suicide, Homocide, Rape and Exhibitionism, etc.,** E. Hammer
- ☐ **AT292-30** $9.00 — **CLINICAL TRACK - SYMPOSIUM: STRUCTURED ART THERAPY PROGRAMS: Pathway Towards Spontaneity and Autonomy for the De-Institutionalized Client,** R. Koppelman; **Structured Inpatient Art Therapy: Framing Goals and Groups,** D. Conger
- ☐ **AT292-33** $9.00 — **GENERAL SESSION: Social Applications of the Arts,** R. Ault, G. Barlow, M. Junge, Moon
- ☐ **AT292-34** $9.00 — **PROFESSIONAL ISSUES TRACK - PANEL: The Other Art Room: Art Therapy in the Schools,** J. Bush, D.L. Burchett, E.S. Garber, P. Isis, M. Hamilton, K. Knuth, L.J. Pfeiffer, I. Platz, R. Taulbee
- ☐ **AT292-36** $9.00 — **RESEARCH TRACK - PAPER: The Use of Drawings in Determining Sexual Abuse,** N. Sidun, D. Chase
- ☐ **AT292-37** $9.00 — **WORKSHOP: Images of Wellness: Chronic Pain and Art Therapy,** R. Halperin-Eaton
- ☐ **AT292-38** $9.00 — **CLINICAL TRACK - PAPER: The Art of Interpretation,** S. McNiff
- ☐ **AT292-39** $9.00 — **RESEARCH TRACK - SYMPOSIUM: ASSESSMENT THROUGH ART THERAPY: Evaluation of Family Structure Through Kinetic Family Drawings - Children from Alcoholic Families,** A. Gardano, B. Sobol; **Comparative Study of D-A-P and Life Size Body Drawings in Assessment of Child Abuse,** C. Malchiodi
- ☐ **AT292-40** $9.00 — **THEORETICAL TRACK - SYMPOSIUM: ART, HEALTH AND SELF ESTEEM: A Health Based Theory of Art as Therapy,** P. Allen; **Art, Process and Self Esteem,** M. Franklin
- ☐ **AT292-44** $9.00 — **PICTORIAL COMMUNICATION TRACK - PAPER: Rene Magritte: Psychoanalytic and Other Perspectives,** E. Handler Spitz

BUY 6 TAPES GET THE 7th FREE!
BUY 12 TAPES GET THE 13th & 14th FREE!

*** The sessions above are a partial list. For a complete list please contact InfoMedix.**

☐ COMPLETE SET **AT292**...SAVE 20%.. **$152.00**

Total No. of Cassettes Ordered ____________

Purchase orders accepted for purchases of $100.00 or more.

Foreign orders: Add 10% surcharge of subtotal for additional shipping & handling.

TOTAL PRICE: $ ____________
SUB TOTAL: $ ____________
SHIPPING & HANDLING: $ ____________
Please enclose $1.00 for the 1st tape and $.50 for each additional tape (Max. $7.00)
TOTAL AMOUNT ENCLOSED: $ ____________

SHIP TO: NAME ____________
ADDRESS ____________
CITY ____________ STATE ________ ZIP ________

Charge my ☐ Master Charge ☐ VISA ☐ Americal Express (Personal checks also accepted)

ACCT. NO. ____________ CARD EXPIRATION DATE ________

Please Allow 4 to 5 weeks for delivery

FOR FASTER SERVICE
Please have your credit card number ready and call
TOLL FREE 1 800 367-9286 (In California) 1 800 992-9286

InfoMedix
THE SOURCE FOR INFORMATION

Signature ____________

12800 Garden Grove Boulevard • Suite F • Garden Grove, California 92643-2043
(714) 530-3454

BEST COPY AVAILABLE

MIAMI®

18TH ANNUAL CONFERENCE PROCEEDINGS
1987 BAL HARBOUR, FLORIDA

The 1987 AATA Conference Proceedings, "New Directions in the 80's" held in Miami, Florida, November, 1987, are available through the AATA National Office in abstract form.

—●—

PRICE PER COPY:

Member - - - - $15.00 each   Non-member - $20.00 each   10 or more - - $12.00 each

QUANTITY ______ x COST ______ = TOTAL ______

SEND TO:

TO ORDER COPIES: Mail order form ▶
along with payment to:

● American Art Therapy Association,
505 E. Hawley Street,
Mundelein, IL 60060.

Please make checks payable
in U.S. funds to AATA.

NAME/INSTITUTION ______ MBR ID.# ______

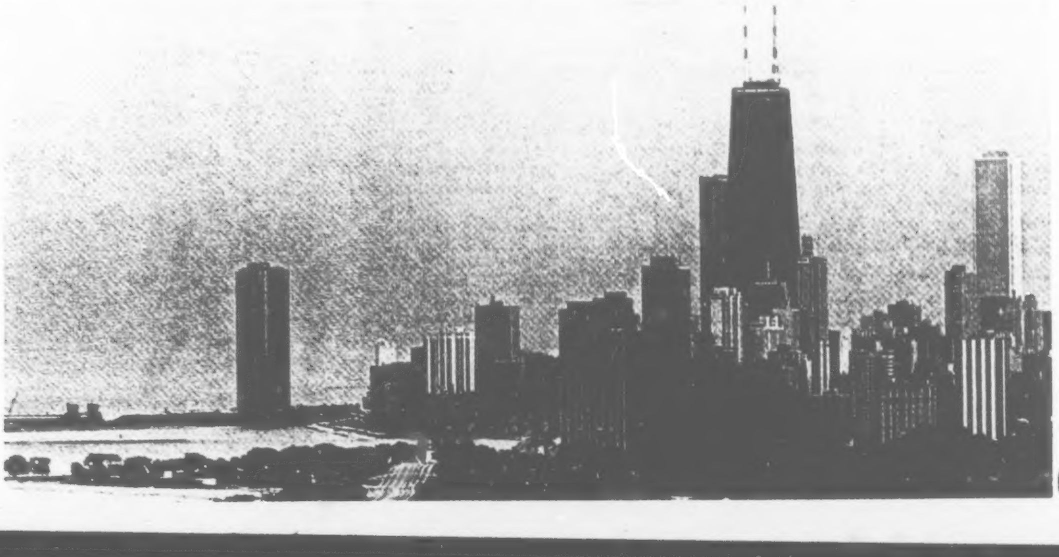
ADDRESS ______

CITY ______ STATE ______ ZIP CODE ______

TELEPHONE ______

19TH ANNUAL CONFERENCE
THE AMERICAN ART THERAPY ASSOCIATION
PRESENTS:
"PROFESSIONALISM IN PRACTICE"

TO BE HELD: NOVEMBER 16-20, 1988
PALMER HOUSE, CHICAGO



ART
THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 505 E. Hawley St., Mundelein, IL 60060

Please enter my subscription for 1987. Enclosed is my check, payable to AATA, for $23.
Name ____________________
Address ____________________
City __________ State ______ Zip ______

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

TAKE ADVANTAGE OF THIS SPECIAL OFFER!

SUBSCRIBERS TO *Art Therapy* and Members of American Art Therapy Association
ENJOY REDUCED RATE!

SUBSCRIBE NOW—AND SAVE 50% OR MORE! *The Arts in Psychotherapy* is a quarterly journal in its 14th successful year of serving practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologist that reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy, THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.

Submit papers in triplicate to Managing Editor, Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583

TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

Pergamon Journals, Inc., Maxwell House, Fairview Park, Elmsford, N.Y. 10523 AATA
Please enter my subscription for Vol. 14, 1987 ☐
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume

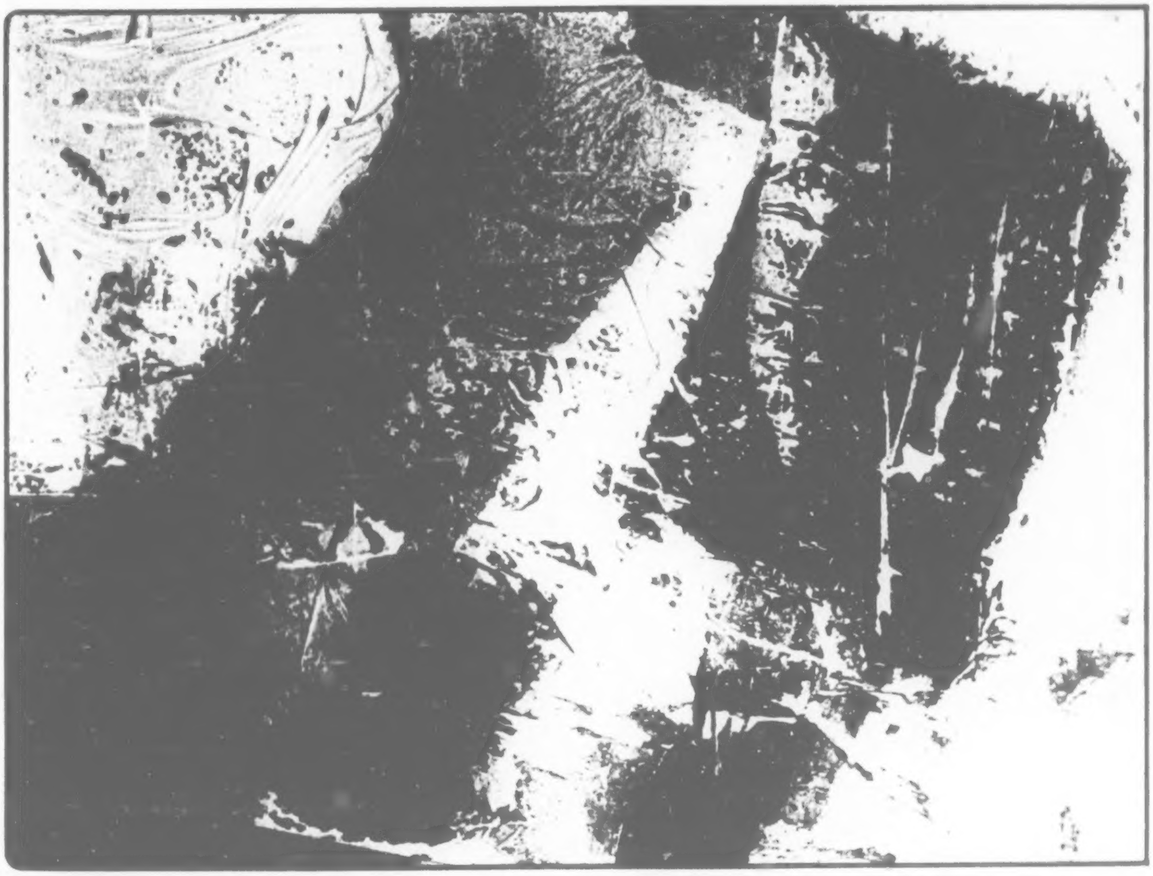
For subscriptions outside U.S. (except Canada) add $2.25 annual postage. Payment must be in U.S. funds.

Name ____________________
Address ____________________
City __________ State ______ Zip ______

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association



Volume 5, Number 2 July 1988

- Adolescence and Family Art Therapy: Treating the "Adolescent Family" with Family Art Therapy
  Shirley Riley, MA, ATR, MFCC
- Creative Process/Therapeutic Process: Parallels and Interfaces
  Cathy A Malchiodi, MA, ATR
  Mariagnese K. Cattaneo, PhD, ATR
- Art Therapy Assessment of Coping Styles in Severe Asthmatics
  Robin Knight Gabriels, MA, ATR

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1988-1989

Board of Directors

President
Cay Drachnik, MA, ATR, MFCC

President-Elect
Linda Gantt, MA, ATR

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, PhD, ATR, MFCC

Committee Chairs

Affiliate Chapters
Virgil Matheny, ATR

Bylaws
Roberta J. H. Shoemaker-Beal, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Cathy A. Malchiodi, MA, ATR

Publications
Pat B. Allen, PhD, ATR

Research
Harriet Wadeson, PhD, ATR

Standards
Doris Arrington, EdD, ATR, NCC

Clinical
Paula Howie, ATR

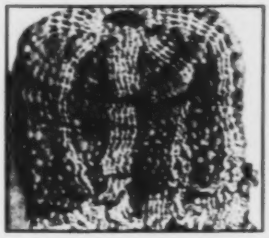
Executive Director

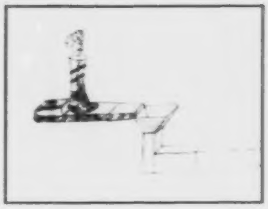
Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association





Editorial

Gary C. Barlow, EdD, ATR 42

Articles

Adolescents and Family Art Therapy: Treating the "Adolescent Family" with Family Art Therapy
Shirley Riley, MA, ATR, MFCC 43
Creative Process/Therapeutic Process: Parallels and Interfaces
Cathy A. Malchiodi, MA, ATR
Mariagnese K. Cattaneo, PhD, ATR 52
Art Therapy Assessment of Coping Styles in Severe Asthmatics
Robin Knight Gabriels, MA, ATR 59

Reviews

August Walla
Leo Navratil
Roland Fischer, PhD 69
The Psychocybernetic Model of Art Therapy
Aino O. Nucho, PhD, ATR
Connie E. Naitove, ATR 71

Viewpoints

Passion in Art: Miracle Department
Harriet Wadeson, PhD, ATR 72
Portfolio 75

Volume 5, Number 2 July 1988

About Our Cover

A collage by an adult in the Art Therapy Clinic, Wright State University, Dayton OH.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Aina O. Nucho, PhD., ATR, ACSW
Brief Communications
Ruth Obernbreit, MA, ATR
Film Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Marcia May-Chambers

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Susan LaMantia O'Connor, MA, ATR
Paul Rodenhauser, MD
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064

Copyright © 1988 American Art Therapy Association

BEST COPY AVAILABLE

EDITORIAL

"Adolescence and Family Therapy," by Shirley Riley, MA, ATR, begins with the statement that "conducting therapy with a family which includes an adolescent child is always a challenge." Riley identifies these challenges within the sections titled "Treatment Dilemmae; Developmental Concerns; Environmental Factors; Assessment; and Setting Goals and Treatment." Her brief case examples speak directly to some of the problems within this therapeutic context, and point the way to some resolution. The case study "expressions" offers insight for the art therapist who might be working with family art therapy, and especially with those cases that involve the adolescent family factors.

Co-authors Cathy A. Malchiodi, MA, ATR, and Mariagnese K. Cattaneo, PhD, ATR, offer the article titled "Creative Process/Therapeutic Process: Parallels and Interfaces." As they point out "Art therapists have constantly reexamined the relationship of creativity to therapy and have differing views on that relationship." Malchiodi and Cattaneo offer insights relative to personal artistic production through the creative process, and the relationship to art therapy and the creative process.

Another article is titled "Art Therapy Assessment of Coping Styles in Severe Asthmatics," written by Robin Knight Gabriels, MA, ATR. This focuses on a particular condition of which there have been few articles, research or investigation in art therapy literature. As art therapists, we need to pay particular attention to our methods and approaches with persons who have identifiable diseases that have "been around" for long periods of time. What have we done in the past (in some cases we have done very little!) and what might we be doing presently and in the future? What is the current research in the field relative to these particular illnesses? This article helps us to focus on some approaches used by an art therapist.

We are pleased to be receiving an increased number of manuscripts from our professional members and others. However, this increase in numbers does contribute to some delay in publishing one's article; some of you might have been concerned with this delay. Perhaps it is time once again to briefly review the process. As each article comes into the Editor's office, a note of correspondence goes to the author informing him/her of the receipt of the article. It is imperative that a style be followed, in the writing of the article, for consistency and practicality of publishing. We have adopted the A.P.A. *Manual* as our guide (the full title is the *Publication Manual of the American Psychological Association*, 3rd ed., 1983, with revisions: 1984) published by the A.P.A., Washington, D.C. This informative manual is a total reference guide to publishing, writing, referencing, and the many other specifics involved with getting an article (or book, manuscript, etc.) into print. The reference style is particularly useful for the art therapist/author and should be noted carefully.

If the article is correctly submitted (i.e., A.P.A. style; abstract included; references clear; photographs labeled and in order; illustrations clear and titled; etc.) then the article is ready for review. If these things are not evident, then the article is delayed. For the article ready for review, it is not unusual for it to take a bit of time; full reviews and perhaps minor rewrites that may be suggested do require time for consideration. If there are major corrections needed, then it will take longer. Please remember that the A.A.T.A. publishes its journal three times a year. Therefore, for an article that is received and reviewed, the earliest that it could be published would be, normally, two issues in the future at the minimum; for many, it would require a longer period of time. An exception to this time frame would be invited articles, or perhaps a quicker time period for a thematic issue.

This delay is not uncommon in professional journals that begin to build a solid reputation; although I have received information only from an informal random sample, I would say that the average length of time for the various journals is approximately one year, although one of our sister professions has a waiting period of at least two years (average) or longer. You, however, can help in this manner: be absolutely certain that you follow the format ("Guidelines for Authors") found in the journal. This will help tremendously in the entire process.

Speaking of submitting to *Art Therapy*, how about some of you writing for "Viewpoints"? What issues do you need and wish to express? What ideas do you have regarding philosophical concerns, or methods of delivery, or art therapy assessment, or clinical documentation? Do you have some graphic images that you would like to share, or a poem that is appropriate for our pages? Send them in for consideration. We'd like to hear from you.

As mentioned in our last issue, our new Book Review Editor is Aina O. Nucho, PhD, ATR, ACSW. I'm sure that she would also like to hear from you regarding any new books that you think should be reviewed in *Art Therapy*. Drop her a note with your suggestions. If we all work together, this journal can only become an even stronger voice for our profession.

For those of you who are heading into a summer vacation, I hope that it is pleasant and enjoyable. For those whose vacation is over, I trust that it was a good one. Let's all look forward to an exciting autumn, and remember: our Conference is just around the corner! Start "talking it up" and let's all meet in Chicago in November.

Gary C. Barlow, Ed.D., ATR
Editor, Art Therapy

Adolescence and Family Art Therapy: Treating the "Adolescent Family" with Family Art Therapy

Shirley Riley, MA, ATR, MFCC, *Faculty, Loyola Marymount University, and Family Art Therapist, Didi Hirsch Community Mental Health Center, Los Angeles, CA.*

Approaches to setting goals for treatment of the family in therapy are discussed relative to the following categories: 1) references to treatment examples; 2) treatment dilemmae; 3) developmental concerns; 4) environmental factors; and 5) assessment. Three case examples ("Art Therapy Expressions") are included that illustrate art therapy with the family members. The "adolescent family" is discussed with a focus on the delay in development and suggesting a series of interventions pointing the way to healthy functioning in the present and the future.

Introduction

Conducting therapy with a family which includes an adolescent child is always a challenge. With a family of this configuration, the therapist anticipates confronting an additional component of resistance to treatment. This stance is expected since a non-complaint attitude is syntonic with the teen-age developmental process. The expectation is reinforced by the knowledge that all members of a family system are normally resistant to change, since they fear that any modification of their familiar patterns may be a threat to maintaining the family unit. However, even greater difficulties are experienced when we therapists are presented with a troubled family where both teen-ager and parents are functioning on an equal adolescent level.

Treatment Dilemmae

Family treatment is built on the premise that there are techniques that will start a process toward symptom reduction by interrupting malfunctioning patterned behaviors. However, in assessing this "all adolescent" family I find more questions than answers when it comes to exact technique and applied family theory.

One treatment approach with parent/child dysfunction is to establish hierarchical boundaries, shore up the adult strengths of the parent, attend to the child subsystem and other structural maneuvers (Minuchin, 1981). With the family wherein the adult has not reached an adult psychological development, we find that these agents of change are not particularly effective. It would be useful to examine how the family art therapist can construct a treatment plan that is tailored to meet the needs of this developmentally delayed family.

Developmental Concerns

To better understand the difficulties involved in treating a family which I will call the "adolescent family," it is necessary to start by briefly re-examining the basic process of adolescent development.

When puberty thrusts the child toward the next step in physical growth, a simultaneous intrapsychic realignment also becomes effective. This change is called adolescence. In this process the youth must give up attachments to parental figures and their protective position. Adolescents turn their attention to the unexpected, uncomfortable changes they are experiencing physically and in their perceptions of themselves. (Mirkin, Koman, 1985)

Detachment from the primary adults of childhood and the single-minded focus on self is recognized as the "narcissistic stance" of adolescence. (Blos 1962) Particularly in the pre-adolescent and early adolescent child, eleven to fourteen years approximately, the pervasive feeling of emptiness and the constant introspective attention to self, limits the available empathy or interest which may be shared with another person. It is recognized that a move from a strictly narcissistic involvement to the capacity to care for another is one of the essential tasks accomplished during the adolescent developmental period. (Carter, McGoldrick, 1980)

Unfortunately many persons falter on the way to achieving the goal of empathic caring and remain at an earlier emotional stage. This is a period when it is next to impossible to expect the youth to be a "giving"

> ***". . . many persons falter on the way to achieving the goal of empathic caring and remain at an earlier emotional stage."***

"The single parent factor compounds the challenge found in conducting treatment."

person since the capacity for demonstrating caring feelings for another person has not yet been achieved. (Malmquist, C., 1978) Now, if we consider the problem of a psychologically delayed adult becoming a parent, we wonder how will that person be able to give protection and nurturance to a child when he or she is still viewing the world from a narcissistic viewpoint? Younger children of these adolescent-adults fare more or less well during childhood if they maintain rigid defenses and if environmental demands are not excessive. Youngsters are unable to express their unmet needs clearly. However as this same child moves into adolescence, where rebellion and resistance to parental authority is the name of the game, the real struggle begins. We now have a situation where both parent and child are attempting to gain sole attention for themselves, giving little or nothing in the way of empathic understanding to the other. Both child and adult are experiencing emptiness and distress which often is handled through impulsive actions that serve as a distraction from the pain. This unfortunate developmental parallel in parent and adolescent child requires a specific series of therapeutic interventions aimed at encouraging maturation in the adult while simultaneously keeping the adolescent child moving along his or her developmental path as normally as possible. This is easier said than done.

The family system referred to above is reminiscent of the environmental and systemic background of the borderline adolescent which is delineated so eloquently by Masterson (1972). The grave consequences of failure by the adolescent to achieve separation and autonomy is described by him in this manner: "The passage of time presents these unfortunates with inevitable life tasks and thereby faces them with truly a Hobson's choice: to avoid the challenge of growth, marriage, and parenthood with the consequent loneliness and suffering that this entails or to take on the challenge though emotionally ill-equipped. Should they opt for the latter they receive the additional dividend of becoming an appalled and helpless eyewitness to the repetition of their own unresolved problems in their children." In these borderline families written about in 1972, the family was often described as headed by an aggressively active mother who resists the child's desire for individuation in answer to her own needs for fusion, and a passive, distant father who encourages this symbiosis. Masterson and others have, since then, relieved the mother of full responsibility for the pathology and modified this dynamic.

There is another very common malfuntioning family system that interferes with child development: the alcoholic or violently abusive family system, where most often the visible pathology is demonstrated by the father. The dependent role in this pattern is taken by the mother.

Many patients recall their own childhood as one where the fathers were either violent or alcoholic or both - a homelife where they were unprotected by mother and triangulated into the parental relationship. These abused children, who are now parents, often engaged in heavy drug or alcohol abuse during their own adolescence which added to their developmental failures. In all the cases described above, it is the adolescent youngster who is delegated by the family to attract attention and gain therapeutic treatment by engaging in various acting out behaviors. (Stierlin, 1979) Once in therapy, I have observed the parent and child expect the therapist to provide quick answers and prompt symptom removal. Contrary to treatment expectations, resistance is not encountered when the family first accepts professional help. It is demonstrated later when the parents feel reluctant to relive painful depressive periods of the past.

When considering an approach to treatment, the configuration in these "adolescent families" that is so fascinating is the mixture of strengths and weaknesses. As in normal adolescent development there exists the overriding component of narcissism, but one can also find idealism, creativity, intellectualization, and other qualities that may be encouraged to achieve a more adult solution to problems. In addition, these families often fall in a grey area of diagnosis. Although they suffer from having borderline or abusive parental backgrounds, they were given just enough caring from some related source to give them a notion of "how it might have been better." (Winnicott, 1976)

Environmental Factors

These "adolescent families" are frequently headed by a single parent. Traditionally, these clients have separated from a mate, whose behavior reproduced similar stress patterns they had experienced in their family of origin. However, contrary to the notion that this pattern is fated to be reproduced again and again, in many instances the mother or father is *cognizant* of the repetition and determined *not* to make the same mistake again. Although the awareness of patterns of the past may be used protectively, it may lead to an additional difficulty for the children. The adult, rather than risk failure, often withdraws from peer-friendships and looks to the adolescent child for companionship. This closeness enhances the diffusion of boundaries between parent and child and promotes symbiosis.

The single parent factor compounds the challenge found in conducting treatment. The therapist cannot piece together strengths of two parents to create a composite executive position from which the adolescent child can either rebel or find protection. Too often the teenager moves into this unfilled role left by the missing parent and is thus deprived of healthy rebellion. The drive to separate continues, but since it is directed against the self (in the substitute parent-role), it turns into self-destructive acting-out behavior.

An additional dilemma in treating these adolescents in family therapy is the realities of the community mental health setting in which they are seeking help. The constriction of time and frequency of treatment must be a serious consideration. Obviously an ideal effective manner of conducting therapy for these developmentally damaged persons is not always possible in a one hour, once a week, short-term contract. Since contact is limited, we must cautiously offer the type of therapy that can be helpful within these restrictions and not attempt to remove defenses or weaken coping mechanisms that are serving a positive function. A systemic/strategic theoretical approach is designed to focus on strengths, reframe behavior and achieve symptom relief within a time limited frame. Therefore, I feel it is the most successful theory to utilize with the families described above. (Riley, 1985)

I will show by case illustrations some of the art therapy techniques to which "adolescent families" seem to have been responsive and which have resulted in a positive outcome for treatment.

Assessment

The presenting picture of the confused, frustrated parent and the defiant, rebellious adolescent is one that is painfully common. The description of the problem that brought them into the clinic does not provide sufficient clues to understand the underlying cause of the behavior. However, if the therapist observes (during the joining phase of the family art therapy), an unusually prolonged competitive struggle being enacted between adult and child, the hypothesis of mutual adolescence should be considered. To explore this possibility further, the art therapist instructs the family to engage in a mutual art task providing an arena for an enactment of the suspected behavior.

Often, the behavior seen by the therapist during a dual drawing demonstrates the diffusion of authority. The parent and teenager vie for attention. They may both draw or refuse to draw, grab for the same color pen, or the parent may defer to the directions given by the child rather than the therapist; these actions together with the messages conveyed in the art product, suggest that there is little adult functioning in this family.

After continued observation, an assessment is made of how the family patterns repeat themselves. If it is established that this is a family where both parent and child are developmentally in adolescence some strategic moves are necessary.

Setting Goals and Treatment

The first goal is to create within the parent an image of competency. This will enable the parent to face the normal trials of raising an adolescent. To accomplish this goal the therapy turns its focus on the parent and momentarily neglects the child and his/her symptoms. If necessary, the counselor invents strengths in the adult's character and, paradoxically, the adolescent will experience relief. Shifting the system will not be an easy achievement, since the family members, (both parent and child) are accustomed to supporting each other in an egalitarian position in the hierarchy. However, the parent gains satisfaction and approval from others by acting more in charge. They will continue to change, and thereby gain narcissistic rewards in an appropriate manner.

Unfortunately there often seems to be such a paucity of ego strength in these individuals, that the therapist must turn to a variety of techniques to achieve the treatment goals. Cloe Mandanes (1981) speaks of how she helps a client to play-act, or *pretend*, to behave in a proscribed manner. In this case a parent is coached how to *pretend* to be an efficient and effective adult. Following this experiment in effectiveness, the client will test if the child can perceive the difference between the farce and reality. The hope is to start a feedback loop where, as the parent "pretends" to provide structure for the family, a welcome release from stress will result. With the positive reinforcement of better family function, the behavior is likely to be retained and integrated as part of the "real" self. "Adolescent parents" feel less threatened if they are told that *they only have to pretend to be grown up for the short period of their child's adolescence.*

In the early stages of treatment, the therapist more openly attends to the parent while still supporting the teenager. The alliance is productive for several reasons: 1) when the therapist aligns with mother and/or father the process leads to the parentified or symptomatic child feeling less needed is free to be a teenager; 2) as freedom to be an adolescent is

---

". . . the art therapist instructs the family to engage in a mutual art task providing an arena for an enactment of the suspected behavior."

---

experienced by the youth the need for acting out behavior is reduced; 3) the child actively participates in art therapy but the main attention is deflected from him, thus age appropriate resistance is diminished; 4) it is more difficult to assist a developmentally-delayed adult through the growth process than aid the child who is doing a similar task on time. The results: as the art therapist helps the parent gain maturation, the teenager finds it possible to achieve a more appropriate relationship with the parent.

To further the attainment of individuation art therapy productions are suggested which allow the client to observe past patterns of the family of origin and observe if they continue to function in the present. Seeing a parallel between past and present maladaptive relationships provides essential information which leads to the desired change. The therapist when reviewing old behaviors makes use of positive connotation, thereby creating a new reality and transforms present perceptions. By observing his or her problems represented in the art therapy, the client may develop and utilize an ego observer. The skill of monitoring one's own behavior is one of the major tasks of adolescence, and an important step toward realizing the goal of maturation for the parent and child.

Brief Case Examples

Shamar, a Caucasian 13-year-old, entered treatment with her mother and younger brother, in spite of the fact that she did not feel she had any problems. She was getting satisfactory grades, she ran the family efficiently, directed her mother's relationships, and parented her younger brother competently. In contrast to Shamar's grandiose perceptions of herself, the mother, Joanne, was filled with anxieties. She tearfully admitted being unable to set rules, oppose her daughter, or enjoy her boyfriend, because Shamar did not approve. The parents were divorced for eight years; however, the father was very active in the family and intruded at will. Mother complained "he bosses me just as my daughter does." In spite of the protestations of the teenager that she was an untroubled girl, her behavior belied her words. She prefaced every statement to her mother with the phrase, "now don't be hurt," "don't cry Mother, but_______." She then was able to list all her frustrations. Her problems reflected the need for structure in the home, her ambivelance maintaining her overcontrolling role and her desire for relief from adult duties. As the therapy progressed the mother bootlegged many individual sessions, on one pretext or another, in order to deal with her own issues. She dwelt on her abusive and critical relationship with her father, whom she feared to this day. She said she wanted to have better relationships with men, to get out from under her ex-husband's rule and made other complaints that were obviously unfinished business from her own adolescence. Joanne was so fixated on her own needs that she had little time or desire left over for her children.

The therapist found the treatment was particularly difficult for the therapist since the suggestions made by the daughter were very sensible and the contributions from the mother were much less workable. However, it would be destructive to allow this complimentary relationship to continue, because no matter how well the girl performed adult duties she was neglecting her own development.

"In the early stages of treatment, the therapist more openly attends to the parent while still supporting the teenager."

The family art therapy was very useful in achieving separation and counteracting family member's enmeshment. The mother and daughter were artistic and were skillful in using the media. Each was able to see the other's product and absorb both the overt and covert messages. Most importantly the art was often non-verbal, which avoided negative blaming, and provided a new problem-solving device. Joanne gained respect from Shamar when she began to teach art and hold a full-time job. The girl was more cooperative when she realized that the mother had a therapist (a grown-up) to lean on, rather than herself. There was a lively period of treatment when the mother in her own quest for autonomy was extremely distracted. This resulted in the daughter becoming insecure and striking out for attention by getting lower grades. This device succeeded in involving the mother, but in an authoritarian role, which was a positive surprise in this relationship.

As therapy progressed, it became apparent that Shamar's mother was not going to quickly achieve the adult status that would be most desirable; therefore, the daughter's contributions to the family were honored by the therapist. Shamar remains a junior partner in the family, a role she plays openly, with structure and limitations set, in the sessions, between the two of them. The young brother of six years, has been given some clear rules about who is the real mother and how much authority the sister has and may use. The chances that this threesome will ever make the ideal family constructed as our paradigm is extremely slim. However, the mother is now able to openly ask for individual sessions and articulate the

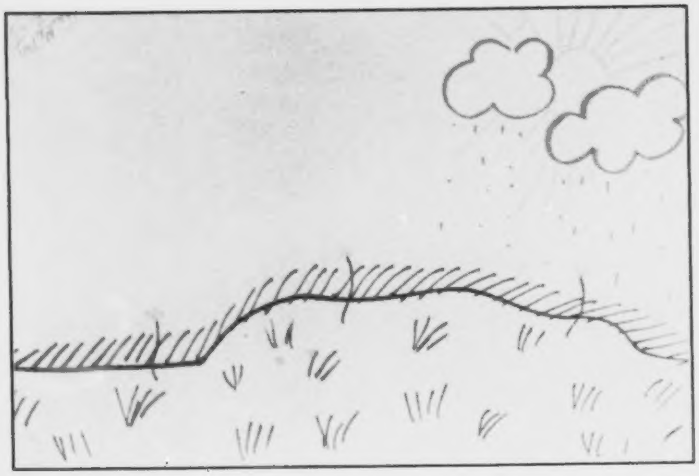


Fig. 1

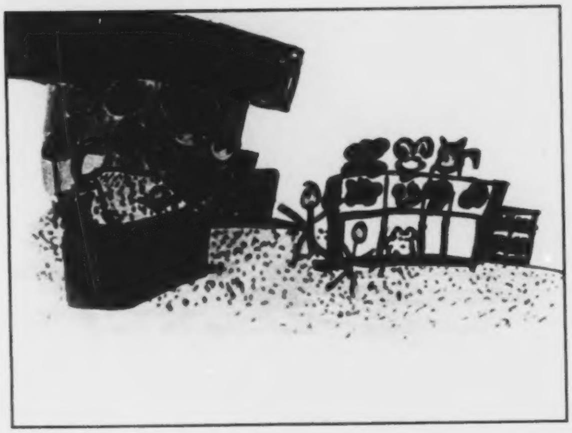


Fig. 2

problems she wishes or needs to address. The daughter joins the sessions every third week where the focus changes to family problems. This is the beginning of a realignment of roles to allow both mother and teenager to begin the work of individuation.

Art Therapy Expressions: CASE I

A brief sampling of the art work done by the mother and daughter discussed above dramatizes the difference in their personalities. The first two figures were drawn in response to the question: *what are the family's problems?* In Figure 1, Joanne drew a pair of clouds obscuring the sun and producing rain. She related that to their conflicts at home. In Figure 2, Shamar drew a picture of going shopping. The girl responded that she never got enough clothes from her mother and if she did they wouldn't fight. The contrast between the empty, minimal drawing of the mother and the concrete pragmatic statement of the daughter revealed their positions in the relationship. Figures 3, 4, and 5 are drawings done by Shamar on two different occasions while we were discussing the struggle over who would get the privacy of the one bedroom. Shamar first drew herself in pastels, a rather complimentary rendering. In the subsequent session, after some rules had been imposed, she gazed intently at her mother while drawing these two "portraits." She excused the red beard as an "accident" and thought the other woman was "happy." Joanne, a delicate and fragile woman with long, fine, straight hair did not resemble these renditions. However, the quality of anger and the aggressive affect portrayed was extremely confrontive and was shared by both daughter and mother.

Fig. 3

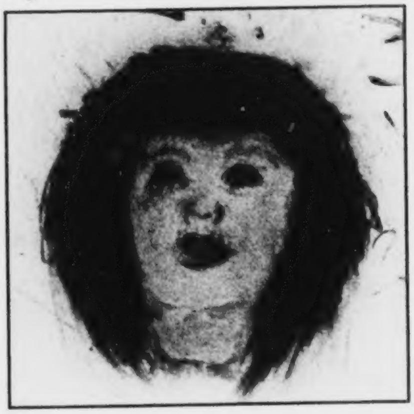


Figure 6 shows Joanne's way of dealing with her feelings about her father, feelings which she felt were identical with her emotional state with her ex-husband. She felt burdened by his characteristics of false pride, guilt, conceptions of ugly sex,

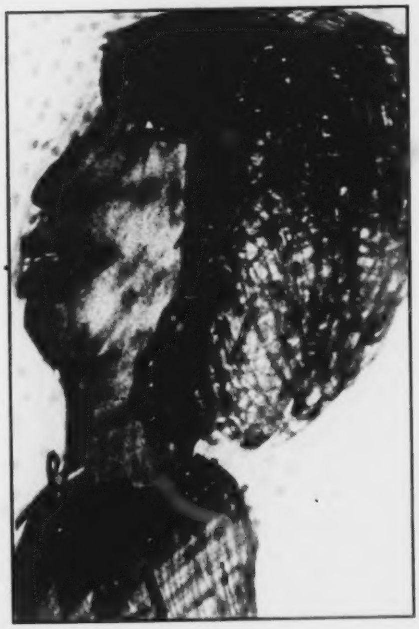
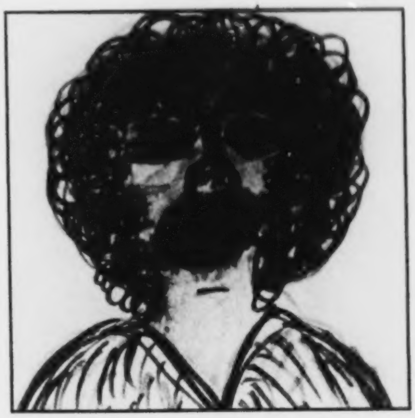


Fig. 4

Fig. 5



her inability to live up to his expectations and, most of all, his violence. She boxed them up and buried them. She felt that the guilt experienced in her present life was derived from this past criticism. Some weeks later she drew a very insightful rendition of the difference between a "fuzzy parent" (on the left of the page) and an "adult parent" (on the right) (Figure 7). I quote her explanation: "the broken pink line means no boundaries, the blue cloud is a dream world that holds back the warmth from the heart, the growth is without roots, and the blue waves show turbulence of emotions. The right drawing has a firm base, calm emotions, growth reaching out and the dreams do not stand in the way of the warmth. The most important feature is the firm but open boundaries." The final drawing, Figure 8, indicates that the process of individuation and maturation is beginning to be realized. The words around a light bulb are: "forming new ideas about what I want from life, creating new relationships, some definite future plans, and a changing family life."

One important aspect of the art in this treatment is the information it supplied which assisted the art therapist in her ongoing assessment of the client's growth and development.

Art Therapy Expressions: CASE II

In the second session a hypothesis for treatment was formed by the art therapist, through drawings done by a Latino father and his twelve-year-old son. Over the last two years these two had lived together, went on Father's dates together, and moved together from one unstable living quarters to another. The father and son had the same name and borrowed clothing from each other. The boy's mother had retained custody of a younger sister, but had turned her husband out of the house because of Dad's immaturity and irresponsibility. Bob, Jr., had decided to go with his Dad.

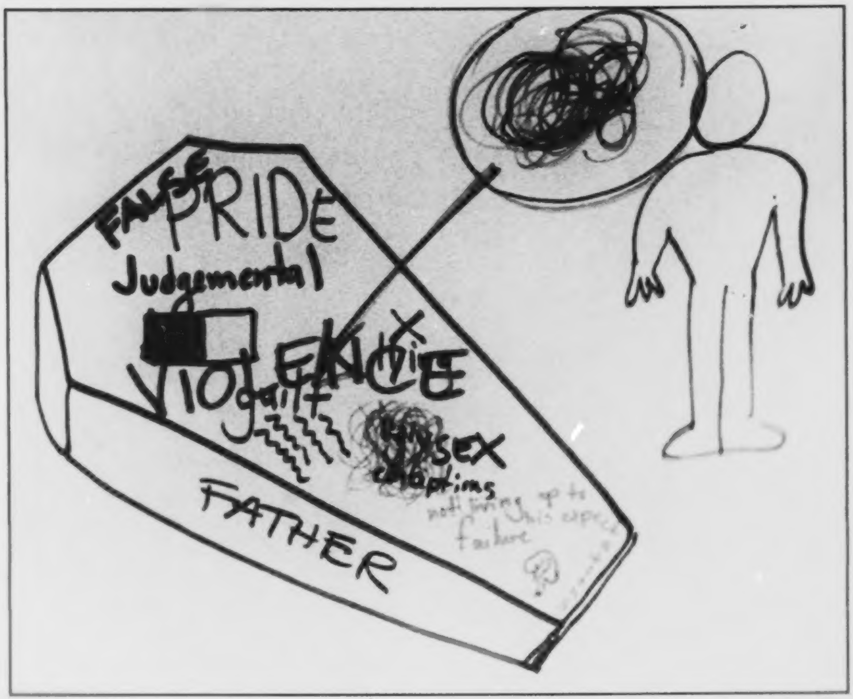
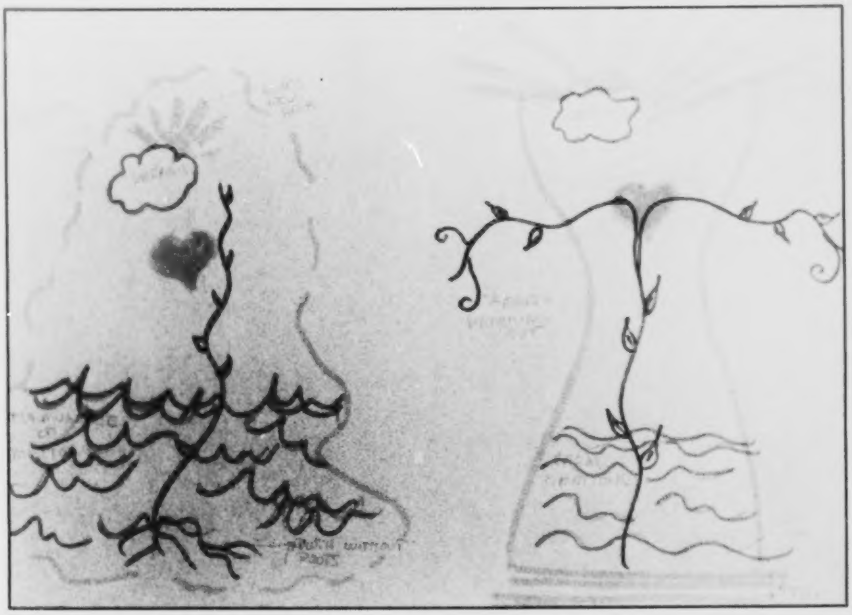


Fig. 6

Fig. 7



The presenting complaint centered on the son's poor school performance. However, it was clear that Father did not respect the school's concern, but felt he was the one persecuted and humiliated when called to school to speak to the teachers. His distress was aimed at the school and not at the boy. He recalled how he was never successful at school and his father was never around to defend him. Figure 9 and Figure 10 were completed after the clients were asked to *show how you* *could help with the problem*. The father drew a single horse whom he jokingly said was going to escape from the corral; the son suggested that they try to be more "thoughtful, honest, kind, helpful, understanding, and happy."

Through these two drawings, we can see which person was more aware of the problem and who was going to run away as soon as possible. Treatment focused on helping a man who never grew up, maturate and appropriately support his son. The boy was encouraged to break away from the symbiosis with his father and gain an identity. There was progress until the father moved them away, as was his pattern. It was encouraging that enough change had been made that he followed through with a referral suggestion and continued treatment elsewhere.

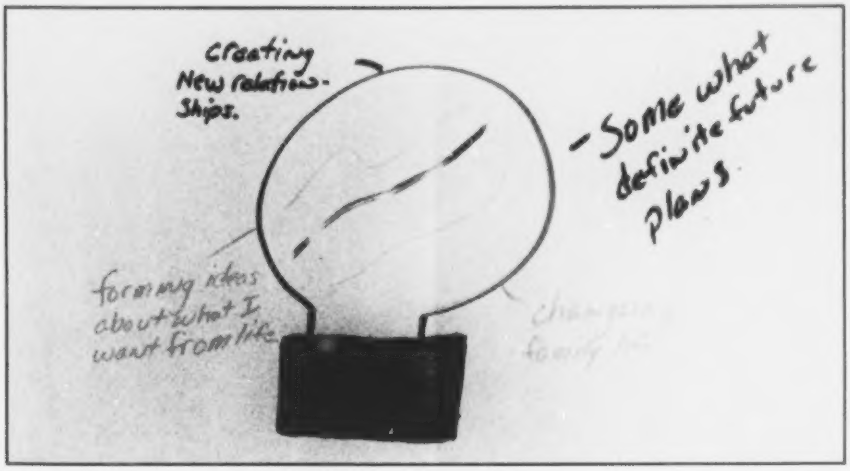

Creating New relationships.
- Some what definite future plans.
forming ideas about what I want from life
changing family life

Fig. 8

Art Therapy Expressions: CASE III

This case was court referred: a black mother and son, the boy age thirteen. He had been taken from the home because of child neglect. The mother, Christi, claimed Jerry was intractably oppositional and never did anything she demanded. The divorced father was in jail because of drug dealing and was completely out of home or family contact. The boy wished to stay at home and said he wanted to learn to control his temper. It became apparent that mother was most interested in her excellent job and wanted Jerry to run the house for her, clean and cook. My perception of this case was that the mother and son acted-out in similar ways with physical violence which is often the behavior that masks adolescent depression. They both had their own forms of temper tantrums and they both ran away from the problems. They each handled the stress in an adolescent manner.

To test how well they could work together, a dual drawing was done. This colorful, solid drawing, Figure 11, gave them great satisfaction and provided them with a pleasurable experience. The empty interior of the house was not interpreted at this time. The tree leaning tenderly on the house and the stop sign were all discussed in length. A positive connotation was used in referring to all images in this significant drawing. The dyad of mother and son rallied strongly after this experience. Work was done with Mother on her parenting skills and a few individual sessions focused on her extremely immature fantasies about being rescued by a "wonderful" man. The termination drawings are presented

Fig. 9

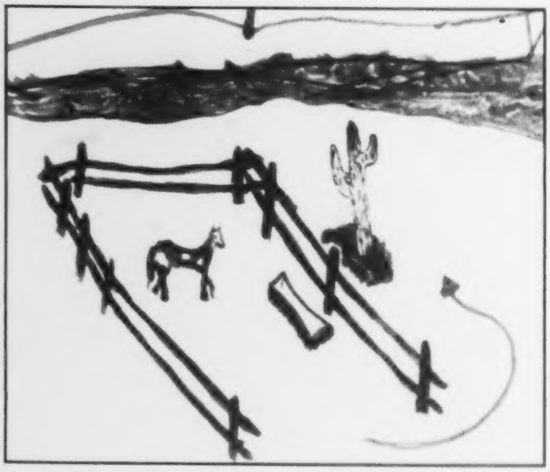
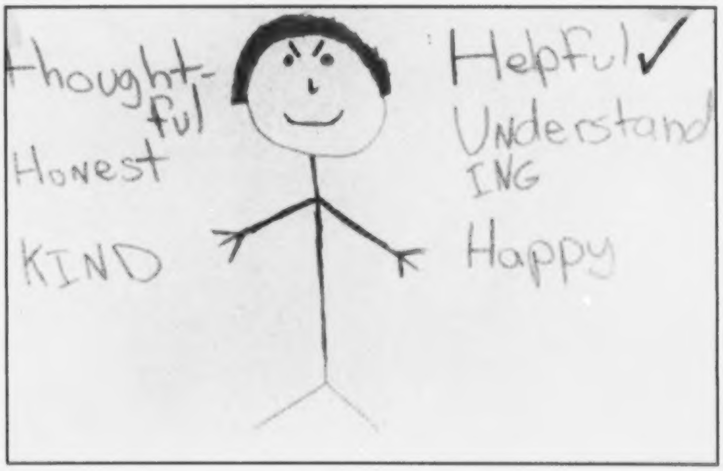


Fig. 10



BEST COPY AVAILABLE

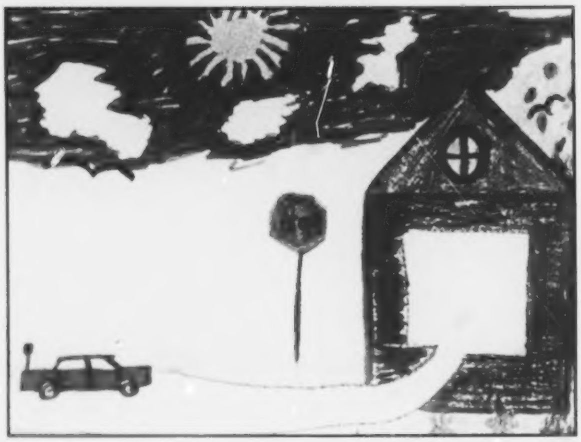


Fig. 11

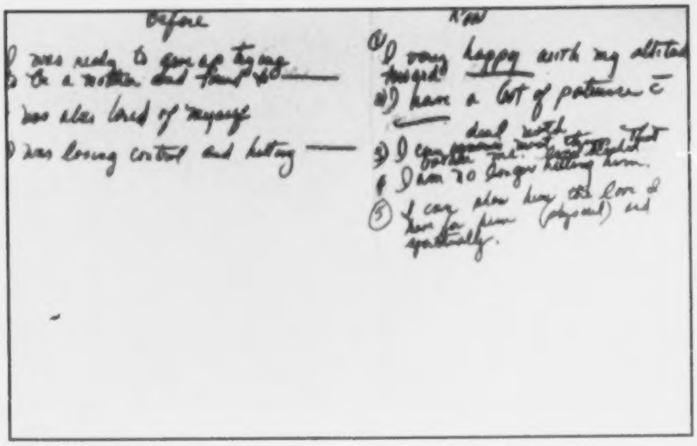


Fig. 12

here. Figure 12 lists Mother's appraisal *before and after therapy. Before,* she was "ready to give up trying, also tired of herself and losing control and hitting." She feels that now she is "happy with her attitude, has a lot of patience, can deal with most things, is no longer hitting and can show him her love." These improvements were reinforced by the happiness of finding a very solid, successful man to marry, who's son happened to be her boy's best friend.

In Figure 13, the teenager pictured the mess his room was in *before he came to therapy* and himself crying as Mother berated him. Now *after therapy* he and his mother go horseback riding together. He claimed that these drawings indicated he felt they had moved from sorrow to pleasure. The minimal use of space and cramped imagery suggest a very careful and controlled, perhaps skeptical, expectation of the permanence of this change.

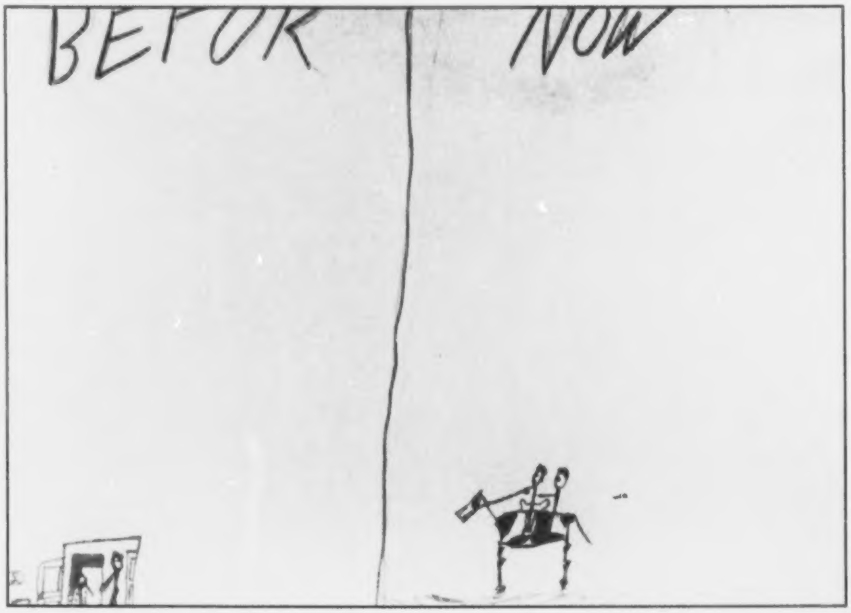
Summary

These three cases had a broad base of commonality. Although the families were widely spread in ethnic backgrounds, they shared similar histories in their extended families. In each case, and with countless more families seen in our outpatient clinic, the parent's childhood was extremely deprived. Role models, nurturance, and acceptance of who they were as individuals were sadly lacking. These parents passed through the pubertal years without completing adolescent developmental tasks. In particular, the inability to identify appropriate persons of the opposite sex in which to engage in a long term relationship was a shared weakness. Because of their own identity confusions they became parents without a notion of what parenting entailed. They did not learn these skills during their children's younger years as they were focused on their own unmet adolescent needs. When their children entered into adolescence they forced their parents to struggle with issues of narcissism, identity and autonomy, both within themselves and in their teenaged progeny.

Families attempting to survive these tumultuous times are helped by a family art therapist who is capable of setting realistic goals and adhering to a specialized treatment plan.

The combination of systemic theory and the art therapy modality has

Fig. 13



proven helpful in treating these adolescent families. Points to consider are: 1) The parent is the main focus of treatment, in the early phase of therapy; however, the art work keeps the youth involved and allows him/her to make a statement in every session; 2) The attention is directed to the parent, and it is deflected away from the teenager. This technique is syntonic with teenage developmental stance; therefore, the youth is willing to come to the sessions; 3) As the parent is led toward achieving or *pretending* to achieve adult skills, the child is relieved of inappropriate assumptions of roles in the family. She or he then turn toward making their own adolescence more successful; and 4) The treatment of these families takes into consideration that a compromise will probably have to be made regarding defining clear hierarchael boundaries. The teenager will often continue to have a large part in the adult duties and decisions, but these activities will be overt, not covert, and therefore open to negotiation and readjustment.

The essential ingredient for the family art therapist is a broad knowledge of adolescent development and the acuity to recognize the delayed patterns when manifest in an adult parent. This is assessed through observation of the behavior between parent and adolescent child and recognition of the problem as displayed in their art therapy expressions.

> ***". . . the inability to identify appropriate persons of the opposite sex in which to engage in a long term relationship was a shared weakness."***

**Case material presented has been modified to preserve confidentiality. Names, circumstances, and dynamics are representative but somewhat generalized to protect privacy.*

References

Ackerman, N.J. (1980). The family with adolescents. In E.A. Carter & M. McGoldrick (eds.), *The family life cycle: A framework for family therapy*. New York: Gardner Press.

Blos, P. (1962). *On adolescence: A psychoanalytic interpretation*. New York: MacMillan.

Carter, E.A. & McGoldrick, M. (1980). The family life cycle and family therapy: An overview. In E.A. Carter & M. McGoldrick (eds.), *The family life cycle: A framework for family therapy*. New York: Gardner Press.

Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.

Haley, J. (1980). *Leaving home*. New York: McGraw Hill.

Landgarten, Helen. (1987). *Family art psychotherapy*, New York: Brunner/Mazel, Inc.

Madanes, Cloé, (1981). *Strategic family therapy*, San Francisco: Jossey-Bass Inc.

Malmquist, Carl. (1978). *Handbook of adolescence*. New York: Jason Aronson, Inc.

Masterson, James. (1985). *Treatment of the borderline adolescent*. New York: Brunner/Mazel, Inc.

McGoldrick, M. (1982). Ethnicity and family therapy: An overview. In M. McGoldrick, J.K. Pearce, & J. Giordano (eds.), *Ethnicity and family therapy*. New York: Guilford.

Minuchin, S. (1974). *Families in family therapy*. Cambridge: Harvard University Press.

Minuchin, S. & Fishman, H. Charles (1981). *Family therapy techniques*. London: Harvard University Press.

Mirkin, M. & Koman, S. (1985). *Adolescents and family therapy*. New York: Gardner Press, Inc.

Riley, S. (1985). Draw me a paradox. *Art therapy, Journal of the American Art Therapy Association*. 2(3), pp. 116-123.

Stierlin, H. (1979). *Separating parents and adolescents: A perspective on running away, schizophrenia and waywardness*. New York: Quadrangle.

Watzlawick, P., Weakland, J.H. & Fisch, R. (1974). *Change: Principles of problem formulation and problem resolution*. New York: Norton.

Winnicott, (1976). *The child, the family, and the outside world*. Harmondsworth: Penguin Books.

Letter to the Editor:

As usual, the *Art Therapy* journal continues to be well written and full of interesting and informative documentation of the effectiveness of art therapy with numerous populations.

The article in the October, 1987, issue "Creative Analysis Involving Multidisciplinary Evaluations of a Case Study," by Edith Zierer, ATR, documents her work nicely. Nevertheless, I would suggest that articles written by her should also mention the use of involving the clients/patients in *written problem statements*. Oftentimes, the fact that the statements are written is overlooked in articles. Having studied under Edith for three years, and having also assisted her in some of her documentation for one summer, I probably should have picked up on this sooner. Why do I make such a request? Mainly, because my approach involves having clients utilize all their senses with the art therapy process, i.e., thinking and visualizing, drawing, writing, and reading aloud are combined with problem statements, free association, and projective imagery. Edith deserves credit for my incorporating written assignments. Also, the art of incorporating written assignments as part of art therapy [is sometimes] questioned and challenged [by others]. Of course, with some populations, statements cannot be written and the approach [must be] modified.

Thank you,

Pearl Spodick, ATR

Creative Process/Therapeutic Process: Parallels and Interfaces

Cathy A. Malchiodi, MA, ATR, *Art Therapy Program, Department of Art, University of Utah, Salt Lake City, Utah.* **Mariagnese K. Cattaneo, PhD, ATR,** *Expressive Therapies Program, Institute of the Arts, Lesley College, Cambridge, MA.*

This paper explores the similarities and connections between the creative process and the therapeutic process and their relationship to art therapy. Because of the nature of art therapy, the focus on the creative process is emphasized more so than in verbal therapies. Art therapists have constantly reexamined the relationship of creativity to therapy and have differing views on that relationship. Some believe the level of creativity is indicative of the degree of sublimation achieved; others connect creativity with the discovery of insights. Because creativity plays a central role in art therapy, it is a theoretical area that art therapists should continue to investigate.

In order to examine the exchange and interplay between the creative process and the therapeutic process, the authors will discuss their personal creative processes as visual artists. How each creates visual imagery will be related and paralleled to the role creativity plays in art therapy and the therapeutic process.

Introduction

There are numerous theories and definitions of creativity. A number of psychologists have written diverse and convergent opinions on the subject (Kris, 1952; Arieti, 1976; Rossman, 1931; Osborn, 1953, to name a few). Others (Lowenfeld, 1939; Read, 1940; Schaffer-Simmern, 1948) have made significant contributions to both the theory and practice of developing creativity in the arts. Florence Cane (1951) explored and outlined conditions she believed to be necessary for creative self-expression in visual art. Through the collective research of these investigators and others, the original concept of creativity, that of an elusive gift belonging to a special few, has undergone an important change. It is now seen as a capacity common to all people. Perhaps not everyone is capable of becoming an artist in the truest sense, but everyone can be creative in some way.

On some level creativity is involved in all therapeutic relationships. Because of the nature of art therapy, the expression and understanding of the self through visual art, the focus on the creative process is accentuated more so than in verbal therapies. As art therapists we are constantly reexamining the interrelation of the creative process with the therapeutic process and have developed divergent views on the dynamics of that interrelationship. Some art therapists believe that the quality of art production and the level of creativity indicates the degree of sublimation achieved (Kramer, 1971). Wadeson (1980) believes that creativity is involved in each art production, no matter how minimal the visual expression, and that important insights can be achieved and psychic changes can occur through the creative process within the therapeutic alliance.

Creativity not only plays an important part in the making of visual art, but is key to the development of a successful and productive therapeutic relationship with the client. Each therapeutic intervention and interaction is a creative act, one that arises from the art therapist's experiences not only with art and psychology, but also from personal experience with the creative process. Rubin (1982) points out that what many art therapists need is permission and support to use the creative parts of themselves in their work with others. Art therapists must understand that in order to be effective in therapeutic interventions they must learn to use their creativity in therapy. This applies not only to the understanding of the process of creative art-making, but also in how to tap inner creative resources to provide support and treatment to clientele. The therapist's creativity, as well as the client's encompasses the entire art psychotherapy process (Wadeson, 1980).

The authors of this paper explore the possibilities for parallels and interfaces of creativity and therapy. Each has utilized her personal experiences with creating visual art as focus for making connections between creativity and therapy. How each approaches the creative process is paralleled with the role creativity plays in art therapy and the therapeutic process. Cattaneo examines the aspect of the creative process

"Creativity not only plays an important part in the making of visual art, but is key to the development of a therapeutic relationship with the client."

known as the encounter and its place in art therapy. Malchiodi discusses the concept of destruction as intrinsic to creativity and explores its possible connections with psychological reconstruction during the course of therapy.

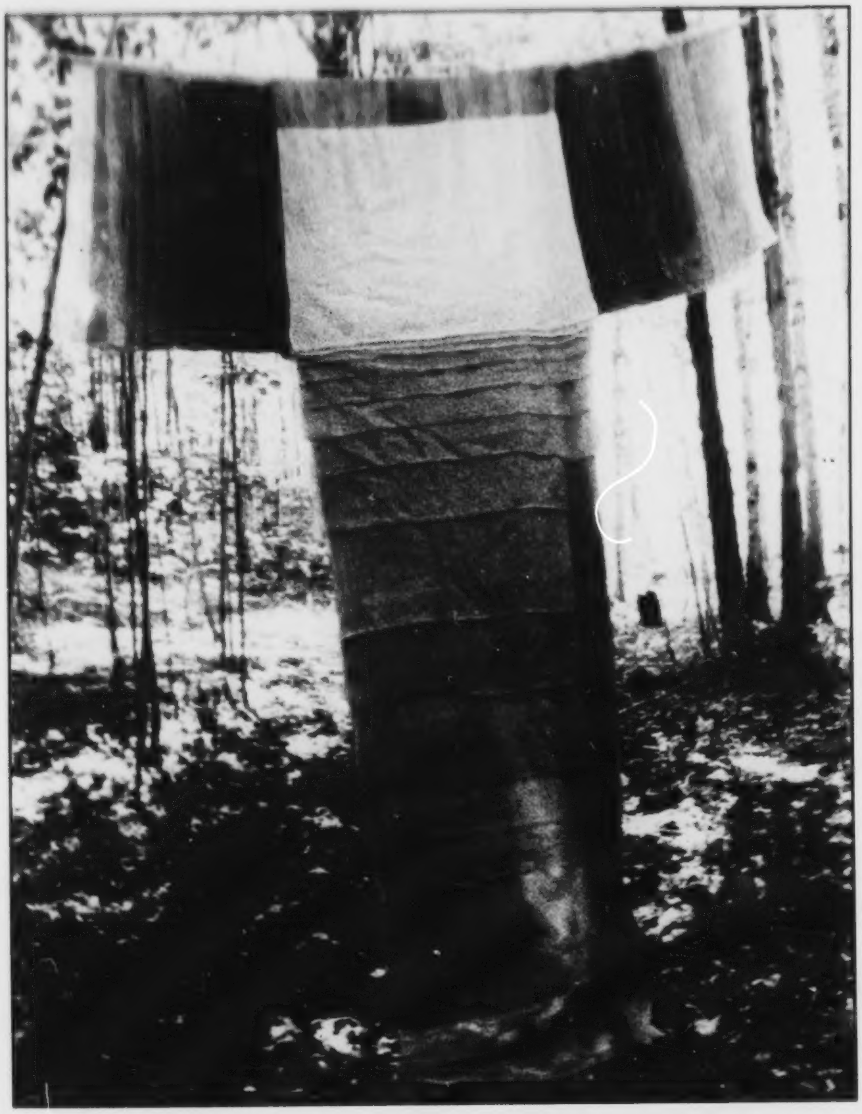


Fig. 1 "Forest Hanging I" by M. Cattaneo (1981); cheesecloth and acrylic, 61" × 90".

Cattaneo:

The stages of the creative process and the therapeutic process are similar and interface with each other. As art therapists we have the capability to consciously use this interface for fostering self-awareness and psychological health in our clients.

Rollo May (1975) identifies a component of both the creative and therapeutic processes called the encounter. In both creativity and therapy there is encounter—the encounter with the vision, the issue, the obstacle, the core of the problem, etc. This encounter, however, cannot be forced. We cannot force ourselves or others to be creative. We cannot force ourselves or others to have insights. But we can give ourselves, we can commit ourselves to the encounter. Writer Alice Walker (1983) talks about one of her encounters in an essay "Writing *The Color Purple*":

"I was hiking through the woods with my sister Ruth, talking about a lover's triangle of which we both knew. She said,'And you know, one day the wife asked The Other Woman for a pair of drawers.' Instantly the missing piece of the story I was mentally writing about — two women who felt married to the same man — fell into place." Walker's experience illustrates how during the encounter the unconscious breaks through opposition into the conscious mind.

Henri Poincare (1952), a French mathematician, describes an encounter resulting in a mathematical insight. He says the most striking aspect of the encounter, what he terms as illumination, was the suddeness and vividness of the illumination and that the insight came with certainty and brevity. He goes on to characterize this illumination by an intensity of awareness and heightened consciousness. The insight to some extent occurs in opposition to what one clings to consciously.

Poincare also states that the time before the encounter or illumination is important. Poincare describes this time before as a time of hard and conscious work and that time of rest and relaxation is very essential for the illumination. May (1975) says that to experience an insight from the unconscious we need to be able to give ourselves to solitude. May Sarton (p. 26, 1973) in "*Journal of a Solitude*" states, "It is never a waste of time to lie down and rest even for a couple of hours. It is then that images float up and then I plan my work."

These authors share the view that after the encounter or illumination a second period of hard work follows. As a visual artist and art therapist, I have experienced many times the moment of the encounter, the time prior to it and the time after, both in personal creative work and my work as a therapist. A particularly vivid experience I had with the moment of encounter occurred in the process of creating the work I call "Forest Hanging" (Figure 1).

"In both creativity and therapy there is encounter—the encounter with the vision, the issue, the obstacle, the core of the problem, etc."

As an artist, I mostly work with fibers and wood. I incorporate within my work environment both nature and natural light with all its variations. A few years ago I spent the summer in an artists' community in the country. My intended project was to make a white, grey and black hanging in a size larger than I normally was used to working. I had prepared myself for this work, made a whole series of sketches and written an extensive proposal.

Prior to going to this artists' community I was teaching in Switzerland. I was on my way back to the U.S., sitting in the plane and waiting to take off. Suddenly I got a very clear image of a very large and many-layered red hanging, hanging in the middle of the woods. There was no way I could overlook it. This moment of encounter with the image was so vivid that I can still feel the excitement of it.

During the seven hours of flight I started to draw, to make sketches of it. The image did not let go of me. Upon arrival in the U.S. I put the proposed plan aside and I never completed it. I started immediately working on the red hanging. It was a time of hard work and perseverence where the mastery of the craft was fully needed.

After more than a month of work I finished the piece. That evening I hung it on the wall of my loft. It not only filled the whole wall, but covered some of the floor as well. It was finally finished and it was exactly like the vision I had. I had already determined the place where it would hang in the forest and had set a date to show it there.

I began to realize that this piece of work only had a strong meaning as a piece of art, but also the image itself was asking me for a deeper understanding of its meaning. There was something in its presence that haunted me. It made me feel extremely uncomfortable and there was an urge to take it off the wall, even to destroy it.

I did not take it down or destroy it, but I started to intellectualize its meaning. I connected the hanging to my cultural heritage. It reflected the reclaiming of the tools and techniques I had once learned and despised. The cutting of the material and the mixing of the paint were like cooking, the dying of the pieces of cloth, dipping them into the paint and hanging them up were like washing clothes and hanging them on the line. I had also ironed the pieces and sewed them together, two additional tasks related to housekeeping.

That evening in my journal I wrote: "I see wash hanging on a clothesline in the sun, moved by the wind. How many pieces of laundry have women hung or laid out to dry? In school I learned to hang up laundry: never underwear together with dish towels, all the pieces neatly grouped according to item, always keeping the visual aspect in mind and thinking about the neighbors. A chaotic washline would reveal a chaotic and bad housewife.

Washing
Washwomen
women washing theirs and other people's clothes in the river
in the communal washhouses
fed by spring water
the washhouses where the women of
the villages met
where they were with
each other
sharing news
gossips
laughing
singing
crying
fighting
a place which was not for men.
Washwoman, a negative word for a woman who likes gossiping.
Washwoman during the French Revolution.
Washwoman, the lowest class of citizens
the lowest servants
Washwomen washing white the stains of the rich.

With this work I show respect for the work women have done for centuries. It is a homage to what I despised for many years. It is a homage to the unknown woman, to the woman who silently did wash which was needed to be done, who lived and survived and died. . ."

These intellectualized connections were at the time helpful. I did not destroy the piece, but I gained respect for it as a homage to women. I was able to hang the piece in the forest and show it to the public. The piece had gained a life of its own.

It was only sometime later that I found the courage to explore and leap into the unknown in the search of a deeper meaning. And as the image had come as an unexpected encounter, bypassing the original plan, so came the encounter with its meaning. In the end, it was the size, visibility and red color of the piece that stood out clearly. My work had previously been mostly white, small in size and subtle. They were pieces of art that one could overlook. This piece was clearly visible and the viewer was confronted with it. The piece had to do with my becoming visible and present, something that made me feel very uncomfortable, something that was not appropriate for a woman in my culture. The image had to do with becoming visible and the obstacles that got in the way as I moved in the world, as I presented myself to it. I had reached an inner readiness to bypass the intellectual explanation and go a step further in the search. My unconscious was able to break through in opposition to the conscious belief.

As art therapists we deal with the encounter twice in the art therapy process. The first is the encounter with the image, the second is the encounter with its meaning. We all know that a premature intellectualization of the image can lead to the wrong path or direction. Sometimes this is a dead end street or a detour. But we also know that clients often take or choose those detours because they are not ready for the encounter. This longer path might be needed as preparation for the encounter with the deeper meaning. It is here where the creativity of the art therapist, the art therapist's understanding of the creative and therapeutic process helps the client to avoid dead end streets and leads the client to the path that brings encounter and breakthrough.

As May (1975) said, we cannot force creativity, we cannot force each other to have insights, but we are committed to search and go the path that leads to the psychological readiness for the encounter and insight.

Malchiodi:

Pablo Picasso once remarked that every act of creation is first of all an act of destruction. Rollo May (1975) characterizes the breakthrough of creative insights in a similar fashion. He has stated that when a creative insight occurs it breaks through into your consciousness against what you have been trying to think rationally. It breaks through in opposition to the conscious belief to which you have been clinging. In the process it may destroy what you previously believed to be true. According to May (1985), "In all creativity, we destroy and rebuild the world, and at the same time we inevitably rebuild and reform ourselves."

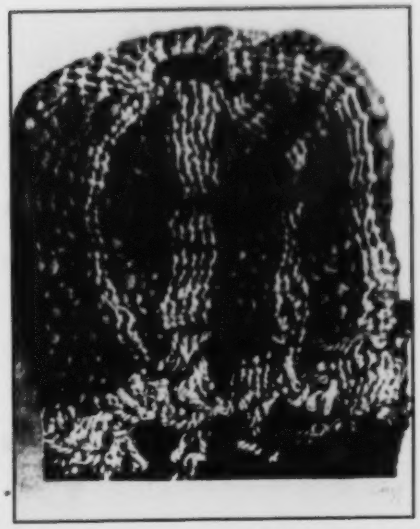


Fig. 2 "Vessel" by C. Malchiodi (1987); collage and pencil, 12" × 16".

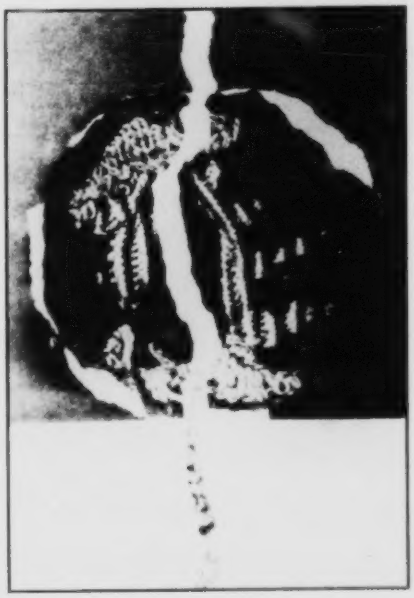


Fig. 3 "An Angry Fear" (1987); collage and pencil, 12" × 16".

Elliot Eisner (1966) defined creativity in terms of an act of destruction he called boundary breaking. Boundary breaking is described by Eisner as the rejection of accepted assumptions. The individual recognizes limitations in present ways of thinking or ways of looking at things and proceeds to develop new premises. In the process old beliefs are destroyed to allow for new ideas to emerge.

As an art therapist and a visual artist, I have observed in my work with clients and in my own art process the act of destruction as a component of creativity. I have also witnessed in my clients and myself how this element of destruction can be the beginning of therapeutic reconstruction and integration. A powerful experience with the act of destruction occurred recently in a series of collage/mixed media pieces I created called "Continuum" (Figures 2-7).

As a theme for this series, I chose a basket I had woven many years before while spending a summer in the Sierra Nevada mountains of California. The basket suddenly seemed to hold a renewed attraction for me in terms of its soft, subtle colors and cylindrical shape. Because it was created from wool and alpaca, it could be molded into various shapes and forms, something I had not considered until this time.

At the time I was working with photos and xeroxed images, combining them with drawing and painting. I decided to xerox a couple of dozen images of the basket, each resulting in a slightly different image because of the way the basket could be molded and shaped on the copier. I then took these images and began to spontaneously tear them into smaller components until I had reduced each one into forms unrecognizable as the original basket.

I began to work with the shapes that had emerged from my destruction. At first I became frustrated, wondering to myself if there was any hope of really working with these shapes in some productive way. Then I began to manipulate, play, rework and reconstruct the shapes. I even continued to tear the pieces while I moved about the chaos of shapes I had created, absorbed in the process and the intrigue of these unknown images.

Hours passed by unnoticed. Visual imagery began to emerge and

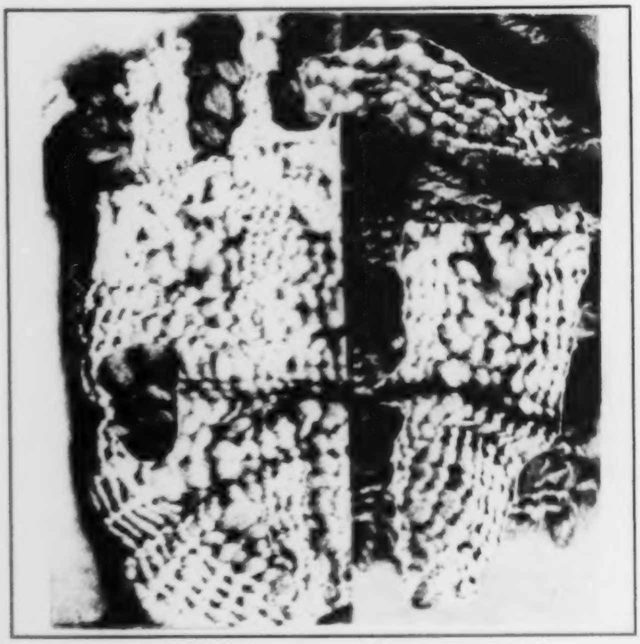


Fig. 4 "Opposing Forces" (1987); collage and pencil, 12" × 16".

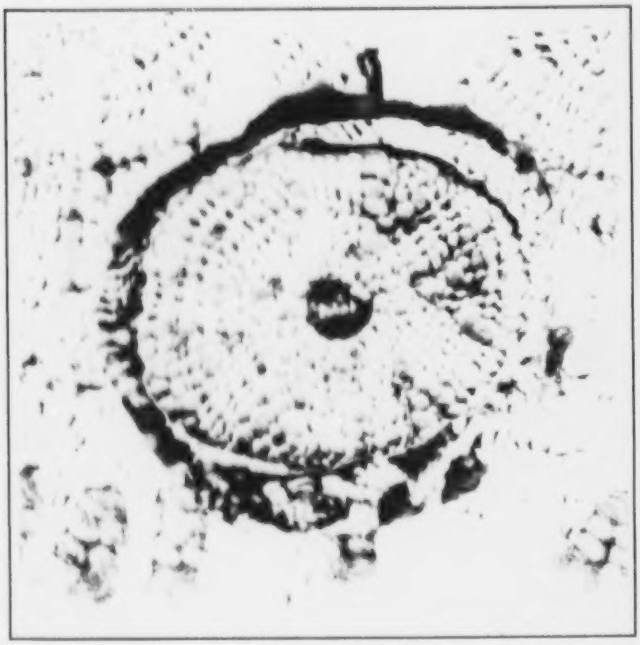


Fig. 5 "Guardian" (1987); collage and pencil, 12" × 16".

each image I created seemed more powerful than the next. Each one also seemed to encourage the next one to come forth. Each took on a distinct personality even though it was formed out of components from the same image. The sequence appeared to have a connection, to be part of a continuum, to have aspects that related to each other in some way.

When I finished the final image (Figure 7), I felt a sense of relief and completion. I felt as though it took the place of the original image, the basket, in some sense. But an understanding of the forms themselves was not within my reach, only the sense of comfort and peace.

It was many months before I would fully understand the meaning of the series. I was halfway around the world when the answers began to emerge. I was in Beijing, in a stone courtyard of a school at which I was teaching. It was the time of the midday meal and the cooks were busy in the cookhouse preparing food for the teachers and students. Each day the cooks brought out a wooden cart into the center of the courtyard. In this cart were several large baskets filled with freshly baked bread, covered with cloths to keep the bread warm until mealtime. We would file past the cart, each taking a piece of steaming bread from the baskets.

In my journal that night I wrote, among other things, about my impressions of the cooks and the baskets of bread. I noted how the cooks waited as we passed by, looking to us for acceptance of what they had to offer us in their baskets that day. Cooks who never spoke, only waited for reaction to what their baskets held today. I also wrote about the baskets—a symbol of nurturance, receptivity, openness, acceptance. They are silent vessels, objects to be filled and emptied, perfectly formed, yet vulnerable.

When I arrived back home I began to make clearer connections between my basket image and those that I saw in Beijing. My destruction of my basket and its reconstruction into new forms revealed more fully some turmoil I had been experiencing in my own life in recent months. In an attempt to deal with the situation instead of confronting it head on, I had remained silent and worked harder, feeling that if I were perfect that I would be safe. I became an overachiever in reaction to my situation, to compensate for the loss of self-esteem I was experiencing. I filled my own personal vessel (the basket) with pain, confusion, frustration and self-doubt.

The act of destroying the basket image was my first step toward liberation and separation. The images that resulted from the chaos of the destruction represented steps to un-

> ***"We tend to view destruction as a negative action when indeed it is often a necessary prelude to reconstruction and creation."***

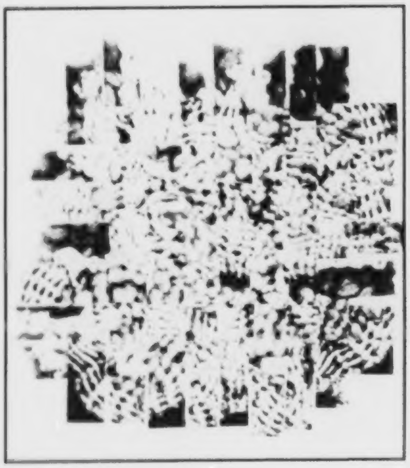


Fig. 6 "Recombinant" (1987); collage and pencil, 12" × 16".

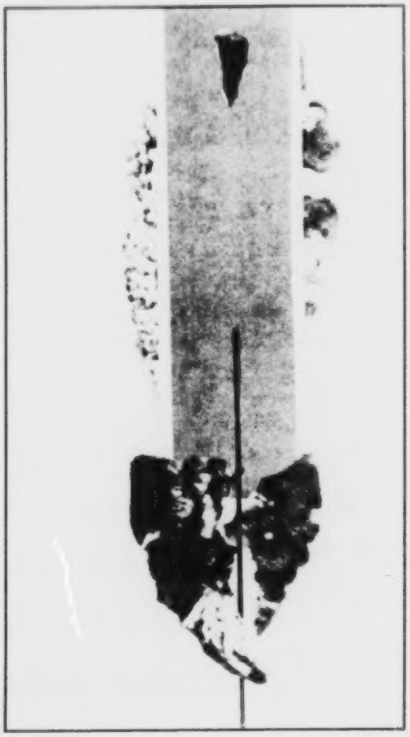


Fig. 7 "Transcendence" (1987); collage and pencil, 12" × 16".

derstanding and identifying my feelings about my situation and the role I played within it. For example, "An Angry Fear" (Figure 3) helped me to identify a composite of emotions I was experiencing. I, like my moldable basket, was feeling pushed and pulled in several directions and angry, but simultaneously fearful of the consequences of revealing my feelings. "Guardian" (Figure 5) became an inner resource to me, a benevolent watchful being within myself who possessed a quiet strength and was accepted for who she was. The final piece of the series, "Transcendence" (Figure 7), represented exhilaration and wholeness, a feeling of clearer understanding, integration as well as separation of myself from an unhealthy situation. In retrospect, the entire series incorporated powerful aspects of my inner experience—the fear, the frustration, the anger, the vulnerability, the inner resources, the separation, and, ultimately, the understanding.

There are some interesting parallels related to this theme of destruction in both the creative process and therapeutic process. We tend to view destruction as a negative action when indeed it is often a necessary prelude to reconstruction and creation. In therapy, a client often may have to destroy old belief systems in order to experience growth just as an artist may destroy old forms in order to construct new, more creative ones. In my case, destruction of an old form brought such results; in my visual work, I was able to realize new imagery and in my psyche, new understanding and self-awareness.

In the examination of my own personal process as a visual artist, I also have observed two components characteristic of the destruction/creation process—insight and imagination. Insight, of course, is an important aspect of therapy. As an art therapist, one hopes to enable the client through visual expression to achieve insights about oneself and one's world. Such insights may include discoveries about behavior, motivations, fantasy and the unconscious. In comparison, in the making of visual art, insight can also be utilized to reconstruct new forms from that which has been destroyed.

Along with insight a second component may also come into play — that of imagination. According to May (1975), imagination involves the ability to consider diverse possibilities, to be able to take chances and risks and dispose of old ideas. Thus imagination may help the individual to generate new ideas out of those discarded or destroyed. Imagination is an important tool in the process of art therapy in which the individual may be able to reorganize or alter accepted thought patterns and perspectives through visual modalities. In my own situation, my imagining new forms from the old ones led not only to the creation of new images, but also the emergence of new perceptions and self-understanding.

Conclusion

There are several important parallels and connections between the creative process and the therapeutic process to consider. The image in both the artist's studio and the art therapy session may come as an unexpected encounter and its meaning may not be immediately apparent. This observation by both authors needs further exploration and raises questions about the time factor required to achieve insights about images during therapy. The encounter with the creativity and the encounter with meaning seem to be separate events connected by an internal process variable in the dimension of time. Immediate meaning is often not apparent and can be misinterpreted, a possible delay to progress and growth.

As a component of creativity, destruction of old images can be key to new ones emerging. The element of destruction can exist in the creative process when old forms are destroyed and new ones result from the chaos. In therapy this destruction can be essential to creating new understanding and awareness. It is an aspect of art therapy which should be given closer examination because of the power of visual destruction and visual reconstruction

> ***"Imagination is an important tool in the process of art therapy in which the individual may be able to reorganize or alter accepted thought patterns and perspectives through visual modalities."***

of perspectives, perceptions and emotions. It is this as well as the encounter with process and meaning which closely connect creativity and therapy. It is obvious that the use of the art process in therapy enhances this connection by providing a visible channel for the encounter, the insight and the reconstruction.

References

Arieti, S. (1976). *Creativity: the magic synthesis*. New York: Basic Books.

Cane, F. (1951). *The artist in each of us*. New York: Pantheon.

Eisner, E. (1966). A typology of creative behavior. In E. Eisner and D. Ecker (Eds.), *Readings in art education* (pp. 323-335). Toronto: Blaisdell.

Kramer, E. (1971). *Art as therapy with children*. New York: Schocken.

Kris, E. (1952). *Psychoanalytic explorations in art*. New York: International Universities.

Lowenfeld, V. (1939). *The nature of creative activity*. New York: Harcourt, Brace and Co.

May, R. (1985). *My quest for beauty*. New York: Norton and Co. (1975). *The courage to create*. New York: Norton and Co.

Osborn, A.F. (1953). *Applied imagination*. New York: Scribner's.

Poincare, H. (1952). Mathematical creation. In Ghiselin and Brewster (Eds.), *Creative process*. Berkeley: University of California Press.

Read, H. (1940). *Education through art*. New York: Pantheon Books.

Rossman, J. (1931). *The psychology of the inventor*. Washington: Inventor's Press.

Rubin, J. (1982). The search for formula, or how to use one's own creativity in art therapy. In A. DiMaria (Ed.), *Art therapy: still growing* (pp. 121-122). Alexandria, Va: AATA, Inc.

Sarton, M. (1973). *Journal of a solitude*. New York: Norton.

Schaffer-Simmern, H. (1948). *The unfolding of artistic activity*. Berkeley: University of California Press.

Wadeson, H. (1980). *Art psychotherapy*. New York: John Wiley and Sons.

Walker, A. (1983). *In search of our mother's garden*. New York: Harcourt, Brace and Jovanovich.

Master's Degree Programs in Expressive Therapies and in Creative Arts in Learning

• •

Offered by the Institute for the Arts and Human Development
Lesley College Graduate School

Master of Arts in Expressive Therapies

For students interested in the creative modalities of art, music, dance/movement, and drama, presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning

For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theater studies.

For more information call or write the Institute for the Arts and Human Development, Lesley College Graduate School, 29 Everett Street, Cambridge, MA 02138-2790. (617) 868-9600, ext. 480.

Lesley College
GRADUATE SCHOOL

Lesley College is an Equal Opportunity/ Affirmative Action institution.

ADVERTISING RATES

Journal of the American Art Therapy Association

Rates	**1x**	**2x**	**3x**
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140
Special Positions			
Cover #2 *(Inside Front)*	$130 additional		
Cover #3 *(Inside Back)*	130 additional		
Cover #4 *(Outside Back)*	165 additional		
Color Rates: Standard Red, Blue and Yellow *(Cover #4 Only)*			
Black & white plus one color	$130 additional		
Black & white plus two colors	260 additional		
Black & white plus three colors	360 additional		
Other colors and special inks	260 additional per color		
Bleed	**1x**	**2x**	**3x**
Per page additional	$90	$85	$80
Inserts	**1x**	**2x**	**3x**
2 pp	$ 800	$ 700	$ 575
4 pp	1.500	1.300	1.150
8 pp	2.200	2.000	1.750
Mechanical Requirements	**Width**	**Depth**	
Full Page	7"	10"	
Half-Page Horizontal	7"	4⅞"	
Half-Page Vertical	3⅜"	10"	
One-fourth Page	3⅞"	4⅞"	

Trim Size: 8½" × 11"
Bleed Size: 8⅝" × 11¼"
Inserts: 8⅝" × 11¼"

15% Agency Discount 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
505 E. Hawley Street, Mundelein, IL 60060 (312) 949-6064

BEST COPY AVAILABLE

Art Therapy Assessment of Coping Styles in Severe Asthmatics

Robin Knight Gabriels, MA, ATR, *National Jewish Center for Immunology and Respiratory Medicine, Denver, CO.*

"Art Therapy Assessment of Coping Styles in Severe Asthmatics" presents a definition of asthma as a psychophysiologic disorder, and provides an introduction to an art therapy technique designed to assess the perceptions asthmatic children have of their illness, and their coping styles.

Four cases are briefly presented demonstrating how this procedure can enhance treatment and highlight psychological factors pertinent to this population.

A comparison of the coping styles and grieving stages is made between terminally ill and chronically ill patients. Other issues specific to asthmatic children are identified in order to compare patients' coping styles.

In conclusion, the use of art therapy is presented as a means of identifying ability to cope with illness in a pediatric asthmatic population. Art therapy can have certain advantages over more traditional therapeutic modalities in this situation.

Introduction

The patients presented in this article were treated on the Pediatric Psychophysiologic Unit at National Jewish Center for Immunology and Respiratory Medicine which is a 24-bed, medical/psychiatric unit where hospitalization averages about three months. Intensive psychologic and family treatment is provided for children ages seven to seventeen. The patients on this unit primarily have asthma or, in some cases other chronic diseases, accompanied by significant psychosocial problems.

> The term psychophysiologic refers to disorders in which there is a significant interaction between physiologic and psychologic components in the clinical picture, with varying degrees of weighing of each component. (Prugh, 1983, p. 337)

It is important when working with these children to have an understanding of asthma and its pathophysiology. During an asthma attack, the small airways of the lungs, or bronchioles, become obstructed by bronchospasms. The muscles around the bronchioles squeeze these tubes so that there is minimal airflow allowed through them. Simultaneously, an increase in production of mucus within the bronchi causes the lining of the tubes to get puffy. The result is a decrease in the amount of airflow in and out of the lungs brought about by an "increased responsiveness of the trachea and bronchi to various stimuli" (Mrazek, 1985, p. 17). In most cases, asthma is controlled by a variety of classes of medications. Unfortunately, many have noxious or uncomfortable side effects.

Most of the patients on the Psychophysiologic Unit are regarded by the clinicians and researchers as "high-risk" asthmatics (Strunk, 1985). This means that they have significant medical, psychological and psychosocial problems which are associated with a greater risk of death from their asthma.

"It is important when working with these children to have an understanding of asthma and its pathophysiology."

Mathis (1981), in his article, discusses three ways in which psychological factors can affect the course of asthma. Emotional factors can precipitate an acute asthma attack, can exacerbate pre-existing asthma, and can impede preventative home care. Psychological stimulants which may precipitate asthma include emotional reactivity to excitement or stress, anxiety, fear, laughter, crying, expressed or suppressed anger and resentment. Conversely, changes in respiration can stimulate emotional reactions. For example, a child may become fearful and panic when experiencing a change in respiration; this, in turn, may heighten or exacerbate the respiratory change. Mathis also identifies the ways psychological factors directly influence asthma management. Illness may come to serve many of the child's unmet needs for parental nurturance. The illness may also serve unconscious needs of others. For example, parents may focus their total attention and energy on the child's illness to avoid dealing with their own marital problems. Medical noncompliance, the failure of the asthmatic child and/or parents to take preventive steps to decrease the risk of an attack, is also in this category. Noncompliance may be a result of psychological conflict, resistance to authority, unconscious death wishes, maladaptive coping styles, poorly developed self-care habits, or conflicting values (Mathis, 1981).

The Technique and Rationale

Many of the patients on the pediatric psychophysiologic unit have a great deal of difficulty verbalizing their feelings, both generally and specifically concerning illness. They also have difficulties revealing their serious psychosocial problems which often contribute to a deterioration of their asthma when they are in the home environment. For these reasons these patients are referred to art therapy for further evaluation and treatment. There are no standard tests or assessment procedures currently utilized at the hospital which deal specifically with assessing how children cope with and perceive their asthma. The art therapy diagnostic technique introduced in this article was designed to address this problem.

Patients are seen in individual art therapy and are instructed to draw three pictures about their asthma. They can choose from a variety of art materials (paint markers, crayons, chalk, and colored pencils). In the first picture, they are asked to depict what it feels like to have an asthma attack or wheeze. Next, they are asked to draw a "helpful/good" environment, either real or imaginary, in which they would not have to worry about having asthma attacks. Finally, they are asked to depict a "harmful/bad" environment, either real or imaginary, in which they would be plagued by asthma attacks. Following each task, they are encouraged in a helpful and nonthreatening way to discuss their pictures. Patient reactions to these tasks are often enlightening and reveal many of their fears, concerns, psychological and psychosocial problems. These pictures are then utilized to improve coping skills by: 1) increasing the patients' awareness of their feelings and concerns related to their asthma; 2) making them more aware of their illness and its impact on their lives; and 3) teaching appropriate self-care and illness management techniques.

The following case examples describe the application of the technique and its usefulness in revealing the perceptions the children have of their illness and what they view as helpful and harmful.

> ***"Patients are seen in individual art therapy and are instructed to draw three pictures about their asthma."***

CASE I

Carl was a 7-year old male, admitted a second time to National Jewish Center. During his first admission, he was found to have a severe psychological component to his asthma. This was evidenced by his increased wheezing as discharge from the hospital approached, which was especially intense during his mother's week-long stay prior to discharge.

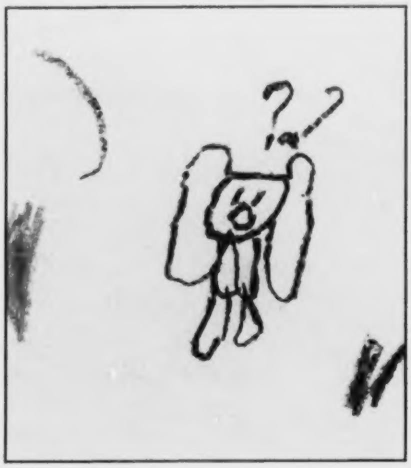
Carl, his mother, and his four older siblings were abused by Carl's father. Carl's mother was unable to protect him from physical harm. In addition, Carl's father did not support medical treatment, but insisted on an organic, natural food approach to treat Carl's asthma. Conflicts between the parents led to their inattention to his medical and psychological needs and interfered with his receiving help when he experienced problems with his asthma. Carl was very reactive to this stress that occurred within his family.

Following Carl's first admission, he was put in a foster home for one and a half years where he did well and was responsive to structure and limit setting. During this placement, Carl's mother divorced her husband and was given custody of Carl's four older siblings. Carl then returned to live with his mother, siblings, and mother's new boyfriend. Almost immediately following his return, Carl began having problems with his asthma which led to several rehospitalizations and a respiratory arrest. Carl's mother initiated the second hospitalization to National Jewish Center because of her fears of Carl's worsening asthma and her difficulties controlling his illness. Carl's return to the family had heightened his anxieties and indicated that further therapy would be necessary to facilitate a better transition home. It was also identified that Carl's medical problems were excerbated by his mothers' inability to properly judge and manage the severity of his illness.

Carl was referred to art therapy to help him modulate and express his feelings and anxieties. Carl was asked to complete the asthma pictures during one of his initial individual art therapy sessions. In his first picture (Figure 1), he described what it was like for him to have an asthma attack by drawing his shoulders "hunched up." He drew question marks to indicate his feeling of not knowing what to do when he had an asthma attack. This picture encouraged him to talk about a past asthma attack when he was alone at home and began to wheeze. Carl related having feelings of fear and discomfort during that time.

In Carl's second picture of a good environment (Figure 2), he depicted himself standing in a large house

Fig. 1



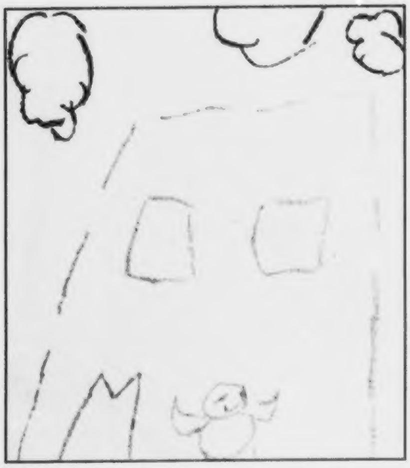


Fig. 2

with "lots of open spaces" so he could breathe. He stated that in his picture, his mother was at the store, but that he would not have to worry about anyone else caring or not caring for him because he would know how to take care of himself. Carl's comments about his picture reflected his mistrust of caretakers and of their ability to care for him. Carl had the unrealistic expectation that he could take full responsibility for his self-care at the age of seven.

Last, Carl depicted a bad environment (Figure 3). In this picture, he drew himself (right) and his mother (left) trapped in a vault-like place where there were no windows, no doors, and no air. He stated that his mother was happy but that he was very scared and sad. Carl was unable to discuss this picture further, and reacted to the powerful content of this drawing by regressing to finger paint. This picture reflected Carl's perception of his mothers' inability to identify or manage his asthma.

As therapy progressed, Carl was more successful at tolerating affective experiences, at using art to vent angry feelings related to his environmental changes, and at identifying issues that caused him much anxiety. Carl also was better able to recognize and accept that other adults could help him with his self care.

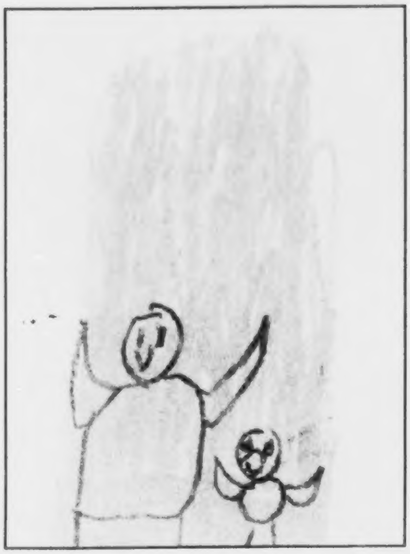


Fig. 3

CASE II

Jamie was a 15-year old, steroid-dependent, asthmatic girl. She was referred to the unit with a primary complaint of moderate to severe asthma which was becoming increasingly difficult to control. The referring doctor and her parents both suspected that emotional factors, including Jamie's oppositional behavior and stress within the home, were exacerbating her asthma. There was a concern that Jamie was frequently noncompliant with her medical regimen and was inconsistent in her self-care. Jamie was also allergic to most pets, yet there were two dogs, a cat and a ferret in the home.

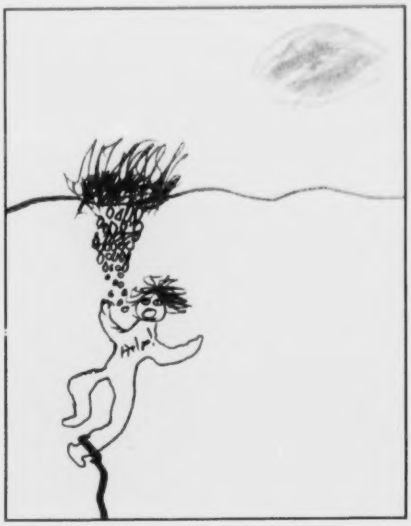
The parents' lack of understanding of Jamie's asthma was problematic. Jamie's mother tended to overprotect her. Yet she was adamant about keeping pets in the home despite Jamie's severe allergy to animals, causing exacerbation of her asthma. Jamie's father also did not take Jamie's asthma seriously, and was not protective enough of Jamie.

> ***"Patient reactions to these tasks are often enlightening and reveal many of their fears, concerns, psychological and psychosocial problems."***

Further, Jamie had significant difficulties individuating from her parents, taking responsibility for her own self-care, and maintaining a stable sense of herself. She refused to take her medications in order to get her parents to do things for her. Her oppositional behavior, particularly medical noncompliance, put her at risk of dying from her asthma.

Jamie was referred to art therapy for further assessment and treatment of: 1) poor self-image; 2) poor understanding of the significance of her asthma; and 3) intense ambivalence about individuating from her parents. Jamie was willing to complete the "asthma" pictures. However, her verbal descriptions of these pictures were minimal and lacked emotion. In her first picture (Figure 4), she drew herself trapped under water and unable to breathe. This picture revealed much more of Jamie's anxiety, pain, and fear about her asthma than she was able to verbalize.

Fig. 4



Jamie depicted a good environment for her asthma (Figure 5) where she was protected from harmful environmental asthma triggers by living in a balloon. She drew herself in a balloon with someone else holding the balloon. It was significant that she presented herself as helpless, relinquishing the responsibilities for her asthma self-care to someone else. In addition, the picture reflected her anxieties of separation from caretakers, fearing that she may be unable to care for herself and her asthma.

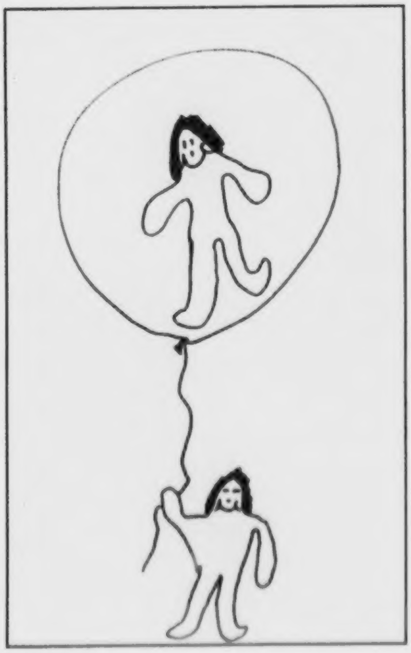
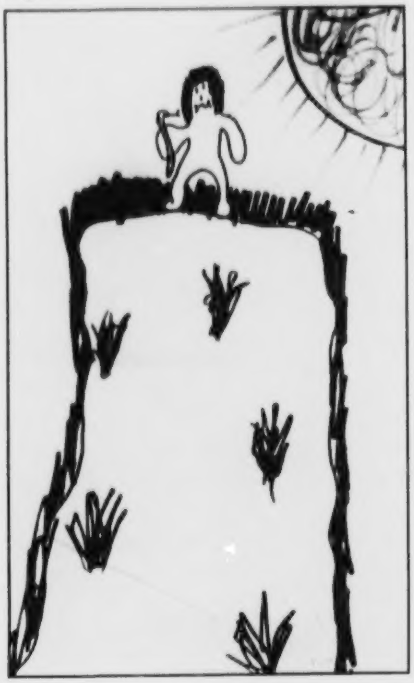


Fig. 5

Fig. 6



In her third picture, Jamie represented a bad environment (Figure 6) by drawing herself alone on a hill surrounded by asthma triggers of: grasses, humidity, and emotions. She stated that in the picture, she was holding a snake which caused her to feel anxious, and this exacerbated her asthma. The picture again reflected her feelings of anxiety related to being left alone to care for herself and her asthma, and her fear that she would be unable to do this. Additionally, Jamie's figure drawings in all three pictures appeared to be of neuter gender which reflected a tenuous self image.

These pictures were used therapeutically to help Jamie become conscious of her anxieties and fears associated with her asthma self-care. These pictures were also shared with Jamie's father in order to: 1) make him more sensitive to Jamie's anxieties about her asthma; 2) encourage him to begin to take Jamie's asthma more seriously; and 3) take interest in helping Jamie make appropriate self-care decisions.

CASE III

Mike was a 13-year old male referred to the unit for evaluation due to concerns about the effects of family stress on his asthma and his medical noncompliance. Mike was the only child remaining at home after his 21-year old brother and 19-year old sister moved out to attend college.

Mike developed asthma at the age of 11 and the following year experienced a respiratory arrest and hypoxic seizure. Approximately six months after Mike's diagnosis, his mother was diagnosed as having asthma, and required several hospitalizations and emergency room visits. During the two years prior to Mike's diagnosis of asthma, the family experienced a number of stresses. Both parents worked and Mike's father had experienced increased stress in his job, requiring him to work longer hours. In addition, Mike's mother had begun a second business. Mike's mother also reported increased marital difficulties characterized by her husband's drinking, anger, and increased time away from home. It was also difficult for the family to handle the emancipation of their two older children. Mike's parents appeared to have limited coping skills in handling the stresses and responded by withdrawing, avoiding activities, and drinking. These unresolved issues seemed to have interfered with their providing mutual support and effective parenting for Mike.

Further, Mike's parents did not provide adequate supervision of his asthma and expected Mike to take almost total responsibility for his asthma care. Mike had reported being afraid to tell his parents when he was having trouble with his asthma. He perceived that they would not know how to respond because of their emotional reactions (e.g., fearing that his father would become anxious and his mother would have an asthma attack).

Mike had experienced social and academic difficulties and related depressive symptoms which appeared to have been a consequence of his emotional difficulties accepting his asthma.

Mike was referred to art therapy to evaluate his self-image and methods of coping with his asthma. Mike willingly completed the asthma pictures, but spent an excessive amount of time drawing the details in his pictures. He made statements about feeling that everything had to be drawn perfectly. This reflected his very compulsive and perfectionistic style as well as an extreme concern about what others think.

In Mike's first picture (Figure 7) he drew himself helplessly tied up and standing on a "treadmill going nowhere." He explained that the tight bonds constricted his ability to move and breathe. This, he said, was similar to how it felt to have an asthma attack. Mike stated that in this picture no one understood or wanted to help him, including doctors and family members, so he would inevitably drop into the tunnel. The "tunnel to nowhere" may have been a metaphor for dying, but Mike could not acknowledge this. This picture and his verbal explanations clearly reflected a sense of hopelessness, helplessness and depression. Mike's perception of himself as a doomed victim was also suggested.

Mike's second picture about a good environment (Figure 8) was also worrisome. He drew himself huddled in the corner of an empty room with his only comfort being a lantern. Mike stated that in this picture he was in a room devoid of asthma and allergy triggers, and away from people and stress. He expressed his wish to be in total control of his asthma management, so he would not have to rely on others. The emptiness of the picture reflected a sense of isolation and perhaps depression. His comments of wanting to care for his asthma by himself and to withdraw from people suggested his inability to allow others to help. This perception may have been related to the fact that his parents had difficulties helping Mike appropriately care for his asthma.

Mike's last picture (Figure 9) of a bad environment also suggested a theme of mistrust of others. Mike explained that the eyes in his picture represented people hiding behind a "wall of bushes." He added that these people did not understand him or his asthma, they were not to be trusted, and they were trying to figure him out. Mike stated that in this picture he was alone, out in the open, and on "unstable ground." This was perhaps suggestive of his own feelings of vulnerability and mistrust of the therapist as well as others. Mike stated that the treadmill from the first picture (Figure 7) was "looming in the distance," (left hand side of this picture) and represented for the impending doom of his having another asthma attack. Again, Mike's perception of himself as a vulnerable, helpless victim was clearly portrayed. Also represented was the paranoid ideation that people were out to harm him, and not to be trusted.

These pictures were helpful in identifying Mike's perceptions of himself as a helpless victim who had asthma and his extreme mistrust of the ability of others to help him. The art therapist informed the multidisciplinary treatment team of Mike's perceptions. This helped the team

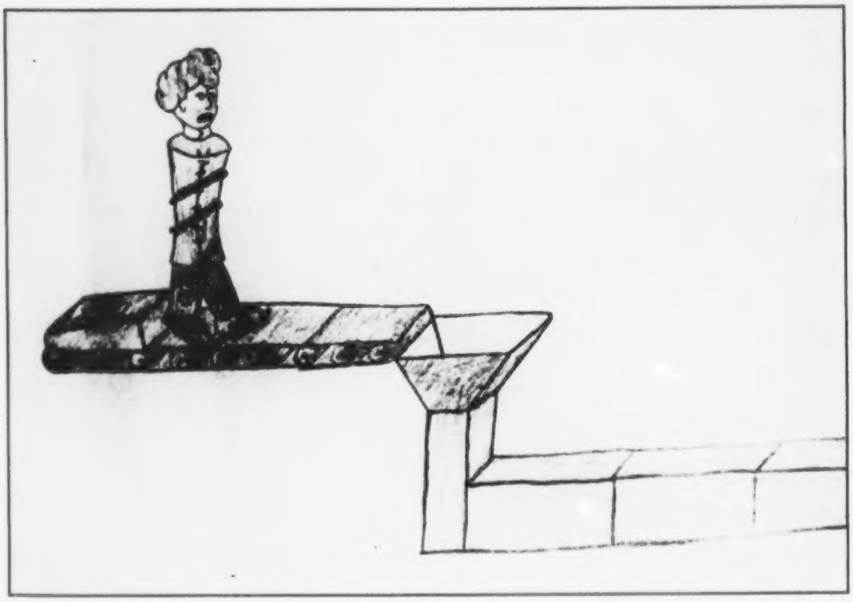


Fig. 7

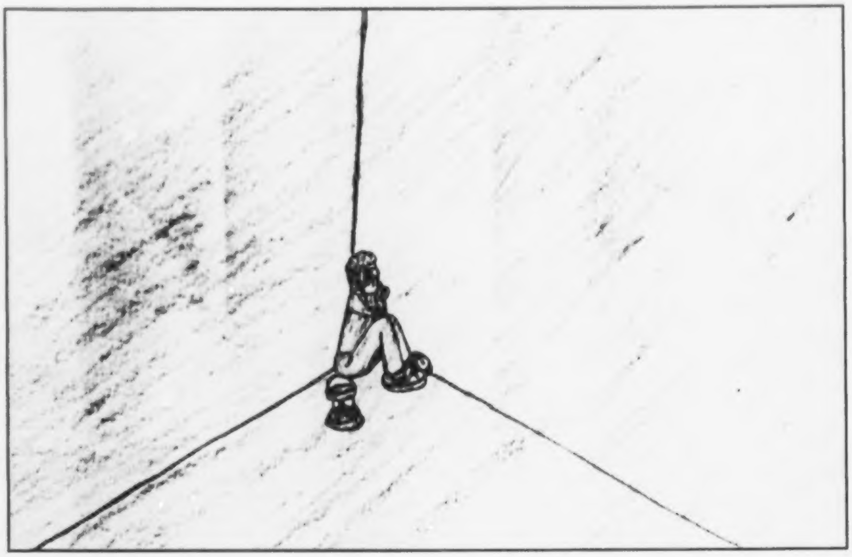


Fig. 8

members to determine appropriate ways to work with Mike as well as to set appropriate self-care goals for him. Progress was made in helping Mike to learn how to care for his asthma, and he began to feel more confident and less helpless in his asthma management. In addition, while in art therapy, Mike began to feel more comfortable trusting in a therapeutic relationship when he experienced having someone else understand his asthma-related fears.

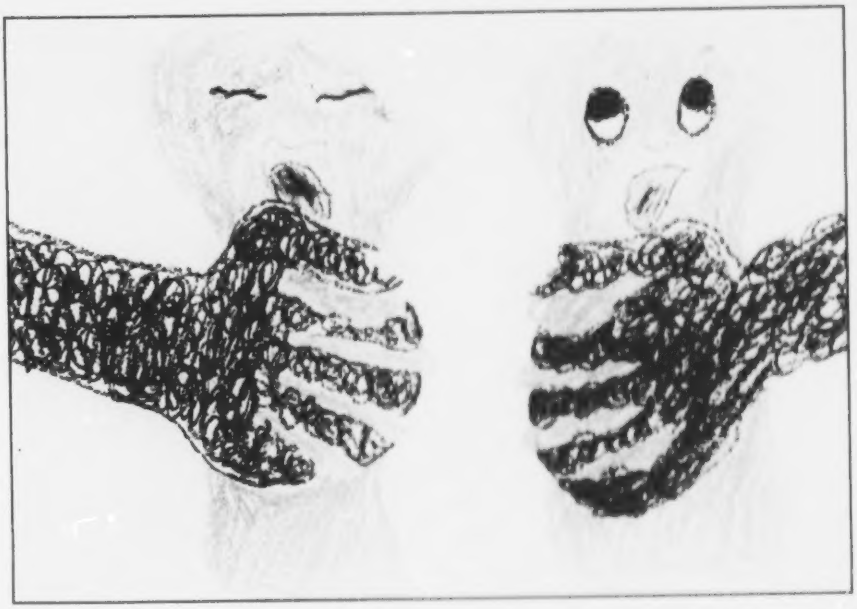


Fig. 10

CASE IV

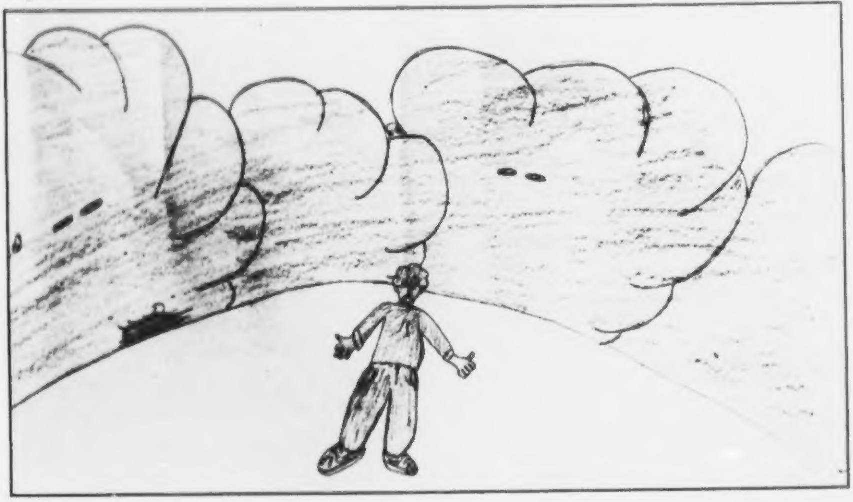
Dana was a 16-year old female who had multiple hospitalizations for her severe asthma. Her asthma was poorly controlled, and she suffered life-threatening attacks despite maximal medical management. Dana was extremely achievement oriented and perfectionistic. She relied heavily on intellectualization, and she had a strong need for control.

Dana was referred to art therapy to assess her use of this media in helping her cope with her anxieties associated with her severe illness. Dana was initially hesitant about completing the asthma pictures because she said she was so tired of doctors and nurses always asking her to explain her asthma symptoms in detail. Dana was finally willing to do the asthma pictures when it was presented to her as a means of explaining her opinions and feelings about her illness.

Dana explained in her first picture (Figure 10) what it felt like to have an asthma attack. She drew her lungs being "squeezed by a monster's hands." She explained that the monster was her asthma, and that it was so big because it was impossible to understand or control. It was pointed out to Dana that she had drawn her lungs so big that the rest of her body could not be included. Dana stated that she felt like just "a pair of lungs walking around" and that she was nothing because her lungs were the only part of her that received attention from people. This picture, and Dana's comments, reflected Dana's feelings of emptiness, powerlessness, and helplessness over her asthma. This picture, and Dana's comments, also reflected identity problems. Her asthma overshadowed any possibility for her to establish a sense of herself beyond being a severe asthmatic. There was a real hopelessness about her perception of her asthma as a monster, that could not even be fully imagined or controlled.

Dana's drawing of a "good" environment for her asthma (Figure 11) was of herself living underwater with fish. She commented that fish were lucky because they "never had to breathe," they could just get air from their gills without effort. Dana stated that she would like to have gills so she would not have to work to breathe. Her picture reflected a retreat from people rather than viewing them as helpful. Her comments about not wanting to work to breathe suggested depression and

Fig. 9



BEST COPY AVAILABLE

perhaps a wish not to live with her asthma.

In Dana's final picture of a bad environment (Figure 12), she depicted herself as extremely small and standing inside a gigantic cigarette box. There was a lighted match which "is about to light the cigarettes." Cigarette smoke had, in the past, triggered life-threatening asthma attacks. Themes of impending doom, depression, and hopelessness were clearly identifiable in this picture and in her verbal descriptions. The gigantic cigarettes and lighted match reflected much anxiety. Her facial features in the drawing did not portray any particular emotion such as distress or fear which suggested her own feelings of apathy regarding a will to live.

Dana had a very difficult time tolerating any further discussion of these pictures after she finished them. She was eager to end the session which indicated her anxiety revealing her depressed and hopeless feelings.

Dana's work in art therapy focused on her gaining a sense of mastery and control over the art work itself, and, at the same time, working with potentially frustrating and less controllable materials such as finger paint. As therapy progressed, she began to make pictures of comfortable environments in which to relax, but also made provisions for her illness self-care. This was much more realistic and reflected more acceptance of her illness than her original drawing (Figure 11).

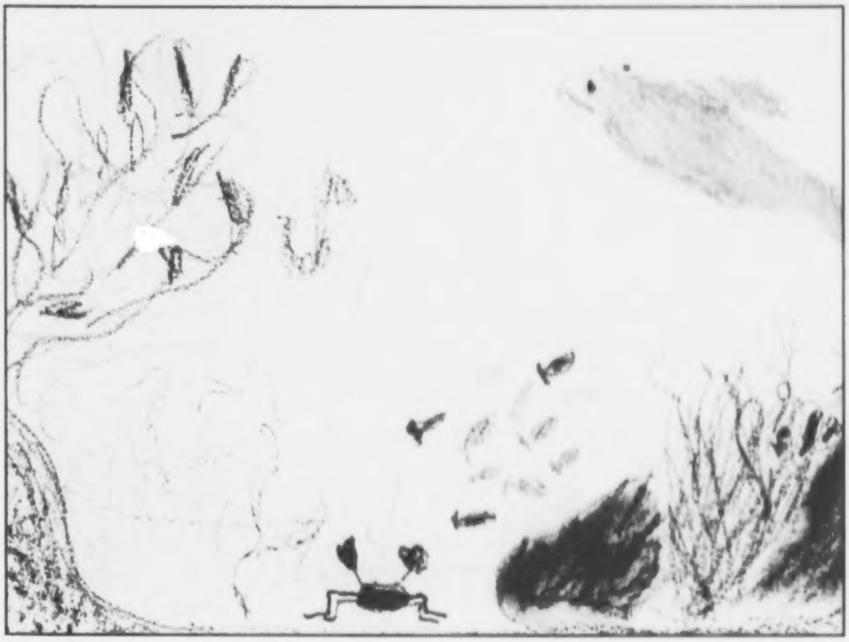
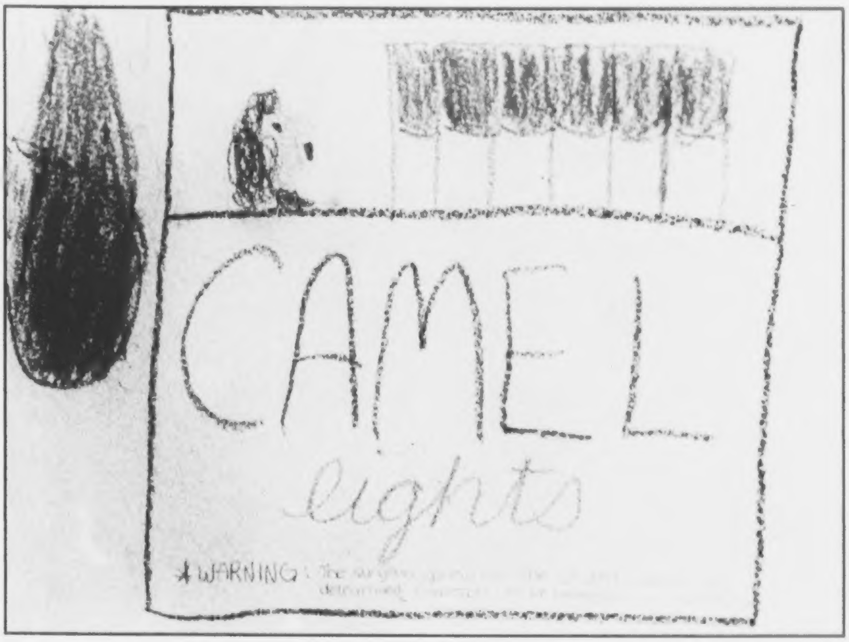


Fig. 11

Fig. 12



Discussion

Several themes were identified by the technique introduced in this article. In general, these children expressed an overwhelming sense of helplessness and lack of control over their illness, feelings of fear and anxiety associated with their illness, and passivity in dealing with their illness. Recurrent themes specific to asthma were feelings of being suffocated, squeezed, trapped and vulnerable.

For the purpose of identifying various coping styles, it is helpful to look at the grieving stages identified by Elizabeth Kubler-Ross in her book, *On Death and Dying*. Kubler-Ross (1969) noted five stages of grieving in the terminally ill: denial, anger, bargaining, depression, and acceptance. These stages of grief are also observed in the coping styles of chronically-ill asthmatic patients. Asthmatic children must cope with a

BEST COPY AVAILABLE

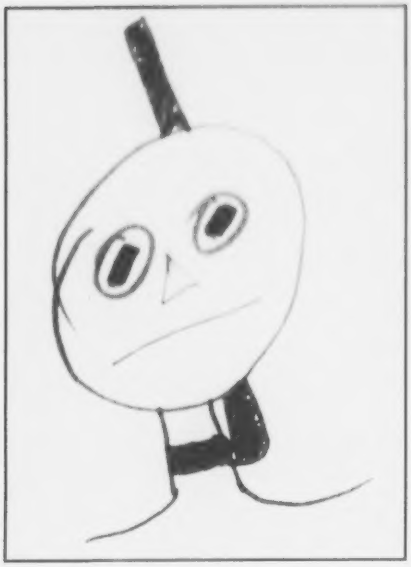


Fig. 13

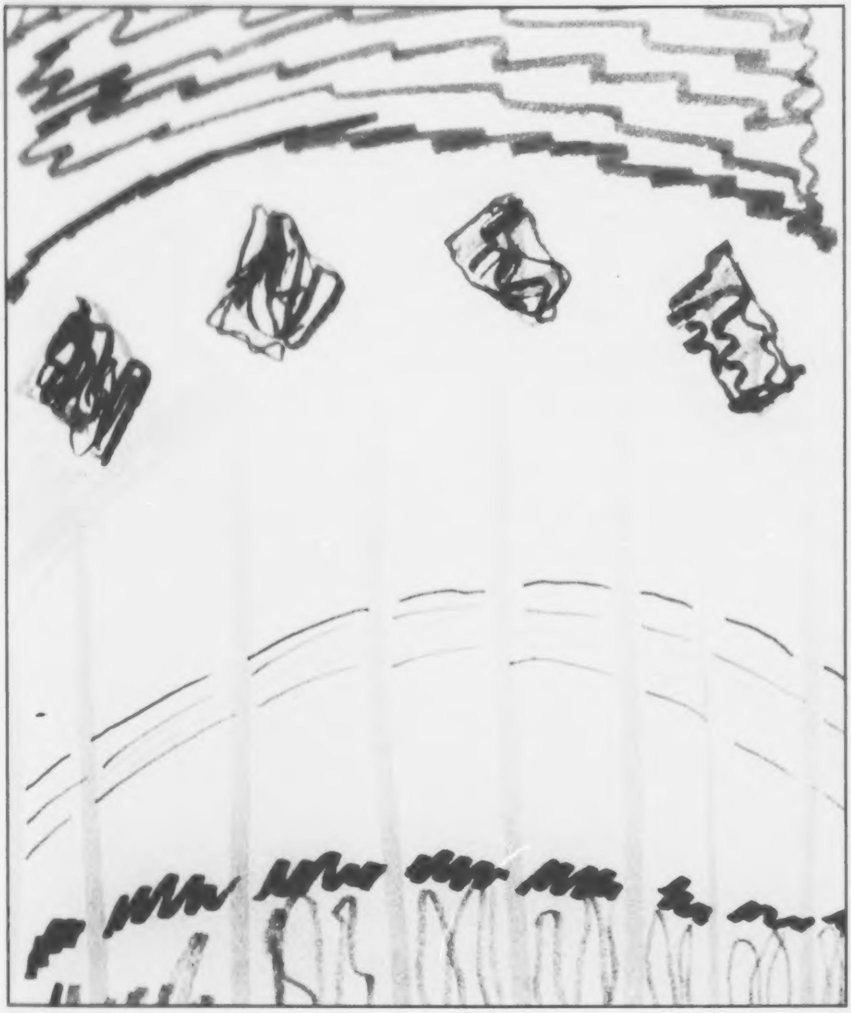


Fig. 14

life of chronic illness. Severe asthmatics must also face the possibility of death. Children who deny the severity of their illness may purposely refuse or forget to take vital medications, or they may continuously expose themselves to harmful allergens. This was true in Cases I, II, and III. Another example is the children who are seriously depressed about having asthma. They may become suicidal and act this out, either by taking an excess of medications or by not taking their medications at all.

Specifically, among the four cases discussed in this article, depression was a common manner of coping that was clearly revealed through the patients' drawings and comments. In every case, the patients presented themselves as helpless and overpowered by their illness. Their depression incapacitated their abilities to successfully manage their asthma.

Closely related to depressive themes, though not referenced in the cases presented, was a sense of helplessness, of giving up, and a wish to die which was indicated in other patients' drawings about their asthma. Figures 13 and 14 were both drawn by a 14-year old, suicidal male patient in response to tasks one and two of the technique. This patient described wheezing in Figure 13 as feeling like he was choking and going to die. Figure 14 was a picture of "heaven," which was identified as the only helpful, good place for him and his asthma. He exhibited his severe depression and suicidal ideations by drawing himself with a noose around his neck (Figure 13) and depicting "heaven" as a place where he wanted to be.

Children who are extremely angry at the idea of having to live with and adjust to their illness may react like those who deny their illness. They may avoid taking vital medications and expose themselves to harmful allergens. This is extremely self-destructive because it puts them at risk for having severe asthma attacks. Figure 15 was a drawing done by a 14-year old, male patient who was extremely angry at having asthma. In this picture, he aggressively

> *". . . stages of grief are also observed in the copying styles of chronically-ill asthmatic patients."*

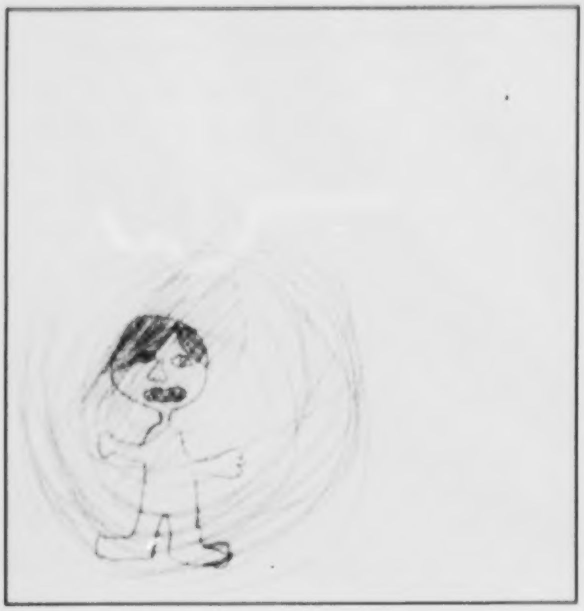


Fig. 15

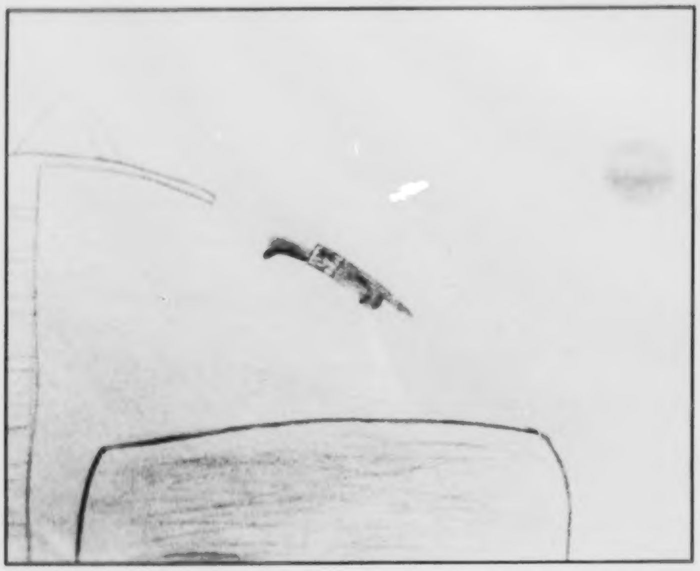


Fig. 16

scribbled over his drawing of himself. This self-destruction in his picture was reflective of his self-destructive behaviors at home of not taking his asthma medications.

The stage of bargaining has not been identified in severe asthmatic children. This is perhaps due to the fact that these patients still maintain some level of control over the course of their illness versus terminally ill patients.

Acceptance of illness was clearly demonstrated in Figure 16, drawn by a 12-year old male. In this picture, the patient attempted to depict a good environment for himself and asthma. This patient shared that he enjoyed diving because this was something he could do well. He also added that swimming helped him to relax when he wheezed. The child's picture and comments reflected his ability to maintain a positive sense of himself despite his illness, and not allow his asthma to incapacitate him.

In order to assess children's coping styles using the technique introduced in this article, the therapist must go through a series of steps. First, the therapist needs to examine all of the elements including art work, verbal associations, and psychological and medical history in order to make appropriate conclusions about patients' coping styles. Second, the therapist needs to consider several general issues regarding coping abilities and determine how they are expressed in the patient's art work and comments. These issues include: 1) self-esteem and body-image; 2) adequate self-care knowledge; 3) compliance with medical treatment; 4) ability to function reasonably well despite illness; and 5) ability to express affect.

It is important that the therapist notes what children depict as harmful to themselves and their illness, such as unhelpful people and environmental and emotional triggers. This may provide further information about children's perceptions of their home environment.

Art therapy has proven to be an effective medium, complementary and sometimes supplementary, to more traditional modes of therapy. Art therapy allows verbally defended children and adolescents to reveal serious concerns and problems unconsciously through their drawings, which can then help to focus the therapeutic process.

> Art is a less customary communicative vehicle for most people, and therefore (is) less amenable to control. Unexpected things may burst forth in a picture or sculpture, sometimes totally contrary to the intention of its creator . . . Unexpected recognition often forms the leading edge of insight, learning, and growth. (Wadeson, 1980, p. 10)

Many of the patients on the Psychophysiologic Unit have great difficulty expressing affect. They express themselves maladaptively through somatization and/or through harming themselves or others. Art therapy provides an appropriate outlet for these patients to express and vent their feelings, some of which include: intense fear, anger, lack of control, aggressive impulses, and depression. "The art object allows the individual, while separating from the feelings, to recognize their existence. If all goes well, the feelings become owned and integrated as a part of the self." (Wadeson, 1980, p. 10)

When patients utilize a great deal of denial, art therapy has particular value. The pictures or sculptures done in art therapy provide a perma-

"Art therapy has proven to be an effective medium, complementary and sometimes supplementary, to more traditional modes of therapy."

nent visual record of problems and concerns revealed, and as such, does not allow for denial of memory in the therapeutic process.

The technique presented in this article facilitates patients' abilities to express feelings about chronic illness and its effect on their lives. The art work allows patients to distance themselves from painful affect, giving them a chance, metaphorically, to separate themselves from their illness, ". . . the painted image can cope with the expression of the infinite and the oblique in ways that language cannot." (Dalley, 1984, p. 132)

This technique has only been used with asthmatic children and adolescents, ages 7 to 17, but may be of benefit to adults. This technique could be modified to be used with patients who have other chronic illnesses.

Further research is needed to make this art therapy technique a more standardized measurement of coping with chronic illness. At present, work is proceeding to develop a system of objective, standardized scoring for this technique.

References

Dalley, T. (1984). *Art as therapy.* London and New York: Tavistock Publications, p. 132.

Kubler-Ross, E. (1969). *On death and dying.* New York: MacMillan Publishing Company.

Mathas, I. (1981). Assessing the nature and clinical significance of psychological contributions to childhood asthma. *American Journal Orthopsychiatry,* 51(2):327-341.

Mrazek, D.A. (1985). Childhood asthma, the interplay of psychiatric and physiological factors. *Adv. Psychosom. Med.,* 14:17.

Prugh, D.G. (1983). *The psychological aspects of pediatrics.* Philadelphia: Lea and Febiger, p. 337.

Strunk, R.C., Mrazek, D.A., Wolfson-Fuhrmann, G.S., LaBrecque, J. (1985). Physiological and psychological characteristics associated with deaths from asthma in childhood: A case controlled study. *JAMA,* 254(9):1193-1198.

Wadeson, H. (1980). *Art psychotherapy.* New York: John Wiley and Sons, p. 10.

Acknowledgments

I would like to extend my sincere appreciation to Gary Boxer, M.D., for his consistent support and supervision pertaining to the writing of this article.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:
Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

REVIEWS

August Walla

Leo Navratil. *Nördlingen: Greno Verlagsgesellschaft, 1988. 240 pp., over 300 illustrations, DM 68 - .*

Reviewed by: ***Roland Fischer, PhD****, University of Basel, Switzerland, was formerly a research professor with the Department of Psychiatry of The Ohio State University, and a researcher at The Maryland Psychiatric Research Center. Honorary member of the Biofeedback Society of America, and the International Society for Psychopathology and Artistic Expression (including the German-speaking Society for Psychopathology and Artistic Expression). His bio-philosophical papers are translated and published in English, French, Spanish, Japanese and Arabic.*

After Pinel, who (1795) in Paris initiated the liberation of the mentally ill—by removing the chains from his asylum inmates—Prinzhorn (named Prinz Wunderhorn in Hermann Hesse's *Steppenwolf*), in 1922, added a revolutionary momentum to the process of liberation by publishing his *Artistry of the Mentally Ill*, comparing the bizarre works of the patients with the art objects of children and aboriginals. Most shockingly, striking parallels were shown between the art of mental patients and the art of the *avant garde* of the day, the German Expressionists. But the selective rehabilitation of the gifted but unrecognized artist among mental patients, that is, the rehabilitation of such patients *qua* artists, was left to Leo Navratil, Austrian psychiatrist (MD, and PhD), who devoted his entire professional life (1959-1986) to this task in the State Hospital for Psychiatry and Neurology at Klosterneuburg-Gugging, near Vienna. In 1981 Navratil could (literally) see the culmination of his career, his *Magnum Opus*, the House of Artists, a two-storey building on the premises of the Hospital, adjacent to a forest, a pavillon with studios for those creative patients who are at work with their rehabilitation as painters and writers. August Walla is one of them, attested by the 300 fantastic (mostly colored) illustrations of Navratil's monograph under review. Although the text is in German, the illustrations speak for themselves, and do so in all languages. Walla, diagnosed as schizophrenic from his early youth on, signs and sells his most original and decorative paintings, which are unburdened from the constraints of conventional art. Accordingly, Walla does not consider himself an artist ("I paint only to please him"—i.e. Navratil), he asserts. Nevertheless, this artist malgre lui is eager to treat himself through art. This kind of art therapy is an iconic reshuffling of one's autobiography, a pictorial process of cognitive self-organization. It may be considered as a creative state that proceeds on a level of arousal that is intermediate between the low arousal level of daily routine and that of schizophrenic hyperarousal. Creativity, in this sense, is another spontaneously organizing process that can also be observed in atoms, molecules, biological cells, organisms and societies; it operates in games and governs the circulation of money, the formation of words from letters, and the creation of galaxies from clusters of nebulae.

But what is a work of art? It's both a "narrative home" and a symptom of the human condition (in the Freudian sense), epitomizing the unity of the psyche's four poles: the wish and its Superego, the Ego and its Reality. Hence we may ask the (therapeutic) question: What kind of an artist is induced by the work of art? Anne Lister (1791-1840) in her diary replies: "I generally feel relief from unburdening my mind on paper." But a work of art is also "an object that is produced by an artist as an embodiment of his emotions or feelings and evokes those emotions and feelings in an observer of the object" (Tolstoy, 1896). "Significant form" on the other hand is the one quality common to all works of visual art, posits Bell (1913), whereas Dickie (1974) contends that an object is a work of art if and only if some member of the art world has conferred the status "work of art" on the object. Apparently, whether an object is a work of art is purely a matter of historically changing convention. In our pluralistic days there is a "framed art," the child of galleries, museums, experts, art schools and art dealers, an art that is cut off from its magical, mythological, political and therapeutic roots (Thévoz). And there is an "art brut," that is, "raw art" (Dubuffet), and Walla belongs to this "school without school." This is a wild, traditionless, highly symbolic art with an individual mythology and very personal defense system. But common to both "framed art" as well as "art brut" is that they display, according to Navratil, three trends for patterning (Gestaltungstendenzen): the trend to physiognomize, to formalize, and to symbolize. What kind of people are artists? The Wittkovers trace "the scholarly and popular belief that artists . . . form a race apart from the rest of mankind," and maintain that "the 'otherness' of artists is widely accepted by the general public," who believe that artists are, and always have been, egocentric and temperamental outsiders: neurotic, rebellious, sensitive and intuitive individuals, unreliable and licentious, extravagant and obsessed by their own work (in short, altogether difficult to live with). No wonder that few parents want their child to become an artist. Walla, and his fellow artist-patients, fit easily into this deviant category.

Walla, born 1936, in Klosterneuburg, was a problem-child. He could not succeed in school, and never learned a profession. Most of the time he lived with his mother and was only occasionally (and for short periods) in psychiatric treatment. His art is during these (drug-assisted) intervals rather plain. Since 1983 he lives in the House of Artists (the Walhalla of Walla), in Gugging, visiting regularly his 92-year-old mother at a nearby geriatric ward. Walla moves in this world of ours like a sleepwalker, covering large canvases and any available surface (inside and outside of the House) with his Gods and Devils, his ornaments and symbols. The figures of this personal religion and self-styled mythology are the pillars of his magical-mystical world: a narrative home in a universe of fiction. Although influenced by Austrian Catholicism, the religion of his upbringing, Walla's Gods and Devils are very personal projections and identifications. So is his symbolism that utilizes the military emblems of the coming and going Nazi- and Russian-occupying forces. The swastika in Walla's paintings, for example, has no political significance but stands for his feminine gender identity, which, so he pretends, was surgically altered by the Russians to make him a communist "double-boy." Walla's writings—on walls, postcards, trees, and all kinds of surfaces—are executed in a calligraphic-ornamental style of his own, emphatically drawing each separate letter and thus amplifying the semiotic aura of these word-icons. In general, it is the connotation of words that overshadows their denotative meaning. The affective logic of higher states of arousal radiates from these hyperphrenic "writings on the wall" reflecting an inner dialogue. These multi-colored and often large-sized combinations of writing-and-painting emanate a childlike innocence of hypnotic persuasion. These are manneristic texts with their own system of signs. Indeed, the entire manneristic universe of Walla is perfused with signs.

In contrast to Museums, the cemeteries of "framed art," an art that is solemnly buried-exhibited for socially approved worship, Navratil's House of Artists is a very lively place, indeed. The ongoing creative performance of its more than a dozen artists-in-residence (painters, poets and writers) may be observed in *statu nascendi*. In retrospect, it could be argued that the Zeitgeist favored and indirectly supported Navratil's relentless efforts to rehabilitate his artist-patients. His era witnessed two new and contrasting phenomena: schizophrenic hyperarousal has been lowered through tranquilizers in practically all mental patients of the Western world, while the relatively low arousal levels of normal daily routine were raised in millions of people taking LSD, psilocybin, mescaline, cocaine, and related psychoactive drugs. In a parallel development one could observe an exchange of creative traits against bizarre symptoms between professional artists and mental patients, with the result that patients are nowadays regarded as less sick and more creative (they paint and write in mental hospital settings, healing themselves through art therapy), while artists are more and more looked upon as potential patients who seem to create art in order to stay (relatively) sane and avoid hospitalization. The formerly sharp dividing line between hyperphrenics and "normophrenics" (an expression coined by A. Bader, Lausanne) becomes increasingly blurred, and Navratil's campaign of rehabilitation did both profit from as well as contribute to this development.

But the proof of the pudding is in the eating. Walla's art work is selling well, and so does the artistic output of the other artists in residence. Hauser's "Naked woman with hat" was auctioned at Christie's, in London, for 35,000 DM. All residents do pretty well; all are owners of a personal TV set. They are visited, filmed, and can be seen all over Europe on the TV. The West-German weekly, Der Spiegel, featured a five-page article on Walla and his art (in the January 25, 1988 issue), and the permanent Walla collection of the Museum of Modern Art, in Vienna, is to be shown in Switzerland, Heidelberg and Berlin.

The House of Artists is the only Art Academy in the world that is located on the campus of a State Mental Hospital. Navratil, who has published dozens of fascinating books (in German) on the relation of schizophrenia to art, literature, and poetry, was able to create a permanent institution that rehabilitates the artist suffering from his own creative sensibility. We can only repeat the same words of salute and praise which were once said of William James: "What a real person he is."

The Psychocybernetic Model of Art Therapy

Aina O. Nucho, PhD, ATR, ACSW. *Charles C. Thomas, Springfield, IL: 248 pp, $34.50*

Reviewed by: ***Connie E. Naitove, ATR;*** *reprinted from the NECCT Newsletter (Vol. 12, #4) with the author and publisher's permission.*

The Psychocybernetic Model of Art Therapy . . . is one of the most important books to be published in the field of expressive therapies, period! Not only does the text carefully explain the background and significance of Nucho's psychocybernetic model, but it does so with clarity, organization and thoroughness. In fact the entire volume is a model of clarity. The first quarter of the book discusses the theoretical foundations of Nucho's concepts involving cybernetics, systems theory, images and symbolization. This is followed by one of the best descriptions of the historical and theoretical foundations of art therapy to be found in print. Nucho then draws the two factors neatly together and, in the second half of the book, explicates, with a series of illustrated descriptions, her psychocybernetic art therapy process. The book concludes with the results of scientific clinical studies designed to ascertain the validity of this approach. This is followed by some illustrated "Case Vignettes" which read like any other projective descriptions of client art work, are not clearly tied to the psychocybernetic theory and could easily have been omitted.

It should be understood that this is NOT a run-of-the-mill art therapy text. Nucho is refreshing in the depth of her research and her choice of references. Indeed, the theories and concepts explored and referenced lend themselves to other arts and therapeutic approaches.

It should also be said that this is NOT a simple book! The very title makes it clear that neither the theories nor the vocabulary are all that familiar or self-explanatory. Nor is this a book wherein the reader can pick out isolated chapters or segments to read and come away with any degree of understanding of the meaning and significance of the psychocybernetic model of art therapy. For best understanding, the book should be read in toto, from beginning to end. It is an ideal text for the classroom, since each segment could be followed by discussion and the opportunity to become comfortable and fluent in the language and concepts.

Many knotty issues are classified within the text, from the role of the therapist as a facilitator (p. 20), to therapeutic significance of such activities as sports and crafts. "It may be therapeutic just as gardening or splitting wood may be therapeutic in that it may help a person feel more effective and worth while. But it has very little to do with the information sorting and processing endeavors which are the core of the psychocybernetic model of helping." (p. 79) Also, Nucho displays a rather refreshing sense of optimism concerning the last half of the 20th century and rapidly encroaching 21st. She regards the "explosion of thinking and practice in the field of human behavior" in a light of philosophical renaissance and anticipates "radical development of new knowledge in the neurosciences and in behavior . . ." which will enable art therapy, per se, and the expressive therapies in general "to play a strategic part in the healing arts (and, we suspect, in education as well) for future generations."

Passion in Art: Miracle Department

Harriet Wadeson, PhD, ATR

Expect the unexpected: in art; in life. Living with passion, making art with passion, makes all the difference.

Kyle was born two months premature, deformed and brain-damaged. Skull x-rays indicated abnormal brain development with one hemisphere smaller than the other. Electrocardiogram showed assymetrical brain activity. An initial eye examination revealed no evidence of vision, but later tests amended the diagnosis to legal blindness. Repeated intelligence tests at the National Institutes of Health during the first years of life scored Kyle mentally retarded. At 18 months the Director of the Diagnostic and Evaluation Center for Handicapped Children at Johns Hopkins University Hospital gave Kyle the definitive prognosis of "never reaching beyond an eight-year-old level."

Figure 1 is one of Kyle's early representations of himself drawn when he had first turned five. He had started talking only a few months earlier. Note the eyes, an accurate portrayal of Kyle's one normal looking eye (in fact the retina was damaged) and the slit where his other eye never developed. The figure is well-developed for a child of Kyle's age, and the hands each have five fingers even though Kyle could not count at this time.

More exceptional is Figure 2, Kyle's representation of a cement mixer drawn a year earlier when he had just turned four. He was passionately interested in vehicles at that time — trains, buses, trucks, helicopters, all of which he drew repeatedly. For a "normal" child of four, this drawing would show advanced development. For a blind, retarded child, Kyle's drawing ability was remarkable.

At age eight Kyle's passion was the piano which he had taught himself to play, Figure 3. Like all his drawings, this one shows exceptional accuracy of detail and spatial relationships. Kyle never drew from a model; his memory was a remarkable visual catalog of unusual exactitude for objects, scenes, and events from both the recent and distant past.

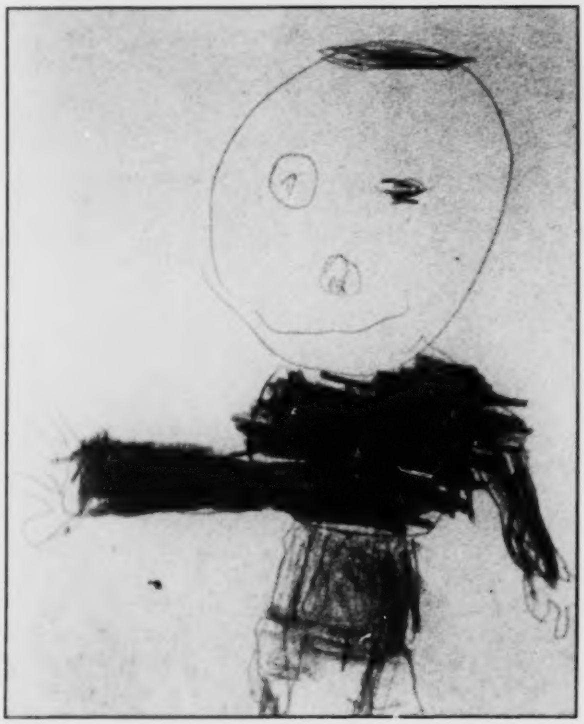


Fig. 1

Now Kyle is grown, and despite a lifetime of rejection by his father and his peers, he continues to live his life with passion. The focus of this supposedly blind young man continues to be visual expression, now in the form of photography. Figure 4 is my photograph of a color enlargement he shot, developed and printed, of me getting ready to take him out to dinner. My dress is a vivid red color that he has captured as accurately as the more subtle flesh tones. Though it has taken him longer than most kids, this boy who "would never reach beyond an eight-year-old level" is about to graduate from college. Though his visual impairment is considerable, he has bicycled hundreds of miles on trips throughout New England and Nova Scotia (another passion: he builds bikes). His university purchases his photographs of campus life for their publicity brochures.

What are we to make of this passion for living and creating that grows against all odds? Certainly Kyle connects to the world and takes it in through his

704

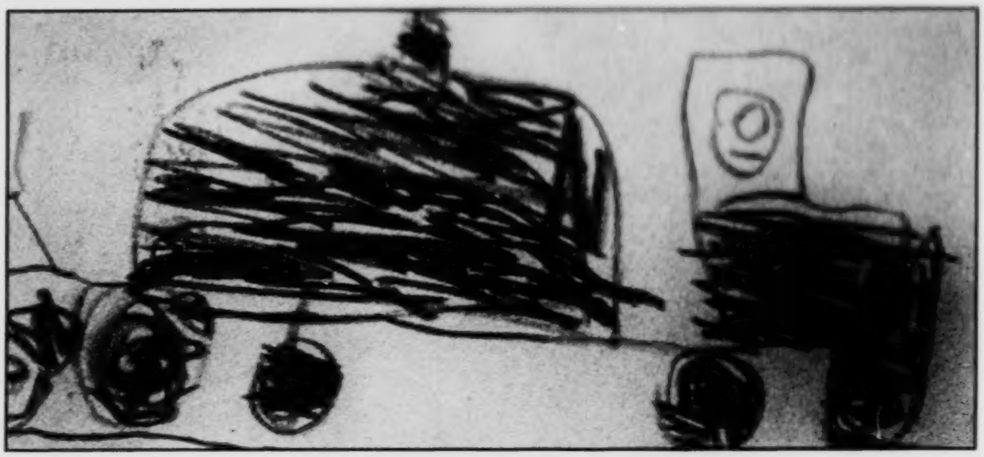


Fig. 2

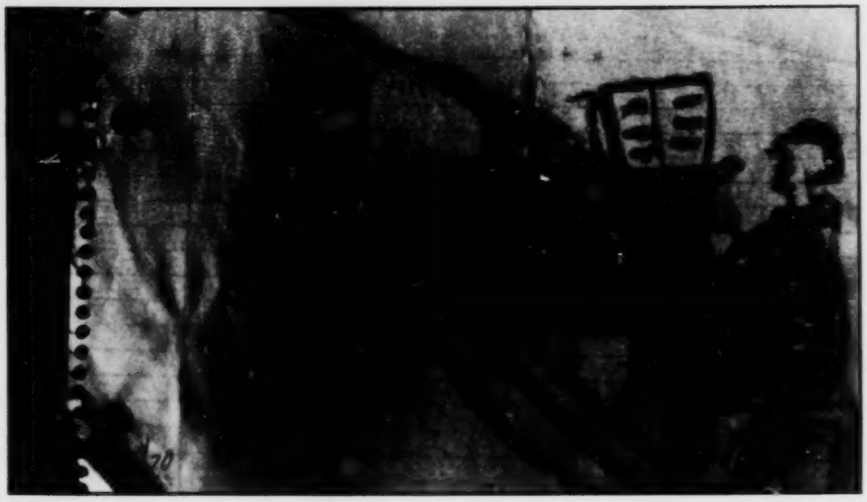


Fig. 3

Fig. 4

limited vision and unique intelligence. But beyond that is his visual re-creation of his world, from the fascinating vehicles that passed his house in earliest memories to the complexities of life at a large university that engage him now. Creating has been a consistent driving passion in his life. It is an integral part of the person he is.

What is the nourishment from within and without that will not let creativity die even under the most unlikely conditions? How is it that one person retains a vital passionate link to the life around him while another with similar hardships would wither and withdraw? Perhaps we are left with only our wonder at the miracles we witness and our gratitude that we may partake of them.

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

GENERAL MEMBERSHIP INFORMATION:

1. The membership year is the calendar year January 1st through December 31st.
2. Contributing, Associate and Student applicants for **NEW MEMBERSHIP ONLY:** Please follow the chart below when submitting membership application.

   Applications received between

   January 1st and May 31st - Full dues payment
   Membership will expire December 31st of the same year.

   June 1st and September 30th - Half year dues plus $5.00 payment
   Membership will Expire December 31st of the same year.

   October 1st and December 31st - Full dues payment
   Membership for the remainder of the current year and the next full year through December 31st applies.
3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval. Contact the AATA office for Professional Membership application packet and Criteria.
4. AATA Membership and AATA Registration (ATR) should not be confused. Each has a separate application procedure. Registration is bestowed only by the Standards Committee. Contact the AATA office for Registration application packet and information.
5. Benefits of AATA membership:
   a. Membership Directory & Bylaws
   b. Subscription to ART THERAPY, the Journal of the AATA
   c. Quarterly AATA NEWSLETTER
   d. Discounts on publications, Annual Conference fees and preconference courses
   e. Availability of group insurance
   f. Special mailings of professional interest
6. National AATA membership is required for Chapter membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES:

PROFESSIONAL - by application only, such members may vote, hold office and serve on committees.

Credentialled Professional Member:
Individuals who have been dually approved for Professional Membership AND Registration (ATR) by the AATA. Dues are $80/yr.

Active Professional Member:
Individuals who have completed professional training in art therapy (education). Dues are $75/yr.

CONTRIBUTING - Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dures are $100/yr.

ASSOCIATE - Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75/yr.

STUDENT - Individuals who do not meet the qualifications of Professional Membership and are currently taking courses in art therapy or related fields. **Requires a current statement or letter from the institution of learning indicating:**

a. Fulltime status: 6 graduate semester units or 12 undergraduate semester units or equivalent

b. Coursework content

Student members may not vote or hold office but may serve on the Student Committee of Membership. Dues are $35/yr.

Make checks payable to AATA
American Art Therapy Association, Inc.
505 E. Hawley St.
Mundelein, IL 60060
(312) 949-6064

NAME ______________________________
LAST FIRST MIDDLE

HOME ADDRESS ______________________________

____

PHONE ( ) ______________________________

BUSINESS ADDRESS ______________________________

____

____

BUSINESS PHONE ( ) ______________________________

EMPLOYER ______________________________

OTHER BUSINESS ADDRESS ______________________________

____

____

PHONE ( ) ______________________________

EMPLOYER ______________________________

PREFERRED MAILING LIST

____ HOME ____ 1ST BUSINESS ____ 2ND BUSINESS

HIGHEST DEGREE RECEIVED ______________________________

LICENSES HELD & STATE ______________________________

____ **PROFESSIONAL MEMBERSHIP** (Please indicate by checking here if you wish to receive application and information packet for Professional Membership)

____ **REGISTRATION** (ATR) Please check here if you also wish to receive application and information packet for Registration.

____ **$100 CONTRIBUTING MEMBERSHIP**

____ **$75 ASSOCIATE MEMBERSHIP**

____ **$35 STUDENT MEMBERSHIP**
See student membership criteria for necessary documents to accompany this application.

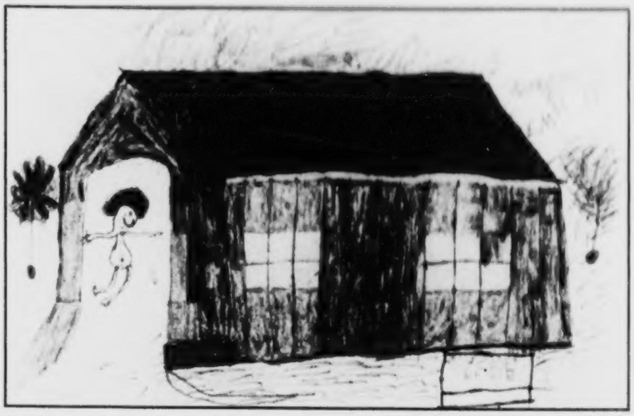
Payable in U.S. Dollars

Dues and expenses related to participation in AATA may be tax deductible as a business expense.

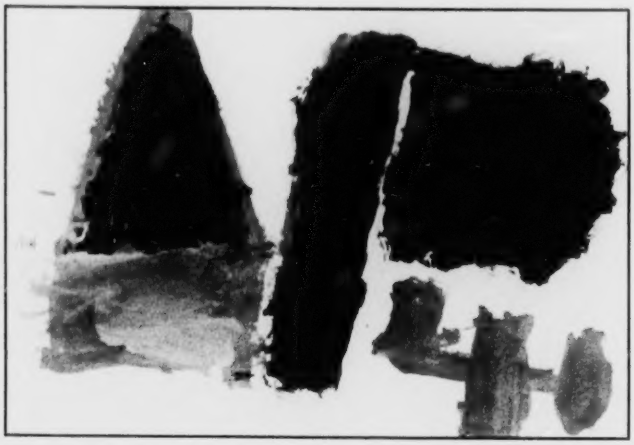
RETURN THIS APPLICATION WITH YOUR REMITTANCE

Art Therapist's Portfolio

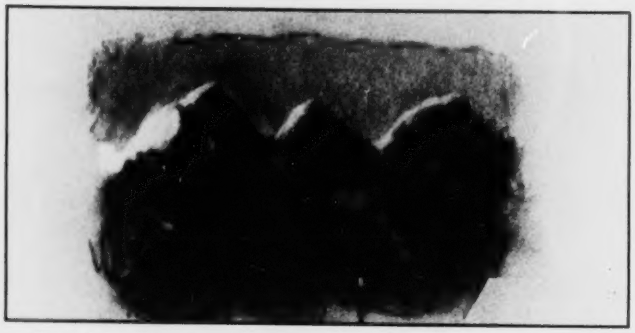
VIEWPOINTS *provides a forum for sharing ideas and graphics about issues facing art therapists. It also encourages the submission of photographs of art by art therapists with an accompanying statement describing the work's meaningfulness to its creator. Submit black and white glossy photographs and four copies of the written material to:* ***Viewpoints,*** *ART THERAPY, 505 E. Hawley St., Mundelein, IL 60060.*



"Jellystone Covered Bridge" - painting by a 75 year old woman in a nursing home. *(Wright State University)*



Painting by an 8 year old learning disabled child. *(Wright State University Art Therapy Clinic)*



Pastel drawing by a quadraplegic college student. *(Wright State University)*

CHARLES C THOMAS • PUBLISHER

New! **FUNDAMENTALS OF ART THERAPY** *by* **Shaun McNiff.** Written in a dialogue format, a major portion of this text discusses questions raised by an art therapist in training. Topics examined include the nature of art, animism and art, archetypal imagery in children's art, theory as creation, diagnostic labels, killing and resurrecting the father, art as dreaming, and eros and image. Throughout the presentation, the author maintains that interpretation is not only fundamental to art therapy but that therapy is itself a process of interpretation. *'88, $34.75*

New! **ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents** *by* **Susan T. Dennison.** This excellent resource manual contains over 100 new and effective therapeutic activities. These interventions have been designed to attract adolescents to therapy and to elicit their full participation once involved. Specific guidelines for their use, timing, and rational are provided through a group therapy practice model and an assessment guide. *'88, $32.75*

THE PSYCHOCYBERNETIC MODEL OF ART THERAPY *by* **Aina O. Nucho.** The first half of this book presents a detailed account of the origins and rationale of art therapy. Then it focuses on the actual therapeutic process of the psychocybernetic model which combines the verbal/analytic and the visual/imagistic symbol systems. The author describes ways to introduce clients to visual forms of expression, the actual "doing" phase, decoding the visual imagery, termination of treatment, and the scope and effectiveness of the model. *'87, $34.50*

VISUAL ARTS AND OLDER PEOPLE: Developing Quality Programs *by* **Pearl Greenberg.** This lucid text provides the background and knowledge necessary to understand and appreciate older adults as artists and to develop quality visual art programs. Chapters explore retirement, gallery and museum programs, adult learning, working with disabled older people, art appreciation, and diverse art mediums. *'87, $30.25*

EDUCATING THE CREATIVE ARTS THERAPIST *by* **Shaun McNiff.** As the first in-depth study of higher education in the arts therapies, this book is essential to all those involved at the more than 200 schools that offer related courses and programs. The author discusses diverse training traditions, areas of concentration, competencies, philosophies, and supervision and evaluation. *'86, $32.75*

THE ARTS AND PSYCHOTHERAPY *by* **Shaun McNiff.** An integrated approach to all of the arts in psychotherapy is presented in this insightful book. The author examines the distinctive and common qualities of the various expressive arts in relation to psychotherapy. He also draws on the statements of artists to develop a psychology of art that views artistic exploration as psychological research of the highest order. *'81, $21.75*

We fill all orders promptly • Books sent on approval
MasterCard, Visa & prepaid orders sent postpaid
Catalog sent on request • Write or call (217) 789-8980

2600 South First Street
Springfield • Illinois • 62794-9265

BEST COPY AVAILABLE

MIAMI®

18TH ANNUAL CONFERENCE PROCEEDINGS
1987 BAL HARBOUR, FLORIDA

The 1987 AATA Conference Proceedings, "New Directions in the 80's" held in Miami, Florida, November, 1987, are available through the AATA National Office in abstract form.

—●—

PRICE PER COPY:

Member - - - - $15.00 each   Non-member - $20.00 each   10 or more - - $12.00 each

QUANTITY   COST   TOTAL

________ x _____ = ______

SEND TO:

NAME/INSTITUTION   MBR ID.#

ADDRESS

CITY   STATE   ZIP CODE

TELEPHONE

TO ORDER COPIES: Mail order form ▶ along with payment to:

- American Art Therapy Association,
505 E. Hawley Street,
Mundelein, IL 60060.

Please make checks payable in U.S. funds to AATA.

19TH ANNUAL CONFERENCE

THE AMERICAN ART THERAPY ASSOCIATION

PRESENTS:

"PROFESSIONALISM IN PRACTICE"

TO BE HELD: NOVEMBER 16-20, 1988
PALMER HOUSE, CHICAGO

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 505 E. Hawley St., Mundelein, IL 60060

Please enter my subscription for 1988. Enclosed is my check, payable to AATA, for $23.
Name ____________________
Address ____________________
City ____________________ State __________ Zip __________

WHAT EVERY THERAPIST SHOULD KNOW

Appears in THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

TAKE ADVANTAGE OF THIS SPECIAL OFFER!

SUBSCRIBERS TO *Art Therapy* and Members of American Art Therapy Association ENJOY REDUCED RATE!

SUBSCRIBE NOW—AND SAVE 50% OR MORE! *The Arts in Psychotherapy* is a quarterly journal in its 14th successful year of serving practitioners, scholars and students of the arts in psychotherapy, mental health and education. It publishes refereed articles (including illustrations) by art, dance/movement, music, poetry, and drama psychotherapists and by psychiatrists and psychologist that reflect advances in theory, research and practice. There are no restrictions on philosophical orientation or application.

AN IMPORTANT SOURCE for news and summaries of national and international conferences and current educational information relevant to the creative arts in therapy, THE ARTS IN PSYCHOTHERAPY contains book reviews, welcomes letters to the editors, dialogue among contributors; has International Editorial and Advisory Boards of highly respected specialists who represent a wide spectrum of experience. It appeals to scholars and practitioners of the arts in psychotherapy and to psychiatrists and psychologists.

THE EDITORS WELCOME ORIGINAL MANUSCRIPTS.

Submit papers in triplicate to Managing Editor, Mrs. Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, N.Y. 10583

TO SUBSCRIBE, fill in coupon and mail now. Enclose proof of subscription to *Art Therapy* or membership in American Art Therapy Association. If student, enclose proof of status.

Pergamon Journals, Inc., Maxwell House, Fairview Park, Elmsford, N.Y.10523 AATA

Please enter my subscription for Vol. 15, 1988 ☐

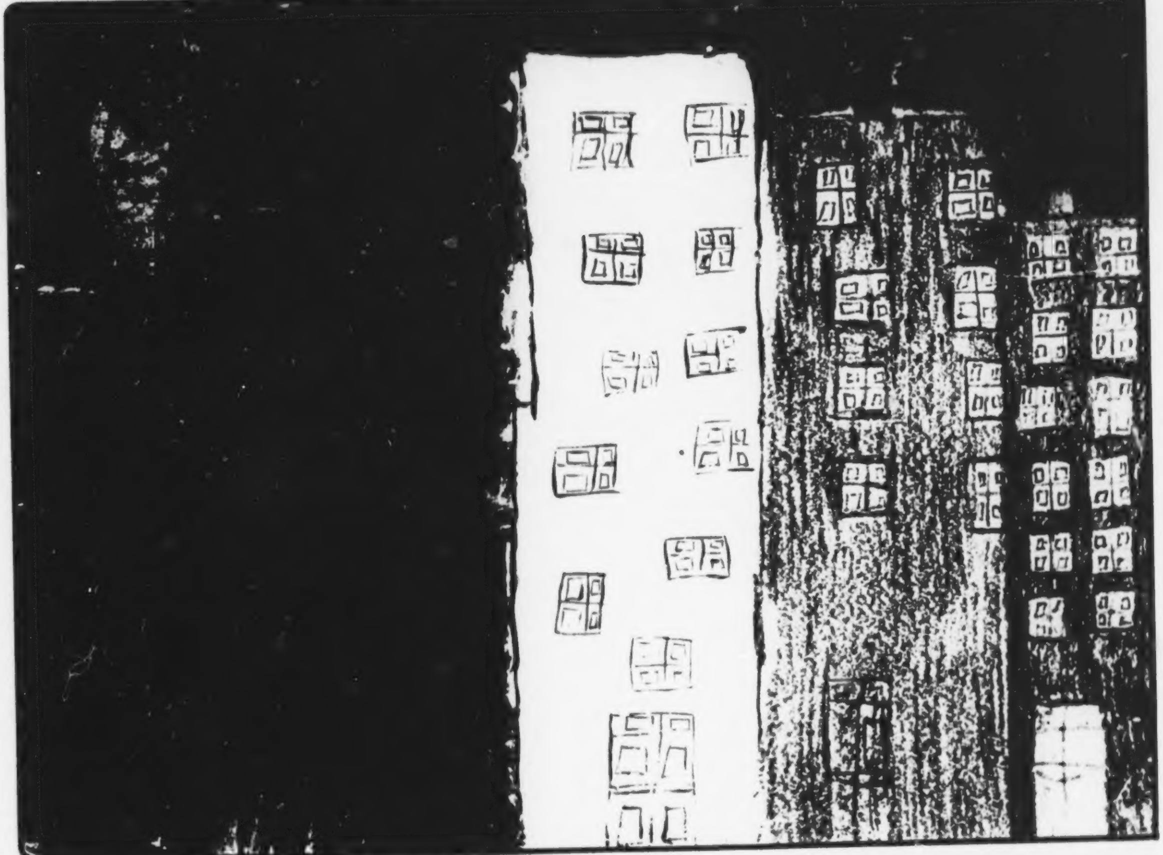
(Regular rate for individuals $40) Reduced rate $20 per volume Students $15 per volume

For subscriptions outside U.S. (except Canada) add $2.25 annual postage. Payment must be in U.S. funds.

Name ____________________
Address ____________________
City ____________________ State __________ Zip __________

ART THERAPY

Journal of the American Art Therapy Association



Volume 5, Number 3

December 1988

- An Inquiry Into Women and Creativity Including Two Case Studies of the Artists Frida Kahlo and Diane Arbus
  Maxine Jung, ATR
- Comparison of Art Psychotherapy and Discharge Diagnoses of Diagnostic Unit Patients
  Barbara Wittels Witlin, MS, ATR
  Roy Augusthy, MD
- Inner Guide
  Vija B. Lusebrink, PhD., ATR

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1988-1989

Board of Directors

President
Cay Drachnik, MA, ATR, MFCC

President-Elect
Linda Gantt, MA, ATR

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, PhD, ATR, MFCC

Committee Chairs

Affiliate Chapters
Trudy Manning, ATR

Bylaws
Roberta J.H. Shoemaker-Beal, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Cathy A. Malchiodi, MA, ATR

Publications
Pat B. Allen, PhD, ATR

Research
Harriet Wadeson, PhD, ATR

Standards
Doris Arrington, EdD, ATR, NCC

Clinical
Paula Howie, ATR

Executive Director

Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, EdD, ATR 78

Articles

An Inquiry Into Women and Creativity Including Two Case Studies of the Artists Frida Kahlo and Diane Arbus
Maxine Jung, ATR 79
Comparison of Art Psychotherapy and Discharge Diagnoses of Diagnostic Unit Patients
Barbara Wittels Witlin, MS, ATR . .
Roy Augusthy, MD 94
Inner Guide
Vija B. Lusebrink, PhD., ATR 99

Reviews

"Creative Expression"—a Video
Michael Campanelli, EdD, ATR
David Berglund, MAT 106

Viewpoints

Poem
"Art Therapists"
Jules C. Weiss, MA ATR
Amy M. Speltz, ATR 108

Volume 5, Number 3 December 1988

About Our Cover

"Where I Live"—a drawing and crayon-resist painting by a 9 year old girl in the Wright State University Art Therapy Clinic.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Aina O. Nucho, PhD., ATR, ACSW
Brief Communications
Ruth Obernbreit, MA, ATR
Film Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Marcia May-Chambers

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Susan LaMantia O'Connor, MA, ATR
Paul Rodenhauser, MD
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064

Copyright © 1988 American Art Therapy Association

BEST COPY AVAILABLE

EDITORIAL

Within the past few years artists, craftspersons and other professionals who work with art materials have been warned about the dangers of working with certain toxic materials over extended periods of time and with improper measures taken relative to safety factors. A book worth our consideration for more information is titled *Health Hazards Manual for Artists* (3rd revised and augmented edition) by Michael McCann, Ph.D., C.I.H., and published in 1985 by Nick Lyons Books, 31 West 21st Street, New York, NY 10010. The book is divided into three primary sections. Part One, "How Art Materials Affect You," focuses on risk factors, effects of art materials on the body, and has separate chapters on solvents and aerosol sprays, acids and alkalis. Part Two, "Hazards of Various Media," has many details on painting; ceramics; stone, plaster, clay and wax sculpture; photography; and numerous other media and processes. Especially enlightening is the chapter on "Children and Art Materials," and the author states that ". . . children are at much higher risk physiologically than adults from exposure to toxic materials. Children and teenagers are still growing and have a more rapid metabolism than adults. As a result, they are more likely to absorb toxic materials into their bodies." (pp. 62-63). Part Three, "Safety in the Studio," covers various aspects of materials and their use, including substitution of safer materials; ventilation; storage and handling of materials; fire prevention; protective equipment; and how to get help. Much of the information is geared specifically to the public school room or the artist's studio; however, with very little adjustment, the art therapist can certainly glean ideas and understandings of the hazards of materials that we use in the clinical setting, and we can begin to comprehend the seriousness of taking a long and hard look at the materials we use and how we use them. There are many books and pamphlets listed in the references, as well as other helps that should be of interest to us.

One of the articles included in this issue is by Maxine Junge, ATR, and titled "An Inquiry Into Women and Creativity Including Two Case Studies of the Artists Frida Kahlo and Diane Arbus." An introduction, including personal references and special meaning to the author, is followed by a working definition of creativity. Next, intensive focus is given to Frida Kahlo, a painter born in Mexico City in the early 1900's, and Diane Arbus, a well-known photographer who was born in New York City in the 1920's. The vignettes and examples are compelling and serve as a foundation for understanding these two artists, as well as relating in a clinical way to their backgrounds, the environment within which each produced their art, and the art work itself.

Barbara Wittels Witlin, ATR, and Roy Augusthy, MD, are the co-authors of "Comparison of Art Psychotherapy and Discharge Diagnoses of Diagnostic Unit Patients." The article focuses on art psychotherapy diagnoses as they are correlated with psychiatric discharge diagnoses on Axis I (of the DSM-III, 1980) with a patient population of 97. With their discussion of the findings pertaining to agreement, disagreement and other stated criteria or categories, suggestions are made for further research. Two psychiatric evaluations are briefly given, with assessment and discussion on each.

"Inner Guide," by Vija B. Lusebrink, ATR, elaborates on the concept that "has universal manifestations in images in the fairy tales, myths, and religions of different cultures" (see abstract). These images, as Lusebrink points out, emerge during physical or mental stress but also can be activated with stabilization and reinforcement occurring. Included in this article are the following general categories: the understanding of the Inner Guide; images in folklore and art, and in dreams and active imagination; emergence of the image in mental illness; active imagination in healing, including the need for visual expression as well as verbal description; and summary with concluding discussion.

Although this editorial is being written prior to the A.A.T.A. Conference in Chicago, by the time you read it the Conference will be history. Let me offer, in advance, my thanks to all of the many people who worked diligently to make the Conference a success. In addition, for those of you who presented papers, panels, forums, workshops and other offerings, you are encouraged to submit to this journal for publication consideration. Check in this—or other—issues for the proper format. Why not send the article in before you forget?

Gary C. Barlow, Ed.D., ATR
Editor, Art Therapy

An Inquiry into Women and Creativity Including Two Case Studies of the Artists Frida Kahlo and Diane Arbus

Maxine Junge, ATR, *Chairperson and Associate Professor, Graduate Dept., Clinical Art Therapy, Loyola Marymount University, Los Angeles, CA 90045*

PART I: THE PERSONAL

"You are original and creative"
—Fortune from a Chinese fortune cookie

About the Process: By Way of an Introduction

I have been thinking about this article since I stood in the sculpture garden of Barbara Hepworth's house in St. Ives on the Cornwall coast of England. Hepworth's garden is connected to the house and studio in which she lived and worked for twenty-five years and in which she died in a fire in 1974. The house was given to the Tate Museum and is now open to the public. Hepworth's work in reproductions seems physically huge and monumental because of its simplicity and abstractness of shape and form and perhaps because of the viewer's associations to her classmate, the other pre-eminent (and monumental) British sculptor of this century, Henry Moore.

In actuality, standing in her garden of no more than thirty-feet square, I was struck by the intimate scale of Hepworth's work and of her environment—almost a miniature, silent and "secret garden" distinctly disengaged from the world behind its high enclosing white walls. To a Californian used to the openess and accessibility of space of the coastal areas, there was the temptation to define the scale of Hepworth's miniature British world as so personal as to be "female." Visiting someone's house we feel we can know them in some essential inner way and as I wandered mostly alone in the house and garden on that bright fall afternoon, I felt intensely connected to Hepworth and moved by her creative vision and by the visible signs and symbols of the daily life she had led. Also possibly hovering about my consciousness that day, was the matron saint of women and creativity, Virginia Woolfe, who had lived, worked and died by suicide just a few blocks away in the house high on the hill overlooking the St. Ives harbor.

Since early adolescence, when I came forcefully in touch with my own powers of creativity in the visual arts and the potential ability of the creative process to aid in the development of my own identity and consolidation of a personality, I have read about the process and products of creativity with dissatisfaction. Most of what I read seemed to offer little explanation, information, nor finally to pierce the essential mystery. For my generation, "creativity" became an all but meaningless catchword with any potential for capturing its qualities and essence apparently lost in the inability of words to describe such elusiveness. Besides, as a visual artist obsessed with the power of imagery, I felt a profound mistrust for mere words.

"An early and precious memory is of accompanying my father on one of his weekend painting trips."

An early and precious memory is of accompanying my father on one of his weekend painting trips. Sometimes we would drive to downtown Los Angeles and on Broadway or Main Street stop to paint from the car. The sweetness of that memory of our special shared closeness of the creative process remains a precious treasure and, I'm sure, a continuing touchstone of definition in my life. Barbara Hepworth speaks also of car trips with her father as a powerful impetus to creativity:

> All my early memories are of forms and shapes and textures. Moving through and over the West Riding landscape with my father in the car, the hills were sculptures; the roads defined the form. Above all, there was the sensation of moving physically over the contours of fulnesses and concavities, through hollows and over peaks—feeling, touching, seeing through mind and hand and eye. The sensation has never left me . . . perhaps what one wants to say is formed in childhood and the rest of one's life is spent in trying to say it . . . (Bowness, 1977).

The dirth of great and recognized women artists throughout history has been used as a truism to explain the lack of recognized women artists and their supposed inadequate creativity in all but the realm of home and hearth—the creativity of anatomy. Gratefully, times have changed somewhat. At least to many today, the fact that a woman who attempts to be an artist historically suffered, and continues to suffer, deeply ambivalent parental and cultural messages which as introjected psychologically can be injurious and crippling is, thankfully, no longer news. Given the powerful cultural edicts, we must marvel at the strength of the need for creative expression that it could continue to exist, even against the overwhelming tides, in some women's lives. We must be thankful that there are more open opportunities, awareness and support today.

There is a series of books in which women talk about their lives and work. (Examples of this genre are Rudick and Daniels, 1977, Gilbert and Moore, 1981 and Miller and Swensen, 1981.) Brewster Ghiselin's classic work *The Creative Process* surveyed thirty-eight (living and dead) of the

> . . . world's outstanding men and women [and] reveal how they actually begin and complete creative work in such fields as art, literature and science . . . a fascinating analysis of how new ideas are born and developed (Ghiselin, 1952).

Out of the thirty-eight, four were women—three writers and a dancer. Unfortunately, more recent "integrated" compendiums have not significantly altered this typical nonrepresentation and women artist's stories remain "ghettoized" in books and art histories specifically about women, by women, and, I suspect, read primarily by other women who are rightfully hungry for models. Further, we are still at the necessary stage of the documentation of creative women's lives (judge by the increasing numbers of biographies), but we have not really reached the time when we have much in the way of satisfactory theory. It is my belief that no matter how much in ill-repute Freud may be currently held, his notions about the sources, motivations, and transformative energy of creativity and that the creative urge is ultimately akin to psychopathology, for better or worse, still pervade current thinking about art and artists and thus warrant a fresh look. Secondly, psychoanalytic methods have provided us with important tools with which to understand the artistic personality and its vicissitudes. Additionally, I am an art psychotherapist and therefore believe that all art is a reflection of the artist, of her environment and of the relationship between them. As an art psychotherapist, I had long been interested in Georgia O'Keefe and what I perceived as the projected visualization in her artwork of a midlife crisis of dependency/independence. Thus, I thought it would be interesting to look into the lives and art work of two other visual artists, the photographer Diane Arbus and the Mexican painter, Frida Kahlo and within an undeniably psychoanalytic (though not strictly Freudian) perspective, explore questions about the genesis, meaning, and uses of creativity in their personalities and lives. Recently, I happened across a journal article by a psychotherapist called "The Woman Artist: A Struggle for Self-Realization" (Cohen, 1983). This article presented an original conceptual framework in which to place the struggles of the woman artist and seemed to me to provide an interesting piece of thinking about these particular problems.

Finally I felt these diverse elements could come together to provide a useful way to proceed that might lead to the asking of provocative questions. Thus the following section presents a working definition of creativity and briefly describes some basic ideas about the subject as it might pertain to women. In the last section of the paper, Arbus and Kahlo will be used as case studies for an inquiry into the role of creativity in their lives and personality development.

PART II: THE THEORETICAL

A Working Definition of Creativity

Although the word "creativity" is used with an easy familiarity suggestive of universal understanding (cf. the fortune cookie quote at the beginning of this paper), and has been defined from a variety of perspectives such as the psychological, the historic, the aesthetic and the behavioral, in reality it is not easy to arrive at a generally accepted definition. *Webster's Ninth New Collegiate Dictionary* states: "Creativity—the quality of being creative" and "Creative" as "marked by the ability or power to create." It is indeed easier to talk about characteristics of the creative process. McWhinney suggests that there are at least four recognizable and alternative forms of creativity and that there should be specifically differential training for their use (McWhinney, 1985). Creativity is the domain of human beings, and (stories of chimpanzees making paintings notwithstanding) it differentiates us from the animals. We have evidence of its continuing existence even in the most extreme and devastating of situations such as the Nazi concentration camps where in the face of an unbearable reality we are reminded of the best that is human. Arieti (1976) cites the importance of distinguishing creativity from spontaneity and originality which are the feelings, ideas and images emerging from unconscious processes, experienced and sometimes acted upon, but which remain relatively unchanged and untransformed. He goes on to describe creativity as "a desirable enlargement of human experience":

> [A creative work] establishes an additional bond between the world and human existence . . . [and] thus may be seen to have a dual role: at the same time as it enlarges the universe by adding or uncovering new dimensions, it also enlarges the universe and expands man . . . . It is committed not just to the visible . . . but to the invisible as well . . . . A new painting, poem, scientific achievement, or philosophical understanding increases the number of islands of the visible in the ocean of the unknown (Arieti, 1976, pps. 4 & 5).

Distinguishing between "ordinary" and great creativity, Arieti postulates a "'magic' synthesis from which the new, the unexpected, and the desirable emerge" (Arieti, 1976, p. 13). For the purposes of this article, Arieti's definition is accepted in its delineation of creativity as arising out of the "raw matter" of the interrelationship between the person and the context, and through a special transformation something new is created which is positive and which expands the relationship between the person and the environment.

"Patriarchal society . . . perpetuated the notion that women had no inclination toward creativity."

Ideas on Women and Creativity

The idea of the innate inferiority of women as creative beings has been mentioned previously in this paper. It is an idea held for centuries and still believed by many. Patriarchal society in which the woman was relegated to the functions of motherhood and home, often as "property" to father or husband, perpetuated the notion that women had no inclination toward creativity. Later, psychoanalytic theory suggested that the motivation to create in women is typically (and "normally") sublimated into the "creation" of children. Neo Freudian Karen Horney, discussing men's contributions to the arts, states:

> Is it not the tremendous strength in men of the impulse to create work in every field precisely due to their feeling of playing a small part in the creation of living being, which constantly impels them to an overcompensation in achievements? (Horney quoted in Cohen, 1983).

Although Horney favorably (if unconvincingly) reframes men's creativity as a kind of "womb envy," she substantially holds to traditional psychoanalytic thinking about women and their corresponding unsatisfactory sublimation process:

> . . . There is much to be said in favor of the view that women work off their penis envy less successfully than men, from a cultural point of view. We know that in the most favorable case this envy (penis) is transmuted into the desire for a husband and child and probably by this envy transmutation it forfeits the greater part of its power as an incentive to sublimation (Horney quoted in Cohen, 1983).

Researchers, basing their models on the prevailing patriarchal assumptions evolved interpretations to support their assumptions. Cattel early in the century statistically studied men of science in this country (1903, 1906). In an article published in 1910, he noted that between 1903 and 1910, women in science had not increased in number nor improved their standing. Thus he concluded that

> There does not appear to be any social prejudice against women engaged in scientific work, and it is difficult to avoid the conclusions that there is an innate sexual disqualification (Cattel quoted in Arieti, 1976, p. 317).

Catell's misguided interpretation of data in which the effects of the social milieu are not even seen and thus the only explanation is biological inheritance is not untypical.

Cora Sutton Castle in 1913, followed Cattell's method and made a list of 868 eminent women (including politicians, mothers, mistresses and rulers) through twenty-six centuries and from forty-two countries. She noted a marked tendency for eminent women to acquire prominance in the same field as their fathers and that they had not been particularly successful as wives. Castle could not seem to decide whether the small numbers meant that women are innately inferior or had a lack of opportunity. She did not recognize that the fact that two-thirds of the women on her list lived in the last two centuries should have shown that environment influences statistics.

Tamar Cohen in her persuasive article "The Woman Artist: Struggle for Self-Realization" essentially grounded in Humanistic personality theory, postulates a conceptual framework based on a developmental model. Cohen, a psychotherapist who has treated artists in her practice, points out an essential theme emerging from recent psychological studies of the creative process: the artist's strong urge to create—both as a means of self expression and as a continuing marker of experience. Cohen quotes Miriam Shapiro, a well-known contemporary feminist artist:

> As a child, as an adolescent, as a college student, I was remarkably simple-minded. I cared most about

> being an artist, about making my art . . . . When I look back on the years of excessive self-doubt, I wonder how I was able to make my paintings. In part, I managed to paint because I had the desire, as strong as the desire for food or sex, to push through to make an image that signified (Shapiro quoted in Cohen, 1983).

It was exactly this urge to create, to witness, to mark and to last, which compelled the artists of the concentration camps. Cohen argues that it is this strong creative urge itself which "throws the woman artist into conflicts as she tries to actualize the artistic core of herself." She suggests that the woman artist, like other women initially internalizes the myths about "woman's role." As she struggles with her feelings about a perceived and/or actual role definition of wife and mother, her creative gifts and urges can become additional burden for her and even a threat to her evolving personality.

Cohen conceives of the woman artist's process as occurring in a three-stage progression during which specific conflicts are dealt with and in which each stage is characterized by the attitude the woman artist shows toward her creative work. In the first stage, the conflict is avoided either by accepting her social role or by consciously or unconsciously avoiding it. The artist Judy Chicago describes the latter position:

> I felt convinced that the only way to make any progress in the art world was to stay unmarried, without children, live in a large loft, and present myself in such a way that I would HAVE to be taken seriously (Chicago quoted in Cohen, 1983).

In either case, the woman artist must repress or deny her needs and straddle the fence of ambivalence. In the second stage, the conflict is displaced. A commitment to the work, Cohen writes, may "touch off a core of uncertainty which, perhaps, has to do with her sense of womanhood." Pervasive questions about the value of her work and feelings of self doubt often hinder the woman artist's ability to work productively. Her lack of productivity leads to further doubting and Cohen suggests that "a typical outcome now is the unsteadiness of the woman's commitment to her artistic work." At this stage the woman may talk of "other demands" which take her away from her art. In the third stage of resolution, the woman artist begins to consciously, if painfully, confront both her commitment to her work and her emotional needs:

> Gaining a new sense of inner confidence, she also seems to be able to respond more positively to the needs of the important others in her life . . . the woman artist is not free of stresses, but she approaches solutions in a fresh and unrestricted manner. As she experiences a deep sense of fulfillment regarding her artistic work, she also feels the inevitable pain which comes with growing (Cohen, 1983).

The woman artist in this stage can work productively and adds personal content and meaning to her art. She may begin to exhibit her work opening herself to criticism. "Much like a mother who has to accept and treat her child as a separate entity," Cohen states, "the woman artist allows separateness from her "final product" (Cohen, 1983). Finally, Cohen suggests a social action role for the woman artist:

> Communicating through her art, the woman artist can transmit her inner reality, her lived experiences, and thus help in removing the prejudices and social obstacles with which she herself has had to struggle (Cohen, 1983).

PART III: CASE STUDIES OF TWO VISUAL ARTISTS, FRIDA KAHLO AND DIANE ARBUS

Introduction

This section is composed of case studies of two visual artists, Frida Kahlo, the Mexican painter, and Diane Arbus, the American photographer. These artists were chosen basically because their work is of interest to me. Additionally, there exist recent, well-documented and complete biographies of the two. An assumption is that artistic creativity springs from and is innately related to the artist's life and that the artist's creativity profoundly influences roads taken and choices made in the artist's life. Further, the cultural, social and psychological milieu of the times are integrally intertwined with the artist and her life. Clearly, this is not in any way a comparative look at men and women. Also, the two women artists will not be formally compared although there will be some attempt to highlight what may be important congruencies within their "stories." Each case study will include, first, the basic sources used and a description of the outlines of the artist's life. Next, discussion will be centered around cultural, social and psychological questions designed to elicit information within an essentially psychodynamic framework to provide an in-depth exploration of the origins and uses of creativity in these women's lives and work and in the development of their personalities.

Frida Kahlo

Source

The information for this study is taken from Hayden Herrera's 1983 book about Kahlo, *Frida, A Biography of Frida Kahlo.* Herrera's book includes excerpts from Bertram Wolfe's 1963 biography of Kahlo's husband, the Mexican muralist Diego Rivera, *The Fabulous Life of Diego Rivera* and quotations from Rivera's *My Art, My Life.*

Description of Frida Kahlo's Life

Less than one year before her death in 1954 at the age of forty-seven, Frida Kahlo's paintings were presented in a one-woman exhibition. This was her first major exhibit in her native land of Mexico. Kahlo was born on July 6, 1907 in Mexico City the third daughter of Guillermo and Matilde Kahlo. Her father was a German Jewish atheist who had immigrated to Mexico at the age of 19. He had been a promising scholar in Germany but suffered brain injury in a fall and thereafter experienced epileptic seizures. Kahlo's mother was attractive, uneducated and a pious Catholic. At the time of Frida's birth, her father was a successful photographer who had just been commissioned to record Mexico's architecture. It was said that she inherited from him her eyebrow that connected across her nose and her intensity of gaze. After Frida's birth, her mother became ill and she was suckled by a wet nurse, an Indian woman.

The Mexican revolution broke out when Kahlo was three years old. Her father lost much of his livelihood which had been supplied by the government and became depressed and distant. At age six, Frida developed polio. She spent nine months in her room during which time she invented an imaginary friend. She emerged from the polio with a withered right leg which was to bother her both physically and emotionally all her life and which she covered with the long skirts of Mexican folk costumes that became her trademark and her mask. After her illness, because of her leg, she was teased and left out by her peers. She became solitary and an "introverted creature." In a family photograph taken shortly after she recovered from polio. Frida stands alone and separate from the family and in paintings of herself as a child, she tends to portray herself as separate.

At the age of 15, Frida attended the best educational institution in Mexico, the National Preparatory School. The school and the students who went there during the climate of change of those years would become the new intellectual leaders of professional and national life. There, at the age of 15, so the story goes, Frida first met the famous muralist Diego Rivera who was painting a mural at the school. Rivera was 36 years old when Frida became infatuated with him. She said: "My ambition is to have a child by Diego Rivera." She married him seven years later against her parents' wishes.

At the age of eighteen, she experienced an accident which would transform her life. Herrerra writes "Frida's life from 1925 on was a grueling battle against slow decay." She was riding on a bus that was hit by a streetcar. Among her other injuries, her spine was broken in three places, her right leg was crushed and an iron rod went through her at the level of her pelvis. She would never be able to have children and would endure thirty-two operations on her spine and foot. After the accident, neither of her parents came to the hospital. Frida said: "My mother was speechless for a month because of the impression it made on her . . . it made my father so sad that he became ill." During her long recovery she began to paint—at first portraits of her friends and of herself. She stated: "I paint myself because I am so often alone . . . because I am the subject I know best."

"[Kahlo and Arbus] were chosen basically because their work is of interest to me."

After her recuperation, she took her artwork to show to Rivera who was painting frescoes at the Ministry of Education. In spite of Rivera's continuing liaisons with other women, their attraction grew and they were married in 1929. She was twenty-two. He was a famous forty-one-year-old Communist artist. Shortly after, she became pregnant, but had a therapeutic abortion, the first of more abortions and three miscarriages. They spent four years in the United States where Rivera had mural commissions but returned to Mexico because of Frida's urging. They continued their tempestuous marriage, were divorced for two years and then remarried. Although she always remained emotionally tied to Rivera and in fact took care of his bills and correspondence during the divorce, she had periodic love affairs with both women and men. Leon Trotsky and Isamu Noguchi the sculptor were two of the men.

Although she focused her life on Rivera and caring for his needs and played down her own career as an artist, she continued her development and was discovered and appreciated (wrongly) as one of them, by the Surrealists in the late 1930's. Through the years, she endured multiple operations which included many incasements in torso-length plaster casts and she continued painting. She died in 1954. Although from entries in her written and drawn diary there is a hint that she committed suicide, the cause of her death is listed as "pulmonary embolism."

Frida Kahlo's paintings are a kind of autobiography of memory and reality. They are physically small, surrealistic and formal in style. Although content—predominantly self portraits—is often bloody, violent and masochistic, the paintings' connection to Mexican primitive folklore and their binding of emotionality through restrained "hard edged" formal qualities provide the viewer with a welcome aesthetic distance. The artwork's overall concern with women, family, the land, suffering and death are both uniquely Kahlo's and also seem ultimately rooted in the paradoxical nature of Mexican culture and of the role of the Mexican woman during Kahlo's lifetime.

The Roots of Creativity in Frida Kahlo's Early Life

There appear to be three central themes that provide clues to the sources of Kahlo's artistic creativity and productiveness. They are: early family dynamics and Frida's attachment to her father, her illness with polio at age six, and the role of illness in the family dynamics and the development of Kahlo's personality.

THE ROOTS

Family Dynamics and Frida's Attachment to Her Father

Kahlo's mother was an uneducated—she did not know how to read or write—and religious woman who became ill after the birth of her third daughter resulting in Frida being nursed by a wet nurse. We can speculate a period, perhaps a lengthy period, of post-partum depression. Although she taught her daughters housewifely skills, it is known that Frida was largely cared for by older sisters. At midlife, Frida's mother began suffering from "seizures" or "attacks" that resembled those of her husband's epileptic seizures. Frida's father, a successful photographer until the Mexican revolution, was a man of silences. He was distant, withdrawn, and suffered more-or-less monthly "attacks of vertigo." During the revolution he lost much of his ability to make a good livelihood through photography and withdrew emotionally more and more. In spite of his depressive nature, Guillermo Kahlo was the most attached to Frida of anyone in the family and encouraged her intellectual adventurousness. She was known to resemble him physically and he said: "Frida is the most intelligent of my daughters. She is the most like me." He lent her books from his library and encouraged her to share his passion for nature. He was an amateur watercolor painter and she would accompany him on his trips, collecting stones and leaves to bring home and observe under a microscope. Of their relationship, Herrera writes:

> When she was old enough, her father shared with her his interest in Mexican archaeology and art and taught her to use a camera and to develop, retouch and color photographs . . . her father's fastidiousness, his concern for minute surface detail would later appear in her own paintings . . . the stiff formality of her father's portraits affected her approach to portraiture . . . Frida once said that her paintings were like the photographs that her father did for calendar illustrations, only instead of painting outer reality, she painted the calendars that were inside her head.

Eleven years after her father's death and two years before her own, she painted his portrait from a photograph he took of himself. In the painting, Frida painted "magnified cells containing dark nuclei afloat in a swarm of small dark marks that suggest sperm" (Herrerra, 1983). It may be speculated that this imagery may reflect her looking through the microscope after collecting trips with her father, her profound and sexual attachment to her father and perhaps her sense of him as a source of primal energy. The inscription in the painting reflects both Kahlo's love and her use of him as a model for her own life of artwork created in spite of illness and suffering and of the rightness of social causes:

> I painted my father, Wilhelm Kahlo of Hungarian-German origin, artist-photographer by profession, in character generous, intelligent and fine, valiant because he suffered for sixty years with epilepsy, but he never stopped working and he fought against Hitler . . . .

There are other examples in art history of women artists who were encouraged by artist fathers and there has been some recent research to suggest that achievement in women may be dependent in part on their relationships with their fathers. Tintoretto's daughter, Marietta Robusti, was one woman artist with an artist father and Diane Arbus is another.

Kahlo's Illness with Polio at Age Six

Her nine months spent convalescing in her room, at a period when the intelligent and normally active child would have spent time with peers and expanding her world resulted in a loneliness and a withdrawal into her own imagination. She invented an imaginary friend who was happy, understanding and physically agile and free:

> . . . I breathed vapor onto one of the first panes. I let out a breath and with a finger I drew a "door" . . . full of great joy and urgency, I went out in my imagination, through this "door" . . . down into the *interior of the earth* where my "imaginary friend" was always waiting for me . . . I was happy.

Frida's illness connected her even more strongly to her father and his experience of illness. Afterwards she was ashamed of her withered right leg and overcompensated by becoming a daring tomboy. Also, some of her descriptions of her treatments during that time echo the fascination with the details of sickness and suffering which would be a predominant theme in the imagery of her paintings.

Illness and the Family Dynamics and Its Role in Kahlo's Personality Development

Because of Guillermo Kahlo's epileptic episodes, this was a family intimately familiar with illness. Hererra describes:

> [When Frida's father had an attack] As a small child, she was hustled out of the way . . . she would lie in bed in fright . . . . He became for her a "kind of fearful mystery, for whom I also had pity."

When Frida was older, she would accompany her father on photography trips to be there to help. She learned to help him with his attacks in the street and also to make sure his camera equipment wasn't stolen. In addition, there were Frida's mother's illnesses, probably depressions, her own bout with polio and her later devastating accident at age eighteen.

Kahlo's early life engendered an "up close" relationship to illness and its ramifications that would continue throughout her life. Her fascination with its clinical details was an ongoing fact of her life and art. Illness' use to bring the secondary gains of attention and specialness would be an essential of her relationship to Diego Rivera—her illnesses often had the power to attract him back to her when she had no other means. That she was hypochondrical is also well-known. She had immense physical problems but there is a real question as to whether she actually physically required her thirty-two operations or whether she had come to need illness and surgery as a way to be in the world. We can speculate that as a young child she must have been rendered terrified, insecure and vulnerable by her parents' illnesses and by her own. In her evolving personality, this resulted in a clinical attraction as a means of mastering and controlling her fears. It is interesting that she intended to pursue medical school and, had the accident not occurred, probably would have. (According to psychoanalytic theory, to be a doctor is (sometimes) a defense mechanism against one's own feelings of vulnerability.) Later, when Frida began to paint, she would find another way to cope with these same profound feelings within the form and content of her artwork.

Frida Kahlo's Artwork: Her Creative Vision and Its Relationship to Her Life

In order to discuss this issue, I have chosen to briefly analyze one painting "The Broken Column" painted in 1944 soon after one of her surgeries. (See plate XXVIII, Herreras, 1983)

In her artwork Kahlo consciously portrayed her autobiography. In this painting she is confined in an "apparatus" such as many she was made to wear to allow spinal healing. Here, in a jagged, bloody opening in the body, a crevice resembling an earthquake fissure, one can see a broken Greek column. Nails pierce flesh and tears fall from eyes. The orthopedic corset is both prison and necessary support. Without it, the body would fall apart. Within its rigid structures, Frida's breasts are contrastingly delicate and vulnerable. The figure is set alone in a barren landscape with cuts and crevices which provides a metaphor for the broken body. At the horizon, there is a strip of ocean—the possibility of comfort—but it is too far away to reach.

Both Kahlo's suffering and her strength which are recurrent and dominant themes in her work are evident in this painting. The subject matter is of almost unbearable anguish and yet the formal stylization gives a sense of solidity and permanence and also provides enough distance so that the viewer can bear to look. The figure, though wrenched apart and in a stance of enforced passivity stands upright and strong. The face is turned slightly to the side. Suffering is signaled by the tears on the cheeks, but the face is masklike and impassive and the eyes connect directly with the viewer. In spite of wounds and tears, there is a sense of dignity and stoicism. Colors are muted except in the flesh which appears distinctly alive and enduring. Shapes are solid, almost classically balanced and in their dimensionality imply durability. The painting is both a poignant cry for attention and an heroic example of survival.

Kahlo is the most personal of painters. She never attempted any subject without intense meaning for her and they were all filtered through the lens of the self and of the imagination of a confined invalid. She was an exhibitionist of her feelings in a stylized, theatrical form. "The girl whose ambition was to study medicine," Herrera says, "turned to painting as a form of psychological surgery."

Interplay Between Conflicts Engendered by Women's Social Role and the Creative Urge

Frida Kahlo virtually up until the last years of her life presented herself as a semi-serious painter. This, in part, was a pose that enabled her to keep her painting strictly for her own uses and not submit to the suggestions and criticisms inherent in exhibits and sales. Diego Rivera created large public paintings. Hers were small and private (and noncompetitive with his).

Since her school-girl days when she had first met Rivera, she put his needs first and adapted herself to them. Rivera's biographer Bertram Wolfe wrote:

> To him she came first after his painting and after his dramatizing of his life as a succession of legends, but to her he occupied first place, even before her art.

In her wedding portrait with Diego, Frida paints him as the great artist with pallette and brushes, the tools of his trade. She is the adoring wife. His head is turned away from her; her head leans toward his shoulder.

Having met Rivera when she took her paintings to him and made him a mentor before she made him her husband, Kahlo recognized that being Diego's wife was a full-time job. Through much of her life, she painted only sporadically at times completing only one or two works a year. She kept the house, cooked what he liked and tried to anticipate his needs. When he was working on a mural she would usually carry his lunch to him in a basket, stopping to do this even when she was engaged in her own painting. In her sorrows, she did not immediately turn to her artwork for solace but to her "housewifely" pleasures:

> We could not have a child and I cried inconsolably but I distracted myself by cooking, dusting the house, sometimes by painting, and every day going to accompany Diego on the scaffold. It gave him great pleasure when I arrived with the midday meal in a basket covered with flowers.

In 1932 the two were in Detroit while Diego worked on commissioned murals. There a newspaper article was written about Frida under the title "Wife of the Master Mural Painter Gleefully Dabbles in Works of Art," indicative of her general attitude toward her work (and also of the writer's attitude toward women).

Kahlo's abortions, miscarriages and inability to have children are both indirectly and directly reflected in her art. After one of her early miscarriages, she painted a picture of her own birth. She was fond of dolls, pets and others' children and recognized them as the substitutes they were. "Me and My Doll," and her self portraits with monkeys are examples. "My Nurse and I," "The Deceased Dimas" and "They Asked for Planes and Only Got Straw Wings" show her sorrow at her childlessness and in her nostalgia for her lost childhood, how she identifies herself with the child she could not have.

Another interesting element of Frida's adherence to a female role was her interest in clothes and how she looked. Once again, in her life and her art, clothes as costume, as theater, as metaphor and as mask, are of essential importance. She covered her leg, withered from polio, with long skirts and was fond of wearing native Mexican costumes both because they covered and because they represented her solidarity with folkloric Mexico. Once she separated from Rivera and cut off her long hair (which he loved). She painted herself with short hair, in a man's suit with her shorn hair lying around her on the ground, as if she were divesting herself of her sexuality. Her clothes reflected a kind of visual language of her inner self. Herrera sees Kahlo's costuming as both a mask and a frame which defined the wearer's identity and provided a boundary to distract from inner pain.

The question of the female role expectations conflicting with the urge for creative self-expression is an especially interesting one with Kahlo. We may speculate that if she had been able to bear and raise children and had a more easy time with Rivera, she might have been satisfied to displace her creative urges onto his career and her children. We may wonder if she had not been so physically restricted, often isolated and in an essentially female, ambivalently wished for yet despised dependency, would she have needed so desperately to have expressed her sense of herself as a functioning, separate, enduring and imagining human being? We can guess that a woman of Kahlo's intelligence, vibrancy and creativity would have needed to find some way toward visual expression. But these are, of course, essentially unanswerable questions. What we *can* know is that Frida herself, in her writings, expressed both sides of the conflict. On the one hand, she denigrated her work. In 1935, in a letter to a friend, Frida wrote:

> I have painted about twelve paintings; all small and unimportant with the same personal subjects that only appeal to myself and nobody else . . . . I sent four of them to a gallery which is a small and rotten place, but the only one which admits any kind of stuff.

And when someone bought a picture she would say she felt sorry for him:

> For that price they could buy something better . . . it must be because he's in love with me.

Expressing the other side of her ambivalence, she wrote:

> As you can observe, I have painted. Which is already something since I have spent my life up until now loving Diego and being a good for nothing with respect to work.

Frida Kahlo, herself, perhaps best spoke to the issue when she wrote:

> Since the accident changed my path, and many other things, I was not permitted to fulfill the desires which the world considers normal, and nothing seemed more natural than to paint what had not been fulfilled . . . my paintings are . . . the most frank expression of myself . . . with the conviction that before anything else I want to give myself pleasure and then that I want to be able to earn my living with my craft . . . many lives would not be enough to paint the way I would wish and all that I would like.

The Psychological Significance of Kahlo's Art to Her Personality

As a young girl Frida Kahlo's intellectual pursuits and her observation of nature had been encouraged by her close relationship with her artist father. Polio at age six and her nine-month convalescence had plunged her into the transcending pleasures of her imagination. Throughout her childhood she faced and coped with the mystery and unpredictability of her father's epilepsy and her mother's depression. During the period of her invalidism after the terrible bus accident at age eighteen, she began to paint which provided her with the pleasures of the creative process, enabled her to continue interpersonal relationships through her portraits, kept her company, and finally brought her to Diego Rivera.

All her life, Kahlo would associate suffering with creativity and physical suffering was intimately connected to psychological suffering. In her artwork physical suffering would express deep psychical wounds and both would be presented unflinchingly—with dignity, control, almost objectivity. She wrote that her inability to "fulfill the desires which the world considers normal" led her to painting. "They thought I was a Surrealist," she said, "but I wasn't. I never painted dreams. I painted my own reality." Painting provided her with the tools to tame, for awhile, that difficult inner reality and outer circumstances. In her artwork, Kahlo could escape into the healing potential of the imagination and express her pain in a visual catharsis. Her paintings were small, personal, symbolic, primitive in style, controlled in form and color and in their careful brush strokes reminiscent of the photographic retouching techniques taught to her as a youngster by her father. To paint at all probably contained for Kahlo the comforting memory of her father's attentiveness and encouragement. But it was in her use of form that she would forcefully and symbolically control and contain her pain, bind overwhelming feelings, ward off terrible vulnerability and fears of death and provide herself the sense of psychic distance that enabled her to survive. Kahlo's particular brand of primitivism conceals and reveals—the small scale, fantasy, and bright color distance the viewer and artist from the intensely painful content. Kahlo's art is a metaphorical representation of two important aspects of Kahlo's personality: her almost clinical fascination with and attraction to pain, indeed her pleasure in pain; and her dignity and courage in the face of it.

There is no question that for Kahlo, her art was healing. "I believe that by working I will forget the sorrows and I will be able to be a little happier" Kahlo wrote. When she was confined to bed much of the time, often encased in orthopedic devices, she could paint when she could do nothing else. When she was required to lie immobile and passive, through painting she could regain the active stance and the independence of creative choice. She could slip out of the bondage of her physical self and escape through the open windows of her vital imagination. Indeed, one can wonder if without painting she would have been able to survive at all.

Diane Arbus

Sources

Much of the biographical material in this study is based on Patricia Bosworth's *Diane Arbus* published in 1984. An additional source is: *Diane Arbus* (1972), an Aperture monograph edited by Doon Arbus (Diane's daughter) and Marvin Israel which includes reproductions of Arbus' photographs and quotations from some of Arbus' interviews, writings and text from tape recordings made at a series of photography classes she taught in 1971. The photograph discussed in this article were taken from this book. Also used for source material is *Diane Arbus' Magazine Work* which Doon Arbus and Marvin Israel published in 1984. This is a chronological presentation of the work Arbus did for magazine publication between 1960 and 1971.

Description of Diane Arbus' Life

Diane Arbus (pronounced Deeann) was born in New York City March 14, 1923. She was the middle child and the first girl of a privileged Jewish family. Her father, David Nemerov, owned a Fifth Avenue department store called Russek's. Her mother was beautiful and distant and the care of the children was left primarily in the hands of nannies. The family milieu was one of separateness and silences within the privileged but protected environment of the very rich. Diane and her older brother Howard Nemerov developed an exceptionally close relationship. As young children they were recognized as gifted, imaginative and of a special intelligence. Howard grew up to become a well-known American poet. Diane attended the Ethical Culture and Fieldston schools in New York. During her school years she showed talent in painting and had a particular interest in the work of George Grosz a painter of grotesques. She met and fell in love with Allan Arbus at the age of fourteen. He was working in her father's store. She wanted to marry him right away but her family insisted she wait. Against their wishes she married Arbus in 1941 when she turned eighteen a month after her high school graduation. Just before this, in her senior year at school, she had denounced all her paintings as "no good" and stated that all she wanted was to become Mrs. Allan Arbus. Despite their wealth, Diane received no money from her parents after her marriage. She was, however, sometimes invited to come down to Russek's and pick out clothes. At times, particularly in her later years alone, making a living was a major problem.

In 1943, during World War II, Allan joined the Signal Corps and Diane followed him until he was shipped to Burma. During his war years, Allan learned photography which he later taught to Diane. With Allan away, Diane moved back with her parents. She discovered she was pregnant and her daughter Doon was born in 1945. Diane refused to let her mother or sister accompany her to the hospital as she said she didn't want anyone close to her there. She believed she had to be alone to truly experience something.

When Allan came home, the two became fashion photographers. Diane's father gave them their first account photographing fashions and furs for newspaper ads, and for the next ten years or so they worked very closely, symbiotically, together turning out photographs for newspapers and most major fashion magazines in the United States. Usually he took the pictures and she attended to the model's clothes, the props, etc. For Diane, the marriage and her role as a housewife and mother were the important things. Nevertheless, in the postwar era of the "housewife heroine," she remained a working woman. Instead of a fashion photographer, Allan longed to be an actor. In 1954, their second baby, another daughter, was born.

In the 1950's the photojournalism of *Life* magazine was dominant and in 1955 there was a huge exhibit of photography at the Museum of Modern Art which was organized by Edward Steichen—"The Family of Man." The overall concept of the show was a romantic, benevolent view of humanity. In contrast to this more sentimental approach, in 1956, when her Grandmother died, Diane took photographs of her in her coffin.

Diane suffered from recurrent depressions where she experienced extreme lassitude. It was said that she could sit for hours silently staring. In 1957, Diane and Allan dissolved their professional partnership and began to do things independently of each other. Allan would continue to run the photography business and Diane would take photographs or work as she wished. It was hoped that the new arrangement would help alleviate Diane's depressions. But they became estranged. Also in 1957, Arbus' father sold his business and, with his wife, moved to Florida where he took up painting full time and exhibiting his paintings.

In 1959, Diane studied with Lisette Model who became her mentor and her artistic role model and offered her a kind of mother-daughter relationship. Model took pictures which were considered revolutionary at the time in terms of their size (16 × 20 prints) and their subject matter—drunks, beggars, ordinary people and the ugly—which she called "extremes" and "exaggerations." Model encouraged Arbus to pursue her own work and to photograph what she had been previously afraid to confront—ugliness, loneliness, freaks and oddities. She began to prowl the city at all hours searching out subjects. She was devastated over the breakup of her marriage.

In 1963, Arbus' father died and she photographed him dead. He had been the first to encourage her talent. During the 1960's she continued to obsessively pursue her photography "of the forbidden" and struggled with the demands of her life as a single mother while enduring continuing depressive episodes and hepatitis. She was treated by psychotherapists and took antidepressant medication which seemed to do little to ease her depressions. She published some of her work in magazines such as Esquire, but much of it was considered too bizarre and confrontive for the mass media. She received two Guggenheim fellowships and in 1967 her photographs were exhibited at the Museum of Modern Art in a show called "New Documents" representing three photographers. Her work was gaining her much recognition which she didn't enjoy.

By the late sixties, both daughters were increasingly away from the house and Diane was increasingly alone. In 1969 she and Allan were finally divorced and he remarried and left New York for Hollywood to pursue a career as an actor. Diane photographed and participated in "be-ins" and peace marches and took portraits of feminists for the London *Sunday Times*. Although she was recognized as an artist she still couldn't make a living as a photographer. In 1971 she taught photography and took pictures of retarded people which she was dissatisfied with. She told friends she didn't think she could go on. Diane Arbus committed suicide on July 26, 1971. In 1972 she became the first American photographer to be exhibited at the Venice Biennale.

Roots of Creativity in Diane Arbus' Early Life

The impetus for virtually all the themes in Diane Arbus' compelling photography can be found in her early life and particularly her family's dynamics. In fact, her work can be seen as a direct result of those dynamics and a kind of obsessive repetition compulsion of early feelings and patterns of behavior. What Arbus could not work through in her early years, she attempted to master first through her controlled life as Allan's "perfect wife" and her daughters' mother. As those demands fell away, increasingly in her artwork in spite of continuous terror, she plunged into the out-of-control, dark excessive world of her sexual and aggressive impulses that was both dangerous and exciting. It finally killed her. That she could not resolve and integrate these conflictual urges resulted in her multiple depressions. For many years she carried her cameras with her at all times and acknowledged them as a "shield" against danger. A camera and the creative process became for

Diane Arbus a transitional safety zone against harm. She said:

> . . . There's a kind of power thing about the camera. I mean everyone knows you've got some edge. You're carrying some slight magic which does something to them. It fixes them in some way . . . I have this funny thing which is that I'm never afraid when I'm looking in the ground glass. This person could be approaching with a gun or something like that and I'd have my eyes glued to the finder and it wasn't like I was really vulnerable.

Finally, she claimed that photography "no longer worked" for her and she killed herself. There is evidence to suggest that even as a child, Arbus displayed schizoid characteristics. She was extremely sensitive and emotional, moody and uncommunicative and would lapse into remote silences which intimidated her parents. Her adulthood probably contained numerous schizophrenic episodes. But if her creative process contained within it the seeds of her destruction, it was clearly for Diane a courageous attempt at mastery and survival. If in the end her art failed her, it should nevertheless not be construed as merely visual pathology. For in her photographs, Diane Arbus transcends confrontation with the dark night of the soul to give a sense of meaning to that profound experience that resides in the depths of all of us.

The Dynamics of the Nemerov Family

According to Diane's sister, the Nemerov family was one "of silences." Diane's beautiful mother Gertrude was not affectionate toward nor attentive with her children. Diane thought she cultivated a "air of supreme indifference" and "never stopped looking in the mirror." (Years later, Diane would repeat this pattern in her photographs when she could not help looking into "the mirror" of herself and others.) Her father, the businessman, was gone most of the time and also showed little warmth or interest in his children. For the first seven years of her life, Diane was brought up by a nanny who was cool and undemonstrative who almost never left her alone. In her privileged, overprotection, Arbus developed many fears, and from an early age a sense of "unreality." She said:

> I was confirmed in a sense of unreality. All I could feel was unreality . . . . One of the things I suffered from as a kid was I never felt adversity . . . and the sense of being immune was, ludicrous as it seems, a painful one.

Recounting her sense of isolation, she told a friend of an experience in summer camp: All her friends had been bitten by leeches and she wasn't. "Not even leeches bite me," she cried. It was this sense of isolation and unreality that later caused Diane to search out and confront any experience that could make her **feel**. She was preoccupied with anything physical, including her menstrual cycle and its blood, because it was the physical that could make her believe she was alive.

The lack of an adequate bonding relationship with a parent caused Diane and her older brother Howard to cling to each other and they developed a symbiotic relationship. They were both gifted, intelligent and noncommunicative except with each other. At times they would refuse to talk with anyone but each other. Their younger sister Renee was "supposed to be the normal one." Howard who would become a well-known poet was all intellect, Diane all emotion. The symbiotic qualities of this relationship would be repeated in Diane's life with Allan Arbus and with her daughter Doon. The exchange of secrets would characterize much of her art. Her struggles to understand and cope with her feelings about attachment and separation and the challenge of establishing a separate identity would be a central theme of her life and would be played out, most particularly, in her photographic obsession with twins.

Diane's Relationship with Her Father

In spite of his lack of interest generally in his children, Diane was her father's favorite child and through her ambivalent attachment to him, she gained some sense of the energy of the outside world. Although he was not home much, Diane would often be taken to visit him at his store. He was a businessman fascinated by drama and excess. Even when he was having financial problems, he spent lavishly to provide the visual acoutrements—the mask of wealth and excitement. His sexuality and sensual nature were openly acknowledged. He said that he wanted his store to be one where men could buy expensive presents for their mistresses and the fact that he had mistresses himself was apparently accepted by his wife.

And he dreamed of becoming an artist. When he went to Europe to see the fashion collections, he always took a sketchbook along. When he sold his store in 1957 and retired, he moved with Gertrude to Florida and became a full-time painter, exhibiting regularly and selling his work. His messages to Diane about artistic achievement when she was young were characteristically ambivalent. He encouraged her but dismissed her art as a hobby. Her real goal, he said, was "to live under the wing of a man."

According to psychoanalytic theory, the adolescent reworks the unfinished tasks of the earlier Oedipal stage. At age fourteen, the height of her threatening sexual feelings for her father, Diane "safely" fell in love with Allan Arbus and thereafter for almost twenty years, displaced her incestuous wishes and her needs for intimacy onto her relationship with him. Ironically, at eighteen, when she married Allan, Diane believed she was creating an independent life for herself.

The Compulsion to Confront the "Forbidden"

With her extreme sensitivity, Diane must have been aware of hidden nuances underneath the surface. It was this awareness which allowed her to feel the pain of her isolation as a child and her sense of separateness. Within the unspoken subtexts of the Nemerov family, she lived in ambiguity. For a young child, the mystery beneath the mask that cannot be spoken about becomes something full of terror—bad and evil and forbidden. The unexpressed rage and sexual impulses go underground, become projected onto the world causing it to seem a fearful place. Her biographer Patricia Bosworth writes:

> Diane said [to the novelist John A. Williams] that she was **always** frightened, no matter what she did—she lived with fear and overcoming fear every day of her life.

This "forbidden" side of Diane was not able to be completely denied or repressed although she tried. In 1957 she studied photography with Lisette Model. The first photos she brought in, according to Model, were "little balloons flying in the clouds—fragile and wispy." She told Model that she couldn't photograph because "what I want to photograph is evil." Model told Arbus: "Evil or not if you don't photograph what you are compelled to photograph, then you'll never photograph." With Model's encouragement, she began photographing people and places that she had been afraid to confront: She went to Coney Island, the Wax Museum, traveling circus, photographed tattooed people and became obsessed with freaks. Bosworth describes:

> Gazing at the human skeleton or the bearded lady, she was reminded of a dark, unnatural, hidden self. As a little girl she had been forbidden to look at anything "abnormal": the albino with his flat pink eyes, the harelipped baby, the woman swollen with fat from some mysterious glandular disease. Forbidden to look, Diane had stared all the more and developed an intense sympathy for any human oddity.

Diane Arbus' Photography and Its Relationship to Her Life

Arbus' portrait of identical twins will be examined. (See first reference, Arbus, D. and Israel, M.) Two little girls about eight years old stand awkwardly together in front of a white cement wall. They wear smocked dresses. They have dark hair and bangs. One twin has a faint smile. The other holds her lips tightly together with strain. They look directly at the viewer with light eyes. Their faces are framed by identical white headbands held on with two identical bobby pins and by their dresses' jagged white collars. On their legs are white lace stockings with patterns that are not identical, as if their mother had run out of "steam." They stand on a brick walk which is splattered with white paint spots from the wall.

This is anything but a relaxed, pleasant portrait of two innocent children. The psychological complexity of the photograph makes the viewer feel that she has never really seen twins before (or, for that matter, children before). One twin stands slightly in front of the other. The effect is of Siamese twins or of a multiple ink blot made from folded paper. They are mirror images and yet different—two parts of a whole—and their intimacy and inseparableness is palatable. They share secrets between them that no one can know. The viewer is drawn into the intensity of their relationship to each other and to the photographer. The feeling is of accidentally stumbling on something hidden; one cannot look away. Arbus said she never arranged her subjects, but simply arranged herself. "I can't seem to do anything that I want," she said. "Except be a spy . . . . I've captured people who will never look that way again. . . ."

The subject matter of the photograph of young children is innocent enough. But the frontality, objectivity and confrontive quality of the form along with the stark black and white shapes seem almost shocking. The white headbands, collars, cuffs and stockings seem to this writer reminiscent of the orthopedic corset in Kahlo's "The Broken Column." They structure, support, and cruely imprison. The effect is of control and order and quiet. However, the dissimilar stockings on the girls and the accidental drops of white paint on the bricks hint at an underlying psychic chaos. The artwork of Arbus and Kahlo are not unlike each other, but Kahlo's primitive style provides the viewer with some distance with which to observe horrible suffering. In its theatricality and exhibitionism, one cannot forget that it is Kahlo, specifically, who suffers. The "super" realism of Arbus' work and its psychological complexity along with the realistic immediacy of the photographic image reveals the more universal dark side of human nature and intensely involves the viewer. The artist is not in the forefront but an intrinsic part. This photograph alters and enlarges our view forever. Arbus' is a dual artistic vision arising out of the splitting in her own personality between the masking normality of surface and the hidden underlying terror. (This can be equated to a coexisting superego and id without the mediating integration of the ego.) This photograph like much of her work, reveals the abnormal in the normal. Arbus said of it: "I thought how ordinary is a charming pair of twins. In some societies twins are taboo, an aberration."

Interplay Between Conflicts Engendered by Women's Social Role and the Creative Urge

Diane Arbus grew up in the years before World War II when the women of her mother's privileged class centered their lives around their husbands. They ran their homes, took care of their husband's needs and in their spare time shopped, played bridge or engaged in charitable endeavors. In spite of Diane's restless, creative spirit she always envisioned her life attached, like a twin, to a man. At age fourteen, when she fell in love with Allan Arbus, she thought she had found the crucial relationship to define her life and that they would love each other forever echoing the romantic notions of the times. He was her mentor, her teacher, her reason for being. She called him "Swami" and he called her "girl." As in her relationship with her brother Howard, Diane was all emotion and she used Allan's cool perfectionistic control as a balance wheel. In marrying Allan, she hoped to achieve a life independent of her family and by marrying (even Allan, whom her parents opposed) she could win her father's approval and enjoy the pleasures of being the "good girl." She was brought up to please. But that she recognized the inherent ambivalent nature of her position is revealed in a school essay she wrote on *Medea*. She described:

> the deep selfish slowness of woman who closes her eyes to everything, including the restlessness of woman whose dreams then become a defense against awareness. Such women were like sleepwalkers . . . a woman wants to be one thing . . . and then she is told to be another. If she doesn't fulfill her destiny, should she hate herself? I don't think so.

Along with the felt ambivalence she might have been describing her own remoteness and depressive episodes, defining them as a defense against creativity. Certainly, she attempted to close her eyes to awareness. Soon after this she began to say she hated painting and that it had been a huge pretence to think of herself as a "great sad artist." One of her friends later suggested that "Diane was simply scared stiff of her talent. It terrified her because it set her so apart."

After marriage, Arbus concentrated on being Allan's wife. During the war years, while he was away, she moved back in with her family where she was treated as a little girl and told how to dress. When her daughter was born in 1945, she refused to allow her mother or sister to accompany her to the hospital. Bosworth writes that she was "terrified of being alone, but she believed she had to be alone to really experience something, only then would it really count." But when she brought her daughter home, her mother had hired a nurse and insisted that the baby be bottle fed. Diane and Allan continued to regularly attend Friday night dinners at the Nemerovs'. Many years later Diane explained to *Newsweek* why she didn't start taking photographs seriously until she was thirty-eight years old:

> Because a woman spends the first block of her life looking for a husband and learning to be a wife and mother, just trying to get those roles down pat; you don't have time to play another role.

Nevertheless, in the postwar era of the housewife as the essence of feminity and normality, Diane was a working wife and must have felt constantly torn. One of her colleagues said:

> [Conflict] was the subtext of our lives. At the office we'd be making decisions, taking creative responsibility for things. At home we were susceptible and passive and dependent on our men. It was confusing.

In the late fifties when Arbus began to finally explore the parameters of the artistic vision that would consume her in just more than ten years, she was thirty-eight years old. Her marriage had recently broken up, her parents had retired and moved to Florida and she struggled to sustain the life of a single mother. She could no longer escape or sublimate the challenge of establishing an independent life for herself. It terrified her and she endured severe depressions. Arbus' descent "into the depths" of the physically and psychologically dangerous world of her art must be seen as an attempt to conquer her fears and save herself. Arbus said "I was terrified most of the time." Bosworth writes:

> But terror aroused her and made her feel. It shattered her listlessness, her depression. Conquering her fears helped her develop the courage she felt her mother had failed to teach her. . . . Part of her motivation [for photographing freaks] was freaks frightened her. She **wanted** to get so scared that her heart would pound and sweat would pop out on her brow, and then she would conquer her fear and stay for hours . . .

For Diane Arbus, the conflict between her expected female role and her creative urge always existed and to achieve a balance was, for her, an impossibility. But in a very real sense the demands of her life as a wife and mother must be viewed as a positive personality dynamic: They did not make her happy, but they provided her with structure, order and the comfort of close relationships thus aided in the survival of a fragile personality. For, at midlife, during the experimental permissiveness of the decade of the sixties, as the roles of daughter, wife and mother fell away from her, and Arbus explored the depths of her creativity, she plunged into the abyss of chaos, unbridled sexuality and loneliness that would finally engulf her life.

The Psychological Significance of Arbus' Art to Her Personality

Diane Arbus' identity as an artist existed from an early age. Even as a child, her talents and giftedness explained and excused her strange, remote behavior. In an artist much "weirdness" is acceptable. She was special and she knew it and felt insulated from others, and those around her knew it too. In adolescence, her strong urges and sensitivities were sublimated into her art and her relationships. Through the artistic imagination she could begin to explore the forbidden territories that existed outside the limits of safety and thus herself still remain safe. For the fearful personality, her art would provide a counter-phobic and socially acceptable means to attempt to master her fears. Later, she would speak of her attraction for freaks in this way:

> Most people go through life dreading they'll have a traumatic experience. Freaks were born with their trauma and they've passed their test in life.

For the isolated, protected youngster, through her imagination she could prick her finger, smell the blood and know that she existed. And the feelings could be expressed and contained on paper and canvas and thus garner for Arbus a measure of control.

There is an important question here that has been alluded to before. We must ask whether in the little more than ten years of her individual work, Arbus' creativity was, overall, of positive benefit to her fragile personality. In the opinion of this writer, it was not. As Arbus' creative urgency loosened the ego's frail constraints and plunged her deeper and deeper into her unconscious processes, her personality shattered.

That her photography offered her a structured medium with a great deal of "technique" through which to approach and express the hidden parts of herself was certainly helpful. "The process itself has a kind of exactitude . . . . It's a little bit cold, a little bit harsh," Arbus said. It also provided her a psychologically "safe" way, through her camera as transitional object of interacting with the world. One is led to wonder whether what we observe in the work is the cathartic and thus helpful reflection of Arbus' underlying aggressive hostility. After being photographed by her, Norman Mailer said: "Giving a camera to Diane Arbus is like giving a hand grenade to a baby." It is this writer's view that what we see in the photographs is not rage, but an unflinchingly honest, objective reporting of a very private reality. Hers is a vision of a reality seen without sentimentality or judgment or scorn. Her subjects look directly at her and, unlike most people, she could not bear to look away. It is this act of direct, human collaboration—in relationship—that gives the works their dignity.

On the negative side, her work increasingly drove her into psychologically dangerous territory. Her affinities to the freaks and oddities she was obsessed with reminded her of her own "freakishness" that was previously held in check. Further, a drawing or a photograph of difficult emotional material has an intensely confrontive impact of its own that is hard to ignore. Words, once spoken, can float away dissipating their impact. Written words can be closed off within the covers of a book. Language is a symbolic representation of a distinctly distant reality. Visual images, on the other hand, speak directly to our most essential psychological and unconscious processes and often spring from the deepest parts of the self. Visual imagery such as Arbus' is permanent over time and continues to demand attention. With them, one cannot hide or deny or distance within socially acceptable "civilized" conventions. That primitive people thought that the camera was able to steal the soul from the person and capture it in the image was for good reason. If Arbus' form had been words, she might have been able to adequately distance. As it was, I would suggest that she became increasingly mired in a circular process from which finally, there was no escape: The more she photographed, the more she confronted her own forbidden self. And the product of her creative process, the immediacy of the confrontive imagery of her photographs, as she worked on the pictures in the darkroom, looked at them, thought about them and showed them to others, constantly caused her to return to the deepest, most hidden and painful parts of herself. This circularity poses an interesting dilemma for a psychotherapist, for in Arbus' life and creative work, there is implied the possibility of choice between the preservation of life and of her essential creative vision. Could she have retained both? It is my hypothesis that in order to preserve the integrity and survival of her personality (and of her life) a psychotherapist treating Arbus would have needed to discourage her unique, obsessional subject matter and help her displace and sublimate her primary process material into a structured, cognitive framework and an overall more distant, secondary process orientation. Additionally, she might have helped Arbus achieve a less chaotic social environment perhaps out of the stresses of New York City, with its anti-traditional, promiscuous and acting-out art world of the 1960's. Indeed, the doing of photography might have been discouraged altogether. If this could have been accomplished (and it is a big "if"), Arbus' life might have been saved. But without her artistic identity and creative artistry could she have survived at all? If Frida Kahlo's paintings helped her cope with her difficult reality and possibly lengthened her life, so it may be possible that Diane Arbus' photographs offered her the same surcease from despair, at least for a time. Through her increasing periods of depression, she roused herself to photograph and thus continued on. Arbus said "I feel like an explorer," and if her relentless explorations devastated her in the end, she left a legacy of meaning which will endure. She changed the direction of photography in the United States and those who look upon her pictures never see the world, nor our hidden selves, in the same way again.

"The artist works within the ambiguous and treacherous territories between the self and the world and there, makes meaning."

The artist works within the ambiguous and treacherous territories between the self and the world and there, makes **meaning**. Out of what is known and what cannot be known a whole new thing is created which, when we experience it, transforms our understanding of our selves and of the essential nature of reality. Arbus' creative power to make meaning is what the fictional painter Gulley Jimson, in Joyce Cary's *The Horse's Mouth* is talking about when asked why he became an artist. He describes walking by a shop window in London and catching a glimpse of a Cezanne painting. "Cezanne," Jimson says, "skinned my eyes for me." Diane Arbus said:

> I do feel I have some slight corner on something about the quality of things . . . [it's] a little embarassing to me, but I really believe there are things which nobody would see unless I photographed them.

Ultimately, we can only be grateful that through her creative vision, Diane Arbus helps us to see.

References

Arbus, D. and Israel, M. (Eds.) (1972). *Diane Arbus: An aperture monograph.* New York, Aperture.

——— (1984). *Diane Arbus magazine work,* New York, Aperture.

Arieti, S. (1976). *Creativity, the magic synthesis.* New York, Basic Books.

Arnheim, R. (1974). *Art and visual perception: The new version.* Berkeley, University of California Press.

Bosworth, P. (1984). *Diane Arbus,* New York, Alfred A. Knopf.

Bowness, A. (1977). *Some statements by Barbara Hepworth.* St. Ives, England, Barbara Hepworth Museum.

Castle, C.S. (1913). "A statistical study of eminent women," In Columbia University, *Contributions to Philosophy and Psychology.* Vol. 22, No. 1, New York, Science Press.

Cohen, T. (1983). "The woman artist: A struggle for self-realization," *Women & Therapy.* Vol. 2, No. 1, New York, The Haworth Press.

Ellis, H. (1904). *A study of British genius.* London, Hurst and Blackett.

Erikson, E. (1968). *Identity, youth and crisis.* New York, W.W. Norton.

Fuller, P. (1981). *Art and Psychoanalysis.* London, Writers and Readers Publishing Cooperative.

Freud, S. (1961). *The Standard Edition of the Complete Psychological Works of Sigmund Freud.* J. Strachey, (ed. and translator), London, The Hogarth Press. (includes Freud citations for 1908 and 1910)

———, (1958). *Sigmund Freud on creativity and the unconscious.* New York, Harper and Row.

Gardner, H. (1982). *Art, mind and brain.* New York, Basic Books.

———, (1985). *Frames of the mind.* New York, Basic Books.

Gilbert, L. and Moore, G. (1981). *Particular passions.* New York, Clarkson N. Potter.

Greenacre, P. (1957). "The childhood of the artist," *Psychoanalytic study of the child.* Vol. 12, New York, International Universities.

Ghiselin, B. (1955). *The creative process.* New York, Mentor Books.

Guildford, J. (1959). "Traits of creativity," in Anderson, H.H. (ed.) *Creativity and its cultivation.* New York, Harper and Row.

Herrera, H. (1983). *Frida: A biography of Frida Kahlo.* New York, Harper and Row.

John-Steiner, V. (1985). *Notebooks of the mind.* Albuquerque, University of New Mexico Press.

Kris, E. (1952). *Psychoanalytic explorations in art.* New York, Schocken Books.

Kubie, L.S. (1965). *Neurotic distortion of the creative process.* New York, Farrar, Straus and Giroux.

Lauter, E. (1984). *Women As Mythmakers.* Bloomington, Indiana University Press.

McWhinney, W. (1985). "Alternative forms of creativity and particular training for their use." Unpublished paper.

Miller, L. and Swenson, S. (1981). *Lives and works, talks with women artists.* New Jersey, The Scarecrow Press.

Munro, E. (1979). *Originals: American women artists.* New York, Simon and Schuster.

Phillips, W. (ed.) (1963). *Art and psychoanalysis.* New York, Meridian Books.

Spacks, P. (1972). *The female imagination.* New York, Avon Books.

Ruddick, S. and Daniels, P. (1977). *Working it out.* New York, Pantheon Books.

Storr, A. (1985). *The dynamics of creation.* New York, Atheneum.

Winner, E. (1982). *Invented worlds, the psychology of the arts.* Cambridge, Harvard University Press.

Wittkower, R. and M. (1963). *Born under Saturn.* New York, W. W. Norton.

Wolfe, B. (1963). *The fabulous life of Diego Rivera.* New York, Stein and Day.

Comparison of Art Psychotherapy and Discharge Diagnoses of Diagnostic Unit Patients

Barbara Wittels Witlin, MS, ATR, *Past-Senior Art Psychotherapist, Fairmount Institute, Philadelphia, PA and* **Roy Augusthy, MD,** *Director Diagnostic Unit, Fairmount Institute*

This paper correlates art psychotherapy diagnoses with psychiatric discharge diagnoses on Axis I according to the **Diagnostic and Statistical Manual of Mental Disorders III,** *(1980). Total patient population (N = 97) was evaluated by one art psychotherapist and one psychiatrist on the diagnostic/evaluation unit: Fairmount Institute, Philadelphia, PA. Based on chart data frequency and percentage of agreement is: affective (N = 48) 40, (83.3%); schizophrenia spectrum (N = 27) 20, (74.1%); organic (N = 15) 10, (66.6%); personality disorders (N = 5) 5, (100%); others (N = 2) 0, (0%). In total population (N = 97), diagnostic agreement is 75 (77.3%).*

This model for future efficacy studies may indicate relative accuracy of art therapy testing in different diagnostic groups. It also suggests future comparisons of efficacy/cost-effectiveness of art with other diagnostic testing. Evaluation of drawings indicates possible usage of art for differentiating between groups of schizophrenics showing brain atrophy on CAT and PET scans, and schizophrenics without detectable brain changes.

Introduction

This study was done retrospectively, covering a two-and-a-half year period, using two sources of information:

1) The discharge diagnosis by the psychiatric director on a psychiatric diagnostic unit.

2) The art psychotherapist's diagnosis of these same patients.

The site is a private psychiatric hospital, The Fairmount Institute in Philadelphia, Pennsylvania. In this setting a number of diagnostic tools are used, including psychiatric interviews, a psychosocial assessment, meetings with the patient's family, a physical examination with follow-up consultations if necessary, psychological testing and laboratory procedures. These are all used to supplement impressions gathered during daily clinical observation.

Art psychotherapy assessments are carried out by a master's degree level art therapist with sufficient internship to qualify for A.T.R. (art therapy registration). Assessments are done without prior information from charts or other written or verbal information.

A literature search shows no previous systematic attempts to correlate art psychotherapy diagnosis with DSM III discharge diagnosis. Also absent from the literature are statistically significant efficacy studies correlating art therapy with psychiatric diagnosis or assessment. A single study such as this, using one art psychotherapist and one psychiatrist with chart information, is not rigorous enough to meet the standards for statistical significance. This research is intended as a basis for heuristic exploration and replication.

> ***"This research is intended as a basis for heuristic exploration and replication."***

The two areas explored are:

1) An examination of the frequency of concurrence of art psychotherapy diagnostic assessments with psychiatric diagnosis.

2) Identification of strengths and weaknesses in art psychotherapy for diagnostic purposes.

A Review of the Literature

Two authors, Ulman (1976) and Kwiatowska (1978), have published a suggested series of drawing tests for diagnosis. Elements of both of these tests are widely used in art therapy testing.

Arieti (1974), Amos (1982), Weiner (1966), and many others have written descriptive literature on pathological art. Dax (1965), Plokker (1965), and Wadeson (1980) have presented statistically significant diagnostic studies, especially distinguishing characteristics of depressed patients' drawings from other psychiatric classifications. Authors are not always in complete agreement on classifications distinguishing one diagnostic group from another.

In his review of findings in neuropsychology, Goldstein (1984) using the Halstead-Reitan test battery, found "many chronic schizophrenics perform in a manner indistinguishable from that of patients with chronic brain disorders," with regard to cognitive deficits.

The present study suggests that art evaluation is useful in determining a patient's diagnosis but, as when using other testing methods, there are difficulties distinguishing schizophrenia from certain types of organic impairment.

> ***"To preclude advanced knowledge of cases . . . charts are not seen and cases are not discussed."***

Methods

Tests administered:

Patients are referred from the diagnostic unit for art psychotherapy assessment if definitive diagnosis is in question and total range of available testing is indicated. Patients, seen individually, are requested to do four drawings:

1) A specific place (real or imaginary).

2) A kinetic family drawing (members of the family doing things). (Burns and Kaufman, 1972).

3) A body of water. (Wittels, 1982).

4) Free choice of subject.

Materials provided are 12" by 18" drawing paper and a box of 12 assorted colored pencils. Based on the patient's response to task No. 1, "draw a place," the remaining tasks may be modified.

A patient's inability to concentrate may necessitate reducing the entire test to the simple task of drawing a house, a tree and a person. A grossly confused patient may be asked to do only an organicity screening involving conceptualizing and copying simple shapes.

Data collection: Sample size $N=97$, is the total population of patients given discharge diagnoses by the coauthor and evaluated by the author. The number of days between art evaluation and discharge diagnosis is usually seven, but ranges from one to ten.

To preclude advanced knowledge of cases or familiarity with the coauthor's diagnostic style, charts are not seen and cases are not discussed. The art psychotherapist does not attend case conferences, nor is she the recipient of written or verbal reports before or after the art therapy evaluation. The physician has access to art evaluation as well as test results from other disciplines. However, the amount of psychiatric observation and multidiscipline-generated information limits the influence of art psychotherapy evaluation on the determination of final diagnosis.

Two cases, selected by the psychiatrist and the art therapist are presented to illustrate the art evaluation process.

Results

Cases are classified as follows: affective disorders; schizophrenia spectrum; organic; and other, depending on discharge diagnosis. Schizophrenia spectrum is defined to include schizophrenia; schizotypal personality; schizoid personality; and borderline personality disorder. (Wender, 1977)

Results are classified into two categories: agreement and disagreement. Agreement is defined as agreement between art therapy diagnosis and discharge diagnosis on Axis I, except when there is disagreement about the existence of borderline, schizoid or schizotypal personality disorder on Axis II.

Table I classifies cases according to the psychiatrist's discharge diagnosis. Agreement or disagreement refers to the art psychotherapist's evaluation.

In the affective disorders group, there is 100% concurrence in the diagnosis of the seven manic cases. In depressed cases 33 out of 41 or 80.5% show agreement.

The affective disagreement group includes six cases which are perceived in a similar way by both evaluators, but which do not match exactly on Axis I. They show agreement in most diagnostic features, but differ in emphasis or degree.

One affective case in the disagreement group agrees on Axis I, but disagrees about the existence of borderline personality on Axis II. The eighth case is diagnosed depressed with paranoia by the physician, schizophrenic by the art therapist. Four of the eight disagreeing cases involve heavy drug abuse.

In the schizophrenic agreement group 20 out of 27 or 74.1% agree. In the disagreement group, three show the same two possible diagnoses, but disagree about which is the "best choice." Four cases show the same components, but are not identical on Axis I (two of these agree on the presence of organic dysfunction on Axis III). The seventh case is inconclusive to both physician and art psychotherapist.

In the organic group, 10 out of 15 or 66.6% agree. All five disagree-

Table I Frequency and Percentage of Agreement and Disagreement of Art Psychotherapy Diagnosis with Discharge Diagnosis

Disorder Classification		Agreement		Disagreement	
Affective	*N*	*F*	%	*F*	%
Affective	48	40	83.3	8	16.6
Manic	7	7	100.0	0	0
Depressed	41	33	80.5	8	19.5
Schizophrenia Spectrum	27	20	74.1	7	26
Organic	15	10	66.6	5	33.3
Personality Disorders*	5	5	100.0	0	0
Others	2	0	0	2	100.0
Total	97	75	77.3	22	22.6

*Other than those classified within Schizophrenia Spectrum ments are toxic psychoses misdiagnosed schizophrenia by the art psychotherapist.

All 5 cases in the personality disorder group were in agreement.

The two disagreements comprising the "other" category are inconclusive to both psychiatrist and art psychotherapist.

Two cases, illustrative of the art assessment process are also examples of an unforeseen result, i.e. possible ability of an art psychotherapist to differentiate between subtypes of schizophrenia. Both cases are diagnosed chronic schizophrenia by physician and art psychotherapist. One shows organic impairment and the other does not.

CASE No. 1:

Psychiatric Evaluation

Mr. X. was a casually dressed, 26-year-old single white male, admitted because of severe agitation and extreme social isolation. He had become physically assaultive to his parents and had threatened to kill them. He had spent a great deal of time alone in his room, at times laughing and shouting. Psychiatric history dated back to the age of 15.

The patient was superficially cooperative. His speech was rather monotonous, with significant looseness of association. Thought process was very disorganized and contained bizarre sexual content. There was evidence of paranoid and grandiose delusions, ideas of reference and auditory and visual hallucinations. He was oriented in all three spheres and there was no evidence of organicity or gross intellectual impairment. Insight was very superficial and judgment impaired.

Art Assessment

Mr. X. did three drawings: a place, his family "doing something" and a body of water. The works were skillfully executed and showed good perceptual-motor skills with no evidence of organicity.

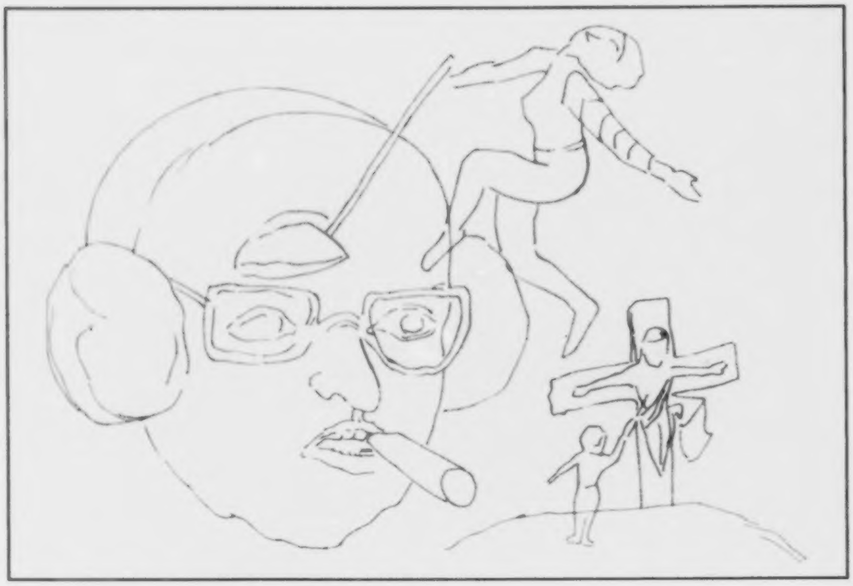


Fig. 1. Delusional family drawing

The first drawing (a place) was a mountainous, other-worldly landscape with a phallic shaped windmill. The picture was not extremely bizarre and drawing skills were excellent. The mood was barren and empty. Sharp, strangely disconnected blades around the windmill suggested the defensiveness of paranoia.

The second drawing (the family) was more bizarre. The father wore earmuffs, according to the patient, to shut out "the voices." The mother was a tiny figure pushing a vacuum cleaner inside the father's head. The patient portrayed himself as Christ being crucified by his sister. Verbalizations made while creating this drawing were tangential and bizarre.

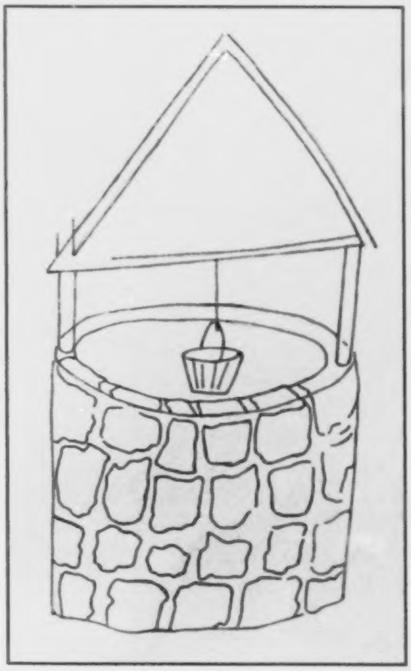
The third drawing (a body of water) was a well with a stone wall and a bucket that could not be lowered. There was no background and the poverty of detail suggested thought blocking following the decompensation seen in the second drawing. Each of the drawings showed characteristically schizophrenic splits into two separate drawing styles or spatial division into unrelated and disconnected components.

CASE No. 2:

Psychiatric evaluation

Mr. Y. was a 21-year-old, single white male, a first psychiatric admis-

Fig. 2.
Schizophrenic body of water drawing



sion because of auditory and visual hallucinations and extreme paranoia. He was highly delusional, feeling that somebody had placed a metal plate in his stomach and this plate controlled his mind and body, making him feel weak. The patient had refused to eat for fear that food might cause the metal plate to explode and had refused to go outside because he saw people who were "radiated." He had refused to bathe and had slept with knives next to him, seriously considering cutting open his stomach with a knife to get rid of the plate.

These symptoms were of one year's duration, but he had received no psychiatric help. There was no history of substance abuse. The patient had sustained a head injury one year prior to admission.

Mr. Y. was a disheveled, poorly groomed, thin white male, suspicious, guarded, and rather uncooperative. His speech was underproductive, with considerable looseness of association. There was evidence of auditory and visual hallucinations. The patient denied suicidal or homicidal feelings, but his mood was angry and his affect was blunted. He was well oriented to person, but not to place and time. There was no evidence of intellectual impairment. His insight was extremely poor and judgment was grossly impaired.

Art Assessment

The drawings of Mr. Y. showed qualities which are characteristic of both organic and/or some schizophrenic drawings, i.e. oversimplification, distortion, lack of affect, concreteness and perseveration, disturbed lines and incompleteness.

> ***"The works (of Mr. X.) were skillfully executed and showed good perceptual-motor skills with no evidence of organicity."***

The first drawing showed the patient with the metal plate he believed to be inside his body. The second drawing showed the patient's concept of himself after the desired surgical removal of the plate. The figures are simple, amorphous shapes. The drawing of the patient after surgery shows an enormous phallic-shaped left arm. This is consistent with sexual identity confusion and magical ideas of changing his sex by removing the offending plate.

The family drawing shows perseverative repetition of geometric bodies without tops on the heads. There is no graphic indication of relatedness within the family.

The fourth drawing of a house shows perceptual distortions and lacking essential details. Two windows above the door reinforced with double lines suggest paranoid eyes. The complete lack of affect and systematic delusions portrayed point to chronic schizophrenia rather than organicity as a primary diagnosis.

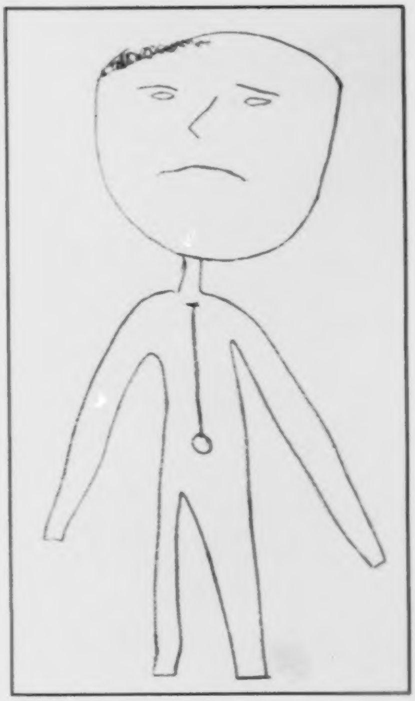
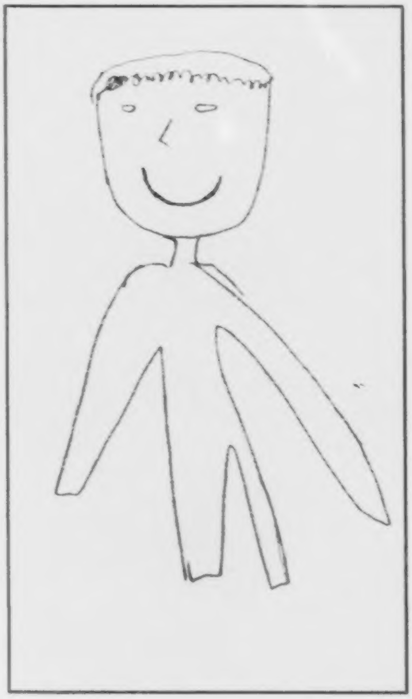


Fig. 3.
Self portrait with delusional metal plate

Fig. 4.
Imagined self portrait after removal of the plate



> ***"(Mr. Y) was well oriented to person, but not to place and time."***

Discussion

Clinically, both cases described clearly met DSM III criteria for schizophrenia, upon admission and discharge. In spite of the clinical similarity in psychiatric evaluations, the drawings in case No. 2 showed a

BEST COPY AVAILABLE

likeness to drawings by patients with organic brain disorders, while drawings in case No. 1 did not.

Frequent difficulty distinguishing between organicity and schizophrenia is not unique to art evaluation, and is found in psychological and neuropsychological testing as well. Still, art is highly sensitive to perceptual difficulties caused by organicity.

CAT scans, PET scans and metabolism scans show a certain percentage of schizophrenics have clearly defined atrophic type brain changes (Gonzalez, Grossman, Masden, 1985). Case No. 2 could belong to that subgroup of schizophrenics which shows atrophic brain dysfunction. Clinically, it is difficult to distinguish between the two groups. Further studies, including psychological and neurological testing, CAT and PET scans may clarify whether a patient such as case No. 1 belongs to the subgroup of schizophrenics without any noticeable brain changes, while patient No. 2 is a schizophrenic with identifiable brain atrophy. Such a study is strongly recommended.

In our own sample, the overall agreement of art psychotherapy testing with discharge diagnosis at 77.3% indicates its usefulness as a diagnostic procedure. Its value is enhanced by low cost and quick results. (An average art evaluation requires a total of about three hours, including interview, study of drawings, and write-up).

The area showing the highest percentage of agreement, 83.3%, is the affective disorders. This is explainable by the unique quality of the drawings which do not usually overlap with other diagnostic categories, if there are no additional serious mental problems to cloud the issue.

Schizophrenia spectrum disorders showed 74.1% agreement. This category showed the following difficulties in art evaluation:

(1) Deciding placement on the schizophrenia spectrum.

"The area showing the highest percentage of agreement . . . is the affective disorders."

---

(2) Pinpointing the predominant problem in cases with schizophrenic as well as depressive symptoms. For example: schizophrenia with depression, versus depression with schizoid or borderline personality.

(3) Overlap with organicity.

Psychiatric diagnosis and art evaluation showed 100% agreement in personality disorders other than those in the schizophrenia spectrum, but sample size, (N = 5) was insufficient to warrant any conclusions.

When no psychosis is present, drawings show great sensitivity to organic impairment. However, with the tools available, art evaluation is not helpful in our study distinguishing toxic psychosis from schizophrenia. Here again, sample size is too small for conclusive findings.

Notes

Barbara Wittels Witlin, M.S., ATR is the senior art psychotherapist of the Fairmount Institute in Philadelphia. Roy Augusthy M.D. is the director of the Diagnostic and Education Unit of the Fairmount Institute.

Requests for reprints should be sent to: Barbara Wittels Witlin, M.S., 102 Seven Oaks Road, Summerville, NC 29483.

Deepest thanks to Hal Rosen, M.D. for his invaluable help and encouragement in preparing this manuscript. Special thanks to Roy Witlin, M.Ed., my mentor and inspiration.

References

Amos, S. (1982). The diagnostic, prognostic and therapeutic implications of schizophrenic art. *The arts psychotherapy J* 9:131-143.

Arieti, S. (1974). *Interpretation of schizophrenia.* N.Y.: Basic Books.

Burns, R. and Kauffman, H. (1972). *Actions, styles and symbols in kinetic family drawings.* N.Y.: Brunner/Mazel.

Dax, E. (1953). *Experimental studies in psychiatric art.* London: Faber and Faber.

Goldstein, G. (1984). Neuropsychological assessment of psychiatric patients. In G. Goldstein (Ed.) *Advances in neuropsychology* (Vol I, pp 55-87) N.Y. and London: Plenum Press.

Gonzalez, C.F., Grossman, C. B., Masden, J. C. (1985). *Head and spine imaging.* N.Y.: John Wiley and Sons.

Kwiatowska, H. Y. (1978). *Family therapy and evaluation through art.* Springfield, IL: Charles C. Thomas.

Plokker, J. (1965). *Art from the mentally disturbed, the shattered vision of schizophrenics.* Boston: Little/Brown.

Spitzer, R. L. (Ed.) (1980). *Diagnostic and statistical manual of mental disorders.* Washington, D.C.: American Psychiatric Association.

Ulman, E. (1976). A new use of art in psychiatric diagnosis. In E. Ulman and P. Dachinger (Eds.), *Art therapy in theory and practice.* N.Y.: Schocken Books.

Wadeson, H. (1980). *Art psychotherapy.* N.Y.: John Wiley and Sons.

Weiner, L. B. (1966). *Psychodiagnosis in schizophrenia.* N.Y.: John Wiley and Sons.

Wender, P. H. (1977). The scope and validity of the schizophrenic spectrum concept. In Rakoff, V., Stancer, H., Kedward, H. (Eds.) *Psychiatric diagnosis.* (Chap. 6) N.Y.: Brunner and Mazel.

Wittels, B. (1982). The body of water as a diagnostic indicator. *The Arts Psychotherapy J* 9:177-183.

Inner Guide

Vija B. Lusebrink; PhD, ATR, *Associate Professor Expressive Therapies, University of Louisville, Louisville, KY 40292*

The concept of inner guide has universal manifestations in images in the fairy tales, myths, and religions of different cultures. Jung explored this concept intuitively first as a child, later through his method of active imagination.

The most common images of inner guide are protective animals and beings, safe and special places, and light and sound images. The image of an inner guide may change over a period of time, representing different levels of depth of the experience. At times an image of the inner guide may be rejected by the individual as inconsequential because it does not correspond with the individual's expectations.

The images of inner guide emerge in times of great physical or mental stress providing for the individual an inner wisdom and healing. These images also can be activated in a relaxed and receptive state through guided daydreams. The visual expressions of the inner guide stabilize the images and reinforce their structural and affective aspects.

Inner Guide as the Wise Helper and Healer

We may have had experiences of making difficult decisions or facing dilemmas in which there seemed to be no way out. We may toss and turn in sleep, we may perseverate thinking about it during daytime, and just as we are ready to give it up, something "clicks." A small voice inside us or some observation suddenly sheds a light on the problem, and we know the way to go.

Jung (von Frantz, 1968) considered that wisdom came from deep and at the same time from transpersonal dimensions of the psyche, namely the Self. In this transpersonal dimension the Self is defined as the organizing center and the totality of the psyche, of which the ego constitutes only a small part (von Frantz, 1968; Edinger, 1973). The Self manifests itself spontaneously in times of extreme stress, when *the individual is forced to give up his/her ego position*. At these times the totality of the inner psyche becomes an inner companion, and an inner guiding factor. The stress precipitating the experience of and the guidance by the Self can be either physical, such as an illness, or catastrophic occurrences in the external environment. The stress can also be emotional or intrapsychic. A manifestation of intrapsychic stress may be the result of the alienation from the Self, which is experienced as a loss of meaning in life (Edinger, 1973).

The connecting link to the Self most often is manifested as a symbolic image. The multidimensional nature of symbolic images link the biological system with the spiritual, transpersonal dimension. The subsequent expression of the symbolic image through art media, music, dance, or stories gives the image a body.

Inner Guide in Jung's Experience

Jung (1963) in his *Memories, Dreams, Reflections* tells of several instances of his encounter with the inner guide. Jung's first experience was when he was about ten years old. During this time his parents were considering separation. Being a sensitive child who spent a large amount of time by himself, Jung reacted strongly to this stress by having anxiety dreams and visions. To subdue his anxiety, Jung carved a little mannequin, to whom he gave an oblong blackish stone, and hid both of them in a safe and secret place. In doing so Jung experienced a feeling of safeness and an absence of the inner torment he had before. Each time when the situation at home became difficult to bear, he would think of his little mannequin and stone; he would also place little scrolls of paper written in his own language with the mannequin. The meaning of his actions did not concern Jung at that particular time. This experience lasted for about a year and it marked the end of his childhood.

Both the image of the mannequin and the stone emerged for Jung after many years, when Jung discovered the image of his stone was similar to that of the soul-stones of primitive tribes, and the little mannequin similar to the representation of a god of the ancient world as seen in the image of a little mannequin reading from a scroll to Aesklepios of Telephorus, Greece. Jung carved similar figures later in his life without any rememberance of his childhood ex-

"A small voice inside us or some observation suddenly sheds light on the problem, and we know the way to go."

This paper was presented at the 17th Annual AATA Conference in Los Angeles, November, 1986.

perience. Jung (1963) states that as a child he had performed the ritual just as done by the natives in Africa; namely, that "they act first and do not know what they are doing. Only long afterwards they reflect what they have done" (pp. 23).

The same figure of the mannequin and an island in the shape of the stone appeared to Jung in a dream again thirty years later during his travel in India. During this time Jung was overwhelmed by the honors bestowed on him. Jung realized afterwards that the dream had taken him back to Western Europe and that his healing and work belonged there. These examples illustrate the spontaneous manifestations of the Self as an inner guide, and how the image of the inner guide remained stable over half a century. Ultimately Jung carved the image of the kabir or little mannequin in a stone by the tower he built for himself at Bollingen.

Jung's other spiritual inner guide was Philemon, who came to him in a dream, which Jung drew afterwards. According to Jung (1963), Philemon represented the force which was not himself. Psychologically Philemon represented Jung's superior insight which was the uniting force behind the different creations of Jung's imagination; Philemon conveyed to Jung also many illuminating ideas as a spiritual teacher.

Images of Self and Inner Guide in Folklore and Art

What are the representations of the Self and inner guide as seen in the myths and art through the ages and different cultures? The most common forms of representation of the Self are through the images of stones, animals and mandalas. Images of light and the place of emergence, like a pool of water, are related to Self, as are special places marked by the knowledge that one has to "stand there." For example, in the biblical story of Jacob's dream he fell asleep using a stone for his pillow, and God's voice in the dream told him to mark that place: "The land where thy liest, I give to you and your seed." Angels in the form of guardian angels may be another manifestation of the Self. Stones have been invested with holiness and special powers by primitives. We still gather stones; could this reflect our reaching for the unchanging part of ourselves? Precious stones are used as symbols of Self, as are the images of flowers such as the lotus or rose.

"The most common forms of representation of the Self are through the images of stones, animals and mandalas."

"The connecting link to the Self most often is manifested as a symbolic image."

The images of animals and birds as helpers and as representatives of a higher Self are abound in mythology, as well as ancient religions. In the biblical story of Elijah in the wilderness, he is fed by the ravens. Wilderness or desert often stand for the psychic stress or alienation (Edinger, 1973). In folklore the inner helper appears often as an animal representing the instinctual, intuitive, innate wisdom. Examples of these helpers are present in the fairy tale of Cinderella or in the Russian tale of the hunchbacked horse. In the Russian story, the hunchbacked horse helps Ivan, similar to Cinderella, to undertake tasks which seem to be impossible; to catch the pig with the golden bristles and silver tusks; and to get the beautiful Tsarina from a faraway land. The little hunchbacked horse saves Ivan's life when Ivan has to jump in a kettle of boiling water. Ivan emerges from this ordeal beautiful and strong and marries the Tsarina. This story is of a particular interest to us in that the little hunchbacked horse is not "perfect" in that he has a hunched back. This impairment is similar to Jung's guide Philemon, who had a lame foot. Many times the inner guide appears to be insignificant, a stranger, or have a defect; namely, it may have a quality for which he or she is rejected at first.

Mandalas are the structural devices of centering leading to the inner core. Jung (1963) drew mandalas for about ten years during the time of his inner turmoil and search in his adult life. This period of his life culminated in the "Liverpool dream" in which the center of a city was marked by a small pool with an island in the middle. The island, despite the surrounding darkness was blazed with sunlight, and on it stood a single tree, a magnolia with reddish blossoms. The tree appeared to be in sunlight and at the same time to be the source of light. For Jung the dream had a sense of a finality of a goal, and this was for him the first inkling of his personal myth, giving an objective view on what had filled Jung's search for many years. Jung's (1963) "Liverpool dream" combines the elements of place, water, light and a flowering plant as demarking the desired place to be. After the dream Jung gave up painting mandalas. The dialogue with the image in the form of painting helped Jung to contact this inner source.

Mandalas as centering and healing devices have been used in different cultures, especially by American Indians and the Tibetan Buddhists. The Navaho sandpaintings (Olin, 1972) have as a center a "place of emergence" which in their my-

"Mandalas are the structural devices of centering leading to the inner core."

thology leads to evolution to a higher plane. Many of the Tibetan Buddhist tankas have the image of Buddha in their center, which is then contemplated and visualized by the individuals to discover their own Buddha nature. The individual, though, has to first confront his own shortcomings and mortal sins in the form of monster images before he or she can reach the Buddha nature. Similarly, in Kioto, Japan, the worshipper has to go past the threatening giant guardian sculptures before he or she can enter the inner shrine of Buddha (Campbell, 1974).

Images of the Inner Guide in Dreams and Active Imagination

In everyday life the Self as an inner guide appears most often in dreams. In women's dreams the inner guide may appear in a human form as a superfemale, such as a priestess, sorceress, earth mother, goddess of nature or love. In men's dreams the Self as an inner guide may be encountered in the image of a guardian, wise man, or spirit of the nature (von Frantz, 1968). A voice making pronouncements in dreams can also be a manifestation of an inner guide.

According to the Jungian thought, the Self is a psychic reality, everpresent and not contained in time. As an archetype the Self can be expressed only through a symbol or image. A conscious connection can be established with the archetypal images through the method of active imagination (Jung, 1960, 1969). This approach presupposes a passive acceptance of the flow of imagery combined with active participation in the imagery. In active imagination, the images seem to have a life of their own, and their symbolic flow develops according to its own logic. Jung (1969) cautions against interrupting the flow of events with conscious thoughts.

Giving the symbolic image a form and voice, and establishing a dialogue with it is an important part in enhancing the contact with the Self. The technique of active imagination is an excellent way to establish such a dialogue between what Singer (1973) calls the "I" and the "Non-I." According to Singer (1973) the use of imagination performs the work of the transcendent function to establish a conscious dialogue between the unconscious and the ego through the objectification in images. Painting and drawing of the images produce a further clarification of them. Thus, dream images which do not seem to yield any meaning of the dream for the dreamer may be called upon in a wake state and actively confronted. Singer (1973) points out that in this process "the conscious side states its position vis-à-vis the dream, or asks the question that the dream has covered. It then suspends all critical judgment and allows the unconscious an equal opportunity to express itself. Often words will come, or ideas, which have meaning, and to which the ego may respond" (p. 362).

A transformation of the personality may take place if the process of active imagination is seriously undertaken. At the same time active imagination may become too fascinating for the individual and may pull him/her toward the unconscious. For this reason active imagination is recommended primarily for individuals with a well defended ego. Series of spontaneous paintings may be regarded as active imagination in process (Lyddiatt, 1971). The act of painting is a reality-directed activity and brings out, in most cases, the integrative aspect of a structure present in the visual expression.

A guided daydream (Leuner, 1978, 1984) uses the principle of active imagination combined with the structure provided by the therapist who presents verbally to the client in a relaxed state a sequence of scenes and actions with a symbolic meaning. The client's images, in turn, become the source for further exploration via active imagination. For example, the sequence of going in a cave and encountering a wise man or woman there with whom the individual establishes a dialogue represents a semistructured way of establishing an inner dialogue with the Self. Going up the mountain and entering a temple on the mountain top is another guided imagery sequence which often leads spontaneously to the encounter with some aspect of the inner Self. Descent and ascent in guided imagery correspond to reaching down in the unconscious layers of the psyche or reaching up towards a spiritual aspiration. If the guided daydream contains some reference to obstacles to be encountered on the way towards the goal, either in ascent or descent, these obstacles provide a point of deeper involvement for the client than just casually following the therapist's instructions. Once overcome, the obstacles may become incorporated in the image representing the self. Thus the transcendence of obstacles in a guided daydream contributes to the emergence of a transcendent function.

The following examples illustrate the transformation of images during

"In everyday life the Self as an inner guide appears most often in dreams."

ascent and descent. In a sequence representing the ascent of a mountain the individual's ascent at first was blocked by a fallen tree log. The image of the tree log became incorporated in a temple on the top of the mountain. The temple was made of logs arranged in octagonal form and in the middle of it was a book of wisdom. In another sequence representing descent into a cave the obstacle was introduced by the therapist in the form of a dragon as an archetypal symbol for the lower, undeveloped aspects of a personality. By actively overcoming the dragon in the guided daydream one individual reached a temple-like structure with a mandala-like stained glass window. In both examples overcoming the obstacles resulted in images representing the Self.

Emergence of the Image of Inner Guide in Mental Illness

The image of an inner guide may spontaneously emerge in mental illness, especially in severe illnesses such as psychosis, acute schizophrenia (Perry, 1962), and multiple personality disorder (Allison, 1974, 1980). In psychosis and acute schizophrenia the inner guide or a representation of the Self usually appears in the image of a wise old man or a woman, which is then stated in the terms of corresponding present day personalities, such as Einstein. The image of Virgin Mary may be an inner guide for a woman. The structure of a mandala also often is present in the visual expressions of these patients.

A schizophrenic patient reflected, in his spontaneous paintings, the emergence and transformation of the image of inner guide. At first the patient identified with the ward physician who had a Freudian orientation. Then an inner image slowly emerged which was "older and wiser" than a specific staff person. After reintegration the patient shared with me his feelings experienced during a trip to a special place where he had felt inner peace and healing. The image of light emerged for him as if coming from the outer space. This sequence of emergent images exemplifies reaching the inner core during acute psychosis, and the subsequent distancing from it.

"In the multiple personality disorder . . . the inner self represents a deeper unifying personality within the individual."

Another acute schizophrenic who was decompensating presented a collage in the form of a mandala, with the structuring and centering of images. Creating the collage provided him with a way to integrate the pressing images, and over a period of time he constructed this collage on the walls of his room. This mandala-like structure, including the image of Einstein as the old wise man provided the client with his own inner structure and guided him towards his subsequent reintegration.

In the multiple personality disorder the inner guide or the inner self represents a deeper unifying personality within the individual. This inner guide or integrative part of the individual establishes a dialogue with the dominant personality to work towards the best interests of the individual.

Allison (1974) in discussing a case of multiple personality, describes her three personalities: a dominant repressed and depressed personality; an aggressive and impulsive personality; and a dependent and submissive personality lacking self-confidence. Eventually the different personalities were integrated with the help of the fourth one who knew what the other personalities were doing and was able to help the main personality to deal with the other personalities and to integrate them. The fourth personality was one who had started as an imaginary playmate when the patient was three years old. Allison (1974) designates this integrative part as the inner guide. In the therapy sessions this part knew how the main personality was feeling and how she could be best helped; it had strength and could encourage strength in the dominant personality. In the case where the inner guide personality did not know the answer directly, she would be able to convey it through automatic writing. Allison reports working with five other multiple personalities, all of whom had such an integrative part as inner guide. According to Allison (1974), this phenomenon is the manifestation of a higher part of the personality which is a derivative of the soul, a part called the Inner Self, the Real Self, the Self" (p. 30). The healing and the integration of the multiple personality can take place only when all the parts of the personality decide to subordinate themselves to the direction taken by the inner guide.

Allison (1974) describes the requirements for the therapist working with the inner guide of the patient: the patient must have a complete trust in the therapist, who must call on the inner guide to come out, unless it is an emergency and the guide will contact the therapist; the therapist must be also in touch with his or her own inner guide who is in communication with the patient's inner guide.

In a case where I, as co-therapist, worked with a multiple personality, the client experienced the emergence of a new and integrative part. Nevertheless, the split-off parts were insistent on their existences, and the grief of letting the other personalities go was strong, since the other parts were experienced as dying. The main personality was portrayed in mourning. Dealing with the grief becomes an integral part of the integrative process and in this case the feelings of grief were experienced by the emerging healthier part. Ultimately this client died of a drug overdose.

Active Imagination and Inner Guide in Healing

The image of inner guide can be used in enhancing healing (Bresler & Trubo, 1979; Korn & Johnson, 1983) by obtaining the advice for the patient from his/her own unconscious through a guided daydream. In contacting the inner guide it is important to establish a safe place and to have an open and nonjudgmental attitude (Bresler & Trubo, 1979; Korn & Johnson, 1983). In using imagery in healing the presentation of a sequence of scenes usually starts with a meadow. The client is asked to imagine the emergence of a being from the woods as a way of establishing a possible contact with the inner guide. The client is encouraged to establish eye and verbal contact with the guide as well as set up a place for further meetings. In this approach the inner guide may often emerge as a light or an animal. This sequence allows the patients to establish a contact with the intuitive part of himself/herself, representing the transcendent function, and ultimately the wisdom of the Self. The sequence reinforces a safe meeting place with the inner guide where future meetings can take place. The spontaneous emergence of the inner guide in this context should be accepted uncritically, since the spontaneous images have the greatest healing power. The imagery becomes an important source of support and enhancement of well-being especially in chronic illnesses.

In trying to contact the inner guide the individual may initially encounter difficulties for the individual in the form of threatening images or closed-off areas. Opposites may be present before the appearance of a unified image, or the images may be just a vague landscape in which one has to find the right direction. The individual may not take the image of the inner guide seriously at first, or may be disappointed that the emergent image does not correspond to his/her own expectations and may change the image accordingly.

The following is an example of the special but everyday quality of the image of inner guide. A woman in her fifties complained of continuous migraine headaches. She was a very responsible person, taking care of everybody's needs in her family including her father who had heart troubles and her mother who was terminally ill with cancer. The woman took part in a group dealing with behavioral approaches in the treatment of migraine headaches.

In the guided daydream of inner guide an image emerged of her deceased little dog who had been a great joy and comfort to her in the past. The woman herself enjoyed the daydream, but was not quite sure of the significance of it. A few months later she had a dream where the little dog wanted to get her out of the house and to play with her. This was an inner wisdom for the woman, whose headaches had reappeared as her dying mother required an inordinate amount of her time and effort.

The therapist has to establish for any client not only safe and relaxed conditions to experience the imagery, but also needs to provide a receptive attitude towards the spontaneously emerging images and attach importance to them. The client may not be able to do these things in the beginning of the treatment. The therapist also reinforces continued contact with the inner guide.

> *"The therapist . . . reinforces continued contact with the inner guide."*

Art Expressions of Inner Guide

The act of giving the image a body through visual expression—or through movement, or any other modality—in addition to the verbal description is an important part of making the contact with the inner guide or wisdom. The visual expression of the healing action and healing agents is similarly important (Achterberg & Lawlis, 1980, 1984). The visual expression may present a structure for the inner guide and the healing process which may be overlooked in the verbalization. Also, the visual images, in turn, are more readily incorporated in dreams and thus speak to the whole organism more readily than the verbal modality which may be more defended. The visual expression of a threatening image may serve as a point of exploration or desensitization regarding the threatening aspects. Vague images may be explored through different media in defining the ambiguous aspects of them. The visual portrayal of opposite images, followed by a third, often helps to synthesize both aspects in a form which transcends the previous split into opposites.

The following are different examples of the images of inner guide drawn after the presentation of a guided imagery of encountering the inner guide in a safe place.

The images can be divided into several general categories. The first category represents social compliance coupled with resistance, or rejection of the emerging images. The inner guide may be initially represented as God or wise man, but upon further probing these images may reveal compliance with expectations, while the spontaneous images may be rejected as inappropriate, as for example a cartoon frog or a little creature (Figure 1). Exploration of these images and feelings associated

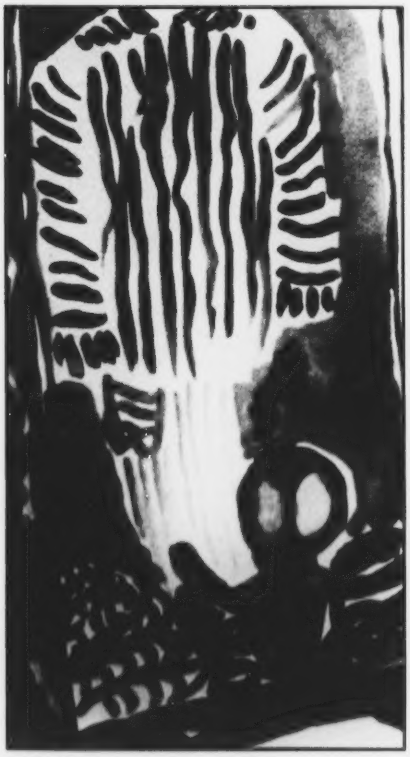


Fig. 1
Inner guide as a little creature in the closet.

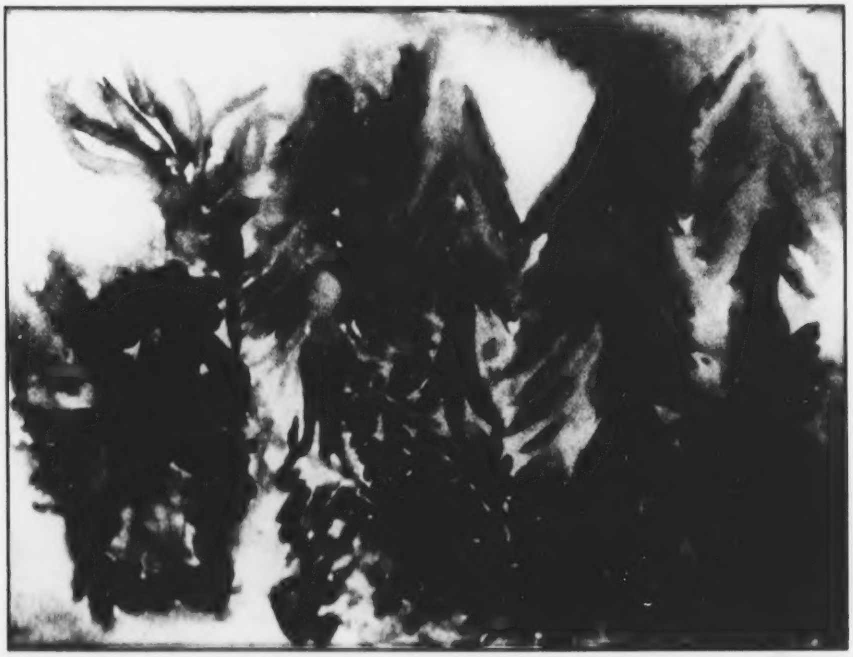
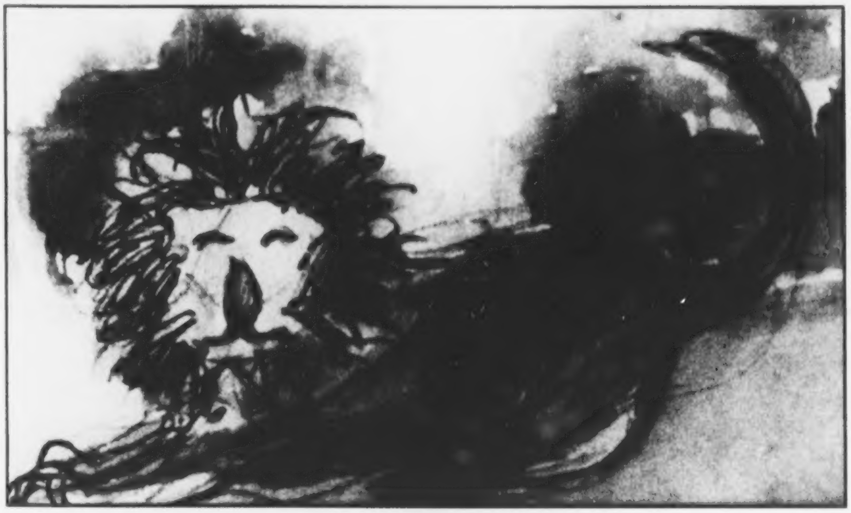


Fig. 2 Inner guide as a light.

with them as well as the expectations of the individual becomes an important part of the process of reaching the inner core.

The spontaneous images of inner guide or special place can be divided in the following four main categories: protective being; safe and special place; light (Figure 2) or positive sound images; and animal image as the inner guide (Figure 3). Often these different elements are combined in one image or a scene. Similarly to the helpers in myths and fairy tales the image of the inner guide may undergo transformations upon repeated experiences representing different levels of the inner experience. The acceptance of the spontaneous images is important in the transformations. The dialogue with the inner guide may reveal the importance of these transformations for the individual. Rejecting the earliest image or interpreting it on the wrong level as a result of ego inflation or delusion of grandeur may result in harm instead of insight (Miller, 1977). Working with healing images places a responsibility on the individual, but this responsibility may be interpreted as the individual's ability to respond to the images. For individuals with masochistic and self-blaming tendencies the individuals are advised to look for strengths, resources, and solutions within themselves. Exploration of the sensations, feelings, and the images associated with the symptom are important preparatory steps for asking advice from the inner guide. In the dialogue the insights gained

Fig. 3 Inner guide as a lion.



from this exploration are shared with the inner guide, as are the needs of the symptom which may have many layers. Turning the insight and advice into a practical action is another important step in the process of using the image of inner guide in healing (Rossman & Remen, 1982).

Summary and Conclusions

Inner guide represents a wisdom coming from deep, and at the same time transpersonal aspects of the psyche, namely the Self in Jungian thought. This aspect emerges in time when the individual undergoes extreme stress either physically or emotionally. Jung's experience with his inner guide Philemon serves as a template for the concept of inner guide. The images of inner guides, especially in the form of helpful animals, abound in folklore and mythology.

Inner guide may emerge in dreams providing the individual with much needed guidance in times of stress. Jung's concept of active imagination is one way to facilitate the individual's experience of the image of an inner guide. Guided imagery also may facilitate the emergence of inner guide. Several examples of the spontaneous manifestation of the inner guide in mental illness, as well as the images of it emerging in guided daydreams, illustrate the different aspects of the inner guide.

References

Achterberg, J. & Lawlis, G.F. (1980). *Bridges of the bodymind*. Champaign, Il.: Institute for Personality and Ability Testing, Inc.

Allison, R.B. (1974). A new treatment approach for multiple personalities. *The American Journal of Clinical Hypnosis*, 17(1), 15-32.

Allison, R.B., & Schwartz, T. (1980). *Minds in many pieces*. New York: Rawson-Wade Publishing Co.

Achterberg, J., & Lawlis, G.F. (1984). *Imagery and disease*. Champaign, Il.: Institute for Personality and Ability Testing, Inc.

Bresler, D.R., & Trubo, R. (1979). *Free yourself from pain*. New York: Simon and Schuster.

Campbell, J. (1974). *The mythic image*. Bollingen Series C. Princeton, N.J.: Princeton University Press.

Edinger, E.F. (1973) *Ego and archetype*. Baltimore, Md.: Penguin Books, Inc.

Jung, C.G. (1960). *The structure and dynamics of the psyche*. Bollingen Series XX. New York: Pantheon Books, Inc.

Jung, C.G. (1963). *Memories, dreams, reflections*. New York: Vintage Books.

Jung, C.G. (1969). *On the nature of psyche*. Princeton, N.J.: Princeton University Press.

Korn, E.R. & Johnson, K. (1983). *Visualization: The uses of imagery in the health professions*. Homewood, Il.: Dow Jones-Irwin.

Leuner, H. (1978). Basic principles and therapeutic efficacy of Guided Affective Imagery (GAI). In J.L. Singer & K.S. Pope (Eds.), *The power of human imagination* (pp. 125-166). New York: Plenum Press.

Leuner, H. (1984). *Guided affective imagery*. New York: Thieme-Stratton Inc.

Lyddiatt, E.M. (1971). *Spontaneous painting and modeling: A practical approach in therapy*. London: Constable.

Miller, S. (1977). Dialogue with the higher self. *Synthesis 2*. San Francisco: Institute for the Study of Humanistic Medicine.

Olin, C.B. (1972). *Navajo Indian sandpainting: The construction of symbols*. Stockholm: Tre Ringar AB.

Perry, J.W. (1962). Reconstitutive process in the psychopathology of the self. *Annals of the New York Academy of Sciences*, 96(3), 853-876.

Rossman, M. & Remen, N. (1982). *Imagine Health!* Privately published.

von Frantz, M.L. (1968). The process of individuation. In C.G. Jung (Ed.), *Man and his symbols* (pp. 157-254). New York: Dell Publishing Co.

REVIEWS

"Creative Expression"—*a Video*

Reviewed by: Michael Campanelli, Ed D, ATR, *Assistant Professor, Art Therapy Wright State University, Dayton, Ohio and* **David Berglund, MAT** *Art Therapy and Activity Therapy Dayton Mental Health Center, Dayton, Ohio*

"CREATIVE EXPRESSION"

Written and Directed by:	*Leslie Wright, RMT* *Nancy Steinberg, MA, ATR*
Producer	*Pat O'Sullivan*
Produced and Edited at:	*New Age Sight and Sound* *Ridgeview Institute* *Atlanta, Georgia*

This video is attractively presented. The color quality vivid and the musical selections intriguing. The body of the tape is comprised of seven segments. Each is composed of a series of still frames which incorporate a script interwoven with visual images and written definitions. A musical score is integrated into the fifteen-minute presentation. Typically, a word that refers to a psychological state is flashed on the screen, briefly defined, and then followed by a series of approximately ten images and a specific musical passage chosen to illustrate that psychological state. Featured are segments devoted to the following: loneliness, anger, denial, depression, confusion, guilt and insight.

A strength of the video is its style of presentation and format. The opening narration effectively illuminates the terrain to be covered and arouses interest in the "visual and auditory" presentation. We are informed that we will witness "the process . . . of interpretation of art and music and the feelings conveyed." The video's content is methodically arranged in digestible portions of information, which follow one another in a regular sequence. This regularity provides a predictable frame of reference for the viewer.

Another positive aspect about this video is that the creators assert the validity of applying music as well as the visual arts in therapy. Art Therapists, immersed in the world of visual imagery, sometimes need to be reminded of the value of other expressive therapies. Here, an Art Therapist and a Music Therapist collaborate, pooling from both modalities to endorse the importance of creative expression. Endeavors such as this benefit both the Art and Music Therapy fields since this complementary effort gives us a more complete understanding of the affective domain as it is communicated through two different sensory dimensions.

While viewing the video important concerns basic to the theory and practice of Art Therapy begin to surface. Crucial issues are inadvertently exposed centering around the video's significant weaknesses. The first crucial concern regards the definition and classification of psychological phenomena. In communicating about their work, Art Therapists need to be clear in identifying the psychological states of their clients. This means being able to accurately define and distinguish between concepts such as emotions, defense mechanisms and cognitive processes. This video fails to differentiate between such concepts and erroneously classifies them, e.g. denial is referred to as an emotion rather than a defense mechanism. Obviously this is not a trivial flaw since the soundness of a therapist's work depends upon his/her ability to perceive the client's condition with the utmost precision. Furthermore, a therapist's accurate understanding and usage of psychological terminology is imperative if we are to dialogue effectively with fellow mental health professionals. Effective communication becomes even more problematic when our terminology fails to denote the full meaning of the concepts we use. Here again, the video falls short of our expectations. For example, insight is defined as "a personal awareness of how positive changes can influence the course of one's behavior." This definition is incomplete because it fails to include the notion that an awareness of negative relationships can also be part of the insight process.

A second important issue evoked while viewing this video regards the classification of art work into discrete categories. This is an issue of long standing significance in the field of Art Therapy. Categorization gives us some frame of reference to make sense of the barrage of images we encounter in visual form. On the one hand, categorization enables accurate diagnosis/prognosis, and predictive validity is established. On the other hand, there is the danger of relying on a fixed formula that reifies Art Therapy phenomenon. In the video this problem is brought to mind since the visual examples of various psychological states might be construed as prototypes for how these states are or should be expressed. Classifying art therapy work in this manner also implies that an art work expresses a singular emotion. This notion is misleading since any one piece of art may be an expression of multiple thoughts and feelings. This kind of classification is problematic, particularly in the case of the non-art therapy viewer and the neophyte Art Therapist where there may be a tendency to latch on to simplistic notions in the interpretation of art work.

What might help the viewer from inferring a simple relationship between the categories and the represented motifs would be a statement at the beginning of the video, such as: "The selection of images chosen by no means exhausts the potential range of images that might be elicited in the expression of any single emotion. Further, it is conceded that a variety of feelings may be expressed in a single piece of art work. The images you will see were selected by the therapist, solicited from various populations, in response to specific directions that focus on the expression of particular emotions." Such a statement would reference the art work within some context and caution the viewer against broad generalizations about art therapy expression and interpretation.

While viewing this video, the issue of classification ascends to dominance because of yet another problem. The viewer is not given enough information to understand why some of the art work is placed in a given category. There are several ambiguous shapes and forms included in categories for no apparent reason. In addition to ambiguity there is confusion created by the occurrence of similar motifs found in more than one category. For example, to illustrate the visual expression of anger, there are several drawings in this segment which portray figures with an emphasis on their mouths and teeth. We are led to believe that such a motif is a graphic clue to interpret anger. Yet we find the very same motif included in the two other categories of denial and depression. The use of the same motif for different categories diminishes the significance of what has been set up as a valid marker for coding a psychological state.

One final problem with the video concerns how music is used in the presentation of Art Therapy material. As stated earlier, the collaborative efforts of art and music therapists are laudable. However such efforts are not without certain hazzards that might impede the delivery of a cogent message. The criticism about the combined use of art and music in this video relates to the contrast between the professional quality of the music coupled with the clinical quality of the art work. The validity of underscoring the images with classical music is questionable. The musical pieces chosen are powerful and have an established universal appeal not on par with the chosen art work. There is a danger of manipulating the viewer into seeing the images in a contrived way, set up by the imposition of the tone and mood of the musical score. The added provocation of music seems to make the art work conformable to a context which may distort the original meanings and intents of the clients. While musical elaboration may enhance a presentation of art therapy ideas, such an intervention must be applied with critical attention to the possible effects of muting or exaggerating the voice of the client.

Although "Creative Expression" contains significant flaws, it is an attractive video which can be used as an instructional tool for Art Therapists. It is important to keep in mind, however, that the most important lessons we can learn from this video may not be those it intends to instruct us about. It stimulates questions about the approaches we employ to interpret art work and brings to mind the weighty responsibility Art Therapists have in clearly communicating about our field. It is therefore recommended that this video be used prudently with full awareness of its shortcomings. The use of video to disseminate art therapy information is relatively new. Hopefully, "Creative Expression" can serve as a base from which future videos can depart, using the content here for elaboration and improvement.

BEST COPY AVAILABLE

VIEWPOINTS

"Art Therapists"

Jules C. Weiss, MA, ATR, *Art Therapist and Consultant in private practice, and the Director of an Older Adult Wellness Program at the Lee Circle YMCA in New Orleans, LA. Mr. Weiss is author of* ***Expressive Therapy with Elders and the Disabled: Touching the Heart of Life,*** *and the* ***Wellness Program for Older Adults*** *published by Haworth Press.*

In the moment,
through the arts,
we call forth a primal relationship.

A relationship which engages the spirit
in expression and acknowledgment of the soul.
A creative task which invites a deeper
and more intimate experience of the self
and the life of the individual.

The pen and brush,
movement and sound
are the wheels and sacraments of the journey.
Authentic expressions of the core.
Experiences, which illuminate our life.

We are the leaders and we are the witnesses
in the authentic, individualistic experience
and empowerment.

Artists, helping others to find and master
the art of their being.

People ask themselves in the midst of a complicated,
computerized, televised age,
"Who am I and where should I place my attention?"
Searching for a path of happiness and fulfillment,
they question how to find and take hold of their
  inner life.
How to face the moment?

We hold a responsibility that reflects
the life task of man:
to be a guide in the journey to know oneself;
to help individuals create in the wisdom of the self;
and to enable people to learn, develop, and
share in the well-being of this world.

We are the new priests,
accompanied by meaningful, vibrant rituals
and rites which inspire the inner life to blossom.

We are the new artists.

Poem—*Amy M. Speltz, ATR, Minnesota*

As I sit here on my bed
Visions of blood fill my head
Hoping and praying to soon be dead
The razor blade will slit my wrist
Trembling in my other fist
Droplets of blood hit my sheet
As a pool of blood forms at my feet
The razor blade goes through my vein
As suicidal thoughts go through my brain
Cutting cutting cutting in deep
Waiting for my peaceful sleep
There's a knock at my door
As I cut a little bit more
A whispering voice "Are you okay?"
As I think "Go away"
I hear them coming through my door
Wait what's happening I hear no more
My head is light and beginning to soar
As I feel them close the door
And as the van begins to speed
They can no longer fill my need
And as my head begins to spin
I realize in suicide there is no way to win

Written by Tricia and Holly, two teenagers who have dealt with suicide. January 1988

Don't wait to hear 'Guilty as Charged' to discover that Professional Liability Insurance is a *Professional Necessity*.

Don't be lulled into a sense of security by a few years of "no incidents." Keep the facts in mind continuously:

Fact #1. A suit for malpractice, whether justified or not, might destroy your career and future security. And it does happen...often.

Fact #2. Trying to forecast a court decision is playing "Russian roulette." Courts may not be familiar with 'appropriate medical practices.'

Fact #3. You can be involved in a malpractice suit even if you were not directly involved in an incident.

Fact #4. If a suit is filed against you, you must be defended, even if the charges are unfounded. And legal fees, alone, can be destructive.

PROFESSIONAL LIABILITY POLICIES ARE *NOT* ALL ALIKE!

Insurance companies which underwrite Professional Liability policies vary widely in coverages, premium rates and claims handling. There are three major areas of difference:

For almost 40 years, Maginnis and Associates, Inc. has been designing and administering Professional Liability Insurance programs for allied health professionals.

Backed by the experience, continuous annual growth and daily exposure within the constantly-changing field of insurance, we sincerely believe that the Professional Liability plan we provide is the best presently available.

Get the details now! Complete and mail the coupon at right for additional information about all the AATA-sponsored insurance plans.

Administered
by

Maginnis and
Associates, Inc.
332 S. Michigan Ave.
Chicago, IL 60604
312/427-1441

a. Coverage Limits. Means the dollar amounts of per-occurrence protection and the aggregate total-per-year protection. Look for top dollars!

b. Premium Rates. Compare this feature carefully. The best insurance buy is the policy that offers the highest coverage limits at the lowest annual premium rate.

c. Don't overlook the "Experience Factor." The best liability programs combine reliable "Old Line" insurance companies with a well-seasoned Administrator.

Maginnis and Associates, Inc.
332 S. Michigan Avenue, Chicago, IL 60604
Please send me information on the AATA-sponsored coverage(s) I've checked.

___Professional Liability
___Group Term Life
___Disability
___Major Medical
___Excess Major Medical
___Cancer Supplement
___Medicare Supplement
___Accidental Death and Dismemberment

NAME________________________________
ADDRESS______________________________
CITY______________STATE________ZIP________

AATA-L-888-03

COLLEGE OF NOTRE DAME

Cool It in . . .

S.F. this Summer
and Collect
Units Toward
Your
ATR

COLLEGE OF NOTRE DAME
Graduate School
1500 Ralston Avenue
Belmont, CA 94002

(415) 593-1606

- The only **Master of Art Therapy** program in Northern California approved by AATA
- A **Master of Art Therapy** and **Marital and Family Therapy** which may lead to the MFCC Licensure
- Job opportunities in clinical, educational, and community agencies
- Master in Art Therapy – 37 units
- Master in Art Therapy & MFT – 51 units
- Graduate Art Therapy Institute – 21 units
- Can be completed in two summers and a winter internship!

ON THE SAN FRANCISCO PENINSULA

1988 AATA
MEMBERSHIP DIRECTORY

Now Available through the National Office

$8.00 member **$50.00** non-member
$100.00 institution

NAME ____________________

ADDRESS ____________________

CITY ____________________

STATE ____________ ZIP ____________

▲ *Mail entire form to:* ▲

AATA NATIONAL OFFICE
505 E. Hawley St./Mundelein, IL 60060

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

HAVE YOU MOVED??

◆

Have you changed your name, address, phone, zip code . . . .

If so, please notify the National Office to insure receipt of your membership benefits.

◆

AATA NATIONAL OFFICE
505 E. Hawley St./Mundelein, IL 60060
(312) 949-6064

The American Art Therapy Association, Inc.
505 E. HAWLEY STREET / MUNDELEIN, ILLINOIS 60060
(312) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapist's Identity *(1976) 118 pages*	$5.00	$7.00
Art Therapy: Expanding Horizons *(1978) 142 pages*	$5.00	$7.00
Focus on the Future: the Next Ten Years *(1979) 151 pages*	$6.00	$8.00
The Fine Art of Therapy *(1980) 124 pages*	$7.00	$9.00
Art Therapy: A Bridge Between Worlds *(1981) 119 pages*	$7.00	$10.00
Art Therapy: Still Growing *(1982) 172 pages*	$10.00	$14.00
Art Therapy: New Directions in the '80s *(1987) 110 pages*	$15.00	$20.00
Art Therapy: Professionalism in Practice *(1988)*	$15.00	$20.00
Art Therapy: Journal of the American Art Therapy Association Rates: Individuals — U.S. $23.00; Foreign $30.00; Institutions — U.S. $27.00; Foreign $36.00		
Art Therapy: Journal — Back issues	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings *Use of the Creative Arts on Therapy (1979)*	$5.00	$7.00
National Art Education Association Journal: Special Issue *Art Education, Vol. 33, No. 4 (1980)*	$3.00	$4.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 x 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

* Note: for **Publications** postage/handling, add $1.50 for the first unit item, $.50 each additional unit.

SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS

FILMS (Rental/Purchase)

Art Therapy: Beginnings *(1977) color/sound, 45 minutes*	16mm Rental only:	$40.00	$50.00
	½" VHS, Purchase only:	$50.00	$80.00
Michael *(1977) color/sound, 12 minutes*	16mm Rental only:	$30.00	$35.00
	½" VHS, Purchase only:	$50.00	$80.00
Art Therapy *(1981) color/sound, 12 minutes*	16mm Rental only:	$35.00	$45.00
	½" VHS, Purchase only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery *(1978) color/sound, 32 minutes*	16mm Rental only:	$40.00	$50.00
	½" VHS, Purchase only:	$50.00	$80.00

* Note: for **VHS Films Purchase** postage/handling, add $2.25 for each film.
* Note: for **16mm Rental** add $7.00 for postage and handling.

ORDER FORM: *Make checks payable in U.S. funds to AATA, and mail to the above address*

Indicate Quantity of Unit Items Below		Cost/Unit		Total
____________	( ) ×	____________	=	____________
____________	( ) ×	____________	=	____________
____________	( ) ×	____________	=	____________
____________	( ) ×	____________	=	____________
____________	( ) ×	____________	=	____________
		____________	=	____________
		Total Unit Costs	=	____________
		*Publications Postage/Handling	=	____________
		*Films Postage/Handling	=	____________
		Total Enclosed	=	____________

10 or more copies of any single issue: 15% discount on total cost.
Discounts are available when purchasing quantities.
Set of four Proceedings (consecutive years): 20% discount on total cost.

SEND TO: ______________________ MBR ID#: __________

____

City ______ State ______ Zip Code ______

10/88

BEST COPY AVAILABLE

PUBLICATIONS

	Member	Non-Member	Institution
Membership Directory/Bylaws	$8.00 (includes postage and handling)	$50.00	$100.00
** Art Therapy Bibliography	*SASE	$1.00	
** Educational Guidelines	*SASE	$1.00	
** Educational Programs List	*SASE	$1.00	
** Standards and Procedures for Registration	*SASE	$1.00	
** Criterion for Professional Membership	*SASE	$1.00	
Professional Membership Application	FREE	FREE	
Registration (ATR) Application	FREE	FREE	
Associate/Student New Member Applications	FREE	FREE	
** Art Therapy Model Job Description	*SASE	$1.00	
** Code of Ethics	*SASE	$1.00	
** Art Therapy Media List	*SASE	$1.00	
** Standards of Practice	*SASE	$1.00	
Model Licensing Bill	$12.00	$25.00	

*SASE — Self addressed stamped envelope

**Available in multiples:

1-9	FREE
10-50	$5.00 Postage & Handling
50-100	$10.00 Postage & Handling

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 505 E. Hawley St., Mundelein, IL 60060

Please enter my subscription for 1988. Enclosed is my check, payable to AATA, for $23.
Name ______________________________
Address ______________________________
City ____________________ State __________ Zip __________

The interdisciplinary journal
devoted to the creative arts as healing arts.

THE ARTS IN PSYCHOTHERAPY

An International Journal

ARTS PSYCHOTHERAPY

Now published by Pergamon!

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Assistant Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

Dedicated to scholarship in the creative arts therapies, THE ARTS IN PSYCHOTHERAPY presents innovative research in artistic inquiry and expression, and its use in the treatment of mental disorders.
THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

SUBSCRIPTION INFORMATION

ISSN: 0197-4556	Volume 15, 1988
Published 4 issues per annum	
One-year Institutional Rate (1988)	US$110.00
Two-year Institutional Rate (1988/89)	US$209.00
Individual Rate (1988)	US$ 40.00
Student Rate (1988)	US$ 16.00

PERGAMON PRESS, INC.
Maxwell House, Fairview Park, Elmsford, NY 10523
PERGAMON PRESS plc
Headington Hill Hall, Oxford OX3 0BW, England
A Member of the Maxwell Communication
Corporation Group of Companies

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Volume 6, Number 1 April 1989

- 19th Annual Conference Overview
  Gary C. Barlow, Editor
- Art for Institutionalized Elderly
  Wendy Weiss, MFA
  Donna E. Schafer, PhD
  Forrest J. Berghorn, PhD
- The Effects of Art/Drama Therapy Experiences on Rigidity, Body Concept and Mental Maturity in Graphic Thinking of Adolescents with Mental Retardation
  Sirkku Sky Hiltunen, EdD, RDT, ATR

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1988-1989

Board of Directors

President
Cay Drachnik, MA, ATR, MFCC

President-Elect
Linda Gantt, MA, ATR

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, PhD, ATR, MFCC

Committee Chairs

Affiliate Chapters
Trudy Manning, ATR

Bylaws
Roberta J.H. Shoemaker-Beal, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Cathy A. Malchiodi, MA, ATR

Publications
Pat B. Allen, PhD, ATR

Research
Harriet Wadeson, PhD, ATR

Standards
Doris Arrington, EdD, ATR, NCC

Clinical
Paula Howie, ATR

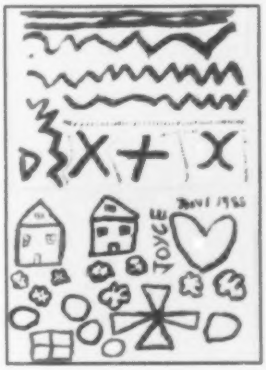
Executive Director

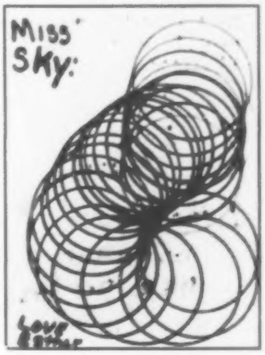
Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association





Editorial

Gary C. Barlow, EdD, ATR 2
Letter to the Editor 3

Articles

19th Annual Conference Overview, Gary C. Barlow, Editor 4
Art for Institutionalized Elderly
Wendy Weiss, MFA
Donna E. Schafer, PhD
Forrest J. Berghorn, PhD 10
The Effects of Art/Drama Therapy Experiences on Rigidity, Body Concept and Mental Maturity in Graphic Thinking of Adolescents with Mental Retardation, Sirkku Sky Hiltunen, EdD, RDT, ATR 18

Special Features

Professionalism in Practice, Presidential address to the 1988 AATA conference
Cay Drachnik, President of AATA 26
Response to the Honorary Life Member Award, Don Jones 28
Response to the Distinguished Service Award, Lewis Shupe 29

Viewpoints

Art Therapy and the Soviet Union, Margaret (Mickie) Anderson 30
What Ever Happened To . . ., Robin F. Goodman, ATR 31

Reviews

The Hero Within: Six Archetypes We Live By, Louise M. White, MA 33
Children Who Don't Want to Live-Understanding and Treating the Suicidal Child, Drew K. Conger, MA, ATR 34
The Dynamics of Art Psychotherapy, Don Jones, ATR, HLM 37

Volume 6, Number 1 April 1989

About Our Cover

Collage/Drawing/Painting by an 80 year old post-CVA woman in a nursing home, Dayton, Ohio.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Aina O. Nucho, PhD., ATR, ACSW
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Marcia May-Chambers

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Susan LaMantia O'Connor, MA, ATR
Paul Rodenhauser, MD
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 505 E. Hawley St., Mundelein, IL 60060 (312) 949-6064

Copyright © 1989 American Art Therapy Association

BEST COPY AVAILABLE

EDITORIAL

The recent 19th annual A.A.T.A. Conference is history and reports have suggested that it was an exciting and profitable series of meetings. Although it is early, I am already looking forward to next year's conference.

This issue of *Art Therapy* includes (as in the past) an overview of the recent Conference. For those of you who wish additional information on papers, panels, etc., you should consult your A.A.T.A. Directory and jot a note to the presenter(s) for the information that you desire. I am sure that any presenter would enjoy hearing from members not only for the requests, but also for a "pat on the back" regarding the presentation.

Also in this issue are two professionally important and timely articles. *"The Effects of Art/Drama Therapy Experiences on Rigidity, Body Concept and Mental Maturity in Graphic Thinking of Adolescents with Mental Retardation"* is by Sirkku Sky Hiltunen, EdD, RDT, ATR, a primary art and drama therapist at The Art and Drama Therapy Institute in Washington, D.C. Dr. Hiltunen presents a study that ". . . focuses on the decreasing of rigidity and consequent enhancement of receptive/expressive cognitive functioning in order to clear the channel of and prepare the groundwork for communication of thoughts and ideas in the further therapeutic intervention." (ref: abstract)

Another study, *"Art for Institutionalized Elderly,"* by Wendy Weiss, MFA, Donna E. Schafer, PhD, and Forrest J. Berghorn, PhD, presents an eight-week textile art education intervention, encouraging skill development and the application to fabric painting. Results show significant improvement in some areas, and point out the need for expanded work with this older population—particularly in selected art areas that encompass some skill development.

My sincere congratulations to two members of the American Art Therapy Association who received well-deserved honors at the recent Conference. First, Don Jones, ATR—a worthy recipient of the Honorary Life Member designation—has proven to be a long-standing, sincere friend of art therapy through his clinical training, work in the field, and commitment to the profession. As a "founding father" of A.A.T.A. he certainly deserves this honor, and joins the ranks of others who hold this recognition.

Second, Lewis K. Shupe, PhD, ATR, the recipient of the first Distinguished Service Award presented by A.A.T.A., is deserving of this honor. Certainly, Lew has given of his time and energies in many ways to the Association and to the professional field, and he has also built many long-lasting friendships through his professionalism, support and forward-looking views of clinical and academic preparation.

Responses from both Don and Lew are in this issue, as is the presentation given by our A.A.T.A. president, Cay Drachnik, in the opening ceremony of the Conference. It is a thought-provoking statement that charges the reader to think not only about "where we are," but "where we should be" as we move ahead toward the year 2000.

In this issue the reader will find a letter to the editor from Barry Cohen, relating specifically to a recently published article (re: *Comparison of Art Psychotherapy and Discharge Diagnoses of Diagnostic Unit Patients*, by Witlin and Augusthy, Dec., 1988, Vol. 5, No. 3). His letter requests the inclusion of additional bibliographic references, and I am pleased to transmit this information to the readers of *Art Therapy*. It is important to convey your thoughts, suggestions and clarifications on published materials as well as ideas for future issues. The "letter to the editor" format is a relatively easy way for the readership to be heard. Thanks to Barry for his letter, and I look forward to other communications as the need arises.

We are receiving an increasing number of submissions for "Viewpoints" and I encourage even more. We will publish accepted entries as they "fit" into each issue. How about some art work from members for this section?

For anyone wishing to have a book reviewed, write to Aina O. Nucho, PhD, ATR, the Book Review Editor of this journal. If you have come across a new book that you think should be shared with our readers, please drop a note to Aina. She will be happy to follow through with the suggestion.

Have a pleasant summer!

Gary C. Barlow, EdD, ATR
Editor, Art Therapy

Letter to the Editor

Dr. Gary Barlow, Editor
Art Therapy
505 E. Hawley Street
Mundelein, Illinois 60060

Dear Gary:

I am writing in reference to the article "Comparison of Art Psychotherapy and Discharge Diagnoses of Diagnostic Unit Patients" (Witlin and Augusthy, December 1988). Such a study is long overdue, and the authors' contribution is to be heartily commended.

I wish to point out that the literature review was not quite complete. The authors bemoan the absence of literature statistically correlating art therapy with psychiatric diagnosis.

Actually, "The Diagnostic Drawing Series: A Systematic Approach to Art Therapy Evaluation and Research" won the 1983 AATA Research Assistance Grant for organizing a national study to do precisely that. Presented at least once each year at the national conference since 1983, this study correlates DSM III diagnoses with structural characteristics of a standardized three picture series using statistical analysis.

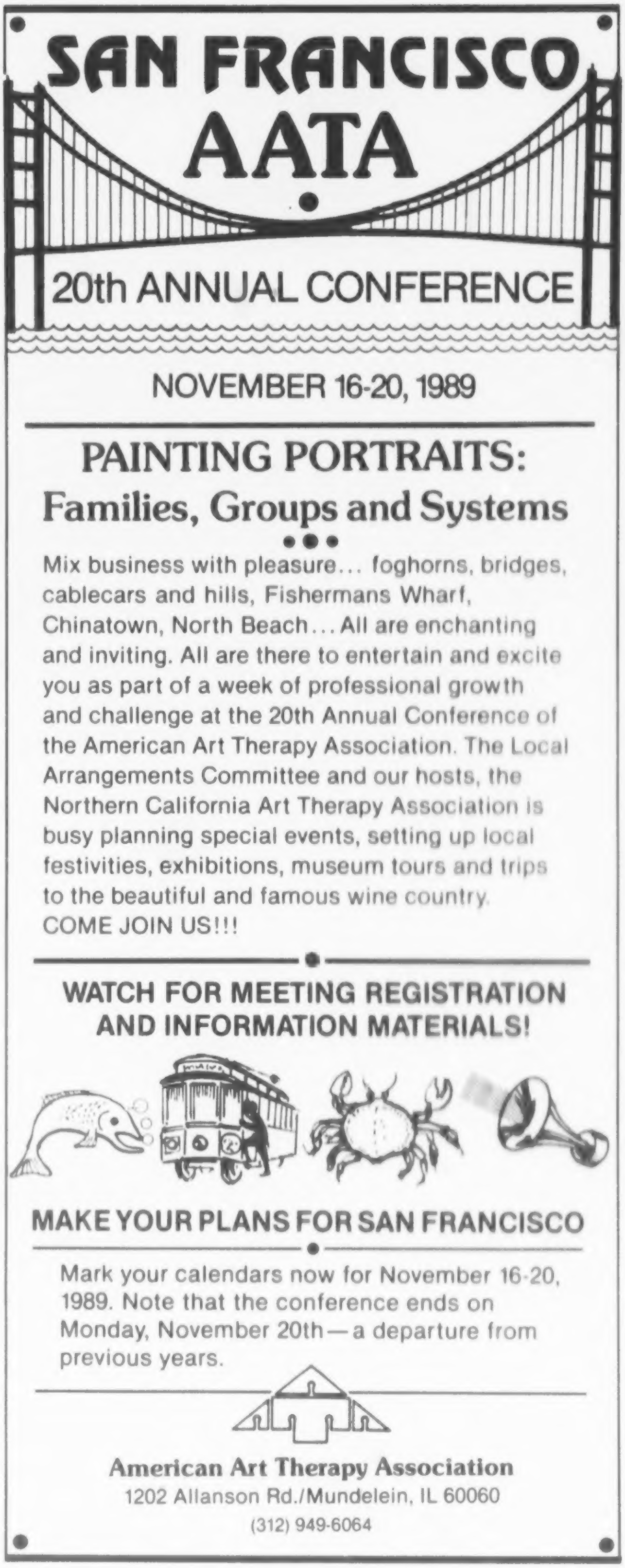
The paper was published in English in the Spring 1988 issue of *Arts in Psychotherapy*[1] journal, which was devoted to assessment in the creative arts therapies. Prior to that, it was published in Holland's journal *Psychologie* (April, 1986).[2] Two major college psychology textbooks cited and illustrated the DDS (Wade and Tavris, 1987[3]; and Benjamin, et al., 1987[4]). These were in addition to the illustrated article published in the American Psychological Association *Monitor* (April, 1985).[5] These publications were noted in the AATA Newsletter research column published in the Fall of 1988.

The authors espouse the scholarly approaches of literature review and replication but have themselves failed to address pre-existing work in the field. I am aware of the lengthy lead time for publishing journals which may overlap the appearance of contemporaneous and relevant papers. This collaborative work, however, has been a well-publicized aspect of art therapy research since 1983. In the final analysis, the responsibility for scholarly accuracy must rest with the journal editor.

Thank you.

Sincerely,
Barry M. Cohen, ATR
Director, Expressive Therapies
Mount Vernon Hospital

1. Cohen, B., et al. (1988). The Diagnostic Drawing Series: A Systematic Approach to Art Therapy Research and Evaluation. *Arts in Psychotherapy*, Vol. 15, 11-21.
2. Cohen, B. (1986). Een Neeuwe Tekentest. *Psychologie*, 26-29.
3. Wade, C. and Tavris, C. (1987). *Psychology*. New York: Harper and Row.
4. Benjamin, L. T., et al. (1987). *Psychology*. New York: MacMillan.
5. Turkington, C. (1985). Therapist Seeks Correlation Between Diagnosis, Drawings, *Monitor*, Vol. 16, No. 4, 93-96.



SAN FRANCISCO
AATA
20th ANNUAL CONFERENCE

NOVEMBER 16-20, 1989

PAINTING PORTRAITS:
Families, Groups and Systems

Mix business with pleasure… foghorns, bridges, cablecars and hills, Fishermans Wharf, Chinatown, North Beach… All are enchanting and inviting. All are there to entertain and excite you as part of a week of professional growth and challenge at the 20th Annual Conference of the American Art Therapy Association. The Local Arrangements Committee and our hosts, the Northern California Art Therapy Association is busy planning special events, setting up local festivities, exhibitions, museum tours and trips to the beautiful and famous wine country. COME JOIN US!!!

WATCH FOR MEETING REGISTRATION AND INFORMATION MATERIALS!

MAKE YOUR PLANS FOR SAN FRANCISCO

Mark your calendars now for November 16-20, 1989. Note that the conference ends on Monday, November 20th — a departure from previous years.

American Art Therapy Association
1202 Allanson Rd./Mundelein, IL 60060
(312) 949-6064

BEST COPY AVAILABLE

AATA Conference Overview

The 19th annual Conference of the American Art Therapy Association — with the theme "Professionalism in Practice" — was held at the Palmer House, Chicago, Illinois, from November 16-20, 1988. The entire Conference was successful, with members and guests coming away with renewed vigor and professional satisfaction. Special thanks must be offered to the Conference Chair, Linda Gantt, and to the Program Chair, Patricia Isis, as well as the many committee members who devoted time and energies in the preparation and follow-through of the meeting.

On the following pages is a listing of the numerous papers, workshops, pre-Conference courses, symposia, panels and other highlights of the Conference. This information is offered (similar to previous years) so that readers may communicate with the presenter(s) for additional information desired on a specific topic. Refer to your AATA Membership Directory, 1988, for addresses, or write to the AATA Office if an address is not listed in the Directory. It should be noted that each entry is printed as it appeared in the Conference program, although specific categories have been grouped together for the reader's convenience. The basic information has not been edited and, therefore, does not reflect any last minute changes that may have occurred at the Conference.

—EDITOR

19TH ANNUAL CONFERENCE COMMITTEE

CONFERENCE CHAIR:

Linda Gantt, MA, ATR

PROGRAM CHAIR:

Patricia Isis, MA, ATR

PROGRAM CO-CHAIR:

Randy Vick, MS, ATR

PRE-CONFERENCE COURSE CHAIR:

Patricia Gould, ATR

PROGRAM COMMITTEE:

Doris Arrington, EdD, ATR
Janet Bush, MA, ATR
Mariagnese Cattaneo, PhD, ATR
Mary Alice Clear, MA, ATR
Barry Cohen, MA, ATR
Penny Dachinger, MA, ATR
Rita Doufal, MA, ATR
Audrey Elkinson-Griff, MA, ATR
Winnie Ferguson, MEd, MAT, ATR
Michael Franklin, MA, ATR
Enid Garber, MEd, ATR
Robin Goodman, MA, ATR
Terri Halperin-Eaton, MEd, ATR
Randi Klaire-Jefferson, MA, ATR
Patricia Klorer, MA, ATR
Jacqueline Linard, MA, ATR
Cathy Malchiodi, MA, ATR
Gina Niewodowski, MA, ATR
Marcia Rosal, PhD, ATR
Roberta Shoemaker-Beal, MFA, ATR
Barbara Sprayregan, MEd, ATR
Joan Unger, LP, ATR
Joanna Wharton, MA

INVITATIONAL COMMITTEE:

Sondra Geller, MA, ATR
Nancy Hall, MA, ATR
Bruce Moon, MA, MDiv, ATR
Cathy Moon, BFA, ATR
Judith Rubin, PhD, ATR

CHICAGO LIAISON COMMITTEE:

Deborah Behnke-Marthaler, MA
Anne Canright, MAAT
Barbara Fish, MA, ATR
Linda Goldman, MEd, ATR
David Henley, MA, ATR
Sharon Hyson, MA, ATR
Connie Livingston-Dunn, MA, ATR
Mary McElwain-Mitchell, SAIC Cert., ATR
Diana Nawrocki, MAAT, ATR
Corazon Pagnani, SAIC Cert.
Debra Paskind, MA, ATR
Wendy Ritchey, MA
Suellen Semekoski, MA
Susan Wish, MA, ATR

OPENING CEREMONY

CAY DRACHNIK, MA, MFCC, ATR, President, AATA
PATRICIA ISIS, MEd, ATR, Conference Program Chair

PRE-CONFERENCE COURSES

1.- **The Psycho-Cybernetic Model of Art Therapy**
AINA NUCHO, PhD, ATR

2.- **Rites of Passage for Older Adults: Art Therapy and Therapeutic Issues**
JULES WEISS, MA, ATR

3.- **The Diagnostic Drawing Series: Its Use in Clinical Practice**
BARRY COHEN, MA, ATR
ANNE MILLS, BA, Dip. AT

4.- **Styles of Coping and Thinking Manifested in Drawings: A Basis for Treatment**
MYRA LEVICK, PhD, ATR, HLM

5.- **Photo Art Therapy from a Jungian Perspective**
IRENE CORBIT, PhD, ATR
JERRY L. FRYREAR, PhD, ATR

6.- **Short-Term Art Therapy: Designing Treatment Plans and Groups**
DREW K. CONGER, MA, ATR
NANCYANN TURNER, MFA, ATR

7.- **Beyond Survival: A Group Treatment Model for Women Sexually Abused in Childhood**
TERRI SWEIG, MA, ATR

8.- **Private Practice: Practical and Ethical Considerations**
SUSAN WISH, MA, ATR
ERNEST R. WISH

9.- **Expand Your Career Fearlessly**
JUDITH GERBERG, MA, ATR-LM

10.- **Stranger in a Strange Land: The Use of Art Psychotherapy with Adolescents**
DIANALEE SKEEN, MS, ATR

SPECIAL PROGRAMS/EVENTS

1.- **Museum Tour and Reception —**
THE ART OF PAUL GAUGUIN — A Retrospective Exhibition

2.- **1988 International Convocation of Art Therapy Educators**

3.- **Mid-Day Exhibit Hall**

4.- **Research and Survey Table**

5.- **Study Groups**

6.- **Member Art Show**

7.- **Exercise Program — Feeling Great**

8.- **Open Studio**

9.- **Annual Meeting and Dialogue with the Board**

10.- **Gallery Night/SU-HU**

GENERAL SESSIONS

1.- **The Arts and Social Responsibility**
BRUCE L. MOON, MA, M Div, ATR, Moderator

2.- **Future Trends in Art Therapy**
LINDA GANTT, MA, ATR, AATA President-Elect, Moderator

3.- **Professional Issues**
CAY DRACHNIK, MA, MFCC, ATR, AATA President, Moderator

KEYNOTE SPEECH

1.- **Gauguin**
JOHN GEDO, MD

SYMPOSIA

1.- Art Therapy with AIDS Patients

A. **Art Therapy with HIV Seropositive Patients**
PAULA HOWIE, MA, ATR

B. **Using Art Therapy in the Counseling of AIDS Patients**
LINDA PROBUS

2.- Art Therapy and Eating Disorders

A. **Art Therapy and Anorexia: Experiencing the Authentic Self**
MARI FLEMING, MA, MFCC, ATR

B. Feed Me . . . Cleanse Me . . . Sexual Trauma Projected in the Art of Bulimics
SANDRA TICHEN, MS, ATR

3.- Art Therapy and Grief

A. The Use of Art Therapy with Bereaved Children
BARBARA BETKER McINTYRE, PhD

B. Drawing Out Feelings of Grief and Loss
MARGE EATON HEEGAARD, MA

4.- Art Therapy and Adolescents

A. Revealing Depression Through Art: A Look at Masked Depression in Adolescence
JULIE DeROSE, MA, ATR

B. Uncommon Interventions: Art Therapy with Suicidal and Self-Mutilating Adolescents
PHILIP E. PERRY, PhD
HELENE BURT, BFA, DTATI

5.- Art Therapy Theory

A. Aesthetics and Empathy: Bridging the Union
MICHAEL FRANKLIN, MA, ATR

B. Words Beyond Words: Articulation of the Art Therapy Experience
CATHY MOON, BFA, ATR

6.- Art Therapy and Multiple Personality Disorder

A. Art as Reparation: The Work of a Patient with Multiple Personality Disorder
LANI GARITY, MA, ATR

B. Breaking the Code: Identification of Multiplicity Through Art Productions
BARRY COHEN, MA, ATR
CAROL COX, MA, ATR

7.- The Artwork of Borderlines

A. Drowning: Understanding the Borderline Experience
RANDALL OVERDORFF, MA, ATR

B. The Diagnostic Drawing Series: Research Update — The Borderline Personality Disorder Sample
ANNE MILLS, BA. Dip. AT

8.- Art Therapy with Degenerative Illnesses

A. Tulips and Two Kisses at the Door: A Case Romance
WENDY MAIORANA, MA, ATR

B. A Rainbow for Anna: Art Therapy in the Treatment of Pick's Disease
HANNE CROWN, MA, ATR

9.- Art Therapy and Cultural Exchange Programs

A. Art Therapy in China
CATHY MALCHIODI, MA, ATR

B. Art Therapy in Russia
MARYANNE HAMILTON, MA, ATR

PAPERS

1.- The Tree Revisited: A Symbolic Richness Beyond the Projective
SISTER KATHLEEN BURKE, PhD, ATR

2.- Art and Brain
DON SEIDEN, ATR

3.- The Transmutation of the Creative and Destructive Imagery in Art and Psychosis
GRETA GARR, MEd, ATR
MARY COOMBS, PhD
FRANK ECHENHOFER, PhD

4.- Nadia Revisited: Mollification of Regression in the Autistic Savant Syndrome
DAVID R. HENLEY, MA, ATR

5.- Mythology and Religion as Inspiration for Creativity
JAMES MESPLE

6.- A Professional Looks Back
DON JONES, ATR, HLM

7.- An Exploration of Group Art Therapy as Ritual Enactment
RANDALL OVERDORFF, MA, ATR

8.- A Chance Meeting: Bringing the Roles of Art Therapy and Mothering Together
DEBRA De BRULAR, ATR

9.- Developmental Stages of an Art Psychotherapy Group in a University Counseling
TALLY TRIP, MA, MSW, ATR
JUARLYN GAITER, PhD

10.- The Concept of Structure in Art Therapy
MALA BETENSKY, PhD, ATR

11.- Structuring Group Art Therapy for Emotionally Disturbed Children
BONNIE STROMER, MA

12.- The Visual Journal Workshop: Model for Self-Awareness, Self-Confidence and Communication
FLORENCE PIETRAFESA, MS
R. GOOEY, BS

13.- **The Forgotten Children: Art Therapy with Children of Alcoholics**
DIANE HODGES, MA, ATR, CPT

14.- **Creating the Human Phase**
JERALD NEUMAN, PhD
MILDRED LACHMAN-CHAPIN, MEd, ATR

15.- **Art Making as a Metaphor for Developing Research in Art Therapy**
PAT ALLEN, PhD, ATR

16.- **Overcoming the Blank Paper: Strategies for Using Prestructured Elements in Art Therapy**
RANDY VICK, MS, ATR

17.- **The Ulman Personality Assessment Procedure: An Analysis of Protocols**
GLADYS AGELL, MA, ATR, HLM

18.- **A Psychoaesthetic Perspective to Creative Arts Therapy and Training**
ARTHUR ROBBINS, EdD, ATR

19.- **A Working Model for Art Therapy Research with HIV Patients**
PAULA HOWIE, MA, ATR
PAUL NEWHOUSE, MD, MC, MAJ

20.- **Family Art Therapy: A Case Study Involving Three Sexually Abused Sisters**
CAROL COX, MA, ATR

21.- **Innisfree Village: Multi-dimensional Approach to Rehabilitation of the Mentally Handicapped Adult**
PHYLLIS FRAME, MA, ATR

22.- **The Healing Nature of Creativity**
EDITH WALLACE, PhD, ATR

23.- **The Past is the Past: Everyone Has One**
BRUCE L. MOON, MA, M Div, ATR

24.- **Traumogenic Dynamics of Sexual Abuse: Its Projection in Latency-Age Drawings**
BOBBIE KAUFMAN, MPS, ATR
AGNES WOHL, MSW, ACSW

25.- **Individuality and Consensus**
JANIE RHYNE, PhD, ATR, HLM

26.- **Lead Into Gold: Reflections on a Jungian Approach to Art Therapy**
J. WILSON, MA

27.- **Is Showing Telling: Art Therapy and Sandplay as Treatment for Dissociative Orders**
TERRI SWEIG, MA, ATR

28.- **The 'Secret Lives' of Snapshots — Photo Therapy in Clinical Practice/Assessment**
JUDY WEISER, Reg. Psych., MS, ATR

29.- **The Alchemy of Clay**
MARK FERRIEGEL, MA

PANELS

1.- **The Use of Clinical Art Therapy with Addictive Disease Populations**
KATHRYN A. WEBB, MA, MFCC
DIANE KREGMAN McELLIGOTT, MA, ATR
SHERRY KREITMAN-DANSKY, MAT, ATR
SR. KATHLEEN BURKE, PhD, ATR
GALE RULE-HOFFMAN, CAC, ATR
ANITA MESTER, MA, ATR

2.- **Outsider Art: From Case Studies to Commodities**
BARRY COHEN, MA, ATR
DAVID R. HENLEY, MA, ATR
MARTHA HAESLER, BA, ATR

3.- **Symptom Formation of Psychoses Reflected in Art Productions by Psychotic Patients**
KAREN S. LEVICK, MS, ATR
MYRA LEVICK, PhD, ATR, HLM

4.- **Art Therapists as Expert Witnesses**
DIANE SAFRAN, MS
MYRA LEVICK, PhD, ATR, HLM

5.- **New Directions for Art Therapy Research**
HARRIET WADESON, PhD, ATR
MAXINE JUNGE, MSW, ATR
JANIE RHYNE, PhD, ATR, HLM
VIJA LUSEBRINK, PhD, ATR
LINDA GANTT, MA, ATR

6.- **A Developmental Model of Supervision**
MARCIA ROSAL, PhD
SANDRA GRAVES, PhD, ATR
VIJA LUSEBRINK, PhD, ATR

7.- **The Interface of Cognitive and Sensuous Ways of Knowing**
ARTHUR ROBBINS, EdD, ATR
MYRA LEVICK, PhD, ATR, HLM
SHAUN McNIFF, PhD, ATR
ROBERT WOLF, ATR

8.- **Through the Looking Glass: When Clients' Tragic Images Illuminate the Therapist's Dark Side**
ROSE MARANO GEISER, MA, ATR
HARRIET WADESON, PhD, ATR
BARBARA FISH, MA, ATR
JOANNE RAMSEYER, MA
JEAN DURKIN, MA

9.- **Lifelong Effects of Sexual Abuse**
DEE SPRING, PhD, MVCC, ATR
SANDRA HURD, MA
PATTY CHURCHILL, MA

10.- Psychological Studies of Artists: Art History and Art Therapy

MARY GEDO, PhD
LAURIE WILSON, PhD, ATR
JUDITH RUBIN, PhD, ATR, HLM
LINDA GANTT, MA, ATR

WORKSHOPS

1.- Art Therapy as a Preventive Intervention in the Nuclear Age

ELLEN SPEERT, MEd, ATR

2.- Developing a Professional Identity as an Art Therapist

KAY STOVALL, MA, MFCC, ATR
DEAN WILSON, PhD, MFCC, ATR

3.- Conflict Resolution Through Photo Art Therapy

IRENE CORBIT, PhD, ATR
JERRY FRYREAR, PhD, ATR

4.- Imaging Ourselves: Enabling Women to Access and Inner Female Authority

MARY DOUGHERTY, MFA, MAAT, ATR

5.- Puppetry: A Modality for the Art Therapist

MICHAEL MARSHALL, MA, ATR

6.- The Interface of Artistic Composition and Appropriate Treatment Interventions

ARTHUR ROBBINS, EdD, ATR

7.- The Turmoil of Aging: Countertransference Issues and the Art Therapist's Role

JULES WEISS, MA, ATR

8.- Draw for Within: Art Therapy for the Survivors of Suicide

LINDA LEE GOLDMAN, MEd, ATR
JUDITH ROTHSCHILD, MS

9.- Dance and Art Therapy: A Combined Treatment Modality

CARRIE DOBIE, MPS, ATR
P. MOWRY, MS, ADTR

10.- Dali and Magritte, Naturalists of the Imaginary, Stimulate Creative Expression

VIRGINIA MINAR, MS, ATR

11.- Killing Me Softly with Your Words: Diagnosis Versus Working with the Image

KRISTINA SLY, MA, ATR

12.- Action Methods as Tools for Creating Your Preferred Future in Art Therapy

LEIGH FILES, MEd, MA, ATR

OPEN FORUMS

1.- Graduate Education

SHIRLEY RILEY, MA, ATR, MFCC, Chair

2.- Standards of Practice

PAULA HOWIE, MA, ATR, Chair

3.- Writing for Publication

PAT ALLEN, PhD, ATR
GARY BARLOW, Editor, *Art Therapy*
WINNIE FERGUSON, PhD, ATR

4.- Undergraduate Education

LORI VANCE, ATR
SHERRY LYONS, MS, ATR, Facilitators

5.- Jobs and Marketing Strategies for Art Therapists

CATHY MALCHIODI, MA, ATR, Chair

6.- Registration and Supervision

DORIS ARRINGTON, PhD, ATR, Chair

7.- Student Forums:

A. Open Forum on Education

BRUCE L. MOON, MA, M Div, ATR
CATHY MOON, BFA, ATR, Moderators

B. Does Relaxation and Computer Art Improve the Quality of Images?

SARAH BRATCHER

C. A Stimulus Drawing Task with Elders and Their Children

BERNIECE BURT

STUDY GROUPS

1.- Art Therapy as a Career: Rewards and Frustrations

JULIE LOMOE-SMITH, MA, MFA, ATR

2.- Mandalas

PHYLLIS FRAME, MA, ATR
BONNIE SMITH-MAY, MA, ATR

3.- Symbolic Language of the Sexually Abused

DEE SPRING, PhD, MFCC, ATR, Facilitator

4.- Current Developments in Draw-A-Person (DAP) and Life-Size Body Drawings (LSBD) in the Assessment of Child Abuse

CATHY MALCHIODI, MA, ATR

5.- Art Therapists Working with Addictions

DIANE KREGMAN-McELLIGOTT, MA, ATR

WORK SESSION

1.- **Standards, Procedures, and Ethical Issues in Supervision**
SHIRLEY RILEY, MA, ATR, MFCC, Chair, Education Committee

POSTER SESSIONS

1.- **The Child's Family Drawing as a Measure of Stressful Family Environment**
JONATHAN BRAKARSH, PhD

2.- **Leaping Beyond Traditional Boundaries**
GUSSIE KLORER, MA, ATR

3.- **Themes of Loss in the Pictorial Language of a Nursing Home**
ANNETTE SHORE, MA

4.- **Adolescent Self-Identity as Expressed in Urban Graffiti**
ELENA GREENBERG, MAAT, ATR
KIM BEREZ, BFA

5.- **Assessing Art Therapy's Effectiveness with Chemically Dependent Adults**
KURT BREWSTER, BA

6.- **The Symbolic Meal: Restoring the Empty Self**
SANDRA TICHEN, MS, ATR

7.- **The Status of Art in Programming for Children in Domestic Violence Agencies in Illinois**
KAREN DESKE, MS

8.- **One Experience of a Course of Majoring in Art Therapy in Brazil**
ANGELA HELENA PHILIPPINI
MARCO ANTONIO CARVALHO SANTOS

9.- **Sharing the Creative Segment of Life: Seniors Produce a Local Art Exhibit**
BERNADETTE CALLAHAN, MS, ATR

10.- **I See What You Are Feeling**
RAYMOND BRACKEN
CATHY MALCHIODI, MA, ATR

11.- **Filing System for Client Artwork Using DSM-III, Apple Computer and Slides**
DAVID BERGLUND, BFA, MAT
LEWIS SHUPE, PhD, ATR

12.- **Using Tree and Person Drawings in Assessment of Chronic Renal Patterns**
SUZANNE BARTON
CATHY MALCHIODI, MA, ATR

13.- **Re-Imaging the Elderly: Art Therapy in a Senior Day Care Facility**
JUDITH A. CHRISMAN, MA

14.- **Once Upon a Time, I Wasn't in Trouble . . . The Treatment of Convicted Women Felons**
KRISTINA SLY, MA, ATR

15.- **Mother-Child Drawing Assessment: An Experimental Projective Technique and Its Use with Children**
AMY B. KINNEY, BFA, MAT
LEWIS SHUPE, PhD, ATR

16.- **Astronomy Meets Psychology at Art Therapy**
CHARLES HAYES, BA

17.- **Effects of a Group Mural Experience on the Dually Diagnosed Mentally Ill/Chemically Addicted Client**
STILLER DAWSON, MS, MFA
S. VULLO, MS

18.- **Art Therapists and the Hospital Marketing Mix**
PENNY ALENE FREE, MA, MSW, ATR
LIN CHILTON, MA, ATR

19.- **Art Therapy Intervention with an Anxious Child**
FRANCES MOORE

20.- **Issues for the Hospital Art Therapist: Joint Commission on Hospital Accreditation (JCAH) and Diagnosis Related Groups (DRG's)**
PAULA HOWIE, MA, ATR

21.- **Quality Assurance: Issues and Recommendations for Art Therapists**
IRENE ROSNER DAVID, MA, ATR

Art for Institutionalized Elderly

Wendy Weiss, MFA, *Assistant Professor, Department of Textiles, Clothing and Design, University of Nebraska, Lincoln, Nebraska*
Donna E. Schafer, PhD, *Assistant Professor, Gerontology Programs, San Francisco State University, San Francisco, California*
Forrest J. Berghorn, PhD, *Professor, Associate Director, Gerontology Center, University of Kansas, Lawrence, Kansas*

Abstract

Institutionalized elderly often lack stimulating and creative activity. An eight-week textile art education intervention introduced an activity that encouraged learning new skills and applying them in an individual and creative manner to fabric painting.

To evaluate the intervention's effectiveness, data were gathered from two interview schedules; one administered to nursing home staff, the other to residents. The sample of forty-nine residents, twenty-six of whom participated in art classes, was drawn from three nursing homes in Lawrence, Kansas.

Results indicate social interaction improved significantly and the quality of art work produced by the majority of participants improved over the course of instruction.

The study suggests that arts programming in nursing homes contributes to social well-being and provides opportunities for learning new forms of creative expression.

The objectives of most nursing home activity programs are to maintain a resident's physical functioning, self-care behaviors, motor skills, mental alertness and social skills. What distinguishes a creative activity from activities such as a group craft project or classroom reality orientation is that in a creative activity the results are always varied. Each participant brings his or her ideas to the activity and is encouraged to use them. Hence, the products will never, and should never, be the same. Creative visual expression is a non-verbal form of communication, making it appropriate for individuals who are experiencing losses in their ability to communicate verbally, as well as personal losses through illness, death of loved ones, loss of lifestyle, and other changes related to aging and institutionalization.

Literature Review

The body of literature on developing art programs for institutionalized elderly is relatively small. Most articles describe specific programs or cases with which art therapists have been involved. Others discuss benefits older people can gain from participating in a creative activity and offer advice for assisting them in achieving the benefits of creative expression.

Harrison (1980) describes an outreach art program she established as a preventive psychological intervention for a community mental health center. Weber (1981) describes a folk art program with day care center and nutrition site participants. Dewdney (1973) pioneered in the development of art therapy programs or exercises for institutionalized elderly. She identifies three levels of functional ability and places emphasis on encouraging students in a constructive atmosphere, at each level, to reinforce the value of both the artists and their work. Wald (1983) describes the use of art therapy to diagnose, evaluate, and treat victims of Alzheimer's disease.

Aspell (1976) delineates the benefits of art education for blind elderly, including flexibility, independence, originality, individuality and sensitivity. According to Aspell, the constant need to make decisions while creating a work of art fosters independence. Developing problem-solving skills and organizing ideas in new ways inherent in artistic activity, promotes flexibility and originality. Additional benefits, Aspell contends, are increased manual dexterity and social interaction. Zeiger (1976) developed an art therapy program based on Robert Butler's (1963) work on the life review. She found that severely impaired residents' drawings of significant past experiences facilitated discussion of repressed memories and resulted in increases in social interaction and clearer perceptions of surrounding activity.

Alpaugh, et al. (1976) suggest that older individuals tend to be more cautious and less willing to take risks than younger people. Consequently, they advise that "older adults will need encouragement to experiment with unusual alternatives . . . the optimal learning situation for older adults is one in which difficulties are minimized and anxiety is alleviated through supportive instructions." (p. 35) Crosson (1976) suggests techniques to encourage spontaneity in geriatric patients, including placing a depressed or resistant student next to an active, motivated one; guiding the hand of

> ***"The body of literature on developing art programs for institutionalized elderly is relatively small."***

a patient to overcome hesitation; using magazine illustrations to inspire subject matter; and exhibiting finished art work and inviting student comment to help relationships develop among patients. Essays in Weisberg and Wilder's collection (1985) address the question of how to encourage elderly participants to communicate with others in the disciplines of music, art, dance, creative writing, photography, and drama. The authors/artists discuss ways to encourage decision making, social interaction, and learning new skills—ingredients essential to the creative process.

The existing literature is useful in providing information about the types of projects artists have used with the elderly population, often with particular groups such as Alzheimer's patients, those living in both institutional and non-institutional settings, and blind elderly. Taken together, it is clear that artists have introduced a full range of visual arts activities to older students, including acrylic painting, collage, drawing, textile arts, ceramics, as well as other expressive arts such as creative writing, music, and drama.

However, with few exceptions (e.g., Clark and Osgood's, 1985, study of creative drama programs for the elderly), the literature has lacked systematic analysis of the impact of arts programming on elderly students. This lack of systematic evaluation, coupled with the variations in the elderly student groups reported in the literature, makes it difficult to determine which teaching methods are most suitable for given groups, what benefits are most likely to occur and for whom, whether or not there is a transference of benefits from an art intervention to the daily lives of elderly students, and whether or not a group of older students are able to improve their capacity for artistic expression. A lack of systematic information not only inhibits us from making our programs more effective, but also prevents us from demonstrating convincingly that creative programs are a good financial investment for those interested in the social and emotional health and well-being of older people.

The textile art program for nursing home residents we conducted, and its evaluation, are presented in the following two sections. In designing the program, we incorporated many of the teaching techniques suggested in the literature. From the literature we formed the hypothesis that participants in our program, relative to a control group, would show statistically significant gains in self-esteem and social interaction as a result of participation. We also hypothesized that program participants would improve, as rated by two independent judges, in their use of elements of artistic composition over the course of the art education program.

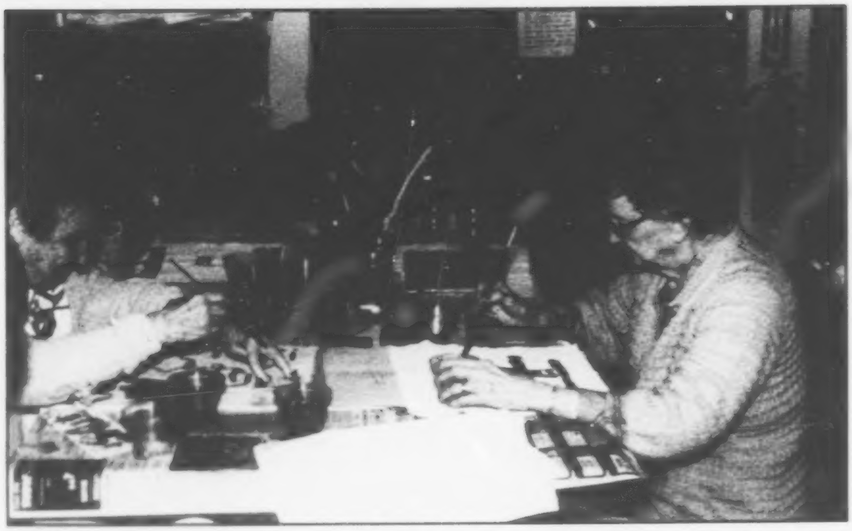


Fig. 1. The classroom is set up with clear plastic cups with paint, water, and extra cups in which to mix colors. Group interaction is encouraged when students need to ask one another for specific colors, mixing cups, or paint brushes.

"Over a seven-month period . . . residents from three nursing homes participated in textile arts classes. . . ."

The Program

Over a seven-month period from October 1985 to May 1986, residents from three nursing homes participated in textile arts classes offered by the Parks and Recreation Department of Lawrence, Kansas. This special program was funded jointly by the Kansas Arts Commission's "Artist in Education Program," the Community Development Block Grant Program, the participating nursing homes, and the City of Lawrence. Activity directors at all five Lawrence nursing homes were invited to participate in the program. They received a letter introducing the creative and research aspects of the program and were given the option to select either an eight-week session that met once per week (costing $100) or three times per week (costing $200). They were told supplies would be provided. In follow-up calls, it was made clear that, if the nursing home was interested in the program but could not pay for it,

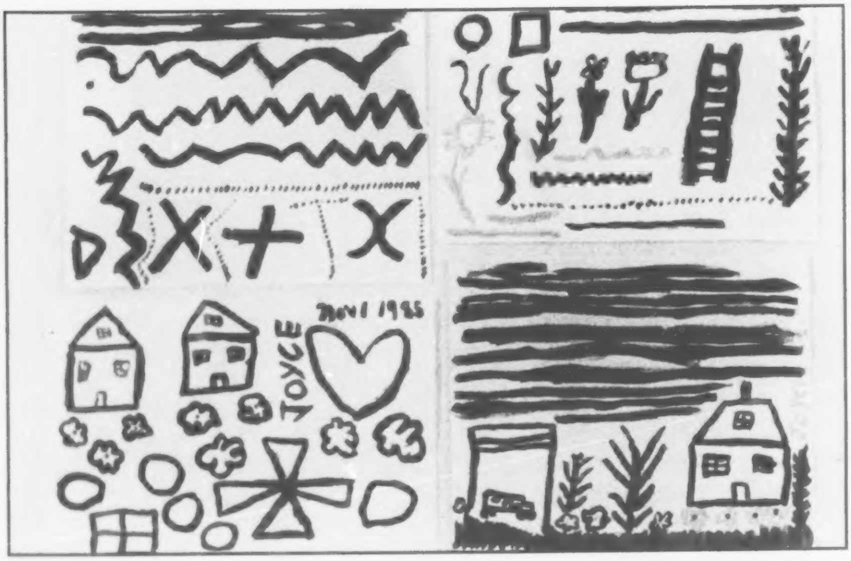


Fig. 2. These four paintings by the same individual were done in sequence from left to right. The student's initial line and shape paintings developed into a body of paintings based on the student's recollection of the buildings on the farm where she grew up.

special arrangements could be made. Two of the five homes declined to participate, one opted for classes three times per week and two requested one class per week. All three participating institutions paid the requested fee. One of these facilities is operated by the county; the other two are privately owned. All have fewer than 100 beds. Classes were scheduled to meet for one hour, with one half-hour allowed both before and after class for set up and clean up.

Class content was similar for all three classes. The class meeting three times per week included a greater variety of exercises on the material covered in all sessions. The three classes followed the same general sequence of design material, with some variation based on the dynamics of each group. Weiss was the instructor for each class. Over the eight-week period, students progressed from painting lines on paper, to color mixing, to painting shapes, to painting on fabric. The students then selected one or more of their fabric paintings to make into a pillow.

The activity room at two of the nursing homes, and the dining room of the third, served as classrooms. Approximately eight to twelve students per session participated. In general, they were reasonably mentally alert, although some were marginally so. All were sufficiently ambulatory to leave their rooms, but some needed assistance. Most had some disabling condition, ranging from slight visual impairment to severe physical impairment. Students had been informed that the class was part of a research project and that regular attendance would be helpful; however, students were not required to come to class and could drop out any time. The work areas at each home were similar, with everyone sitting together at one table. Before class, Weiss set the table with water jars for cleaning brushes and clear plastic cups containing tempera paint or fabric paint, depending on the day's project. Students sharing paints from cups facilitated clean up and, more importantly, created an opportunity to interact with each other when in need of a particular color. The palette Weiss used included primary colors, and sometimes black and white. To obtain a full spectrum of color, one may use primary red, fushia red, turquoise blue, primary blue, golden yellow, and lemon yellow. Students learned to mix whatever colors they needed.

In the first group sessions, students explored different ways to paint a line using tempera paint on paper. Usually, the first paintings were monochromatic, based on a selection from the primary colors. For students who hesitated to start, Weiss provided verbal directions and a demonstration of all the steps required to handle a paint brush (i.e., picking up and holding the brush, dipping it in the water jar, saturating the brush in the desired color, wiping excess paint off the brush, and making the first mark). Because most students had never painted before, this instruction was basic to introducing the painting process. As much experimentation as possible was encouraged, taking into consideration the limitations of individual students. Weiss suggested students paint a crooked or wavy line, from one side of the paper to the other. Failure to paint a straight line immediately can be discouraging to students with conditions that make it difficult to handle the brush in a steady manner. Students begin to see compositions developing and the first hurdle of trying something new is generally overcome in the line painting session. In design terms, the first assignment makes sense because line is one of the tools used in developing a composition. Students naturally start organizing their marks after a few efforts, even if the instructor says nothing about composition.

The second stage of instruction can either be mark making, shape or color mixing. Weiss introduced color mixing because students were already asking how to obtain specific colors. Color can be approached in many ways. However, for this proj-

"After . . . four weeks of classes, students began to paint on fabric."

ect, students were asked to make color stripe paintings. They selected an initial primary color and gradually added another primary, painting a stripe of each color gradation. Some continued to add a third color. A few students were able to grasp the subtlety of the problem and others needed extensive assistance throughout the process. Some students interpreted the idea of painting stripes as painting wavy lines or shapes, using color gradations.

The color mixing problem allows the student to see how to create secondary colors (orange, green, and violet) from the primary colors (red, yellow, and blue). They discover that mixing all three primaries yield various hues of brown. The instructor can reinforce the knowledge acquired in these sessions, especially when a student asks how to mix a color. One can refer to an example of the desired color and ask the student to name the colors from which it is made or ask the student to guess or try the experiment again. As with any learning experience, the sense of discovery and accomplishment is vital to making new information meaningful.

An exercise using cut-out shapes followed the color mixing exercise. Students were asked to name shapes, cut them out for themselves or for each other, and develop compositions using them. They could either trace around the cut shapes or try to draw from them, as in a still life. It is useful to provide examples of other artists' work to help reinforce and legitimize what one is teaching. Wald (1983) introduces collage exercises with a lecture on the history of collage. She says this elevates what some students consider a childish task to a mature level. Henri Matisse is a good example since he continued to produce art until he died, devising methods to overcome his losses due to age and illness. Students respond to the bright colors and shapes of the paper cut-outs of Matisse's later years. Sonia Delauney is another artist whose use of bold shapes and colors appeal to beginning older students.

After the first four weeks of classes, students began to paint on fabric. If some individuals needed extra feedback to get started, Weiss provided direction. The art instructor must differentiate between "learned helplessness" (Selig, 1975) and true functional inability to execute a task. It is important to attempt to determine how much an individual can manage on his/her own, and, when help is needed, to look for ways to assist that will allow the individual to work as independently as possible. At the conclusion of each session, participants were invited to describe and explain to other group members the work(s) they produced during that session and comment on the success of, or extent to which they were pleased with, their efforts. Other participants had the opportunity to comment on the work(s) being shown.

During the seventh week, each student selected a fabric painting he/she wanted to make into a pillow. Although many residents were excellent handsewers and some were interested in using a sewing machine, time limitations dictated that the instructor heat-set (by ironing) the fabric paint and stitch fabric backs to the pillow between classes. The instructor left an opening in which the students could insert stuffing during the last class meeting. This last session generally turned into a group effort, with more mobile individuals helping those with restricted movement and sewers stitching and closing the gaps for non-sewers. Communal sewing projects, such as stitching the binding on a group-painted quilt project, are an excellent way to stimulate conversation among participants.

When students are able to execute all the work on a project, they identify more with the finished product and gain a greater sense of accomplishment. Consequently, in projects that activity directors provide for residents, and longer term projects with artists, we recommend that students participate as fully as possible in the finishing work, such as ironing the painted textile pieces to heat set them and handstitching the entire pillow or object. This recommendation is consistent with recommendations of other investigators working with institutionalized populations (e.g., Schafer, et al., 1986; Langer and Rodin, 1976; Morganti, et al., 1980; Harel and Noelker, 1982; Saul and Saul, 1974; Fontana, 1977) who suggest that full participation, decision making and control over events/activities among nursing home residents are quite important if residents are to benefit.

Evaluation

Participants

Nursing home staff members in each of the three participating facilities were asked to identify ten to twelve residents whom they felt were mentally and physically capable of participating in art classes. Included in the evaluation are all residents identified by staff meeting these criteria and those who agreed to participate and sign an informed-consent form. Information was gathered on forty-nine residents. All were evaluated by nursing home staff members. Twenty-six participated in art classes, thirteen of whom were pre- and post-tested and thirteen of whom were post-tested only to control for test-retest effects. Eight residents were pre-tested but dropped out of the program or were, for various reasons such as ill health or hospitalization, unavailable for post-testing. Eleven residents identified by staff as potential participants chose not to participate or were unable to do so. Four residents, who were assigned to a no-treatment control group, were pre- and post-tested but did not participate in art classes. Of the forty-nine residents included in the study, twelve (24.5%) were male and thirty-seven (75.5%) female. Forty-seven residents were white. Residents' ages ranged from 60 to 96 years (M=79.4; SD=9.7). Residents had completed an average of 10.5 years of schooling (SD=2.8). Length of stay in a nursing home ranged from one month to six years, with the largest number of residents living in a nursing home for twelve months (M=15.7; SD=18.6).

Measures

Two interview schedules were developed for this study. One was given to nursing home activity directors and included background information about residents' health conditions, whether or not they had participated in the decision to move into the nursing home, how frequently they received visitors, and how frequently they participated in the nursing homes' activities. The other instrument was administered to residents and forms the basis for pre- and post-test results of the art program's effectiveness.

Nine variables in the resident questionnaire are demographic or background variables. These, like the variables in the activity director evaluations, are considered to be independent; that is, not likely to be affected by participation in art classes. The principal function of this set of variables is to test for compositional differences among those in the participant, attrition, and control groups. They include sex, race, age, prior residence, schooling, tenure in the nursing home, marital status, previous occupation, and value orientations (preference for independence, family interaction, friendship formation, or community involvement).

Three dependent variables are included in the resident questionnaire to test the effectiveness of participating in art classes. One is an attitudinal measure; two are behavioral. The attitudinal measure is a ten-item self-esteem scale developed by Rosenberg (1965). Scoring procedures have varied in different studies using this measure (Breytspraak and George, 1982). In the present study, a value of 0, 1, or 2 is assigned for each item depending on whether a respondent agrees, is not sure, or disagrees with a statement. Responses are recoded so that a "2" is assigned for the high self-esteem response. The additive scale ranges from 0 to 20. The mean score for pre-tested residents is 14.9 (SD=3.6).

One behavioral variable is the number of other residents in the nursing home a subject reported knowing by name (range 0-11, M=2.8, SD=3.4). A second behavioral variable was created to reflect the nature of a person's interaction with the facility's other residents. Responses were coded to reflect the degree of spontaneous activities initiated by the resident (range 1-3, M=1.9, SD=.9).

Finally, four art works were randomly selected from among the class projects of each participant. The date the work was produced was concealed. Two experienced judges using a five-point scale independently evaluated the degree to which each work reflected a judicious use of the elements of composition (line, color, shape, space) and an overall assessment of the success of the work.

An average score was computed for each work from the two evaluations. A variable was then created that measured the extent to which each participant improved in the use of composition elements over the sequence of four works. If each successive work by a participant was judged more favorably than the one that preceded it, a value of 3 was assigned. If two works were judged better than those that preceded them, a value of 2 was assigned. If at least one work was judged more favorably than a preceding work, a value of 1 was assigned. A value of 0 was assigned if no improvement in successive efforts was noted. Thus, the range of the art work improvement variable is 0 to 3 (M=1.27; SD=.72).

Statistical Procedures

One-way analysis of variance was used to compare resident pre-test results for art class participants who were pre- and post-tested with the pre-test scores for attrition group members on dependent variables and selected background characteristics. One-way analysis of variance was also used to detect differences, if any, in the background variables constituting the activity director evaluations for art class participants, attrition group members, potential participants identified by activity directors who did not participate, and control group members. Following the one-way analysis of variance, the Newman-Kewls post-hoc test with studentized range statistic was computed to identify group means that were significantly different. The purpose of these analyses was to determine whether there were compositional differences among the various groups in the study.

One-way analysis of variance was used to compare post-test scores on the dependent variables for art class participants who were pre- and post-tested with post-test scores for art class participants who were post-tested only. The purpose of this analysis was to determine whether or not there were test-retest effects among those participants who were pre- and post-tested.

Finally, a T-test of group means was used to compare the pre- and post-test mean scores on dependent variables for the participant group that was pre- and post-tested with the mean scores on dependent variables for the control group. The purpose of this analysis was to determine whether or not participation in the art classes brought about significant improvement in self-esteem, the number of people known, and interaction quality relative to people who did not participate.

Results

Group Composition

A comparison of pre-test scores for art class participants who were pre- and post-tested with members of the attrition group revealed two significant differences. The pre-test mean score for art class participants on the self-esteem measure (M = 16.5) was significantly higher than the pre-test mean (M = 12.0) for members of the attrition group (F Ratio = 8.8; P = .009). That is, those residents who participated in art classes and were pre- and post-tested had, at the outset, higher self-esteem than those who were pre-tested but dropped out of the classes or were, for whatever reason, unavailable for post-testing.

Second, a significant difference in gender existed between the participant and attrition groups. The participant group mean score (M = 1.8) was significantly higher than the mean (M = 1.4) for the attrition group (F Ratio = 5.9; P = .03). Since a value of 1 was assigned to males and 2 to females, these results indicate that females were disproportionately participants while males were more likely to be drop-outs. Other variables in this analysis that were not significantly different between the two groups are the following: age, schooling, tenure in the facility, value orientations, number of people known to the respondent, and interaction quality.

An analysis of the evaluations activity directors completed on the forty-nine individuals in the study revealed two significant differences among groups. Those individuals (N = 11) who were identified as potential participants by the activity directors but chose not to participate or did not do so were judged to have significantly more difficulty walking than members of all other groups (P = .003). Individuals in this group also were significantly less likely to participate in nursing home activities (M = 3.00) than those residents (N = 13) who participated in art classes and were post-tested only (M = 4.08; P = .02). Other variables in this analysis that did not significantly differ by group are the following: tenure in the facility, frequency of outside visitors, participation in the decision to enter the nursing home, hearing problems, vision problems, reading problems, bowel or bladder problems, stroke, senile dementia or confusion. Thus, the individuals in the non-participant group in this study are less frequent participants in other activities, which may be related to their mobility impairments.

Taken together, these results suggest that drop-outs and non-participants in the art classes were somewhat more frail, both psychologically and physically, and less active than those who completed the program. While not surprising, this finding does underscore the difficulties that activity directors experience in providing group activities for more vulnerable residents and the problem they have in involving male residents in nursing home activities.

Test-Retest Effects

The twenty-six participants in art classes were divided into two groups of thirteen. One group was pre- and post-tested, while the other was post-tested only. A comparison of post-test scores on the dependent variables (self-esteem, number of people known to the respondent, interaction quality, and improvement on art work) revealed no significant differences between the two groups. Therefore, the experience one group had of answering the same questionnaire items previously apparently had no effect. Consequently, pre- and post-test scores for participants can be compared with greater confidence that results reflect the impact of the art class experience, rather than practice in test-taking.

Impact of Art Classes on Dependent Variables

A comparison of pre- and post-test means on the dependent variables for those participants who were pre- and post-tested appears in Table 1.

Table I. Pre- and Post-Test Means for Dependent Variables

ART CLASS PARTICIPANTS (N = 13)

VARIABLE	Pre-Test Mean	Post-Test Mean	DF	Prob.
Self-Esteem	16.45	17.00	10	.60
People Known	2.50	3.92	11	.14
Interaction Quality	1.62	2.08	12	.01*

*Statistically significant difference

While all post-test means are somewhat higher than the corresponding pre-test means, only interaction quality is significantly higher statistically on the post-test. That is, following participation in art classes, residents were significantly more likely to interact with other residents and spontaneously initiate conversations or activities with them. It should be recalled that residents in the participant group had significantly higher self-esteem on the pre-test than residents in the attrition group. It is possible, therefore, that the lack of significant improvement from pre- to post-test in self-esteem reflects a ceiling effect. That is, there may not have been much room for improvement in the self-esteem of participating individuals whose self-esteem, relative to their peers, was already high prior to participation.

Pre- and post-test means on the dependent variables were also compared for control group members, of whom there were only four remaining at the end of the study period. No significant differences were found.

Impact of Art Classes on Artistic Composition

Table 2 summarizes the mean score for the twenty-six art class participants on successive projects as rated by the judges.

Table II. Group Means on Successive Artistic Works

Art Work Sequence	Group Mean	Standard Deviation
First Work	2.96	.80
Second Work	3.38	.71
Third Work	3.56	.73
Fourth Work	3.46	.80

The increase in mean scores through the third work, though slight numerically, suggests that art class participants did improve in their ability to successfully use elements of composition in the projects they produced in class. It is not clear why the group mean score for the fourth is slightly below the mean for the third work. It is possible that participants may have reached a plateau in their mastery of composition elements. Table 3 demonstrates that a majority of participants did improve, at least somewhat, in their use of composition elements in their art work.

Table III. Individual Improvement in Use of Composition Elements

Amount of Improvement	Number	Per Cent
(0) No Improvement	3	11.5
(1) Slight Improvement	14	53.8
(2) Moderate Improvement	8	30.8
(3) Substantial Improvement	1	3.8
TOTAL	26	99.9

Only three individuals failed to improve at all over the course of class instruction. At the other extreme, only one person improved substantially. The majority of individuals had at least one work that was judged more favorably than a preceding one, and eight participants had two works that were evaluated more favorably than those that preceded them.

Since it was beyond the scope of this study to compare the artistic progress of a group of nursing home residents with a group of non-institutionalized elderly, or with people in other age groups receiving similar instruction, it is not possible to determine whether the amount of improvement demonstrated by this group is impressive or unexceptional. However, it is certainly reasonable to suggest that most nursing home residents are capable of learning some new skills, and that they improved in their use of elements of artistic composition as a result of the instruction they received in this program.

Discussion

To summarize, the principal findings of this study are: that the majority of art-class participants improved, at least somewhat, in their use of elements of artistic composition; that taking part in art education classes brought about a significant increase in the quality of participants' interaction with other nursing home residents; and that self-esteem was not affected by participation in the classes.

These findings must be considered in light of the size of the sample being discussed. Although the sample included forty-nine persons, some sub-groups became quite small because of attrition. Small sub-sample size is a common problem among studies undertaken in nursing homes for several reasons. First, one can expect a high attrition rate when studying frail, institutionalized elderly. Also, most nursing home interventions, if they are to be effective, must limit the number of persons in any group session. Finally, to secure a large sample an investigator must have the time and resources to involve a great many nursing homes, since each will have a small number of potential participants.

Art-class participants had relatively high self-esteem scores at the beginning of the intervention; this may explain the lack of significant change over the intervention period. Because of the selection criteria, those eligible for the art classes were in better physical and mental condition than the balance of nursing home residents. Moreover, it was found that those completing the program had significantly higher self-esteem than those who dropped out. We would suggest that the self-esteem of art-class participants reflects their assessment of themselves in relation to other nursing home residents. Such a comparison would reveal that, even with their own physical problems, they were better off than most of their peers.

Given the significant change that occurred in "interaction quality," another explanation for the stability of "self-esteem" is possible. If one considers benefits to be gained from participating in a therapeutic intervention in terms of either attitudinal or behavioral outcomes, it may be that some interventions are likely to affect one category more than the other. In the present instance in which participants created at least one tangible artwork per session, it was found that the one dependent variable significantly affected by the intervention was behavioral, the extent to which participants initiated interaction with other residents outside the class. By contrast, Berghorn and Schafer (1987), in a study of

". . . most nursing home residents are capable of learning some new skills. . . ."

reminiscence groups in nursing homes (an entirely verbal activity), found that the reminiscing experience had a substantially greater effect on the attitudes of participants than on their actual behavior. Further, their study underscores the need for research that compares the characteristics of those persons who benefit from a given intervention with the characteristics of those who do not benefit. The findings of the present study suggest that, in addition, future research on therapeutic activities should consider the relation between the type of intervention and the type of benefit, if any, achieved.

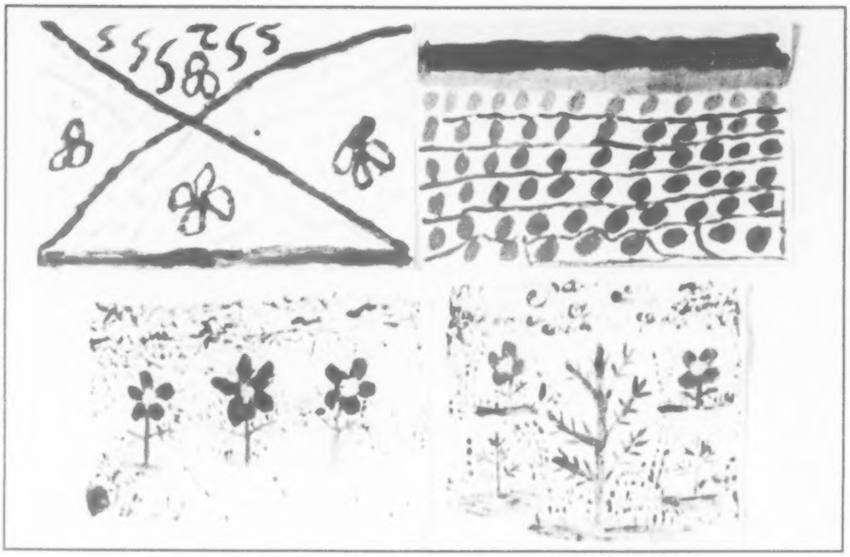


Fig. 3. This individual used circles and lines to interpret the color mixing problem. Her paintings developed into images of flowers, using a variety of patterns to make the grass.

> *". . . most nursing home interventions, if they are to be effective, must limit the number of persons in any group session."*

References

Alpaugh, P., Renner, V. J. and Birren, J. (1976). Age and creativity: Implications for education and teachers. *Educational Gerontology*, 1:17-40.

Aspell, A. (1976). Why art education for the elderly blind? *Educational Gerontology*, 1:373-378.

Berghorn, F. and Schafer, D. (1986-87). Reminiscence intervention in nursing homes: What and who changes? *International Journal of Aging and Human Development*, 24:2, 113-127.

Breytspraak, L. and George, L. (1982). Self-concept and self-esteem, In David Mangen and Warren Peterson (eds.). *Research Instruments in Social Gerontology: Clinical and Social Psychology*, Vol. I, Minneapolis, Minn: University of Minnesota Press, 241-302.

Butler, R. (1963). The life review: An interpretation of reminiscence in the aged. *Psychiatry*, 26:65-76.

Clark, P. and Osgood, N. (1985). *Seniors on Stage: The Impact of Applied Theatre Techniques on the Elderly*, New York, Praeger.

Crosson, C. (1976). Art therapy with geriatric patients: Problems of spontaneity. *American Journal of Art Therapy*, 15:51-56.

Dewdney, I. (1973). An art therapy program for geriatric patients. *American Journal of Art Therapy*, 249-254.

Fontana, A. (1977). *The Last Frontier*, Sage Library of Social Research, 4.

Harel, Z. and Noelker, L. (1982). Social integration, health, and choice: Their impact on the well-being of institutionalized aged. *Research on Aging*, 4:1, 97-111.

Harrison, C. (1980). Therapeutic art programs around the world—XIII: Creative arts for older people in the community. *American Journal of Art Therapy*, 19:99-101.

Langer, E. and J. R. (1976). The effects of choice and enhanced personal responsibility for the aged. *Journal of Personality and Social Psychology*, 34:191-198.

Morganti, J., Nehrke, M. and Hulicka, I. (1980). Resident and staff perceptions of latitude of choice in elderly institutionalized men. *Experimental Aging Research*, 6:367-384.

Rosenberg, M. (1965). *Society and the Adolescent Self-Image*, Princeton, NJ: Princeton University Press.

Saul, S. R. and Saul, S. (1974). Group psychotherapy in a proprietary nursing home. *The Gerontologist*, 14:446-450.

Schafer, D., Berghorn, F., Holmes, D. and Quadagno, J. (1986). The effects of reminiscing on the perceived control and social relations of institutionalized elderly. *Activities, Adaptation and Aging*, 8:3-4, 95-110.

Selig, M. (1975). *Helplessness: On Depression, Development and Death*, San Francisco: Freeman & Co.

Wald, J. (1983). Alzheimer's disease and the role of art therapy in its treatment. *American Journal of Art Therapy*, 22:57-64.

Weber, B. (1981). Folk art as therapy with a group of old people. *American Journal of Art Therapy*, 20:47-53.

Zeiger, B. (1976). Life review in art therapy with the aged. *American Journal of Art Therapy*, 15:47-50.

The Effects of Art/Drama Therapy Experiences on Rigidity, Body Concept and Mental Maturity in Graphic Thinking of Adolescents with Mental Retardation

Sirkku Sky Hiltunen, EdD, RDT, ATR, Primary Art and Drama Therapist,
The Art and Drama Therapy Institute, Inc. (ADTI),
6045 16th Street, NW, Room 215, Washington, DC 20011

Abstract

Subaverage and rigid cognition is the primary dysfunction in mental retardation. This study focuses on the decreasing of rigidity and consequent enhancement of receptive/expressive cognitive functioning in order to clear the channel of and prepare the groundwork for communication of thoughts and ideas in the further therapeutic intervention. Only this cognitively-oriented preparatory phase was the focus of this article. An art and drama therapy program was designed for 21 Mentally Retarded (MR) students at the Kennedy Institute, a private special education facility, in Washington, DC. For this study, an art and drama therapy curriculum using Piaget's theoretical framework of cognitive development was implemented. The curriculum was designed to bombard the cognition of MR participants through graphic, movement, visual and auditory thinking as alternative modalities for verbal thinking. Drawings were assessed regarding body concept, rigidity, and mental maturity to determine the effects of the Art and Drama Therapy Program on participants' graphic thinking. Data show movement from rigidity in graphic thinking toward flexibility. Statistical analysis in general suggested that the subjects had reached the oscillatory stage, fluctuating between rigid and flexible responses. The author conjectures that longer art and drama therapy intervention might firmly establish the acquired new flexible responses. Significant differences in body concept in graphic thinking were observed. This suggests that the art and drama therapy experiences improved students' conceptual knowledge of the body. Some improvement in mental maturity was also measured in Female Figure and Self 2 drawings.

Background

Cognition, thinking, and intelligence are often used synonymously. Furth and Wachs (1972) developed a curriculum that categorized cognitive processes as movement, visual, auditory, graphic, logical thinking, and social thinking. These researchers suggest that cognition can be enhanced by games that use various thinking modalities. Their suggestion relies on the Piagetian premise that cognition is not limited to logical thinking, but intelligence can also operate through sensory perception (visual, auditory, kinesthetic).

For this study, cognition and intelligence are synonymous. Furthermore, cognition is defined in its widest Piagetian sense as an ability to obtain, retain, and apply knowledge in a developmentally significant manner. The knowledge may be received or expressed visually, verbally, graphically, through imagery, or through movement, drama, or other sensory-motor media.

Inhelder (1968) refers to "viscosity" and "fixation," Webster to "repetitiousness" and "inflexibility," and Stellern *et al.* (1976) to "rigidity" and "perseveration" when discussing the ideational or visual-motor repetition of the same response, which manifests deficits in the adaptive performance of the MR population. This study did not focus on the affective etiology of rigidity, for the subjects of this study were not dually diagnosed, but primarily diagnosed as mentally retarded.

The lack of body awareness and body concept among the MR population is pointed out by Lowenfeld (1957), Crawford (1962), Weininger *et al.* (1972), and Wilson (1977).

Piagetian psychology acknowledges thinking as manifested through movement. The interrelationship of cognition and movement or movement and graphic expression is reported in Webb and Koller (1979), Cane (1951), Ulman (1965), Lachman (1973), and Fino (1979).

Silver (1975a, 1975b, 1976, 1977) studied the connection between cognition and art production (graphic thinking). She developed a cognitive rating scale, which is based on Piagetian assumptions. The scale is the basis for Form III of this study.

According to Bettelheim (1977), the simplification of fairy tale characters makes it easier for a child to acquire concepts needed to understand reality.

Overview

Mental Retardation can not be classified as an illness, the pathology of which could be identified and for which medication and cure could be provided. DSM III (1980) states that the essential features of MR are (1) significantly subaverage general intellectual functioning; (2) resultant or associated impairments in adaptive behavior; and (3) onset before age 18.

For this study, an Art and Drama Therapy curriculum using Piaget's theoretical framework of cognitive development was designed to address the problems of delayed cognitive development (mental maturity), rigidity (perseveration), and lack of body concept. The objective of the therapeutic intervention was to "bombard" the cognition of MR participants through multiple media (drawing, painting, mask making, movement, pantomime, mask pantomime, and fairy tale imagery) to elicit more flexible responses in both graphic and movement expressions, to enhance body concept, and to enhance mental maturity. Graphic responses were measured to assess change in the subjects. Fairy tales were presented to participants verbally to elicit mental imagery. Because images in the fairy tales mediate the information holistically, the MR participants did not have to understand every word. Fairy tale characters personify a concept in a straightforward manner. The character is either clever or stupid, beautiful or ugly, strong or weak. Thus, the characters can enhance the comprehension of each component concept. The translation and transmission of mental imagery into graphic form, movement, drama, or verbal expressions of the participants provided measurable/observable data for the assessment of this cognitive process.

The effects of the art and drama therapy intervention on the graphic thinking regarding body concept, rigidity, and mental maturity of the MR participants were assessed through their drawings (Silver Cognitive Evaluation Scales, Harris HFD test, and Bender Gestalt test).

> *"The objective of the . . . intervention was to 'bombard' the cognition of . . . participants through multiple media. . . ."*

Subjects

The 21 students, whose parents had given permission for participation, in this study were the total population of two junior high school classes at the Kennedy Institute, a private special education facility in Washington, D.C. Subjects ranged in age from 13 to 20 years. Eleven (11) subjects were males and ten (10) females.

Nineteen of the participating students were in the IQ range of 50-70, classified as Mild Mental Retardation. One student had an IQ of 40, classified as Moderate Mental Retardation, and another of an IQ of 84, corresponding to Borderline Mental Retardation (DSM III, 1980).

Procedure

The 21 students were divided into groups of five or six. Each group participated in three sessions weekly for a total of 29 sessions, conducted over the 15-week period in the school's art therapy room. Three weeks were not actively programmed because of the Easter holiday and several field trips. The participation rate was high. Of the 29 possible sessions, the average number of sessions attended was 25.7; one student could participate in only 17 sessions, and one other missed 8 sessions.

> *"Fairy tales were presented to participants verbally to elicit mental imagery."*

The Art/Drama Therapy intervention lasted from the 15th of March to the 10th of June. The pre- and posttests (Harris and Bender) were administered and scored by an outside school psychologist during the weeks prior to and following the intervention. The psychologist also scored additional self drawings, which had been administered by the researcher after the MR students participated in self-body confrontation and body-parts naming in front of a mirror during Units I and VII. The pre- and post-body-concept checklist was also used for the assessment. Rater 1 (the researcher) and Rater 2 (a developmental psychologist) evaluated pre, intermediate, and post drawings (Silver's rating scales) to assess cognitive changes.

Mask Pantomime Therapy Curriculum

The holistic art and drama therapy intervention consisted of creating and expressing a recited fairy tale through drawing, water color painting, mask making, movement, pantomime, and mask pantomime improvisations. The program sessions were divided among seven units (I-VII).

The processes followed an established progression:

(1) From receptive verbal and imagery (fairy tale) to expressive graphic and imagery (drawing);

(2) From receptive verbal and imagery (fairy tales) to expressive movement (movement improvisations, pantomime, mask pantomime);

(3) From receptive verbal and imagery (fairy tales) and movement (pantomime, etc.) to expressive graphic and imagery (drawing);

(4) From receptive verbal and imagery (fairy tales) and visual (observing pantomime) to expressive graphic and imagery (drawing, painting).

The therapeutic intervention for movement, graphic, visual, and verbal stimuli progressed in a similar manner. For the pre- and post- evaluation, Grimm's fairy tales and Aesop's fables were used. *The Wizard of Oz* (Baum, 1957) was used for the major intervention; it proved to be an excellent and meaningful choice for all participants.

The distinction between reality and fantasy was strongly emphasized throughout the art/drama therapy intervention. This distinction was especially clear in the use of masks and in assuming a fictional character identity. Each student selected a character in *The Wizard of Oz* and made a mask for it. Brigette Taylor's character identity was Dorothy (Figure 1).

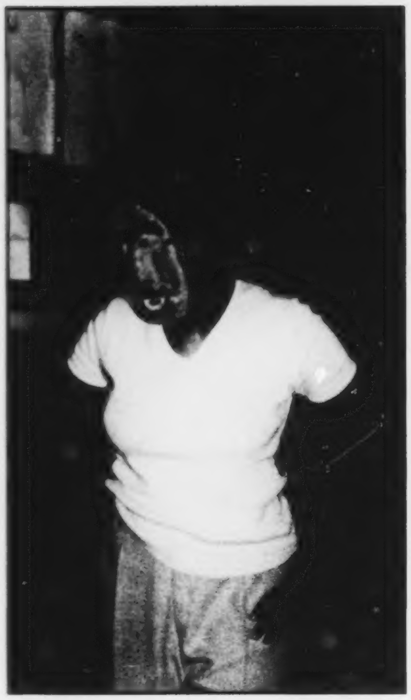


Fig. 1 Mask made by Bridgett Taylor
Character Identity: Dorothy

Methods and Results

The pre- and post-Harris tests were administered and scored by the outside school psychologist. Working in a one-on-one setting during testing, the students drew three human figures (1) Male, (2) Female, and (3) Self. This order was held constant regardless of the subject's sex. The self drawings produced during the pre- and post-test situations were called "Self 1."

The second self drawing (Self 2) was drawn during class evaluation period in group settings. Self 2 was drawn both during Unit I, which followed the pre-test, and during Unit VII, which preceded the post-test. During both pre- and post-test class evaluations, the Self 2 was drawn immediately after the mirror self-confrontation; the therapist pointed out body parts without giving verbal prompts. After looking at him/herself in the mirror, the student then named the appropriate body part. Responses were recorded in the Body Parts Check List, which provided a measure of the subject's vocabulary of body-parts and clothing. After this task, each student was asked to look in the mirror once again and then draw his/her own picture. Thus, comparative self drawing data were provided for scoring.

Results of the two-tailed t-test indicate significant differences in pre- and post-measures of both Female figure ($p<.05$) and Self 2 ($p<.001$) drawings. This suggests some improvement in body-concept and mental maturity resulting from the art/drama therapy intervention.

> ***"The distinction between reality and fantasy was strongly emphasized throughout the art/drama therapy intervention."***

After scoring the Bender tests, the school psychologist isolated the perseveration score to identify changes in visual-motor rigidity. Two-tailed t-tests on the Bender scores indicate no significant change in either visual-motor maturity or perseveration measures ($p>.05$). The isolated perseveration score perhaps was not sufficient to measure the cognitive and functional rigidity of the MR participants.

The subjects' abilities to name body parts as they were pointed out during mirror self-confrontation was assessed through the Body-Concept Check List. The results indicate significant differences in pre- and post-measures ($p<.001$) and suggests that the art/drama therapy experience improved students' conceptual knowledge of the body.

During Unit I through VII MR participants produced 386 drawings and paintings. Qualitative research data, drawn from the experimental unvalidated evaluation forms, were analyzed statistically. The forms provided a measure of the participants' cognitive abilities, as reflected in their art work.

Two raters evaluated the cognitive abilities by Silver Rating Scales (to select, combine, represent, express movement, and express artistically): Rater 1, the researcher, has a background in art and drama therapy with the MR population. Rater 1 scored 386 drawings (mean of 18.6 per subject); Rater 2, the outside judge, has a background in educational psychology and art education, exposure to child art, but no experience with the MR population. Rater 2 scored 121 drawings (mean of 5.7 per subject). The scores for those 121 drawings rated by both raters were analyzed statistically. The remaining 265 drawings, rated only by Rater 1, were used qualitatively.

A repeated measure ANOVA with Tukey post-hoc procedure was applied to assess significant differences in the cognitive abilities of the students, as reflected in their graphic responses throughout the program.

The means and standard deviations for the measured cognitive abilities were derived. The mean scores of Rater 1 and Rater 2 for the same 121 drawings were used. The means were found to be significantly different for the cognitive abilities to combine, to represent, and to express movement. No significant results were indicated for the abilities to select and to express artistically.

When the Tukey post-hoc technique was applied to the resulting pair-wise comparisons, some differences emerged. A comparison of means for Unit I, Unit III, Unit IV, and Unit VII showed no paired differences for the ability to select. Hence, the Unit samples did not significantly improve the ability to select. The ability to combine improved from Unit III to Unit IV, while other comparisons stayed statistically equal. For the ability to represent, Unit IV sample scores were significantly greater than scores for both Unit I and Unit III. The ability to express movement improved; Unit IV scores were significantly greater than scores for both Unit I and Unit III. Artistic abilities showed no significant differences in any comparisons. However, a comparison of Unit I and Unit IV scores showed a positive trend of improvement.

From the graphic responses of the students, the cognitive abilities to combine, represent, and express movement showed general improvement from Unit I and/or Unit III to Unit IV.

Pre- and Post-Evaluation

A correlated t-test assessed the differences in the pre-evaluation means of 39 drawings (1.9 per student) and the post-evaluation means of 42 drawings (2 per student). Rater 1 and Rater 2 independently evaluated the same 81 drawings.

For Rater 1, the post-evaluation mean for the abilities to select, represent, and artistic abilities was significantly higher than the pre-evaluation mean ($p<.001$). Significant differences in results also occurred for the ability to express movement ($p<.05$).

For Rater 2, the pre- and post-evaluation means were not significantly different in any of the graphic response measures ($p>.05$).

Inter-rater Reliability

The pre- and post-graphic response measures to assess the cognitive abilities to combine, to represent, to express movement, and the artistic abilities had a reliability range from .589 to .908 ($p<.001$, except for the pre-test measure of the ability to represent). The pre-evaluation of the ability to select showed no significant correlation between the raters.

Influencing Factors

The test and class evaluation results might have been influenced by unanticipated timing constraints. Eight sessions were rescheduled due to field trips; this delayed post-tests and class evaluations about two weeks. Post-tests and post-class evaluations were conducted during the last weeks of the spring semester; school work had ended and the school was preparing for the spring festivals. The outside school psychologist also observed the change in students' attention spans and concentration, noting in her final report that, at the time of the post-test in June, the students' day "was not structured and they were easily distracted because of their activities."

This observation strongly suggests that the circumstantial variable was not controlled, did not match the pre-testing situation, and might have skewed the results negatively.

The significant improvement in Self 2 drawings could have been caused by (1) students' familiarity with the therapist/researcher and her expectations; (2) familiarity with the drawing activities and structure of the sessions; and/or (3) higher motivational level.

To record the MR participants' smaller steps in progress, the Silver Cognitive Evaluation Scale (Form III) was revised after results were obtained. A rating scale to access the developmental level in drawing human figures was added. A means of measuring cognitive rigidity and flexibility replaced the creativity measure.

Statistical evaluation of improvements in the cognitive rigidity of the MR subjects clearly showed three major phases in their graphic responses: (1) rigid, (2) oscillatory, and (3) flexible.

The general variability of significance levels in the test results for this study suggest that the subjects had reached the oscillatory stage, which is characterized by fluctuation between old and new and/or a synthesis of rigid and flexible responses.

This sample of John Duvall exemplifies the successful transfer from a rigid and perseverative response to a flexible one (see Figures 2-9). Figure 2 was his first drawing, Figure 9, his last.

Figures	John's Responses
2-4	Rigid and Perseverative
5, 7, 8	Oscillatory
6, 9	Flexible

RIGIDITY vs. FLEXIBILITY (2-9)

Rigid

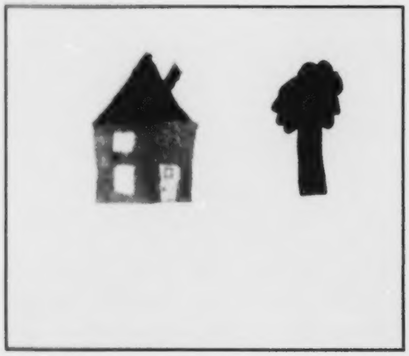


Fig. 2 John Duvall — "Hansel and Gretel"

Rigid/Perseverative

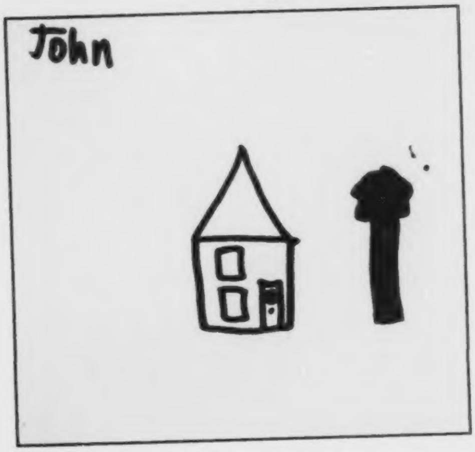


Fig. 3 John Duvall — "Free Choice after "Hansel and Gretel"

Rigid (Perseverative) Grass suggests emerging flexibility

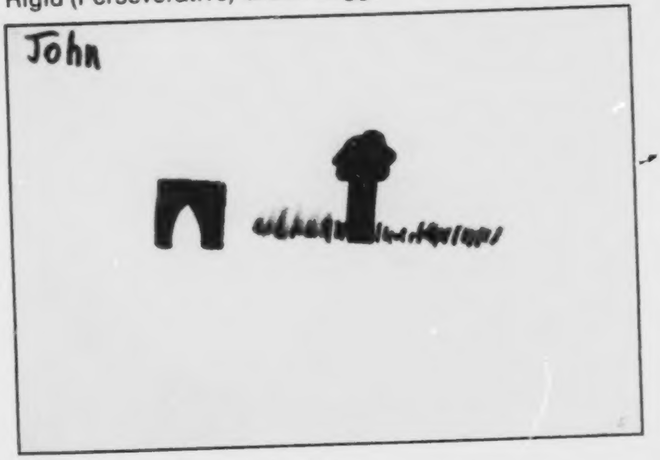


Fig. 4 John Duvall — Free Choice

Oscillatory

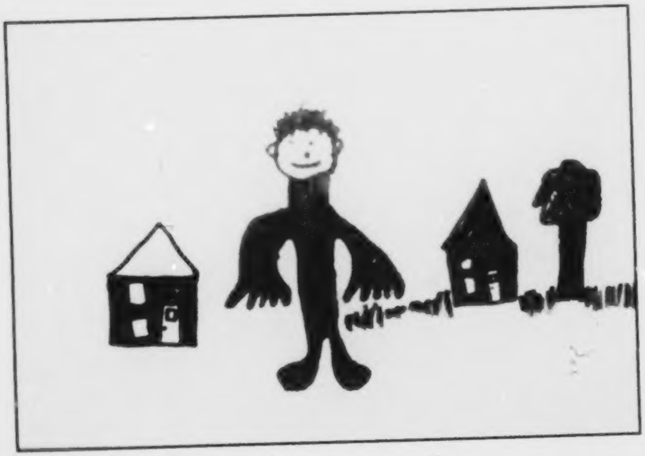


Fig. 5 John Duvall — Free Choice

Flexible

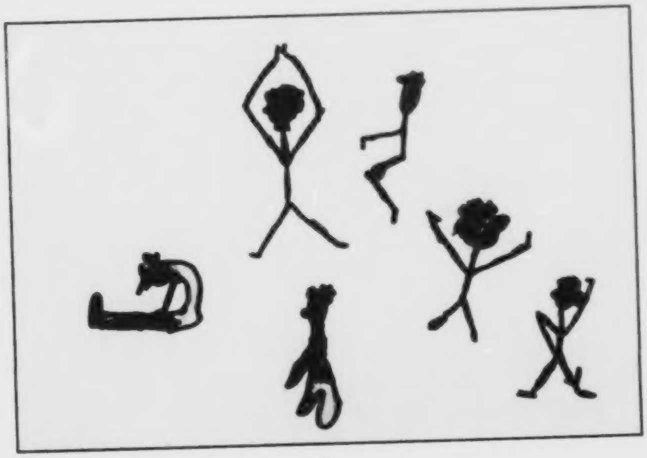


Fig. 6 John Duvall — "Movement"

Oscillatory

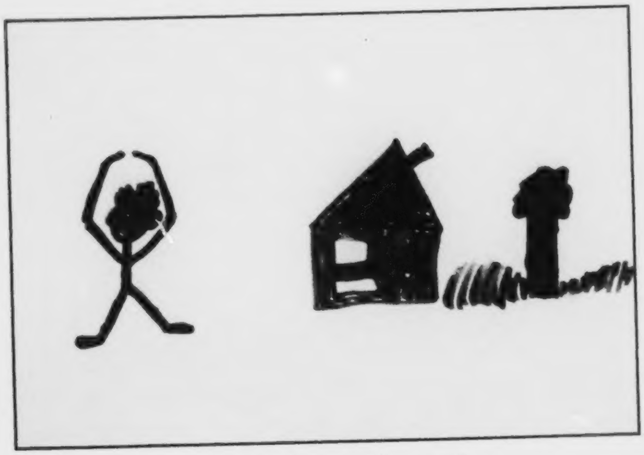


Fig. 7 John Duvall — Free Choice after Movement

Oscillatory

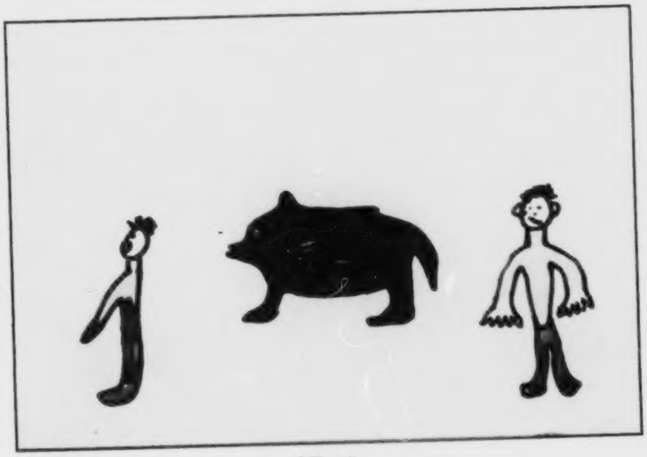


Fig. 8 John Duvall — "Man and Dog"

Flexible

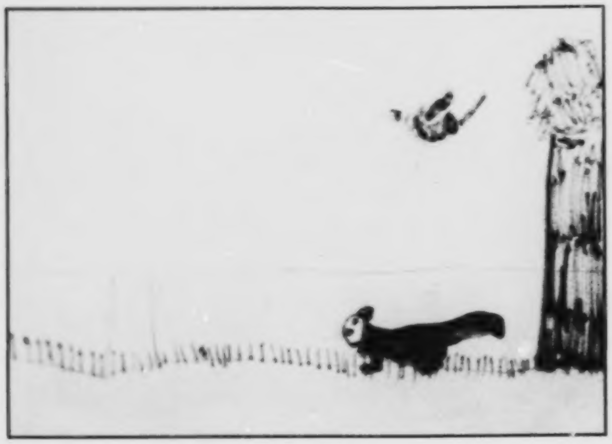


Fig. 9 John Duvall — "The Fox and the Crow"

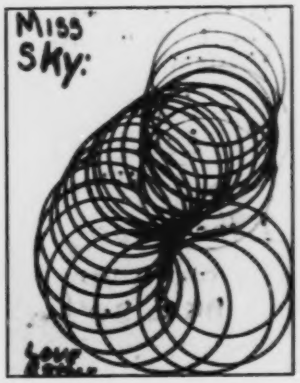


Fig. 10 Esther Harris — Abstract free choice drawing

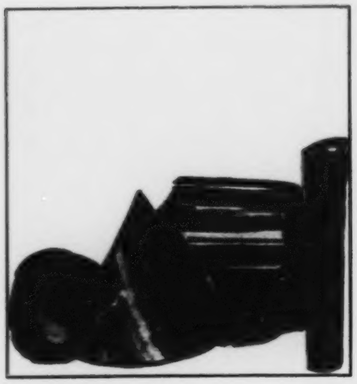


Fig. 11 Esther Harris — Abstract free choice drawing

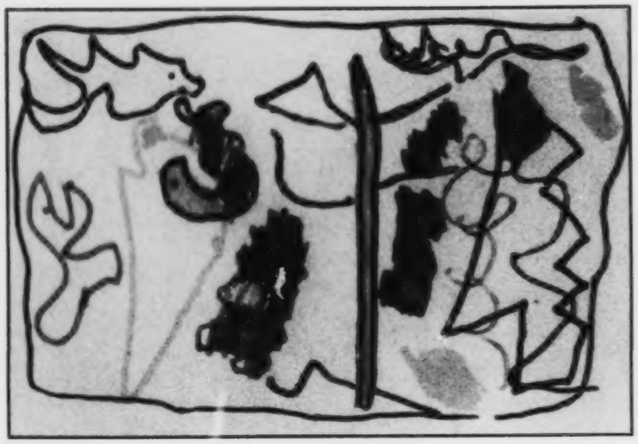


Fig. 12 Richard Coulter — Unit II

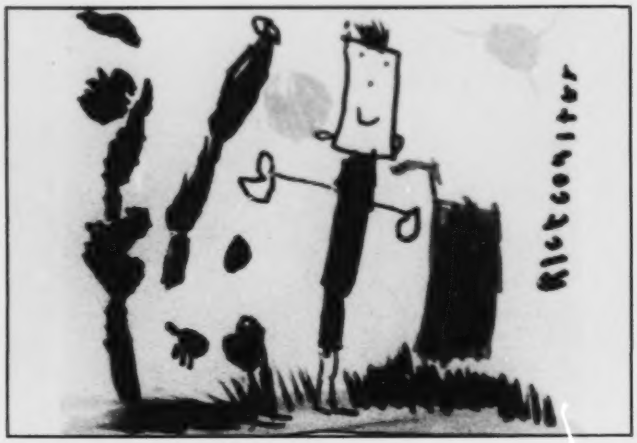


Fig. 13 Richard Coulter — Unit IV

It is significant to note that Mr. Duvall's drawings illustrate the impact of movement on his rigid and perseverative graphic thinking. His first flexible example of graphic thinking occurred after movement experiences.

The progress of graphic thinking from rigid to flexible responses was also reflected in the work of a number of John's classmates. This progress is demonstrated, for example, in Esther Harris's abstract drawings in which rigid repetitive copied black circles (Figure 10) were transformed into free line formations with splendid color (Figure 11). In another example, Richard Coulter initially drew controlled scribbles (Figure 12) which evolved into drawings of a representational human figure (Figure 13). The change in body concept is also exemplified in Esther Harris's drawings: from minute and immature stick figures (Figure 14) to more mature two dimensional human figures (Figure 15). Changes in the body concept of representational drawings by Brigette Taylor occurred from her first graphic expression (Figure 16) to her intermediate work (Figure 17) to her last drawing (Figure 18). In general, the focus of graphic, movement, visual, or image thinking modalities that replaced or supported the verbal thinking appeared as an effective way of approaching cognitive tasks for the participating MR adolescents.

The aim of this study was to prepare the subjects for further art and drama therapy in which the identification and expression of not only their thoughts and ideas, but also their conscious and unconscious feelings are essential components of the therapeutic process. It is often a danger when working with the MR population to interpret their deficient responses as emotionally based, when, in fact, their inability to receive and express cognitively may cause their responses. The differentiation of cognitive and affective etiology in their responses is one of the major challenges in working with the MR population.

BEST COPY AVAILABLE

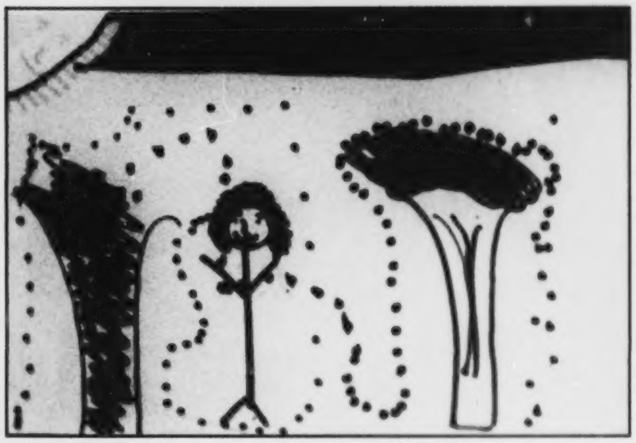


Fig. 14 Esther Harris — Unit I "Hansel and Gretel"

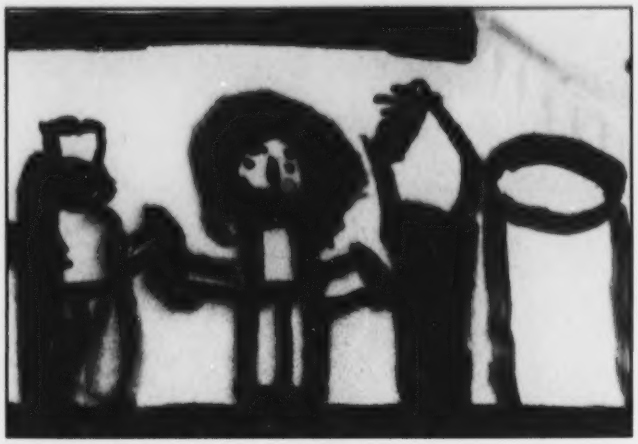


Fig. 15 Esther Harris — "Wiz II" Unit III

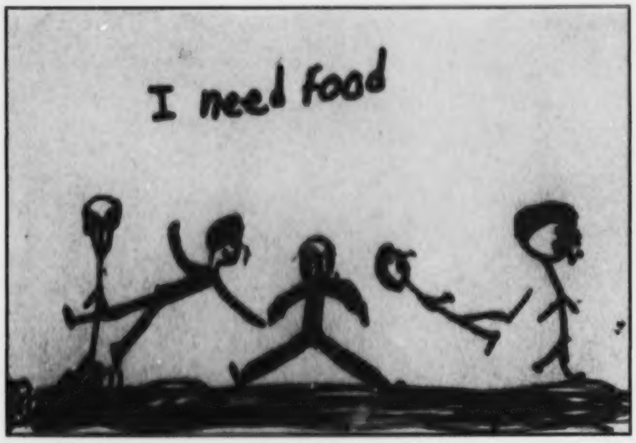


Fig. 16 Bridgett Taylor — "Hansel and Gretel" Unit I

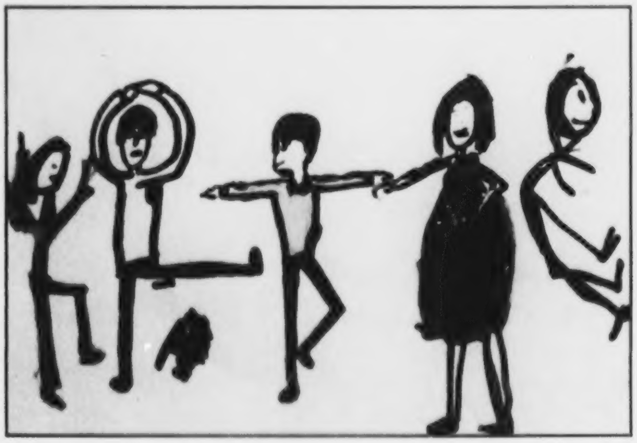


Fig. 17 Bridgett Taylor — "Movement" Unit II

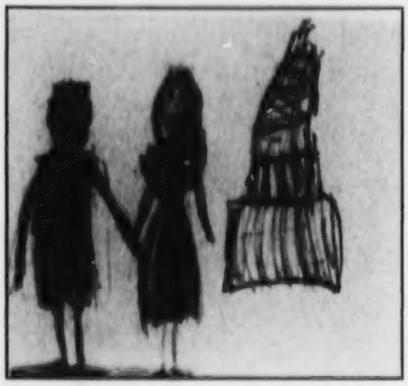


Fig. 18 Bridgett Taylor — "Sun Prince and Sad Princess" Unit VII

Recommendations

Longer art/drama therapy intervention might firmly establish the acquired flexible responses. The common oscillation between rigid and flexible responses in the subjects' drawings suggested that there was too little time to establish new schemes in the students' cognitive and graphic vocabularies. The MR population's development takes time; however, during the brief intervention the observed pace was even more time-consuming than anticipated. Therefore, time is an important element for the art/drama therapy intervention. For further research, the time frame should be expanded to reinforce and to stabilize the MR subjects' change from rigid to perseverative to more flexible graphic thinking patterns.

A control group, which the author did not obtain, should be used for further data collection and comparison.

> ***". . . during the brief intervention the observed pace was even more time-consuming than anticipated."***

Because it sensitively measures the slow progress of the MR subjects, the revised form of Silver Cognitive Rating Scale should be used for further research and implementation of the designed and revised curriculum. Also, other measures need to be developed to document

". . . measures need to be developed to document changes in rigidity and flexibility of graphic, image, movement and verbal thinking."

changes in rigidity and flexibility of graphic, image, movement and verbal thinking.

References

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorder (DSM-III)*. Washington, DC.

Baum, L. F. (1957). *The wizard of oz*. East Lansing, Michigan: Michigan State University Press.

Bettelheim, B. (1977). *The uses of enchantment—the meaning and importance of fairy tales*. New York: Pantheon Books.

Cane, F. (1951). *The artist in each of us*. New York: Pantheon Books.

Chiaci, G. and Richardson, J. T. E. (1980). The effects of dramatic play upon cognitive structure and development. *The Journal of Genetic Psychology*, 136:77-105.

Crawford, J. W. (1962). Art for the mentally retarded: Directed or creative? *Bulletin of Art Therapy*, 2:67-72.

Fino, J. K. (1979). Guided imagery and movement as a means to help disturbed children draw together. *American Journal of Art Therapy*, 18:61-62.

Furth, H. G. (1969). *Piaget and knowledge*. Englewood Cliffs, New Jersey: Prentice-Hall.

Furth, H. G. and Wachs, H. (1975). *Thinking goes to school—Piaget's theory in practice*. New York: Oxford University Press.

Ginsburg, H. and Opper, S. (1979). *Piaget's theory of intellectual development*. Englewood Cliffs, New Jersey: Prentice-Hall.

Harris, D. B. (1963). *Children's drawings as measures of intellectual maturity*. New York: Harcourt, Brace and World.

Hiltunen, S. M. (1983). Mask pantomime for the mentally retarded: A development from Finland. *The Alberta Art Therapy Association Journal*, 1:1.

Horowitz, M. J. (1971). Image formation: Clinical observations of a cognitive model. *The functions and nature of imagery*. Sheehan, Peter W. (ed.). New York: Academic Press.

Inhelder, B. (1968). *The diagnosis of reasoning in the mentally retarded*. New York: The John Day Company.

Koppitz, E. M. (1964). *The Bender-Gestalt Test for young children*. New York: Grune and Stratton, Inc.

Koppitz, E. M. (1975). *The Bender-Gestalt Test for young children. Vol. II, research and applications, 1963-1973*. New York: Grune and Stratton, Inc.

Lachman, M. (1973). The use of movement in art therapy. *Bulletin of Art Therapy*, 13:22-39.

Lowenfeld, V. (1957). *Creative and mental growth*. New York: Macmillan.

McGregor, M. (1973). Cognitive development through creative dramatics. *The Speech Teacher*, 23:175-182.

Milgram, N. A. and Furth, H. G. (1963). The influence of language on concept attainment in educable retarded children. *American Journal of Mental Deficiency*, 67:733-739.

Piaget, J. (1951). *Play, dreams and imitations in childhood*. New York: W. W. Norton and Company.

Piaget, J. and Inhelder, B. (1969). *The psychology of the child*. New York: Basic Books, Inc.

Silver, R. A. (1975). Children with communication disorders: Cognitive and artistic development. *American Journal of Art Therapy*, 14:399-447.

Silver, R. A. (1975). Clues to cognitive functioning in the drawing of stroke patients. *American Journal of Art Therapy*, 15:3-8.

Silver, R. A. (1977). The role of art in developing and evaluating cognitive skills. *Journal of Learning Disabilities*, 10:27-35.

Stellern, J., Vase, S. F. and Little, J. (1976). *Introduction to diagnostic-prescriptive teaching and programming*. Glen Ridge, New Jersey: Exceptional Press.

Ulman, E. (1966). Therapy is not enough. *American Journal of Art Therapy*, 17:13-16.

Ulman, E. (1977). Art education for the emotionally disturbed. *American Journal of Art Therapy*, 17:13-16.

Webb, C. and Koller, R. (1979). Effects of sensorimotor training on intellectual and adaptive skills of profoundly retarded adults. *American Journal of Mental Deficiency*, 5:490-496.

Webster, G. (1970). Unique aspects of emotional development in mentally retarded children. *Psychiatric Approaches to Mental Retardation*. Menolascino, F. (ed.). New York: Basic Books.

Weininger, O., Rotenberg, G. and Henry, A. (1972). Body image of handicapped children. *Journal of Personality Assessment*, 36:1.

Wilson, L. (1977). Theory and practice of art therapy with the mentally retarded. *American Journal of Art Therapy*, 16:87-97.

Professionalism in Practice

Presidential Address to the 1988 AATA Conference

Cay Drachnik, President, AATA, 1988-89

The theme of this conference is *Professionalism in Practice*. One day when I was thinking about what I might say on this subject, I happened to read a story in the newspaper about an elderly lady who was reluctant to fly on an old jetliner. Before climbing up the jet's rear stairs to board, she gazed up in dismay at the peeling paint and the nicks and dents in the plane's nineteen year old belly. "Captain" she called out to the pilot who was standing under the wing, "is this old plane really safe?" "Lady," he replied, "if this old plane wasn't so safe it wouldn't be so old."

Well, as art therapists, we have a knack for visualization and having read that story my mind started visualizing AATA as that nineteen year old plane getting ready to take a journey. As I visualized, it came to my mind that AATA, too, has had a rather bumpy past.

We've been financially broke, and financially flush; we've argued over philosophy, ethics, policy and procedure; we've fought amongst ourselves and with other organizations, in other words we've had our peeling paint and our nicks and dents. But you know what—just like that old plane we're still safe and we can still fly. And for another thing, there is now room on that plane for all of us, all our different philosophies—analytical, Gestalt, Jungian, behavioral, educational, humanistic—you name it. I believe we're all in there together, working toward the same goal—getting that plane off the ground, getting it to soar high and getting it to reach its secure destination. Can you all see it? Can you visualize it? I certainly hope so because I feel we are on the verge of a new beginning, a new journey to greater heights.

However, the weather report says that there are still some big black storm clouds ahead. So we will need to figure out how we can either get around them or fly through them in order to achieve the professionalism that is our goal and destination.

One of those clouds has to do with our job opportunities. We have a membership of approximately 2,600 people. In the United States, according to the American Hospital Association, there are a total of 60,841 hospitals. Out of that number there are 652 psychiatric hospitals. Not all of these psychiatric hospitals employ art therapists. Some of the other hospitals have psychiatric units and *may* employ art therapists. But you can see from the numbers that although hospitals may absorb quite a few of our members there is a discrepancy of about 1,000 to 1,500 people.

A number of *these* art therapists are currently working in substance abuse programs, convalescent hospitals, some with the developmentally disabled and some in outpatient mental health clinics. But if we are to grow, we need more employment opportunities. Therefore, I suggest we need to look seriously at two other options. One is private practice and the other is working for health maintenance organizations—HMO's as they are called.

For both of these we will need licensure or certification. Why? Because the Kennedy Waxman Bill, a national health bill that currently is working its way through the legislative process in Washington, D.C., calls for licensing or certification in the mental health section. We have been requesting that "registration" be added to that list, but have our doubts that this will come about. If this particular bill is not passed, there will most certainly be another similar one passed in the near future.

Today, we have art therapists licensed in three states, California, Texas and Florida. A few art therapists have been certified by the *National Academy of Certified Mental Health Counselors*, a national counseling certification agency. How have these art therapists been able to become licensed and certified? The answer is by taking counseling courses in addition to their art therapy curriculum.

I recently talked to Dr. Michael Campanelli of Wright State University. He said Wright State is well aware of the need for licensure for art therapists and their projected PhD program in art therapy will have a component geared toward that goal.

Currently AT students in their MA program are taking course work in the counseling departments and getting their degree there in order to become licensed. The same is true for California State University, Sacramento and other universities as well. Loyola Marymount and the College of Notra Dame in California are both working for accreditation with the American Association of

Marriage and Family Therapists so that their students may continue to be licensed.

Other university programs are taking a serious look at their options; unfortunately others are not. Some of our educational institutions are continuing to churn out poorly trained master degree art therapists who are unable to find jobs in their field or jobs that pay a decent wage. This is very unfair to our students. That's one of the big thunder clouds in the sky. Let's hit this one directly on and solve it—let's all urge our educators to look at national certification and their state licensing requirements and to add or incorporate the necessary psychological component to their core curriculums, before we turn students off to art therapy education. The board is also looking at the possibility of national certification just for art therapists but this may be a very expensive process and it may be a long way down the road. We shall see.

Another controversial cloud is the suggestion that a masters degree be required for AATA registration. At this time, we are still registering people with BA's plus 21 units in art therapy course work. Art therapists in the past have opted for alternate ways of becoming registered but that was the past; we are now looking at the future. If we accept the premise that we are counselors as well as art therapists, and we want to demonstrate that we are professionals, we must become more attuned to today's political realities, we must make our requirements stringent enough so that our members can become licensed or receive certification by an accredited national certifying agency and this of course will require a masters degree.

What about health maintenance organizations? Did you know that nearly two thirds of the major corporations offer HMO's as part of their benefit programs? Approximately 21 million people belong to them and some industry analysts believe that about half of all Americans will be enrolled in them by 1995. That's *big* business. Most HMO's limit the number of psychotherapy sessions that they will cover. But information from my friends who work for HMO's tell me that once the prescribed number of sessions are over, the patient frequently continues with them in private practice. Cost effectiveness and putting therapy on a business-like foundation is the way of the future. What could be more cost effective than having art therapists working with children using low cost art supplies versus expensive toys for play therapy. What more cost effective way is there of working with families, than using art materials to observe their true interactions while involved in an art therapy task. We truly are *cost effective*.

In addition to a few big black clouds I want to briefly point out the silver linings. We've made tremendous progress in the past 19 years. We have registration, we have a new Code of Ethics and a Standards of Practice ready for discussion and approval. In the past two years our chapters have doubled from 12 to 27. We have a program approval process in place. We have a newsletter, a journal, malpractice insurance, some of us are licensed and we are becoming so well known and so highly respected that others, less qualified, seem to be trying to take over our business. That we must prevent.

So let's all gather together—all the creative, caring, sensitive art therapists and board the jet together. Let's resolve to leave all the infighting, the rivalry, the fractionalism, all the old baggage behind. Instead, let's visualize ourselves sitting on that plane talking together, working together; let's visualize us reaching that goal of true professionalism in practice. We are the best, we know it, so let's make this vision a reality, let's make it really come true.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

Response to the Honorary Life Member Award:

Graces, Epiphanies and Exclamations

I am already a life member of the arts by virtue of my Welsh inheritance. "Blessed is the man born Welsh, not with a silver spoon in his mouth but with music in his heart and poetry in his soul."

My theme for my presentations at this conference has been, life is full of *graces, epiphanies* and *exclamations*. This moment is a combination of all three for me.

I am here by the *grace* of the influence of the sum total of those who have stood here, those bypassed who might have stood here, and those yet to be on this spot, symbolically speaking. If it were not for you, colleagues, students, friends of the present and past, I would not be receiving this 1988 Honorary Life Membership.

And looking to the future, if it were not for those who will yet stand here, I would not feel comfortable or complete. Anything worth doing takes more than one lifetime but each of us is allotted only one span. So, I am your root! You are my continuity!

Epiphanies are those high moments, manifestations of something greater than ourselves. Doing creative activity is such an experience for me, personally, but there have been even higher sacred moments of human exchange with patients practicing art in art therapy.

Art has a dynamic life and organic reality of its own. To ignore the power of the expressive art process, its dynamic content and action, is "like standing on a whale fishing for minnows."[1]

Looking back, such high occasions for me involved working with the people on the original ad hoc committee, the "pioneer-founders." Bob Ault and I at Menningers', a long time ago, had a dream now become reality. Myra Levick's natural executive ability graced and managed many of those early occasions. It was Felice Cohen's applied humor that salvaged the tough moments and loosened the tight situations. (I pause here and look over my left shoulder because Felice promised to be here in spirit in this moment.) Elinor Ulman added a clarity and intensity of purpose.

There were *exclamations* of confusion, competition and misunderstanding as we hammered out practical details. We went around and around but persisted for a couple of years discovering that we moved not in divergent directions but in concentric circles. The centrifugal force of our vision gradually centered our efforts and brought us to consensus and finally unanimity. Others were soon caught up in the swirl of energy and exuberance.

Even so, be reminded that art therapy's development is not so much determined by individuals as it is by the force and logic of the creative process. In the minutes before my being installed as the fourth president of AATA, I spontaneously recalled and shared with Bob Ault my childhood memory of a small, wide-eyed, anxious boy going to the circus. The ringmaster had announced that the first twelve kids to race to the center could ride on an elephant. A dozen of us climbed on. The beast rose up from a kneeling position. Suddenly came the awareness that it was alive and moving and that riding on the back of an elephant was by its grace and with its indulgence. (It reminded me that all who serve this organization do so with the assent of the collective, creative brawn of the membership body.)

Doing art is a phenomenal expediter of expression, of insight, of comprehension . . . and more. Dostoevsky declared that beauty will save the world and Matthew Arnold believed that we shall be saved by poetry.

I would like to assume that I am receiving this Honorary Life Membership because you have recognized what I have believed and demonstrated in the field of art therapy. *The aesthetic spirit is indeed life saving!* My further hope and conviction is that beauty and poetry may help to save the world. The experiences of conception, birth, nurturing and growth of the American Art Therapy Association have been full of *graces, epiphanies* and *exclamations* for me.

I cannot resist one final exclamation to all of you, *"THANK YOU!"*

Don Jones ATR-HLM

---

[1] Joseph Campbell

Response to the Distinguished Service Award

To receive the Distinguished Service Award from the American Art Therapy Association is a very special honor that must be shared with many of my friends and colleagues within the profession. I regret that I was unable to be in attendance at the 1988 Annual Conference to accept the honor in person when it was presented by our President, Cay Drachnik. A minor medical condition precluded my being there and I appreciate all of the greetings and well wishes from my friends.

Being a past member of the Education and Training Board has allowed me the opportunity to work closely with faculty, staff and students of most of the university, clinical training, and the institute programs. Having been a member of on-site review teams to evaluate art therapy programs throughout the country has strengthened my commitment to the uniqueness and importance of the art therapy profession and the need to retain our diversity in our graduate programs. The excellence that is noted in these individual differences of our training programs is perceived as a unique strength of AATA.

In dialogue with administrators while on review-team visits, I know that we are perceived as a young profession; being small in number when compared to other associations can sometimes interfere with rapid growth within our home institution. I have welcomed the opportunity to "sing the praises of art therapy" to administrators at other institutions in support of my colleagues and their quality programs. Our collective support for each others' programs is a must and I continue to encourage the cooperation that is being fostered by the current AATA officers.

I am honored to have been able to represent the art therapy profession in programs throughout the country, and look forward to continued professional associations. Thank you for honoring me with this distinction from the Association. I share it with my friends and colleagues and look forward to my continued associations with you.

Lewis K. Shupe, PhD, ATR, CCC-Sp
Professor, Art Therapy & Communication
Wright State University
Dayton, Ohio

COLLEGE OF NOTRE DAME

Cool It in . . .

S.F. this Summer
and Collect
Units Toward
Your
ATR

- The only **Master of Art Therapy** program in Northern California approved by AATA
- A **Master of Art Therapy** and **Marital and Family Therapy** which may lead to the MFCC Licensure
- Job opportunities in clinical, educational, and community agencies
- Master in Art Therapy – 37 units
- Master in Art Therapy & MFT – 51 units
- Graduate Art Therapy Institute – 21 units
- Can be completed in two summers and a winter internship!

COLLEGE OF NOTRE DAME
Graduate School
1500 Ralston Avenue
Belmont, CA 94002

(415) 593-1606

ON THE SAN FRANCISCO PENINSULA

Master's Degree Programs in Expressive Therapies and in Creative Arts in Learning

Offered by the Institute for the Arts and Human Development Lesley College Graduate School

Master of Arts in Expressive Therapies

For students interested in the creative modalities of art, music, dance/movement, and drama, presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning

For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theater studies.

For more information call or write the Institute for the Arts and Human Development, Lesley College Graduate School, 29 Everett Street, Cambridge, MA 02138-2790. (617) 868-9600, ext. 480.

Lesley College
GRADUATE SCHOOL

Lesley College is an Equal Opportunity/Affirmative Action institution.

BEST COPY AVAILABLE

Making Connections: Art Therapy and the Soviet Union

Margaret (Mickie) Anderson, *19571 Farwell Avenue, Saratoga, California 95070*

Last spring, I traveled to the Soviet Union with a group of 16 therapists, psychologists, and a psychiatrist. Two of us were Art Therapists. Our purpose was to meet with Soviet therapists, psychologists, and psychiatrists in the cities of Kiev (Ukraine), Moscow, and Villnius (Lithuania) for an exchange of workshops. These meetings had been set up by two members of our group who had been to the Soviet Union previously. As a group, we were prepared to present 6 to 8 workshops at any one time. Colleen Wells, the other Art Therapist on the trip, and I were to present the Art Therapy Workshop.

The whole trip was intense and exciting. Until we reached each city, we did not know the group(s) we would meet or the format of our meetings. We had to be flexible. We met in Soviet participants' apartments, halls of institutions, and even a small building in a park. In Kiev, we met with several different groups: family therapists, state psychiatrists, research psychologists, and creative psychologists. In both Moscow and Villnius, we had two day exchanges with the same groups. In Villnius we were greeted at the University as an "official" delegation, while in the other cities we were met more informally. Sometimes, the Soviets were not as interested in having an exchange as they were in hearing from us. Other times, we got into lively discussions of cases, methods of doing therapy, and emotional indicators in art.

I was excited to find art therapy techniques being used in a variety of ways in the places that we visited, with more of an emphasis on their use with children and as a diagnostic tool. Although we didn't have any workshops in Leningrad, we did visit a Polyclinic there which specialized in treating children with "neuroses." The walls of the therapists' offices were filled with art the children had done in therapy, and we interrupted several play therapy sessions. I did not see any sand trays but there were many puppets and toys.

In my workshop in Moscow, I met two Art Therapists/psychologists (Helen Novikova and Natasha ____) who act as consultants to the schools. They regularly use a series of projective drawings to assess children who are having problems. The projective drawings they use are as follows: self, family, class, teacher, and imaginary animal (accompanied by a story). We went through many of their examples and found that our way of looking at the art was very similar, with the exception of certain details. For instance, they did not consider knotholes in trees to have any projective significance and, in fact, said Soviet children didn't draw knotholes. We laughingly made many speculations about this interpretive difference, such as, "Trees grow differently in the Soviet Union," or "All Soviet children have happy trauma free childhoods." Actually, going through their children's artwork, and discussing the problems that they represented was not much different than going through the artwork of a similar population here. These were children that were causing problems in school and in their art were indications of aggressive tendencies, low self-esteem, need to protect oneself; histories of broken homes, alcohol abuse, and physical abuse. The therapists have their own Soviet sources of information but are also familiar with the work of Landgarten and Koppitz.

In Villnius, my co-leader for the exchange was Gintaras Khomentauskas, a psychologist who regularly uses art therapy techniques for their therapeutic value as well as their projective value. He is the author of a chapter on the use of family drawings as a diagnostic technique in a new Soviet text, *General Psychodiagnostics*, and is familiar with Helen Landgarten's book, *Clinical Art Therapy*.

This trip was a journey for me on many different levels and has had a great impact on my life, both personally and professionally. It has released a great deal of creative energy. I have several proposed cross cultural research projects with the psychologists in Moscow and Villnius and would welcome the participation of other Art Therapists. This is an era of great change in the Soviet Union and a time which lends itself to broader and deeper contact between our two countries. To me, the work that we do as Art Therapists can look beyond our obvious cultural differences and into some of our deeper concerns as human beings. It also gives us the opportunity to investigate how our cultural differences influence the way we look at things (art, for instance).

But the dream close to my heart is to have Helen

Novikova and Gintaras Khomentauskas come to the U.S. for a continued exchange. My goal is to have them here for our conference in San Francisco in November 1989. It will be a wonderful opportunity to expand on the concept of "family." I hope to make their visit multifaceted and welcome ideas toward this end.

What Ever Happened To . . .

Robin F. Goodman, ATR

Recently I came across a registration slip in the psychiatric emergency room of the large metropolitan hospital I now work in. The patient's name was familiar. The age could be correct, after all these years. Then I glanced at him through the glass of the nursing station. I looked up; he was almost two feet taller than I had remembered him some 9 years ago. Since it was a holiday and his "residence" clinic was closed he only came to the hospital for a check of the side effects he was having from his medication. I was quietly grateful he was not in distress. I interviewed him about his problem. The voice was deeper, that of a man, not a school age boy. Yet his flat, choppy speech and use of language was all too familiar. I listened to his story with more than the usual curiosity. He did not recognize me. I decided to call to check on his situation and spoke to a social worker who, once I identified that "I knew him when," wanted more information from me than I from her. In fact, the patient was new to the facility, was working on finishing his high school diploma and had recently stopped living with his father. The social worker was quite relieved to know that his current psychological state was a grown up version of what I had seen many years before. She was glad this was not some "downward drift." Before we sent him on his way I reminded him of our days together way back when. He remembered the place and groups, but not so accurately as me. Somehow I was happy to see that one boy was not failed by the system. Perhaps he would have survived and done as well given other intervention, but I believed that in some way, I contributed to a "treatment plan" that worked. I reassured myself that indeed he was functioning up to his potential and the various supports he had in his young life were offered and used wisely.

I can't help it. Every now and then I catch a glimpse of someone who seems familiar. Then I realize that I am wondering if it is a grown up version of a child I once worked with in art therapy. I teach a class and talk about a "favorite" patient or a "challenging" case and wish I had the long-term follow-up addendum to tell. The nature of our business is such that we often find ourselves doing work with no concrete finish and asking ourselves how what we do fits into the total scheme of someone's life. There are those days when I come home and wonder if I made a difference. I reformulate my short- and long-term goals, to hone in on something manageable. I tell myself that therapy is sometimes an uphill struggle for client and therapist. I tell myself "How dare I think I should be able to see change so quickly in a life that has been plagued by abuse, neglect, institutionalism, or chronic illness?" I repeat those lines, long familiar and sometimes faded, that I am a small speck in a life; I can not be a savior. I convince myself of the fact that however few or many art therapy sessions some are better than none. There are also those many minutes and days when it all works, it "clicks." I am walking on air after a session because no paper was ripped up, no one needed time out, a parent says her son is getting along better with kids at school, a cancer patient says he remembers the days he was cooped up in the hospital in isolation and I came in and "played and did stuff."

Thinking back, I can recall other incidents that brought home the notion of how my doing art therapy is a part of a whole person's whole life. There was the bright, energetic adolescent cancer patient who liked to help the younger children in the clinic with their art projects. She continued her own hobby of making dolls even while bedridden. We had talked about what I did and she asked about enrolling in an art therapy class while she was on leave from her own college. Her artistic mother has since carried on in her daughter's footsteps and is finishing her own degree in art therapy. She is thrilled with the new world that has opened up for her and recently told me "now I know what you were doing!" Then there was the beverage delivery boy who followed me down an aisle in the grocery store one day. He stopped me and asked if I was the art lady at the children's psychiatric hospital. He was married now with two young children. He said the hospital was a "crazy place" and he had to get out of there but the art was good and he remembered me and the three art therapists who had worked with him seven years ago.

Certainly there are those times when I surreptitiously hear about a patient of long ago who may not be doing as well as I hoped and whose name may be splashed across the news. Or I have found a student supervisee working with an adolescent who has returned three years later to the same hospital where I had seen him as a child. Whether working in large institutions or privately, we often do not have the luxury nor do circumstances allow that we terminate treatment when the work is done. There are many forces with which we must contend. We do the best we can given the situation and try to do the most we can while we have the chance. The reasons why I went into the field of art therapy are different from the reasons for my staying in the field over the years. But I do realize I have always been propelled by the quest for some personal reward. The feeling I get when I work with a patient and I think I am doing exactly what I want to do in life is difficult to articulate and possibly easier to express with color and paper. Our patients do not always say thank you, and working in a hospital they do not even pay us directly. Their appreciation or show of hard work often comes in a metaphoric message and in unpredictable ways. Not every session or case is a "success," but maybe, just maybe those three months or three years made a difference in someone's life and he or she is in a better place because of our time together. So we as therapists find ways to take care of ourselves, pat each other on the back, and delight in those simple unexpected events when we are acknowledged for our efforts. As an association and field of peers and peers-to-be, we support each other. Then, when we least expect it, there is a turning point in the therapy, or someone comes up to you and remembers the art, the trouble he or she shared, and your heart is touched again. And that one time in all the hundreds of encounters is what keeps me going and reminds me why I do this.

1988 AATA
MEMBERSHIP DIRECTORY
✸
Now Available through the National Office

$8.00 member **$50.00** non-member
$100.00 institution

NAME ____________________
ADDRESS ____________________
CITY ____________________
STATE ____________ ZIP ____________

▲ *Mail entire form to:* ▲
AATA NATIONAL OFFICE
1202 Allanson Rd./Mundelein, IL 60060

REVIEWS

The Hero Within; Six Archetypes We Live By

Carol S. Pearson, PhD, *Harper & Row, Publishers, San Francisco, 1986. 176 pages, $8.95*

Reviewed by: **Louise M. White, MA,** *Writer and Editor, Office of University Relations and Development, University of Maryland Baltimore County*

To begin, let us draw from May Sarton's *Joanna and Ulysses.* It is the story of Joanna who, as a child, witnesses the persecution and death of her mother and maiming of her brother, then lives with the sorrow of her father, and then joins the family in repressing the misfortune. One day, Joanna throws away the boredom of a clerical job, wanders, saves a dying animal, learns to express herself, and in finding herself saves herself, and saves her father. The story is about the hero within, and Joanna is the magician—not in the realm of magic shows and black magic, but as in the culmination of a journey.

That journey is the framework for Carol Pearson's *The Hero Within; Six Archetypes We Live By.* From among the many, Pearson has chosen six archetypes, those patterns in the human psyche—the martyr or the warrior, for example—which can be observed in action and even in body language; and has shown that by knowing the language of the archetypes we can "converse" with ourselves. The archetypes are friendly—they help us evolve and through them we grow. To the archetypes she has added the concept of the hero and the journey and the quest and the victory.

Heroes are no longer elite white men. There are no dragons, and the prize is not the damsel-in-distress. Rather, these heroes grow and change and journey but also help transform the kingdom. Pearson's hero, the hero within, effects change while meeting and dealing with the six archetypes.

The journey begins with the innocent. Loving, believing, a natural for children, the fall occurs through disillusionment with parents, or God, or government, et al. Then the escape, through work or addictions, which produces similar disillusionment and paranoia. Thence, the orphan, who sees that one must move out of the abyss, who fears being dumped, and who then looks for the rescuer—the sugar daddy, the political ideal—who is the warrior or martyr, who has only recently been an orphan and so needs to save and control. At the same time, filled with guilt and shame, the orphan looks for someone to blame, and finds "mother." Some orphans journey to become martyrs—replicating their mothers' actions—sacrifice and control—to their children. Others become warriors, getting all for themselves. For them, the danger is despair—the key to movement is hope. Within Pearson's configuration, there is the archetype of the wanderer, who begins in captivity, who needs to change, to recognize the person and the captor for what they are, and who needs to breach conformity. The wanderer must develop ego to develop self knowledge, without which one cannot give love or take love in. The wanderer is feared by men, who fear intimacy; and by women who, fearing loneliness, hang in as martyrs.

And finally, there is the archetype magician, only arrived at as the journey concludes. Not an overlord, not rabbit-in-the-hat, not martyr gift-giver but capable of great gifts; a wanderer who has found and is comfortable with the universe. The magician is not the warrior but the rain maker, not supernaturally empowered to make rain but for whom the rain can come. And finally, having coped with the Shadows, the magician, although not perfect, is revealed to be ourselves.

Pearson wrote *The Hero Within* while on sabbatical from the University of Maryland College Park, where she taught women's studies. With Katherine Pope, she has edited *Who Am I This Time? Female Portraits in American and British Literature* and has written *The Female Hero in American and British Literature.* Today, she is president of Meristem.

The Hero Within is scarcely confined to therapists, group workers, employers, teachers and others in the helping professions. It has appeal for general readers, too, because the book is about ourselves. We see ourselves, past or present, in the innocent, the orphan, the martyr, the warrior, the wanderer, and indeed, to some respect, in the magician. And in so doing, we see that the hero's journey is not linear, but a spiral—woven of the threads of the various archetypes. *The Hero Within* can also be used as a diagnostic tool for determining where clients, students, or employees are in their lives. Pearson suggests that the book, therefore, can help practitioners determine what kinds of therapy might best serve those clients whose current emphasis is on a particular archetype, and points to teachers and employers who deal with orphans (they need to work by rules); with martyrs (they need to be more autonomous); and with wanderers (they ought not be involved in teamwork).

This is not an "easy read" because the subject is complex and extremely thought-provoking. Not only are there several concepts of the journey, the hero and the archetypes. There is also the revision of the mythical hero as white male, saving the damsel in distress. And although God is not dead, gender (i.e. Goddess) is at issue.

Pearson writes well. She is a master at organization of very complex material, but somehow she is able also to weave in other concepts—differences between men and women, and dilemmas surrounding areas such as affirmative action. And, I suspect that Pearson is an excellent teacher, because she makes a point and drives it home by cogent examples, often drawn from current popular literature or film, examples which enable even the lay reader to grasp the point instantly. We all know Shug in *The Color Purple*. Shug is the magician. We all know about the struggle of Salieri when faced with the genius Mozart. Salieri is the martyr.

I enjoyed this book. It is optimistic and engaging. It commands you to think, but it works with you through to the end, inviting you to make your conclusions, and then even gives you a chance to discover the archetypes at work in your life. I found mine, all right. Read *A Hero Within* . . . and find yours.

Children Who Don't Want to Live—Understanding and Treating the Suicidal Child

Israel Orbach. *San Francisco, Calif.; Jossey-Bass Publishers, 1988, 267 pages, 6 examples of art work.*

Reviewed by: ***Drew K. Conger, MA, ATR,*** *Art Therapist in Private Practice, Harvard, Mass.*

"We can no longer tell ourselves reassuringly that very young children are incapable of contemplating, attempting or actually committing suicide . . . in this book, I have taken the position that suicidal behavior in young children develops in a particular kind of family setting—namely, a setting where the child is forced to try to solve an unresolvable problem. . . ." These phrases from the conclusion of this book may convey the importance of its entire message. Those of us who have worked extensively with the suicidal young have been waiting for a volume such as this; author Orbach's message is both urgent and timely.

Israel Orbach is senior clinical psychologist at the Adolescent Suicide Clinic of Albert Einstein School of Medicine, Yeshiva University, New York. He has been on leave from Bar-Ilan University in Israel since 1987. For thirteen years he has done clinical work in suicide and has developed suicide prevention programs, conducted research and published in this field. He clearly is well qualified to write on the topic of suicidal children.

Using a comprehensive review of current research and theory, followed by careful delineation of his own extensive phenomenological model (centered on the thesis of the unresolvable problem), Orbach has written a text of relevance for every therapist working with young clients; it also can be helpful to other professionals (e.g., teachers) in a position to assess suicidal risk in children. He presents his material in a clear and unpretentious style, with well-organized chapters, using case study vignettes throughout to illuminate his concepts. In addition, art therapists will note that he has included a few (very few) examples of suicidal children's art work in the text. Although Orbach writes more about young children, twelve years old and under, he also presents clinical material on adolescents.

The major portion of the book concerns the dynamics of suicidal thought. Indeed only the final chapter (out of eleven) addresses the evaluation and treatment of the suicidal child. An early chapter summarizes several theories of adult self-destruction, a far more extensive body of material than that concerned with suicidal tendencies in the young, and considers the implications for understanding the suicidal child. The author reviews psychoanalytic theory, Durkheim's sociological approach, Shneidman's phenomenological model, Smith's vulnerable personality theory and Maris' theory of the suicidal career.

In the third chapter Orbach offers a well-founded proposition that the most frightening aspect of children's self-destructive behavior, which rarely culminates in suicide, is that it is frequently a precursor to similar actions at an older age, sometimes ending in suicide. Of interest is his description of how children communicate their need for help and their preoccupation with death through words and through creative activity, and his outline of how suicidal behavior evolves. This chapter is followed by a discussion of children at risk, probing the role of personality traits (or states), especially the relation of depression to self-destructive wishes, and the clinically more useful identification of hopelessness as a diagnostic indicator. The author also explores the relationship of aggression, serious psychopathology, poor self-control, rigid thinking, suggestibility or oversensitivity, masochistic and obsessive inclinations, and sex and age differences to the development of suicidal wishes. This chapter offers the surprising (to this reviewer) conclusion that overt aggression or even impulsivity are not common factors among suicidal children, even though in other parts of the book Orbach stresses the frequency of violence in their families and violent means of death children most often choose.

Central to the author's theory is his thesis that child suicide is connected with specific life circumstances rather than to specific personality traits. In the chapter on this thesis he advocates the need to understand children's experiences through their own subjective impressions. These life circumstances include significant loss (especially death of a parent), parental suicide and depression, child abuse and neglect, family aggression, family crises and school pressures. The author considers their role in either directly fostering the conditions leading to self-destruction, or impacting indirectly through feelings of low self-esteem, depression or hopelessness, or even just increasing the stress in the child's environment. When destructive, all these conditions seem to present an unresolvable problem which the child must face.

In the following chapter the author presents convincing data on how children develop an early understanding of the nature of death. Of particular interest is the information that self-destructive children "distort death in a way that makes the execution of it or the consideration of it easier," as a defense enabling them to view their own death, but not death in general, as a better form of life. I confess to a little disappointment that not here nor anywhere else in the book does Orbach mention the possible effect television programs might be having on children's concept of death, particularly violent death.

One can hardly understand a child without understanding her family. In the next chapter, the author stresses the force a symbiotic family relationship that lacks empathy can exert on a child's decline to suicidal behavior. He also considers the impact of the multiple-problem family on that decline and the "deadly message" of rejection some children receive.

After a complex in-depth case study, Orbach then focuses on child suicide theories, including Schechter's psychoanalytic "internalization of aggression" explanation, Ackerly's theory of the fear of losing control of aggressive sexual feelings toward the parents, Furman's theory of the "sadistic-masochistic nucleus," Sabbath's "expendable child" theory, Pfeffer's ideas of object relations and negative self-image, Richman's concern with symbiotic relations as a cause of child suicide, and a consideration of the impact of familial pessimism toward life. The author then reviews how the slow growth of suicidal thought is related to increased isolation (Jacobs) and to conflicts with the self (Novic), and finally describes his own model of multiple dynamics leading in different ways to self-destruction. Nor does Orbach neglect to mention the recent research into genetic and biochemical variables which may contribute to suicidal feelings. He sums up this section by pointing out that there are probably only three causal constructs underlying suicide theory: attribution of suicide to special life situations, to developmentally increasing stressors, and to "potential interactions between given circumstances and personality dimensions." He then offers his own theoretical postulate: the thesis of the unresolvable problem.

The thesis is compelling because it clarifies the child's subjective feeling that she cannot solve an important dilemma thrust upon her, is restricted in choices, finds new frustration with each attempt at solution, while at the same time her own struggle merely hides a larger, deep family conflict. The author cites pertinent clinical material to illustrate each aspect of this complex phenomenological state. Discussing the ambivalence inherent in the death wish and the four attitudes it engenders (repulsion and attraction to death, repulsion and attraction to life), Orbach describes two of his own empirical studies (Orbach et al., 1983, 1984) which seem to have important implications for diagnosis and treatment of the suicidal child. Results indicated that "Children with suicidal tendencies maintain their thirst for life; their attraction to death is a defense serving their self-destructive tendencies."

The next and to me most significant chapter of the book is the final one which outlines assessment and therapy issues. The author suggests directions for treatment, starting with assessment of the family as a means of identifying the unresolvable problem which he believes can only be revealed through family sessions. Evaluation of parental conflicts and parental depression, the child's alienation, symbiotic processes, the child's attraction to death and the child's social and emotional responsiveness should be accomplished first. Once the unresolvable problem has been isolated, Orbach states, the therapist often must work on it at multiple emotional levels starting sometimes with the parents alone. Other treatment issues include encouraging flexibility in the family's coping skills, helping the members work through crises, uncovering destructive family secrets and dealing with resistance in the form of denial and even aggression toward the child, while reducing symbiosis. Goals of the therapist include increasing the family's tolerance of conflict and positive communication. Then, differentiating in a helpful way between treating the suicidal child and other child clients, Orbach provides a framework of interventions which include providing corrective experiences (e.g. affection), giving alternatives to self-injury, confronting death fantasies, examining the suicide choice in an empathetic manner, splitting between the positive and negative self-images and allying with the positive self rather than confronting the suicidal self.

The only area in which this book seems deficient and even misleading is in the presentation of the art work of these despairing children. Orbach suggests that one boy tried to "sublimate" his suicide through drawings of cemeteries, crosses, hanging figures. It would seem more likely to an art therapist that this child was desperately trying to gain control of his frightening thoughts through these pictures; sublimation through art is rare indeed. Orbach refers to overt suicidal expressions as "death wishes and suicide threats; displays of pathological curiosity regarding death; repeated games dealing with death and suicide; and, *more obliquely*, drawings, songs and stories of destruction" (italics are the reviewer's). However, most of us would agree that many suicidal children's drawings are far from "oblique." He also writes of the function of creative expression as a means to "postpone" death but does not reference this statement. And although he acknowledges the usefulness of drawings for information on how young children view death at different ages, his statement about one of his client's art work that "some of the drawings reflected sadness and depressive qualities: dark colors, black skies and earth," reflects a simplistic view of children's use of color which can be highly idiosyncratic. In relation to one drawing in the text (Figure 5) in which a twelve-year-old girl had X'd out a face and scratched lines across a human form, he relates a story of failure that the girl told about the picture and comments, "The story that accompanies the drawing demonstrates the validity of such drawings as a diagnostic sign of suicidal tendencies." It would seem apparent to an art therapist that the painfully explicit picture has its own validity, and indeed that drawings without words are sometimes the only means very young or inarticulate suicidal children may have to describe their anguish and to ask for help. Finally, as might be inferred from the above comments, Orbach never acknowledges the existence of art therapy, consistently referring only to "drawings" as a diagnostic tool, and neither art nor art therapy are included in the Index, only "Drawings."

In balance, however, *Children Who Don't Want to Live* is an invaluable aid to the understanding and treatment of the self-destructive child, clearly written, well researched and timely, with an extensive reference list and adequate (based on random check) index. The excellent blend of theory, empirical research, case material and therapy suggestions, as well as the significant questions this book raises about children's heretofore underestimated comprehension of life and death, make it an important contribution to the fields of suicidology and psychotherapy.

The Dynamics of Art Psychotherapy

Harriet Wadeson, PhD, ATR *(New York: Wiley, 1987, 328 pages)*

Reviewed by: ***Don Jones, ATR, HLM***

The Dynamics of Art Psychotherapy overarches many facets of the broad spectrum of the field of art therapy in four major parts: The Art Therapist, The Elements of Art Therapy, Phases of Art Therapy and Context of Art Therapy. Each principle section is subdivided. Part One rightly emphasizes that it is not the "what" but the "who" which is essential; the therapy process begins with the person. Part Two concentrates on the elements of art therapy but the *focus* is far-ranging beyond a simple description of materials, spaces and project characteristics converging more on relationships and group approaches.

The title including the words 'dynamic' and 'psychotherapy' led me to expect (or project) a clinical presentation of the 'psychodynamics' of art therapy. Even so, Parts Three and Four were not disappointing. This book is well organized to serve as a text for students, interns, as well as being a ready reference for the beginning clinician. It is the kind of compilation of material that few besides Harriet Wadeson, with her extensive experience, could do.

Together with her first book, *Art Psychotherapy* focused on specific clinical syndromes, one has an anthology of valuable information and vicarious experiences. The choice word is not eclectic but "synergistic," a sensitive fusing of information and insights by a practiced art therapist.

The autobiographical style is education at its best, a one-to-one, tutorial approach. The author generously and intentionally reveals her personality to the reader in photographs, self portraits, projects and descriptions of clinical interactions. We are invited to enter her inner private spaces and view her as teacher and role-model.

Parts One and Two may seem to be familiar material to many who have explored other previously published literature. I became most interested at Part Three, which deals with assessment and treatment of diverse populations, and Part Four relating the art therapist's practice in a broader context to include other professional disciplines and the community.

I look forward to a third book, perhaps, even more specifically and intensively centering on the art therapist's understanding of the psychodynamics of art psychotherapy.

● **AATA** ●
is Moving
to new and more convenient office space.
•●•
Our new address effective April 1, 1989 will be
1202 ALLANSON RD.
MUNDELEIN, IL 60060
Phone No. (312) 949-6064
Fax No. (312) 566-4580
Management has not changed.
You may still contact:
EDWARD J. STYGAR, *Executive Director*
MARCIA CHAMBERS, *Administrative Assistant*
MARY BUCKLEY, *Director of Convention Services*

MIAMI®

18TH ANNUAL CONFERENCE PROCEEDINGS
1987 BAL HARBOUR, FLORIDA

The 1987 AATA Conference Proceedings, "New Directions in the 80's" held in Miami, Florida, November, 1987, are available through the AATA National Office in abstract form.

—●—

PRICE PER COPY:

Member - - - - $15.00 each   Non-member - $20.00 each   10 or more - - $12.00 each

QUANTITY   COST   TOTAL

________ x ______ = ______

SEND TO:

TO ORDER COPIES: Mail order form ➧
along with payment to:

- American Art Therapy Association,
1202 Allanson Rd.
Mundelein, IL 60060.

Please make checks payable
in U.S. funds to AATA.

NAME/INSTITUTION ______________________ MBR ID #

ADDRESS ______________________

CITY ______________ STATE ______ ZIP CODE ______

TELEPHONE ______________________

- -

◉ CHICAGO ◉

19TH ANNUAL CONFERENCE PROCEEDINGS
1988 CHICAGO, ILLINOIS

The 1988 AATA Conference Proceedings, "Professionalism in Practice" November, 1988, are available through the AATA National Office in abstract form.

PRICE PER COPY:

Member - $15.00 each   Non-member - $20.00 each   10 or more - $12.00 each

QUANTITY   COST   TOTAL

________ x ______ = ______

SEND TO:

TO ORDER COPIES: Mail order form ➧
along with payment to:

- American Art Therapy Association,
1202 Allanson Rd.
Mundelein, IL 60060.

Please make checks payable
in U.S. funds to AATA.

NAME/INSTITUTION ______________________ MBR ID #

ADDRESS ______________________

CITY ______________ STATE ______ ZIP CODE ______

TELEPHONE ______________________

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(312) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS	**Members**	**Non-Members**
Creativity and the Art Therapist's Identity *(1976) 118 pages*	$5.00	$7.00
Art Therapy: Expanding Horizons *(1978) 142 pages*	$5.00	$7.00
Focus on the Future: the Next Ten Years *(1979) 151 pages*	$6.00	$8.00
The Fine Art of Therapy *(1980) 124 pages*	$7.00	$9.00
Art Therapy: A Bridge Between Worlds *(1981) 119 pages*	$7.00	$10.00
Art Therapy: Still Growing *(1982) 172 pages*	$10.00	$14.00
Art Therapy: New Directions in the '80s *(1987) 110 pages*	$15.00	$20.00
Art Therapy: Professionalism in Practice *(1988)*	$15.00	$20.00
Art Therapy: Journal of the American Art Therapy Association Rates: Individuals — U.S. $23.00; Foreign $30.00; Institutions — U.S. $27.00; Foreign $36.00		
Art Therapy: Journal — Back issues	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings *Use of the Creative Arts on Therapy (1979)*	$5.00	$7.00
National Art Education Association Journal: Special Issue *Art Education, Vol. 33, No. 4 (1980)*	$3.00	$4.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 x 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

* Note: for **Publications** postage/handling, add $3.00 for the first unit item, $.75 each additional unit.
SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS.

** *Foreign Orders: Require pre-payment for items and then will be* ***billed*** *for shipping charges as you instruct on order:*

Air Mail charges (1 week delivery) or Ground Services charges (2 month delivery)

FILMS (Rental/Purchase)			
Art Therapy: Beginnings *(1977) color/sound, 45 minutes*	16mm Rental only:	$40.00	$50.00
	½" VHS, Purchase only:	$50.00	$80.00
Michael *(1977) color/sound, 12 minutes*	16mm Rental only:	$30.00	$35.00
	½" VHS, Purchase only:	$50.00	$80.00
Art Therapy *(1981) color/sound, 12 minutes*	16mm Rental only:	$35.00	$45.00
	½" VHS, Purchase only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery *(1978) color/sound, 32 minutes*	16mm Rental only:	$40.00	$50.00
	½" VHS, Purchase only:	$50.00	$80.00

* Note: for **VHS Films Purchase** postage/handling add $2.50 for each film.
* Note: for **16mm Rental** add $7.00 for postage and handling.

ORDER FORM: *Make checks payable in U.S. funds to AATA, and mail to the above address*

Indicate Quantity of Unit Items Below		Cost/Unit		Total
____________________	( ) ×	____________	=	____________
____________________	( ) ×	____________	=	____________
____________________	( ) ×	____________	=	____________
____________________	( ) ×	____________	=	____________
____________________	( ) ×	____________	=	____________
		____________	=	____________
		Total Unit Costs	=	____________
		*Publications Postage/Handling	=	____________
		*Films Postage/Handling	=	____________
		Total Enclosed	=	____________

10 or more copies of any single issue: 15% discount on total cost.
Discounts are available when purchasing quantities.
Set of four Proceedings (consecutive years): 20% discount on total cost.

SEND TO: ______________________________ MBR ID#: ____________

____

____
City State Zip Code

BEST COPY AVAILABLE

PUBLICATIONS

	Member	Non-Member	Institution
Membership Directory/Bylaws	$8.00 (includes postage and handling)	$50.00	$100.00
** Art Therapy Bibliography	*SASE	$1.00	
** Educational Guidelines	*SASE	$1.00	
** Educational Programs List	*SASE	$1.00	
** Standards and Procedures for Registration	*SASE	$1.00	
** Criterion for Professional Membership	*SASE	$1.00	
Professional Membership Application	FREE	FREE	
Registration (ATR) Application	FREE	FREE	
Associate/Student New Member Applications	FREE	FREE	
** Art Therapy Model Job Description	*SASE	$1.00	
** Code of Ethics	*SASE	$1.00	
** Art Therapy Media List	*SASE	$1.00	
** Standards of Practice	*SASE	$1.00	
Model Licensing Bill	$12.00	$25.00	

*SASE — Self addressed stamped envelope

**Available in multiples:

1-9	FREE
10-50	$5.00 Postage & Handling
50-100	$10.00 Postage & Handling

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

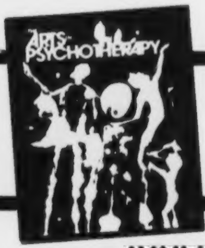
Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1989. Enclosed is my check, payable to AATA, for $23.
Name ________________
Address ________________
City __________ State _____ ZIP _____

The interdisciplinary journal devoted to the creative arts as healing arts.

THE ARTS IN PSYCHOTHERAPY

An International Journal



FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Assistant Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

Dedicated to scholarship in the creative arts therapies, THE ARTS IN PSYCHOTHERAPY presents innovative research in artistic inquiry and expression, and its use in the treatment of mental disorders.
THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

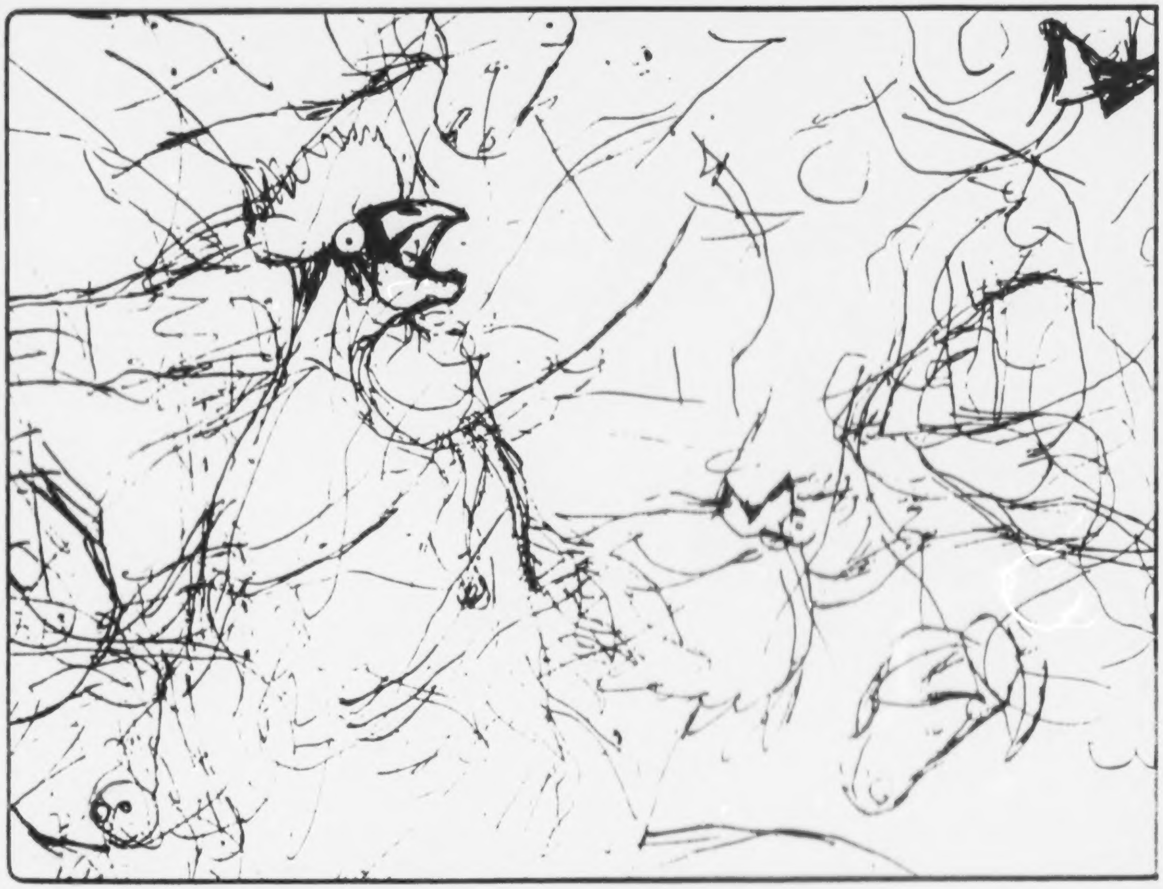
SUBSCRIPTION INFORMATION
ISSN: 0197-4556 Volume 16, 1989
Published 4 issues per annum

Annual Institution Subscription Rate (1989)	US$110.00
Two-year Institution Rate (1989/90)	US$209.00
Individual Rate (1989)	US$ 40.00
Student Rate (1989)	US$ 16.00

PERGAMON PRESS, INC.
Maxwell House, Fairview Park, Elmsford, NY 10523
PERGAMON PRESS plc
Headington Hill Hall, Oxford OX3 0BW, England
A Member of the Maxwell Communication Corporation Group of Companies

ART THERAPY

Journal of the American Art Therapy Association



Volume 6, Number 2 July 1989

- Nadia Revisited: A Study into the Nature of Regression in the Autistic Savant Syndrome
  David R. Henley, MA, ATR
- Visual Transitions as Art Therapy
  Gerald S. Evans, MA
  Jerry L. Fryrear, PhD, ATR
  Irene E. Corbit, PhD, ATR
- Drawing Out the Unique Beauty: Portraits
  Judith Costello - Du Bois, MA
- Post-Graduate Group Supervision for Art Therapists
  Debra Greenspoon Linesch, MA, ATR, MFCC

792

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060 (312) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1988-1989

Board of Directors

President
Cay Drachnik, MA, ATR, MFCC
President-Elect
Linda Gantt, MA, ATR
Secretary
Elaine Laskey, MA, ATR
Treasurer
Dee Spring, PhD, ATR, MFCC

Committee Chairs

Affiliate Chapters
Trudy Manning, ATR
Bylaws
Roberta J.H. Shoemaker-Beal, MFA, ATR
Education
Shirley Riley, MA, ATR, MFCC
Governmental Affairs
Nancy Hall, MA, ATR
Membership
Cathy A. Malchiodi, MA, ATR
Publications
Pat B. Allen, PhD, ATR
Research
Harriet Wadeson, PhD, ATR
Standards
Doris Arrington, EdD, ATR, NCC
Clinical
Paula Howie, ATR

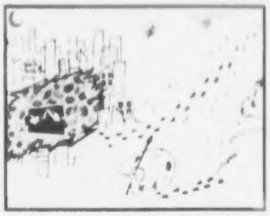
Executive Director

Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association



Editorial

Gary C. Barlow, EdD, ATR 42

Articles

Nadia Revisited: A Study into the Nature of Regression in the Autistic Savant Syndrome,
David R. Henley, MA, ATR 43
Visual Transitions as Art Therapy,
Gerald S. Evans, MA,
Jerry L. Fryrear, PhD, ATR
Irene E. Corbit, PhD, ATR 57
Drawing Out the Unique Beauty: Portraits
Judith Costello-Du Bois, MA 67
Post-Graduate Group Supervision for Art Therapists
Debra Greenspoon Linesch, MA, ATR, MFCC 71

Viewpoints

Poem: "Michael" (Whom Carol Loves)
Perie Longo, PhD 76

Reviews

Adolescent Art Therapy
by Debra Greenspoon Linesch, MA, ATR
Reviewed By: Marcia Rosal, PhD. ATR, ... 77

Volume 6, Number 2 July 1989

About Our Cover

Sophisticated drawing of a cockerel by Nadia, an autistic savant at the age of 6.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Aina O. Nucho, PhD., ATR, ACSW
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Marcia May-Chambers

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Susan LaMantia O'Connor, MA, ATR
Paul Rodenhauser, MD
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 1202 Allanson Rd., Mundelein, IL 60060 (312) 949-6064

Copyright © 1989 American Art Therapy Association

BEST COPY AVAILABLE

EDITORIAL

Four excellent articles — with an interesting variety of content — are presented in this issue. David Henley writes about his visits with Nadia, the autistic savant about whom much has been written. "Nadia Revisited: A Study into the Nature of Regression in the Autistic Savant Syndrome" offers insight into her art work and behavior after a lapse of approximately twenty years, when her story first was told. Henley visits Nadia at her home in England and tells of his interesting experiences and personal insights.

"Visual Transitions as Art Therapy," by Gerald S. Evans, Jerry L. Fryrear and Irene E. Corbit, is the documentation of a study involving a multimodal art therapy procedure using photography, art, movement, video and verbal discussion. The authors provide a theoretical rationale for their work and statistical evidence for the effectiveness of this multi-arts procedure.

Judith Costello-Du Bois writes about her portrait work with patients or clients in the article "Drawing Out the Unique Beauty: Portraits." She mentions that she has done portraits "of old people, hospice patients, children with critical illnesses, and adults who have been struggling with a mental illness." Costello-Du Bois shares her thoughts about using portraiture with patients, and the uniqueness of the process within these special settings.

"Post-Graduate Group Supervision for Art Therapists" is the title of the article by Debra Greenspoon Linesch, with interviews by Julie Holmes, Marcia Morton and Sandra Stark. Their comments on the beginning stages of treatment, setting goals, special techniques and clinical style illustrate how the group discussed parallel and different stages of clinical development.

The Viewpoints section offers a poem by Perie Longo. We are pleased to publish this poem (and others in previous issues), art work by art therapists or others, statements by persons who have views on issues or concerns that affect us all. I want to encourage your participation in this Viewpoints section, for it is one way to share your concerns about certain issues, offer your support in specific areas, bring to the fore an important consideration for readers to think about, and to let others appreciate personal art statements. All submissions should be appropriate for this journal, and should fit into the format on one or two published pages. Submissions are subject to editorial review.

It is important to occasionally remind readers about the need for confidentiality when working with clients or patients, and to exercise the utmost care when submitting articles for publication. As has been mentioned in previous issues of *Art Therapy,* the author must obtain clearance or release forms from those patients or clients (or from other legally designated persons), and must keep these forms on hand for reference when needed. Pseudonyms should be used, and submitted art work (i.e., photographs of art work) should not include names of clients or patients. If a name occurs on the piece of art work, the name should be blocked out prior to photographing. *Never* send a photograph with a name on it; this violates confidentiality of the client or patient.

As an example of what *should* be done, the authors of the article "Visual Transitions as Therapy" (Evans, Fryrear and Corbit), included in this issue, sent copies of the release forms with their article. Notations were also made that "Fred" and "Connie" are pseudonyms of the people cited in their article. This seems to be correct procedure that is easy to follow and yet follows the rule of addressing the issue of confidentiality.

It is the responsibility of the author to address the issue of confidentiality when preparing an article. Be sensible and take the necessary precautions for personal protection and client anonymity relative to publication and dissemination of information. The author may wish to include copies of release forms (not the originals) with the submitted article. Whether submitted or not, certainly the author must have the original copies in his/her possession prior to submitting the article for review and possible publication.

It is not too early to plan for the coming annual A.A.T.A. Conference, to be held in San Francisco, California, November 16-20, 1989. Note that the Conference ends on Monday (November 20th); this is a change from previous years. Our 20th annual meeting has "Painting Portraits: Families, Groups and Systems" as its theme. Plan now for the trip West, and for what will undoubtedly be an outstanding conference.

Gary C. Barlow, EdD, ATR
Editor, Art Therapy

Nadia Revisited: A Study into the Nature of Regression in the Autistic Savant Syndrome

David R. Henley, MA, ATR, *Associate Professor of Art Education and Art Therapy, School of the Art Institute of Chicago*

Abstract

This paper addresses artistic and behavioral regression in individuals diagnosed as being autistic savants. It recounts a research study undertaken which led the author to visit Great Britain to work with Nadia who is perhaps the most notable case of savantism. Nadia's case account, first published by Selfe in 1972, described the five year old developmentally disabled, autistic child who despite a range of severe deficits, created drawings in an astoundingly precocious, mature style. Over the years, however, her gifts began to inexplicably fade until her art plateaued at a level commensurate with the child's retardation. The scope of this paper addresses this art therapist's attempts to reawaken Nadia's creative drive in both an aesthetic and therapeutic context.

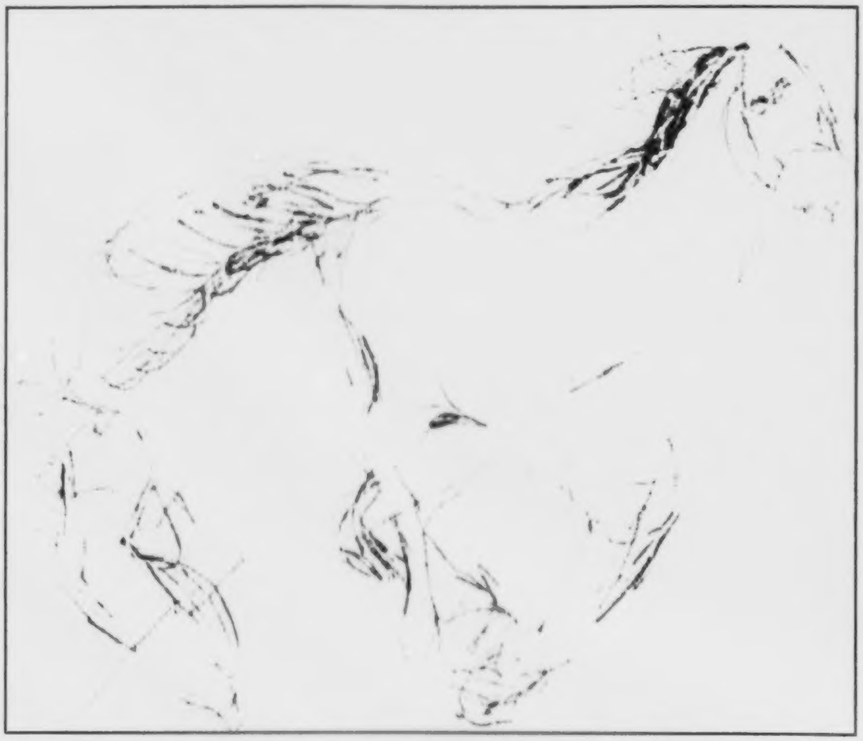


Fig. 1 Remarkably drawn horse drawn in motion at age five.

Introduction

In 1977, British psychologist Lorna Selfe published a seminal study involving an autistic child who possessed extraordinary artistic ability. During the period of Selfe's research, Nadia was a six year old, functionally retarded child, whose deficits included echolalic speech, poor motor coordination, cognitive retardation and autistic affect. Despite the profundity of these handicaps, Nadia created contour drawings in a precocious representational style. Her works, which were drawn from memory, were not merely realistic reproductions which displayed optical accuracy. While they did utilize sophisticated elements of foreshortened perspective and anatomical realism, they also possessed an improvisatory, idiosyncratic charm. The line work combined compulsive, chaotic scribbling with airy, flamboyant draftsmanship. So great was Nadia's virtuosity at six years, that her work was compared to such masters as Daumier (Pariser, 1981), Delacroix (Arnheim, 1980), Ucello (Gardner, 1980) and Da Vinci (Winner, 1986). (Figure 1)

Nadia's giftedness emerged quite spontaneously as she was not trained or encouraged to draw as a child. Her style inexplicably manifested in relatively mature form. However, after five years of remarkable artistic productivity, her drawing prowess gradually began to wither until at age 20, her work was commensurate with a mentally retarded individual functioning in the severe range. (See Figure 5) It was this dramatic regression that makes the case of Nadia all the more mysterious and sensational.

What precipitated such a dramatic loss? What measures, if any, could have supported the child through this regression? What effect might art therapeutic interventions have had upon averting or mollifying this regression?

This article recounts a recent trip to Great Britain where I conducted research on the autistic savant syndrome as a visiting fellow at the University of Kent in Canterbury. With the support of the Rotary Foundation and the American Art Therapy Association, I visited and studied autistic savants under the tutelage of Roger Cardinal, author of *Outsider Art*. As part of this project, I sought to include a visit with Nadia. After two years of negotiation with Lorna Selfe and Nadia's family, I was invited to visit and possibly work with the former prodigy.

My intentions were initially quite clear; first, I must admit, was to satisfy my curiosity which had stirred since the late seventies when this fascinating case was first published. I hoped to learn what had become of Nadia and her art. I felt the multidisciplinary community might also share in this desire to follow up such a sensational case. However, as the project evolved, the emphasis eventually took a different turn. The focus soon became more active, as I eventually attempted to offer my services to Nadia and her family as one who is skilled at facilitating the art process in individuals with autism. The goal then became to attempt to reawaken Nadia's creative urge so that art could be an enriching part of her life once more.

Definition of Autism and the Savant Syndrome

In the 1940's Kanner first described the symptoms that later came to be known as Classical Early Infantile Autism. These symptoms included intense degrees of self-stimulation, obsessively ritualized behavior, echolalic speech, hyper/hypo sensitivity to sensory stimuli and a pronounced affective indifference to interpersonal contact. While this definition has broadened over the years, it still effectively describes a population which differs from the mentally retarded who exhibit autistic-like behaviors. Classically, autistic children are often physically striking, with delicate features and excellent motor coordination, who seem also to possess intact intelligence. Goodman (1972) first discriminated the autistic savant from the idiot savant in deference to the parents of autistic children, who understandably objected to the inaccurate and pejorative connotations of the word idiot. Rimland (1976) and Hill (1978) were first to discriminate the autistic savant from the purely autistic individual, by denoting the 'islets of intelligence' syndrome. Rimland studied 5,400 case studies of autistic children and found that 531 cases showed isolated yet extraordinary abilities in areas such as music, motor coordination, extra sensory perception, mechanical genius, memory and visual art. Out of all of these categories, 30.4% of autistic savants demonstrated visual art proficiency. Hill (1976) found a much lower incidence of savantism among the mentally retarded, studying 90,000 institutionalized retardates, with 54 cases emerging as 'idiot' savants at .06%. In keeping with the autistic population as a whole, male savants outnumbered females four to one.

The most striking feature of the savants' 'islets of intelligence' phenomenon is the profound contrast between the extraordinary skill and the individual's overall functioning. In most instances, the giftedness is so intensely focused or narrow in its application, that it does not contribute to the individual's capacity to function in the day-to-day world. For example, the savant who can instantly memorize a list of twenty digit serial numbers may lack the ability or motivation to master the simplest self-help activity such as feeding or dressing. This phenomenon was present in Nadia's case; she demonstrated a range of debilitating handicaps which contrasted sharply with her drawing skill. Yet even Nadia's artistic ability was pervaded by a tenuousness and fragility. Her work could only proceed under certain conditions—she would not draw on command, which precluded structured art education; her medium was limited to one certain type of pen and her themes obsessed over an idiosyncratic group of animals. Nadia's perseverative and obsessed artistic process and products are, however, within the norm for this extraordinary population. Most case accounts involving autistic or idiot savantism point to an obsession with particular media, theme, studio conditions and artistic style (Henley 1986, 1989).

"After two years of negotiation . . . I was invited to visit and . . . work with [Nadia]."

". . . Nadia's artistic ability was pervaded by a tenuousness and fragility."

Etiology of Savantism

Before the issue of regression in the population can be addressed, some remarks concerning the etiology of autistic savantism are in order. For the purposes of this paper I have chosen to follow a physiological model of autism, drawing upon the work of Rimland's neurological theory. Following this review, I will attempt to extend his theoretical framework to consider the affective implications of autism and savantism.

The principal construct of Rimland's theory (1978) is that autistic savantism is a neurologically based disorder involving problems with sensory modulation and cognition which results in attention deficits. Rimland considers the savant as having a severe disorder of the attentional mechanism that is pathologically locked into a indestructible

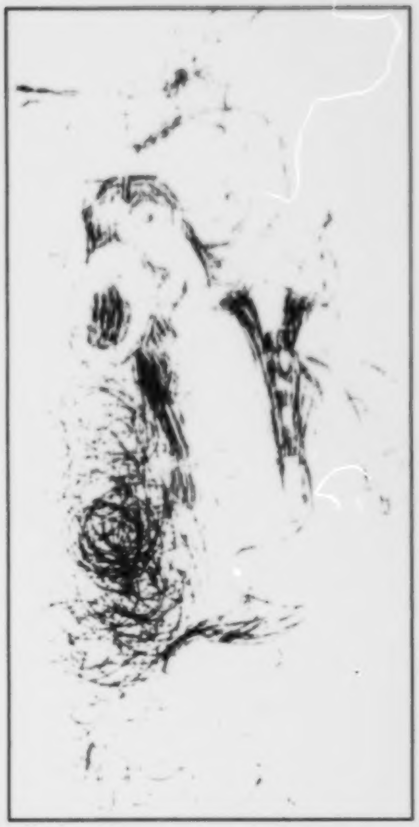


Fig. 2 As in other cases of savantism, Nadia perseverated upon certain elements in her drawings to the exclusion of other areas which would ordinarily warrant the artist's attention.

super intense mode of concentration (pg. 77). Savants are essentially 'hooked' into the most narrow beam of stimuli at the expense of processing non-specific stimuli. Thus, a sacrifice or 'trade-off' ensues, where the autistic child zeroes in on a few, seemingly arbitrary objects or sensory sources, such as in Figure 2, where a rider's leg is worked to utter oblivion—to the exclusion of a broader range of other details. Rimland refers to this as "high fidelity attention" (pg. 56). Nadia's mode of perception was thus, a reflection of lack of concept formation and hyper concentration with obsessive/compulsive features. Cognitively oriented theoreticians such as Rimland, Pariser (1981) and Selfe might agree that the purported giftedness is purely a symptomatic expression of autistic and attention disordered psychopathology. (The fact that the manifest symptoms happen to be wonderful works of art is beside the point.) Because autistic individuals lacks the control or decision-making ability to deploy his/her attention to both narrow and broad ends of the stimulus spectrum as circumstances require, their aberrant skills or gifts remain inextricably tied to the handicapping condition. (Thus, according to Rimland, "distractibility" is seen as an evolutionarily valuable trait while excessive indistractibility is construed as being potentially a threat to the organism's very survival.) It is this frightening discrepancy between "apprehending" visual or sensory stimuli without "comprehending" its relevant information in a meaningful context, which Rimland sees as precipitating the "secondary" emotional disorders so prevalent in this population.

Thus, in cognitive oriented therapy, the thrust of remediation is to train the autistic individual to shift his/her attention from self-stimulating, hyper-focused modes of attending in favor of processing and comprehending the demands of the real world.

In order to accomplish this shift of attention, the cognitive therapist utilizes behavior modification techniques to train the individual by means which may or may not include aversive or punitive strategies. Regardless of how noxious or alien the demands are to the autistic individual, the emphasis centers upon refocussing the individual by suppressing his/her symptoms. In the process of suppressing inappropriate behaviors in favor of expanding those which are more adaptive, the object of the autistic individual's hyper concentration (*in Nadia's case, her art*) may be lessened, lost or otherwise affected. Most theorists contend that because Nadia was given intensive speech therapy and cognitive training, that her gift became a casualty of the behavioral growth process. As Nadia's self-stimulatory and other obsessive making behaviors were obstructed, the idiosyncratic nature of her artistic gift may have similarly evaporated. Indeed, what the psychodynamically trained practitioner would refer to as Nadia's "artistic regression," under certain circumstances, might be considered an indication of progress by the cognitively oriented clinician. Given the decidedly cognitive emphasis of Nadia's treatment, several writers voiced their concern over what they saw as a punitive, coldly clinical approach. Dennis (1979) raised the concern that forcing Nadia to relate and verbalize at a more "trainable level" hindered the preservation of her one admirable characteristic—her art. Dennis argued that Selfe and her staff irreparably destroyed her "priceless gift" in order to create an average state of subnormality (pg. 15). Tinbergen (1983) echoed a similar sentiment, stating that Nadia's affective life was not considerd during her treatment. Indeed, in subsequent conversation with Selfe, she somewhat apologetically maintained that affective therapy was neither her field nor her mission. In retrospect, she agreed that Nadia might have benefited from more affectively oriented therapy. It was upon reaching this insight during my lengthy discussions with Selfe, that she suggested that I might visit and possibly work with Nadia, in the hope that she might respond to art therapeutic interventions as a means of rekindling her artmaking.

Nadia's Background

Nadia was born in 1967 to Ukrainian emigres who settled in Central Britain but retained their ethnic language and customs. According to the father, Nadia showed the rudiments of speech by the age of one year but by the age of two, her language development began to falter. This stage coincided with a traumatic period when the much cherished mother was hospitalized for over three months while Nadia languished in isolation with her deeply introverted grandmother. It was upon the mother's discharge that Nadia began to spontaneously draw and exhibit her remarkable precocity. Despite her artistic activity, Nadia was still retarded in her overall development. She was sufficiently withdrawn and self-stimulatory to warrant a diagnosis of autism. At age six, Nadia was referred to the Child Development Unit at Nottingham University. It was here that the mother bashfully showed the Unit's Director, E. Newson, the first drawings, thinking they might be of 'interest.' Newson's initial response was naturally one of disbelief. Subsequently, Newson handed the case over to Lorna Selfe, then a graduate student, who exhaustively studied Nadia's cognition and perception for the next five years.

In keeping with her autistic symptomatology, Nadia's art process was not merely a recreative or casual affair. Despite the fact that it was characterized by intense ritual and obscure perceptional and thought processes, Nadia's affect was one of great excitement and pleasure during the art process. In fact, it was the only instance when her passivity and lethargy gave way to animation and vivacity. The inspiration for Nadia's work was no less extraordinary. Images suddenly emerged, sometimes weeks after the child would repeatedly stare at one image from a favorite story book. This was not simply a process of looking, gaining inspiration, then copying in response. The storybook illustrations that prompted Nadia's work were ordinary, farm-yard animals such as horses and cockerels, created in an adult commercial, artistic style. Nadia's renditions were reminiscent in that they utilized elements of the basic figure—its pose, its detailing, but then she would begin to improvise. In comparison to the mundanely conventional illustration, Nadia's linework would boil with kinesthetic intensity, her contours elegantly drawn, facial features would appear in fragments in different parts of the picture (even on the reverse side) frozen in autistic fear, pain or shock. As figure 2 attests, barely controlled scribbling would often appear with these mature contour drawings, suggesting that Nadia's artistic precocity existed with indications of developmental arrest.

"Despite Nadia's blazing artistic output, she failed to thrive."

Despite Nadia's blazing artistic output, she failed to thrive. Neither self-help nor academic skills advanced although she received a great deal of speech therapy and other special education. Nadia's expressive language never attained a fully functioning status and her behavior remained autistic. Her emotional development suffered further setbacks as the mother, suffering from cancer eventually died; at this time, the child began to phase out drawing altogether.

The Visit

With Selfe's support, I was naturally excited at the prospect of working with this mythic autistic savant. I was flushed with ideas and strategies, expectant of what I might discover. However, as my long journey neared its end and I finally found Nadia's home and entered it, expectation gave way to discomfort. I immediately felt how intrusive my visit was. The father is a shy, retiring, elderly man, foreign speaking and obviously uncomfortable at having a stranger observe his retarded daughter and their strained relationship. Furthermore, the home seemed as though no one *ever* visited. Making matters worse was Nadia's initial reaction of complete indifference which was followed by overt hostility.

These responses immediately forced me to appreciate the complexity of working with clients and their families, particularly when the focus is upon research rather than treatment.

I spent the initial moments of the visit feverishly reflecting upon exactly what it was that I was doing there, by what motives and to what expected end. My soul search was interrupted, however, by Nadia herself, who began to echolalically chant about some of her favorite things—many of which were found in the equivalent of a Sears catalog. Although she was raving obsessively, this was clearly some attempt at communication. Awe struck, I sat across from Nadia as she robustly handled the stack of heavy catalogues. She interrupted herself by going into the kitchen to prepare lunch, which she accomplished quite independently. The sight of this large-boned young woman dressed as a Ukrainian peasant, mixing a huge wooden bowl of porridge is one which I will always retain.

Within this flurry of activity, my feelings of discomfort and self-consciousness diminished as I was slowly able to assimilate, somewhat, into their daily routines. After her lunch, I felt it might be time to attempt to interact with Nadia. My objective was, of course, to gain some modicum of rapport, despite the fact that this poses an enormous obstacle with autistic individuals. Indeed, as Nadia noticed the increase in my activities and interactions, her first words to me were "You Go Now!" I responded by taking my leave to walk in the back garden. During this respite from my presence, I was viewed through the large bay window. Nadia was given the opportunity to size me up while she remained safely partitioned in a kind of observation blind. Eventually, I ventured back into the house, where I remained unobtrusive and cautious in my actions. After several hours of a kind of parallel play (one is reminded of Fossey's technique (1983) of parallel existence with the illusive primates she studied) I was able to interact with her favorite objects in her environment. I decided then to sit opposite her and thumb through my own catalog. I cautiously began to point out objects of interest, first talking quietly to myself, eventually making eye contact with her. Soon we were exchanging pictures of objects such as cameras, radios, and other mechanical things which are so often within the repertoire of autistic individuals. Once I was properly introduced to her "things," I felt that some rapport was established and I bid her goodbye for the day, promising to bring her a gift tomorrow.

The second day of the visit I resumed our picture viewing until I thought Nadia was sufficiently relaxed to introduce the art materials. These included several pads of 14 × 18" rag paper, a range of rolling writers, and berol black fine tip pens. Encouraged by her father to draw something for "our visitor," Nadia turned away and refused. After a half hour or so, I asked the father if he would leave since his presence was distracting and agitating Nadia. Nadia often obsessed over him with bizarrely aggressive mannerisms and echolalic raving. At this time I, too, left the table to sit across the room, out of her range of vision. This was to ensure that I was not additionally aggravating or distracting her. Eventually however, Nadia begin to timidly scribble with the pen. Slowly, as she became absorbed in her drawing, I felt she might endure me sitting in closer proximity. While sitting across from each other, I assured her that the materials were for her as a gift, and that she could use them as she saw fit. Nadia smiled at the word "gift," and after a few moments with her eyes strangely locked to mine in that powerful autistic gaze, she began to draw. On page one, she quickly drew a stereotyped cloud-form. (Figure 3) Page two, she drew another isolated, schematic cloud. Page three, another. Soon, Nadia was scribbling cloud after cloud, one to a page. I remained uneasily "supportive" with a nervous smile pasted to my face. Almost an entire sketchbook of hastily scribbled images went by until Nadia felt sufficiently assured that these materials were indeed for her. She began yet another series, this time, perseverating upon an audio cassette form. This succession consumed another twenty pages or so, all the while Nadia measured my reaction. I strained to remain unconditionally accepting in the face of Nadia's testing of my sincerity and, indeed, empathy.

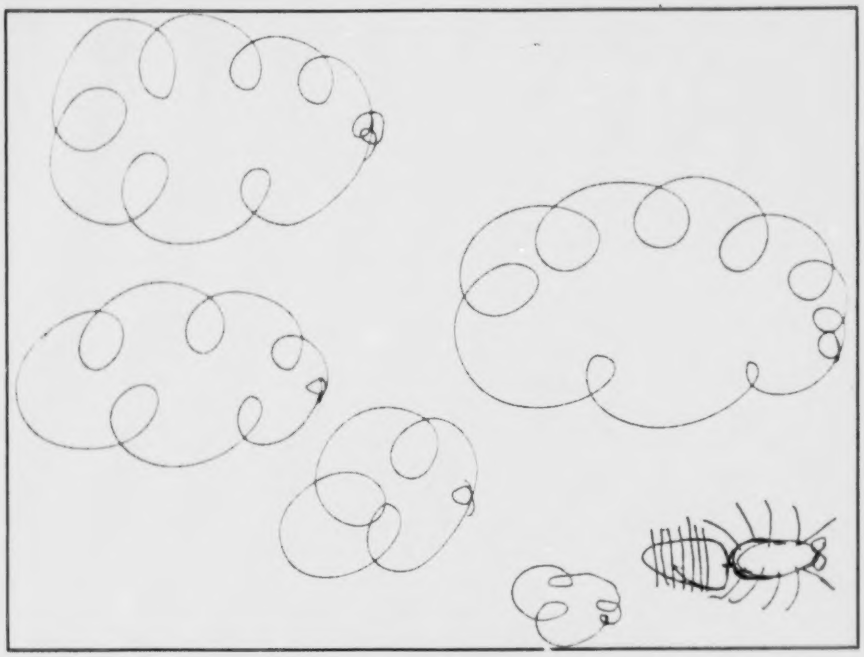


Fig. 3 Nadia often drew in disparate developmental modes as evidenced by the coexistence of circular scribblings and sophisticated realism.

In response to this perseveration, I thought of countless motivational interventions I could apply in this instance, such as a 'Lowenfeld dialogue' (1987). I restrained the impulse to intervene until she demonstrated the capacity or willingness to accept such an intrusion. Nadia herself soon became bored of consuming countless pages of drawing paper, as she began to look up at me as if desiring someone or a need for direction. With these interactions, I thought it might be time to intervene. I did begin with a Lowenfeldian commentary, which, in this case, was applied in a parallel fashion. I spoke softly, to no one in particular, how I enjoy horses—describing in great detail their form, movement, their colors, smells, etc. Since Nadia's most extraordinary

"I restrained the impulse to intervene until [Nadia] demonstrated the capacity or willingness to accept such an intrusion."

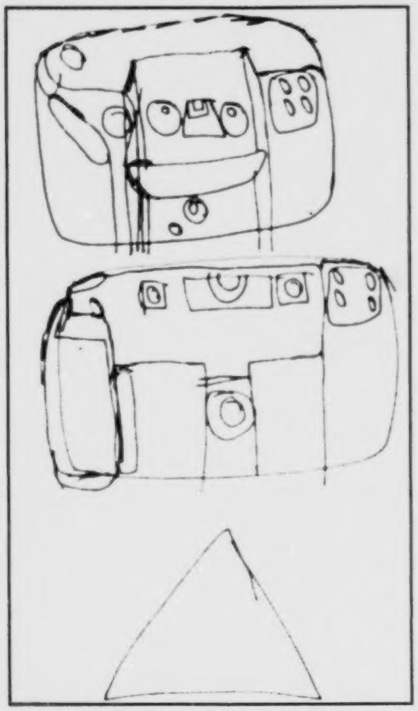


Fig. 4 Nadia's first elaborated images revolved around her "objects." Note the figurative elements invested in this inanimate camera.

drawings had once involved horses I attempted to exploit this concept by zeroing in on past perservations in the hopes of eliciting a response. Nadia ignored this line of dialogue. I decided to go back to the "objects" in which Nadia had seemed invested. I began by discussing the cameras pictured in the catalogues and encouraged Nadia as she created the first of her more embellished drawings. (Figure 4)

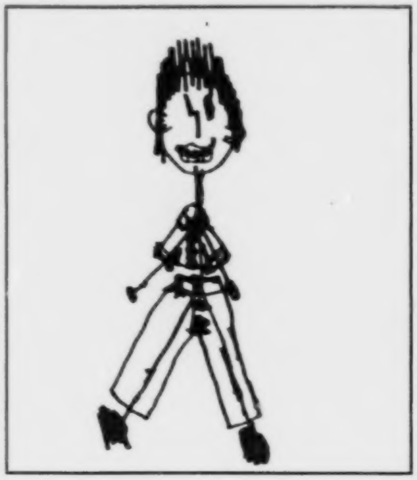
This camera drawing is in keeping with much of the autistic art I have encountered in my practice with this population. Mechanical objects are a preferred theme and are sometimes endowed with a figurative quality, alluding to the problems of object relations, constancy and affective inhibition or avoidance (Tinbergen 1983, Henley, 1988). In this piece, Nadia invests two seemingly ordinary objects with a degree of animation and quizzical affect. Her choice of the camera seemed an effective means of problem solving, maintaining her relationship with inanimate objects while also exploring and expanding that relationship in figurative terms. It seemed a logical first step at expressing a modicum of self-concept and image. In this and other cases with this population, there is often such a transitional object which softens and buffers the anxieties that come with relating to, or interacting with, people.

I was fascinated watching Nadia create this picture. While engaged in the art process, she seemed transformed, free of any suggestion of psychopathology. Beforehand, behavioral symptoms were ever present and dominating, yet, they became minimized while drawing. Nadia sat with knitted brow, her fingers lightly supporting her at the temple with an expression of concentration upon her face. The need to self-stimulate or perseverate was seemingly redirected through the art process. She appeared as any freshman art student, intently studying the model, looking, sketching, and looking once again—drawing exactly what she saw with great determination and intensity.

As Nadia was able to relate to mechanical objects and draw them in the anthropomorphic style that is so pervasive among autistics, the next step was to transfer her figurative awareness and fascination with inanimate objects toward live subjects. In this I hoped to facilitate an interaction with people on at least a symbolic basis. I then asked Nadia if she would enjoy drawing a person. In response, Nadia began scribbling a tight black circle, which was followed by an equally anxious-looking stick person. (not shown). Amazed at the pace of this progression from stereotype, to autistic imagery, to regressed intensely cathected scribbling and figure, I grew concerned that I might be pushing her too quickly. However, it soon became clear that Nadia was in fact, in control of the pace, since in her next sketch, she spontaneously drew another figure, exclaiming it to be "Daddy," with much more affective expression than the previous figure. (Figure 5) I ventured next to see if she would consider drawing a "girl," which I considered was a fairly provocative intervention for an autistic individual. Again Nadia quelled my concern by rapidly sketching Figure 6. This innocent image was certainly a self-portrait, as it clearly portrayed Nadia's blouse and page-boy hairstyle. Although somewhat stereotyped and rigid in form, its affect is fairly neutral, with a pleasant, innocent expression. It also bears an uncanny resemblance to her preceding camera "faces," suggesting the disturbing interrelatedness between Nadia and her world of objects. However, Nadia had also demonstrated extraordinary ease at giving life to her figures which suggested her potential for growth.

Wishing to consolidate these modest gains, we broke for a long lunch and walk in the garden. Upon returning, I presented Nadia with a picture first published in Selfe's book—a story book illustration of a horse which had evidently served

Fig. 5 Nadia's first human figure, "Daddy," displayed marked anxiety, aggression and stereotypic defense. At age 20, her figurative drawing had assumed an impoverished and stereotypic form.



BEST COPY AVAILABLE

loosely as a model for Nadia's mature horse and rider drawings. Nadia studied this picture intently. It was difficult to discern an expression of recognition in her face. Still she seemed interested and in response I asked her if she would draw this figure. Nadia echoed "Draw the horse!" and began sketching once again. The result was a naively drawn contour drawing, focusing upon the face, which possessed the form and style commensurate with that of an intact ten year old. (Figure 7) The figure was relatively simplified with few details. However, after this piece was completed Nadia's impulse to draw spontaneously gained momentum. She also began to look through Selfe's book as though thumbing through one of her catalogues. Nadia's interest in her own book prompted me to wonder what would happen if she were to render the mature drawings of her sixth year period?

Introduction of the Early Drawings

On the third day of our visit, Nadia seemed to anticipate my arrival. Like many other autistic individuals, Nadia might have associated me not so much as a person with whom to interact, but as the giver of art materials and opportunities for expression. In my clinical practice I often capitalize on this association in order to solidify a working relationship with the autistic individual as it constitutes a minimally provocative approach. Thus, with rapport established, Nadia completed several warm-up exercises in which she engaged with little resistance and, more importantly, demonstrated scant obsessional or stereotypical work. Therefore, I felt it time to reintroduce the drawings she had done as a six year old. As I presented Nadia with the famous "Horse and Rider" (Figure 8) which had graced the cover of Selfe's book, I asked her "Who drew this?" She immediately responded "Nadia!" I then asked (somewhat tentatively knowing it to be a loaded question) if she could draw this picture. Nadia considered this request for what seemed like minutes, then took up her pen.

Although the resulting production (Figure 9) pales in comparison to the original on a number of fronts, I was astounded that she was able to get through it at all. In any case, the verve, the flair, the audacity of the original is absent in this creation. The draftsmanship is spare and brittle—a pared down inventory of lines and forms compared to the wild flourishes in the original. It is unreasonable and perhaps somewhat demeaning to compare the two on an aesthetic basis in light of the continued circumstances of the present drawing. However, as I studied the two works I found the rendering to be more than just a credible job of copying. There is certain sophistication about the interplay of arcs, serrations, and circles that comprise the piece.

I was particularly interested in Nadia's treatment of the human figure. In the original, the rider is puppet-like and seemingly at the mercy of the hot-blooded galloping beast. Attached to the saddle like so much baggage, is a grotesque head and body of a small animal. These disturbing images were indeed carried over yet, there was a lack of elaboration of detail and intensity that pervades the original.

The foreshortened angle and cropped view of the re-created horse

"Nadia echoed 'Draw the horse!' and began sketching once again."

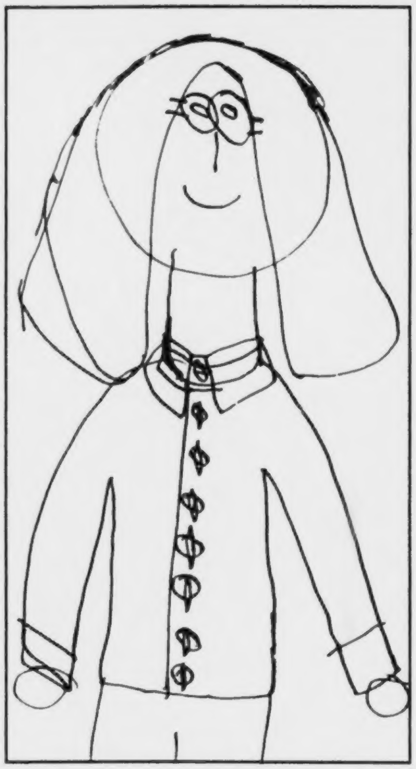
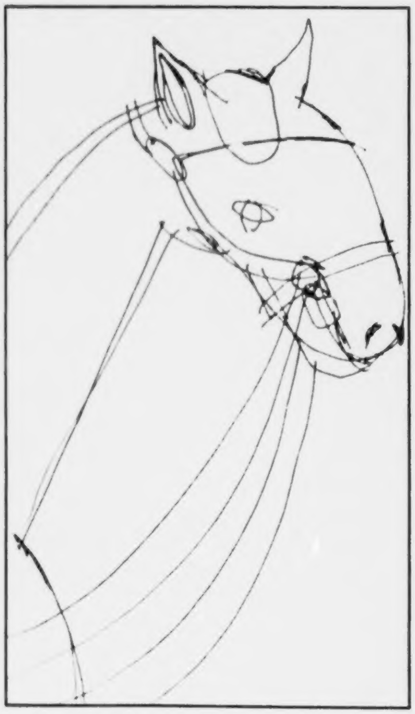


Fig. 6 Nadia's quizzical self-portrait is reminiscent of her images of cameras.

Fig. 7 The re-created horse.



BEST COPY AVAILABLE

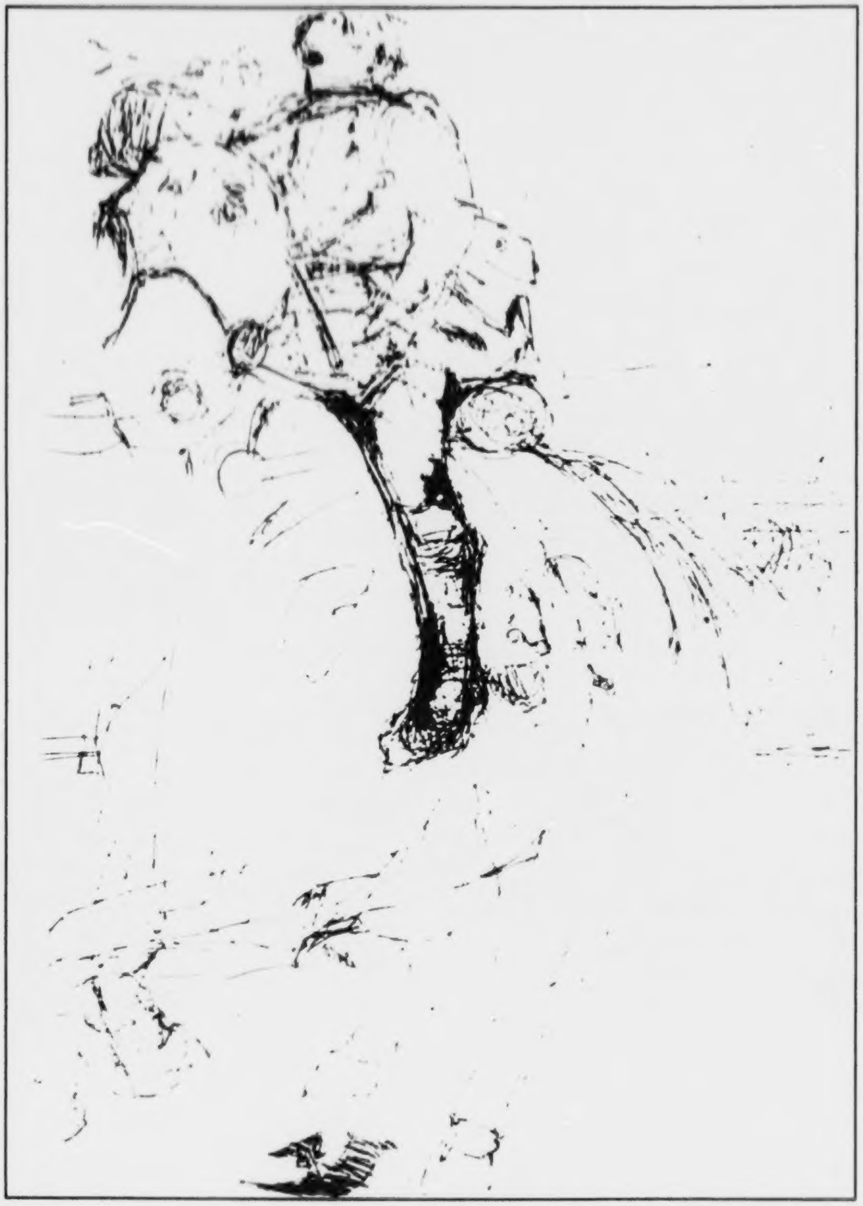


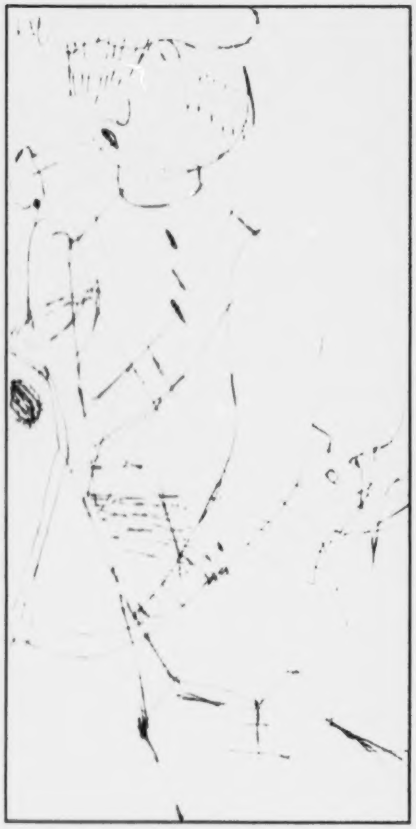
Fig. 8 The horse and rider piece is among Nadia's most celebrated images. Drawn at age 5.

are quite bold, as is the flowing tail that trails behind. Regardless of its lack of complexity and flair, it stands as a remarkable effort by an individual who functions in the upper range of severe mental retardation. Nadia's powers of observation seem to have survived intact. Her response to this work was inscrutable: she exhibited keen interest yet affectively she was exceedingly hard to read.

The next series involved the "cockerels," which were another of Nadia's preferred subject matter during her mature artistic period at age six. Once again, I presented Nadia with the story book illustration from the Selfe book to serve as the initial model. (Figure 10) Nadia responded by drawing this figure in her careful look-draw-look-draw manner. (Figure 11) The finished drawing is once again, a credible job of copying but remains just that—it retains little of the improvisational, sensitive linework that made the original cockerel interpretations so superb. It is a relatively flat, schematic piece which flows off the paper despite Nadia's attempts at abreviating the forms so as to squeeze the entire figure into the composition. I noted, however, that Nadia became noticeably more animated when rendering the layered feathers. Indeed, the arabesques of horses' tails and cockerels' feathers were elements treated to special boldness in Nadia's early and middle period pieces. Evidently these forms awakened in their repetitive and dynamic shapes, something rhythmic and pleasureful that had survived intact through the years.

Next, Nadia was introduced to the other vintage cockerel drawings created at age six, which are one of her

Fig. 9 Nadia's re-creation of her formative masterpiece.



"Once it was clear that I would be leaving soon, Nadia was overtly distracted from her drawing."

most powerful images (Figures 14–19). In one of the originals (Figure 12), the figure is formed from a maelstrom of loosely scribbled linework. It seems to have emerged in a spasm of creative energy, where the abstract draftsmanship is counterpointed by a kinesthetic energy that launches an everyday farm animal into an abstract vision. Throughout the collection of Nadia's cockerels, there are numerous fragments of the rooster's face, eyes bugging out, beak opened wide, and head rocking back. Despite all this perseveration and impassioned obsessiveness, the contours are at once loose and precise, utilizing an economy of means that furthers its sophistication and visual impact.

Upon studying this and several other extraordinary cockerel drawings, however, Nadia seemed to remain untouched by their evocative powers. Remaining calm and consistently studious, Nadia treated this exercise in a most academic manner. Her interpretation of Figure 12, (Figure 13), centers upon the head—the seat of the figure's sensory awareness and affect. In the original the jaws appear agape, the eyes roll back in some unfathomable pain or terror. Such intensity is lacking in the present rendering. It appears once again as an inventory of optical facts which have been compromised and schematized into a sort of shorthand for easier transcription. Yet, seen with a comparison of the overpowering original, this piece does sustain graphic interest in its own right. The composition is a careful mixture of intensely encased linework, circular and serrated forms which contrast to contained volume of untreated white space.

The afternoon of the third day of this visit, was mainly spent walking through the garden and chatting at the family table, interspersed with several drawing activities as part of our termination process. Once it was clear that I would be leaving soon, Nadia was overtly distracted from her drawing. Indeed, her parting pieces regressed back to a twelve part succession of stereotyped clouds. Instead of repeating the solitary clouds that initiated our session, these were grouped in sixes or eights, each element briskly scribbled with autistic precision and sameness. (These pieces were occasionally counterpointed with astutely drawn insect images drawn from life through the bay window.) This concluded our studio sessions.

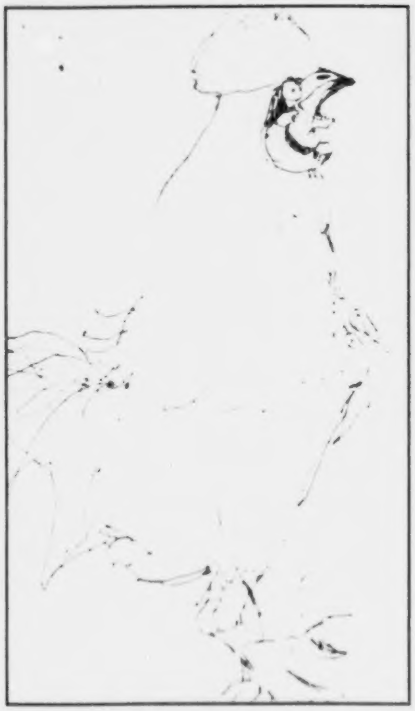
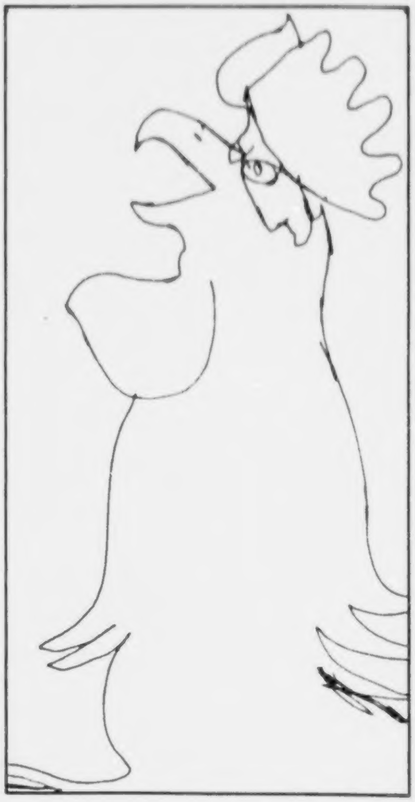


Fig. 10 An original drawing of a cockerel.

Fig. 11 The re-created cockerel.



Discussion

In 1986, I described a research study for autistic children who, although not savants, experienced behavioral and artistic regression during the two year treatment period. The ebb and flow of emotional stability and the fluctuation in once mastered skills were painful and exasperating to witness. The precipitating factors that plunged, especially one of the children into inconsolable trauma, remained inexplicable despite a careful analysis of physiological history, family dynamics and environmental factors.

In twelve years of clinical work, I have witnessed numerous instances of uneven growth in autistic individuals. I am convinced that regression in individuals with autism is an expected, possibly unchangeable element of their physiological and ontological condition. While not always as severe as the regression cited in Henley, (1986) (which involved regressing to self-injurious head banging) or as sensational as the case of Nadia, regression remains an omnipresent phenomenon that pervades the day to day life of autistic individuals. The forces that drive regression may include irreversible neurological damage, sensory distortion, genetic liability as well as defective environmental nurturing and emotional trauma. It is probable that in most cases there is a complex interplay between several factors. The activation of both physical and environmental variables working in concert may create a cycle as each factor interacts, aggravates the other, escalating the entire process toward greater devastation.

Thus, in the case of Nadia, I cannot subscribe to the theory which links the child's loss of drawing prowess solely to the supposed progress made in broadening attending behavior. It is documented, both by Selfe's study and my subsequent visit, that functional expressive language never truly developed. Nor did Nadia expand dramatically in any other academic or social capacity. She essentially remained autistic and retarded despite persistent attempts to provide her with development language and other adaptive behaviors.

It is significant, however, that the very persistence of cognitive oriented programming might have aggravated the child's regression by failing to support her during a time of personal crisis. It cannot be overlooked that the child's brief artistic career was inextricably bound, not to the failure to formulate concepts on a verbal level (Selfe, Newson p. 129), but to the fervent symbiotic ties to the mother. Nadia began her spontaneous drawing at age 3½, which roughly corresponded to the mother's discharge after three months of hospitalization. Prior to the mother-child reunion, Nadia had been essentially deprived of material nurturance and sensory stimulation (given the grandmother's extreme introversion and inability to cope with a handicapped child) resulting in a period of deprivation and subsequent autistic withdrawal. It is probable that the child was profoundly affected by the intermittent loss and regaining of the mother. Nadia's outpouring of creative activity may be seen as a celebration of this reunion. Paradoxically, the child's output during the periods of the mother's absence might have been fueled by the symbolic need to re-create the lost object (the mother) (Allen, 1989). Such a mobilization of inner resources despite the child's emotional trauma may point, however, to the role of the art process as an empowering and mollifying agent. Such self-art therapy may have been Nadia's only resource to process the feelings of abandonment and bereavement, with the art acting both as a bridge and outlet for affect which was incapable of being expressed through any other means.

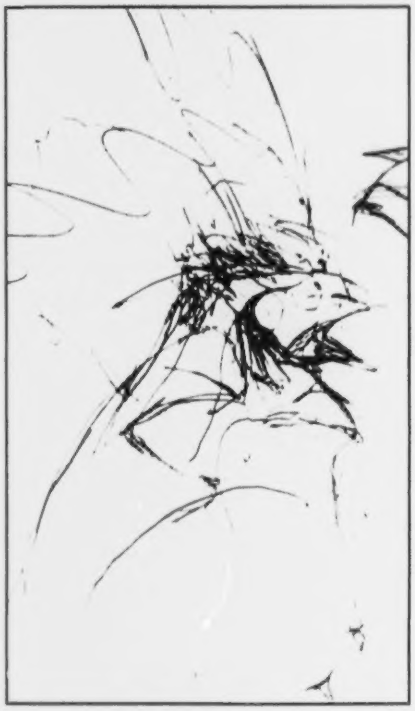
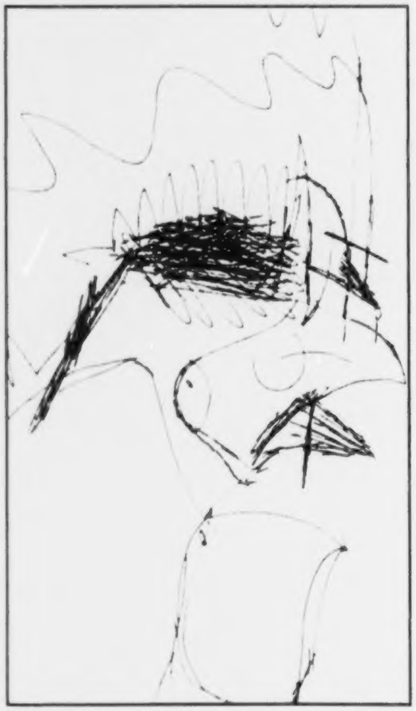


Fig. 12 Nadia's cockerels were among her most powerful and extraordinarily drawn images.

Fig. 13 One of the looser, more kinesthetic and abstract re-created cockerels.



In the face of the child's physiological problems and emotional trauma, autistic withdrawal in the form of hyper-focussing attention upon the artwork can be viewed as an adaptive response. The drawing activity in this respect may have additionally functioned as a means of displacing the pressures of social, familial and academic expectation which were probably alien and upsetting to the child. By focusing upon her story books and subsequent drawings, Nadia was able to escape or manage in her autistic way, these incomprehensible demands. Thus, I firmly believe that through her art, Nadia effectively communicated the breadth of her issues. It is in regard to this question, that I disagree with Gardner, who has stated that Nadia "displayed no interest in capturing her ideas, feelings and concepts in a medium that might convey meaning to others." Gardner need only survey the countless cockerels whose mouths were forever drawn open in desperate hunger, like chicks frantically straining for sustenance at an abandoned nest. (Figures 13–17) The eyes of her cockerels, horses and people clearly act as the windows of the soul, as the perfectly drawn spheres bulge and strain, their pupils masterfully positioned to convey a range of emotional drama.

BEST COPY AVAILABLE

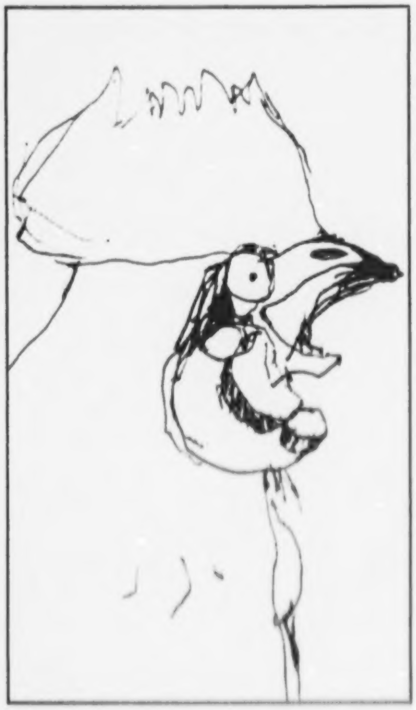


Fig. 14

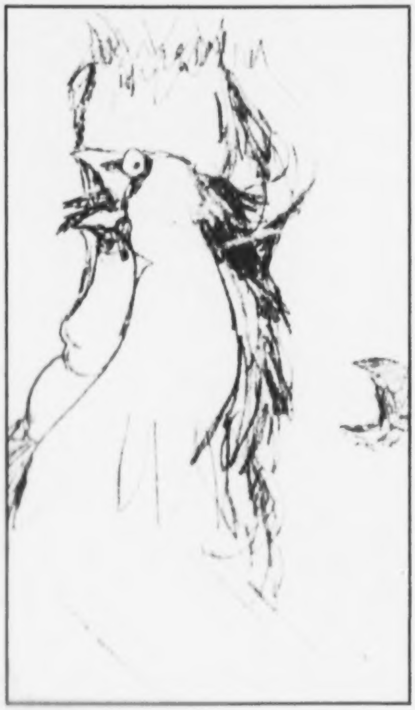


Fig. 15

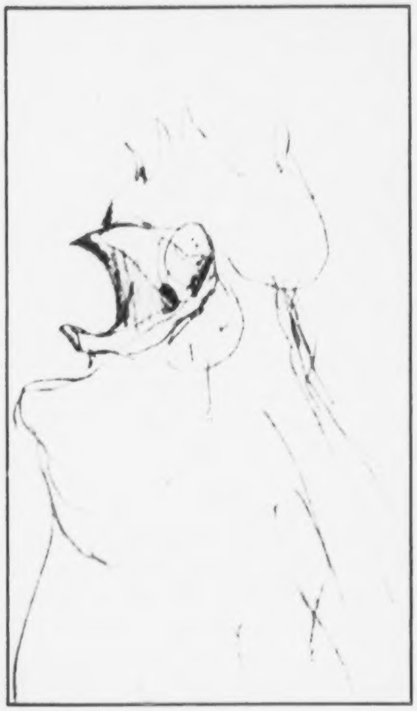
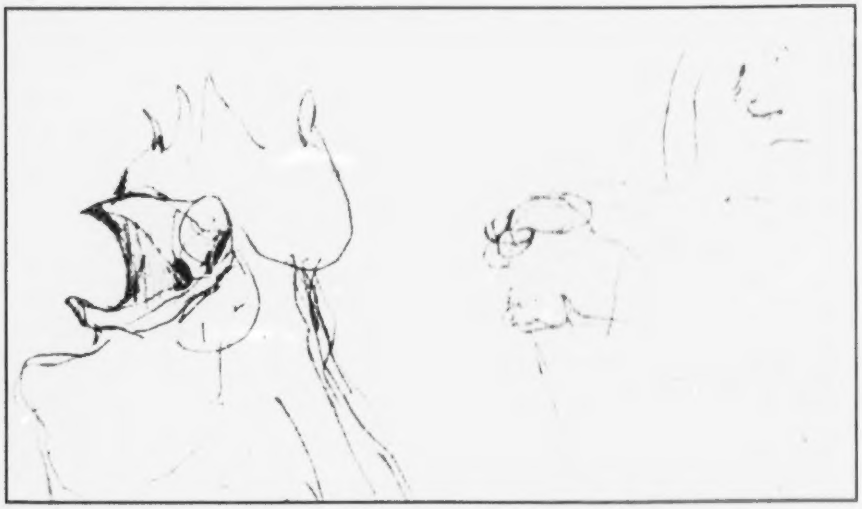


Fig. 16

Figs. 14–19 Countless cockerels and cockerel fragments were drawn in a more evoking intense affect, lending credence to the idea that Nadia's images were indeed created as a vehicle for emotional release and catharsis.

These haunting images stand as powerful metaphors for the child's emotional requirements which, given the circumstances, were probably not met during her times of crisis. Thus, the possible meanings of Nadia's symbolizations were never taken into consideration by her cognitive practitioners despite the fact that the issues were constantly repeated throughout her imagery. Those who work with autistics on a more empathic level realize that perseveration is not simply mindless repetition without significance. What is said, drawn, sung or written often holds the key to the child's salient concerns. One only need to listen seriously and see in order to partake of their struggles.

Fig. 17



Although Nadia probably did benefit from Selfe's attention and encouragement to draw, she essentially was not specifically supported during her time of crisis and loss. She was left to fend with whatever limited resources she could marshall. The issues of sensory deprivation, maternal loss, academic pressure and bereavement were to be faced squarely by the child without therapeutic support. Art therapy was unfortunately not considered as a viable option as a means of supporting and sustaining the child.

Left undefended, Nadia could have regressed into a number of fight or flight positions (Tinbergen 1983). Individuals with intact resources may strike back—assaulting their aggressors or by turning their

BEST COPY AVAILABLE

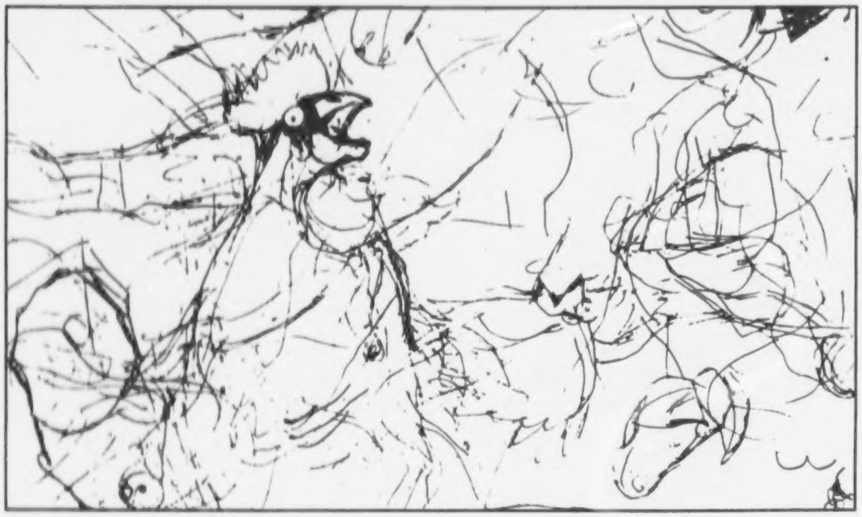
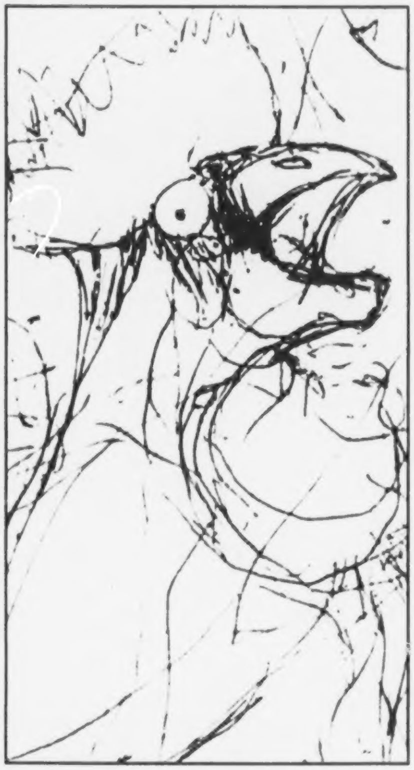


Fig. 18

rage against the self in the most virulent form of assault—self-injurious behavior (which Nadia reportedly engaged in for years after the mother's death). Others may take flight; some literally eloping, but most often by sinking deeper within themselves, unresponsive to even the most tenacious attempts at behavior modification or psychodynamic therapy. In less acute reactions, the autistic individual may take solace in the world of "objects"—where controllable or stereotypical things offer predictable or "safe" stimulation. In its most pathological form, this behavior takes on a more compulsive, ritualized or self-stimulatory quality that effectively binds anxiety (Henley 1989).

Fig. 19



These dynamics were certainly operating during my visit to Nadia. Initially, there was a flight response whereby Nadia essentially ignored my presence until I was forced upon her by her embarrassed father. Once prodded, Nadia shouted "You Go Now!" whence I deferred and took my leave. Then a period of parallel "play" allowed for my cautious assimilation. Once the art making proceeded, there was resistance, testing of limits and indications of autistic withdrawal in the form of perseverative, stereotypical cloud scribblings. Once some rapport was established (more of an uneasy coexistence) resistance involving stereotypes gave way to more formed expression, although the themes were still decidedly "object" oriented. Then a momentum developed, allowing for more spontaneous expression, as well as interpersonal relatedness and artistic productivity. Once termination became a factor, however, Nadia's art and behavior slightly regressed, returning to more defended, stereotyped expressions. Upon our separation, there were spontaneous displays of ambivalence over our attachment and the art experience we had shared together. In the end, Nadia's echolalic pronouncement was still obsessively intact, yet the intonation had changed. "You Go Now!" had become a tentative "You Go Now??" Despite the probability that I had unwittingly precipitated another instance of loss and abandonment by our stirring yet all too brief visit, Nadia appeared capable of dealing with our separation as well as coping with the potentially provocative renewed impulse to make art. Such fortitude might point to Nadia's constitutional resilience as much as the tendency to regress. The fact that she was handling our relationship, solving artistic problems, and broadening her repertoire of responses supports the possibility of increasing ego strength.

If regression and its manifest autistic symptomatology can be thought of as part of the physiological and existential dilemma facing these individuals, then possible downward slides of performance could be anticipated and be part of the clinician's expectation. In response to the ebb and flow of one's performance the child should be nurtured, supported and guided through his/her troubling times, with skills being maintained as best as possible until the child is in a position to meet new challenges. While an emphasis of teaching skills and developing adaptive, attending behavior is a vital part of the treatment process, the clinician must be sufficiently insightful to know when to lessen one's performance expectations. Regardless of the educator's tenacity, the growth process cannot proceed by merely suppressing symptoms and forcing behaviors. Some kind of compromise must be made—one that accommodates the emotionally labile child while taking care not to succumb to the autistic child's formidable powers of manipulation and task avoidance.

Autistic symptoms are compelling signals of psychic unrest. They cannot be simply ignored or suppressed. Such primary process discharge is subject to hydraulic phenomenon—with the drives finding discharge regardless of the attempts at their "extinguishing," with symptoms often surfacing in others areas of affective expression. Bettelheim (1953) was correct in maintaining that the clinician must energetically seek out any evidence of ego strength in these children, such as apparent in autistic art, and gently support efforts which will eventually become both pleasurable *and* useful.

Conclusions

The experience with Nadia and that of the other savants I had the pleasure of visiting during the twelve weeks in Britain was more than instructive. Delving into the artistic, and in some cases, the personal lives of these special people sensitized me further as to the breadth of issues one must face if he or she is to maintain a humanistic approach to research.

A salient issue which emerged was the need to balance academic investigation with maintaining an ethical and therapeutic approach. As I was initially preoccupied with the observation, intervention and collection of data, Nadia and the others shook me into a greater awareness. Catching myself in a potentially self-serving and intrusive situation, I was prompted to reflect over my motives, methods and end results. The focus upon research eventually became more aligned with the possibility of contributing something to the clients' welfare; i.e., advocating for services, consulting with those in charge of programs and home life—in short, promoting art, education and therapy as it met with the individual's need. For example, I consulted with Nadia's father with suggestions that he might utilize in order to cope with Nadia's inappropriate behaviors. Having only dealt with behavior modification in the past, he was quite interested and grateful to learn of more empathic means of redirecting and processing aggressive and self-stimulatory behavior. I also assisted him in motivating Nadia to diminish her incessant television watching and other obsessions, so as to utilize the art materials as well as other leisure time activities (such as gardening), on a more constructive basis. Finally, I looked into the local mental health services which might offer Nadia a more structured, longer term therapeutic environment. In this case and in several others, the measure of my success eventually took the form of providing modest services as well as gathering information.

In so far as formulating conclusions regarding savantism, I believe that Rimland's theoretical constructs on the nature of autism and regression are sound. Nadia's giftedness may well be a result of some aberrant, hyper-concentrated attention mechanism defect. It is the response to this diagnosis that is misguided. First, I agree that it would prove dangerously naive to assume that autistic individuals are happy in their state of hyper-sensitivity and isolation. I agree with Selfe that it *is* in their best interest that the clinician or educator intervene, sometimes provocatively, to counteract the effects of developmental arrest, cognitive retardation and sensory distortion. Yet, in this case, the process of making art should be seen not simply as an elaborate symptom but as an adaptive, positive means of self-expression that has value as a conduit toward both creative and mental growth. Rimland himself points out that many of history's most creative geniuses had autistic attributes. He suggests that Isaac Newton, Albert Einstein, and Howard Hughes are individuals whose single-minded intensity, obsessiveness and ritualization were more than just casual eccentricity. Nadia, as an artist, follows thousands of mature artists who are self-absorbed, compulsive, isolated, idiosyncratic individuals whose art processes are also subject to violent changes. These changes are often inextricably bound to emotional turmoil and creative impulsivity. Kris (1952) and Kramer (1986) argue that regression is a vital ingredient in properly "cooking" the art product. Without our ability to tap the wellspring of innermost desires, phantoms, and visions, our art is reduced to academic mechanistic exercises, devoid of richness and energy. Yet, access to the primary process can be hazardous, as it demands that the artist must possess sufficient ego strength to resist the gravitational pull of complete regression and disintegration. To manage this, the ego must be firmly in control; such control is, by definition, not within the realm of the autistic artist. However, those autistic individuals whose tenuous egos constantly flirt with oblivion can be guided and supported during their art process by what Kramer (1986) terms the "auxiliary ego." As Nadia's controls began to slip away, there could have been some art therapeutic or other auxiliary support system that complemented artistic, emotional and academic skills, so that they might survive the episodes of regression intact.

In working with these clients, art therapists begin by fostering any talent in evidence by cautious and sensitive interventions that cause a client minimum anxiety or stress. Although art therapy and the art experience are seen as a growth process, these interventions must respect clients' resistance to change (especially their obsession with certain stereotypes), for it bespeaks their vulnerability.

We should concentrate upon providing a stable yet sensorially stimulating environment where the timid client is encouraged to explore, solve problems, and take creative risks without resorting to extreme defenses. The art therapist can assist in this process by providing a model with whom autistic persons can identify and begin to incorporate appropriate behaviors, such as artistic skills, into their own creative and behavioral repertoire. By remaining calm, firm and consistent in the face of bizarre or tedious acting-out behaviors, we communicate our commitment to assist the autistic artist to make positive and productive changes in the studio. The art process can then be promoted as a serious educational and therapeutic activity that engages and challenges the multi-faceted faculties of each individual. Ultimately, the goal is to open channels for the transformation of the client's ideas, concerns and issues into forms that are comprehensible to others.

References

Allen, P. (1989). Personal communication.

Arnheim, R. (1980). The puzzle of Nadia's drawings: Arts and psychotherapy. Vol. 7.

Bettelheim, B. (1953). The empty fortress. Glencoe: New York.

Cardinal, R. (1979). Drawing without words: Comparison #10.

Dennis, N. (1978). Portrait of the artist: New York Review of Books. Vol. 25.

Fossey, D. (1983). Gorillas in the mist. Houghton-Mifflin. Boston.

Gardner, H. (1980). Artful scribbles. New York: Basic Books.

Gardner, H. (1979). "Children's art: Nadia's challenge." *Psychology Today:* September.

Goodman, J. (1972). "A case of autistic savant: Mental function in a psychotic child with markedly discrepant abilities." *The Arts in Psychotherapy. J. of Child Psychology and Psychiatry.* 13:267.

Henley, D. (1986). Emotional handicaps in low functioning children: Art education/art therapeutic interventions. *The Arts in Psychotherapy.* Vol. 13, #1.

Henley, D. (1986). "Approaching artistic sublimation in low functioning individuals," *Art Therapy,* Vol. 3 (2).

Henley, D. (1989). "Artistic giftedness in the multiply handicapped" from *Advances in Art Therapy,* Harriet Wadeson, Editor, New York. Wiley and Sons.

Hill, A. L. (1976). Idiot savants: A categorization of abilities in mental retardation 12 (6): 12.

Kramer, E. (1986). "The art therapist's third hand: Reflections on art, art therapy and society at large," *AJAT,* 24 (3).

Kris, E. (1955). "Neutralization and sublimation." The Psychoanalytic Study of the Child," 10:30–46.

Lowenfeld, V., and Brittain, W. (1987). *Creative and mental growth.* New York: Macmillan Publishing Company.

Morishma, A. (1974). "Another Van Gogh of Japan: Superior artwork of a retarded boy," Exceptional Children (1974) 41, 92–6.

Morishma, A. (1968). "Shyochan's drawing of insects," *Japanese Journal of Mentally Retarded Children* 119: 44–7.

Pariser, D. (1979). A discussion of Nadia. Technical Report #9. Harvard Project Zero, Cambridge, MA.

Rimland, B. (1978). "Savant capabilities of autistic children and their cognitive implications." From *Cognitive Defects in the Development of Mental Illness,* Edited by G. Serbon Brunner/Mazel, New York.

Sacks, O. (1987). The man who mistook his wife for a hat. New York: Summit.

Selfe, L. (1977). Nadia: A case of extraordinary drawing ability in an autistic child, Academic Press. New York.

Selfe, L. (1983). Normal and anomalous representational drawing ability in children, Academic Press, New York.

Tinbergen, N. and E. A. (1983). Autistic children: New hope for a cure. London. George Allen and Unwinn Ltd.

Winner, E. (1986). How kids draw: *Psychology Today*: August.

AATA

▾ Our new address ▾

1202 ALLANSON RD.
MUNDELEIN, IL 60060
Phone No. (312) 949-6064
Fax No. (312) 566-4580
Management has not changed.
You may still contact:
EDWARD J. STYGAR, *Executive Director*
MARCIA CHAMBERS, *Administrative Assistant*
MARY BUCKLEY, *Director of Convention Services*

Visual Transitions as Therapy

Gerald S. Evans, PhD, *Director of Stress Management Consulting and Adjunct Faculty, University of St. Thomas, Houston, Texas.* **Jerry L. Fryrear, PhD, ATR,** *Professor of Psychology, University of Houston/Clear Lake, Psychologist and Art Therapist in Private Practice, Houston, Texas.* **Irene E. Corbit, PhD, ATR, LPC,** *Art Therapist and Psychotherapist in Private Practice in Houston, Texas and Adjunct Faculty, University of Houston/Clear Lake.*

Abstract

The present study describes a multimodal art therapy procedure using photography, art, movement, video and verbal discussion, **Visual Transitions,** ***and attempts to provide a theoretical rationale for the procedure as well as statistical evidence for its effectiveness. A group of volunteers took part in a seven-week program and filled out questionnaires before and after the experience. The Adjective Check List, the Personal Orientation Inventory, and a self-report critique show moderate but positive results for the program. The results are discussed and suggestions for future research are offered.***

Initiating personal growth and change is recognized as the underlying objective for psychotherapy. To affect this change in human behavior, therapists employ specific therapeutic procedures designed to deal with issues confronting clients. Some issues require a combination of therapeutic interventions, rather than a single treatment modality. This blending together of several accepted modes of psychotherapy brings with it the anticipation of discovering a viable, effective alternative procedure—one in which the benefits provided by each individual therapeutic method can be simultaneously realized in one multimodal therapy. It is this combining of therapies, specifically art therapies, that is the subject of this discussion. We call this combination *Visual Transitions.*

Visual Transitions

To achieve its goals, *Visual Transitions* therapy incorporates still photos, art, movement, video and verbal discussions. The participant has the opportunity to observe and experience his or her "stuckness," move to a new, more alive and meaningful state of being, then opt for transiting more fully to that state or determine a comfortable place on the continuum (Corbit and Fryrear, 1985; Fryrear and Corbit, 1989). Operationally, the clients are provided with experiential exercises which allow them, through photography, to observe themselves in their present state (indicating "stuckness" or "constriction"), and their more preferred state (indicating "freedom" or "non-constraint"). Still photos are combined with artwork to show a relationship between these two states. Body movement becomes part of the therapy as clients enact feelings and actions which characterize these respective states. The movement is shared with others, who in turn assume the same poses in group fashion for psychodramatic effect. Video is utilized to facilitate transition between the two states and becomes an instrument of reinforcement. *Visual Transitions,* as a therapy, attempts to label, artistically and verbally, two points on a continuum—a constricted behavior often characterized by insecurity and low self-esteem; versus a behavior pattern indicating feelings of security, self-worth, high self-esteem and a sense of freedom. The artwork (which includes the still photos), the movement, and the video all become metaphors for change.

Even though the various component expressive therapies which constitute *"Visual Transitions"* are among some of the more accepted and commonly practiced psychotherapy strategies, an examination of their combined features deserves consideration. Basic questions that must be dealt with include:

1. Is this really a therapeutic procedure?
2. How effective is this procedure both in terms of statistical significance (objective), and personal evaluation by clients (subjective)?
3. What reaction might the mental health community have with regard to this method?

In order to address the first question, it is desirable to explore some important facets of this new art therapy modality. Such key factors as the relationship of art to the arts therapies, and an examination of the specific art therapies involved in this method need to be considered to better appreciate their respective features and benefits contributing to the effectiveness of *Visual Transitions.*

As Fleshman and Fryrear (1981) wrote, "the process of all art involves more aspects of the individu-

> ***"The artwork . . . , the movement, and the video all become metaphors for change."***

al than the verbal therapies can touch. The arts require the involvement of primal elements found in the connection of mind and body. Many of the arts are nonverbal and can deal with presymbolic and nonsymbolic subject matter. For example, arts processes involve breaking down and restructuring of conceptual structures. Body rhythms are basic to music, dance, and poetry. They are implied in the structural relationships within painting, sculpture, and architecture. Psychological dynamics may develop out of such physical processes as eating and excreting, sex, locomotion, tension, relation patterns, states of excitement, perception, sensation, fine-motor coordination, and visual motor coordination. Processes that are recognized in the more verbal therapies, such as sublimation, symbolization, identification, and catharsis can be contacted and controlled more directly through the arts. Meaningful areas of the personality that are often quite elusive to the more verbal therapies may be, so to speak, seen and heard, touched and handled through the arts therapies." (pp. 6-7)

Fleshman and Fryrear further assert in this same text that the field of arts therapies simply is "the use of the elements found in the arts, either in individual form or in combination, to bring about positive changes in the lives of persons needing help . . . that all areas have much in common. They share a therapeutic purpose and are basically similar in therapeutic philosophy and rationale." (p. 8)

" . . . the field of arts therapies simply is "the use of the elements found in the arts, . . . to bring about positive changes in the lives of persons needing help."

Regarding art therapy, Wadeson (1980) rhetorically questions the "why" and "what does it have to offer" over other more conventional forms of therapeutic intervention. First of all, she says we, as humans, tend to think in images. We thought in images before we had words. Not only is imagery woven into the core of human personality, but it is also recognized as a primary component of unconscious phenomena, which include dreams. Wadeson mentions that in art therapy the dream, fantasy, or experience is depicted in image form rather than having to be translated into words, as in purely verbal therapy.

Wadeson notes that art objects tend to decrease our defenses in terms of communications. Verbal communication brings with it the ability to use various ways to disguise or modify our thoughts when actually expressing them verbally. Art reveals our images through symbols in a fashion that cannot be easily altered to disguise meaning.

Another facet or unique attribute of art therapy noted by Wadeson is that of objectification—the art object becomes a tangible product. This brings with it one of the central, most important aspects of art therapy—the ability for a resistant client to relate to the art object, since it is often easier than relating directly to the self.

Permanence of the art object is also a feature indigenous to art therapy. The art object is not subject to the distortion of human memory. Wadeson also points out that through reviewing art productions with clients, often new insights develop. The client or therapist may notice emerging patterns in a series of art works which may not be apparent when the work is viewed singly. Other advantages of the art object's permanence are found in its usefulness for research data, and its therapeutic value in group sharing.

Yet another distinct advantage of art therapy over verbal therapy alone is its spatial matrix feature. Wadeson points out that art expression need not obey the rules of language—grammar, syntax, or logic. Wadeson mentions its spatial nature. "In a picture, I can portray it all at once. I can show closeness and distance, bonds and divisions, similarities and differences, feelings, particular attributes, context of family life, *ad infinitum*." (p. 11)

Art therapy also seems to provide its participant with a sense of creative and physical energy. Wadeson mentions an "enlivening quality" to be found in art therapy; that in discussion after an exercise, members seemed to be more open, revealing, and receptive than in initial discussions—a change in energy level activated by art therapy.

This healing process resulting from art therapy is revealed in Corbit's study (1985) involving a group of combat veterans besieged by terrifying, recurrent playback nightmares. According to Corbit, these nightmares were depotentiated and diminished through a veterans' dream group experience involving logging their dreams, drawing them, and discussing their nightmares within the group. Corbit further points out that ego-esteem and self motivation also showed improvement as these veterans gained a new sense of mastery from working on their dreams through their drawings.

Photography constitutes another of the modalities of *Visual Transitions* therapy. Stewart (1979) points to phototherapy as a new use of photography. He defines phototherapy as "the use of photography in a therapeutic setting, under the direction of a trained therapist, to reduce or relieve painful psychological symptoms, and as a method of facilitating psychological growth and change." (p. 41) Stewart further asserts that phototherapy fits most of the requirements for a sound theory, since it allows for the formulation and testing of hypotheses.

One of the major advantages found in phototherapy is its analogous nature to art therapy—that of projectiveness. It becomes the bridge for communication between therapist and client as it takes on metaphorical significance in relating to underlying problems.

Krauss and Fryrear (1983) have divided the literature on the use of photographs in therapy into eleven broad areas: 1) the evocation of emotional states; 2) the elicitation of verbal behavior; 3) modeling; 4) mastery of a skill; 5) facilitation of socialization; 6) creativity/expression; 7) diagnostic adjunct to verbal therapies; 8) a form of nonverbal communication between client and therapist; 9) documentation of change; 10) prolongation of certain experiences; and 11) self-confrontation.

Gosciewski (1975) underscores the applicability of phototherapy as one of the modalities of *Visual Transitions* therapy by relating his viewpoint that "photographs can serve as a transition in discussing 'there and then' situations with 'here and now' issues and concerns." (p. 600) It is this concern with pictorially representing a "constriction" on the one hand, and then a "freedom" pose on the other, that is central to *Visual Transitions*. Krauss and Fryrear (1983) assert that photographic images reveal a metaphoric map that relates to one's participation in life; they may range from the extremes of a narrow constricting viewpoint to the lack of structure or boundaries of any type. The authors further speak of the strength of phototherapy as a self-confrontation device—one of the key facets of *Visual Transitions* therapy. They write that "Many of the studies using photography as a self-confrontation approach have operated using the theory that if individuals can see themselves as objectively as others see them, then they will use this new information to help themselves change for the better." (p. 17) Krauss and Fryrear also point out the symbiotic relationship of art therapy to phototherapy. Their viewpoint is that since art therapy is dependent on externalized internal subjects and phototherapy is dependent on internalized external subjects . . . both are projections and symbolic representations of a client's reality.

In addition to the modalities of art therapy and phototherapy, *Visual Transitions* therapy utilizes video to facilitate change. Consistent with the blending of several arts therapies modalities for an effective procedure, Hung and Rosenthal (1981) provide their support by concluding that visual feedback of the videotaped self has its maximum impact when conjoined with other therapies. Fleshman and Fryrear (1981) state that there are several concepts supporting the use of this type of equipment. "One set of concepts assumes that a person is taped and then views himself on a television monitor. The feedback serves as self-confrontation, provides immediate and impersonal evidence of the quality of group interactions, aids in the patients' and the therapists' recall of therapy events, stimulates individual or group psychotherapy, and tends to equalize patient and therapist." (p. 156)

"One of the major advantages found in phototherapy is its analogous nature to art therapy - that of projectiveness."

There are some interesting theories as to why videotherapy works. According to Heilveil (1983), the image on the screen interprets, questions, clarifies, suggests, criticizes, encourages, and contradicts the viewer. Video feedback then becomes a type of self-confrontation which forces the client to face reality. Video has also been credited with affecting change through cognitive restructuring. Changes occurring as the result of this self-confrontation therapy can be attributed to an "objective shift" in which the client alters consciousness into a more objective, observing posture (Wicklund, 1975). Yet another theory which supports the use of videotherapy focuses on its value as a therapeutic tool in eliciting clients' previously unconscious identifications with unresolved issues revolving around relationships with parents, spouses, or siblings. These recognitions can sometimes trigger insight capable of fostering change (Reivich and Geertsma, 1968).

Movement therapy is the last of the modalities to be highlighted as a component of the *Visual Transitions* therapy. Movement is the "fluid" that provides the metaphorical transition from "constriction" to "freedom." Heilveil (1983) reminds us that movement is both kinetic and cognitive. While movement is experienced largely through a kinetic sense, a person thinks about the world in new ways while engaged in unaccustomed forms of movement. Alperson (1976) feels that the focus of movement therapy is maintained primarily on the "here and now reactions" of the individuals involved. As clients move, they spontaneously make associations to past, unresolved situations in their lives. They explore the meaning of these recollections to present life events. While associations to unresolved old situations occur frequently in the process of moving, closure and new solutions can only be discovered by the person in the present.

This examination of the various component arts therapies modalities which collectively form *Visual Transitions* therapy supports the following rationale: Given that these respective modalities are as therapeutically sound as the cited professional references indicate, and that, while each modality is capable of providing the full range of therapeutic benefits for which it was designed, it follows that this blending of arts therapies should provide a sound and effective multimodal therapeutic procedure. Further, it is hypothesized that data will bear out the effectiveness of *Visual Transitions* as a therapeutic procedure.

Method

Subjects

The group of 11 subjects consisted of 9 females and 2 males, ranging in ages from 34 to 58, with an average of 46. There were four practicing psychotherapists, three full-time students, one research technician, one graphic artist, and two administrative office workers. The subjects responded to a direct mail pamphlet which advertised the procedure.

Therapeutic Materials

All group members were supplied with the following photographic and art materials for completing their respective art objects:

1. Still photo cameras (Polaroid* 600 Land cameras) and film
2. *Art Materials*
   Poster board, scissors, glue sticks, Cray-pas (oil pastels) colored chalks, and colored marking pens
3. RCA Newvicon color video camera system
   a. Color video camera (including zoom lens, rear-viewing monitor, and tripod)
   b. VHS player recorder, Zenith color TV monitor (including hand-held motion control device) The video system was used to provide a replay of presentations.

Testing Materials

1. ***Personal Orientation Inventory (POI).*** The POI is a self-report instrument designed to measure personal maturity as based on Maslow's concepts of self-actualization. The POI consists of 150 paired-opposite items of antithetical, self-characterizing statements concerning value and behavior judgments.

The POI consists of two ratio scores that assess general personality effectiveness and 10 variables represented by 10 subscales. These scoring categories, in which higher scores indicate better personal adjustment, are as follows:

Ratio Scores

Time Incompetence/Time Competence—measures the ability to live fully in the present.
Other/Inner Support—measures whether or not guidance comes from within the self or from others.

Subscales

Self-Actualizing Values—measures the degree to which one holds the values of self-actualizing people.
Existentiality—measures the ability to react according to the situation without rigidly adhering to principle.
Feeling Reactivity—measures the extent of responsiveness to one's needs and feelings.
Spontaneity—measures the ability to respond and express one's feelings spontaneously.
Self-Regard—measures the level of self-esteem.
Self-Acceptance—measures acceptance of oneself despite one's imperfections.
Nature of Man—measures the degree to which man is seen as intrinsically good.
Synergy—measures the ability to resolve opposites.
Acceptance of Aggression—measures the extent of tolerance of one's own hostility and aggression.
Capacity for Intimate Contact—measures the ability to form and maintain non-manipulative intimate relationships.

2. ***Adjective Check List (ACL).*** The ACL is a self-administering instrument designed to assess personality needs and traits. The ACL consists of 300 adjectives, organized into 24 basic scales. Only the scales of "Number of favorable adjectives checked," "Number of unfavorable adjectives checked," and "Personal adjustment" were included in this study.

3. ***A self-report critique.*** A self-report was included to measure the extent of participants' satisfaction and their comments regarding the effectiveness of *Visual Transitions*. Eleven questions were used. A rating scale from 1 to 5 was proposed which ranged from an appraisal of "poor," "negative feelings," or "disagree strongly" (1), to that of "excellent," "superior," "very positive feelings," and "strongly agree" (5).

Further, each question asked for a brief comment in addition to the numerical rating value (see Appendix A).

Procedure

The extended workshop was organized as a series of seven, three-hour sessions. At the beginning of the first session, participants were asked to sign a workshop release form. They then completed the POI and the ACL. The pre-test scores of these instruments were later compared with post-test scores from these same instruments recorded at the conclusion of the program.

After the pretest, group members introduced themselves nonverbally using only gestures and movement as their means of expressing themselves to the group. This exercise is usually begun by the group leaders who introduce themselves with a dance or a handshake or an airy walk around the group. This beginning exercise helps group members to get in touch with their bodies, and sets the pace for the visual nature of the therapy and the enactment of feelings.

Videotaping can occur throughout the entire session or during any specific phase. Release forms are considered a necessity in videotaping any therapeutic procedure. Additionally, if participants do not wish to be videotaped, or if once taped they wish to have the tape erased, these requests are honored.

In the next phase of the workshop, participants formed into pairs to photograph one another. Instant cameras were used to take two photographs of each other. One pose described the "constriction" or "as I was." This pose reflected the participant "as I was" before therapy, or "as I was" during a time of emotional conflict or when entrapped by personal constriction. The second pose portrayed "as I would like to be." This represented the way the participant ideally wanted to feel—a "freedom" from constriction.

After the still photos were taken, the group members were provided with art materials. The participants were then instructed to cut out the two photos, to mount them on the poster board in whatever manner they wished, somehow relating the two images to each other with the art materials, and to label these two images with one or two words.

When this exercise was completed, the group members reseated themselves for group discussion/processing of the art objects. Each member presented his/her artwork and explained the relationship of the two photo images, as well as the various symbols drawn to relate them (colors, figures, etc., and in some cases, the lack of them). Immediately after each group member's presentation, he or she then demonstrated the first pose, then the second. Each member was encouraged to repeat the two poses, concentrating upon the feeling aspect of each pose and the transition movement necessary for moving from one pose to another. Some sequences were repeated several times in order to grasp more fully the transitional feelings associated with movement between the two poses. The entire group then simultaneously joined the presenter for a succession of further enactments of this same exercise. They were encouraged to experience the presenter's same feelings of transition in moving from the first pose to the second. The group leaders repeatedly asked the presenter, as well as the other group members, to be aware of feelings of tightness, rigidity, or tension, related to the first pose, and then to sense any feelings of freedom, relief, or joy, related to the second pose. The transition was enacted like a group choreography, with members becoming aware not only of their empathic feelings with the presenter, but also attending to personal body sensations and feelings during the reenactment.

The entire sequence, from presenter's discussion of his or her artwork through the group transition movement, was recorded on video tape. Following each presentation, the video was played back immediately for group viewing and discussion. Members were encouraged to interrupt the playback at any time for comment or discussion. The video allowed each member to see himself/herself going through the transition from "as I was" to "as I would like to be." The artwork and the movement became metaphors for change, as did the images captured by the still photos and the moving tape.

The last phase of the program was the general sharing of the experience, relating the experience to more elaborate possible change in the outside world, and sharing common experiences and feelings. For example, many of the group members' poses were quite similar, both in terms of "where they were" and "where they wanted to be." Some of their transitional movements were similar as well. This similarity was helpful in convincing group members of the universality of their concerns—a common phenomenon in verbal group therapies also. This also became a time for closure in which several members dealt with their feelings regarding the overall therapeutic effect of the procedure.

The POI and ACL were re-administered, and the self-report critique questionnaire completed.

Results

Personal Orientation Inventory (POI)

The POI group mean profile reveals consistently higher scores on the post-test versus the pretest (see Figure 1). As mentioned earlier, higher scores indicate better personal adjustment. The Figure 1 profile shows that, while most subscales showed an increase resulting from therapy, one remained unchanged, and yet another even showed a decrease. An ANOVA comparing the pretest and post-test scores show that "Spontaneity" and "Capacity for Intimate Contact" were significant at the .07 level of confidence (F = 3.912; F = 3.683), and that the results for the subscale of "Existentiality" showed significance at the .11 level of confidence (F = 2.911). These comparisons indicate an improvement in the group members' ability to express feelings spontaneously, a greater capacity for warm interpersonal relationships, and increased flexibility to react ac-

"The similarity was helpful in convincing group members of the universality of their concerns."

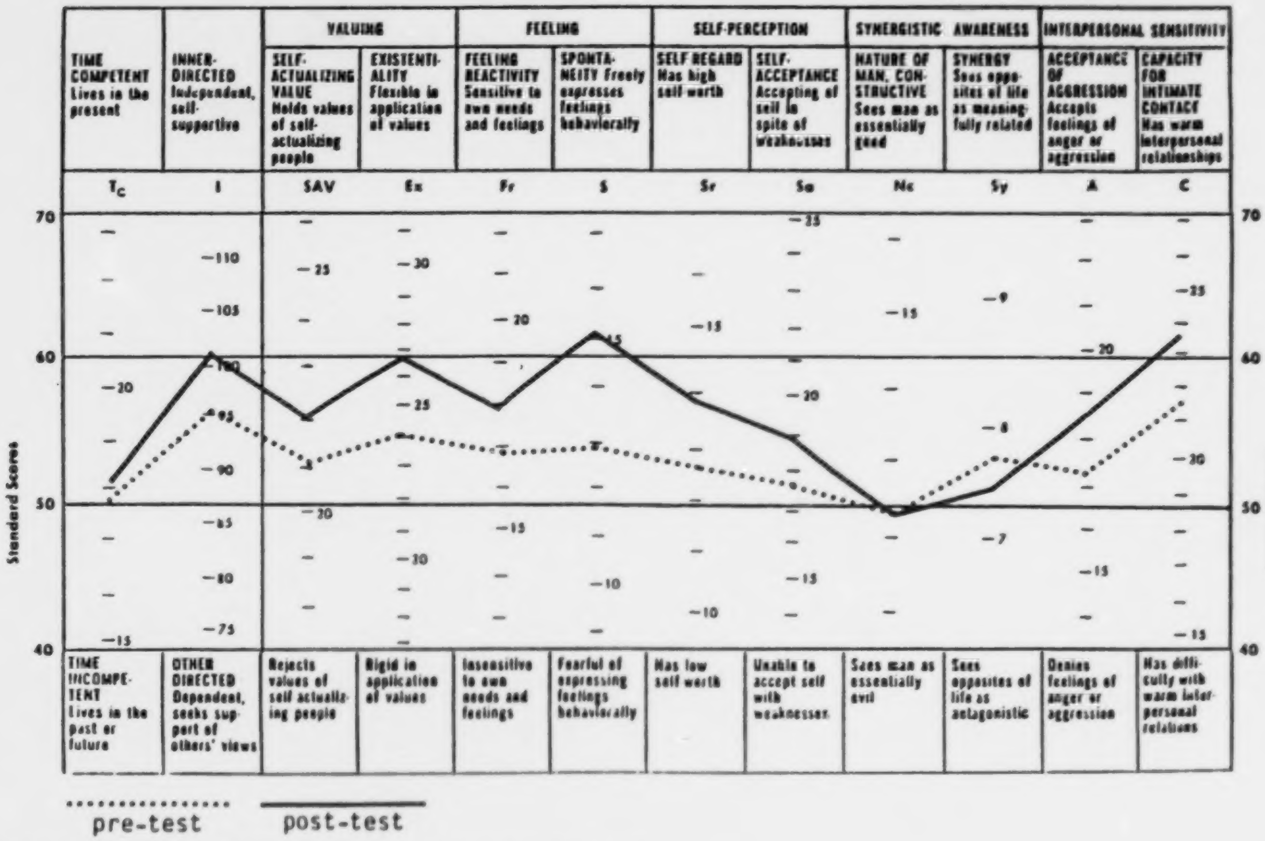


Fig. 1 Group mean profiles for the Personal Orientation Inventory.

cording to the situation without rigidly adhering to principles or values.

Adjective Check List (ACL)

The ACL was reported in standard scores and was analyzed by a 1-way ANOVA design with only three subscales being considered for comparison. The pretest mean for the Number of Favorable Adjectives Checked was 55.727, as compared to a post-test mean of 59.090, F (1, 20) = 1.317, $p > .25$. The pretest mean for the Number of Unfavorable Adjectives Checked was 43.454, as compared with a post-test mean of 41.727, F (1, 20) = .787, $p > .25$. The pretest mean for Personal Adjustment was 52.455, as compared with a post-test mean of 57.273, F (1, 20) = 2.354, $p = .16$. Even though the score differences were in a positive direction, they did not reach accepted levels of statistical significance.

Self-Report Critique

The critique showed uniformly positive assessment ratings and evaluation comments by the group participants on *Visual Transitions* therapy. Of the 17 areas rated on a scale of 1 to 5 (1 = poor; 5 = superior), the mean rating per question was 4.203; and out of a possible total of 85 points, the mean for the 11 participants was 71.458.

Discussion

This extended workshop program on *Visual Transitions* was conducted to acquire additional information about several aspects of the procedure.

One of the basic questions to be addressed was whether or not *Visual Transitions* should rightfully be considered a therapeutic procedure. The introductory comments regarding the literature on the component therapeutic methods and their use in combination seems to us to be a clear rationale for considering the *Visual Transitions* multimodal arts therapies method as a legitimate therapeutic procedure.

Regarding the effectiveness of Visual Transitions, the present study provides some evidence, though not overwhelming, that the procedure is effective. Clearly, the participants were satisfied with the experience and felt that it was helpful to them, as their ratings and comments on the critique show. The more objective ratings on the POI and ACL are more equivocal. Even though the ANOVA design did not yield statistically significant results within the commonly accepted .05 confidence interval, two of the POI subscales, "Sponteneity" and "Capacity for Intimate Contact," did reach a .07 level—and all but two subscales

BEST COPY AVAILABLE

showed some level of improvement. Also, the ACL showed positive, if statistically insignificant changes on the three relevant subscales. There was, of course, the possibility of discovering "no change" or even "negative change" results.

The fact that the POI and ACL results were marginally statistically significant may be a function of the length of the workshop and the types of areas in which change was expected. To deal effectively with deep-rooted issues that have formed over extended periods of time, perhaps more time is needed to affect significant levels of change. Another possible reason for lack of large statistically significant findings may lie in the homogeneity of this group—a reasonably well-functioning group of adults in which variances were difficult to discern. Positive change did occur. The question seems to be one of determining either the appropriate length of time needed to affect the desired amount of change in terms of statistical significance, or perhaps selecting a more diverse group of individuals or individuals with more significant psychological symptoms.

As with any study that focuses on a small, homogeneous group of individuals, we cannot generalize to other populations. We cannot state whether the procedure will be more or less effective with psychiatric patients, alcoholics, children, or others without further study. We encourage readers to report on the method with other populations.

Concerning the reaction which might reasonably be expected by the mental health community regarding this therapeutic procedure, one might logically anticipate the same general level of acceptance as for the various constituent arts therapy modalities included within its framework. Understandably, receiving much stronger statistical results on the POI and ACL would have been more convincing to those not as well acquainted with the benefits of the arts therapies. Four of the group members in the present study were practicing mental health workers, and, according to the self-report critique, these individuals are accepting of *Visual Transitions*.

The present study was undertaken in a preliminary attempt to determine the effectiveness of *Visual Transitions* for those interested persons within the mental health community. It should be considered only as one of many subsequent investigations. Further research in this area using different types of groups, methods of measurement, modification in presentation, and inclusion of other modalities, such as drama, in the procedure should be explored. What is known is that these various individual modalities are continually being demonstrated as effective therapeutic procedures on their own merits. With this in mind, if one considers the notion that the *Visual Transitions* model of photo art therapy features a framework specially designed to blend these procedures, then how can one not recognize the advantage of having this multifaceted resource at one's therapeutic disposal?

In conclusion, and for the reader's interest, this section has been expanded to include selected brief discussion comments made by two of the presenting group members and the therapists during the actual therapy sessions. Photos are also included of the two participants' artwork.

Fred's (a pseudonym) constriction focused on a lack of self-acceptance. The "as I am" pose involved an "unforgiving," even shaming posture (sitting curled up as he shames himself with fingers). He depicted his "as I want to be" pose as one of "conqueror" (standing erect with one foot on chair, and finger pointing to chest boastfully).

> ***"Another possible reason for lack of large statistically significant findings may lie in the homogeneity of this group . . . "***

Comments:

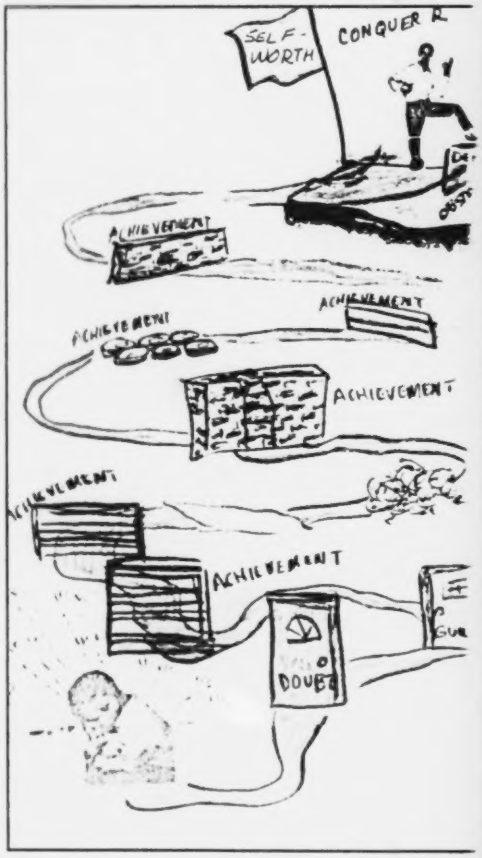
Fred *(when asked about first pose)*: "I feel like I'm not worth anything, everyone is looking at me, just not measuring up."

Fred *(when asked about art object)*: "I'm fighting several obstacles to get to the top."

Dr. Corbit: "How old were you when you first recognized this?"

Fred: "When I was a kid, I was really a klutz. I was a terrible football player in high school and was constantly compared to my older brother who was great. This really

Fig. 2 Fred's first artwork.



BEST COPY AVAILABLE

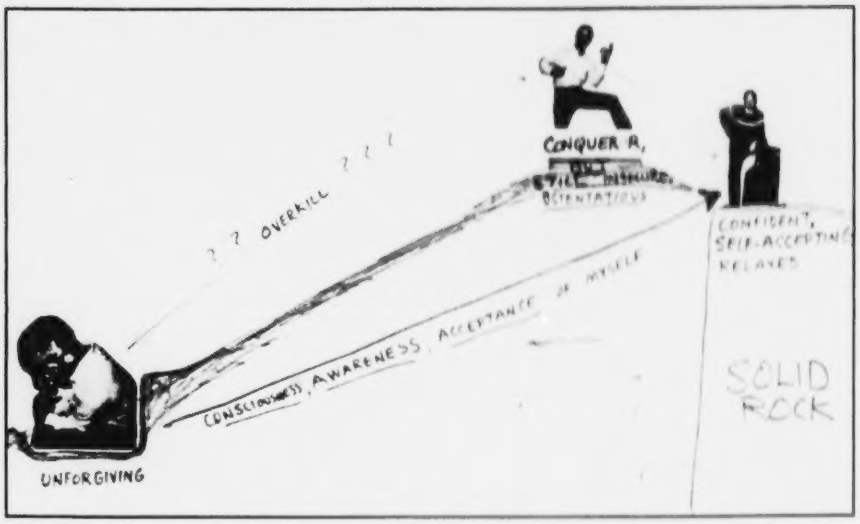


Fig. 3 Fred's second artwork.

did a world of good for me. Later in life, I decided I could excel in scholastics, so I went back to school. This has been my thing. It hasn't been easy for me, but I feel I'm intellectually gifted."

Fred *(pointing to art object)*: "These are my hurdles. The things I can jump over are school, and the things I couldn't get over are athletics. You can see all of this achievement here, that is school."

Dr. Corbit: "Let's try another pose. What is it?"

Fred: "I feel like I want to change that second pose to confidence; this other pose looks a bit conceited for how I want to feel." (Fred then created a second art object in which he illustrated this more preferred transition).

The "as I am" pose for Connie (a pseudonym) is labeled "I can't" (standing slump shouldered, arms crossed, head down). This is contrasted with the "as I want to be" pose entitled "I can!" (illustrated by jumping into the air with heels clicking).

Comments:

Connie: In my first pose, I'm pressing on my right leg and chewing on my lip—and my arms are crossed as a way of holding myself together."

Dr. Corbit: *(assuming the same pose)*: "I'm feeling having been aggressed upon—a lot of hurt."

Connie: "I was the middle of five children—the scapegoat. I was moody and temperamental, and I would stand like this a lot (showing the first pose) . . . a feeling like I didn't need anybody. I wouldn't let them know I was hurting, and I wouldn't let anyone in."

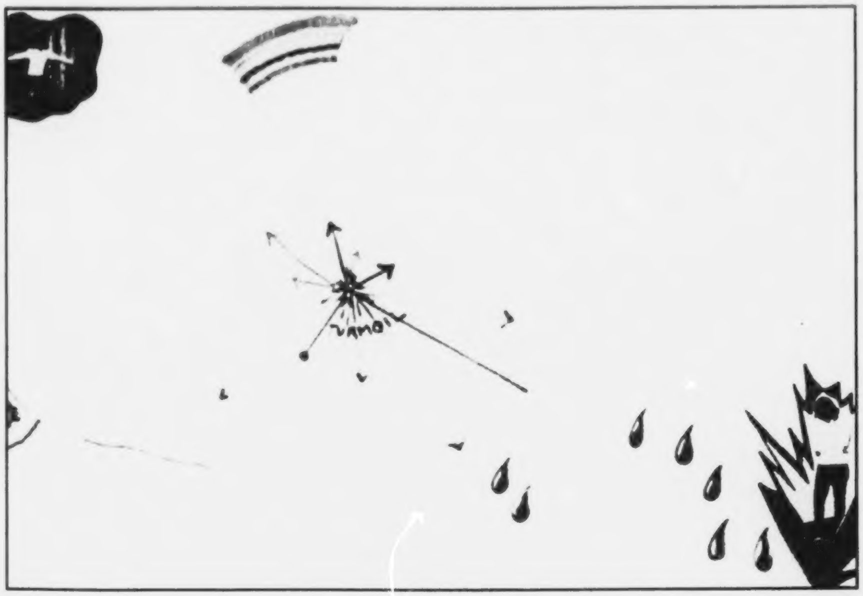
Connie *(illustrating second pose)*: "I've noticed that when I feel really good about something, or I'm happy about something, I'll give a hop, skip and jump (similar to pose), and it feels so good."

Dr. Fryrear: "One thing for sure, you can't jump while you are holding your arms crossed and biting your lip."

Connie: "Right. I wasn't aware that body posture could make you feel a certain way."

Connie *(about her decision to grow)*: "It was a decision to either give up, or go on. I asked myself, 'are you or aren't you?' When I made that decision (to go on), I decided not to go on filled with torment. I felt like if I had a sense of hope, I could try. Ever since then, I'm not at a loss of control over my life. If I lose it tomorrow, it'll be all right—but I know I won't be the one that does it—and I feel peaceful about that. But for a long time I didn't. Because I knew I could always do that if I couldn't take it any more. But now, I know I don't want to."

Fig. 4 Connie's first artwork.



BEST COPY AVAILABLE

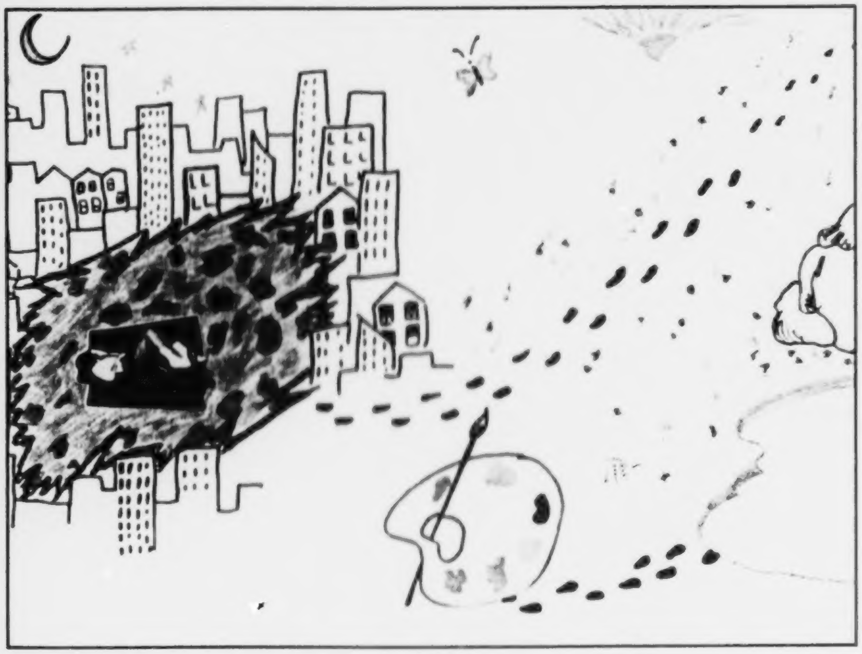


Fig. 5 Connie's second artwork.

Connie subsequently created an art object in which she pictures herself at peace within the elements of the city, in juxtaposition to the tranquility of her worlds of art and nature.

References

Alperson, E. D. (1976). Experiential movement psychotherapy. *Art Psychotherapy, 3,* 3.

Corbit, I. E. (1985). *Veterans' Nightmares: Trauma, Treatment, Truce*—Doctoral Dissertation.

Corbit, I. E., & Fryrear, J. L. (1985). Visual transitions: metaphor for change. *Phototherapy, 3,* 5–9.

Fleshman, B. & Fryrear, J. L. (1981). *The arts in therapy.* Chicago: Nelson-Hall.

Fryrear, J. L. & Corbit, I. E. (1989). Visual transitions. In H. Wadeson, J. Durkin, & D. Perach (Eds.) *Advances in art therapy.* New York: John Wiley and Sons.

Gosciewski, W. F. (1975). Photo counseling. *Personnel and Guidance Journal,* 53(8), 600–604.

Heilveil, I. (1983). *Video in mental health practice: An activities handbook.* New York: Springer Publishing Company.

Hung, J. H., & Rosenthal, T. L. (1981). Therapeutic videotaped playback. In J. L. Fryrear and B. Fleshman (Eds.), *Videotherapy in mental health.* Springfield, IL: Charles C. Thomas.

Jungels, G. (1985). The art of healing: the work of Edward Adamson. *Art Therapy,* 2(2), 79.

Krauss, D. A. & Fryrear, J. L. (1983). *Phototherapy in mental health.* Springfield, IL: Charles C. Thomas.

Reivich, R. S., & Geertsma, R. H. (1968). Experiences with videotape self-observation by psychiatric inpatients. *Journal of the Kansas Medical Society, 69,* 39–44.

Stewart, D. (1979). Photo therapy: Theory and practice. *Art Psychotherapy, 6,* 41.

Wicklund, R. A. (1975). Objective self-awareness. In L. Berkowitz (Ed.), *Advances in experimental social psychology, 8.*

Wadeson, H. (1980). *Art psychotherapy.* New York: John Wiley & Sons.

Appendix A

Self-Report Critique

Please provide a rating value to each of the questions below, and then a brief comment after each to indicate your feelings about that specific area. Please rate accordingly:

1 = poor, inadequate, negative feelings, disagree strongly

2 = less than desired, some disagreement

3 = average, generally acceptable, neutral feelings

4 = good, better than average, general agreement

5 = excellent, superior, very positive feelings, agree strongly

1. How do you feel about the effectiveness of *Visual Transitions* as a therapeutic method? As a therapist, would you use it? Why or why not?
   Rating ________
   Comment:

2. How do you feel about the method of presentation?
   Rating ________
   Comment:

3. How do you feel about the number of sessions?
   Rating ________
   Comment:

4. Do you feel that you experienced some level of growth with respect to your specific area of concern? Please describe.
   Rating ________
   Comment:

5. How do you feel about having cotherapists rather than a single therapist?
   Rating ________
   Comment:

BEST COPY AVAILABLE

6. How do you feel about the group approach in presenting *Visual Transitions* rather than one-on-one?

   Rating ________

   Comment:

7. Do you feel you were able to express your feelings about your particular constriction? Please comment.

   Rating ________

   Comment:

8. Please comment on the group support you felt you received or did not receive.

   Rating ________

   Comment:

9. Do you feel that the mental health community would be receptive to this method? Why or why not?

   Rating ________

   Comment:

10. How do you personally feel about the validity of *Visual Transitions* as a therapeutic procedure?

    Rating ________

    Comment:

11. It is possible to outline the workshop experience as seven elements. How important or helpful was each?

	Rating
Posing and photography	________
Artwork	________
Group discussion of artwork	________
Body movement	________
Video playback of movement	________
Group discussion of movement	________
Group discussion of relationship between art and movement	________

Comment:

ART THERAPY

Journal of the American Art Therapy Association

ADVERTISING RATES

RATES	1x	2x	3x
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140

SPECIAL POSITIONS	additional
Cover #2 (Inside Front)	$130
Cover #3 (Inside Back)	130
Cover #4 (Outside Back)	165

COLOR RATES: Standard Red, Blue and Yellow (Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x
Per page additional	$90	$85	$80

INSERTS	1x	2x	3x
2 pp	$ 800	$ 700	$ 575
4 pp	1,500	1,300	1,150
8 pp	2,200	2,000	1,750

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" x 11"

Bleed Size: 8-5/8" x 11-1/4"

Inserts: 8-5/8" x 11-1/4"

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, IL 60060
(312) 949-6064

BEST COPY AVAILABLE

"Drawing Out the Unique Beauty: Portraits"

***Judith Costello-Du Bois, MA** in Human Development, with emphasis on Art Therapy, Co-founder of Amber Woods Studio, consulting Art Therapist in Zimmerman, Minnesota.*

Abstract

This article focuses on drawing portraits of the client or patient by the art therapist. The author states "This article is an attempt to underscore the therapeutic value of drawing portraits and its [portraiture] potential role in the field of art therapy." Identifying some underlying purposes, the author describes briefly her work with two patients—Amanda and Ted—and concludes with some statements on the reasons for considering this approach when it seems appropriate in the therapeutic context.

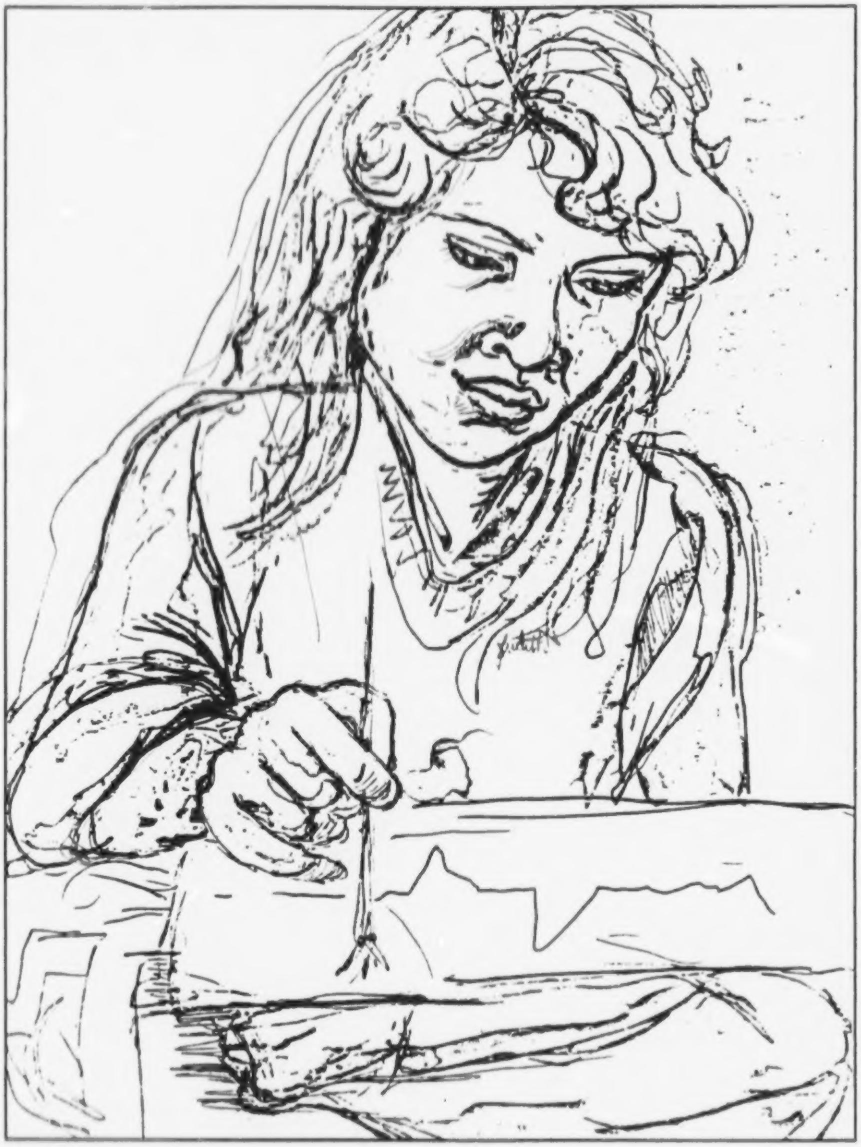


Fig. 1 A girl with cystic fibrosis draws her "life line" while I draw her.

> ***"Throughout my work in the field of art therapy, I have drawn portraits in the quiet moments, when the people . . . are busily working."***

As John worked on his painting he became aware of my eyes studying his face. I asked if I could draw him. He said "yes" and shared his own interest in closely studying the faces and the movements of others. Struggling with a menial illness, John seems to search out his own identity by being a careful observor of others. He seemed content to be the *object* of observation when it was the affirming eyes of my paint brush. He left for the day delightedly hugging the picture I had given him. He said, "This makes my day. I will treasure this, even if maybe I shouldn't because it's of me." His oftentimes averted eyes and guarded expression blossomed into a smile.

Throughout my work in the field of art therapy, I have drawn portraits in the quiet moments, when the people I have been working with are busily working. This article is an attempt to underscore the therapeutic value of drawing portraits and its potential role in the field of art therapy.

Prior to my work as an art therapy student, I drew portraits of street

BEST COPY AVAILABLE

people at a hospitality house. It was a peaceful time for me and the subjects responded to my drawings. It seemed to be a way of giving quiet affirmation. Although I can't document it, the people who were often prone to violence and self abuse seemed to be less so in the days following our time together.

I began my training as an art therapist in 1984, and have now done portraits of old people, hospice patients, children with critical illnesses, and adults who have been struggling with a mental illness. At the hospital where I worked, parents or grandparents would sometimes rush out of a sick child's room, to ask me if I would please come and draw a portrait. No one has ever refused me when I have asked, "May I draw your picture (while we talk or while you're working on that)?" And both the family members and my subjects seem to have felt an impact from this kind of interaction, as well as the end product.

The purpose of art is to communicate nonverbally—touching deeper layers of reality. The artist in me, while doing therapy, has often wanted to share my nonverbal vision with those with whom I work. And so I have taken up pen, pencil or brush at times when I have intuitively sensed that I was ready to communicate via portraiture. And because I have not been trained in commercial portraiture, and where the artist often leaves out wrinkles or 'imperfections' for the purpose of flattery, I am never sure of what I will come up with except that it is my immediate observation and feelings about the person.

The following are some of my experiences in doing this, as I have recorded them in my journals:

"It seemed to be a way of giving quiet affirmation."

"The purpose of art is to communicate nonverbally—touching deeper layers of reality."

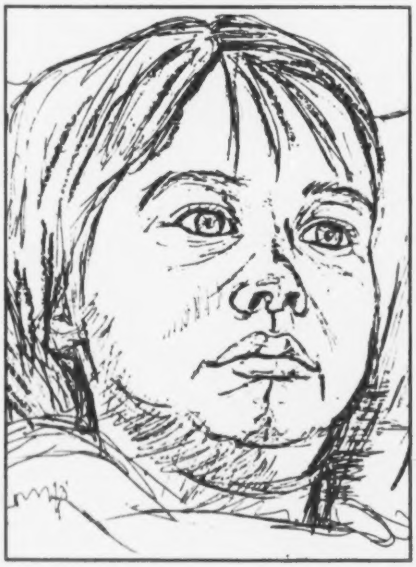
Amanda was one of the first women I drew while doing an internship in art therapy at a Minnesota nursing home. She is a tall, white-haired, very sociable woman—85-years-old—who is constantly chatting to anyone who will listen or pretend to listen, which is what many of them do. Usually she is weaving an elaborate story which frequently includes seeing herself as a young woman coming and going in her parents' house. She deals with the reality of her institutionalized existence by living much of the time in the past or in a fantasy world. But when I sat down next to her to draw her face, I saw another side of Amanda. Before that time she couldn't sit still in the art room long enough to work on much. But on this day she watched my hand with careful attentiveness and was the best, though toughest critic I have had in a long time. She asked if maybe I was really drawing a horse, and "isn't that eye too close?" "There. That's better," she would say and then comment on another line. Eventually she acknowledged liking the picture. After spending forty minutes with Amanda in this portrait session, I realized that she could be lucid and clear when she had a reason to be in the present. She had contributed to the picture by her comments and proudly went off to show it to the nurses and to hang it in her room. She seemed to enjoy coming to the art room more after this time.

Shortly after my time with Amanda I decided to lead a session on body image. It is no wonder that in our youth-obsessed culture, many elders suffer from a poor self concept. Their bodies are wrinkled and don't function in the way they used to. On television and in all of our media, the young and "beautiful" are the focus of attention, while elders are ignored or the object of laughter. As a result of the societal and internalized ageism most of my elderly subjects have felt self conscious but my insistence that "Yes, I do want to draw them," causes a reevaluation of each one's bad feelings about his/her body image.

For the hospital patient who is having a portrait drawn, oftentimes he/she is surprised and pleased to get this kind of individual and intense attention. Like the older person in a nursing home, the hospitalized patient may also feel poorly about his/her body—it seems to have let him/her down. That I would want to draw the person "as he/she is" seems to enhance one's self-esteem.

For the families of critically ill children, who are reluctant to take photos because they don't want to re-

Fig. 2 I didn't realize how scared this boy was until I finished this portrait. He has a life-threatening illness.



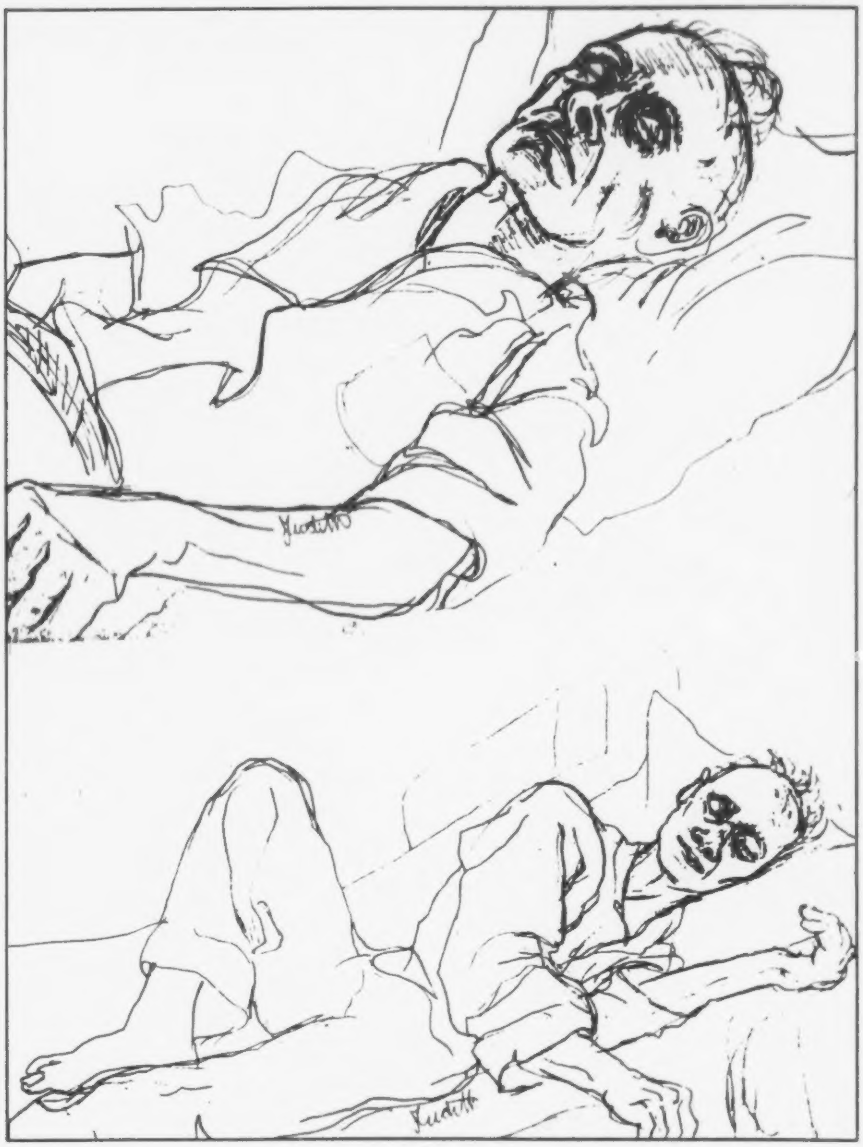


Fig. 3 Al—a hospice patient with cancer. He rested after drawing his self portrait.

member hard times, my portraits might be the last precious picture they have of their child. Children at the hospital have had caricature artists come in but they often react strongly against such a portrayal of themselves, perhaps having already felt laughed at because of the changes in their physical appearance due to illness or treatment. The children I have met prefer to see caricatures done of their family members. Feeling that they are the ones who are odd or different is a sensitive issue for many of these children. My serious portraits seem to convey a sense of acceptance and "ok-ness."

Ted is a young man suffering from schizophrenia. He used to come to our groups spending the entire time complaining about his "horrible, incurable illness." He started out painting muddy messes, always starting in the same way and ending with the same effect, while talking about how he would never get better. One day I felt the need to reach out to Ted and establish a better connection. While he painted, I drew his face, using charcoal to indicate his unshaven look. I was unsparing in my portrayal of his unkempt appearance and yet also captured his slender and refined features. When I was through Ted stared at my drawing for a long time. He didn't have much to say on that day, but at our next group he appeared with a clean shaven face and hair cut. His next series of watercolors were circles of color with connecting lines expressing his sense of connection with those around him. He then decided that he would like to draw faces. I had him look in a mirror and attempt to draw his own face. He said, "My mirror at home makes me look better." He found the mirror more confronting than my portrait. His drawings now became cartoon faces and totem-like structures. During this time he stopped focusing solely on his illness. Eventually he left our group saying that he wanted to find a job.

"My serious portraits seem to convey a sense of acceptance and 'ok-ness'."

Conclusions

Really observing another person's face makes me keenly aware of the beauty and uniqueness of the person I am drawing. I find it to be a profound experience when I can pay attention to the individual—and portray something about his/her spirit. To find beauty in a face—no matter how distorted by illness, or worn by hardship—is an opportunity to experience the connectedness of all life.

This experience of seeing and recording what I see, is what I pass on to others when I share art materials. Really seeing and connecting to the

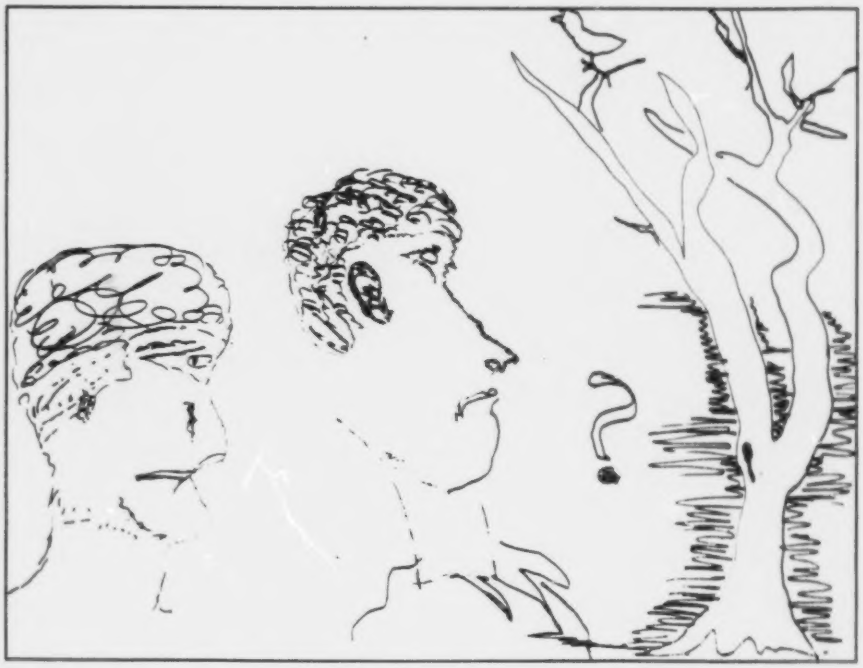


Fig. 4 Al's self portraits with a tree. Al drew this picture while I was drawing him.

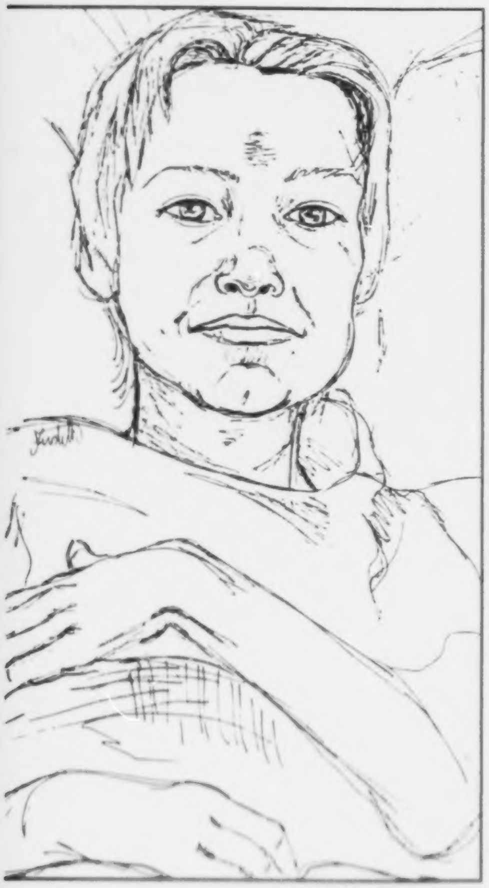


Fig. 5 "Trying to keep a stiff upper lip"—the sensitive face of a young boy in the hospital.

life around us and to our inner experience are essential to mental health.

Drawing faces has been a way for me to spend quiet, special time with people, and a chance for them to see themselves through my eyes. For those whose self-esteem has suffered in facing their physical, mental or emotional problems, this process seems to give them a feeling that their existence is acknowledged. Sometimes, while I draw, they draw too, or sometimes they share ideas about how they want the picture to look. While working with children who have cancer, I have added hair and left out masks and tubes for those who want to see themselves this way. I am beginning to understand this as an important part of my work as an artist and therapist. Not only can people be healed through creative expression and therapeutic interactions, they can also find my art and the products of my vision to be healing.

> ***"Sharing my drawings with those with whom I work has been a major step towards trust building."***

Sharing my drawings with those with whom I work has been a major step in trust building. It breaks down the client/therapist barrier as I share this part of myself. At times it has also been a challenge to those I work with, as in Ted's case. It is a reality check—bringing my subjects into an awareness of their body in a nonthreatening way.

Originally I was worried that my drawing would be intimidating, but I have not found this to be the case. Instead, it seems that it is encouraging and inspiring. It is one way I can participate in drawing out the uniqueness of the individual.

HAVE YOU MOVED??

Have you changed your name, address, phone, zip code....

***If so*, please notify the National Office to insure receipt of your membership benefits.**

•

AATA NATIONAL OFFICE
1202 Allanson Rd./Mundelain, IL 60060
(312) 949-6064

"Post-Graduate Group Supervision for Art Therapists"

Debra Greenspoon Linesch, MA, ATR, MFCC, *Associate Director and Assistant Professor, Graduate Department of Marital and Family Therapy (Art Therapy), Loyola Marymount University, Los Angeles, California;* ***Julie Holmes, MA, ATR; Marcia Morton, MA, ATR, MFC; Sandra Stark Shields, MA, ATR, MFOC***

Abstract

This article describes the experiences of three recent graduates of an Art Therapy Master's Degree Program as they participated in a post-graduate supervision group. The group offered the participants a context for exploring and developing their emerging identity as clinicians by sharing and confronting their clinical work with one another. The six most important themes that emerged are discussed by the participants: 1) Beginning treatment/assessing clients; 2) Establishing goals; 3) Therapists' techniques; 4) What is psychotherapy anyway?; 5) Understanding transference; and 6) Clinical style.

Introduction

Three recent graduates—Julie, Marcia and Sandra—of a Master's Degree Program in Art Therapy participated in a year-long post-graduate supervision group. This group offered the members a context for exploring and developing their emerging identity as clinicians by sharing and confronting their clinical work with one another. To the gratification of the group leader and its members, the experience became a powerful learning process and motivated this attempt to document the group's (and the group members') evolution.

For the purposes of this article, the year-long process has been divided into the six most important themes that emerged as particularly significant for the group members. Each of the participants addresses—briefly, but succinctly and with personal meaning—the six categories in an effort to illustrate how the group provided the opportunity to support the participants' parallel but differentiated clinical development.

Beginning Treatment/Assessing Clients

Post-graduate supervision appears to begin with an interesting paradox, the well-trained supervisee who feels she knows nothing. Apparently needing to regress to a dependent mode of learning, the recent graduate approaches this new training experience in a way that catalyzes a fresh developmental process. Just as the group found it necessary to experience the beginning stages of group process, the individual participants (in an apparent recapitulation of their clinical training) found it necessary to reexperience the beginning stages of psychotherapeutic education. The questions and issues were the most basic and focused on developing a procedure for connecting with and assessing clients. Concurrent with these explorations the group members were developing communicative styles for sharing their very personal experiences as clinicians.

Julie

The transition from intern to professional was a difficult one. As an intern I did not have the exposure to the responsibility that is experienced by the professional. The added expectations for skilled performance at this transition filled me with anxiety concerning my abilities. I recognized my responsibility to the clients who were looking to me for guidance, and felt I was not fully up to the demands of the professional requirement. I was looking for a review of the clinical techniques and skills I had acquired to boost my confidence. The shared experience with my associates revealed a community of anxiety that was reassuring, and the guidance of the supervisor allowed a building of confidence in my acquired professional skills. The finding that other professionals at my level were experiencing the same feelings of inadequacy and the strength gained through the sharing of those feelings coupled with the leadership provided by the supervisor was useful in allowing me to proceed in my professional pursuits with confidence.

Marcia

The major source of anxiety that surfaced in the initial phase of treat-

> ***"The desire to perform well and see immediate improvement in the client was intense."***

BEST COPY AVAILABLE

"I remember coming to the group feeling like a small dinghy, separated from the mother ship in rough water."

ment arose out of my reluctance to trust my knowledge and instincts and what is even worse to be unaware of what I actually knew. The desire to perform well and see immediate improvement in the client was intense. This desire inhibited my ability to react instinctively and creatively to the needs of the client.

Hearing my peers' share their similar anxieties, fears and what they referred to as "mistakes" was an important factor in lessening my anxiety and increasing self-confidence. The universality of seeing our similarities helped us to accept ourselves less critically.

Sandra

I think my sense of need when I entered the supervision group was a result of many concurrent stressors. First, I had endured a very demanding year-long practicum where case management requirements left little opportunity for positive feedback from supervisors. Second, after graduation I had conducted an intensive four-month job search that further negated my self-esteem. Third, I began a new job the same week that the group started and had the "new job jitters." Finally, the act of leaving school behind brought some unexpected emotional consequences. Suddenly I was supposed to be the "art therapy expert" and could not hide behind the safe role of "student."

I remember coming to the group feeling like a small dinghy, separated from the mother ship in rough water. My questions to the group were asked as if to say, "Please give me something solid, understandable and predictable . . . a little piece of land where I can moor my boat for a while."

Establishing Goals

As the group members began to redevelop a sense of themselves in the psychotherapeutic process, and concurrently develop group norms for the exploration of clinical material, treatment concerns focused on the establishment of goals. Like most novice clinicians, group members developed unrealistically high goals, apparently too idealistic and inexperienced to be able to ground their approach in a realistic assessment of their clients. The group focused for some time on the utilization of the art process as a mechanism for sustaining a goal orientation that is attentive to the clients' needs. Although the shared clinical material was comprised of very diverse populations (adolescent groups, recovering addicts and abused children) this theme held constant as group members attempted to accept responsibility for structuring treatment.

Julie

I was working with a population of very disturbed adolescents in a day treatment center. My expectations for the population were beyond what they were capable of. They were not ready to be cohesive in a group and share their experiences, and I was disappointed at being unable to contain them. I found it necessary to reassess my goals for this population and to look at the clients' needs rather than my own. This evolutionary process (in my professional development) was encouraged and supported by the supervision group.

Marcia

Nothing less than a complete "cure" with remission of all symptoms seemed an acceptable treatment goal at first. As a beginning therapist I felt obliged to "fix" the client and make him or her "well" or at least conform to my definition of wellness.

The art, we began to explore in group supervision, could provide a valuable tool in helping to establish more realistic goals that would serve the client's immediate needs. To finally accept a less ambitious goal was liberating and allowed me to be a more attentive and patient therapist.

Sandra

Establishing realistic goals has been and continues to be, a constant struggle for me. Through the supervision group I learned that my idealism often interfered with the establishment of appropriate therapeutic goals. I sheepishly began to admit that the lofty standards I had been setting had more to do with my needs, issues and values than with my clients'.

In supervision group I learned to make a thorough assessment of my clients' needs, strengths, weaknesses, and hopes for treatment, then begin to formulate what was "do-able" in this context. Consequently, I stopped taking over so much of the responsibility for helping clients "get better" and stopped assuming all the credit for therapeutic "successes" and "failures." Most importantly, the group provided a forum for grappling with the input my idealism had had on my feelings of professional "burnout."

Therapists' Techniques

As each of the group members increased her repertoire of clients and therapeutic experiences, the group

"Establishing realistic goals has been, and continues to be, a constant struggle for me."

became a vehicle for sharing successful and unsuccessful techniques. It appeared that the members had reached a more autonomous level of functioning as clinicians and were able to communicate with one another as peers and mutual resources. Ideas about murals, art materials and specific kinds of directives were explored and were just as often initiated by group members as by the group leader.

Julie

Once the early problems of confidence were overcome, the group became not only a valuable and stimulating source of ideas, but a satisfying forum for expressing my own ideas and techniques. The opportunity to share with my peers and witness the process by which they developed techniques, augmented my skills in generating ideas. It was exciting to witness the manner in which new techniques evolved within the group discussions.

Marcia

Group supervision became a rich resource for expanding my repertoire of techniques. The supervisor and fellow group members offered suggestions for directives, art materials and innovative approaches from their particular areas of expertise. As an altruism developed in the group as we shared our similar problems, members became extremely generous with both technical suggestions and moral support. Because of this I feel that the group supervision was perhaps a richer experience than individual supervision might have been.

Sandra

As the group became more cohesive and supportive, it became "safer" to question other members about their work and to share ideas. Often each member contributed suggestions based on their unique outlook, style and area of expertise. Occasionally, members would also discuss books they were reading or brought articles of interest to the group.

The group developed to a point where we began to "be in charge" of the process, as we relied more on each other and less on our facilitator. This was important not only to our growth as therapists, but also to our development as potential future supervisors.

What Is Psychotherapy Anyway?

Once the group's norms had been established and each of the participants had begun to feel comfortable with her developing professional identity, larger questions began to emerge. It became evident that graduate school internships, which had been time-limited and focused on acquisition of skills, had not provided an adequately sophisticated appreciation of the psychotherapeutic process. With the increasing sense of themselves as "professional clinicians" the participants appeared ready to genuinely question the true meaning of psychotherapeutic change. Moving into the middle stages of treatment with many of their clients, they themselves seemed to take tremendous leaps forward into the tentative ground of attempting to comprehend the complex process of facilitating change in another human being.

Julie

My understanding of the psychotherapeutic process moved from an academic question to the central issue of effecting change. This transition to meeting the real challenge of my work was at once exciting and difficult. The group process was very effective in providing an opportunity for exchange with other professionals that were at this delicate juncture as well.

Marcia

I had hoped to address in this group the question that had only been dealt with superficially in graduate school, i.e., how does psychotherapy heal? and how do people change? Seeing a client over a relatively long period of time provided an opportunity to deal with this issue in group supervision. Confrontation of this question motivated reading and much discussion. An insight that emerged often within the group was that "being there" emphatically for the client might be more therapeutic than brilliant insightful interventions, a difficult concept to accept for a beginner who is anxious to help.

Sandra

It seemed that all members of the group supervision began to wonder what "healing" was. In my work with children I would often feel that nothing at all was happening in the treatment. Without fail, the group amazed me by pointing out meaning in the work that I had missed. Often I couldn't see any value in what had occurred precisely because the client wasn't up to my ideals of what I thought he was supposed to be working on and what I thought therapy was supposed to be about. My colleagues helped me pare down my expectations and understand what therapy was actually accomplishing.

As a group we learned that there were not final answers to our many questions; rather, as therapists, we were involved in a lifetime sequence of experiencing, revising, growing, and asking still more difficult questions about the therapeutic process.

Understanding Transference

As the concerns of the group turned toward the increasingly complicated issues of psychotherapeutic progress, transference (and countertransference) manifestations became a focus of attention. Each of the participants appeared to be confident and comfortable enough to explore the sometimes disturbing subtleties of the psychotherapeutic

". . . how I responded in the group situation often gave me insight into my relationship with my clients."

relationships in which she was involved.

Julie

I had my own place and identity within the group and how I responded in the group situation often gave me insight into my relationship with my clients. The group supervision was useful in clarifying the importance of transference in the therapeutic process. It also encouraged me to become increasingly comfortable and confident in the exchange between myself and my clients.

Marcia

As supervision progressed I was confronted with the reality of my importance to my clients, a fact that is often difficult for beginning therapists to accept. Over the year I was helped to become aware of the development of my clients' transference reactions. It was reassuring to have an opportunity to present the dialogue between myself and my clients from a previous week's session. The feedback from supervisor and peers helped me become more sensitive to the dynamics of the therapy session and, importantly, to the client's transference reaction and to my own countertransference.

Sandra

During my time in the supervision group, my understanding of transference grew from seeing it as a phenomenological oddity defined in the literature, to using it as a vital part of treatment. A similar change occurred in my view of the concept of countertransference. As an intern, I remember feeling horrified when supervisors would point out my countertransference about a case. While in the group supervision I began to notice, to my own surprise, that discussions about transference and even my own countertransference no longer made me feel exposed. I became better able to talk about and use these insights for my growth as a person and as a therapist. I think this was aided by the fact that there was increasing evidence that I could do the work and, thus, I no longer dreaded what the process of doing therapy with clients would reveal about myself.

Clinical Style

Although the categories outlined above demonstrate how a professional developmental process was delineated in a somewhat linear manner, a more important process that pervaded the life of the group seems to evade these categories. In a remarkable and profound way, each of the group's participants was able to integrate the understanding she developed and the skills she acquired with her own interpersonal style to create a unique clinical approach. It is this concept that is the most significant aspect of post-graduate supervision and one that validates the use of group process for this training experience. Graduate training, which focuses on "becoming a therapist," provides the necessary groundwork for the post-graduate process of "integrating the therapist identity." Within the context of peer group supervision, each of the participants was able to define and differentiate herself from the training model to become a unique integration of theoretical and interpersonal approaches.

Julie

The group provided feedback to the way I did things, and its acceptance validated my own style. Jealousy was never expressed concerning the individual styles that emerged but rather honest appreciation for the differences in style was evident. This recognition and appreciation for individuality allowed me to fully develop my style with confidence. In some cases when we shared experiences, one of the other group members' own style stimulated something in myself. While not entirely natural to me, such an alternate approach was often useful to my clients' needs and did enrich my developing style.

Marcia

It is still very difficult for me to recognize that I may have a clinical approach that is unique and personal. Clinical style seems to be unconscious and instinctive and once one becomes conscious of style it seems in danger of disappearing or becoming a mannerism. However, I gradually became aware that each of my peers had a characteristic interpersonal manner. As I began to gain self-confidence I sensed that my approach to therapy (based on my training, beliefs and personal psychotherapy) was emerging, although I would continue finding this approach or style difficult to define.

Sandra

One of the striking elements absent in the supervision group was competition. Perhaps in the omission of competition lies the true purpose of post-graduate supervision: that beyond "standardized learning"

". . . honest appreciation for the differences in style was evident."

BEST COPY AVAILABLE

comes "individualized doing," where each person must do the work according to his/her own interests, strengths, goals and personalities. By the end of the year each of us had transformed what we had learned about doing therapy in school into personal clinical styles. Each member openly admired the style of each of the other members, but no one felt that she had to "measure up to" or "become like" the others.

FINAL STATEMENT

The first post-graduate year in a therapist's professional development is a very significant one. The academic and internship training is solidified and integrated with the clinician's personal beliefs and values. Identity begins to be established, providing a springboard for ongoing professional development. The experience of three beginning art therapists attests to the importance of post-graduate supervision and the value of a peer orientation to this learning opportunity.

Guidelines for Authors

Please submit four (4) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed, ATR, Wright State University, Creative Arts Center, 228 Creative Arts Center, Dayton, OH 45435. Send manuscripts and illustrations certified mail, with return receipt requested. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

CONFIDENTIALITY: Client/Patient confidentiality must be protected in title, abstract, text, photos and other accompanying material. Proper releases must be obtained.

BEST COPY AVAILABLE

VIEWPOINTS

"Michael" (Whom Carol Loves)

Carol Cockrum, ATR

This poem was written by my friend and colleague, Perie Longo, in response to my case presentation of two years of art therapy with a preadolescent boy in residential treatment. Perie is a registered poetry therapist who frequently lectures in my courses for the University of California at Santa Barbara Extension. I wanted to share Perie's poem since it so powerfully captures the essence of our profession and expresses the resonance creative art therapists of all kinds can experience as working colleagues.

When he is finished making
explosions on paper
with his fat markers
fighter jets
bang shoot
machines with faces
people with none
volcanos with one eye
at the top of their heads
he asks are there survivors
in space

help help
cries a tiny person
who eats too much who fractures
into uncountable slashes
of uncontrolled red

then draws again a dwarf tree
beside a snowcliff
one swipe would demolish such
helpless green

but Carol knows to gently
mark in one survivor always
even after journeying to an
Unknown Planet
Set on paper a fat full city
mounted
on top
a spindle
set on a
tottering
rock

and they battle on paper
she blue he green he blue
she green and finally one day
he fools her
one small survivor

drifting in from space
onto a field of white in a world
of black
then Michael moves off into gray

after removing all cancer
from clay man's body
and Carol keeps drawing
away

PERIE LONGO, PhD

REVIEWS

Adolescent Art Therapy

Debra Greenspoon Linesch, MA, ATR, MFCC, *Brunner/Mazel Publishers, 1988, 245 pages.*

Reviewer: **Marcia Rosal, PhD, ATR,** *Assistant Professor, Expressive Therapies, University of Louisville.*

Adolescence is a time of self-expression. Expressing one's self is vital in order to make the transition from dependent child to individuated adult. Linesch's book carefully outlines how self-expression through art in therapy can aid this time of transition for adolescents with troubled lives.

Ms. Linesch is an art therapist who has extensive experience working with adolescents in both clinical and educational settings. Her book is the first art therapy text written specifically on adolescents. Although the main topic is art therapy, the book could benefit clinicians from other disciplines who work with adolescents. Linesch's book offers a format to *think* about how to work with adolescents rather than displaying a smorgasboard of activities for the adolescent. The book, therefore, is thought provoking and expanding and is not solely a reference book. The book is written in clear language and is easy to read.

Adolescent Art Therapy offers a psychodynamic perspective on how to understand and impact problems of adolescence through the use of art media. The cornerstone of this volume is Linesch's use of case material to elaborate on her ideas and to enrich the reader's understanding of adolescent issues.

The book first focuses on the creative process in adolescence and the relationship between creativity and mental health. Next, diagnostic considerations for adolescents are covered. Diagnosis is covered through describing inadequate defense mechanisms of adolescence and through the diagnostic categories of the DSM III-R. Linesch thinks the DSM III-R outlines behaviors that suggest a particular diagnosis but does not help the clinician to understand the underlying causes of the problem. Therefore, the delineation of the defense mechanisms serves as the theoretical basis for her work with the adolescent population. A chapter on how to interact with adolescents is followed by case examples. Three chapters are devoted to different tasks that an art therapist who works with adolescents may be asked to perform. First, the art therapist's role as an adjunctive therapist is addressed. Second, the role as a group leader is discussed. Third, Linesch describes how the art therapist can work with the families of the adolescent client. A clinical research study is reported in the final chapter.

The chapter on Art Therapy Approaches describes techniques and therapeutic tools that art therapists can enlist in order to engage with the adolescent client and therapeutic tools necessary to move the client therapeutically. Although Linesch states that she is psychoanalytic in her approach, she acknowledges the use of active intervention when the situation is warranted. In the following chapter Linesch uses two case studies to illustrate the ideas outlined in the approaches chapter.

One example of how Linesch carefully explains her approach and then illustrates the technique concerns a young man whose fears of aggression have immobilized him. One of the techniques concerns active intervention. Linesch discusses the need to thoughtfully plan, sensitively word, and supportingly direct art experiences. Linesch asked the client to create a three-part collage: I fear, I am, and I wish. Producing this collage allowed the client to depict "his impulses, his reactive defenses, and his consequent behaviors" (p. 83). Through this collage experience the client demonstrated his ability to cope with "psychotherapeutic exploration" (p. 86) and his ability to make connections between the collage and his life. The underlying message in this book is that Linesch thoroughly thinks through a case before directing an art experience or using a particular activity. Her interventions are based on solid information about the client and his or her defense system.

Although the clinical case material is impressive and informative the book has two weaknesses. The first is the limited literature reviewed within the theory chapters. The second is the report of the research study.

In chapters one and two, theoretical material is reviewed and discussed as a basis and justification for the approaches Linesch presents. In Chapter One, the creative process is addressed. The amount of information available on adolescents and the creative process is monumental and not easily condensable into one chapter. However, Linesch limits her discussion to two psychoanalysts, Blos (1962) and Malmquist (1978) and one art therapist, Landgarten (1981). The parameters of three authors constricts rather than enlivens this chapter which could have been rich in its depth and breadth.

In the chapter on diagnosis, Malmquist (1978) is the sole author cited in the discussion of adaptive and maladaptive defense mechanisms. The limited point of view may leave the reader with many questions about this topic.

The other weakness of the book is Linesch's attempt at a systematic study. The study was to investigate the relationship between self-expression in art productions and the observable behaviors of the adolescent within a milieu treatment facility. Although Linesch admits that the study is exploratory, and therefore limited, she does not provide the reader with the necessary tools to fully evaluate the work. The protocols for observing the client's behavior are not provided nor are the criteria for assessing the pre- and post-test directed art experience. Without this information the case examples seem flat and purposeless.

However, the weaknesses do not negate the richness the book offers therapists who work with adolescents. Clinically, the book has much to offer in the realm of adolescent therapy.

References

Blos, P. (1962). *On Adolescence*. NY: Free Press.

Landgarten, H. (1981). *Clinical Art Therapy*. NY: Brunner/Mazel.

Malmquist, C. (1978). *Handbook of adolescence*. NY: Jason Aronson.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

1988 AATA

MEMBERSHIP DIRECTORY

Now Available through the National Office

$8.00 member **$50.00** non-member
$100.00 institution

NAME ____________________

ADDRESS ____________________

CITY ____________________

STATE ____________ ZIP ____________

▲ *Mail entire form to:* ▲

AATA NATIONAL OFFICE
1202 Allanson Rd./Mundelein, IL 60060

COLLEGE OF NOTRE DAME

Cool It in . . .

S.F. this Summer
and Collect
Units Toward
Your
ATR

- The only **Master of Art Therapy** program in Northern California approved by AATA
- A **Master of Art Therapy** and **Marital and Family Therapy** which may lead to the MFCC Licensure
- Job opportunities in clinical, educational, and community agencies
- Master in Art Therapy – 37 units
- Master in Art Therapy & MFT – 51 units
- Graduate Art Therapy Institute – 21 units
- Can be completed in two summers and a winter internship!

COLLEGE OF NOTRE DAME
Graduate School
1500 Ralston Avenue
Belmont, CA 94002

(415) 593-1606

ON THE SAN FRANCISCO PENINSULA

Master's Degree Programs in Expressive Therapies and in Creative Arts in Learning

Offered by the Institute for the Arts and Human Development
Lesley College Graduate School

Master of Arts in Expressive Therapies

For students interested in the creative modalities of art, music, dance/movement, and drama, presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning

For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theater studies.

For more information call or write the Institute for the Arts and Human Development, Lesley College Graduate School, 29 Everett Street, Cambridge, MA 02138-2790. (617) 868-9600, ext. 480.

Lesley College
GRADUATE SCHOOL

Lesley College is an Equal Opportunity/Affirmative Action institution.

SAN FRANCISCO
AATA

20th ANNUAL CONFERENCE

NOVEMBER 16-20, 1989

PAINTING PORTRAITS:
Families, Groups and Systems

Mix business with pleasure... foghorns, bridges, cablecars and hills, Fishermans Wharf, Chinatown, North Beach... All are enchanting and inviting. All are there to entertain and excite you as part of a week of professional growth and challenge at the 20th Annual Conference of the American Art Therapy Association. The Local Arrangements Committee and our hosts, the Northern California Art Therapy Association is busy planning special events, setting up local festivities, exhibitions, museum tours and trips to the beautiful and famous wine country. COME JOIN US!!!

WATCH FOR MEETING REGISTRATION AND INFORMATION MATERIALS!

MAKE YOUR PLANS FOR SAN FRANCISCO

Mark your calendars now for November 16-20, 1989. Note that the conference ends on Monday, November 20th—a departure from previous years.

American Art Therapy Association
1202 Allanson Rd./Mundelein, IL 60060
(312) 949-6064

BEST COPY AVAILABLE

Don't wait to hear 'Guilty as Charged' to discover that Professional Liability Insurance is a *Professional Necessity*.

Don't be lulled into a sense of security by a few years of "no incidents." Keep the facts in mind continuously:

Fact #1. A suit for malpractice, whether justified or not, might destroy your career and future security. And it does happen...often.

Fact #2. Trying to forecast a court decision is playing "Russian roulette." Courts may not be familiar with 'appropriate medical practices.'

Fact #3. You can be involved in a malpractice suit even if you were not directly involved in an incident.

Fact #4. If a suit is filed against you, you must be defended, even if the charges are unfounded. And legal fees, alone, can be destructive.

PROFESSIONAL LIABILITY POLICIES ARE *NOT* ALL ALIKE!

Insurance companies which underwrite Professional Liability policies vary widely in coverages, premium rates and claims handling. There are three major areas of difference:

For almost 40 years, Maginnis and Associates, Inc. has been designing and administering Professional Liability Insurance programs for allied health professionals.

Backed by the experience, continuous annual growth and daily exposure within the constantly-changing field of insurance, we sincerely believe that the Professional Liability plan we provide is the best presently available.

Get the details now! Complete and mail the coupon at right for additional information about all the AATA-sponsored insurance plans.

Administered
by

Maginnis and
Associates, Inc.
332 S. Michigan Ave.
Chicago, IL 60604
312/427-1441

a. Coverage Limits. Means the dollar amounts of per-occurrence protection and the aggregate total-per-year protection. Look for top dollars!

b. Premium Rates. Compare this feature carefully. The best insurance buy is the policy that offers the highest coverage limits at the lowest annual premium rate.

c. Don't overlook the "Experience Factor." The best liability programs combine reliable "Old Line" insurance companies with a well-seasoned Administrator.

Maginnis and Associates, Inc.
332 S. Michigan Avenue, Chicago, IL 60604
Please send me information on the AATA-sponsored coverage(s) I've checked.

- ___Professional Liability
- ___Group Term Life
- ___Disability
- ___Major Medical
- ___Excess Major Medical
- ___Cancer Supplement
- ___Medicare Supplement
- ___Accidental Death and Dismemberment

NAME________________________________

ADDRESS______________________________

CITY_____________STATE______ZIP_______

AATA-L-888-03

The American Art Therapy Association, Inc.

1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(312) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapist's Indentity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) 110 pages	$15.00	$20.00
Art Therapy: Professionalism in Practice (1988)	$15.00	$20.00
Art Therapy: Journal of the American Art Therapy Association Rates: Individuals — U.S. $23.00; Foreign $30.00; Institutions — U.S. $27.00; Foreign $36.00		
Art Therapy: Journal - Back issues	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings *Use of the Creative Arts on Therapy (1979)*	$5.00	$7.00
National Art Education Association Journal: Special issue *Art Education, Vol. 33, No. 4 (1980)*	$3.00	$4.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 x 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

*NOTE: for **Publications** postage/handling, add $3.00 for the first unit item, $.75 each additional unit.

SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS.

** Foreign Orders: Require pre-payment for items and then will be billed for shipping charges as you instruct on order:
Air Mail charges (1 week delivery) or Ground Services charges (2 months delivery)

10 or more copies of any single issue: 15% discount on total cost. Discounts are available when purchasing quantities. Set of four Proceedings (consecutive years): 20% discount on total cost.

Indicate Quantity of Unit Items Below		Cost/Unit		Total
____________	( ) X	________	=	________
____________	( ) X	________	=	________
____________	( ) X	________	=	________
____________	( ) X	________	=	________

*Publications Postage/Handling = ________ Total Publications Costs = ________

FILMS (Rental/Purchase)

Art Therapy: Beginnings (1977) color/sound, 45 minutes	16mm Rental Only:	$40.00	$50.00
	½″ VHS, Purchase only:	$50.00	$80.00
Michael (1977) color/sound, 12 minutes	16mm Rental only:	$30.00	$35.00
	½″ VHS, Purchase only:	$50.00	$80.00
Art Therapy (1981) color/sound, 12 minutes	16mm Rental only:	$35.00	$45.00
	½″ VHS, Purchase only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery (1978) color/sound, 32 minutes	16mm Rental Only:	$40.00	$50.00
	½″ VHS, Purchase only:	$50.00	$80.00

*Note: for **VHS Films Purchase** postage/handling add $2.50 for each film. *Note: for **16mm Rental** add $7.00 for postage and handling

Indicate Quantity of Unit Items Below		Cost/Unit		Total
____________	( ) X	________	=	________
____________	( ) X	________	=	________

*Films Postage/Handling = ________ Total Films Costs = ________

ORDER FORM: ***Make checks payable in U.S. funds to AATA, and mail to the above address***

SEND TO: ______________________________ MBR. ID#: ____________

____

City State Zip Code

Member ID# Required__________		*****Member**	**Non-Member**
** Educational Guidelines		*SASE (25¢)	$ 1.00
** Educational Programs List		*SASE (25¢)	$ 1.00
** Standards and Procedures for Registration		*SASE (25¢)	$ 1.00
** Criterion for Professional Membership		*SASE (25¢)	$ 1.00
** Art Therapy Model Job Description		*SASE (25¢)	$ 1.00
** Code of Ethics		*SASE (25¢)	$ 1.00
** Art Therapy Media List		*SASE (25¢)	$ 1.00
** Standards of Practice		*SASE (25¢)	$ 1.00
** Art Therapy Bibliography		*SASE (25¢)	$ 1.00
** Practice Specialty List		*SASE (45¢)	$ 1.00
** Associate Student New Member Applications		*SASE (25¢)	*SASE (25¢)
Professional Membership Application	(9x12)	*SASE (65¢)	*SASE (65¢)
Registration (ATR) Application	(9x12)	*SASE (65¢)	*SASE (65¢)
Model Licensing Bill		$12.00	$25.00
Membership Directory/Bylaws (Institution $100.00)		$ 8.00	$50.00
General Information Packet (Includes first three items)		$3.00	

*SASE — Self Addressed — Legal Size — Stamped Envelope — 25¢ postage per item

**Available in multiples: per item, 1-9, SASE ($1.65), 10-50, $5.00 (UPS), 50-100, $10.00 (UPS)

BEST COPY AVAILABLE

CHARLES C THOMAS • PUBLISHER

NEW!

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 254 pp. (6¾ × 9¾), 56 il., about $38.25.

By **Shaun McNiff,** *Lesley College Graduate School, Cambridge, Massachusetts.* CONTENTS: Introduction; Nomenclature; Interpretation; Re-Imagining the Artist as a Therapist; Self Inquiry. Bibliography.

NEW!

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (7 × 10), 34 il., $38.25.

By **Shaun McNiff,** *Lesley College, Cambridge, Massachusetts.* CONTENTS: Ideas and Process; Jill's Image Work; The Art Therapist's Art. Bibliography.

NEW!

☐ Farber, Norman E., Edmund J. McTernan & Robert O. Hawkins, Jr.—**ALLIED HEALTH EDUCATION: Concepts, Organization, and Administration.** '89, 362 pp. (7 × 10), 17 il., 12 tables, $52.75.

NEW!

☐ Geldard, David—**BASIC PERSONAL COUNSELING: A Training Manual for Counselors.** '89, 212 pp. (7 × 10), 28 il., about $29.75, paper.

NEW!

☐ Dennison, Susan T.—**ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents.** '88, 236 pp. (7 × 10), 36 il., 26 tables, $36.25.

NEW!

☐ Crow, Gary A. & Letha I. Crow—**THE FUNCTIONING OF THE FAMILY SYSTEM: An Educational Approach to Positive Procedures Within Areas of Family Life.** '88, 208 pp. (7 × 10), $32.75.

NEW!

☐ Fine, Aubrey H. & Nya M. Fine—**THERAPEUTIC RECREATION FOR EXCEPTIONAL CHILDREN: Let Me In, I Want to Play.** '88, 362 pp. (7 × 10), 9 il., 22 tables, $49.25.

☐ Dennison, Susan T. and Connie K. Glassman—**ACTIVITIES FOR CHILDREN IN THERAPY: A Guide for Planning and Facilitating Therapy with Troubled Children.** '87, 304 pp. (8½ × 11), 203 il., 12 tables, $36.25, spiral (paper).

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 × 10), 1 table, $34.75.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $36.25.

By **Shaun McNiff,** *Lesley College, Cambridge, Massachusetts.* CONTENTS: Introduction; Historic Trends in American Higher Education; Definition of the Profession Through Education; Characteristics of Academic Training Programs; Common Educational Elements in the Creative Arts Therapies; Specific Media Competencies; Supervision and Evaluation; An Artistic Theory of Mental Health and Therapy; Students; Faculty; Dialogue with Educators.

☐ Nucho, Aina O.—**THE PSYCHOCYBERNETIC MODEL OF ART THERAPY.** '87, 248 pp. (6¾ × 9¾), 50 il., 4 tables, $38.00.

By **Aina O. Nucho,** *University of Maryland, Baltimore.* With Forewords by **Irene Jakab** and **Akhter Ahsen.** CONTENTS: An Invitation to Change; Art Therapy, Psychocybernetics and Systems; Images and Cognition; The Merging of Art and Therapy; Varieties of Art Therapy; Contours of the Psychocybernetic Model; The Unfreezing Phase; The Doing Phase; The Dialoguing Phase; Ending and Integrating; Scope and Effectiveness of the Model. Bibliography.

NEW!

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $44.75.

NEW!

☐ Thyer, Bruce A.—**BEHAVIORAL FAMILY THERAPY.** '89, 352 pp. (7 × 10), 11 il., 7 tables, about $56.75.

NEW!

☐ Lakebrink, Joan M.—**CHILDREN AT RISK.** '89, 398 pp. (7 × 10), 21 il., 6 tables, $63.75.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $74.25.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $42.00.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $24.75.

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $26.50.

Books sent on approval • Catalog sent on request • Write or call (217) 789-8980

2600 South First Street Springfield • Illinois • 62794-9265

BEST COPY AVAILABLE

MIAMI®

18TH ANNUAL CONFERENCE PROCEEDINGS
1987 BAL HARBOUR, FLORIDA

The 1987 AATA Conference Proceedings, "New Directions in the 80's" held in Miami, Florida, November, 1987, are available through the AATA National Office in abstract form.

—●—

PRICE PER COPY:

Member - - - - $15.00 each Non-member - $20.00 each 10 or more - - $12.00 each

QUANTITY COST TOTAL

________ x ____ = ______

SEND TO:

TO ORDER COPIES: Mail order form ➧
along with payment to:

● American Art Therapy Association,
1202 Allanson Rd.
Mundelein, IL 60060.

Please make checks payable
in U.S. funds to AATA.

____
NAME/INSTITUTION MBR ID #

____
ADDRESS

____
CITY STATE ZIP CODE

____
TELEPHONE

◉CHICAGO◉

19TH ANNUAL CONFERENCE PROCEEDINGS
1988 CHICAGO, ILLINOIS

The 1988 AATA Conference Proceedings, "Professionalism in Practice" November, 1988, are available through the AATA National Office in abstract form.

PRICE PER COPY:

Member - $15.00 each Non-member - $20.00 each 10 or more - $12.00 each

QUANTITY COST TOTAL

________ × ____ = ____

SEND TO:

TO ORDER COPIES: Mail order form ➧
along with payment to:

● American Art Therapy Association,
1202 Allanson Rd.
Mundelein, IL 60060.

Please make checks payable
in U.S. funds to AATA.

____
NAME/INSTITUTION MBR ID #

____
ADDRESS

____
CITY STATE ZIP CODE

____
TELEPHONE

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

THE ORGANIZATION

The American Art Therapy Association (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3000 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice; AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliated Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive:

Publications

- *Art Therapy*, the official journal of the AATA.
- The quarterly *AATA Newsletter*.
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- Free AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payers.
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy.

Professional Standards

- Development of model job and licensure laws.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

GENERAL MEMBERSHIP APPLICATION

1. The membership year is the calendar year January 1st through December 31st.

2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY: Please follow the chart below when submitting membership application.
Applications received between

   Jan. 1st and May 31st — Full dues payment; Membership will expire Dec. 31st of same year.

   June 1st and Sept. 30th — Half year dues plus $5.00 payment; membership will expire Dec. 31st of same year.

   Oct. 1st and Dec. 31st — Full dues payment; membership for the remainder of current year and the next full year through Dec. 31st.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval.

4. AATA Membership and AATA Registration (ATR) each have a separate application procedure. Registration is bestowed only by the Standards Committee.

5. National AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL — by application only; such members may vote, hold office and serve on committees.

> **Credentialed Professional Member:** Individuals who have been dually approved for Professional Membership and Registration (ATR) by the AATA; dues are $80 per year.
>
> **Active Professional Member:** Individuals who have completed professional training in art therapy; dues are $75 per year.

CONTRIBUTING — Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $100 per year.

ASSOCIATE — Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75 per year.

STUDENT — Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Student members may not vote or hold office but may serve on the Student Subcommittee of Membership. Dues are $35 per year.

See other side for Application Form

Mail entire form to:

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, IL 60060
(312) 949-6064

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

NAME ______________________
last first middle

HOME ADDRESS ______________________

____

PHONE (   ) ______________________

BUSINESS ADDRESS ______________________

____

__________ ______________________

BUSINESS PHONE (   ) ______________________

EMPLOYER ______________________

JOB TITLE ______________________

LICENSES HELD & STATE ______________________

PREFERRED MAILING LIST

___ HOME ___ BUSINESS

Please indicate which of the following you are applying for:

___ PROFESSIONAL MEMBERSHIP (an application packet for Professional Membership will be sent to you)

___ REGISTRATION (ATR) (an application packet for Registration will be sent to you)

___ $75 PROFESSIONAL MEMBERSHIP (after approval)

___ $80 ATR MEMBERSHIP (after approval)

___ $100 CONTRIBUTING MEMBERSHIP

___ $75 ASSOCIATE MEMBERSHIP

___ $35 STUDENT MEMBERSHIP (see student membership criterion for necessary documents to accompany this application)

PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO AATA
American Art Therapy Association, Inc.
1202 Allanson Rd./Mundelein, IL 60060

Please complete this survey:

Education (please check highest degree earned)

1 ___ Doctorate Degree
2 ___ Master's Degree
3 ___ Bachelor's Degree
4 ___ Associate/Certificate
5 ___ Other

Work Setting (please check one only)

1 ___ Hospital
2 ___ Clinic
3 ___ Day treatment center
4 ___ Rehabilitation
5 ___ Sheltered workshop
6 ___ Correctional facility
7 ___ Residental treatment
8 ___ Out-patient mental health
9 ___ School system
10 ___ Elderly care facility
11 ___ College/University
12 ___ Clinical training program
13 ___ Institute training program
14 ___ Counseling center
15 ___ Private practice
16 ___ Other ___________

Area(s) of Specialization (please check up to three)

1 ___ Addictions
2 ___ Adolescents, Hospitalized
3 ___ Adolescents, Psychiatric
4 ___ Adults, Hospitalized
5 ___ Adults, Psychiatric
6 ___ Art History
7 ___ Art Therapy Education
8 ___ Art Therapy in Schools
9 ___ Children, Hospitalized
10 ___ Children, Psychiatric
11 ___ Domestic Violence
12 ___ Eating Disorders
13 ___ Families
14 ___ Gerontology
15 ___ Hospice/Terminally Ill
16 ___ Learning Disability
17 ___ Mental Retardation
18 ___ Neurological Disease
19 ___ Prisoners
20 ___ Post Traumatic Stress
21 ___ Psychotherapy
22 ___ Rehabilitation
23 ___ Research
24 ___ Sexual Abuse
25 ___ Visual Art
26 ___ Other ___________

Voluntary Information:

Age:

1 ___ 20-24
2 ___ 25-29
3 ___ 30-34
4 ___ 35-39
5 ___ 40-44
6 ___ 45-49
7 ___ 50-54
8 ___ 55-59
9 ___ 60 +

Salary Range:

1 ___ under $10,000
2 ___ $10-15,000
3 ___ $15-20,000
4 ___ $20-25,000
5 ___ $25-30,000
6 ___ $30-35,000
7 ___ $35-40,000
8 ___ $40-45,000
9 ___ $45-50,000
10 ___ $50,000 +

Gender:

1 ___ Female
2 ___ Male

Hours Worked per Week:

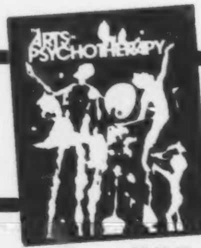
1 ___ 0-10
2 ___ 10-20
3 ___ 20-30
4 ___ 30-40

ART THERAPY
Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1989. Enclosed is my check, payable to AATA, for $23.
Name ____________________
Address ____________________
City ____________________ State __________ ZIP __________



The interdisciplinary journal
devoted to the creative arts as healing arts.

THE ARTS IN PSYCHOTHERAPY
An International Journal

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Assistant Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

Dedicated to scholarship in the creative arts therapies, THE ARTS IN PSYCHOTHERAPY presents innovative research in artistic inquiry and expression, and its use in the treatment of mental disorders.
THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

SUBSCRIPTION INFORMATION
ISSN: 0197-4556 Volume 16, 1989
Published 4 issues per annum

Annual Institution Subscription Rate (1989)	US$110.00
Two-year Institution Rate (1989/90)	US$209.00
Individual Rate (1989)	US$ 40.00
Student Rate (1989)	US$ 16.00

PERGAMON PRESS, INC.
Maxwell House, Fairview Park, Elmsford, NY 10523
PERGAMON PRESS plc
Headington Hill Hall, Oxford OX3 0BW, England
A Member of the Maxwell Communication Corporation Group of Companies

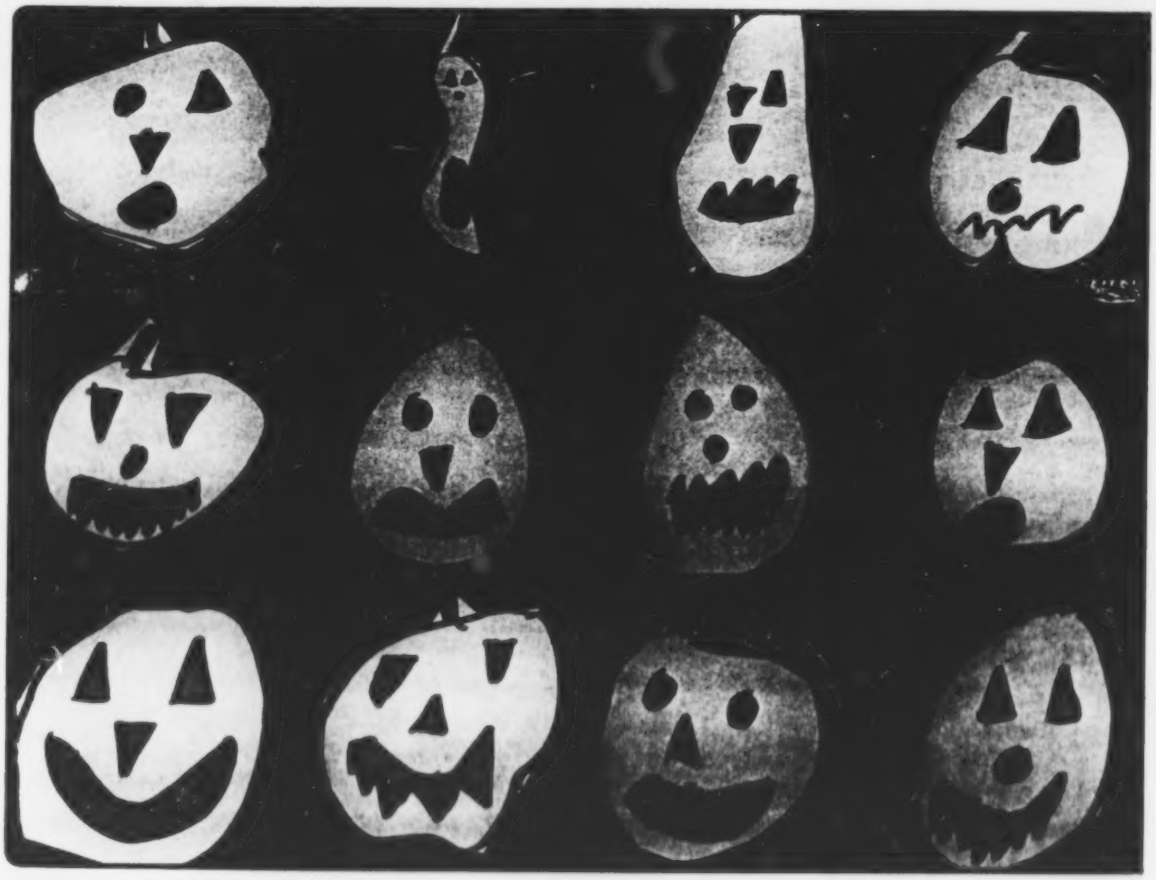
BEST COPY AVAILABLE

CONFERENCE DAYS CHANGE FOR '89

The days for the 1989 Conference will change for 1989. The days and dates for this year shall be from Thursday, November 16, 1989 to Monday noon, November 20, 1989. Please mark these days on your calendar.

ART THERAPY

Journal of the American Art Therapy Association



Volume 6, Number 3 November 1989

- Characteristics of Artwork in Children with Post-Traumatic Stress Disorder in Northern Ireland
  Terry J. Tibbetts, PhD, ATR
- Change: The Reality of the Mental Health Providers' World in the 1990's.
  Shirley Riley, ATR, MFCC
- Art Therapy Education at the Crossroads
  Harriet Wadeson, PhD, ATR
- Beyond Psychic Numbing: Child Art Therapy and the Nuclear Taboo
  Ellen Speert, MEd, ATR

842 BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1988-1989

Board of Directors

President
Cay Drachnik, MA, ATR, MFCC

President-Elect
Linda Gantt, MA, ATR

Secretary
Elaine Laskey, MA, ATR

Treasurer
Dee Spring, PhD, ATR, MFCC

Committee Chairs

Affiliate Chapters
Trudy Manning, MS, ATR

Bylaws
Roberta J.H. Shoemaker-Beal, MFA, ATR

Education
Shirley Riley, MA, ATR, MFCC

Governmental Affairs
Nancy Hall, MA, ATR

Membership
Cathy A. Malchiodi, MA, ATR

Publications
Pat B. Allen, PhD, ATR

Research
Harriet Wadeson, PhD, ATR

Standards
Doris Arrington, EdD, ATR

Clinical
Paula Howie, ATR

Executive Director

Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, EdD, ATR 90
Letter to the Editor
Rawley Silver, EdD, ATR 91

Articles

Characteristics of Artwork in Children with Post-Traumatic Stress Disorder in Northern Ireland
Terry J. Tibbetts, PhD, ATR 92
Change: The Reality of the Mental Health Providers' World in the 1990's
Shirley Riley, ATR, MFCC 99
Art Therapy Education at the Crossroads
Harriet Wadeson, PhD, ATR 103
Beyond Psychic Numbing: Child Art Therapy and the Nuclear Taboo
Ellen Speert, MEd, ATR 106

Viewpoints

Stitched to the Beat of a Heart, to Comfort the Terrors of the Dark
Judy Weiser, MSEd, ATR, RSW 113

Reviews

Advances in Art Therapy
by: Harriet Wadeson, PhD, ATR, Jean Durkin, MA and Dorine Perach, MA
Reviewer: Winnie J. Ferguson, PhD, ATR 115
Gods in Everyman: A New Psychology of Men's Lives and Loves
by: Jean Shinoda Bolen, PhD
Reviewer: Joseph Mancini, Jr., PhD, MSW 117
Adolescent Art Therapy
by: Debra Greenspoon Linesch, MA, ATR
Reviewer: Susan Evans Spaniol, MA, ATR 119

About Our Cover

"Pumpkin Patch" is a cut-paper, marker and paint collage done by an 11-year-old boy with severe attention deficit disorders and perceptual problems. This artwork was done during an art therapy summer camp for children at the Wright Patterson Air Force Base in Dayton, Ohio.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

Volume 6, Number 3 November 1989

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Aina O. Nucho, PhD, ATR, ACSW
Brief Communications
Ruth Obernbreit, MA, ATR
Film Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Marcia May-Chambers

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Susan LaMantia O'Connor, MA, ATR
Paul Rodenhauser, MD
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

American Art Therapy Association, Inc. 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064

Copyright © 1989 American Art Therapy Association

BEST COPY AVAILABLE

EDITORIAL

We are receiving, as I mentioned in earlier issues of *Art Therapy*, a number of articles submitted for review and possible subsequent publication. I appreciate each reader's patience in understanding the time it takes to move everything from the submission of an article, through the entire review process, to publication. As Editor, I also may hold an article for a time in order to "balance" an issue—both in content as well as design. If, for example, there are three articles ready for publication and none of these has visual materials to accompany the article, I will probably pull one for a subsequent issue and replace it with an accepted article that has photographs. Providing that this new article "fits in" with the overall content (an editorial judgment) the photographs will add to the total design of the particular issue. Additionally, the same process may be used relative to the particular content for an issue. A balance of content coupled with good visual design are hallmarks of an attractive, meaningful issue.

In this issue of *Art Therapy* there is a variety of articles, viewpoints, reviews and other information that should pique the interest of each reader. With a cross-cultural perspective, Terry J. Tibbetts, Ph.D., ATR, writes on "Characteristics of Artwork in Children with Post-Traumatic Stress Disorder in Northern Ireland." The horror of war and its tentacles that encircle unwilling participants (in this article, a focus is on children and adolescents) are presented through direct interviews and pictures that seem to underscore the fear and helplessness of battle and the bleakness of life within these conditions.

In a different part of the world—Southern California—Shirley Riley, ATR, MFCC, speaks of some issues that also threaten the life condition—those of safety, chemical abuse, conditions for clinical treatment—and offers advice and direction in "Change: The Reality of the Mental Health Providers' World in the 1990's."

Harriet Wadeson, Ph.D., ATR, similarly describes crises in our professional field (and allied fields), coupled with ideas on art therapy training programs, theory and research, the problems of low pay and questionable training practices. In her article "Art Therapy Education at the Crossroads," she mentions (under "Implications for Training"): "In considering these many possibilities, I encounter more questions than answers." Nonetheless, it seems as if we are at "a crossroads," and Wadeson poses specific areas of concern that (like Riley) challenges the professionals in art therapy to sit up and take notice, to face the issues with understanding, compassion, directness and a sense of purpose for the future.

Ellen Speert's article "Beyond Psychic Numbing: Child Art Therapy and the Nuclear Taboo" presents us with a challenge. Do we, as Speert asks, explore the issue of nuclear existence with openness and sensitivity or do we remain "focussed only on more tangible distress"? In her article, the author identifies Art Therapy as a preventative intervention and discusses how to face the challenge both professionally and personally. It is a timely article about a disturbing topic.

The Viewpoints presentation by Judy Weiser is a poignant account of her volunteer work in the Vancouver Art Gallery during the exhibition of the AIDS Quilt. It is a moving account of some of the experiences (both felt and observed) by her during this exhibit. It also points out the dynamic of the art image as it is presented in various forms and contexts.

Ben Shahn revisited:

"There are, roughly, about three conditions that seem to be basic in the artist's equipment: to be cultured, to be educated, and to be integrated . . . my choice of terms is arbitrary; many words could be substituted and mean approximately the same thing. . . . Begin to draw as early in life as possible. . . . Draw and draw, and paint, and learn to work in many media."[1]

Enjoy the winter months. Maybe it will be the time to start that drawing, or to get back to that unfinished painting. Draw and draw, and paint and paint, and. . . .

Gary C. Barlow, EdD, ATR
Editor, Art Therapy

---

[1] Shahn, B. (1957). The shape of content. New York: Vintage Books, A Division of Random House. pp 128-135.

Letter to the Editor

9/21/89
Gary Barlow, EdD, ATR, Editor
ART THERAPY
228 Creative Arts Center
Wright State University
Dayton, Ohio 45324

Dear Gary:

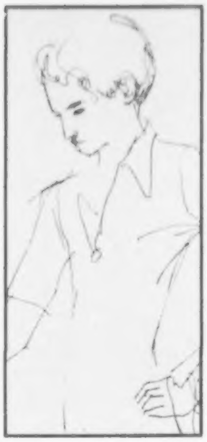
Having just read the article on portraits of patients by Judith Costello-DuBois in the July 1989 issue, I would like to add a few words in support of her approach to art therapy.

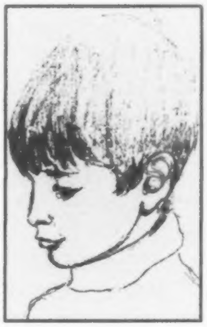
During the 1960s when manual language was forbidden in schools for the deaf, I too found that sketching portraits can be very helpful. For one thing, it can establish an atmosphere of shared work and enjoyment, particularly at the start of a program. In addition, the process of drawing, as well as the drawings produced, can be beneficial. My pleasure in drawing was contagious and my portraits served to communicate feelings of admiration and respect.

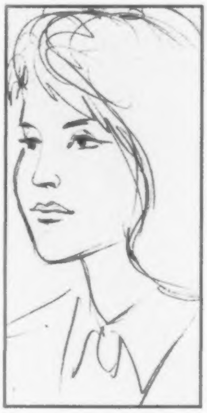
Enclosed are some sketches of children with auditory or language impairments.

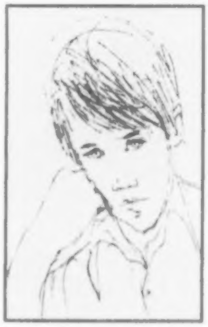
Sincerely,

RAWLEY A. SILVER, EdD, ATR









CORRECTION

In the published overview of the A.A.T.A. 19th Annual Conference (*Art Therapy*, Vol. 6, No. 1, April 1989) paper #14 (p. 7) was incorrectly listed as "Creating the Human Phase." It should be corrected to read "Creating the Human Face." Our apologies to the presenters, Jerald Neuman, Ph.D., and Mildred Lachman-Chapin, M.Ed., ATR, for this error.

ART THERAPY

Journal of the American Art Therapy Association

ADVERTISING RATES

RATES	1x	2x	3x
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140

SPECIAL POSITIONS	additional
Cover #2 (Inside Front)	$130
Cover #3 (Inside Back)	130
Cover #4 (Outside Back)	165

COLOR RATES: Standard Red, Blue and Yellow (Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x
Per page additional	$90	$85	$80

INSERTS	1x	2x	3x
2 pp	$ 800	$ 700	$ 575
4 pp	1,500	1,300	1,150
8 pp	2,200	2,000	1,750

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size:	8-1/2" x 11"
Bleed Size:	8-5/8" x 11-1/4"
Inserts:	8-5/8" x 11-1/4"

SUBMISSION DEADLINES:

January 7 for March issue; April 7 for June / July issue; September 7 for November issue

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, IL 60060
(708) 949-6064

Characteristics of Artwork in Children with Post-Traumatic Stress Disorder in Northern Ireland

Terry J. Tibbetts, PhD, ATR, Psychological Trauma Center, Los Angeles, California

Abstract

Continuing civil and military violence in Northern Ireland has resulted in extreme stress and trauma for many children and youth in that region. A total of 14 children and youth, 6-17 years of age, who met DSM-III-R criteria for Post-Traumatic Stress Disorder, were interviewed and asked to draw a picture of their choice. Characteristics of the resulting drawings included fixation on traumatic events, emotional regression, constricted focus, lack of background integration, distorted body image, depressive indicators, somatic concerns, anger and anxiety. Characteristics were also found to vary by age. Suggestions for further studies are discussed.

Psychic trauma occurs when an individual is exposed to an overwhelming event that results in helplessness in the face of intolerable danger, anxiety and instinctual arousal (Eth & Pynoos, 1985). When exposure to such an external stressor results in a significant impairment in the quality of the individual's psychological and/or adaptive functioning, Post-Traumatic Stress Disorder (PTSD) becomes a primary diagnostic consideration.

The characteristic symptoms associated with PTSD include persistent and intrusive reexperiencing or recollections of the traumatic event, an avoidance of stimuli associated with the event or a numbing of general responsiveness, and increased arousal not present prior to the event, all of which have lasted in excess of one month (American Psychiatric Association, 1987). While the initial conceptualization of PTSD as a specific psychiatric disorder was primarily concerned with its features as seen in adults, extensive research evidence in the past few years indicates that children are equally as, if not more, susceptible to PTSD (Eth & Pynoos, 1985).

Eth (1985) has noted that children who have been directly exposed to terrorist activities are at high risk for development of PTSD, and other research has demonstrated that children exposed to warfare and violence often demonstrate pathogenic behaviors symptomatic of PTSD (Arroyo & Eth, 1985). More importantly, there is strong evidence to suggest that children who have been exposed to violence, but not physically injured, can demonstrate similar PTSD symptomatology (Eth, Arroyo & Silverstein, 1985).

Northern Ireland, nominally a part of Great Britain, has been a center of continuing violence and civil war for almost 20 years. Since 1969, the provisional Irish Republican Army (IRA), a guerilla military organization supported by a large Catholic minority, has sought to defeat British military forces, supported by the Protestant majority, in order to achieve reunification with the Irish Republic. In this struggle, more than 2,700 individuals have been killed, and it has been estimated that by 1975, nearly one family in every six had experienced a relative killed or injured (Rose, 1976). In comparable terms, a similar level of violence in the United States would have resulted in a current death toll of more than a quarter of a million people (Cairns, 1987). Within this setting, children and youth have had little opportunity for escape from ever-escalating cycles of violence. More than one-third of the Northern Ireland population is under 17 years of age (Harbison, 1983), meaning that these individuals have lived their entire lives within the present period of violence which began in 1969.

Other available demographic data suggest additional and ongoing stressors impinging upon the lives of Northern Ireland children and youth. The birth rate is consistently 40% higher, and the average household size more than 20% larger, than for the rest of Great Britain (Berthoud, 1982). Review of infant death trends shows that Northern Ireland demonstrates a higher rate than any other part of Great Britain. The unemployment rate in Northern Ireland is over 25% and more than 30% of children live in a low-income family (Evason, 1976, 1978). Housing in Northern Ireland has been described as "the worst in Europe" (Harbison, 1983), and a 1979 study indicated that one out of five houses was statutorily unfit (Harbison & Harbison, 1980).

Efforts to systematically measure the effects of the ongoing violence and stressors upon children in Northern Ireland, however, have remained minimal, due to several fac-

> ***"Within this setting, children and youth have had little opportunity for escape from ever-escalating cycles of violence."***

tors. Prior to 1978, there was no organized mental health effort to evaluate the impact of continuing violence in Northern Ireland upon children and youth. The few published studies that do exist contain numerous methodological defects and inadequacies, and have done little to further professional knowledge in this area (Harbison & Harbison, 1980).

A further area of confusion is typified by some recent British studies suggesting that the violence in Northern Ireland is producing antisocial or conduct disorders in children and youth rather than post-traumatic stress reactions. Despite research consistently noting that adolescents experiencing post-traumatic stress disorders are prone to unpredictable explosions of aggressive behavior and acting-out behavior (Eth, 1987), the emphasis in British studies has been upon the delinquency of Northern Ireland youth rather than upon the context of overwhelming stress and violence within which such behaviors are generated (Fee, 1980; McAuley & Troy, 1983). Because many British researchers are functionally operating as a part of the British government through its National Health Service, the degree of potential bias is also uncertain. Further adding to the difficulties of accurate assessment, the population most at-risk for PTSD symptomatology, Catholic children and adults who have had traumatic experiences with British military forces, is least likely to cooperate with employees of the British government.

Independent research, however, suggests that there are both quantitative and qualitative differences between those Northern Ireland youth arrested for delinquent community activities, and those arrested for specific behaviors directed against British military forces (referred to by the British criminal system as "scheduled" offenders). For example, Elliot and Lockhart (1980) found that scheduled offenders, when contrasted to regular offenders, were more intelligent and had better educational attainments. Curran (1984) found major differences in that the scheduled offenders scored lower in terms of aggressiveness, autism and value orientation (sensation-seeking) than did regular offenders.

". . . continuing civil and military violence in Northern Ireland has had major effects upon the emotional health of local children and youth."

Regardless, it is inescapable that the continuing civil and military violence in Northern Ireland has had major effects upon the emotional health of local children and youth. For example, the rate of involvement of young people in major criminal offenses in Northern Ireland, expressed as a proportion of the total juvenile population, is approximately 13 times the rate for other areas of Britain, and for children under the age of 18 suspected of murder, the rate is 22 times higher (Millham et al, 1978). It is perhaps not surprising that in 1981, the head of the British military forces in Northern Ireland called the children of the community "a lost generation" (Lawson, 1981).

There remains little or no research data, however, attempting to explore the extent of PTSD among children and youth in Northern Ireland, nor have any studies attempted to explore the clinical dynamics of Northern Ireland children and youth who demonstrate PTSD symptomatology.

The present study, accordingly, was undertaken to obtain clinical data on the characteristics of such children and youth demonstrating PTSD symptomatology as expressed in artwork.

". . . almost all children drew pictures specifically depicting the traumatizing incident or related to it."

Method

The author spent several weeks in the nationalist areas of urban Belfast and Derry over a period of two summers. During this period of time, numerous children and adolescents were identified by community sources as evidencing symptoms consistent with PTSD. After obtaining parental consent, these individuals were interviewed, utilizing a modified form of the protocol suggested by Eth and Pynoos (1985).

Of those children identified by community sources and subsequently interviewed by the author, all demonstrated at least two of the diagnostic indicators considered by DSM-III-R as indicative of PTSD. However, only 14 met the full criteria required by DSM-III-R for formal diagnosis. These 14 individuals, ranging in age from 6-17 years of age, reported persistent and intrusive thoughts of the traumatic events they had experienced; they reported recurrent dreams of the traumatic events; they demonstrated emotional detachment and flat affect; and they were reported by their parents to have exaggerated startle reactions and hypervigilant behavior. Additionally, several of the children appeared to have varying stages of generalized avoidance reactions to stimuli reminding them of their particular traumatizing experience.

The interview format consisted of the author initiating a brief, supportive discussion of the child's traumatizing experience. The child was

"The emotional symptomatology demonstrated by these children was highly significant and easily observable."

then asked to draw a picture and to tell a story about his or her picture. Although children were not specifically requested to draw a picture related to their trauma, almost all children drew pictures specifically depicting the traumatizing incident or related to it. These pictures were typically drawn in a rapid style that showed little attention to detail or background except the minimum needed to illustrate or to explain the trauma.

Eth and Pynoos (1985) have indicated that as PTSD children begin to share their drawings with the adult interviewer, there is often an emotional release which initiates the therapeutic process of overcoming the passive stance of victimization. By contrast, those children interviewed in the present study rarely demonstrated such emotional responses. While a few children interviewed did begin to cry openly as they spoke of the trauma represented by their pictures, they did so only after extensive, directive intervention and reassurance by the interviewer. The majority of children demonstrated a flat and generally depressed affect during the post-drawing interviews, and actively resisted interviewer attempts to elicit their feelings about the traumatizing event. While such differences may have reflected a difference in professional interview style, environmental differences may also have influenced emotional responses. While most of the children in the Eth and Pynoos (1985) study had experienced one major trauma in an otherwise uneventful life, the children in the current study have been forced to continually experience a social environment that promotes violence, routinizes trauma and provokes almost constant anxiety. Thus, these children may have considerably more difficulty in their ability to allow themselves emotional release.

The emotional symptomatology demonstrated by these children was highly significant and easily observable. As noted, while many of the children evidenced marked anxiety and agitation while drawing their pictures, they nevertheless described the actual traumatic event itself in flat, detached voices and actively avoided interviewer efforts to initiate more intensive affect. These children often claimed to have forgotten key elements of the traumatic event, although upon further questioning, were able to recall many of them. Children and their parents both reported significant increase in somatic symptoms such as headaches and stomach aches, although with some children who had suffered actual significant physical trauma, it was difficult to differentiate between somatic and actual physical difficulties. The younger the child, the more likely somatic complaints were to be present.

The adolescents in this sample experienced particular difficulties in focusing upon the specifics of the traumatic event, emphasizing instead ways in which they had attempted to regain a sense of self control through activities such as graffiti, throwing rocks at military and police vehicles, and even paramilitary action against British or local police forces. These adolescents also demonstrated an emotional lability that appeared reflective of what Eth and Pynoos (1985) have identified as a PTSD-induced "reduced capacity for modulation," and which may explain the emphasis of British research on the acting-out activities of this adolescent population. Interestingly, and paradoxically, these same adolescents simultaneously exhibited a touching and poignant sense of their own mortality, and in some ways appeared more philosophically mature and morally developed than many adults in their same community.

Additional characteristics of this sample of Northern Ireland children with PTSD symptomatology can be identified within the context of the drawings made during their individual interviews.

Discussion of Drawings

In reviewing the drawings provided by the children and adolescents in this study sample, a number of similarities common to this particular PTSD population were identified.

Emotional Regression—Many children in the sample drew highly constricted pictures which suggested regression to an emotional level significantly below their chronological ability. Figure 1 was drawn by a 10-year-old boy who was shot with plastic bullets by a passing British patrol while he was kicking a soccer ball against a building. The lack of detail and the poor figural integration are both highly noticeable, as is the relatively small size of the figure when compared to the total size of the paper upon which the drawing was made. Interestingly, while this child was actively resistant to drawing the actual trauma itself, he did make random dots on the paper while discussing the event, which bear a similarity to bullet holes. The handle on the door also appears suggestive in some ways of a weapon.

Constricted Focus—As noted, almost all children drew pictures specifically related to the primary traumatizing event, focusing almost completely on one or more specific symbols or memories of the traumata, and with little interest or concern in drawing background. In Figure 2, a 9-year-old boy drew his

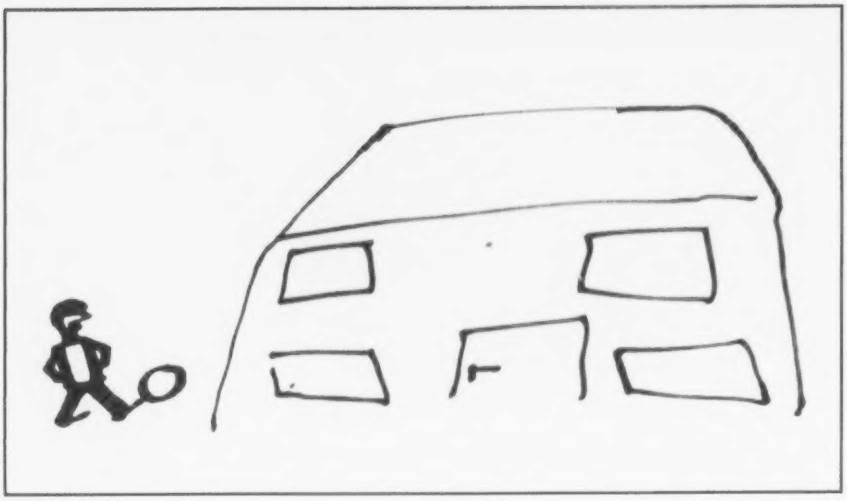


Fig. 1

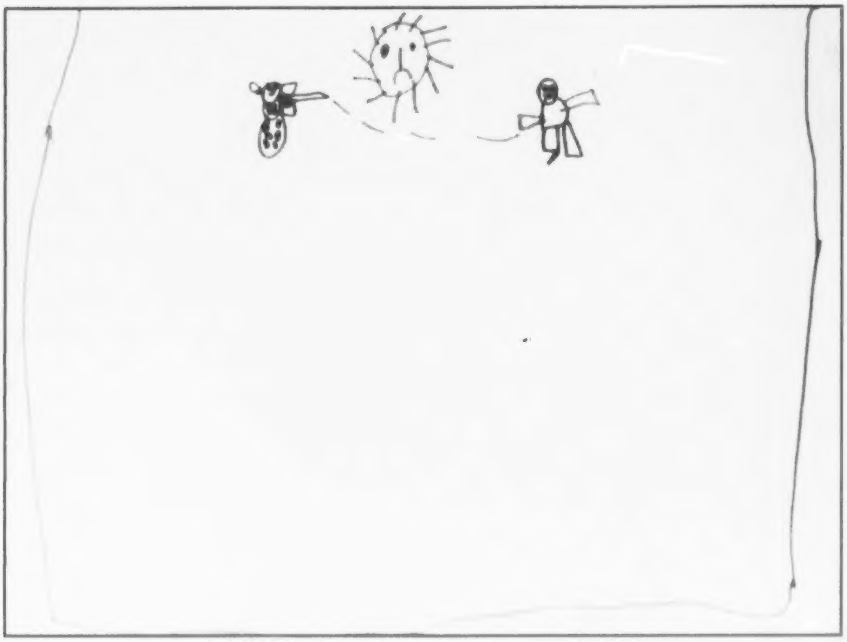


Fig. 2

version of an event in which a British soldier (in the dotted camouflage) suddenly opened fire with plastic bullets upon an individual walking down the street. This individual was unarmed, but was a known leader of the community resistance. The child was only a few yards down the street, and saw the individual hit and collapse in the street from the impact of the bullets.

Again, the quality of this picture appears somewhat impaired from what we could consider typical of a 9-year-old child. Note the lack of hands on the victim, signifying an inability to fend off or to defend against the unanticipated attack. The lines encircling the drawing, which appear functionally unrelated to the picture content, were spontaneously added by the child in an attempt to bind his anxiety, as he described his drawing to the interviewer. The sun with a sad face, often symbolic of children exhibiting depressive symptomatology, was the first object drawn by the child in this picture, who repeated several times during his story that it was a "hot day" when the shooting occurred.

Need for Safety and Security—Some children deliberately chose to exclude themselves from their drawings of the traumatizing events, even when encouraged to include themselves by the interviewer. These children generally appeared to demonstrate the most overt signs of anxiety and mood lability. Other children were able to place themselves into their drawings with little or no encouragement by the interviewer. These latter children, however, tended to symbolically demonstrate their fears and anxiety around the traumatizing event by drawing their bodily boundaries with much thicker and more heavily emphasized lines than other parts of their drawings. This can be seen in Figure 1, and also in Figure 3. In the latter drawing, a child was deliberately targeted and run over by an armored British patrol car. In this drawing, the bodily emphasis is given to the arms, as the child described being so frightened by the apparition bearing down on him that "I hugged myself because I was so afraid."

Lack of Background Integration—As discussed above, the primary focus of the children upon the traumatizing events often resulted in a lack of concern with integrating background into the drawing, unless that background operated in some way as an associated trigger with the trauma itself. In Figure 4, for exam-

---

". . . one of the more striking findings . . . is the almost constant lack of color utilized in the drawings."

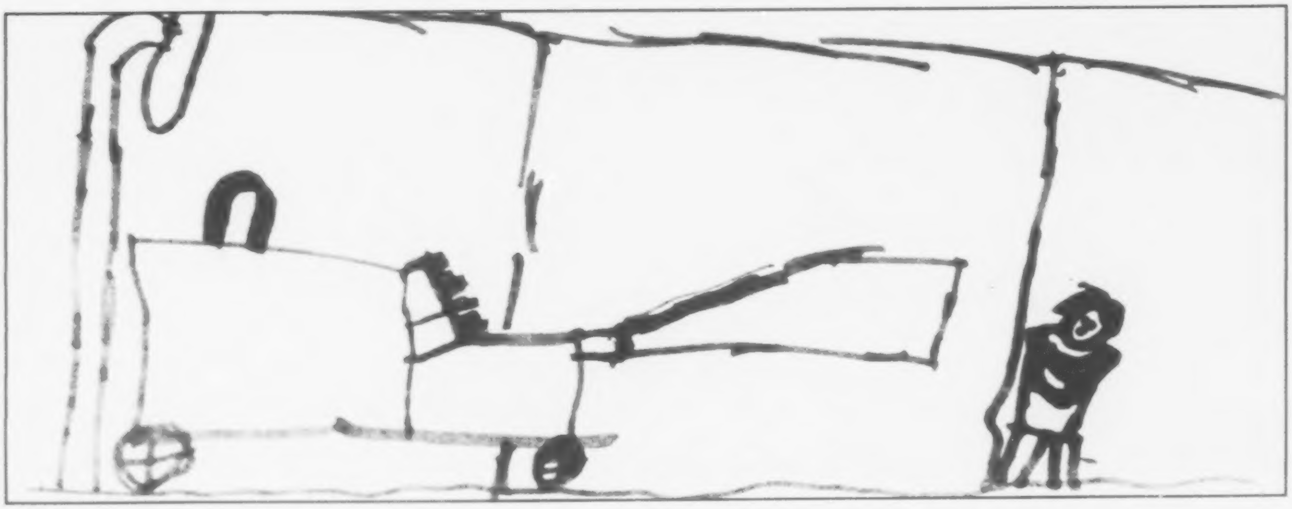


Fig. 3

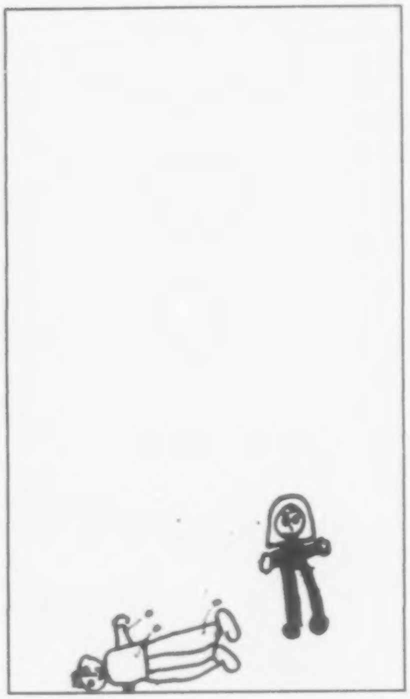


Fig. 4

ple, a 7-year-old girl drew a picture watching an unarmed individual deliberately shot by pro-British terrorists outside her house. With a great deal of emotional detachment, she discussed how they first shot the individual in the leg, then in the arm and finally in the stomach.

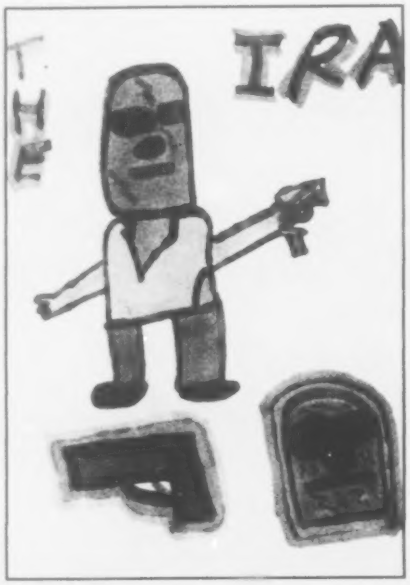
Although this event occurred within a crowded housing project, the child's drawing includes only the two individuals as seen from her front door. The terrorist, drawn with a hood over his face, is completely colored over in an attempt to bind anxiety. Also the child chose not to draw the weapon. Interestingly, however, a sad sun is also visible in this drawing, as is her conception of a British military helicopter, which hovered over the street throughout the incident.

Depressive Indicators—In addition to other depressive indicators already noted, one of the more striking findings in this sample is the almost constant lack of color utilized in the drawings. Only two drawings from the entire sample actively involved multiple colors. Almost all remaining drawings were drawn in either black or monochrome, despite interviewer encouragement to "use as many colors as you like." The two drawings which used multiple colors are particularly interesting from a clinical standpoint, in that these were the only two drawings which appeared to represent active attempts by the individuals to engage in activities designed to resolve their feelings of trauma.

Figure 5 is a drawing completed by a 10-year-old child who stated his desire to grow up and become a member of the IRA so that he could fight the British and "help my country." A more symbolic version of this attitude is seen in Figure 6, drawn by a 17-year-old male, in which a hand, torn by barbed wire, reaches upward through a pool of blood for Irish freedom. The hand is flanked by a flag of the Irish Republic and a flag of the Irish nationalist movement.

Somatic Indicators—Younger PTSD children in this sample tended to avoid discussing particular trauma. Typically, they denied any sig-

Fig. 5



nificant memories of the traumatizing events. Instead, they drew pictures of monsters, and described having nightmares of such creatures during a period of time ranging from a few days to several months subsequent to the traumatizing events. In Figure 7, a 7-year-old boy drew a picture of a vampire, of whom he regularly dreamed. This boy, whose father was an active member of the nationalist movement, had been physically held and assaulted by a British military patrol, including being repeatedly jabbed in the stomach with an automatic rifle, while being told that his father was going to be shot and killed.

In drawing this figure, the child's anxiety was significantly raised, and he immediately drew a box around the vampire in an effort to keep his rising anxiety under control. The lack of both arms and feet is suggestive of the child's feelings of powerlessness concerning the traumatic event itself. It is also interesting to note that what the child spontaneously drew and identifies as the vampire's "heart" corresponds to the stomach area where the child was repeatedly struck with the rifle.

A 6-year-old child from another city also drew a representation of his nightmares as a vampire. As seen in Figure 8, this vampire has stunted limbs and lacks fingers or toes, as well as appearing to be suspended by itself at the top of the paper. In discussing his drawing, the child began by talking about being "scared all the time" and that "there's nothing I can do, they all just keep shooting." As his discussion progressed, however, he grew increasingly disorganized and associational in his statements; accompanying this, he picked up a marker and began to draw hair on the vampire. Still anxious, he then boxed in the vampire, stating than when vampires die, they are put in a big coffin. The child then drew a figure underneath the vampire, which he identified as the vampire's gun. As the child continued to talk, he then began to draw initials. When asked what these were, he denied that he was making initials (which did not correspond to his own), and crossed one out. He later drew a third initial, but again denied that it had any meaning.

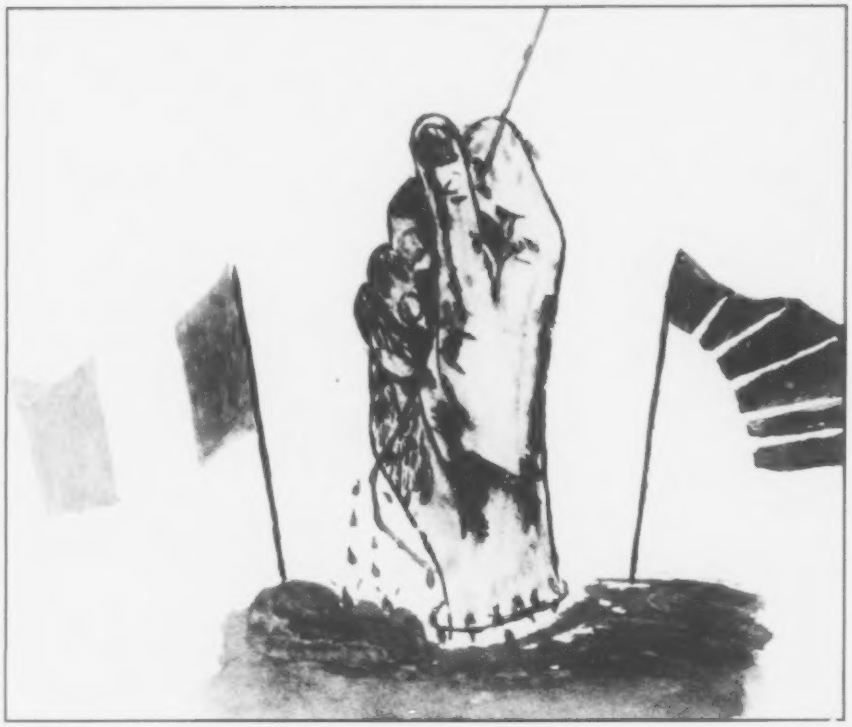


Fig. 6

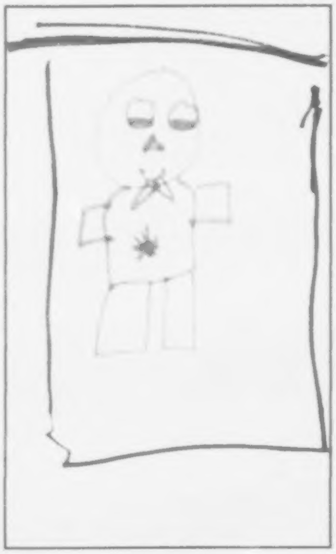


Fig. 7

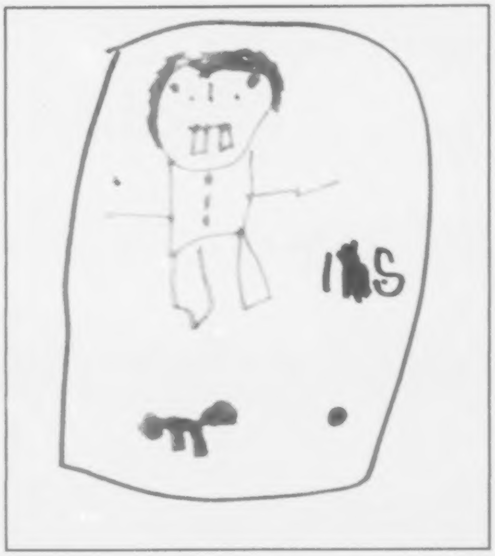


Fig. 8

Summary

From a clinical viewpoint, it is clear that many children in Northern Ireland have responded to the continuing violence in that country by the development of identifiable

PTSD symptomatology. It is equally clear that such symptomatology is manifested in the artwork of these children. Emotional regression, constricted focus, lack of background integration, distorted body image, depressive indicators, somatic concerns, anger and anxiety all predominate in the artwork of the children discussed in this paper, and are further underscored in their discussions of their artwork.

While there is an increasing amount of research in the area of PTSD with children (cf. Eth & Pynoos, 1985), however, there has been little done in the area of diagnostic identification of children with PTSD through artwork, nor ways in which artwork may differentiate subgroups of PTSD children. For example, it is unknown whether artwork characteristics might differ or change as a function of length of time subjected to a traumatizing situation (e.g., chronic violence in Northern Ireland as compared to exposure to a severe earthquake); similarly, the degree of similarities and/or differences in children's PTSD artwork across cultural settings remains an open question. Additionally, there is little research in the area of clinical treatment of PTSD children through art therapy interventions.

It is hoped that this article will serve to stimulate further research in the area of artwork with PTSD children. Only by such research will the necessary knowledge be gained to reduce, and hopefully to ultimately eliminate, the pain and trauma such as that experienced each day by the children of Northern Ireland.

References

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. revised). Washington, D.C.: Author.

Arroyo, W., & Eth, S. (1985). Children traumatized by Central American warfare. In S. Eth & R. Pynoos (eds.), *Post-traumatic Stress Disorder in Children*. Washington, D.C.: American Psychiatric Association Press.

Berthoud, R. (1982). "United kingdom?" *New Society*, January 14, 1982.

Cairns, E. (1987). *Caught in Crossfire: Children and the Northern Ireland Conflict*. Syracuse, New York: Syracuse University Press.

Curran, D. (1984). Juvenile offending, civil disturbance and political terrorism: a psychological perspective. Unpublished paper, cited in Cairns: *Caught in Crossfire: Children and the Northern Ireland Conflict*. Syracuse, New York: Syracuse University Press.

Elliot, R., & Lockhart, W. H. (1980). Characteristics of scheduled offenders and juvenile delinquents. In J. Harbison & J. Harbison, (eds.), *A Society Under Stress: Children and Young People in Northern Ireland*. Somerset, England: Open Books.

Eth, S. (1987). Long-term effects of terrorism on children. *The Western Journal of Medicine*, 147 (1).

Eth, S., Arroyo, W., & Silverstein, S. (1985). A psychiatric crisis team response to violence in elementary schools. In I. Berkovitz & J. Seliger (eds.), *Expanding Mental Health Interventions in Schools* (Volume I). Dubuque, Iowa: Kendall/Hunt Publishing Company.

Eth, S., & Pynoos, R. (1985). Developmental perspective on psychic trauma in childhood. In C. Figley (ed.), *Trauma and Its Wake*. New York: Brunner/Mazel.

Evason, E. (1976). *Poverty: The Facts in Northern Ireland*. Poverty Pamphlet 27. London: Child Poverty Action Group.

Evason, E. (1978). *Family Poverty in Northern Ireland*. Poverty Research Series 6. London: Child Poverty Action Group.

Fee, F. (1980). Responses to a behavioral questionnaire of a group of Belfast children. In J. Harbison & J. Harbison (eds.), *A Society Under Stress: Children and Young People in Northern Ireland*. Somerset, England: Open Books.

Harbison, J. (1983). Children in a society in turmoil. In J. Harbison (ed.), *Children of the Troubles: Children in Northern Ireland*. Belfast: Stranmillis College Learning Resources Unit.

Harbison, J. & Harbison, J. (1980). Unless you're from the place, you can't start to understand it. In J. Harbison & J. Harbison (eds.), *A Society Under Stress: Children and Young People in Northern Ireland*. Somerset, England: Open Books.

Lawson, R. (1981). Presentation to Belfast Rotary Club, April 6, 1981.

McAuley, R., & Troy, M. (1983). The impact of urban conflict and violence on children referred to a child guidance clinic. In J. Harbison (ed.), *Children of the Troubles: Children in Northern Ireland*. Belfast: Stranmillis College Learning Resources Unit.

Millham, S., Bullock, R., & Hosie, K. (1978). *Locking Up Children*. London: Saxon House.

Rose, R. (1976). *Northern Ireland: A Time of Choice*. New York: Macmillan.

". . . there is little research in the area of clinical treatment of PTSD children through art therapy interventions."

Change: The Reality of the Mental Health Providers' World in the 1990's

Shirley Riley, ATR, MFCC, *Field Placement Coordinator, Graduate Department Clinical Art Therapy, Loyola Marymount University, Los Angeles, California*

Abstract

It is important for the art therapist to focus on our environment, the social changes, our professional standards and our training for mental health providers, and to be alert to changes that may be needed for the 1990's. With these issues in mind, the author focuses on three areas for discussion and raises important questions relative to these particular areas: (1) Education (including a focus on legal matters, the plea for the inclusion of methods of safety measures in our curricula, and a better understanding of chemical abuse); (2) New techniques and goals in treatment (with the challenge to move from "tried and true formulae for treatment to unexplored and unfamiliar interventions"); and (3) National/Professional Organizations (with brief recommendations for professional associations, publications and planning for the future).

An article in the *Los Angeles' Times* newspaper (Brian Cahill, January 22, 1989) reviewed the state of affairs concerning the 1.75 million children living in poverty in the State of California as well as the 48,000 in foster care. He found all proper care sadly lacking and in fact diminishing. The general erosion of funds that support Family and Child Services and the loss of mental health monies for general programs begins on the state and federal levels. The population that formerly was housed and served in hospital settings is now directed to find help in out-patient clinics. The clinics in turn are urged to do short-term therapy with only severely disturbed people and to disregard pleas for preventative work. To make the circle complete, many hospitals are under-utilized because they require insurance coverage to pay for cost of service and insurance companies are cutting back payments. As the brunt of demand for treatment falls on the community mental health centers they are caught in the bind of providing services in response to dollars rather than patient needs.

For example, if the clinic has gotten a grant for families with child abuse, those are the families served. Other families with equally serious problems are put on a waiting list that moves at Dickensonian speed through the system. (See Little Dorritt.)

In addition to these hard facts, the neglect often leads to more severe problems. We have, at least in Los Angeles, the ever-widening influence of drugs and gang violence, moving from the south central city and permeating the whole population of this great area. Drugs, crime and broken homes are not special only to Southern California. Across our nation we have many areas where mental health workers in an infirmed system attempt to give aid to persons overwhelmed by an all too powerful aversive ecosystem.

The situation today is one which forces us to evaluate our standards and to question the following areas: 1) Are we training therapists in our educational settings to deal with the real world? 2) Have we modified our theoretical base and therapeutic techniques to be as effective as possible, given the population we service? 3) Are our national professional organizations recognizing and supporting the changing demands on mental health clinicians?

As a family therapist who has been employed by the same community mental health center since 1975 in the Family and Child Division and who has taught in a master's level art therapy program for approximately the same length of time, I would like to share some thoughts on these three areas that affect our future.

Education

The challenge for Master's programs, in my opinion, is to maintain the ground work required in the core curriculum adopted by the American Art Therapy Association and attend that the content runs parallel to state licensing requirements. We may have to increase the credit hours to prepare for the new demands placed on students in practicum. The intern must bring to practicum a much broader knowledge in many areas than was needed in the past.

In addition (see core curriculum in the AATA Guidelines for Education) somewhere we must find the time to educate our students how to deal with some neglected issues listed below.

1) A greater emphasis and familiarity with legal matters. The prepracticum students must understand all reporting laws that have to do with abuse. The ethical concern for child and elder abuse and laws protecting clients who are threatened or are threatening violence are quite clear. However, the responsibility

> *"Drugs, crime and broken homes are not special only to Southern California."*

"The intern must bring to practicum a much broader knowledge in many areas than was needed in the past."

the therapist has in legally protecting herself and the client in cases where the records may be subpoenaed for child custody or in a contested divorce is an area that is rarely discussed in class. There are different approaches to the issue of how much clinical observations or second party reporting should be entered into the progress notes. If the therapist is called to court and held accountable for incidents written into the record the whole matter of confidentiality has to be reconsidered. Each agency has a policy and, hopefully, legal counsel to advise and to deal with these contingencies. The students must be educated how to ask for help if they are called to court, but better still, to ask for instruction how to avoid going to court unless it is absolutely necessary. If the art therapy product is regarded as part of the case record, the students should be very clear what they can say about the art expression and how much of the clients' verbal references they remember or have recorded concerning each art task. Emotional and psychological support should be given students when they anticipate having to give testimony in court or have any dealings with attorneys seeking information. Their status in a court battle or the pressures that may be brought to bear on them is not part of what we usually discuss when advising students about their training in the field.

In California in 1988-89 eighteen million dollars were eliminated from the mental health budget. This resulted in closing many centers that cared for severely chronically mentally ill patients. When these unfortunates became street people, needing medication, having no place to turn where their level of disturbance could be monitored, often the result of these multiple difficulties ended with an outburst of violent behaviors. In February of 1989 a counselor was stabbed to death by a patient who was frustrated by the system. Of course, we recall that this isn't the first time that a therapist was in mortal danger as a result of uncontrolled behavior of a client. However, what is so painfully apparent at this time is that the safety devices that might be life saving such as a panic button system or an active guard service, cannot even be planned since there are no funds to implement the change. So what should the training programs do? Paint and marking pens are not a defense against guns. We must teach our students procedures about self protection and techniques of restraining a violent person. We must alert them to defend themselves against dangers in society—i.e. the neighborhood, working late hours, the need to have colleagues present in offices close by—the informal guarding that therapists can do for one another. A class like this may be more valuable than any one of us can imagine at this time!

Another area of concern is common use of street drugs. The treatment of persons who abuse drugs can be learned from texts, other clinicians, and in supervision. However, what is often missing is help in learning to quickly recognize the behavior of a client who is high on drugs or experiencing hallucinations due to a chemical reaction. The client may be chronically unable to use cognitive abilities normally because of drug-induced brain damage and therefore be irresponsible. Learning to recognize when the client has used alcohol or street drugs or both, and is out of control, is a course that could be called "Saving Your Life." This title is facetious, but self protection and awareness of potential violence in mental health settings must also be a part of our curriculum.

New Techniques and Goals in Treatment

The second section of this article which studies therapeutic techniques designed to "fit" the changed population we serve is a much more personal, individual concern. The challenge is to move from tried and true formulae for treatment to unexplored and unfamiliar interventions. This shift is not always desired by the practitioner. However, the practice of regularly reexamining the theoretical, technical and creative approach to performing therapy is a task even more important than it has been in the past. If society, economics and violence have radically changed the world in which our clients live, how can we assume that the "old way" we have worked with people will continue to be effective under these changed conditions? It is up to each therapist to consider how or if modifications in technique and theory could enhance his or her effectiveness with patients.

For myself, the struggle has always been to fit everyone I see into a crisis or short-term therapy framework. However, I have very little choice, except in private practice, because the clinic has a mandate by the state to limit treatment to accomplishing short-term goals. This is not always successful and it is unrewarding and disappointing to offer a service that appears inadequate to meet the task.

"We must teach our students procedures about self protection and techniques of restraining a violent person."

A few techniques that I have been using more often at this time are identified below. Each art task and construct is designed to enrich a limited once-a-week treatment schedule.

I use many more art therapy homework tasks. Often I suggest an art therapy journal which will focus on helping the individuals observe their own and their families' patterned behavior. That task may be coupled with a proscribed family ritual, formulated to interrupt redundant behaviors. Thus the individual has her/his own focused task and the whole family joins together in different ritualistic tasks. This has proven fairly effective, particularly because the art work has a therapeutic component all of its own. This, contrasted with the "action" requested in a family ritual, seems useful.

A second technique was developed in response to my own confusion in keeping track of the chaotic home life history of many of my clients. A large percentage of the older adolescent youths whom I see in treatment have lived more lives in their limited years than most of us ever will. They often have "done it all" by sixteen years. They often have begun to say "no" to a variety of toxic substances, but the one "no" they cannot say is the "no" their parents must say for themselves concerning their own addiction. Many adolescents and children have, to all intents and purposes, lost their parents completely to the streets, to drugs or to jail. The youths survive in spite of it all—some more successfully than others. I felt that a technique was needed to enhance clarification and appreciation of all the catastrophic events and traumas my patients had survived. By drawing or creating a long "Chinese scroll" piece of paper, a chronological record of their lives is recorded. By reliving these events in the art and gaining some psychic distance, they can achieve some overview of their strengths as they struggle with adversities. They see how they were too young to have the power to change many of the life events. This experience of reliving their lives generally offers an opportunity to relinquish guilt and to mourn and then release the parents who failed them. The scroll becomes a visible record of a battle that has succeeded and a journal of triumph over impossible challenges. An important goal may be reached by these young people—to gain a sense of self worth and pride in their endurance.

Perhaps the greatest change I personally have experienced over the last tumultuous years has been the manner in which I view a family. I rarely see an intact family, in the traditional sense of a married couple with "x" number of children, living together with long-term commitment.

For example, the emergence of the grandparent as parent, and often an unwilling parent for many reasons, is a common family constellation. This often leads to a situation where a youth actively seeks a home environment less stressful than a grandparent's home. This may be manifested by "running away." I have supported that activity if I feel that I can set up a system where the client lets the grandparent family know where they have run in exchange for reducing the demand that they return home. This encouragement is given sparingly and only on a case-by-case consideration. An example follows: an adolescent whose mother and father were entirely out of the picture lived with the grandparents who were confirmed alcoholics. When the girl found a friend who would take her in, and, with the grandparents' consent, I supported this "run away." During this search for a home many of the friends had rejected her, but she persisted until she found a pseudo-foster home for herself. The grandparents approved of the family and were relieved to give up the responsibility of her care.

> ***"Many adolescents and children have . . . lost their parents completely to the streets, to drugs or to jail."***

Often in cases like these the weekly therapy session becomes the only time when grandparents and grandchild can meet on neutral ground and examine the realities in the protected environment of the clinic. Helping the grandparent to help the child to "run away" keeps a relationship alive and provides both generations with a feeling that they have maintained some power and preserved their attachment.

There are many other situations where I can only provide limited services because the larger system has more control than I have in the patients' lives. For example, I see a foster mother and her eight foster children in a family group session. Each one of these boys and girls has a history of abuse and neglect that would qualify him/her for individual therapeutic attention. However, considering that they will live together as long as the court allows and that the clinic would be hard pressed to find eight individual hours for these needy children, we do family group art therapy! It is extremely useful that each member can draw about his or her own troubles and also about mutual attempts to reduce stress in the foster home. I do not feel this is poor treatment, but I do feel a sense of helplessness when a child is removed from the "foster family" by the court and there has been no opportunity to clarify any progress or to deal with separation. So again, we are confronted with compromise and questions concerning choices of treatment.

Throughout all of the examples cited above, and in many other clinical cases too numerous to mention, the one constant that has remained positive is the use of the art therapy modality. More than ever the clients need permanence and security. The real and metaphoric value of the concrete expression that can be brought into a future session, or taken home, as a transitional object, has proven worthwhile. Another component of the art task lies in the duplicity of the work. Many families are court ordered and therefore resentful and resistant to treatment. When they are asked to engage in the mild or non-threatening expressive activity, they are often more compliant. The pleasure component in working together with media, or at the least, keeping eye contact to a minimum, as they focus on the drawing, provides a more positive experience for the reluctant client.

I feel that each of us has an arsenal of creative ideas which will result in therapeutic modifications we desire. If the real world of the clients is acknowledged and incorporated into treatment, there may be a greater success rate for the families and satisfaction for the clinician.

National/Professional Organizations

The individual therapist seeks support and confirmation from peers and from the group that represents him/her professionally. Therefore, if there is a lack of awareness on the state/national level of life on the front-line of mental health service, there will be a break-down in understanding of the larger needs of the professional practitioner. Rather than maintaining an elitist stance, separated from other mental health disciplines, it would be useful to be educated as to the manner in which these are changing disciplines. Conferences can no longer dwell only on clinical presentations, but should give participants practical information, for example, how to write grants, where to find legal advice, how insurance coverage has been challenged, how to lobby, and other political necessities.

The national organization should be courageous and take the undesirable position, when necessary, of leading the members into professional changes that may be unpopular or uncomfortable for many. These changes cannot be legislated without due process, but the members must be clearly informed if there is a threat to their future by neglecting to take certain action. The leaders who have been elected by membership must research the climate of the mental health community at large and guide the members into taking steps that will protect their economic life and their human life.

It is important that the professional publications select material to publish that is reflective of new trends in the mental health field. Change in therapeutic theory and techniques is not only an intellectual challenge but is an economic necessity. For a helping professional to be unaware of current directions in thinking leaves him or her behind when interacting with other professionals. Publishing the current speculations on treatment allows the practitioners in our field to examine the theory and make decisions whether or not it is valid for them. The irresponsible position is *not* to take the chance of exposing readers to what may, in the long run, be just "trendy." The market place is interested in hiring persons who can "talk therapy" with other professionals. They may then justify the individual choices they have made to be effective therapists.

Cultural diversity is an ever growing factor in our society. The national organization must be willing to demand fair representation of all ethnic groups on the various administrative committees. If the membership has not voted, for whatever reasons, for persons who can voice the concerns of minority groups, then consultants can be brought in from membership to enlarge the world view of the executive committees. There are many other solutions which may very well be more inventive and workable and answer this need.

> ***"Change in therapeutic theory and techniques is not only an intellectual challenge but is an economic necessity."***

In the long run the national/state group must change its thinking from linear to systemic. We start with the individual art therapist in the educational system, who graduates and joins the professional mental health service system, who then interfaces with the larger social system and is supported and informed by his/her own state and national professional system. All of these worlds interlock and cannot be seen as functioning independently. This concept is not original or unique by any manner or means, but to operate on all levels with this image in mind seems to be difficult for many therapists.

Summary

The day the mental health worker was stabbed to death in Los Angeles started a ripple effect that impacted the whole state of California mental health service and its economic and moral awareness. My hope is that through education, expert professional techniques, social awareness aided by direction and support of the state and national professional organizations, we can start the same impactful movement toward change without encountering violence and sudden death. The only armor against fear is knowledge. Knowledge of how to stay alive and useful in a system that at this time in history seems to be threatening. The struggle is worth the price and invites growth and change and provides another challenge for each art therapist's creativity.

Art Therapy Education at the Crossroads

Harriet Wadeson, PhD, ATR, School of Art and Design, University of Illinois at Chicago

Abstract

This paper attempts to note the implications for training arising from the contextual development of the profession so that Art Therapy's growth may be purposeful and directed rather than merely reactive. There is a reciprocal relationship between training and practice; training shapes our future professionals, but influences on the profession direct the shape that training takes. Some of these influences include the effort to gain licensure for art therapists, increasing numbers of art therapists who have undertaken doctoral work and low pay scales for art therapists. Additionally, various training programs are presently training different kinds of professions. One possible outcome may be more clearly delineated diversity within Art Therapy.

The hybrid profession of art therapy has never been particularly light on its feet in straddling the very different worlds of art and therapy, with one foot in each as it shifts its weight back and forth trying to maintain its balance. The question that has been raised throughout art therapy's existence—are we artists or therapists?—has never been resolved.

The question of who we are and what we do is central to art therapy education. What are we training our students to become? There are those among us committed to the identity of the artist who see our mission as fanning the creative spark in others so that they too may know the warmth and nourishment we artists derive from our creative expression. Others among us view art therapy as a helping, healing profession whose aim is human growth and whose means is image-making. Some have claimed that art therapists are trying to become psychotherapists by entering that world "through the back door." And there are the rest of us, probably most of us, who shift back and forth depending upon the needs of our clients and patients and the setting and circumstances of our work.

> *"The question of who we are and what we do is central to art therapy education."*

There is a reciprocal relationship between training and practice. Training shapes our future professionals and therefore the directions the profession will follow. Conversely, influences upon the profession direct the shape that training will take. Some recent events have significantly impacted art therapy training and art therapy practice.

Crisis in California

California, the last frontier in the pioneering of our country, is often the first frontier of new ideas, trends, styles, and practices. California gave us Esalen, New Age, Human Potential, and, politically, Ronald Reagan, John Birch, and Richard Nixon. But more recently, California has given licensure to art therapists. If one has followed California art therapists' struggle with eligibility requirements for the Marriage and Family Counseling Certification license, then one realizes that this license was readily obtained by art therapists until recently. A couple of years ago MFCC eligibility was tightened and initially art therapists were no longer permitted to apply. After a long and arduous struggle, however, art therapists gained the right to sit for the MFCC examination *provided* they had taken the following courses:

> *"There is a reciprocal relationship between training and practice."*

Human Growth and Development
Human Sexuality
Psychopathology
Cross Cultural Mores and Values
Theories of MFC Counseling
Professional Ethics and Law
Human Communication
Applied Psychotherapeutic Techniques
Research Methodology
Psychological Testing

As is apparent, a heavy clinical and sociological preparation is now required. Art therapy training programs as previously organized faced the possibility of losing students. In the past, students graduating with a Master's degree in art therapy programs were eligible for California licensure. In that most art therapy programs were not offering all the newly required courses, this was now no longer the case. The results of this condition have brought about changes in California art therapy training. Two examples are cited:

1) Loyola Marymount College in Los Angeles has reorganized its training to provide the necessary course content to meet MFCC requirements. Two of its faculty even traveled to Washington, D.C. to the Marriage and Family Counseling Association headquarters for advice and recommendations.

2) The art therapy Master's degree program that for many years had been located in the Art Department of Sacramento State University was discontinued and a new program inaugurated. This program is a Master's degree in counseling with a specialization in art therapy. It is located in the Counseling Department, and students, in addition to taking the MFCC required courses, must also take the basic counseling courses required by the department. The result is that there are relatively few art therapy courses that are a part of the program.

This latter model of art therapy training poses significant questions for the development of the profession. Due to licensing considerations, will art therapy become a subspecialty of one or another mental health professions (counseling, social work, clinical psychology)? Will training emphasize clinical, non-art based courses as it must in California for license eligibility and as it may for art therapists to be covered by National Health Insurance when it is eventually enacted? For example, Nancy Hall, AATA Government Affairs Chair, has stated that in order to qualify as a mental health profession with "equivalent training" to those likely to be insured, art therapy training will probably need "a more uniform core curriculum, and one that is in line with those for counseling programs" (Memorandum to AATA Board of Directors, February 25, 1988, p. 2).

Directions of "Doctors"

There are other developments as well that both result from training and impact upon it. As our profession has matured, and more training opportunities have proliferated, more and more practitioners are seeking and obtaining doctorate degrees. In Chicago, several art therapists who have earned doctorates in clinical psychology and are presently employed as psychologists, not as art therapists. At the same time, some art therapy training programs are pursuing the possibility of developing doctoral degrees in art therapy (Lesley College and Wright State University, for example). On the one hand, therefore, some of our "doctors" are leaving art therapy, whereas on the other hand, there are likely to be art therapists with advanced training invested in further development of art therapy as an intact profession.

"As our profession has matured . . . more practitioners are seeking and obtaining doctorate degrees."

Theory and Research

In the realm of doctoral work, it appears that what is needed in the profession is theory building and research. Interestingly, in editing a book titled *Advances in Art Therapy* (John Wiley Publishers, in press, 1989), I had hoped to include chapters on theory and on research. The material submitted reported expansion of the field in new populations treated and new methods used, but there was hardly any work in theory building or research. This representation of new work in art therapy is an accurate picture of the way we are advancing—in clinical rather than scholarly directions. What does this imply regarding advanced training? Is there a sufficient body of knowledge to support doctoral work? Or on the other hand, will it be doctoral dissertations that will supply the theory and research the field needs?*

Low Pay

There are other influences within the profession that may develop into directions as well. Some art therapists have become disenchanted with the low pay and low status of art therapy in the mental health hierarchy.

Although attrition is expectable in any profession, low pay has caused some of art therapy's educators to leave the field altogether. Three directors of art therapy training programs who have moved into the financial area come to mind. (One told me recently that her present salary for selling securities is triple what she earned as an art therapy educator!)

Another result has been a movement away from the usual institutions that house art therapy. For example, in Chicago, Gail Wirtz, ATR, has formed The Creativity Development Center, a private entity that is composed mostly of upper middle class "well" children's groups. The purpose appears to be more growth-oriented than problem-oriented. The staff are referred to as "art instructors." Other "centers" utilizing this model have been formed in Chicago for less privileged children. Might more art therapists move in this direction?

Questionable Training

The movement away from a clinical approach has spawned some questionable training as well. Recently I read an advertisement for art therapy training at a "growth cen-

". . . it appears that what is needed in the profession is theory building and research."

---

*For further discussion of advanced training, see Wadeson, H. (1987). *The Dynamics of Art Psychotherapy*, chapter 13, John Wiley, New York.

ter" that claims to prepare students for art therapy registration. The advertisement spoke of "soul birthing." Would one enter such training to obtain a soul? Is it implied that a student doesn't have a soul until it is born in the training? What does such advertising say about art therapy training and the profession? Do we want others to believe that we will provide them with souls?

Summary of Influences

It seems to me that at present art therapy education runs the gamut from highly clinical (MFCC), to more art and art education based, to out-and-out flakey. It appears as well that influences such as licensure and third-party payment are likely to encourage training of art therapists as specialists in other mental health professions. It is also likely that the low salaries in art therapy will encourage our more ambitious practitioners to leave the field or develop private practices. (The latter may require considerably more financial backing initially than most art therapists have and therefore provide possibilities limited to few.) And finally, the increased number of art therapists earning doctorate degrees will likely have the double effect of enabling some of our most promising professionals either to leave the field or to strengthen it.

Implications for Training

In considering these many possibilities, I encounter more questions than answers. It seems apparent, however, that training will both respond to prevalent directions and create them. If art therapy is true to its past, it will remain divergent. And perhaps the pattern we will see emerge will be one of even greater divergency. The emergent direction may be an even greater division between art and therapy. We may find ourselves embracing clearly identified clinicians who use art, artists who heal, and scholars who conduct research.

With these considerations in mind, it behooves those responsible for art therapy education to recognize that any one training program would be hard pressed to provide an adequate foundation for all directions. In other words, it is likely that the greater divergency in art therapy practice will be paralleled by a greater divergence in art therapy training programs. Art therapy educators, therefore, should plan training carefully for the *kind* of art therapist they are preparing. They should be clear about the objectives of the particular training they provide and identify themselves accordingly.

Hopefully, the profession's public relations efforts would reflect the increasing diversity within the field so that those who hire art therapists and utilize our services will be aware of the profession's many possibilities. Such publicity would inform prospective art therapy students that becoming an art therapist offers a choice of directions. As training programs identify themselves along a continuum of possible training and resultant professional routes, applicants would be able to acquaint themselves with the different objectives of each and matriculate accordingly.

The Crossroads

It is important that art therapists and especially art therapy educators make themselves aware of the strong winds that are blowing and the tides that are shifting in our field. I believe we have reached a point of departure toward possibilities of greater divergence and that this new place is a crossroads for art therapy education.

As a hybrid profession of creative individuals, we have always resisted uniformity. If our emergent pattern is even greater divergence, hopefully the path we follow will be one that embraces our differences with understanding, grace and sensible planning.

Finally, although the picture I am painting might appear to be that of a profession flying to pieces, I believe our developing doctoral programs hold the potentiality of providing us with scholars who will articulate theoretical common ground on which we can all maintain our balance. That in itself will be another new direction.

WRIGHT
STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

Beyond Psychic Numbing: Child Art Therapy and the Nuclear Taboo

Ellen Speert MEd, ATR, *Instructor University of California San Diego, Adjunct Faculty, the Union Institute, Lecturer, Institute de Perfectionment de Travailleures Sociaux in Lusaunne, Switzerland, Private Practice in San Diego*

Abstract

The existence of nuclear weapons and its effect on the pyschological development of children present art therapists, and indeed all those who have any contact with the young, with an unprecedented challenge. Do we as mental health professionals explore openly and sensitively this frightening issue (as we have been trained to do with other previously held taboos such as sexuality) or do we retreat, ignoring the signs, misinterpreting the graphic message, remaining focused only on more tangible distress? This article presents the school age child's dilemma: being aware of the risk of nuclear annihilation but lacking the psychological defenses with which to protect him/herself. Studies are cited demonstrating this knowledge and a framework is presented in which to view the psychological and behavioral ramifications. Art therapy is presented as a preventative intervention and the inclusion of examples of children's art work illustrates both early awareness and concern. The author concludes by addressing the implications for the therapist in meeting this societal taboo both professionally and personally.

> *"This nuclear vision may overwhelm the imagination but the subconscious cannot block it out. And the young, with their higher degree of susceptibility, their more active imagination, also have more fragile defenses. Some begin to believe it's easier not to grow up . . . the future seems too terrifying, too negative, too black."*
>
> HELEN CALDICOTT, MD
> President of Physicians for
> Social Responsibility

Our society is becoming increasingly aware of the sensitivity and concern with which children view the world situation and the threat to survival posed by the existence of nuclear weapons. Yet because of the immensity of the situation and the lack of existing guidelines on how to address these issues, most adults have chosen the path of least resistance: numbing themselves to this awareness, keeping busy, addressing more immediate or tangible issues. Perhaps it is as Joanna Macy (1983) contends in *Despair and Power in the Nuclear Age*, that our society frowns on raising a problem without a solution. We as art psychotherapists are not in the business of providing solutions. Rather, we are the providers of a frame inside which individuals can enact the creative struggle, regardless of the question raised or the problem explored. Do we by our own avoidance of issues without answers, our own fear of confronting not individual death but global death, sidestep an issue which is subtly brought into the art therapy session? Perhaps we contribute to our young clients' sense of isolation and despair by our own "psychic numbing." This is a term Robert Lifton (1982) coined to describe the denial of reality in order to protect oneself from what would otherwise be too overwhelming.

Developmental Theory

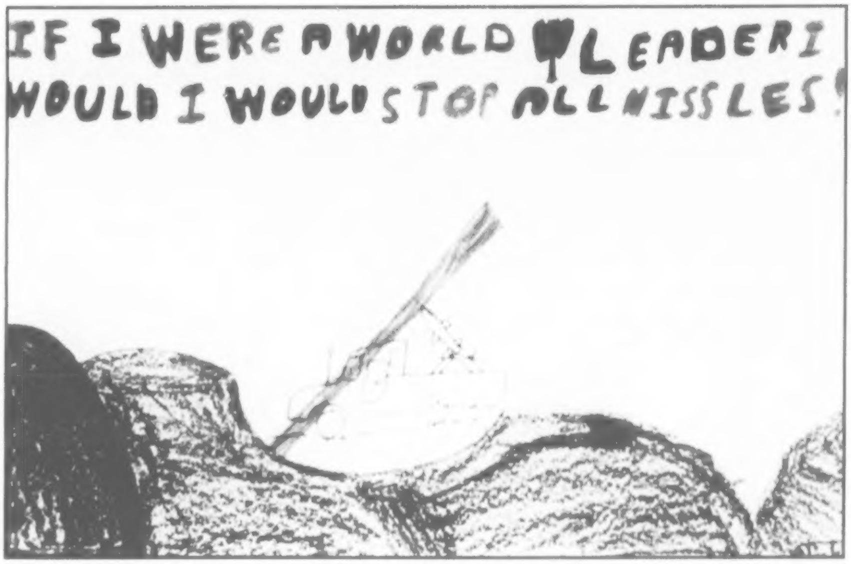
A brief citing of developmental perspective will provide the framework through which to view elementary school children's art and to understand the research studies listed. The way children meet the challenges of growing up is greatly influenced by the physical and emotional environment in which they find themselves. Placing this in the context of Erikson's "Ages of Man," one can look at the two primary developmental tasks. The first is "Industry vs. Inferiority" in which the child either becomes absorbed in creative involvement with peers and environment, or withdraws, giving up in such endeavors. The second stage, "Ego Identity vs. Identity Confusion," hinges on the existence of viable adult role models: adults who supply strong, reliable examples for the child to emulate. Are these two tasks being compromised? Does the knowledge of adult responsibility for the nuclear crisis we face interfere with the child's desire to identify with these adults?

Another framework within which to view child development is object relations theory. Mahlher and Kernberg write of the need to integrate the good/bad in the emerging sense of self and others (p. 30, Greenwald and Zeitlin). In order for the child to develop as a separate and individual human, possessing a sense of empathy, this split must be integrated. How does our society, with its rhet-

"The way children meet the challenges of growing up is greatly influenced by the physical and emotional environment in which they find themselves."

oric posing the United States as all good and "God fearing" and the Soviets as the "evil empire," affect this psychological development? This posing of enemies may inadvertently exacerbate the good/bad split.

As the following research demonstrates, beginning at a very early age children possess both awareness and deep emotional response to the nuclear issue. The studies are listed here beginning with high school seniors and descending in age down to the final study of pre-schoolers.


IF I WERE A WORLD LEADER I
WOULD I WOULD STOP ALL MISSLES!

Research Findings

Bachman (1983), at the University of Michigan, conducted a ten-year nation-wide study of 17,000 high school seniors, finding with each successive year an increase in the number of students worrying about the nuclear threat (p. 86-104).

Goldenring and Doctor (1985) studied children in the seventh through twelfth grades. Presenting a list of twenty fearful situations, they asked each child to rank in order the five that worried them the most. These children responded that nuclear war was second only to the death of a parent as the most frightening (p. 112-133).

Escalona (1965) conducted a study of children ranging from ten to seventeen years old, asking them to describe "What will the world be like ten years from now?" In their response 70% spontaneously mentioned nuclear weapons or destructive war (p. 23).

Educators for Social Responsibility (1982) interviewed 2,000 high school students and found that 80% thought that there would be a nuclear war within the next twenty years. Further, 90% of those who predicted nuclear war felt that the world would not survive it (p. 8, Mack, J. E. 1982).

Snow and Chivian (1983) interviewed first graders and reached the conclusion in their research that "The word 'nuclear' makes first graders think about dying," according to their report delivered at the sixtieth annual meeting of the American Orthopsychiatric Association.

Friedman (1984) studied four year old pre-schoolers, presenting them with children's stories including conflict. Then, through the use of associative techniques, he observed their responses. He found that 12% of these pre-schoolers spontaneously included references to nuclear weapons in their play and verbal responses (p. 2).

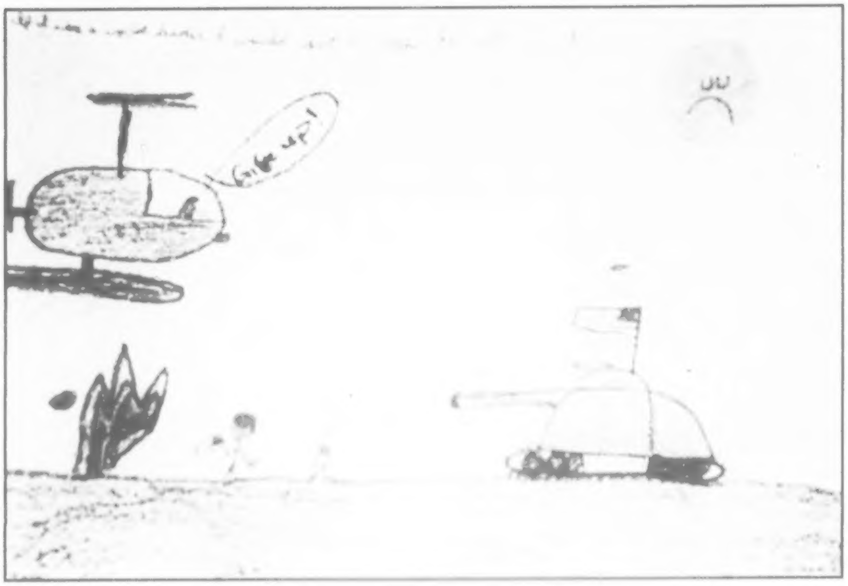
Goldenring and Doctor, as well as other researchers found that students who worried more about nuclear war had better scores with respect to adjustment and self-esteem than the less worried students (Greenwald and Zeitlin, p. 26). These were children who, as a result of their concerns, talked more with their parents and other adults thus gaining hope as they broke through the veil of silence.

Let us now look at the effects on personality development of growing up under the nuclear threat. Beardslee and Mack (1981), researchers at the Harvard Medical School, in their report to the American Psychiatric Association, describe the effect a sense of futurelessness has on children:

> Within themselves, children carry an 'ego ideal', an image of their best selves or of what they would wish to be like. This image, often reflected in hero worship, gives children a vision to mitigate disappointments and to sustain them into adulthood as they experience their childhood limitations. To build a healthy ego ideal and grow toward maturity, children must perceive life as stable and the future as reliable. The building of enduring values within an individual depends upon the delay of present satisfactions in favor of future goals and satisfactions. But the formation of the psychic structures upon which such development depends is compromised

---

". . . beginning at a very early age children possess both awareness and deep emotional response to the nuclear issue."



> when the possibility of a future appears to have been destroyed by the adults to whom its preservation was ostensibly entrusted.

It is the contention of Dr. Robert Lifton of Yale University School of Medicine that childhood behavior is also being affected by nuclear fears. Meeting with psychiatrists from around the country in 1982 he drew up the following list of significant behavioral changes.

1. A sense of futurelessness
   —nothing lasts so all is meaningless.
2. Space and technology as escapes
   —escapism through the use of video and computer games and movies. This world is unsafe, therefore the need to move to space.
3. The turning to religious cults
   —reassurance and power come from having "the answers."
4. Increased use of drugs and alcohol
   —substance abuse as self medication for stress.
5. Increased suicide rate
   —teens are the only age group in the United States with an increasing death rate.

Early adolescents (age twelve to fourteen) appear to be the most at risk psychologically. They possess more factual information on the nuclear issue than their younger schoolmates, but they lack the coping skills, the mechanisms with which to protect themselves. Unlike older adolescents and adults, they have not yet developed the tools of abstraction and psychic numbing. As Maxine Junge (1987) writes, "Typically the adolescent needs to retain the sense of personal immortality in order to forge an identity. If the young person is repeatedly assaulted by death, that sense of immortality is destroyed" (p. 123).

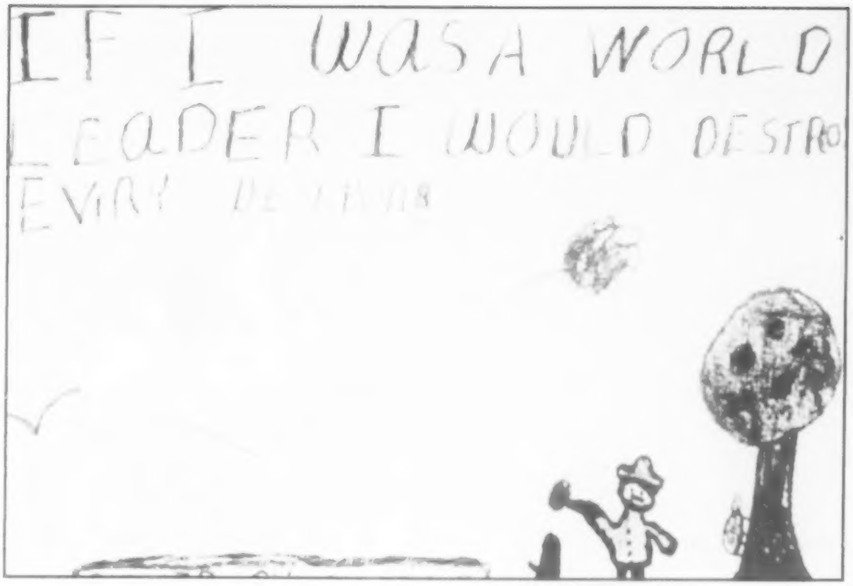
". . . childhood behavior is also being affected by nuclear fears."

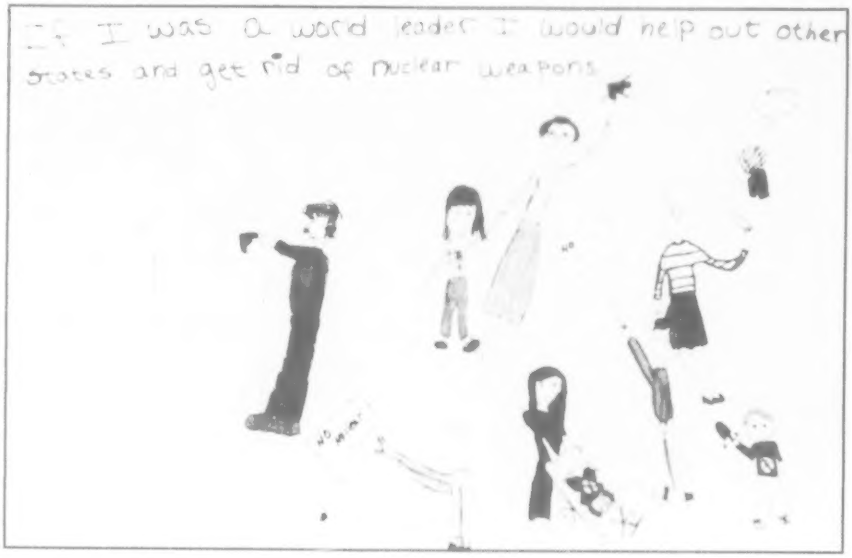
Art Therapy in Nuclear Education

This author contends that we must now address the emotional needs of the "normal" child in order to prevent the trends which Beardslee and Mack are observing. Art therapy has primarily been utilized reactively, in the treatment of childhood dysfunction, in an effort to undo the pathology created by the environment. But now we must begin to think in terms of pro-active treatment, addressing the psychological climate created by the threat of nuclear extinction. Judith Rubin (1978) has referred to art therapy as a natural discipline for primary prevention, pointing to the public schools as a logical place for its implementation. Rubin writes of the use of art in this way to serve as a vehicle for increasing self-esteem, feelings of competence and coping skills. It is the lack of these very attributes which leads to the behavioral changes Lifton describes (p. 85-86).

The need for information about nuclear weapons and technology has been recognized by educators and parents on a national level already. In 1985, the National PTA published a resolution which states in part that:

> Psychological studies have shown that the threat of nuclear war and its possible consequences may have a destructive effect on the well-being and emotional health of some children and youth; . . . be it resolved that the National PTA use studies, forums, educational materials and programs and work with community organizations to inform its membership about nuclear age education . . . to effectively address children's fears concerning perceived nuclear dangers (p. 13, Beyond War Resource Packet).




If I was a word leader I would help out other
states and get rid of nuclear weapons

Following this statement, the California State Assembly went further to mandate curriculum in nuclear education by passing Assembly Bill #3848. This legislation acknowledges the needs of young students by addressing ". . . the inherent right of our children to pursue their educational objectives free from the immobilizing threat of nuclear war and their own annihilation" (p. 15-17, Beyond War Resource Packet). In cities around California, committees are working to develop a Social Studies curriculum on nuclear education to respond to this mandate.

As the information is introduced and the veil of silence is lifted on this subject a vital first step is taken. Removal of the taboo against discussion of the nuclear issue will begin to break through adult psychic numbing and release children from their sense of isolation. Yet there remains the emotional component to be addressed, and it is here that art therapy may serve a valuable function. This writer prepared a proposal for the San Diego city schools to add art therapy into the kindergarten through sixth grade curriculum in order to facilitate the communication and processing of this emotional material.

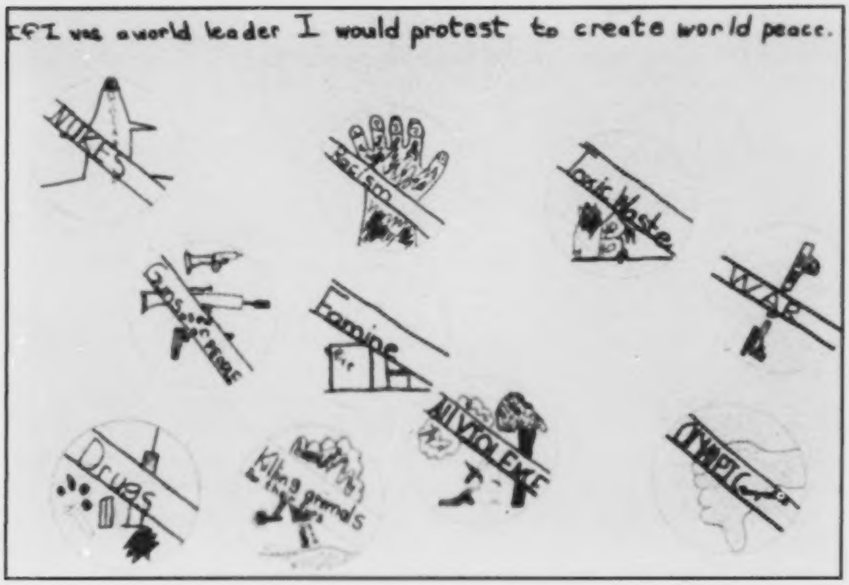
Guilda Grossman (1979), a Toronto art therapist, speaks of sensitizing parents and teachers, within the school context, to the needs of children as expressed through their art. This author feels that nowhere in the public school curriculum is it more important to include an expressive arts component than in the teaching of such an anxiety-provoking topic.

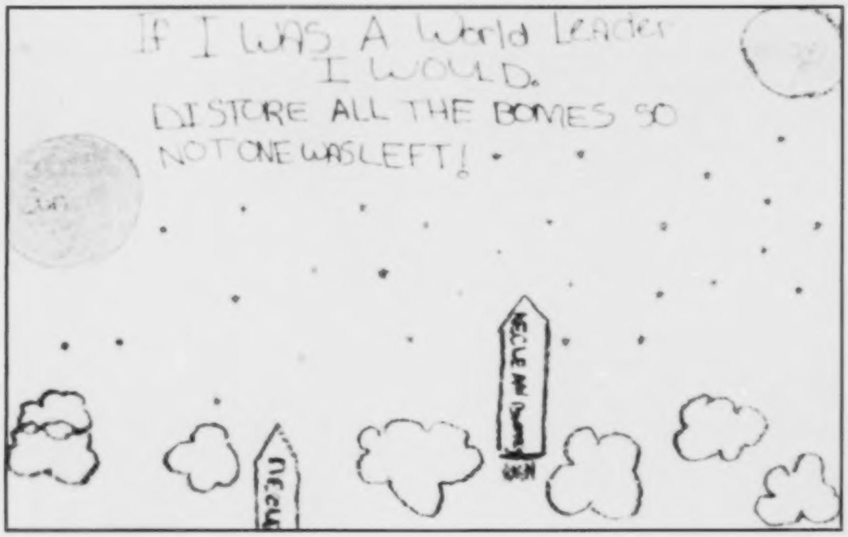
"Removal of the taboo against discussion of the nuclear issue will begin to break through adult psychic numbing and release children from their sense of isolation."

The following hypotheses are the foundation of the program which was presented to the San Diego schools.

1) Children are aware of the crisis we face in living in the nuclear age and are deeply troubled by it.
2) Children benefit emotionally and psychologically by having an outlet for unspoken fears.
3) Children can teach each other, and adults, a new way of viewing present problems and the future, offering fresh insights and perspectives.
4) Art provides benefits to both educators and students.
    a) There is a reduced sense of isolation as children see they are not alone in their feelings, even though few adults openly talk with them about the nuclear crisis.

BEST COPY AVAILABLE




IF I WAS A World Leader
I WOULD.
DISTORE ALL THE BOMES SO
NOT ONE WAS LEFT!

b) Art increases a sense of mastery as children draw or map out ideas, graphically solving problems.

c) Teachers gain a sensitive tool in understanding the level of concern of each student.

5) Self-concept is enhanced as children take action on issues and feel that their concerns are appreciated by adults. This leads to an increased sense of social responsibility.

Although art therapy has not yet been formally included in the curriculum, some teachers and counselors in the schools are using drawings to both assess children's concerns and provide the students with a productive, problem-solving orientation. The children in several San Diego elementary schools were presented with the directive "If you could teach the world leaders something, what would it be?" These drawings were done before any nuclear curriculum had been introduced and yet a striking number spontaneously included images of war and nuclear weapons. (Not all the drawings were available for review so exact percentages cannot be provided.) This first observation, the choice of nuclear imagery, supports the research findings cited earlier of widespread awareness and concern by young children.

A second finding in the artwork was the inclusion of imminent danger to the head of the person in the drawing in almost every picture. (See photos.) It is all the more striking considering the neutral nature of the directive given, that these children responded with a sense of impending personal threat. While much more research needs to be done before generalizations can be drawn, this is a possible indicator for art therapists to be aware of. As Myra Levick (1986) states, "As society continues to change, it will be more and more common to see these changes reflected in children's drawings." Being sensitized to these signals will aid in appropriate therapeutic interventions.

Implications for Therapists

Those of us who choose to be truly open to the concerns of young clients must first look within ourselves, to assess the degree of psychic numbing. We must attempt to free ourselves of denial, openly exploring the personal implications, so that these blind spots may be at least somewhat reduced, allowing us to be more fully available to deal with the nuclear crisis we all face. As Bert Shacter (1986), a social worker, so clearly writes:

> . . . we can safely say that the matter of the nuclear arms race—and its effects on the perceptions, hopes, aspirations, identities and relationships between human beings—can no longer be ignored. As mental health clinicians, we will need to become attuned to clues from our clients related to nuclear anxieties and despair. We will need to understand better the interplay between developmental experience, intrapsychic life, and family process

BEST COPY AVAILABLE

> on the one hand, and a potentially catastrophic nuclear confrontation that threatens human existence on the other. We will need to translate our understandings into relevant interventive strategies and techniques. . . . Finally, those of us who might help calm the fears of the younger generation and demonstrate some measure of empowerment and realistic reassurance must become more aware of how our own perceptions of nuclear matters influence our clinical work (p. 191).

Once we begin taking action, going beyond our psychic numbing and breaking through the conspiracy of silence surrounding this, the taboo topic of our time, we become empowered, less isolated. These feelings are then subtly passed on to our clients. Erik Erickson (1968) states that "children gain hope when they see adults take action." What specifically can we do?

—Educate ourselves: read the paper, follow the news .

—Respond by writing letters or phoning our congressperson or the White House (every letter or call is counted as the opinion of 100 people)

—Write letters to the editor

—Vote

—Join with others to discuss ideas

—Act on our beliefs

Summary

This paper has presented a basis for the position that children are inundated with the emotionally laden awareness of the nuclear threat but lack the defense of psychic numbing for self protection. By perpetuating the taboo against dealing with this sensitive topic, we as art therapists are subtly reinforcing the sense of isolation and despair which children carry. It is therefore our task to confront our own denial, sensitize ourselves and take action in whatever way we can in order that we may instill trust and renew our children's faith in the future. We as art therapists possess a unique tool with which to both gain understanding and promote well-being. This author has noted one possible graphic indicator of nuclear concern. Research needs to continue to provide the foundation for greater understanding. Through our commitment to dealing with this sensitive topic we can both empower ourselves and improve the quality of our work with children.

References

Bachman, L. (1982). American high school seniors view the military: 1967-1982. *Armed Forces and Society* V10 N.1. (pp. 86-104).

Barash, D. P. (1986). What to tell children about nuclear war. *Science Digest*. July.

Beardslee, W., Mack, J. E. (1983). The impact on children and adolescents of nuclear developments. American Psychiatric Association Task Force Report No. 20. *Psychosocial Aspects of Nuclear Developments*. (pp. 64-93). Washington, D.C.

Beyond War Resource Packet. (1985). *Children in the Nuclear Age*. Palo Alto, Ca.

Brauner, A., Brauner F. (1986). Children's drawings and nuclear war. *Journal of the American Medical Association* V 256. No. 5. (pp. 613-616). August.

Carey, M. (1983). Growing up in the nuclear age. *Bulletin of the Atomic Scientists*. (pp. 36-42).

Chivian, E., Snow, R. (1983). There's a nuclear war going on inside me: What children are saying about nuclear war. *IPPNW Report*.

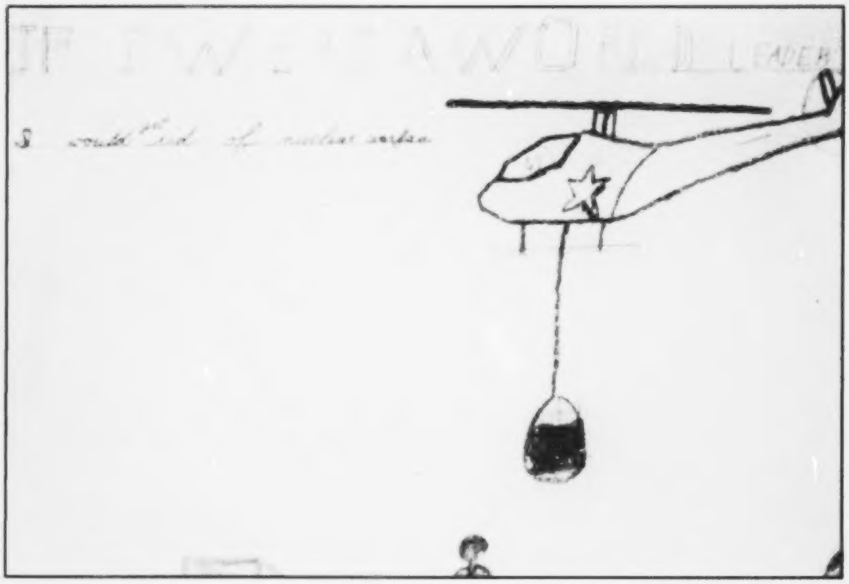
Dew, A., Polyson, J. (1984). *Effects of the nuclear war threat on children and youth: implications for educators*. Paper presented at the annual meeting of the American Psychological Association. Toronto, Canada.

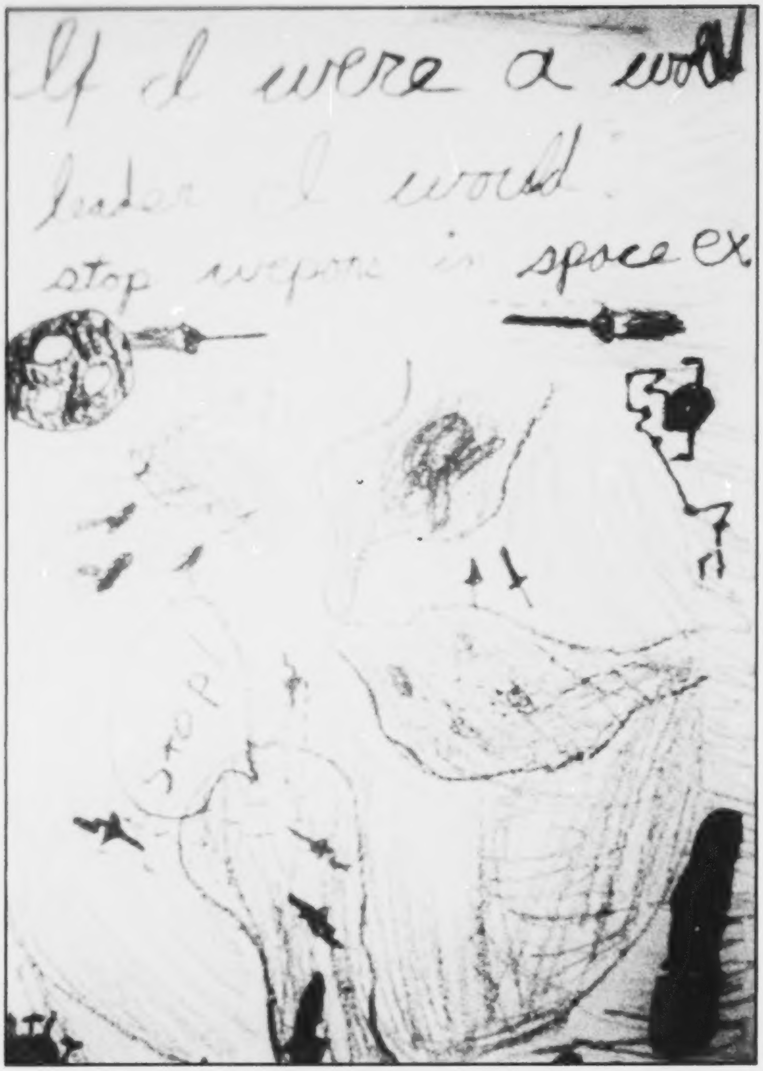
Erikson, E. H. (1968). *Identity: Youth and Crisis*. New York: Norton.

Escalona, S. (1965). Children and the threat of nuclear war. *Behavioral Science and Human Survival*. Science and Behavior Books. California.

Friedman, B. (1984). Preschooler's awareness of the nuclear threat. *California Association for the Education of Young People Newsletter*. 12. (p. 2).

Goldenring, R., Doctor, L. (1985). California adolescents' concerns about the threat of nuclear war. In T. Solantaus, E. Chivian, M. Var-


IF I WAS A WORLD LEADER


If I were a world
leader I would
stop wepons in space ex
stop

tanyan and S. Chivian (Eds). *Impact of the threat of nuclear war on children and adolescents.* (pp. 112-133). Proceedings of the International Research Symposium. Boston.

Gould, B. B., Moon, S., Van Hoorn, J. (Eds). (1986). *Growing up scared!: The Psychological Effect of the Nuclear Threat on Children.* Open Books. Berkeley, California.

Greenwald, D. S., Zeitlin, S. J. (1987). *No Reason to Talk About It: Families Confront the Nuclear Taboo.* W. W. Norton & Co. N.Y.

Grossman, G. (1979). *Art Therapy Room in Next Decade: An Oasis for Growth, Prevention and Treatment for Children Under Stress.* Proceedings of the Tenth Annual Conference of AATA. (p. 94).

Junge, M. (1987). Feminine Imagery and a Young Woman's Search for Identity. *The Arts in Psychotherapy.* V 14. No. 2. (pp. 121-133).

Levick, M. (1986). *Mommy, Daddy, Look What I'm Saying.* M. Evans & Co., Inc. N.Y.

Lifton, R. J. (1982). Beyond psychic numbing: a call to awareness. *American Journal of Orthopsychiatry.* 52. (pp. 619-629).

Mack, J. E. (1982). Research on the impact of the nuclear arms race on children in the USA. *IPPNW Report.* V 2. No. 1. Winter. (pp. 7-14).

Mack, J. E. (1984). Resistances to knowing in the nuclear age. *Harvard Education Review.* V 53. No. 3. August. (pp. 27-32).

Macy, R. (1983). *Despair and Personal Power in the Nuclear Age.* New Society Publishers. Philadelphia.

Myers-Walls, J. A., Fry-Miller, K. M. (1984). Nuclear War: Helping children overcome fears. *Young Children.* May. (pp. 27-32).

Newcomb, M. D. (1986). Nuclear attitudes and reactions: associations with depression, drug use and quality of life. *Journal of Personality and Social Psychology.* V 50. No. 5. (pp. 906-920).

Pratzman, P. (1978). *The Friendly Classroom for a Small Planet.* Avery Publishing Group. Wayne, N.J.

Rubin, J. A. (1978). *Child Art Therapy.* Van Nostrand Reinhold Company. New York.

Schwebel, M. (1963). Students, teachers and the bomb. *National Education Association Journal.*

Shacter, B. (1986). Growing up under the mushroom cloud. *Social Work.* May-June. (pp. 187-192).

Snow, R., Chivian, E. (1983). *Issues and solutions, the nuclear threat.* Report delivered at the Sixtieth Annual Meeting of the American Orthopsychiatric Association. Boston.

Solantaus, T., Goldenberg, S., Levinson, D., Ross, C., La Combe, S. (1984). *Children's mental health and the threat of nuclear war:* a Canadian pilot study paper presented at the IV Congress of IPPNW. Finland. June.

Van Ornum, W., Van Ornum, M. W. (1984). *Talking to Children about Nuclear War.* Continuum. N.Y.

Verdon-Roe, V. (1983). Growing up in the nuclear age: what the children can tell us. *East-West Journal.* Jan. (pp. 24-31).

Walsh, R. (1984). *Staying Alive: The Psychology of Human Survival.* New Science Library. Boston.

Stitched to the Beat of a Heart, to Comfort the Terrors of the Dark

Judy Weiser, M.S.Ed., ATR, R. Psych., *Director PhotoTherapy Centre/PhotoExplorations, Vancouver, British Columbia, Canada*

To me Art Therapy signifies the bridge between inner meanings and the outer world of "translations" that try to represent all these unconscious feelings, thoughts, memories, etc. The symbols that we use at a conscious level are very personal/private representations from each person's unique unconscious—and yet simultaneously can aim for mutual comprehension by others so that they might somehow understand what we are trying to convey.

It is in this light that I perceive the "AIDS Quilt" as a spontaneously-created, grass-roots level expression of art used not only as creative product to communicate the remembrance of a life now ended, but also (and simultaneously) as a form of "natural" therapy for all concerned with the Quilt panels' making, viewing, and reflective discussing. The art-making as therapy; the icons, symbols, colors and media within each individual panel as unique, yet frequently (and unknowingly) archetypal; the strong need to have others comprehend the meaning and value of each individual's life; the permanent trace of that person's life that will last long after the tragedy of the death event—all of these communicate to me the healing (and therapeutic) value of this incredible exhibition stitched from people's hearts and minds.

I volunteered to be an "emotional support" worker at the recent local showing of the Quilt. From my experiences I found myself emotionally mandated (from my own unconscious) to write it all down.

There is no single reason for the Quilt; no solitary way to understand it. Death is not that simple; grief cannot be that easily scheduled.

The Quilt started out of grieving individuals' wish to honor their own casualties; it has spread to cover all of humanity as women, babies, and others besides Gay men have died of AIDS and have had their lives marked for remembrance with panels describing their lives and their love. The original territorial possession of the Quilt by the Gay community has given way to more universal mourning.

Some say grief is private and shouldn't be shared with, or even witnessed by, strangers. Some say once a person has finished grieving you should shut that door and get on with life (while some call that denial of the depth of it and an attempt to put a lid on feelings much too early). Others say that the pain never disappears, that you only learn finally how to live with its presence. Most agree that no one knows when the right time is for another person to finally "let go."

Very simply, those who didn't need or want to be there didn't come—but nearly 15,000 did, and the sheer magnitude of the exhibit at the Vancouver Art Gallery made the abstract experience of AIDS and its death sentence far more personal and individualized than statistics ever could.

* * * * * *

As he finished viewing the room full of brightly decorated soft fabrics representing our British Columbia deaths, the 60-ish gentleman said to me: "I haven't spoken to my son since the day he told me he was homosexual. I told him that in my mind, I no longer had a son, and that if he got sick with AIDS, that I didn't want to know about it. My wife forced me to come down here, so I did. I warned her that it wouldn't change my mind any . . . but I want to tell you that I'm going home to phone my son right now and try to talk to him if he'll let me . . . before it's too late."

* * * * * *

The whole of it all, the sum of all those hundreds of uniquely memorializing details that define and contain a life of a treasured friend, lover, brother, sister, or child make up a mosaic of raw feelings in people that beg to be verbalized, yet still lose something in their essential intensity as they arise to conscious description. People came, each for their own reasons, with their own expectations of death no longer at arm's length. Others wandered in from other exhibits in the building, not knowing until they found themselves in the midst of it all exactly what they were seeing—and they too usually stayed on and paused and received whatever messages were their own.

* * * * * *

"This was my brother; he died in Ottawa; his lover made this Quilt and we haven't seen it until today. He asked to be cremated, so there's no gravestone; this is all we've got as a memorial that survives him." She had stood, in tears, before the panel photographing it and being photographed beside it. "I wanted to have a last photo of him, and he died before I could get to Ottawa; this is the next best thing, because he's gone now and we hadn't visited in years."

* * * * * *

Some of the visitors kept their tears clutched tightly to their chest, stories mute, secrets kept. Others would seek out emotional support workers standing nearby and their stories spilled out, flooding details of special moments—how they were connected to this Quilt panel or that, not satisfied with their private grief but finding that it demanded to be witnessed, recorded in the reality of now and in the minds of others so that the memories were kept living.

The anecdotes and explanations validated not only the grief, but also the proof that *this* person mattered, that this life was not in vain or lost to anonymity, and therefore could be seen to have had purpose. It was a salve to those who grieved to see how others were touched enough to pause and read and know and share the pervasive sadness and the insane waste of life.

* * * * * *

"We didn't know our son was Gay until two weeks before he was hospitalized, and then he died that same month. We rushed to be at his bedside down in the States and met his lover, who said he had written us a letter in case we didn't make it in time. I have that letter with me; it's been in my purse, by my heart ever since; would you like to read it? I would like to share it with you."

* * * * * *

The names were read each hour; those who had died sometimes identified by full name, sometimes by first name or coded initials only. It crept into my ears as I wandered through the exhibit; sometimes I felt punched in the chest as I heard a name I recognized, but hadn't expected to be dead. Most people were overwhelmed long before halfway round the exhibit. Eyes and hearts saturated, viewers appeared stunned and muted.

To me it's not just an AIDS Quilt—but it's also a universal grief Quilt. A Quilt to comfort against the terrors of the dark, hugging warmth tightly around. I watched as it tucked people into their memories and thoughts; the pervasive sadness at a deeply subconscious archetypal level beyond individual stories became also empowering, the isolation joining through its crushing grief into community of shared experience. It originally belonged to people losing lovers, but in its "spread of hope" it has moved beyond that into the very fragility of life and our own mortality.

One answer I find myself giving about the power of the Quilt is that it quickly becomes clear that you don't have to be Gay to understand, and that once you've encountered the Quilt and its message of love-and-loss, that differences may not make such a difference anymore. It is not just a sadness, but also a stubborn defiance.

Five panels were added during the exhibit; two Vancouver people died of AIDS during the five days while it was displayed. It was not what made "them" so different from "us" that hits us all so hard, but what makes us all so much the same in our vulnerable human fragility, the much-too-early deaths so unjustly imposed. Certainly, tears do not have any sexual politics.

NOTE: Sections of this Viewpoints article were previously published in an article on the Editorial page of the *Vancouver SUN*, July 22, 1989.

1988 AATA
MEMBERSHIP DIRECTORY

Now Available through the National Office

$8.00 member **$50.00** non-member
$100.00 institution

NAME ____________________
ADDRESS ____________________
CITY ____________________
STATE ____________ ZIP ____________

▲ *Mail entire form to:* ▲
AATA NATIONAL OFFICE
1202 Allanson Rd./Mundelein, IL 60060

REVIEWS

Advances in Art Therapy

Harriet Wadeson, PhD, ATR; Jean Durkin, MA; Dorine Perach, MA, *(Editors), John Wiley & Sons Publisher, 1989, 451 pages.*

Reviewer: ***Winnie J. Ferguson, PhD, ATR,*** *Assistant Professor of Art Therapy, Wright State University, Dayton, Ohio.*

Advances in Art Therapy guides the reader through the development of the art therapy profession in the 1980s. The editors have gathered chapters from a broad range of contributors who are actively enlarging the scope of art therapy. The book is rich both in narrative and in illustrations. The individual contributors have provided an abundance of artwork to clarify the valuable case studies which are provided throughout the book. Harriet Wadeson, one of the editors of the book, authors the preface to the book, the introduction to each of the three parts of the book, and the final chapter entitled "The Art Therapy Termination Process Group." In the preface, Wadeson sets the stage for the broad scope of the book when she says, "By nature of their work, therefore, art therapists are creative people. But beyond the creativity in work with individual clients and groups, art therapists are creative in evolving their profession. It is this later creativity that is the subject of this book" (p. xiii).

This book is divided into three parts; each is divided into a series of chapters which deals with intriguing art therapy developments. The first part of the book, "New Populations," provides descriptions of work which has been given little discussion in art therapy literature prior to this publication. The second part, "New Methods," presents fresh ways of approaching the art therapy process. The final part, "Art Therapy Training," provides some insights into training developments in our field.

The dimensions of art therapy are explored in the first part of this book. Wadeson says, "It is noteworthy that the 'New Populations' section of this book comprises over half its chapters. Art therapy's greatest movement appears to be horizontal at this time. We are still a young profession, sufficiently unformed to be able to adapt art therapy's essential potential for enhancing self-expression, understanding, and creativity to the varying needs of widely diverse populations who can benefit from its services" (p. 1).

In chapters 1 and 2, cross-cultural experiences in art therapy are shared by Golub, Thrasher, Yee and Zahnstecher. They offer important insights for the art therapist working with those from other ethnic groups. Golub's chapter provides specific information relating to clinical issues found in the adolescent Cambodian refugees encountered in her experiences; however, her valuable appendix which outlines the trauma is applicable in other situations.

Zambelli, Clark and Heegaard (in chapter 3) focus on bereaved children and the therapeutic art processes. The implementation of the elementary school bereavement intervention program described is practical and challenging for art therapy. Chapters 4 and 5 focus on the issues of women with an examination of Mary Cairns's program for mothers in a short-term psychiatric setting, and Rosemary Lagorio's program for battered women. The issues which are specific to these populations are being dealt with in many facilities across the country by other art therapists. The mother's feelings of depression following the sudden separation from her children are universally shared by other women. Lagorio says, "The application of art therapy . . . proved to be an effective tool in terms of education, identification of feelings, and, in general, an enjoyable engagement with the art-making process itself, oftentimes evoking hidden feelings as well as latent talents" (p. 96).

In chapter 6 Julie Serrano writes about "the evolution of a sexual abuse group whose members moved from victim to survivor using the arts in therapy" (p. 114). This author has provided a series of three charts which would be helpful in developing an art therapy program with this population. The charts outline a program from the beginning stages of therapy through termination stages.

Incarcerated clients are the focus of chapter 7 by Day and Onorota. The population is one which is challenging for art therapists. Both the facility and the client would benefit from this type of program.

Day and Onorota found that "Group art therapy provides . . . building appropriate cohesiveness on the unit. . . . Group cohesiveness is paramount in alleviating inmates' feelings of isolation and depression" (p. 146).

Chapters 8 through 11 inform about clients with physical health problems. Penny Baron provides a stimulating chapter on "Fighting Cancer with Images." Her case studies and accompanying client artwork gives the reader a clear path following the therapist's treatment plans. Further elaborations are illustrated by Fleming and Cox in chapter 9 as they share their work with clients who have psychosomatic illness. These authors have provided the readers with an outline of the treatment plan developed for treating clients with the somatic-affective process they found effective. The work of Baron, Fleming and Cox offers the possibility that art therapy may shape physical and emotional improvements.

The next two chapters by Judith Wald explore additional medical problems of severe head injuries and of Alzheimer's disease and related disorders. Wald's work provides background information on the knowledge necessary for the art therapist working as part of a rehabilitation team. The importance of working within the "medical model" with this team demands that the art therapist understand and use the vocabulary of the team. Wald's conclusion recognizes the difficulty which art therapists find in the receipt ". . . of insurance reimbursement and understanding of our role in a medical model-oriented facility" (p. 203). In her discussion relating to dementia illnesses Wald says, "The primary goal is to help offset these losses [intellect, memory, speech and physical abilities] by providing activities within a framework in which the patient can succeed" (p. 215). Wald shares some practical suggestions for art therapy sessions with clients with dementing illnesses.

Robert Ault's chapter "Art Therapy with the Unidentified Client" extends the scope of the teacher-therapist. A new dimension for the art therapist is offered in this thought-provoking chapter. The positive effects of the process of art with "unidentified" patients can be useful for art therapists in an art school setting, and may open new vistas for the field of art therapy.

David Henley concludes the "New Population" segment of this book with a chapter entitled "Artistic Giftedness in the Multiple Handicapped." Henley's work with this population is evidenced by the sensitivity which he uses to describe his work with clients. His program has allowed assessment for artistic giftedness with his clients. The criteria for the assessments and the case studies are valuable for those art therapists working with this population. Henley concludes the chapter with discussion of the ethics of "outsider" art in which he presents the problems facing the therapist when answering the needs of the gifted person with multiple handicaps.

The second part of this book looks at some "New Methods" in art therapy. These methods are creative approaches which the contributors to this book have developed. Wadeson says, "They are never an end in themselves, but always a means to achieve a larger end in the realm of human functioning" (p. 273).

Jerry Fryrear and Irene Corbit have written an interesting chapter in which they discuss "Visual Transitions," a method using videotaping and photography in their art therapy program. The discussion, case study, and art examples could provide a basis for other art therapists wishing to utilize this method. Fryrear and Corbit conclude, "It is primarily visual, . . . ; it is multi-modal, enabling clients to use a choice or combination of modalities to achieve therapeutic change and personal growth; it provides for metaphoric change within the therapeutic session . . ." (p. 292).

Devorah Canter, in chapter 15, shares her experiences with "Art Therapy and Computers." Most facilities have these machines available; however, few seem to utilize the proper software to produce graphics. Canter uses the Apple Macintosh in her program which she reports is easy to use with a variety of clients. Her chapter explains the terms such as "hardware, software and program" in a clear manner. The case examples, computer-generated graphics (including an original music score) and discussion should provide support for those interested in computer art therapy methods.

Art therapy and psychodrama are united in the following chapter authored by Jean Peterson in collaboration with Leigh Files. The authors have provided the reader with a brief history and discussion of psychodrama leading into the method of combining the two into a single process. The art therapist interested in extending his/her creative self into additional expressive arts therapies will find this chapter helpful.

Lenore Steinhardt's chapter offers "Six Starting Points in Art Therapy with Children." These six interventions, developed in her practice, are clearly outlined and discussed as a resource for other art therapists. Also, Susan Buchalter-Katz's chapter proffers a method which she has found effective in working with depressed clients. Her "Barrier" drawings have evolved from long experience as an art therapist with depressed clients. She reports success in the method which has ". . . proven to be a more direct route to conscious and unconscious material than spontaneous art when used with depressed patients" (p. 371).

The final part of the book highlights "Art Therapy Training." In her introduction Wadeson says, ". . . training both develops new opportunities and seeks to meet their challenges" (p. 373). Training programs are constantly striving to stimulate new thinking as well as to promote and develop new research in art therapy.

Barbara Fish targets the problem of countertransference for the art therapist. She says, "I am writing this chapter with the hope that other art therapists will be encouraged to use their own images to monitor and explore themselves within their therapeutic relationships" (p. 376). Her frank discussion of this issue can be used in training and by practicing art therapists. A combined authorship by Jean Durkin, Dorine Perach, Joanne Ramseyer and Ellen Sontag presents "A Model for Art Therapy Supervision Enhanced Through Art Making and Journal Writing." This chapter reports on a model in which the art therapy intern and the site supervisor shared artwork and journals as a method to enhance the therapeutic relationship. Many programs use similar methods to help the student communicate with site and university supervisors; however, this chapter provides specific case studies and artwork to document the development of the process. The final chapter of this section of the book is authored by Harriet Wadeson, and deals with a course focused on the termination process. By the development of parallel objectives the students gain an awareness of the importance of termination with clients while also understanding their own termination issues from the training program. The interns' involvement in the art making and subsequent processing of the experience could encourage new professionals to utilize the process for themselves for self-reflection upon leaving the school environment. This approach could be used in other training programs.

Advances in Art Therapy contains information not available from other sources. It is welcomed as a supplement to texts in training programs and by professionals in art therapy and other human services areas. Since the receipt of this book I have recommended it to students as a resource for research and for clinical information. The authors, for the most part, have written little about their work prior to this book; however, their easy-to-read text will be well used in the future as a reference by students and professionals alike. Harriet Wadeson's style shines through the book and she should be encouraged to continue with editing this type book as well as with her own writing.

Gods in Everyman: A New Psychology of Men's Lives and Loves

Jean Shinoda Bolen, PhD, *Harper & Row, 1989, 336 pages, $18.95 (hardcover).*

Reviewer: ***Joseph Mancini, Jr., PhD, MSW,*** *Visiting Professor of English at The George Washington University, teaches American literature, Jungian psychology and literature, autobiographical writing, and men's studies. Clinical Social Worker, Affiliated Community Counselors, Inc. Rockville, Maryland.*

The Many Faces of the Masculine

During the last three decades the dominant image of the feminine has been reconstructed to reflect a multitude of ways of manifesting the female principle. In contrast, efforts to change the ruling image of the masculine have resulted either in grudging tolerance of those supposedly negative traits associated with the masculine—e.g., objectivity, impersonality, competitiveness, toughness, self-reliance, lack of the more "tender" emotions—or in ready dismissal of those features in favor of the cultivation of characteristically feminine qualities. What has been missing in these efforts is a principle or schema designed to guide development of more acceptable masculine images and/or to revise the meaning of current images. Such a guiding principle is found in Jean Shinoda Bolen's newest book, *Gods in Everyman: A New Psychology of Men's Lives and Loves.*

Well suited to develop such a guideline, Bolen, a clinical professor of psychiatry at the University of California, San Francisco, makes use of her training as a Jungian analyst, arguing that the masculine principle is a multi-dimensional archetype and so cannot be encompassed by any one image. As an archetype—a universal, innate predisposition for being, perceiving, and behaving in certain ways—the masculine principle operates in both men and women. Though the multi-faceted masculine archetype predisposes individuals to act and react in generally patterned ways, nevertheless, its particular manifestation or image in a particular person at a particular time varies according to the impact of environmental influences that can suppress, enhance or modify different dimensions of the masculine principle.

In *Gods in Everyman*, Bolen examines some configurations of the masculine principle imaged as Greek gods, specifically Poseidon, Hades, Zeus, and the latter's sons, Apollo, Hermes, Ares, Hephaestus, and Dionysus. By investigating how these gods establish relationships with each other, with goddesses, and with the natural and human environment, Bolen creates for each a gestalt of personality traits. Every gestalt becomes an image of one way a man (or woman) may manifest and develop the multi-faceted masculine principle. And every person is born with the potential for actualizing each one of these gods or personality patterns. However, in a particular individual, any one potential god-pattern (and even some aspects of that pattern) of being masculine may never be developed, may be overdeveloped, or may be rigidly compartmentalized from every other masculine pattern.

Bolen emphasizes that at birth one archetypal image or god rules or at least predisposes the individual's expression of masculinity. Then (focussing now on males), the boy's private and public environments will help determine whether the actualization of the constitutional pattern will be positive or negative or admit of modification through the cultivation of another masculine image(s). For instance, a child born with Apollo dominant in his psyche will have, among other characteristics, a penchant for logicality, objectivity, clarity, moderation, law and order. If his environment supports the development of these traits in a positive way, the Apollo male might become, among other possibilities, a renowned lawyer or jurist dedicated to impartiality and the maintenance of viable precedents for social intercourse. If, in contrast, his familial and social contexts promote negative development, the Apollo male, says Bolen, may become emotionally inaccessible and develop a slavish allegiance to outworn principles and traditions, a development that, eventually and paradoxically, creates chaos. Still another possibility is that the Apollo male will allow, albeit with difficulty, some development in himself of a complementary, perhaps opposing masculine image, that of Dionysus with his proclivity for sensate experience in contrast to abstract intellectualizing and for passionate intensity in contrast to measured restraint.

As Bolen presents each of the masculine personality gestalts (and the many facets of each), the reader easily develops an awareness of the enormous complexity of the masculine principle. A man (and woman) will have within his psychic potential, for example, Zeus' decisiveness and generativity, Poseidon's fierce, passionate loyalty, Hades' penchant for creating an imaginal inner world, Apollo's goal-seeking and mathematical precision, Hermes' ability to communicate concepts and network with others, Ares' emotional expressiveness, Hephaestus' appreciation of beauty and ability to work with his hands, and Dionysus' love of the natural world and capacity to experiment with the dissolution of forms and boundaries. Bolen also begins to revise some of the masculine images often reviled by the general populace; for instance, she emphasizes that Ares, the God of War, is also a lover and a dancer, using the grace of the latter role to integrate mind and body; moreover, unlike the detached, often aloof Zeus, Ares represents the masculine potential for passionate involvement and risk-taking to defend a principle.

Though Bolen has done a very capable job of providing a schema for envisioning and revisioning and ultimately appreciating a multitude of ways of expressing the masculine archetype, she has difficulty maintaining a compassionate space for Zeus in her pantheon of masculine patterns. She does underline the fact that Zeus-like oversight and definitiveness are necessary to counterbalance, for example, the emotional explosiveness of a Poseidon man; and she does approve of the example of Zeus' fatherly support of at least three of his immortal sons. However, these gestures of appreciation are far overshadowed by her unduly long chronicle of the negative effects of this masculine pattern on both men and women. She also fails to give due weight to the contribution of the feminine to the development and maintenance in men of Zeus-like, patriarchal excesses. In her assessment, women tend to be portrayed merely as victims of male domination who benefit in no self-serving way from such a posture. In short, Bolen tends at times to play down the fact that patriarchy, like matriarchy, is an archetypal predisposition in the human psyche and is to be condemned only in its excesses and refusal to be modified by other archetypal patterns.

Bolen's general bias against Zeus-like abstraction and control comes back to haunt her in her own work: the book's organization, while offering a clear hierarchy of topics and subtopics covering all manner of psychological and social consequences of adopting each pattern, becomes over-schematized and thus tedious. Moreover, the lack of highly detailed human and divine case histories makes the work seem rather "bloodless"; the stories Bolen does include are often condensed to near-lifelessness or focus too often merely on the personae of famous men as examples.

Readers, especially therapists and art therapists in particular, will also find disappointing Bolen's chapter on finding one's own masculine mythos by remembering the lost or undeveloped masculine dimensions. Her instructions are sparing, rather abstract, and little more than preliminary: "Through knowing the gods as archetypes, you can see yourself and others more clearly. You can identify whom you most naturally resemble, see which one you may have tried to be, and which of them you have not accepted." What is missing are some practical, experiential accounts of such transformation or at least some workable exercises—beyond the reading of the book itself—to stimulate exploration.

But imaginal workers in psyche will find in Bolen's work a substantial body of new perspectives and revised images with which to bring about new appreciation for the archetypal masculine principle, without which the equally sacred feminine ceases to have its full meaning and being.

Adolescent Art Therapy

Debra Greenspoon Linesch, MA, ATR, MFCC, *New York: Bruner Mazel, 1988, 245 pages.*

Reviewer: ***Susan Evans Spaniol, MA, ATR,*** *Art Therapist at Fresh Pond Day Treatment Center in Cambridge, Mass., and Doctoral Student in Human Development at Boston University.*

NOTE:

This is a second review and should be used as a companion to the first review published in the July 1989 issue.

Adolescence is indeed a challenge. It challenges all youngsters as they experience the onslaught of physical, emotional and social changes that constitute the transit from childhood to adulthood. It also challenges mental health professionals who intervene when vulnerable adolescents become overwhelmed by the turmoil of rapid change. *Adolescent Art Therapy* by Debra Greenspoon Linesch makes an important contribution to the literature on art therapy because the relatively young field has lacked a comprehensive guide to working with this difficult population. The book identifies the central developmental tasks of adolescence and demonstrates the unique ability of art activity to assist adolescents in meeting and completing those tasks. It begins by providing a theoretical rationale for the unique healing power of art for the adolescent, and proceeds by translating theory into practice, providing relevant case studies and illustrations of over 120 artworks. Clinical populations covered range from severely disturbed adolescents residing in psychiatric hospitals to high-functioning youths seen in outpatient clinics; and treatment applications addressed include individuals, families and groups. This breadth of populations and settings provides the student and professional art therapist with a wide-ranging overview of the use of art in the psychotherapeutic treatment of adolescents. The book may also become a reference for other mental health workers who wish to introduce art into their therapeutic practices, because the author does not presuppose any special training or background in the arts. However, it is precisely this lack of grounding in the fundamentals of art that constitutes the major weakness of this book. By presenting art as an activity requiring no specialized technical knowledge or discipline on the part of practitioner or patient, the book takes the "art" out of art therapy, thereby divesting art therapy of a major source of its potency.

The author bases her procedures and formulations on psychoanalytic principles. Those readers who prefer a more eclectic orientation may become frustrated by the narrow frame of the book. However, the value of this point of view is in providing a unifying theoretical basis for understanding adolescent behavior. Linesch uses psychoanalytic constructs to justify her primary thesis that art activity is egosyntonic with the adolescent's struggle to establish autonomy from the parents and to create an adaptive identity. Citing analysts Blos and Malmquist, she defines the adolescent's development of ego strength as a creative process in which self-expression and fantasy foster emotional maturation. Through art activity, the adolescent is enabled to explore her or his feelings, experiment with new behaviors, and experience acceptable and productive gratification of instinctual drives. Emotional maturation is facilitated by this control and transformation of instincts. The process of creating artwork thereby facilitates the adolescent's process of creating a new identity and attaining emotional well-being.

Psychoanalytic constructs also inform the discussion of how artwork aids diagnosis. To provide a frame of reference for viewing disorders of adolescence, Linesch defines the characteristic defense mechanisms as responses to two basic conflicts: anxiety related to separation from the parents and/or impulsivity stimulated by unsuccessful separation from them. Given this no-win situation, the adolescent inevitably suffers conflicts that generate the formation of defense mechanisms, which may be adaptive or non-adaptive. The author presents adolescent disorders as maladaptive defenses against developmental or environmental stress. She bases her discussion of these disorders on DSM-III-R diagnostic categories. However, Linesch supplements the limited behavioral descriptions in the diagnostic manual with psychodynamic interpretations of underlying conflicts based on the writings of Malmquist. Furthermore, artwork is selected to illustrate the dynamics of each category, demonstrating how art therapy provides graphic evidence of intrapsychic processes. By viewing artwork as a form of unconscious communication by the patient, the practitioner can use it as a guide for treatment.

The book's discussion of defense mechanisms and diagnostic categories may seem oversimplified because it is formulaic. Artistic responses are reduced to symptoms in the service of demonstrating the relationship between artwork and psychopathology. Richly complex behavior is defined by a limited number of defensive maneuvers and translated into the DSM-III-R argot that is the currency of health insurance providers. Topical issues of concern, such as physical and sexual abuse, sexuality, drug use and trauma, are not addressed directly—perhaps because they do not fit within the classically defined categories of disorders. However, these very sensitive and serious areas of concern often represent the basis for referral and cause of emotional turmoil for many troubled adolescents. A discussion of the use of art therapy in directly addressing such issues would have been welcomed by those who deal with youth in crises. Despite its simplification and omissions, this particular section of the book makes a useful contribution towards professionalism in the field. It provides art therapists with a basic clinical framework for understanding the process of adolescent art therapy and a professional vocabulary for describing its products.

Across the country, art therapists are struggling to attain licensure and the professional recognition that accompanies the credential. However, attainment of these goals may be hampered by the inherent paradox between the modality of art, which is often seen as intuitive and synthetic, and the field of therapy, which is frequently viewed as diagnostic and analytical. Our culture still retains romantic notions about the arts and artists as inviolate and beyond the reach of objective scrutiny, classification and judgment. Some art therapists may be reluctant to use the diagnostic labels of psychological assessment, or to take the scientific stance of clinical psychology, or to adopt the techniques of dynamically oriented psychotherapy. *Adolescent Art Therapy*, with its clear description of how adolescent artwork can aid diagnosis, can contribute to the art therapist's pursuit of professional status.

Having established the psychoanalytic and developmental parameters of her approach to art therapy, Linesch describes the nature of the therapeutic alliance with the adolescent and the special role art can play in the treatment process. In this discussion, Linesch reveals herself to be a sensitive clinician. Her general guidelines begin with a description of the formation of the transference relationship as a means of creating a therapeutic alliance. Based on the adolescent's task of separating from early object relations, the author portrays the delicate balance that must be maintained between limiting replays of *earlier* relationships while encouraging re-creations of the *present* parental relationship. Too old for the fantasy of play therapy and too young for unpremeditated free association, the adolescent can express her or himself spontaneously with the art media while maintaining a sense of control over the process and product. Other clinical guidelines for adolescent art therapy include the use of directives to guide the treatment process, the utilization of art review, the role of imagery journals, and a description of how various art media can be used to influence expression. These topics are supported by illustrated case reviews, which include descriptions of art therapy tasks that can easily be adopted or adapted by other art therapists.

Perhaps one of the most valuable guidelines of Linesch's approaches to practice is her explanation of the crucial role of metaphor in adolescent art therapy. She introduces it in her discussion of interpretation, and develops it in a chapter on the adjunctive role of the art therapist within the treatment team. Metaphor is presented as an indirect means of "making the unconscious conscious." Visual metaphors are rich conveyors of meaning, frequently communicating more than could be said in words—especially by the typical adolescent who is often reluctant or unable to express her or himself verbally. Less threatening than direct verbal interpretation, metaphoric communication respects the self-protective defenses of the adolescent while encouraging her or his self-expression. The author instructs the art therapist to remain with the adolescent's metaphor, responding with empathy to her or his manifest content rather than interpreting latent meaning.

Working within the metaphor helps define the parameters of the art therapist's role as a treatment team member. Straddling various disciplines (psychotherapy, education, and rehabilitation) often produces a diffuse sense of professional identity for the art therapist, and a feeling of confusion or even conflict with the rest of the staff. Linesch distinguishes between the art therapist as adjunctive therapist, and the social worker or psychologist who serves as primary therapist. Although both stimulate and deal with transference issues, the art therapist is urged to respond with empathy to the "here and now" meaning of the visual symbols supplied by the patient. In contrast, the primary therapist on the treatment team generally uses interpretations to respond to verbal communications related to past life events and family relationships. In effect, the adjunctive art therapist brings about insightless change, while the primary therapist facilitates growth based on insight. This clarification of boundaries, which places the art therapist in a complementary (but not subsidiary) role in relationship to the primary therapist, helps minimize conflict within the team and maximize treatment of the adolescent.

One of the strengths of Linesch's book is its explication of how creative artistic expression aids adolescent mental health and emotional maturation. In light of this correlation, it is distressing that fifty of the 120 illustrations of adolescent artwork in the book contain no original imagery whatsoever. Rather, they are collages composed of pictures cut from periodicals and accompanied by written words. Magazine pictures can provide a non-threatening transition towards more direct interaction with art media. However, Linesch's heavy reliance on second-hand images and verbal phrases seems to represent a crutch, not a bridge.

The lack of emphasis on creative art activity stimulates the crucial issue of the role of art in art therapy. Art therapy approaches may be identified as ranging along a broad continuum from art as therapy, which emphasizes the product and employs procedures of art education, to arts psychotherapy, which values the process above all and is modelled after psychoanalytic practice. Most art therapists today seek to move flexibly between these two poles, adapting their methods to the particular needs of their clients. *Adolescent Art Therapy* excels in its presentation of the psychodynamic approach to treatment, deftly communicating the attitude, values and behavior that characterize the clinical role. However, it is quite weak in describing how the creative act itself may promote healing.

Art is a process of giving form to feeling. Artistic production is therapeutic in a broad sense because it can force the creator to impose conscious order on the chaotic contents of the unconscious. Emotional development may accompany artistic achievement because the artist's deliberate struggle to manipulate and control the media may parallel intrapsychic struggles to gain control over conflicting impulses. To fail to encourage the adolescent to explore and master the art media, as Linesch does, is to deprive her or him of an opportunity to express conflict and master anxieties.

Adolescent Art Therapy by Linesch is recommended for those art therapists who have mastered the fundamentals of the artistic process, yet wish to enhance their clinical skills and professional stature. It provides a basic understanding of adolescence as a developmental stage on the way to maturity, and aids the art therapist in using art to assess the conflicts blocking that development. It also provides a sensitive guide to the development and maintenance of the therapeutic relationship based on a psychodynamic model. The book is not enthusiastically recommended for clinicians in other fields who lack knowledge of art materials and their use because it could encourage a superficial use of imagery that fails to engage the adolescent in an interaction with art materials leading to an integration of personality.

CHARLES C THOMAS • PUBLISHER

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¼ × 9¾), 56 il., $38.25.

By **Shaun McNiff,** *Lesley College Graduate School, Cambridge, Massachusetts.* CONTENTS: Introduction; Nomenclature; Interpretation; Re-Imagining the Artist as a Therapist; Self Inquiry. Bibliography.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $36.25.

By **Shaun McNiff,** *Lesley College, Cambridge, Massachusetts.* CONTENTS: Introduction; Historic Trends in American Higher Education; Definition of the Profession Through Education; Characteristics of Academic Training Programs; Common Educational Elements in the Creative Arts Therapies; Specific Media Competencies; Supervision and Evaluation; An Artistic Theory of Mental Health and Therapy; Students; Faculty; Dialogue with Educators.

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $18.00.

By **Donald E. Michel,** *Texas Woman's University, Denton.* CONTENTS: The Field of Music Therapy; Music Therapy for Children and Adolescents; Music Therapy for Adults; The Professional Music Therapist: Responsibilities and Attitudes; Music Therapy Education and Training.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $19.25, spiral (paper).

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $42.00.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $24.75.

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $26.50.

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $20.50.

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $42.25.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $44.75.

By **Rudolf E. Radocy,** *The University of Kansas, Lawrence,* and **J. David Boyle,** *The University of Miami, Coral Gables, Florida.* CONTENTS: Introduction; Music: A Phenomenon of Man, Society, and Culture; Psychoacoustical Foundations; Rhythmic Foundations; Melodic and Harmonic Foundations; Affective Behaviors and Music; Musical Preferences; Functional Music; Musical Ability; Music Learning; Future Research Directions.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (7 × 10), 34 il., $38.25.

By **Shaun McNiff,** *Lesley College, Cambridge, Massachusetts.* CONTENTS: Ideas and Process; Jill's Image Work; The Art Therapist's Art. Bibliography.

☐ Harrower, Molly R.—**THE THERAPY OF POETRY.** '72, 128 pp., $15.75.

☐ Krauss, David A. & Jerry L. Fryrear—**PHOTOTHERAPY IN MENTAL HEALTH.** '83, 260 pp. (6¾ × 9¾), 61 il. (5 in color), 1 table, $36.25.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 × 10), 1 table, $34.75.

☐ Nucho, Aina O. — **THE PSYCHOCYBERNETIC MODEL OF ART THERAPY.** '87, 248 pp. (6¾ × 9¾), 50 il., 4 tables, $38.00.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $27.25.

☐ Benenzon, Rolando O.—**MUSIC THERAPY MANUAL.** '81, 178 pp., 20 il., $23.00.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $74.25.

☐ Kwiatkowska, Hanna Yaxa—FAMILY THERAPY AND EVALUATION THROUGH ART. *'78, 304 pp., 125 il. (12 in color), 7 tables, $40.00.*

☐ Benenzon, Rolando O.—MUSIC THERAPY IN CHILD PSYCHOSIS. *'82, 112 pp., 34 il., $19.00.*

☐ Singer, Florence—STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children. *'80, 144 pp., 33 il., $19.25.*

Books sent on approval • Catalog sent on request • Write or call (217) 789-8980

2600 South First Street Springfield • Illinois • 62794-9265

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(708) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapist's Indentity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) 110 pages	$15.00	$20.00
Art Therapy: Professionalism in Practice (1988)	$15.00	$20.00
Art Therapy: Journal of the American Art Therapy Association Rates: Individuals — U.S. $23.00; Foreign $30.00; Institutions — U.S. $27.00; Foreign $36.00		
Art Therapy: Journal - Back issues •	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings *Use of the Creative Arts on Therapy (1979)*	$5.00	$7.00
National Art Education Association Journal: Special issue *Art Education, Vol. 33, No. 4 (1980)*	$3.00	$4.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 x 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

*NOTE: for **Publications** postage/handling, add $3.00 for the first unit item, $.75 each additional unit.

SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS.

** Foreign Orders: Require pre-payment for items and then will be billed for shipping charges as you instruct on order:
Air Mail charges (1 week delivery) or Ground Services charges (2 months delivery)

10 or more copies of any single issue: 15% discount on total cost. Discounts are available when purchasing quantities.
Set of four Proceedings (consecutive years): 20% discount on total cost.

Indicate Quantity of Unit Items Below		Cost/Unit	Total
____________	( ) X	________	= ________
____________	( ) X	________	= ________
____________	( ) X	________	= ________
____________	( ) X	________	= ________

*Publications Postage/Handling = ________ Total Publications Costs = ________

FILMS (Rental/Purchase)

Art Therapy: Beginnings (1977) color/sound, 45 minutes	16mm Rental Only:	$40.00	$50.00
	½″ VHS, Purchase only:	$50.00	$80.00
Michael (1977) color/sound, 12 minutes	16mm Rental only:	$30.00	$35.00
	½″ VHS, Purchase only:	$50.00	$80.00
Art Therapy (1981) color/sound, 12 minutes	16mm Rental only:	$35.00	$45.00
	½″ VHS, Purchase only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery (1978) color/sound, 32 minutes	16mm Rental Only:	$40.00	$50.00
	½″ VHS, Purchase only:	$50.00	$80.00

*Note: for **VHS Films Purchase** postage/handling add $2.50 for each film. *Note: for **16mm Rental** add $7.00 for postage and handling.

Indicate Quantity of Unit Items Below		Cost/Unit	Total
____________	( ) X	________	= ________
____________	( ) X	________	= ________

*Films Postage/Handling = ________ Total Films Costs = ________

ORDER FORM: ***Make checks payable in U.S. funds to AATA, and mail to the above address***

SEND TO: ______________________ MBR. ID#: ________

____

City State Zip Code

BEST COPY AVAILABLE

Member ID# Required__________		***Member	Non-Member
** Educational Guidelines		*SASE (25¢)	$ 1.00
** Educational Programs List		*SASE (25¢)	$ 1.00
** Standards and Procedures for Registration		*SASE (25¢)	$ 1.00
** Criterion for Professional Membership		*SASE (25¢)	$ 1.00
** Art Therapy Model Job Description		*SASE (25¢)	$ 1.00
** Code of Ethics		*SASE (25¢)	$ 1.00
** Art Therapy Media List		*SASE (25¢)	$ 1.00
** Standards of Practice		*SASE (25¢)	$ 1.00
** Art Therapy Bibliography		*SASE (25¢)	$ 1.00
** Practice Specialty List		*SASE (45¢)	$ 1.00
** Associate Student New Member Applications		*SASE (25¢)	*SASE (25¢)
Professional Membership Application	(9x12)	*SASE (65¢)	*SASE (65¢)
Registration (ATR) Application	(9x12)	*SASE (65¢)	*SASE (65¢)
Model Licensing Bill		$12.00	$25.00
Membership Directory/Bylaws (Institution $100.00)		$ 8.00	$50.00
General Information Packet (Includes first three items)		$3.00	

*SASE — Self Addressed — Legal Size — Stamped Envelope — 25¢ postage per item

**Available in multiples: per item, 1-9, SASE ($1.65), 10-50, $5.00 (UPS), 50-100, $10.00 (UPS)

Guidelines for Authors

Please submit four (4) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed, ATR, Wright State University, Creative Arts Center, 228 Creative Arts Center, Dayton, OH 45435. Send manuscripts and illustrations certified mail, with return receipt requested. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5″ × 7″ black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

CONFIDENTIALITY: Client/Patient confidentiality must be protected in title, abstract, text, photos and other accompanying material. Proper releases must be obtained.

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

THE ORGANIZATION

The American Art Therapy Association (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3000 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice; AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliated Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive:

Publications

- *Art Therapy,* the official journal of the AATA.
- The quarterly *AATA Newsletter.*
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- Free AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payers.
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy.

Professional Standards

- Development of model job and licensure laws.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

GENERAL MEMBERSHIP APPLICATION

1. The membership year is the calendar year January 1st through December 31st.

2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY: Please follow the chart below when submitting membership application.
Applications received between

Jan. 1st and May 31st — Full dues payment; Membership will expire Dec. 31st of same year.

June 1st and Sept. 30th — Half year dues plus $5.00 payment; membership will expire Dec. 31st of same year.

Oct. 1st and Dec. 31st — Full dues payment; membership for the remainder of current year and the next full year through Dec. 31st.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval.

4. AATA Membership and AATA Registration (ATR) each have a separate application procedure. Registration is bestowed only by the Standards Committee.

5. National AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL — by application only; such members may vote, hold office and serve on committees.

Credentialed Professional Member: Individuals who have been dually approved for Professional Membership and Registration (ATR) by the AATA; dues are $80 per year.

Active Professional Member: Individuals who have completed professional training in art therapy; dues are $75 per year.

CONTRIBUTING — Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $100 per year.

ASSOCIATE — Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75 per year.

STUDENT — Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Student members may not vote or hold office but may serve on the Student Subcommittee of Membership. Dues are $35 per year.

See other side for Application Form

Mail entire form to:

The American Art Therapy Association, Inc.

1202 ALLANSON ROAD/MUNDELEIN, IL 60060

(708) 949-6064

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

NAME ______________________________
last first middle

HOME ADDRESS ______________________________

____

PHONE ( ) ______________________________

BUSINESS ADDRESS ______________________________

____

____

BUSINESS PHONE ( ) ______________________________

EMPLOYER ______________________________

JOB TITLE ______________________________

LICENSES HELD & STATE ______________________________

PREFERRED MAILING LIST

___ HOME ___ BUSINESS

Please indicate which of the following you are applying for:

___ PROFESSIONAL MEMBERSHIP (an application packet for Professional Membership will be sent to you)

___ REGISTRATION (ATR) (an application packet for Registration will be sent to you)

___ $75 PROFESSIONAL MEMBERSHIP (after approval)

___ $80 ATR MEMBERSHIP (after approval)

___ $100 CONTRIBUTING MEMBERSHIP

___ $75 ASSOCIATE MEMBERSHIP

___ $35 STUDENT MEMBERSHIP (see student membership criterion for necessary documents to accompany this application)

PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO AATA
American Art Therapy Association, Inc.
1202 Allanson Rd./Mundelein, IL 60060

Please complete this survey:

Education (please check highest degree earned)

1 ___ Doctorate Degree
2 ___ Master's Degree
3 ___ Bachelor's Degree
4 ___ Associate/Certificate
5 ___ Other

Work Setting (please check one only)

1 ___ Hospital
2 ___ Clinic
3 ___ Day treatment center
4 ___ Rehabilitation
5 ___ Sheltered workshop
6 ___ Correctional facility
7 ___ Residental treatment
8 ___ Out-patient mental health
9 ___ School system
10 ___ Elderly care facility
11 ___ College/University
12 ___ Clinical training program
13 ___ Institute training program
14 ___ Counseling center
15 ___ Private practice
16 ___ Other ___________

Area(s) of Specialization (please check up to three)

1 ___ Addictions
2 ___ Adolescents, Hospitalized
3 ___ Adolescents, Psychiatric
4 ___ Adults, Hospitalized
5 ___ Adults, Psychiatric
6 ___ Art History
7 ___ Art Therapy Education
8 ___ Art Therapy in Schools
9 ___ Children, Hospitalized
10 ___ Children, Psychiatric
11 ___ Domestic Violence
12 ___ Eating Disorders
13 ___ Families
14 ___ Gerontology
15 ___ Hospice/Terminally Ill
16 ___ Learning Disability
17 ___ Mental Retardation
18 ___ Neurological Disease
19 ___ Prisoners
20 ___ Post Traumatic Stress
21 ___ Psychotherapy
22 ___ Rehabilitation
23 ___ Research
24 ___ Sexual Abuse
25 ___ Visual Art
26 ___ Other ___________

Voluntary Information:

Age:

1 ___ 20-24
2 ___ 25-29
3 ___ 30-34
4 ___ 35-39
5 ___ 40-44
6 ___ 45-49
7 ___ 50-54
8 ___ 55-59
9 ___ 60 +

Salary Range:

1 ___ under $10,000
2 ___ $10-15,000
3 ___ $15-20,000
4 ___ $20-25,000
5 ___ $25-30,000
6 ___ $30-35,000
7 ___ $35-40,000
8 ___ $40-45,000
9 ___ $45-50,000
10 ___ $50,000 +

Gender:

1 ___ Female
2 ___ Male

Hours Worked per Week:

1 ___ 0-10
2 ___ 10-20
3 ___ 20-30
4 ___ 30-40

COLLEGE OF NOTRE DAME

Cool It in . . .

S.F. this Summer
and Collect
Units Toward
Your
ATR

COLLEGE OF NOTRE DAME
Graduate School
1500 Ralston Avenue
Belmont, CA 94002

(415) 593-1606

- The only **Master of Art Therapy** program in Northern California approved by AATA
- A **Master of Art Therapy** and **Marital and Family Therapy** which may lead to the MFCC Licensure
- Job opportunities in clinical, educational, and community agencies
- Master in Art Therapy – 37 units
- Master in Art Therapy & MFT – 51 units
- Graduate Art Therapy Institute – 21 units
- Can be completed in two summers and a winter internship!

ON THE SAN FRANCISCO PENINSULA

Master's Degree Programs in Expressive Therapies and in Creative Arts in Learning

• •

Offered by the Institute for the Arts and Human Development Lesley College Graduate School

Master of Arts in Expressive Therapies

For students interested in the creative modalities of art, music, dance/movement, and drama, presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning

For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theater studies.

For more information call or write the Institute for the Arts and Human Development, Lesley College Graduate School, 29 Everett Street, Cambridge, MA 02138-2790. (617) 868-9600, ext. 480.

Lesley College
GRADUATE SCHOOL

Lesley College is an Equal Opportunity/ Affirmative Action institution.

BEST COPY AVAILABLE

◉CHICAGO◉

19TH ANNUAL CONFERENCE PROCEEDINGS
1988 CHICAGO, ILLINOIS

The 1988 AATA Conference Proceedings, "Professionalism in Practice" November, 1988, are available through the AATA National Office in abstract form.

PRICE PER COPY:

Member - $15.00 each　　Non-member - $20.00 each　　10 or more - $12.00 each

QUANTITY　　COST　　TOTAL

________ × ______ = ______

SEND TO:

TO ORDER COPIES: Mail order form ➧
along with payment to:

- American Art Therapy Association,
1202 Allanson Rd.
Mundelein, IL 60060.

Please make checks payable
in U.S. funds to AATA.

NAME/INSTITUTION　　MBR ID #

ADDRESS

CITY　　STATE　　ZIP CODE

TELEPHONE

SAN FRANCISCO

20TH ANNUAL CONFERENCE PROCEEDINGS
1989 SAN FRANCISCO, CALIFORNIA

The 1989 AATA Conference Proceedings, "PAINTING PORTRAITS, Families, Groups, & Systems" November, 1989, are available through the AATA National Office in abstract form.

PRICE PER COPY:

Member - $15.00 each　　Non-member - $20.00 each　　10 or more - $12.00 each

QUANTITY　　COST　　TOTAL

________ × ______ = ______

SEND TO:

TO ORDER COPIES: Mail order form ►
along with payment to:

- American Art Therapy Association,
1202 Allanson Rd.
Mundelein, IL 60060.

Please make checks payable
in U.S. funds to AATA.

NAME/INSTITUTION　　MBR ID #

ADDRESS

CITY　　STATE　　ZIP CODE

TELEPHONE

ART THERAPY

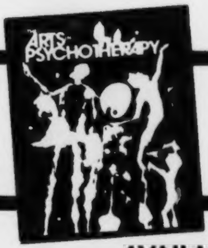
Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1990. Enclosed is my check, payable to AATA, for $23.
Name ____________________
Address ____________________
City ____________________ State __________ ZIP __________

The interdisciplinary journal
devoted to the creative arts as healing arts.



THE ARTS IN PSYCHOTHERAPY

An International Journal

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Assistant Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

Dedicated to scholarship in the creative arts therapies, THE ARTS IN PSYCHOTHERAPY presents innovative research in artistic inquiry and expression, and its use in the treatment of mental disorders.
THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

SUBSCRIPTION INFORMATION

ISSN: 0197-4556	Volume 16, 1989
Published 4 issues per annum	
Annual Institution Subscription Rate (1989)	US$110.00
Two-year Institution Rate (1989/90)	US$209.00
Individual Rate (1989)	US$ 40.00
Student Rate (1989)	US$ 16.00

PERGAMON PRESS, INC.
Maxwell House, Fairview Park, Elmsford, NY 10523
PERGAMON PRESS plc
Headington Hill Hall, Oxford OX3 0BW, England
A Member of the Maxwell Communication Corporation Group of Companies

ART THERAPY

Journal of the American Art Therapy Association

Volume 7, Number 1 March 1990

- 20th Annual Conference Overview
  Gary C. Barlow, EdD, ATR, Editor
- Edvard Munch: An Art Therapist Viewpoint
  Helen Landgarten, HLM, ATR
- Feed Me . . . Cleanse Me . . . Sexual Trauma Projected in the Art of Bulimics
  Sandra Ticen, MS, ATR
- Art for Special Needs: A Learning Disabled Child in a Special Art Program
  Edith DeChiara, EdD
- Art Therapy Education: A Tool for Developing Verbal Skills
  Lucy Andrus, MS, ATR

BEST COPY AVAILABLE

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1990

Linda Gantt, MA, ATR, *President;*
Robin F. Goodman, PhD, ATR, *President Elect;*
Cathy Malchiodi, MA, ATR, *Secretary;*
Virginia Minar, MS, ATR, *Treasurer;*
Doris Arrington, EdD, ATR, *Director;*
Shirley Riley, MA, ATR, MFCC, *Director;*
Deborah Good, MA, ATR, *Director;*
Dean Wilson, ATR, *Director;*
Trudy Manning, MS, ATR, *Affilitate Chapters*

Executive Director

Edward J. Stygar, Jr.

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, EdD, ATR 2

Articles

20th Annual Conference Overview
Gary C. Barlow, Editor 4
Edvard Munch: An Art Therapist Viewpoint
Helen Landgarten, HLM, ATR 11
Feed Me . . . Cleanse Me . . . Sexual Trauma Projected In the Art of Bulimics
Sandra Ticen, MS, ATR 17
Art for Special Needs: A Learning Disabled Child in a Special Art Program
Edith DeChiara, EdD 22
Art Therapy Education: A Tool for Developing Verbal Skills
Lucy Andrus, MS, ATR 29

Special Features

Introductions and Presentation of AATA 1989 Awards
Cay Drachnik, MA, ATR, MFCC, President 39
Honorary Life Membership Acceptance Speech
Felice W. Cohen, ATR, HLM 39
Distinguished Service Award Acceptance
Suzanne Canner Hume, MEd, ATR 42

Viewpoints

Dialogue Letter Writing: A Collaborative Technique for Beginning Art Therapists and Their Supervisors
Michael Campanelli, EdD, ATR 43

Reviews

Video- Art Safety: Hazards and Precautions
Winnie Ferguson, PhD, ATR 45

About Our Cover

Painting by an adult, schizophrenic male at a Mental Health Center in Southwestern, Ohio.

Volume 7, Number 1 March 1990

EDITORIAL BOARD

Editor
Gary Barlow, EdD, ATR
Viewpoints
Harriet Wadeson, PhD, ATR
Book Reviews
Aina O. Nucho, PhD, ATR, ACSW
Brief Communications
Ruth Obernbreit, MA, ATR
Film/Video Reviews
Georgiana Jungels, MA, ATR
Managing Editor
Marcia May-Chambers

Contributing Editors
Frances E. Anderson, EdD, ATR
Robert Ault, MFA, ATR
Lynn Cashell, MCAT
Dana N. Christensen, PhD, ATR
Linda Gantt, MA, ATR
Susan LaMantia O'Connor, MA, ATR
Paul Rodenhauser, MD
Ellen A. Roth, PhD, ATR
Lewis K. Shupe, PhD, ATR
Suzanne Silverstein, MA, ATR
Robert Wolf, MPS, ATR

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

American Art Therapy Association, Inc. 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064

Copyright © 1989 American Art Therapy Association

BEST COPY AVAILABLE

EDITORIAL

The variety of articles in this issue should appeal to all of our readers. From Edvard Munch, to working with a learning disabled child, to sexual trauma in the art of bulimics, to a tool for developing verbal skills—these interesting and informative articles are presented by authors Helen Landgarten, HLM, ATR, Edith De Chiara PhD, Sandra Ticen, ATR and Lucy Andrus, ATR.

Additionally, we are presenting our annual feature—the overview of the A.A.T.A. national conference (our 20th annual meeting). This feature has been included in *Art Therapy* for the past few years to help the reader who did not attend the national meeting to become familiar with the various presentations (such as papers, panels and workshops) and also to offer this feature for those who wish to obtain additional information relative to a topic or area that was shared with conference participants. Please take advantage of this service—that is, if you would like to have additional information, please communicate with the presenter.

I am pleased to add my "congratulations" to the recipients of the awards bestowed by the American Art Therapy Association at the California conference. The Honorary Life Member designation was awarded to Felice W. Cohen, ATR, one of the founding members and former president of our professional association. She is indeed worthy of this honor, and joins the ranks of the distinguished members who have previously been awarded the HLM. The Distinguished Service Award was presented to Suzanne Canner Hume, ATR, for her comprehensive work in the A.A.T.A.—particularly as member and chairperson of the Education and Training Board. Both Felice Cohen and Suzanne Canner Hume represent the American Art Therapy Association with dignity and professionalism. Congratulations to each of you!

"The Childhood Origins of Natural Writing" is a chapter in an interesting and informative book by Gabriele Lusser Rico[1] and within this chapter is a section titled "Wonder and Storying." In discussing "wonder" and the relaxed attitude and receptivity that are basic requirements that support the sense of wonder, plus intuitiveness, openness and participation, the author states that we all have these qualities in childhood and need [must] recapture them in our adulthood. "Children make sense of their world by wondering" says Rico, "and as a result create their own realities in answer to that wonder" (p. 51). The Russian linguistic scholar Komel Chukovsky writes that the child from two to five is the most inquisitive creature on earth in the service of comprehending its world . . . He cites an example of five year old Volik:

> After swallowing each bit, Volik would stop and listen to what was happening inside of him. Then he would smile gaily and say: "It just ran down the little ladder to the stomach." "What do you mean—down the little ladder?" "I have a little ladder there (and he pointed from the neck to the stomach); everything I eat runs down this ladder . . . and then there are other little ladders in my arms and legs . . . all over what I eat runs down little ladders to my body. . . ." "Did someone tell you all this?" "No, I saw it myself." "Where?" "Oh, when I was in your tummy, I saw the kind of ladders you had there . . . and that means that I, too, have the same kind. . . ." (Rico, p. 51).

Wondering leads to storying, and storying leads to additional creative development during the formative stages. "As soon as children learn to talk, words and ideas tumble forth in an uninhibited flow, limited only by the boundaries of their vocabulary. Storying expresses an innate human need to make mental connections, to perceive patterns, to create relationships among people, things, feelings, and events—and to express these perceived connections to others." (Rico, p. 51)

Writing is like that. We make connections, perceive patterns and create relationships. We observe events, experience feelings, express our uniqueness, and communicate to ourselves and with others. Is there something—some advice—that both "seasoned" and beginning authors can glean from these thoughts? I suppose it is this: Dare to wonder . . . to "story" . . . to make the connections . . . to identify the feelings . . . to share the uniqueness . . . and, finally . . . to write!

Gary C. Barlow, EdD, ATR
Editor, Art Therapy

---

[1] Rico, G. L. (1983). *Writing the natural way* Los Angeles, CA: J. P. Tarcher, Inc.

BEST COPY AVAILABLE

CLARIFICATION

Maxine Junge, MSW, LCSW, ATR, *Chair and Associate Professor*
Department of Marital and Family Therapy (Clinical Art Therapy)
Loyola Marymount University
Los Angeles, California

Harriet Wadeson's article "Art Therapy Education at the Crossroads" in the November 1989 journal described the art therapy/marriage, family, child therapy licensing issues in California. It erroneously stated that our program at Loyola Marymount University had recently changed its curriculum to meet these requirements and implied that in so doing, it may have lost a significant portion of its art/art therapy emphasis.

First: since 1979, our curriculum has continuously met the educational requirements for MFCT licensing in California; it continues to do so today. Second: rather than de-emphasizing art therapy as a result, our program provides an integrated perspective which is based in art therapy theory and practice in all its aspects. We do not typically separate out clinical and art therapy courses, but rather integrate them as for example, "Family Art Psychotherapy," and "Child Development/Art Psychotherapy: Theory and Practice." Actually, rather than less, our program has more art in it than previously. We have always been and remain committed to a clinical art therapy program which trains art psychotherapists. We have been "Approved" By AATA since 1979. In May of 1989, our degree title was changed to Marital and Family Therapy to reflect our systems approach.

In my own opinion, there is a false dichotomy and a wrong-headed scarcity model in our continuing discussion of art versus therapy suggesting that as you have more of one you have less of the other. Art therapy education has been enriched by a diversity of perspectives. But while we may be different kinds of animals we are all in the same forest. Perhaps dialogue from our communal vision and toward synthesis and integration would provide interesting conversation for us all.

Response: Harriett Wadeson, PhD, ATR

Maxine Junge is correct in stating that I erroneously reported that Loyola Marymount changed its art therapy course offerings to meet MFCT licensing requirements. Several years ago, changes were made to meet the American Association of Marriage and Family Therapists guidelines. The point remains the same however; training programs are being influenced by credentialing bodies outside of art therapy.

ART THERAPY
Journal of the American Art Therapy Association

ADVERTISING RATES

RATES	1x	2x	3x
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140

SPECIAL POSITIONS	additional
Cover #2 (Inside Front)	$130
Cover #3 (Inside Back)	130
Cover #4 (Outside Back)	165

COLOR RATES: Standard Red, Blue and Yellow (Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x
Per page additional	$90	$85	$80

INSERTS	1x	2x	3x
2 pp	$ 800	$ 700	$ 575
4 pp	1,500	1,300	1,150
8 pp	2,200	2,000	1,750

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size:	8-1/2" x 11"
Bleed Size:	8-5/8" x 11-1/4"
Inserts:	8-5/8" x 11-1/4"

SUBMISSION DEADLINES:

January 7 for March issue; April 7 for June/July issue; September 7 for November issue

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, IL 60060
(708) 949-6064

BEST COPY AVAILABLE

AATA Conference Overview

"Painting Portraits: Families, Groups & Systems" was the theme of the 20th Annual Conference of the American Art Therapy Association. This meeting was held in San Francisco, California, from November 16-20, 1989, at the spacious and impressive San Francisco Marriott Hotel. As always, the series of meetings and presentations proved to be professionally relevant, stimulating and "re-charging," and once again, it was good to greet old friends and to meet new ones.

A hearty "thank you" must be given to the Conference Chair, Linda Gantt and to the Program Chair, Randy Vick as well as to Mary Lou Hanzlik, Program Co-Chair and Patricia Gould, the Pre-Conference Course Chair. They—and their committees, listed below—did a superb job in pulling everything together by devoting much time and energy to the gigantic task of organizing a national conference.

As in the past, the tradition of presenting a post-conference overview in *Art Therapy* is continued in this issue. On the following pages is a listing of the papers, symposia, panels and the many other highlights of the conference. This information is offered so that readers and members who can not attend the California meeting could communicate with the presenter(s) for additional information desired on a particular topic or research interest. Please refer to your AATA Membership Directory for addresses, or write to the AATA Office if additional information is needed. Specific categories (such as "Panels") have been grouped together for the reader's convenience. The basic information listed here was taken directly from the Conference Program, and pertinent corrections were made as they became available. If other corrections are necessary and are brought to the Editor's attention, this information will be made available in the next issue of *Art Therapy*.

—EDITOR

20TH ANNUAL CONFERENCE COMMITTEES

CONFERENCE CHAIR:
Linda Gantt, MA, ATR

PROGRAM CHAIR:
Randy Vick, MS, ATR

PROGRAM CO-CHAIR:
Mary Lou Hanzlik, ATM, ATR

PRE-CONFERENCE COURSE CHAIR:
Patricia Gould, MA, ATR

PROGRAM COMMITTEE:
Patricia Allen, PhD, ATR
Valerie Appleton, MA, MFCC, ATR
Deborah Behnke-Marthaler, MA
Mariagnese Cattaneo, PhD, ATR
Abby Calish, MA, ATR
Barry Cohen, MA, ATR
Barbara Fish, MA, ATR
Winnie Ferguson, PhD, ATR
Michael Franklin, MA, ATR
Linda Goldman, MEd, ATR
David Henley, MA, ATR
Patricia Isis, MEd, ATR
Mildred Lachman-Chapin, MEd, ATR
Wendy Lauter, MA, ATR
Cathy Malchiodi, MA, ATR
Rose Marano Geiser, MA, ATR
Susan Orr, MA, ATR
Elizabeth Ratcliffe, MS, MFCC, ATR
Marcia Rosal, PhD, ATR
Suellen Semekoski, MA
Nancy Sidun, PsyD, ATR
Patricia Vedder, MA, ATR
Susan Wish, MA, ATR

PRE-CONFERENCE COMMITTEE:
Douglas Horner, ATR
Debra Linesch, MA, ATR, MFCC

SAN FRANCISCO LIAISON COMMITTEE:
Doris Arrington, PhD, ATR
Judy Baker, MFCC, ATR
Nadine Blaschak, ATM
Linda Chapman, ATM, ATR
Linda Cohn, MFCC, ATR
Catherine Crawford, BA
Helen Haight, ATM, ATR
Mary Lou Hanzli, ATM, ATR
Vaughn Hills DeGuigne, ATM
Christi Insull, ATM
Pat Keefe, ATM, ATR
Charlene Kelzer, MFCC, ATR
Laura Langdon, BA
Jacqueline McAbery, ATM
Karen McMichael, ATM, ATR
Tatjana Meschede, BA
Toni Morley, ATM
Barbara Noblin, ATM
Sahnta Pannutti, ATM
Claudia Ronaldson, MFA, ATR
Rondi Saslow, MFCC, ATR
Diana Young, ATM

BEST COPY AVAILABLE

OPENING CEREMONY

CAY DRACHNIK, MA, MFCC, ATR, President, AATA
RANDY VICK, MS, ATR, Conference Program, Chair

PRE-CONFERENCE COURSES

1. **The Ulman Personality Assessment Procedure**
   GLADYS AGELL, ATR, HLM
   ELINOR ULMAN, ATR, HLM, DAT
2. **Getting a Better Picture—Family Systems Therapy Using Family Snapshots and Albums**
   JUDY WEISER, MSeD, ATR, RCAT
3. **Dinosaurs and Dragons—Insight Oriented Art Therapy with a Pre-School Psychiatric Population**
   BETH YOUNG, MS, MPS, ATR
4. **The Diagnostic Drawing Series: Its Use in Clinical Practice**
   BARRY M. COHEN, MA, ATR
   ANNE MILLS, BA, DipAT
   CAROL THAYER COX, MA, ATR
   JEANNE N. CREEKMORE, MA
   CYNTHIA LEAVITT, PhD, ATR
   YURIKO YAMASHITA, MA
5. **Integrating Into Their Past and Present "Families" Art Therapy with Older Adults**
   JULES WEISS, MA, ATR
6. **Three Instruments for Assessing the Emotional or Cognitive Content of Drawings**
   RAWLEY SILVER, EdD, ATR, HLM
7. **Creative Art Therapy Treatment Approaches for Child Sexual Abuse: The Three Stages of Pre-Disclosure, Diagnosis and Treatment**
   MICHELLE MCLEAN, MA
   LESLIE P. KNOWLES, MA, ATR
8. **Techniques of Supervision in Art Therapy**
   LAURIE WILSON, PhD, ATR
9. **Art Therapy with Group**
   DEBRA LINESCH, MA, ATR
10. **Clinical Art Therapy with Addictive Populations: Applications of the Systems Model**
    DIANE KRIEGMAN McELLIGOT, MA, ATR
    KATHERYN A. WEBB, MA, MFCC, ATR

SPECIAL PROGRAMS/EVENTS

1. **Opening and Closing Receptions**
2. **Assembly of Chapter Affiliates**
3. **Networking Lunch**
4. **Notre Dame Special Event/Ralston Mansion Tour, Exhibit and Reception**
5. **Art Exhibits**
6. **Exercise Program—A Picture of Health**
7. **Art Therapy Educators' Convocation**
8. **Open Art Studio**
9. **Annual Business Meeting**
10. **Slides by Art Therapists**
11. **Hospitality Booths**
12. **Circle Gallery Reception/Frank Lloyd Wright Architecture**

EXHIBITING COMPANIES AND SCHOOLS

Companies:

1. Amaco/Brent, Indianapolis, IN
2. Bookpeople (Wingbow Press), Berkeley, CA
3. Dean L. Frantz, Fort Wayne, IN
4. Nasco West, Modesto, CA
5. Scutt Ceramic Products, Inc., Portland, OR
6. Stern's Book Service, Chicago, IL
7. Texas Art Supply, Houston, TX
8. Therapy Puppets, Berkeley, CA
9. Royal Arts and Crafts, Atlanta, GA
10. Playrooms, Petaluma, GA
11. Sandplay, Etc., Los Altos, CA

Schools, Programs, Departments:

1. California College of Arts and Crafts, Oakland, CA
2. California Department of Mental Health, Sacramento, CA
3. College of Notre Dame, Belmont, CA
4. University of Louisville, Louisville, KY
5. George Washington University, Washington, DC
6. Loyola Marymount, Los Angeles, CA

7. Phototherapy, Vancouver, BC
8. Pratt Institute, Brooklyn, NY
9. School of the Art Institute, Chicago, IL
10. The Northwest Institute for the Creative Arts, Eugene, OR
11. Ursuline College, Pepper Pike, OH
12. Vermont College of Norwich University, Montpelier, VT
13. Wright State University, Dayton, OH

GENERAL SESSIONS

1. **"Are There Differences?"**
   CAY DRACHNIK, AATA, *President*
   EDWARD STYGAR, Jr., AATA *Executive Director*
2. **"Painting Family Portraits: Four Perspectives on Family Art Therapy"**
   RANDY M. VICK, MS, ATR
   SHIRLEY RILEY, MA, ATR, MFCC
   DORIS ARRINGTON, EdD, ATR
   MARI FLEMING, MA, ATR
   BARBARA SOBOL, MA, ATR
3. **"Avoiding Malpractice"**
   NANCY KNAPP, MA, ATR
   CAY DRACHNIK, MA, ATR

KEYNOTE ADDRESS

"Young and Adult Children 'Changing Family Legacy'"
CLAUDIA BLACK, MSW, PhD

SYMPOSIA

1. **Screening for Children at Risk**
   - **A. Screening for Depression Through the Draw-A-Story Task**
     RAWLEY SILVER, EdD, ATR, HLM
   - **B. Identifying Students at Risk Through Artwork in a Public School**
     DEBORAH F. DEBEVEC, MAT
     WINNIE J. FERGUSON, PhD, ATR
2. **Painting Portraits: Fathers and Daughters**
   - **A. Painting Portraits: Fathers and Daughters**
     HAINE CROWN, MA, ATR
   - **B. Portrait of the Artist as an Elderly Gentleman: A Case Retrospective**
     WENDY MAIORANA, MA
3. **Perspectives on the Profession of Art Therapy**
   - **A. Changing Systems: The Mental Health Providers' World in the 1990's**
     SHIRLEY RILEY, MA, ATR, MFCC
   - **B. Freud as Metaphor: Ambivalence and Integration in the Art Therapy Profession**
     LYNN KAPITAN, MPS, ATR
4. **Art Therapy in Groups**
   - **A. Portrait of a Difficult Art Psychotherapy Group: Effective Intervention and Strategies**
     PATRICIA D. ISIS, MEd, ATR
   - **B. Behind the Mask: Exploring Roles and Defenses in Groups and Family Systems**
     KATHRYN A. WEBB, MA, ATR, MFCC
5. **Art Therapy and the Dementias**
   - **A. The Use of Art Therapy with Alzheimer's Disease Patients**
     ANNETTE SHORE, MA, ATR
   - **B. Beyond the Patient to the Person: Promoting Autonomy in Individuals with Dementia**
     JANE E. HARLAN, MA
6. **Art Therapy and Three-Dimensional Materials**
   - **A. Why Jonni Can't Sculpt . . .**
     MARIA MIRON, MCAT
     RONALD E. HAYS, MS, ATR
   - **B. Clay as a Way to Integration in Art Therapy with Children**
     JUDITH DUBOFF, MA, ATR
7. **Art Therapy and Community Bereavement**
   - **A. A Precious Loss: Community Bereavement Following the Carrollton, Kentucky Church Bus Tragedy**
     LINDA A. PROBUS, MA
   - **B. Grief Time: A Change of Destiny, A Children's Play**
     BARBARA BETKER MCINTYRE, PhD, ATR
     JULIE NUTTER, RMT-BC
     JULIE ADAMS
8. **Women's Issues**
   - **A. Pregnancy and the Art Therapist: Clinical Issues**
     AUDREY ELKINSON-GRIFF, MA, ATR
   - **B. Uses of Art Psychotherapy in the Treatment of Unconscious Conflicts in Women**
     MARY DOUGHERTY, MFA, MAAT, ATR

BEST COPY AVAILABLE

9. **The Circle of Abuse**
   - A. **The Child Molester as Victim: Treatment Through the Use of Art Therapy**
     SHERRY KREITMAN-DANSKY, MAT, ATR

10. **Portraits of Teamwork**
    - A. **Portrait of Teamwork: Art Therapy in the Acute Care Oncology Setting**
      ANN BUSSARD, MA, ATR, MFCC
      PENELOPE PECK, RN
      LAURA EATON, BA
    - B. **Family Ties: Integrating Creative Arts and Recreational Therapists Under One Roof**
      STEWART A. AULT, MFA, MA, ATR

11. **Art Therapy in Groups**
    - A. **Latency-Age Group Art Therapy and the Family System**
      BARBARA MESCHER, MA
    - B. **Using a Multi-Family Art Therapy Group to Engage Families in Treatment**
      TERRY DOYLE, MA, ATR
      TERESA HOLTGRAVES, MA, ATR

PAPERS

1. **Family Systems Therapy Using Family Snapshots and Albums**
   JUDY WEISER, MSEd, ATR, RCAT, RSW
2. **Sandplay and Inner Work**
   TERRI L. SWEIG, MA, ATR
3. **Art Therapy and Second-Order Cybernetics: Contricutions of Bateson, Maturana, Vonfoerster**
   ROBERT SCHOENHOLTZ, MS, ATR
4. **Contour Drawing as a Psychotherapeutic Process**
   ROBERT E. AULT, MFA, ATR, HLM
5. **Emotions and Art Media: Structural Approach to Media Applications**
   VIJA B. LUSEBRINK, PhD, ATR
6. **Perception of Family Roles: Using Art with Adult Children of Alcoholics**
   MARCIA F. TAYLOR, PhD, ATR
   AUDRIE S. PERRINE, BA
7. **Precious Gifts: Images of Sexuality, Relationship and Wholeness**
   BRUCE MOON, MDiv, MACE, ATR
   DEBRA DEBRULAR, ATR
8. **Hildegard of Bingen and Georgia O'Keefe: Divergent Portraits of Art Therapy**
   SISTER KATHLEEN BURKE, PhD, ATR
9. **An Art Therapist's Reflections on the Natural History of Visual Perception**
   EDITH KRAMER, ATR, HLM
10. **From Way Below to the Light Side; Identifying Alters in MPD**
    DEE SPRING, PhD, ATR, MFCC
11. **Multi-Cultural Approaches to Art and Mental Health**
    KRISTIN G. CONGDON, PhD
12. **The Self-Employed Art Therapist: Challenges, Freedom and Money**
    JOAN PHILLIPS, MA, MS, ATR
    DIANALEE SKEEN, MS, ATR
13. **Art Therapy with HIV Positive Patients—Mourning, Restitution and Meaning**
    GAIL M. FENSTER, ATR
14. **Projection: A Technique for Understanding**
    GLADYS AGELL, MA, ATR, HLM
15. **Two Views of One Case: Self Psychology Approach and Jungian Interpretation**
    MILDRED LACHMAN-CHAPIN, MEd, ATR
    VIJA LUSEBRINK, PhD, ATR
16. **The Therapist's Drawings of the Clinical Hour: Object-Relations Illustrated**
    MARDY S. IRELAND, PhD
    SYBIL MEYER, ADTR, MFCC
17. **Discovering Life with Less Pain: Art Therapy with Rheumatology Patients**
    KARIN DANNECKER, MA
18. **The Diagnostic Drawing Series in the Integration Process of Multiple Personality**
    BARRY M. COHEN, MA, ATR
19. **The Impact of Imagery in Children's Picture Books**
    ELLEN HANDLER SPITZ, PhD
20. **Alexithymia in an Addiction-Affected Society: Art Therapy Rekindles the Emotional Experience**
    DIANE KRIEGMAN McELLIGOTT, MA, ATR
21. **Art as Prayer**
    CATHY MOON, BFA, ATR

BEST COPY AVAILABLE

PANELS

1. **Confronting the Year 2000: The Art Therapist and Social Change**
   MAXINE JUNGE, MSW, LCSW, ATR
   JANISE FINN, MA, ATR, MFCC
   ANNE KELLOGG
   CHRISTINE VOLKER

2. **Where is the Art in Art Therapy?**
   CATHY A. MALCHIODI, MA, ATR
   MARIAGNESE K. CATTANEO, PhD, ATR
   PATRICIA B. ALLEN, PhD, ATR

3. **Sacrifice, Secrets and Sabotage: Scandal and Interplay of Abuse and Addictions**
   DEBBIE GOOD-GARCIA, MA, ATR, Moderator
   PATTY CHURCHILL, MA, ATR
   HELEN HEDDENS, MA, ATR
   DIANE McELLIGOTT, MA, ATR
   DEE SPRING, PhD, ATR, MFCC
   SANDRA TICEN, MS, ATR
   KATHRYN WEBB, MA, ATR, MFCC

4. **Heading Them Off at the Pass: An Expressive Therapies Program for Adolescents**
   MARCIA ROSAL, PhD, ATR
   SUE MCCOLLOUGH
   SUSAN MALONE, MA

5. **Innovations in Medical Art Therapy: Defining the Field**
   JANET K. LONG, MA, MFCC, ATR
   VALERIE APPLETON, MA, MFCC, ATR
   SUZANNE PALMER, MA, ATR
   LINDA M. CHAPMAN, MA, ATR

6. **Suicide: What is the Role of the Art-Therapist?**
   LINDA GOLDMAN, MEd, ATR
   JUDITH ROTHSCHILD, MS
   JEROME A. MOTTO, MD
   CHARLOTTE ROSS
   PATRICIA ALLEN, PhD, ATR
   SANDRA GRAVES, ATR

7. **Advances in Research**
   LINDA GANTT, MA, ATR, Moderator
   GLADYS AGELL, MA, ATR, HLM
   BARRY COHEN, MA, ATR
   CAROL COX, MA, ATR
   CARMELLO TABONE, MA, ATR

8. **Short-Term Art Therapy at a Psychiatric Crisis Intervention Ward**
   FABRA MATTHIAS, MD
   CHRISTINE HESSE
   HORST BERZEWSKI, MD

9. **The Extended Family Picture: International Development of Art Therapy**
   BOBBI STOLL, MA, MFCC, ATR
   ASHOK SHAH, ATR
   MIMI MARINOVIC
   DIANE WALLER
   Y. TOKUDA, MD
   ANNETTE COULTER-SMITH, MA

10. **Kinetic Family Drawings: Past, Present and Future**
    JANIE RHYNE, PhD, ATR, HLM, Moderator
    ROBERT C. BURNS, MS
    JONATHAN BRAKARSH, PhD

11. **The Circle and The Art Therapist**
    LILLIAN RHINEHART, MA, ATR
    PAULA ENGELHORN, MA, ATR
    EDITH WALLACE, PhD, MD
    SANDY GELLER, MA, ATR
    JOAN KELLOGG, MA, ATR
    RUTH-INGE HEINZE, PhD

WORKSHOPS

1. **Solution-Oriented Art Therapy with Adult Survivors of Childhood Abuse**
   MOLLY H. GUZZINO, MA, ATR

2. **Therapeutic Cartooning with Adolescents: A New Tool for Art Therapists**
   KURT BREWSTER, MA

3. **Imagination: Action-Methods in Group Art Therapy**
   LEIGH FILES, MEd, ATR

4. **Family Art Therapy with Adolescents**
   CHARLENE KOHL KELZER, MA, MFCC, ATR

5. **Getting It All Together and Taking It On the Road**
   AUDREY DI MARIA, MA, ATR

6. **Baba Yaga: Metaphor for Renewal**
   ROBERTA PASHLEY, BA, ATR

7. **Transformation and Self-Discovery Through Collage**
   ANNE SCHNEIDER CANRIGHT, MAAT

8. **Exploring the Expressive Use of Clay in Short-Term Art Therapy Groups**
   E. CARBERY NEAL, MA, ATR

9. **Family Roles/Family Traps: Scripts for Survival and Coping with Addictions**
   DIANE KRIEGMAN McELLIGOTT, MA, ATR

JULIE LEON, MA
LYNN JONES, MA, ATR, CDC
KATHRYN WEBB, MA, ATR, MFCC

10. **Mirroring and Merging in the Intimate Interplay of Images Between Therapist and Client**
    HARRIET WADESON, PhD, ATR
    ROSE MARANO GEISER, MA, ATR
    JEAN DURKIN, MA
    JOANNE RAMSEYER, MA, ATR

OPEN FORUMS

1. **Understanding the AATA Approval Process—Education and Training Board**
   JULIA BYERS, ATR
   MARI FLEMING, ATR
   MARY ST. CLAIR, ATR
   PAT ST. JOHN, ATR
   FRANCE ANDERSON, EdD, ATR
   MARCIA ROSAL, PhD, ATR

2. **Clinical Committee**
   PAULA HOWIE, MA, ATR CHAIR
   BARBARA SOBOL, MA, ATR
   KIM PAWLEY HELFGOTT, MA, ATR
   JEANETTE FINO, MA, ATR
   SALLY BRUCKER, MA, ATR
   NANCY SCHOEBEL, MA, ATR
   JUDY RUBIN, PhD, ATR
   LAURIE WILSON, PhD, ATR
   RANDY M. VICK, MS. ATR

3. **Making an Impact on Government—Governmental Affairs Committee**
   NANCY HALL, MA, ATR
   ROBIN KNIGHT GABRIELS, ATR
   DEBORAH GOOD-GARCIA, ATR

4. **American Art Therapy Association—Membership Survey**
   CATHY A. MALCHIODI, MA, ATR, Membership Survey
   CAROLYN WALLER, BFA, Student Committee Chair

5. **Publications/Writing for Publication**
   PATRICIA ALLEN, PhD, ATR
   GARY BARLOW, EdD, ATR, Editor, *Art Therapy*

6. **Research Guide**
   HARRIET WADESON, PhD, ATR

7. **Education/Graduate and Undergraduate**
   SHIRLEY RILEY, ATR, MFCC

STUDY GROUPS

1. **Art Therapy with the Elderly**
   ANNETTE SHORE, MA, ATR

2. **Mandala Study Group**
   PHYLLIS FRAME, MA, ATR
   BONNIE SMITH-MAY, MA, ATR

3. **U.S. Study Group on Symbolic Language**
   DEE SPRING, PhD, ATR

4. **International Network**
   BOBBIE STOLL, MA, MFCC, ATR

PRESENTATION

1. **Research Built Upon Research: Old Masters Collage and Selected Visual Preference Test**
   DORIS ARRINGTON, EdD, ATR
   ELIZABETH RATCLIFFE, MA, MS, ATR

POSTERS SESSIONS

1. **Channeling and Challenging the Survivor of Head Injury Through Art Therapy**
   DIANA M. NAWROCKI, MAAT, ATR

2. **Life Sized, Three-Dimensional Dolls as Therapy with Child Sexual Abuse Victims**
   EVAN N. SMITH, MS, ATR

3. **Integrating Art Therapy Concepts in Pre-School Education**
   SIMONE ALTER MURI, MEd, ATR

4. **Couples in Therapy: A Study of Art in the Initial Interview**
   RUSS MESSING
   JUDY BAKER, MFCC, ATR

5. **When Words Aren't Enough . . . Art Therapy and the Chemically Dependent Adolescent**
   SISTER KATHLEEN BURKE, PhD, ATR

6. **The Bridge Drawing as a Projective Technique in Art Therapy with Addictive Patients**
   RONALD E. HAYS, MS, ATR
   SHERRY J. LYONS, MS, ATR

7. **I Will Show You What I'm Unable to Say**
RAYMOND BRACHEN
JAMES KAHN, PhD
CATHY A. MALCHIODI, MA, ATR

8. **Self-Healing Through Symbolic Resolution: A Case Study**
HELEN HAIGHT, ATM

9. **A Comparative Analysis of the Symbology of Pre- and Post-Ect Drawings**
JANICE HOSHINO, MA, ATR
RICHARD R. SILBERT, MD

10. **The Rose Window Shattered: Art as Therapy in Loss and Transition**
HAINE CROWN, MA, ATR

11. **The Critical Importance of Art Therapy: An Examination of the Dissociative Disorders**
SUSAN ROLLER, MFA

12. **Body Image Disturbance in Chronically Medically Ill Adolescents**
SUSAN CHEYNE-KING, MS, ATR

13. **Guidelines for Exhibitions of Art by People with Mental Illness**
SUSAN SPANIOL, MEd, ATR

14. **The Study of a Father's Role in Family Art Therapy**
SALLY SHOCK, MAT
WINNIE FERGUSON, PhD, ATR

15. **Madame H., A Senior in a Multi-Cultural Facility: A Psychoanalytic Understanding**
JOSEE LECLERC, MA

16. **Art Therapy with Children from Violent Homes: A Model Job Description**
CATHY A. MALCHIODI, MA, ATR

17. **Evaluation of Drawings by Young People with Chronic Renal Disease**
SUZANNE BARTON, MAAT

18. **Creating Family Art Therapy Video Tapes**
LAURA EATON, MA
MADELINE LIEBLING
MARY BLAYLOCK
NANCY ACKERMAN
SHELBY ROBISON

19. **Visualizing the Bridge: Linking Substance Use to Psychiatric Problems Among Adolescents**
BARBARA C. DISCENNA, MA, ATR
PAMELA BERTAUD KLIER, MA, ATR

20. **Occupational Stress and Emergency Medical Personnel: Assessment and Group Treatment**
DIANE L. TONKYN, BFA, MCS, MA, ATR

21. **DDS: Research Protocol as a Format for Inpatient Art Therapy Groups**
JEANNE N. CREEKMORE, MA

22. **Cartoon Aided Spousal Communication: An Experiment**
JANET SORESSI

23. **Environmental Drawings and Behavior in Children from Violent Homes**
JULIE EPPERSON

24. **Reminiscence and Life Review Using Art Therapy with the Elderly**
BERNEICE BURT
KIRSTEN BALL, MA
CATHY A. MALCHIODI, MA, ATR

25. **The Draw, Win, and Learn Family Art Therapy Assessment**
JOANNE KAUFMANN
SALLY SHOCK, MAT
WINNIE FERGUSON, PhD, ATR

Master's Degree Programs in Expressive Therapies and in Creative Arts in Learning

. . . .

**Offered by the Institute for the Arts and Human Development
Lesley College Graduate School**

Master of Arts in Expressive Therapies

For students interested in the creative modalities of art, music, dance/movement, and drama, presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning

For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theater studies.

For more information call or write the Institute for the Arts and Human Development, Lesley College Graduate School, 29 Everett Street, Cambridge, MA 02138-2790. (617) 868-9600, ext. 480.

Lesley College
GRADUATE SCHOOL

Lesley College is an Equal Opportunity Affirmative Action institution.

BEST COPY AVAILABLE

Edvard Munch: An Art Therapist Viewpoint

Helen Landgarten, HLM, ATR

Abstract

Edvard Munch is introduced with a brief look at his family—their tragedies, focus and behaviors. His writing and painting and drawing served as a therapeutic expression in his teen years, with themes occurring as polarizations of conflicts. After hospitalization from work and alcohol, Munch's art returned to the man-woman theme. The author discusses dual painting techniques (clues to inner conflicts) and psychological clues (relative to the House, Tree, Person Projective Test). The author poses the question "What would I have done if I had the opportunity to treat Edvard Munch through the art psychotherapy at the time of his psychiatric hospitalization in 1908?" and proceeds to discuss her art psychotherapy treatment plan.

Introduction

Edvard Munch, the most illustrious Norwegian artist, was born in 1863. A developmental history reveals a childhood filled with horrendous traumas. When Munch was merely five his mother died of tuberculosis. A few years later that same disease killed his fourteen-year-old sister. Yet additional tragedies followed shortly afterwards when a younger sister was found to be severely disturbed and his brother died. In his youth Munch's own health was poor due to tuberculosis.

The artist's father, a military physician, was fanatically religious. The man was plagued with the fear of fire and brimstone and believed it was absolutely necessary to raise his children with strong disciplinarian actions. He frequently punished them physically as well as psychologically through his constant threats of eternal damnation. In spite of his value system, Dr. Munch agreed to let his son Edvard attend an art school where the boy's exceptional talent was soon discovered.

At the age of seventeen, Munch recorded his need for self expression through the creative process, acknowledging the catharsis which it provided him. After an argument with his father he wrote, "I went home to reconcile myself with my father, but he had already gone to his bedroom. Quietly I opened the door and saw my father kneeling by his bedside praying. I had never seen that before. I closed the door and went to my room. I was restless, unable to go to sleep. At last I fetched my drawing board and began to draw. I drew my father, kneeling by the bed, the light on the table throwing a faint, yellow glow over his nightshirt. I got out my paintbox and put in some color. At last I succeeded and lay down, comforted, falling asleep quickly."[1]

Aside from the art school Munch was essentially self-taught. He began to exhibit at the age twenty.

The most prevalent themes in Munch's art portrayed his polarized conflicts: love and hate; good and evil; rage and peace; life and death. He dealt directly with man's primary emotions perceiving sex as the essential driving force. Munch viewed love as a demonic element which lent itself to the inflictions of pain, abandonment, despair, and loneliness. The artist relentlessly believed himself to be both the perpetrator and the victim of passion, sin, and destruction. He fiercely grappled with his life in the past, present, and future and hereafter.

By 1904, the European art world recognized Munch as an eminent "Independent." He was an artist who did not follow the tenets of any group style. Nevertheless, it is important to note that he bore a tremendous influence on the German impressionists; current critics have acclaimed him as the Father of German Expressionism.

Between 1892 and 1909 Munch had an overwhelmingly creative drive. During that seventeen-year period he exhibited in 106 shows. The overload of work plus his alcohol abuse were main contributing factors to Munch's psychological breakdown. He placed himself in a Danish psychiatric sanitarium in 1909 where he stayed for a period of eight months.

After the hospitalization, Munch's art returned to the man-woman theme. However, there was a major change in the emotional tone of this same subject matter. It was evident that his personal erotic torment and suffering was abandoned, as he turned to primeval times when the idyllic link between the sexes was continuous and everlasting.

As time went on, Munch had greater difficulty in parting with his art. He called his work his children and his friends. When he was convinced to sell his art he experienced the separation as such a void that he

> *". . . Munch recorded his need for self expression through the creative process, acknowledging the catharsis which it provided him."*

---

[1] Stenerson, 1950, pp. 12

compulsively filled it by creating a duplicate piece of work to take its place.

Munch's long career brought him numerous outstanding accolades. Many honors were bestowed upon him in his native land and abroad. He was a functioning artist right up to the end of his life and died at the age of eighty in 1940.

Dual Painting Techniques: Clues to Inner Conflicts

Edvard Munch revealed his inner oppositional conflicts in a number of ways. The first to be explored herein is his two diverse styles of painting. To illustrate this premise, I shall contrast *The Scream* (see Figure 1) and *The Drinking Bout* (Figure 2). In examining *The Scream* one sees it as a powerful work which contains a single undulating figure with a skull face and a mouth that is wide open as it shrieks out in horror. One can experience the speed of the person running down a bridge since it is accentuated by an exaggerated perspective that runs off to the bottom of the picture, and in one's mind's eye, continues beyond, thrusting itself onto the viewer. Additional force is fostered upon us, through the vibrating bands of color depicting the sky and waters. The entire painting with its imposing lined quality conveys a symphony of agonizing sound.

I find several features in this work similar to the art of psychotic persons; that is, the lack of negative space and the common skull-faced symbol. However, the major difference is in the use of color. The de-

"The overload of work plus his alcohol abuse were main contributing factors to Munch's psychological breakdown."

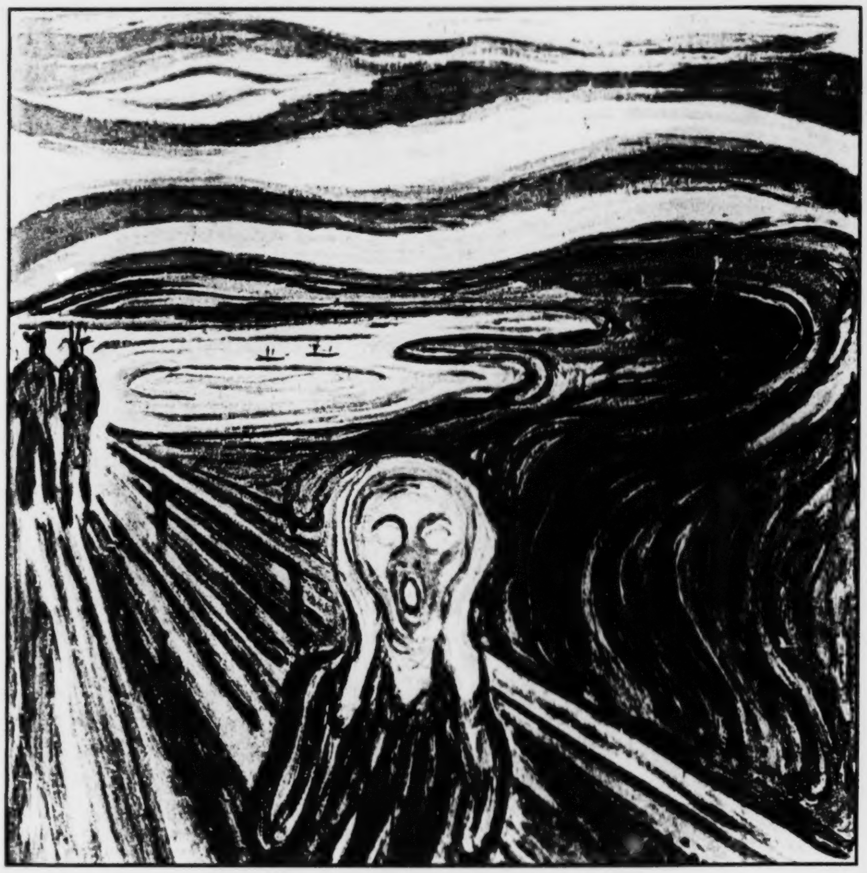
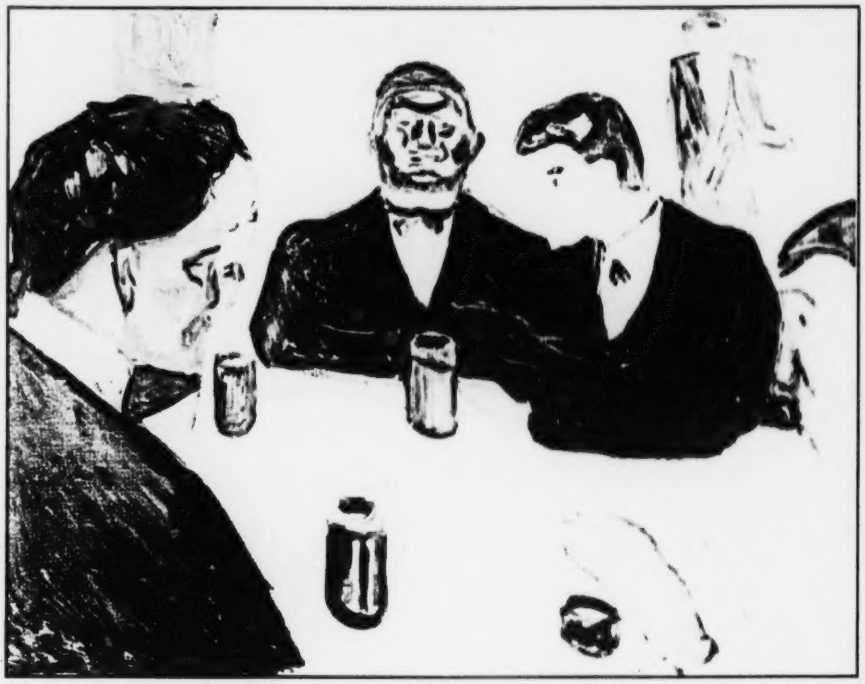


Fig. 1 The Scream, 1893/94

Fig. 2 Drinking Bout, 1906



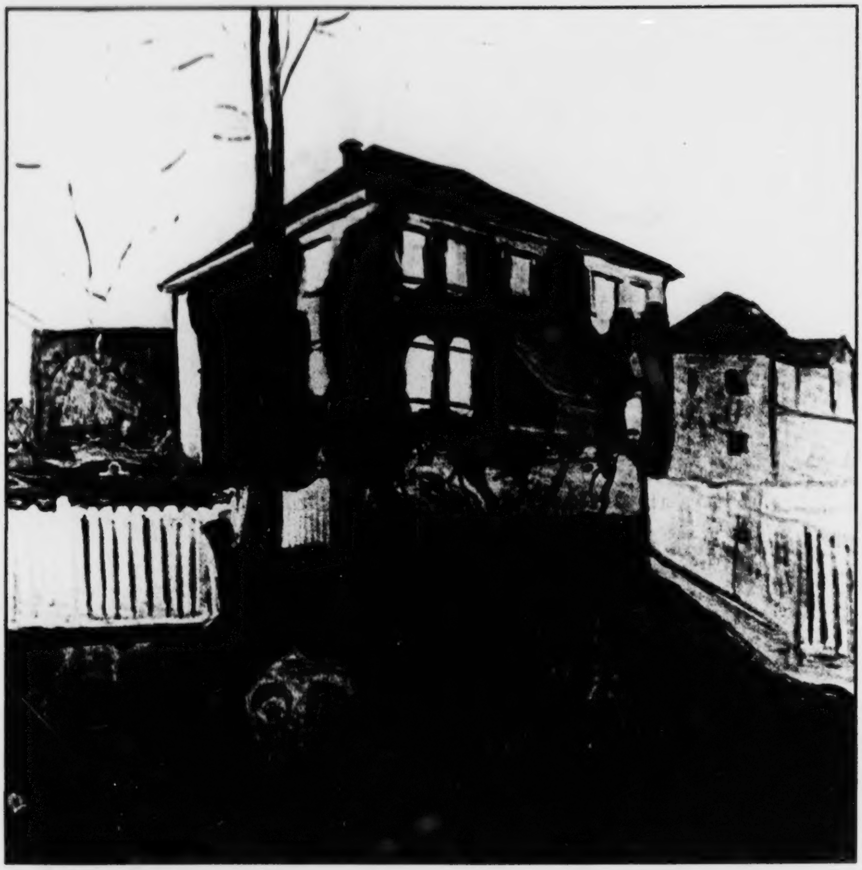


Fig. 3 Virginia Creeper, 1900

compensated individual tends to paint in primary colors whereas *The Scream* exhibits an exquisite intellectual use of the secondary process and colors possibly to prevent visual overload.

The style of *The Scream* painting is in contrast to *The Drinking Bout* which contains a group of men seated at a table drinking liquor. The major focus is on a red-faced man whose posture is rigid, seemingly in an attempt to control himself. This particular work of art may have served as a means of sublimation or a compensatory device since Munch, himself, had once killed a man while in a drunken brawl.[2] *The Drinking Bout* contains a very different painting technique than *The Scream,* since it is composed of very broad flat brush strokes. Importance is given to the negative spaces that serve as showcases for the positive images and are beautifully articulated shapes in their own right.

Psychological Clues: House, Tree, Person Projective Test

Aside from viewing the duality in painting techniques, there are additional psychological clues that may be obtained from Munch's art. There is a well-researched and validated projective test known as the HOUSE, TREE, PERSON, referred to as the H.T.P.[3] It is a test which requires the subject to draw each of the three symbols. These particular images provide a deeper understanding of the person's underlying dynamic and is a valuable tool for psychological assessments.

With the H.T.P. in mind, I have examined Munch's work. Initially I will focus on the *house.* This object represents one's family life; for the unmarried adult it refers to the subject's home life as a child.[4]

Since Munch's painting titled *Virginia Creeper* or *The Red Vine* (see Figure 3) contains all three symbols of *house, tree, and person,* it will serve as an example of my premise that the H.T.P. projective test offers insightful intrapsychic clues to Edvard Munch.

In the *Virginia Creeper* canvas there is a house which appears, either on fire or bathed in blood. Either choice depicts destructive life forces. In my experience, I have found that pictures related to this type of painting, are usually done by persons who have had one or several of the following in their developmental history: 1) a seriously ill family member; 2) a family life that was filled with tension, rage and guilt; 3) physical abuse by a parent. In Munch's case, all three of these clues are true. He had repeated experiences of illness and death among family members. In addition, his father's physical and psychological methods of punishment must have been accompanied by tension, anger and guilt, in Edvard as well as in his sisters and brother. The artist remembering his abused childhood once stated, "Father was almost insane in his violence when he punished me."

In the picture of *Virginia Creeper* I also noticed the absence of a *door.* The door as an object lets people in and out. It represents the artist's accessibility. This canvas of Munch's reveals his lack of psychological accessibility. This characteristic is proven by the facts that he was alienated from society and had been unable to establish an intimate relationship. Munch's doorless house, that is set aflame, is a place where the family is boxed in forever. These findings parallel his developmental history, since family members either

---

[2] Werner 1979, pp. vii introduction

[3] Buck 1970, Jolles 1971

[4] Buck and Jolles

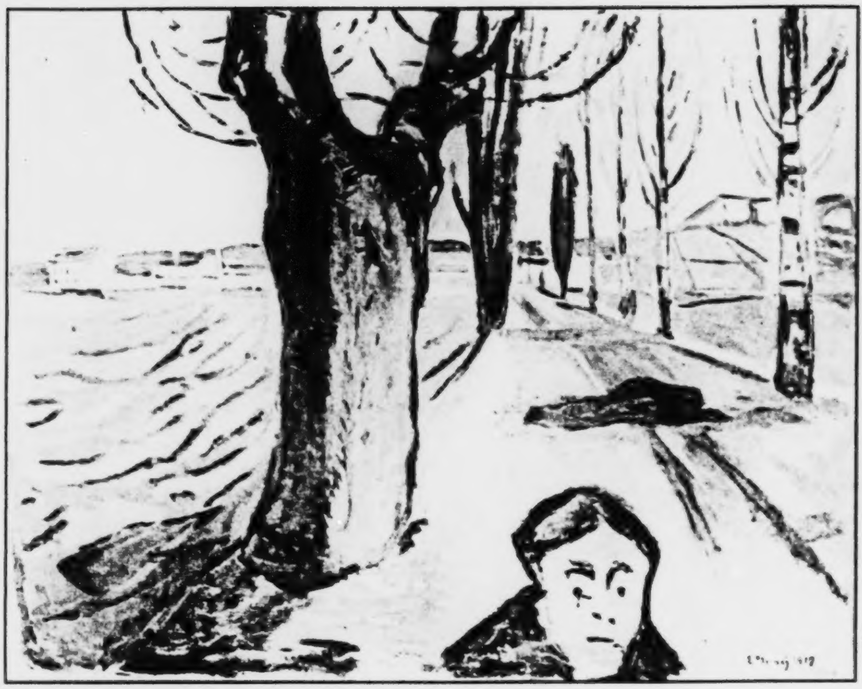


Fig. 4 Murder in the Avenue, 1919

died or were psychologically impaired in their early childhood.

Virginia Creeper was only the beginning of my search for the "missing door." As I reviewed a number of books and catalogs I saw this phenomena repeated over and over again. In fact, while over a hundred pictures and slides were reviewed by this author, only five had doors, and a few more that may have indicated doorways, were in fact too vague to be identifiable as a door per se. (Refer to *pictorial references.*)

The second object in the H.T.P. projective test is the *tree*. A great many trees are seen in Munch's painting and prints. At times he intentionally used them to depict anthropomorphic or personal messages. While other times it was included in the landscape as the subject matter for composition purposes.

In the H.T.P. projective test, the *tree* is a metaphor for the artist's emotional experiences and development. That is, the creator's psychological life history. The trunk stands for self-concept and ego-strength with the extremities as indicators of one's relationship with the environment. Traumas are depicted through scars or knotholes on the trunk and broken or cut limbs and branches.

The tree trunk's knotholes often offer information regarding the particular year when difficult life events occurred. This assumption has frequently been validated by myself during the twenty-two years of my clinic practice. A formula which exists[5] claims the length of the tree trunk is equivalent to the subject's current age. The traumatic experiences are dated by the placement of the hole in the tree trunk. Figuring from the bottom up, if a hole is shown half way up the trunk it would indicate trauma half way through the individual's life; a hole three-quarters up would display trauma at an age which is seventy-five percent of the subject's current age, and et cetera.

I believe it is necessary to note that tree drawings may be depicted differently at different times, since it reflects the artist's empathic identification to the psychological environment portrayed at a particular time.

Returning to *Virginia Creeper*, the emphasis is now on the *tree*. Considering the cut off limb near the bottom left of the trunk, the trauma in this case would be placed at the approximate age of five. This is the time of Edvard's mother's death. The top part of the trunk indicates a split, which may represent Munch's inner conflicts. This particular symbol had been repeated by this artist a great many times. In addition, the barrenness of the tree symbolizes isolation and emptiness in the area of relationships. Another tree picture is *Murder in the Avenue* (Figure 4). It reveals a trauma through the scar on the upper part of the trunk. According to the age formula, Munch would be approximately 32; a time that coincides with the death of his brother Andres. Upon investigation, I found this artist's trees as reflective of his traumas and troubled personality in the vast majority of his works.

In the winter of his life when Munch was 77 years old, he produced the *Self Portrait at the Window*. The viewer can see Munch himself, and placed next to him is a window through which a number of snow laden trees are seen. One tree-figure stands out naked and unencumbered. It is thin and barren yet strongly defined. Although the bottom of the trunk is bent indicating difficulties in early childhood, the trunk remains tall and stiff, similar to the self-portrait counterpart.

In the H.T.P. the *person* image portrays the subjects' own body image perception and self-concept. It provides clues to the individual's inner personality.[6]

Karen Machover (1965) found clinical verification that persons directed to draw a person related "inti-

---

[5] Buck

[6] Hammer 1971

BEST COPY AVAILABLE

mately to the impulses, anxieties, conflicts and compensations of that individual." She claimed that the drawing analyst "should feel free to interpret directly aspects which, with striking literalness, often reflect real life problems and behavior of the individual who is drawing."

Although subjects frequenty tend to unconsciously reveal their inner self, Munch consciously chose to display his inner thoughts and emotions. Until 1910, he unlayered himself down to the rawest, most vulnerable parts of his being. He transposed the covert into the overt. The viewer does not need an analysis of the hidden meaning behind Munch's painting, for the meaning is blatantly set forth in his artwork. However, upon reviewing an Edvard Munch retrospective show at the Newport Harbor Museum of Art in California (1983), the lack of fingers on the hands of Munch's figures was discovered. Fascinated by this observation, I reviewed books and catalogs to find only a few pictures out of several hundred contained well-defined fingers on the hands. For example, in the Newport Art Museum catalog titled EDVARD MUNCH EXPRESSIONIST PAINTINGS 1900–1904,[7] there are 33 paintings which depict figures of approximately 80 sets of painted hands yet only one picture displays fingers which are fairly well-defined. In another book, EDVARD MUNCH: SYMBOLS AND IMAGES, published by the National Gallery of Art, Washington, D.C., approximately 190 sets of hand images displayed only five contained well-defined fingers.

Fingers are essential in the experiential pattern of the person, claims Machover, since they are the individual's contact-points. The mitten-type hand and finger, most frequently featured by Munch is identified by Machover as a subject who has "repressed aggression." Isaac Jolles states that the omission of fingers depicts a person's feeling that they are unable to make more refined adjustments to interpersonal problems. Both of these statements coincide with Munch's characteristics of repressed aggression, unsuccessful love relationship and asocial behavior.

> ***"[From 1892–1907] the theme of eros, death, anxiety and despair were obsessively repeated."***

Art Psychotherapy Treatment Plan

My final comments deal with the question, "What would I have done if I had the opportunity to treat Edvard Munch through the art psychotherapy at the time of his psychiatric hospitalization in 1908?" His case, with the exception of his extraordinary talent, is not so different from patients with whom I have worked.[8]

Munch's work from 1892–1907 contained a great many very *large* canvases. They are filled with spontaneously applied color. The theme of eros, death, anxiety and despair were obsessively repeated. I believe these factors had some influence on keeping the artist in a heightened emotionally unbalanced state, for Munch's creativity paid its price through a continued overwhelming confrontation with the self. Viewing one's ego mirror image can lead to the breakdown of defenses and ego functioning rendering the person too vulnerable to live a reality-oriented, everyday world. *Munch's demons were not exorcised through his art, they served to fan his torment.* The artist once stated, "A work of art can arise from man's inner self. Art is man's longing for crystallization."[9] However, I believe crystalization is not always a working-through process and in this artist's case it became a visual and internal form of rumination and kept him in the vice of psychopathology. Therefore, my clinical art therapy treatment plan would have included the following: (1) a distancing means for self-expression; (2) narrowing the focus to reality images; (3) setting limits through the use of space and media.

My treatment plan would have paralleled what *actually* did happen to Munch when he was hospitalized in 1908–1909. At that time he became a frequent visitor to the zoo. This resulted in his producing a series of animal lithographics, a subject which may be expressive of a person's primitive inner life; yet it contains a necessary veiled safety factor. For the patient who is in the midst of a break, it is important to diminish the fantasy which exacerbates or amplifies their heightened emotional response. The reality orientation goal was fulfilled through Munch's interest in making graphic portraits of the nurses, children, friends, and their wives and subsequent themes related to nature. These representational pictures kept the artist focused on an immediate task and aided him in avoiding self exploration.

Prior to the artist's hospitalization his tortured existence was kept alive not only through the psychological intensity of his subject matter, but also through: (1) his identification and immersement in painting; (2) the openness of the large-sized canvases; and (3) the multiple use of colors. Therefore, as an art psychotherapist, I would have offered the patient *symbolic containment* where parameters were pulled in and greater control would be required. In addition to the smaller size, containment would also be aided through the limited use of color and hue. For in cases such as Munch's, the overwhelming visual input serves to floor the patient psychologically. The nature of the *print-making* media provides the necessity for both structure and control: these two elements were necessary for Munch to function as a person, one who would cease his self torture and self destruction.

---

[7] Eggum, A. 1982

[8] Landgarten, H.B. (1980). *Clinical art therapy: a comprehensive guide*. New York, NY: Brunner Mazel.

[9] Timms, p. 8

Through the shift in theme, limiting the quantity and hue of the color, changing the media and size of the artwork, I believe that a part of Munch's healing process did lay in the fortunate change from painting to print-making since the graphics required both a reduction in dimensions and color and the discipline of simplification. These factors provided a therapeutic base in the realm of physical and psychological space.

Munch proceeded to work almost exclusively in graphics from the time of his hospitalization at age 35 until his mid-60's when he returned to painting. Although the subjects of his past reappeared on later canvases, they were no longer psychologically destructive for the spontaneity and emotionality were gone. For the artist Edvard Munch, it was fitting, to end his life in the midst of color and limited passion.

References

Buck, J.N. (1970). *House-Tree-Person technique*. Los Angeles, CA: Western Psychological Services.

Eggum, A. (1982). *Edvard Munch expressionist paintings 1900–1940*. Madison, WI: Wisconsin University Ehluhjem Museum.

Hammer, E. (1971). *The clinical application of projective drawings*. Springfield, IL: Charles C. Thomas.

Landgarten, H.B. (1980). *Clinical art therapy: a comprehensive guide*. New York: Brunner Mazel.

Hammer, E. (1986). Correspondence with Landgarten.

Jolles, I. (1971). *A catalog of qualitative interpretation of the House-Tree-Person (H-T-P)*. Los Angeles, CA: Western Psychological Services.

Machover, K. (1965). *Personality projection in the drawing of the human figure*. Springfield, IL: Charles C. Thomas.

Stenerson, R. (1950). *Edvard Munch*. Stockholm a.m. Zurich.

Timms, W. (1969). *The graphic art of Edvard Munch*. Greenwich, NY: New York Graphic Society Ltd.

Werner, A. (1979). *The graphic art of Edvard Munch*. New York, NY: Dover Publications.

Woll, G. (1978). *Edvard Munch: Symbols and images*. Washington, DC: National Gallery of Art.

1988 AATA

MEMBERSHIP DIRECTORY

*

Now Available through the National Office

$8.00 member **$50.00** non-member
$100.00 institution

NAME ______________________________

ADDRESS ______________________________

CITY ______________________________

STATE ______________ ZIP ______________

▲ *Mail entire form to:* ▲

AATA NATIONAL OFFICE
1202 Allanson Rd./Mundelein, IL 60060

Feed me . . . Cleanse me . . . Sexual Trauma Projected in the Art of Bulimics

Sandra Ticen ***MS, ATR,*** *received her Masters Degree from State University College at Buffalo. She is a registered art psychotherapist in psychiatry and the eating disorder program at Bry-Lin Hospital, Inc. in Buffalo, New York. Ms. Ticen has lectured around the country on the topics of sexual abuse, eating disorders and multiple personality disorder.*

Abstract

Very little has been written to address the issue of eating disordered behavior as it may relate to sexual victimization. Eating disorder programs are just beginning to report statistics which shockingly reveal that over 50% of patients have experienced some form of sexual trauma. Bulimic patients who have been sexually abused often speak of an intense desire to wash or purify, even to the extent of eliminating the body. Finding it difficult to control impulses, the bulimic needs a safe, structured place to grieve and recreate her purging metaphor. The art therapy process can provide this while at the same time assisting the patient in the creation of a symbolic meal, leading to restoration of the self.

The statistical data on sexual abuse is frighteningly high and has been well reported in the media and literature. Coping mechanisms are often manifested in maladaptive behaviors such as chemical dependency, sexual dysfunction, withdrawal and silence, self-mutilation, dissociation, suicidal ideation and post traumatic stress symptomology (Johnson, 1987; Spring, 1984; McCarthy, 1986). Very little, however, has been written addressing the issue of eating disordered behavior as it may relate to sexual trauma. In a recent article published in the "International Journal of Eating Disorders," McFarland, McFarland and Gilchrist report similarities in the psychological processes of post traumatic stress and eating disorders (1988). Both cognitive and affectual disturbances are marked by intrusive thoughts and compulsive behaviors related to eating. The authors postulate that disorders of weight may be triggered by traumatic events since the preoccupation with food is less disturbing than the intrusive thoughts of the trauma, thus giving the victims a sense of control.

Programs across the country which treat eating disordered patients, suffering with anorexia nervosa and bulimia nervosa, are just beginning to report statistics which shockingly reveal that more than 50% have experienced sexual victimization (Wooley, 1987). In Bry-Lin Hospitals' seven-bed unit, these statistics rang true as patients struggled with the effects of either overt or covert sexual victimization. Although no validation studies have yet been reported, the numbers indicate that sexual traumatization is an issue which must not be overlooked with this population. This is not to say that sexual abuse causes anorexia or bulimia, for, of course, not everyone who has been sexually abused will develop an eating disorder. But, sexual traumatization will certainly affect the treatment approach and outcome. Even with the most careful history taking, the silent patient may not reveal a clue, and, even when the crime is disclosed, she may remain emotionally and verbally paralyzed. Because of what mental health professionals now know about the visual common language of sexually traumatized victims (Figure 1), art therapists can play a valuable role in the assessment phase of hospitalization, providing non-verbal information which may indicate further investigation into the patient's history.

Geneen Roth, in her book "Feeding the Hungry Heart," emphasizes the fact that one must first identify what one is hungry for and only then can treatment providers begin to find the appropriate nourishment (1982). The sexually abused patient is going to require a different "menu" than her eating disordered sisters. This becomes the main task of the art therapist, to assist her in preparing, ingesting, digesting and eliminating her own "symbolic meal."

There has been some speculation that patients who have experienced incestuous victimization at an early age tend to develop the restricting behaviors of anorexia, usually manifesting themselves just before the onset of menses. As one would assume, maturity fears tend to be prominent. Bulimic symptoms most commonly begin to emerge around the age of 18 (Johnson and Connors, 1987), after a significant trauma which may range from familial sepa-

"Both cognitive and affectual disturbances are marked by intrusive thoughts and compulsive behaviors related to eating."

Ms. Ticen is currently employed as Primary Therapist at Park Ridge Health Systems Inc., Rochester, N.Y.

ration to a life-threatening experience. In the case of rape, the binge-purge cycle seems to become a cleansing ritual which victims speak of as an intense desire to wash and purify even to the extent of eliminating the body, if necessary.

Most of the sexually abused patients with whom I have worked have been difficult to categorize, since many have experienced early incest and were later revictimized by rape and other forms of sexual exploitation. Thus, the eating disorder will often be manifested as a combination of anorexic and bulimic behaviors. There is, however, always an attempt to purge, to spit out, to void. Many patients may have started out restricting and found that thinness does not relieve anxiety, turning instead to binging and purging as a means to control affect and restore internal balance. This too fails, with patients finding themselves more and more out of control while becoming increasingly malnourished. This malnutrition leads to a vicious cycle of depression, mood swings, and increasing withdrawal from the world. Most of the patients studied range in age from late adolescence to late thirties and are in the throes of a post-traumatic syndrome, often experiencing fear of annihilation of the self (Figure 2).

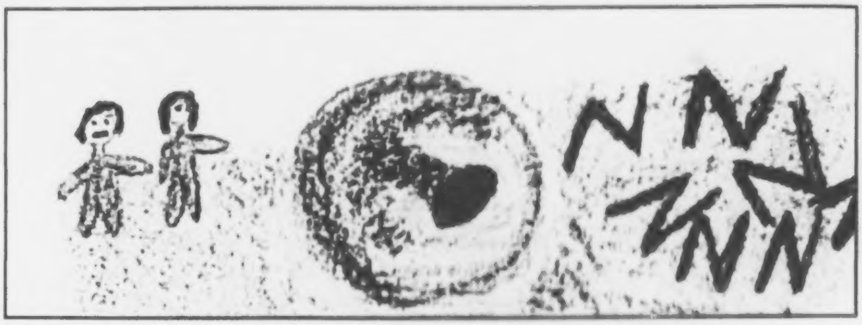


Fig. 1 Through the on-going research of the U.S. Study Group on the Symbolic Language of the Sexually Abused, the eye and wedge configuration has been identified as common visual language. (Spring, 1984). In this image, the threatening wedges evoke fear as the unprotecting parents watch.

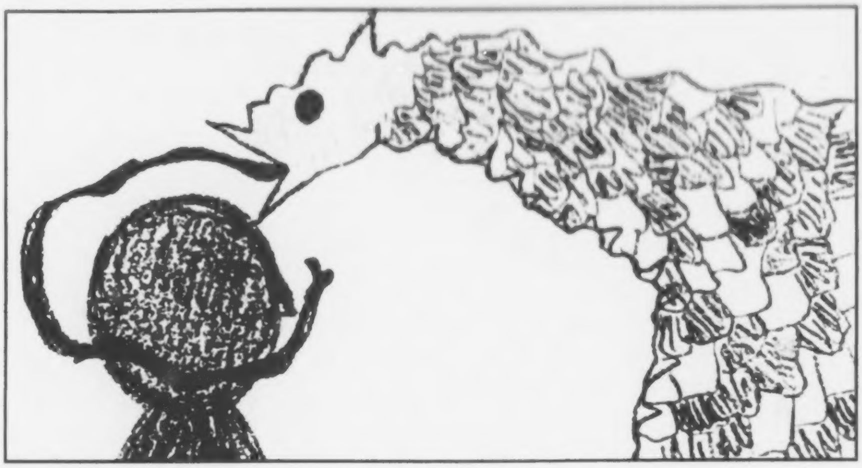


Fig. 2 A bulimic monster attempts to devour the self.

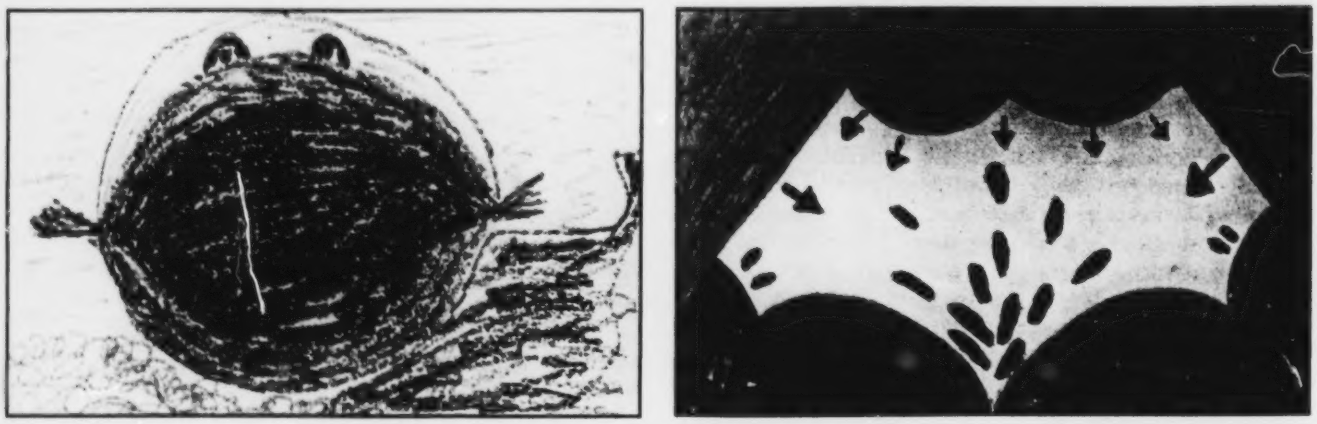
The more traumatized the victim, the more restricted the art will be. With consistent, ongoing abreactive work in art therapy, the imagery will gradually become more fluid, more colorful, more integrated and more dynamic. It is within this desensitization process that the bulimic patient will learn to establish boundaries and retake control of her life. This control is mirrored in her art productions, giving her validation and reinforcement. It is important to note that this attempt to restore inner control is taking place simultaneously with refeeding, behavior modification and psycho-educational processes to assist her in establishing external boundaries as well.

Wooley, in her work with sexually abused bulimics, reports "a progression of responses from blocking and denial, to rage, to shame, and finally to self acceptance" (1986). All this takes place visually and becomes a grieving process on paper and in clay. The bulimic patient, often an abuser of purgatives including laxatives, finds it difficult to control the losses to the self, both control of thought and bodily processes. She needs a safe place to grieve where the maladaptive oral and anal behaviors may be transferred and channeled into productive energy (Figures 3,4). This sublimation will allow for grief, resolution and mastery of her victimization to evolve. Art therapy creates an adaptive method where the patient can symbolically binge-purge, mess-cleanse, feel-create while the therapist sets the table for self discovery.

I have found that there are few differences in working with the sexually abused anorexic and the sexually abused bulimic. Both are locked into their own obsessive-compulsive

"The more traumatized the victim, the more restricted the art will be."

BEST COPY AVAILABLE



Figs. 3 and 4 Oral and anal impulses become overwhelming. These were drawn by a 36-year-old victim of rape and repeated sexual exploitation. She coped through purges of food, laxatives and alcohol.

prisons, attempting to escape from the intrusiveness of life. However, generally speaking, depending on the severity of traumatization and malnutrition, and the degree of eating disordered entrenchment, the bulimic patient will show more affectual response, take more risks, and usually reach treatment goals more quickly. No effective psychotherapy can be expected to take place if a patient is severely malnourished. Since most bulimic patients are not as nutritionally compromised as the anorexic, cognitive processes are usually clearer, allowing for a faster restorative pattern to occur, both physiologically and psychologically. The criteria for bulimia are briefly reviewed in the following paragraphs, with a look at common symptomology.

Bulimia, or "ox-appetite," is a private food obsession, often triggered by the drive for thinness and compulsive dieting, which grows into an addiction to control affect and anxiety. It is identified by the consumption of large quantities of food in a short time (usually within two hours) with a progressive feeling of loss of control. This is followed by purges which may include induced vomiting, fasting, laxative abuse, enemas and rigorous exercise. Bulimia nervosa is a life-threatening illness which has become rampant on today's campuses. Most of the research has focused on the female population. It is now believed, however, that there are large numbers of males who suffer from this illness and clinicians hope the emphasis on bulimia as a "female illness" will be lessened to allow these men to more easily seek treatment. Medical implications can lead to death as electrolyte imbalances, particularly a decrease in potassium, can cause muscle weakness (including the heart) and cramping. Weight fluctuations and compulsive dieting can lead to premorbid obesity as the body's natural set point weight is forced out of its genetically normal range. There is a decrease in bowel tone, especially if laxatives have become an addiction. Dehydration, swelling of the parotid glands, tooth decay, esophaegeal and gastric ulcers and ruptures are all possible occurences.

Psychologically, the patient may see herself as the failed anorexic only with a sense of being out of control. She is impulsive with an inability to delay gratification. There is a strict, punishing but ineffective superego and the patient exhibits a fatalistic outlook on the world. Where there is an overwhelming sense of helplessness, depression and anhedonia, the prognosis becomes poorer. Any type of sensual pleasure is taboo. The fantasy is, "when I am thin, I will be perfect and then I will be happy." The drive to lose weight is a conscious decision and usually there is a magical weight goal. Often, clinicians have observed the perceptual distortions in body size in the anorexic are not as intense in the bulimic who may describe her body accurately but affectually distorts what she sees. Studies indicate that body dissatisfaction as a generality is greater in the bulimic than in the anorexic (Johnson, Conners, 1987). Obviously, research must be done to understand more clearly the body image disturbances in the bulimic and how sexual abuse will impact on this area. Many persons with bulimia will appear to be at normal weight. Starvation is invisible, but the malnutrition is real. Like the anorexic, the bulimic confuses physical and psychological needs. This is the basis for the symbolic meal research, an holistic approach to heal-

"No effective psychotherapy can be expected to take place if a patient is severely malnourished."

ing. Also, bulimics fear intimacy and revealing the true self. Often lying, stealing and chemical dependency go hand in hand with bulimic behaviors. The presence of a character disorder is not uncommon but must be carefully ruled out since many patients who have been victims of abuse present with post-traumatic stress syndrome. In many, there may be an intense hatred and anger toward men as well as toward the self. As one might expect, this is magnified in the sexually abused patient who is often caught up in the victimization cycle. Male therapists need to be aware of the powerful transference issues when working with this group. Like the anorexic, the bulimic sees the world in black and white. The role of the therapist is to help her see the grays and eventually develop a chromatic world.

It has been documented in most of the literature on eating disorders that these patients have great difficulty identifying and expressing internal feeling states (Garner and Garfinkel, 1985; Johnson and Connors, 1987; Levonkron, 1983; Bruch, 1968). Johnson and Connors (1987), in their comprehensive study on bulimia nervosa, observed from the EDI research that bulimics report more difficulty with interoceptive awareness than restricting anorexics. This is closely aligned with body image disturbance and ineffectiveness. This lack of interoceptive awareness, coupled with the invisible scars of the silent victim, make art therapy even more desirable as a treatment modality with this population. To paraphrase the journal entry of one patient, "It seems that words are inadequate and un-usable." Marian Woodman, in her book "The Owl was a Baker's Daughter" (1980), reflects on a split between body and spirit, and the need to reconnect these integral parts of the self if healing is to occur. Reflecting on Woodman's case study of Anne, she writes, ". . . art becomes a prayer."

I believe that the creative is deeply rooted within the spirit and, in the work of art therapists, patients are taught to pray, as well as tap into their own God-given abilities to heal themselves from the inside out. Guided imagery, creative visualization, poetry, music, movement, meditation, and storytelling can be transformed by the patient into personal metaphor, which then becomes visual, documented, tangible evidence of the patient's internal strengths. This reassures her that the creative is not dead but only covered up by the dark, heavy colors which have dominated her vision. Art therapy allows the patient an adaptable method to sublimate and achieve catharsis while providing an extension between self and trauma (Golub, 1985). The patient feasts on media and eliminates that which causes pain through her product, creating a sense of empowerment and perhaps even a little bit of fullness.

Working abreactively with the victim of sexual abuse, the therapist must attempt to regulate the flow of affect if it appears that the imagery may flood the ego, causing the patient to feel more out of control. The bulimic, unlike the anorexic, has very weak ego boundaries. When and what media to offer, when to intervene, when to confront are all issues to which the therapist working abreactively must be sensitive without taking away control or being intrusive. It is often a very slow process. Frequently reminding the

Figs. 5 and 6. These were drawn by a 38-year-old incest survivor suffering from post traumatic stress symptomology. We see the child within. Note the blockage in the throat and chest area (Figure 5).

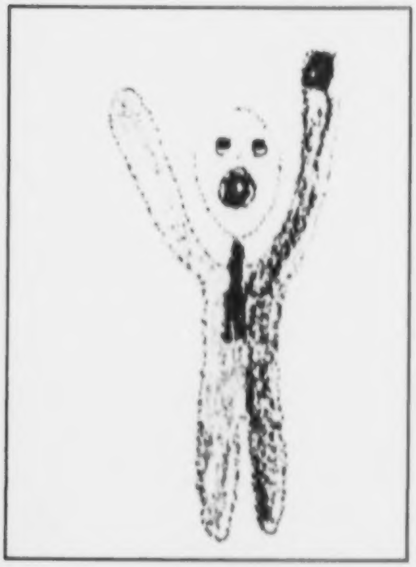
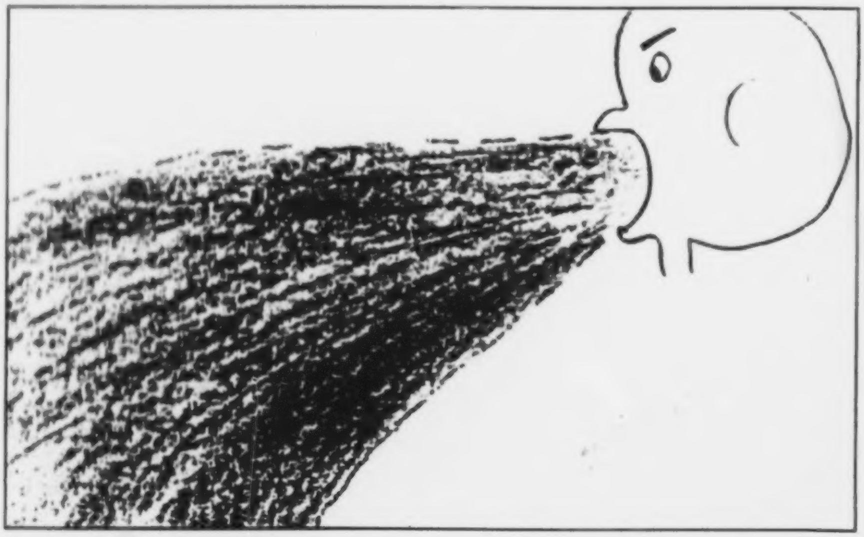


Fig. 6 She said that this child would scream if she could. It became a symbolic purge (Figure 6).



patient that she is safe and in control, and that the therapist will attempt to help to keep her that way is an important message which gives her permission to vomit out her pain in a symbolic purge (Figures 5,6). Many times, in an intense abreactive session, the patient will need to wash or brush her teeth. The art therapist assures her that she will offer her whatever support she needs. Ego defenses cannot be stripped away without an adequate replacement. The key to unlocking the healing powers of the creative lies in the use of the patient's own metaphor. The therapist must get ideas and direction from the patient. It is essential to listen to what is and what is not said. At the end of each individual abreactive session, I have found it useful to allow the patient an opportunity to tap into her spirit and find a peaceful, beautiful, personal image she can then make real. While helping to decrease anxiety, and the need for physical purging, it offers her a permanent record of her inward strength and validation that it is still there. Asking her to discover a secret garden, replacing hatefulness with gentle loving eyes from someone in her past, will help her to find personal images she can use outside therapy sessions. These images can be useful as thought-stopping tools when she may become tormented by an intrusive image or is fixated on the need to self mutilate. One of my patients, a victim of incest, tacked up in the dining room a beautiful mandala of the place she goes when she dissociates. This is an attempt to decrease dissociation when eating, as it decreases tension during meals and helps her to focus, maintaining her nutritional prescription.

One of the most paralyzing effects of sexual abuse is seen in the art projections of the self, revealing intense hatred and body dissatisfaction. Many patients have not looked at their naked bodies in years. The body is seen as disgusting, shameful, and a source of guilt. The binge-purge becomes a dichotomous and maladaptive means to self nurture by stuffing painful feelings, then cleansing themselves of the guilt, shame and anxiety. Wolf, Wilmuth, and Watkins (1986), believe that the more serious the disturbance in self esteem, the more intense the body image distortions will be. As mentioned previously, the distortion in the bulimic may not be related so much to size as to worth. With sexual abuse in the background, body image work must be approached gingerly and sensitively. Through the symbolic meal process, the patient is given the opportunity to self-nurture in a gentle, intellectual, as well as emotional, manner. She is given the task to create her own recipe of the self, and in the process learn to explore and eventually accept herself as worthy of attention and symbolic food. *The ultimate goal is to help her love herself, for without this ingredient, she will continue to spit out whatever is healthy and life-giving.* Collage work with body tracings and placemats to be used in the dining room are just two exercises used in the process of spiritual and emotional renourishing of the self. Group art psychotherapy is held in the dining room, and each member is given a napkin to use for smearing and cleaning. With every opportunity, the patient's own metaphor is utilized to assist her in restructuring cognitive distortions. Exploring the media is exploring the self. The "buffet" of media is spread out so she may easily select or reject whatever ingredients are needed to fill her at that moment. Roth writes that the quality of life is dependent on the ways one nourishes oneself (1982). Exploring the self with the bulimic is remembering that "man does not live by bread alone." As artists, art therapists naturally feast on media, finding release and recreation while processing the pain absorbed in working with this population. Hopefully, both the clinician and the patient will come away from this table a little fuller.

References

Brunch, H. (1978). The golden cage. *The enigma of anorexia nervosa.* Massachusetts: Harvard University Press.

Garner, D. and Garfinkel, P. (1985). *Handbook of psychotherapy for anorexia nervosa and bulimia.* New York: Guildford Press.

Golub, D. (1985). Symbolic expression in post-traumatic stress disorder: Vietnam combat veterans in art therapy. *The Arts in Psychotherapy, 12,* 285–296.

Johnson, C. and Connors, M. (1987). *The etiology and treatment of bulimia nervosa, a biopsychological perspective.* New York: Basic Books, Inc.

Johnson, D. R. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy, 14,* 7–13.

Levonkron, Steven. (1983). *Treating and overcoming anorexia nervosa.* New York: Warner Books, Inc.

McCarthy, B. (1986). A congitive-behavior approach to understanding and treating sexual trauma. *Journal of Sex and Marital Therapy, 12,* 322–329.

McFarland, A. C., McFarland, C. M. and Gilchrist, P. N. (1988). Post-traumatic bulimia and anorexia nervosa. *International Journal of Eating Disorders, 7,* No. 5, 705–508.

Roth, G. (1982). *Feeding the hungry heart.* New York: Bobbs-Merrill Co. Inc.

Spring, D. (1984). *A perspective and art therapy treatment model for the effects of rape and incest.* Treatment manual, Earthwood Center, Ventura, California

Wolf, J., Willmuth, M. and Watkins, A. (1986). Art therapies' role in the treatment of anorexia nervosa. *The American Journal of Art Therapy, 25,* 39–46.

Woodman, M. (1980). *The owl was a baker's daughter.* Toronto: Inner City Books.

Wooley, S. (1987). *The Enigma of Eating Disorders Conference,* (presentation). Buffalo, New York.

"Art for Special Needs: A Learning Disabled Child in a Special Art Program

Edith De Chiara, EdD, *Associate Professor, Department of Early Childhood and Elementary Education, Herbert H. Lehman College, City University of New York*

Abstract

This case study describes the experiences of Peter, a learning disabled child, in a special art program. The objectives of the program were threefold: 1) to improve the body image concept of children with learning disabilities, through art activities which focused on the human figure; 2) to learn more about the learning disabled child's behaviors and skills in an art classroom; 3) to determine what kind of special teaching strategies are necessary for teaching art to this population of learners. Although Peter's response to and progress in the program was erratic at the beginning, his later accomplishments demonstrated that behavioral adjustments and improvement of his body image concept had occurred through his experiences in the art program.

Many learning disabled children are being mainstreamed into regular classes for art. In order to work with these children successfully, it is necessary that art teachers (or classroom teachers) become more familiar with the learning styles and problems experienced by these pupils. However, the learning disabled population is heterogeneous and it is impossible to precisely describe "the" learning disabled child. According to the most common definition, children identified as having learning disabilities are of average intelligence, have intact sensory and emotional functioning, but exhibit a disorder in one or more of the psychological processes involved in learning (Federal Register, 1976).

This article describes one learning disabled child's experience in a special art program which was designed to: 1) improve the body image of learning disabled children through their participation in visual arts activities; 2) to learn more about learning disabled children's behaviors in an art learning situation (e.g., art skills, problem solving competence, capability to remain on task, learning styles and self-discipline); and 3) to determine what kind of special teaching strategies and adaptations are necessary for the teaching of art to this population of learners.

Body image as defined in this program refers to the knowledge and perceptions that a child has about the structure of his/her body—its parts, actions, and its relationship to space. It has been noted that children with learning disabilities may lack the ability to adequately receive and process information from sensory channels. Consequently, they may not have a clear image or knowledge about the appearance (configuration) of their bodies (body image). Thus, the central theme for all the art activities (two-and three-dimensional) focused on the human figure.

Ten children between the ages of 8 and 11 were randomly selected from three self-contained classes for the learning disabled in a public school to participate in the experimental pull-out art program. The group met twice a week for one hour, for ten weeks. The children were tested to determine the status of their concept of the body image by four measures: a human figure drawing test; a manikin assembly task; an imitation of postures task; and a task involving identification of the body parts in response to verbal instructions.

The Special Art Program

The program was comprised of three phases (Uhlin, De Chiara, 1984). Phase one, Body Schema, focused on art activities which directed the children's attention to the body's parts, their functions and actions. Activities were selected which could be completed within one session and did not require pre-planning. All the children were directed to use the same materials and techniques. Limiting options during the first phase was intentional; it allowed time for children to adjust to the new art learning situation. Phase two, Body Image, focused on activities which integrated, synthesized and built on concepts learned during Phase one. The body was viewed holistically. Pre-planning was introduced during this phase, whereas in the initial phase, activities tended to be spontaneous. Some of the activities were extended over several sessions, rather than a single session which characterized Phase one. The children were also given more options in regard to materials. In con-

> *". . . children with learning disabilities may lack the ability to adequately receive and process information from sensory channels."*

trast to activities in Phase one, those in Phase two were more open-ended and required greater problem solving abilities. In Phase three, Spatial Awareness, activities were focused on a person's relationship to objects and the environment. Activities during this phase extended over several sessions, were less teacher directed, offered greater options in materials and techniques and encouraged individual and expressive solutions.

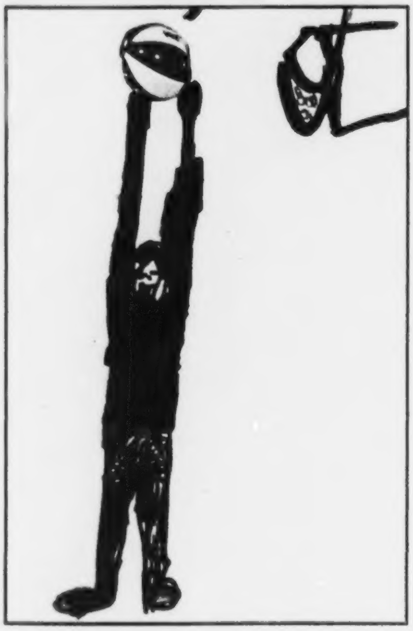


Fig. 1 Drawing of a person using visual clue. Materials: colored markers.

Case Study of Peter

Peter, a ten-year old boy, classified as learning disabled, was one of the participants in the art program. The youngest of three children, he lives with his mother and two older brothers. His parents separated when he was four years old. Peter was eight years old when he was placed in a self-contained special education class for the learning disabled. His record describes him as hyperactive, distractible and unable to remain on task for long periods of time; consequently, his concentration skills are described as "poor." His anecdotal records include repeated comments by his teachers about his disruptive behavior and hyperactivity. Test results disclose that Peter has difficulties in eye-hand coordination, an uneven gait and an immature body image. His receptive language skills are considered poor (e.g., it is necessary to repeat instructions several times before Peter is able to understand what is required of him). The source of his learning difficulties, according to a psychologist's report, stems from his hyperactivity and perceptual-motor problems, rather than from intellectual limitations. His behavioral disruptions in the classroom are attributed to frustration in attempting to "make sense of and organize" information being presented, rather than being the results of emotional lability. In the area of academic testing, results revealed reversals of some letters in reading. The general prognosis for Peter being able to function and learn in a regular or mainstreamed setting was considered unfavorable.

Phase one, Body Schema—The art activities for the first and second sessions of this phase were figure completion drawings. For these activities the children were provided with drawing paper on which visual clues (magazine images) had been pasted. The children were directed to use colored markers to complete the drawings. For the first assignment they completed a drawing of a person on a paper on which had been pasted a picture of an article of clothing. The second assignment required that they complete a drawing by having a person "relate" to an object. In this instance, the visual clue was a picture of an object such as ball, tennis racket, or baseball bat (Figure 1).

> ***"The . . . prognosis for Peter being able to function and learn in a regular or mainstreamed setting was considered unfavorable."***

During these highly structured and teacher directed early sessions of the program, Peter was quiet and remained on task. He was overheard telling the children seated at his table that he "loved to draw" and produced several drawings each session. His drawings of the human figure contained a fair degree of differentiation.

Phase two, Body Image—During this phase, the technique of relief (work of art in which forms project from a flat surface) was introduced. The children were instructed to represent the figure of a person "doing something" using found objects (e.g., small boxes, paper tubes, plastic spoons, paper straws) as equivalents for the body parts. Each child was given a cardboard tray and allowed to go to the supply table to select the found objects. Peter's difficulties began when he was given permission to leave his table; he bolted up from his seat, ran over to the table and "grabbed" supplies. Several minutes later, he returned for different materials complaining that what he had initially selected "didn't work." Peter appeared to be having greater difficulty assembling the figure from found objects than drawing it. As he tentatively placed the objects that he had selected for the body parts on the cardboard background, he kept looking at what his friend Edward was doing. Peter finally resolved his problem by copying Edward's work as closely as he could. He apparently was very dissatisfied with his solution however, for he left the room at the end of the session with an expression of anger.

When the group was assembled for the fourth session, Peter ran into the clothing closet in his classroom and refused to come out. He shouted out that he hated the art program and wanted to go to gym instead with the rest of his class. After some persuasion, he con-

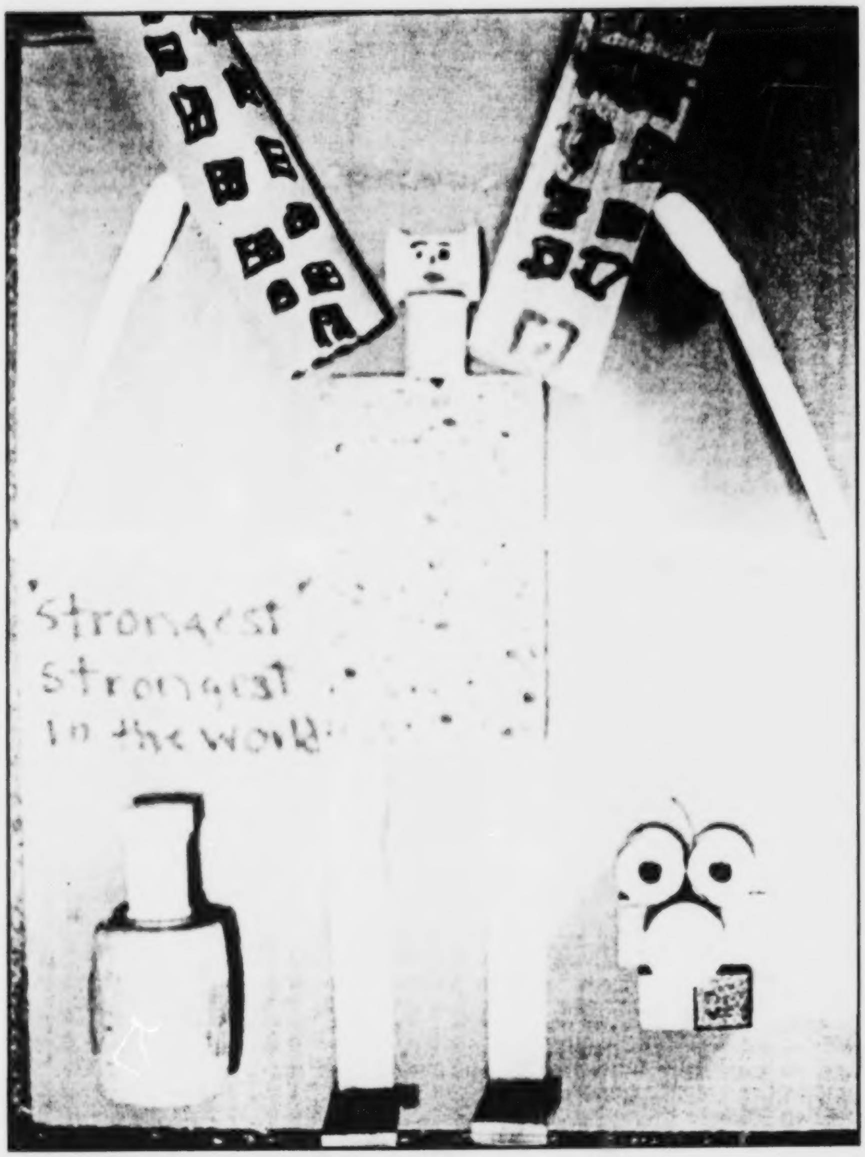


Fig. 2 Relief construction of a person with buildings on each shoulder. Materials: found objects.

sented to leave his hiding place and joined the group.

When the children arrived in the art room, Edward announced that he wanted his construction of a person back so that he could "fix it." Peter then said he also wanted to "fix *his* person." Edward removed the paper tubes he originally had used for his person's arms and replaced them with popsicle sticks. Peter imitating him, did the same. Once he had substituted the material for the arms, Peter approached his work with noticeable enthusiasm and ability to solve the rest of his construction independently (Figure 2). Apparently, Peter's frustration with his work of the previous session had come about because of his dissatisfaction with some of his choices of equivalents for parts of the body. However, until he saw Edward's solution, he was unable to resolve the problem. (Through study of the children's productions for this activity, it became apparent that the choice of equivalents for body parts was very closely related to the level of body image articulation. Those children with a higher degree of body differentiation sought out materials that closely resembled the body parts, whereas those with a lower degree of articulation were satisfied with a more general equivalent. The availability of structured materials (found objects), unstructured materials (paper, aluminum foil) to form body parts and drawing materials for further delineation, provided for the differences of body image development among the children. Edward then proudly announced that he was going to construct a superhero holding a building in *each* hand. Peter, in competition then stated that he was going to make an "even stronger superhero" who could hold two buildings in *one hand*. (Figure 3) After he completed this construction, Peter made a third, this time using both construction and drawing to represent his person's arms (Figure 4). Peter left the art room at the end of these sessions obviously pleased with his accomplishments.

Unfortunately, his positive attitude toward the art program was very short lived. When the children were assembled for the next session, Peter once again stated that he preferred going to gym. He only joined the art group when it was agreed that he could attend art for a half hour and then go to gym.

The art activity for this session was to form a representation of a person using cookie dough as the modeling material; Peter quickly announced that he would stay for the entire art session. Each child was provided with enough dough to complete a small figure. Small candies were made available for the facial features and clothing but the children were instructed to form the figure before adding the candy detail. Before even starting on the formation of his figure, Peter complained that he had not been given a

BEST COPY AVAILABLE

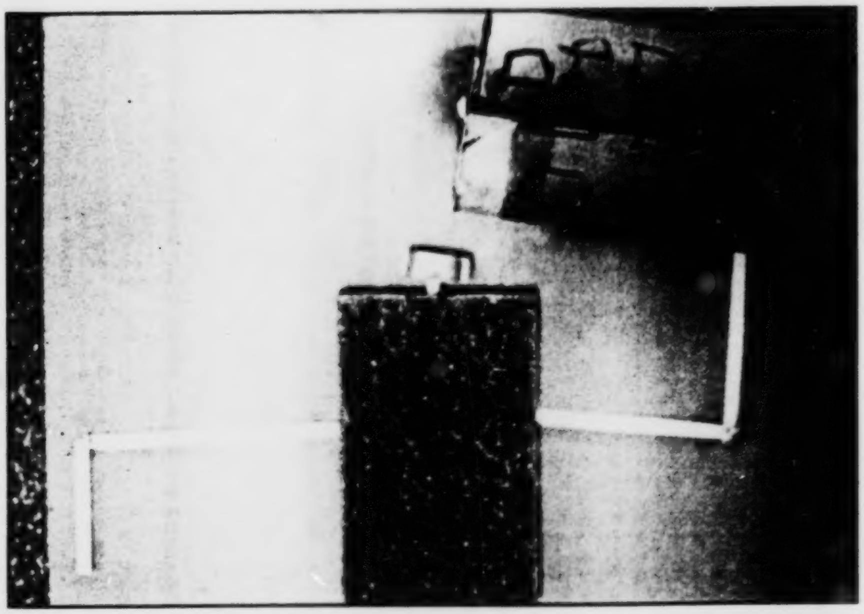


Fig. 3 Relief construction of a person holding two buildings in one hand. Materials: found objects.

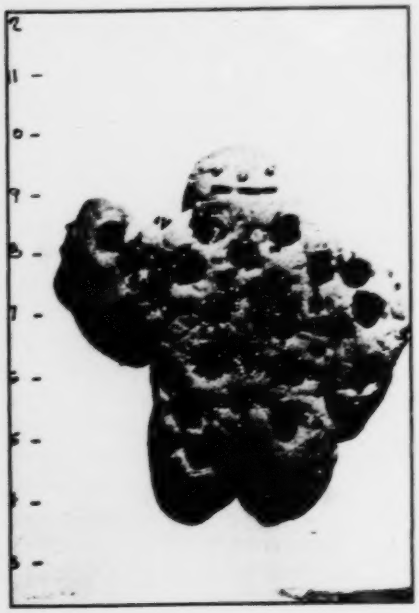


Fig. 5 Modeled figure of a person. Materials: cookie dough and chocolate candy.

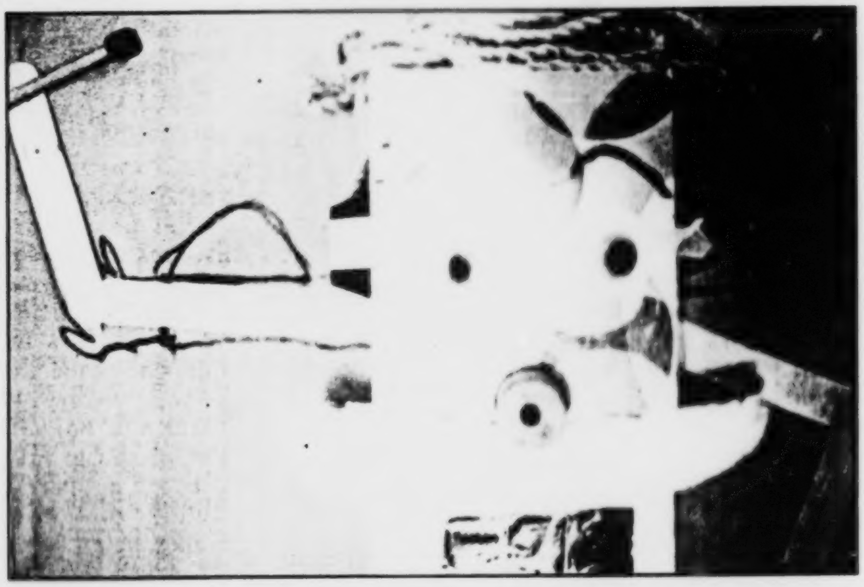


Fig. 4 Detail of a relief construction of a person which combines techniques of construction and drawing for treatment of the arms. Materials: found objects and colored markers

sufficient amount of cookie dough. He went up to the supply table for more dough and while there filled a plate with candy. As he worked, he nibbled on the candy. His completed form was a large undifferentiated representation of a person with chocolate bits placed indiscriminately over the entire surface (Figure 5). When it was suggested that Peter remove the candy and work on the figure some more, he refused saying, "Can't you see, I'm finished?"

For the next session, only two children were brought to the art room at one time because of the nature of the activity planned. The first part of the hour was used for the children's participation in a game called the "movie director-actor" game. In this game, the children took turns being the director and actor. The purpose of the activity was to develop the children's abilities to give and implement directions pertaining to body positions. In the role of director, the child instructed the actor (the other child) to portray a character by giving explicit directions about the pose that was to be taken. When satisfied with the pose, the director photographed the actor with a Polaroid camera. The children then changed roles.

When the game was explained to Peter he flatly announced that he "only" wanted to be the director. When his turn came to be the actor, he was uncooperative and refused to follow the director's instructions. His reluctance to be the actor may be attributed to Peter's language reception difficulties, for the activity required translating verbal instructions into body action. In this instance, his lack of cooperation may be ascribed

"He filled in the outline of the body tracing, painted a shirt and pants and then became involved in adding a belt."

to his attempt to mask his frustration and fear of failure.

The activities for the next three sessions involved body tracing and painting. Peter was very cooperative when he had to lie down on brown paper to be traced, but lost interest when it was his turn to trace another child. He was very eager to paint and filled his muffin tin up to the brim with poster paints. He filled in the outline of the body tracing, painted a shirt and pants and then became involved in adding a belt. At this point Peter appeared to perseverate and not be able to move on. He painted and repainted the same belt until the colors became "muddy" and the image of the belt extended far beyond its original contour. In frustration, Peter dropped his paint brushes on the floor, announced that his painting was a mess and that he was never coming to the art class again. Because several of the children shared Peter's frustration with facial features, it was decided to postpone completion of the painting activity and introduce a portrait activity with cookie dough as the modeling material. The children were shown art reproductions of modeled portraits and given mirrors to use for reference. Peter was so eager to begin modeling with the cookie dough that he constantly interrupted the introductory discussion. Once the actual work began, however, he took great care in forming the face and modeled, rather than incised (cut into the clay), to indicate features.

At the next session, the children completed the life-sized paintings, cut them out and mounted them on the wall. They then posed next to them and were photographed. Peter was excited about being photographed with his life-sized image as he had successfully resolved the facial features and the belt and had added final details to this painting.

The turning point in Peter's behavior and the beginning of a more consistent positive attitude occurred half way through the program, at the point when a rod puppet activity was presented. A papier maché technique was introduced for forming a life-size puppet head, with an inflated balloon serving as the basic core for the head. Small lightweight materials were then added to the core for the facial features. The puppet core was then built up with pariscraft (strips of gauze impregnated with plaster which when dipped into water adheres to a core). The puppet was then painted and elaborated with additional objects and the body added (a wood cross bar and rod), draped with cloth or dressed in children's clothes. Peter began this project with enthusiasm; he promptly selected his materials and began to work. All went smoothly until the point where Peter had difficulty holding some of the found objects in place until he could cover them with pariscraft. His frustration was quickly replaced with anger when he looked down and noticed that he had particles of plaster on his pants. Peter jumped up and unescorted ran back to his classroom cursing loudly.

"The turning point in Peter's behavior and the beginning of a more consistent positive attitude occurred half way through the program."

I quickly followed him taking the puppet head (which by now had hardened) with me. I showed him how much he had successfully accomplished and how to remove the plaster from his pants with a sponge and water. Peter looked at the puppet head, obviously pleased, but stated that he intended to "quit" the art class anyway. The following day, I went to Peter's classroom an hour before the session to invite him to come to the art room to do more work on his puppet head. Much to my surprise, he agreed to come.

As Peter worked on the puppet head, he related stories about his family life. He said that his father did not live at home and that he was frequently "hit" by his mother and brothers. He admitted that he had become "really scared of being hit" when the plaster got on his pants. By the time the group assembled for the art class, Peter had completed the preliminary work on his puppet head and was ready to paint. He was particularly pleased because he was "even ahead of some kids."

Phase three, Spatial Awareness—Peter's individual session and his success with the puppet experience really impacted on his attitude and behavior in the art class. Now instead of being at the end of the line when the children were escorted to the art room, Peter and Edward would run ahead of the group. Peter's success with the puppet activity had also built his confidence towards implementing the art activities in Phase three, which were less structured and required more expressive solutions. He was also more able to maintain his focus during the "idea search" component of an art task and problem solve when confronted with technical problems. For example, when given clay to model an upright (free-standing) figure of a person in action, Peter selected to form a baseball player and flattened his clay, pancake-style (Golomb, 1988) to form the figure. Conse-

BEST COPY AVAILABLE

Fig. 6 Modeled figure of a person in a boat. Materials: self-hardening clay and found objects.

quently, when he attempted to stand the figure up, it collapsed. This time instead of "giving up," he requested help. Once given a demonstration as to how to model freestanding figures in clay, Peter began again and successfully formed a baseball player with bat in hand. He worked independently until he experienced difficulty forming a cap for his figure. It was suggested that the cap be formed by modeling it over a bottle cap. Peter was delighted with the results and went on to model a man in a boat (Figure 6). As Peter left the art room, he stated that he would like to be in the art class the following year.

For the next session, colored plasticene was introduced to facilitate the differentiation of the body parts. The task was to model a person involved in an activity using an object. To simulate the objects, candy (lollypops, Easter eggs covered with foil and gold covered chocolate coins) were made available. (This session was our last before the Easter holidays and the same kind of candy was to be distributed at the end of the session.) The children were asked what they thought the candy could represent in their sculptures. Peter contributed many imaginative responses. He stated that he was planning to make a man digging for gold out west and that he was going to use a lollypop for his shovel.

The themes for the last few sessions involved people relating to large objects (e.g., cars) and to the environment. The children were allowed to select the techniques (e.g., drawing, modeling, constructing) and materials they preferred to work with (drawing materials, found materials, clay or colored plasticene). Peter selected clay or plasticene for all the final projects. The subject for one sculpture in clay was a man in a racing car; Peter added plastic checkers for the wheels. When the sculpture dried and the wheels fell off, Peter solved the problem by adhering them with glue. This was in distinct contrast to his behavior earlier in the program, when an occurrence such as this would likely result in destruction of the product or his angry exit from the art room. An example of his being better able to deal with disappointment occurred when one of his clay pieces fell apart upon drying. He picked up the pieces, looked at them and said to the instructor, "Don't worry, I can make another just like it."

Another demonstration of the change in Peter's artistic and emotional behavior was evidenced when the children were involved in activities relating the figure to an environment. The task was to form a person out of colored plasticene and place it on a magazine picture of an environment so that it related to the setting. Peter studied all the available pictures but could not find one to his liking. Again, in contrast to his prior behavior, instead of becoming frustrated and angry, he came up with another solution. He decided to form his own environment with the plasticene (in lieu of the magazine background) and then place a representation of the human figure on it (Figure 7).

When the group met for the last time they were told that they would be able to have all their work once it was photographed. During the course of the session, Peter stressed several times that he wanted *all* his work back so that he could show it to his mother. As the children left the art room for the final time, he turned back and exclaimed, "And don't forget, I'm coming back next year!"

Conclusion

Peter's improved representation of the figure over the course of the art

". . . instead of becoming frustrated and angry, he came up with another solution."

program and his gains on the post-test drawing of a person demonstrated that a program focused on the human figure can improve the body image concept of children. Further, it became apparent that the learning disabled children were a heterogeneous group, each with his/her own learning style, individual needs, strengths and interests which have to be identified and attended to by the teacher if the children are to have a positive art learning experience. Peter, for example, appeared to function best when in a new art learning situation (the earlier stages of the program) he was provided with a definite structure (visual clues or model) and limitations (choice of materials, techniques, movement). Once he comprehended what was required, Peter was able to concentrate and remain on task. Further, given ample structured experiences and some success, Peter became more confident and able to actualize his projects imaginatively. In contrast, when confronted with a state of confusion, frustration tended to escalate to anger and the consequent loss of focus of control within a short space of time. Recognition of Peter's individual learning and behavioral changes brought about his positive attitude and desire to continue in the art program the following year.

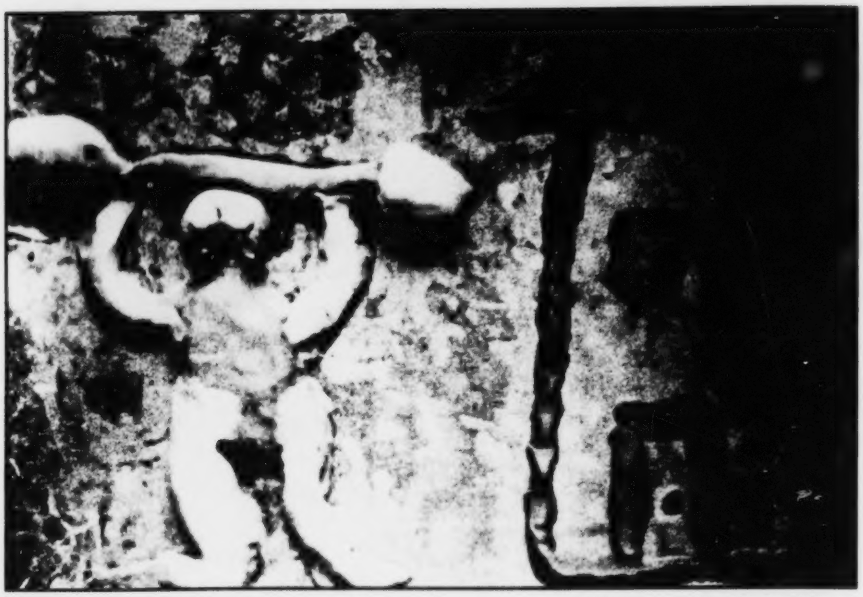


Fig. 7 Modeled relief of a person within an environment. Materials: colored plasticene on a cardboard backing.

References

De Chiara, E. (1982). A visual arts program for enhancement of the body image. *Journal of Learning Disabilities*. *15*(7), 399–405.

De Chiara, E., & Uhlin, D. (1984). *Art for exceptional children* (3rd ed.). Iowa: Wm. C. Brown.

Golomb, C. (1988). Early representational concepts of the human figure in a three-dimensional medium. *Studio Potter*. *16*(2), 35–38.

WRIGHT
STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

BEST COPY AVAILABLE

Art Therapy Education: A Tool for Developing Verbal Skills

Lucy Andrus, MS, ATR, Assistant Professor and Coordinator, Art Therapy Studies, State University College at Buffalo, N.Y.

Abstract

The ability to make verbal interventions and use spoken language in a therapeutic manner is an essential competency for the art therapist to possess. Those responsible for the education and training of future art therapists must devote more direct attention to the development of verbal skills for our students within the art therapy curriculum. Many agencies who take our students for fieldwork as well as those who employ our graduates expect art therapists to counsel verbally in addition to providing art therapy services. Feedback from students as well as graduates who are now working as professionals in the field clearly indicates that this area of art therapist competency is one that needs greater attending to. In this article, the author addressed this very real need by offering a teaching-learning tool for students, supervisors, and art therapy educators.

Background

In my work as an art therapy educator, I have realized that those of us responsible for the education and training of future art therapists must devote more direct attention to the development of verbal intervention skills for our students within the art therapy curriculum. Given today's competitive mental health job market, the new kinds of job opportunities that are opening up for which art therapists may be eligible, and the realities of becoming licensed in order to practice psychotherapy in many cases, we are obligated to prepare our students to best meet these challenges that lie ahead of them. In addition to knowledge, skill, and sensitivity to the therapeutic use of art making, our students need to be skilled in using language and making verbal interventions in art therapy treatment. Listening to feedback from students as well as graduates who are now working as professionals in the field clearly indicates that this area of art therapist competency is one that needs greater attending to.

In this article, I address this very real need by offering a teaching-learning tool for students, supervisors and art therapy educators.

Throughout the course of study in the art therapy program at S.U.C.B., one of the instruments used in assessment of student knowledge and skill is the AATA Art Therapy Competencies form. Each semester, the form is completed for all students by their clinical fieldwork supervisors and by the students as a means of self-assessment. The competencies are then reviewed by the ATR faculty advisor along with the student advisees. Review of these student assessments coupled with faculty observations of students on site as well as material surfacing in group supervision classes revealed a recurring area of need that appeared to be fairly universal to the student body as a whole. That is, the ability to utilize spoken language in combination with the art as a tool in verbal therapy when this approach is necessary. In their self-assessments, the majority of students indicated that they felt the least skillful and comfortable in using words to verbalize thoughts and observations, to facilitate insight on a cognitive level through verbal processing of an art therapy session, and to make verbal interventions where called for. As might be expected, students rated themselves higher in the items pertaining to the therapeutic use of art making. This seemed to be the case with advanced level students as well as beginning and intermediate level students performing their clinical work in the field.

During supervision classes when students present their clinical case material, questions concerning verbal technique and intervention often arise ranging from "what do I say when . . .?" posed by beginning level students to "how can I more effectively integrate verbal technique(s) with the art making process in order to . . .?" posed by intermediate to advanced level students. While most students had little difficulty in applying the "art part," they clearly felt uncomfortable using words. A recent example in supervision concerned a number of students who disclosed their hesitancy to verbally confront their clients with insights gained from the images for fear that by making the non-verbal verbal thus more conscious and overt, they might somehow "scare

". . . our students need to be skilled in using language and making verbal interventions in art therapy treatment."

off" the client. Obviously, in processing this issue with students, several elements called for elucidation including the development of clinical judgment in making timely and appropriate confrontational interventions as well as awareness of possible countertransference. It became increasingly evident, however, that in addition to their coursework in theories and techniques of counseling and psychotherapy, students needed more focused attention to the development of verbal intervention skills that could be didactically addressed within their art therapy courses and specifically integrated with art therapy material. Addressing these skills as they may have come up in supervision did not appear to be sufficient in helping students to achieve verbal competency.

While the central activity of the art therapy experience is the creation of images and the "creative exploration of those images" (Wadeson, 1987, p. 15), few would argue that verbal competence is an essential skill for the art therapist to possess. One example that comes to mind immediately is the ability of the therapist to illuminate process in group work (Yalom, 1975), both in individual interactions as well as in commentary directed towards the group as a whole. As art therapists, we are well aware of the power of art as well as the art making in illuminating process. Indeed, there are times in art therapy where the art making and the art itself suffices as an agent of therapeutic process/progress, and there are also times when the art work serves as a catalyst for increased verbalization and self-disclosure on the part of the client (i.e., opening the "verbal floodgates") that require effective verbal response on the part of the art therapist. In my own practice, it has often been the case where the client uses the art as a point of departure for discussion moving far from the original image. There have been times when the greater part of a session with a client has been verbal therapy as this approach was judged necessary to best facilitate and further the therapeutic process for the client. It is not always enough for the art therapist to be able to put into words something of what he or she sees in the clients' imagery in helping them to become more conscious about it, we must also be able to make independent verbal interventions when and if the situation calls for it. These abilities are new experiences for the art therapist-in-training and as I have seen in our program, students can benefit greatly from more direct and focused attention to verbal counseling skills within the art therapy coursework.

> ***"While most students had little difficulty in applying the 'art part,' they clearly felt uncomfortable using words."***

Deserving equal consideration in the determination of need to address verbal counseling skills is the very real fact that many agencies expect art therapists to be competent and able to counsel verbally. This holds true for the student-in-training as well as the professional. In her discussion of art therapy supervision, Riley (1984) states that "since the supervisor must guide the students in the theoretical model preferred by the agency in which they train, they must teach them specific techniques which will enhance the art therapy treatment within this framework." (p. 102) In the October 1988 edition of the AATA Newsletter, Cay Drachnik, past president of the AATA, makes a compelling case for preparing students now to be eligible for licensure under existing laws. She states that we are attempting to get licensed without appropriate educational credentials and strongly urges that master's degree programs add and or enhance coursework in psychology and counseling. Drachnik goes on to say that she in no way suggests that we take the art or creativity out of art therapy, but expresses her belief that "by following this course of action, we would extend and enhance our programs so we could better communicate with other professionals in the mental health field and to be quite frank, have an easier time getting jobs." (1988, p. 1) She points out that if art therapists could demonstrate that they possess the proper credentials and educational training for a counseling license, then legislators would be hard pressed to turn us down for licensing. More direct attention to the development of verbal counseling skills for students within their art therapy coursework is one way to meet this need.

> ***"The ability to do 'good therapy' is as dependent on the personality of the therapist as it is on his or her knowledge."***

Requiring students to take additional coursework in psychology and counseling departments may be a first step. A second step would be to integrate the necessary didactic material more purposefully into current art therapy curricula. What seems to be more successful for our students is combining these approaches as they gain a basic foundation of knowledge in their outside elective courses and then review and translate this knowledge into practical clinical skill within the art therapy coursework.

It is important to offer some cautionary thoughts for consideration. First, no amount of knowledge and grasp of technique alone suffices in making a person an outstanding clinician. The ability to do "good therapy" is as dependent on the personality of the therapist as it is on his or her knowledge. There are certain personal characteristics and qualities that one ought to possess that appear to be essential to being a good therapist. These cannot be "taught," per se, but they can be shaped and developed. Rubin (1984) states that "an art therapist must *know* certain things, must *believe* in others, and must *be* a certain sort of person" if one is to achieve "artistry" as an art therapist. (p. 67) A unique quality inherent in most art therapists is their potential and ability to utilize their own creativity in doing therapy and to apply creative thinking in finding solutions and approaching the therapeutic task at hand. Second, I am keenly aware of the pitfalls that lie in looking for "easy" and "pat" solutions to the complex problems involved in doing therapy. It can be inadvertently tempting to search for and rely on a "set of techniques" in considering ways to facilitate treatment. I have seen this happen all too often not only in art therapy but in other mental health disciplines. A recent example concerns a clinical social worker who, intrigued by the therapeutic use of art, brought art making into her sessions and began to inquire as to the availability of written materials where she might "look things up" (for purposes of interpreting the artwork) and learn art therapy "techniques." Beginning students are often susceptible to what I call the "cookbook" approach. This kind of approach is a misuse of technique and certainly is not in the service of good therapy.

"The aim is to develop and enhance clinical skills in the endeavor for continued growth and maturity as effective art therapists."

Given these cautions and with the understanding that knowledge and "knowing therapy" is one essential ingredient in becoming an effective clinician, I offer the following to art therapy educators, supervisors and students as a teaching-learning tool for the development of competency in verbal therapy skills.

Verbal Techniques in Counseling and Therapy: A Continuum of Leads with Examples

The following verbal interventions are listed in the order of the least amount of leading to the greatest amount of leading. This listing is in no way meant to be inclusive of the great variety of techniques and approaches the therapist may use in counseling and therapy but is intended as a teaching-learning tool to supplement other learnings within the art therapy curriculum. The techniques discussed have been abstracted from an array of theoretical frameworks including Psychoanalytic, Behavioral, Cognitive, Gestalt, Transactional Analysis, Rational-Emotive, and Reality Therapies. Examples of each verbal technique are offered with the understanding that they are just that and may not necessarily be generalized to the wide variety of client populations and settings that the art therapist may encounter. Since the intention is to focus on language, I have included very few examples of art making applications with the challenge to students, supervisors, and art therapy educators to creatively integrate the verbal with the visual in their own work.

In addition to use by the student-learner, the professional alike is invited to use this paper as a tool in supervision for exploring and examining which kinds of interventions one uses most frequently and least frequently, and which kinds of interventions one might be avoiding and why. The aim is to develop and enhance clinical skills in the endeavor for continued growth and maturity as effective art therapists.

1. ***Acceptance***	Therapist's (Th.'s) non-judgmental acknowledgment, acceptance, and positive regard for client (cl.).
Silence:	Th.'s silence as cl. expresses self implies openness to cl. and acceptance of cl.'s feelings, issues, etc.
Non-Verbal:	Th.'s attending indicated through body language, eg., nodding head, body posture, etc.
Verbal:	Th.'s active acknowledgement/recognition/acceptance (Th.) "I understand . . ., I hear what you're saying . . ., I understand it's not easy for you to . . , etc.
2. ***Restatement***	A low level response where th. takes what cl. says and gives it back.
Of Content:	(Cl.) "I really had a hard time understanding what she meant . . .," (Th.) "You had a hard time understanding what she meant."
Selective:	Th. selects pertinent statement of cl.'s to focus on and restates part of what cl. has said. (Cl.) "I really had a hard time understanding what she meant . . . I kept thinking about it but I didn't know what to say. It really made me angry . . . Sometimes she makes me so frustrated . . ." (Th.) "It really made you angry when . . ."

3. *Clarification*	Th. probes/searches for clarification of cl.'s responses.
Of Content or Feeling:	(Th.) "I don't understand . . ., Could you describe (make a picture of) that feeling . . ., I'm confused . . . " (Th., in reference to image) "Can you tell me what this area/line/shape/configuration/etc. is . . ."
Semantic:	Th. asks for clarification/meaning of word(s) used a certain way, eg., slang.
4. *Summary*	Th. extracts the main message contained in cl.'s statements, paraphrases it in summary, and gives it back to the cl. (the cl. gives the th. a lead). (Th.) "It was difficult for you to understand her and it was hard for you to respond. You felt frustrated."
5. *Reflection*	A higher level of leading where the th. puts the cl.'s perception(s) in different words and gives it back, i.e., same content, different words. (Th., in reference to cl.'s statements in number 2 above) "It seems that it was difficult for you to express your feelings."
6. *General Leads*	Th. initiates leads and questions used are open-ended.
General Leads:	(Th.) "Really . . ., Tell me more about that . . ., How are you doing? . . . Th. poses questions that cannot be answered with a yes or no response.)
Information Giving:	Th. gives back basic information, eg., referral information. (Th.) "I understand that you sought out/were referred for therapy because you are having difficulty with _."
Incomplete Thought:	Th. begins a statement and allows the cl. to complete. (Th.) "So when that happened, you . . ."
Cues:	Th. looks for the how or what and excludes extraneous information by presenting a stimulus for the cl. to respond in a certain way. (Th.) "Tell me about _, Make a picture of _, How are things going at home?, I'm wondering how you feel when (cl.'s description) happens? Can you make a picture of how you feel when (cl.'s description) happens?"
Structuring of Process:	(Th.) "My job as a therapist is to help you, how can I help you?" (puts structure on cl.) (Th.) "In art therapy, making pictures/images can offer you another way to express your ideas and feelings, we can look at your pictures/images together and see what messages they might hold for you." (Cl.) "Sometimes he makes me so frustrated . . . I just can't communicate with him . . . It's hard to explain . . ." (Th.) "Why don't you try using the pastel chalks and see if you can make a picture of what that "frustration" looks like?"
7. *Interpretation*	The th. invites the cl. to look at the situation through the th.'s eyes.
Tentative Analysis:	(Th.) "I'm wondering if it's difficult for you to express feelings of anger."
Reflection:	Th. does not reflect content per se, but the subtle messages underlying the content. The th. captures the essential content and adds the affective aspect, i.e., interpreting feelings within the context of the cl.'s content. (Th.) "It seems that you have angry feelings towards her that may be difficult for you to express, and this appears to contribute to your feelings of frustration."
Diagnosis:	If diagnosis is seen in a broader context beyond formal procedures and terminology, it can be a dimension of the therapeutic process. As Corey (1982) states, the th. ought to raise certain questions as the th. and cl. are engaged in the search-and-discovery process throughout each session: What is going on in the cl.'s life now, and what does the cl. want from therapy? What are the cl.'s strengths and limitations? What are some of the dynamics going on in the cl.'s life at this time? etc. In dealing with these questions, the th. is formulating some idea of what the cl. wants and needs and how they might best attain their goals thus; diagnosis becomes a form of making tentative hypotheses which can be formed with and shared with cls. throughout the process.
Hypothesis:	The th.'s hunches are guesses as to the cl.'s underlying psychodynamics and their meanings. As a form of interpretation, the th. can present hypotheses or hunches so that the cl. can consider the meanings of certain behaviors and begin to examine the relationship between earlier behavior and present behavior. Presenting hypotheses as open-ended sharing that can be explored in the sessions allows the cl. to take responsibility for examining his/her behavior. (Th.) "I'm wondering if . . ., Could it be that . . ., As a hunch . . ."

BEST COPY AVAILABLE

(Th.) "I'm wondering if you may have unresolved anger towards her that interferes with effective communication and prevents you from getting your needs met."

Confrontation: The th.'s use of confrontation is not an attack on the cl., but when it is done in a therapeutic manner out of caring and respect in a trusting and supportive environment, it can be an invitation for the cl. to take a closer look at discrepancies between attitudes, thoughts and behaviors. The cl. is encouraged to look at discrepancies and become aware of how these might be blocking the cl.'s strengths, goals, and desires to change. As Corey (1982) states: "Support is related to confrontation,for a therapist who would limit his or her style to being predominantly reassuring and comforting would not encourage clients to become much more than they presently are. When a climate of trust is created by genuine support, the relationship can endure the challenge." (p. 237) Confrontations must be appropriate and timely and are usually presented within their own continuum of directness and intensity.

The th. may do a number of things to confront/challenge the cl.:

Th. confronts discrepancies between what the cl. says and what the cl. does:

(Th.) "You say that you believe there is trust in your relationship with him, but you're afraid to let him know how you're really feeling inside."

(Th.) "I understand that you want to improve communication with him and you say that you're trying to be more open, but when he does something that makes you feel angry or upset, you don't share these feelings with him."

Th. calls attention to possible forms of self-deception; acquaints cl. with the reality of the situation:

(Th.) "Is it reasonable/realistic to expect him to respond to your needs/wishes if you're not being direct about how you really feel?"

Th. points out games and manipulations:

(Th.) "When you're angry with him, you don't let him know but you expect him to respond to you in a certain way. When he doesn't, you withdraw and withhold which seems to contribute to creating a whole cycle of anger between both of you that escalates to a point where neither of you seems to know what's really going on."

Th. points out resistances and evasions: Cl. cancels two sessions at the last minute following a session which resulted in significant self-disclosure.

(Th.) "You've cancelled two recent sessions at the last minute. Is there something going on we ought to take a look at?"

During a couples session, one cl. repeatedly expresses herself in terms of the other person, "she said this, did that, feels . . ."

(Th.) "What do *you* think/feel/do . . .?, Are you avoiding accepting responsibility for your own thoughts/actions/feelings?"

Th. calls attention to the way(s) the cl. is not recognizing resources or potentials:

(Th.) "The fact that you've sought help indicates that you want things to be different which shows your commitment and efforts to making changes for the better."

(Th.) "The way you manage a household, work outside the home, and care for your children shows a great amount of strength, determination, ability to be organized . . ."

Th. confronts cl. with way(s) he may be engaging in self-deprecation:

(Th.) "I hear you put yourself down repeatedly and you don't seem to take enough credit for what you have accomplished. I'm wondering if it's difficult for you to be in touch with and own that part of you that is strong, positive and successful."

8. *Advice*

Giving advice as a style is not recommended as this would undermine the therapeutic goal of helping cls. to independently make choices and have the courage to accept the consequences of their choices. The th.'s task is to help cls. discover their own solutions and recognize their own freedom of action and thus avoid the pitfall of enabling cl. dependency. There are, however, appropriate times for direct advice such as when cls. may be in danger of harming themselves or others, or when for the time being they are unable to make choices.

The th. presents an idea, suggestion or advice in a non-judgmental manner and frequently in the form of a question which helps the cl. to take responsibility for his or her own problem-solving and decision-making, thus facilitating greater self-reliance in the process.

Suggestion: (Th.) "I'm wondering what might happen if you . . ., What possible alternatives are open to you?"

Advice: (Th.) "I would suggest/advise that you . . ."

Probing: (Th.) focuses on the process quickly by putting statement in the form of a question that calls for a one-word answer.

(Cl.) "She didn't do what I hoped she would."

(Th.) "Did you tell her what you wanted/expected?"

Interpersonal Projection: The th. asks the cl. to look at the situation from an opposite/alternative/another's point of view.

(role reversal) (Th.) "What do you think *he* was feeling/thinking when . . ."

Personal Projection in Time: The th. encourages the cl. to focus on the possible results of his or her choice/decision/behavior.

(Th.) "If you continue to __, what do you think will happen?"

Modeling/Illustration: (impersonal) (Th.) "I know someone in a similar situation who . . ."

Modeling/Illustration: (personal) The th.'s self-disclosure must be appropriate, timely, and done with authenticity. It should serve the needs and interests of cls. and should not place a burden on them or hinder them in exploring and understanding themselves more fully. Th. self-disclosure must be facilitative to the therapeutic relationship and serve to move the therapy forward. There are two forms of self-disclosure the th. may employ, the first usually being more conducive to the therapeutic process:

One, where the th. discloses his/her here and now reactions and feelings to the present transaction of the session. For example, during a session where the cl. is disclosing a traumatic and painful past event, it may be appropriate for the th. to disclose his/her own authentic feelings in reaction to hearing/reliving the event with the cl. This may enhance the relationship as it reinforces the cl.'s awareness of the th.'s caring and ability to "get inside" and understand the cl.'s subjective experience. In this situation, the art therapist may choose to share his/her feelings and reactions visually by making artwork alongside of the cl. Another example might be where the th. is feeling consistently bored, angry, or irritated in several sessions over time, then it may be essential to disclose the feeling. In this case, the disclosure must be facilitative to moving the therapy forward. This is a difficult judgment to make and the neophyte therapist is encouraged to seek professional consultation in supervision before attempting this kind of self-disclosure.

The second form of disclosure that may at times be appropriate in serving the therapeutic relationship is where the th. identifies with the cl.'s situation based on a personal past experience:

(Th.) "When I've had that experience, I've felt angry, too."

It is important to understand the nature and usefulness of the disclosure as th. self-disclosure often originates from the th.'s own needs and the cl.'s needs become secondary. The th. must be in touch with possible countertransference and needs to ask why s/he is revealing him/herself and to what degree it is appropriate. In discussing the therapeutic benefits of the th.'s ability to share the cl.'s subjective world, Rogers (1977) and Corey (1982) remind us that in the process, the th. must not lose the separateness of his/her own identity, and must be aware of the dangers of blurring the distinction between helper and one who is helped.

Counter-Propagandizing: The th. encourages the cl. to become aware of the irrational beliefs they have incorporated into their way of being, and challenges the self-defeating propaganda the cl. originally accepted without question as well as the ways in which the cl. may be sabotaging him/herself in order to cling to these beliefs.

(Th.) "That sounds like an 'old' response of I'm not good enough to deserve . . . How can you get what you want now if you look at the situation in the reality of your here and now experience? What would happen if you were to look at the situation like . . .?"

Urging: There are times when it is appropriate for the th. to use persuasion and strongly urge the cl. to try/do something if it is not overdone. It is a way of saying that the th. has confidence in the cl. even if the cl. has little confidence in him/herself, and if the cl. can trust in the th.'s confidence then s/he may be able to discover this in him/herself. The th. needs to be aware of the cl.'s readiness to try something. The th. must also be vigilant of the possible dynamic that the cl. may be highly invested in "pleasing" the th. and thus may be following the th.'s suggestion out of a need to receive the th.'s approval instead of working towards self-approval. An example of th. persuasion would be urging a cl. who fears s/he will never succeed to apply for a promotion at work (which the cl. desires and is well qualified for).

When judging the appropriateness of advice-giving, Corey (1982, p. 283) recommends that the th. keep in mind the following questions to ask cls.: "If I were able to solve this particular problem, how would this help you with future problems? Are you asking me to assume responsibility for you? What possibilities do you see? How have you avoided accepting responsibility for directing your own life in the past? Can part of your present problem stem from listening to the advice of others earlier?"

9. *Complex Intervention*

A higher level of th. intervention that focuses on helping cls. to change (and maintain/retain change) undesirable behaviors/feelings/ideas once acknowledgment, awareness, and insight are achieved.

Approval: The th. expresses approval of the cl's. behaviors and actions. This can be nonverbal (nodding head, etc.) as well as verbal.

(Cl.) "This time I was able to . . ."

(Th.) "You handled the situation in a more effective manner."

Reinforcement: The th. praises cls. when they acquire/perform the desired responses/actions, thus encouraging the cl. to repeat the target behavior(s) more often.

(Th.) "That's a really important insight and it indicates how much progress you've made in . . ."

(Th.) "You did a terrific job in . . ."

Shaping: The th. uses successive approximations of reinforcement, i.e., the desired behavior/response is shaped on a gradual basis through the use of praise.

Reorientation: The th. assists the cl. in putting insight into action and focuses on helping the cl. to consider alternative beliefs, attitudes, behaviors, and goals that are more functional and that will help to make the cl. more effective. The th. both encourages and challenges the cl. to develop the courage needed to take risks and make changes. Cls. are asked to catch themselves in the process of repeating old habits that lead to ineffective behavior.

(Th.) "The next time _ happens, pay attention to your actions and see if you find yourself retreating into an angry silence."

The th. encourages the cl. to act as if they were the person they want to be; this helps in challenging self-limiting assumptions.

Cognitive Restructuring: The theory here is that people create their own emotional and behavioral disorders through their persistence in irrational thinking with the assumption that a person's cognitive system can be changed directly and that this change will result in altered and more appropriate behaviors (Ellis and Grieger, 1977). Cls. are helped in the task of developing alternative interpretations of events thus changing the feelings and emotions surrounding these events (Beck, 1976). The th. demonstrates to the cl. how some of their assumptions and beliefs about themselves and the world are unrealistic and helps the cl. to discover their own cognitive distortions and to learn how these assumptions influence behavior. The th. and cl. then collaborate in learning alternative sets of interpretations.

The th. asks the cl. to look at their inferences which may be faulty. The th. challenges the cl.'s conclusions when evidence for such conclusions is lacking, and may ask the cl. to list/state other possible reasons for the given event.

(Cl.) "I'm feeling stressed out at work again."

(Th.) "What's going on?"

(Cl.) "My boss evaluated me today. He said I could do better in two areas! That criticism depressed me for the rest of the day. It's like I can't do anything well enough [he must think I'm stupid]."

(Th.) "What is your understanding of an employee evaluation at your firm?"

(Cl.) "Well, they're supposed to evaluate you periodically and assess your performance."

(Th.) "Does the evaluation include suggestions for continued growth?"

(Cl.) "Yes, I guess it's supposed to."

(Cl.) "Yes, I guess it's supposed to."

(Th.) "Do you think a good supervisor would challenge his/her employees to strive for further growth during the next phase of their work?"

(Cl.) "Yes, I guess that makes sense. I guess I would do the same if I were in his shoes."

(Th.) "Were there positive statements in the evaluation concerning your strengths and abilities?"

(Cl.) "Well, yes. As a matter of fact, most of it was positive."

(Th.) "Do you think it's reasonable then to see the criticisms as areas or challenges for you to work towards as you continue to grow professionally?"

(Cl.) "I hadn't thought of it like that, but, yes."

(Th.) "Given the fact that the evaluation was positive overall, do you think it's realistic to assume that your boss has such little regard for you?"

(Cl.) "I guess it doesn't make much sense, does it." etc.

Role Rehearsal: The th. utilizes role playing during sessions where effective and ineffective behaviors in interpersonal situations are explored and critiqued, and performances are practiced in a variety of situations. Role playing can be done in individual as well as group therapy.

Restatements: Cls.' speech patterns can often be an expression of their feelings, attitudes and thoughts, and often reflect behaviors that may be maladaptive or unconstructive. The th. gently confronts the cls. using interventions that help the cls. to become aware of the effects of their language patterns on their behaviors.

Depersonalized language:

(Cl.) "It is difficult to do . . ."

Th asks the cl. to restate by making an "I" statement.

(Cl.) "I have trouble doing . . ."

Qualifiers:

Th. points out how qualifiers such as maybe, perhaps, I guess, sort of, I suppose, etc. undermine one's effectiveness and keep one ambivalent.

(Cl.) "I suppose I will . . ."

Th. asks the cl. to omit the qualifier, thus helping to change ambivalent messages into clear and direct statements.

(Cl.) "I will do . . ."

Disclaimers:

A cl. may deny his/her personal power by adding a disclaimer to his/her statements.

(Cl.) "I know that I'll need to __, but I have no choice."

Th. may ask the cl. to restate eliminating the "but" and what follows.

Shoulds, oughts, could haves, etc.:

Th. may ask the cl. who frequently makes should and ought statements to restate by changing these to I choose, I want, etc.

(Cl.) "I should have done that a long time ago."

(Cl.) "I can do this now, I am doing this now, I want to do . . ."

A word of caution to the therapist as careful use of these interventions is needed so that cls. don't come to feel as if everything they say is being scrutinized.

Non-Verbal Cues: The th. pays attention to the cl.'s posture, movements, gestures, etc. for noting incongruities between verbalizations and what the cl. is doing with his/her body. The th. might ask the cl. to speak for and become his/her gestures or body parts.

Cl. responds to th.'s question by stating that "everything is fine" as she is nervously tapping her foot.

(Th.) "What is your foot saying? If you foot could talk, what would it say at this moment?"

Fantasizing: The th. asks the cl. to play out/make an image of their "fantasies" and imagined outcomes/expectations of a given situation. This often helps cls. who are stuck for one reason or another, particularly cls. who are stuck because of "catastrophic expectations" and who imagine that something terrible will happen if they take a certain action. These unreasonable fears often prevent cls. from taking the risks that are necessary for growth and maturity. In response to a cl.'s statements of "I can't do that . . . I don't know where to go from here . . . If I do that then this will happen," the th. might ask the cl. to imagine/draw what s/he thinks or "fantasize" will happen, what is the worst possible outcome you can imagine if you . . ., etc.

Making images of fantasies can be especially useful for the cl. who may have a well-guarded personal secret or who may be experiencing strong and persistent feelings that cannot be acted out in reality. This technique permits exploration of possible feelings of shame or guilt. For example, a cl. was abused as a child by his parent and is engaged in the healing process, however, appears to be stuck in the task of "letting go" and moving forward. The th. surmises, and the cl. confirms, that the cl. is experiencing persistent feelings revolving around "revenge, retaliation, and restitution." The th. asks the cl. to explore these fantasies through art making and the cl. creates images of retaliation followed by images of restitution. The cl.'s "revenge" drawings offer him an opportunity to release the feelings that are blocking him and the "restitution" drawings offer the opportunity for helping the cl., to discover ways in which *he* can now nurture the child within himself, thus facilitating the process of letting go and moving forward.

Dialoguing: The th. asks the cl. to engage in a dialogue with opposing tendencies in the cl.'s personality and experiencing with the cl. playing all the parts involved in the conflict. The aim is towards integration of the whole self as the cl. accepts and learns to live with the polarities and conflicts that exist in everyone. The th. may use the empty chair technique where the cl. is asked to sit in a chair and fully assume and exaggerate one position/role and then switch to the other chair and assume the opposite role. The art therapist may adapt this technique by engaging the cl. in a visual dialogue. Creating mandalas is also a useful and effective means for cls. to explore polarities and conflicts. These techniques allow the cl. to experience the conflict more fully and get in touch with feelings or a side of themselves they may be denying, thus discouraging the cl. from disassociating from his/her feelings. The conflict can be resolved by the cl.'s acceptance and integration of both sides of the self.

Homework Assignments: The aim of using outside assignments is to facilitiate the process of helping cls. to apply what they've learned in the therapy sessions to their outside lives. Once cls. have achieved insight and increasing awareness it becomes essential for them to put their new understandings into practice in their lives. The cl. can decide what behaviors s/he would like to experiment with outside of the sessions and the th. assists in formulating specific tasks to be performed that will help in acquiring new skills and overcoming inhibitions.

10. Rejection The th. may reject a cl.'s behaviors or dialogue as inappropriate and/or self-defeating and does not condone or excuse any of the cl.'s irresponsible actions. The th.'s accepting attitude may be conditional on cl.'s willingness to face his/her problems and make plans to solve them. The challenge to the th. is to create a therapeutic climate that is free of excessive criticism at the same time as setting limits and maintaining a posture of the cl. being ultimately responsible for his/her own happiness. Care must be excercised in using these techniques as they must benefit the cl. and serve to move the therapy forward with the th.'s attention to authenticity and possible countertransference. Once again, the beginner is cautioned to seek guidance in supervision.

Impersonal Rejection: The th. judges the cl.'s behavior as not appropriate.
The th. may, for example, reject a cl.'s abusive behavior towards another during a session, or the th. may reject a behavior that is socially unacceptable such as physical violence, child abuse, sexual abuse, etc.

Personal Rejection: The th. may reject a cl.'s statement.
(Th.) "I don't believe that is what you really want."

Threat: The th. may make a clear and direct statement of likely outcome resulting from the cl.'s behavior.
(Th.) "If you continue to _, then _ will happen."

Coercion: The th. compels the cl. to act or choose.
(Th.) "I cannot continue to work with you if you don't attend our sessions on a regular basis."

In Conclusion

The compilation of verbal techniques presented here is by no means inclusive. It is not meant to replace in-depth exploration of techniques in counseling and therapy by any means, but to encourage further study. The intention is to offer a beginning reference for the therapist-in-training and a teaching tool for art therapy educators to supplement basic foundation learning within the art therapy curriculum.

As our young profession continues to evolve and mature, we will continue to struggle with issues of professional identity and work through the on-going process of defining who we are and what we do. As in any other growth process, many of us are and will be faced with conflicting feelings, thoughts, and opinions, Indeed, I grapple with

BEST COPY AVAILABLE

these issues daily, both personally and as a trainer of future art therapists. In the meantime, however, the fact remains that an art therapy education and training program must be responsive to current student need. Ongoing assessment of students' clinical competence in our program at the S.U.C.B. revealed that students need and desire more direct attention to the development of verbal skills within the art therapy curriculum. This is also a common concern for the neophyte art therapists, many of whom are expected by their employers to be competent in verbal counseling as the need arises. This appears to be especially true for those art therapists who are landing jobs in outpatient clinics such as those offering addictions services.

As an art therapy educator, my major responsibility is first and foremost to my students, and I feel that we are doing our students a disservice if we are not directly addressing this very real need in the endeavor to graduate art therapists who are competent as well as competitive in the job market.

References

Beck, A.T. (1976). *Cognitive therapy and emotional disorders*. New York: International Universities Press.

Corey, G. (1982). *Theory and practice of counseling and psychotherapy* (2nd Ed.). Monterey, Calif.: Brooks/Cole.

Drachnik, C. (1988). From the president. *American Art Therapy Association Newsletter*, 20(4), 1.

Ellis, A. & Grieger, R. (1977). *Handbook of rational-emotive therapy*. New York: Springer.

Riley, S. (1984). Part II: The middle phase of therapy and supervision. In L. Wilson et al. Art therapy supervision. *Art Therapy*, 1(3), 100–105.

Rogers, C. (1977). *Carl Rogers on personal power: Inner strength and its revolutionary impact*. New York: Delacorte.

Rubin, J.A. (1984). *The art of art therapy*. New York: Brunner/Mazel, Inc.

Wadeson, H. (1987). *The dynamics of art psychotherapy*. New York: John Wiley & Sons, Inc.

Wadeson, H. (1983). Speaking for the "art psychotherapy" position. In E. Kramer et al. The great debates: The place of art in art therapy. *Art Therapy: Still growing*. The Proceedings of the thirteenth annual conference of the American Art Therapy Association, Philadelphia, Pennsylvania, October, 1982, 108–110.

Yalom, I. (1975). *The theory and practice of group psychotherapy*. New York: Basic Books.

COLLEGE OF NOTRE DAME

Cool It in . . .

S.F. this Summer
and Collect
Units Toward
Your
ATR

- Job opportunities in clinical, educational, and community agencies
- The only AATA-approved Art Therapy Program in Northern California
- A Master in Art Therapy – 37 units
- A Master in Marital and Family Therapy leading to MFCC Licensure – 51 units
- Graduate Art Therapy Institute – 21 units

Can be completed in two summers and a winter internship!

COLLEGE OF NOTRE DAME
Graduate School
1500 Ralston Avenue
Belmont, CA 94002

(415) 593-1606

ON THE SAN FRANCISCO PENINSULA

CREATIVE ARTS THERAPY

SPRING AND SUMMER INSTITUTES & EXPO

Pratt Expo • March 10
Sexuality, Creativity and Art Therapy
at Pratt Institute, Brooklyn, N.Y.

Spring Institute • March 11-16
Graduate workshops & courses on Art Therapy,
Movement Therapy, Creativity Development
at Pratt Institute, Brooklyn, N.Y.

Summer Institute • June 18 - July 20
Workshops and courses in expressive creative
therapies, ranging from 1-4 weeks.
Special week of workshops and classes for
Mental Health Professionals July 13 - 20.
Held in Lincoln, New Hampshire.

Also offered: Summer Masters' Program
in Brooklyn and New Hampshire.

For information: call **718•636•3428/3597**, or write:
Graduate Art Therapy
Pratt Institute
200 Willoughby Avenue
Brooklyn, NY 11205

pratt
Continuing Education

BEST COPY AVAILABLE

Presentation of AATA Awards

Introduction by Cay Drachnik, President

At this time I would like to thank the Honors Committee for their hard work. This committee was headed by Gwen Gibson, and the committee members were: Michael Campanelli, Judith Gerber, Helen Landgarten and Kay Stovall. I am happy to announce [that] we are presenting two awards today—The AATA Honorary Life Member recognition and The AATA Distinguished Service Award.

Honorary Life Member Award

[From the introduction given by Cay Drachnik, President, AATA]:

Today we honor another member with AATA's highest award—Honorary Life Member. This year we honor a person who was one of the founders of our organization. She was our first secretary and third president and served on the committee that wrote our original by-laws. Since that time she has served in numerous roles (chairperson and member) for AATA committees.

She is a Distinguished Fellow with the American Society of Psychopathology of Expression, and an Honorary Life Member of the Buckeye (Ohio) Art Therapy Association and the South Texas Art Therapy Association. Her vita lists twelve pages of articles that she has written and lectures that she has presented.

But Felice has really distinguished herself and our profession by research on *Incest Markers in Children's Art Work*. This study was published in *The Arts in Psychotherapy*, vol. 12, 1965. Currently this study has been redesigned and a normal population has been added to the original study and the redesigned study is being submitted to judges for evaluation and assessment. This research is highly significant at this time of professional growth of the American Art Therapy Association.

Felice has developed video presentations of her work in art therapy; [these are focused] specifically with abused populations. Two recent productions are: *Child at Risk*, a film produced at Channel 8, Public Broadcasting System, 1986, and won an Emmy award, and the other production is *Breaking Silence*, another film produced at Channel 8 in 1987.

Felice recently retired from the University of Texas Mental Sciences Institute in Houston, Texas. Prior to that she served as Chief of Art Psychotherapy at the Texas Research Institute of Mental Sciences.

Since her retirement she has continued to work in private practice and is still an advocate for art therapy, remaining active as a lecturer, consultant and researcher, and adding a few more pages to the twelve already in her vita.

I am honored to be able to present this Honorary Life Membership Award to one of our past presidents and founders, and a lovely lady as well . . . Felice Cohen.

Response to the AATA Honorary Life Member Award

Felice W. Cohen, ATR.

Delivered November 18, 1989. AATA Conference, San Francisco, Ca.

Madam President, Members of the Executive Board, Members of the Honors Committee, Colleagues and Friends. In 1976, the Buckeye Art Therapy Association honored me with their H.L.M. and in 1985, the South Texas Art Therapy Association honored me with their H.L.M. and now, today, I am again humbled to be the recipient of the AATA's highest honor, Honorary Life membership.

In particular, I wish to thank my dear friends and colleagues, Lew Shupe and Gary Barlow, for submitting my name in nomination, and submitting my name in nomination, and submitting my name in nomination to the Honors Committee.

Top credit goes to my husband, Aaron, for without his support and confidence in me, I not only would not have attended that exciting meeting at Hahnemann Medical College on December 5, 1968, but I would not have been able to serve the AATA as its first Secretary, President-Elect, President and also serve on Committees through this time. He was then and continues to be the engineer of my train, saying: "I know you can, I know you can."

When I was notified that I was to be the recipient of the H.L.M. this year, it brought out the nostalgia in me. There is so much of the early history of the AATA that many of you are unaware of. I hope that those of us who are referred to as pioneers will someday record our reminiscences for posterity. There were good times and there were difficult times; there were many disputes and polarizations but after twenty years, I know that we would not have reached this pinnacle without having experienced such times. Therefore, some of my rememberances are shareable and others are best not shared at this time.

Picture this scenario. In 1968 some of us who were "practicing art therapists" throughout the country received a letter from Myra Levick stating that the Chairman of the Department of Psychiatry at Hahnemann Medical College and Dr. Paul Fink, then Coordinator of Education and Training at Hahnemann, supported an organizing meeting to be held there for the purpose of defining our discipline as a recognized profession and also to found a national art therapy association. A date in our history, December 5, 1968!

The meeting was held in conjunction with a guest lecture presentation by Elinor Ulman. After the lecture we met to elect an ad-hoc committee charged to develop guidelines for the organization of a national art therapy association. I was in awe to finally meet those whose writings were the source of my art therapy knowledge: Margaret Naumburg, Elinor Ulman, Edith Kramer, Hanna Kwiatowska, Harriet Wadeson, and Myra Levick, to name a few. We had disagreements instantaneously—it was worth it. Those present elected Myra Levick, Bob Ault, Elinor Ulman, Don Jones, and me to be the members of the ad-hoc committee and we were charged with preparing for the founding of a national art therapy association.

For me, ignorance was bliss and I jumped in with both feet. Bob Ault and Don Jones were to send letters to the Editors of Professional Journals, Myra Levick was to send questionnaires to all the art therapists she could locate within one month, and Elinor Ulman was to assist with this. I was to write a cover letter introducing ourselves and also introducing the concept of the Steering Committee. The letter was to cover four things: 1. PROMISE an organization, 2. PROVE what we were attempting to accomplish, 3. PUSH for a response to the questionnaires and 4. PRESENT notification of a spring meeting to be held at the University of Louisville.

At the Philadelphia Meeting on December 5th, 1968, Bob Ault reported that $200.00 had been received in donations for the work of the Steering Committee. Due to expenses incurred, we had left a grand balance on hand of $191.00.

On June 27, 1969 the Organizational Meeting was hosted by the University of Louisville and Sandra Kagin-Graves and it was during that meeting that I first realized that giving birth to the AATA was going to be a painful experience and the labor hours lengthy. I wondered if forceps might have been necessary to deliver an unscathed birth. It happened, the AATA was delivered and the birth was eventful!

The first officers were elected: Myra Levick, President; Bob Ault, President-Elect; Marge Howard, Treasurer; I was elected Secretary; Don Jones, Publications; Bernard Stone, Membership; Helen Landgarten, Public Information; Ben Ploger, Standards; and Sandra Kagin-Graves, Education.

In my opinion, the AATA would not be in existence today if it had not been for the devotion, dedication, hard work and marvelous sense of humor of our first Treasurer, Marge Howard. No one could pinch pennies like Marge. If a member was a day late paying dues, Marge wrote a scathing personal note on the bill and sketched an appropriate cartoon on it as well—it worked. In 1969, dues were $15/year for active members and $3/year for students.

By September 15, 1970, at our first Conference at the Airlee Foundation, we had seventy-eight active members and four students and those dues coupled with an anonymous donor's gift, pushed our cash balance to $2,901.95 and we were wealthy!

Today, we are all concerned with licensure for art therapists, this is not new. By May, 1979, I had written a Rationale for Art Therapists Certification Act as well as a Bill to be presented to the Senate of the State of Texas. Linda Gantt had graciously agreed to meet me at the State Capitol in Austin to present the Bill with me. However, while Linda was in flight to Austin, some renegade Senators, some of whom we were to see, left the Senate and Austin for political reasons and no one could find them. They did not return until the session closed. We were unable to have our Bill presented. Ten years later we are still trying and let's not stop trying until we are successful.

Back in the late '50's and early '60's, the trust was far from licensure. At that time we were busy trying to educate the psychiatric and medical communities just what art therapy was, that what we did was valuable and that we were needed. How times have changed. I recall asking for the opportunity to give art therapy presentations to anyone, any time, and any place. I recall always asking at the beginning: "How many of you have heard of art therapy?" Dead silence. Today that question is no longer asked. We are called upon to share our knowledge and the demand for art therapists is overwhelming. We certainly have been doing something right for twenty years!

In the early years of the AATA, the elected officers had the total responsibility for their jobs. There was no Executive Office. I recall typing as many as two hundred letters a month. If nothing else, my typing skills improved but I still had to beg Marge Howard for stamp money.

Now when I read notices for job openings for art therapists today, the Master's in Art Therapy is required as is the ATR. We so-called pioneers cannot qualify today. Yes, we can have a Master's or PhD degrees, but not in art therapy. We were so busy writing and educating future art therapists for that degree and we could not give ourselves that degree in the colleges or universities where we were teaching.

How did we become ATR's in those days? The Grandfather's Clause. A wonderful art therapist, artist and teacher, Ben Ploger, was the AATA's first Chairperson of the Standards Committee. In 1970 he presented the following at our Conference: "and it was unanimously agreed that there must be a clear understanding that the AATA considers the patient-art therapist relationship to be dynamically oriented. If the art therapist is teaching art in a school or any other settings of this type, this is not considered dynamically oriented art therapy. Therefore, all those art therapists making application, who hold active membership as of June 30, 1970, will receive certification from the AATA under our Grandfather Clause providing the art therapist has been working in a psychiatric setting under the direct supervision of a psychiatrist as an art therapist for the past five years up to June 20, 1970. Under this same Grandfather Clause, those art therapists who are active members and have been working for any amount of time under five years and remain active members will receive their certification when they have completed the specified five years. This Grandfather Clause does not apply to any member making application for membership after June 30, 1970." I would suggest that we were demanding of all those who would be eligible for the ATR under the Grandfather Clause. Such requirements were somewhat discouraging to some and yet we were determined to make it work and it did work.

When I learned that I would be the recipient of this year's H.L.M., my first thoughts returned to my own involvement in presenting the first H.L.M. to Margaret Naumburg at the Airlee Conference in 1970. Before the first Executive Board Meeting in Tulsa in 1969, I agreed to have the plaque made in Houston. The first fiasco—I misspelled Naumburg. I had another one made and took it to Tulsa for the Board to see. After the Meeting Myra Levick took the plaque, put it in her suitcase and her suitcase was lost in Chicago and she lived in Philadelphia.

Because papers from the Tulsa Meeting were in her suitcase along with the plaque, the name of Marge Howard who lived in Tulsa was noted by the airline that found the bag. It was sent back to Marge in Tulsa who then sent it on to Myra. My husband and I flew to Philadelphia and the plan was for us to drive to the Conference in Warrenton, Virginia with the Levicks. We began our drive and were some great distance from Philadelphia on a turnpike when Myra asked me if I had the plaque. I in turn said that I thought she had it. We had left the plaque in Philadelphia. We had to go back to get it and when I presented it to Margaret, I could only stutter: Margaret Naumburg.

My life has been significantly enriched as a result of my association and work for the AATA. I have memories of lengthy and more often than not, heated Executive Board Meetings as well as Business Meetings at Conferences. Oftentimes the Executive Board Meetings lasted until 3:00 a.m. and we consumed pots and pots of coffee. Oftentimes the Business Meetings at Conferences were froth with disagreements and it was not uncommon to have to stop these Meetings and resume them in the evenings to finish the business at hand. We even argued over Robert's Rules of Order. As President, I was able to convince the Board that we could function more expeditiously if we hired an impartial Certified Parliamentarian and in 1974, our first Parliamentarian, Mrs. Kinsman, served us well. I am delighted that we continue to use this professional service.

There were factions that were formed at the December, 1968 Meeting. There were different philosophies voiced then and this has continued to this day. Only the faces have changed. I think that this has been healthy for us. At times some of us feared that our baby AATA would be obliged to mature in a dysfunctional family, but now twenty years later, our family is healthy, strong, still opinionated but functional. Let us all work to keep it this way.

Again, my heartfelt thanks for this wonderful accolade.

Felice W. Cohen, ATR

Distinguished Service Award

The first award is the Distinguished Service Award. The person to whom this award goes was co-founder and chair of the Massachusetts Coalition of Creative Arts Therapists and was editor of their quarterly newsletter. She has spent untold hours working on legislative issues for the coalition. She is a member of the New England Association of Art Therapists and has served as their vice-president and secretary. She has made a great contribution to AATA's Education and Training Board, having been its chair from 1985 to 1987. She still serves on that Board.

She graduated cum laude from Radcliffe College in Harvard University. She has written articles and given presentations too numerous to mention today. Currently she works as an art therapist with the Boston-North Shore Association and is in private practice. She is also a doctoral student at the Fielding Institute.

I am delighted to present this Distinguished Service Award to Suzanne Canner Hume. (Editor's note: *Shirley Riley accepted this award for Suzanne Canner Hume and read the following response*).

Response to the AATA Distinguished Service Award

Suzanne Canner Hume

I regret not being able to be with you this week in San Francisco. Some recent pregnancy complications have forced me to cancel travel plans—and begin "mothering" a few months before my daughter arrives.

I've asked Shirley Riley to accept this award on my behalf and to express my appreciation for the Board's recognition of the yeoman's work quietly done by the Education and Training Board. The ETB's tasks grew monumentally in the seven years I was a member, and two I was the Chair. Our challenge was to develop, with the Education Chairs, policies and procedures that could make a clearer, fairer, and more efficient process for the growing number of Master's Programs, Institutes, and Clinical Training Programs seeking to meet AATA's training standards.

The process of a program's obtaining approval takes many steps and sometimes several painful years! I would like to think that the thoughtful evaluation the ETB gives to each program helps it to shape its own character and focus, cultivate its strengths, and improve its weaknesses, while helping AATA to uphold high but fair educational standards, with room for diversity and creativity in art therapy education.

I thank all the colleagues I worked with over those years, especially those with whom I worked most closely (first Board Chair Carolyn Kniazzeh, ETB members Lew Shupe, Bob Wolf, Bob Ault, Maxine Junge, Mari Fleming, Julie Byers, Mary St. Clair, ETB Secretaries Sandy Graves, Tricia Gould and Pat St. John, and Education Chair Shirley Riley) who helped make for a series of great teams to be part of. I have never collaborated with people so willing to disagree intelligently—but so committed to dialogue for as many hours and days as it took to arrive at intelligent and respectful decisions. I thank AATA for recognizing how important the ETB branch is to our profession's development.

Best wishes for a successful conference and I hope to see you in Washington!

Suzanne Canner Hume, MEd, ATR

VIEWPOINTS

Dialogue Letter Writing—A Collaborative Technique for Beginning Art Therapists and Their Supervisors

Michael Campanelli, EdD, ATR, *Assistant Professor, Art Therapy, Wright State University, Dayton, Ohio.*

A seminar for Art Therapy graduate students functions as one part of group supervision for AT interns who are in practicums at various agencies, hospitals, and schools in our area. The purpose of the seminar is to facilitate the professional growth of interns by providing the kind of feedback they need to become more effective therapists.

To offer the proper support and guidance, I believe a supervisor must respond to each intern's developing professional perspective. This entails meeting each intern at his/her level, understanding each one's particular needs for professional growth, and learning each individual's clinical style. To individualize supervision in this way, the supervisor and intern must engage in an ongoing professional dialogue where they can both gain a perspective about the intern's clinical experiences and his/her evolving professional identity. This kind of dialogue is important not only because it facilitates the intern's processing of thoughts and feelings about clinical issues, but also because it helps the intern to develop and enhance the ability to communicate in a professionally effective way. Interns need practice in professional discourse, and supervisors help them exercise and sharpen their communication skills through cultivating a dialogue relationship.

It is often difficult (sometimes impossible) to find enough time during our weekly sessions to talk with every student; we usually have two case presentations which become the focus of the seminar discussions. All interns are expected to consult together about the cases and offer feedback to the presenters. This kind of cooperative interaction with their AT peers is, of course, a critical part of the interns' training. Yet to carry the process of involvement in seminar further, I believe the supervisor must understand and respond uniquely to each intern's experiences. Keeping track of each intern's growth has necessitated spending a great deal of out-of-class time developing rapport with students, discussing specific areas of concern, and providing individual advice and resources for their clinical work.

In my search to find a more efficient means of maintaining one-to-one contact with each intern, I stumbled upon an article in *Language Arts* (Staton, 1980) titled "Writing and Counseling: Using a Dialogue Journal." In this article, the author emphasizes the importance of written communication in the learning process and illustrates the use of a dialogue technique that personalizes education and enhances the teacher/student relationship. In addition to addressing academic issues, this dialogue technique may be used to provide guidance for students with personal concerns. When I read of this method's beneficial effect on student's attitudes and self-understanding, I decided to give it a try in my seminar classes. The results have been so successful that I have been employing this method for two years now. In sharing what dialogue writing is about, I hope I may lead other beginning Art Therapists and their supervisors to discover its value.

The first important point to note about this method is that it must be based on mutual trust. Each intern needs to know that I will value whatever is written and that I will respect their dialogues as confidential correspondence. I emphasize that I am the only one who will read their dialogues. After confidentiality is assured, I explain that this type of writing is like personal journal writing and as such, is primarily for themselves. Using a letter format, they are asked to write each week about their internship experiences. They may share many things that have happened or focus on one seminal issue. I tell them that writing things down may better enable them to understand themselves and their experiences. I encourage them to share questions, fears, doubts, and problems. They may begin writing with a brief description of a clinical situation or with a perception they had about a client, staff member, or the agency as a whole. Although their entries need not be about exceptional events, I encourage them to record internship experiences that have made a strong impression on them. It is also recommended that they include a drawing or painting to expand upon what they write. To allay anxiety about the writing process, we deemphasize the final product. The purpose is not to have them compose their dialogues as formal academic essays but to help them freely express what they think and feel. They are simply to write down what comes to mind allowing the dialogue to be an honest description of their experiences.

It is best if their dialogue writing is done at their sites during or after their internship day when experiences are still fresh in mind. As a starting place, they write questions and comments as they occur. They can then refer to some or all of these notes when they write their weekly dialogue letter. I ask interns to spend a minimum of twenty minutes writing and not to worry much about grammatical correctness. The completed dialogue is dated and then handed in at the seminar. Dialogues are filed in separate folders for each intern and during the week I write back to every student replying to their concerns. My responses are ready for them to read at the next seminar session.

The interns' initial reactions to the idea of dialogue writing are not always positive. Many interns are skeptical of this method's usefulness for them. This is especially true with students for whom writing is difficult. Once over their initial fears and resistances, however, interns come to realize the value of dialogue writing. They gradually come to use the dialogue process as a way to recognize areas of their work that need attention. They appreciate the individualized responses they receive and the professional partnership that grows out of the dialogue. As the interns become more involved in the dialogue process, thoughts and feelings that had been repressed or forgotten are uncovered. Ideas that were nebulous to them before can be analyzed and understood. How much the intern reveals of himself or herself varies from person to person but for most, the writing becomes a means of gaining clarity and insight about one's work.

My students have found this process very rewarding. The dialogue format gives them an opportunity to process their clinical experiences immediately and enables them to discuss many more concerns than they normally would. Another benefit is that many interns are more willing to speak up in seminar. The writing seems to activate their verbal participation as well as increase their confidence in addressing clinical issues.

As a supervisor, I have found that this method enables me to get to know the interns better. I can feel a greater appreciation for their struggles and can more easily share in the satisfaction of their successes. Through our dialogues, I play a very active part in each intern's practicum. I can quickly find out what each intern needs, examine therapy strategies, and detect existing and potential problems with clients and co-workers. The dialogue automatically individualizes supervision since I can respond to each intern working at his or her own pace, exploring various ways to handle unique clinical situations. Our correspondence allows for a thorough examination of clinical material. Issues that are not raised in seminar can be addressed in their dialogues. The dialogue method also enables me to address topics at seminar sessions that are pertinent to the whole group. Informed by the dialogue reports, I am prepared to discuss issues that bear on matters that are immediately relevant for all the interns. Focusing on dialogue issues of common concern contributes to a greater group cohesiveness and involvement in the seminar.

Over the course of a year's writing, I can easily keep track of each intern's progress and also see the development of each one's emerging clinical style. Interns discover and cultivate responsible, professional attitudes by reflecting on their professional beliefs and values. The result is that the dialogue document not only becomes a record of each intern's unfolding potential, but also a method of self-exploration that contributes to the development of a professional identity.

Although the dialogue method is very worthwhile, it can be a time-consuming process, difficult for many supervisors to include in their already busy schedules. Where this is the case, a selective use of the dialogue during certain critical times is recommended. For example, the dialogue might be employed the first and last weeks of internship or periodically when an intern is feeling confused or distressed over an internship experience. A supervisor might also choose to use the dialogue to establish rapport with an introverted intern who may have difficulty communicating face-to-face. Whether the dialogue is employed on an ongoing basis or only at special times, a supervisor's responses do not always have to be lengthy. A few incisive comments can sometimes offer the support or advice that is needed while also serving to keep the dialogue process going.

I have known many Art Therapy students who dislike and fear writing, feeling unable to function at their fullest capacity in a written-verbal format. Not surprisingly, our profession attracts a sizable number of individuals, who though highly skilled in artistic expression, need some practice in learning to be effective written and oral communicators. Such skills are obviously crucial to our therapeutic work. No matter how proficient an Art Therapist is at nonverbal communication, one will be severely handicapped if he or she is not a sufficiently articulate professional. Our clients and our co-workers depend on us to translate what we see into oral and written descriptions so they can understand and appreciate what Art Therapy is. Through such communication,

continued on page 50

REVIEWS

VIDEO REVIEW

Art Safety: Hazards and Precautions (Video Tape)

Michael McCann, *Center for Safety in the Arts, New York, 1988, $200.00.*

Reviewed by: ***Winnie Ferguson, PhD, ATR,*** *Instructor, Art Therapy, Wright State University, Dayton, OH.*

With great anticipation I awaited the arrival of this video tape produced by the Center for Safety in the Arts. Because we, as art therapists, use all media with wide varieties of clients, do we constantly expose ourselves and clients to untold dangers? As professionals, we know that using certain material such as permanent markers (i.e., those with toxic levels) is harmful, but what additional information might this video disclose? I have used McCann's book *Health Hazards Manual for Artists* (1985) and found it useful for both myself and for students. The promotional materials informed me that the video was two hours in length. While that is extremely long, I did not anticipate how long two hours of video lecture would seem.

The tape consists of two parts. Part I covers the topic of who is at risk. The second portion of the tape discusses what one can do about the risks. The tape, presented as a lecture by McCann, appears to be in an office setting which is unchanged for the entire two hours. Although the information is valuable, the presentation and delivery make it difficult to comprehend with the lengthy viewing time.

The risk factors discussed verbally by McCann are augmented by a visual list of factors to help the viewer remember the focus of each point of the lecture. The technique of alternating the image of McCann speaking and the information lists was used extensively throughout the tape. While this method is effective when used in a classroom lecture or even in a video with other images offered, in this case, the constant flashbacks were distracting to this viewer.

McCann's focus on children (and the hazards which increase due to the children's smaller size and perhaps sometimes unclear understanding of directions) should be noted by all those working with youngsters. In addition, there are cautions regarding the use of art materials with the elderly who are sometimes frail, and persons with disabilities who may tend to ingest media due to mouth painting, or visually impaired individuals working very close to the product. Warnings regarding contamination of food by eating while producing art work or placing hazardous materials in eating utensils were good reminders of dangers we all should remember.

Another important item included in the tape was a discussion regarding knowing the content of art materials. As art therapists we need to be vigilant in this regard. Our well-being, as well as that of our clients, depends on our selection of safe materials to be used in our art therapy sessions.

An enumeration of the types of illnesses resulting from the use of hazardous art materials was somewhat frightening. The list included the following ailments: skin allergies, eye disease, respiratory illness, heart and circulatory diseases, kidney and bladder disease, liver disease, nervous system disturbances, and reproductive system dysfunctions. When reminded of the dangers posed to our clients by careless selection and use of art materials, we must accept the responsibility to safeguard our trust.

Part II of the video provided the viewer with precautions one can take to protect against the hazards in art materials. First and foremost is the need to know the materials. Be sure to know the components of materials and the physical condition of the client. Beware of substitutions either by the manufacturer or by yourself.

Some of the cautions shared in the lecture were simple and ones that we all take for granted. Be careful to use adequate ventilation in the workroom. McCann points out that the open window or door would not provide proper ventilation because the air flow cannot be controlled. Use exhaust fans when working with clay or materials with fumes. Store flammable and inflammable materials in separate storage areas. Have workable fire extinguishers near your work spaces. McCann suggests that persons working with art materials have regular physical check-ups.

In discussion of product labels McCann says the only one which should be recognized is the health label from *Arts and Crafts Materials Institute*. This organization lists all hazardous materials in products.

continued on page 50

◉CHICAGO◉

19TH ANNUAL CONFERENCE PROCEEDINGS
1988 CHICAGO, ILLINOIS

The 1988 AATA Conference Proceedings, "Professionalism in Practice" November, 1988, are available through the AATA National Office in abstract form.

PRICE PER COPY:

Member - $15.00 each Non-member - $20.00 each 10 or more - $12.00 each

QUANTITY COST TOTAL

________ × _____ = _____

SEND TO:

TO ORDER COPIES: Mail order form ➧
along with payment to:

- American Art Therapy Association,
1202 Allanson Rd.
Mundelein, IL 60060.

Please make checks payable
in U.S. funds to AATA.

NAME/INSTITUTION MBR ID #

ADDRESS

CITY STATE ZIP CODE

TELEPHONE

SAN FRANCISCO

20TH ANNUAL CONFERENCE PROCEEDINGS
1989 SAN FRANCISCO, CALIFORNIA

The 1989 AATA Conference Proceedings, "PAINTING PORTRAITS, Families, Groups, & Systems" November, 1989, are available through the AATA National Office in abstract form.

PRICE PER COPY:

Member - $15.00 each Non-member - $20.00 each 10 or more - $12.00 each

QUANTITY COST TOTAL

________ × _____ = _____

SEND TO:

TO ORDER COPIES: Mail order form ►
along with payment to:

- American Art Therapy Association,
1202 Allanson Rd.
Mundelein, IL 60060.

Please make checks payable
in U.S. funds to AATA.

NAME/INSTITUTION MBR ID #

ADDRESS

CITY STATE ZIP CODE

TELEPHONE

The American Art Therapy Association, Inc.

THE ORGANIZATION

The American Art Therapy Association (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3000 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice; AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliated Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive:

Publications

- *Art Therapy*, the official journal of the AATA.
- The quarterly *AATA Newsletter*.
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- Free AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payers.
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy.

Professional Standards

- Development of model job and licensure laws.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

GENERAL MEMBERSHIP APPLICATION

1. The membership year is the calendar year January 1st through December 31st.

2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY: Please follow the chart below when submitting membership application.
Applications received between

   Jan. 1st and May 31st — Full dues payment; Membership will expire Dec. 31st of same year.

   June 1st and Sept. 30th — Half year dues plus $5.00 payment; membership will expire Dec. 31st of same year.

   Oct. 1st and Dec. 31st — Full dues payment; membership for the remainder of current year and the next full year through Dec. 31st.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval.

4. AATA Membership and AATA Registration (ATR) each have a separate application procedure. Registration is bestowed only by the Standards Committee.

5. National AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL — by application only; such members may vote, hold office and serve on committees.

> **Credentialed Professional Member:** Individuals who have been dually approved for Professional Membership and Registration (ATR) by the AATA; dues are $80 per year.
>
> **Active Professional Member:** Individuals who have completed professional training in art therapy; dues are $75 per year.

CONTRIBUTING — Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $100 per year.

ASSOCIATE — Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75 per year.

STUDENT — Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Student members may not vote or hold office but may serve on the Student Subcommittee of Membership. Dues are $35 per year.

See other side for Application Form

Mail entire form to:

The American Art Therapy Association, Inc.

1202 ALLANSON ROAD/MUNDELEIN, IL 60060

(708) 949-6064

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

NAME ______________________________
last first middle

HOME ADDRESS ______________________________

____

PHONE (   ) ______________________________

BUSINESS ADDRESS ______________________________

____

____

BUSINESS PHONE (   ) ______________________________

EMPLOYER ______________________________

JOB TITLE ______________________________

LICENSES HELD & STATE ______________________________

PREFERRED MAILING LIST

___ HOME ___ BUSINESS

Please indicate which of the following you are applying for:

___ PROFESSIONAL MEMBERSHIP (an application packet for Professional Membership will be sent to you)

___ REGISTRATION (ATR) (an application packet for Registration will be sent to you)

___ $75 PROFESSIONAL MEMBERSHIP (after approval)

___ $80 ATR MEMBERSHIP (after approval)

___ $100 CONTRIBUTING MEMBERSHIP

___ $75 ASSOCIATE MEMBERSHIP

___ $35 STUDENT MEMBERSHIP (see student membership criterion for necessary documents to accompany this application)

PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO AATA
American Art Therapy Association, Inc.
1202 Allanson Rd./Mundelein, IL 60060

Please complete this survey:

Education (please check highest degree earned)

1 ___ Doctorate Degree
2 ___ Master's Degree
3 ___ Bachelor's Degree
4 ___ Associate/Certificate
5 ___ Other

Work Setting (please check one only)

1 ___ Hospital
2 ___ Clinic
3 ___ Day treatment center
4 ___ Rehabilitation
5 ___ Sheltered workshop
6 ___ Correctional facility
7 ___ Residental treatment
8 ___ Out-patient mental health
9 ___ School system
10 ___ Elderly care facility
11 ___ College/University
12 ___ Clinical training program
13 ___ Institute training program
14 ___ Counseling center
15 ___ Private practice
16 ___ Other ___________

Area(s) of Specialization (please check up to three)

1 ___ Addictions
2 ___ Adolescents, Hospitalized
3 ___ Adolescents, Psychiatric
4 ___ Adults, Hospitalized
5 ___ Adults, Psychiatric
6 ___ Art History
7 ___ Art Therapy Education
8 ___ Art Therapy in Schools
9 ___ Children, Hospitalized
10 ___ Children, Psychiatric
11 ___ Domestic Violence
12 ___ Eating Disorders
13 ___ Families
14 ___ Gerontology
15 ___ Hospice/Terminally Ill
16 ___ Learning Disability
17 ___ Mental Retardation
18 ___ Neurological Disease
19 ___ Prisoners
20 ___ Post Traumatic Stress
21 ___ Psychotherapy
22 ___ Rehabilitation
23 ___ Research
24 ___ Sexual Abuse
25 ___ Visual Art
26 ___ Other ___________

Voluntary Information:

Age:

1 ___ 20-24
2 ___ 25-29
3 ___ 30-34
4 ___ 35-39
5 ___ 40-44
6 ___ 45-49
7 ___ 50-54
8 ___ 55-59
9 ___ 60 +

Salary Range:

1 ___ under $10,000
2 ___ $10-15,000
3 ___ $15-20,000
4 ___ $20-25,000
5 ___ $25-30,000
6 ___ $30-35,000
7 ___ $35-40,000
8 ___ $40-45,000
9 ___ $45-50,000
10 ___ $50,000 +

Gender:

1 ___ Female
2 ___ Male

Hours Worked per Week:

1 ___ 0-10
2 ___ 10-20
3 ___ 20-30
4 ___ 30-40

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(708) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapist's Identity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) 110 pages	$15.00	$20.00
Art Therapy: Professionalism in Practice (1988)	$15.00	$20.00
Conference Proceedings (1989) *Painting Portraits: Families, Groups & Systems*	$15.00	$20.00
Art Therapy: Journal of the American Art Therapy Association Rates: Individuals — U.S. $23.00; Foreign $30.00; Institutions — U.S. $27.00; Foreign $36.00		
Art Therapy: Journal - Back Issues	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings *Use of the Creative Arts on Therapy (1979)*	$5.00	$7.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 x 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

*NOTE: for **Publications** postage/handling, add $3.00 for the first unit item, $.75 each additional unit.

SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS.

**Foreign Orders: Require pre-payment for items and then will be billed for shipping charges as you instruct on order: Air Mail charges (1 week delivery) or Ground Services charges (2 month delivery)

10 or more copies of any single issue: 15% discount on total cost. Discounts are available when purchasing quantities. Set of four Proceedings (consecutive years): 20% discount on total cost.

Indicate Quantity of Unit Items Below		Cost/Unit		Total
____________	( ) X	________	=	________
____________	( ) X	________	=	________
____________	( ) X	________	=	________
____________	( ) X	________	=	________

*Publications Postage/Handling = ________ Total Publications Costs = ________

FILMS (Rental/Purchase)

Art Therapy: Beginnings (1977) color/sound, 45 minutes	16mm Rental Only:	$40.00	$50.00
	1/2" VHS, Purchase Only:	$50.00	$80.00
Michael (1977) color/sound, 12 minutes	16mm Rental Only:	$30.00	$35.00
	1/2" VHS, Purchase Only:	$50.00	$80.00
Art Therapy (1981) color/sound, 12 minutes	16mm Rental Only:	$35.00	$45.00
	1/2" VHS, Purchase Only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery (1978) color/sound, 32 minutes	16mm Rental Only:	$40.00	$50.00
	1/2" VHS, Purchase Only:	$50.00	$80.00

*NOTE: for **VHS Films Purchase** postage/handling add $2.50 for each film. *NOTE: for **16mm Rental** add $7.00 for postage and handling.

Indicate Quantity of Unit Items Below		Cost/Unit		Total
____________	( ) X	________	=	________
____________	( ) X	________	=	________

*Films Postage/Handling = ____________ Total Films Costs = ________

ORDER FORM: ***Make checks payable in U.S. funds to AATA, and mail to the above address***

SEND TO: ______________________________ MBR. ID#: __________

____

____

City State Zip Code

BEST COPY AVAILABLE

Member ID# Required________		***Member	Non-Member
** Educational Guidelines		*SASE (25¢)	$ 1.00
** Educational Program List		*SASE (25¢)	$ 1.00
** Standards and Procedures for Registration		*SASE (25¢)	$ 1.00
** Criterion for Professional Membership		*SASE (25¢)	$ 1.00
** Art Therapy Model Job Description		*SASE (25¢)	$ 1.00
** Art Therapy Media List		*SASE (25¢)	$ 1.00
** Standards of Practice		*SASE (45¢)	$ 1.00
** Art Therapy Bibliography		*SASE (25¢)	$ 1.00
** Member Specialty List		*SASE (45¢)	$ 1.00
** Membership Survey		*SASE (25¢)	$ 2.00
** Associate Student New Member Applications		—	—
Professional Membership Application	(9x12)	*SASE (65¢)	*SASE (65¢)
Registration (ATR) Application	(9x12)	*SASE (85¢)	*SASE (85¢)
Membership Directory/Bylaws (Institution $100.00)		$ 8.00	$ 50.00

General Information Packet (Includes first three items) $3.00

*SASE — Self Addressed — Legal Size — Stamped Envelope — 25¢ postage per item

**Available in multiples: per item, 1-9, SASE ($1.65), 10-50, $5.00 (UPS), 50-100, $10.00 (UPS)

Dialogue Letter Writing (cont'd)

Art Therapists also deepen their own understanding and appreciation of Art Therapy concepts since learning to use language effectively is learning to define, order, and clarify ideas.

Dialogue writing is a powerful resource for developing the kind of heightened awareness and usage of language that Art Therapists need in order to effectively respond to their professional experiences.

Reference:

Staton, J. (1980). Writing and counseling: Using a dialogue journal. *Language Arts, 57*, 514-518.

Art Safety (cont'd)

He also points out that manufacturers must give the consumer specific information regarding the content of a product upon request.

This video tape presents one method to learn about the materials information offered. However, in a classroom lecture the student may ask questions and request clarification of a fact. In a video tape there is no opportunity for this interaction. The art therapist should spend a few dollars to buy the *Health Hazards Manual for Artists* (1985) published by Nick Lyons Books (New York: NY). The book provides a simple synopsis of the entire content of this video. It is the reviewer's opinion that most art therapists will find the $20.00 cost of the book much more palatable than the $200.00 purchase price for this video. It is, nevertheless, important and necessary content (in whatever package it comes) for the art therapist to learn about the nature of art materials and to know the intricacies of safety features of paint, clay, various kinds of drawing materials and numerous other art supplies we all incorporate in our art therapy work.

Guidelines for Authors

Please submit five (5) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed, ATR, AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060. AATA cannot be responsible for submissions sent to any other address. Send manuscripts and illustrations certified mail, with return receipt requested. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

CONFIDENTIALITY: Client/Patient confidentiality must be protected in title, abstract, text, photos and other accompanying material. Proper releases must be obtained.

BEST COPY AVAILABLE

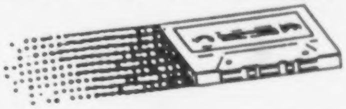
THE AMERICAN ART THERAPY ASSOCIATION, INC.

20TH ANNUAL CONFERENCE

PAINTING PORTRAITS: FAMILIES, GROUPS & SYSTEMS

NOVEMBER 16-20, 1989 SAN FRANCISCO, CA

Order Now



HERE IS YOUR CHANCE TO REVIEW THE **20TH ANNUAL CONFERENCE** AT YOUR LEISURE. "ATTEND" SESSIONS YOU MAY HAVE MISSED, OR COMPLETE YOUR TAPE LIBRARY. ALL PRESENTATIONS ARE UNEDITED, VERBATIM MATERIAL. ORDER TODAY BY PHONE, FAX OR MAIL IN THE ENTIRE FORM. THANK YOU!

PLEASE CHECK THE BOX BY THE SESSIONS YOU WISH TO ORDER.

☐	PB291-1 $10.00	Opening Ceremony, C. Drachnik, R. Vick
☐	PB291-2 $10.00	KEYNOTE: Young & Adult Children Family Legacy, C. Black
☐	PB291-3 $10.00	Are There Differences? C. Drachnik, E. Stygar, Jr.
☐	PB291-4 $10.00	Screening for Depression through the Draw-A-Story Task, R. Silver: Identifying Students at Risk Through Artwork in a Public School, D. Debevec, W. Ferguson
☐	PB291-5 $10.00	Painting Portraits: Fathers and Daughters, H. Crown; Protrait of the Artist as an Elderly Gentlemam A Case Retrospective, W. Maiorana
☐	PB291-7 $10.00	Sandplay and Inner Work, T. Sweig
☐	PB291-8 $10.00	Confronting the Year 2000: The Art Therapist and Social Change, M. Junge, J. Finn. A. Kellogg, C. Volker
☐	PB291-9 $10.00	Where is the Art in Art Therapy? C. Malchiodi, M. Cattaneo, P. Allen
☐	PB291-10AB $10.00 (2 tapes)	Sacrifice, Secrets and Sabotage: Scandal and Interplay of Abuse and Addictions, D. Good-Garcia, H. Heddens, D. McElligott, D. Spring, S. Ticen, K. Webb, Wedeen, Yannakone
☐	PB291-11 $10.00	Art Therapy and Second-Order Cybernetics; Contributions of Bateson, Maturana, Vonfoerster, R. Schoenholtz
☐	PB291-12 $10.00	Contour Drawing as A Psychotherapeutic Process, R. Ault
☐	PB291-13 $10.00	Heading Them Off at the Pass: An Expressive Therapies Program for Adolescents, M. Rosal, S. McCollough, S. Malone
☐	PB291-14 $10.00	Changing Systems: The Mental Health Providers' World in the 1990's, S. Riley; Freud as Metaphor: Ambivalence and Integration in the Art Therapy Profession, L. Kapitan
☐	PB291-15 $10.00	Portrait of a Difficult Art Psychotherapy Group: Effective Interventions and Strategies, P. Isis; Behind the Mask: Exploring Roles and Defenses in Group and Family Systems, K. Webb
☐	PB291-16 $10.00	Innovations in Medical Art Therapy: Defining the Field, J. Long, V. Appleton, S. Palmer, L. Chapman
☐	PB291-17 $10.00	Emotions and Art Media: Structural Approach to Media Applications, V. Lusebrink
☐	PB291-19 $10.00	Precious Gifts: Images of Sexuality, Relationship and Wholeness, B. Moon, D. DeBrular
☐	PB291-20 $10.00	Hildegard of Bingen and Georgia O'Keefe: DivergentPortraits of Art Therapy, Sister, K. Burke
☐	PB291-22 $10.00	An Art Therapist's Reflections on the Natural History of Visual Preception, E. Kramer
☐	PB291-24 $10.00	From Way Below to the Light Side: Identifying Alters in MPD, D. Spring
☐	PB291-25 $10.00	Multi-Cultural Approaches to Art and Mental Health, K. Congdon

BEST COPY AVAILABLE

......ON AUDIOCASSETTE TAPES

☐ **PB291-26** $10.00	**The Self-Employed Art Therapist: Challenges, Freedom and Money, J. Phillips, D,. Skeen**
☐ PB291-27 $10.00	Art Therapy with HIV Positive Patients - Mourning, Restitution, and Meaning, G. Fenster
☐ PB291-28 $10.00	The Use of Art Therapy with Alzheimer's Disease Patients, A. Shore; Beyond the Patient to the Person: Promoting Autonomy in Individuals withDementia, J. Harlan
☐ PB291-29AB $20.00 (2 tapes)	Suicide: What is the Role of the Therapist? L. Goldman, J. Rothschild, J. Motto, C. Ross, P. Allen, S. Graves
☐ PB291-31AB $20.00 (2 tapes)	Advances in Research, L. Gantt, G. Agell, B. Cohen, C. Cox, C. Tabone
☐ PB291-32 $10.00	Short-Term Art Therapy at a Psychiatric Crisis Intervention Ward, F. Matthias, C. Hesse, H. Berzewski
☐ PB291-33 $10.00	The Extended Family Picture: International Development of Art Therapy, B. Stoll, A. Shah, M. Marinovic, D. Waller, Y, Tokuda, A. Coulter-Smith
☐ PB291-34 $10.00	Painting Family Portraits: Four Perspectives on Family Art Therapy, R. Vick, S. Riley, D. Arrington, M. Fleming, B. Sobol
☐ PB291-35 $10.00	Avoiding Malpractice, N. Knapp, C. Drachnik
☐ **PB291-36** $10.00	**A Precious Loss: Community Bereavement Following the Carrollton, KY, Church Bus Tragedy, L. Probus; Grief Time: A Change of Destiny, A Children's Play, B. Betker McIntyre, J. Nutter, J. Adams**
☐ PB291-38 $10.00	Protrait of Teamwork: Art Therapy in the Acute Care Oncology Setting, A. Bussard, P. Peck, L. Eaton; Family Ties: Integrating Creative Arts and Recreational Therapists Under One Roof, S. Ault
☐ PB291-41 $10.00	The Therapist's Drawing of the Clinical Hour: Object-Relations Illustrated, M. Ireland, S. Meyer
☐ PB291-42 $10.00	Discovering Life with Less Pain: Art Therapy with Rheumatology Patients, K. Dannecker
☐ PB291-43 $10.00	The Diagnostic Drawing Series in the Integration Process of Multiple Personality, B. Cohen
☐ PB291-44 $10.00	Latency-Age Group Art Therapy and the Family System, B. Mescher; Using A Multi-Family Art Therapy Group to Engage Families in Treatment, T. Doyle, T. Holtgraves
☐ PB291-45 $10.00	Projective Family Drawings: Past, Present and Future, J. Rhyne, R. Burns, J. Brakarsh
☐ PB291-46 $10.00	The Circle and The Art Therapist, L. Rhinehart, P. Engelhorn, E. Wallace S. Geller, J. Kellogg, R. Heinze
☐ PB291-47 $10.00	The Impact of Imagery in Children's Picture Books, E. Handler Spitz
☐ PB291-48 $10.00	Alexithymia in an Addiction-Affected Society: Art Therapy Rekindles the Emotional Experience, D. Kriegman McElligott
☐ PB291-49 $10.00	Art as Prayer, C. Moon

BUY 6 TAPES AND GET
THE 7TH TAPE FREE!!

BUY 12 TAPES AND GET THE
13TH & 14TH TAPES FREE
PLUS A VINYL CASSETTE HOLDER!!

☐ COMPLETE SET PB291................$352.00...............SAVE 20%

FOR FASTER SERVICE
Please have your credit card number ready and call
TOLL FREE 1 800 367-9286; (in California) 1 800 992-9286
Internationally FAX your order 1 714 537-3244

MAIL IN ENTIRE FORM

SHIP TO: NAME ______________________
(please print)
ADDRESS ______________________
CITY______________ STATE __________ ZIP__________
Please Charge This To My Credit Card: VISA ☐ M.C. ☐ or A/E ☐
(Minimum Credit Card Order $25.00)
ACCT. NO. ______________ CARD EXPIRATION DATE__________
DAY TIME PHONE NO. __________ ______________
Signature

# of tapes ordered ________ TOTAL PRICE: $ __________
CA Residents add 6¼% sales tax $ __________
SHIPPING & HANDLING : $ __________
(Include $1 for each tape
up to a maximum of $7.00)
TOTAL AMOUNT ENCLOSED: $ __________

BEST COPY AVAILABLE

All Sales Final
FOREIGN ORDERS:
Add 10% Surcharge of subtotal for additional shipping & handling.
Purchase Orders accepted for purchase of $100 or more

Send Order and
Remittance To:
InfoMedix
THE SOURCE FOR INFORMATION
12800 Garden Grove Boulevard • Suite F • Garden Grove, CA 92643
(714) 530-3454

Please Allow 4 to 5 weeks for Delivery

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

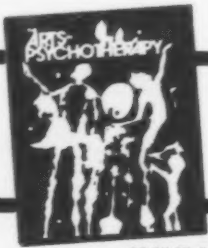
Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1990. Enclosed is my check, payable to AATA, for $23.
Name ______________________________
Address ______________________________
City ____________________ State __________ ZIP __________

The interdisciplinary journal
devoted to the creative arts as healing arts.

THE ARTS IN PSYCHOTHERAPY

An International Journal



FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Assistant Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

Dedicated to scholarship in the creative arts therapies, THE ARTS IN PSYCHOTHERAPY presents innovative research in artistic inquiry and expression, and its use in the treatment of mental disorders.
THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!

Members of qualifying societies can receive a discount on one-year Professional subscriptions the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

SUBSCRIPTION INFORMATION

ISSN: 0197-4556 Volume 16, 1989
Published 4 issues per annum

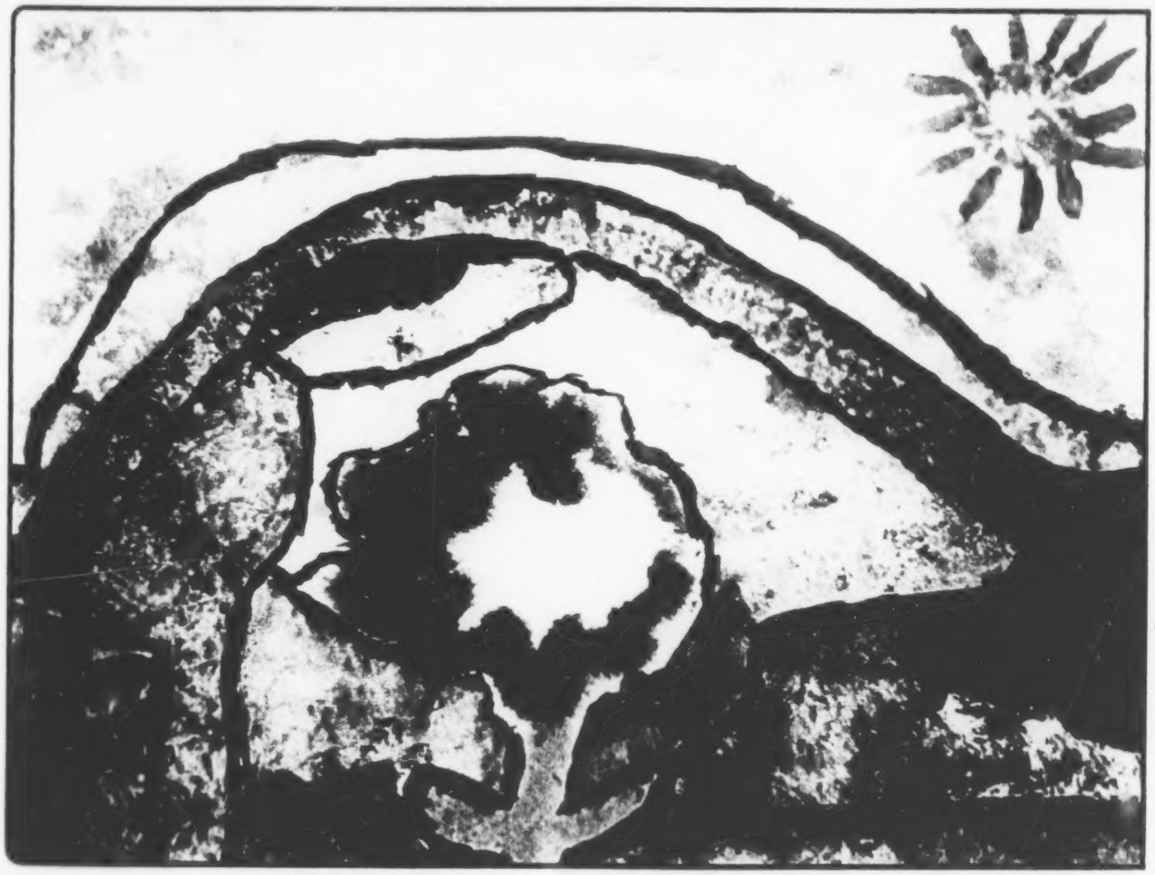
Annual Institution Subscription Rate (1989)	US$110.00
Two-year Institution Rate (1989/90)	US$209.00
Individual Rate (1989)	US$ 40.00
Student Rate (1989)	US$ 16.00

PERGAMON PRESS, INC.
Maxwell House, Fairview Park, Elmsford, NY 10523
PERGAMON PRESS plc
Headington Hill Hall, Oxford OX3 0BW, England
A Member of the Maxwell Communication Corporation Group of Companies

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association



Volume 7, Number 2 July 1990

- Art Therapy with Homeless Women and Children in a Bridge Housing Program in Scranton, Pennsylvania
  Sister Dorothy McLaughlin, R.S.M., Ed.D., A.T.R.
- Visceral Learning: The Integration of Aesthetic and Creative Process in Education and Psychotherapy
  Robert Wolf, M.P.S., A.T.R.
- Exhibiting Art by People with Mental Illness: Issues, Process and Principles
  Susan Evans Spaniol, M.A., A.T.R.
- An Art Therapy Curriculum in an Early Intervention Program for Visually Impaired Children
  Roberta Weiss, A.T.R.
- When a Mother Kills Her Child
  Rose Marano Geiser, M.A., A.T.R.

940

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1990

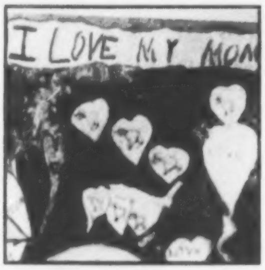
Linda Gantt, M.A., A.T.R., *President;*
Robin F. Goodman, Ph.D., A.T.R., *President Elect;*
Cathy Malchiodi, M.A., A.T.R., *Secretary;*
Virginia Minar, M.S., A.T.R., *Treasurer;*
Doris Arrington, Ed.D., A.T.R., *Director;*
Shirley Riley, M.A., A.T.R., M.F.C.C., *Director;*
Deborah Good, M.A., A.T.R., *Director;*
Dean Wilson, A.T.R., *Director;*
Trudy Manning, M.S., A.T.R., *Affilitate Chapters*

Executive Director

Edward J. Stygar, Jr.

ART THERAPY

Journal of the American Art Therapy Association



Editorial

Gary C. Barlow, Ed.D., A.T.R. 2

Articles

Art Therapy with Homeless Women and Children in a Bridge Housing Program in Scranton, Pennsylvania
Sister Dorothy McLaughlin, R.S.M., Ed.D., A.T.R. 55
Visceral Learning: The Integration of Aesthetic and Creative Process in Education and Psychotherapy
Robert Wolf, M.P.S., A.T.R. 60
Exhibiting Art by People with Mental Illness: Issues, Process and Principles
Susan Evans Spaniol, M.A., A.T.R. 70
An Art Therapy Curriculum in an Early Intervention Program for Visually Impaired Children
Roberta Weiss, A.T.R. 79
When a Mother Kills Her Child
Rose Marano Geiser, M.A., A.T.R. 86

Reviews

Freedom to Create
Lucy Sollers Wood, M.F.A., A.T.R. 94
The Living Psyche: A Jungian Analysis in Pictures
Howard McConeghey, Ed.D., A.T.R. 95

On the Cover

"Morning Glory" "My daughter is like a morning glory." An abstract watercolor painting by a homeless mother in the Catherine McAuley Bridge Housing Program in Scranton, PA.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

Volume 7, Number 2 July 1990

EDITORIAL BOARD

Editor
Gary Barlow, Ed.D., A.T.R.
Viewpoints
Harriet Wadeson, Ph.D., A.T.R.
Book Reviews
Aina O. Nucho, Ph.D., A.T.R., A.C.S.W.
Brief Communications
Ruth Obernbreit, M.A., A.T.R.
Film Video Reviews
Georgiana Jungels, M.A., A.T.R.
Managing Editor
Marcia May-Chambers

Contributing Editors
Frances E. Anderson, Ed.D., A.T.R.
Robert Ault, M.F.A., A.T.R.
Lynn Cashell, M.C.A.T.
Dana N. Christensen, Ph.D., A.T.R.
Linda Gantt, M.A., A.T.R.
Susan LaMantia O'Connor, M.A., A.T.R.
Paul Rodenhauser, M.D.
Ellen A. Roth, Ph.D., A.T.R.
Lewis K. Shupe, Ph.D., A.T.R.
Suzanne Silverstein, M.A., A.T.R.
Robert Wolf, M.P.S., A.T.R.

American Art Therapy Association, Inc. 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064

Copyright © 1990 American Art Therapy Association

BEST COPY AVAILABLE

EDITORIAL

It is not too early to think about our annual conference, and excitement is building for our meeting that will be held in Washington, D. C., November 15, 1990, at the Grand Hyatt Hotel and the Holiday Inn Crowne Plaza. The theme is "Creativity Through Collaboration," and will focus on a variety of papers, workshops, seminars and other highlights involving not only the American Art Therapy Association, but also our related professions: The American Association for Music Therapy; The American Dance Therapy Association; The American Society of Group Psychotherapy and Psychodrama; the National Association for Drama Therapy; The National Association for Music Therapy; and the National Association for Poetry Therapy. These groups have been working diligently to make certain that the series of meetings will be especially valuable for us all. Mark your calendar and plan to attend. Washington, D. C. will offer its unique brand of hospitality and I hope that each of you will consider joining us for our 21st annual conference.

This issue of *Art Therapy* highlights a wide variety of thought-provoking and stimulating articles, selected for their intensity of content and importance for us as health-related professionals. "Art Therapy with Homeless Women and Children in a Bridge Housing Program in Scranton, Pennsylvania" is presented by Sister Dorothy McLaughlin, and focuses on an area that is of increasing national concern—that of homeless and displaced persons.

"When A Mother Kills Her Child," an article by Rose Marano Geiser, is concerned with a topic that is both horrifying and piognant, and certainly one of special concern for the art therapist who works with individuals within family constellations.

"Art Therapy Curriculum in an Early Intervention Program for Visually Impaired Children," by Roberta Weiss, points out the need for intelligent curricular strategies and content relative to special populations.

In the article "Exhibiting Art by People with Mental Illness: Issues, Process and Principles," Susan Evans Spaniol raises questions for each of us: When should we exhibit clients' work? How should it be exhibited? Why is it exhibited? What are some cautions to be considered? There are many other questions that are also suggested for thought and discussion.

Finally, a penetrating article by Robert Wolf, titled "Visceral Learning: The Integration of Aesthetic and Creative Process in Education and Psychotherapy," probes into many facets related to being an art therapist, artist, a psychoanalyst, teacher or author, and illustrates various communication needs, levels and strategies relative to the give-and-take between patient and therapist, as well as the insight that a therapist gains of himself/herself within the various roles of responsibilities.

As readers of this journal know, manuscripts are submitted following certain guidelines (see "Guidelines for Authors" elsewhere in this issue). The various categories are outlined that need to be followed, such as the form that the manuscripts are to take, suggestions for section headings, and so on. Two areas must be emphasized from this listing, primarily because they are not given full consideration by many authors who submit articles for review. These two areas are "Abstract" and "Style."

An abstract (100–125 words outlining the main ideas of the paper is required) must be submitted with each article. Often, an author neglects to submit an abstract, and this will delay the processing of the article. Occasionally, as Editor, I have sketched out an abstract for an article if deadlines are upon us and it needs to be done quickly; this, however, takes time away from other important pre-publication duties. If an author is uncertain about the style or "look" of an abstract, he/she should scan other abstracts at the beginning of articles in precious issues of *Art therapy* and review the appropriate sections on abstracts in the *Publication Manual of the American Psychological Association* (3rd edition),[1] available from many bookstores, libraries, or from: Order Department, American Psychological Association, P. O. Box 2710, Hyattsville, MD 20784. An author must follow the guidelines presented in this manual relative to style, form, and manuscript preparation.

The second area of concern is style. Because references, especially, are often not submitted in the proper style, it is important for a prospective author to review pages 119–133 in the *Publication Manual of the APA*. Within these pages correct style is given for book references, periodicals, technical and research reports, proceedings of meetings and symposia, nonprint media, and much more. Relative to many articles submitted in the past, numerous references have had to be redone to comply with the APA style. It would be of immense help if each author would review the correct format and style prior to submitting an article for consideration. This, too, would save time for the Editor and/or reviewers.

Enjoy the remaining days of summer and autumn. I will look forward to seeing each of you at our fall conference in Washington.

Gary C. Barlow, Ed.D., A.T.R.
Editor, Art Therapy

---

[1] American Psychological Association (1983) *Publication Manual of the American Psychological Association* (3rd ed.). Washington, D.C. 20036: Author.

Art Therapy with Homeless Women and Children in a Bridge Housing Program in Scranton, Pennsylvania

Sister Dorothy McLaughlin, R.S.M., Ed.D., A.T.R., *Professor Graduate Art Therapy Program, Marywood College, Scranton, PA*

Abstract

This article describes an art therapy program for homeless women and their children in a state-funded Bridge Housing Program in Scranton, Pennsylvania. The goal of this program is to provide a bridge of community services enabling homeless women to reach self-sufficiency.

Art therapy, provided by graduate students of Marywood College under the supervision of the program director, is a means of evaluation and continuing personal development.

Individual evaluation sessions, group art therapy experiences and a case study of a woman who has successfully completed the one year program are presented to demonstrate the use of art therapy in a program for homeless women and their children.

Art therapy is an effective method of evaluating a homeless woman, and it is one of the most successful components of the Catherine McAuley Center Bridge Housing Program in Scranton, Pennsylvania. The goal of the program is to enable homeless women of limited income, living in scattered sites, to cross a bridge of community services to reach self-sufficiency.

A Bridge Housing Grant from the Commonwealth of Pennsylvania, Department of Public Welfare, was received in 1986, by Sister Anne Paye, R.S.M., Ph.D., Executive Director of the Catherine McAuley Center. The program, under the direction of Sister Kathleen O'Halloran, R.S.M., provides a support system based on the right to shelter, dignity and personal decision-making. A total of thirty-five women and fifty-seven children have been served by the Catherine McAuley Bridge Housing Program.

The art therapy is provided by graduate students from Marywood College, Scranton, Pennsylvania, under the supervision of the author. Art therapy is a means of evaluation and is part of the screening process for acceptance into the program. Personal growth and development, goal setting, development of communication and socialization skills, enhancement of self-esteem and emotional expression are some of the major objectives of the weekly individual and group art therapy sessions.

Prior to admission, each woman participates in an art therapy evaluation series conducted by an art therapist. The following series, adapted from the Family Evaluation of Hanna Yaxa Kwiatkowska (Kwiatkowska, 1978) is used: **1.** *Draw anything;* **2.** *Make a scribble drawing or an abstract drawing;* **3.** *Draw a house, a tree and a person;* **4.** *Draw your original family doing something together;* **5.** *Draw a geometric shape and select a color for yourself, then draw a geometric shape and select a color for each member of your original family;* and **6.** *Draw anything.* Six individual sessions are generally recommended; however, three sessions are deemed best in this program. The three are: **1.** *Draw anything and scribble drawing;* **2.** *Kinetic family and geometric family;* and **3.** *House-tree-person and Draw anything.* The evaluation series helps to determine the potential ability of the woman to make personal decisions, to function independently and to manage her own life. Art therapy provides information that supplements the initial interview by the director.

The first art therapy session is important because the establishment of rapport between the client and the therapist leads to a relationship that can be positive or negative. This fact must be recognized at the beginning of therapy. The unconscious process that affects the relationship of the client to the therapist, known as "transference," and the art therapist's feelings toward the client, or the "countertransference," affects the outcomes of future sessions. A working relationship between the woman and the art therapist is essential (Wadeson, 1987). In the first session, the art therapist notes the choice of art materials, the size of the paper, the manner of working, the choice of subject matter, the woman's mode of expression, representational or abstract, and her interests. Color, as perceived by each person, is important in determining

---

"Art therapy is a means of evaluation and is part of the screening process for acceptance into the program."

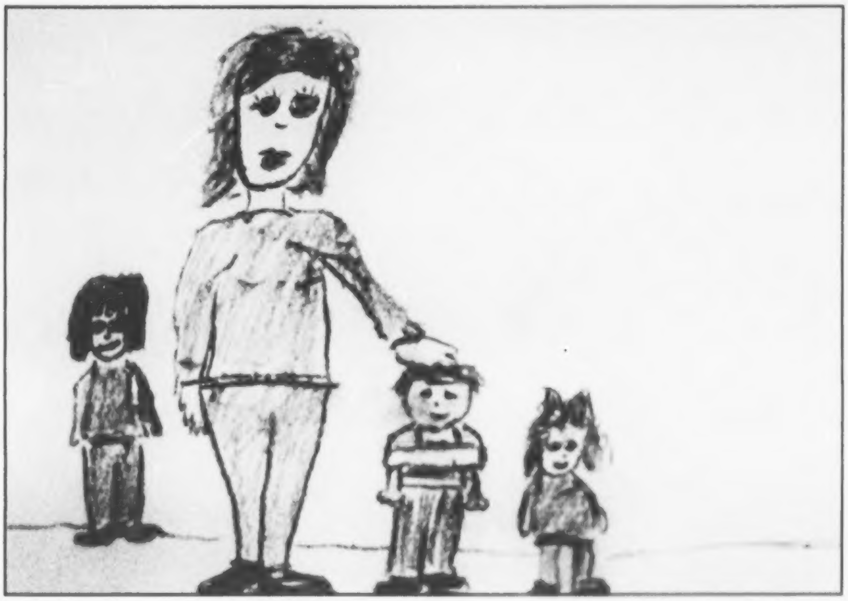


Fig. 1 Evaluation Series No. 6 "Draw Anything"

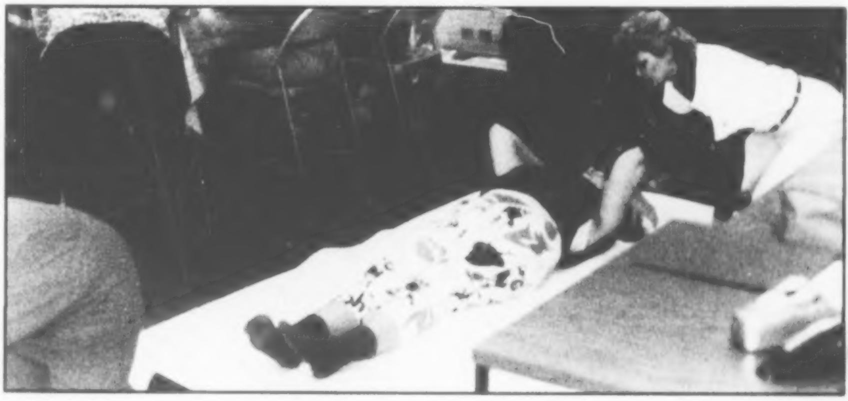
feelings in future sessions. The therapist does not interpret color without the woman's personal description of her color choices.

One of the women recently accepted into the Bridge Program drew a sun at the top of the page and said, "I guess I wanted the sun to shine since it's a cloudy day." The page was empty, except for the sun at the top of the paper. In contrast her final drawing depicts her with her three children and her comments were, "I wish to get my life and my children back in order." She has her two children to the left with her. The child to her right is with the father's family. This woman's wish is to be united as family. (Figure 1)

> *"The evaluation series helps to determine the potential ability of the woman to make personal decisions, to function independently and to manage her own life."*

The kinetic family drawing and the symbolic, geometric family with color assigned to each family member is of great importance in this art therapy evaluation with a homeless woman. The majority of women in the program have a family support system that is meager or non-existent. Each woman, rejected by boyfriend or spouse and family, is seeking a support system elsewhere. In most cases there is no role model for mother. These two family drawings are considered to be the most important in the evaluation series for the women in this program because they generally indicate the break-down in the original family and in the current family structure. Family relationship problems may pin-point current relationship problems.

Fig. 2 Body Tracing



The house, tree, person drawing using colors is a means of reflecting upon concepts familiar to the individual and is an emotional experience which conjures up memories, pleasant and unpleasant (Hammer, 1958). Drawing the house, tree and person on the same paper instead of using a separate sheet for each provides a means of discerning relationships and extends the House, Tree, Person Test of Buck and Hammer, which elicits a projection of self into each of the topics (Hammer, 1958).

The drawing of choice provides the opportunity for the woman and the art therapist to review the series of drawings together and to discuss the art experiences and the continuance of the art therapy program. The relationship between client and therapist, based upon the therapist's belief in the potential of the client and the woman's trust in the therapist, can lead to a healing experience for both.

Group art therapy sessions with the women include the following themes to achieve specific objectives:

1. *Body tracing:* Working in teams of two, one tracing the outline of the

"The majority of women in the program have a family support system that is meager or non-existent."

other, is a task beneficial to the women and their children. The cut-out, completed body portraits provide the opportunity for self-reflection and allow for the in-put of the group. The objective of the session is to develop self-esteem through self-reflection and group support by discussing the body tracing with the others. (Figure 2)

2. *Personal mandala:* The women are from diverse religious backgrounds; about 10% are Catholic. They all believe in God, so art as a spiritual experience is included as a meditation experience. After a discussion of one's color psychology and the varied, individual responses to color connotation, each woman lists her favorite-to-least-favorite colors and what each hue or color means to her. This experience enables her to select the color that best describes her reflection during the meditation experience. Using heavy water color paper with a pre-drawn 12" diameter circle and wet-on-wet water color technique, each woman designs a personal symbol for herself and places this in the center of the circle. After the personal symbol is completed, she is asked to center in on "Forgiveness" and "Thanksgiving." As she recalls a time when she needed to forgive or be forgiven, she uses colors that express her feelings, and she meditates on the remembrance. Events and experiences which are perceived as gifts or joys are expressed as thanksgiving experiences. Each woman shares her meditative experience with the group. The objective for this mandala meditation is to express forgiveness of self and others and to thank God for the gifts and joys received in the day-by-day events of life. (Figure 3)

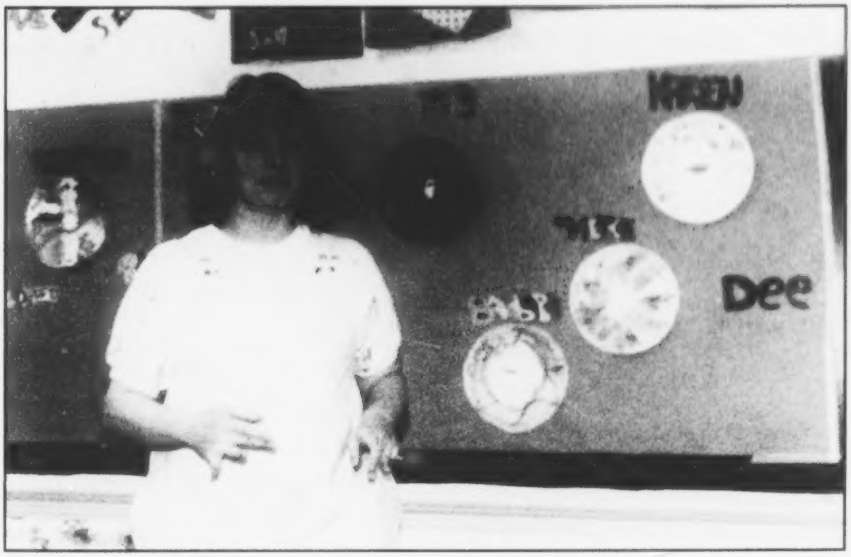


Fig. 3 Personal Mandala

3. *Group mandala:* Three groups of four women design a symbol for the center of a mandala, 36" in diameter using crayons, pastels or markers. Each person draws what her involvement in the Bridge Housing Program means to her and discusses the group mandala with everyone. The objective of the group mandala is to demonstrate the ability to work together and to express thoughts and feelings openly to the group.

4. *Short-term goals:* Each woman selects a goal that she would like to achieve and symbolizes in a drawing how she will go about accomplishing this. She shares her goal with the group and together they discuss the pros and cons of the task. The objective of this session is to identify a short-term goal that is essential to her personal growth and to draw and list ways to achieve this.

Case Study

One case study of a graduate of the Catherine McAuley Bridge Housing Program illustrates the success of the program and the importance of art therapy. Lucy is thirty-one years old and is the mother of seven children, six boys and one girl, ranging in ages from fifteen to four.

Lucy was abandoned by her mother when she was two years old. Her father was an alcoholic, and the court denied him custody of the children. Lucy and her older sister were raised by their maternal grandmother, and her younger sister was adopted by her father's sister. Lucy was married at the age of fifteen.

"The relationship between client and therapist, based upon the therapist's belief in the potential of the client and the woman's trust in the therapist, can lead to a healing experience for both."

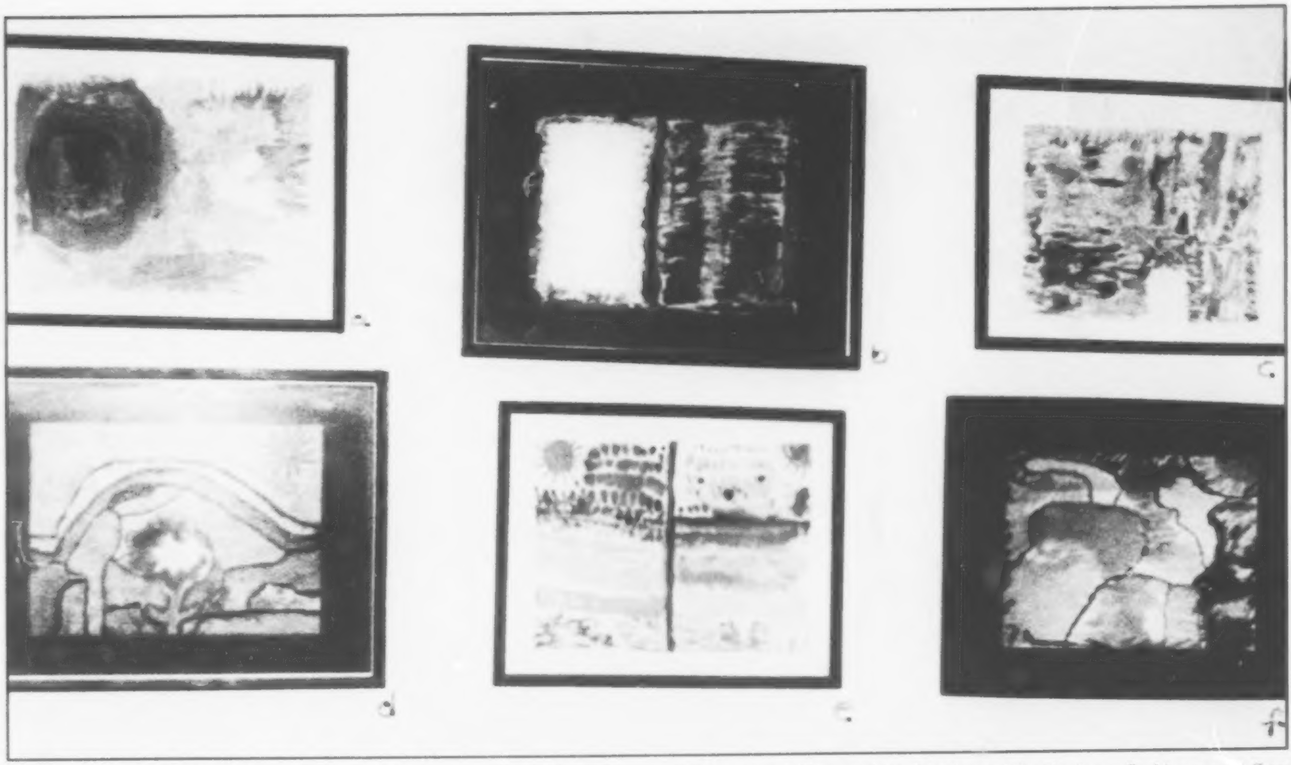


Fig. 4 Top: **a.** Oldest Son **b.** Second Oldest Son **c.** Third Son Bottom: **d.** Betty (daughter) **e.** The Twins **f.** Youngest Son

Subsequent events in her life demand confidentiality so they are deleted from this account. Lucy has always wanted to have a large family.

Lucy moved to Scranton and was living in a house that was condemned, and the family was evicted. Because she was a single parent with seven children, it was difficult for her to get housing; landlords do not like to rent to families with children. Her housing need was apparent, so she was able to get a four-bedroom apartment in one of the projects. Lucy was accepted into the Bridge Housing Program and she became involved in the programs.

Art therapy was well received by this family, especially by Lucy, who has always wanted to paint. She loves color and expresses herself best in abstract drawings. Lucy never complains about having to care for seven children. Her greatest joy seems to be her children.

As a means of getting to know her better and to give her the opportunity to paint, the author held individual art therapy sessions with Lucy each week, using water colors, wet-on-wet technique. Lucy began with an abstract painting of her only daughter, age six, and she discussed how precious this little girl is as she painted a morning glory. "She always wakes up happy," is the way Lucy described Betty. (Figure 4, d) Lucy discussed each child as she painted. She described her oldest boy as warm and loving and laments that she may require too much of him because he is the oldest and assumes a responsible role in the family. She painted a big, red doughnut and made a black center as she commented on his anger. (Figure 4, a) Lucy retained the blank white paper for almost half of the drawing as she described her second oldest as mysterious. (Figure 4, b) Her third oldest she said was like the second oldest. (Figure 4, c) She feels she does not really know these two boys as well as she should. Both boys are introverted. She described the twins as somewhat alike, yet different, and she used the same colors while talking about each. (Figure 4, e) Her youngest son is multi-colored because he is a little bit like each of the other children. (Figure 4, f) We matted and framed her paintings of each child. The art therapy sessions continued at their home where the seven children made a collage about their mother. (Figure 5) After the framing of the collage and the other paintings, the two oldest boys hung the paintings in the living room.

Some of the family art therapy sessions, conducted every Friday evening from 6 until 8 o'clock were: Design a house, design your own room, and make a clay model of yourself. A short-term goal was: no fights in the neighborhood for one week.

Lucy has graduated from the program and is now living in a large, five-bedroom house. She received a certificate as a geriatric nursing aide

> ***"The potential for using art therapy as a catalyst for personal growth and development for homeless women and their children is evident."***

from Marywood College. Now she is ready to commit herself to full-time study. She asked to continue the art therapy as a means of her setting short-term goals and discussing them with another adult. Each Wednesday, the author has volunteered to have an art therapy session focused on goal setting. Lucy's goal is to begin her career in a role focusing on children. (Figure 6) The Bridge Housing Program still provides a support system and the art therapy continues to contribute to the development of a cohesive family system.

Through the Catherine McAuley Center Bridge Housing Program, one small candle has been lit in Scranton, Pennsylvania. The potential for using art therapy as a catalyst for personal growth and development for homeless women and their children is evident. Art therapy is a viable means of expression, a process of identifying goals, a way of developing self-esteem, communication and socialization skills. The establishing of personal relationships leading to a caring support system is the healing gift that blesses all persons involved in crossing a bridge to wholeness.

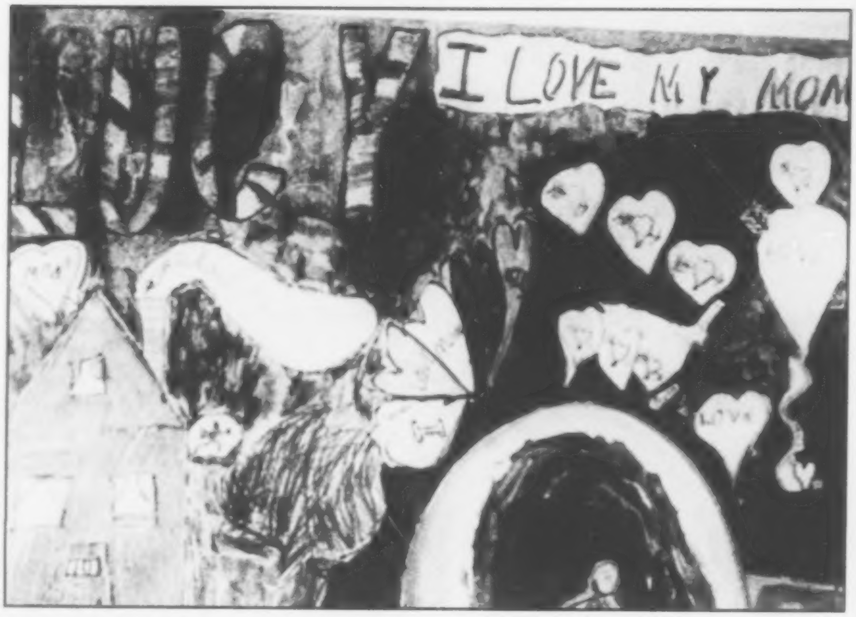


Fig. 5 Collage of Mom

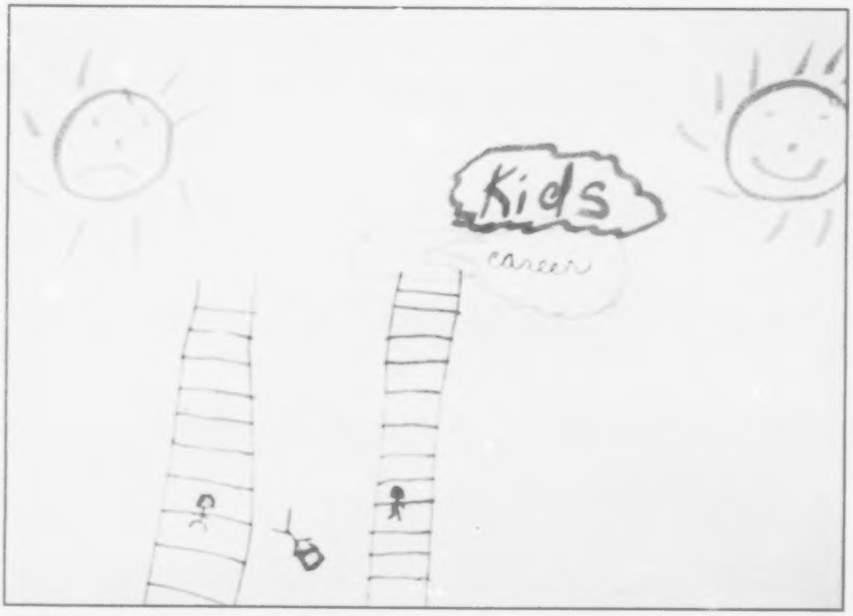


Fig. 6 Lucy's Goal

References

Hammer, Emanuel F. (1958). "The chromatic H-T-P, a deeper personality-tapping technique." In E.F. Hammer (Ed.), *The clinical application of projective drawings* (pp. 208–235). Springfield: Charles C. Thomas, Publishers.

Kwiatkowska, Hanna Yaxa (1978) *Family therapy and evaluation through art*. Springfield: Charles C. Thomas, Publishers.

Wadeson, Harriet (1987) *The dynamics of psychotherapy*. John Wiley & Sons.

Visceral Learning: The Integration of Aesthetic and Creative Process in Education and Psychotherapy

Robert Wolf, M.P.S., A.T.R.

Robert Wolf *is a faculty member at the College of New Rochelle, in the Graduate Art Program, a Visiting Professor for Pratt Institute and a Senior Member of the Faculty of the Training Institute of the National Psychological Association for Psychoanalysis. For over two decades he has taught courses in psychoanalysis, art therapy, sculpting and photography at these and other institutions. As a practicing sculptor, he has exhibited work through galleries in New York City, Westchester, Albany, Washington, D.C. and Boston.*

(Parts of this paper have been taken from the Introductory Statement and Gallery Talk *held in conjunction with* COMPLEXITIES: *An Exhibition of Wood and Stone Sculpture by Robert Wolf, at the Center Gallery of the College of New Rochelle, October, 1989.)*

Abstract

The author discusses and explains how being a creative artist has been an integrative factor and an influence on experiences as a teacher, author, art therapist, psychoanalyst and artist. With focus on non-verbal communication and symbol formation, aesthetic response and modification, and visceral learning (integration of cognitive and affective growth), the author discusses application on many educational and training levels. In graduate art therapy training the author gives, as examples, image transformation classes, phototherapy groups, and art therapy practicum groups. The application within psychoanalytic institute training offers examples such as advanced seminars on countertransference (with a case example presented here). The application in clinical practice offers a case illustrating the resistance conflict through drawing and the working through this resistance through creative imagery exercises as well as working with the transference. This many-faceted article outlines how the author integrates concepts of aesthetics in the creation of two- and three-dimensional art within studio art training, art therapy training, psychoanalytic training and clinical practice.

The Artist's Introduction

As I look back over my professional career which now extends through a period of over twenty-one years, I realize the difficult and complex task, I have faced in attempting to integrate my experiences as a teacher, author, art therapist, psychoanalyst and artist.

I have discovered that my own creative work, particularly my sculpture, has facilitated this process of integration. This article is an attempt to explain how my experience as a creative artist has influenced my work in these various areas of my life.

PART I

Non-verbal Communication and Symbol Formation

We all, at first, experience our early environments on a non-verbal level. As perceptual experience becomes more differentiated we react viscerally to what we perceive as images, sounds, smells and feelings. We express ourselves through action and gesture. Later, we learn to organize our thoughts into symbols and eventually we further synthesize our experience into secondary process language. For most people, words and cognitive thought begin to take precedence and cover over the more powerful precursors of language, even though these affective perceptions continue to be present on all levels of interactive experience.

Photograph of the author with a recent sculpture in orange alabaster

As artists, we continue to explore our non-verbal imagery and by doing so, become familiar with and seek to integrate our primary process functions with secondary process (Robbins, 1987). Through the process of creating artwork we can go back to our basic visceral form of experience and learn to re-own powerful, pre-verbal parts of ourselves.

Our unconscious and preconscious are receptive devices which collect raw perceptual data; we never truly forget what we experience. We are constantly collecting data on a variety of perceptual levels. In fact, most perceptual information comes to us non-verbally and is held in our unconscious; otherwise our conscious thought processes would be quickly inundated. We condense and store much of these data as visual images or symbols but we can learn to recapture the importance of these experiences, and foster integration, only if we train ourselves to encourage the ego regression which we must undergo in order to reach these primitive places within ourselves. Once we retrieve these symbols, we must learn how to work with them in order to unlock their meaning and power. In fact, they may even be distorted and in need of aesthetic restoration or modification before their true meaning may be understood.

"We are constantly collecting data on a variety of perceptual levels."

Aesthetic Response and Modification

The concept of aesthetics may be seen, within this framework, as a physical manifestation of what feels subjectively 'right' on a variety of levels. We often say that something is aesthetically pleasing or not pleasing based on this inner subjective experience which monitors the variety of affective levels described above.

Certain aspects of aesthetic response may be culturally or *personally* influenced, such as one's sense of optimally spacial distance between the subject and the object, while others may take on a more universal quality, such as when we agree that a particular work is indeed a 'masterpiece' or 'classic.'

Certain schools of art therapy and expressive therapy suggest that if we discover that a person's sense of aesthetics is 'out of balance' with what is our accepted norm, we can influence him or her to correct this aesthetic sensibility to conform to higher aesthetic standards, and in doing so, we may simultaneously improve his or her inner state of psychological balance. Simply stated: as we strive to correct aesthetic distortions in our artwork, we are simultaneously attempting to reshape the impact of our earliest visceral experiences which have contributed to the original formation of the art/image. This can have an integrating effect on us.

For example, Zierer (Zierer, 1987) has introduced the idea of the art therapist deliberately adding what she called "push strokes" to a patient's work to intentionally break up the aesthetic balance. The patient is then instructed to re-work the painting, this time pushing it toward a higher level of aesthetic integration. She claims, through this approach, to demonstrate a parallel improvement in her patient's mental functioning.

Robbins (Robbins, 1989), in his discussion of Ehrenzweig's concept of "ego rhythms," proposes that depth-oriented psychotherapy which aims to promote structural change, must help patient move between the ego states of "formlessness and form" or, to put it differently, between primary and secondary processes. Because one's ego is most easily receptive to modification through assimilation on this visceral level of experience, one's sense of identity and 'self' are seen as being enriched or enhanced through the exercise of this rhythmic process.

My concept of being 'out of balance' and striving to achieve 'balance' moving back and forth between these divergent ego states adds further dimension to these ideas. By letting my art serve as a reflection of primary process, on a level of visceral perception, I can then shift to secondary process functions which help me to recognize, organize and ultimately metabolize this energy in an integrative manner.

How These Concepts Effect My Work as a Sculptor

As a sculptor, I use this same process to externalize feelings stirred by intensive clinical work and personal experience. By creating my own art, I am able to see where I become 'out of balance,' as it is reflected back to me through the various forms which may then too, seem 'out of balance.' As the artist in me then strives to correct this imbalance, a subtle change often occurs within me which translates into renewed objectivity within my clinical work. Personal issues, not exclusively related to clinical work, but often interwoven within the experience, may also be unwoven and worked through in this process. This technique is often accompanied by secondary process associations which bring cognitive understanding

"The concept of aesthetics may be seen . . . as a physical manifestation of what feels subjectively 'right' on a variety of levels."

to the experience, and may indeed be likened to Freud's concept of 'Self-Analysis.'

Each piece of my own scultpture reflects a time in my life within which an affective issue was externalized and restructured through this process. Some may represent clinical dilemmas stimulated by an interaction with a current patient, while others are more personal in nature. It is very likely that even clinically stimulated issues had some personal conflict interwoven, as is often the case with complex transference/countertransference phenomena.

Certain of these experiences are clearer to me than others. For example the 'COMPLEXITIES' piece itself, which I chose as the title-piece of a recent Solo Exhibition, took well over five years to complete and clearly reflects a time when I struggled to integrate seemingly diverse parts of myself, the artist and the psychoanalyst, and to find a new integrated identity within these complex and challenging personal and professional worlds (see illustration 1). Another piece, titled 'THE BEGINNING' was created during a period when my wife was pregnant with our first child (see illustration 2). I sculpted the form with steadfast determination, moved by a driving force which I did not at that time understand. Months later, looking at the finished piece I was struck with the embrionic sense of form and gesture. It was only then that the full

> ***"There is great satisfaction in developing new ways to teach artists, art therapists and psychoanalysts how to recognize and harness the power of their individual creative energies."***

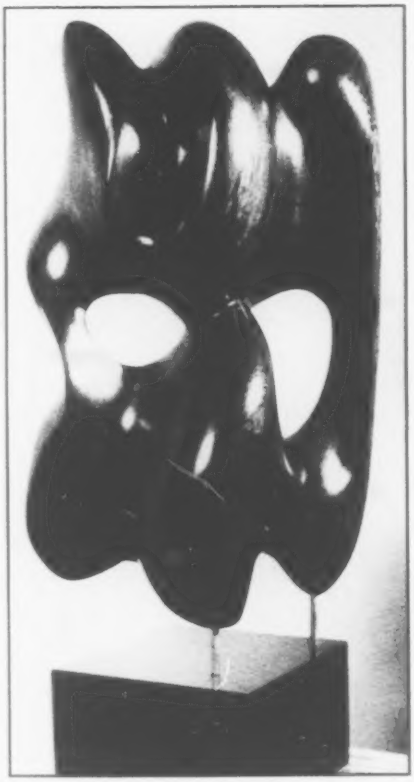


Fig. 1 "Complexities"

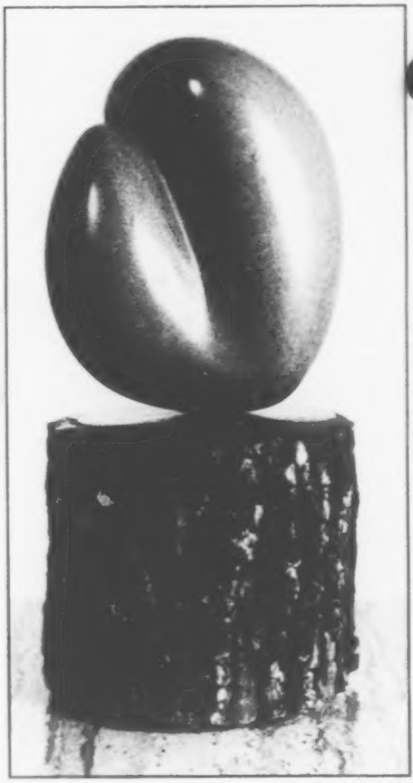
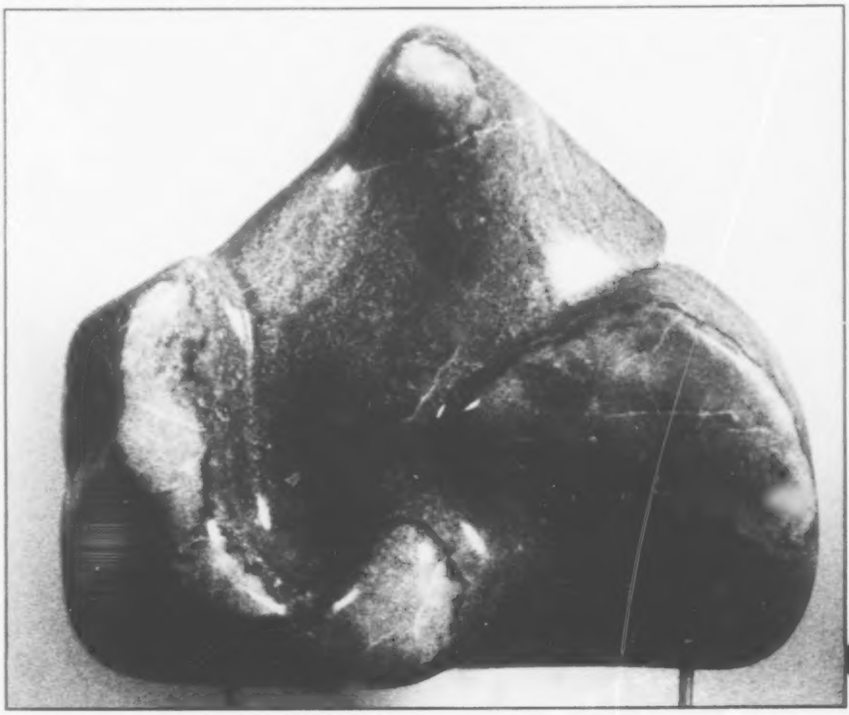


Fig. 2 "The Beginning"

Fig. 3 "Woman Holding a Secret"



impact of my 'sympathetic pregnancy' and parallel emotional experience was revealed to me. Another piece, THE WOMAN HOLDING A SECRET, was named by a close friend who took one look at the finished sculpture and spontaneously articulated what I had been trying to communicate, but had been unable to put into words (see illustration 3). In time I realized that this piece served to help me work through strong feelings of loss associated with another friend who had suddenly been diagnosed as having a terminal illness. She was indeed holding a secret which was to unfold throughout the next few months with devastating impact.

PART II

Visceral Learning: Integration of Cognitive and Affective Growth Through Creative Experience

This part focuses on the impact of conducting psychotherapy on creating artwork and the effect of creating art on one's ability to practice psychotherapy and teach. The concept of 'Therapist' is expanded to also include 'Teacher.'

There is great satisfaction in developing new ways to teach artists, art therapists and psychoanalysts how to recognize and harness the power of their individual creative energies. This process for me is yet another expression of my own drive for aesthetic experience and creative expression.

As a Psychoanalyst, Training Analyst and Graduate Art and Art Therapy Faculty member, I have discovered that one of the most helpful and provocative concepts which I can use in my clinical work and demonstrate to students, is how to get in touch with one's inner nonverbal imaginal responses or reactions to one's external experience, and how to use it both clinically with patients and within oneself to promote psychic growth and integration. This concept is demonstrated in the following sections, with specific modifications, for each of these educational and clinical settings.

Application in Graduate Art Therapy Training

A. *Bridge Courses:*

Within the Graduate Art Therapy Curriculum I've developed what I call 'Bridge Courses' which provide studio art quality experience within the framework of Art Therapy Training Groups. Students are exposed to sensory stimuli and are encouraged to react through visual images. These images are then transformed into three-dimensional models and finally into gallery quality stone sculpture. This process demonstrates the power and importance of personal images, as each finished piece generates a personal field of energy within which the student/artist may resonate and rediscover a previously lost part of himself/herself. This reemergence of lost symbols is often accompanied by powerful affective reactions, similar to abreactive responses to well timed psychoanalytic interpretations which are designed to push one towards bringing repressed material into consciousness. This experience demonstrates the power of art therapy in an affective manner so the 'learning experience' takes on a vitality beyond the limitations of a purely didactic or cognitive exercise.

Example 1: *Imagery Transformation Class*

Donna, a first year art therapy graduate student, began to carve a piece of alabaster in the shape which she had evolved first in two dimensions. After a short while, it was apparent that Donna was having a very difficult time learning how to master the tools effectively. She seemed unable to have much impact upon the stone. The harder she tried, the more the stone seemed to have a mind of its own and resist her effort. As Donna was as physically capable as any of her classmates, who were all pulling farther ahead in their work on similar stones, we became aware that this 'experience' was communicating something for us to understand, on a deeper level.

When asked to describe her feelings about the stonecarving experience, Donna began to explain that she had recently been hospitalized and found to have a previously undiagnosed illness. She described her reaction to this discovery as her being angry, frustrated and hopeless, but she had tried to *overcome* these feelings by surrounding them with an emotional wall, "for otherwise, I might not be able to function effectively in my everyday life."

It soon became clear to Donna and the class, that the process of chipping away at the stone closely paralleled the feeling of chipping away at her 'emotional wall.' Because Donna feared the reemergence of her angry, futile feelings, she was unable to effectively cut through the stone which had become a symbol for her defensive stance, while displacing the affect of frustration onto the stone. As we explored this phenomenon, Donna was able to see that experiencing her anger and futility was actually essential for her to work through this traumatic discovery.

By looking at Donna's overall experience in attempting to carve her stone and viewing it as an unconscious communication which was being sent out into the world, needing to be received and understood, we were able to help Donna re-integrate this important split-off part of herself.

B. *Phototherapy Training Groups:*

Within the Graduate Art curriculum I have developed a sequence of courses, starting in basic photography and leading to advanced photography and ultimately phototherapy, which explores the value of non-verbal communication through photographic images. Here, at this most sophisticated level, technically skilled students work together as a group to explore their own reactions to creative exercises.

Students are assigned stimulating creative projects such as 'redesign your childhood through modifying family snapshots' or 'create a self-portrait photograph without using an image of yourself.' The results of these exercises are systematically explored and processed by the ongoing group. Eventually, the art therapy students may go on to develop and apply these and other original techniques in clinical settings. For the art students who engage in this process, the results can be quite gratifying as they experience the power of their unconscious and begin to understand its effect upon their creative imagery. The over-worked stereotyped view that 'therapy' inhibits one's creative expression is exposed as untrue and, in fact, is clearly experienced as just the opposite!

Example 2: *Phototherapy Training Process*

Melissa, a graduate art therapy student enrolled in a PHOTOTHERAPY class, presented her experience as she began to work on her FAMILY HISTORY ELABORATION project. The directive had been: Re-photograph various family snapshots taken when you were a child or later as an adult, and, using a variety of creative darkroom techniques, elaborate or change the images to express something that you would have liked to be different.

Melissa explained how as she began to sort out a batch of old photos, she had spontaneously burst into tears as she was suddenly gripped by intense feelings which seemed to come up without warning. She explained that she could not immediately understand her sadness, but had, upon reflection, realized that she had been drawn to examining a particular time in her childhood when she seemed to suddenly look and obviously feel 'different.' She went on to explain that in spite of careful exploration of her childhood in ongoing psychoanalytic psychotherapy, she had been unable to understand, more precisely, her vague feeling that "something had happened along the way" which had had great impact upon her. This intrapsychic shift had eluded a more detailed verbal exploration until now. For Melissa had begun to see, when she spread out her family album photos, a particular time in her life when both maturational and familial factors converged in a traumatic way. Without this visual experience, these issues might not have been identified and explored. The impact of the visceral image was able to break through secondary process defense structures and overcome a therapeutic stalemate.

This shared experience was a wonderful learning tool as it communicated on a powerful, affective level, the effectiveness of using photographic images in psychotherapy. Both Melissa and her classmates were deeply moved by the experience.

C. *Art Therapy Practicum Groups*

In the art therapy Practicum, students learn to draw their image responses to clinical concepts and case material. As they become familiar with this level of communication we continue to demonstrate the power of the non-verbal part of ourselves which is constantly reacting to nonverbal parts of our patients and ourselves. Students become highly sensitized to the power of their own imagery, and its ability to transcend secondary process defenses.

Example 3A:

Betty, a second year art therapy student, presents a case from her clinical fieldwork to her Art Therapy Practicum group. As she begins to drone on about her case which 'seems' interesting, her affective disconnection from the material, along with her defensive intellectualization, are reflected back to her by her classmates who have been instructed to react to class presentations by drawing their spontaneous image responses and share them with the presenter. This technique demonstrated how the peer group can focus on non-verbal levels of communication offered by the presenter. The instructor structures the resulting discussion to explore images which arise in response to both the patient's and presenter's unconscious process. These images are examined within this transference-countertransference paradigm.

The group's drawings are compartmentalized, rigid and fragmented. Chaotic forms were drawn often encased in thick lines or shattered in splintered pieces. Surprised by the group's response, Betty struggles to find the source of her disconnectedness, and cautiously reveals striking similarities between the patient and an ill family member. As she descibes this realization, she becomes more connected to her feelings and the presentation proceeds in a more integrated manner, as her over-identification and initial defensiveness are understood and worked through.

Example 3B:

We recently began another Practicum supervision group and became aware that one member, Marlene,

---

". . . my work as a clinician has taught me to have a great deal of patience, which is also an important factor in stone sculpting."

---

seemed to be engaged in an internal struggle whether or not to present a case with which she was having difficulty. Fellow students quickly picked up her tension and questioned her about it. With reluctance, she admitted that she was about to 'give-up' and admit 'defeat' with a case of a eight year old boy whose parents had both recently died of AIDS. He was living with an aunt who complained that he was out of control and she was at her 'wit's end' in dealing with his abusive behavior. This boy had begun art therapy sessions and had consistantly tested the limits which Marlene had established. She had adapted a position of trying to contain his aggression. This theoretical stance had led to a further regression whereby Tommy had most recently begun to throw bits of clay at her. Marlene justified her position quoting concepts by Bion and Winnicott, yet, something felt 'out of balance'' given the escalation of Tommy's behavior and his subsequent refusal to come to future sessions.

The group absorbed her story and sat, for a few moments, in deep thought. I asked for people to describe their images to us. One person described wanting to reach out and shake Tommy, another described how she'd like to take a large bull-horn and yell at Tommy to "Stop it." This image struck Marlene, who described how her supervisor had mentioned that she seemed to be too uptight and needed to loosen up and 'play' more with her child clients. I asked her to elaborate this image and as a group we came up with a creative intervention for her to employ. She would draw a comic book for Tommy and in it, illustrate this cartoon of her 'giving up,' and letting Tommy 'win' the battle over control of the art therapy sessions. She would be able to distance herself enough from the feeling of being stuck to creatively articulate the situation in a humorous way, mirroring back to Tommy, a sense of being understood and therefore, paradoxically, not abandoned. This felt aesthetically 'right' to her.

In the discussion which followed, it became apparant that the initial feeling of 'giving-up' was a multi-determined communication starting with Tommy, as a feeling of deep despair and loss, and projected onto Marlene, for her to either use as a device to deeply empathize with Tommy, or, to act-out and re-confirm that the world is indeed a hopelessly rejecting place. This experience of Tommy being out of control, touched a profoundly similar experience from Marlene's past and she had begun to close off this affective connection by adapting the defensive position of closing down and disconnecting. With the help of the group, Marlene was able to begin to understand this process. Her dilemma was clearly understood and a solution was discovered through the use of creative imagery which bound up the destructive potential of the projective identifications.

Application Within Psychoanalytic Institute Training

Next, at the Psychoanalytic Training Institute, I have developed ways for the analyst-in-training to become sensitive to his or her own affective and imagery responses to patients. I demonstrate how these responses may be visual in nature and show how and when we can use these responses in our clinical work (Wolf, 1985).

Example 4: *Advanced Seminar on Countertransference*

Mona, a psychoanalytic candidate, presented the following material:

"During a recent session with my patient, a middle aged woman who I've been seeing 3x a week for the past 2 years, the patient, who I'll call 'P' suddenly bolted up from the couch as I made an interpretation and announced, as she literally cringed, that she experienced my comment as an attack or assault upon her."

Mona reported her own countertransference reaction as being confused, feeling suddenly in the middle of a turbulent place. I asked if she could find an appropriate IMAGE and she replied: "I'm swept up in a *tidal wave*, spinning around and around."

I explore this further and ask her to close her eyes and imagine she's in the wave now and describe to us what happens. "I'm spinning, bobbing up and down, gasping for air, afraid I'll drown." She's visibly shaken and I ask her now for associations. "Beaches, as a child, with my mother I almost drowned. We were together in the ocean waves, and we were both swept away, several times and almost drowned!" What about mother's presence, I asked? "She was hysterical, worse than me, she incited anxiety and panic and was no help to me."

I said: Your patient reacted to your interpretation with a sudden and startling feeling of being assaulted and this frightened you. You couldn't, at that moment, call upon the soothing and calming presence of your internalized mother because your mother was not, in reality, that way, so you grew panicky and were inundated and overwhelmed by your patient's intensity. In your anxious state, like that of your own mother, you couldn't be with your patient to calm her and explore where, for her, this sudden transference reaction was coming from!

As I said this, Mona relaxed. She was clearly less agitated and seemed to understand what I had said, on a visceral level.

Next week in class Mona reported that it seemed as if her patient had been listening to our discussion in class the week before. She had reported that she felt confusion and turmoil during the session in which she reported feeling assaulted. Mona had then shared her image of being swept up in a tidal wave and the patient said, "that's right, I felt like I couldn't tell who was being swept away, you or me!" Once having cleared the air in this manner, Mona was able to go back to the patient's material and explore it in more detail. She was able to become a calming and soothing presence for her patient who needed this to counteract the intensity of the negative transference reaction.

Mona's image of the tidal wave served to help externalize her own countertransference feelings which were triggered by feeling "swept away" by her patient. For as she had been trying to maintain an empathic connection with 'P' by making interpretations, 'P' seemed overwhelmed, out of control and far away. As these issues were brought out into conscious awareness, Mona was freer to see the differences between herself and her patient. She was no longer swept away. She said "I can now see how my identification with my helpless, ineffectual mother was also a defensive reaction to being accused of attacking 'P,' and, by being stuck in that place, I couldn't piece this all together until now."

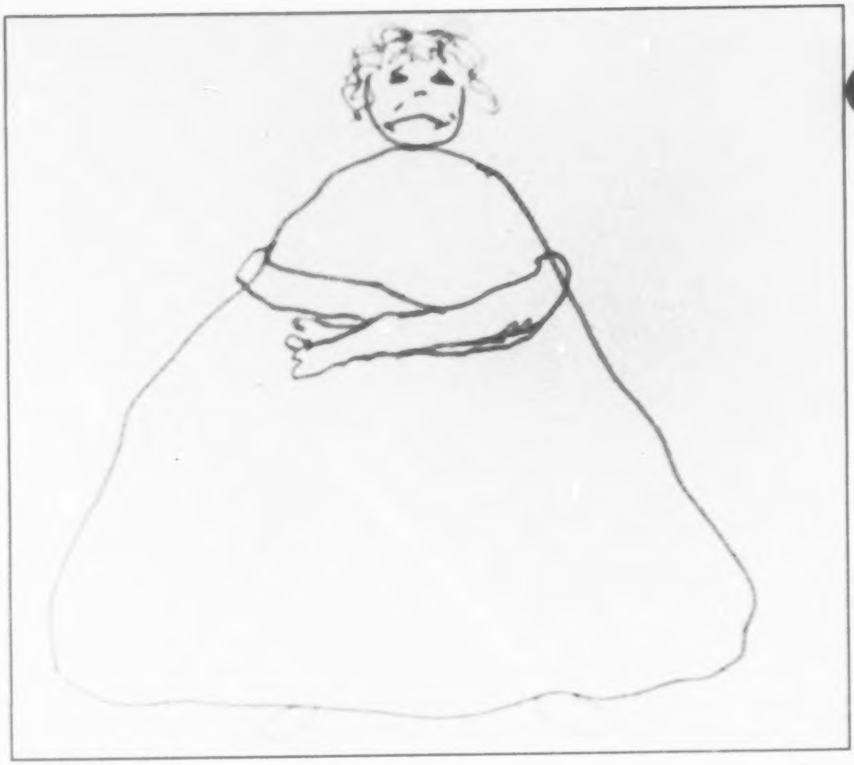


Fig. 4 "Vanessa: The Rock"

Application in Clinical Practice

Within my clinical practice I use my artistic skills to scan material presented by patients and sense where there is an aesthetic imbalance. I then refocus the patient in this direction and help guide patients to deeper personal insight and understanding through a variety of clinical interventions.

Example 5: *Integration of Aesthetic Experience Within Psychoanalytic Psychotherapy*

The following is a transcript of a sequence of three psychoanalytic psychotherapy sessions which demonstrates how the artist in me influences my work as therapist. As an artist, comfortable with the complexities of multidetermined levels of communication, I am able to listen and flow with the multiplicity of issues presented by this patient. I use my creative energy to react to her in ways which foster a clarification of these issues and promote insight, growth and integration.

VANESSA

History:

Vanessa, a 29 year old artist, has been in psychoanalytic psychotherapy for five years (individual + group). She has recently experienced a strong phase of resistance to our work which has manifested in her 'feeling stuck.' The manifest issues which she presents have to do with problems she is experiencing with her two year old child, with her weight problem and with her relationship with her husband Jerry. As these sessions unfold we begin to see how these issues are woven into a fabric which needs to be responded to in creative ways in order for Vanessa to untangle them, understand their impact on her life and integrate this understanding within a new, more resilient ego structure.

Session 1: *Identifying the resistance conflict through drawing:*

P: "I'm not getting along with Jerry lately—I hate him, we're always arguing. The baby threw up in the car and he was no help to me, he just spaced out, I yelled "Help me!" My friend Kathy just walked out on her husband, he was such a jerk!'". . . . Jerry says after all these years of therapy I'm still so miserable, complaining, unhappy and negative, maybe therapy isn't working for me and I should quit. Why do I hold onto so much old shit? I want to change but I keep waiting for 'it' to happen to me, I get so MAD when I realize that I have to do 'it' myself. I waste so much time. . . . I realize I could set it up so Jerry would leave me if I keep this up."

TH: "Or, you could make your relationship work well."

P: "Yes, that's true. I use a lot of energy being stubborn and negative, I feel smug like a child sitting like a rock saying "You can't make me do it, *I won't do it for you!* As a child nobody liked me the way I was, so I tried to be whatever they wanted me to be. The ROCK was my way to say fuck you—I won't be what you want me to be."

TH: "Can you imagine yourself as the ROCK?"

P: "Yes, it's triangular, with two little feet and hands, arms crossed with a tiny head balanced on top (see illustration 4)."

TH: I ask her to draw, she reluctantly agrees and I laugh at her ambivalence, and say "you know, rocks really don't draw!" She laughs at my playful remark as it points out to her that while she may feel like a rock, only part of her is experiencing herself as the rock, and that there is a healthier side which is striving to overcome this resistance.

I ask her to describe what she sees in the drawing.

P: "Now I'm angry, infuriated—I feel I'm in a straight jacket, like my head could roll away, like it's not attached, but I know better, I don't want to go there now."

TH: "You act as though experiencing this image will give it power over you, but, in reality it won't."

P: YELLS—"I didn't do this to myself! Someone else did this to me! I didn't do this, someone should take me out. I don't have any responsibility for doing this. I'm mad, look at me, I didn't do this. I want to scream."

TH: "It looks to me like the figure is actually behind the rock, HOLDING ONTO IT!"

P: "I don't want to feel that I'm doing this to myself. I don't want to take the responsibility for doing it, *because then I'd have the control to let go of it!* I have such resistance to hearing you say this. It's so simple, how can I justify the past and all that pain if I admit that I caused so much of it by holding on."

TH: "So you'd continue to carry this rock forward into your life and risk your marriage and your daughter, in order to 'justify' your past behavior?"

P: Indignantly "Yes!" she cries. . . . "I'd be naked without my ROCK!"

TH: "What would you look like without the rock?"

P: (finding new strength from this idea) "I could buy new clothes that I liked. I see that I'm dead with the rock, but without it there'd be room to change. I need to chip away at this!"

Session 2: *Further working through the resistance through creative imagery exercises:*

P: "My life is too hectic, I need time for myself, to paint . . ."

TH: (Getting back to last session's image) "Paint ROCKS?"

P: "You'd be the one to chip away at my rock, you're the sculptor. I'd just be holding it. I'm so afraid to change it myself, afraid of what is inside and what would come out. I'm afraid I'd smash it or chip away too much so I couldn't put it back."

TH: (bringing in the weight issue) "Like the way you're afraid to lose too much weight?"

P: "Yes, I'd have less of a barrier between me and the world. I'd feel raw, vulnerable, yet ALIVE, but I'd have no insulation. Men would find me too attractive and I'd have to say yes. I'd have NO BOUNDARIES."

TH: "So loss of weight means loss of boundaries?"

P: "Yes, that's what it is. I'd leak out into a puddle and lose my shape. My skin would be too thin to hold me together. I couldn't stay intact! I'd have nothing left, no core, nothing but dust!"

TH: Genetic interpretation of underlying conflict: "You never discovered how to establish boundaries without creating your rock, but you're beginning to understand the price you pay for holding onto this rock."

P: (confirms my interpretation) "I always separated myself from my family by being the 'fat' one. Jerry has been losing weight lately, he looks so great, I'm so jealous. . . ." (begins to go off on tangent)

TH: (feeling resistance come alive in the room) "You're feeling resistant now?"

P: "I'm very aware of holding the rock at this moment, and I don't know what to do with it. I can't chip away at it if I'm holding it, if I drop it it'll break and crumble, and if I put it down it's not covering me. I NEED IT!"

TH: "Talk to the rock."

P: ". . . I need you. I need to hold you, hold onto you forever, yet my arms get tired and I can't do anything else while I hold you. I have no freedom, I have to use all my strength to hold you, then I have nothing left."

TH: "Now you be the rock and answer."

P: ROCK: "I'm dead. I feel nothing, I don't care what you do with me, I have no purpose in all of this except to 'BE.' This is your thing—not mine!"

P: Insight: "When I'm the rock I feel dead, when I'm me I enfuse my energy into the rock. It's a neat package. It rationalizes my not doing anything to change."

Session 3: *Working with the Transference:*

P: "Still feel smug and defiant. I want you to make me change but if you dare try to push me I'll dig my heels in deeper. I want you to make an interpretation which will make all of this go away so I can move forward."

TH: "Maybe this is what you need to be doing, and it doesn't have to be the Met, or the greatest opera singers, or the greatest interpretations by other people that will make everything better."

P: "My child is so strong-willed, she's a mirror of me. We butt heads, I'm out of control, I'm her slave, yet I admire her strength. I want to be the child, but who will take care of me?"

TH: Transference Interpretation: "You're playing out your conflict over control and power with your daughter, and also here with me."

P: "I feel like this big baby and we battle for space. My mother said that I never did this with her. I was terrorized into not doing it. But by playing this out now, for the first time, I feel so powerful and in control of the whole world. I want to give my daughter this sense of being empowered, in a healthy and good way. But instead I just engage in power struggles with her. I'm afraid to be firm with her and I let her run wild, then I feel terrorized by her. I roll in the shit and complain of being powerless. I love wallowing in shit."

TH: "Can you imagine yourself in the shit?"

P: "Yes, I'm alone, going at my own pace, exploring it, feeling it, I don't ever have to stop." Insight: "I never had this kind of 'unlimited space' as a child. Mother would always intrude on my space."

TH: "Now we can understand why you have needed this space to feel stuck, and not be pushed out of the shit until you are ready to move out."

P: "It just felt like you took two wires out of my head and reversed them and stuck them back in a different way. It's like things are re-framed for me."

TH: "When you are ready to move on you will do so and feel empowered to make changes in your life, whereas if you're pushed out before you're ready, you'll feel helpless and powerless and 'rescued' by the powerful other person."

Over the next few weeks, Vanessa was able to slowly metabolize the insight gained through this creative, therapeutic experience. We were able to use other drawings to further articulate feelings and conflicts during this particularly important phase of psychoanalytic treatment.

If I had taken a more classical psychoanalytic view and simply interpreted her resistance *as merely resistance*, I would have missed the opportunity to explore and understand the significant issues which were being communicated through the resistant behavior. We needed to shift gears so to speak, and move from the language of words to the language of images, and back to words. These images contained the raw power and energy which had been split off and inaccessible to verbal intervention. As they were discovered and explored, Vanessa began to play with her conflicts in a way which gave her space to see the issues more clearly and ultimately move ahead and out of the resistance phase. This is a clear example of how a creative act may be utilized to overcome a resistance (Robbins, 1975), as well as an example of how patients need to understand the value of their resistance and defense mechanisms (Robbins, 1989)

I believe that it is the same quality of elasticity of my own ego, which I exercise and utilize in my creative work as a sculptor, which I also utilize here in clinical work to move in and out of the complex layers of communication presented by this patient. Ultimately however, I must rely on my knowledge of theory and experience as a trained psychoanalyst to synthesize my own levels of perceptual and affective experience and formulate appropriate interventions. This case presents to us a clear example of how this form of ego splitting within the therapist, along with his ability to move easily from secondary to primary and back to secondary process level of thought and communication, clearly benefitted this patient who might have continued to feel 'stuck' if a more traditional method of treatment had been rigidly adhered to.

Some Thoughts on Parallels Between Personal Artwork and Clinical Experience

As I begin to think about the similarities between stone carving and clinical work I am aware of many parallel experiences. For example I can see how my work as a clinician has taught me to have a great deal of patience, which is also an important factor in stone sculpting. Perseverence, and an appreciation of the time needed to evolve and integrate new ideas and connections has been taught to me through my work in both of these disciplines.

My work with patients has taught

me to use my sensitivity to know when to dig more deeply, or when to retreat and back away. It has taught me to respect the power of the unconscious and to feel comfortable enough to permit ego regression, which encourages the externalization of highly cathected symbols. It has taught me how and when to mirror a patient and as a result, I find a heightened ability to resonate with my stone, to reach a place where it feels like the stone is telling me what it needs to have done to it.

This experience may indeed be similar to Winnicott's 'Primary Illusion' where the infant child believes that he magically creates that which he needs, i.e., that which is really coming from the outside is experienced as magically created from within (Winnicott, 1975). In my example, there is, through the process of projective identification, a remarkable reversal whereby I am identified with the stone and I feel as though I magically create myself!

As the years go by, for those of us who engage in depth-oriented clinical work, there is an increasing need to find some way to externalize the toxic inductions, projections and introjections which are inevitably taken in. As therapists, we learn to discipline ourselves, to not act-out these induced feelings with our patients. I have become increasingly aware of the importance of my artwork in facilitating an important avenue of discharge of these feelings. At times when I am struggling with how to deal with a particularly difficult patient I seek the organizing effect of the sculpting process. Other times I may just need a more general experience of seeing some concrete change effected by my energy to counterbalance the painfully slow and imperceptible changes in certain patients, which tend to build up as frustrations within me.

Finally there comes the question, "When do you know when a piece is finished?" Here too is a parallel: "How do you know when a patient has gone as far as he can in treatment?" I have learned to listen carefully to the patient, to listen for clues that an integration of the resolution of issues which has led to growth has been achieved, and for the moment, the growth seems to be stabilized. There is often a feeling of 'balance' about this person, an inner peacefulness along with a sense of vitality and energy which has been freed from psychic conflict to now be used in the pursuit of quality life experience.

In deciding when a piece of sculpture is finished I look for a similar kind of balance and integration. The form should work well from all angles. There should be tension, excitement or energy present which had not existed before.

At times a patient may return to treatment at a later period of his life. What had been resolved sufficiently, at an earlier period, may now need further work. Sometimes certain people, especially young people, have had only limited life experiences and some conflicts may not have had the opportunity to be exposed prior to entering treatment therefore necessitating further treatment at a later time. I have found the same is true with my sculpture. I sometimes feel a piece is ready to be polished only to find that when I view the finished piece, there is still something out of balance or incomplete. Sometimes this feeling may not be immediately apparent to me, and I may wait months, or even years for the piece to become, once again, 'unresolved.' This may of course never happen to a piece which can remain 'resolved' forever (if there is such a time-frame!). I believe that there are times when it is best to leave the piece alone, even if it loses some of it's power for you, and other times when re-opening and re-working the piece may lead to some further integration. This decision must be made intuitively, just as one must carefully weigh the decision whether or not to re-enter treatment.

CONCLUSION

In this article I have attempted to outline how I have been able to integrate concepts of aesthetics, or what I call 'Visceral Experience,' as found in preverbal perception and symbolization which occurs in the creation of two- and three-dimensional art, within the seemingly diverse areas of studio art training, art therapy training, psychoanalytic training and clinical practice.

On a final note, I truly believe that the very best way to enhance one's training as a depth-oriented psychotherapist, whether verbal, nonverbal or expressive, and be able to meet your patients on whatever level of relating they are functioning, is to develop your own artistic and creative skills. The flexibility of ego states which is constantly being exercised and strengthened through creative work, along with theoretical, clinical and personal knowledge, becomes your greatest assest in these challenging and demanding professions.

References

Robbins, A. (1975). *Expressive therapy: A creative arts approach to depth-oriented treatment.* New York: Human Sciences Press.

Robbins, A. (1987). *The artist as therapist.* New York: Human Sciences Press.

Robbins, A. (1989) *The psychoaesthetic experience, an approach to depth-oriented treatment.* New York: Human Sciences Press.

Winnicott, D.W. (1975). "Transitional objects and transitional phenomena." *Through paediatrics to psychoanalysis.* New York: Basic Books.

Wolf, R. (1985). "Image induction in the countertransference: A revision of the totalistic view." *Art therapy,* Vol. 2, No. 3, October, 1985, pp. 129–133.

Zierer, E. (1987). "Creative analysis involving multidisciplinary evaluations of a case study." *Art therapy,* Vol. 4, No. 3, October, 1987, pp. 113–125.

BEST COPY AVAILABLE

Exhibiting Art by People with Mental Illness: Issues, Process and Principles

Susan Evans Spaniol, M.A., A.T.R., *Art Therapist at Fresh Pond Day Treatment Center, Cambridge, Mass*

Abstract

Growing interest in art by people with mental illness is reflected in the increasing number of exhibitions devoted to art by patients and ex-patients. As the facilitators of this art, art therapists are often in a position to advocate for these artist and to arbitrate the ethics governing exhibitions of their art works. Despite increasing awareness of the issues and problems involved in exhibiting art by people with psychiatric disabilities, general guidelines and specific protocols have been unavailable to art therapists. This article presents key issues, processes and principles governing exhibitions of art by people with mental illness based on the experience of the Committee for Advocacy Through Art in organizing the juried exhibition, "Art and Mental Illness: New Images" held at Boston University in the fall of 1989.

Historical Context

Although art by people with mental illness was rarely exhibited in this country before the 1980s, it has been a vital undercurrent in the European art world since the beginning of this century, when psychiatrist and art historian Hans Prinzhorn amassed a collection of 6,000 art works by patients in Europe's barren, isolated mental asylums. Long before the advent of occupational or art therapy, Prinzhorn had observed that many patients used great resourcefulness in obtaining materials for drawing, rescuing scrap paper from wastebaskets, opening old envelopes and stealing toilet paper to use as drawing surfaces. Apparently driven by strong inner needs for self-expression, it was not uncommon for many of these untrained artists to spend much of their time creating drawings of strong individuality, originality and beauty.

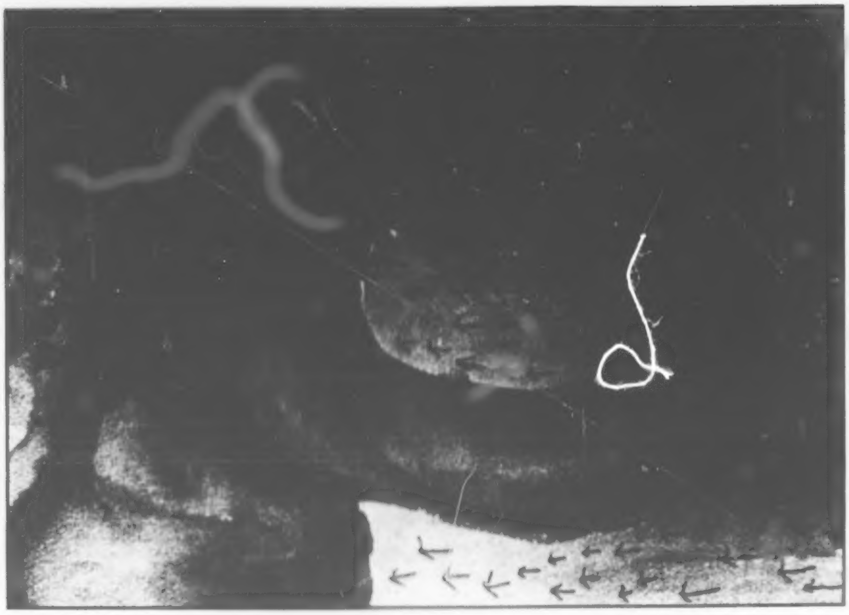
In 1922, Prinzhorn published *Artistry of the Mentally Ill* (Prinzhorn, 1972-revised), based on his collection. His book was reprinted several times and selections from his collection traveled to various locations in Europe, profoundly affecting the development of modern art. Twentieth century European artists, such as Paul Klee, Max Ernst and Jean Dubuffet, were impressed by the modernism of the drawings in Prinzhorn's collections. Like the expressionists, the untrained artists often used colors and shapes in an uninhibited way suggesting intense emotion. Like the cubists and their followers, many intuitively employed techniques developed by established artists in reaction to classicism, such as fragmentation, distortion and condensation.

In 1985, selections from Prinzhorn's collection made their first appearances in this country, touring four American museums and startling the art public with their powerful visual imagery and symbolic content. Since then, art by people with mental illness has begun to enter the mainstream of the American art world through exhibitions in established galleries, such as Rosa Esman's Gallery and the Calvin-Morris Gallery in New York City. In Maryland, a community support organization for people with mental illness, People Encouraging People, is in the process of establishing an American Visionary Museum that will provide gallery and storage space for a national collection of art by untrained people with mental illness. During the fall of 1989 several exhibitions of patient and ex-patient art were held nationwide concurrent with National Mental Illness Awareness Week during the first week of October. One of those exhibitions was "Art and Mental Illness: New Images" at Boston University. This Massachusetts exhibition was organized by the Committee for Advocacy Through Art, a coalition of diverse groups and individuals with the common belief that art can break through stereotypes of mental illness and the resulting social stigma (Spaniol, 1989, 1990). The committee was sponsored by the Centers for Psychiatric Rehabilitation at Boston University.

From Bias to Concensus

Members of the Committee for Advocacy Through Art included state-wide mental health organizations, ex-patient groups, university departments, ex-patient artists and the author—an art therapist and a doctoral student at Boston University. With such a varied membership, the Committee often seemed like a microcosm of society. When the committee began meeting, each indi-

> ***"Organizing an exhibition of art by people with mental illness can force exhibitors to confront their own biases and question their values."***



DEPRESSION (Watercolor)

vidual appeared to have a somewhat different agenda and latent biases. As we continued to meet, these differences emerged as assets because they allowed the committee to view complex and sensitive issues from varying perspectives. The committee's discussions were often provocative, sometimes frustrating and always lively. From our ealiest meetings, when it took nearly two months to agree on a title for the exhibition, we struggled with the issues raised, striving to protect the privacy and dignity of the artists while providing an opportunity for them to communicate with a broad audience through their art. Although many of the problems the committee faced did not allow conclusive resolutions, we were able to reach a concensus on the questions raised. This article shares our accumulated learnings with future exhibitors so they, and the artists they represent, may benefit from our experiences.

Organizing an exhibition of art by people with mental illness can force exhibitors to confront their own biases and question their values. The decision to mount a show of art by patients and ex-patients is itself controversial. In addressing the complex issues involved in presenting a show of art by people with mental illness, it can be instructive to consider exhibitions of art by other exclusive categories of artists in America during the past several decades. A few decades ago, cultural leaders of the African-American community began trying to organize art exhibitions exclusively for African-American artists. A major goal was promoting pride in their artistic achievements and educating the white community about the major contributions African-American artists have made to the American art world. The predominantly white art establishment typically responded by offering to represent greater numbers of African-American artists in their exhibitions of contemporary American art. Through their persistence, African-American cultural leaders mounted their own exhibitions of art solely by African-American artists and were also able to convince many established museums and galleries to do the same. Public exposure to these diverse examples of universal human expression contributed to awakening awareness of racial biases and social stereotypes.

When the women's movement gained strength during the past decade, it recognized that cultural events could also function as strong political and social acts. Although many of their attempts to organize exclusive artistic events were at first met by resistence, they persisted in arranging cultural events that awakened public consciousness of latent biases and also celebrated women's contributions to society.

The past few years have witnessed a proliferation of exhibitions devoted to art by people who have experienced mental illness. It is likely that the increasing popularity of art by people with psychiatric disabilities reflects a readiness on the part of the patient and ex-patient communities to confront the general public with its biases. It may also signal a new willingness on the part of the public to examine its stereotypes related to mental illness.

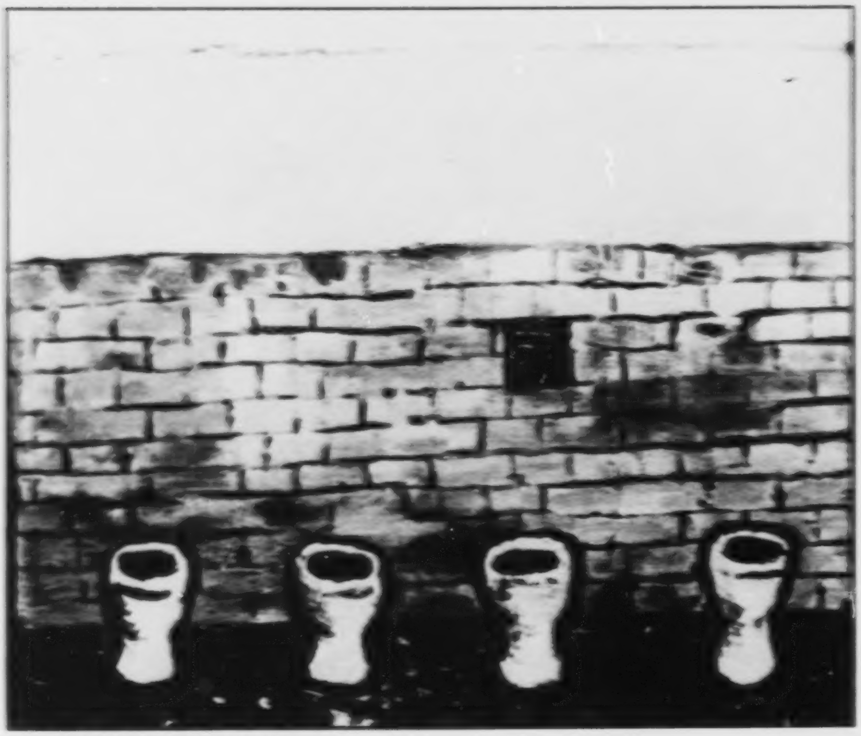
In fact, objections to exclusive exhibitions for particular groups of people may be symptomatic of public stigma against them. As an illustration, a prominent Boston hospital recently organized a juried exhibition of art limited to works by people who experienced severe headaches. No public objection was raised to the creation of a separate category of art for people with that particular disability, probably because there is little stigma attached to it. However, the mention of psychiatric disabilities often evokes strong feelings. Hopefully, as the public becomes less biased towards people with mental illness, exhibitions of art by people with mental illness will be no more controversial than shows of art by people who experience severe headaches.

Language Usage

One of the first tasks confronting the exhibition committee was choosing a title. This seemingly simple task became surprisingly complex as

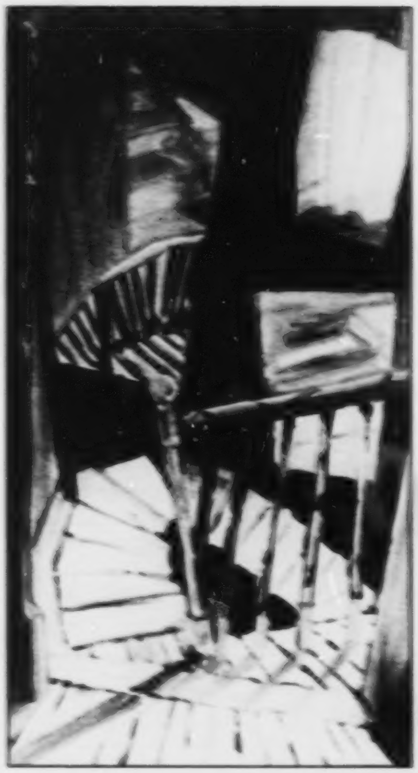
BEST COPY AVAILABLE

we realized that our choice of words would have a strong impact on how the exhibition was perceived. The term commonly used in the United States for art by people with mental illness is "outsider art," first used by the British humanities professor Roger Cardinal in 1972 as the title of his book about untrained artists. Although suitable to characterize spontaneous art works by inmates in Europe's mental asylums, the committee felt this term was inappropriate to describe the broad range of expression by the diverse population of artists with mental illness in America today. The term "outsider art" connotes alternative art outside the cultural norm done by people who are alienated from society. It is usually used to describe art works (often of haunting power and originality) that express inner visions without premeditation or censorship. However, the committee anticipated that the artists contributing to our exhibition would represent a heterogeneous cross section of humanity both in terms of their art work and lifestyles. To characterize them as outsiders could, in fact, reinforce the social stigma associated with mental illness.

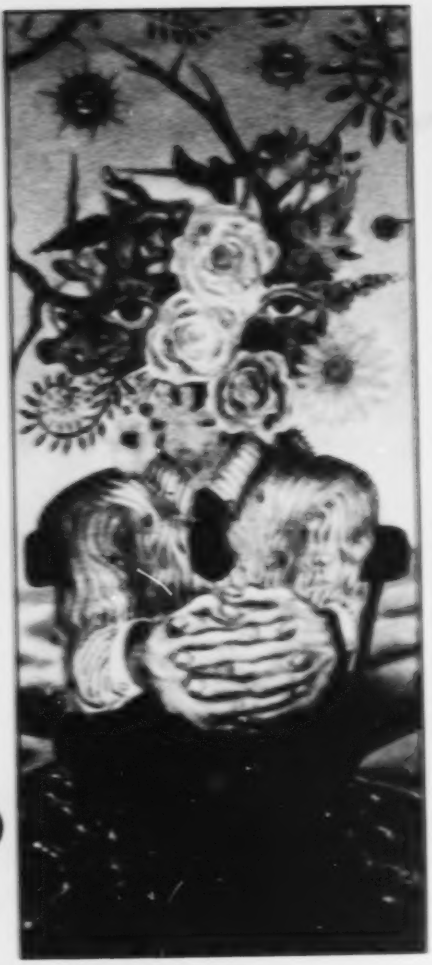

STATE HOSPITAL LAVATORY (Acrylic)

At first the committee avoided using the term "mental illness" in the exhibition title because it sounded startling in its directness. We considered more poetic phrases, such as "images of the soul" and "inner visions," but decided that they suggested spiritual or nonconforming art works, rather than a wide range of styles. The committee finally decided to name the exhibition "Art and Mental Illness: New Images" rather than using a euphemistic phrase because it suggested that the exhibition would offer a new way to perceive people with psychiatric disabilities and their art. It was hoped that public use of the phrase "mental illness" would contribute towards neutralizing the term by relating it to a positive set of associations.

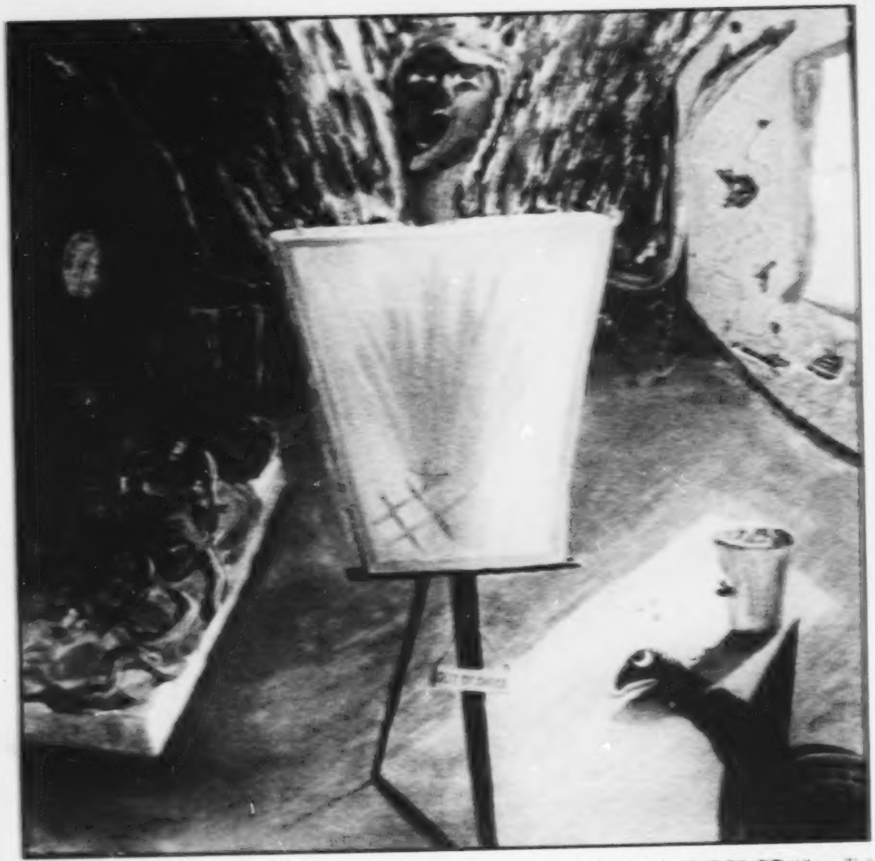
When the committee became sensitized to the function of language in influencing thought and perception, our awareness of language usage extended to ways of writing and talking about the exhibition. As a guide, we referred to the "Guidelines for Reporting About People with Disabilities" supported by the National Institute of Disability and Rehabilitation Research and adopted by the *Associated Press Stylebook* (Research

STAIRS NO. 1 (Oil)


"The term 'outsider art' connotes alternative art outside the cultural norm done by people who are alienated from society."



THE THERAPIST (Oil)



I GOT STUCK IN TRANSITION AND WAS CRUCIFIED IN LIVING COLOR (Acrylic)

and Training Center on Independent Living, 1987). These guidelines represent a concensus of over one hundred national disability organizations. They were prepared for the news media because the press shapes public images of groups of people through the words they use. The guidelines urge them to use language that focuses on individuals rather than their functional limitations, and to reserve diagnostic labels for technical medical writing. In keeping with these guidelines, one would write or say "people with mental illness" rather than "the mentally ill," and would use general terms like "mental disorder" and "psychiatric disability" instead of diagnostic terms such as psychotic and schizophrenic. Although this new descriptive style felt self-conscious and stilted at first, it soon became more natural, like saying "Ms." instead of "Mrs." and writing "she or he" rather than using only the masculine pronoun.

Selection of Art Works

One of the major tasks of the committee was establishing the procedures and developing the protocols for organizing the exhibition. Hoping to find prototypes for this sensitive task, we researched the literature and networked by phone and mail with people nationwide who had arranged similar exhibitions. Not surprisingly, the most useful resources were located in art therapy publications.

Several years ago, Pat Parsons helped introduce "outsider art" to the art therapy community with an article that provides an historical context and examines complex problems of definition (Parsons, 1986). The concept of "outsider art" is critiqued by Martha Haeseler in an article that conveys a strong respect for the privacy and dignity of artists with mental illness (Haeseler, 1988). A psychoanalytic approach is employed by psychiatrist Aaron Esman in his exploration of the ambiguous relationships between art, creativity and psychopathology (Esman, 1988). A rich resource was provided at the 19th Annual Conference of the American Art Therapy Association by a lively panel discussion that addressed many of the controversial issues faced by those exhibiting "outsider art" (Cohen, B., Henley, D., Haeseler, M. & Parsons, P., 1988).

While recent art therapy literature

speaks to sensitive issues raised by exhibiting art by people with mental illness, it has not yet provided specific protocols and guidelines for organizing such shows. With few resources as guides, the committee relied on general information available about organizing exhibitions, and adapted it to the needs of our special population.

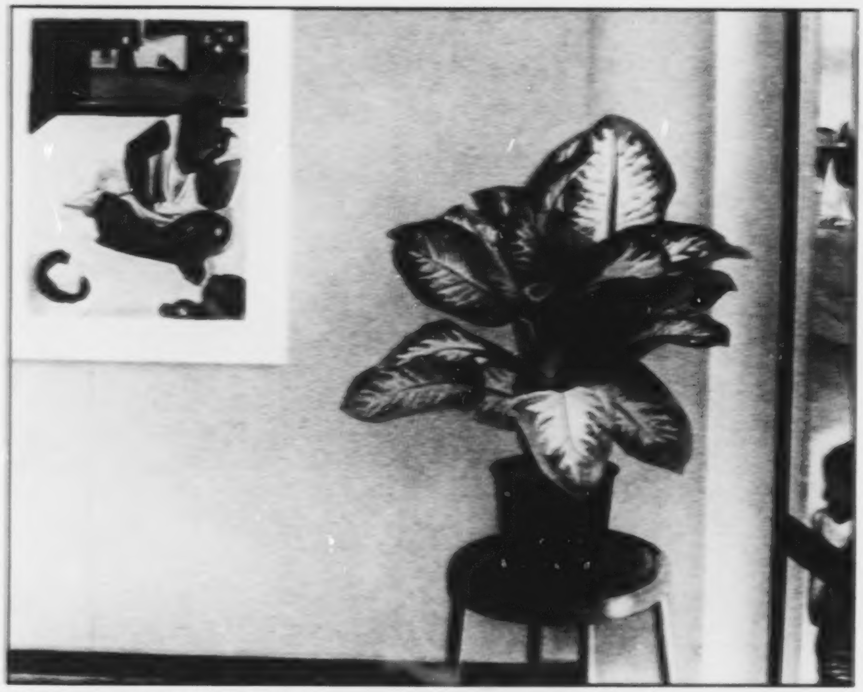
Unarguably, one of the most critical tasks in arranging an exhibition is the selection of art works. For the committee, the selection process became a three-step procedure: (1) solicitation of artists' interest; (2) artists' submissions of slides of their art works; and (3) jury selection of art works from slides.

Potential applicants were contacted through telephone calls, a press release and a mailing of 1700 brochures statewide to art schools and art therapists; universities and libraries; psychiatric hospitals, residences and half-way houses; and local chapters of patient self-help and advocacy groups. Only art works submitted directly by the artists themselves, rather than their caregivers, were considered. This policy was adopted to assure that the individual artists could retain control over the application process and the fate of their art work from the beginning. Soliciting art works was fascinating but unpredictable. It felt like casting a giant net across the state to see what we could pull in. We received over three hundred requests for applications. As a result, one hundred fourteen artists submitted more than five hundred slides for consideration.

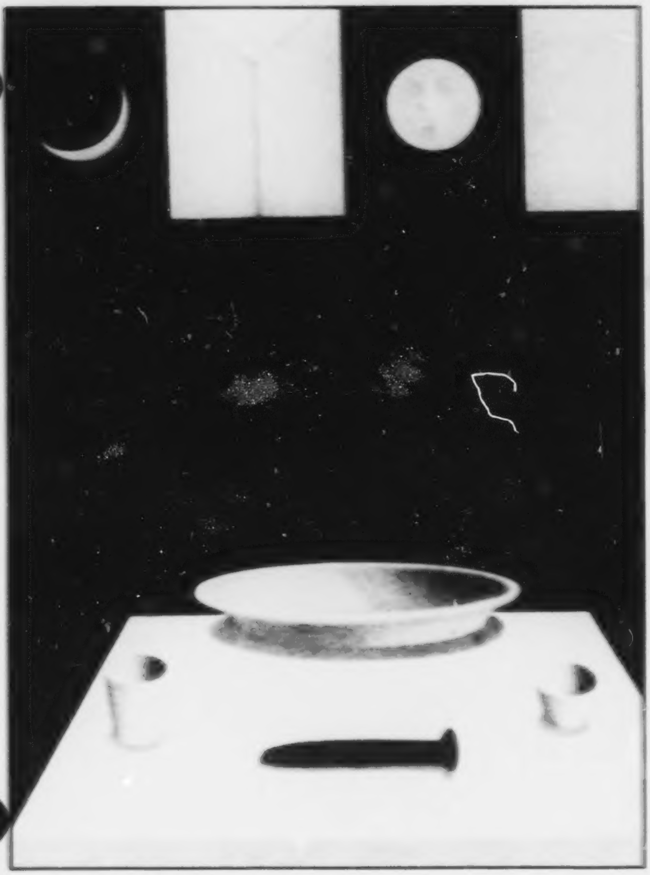
After much deliberation, the committee decided to select works indirectly from slides, rather than judging directly from art works. While judging from the art works themselves has definite advantages because art can never be adequately represented in slides, it could also be a cumbersome and awkward process for the exhibitors and artists as well, especially those whose works were not selected for exhibition. On the other hand, the use of slides made possible several unique aspects of the exhibition.

Art works that were not selected for exhibition were shown in a continuous slide presentation; thus, all people who submitted slides could have their art works viewed by the public. This slide showing became a focal point of the exhibition, capturing the attention of large numbers of gallery visitors at any given time. The use of slides also allowed the committee to create two different sets of permanent records of the exhibition: (1) slides of all the works submitted were recorded on videotape using a dissolve unit; and (2) use of slides also permitted the establishment of a permanent slide registry of the artists and their works. With the artists' permission, we plan to keep the videotape and slides at the University as educational resources and also as resources for interested collectors.

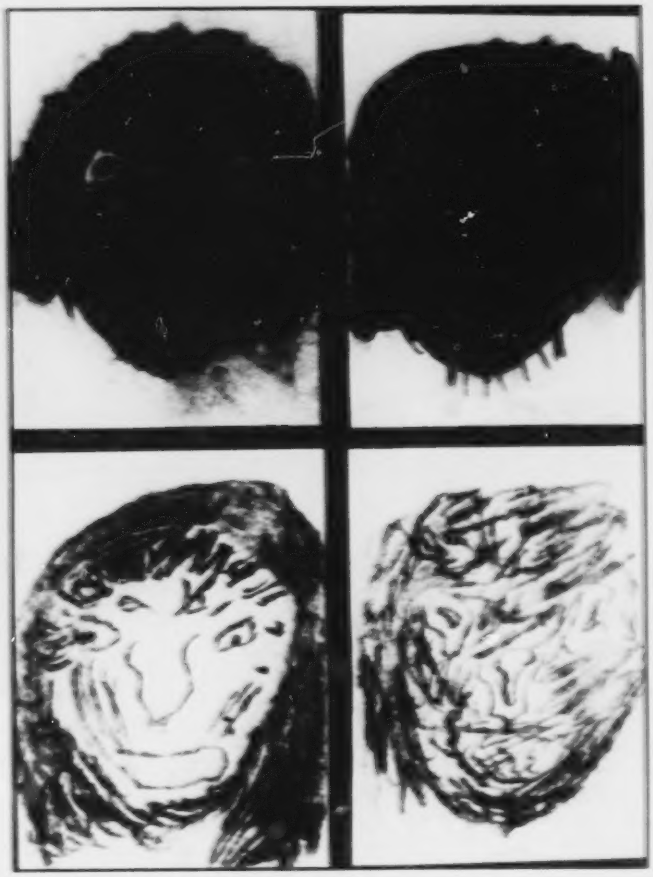
In choosing art works for an exhibition, it is important to establish criteria that are firmly based on a stated mission that provides focus. The committee defined its mission as reducing the stigma of mental illness by exhibiting art works of high quality by Massachusetts residents who had experienced mental illness. To avoid using diagnostic labels and clinical material, we decided to use self-report as our only criterion for mental illness. We assumed that people would not misrepresent themselves as mentally ill due to the immense social stigma associated with psychiatric disability. The focus of the exhibition was the art works as art and the artists as artists, not mental illness itself. Therefore our main criterion for selection of the art works was artistic merit. We also wanted strong works that expressed


HOMAGE TO GAUGUIN (Oil)

"Only art works submitted directly by the artists themselves, rather than their caregivers, were considered."



UNTITLED (Oil)



THE FOUR BROTHERS (Charcoal)

a broad spectrum of universal human emotions through a variety of styles and media.

Actual selection of art works was conducted by a jury of three art experts in the field. The committee used the jury process although it is more time-consuming and complicated than selection by an exhibition committee. We believed it would confer credibility on the exhibition because decisions would be professional and unbiased. An unexpected consequence of the jury selection was mixed reactions by committee members to some choices of the jury. We had each become attached to particular art works and many of us felt disappointed or let down at first when some of our favorites were not selected. However, when we viewed the exhibition as a whole we all felt satisfied that the exhibition reflected our mission and our focus.

Although the art works were selected without knowledge of the artists, choices reflected a broad cross section of the population who have experienced mental illness. Some of the artists whose works were chosen are highly skilled professionals who exhibit in established galleries, while others are untrained artists who have never exhibited their works, including an outstanding sculptress who had never before shown her work to anyone outside her family. The artists' lifestyles also represent a wide range, from those who live in their own homes and in artists' housing to residents of half-way houses and mental hospitals. Their art works reflect a variety of human emotions, from joy to anguish, and from warm affection to the despair of betrayal. Many are highly proficient renderings that represent current art trends while others are raw and direct expressions of intense private feelings. Despite this diversity, each work evokes our shared human emotions and experiences with striking power and originality.

Once art works had been selected, our goal was to design a registration process that would protect the rights and confidentiality of the artists while allowing us to disseminate information about their art works. This dual goal was accomplished by creating an identification form that allowed artists to describe their art works or their process for making art, while saying as much or as little as they wished about themselves. The artists had the option of remaining completely anonymous, or of being named and writing nothing, or writing an essay of up to five hundred words about themselves, their art and the role of art in their lives. Information furnished to the news media and the public about the artists was, by and large, limited to statements written and signed by them. Any kind of analysis was thereby avoided. The artists' comments provided moving and thought-provoking text for the illustrated catalog that accompanied the exhibition. Their comments were also made available to gallery visitors to enrich their viewing.

Opening Celebrations

Our opening reception was held in three phases to serve three distinct purposes. The first was a small private viewing to thank and congratulate the artists; the second was a press opening to enable the news media to preview the exhibition; and the third was a grand public opening to allow the artists to celebrate with family, friends, committee members and the interested public. All artists who had submitted work to the exhibition were invited to all phases of the opening, including those whose works had not been chosen for exhibition.

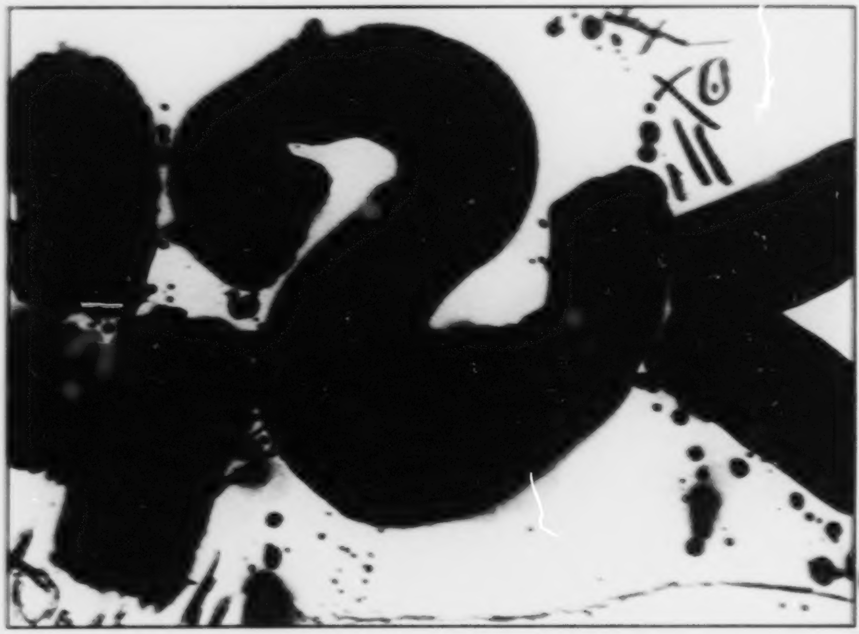
The private opening gave artists a chance to enjoy an uncrowded viewing of the show and also enabled them to meet one another. Of the thirty-one artists whose works were exhibited, twenty-eight attended the opening, as did other artists whose works were part of the slide showing. For many, it was their first awareness of belonging to a community of artists who shared similar issues and concerns. For others, it was an opportunity to begin to network and establish a support system.

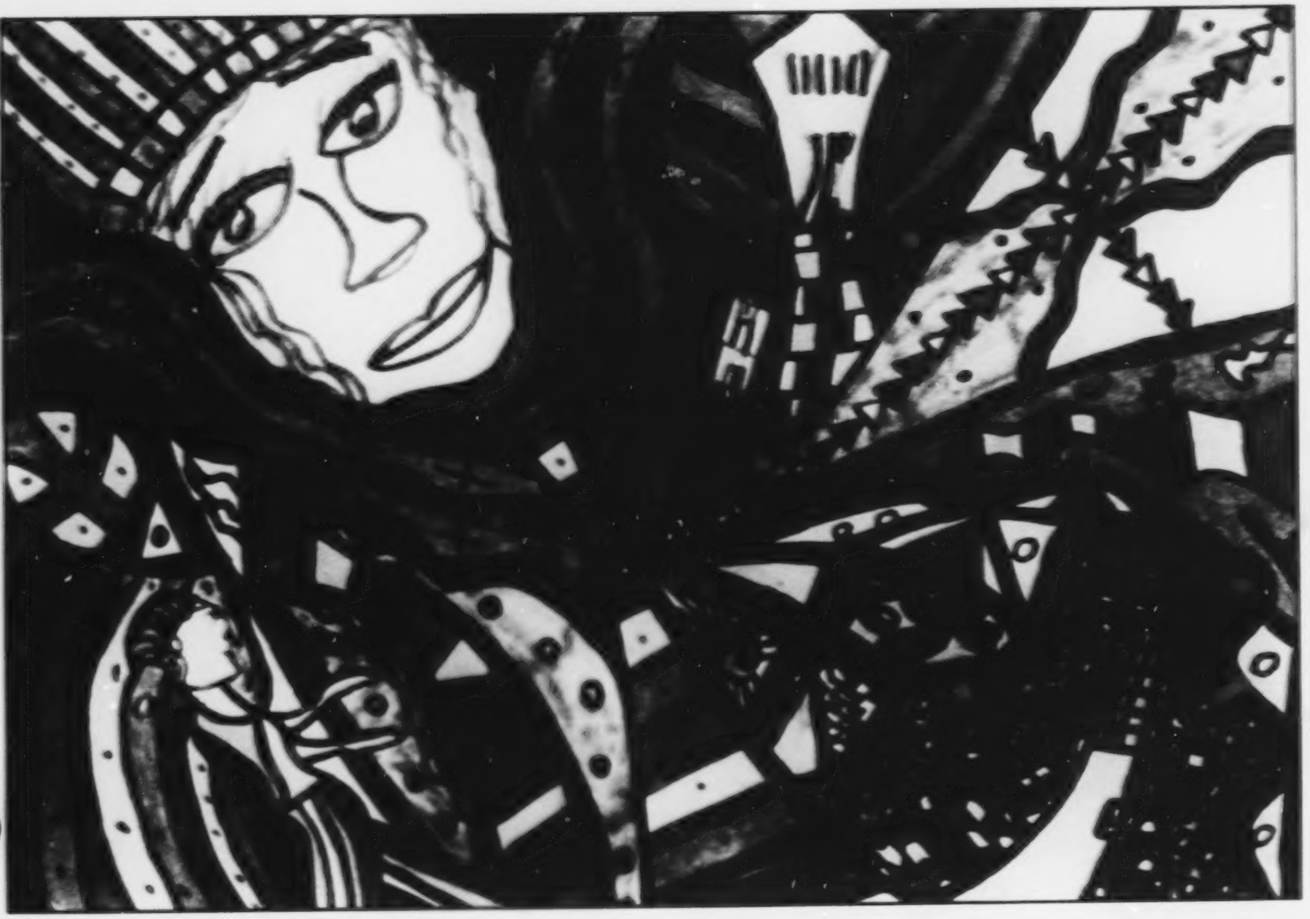
During the media viewing that followed the private preview, artists who were willing to speak to the press were identified by a gold sticker on their name tags. The press was informed that only those with gold stickers were available for interviews and photographs. As exhibitors of art by a population vulnerable to public exposure, the committee's attitude towards the press was ambivalent. On the one hand, we hoped for a broad dissemination of information about our exhibition. On the other, we feared that the media would make insensitive statements about the artists or their art. News coverage by the local media of past shows of art by patients and ex-patients had sometimes included inappropriate case material and unflattering portrayals. However, by screening the artists who wished to be interviewed and by limiting our printed information to comments written and signed by the artists, the committee was able to exert some control over the publication of information and encourage sensitive handling of the material.

> ***"The reporters tended to focus on the relationship between creativity and mental illness rather than the art works themselves."***

Our major disappointment with the press coverage was its oversight of the aesthetic elements of the art works. The reporters tended to focus on the relationship between creativity and mental illness rather than the art works themselves. Despite the committee's careful monitoring, reports of personal aspects of artists' lives seemed unavoidable. Diagnoses and case material found their way into articles because some of the artists conveyed the information to the press during interviews. It may be that a certain fascination with artists' lives must be expected. It is not uncommon for the public to romanticize artists' lives, especially their mental illness and unconventional behavior. Biographical tales of Van Gogh's excesses, Gauguin's escapism and Nolde's obsessions stimulate our interest in their art work.

McCOY-TYNER VISION (Acrylic on paper)





FACE VIEW WITH SPECTRUM (Magic marker)

Exhibition catalogs of "outsider art" often offer absorbing descriptions of the artists' eccentricities and titillating glimpses of their aberrant behavior. It may be that advocates for artists with mental illness cannot completely censor references to clinical material; however, it is possible to structure a public relation campaign to minimize and control such references.

The large public preview of the exhibition was a gratifying success. About four hundred guests visited the show during a three hour period. A classical guitarist supplied background music and ample food was available. Anyone who did not know the artists would have had difficulty distinguishing them from the university community. Those who knew them could witness their visible pleasure in sharing their art with family, friends and others.

The Show Goes On

Gallery attendance appeared to increase greatly during the exhibition. Students who did not ordinarily visit art galleries were drawn to the show. Groups of people from treatment programs and residents of half-way houses and hospitals visited the exhibition. Others remarked that they had returned several times to view it, sometimes bringing friends. It was not unusual for groups of people to gather and linger in front of particular art works discussing and debating their meanings. The empathic responses of many of the viewers suggest that the art depicted shared human experiences that transcend disabilities. The New England Art Therapy Association held its fall symposium in the exhibition galleries, where the author led a gallery tour and discussion. The response of the audience suggested that many art therapists are keenly aware of the issues involved in arranging such exhibitions, and feel a need to debate and clarify them.

Guiding Principles

Developing guidelines for exhibiting art by people with mental illness was a synergetic process. By merging the diverse value systems of the various committee members, we arrived at a consensus that seemed to represent general standards that could be applied to all exhibitions of art by people with disabilities or members of minority groups. These principles can be summarized by three words: opportunity, safeguards and empowerment.

Providing opportunity meant creating the occasion for exhibition participants to define themselves as artists. The committee provided a professional context for participating artists by issuing a call for art, selecting works by jury, using an art appraiser to set prices, publishing a handsome catalog and, of course, installing the exhibition in an art gallery.

Risk is inherent in any new step. Due to the strong social stigma associated with mental illness, public disclosure is especially risky. To safeguard participating artists, protections must be built into the process. Foremost among these safeguards is assurance of confidentiality. Exhibitors must obtain written permission before disclosing any verbal or visual information about the artists. (Art therapists are advised to consult the section on confidentiality in the code of ethics drafted by their professional organization in October, 1989.) The committee found that strictly limiting dissemination of information to statements written and signed by the artists allowed them to communicate as much as they wished while assuring them confidentiality.

Empowerment of the artists is perhaps the most significant principle that can govern an exhibition of art by people with mental illness. Procedures should be structured so artists are included in the decision-making and can participate in each step of the process. Including artists with psychiatric disability on the exhibition committee is invaluable because they are able to provide direct feedback on how policies will affect contributing artists. Providing options for the artists also gives them an active role in the exhibition process. Our committee offered artists choices about framing, pricing and selling their art works, and determining what they would communicate about themselves and their art. Arranging a private opening for the artists was also a means of empowering them because it created a community of peers and provided an opportunity to network and seek support.

Conclusion

Due to the growing popularity of art by people with mental illness in this country, all art therapists should be prepared to grapple with issues and conflicts raised by exhibiting this art. The principles of opportunity, safeguards and empowerment can serve as frameworks for developing and refining procedures and protocols that are sensitive to a vulnerable population. Art therapists can also participate in this process by reflecting on their own personal values; they can debate issues that arise with other art therapists and interested colleagues; and, equally important, they can seek feedback from their own clients to gain insight into their perspectives.

As art therapists we must be prepared to advocate for our clients. We must learn to concentrate on their creative abilities as well as their psychiatric disabilities. In so doing, we will be better able to help the public overcome its biases towards mental illness and assist those with mental illness to acknowledge their value as artists and as human beings.

> ***"To safeguard participating artists, protections must be built into the process."***

References

Cohen, B., Henley, D., Haeseler, M. & Parsons, P. (1988, November). Outsider art: From case studies to commodities. In *Professionalism in Practice*. 19th Annual Conference of the American Art Therapy Association, Chicago.

Esman, A. (1988). Art and Psychopathology: The message of outsider art. *The American Journal of Art Therapy*. *27*, 13–21.

Haeseler, M.P. (1988). Outsider art: A point of view. *The American Journal of Art Therapy*, *26*, 83–88.

Parsons, P. (1986). Outsider art: Patient art enters the art world. *The American Journal of Art Therapy*, *25*, 3–12.

Prinzhorn, H. (1972, rev.). *Artistry of the mentally ill*. New York: Springer-Verlag.

Research and Training Center on Independent Living. (1987). *Guidelines on reporting and writing about people with disabilities* (2nd ed.). Lawrence, Kansas: University of Kansas.

Spaniol, S. (1989). Introduction. *Art and mental illness: New images*. Boston: Center for Psychiatric Rehabilitation, Boston University.

Spaniol, S. (1990). *Organizing exhibitions of art by people with mental illness: A step-by-step manual*. Boston: Center for Psychiatric Rehabilitation, Boston University.

Staff. (1989, October). Draft proposal: Code of ethics for art therapists. *American Art Therapy Association Newsletter*. pp. 16–17.

An Art Therapy Curriculum in an Early Intervention Program for Visually Impaired Children

Roberta Weiss, A.T.R., *part-time Therapist, Jewish Guild for the Blind Early Intervention Program, Master of Professional Studies in Art Therapy, Pratt Institute, Brooklyn, N.Y.*

Abstract

Art therapy provides a pleasurable vehicle to promote learning for the visually impaired young child. Through the use of various art media, the visually impaired child can develop and refine motor skills, spatial relationships and a sense of identity and self-esteem. A basic goal-oriented curriculum is provided including objectives and activities for birth-to-five year old visually impaired children.

Introduction

It has been determined that 80% of a child's learning occurs through visual experiences. A child with a visual impairment must learn to compensate for his or her lack of useful vision by maximizing the development of other senses to develop important educational skills. The child must be an active participant in using his/her remaining intact senses (seeing, hearing, feeling and tasting) by directly interacting with his/her environment (Lowenfeld and Brittain, 1987). Children need instruction in the use of residual vision and other senses to develop their fine motor skills, spatial relationships, and sense of identity and self-esteem. Learning through the creative art therapies allows the child to secure this extra input, while participating in enjoyable activities.

Many visually impaired children experience a variety of emotional feelings. They may experience anxiety and apprehension about new experiences and the outside world. An excessive sense of dependency, especially maternal, is also commonly seen (Lairy, 1969). The art therapist makes a special connection with the child by using various art media to help foster independence and a sense of identity.

Because of its varied malleable qualities, art material affords the visually impaired child the opportunity to gain a sense of control over his/her intentions. With paint and crayons, a child learns the concepts of up and down, next to, and over and under. One's understanding of shapes and colors is also reinforced. Large crayons and paper encourage the child to scribble. He/she thereby learns to use art materials in a purposeful manner, and develops skills that will be important in later preschool experiences. Holding crayons and scribbling also helps to strengthen muscles and assists in developing fine motor coordination. The child learns that he/she can control one's arm and hand to make the crayon move in many different directions (round circles, up and down, zigzag lines) (Miguel and Cecilia, 1964).

Three dimensional art materials (clay, wire and wax) are useful in helping to overcome those restrictions that visual impairment may impose upon a child. Working with and manipulating these materials can assist the child in attaining control of oneself and one's environment through direction of his/her hands to create something. Coordination improves as the child learns to use his/her hands together as a tool to accomplish the goal of working on a purposeful activity. It also helps to develop a sense of body image and foster a healthy sense of identity. The child's awareness of shapes, forms and textures of objects is promoted. Working with clay becomes an exercise in expression, as the child is encouraged to pound, pull, poke and roll it (Haupt, 1964).

The development of language and self expression in a child is associated with one's growing awareness between people and objects. Piaget states that there is an intimate relationship between language and thought. The need to express oneself is a direct association between thoughts that are based on reality and linked to language. Visually impaired children often have difficulty with self expression because of the lack of visual stimuli which serves to connect them with the outside world. Creative puppetry can enchance a child's expressive skills by providing an alternative method of expression (Rogow, 1965). By making a puppet out of a variety of materials, the child includes any fea-

---

"A child with a visual impairment must . . . compensate for [a] lack of useful vision by maximizing the development of other senses. . . ."

---

tures which are important. This puppet becomes the vehicle through which the child identifies and speaks. One's feelings, inner conflicts and thoughts can be acted out in puppetry.

A visually impaired child may experience a sense of isolation since his/her world is largely limited to touch and sound. One may be slow to realize that his/her arms, legs, hands and feet belong to oneself. In order for the child with visual handicaps to form and maintain a working relationship with external surroundings, one must first become aware that the body is separate from everything else. One needs to know body parts, their functions and their relationship to the environment outside themselves (Lydon and McGraw, 1973). Through the use of art material and creative activities, a positive self image and sense of self separate and apart from the outside world can be attained.

Art therapy holds a special place in the early intervention program for visually impaired children. Activities and media are chosen with consideration for their educational and therapeutic objectives. Along with other disciplines, the art therapist pays special attention to improving visual, perceptual, sensory and fine motor skills, as well as building confidence, mastery, self-esteem and self image (Lindsey, 1972). The use of art material allows for self expression and creativity, which are often stymied in the visually restricted child. We have found that the children in our program respond favorably to the creative art therapies. It is their own motivation to participate in a pleasurable activity which serves to promote learning.

Because there is so little information written about art therapy for the very young visually impaired child, it is important to develop a series of developmental activities and incorporate the principles of art therapy to help the child meet his/her goals. The following section presents objectives and coordinating activities in an ongoing art therapy program for preschool visually impaired children. The activities are correlated to appropriate age levels and stages of development.

> ***"The art therapist makes a special connection with the child by using various art media to help foster independence and a sense of identity."***

In the first year, the activities are similiar to those employed by the vision and the motor development specialists. After the first year, the activities become more specialized utilizing art media and specific therapeutic techniques. Many of the activities designed for the 2–5 year olds are very visual to encourage the use of residual vision. The totally blind child would obviously be utilizing tactile media.

ART THERAPY CURRICULUM

0—6 Months

Objective	**Activity**
1. Child will begin to grasp objects placed in his/her hand.	**a.** Offer an easy to hold squeeze toy in child's hand. **b.** Demonstrate how toy sounds when child holds it and squeezes it. **c.** Encourage child to hold toy on his/her own. **d.** Praise child for each successful try.
2. Child will begin to develop a sense of cause and effect.	**a.** Have child hold squeeze toy. **b.** Show child how the toy sounds each time he/she squeezes it.
3. Child will begin to develop a sense of object permanence.	**a.** Have child hold squeeze toy or rattle. **b.** When child drops toy, help him/her to find it with his/her hands. **c.** Place toy under a blanket. **d.** Help child locate toy by guiding his/her hands to feel the shape of the toy under the blanket. **e.** Help child to manipulate the blanket so that toy makes noise. **f.** Pull blanket off of the toy while saying, "surprise!" **g.** Repeat this game until child begins to move towards blanket to uncover toy.

continued

6 Months—12 Months

Objective	Activity
1. Child will learn to imitate gestures and correlate them to present experience.	a. At the end of each activity say, "No more," while holding child's hands up. b. At the end of the session, say, "Bye-bye," while waving child's hand with yours. c. Praise each attempt at independent gesturing.
2. Child will imitate facial expressions.	a. Hold child's hands on your face. Child feels your changing facial expressions while you explain that are you are smiling, frowning, etc. b. While holding child's hands on his/her own face, child feels his/her own expression, as you verbalize.
3. Child will hold and transfer from hand to hand various colorful and tactually interesting objects.	a. Offer a varied supply of toys to the child while he/she sits in your lap. b. Assist the child to hold toy in both hands. Help child explore the properties of the toy. c. Help the child to play with the toy first in one hand, then the other. d. Reward independent holding and transferring of toy from hand to hand.
4. Child will use index finger to make poking motions.	a. Provide clay, sand and other tactually interesting medium. b. Assist child in holding index finger out from the rest of the hand. c. Help child to poke holes in the clay or sand, while singing rhythmic song or rhyme.
5. Child will use finger and thumb to grasp object.	a. Provide different toys and objects for child to handle. b. Encourage child to use finger and thumb to pick up toy.

12—18 Months

Objective	Activity
1. Child will hold crayon in a palmer grasp.	a. Provide large crayons for child to pick up. b. Assist child to hold crayon in a position which leads to scribbling. c. Provide paper for child to use crayon on.
2. Child will scribble when presented with crayons.	a. Provide brightly colored, large crayons and large pieces of paper. b. Using hand over hand, show child how to hold crayon, and guide his/her hand to scribble using various movements. Up and down, circles, squiggle lines, back and forth. Explain to child which motion he/she is making. c. Allow child to scribble independently, praising each try.
3. Child will use his/her arm and hand to imitate a vertical line.	a. Provide sand, water and various textured papers. b. Gently guide child's hand while he/she explores the surfaces.

continued

Objective	Activity
	c. Guide child's hand in up and down motions, while singing a song about what he/she is doing. Praise each try. d. Encourage child to do the same on his/her own.
4. Child will tactually explore his/her own body.	a. Gently guide child's hands to touch his/he own body parts, while naming what he touches. b. Play a game of "Show me," i.e.—"Show me your nose." Praise each try. c. Use a variety of textured material to tactually highlight areas of child's body, while naming parts.

18 Months—2 Years

Objective	Activity
1. Child will imitate a horizontal line, a circle and a V-stroke.	a. Using hand over hand assistance, guide child's hand in a back and forth motion. b. Using sand, water or clay, help child track horizontal hand movements. c. Provide salt spread over a black surface. Assist child in drawing several horizontal lines, circles and V-strokes. This surface provides a contrast which is more easily seen. d. Provide crayons and paint. Use hand over hand to help the child to draw varied lines.
2. Child will attend to picture books and identify common objects.	a. Read books to child that contain pictures of common everyday objects. Point to the picture and name the object. b. Say to the child, "Show me the _______." Have child point to that picture. c. Praise child for each correct response.
3. Child will point to and identify 2-3 of his/her own body parts.	a. Ask child to "Show me your nose." Continue with all facial features. Praise each correct response. b. Use large colorful stickers to decorate a paper plate face. c. Hold child's hand on a piece of paper. Trace his/her hand with a marker, counting and naming his/her fingers. Show child the tracing and again, point to, count and name each finger. d. Do the same activity using child's foot.

2 Years—3 Years

Objective	Activity
1. Child will match and identify colors (red, yellow, green and blue).	a. Provide a variety of material (paper, cloth, ribbon, etc.) using two colors. Mix pieces up on a tray. Have child sort out all material of the same color. Repeat this with two other colors. b. Use sorted material to create a "color book." Have child paste all the material of the same color onto one page. After all of the colors are completed bind book for the child to keep.

continued

Objective	Activity
	c. Provide red, yellow, green and blue sand. Show child a simple outlined picture with the colors filled in. Ask child to name the color space on the picture, put glue on top of that color and choose the color sand that matches. Child will then sprinkle the colored sand onto the colored space. d. Discuss with child everything that he/she is familiar with that is green, yellow, or blue. Focus on one color each session. Provide paint, Play Dough and other material in one color.
2. Child will identify and match shapes (square, circle and triangle).	a. Provide various textured material cut into squares, circles and triangles. b. Ask child to sort out the material according to shapes. c. Have child paste all of the material of one shape onto a piece of paper. d. When child completes this with all three shapes, bind the pages into a book which child can keep. e. Provide different colored shapes cut from paper. Have child create a "shape picture," naming each shape as he/she chooses it and pastes it on paper. f. Provide Play Dough and cookie cutter shapes. Assist child to roll the dough, flatten it and cut out the shapes. Have child identify which shape he/she is using.
3. Child will identify gross and fine body parts (self).	a. Take a large piece of paper to the floor. Help child lie down on the paper. Using marker, trace the outline of the body, naming all of the parts while drawing. b. Provide yarn, buttons, pre-cut felt pieces, material and markers. Assist child in filling in and decorating his/her tracing. c. Provide a variety of colored and textured material and a paper plate. Help child to create a mask, naming where the eye, nose and mouth belong. d. Give child a ball of clay and help him/her to make a self-presentation, by first using his/her own facial features.
4. Child will draw a person (face, arms and legs).	a. Provide crayons and marker. Using hand over hand, assist child to draw a person. Identify parts as the child draws.
5. Child will begin to use art material appropriately.	a. Provide paints and brushes, paper, crayons, chalk, paste, scissors and Play Dough. b. Show child how to use each of the media, demonstrate all of their possibilities, and allow the child the freedom to play, experiment and create with each of the presented material. c. Place the material to be used in a given session on a tray. This helps to define their space and helps the child to focus on the material at hand.

continued

3 Years—4 Years

Objective	**Activity**
1. Child will identify and distinguish between textures (hard and soft, rough and smooth, wet and dry).	a. Provide a tray containing a variety of tactually diverse material. Dry sponges, fur, plastic pieces, rocks are some objects to use. Assist child to sort the material according to type of feel. b. Use plastic meat trays to collect different textured items. Child will put all of the soft material into one tray, all of the rough material in another, etc. The material can then be pasted onto the trays and the child then has a permanent collection to refer to. c. Provide a small tub of water for child to play in. Emphasize how water feels wet against his skin. Use sponges for child to play with when dry and when wet.
2. Child will trace a diamond shape and copy a cross shape.	a. Provide a raised relief drawing of a diamond shape and a cross shape. b. Ask child to use a crayon to outline and fill in the drawing. Assist the child in making controlled vertical and horizontal lines. c. Use salt on a black tray (good contrast) and assist child to use his/her finger to trace the diamond and cross.
3. Child will begin to express himself/herself through art work.	a. Provide markers, crayons, paint and colorful shape stickers. b. Ask the child, "Can you make a happy picture?" Sad and angry feeling can also be substituted. c. Ask the child, "Can you make a picture about how you feel today?" d. Encourage the child to relate an important experience. Then ask if he/she can draw a picture showing that event.

4 Years—5 Years

Objective	**Activity**
1. Child will begin to bring in and use discarded items from home. Creativity and imagination are enhanced as child uses these items for art projects.	a. Have child bring in egg cartons, milk containers, yarn, broken egg shells, macaroni, etc. b. Use the item as the basis for an art project, i.e., carton caterpillar.
2. Child will begin to pay attention to the colors, textures and shapes which he/she encounters outside the home. This helps to increase visual and tactual awareness.	a. Take child outside on a field trip to the park. Feel the leaves, bark, grass, rocks and everything else encountered outside. Have children draw birds using crayon and paper. b. Encourage child to discuss what he/she sees, feels and touches.
3. Child will begin to work on a group art project with a small group of children.	a. Include child in a small group of children. b. Set up a large piece of paper taped on the wall. Provide colorful markers. Give each child his/her own space to draw on the paper, thereby creating a group mural. Praise each child's efforts at working together.

continued

Objective	Activity
	c. Other group projects include: 1) Decorating a paper tree taped on the wall. This tree can be set up all year. The children can use many themes during the course of the year. 2) Creating a group story. Begin to tell the children a story. Ask each child to continue by adding his/her own idea. After the story is completed, read it back to the group. Provide markers and crayons and encourage each child to draw his/her portion of the story. Display the picture and the written story in sequential order.
	d. Create a simple group quilt. Provide colorful fabric markers and fabric squares. Ask each child to draw a design on the fabric. Sew the pieces together (perhaps with the help of the parents), and secure it to a backing.
4. Child will begin to use and be responsible for the art material in an appropriate manner.	a. Child will assist in putting the material back, washing the brushes, and putting the Play Dough in the container.

References

Winnicott, D.W. (1971). *Therapeutic consultation in child psychiatry.* N.Y., Basic Books, Inc. 1971.

Lowenfeld, V. and Brittain, W. (1987). *Creative and mental growth* (8th ed.). N.Y.: Macmillan Company.

Lairy, G. (1969). *Problems in the adjustment of the visually impaired child.* New Outlook for the Blind, Vol. 63, No. 2, February.

Miguel, Sr. M. and Cecilia, Sr. M. (1964). *Helping the preschool blind child.* New Outlook for the Blind, June.

Haupt, C. (1964). *Improving blind children's perceptions.* New Outlook for the Blind, Vol. 58, No. 6, June.

Lydon, W.T. and McGraw, M.C. (1973). *Concept development for visually handicapped children.* AFB, N.Y.

Rogow, S. (1965). *Puppetry as an aid in language development.* New Outlook for the Blind, Vol. 59, No. 8, October.

O'Brien, R. (1976). *Alive, aware, a person.* Rockville, MD, Montgomery County Public Schools.

Lindsay Z. (1972). *Art and the handicapped child.* New York: Van Nostrand Reinhold Co.

Pieget, J. (1959). *The language and thought of the child.* New Jersey: Humanities Press.

Acknowledgement:

This article is based upon my work at the Jewish Guild for the Blind, Early Intervention Program. This Program, directed by Dr. Ellen Triet, is designed to meet the special needs of infants and pre-school children who have a variety of visual disorders. The staff is comprised of professional therapeutic specialists in the fields of vision rehabilitation, sensory stimulation, motor development, speech therapy, art therapy, music therapy and physical and occupational therapy.

WRIGHT
STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:
Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

BEST COPY AVAILABLE

When a Mother Kills Her Child

Rose Marano Geiser, M.A., A.T.R., *Art Therapist and Case Management Worker for Bridgehaven, a psychosocial program for adults in Louisville, Ky.*

Abstract

While listening to the news one will all too often hear a story about the murder of a child. At times we hear of a child who dies after severe physical abuse by the guardian. Less often we hear about the death of a child who had been killed by a parent who had no previous history of abuse toward the child. The act of infanticide raises the implication of suicide and identity fusion with the child by the parent. This article presents a case study of a woman who was incarcerated for the murder of her child. A description of the jail situation, background of murdering parents and possible underlying motivation for child murder by the parent is discussed.

Introduction

During my work in a jail psychiatric program, I was introduced to areas of mental health which are often overlooked. This is partly due to the fact that in jail incarcerated individuals are seen as criminals rather than as needing care. Despite their criminal behavior those incarcerated are some of the neediest people. Many people incarcerated in a jail are those with mental disorders. They are those individuals who are no longer maintained by long-term, state-run mental health facilities. For those without supportive families and adequate income, jail has become a part of the revolving-door existence they lead. They pass through doors of short-term facilites, halfway houses, street life and jail. Often they are arrested for vagrancy, disturbing the peace and loitering. Their life is in constant chaos. Jail only adds to their confused thoughts, for jail is a warehouse of bodies waiting for the judicial system to take the next step. The waiting period for a hearing can take up to one year and sometimes longer. During this time the individual waits along with hardened criminals who are physically threatening and emotionally fearful.

My experience was with a major metropolitan department of corrections, one of the largest jails in the country, housing 5,000 inmates. Within this complex, psychiatric services are provided on a crisis intervention basis. The facilities include an acute psychiatric unit, a residential unit for men and a psychiatric unit for women. Treatment is short-term and attempts to achieve remission of mental health problems for the purpose of returning the inmate to the general population of the correctional facility (Cherian, Goldstein, Hardigan, and Simmons, 1981). Therapeutic services are at a minimum with individuals kept in the psychiatric department until medication enhances stabilization. The jail acts as temporary placement for most inmates. Here, an individual waits for a hearing or trial which will determine whether long-term incarceration will be in a penitentiary or a mental health institution. I found the environment to be bleak which added to depression. The walls were constructed from cinder blocks or drab colored tiles. There were only benches and plastic chairs for seating. The lighting was often harsh and added to the nighmarish atmosphere creating a sense that all encounters with individuals were a part of an interrogation process. The short-term situation of the jail restricts most therapy to helping inmates cope with the stress of incarceration. Often, I would see individuals only once, or for a few weeks before they were transferred or released without my knowledge. I was, however, able to work with a few individuals for longer periods.

Among those incarcerated were women who had been jailed for killing their children. Those women seemed out of place in jail. Usually they were actively psychotic and unaware of what was happening to them. Several had killed their infants, some had killed slightly older children, all without premeditation. Their needs were of mental healt and not criminal incarceration. (I wi generally refer to the killing of a child by a parent as infanticide although there are several terms used.)

Infanticide

The killing of children is certainly not a new occurrence to be attributed to the stress of modern times. Humanity, in fact, has a long history of this continuing horror. Stern (1948) provides a historical description of the killing of children throughout time involving various cultures worldwide. He notes the acknowledgement of infanticide in mythology, religious practice and liter-

"For those [incarcerated persons] without supportive families and adequate income, jail has become a part of the revolving-door existence they lead."

ature. He cites various literary works which tell the tale of child murder by the parent. He traces infanticide in literature to Greek mythology which includes the story of Cronos who ate his children and to Medea who killed her sons in revenge of her husband's infidelity. Clinically, he uses the term "Medea Complex" to describe a mother with homicidal wishes toward her child. In her studies, Dr. Maria Piers (1978) describes infanticide to be a secret fantasy held by all individuals. She explores this fantasy in pointing to the lyrics of lullabies such as "Hushaby Baby" where a rocking cradle is threatened by a breaking bough. In a German song the baby is threatened to be bitten by a sheep if the child does not sleep. While working with children, Dr. Dorothy Block (1978) found that many frightful fantasies that children experience reveal their fear of infanticide. In exploring children's fear of their parents, Block points out that fear of infanticide is justified in that parents may actually have that wish. She refers to Dr. Hyman Spotnitz as having pointed out that Freud ignored the first part of the Oedipal myth. Here the parents abandon him on a hillside to die.

Specifics of Infanticide

Having reviewed various cases of child murder, Resnick (1969) developed a classification system to define types of infanticide and the underlying motive. He states that infanticide is a general term for child murder. He uses the term "Filicide" for the murder of an older child. "Neonaticide" refers to a child murdered less than twenty-four hours after birth. He also found that at six months of age the child is in a high risk period due to maternal post partum psychosis. Adelson (1961), D'Orban (1979) and Hamilton (1982) have also pointed out the high risk of infanticide during post partum psychosis.

> ***"More than half of altruistic filicide is linked with suicide and is enacted mainly by mothers."***

After examining several studies Resnick (1969) found that the rate of maternal infanticide was higher than paternal infanticide. He noted that the mothers' age ranged between 20–50 years old and fathers' age ranged from 25–35 years old. Mothers were found to be labeled schizophrenic and fathers were said to be "non-psychotic." Diagnostic procedures did vary, therefore, proved to be unreliable. Adelson (1961) implied that fathers kill their children while highly frustrated by prolonged crying or other uncontrollable behaviors. Mothers were not found to kill for this reason. Infanticide by a father was usually followed by the murder of the wife. Women usually killed themselves and their children. In researching literature in this area, I found that mostly women are documented as having killed their children.

Resnick (1969) described five motives for infanticide. "Altruistic filicide" occurs with the parent(s) wishing to prevent the child from suffering. Parents have committed filicide prior to suicide to prevent abandonment of the child. Filicide has also been committed to prevent or relieve a child's suffering, real or imaginary. "Acutely psychotic filicide" defines the murder as occurring when the parent is mentally ill. This includes cases in which no apparent motive could be determined. "Unwanted child filicide" occurs when the child is viewed as an impediment to the parent's life. The child may be illegitimate, seen as a financial burden or seen as preventing romantic relationships from occurring. "Accidental filicide" results with physical abuse as part of the battered child syndrome. "Spouse revenge filicide" is associated with the Medea Complex.

"When filicide/infanticide is associated with a suicidal parent, the child is viewed as an extension of the parent. More than half of altruistic filicide is linked with suicide and is enacted mainly by mothers. The suicidal mother may identify her child with herself and project her own unacceptable symptoms on the victim," (Resnick, 1969, p. 331). The parent may also be trying to prevent the child from reliving the negative aspects of the parent's life. These motives contribute to filicide occurring rather than suicide. "In many cases there is evidence that the aggression acted out on the child was displaced from the murderer's mother, father, spouse or sibling" (Resnick, 1969, p. 331). In cases of altruistic and acutely psychotic filicide, the parent expressed a relief of tension. This may be a reason why the parent did not continue with suicide. These parents also sought help after the child's murder. Unwanted child filicide and accidental child filicide usually resulted in the parent tying to conceal the child's death (Resnick, 1969).

Lauretta Bender (1934) first addressed the implication for suicide through infanticide. In cases of infanticide committed by mothers, Bender concluded that the act itself was a gesture of suicide due to an over identification with the child. The suicidal desire changed from wanting to kill the self and the child to only killing the child. After the act the parent often expressed a sense of relief from symptoms associated with schizophrenia and manic-depressive psychosis which had been projected onto the child. Bender also found that in some cases after the murder, the parent recovered from prevailing symptoms. Teutus and Glotzer (1954) also found cases of infanticide by mothers to be an aspect of suicide attempted by the mother, although individual motives for the crime varied.

Diagnosis of the Parent

From all the available literature one can only conclude that a definite diagnosis of the infanticidal parent is a difficult one to make. A general consensus is that the majority of parents who attempted or committed infanticide were suffering from a depression. After the act was committed suicidal ideation and suicide attempts most often follow (Harder, 1967). Focussing on the diagnosis of depression, Harder presented varying viewpoints as to how the depressive state was to be diagnosed. He agreed with Gormensen's (1962) and Hopwood's (1927) findings that generally suicide followed infanticide, but the diagnostic terms differ. He cited Batt (1948) as using the term depressive psychosis to indicate melancholia. Batt also stated that since suicide is an aggressive act against the self, it may be considered that homicide is an extended aggression from the self to include those who are closest to the self such as the child or spouse. Hopwood classified some infanticidal parents to be manic-depressive and others were diagnosed with exhaustion psychosis induced by lactation in nursing mothers. McDermaid and Winkler (1955) labeled infanticide to be a result of child-centered obsessional depression. Rodenburg (1970 and 1971) also emphasized underlying depression in infanticidal parents. He concluded that the risk of infanticide is greater when the parent is suicidal. A history of tension, depression and suicidal ideation, along with obsessional preoccupation for the child's welfare may account for many acts of infanticide.

Case Study

While I worked with the incarcerated women of the jail, I took note that some were especially withdrawn, not only from the staff but from the other female inmates as well. Having committed infanticide these women dared not to share their story with others in fear of being tormented by the others. In my experience most often women who have committed infanticide initially block out the incident and deny the death of their child. For those who were aware of their actions, it was a secret difficult to share. Some explained that they had acted out in obedience to orders given by hallucinated voices. Others seemed to have acted on psychotic impulse in not being able to control their inner rage.

Over a period of nine months I worked closely with one woman who was charged with shooting and killing her daughter. From this particular case I had questions about the underlying drives for this woman. Was the child disliked by the mother? Did the mother project herself on to the child? In killing her child was the mother actually attempting suicide? Another aspect of this case which separated this woman from the other infanticidal mothers was that her child was a toddler and not an infant. Most of the women had committed infanticide while experiencing post partum psychosis. Through the following art work and discussion I will be exploring one case of infanticide in which an element of confusion between the mother's identity and that of her daughter becomes apparent.

This was Terry's first incarceration and she had no previous hospitalizations nor mental health treatment. She was married and had one daughter who was four years old at the time of death. Three months before the incident, Terry and her daughter left her husband and moved into her parent's house where her sisters also lived (one of whom was her twin). Her reasons for leaving her husband were vague; she said that he had been physically abusive, but would not elaborate on those incidents. Partly because of the nature of the jail, extended information on Terry's history was unobtainable. I was not able to speak with her family in order to clarify some of the information she gave me.

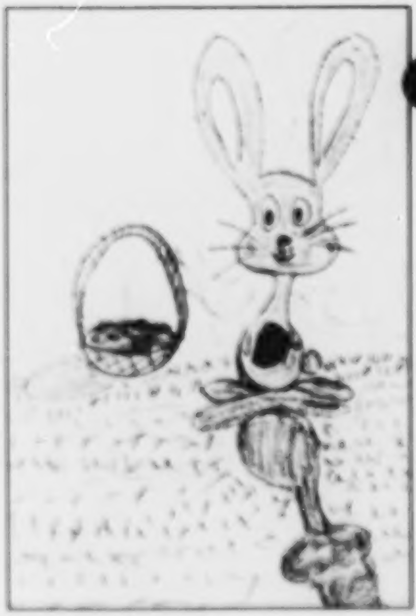


Fig. 1 T.'s first drawing depicts an Easter rabbit with a black abdomen.

Much of what Terry said in our sessions seemed unclear to me. She did not give enough information about her part nor her present situation. Some of the things she told me seemed contradictory. Most often she was releasing her feelings of remorse, pain and confusion about her actions. She was also trying to face her future. The jail, with all it's restrictions and authoritative rules added to the inhibitions that inmates experienced in that setting. We first met during the initial intake at the jail where Terry was interviewed. At that time she refused to answer questions until she had contacted her lawyer. She was placed on the acute psychiatric unit for observation. While on this unit, Terry attended an art therapy group in which participants were asked to draw whatever they wished to share with others. Remaining silent, Terry produced an Easter scene (Figure 1) and withdrew whenever she was asked any questions about her drawing. After the initial days of observation, Terry was placed on the psy-

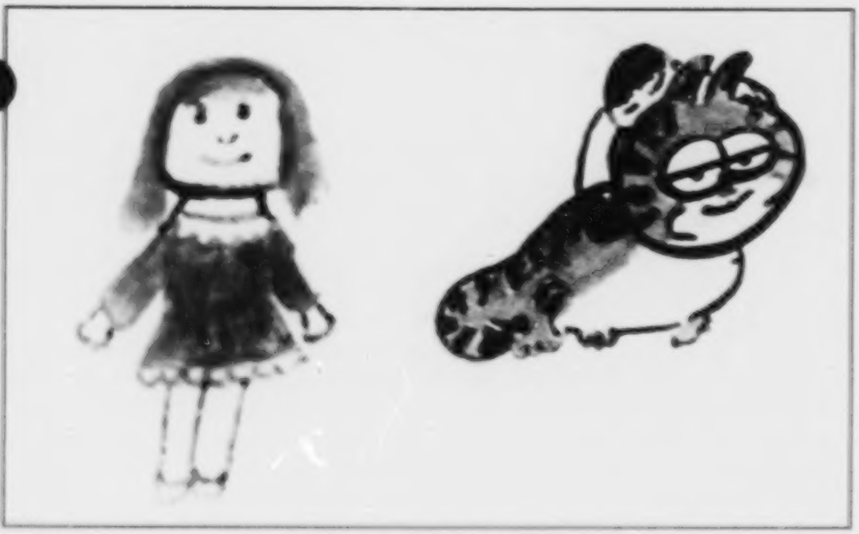


Fig. 2 T. hugs her cat who is drawn as large as her daughter.

chiatric tier of the Women's Division. She was placed in a group of women charged with child abuse and infanticide; still she remained passive and withdrawn. Her passivity prompted a referral to individual art therapy sessions, to which she agreed. Terry and I met once weekly.

In our first session, Terry began with a cheerful demeanor. Beginning with a painting of "Garfield" the cat (Figure 2), she described her love of her own cat who was then at her parents' home. She added herself hugging the cat and then added a picture of her daughter who she said had been central in her life. With that Terry's pleasant mood diminished into tears and depression. She described her daughter as an attractive and good child who began to change shortly after Terry and her husband separated. At that time her daughter appeared to regress to a "baby stage" by wanting to dress in baby clothes and diapers. She noted her daughter became aggressive at the time by choking and kicking others. Continuing, she talked about her feelings of having a child and how disappointed she was having had a girl. She felt that she would not know how to raise a girl. Expressing her feelings of anger, Terry described a fear of hurting her child, and thus, locked herself in the bathroom whenever those feelings arose. Although she informed her family and husband of these hostile feelings, no one took her seriously. Terry said she had asked for help, but no one provided any solutions and she did not seek professional help herself. In her drawing, the cat is as large as her daughter and larger than herself. In depicting herself hugging the cat, she seems to be almost hiding behind it. The animal may have come to represent something she loves and has not harmed.

Terry spoke of being afraid of her older sister, fearing that she would take her daughter away from her, although there was not known probability for this occurring. At the time Terry was crying profusely and went on to say that she was afraid that her daughter would be placed in a foster home where she would be beaten and raped. Again there was no apparent reason for this to occur and may have been a delusion. In order to prevent her daughter from experiencing such a life, Terry purchased a toy to distract her daughter and then shot her. She explained that as the gun fired, she could not believe what had happened in that she did not think the gun was real; however, as her daughter cried out she knew she had to kill her. Logistically, she explained that if she had not killed her daughter, the child would have been taken away. She also added that her daughter would not have overcome the trauma of being shot.

In the next session, Terry filled a sheet of paper with a portrait of her daughter. (This was lightly drawn and did not photograph well.) She spoke of her wish to tell her daughter that she was sorry. When asked how she thought her daughter would respond, Terry did not think that her daughter would believe her. Remembering an earlier incident of shaking her daughter in anger, she remembered apologizing to her daughter who in turn rebuked her mother for not being sincere. Terry explained feeling shocked by her daughter's response because she felt her daughter was correct. As there was time left in the session, Terry drew a full length drawing of herself showing how she felt about herself. She described herself as looking defensive, but felt like a mannequin. In jail one is always told what to do and that made her feel like a child again. In these two pictures she presented some of the overwhelming feelings that she may have felt by her daughter's presence as her daughter was drawn three times larger than herself. The largeness of her daughter's portrait may reflect the great amount of need the child demanded with which Terry could not cope. These may not have been provided for her and, thus, she could not provide them for her child. During this session she also discussed her family relationships.

"Her passivity prompted a referral to individual art therapy sessions, to which she agreed."

"In the next session, Terry filled a sheet of paper with a portrait of her daughter."

Her parent and sister relations were presently improving since her daughter's death (i.e., they all wanted to take care of her). She talked of her husband with whom she did not get along. Reflecting on her marriage she spoke of fights they had which she said included physical abuse.

Terry often complained of nightmares and drew one that she remembered (Figure 3). In this dream she is pregnant a second time and is hysterical in not wanting the baby. Here she wants her daughter. We talked of her feelings during her real pregnancy. At that time she also did not want to be pregnant and thought of arranging an abortion, but was convinced by her sisters not to do so. Contradicting these sentiments, Terry expressed how much she had loved her daughter and emphasized that she had never hit her. In her description she seemed to have idealized her daughter; doing so may have only added to her overwhelming needs.

During Terry's incarceration her twin sister was hospitalized for a potential nervous breakdown. The twin blamed herself for what was happening because she was not more aware of the situation. Depressed about her sister's situation, I asked Terry to draw herself with her sister. The picture (Figure 4) shows Terry (left) sitting in the kitchen with her twin (middle) and older sister (right). She reminisced about the times they would talk together at the kitchen table. Terry was depressed about the fact that these talks stopped once she moved back to her parents' home. Now she felt that her sisters and father would talk about her and stop whenever she entered the room. She added that she felt she and her daughter had imposed on her family (i.e., her daughter would play with her sisters "all of the time"). From listening to Terry speak of this imposition, I was feeling a sense of envy or jealousy on her part. She stressed that her daughter began to spend all of her time playing with the sisters. Envious feelings seemed to have been felt toward the sisters since they received all the child's attention. In addition envious feelings seemed to have been directed toward the child for receiving all of the sisters' attention.

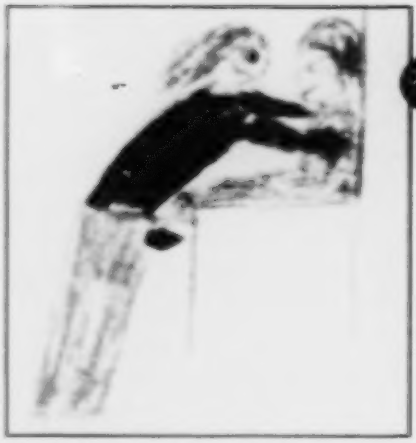
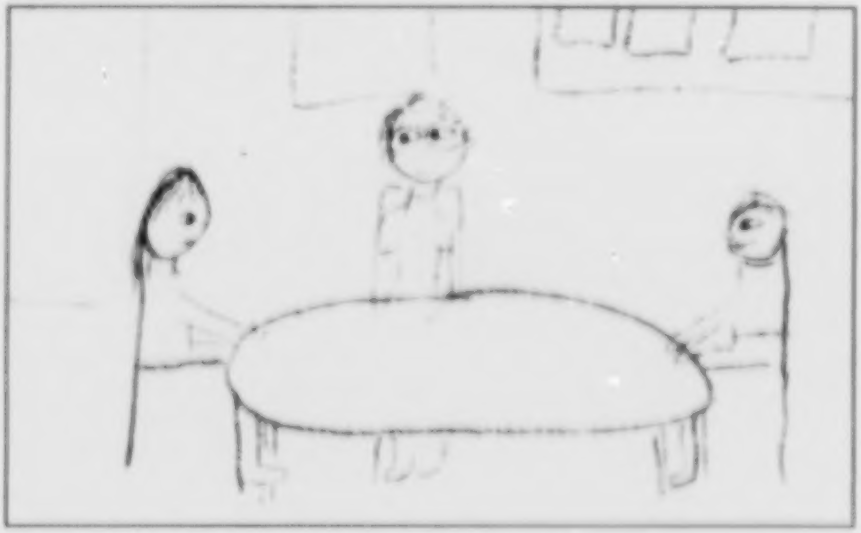


Fig. 3 One dream in which T. expressed fear of pregnancy.

Fig. 4 Sitting with her sisters, T. remembers pleasant times shared together.



Terry spoke of experiencing su[illegible]cidal ideations because of her imposition on her family. She described several planned approaches to suicide such as cutting her wrists, electrocuting herself and shooting herself. These plans were never carried through due to "interruptions." The shooting incident was then recounted. Terry explained that she did not commit suicide due to her realization that she would endure a great deal of pain, but would not feel the pain if she shot her daughter. She added that she felt that her daughter was now in peace and that God intended for the incident to occur because, otherwise, He would not have allowed her to kill her daughter.

Dreams were often the topic of discussion. In the following dream, Terry sees her daughter seated in a high chair (both figures are about the same size). The child is telling Terry that she (daughter) is going to die and would not see her any more In her dream she walked toward the

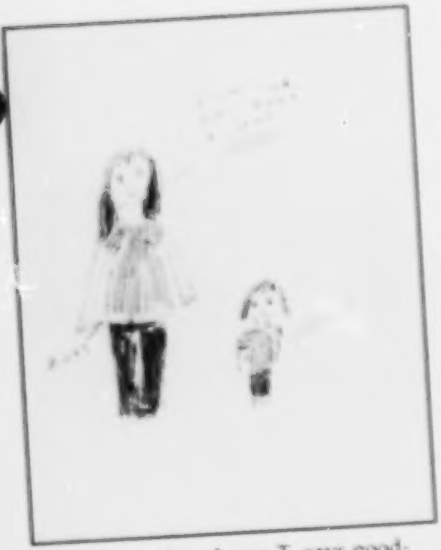


Fig. 5 In another dream T. says good-bye to her daughter. In the drawing, both are equal in size and the mother's hands are fused against her daughter's body.

child, then turned away and then returned to hug and kiss her good-bye (Figure 5). She explained the sense of relief she felt upon waking from the dream. The dream was described as God's way of telling her not to worry because her daughter would be fine. Both sisters agreed that the dream was indeed a sign. To them it gave credence to the daughter's purpose in life which was to get the family to acknowledge Terry's need for help. After drawing the dream, Terry laughed and felt that she had made herself look like a "madman." She laughed saying she could not understand why she looked like a madman when she had so much love for her child. In her drawing Terry's expression appears sinister. She had first drawn her hands pincer-like grasping the child. Upon completion of the drawing she smeared the hands as they now appear fused with the child's body.

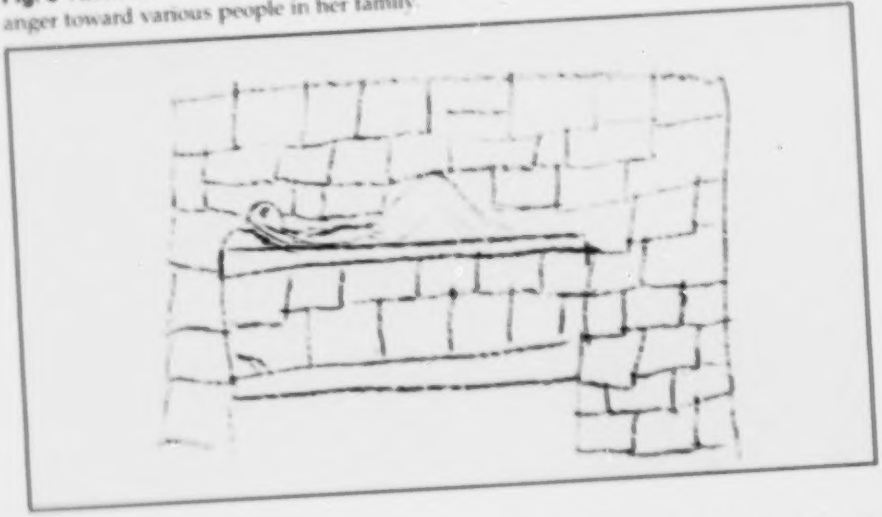
During her stay in the jail, Terry underwent several psychiatric evaluations given through the court (I did not have access to these). Evaluation was to determine sanity which would influence sentencing to be hospitalization or long-term incarceration. She disliked these because of the series of direct questioning. Feeling pressured, she talked of her depression and that it all felt hopeless (Figure 6). Lying in her cell she is depressed and trying not to think. Asking her to describe her depression in the drawing led to some overt expression of anger. She blamed her mother-in-law and husband for what happened, emphasizing that they put pressure on her. She also felt that her father resented her when she moved back home. Both parents and sisters were blamed for not listening to her cries for help. Throughout our sessions, Terry seemed to project all her depression and anger toward the "bad" people in her life which included everyone in her family.

In the final weeks that we met, our sessions focussed more on the hearing and its outcome. Terry's lawyer assured her that they would win the case in court which would lead her to a state mental health facility for treatment. Several of the women on her tier were familiar with the hospital and described parts of it to her. In this session we focussed on her going to the hospital. The drawing she did presents three levels of what she expected the hospital to be like (Figure 7). Others had informed her that the hospital had a piano in the dining room where she drew herself playing while other patients sat at the dinner table. She felt like she would rather play the piano then eat because she was afraid that the others might find out what her charges were. She also pafeared being raped by the male patients and not being able to resist her own sexual desires. As in the previous dream picture, there seems to be an underlying fear of pregnancy in this description.

The second level of the drawing (Figure 7) shows Terry lying on a table where she will be examined by a physician. In a chair she is waiting to be given a dental exam. She spoke of hating to be poked at and was feeling angry. The third level in her drawing depicts visiting day at the hospital. The family was described as having been drawn transparently due to her feelings of uncertainty. It was easy for her to relate to her sisters, but not with her parents.

With a court date approaching, Terry centered on her anxiety. In her courtroom drawing (Figure 8) two lawyers are facing the judge who was described as being understanding of mental illness. The lawyers were said to be scared. To the left are two psychiatrists who evaluated her. Terry is seated at the right table

Fig. 6 Alone in her cell, T. drew herself feeling depressed, but verbally expressed her anger toward various people in her family.



BEST COPY AVAILABLE

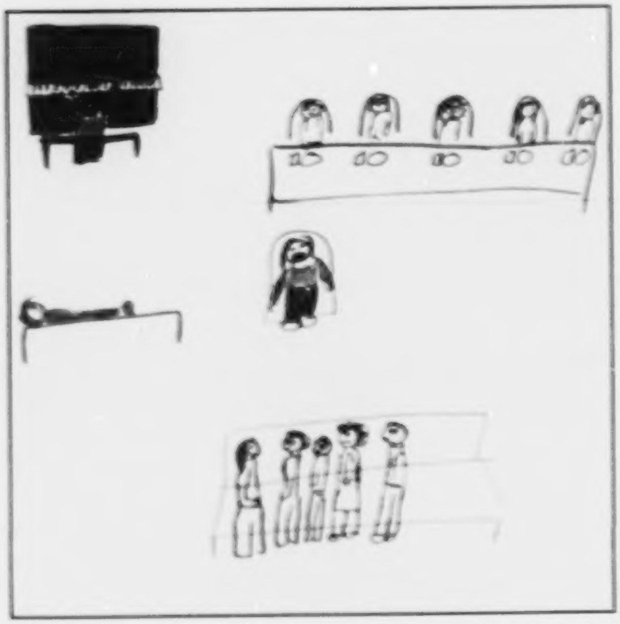


Fig. 7 Preparing for the possibility of entering a state mental health facility initiated fear, anxiety and anger.

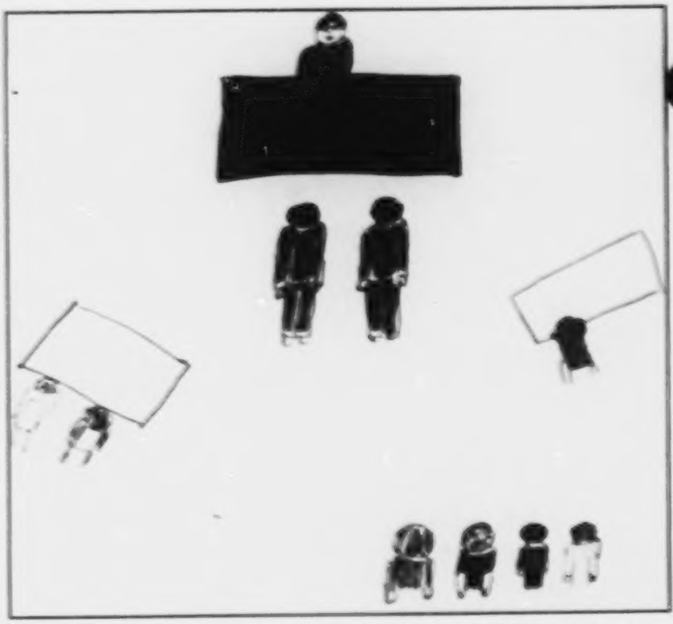


Fig. 8 Anticipating her trial, T. wished that she had died, so that she would not have to endure the pain stemming from the trial.

and is crying. Her family is in the foreground. The courtroom was said to be a dreadful place where she would have to hear about the incident again. She described herself to be crying and wishing that she had been given the electric chair which would have eliminated all of this. Continuing she explained the irony of the whole situation as she previously thought that she would go to jail and die, but now she has to face life ahead of her.

During the week of the hearing we met and Terry was in good spirits; she was happy that it had started. As we talked she began to disclose anger. She was angry because she felt that the lawyer had made her look too ill. The anger appeared to be fear that she would be locked away for a long time. She also expressed outrage that the lawyer said she was jealous of her mother-in-law. Next Terry directed her anger toward her twin who had left home without telling anyone where she was going. Anger was directed toward her mother for being more concerned with her sister. Finally anger was directed toward the jail for not providing her with enough treatment. Mentioning that I felt she might be angry with me, she quickly responded by laughing as she explained that I could leave the jail anytime and I could not help her to get out. She added that she felt safe in jail, often more safe than being on the outside. She drew an image which represented how she was feeling at the moment (Figure 9), she said it looked frightened, but mad. She continued saying that the eyes probably resembled the look she had after shooting her daughter. Terry talked of being mad at everyone and afraid of what will come. We talked more about her loss in life and of the people she loved.

"Although she attempted to develop as an adult, she was unable to cope with the responsibilities of adulthood."

Conclusion

Anger stemming from envy appeared to be the underlying feeling Terry had toward others. By killing her daughter she had regained the child's place in the family once again. Now Terry's family was providing for her needs by taking care of her. Although she attempted to develop as an adult, she was unable to cope with the responsibilities of adulthood. Her inner rage attributed to the constant ambivalence she expressed whenever she tried to be independent. Through our sessions Terry had traced her life history. She recollected her first years of life as being troublesome, expressing that as a child she had an aggressive attitude toward her mother. She seldom spoke of her mother and usually confined discussion of her in negative terms. These aggressive attacks of the child toward the mother were repeated by Terry's daughter. She explained that she had felt shocked when her daughter appeared as behaving violently by kicking and choking others after she and her husband separated. Seeing

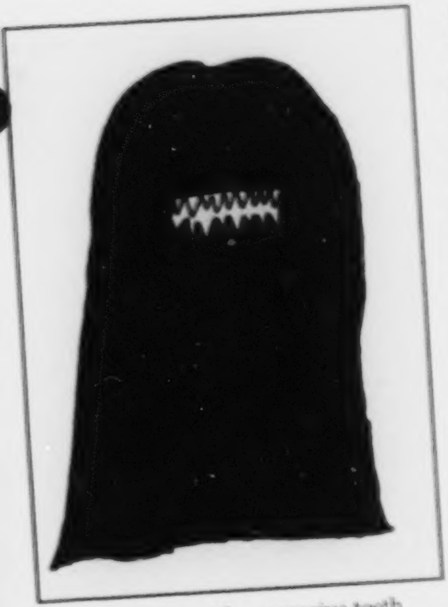


Fig. 9 A figure with aggressive teeth and frightened eyes depicts T.'s present fears and anger as was felt at the time of the murder.

this behavior in her daughter may have added to a fusion of identification with the child. The child-like quality of her art work, portraying herself as a child and stating that she had much of the child within her, also seemed to be indicating Terry's fusion with her daughter.

The projection of the bad object is apparent in all of Terry's relationships, with her sisters, parents, spouse and mother-in-law. All of these people were most often spoken of in negative terms which exemplified a feeling that these people did not provide enough attention and support. They were blamed for her inability to be independent, inability to be helpful and blamed for the death of her child. Perhaps included in the group of individuals seen as bad, was the therapist. Terry often told me how glad she was to have our sessions as they provided some relief from the pressures she experienced on the tier. However, she often expressed concern that I did not like her. Although I tried to show her that I did like her, it seemed difficult for her to believe that people could accept her after what she had done. She expressed her anger toward me for not being able to free her from jail. Here I was not being the good therapist in providing her with what she needed. Perhaps, I, like her family was not providing enough to fulfill her needs. Her constant questioning of my approval emphasized her own pain and fear surrounding her action. It is a fear I believe to be felt by the general population as well. Presently we need to gain awareness of the complexity of the emotional ties that parents and children share. From research we are learning that mothers who kill their infants during post partum psychosis do so as a result of hormonal and chemical change attributed to child birth. Terry's case does not fit this category. Her situation was also not simply a murder, but an intricate, uncontrolled release of rage and confusion stemming from her own childhood experiences. These are incidents which are not easy to understand nor are they easy to explore.

References

Adelson, L. (1961). Slaughter of innocence. *New England Journal of Medicine*, 264, 1345–1349.

Batt, J.C. (1948). Homicidal incidence in the depressive psychosis. *Journal of Mental Sciences*, 94, 782–792.

Bender, L. (1934). Psychiatric mechanisms in child murders. *Journal of Neurosis and Mental Disorders*, 80, 32–47.

Bloch, D. (1978) *So the witch won't eat me, fantasy and the child's fear of infanticide*. New York: Grove Press, Inc.

Cherian, P., Goldstein M., Hardigan, P., and Simmons, R. (1981). The development of a comprehensive psychiatric program within a correctional setting. *Federal Probation*, 45(3), 38–42.

D'Orban, P.T. (1979). Women who kill their children. *British Journal of Psychiatry*, 134, 560–571.

Hamilton, J.A. (1982). The identity of postpartum psychosis. In I.F. Brockington and R. Kunar (Eds.) *Motherhood and mental illness*, (pp. 1–17). New York: Grune and Stratton.

Harder, T. (1967). The psychopathology of infanticide. *ACTA Psychiatricia Scandinavia*, 43, 196–245.

Hopwood, J.S. (1927). Child murder and insanity. *Journal of Mental Science*, 73, 98–108.

McDermaid, G. and Winkler, E.G. (1955). Pathology of infanticide. *Journal of Clinical and Experimental Psychopathology*, 16, 22-41.

Piers, M.W. (1978). *Infanticide*. New York: W.W. Norton and Company, Inc.

Resnick, P. (1969). Child murder by parents: A psychiatric review of filicide. *American Journal of Psychiatry*, 126, 325–334.

Rodenburg, M. (1971). Child murder by depressed parents. *Canadian Psychatric Journal*, 16, 41–44.

Rodenburg, M. (1970). Child murder by depressed mothers: A case report. *Canadian Psychiatric Journal*, 16, 49–53.

Stern, E. (1948). The Medea complex: The mother's homicidal wishes to her child. *Journal of Medical Science*, 94, 321–331.

Tuteus, W. and Glotzer, J. (1954). Murdering mothers. *American Journal of Psychiatry*, 116, 447–452.

Material from this article appears in *The Dynamics of Art Psychotherapy*, by Harriet Wadeson (1987), New York: John Wiley and Sons, pp. 211–219. In the book focus was placed on the phases of art therapy treatment. This current article focuses on the underlying motives for infanticide.

REVIEWS

Freedom to Create

***Florence Ludins-Katz, M.A.** and **Elias Katz, Ph.D.**, Richmond, California, Institute of Arts and Disabilities, 1987. 76 pages, including black and white photographs and line drawings, $10.*

Reviewed by: ***Lucy Sollers Wood, M.F.A., A.T.R.**, Assistant Professor of Art at Towson State University, Towson, Maryland.*

Freedom to Create is a concise handbook outlining basic methodology for establishing basic routines and adapting art processes to the needs of individuals with varied disabilities. The central section of the book (by both placement and length: 40 pages) consists of a series of ten art lessons, ranging from experimental/expressive painting through papier mache maskmaking, printmaking and painting still lifes using various approaches. For each lesson, practical hints are given for organizing materials, equipment and space, preceded by reasons (the intended value) of the lesson, possible problems and ways of dealing with or circumventing these, ways of further developing the lesson, and uses of the product.

In the introductory section there is a strong emphasis in encouraging creativity, and on the unique role of artistic creativity in the lives of the disabled. Attention is called to the encouragement and acceptance of individual approaches to problem-solving and interpretation, as well as to sensitively accepting true limitations of perception and skill, while remaining open to the delight of achieving transcendency over these. They state:

> Creative self-expression is the outward manifestation in an art form of what one feels internally. This expression may find its outlet in painting, sculpture, music, dance, poetry, or in many other forms. It may be inspired by what one sees in the environment or a transformation of it; or it may be a reaction to inner moods, feelings or sensations (page 3).

The separate sections of this definition are discussed, relating them to children with disabilities, to a philosophy of art teaching, and to a credo for art teachers.

The approach is strongly child or client-centered; the emphasis is on the creativity of the client, acceptance of developmental abilities, a positive and constructive approach to the artist and his work. The role of the teacher is seen as stimulating, encouraging, fostering excitement and the desire to experiment and discover. As might be expected, references to Lowenfeld, Rogers and Maslow are included in the short but helpful Bibliography.

The concluding section consists of practical hints for adapting processes and equipment for differing needs. Safety of materials and non-toxicity are emphasized, as are sources for inexpensive or free materials and equipment. Although specific adaptations are offered, the approach is not prescriptive. Rather, the teacher is expected to work with student-artists in designing adaptations to meet individual needs.

Photographs of both children and adults at work, as well as of art products, illustrate each of the lessons. The artists consistently show intense involvement with their work.

The authors have been instrumental in founding four art centers for disabled people between 1973 and 1987. Ms. Ludins-Katz is an artist, teacher and art critic, and Dr. Katz is a clinical psychologist. Their enthusiasm and dedication to their clients rings through the concise but well-filled discussion of creativity and art in the lives of their clients. An earlier book (*Art and Disabilities*, reviewed in *Art Therapy* in October, 1983) discusses the intricacies of establishing and running an art center for the disabled. They bring to this new book a good deal of experience and energy.

There seem to be two primary focuses in this handbook: practical information for management of the room and materials for an active art room, and developing the sensitivity to inner and outer stimuli seen as needed for a creative approach to art-making. The two purposes do not seem, within the structure of the book, to come together. The lesson "plans" do not include many suggestions to encourage open-ended questioning and reflective observations that would help a teacher inexperienced with aesthetic sensitivity to provide sufficient stimulation to encourage creative work. Yet some of the detailed information of set-up and procedures would be unnecessary for an experienced art teacher or therapist attempting to adapt to a disabled population. At times reference is made to displaying the "best" art work, but without discussion as to the criteria for "best." Is this an aesthetic judgment and if so, relative to the student/artist, the teacher, the goals of the plan, or an audience of the general public, since exhibits in public buildings are mentioned? Perhaps the reader best served by *Freedom to Create* would be the artist, already sensitive to inner and outer nuances of stimuli, who wishes to share that excitement and instill it in those who will greatly benefit from the richness of visual art and the valuing of individual uniqueness that should be implicit in the creative process.

Despite my cautiousness regarding intended audience, I feel Ludins-Katz and Katz have something of great value in offering, and encouraging others to offer, a personalized approach to art that emphasized using students' highest and best functioning. A verbal vignette describing the invention by a cerebrally palsied artist of a way of monoprinting is genuinely moving. Perhaps including more such portraits of the process in action would elucidate the underlying philosophy and its assumptions in a more integrated way.

The Living Psyche: A Jungian Analysis in Pictures

Edward F. Edinger, M.D., *Jungian Analyst Chiron Publications, Wilmette, Il., 1990, 205 pages.*

Reviewed by: ***Howard McConeghey, Ed.D., A.T.R.,*** *Professor Director of graduate art therapy program, The University of New Mexico, Albuquerque, N.M.*

As an example of the classical Jungian point of view this book is of unique and important value, especially to art therapists. Although the author suggests that a basic knowledge of Jungian psychology is presupposed, a careful reading of the 104 images, the short description of each by the client, and the analyst's brief comment on each painting, offers meaningful insight into Jungian theory.

Dr. Edinger writes in a manner which is easy to read and which will be clear to any thoughtful reader whether familiar with Jung's psychology or not. He himself was analyzed by Jung. His perception of archetypal content and of the eminence of the numinous psyche are well founded. He attained his medical degree from Yale University in 1946 and is former chairman of the C.G. Jung Training Center in New York, where he practiced as a Jungian analyst for many years. He has written many books, the best known of which include, *Ego and Archetype, Anatomy of the Psyche,* and *Jung's Myth for Modern Man.*

For art therapists the book is especially valuable because it consists of the reproduction of 104 paintings with only brief text. Half of the content is visual. We must, I believe, bear in mind that the author is not an art therapist and that the Jungian approach is not one of art as therapy but rather one of art used in the service of therapy—as a tool for analysis. There is, for example, little concern for the structure of the work as it would constitute the visual context of the image.

Both art and psychotherapy have much to offer our own profession, and we must not neglect either or simply use either as a tool in the service of the other.

Jung insisted that what he and his patients created was not art (although his anima told him that it was art) and he thought that the more aesthetic the work was the less symbolic. It does seem that artistic clients and art therapists themselves work in a different style when consciously attempting to portray their psychological inner states.

The patient in the case presented by Edinger, "began analysis at the age of 36 with the chief complaint being that in spite of a successful career in the arts he had lost his sense of life-purpose and was on the verge of despair." It would be interesting to see examples of his professional art work. His "career in the arts" is not further clarified. However, because a number of the images show stage settings, and most of them emphasize dramatic episodes, and because the work in general tends to lack detail, one might suppose the client's art work was as a set designer in the theater.

This leads me to wonder whether there is an inherent difference between the work one does in therapy and the work the same person would do in simply expressing himself/herself through the visual arts or through professional art work. Although this client had a successful career "in the arts," the paintings over a five year period do not indicate any appreciable artistic progress. By this I mean a greater unity or greater structural complexity, or clarity of emotional involvement, all of which I would think might, in art therapy, coincide with psychological improvement and health.

The question occurs to me whether in art therapy as well as in Jungian analysis, the emphasis on psychological theory and the minimization by the therapist of the artistic quality of the work may influence the client's attitude toward his/her artistic production. (Perhaps we don't really appreciate the client's work *as art*.) I am not speaking of academic conventions of aesthetic quality but of an aesthetic expressive quality—what I believe Edith Kramer means by "formed expression," and what Henry Schaefer-Simmern defines as a developing discrimination of "visual conceiving." Visual conceiving means " a definite mental activity of conceiving relationships of form in the realm of pure vision."

Structural aspects offer a symbolic and archetypal content which may be "amazing" to the analyst if he notices them. Nonetheless, few artists or critics would call this picture an "amazing" or "profound" work of art. My question is whether art therapy might expect formal results equally as profound as the narrative theme itself. Rosenberg has told us that the experience of each individual will be "the ground of a unique inimitable form" and Schaefer-Simmern has shown that ordinary persons in business and the professions as well as delinquent youths and even retarded persons can achieve truly amazing results in visual conception when the subject matter lies in the realm of their interest. The work of his students did achieve progressively greater structural unity and complexity as well as profound clarity of emotional involvement and insight. Such formal development, hand-in-hand with conscious awareness of archetypal numinous values will minister to the integration of personality.

In other words, as there is an interconnection between the formative process and the psychophysical responses of the originator, it can be said that he who forms artistically in turn forms himself. (Schaefer-Simmern, H, *The Unfolding of Artistic Activity*, 3rd ed., Berkley: University of California, 1970, p. 28).

This emphasis on aesthetic form as opposed to what Kramer calls anti-art is the difference I see between art therapy as a unique profession and psychotherapy which may use art as a tool for analysis.

As a study in classical Jungian analysis *The Living Psyche* will be interesting to all therapists, as a clear depiction of art in the service of psychotherapy. By contrast to our mode of formative aesthetic therapy it can help art therapists to recognize the uniqueness of our own profession among other professions of psychotherapy. At least the emphasis on art and the preponderance of visual presentation in this book is a welcome innovation.

ART THERAPY
Journal of the American Art Therapy Association

ADVERTISING RATES

RATES	1x	2x	3x
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140

SPECIAL POSITIONS	additional
Cover #2 (Inside Front)	$130
Cover #3 (Inside Back)	130
Cover #4 (Outside Back)	165

COLOR RATES: Standard Red, Blue and Yellow (Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x
Per page additional	$90	$85	$80

INSERTS	1x	2x	3x
2 pp	$ 800	$ 700	$ 575
4 pp	1,500	1,300	1,150
8 pp	2,200	2,000	1,750

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size:	8-1/2" x 11"
Bleed Size:	8-5/8" x 11-1/4"
Inserts:	8-5/8" x 11-1/4"

SUBMISSION DEADLINES:

January 7 for March issue; April 7 for June / July issue; September 7 for November issue

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, IL 60060
(708) 949-6064

The American Art Therapy Association, Inc.

THE ORGANIZATION

The American Art Therapy Association (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3000 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice; AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliated Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive:

Publications

- *Art Therapy*, the official journal of the AATA.
- The quarterly *AATA Newsletter*.
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- Free AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payers.
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy.

Professional Standards

- Development of model job and licensure laws.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

GENERAL MEMBERSHIP APPLICATION

1. The membership year is the calendar year January 1st through December 31st.

2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY. Please follow the chart below when submitting membership application.
Applications received between

Jan. 1st and May 31st — Full dues payment. Membership will expire Dec. 31st of same year.

June 1st and Sept. 30th — Half year dues plus $5.00 payment; membership will expire Dec. 31st of same year.

Oct. 1st and Dec. 31st — Full dues payment, membership for the remainder of current year and the next full year through Dec. 31st.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval.

4. AATA Membership and AATA Registration (ATR) each have a separate application procedure. Registration is bestowed only by the Standards Committee.

5. National AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL — by application only; such members may vote, hold office and serve on committees.

Credentialed Professional Member: Individuals who have been dually approved for Professional Membership and Registration (ATR) by the AATA; dues are $80 per year.

Active Professional Member: Individuals who have completed professional training in art therapy; dues are $75 per year.

CONTRIBUTING — Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $100 per year.

ASSOCIATE — Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75 per year.

STUDENT — Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Student members may not vote or hold office but may serve on the Student Subcommittee of Membership. Dues are $35 per year.

See other side for Application Form

Mail entire form to:

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, IL 60060
(708) 949-6064

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

MEMBERSHIP APPLICATION

NAME ___________________________
last first middle

HOME ADDRESS ___________________________

____

PHONE (   ) ___________________________

BUSINESS ADDRESS ___________________________

____

____

BUSINESS PHONE (   ) ___________________________

EMPLOYER ___________________________

JOB TITLE ___________________________

LICENSES HELD & STATE ___________________________

PREFERRED MAILING LIST

___ HOME ___ BUSINESS

Please indicate which of the following you are applying for:

___ PROFESSIONAL MEMBERSHIP (an application packet for Professional Membership will be sent to you)

___ REGISTRATION (ATR) (an application packet for Registration will be sent to you)

___ $75 PROFESSIONAL MEMBERSHIP (after approval)

___ $80 ATR MEMBERSHIP (after approval)

___ $100 CONTRIBUTING MEMBERSHIP

___ $75 ASSOCIATE MEMBERSHIP

___ $35 STUDENT MEMBERSHIP (see student membership criterion for necessary documents to accompany this application)

PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO AATA
American Art Therapy Association, Inc.
1202 Allanson Rd./Mundelein, IL 60060

Please complete this survey:

Education (please check highest degree earned)

1 ___ Doctorate Degree
2 ___ Master's Degree
3 ___ Bachelor's Degree
4 ___ Associate/Certificate
5 ___ Other

Work Setting (please check one only)

1 ___ Hospital
2 ___ Clinic
3 ___ Day treatment center
4 ___ Rehabilitation
5 ___ Sheltered workshop
6 ___ Correctional facility
7 ___ Residential treatment
8 ___ Out-patient mental health
9 ___ School system
10 ___ Elderly care facility
11 ___ College/University
12 ___ Clinical training program
13 ___ Institute training program
14 ___ Counseling center
15 ___ Private practice
16 ___ Other ___________

Area(s) of Specialization (please check up to three)

1 ___ Addictions
2 ___ Adolescents, Hospitalized
3 ___ Adolescents, Psychiatric
4 ___ Adults, Hospitalized
5 ___ Adults, Psychiatric
6 ___ Art History
7 ___ Art Therapy Education
8 ___ Art Therapy in Schools
9 ___ Children, Hospitalized
10 ___ Children, Psychiatric
11 ___ Domestic Violence
12 ___ Eating Disorders
13 ___ Families
14 ___ Gerontology
15 ___ Hospice/Terminally Ill
16 ___ Learning Disability
17 ___ Mental Retardation
18 ___ Neurological Disease
19 ___ Prisoners
20 ___ Post Traumatic Stress
21 ___ Psychotherapy
22 ___ Rehabilitation
23 ___ Research
24 ___ Sexual Abuse
25 ___ Visual Art
26 ___ Other ______

Voluntary Information:

Age:

1 ___ 20-24
2 ___ 25-29
3 ___ 30-34
4 ___ 35-39
5 ___ 40-44
6 ___ 45-49
7 ___ 50-54
8 ___ 55-59
9 ___ 60 +

Salary Range:

1 ___ under $10,000
2 ___ $10-15,000
3 ___ $15-20,000
4 ___ $20-25,000
5 ___ $25-30,000
6 ___ $30-35,000
7 ___ $35-40,000
8 ___ $40-45,000
9 ___ $45-50,000
10 ___ $50,000 +

Gender:

1 ___ Female
2 ___ Male

Hours Worked per Week:

1 ___ 0-10
2 ___ 10-20
3 ___ 20-30
4 ___ 30-40

CHARLES C THOMAS • PUBLISHER

☐ Boy, Angelo V. and Gerald J. Pine—**A PERSON-CENTERED FOUNDATION FOR COUNSELING AND PSYCHOTHERAPY.** '90, 234 pp. (7 × 10), 2 il., about $42.75.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 226 pp. (6⅛ × 9¼), 21 il., about $42.75.

☐ Pine, Vanderlyn R.—**UNRECOGNIZED AND UNSANCTIONED GRIEF: The Nature and Counseling of Unacknowledged Loss.** '90, 198 pp. (7 × 10), about $34.75.

☐ Chaika, Elaine Ostrach—**UNDERSTANDING PSYCHOTIC SPEECH: Beyond Freud and Chomsky.** '90, 380 pp. (7 × 10), About $58.75.

☐ Crespi, Tony D.—**CHILD AND ADOLESCENT PSYCHOPATHOLOGY AND INVOLUNTARY HOSPITALIZATION: A Handbook for Mental Health Professionals.** '89, 162 pp. (7 × 10), 1 table, $31.75.

☐ Morse, H. Newcomb—**COMMENTARY ON LEGAL PSYCHIATRY.** '89, 300 pp. (7 × 10), $47.75.

☐ Dennison, Susan T.—**TWELVE COUNSELING PROGRAMS FOR CHILDREN AT RISK.** '89, 430 pp. (7 × 10), 55 il., $64.75.

☐ Foxman, Joel—**A PRACTICAL GUIDE TO EMERGENCY AND PROTECTIVE CRISIS INTERVENTION.** '89, 320 pp. (7 × 10), $49.75.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6⅛ × 9¼), 56 il., $38.25.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 186 pp. (7 × 10), 11 il., 3 tables, $44.75.

☐ Brandt, David E. & S. Jack Zlotnick—**THE PSYCHOLOGY AND TREATMENT OF THE YOUTHFUL OFFENDER.** '88, 262 pp. (7 × 10), 1 il., 5 tables, $32.75.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (7 × 10), 34 il., $38.25.

☐ Berger, Arthur S.—**EVIDENCE OF LIFE AFTER DEATH: A CASEBOOK FOR THE TOUGH-MINDED.** '88, 160 pp. (7 × 10), $25.25, paper.

☐ Crow, Gary A. & Letha I. Crow—**THE FUNCTIONING OF THE FAMILY SYSTEM: An Educational Approach to Positive Procedures Within Areas of Family Life.** '88, 208 pp. (7 × 10), $32.75.

☐ Dennison, Susan T.—**ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents.** '88, 236 pp. (7 × 10), 36 il., 26 tables, $36.25.

☐ Mendelson, George—**PSYCHIATRIC ASPECTS OF PERSONAL INJURY CLAIMS.** '88, 296 pp. (7 × 10), 3 il., 5 tables, $43.75.

☐ Hosford, Bowen—**WINNING IN YOUR PROFESSION BY WRITING BOOKS: A How-To Book for Professionals in the Biomedical and Behavioral Sciences and the Law.** '90, 212 pp. (7 × 10), 9 il., $36.75.

☐ Harman, Robert L.—**GESTALT THERAPY DISCUSSIONS WITH THE MASTERS.** '90, 238 pp. (7 × 10), about $34.75.

☐ Ho, Man Keung—**INTERMARRIED COUPLES IN THERAPY.** '90, 154 pp. (7 × 10), 2 il., About $29.75.

☐ Felthous, Alan R.—**THE PSYCHOTHERAPIST'S DUTY TO WARN OR PROTECT.** '89, 194 pp. (8½ × 11), 6 tables, $35.75.

☐ Geldard, David—**BASIC PERSONAL COUNSELING: A Training Manual for Counselors.** '89, 214 pp. (7 × 10), 28 il., $29.75, paper.

☐ Gregg, Charles H., Judy L. Robertus & J. Blair Stone—**THE PSYCHOLOGICAL ASPECTS OF CHRONIC ILLNESS.** '89, 344 pp. (7 × 10), 7 il., 15 tables, $49.75.

☐ Farmer, James A.—**POSITIVE INFLUENCE: A Practical Guide for Dealing With Teenage Aggression.** '89, 100 pp. (7 × 10), $22.75.

☐ Harman, Robert L.—**GESTALT THERAPY WITH GROUPS, COUPLES, DYSFUNCTIONAL MEN, AND DREAMS.** '89, 162 pp. (7 × 10), $31.75.

☐ Jewell, David L.—**CONFRONTING CHILD ABUSE THROUGH RECREATION.** '89, 358 pp. (7 × 10), 1 il., 28 tables, $53.75.

☐ Lester, David—**SUICIDE FROM A SOCIOLOGICAL PERSPECTIVE.** '89, 138 pp. (7 × 10), $27.75.

☐ MacHovec, Frank J.—**CULTS AND PERSONALITY.** '89, 210 pp. (7 × 10), $34.75.

☐ Roth, Nathan—**THE PSYCHIATRY OF WRITING A WILL.** '89, 86 pp. (7 × 10), $24.75.

☐ Steen, Charlene & Barbara Monnette—**TREATING ADOLESCENT SEX OFFENDERS IN THE COMMUNITY.** '89, 212 pp. (7 × 10), 61 il., $39.75.

☐ Weiss-Lambrou, Rhoda—**THE HEALTH PROFESSIONAL'S GUIDE TO WRITING FOR PUBLICATION.** '89, 160 pp. (7 × 10), 2 il., 12 tables, $29.75.

☐ Malcolm, John Gulton—**TREATMENT CHOICES AND INFORMED CONSENT: Current Controversies in Psychiatric Malpractice Litigation.** '88, 136 pp. (7 × 10), $30.75.

☐ Gutsch, Kenneth Urial—**PSYCHOTHERAPEUTIC APPROACHES TO SPECIFIC DSM-III-R CATEGORIES: A Resource Book for Treatment Planning.** '88, 276 pp. (7 × 10), $40.25.

☐ Haig, Robin Andrew—**THE ANATOMY OF HUMOR: Biopsychosocial and Therapeutic Perspectives.** '88, 224 pp. (7 × 10), 6 il., 3 tables, $32.75.

Books sent on approval • Catalog sent on request • Write, call (217)789-8980 or FAX (217)789-9130

2600 South First Street Springfield • Illinois • 62794-9265

Professional Safety Net

Prudent healthcare professionals take specific steps to protect themselves against catastrophic losses. The legal interpretations of acceptable practice and professional problems change from day to day. As a result, anything can happen... suddenly and without warning. One lawsuit — and you could lose everything.

Our Professional Liability Insurance Program offers the winning combination of comprehensive protection at a very economical price. This outstanding sponsored plan not only provides million-dollar limits, but also includes reimbursement for legal fees, court costs and more!

Get all the facts by calling 1-800-621-3008 Ext. 105 or clip and return the attached coupon today!

[illegible]

Yes! I would like to learn more about the AATA sponsored liability program described above. Please send complete details.

Name ______________________________

Address ______________________________

City ______________________________

State ______________________________

Zip ______________________________

Maginnis And Associates, Inc.
Professional Insurance Administrators
332 South Michigan Ave., Chicago, IL 60604
1-800-621-3008; ext. 105

SAN FRANCISCO

20TH ANNUAL CONFERENCE PROCEEDINGS
1989 SAN FRANCISCO, CALIFORNIA

The 1989 AATA Conference Proceedings, "PAINTING PORTRAITS, Families, Groups, & Systems" November, 1989, are available through the AATA National Office in abstract form.

PRICE PER COPY:

Member - $15.00 each
Non-member - $20.00 each
10 or more - $12.00 each

QUANTITY		COST		TOTAL
________	x	______	=	______

SEND TO:

NAME/INSTITUTION ______________________________ MBR ID #

ADDRESS ______________________________

CITY ______________________________ STATE ________ ZIP CODE ________

TELEPHONE ______________________________

TO ORDER COPIES: Mail order form ► along with payment to:

● American Art Therapy Association,
1202 Allanson Rd.
Mundelein, IL 60060

Please make checks payable in U.S. funds to AATA.

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(708) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapist's Identity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) 110 pages	$15.00	$20.00
Art Therapy: Professionalism in Practice (1988)	$15.00	$20.00
Conference Proceedings (1989) *Painting Portraits: Families, Groups & Systems*	$15.00	$20.00
Art Therapy: Journal of the American Art Therapy Association Rates: Individuals — U.S. $23.00; Foreign $30.00; Institutions — U.S. $27.00; Foreign $36.00		
Art Therapy: Journal - Back Issues	$9.00 each	$12.00 each
American Psychiatric Association Special Conference Proceedings *Use of the Creative Arts on Therapy (1979)*	$5.00	$7.00
AATA Newsletter Subscription		$9.00
Full Color Poster (16 x 20)	$1.00	$2.00
Art Therapy in the Schools	$6.00	$10.00

*NOTE: for **Publications** postage/handling, add $3.00 for the first unit item, $.75 each additional unit.

SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS.

**Foreign Orders: Require pre-payment for items and then will be billed for shipping charges as you instruct on order:
Air Mail charges (1 week delivery) or Ground Services charges (2 month delivery)

10 or more copies of any single issue: 15% discount on total cost. Discounts are available when purchasing quantities. Set of four Proceedings (consecutive years): 20% discount on total cost.

Indicate Quantity of Unit Items Below		**Cost/Unit**		**Total**
____________	( ) X	________	=	________
____________	( ) X	________	=	________
____________	( ) X	________	=	________
____________	( ) X	________	=	________

*Publications Postage/Handling = ________ Total Publications Costs = ________

FILMS (Rental/Purchase)

Art Therapy: Beginnings (1977) color/sound, 45 minutes	16mm Rental Only:	$40.00	$50.00
	1/2" VHS, Purchase Only:	$50.00	$80.00
Michael (1977) color/sound, 12 minutes	16mm Rental Only:	$30.00	$35.00
	1/2" VHS, Purchase Only:	$50.00	$80.00
Art Therapy (1981) color/sound, 12 minutes	16mm Rental Only:	$35.00	$45.00
	1/2" VHS, Purchase Only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery (1978) color/sound, 32 minutes	16mm Rental Only:	$40.00	$50.00
	1/2" VHS, Purchase Only:	$50.00	$80.00

*NOTE: for **VHS Films Purchase** postage/handling add $2.50 for each film. *NOTE: for **16mm Rental** add $7.00 for postage and handling.

Indicate Quantity of Unit Items Below		**Cost/Unit**		**Total**
____________	( ) X	________	=	________
____________	( ) X	________	=	________

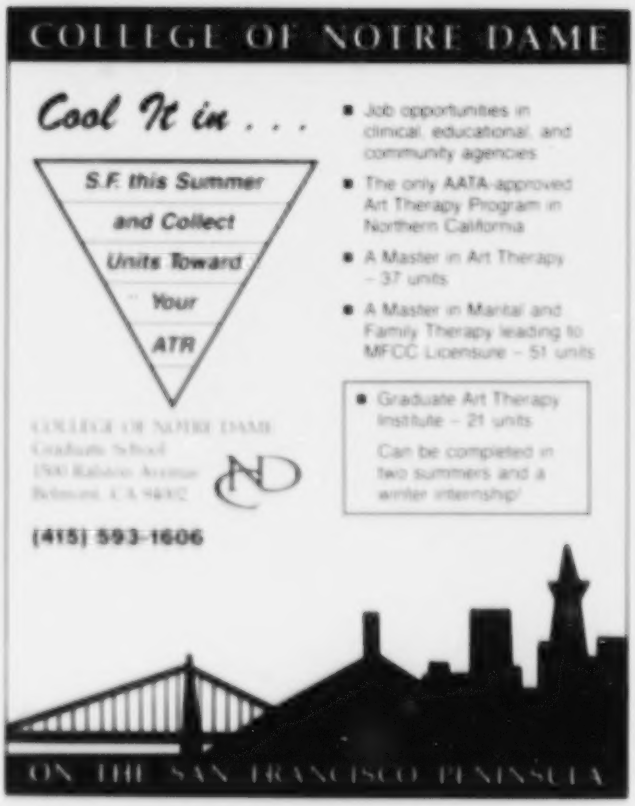
*Films Postage/Handling = ________ Total Films Costs = ________

ORDER FORM: ***Make checks payable in U.S. funds to AATA, and mail to the above address***

SEND TO: ______________________ MBR. ID# ________

____

City ____________ State ____________ Zip Code ____________


COLLEGE OF NOTRE DAME

Cool It in . . .

S.F. this Summer
and Collect
Units Toward
Your
ATR

- Job opportunities in clinical, educational, and community agencies
- The only AATA-approved Art Therapy Program in Northern California
- A Master in Art Therapy – 37 units
- A Master in Marital and Family Therapy leading to MFCC Licensure – 51 units

- Graduate Art Therapy Institute – 21 units

Can be completed in two summers and a winter internship!

COLLEGE OF NOTRE DAME
Graduate School
1500 Ralston Avenue
Belmont, CA 94002

(415) 593-1606

ON THE SAN FRANCISCO PENINSULA

Master's Degree Program in Expressive Therapies and in Creative Arts in Learning

**Offered by the Institute for the Arts
and Human Development
Lesley College Graduate School**

Masters of Arts in Expressive Therapies
For students interested in the creative modalities of art, music, dance/movement, and drama, presented in a clinical and theoretical framework for a variety of settings.

Master of Education in Creative Arts in Learning

For students who wish to learn how to integrate the arts for careers in schools, cultural institutions, and human services institutions. Specializations in storytelling and theater studies.

For more information call or write the Institute for the Arts and Human Development, Lesley College Graduate School, 29 Everett Street, Cambridge, MA 02138-2790. (617) 868-9600, ext. 480

Lesley College
GRADUATE SCHOOL

Leslie College is an Equal Opportunity/Affirmative Action institution.

Guidelines for Authors

Please submit five (5) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed.D., A.T.R., AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060. AATA cannot be responsible for submissions sent to any other address. Send manuscripts and illustrations certified mail, with return receipt requested. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

CONFIDENTIALITY: Client/Patient confidentiality must be protected in title, abstract, text, photos and other accompanying material. Proper releases must be obtained.

The Biggest Event for Creative Arts Therapists this Century!

CREATIVITY THROUGH COLLABORATION

CREATIVITY THROUGH COLLABORATION

Over 300 Sessions!
Pre-Conference Intensives!
Both Interdisciplinary
and Single Modality
Workshops!

November 1 – 5, 1990
Thursday morning
through Monday noon
Grand Hyatt Hotel and
Holiday Inn Crowne Plaza
Washington, D.C.

It's like having
your own conference
plus
much, much more!

National Coalition Of Arts Therapy Associations Conference

The Joint Annual Meetings of American Art Therapy Association, American Association for Music Therapy, American Society of Group Psychotherapy and Psychodrama, American Dance Therapy Association, National Association for Drama Therapy, National Association for Music Therapy

- **SPECIAL FOCUS on each of the creative arts therapies in the treatment of AIDS, addictions, terminally ill, PTSD, brain injury, geriatric, and psychiatric populations.**

FEATURED SPEAKERS:

- **Rollo May**
  Author of *Love and Will, Man's Search for Himself, The Courage to Create.*
- **Edith Wallace, M.D., Ph.D.**
  Respected Jungian analyst and award-winning artist. Editor-in-chief Emeritus of the *International Journal of Arts in Psychotherapy.*
- **Joseph Noshpitz, M.D.**
  Noted psychiatrist and child psychoanalyst.
- **Celeste Holm**
  Celebrated actress of the stage and screen; President of the Creative Arts Rehabilitation Center in New York City.

FEATURED ENTERTAINMENT:

- **Spalding Gray**
  Writer and performer of autobiographical monologues. Movies include "The Killing Fields" and "Swimming to Cambodia."
- **Baba Olatunji**
  Master percussionist from Nigeria whose albums include Drums of Passion and Dance to the Beat of My Drum.
- **Susan Osborn**
  A lead singer with the Paul Winter Consort and workshop leader in exploring one's own voice.

Registration material will be mailed out in July 1990 through your professional association. If you are not a member of one of the co-sponsoring organizations and you would like to be placed on the mailing list, call NCATA at 609-848-1000 Ext 213.

The Pre-registration Deadline is September 10, 1990.

NEW & IMPORTANT BOOKS FROM JOHN WILEY & SONS
Stern's Book Service
2004 West Roscoe, 2nd Floor Chicago, IL 60618 (312) 883-5100

BLUME, E. Sue, Secret Survivors: Uncovering Incest and Its Aftereffects in Women. 1990 $19.95.

ROSS, Colin. Multiple Personality Disorder: Diagnosis, Clinical Features & Treatment. 1989 $45.00.

GOLDSTEIN & Goldstein. Managing Attention Disorder. $49.95.

SCHAEFER, Charles & Steven Reid. Game Play. 1986 $39.95.

SCHAEFER, Charles. Innovative Interventions in Child & Adolescent Therapy. 1988 $45.00.

SCHEIKH & Scheikh. Eastern & Western Approaches to Healing: Ancient Wisdom & Modern Knowledge. 1989 $55.00.

WADESON, Harriet. The Dynamics of Art Psychotherapy. 1987 $32.95.

WADESON, Harriet, Jean Durkin & others. Advances in Art Therapy. 1989 $47.95.

TO ORDER: Please call or write us at Stern's. Stern's accepts personal checks, purchase order numbers, Visa, MCard & AmExpress. By mail, please include $3.00 shipping for the first book; 50¢ for each title after the first. We ship via UPS (no PO boxes please). For foreign shipments or airmail, please call or write for shipping amounts.

1988 AATA
MEMBERSHIP DIRECTORY

Now Available through the National Office

$8.00 member **$50.00** non-member
$100.00 institution

NAME ______________________________
ADDRESS ___________________________
CITY ______________________________
STATE ______________ ZIP ___________

Mail entire form to:
AATA NATIONAL OFFICE
1202 Allanson Rd./Mundelein, IL 60060

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1990. Enclosed is my check, payable to AATA, for $23.
Name ____________________
Address ____________________
City ____________________ State __________ ZIP __________

The interdisciplinary journal
devoted to the creative arts as healing arts

THE ARTS IN PSYCHOTHERAPY

An International Journal

ARTS PSYCHOTHERAPY

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Associate Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

PERGAMON PRESS
Maxwell House, Fairview Park, Elmsford, NY 10523
Headington Hill Hall, Oxford OX3 0BW, England
Member of Maxwell Macmillan Pergamon Publishing Corporation

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!

Members of qualifying societies can receive a discount on one-year Professional subscriptions to the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

Editors welcome original manuscripts. Submit papers in triplicate to: Managing Editor, Sylvia Halpern, 20 Ridgecrest East, Scarsdale, NY 10583

SUBSCRIPTION INFORMATION

ISSN: 0197-4556	Volume 17, 1990
Published 4 issues per annum	
Annual Institution Subscription Rate (1990)	US$130.00
Two-year Institution Rate (1990/91)	US$247.00
Professional Rate (1990)	US$ 40.00
Student Rate (1990)	US$ 16.00

BEST COPY AVAILABLE

ART THERAPY

Volume 7, Number 3
Fall 1990

Journal of the American Art Therapy Association

- Through the Looking Glass: Dark Sides I, II, III
  I. Harriet Wadeson, Ph.D., A.T.R.
  II. Rose Marano Geiser, M.A., A.T.R.
  III. Joanne Ramseyer, M.A., A.T.R.
- Screening Kindergarten Students: An Art Therapy Assessment
  Winnie Ferguson, Ph.D., A.T.R.
  Deborah Debevec, M.A.T., A.T.R.
- Grants: Demystifying the Mystique and Job Connections - Part II
  Doris Arrington, Ed.D., A.T.R.
- Imagery as Interpersonal Process
  Pierre A. Gregoire, Ph.D., A.T.R.
- Enhancement of Body Image: A Structured Art Therapy Group with Adolescents
  Stanley Schneider, Ph.D.
  Shelley Ostroff, M.A., A.T.R.
  Nancy Legow, M.A., A.T.R.

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). Single copies are available at $9. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1990

Linda Gantt, Ph.D., A.T.R., *President;*
Robin F. Goodman, Ph.D., A.T.R., *President Elect;*
Cathy Malchiodi, M.A., A.T.R., *Secretary;*
Virginia Minar, M.S., A.T.R., *Treasurer;*
Doris Arrington, Ed.D., A.T.R., *Director;*
Shirley Riley, M.A., A.T.R., M.F.C.C., *Director;*
Deborah Good, M.A., A.T.R., *Director;*
Dean Wilson, A.T.R., *Director;*
Barbara Fish, M.A., A.T.R, *Affilitate Chapters*

Executive Director

Edward J. Stygar, Jr.

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, Ed.D., A.T.R. 105

Articles

Through the Looking Glass: Dark Sides I, II, III
I. Harriet Wadeson, Ph.D., A.T.R.
II. Rose Marano Geiser, M.A., A.T.R.
III. Joanne Ramseyer, M.A., A.T.R. 107

Screening Kindergarten Students: An Art Therapy Assessment
Winnie Ferguson, Ph.D., A.T.R.
Deborah Debevec, M.A.T., A.T.R. 119

Grants: Demystifying the Mystique and Job Connections - Part II
Doris Arrington, Ed.D., A.T.R. 126

Imagery as Interpersonal Process
Pierre A. Grégoire, Ph.D., A.T.R. 128

Enhancement of Body Image: A Structured Art Therapy Group with Adolescents
Stanley Schneider, Ph.D.
Shelley Ostroff, M.A., A.T.R.
Nancy Legow, M.A., A.T.R. 134

Reviews

Depth Psychology of Art
Gary C. Barlow, Ed.D., A.T.R. 139

The Discovery of the Art of the Insane
Aina O. Nucho, Ph.D., A.T.R., ASCW 140

Developing Cognitive and Creative Skills through Art: Programs for Children with Communication Disorders or Learning Disabilities (3rd Ed)
Marcia Rosal, Ph.D., A.T.R. 142

On the Cover

"Our House on the Lake." A painting completed by an 83 year old woman in art therapy, in a Dayton, Ohio nursing home.

Volume 7, Number 3 Fall 1990

EDITORIAL BOARD

Editor
Gary Barlow, Ed.D., A.T.R.
Book Reviews
Winnie Ferguson, Ph.D., A.T.R.
Managing Editor
Marcia May-Chambers

Contributing Editors
Frances Anderson, Ed.D., A.T.R., HLM
Michael Campanelli, Ed.D., A.T.R.
Susan Cheyne-King, M.S., A.T.R.

Carol Cox, A.T.R.
Maxine Junge, A.T.R.
Paulo Knill, Ph.D., A.T.R.
Wendy R. Lauter, A.T.R.
Vija Lusebrink, A.T.R.
Howard McConeghy, A.T.R.
Paul Rodenhauser, M.D.
Marcia Rosal, Ph.D., A.T.R.
Lewis Shupe, Ph.D., A.T.R.
Sandra Ticen, M.S., A.T.R.
Betty Jo Troeger, Ph.D., A.T.R.
Robert Wolf, M.P.S., A.T.R.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

American Art Therapy Association, Inc. 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064

Copyright © 1990 American Art Therapy Association

EDITORIAL

In the book *Acting-In, Practical Applications of Psychodramatic Methods**, the author is concerned with, among other issues, the principles and pitfalls relative to effective helping relationships. In chapter seven Adam Blatner, M.D., writes about the sense of professional commitment and intellectual humility together with the formation of a "truly mutual relationship with clients." (p. 102) Within the section titled 'The Context of Mutuality,' (referring to the wholehearted respect of the client as one who is growing and exploring) the author states that "within the group the sense of mutual trust can only grow when based on norms of respect." (p. 102) Further, in his discussion on professional humility, the author states that it is essential that the director (and therapist) have an awareness of the strengths and limitations of the many methods in helping personal development.

"Over the last decade" says Blatner, "scores of innovations have been introduced into the fields of psychotherapy, education, and management. All too often the proponents of these new methods tend to idealize their pet approach. This leads to the pitfall of applying that method indiscriminately: Those protagonists for whom a certain approach is ineffective may be coerced into useless efforts at staying with that method. The true professional knows that there are many varied populations that require different therapeutic or educational approaches." (pp. 103–4)

Blatner's writing raises implicit cautions for the art therapist. How cognizant are we to the exploration of various approaches or beliefs in addition to the one(s) with which we are most comfortable? How often do we explore other avenues that are available for those with whom we work (client, colleague, parent, and others)? Is it possible that we might fall into a stereotyped approach, method or expected outcome? If so, we need to identify, and practice, ways that can begin to break through the barriers that may hamper further insight and understanding.

The author's brief discussions of "pathological spontaneity" (p. 104) and "Action vs. Awkwardness" (p. 105) are compelling in stimulating personal thinking and evaluation and, although discussion cannot be presented here because of space, these issues are important for any of us to consider. The paperback is a second edition publication, and worth our reading and thinking about.

The articles in this issue are by the following authors: (1) Harriet Wadeson, Rose Marano Geiser and Joanne Ramseyer; (2) Winnie Ferguson; (3) Doris Arrington; (4) Pierre Grégoire; and (5) Stanley Schneider, Shelley Ostroff and Nancy Legow. As in the articles published in past issues of *Art Therapy*, I believe that the readers will find these current articles timely and pertinent for our field. It is gratifying, as an editor, to receive creative, informative and well-written articles that 'say something' to the readership. It has always been a policy to present the various issues of *Art Therapy* in a format that is not only attractive in design, but also carry important messages relative to our profession. So, let me offer my congratulations and appreciation to all past and present authors for a 'job well done,' and I encourage future authors to continue writing important articles to share with others.

I look forward to working with the new A.A.T.A. Editorial Board of Art Therapy. These members are: Paulo Knill; Susan Cheyne-King; Robert Wolf; Paul Rodenhauser; Lewis Shupe; Carol Cox; Maxine Junge; Michael Campanelli; Howard McConeghey; Sandra Ticen; Wendy R. Lauter; Marcia Rosal; Betty Jo Troeger; Vija Lusebrink; and Frances Anderson. In addition, Winnie J. Ferguson has agreed to serve as the journal's Book Review Editor since Aina O. Nucho has stepped down from this position. Aina has done a tremendous job, and I thank her for the time and effort given in this capacity. Similarly, the past members of the Editorial Board have contributed time and talent to help make our journal an outstanding one. Sincere appreciation goes to each of them for their excellent work.

"There is always one moment in childhood when the door opens and lets the future in." (Quote by Graham Greene; specific reference unknown) Have a happy, profitable and satisfying New Year!

Gary C. Barlow, Ed.D., A.T.R.
Editor, Art Therapy

---

*Blatner, A., M.D. (1988). *Acting-In, Practical Applications of Psychodramatic Methods*

Through the Looking Glass: I. When Clients' Tragic Images Illuminate the Therapist's Dark Side

***Harriet Wadeson, Ph.D., A.T.R.,** Coordinator, Art Therapy Graduate Program, School of Art and Design, University of Illinois at Chicago*

Abstract

Three art therapists utilize their own art work to explore their relationship to their clients' images of horror, the "darkside" of their lives that is exposed to art therapists. The authors seek to understand their decision to be confronted with the tragic realities their clients present. Questions are raised as to how this work serves the therapist and related cautions are given. Using one's own post-session art to process strong feelings, increase empathy, explore merging by using the client's symbols, and the impact of the work on the "artist self" are examined.

This paper and the 1988 AATA Conference panel that spawned it constitute a work in progress. For me the issues here addressed are at the heart of our work. They challenge us to look beyond the mirror of surface images, "through the glass darkly," to discover who we are and why, as art therapists, we make the choices to work with the troubled people whom we have invited into our lives.

Our explorations of the "dark side" originated in a training group I established for art therapists who wished to learn to do art therapy supervision. Each participant brought in case material and we discussed together how a supervisor might approach the therapist in handling it. Early on, one of the members described her feelings of nausea as a client drew and detailed being raped as a child and recently as an adult. The therapist did not know what to do and asked the group how to deal with such feelings. Another member related her outrage, troubled feelings, and confusion when she, as a new mother, worked with a woman who had murdered her young child. A third member spoke of her own sense of craziness and the fascination she felt in working with psychotics. We were off and running, intrigued by the powerful feelings evoked in all of us as we glimpsed the primitive and provocative in the lives of those with whom we work. I thought of my experience in treating and conducting research with unmedicated acute schizophrenics and my choice to work with child abusers. We shared our stories, made art, and tried to puzzle out the meaning of our decisions to work with the sort of people we do.

We felt the need to expand our inquiry beyond our small group and involve other art therapists in our explorations. To do so we conducted a workshop at an AATA Conference, entitled, THE UNDERSIDE: FASCINATION/REVULSION. The title denoted the underside of a rock, usually hidden from the light, the dank, dark side from which creepy, slimy creatures crawl. This is the side of life civilization shuns, the side that comfortable middle class members of our society seek to avoid. But the underside is exposed to therapists, and to art therapists it is portrayed in dramatic imagery. Why do we in the helping professions in general, and in art therapy in particular, turn over the rocks to view what is underneath? Why do we choose to work with psychotics, violent prisoners, rape victims?

We asked the workshop participants to tell a horror story from one of their clients in the first person as if it were their own story. Next, they were to draw it in the style of their client. The picture was then discussed in the small group in which they had told the story. The purpose of these two exercises was to put participants back in touch with the experience of working with horrific material brought forth in therapy. The next task was to discover one's own relationship to the horror story of the client. To do so, we asked participants to draw a personal experience from their own past that connected with the horror story, the effect of it on the therapist, or one's feelings in response to it.

As I applied the same processes to my own clinical experience, some specific horror stories sprung to mind. These were stories that compelled me to think about them over and over as I was working with the clients who lived them and many times since. They came from a child abuse facility where I consulted. I had been hired to train the staff in

"We shared our stories, made art, and tried to puzzle out the meaning of our decisions to work with the sort of people we do."

using art with their clients, mostly children who had been sexually abused. But my interest was to work with the abusers. On the surface I believed that my motivation stemmed from my belief that abuse can be eliminated only if we understand the needs it fulfills for the abuser. As I heard their horror stories of mutilation and cannabalism and made my own art, I began to see deeper purposes in my choices.

There were two clients, in particular, who were convicted of child sexual abuse and who illuminated my own fascination with the dark side. The first was a very large imposing 35-year-old man whom I will call Harold. He had no teeth. Abused at age 13, as an older teenager he then began seeking out young boys for sexual contact. He estimated that he had probably molested at least fifty boys. Our therapy focused on his lack of employment, his difficulties with his wife and children, his family of origin with whom he was very enmeshed, and especially his feelings of inadequacy in relation to his father and brother. He referred briefly to Vietnam war experiences, and when I mentioned this to the two male psychologists who saw him in a men's therapy group for abusers, they believed he was fabricating the veteran experience.

One day he was particularly agitated in the session. He had been dealing with fears of homosexuality, surreptitiously going to gay bars to pick up men and feeling guilty afterward. He said he had something to tell me, but couldn't. I told him not to push himself, that he would tell me when he was ready. I saw another client after his session, and when it was over, I found Harold waiting for me. He had to talk to me, he said. I had an appointment in another building but told Harold that he could walk with me. As we crossed the parking lot he blurted out that he was in a Vietnamese prison camp with his best friend from childhood. His buddy died there. Harold cannibalized him. When he came home, he had all his teeth pulled.

The second client, Bill, was also a Vietnam vet. He was convicted of sexually abusing his wife's two daughters from a former marriage. They were white; he was black. Bill claimed that the children had framed him, that he was innocent, but he pleaded guilty because, as a black man accused of molesting white girls, he would not stand a chance in court. He, too, was a large imposing man and had serious employment problems. He presented himself as a person who always tried to do the right thing. He was very bright and an excellent artist. He had had a psychotic break and impressed me as a pack of dynamite with a very short fuse . . . and the sparks were flying.

Bill dealt with family life a great deal, past and present. He drew pictures of his war experience. Finally, the following story emerged: Bill had been raped and beaten when captured by an enemy soldier. He escaped and returned to his own unit. For three months he searched for his captor. Then the enemy soldier showed up in a group his unit had captured. Bill asked his comrades to let him take care of this prisoner. He took the man out into the woods where for two hours he mutilated him. Finally, he stuck his pistol up the prisoner's rectum and shot him.

What is your reaction to these stories? Mine was horror. It was difficult to stop thinking about them. These were not the violent thrillers of TV and film that I assiduously avoid. These were events in the lives of people I knew. This was life that was totally foreign to my white upper middle-class protected American existence. My clients plunged me into another world. This was life that was raw, primitive, horrible, and . . . yes . . . fascinating.

As foreign as mutilation, murder, cannibalism, and child sexual abuse are to my own life and probably to yours as well, there was something about it naggingly familiar—the fascination part. I tried to probe my own dark nature, reflect on my enjoyment of working with bizarre, non-medicated psychotics, explore my responses with the Learning Supervision group, look at reactions of other art therapists to client horror stories in the "Underside" workshop, and share my own artwork and understand the art of the other panelists in the "Dark Side" panel. The question that nags at me is why do we therapists choose to expose ourselves to the seamy side of life? Why do we "muck around in the miseries"?

> ***"There were two clients . . . who were convicted of child sexual abuse and who illuminated my own fascination with the dark side."***

My own art work has much to say about my relationship to the dark underside. My experience in working with non-medicated psychotics and child abusers was that they taught me much of life. But when I view my own art, I believe that they also taught me much about myself. Masks made on my own face, taking its form, reveal to me aspects of myself that connect with and identify with painful issues in my clients' lives. These strange visages are very much me. Figure 1 is a concubine, a decorative victim with her eyes closed. Figure 2 is the exciting primitive side that is allowed so little expression in our society. Figure 3 is a brilliant red screaming face—once again an expression that is not allowed. When I began Figure 4, I was determined to make a pretty face since many of my masks are bizarre. I ended up dripping wax all over it, giving it steel wool hair and broken shell eyes. To me it looks tortured. Figure 5 perhaps expresses the ideas of this paper most ex-

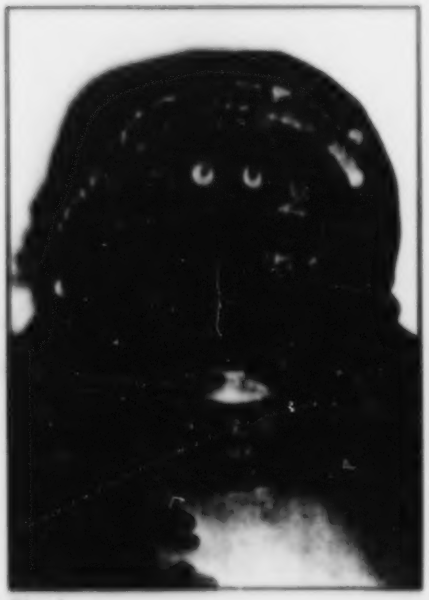


Fig. 1

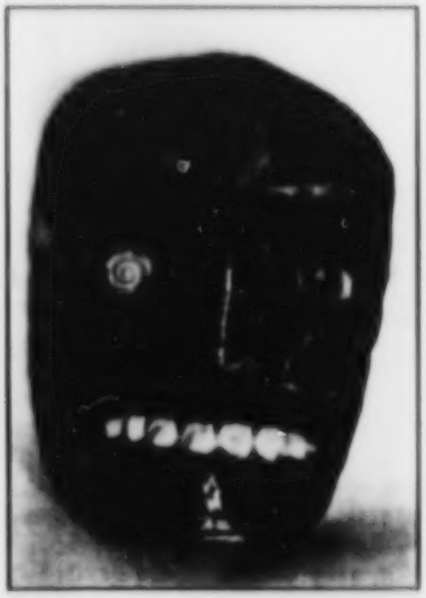


Fig. 2

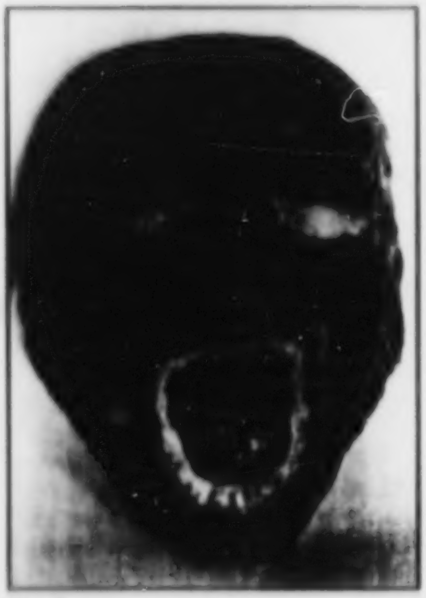


Fig. 3

plicitly. The face has a lifeless, china doll look. The hair style is very staid. Cutting my own "face" was a very impactful experience. Through the crack emerges brilliant red, staining the torn edges of the crevice. The placid facade cannot contain the passion, rage, life within. The mask is a metaphor, an image that tells me of my fascination with the underside, the darkside. It is life that needs to break out of the constrictions that contain it.

Unlike the artwork of the other panel members and the participants in the "Underside" workshop, these pieces are not directly related to specific clients, but rather to the themes of victimization, rage, pain, wildness, fear, but especially important is the frozen face that seeks to cover the consuming heat within. These images, the stories of my clients, and those of others have led to a tentative formulation of ideas that speak in response to the questions raised.

The "Underside" workshop brought forth very direct connections between clients' horror stories and therapists' own life experiences. It seemed likely that through the collaboration with the client of trying to heal the client's life, the therapist moved toward his or her own healings as well. The therapist could achieve distance and connection at the same time. One of the most moving aspects of the workshop was the surprise of the participants at the strength of their feelings. In some instances participants remarked that they thought they had resolved the issues that the clients had brought up for them, only to find themselves in tears again over their own painful pasts.

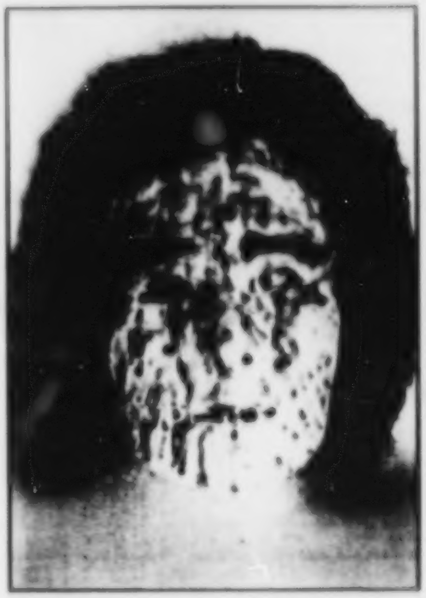


Fig. 4

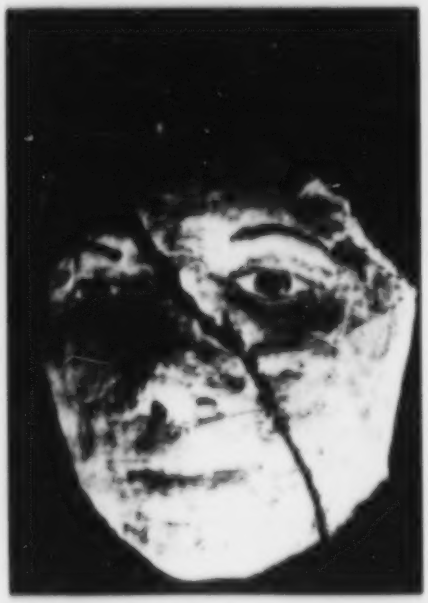


Fig. 5

For me, the connections were much less direct, the issues much less specific. I believe that the protected upper middle-class existence that most of us live has about it significant repression of violent, sexual,

BEST COPY AVAILABLE

id-related experience that in our own lives surfaces only in our dreams, nightmares, and fantasies. The relative safety of our lives may be bought at some cost in excitement and stimulation. Depression and apathy plague many of us at one time or another. As therapists, some of us may counter the relative blandness of our own lives through our fascination with the bizarre realities of our clients' lives. We remain out of danger while voyeuristically participating in events we would not choose to experience directly.

These thoughts reminded me of the play *Equus**, in which the psychiatrist envies his "insane" patient: ". . . But that boy has known passion more ferocious than I have felt in any second of my life. And let me tell you something: I envy it . . . I settled for being pallid and provincial out of my own eternal timidity . . . I use that word endlessly: '*primitive*' . . . and while I sit here baiting a poor unimaginative woman [his wife] with the *word* that freaky boy tries to conjure the *reality*! I sit looking at pages of centaurs trampling the soil of Argos—and outside my window he is trying to *become one* . . . I watch that woman knitting, night after night—a woman I haven't kissed in six years—and he stands in the dark for an hour sucking the sweat off his God's hairy cheek!" [a horse] (p. 73-74)

"The key to working with patients in an emotionally non-exploitive, clinically responsible way is self-awareness."

If we, too, are drawn to the passion in our clients' lives to spice the bland flavor of our own, are we not in danger of exploiting them for the excitement they provide, perhaps even encouraging their acting upon their darker urges, or at a minimum, portraying them in their art? Certainly utilizing art for the expression of violent impulses is preferable to committing violent acts. Nevertheless, encouragement of such portrayals for the art therapist's stimulation is not in the patient's best interest.

I doubt that there is any art therapist who would do so deliberately. But certainly, our own unconscious need to rebel against society's strictures could ally itself with the patient's more primal behavior. We have only to look at our own artwork for confirmation of the possibility (at least the expressive depictions some of us create).

I have come full circle. The key to working with patients in an emotionally non-exploitive, clinically responsible way is self-awareness. If we can recognize our own wishes for the stimulation of the exotic or dangerous or violent passion our patients bring into our lives, then we will be free to choose how we deal with it clinically to effect the best therapy we can, neither denying and avoiding it through fear, nor luxuriating in it through need.

Through the unique and individual story each client brings us, our work remains ever-interesting, seldom routine. Each client is a new challenge, a new adventure. We need not add further excitement. With conscientious attention to ourselves in relation to the roles our clients play in our lives, we are able to guide the therapeutic ship safely through the turbulent waters and dangerous shoals that may threaten the voyage our clients take with us.

As therapists, we wrestle with forces of life and death in our clients and in ourselves. As art therapists, we are privileged to find in our clients, and to create for ourselves, images of the dynamic dance of the chaos and containment that shape our lives. We play with fire that can both burn and weld. Our ability to see the choice is essential to our work.

---

*Shaffer, Peter. (1973) *Equus*. *New York: Samuel French, Inc.*

Through the Looking Glass:
II. Impact on the Artist Self

Rose Marano Geiser, M.A., A.T.R., *Art Therapist for the Center for Consulting Services, Louisville, Kentucky*

Thinking about the title of this panel, I wondered as I have done before while looking at my own reflection in the morning mirror, what does exist on the other side? What lies inside? So many myths and fairytales use the mirror as a magic door which opens to a (sometimes dark) secret passage. The shaman enters a hidden passage, descends to the center and is illumined to the "Truth." "Shamanic enlightenment

" . . . essentially every time I sit with a client, work with a client, I am before a looking glass. . . ."

is the literal ability to lighten the darkness, to see in the darkness what others cannot perceive." (Harner, 1980, p. 28)

Having thought about the meaning of being a therapist, I have thought that essentially every time I sit with a client, work with a client, I am before a looking glass so to speak. Images emerge from the surface presented to me as the persona stands guard to the inner personal world of the individual who allows me entrance. In one way this may keep me (as therapist) from getting to the other side (inside) too quickly. As a result I am encouraged to enter this world of the client slowly, cautiously through examining my own reflection, which is so often difficult to do. I am encouraged to look beyond the surface, into the reflection to uncover (dark) hidden realities.

.Moving cautiously means being aware of what I bring to the therapeutic relationship. It does not mean that I shy away from taking risks. It does mean joining in the journey through darkness as a partner who guides toward tranformation into light. It is that darkness that surfaces in our therapeutic relationships that we are exploring. As art therapists we not only hear about the darkside, we see it in the images that clients' draw, paint and construct.

During a past (1987) AATA Conference, Harriet Wadeson and I gave a workshop which focused on the darkside as presented to us by clients. All of us who participated explored through making art, how the darkside of our clients impacts upon us as therapists, how it reveals and reflects our own painful issues. The 1988 AATA Conference panel continued the sharing of personal experiences in facing the darkside encountered in the therapeutic alliance. What are the effects upon the self? All of us on the panel use art making as a means toward a fuller understanding of what we encounter as therapists.

I have been looking at how my artist self and therapist self overlap as art therapist. In another paper (1989) I noted that working face to face with the darkside evoked some unconscious art making on my part. The series of drawings I made as "artist," reflected the ominous world I experienced as "therapist" working in corrections. Since that first recognition of therapy entering my art work I have tried to separate the two. This only increased frustrations and hindered any art making at all. I found myself playing with clay, constructing merely decorative pieces. Serious art making became increasingly difficult and scarce. For about two years I did not draw, paint or sculpt. All creative energies were drained into being a therapist. Since I had been an artist longer than being a therapist, that ignored part of me was fighting to survive. I wanted to be an artist again, but what interested me were the people with whom I worked. This past year I deliberately set out to interpret them through art in an attempt to satisfy both artist and therapist. I did this by taking an element of my clients' art therapy work and reworked it as part of my own art.

Delving into the darkside of clients' lives has pulled me toward an exploration of the merging process which often develops within the therapeutic relationship. There is much literature, both pro and con in exploring the merger between therapist and client, but I am investigating the idea of merger from the perspective of being an artist as well as therapist. What happens between the art therapist and the client in the process of making art? How does that relationship differ from the more traditional verbal therapies? If it is strictly "looking at the situation" that a client presents, we ignore our conscious and unconscious response to the image and the multiple symbols which make-up the whole art work. As an artist-therapist how does my formal training in aesthetics influence my response to client art? How does my own data bank of symbols mix with the symbols my clients depict in their art?

Two individuals with whom I have worked had been difficult as they had been defensive and resistive in examining their dark realities. Robbins states "Defended patients transmit nonverbally their symbolic material and the therapist becomes receptacle for the material which will in turn demand some type of inner exploration." (Robbins, 1988, p. 41) The two clients presented below did not verbally transmit their symbolic material, but did so visually in their art work. I responded visually in my exploration of what they presented to me in trying to understand their symbols.

Michelle is a 25-year-old woman who had been in an abusive and incestuous relationship with her father for 20 years. When I first began working with her, she did not discuss the relationship and left out any direct referral to the sexual abuse. Instead she focused on her chemical dependency. She had been given various diagnoses none of which fit

"Delving into the darkside of clients' lives has pulled me toward an exploration of the merging process which often develops within the therapeutic relationship."

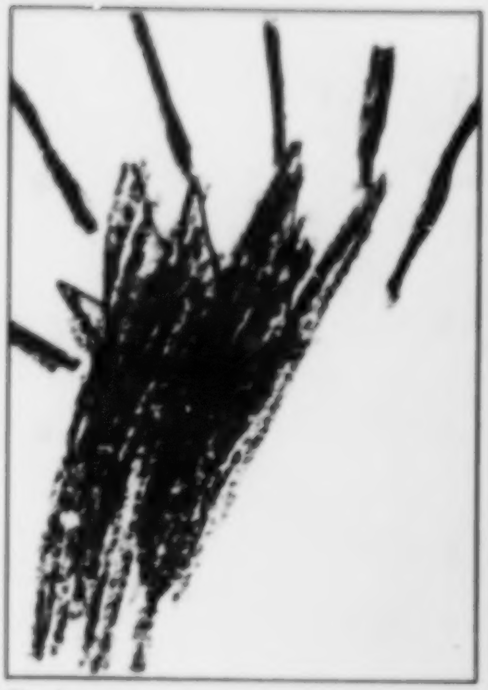


Fig. 1

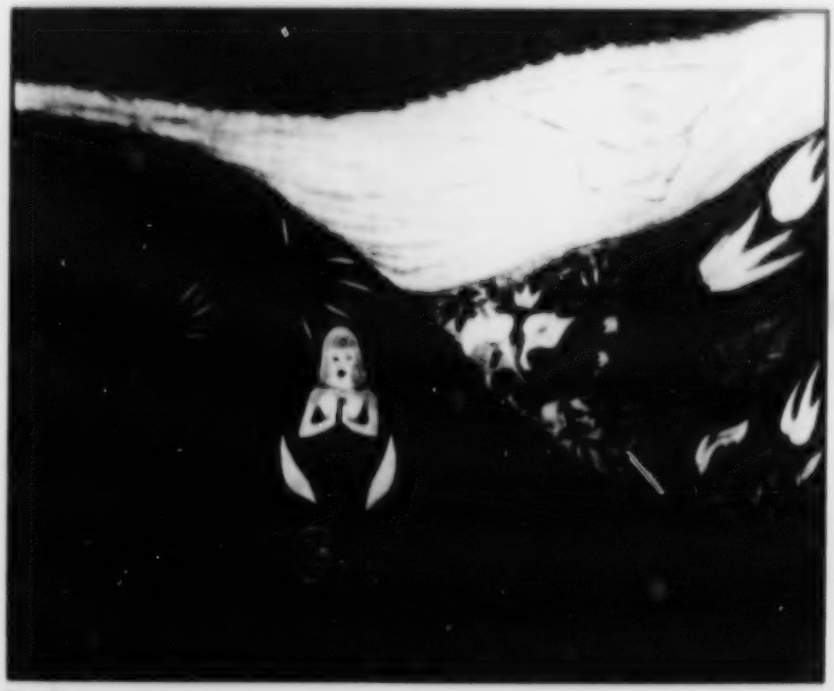


Fig. 2

with what I had observed. In the beginning of our relationship I had difficulty grasping what was happening in our session as she seemed entranced whenever painful issues surfaced. She was later diagnosed with Dissociative Disorder. She presented me with several symbols in her drawings. One of these symbols was a hand with rays extending from the fingertips (Figure 1). At first she drew the hand alone saying that it had power and was the hand of a magician. Later in family portraits her father was drawn with the same hands. In the drawing of her "Higher Power" the hands were again present. At times, in self-portraits, her own hands were drawn with the rays. She did not verbally recognize that her father was drawn with rays nor did she acknowledge that he was connected with power.

The symbol of the hands impacted upon me not only as therapist, but also as artist, and I sketched those hands trying to understand that meaning of power. In one of the drawings I completed using the hands with rays (Figure 2), I thought of her as a mythical figure, a type of St. Joan who accepted her flames ignited by her belief in the father. Her spiritual self escapes as did her mother who symbolically dissociated from the reality of incest.

Jack is a 30-year-old man diagnosed with Schizophrenia. His art work often presented archetypal images of a female warrior, wise woman, animals and biblical figures. He never explained what he had in mind about the drawings. Most often he was defensive and angry. He stated that he did not trust anyone, not even me, because I was just his worker who was an employee of the agency. When he alluded to this I felt quite angry and hurt as I envisioned our relationship to be a positive one.

One drawing he did interested me as it contained animal images connected to my own dream symbols (Figure 3). I decided to redraw his picture in an attempt to feel what he felt. His anger evoked my own anger. I incorporated the main elements of his drawing but added a portrait of him as well (Figure 4). The portrait, however, turned out to be that of a frightened boy rather than that of an angry and defensive man. To see my own drawing helped to dissipate my anger and frustration with him. It had freed me to accept him in his anger and recognize more clearly my own angry reactions to his defensiveness.

I recognize from these drawings I made, that clearly I was working through countertransference in the relationships. Also, these were drawings I made for myself and would not share with these clients. What has surprised me is the idea of merging with these clients through the art work. I have since been investigating the idea of merger with the client through readings about shamanism. Harner (1980) speaks about how the shaman becomes the patient and likens it to the process of countertransference in Western psychoanalysis.

Eliade (1964) and Harner (1980) describe the process of the shaman removing illness from a patient. The shaman actually attempts to "suck" out from the patient any intrusive

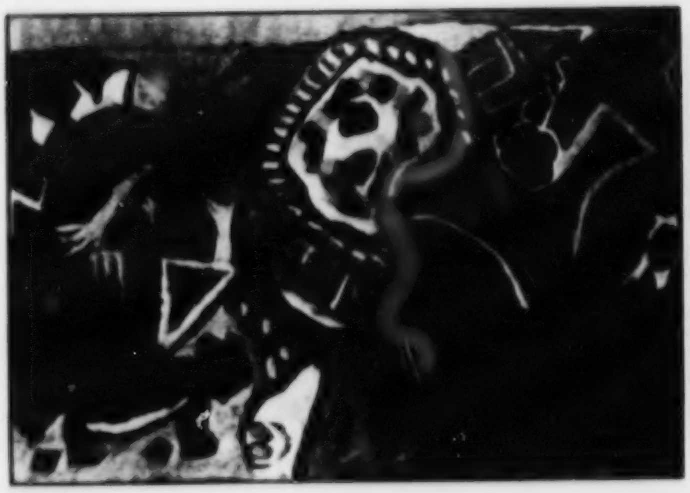


Fig. 3

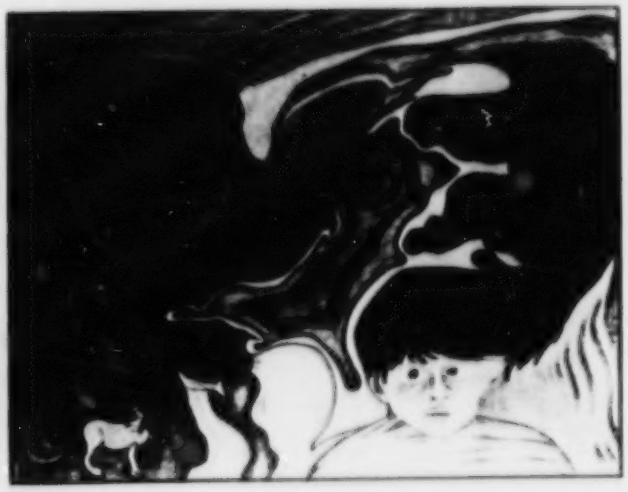


Fig. 4

power which is causing illness. Kalweit (1984) describes how some shamans try to take on or internalize the patient's illness in order to destroy it. In a sense there is a merger between shaman and patient. "The procedure for extracting or removing a power intrusion is the same as understanding the journey for a patient, up to a point." (Harner, 1980, p. 151) The merger is controlled before the shaman has gotten very far from an earthly consciousness. The art work acts as control for the therapist and the client in the merging process. The art work I made, was itself the merging process as it occurred through an empathic response to the image.

The effects upon my artist self at this point as art therapist have been a blending of the two. I cannot separate art making from the influence of being a therapist. Art reflects with what the artist is involved. "In order to make it all understandable, the abstract life of the psyche is concretized and expressed as myth. . . ." (Kalweit, 1984, p. 241) Art also expresses reality through myth and is the concrete expression of the psyche. As a therapist making art about the people with whom I work, I am in effect attempting to make abstract symbols from my clients more concrete. It is not an attempt to change the meaning of the symbol for the client, but an exploration of my personal reactions to the image.

The profession of therapist can certainly be a prurient venture in order to experience other realities, but the process of mirroring and merging between therapist and client does not allow for simple voyeurism. The process brings to consciousness the driving force behind the choice to be a therapist. From our 1987 workshop colleagues have shared personal reasons for becoming therapists and choosing to work with the darkside. Personal experiences with sexual, physical and emotional abuse, loss, physical handicaps and living with alcoholic parents have pulled at many therapists. We can recognize and be reminded of the fragility of our own lives through the lives of our clients. In mirroring and merging we reflect to each other the many faceted experiences we live and the symbols we collectively share.

References

Eliade, M. (1964). *Shamanism: Archaic techniques of ecstasy*. Princeton: Princeton University Press.

Harner, M. (1980). *A guide to power and healing: The way of the shaman*. New York: Bantam Books.

Kalweit, H. (1984). *Dreamtime and inner space: The world of the shaman*. Boston: Shambhala Publications, Inc.

Marano Geiser, R. (1989). A therapist's exploration: Face to face with the dark side. *The Arts in Psychotherapy*, 16, 133-136.

Robbins, A. (1988). *Between therapists: The processing of transference/countertransference material*. New York: Human Science Press, Inc.

Through the Looking Glass:
III. Exploring the Dark Side Through Post-Session Artwork

Joanne Ramseyer, M.A., A.T.R., *Art Therapist and Clinical Supervisor, Edgewater Uptown Community Mental Health Center, Chicago, Illinois, Adjunct Assistant Professor at the University of Illinois at Chicago Graduate Art Therapy Program*

Several years ago, after a particularly emotional session with a sexual assault victim, I began creating art in response to the profound impact her story had upon me. Despite specialized training and experience in this area, the client's sorrow and gruesome details of a childhood rape were difficult to shake when the session ended. In an effort to "detoxify" from the dark intensity that had permeated the hour, I instinctively turned to my own art. Figures 1 and 2 are pictures I created immediately following the session.

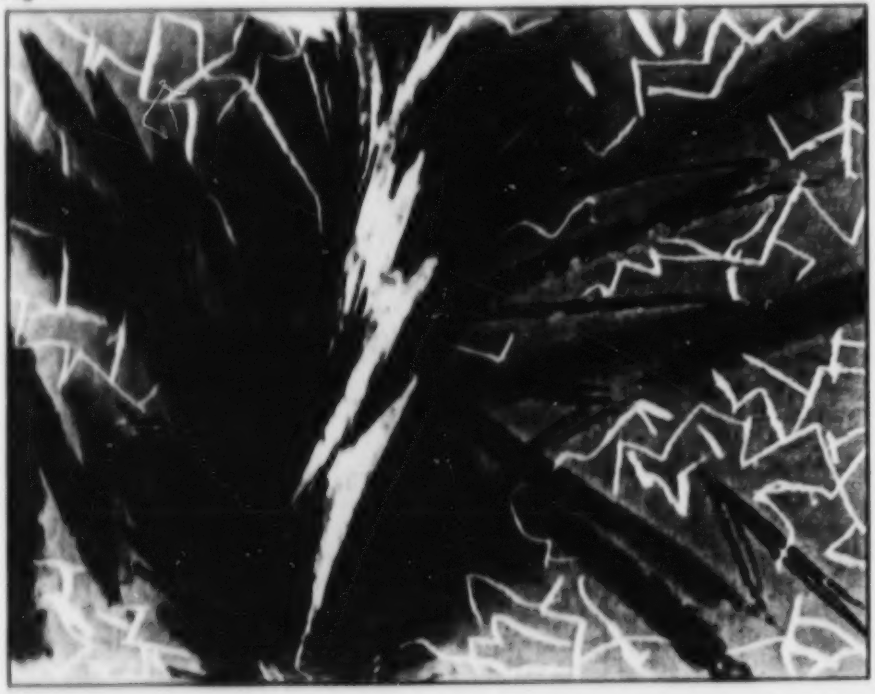
In Figure 1 yellow cracked lines cover a red background to express the client's emotional shock and physical pain. Thick black and purple jagged lines are scattered throughout the picture and also surround a section of bright yellow in the center to represent the violence of the assault and her shattered childhood.

Reflecting upon the picture, I realized it held a dual meaning for me. Although I initially created it to explore my perception of the client's feelings and experience, I quickly recognized the horror, shock and outrage I had vividly expressed in the picture. Her story was a brutal reminder to me of the darker, sinister side of life that is often difficult to comprehend and even more complicated to talk about. Through the picture I was able to express powerful reactions about the client's specific assault and identify my own feelings related to victimization. Most importantly, though, I found myself intently questioning my choice to work in a profession that involves continuous exposure to the underside of life and wondered about the long-term effects, professionally and personally.

Needing to explore my thoughts and reactions further, I drew a second picture. A detail of the client's story was haunting me, so I decided to re-create the scene visually with my own images, hoping to understand its significance more clearly. After describing the events of the rape, the client had tearfully shared how she had gone to a familiar pond near her house, to wash off the blood before she returned home. She was in severe physical pain, and "knew something very terrible had happened." In spite of this, she painfully recalled stopping to frolic with the fish as she'd always done, while swirls of blood gradually colored the water. It seemed the client was trying to describe her dimly realized loss of innocence at that moment. My picture was a visual response to her story of profound loss.

In Figure 2 the fish and swirls of blood are drawn in the lower right-hand corner. Abstract shapes and red and yellow colors are used again to express the client's violation, physical pain and betrayal of innocence. Black shapes encompass the central image, emerging from it to form a gloomy background atmos-

Fig. 1



BEST COPY AVAILABLE

". . . I quickly recognized the horror, shock and outrage I had vividly expressed in the picture."

phere. The colors and shapes portray the overall darkness of the event and the depression engulfing the client's life. The client had stated she'd never reported the rape to anyone, which is not unusual for sexual abuse victims. Instead, she "had tried to forget it ever happened." Yet her presenting complaint had been a vague, chronic depression which finally precipitated the serious suicide attempt that led her to therapy.

The imagery in Figure 2 visually emphasizes the strong connection between the client's current and past depression, and her unresolved grief. I had created the picture quickly, without attempting to control the outcome. Still, I trusted it as an accurate assessment of the client's need to consciously acknowledge and explore the impact of her traumatic loss of childhood before she could alleviate her depression. In this respect, the drawing intuitively formed a clinical picture that powerfully affirmed the same assessment I had intellectually formed.

In addition to providing useful clinical information and an outlet for expressing my strong reactions to her story, both pictures deepened my empathy for the client. Because art making is an emotionally expressive experience, the process of creating the pictures and the completed products provided an additional way to resonate with the client's story that was difficult to achieve only at a cognitive level. The permanence of the pictures also offered me the opportunity to reflect upon them more carefully over time, after the session and later in supervision. This helped me to separate more clearly my identifications and personal reactions from the client's treatment issues and needs.

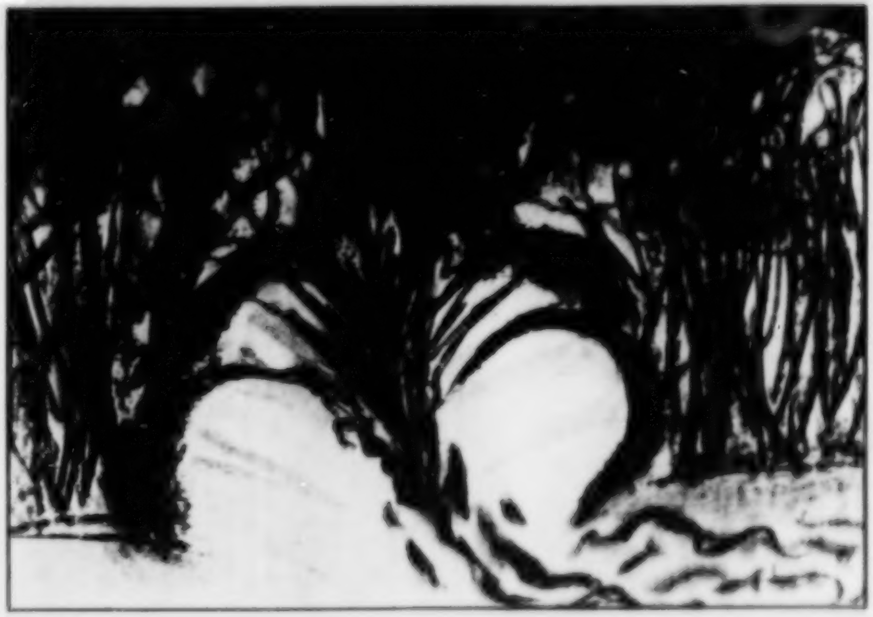


Fig. 2

Despite the many benefits of the post-session artwork described above, I continued to feel disturbed by the dark reality of the client's tragic story. I knew it was necessary, therefore, to explore this reaction at a deeper level than I had previously attempted in my work. To do this, I decided intentionally to use my own art to examine the specific effects of the darker side of therapy.

Having worked for many years with chronically mentally ill clients and higher functioning sexual abuse victims, I'm no stranger to disturbing stories and images of insurmountable pain and loss, violence, hardship, isolation, frightening and primitve regression, and a host of bizarre human conditions. Like most therapists, I've developed a protective immunity that generally allows me to maintain contact with many levels of despair and craziness without becoming overwhelmed by them.

At times, however, waging the battle against darkness with clients can take its toll and break down my defenses. When this occurs I've tried to discuss it with co-workers and supervisors. Although I've found them sympathetic, most of them seem to have as difficult a time as I trying to articulate their own discomfort with the atrocities of many clients' lives.

Suggestions are frequently made to explore boundary issues, projections, overidentification, and countertransference—which are imperative to examine and monitor. Yet confining these reactions to clinical concepts seems to me to limit their value as potential opportunities to confront and transform the shadowy

". . . viewing our responses [to clients' tragedies] only from an intellectual perspective diminishes the power and energy of their very real emotional content."

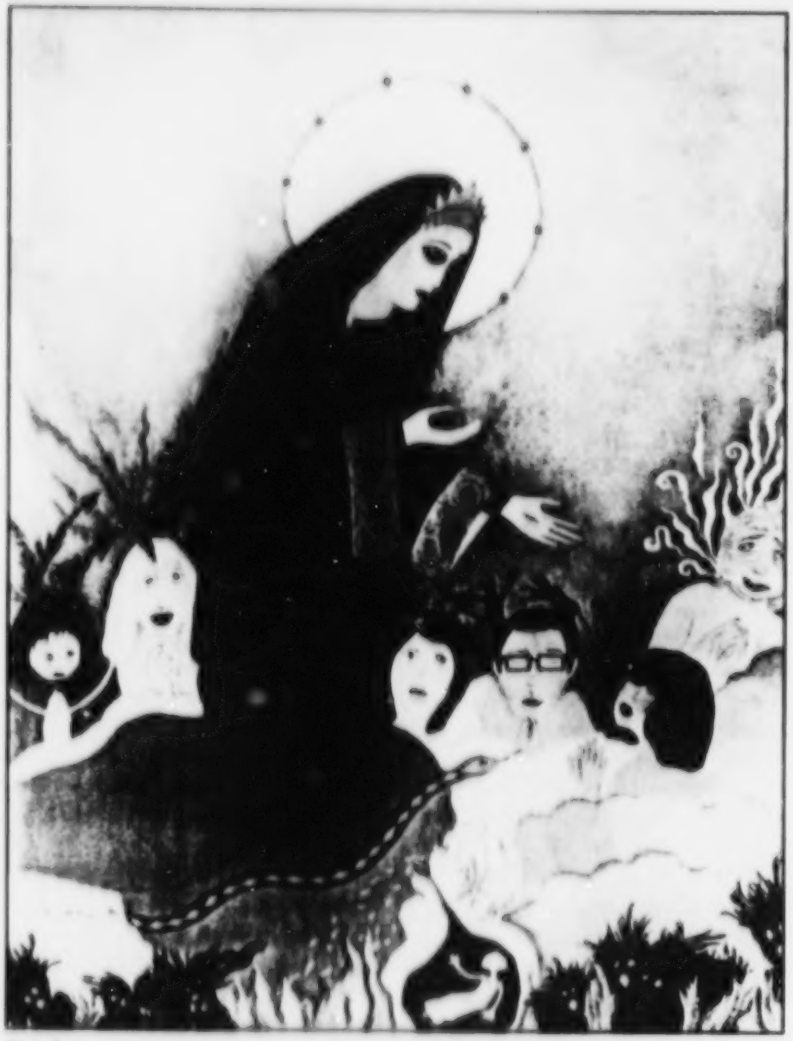


Fig. 3

elements of our own lives. Furthermore, viewing these responses only from an intellectual perspective diminishes the power and energy of their very real emotional content. For some therapists, this may be the way to maintain a tight rein over the threat of painful identifications evoked by their clients. Needless to say, I've observed many excellent therapists working from a theoretical stance that requires more emotional distance from their clients than other orientations, in order to effectively practice their brand of therapy.

But I've also seen therapists from all theoretical backgrounds seem to miss the heart of their clients' struggles because of their own conscious and unconscious fears of the darker elements in a client's story or behavior. Hoping to avoid the discomfort of feeling our own emotional vulnerability and psychic wounds, we may be quick to try to clean up the client's life, to organize the pain, or move the client through darkness too fast, so as not to be reminded of our own sorrow, frustration, aloneness or other personal battles.

On the other hand, cultivating an ability to live more closely with our own craziness and tragedies equips us to help our clients move through their crazy, tragic and inexpressable moments without feeling helpless, hopeless, controlling or burned out professionally.

While this is certainly not a new idea, the use of art to explore the impact of our clients' dark experiences may be of importance to other art therapists. Not only has it enhanced my clinical work as an art therapist, it has also affected the focus and content of my art, and influenced my supervision and teaching of graduate art therapy students. Perhaps most importantly, it has helped me begin to communicate to other professionals about my personal struggle to understand and integrate the darker side of doing therapy more fully with the rewards of the light. The following discussion will illustrate how this process has evolved, heightening my awareness of the value and dangers of exploring the dark side through art.

Figure 3 is a painting entitled, "Madonna Therapist" that I created during a time when it seemed that half my clients were regressing or simply stuck in their treatment. Their hostile negative transference reactions and distorted dependency issues were evoking in me intensely negative countertransference feelings, and simultaneous frustration at myself for reacting that way. I was also becoming more acutely aware of the chronicity and ravaging nature of mental illness. I felt both sad and angry, once again, about being reminded of the darker side of life through my clients' disturbing affects, behavior and imagery.

Unlike the spontaneous drawings through which I had been channeling these feelings previously, I now felt a need to create artwork in which the process would nurture my worn-out therapist side. I chose to paint a tightly controlled picture about my role as a therapist, because of the soothing, meditative effects of this type of painting for me. The theme of painting about my therapist role seemed especially appropriate at this stage in my professional growth. I had worked for several years with the chronic mentally ill population. The slow, tedious progress of these clients and their harsher lifestyles were becoming painful realities, dampening my early enthusiasm and zest as a novice therapist.

I began the picture feeling angry and frustrated toward my clients and myself for having over-idealized my role as an all-nurturing, rescuing Madonna. The clients are portrayed as innocent children, waiting passively for the Madonna's help. Various symbols are used to represent each client's unique brand of craziness or symptomatic behavior. Demons dance around a religiously obsessed man's head, another client's skull is cracked open with wavy lines pouring out to symbolize his disorganized thoughts. A third client is shown with a dangling cigarette, its smoke billowing around his head, to represent his endless chain-smoking, and so forth.

The client I felt most drained and repulsed by is placed in "therapy hell" with the frightening, crazed demons I imagined populated this place. She was diagnosed with a borderline personality disorder, and was evoking an intensely negative reaction from me because of her obvious, overwhelming desire to psychologically merge with me. I felt frightened by her inability to make even the slightest progress in her treatment, and by the psychic emptiness that seemed to permeate her personality and artwork. This client's unrealistic idealization of me, and her piercing, hungry eyes made me feel as though I was truly an object, particularly because I had assessed that neither my nor anyone else's relationship could heal her at this point.

In the painting she is shown praying for help, but already lost to a darker, painful world that expresses my perception of the living nightmare she was inhabiting. Inside this client is a small, emaciated, hungry child clutching for emotional food. Clearly this picture expressed my strong countertransference, my desire to be a perfect therapist, and quite negative images of the darker aspects of these clients' personalities. Yet, it also had a remarkable transformative effect upon me.

> ***" . . . keep the task of attending to our clients' treatment goals as a priority, rather than becoming overly intrigued with their suffering or tragedies."***

The technical control required to paint the picture gave me a sense of self-control at a time when I felt most helpless and hopeless about these clients' tragic lives. And the painting did indeed have a meditative effect upon me. As I painted each individual, I not only expressed my negative feelings toward them, but gradually recalled all the wonderful, lively, special qualities and strengths they possessed. The result was regenerative, allowing me to express my hostile feelings in an ethical manner in the art, rather than destructively acting out in the relationship, while gradually recovering my compassion for them.

At the same time, I was able to recognize bits and pieces of my own struggles and wounds, my own dependency issues, potential addictive traits, etc. through the clients I had chosen to portray. Although not as tormented or wounded as these individuals, I recognized issues and feelings of my own that I had thought were resolved, "once and for all" through my own therapy and personal growth efforts. The painting taught me about the "chronicity" of my own psychological struggles stirred up by these clients, and that I would be called upon to work through those struggles repeatedly, if only to develop a firmer resolution.

The process of creating this painting, and exploring its imagery, allowed me to return to the "therapeutic battleground" with a renewed sense of energy and empathy. It also helped me to explore my sense of failure and desire to be a perfect mother figure in the role of therapist, even to understand more deeply the roots of my choice to enter the helping professions. (The Catholic symbolism is not accidental.)

I would like to underscore, however, that the painting's primary significance was its power to provide a constructive outlet for the strong emotions I could not articulate related to the darker side of doing therapy. Although the painting helped me to resolve the countertransference feelings I had been working on diligently in supervision, the art process was the key to helping me understand, at an emotional level, the complex interconnections between my dark psychological struggles and the clients' dark battles. I have continued to reflect upon this painting, knowing many levels of its meaning will be revealed more fully over time to help explain the connections between my therapist role, my own dark side and my clients' dark experiences.

I would now like to point out some of the potential dangers I've discovered while attempting to come to grips with the dark side through post-session artwork. The most obvious is the danger of exploiting the clients—by remaining distanced from one's own pain, experiencing it only vicariously through the clients' tragedies and suffering. It has been my experience that it's easy to be seduced into a fascination with the dark side, via clients' stories and images, for a number of reasons. There is a tremendous sense of power and mastery when one is able to face one's demons and live with a conscious awareness of their existence and impact. This form of power may be abused and become destructive or used constructively just as any other form of power. Using our work with clients to develop this power should be approached with the utmost intention of avoiding this exploitation.

This may be difficult because there seems to be a natural tendency for artists and other creative persons to be intrigued by the darker, bizarre, noncomforming side of life due to its ability to fuel the creative fire. It is important, therefore, to keep the task of attending to our clients' treatment goals as a priority, rather than becoming overly intrigued with their suffering or tragedies.

I admit this is occasionally difficult for me. When clients create dark, disturbing but riveting images based upon their pain, these images often remain with me after the session. This is not only because of their psychological content, but because of my own desire to create art that is also unusual and striking. My artist self may become more active in the relationship at this point, wanting to respond to the clients at a visual level. The danger of unethical appropriation may be a possible outcome here, as well as subtly attempting to manipulate the clients' creation of artwork that is only personally interesting to us.

Another danger of exploring the dark side through art is that in setting up such a directive for oneself, it is possible to create art that may become forced or contrived. At one point, I found myself becoming overly invested in creating visual expressions of my own layers of craziness, under the guise of attempting to relate more fully to the clients' experience of mental illness. The resulting pictures were enlightening, but I felt the boundaries between myself and my clients becoming blurred and my images becoming less authentic than those that had arisen spontaneously following difficult sessions.

At the other end, I've created pictures about the dark side that were almost too threatening because of their evocative emotional power. The pace of exploring the spookier side of life containing our demons should therefore, be approached naturally, with caution and respect. In my opinion, it is also essential to share both images and process with other professionals who are comfortable exploring their own dark side.

Based upon the work presented above, I would like to encourage more art therapists to share the use of their own art in exploring their emotional reactions to clients' disturbing images and stories. It seems important to communicate more openly about these reactions to our work. We are in a unique position to do this through our imagery, since these complex emotional reactions to clients are often difficult to articulate through words alone. Sharing my personal thoughts and art about this subject has not been easy for me because of the fear of exposing my vulnerabilities to other professionals publicly. Yet, I'm well aware that most therapists struggle with similar feelings throughout their careers.

This leads to a second suggestion to expand the work published in this area. While there are publications emphasizing the importance of art in processing the clinical training of art therapy graduate students, there are few pertaining to post-graduate development of the art therapist. It is likely that art therapists move through different stages of professional growth that would be helpful for us to recognize. I would be most interested, personally, in seeing these stages illustrated through the development of the art therapists' art.

Finally, I believe it is important to continue to develop and elaborate upon the various methods we might employ to process our clinical work through art. Since beginning my journey to explore the dark side through art, I've expanded its use to explore many other aspects of my clinical work and therapist role. In addition to creating art about the clients' stories and images, I've created art using their exact media and images, imitating their creative process to obtain a stronger feel for their psychic issues at a physical level. These images are used to assess the clients through *art*, rather than doing this only at an intellectual level. Not only has this helped me understand their dark side, it has been an excellent assessment tool in general, and establishes what I refer to as "visual empathy." These types of clinical methods are important to develop and contribute to art therapy theory.

Although clients' dark images and stories are sometimes painful to view and hear, allowing me to share their struggles has helped to transform some of my own tragedies and enhanced my professional skills. And even if clients use the creative process only to express the dark, destructive side of their lives, the joy and energy they seem to derive from reconnecting to their creative selves has been immensely rewarding to facilitate. The life-promoting nature of creative work was the force that inspired me to enter the field of art therapy and one that I try to hold on to during moments when clients' lives feel too disturbing. Using my own art to respond to their pain, to understand theirs and mine more fully, is an evolving process I will continue to explore.

Screening Kindergarten Students: An Art Therapy Assessment

Winnie Ferguson, Ph.D., A.T.R., *Assistant Professor, Art Therapy, Wright State University, Dayton, Ohio*
Deborah Debevec, M.A.T., A.T.R., *Art Teacher, Dayton City Schools, Dayton, Ohio*

Abstract

Many young children cannot be accurately evaluated with traditional assessment procedures. Early recognition of the dysfunctional child would allow for the school system to provide necessary support of the child and his/her family. Assessment through art tasks may provide identification of both below average children and above average children. In a study of 108 kindergarten children six factors were used to evaluate art products: developmental level, motor control, content, color, line quality, and space. Three different thematic directives were used with the media of pencil, paint, collage and clay to elicit data for the study. Analysis of the data and suggestions for future study are discussed.

Introduction

Art educators, art therapists, and psychologists have attempted to identify the child having emotional, developmental, or other problems through his/her art product (Kellogg, 1969; Lowenfeld, 1957; Harris, 1963; Machover, 1952; Silver, 1978). The communications link which a child may use in the art process provides data not usually gained through interviews or written assessments. Many younger children cannot be accurately evaluated with traditional assessment procedures. The authors of this article have attempted to discover if the "at risk" child can be identified by the art teacher/therapist through evaluation of a series of art tasks. The development of an art therapy/education screening tool aims to provide identification of the kindergarten child who might be gifted, at risk, or normal.

Early recognition of the dysfunctional child would allow the school system to provide necessary support of the child and his/her family. All children at risk are not identified in the current assessment processes, therefore the authors initially focused on the identification of low functioning children who would be in need of additional school services. As the research progressed it became increasingly evident that the gifted child was also being identified through the assessment tool being developed.

The study subjects were five kindergarten art classes with 108 children assigned to a public school art class. Each class met for a 45-minute art period one day a week. The study covered twelve weeks of school. Data were collected and analyzed by the authors following the close of the school year. All data were collected and identified by an art therapy intern who did not participate in the analysis of the data. Subjects who had over fifty percent absence were eliminated from the final assessment due to incomplete data on those individuals. After removing the incomplete data subjects there were 94 sets of data remaining for analysis. Scoring of each individual art product was conducted by each evaluator prior to any discussion of the art work.

The authors selected four media for the subjects to utilize in the process of their art production. Pencil is traditionally used in art assessments (Silver, 1968; Machover, 1952; Goodenough, 1926) so it was the first medium used by the subjects in this study. Collage was selected as the second medium since it allows evaluation of the child's motor control as well as his/her ability to choose between a variety of materials. The third medium, paint, was selected because of its fluid qualities. It was assumed that most children would have had little experience with this medium and that additional information might be forthcoming through the use of paint. Clay was the final medium offered to the children in the study. The three-dimensional aspect of this medium was provided to promote discovery of the subject's ability to control this unfamiliar material (Betensky, 1973). Lowenfeld (1957) found that the tactile stimulation of clay was of exceptional value in working with visually impaired individuals; consequently, a relationship between the tactile experience and the young child was included in the hypothesis of this study. The subjects were introduced to each art experience with exactly the same instructions by the classroom teacher/therapist.

Three different motivational themes were utilized in the study. First, the children were asked to draw themselves (Goodenough, 1926; Harris, 1963; Koppitz, 1968). Second, they were asked to draw their family "doing something together" (Burns & Kaufman, 1970). Third and last, the children were asked to draw "a place where you spend lots of time." The thematic approach focused on information which the child would know and for which they would have a concept (Lowenfeld & Brittain, 1987; Kellogg, 1970). Most art therapists/educators concur that the child can draw only what he/she knows. Thematic material that was understood by all subjects was chosen.

Literature Review

Although many researchers have utilized the visual art product to evaluate both children and adults, the authors discovered no assessments which were specifically geared for the kindergarten child. In addition, none of the assessments was designed to be utilized as a screening process for a group or classroom environment. It was important to separate the substance of the child's art product into at least two categories: those which were specific to mental age and those which were indicators of the child's individual characteristics (Kramer, 1971).

The developmental stages have been identified with chronological ages by art educators, art therapists and psychologists (Lowenfeld & Brittain, 1987; Kellogg, 1969; Machover, 1952; Kramer, 1971; Piaget & Inhelder, 1967). It must be noted that children all over the world develop at a typical and predictable sequence (Kramer; Lowenfeld & Brittain). The developmental stages identified by Lowenfeld & Brittain were used by the authors of this study to identify the developmental level of the subjects. The clinician with a clear understanding of these stages would have little difficulty with developmental identification of children's art products (Oster & Gould, 1987).

Rhoda Kellogg (1969) wrote "Child art could be used as a mental test in the sense that a group of drawings done by a child could be evaulated as 'standard,' 'below,' or 'above' what is commonplace or normal at certain age levels, once such norms were set" (p. 190). She continued to point out that one would need to look at quantities of art work in the evaluative process. The authors of this study designed this research to move toward the goal of establishing an assessment which could identify these groups of children.

The human figure has been identified as usually the first representational symbol a child attempts (Lowenfeld & Brittain, 1987). The use of the self-portrait in this assessment was based upon the knowledge that the self was known to the subjects. The Goodenough-Harris Test (Harris, 1963) corresponds highly with standardized tests such as the Stanford-Binet Test (Oster & Gould). Although the authors did not attempt to use the scoring of either the Goodenough-Harris Test or the Machover Draw a Person Test (DAP) (Machover, 1952), the use of the self-portrait was influenced by the success of these assessments based on the child's perception of self. Through the use of assessments, the art educator/therapist could readily screen kindergarten children in the first weeks of the school year to identify special students.

The family pieces were examined for accuracy in content, such as number of family members, absence of a family member, and inclusion of others. In addition, the child's proximity to his/her parents and expressions of the parents were noted in the assessment of each piece (Burns & Kaufman, 1970; Wohl & Kaufman, 1985).

The authors looked at the use of color in the art products. At this stage of development the child's use of color is not given major significance as a developmental indicator (Lowenfeld & Brittain, 1987). Since the authors elected to allow the subjects in this research a choice of colors, they were a part of the total assessment score.

Another component of the assessment of the art products was based on the pressure used by the subject with his/her art tool. The emotional indicators cited by other authors indicate that line quality should be addressed in the evaluation of the art product (Oster & Gould, 1987). In addition, including the use of space in the evaluation criteria of the study the subjects above or below the typical kindergarten norm were easily identifiable (Kramer, 1970; Lowenfeld & Brittain, 1987).

The media selected for this assessment were pencil, paint, collage, and clay. These basic media are appropriate for the developmental stage of the subjects (Kramer, 1970; Lowenfeld & Brittain, 1987). Most children were familiar with pencils, crayons, and markers. Clay was not familiar to children in the kindergarten grade; however, they were usually familiar with the commercial modeling material "play-dough" and readily understood the three-dimensional activity of modeling. Although few children had used paint prior to the experience in the art class, they were eager to experience the colors and fluid qualities of the medium. Some children who had prior experience with the medium were able to control the brush and demonstrated their understanding of painting.

Literature available in the art assessment area has focused mostly on pencil (Oster & Gould, 1987). However, it would have been impossible for the authors to gain a well founded assessment of these kindergarten subjects with only pencil. The other media did add both breadth and depth to the data collected. Although a formal testing tool has not previously utilized components such as space and color, both art therapy and art education literature recognize the importance of these heretofore unstudied components. The assessment tool was based on earlier research which clearly identifies the developmental levels of the kindergarten child (Lowenfeld & Brittain, 1987; Kellogg, 1969; Machover, 1952; Kramer, 1971; Piaget & Inhelder, 1967).

Method

This study was designed to be incorporated in a kindergarten art curriculum at the onset of the school year. It provides a working structure for the art teacher and his/her students to carry out general studio art room activities. The artwork collected from the specific activities outlined in this article serves as a record of responses for the evaluation methods designed and implemented to support this study, "Identifying the student-at-risk through artwork in a public school setting."

Subjects

Five kindergarten art classes participated in this study as part of a research grant supported by a midwestern metropolitan University.

Three of five kindergarten classes were enrolled at a midwestern primary public city school. The school serves as a pilot program designed to foster a cooperative working relationship between the City Schools and the University's College of Education and Human Services.

Student enrollment is based on: (1) student's residencey; (2) written application by parent or guardian; and (3) random lottery keeping within state mandated desegregation codes.

The remaining two kindergarten classes were enrolled at another public city school. Student enrollment was based on residency. Residency is based on boundaries defined by the Board of Education.

The total population of 108 kndergarten students contained 20 white males, 38 black males, 24 white females, and 26 black females. The ages ranged from four years four months to six years eleven months.

Apparatus

A standard art room was used in this study including six hexagonal tables, child-size chairs, teacher demonstration table, sink, and drying rack.

Individual portions of media and tools were provided for each subject. Drawing supplies were a primary lead pencil, 8½" × 11" white drawing paper, and a rubber eraser. Collage supplies were 10—6" × 4½" construction paper (packs of black, brown, white, pink, purple, orange, green, red, blue, and yellow), primary blunt-tip scissors, white glue, assorted crayons, set of twelve "Mr. Sketch" water-color markers, and 12" × 18" white construction paper. Painting supplies were six 1—2 oz. cups of tempera paint (red, blue, yellow, white, brown, and black) easel paint brushes, water cans, paper towels, newspapers, and 12" × 18" white construction paper. Clay supplies were one pound red earthenware clay, clay tools, pencil and paper clip, and 9" × 12" cardboard school lunch tray. Clay work was photographed prior to firing with ASA 200 color slide film.

Colored construction paper 36" × 24" was folded and stapled to serve as individual student portfolios. An observational data chart was designed to record on-task behavior by research assistants during work activity. Children's books, scrap crayons, and paper were set up in a clsssroom corner for use by subjects completing art tasks early before dismissal.

Experimental Procedures

This study was incorporated into the regular art class schedule required by state-mandated course curriculum. Prior to this study, letters were hand-delivered by student participants to parents and guardians to inform them of the study and events to take place. Administrators and homeroom teachers were informed of this study to promote cooperative support.

Preparation for each art task was executed by the resident art teacher and the art therapy intern prior to art class activities. Kits containing media and tools were prepared to increase free expression by the individual student and discourage student interaction with peers during the work activity. Paper and clay to serve as final product were premarked with a student identification number and letter to insure proper placement in individual student portfolios, to secure student participant's anonymity, and to increase objectivity during the evaluation process.

The project required twelve weekly 40-minute sessions. The art tasks were presented in the twelve weekly sessions. Art tasks were offered and demonstrated by a state certified art teacher.

The graduate art therapy student assisted in the distribution of materials and tools to subjects, assisted in the observation and recording of subject on-task behavior during work activity, and collected artwork at closing of each session.

The twelve works consisted of four media (pencil, collage, paint, clay) for each of three topics (self, family, place). Since each category was expressed in four media, twelve separate works were collected by the end of the study from each participant and compiled in individual portfolios.

Art activity procedures began when the homeroom teacher escorted the subjects to the art room. Subjects entered the room and sat in assigned seats organized prior to this study. Seat assignment varied according to the individual child's ability to work with peers at the same table. The art teacher verbalized class expectations and objectives immediately after all subjects were seated. Lights were turned off during this period to emphasize and signal total class cooperation during the teacher's instruction. The graduate art therapy student and the art teacher distributed media and tools to subjects by each subject's identification number. The art teacher directed students to: (1) refrain from touching distributed materials; (2) listen to class objective; (3) observe teacher demonstration of media procedures; (4) refrain from talking to peers or sharing work and ideas with peers; (5) raise hand upon work completion for teacher collection. After the teacher instruction, subjects were verbally prompted to raise his/her hand if clarification of class objectives and procedures were needed. A moment of silence prompted by the art teacher signaled subjects to prepare for work activity. This orientation required ten to fifteen minutes.

When the art teacher turned lights on the work activity began. Approximately twenty minutes was allotted for work activity. Media and class behavior varied the time allotment.

The graduate art therapy student observed subjects' on-task behavior in three-minute intervals and recorded these data accordingly on the observational report designed for this study. The art teacher assisted subjects by insuring that materials were at hand. However, the art teacher refrained from unnecessary verbal interaction with subjects. When a subject requested assistance, (granted only by a raising of hand to discourage talking out), teacher intervention was limited to verbal repetition of the initial task objectives.

Subjects completed work at his/her own pace but were limited to one class period. Upon completion of the task, the art teacher or graduate art therapy student met individually with the subject and prompted verbal clarification of the visual expression (subject artwork). Responses such as, "This is me," or "This is Mom washing the dishes" were recorded in pencil directly on the back of the artwork as pertinent information used in the evaluation process.

Completed artwork was set aside and subjects were directed to clean-up and sit quietly with children's books, crayons, and paper until class dismissal. Upon dismissal, the class lined up at the artroom door and was escorted back to the homeroom by the homeroom teacher.

Data Collection

Individual portfolios compiled for evaluation included nine two-dimensional works in pencil, collage, and paint and three slides of three-dimensional work in clay. The 108 portfolios were delivered to the University's Art Therapy graduate program, for study and evaluation.

The evaluation procedure was designed and implemented by the authors. The criteria for evaluation were based on the problem statement "Identifying the student at-risk through art in the Public School setting," and six areas supported in this study by literature on children's art. The six factors for evaluation included:

- Developmental level of artwork (intellectual)
- Motor-control exhibited in artwork (physical/neurological)
- Content appropriateness to task directives
- Color (dark, light, normal)
- Pressure exhibited by art tools used in production (heavy presure, light pressure, normal pressure)
- Use of space exhibited in artwork (empty, well-used, normal).

Following input from a statistician and a computer analyst a five-point rating scale was devised for each of the six areas indicated as:

- 1) artwork exhibiting below normal-risk characteristics
- 2) artwork exhibiting below normal characteristics
- 3) artwork exhibiting normal characteristics
- 4) artwork exhibiting above normal characteristics
- 5) artwork exhibiting gifted characteristics

Though "giftedness" was not initially intended to be identified in this study, researchers concurred after an informal review of portfolios that some students clearly demonstrated high developmental, cognitive, and motor capabilities in their artwork. The five-point rating scale served to encompass low, normal and high level responses to task directives. A chart was designed to place scores in an organized manner for ease in the evaluation process and input into the computer program. A total of sixty-six scores were given in each student art portfolio evaluation. Researchers evaluated and rated each portfolio individually recording scores on the devised rating chart.

Students with less than six pieces of art in the portfolio were excluded from this study. Researchers concurred that to increase the reliability of evaluating subject responses to media, at least two examples in each media should be available. Ninety-four remaining portfolios were evaluated and rated. Scores by both researchers were submitted for computer analysis. An analysis of inter-rater reliability was completed.

Analysis, Findings and Summary

Analysis

Following the data collection and rater evaluation all numerical scores were analyzed through the use of the computer facilities at the university. The inter-rater reliability was compiled by manually recording the agreement and disagreement of evaluated data between the two researchers.

The researchers analyzed the data for the hypothesis that "there would be a difference in the score of male and female subjects in this assessment." A one-way ANOVA (analysis of variance) was used to test this hypothesis. In this analysis gender was the variable investigated. The hypothesis was disproved with no difference between sex being found in the analyzed data.

In the total scores for collected data the top score was 330, the median score was 178.5, and the lowest score was 80. The Univariate (descriptive) analysis indicated that subjects with a score of 80 or below might be considered at risk; those with a score of 80-133 might be considered below average; 133-239 could be average; 239-292 could be above average; and scores over 292 could be gifted.

The analysis of variance procedure first used was Duncan's Multiple Range Test for Variable. Analysis found that collage was different from pencil, paint and clay. There was no difference in the scores between pencil and paint, however, the scores for clay were different from all others. In addition to the Duncan's procedure the data was also analyzed with Tukey's Studentized Range (HSD) Test for Variable. These findings were the same as found in the previous analysis. Finally the data was analyzed with the use of Scheffe's Test for Variable. Again, the data analysis concurred with the findings in Duncan's Test.

A second hypothesis for this research was that "a difference between the four media and the gender of the subject would be significant." In this analysis a two-way ANOVA was utilized. The independent variables were media and sex of the subject.

To analyze the possible difference in scores based on sex the data was once again analyzed through the use of Duncan's, Tukey's and Scheffe's tests for variable. All analysis concurred that the score for girls was significantly higher than scores for boys. This analysis was based on medium scores for each male and female subject in the research study.

Final analysis of data found that while there were significant differences between groups (medium and sex) there was no interaction between media and sex. One factor does not influence the other.

In determination of the inter-rater reliability the authors decided scores of one or two would be accepted as agreement. The score of three required a matching score of three from both raters. The scores of four or five were also counted as agreement between raters. This system appears to have been unfairly stringent in determination of inter-rater reliability. A more acceptable system for determination of inter-rater reliability will be developed for future research. The inter-rater reliability varied between the classes. The agreement in the initial evaluations ranged from a high of 98.5% to a low of 8% for a given subject. Following the analysis of the data the researchers discussed the portfolios of selected subjects where the inter-rater reliability was low. After the clarification of standards to be used in evaluation the researchers independently re-evaluated five selected portfolios with significant improvement in the inter-rater reliability. The five selected portfolios had an inter-rater reliability of 77%, ranging from 100% to 56%. The greatest agreement was found between the below average scores and the above average scores.

Findings

Developmental Level

Developmental level of an art product is defined in a range of ages such as Lowenfeld's stages (Lowenfeld & Brittain, 1987). The pre-schematic stage which includes the chronological ages of the kindergarten subjects in this research study were familiar to both evaluators.

Figures 1, 2, and 3 illustrate the typical range of examples which were obtained in the study using the directions "Make a collage of your family doing something together." Figure 1 provides an example of artwork of a low-scoring child. The figure drawing is abbreviated with feet either absent, or useless in their formation. Additional data provided the information that this child has a long history of "foster homes." Figure 2 illustrates an average example of the figure drawings collected in this research. This example not only shows more complete figure schema, but also shows use of the collage media to depict several of the family members. The child's example in Figure 3 not only shows a more mature figure schema, but also shows organizational qualities moving into the schematic developmental levels as defined by Lowenfeld (1987). The inclusion of hair, fingers and clothing provides clues to an advanced intellectual level (Goodenough, 1926; Harris, 1963; Koppitz, 1968; Machover, 1952).

It was found that the pencil drawing, the collage, and the painting were usually comparable in developmental level; however, the clay work was, in many cases, out of agreement with the other three media. A subject who appeared to function at a level above average might have a clay product which scored very low; conversely, a subject who scored very low in pencil, paint and collage would sometimes score quite high in clay. This variability in media is an area which will demand more investigation.

Motor Control

The collage experience was selected to provide the researchers an opportunity to judge the subject's ability to use scissors, glue and drawing materials other than pencil. The subject who functioned above average offered exceedingly elaborate collage products with intricate fold-overs and layers of forms. These same subjects were able to carefully draw their forms and to cut the same form with dexterity. The below average subject usually pasted large squares of construction paper on a background as his/her attempt to create a collage. Figure 3 shows an exception to the utilization of the collage materials; this child chose to use the large rectangles of colored construction paper to indicate a playing field for a family football game.

Figure 2 provides an example of the typical cutting skills found in most children in the study. The rough, torn edges of the cut forms illustrated in Figure 1 were due to poor cutting skills.

The collage was definitely a diffi-

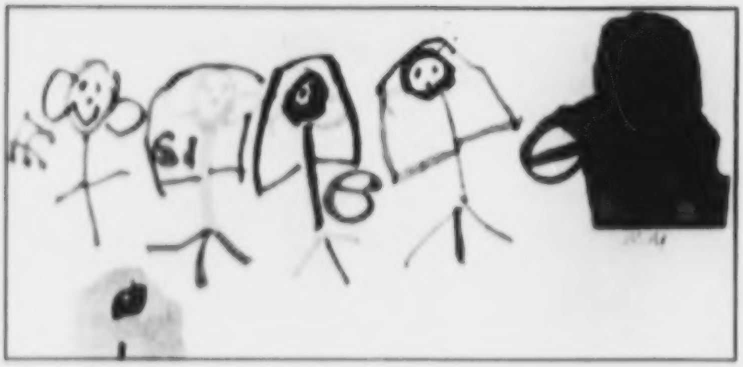


Fig. 1

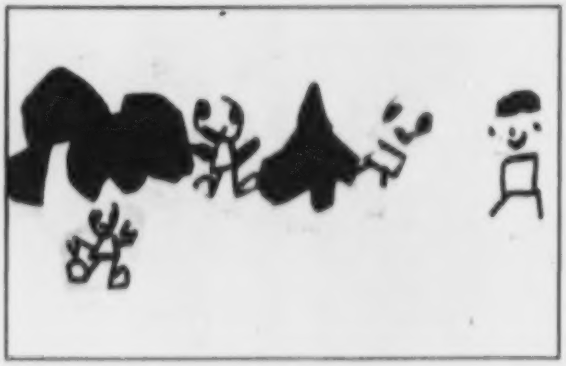


Fig. 2

cult task for those subjects with large families, since the subject needed to spend a great amount of time drawing, cutting and pasting each member of the family. The authors have looked at the time allotment for the family collage and found it probably was restrictive to those children with many family members; therefore, a change will be to increase the time allowed for this task in further development of the assessment.

Content

In studying the content of the art products the authors found emotional indicators in the 'family and place' products more than in those of the 'self' products. Often subjects from families with divorced parents included the absent father in family drawings. In Figure 1, the child living with foster parents, no father is included and the mother is isolated with the use of collage materials. In addition, this child appears to encapsulate most figures.

It was also noted that teeth were often present in specific family members. The teeth were usually included in more than one of the pieces of artwork. Since teeth may indicate aggression, this information could be identified as significant information in regards to the subject's family (Oster & Gould, 1987).

One dilemma which was found in analysis of the content of the art product was being able to distinguish between a healthy double image and an unhealthy one in the self-portrait. Often a young subject would include a close friend or family member in his/her self-portrait. A similar example of this problem is illustrated in Figure 3 where the child illustrated his extended family rather than his nuclear family. This child explained the picture with the title "Playing football" and told about the games he enjoyed with his male relatives. The authors selected to utilize the subject's explanation which was noted on the art product in this analysis.

Color Used

Significant data were primarily evident in work where the subject selected white or light yellow to paint specific family members or himself/herself. The subject's use of color was not used as a single factor in evaluating the art product, but was one score among six on each piece of art, and four scores in sixty-six in the total assessment picture of each subject.

The subjects often became so engrossed in the process of painting that dark, muddy colors resulted. This was not significant in the color assessment since it was often the subject's first experience with the medium. It was noted that a significant change in the first "self" painting and the last "place" painting demonstrated the subjects, increased knowledge of the medium. The art teacher did not attempt to instruct subjects on use of materials in this research.

Pressure Used

The lightly sketched line was evident more often than was extreme pressure in the assessed work. There was little fluctuation in line quality with most subjects displaying normal pressure with the drawing tool (Koppitz, 1968). The emotional indicators of line quality, shading, teeth and absent appendages were found in some of the art products assessed (Oster & Gould, 1987).

Space Use

The subject's self-portrait which was drawn in only a small corner of the paper usually corresponded with the subject's painted self-portrait which used the lightest yellow or even white. The normal array of color was lost when the subject attempted to make himself/herself as small and insignificant in the art product constructed during class as he/she felt in life. Figure 1 illustrates an example of restricted use of space. In the example each encapsulated figure is constricted in individual space while adequate unused space remains on the drawing surface.

This contrasted with the child (Figure 3) who drew and painted with confidence and joy. He filled the paper with distinct images and appropriate colors to assert his right to be recognized as a part of society. Although a piece of art doesn't tell it all, a series of pieces of art gives a good understanding of the child (Wadeson, 1980).

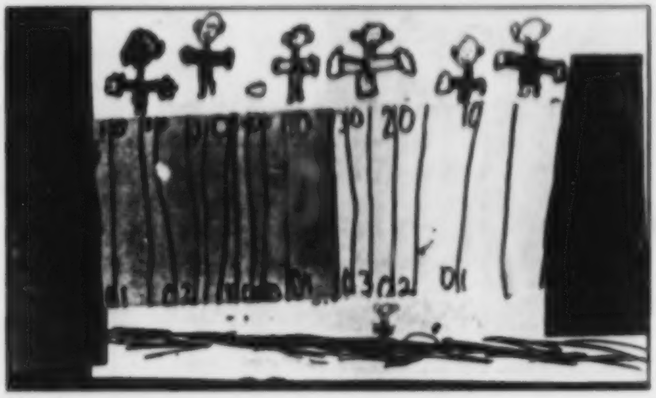


Fig. 3

Summary

This research has opened the door to a possibility of an art therapy assessment which could be implemented with all kindergarten children. The assessment criteria are based on the understanding of knowledge with which both art therapists and art educators are familiar. It is hoped that after further development of this assessment, it could be used with all kindergarten children as a first assessment in their school career.

The authors conducted the initial assessments of the portfolios without discussion of individual expectations on each of the six concepts assessed. Following the completion of the assessment, five portfolios on which the inter-rater reliability was low were selected for discussion of the expectations of each evaluator. It was found that the two evaluators had some disagreement of the average expected for certain of the criteria. Following discussion and agreement on the standard of average the five portfolios were re-evaluated by the evaluators resulting in an increase in inter-rater reliability.

Additional assessment is now underway with current kindergarten subjects. The authors have reduced the number of sessions from twelve to six by eliminating the thematic area of place and the medium of clay. It was found that little or no new data were found in place which was not in the family art products. Clay was also very difficult to document since photos were taken of the work. The photos were not as clear as the products themselves; however, the task of firing, protecting and transporting numerous delicate sculptural pieces would be unpractical for realistic assessment practices.

In addition, the new art therapy assessments will utilize the subjects' scores in the standard readiness assessments to look for correlation between that assessment and this art therapy assessment. Plans are in place to increase the raters for the next phase of the development of this assessment. The authors believe there is significant information to be gained from this tool.

It has been noted by many researchers that early identification of children with special needs is important. Since the kindergarten class is the earliest recognized public school class available in most areas of the United States it seems important to develop a method which can be used at this early age. It also seems necessary to assess these youngsters as soon as possible following entrance in school. This assessment is non-verbal and non-threatening since it utilizes the concepts of the child. Further development will provide an important aid to the identification of children's needs.

References

Betensky, M., (1973). *Self discovery through self-expression*. Springfield, IL: Charles C. Thomas.

Burns, R., & Kaufman, S., (1970). *Kinetic family drawings (KFD): An introduction to understanding children through kinetic drawing*. New York: Brunner/Mazel.

DiLeo, J., (1973). *Children's drawings as diagnostic aids*. New York: Brunner/Mazel.

Goodenough, F., (1926). *Measurement of intelligence by drawings*. New York: Jason Arson.

Harris, D., (1963). *Children's drawings as measures of intellectual maturity*. New York: Harcourt, Brace & World.

Kellogg, R., (1969). *Analyzing children's art*. Palo Alto, CA: Mayfield Publishing Co.

Koppitz, E., (1968). *Psychological evaluation of children's human figure drawings*. New York: Grune & Stratton.

Kramer, E., (1971). *Art as therapy with children*. New York: Shocken Books.

Lindstrom, M., (1957). *Children's art*. Berkeley, CA: University of California Press.

Lowenfeld, V., (1957). *Creative and mental growth*. New York: MacMillan and Co.

Lowenfeld, V., & Brittain, W., (1987). *Creative and mental growth. 8th ed*. New York: MacMillan and Co.

Machover, K., (1952). *Personality projection in drawing of human figure*. Springfield, IL: Charles C. Thomas.

Oster, G., & Gould, P., (1987). *Using drawing in assessment and therapy. A guide for mental health professionals*. New York: Brunner/Mazel.

Piaget, & Inhelder, B., (1967). *The child's concept of space*. New York: W. W. Norton & Company.

Silver, R., (1978). *Developing cognitive skills and creative skills through art*. Baltimore, MD: University Park Press.

Wohl, A., & Kaufman, B., (1985). *Silent screams and hidden cries*. New York: Brunner/Mazel.

Grants: Demystifying the Mystique and Job Connections—Part II

***Doris Arrington, Ed.D., A.T.R.**, Associate Professor and Director, Art Therapy Program, College of Notre Dame, Belmont, California*

Abstract

As a follow-up to an earlier article published in* Art Therapy *(volume 3, 1986), the author presents information relative to grants that were funded in the following categories: 1) family employer; 2) student employer; 3) practicum placement; and 4) community organizations. In the author's conclusion, it is reemphasized that grant writing is a viable activity for the student and for clarifying the role as an art therapist.

For students in the Art Therapy Program at the College of Notre Dame in Belmont, California writing a grant is beginning to lose some of its mystique, but it hasn't always been that way. Like many other Art Therapy Programs in their formative years our graduates also had to carve out their 'niche in the real world' because agencies, hospitals and special schools did not recruit nor roll out their red carpet eagerly clamoring to hire art therapists. Today male and minority students are usually hired prior to graduation. Other graduates are actively recruited by state hospitals and senior facilities. They find jobs in family agencies, special schools and hospitals; but, art therapists are creative individuals who have their own personal dreams and fantasies as to when and how they want to work and live. One challenging way our school encourages creative students to live out those personal dreams is to write a grant in lieu of a thesis.

Our college is fortunate enough to be located in a metropolitan area with large community foundations that provide comprehensive libraries and grant writing classes. In addition the college offers grant writing workshops and/or grant writing assistance. During the past year, nine grants were written. So far, more than $90,000 has been received for seven grants.

The success of grant writing is presenting the right idea to the right funding source at the right time. The following grants have been either funded, or are in the process of being funded, by sources that could be available to art therapists in other sections of the country. They are presented by their funding sources.

Family employer

Maggy Conroy, an artist and an art therapist, believes that the process of artistic creation comes naturally to children and non controlled expression is important in a child's emotional growth. Maggy's daughter attends the Apple Computer Child Care Center where her husband is employed. Maggy proposed to Apple that art could be therapeutic in calming an active child, in releasing energy and in giving children an added ability to communicate. She further proposed that the children in the center be given the experience of producing artwork with quality materials and their art works be displayed in a special way in their center. Apple funded the proposal which resulted in:

1. Six different showings in other Apple divisions and buildings within the Company prior to returning the show to its home in the Apple Child Care Center.
2. A request from a parent advisory group for a second show involving the work of older children of Apple employees.
3. A request that the children's work be available for purchase with funds going to a local charity.
4. An original art piece by a 4-year-old hangs in the office of a Senior Vice President.
5. An exchange of children's art with representatives of other countries.
6. Interest in applying the "process over product" principle by other preschools in the area.
7. A traveling lecture, slideshow and workshops about the project.

Student employer

Beverly Stone paid for her education by working as office manager for an energy corporation. Like most corporations it funds local charitable projects yearly. The firm was impressed with Beverly and her career goals. It funded her proposal to run an art therapy group for sexually abused females at a psychiatric treatment center for children.

Ann Reidy works at the Veterans Administration Hospital with Vietnam Veterans with Post Traumatic Stress Disorder (PTSD). Art therapy has been an intregral part of this unit since 1981. Since that time over 1500 drawings and paintings done by veteran patients have accumulated. Ann proposed that she be given release time to systematically organize the art and develop a computer data base for storing and retrieving information as it relates to imagery and stress disorders. This VA approved proposal could be the basis for future art therapy research in areas of PTSD.

Practicum placement

Nadine Blaschak interned with an

art therapist in a hospital that had funded an art therapy program since 1978. Knowing the hospital was supportive of art therapy, Nadine researched the possibility of providing art therapy groups in areas not currently served. After Nadine completed a pilot study in this new area, the hospital funded her proposal.

Elaine Beaver interning with schizophrenic patients in a state hospital became aware of the need for both outpatient therapy and education for clients and their families. She proposed preventive art and family therapy to deter or eliminate the need for first or readmittance to the hospital. Upon the recommendation of employees in the State Department of Mental Health and Mental Retardation, a local outreach clinic funded this program.

After completing a pilot art therapy program in a school for neurologically impaired, learning disabled and severely emotionally disturbed youth, Carol Johnson with the assistance of her administrators at her placement proposed a three year grant to 10 corporate and special event organizations for a Therapeutic Arts Curriculum Program. Carol has been hired by the agency while waiting for responses from the diversified funding groups. If approved, this program could be replicated in other special educational settings throughout the state and country.

Community organizations

Connie Holmlund proposed publishing an Appointment Calendar featuring color photographs of art work created by children who are patients at the state hospital. Connie believes that publication of the children's art work is a concrete validation of the children's artistic efforts. In addition, she believes the publication will serve to educate others about art therapy and give credence to the power of art as a means of expression for children with psychiatric problems. Connie, quoting from the California Task Force to Promote Self-Esteem noted, that "the arts in their most elemental form— rhythm, song, dance, drawing and play acting—are integral to a child's ability to communicate and interact in the world" as well as offering access to much needed experiences of success. The local foundation funded half of the expenses while requiring the other half to be matched. The Hospital Volunteer Service Group matched the funds within a week.

Cathleen Meadows helped pay her college expenses working for Traveling Art, a program for children on the Peninsula who are confined to hospitals, institutions or shelters. When she prepared to return to her home in Colorado she contacted former associates in Colorado community organizations proposing a similar program. Cathleen has been assured of funding when she returns to the area.

Conclusion

We have concluded that writing a grant continues to be a viable avenue toward not only creating a job that provides income, clarifying a student's role as an art therapist, promoting the field of art therapy, and establishing personal feelings of success and competence but also living out one's personal dreams and fantasies. We have found that writing a grant can make a difference in the grant writer's life as well as in the lives of the grant recipients.

This is a sequel to an article "*Grants—Demystifying the Mystique and Creating Job Connections,*" written by Frances E. Anderson, Ed.D., A.T.R. and Doris B. Arrington, Ed.D., A.T.R. and published in *Art Therapy* (1986) Volume 3, Number 1, 34–38.

MARITAL AND FAMILY THERAPY

Loyola Marymount University invites applications for a tenure-track position beginning Fall semester, 1991, in its strong clinical training program that prepares students in the art therapy modality. Applicants should hold a Ph.D. or equivalent terminal degree (by August, 1991) and have expertise in art therapy. They should be a registered art therapist (ATR) and have relevant clinical and supervision experience.

Responsibilities include graduate teaching (nine semester hours) and additional administrative responsibilities, including admissions and co-organizing conferences. Applicants should have a professional commitment to pursue research and scholarship.

Rank: Assistant Professor. Salary: Competitive. Application deadline: December 15, 1990. Women and minority candidates are specifically invited to apply. Applicants should send curriculum vitae and the names of three references to:

MAXINE JUNGE, *Chair*
Department of Marital and Family Therapy
LOYOLA MARYMOUNT UNIVERSITY
Loyola Blvd. at West 80th Street
Los Angeles, CA 90045
Loyola Marymount University is an
Equal Opportunity, Affirmative Action Employer

Imagery as Interpersonal Process

Pierre A. Grégoire, Ph.D., A.T.R., Concordia Art Therapy Program, McGill University Department of Psychiatry; Royal Victoria Hospital, Montreal, Quebec

Abstract

Art therapy presents a unique and privileged situation in which the image can be analyzed as language, which is creation resulting from both the therapeutic process and also the interpersonal relationship between client and therapist. This paper presents the results of a research in which the interpersonal factors are studied as being one of the determinants to the language of therapy and also of the imagery. A theoretical formulation is presented (Part I) along with statistical analysis of data produced by the same clients working alternatively with two therapists (Part II). Rorschach categories of scoring are used in the analysis of the images and recommendations are presented in the integration of experiential and transferential dimensions in the study of language in therapy.

PART I

Studies of the psychological mechanisms and functions of the imaginal and verbal processes have underlined their constant interplay and interdependence (Paivio, 1975; Hebb, 1968) rendered all the more complex when such processes are placed in the perspective of interpersonal interaction such as in the context of the psychotherapeutic relationship. While many theories (Strupp, 1978) attempt to identify the therapeutic factors involved in such a process, very few studies have actually addressed the changing roles and attributes of language within the therapeutic relationship; the language, which is not only the vehicle of the communication between therapist and client but constitutes also, a major modality of the therapeutic process.

Starting from a relatively cognitive concept of language, in which the verbal expression is descriptive and basically informational, we have at least in some of the theoretical frameworks (Rogers, 1967; Gendlin, 1962; Havens, 1978) come to redefine the language as being in itself part of the therapeutic modality, in the 'here-and-now' of the therapeutic relationship and thus needing to be addressed as not only information but as very much both vehicle and integral part of the therapy. The multi faceted dichotomies which have been used in regards to language have included the dimensions of sign/symbol (Saussure, 1974), classical/romantic (Todarov, 1977), structural/phenomenological (Merleau-Ponty, 1964), analytical/experiential (Rogers, 1980), accomodation/assimilation (Piaget, 1950), as also the distinction made in reference to language as vehicle of the transferential/existential discourse of the client (Boss, 1979). In these distinctions can be seen two basically different functions of language which consist of making reference to an absent and objective reality as also remaining very much an element of the here and now and experienced as a modality of the subjective interpersonal relationship. We then extend these issues to the complex role of imaginal and verbal language in art therapy, and the language of therapy is all the more brought to the forefront with the highly symbolic and experiential features which it presents. We also are aware of the constant references to an objective reality, recalled, represented and made real and immediate in the ongoing process of the art inherent to the art therapy situation (Wadeson, 1980). That art can be part of a communicative process as well as media of a creative, self-expressive and aesthetic experience forms the basis on which art therapy has gained its momentum. Yet this complex role of the image has remained basically unexplored in terms of its implications as to the therapeutic process of the art therapy situation, as indeed the role of language is also unresolved in terms of the major issues of the psychotherapeutic approaches across theoretical and technical orientations. Emphasis is being placed alternatively on the experiential aspects of the therapist/client relationship or on the diagnostic and prescriptive aspects of this relationship as major contributor to the therapeutic change. In art therapy, when the process of communication between therapist and client is made all the more substantial by the actual creation of a unique and constantly evolving language, the importance of exploring the diverse components of this complex psychological process is crucial. Such analysis is indeed essential, so as to better understand the role and functions of language in psychotherapy and also to better grasp the constant interplay of the experiential and structural aspects of the imagery process in pyschopathology as underlined by Prinzhorn and Delay (Jakab, 1956). The language in art therapy is more than a media of communication between two persons, and in fact represents also a reality of its own which must be seen as resulting from the interaction between client and therapist and needing to be understood as expression of the unexplored dynamics of this relationship. The art and language of art therapy is a reality with a multiplicity of semantic, experiential and symbolic elements out of which the therapeutic process will result. The unique situation of art therapy in regards to this exploration of language in therapy is addressed in this article in reference to the interpersonal aspects of imagery. A brief overview of the theoretical implications of this issue is presented, and also a brief report of a study which was undertaken to verify in the clinical setting some of the issues pertaining to this hypothesis.

Art as experience, art as relationship

In the interplay between assimilation and accommodation to the world (Piaget, 1950) the individual is constantly involved in the integration of both an inner world of subjective experience as also of the immediate reality of the objective world out of which integration a creative equilibrium will hopefully result, albeit in a constant state of change. The symbolic structures will in some way reflect this basic polarity (Durand, 1969). One of the major functions of the human organism is this constant process of dynamic and creative mobility in which a dialogue must be established between the individual's subjective world (as it exists in continually changing patterns of relationships) to an objective reality. Reflecting these constantly changing, ever-renewed sets of reciprocal interactions, language as also the imaginal process, partake in these different aspects of the human organism's basic motives. Art as language is both an expression of an experiential, phenomenological and subjective reality, and expresses involvement in the immediate ongoing reality of the relationship to the world as it exists. From the very beginning of one's existence, the child proceeds from these dual realities, not only being involved in expression but also his basic drive being one of involvement with the world. The child's very survival rests on the capacity to express and to be understood by the significant other. The language as modality of adaptation will thus result from a mutual commitment to the self and to the world, the language between the child and the significant other being molded along the lines of both expression and relationship.

Psychopathology as language

Among the many discoveries about human nature which we owe to the clincial situation of psychotherapy, the process of transference has been most central to our understanding of the affective relational components of psychopathology. In all of the psychopathologies, the inner drama of the individual is basically not only an inner experience, but is made up of perceptual, cognitive, affective and symbolic processes which seek an object and a relationship with whom the communicative dimension of the pathology may find expression.

Defined as pertaining to the specific situation of psychotherapy, the concept of transference is but one of the issues pertaining to the "projective hypothesis" (Rapaport, 1968) long held as one of the basic elements in diagnostic assessments and central to our understanding of the interactional and expressive dimension of the human discourse. In its historical development, transference (Heidbreder, 1933) was first perceived with a certain apprehension in that the affective transference to the therapist could become an obstacle to the proper therapeutic exchange. Eventually, it came to be seen as a direct encounter with the client's pathology and presenting important issues to be worked through in therapy. While there are many dimensions and attitudes on the part of art therapists to the issue of transference (Ulman, 1981) one can focus on the art experience in its relationship aspects (Robbins, 1981) in that the pathological states are not self-directed and static but are clearly attempts to communicate. The illness is intimately intertwined as part of the communicative process. In this perspective, pathology is in the most fundamental sense a communication; it represents the basic message of the individual as well as his/her basic (or only) available means of communication. The psychosomatic theories have extended this symbolic dimension to the area of somatic illness and, to some extent, to a systemic model in which the illness is not only an expression but may well be observed as in some pathological families as being part of a communicative process (Ehrenwald, 1963) having become a modality of exchange between the individual and the significant others. In this context, psychopathology, with its symptomatic, transferential and relational aspects may well be seen as a language not only of a cognitive and factual nature, but a message charged with affect and intent.

This language may be very much directed and addresses the elements of the situation and relationship in which it is explored and experienced. The language of therapy, and more systematically so in the modality of art therapy, is not a modality to be observed and analyzed by the therapist but as a modality of interpersonal commitment in which the language is symbolic of the pathology of the client, as experienced in the interpersonal therapeutic situation with its complex and multiple parameters which include and involve the therapist. In art therapy, this creative dimension of the client-therapist's communicative process is made all the more real in the image which then becomes its expression and its symbolic reference.

Art as interpersonal involvement

The creative arts are not isolated and self-enclosed activities, but are part of an effort to communicate and to relate to significant others (Eco, 1965). This has been emphasized both in the attempt of contemporary art to translate the subjective experience into the modality of the art media as well as in the continued search for ever renewed language by which the impact of the work can also achieve its aesthetic and communicative form (Huyghe, 1960). In this perspective, art represents not only a modality of expression but also a contextual statement. Along with the advent of art therapy and certainly intertwined with its development, is the evolution of contemporary art which has progressively addressed the issue of the art and of the creativity of the artist in the context of likewise the creativity and the creative experience of the spectator. The spectator has been taken from his/her passive and receptive roles, to be equally involved in the process of creation.

Parallel to this we have the studies on the psychological mechanisms of perceptual processes (Kuffler, 1976) which have underlined the active mechanisms of perception not as simple recording of outside events but as a creative organization and selection of data with emphasis in both scientific and artistic endeavors to explore the phenomenology of the perceptual happening. The spectator and artist become thus involved in an acknowledged relationship of mutual interaction as "the new intents of the artist are no longer to be confined to a monologue but his gesture and his actions are to be met by an act of recognition on the part of the spectator" (Vergine, 1974). The artist is seeking to be confirmed in his/her identity and to find an "other" who is willing to be part of a dialogue. Some of the art concerns have thus become increasingly involved and interested in the "public" and in the creative response which must be engendered so as to have the art work become an integral part of an unfolding awareness and mutuality. In many ways, this evolution of the creative arts has laid the foundation for the establishment of art therapy, with art becoming the expression of a subjectivity and defined as a modality of inquiry. It is no longer an isolated entity but a contextual event, very much a part of the world of subjective and interpersonal relationships. The art of art therapy represents in this way one of the facets of the research that contemporary art has undertaken.

PART II

Imagery as interpersonal process[1]

The interpersonal dimension of the image confers to it a systemic position. The image represents an element partaking in a series of interactional and interpersonal processes, involved in the interaction with the art therapist, not only in terms of a cognitive and informative expression of the client but in terms of a communication to the art therapist. The client in art therapy not only describes his/her inner world, but experiences it also in terms of the contextual factors of the relationship with the therapist.

This definition of imagery as involving an interpersonal process has led to the setting up of a clinical protocol designed to verify its implications. The basic hypothesis of the protocol was that the ongoing specific relationship with the art therapist could be defined as having an impact on the imagery created in the course of the session and that given the appropriate conditions one could observe and establish some type of measurement of this interpersonal dimension of the image.

Methodology

In order to operationalize this hypothesis, it was assumed that given different interpersonal and contextual elements in the imagery created in art therapy, there would be differences in the client's imagery, dependent upon the specific therapist the client is involved with. For this purpose, twelve clients (six males and six females) with average ages between 26 and 29 were all assigned alternatively with two therapists of the opposite sex and of a 15 years age difference. All clients were inpatients of a psychiatric unit in a large general hospital, and the various working diagnoses included depression, schizophrenia and personality disorders. Patients were of mixed socioeconomic background. The maximum length of time between sessions with both therapists was three days. To deal with the effect of sequential order, one half of the clients were first seen by the female therapist and then by the male therapist

---

[1] The author wishes to thank Mrs. Mary B. Hooper who has contributed to the experimental phases of this project.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

and the other half of the clients followed the alternative sequence of first being seen by the male therapist and then by the female therapist. Clients were offered a variety of drawing materials with the instruction to: "Make an image that will represent what is most relevant to you, what is on your mind, right now, the things you are thinking about." Upon completion of the first drawing, the client was instructed to make "A picture representing a landscape." These images were requested to obtain both a spontaneous and a standardized image. Some of the rationale for these particular sets of conditions came from the work carried out in areas of psychological assessment in which situational and interpersonal factors (Masling, 1960) were explored in relationship to variables such as sex and age of interviewer.

Other studies have expanded on these issues (Guillaumin, 1965) and addressed the question of the personality of examiner as possibly having an impact on some aspects of the outcome of the assessment. In the context of psychotherapy research the person of the therapist has also been identified as a determining factor in the therapeutic experience of the client. (Barron, 1978; Van der Veen, 1967; Wadeson, 1986; Strupp, 1978)

1) Scoring and assessment

To measure and statistically compare the client's drawings when involved alternatively with the two therapists, an established method of scoring (Klopfer, 1954) used when analyzing the responses to the Rorschach projective test were employed. The use of the Rorschach scoring methodology in analysis of drawings has been explored in previous studies (De Luca, 1961). In part, the rationale for such an analysis of the images stems from an analogy which exists in that both situations involve projective mechanisms in the context of perceptual-visual elements taking into account both content and structure of the client's works as underlined by De Luca but also by H. Rorschach in the general introduction of the test.

2) Form and movement

These categories referred to as determinants of the subject's responses in Rorschach terminology were translated in the analysis of the image as they refer to the form level with drawings given a rating of (F +) for definitely shaped concepts, (F o) for vaguely shaped concepts and a (F −) for an inappropriate or inaccurate shape. The form was also placed in the context of its relationship to movement with a score of M for a human figure in movement and a score of Fm for an inanimate object depicted in movement such as a falling rock.

3) Shading

The figures depicted with shading or a choice of color intended to give the impression of texture were scored Fc. When the shading or perspective was used to give the impression of three dimension or depth, we used the score FK. Forms alone, without shading were scored F.

4) Form color

In this category of rating, the relationship between the form and the color of the figures is scored with FC when there is an attempt to place the appropriate color on a good form, while the score of CF was used when the color predominates with a form which is indefinite.

5) Content

The content of the drawings were scored along the categories of human, animal, nature, inanimate objects, geography (such as maps) and abstract forms.

These categories of scoring were retained following a series of trial in which they had proven to be sufficiently easy to assess yet also allowing for an establishment of a scoring that appeared sensitive to the important issues in this study. It remained part of our interests to see if the dynamics of the therapeutic situation might in fact be defined by this process, in that not only would there be a difference in the imagery created but also that we could establish some tentative conclusion as to the underlying dynamics which this involved, as these measures would then be analyzed in the context of the projective tests literature.

Results

The drawings were scored individually by two judges and the results were analyzed using the t-test statistics so as to verify if the differences between the means and deviations of individuals or groups in two separate conditions were significant (Two-tailed test, Siegel, 1956). The different conditions included the comparison of images drawn by the clients when in session with either of the two therapists, also the clients' images were compared when grouped according to whether the therapist was of the same sex or of the opposite sex of the client. Emphasis is placed on the sexual factors in the context of some of the work carried out on the sex of the assessor as having an impact on the results of the projective tests (Guillaumin, 1965), it remains, that the distinction between therapists is in terms of a global personal style, the person of the client and the person of the therapist representing the important factors to be underscored as relevant to the imagery process under study.

When comparing the images produced in relationship to the two therapists, the female therapist significantly brought about more good form (F+) type of responses ($df = 11$, $t = 2.46$, $p > .05$)* than the male therapist. Also clients tended to center their images (di) more when in the presence of the female therapist ($df = 11$, $t = 1.85$, $p > .10$). In the context of working with the male therapist details as opposed to whole objects seemed to be somewhat more readily produced ($df = 11$, $t = 1.92$, $p > .10$). There was also a trend ($p > .20$) in that a greater number of Fm was produced ($df = 11$, $t = 1.449$, $p > .20$) when the client was working with the male therapist.

---

*(p = probability associated with the occurrence under a null hypothesis of a value as extreme as or more extreme than the observed value)

The comparison of the clients' images when working with a therapist of the same sex as opposed to a therapist of the opposite sex resulted in statistically significant differences in the area of content analysis, with inanimate objects appearing more often when the clients were working with a therapist of the same sex ($df = 11$, $t = 2.60$, $p > .05$). Human figures ($df = 11$, $t = 1.59$, $p > .20$) and geographical representations ($df = 11$, $t = 1.49$, $p > .20$) were seen more often when clients were working with a therapist of the opposite sex while also a noteworthy difference was observed in the number of nature drawings such as plants and trees that were produced when the client was working with a therapist of the same sex ($df = 11$, $t = 1.82$, $p > .10$).

As we try to further analyze the images produced by the female clients when in session with the male or female therapist the noteworthy difference was in the client showing human forms in movement when working with a male therapist ($df = 5$, $t = 1.58$, $p > .20$) while nature was more often depicted when working with the female therapist ($df = 5$, $t = 2.23$, $p > .10$). As for the male clients, they tended to produce more well defined objects, ($df = 5$, $t = 3.87$, $p > .02$) while also placing the images toward the center ($df = 5$, $t = 2.24$, $p > .10$) and including more human figures ($df = 5$, $t = 1.74$, $p > .20$) when working with the female therapist.

Interpretation of these differences suggests that in the work carried out with the female therapist, clients tended to display more control and ego strength (associated with F+ responses) whereas with the male therapist, they tended to address underlying conflicts and unresolved issues (Fm,d). As to other aspects of the analysis, when the therapist and client were of the opposite sex, issues were either more of an interpersonal nature (with humans being part of the imagery) or more of a defensive nature (maps) whereas when therapist and client were of the same sex the imagery tended to be more object related with the drawing of inanimate objects and scenes from nature.

The more elaborate responses in terms of ego functioning (M, F+) were observed in the work carried out by male clients working with the female therapist. These interpretations are derived from the Rorschach literature (Klopfer, 1954, Rickers-Ovsiankina, 1960) and attempt to underline the relevance of the differences that were observed and should not be taken as a definitive interpretation of such a scoring procedure. These results confirm the work carried out in areas of diagnostic assessment, in which the person of the assessor appeared to influence some of the results obtained on projective tests. In the cases analyzed here, some statistically significant differences ($p > .05$) and some trends ($p > .20$) could be seen in the images produced alternatively by the same clients but involved with two different therapists. Our conclusions must be seen in the context of the experimental design in which for the necessity of simplification we had to establish a situation parallel to but certainly not equivalent to a long-term art therapy relationship.

Art therapy and the interpersonal process

As could be observed in the imagery produced with two different therapists, some elements were specific to the person of the therapist, while other elements of the images were related to other factors such as same sex / other sex of the client therapist dyad. This underlines that the imagery produced by the client in the context of art therapy involves elements of the therapeutic process with both client and therapist being participant in the creation of the language of the relationship. The imagery created in the course of therapy is both an expression of a structural reality which the client is consistently involved with and attempting to actualize in his expression but also the image is a reflection, in some of its components of the immediate and contextual variables which the therapist must take into account as equally being very much a part of the client's verbal and nonverbal discourse.

Art therapy stands in a privileged perspective in its use of the image as mediator as well as created language in the 'here-and-now' of the relationship. The Art Therapist is thus presented with an issue still left basically unexplored in the models and theories of the more traditional psychotherapies: the role and function of language needing to be studied as the mediating process between client and therapist and from which the curative process of therapy is brought about. The image thus challenges the restricted understanding we have so far of what communication between therapist and client may involve into as well as the yet unresolved question of the complexity of the symbolic process which allows for the intersystemic translation and transformations observed in therapeutic work.

References

Barron, J. (1978). A prolegomenon to the personality of the psychotherapist: Choices and changes. Psychotherapy: Theory, research and practices, vol. 15, 4, pp. 309–313.

Boss, M. (1979). Existential foundation of Medicine and Psychology. New York: Arsonson.

De Luca, P. L. & Sacchettini, S. (1961). Painting as a means of psychodiagnostic research: Relationship with the Rorschach test. N.Y.: Karger Basel.

Durand, G. (1969). Les structures anthropologiques de l'imaginaire. Paris: Bordas.

Eco, U. (1965). L'oeuvre ouverte. Paris: Seuil.

Ehrenwald, J. (1963). Neurosis in the family and patterns of psychological defense. N.Y.: Hoeber.

Gendlin, E. T. (1962). Experiencing and the creation of meaning. N.Y.: Free Press of Glencoe.

Guillaumin, J. (1965). La dynamique de l'examen psychologique. Paris: Presses Universitaires de France.

Havens, L. (1978). Explorations in the uses of language in psychotherapy. Psychiatry, vol. 41, pp. 336–345.

Hebb, D. D. (1968). Concerning imagery. Psychological Review, 74, pp. 466–477.

Heidbreder, Edna. (1933). Seven psychologies. New York: Appleton-Century-Crofts.

Huyghe, R. (1960). L'art et l'âme. Paris: Flammarion.

Jakab, I. (1956). Dessins et peintures des aliénés. Budapest: Acad. des Sc. de Hongrie.

Klopfer, B., Ainsworth, M., Klopfer, W., Holt, R. (1954). Developments in the Rorschach technique. New York: Harcourt, Brace & World.

Kuffler, S. W., Nicholls, J. G. (1976). From neuron to brain. Sinauer, Sunderland.

Masling, J. (1960). The influence of situational and interpersonal variables in projective testing. Psychol. Bull., 57, pp. 65–85.

Merleau-Ponty, M. (1964). Le visible et l'invisible. Paris: Gallimard.

Rickers-Ovsiankina, M. A. (1960). Rorschach Psychology, N.Y.: John Wiley.

Paivio, A. (1975). Imagery and synchronic thinking. Cdn Psych. Rev., vol. 16, 3, pp. 147–163.

Piaget, J. (1950). The psychology of intelligence. N.Y.: Harcourt, Brace.

Rapaport, D., Gill, M., Schafer, R. (1968). Diagnostic psychological testing. N.Y.: International Unity Press.

Robbins, A. (1981). Transference and countertransference in art therapy. Amer. Jrn. of Art Therapy, 21, Oct., pp. 3–5.

Rogers, C.R. (1980) A way of being. Boston: Houghton Mifflin.

Rogers, C. R. (1967). The therapeutic relationship and its impact. Madison: Univ. of Wisconsin Press.

Rorschach, H. (1953). Psychodiagnostic. Paris: Presses Universitaires de France.

Saussure, F. de (1974). Cours de linguistique générale. Paris: Payot.

Siegel, S. (1956). Nonparametrics statistics for the behavioral sciences. N.Y.: McGraw-Hill.

Strupp, H. H. (1978). Psychotherapy research and practice: an overview. In: Hdbk of Psychotherapy and Beh. Chg., Ed. S. Garfield & S. Bergin, N.Y.: Wiley.

Thomas, C. B., Ross, D. C., Freed E. S., (1964). An index of Rorschach response. Baltimore: Johns Hopkins Press.

Todorov, T. (1977). Théories du symbole. Paris: Seuil.

Ulman, Elinor. (1981). Transference and countertransference in art therapy. Amer. Jrn. of Art Therapy, 21, Oct., pp. 3–5.

Van der Veen, F. (1967). The effects of the therapist and the patient on each other. In: The therapeutic relationship and its impact. C. R. Rogers ed., Madison: Wisconsin Press.

Vergine, L. (1974). Il corpo come linguaggio. Milan: Giampaolo Prearo.

Wadeson, H. (1980). Art psychotherapy. N.Y.: Wiley.

Wadeson, H. (1986). The influence of art-making on the transference relationship. Art Therapy, 3,2, pp. 81–88.

COLLEGE OF NOTRE DAME

Cool It in . . .

S.F. this Summer
and Collect
Units Toward
Your
ATR

- Job opportunities in clinical, educational, and community agencies
- The only AATA-approved Art Therapy Program in Northern California
- A Master in Art Therapy – 37 units
- A Master in Marital and Family Therapy leading to MFCC Licensure – 51 units
- Graduate Art Therapy Institute – 21 units

Can be completed in two summers and a winter internship!

COLLEGE OF NOTRE DAME
Graduate School
1500 Ralston Avenue
Belmont, CA 94002

(415) 593-1606

ON THE SAN FRANCISCO PENINSULA

Enhancement of Body-Image: A Structured Art Therapy Group with Adolescents

Stanley Schneider, Ph.D., *Director, Summit Institute, Jerusalem, Israel*
Shelley Ostroff, M.A., A.T.R., *Director, Vocational Rehabilitation Center, Summit Institute, Hebrew University, Jerusalem, Israel*
Nancy Legow, M.A., A.T.R., *Intern in Art Therapy, (1986) Summit Institute, Jerusalem, Israel*

Abstract

This paper presents a structured, short-term art therapy group designed to enhance the self and body image of adolescents with emotional disturbances. The concept of self and body image is reviewed with a focus on the developmental phase of adolescence. The focused exercises utilized in the group is described with explanations and descriptions of purpose.

The influence of the group on the development of the self concept is explored in general, and the specific therapeutic use of the group in this context is emphasized. This art therapy group has been developed and used at the Summit Institute, a psychiatric residential treatment facility for emotionally disturbed adolescents and young adults in Jerusalem, Israel, and has been found effective in providing group members with an experience whereby they can begin to perceptually, emotionally and cognitively work through conflictual issues related to their self and body image.

Self Image/Body Image: Theoretical Formulation

The first written description of body-image disturbance was from a neurological frame of reference and is found in the works of Ambrose Paré, a sixteenth century surgeon. He wrote about phantom limb disturbances in patients following amputation (Kolb, 1959); a unique neurological phenomena whereby the *inner* neurological percepts belie the *outer* reality of a missing limb. However, it was not until the writings of Head, the neurologist, in 1920, that the basic concepts of the body-schema, as we know it today, began to take shape.

The application of body-image theory to psychiatry was pioneered in the works of Paul Schilder (1950), who conceived of a tripartite, tridimensional unity: a physiological and sociological basis, and a libidinous structure. Narcissism, expression of emotion, social relations and identification were some of the psychological concepts he introduced to the body-image literature. He suggested that "the development of the body-schema probably runs to a great extent parallel with the sensori-motor development" (Schilder, 1950).

With the works of Melanie Klein (1946), Bion (1962), and Guntrip (1968), object relations theory moved forward; we now note an articulation of the interaction between subject and object not only on a physical level, but also on a feeling level. Sandler (1976) carried this further with his concept of role-responsiveness.

In the literature we find various terms that are used interchangeably with body-image: "self awareness, self-concept, the self, body-ego, self-identity, and body-schema" (Schonfeld, 1969). Torras De Beà (1987) notes that in the field of psychoanalysis, the term most frequently used has been 'body-schema.' "This is probably because the term 'body-schema' has been used to denote the *representation of the body in the mind* . . . (and is) the identity factor that represents the body (1987)". This holds true for the parent as well as for the child's conceptualization of the body percept. The introjection and projectives (including projective identification) that take place between mother and child, will influence not only the emotional development of the child, but also the body schema of the child which is part of the object relations realm.

Thus, body-image can be seen as an interactive process between the structural internalizations and the object relations dyad. Schonfeld (1969) defines the structure of the body-image as being determined by: "1. subjective perception of appearance and ability to function . . . 2. internalized psychological factors . . . 3. sociological factors . . . 4. ideal body-image." Torras De Beà's (1987) object relations view is that "the child partly 'receives' its body schema from the mother and father and from the sensorimotor experiences with all their relational and affective components."

Melanie Klein added "life" to the world of objects. Laplanche and Pontalis (1980) stated: "Objects (projected, introjected) actually *act* upon the subject—they persecute, reassure him, etc." In Kleinian terms, the interrelationship between subjects (objects) is not only a physical-spatial one, but also an experiential-emotional one. Identity, in the Kleinian view, takes on a *feeling* aspect. This parallels the thinking of Federn (1952) who had differentiated the ego from the body-image and attempted to separate a mental and body ego. Bodily ego boundaries and ego-feeling included not only somatic but also mental/emotional phenomena.

Adolescence and Body Image

In dealing with adolescents who are, developmentally, in the continuous process of ego-identity formation—the concept of body-image and its potential disturbance, is of paramount importance. Erikson (1964) wrote of the resolution of the boundaries of ego development as part of the process of adolescence. The boundaries help delineate the internal structures and repositories of feelings from external aspects. On an emotional level, the 'inner' and 'outer' dimension of the identity process allows the person to recognize himself/herself and to feel recognized" (Erikson, 1964; cf. Schneider, Berman, Aronson, 1984).

Body schema occupies an important part in the adolescent's emotional development with a quickening of concern, internal (and sometimes, external) conflicts and fantasies. The physical changes of adolescence awaken new and unfamiliar feelings with a concomitant intensification of emotional turmoil. Parallel development of cognitive capabilities such as introspection and abstraction enable the adolescent to "look at" what s/he is feeling. This involves perception of self by herself/himself as well as concern regarding one's perception in the eyes of others.

The adolescents' attempt at integrating the dramatic physical and psychological changes into a coherent self image are largely determined by the ego strengths s/he brings to this developmental stage as well as by the way in which s/he perceives herself/himself in the eyes of others. This self percept may be relatively realistic or distorted. The generally difficult and painful growth process of formulating a healthy, positive and integrated body image may be complicated in the adolescent with emotional difficulties and unresolved conflicts from previous stages of development, or in the adolescent with perceptual and/or learning disabilities.

The adolescents' preoccupation with her/his changing body is generally an intra-psychic process and certain aspects of the body image which are unacceptable to her/him because of real or fantasized deviations from the norm are often magnified beyond proportion. Oftentimes this may emerge as a fixation on a particular body part. When the adolescent has had inadequate preparations for the physiological changes which occur, these changes may be perceived as frightening and incomprehensible. Information sought out "secretly" may be internalized in distorted ways, further impeding the integration of a healthy body image. Mocking and scapegoating those with deviant physical appearances serves for some as outlets for internal tension over what is an uncomfortable and even taboo subject. While the adolescent is constantly (overtly/covertly) comparing herself/himself with peers, the difficulty in dealing directly with the subject of body image, and the embarrassment surrounding it, prevents her/him from sharing concerns and fears and confronting them with reality. Parents sensing their adolescent's anxiety and her/his focusing on a certain body part, may "adopt" the adolescent's concern, thus reinforcing it as a genuine problem. The symptom then takes on the quality of the focus of attention rather than the underlying anxiety. Among the more emotionally disturbed adolescents, these concerns are often converted into somatic symptoms. Sometimes adolescents utilize denial and repression as defense mechanisms in an attempt to continue being a dependent child. Fears may be manifested overtly and may be expressed as sexual acting-out or verbalized concern about sexual identity.

A Structured Therapy Group

Our plan was to create a carefully structured art therapy group on the subject of the human figure which we hoped would encourage the formation of a more positive, healthy and integrated body image. The art materials and structured exercises provide media with which the group could actively explore, confront, and create images of the human body. The metaphoric and symbolic qualities of art provide a safe realm in which the participants can begin to cognitively, tangibly and emotionally work-through distortions, anxieties, confusion and conflictual issues related to their own body images and identity.

Because of the significance of the peer group in the formation of the adolescent's self image, we utilize the group as an important part in the therapeutic process. Concepts of self-image and body image are interrelated as a complex perception by the individual of herself/himself based on physiological, psychological and social factors. Self and body image are directly related to the feedback an individual receives from others. A person feels a stronger sense of her/his own existence when s/he is related to and not ignored by others. Her/his attitude toward self is, in a large part, based on past experiences of positive and negative feedback.

Even though art work is, in many ways, perceived as an extension of self, it nonetheless provides a less threatening transitional medium for communication and feedback on the subject of self and body image. The group meets for twelve sessions. Each of the sessions ends with a group discussion where members are encouraged to relate to their own art work as well as to that of others.

Many adolescents are so narcissistically preoccupied with their own self image, seeing themselves as inferior or different and perceiving the other as superior, enviable, etc. that they are often not realistically aware of the individual differences among others or of shared anxieties. Being confronted with different "body images," emotions, figures, portraits and facial expressions as expressed in the art work, forces a *confrontation with differences* in terms other than "good"/"bad", "acceptable"/"unacceptable." When the group has established a safe, intimate sense of cohesion and trust, these differences are often spontaneously related-back from the art work to the group members. However, this occurs on their own initiative and only at the level with which they feel comfortable. As an example, if a person places her/his clay figure apart from the clay figures of others and says that the figure is alone s/he *may continue* by saying that maybe it is because s/he too feels alone.

A range of activities involving a variety of media were designed to focus on different areas of cognitive, perceptual, and motoric functions and skills and emotional conflicts regarding body image. In addition, the group provides the adolescents with an enriching and ego-building encounter with art activities. A description of the activities is presented in chronological order. Because of the emotionally conflict-laden aspect of the theme of this group, resistance was initially anticipated. Participation in the group is voluntary, although, after the initial commitment, obligatory as a therapeutic activity. Indeed, certain adolescents rejected the idea outright. Yet, the majority in this setting accepted it enthusiastically, particularly after hearing about the group from previous participants, as a rewarding experience. The activities were carefully designed so that they progressed from more simple and less threatening to a more direct and complex confrontation with the subject matter.

Activity 1 (session #1)—*Collage*

Materials: colored paper, scissors, glue

Description of activity:

Construction of a collage figure using colored paper and involving the cutting-out and pasting of simplified shapes of the body onto a background of colored paper.

Rationale:

This activity allows for a simple expression of the body. It requires the basic steps of identifying and placing parts of the body, taking into consideration their relationship and proportions to one another. This exercise is somewhat non-threatening in that it permits a superficial approach without evoking the need to defend against relating to more emotionally laden areas of the body in a detailed manner. The colorful materials and relative simplicity of the task ensure an aesthetically pleasing outcome with little performance variability among group members based on talent or sophistication.

Activity 2 (session #2)—*Clay figure*

Materials: Clay, clay tools, wooden artist's mannequin

Description of activity:

After a demonstration by the art therapist of two methods of building clay figures, the parts of the body are pointed out using an artist's wooden mannequin. The participants decide on the movement of the figure and the feeling expressed in the movement and then demonstrate on themselves the position they choose. They then create the clay figure. The closure of this activity involves the group members placing their figures on a clay base, in relation to one another.

Rationale:

Clay is provided to encourage and develop a three-dimensional, tangible, tacticle sense of the body's mass and to consider it from less familiar perspectives. Clay does not require fine coordination but is geared towards a grosser conceptualization of the figure while still allowing for the avoidance of details. The bodily movement exercise invites group members to begin to relate to their own bodies, how they move and to actively think about the body as a dynamic mass in space. The placing of the figures in relation to each other is designed to stimulate the awareness of, and interaction with, other members of the environment. The group members, in a "story-like manner," discuss their figures' actions and feelings in relation to "other" sculptures, and, in doing so, interact indirectly with each other on a symbolic level.

Activity 3 (session #3)—*Two portraits in color expressing feeling*

Materials: 8½" × 11" paper, pencil, eraser, oil pastels

Description of activity:

Two portraits in color are drawn in order to convey two different emotions. The expressive, rather than realistic, quality of the picture is focused on, and portraits of famous artists are shown with a discussion of the use of line, color, expression and composition. Mirrors are available so that group members can study their own faces and changes in expression. Emotions expressed by the group members spontaneously in this session are explored in this context.

Rationale:

At this stage, the group is beginning to experience itself as a cohesive entity with a strong involvement in their shared group experience. It is felt important to allow for and encourage an open airing of some of the feelings and emotions existing in the group. The face is the most expressive part of the body, and the most important center of communication. The ease and familiarity with which the face is drawn provides a non-threatening stepping-stone for later drawings of the full figure.

Since group members are often overwhelmed with a particular feeling (sadness, anger, anxiety, etc.), they "forget" the experience of other feelings at that time, so the portrayal of two different emotions and the exposure to the numerous expressions of other group members encourage the awareness of, and identification with, a variety of emotions. This allows for the exploration of the complexity and ambivalence of feelings, permits a sense of universality and engenders feelings of not being alone. By seeing other group members' pictures and by receiving feedback to their own pictures, group members can see and hear other feelings rather than being "stuck" within their own dominant feeling of the moment.

Activity 4 (session #4)—*Sketching group members*

Materials: 8½" × 11" paper, pencil, eraser, charcoal

Description of activity:

The group does a movement exercise to music where the possible directional movements of the various body parts are explored. The group members take turns posing in different positions while the others do quick (approximately two minute) sketches. This is repeated a second time. The focus is on achieving a *very rough sense* of the movement of the body. Another round of longer (ten minute) poses follows.

Rationale:

The movement exercise is designed to stimulate thought and awareness about the different parts of the body and the way in which they can move, by simultaneously and experientially combining physical, visual and cognitive processes. The sketches are meant to continue this theme by focusing attention on, and visually re-creating, a variety of movements on paper. Drawing the other members of the group stimulates awareness of the other. The discussion afterwards may relate both to the experience of becoming aware of others and to the feelings relating to being the focus of attention (being watched, judged, etc.). The rounds of two minute sketches prior to the ten minute sketches, function as practice-rounds to train the eye to take in the complete body movement in a general sense. This facilitates a more integrated perception by the time the second round is accomplished. The swiftness of the exercises and the intense concentration on the gestalt of the movement frees-up group members from previous stereotypes and fixations on particular conflict-laden areas of the body, evident in previous figure drawings.

Activity 5 (session #5)—*Picture of a human figure in color*

Materials: 14" × 16" paper, pencil, eraser, oil pastels

Description of activity:

The way in which movement expresses feeling is discussed and various artworks are displayed to show how artists use movement, color, line, composition and environment to convey a certain mood and character. Group members are asked to choose and depict a character, his/her personality and mood while considering the above mentioned factors in the picture.

Rationale:

The aim of this exercise is to stimulate awareness of the relationship between the psychological/emotional aspects of the person and his/her body. The environment is taken into account as a factor in the drawing and group discussion in order to stimulate awareness as to the relationship (or lack of it) between group members' feelings and the environment.

Activity 6 (session #6)—*Picture of an interaction between two people, in color*

Materials: 14" × 16" paper, pencil, eraser, oil pastels

Description of activity:

The same materials and concepts are used as in the previous activity, but this time artists' works are used to illustrate the nature and mood of the interaction or relationship between two people. The group is then asked to imagine and depict an interaction between two people.

Rationale:

The aim of this activity is to explore various possibilities of dyadic interactions and the feelings associated with them. Group members at this stage have become more aware of each other and are beginning to feel more secure with themselves and with each other.

Activity 7 (sessions #7—12)*Life-size color picture of human figure*

Materials: large paper, pencil, eraser, gouache paints, paint-brushes, full-length mirror

Description of activity:

The final activity involves the drawing and painting of a realistic life-size figure; not necessarily a self-portrait. Emphasis is placed on the careful examination and consideration of the various body parts, shapes, sizes and colors. Again, the members are asked to choose a character to paint, to consider his/her personality and mood, and to think how these can best be conveyed in the movement, choice of line, color and environment. The focus is on a realistic rendition of a person which demands close examination of oneself in the mirror.

Rationale:

This final task is a culmination of the previous tasks and demands paying close attention to various parts and details of the body, their relationship to each other, their shapes, sizes, proportions and colors on a life-size scale.

Because of the attention paid to these details, the psychological distancing enabled by the metaphoric aspect of the previous exercises is no longer readily available. Standing opposite the picture involves the person "measuring" and considering his/her own body parts. By this stage, all the elements involved in the activity are familiar so that the project is less threatening than it would initially seem. This task takes place over a series of five weeks so that time can be invested in achieving a realistic and satisfying result and the art therapist can spend time dealing with each person and with the particular issues which may arise. The end-product is generally experienced as a very strong assertion of the self.

Summary:

The issue of body-image in adolescents is a potentially conflictual issue. In the emotionally disturbed and learning disabled adolescent, this area is even more problematic due to the perceptual, cognitive and integrative deficits, as well as concomitant emotional adolescent turmoil.

This paper describes a time-limited art therapy group whose primary goal is to work on systematically developing a more integrated concept of the body. This structured art therapy group utilized the metaphoric and symbolic qualities of the art in order to provide a safe realm in which group members can begin to cognitively and emotionally work-through misperceptions, confusions and conflicted issues related to their own body-images.

A secondary but related goal of

the group was to foster healthy and positive interaction and relatedness between group members. Self image as mentioned is a function of the way in which others relate to us, thus the enhancement of social skills via the group is a central issue.

References

Ajuriaguerra, J. (1965). *The body percept*. New York: Random House.

Bion, W. R. (1962). *Learning from experience*. London: Heinemann.

Erikson, E. H. (1964). *Insight and responsibility*. New York: W. W. Norton.

Federn, P. (1952). *Ego psychology and the psychoses*. New York: Basic Books.

Guntrip, H. (1968). *Schizoid phenomena, object relations & the self*. London: Hogarth.

Head, H. (1920). *Studies in neurology*. London: Oxford University Press.

Jacobson, E. (1964). *The self & the object world*. New York: International Universities Press.

Klein, M. (1946). "Notes on some schizoid mechanisms." In: J. Reviere (ed.) *Developments in Psychoanalysis*. London: Hogarth, 1952.

Kolb, L. C. (1959). "Disturbances of the body-image." In: S. Arieti (ed.) *American Handbook of Psychiatry*, Vol. I. New York: Basic Books.

Laplanche, J. & Pontalis, J-B. (1980). *The language of psychoanalysis*. London: Hogarth.

Sandler, J. (1976). "Countertransference and role-responsiveness." *International Review of Psychoanalysis*, 3:43–47.

Schneider, S., Berman, C. & Aronson, D. (1984). "Sexuality as a treatment issue with a special population of adolescents." *Adolescence*, 19 (73): 201–206.

Schonfeld, W. A. (1969). "The body and the body-image in adolescents." In: G. Caplan and S. Lebovici (eds.) *Adolescence: Psychosocial Perspectives*. New York: Basic.

Schilder, P. (1950). *The image and appearance of the human body*. New York: International Universities Press.

Torras, De Beà E. (1987). "Body schema and identity." *International Journal of Psychoanalysis*, 68:2, 175–184.

Guidelines for Authors

Please submit five (5) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed.D., A.T.R., AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060. AATA cannot be responsible for submissions sent to any other address. Send manuscripts and illustrations certified mail, with return receipt requested. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with at least 1½ margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

CONFIDENTIALITY: Client/Patient confidentiality must be protected in title, abstract, text, photos and other accompanying material. Proper releases must be obtained.

Master's Degree Program in Expressive Therapies

• • • • • • • • • • •

Offered by the Institute for the Arts and Human DevelopmentLesley College Graduate School

Master of Arts in Expressive Therapies
For students interested in the creative modalities of art, music, dance/movement, and drama, presented in a clinical and theoretical framework for a variety of settings.

The Music Therapy Specialization

This program follows the guidelines of the American Association for Music Therapy (AAMT). As a part of the Expressive Therapy degree, the Music Therapy Specialization is unique in that exposure to other creative arts therapy modalities is required.

For more information call or write the Institute for the Arts and Human Development, Lesley College Graduate School,
29 Everett Street, Cambridge, MA 02138-2790.
(617) 868-9600, ext. 480.

Lesley College
GRADUATE SCHOOL

Lesley College is an Equal Opportunity/ Affirmative Action Institution.

BEST COPY AVAILABLE

REVIEWS

Depth Psychology of Art

Shaun McNiff, Ph.D., A.T.R., *Springfield: Charles C. Thomas, 1989. 252 pp. $38.25.*

Reviewed by: ***Gary C. Barlow, Ed.D., A.T.R.,*** *Editor, Art Therapy*

Depth Psychology of Art, as with Shaun McNiff's other books (*The Arts and Psychotherapy; Educating the Creative Arts Therapist: A Profile of the Profession;* and *Fundamentals of Art Therapy*), entices the reader, invites him/her to participate in a dialogue, encourages the probing of philosophical issues, and at the same time, educates about things, feelings, people, illuminates typologies, shares personal insights about the past, the present, and looks to the future. McNiff pushes the reader (sometimes not too gently!) into formulating and reformulating one's own thoughts, aesthetic insights, clinical methods and procedures, and even life itself. The first section of the first chapter is titled "Attending to Soul." Dr. McNiff does indeed 'attend to the soul' in his writing, and the reader is enriched through his insight and dialogue. "I have discovered" says McNiff "that the arts . . . deepen life." ". . . Depth psychology is closer to religion, philosophy and the arts." (p. 3) The reader is invited into this book with the understanding that religious and artistic creations, and not science, serve to describe pychoanalysis and early depth psychologies, and the author affirms this relationship. "Theories always give way and subordinate themselves to life . . . to the terrain that we share . . . Life and interpretation continue and not necessarily the theory. We are always working from the basis of our personal experience, our craft and our historical epoch." (p. 4)

McNiff states that although he has had difficulty referring to himself as an art therapist because it signified to many people that this symbolized an adjunctive role within a medical system, his definition now returns to the classical origin of the word psychotherapy as "attending to soul." "I now realize," he states, "that I have the freedom to re-imagine the nature of the profession and the tradition from which it emerges . . ..I have found that it is through concentration on organic things that we gain access to soul." (p. 5)

In the second chapter ("Nomenclature") the author defines terms ("In psychology we do too little of this.") and he presents or discusses many examples; the ones listed for this review are selected from the many categories listed. In the book some are more descriptive in presentation, others in more depth or detail. Selected terms are: psychology; emotion; health; psychoaesthetics; the unconscious; religion; art as unconscious religion; art; will; clinical realism; evocation; interchangeable interpretations; imagination; genius; therapy; healing and art; emotional jujitsu; destruction; theory indigenous to art; organic thought; interpretation; image; symbol; metaphor; and openness. What a rich source of language descriptors and interplay that set a stage (many stages) for the reader!

Chapter 3 ("interpretation") asks us, as therapists, to consider not only what we do, but how we do it, and on what basis our interpretation is grounded. "Water, sea and depth," for example, is presented in ten pages—meanings, recurring images, myths and associations. References are abundant: the *Inferno*: D. H. Lawrence (whom the author references in some of his previous writing); Gaston Bachelard; and Herman Melville (*Moby Dick*). A section titled "Fire and Water" follows ("The former is 'heavy' and dark while the latter is 'light' and illuminating . . . They have commonly been perceived as representing male and female, sun and moon.") (p. 85). Interpretation is complex, implies McNiff, and is a process of "inward seeing" that promotes contemplation through a dynamic system; it is "never final, just as we can never establish a single, complete and all-encompassing image of a single phenomena." (p. 89) The image is mysterious, and McNiff implores the reader to recognize the many meanings that the image has for us. This is the dynamic, the ever-reaching, the on-going potential between the maker and the receiver.

Succeeding chapters are titled "Re-imagining the artist as a therapist" (as in earlier writings, McNiff revisits Shamanic origins), and "Self inquiry." McNiff's earlier works emphasized being an outsider, looking and engaging artworks made by other people; this book does not deal with the engagement of the psychotherapeutic relationship between client and therapist, but to a new direction of moving to the inside of artistic expression.

In the last 113 pages of the book McNiff includes 56 illustrations of his personal artwork ("Self inquiry") with notations, comments, answers to posed questions, and revelations pertaining to the images. He uses dialogue as a mode of inquiry ("The other voice helps me to see myself and the art object.") (p. 124) It is important, asserts McNiff, for a person to have a direct relationship with art, with the making of art, and dialoguing with the art piece. McNiff is direct, and he is honest. The reader moves with him in the process of artistic creation, and in the dialogue it generates. People, animals, energies, giving, taking, remembrances, destroyers, conflicts, religion, aggression, emergence, urgency, passage, interconnections—it's all here, and it's all compelling. This work was done in foreign cities and countries (Finland, Amsterdam, Switzerland, Sweden, Florence, Israel) where the author, over the past number of years, has conducted seminars and courses.

Depth Psychology of Art is an important book (252 pages, with an excellent bibliography) for the professional field of art therapy. The book makes one think, retrieve, ponder. I could not read it in one sitting. I read a chapter, then re-read it. I was into Chapter 4, and I discovered that I was still thinking about Chapter 3. I was compelled by the author's personal artwork, and his honest dialogue. I wish some of the artwork were in color, but I am grateful for the power of the presented black-and-white photographic images. Mark it *"absolutely necessary"* for your next book order; it is highly recommended for all of us in art therapy, and I suspect it will be important reading for others as well.

The Discovery of the Art of the Insane

John M. MacGregor, Ph.D.*, Princeton, University Press, 1989, 390 pp. $49.50.*

Reviewed by: ***Aina O. Nucho, Ph.D., A.T.R., ACSW,*** *Board Certified Diplomate in Clinical Social Work; Distinguished Fellow, American Society of Psychopathology of Expression; Associate Professor, School of Social Work, University of Maryland at Baltimore.*

The Discovery of the Art of the Insane is a monumental, superbly illustrated, exemplary piece of scholarship that significantly elucidates a long neglected and often misunderstood area of human endeavor.

MacGregor sets out to define, document, and trace the degree of acceptance and rejection encountered by the art of the mentally ill. He notes the changing psychiatric terminology and wisely decides to retain the terms "lunatic, madman, and insane where they contribute to the correct portrayal of historical attitudes and material" (p. 8). The retention of the term "insane" in the title, however, is unfortunate as it conveys endorsement of a derogatory and outdated notion of mental illness.

MacGregor defines the art of the insane as consisting of drawings, paintings, and sculptures executed by individuals who were clearly diagnosed as mentally ill (p. 6). He states that he is not concerned with the examination of the life and work of celebrated artists who may have exhibited symptoms of mental illness. In the course of the study, however, this distinction proves to be rather tenuous, and the lines between the two categories become somewhat blurred.

The "discovery" is not a single act as the term would suggest but a process that stretches over several centuries and repeats itself in various places in the Western world. The author guides the reader through the process of growing appreciation, excitement, frustrations, dead ends, and eventually an increasing aesthetic pleasure in the art of the mentally ill.

The theme that weaves throughout the book is how the art of the mentally ill, "a product of terrifying intensity and feeling" is gradually admitted to "the charmed but curiously undefined circle of art" (p. 4). The seventeen meticulously researched chapters discuss insanity in the context of Romanticism; Jonathan Martin of Bedlam; Cesare Lombroso and the theory of genius; Paul-Max Simon whose efforts although less well known predate those of Lombroso; the Victorian Bedlam and the case of Richard Dadd; William Noyes and the case of "G"; the Chicago Conference; Marcel Reja, the critic of the art of the insane; Hanz Prinzhorn and the German contributions; the world of Adolf Wolfli; the relationship between German Expressionism and the art of the mentally ill; psychoanalytic studies of psychotic art; the Nazi purge of "degenerative" art; surrealism; Dubuffet and the aesthetic of Art Brut.

The Discovery of the Art of the Insane is a project of immense complexity. It offers fascinating glimpses of patients, physicians, changing concepts of art and of mental illness, art movements, and the formation of institutions for the care of the mentally ill. Mac-

Gregor has sifted through material buried in antiquated and difficult to obtain psychiatric journals and unpublished documents. He examines the contributions of long forgotten psychiatrists, and he adds his own observations and materials gathered through interviews and correspondence with contemporary psychiatrists, art historians and experts in the field of psychopathology of expression.

The current patterns of care of the mentally ill, MacGregor notes, make the image making activities in danger of disappearing. Many roam the streets without access to a safe and caring environment. MacGregor also comments on the dangers of the massive use of powerful and little understood mood altering drugs that often interfere with the process of self-healing (p. 310). These factors, combined with the manipulations and intimidation that often exist on psychiatric wards of general hospitals, make the art of the mentally ill an endangered species. An additional source of danger to the art of the mentally ill, MacGregor points out, is the changing medical education that makes it less likely that modern physician possesses the breath of culture necessary to respond to the art of the mentally ill. "The average psychiatrist is uncomfortable with any artistic manifestation, whether it is in patients or elsewhere" (p. 310). It is to be hoped that art therapists will make significant contributions in these areas in the future.

MacGregor brings impressive qualifications to the study of the art of the mentally ill. The book originated in his dissertation at Princeton where he received his PhD in art history. He also studied at the School of Psychiatry of the Menninger Foundation; the C. G. Jung Institute in Zurich; the Tavistock Clinic in London; and with Anna Freud at the Hampstead Clinic in London. He was a visiting fellow of Bethlem Royal Hospital in Kent and at the Maudsley Hospital in London. He gained access to the archives of these famous institutions, and he had contacts with leading scholars in Germany, Austria, Italy, France, and Switzerland. For fifteen years he was a lecturer in art and psychiatry at Ontario College, and he spent two sabbatical leaves, each of fifteen months duration to complete the manuscript.

MacGregor is no stranger to the readers of *Art Therapy*. In 1983 his article, "Paul-Max Simon: The Father of Art and Psychiatry" was published in the very first issue of *Art Therapy*. Except for its useful subheadings, this material now forms chapter seven in the book.

MacGregor notes briefly that the investigation of the function of art in the patient's life and illness has lead to the development of "the clinical field of art therapy and of diagnostic techniques that utilize drawings" but he states that these topics are outside the limits of his subject (p. 8). He mentions the work of Raymond Stites, and he refers approvingly to the contributions of Margaret Naumburg several times. (Her name unfortunately is misspelled in the Index.) As for art therapy, he dismisses it with the comment that "much of what is done in the name of art therapy has little to do with either therapy or art" (p. 311). It would seem that art therapy still has a long way to go to gain acceptance and understanding among mental health professionals and art historians.

The folio size book contains fourteen pages of selected bibliography, arranged in two columns per page. The notes, arranged in two columns per page, cover forty-two pages and should prove to be a gold mine of information and inspiration to young scholars searching for dissertation topics. The index, organized in three columns per page, extends over eleven pages. There are twenty-seven plates in full color and almost two hundred black-and-white illustrations.

The book is written in clear, jargon free language that will delight the general reader and scholar alike. It should prove to be of particular interest to art historians, art educators, phychologists, psychiatrists, art therapists, and all those who are concerned with the understanding of the symbol making functions of the mind and healing.

1990 AATA
MEMBERSHIP DIRECTORY

Now Available through the National Office
($2.40 Postage & Handling)
$10.00 member **$50.00** non-member
$100.00 institution

NAME ______________________
ADDRESS ______________________
CITY ______________________
STATE ____________ ZIP ____________

▲ *Mail entire form to:* ▲
AATA NATIONAL OFFICE
1202 Allanson Rd./Mundelein, IL 60060

Developing Cognitive and Creative Skills through Art: Programs for Children with Communication Disorders or Learning Disabilities (3rd ed.)

***Rawley A. Silver, Ed.D., A.T.R., HLM,** Ablin Press, 1989, 263 pages.*

Reviewed by: **Marcia L. Rosal, Ph.D., A.T.R.,** *Assistant Professor, University of Louisville.*

The first edition of Rawley Silver's book was published in 1978. At that time, Cohen (1980) wrote, "This book is an invaluable contribution to those who are, who have been, and who will be in the future, concerned and involved with deaf and learning-disabled children" (p. 233). Now, eleven years later, the future has arrived and indeed, Cohen's remarks are true. Today the book is still invaluable to those involved with children with communication and learning disorders.

Basically, the book has not changed since 1978. It is divided into two sections: part one explores the role of art in helping children with handicapping conditions to learn, and part two specifically addresses ways to help these children and reports on methodologies and the research which supports Silver's theories and hypotheses.

In part one, the role of art is discussed through three major concepts: cognition, adjustment, and assessment. As Aach (1978) stated about the text, "Silver richly documents her text with case material on individual children and illustrations of their art work" (p. 116). This section also includes a chapter entitled, "Expectations," which addresses the problems of adults who work with such children and how expectations can affect the performance of the child. Again, case material illustrates her thoughts and ideas on the problems of the helping professionals' issues in relation to helping this population.

Also in part one is a chapter reporting on studies that Silver conducted regarding the creative skills of deaf and communication disabled children and adults. In 1978, Silver reviewed literature which indicated that researchers and educators had low expectations of the creative abilities of hearing-impaired individuals. Silver argued that the studies used verbal modalities to measure creativity and that nonverbal means would be more accurate. She then conducted three studies using art as a measure of creative abilities and the results are discussed.

Part two of the book, in Silver's words, "is concerned with objectives and practices in working with impaired and unimpaired children and adults" (p. 103). This section is filled with the data Silver has collected from studies she conducted to support her theories that art is a means towards helping children and adults learn.

In Chapter Six, Silver writes about three controversies which plague art educators and art therapists concerning the ultimate goals of the art experience: form versus content, therapy versus aesthetics, and instruction versus spontaneity. In the chapters that follow, Silver reports on studies that not only shed light on possible answers to these three questions but also on whether drawings can be used as tools in assessing and remediating the cognitive and creative abilities of children who have difficulties with language.

The three cognitive skills that Silver studies are: (a) the ability to associate and represent concepts through drawing from imagination, (b) the ability to order sequentially and conserve through painting, and (c) the ability to perceive and represent concepts of space through drawing from observation. There is a chapter devoted to each of these three skills. Each chapter describes the methodology, assessment tools, and results of the study. Again, there is case material which serves to illustrate how these skills and methods can be useful in a pragmatic manner.

The third edition has two epilogues which describe updates on Silver's work. In the 1986 epilogue, she describes the Silver Drawing Test of Cognitive and Creative Skills and a research project which used the test as a pre- and post-test measure. From this research, Silver developed a Projection scale to rate drawings for distress.

In the 1989 epilogue, Silver reports on two research projects. One concerns gender differences between males and females on the Silver Drawing Test. The other project examines relationships between negativity and depression using the same test.

There are two major problems with the new edition of this text. The first revolves around the lack of updated literature within the text itself. Even in the first edition, Aach (1978) noted that there was not "a framework around which the reader can integrate the information presented" (p. 116). This flaw seems more evident in the third edition as there is no attempt to update the scant original literature review. The amount of research completed with this population over the past decade has been extensive and fascinating and should have accompanied this new edition.

The second problem involves Silver's insistence on discussing too many issues in one book. On one hand, she has a strong thesis concerning the use of art to help those who have language barriers. Then, on the other hand, she begins to argue about wider topics such as instruction over spontaneity and the philosophy surrounding this issue. It is either too overwhelming for a small text and readers may find themselves lost in trying to decipher the major focus of the book or there should be more information given on the latter topic and more of an attempt to integrate the two. This problem was also addressed in the review by Aach (1978), ". . . she would have done well to review them [the three controversies] at greater length and in relation to specific tasks in her approach" (p. 116).

The two epilogues are added in the same patchwork manner as the three philosophical questions. No doubt they are valuable studies that the field of art therapy needs, but there was no attempt to integrate the information into the basic thesis of the text. Somehow the data seems aloof rather than a welcome addition to our knowledge of the use of art with language-limited individuals.

Today, as a decade ago, Silver's book represents a landmark in the field of art therapy. The dedication and persistence of Dr. Silver's work are evident in each study she describes and in each client's case she presents. She has been a leading researcher in the arts for the handicapped and it is in this area that the book has the most impact. It is specifically for professionals working with children who are language impaired that this text will be most useful.

References

Aach, S. R. (1978). Review of *Developing cognitive and creative skills through art*. American Journal of Art Therapy, *17*, 115–116.

Cohen, F. W. (1980). Review of *Developing cognitive and creative skills through art*. *The Arts in Psychotherapy*, *7*, 233.

ART THERAPY

Journal of the American Art Therapy Association

ADVERTISING RATES

RATES	1x	2x	3x
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140

SPECIAL POSITIONS	additional
Cover #2 (Inside Front)	$130
Cover #3 (Inside Back)	130
Cover #4 (Outside Back)	165

COLOR RATES: Standard Red, Blue and Yellow (Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x
Per page additional	$90	$85	$80

INSERTS	1x	2x	3x
2 pp	$ 800	$ 700	$ 575
4 pp	1,500	1,300	1,150
8 pp	2,200	2,000	1,750

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size:	8-1/2" x 11"
Bleed Size:	8-5/8" x 11-1/4"
Inserts:	8-5/8" x 11-1/4"

SUBMISSION DEADLINES:

January 7 for March issue; April 7 for June/July issue; September 7 for November issue

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, IL 60060
(708) 949-6064

The American Art Therapy Association, Inc.

1202 ALLANSON ROAD/MUNDELEIN, IL 60060

(708) 949-6064

THE ORGANIZATION

The American Art Therapy Association (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3000 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice; AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliated Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive:

Publications

- *Art Therapy*, the official journal of the AATA.
- The quarterly *AATA Newsletter*.
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- Free AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payers.
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy.

Professional Standards

- Development of model job and licensure laws.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

GENERAL MEMBERSHIP APPLICATION

1. The membership year is the calendar year January 1st through December 31st.

2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY. Please follow the chart below when submitting membership application.
Applications received between

   Jan. 1st and May 31st — Full dues payment; Membership will expire Dec. 31st of same year.

   June 1st and Sept. 30th — Half year dues plus $5.00 payment; membership will expire Dec. 31st of same year.

   Oct. 1st and Dec. 31st — Full dues payment; membership for the remainder of current year and the next full year through Dec. 31st.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval.

4. AATA Membership and AATA Registration (ATR) each have a separate application procedure. Registration is bestowed only by the Standards Committee.

5. National AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL — by application only; such members may vote, hold office and serve on committees.

> **Credentialed Professional Member:** Individuals who have been dually approved for Professional Membership and Registration (ATR) by the AATA; dues are $80 per year.
>
> **Active Professional Member:** Individuals who have completed professional training in art therapy; dues are $75 per year.

CONTRIBUTING — Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $100 per year.

ASSOCIATE — Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75 per year.

STUDENT — Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Student members may not vote or hold office but may serve on the Student Subcommittee of Membership. Dues are $35 per year.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $23 (US); $30 (Foreign). Institutions: $27 (US); $36 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1990. Enclosed is my check, payable to AATA, for $23.
Name ______________________________
Address ______________________________
City ____________________ State __________ ZIP __________

The interdisciplinary journal devoted to the creative arts as healing arts.

THE ARTS IN PSYCHOTHERAPY

An International Journal

ARTS PSYCHOTHERAPY

FREE SAMPLE COPY
AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Associate Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music; poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

PERGAMON PRESS
Maxwell House, Fairview Park, Elmsford, NY 10523
Headington Hill Hall, Oxford OX3 0BW, England
Member of Maxwell Macmillan Pergamon Publishing Corporation

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions to the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

Editors welcome original manuscripts. Submit papers in triplicate to: Managing Editor, Sylvia Halpern, 20 Ridgecrest East, Scarsdale, NY 10583

SUBSCRIPTION INFORMATION

ISSN: 0197-4556	Volume 17, 1990
Published 4 issues per annum	
Annual Institution Subscription Rate (1990)	US$130.00
Two-year Institution Rate (1990/91)	US$247.00
Professional Rate (1990)	US$ 40.00
Student Rate (1990)	US$ 16.00

BEST COPY AVAILABLE

ART THERAPY

Volume 8, Number 1
Spring 1991

Journal of the American Art Therapy Association

- The Arts in Therapy—France
  Geoff and Hyacinthe Troll
- Perceptions of Art Education in the People's Republic of China
  Dorothy McLaughlin, R.S.M., Ed.D., A.T.R.
- The Healing Qualities of Art
  Klaus Boegel and Louis van Marissing
- A Comparison of the Traditional Education of Native American Healers with the Education of American Art Therapists
  Phoebe Mills Dufrene, Ph.D., A.T.R.

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $25 (US); $42 (Foreign). Institutions: $36 (US); $53 (Foreign). Single copies are available at $9 member; $16 non-member. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1991

Linda Gantt, Ph.D., A.T.R., *President;*
Robin F. Goodman, Ph.D., A.T.R., *President Elect;*
Cathy Malchiodi, M.A., A.T.R., *Secretary;*
Virginia Minar, M.S., A.T.R., *Treasurer;*
Doris Arrington, Ed.D., A.T.R., *Director;*
Shirley Riley, M.A., A.T.R., M.F.C.C., *Director;*
Deborah Good, M.A., A.T.R., *Director;*
Dean Wilson, Ph.D., M.F.C.C., A.T.R., *Director;*
Barbara Fish, M.A., A.T.R, *Affilitate Chapters*

Executive Director

Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

Editorial

Gary C. Barlow, Ed.D., A.T.R. 2

Articles

The Arts in Therapy—France
Geoff and Hyacinthe Troll 3

Perceptions of Art Education in the People's Republic of China
Dorothy McLaughlin, R.S.M., Ed.D., A.T.R. 7

The Healing Qualities of Art
Klaus Boegel and Louis van Marissing 12

A Comparison of the Traditional Education of Native American Healers with the Education of American Art Therapists
Phoebe Mills Dufrene, Ph.D., A.T.R. 17

Special Feature

Remarks on Receiving Honorary Life Membership
Frances E. Anderson, Ed.D., A.T.R. 25

Reviews

Dreams in Analysis
Vija B. Lusebrink, Ph.D., A.T.R. 27

Art as Technology: The Arts of Africa, Oceania, Native America, Southern California
Phoebe Dufrene, Ph.D., A.T.R. 29

On the Cover

"Self-Portrait" painted by a 5-year-old girl from Tokyo, Japan. From the children's art collection at Wright State University, Dayton, Ohio.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

Volume 8, Number 1 Spring 1991

EDITORIAL BOARD

Editor
Gary Barlow, Ed.D., A.T.R.
Managing Editor
Marcia May-Chambers

Frances Anderson, Ed.D., A.T.R., H.L.M.
Michael Campanelli, Ed.D., A.T.R.
Susan Cheyne-King, M.S., A.T.R.
Carol Cox, M.A., A.T.R.
Maxine Junge, Ph.D., A.T.R.
Paulo Knill, Ph.D., A.T.R.
Wendy R. Lauter, M.C.A.T., A.T.R.
Vija Lusebrink, Ph.D., A.T.R.
Howard McConeghy, Ed.D., A.T.R.
Paul Rodenhauser, M.D.
Marcia Rosal, Ph.D., A.T.R.
Lewis Shupe, Ph.D., A.T.R.
Sandra Ticen, M.S., A.T.R.
Betty Jo Troeger, Ph.D., A.T.R.
Robert Wolf, M.P.S., A.T.R.

American Art Therapy Association, Inc. 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064

Copyright © 1991 American Art Therapy Association

BEST COPY AVAILABLE

EDITORIAL

Congratulations to Frances E. Anderson, Ed.D., A.T.R., H.L.M., who was awarded the "Honorary Life Membership" in the American Art Therapy Association. Frances has long been an active member of our association (she was present at the founding meeting in Louisville, Kentucky, June, 1969), and has contributed much to our professional association as well as to education, art education and art therapy. She is most deserving of this honor. Her acceptance response is printed in this issue.

In this issue of *Art Therapy* we are assuming an "international flavor," and the multi-cultural articles give insight into historical perspectives (*"The Arts in Therapy—France,"* by Geoff and Hyancinthe Troll), a citizen ambassador's perspective of art education (*"Perceptions of Art Education in the People's Republic of China,"* by Dorothy McLaughlin), a healing performance (*"The Healing Qualities of Art,"* by Klaus Boegel and Louis van Marissing), and a study of art therapists and Native Americans (*"A Comparison of the Traditional Education of Native American Healers with the Education of American Art Therapists,"* by Phoebe Mills Dufrene). These articles offer much insight and information that will be valuable for developing greater understanding of cross-cultural aspects of art therapy and education, and they should be an important resource for the professional art therapist as well as the student and the researcher. Your responses to these articles, and to various aspects of therapy within multi-cultural settings, are welcome.

Recently I have been revisiting a book titled *Design Yourself!* by Kurt Hanks, Larry Belliston and Dave Edwards.* It is an interesting book—and fun to read—comprised of many parts and many formats. The authors state that "it is not just a book; actually it is more like a special visual device with which you can examine your relationship to design and your role as a designer . . . the book is a little bit of everything in the way of ideas, games, puzzles, experiences and exercises and much of what it says depends upon your feelings, your interpretation, present and past experiences and what you will do about it all." (p. 1) This book offers motivation for thinking, analyzing, visualizing, communicating and planning in this 'personal design' plan. There is much information presented that has direct bearing on the motivations, understandings and actions of an art therapist. For example:

> We all have ways of thinking which cause us difficulty, at times, in perceiving or solving problems. . . . Once able to recognize these mental "blocks" to problem-solving, we are better prepared to side-step or deviate them . . . (These blocks are): 1) The tendency to limit a problem too closely (Expand the mind where limits don't restrict it); 2) Isolating a problem (One must learn to isolate the real problems from the apparent ones); 3) Stereotyping (. . . seeing what you expect to see); 4) Saturation (. . . when the mind subconsciously ignores sensory inputs because they are familiar sights . . . Look at the world upside down . . . You'll be surprised at how many details are now noticeable when looked at from a different perspective); and 5) Failure to utilize sensory inputs (Might it . . . be true that people who see rely heavily on vision and partially ignore their other senses?) (pp. 77–78)

From the authors' section on "Judgment," they write:

> It is essential not to judge too early. Newly formed ideas are fragile and imperfect and they need time to mature and acquire detail before they can be judged adequately. Also, new ideas often lead to other ideas for problem solving. Many techniques of conceptualization, such as brainstorming, depend for their effectiveness on maintaining "way-out" ideas long enough to let them mature and spawn more realistic ideas. It is sometimes difficult to hold on to such ideas because people generally do not want to be suspected of harboring impractical thoughts. One should not judge too quickly! (p. 82)

Two thoughts that should be comforting to persons who are experimenting with new ideas, and new ways of thinking, expressing, communicating or sharing are quoted by the authors:

> Almost all really new ideas have a certain aspect of foolishness when they are first produced. —Alfred N. Whitehead (p. 109)
>
> No idea is so outlandish that it should not be considered with a searching but at the same time a steady eye. —W. Churchill (p. 109)

A reminder for prospective authors who wish to submit articles and other materials to *Art Therapy:* Please review the "Guidelines for Authors" found elsewhere in this issue. Manuscripts must be sent directly to the AATA National Office. Please remember that the article must contain an abstract, and must follow APA guidelines for article preparation. By carefully following the format as delineated in "Guidelines for Authors" you will make the entire process more efficient. In addition, since we are in a transition period from an earlier plan to the present one, your patience is greatly appreciated. Any suggestions from readers on this structure, of course, are welcome.

Gary C. Barlow, Ed.D., A.T.R.
Editor, Art Therapy

---

*Hanks, K., Belliston, L. and Edwards, D. (1978). *Design Yourself!* Los Altos, CA: William Kaufmann, Inc.

The Arts in Therapy—France

Geoff and Hyancinthe Troll

Geoff Troll is President of the Federation Francaise des art-the'rapeutes, and holds a Diploma of art therapy, Faculty of Medicine, Tours. Mr. Troll works as an art therapist at Dieppe General Hospital. He teaches art therapy at the Institute National de Perfectionment "INPER" in Lausanne, Switzerland and continues a promising career as artist, sculptor with exhibits throughout France and Europe.

Hyacinthe Troll has a Ph.D. in Anglo-American Studies, Rouen University. She teaches in Normandy, and has a great interest in art therapy following some work in psychiatric institutions in Great Britain.

Abstract

Following a brief timeline overview of the development of significant occurrences in the arts in therapy in France, the authors focus on more current developments that illustrate the rapid growth of arts therapies services, and particularly art therapy, in that country. With a narrative description, the authors cover not only the historical development, but focus on current training, goals and objectives regarding specialized training. The authors reiterate that there is a rapid movement in France relative to the acceptance of arts therapies as a viable professional thrust, with the control of professional standards, training and registry.

If one were to give a brief timeline of the development of the arts therapies in France, it would certainly include the following:

The 19th Century

1840: Seguin used music for the "education of idiots."

1880: Paul Max Simon studied the drawings of the insane.

1884: Regis noticed a variation of graphic expression during manic-depressive psychosis.

The 20th Century

The psychoanalytic approach of Freud influenced the development of art therapy. During the first part of this century we began to see a real development of artistic techniques in the care and treatment of patients.

1950: The first World Congress of Psychiatry in France provided the foundation for *L'art psycho-pathologique*, the major work by Robert Volmat. This book remains one of the main references in art therapy in France today. There is very little literature in French on the creative arts therapies. Also, a consequence of this congress was the creation of a workshop of plastic expression for treatment of psychiatric patients in Ste. Anne Hospital in Paris. The directors of the program were Robert Volmat and later, Claude Wiart. It was in this workshop that Bernard de Panafieu investigated the possibilities of working with masks as a therapeutic technique. Shortly before Silvano Arieti's psychoanalytic study of creativity was published in the United States (Arieti, 1973), Chasseguet-Smirgel (1971) wrote *Pour une psychoanalyse de l'art et créativité* in France.

1976: The Association Française de Recherches et Applications des Techniques Artistiques en Pédagogie et Médecine (AFRATAPEM) was formed.

1980: The first governmental inquiry into the state of art therapy led to the Gallot report (Genneviève Gallot, chargée de mission) which highlighted the lack of art therapy.

May, 1981: The first international conference organized by AFRATAPEM led to the publication of the first journal in France devoted specifically to art therapy.

1984: A commission was set up by the French health ministry. Its report has yet to be published.

1987: Several organizations and individuals started art therapy training programs. All of them are part-time and are designed chiefly for people already working in the helping professions (such as nurses, psychologists, and special education teachers), providing possibilities of new approaches to their work. Government policy provides a special budget designed for continuing education (known as "formation continue") for people who are already employed. (These training programs are described in greater detail later.) "Formation continue" encourages the existing medical staff to try to use artistic techniques in a therapeutic milieu but the policy does little for the artists who have completed their training in fine arts who would like to use their creative sensitivity within an institutional setting.

Two universities had shown some interest in being associated with the training programs. The first was the Faculté de Médecine, Tours, associated with AFRATAPEM. The second was the University of Paris with Dr. J. P. Klein. The latter has now closed in favor of a private institute also run by Dr. Klein. For the moment, it is highly unlikely that any full-time university chair will be created without government recognition of the profession.

1988: Due to the rapid development in the last few years, it was necessary to have a national organi-

BEST COPY AVAILABLE

zation to represent art therapists, both to the public and the government and to other authorities. Hence the Federation Française des Arts-Thérapeutes was born. The inaugural meeting took place on May 28th, and a good cross-section of artists and therapists from many different backgrounds and training elected the first council of administration. This council has defined their main objectives as:

(1) Define the aims of the profession, its ethical code, and its standards;

(2) Establish the conditions for selection and training of art therapists;

(3) Obtain professional status for art therapy through legislation;

(4) Promote recognition of creative process as applied by art therapists; and

(5) Participate in writing a constitution for a European association.

A FIRST-HAND ACCOUNT—
H. Troll

I am English and live in a tiny Norman village situated 35 kilometers from Dieppe, France, where I am the art therapist and one of the founders of the department of creative therapies in collaboration with Dr. C. Reboul who was the head of the psychiatric department of Dieppe General Hospital. My previous experiences in England consisted of instructing mentally handicapped adults and working as both a psychiatric and a general nurse. It was in the early days of psychiatric nursing that I, already a keen amateur painter and song writer, became extremely interested in the work of Terry Sellars, an art therapist at Runwell Hospital, Essex. Looking back, I do not know how I managed to get a job in Dieppe. My knowledge of French was, to say the least, extremely poor. What made things worse was that the few words I had learned were more or less obsolete in modern French day-to-day conversation. What a fantastic chance to learn about nonverbal communication, especially with the patients who also had great fun teaching me all the words I shouldn't know!

Anglo-French cultural differences are many, but in therapy they rarely create negative reactions; on the contrary, the need for acceptance and mutual respect is a foundation for lively exchanges. It seems that cultural differences are nearly always counterbalanced by similarities, simultaneously allowing for the maximum exploitation of the individual identity.

Dieppe is a fairly important tourist center and cosmopolitan town, so in addition to my French patients I quite often have overseas clients: Australian, Canadian, American, and Yugoslav, to mention just a few. Their integration in my creative therapy groups always has a positive, stimulating effect, each person adding an original, creative stance influenced by his or her own cultural resources. When communication is too easy and people speak the same language, the result can be superficial; there can be misinterpretation of the real meaning due to differences in sub-cultural terminology. For example, the word *depression* can mean "a hole in the ground" or "a state of mind." John Henzell, senior lecturer for the postgraduate diploma program in art therapy at Herts College of Art and Design in Great Britain, states:

> The failure of speech adequately to apply is difficult to see just because it is difficult to describe. It cannot, for example, picture the place of a part in a whole as a map does, compare fingerprints, inform others of what sort of person we are as well as keep us warm as clothes do, picture the play of light on a surface, convey exactly how someone looks or moves, actually indicate the humour, tragedy, or majesty of a human face, and so on. (Henzell, 1984:18)

Without this facility of exchange, as inefficient as it is, if people want to communicate they are obliged to develop deeper understanding.

France is a country extremely rich in culture with numerous regional variations. Perhaps that is one of the reasons why art therapists have not attained national acknowledgment or a recognized professional status. However, there are a few organizations working toward this end and have instigated art therapy training programs.

AFRATAPEM offers a Diploma in Art Therapy. Perhaps it is not by accident that its main office and school are situated close to the birthplace of Gothic art and to the Loire Valley, an important location during the French Renaissance. This organization, also known as the Ecole de Tours, is associated with the Department of Medicine of the University of Tours, which has helped them to bring together many important personalities from both the medical and artistic worlds. Its aims are:

(1) To be a meeting place and to enable exchanges between people of different disciplines;

(2) To apply art therapy in medical, para-medical and educational settings;

(3) To re-evaluate and reconsider the worth of the artistic phenomenon; and

(4) To create a research center and develop approved education for art therapists.

Their research includes investigating the relationships between the senses, the autonomic nervous system, subcutaneous phenomena, nonverbal communication, the unconscious, the effects of rhythm, and art and education.

This organization is recognized by the Ministry of "Temps Libre" (leisure-time activities), Youth and Sports as an approved body for the education of art therapists. One aspect of l'Ecole de Tours is the fact that it is open to all forms of artistic expression. Richard Forestier, an art therapist and director of research at AFRATAPEM, published *L'art ou le droit d'être* (Art and the Right to Exist), followed by a joint publication *Art thérapie: Des concepts à la pratique* with J. P. Chevrollier, a psychiatrist and a member of the research committee of AFRATAPEM. This work is a methodological approach to art therapy which now has been translated into English.

L'Ecole de Tours held an international conference in 1986 on the theme of nonverbal communication, with some speakers from the United States.

Examples of Training Programs in France

AFRATAPEM Training

I am able to give a first-hand account of this program as it is one in which I have participated. The Ecole de Tours promotes a complete artistic vision in all artistic fields; in its teaching and therapeutic process, one finds a refreshing wholeness both innovative and anti-fragmentary. Selection of candidates is rigorous. The work includes theory and practice in arts and psychotherapy. It demands the development of one's creative resources, looks at the technique of teaching and learning, the research into artistic form and the understanding of one's original expression. Its multidisciplinary approach to training meant that although I had given proof of my artistic involvement in the plastic arts (painting, collage, and sculpture) they insisted that I try to revive my abilities in playing a musical instrument after eighteen years of abstinence. The process of doing this now gives me great pleasure. I find it not only compatible with my involvement with the plastic arts but an active, stimulating dynamic in both my professional life and spare time.

All candidates participate in a week's introduction/selection. There is a presentation about the association and its politics in relation to the creative arts therapies, followed by active experience in art therapy, music, dance, sensory games, and group dynamics. Intensive and comprehensive sessions are a great way of finding out about art therapy and allows a realistic assessment by both the participant and the association. For the successful candidates, the course is a part-time one which must be completed within four years from the preliminary week. It is comprised of four parts:

(1) The artistic phenomenon and method;

(2) The history of art in medicine;

(3) Neuro/psychophysiology and psychiatry; and

(4) The practical aspects of art therapy (work experience).

In all there are about 270 hours of classes and workshops with a considerable amount of personal work and preparation. Passing a written examination gives the candidate entry to the preparation of a thesis which is presented orally in front of a specialized jury. (My own jury consisted of a professor from the faculty of psychiatry at the University of Tours, a child psychiatrist/psychoanalyst, a music teacher, and an art therapist.)

Dr. Jean Pierre Klein

Dr. Klein has initiated a course for art therapy students on a 2-year part-time basis, with five 3-day weekends a year. His program is called the Institute National d'Expression, de Creation, d'Art et de Therapie. Dr. Klein organizes conferences and specific 4- or 5-day courses from time to time. A recent one devoted to creative expression by special populations included research into prisoners, patients in comas, homosexuals, the elderly, and the physically handicapped.

Formation ATEPP

The "Atelier d'expression plastique les Pinceaux" is a workshop originally set up in 1956 as a center for free expression for children in Paris by the artist Gladys Jarreau. Later, this developed into a workshop for adolescents and adults. Surprised by the creations of certain children and adolescents, Jarreau studied psychology and Freudian and Adlerian analysis, and became both friend and collaborator with Sara Pain, professor of psychology at the University of Paris North Bobigny, and Dr. Jean-Charles Febrinon-Piguet, a psychiatrist and psychoanalyst. They began a course in art therapy in 1984 which is designed to help artists and other interested people in associated professions such as nurses and teachers to use artistic techniques in a form of art therapy.

Jarreau (1984) outlined her theory of two types of art therapists—artists and psychologists. For the former, she stresses a creation/therapy paradox and analyzes the motives which prompt artists to express themselves with the patients, while she questions the advisability and the origin of this technique. She distinguishes between two forms of creative approach: that of the patient and that of the artist. With artists, the interest lies in the creative process, whereas with patients, it is the finished work that matters. This is a theory that opposes a global approach where the art therapist can follow and participate in active therapy.

IRAE (Midi-Pyrénées)

IRAE gives courses to help in instigating psychotherapeutic expressive arts workshops within the institution, with an emphasis on research into language and creation, art as a means of analytic work, and the personal implication of the art therapist and its effect on the individual and collective dynamic.

Université Rene Descartes

A recent breakthrough is a very thorough training at the University Rene Descartes Paris V. It is over a three year part time period and is recognized by the Minister of Culture and Functions in liason with the Health Ministry.

INPER—The Institute National de Perfectionment

Just across the French border in the beautiful lakeside town of Lausanne, a private institute in typical Swiss tradition, organizes a training scheme on a truly international scale with faculty members coming from France, USA, Switzerland and Germany. The courses are in French or with simultaneous translation. This provides a very wide view point of art therapy raising some excellent cross cultural issues. The students are mainly professionals from the psycho social sector and use the training as a specialization rather than fundamental professional training.

Other Programs

There are one or two other institutes that train art therapists in depth, notably *Marionette et thérapie* in Paris and INFIP in Lyon. There are others throughout France that offer weekend courses on the introduction to art therapy such as the University Paris VII, Instep in Marseille or ARTA in Bordeaux.

Journals

There are two journals in France disseminating facts about art therapy on a major scale. One is *Psychologie Médicale*, a publication created in 1969 by the French association for medical psychology. It is directed at the medical profession, has many advertisements for pharmaceuticals, and therefore, is not on sale to the general public. This journal often publishes articles on the arts and therapies. It has good coverage of the conferences of the Société Internationale de Psychopathologie de l'Expression.

Art et Thérapie was founded in 1981 by Dr. Jean-Pierre Klein. Its birth was a necessity. Following a conference on art therapy organized by AFRATAPEM in 1981, Dr. Klein tried to find a journal to publish the conference papers. However, all the usual medical and para-medical magazines refused, saying that the subject was too specialized. At the beginning, fifty percent of *Art et Thérapie* was sponsored by pharmaceutical companies. But since December 1984, because it was in general circulation, pharmaceutical advertisements are no longer allowed, causing considerable financial hardship. Apart from the medical profession, Klein wants it to be available to artists and art colleges where he thinks there is the greatest potential for the future of art therapy. It is the only journal specific to art therapy; its contents are interesting, timely, and of high standards.

The Future

The field is beginning to grow and develop, and the enthusiasm and excitement is fast becoming a forceful power. We now have a central governing body to control professional standards, training, and a registry. In the long term, the government should give even greater recognition to our existence. There is still a long way to go, but it is an unavoidable progression if France continues to be a caring, humane society.

References

Arieti, S. (1973). *Creativity: the magic synthesis*. New York, NY: Basic Books.

Chasseguet-Smirgel, J. (1971). *Pour une psychanalyse de l'art et de la créativité*. Paris: FBP.

Henzell, J. (1984). In T. Daley, Ed., *Art as therapy*. London: Tavistock.

Jarreau, G. (1984). Expression et signe. *Psychologie Médicale, 16*, (10):1759-1762.

Guidelines for Authors

Please submit six (6) copies of manuscripts to: **Art Therapy** Editor Gary Barlow, Ed.D., A.T.R., AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060. AATA cannot be responsible for submissions sent to any other address. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½ × 11 inch bond paper, with 1" margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

CONFIDENTIALITY: Client/Patient confidentiality must be protected in title, abstract, text, photos and other accompanying material. Proper releases must be obtained.

"Perceptions of Art Education in the People's Republic of China"

Dorothy McLaughlin, R.S.M., Ed.D., A.T.R., *Professor/Director: Graduate Art Therapy Program, Marywood College, Scranton, PA.*

Abstract

A group of art educators from the United States, members of the Citizen Ambassador Program of People to People International, met with art educators from the People's Republic of China in July, 1988. This article reports on the personal impressions of one member of the delegation.

China is in the process of change, visible in the construction of modern buildings and in the energetic everyday lives of the Chinese people. Change in ideology is affecting the attitudes and values of the people and the educational system as a result of the implementation of the Seventh Five-Year Plan of 1986.

Art education is trying to catch up with the times in China after years of political struggle. However, art curricula, facilities, and programs are in a state of flux.

In 1988, a delegation of art educators was invited to meet with art educators of the People's Republic of China by the Citizen Ambassador Program of People to People International. People to People was founded by President Dwight D. Eisenhower in 1956. Eisenhower believed that people from the United States reaching out to people of other nations could contribute to world peace. The organization, administered by the State Department until 1961, is now a private, non-profit corporation directed by Mr. Joyce Hall, founder of Hallmark and a friend of Eisenhower.

Led by Dr. Al Hurwitz, the delegation sought to exchange information regarding the objectives, content, and methods of art instruction on all levels from primary school to the academy (Al Hurwitz, personal communication, March 14, 1988). Briefing for the group at the Four Seasons Hotel, Seattle, Washington, on July 13, 1988, was conducted by Mr. John Luppert, Director of the Science and Technology Programs for People to People. After an overnight stay in Narita, Japan, the 47 delegates left for Beijing, China. The 3000 year-old city of Beijing has architecture ranging from ancient temples to 19th Century European and Russian styles, to several ultramodern hotels. This northern capital city revolves around the Forbidden City and Tian Anmen Square. In addition to these historic places, the Great Hall, Ming Tombs, the Summer Palace, Temple of Heavenly Peace and a Children's Palace were a part of the tour agenda.

The American delegation of art educators was greeted by Mr. Zhu Xuesan, the Vice President of the Standing Committee, in the Great Hall of the People where presidents and other dignitaries were once welcomed. The first meeting between the art educators of both nations was held at the Beijing Academy of Fine Arts. The Academy, opened in 1918, built as a new site in 1945, was initially a primary school. The Beijing Academy of Fine Arts, like all universities, was closed during the Cultural Revolution from 1966 to 1970 (Adams, 1987). The building is currently in poor condition, possibly due to neglect during the long political struggle. However, in the words of one Chinese art educator, "The quality of teaching and artistic performance are the best in all of China."

Fig. 1 People to People International—Citizen Ambassador Program: Tour Guide and Sr. Dorothy McLaughlin at the Great Wall in Beijing, China.

According to the Chinese, the art curriculum is being adjusted, the system of the academy is being changed, and the art facilities are to

. . . the art curriculum is being adjusted, the system of the academy is being changed and the art facilities are to be improved.

BEST COPY AVAILABLE

be improved. Government subsidies and scholarships are currently granted for the study of art, and talent and intelligence are required for entrance into the university. The present philosophy of art education is that the past serves the present; in other words, the Chinese study and inherit their heritage. The sharing of art information was very one-sided. It must have been evident to the Chinese that they had little to contribute to the modern art world because of their struggle (Mosher, 1988).

A second meeting between the delegation and Chinese art educators was held at the Beijing Central Academy of Applied Arts. After viewing slides of student art works, the delegation visited the student art gallery and discussed the art with the students and faculty through the aid of an interpreter. Although the oil paintings were skillfully executed, they were imitative and were influenced by the Expressionists, Impressionists and Cubists of the Western world. Traditional Chinese water color paintings are still highly prized and these painters are respected throughout China. This style is characteristic of Chinese art and is appreciated throughout the world, so it is one "revival" of artistic style that is already flourishing.

One observation made by this writer was that the Chinese art educators were mostly middle-aged men who did not have formal degrees. One of the outcomes of the Cultural Revolution was that college faculty educated from 1950 to 1970 seldom had degrees. The very old and the very young have degrees, but the middle-aged college faculty will probably never have degrees (Boone, 1988).

The direction of education within the next five years may depend on the implementation of the Seventh Five-Year Plan proposed in April, 1986. Ideological shifts in the People's Republic of China are evident in that plan. According to Li Shenzhi, Vice Chairman of Social Studies, the political focus has changed. Some of these changes include changes from class struggle to economic construction; from looking down on intellectuals to respecting educated people; from treating knowledge and culture as foreign and antiquated to stressing their importance; from endeavoring to promote world-wide Socialist revolution to striving to maintain world peace (Swanson and Zhian, 1987). The plan has changed the attitudes of the Chinese people toward their culture and the arts are currently being promoted.

Emphasis on vocational technical education is consistent with the movement toward economic growth.

According to Swanson and Zhian (1987), all expansion in the senior middle schools will be in vocational and technical areas. China intends to increase enrollments in these schools by 65%. Currently, there are 104,000 middle schools (regular and vocational) enrolling 48.6 million students, about 68% of the school age population (U.S. Dept. of State). Emphasis on vocational technical education is consistent with the movement toward economic growth. The purpose of education at this level focuses on preparing people for jobs. The delegation observed skilled artists and artisans working in factories who produce arts and crafts for sale to visitors; tourism in China is an important business.

After five days in Beijing, we flew to Xi'an where there are about 20 universities, colleges and research institutes. No visits to any of these institutions were arranged, and the visit was more historic in nature than the Beijing tour. The delegation toured the Qin Army Vault Museum in Xi'an which contained the terracotta army of more than 8,000 soldiers made to protect the tomb of the emperor 2,180 years ago. The tomb was discovered by local people digging a well in 1974. Researchers believe kilns were built around the figures and then destroyed after firing (Malloy, 1988).

The history of the Tang Dynasty was evident throughout the tour of Xi'an. Recreated Tang Dynasty Music and Dance provided a cultural and recreational treat after a banquet at the People's Hotel. Even the hotel, opened in 1987, was built by the Japanese in Tang Dynasty Style.

Although the American delegation did not visit the universities, factories were visited and artists were observed embroidering, batiking, sewing, painting and carving ivory and jade. School graduates were viewed on-the-job creating arts and crafts for sale to tourists, demonstrating that tourism is an economic factor in Xi'an, as in Beijing.

The most intellectually stimulating experiences were the meetings with the Shanghai delegation at the Hua Ting Sheraton Hotel in Shanghai, where Dr. Hurwitz presented a slide lecture of the art works of children in the United States. The art educators then broke up into three groups discussing art in higher education, primary education, and secondary education/administration.

The dialogue continued at a banquet for the art educators. Six of the higher education members sat at one table and continued the earlier discussion. Zhang Zishen, Vice President of Shanghai University, College of Fine Arts, asked the question, "What is art therapy?" Two Chinese art educators at the table observed

(Chinese educators) expressed interest in learning about this concept (of Art Therapy).

art therapy to be a viable experience for their elderly population. Since both were professors of art teaching the talented and gifted on the university level, they did not respond to the use of expressive art for everyone. The fact that the first program for the mentally retarded was developed in 1984 (Malchiodi, 1988) may explain why the concept of art therapy was new to these art educators.

At the close of the banquet, each American was given a jade or a bloodstone chop as a remembrance of China. Most had their name in Chinese and a logo inscribed on the chop in the city of Guangzhou. These gifts served as a reminder to the delegation of their Shanghai visit.

The American delegation also visited the Chinese Welfare Institute (CWI) Children's Palace which was established by Soong Ching-ling (Madame Sun Yat-sen) in 1953. Children, aged six to sixteen, attend classes in literature, arts, science, and technology. A children's computer center and the Shanghai Little Companion Art Troupe have been established at this Children's Palace (China Welfare Institute Brochure, no date). Dough sculpture, a Chinese art, was made by the children and sold in the gift shop. The use of computer graphics by these children has great possibilities for the future.

The group watched children painting and drawing and observed their joy as they freely expressed themselves through the art media. The art teacher invited the American delegation to select one child's painting as a gift. This experience differed from the approach noted in Beijing where a Design Book of copy exercises was given to each of us at that time. The copy method of teaching art is still evident in China. We observed an older group of children in a class drawing from molds. The delegation was also treated to a performance of The Shanghai Little Companion Troupe and a Magic Show.

The Children's Palaces are also training centers for teachers and coaches (Children's Palace Brochure, no date). There are twenty-three palaces in Shanghai, some of which are old mansions built by wealthy capitalists (Malloy, 1988). There was no evidence of programs for special populations in any of the Children's Palaces. All children observed were apparently gifted.

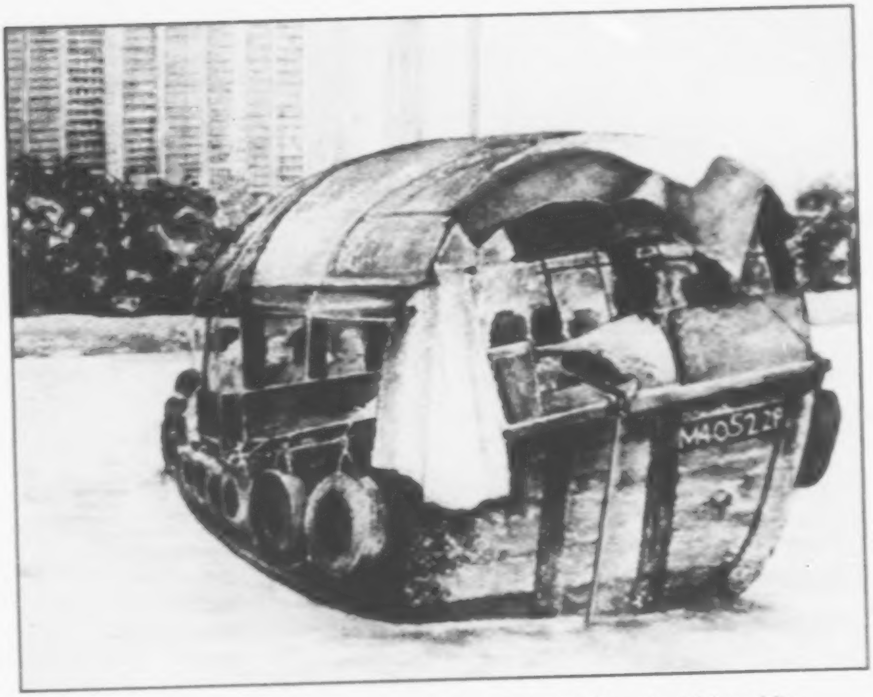


Fig. 2 Boat Taxi, Hong Kong, water color, 9" × 12" by Sr. Dorothy McLaughlin.

The delegation then flew to Guilin, an ancient cultural city with lush, green hills, clear water and enchanting caves. Originally, Guilin was covered by the sea and the limestone on the sea bed rose and became land, with erosion creating the peak-shaped hills. A boat trip on the Li River, from Guilin to Yangshuo, through enchantingly beautiful countryside, provided an aesthetic experience. Guilin, like other Chinese cities, offered sidewalk sales of arts and crafts to tourists.

From Guilin via Hangzhou, the group traveled to Guangzhou. Many of the arts and crafts became gifts for the American tourists to bring home to family and friends. Each province of China was rich with its own culture. This uniqueness was especially evident in the foods served and in the specialized crafts displayed.

The final journey from the People's Republic of China included a train trip from Guangzhou to Hong Kong. The Citizen Ambassador Delegation of Art Educators got their last look at the beautiful countryside of China as the train crossed the border and tunneled through the mountain into busy Hong Kong.

The only art exchange in Hong Kong was at the Hong Kong Academy of Fine Art in Kowloon where the group met Hoi-Ying Chan, President of the Academy, and Christopher W. M. Chan, interpreter. Professor Hoi-Ying Chan presented an exhibit of his paintings, which were influenced by the style of John Singer Sargent; his teacher had been a student of Sargent in the United States. This experience was like going back thirty years to the art institute training schools in the large

BEST COPY AVAILABLE

American cities. The art and the academy did not represent the ultra-modern buildings dominating the landscape.

Conclusion

Art education currently is trying to catch up with the times in China after the years lost with the closing of universities and schools during the Cultural Revolution. The great elder art masters are gone; the experienced, educated artists are few in number. Middle-aged artists, deterred from their art practice and study by the Cultural Revolution, are beginning anew. Younger artists are being educated and will eventually replace their teachers.

Art with special populations, a new concept in China, may influence the teacher-training programs and develop art skills for the handicapped. Vocational and technical middle-school education promotion will include art programs since so many factories produce arts and crafts, essential to the tourist industry. Education for architects, interior designers, fashion designers, illustrators, advertising artists, computer graphics specialists, and stage designers is in the initial stage of development.

Educational and cultural exchanges such as the Citizen Ambassador Program of People to People International can continue to draw the Chinese people and the American people closer together. The art educators of the future, working together, will broaden the scope of all aspects of art on all levels of education. As China moves into the next century, other nations will lend their expertise in those areas of art education needing development.

References

Adams, J., editor (1987). *China.* Washington, D.C.: United States Department of State, Bureau of Public Affairs, 1-23.

China Welfare Institute, Children's Palace (no date). Shanghai: People's Republic of China. Brochure.

Citizen Ambassador Program (no date). Spokane, Wash.: People to People International. Brochure.

Malchiodi, C. A. (1988). Bringing art therapy to China. *American Journal of Art Therapy, 27,* 54-60.

Malloy, R. L. (1988). *Fielding's People's Republic of China.* N.Y.: Fielding Travel Books, William Morrow & Co., Inc.

Mosher, S. (1988). The U.S. and China step toward opening mainland China. *Current.* July/August. 304, 39-40.

Shanghai Little Companion Art Troupe (no date). Shanghai: Children's Palace. Brochure.

Swanson, A. D. and Zhian, Zhang. (1987). "Education reform in China." *Phi Delta Kappan, 68,* 373-378.

Discussion

Cathy A. Malchiodi, M.A., A.T.R., *Director, Art Therapy Graduate Studies, University of Utah, Salt Lake City, Utah.*

In 1987, at the request of Very Special Arts International (VSAI), Kennedy Center, Washington, D.C., I travelled to Beijing, China, to conduct a series of training workshops for the purpose of teaching basic concepts of art therapy to special educators, artists and health professionals. I was part of a five-person training team, including a dance specialist, a music therapist and two drama specialists. The exchange was the first of its kind between the two nations and culminated in the first Very Special Arts Festival held on mainland China (for more information, see Malchiodi, 1988).

Like Professor McLaughlin, I was optimistic about the Chinese people's enthusiasm and their apparent desire to learn our methods and ideas. I also sensed that they were intrigued by the concept of art therapy, particularly with the elderly and disabled. However, what they were most interested in were pragmatic solutions to rehabilitation through creation of salable arts and crafts by their handicapped populations; during my stay in China, educators were eager to hear any pointers I could offer that might help disabled people create crafts for sale. On the whole, the idea of art as an expression of personal feelings and as a representation of the individual's inner world seemed vague to them, for many reasons, both societal and political.

For example, training in studio art, from primary school to the academy, is generally conducted through observation and copying of work of a master teacher. To be like others is considered more admirable than it is to be different; this is true not only in the arts, but also in Chinese society as a whole. This differs, of course, from American society where individuality is a possibility. Because the concept of art therapy is based largely in the creation of spontaneous imagery and free expression, our methodology does not always make much sense to the Chinese, in light of basic cultural differences as well as the goals they seek to achieve through therapeutic rehabilitation. Also, the Chinese tend to emphasize the practical aspects of any therapeutic endeavor; this explains their interest in developing arts programs for special needs populations that will integrate the disabled into the larger community and help them to become economically independent. Therefore, programs which include production of arts and crafts, which can be sold to tourists by the handicapped, have great appeal.

Although politics and governmental influence have traditionally affected art in China, it is clear that Chinese art has been reinvigorated in the post-Mao era (Cohen, 1986). It was my observation in 1987 that art education programming was also improving and expanding because of various exchanges both with VSAI and Harvard's Project Zero under the direction of Howard Gardner. However, artists and art teachers still face political control and the related governmental fear of foreign influences. Although, in recent years, adventurous artists groups such as the Ying Ying (Star Star) have produced art which radically deviates from traditional Chinese art, the issue of political control is still central to what kinds of art are produced and how art is taught. Also, the government, in contrast to the United States, is still the principal patron of the arts. These obstacles affect not only the kinds of art that is produced, but how art educators teach studio art and how art is viewed by the greater community.

Certainly, in 1987, the VSAI visit was considered to be a positive sign that the Chinese were willing to at least allow their professionals to be exposed to Western ideas concerning arts education, arts therapies and mental health (Gladstone, 1988). The invitation to come to China was sought after by the VSAI for several years before a formal welcome was extended by the Chinese government. Part of this invitation was due to the influence of Deng PuFang, the son of then Chinese President Deng Xiaoping. Deng PuFang, who himself is handicapped as a result of an accident during the Cultural Revolution, had a special interest in rehabilitation because of his own disabilities. This unusual situation of a handicapped person being in a somewhat powerful position was probably an overriding factor in allowing the VSAI to gain entrance, rather than cultural reawakening. Again, this circumstance supports the idea that governmental influence is crucial to allowing transmittal of information and exchange of ideas to occur.

Since Professor McLaughlin's and my visits, there have been many changes in China. We are all aware of the disturbing events that occurred in China two years ago. I myself am acutely aware of these events, because former colleagues and friends in China are no longer accessible to me; since the incidents in Tian Anmen Square in 1989, I have received no answers to any of my letters, sent to both professionals and personal friends. Additionally, I have also stopped writing in recent months, fearing that my letters might subject someone to unnecessary suspicion or questioning.

I did have the opportunity to see some of the outcome of the VSAI training team's visit to Beijing when I attended the First International Very Special Arts Festival at the Kennedy Center as a delegate and Master Teacher in June of 1989, shortly after the beginning of the unrest in China. At that time, I met with the Chinese delegation leaders, Mr. Gan Bolin and Mr. Yao Zhenhuan of the China Disabled Person's Federation (CDPF), an organization which oversees arts for the disabled. Because it seemed highly inappropriate at the time, I did not ask any direct questions about the current situation in China, respecting that it would be uncomfortable for these men to speak openly about recent events. However, I did find out from the delegates that there had been some significant changes in the nascent arts programming for special populations. The CDPF, along with the Chinese government, was encouraging art activities among the disabled, particularly in the area of musical and dance performance. A national art festival for the disabled had taken place in Beijing in March of that year, attracting more than 300 disabled artists from all over the country. It seemed that the Chinese had adopted at least the concepts of the Very Special Arts Festivals held here in the U.S. and were beginning to develop a national organization of disabled artists.

It will be interesting to see the continuing developments in China in regard to both art education and art therapy as more art educators and art therapists have the opportunities Professor McLaughlin and I enjoyed. However, from my own experiences and in light of recent events, I am both cautious and respectful of how the Chinese will proceed in incorporating Western concepts of both art education and art therapy into their society.

References

Cohen, J. (1987). *The new Chinese painting, 1949–1986.* New York: Abrams, Inc.

Gladstone (1988). West meets East. *Very Special Arts International Magazine, 1* (1), 6–9.

Malchiodi, C. (1988). Bringing art therapy to China. *American Journal of Art Therapy, 27,* 54–60.

BEST COPY AVAILABLE

The Healing Qualities of Art

Klaus Boegel, *visual artist, an instructor of art therapy, and a supervisor with the Hogeschool Midden-Nederland (Higher Vocational Education)* **and Louis van Marissing**, *visual artist, an instructor of art therapy, and a supervisor with the Hogeschool Nijmegen (Higher Vocational Education)*

Translation: **M.A.H. de Swart**, *Velp, The Netherlands*

Abstract

The authors describe the performance that Klaus Boegel made on the occasion of the death of his wife Carla. This article presents a description of the healing function of art. Analyzing an art/performance ("The Carla Performance"), the authors distinguish two levels of experience in art: the concrete level, in which the process of shaping takes place, and the archetypical level, in which the personal imagination and transformation is connected with collective images. The structures of these levels makes the healing function of art demonstrable.

PART I:

The Carla Performance,

by *Louis van Marissing*

Klaus has invited me along with 8 others to be a fellow-witness of the performance that he wants to make on the occasion of his wife Carla's death.

Saturday, December 19th. It is a glorious mid-winter day. We assemble at his house and at twelve o'clock the ten of us walk to the cemetery. Klaus has taken Carla's bright pink carryall with him. One of the men carries a large rolled reed mat, and I carry ten bamboo canes 2.5 meters in length. We stop at the grave which Carla shares with Ninja, their little girl who died in 1983. As a result of the warm weather the daffodils that Klaus has put on the grave yesterday have burst into bloom. He takes an anthracite-black stone with a white line and goes before us to the field behind the cemetery.

The field is fenced in and the size of a football field. It is bumpy with deep tracks of caterpillar tractors and short, clumpy grass. We are in the middle of it with our backs to the houses hidden behind overgrowth, and facing the sun that is at its wintry zenith. On the right at the edge of the cemetery there are beehives in a row perpendicular to the railway from Baarn to Amersfoort. A rabbit frisks from the compost pit, at the left in the direction of the beehives.

Klaus welcomes us. He squats near the carryall at his feet and takes out an oval stone, a black lacquer box and a photograph of Carla. He ties the photograph to the stone with brass wire. He acts carefully and purposefully. Standing with his eyes closed he keeps the stone with his hands at navel height; he takes his time. Then he turns and walks away.

He walks in the direction of the beehives, quickens his pace and walks faster, then trots with the stone in his hands along the outline of the field. When he is halfway around the rabbit catches up with him from the beehives and overtakes him in a bowed diagonal across the field. We, who are witness of this, yell elatedly. Panting, Klaus returns to the center of the field and continues in a southerly direction.

At a distance of about ten meters from us he is standing there facing the sun. He throws the stone in the air and catches it, throws it again, but higher now. He catches it. Still higher he throws, catches it and throws again. Finally, he throws the stone in the air and roars: "Carla!"

From the spot where the stone has fallen with a dull flump on the squelchy field, he unrolls the reed mat northward. He places the ten bamboo canes around it in a ring. He spreads a white sheet over the reed mat and lies over it, bending down with his head facing the stone. Silently he is lying there.

He squats beside the mat, cleans his spectacles with the sheet, and as the wind threatens to blow it away he puts the anthracite-black stone with the white line on the head of the sheet. Very devotedly and carefully he then takes Carla's personal possessions out of the pink carryall and displays them in heaps on the sheet: a pink hat, a blue dress, yellow wedding shoes with high heels, a small snakeskin bag with jewelery, trinkets, gloves with threads of wool, pieces with a tiger pattern, a belt, bracelets, sunglasses. . . .

We who are witnesses react silently. Klaus puts Carla's belongings into individual white cotton pouches. With tender gestures of farewell, he puts the well-loved objects in a white sack, buttons it and ties the bundle to one end of the bamboo canes, stands up and drives the cane forcefully into the earth. A circle of canes with white bundles at the top is created. The cotton pouches fly like flats in the wind. The low position of the sun gives the circle an embracing intensiveness in lowering backlight.

He throws the stone in the air and catches it, throws it again but higher now.

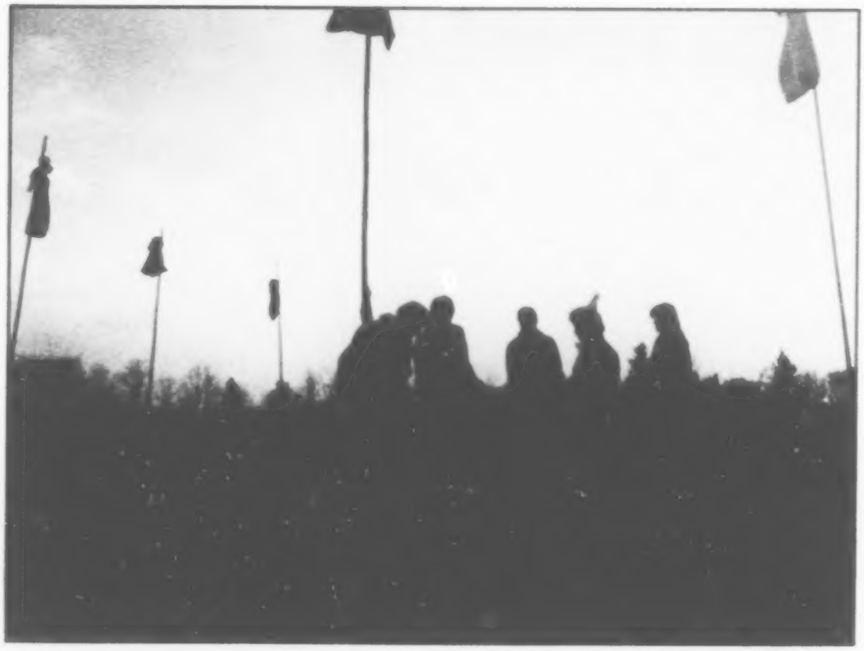


Fig. 1

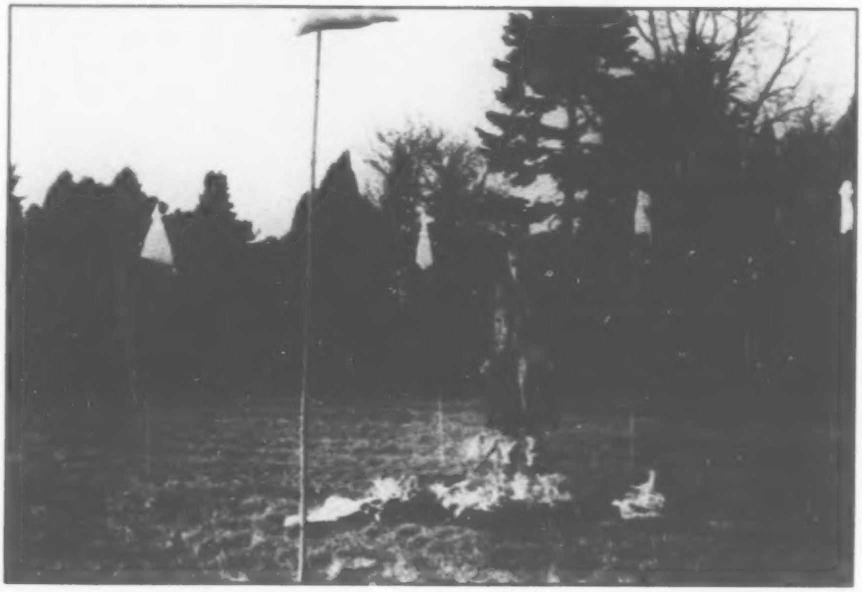


Fig. 2

From the pink carryall Klaus takes a deep yellow dress embroidered with little flowers. He spreads Carla's wedding dress on the reed mat. He bends forward and kisses the dress. Then he asks four of us to raise the reed bed so that he can attach it to the hooks that he has fixed with kite strings to the ends of the bamboo canes. When we lower the bed the strings pull tight. The bamboo canes bend, the cotton bundles move, the reed bed with the wedding dress on it slightly touches the ground astride. Klaus sprinkles fuel over the dress and lights the fire. The dress, the sheet and the reed mat flare up. The fire makes the kite strings snap, then the trembling bamboo canes leap erect. For a long time the bed burns till it has become an ashen-black rectangle in the winter-green field.

Silently, he squats beside the spreading, flaring and then smouldering fire. The wind chases long wisps of smoke across the field. In the distance, near the railway, noisy sparrows swarm in the bare trees. When only the far ends are still smouldering, Klaus takes some ashes of the dress and puts them in the lacquer box. He puts it away in the pink carryall. Then he goes to the oval stone and unties the copper wire, loosens the photograph and puts it away as well. He sets aside the stones to take with him.

While untying a cotton bag from the bamboo canes he turns towards us and asks each of us to untie a bundle and take it home. We who had been witnesses, swing into action. I gather the bamboo canes, Klaus takes the pink carryall, and each of us has a white bundle. We go to the grave of Carla and Ninja. Klaus puts the stones in their place. Carla's girlfriend puts down red carnations.

Walking closely together we go back from the cemetery through Baarn to his house at the Sparrenlaan.

PART II:

Theoretical Considerations

by *Klaus Boegel*

Art has a healing function. In the following, I describe how I experienced the healing effects of art, after the death of my wife Carla. Using the example of the "Carla performance," I want to make evident structures of reality that have to do with change and transformation. Herewith, I create a framework within which the healing function of art is nameable. I describe the structure on

BEST COPY AVAILABLE

two levels: the concrete level, and the archetypical level, which together are an unbreakable unity which forms the basis of healing.

By the concrete level I mean the concretely visible and tangible reality of an act in or with materials. The archetypical level is the dimension in which the concrete realization may vary much while retaining the collective meaning. "The artistic act is a remedy for the incomplete fragmentary form of life," the art critic Arnold Hauser remarks. The countless contradictions in human nature—light and dark, good and evil—can never be solved but may be reconciled to each other and united. Art may be a way of enabling one to experience the apparently fixed static contrasts as elements in a dynamic whole. In the creative process old structures are broken open in such a way that something new may be created. In this process healing may take place. Creating, ie., creating with materials on the concrete level, requires action. That act with materials is concrete and immediately visible and tangible. Then a static whole begins to move, to make way for a creation. Each act with materials brings about a change.

In the Carla performance these two structures became visible. On the concrete level I performed a number of acts that aimed at my being able to take leave of "central symbols" (van der Hart, 1978) like the wedding dress and other precious things. I chose and used materials (the bamboo canes, the cotton pouches, and the reed mat) in order to create a structure within which the parting could take place in my own way. Each part of the process was important; the total of the acts was just as important.

To illustrate my points I will describe a few aspects of the performance. I chose long bamboo canes which I drove into the earth in a circle around the reed mat. One by one I took the precious things from the pink carryall, I felt them, looked at them, and divided them into ten heaps on the reed mat. In that way I showed them to the witnesses. I moved them from a cupboard in my house to the open space in the large field. Carla's things began to move, to be taken from their old order and become part of a new order. Meanwhile, they were looked at and felt one-by-one, chosen from many things. By putting them in a completely new context (in this case, the field outside) and by showing them to other people, my relation to these things changed and began to move. I looked at them in a different, new way.

From the pink carryall Klaus takes a deep yellow dress embroidered with flowers.

Next I carefully put the things in the ten cotton pouches and hung them on the ends of bamboo canes. Then they were hidden from view again. They were hanging free from the earth in a circle in a border area between heaven and earth. They surrounded the wedding dress which I put on the reed mat. The mat was fastened to the sticks by pieces of string and floated just over the earth. The wedding dress was the center on which attention was fixed. I set fire to it and while the dress was transformed, changing from matter to smoke ascending to the sky, the pouches were hanging on the ten bamboo canes, silent witnesses blowing in the wind. They were the material, permanent environment for the radical and total process of change, which took place in the middle of the circle.

This change, the definitive transition from one form to another, I felt intensely. I was convinced of the sense: this is the last act, after this it is finished and I shall never again see the wedding dress in its familiar form. Breaking away . . . parting by creating for yourself a structure in which the different acts with material are important . . . these are essential steps to reach the goal: taking leave.

By creating with concrete material the apparently fixed order begins to move, and with that, the way in which the creator related to those things changed as well. That relationship had to be reconsidered, with the result that the "external" movement caused an "internal" movement. The active act with materials on the one hand led to a concrete and perceptible result, and on the other hand set something in motion inside me. This was made clear by the example of the wedding dress. After it had been burnt I could neither look at the dress anymore nor feel the material between my fingers. The tranformation from dress to ashes forced me to a different inner perception. Something standing for an important change in my life was not there anymore, at least not in its familiar form. Carla's precious things, put away in pouches, were given to the witnesses at the end of the performance. I broke away from them, I literally gave them away and entrusted them tc a circle of people. These things were not exclusively my personal memories any longer, but for a number of people they became memories of Carla and me. I acted

The countless contradictions in human nature—light and dark, good and evil—can never be solved but may be reconciled to each other and united.

actively by choosing my personal form and thereby I newly created a piece of reality, to which I have to relate once again. I had to make a move in order to reach a new balance.

Something standing for an important change in my life was not there anymore, at least not in its familiar form.

According to C. G. Jung, healing starts where we remember resources behind the "personal." This archetypical level may be expressed in different ways; archetypical images are expressed, for example, in dreams, fairy tales, myths and artistic expressions.

On the archetypical level, a structure that goes beyond the personal may be distinguished. The aim of the Carla performance was specifically taking leave of "central symbols" (wedding dress and precious things). I did this by means of a drastic act with the wedding dress. In the fire the complete transformation took place; the material dissolved in smoke that ascended to the sky and disappeared. The only thing that remained was ashes.

It was not only grief for my deceased wife. An image was created of the transitory nature of the material. The material disappeared, dissolved and in that way was included in the eternal cycle of birth and death. The impulse to express is the desire to approach what is unspeakable and elusive. How can you get access to the mystery of death?

At the beginning of the performance I threw a stone in the air; on this stone was tied a photograph of Carla. I called her name. Against the laws of gravity a message was forcefully sent to heaven, to the deceased person. For a moment it seemed as if heaven might receive this sign, the stone went up in the air, higher and higher, but fell so much harder on the earth again after the third time and the highest flight. Gravity won.

We, the living, are tied to these laws and therefore come upon the border of the world of the dead. Here, other laws apply. We cannot live in both worlds at the same time. A desperate effort, a cry that may have crossed this border . . . who knows? The apparently static factor—death as the end of life—has been put in motion by this artistic act. I created images, structures in which the factor of death was part of the dynamic whole, the level of the archetypes, in which individual and collective images coincided. In this, the resources are to be found. By completely going through the pain of loss, the idea that we are a part of a larger whole and are included in something that transcends the personal may be remembered. And then the help that has been always available may be gotten. Then the healing effects may start. What happens then cannot be described in general terms. It depends on what one needs at the moment.

Finally, in both the process of mourning and the creative process, loss is involved, and there are temporary experiences of being "not complete," or of being able to acquire something in the end. Instead of division as the result of a constantly advancing process of splitting up, there is the experience of wholeness as a result of synthesis.

Reference

van der Hart, O. (1978). *Rituelen in psychotherapie (Rituals in Psychotherapy)*. Deventer, The Netherlands: Van Loghum Slaterius BV.

The apparently static factor—death as the end of life—has been put in motion by this artistic act.

Discussion

Linda Gantt, Ph.D., A.T.R.

In his description of a specially constructed (as opposed to a traditional or prescribed) event Boegel demonstrates both the individual and the universal aspects of memorial rituals. There are several points which art therapists might derive from this article. The first is the necessity of giving full voice and responsibility of the direction and content of the ritual to the chief mourners so that the elements of the process and the symbolic props are consonant with the survivors' needs. Psychotherapy has demonstrated the crucial need for attention to individual experience and individual interpretation. This was a unique ceremony and celebration. Due to the many personal ingredients, it cannot be repeated. So we do not have here a specific template for future rituals which could be applied as is to another situation. And yet, Boegel's memorial observance has elements in common to other rites of passage such as sacrifice, destruction, and implied renewal. These are the same metaphorical components that cremation of the corporeal body has. That is the second point: that through a careful study of other cultures we can learn the general forms such ceremonies take and thus can help our clients in devising their own. Through our understanding of universal processes we can support clients' choices and stress their connectedness to others. Flowers, fire, ashes, precious possessions, symbolic acts (for example, communication sent in the direction of heaven), leave-taking, and radical transformation of objects are features commonly found around the world, not just in funerals but in ceremonies of all types. Fire (and its opposite, water) is frequently connected with a transition to other states (especially initiation). Ashes are not only a return to the earth ("ashes to ashes, dust to dust") but a symbol of rebirth (as in the story of the phoenix). In India, ashes were the "seed of Agni" (the consort of Destroying Kali) (Walker, 1988: 340).

Arnold van Gennep describes 3 major phases of rites of passage—separation, transition, and incorporation. "The individual would first be ritually removed from the society as a whole, then would be isolated for a period, then would be incorporated back into the tribe in his or her new status" (Haviland, 1978: 344). While van Gennep cautions "these three subcategories are not developed to the same extent by all people or in every set of ceremonies" (van Gennep, 1960: vii-viii), we can use our knowledge of these stages to better frame a client's ritual.

The third point is that doing something (symbolic action) is crucial to the mourning process. Here our guides can be the psychodramatists (Moreno and Moreno, 1959). Of course, through art we can condense a symbolic act into pictorial form. If one cannot go to a cemetery to place flowers on a grave, one can draw the event. Perhaps the creation of a memorial picture, sculpture or special object is psychologically satisfying because it requires sustained action on the part of the creator as well as being permanent and concrete.

The art therapist must support the natural tendency to give vent to emotion through symbolic expression especialy in those whose grieving has been thwarted by well-meaning relatives, religious custom, or unacknowledged anger. Knowing that virtually all rites of passage require a special place for their conduct, the art therapist can encourage the construction or selection of such a place. All details of the ritual can be tailor-made to the situation, shaped by the participant(s) and supported by the therapist.

In her book on art and anthropology Evelyn Hatcher states ". . . whatever the theoretical explanation, it is clear that art somehow helps human beings cope with the trauma of death. Beauty and art forms have been part of funeral ceremonies since Neanderthal times. This universal human problem is met everywhere with symbolic solutions to satisfy the mind and esthetic solutions to release the emotions" (Hatcher, 1985:106-107).

References

Hatcher, E. (1985). *Art as culture.* Lanham, MD: University Press of America.

Haviland, W. (1978). *Cultural anthropology* (2nd Edition). New York, NY: Holt, Rinehart and Winston.

Moreno, J., and Moreno, Z. (1959). *Psychodrama.* Beacon, NY: Beacon House.

van Gennep, A. (1960). *The rites of passage* (translated by M. Vizedom and G. Caffee). Chicago, IL: University of Chicago Press.

Walker, B. (1988). *The woman's dictionary of symbols and sacred objects.* New York, NY: Harper & Row.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:

Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

A Comparison of the Traditional Education of Native American Healers with the Education of American Art Therapists

Phoebe Mills Dufrene, Ph.D., A.T.R., Assistant Professor, Art and Design, Purdue University, West Lafayette, Indiana

Abstract

This study compared the traditional education of Native American healers with the education of American art therapists. This first part of the article gives an overview of traditional Native American healing practices. The second part describes results of a survey conducted with 20 Native American healers and 16 art therapists using a descriptive field study approach.

For art therapists working with Indian clients, knowledge of the Indian philosophy of health may help to overcome cultural barriers. Mutual respect for both cultures will more easily facilitate a therapeutic relationship.

Introduction

Preparing art therapists to be sensitive to their clients' needs, feelings, strengths, weaknesses, and cultural perspectives is as demanding of the educator as the art therapy student. With the cultural diversity prevalent in most of the United States, it is particularly difficult for an aspiring professional in the helping professions to always be aware of the subtleties needed to work with clients of varying backgrounds. This seems especially true when the client is a Native American, an ethnic group not even legally recognized in some American communities (Katz, 1986).

Until the passage of the 1978 Freedom of Religion Act, many Native Americans had difficulty obtaining access to Native American healers due to laws prohibiting the practice of traditional religion and medicine. American Indians must often rely on publicly funded health facilities whose staff members approach mental health problems from a classical Western psychoanalytic perspective.

Art therapists have a responsibility to their clients to determine the most appropriate and efficient observation techniques, the extent to which their creative productions are influenced by tribal, religious, and other cultural factors. There is much that is universal to all humankind, but when differences do exist, different solutions for treatment must be considered (Joseph, 1974).

It is also difficult for therapists and educators of the same ethnic background as their clients to work with those who are caught in two worlds—the world of their family origin and the world of the general American society. Traditional healers, working with American Indian patients with a host of problems ranging from the physiological to the emotional, are also coping with concerns around sensitivity to tribal identity.

The inclusion of . . . Native American healing techniques . . . in institutions that serve Native Americans is extremely important. . . .

Part I—Background

The inclusion of traditional Native American healing techniques, particularly the use of the arts in institutions that serve Native Americans is extremely important because a disproportionate number of Indians are seeking the services of psychiatric hospitals, mental health clinics, and special education schools. This is due to the devastating social, economic, and environmental pressures of racism, poverty, alcoholism, substandard reservation housing conditions and a hostile education system (Jilek, 1982). In many cases, the therapists Indians encounter have little experience in understanding the dual problems of having psychologically based disorders and the social stresses of being dislocated/relocated away from traditional land bases due to United States government policies.

The role of minorities in art therapy, both as patients and as therapists, is well documented by Joseph (1974). The use of art for creative/therapeutic purposes by Native Americans, Africans, and Asians is also being documented by New York-based psychiatrist, Dr. John Bolling. Documentary information on Third World mental health issues is being compiled by the National Alliance of Third World Therapists. Contemporary medicine men/women such as the faculty of the *Traditional Indian Medicine Conferences* (1985 to the present), are nationally

---

Note: This article is based on a dissertation by the same title written by Dr. Dufrene at the University of Maryland under the direction of Randall J. Craig, Ph.D., in 1988. Copies of the complete dissertation are available through University Microfilms International, Ann Arbor, Michigan (order number 8818390).

recognized for helping in the current revival of traditional Native American healing methods.

During the Eisenhower years the religious ceremonies of many tribes, such as ritual dancing, sweat bath purification, peyotism (using the hallucinogenic cactus peyote), and vision quests, were done openly after many decades of suppression. Indians began to rediscover their own culture; they began to describe the reality of their own religious experience and to distinguish between the technological superiority of Western culture and the moral corruption of the West (Deloria, 1973). Tremendous interest in tribal religion manifested itself in the recent activist movement which has attempted to recoup lost ground and return to the culture, outlook, and values of the old days.

As tribal religions re-emerge and begin to attract younger Indians, problems of immense magnitude appear. Many people are trapped between tribal values constituting their unconscious behavior responses, and the values they have been taught in schools and churches which demand primarily conforming to seemingly foreign ideals. Alcoholism and suicide mark the tragic fact of reservation life. People are not allowed to be Indians and cannot become whites (Deloria, 1973).

Formerly, one of the main functions of the tribal religions was the performance of healing ceremonies. This function was impaired by lack of any rights to train new people to perform the ceremonies and a general lessening of dependence on tribal medicine due to the presence of U.S. Public Health Service hospitals on the larger reservations. Indian healers were generally considered to be superstitious magicians by the missionaries and government officials and segments of the healing arts were lost to many tribes.

The revival of Indian customs and traditions seems to be one of the answers to many Indian problems. Conscious efforts are made by Indian leaders to uphold to the young Native generation the exemplary ideal of Indianness, a pan-Indian rallying sign (Jilek, 1982).

The revivals occurred between the mid-1950's and late 1960's which was the era of global decolonization and geopolitical retreat by Western powers. It was in such a changing climate that Native Americans turned to their own heritage and that health professionals came to recognize the value of Native therapeutic resources.

The interest in indigenous healing ceremonies cannot be attributed to a lack of modern treatment services; it has more to do with a lack of culture-congenial and holistic approaches in modern medicine. The persistent tendency of most Western therapists (art therapists included) to approach the problems of Third World people from a Western psychoanalytic perspective is unrealistic (Burns and Ruiz, 1974).

Today, healing remains one of the major strengths of tribal religion. This particular field is thus open for Indian religious figures who have received specific healing powers and are being recognized by the Public Health Service as competent to perform certain ceremonies. Special grants have been given to train more medicine men/women and to have them work closely with doctors trained in internal medicine.

Almost all of the healing disciplines came originally from religious beliefs and the spiritual leader's practices. The severing of medicine and psychology from religions has only been a recent event. Throughout North America there are Native American secret societies in which holy people share the power of their visions with a group of initiates, sometimes their former patients (for example, the Iroquois Society of the Mystic Animals, the Midewin of the Ojibwa, the numerous societies of the Pueblos and Navahos) (Tedlock and Tedlock, 1975).

Today, healing remains one of the major strengths of tribal religion.

The revival of Indian customs and traditions seems to be one of the answers to many Indian problems.

The Shaman

The medicine person and/or shaman is a traditional doctor, practitioner of medical magic, seer, prophet, and herbalist. Classifications vary with tribes. There are slight, subtle differences between the terms medicine man/woman and shaman, although sometimes they are interchangeable. Generally, the shaman acts out vividly and dramatically through ecstatic trance the ascension and descension to other "worlds." The medicine person draws upon a vast body of traditional symbolism (paintings, prayers, and songs) but does not go into an altered state of consciousness (Sandner, 1979). The word *shaman* comes from the Tungus people of Siberia, and has been widely adopted by anthropologists to refer to persons in a great variety of non-Western cultures who were previously known by negative terms such as witch doctor, sorcerer, or wizard (Halifax, 1981).

Shamanic knowledge is remarkably consistent across the planet. In spite of cultural diversity and the migration and diffusion of peoples across the earth, and the basic themes related to the art and practice of shamanism form a coherent complex. There are superficial features as well as deeper structures which appear to be constant (Halifax, 1981). Trance, dance, painted drums and shields were as central to early shamanism as they are to its continuing practice today. For the shaman, the cosmos is personalized. Rocks, plants, trees, bodies of water, two- and four-legged creatures—all are animate. The world of the human being and the world of nature and spirit are essentially reflections of each other in the shaman's view of the cosmos. This special and sacred awareness of the universe is codified in song and chant, poetry and tale, carving and painting.

Common Symbols

In Eskimo stone carvings and Native American paintings, the eagle symbolizes transportation to other realms. The eagle, rising to great heights, overcomes the earthly world and enters the gateway of immortality, the place of origin. The shaman's association with bird figures is found all over the world. The bird always denotes rising, activation, change, and vitality. In some traditions, the bird is symbolic of the soul; in others, the bird is recognized as an intelligent collaborator with man, the bird being the bearer of celestial messages (Halifax, 1981).

Among the Eastern Woodland Indians, birdstones were used by the medicine men as talismans or charms to protect against disasters. Some medicine men wore a small black bird over one ear as a badge of office (Leftwick, 1970). Masks resembling snakes, bears, and other animals were carved from wood by Cherokee medicine men. Other materials used for making masks were hornets' nests, gourds, bear skin, woodchuck hair and dyes from sassafras and red earth.

The use of animals and other symbols to portray religious longings, visions, tribal affiliations and other deep-seated beliefs is a universal phenomenon. Carl Jung was one of the first Western therapists to show that symbolism produced by his patients and the symbolism found in mythologies from various parts of the world have basic similarities.

> ***Shamans, medicine people, seers, and visionaries still practice the arts of traditional healing in the Native American community. . . .***

Among the Navaho, cultural symbols are expressed by the medicine men during sand painting ceremonies. The presentation of origin myths in song, prayer and sand painting allows the patient to identify with those symbolic forces which once created the world, and by entering into them to re-create himself/herself in a state of health and wholeness (Sandner, 1979).

One of the main functions indigenous healing shares with mythology in general is the construction of a symbolic world in which the individual can feel familiar, safe and comfortable. Sometimes, as among the Navaho, this is done with sandpaintings. The Tibetans and the American Indians have developed mandala-like forms (*mandala* being the Sanskrit word for circle) to a degree found nowhere else. These art works are chiefly geometric shapes in a concentric organization. The mandala is primarily an *imago mundi;* it represents the cosmos in miniature and, at the same time, the pantheon. These images of world order are in the form of a schematic diagram showing the balance of forces in the symbolic universe (Sandner, 1979). Black Elk, of the Lakota Nation, describes a mandala in the form of a medicine wheel, an ancient symbol used by almost all the North and South American tribes. It is a ceremonial circle of stones with horizontal and vertical lines drawn through the center where an eagle feather is usually attached. The circle represents the sacred outer boundary of the earth; the vertical and horizontal lines represent the sun's and man's paths respectively; the crossing of the lines indicates the center of the earth where one stands when praying with the pipe; the eagle feather is a sign of the Great Spirit's power over everything. The wheel is often marked with sacred colors. It symbolizes the four cardinal directions, the four symbolic races, and other relationships expressed in sets of four (Stolzman, 1986).

The Tibetans make large four-sided designs in sand on the temple floor, just as the Navaho do in the hogan. These are also oriented to the four directions, and bring into relationship around the center of the mandala the powers ruling those directions. Both the Tibetan and Navaho sand paintings are destroyed and remade each time the ceremony is given. Both are expected to bring about important transformations in the participants (Sandner, 1979).

Shamans, medicine people, seers, and visionaries still practice the arts of traditional healing in the Native American community and in various parts of the world. Many are attempting to pass on the wisdom of the ancient ones to the people of today. They know that the traditions of the past are threatened by modern technology. The return to the "Medicine Way" involves a bridging of culture and time. According to Halifax (1981), shamans are trained in the art of equilibrium, moving with poise and surety on the threshold of opposites.

Part II—The Survey

A descriptive field study using surveys and on-site visits to reservations and healing ceremonies were conducted to compare related techniques and training among Ameri-

BEST COPY AVAILABLE

can art therapists and Native American healers.

Subjects

The respondents consisted of traditional Native American healers living both on and off reservations and American art therapists. Most of the Indian subjects were selected for nation/tribal affinity and religion.

The American Art Therapy Association listed approximately 1,000 art therapists in its 1987 membership directory. From that list, 100 were randomly chosen to contact via mail.

According to the National Indian Health Board, there were approximately 500 practicing traditional Indian healers in the 1980's. Of that 500, 50 were contacted by mail. The list of 50 names was generated by the National Indian Health Board and the National Indian Health Service. Due to the various tribal rules regarding secrecy, it was impossible to generate a random list from a directory. The names were suggested based on the healers' willingness to discuss medicine matters with someone outside their respective tribes.

Sixteen responses were received from art therapists. This 16% response rate was disappointingly low. Twenty responses were received from Native American healers (a 40% response rate). This is a high rate considering the secrecy associated with many traditional Indian customs, especially in regard to discussing medicine matters. Despite the relatively low numbers, the study is representative because of the regional variety. The art therapy respondents included persons who had studied in art therapy graduate schools across the United States and are now working in a variety of cities. The traditional healers came from the main regional areas: the Eastern Woodlands, the Southeast, the Southwest, the Plains, and the Pacific Coast.

A detailed analysis of the findings, including comparisons between the two sets of responses, provided answers to the research questions and a better understanding of procedures necessary to collect data from traditional peoples.

The Questions

The research questions included:

- What are similar and different variables in the education of art therapists and traditional Native American healers?
- How has the education of traditional healers changed since contact with Europeans?
- Do Native Americans still study under the direction of traditional medicine practitioners?
- How important is the use of art in the education of traditional Native American healers?
- Is American art therapy education relevant for Native American healers?
- Is the traditional education of Native American healers relevant for American art therapists?

The Procedures

Descriptions of the education and techniques of traditional Native American healers and American art therapists were obtained. Both groups were surveyed on their training and general practice (see sample letters). A comparative analysis of the two sets of responses was conducted.

The Findings

1. What are similar and different variables in the education of art therapists and traditional Native American healers?

The similar variables are: previous illness as an incentive, inspiration, or requirement to be a healing practitioner; validity of healing techniques for a variety of races or nationalities; the types of people who enter healing professions; availability of healers in one's community; percentage of population seeking healers; the use of art in the training process; reasons for people to seek healers; and percentage rate of cures or recovery. The different variables are: length of training; formal versus informal education; evaluation criteria; age to prepare for a healing profession; admission into program of study; sex and gender; race or nationality; the roots of art therapy and traditional healing; learning alternative techniques; individual versus group training; sexual habits; retirement; payment; physical environment; definition of the term *art*; prediction; and legal regulations.

2. How has the education of traditional healers changed since contact with Europeans?

Traditional healing has been forced to change adversely since contact with Europeans. Changes have been forced due to colonial and present-day expansion onto Indian lands, forced conversion to Christianity by overly zealous missionaries, laws enacted to either forbid or restrict the use of traditional Native American healing, and compulsory education for Indian children (Myers, 1987).

Ninety-nine percent of the traditional healers who responded to the survey reported that Federal and local governments imposed legal restrictions on their activities and the majority reported that there were times when Indians had to practice traditional healing in an "underground," covert, or hidden manner. Even with the passage of the 1978 Freedom of Religion Act, there are still restrictions. Some of the grievances cited that affect traditional healing are the inaccessibility to former sacred grounds, cultural bias, Bureau of Indian Affairs dominance over reservation activities, restrictions on using eagle feathers which are required for most medicine/religious procedures, loss of indigenous languages, and loss of psychic abilities due to assimilation.

Another way in which traditional

healing has changed is its inability to treat certain illnesses. Prior to European contact, most physical ailments could be treated with herbs, natural hot springs, sweatbaths, massage, and the setting of broken bones. However, Indians had no natural immunities or herbal remedies for European epidemics such as tuberculosis, smallpox, measles, and venereal disease. When traditional healers were unable to cure European-introduced diseases, many lost the respect of their tribal members. Those who were still respected had difficulty obtaining the necessary herbs and roots due to loss of their original land. Compulsory education has interfered with the preliminary training of young children for the roles of traditional healers. Indian youth often have to start training at a much later age, after the completion of public school requirements. Students who attended boarding schools often became alienated from Indian culture (Myers, 1987).

One positive way in which traditional healing has changed is the new merging of Western medicine/psychological techniques with traditional Indian therapeutic measures. Since the Pan-Indian movement of the 1960's, younger, educated Indians are trying to retain traditional values of health and also study Western health concepts. Indian schools in the Southwest afford students the opportunity to study and integrate indigenous and Western modalities.

3. Do Native Americans still study under the direction of traditional medicine practitioners?

Despite the numerous negative obstacles that have to be overcome, Native Americans still resort to traditional shamans and medicine people. After a sharp decline in the use of traditional healing, there is a re-emergence of Indians wanting to be treated by Indian medicine and wanting to study Indian medicine.

There is an Indian ideology that is, like the Egyptian or Christian world-view, bound up in rituals, dances, and other aspects of an elaborate oral tradition. For Indians who lived prior to the final subjugation of the native peoples of America, roughly at the turn of the century, this ideology was commonplace and was apparent everywhere in their arts. For the Indian artist at the middle of the 20th century there is often a gap between his identification with Indians and his legal identity as an Indian. Many Indians have made an effort to rediscover what it is to be an Indian in language, ritual, and values (Highwater, 1976).

4. How important is the use of art in the education of traditional Native American healers?

Respondents to the Native American survey indicated that art is very important in the education of traditional healers. However, the term *art* is used in a broader sense among Indians, often referring to the natural beauty found in nature, ritualism, the blending of all the arts (singing, chanting, drumming, and dancing), beadwork, and the physical design of the healing environment. Apprentices are trained in the construction of a tipi, hogan, medicine wheel, or sweatlodge, and taught the appropriate colors and symbols to decorate the medicine environment.

5. Is American art therapy education relevant for Native American healers?

Based on the findings from the survey, literature in the field, and participation in traditional ceremonies, this researcher has concluded that art therapy education is relevant for Native American healers who are interested in pursuing Western therapeutic techniques to complement traditional healing. With the exception of some of the Canadian tribes and some of the elders in the Southwestern tribes, most Indians are now living in two worlds and need a dual approach to health care. Because of poverty, racism, and substandard reservation housing conditions, alcoholism and suicide have become prevalent in many Indian communities. Perhaps these social ills could be addressed and treated by a blend of traditional healing techniques and contemporary mental health techniques such as art therapy.

6. Is the traditional education of Native American healers relevant for American art therapists?

Unfortunately, the issue of American art therapists learning the value of traditional Indian education or any other non-Western techniques has not been explored as much as the reverse situation. When questioned about learning therapeutic modalities other than art therapy, no art therapist mentioned any interest in non-Western education or culture. The types of alternative therapies they had studied had their roots in Freudian analysis or some other Western model.

The lack of interest or insensitivity to other cultures affects the treatment of Indians and other ethnic groups seeking counseling (Joseph, 1974). For art therapists working with clients of Indian descent, a knowledge of some of the basic elements in the Indian philosophy of health and medicine may help to overcome cultural barriers between the art therapist and the Indian client. With mutual respect for both cultures, both the art therapist and the Native American client can facilitate a therapeutic relationship.

Conclusions and Recommendations

This comparative study of the education of American art therapists and traditional Native American healers explored issues for those interested in alternative methods of training health professionals. It explored techniques of promoting mental health and well-being not usually taught or discussed in Amer-

BEST COPY AVAILABLE

ican institutions of learning, i.e., traditional shamanic healing. It was felt that this type of exploratory research would be beneficial for art therapists working with Native American populations. Non-Indian populations were also considered for modified uses of traditional Indian healing techniques. The stimulation of further research into the creation of art therapy educational techniques that are relevant for American Indians and also universal for other art therapy clients was a research goal.

The recommendations supported by the conclusions of this study pertain to further research. It is recommended that:

- Art therapists working with Native Americans and other diverse ethnic populations have an understanding of the traditional beliefs of the population they serve;
- Art therapists incorporate multicultural art forms and techniques in their art therapy practice;
- Art therapists consider the spiritual dimension of a client during evaluation and treatment;
- More dialogue and exchange take place between traditional healers and art therapists and other health professionals;
- College educators be more flexible in their requirements for adherence to the "scientific method" when research is conducted on topics that do not conform to the scientific model, i.e., shamanic or traditional healing;
- Art therapists be more involved with the social issues that affect clients and place more emphasis on helping clients develop positive strengths for bringing about social change. Art can be used as a cohesive force with the power to bring oppressed people together, inspiring them to action;
- Organizations such as the American Art Therapy Association establish inexpensive training alternatives for those who cannot afford prohibitive college tuition;
- People of Native American heritage as well as other diverse ethnic groups be encouraged to enter special education and mental health professions, thereby providing appropriate responses to culture-specific emotional disorders; and
- The National Indian Health Board and the National Indian Health Service seek matching grants for exchange programs involving traditional Indian healers and art therapists or other health professionals/educators.

Sample Letter to Traditional Native American Healer

Dear ________:

May this letter reach you at a time when you and the members of your community are in good health and enjoying peaceful relations. Your name was given to me by ________ of the ________ organization. You were mentioned as a respected traditional healer.

I am an art therapist, working with handicapped children in the public school system of Washington, D.C. At the same time, I am trying to further my own education so that I may help the people. It is for this reason that I am writing you. The gift of tobacco and cloth of the four sacred colors is a prayer that you will hear my request, which is to ask you some questions having to do with my studies.

My mother's family is of Powhatan heritage, the indigenous Indian nation of Virginia. My family encouraged me to pursue an academic course of study that will enhance our Native American heritage. To accomplish that, I am writing a doctoral dissertation on the topic, "A Comparison of the Traditional Education of Native American Healers with the Education of American Art Therapists." As an art therapist, I am interested in the ways both Indians and art therapists use art in healing.

Officials at my school, the University of Maryland, requested that I develop a survey. Although obtaining knowledge from a survey is not the traditional way to seek information about Indian healing, I am in the difficult position of having to comply with university requirements. I would be very grateful if you would take the time to read and answer the survey based on your knowledge as a traditional healer. Thank you for taking the time to read this letter.

In Unity,

PHOEBE DUFRENE

Sample Questionnaire to Tribal Chiefs and/or Native American Healers

1. Are there any traditional healers working in your tribal community?
2. How many traditional healers are currently practicing?
3. What are the Indian names and English translations for persons practicing traditional healing?
4. What percentage of the population uses traditional healers only?
5. What percentage of the population uses only Western healers such as physicians, psychologists, psychiatric social workers, etc.?
6. What percentage of the population uses both traditional and Western-trained healers?
7. Can you please supply me with the following information concerning the training/education of traditional healers?
   a. At approximately what age or stage in life do people prepare for training as a healer?
   b. How are people chosen and/or accepted for training as a healer?
   c. Is being a former patient sometimes a requirement for being a healer?
   d. If so, what percentage of healers are former patients?
   e. Are traditional healers isolated from Western-oriented educational institutions?
   f. Are traditional healers encouraged to also learn Western healing methods?
   g. Are there specific healing societies that train groups of students or is training conducted individually?
   h. Are women trained to be traditional healers?
   i. Are there any restrictions placed on women in training that are related to menstruation and/or menopause?
   j. Is there an age when healers "retire" or cease to work?
   k. Is there any kind of payment required of the student? If so, what kind of payment?
   l. Is celibacy required or encouraged during part of the training period?
   m. Is the use of art important in the training process?
   n. Are ritual masks used in healing ceremonies? If so, how are they used?
   o. Are certain colors significant in ritual objects? If so, how or why are certain colors used?
   p. Is body paint used?
   q. Is the design or architecture of the healing place important?
   r. Does the traditional tribal language have a word that is comparable to "art"?
   s. Do healers have a term that approximates "art therapy," the use of the arts in the healing process?
8. For what reasons do people seek traditional healers?
9. What is the percentage rate of "cures" from traditional healing?
10. Is divination or prediction used in healing?
11. How has the forced relocation of Native Americans onto reservations affected the training process of traditional healers?
12. Did the U.S. government ever impose legal restrictions on the activities of traditional healers?
13. Was there a period when traditional healers practiced in an "underground," covert, or hidden manner, to avoid U.S. government interference?
14. Are legal restrictions still in progress?
15. If not, when were U.S. government restrictions on traditional healers ended?

Sample Letter to Art Therapists

Dear ______:

I am a registered art therapist, currently pursuing a doctorate at the University of Maryland, College Park. As part of my dissertation research I am compiling the results of a survey mailed to American art therapists. My research topic is a comparative study of the ways both art therapists and traditional Native American healers use the arts in the healing process.

If you will please take the time to respond to the enclosed questionnaire, I would greatly appreciate it. Confidentiality will be assured.

Yours truly,

PHOEBE DUFRENE, A.T.R.

Sample Art Therapy Survey Questionnaire

1. Are there any art therapists in your community?
2. If so, approximately how many art therapists are currently practicing?
3. What percentage of the population uses art therapists?
4. What percentage of the population uses other therapists such as physicians, psychologists, and social workers?
5. What percentage of the population uses both art therapists and other types of therapists?
6. Can you please supply me with the following information concerning the training/education of art therapists at the institution you attended or are presently attending?
    - a. At approximately what age or stage in life do people prepare for training as an art therapist?
    - b. How are people chosen and/or accepted for training as an art therapist?
    - c. Are art therapy students required to undergo therapy before, during or immediately following the training period?
    - d. What kind of educational background is required of the art therapy student?
    - e. Are art therapy students encouraged to learn other therapeutic techniques?
    - f. Is training/education conducted individually or in groups?
    - g. Are women accepted as art therapy students and practitioners?
    - h. Are there any restrictions placed on women in training that are related to menstruation and/or menopause?
    - i. Is there an age when art therapists retire?
    - j. Is there any kind of payment required of the student? If so, what kind or how much?
    - k. Is celibacy required or encouraged during part of the training period?
    - l. Is the use of art important in the training process?
    - m. Is understanding color symbolism important?
    - n. Is the technique of mask-making used in the art therapy process?
    - o. Is face or body paint used in the art therapy process?
    - p. Is the design or architecture of the art therapy environment (office, hospital room or classroom) important?
    - q. How would you define "art"?
    - r. How would you define "art therapy"?
7. For what reasons do people seek art therapists?
8. What is the percentage rate of cures/recovery?
9. Are there legal regulations/restrictions for practicing art therapy with clients?
10. What role does prediction/prognosis play in art therapy?

References

Burns and Ruiz (1974). Lectures at Pratt Institute, New York, N.Y.

Deloria, V. (1983). *God is red.* New York: Dell Publishing.

Fawcett, A. (1981, November). Visions of the rainbow woman: Brooke Medicine Eagle's healing power. *East West Journal:* 30–37.

Halifax, J. (1981). *The shaman.* New York: Crossroad.

Highwater, J. (1976). *Song from the earth: American Indian painting.* Boston, MA: Little, Brown & Company.

Jilek, W. (1982). *Indian healing: Shamanic ceremonialism in the Pacific Northwest.* Canada: Hancock.

Joseph, C. (1974). *Art therapy and the third world.* New York: Cliff Publications.

Katz, W. (1986). *Black Indians: A hidden heritage.* New York: Athenium Press.

Leftwick, R. (1970). *Arts and crafts of the Cherokee.* North Carolina: Land-of-the-Sky Press.

Myers, W. (1987). Cross-cultural medicine. *Behavioral Sciences Exchange, 8:* 113–119.

Sandner, D. (1977). *Navajo medicine men sandpainting.* New York: Dover.

Stolzman, W. (1986). *The pipe and Christ.* South Dakota: St. Joseph's Indian School.

Tedlock, D. and Tedlock, B. (1975). *Teachings from the American earth: Indian religion and philosophy.* New York: Liveright.

Traditional Elders Circle (1987). *Fifth Meeting of the Traditional Elders Circle,* Northern Cheyenne Nation, October 5, 1980, Rosebud Creek, Montana; *Sixth Meeting of the Traditional Elders Circle,* Onondaga Nation, August 9–14, 1981, Nedrow, New York; *Seventh Meeting of the Traditional Elders Circle,* Navajo/Hopi Joint Use Area, Arizona, August 27–29, 1982; *Eighth Meeting of the Traditional Elders Circle,* Santa Clara Pueblo, New Mexico, June 2–5, 1983; *Tenth Meeting of the Traditional Elders Circle,* Pine Ridge, Lakota Nation, South Dakota, June 12, 1986. Compiled and printed by Northwest Indian Women's Circle, Yelm, Washington.

Remarks on Receiving Honorary Life Membership—November 3, 1990

Frances E. Anderson, Ed.D., A.T.R., *Professor of Art, Illinois State University, Normal, IL.*

I want to thank Doris Arrington for her belief that I should be standing here right now. I also want to thank Marcia Rosal and Doris Arrington for nominating me for this award. For all the words that I have written and spoken in my 26 years in the academic world, I am at a loss for words at this moment.

Back in 1963 when I was considering career options and trying to decide where to go for graduate school, I had wanted to study art therapy. My search led me to ponder occupational therapy and to consider becoming an activity therapist—however what I knew of these fields did not "fit" my professional model.

My search led me to study in a related field, art education. I did not learn about the one program in the country that offered art therapy courses—Hahnemann Medical School in Philadelphia—until I was almost finished with my doctoral studies in art education at Indiana University. By then it was better to finish my work at Indiana University.

A year later in 1969, I heard of the founding meeting of AATA and went.

I am flooded with images from that founding meeting on June 27, 1969 at the University of Louisville in Kentucky. I remember that day vividly. The meeting was held in a room in the University College Building. There were about 50 in the room. I remember someone standing up and saying something like, "Well, we all know why we are here! This is the founding meeting of the American Art Therapy Association. Do we have suggestions as to who will fill the various offices?" At that point, people began to suggest names for various offices, and these were written on a green chalkboard. There was a general consensus as to who was to fill what office. I remember someone stating that Sandra Kagin (Graves) had agreed to fill the office of Education Chair—and that she was interviewing for a job at that very moment on the University of Louisville campus.

I knew only one person in that room: Ms. Dorothea Lange who was the Director of Activity Therapy at Our Lady of Peace Hospital in Louisville. I had met Ms. Lange while doing research on a seminar paper on art therapy for one of my doctoral classes at Indiana University. Ms. Lange, knowing of my work, wanted to nominate me for Research Chair. I did not feel at all qualified and begged off. When all the positions of the newly formed AATA Board were filled the meeting was adjourned. I remember offering to serve as cab driver to help those who needed to make transportation connections. I took one attendee to the bus station. I do not remember this woman's name but in retrospect she looked very much like Edith Kramer, and spoke with a German accent. She told me she had come all the way from New York City by bus to be at the meeting.

I remember seeing a brief (about one inch long) report in *The Louisville Courier Journal* the next day. The headline read: "Art Therapy Organization Formed." The rest is history.

Some time later after completing our graduate work, Sandra Packard, a colleague and fellow doctoral student at Indiana University, and I discovered our mutual interest in art therapy. When I visited Sandra in 1975, we debated the antecedents of both fields and ended up mapping the content for an article that was published in the *American Journal of Art Therapy* which we titled, "A Shared Identity Crisis: Art Education and Art Therapy" (Packard & Anderson, 1976).

That same year I was invited to be a part of a general session panel at the 1976 AATA Convention in Baltimore, Maryland. The panel discussed the origins and precursors of the field. As a part of my remarks I asked members of the audience to raise their hands if they had come into art therapy from an art education background. Three-fourths of the audience of over 800 raised their hands (Anderson, 1977). My point had been graphically made—that art therapy needed to acknowledge some of its roots from the field of art education. Today I want to ask that same question because I think it is important to know our heritage and to "own" it. Would those of you who have come from an art education background please raise your hands? (About one quarter of the audience raised their hands.) I think the major difference between 1976

1064

and 1990 is that now there are over 20 AATA-approved training programs in this country and Canada.

I want to also state that had it not been for my training in research and scholarship in an art education graduate program, I would not have had the preparation to conduct all those research studies, to write all those articles, grants and monographs. And had it not been for a mentor at Indiana University (the late Mary Rouse) who instilled in me a missionary zeal and passion for documenting with hard data what we as art professionals know—that art therapy works—some research would never have been undertaken, for instance the first survey in 1974 of Mental Health Agencies and Hospitals in Illinois and Los Angeles and the job potential for art therapists (Anderson & Landgarten, 1974; 1975). Or the nationwide evaluation project for Very Special Arts in Washington, D.C., in 1984 that documented with hard data that the Very Special Arts Festival programs were one of the only places where handicapped persons could participate and be integrated with nonhandicapped persons (Anderson & Morreau, 1984; Anderson, 1986; Anderson, 1991).

I want to add another more personal note to encourage art therapists to engage in research of all kinds so that the body of knowledge in art therapy can grow. I also want to encourage art therapists to consider a career in teaching. There has been great concern expressed by art therapy educators as to where the next generation of university teachers will be found. I urge the new generation of art therapists to seriously consider teaching. It's the hardest job you will ever love.

I want to further encourage this group of bright and gifted art therapists to consider undertaking doctoral studies in rigorous traditional institutions of higher education. All the universities of which I am familiar do not permit someone with a master's degree to teach graduate courses. Additionally, doctoral dissertation research in art therapy will further the knowledge base of art therapy in a systematic way with deliberate speed.

Lest you think that this charge is impossible or unattainable, I will add a personal note about my own experience in graduate school. I did so poorly on my own Graduate Record Examinations that I was conditionally admitted to Indiana University. Few endeavors in the academic world have ever come easily for me. I am a very slow reader and writing is a very slow and difficult task for me. The reasons for these difficulties were not apparent until ten years ago when, as part of the treatment of a head injury due to an auto accident, I discovered that I had a learning disability. I was told by the Harvard University psychologist who did the evaluation that if I were entering public schools that year (1980), I would qualify for special education services.

So I must add, *if I can do it, you can do it*! I also am aware of a great deal of test anxiety that surrounds issues related to licensure and certification for art therapists. This has been evident in the sessions during this conference that have included discussions of the prospects of having a national certification test for art therapists. I again say . . . if I can do tasks related to writing and testing, *you can do these tasks also*!

Finally, I must acknowledge that because of my own upbringing which instilled in me the rubric that "one never toots one's own horn," it is difficult to "own" things that I have accomplished. So I have some difficulty owning this award. You see my life and actions have been governed by the statement made by a primitive tribesman, "We have no word for art, we do everything as well as we possibly can." My profound hope and aim is that this philosophy will continue to govern all my actions. Thank you.

References

Anderson, F.E. (1977). Art therapy: an exploration of definitions, art therapy and art education. In R. Shoemaker and S.E. Gonick-Barris (Eds.) *Creativity and the art therapist's identity, Proceedings of the Seventh Annual Conference of the American Art Therapy Association, Baltimore, Maryland, October 28-31, 1976*; (pp. 90–95). Pittsburgh, PA: American Art Therapy Association.

Anderson, F.E. (1991). Evaluating the Very Special Arts festival programs nationwide: An attempt at combining subjective and quantitative approaches, *Evaluation and Program Planning: An International Journal, 14*, 99–112.

Anderson, F.E. & Morreau, L. (1984). *The Very Special Arts festival programs of the National Committee—Arts for the Handicapped*. Washington, D.C.: Very Special Arts.

Anderson, F.E. (1986). *The very special arts evaluation project: Phase two: Final report*. Washington, D.C.: Very Special Arts.

Anderson, F.E. & Landgarten, H. (1975). Art in mental health. *Studies in Art Education, 15* (3), 45–56.

Anderson, F.E. & Landgarten, H. (1974). Survey on the status of art therapy. *American Journal of Art Therapy, 14* (4), 40–51.

Packard, S. & Anderson, F.E. (1976). A shared identity crisis: Art education and art therapy. *American Journal of Art Therapy, 16* (3), 21–28.

REVIEWS

Dreams in Analysis

***Nathan Schwartz-Salant** and **Murray Stein (Eds.)**, (1990) Wilmette, IL: Chiron Publications. $15.95, with black and white illustrations.*

*Reviewed by: **Vija B. Lusebrink, Ph.D., A.T.R.**, Professor, Expressive Therapies, University of Louisville, Louisville, KY.*

Dreams in Analysis is a thoughtful and thought-provoking book for the psychotherapist versed in Jungian concepts and approach as well as for the novice.

The book consists of eight main chapters, five of which (by Whitmont, Stein, Kirsch, Humbert, and Barz) deal with the main concepts of Jungian dream analysis. Two chapters cover topics related to the archetypal feminine (Meador) and nuclear warfare in dreams (Redfearn). One chapter (Perera) presents a conceptual framework for dealing with dream cognition through the analogy of the non-linear pattern of Celtic designs.

Whitmont differentiates between easily decipherable dramatic exhibition dreams which can be seen as metaphors, and dream dynamics which can be only intuited, thus indicating their symbolic nature. According to Whitmont, the Jungian approach presumes that "each dream dips into basic existential pattern or archetypal motives" (p. 8), whereby the dream constitutes a bridge to the archaic level. Dream interpretation is seen as inadequate if it does not bring into awareness new insights. Whitmont also points out that dream interpretation requires adequate ego functioning and some self-introspective quality.

Stein, in reflecting on dreams and history in analysis, highlights complexes as the building blocks of the personal unconscious; at the same time, they possess an archetypal core.

Thus dreams represent personal history, as well as symbolically reflect the psyche's drive for wholeness. One of the main axioms of analytical psychology is that the unconscious assimilates experience by comparing it to the past; thus dreams use history as a metaphor clarifying the present. In a therapeutic transformation the memory structures and affective patterns are changed. Stern gives the example of toilet dreams as an indication of a need for change. According to Stein, the ego-syntonic material needs to renew itself through the contact with the archetypal layer of psyche. This need is counteracted by the separation anxiety of letting go of personal history. The contact with the archetypal substratum transforms personal history into personal myth.

Perera examines dream design through an analogy to the designs and forms of Celtic art and mythology. Dreams interweave pertinent information from past, present, and future, based on the individual, socio-cultural, and archetypal dimensions. The eternal archetypal energy pattern which underlies the complexes may be expressed by the analysand in visual notations. According to Perera, Celtic designs provide a metaphor or a guide for the nonlinear levels of cognition which reflects the underlying contextual and emotional processes of the archetypal patterns. Perera discusses the designs of spiral, maze, interlacing, and double spiral interlace as conceptual templates for relating to dream cognition.

The dream may appear at first like a chaotic maze, but it eventually reveals its center. The interlace pattern assists to find a "psychologically meaningful crossing point between associations, explanations and amplifications" (p. 59). The double spiral interlace represents the union of opposites, and integrates the personal complex with the archetypal image.

Kirsch, in his chapter on a pedestrian approach to dreams, considers changes in his attitude towards dreams in analysis over the past 25 years. Kirsch's emphasis is on the affect present in all the analysand's expressions, since, in his view, emotions tap into the archetypal psyche. Resistances can be manifested as long and complicated dreams without a particular thread, or as an intruder or other circumstances which keep the analysand from communicating to the therapist. Kirsch emphasizes the importance of the first association. He also discusses Matton's paradigm of correct dream interpretations, namely, whether the dream "clicks" with the analysand and acts for him/her in bringing a new vitality in the therapeutic relationship; whether it is confirmed by subsequent dreams; and whether the interpretation is followed through with actions and occurences in the dreamer's waking life.

Humbert emphasizes dream experience as a lived experience during dreaming, whereas the dream sequence forms memories which then can be reviewed or told as a narrative to others. The dream provides access to a superior part of the psyche and thus activates "unsuspected potentialities" of it which then are translated in the framework of social and cultural norms. The integration of the plural parts of self acted out in dreams takes place in daytime consciousness.

Barz applies psychodrama methods to dream work in a Jungian frame of reference. The psychodrama is played following the Protagonist's conscious dream content, while the co-players contribute their feelings, associations, and ideas similarly to the analyst in individual therapy. The observation of the ritualistic format of psychodrama creates a *participation mystique* among the participants. In this procedure the Protagonist's Self is not projected on the group, but emerges as an autonomic dynamic experience based on the group's definition of a symbol.

Meador's chapter on "Forward into the Past" explores the archetypal feminine based on Goddess images from Paleolithic and Neolithic cultures. Meador points out that much of this art was created by women, whereby the goddesses were portrayed as rulers of fertility and givers of life and death. The contemporary woman needs to reestablish a connection to the unconscious archetypal matrix of her psyche with the assistance of archetypal images in dreams. The psychological conflict in woman is related to her body and its functions which are seen as obstacles to creativity instead of being "imbued with a divine meaning." A part of her still may feel like an abandoned little girl, living in an "animus prison." The connection with the feminine Self leads to the healing of the injured child, and emergence of a new animus.

Redfearn deals with the topic of nuclear warfare in dreams as opposing forces within the psyche of the dreamer. These forces can shatter the defenses, but if this struggle is brought on a conscious level, it can lead to a stronger and enriched personality. The shattering effect of the dream is felt by the ego like the end of the world; at the same time, it can be experienced as a moment of truth.

Examples of dreams presented throughout the chapters illustrate the conceptual discussions. The visual examples of Celtic and Neolithic art elaborate on the concepts presented by Perera and Stevens. The chapter on book reviews by Cwik is very useful in that it summarizes a number of works of analytical psychology on dreams, as well as provides comparative overview of other approaches. The two brief chapters by Stevens and Corbett as discussions of two other chapters do not add much to the overall view of the book.

Dreams in Analysis presents rich material; several of the chapters reveal additional insight on rereading them, especially those by Perera and Stein. Humbert's chapter raises interesting questions about dream consciousness, but at times it is harder to follow than the others, possibly due to its translation from French. The chapter by Stein stands out in that it deals with the role of personal history. Not every dream is indicative that the archetypal level of the psyche has been activated, as seems to be implied in most of the material covered.

The information covered by the different authors addresses different functions of dreams. For example, Whitmont states that dreams integrate past information while Humbert contends that dreams are "explicit dramas" in which the integration takes place in daytime consciousness. An overview by the editors of the material covered in the book could have bridged the different aspects presented; a subject index would have helped the reader to locate these aspects in the different authors' work.

As an art therapist who is familiar with the power of images, especially archetypal images, and the reciprocal influence of their external representations on the psyche and dreams, I have an additional thought. Books like the present work would benefit from a Jungian viewpoint of the perceptual activation of the client's psyche through the exposure in visual and other modalities to archetypal and mythological images. Through works of art, myths, and rituals, such images have spoken to the human psyche through millenia, and still are capable of evoking strong responses even in individuals with a limited capacity for insight. Sophisticated therapists are not the only ones who can resonate with mythic, visual images.

As a therapist who is not a Jungian analyst, but has a strong interest in and knowledge of Jungian thought, I can recommend this book as a rich source of information for approaching and working with the archetypal healing layer of the psyche.

1067

Art as Technology: The Arts of Africa, Oceania, Native America, Southern California.

*ʼ**Arnold Rubin** (1989). Beverly Hills, CA: Hillcrest Press, 184 pages. ISBN 0-914589-0-4-0*

Reviewed by: ***Phoebe Dufrene, Ph.D., A.T.R.,*** *Assistant Professor of Art and Design, Purdue University, West Lafayette, Indiana*

Arnold Rubin's *Art as Technology: The Arts of Africa, Oceania, Native America, Southern California* examines the structures relevant to the production and use of art within a cultural context. Similarities and differences between the arts of Africa, Oceania, Native America and Southern California are analyzed through social, political, and economic systems. Instead of using terms like Primitive Art, Exotic Art, Traditional Art, Folk Art, and Tribal Art, Rubin uses geographical terms that are more neutral.

The text stresses the cultural systems that both shape art and are conversely shaped by art. This approach of understanding other cultures through their art, beliefs, and behaviors emphasizes the research of social scientists.

> However, the focus is art, and the points of departure and destinations will always be objects, where they come from, why they look the way they do, and what they mean. Objects are records of cultural process, and they provide direct, unmediated access to the values and experiences of their producers—if we know how to read them. (p. 12).

The author feels that 20th century European Cubists and Expressionists used non-Western art objects as a means of aesthetic exploitation. Instead of using non-Western art objects for insightful or informative purposes, French Cubists and German Expressionists used non-Western arts as "found objects" comparable to scraps of mass-produced industrial materials. Rubin deplores the fact that few European artists were concerned about the cultural contexts from which the objects were produced or motivated to "try to explain why they look the way they do, to reconstruct their origins and evolutions in order to dissipate their aura of exoticism and threatening strangeness" (p. 13). Rubin offers the reader a different and controversial position that challenges the usual interpretation of African, Asian and Oceanic influences on 20th century avant-garde artists.

As a way of understanding art outside of our own culture, the author offers three relatively universal areas that delineate the ways art functions in a society. The first broad area is the establishment and proclamation of individual and group identity; the second, a didactic system that links generations in shared beliefs and behaviors, and the last, a form of technology by which people relate to their environment and secure their survival. According to this theory all art has three properties: material (wood, ivory, clay, jade, etc.), motif (representational figures or abstract forms) and workmanship (the degree of capability the artist brings to the execution).

> Viewed as such, art is no longer self-contained, gratifying by itself. A function is implicit. Due attention is now given to the purposes of art, which range from concrete (healing, influencing the environment) to more abstract (unifying the community, enculturation, individual identity). Artists are now introduced as technicians and they are acknowledged and expected to be individuals who contribute to the orderly functioning of the community. (p. 17).

According to the author, the treatment of artists as technicians does not depreciate their role or status. It is a positive contrast to the "exalted" or "elite" position dominant in an industrial society that separates the artist from "the people." Rubin's stance may be criticized by those in the art establishment who prefer stricter boundaries between artist/artisan and fine arts/crafts.

In Rubin's world view the artist is a conveyer of the community's social and cultural values, a person who has the potency to effect social coherence and cultural integration. Formal and stylistic analysis is not sufficient in understanding art's social context and function. To understand art outside of our culture, *Art as Technology* asks us to consider the following questions:

> Where is it from? Who made it (the ethnic group and the artist)? Who uses it, actually and symbolically? In what social context is it used? What is it called by the people who use it? (p. 23).

A goal of this book is to search for rules and principles associated with the arts in all human societies. One of the universal factors appears to be the exploitation of both ephemeral and enduring materials. In many societies enduring materials such as skeletal remains, crystals, sea shells, and cast metal are chosen for intrinsic symbolic content. Body art, often ephemeral, is connected with conceptions of individual identity and group membership. Body art has a "function in helping to choregraph relationships between individuals and groups—a major mode of non-verbal communication" (p. 28).

The West African Fulani aesthetic system is oriented toward the body. At annual ceremonies, young men participate in a male beauty contest. The body is painted and adorned "to the point that a blurring of boundaries between male and female systems of dress and adornment is considered to enhance their attractiveness rather than diminish it." (p. 70).

Also ephemeral are the dry paintings of colored sand and other powdery materials executed by the Australian Aborigines and Navajo Indians. Navajo dry paintings are created in connection with curing procedures in which the patient sits on the sand composition, absorbing the energy and thereby "destroying" the painting.

Also found throughout the world are containers associated with women's art activities such as basketry and pottery, often extending to responsibility for erecting shelter as well. Consistently found on containers throughout the world is geometric, non-representational ornamentation. Containers tend to be relegated to a lower level of significance, as craft rather than art because of their utilitarian functions.

Rubin dismisses art historians who erroneously describe these geometric designs as purely ornamental and asserts that the designs have cultural content and philosophical meaning associated with the primacy of centering, dynamic balance of complicated elements within the design field, and a striving to harmonize the natural world. The designs are described as representations of spirit principles or shamanic helpers and are used to solve the general problem of representing spiritual entities in art.

The technological shift from an itinerant to a sedentary way of life also influences art production. The extension of textile motifs and techniques to works in other media can be traced to this shift. When containers did not have to be carried long distances there was a transition from basketry to pottery. The transition from itinerant hunting and gathering to sedentary cultivation also led to the emergence of permanent public works such as architecture, roads, and an expanded material culture.

The geometric symbolism that began with the presedentary life style continued during the technological transition and is evident today in Native American Southwest pottery and architectural motifs that identify villages. Modern potters such as Maria Montoya Martinez, Lucy Lewis, and Nampeyo created new forms based on old traditions.

Throughout *Art as Technology* the author discusses the phenomena of cultural confluence, "the blending of previously distinct cultural streams and the effects of that blending on the arts" (p. 124). The Native American Athapascan experience is one of the examples cited by Rubin for studying cultural confluence. Athapascan art in the Far North is influenced by Inuits (Eskimos), but also reveals some divergence. Athapascan interaction with North West Coast peoples and those of the Great Lakes also shows a combination of influence and divergence. Southwest Athapascans (Navajo and Apache) also reveal selectivity. Weaving and dry painting were borrowed from the Pueblos but among the Navajo these weavings were done by women rather than men.

Also documented as an example of cultural confluence is the West African Asante nation. Aspects of their art are borrowed from the Niger Bend in the north and other tribes in the east, south, and west. Asante art and culture has survived intact despite colonialism. The emergence of the Asante nation into preeminence was partly due to their synthesis of diverse elements as evident in the king's regalia. His kente cloth is made of rewoven Chinese silk traded by the Portugese. His thrones are derived from European chairs and his royal parasols from Islamic states. Gold ornaments that are reflections of the Asante king's wealth and political power are "analogous to jade among the Maya and Maori; their forms relate to proverbs, aphorisms, and other elements of folklore and traditional wisdom" (p. 124).

Rubin's premise is that favorable conditions and an ethnic balance give cultures time and latitude to adjust and adapt to alien cultural forms. Under positive circumstances, confluence can approach the utopian scene painted on a 16th century Peruvian wooden beaker in which a Spanish trumpeter, African drummer, and Indian official share equal ground. However, the Plains Indians were not given sufficient time by European expansionism to successfully adapt to change and their culture suffered extreme devastation.

Cultural confluence had an impact on the late 19th century revival of traditional Maori art. The rounded, volumetric approach to form and a restrained use of ornamental detail typical of older works changed to an icy brilliance, a profusion of decorative details, and a conventionalized perfection, although the basic system remained intact: large heads, bowed limbs, and complex arrangements of forms and ornamentation.

Other Oceanic art, such as the Australian Aborigine has not been greatly influenced by outside factors. Among the Australian Aborigine, direct association with nodal sites, contact with one's ancestors, and sources of creation inspire the more ephemeral arts of singing, dancing, and body painting. Body painting renews and revitalizes the Dreamings (demiurges whose movements and activities produce the landscape); it is an expression of territoriality and cultural heritage through generations.

Throughout Rubin's book, he emphasizes the impact of society on art. He discusses how centralized societies reflect specialization at all levels and subordination of the individual to the social order. A sense of collective identity beyond the community is enforced through direct administration in which the arts play major roles. Large-scale projects and glorification of the worldly dominate the arts. Representational portraiture emerges to document historical occurrences such as births and deaths of the elite, battles, and political alliances.

These characteristics of centralized societies are evident among Mayan art in southern Mexico and Quatemala. At one time, historians thought that Mayan inscriptions and art depicted deities and myths. Later evidence revealed that most of Mayan art is dedicated to the glorification of the ruling elite. Their battles, marriages, alliances, and tributary relationships were propagandized through public art works that reinforced their elite status.

Modern Hispanic culture in southern California is a combination of indigenous Mexican Indians and their Spanish conquerors. The Los Angeles Hispanic "Day of the Dead" parade recalls traditional Mexican rituals. Death is celebrated as a reinforcement of the continuity between the living and their ancestors. Other forms of cultural continuity are expressed in the Mexican mural tradition that interprets the Pre-Columbian, Colonial, and Modern phases of life. Symbols and motifs drawn from many sources are used to interpret traditional, historical, and present events, thus creating a contemporary collective identity that unifies the Hispanic population.

An important premise that permeates *Art as Technology* is the usefulness of studying the art of all cultures. Art directs us to the heart of a community's values and reveals how successfully or poorly it functions. African, Oceanic, and Native American art reinforces networks of collective responsibility, however different the forms may appear to those of us outside some or all of those cultures. Rubin does an excellent job of enticing us to delve deeper into culture areas that we may be unfamiliar with.

African, Oceanic, and Native American combinations of art, architecture, music, and dance are most concerned about people—their values, beliefs, and behavioral conventions within a community rather than about objects per se. Anthropologists and other social scientists have a history of exploring these concerns. Recently, humanities scholars have combined the methods and perspectives of art history with those of anthropology in order to better understand African, Oceanic, and Native American art.

> Consciously, willingly, unconsciously or unwillingly, every person can and does participate in a web of decision-making about art and material culture analagous to that which has been at the core of this book. That is, moreover, not a remote, esoteric abstract phenomenon of the sort usually termed "aesthetic." Rather, it is bound up with every community's most fundamental social, political, economic and spiritual values. (p. 162)

Art as Technology was written as a supplement to Rubin's UCLA art history class prior to his death. Rubin attempted to add the technological model to further understand art across cultures. The experiences of other peoples offer essential information on available options for our own developing cultures. Rubin's technological model is a way of uniting people's cultures through time and space.

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

THE ORGANIZATION

The American Art Therapy Association (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3000 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice. AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliated Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive

Publications

- *Art Therapy*, the official journal of the AATA.
- The quarterly *AATA Newsletter*.
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- Free AATA literature, such as Educational Porgrams List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payers.
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy.

Professional Standards

- Development of model job and licensure laws.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

GENERAL MEMBERSHIP APPLICATIONS

1. The membership year is the calendar year January 1st through December 31st.

2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY. Please follow the chart below when submitting membership application.

Applications received between

Jan. 1st and May 31st—Full dues payment. Membership will expire Dec. 31st of same year.

June 1st and Sept 30th—Half year dues plus $5.00 payment, membership will expire Dec. 31st of same year.

Oct. 1st and Dec. 31st—Full dues payment, membership for the remainder of current year and the next full year through Dec. 31st.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval.

4. AATA Membership and AATA Registration (A.T.R.) each have a separate application procedure. Registration is bestowed only the Standards Committee.

5. National AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL—by application only; such members may vote, hold office and serve on committees.

Credentialed Professional Member: Individuals who have been dually approved for Professional Membership and Registration (A.T.R.) by the AATA; dues are $80 per year.

Active Professional Member: Individuals who have completed professional training in art therapy; dues are $75 per year.

CONTRIBUTING—Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $100 per year.

ASSOCIATE—Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75 per year.

STUDENT—Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Student members may not vote or hold office but may serve on the Student Subcommittee of Membership. Dues are $35 per year.

The American Art Therapy Association, Inc.
1202 Allanson Road • Mundelein, IL 60060 • (708) 949-6064

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(708) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapist's Indentity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) 110 pages	$15.00	$20.00
Art Therapy: Professionalism in Practice (1988) 127 pages	$15.00	$20.00
Painting Portraits: Families, Groups & Systems (1989) 141 pages	$15.00	$20.00
American Psychiatric Association Special Conference Proceedings *Use of the Creative Arts on Therapy (1979)*	$5.00	$7.00
Art Therapy in the Schools	$6.00	$10.00

*NOTE: for **Publications** postage/handling, add $3.00 for the first unit item, $ .75 each additional unit.

SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS.

** Foreign Orders: Require pre-payment for items and then will be billed for shipping charges as you instruct on order:

Air Mail charges (1 week delivery) or Ground Services charges (2 month delivery)

10 or more copies of any single issue: 15% discount on total cost. Discounts are available when Purchasing quantities. Set of four Proceedings (consecutive years): 20% discount on total cost.

Indicate Quantity of Unit Items Below		Cost/Unit		Total
____________	( ) X	________	=	________
____________	( ) X	________	=	________
____________	( ) X	________	=	________
____________	( ) X	________	=	________

* Publications Postage/Handling = ________ Total Publications Costs = ________

WE DO NOT ACCEPT PURCHASE ORDERS

		Members	Non-Members
Art Therapy: Journal of the American Art Therapy Association			
Subscription Rates: Individuals — U.S. $25.00; Foreign $42.00; Institutions — U.S. $36.00; Foreign $53.00			
Art Therapy: Journal - Back Issues	each	$9.00	$16.00
AATA Newsletter Subscription		—	$16.00

FILMS (Rental/Purchase)

Art Therapy: Beginnings (1977) color/sound, 45 minutes	16mm Rental Only:	$40.00	$50.00
	½" VHS, Purchase Only:	$50.00	$80.00
Michael (1977) color/sound, 12 minutes	16mm Rental Only:	$30.00	$35.00
	½" VHS, Purchase Only:	$50.00	$80.00
Art Therapy (1981) color/sound, 12 minutes	16mm Rental Only:	$35.00	$45.00
	½" VHS, Purchase Only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery (1978) color/sound, 32 minutes	16mm Rental Only:	$40.00	$50.00
	½" VHS, Purchase Only:	$50.00	$80.00

*NOTE: for **VHS Films Purchase** postage/handling add $2.50 for each film

*NOTE: for **16mm Rental** add $7.00 for postage/handling

Indicate Quantity of Unit Items Below		Cost/Unit		Total
____________	( ) X	________	=	________
____________	( ) X	________	=	________

*Films Postage/Handling = ________ Total Films Costs = ________

ORDER FORM: ***Make checks payable in U.S. funds to AATA, and mail to the above address***

SEND TO: ______________________ MBR. ID. NO. ____________

____

____

City State Zip Code

WE DO NOT ACCEPT PURCHASE ORDERS

BEST COPY AVAILABLE

Books by Rawley Silver, Ed.D, A.T.R, HLM
now available from
Ablin Press Distributors
3332 Hadfield Greene, Sarasota, Fl 34235

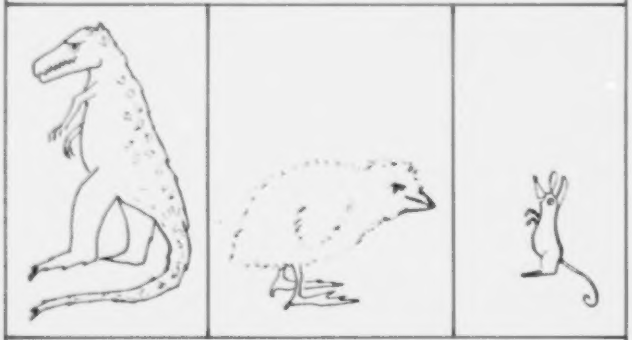
___*DEVELOPING COGNITIVE & CREATIVE SKILLS THROUGH ART* Third Edition, Revised $24.95

____*DRAW A STORY: SCREENING FOR DEPRESSSION AND EMOTIONAL NEEDS* $19.95

____*STIMULUS DRAWINGS & TECHNIQUES* Fourth Edition, Revised $19.95

SILVER DRAWING TEST OF COGNITIVE SKILLS AND ADJUSTMENT Second Edition, Revised

_____Complete Battery	$39.95
_____Manual only	$27.95
_____Expansion set	$15.95



Please Enclose Payment with Order

Name_______________________________
Address_____________________________
City________________State_____Zip_________

*Books*_________
Postage and handling _________
($2.00 4th class, $3.50 priority mail)
Tax (Florida residents)_________

*Total Enclosed*_________

LOOKING FOR JUST THE RIGHT WORDS TO DESCRIBE A CLIENT'S BEHAVIORS?

You'll find them in **The Clinician's Thesaurus 2E**. You can tailor your narratives choosing from 17,000+ descriptive terms and standard phrases for all aspects of psychological and social evaluations.

Perfectly organized for easy access, to prompt your recall of a client, to stimulate your thinking, and to sharpen your writing. It offers hundreds of descriptors for Mental Status and cognitive functioning, words and phrases for Behavioral and Interpersonal Observations, Affects, ADLs, Vocational, Recreational and Social Functioning, all Personality Disorders, Diagnoses, Prognoses, Closing the report, Recommendations, Confidentiality Notices, and more handy items.

Suitable for older children and adults, and any orientation or evaluation purpose. Ideal for students and refreshing for the senior practioner. 16,000+ sold. Order today and you will have it in 2 weeks with a money back guarantee of satisfaction. $23.50 includes shipping to Three Wishes Press AT1, Box 81033, Pittsburgh, PA 15217 *Thanks*

1991 AATA
MEMBERSHIP DIRECTORY

✸

Now Available through the National Office
($2.90 Postage & Handling)
$10.00 member **$50.00** non-member
$100.00 institution

NAME ______________________________
ADDRESS ___________________________
CITY ______________________________
STATE ______________ ZIP ____________

▲ *Mail entire form to:* ▲
AATA NATIONAL OFFICE
1202 Allanson Rd./Mundelein, IL 60060

CHARLES C THOMAS • PUBLISHER

☐ Chandler, Louis A. & Virginia J. Johnson—**USING PROJECTIVE TECHNIQUES WITH CHILDREN: A Guide to Clinical Assessment.** '91, 140 pp. (7 × 10), 13 il., 1 table, About $25.75.

☐ Hardy, Richard E.—**GESTALT PSYCHOTHERAPY: CONCEPTS AND DEMONSTRATIONS IN STRESS, RELATIONSHIPS, HYPNOSIS, AND ADDICTION.** '91, 142 pp. (7 × 10), about $25.50.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¼), 21 il., $32.75.

☐ Harman, Robert L.—**GESTALT THERAPY DISCUSSIONS WITH THE MASTERS.** '90, 198 pp. (7 × 10), $34.75.

☐ Boy, Angelo V. and Gerald J. Pine—**A PERSON-CENTERED FOUNDATION FOR COUNSELING AND PSYCHOTHERAPY.** '90, 234 pp. (7 × 10), 2 il., about $41.75.

☐ Hosford, Bowen—**WINNING IN YOUR PROFESSION BY WRITING BOOKS: A How-To Book for Professionals in the Biomedical and Behavioral Sciences and the Law.** '90, 212 pp. (7 × 10), 9 il., $36.75.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¼), 56 il., $42.25.

☐ Felthous, Alan R.—**THE PSYCHOTHERAPIST'S DUTY TO WARN OR PROTECT.** '89, 194 pp. (8½ × 11), 6 tables, $39.50.

☐ Dennison, Susan T.—**TWELVE COUNSELING PROGRAMS FOR CHILDREN AT RISK.** '89, 430 pp. (7 × 10), 55 il., $71.25.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (7 × 10), 34 il., $42.25.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $49.25.

☐ Gutsch, Kenneth Urial—**PSYCHOTHERAPEUTIC APPROACHES TO SPECIFIC DSM-III-R CATEGORIES: A Resource Book for Treatment Planning.** '88, 276 pp. (7 × 10), $44.50.

☐ Nucho, Aina O. — **THE PSYCHOCYBERNETIC MODEL OF ART THERAPY.** '87, 248 pp. (6¾ × 9¼), 50 il., 4 tables, $42.00.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $30.00.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $40.00.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $27.25.

☐ Schwenn, John O., Anthony F. Rotatori and Robert A. Fox—**UNDERSTANDING STUDENTS WITH HIGH INCIDENCE EXCEPTIONALITIES: Categorical and Noncategorical Perspectives.** '91, 270 pp. (7 × 10), 4 il., 15 tables, about $39.75.

☐ Pine, Vanderlyn R., Otto S. Margolis, Kenneth Doka, Austin H. Kutscher, Daniel J. Schaefer, Mary-Ellen Siegel, & Daniel J. Cherico—**UNRECOGNIZED AND UNSANCTIONED GRIEF: The Nature and Counseling of Unacknowledged Loss.** '90, 190 pp. (7 × 10), $34.75.

☐ Chaika, Elaine Ostrach—**UNDERSTANDING PSYCHOTIC SPEECH: Beyond Freud and Chomsky.** '90, 342 pp. (7 × 10), $53.75.

☐ Lester, David—**UNDERSTANDING AND PREVENTING SUICIDE—New Perspectives.** '90, 148 pp. (7 × 10), About $26.75.

☐ Ho, Man Keung—**INTERMARRIED COUPLES IN THERAPY.** '90, 156 pp. (7 × 10), 2 il., $29.75.

☐ Haig, Robin A.—**THE ANATOMY OF GRIEF: Biopsychosocial and Therapeutic Perspectives.** '90, 170 pp. (7 × 10), about $34.75.

☐ Harman, Robert L.—**GESTALT THERAPY WITH GROUPS, COUPLES, SEXUALLY DYSFUNCTIONAL MEN, AND DREAMS.** '89, 162 pp. (7 × 10), $35.00.

☐ Farmer, James A.—**POSITIVE INFLUENCE: A Practical Guide for Dealing With Teenage Aggression.** '89, 100 pp. (7 × 10), $25.25.

☐ Geldard, David—**BASIC PERSONAL COUNSELING: A Training Manual for Counselors.** '89, 214 pp. (7 × 10), 28 il., $32.75, paper.

☐ Gregg, Charles H., Judy L. Robertus & J Blair Stone—**THE PSYCHOLOGICAL ASPECTS OF CHRONIC ILLNESS.** '89, 344 pp. (7 × 10), 7 il., 15 tables, $54.75.

☐ Crespi, Tony D.—**CHILD AND ADOLESCENT PSYCHOPATHOLOGY AND INVOLUNTARY HOSPITALIZATION: A Handbook for Mental Health Professionals.** '89, 162 pp. (7 × 10), 1 table, $35.00.

☐ Jewell, David L.—**CONFRONTING CHILD ABUSE THROUGH RECREATION.** '89, 358 pp. (7 × 10), 1 il., 28 tables, $59.25.

☐ Lester, David—**SUICIDE FROM A SOCIOLOGICAL PERSPECTIVE.** '89, 138 pp. (7 × 10), $30.75.

☐ Dennison, Susan T.—**ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents.** '88, 236 pp. (7 × 10), 36 il., 26 tables, $40.00.

☐ Haig, Robin Andrew—**THE ANATOMY OF HUMOR: Biopsychosocial and Therapeutic Perspectives.** '88, 224 pp. (7 × 10), 6 il., 3 tables, $36.25.

Books sent on approval • Catalog sent on request • Write, call (217)789-8980 or FAX (217)789-9130

2600 South First Street Springfield • Illinois • 62794-9265

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association

ADVERTISING RATES

RATES	1x	2x	3x
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140

SPECIAL POSITIONS	additional
Cover #2 (Inside Front)	$130
Cover #3 (Inside Back)	130
Cover #4 (Outside Back)	165

COLOR RATES: Standard Red, Blue and Yellow (Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x
Per page additional	$90	$85	$80

INSERTS	1x	2x	3x
2 pp	$ 800	$ 700	$ 575
4 pp	1,500	1,300	1,150
8 pp	2,200	2,000	1,750

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size:	8-1/2" x 11"
Bleed Size:	8-5/8" x 11-1/4"
Inserts:	8-5/8" x 11-1/4"

SUBMISSION DEADLINES:

January 7 for March issue; April 7 for June/July issue; September 7 for November issue

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, IL 60060
(708) 949-6064

ART
THERAPY
Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $25 (US); $42 (Foreign). Institutions: $36 (US); $53 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9 member; $16 non-member. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1991. Enclosed is my check, payable to AATA, for $25.
Name ______________________________
Address ______________________________
City ______________________ State __________ ZIP ____________

The interdisciplinary journal
devoted to the creative arts as healing arts.

THE ARTS
IN PSYCHOTHERAPY
An International Journal

ARTS PSYCHOTHERAPY

FREE SAMPLE COPY
AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Associate Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

PERGAMON PRESS
Maxwell House, Fairview Park, Elmsford, NY 10523
Headington Hill Hall, Oxford OX3 0BW, England
Member of Maxwell Macmillan Pergamon Publishing Corporation

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions to the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

Editors welcome original manuscripts. Submit papers in triplicate to: Managing Editor, Sylvia Halpern, 20 Ridgecrest East, Scarsdale, NY 10583

SUBSCRIPTION INFORMATION

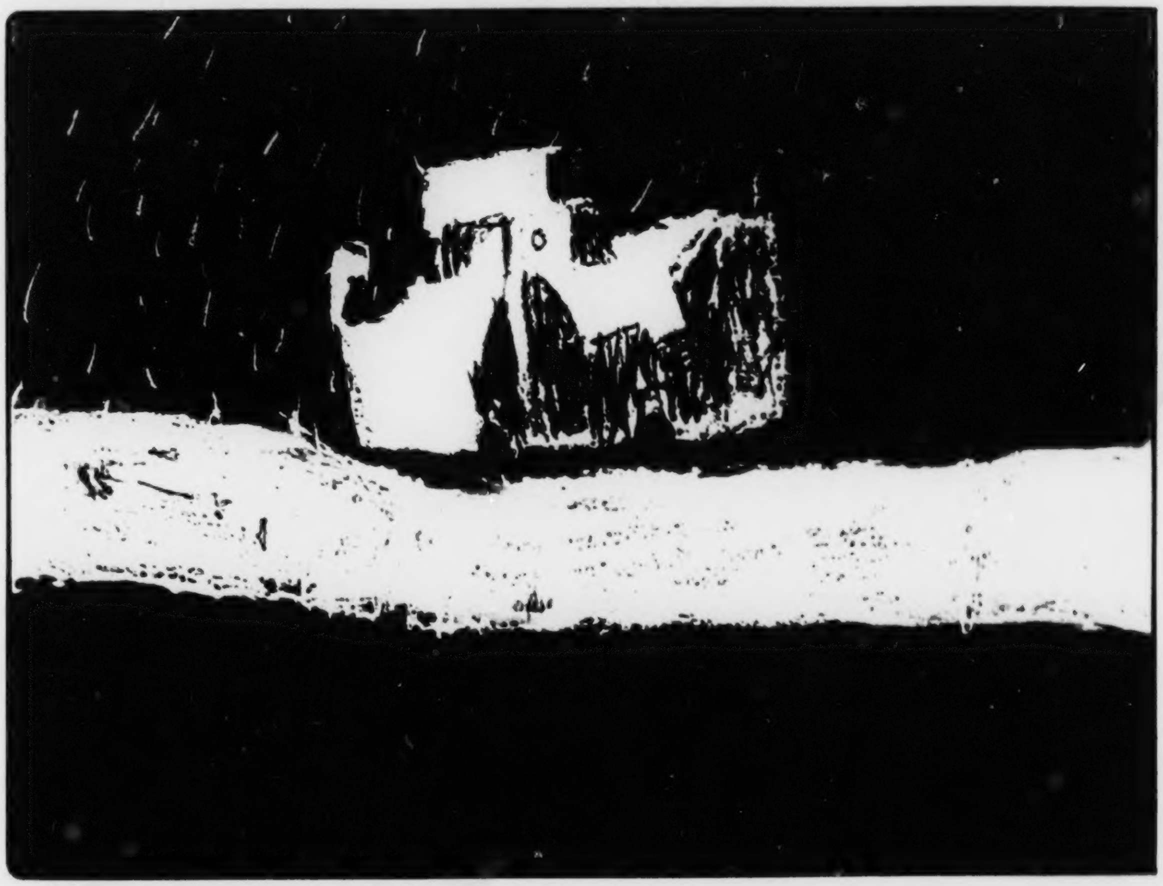
ISSN: 0197-4556	Volume 17, 1990
Published 4 issues per annum	
Annual Institution Subscription Rate (1990)	US$130.00
Two-year Institution Rate (1990/91)	US$247.00
Professional Rate (1990)	US$ 40.00
Student Rate (1990)	US$ 16.00

BEST COPY AVAILABLE

ART THERAPY

Volume 8, Number 2
Autumn 1991

Journal of the American Art Therapy Association



- Couples Therapy/Art Therapy: Strategic Interventions and Family of Origin Work
  Shirley Riley, M.A., A.T.R., M.F.C.C.
- An Informal Survey of Assessment Use in Child Art Therapy
  Anne Mills, M.A., A.T.R. and Rachel Goodwin, M.A.
- Art Therapists' Countertransference and Post-Session Imagery
  Joanne Kielo, M.A., A.T.R.
- Comprehensive Updated 1991 Membership Survey
  Trudy Manning, M.S., A.T.R. and Raymont A. Gordon, Research Associate

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $25 (US); $42 (Foreign). Institutions: $36 (US); $53 (Foreign). Single copies are available at $9 member; $16 non-member. Printed in the U.S.

Advertising: For information, write or call the AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064.

Authorization to Copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

AATA BOARD OF DIRECTORS
1991

Linda Gantt, Ph.D., A.T.R., *President*
Robin F. Goodman, Ph.D., A.T.R., *President Elect*
Cathy Malchiodi, M.A., A.T.R., *Secretary*
Virginia Minar, M.S., A.T.R., *Treasurer*
Doris Arrington, Ed.D., A.T.R., *Director*
Shirley Riley, M.A., A.T.R., M.F.C.C., *Director*
Deborah Good, M.A., A.T.R., *Director*
Dean Wilson, Ph.D., M.F.C.C., A.T.R., *Director*
Barbara Fish, M.A., A.T.R, *Affilitate Chapters*

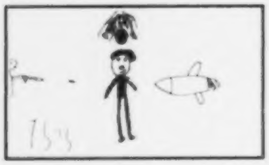
Executive Director

Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ART THERAPY

Journal of the American Art Therapy Association



Editorial

Gary C. Barlow, Ed.D., A.T.R. 2

Articles

Couples Therapy/Art Therapy: Strategic Interventions and Family of Origin Work
Shirley Riley, M.A., A.T.R., M.F.C.C. 4

An Informal Survey of Assessment Use in Child Art Therapy
Anne Mills, M.A., A.T.R. and Rachel Goodwin, M.A. 10

Art Therapists' Countertransference and Post-Session Imagery
Joanne Kielo, M.A., A.T.R. 14

Comprehensive Updated 1991 Membership Survey
Trudy Manning, M.S., A.T.R. and Raymont A. Gordon, Research Associate 20

Viewpoints

Art Therapy in a War Zone
Hannah Sherebrin, A.T.R. 30

Poems
Teddy Ramsden, A.T.R. 32

Reviews

Art and Interaction: An Academic Fieldwork Program for Colleges, An Activities Program for Institutions
Lynn Kapitan, M.P.S., A.T.R. 33

Multiple Personality Disorder from the Inside Out
Louis W. Tinnin, M.D. 34

On the Cover

"My Father's Car in the Rain" . . . a combination drawing and painting by a seven-year-old-boy in the Art Therapy Clinic, Wright State University, Dayton, Ohio.

STATEMENT OF PURPOSE

ART THERAPY is the official journal of the American Art Therapy Association. The purpose of the journal is to advance the understanding of how art functions in the education, enrichment, development, and treatment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, and research. An emphasis will be placed on the visual arts but articles in related disciplines that have relevance to art therapists will also be published.

Volume 8, Number 2 Autumn 1991

EDITORIAL BOARD

Editor
Gary Barlow, Ed.D., A.T.R.
Managing Editor
Marcia May-Chambers

Frances Anderson, Ed.D., A.T.R., H.L.M.
Michael Campanelli, Ed.D., A.T.R.
Susan Cheyne-King, M.S., A.T.R.
Carol Cox, M.A., A.T.R.
Maxine Junge, Ph.D., A.T.R.

Paulo Knill, Ph.D., A.T.R.
Wendy R. Lauter, M.C.A.T., A.T.R.
Vija Lusebrink, Ph.D., A.T.R.
Howard McConeghy, Ed.D., A.T.R.
Paul Rodenhauser, M.D.
Marcia Rosal, Ph.D., A.T.R.
Lewis Shupe, Ph.D., A.T.R.
Sandra Ticen, M.S., A.T.R.
Betty Jo Troeger, Ph.D., A.T.R.
Robert Wolf, M.P.S., A.T.R.

American Art Therapy Association, Inc. 1202 Allanson Rd., Mundelein, IL 60060 (708) 949-6064

Copyright © 1991 American Art Therapy Association

BEST COPY AVAILABLE

EDITORIAL

Included in this issue of *Art Therapy* is a variety of important and relevant articles for the art therapist. "Couples Therapy/Art Therapy: Strategic Interventions and Family of Origin Work" presented by Shirley Riley, "An Informal Survey of Assessment Use in Child Art Therapy" by Anne Mills and Rachel Goodwin, "Art Therapists' Countertransference and Post-Session Imagery" by Joanne Kielo as well as a 1991 updated Comprehensive Membership Survey compiled by Trudy Manning and Raymont A. Gordon.

In addition to these excellent articles, we have in "Viewpoints," "Art Therapy in a War Zone" by Hannah Sherebrin and two poems written by Teddy Ramsden. I hope that for future issues there are more submissions for the "Viewpoints" section; this is your chance to offer views, advice, concerns, art work and other content relevant to art therapy, and for art therapists.

A Recommended Book

The Triarchic Mind, A New Theory of Human Intelligence is a fascinating book by Robert J. Sternberg (published in 1988 by Penguin Books, 40 West 23rd St., New York 10010). "In seeking to understand intelligence," says Sternberg, "we should inhibit our desire to look in obscure nooks and crannies, and dampen our fascination with the unusual and bizarre." The author says that we should instead look in "the most obvious places—ordinary people living their everyday lives—to gain some insight into what intelligence is, how it should be measured, and how it might be improved. Most important, we need to understand that intelligence comprises those abilities that order and make the most of our daily environment, not just environments artifically created in psychologists' tests or laboratories." (p. 6)

In developing his rationale for a theory of intelligence, Sternberg looked at the major theories of intelligence that were proposed during the twentieth century. His review led to understanding of intelligence by paying attention to three things: "the internal world of the individual; the external world of the individual; and the experience with the world that mediates between the internal and the external worlds." (pp. 58–59) The convergence of this analysis of literature and the author's personal experiences led to a 'triarchic' theory of human intelligence—one that recognized and gave emphasis to these three aspects: 1) the relationship of intelligence to the internal world of the individual: components of intelligence; 2) the relationship of intelligence to the experience of the individual: facets of human intelligence; and 3) the content of intelligence: functions of mental self-management.

With questions about intelligence, a view of metacomponents and performance components, as well as knowledge-acquisition components, the author discusses applications of the triarchic view, and writes about "People's conceptions of the nature of intelligence." (pp. 230) Styles, functions and self-management—they are all included here, and give the reader a review of literature while posing important questions (such as: "Is intelligence inherited?" p. 75; "What about Gardner's Theory of Multiple Intelligences?" p. 73). I recommend the book for a revisit into the study of intelligence and what effect it may have on our own lives as well as our work in art therapy.

Odd and Ends To Think About

> "At the rate at which knowledge is growing, by the time a child born today graduates from college, the amount of knowledge in the world will be four times as great. By the time that child is 50 years old, it will be 32 times as great, and 98% of everything known in the world will have been learned since the time he [or she] was born"
>
> **Dr. Robert Helliard, US Federal Communications Commission**

> "The doubling time for information is currently five years, and because of advances in science and technology, within the next few years the doubling time for information will be reduced to approximately twenty months."
>
> **John Naisbitt**, *Megatrends*

What might we do—or what are we doing—to meet the rapidly changing society and the technological demands that are inherent in this change? What should we be doing *now* in order to be more efficient and effective human service providers in the future? How can we embrace new ways of thinking and dealing with human problems that may lead us to new insight in the delivery of services? How can we embrace the new technologies so that we can maximize their potential for our professional field of work?

We have much to learn and to do. . . .

. . . And Finally

With this issue I am bringing to a close my term as editor of *Art Therapy*. I remember our first issue (Volume 1, Number 1, October, 1983) and what a milestone for the American Art Therapy Association! Barbara Katz Mandel, 1981–83 Publications Chair, and the Journal Planning Committee, together with Vija Lusebrink, Harriet Wadeson, Sandra Packard, Anita DeVivo, Debra Bass, Scott Stoner and the A.A.T.A. staff all worked diligently to bring this new journal forward. I was brought on board to serve as Editor beginning with the second issue. Although there were some hectic and trying times in those initial stages, it was exciting to play a part in the establishment and growth of our own professional journal. Personnel changed over the years, but the excitement of the challenge has remained constant as all of us have attempted to not only build, but maintain, this highly professional quality publication in Art Therapy.

To Ed Stygar, Executive Director, and the many A.A.T.A. staff personnel who have worked diligently behind the scenes to bring forth each issue, I owe a debt of gratitude—especially to Marcia May-Chambers, Managing Editor, with whom I have worked closely during recent years. (I will miss our long "proofing the galleys" sessions by telephone!) I am sincerely grateful to our officers and the many other people in our Association who have encouraged me in my efforts, and who have offered their enthusiasm for the "look, feel, texture and soul" of the journal. To the various members of the Editorial Board, I offer my sincere thanks for their hard work, patience, and at times having too much to read, while at other times not having enough. To the countless authors who submitted manuscripts for publication, your work has been greatly valued, for each of you has helped our readership to understand and appreciate the importance of our field through your narratives, case studies, documentation and research. Poems, art work and personal concerns have piqued our interest through the "Viewpoints" section, and many persons are to be thanked for their contribution to this aspect of *Art Therapy*.

My congratulations to the new Editor, Cathy Malchiodi M.A., A.T.R. who was appointed at the A.A.T.A. Conference in Denver. Let's all offer support and encouragement to the new personnel associated with our journal, and make a personal commitment to submit that article, photograph or viewpoint in the coming year. With the American Art Therapy Association's tradition of perseverance for excellence, we will continue to produce a professional journal of which we all can be proud.

Gary C. Barlow, Ed.D., A.T.R.
Editor, Art Therapy

ART THERAPY
Journal of the American Art Therapy Association

ADVERTISING RATES

RATES	1x	2x	3x
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140

SPECIAL POSITIONS	additional
Cover #2 (Inside Front)	$130
Cover #3 (Inside Back)	130
Cover #4 (Outside Back)	165

COLOR RATES: Standard Red, Blue and Yellow (Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x
Per page additional	$90	$85	$80

INSERTS	1x	2x	3x
2 pp	$ 800	$ 700	$ 575
4 pp	1,500	1,300	1,150
8 pp	2,200	2,000	1,750

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" x 11"
Bleed Size: 8-5/8" x 11-1/4"
Inserts: 8-5/8" x 11-1/4"

SUBMISSION DEADLINES:

January 7 for March issue; April 7 for June/July issue; September 7 for November issue

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, IL 60060
(708) 949-6064

Couples Therapy/Art Therapy: Strategic Interventions and Family of Origin Work

Shirley Riley, M.A., A.T.R., M.F.C.C. Faculty: Graduate Department of Marital and Family Therapy, Loyola Marymount University, Los Angeles, California; Didi Hirsch Community Mental Health Center, Los Angeles; Clinician of the Year in Family Service, 1990, American Art Therapy Association

Abstract

Couples therapy is often focused on conflicting world views and expectations concerning male/female role assignment which had been learned in each person's family of origin. Misunderstanding and conflict arising from these issues, as well as other problems, have a tendency to lead toward rigid and nonproductive repetitive patterns of problem solving. These unacknowledged metamessages challenge the therapist in her attempts to clarify the difficulties presented by the clients.

The usefulness of the art therapy modality in making visible the covert messages and hidden edicts from the family of origin will be illustrated. Through use of art materials couples are given an opportunity to solve problems in a manner which is unique and unfamiliar. The challenge of art tasks leads the couple to problem-solving and a creative approach in mastering a change in their relationship.

"She's fat, just to embarrass me and inhibit my career." "He's thin, to spite me and he eats twice as much as I do!" "This is making our marriage a failure. How can you help us?" How many couples have come into treatment with equally impossible tasks for the therapist to solve? However, if we try not to listen to the words and just attend to the message, perhaps something can be accomplished.

Couples therapy can be exciting and challenging both for the client and the therapist. It provides a particularly creative opportunity for the therapeutic relationship. The very nature of the triadic structure of art therapy gives mobility and flexibility to the joining and destabilization processes available to the therapist. Treatment may be based on a variety of theoretical approaches; the concepts described in this paper have been the most helpful when combined with art therapy.

Theoretical Overview

These theories of family therapy have proven to be useful in the ongoing process of evolving a better understanding of how to treat couples.

I have freely translated notions from many authors of family treatment and I dare say they may be uneasy with my interpretation of their ideas, and I anticipate incorporating other concepts as I change and learn. However, I believe that most practicing therapists educate themselves in the hopes of finding a methodology that synthesizes other persons' ideas with their own ideas. The clinician then evaluates if this "grouping" of concepts proves helpful in facilitating their clients' treatment plan. In the material below I have briefly discussed some of my convictions at this time.

Family functioning is an interactional system—not in the sense of the mechanical cybernetic model—but as a human system with the power to modify patterns of behaviors. Therefore, a therapist must observe the system with sensitivity to gender issues and larger social impingements. Strategic interventions, including those which use art therapy modalities, are useful to achieve a successful outcome for some families (Riley 1988; 1990). Interventions made through an art task often help the family become aware of their redundant patterns in unsuccessful problem-solving.

In addition to strategic/systemic theories, there are multiple ways of looking at family treatment that are complementary to this philosophy of therapy. Murray Bowen (1988) provides a conceptualization of the complementary nature of relationships seen in couples work. His explanations free the therapist from seeing one or the other partner in a judgmental manner and reinforce the stance that each member of a "marriage" chooses the other for the ideal "fit" to balance out their strengths and weaknesses. This balance is not obvious to the therapist or even to themselves, but, with patience, the nature of the impeccable selection process becomes known.

I differ with Bowen's proposal that individual treatment may be as effective as family or couples work and feel strongly that the couple must be seen together. My goal is to encourage an increased individuation and differentiation for each of the relational partners. The conjoint therapy encourages and acknowledges each member's growth and the growth of the relationship. It does not either avoid or encourage the maintainance or dissolution of the marriage, which is always a possibility when change is experienced.

Bowen describes the process of differentiation from family of origin as one of the basic tasks that must be successfully completed to achieve adulthood and establish a functional, intimate relationship. The growth that he refers to is an individual's internal acceptance that he or she has developed a "real self" with values and perspectives that differ from those learned in early childhood. He further discusses how, later in life, each of us is attracted to others that have achieved similar degrees of individuation from their families of origin. On this basis we seek a more or less successful relationship. Bowen observes:

> It is the *basic* level of differentiation that is largely determined by the degree of *emotional separation* a person achieves from his family of origin. Since one of the main variables that influences how much emotional separation (and basic differentiation) a person achieves is the amount of emotional separation (and basic differentiation) his parents achieved, and since how much the parents achieved was influenced by how much their parents achieved, basic differentiation is determined largely by a multigenerational emotional process. . . . People can function at levels that are higher or lower than their basic level depending on the circumstances of the relationship system in which they are operating. (Bowen, p. 98)

Since differentiation is an internal process, the external manifestations may cover up the degree a person has become an autonomous individual. Successful individuation does not preclude deep attachment.

Bowlby (1969) although not a family therapist, added important, fundamental understanding to the appreciation of early development. The part I emphasize and which I feel is directly related to couples work is related to an understanding (at least superficially) of the touching, holding, bonding attitudes of the family of origin. However, we accept that this report from the client will be biased information, seen through the lens of the persons who are being treated. For example, youngsters that are stroked and cuddled bring a far different kinesthetic sense to the marriage bed, than those who have been treated in a distant manner, or, far worse, cuddled and rejected at the same time. Obviously, in short term treatment these profound and basic introductions into the couples' early life experiences are not going to be fully explored. But, even a modest sharing of how each partner recalls his or her childhood moments of intimacy or yearning for affection can be very revealing and helpful in couples' work.

Another concept that may help the therapist induce some movement into a relationship that appears helplessly role-bound is the notion of "delegation." A concept is well-described by Helm Stierlin (1981) and delineates how different children in families are chosen to carry out some unfinished developmental business of a parent. These children are subtly trained to go out in the world and master the tasks that were never accomplished by a parent. The deeds they go forth to do are more or less worthwhile; indeed, how faithfully the child chooses to act on this mission varies with each and every youth. Many times I have seen clients feel ecstatic when they recognize that they no longer have to "be" for someone else (the parent)—that their own desires and goals are valid. When a wife and husband share this experience, they find strength in the mutual recognition that they no longer have to be the "chosen" one. Furthermore, this concept of a child being assigned a role to achieve gratification for a parent can be a useful subject for discussion when a couple wishes to have or has children. A session can be based on how, or if, they might identify with a parent who chooses to impose a role on a child.

Within the above amalgamation of ideas let me now state that I believe that most persons are positively motivated as they attempt to solve problems and change their partner to "make it better." It is not the motivation that seems to go wrong, but the numerous unsuccessful attempts to achieve this goal which have failed. Therefore, it is the repetitive manner of problem solving that is the problem. This has been very well explained by the MRI group in Palo Alto, California (see Watzlawick, et al, 1974; Fisch, et al, 1982).

None of these belief systems can stand alone or can be valid without taking into consideration the social system in which each exists. Social constructivism theory opens the horizon to include not only all the factors that enter into the creation of each person's perceptions of his/her world, but also the impingement of the outside social structures that may traumatically influence a couple's world view. The theory of social constructivism (Watzlawick et al, 1984) looks at the invented worlds we all uniquely construct, the power of words to shape our thinking, and the necessity to be gender-sensitive in defining problems. It appears that within this framework the other theorists may exist in comfort and assist a couples' therapist with the business of treatment.

Every couple, as they tell their stories and explain their world views, stimulates the therapist to respond through herself and her knowledge and to choose what appears to be the theory, or grouping of theories, that best "fits" the problematic situation and the personality of the clients. The final criteria is not to mold their treatment into a theory, but to allow the couple to lead the therapist into the theoretical framework that best holds their own picture of themselves and their lives.

Role of Therapy in Couples Work

And what about the art? How is this component valued in all the talk about theory and techniques? The art product is the foundation on which all the theory rests. It is the window to the clients' world and the resource that informs the therapist about the couple's meaning to their stories. Above all, the art tasks give the couple an action oriented mode of solving problems. The action is based on creativity, both in the execution of the art expression and in the invitation to be creative toward problem-solving. The art moves the clients from the frame of a rigid unsolvable problem toward one that is manageable and resolvable. The art product reveals the second level meanings and invites a fresh look at long-standing beliefs.

With encouragement from the therapist, the couple can look at their situation through the art product, create a new meaning for old patterns and invent a future that meets their desires. The therapist is able to be more effective since the information in the art work allows her to wear a similar set of lens, enabling her to see the couple's world and appreciate their viewpoint. With these unique lens, the art therapist can utilize many theories, many modes of interventions, and introduce a variety of art directives that reflect the couple's story, giving new meaning to the ancient myths of the family.

Case Example I

Cindy and Larry sat in despair in the office. They both expressed how hopeless they felt about resurrecting their dying relationship. The facts were concrete—there was no hope for change. I was to help them through this time which probably would lead to separation. The sadness they both felt was over the fact that they still felt love for each other, but that "wasn't enough to make the difference."

The major problem was (as they presented it) the fact that Cindy was six years older than her husband. He was thirty-six and she was forty-two. Everything was tainted by the dire reality that she stayed six years older. She had "consistently" been six years older all through their seven year marriage, the birth of their son three years ago, the blossoming of his career, and her decision to retire from work and be an at-home mother. They both shared guilt over their respective ages. He tried to get older faster—but it never worked.

Faced with this situation, I decided not to be helpful. I listened and empathized with the reality, the inevitability, and the clarity of the difficulty. I then asked them to return the following week with copies of their birth certificates. They were each to do their own zeroxing and be responsible for bringing the copy to the session. I did not discuss the reason for this request with the couple and they left somewhat puzzled.

The following week they each had complied with my recommendation. Without further discussion I immediately presented them with an 18" × 24" piece of construction paper (they chose the color), two pairs of scissors and glue. I asked them to cut apart their birth certificates and create a single collage made of the two documents. They began their work slowly, but in due time she took a decorative theme from his certificate border and extended it onto hers. He took the dates of their births and cut them out and scramble their order. She made inventive shapes of the hospital names. This continued until the two original certificates were unrecognizable. What resulted was a rather attractive collage which was embellished with a large golden seal they had created together and placed on the bottom of the paper with the date of the session inscribed.

From this experience Cindy and Larry seemed to simultaneously understand what they were destroying and what they were creating. They needed very few words. They touched hands, chuckled a lot, encouraged each other to press on with the collage process and smiled at their completed project.

The final step was my request for them to take it home, frame it, and place it in a prominent place, at least for a little while. They agreed and their response appeared to be one of relief, a feeling not expressed through words, but through their heightened affect and their embrace of each other at the door as they left. They remained in treatment and never mentioned age again. They were released from this dilemma and were able to move on to other difficulties in their relationship for which the "six years" issue had served as an avoidance device.

Interventions made through an art task often help the family become aware of their redundant patterns in unsuccessful problem solving.

Discussion

This example addresses a basic theme in couples' therapy. These two people were tormented by multiple stereotyped messages from society and their families about age in relation to roles of men and women. At the initial session, there was no time to pick apart these issues. The couple were covertly asking me to save their marriage and release them from their symbolic symptom that stood in the way of facing the real distress they felt. I gave them a chance to solve the problem, without interpretation, and create a new reality.

Symbolically through the art, they addressed the meta-meaning of age. They started on the path of therapy by establishing their own family interpretation of age by working on a meta-level that paralleled their trouble. Cindy and Larry presented a problem that defied a logical solution. Therefore, it was syntonic to find a solution to the problem in a non-logical way. The resolution did not need to be verbalized. It was visual, concrete, and creative.

It is important to note that the first

session in couples therapy presents the therapist with a variety of opportunities for establishing a framework for the ongoing therapeutic relationship. In all cases the primary necessity is joining with each partner. However, the choice of how one joins is a constant variable. Confrontation or disbelief in the seriousness of a problem that a couple present in the initial session is often fatal to a therapeutic commitment. In the case example, the implied message was one of help/do not help, delivered equally by both wife and husband. This created a doublebind for the therapist which could only be addressed by moving to another plane (Bateson, 1956). By first engaging in attentive listening and then shifting to the art task, both of the conflicting signals were responded to in a unique manner that allowed Cindy and Larry to bypass their paradoxical request. Their fears of looking into other matters were covered by challenging the therapist to solve an impossible difficulty such as their respective years on earth. The metamessage was, "we offer you this unsolvable task—we will drive you away—and our relationship will not be threatened by change, even though it is far from ideal."

The metaphoric power that lies in an art task gives the client(s) an opportunity to take charge of creating new possibilities in their problem-solving skills. What deeper level meaning this creative process speaks to in the client may never be fully understood by the therapist and she/he can only observe subsequent behaviors and acknowledge the importance of the art product. The client's acknowledgement of the art mirrors the recognition that there is a profound meaning greater than the product itself. Rather than the therapist being solely responsible for triangulating with the couple and moving the relationship in that manner (Andolphi 1989), the art becomes the third person with mystical skills. These skills are contained in the projective power of the art which reflects the intimate world view of the clients. For the therapist to presume to understand how the client perceives the world would most probably be faulty, particularly in the first few sessions. Therefore, we observe and listen to the family story and the illustration provided through the art task.

. . . the art tasks give the couple an action-oriented mode of solving problems.

Case Example II

The evolution of family work into conjoint marital therapy is very common. Most family treatment benefits from some adult sessions after the systems have been regulated and the children relieved of their delegated roles (Steirlin, 1981). It is not unusual at various times in the developmental growth of either of the parents, the children or the family, stressors impact the couple to a degree they perceive as unmanageable. At these times of flux couples in rigid relationships who have not developed coping skills for change often turn to therapy. The following example illustrates how two apparently high-functioning adults were no longer able to maintain their facades when developmental pressures escalated.

Soon after Ellen and Craig started family treatment it became apparent that it was a relationship problem between these parents and not the difficulties with their teen-aged daughters that needed attention. The stress of adolescent rebellion had stirred up their own problems around individuation. For this reason, we moved to conjoint sessions.

Both Craig and Ellen were well-educated, financially secure since birth, committed to good ethics and rigidly programmed by their families in the "proper" roles and behavior of each sex. They had a sixteen-year marriage, and although at this time they were very unhappy with each other, they had no desire for divorce. Their situation seemed clearly to indicate a need to explore their family of origin, and look at the question of differentiation theories referred to above.

We began by doing a genogram which was then amplified by art therapy in the following manner. Utilizing the usual indicators of sex, relationship through marriage, age, children and death (see McGoldrick & Carter, 1988), the genogram also introduced color to express dominant trigenerational personality traits. For example, a circle used to indicate "grandmother" was colored in red, blue and a little green. It had been agreed by the couple that these colors would respectively show anger, depression and nurturing. The connecting lines on the genogram that show relationships were colored-coded to express behavioral traits such as affectionate, cold or violent. How they indicated these traits through a color or a combination of colors helped to clarify how the families taught their children how to "be."

As Ellen and Craig explained and compared their genogram, they better understood how they were carrying on the family beliefs and the inheritance became clear. They observed the following: her mother was dominant and ferociously rude; his mother was passive and weak; his father was a male mirror of her mother and her father was the retiring "sweetie." What they hated in themselves were behaviors incorporated from their same sex parent; what they feared in the other was the threat of having to live with a duplication of the opposite sex role that they grew up with. Con-

The art product . . . is the window to the client's world.

sciously, they were only partially aware of these roles and dynamics.

To help make the above characteristics more visible, the next task was to "do a collage of your parents." Using magazine pictures each one created a composite of family traits. How amazed they were when they found the many similarities in their families of origin. They learned a great deal by being able to distance themselves from the strong personalities of their parents and feeling more free to criticize a collage rather than a real person or parent. At last Ellen could say she didn't want Craig to be a "wimp" like that picture of her father on the page. Finally, he had the courage to say that when she was like her mother, he cringed inside as he always had with his father. The major gain was to see that they each wanted the same change from the other partner and to say to each other, "please don't be your parent."

Following this exploration of roles and learned behavior the next step was learning how to be who they wanted to be. Late individuation in adults who have neglected this process in adolescence always offers a therapeutic challenge. To explain the process of this treatment is too extensive for this paper. However, I can note that we used the art therapy to rework, in the light of adult understanding, real and concrete residual events of the past.

After a six-month period, their daughters showed remarkable improvement [sic] and the couple terminated with the resolve to keep on "becoming themselves." An unexpected plus was the reward that the relationship with their own parents had become much easier. They no longer felt controlled and therefore could spend more pleasurable time together and observe them from a position of action rather than reaction.

Discussion

The choice of partner is one of the most important decisions we make. It is often a puzzle to the therapist how each member of a dyad has chosen the other. However, as we look at the visual representations of the relationships, expressed through art, of their family of origin, it becomes clear that past behaviors and patterns remain alive in the present.

In the second case example, recognition of the mirroring is difficult to achieve with words, but dramatically clear in the art. It is a real triumph when Ellen is able to say "I heard myself sounding just like my mother, and I think he is acting just like *his* mother. I hate both those women in myself and in my husband." At this moment she was able to transcend sexual identity, recognize the source of the behavior, and move toward change. Moreover, when couples draw their family of origin in a manner that displays relationships they are able to compare parallels in the drawings of how they, in turn, have created their own dependency relationships. With freedom to redraw, cut out, amplify, and expand a family drawing, the ability to recreate and reinvent new meanings to the process that "shaped" those individuals becomes a more manageable task.

This case also presents a good example of a man and woman who, at first meeting, seem to have achieved full adult functioning in the family and socio/economic areas of their lives. Only under the stress that arose from confronting two teenage children did their undifferentiated emotional attachment to their family of origin become an issue. They experienced great frustration as their own daughters strove for differentiation from them as parents, since their own unresolved individuation from their parents left them deficient in skills to manage this crisis. Two generations were struggling to accomplish this same goal and, instead of differentiating, they were emotionally escalating their dependency. It was no surprise that as the parents became more aware and capable of establishing their own sense of self, the daughters in turn, made progress toward autonomy and conflicts diminished. This ripple effect is one of the ongoing pleasures family therapists experience when they observe parents change and children benefit.

In conclusion, it is important to be curious, modest in hubris, aware that each person's reality is a creation of his or her own, and to understand the power of early teaching of the families of origin. The therapist must also look for the possibility of conflict between overt behavior and what those observable actions truly represent. An ability to sprinkle sessions with humor, be comfortable talking about sex, and realize that you are a temporary part of the system—comprise a realistic formula for the therapist interested in doing couples therapy.

Add to this a willingness to let the art process inform the art therapist and lead the way, through pictures that both surprise and illuminate the couples' story. It is particularly important to look for the second-level message in the visual expression. Vital material to both clients and therapist is more easily assessible through the image and indicates the dormant possibilities of change in the tarnished script of the relationship.

Modifying undesired patterns through a creative solution can be a festive occasion in couples therapy. To paraphrase Bateson, art is the difference that makes a difference.

References

Adolfi, M., Angelo, C., & de Nichilo, M., (1989). *The Myth of Atlas*. New York: Brunner/Mazel.

Bateson, G., Jackson, D., Haley, J., Weakland, J., (1956). "Toward A Theory of Schizophrenia," *Behavioral Science, 1*, 251–264.

Berman, E., Lief, H., & Williams, A., (1981). *The Handbook of Marriage and Marital Therapy*. New Jersey: SP Medical and Scientific Books.

Bowlby, J., (1969). *Attachement*. New York: Basic Books.

Carter, B., & McGoldrick, MSW M., (1988). *Family Life Cycle*, 2nd ed., New York: Gardner Press.

Efran, J., Lukens, M., & Lukens, R., (1990). *Language, Structure, and Change*. Norton & Co.

Fisch, R., Weakland, J., & Segal, L., (1982). *Tactics of Change*. San Francisco: Josey-Bass.

Kerr, M., & Bowen, M., (1988). *Family Evolution*. New York: Norton & Co.

Landgarten, H., (1987). *Family Art Psychotherapy*. New York: Brunner/Mazel.

Lederer, W., & Jackson, D., (1968). *The Mirages of Marriage*. New York: Norton & Co.

Papp, P., (1983). *The Process of Change*. New York: Guilford Press.

Pittman, Frank, (1987). *Turning Points*. New York: Norton & Co.

Riley, S., "A strategic family systems approach to art therapy with individuals," *American Journal of Art Therapy, 28*, 71–78.

Riley, S., "Adolescents with Family Art Therapy: Treating the 'Adolescent Family' with Family Art Therapy." *Art Therapy, 5*, 2, 48–51.

Simon, F., Stierlin, H., & Wynne, L., (1985). *The Language of Family Therapy*, Family Process.

Stierlin, H., (1981). *Separating Parents and Adolescents*. New York: Jason Aronson.

Vishir, E., & Visher, J., (1988). *Old Loyalties, New Ties*. New York: Brunner/Mazel.

Weeks, G., (1989). *Treating Couples*. New York: Brunner/Mazel.

Watzlawick, P., Weakland, J., & Fisch, R., (1974). *Change*. New York: Norton & Co.

ANNOUNCEMENT

THE ART THERAPY ASSOCIATION
OF FLORIDA
IS PLEASED TO ANNOUNCE ITS
1992 STATE-WIDE CONFERENCE
AT THE HERITAGE HOTEL
IN
ST. PETERSBURG, FL
FRIDAY/APRIL 24 TO
SUNDAY/APRIL 26, 1992
THE CONFERENCE WILL FOCUS
ON

"ART AND THE OLDER ADULT"

•

Workshops and presentations will be offered on Life Review process using art therapy, Expressive Therapy with addictive disorder clients, Test results from recent data collected by Dr. Rawley Silver, with other presentors all sharing insights from working with older age adults using the arts in various settings. Special guest speaker will be Larry Barnfield, A.T.R. from Charleston, S.C. sharing his knowledge on art programs mindful of the environmental-housing needs of older adults.

A private dinner and after hours tour at the Salvador Dali Museum will begin the conference on Friday evening, presentations on Saturday and concluding Sunday at noon.

For further information, write
GERALDINE WILLIAMS, A.T.R.
1300 Bridlebrook Dr., Casselberry, FL 32707

An Informal Survey of Assessment Use in Child Art Therapy

Anne Mills, M.A., A.T.R.; Rachel Goodwin, M.A.

Abstract

The authors surveyed participants at a national art therapy conference on the use of assessments in art therapy with children. Different levels of experience, geographical areas and training programs were represented by thirty-seven respondents. Relative familiarity with projective tools was greater than with art therapy assessments. However, most respondents cited preferred tools which relied on modifications of existing projectives and art therapy techniques, and unpublished assessments. The authors infer from their results that art therapists have a great diversity in training and approach to assessments, coupled with a strong need to innovate. The results, although from a small sample, have implications for both clinicians and researchers.

Art therapists who work with children observe that, with some exceptions, children do not need suggestions about what to draw or sculpt (Koppitz, 1968; Nucho, 1987). In fact, direction can sometimes be a form of interference (Rubin, 1978). Further, 'non-directed' or 'free' drawings are considered of primary importance by some theorists (Naumburg, 1966; McNeilly, 1983). However, the skilled art therapist must be prepared to assess clients (McNiff, 1986). As the art therapist plans the assessment of a child, it may be that directed drawing tasks from the art therapy or psychology literature as well as non-directive methods are considered.

It is because of the philosophical and practical questions raised in assessment that the authors wished to learn more about the frequency and type of assessments given children in contemporary art therapy practice.

Method

We designed a questionnaire that was distributed at the 20th Annual Conference of the American Art Therapy Association in San Francisco, 1989. Respondents were asked to identify themselves by: level of training (undergraduate or graduate student); professional status (student, alumni); institution where training took place; number of years of experience; work setting; and age range of child or adolescent clients. We listed twelve published assessments (see below) and asked respondents which ones they had used. Included were assessments like the Ulman (1975) and the Diagnostic Drawing Series (DDS) (Cohen et al., 1988), which are commonly associated with assessment of adult populations, but which are also used with adolescents. Several pencil-and-paper projective techniques were also included. Although originating in the field of psychology, such directive drawing tasks seem to be in widespread use in contemporary art therapy practice.

The authors also asked which assessment the participants had found to be most "beneficial to my clients." Space was provided for respondents to indicate any other assessments, including ones of their own devising, which were not listed in the questionnaire.

Results

Approximately 100 questionnaires were distributed. The majority were picked up by conference participants from a conference message board. A number were given to participants after discussing the survey. Ten were delivered to three graduate programs in art therapy that are widely separated geographically and philosophically. Of the 100 questionnaires distributed, 37 were returned.

Graduates of art therapy programs accounted for more than three-quarters of the respondents. The remainder of the respondents were students. All respondents were either in graduate programs or were Master's-level art therapists. No bachelor's-level practitioners responded, nor did any non-art therapists. The participants were: seven students; nine M.A./M.S. graduates; and 17 A.T.R.s (nine of whom had more than ten years of experience).

Almost all the student responses came from one graduate school. With this exception, the distribution of participants across North America (judged by college where training was received) appeared to be good. The survey, although small, is somewhat representative because of regional variety. Seventeen different colleges and universities and one institute were represented in the sample.

In most categories, similar responses were given by art therapy students, Master's-level art therapists, A.T.R.s, and A.T.R.s with more than ten years experience.

Child clients were reported as predominantly: younger than school age (3 respondents); six- to twelve-years (28); and adolescents (17).

Child clients were seen in the following settings: schools (7); medical (3); psychiatric/substance abuse (14); and private practice (6). Other settings mentioned by respondents were family or community clinics, and residential settings and outpatient clinics for survivors of sexual and other abuse.

The choices offered are listed below in the manner presented in the survey. The first number in brackets indicates the number of respondents who had used that particular assessment with children. The second number, in bold type, indicates how many respondents selected that assessment as "most beneficial" to their clients.

- Bridge (Hays, 1981) [4] **[0]**
- Diagnostic Drawing Series (Cohen et al., 1988) [5] **[1]**
- Draw a Person (Harris, 1963) [19] **[0]**
- Favorite Kind of Day (Manning, 1987) [3] **[0]**
- House Tree Person (Buck, 1948) [16] **[4]**
- Kinetic Family Drawing (Burns & Kaufman, 1970) [21] **[5]**
- The Kramer Assessment (Kramer & Schehr, 1983) [15] **[6]**
- The Rubin Assessment (Rubin, 1984) [10] **[5]**
- The Scribble Technique (Cane, 1951) [13] **[1]**
- Stimulus Drawings (Silver, 1986) [4] **[1]**
- The Squiggle Game (Winnicott, 1971) [6] **[0]**
- The Ulman Assessment (Ulman, 1975) [8] **[2]**

Respondents were very familiar with the DAP (Harris, 1963), H-T-P (Buck, 1948; Buck & Hammer, 1969), and the KFD (Burns & Kaufman, 1970; Burns & Kaufman, 1972). In fact, respondents signalled almost as much familiarity with these three projective drawing tasks (56 total) as with the other art therapy techniques combined (66 total).

Simple familiarity with a given assessment did not necessarily predict it would be judged as "most beneficial" by participants. The projective drawings were voted "most beneficial" only nine times in total, as opposed to the combined art therapy techniques, selected 16 times in total. That is, one in six art therapists familiar with these projective drawings selected it as "most beneficial," whereas one in four art therapists familiar with an art therapy tool selected it as "most beneficial." Despite greater familiarity with and a strong acceptance of projective drawings, art therapists tended to prefer the art therapy tools.

When the listed methods were broken down into high and low levels of structure in the manner of Bolander (1977), more art therapists preferred tests where stimuli are relatively unstructured and responses are not limited. However, structured tests also were frequently used.

Some published and well-known techniques were also cited by respondents who had either used them or found them most beneficial (see below). For reasons of space and/or simplicity they had not been included in the questionnaire's list of 12 possible assessment tools.

However, it is important to note that respondents at all levels of experience modified existing techniques and created new ones, rather than relying on published tools. Some techniques cited by respondents were not known by the authors. Where this was the case, we have not appended a bibliographic reference. We conjecture that such tools were created by the respondents themselves, or that they may have been taught them via a sort of "oral tradition" of art therapy education and supervision.

The following is an alphabetized list of assessments, techniques and modifications that were submitted by participants. They were proffered either as an assessment the respondent had used or as the one considered "most beneficial." The participants' own descriptions are quoted.

- "A combination of two—one multiple picture assessment (DDS or Kramer) *and* one person picture (DAP or KFD)"
- "A drawing of a tree, a bird, and a ball — then tell a story about the drawing"
- "A Scary Dream"
- "A seven-drawing series with 8" × 12" paper and various drawing materials: (1) favorite weather (2) developed scribble (3) DAP (4) Draw person of opposite sex (5) KFD (6) Abstract family (7) free choice"
- "Affect drawings: sad, angry, happy, scared, on 8½" × 11" paper with markers and pencils"
- "Combination of DAP and KFD"
- "DAP modified"
- "Dot-to-Dot" (Hays, 1979)
- "Design—lines—shapes—colors—don't look like anything—associates feelings to colors and lines"
- "Draw a person of the opposite sex" (Hammer, 1975)
- "Draw what happened to you" (similar to the Event Drawing, Burgess et al., 1987)
- "Family Portrait" (Kwiatkowska, 1978)
- "Free drawing—choice of subject and materials"
- "Free drawing and directed second picture, such as DAP"
- "HFD" (Koppitz, 1968)
- "HTP modified"
- "HTP, combined chromatic and monochromatic"
- "KHTP" (Burns, 1987)
- "Kramer assessment modified in materials and protocol. Specifically, markers and colored pencils are also provided and the order of the tasks is determined by the child."
- "Kramer with HTP, substituting scribble or squiggle when there is resistance to drawing"
- "Kwiatkowska Family Art Evaluation" (Kwiatkowska, 1978)
- "Life Size Body Drawings" (Malchiodi, 1987; Malchiodi, 1990)
- "Mandala" (Slegelis, 1987; Bush, 1988)
- "MARI cards combined with Mandala" (Kellogg et al., 1977; Kellogg, 1978)
- "Reasons for hospitalization"
- "Rubin assessment modified"
- "Sequence: telling a story in eight squares"
- "Sandtray" (Kalff, 1980)
- "Shared drawing"
- "What is it like to be your age?"

Four participants responded that they do not use assessments. The authors suspect this number is deceptively low; other art therapists who do not use assessments would tend not to pick up or complete such a survey. One art therapist prefers to not use assessments but monitors "the gestalt of their art over time." Another participant noted that her job duties preclude assessments because, due to time pressure, "testing is completed by others."

Discussion

A question that is begged by the proliferation of assessments above is the difference between subjects or themes for drawings, and evaluations or assessments. If a clinician finds that requesting a certain subject yields useful information, we presume s/he will use it regularly and will develop a special understanding of the many ways clients respond to this subject. Can this then be termed an 'assessment,' even if it is not widely known and accepted? As Kinget wrote more than thirty years ago (Hammer, 1958), a technique's value is limited by the worker's mastery, which can be acquired by time and systematic study alone. A full discussion of this issue is, however, beyond the scope of this report.

The presence of a number of assessments with which the authors were unfamiliar seems evidence of an 'oral tradition' operating in the field of art therapy. That is, an assessment's publication may be delayed, thus limiting knowledge of it (and its influence) to others in the same geographical area or professional network. The authors wonder if every lesser-known assessment has its own proponents who are linked by ties of familiarity and loyalty and who share similar training and ideology (Kuhn, 1962).

Virtually all respondents offered an assessment or modification that seemed of their own devising. This may be testimony to our professional identity as artists and innovators. It may also indicate widespread unfamiliarity with or rejection of published assessments. Some respondents were very eager for information on assessments and requested copies of the questionnaire because it listed citations. A hypothesized lack of familiarity with art therapy techniques is interesting in view of the continued use, teaching, and, in some cases, preference for projective techniques. Despite ethical and legal concerns regarding areas of competency and proprietary use of tools, and the postulated drive to innovate among art therapists, interest in tools derived from psychology remains robust. In contrast, it is noteworthy that support for projective drawing techniques has declined within the psychology community after repeated tests failed to support their usefulness for research or clinical work (Pruitt, Smith, Thelen & Lubin, 1985).

Philosophical and other differences among training programs suggest that each charts its own course about whether or how assessments be taught. One respondent noted, under the name of the college where s/he received training, "But, really, I've learned assessment on my own, with experience."

There were, not surprisingly, no repetitions among the list of personalized or modified assessment techniques. This lack of consensus hints at a difficulty that faces researchers who seek art therapists' involvement in studies that employ standardized procedures, in that clinicians may tend to resist or reject any standardization, *a priori*. It also implies a degree of diversity among clinicians that may compromise accountability and communication around clinical issues.

The authors acknowledge the effect that the simplification of the concept "most beneficial" had on the questionnaire. It is important to note, as participants pointed out, that, "most beneficial to my clients" may not be the same as "most preferred," "most used," or even "most beneficial to the therapist." It may be, in the press of daily work, that the tool the therapist considers ideal, preferred or even most beneficial, is not used. Some assessments are more time-consuming or unwieldy than others. Some institutions, in fact, may specify what evaluation is to be used. As another respondent very correctly points out, there is "no single assessment that will fit the needs of all children, all the time."

Conclusion

Certainly art therapists wish to clearly understand the problems of child clients. However, respondents demonstrate diverse opinions about the place and value of assessments in clinical practice. Some say they do not assess, but perhaps perform a similar function in a different or more informal manner.

Others show an eagerness for information about assessments and a need to modify and create adequate tools for assessment. Still others prefer tools which are familiar to art therapists but have their origins in other disciplines. From this the authors infer that some art therapists lack knowledge about or are dissatisfied with extant art therapy assessments.

This questionnaire asked only about frequency and preference and should not be mistaken as a statement about the value of each tool. That is, of course, dependent on the skill of the clinician (Bolander, 1977).

Our hope is that this report on the outcome of a small, relatively informal survey may foster awareness and discussion of attitudes toward the use of assessments.

References

Bolander, K. (1977). *Assessing personality through tree drawings*. New York: Basic Books.

Buck, J. N. (1948). The H-T-P test. *Journal of Clinical Psychology, 4*, 151–159.

Buck, J. N., & Hammer, E. F. (Eds.) (1969). *Advances in the House-Tree-Person test: Variations and applications*. Los Angeles: Western Psychological Services.

Burgess, A. W., Hartman, C. R., Wolbert, W. A., & Grant, C. A.

(1987). Child molestation: Assessing impact in multiple victims (Part I). *Archives of Psychiatric Nursing, 1* (1), pp. 33–39.

Burns, R. C., & Kaufman, S. H. (1972). *Actions, styles, and symbols in Kinetic Family Drawings (K-F-D): An interpretive manual.* New York: Brunner/ Mazel.

Burns, R. C., & Kaufman, S. H. (1970). *Kinetic Family Drawings.* New York: Brunner/Mazel.

Burns, R. C. (1987). *Kinetic-House-Tree-Person Drawings (K-H-T-P): An interpretive manual.* New York: Brunner/Mazel.

Bush, C. A. (1988). Dreams, mandalas, and music imagery: Therapeutic uses in a case study. *The Arts in Psychotherapy. 15,* 219–226.

Cane, F. (1951). *The artist in each of us.* New York: Parthenon Books.

Cohen, B. M. (1988). Diagnostic Drawing Series Workshop. Michigan Art Therapy Association, Detroit, 15 May.

Cohen, B. M., Hammer, J. S., & Singer, S. (1988). The Diagnostic Drawing Series: A systematic approach to art therapy evaluation and research. *The Arts in Psychotherapy, 15* (1), 11–21.

Gabel, S. (1984). The Draw a Story Game: An aid in understanding and working with children. *The Arts in Psychotherapy. 11,* 187–198.

Goodenough, F. L. (1926). *Measurement of intelligence by drawings.* Chicago: World Book Company.

Hammer, E. F. (Ed.). (1958). *The clinical application of projective drawings.* Springfield, IL: Charles C Thomas.

Harris, D. B. (1963). *Children's drawings as measures of intellectual maturity.* New York: Harcourt, Brace, and World.

Hays, R. E. (1979). Dot-to-Dot: Rationale for a "new projective" for children under ten. Focus on the future: The next ten years. *Proceedings of the Tenth Annual Conference of the American Art Therapy Association.* AATA, Inc., 116–120.

Hays, R. E., & Lyons, S. J. (1981). The bridge drawing: A projective technique for assessment in art therapy. *The Arts in Psychotherapy. 8,* 314.

Kalff, D. M. (1980). *Sandplay: A psychotherapeutic approach to the psyche.* New York: Sigo Press.

Kellogg, J. (1978). *Mandala: Path of beauty.* Baltimore: Mandala Assessment and Research Institute.

Kellogg, J., MacRae, M., Bonny, H. L., & Di Leo, F. (1977). The use of the mandala in psychological evaluation and treatment. *American Journal of Art Therapy. 16,* 123–134.

Koppitz, E. M. (1968). *Psychological evaluation of children's human figure drawings.* New York: Grune & Stratton.

Kramer, E., & Schehr, J. (1983). An art therapy evaluation session for children. *American Journal of Art Therapy, 23,* 3–12.

Kuhn, T. S. (1962). *The structure of scientific revolutions.* Chicago: The University of Chicago Press.

Kwiatkowska, H. Y. (1978). *Family therapy and evaluation through art.* Springfield, IL: Charles C Thomas.

Machover, K. (1949). *Personality projection in the drawing of the human figure.* Springfield, IL: Charles C Thomas.

Malchiodi, C. (1987). Comparative study of the DAP and Life Size Body Drawing in the assessment of child abuse. *Proceedings of the 18th Annual Conference of the American Art Therapy Association.* AATA, Inc., 105.

Malchiodi, C. A. (1990). *Breaking the silence: Art therapy with children from violent homes.* New York: Brunner/Mazel.

Manning, T. M. (1987). Aggression depicted in abused children's drawings. *The Arts in Psychotherapy. 14,* 15–24.

McNeilly, G. (1983). Directive and non-directive approaches in art therapy. *The Arts in Psychotherapy. 10,* 211–219.

McNiff, S. (1986). *Educating the creative arts therapists: A profile of the profession.* Springfield, IL: Charles C Thomas.

Naumburg, M. (1966). *Dynamically oriented art therapy: Its principles and practices.* New York: Grune & Stratton.

Nucho, A. O. (1987). *The psychocybernetic model of art therapy.* Springfield, IL: Charles C Thomas.

Pruitt, J. A., Smith, M. C., Thelen, M. H., & Lubin, B. (1985). Attitudes of academic clinical psychologists toward projective techniques: 1968–1983. *Professional Psychology: Research and Practice. 16* (6), 781–788.

Rubin, J. (1978). *Child art therapy.* New York: Van Nostrand Reinhold Company.

Rubin, J. A. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Sandburg, L., Silver, R. A., & Vilstrup, K. (1984). The Stimulus Drawing Technique with adult psychiatric patients, stroke patients, and in adolescent art therapy. *Art Therapy. 1*: 3.

Silver, R. A. (1987). Sex differences in the emotional content of drawings. *Art Therapy. 4*: 2, 67–77.

Slegelis, M. H. (1987). A study of Jung's mandala and its relationship to art psychotherapy. *The Arts in Psychotherapy. 14,* 301–312.

Ulman, E. (1975). A new use of art in psychiatric diagnosis. In E. Ulman & P. Dachinger (Eds.), *Art Therapy in Theory and Practice.* (pp. 361–386). New York: Schocken Books.

Winnicott, D. W. (1971). *Therapeutic consultations in child psychiatry.* New York: Basic Books.

Ziegler, R. G. (1976). Winnicott's squiggle game: Its diagnostic and therapeutic usefulness. *The Arts in Psychotherapy. 3,* 177–186.

Art Therapists' Countertransference and Post-Session Therapy Imagery

Joanne B. Kielo, M.A., A.T.R., Art Psychotherapist, Montreal Canada

Abstract

This article presents an overview of a study on countertransference and art therapy based on interviews with fourteen professional art therapists exploring their use of drawings they did after sessions with clients. While none of these art therapists suggested that they relied on this method to identify their countertransferential issues, the experiences of several showed that post-session art making was useful for them in developing an empathic capacity, clarifying confused feelings, or rendering unacknowledged feelings into form.

Whether the focus of art therapy treatment lies in the interpretation of the relationship through the use of art or primarily within the artistic experience, most art therapists agree that transference and countertransference exist within art therapy (Agell et al., 1981). In fact, by the very nature of their profession, art therapists may be particularly sensitive to unconscious messages that constitute a large part of communication. In describing the intrapsychic and interpsychic dynamics of art therapy, a number of authors have suggested that art therapy can open the door to the pre-verbal world that was experienced through images and sensations (Lachman-Chapin, 1987; LaMonica & Robbins, 1980; Wolf, 1985; Wood, 1984).

Unconscious reactions are unavoidable as the art therapist travels with his or her client into pre-verbal territory, no matter how much analysis or psychotherapy the therapist has undergone. The art therapist's effectiveness depends partially on an ability to gain insight into such personal reactions as the subtle interplay of projections, unconscious distancing, or undefined feelings so that they may be used to facilitate the treatment process.

Too often art therapists' attention to the pictorial image is client-sided, employing verbal means for the exploration of the art therapy interaction. This study explores the use of image-making by art therapists as a way of examining countertransferential reactions within the art therapeutic interaction and promoting effective interventions.

Countertransference

One of the problems encountered in discussing countertransference is that the term is used in a variety of ways. On one end of the spectrum are the therapists who consider countertransference as consisting of the therapist's unconscious resistance based on early object internalizations, and as an interference in the therapeutic process. At the other extreme are those therapists who view the term from a broader perspective as including the sum total of their reactions in the therapeutic relationship. In this view, countertransference is seen as a helpful tool for exploring clients' projections as well as the therapist's perceptions. Enrique Racker's (1968) concept of countertransference, including the entirety of this spectrum, is the framework used in this study to examine art therapists' countertransference responses.

The first psychoanalyst to present a systematic study of the transference/countertransference paradigm, Racker conceptualized the therapeutic relationship as a dynamic process wherein the exchange between the therapist and client is considered. Racker provided a definition of countertransference which takes into account the gamut of the therapist's emotional reactions. He suggests that there is "no 'normal' emotional state for the therapist, but [that] the inner state is continuously, profoundly and in certain precise and definable ways, responsive to the patient and to what the patient is saying or doing." (cited in Hunt & Issachoroff, 1977, p. 97).

Within this definition which encompasses the therapist's emotional reactions and conscious or unconscious responses, Racker described three categories of countertransference: neurotic countertransference (direct countertransference), countertransference proper which consists of concordant and complementary countertransference (direct countertransference) and indirect countertransference (Racker, 1968).

His concept of neurotic countertransference, resembling Freud's definition of countertransference, has been defined as the unconscious identification of therapists with infantile feelings within themselves in connection with their patients, and their defenses against these feelings. Therapeutic progress is brought to a

---

This article is based upon the author's thesis in partial fulfillment of the requirements for a Degree of Master of Arts at Concordia University, Montreal, Québec, Canada.

Kielo has developed an art therapy program which serves over 1,000 children at the Protestant School Board of Greater Montreal. She is also in private practice, consulting and providing some services at a drug and alcohol detoxification centre for adults in Montreal. She is the past-president of the Association des art-therapeute du Québec, inc., and a professional member of the American Art Therapy Association.

The author would like to acknowledge the assistance of Rachel Garber for editing the article.

standstill until the neurotic countertransference has been identified, effecting a transformation into countertransference proper (Lambert, 1981). This latter is understood either as a kind of ongoing empathic response through the inner experience of the therapist's reactions: (concordant countertransference) or as reactions giving information about the patient's significant early objects: (complementary countertransference). Indirect countertransference involves a third party such as the therapist's teacher, supervisor, or colleague who plays a role in the therapist's responses. Depending on the status of the treatment, the therapist's mood is determined by his or her fantasies of praise or censure by this significant other person (Hunt & Issachoroff, 1977).

Art Therapy and Countertransference

Lachman-Chapin (1987) has proposed that art therapists are particularly drawn to the empathic way of relating to the world because of the nature of their artistic pursuits. Artists project their state of mind onto the art work, while their work objectifies and presents their introspections in a form outside of themselves which others can understand through vicarious introspection. As she put it:

> We [art therapists] . . . grasp empathically the art work produced by others. Thus we, as artists, are attuned to the empathic response as a therapeutic element, especially as we help clients to produce expressive works of art and as we respond to their creations. (Lachman-Chapin 1987, p. 80)

Viewed alone, Lachman-Chapin's description seems idealistic; unfortunately art therapists are not omniscient. Some authors have recognized that this ideal state of relating to the imagery and the client breaks down. Wood suggested that although the client's art work is the container for the transference, the art therapist is subject to the "overspill of unconscious content, at unconscious levels of interactions" (1984, p. 70), and that the art therapist must deal with countertransferential material relating to both the client and the client's art work. As well, LaMonica and Robbins (1980) suggested that because of the preverbal nature of the unconscious interchange between the art therapist and the client, the art therapist will occasionally contribute to the re-creation of past traumas.

The present study set out to explore the ways some art therapists successfully use their post-session imagery to understand countertransference . . .

Examples from the interviews with art therapists completed in the present study seem to support these suggestions. One of the interviewees described a reaction to a client's imagery, exemplifying a neurotic countertransference:

> Another example was when I was depressed and the client was depressed. The [client's] art symbols made me feel my depression. I was so overwhelmed by the depression in the art work that I had a sense of futility and uncertainty, and I was not able to respond adequately to the client. The client's symbols corresponded so closely to my own inner state. The therapist in me folded up her suitcase and went home because the part of me which was depressed had taken over. (Kielo, 1988, p. 142)

Circumstances may also arise in art therapy where the art therapist's reactions are not solely motivated by the art. Another interviewee described one of these experiences:

> I knew I was feeling anxious and sometimes getting angry at the client, not during the drawings but in situations where she would refuse to leave at the end of a session. (Kielo, p. 116)

Robbins made the point that art therapists must not "fool themselves with false notions of professionalism or objectivity" (Agell et al., 1981, p. 7). He contended that art therapists are susceptible to primitive, nonverbal messages and may use defenses that inevitably interfere with therapeutic progress. According to Wolf (1985), a common limitation of therapists is in not receiving and creatively using the countertransference as a tool for understanding their clients.

Both Robbins and Wolf suggested that art work by the therapist could help clarify countertransference issues. LaMonica and Robbins (1980) proposed that drawing an artistic representation of the client can help the art therapist evolve a better understanding of both the transference and countertransference. They suggested that this could be done outside of the session. Similarly, Wolf described a particular intervention whereby the therapist attempts to maintain an empathic connection with the primitive organization of the client's psyche by drawing. The therapist draws spontaneously during the session as the client talks and draws, which could result in the therapist's artistic rendition of the client's projection or the complementary countertransference.

Purpose of the Study

The present study (Kielo, 1988) set out to explore the ways some art therapists successfully use their post-session imagery to understand countertransference issues and to facilitate therapeutic progress.

The basis for this inquiry is the idea that therapeutic progress is partially contingent upon the therapist's personal capacity to respond in such a way as to further the relationship. If image-making by the client is an integral part of the client's growth, what then is the potential of image-making by the art therapist as a means of responding to the therapeutic relationship, monitoring countertransference responses, and clarifying conscious and unconscious communications?

Method

This exploratory study was designed to investigate art therapists' experiences in relation to their own post-session art work. The part of the study described in this paper included open-ended interviews with professional art therapists, examining their experience with art and art therapy; a second phase, which will not be described here, included an exploration of some of the author's experiences with her own post-session art work.

Tape-recorded interviews with 14 art therapists were conducted individually and privately on an informal basis, lasting 20–35 minutes. Each interview began with an open-ended question: "How do you as an art therapist use your art in relationship to the art therapeutic process?" More directed questioning followed, depending upon the path the interview was taking. Each interview was transcribed and returned to the interviewee to be edited.

Results

Of the 14 art therapists who were interviewed, 12 returned their edited versions. Eleven interviews were included in the study because one was returned too late for review. While the number of interviews was too small to permit extrapolations regarding art therapists in general, a content analysis of the interviews did provide some interesting indications for future investigations.

The analysis followed guidelines for qualitative research described by Polet and Heingler (1983), beginning with a search for themes, or commonalities. A theme was delineated by at least two art therapists describing similar experiences. In an attempt to validate the results of this procedure, the iterative approach was used, reviewing the themes to see if the material reflected the subject and then refining them if necessary.

Of the 11 interviewees, two art therapists said that they never used post-session art as a means to help clarify the art therapeutic relationship. Although they both explicitly stated that they did not use their art in relation to the therapeutic situation, they did not deny its potential usefulness. Rather, in response to the question that was put directly to both of them, "Do you ever do art to help clarify the therapeutic session?," both responded by reflecting on the limitation of time.

Like countertransference, the term *art* has many meanings: Each of the interviewees used it to represent at least two if not three different experiences. At one end of the spectrum, there was art which was created separately and considered separately from the art therapeutic situation. Terms such as "academic art," "social art," "art art," "proper fine art" and "authentic art" were used to describe one approach. The general consensus of this variety of terms seemed to be that this art is created for its own sake.

Another type of art was "art work for a (personal) therapeutic reason." This art was described variously as "self-restoration art," "art therapy art," "non-art," "clean-the-slate art," or "spontaneous art." The principal purpose for doing this art was as a therapeutic experience, whether for catharsis or self-exploration.

The third category of art work cited was that done by the therapist in relation to the art therapeutic experience. This included art work done inside the session as well as art work done outside the session but related to the session. This latter type, post-session art work, is the focus of this paper.

The themes which emerged from the interviewees' experiences with their post-session art work were:

1. Art used to develop empathy through replication of client's imagery;
2. Art used to clarify feelings;
3. Art used to explore the preconscious and unconscious;
4. Art used to help differentiate affect;
5. Art used to explore the relationship.

The countertransference experiences, clarified through post-session imagery, described in this study will be considered in the context of Racker's concept of countertransference. Complementary countertransference is indicated by a description of the imagery and the art therapist's experience which suggests the client's projections of early significant objects onto the art therapist. A description of an experience which developed a more empathic understanding of the client and the client's imagery is referred to as concordant countertransference. Neurotic countertransference is identified when the art therapist's reactions to the clients' art work or the client were not recognized and in some way made the art therapist less effective. Indirect countertransference is not reviewed in the following discussion since it was not mentioned by any of the art therapists who were interviewed.

Themes

That concordant countertransference is not always achieved within the immediacy of the art therapy session was exemplified in the situation of the interviewee who was unable to respond adequately to the client due to his or her own emotional state (Kielo, 1988). Looking at the described experiences of most of the art therapists interviewed, it would seem that they used their post-session art work to help them develop a concordant countertransference toward their clients and their clients' imagery.

Robbins (1987) pointed out that the skill of the art therapist is in maintaining a positive supportive relationship to ensure effective art therapeutic intervention. Edwards (1987) suggested that the art therapy process is best served when the art therapist "is able to channel countertransference feelings into caring about and bringing ideas to the image" (p. 104). This ability to maintain an effective relationship with both the client and the client's imagery depends upon the art therapist's concordant countertransference. That is, the art therapist must be able to empathize with both the client and the client's imagery. Beres and Arlow (1974), two psychoanalysts who addressed the issue of empathy, concluded that the empathic response involves transient identification with as well as a remaining separateness from the object. It is not only a matter of being *with* the person but also of thinking *about* the person. According to Beres and Arlow, both the *with* and *about* are essential components of the empathic process.

Three art therapists made specific reference to the idea of replication of clients' art productions as a means of developing their empathy. As one said:

> Occasionally if there is some client's art work I'm having particular difficulty understanding or empathizing with, I will try to replicate this work myself and thereby hope to 'get inside' it. (Kielo, p. 161)

To the author's knowledge, there has been no published research into the motivation and the outcome of replication of client's imagery as a way to develop empathy. Although not within the scope of this study, an interesting avenue of investigation in this area would be that of an analogue to empathic processes in mimicry and dance. It has been suggested by some psychoanalysts (Feinichel, 1926; Jacobs, 1973) that emotion can be transmitted through identification by way of the emotion we see in action. The following description provides another example of the art therapist copying the client's productions:

> In art therapy I have drawn with the client in mind independent of the sessions and I have copied the work of clients (dynamic of the art process experiences). It made me observe more closely the person and the work and because of that observation, that attention, that "living with the image," I would be more empathic. (Kielo, p. 140)

Being *with* is one aspect of concordant countertransference, but just as *important* is the capacity to separate and think *about* the client. "Living with the image" suggests the being *with* the patient's imagery, while the more differentiated state is suggested by the interviewee's observations *about* the imagery. The art work, as concrete evidence, appears to have facilitated a growing empathic response.

For some interviewees, post-session art served as a way to clarify feelings by means of identifying with the client's symbols and experiences. G. described an evolving concordant countertransference situation:

> I often made countertransference drawings after my sessions when I was working with a client who was working through incest issues. She used the metaphor of broken glass. The image of being cut by glass is extremely painful. Although I hadn't been sexually abused, but analytically had dealt with the fantasized elements in my personal therapy, I had been recently mugged. In a separate but perhaps parallel way, I was responding to what it felt like to be violated or intruded upon. My drawings reflected the "fear of life leaving you." Psychodynamically, once you have been sexually abused your damaged body often is felt as it is never being truly yours again. (Kielo, p. 137)

The paradox of being *with* and thinking *about* the client and the client's imagery is illustrated in G.'s experience of concordant countertransference. The "countertransference drawings" seemed to permit G. to identify with a shared affective experience, i.e. "through introjection I feel that this part (metaphor of the broken glass) of you is me and through projection I feel this part (fear of life leaving you) of me is you." The affective reactions of both the therapist and the client were also clarified through observation and associations.

A similar processing of introjection and projection was remarked upon by B.:

> I produced four pictures with the client in mind, with minimal intellectual processing. They seemed entirely spontaneous. At least, the first one was. The first painting showed the persecutory aspects of the transference, the constellation of the mother complex. I knew I was feeling anxious and sometimes getting angry at the client, not during the drawings but in situations where she would refuse to leave at the end of a session. It wasn't until I produced the four drawings that I realized these feelings were persecutory. I don't know how much it helped me with the processing but the drawing refined what the feelings were and enabled me to pinpoint the hypothetical age to which she had regressed. It was possible to gain access to this information by the feelings she was evoking in me and presumably the feelings I was evoking in her. I have a feeling

Like countertransference, the term art *has many meanings.*

BEST COPY AVAILABLE

> that sometimes when one does spontaneous art work that sort of thing does come out, if one but knew it. I probably have other pictures that came about as a result of something that happened with a client. (Kielo, p. 117)

It may be deduced from this description that prior to doing the drawings, B. was caught in the introjective phase, feeling anxious and angry. Money-Kyrle (1956) described these states as periods of non-understanding. According to him, these periods, if not clarified, can lead to conscious or unconscious anxiety which in turn continues to diminish the possibilities of understanding. He also suggested that this anxiety is likely to affect the patient. B.'s imagery provided an opportunity to refine the therapist's feelings, become conscious of the shared experience of "persecution" and to lower the anxiety level. This clarification of feelings resulted in a better understanding of the client.

J.'s experience with post-session imagery provides an example of clarification of feelings; however, in this case the feelings were unconscious:

> It [the post-session imagery] shows me a little bit and sometimes it's no surprise, nothing much happened. Or sometimes I think I've been supportive and I find out from my art work that I really was quite angry at what was happening or I was frustrated because . . . of whatever. It [post-session art] is very helpful. (Kielo, p. 151)

According to LaMonica and Robbins (1980), the process of creating can provide a relaxed atmosphere where free association is possible. They suggested that art therapists who use their own imagery are involved in an experiential interplay of the art process, the art product and a free associational response to the patient in absentia. Thus, while involved in the act of creating, the art therapist is in a fully enmeshed state where he or she becomes aware of early impressions. These impressions can be experienced through the art-making process and sensations, providing the therapist with an access to pre-verbal material. On the other hand, the process provides a distance between what is experienced (the fully enmeshed state of doing the art) and what is observed (the looking at the art).

What had been experienced in a fully enmeshed state during the art therapy session seemed to be differentiated for some of the interviewees through post-session imagery. The following comments suggest such experiences. J.:

> Yes [the after-session drawings help to evalute and clarify the countertransference]. Anyway you can help yourself to clarify what went on in the session. You have to realize you are one half of the human element in the session. It is important to clarify and separate what has been happening in the session. The more we clarify what was happening with us, the more we can separate it from what was happening with the client and the more we can see how the interrelationship leads to a healthier functioning for the client. (Kielo, p. 153)

G. commented:

> I used response drawings to sort out a separation between my feelings and those of my clients. (Kielo, p. 133)

And C. said:

> As I reviewed the process I would ask the question: Was I furious or was it the kid's [the client's] fury I was picking up on? (Kielo, p. 120)

The clarification of boundaries can result in a clarification of the complementary countertransference and subsequently, in the renewal of the concordant countertransference. As H. said:

> Drawing with the client in mind probably doesn't help me so much with the understanding of the client as much as an understanding of my own dynamics and what's going on with my relationship with that client. It helps me clarify things because I can then figure out what's "me" and what's "them" a little better. For example, I had a client who every week did something that related to me or some work of art I had done, and it was a little eerie. I spent a lot of time thinking this through because it was so close. I sat down and drew specifically. The drawing helped to clarify the relationship or the role I played to that client in what ways I was replaying for the client what the role that his mother had in relationship to him and what aspects of my personality played into this. (Kielo, p. 140)

Through the art work, H. was able to differentiate the therapist's affect from that of the client's. This differentiation led to a more profound understanding of an unconscious identification with the patient's projected internalized object—the complementary countertransference. Ultimately, H. was able to renew the concordant countertransference.

Another experience illustrates a developing awareness of the complementary countertransference. B. commented:

> In my own art work it moved me to be more self-aware, so that I didn't become debilitated and therefore ineffectual to the client. One of the fears at that particular stage of development (or regression) is that she would destroy the nurturing figure. In some ways that can be done, the energy can be sapped. What helped me was the acknowledgement of that, and therefore I became a little clearer with my boundaries so that she couldn't scoop me out any more.

. . . post-session art served as a way to clarify feelings by means of identifying with the client's symbols and experiences.

> This was clarified for me through my art work. (Kielo, p. 118)

The imagery helped B. to recognize an unconscious identification with the patient's internalized part object and to clarify the boundaries within the complementary countertransference. Concordant countertransference resulted, making the interchange more effective.

Conclusion

Creating post-session art is not always necessary to clarify the countertransference response. None of the art therapists who were interviewed suggested that they relied on this method on a continual basis. Some, in fact, never used post-session art. Nonetheless, the experiences of several of the art therapists seem to demonstrate that post-session art was useful as a means to develop an empathic capacity, to clarify confused feelings or render acknowledged feelings into form, and to evaluate an array of countertransference reactions.

References

Agell, G., Levick, M., Rhyne, J., Robbins, A., Rubin, J., Ulman E., Wang, C., & Wilson, L. (1981). Transference and countertransference in art therapy. *American Journal of Art Therapy, 21*, 3–24.

Beres, D., & Arlow, J. A. (1974). Fantasy and identification in empathy. *Psychoanalytic Quarterly, 43*, 27–47.

Edwards, M. (1987). Jungian analytic art therapy. In J. A. Rubin (Ed.), *Approaches in art therapy* (pp. 92–113). New York: Brunner/Mazel.

Feinichel, Otto. (1926). Identification. In *Collected papers of Otto Feinichel: Vol. 1* (pp. 97–112). New York: W. W. Norton.

Hunt, W., & Issachoroff, A. (1977). Heinrich Racker and countertransference theory. *Journal of American Academic Psychoanalysis, 5* (1), 95–105.

Jacobs, T. (1973). Posture, gesture and movement in the analysts: Cues to interpretation and countertransference. *Journal of American Psychoanalysis Association, 21*, 77–92.

Jacoby, M. (1984). *The analytic encounter*. Toronto: Inner City Books.

Kernberg, O. (1965). Notes on countertransference. *Journal of the American Psychoanalytic Association, 13*, 38–57.

Kielo, J. B. (1988). *A Study of Art Therapists' Countertransference and Post Session Imagery*. Unpublished master's thesis, Concordia University, Montreal, Qc.

Lachman-Chapin, M. (1987). A self psychology approach to art therapy. In J. A. Rubin (Ed.), *Approaches in art therapy* (pp. 75–91). New York: Brunner/Mazel.

Lambert, K. (1981). *Analysis, repair and individuation*. London: Academic Press.

Money-Kyrle, R. E. (1956). Normal countertransference and some of its deviations. *International Journal of Psychoanalysis, 36*, 360–366.

Polet, D., & Heingler, B. (1983). *Nursing research, principles and methods*. New York: J. B. Lippincott.

Racker, E. (1968). *Transference and countertransference*. London: Hogarth Press.

Robbins, A., & LaMonica, M. (1980). Creative explorations of countertransference experiences. In A. Robbins (Ed.), *Expressive therapy* (pp. 58–72). New York: Human Science Press.

Robbins, A. (1987). An object relations approach to art therapy. In J. A. Rubin (Ed.), *Approaches in art therapy* (pp. 63–74). New York: Brunner/Mazel.

Wolf, R. (1985). Image induction in the countertransference: A revision of the totalistic view. *Art Therapy, 2*, 129–133.

Wood, M. (1984). The child and art therapy: A psychodynamic viewpoint. In T. Dalley (Ed.), *Art as therapy* (pp. 62–81). London: Tavistock.

1990–91 Membership Survey Report

Raymont A. Gordon, *Research Associate, Eastern Virginia Medical School, Dept. of Psychiatry and*
Trudy Manning, MS, A.T.R., *AATA Membership Chair*

In 1990 and 1991, a demographic survey was mailed to AATA Members along with annual membership dues billing. Members were asked to provide information regarding their areas of specialization, job setting, types and ages of populations with whom they work, as well as optional demographic information such as gender, age, hours worked, job title and salary. Of the 3492 surveys mailed, 1633 were returned, representing a 46.8% return rate. Reflected in this high return rate is the marked increase in AATA membership. As can be seen in Table 1, there has been a significant increase since 1989 in all but one membership category.

The rate of overall membership has increased two-fold (9% to 18.4%) from the last survey. Illustrations A and B provide national and international membership statistics.

The educational level of survey respondents shifted slightly between categories as can be seen in Table 2. Many of the respondents with Bachelor's degrees noted that they were currently working toward a Master's degree or higher indicating a commitment to high professional standards within AATA.

Specialty Areas: As in the 1988–89 survey, specialties listed by AATA members reflect current mental health trends and areas where art therapists are finding employment. Note, however, that these figures may be an underestimate of actual specialization because only the first three areas were included in Figure 1. Many members chose more than three (some up to 15) contrary to the survey instructions.

Many members (N = 293) selected the "Other" category as an area of specialization. The most frequent of these areas is listed in Table 3. Less frequent categories included adult children of alcoholics, hearing impairments, crisis intervention, child neglect/abuse, depression, art teaching, personal growth, sexual offenders, hypnotherapy, homeless, and workshops and seminars. (Note the percentage column in Table 3 repre-

Table 1: AATA Membership Category Statistics

Membership	09/30/89	07/31/91	Increase	%
Professional A.T.R.	1596	1893	297	18.6%
Professional	154	182	28	18.2%
Associate	563	747	184	32.7%
Student	580	605	25	4.3%
Life Member	15	15	0	0.0%
Hon. Life Member	11	13	2	18.2%
Contributing	7	9	2	28.6%
Retired	24	28	4	16.7%
Total	2950	3492	542	18.4%

Table 2: Respondents' Educational Degree

Degree	1988-89	%	1990-91	%
Master's Degree	779	86.30%	1335	81.8%
Bachelor's Degree	79	8.80%	186	11.4%
Doctoral Degree	35	3.90%	111	6.8%
Associate/Certificate	4	0.04%	5	0.3%
Other	6	0.06%	92	5.6%
None	N/A		35	2.1%

Illustration A: AATA U.S. National Membership

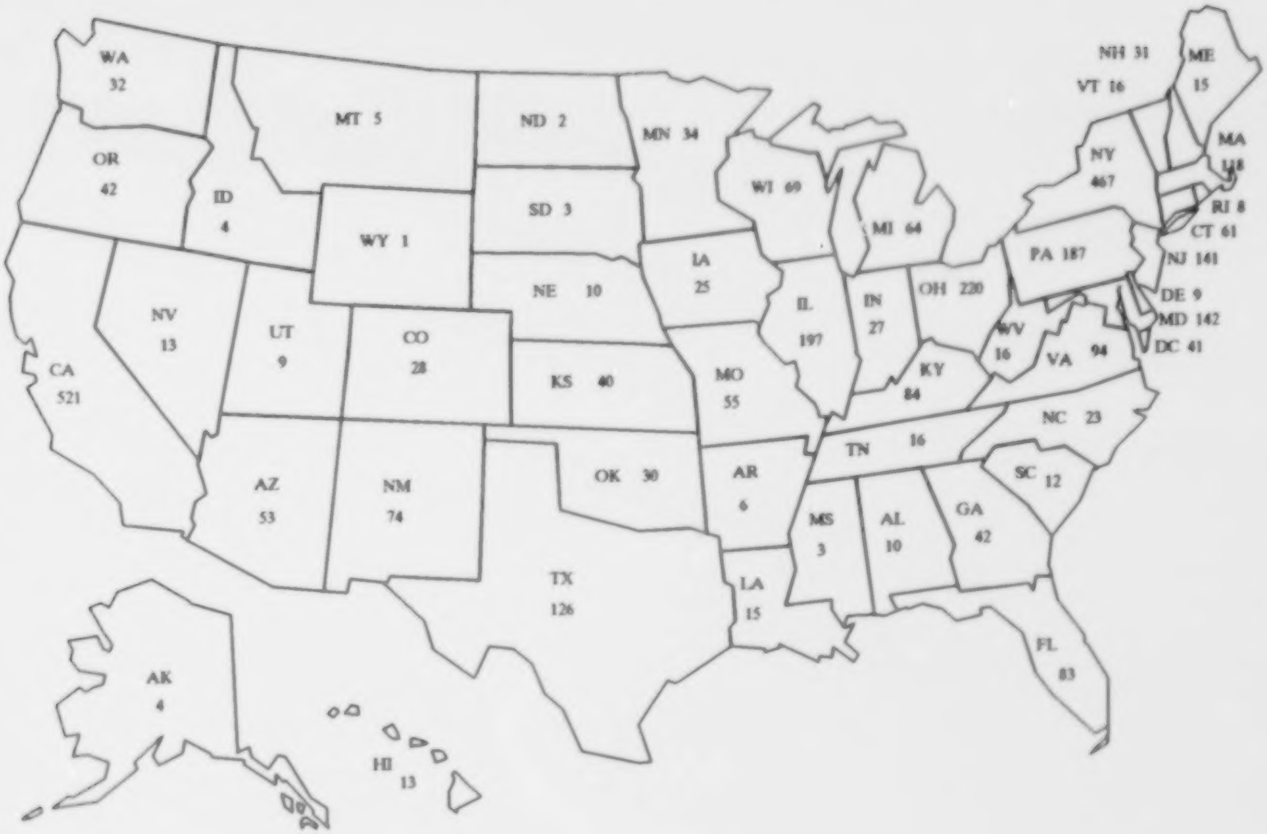

WA 32
OR 42
ID 4
MT 5
WY 1
NV 13
UT 9
CA 521
AZ 53
CO 28
NM 74
ND 2
SD 3
NE 10
KS 40
OK 30
TX 126
MN 34
IA 25
MO 55
AR 6
LA 15
WI 69
IL 197
MI 64
IN 27
OH 220
KY 84
TN 16
MS 3
AL 10
GA 42
FL 83
SC 12
NC 23
VA 94
WV 16
PA 187
NY 467
VT 16
NH 31
ME 15
MA 118
RI 8
CT 61
NJ 141
DE 9
MD 142
DC 41
AK 4
HI 13

Illustration B: AATA International Membership

Australia	4
Austria	1
Brazil	4
Canada	95
Chile	3
Denmark	1
Finland	1
France	3
Germany	7
Greece	1
Iceland	2
India	1

8	Israel
2	Japan
2	Mexico
2	Netherlands
1	Norway
1	Pakistan
1	Puerto Rico
7	Switzerland
3	Taiwan, ROC
1	U.S. Virgin Islands
3	United Kingdom

Figure 1: Areas of Specialization

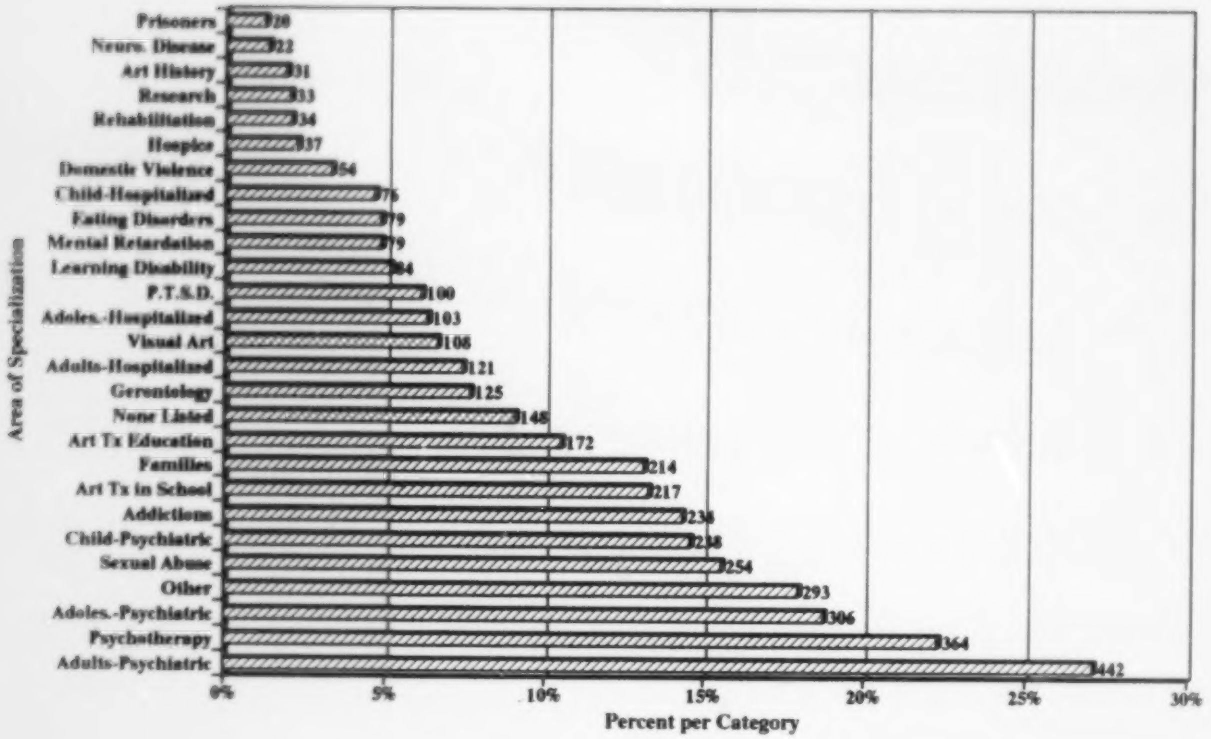


Table 3: List of Most Frequent "Other" Specialties

Specialty	Number	%
MPD/Dissociative Disorders	21	7.2%
HIV Positive (AIDS)	16	5.5%
Bereavement/Grief/Loss	16	5.5%
Chronic Illness/Adjustment to	12	4.1%
Residential Tx-Children/Adoles.	11	3.8%
Abused/Neglected Children	10	3.4%
Substance Abuse/CD Problems	10	3.4%
Creativity	9	3.1%
Day Tx-Child/Adoles.	9	3.1%
Spirituality	8	2.7%
Total	122	41.6%

sents the percent of those citing "Other" as an area of specialization.)

Primary and Secondary Work Settings: In several cases members selected more than one work setting. Figures 2 and 3 reflect only the first setting selected for each job. From this over-selection of settings, it seems members have diverse interests and employment. Also, many members neglected to complete this section of the survey even though they completed other sections.

Ages of Populations: Figure 4 presents the age ranges of clients with whom members work on their primary and secondary jobs.

Major Job Activities: Figures 5 and 6 display the breakdown of members' three major job activities. Percent of time spent performing activities on their primary job are as follows: Supervision, 31.1%; research, 5.1%; teaching/training, 27.3%; administration, 16.4%; individual therapy, 71%; group therapy, 60.3%; family therapy, 21.3%; organ-

Figure 2: Primary Work Setting

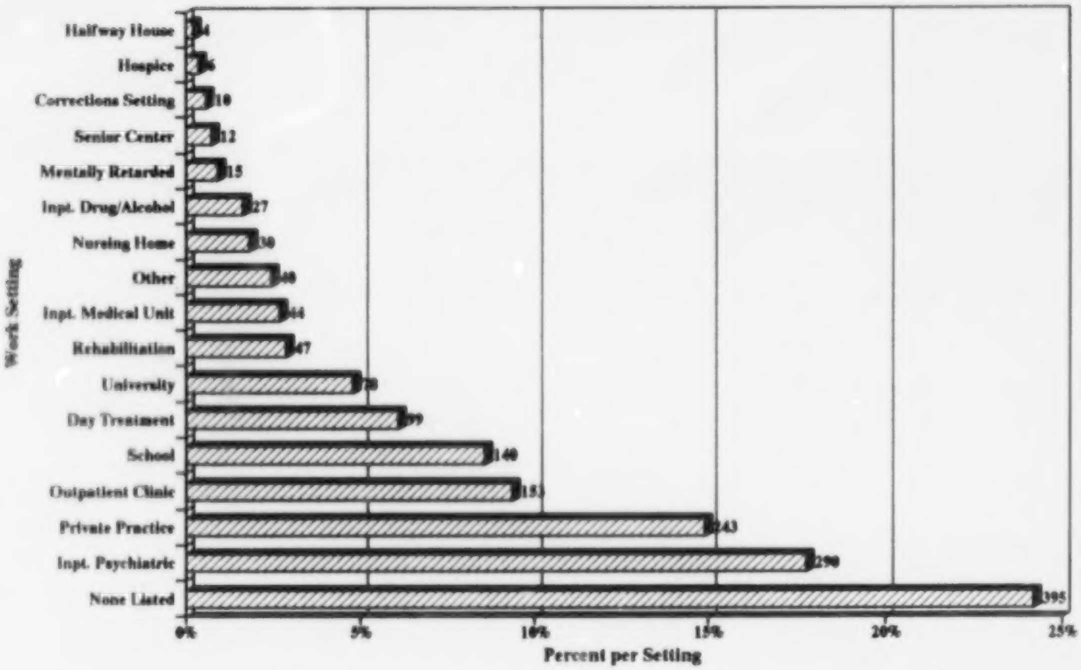


Figure 3: Secondary Work Setting

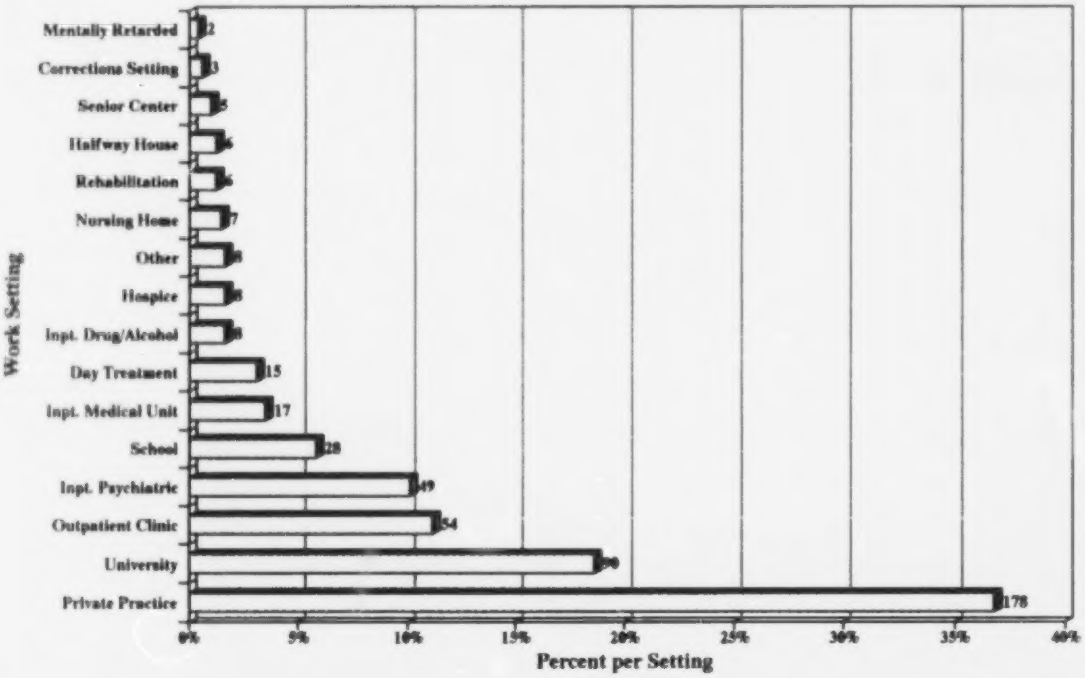


Figure 4: Ages of Populations for Primary and Secondary Jobs

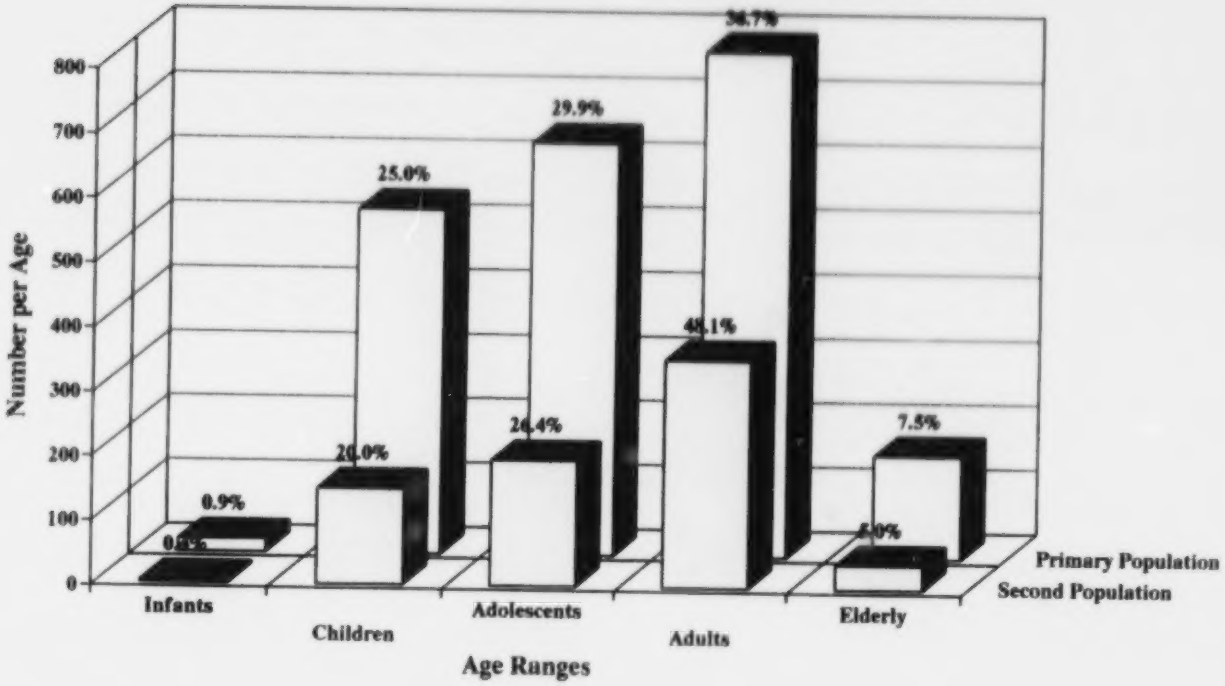
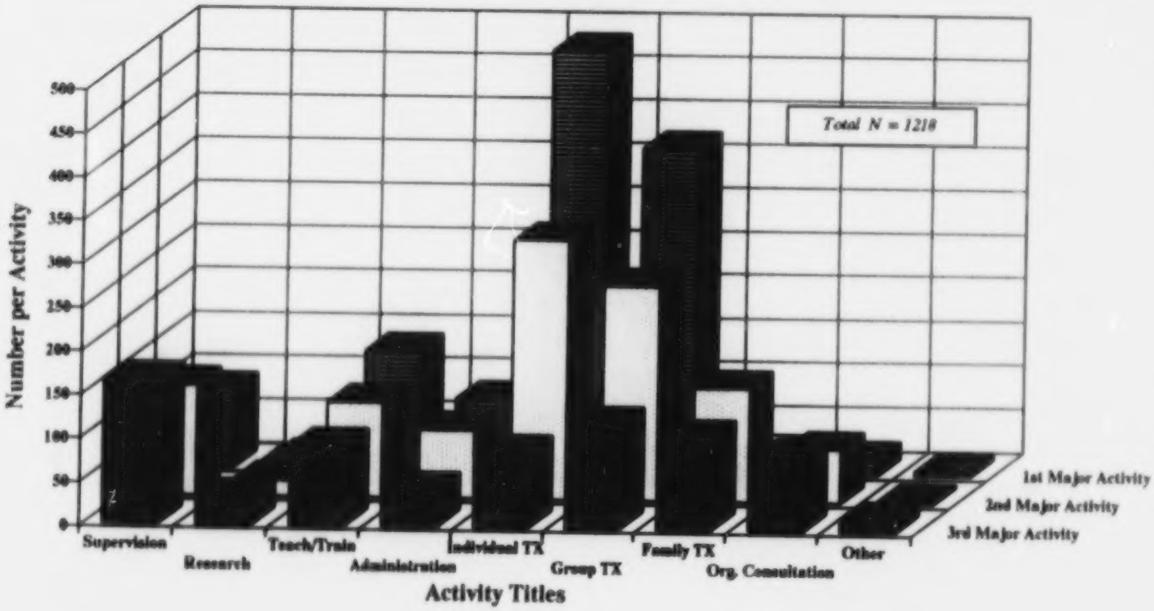


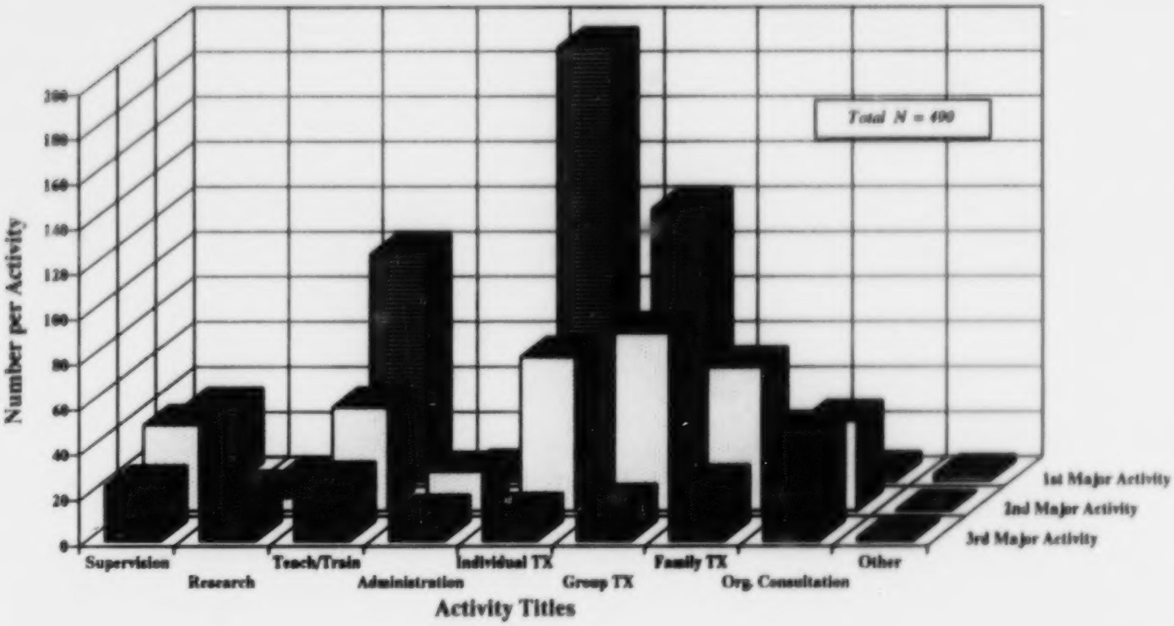
Figure 5: First 3 Major Activities of Primary Job



izational consultation, 12.2%; other activities, 1.8%. (Note that totals add to more than 100% due to three rank ordered activities being combined.) Other activities not listed but suggested as additional categories consisted of workshops, assessment/evaluations, paperwork, and writing books.

Time spent performing activities on their secondary job are: Supervision, 19.4%; research, 6.1%; teaching/training, 35.3%; administration, 6.7%; individual therapy, 55.7%; group therapy, 44.1%; family thera-

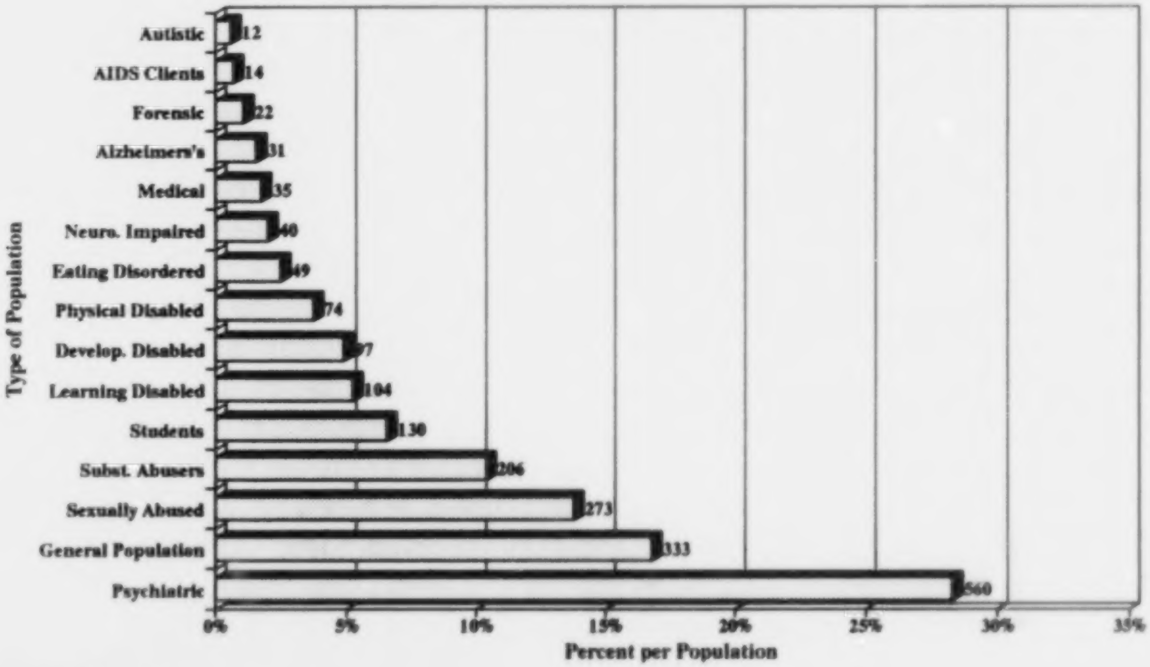
Figure 6: First 3 Major Activities of Secondary Job



py, 22.4%; organizational consultation, 18.4%; other activities, 0.8%. Information used to create Figures 5 and 6 is based on only the first three rank ordered activities listed by members. Many respondents indicated numerous activities per job that were disregarded due to failure to follow directions. Four hundred fifteen members left this section of the survey blank.

Population Types: Figures 7 and 8

Figure 7: Populations of Primary Job



BEST COPY AVAILABLE

Figure 8: Populations of Secondary Job

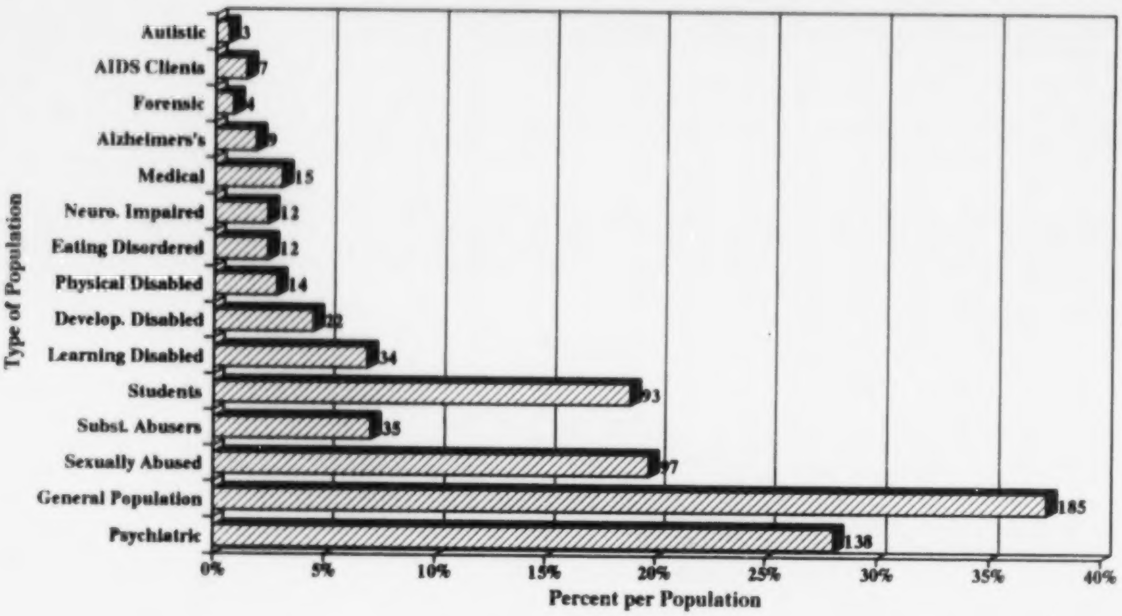
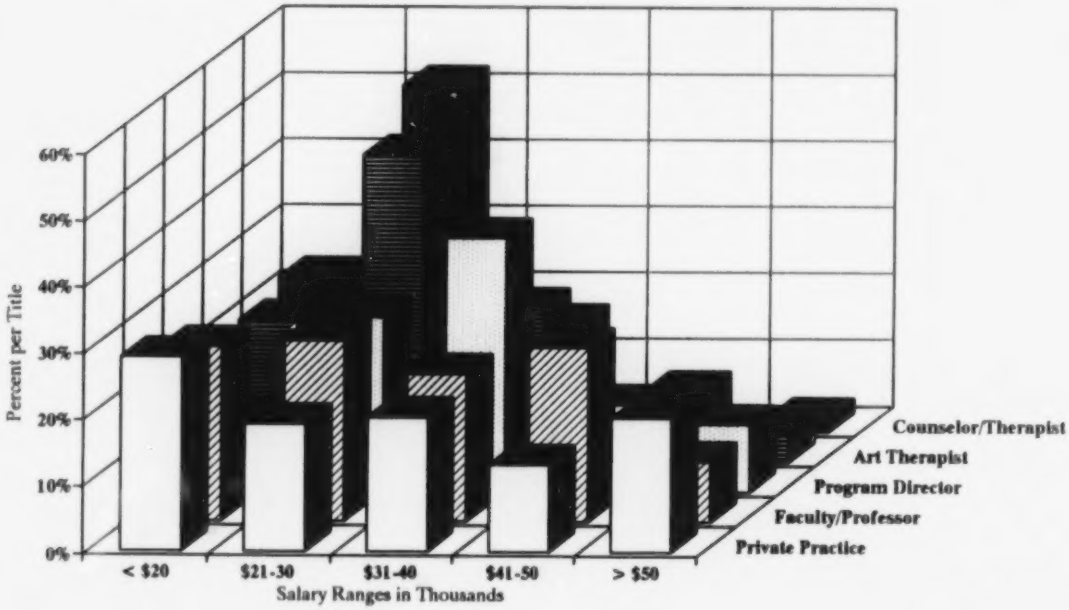


Figure 9: Total Salary by Job Title



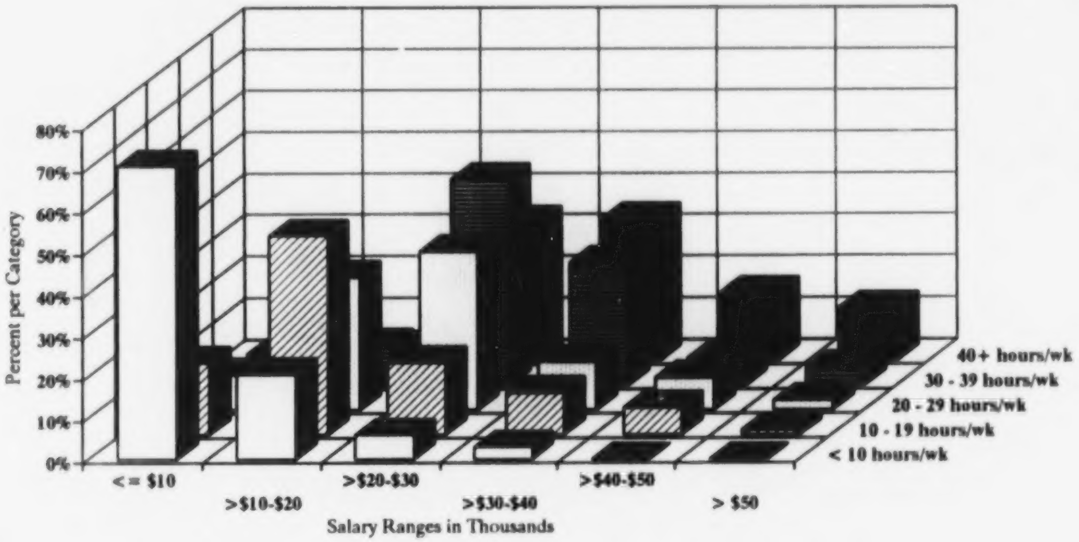
show the types of populations worked with by members. Only the first two population types listed by members were used in these figures.

Salary by Title and by Hours Worked: A total of 1022 members answered this question. Some repondents indicated that this question was too personal to answer. Others noted that they were unsure of their income due to variable billing and/or multiple jobs. Figure 9 presents a breakdown of salary ranges by five broad job categories. The figure titles used approximate the titles listed by respondents. Table 4 provides a summary of this data in $5000 increments.

Table 4: Detailed Summary of Salary by Job Title

Salary Range	Job Title									
	Director		Art Therapist		Counselor		Faculty		Private Practice	
< 20K	11	11%	126	21%	16	23%	31	26%	16	29%
20-25K	13	13%	129	22%	11	16%	15	12%	8	14%
25-30K	13	13%	141	24%	25	36%	18	15%	3	5%
30-35K	15	15%	87	15%	7	10%	13	11%	6	11%
35-40K	23	23%	49	8%	4	6%	13	11%	5	9%
40-45K	7	7%	26	4%	2	3%	11	9%	2	4%
45-50K	6	6%	16	3%	2	3%	9	7%	5	9%
50-55K	3	3%	9	2%	0	0%	3	2%	0	0%
55-60K	2	2%	7	1%	1	1%	1	1%	4	7%
>60K	5	5%	6	1%	1	1%	7	6%	7	13%
Total N	98		596		69		121		56	
Average	$35,224		$27,492		$27,876		$31,673		$37,007	

Figure 10: Total Annual Salary by Hours Worked Each Week



Figures 10, 11, and 12 provide members' salary ranges broken down on an hourly basis. Figure 10 gives information for total salary and Figures 11 and 12 display salary data for members' primary (N = 1022) and secondary (N = 483) jobs.

Age, Gender, and Race: Figure 13 provides data concerning the age distribution of AATA members. 1512 members provided age information. Figure 14 shows data for gender of members. 1627 respondents provided gender information. Table 5 gives a breakdown of members' racial background. 1573 members provided information for this data.

Survey Limitations: The primary limitations of this survey are: 1) it was incompletely or incorrectly filled out, and 2) many members failed to return their surveys. The percentage of incomplete data ranged from 0.4% (Sex) to 37.4% (Salary). Also, data such as areas of specialization or type of population were overselected. However, a return rate of 46.8% is an acceptable percent of return, and even though specific directions to limit responses were not followed, respondents did provide usable information (e.g., areas of specialization was answered by 91% of respondents).

A copy of this survey may be obtained by AATA, Inc. members by sending a SASE (52¢ postage) to the AATA, Inc. National Office (Also available to nonmembers for $2.00 per copy.)

Figure 11: Salary of Primary Job by Hours Worked Each Week

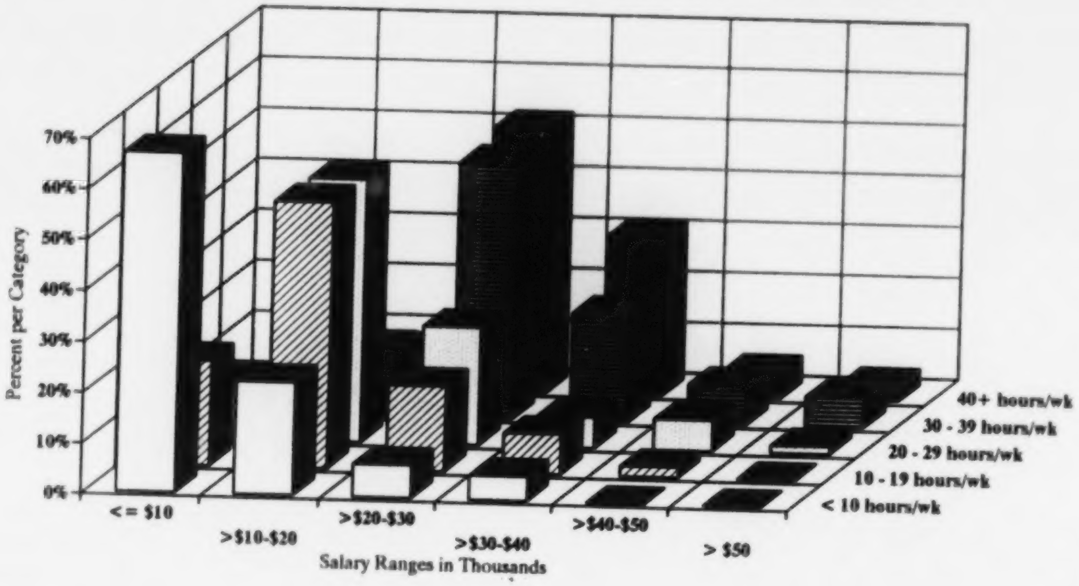


Figure 12: Salary for Secondary Job by Hours Worked Each Week

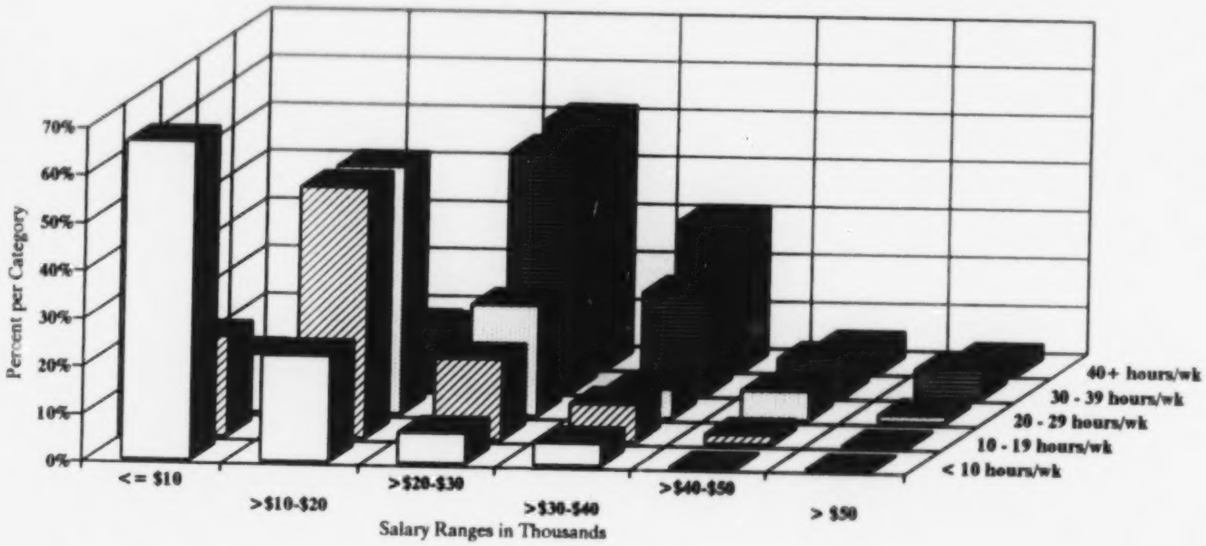


Figure 13: Age of Respondents

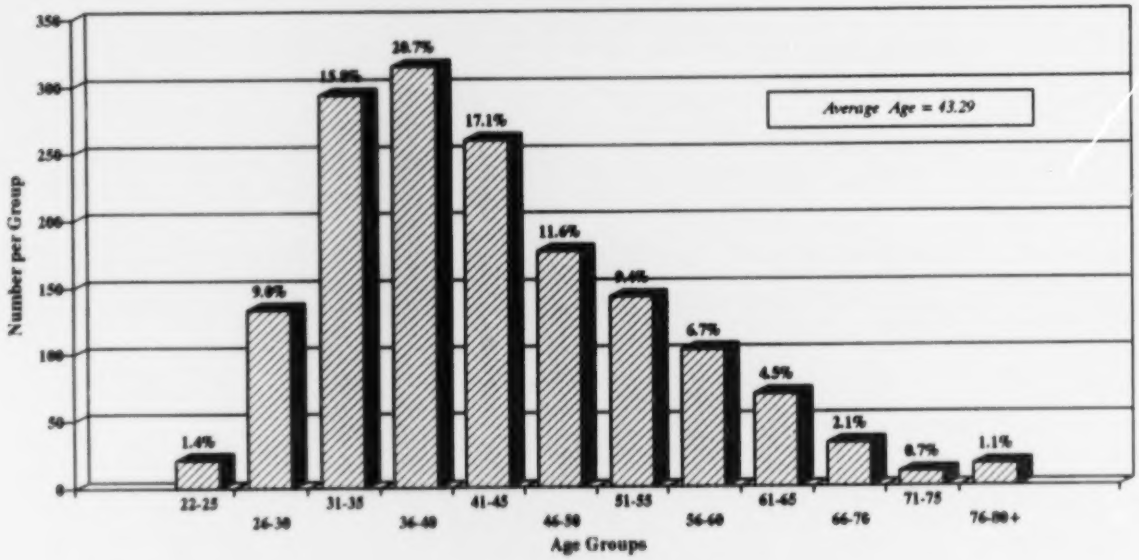


Figure 14: Gender of Respondents

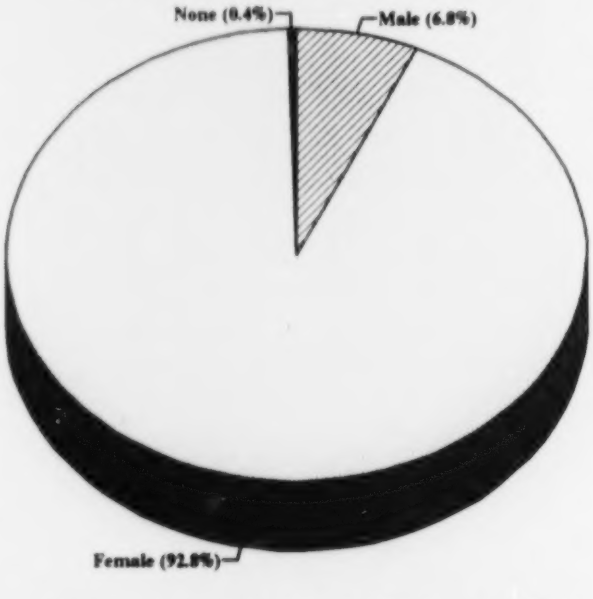


Table 5: Summary of Racial Background Data

Race	Number	Percentage
African American	10	0.6%
Asian American	10	0.6%
Caucasian	1512	92.6%
Hispanic	13	0.8%
None	60	3.7%
Other	28	1.7%

VIEWPOINTS

Art Therapy in a War Zone

Hannah Sherebrin, A.T.R.

When I left Canada on December 2, 1990 to visit family in Israel, I had no inkling that I would be needed in a professional capacity. Because I had lived in Israel from 1944 until 1967, I am fluent in Hebrew, and therefore was able to lend a hand in alleviating some of the anxieties and tensions of professional therapists in the midst of SCUD attacks. On January 30, I conducted a workshop for the southern section of the Israel Arts Therapies Association in Beer Shevah, a thriving southern town.

Despite the nightly SCUD attacks, the reluctance to go out at night was overcome on that evening by close to thirty-five members, who came from the surrounding area to participate in a workshop exploring their own fears and reactions. The eerie sight of a row of gas masks lining one wall was a grim reminder of the frightening possibilities. I sensed the tension mounting as participants anticipated the nightly air raid. Laughter, work, and sharing started as I announced that I have a communique from the "highest authority" that there would not be an attack that night. One participant asked "What about tomorrow?" to which I replied that we should concentrate on one day at a time. The "high authority" did not disappoint me, and we were able to work through some of the tensions.

Not surprisingly, much of what had to be worked through was baggage from other times of stress. Grieving past wounds and reliving fears was a commonly shared experience. Anger surfaced, along with much of the worry about the children and the elderly.

Workshop participants also directed criticism toward men. This war was particularly difficult on the men since in the past, they were used to kissing their wives and children goodbye and going to the front as protectors. In this war, the entire country became the front, and the reserves were not called up! For the first few weeks of war, there was no school and only essential services were operating, forcing most men and women to stay home with their children. On the positive side, it created opportunities to get to know the children much better, and to have a feeling of togetherness in many families. The television station provided programs 24 hours a day; some of the programs concentrated on instruction in common family activities for the homebound population. Some men, however, chose not to wear their masks as a form of protest and a "macho" demonstration, which did not provide good examples for the children, and there were programs in which psychologists warned about the results of such behavior.

One of the techniques I used at the workshop to enable participants to explore and share was the Personal Shield drawing. This technique was adapted to Jewish culture by the use of the Star of David as the shield. Another was the folio envelope on which participants paste cut-out magazine pictures of objects or draw and paint things about themselves that they want to present to the world. This is their "mask" which they are willing to share. Inside they could represent the significant things they want for themselves, but cannot or will not share. It was interesting to see one of the participants, with a smile, stash her Personal Shield drawing in the envelope for safekeeping.

Since returning to Canada I have received encouraging letters from participants in the workshop. Some sent newspaper clippings on the various uses of art therapy within the schools, and with victims of the attacks who lost their homes. I would like to share some of those with you, but since they are in Hebrew, you will have to trust my translation. I will certainly make the originals available to those of you who want them.

DRAWING THE FEAR

(Maariv, Beer Shevah and the Negev, February 22, 1991)

THE CHILDREN WHO HEARD FOR THE FIRST TIME THIS WEEK AN EXPLOSION OF A MISSILE, GAVE EXPRESSION TO THEIR FEELINGS.

Until last Saturday the southern Israel region did not suffer long stays in the sealed rooms. The heroes were definitely the children who without realizing why, had to experience the masks and the loud booms which were heard clearly over the city. We asked the children to draw their feelings. Naomi Traklin, an educational psychologist, explained that the fears were transferred to drawings, which became manageable. The drawing of viper snakes (the code used on the radio before each actual alarm was sounded) pinpointed the moment of fear to the

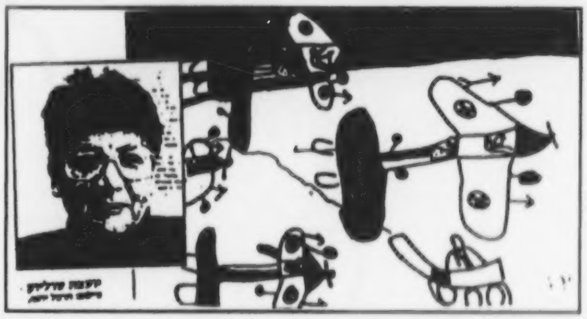


Fig. 1 Consultant Traklin and a drawing of a six-year-old student.

sounding of the alarm. The resourcefulness and mental strength of the school population was praised by Traklin, who exclaimed, "Where else in the world did you see that children, after a night of alarms, pick up their gas masks and go to school to study? . . . We have to appreciate the mental strength that both children and adults who accompany them have displayed."

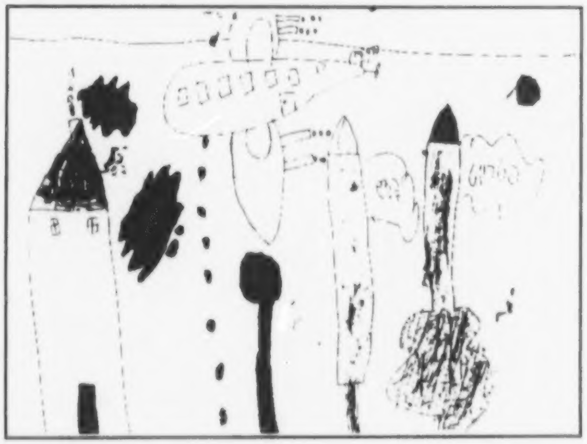
The lack of experience that the children and youth have in horrors of war can be to their benefit. They learn to cope with the dangers, and the aids that were provided, such as art therapy, help to decrease the fears.

SCUD DRAWINGS

(Al Hamishmar, February 22, 1991)

The Israel Art Museum in Ramat Gan was closed because it is located in an area which was hit by SCUDs several times. The museum staff, including artists and art therapists, went to work with the displaced families whose homes were demolished. The aim was to help externalize their anger by channelling it into creative drawings. The drawings are now displayed in the museum, and despite the fears and feelings which are revealed, the works portray aesthetic sensitivity and authenticity.

Fig. 2 A nine-year-old boy's drawing.



Many other articles appeared by art therapists, extolling the virtues of the use of art therapy. This is a curious after-effect of an unfortunate situation, which aided in bringing to the awareness of the general population the benefits and power of our profession. I would like to close with a letter which appeared in the second week of the war, while I was still there. This is a dialogue which was recorded by a sensitive father of two daughters, five-year-old Lilach and seven-year-old Iris. The two drawings were done by the children spontaneously.

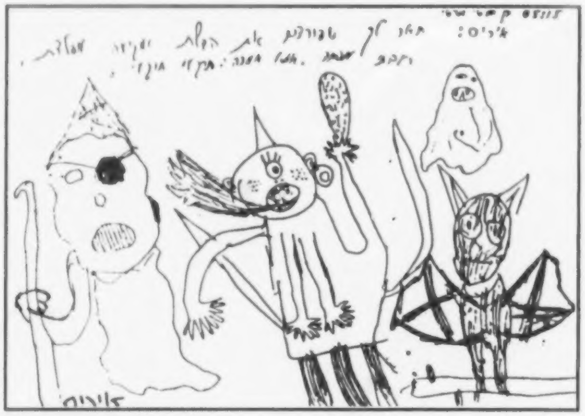


Fig. 3 Seven-year-old Iris

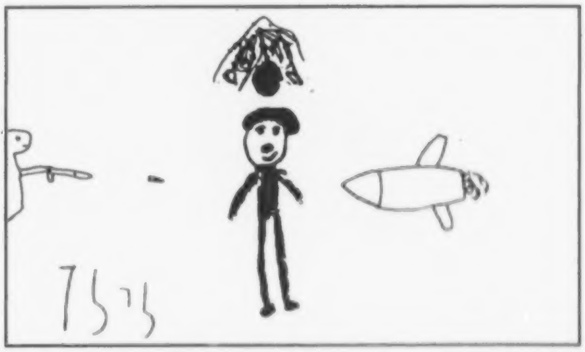


Fig. 4 Five-year-old Lilach

A DIALOGUE BETWEEN LILACH AND IRIS

(Haarez, January 25, 1991)

This dialogue took place in the sealed room on the first night of the SCUD attacks between Thursday and Friday.

LILACH: I thought Sadam will arrive here, break down the door and fight us.

IRIS: And what will happen then?

LILACH: I don't know what will happen. He did not materialize.

IRIS: I felt like throwing up from this mask. I almost choked. I felt I have no strength left. This is the first time I see such a long war. Imagine that the door is flung open and a monster arrives. I shuddered from fear. Mother told me "relax, relax." I coughed and felt a total collapse.

LILACH: And how come you did not collapse?

IRIS: Mother calmed me down.

LILACH: What day is today?

IRIS: Friday, so we will see on television "The Beautiful Animals." Maybe it will be good to kill Sadam's wife?

LILACH: What, he has a wife? Does he love her? She must be ugly for sure. Instead of killing her, maybe they and their helpers could be disarmed?

IRIS: I wish they announced that war is over. You can be free. But maybe we should not go to school or work for a week.

LILACH: Why should we not go?

IRIS: Because maybe the Iraqis have planted a bomb or a mine and we will go out and step on it and it will blow us up. I pray that on Shabbat there will be no air raids. It will spoil our Shabbat.

LILACH: I pray that there will be no wars, period.

At 6:25 that morning Iris calls up her friend Mor, and tells her: "First we were afraid that the bomb contained gas, but it turned out that it was only a firebomb. So, Mor, do you want me to come over to your place someday when they will tell us that war is over and there is no need for masks any more?"

These last two drawings were produced at the time of the stay in the sealed room. Most families prepared their rooms with plenty of art supplies, books, games and other materials to occupy the people while in this state of isolation.

The war is over now, and I am sure that Iris has gone to visit Mor. Only time will tell if there are lingering psychological effects on the population of the entire region. Also, we should not forget that more than half of the population of Israel are either survivors or children of survivors of the Holocaust.

The experience of living through the recent Gulf War in Israel has filled me with awe and admiration for the spirit of restraint shown by one and all. There was a determination in everyone I met to see that life should get back to "normal" as soon as possible. I hope we can find encouragement in the positive use of art therapy and in the increased profile it is achieving as a result of the war.

For my clients

Teddy Ramsden, A.T.R., 1990

Approaching the door of health
you see light seeping.
As the door opens
you enter.

Out of your hearts leap colors of the spirit
the pain and joy of your living.

In the shadows of the deep crevices
the murderer of pleasure can be put to rest
once expressed.

What one feels can be said in art.
Truth is welcomed here
the truth of ink
the truth of colors
the rainbow after the storm.

Put your pain on paper.
Transform the serpent with fire red.
Let him breathe a gentler pink.
Laugh in yellow.
Cry in green, healing.

I have this button
that lies close to my heart
propelled also
by my mind and knowledge.
I press it when I get to work.
I call it my helper button.

I turn it on
and reach
and think
and love carefully
profoundly.
It's light is not red
but green
for healing.

REVIEWS

Art and Interaction: An Academic Fieldwork Program for Colleges, An Activities Program for Institutions

***Judith Peck**, Ramsey, NJ: Ramapo College of New Jersey, 1990.*

Reviewed by: **Lynn Kapitan, MPS, A.T.R.,** *Director of Graduate Art Therapy, Mount Mary College, Milwaukee, WI.*

For the past fifteen years, Judith Peck, Associate Professor of Art at Ramapo State College of New Jersey has led an undergraduate fieldwork program with unique qualities. Students from diverse majors and areas of the college enroll in the course for a first-hand opportunity to bring art and social interaction to people living in institutions. The objectives of the program are two-fold: 1) To benefit those who live in a state of confinement by generating creative activity, enhancing self-esteem and confidence, and 2) to provide students with a field-based educational opportunity, fostering personal contact with "out-of-reach individuals and their distinctive situations and problems" (p. 1).

Consequently, the field manual *Art and Interaction* is written to inform the institution of the scope and sequence of such an art activity program, as well as to help the student and college support personnel who will carry it out. Peck decided to publish the field manual as more and more institutions and students were attracted to the program, recognizing its potential use in other colleges and universities. Indeed, the manual is very thorough in its presentation of the many complexities of undergraduate fieldwork. Because of the extensive detail contained in the manual, it is conceivable that the Ramapo College "Art and Interaction" interdisciplinary course could be replicated and serve as a model for a variety of related fieldwork programs.

The manual is divided into seven parts, beginning with an overview of the concept and design of the program and a description of the "magic mix: art and social interaction" as a basis for art programming in institutions. Part Two details the wide range of needs and characteristics which students and supervisors encounter when working in the field. Barriers to success are given attention, focusing on the impact of volunteers brought into the established routines of the institution. The reader is given many thoughtful ideas and suggestions for dealing with typical obstacles to the acceptance of art-making activities. Part Three describes how to combine the fieldwork component of the program with academic concerns and needs, and is written with an eye toward involving faculty of various disciplines. The detailed logistics of developing an undergraduate fieldwork course are provided, from curriculum planning to budgeting supplies. Part Four shifts to finding appropriate sites for the program, and emphasizes communication with on-site personnel who will be involved. Part Five presents the art projects that have been used successfully in the program with diverse populations. Readers who are unfamiliar with art processes can look to the program manual for a source of creative ideas and ways of presenting them to others who may be equally unfamiliar with art media. Suggestions for presenting the projects, displaying artwork, and interacting with the participants help the reader understand how the program works on a concrete level. Finally, evaluation criteria are discussed, followed by detailed appendices of evaluation instruments which have been useful. The detailed thoughtfulness of the material reflects a program that has been many years developing. Peck has anticipated and answered the questions of her readers from the sheer experience of finding the best means to deal with the unique challenges of field programs.

While the program presented is specific to an undergraduate non-major fieldwork course, supervisors, students, instructors and institutions may find this a useful book for developing art activities programming. In particular, institutions may look to it as a concrete example of an art activity program that is successful without being overly idealistic. Communication between the institution and those who carry out the program is well addressed; art therapists who are attempting to bring a new program into an institution will find this manual useful because it addresses many of the initial assumptions, problems and challenges involved.

The thoroughness of detail, however, is both of

1111

value and a possible detriment to some of the manual's potential users. In this very specific form, Peck describes a program that could easily be misidentified and misconstrued as an art therapy program despite the care with which she claims it not to be. Art therapy programs in institutions aspire to identical goals and objectives, yet carry them out through trained expertise and long-term commitment. The danger in "how-to" manuals is their use by unknowing persons who are attracted to techniques but unaware of or unconcerned about the principles on which those techniques are based. The espoused value of bringing art into the lives of institutionalized people can be unwittingly trivialized when presented as a "free" program using student volunteers and short-term projects.

Art therapists who read the manual may also have difficulty with the use of art as a hand-maiden to other goals. Art in the program serves as a tool for college students with or without an art background to make contact with out-of-reach people, supported by the perspectives of non-art related professors and supervisors. Students in the course may have no contact with art other than having been taught how to do the projects for their presentations. If the value of art is not of great importance in the lives of the providers of the experience, it is difficult to imagine how its value will be communicated to those on the receiving end of these experiences.

After the manual is disseminated to a generic assortment of disciplines, who among those who use the manual will be committed to preserving the important, delicate balance which differentiates a solid art activity program from its identical-looking but superficial cousin? This is no small concern since Peck advises that institutions which have use for her program must demonstrate need, that is, should have no similar art program. In-patient and out-patient psychiatric patients, substance abuse, emotionally disturbed youth and abused children are among the populations targeted for this program—people who have critical needs that may be better served by art therapist than by student volunteers.

Because this is not an art therapy program, Peck does not focus on the profession other than in passing reference to training and expertise. Ironically, *more* reference to art therapy would have served as a professional "anchor" here which would do much to prevent the type of misinformed use the manual may unwittingly encourage. Readers would be able to see the interrelation and overlap of the various disciplines from which this manual draws, and understand how *Art and Interaction* is both different from and similar to art therapy, the field to which this program is most closely related.

When compared to some of the familiar artist-in-residence field-based programs which bring artists into institutions for a similar purpose, this manual is a welcome improvement. Often structure is lacking, goals are lofty and unrealistic, and presenters are unprepared and disruptive to the existing programming. It is apparent that Peck has been instrumental in making the *Art and Interaction* program an excellent one, and she has been sensitive to the many issues it raises. A lingering question, however, is how can she safeguard the values on which she bases this manual when the how-to is made accessible without a full context for understanding the foundation on which it is based? Art programs are often seen by non-art professionals as a "magic-mix," to use Peck's term, and the idea of bringing in art is not explored beyond vague enrichment goals. Peck acknowledges the magic, but supports it with the hard work, care, and complexity that is intricately involved whenever people and institutions meet for art and interaction.

Multiple Personality Disorder from the Inside Out

Barry M. Cohen, M.A., A.T.R., Ester Giller, Lynn W., *(Editors), Baltimore: The Sidran Press, 1991, 272 pages, $14.95 (paperback).*

Reviewer: ***Louis W. Tinnin, M.D.,*** *Associate Professor of Psychiatry, West Virginia University, Morgantown, West Virginia.*

"What can I read about MPD (multiple personality disorder)?" It used to be that there was one answer for your clients, another for your supervisees, and still another for your colleagues. Now, the answer can be the same for all: "Start with *Multiple Personality Disorder from the Inside Out.*" The idea for this book must have been a Eureka! experience for art therapist Barry Cohen who wanted a collection of writings by clients with MPD to hand out at his Eastern Regional Conferences on Abuse and Multiple Personality. His co-editor, Lynn W., publisher of *MANY VOICES*, a newsletter for clients, solicited contributions from some 2300 readers. One hundred and fifty responded, and writings of 132 individuals are in the book. The other co-editor, Esther Giller, arranged publication by the foundation that she directs, the Sidran Foundation. The Sidran Press was established to publish this book.

The main text of the book is the contributions by clients with a final chapter by family members. The first chapter deals with feelings about the diagnosis of MPD: "We're not crazy; we just lead complicated lives." Other chapters express the pain of unresolved trauma, the mutual resentment between people with MPD and skeptical mental health workers, the "Vanishing Friend Syndrome" ("friends just drifted away"), and "Straight Talk for Therapists." This is what Julie W. wants all therapists to know:

> 1. ***Keep your hands to yourself.*** *Child alters are in an adult body and that body has no business in your lap, being kissed, being cuddled. . . .*
>
> 2. ***You're not our parents. . . .*** *You can't replace what never was and never will be. Child alters are not "your children" and you cannot re-raise us.*
>
> 3. ***Keep your opinions and emotions to yourself.*** *We don't need your tears or your anger. We have a gracious plenty of our own. . . .*
>
> 4. ***Don't foster and encourage our dependence, helplessness and fears. . . .*** *Playing God may be fun, and for us, having someone who will love and protect us at every turn is enticing and seductive, but you're not God and we're not children!*
>
> 5. ***We're not there for your entertainment.*** *Things that happened are not substance for "let's amaze the neighbors." Don't tell or hint at our stories to others (especially to those who know us), other multiples included. . . .*
>
> 6. ***I'm not your therapist. . . .*** *Take the money we pay you and go get your own therapist.*
>
> 7. ***You are not going to heal us.*** *Given support, guidance, boundaries, the freedom to err, make our own decisions, patience, honesty, we are the only ones who can heal us. You are not a mechanic, and we are not cars.*
>
> 8. ***Remember that we are real, living, breathing people.*** *At the end of the hour, we don't get to leave our memories behind. . . .* (pp. 142–143).

There is an excellent overview of multiple personality disorder and dissociation in just three pages of the introduction. The book also has lists of treatment programs, non-profit organizations, periodicals, tapes, and books.

Art therapists will find that the book's weakness is the lack of pictures. The poetry and prose engage the reader but pictures by the contributors would really make a connection.

The unique quality of this book is the authentic voice of the person with multiple personality disorder describing an unimaginable experience of life that becomes comprehensible and familiar. At some point the therapist who is learning about MPD must gain this understanding from the inside out and this can be a slow process when working with only one or a few individual clients. This book offers a giant step towards this understanding.

WRIGHT STATE

Wright State University
Dayton, Ohio 45435

Master of Art Therapy

- academic study
- clinical practicum
- media experience
- elective options
- arts involvement
- program approved by AATA

For additional information:
Gary C. Barlow, Ed.D., ATR
Coordinator, Art Therapy
228 Creative Arts Center
Phone 513/873-2758 or 2759

The American Art Therapy Association, Inc.

1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(708) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapist's Indentity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) 110 pages	$15.00	$20.00
Art Therapy: Professionalism in Practice (1988) 127 pages	$15.00	$20.00
Painting Portraits: Families, Groups & Systems (1989) 141 pages	$15.00	$20.00
Image & Metaphor: The Practice & Profession of Art Therapy (1991)	$15.00	$20.00
American Psychiatric Association Special Conference Proceedings *Use of the Creative Arts on Therapy (1979)*	$ 5.00	$ 7.00
Art Therapy in the Schools	$ 6.00	$10.00

*NOTE: for **Publications** postage/handling, add $3.00 for the first unit item, $ .75 each additional unit

SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS.

** Foreign Orders: Require pre-payment for items and then will be billed for shipping charges as you instruct on order:
Air Mail charges (1 week delivery) or Ground Services charges (2 month delivery).

10 or more copies of any single issue: 15% discount on total cost. Discounts are available when Purchasing quantities.
Set of four Proceedings (consecutive years): 20% discount on total cost.

Indicate Quantity of Unit Items Below **Cost/Unit** **Total**

____________ ( ) X ________ = ________
____________ ( ) X ________ = ________
____________ ( ) X ________ = ________
____________ ( ) X ________ = ________

* Publications Postage/Handling = ________ Total Publications Costs = ________

WE DO NOT ACCEPT PURCHASE ORDERS

Art Therapy: Journal of the American Art Therapy Association
Subscription Rates: Individuals — U.S. $25.00; Foreign $42.00; Institutions — U.S. $36.00; Foreign $53.00
Art Therapy: Journal - Back Issues each $9.00 $16.00
AATA Newsletter Subscription Non-Member U.S. $16.00 Foreign $28.00

FILMS (Rental/Purchase)

Art Therapy: Beginnings (1977) color/sound, 45 minutes	16mm Rental Only:	$40.00	$50.00
	½" VHS, Purchase Only:	$50.00	$80.00
Michael (1977) color/sound, 12 minutes	16mm Rental Only:	$30.00	$35.00
	½" VHS, Purchase Only:	$50.00	$80.00
Art Therapy (1981) color/sound, 12 minutes	16mm Rental Only:	$35.00	$45.00
	½" VHS, Purchase Only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery (1978) color/sound, 32 minutes	16mm Rental Only:	$40.00	$50.00
	½" VHS, Purchase Only:	$50.00	$80.00

*NOTE: for **VHS Films Purchase** postage/handling add $3.00 for each film

*NOTE: for **16mm Rental** add $7.00 for postage/handling

Indicate Quantity of Unit Items Below **Cost/Unit** **Total**

____________ ( ) X ________ = ________
____________ ( ) X ________ = ________

*Films Postage/Handling = ________ Total Films Costs = ________

ORDER FORM: ***Make checks payable in U.S. funds to AATA, and mail to the above address***

SEND TO: ______________________ MBR. ID. NO. ________

____

City ________ State ________ Zip Code ________

WE DO NOT ACCEPT PURCHASE ORDERS

The American Art Therapy Association, Inc.

THE ORGANIZATION

The American Art Therapy Association (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3000 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice: AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliated Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals, information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive

Publications

- *Art Therapy*, the official journal of the AATA.
- The quarterly *AATA Newsletter*.
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- Free AATA literature, such as Educational Porgrams List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payers.
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy.

Professional Standards

- Development of model job and licensure laws.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

GENERAL MEMBERSHIP APPLICATIONS

1. The membership year is the calendar year January 1st through December 31st.

2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY: Please follow the chart below when submitting membership application.

Applications received between

> **Jan. 1st and May 31st**—Full dues payment. Membership will expire Dec. 31st of same year.
>
> **June 1st and Sept 30th**—Half year dues plus $5.00 payment, membership will expire Dec. 31st of same year.
>
> **Oct. 1st and Dec. 31st**—Full dues payment, membership for the remainder of current year and the next full year through Dec. 31st.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval.

4. AATA Membership and AATA Registration (A.T.R.) each have a separate application procedure. Registration is bestowed only the Standards Committee.

5. National AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL—by application only; such members may vote, hold office and serve on committees.

> **Credentialed Professional Member**: Individuals who have been dually approved for Professional Membership and Registration (A.T.R.) by the AATA, dues are $80 per year.
>
> **Active Professional Member**: Individuals who have completed professional training in art therapy, dues are $75 per year.

CONTRIBUTING—Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $100 per year.

ASSOCIATE—Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75 per year.

STUDENT—Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Student members may not vote or hold office but may serve on the Student Subcommittee of Membership. Dues are $35 per year.

The American Art Therapy Association, Inc.

1202 Allanson Road • Mundelein, IL 60060 • (708) 949-6064

LOOKING FOR JUST THE RIGHT WORDS TO DESCRIBE A CLIENT'S BEHAVIORS?

You'll find them in The Clinician's Thesaurus 2E. You can tailor your narratives choosing from 17,000+ descriptive terms and standard phrases for all aspects of psychological and social evaluations.

Perfectly organized for easy access, to prompt your recall of a client, to stimulate your thinking, and to sharpen your writing. It offers hundreds of descriptors for Mental Status and cognitive functioning, words and phrases for Behavioral and Interpersonal Observations, Affects, ADLs, Vocational, Recreational and Social Functioning, all Personality Disorders, Diagnoses, Prognoses, Closing the report, Recommendations, Confidentiality Notices, and more handy items.

Suitable for older children and adults, and any orientation or evaluation purpose. Ideal for students and refreshing for the senior practioner. 16,000+ sold. Order today and you will have it in 2 weeks with a money back guarantee of satisfaction. $23.50 includes shipping to Three Wishes Press AT1, Box 81033, Pittsburgh, PA 15217 *Thanks*

1991 AATA
MEMBERSHIP DIRECTORY

Now Available through the National Office
($2.90 Postage & Handling)
$10.00 member **$50.00** non-member
$100.00 institution

NAME ____________
ADDRESS ____________
CITY ____________
STATE ____________ ZIP ____________

▲ *Mail entire form to:* ▲
AATA NATIONAL OFFICE
1202 Allanson Rd./Mundelein, IL 60060

Guidelines for Authors

Please submit six (6) copies of manuscripts to: **Art Therapy Journal,** AATA National Office, 1202 Allanson Rd., Mundelein, IL 60060. AATA cannot be responsible for submissions sent to any other address. Only original articles that are not under review by another periodical are acceptable.

FORM: Typewritten, double-spaced on 8½" × 11"-inch bond paper, with 1" margins.

STYLE: Prepared to conform to the *Publication Manual of the American Psychological Association* (Third Edition), available from APA Headquarters, 1200 17th Street, NW, Washington, DC 20036.

COVER PAGE: A detachable cover page to facilitate blind review should include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent.

ABSTRACT: An abstract of 100-125 words outlining the main ideas of the paper is required.

SECTION HEADINGS: The organization of the paper should be clearly indicated by headings and sub-headings, if appropriate.

FIGURES: For line drawings, use black ink and a good grade of white drawing paper. Photographs must be 5" × 7" black-and-white glossy prints with high contrast. Charts, diagrams and tables should be of professional quality, and legible enough to withstand reduction.

Write figure numbers on gummed labels and attach to the back of all figures. Captions must be typed and submitted on a separate sheet. In the text, refer to figures as Figure 1, Figure 2, etc.

Authors must obtain permission to reproduce the figure from a copyrighted source.

REFERENCES: References must be typed, double-spaced, in alphabetical order, on a separate sheet.

CONFIDENTIALITY: Client/Patient confidentiality must be protected in title, abstract, text, photos and other accompanying material. Proper releases must be obtained.

BEST COPY AVAILABLE

CHARLES C THOMAS • PUBLISHER

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¼ × 9¼), 28 il., about $35.00.

☐ Jones, Carroll J.—**ENHANCING SELF-CONCEPTS AND ACHIEVEMENT OF MILDLY HANDICAPPED STUDENTS: Learning Disabled, Mildly Mentally Retarded, and Behavior Disordered.** '92, 256 pp. (7 × 10), 7 tables, about $45.75.

☐ Thorne, Elizabeth and Shirley Herscovitch Schaye—**PSYCHOANALYSIS TODAY—A Case Book.** '91, 458 pp. (7× 10), about $69.75.

☐ Hardy, Richard E.—**GESTALT PSYCHOTHERAPY: CONCEPTS AND DEMONSTRATIONS IN STRESS, RELATIONSHIPS, HYPNOSIS, AND ADDICTION.** '91, 142 pp. (7× 10), about $25.50.

☐ Chaika, Elaine Ostrach—**UNDERSTANDING PSYCHOTIC SPEECH: Beyond Freud and Chomsky.** '90, 342 pp. (7 × 10), $53.75.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¼ × 9¼), 21 il., $32.75.

☐ Pine, Vanderlyn R., Otto S. Margolis, Kenneth Doka, Austin H. Kutscher, Daniel J. Schaefer, Mary-Ellen Siegel, & Daniel J. Cherico—**UNRECOGNIZED AND UNSANCTIONED GRIEF: The Nature and Counseling of Unacknowledged Loss.** '90, 198 pp. (7 × 10), 7 il., about $34.75.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $42.25.

☐ Harman, Robert L.—**GESTALT THERAPY WITH GROUPS, COUPLES, SEXUALLY DYSFUNCTIONAL MEN, AND DREAMS.** '89 162 pp. (7 × 10), $35.00.

☐ Crespi, Tony D.—**CHILD AND ADOLESCENT PSYCHOPATHOLOGY AND INVOLUNTARY HOSPITALIZATION: A Handbook for Mental Health Professionals.** '89, 162 pp. (7 × 10), 1 table, $35.00.

☐ Felthous, Alan R.—**THE PSYCHOTHERAPIST'S DUTY TO WARN OR PROTECT.** '89, 194 pp. (8½ × 11), 6 tables, $39.50.

☐ Dennison, Susan T.—**TWELVE COUNSELING PROGRAMS FOR CHILDREN AT RISK.** '89, 430 pp. (7 × 10), 55 il., $71.25.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (7 × 10), 34 il., $42.25.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $49.25.

☐ Nucho, Aina O. — **THE PSYCHOCYBERNETIC MODEL OF ART THERAPY.** '87, 248 pp. (6¾ × 9¾), 50 il., 4 tables, $42.00.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $40.00.

☐ Richie, Nicholas D. & Diane E. Alperin—**INNOVATION AND CHANGE IN THE HUMAN SERVICES.** '92, 180 pp. (7 × 10), 4 il., 3 tables, about $32.50.

☐ Chandler, Louis A. & Virginia J. Johnson—**USING PROJECTIVE TECHNIQUES WITH CHILDREN: A Guide to Clinical Assessment.** '91, 140 pp. (7 × 10), 13 il., 1 table, $27.75.

☐ Emener, William G., and Margaret A. Darrow—**CAREER EXPLORATIONS IN HUMAN SERVICES.** '91, 330 pp. (7 × 10), 13 il., about $49.75.

☐ MacNamara, Roger D.—**CREATING ABUSE-FREE CAREGIVING ENVIRONMENTS FOR CHILDREN, THE DISABLED, AND THE ELDERLY: Preparing, Supervising, and Managing Caregivers for the Emotional Impact of Their Responsibilities.** '91, 220 pp. (7 × 10), 4 tables, about $53.75.

☐ Schwenn, John O., Anthony F. Rotatori and Robert A. Fox—**UNDERSTANDING STUDENTS WITH HIGH INCIDENCE EXCEPTIONALITIES: Categorical and Noncategorical Perspectives.** '91, 270 pp. (7 × 10), 4 il., 15 tables, about $39.75.

☐ Gutsch, Kenneth U. & David Sisemore—**HOW TO PLAY THE RELATIONSHIP GAME: The Use of Psychological Principles to Change Human Behavior.** '91, 112 pp. (7x10), $24.75.

☐ Harman, Robert L.—**GESTALT THERAPY DISCUSSIONS WITH THE MASTERS.** '90, 198 pp. (7 × 10), $34.75.

☐ Haig, Robin A.—**THE ANATOMY OF GRIEF: Biopsychosocial and Therapeutic Perspectives.** '90, 196 pp. (7 × 10), 1 table, $34.75.

☐ Boy, Angelo V. and Gerald J. Pine—**A PERSON-CENTERED FOUNDATION FOR COUNSELING AND PSYCHOTHERAPY.** '90, 244 pp. (7 × 10), 2 il., $41.75.

☐ Gregg, Charles H., Judy L. Robertus & J Blair Stone—**THE PSYCHOLOGICAL ASPECTS OF CHRONIC ILLNESS.** '89, 344 pp. (7 × 10), 7 il., 15 tables, $54.75.

☐ Jewell, David L.—**CONFRONTING CHILD ABUSE THROUGH RECREATION.** '89, 358 pp. (7 × 10), 1 il., 28 tables, $59.25.

☐ Geldard, David—**BASIC PERSONAL COUNSELING: A Training Manual for Counselors.** '89, 214 pp. (7 × 10), 28 il., $32.75, paper.

☐ Steen, Charlene & Barbara Monnette—**TREATING ADOLESCENT SEX OFFENDERS IN THE COMMUNITY.** '89, 212 pp. (7 × 10), 61 il., $43.75.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $30.00.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $46.25.

Books sent on approval • Catalog sent on request • Write, call (217)789-8980 or FAX (217)789-9130

2600 South First Street Springfield • Illinois • 62794-9265

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(708) 949-6064

ART THERAPY

Journal of the American Art Therapy Association

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $25 (US); $42 (Foreign). Institutions: $36 (US); $53 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9 member; $16 non-member. Printed in the U.S.

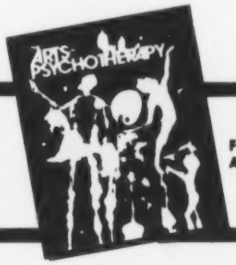
Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1991. Enclosed is my check, payable to AATA, for $25.
Name ____________________
Address ____________________
City ____________________ State __________ ZIP __________

The interdisciplinary journal
devoted to the creative arts as healing arts.

THE ARTS IN PSYCHOTHERAPY

An International Journal



FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Associate Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

PERGAMON PRESS
Maxwell House, Fairview Park, Elmsford, NY 10523
Headington Hill Hall, Oxford OX3 0BW, England
Member of Maxwell Macmillan Pergamon Publishing Corporation

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions to the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

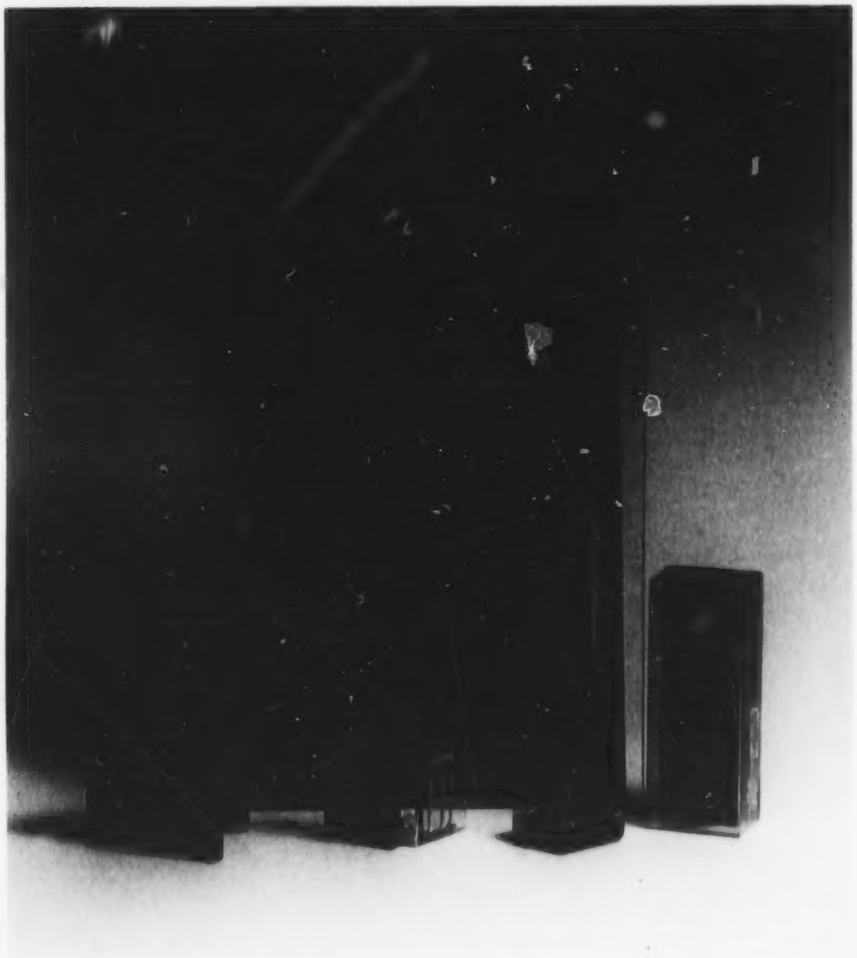
Editors welcome original manuscripts. Submit papers in triplicate to: Managing Editor, Sylvia Halpern, 20 Ridgecrest East, Scarsdale, NY 10583

SUBSCRIPTION INFORMATION

ISSN: 0197-4556	Volume 17, 1990
Published 4 issues per annum	
Annual Institution Subscription Rate (1990)	US$130.00
Two-year Institution Rate (1990/91)	US$247.00
Professional Rate (1990)	US$ 40.00
Student Rate (1990)	US$ 16.00

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION



VOLUME 9, NUMBER 1, 1992

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 36-3180580) is published triannually by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $25 (U.S.) and $42 (Foreign); Institutions: $36 (U.S.) and $53 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Advertising: Please see advertising rates listed elsewhere in this journal or contact the American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 (708) 949-6064. The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, M.A., A.T.R.
University of Utah, Salt Lake City, UT

Associate Editor
Patricia St. John, Ed.D., A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor
Elizabeth Radcliffe, M.S., MFCC, A.T.R.
College of Notre Dame, Belmont, CA

Film/Video Review Editor
James Consoli, M.A., A.T.R., NCC
Eastern Virginia Medical School, Norfolk, VA

Production Editor
Marcia May-Chambers

Editorial Board
Frances E. Anderson, Ed.D., A.T.R., HLM
Illinois State University, Normal, IL
Julia G. Byers, M.A., A.T.R.
Concordia University, Montreal, Quebec
Michael Campanelli, Ed.D., A.T.R.
Wright State University, Dayton, OH
Susan E. Cheyne-King, M.S., A.T.R.
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, M.A., A.T.R.
George Washington University, Washington, D.C.
Maxine Borowsky Junge, Ph.D., LCSW, A.T.R.
Loyola Marymount University, Los Angeles, CA
Paolo Knill, Ph.D., A.T.R., CMT-BC
Lesley College, Cambridge, MA
Wendy Lauter, M.C.A.T., A.T.R.
Oak Park, IL
Vija B. Lusebrink, Ph.D., A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, Ed.D., A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Trudy Martin Manning, M.S., A.T.R.
Eastern Virginia Medical School, Norfolk, VA
Shirley Riley, M.A., MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Paul Rodenhauser, MD
Tulane University, New Orleans, LA
Marcia L. Rosal, Ph.D., A.T.R.
University of Louisville, Louisville, KY
Lewis Shupe, Ph.D., A.T.R.
Wright State University, Dayton, OH
Sandra Ticen, M.S., A.T.R.
Canisius College, Buffalo, NY
Betty Jo Troeger, Ph.D., A.T.R.
Florida State University, Tallahassee, FL
Robert Wolf, M.P.S., A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President
Robin Goodman, Ph.D., A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ARTherapy
JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Editorial

Beginnings and Endings
Cathy A. Malchiodi, M.A., A.T.R. 2

SPECIAL FEATURE:
Tributes to Elinor Ulman, D.A.T., A.T.R., HLM 5
  In Memory of Elinor Ulman
  Linda Gantt, Ph.D., A.T.R.
  Elinor Ulman (1910-1991)
  Gladys Agell, Ph.D., A.T.R., HLM

22nd Annual Conference Overview 14

HLM Award Acceptance by Cay Drachnik, M.A., A.T.R., M.F.C.C. 17

DSA Award Acceptance by Cathy Malchiodi, M.A., A.T.R. 20

Articles

Artist in Residence, An Alternative to "Clinification" for Art Therapists
Patricia B. Allen, Ph.D., A.T.R. 22

Application of Child Art Theories to the Interpretation of Children's Art
Betty Jo Troeger, Ph.D., A.T.R. 30

The Effects of Stimulant Medications on the Art Products of A.D.H.D. Children
Julie Epperson and J. Lane Valum 36

Viewpoints

Finding Light at the End of the Funnel: Working with Child Survivors of the Andover Tornado, Andover, Kansas
Tamara Kay McDougall Herl, M.S. 42

Reviews

The Art Therapist's Third Hand—Reflections on Art, Art Therapy and Society
James J. Consoli, M.A., A.T.R., N.C.C. 48

About the Cover: "Considering Context—Collecting Data", plexiglass/collage box by Carleen Jimenez. About the piece, Ms. Jimenez says: "Art therapists make art; that's what we do that makes us unique. That's how we do our personal research. Art is our method for collecting data, as well as gifts of the self."

Neirvouse
And
Scared

VOLUME 9 NUMBER 1, 1992

Art Therapy: Journal of the American Art Therapy Association, 9(1) pp. 2-4 © AATA, Inc. 1992

Editorial

Beginnings and Endings

Cathy A. Malchiodi, M.A., A.T.R., *Editor*

The position of Editor of *Art Therapy: Journal of the American Art Therapy Association* is an adventure that I am honored to undertake. Although *Art Therapy* begins its ninth year of publication with this issue, there have been only two previous Editors of this journal. In 1983, Linda Gantt, Ph.D., A.T.R., served as Interim Editor along with Mildred Lachman-Chapin, M.Ed., A.T.R., who served as Interim Associate Editor. Gary Barlow, Ed.D., A.T.R., was later named Editor, beginning with the second issue of *Art Therapy*. During the collective terms of these three individuals we have witnessed a tremendous growth in AATA membership, educational programs, standards and professional diversity. The latter has been reflected in the variety of articles presented in the journal during the last eight years, with topics focusing on theoretical issues, practice and application, and research.

To some extent, *Art Therapy* guides the identity of our profession. All the various authors who have written articles, viewpoints and reviews for the journal have contributed in a very important way to the direction our profession has taken over the years. For this reason, *Art Therapy* has become a unique forum for the exploration and discussion of ideas about the theory and practice of art therapy within the profession. It provides the opportunity for our observations and conjectures to be tested and critiqued, refined and reconsidered. This constant reevaluation, integration and synthesis of ideas makes our professional field accountable in both concept and application.

You have probably noticed that there have been some dramatic changes in the look and style of *Art Therapy*, which I hope you will find refreshing. Members of the Editorial Board and I felt that it was important to create a new image for the journal that was both contemporary and professional. I wish I could take full credit for the fresh new graphics and fonts, but that credit belongs to David Larson and Tom Rose, Department of Graphic Design at the University of Utah. They listened carefully to the ideas and suggestions I presented for *Art Therapy* and designed a new cover and layout that would meet our esthetic and practical requirements.

With regard to the layout, some of the section headings in *Art Therapy* are familiar to you, and others are new to this issue. When submitting manuscripts or other materials to *Art Therapy*, please consider the suggested intent of each of the following categories:

1. **Full-length Articles**. Full-length articles are received by *Art Therapy* at any time, and may focus on theory, practice and research in art therapy or related areas relevant to art therapy. Submissions in this category must include an abstract of approximately 75-125 words summarizing the major point of the article.

2. **Brief Reports**. This section is new to *Art Therapy* and is intended for short articles which focus on the results of research. Submissions should include information on research design, methodology and results; an abstract of approximately 75-125 words should also be included.

3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.

4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted for consideration at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office.

5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office.

6. **Commentaries.** This is a new section which includes brief comments on articles published in *Art Therapy*, issues critical to the profession, or letters to the Editor.

Art Therapy, as stated in the *Guidelines for Submissions* (see the back section of this issue) and the policies and procedures of the journal, uses a blind peer review system to determine publishability of theoretical, methodological and research articles. Each submission (except Viewpoints, Book or Film/Video Reviews, and Commentaries) is reviewed by two individuals for style, content, strength of thesis/data presented, and relevance to art therapy. If accepted, it is generally expected that the author will be asked to make some revisions to the manuscript before resubmission and eventual publication. This process insures that all submissions are treated equally and that the highest standards of excellence and scholarship can be applied.

There are three aspects of submissions to *Art Therapy* I would like to encourage. The first is that a critical review of the literature be undertaken by all authors. The most provocative articles often begin with a hard look at what has been previously presented; they do not simply recount what has been already done. Raising questions about the theoretical bases and practical applications of art therapy, while drawing upon the literature and the author's own observations, enhances the strength of an article and leads to the discourse necessary to advance our professional field.

Secondly, I would also like to encourage a greater number and variety of research submissions to *Art Therapy*, both as full-length articles and as brief reports. It is necessary to have a variety of methodological models presented, not only to demonstrate the multiplicity of possible approaches, but because different models measure different aspects of what we do as art therapists and how we perceive the art expressions of our clients. Case studies, which have been the staple of submissions over the years, can be useful if a specific model of case study research is used; however, it is the Editorial policy of *Art Therapy* to discourage lengthy case studies that are not guided by a precise methodological approach.

Lastly, I would like to encourage visual art to become a more prominent part of *Art Therapy*. Articles, brief reports, viewpoints and commentaries which emphasize the centrality of visual art to the practice and theory of art therapy are especially welcome. Also, I encourage you to submit art created by art therapists as well as client art expressions (with appropriate releases, of course) for consideration for publication on the front cover of the journal. It is equally important to honor the "art" part of our lives as it is to display our talents as clinicians and educators.

To begin my term as Editor I have at my side an admirable group of individuals, including: Patricia St. John, Ed.D., A.T.R., who will serve as Associate Editor; Elizabeth Radcliffe, MFCC, A.T.R., Book Editor; James Consoli, M.A., A.T.R., NCC, Film/Video Editor; and Frances E. Anderson, Ed.D., A.T.R., HLM, who has been appointed as Publications Chair. Additionally, there is an impressive list of members of the Editorial Board (see inside cover) who represent areas of clinical, educational and related expertise necessary to a well-balanced professional viewpoint.

An Ending

Lastly, as I began my term as Editor of *Art Therapy* in December, the field of art therapy lost one of its finest editors, clinicians and educators, Elinor Ulman, D.A.T., A.T.R., HLM (please see special feature following this editorial). Dr. Ulman was the founder and long-time editor of the *Bulletin of Art Therapy* (started in 1961), later renamed the *American Journal of Art Therapy*. For many, the *Bulletin* was a lifeline during a time when very few published works on art therapy were available. Art therapists and students could finally read about the experiences of other art therapists and, for the first time, had a forum to share their observations and discoveries about an emerging field. The *Bulletin* became not only a vehicle for communication, but it also validated and affirmed the work of art therapists throughout the U.S. and beyond.

I was not exposed to the *Bulletin* and the *American Journal of Art Therapy* until almost two decades from its inception when I was a graduate student in art therapy. It was obvious to me, even as a novice, that Elinor Ulman had a unique capacity as editor for recognizing a variety of theoretical approaches and techniques, while at the same time maintaining a high standard of excellence in these two publications. And, as many graduate students, I poured over all the volumes of the *Bulletin* and the *AJAT*, encouraged and excited by the wealth and diversity of information on those pages.

In a recent conversation regarding Dr. Ulman's death, Cay Drachnik, MFCC, A.T.R., HLM, observed that Elinor Ulman was an important force in the lives of many art therapists as well as the milestones of our collective history as a profession. Cay emphasized how the course of her own life was greatly affected by Elinor Ulman and, because of her encouragement, Cay helped to establish the Northern California Art Therapy Association (NCATA), became legislatively active in both the NCATA and the AATA, and eventually successfully ran for President-Elect of the AATA. It is likely that many, many other achievements and important events in the lives of art therapists were a direct result of Dr. Ulman's broad influence, support and advice.

In the first issue of *Art Therapy* in October 1983, Mildred Lachman-Chapin, M.Ed., A.T.R., also observed the effect that Elinor Ulman has had on our field, particularly in her ability to exquisitely articulate and logically analyze the issues we struggle with as a profession. Of Dr. Ulman, she said:

"Through her writings she clarified some of our basic concepts. She has been a relentlessly demanding editor of that journal (*AJAT*), insisting on the highest standards of clarity in thinking and writing. Not only did she require you to have something meaningful and relevant to say, but she also insisted that you say it well, which, I think, comes down to combining the word-language of the scientist on one hand with the poet's reconstruction of reality on the other" (Lachman-Chapin, 1983, pp. 48-49).

I am honored and humbled to have the opportunity to pay tribute to the passing of one of the most significant historical figures in our field. I hope to begin and continue my term as Editor of *Art Therapy* in a tradition of excellence that Dr. Elinor Ulman, A.T.R., HLM, established for our profession.

References

Lachman-Chapin, M. (1983). Making verbal the non-verbal: A commentary. *Art Therapy: Journal of the American Art Therapy Association, 1*(1), 47-49.

Art Therapy: Journal of the American Art Therapy Association, 9(1) p. 5 © AATA, Inc. 1992

SPECIAL FEATURE:

Tribute to Elinor Ulman, D.A.T., A.T.R., HLM

Elinor Ulman, D.A.T., A.T.R., HLM, adjunct professor emeritus of art therapy at George Washington University, died on December 11, 1991. According to a personal communication from Claire Levy, Dr. Ulman "died peacefully in her chair in her apartment. She simply fell asleep after dinner with friends."

An obituary in the *Washington Post* dated December 15, 1991, read as follows:

"Elinor Ulman, 81, adjunct professor emeritus of art therapy at George Washington University, died of congestive heart failure Dec. 11 at Sibley Memorial Hospital. She had lived in Washington since 1945.

She retired in 1988 from George Washington, where in 1971 she helped establish the art therapy training program in the Graduate School of Arts and Sciences. A pioneer in art therapy starting in the 1950's, she was founder and editor of the *American Journal of Art Therapy*.

Dr. Ulman was a native of Baltimore. She was a Phi Beta Kappa graduate of Wellesley College and had a second bachelor's degree, in landscape architecture, from the University of Iowa. She also studied drawing and painting privately in the United States and China. She had an honorary doctorate degree in art therapy from the Vermont College of Norwich University.

Her paintings were exhibited at the Corcoran Gallery of Art, the New York World's Fair of 1939, the Phillips Gallery, and the Baltimore Museum of Art, where she also helped catalogue and manage the Cone Collection.

She was a psychiatric art therapist at D.C. General Hospital from 1955 to 1965, and until 1973 taught art therapy at the Washington School of Psychiatry.

Dr. Ulman was editor of two collections of selections from the *American Journal of Art Therapy*. She belonged to the American Art Therapy Association and the Phi Beta Kappa Association.

Survivors include a brother, Joseph Ulman of Bethany, Conn."

A service was held for Dr. Ulman on January 18, 1992, at The George Washington University, Marvin Center Ballroom, Washington, D.C. Contributions in Elinor Ulman's memory may be made to: Craftsbury Library, Craftsbury Common, VT 05827 or to: Founder's Fund for Art Therapy, 4101 Cathedral Avenue NW # 610, Washington, DC 20016.

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 9(1) pp. 6-11 © AATA, Inc. 1992

IN MEMORY OF ELINOR ULMAN

1910-1991

by **Linda Gantt, Ph.D., A.T.R.**

ELINOR ULMAN (Photo by Michael Franklin)

Elinor Ulman, who, more than any other individual, gave us precise words to describe what is often called a nonverbal therapy, died of congestive heart failure on December 11, 1991, in Washington, D.C. At the time of her death, she was the Executive Editor of the *American Journal of Art Therapy*, the professional journal she had founded 30 years before. That scholarly publication, established when there were an estimated 30 practicing art therapists, linked previously isolated individuals together, offered theoretical points and clinical technique, informed them of lectures and training courses in the United States and the rest of the world, and served as the forum for discussing the pros and cons of developing an association.

Background

Elinor was born in Baltimore, Maryland, where her father was a liberal judge. He was an excellent writer; both Elinor and her brother Joseph had similar skills. Elinor received a bachelor's degree in English from Wellesley College where she was a member of Phi Beta Kappa. She obtained another bachelor's degree from the Iowa State College in landscape architecture and had a brief apprenticeship under Frank Lloyd Wright.

As Elinor stated a number of times, "My talent and taste for literary expression are at least equal to my talent and taste for the visual arts" (Jordan, 1986, p. 128). Her initial selection of a profession was that of an artist. Her painting teachers included George Grosz, Maurice Sterne, and Othon Coubine. She studied brush painting in China. Her paintings were exhibited at the New York World's Fair (1939), the Corcoran Gallery of Art and the Phillips Gallery (both in Washington), and the Baltimore Museum of Art. It was at the Baltimore Museum where she served as the curator of the Cone Collection.

Becoming an Art Therapist

In 1945, Elinor moved to Washington. By the early 1950's she had "drifted" into art therapy because she had become a "frustrated painter." She entered psychoanalysis "shortly before [her] first foray into art therapy" and ultimately had three analyses with Freudian therapists (Jordan, 1986, p. 128). When she began working for the District of Columbia Health Department in 1951, she considered herself to be an art teacher. She led an art group and supervised a program of occupational and recreational therapy for patients of the Alcoholic Rehabilitation Clinic, District of Columbia Department of Mental Health. For ten years (1955-1965) she was the director of the art therapy program she had initiated at the District of Columbia General Hospital.

It was at DC General that she developed and refined her assessment procedure (now termed the Ulman Personality Assessment Procedure). This three-picture series is a carefully thought-out process designed to elicit a patient's response to certain types of situations. Dr. Bernard Levy, a psychologist with whom Elinor worked, encouraged her to standardize the materials and method of instruction. Bernie, an excellent watercolorist, became Elinor's life-long friend and professional colleague and devoted almost as much energy to promote art therapy as she did.

Founding the *Bulletin of Art Therapy*

In 1961, at Bernie's urging, Elinor launched the *Bulletin of Art Therapy*. The Levy family contributed more than moral support and encouragement to this publishing venture: Bernie served on the Editorial Board and wrote "pithy" (one of his favorite words) book reviews and his wife Claire became Book Review Editor, Editorial Assistant, and Office Manager (which entailed handling mail, subscriptions, and heavy packages as well as serving as a sounding board). Subscriptions increased by word-of-mouth and by the third year, there were readers throughout the United States and in 21 countries.

Elinor found her own writing to be an arduous process, as had happened earlier with her painting, but she devoted her energies to becoming a superb editor. The articles she painfully and painstakingly crafted about professional issues are worth reading today for their timeless quality. And sprinkled throughout the three decades of issues are tiny gems such as the four-part series on the "War Between English and Therapese." In these brief essays, she urged readers to send examples and to monitor the *Bulletin* "if you spot a fancy word . . . where a plain one would serve" (1962, *Bulletin of Art Therapy*, 2, (2):p. 77). After Elinor's death, Edith Kramer said she had urged Elinor repeatedly to add to the series but to no avail.

Elinor loved to have a juicy topic to punch up the "Reader's Forum" and delighted in printing the letters whose writers said she would not print. (My personal favorite is an exchange of letters about one of Edith Kramer's articles with the counterpoints being made by Elinor's brother Joseph, who was himself a professional editor. He objected to an interpretation of a particular picture (1964, *Bulletin of Art Therapy*, 3 (2):42) and this brought several thought-provoking responses (1964, *Bulletin of Art Therapy*, 3 (3):82, 117-118)).

The *Bulletin*'s regular features included news and listings of recent publications from around the world and became an unofficial record of the field's development. The back issues still remain the best source for anyone interested in art therapy's historical material.

Elinor joined the faculty at the Washington School of Psychiatry the same year she launched the *Bulletin*, and taught both introductory courses and advanced seminars on art therapy there until 1973. It was at the Washington School that I took such courses with Elinor and I count myself as quite fortunate to have been in class the night Bernie asked which of us would like to get a Master's degree in art therapy. He and Elinor had been working on plans for a graduate training program at The George Washington University where she had become an Assistant Professorial Lecturer in 1968, and Bernie was Professor of Psychology and the head of the Psychology Department. When six of us agreed to apply for special status in the graduate school, Bernie was certain he could convince the Dean that there was sufficient interest in the field to warrant a full-fledged program. The program officially began in 1971 with Elinor in the position of adjunct Assistant Professor and Coordinator of Training. Elinor's devotion to high standards was supported by other faculty members with similar convictions. In addition to Bernie, they included Hanna Yaxa Kwiatkowska and Edith Kramer who came once a month from New York City. By this time, Elinor had left DC General and was a Consultant in Art Therapy for the Northern Virginia Mental Health Institute.

The Formation of the Association

In its October 1968 issue, the *Bulletin* carried an announcement of a meeting to be held in Philadelphia on December 5, for art therapists interested in forming a national association. Elinor was invited to give a lecture following that afternoon meeting. When the group met the following year to make the American Art Therapy Association official, Elinor duly reported that in the *News* section.

Initially, Elinor was not in favor of having an association (Jordan, 1988). To her, such a step seemed premature and more likely to hinder innovation in the field rather than promote it. However, unlike Margaret Naumburg who did not actively participate in creating a national organization, Elinor reluctantly joined the crucial discussions about its purpose, proposed committees, and standards. When Elinor realized that she could not quell the impetus toward forming such a group, she concluded that "I didn't like organization, but if I was going to be organized, I would rather organize than be organized by other people" (Jordan, 1988:107).

In the same issue in which she reported the beginnings of the AATA she announced that her publication would become the *American Journal of Art Therapy*. She modestly characterized her own part in the formation of the Association as "indirect." But many have credited her with greatly hastening the birth of the organization even though she certainly did not intend to. She acknowledged that her prophesy in the *Bulletin*'s beginning was that a professional association would bring about "an eventual decrease in both the naive foolishness and the creative adventure subsumed under the name of art therapy" (1969, *American Journal of Art Therapy*, 9 (1):2).

Association Work

Not too long after the Association was formed Elinor offered a discount on subscriptions for AATA members (1970, *American Journal of Art Therapy*, 9, (3)). At that time she stated that the *Journal* had always operated at a loss—but she did not ever write of that issue again. As sole owner and publisher, she bore all the costs of the operation and bailed it out when necessary. In 1966, she had formed a corporation (the Association for Art Therapy) with the "principal objective [being] to assure continued publication of the *Bulletin of Art Therapy*" (1966, *Bulletin of Art Therapy*, 5, (3):86, 104). A major task of the corporation was to seek additional funding. While Elinor had hoped that as subscriptions increased they would cover the considerable costs of editing and production, they never did. When I was the AATA Publications Chair I urged her to raise the subscription rates but she refused, saying that she wished to make it available to as many people as possible.

At the AATA's Second Annual Meeting, September, 1971, Elinor was elected to serve as Education Chair and Board member for two years. In that capacity, she (assisted by members of the Education Committee) wrote the first *Guidelines for Art Therapy Training*, adopted by the Board in 1973. This position was followed by another Board term as Recording Secretary (1975-1977). In 1972, the Association bestowed on her its third Honorary Life Membership. Her chief contribution to the Association was as its conscience—to point out truths and principles which others would not voice.

Elinor served as a catalyst to the formation of the Potomac Art Therapy Association in October, 1975, just as she had in the formation of the AATA in that she provided us with the mailing list of Washington, D.C., subscribers to *AJAT*. She and Bernie attended the first meeting at which the bylaws were adopted but never attended another formal business meeting after that. I thought that they had, by attending that initial meeting, determined that the group was on solid ground and that they need not worry about its direction.

Because Elinor did not talk about the precarious financial situation of *AJAT*, most of the AATA members had no idea of the amount of money needed for publishing a journal of high quality. But financial costs were the least considered when a debate about the *AJAT*/AATA affiliation arose. In 1974, *AJAT* entered into a formal affiliation with the AATA, with the expressed intent of having the Association own the *Journal* one day. The first two AATA representatives to the Editorial Board were Barbara Treasure and Mildred Lachman (later Lachman-Chapin), Chair of the Publications Committee. But Elinor continued to be the Editor and the chief rescuer from debt. The association paid for the subscriptions to members but did not underwrite any other costs.

For a long time, the *Journal* served as the only publication of its kind. When *The Arts in Psychotherapy* was established, some members sought to have a choice of subscription. Bitter debates ensued. A rallying point was the selection of book reviewers (see, for example, S. McNiff, 1981:2). During the Annual Membership meeting at the 9th Annual Conference the members passed a motion to separate the dues from journal subscriptions. Since there was a binding contract in force at the time, a full membership vote could not be immediately taken.

An editorial in the *AATA Newsletter* (Vol. X, No. 2, April/May 1980, p. 10-11) supporting continued affiliation attempted to give an assessment of the *Journal* place:

> . . . Ms. Ulman would not want to be lauded for her monetary contributions, the extent of which few have known until now, but for her literary contributions which have earned the *Journal* respect far be-

yond art therapy circles as evidenced by a readership three times the Association's membership.

That the *Journal* has adhered to the highest standards of scholarship is not in dispute. It can be confirmed by perusing past volumes. Ms. Ulman has labored to create a publication which presents a wide variety of well-written articles by authors representing different theoretical stances, philosophical bases, and professions. A brief scanning of the indices for recent years shows contributions by art therapists and allied professionals from Germany, Ireland, England, Israel, Brazil, Romania, Czechoslovakia, and Italy.

That the *Journal* has been involved in heated debates is not in dispute either. Ms. Ulman has never backed away from a topic or opinion because it was controversial or unpopular. The maiden issue carried an editorial which outlined the hopes and plans for the new publication which 'should be first and foremost a forum for the vigorous discussion of ideas.'

Acrimonious debate led to the passage of the motion at the Conference but cooler heads prevailed, and the AATA Board voted to continue the relationship. When the question was submitted to the entire membership by mail ballot in 1982, 248 members voted for continuing affiliation and 88 voted against it.

Those who want the details of the subsequent negotiations can find a detailed chronology in the *AATA Newsletter* (Vol. XII, No. 2, April, 1983). When the negotiations were irreparably broken off, the AATA formed a journal planning committee and began its own journal in October, 1983.

Vermont

Elinor, having fallen in love with Vermont, had established a summer home there. A fortunate result of this was her relationship with Gladys Agell. The all-day workshop Elinor conducted in 1973 at Vermont State Hospital at the request of Gladys who was then Acting Director of Activities at the hospital eventually led to development of another graduate training program, first at Goddard College and then at Vermont College. (Later, Norwich University acquired Vermont College. For her contributions to the development of the field, the university bestowed on Elinor the first honorary Doctorate of Art Therapy.) Bernie Levy and his family had come to buy their own summer place so he was available for teaching.

AJAT's Move to Norwich

In the fall of 1984, *AJAT* accepted an offer from Norwich University to move its operations there. Elinor was given the permanent position of Executive Editor and Barbara Sobol served briefly as Editor. Gladys Agell, who was instrumental in getting Norwich to become the publisher, is now the Editor. Elinor worked on *AJAT* until her death, reviewing and commenting on every article considered for publication.

Later Life

Those who knew Elinor for any length of time continued to be surprised at her capacity to overcome physical illness. She had a serious bout with breast cancer in middle age, and severe heart problems (she underwent a valve replacement and installation of a pacemaker). Yet, these major health problems did not keep her from swimming in her cold Vermont pond, taking long walks in the woods, and presenting at the 1990 AATA Conference in Washington.

When she retired from George Washington in 1988, *AJAT* and GW established the annual Elinor Ulman Prize for Writing. She held the title Adjunct Professor Emeritus at her death.

Special Relationships

At her memorial service those of us who knew her only through art therapy were treated to a different side of her personality as we heard family and friends describe in detail her generosity (especially toward children), her delight in cats, her love of beautiful objects, her collection of children's drawings on the second floor of her Vermont farmhouse, her pleasure in European trips, her excitement over new experiences, and a brief note found in her desk after she died which described her thoughts about her failing health. One of the most passionate statements was made by a man who spoke of Elinor's mentorship for his career as an artist and told how she introduced him to the works of her favorite painters by taking him to museums.

Her often brusque demeanor in professional situations seldom gave an inkling of this aspect of her that she reserved for a select few. But those with whom she had a personal relationship were rewarded with a magnanimous spirit.

Assessment of Her Contributions

Elinor wrote, "Perhaps the quality most needed by the art therapist is courage", Ulman, 1975, page 6. That she had in spades. In 1988, Edith Kramer wrote a public letter of appreciation: "I have often told Elinor that she is the Eleanor Roosevelt of art therapy, brilliant, incorruptible, and ready to do battle. As all just individuals she has not hesitated to prod and mobilize those who shared her ideas, but would have avoided battle and retired into discontented inertia" (Kramer, 1988: 112). In an interview with Henrietta Jordan, Elinor summed up her views: "Edith Kramer and I recently agreed that we both tended to enjoy the isolation that goes with being a pioneer because it gave us great freedom and we liked being unencumbered, self-directed, accountable only to ourselves. I have often told students how it pleased me in the early days that nobody around me knew as well as I did what I was supposed to be doing. I don't envy today's students their chance to study in degree programs in preparation for their careers as clinicians. Edith suggested that this helps explain why I started *AJAT* single-handed, and was as willing to foot the bills as I was unwilling to compromise" (Jordan, 1988: 11).

Biographical details convey only part of what Elinor was like. That some of her relationships with other officers and members of AATA were difficult is an understatement. Her insistence on rigorous thinking and accurate writing was legendary. As a result, some people had a hard time seeing why she was so insistent on certain points. But she had no need to be liked by large numbers of others. She accepted conflict as an innate part of human existence (Ulman, 1986, p. 125) and never shrank from it, be it internal or external. But it was not conflict for its own sake that she relished but the battle to uphold a cherished principle.

Since writing was difficult for her, the book she wanted to write never materialized. Instead, she turned her labors to editing the works of others. Many authors (especially students who received their first papers bleeding with her corrections) felt physically wounded. But her editing was not a hostile act; it was more like an annealing process—tried by fire and Elinor's red pencil!

To describe Elinor as the backbone of art therapy may sound like a strange metaphor, yet this is precisely the way she functioned. She provided both a structure for the developing field by giving shape to ideas about its definition and a conscience for its members. An extraordinary woman, she had rare attributes—not of compromise and diplomacy but of intelligence and tenacity.

All art therapists and art therapy students should read her last extensive article (Ulman, 1986) and her interview with Henrietta Jordan (Jordan, 1988) to gain a perspective on her views. Far from contributing to polarizing the field, Elinor pointed out the utter necessity of remaining flexible in one's approach. Whether one used ***art as therapy*** or ***art psychotherapy***, one must make the choice according to the situation so as to better serve the client. But ". . . every choice entails as a sacrifice of whatever lies along and at the end of the road not taken" (Ulman, 1986: 131). By not only pointing out such complexities but celebrating them, Elinor Ulman has left to us a precious legacy.

References

Jordan, H. (1988). An interview with Elinor Ulman. *American Journal of Art Therapy*, 26:107-112.

Kramer, E. (1988). Letter: "Elinor Ulman, friend, collaborator, comrade-at-arms," *American Journal of Art Therapy*, 26:112.

McNiff, S. (1981). To the barricades, once again! [letter to the editor] *American Journal of Art Therapy*, *21*(1):2.

Ulman, E. (1986). Variations on a Freudian theme: Three art therapy theorists. *American Journal of Art Therapy*, *24*:128.

Ulman, E. (1975). Symposium on Divergent Views, page 6.

Ulman, E. (1962). The war between therapese and English: I. *Bulletin of Art Therapy*, 2(2):77.

Ulman, E. (1963). The war between therapese and English: II. *Bulletin of Art Therapy*, 2(3):127-128.

Ulman, E. (1963). The war between therapese and English: III. *Bulletin of Art Therapy*, 3(1):28-29.

Ulman E. (1964). The war between therapese and English: IV (A skirmish). *Bulletin of Art Therapy*, 3(2):65.

An Ulman Bibliography

Ulman, E. (1953). Art therapy at an outpatient clinic. *Psychiatry*, *16*:55-64.

Ulman, E. (1959). Implications of art for psychotherapy and psychodrama. *Group Psychotherapy*, *12*(4).

Ulman, E. (1960). Psychiatry and the creative process: An exchange of insights. *Psychiatry*, 23(1):109.

Ulman, E. (1961). Art therapy: Problems of definition. *Bulletin of Art Therapy*, *1*(2):10-20, Winter.

Ulman, E. (1962). Congress report: 3rd International Congress of Psychopathological Art. *Bulletin of Art Therapy*, 2(1):40-43.

Ulman, E. (1962). The war between therapese and English: I. *Bulletin of Art Therapy*, 2(2):77.

Ulman, E. (1963). The war between therapese and English: II. *Bulletin of Art Therapy*, 2(3):127-128

Ulman, E. (1963). The war between therapese and English: III. *Bulletin of Art Therapy*, 3(1):28-29

Ulman, E. (1965). A new use of art in psychiatric diagnosis. *Bulletin of Art Therapy*, *4*(3):91-116.

Ulman, E. (1966). Therapy is not enough: The contribution of art to general hospital psychiatry. *Bulletin of Art Therapy*, *6*(1):3-21.

Ulman, E. (1971). Art education for the emotionally disturbed. In: L. C. Deighton (Ed.), *Encyclopedia of education*, Vol. 1, Art education for special groups, Part 2, pp. 311-316. New York, NY: Macmillan. [Also: *American Journal of Art Therapy*, *17*(1).]

Ulman, E. (1971). The professional development of art therapy. *Japanese Bulletin of Art Therapy*, 3. [Also: *American Journal of Art Therapy*, *10*(4):186.]

Ulman, E. (1971). The power of art in therapy. In: I. Jakab (Ed.), *Psychiatry and art*, Vol. 3 Proceedings of the 4th Annual Meeting of the American Society of Psychopathology of Expression. Basel: S. Karger, pp. 93-102.

Ulman, E. (1975). Innovation and aberration. In: B. I. Levy et al., Symposium: Integration of divergent points of view in art therapy. In: E. Ulman & C. Levy (Eds.), *Art therapy viewpoints* pp. 4-6. New York, NY: Schocken Books.

Ulman, E. (1983). The significance of Florence Cane and Margaret Naumburg for art therapy. In: Detre, K. et al., Roots of art therapy: Margaret Naumburg (1890-1983) and Florence Cane (1892-1953), a family portrait. *American Journal of Art Therapy*, 22(4):122-123.

Ulman, E. (1986). Variations on a Freudian theme: Three art therapy theorists. *American Journal of Art Therapy*, *24*:125-134. [Also published as a chapter in J. Rubin (Ed.), *Approaches to art therapy*. New York, NY: Brunner/Mazel.]

Ulman, E. (1986). Commencement address at Vermont College: Your garden is your world. *American Journal of Art Therapy*, *24*:87-91.

With others:

Agell, G.; Levick, M.; Rhyne, J.; Robbins, A.; Rubin, J.; Ulman, E.; Wang, C. & Wilson, L (1981). Transference and countertransference in art therapy. *American Journal of Art Therapy*, *21*(1):3-24.

Kramer, E. & Ulman, E. (1977). Postscript to Halsey's "Freud on the Nature of Art." *American Journal of Art Therapy*, *17*(1):21-22.

Levy, B. I. & Ulman, E. (1967). Judging psychopathology from paintings. *Journal of Abnormal Psychology*, 72(2):182-187.

Ulman, E. & Champernowne, I. et al. (1963). Psychotherapy and the arts at Withymead Center. *Bulletin of Art Therapy*, *2*(3):91-119, Spring.

Ulman, E. & Dachinger, P. (Eds.) (1975). *Art therapy in theory and practice*. New York, NY: Schocken Books.

Ulman, E., Kramer, E., & Kwiatkowska, H. Y. (1977). In: P. Valletutti & F. Christoplos (Eds.) *Interdisciplinary approaches to human services*. Baltimore, MD: University Park Press.

Ulman, E., Kramer, E., & Kwiatkowska, H. Y. (1978). *Art therapy in the United States*. Craftsbury Common, VT: Art Therapy Publications.

Ulman, E. & Levy, B. I. (1973). Art therapists as diagnosticians. *American Journal of Art Therapy*, *13*(1): 35-38.

Ulman, E. & Levy, B. I. (1968). An experimental approach to the judgment of psychopathology from paintings. *Bulletin of Art Therapy*, *8*(1):3-12, October.

Ulman, E. & Levy, C. (Eds.) (1980). *Art therapy viewpoints*. New York, NY: Schocken Books.

Presentations at Major Conferences:

Ulman, E. (1964). Presentation—A new use of art in psychiatric diagnosis, Syracuse University Summer Session Symposium on "Creativity for the Exceptional Individual," Syracuse, NY, July.

Ulman, E. (1966). Presentation at "Art therapy and general hospital psychiatry," sponsored by Harvard Medical School Psychiatry Service at Boston City Hospital; the Massachusetts Association for Mental Health; and the Northern New England District Branch of the American Psychiatric Association, January. [See report in *Bulletin of Art Therapy*, *5*(3):116-121.]

Ulman, E. (1967). Workshop, "Creative arts programs in various settings," American Orthopsychiatric Association, Washington, DC, March.

Ulman, E. (1968). Lecture, art therapy training program, Hahnemann Medical College, December 5, Philadelphia, PA. [presented after the meeting to form a national association]

Ulman, E. (1968). Exhibit—"Art therapy and the talented patient," Aspects of art therapy, Annual Meeting, American Psychiatric Association, Boston, MA, May 13-17.

Ulman, E. (1969). Therapy is not enough. Symposium on "Clinical and Theoretical Approaches to Art Therapy," Annual Meeting, American Psychological Association, Washington, DC, September 1.

Ulman, E. (1969). Panel discussion on art therapy. Annual Meeting, American Psychiatric Association, Miami, FL, May 8.

Ulman, E. (1969). The power of art in therapy. Annual Meeting, American Society of Psychopathology of Expression, Belmont, MA, October 16.

Ulman, E. & Levy, B. I. (1971). Psychiatric diagnosis from painting. 2nd Annual AATA Conference. Milwaukee, WI.

Ulman, E. & Levy, B. I. (1973). Art therapists as diagnosticians. 4th Annual AATA Conference, Columbus, OH.

Art Therapy. Journal of the American Art Therapy Association, 9(1) pp. 12-13 © AATA, Inc. 1992

ELINOR ULMAN (1910-1991)

Gladys Agell, Ph.D., A.T.R., HLM.

Elinor Ulman died peacefully on December 11, 1991. She had returned to her apartment, following dinner with Claire Levy and a close mutual friend, when she fell asleep in her chair. She did not awaken.

When I spoke with Claire about a memorial service she and Katherine Williams were planning I remarked, not really meaning it as a question but rather as a statement, "How can I write about Elinor . . . who will edit what I write."

Edith Kramer preceded me as a speaker at the memorial service and she opened her tribute with a similar question that she too meant as a statement. Elinor's love of the English language and her marvelous precision in its use was throughout the day repeatedly noted by those who spoke of her and loved her. It was her hallmark and one of the gifts she conferred on others . . . by her own admission, not always to their liking.

Elinor was born and raised in Baltimore, Maryland. I don't know much about her childhood other than that over the years she introduced me to many of her childhood friends with whom she still maintained close relationships. A woman with whom Elinor had lost contact, read of the memorial service in the morning paper. She said that she had been a tentmate of Elinor's when they were 11-year-old campers. She also spoke of Elinor's governmental position as an industrial designer of kitchen's for the poor during the thirties . . . a surprise to many of us.

Elinor received a Bachelor of Arts degree from Wellesley College (1930) and a Bachelor of Science in Landscape Architecture from Iowa State University (1943). Shortly after graduating from Wellesley she began serious studies in drawing and painting with several well-known artists, including Maurice Sterne, George Grosz, and Othon Coubine. From 1934 to 1936 she studied Chinese brush painting in Peiping. On her return to the United States she taught painting and exhibited her own paintings at the Corcoran Biennial, the New York World's Fair of 1939, the Pennsylvania Academy, the Baltimore Museum of Art (one-person show), and the Phillips Memorial Gallery. Her work is included in the Cone Collection at the Baltimore Museum of Art.

Although she taught art to children with disabilities, it was not until she led a group for the Alcoholic Rehabilitation Program of the District of Columbia that she called herself an art therapist. In 1955 she became a psychiatric art therapist for the D.C. General Hospital where she remained for ten years. It was then that she cemented her close friendship with Bernard I. Levy.

During the fifties, sixties, and early seventies Elinor became firmly allied with the nascent field of art therapy. She attended lectures of Margaret Naumburg, became a faculty member at the Washington School of Psychiatry and a guest lecturer in art therapy for Edith Kramer at the Turtle Bay Music School.

Encouraged by Bernie, Elinor, in 1961, became the founding editor and publisher of the *American Journal of Art Therapy* (formerly the *Bulletin of Art Therapy*). She remained as editor/publisher until 1985 when she became the executive editor. In part, because of the influence the *AJAT* had in bringing together isolated individuals who established the art therapy profession. In 1971 the American Art Therapy Association conferred on Elinor their highest honor, the Honorary Life Membership.

In 1968-1969 she was an Assistant Professorial Lecturer at The George Washington University (GWU). From 1971-1988 she was the Coordinator of Training in the Master's Degree Program in Art Therapy at GWU and one of the people responsible for founding the program. A late starter, Elinor was well into her late seventies when she retired from GWU.

It is clear that Elinor was an accomplished woman who had a remarkable life. Thus it is not surprising that she had an effect on so many of us who knew her.

The striking influence Elinor has had in shaping my professional life has been as profound as it has been wide-ranging. My indebtedness to her had steadily increased over the twenty some years that we were friends and colleagues.

It was 1969 or '70 when Edith Kramer introduced us. In 1971, Elinor asked me to become a member of the committee she chaired for the American Art Therapy Association, the Education Committee. As a girl scout dropout I had vowed never again to be a joiner, nevertheless, Elinor was the prize, so I became a committee member . . . and my education began.

My formal training started when I invited Elinor to teach the Ulman Diagnostic at Vermont State Hospital. I didn't anticipate the impact that Ulman, both the procedure and the person, would have in shaping my focus.

Several years later Elinor, audacious and determined that I would be her successor on the Executive Board, spearheaded a write-in campaign, nominating me to the Education chair. Because of Elinor's endorsement I defeated a shoo-in, an AATA past-president. Those glorious and slightly self-righteous days were the beginning of Elinor's mellifluous rewriting of my undistinguished prose. That same year Elinor was elected to the Board as the AATA Recording Secretary. She claimed, and rightly so, that the first time the Association had correct minutes was when she was Secretary. During those days when we both served on the AATA Board, I had the opportunity to scrutinize and learn from her every move.

Later on, because of the warm reception received by a workshop Edith Kramer and Elinor had given, a Goddard College Dean talked to me about developing an art therapy program at the college. Elinor taught the Case Studies course and the Ulman Diagnostic the summer the art therapy program opened. To this day, students recall Elinor's editing of their papers, particularly the Ulman Diagnostic. Some students were challenged and continued to write . . . some chuckled and chucked their typewriters for a paintbrush.

Although Elinor taught Case Studies for only three summers, she remained on the Program's Advisory Board. Until two summers ago she taught and presented the Ulman Diagnostic, renamed the Ulman Personality Assessment Procedure (UPAP), at Vermont College of Norwich University. The President of Norwich University awarded Elinor with the first and perhaps the only Honorary Doctorate in Art Therapy in the field.

For many years Elinor and Bernie co-led seminars of the UPAP. Following Bernie's death Elinor and I teamed up. Kibitzing with her as we led a workshop was my great pleasure. Until her death we had been collaborating on a UPAP manual.

The *AJAT* had for a number of years been the AATA affiliated journal until it was brutally excised from the AATA in 1983. Soon after the coup, the *AJAT* was acquired by Vermont College of Norwich University. Elinor became the Executive Editor. Although she no longer did line by line editing, she had been instrumental in selecting and reviewing final article drafts for publication. The week before she died Elinor returned a manuscript on which she had red penciled corrections several editors, myself included, had overlooked. She had a remarkable eye and a tireless red pencil. Her marginal comments as I'm sure Kirsten Gardner recalls, were priceless—accurate and witty—and not to be seen by others.

Linguistic acuity and conceptual clarity were certainly Elinor's endowments as evidenced by the too few, but brilliant articles that she did write. She claimed that as a child learning about language occurred at her dinner table where the dictionary was kept. I put a dictionary on my dinner table . . . and I'm still waiting.

Since her death I've caught myself reaching for the phone to talk with Elinor about the *Journal* or some quixotic event of the day. Her phone has been disconnected. Elinor as she said in anticipation of her death has "been called to Harvard!" Lucky Harvard.

BEST COPY AVAILABLE

Art Therapy. Journal of the American Art Therapy Association, 9(1) pp. 14-16 © AATA, Inc. 1992

THE AMERICAN ART THERAPY ASSOCIATION
22nd ANNUAL CONFERENCE

Marriott City Center/Denver, Colorado

NOVEMBER 13-17, 1991

November 13

Pre-Conference Courses

The Use of Art Therapy in Grief and Loss/*Barbara Betker McIntyre, Julie Adams, Sandra Graves, Linda Lee Goldman, Judith Rothschild*

Sexual Abuse: Interventions and Issues with the Child, Family and Court System/*Joan Phillips*

Illuminating the Monster: Documentation in the Mental Health Care Setting/*Josie Abbenante*

Imaginaction: Action Methods for Art Therapists/*Leigh Files*

Art Therapist's Art: Its Use for Professional Processing/*Harriet Wadeson*

The Expressive Therapies Continuum/*Vija B. Lusebrink*

Healing Through Sandplay/*Terri L. Sweig*

Developmental Analysis of Visual Form/*Patricia St. John*

The Symbolic World of the Multiple: Treatment Strategies & Techniques/*Dee Spring*

Uses of Mandala Assessment in Art Therapy/*Phyllis Frame, Carol Cox, Patty Morini*

November 14

Opening Ceremony/*Linda Gantt*

Welcoming Remarks/*Cecily Mermann*

Art Therapy: Post Mortem/*Cathy Malchiodi, Mariagrese Cattaneo, Patricia Allen*

Using Creative Thinking Strategies to Image a 21st Century AATA/*Doris Arrington, Cay Drachnik, Paul Howie, Judy Rubin*

Poster Sessions

Art in Assessment: Identification of Sexual Abuse in the Images of Adolescents/*Elaine Genser*

Art Therapy with Mexican-American Alcoholic Families/*Renee Magana*

The Man Behind the Sunglasses: The Inner City Child's Personal Metaphor and Model/*Lorin L. Davis*

Study Groups

International Networking Group Open Discussion/*Bobbi Stoll*

Study Group on Ritual Abuse/*Trish Knode*

Papers

Unmasking Anger Through Caricature/*Judith Wald*

Drawing & Talking with Pediatric Cancer Patients: Does It Make a Difference?/*Robin Goodman*

Ethnicity Illuminated in Humor and Art Therapy/*Christina R. Mango*

The Use of Art Psychotherapy Evaluations of Children in Custody Disputes/*Sherry J. Lyons*

Adventures in Short-Term Group Art Therapy: Reservations, Itineraries and Baggage Handling/*Patricia D. Isis*

Art Therapy Meets Hypnosis and Neurolinguistic Programming/*Sandra Lee Zavadil*

Panels

Art Therapy Treatment of Sexually Abused Clients: Child, Adolescent, Adult/*Mimi Farrelly-Hansen, Heidi Lack, Diane Safran, Terri Sweig*

From Outside In and Inside Out: Viewing AIDS Thru Art Therapies Window/*Sandra White, Gail Fenster, Michael Franklin, Irene Rosner-David, Judy Weiser*

Manifestations of Health: Art Therapists Creating Art/*Lin Carle-Anderson, Mimi Farrelly-Hansen, Ron Hueftle*

Art by Abuse Survivors: A Lifecycle/*Carol T. Cox, Barry M. Cohen, Anne Mills, Barbara Sobol*

Symposia

An Inquiry into Systems of Creativity: An Alternative Realities Approach/*Maxine Junge*

Family Art Therapy from an Alternative Realities Perspective/*Christine Lind, Jane Walter, Maxine Junge*

From Image to Metaphor—Why Don't You Just Say What You Mean?/*Debra Behnke-Marthaler*

Visual Metaphor: Its Role in Therapy/*Vija B. Lusebrink*

Applications of Art Therapy with the Elderly/*Kevin Forrest*

Illuminations: Program Concept for Art Therapy with the Elderly/*Bernadette Callanan*

Was It Schizophrenia, or Ritual Abuse?/*Cay Drachnik*

Surviving the Survivors of Ritual Abuse: Images of the Client and Therapist/*Kathryn L. Cox*

November 15

Student Open Forum/*Ruth Cohen*

Sharing and Networking About Helping HIV Positive Clients and Families/*Judy Weiser*

Addictions/*Lynn Jones*

U.S. Study Group on Symbolic Language (Sexual Abuse and MPD)/*Dee Spring*

Mosaic: A Clinical Approach to Racial, Ethnic and Cultural Differences/*Charles W. Anderson*

Keynote Address—The Art of Dying: Images, Insights and Interventions/*Sandra L. Bertman, Linda Gantt*

Study Groups

Personality and the Arts Therapies: Partners in the Dance of Healing/*Sondra Geller*

U.S. Study Group on Puppetry and Dollmaking in Art Therapy/*Matthew Bernier*

Poster Sessions

Symbiosis in the Artwork of Clients with Borderline and Narcissistic Personality Disorders/*Mary Ellen McAlevey*

Exploring the Ecology of the Mind: The Landscape Montage Technique/*Michael Campanelli*

Psychoaesthetics Dolphin Project/*Barbara A. Levy, Clio Pavlantos, Jackie Hand-Vigario, Marina Zurkow*

Papers

Liberty and Conflict: Images from Psychologists in a War-Torn Country/*Marcia L. Rosal*

An Image in Transition: From Student to Professional/*Peg Schwartz, John Bolde*

Journey to Recovery: One Step at a Time/*Marietta M. Miller*

Multiple Family Group: Art Therapy with Hospitalized Adults and Families/*Kay Stovall*

Image as Healer, Metaphor as Helper/*Edith Wallace*

Creative Therapies for Adult Children of Addiction Recovering from Alcoholism/*Ursula Goebels*

Illustrating the Family Story: Art Therapy—A Lens to Viewing the Family's Reality/*Shirley Riley*

Maybe Tomorrow: Art Therapy with AIDS Patients/*Winnie Ferguson, Donna Kronick*

Case Study: A Woman with a Dissociative Disorder/*Gladys Agell*

Artistic Expression of Alzheimers in Adult Daycare, Assisted Living, and Skilled Nursing/*Kathleen Kahn, Michelle Tarsitano*

Art Rx: Art Expression and Physical Health/*Cathy Malchiodi*

Dedication to the Contemplative Life/*Leslie Howard, Mari Flemming*

Images as Defense Mechanisms/*Vija B. Lusebrink, Myra Levick, Roberta Jonkers, Robert Gorstein*

Aggression Depicted in Abused Children's Drawings: Development of an Assessment Tool/*Trudy M. Manning*

Panels

Confronting Cancer Through Art: A Collaborative Effort by Hospital, Patient and Therapist/*Virginia M. Minar, Julie Erdmann, Lynn J. Kapitan, Susan D. Richter-Loesl, Lori Vance*

Systems Approach to Art Therapy/*Robert Schoenholtz, Aina Nucho, Vija B. Lusebrink, Janie Rhyne, Judy Weiser*

My God Left Me? Spirituality, Wholism and the Transpersonal in Art Therapy/*Roberta Schoemaker-Beal, Dean Frantz, Bruce Moon, Sheldon Kopp*

Bringing Down Additional Walls for Greater International Understanding/*Bobbi Stoll, Angela Philippini*

The Dominions of Transference/*Debra Behnke-Marthaler, Abby Calish, Anne Canright, Suellen Semekowski, Harriet Wadeson*

Symposia

Comparison of Verbal and Art Group Therapies with Adult Female Incest Survivors/*Carolyn S. Waller, Cathy Malchiodi*

Ceramic Mural Messages from Incest Survivors/*Frances E. Anderson, Karen Deske*

Gay/Lesbian Open Forum

November 16

Papers

Art Therapy—Adjunctive and Primary in a Therapeutic Community for Children/*Judith Duboff*

Deja Vu: Comparing Schizophrenic and Affective Psychotic Patients Utilizing the Bridge Projective/*Ronald E. Hays, Sherry J. Lyons*

Using Expressive Journals to Measure Feelings in an Adolescent Group/*Jennifer Morgan, Marcia Rosal*

Ritual, Rhyme and Reason: Art Therapy with a Child and an Adult Multiple/*Patty Churchill, Dee Spring*

A Three Session Package for Assessment, Confrontation and Treatment Planning/*James J. Consoli*

Hard Time Art: Creative Expression in Prison/*Marcia F. Taylor, C. Eamon Walsh*

The Effects of Stimulant Medications on the Art Products of ADHD Children/*Julie Epperson, J. Lane Valum*

Art Therapy—The Tool for Treating Multi-Abuse/*Nancy Slater*

Reality and Relationship: A Structured Art Therapy Approach with Schizophrenic Adolescent Patients/*Trudy M. Manning*

Images of God: The Effects of Abuse on God Representatives/*Cathy Moon*

Artistic Expression of Large Mammals Confined to Zoological Institutions/*David R. Henley*

Doorways to Life: Art Interventions with Suicidal Clients/*Drew K. Conger*

Linking Interpretations of Children's Visual Images to a Developmental Art Scale/*Betty Jo Troeger*

Art Therapy Treatment of a Narcissistic Adolescent with Asthma: Case Study/*Robin L. Gabriels*

Personal Snapshots—Mirrors with Memory: Phototherapy Techniques for Bringing Abuse to Light/*Judy Weiser*

Exhibiting Art by People with Mental Illness: Issues, Process and Principles/*Susan Evans Spaniol*

Finding a New Niche: An Art Therapy Program in a Public School/*Monica Otcasek*

The Perception of Doors/*Maxine Junge*

Being in Creation: Revisioning the Artist in the Identity of Art Therapists/*Lynn Kapitan, Lori Vance*

November 17

Papers

A Systemic Approach to Understanding Drawing as Visual Languaging/*Janie Rhyne*

Art Therapist Providing Services to Children and Adolescents/*Deirdre M. Cogan, Martha Giles, Carol Cox*

Idealization, Transformation and Disillusion in the Art of a Cross-Addicted Transsexual/*Renee Obstfeld*

The Canvas Mirror: Images of Existential Art Therapy/*Bruce Moon*

Dying of a Broken Heart: Imagery of Eating Disorder Patients/*Mary Davies Cole*

Healing Medical Symptoms Exacerbated by Stress: Using Art Psychotherapy/*Gretchen Tartakoff*

Workshops

Assessing Selected Jungian Based Images—The Visual Preference Test/*Doris Arrington, Christian Arrington*

Images of Loss—Growing Stronger Through Loss/*Carole Kunkle-Miller*

Art Works! Art Activities for People with Severe and Profound Mental Retardation/*Jacquelyn M. Martin, Diane Meros*

Using Visualization and Art to Promote Ego Development/*Joan Bloomgarden, Frances Kaplan*

Exploring Therapeutic Resistance Within a Psychodynamic Context/*Arthur Robbins*

The Window: A New Media for Witnessing the Self and the Other/*Janet Long, Hella Bahnsen Merrill*

The Self-Portrait Box: A Photo Art Therapy Workshop/*Irene Corbit, Jerry Fryrear*

Art Therapy and the Older Person: Images of Yesterday and Today/*Gary C. Barlow, Winnie Ferguson, Lewis Shupe*

Anger Monsters and Fearful Friends: Taming the Negative Within/*Kurt Brewster*

Transformation of Women's Loss and Grief into Creativity and Power/*Ellen Speert*

Treating Sexual Trauma Through Integration of Mind, Body and Emotions/*Becky Olivera, Daryl Hlavsa*

Guided Imagery or Misguided Trauma?/*James J. Consoli*

Panel

Comparisons of Drawings Produced by Abused Children and Survivors in Adulthood/*Myra Levick, Karen L. Gomer*

For additional information, contact American Art Therapy Association, Inc., 1202 Allanson Rd., Mundelein, IL 60060 USA. Tel: (708) 949-6064.

Art Therapy: Journal of the American Art Therapy Association, 9(1) pp. 17-19 © AATA, Inc. 1992

American Art Therapy Association Honorary Life Member Award—

Cay Drachnik, MFCC, A.T.R., HLM

Awarded at the 22nd Annual Conference of American Art Therapy Association, Inc., Denver, Colorado, on November 16, 1991.

CAY DRACHNIK

Cay Drachnik was tenth President of the American Art Therapy Association, from 1987-1989, and President-Elect from 1985-1987. Previous to her election to the presidency, she was active in a number of AATA committees, serving as Region I Standards Chair, on the Board of Ethics and Professional Practice, and as a member of the Governmental Affairs Committee from 1979 to 1984. In addition, Cay has spent numerous hours assisting states in developing job descriptions for art therapists and travelling on her own personal time to give legislative support to art therapists seeking licensure.

Cay Drachnik is well-known for her legislative efforts to promote and protect art therapy. She was appointed to a four-year term on the State of California Health Facilities Advisory Board by the Governor of California, where she monitored regulations in order to protect the interests of art therapists. As a member of this Board, she took personal time off from work and forfeited pay in order to attend meetings. For this and other legislative work she did in California, she was made the first Honorary Life Member of the Northern California Art Therapy Association. She has also continued to be involved in the ongoing battle to keep Marriage, Family and Child Counselor licensing available to art therapists in the state of California. Because of her efforts in this area, California is one of few states where it is

BEST COPY AVAILABLE

possible for art therapists to receive third party payments under the MFCC umbrella.

On a regional level, Cay Drachnik is one of the founders and charter members of the Northern California Art Therapy Association (NCATA). She also served as the Vice President and as Legislative Representative of that regional association and has been continuously involved in various Northern California activities for over a decade. While on the NCATA Board, she was instrumental in achieving state civil service job classification for art therapists to prevent occupational therapy from becoming the only rehabilitation therapy to head rehab departments in state agencies. She also helped to found the first coalition of rehabilitation therapists in California. Because of her efforts to support and protect art therapy in Northern California, Cay was presented the Distinguished Service Award by NCATA in 1990.

Cay has worked as an art therapist at Psych West (formerly Eskaton) for more than 15 years, providing model art therapy services to adults, children and families. She has been a lecturer at colleges and universities on topics such as sexual abuse, symbols of psychopathology and brief art therapy with the mental health client and has contributed articles on clinical practice and governmental affairs to professional journals. She has also presented at the annual AATA conference as well as regional conferences as an invited speaker on clinical, ethical and legislative issues.

Cay Drachnik has made many outstanding contributions to the AATA and has worked as an art therapist and art therapy educator for twenty years. Her work in legislative and governmental affairs, education, and clinical work has made a significant impact on the American Art Therapy Association as well as the field of art therapy in general.

Remarks Upon Receiving the AATA Honorary Life Membership

Thank you!—I feel like I just won the Academy Award. I want you to know I am truly grateful to all of you for having bestowed this high honor upon me. To be recognized by one's peers is indeed something very special in one's life.

I know that I have held offices and have been involved with art therapy committees, both state and national, for the past 20 years, but my most significant contribution, I am sure, has been in the field of governmental affairs. I believe that in bestowing this honor upon me, you have recognized the importance of legislative activities in our organization, and for that I am doubly pleased.

This honor, however, should be shared with many others who have worked so diligently in the field of legislation on behalf of the American Art Therapy Association. I may have led the battles on many occasions, but nothing could have happened without the support of all the others.

It's kind of fun to look back and remember how I got started in all of this. My husband and I were moving from Washington, D.C., to the Bay Area in 1972. Elinor Ulman gave me a list of subscribers to the *American Journal of Art Therapy*. I looked up Vija Lusebrink and Janie Rhyne, and the Northern California Art Therapy Association was born.

Shortly after, we moved to Sacramento, the state capital, and I was given the task of trying to get art therapy a state civil service job classification. After 30 phone calls trying to find who to talk to, with negative results, I gave up. Within a week, I received a phone call from a man who said he had been searching for the past three months for an art therapist, in order to help set up a state civil service job classification for art therapists. He had gotten my name from a music therapist who I had just happened to meet along the way. So all my 30 phone calls were for naught, but we did get our classification.

Then there was the time we were trying to get defined in Title 22 of the State's Health Regulations. Helen Landgarten flew up from Los Angeles to help out in this. At this time, we had a total of 60 members in both the Northern California and Southern California Art Therapy Associations. Naturally, during Helen's testimony before the regulatory committee, she was asked about how many art therapists there were in the state. She gulped, did some quick thinking and decided that, although there were only 60 official art therapists, there must be loads of people out in the hills of California who claimed to be, so she replied that a rough estimate might be 300 to 500. We got our definition based on those numbers; however, now that we are organized, we are trying to get rid of those same people who call themselves art therapists, but who don't have the necessary qualifications. They served their purpose at that time. That is politics for you.

Another person who in the early days was important to our legislative efforts in California was Dr. Don Uhlin, now deceased, who headed the art therapy program at Sacramento State University. He was a big, imposing man, something like Matlock, except he was always in a wheel chair. He had had polio as a youth. He served on the board of the AATA as Secretary, and was one of the finest men I have ever known. We disagreed on many issues, but agreed totally that art therapy was the greatest thing that ever happened to both of us.

Anyway, the occupational therapists in California were trying to get licensed, and we, along with the rest of the creative arts therapists and the physical therapists, were opposed. We got inside information that they were going to wheel in some patients to make an impression on the hearing committee. When we got to the hearing, they had three little old skinny women in wheel chairs, but we wheeled in our 260-pound Don Uhlin, and with flags flying, counteracted their act. We won that day!

Then, later in 1985, the Board of Behavioral Science Examiners threatened to take away the marriage and family counselor licenses of art therapists who were already so licensed. That was a battle that took many warriors. All the troops from Northern and Southern California assembled: Helen Landgarten, Maxine Junge, Shirley Riley, Doris Arrington, and Mari Flemming, plus others too numerous to mention.

We reinstated the coalition with the help of David Read Johnson, wrote letters, made phone calls, and were doing fairly well until one hearing before an august body of men. It was a time when anyone in the audience could come up to the podium and speak, and up tripped a dance therapist—and I mean tripped: she wore sandals with no stockings, a long flowering chiffon gown, jangling bracelets and earrings, topped off with flowers in her hair. In a lilting voice, she said to this imposing body of men in their gray flannel suits, "I am a movement therapist and I move . . ." and with that, she danced down the hall and out the door. We all looked at one another and we thought our chances of convincing this committee that we were professionals had gone right out the door with her.

At about that time I was teaching my regular summer session class at the College of Notre Dame, when Doris Arrington came into my classroom with fifty assorted sheets of stationery and envelopes. She told the students that if they wanted to pass this class, they had to write two letters, one to their assemblyman and one to their state senator, protesting the BBSE's action to divest us of our MFCC licenses. The variety of papers and envelopes were used so that it wouldn't look like a "put up job." My, we were clever in those days!

As you can see in legislative affairs, along with the hard work of writing position papers, testifying before legislative committees, making phone calls, and getting letter writing campaigns going, there is nonetheless a lot of fun and excitement, and even a few cheap thrills.

All of those early experiences helped out later, when art therapists in other states were trying for state job classification and licensure. Other art therapists who have worked hard on legislative issues and who deserve a great deal of credit are: Nancy Hall, who did a magnificent job as Governmental Affairs Chair when I was President, and who, along with Robin Goodman and Laurie Wilson, got art therapists' state civil service job classification in the state of New York. Suzanne Canner Hume spent untold hours working on licensing in Massachusetts. Deborah Good practically moved into the capital building in New Mexico, trying to get art therapists licensed there—she didn't succeed, but she's still trying.

Robin Gabriels did get art therapists licensed as counselors in Colorado, and continues to work for the AATA as our Governmental Affairs Chair—and doing an outstanding job. Nina Denninger and Karen McMichael deserved a lot of credit, too—they are currently working with me on a new state definition for art therapists in California. It's like having a baby—we've been at it for nine months, now!

Others, too, have made major contributions, but because of time constraints, I can't name them all today; however, I want them to know that I gladly share this honor with them.

As a result of their hard work, art therapists can now be licensed as counselors in Florida, California, Massachusetts, Maryland, Louisiana, Alabama, Colorado, Oklahoma, and Texas and can be certified in Nebraska and Washington State. Art therapists are in the process of applying for licensure in both Michigan and Delaware.

It's been a long, hard road—but we've come a long way, and I am extremely proud to have been a contributor to this process. Thank you again for this wonderful honor. We hope to move soon to Carmel, California, where Clint Eastwood lives, and as he would say, "You've made my day!"

Art Therapy: Journal of the American Art Therapy Association, 9(1) pp. 20-21 © AATA, Inc. 1992

American Art Therapy Association Distinguished Service Award—

Cathy A. Malchiodi, M.A., A.T.R.

Awarded at the 22nd Annual Conference of the American Art Therapy Association, Inc., Denver, Colorado, on November 16, 1991.

CATHY MALCHIODI

Cathy A. Malchiodi, M.A., A.T.R., is currently the Director of the Graduate Art Therapy Program, University of Utah, Salt Lake City. She also maintains a private practice specializing in domestic violence, child abuse and chronic illness. She has recently published a book, Breaking the Silence: Art Therapy with Children from Violent Homes *and has produced the educational video,* Art Therapy: Releasing Inner Monsters. *She has presented workshops and papers on art therapy regionally, nationally and internationally in Europe, Canada and Asia, and has presented at all the AATA national conferences since 1982. In 1987, she went to Beijing, China, at the request of Very Special Arts International (Kennedy Center, Washington, D.C.), the Chinese government, and the U.S. Information Agency, to teach educators and mental health professionals in China about art therapy. While there she participated in the first Very Special Arts Festival on mainland China and appeared on China Central Television before an audience of over 300 million to discuss and demonstrate art therapy.*

Cathy Malchiodi is a charter and founding member of the Rocky Mountain Art Therapy Association and currently serves as its Bylaws Chair; she also served as Program Chair for the first Four Corners Regional Art Therapy Conference. She is also past-president of the New England Association of Art Therapists and served as Chair of various NEAAT committees, including Public Information *and Education. Since 1982, Cathy has been actively involved in many AATA committees, including Public Information, Finance, Ethics and Professional Practice, Membership, and National Conferences; she was also Pre-Conference Chair (two years) and the Chair of the AATA Film Festival (two years). She has also served on the AATA Executive Board as Membership Chair (1987-89), Ethics Chair (1987-1990), and Certification Chair (1989-1991). Cathy chaired efforts to create a revised Code of Ethics, and developed an AATA Membership Brochure, a Membership Survey and Specialty List, and an Art Therapy Media List. She also held the position of Secretary (1989-1991) on the AATA Executive Committee, overseeing the Bylaws, Policies and Procedures Committee and the Publications Committee.*

Cathy has received many awards for her work in the field of art therapy, including: Recognition of Service Awards from the China Fund for the Handicapped and Hong Kong Social Services for art therapy training seminars presented in Beijing and Hong Kong, an Outstanding Service Award from Very Special Arts for distinguished service and teaching, the Art Therapy Pioneer Award from the Four Corners Art Therapists, and recently received a Thomas Dee Distinguished Educator Award for research in art therapy.

Remarks Upon Receiving the AATA Distinguished Service Award

First, I want to say that this is going to be a very short "distinguished moment," due to time constraints!

I want to thank the Honors Committee for selecting me and the AATA Board of Directors for approving of their selection. Without all of you, I would not be standing here today.

I also want to thank my husband, David, because at least one-half of this award belongs to him. He has shown a great deal of distinguished service in answering AATA related telephone calls and making many dinners when I was busy with one art therapy project or another. Without David's support, I would not be standing here today because it was he who encouraged me to pursue training in art therapy over a decade ago.

What has been most important to me in serving and promoting art therapy has been all the fine people I have met as a result of my involvement with the AATA, people who have given me great joy and people whose friendships I cherish. And, even through the politics and power struggles that come with Association work, you have always been there for me and I continue to be inspired by you.

So, I particularly want to thank you for this special gift as well as this honor you have given me today. Thank you.

BEST COPY AVAILABLE

Art Therapy. Journal of the American Art Therapy Association, 9(1) pp. 22-29 © AATA, Inc. 1992

Artist-in-Residence: An Alternative to "Clinification" for Art Therapists

Patricia B. Allen, Ph.D., A.T.R., River Forest, Illinois.

Abstract

This article identifies and describes the "clinification syndrome," a process where art therapists gradually cease making art as clinical skills become the primary career focus. Priorities of training programs and the policies of the American Art Therapy Association contribute to this trend. Lack of research and theory development in art therapy are seen as major ramifications of the clinification syndrome. Several suggestions are offered to anchor art therapy students and beginning professionals more firmly in an art-based practice.

As an art therapy educator and supervisor, I have noticed over the years certain phenomena which I will be so bold as to label a syndrome. I refer to a trend in the field of art therapy towards a "clinification" of the art therapist as he or she proceeds along a career path. This clinification syndrome can be described as a dual developmental process whereby the art therapist gradually takes on the skills and characteristics of other clinicians, while at the same time investment in and practice of art skills decline. While the issue of whether one is primarily an artist or a therapist or some amalgam of the two has been addressed in a number of presentations and articles (Ault, 1977; Landgarten, 1989; Rosenberg, et al, 1983; Wadeson, et al, 1977), the ramifications of one's choice and the long-term impact on the field have not been investigated. What are the benefits, concrete and intangible, which accrue to the art therapist who is able to remain an art maker? What is the long-term effect on the field of art therapy, still in a nascent stage of development, when art therapists give up making art?

The Clinification Syndrome in Art Therapy

Clinification occurs when the primary focus in art therapy is the discussion and interpretation of the art product. The art therapist provides basic art supplies, such as markers, pencils, cray pas and pastels and allots a limited amount of time for the use of such materials. The understanding of a particular issue or image is the major goal. Often such work takes place in an office or other non-studio environment, such as a patient dining room. Little or no effort is made to engage the client in experimentation with a range of art processes. The marks on paper are a means to an end of insight into a problem the client is having.

Often a directive is given to aid the client in focusing on the problem. The products of such sessions are usually graphically rudimentary, and may combine words to clarify the meaning or use magazine pictures in place of self-created images. The interventions of the art therapist tend to be verbal, encouraging the client to look for meaning in the picture or, at times, offering possible meanings to the client. The image is generally understood in relation to the client's clinical diagnosis. So, for example, if a client with a diagnosis of depression draws a yellow sun with a smiling face, denial of depression may be deduced. The frequent impoverishment of such images is seen as evidence of the pathology of the client in graphic terms and used in team meetings to support the treatment plan. In fact, such art may reflect the impoverishment of the environment which is ill equipped to sustain the production of more realized art work.

The style of art therapy briefly described here has many variations and can be useful in clarifying underlying conflicts, seeking solutions to problems, and identifying hidden emotional factors. While

---

Editor's note: The author wishes to thank students and supervisees, both past and present, for stimulating much of the thinking contained in this paper. Thanks also to those art therapists who read and critiqued this paper while in progress: Evelinha Carvalho Weber, Susan O'Brien, Dayna Block, and especially Deborah Gadiel.

emotions may be aroused by these means, the primary process at work is one of identifying and naming whatever emotions do surface. The value of such work is evident to anyone who has seen the light bulb of insight go on for a client who then takes steps to change detrimental behavior patterns. However, insight alone does not guarantee that behavior changes will occur.

There are two major limitations in regard to this clinified art therapy that I wish to offer for scrutiny. First, such work can successfully be done by any well-trained, reasonably sensitive clinician. Discussion of the art product in relation to the client's psychological issues requires knowledge of the client more than knowledge of art, as well as a good measure of common sense. To use a visual image as a starting point for dialogue is a small shift for the clinician practiced at active listening and used to pointing out figures of speech as a form of imagery. Bernie Siegel, M.D., (1986) the well-known surgeon, is an example of someone without psychiatric training, yet able to use drawings with cancer patients to elicit their unconscious beliefs about disease and treatment due to his high degree of empathy for the experience of cancer. Jeanne Achterberg and G. Frank Lawlis (1978) have studied the medically predictive value of patient images by correlating drawings and blood chemistry. In fact, the medical training of such individuals allows them a broader range of understanding of the potential meaning contained in the images of ill patients than most art therapists would generally have.

The second and most troubling aspect of clinified art therapy is that it neglects to employ the very specialized knowledge that derives from our background in art making itself. This knowledge comes most directly from the art therapist's first-hand experience in using the art process to negotiate his/her own emotional life. It is this concrete and specific fluency with materials as emotional equivalents that forms the art therapist's intuitive response to the client and enables him/her to empathetically witness and facilitate the transformation of primary process and the expression of metaverbal states. The knowledge of the effect of working with various materials—the difference between watercolor and tempera, between using a 4H pencil versus a 6B pencil, between working on a 4' × 4' piece of paper hung on a wall or a 8" × 11" piece with a ruled border—are things the average clinician cannot relate to as appropriate containers for emotional states.

The uniquely therapeutic potential of the art process is that it allows sustained experience of emotional states to the point where integration of a change in such a state can occur. For example, the realization that one is feeling sad may or may not lead to the insight that sadness is connected to the anniversary of a significant loss. Insight may produce some relief in that meaning arises from the ability to name the feeling "sadness" and identify that one is experiencing grief. But, grief once named does not abate and indeed, may intensify. It is the sustained experience of the feelings and memories associated with the loss that makes way eventually for peace. The art making process provides the means to dwell deeply and fully in those memories and feelings. The engagement with materials helps to regulate and temper the experience of emotional states that might otherwise be overwhelming and engender a defensive response. These are the aspects that enable art therapy to be a discipline in its own right and not only a means to jump start psychotherapy. In the creative and emotionally appropriate use of materials art becomes therapy and moves beyond a diagnostic adjunct to verbal work.

Clearly, useful work can be accomplished with standard materials. In such work, the therapist must rely upon a thorough understanding of the clinical situation the client is facing. A whole-hearted emphasis on inculcating such understanding has been pursued by some graduate art therapy training programs by introducing courses in many aspects of traditional clinical work. While clinical understanding is a basic requirement in working with clients in therapy, the emphasis on the clinical over the art has led to a stunting of the development of art therapy as a discipline in its own right. Understanding of the therapeutic potential of art media can best be gained by doing art, in a sustained, mindful and self-invested way.

Factors That Predispose the Development of the Clinification Syndrome

There are a number of factors that predispose the occurrence of the clinification syndrome. Our national organization (AATA) and our training programs inadvertently encourage the development of the syndrome. For example, emphasis on the prerequisite nature of art involvement for the beginning art therapy graduate student ensures that some exposure to and involvement with art materials has taken place, though rarely beyond the survey level. Most art departments and even schools of art tend to emphasize technique over content at the undergraduate level. Few teachers on the college level can relate to or nurture a psychological approach to art making that is compatible with art therapy. These art skills need to be developed in an atmosphere of support and trust rather than in competitive critiques. Admission portfolios to art therapy graduate programs routinely show a range of levels from undeveloped skills in rendering, color, and form, to adequate skills with little relation to personal content. Occasionally, powerful personal content is well executed, but without the sort of psychological awareness necessary for an art therapist. None of these inevitabilities would be a problem if continued art making was a mandated and supported part of graduate art therapy training. Art therapists need to concurrently learn to attend to art, listen sensitively, and respond empathetically while knowing how to engage fully with materials. The therapeutic skills need to be grounded in an immersion in an art environment.

However, although the majority of students accepted into art therapy training need to develop depth or skill in their art making, opportunities to do so elude them. McNiff (1979) reporting a survey of art therapists about perceived importance of art making wrote: "A problem which contributes to the artistic inactivity is the fact that courses for personal artistic development are not included in training programs" (p. 105). Graduate art instructors are unwilling to allow such students into their classes whose portfolio work or commitment to a particular art area doesn't measure up. Even students with exceptional talent who would be welcomed into a graduate painting or sculpture seminar have difficulty finding the sufficient time, amid the demands of internships and class work, to devote to creating ongoing work. Hence, they complain, they are not taken seriously by instructors.

While the art work created in art therapy seminars is crucial to the understanding of the art therapist, it is neither wholly therapy nor fully art due to the didactic restraints imposed by trying to experientially teach students what might be done with clients. These experiences may serve to challenge the doctrinaire art school concepts students enter with and, at times, result in wonderful bursts of talent or insight. Ideas for new directions may blossom in the creatively stimulating environment of "art therapy art making." Yet, little is done in graduate training to nurture that creativity to fruition to ensure that it will take firm root and continue to nourish the student in the transition to beginning professional and beyond. The lack of a portfolio requirement for A.T.R. registration, as even a symbolic reference to the necessity of art making, conveys to the student that being an art maker is unnecessary to the professional self.

A second factor contributing to the clinification syndrome stems from ambivalence around clinical skills among art therapy educators. Training programs are faced with sending students into a multiplicity of settings for internship and eventual work where expectations for clinical expertise vary widely. Educators would like students to gain sufficient clinical understanding to inform an art-centered practice. But, knowing that clinical therapeutic skills may aid their stature in the work place and facing a dearth of genuine art therapy theory, educators usually fall back trying to convey clinical expertise gleaned from established areas of psychology—psychoanalytic, Jungian, client-centered, gestalt or some eclectic amalgam—suited to the individual personality. Partly this has been a political decision to save the art therapist from the disempowered position of the "adjunctive therapist" label. The unfortunate result has been an over-saturation with a hodgepodge of clinical concepts. It can also engender a chronic fear of clinical inadequacy that results in a sort of "catch-up" mentality. Some students respond by over compensating, becoming the "star clinicians" in their placements or jobs.

In the previously cited report, McNiff also states that art therapists reported that: "An excessive intellectual analysis of art works and the habit of interpreting every expression tends to produce self-consciousness and inhibition; and the pressures to develop a clinical rather than an artistic identity generally dominate the consciousness of the art therapist" (p. 105). This 'pressure to develop a clinical identity' arises out of failure of nerve in leading with the art and neglect of the sort of primary studio research that would help articulate what happens in the art process, rather than any action taken by forces outside the field. This leads to factors in the work place which encourage the clinification syndrome.

Isolation

After some level of camaraderie in graduate school where the students travel with a peer group, the neophyte art therapist is often alone in his or her first job. It is human nature to become like those around us both to fill needs for affiliation as well as to develop a professional identity. If one is the lone art therapist among other clinicians, the likelihood of absorbing the style and information of others is great, especially if they are welcoming and seen as competent. Inservices, workshops, and supervision in the work place are likely to stress shared clinical aspects to which the art therapist will respond in an effort to find a common ground. While work supervisors and other staff will often enjoy learning from the art therapist, few will be in a position to challenge him/her to grow or enlarge his/her conceptualizations about art therapy. Supervision from a more experienced A.T.R. certainly can alleviate this problem somewhat though that, too, is often an isolated occurrence and often takes place outside the work environment. Additionally, new grads with heavy debts from training and entry level salaries may defer A.T.R. supervision for economic reasons, making due with little or no supervision on the job.

Couple these pressures with the sheer rigor of a full-time clinical job, which is financially required by most new grads, and one quickly begins to wonder how any art therapist continues as an artist for long. Within the job itself charting, team meetings, and case consultation all eat into the art therapist's time so that some don't even have a balance of client contact hours. All these activities have certainly contributed to the awareness of art therapy in institutions and have raised perception of its value in the eyes of other health care professionals. But, what profiteth he who gains the respect of the whole staff if in so doing he loses his soul?

The end result of this type of skewed development is that after a period of a few years, the art therapist's actual work with clients may be indistinguishable from that of a social worker, psychologist, or counselor who has a bent toward art or has taken a few art therapy workshops. Some art therapists go on for one of those credentials and the transformation is complete. Why is this a problem? I believe the clinification of the art therapist is a factor contributing to several problems endemic to our field:

1. Burn out
2. Career drift
3. Lack of art therapy research
4. Lack of theoretical depth

These first two problems may be grouped as existential ones in which the purpose and drive of the art therapist to do good, to help others, to learn about human behavior through art begins to wane. A sense of futility may overtake the art therapist who sees patients released after a numbingly brief length of stay during which one or two art encounters ensued. S/he begins to doubt his/her career choice. Clinified art created and used to search out or confirm pathology conveys an emptiness. The art therapist may begin to wonder, "What was so important about the art?" No longer a conduit to the client's inner life force, the art can seem contrived, hollow, meaningless. In fact, these feelings mirror the art therapist's own abject emptiness arising from a disconnection from his/her own art and own center. The estrangement from one's own art inevitably leads to an estrangement from the art of the client. The art of the client can become a painful reminder of the lack of art in the life of the art therapist.

Other professions seem more attractive, with greater financial rewards to offset a sense of helplessness. Becoming a psychotherapist circumvents the painful conflict about the place of art in the life of the art therapist. When taking stock of work duties, the art therapist begins to see that she is doing a form of psychotherapy, yet somehow that is not what she set out to do. At this point the art therapist may begin to think about returning to school for another degree in a related field, feeling ill-equipped to meet the needs of the job as perceived. Several art therapists have expressed the concern that they were "not doing enough for the clients" by "only" providing art. Without good art therapy supervision, this perception can erode the art therapist's sense of confidence completely.

The second two problems are pragmatic ones, though they follow from the first two. Theoretical depth can only come in tandem with research. This means research in the most basic sense: a thorough and rigorous immersion in the study of some human phenomenon, methodology being a secondary consideration. The human phenomena in which art therapists are presumably interested is art making and the effects of art making on human behavior and emotional life. If little art making is taking place, or comes to be considered as second in importance to insights or verbalization, no art therapy research can occur and thus no art-based theory can be derived.

This paper proposes a philosophical shift as well as several concrete suggestions that intend to wed the artist to the therapist in a consciously articulated and morally necessary marriage. The artist-therapist who sustains the conceptualization of art-centered art therapy is crucial for the survival of our field: ". . . the effectiveness of therapists depends upon the nature of their personal relationship to art" (McNiff, 1989, p. 121).

BEST COPY AVAILABLE

A Modest Proposal

The changes suggested are ones requiring only a slight shift of vision, but if they take hold, can have major ramifications for the health of art therapy and art therapists. First, training programs must look hard at the internship sites in use and develop a better balance between hospital placements and alternative sites where art making can serve a more central role. Secondly, all new grads who seek employment in a facility which does not already employ a registered art therapist on staff should be encouraged to negotiate for A.T.R. supervision to be paid for by the agency. At the very least they should request this support for long enough to attain their own A.T.R. A small but growing number of former students have been successful in negotiating for paid outside supervision as a professional necessity by stressing the specialized nature of the work they perform. Facilities see this cost as an investment in staff development which will eventually allow the art therapist to bring in students and help to insure high quality service. By taking this step the art therapist is seen as a dedicated professional and addresses the issue of specialization directly. Whatever supervision is provided by the agency should be seen as necessary as well and not seen as replaced by A.T.R. supervision.

The next proposition is more controversial: art therapists have a right and even a responsibility to make art at their placements during training and subsequently at their jobs. I am not talking about superficial sketches dashed off during an art therapy group. Rather, I am suggesting that the opportunity for clients to observe involved art making is in itself therapeutic. Many individuals harbor mistaken ideas about how artists work, or have no idea about how an art piece comes to look the way it does when finished. They have no reference for visual experimentation nor skills for translating complex inner experiences into satisfying images. Art therapists assume such capacities are present or at least latent in everyone and fail to realize some effort must be made to allow such capacities to manifest. Here is a crucial point where art therapy differs substantially from psychotherapy. The art therapist must do a certain amount of teaching in order to help the client articulate inner experience. This is not teaching in terms of content, giving directives that tell the client what he or she ought to make art about, but rather how to use one's whole hand to smear pastel chalk over a large space, how to physically loosen up and draw with one's body and not only the wrist, that it's okay for charcoal to break and paint to drip. Learning through direct observation is extremely effective. Martha Haeseler (1989) writes that when she uses strong colors and works intensely with materials, clients become able to do likewise. "If I work spontaneously and express strong affect, I demonstrate that art can contain and express strong feelings without overwhelming the artist, and clients will follow suit" (p. 71).

Last Spring, an energetic student at the School of the Art Institute, Deborah Gadiel, crystallized this idea into a simple yet powerful concept. She proposed that some portion of her hours during her major internship of her second year of training be devoted to functioning as an "artist-in-residence" at her site. She would carry out regular duties in assessment, individual and group art therapy as well. During the artist-in-residence time she would pursue her own art making and clients and staff would be welcome to come and observe or participate in their own art making. These hours would count as contact hours. Deborah's use of the term artist-in-residence, a familiar one from the intersection of education and the art world, creates a bridge to and from her core self to her role as therapist. She recognizes that her artist identity is an asset to her art therapy work and it would be a waste not to utilize it in her job. Deborah says:

> "I see my identity as that of an artist. I am most in sync when I am making art. This drive to do art work, this enthusiasm for the artistic journey is the most powerful tool I have to share with the client. It's the opportunity to share the most unique part of me every time I make a piece" (D. Gadiel, personal communication, 1991).

Deborah continually experiments with materials and methods and so does not fall prey to simply handing out the same things over and over. By acting as a witness to the centrality of art in her life, she presents a role model of commitment and self-esteem. She continually renews and reinvents herself in the work place and is able to model what is good and right about work: discipline, struggle, serendipity, enterprise and invention.

Rather than attempting a schizoid solution of therapist by day and artist by night, weekend or during periods of illness, art therapists have an opportunity to place themselves squarely in their souls and remain true to themselves and grounded in their identity. Training and experience being equal, art therapists who are active art makers will become the better clinicians by the very fact of remaining more in touch with themselves. Deborah continues:

> We as artists can demonstrate problem solving, risk taking, and self-fulfillment. We can create an atmosphere of involvement. We model a dialogue between ourself and a piece of art (D. Gadiel, personal communication, 1991).

The art therapist working in this way will be continually reminded that whatever healing there is comes *through* us in the vehicle of the art, we make way for something already existent within the client to become manifest.

The Work Place

> "More and more, we take for granted that work must be destitute of pleasure. More and more, we assume that if we want to be pleased we must wait until evening, or the weekend, or vacation, or retirement. More and more, our farms and forests resemble our factories and offices, which in turn more and more resemble our prisons—why else should we be so eager to escape them?. . . . We are defeated at work because our work gives us no pleasure" (Berry, 1990, pp. 139-140).

Many art therapists say, "Oh, how will the site react to these demands? I couldn't possibly ask for that!" One **must ask** for what one needs. So far, my observation has been that new sites, accepting students or hiring their first art therapist are open to whatever the art therapist says is needed. No art therapist would settle for using ball point pens and typing paper without first explaining that proper supplies are necessary to carry out their work. The picture may be different in facilities where art therapy is already established. The art therapist, already suffering from the clinification syndrome, may be far more resistant to the proposal for artist-in-residence time. Additionally, nearly any community-based site, mental health center, day treatment, sheltered workshop, special school, or halfway house will be more accepting of such a plan than an inpatient hospital unit, in most cases.[1] In many such facilities, a rigid hierarchy is already in place and art therapy is likely to be rather circumscribed. The art therapist on staff may be unwilling to support a major departure from the established routine and risk whatever positive perceptions have been created about art therapy already. Space is a crucial issue for the art therapist. Shared or transitory space defeats our purpose which is to create a culture of creativity, an art-enabling space that is both safe and stimulating, and invites and allows art making behavior with its messy aesthetic.

The final suggestion is for art therapists as soon as possible to form peer support groups. In the early stages these can serve as support in finding jobs and sharing resources, later as peer supervision or shared art making times. In any case the cost is only time to deepen one's skills together and keep focused on one's professional goals and development. A "scarcity" mentality about jobs is self-defeating. When viewing one another as peers in a support network, art therapists can organize and effect the work place by sharing strategies.

A Starting Place

Not all art therapy interns or new grads may be interested in the challenge of blazing new trails for art therapy into untried institutions. Not all art therapists will feel comfortable with the artist-in-residence concept. For some, the clinified art therapy approach is comfortable and works well enough. However, if just a handful make this attempt, in a few years, they, too will have students and be able to offer them a model of practice that includes remaining active as an artist. Working in this way and sharing the outcome is a valid and important form of primary research of paramount importance to our field. Certainly some sites are more likely candidates for this proposal than others. Deborah Gadiel, the student mentioned earlier, originally planned to do her long practicum in a state psychiatric hospital well known for its clinical training. After discussing her proposal with her prospective supervisor, who cited space and time constraints, Deborah realized her goal might be more easily met elsewhere and set about to call sites and inquire about their willingness to meet her requirements. She ended up with several to choose from.

Conclusion

To be an artist in the work place is to risk some of our ego-reassuring status. When we make art in an open studio, amongst clients and staff, we are vulnerable because we are as exposed as the client. Only continued practice of our art can keep us spiritually fit for such a challenge and prevent our art making from being an exhibitionistic dodge. What we are saying is that it's all right not to know, to show one's self. We affirm that we, like all human beings, are in process, never finished with growth and change.

If, however, clinified art therapy is the sum and substance of what we do, the field of art therapy is in danger of being subsumed into counseling or other related disciplines. Why not just get a counseling degree to begin with, if a few art therapy electives can be had along with the more conventional degree? We have created our own orthodoxy in an ironic attempt to protect our field from interlopers while at the same time feeling no compunction to mimic the courses of counselors and social workers. Consequently, it is those outside of art therapy, artists like Tim Rollins and K.O.S.[2] and Michelle Cassou of "The Painting Experience"[3] who are working in fresh and exciting ways, helping others, maintaining themselves as artists, and by the way, disavowing any connection to the field of art therapy. Nor are we stopping clinicians who have discovered the methods of using art to elucidate the issues their clients present. As my friend, art therapist Barbara Fish, A.T.R., likes to say, "you don't need a prescription to buy a box of crayons." The most crucial factor in the life or death of the field of art therapy is not certification, not licensure, but whether sufficient numbers of individual art therapists maintain an ongoing connection to their own art. Without that, the work has no depth, no life, no spark and can be carried out by almost anyone, from a decent O.T. to a well-meaning volunteer.

---

[1] See Existential Art Therapy: *The Canvas Mirror* by Bruce Moon for a description of artist-in-residence in an inpatient setting.

Work life is ego life. In the worst of cases it is only ego. If our work is not connected to our soul, our very selves become stagnant, even toxic; illnesses and injuries abound in the ranks of unhappy workers. Institutional politics take the place of job satisfaction in providing the spark and interest that keep us showing up every day. The immersion in one's art is risky, dangerous, invigorating. To walk that path is to be alive. Originally, we art therapists believed ourselves to have something unique to offer; as artists we have the capacity to see differently, be agents of change, be humanizers. We can be subversive in this most human of ways, reminding ourselves and others of truth by staying in contact with it ourselves. Without our art we are more at risk than even the average worker to succumbing to ennui and creation of a false self. We have firsthand knowledge of authenticity and we got that knowledge through our own art making. Each person's epithet is written or, in our case, drawn, with our own hands.

> "To overcome the anxieties and depressions of contemporary life, individuals must become independent of the social environment to the degree that they no longer respond exclusively in terms of its rewards and punishments. To achieve such autonomy, a person has to learn to provide rewards to herself. She has to develop the ability to find enjoyment and purpose regardless of the external circumstances. . . . And before all else, achieving control of experience requires a drastic change in attitude about what is important and what is not" (Csikzentmihalyi, 1990).

References

Achterberg, J., & Lawlis, F. (1978). *Imagery of disease.* Champaign, IL: Institute for Personality and Ability Testing.

Ault, R. (1977). Are you an artist or a therapist?—A professional dilemma for art therapists. *Proceedings of the 1976 Annual AATA Conference: Creativity and the Art Therapist's Identity* (pp. 53-56). Baltimore, MD: AATA.

Berry, W. (1990). *What are people for?* Berkeley, CA: North Point.

Csikzentmihalyi, M. (1990). *Flow: The psychology of optimal experience.* New York: Harper.

Cushman, A. (1991). The spirit of creativity: Reclaiming the joys of creativity. *Yoga Journal, 100,* 50-103.

Haeseler, M. (1989). Should art therapists create artwork alongside their clients? *American Journal of Art Therapy, 27,* 70-79.

Landgarten, H. (1989). Art therapy's influence on my artistic and personal development. *American Journal of Art Therapy, 27,* 106.

McNiff, S. (1979). The art therapist as artist. *Proceedings of the 1978 Annual AATA Conference. Art Therapy: Expanding Horizons* (pp. 103-105). Baltimore, MD: AATA.

McNiff, S. (1989). *Depth psychology of art.* Springfield, IL: Charles C. Thomas.

Nilson, L. (1988). From dead end to avant garde. *ARTnews, 87,* 132-137.

Rosenburg, H., Ault, E., Free, K., Gilbert, J., Joseph, C., Landgarten, H., & McNiff, S. (1983). Visual dialogues: The artist as art therapist, the art therapist as artist. *Proceedings of the 1982 Annual AATA Conference. Art Therapy: Still Growing* (pp. 124-125). Baltimore, MD: AATA.

Siegel, B. (1986). *Love, medicine and miracles.* New York: Harper.

Wadeson, H., Landgarten, H., McNiff, S., Free, K., & Levy, B. (1977). The identity of the art therapist: Professional self-concept and public image. *Proceedings of the 1976 Annual AATA Conference: Creativity and the Art Therapist's Identity* (pp. 38-42). Baltimore, MD: AATA.

---

[2] See *ARTnews* for a description of artist Tim Rollins and his group of inner city kids who create art as a group. The name they chose, "Kids of Survival," speaks about the therapeutic, even lifesaving role art making has come to play in their lives.

[3] See "The Spirit of Creativity" by Anne Cushman in *Yoga Journal, September/October, 1991.* Cassou teaches individuals to use their intuitive self as a guide in painting.

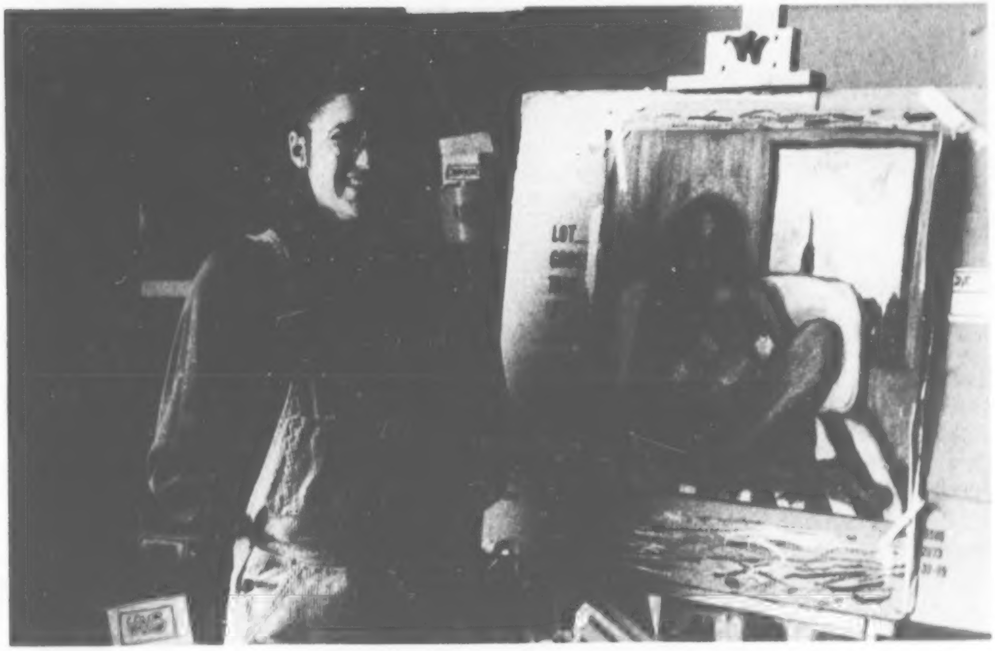


Fig. 1 Art therapist Dayna Block beside a self-portrait created during open studio at Pilsen Little Village Mental Health Center.

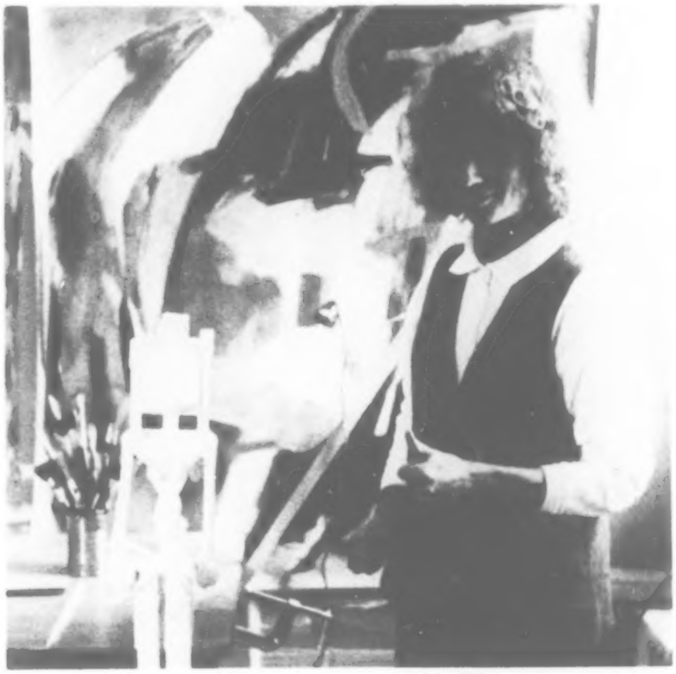


Fig. 2 Art therapy graduate student, Deborah Gadiel works in both sculpture and painting during the artist-in-residence portion of her internship hours.

BEST COPY AVAILABLE

Art Therapy. Journal of the American Art Therapy Association, 9(1) pp. 30-35 © AATA, Inc. 1992

Application of Child Art Theories to the Interpretation of Children's Art

Betty Jo Troeger, Ph.D.; A.T.R., Associate Professor, Florida State University, Tallahassee, Florida.

Abstract

The primary purpose of this paper is to assemble information about theories of child art into a conceptual basis related to the interpretation of children's art. A general overview of nine theories or models of child art (naïve realism, recapitulation, personality, developmental, intellectualist, haptic-visual, perceptual development, perception-delineation model, and the author's synthesis) gives implications for existing concepts and interpretations of art.

One of the most effective ways to comprehend theories is to use them in practical applications. Three of the theoretical concepts described in the paper provide a framework for an interpretation of one child's art work to illustrate three points of view. Art therapists should be familiar with the current literature before making assumptions about the meaning of specific features in children's art.

Art therapists look at children's drawings, paintings, sculptures and other personal expressions in art media for a variety of reasons. These art works are often used for assessment of developmental and/or emotional stages of growth. Understanding implications of atypical art is heightened when it is contrasted to images considered to fall within normal ranges of artistic expression. Children's art can also serve as a diagnostic tool for certain indicators of psychological disorders, sexual abuse and neurological dysfunction. Researchers are striving to validate the recurring use of specific symbols, color choices, techniques and spatial organization as significant in diagnosing disabling conditions.

A number of theories about children's artistic expressions exist. The major theories espoused by art therapists are generally linked to a psychological theory which informs their practice. Both theory and practice in art therapy have diversified from a primarily psychoanalytical approach to include creative, developmental, psychoeducational and humanistic/existential approaches. Rubin (1984) cites Freudian, Jungian, Gestalt, humanistic and phenomenological psychological frames of reference for the practice of art therapy; cognitive and behavioral psychology guide some art therapists. Nevertheless, the visual image of the client remains an integral part of each practice period. The primary purpose of this paper is to help art therapists assimilate available information about artistic expression into concepts related to interpreting visual images of children.

A general overview of nine influential theories or models of child art (naïve realism, recapitulation, personality, developmental, intellectualist, haptic-visual, perceptual development, perception-delineation, and the author's synthesis) gives implications for interpretations of art. These theories are presented in Table I. Our knowledge has moved beyond Cizek's 19th century view of child art which concluded that all children possess a universal language of visual symbols (Wilson & Wilson, 1982). Children were thought to experience a natural unfolding of skills when there was no interference.

The theories of naïve realism, recapitulation and personality evolved during the first half of the 20th century. **Naïve realism** assumes children or adults can draw the same way with the development of proper motor skills (McFee, 1961). The **recapitulation theory** (Kellogg, 1969) is closely associated with Jung and archetypal images, ie., those symbols which occur universally, appearing in divergent groups of people who have not been influenced by other cultures. Freud's concepts of the role of the subconscious and free association are linked to the **personality theory** (Clarke, 1979).

Table I

naïve realism theory

- postulates that there is no difference between the physical object and its image as perceived by the mind.
- considers differences in motor control responsible for the variations in the art of children and adults.

- limits art activity to reproduction.
- omits influences of emotions, improvising, and inventing.
- assumes that realism is the same for all people, with no consideration of cultural effects.

recapitulation theory

- embraces the concept that a child evolves through stages of artistic expression as reflected in the development of the human species.
- links interpretation of symbols to universal images (Jung, 1964).
- identifies Kellogg (1969) as a leading proponent of this interpretation of children's art.

personality theory

- accepts Freud's perception that art reveals unconscious states.
- examines children's art work according to the quality of expressiveness; art primarily reflects how the individual feels.
- influences majority of art therapists' interpretations of art. This majority shares a psychodynamic perspective.

developmental theory

- associates Piaget (1971) with stage-theory interpretation of cognitive development.
- establishes criteria for child's knowledge through examination of art product, extent of detail and chronological age of child.
- postulates that learning is linked to prior learning, and the ability to symbolize complex life experiences is identified through emerging imagery.
- indicates that the content and organization of the child's art work reflects the child's cognitive development.
- incorporates recent pluralistic approach to cognition, ie., multiple human symbol systems of Gardner (1985), multiple cognitive domains of Feldman (1980).

intellectualist theory

- possesses many of the attributes of the cognitive development theory.
- postulates that what a person knows about an object is his concept of it.
- supports the view that both concept formation and visual analysis are influenced by training, experience, and culture.
- acknowledges that mental age can vary widely from chronological age.
- incorporates formal testing of drawing abilities into mental development.
- Goodenough's Draw-a-Man test associates with this theory (Harris 1963).

haptic-visual theory

- attributes an individual's space orientation to a biogenic factor.
- describes haptic individuals as more dependent on their own emotional and bodily feelings, and visual people as more dependent on their visual environment.
- identifies differences between children and adults in the ways in which they orient themselves in space.
- encourages use of both internal and external cues for artistic expression.
- Lowenfeld's (1978) work associates with this theory.

perceptual development theory

- identifies Gestalt psychologists as providing basic structure for this theory.
- describes perceptual growth as an increase in the ability to use visual information that is available, to organize and synthesize it so one can respond to it.
- establishes the concept that a child first perceives undifferentiated wholes and is gradually able to discriminate details.
- recognizes Arnheim's view (1974) that perception is linked to culture and related to intellectual ability.

perception-delineation model

- accepts psychological and biological findings that every individual has a somewhat unique potential for learning.
- indicates that culture influences a person's perceptual training by giving more opportunities and rewards for observing things important to that particular group.
- considers the psychocultural as well as the visual/physical learning environment effects on information handling.
- states that delineating and responding to art encompasses development of visual images and symbols.
- presents a feedback interaction system which includes student development, teaching effectiveness, and assessment of changes in readiness.

author's synthesis

- defines physical and mental maturation as evidenced in art growth.
- acknowledges numerous individual differences and learning styles within this maturation process.

- views environment as affecting learning.
- describes art as an expressive mode of knowing which gives ideas visual form.
- recognizes art as a symbol system which can be understood through the study of art history, art criticism, aesthetics and production.

SOURCES for Table I: Arnheim (1974), Clarke (1979), Gardner (1985), Gesell and Ames (1946), Harris (1963), Lowenfeld and Brittain (1978), McFee (1961), McFee and Degge (1977), Piaget and Inhelder (1971), and Troeger (1985).

By mid-century the research on human development had a major influence on the interpretation of children's artistic expression. Piaget developed a universal view of human intellect linked to stages of mental growth, ie., concrete operations achieved in childhood and formal operation achieved in adolescence. Both Schaefer-Simmern (1948) and Lowenfeld (1971) incorporated these concepts into their views of art development. In the practice of art therapy Rubin (1984) maintains that theoretical underpinnings should include developmental considerations as well as psychodynamic ones. A basic understanding of art development can extend insights into art expressions. For example, scribbling is associated with two to four years; preschematic or the early attempts at symbolic representation is linked with four to seven years. Schematic or repeated use of symbols is attributed to seven to nine years, while realism generally begins at nine years and becomes more accentuated by age thirteen (McFee, 1961). These concepts of normal development provide a structure for identifying images which are atypical at particular levels of growth.

Developmental theory from a universal view has been reflected in the work of Piaget (1971). Additionally, contemporary perspectives in developmental psychology have been expanded to include a pluralistic approach to cognition, focusing on multiple human symbol systems. Gardner (1985) enumerates these as linguistic, logical, numerical, musical, bodily, spatial and personal symbol systems. Feldman (1980) extended Piaget's "unilineal" developmental scheme to five domains:

1. universal, which is achieved by all humanity;
2. cultural, which is achieved by all members of a culture;
3. discipline-based, which is achieved by a small segment of a culture;
4. idosyncratic, which is achieved by a few members of the culture;
5. unique, which is achieved by an individual. (Feldman, 1980, p. 31)

The intellectualist theory is associated with Goodenough's initial Draw-a-Man test. Measurement of mental aptitudes is linked to drawing abilities and is the main factor in determining how a child draws his/her concept of the object or idea (McFee, 1961). Lowenfeld's (1978) application of several of the theories to art education is well documented in the literature, specifically his views on creative expression; but he is most closely associated with the **haptic-visual theory** when interpreting child art. According to this view, variations in images occur depending on the individual's internal or external motivations for expression.

Other child art theories influencing contemporary practices in interpreting children's art are found in the **perceptual development theory**, the **perception-delineation model** and a **synthesis** of existing views. Gestalt psychologists' points of view (Bigge, 1982) as well as the work of Arnheim (1974) are reflected in the **perceptual development theory.** Children's capacities to perceive the world around them are linked to maturation, intellectual abilities and cultural views regarding learning and artistic expression. McFee (1961), an art educator with a sociological orientation, developed the **perception-delineation model.** This holistic concept of a child's art development encompasses the learning environment, the teacher and the individual's readiness levels, unique abilities and cultural conditioning.

A **synthesis** of models is not yet stated in a precise theoretical framework, but has been developed in the practice of the author (Troeger, 1985). Recent advances in cognitive psychology provide new concepts for interpreting symbols. Various cultural influences in art images and children's formal study of art objects also affect perceptions and interpretation.

One way to comprehend theoretical structures is to apply them. Anderson (1978), author of *Art for All the Children*, suggested an actual interpretation of a child's art work to illustrate different points of view. Three theoretical concepts have been described in this paper, providing a framework for that practical application. All of the theories or a synthesis of current views can be found in interpretations of visual images done by contemporary art therapists. The **personality theory**, the **developmental theory** and the **current synthesis** are used in discussing the selected drawings of one child.

Lucinda (a pseudonym), a seven-year-old African American girl with congenital deformities in the upper extremities, attended a special school for students with physical disabilities and health impairments. The child exhibited average intelligence and normal social adjustment as evidenced in her school records. Her foster home environment was also described as very supportive. Because one arm was not developed and her other arm extended to a wrist with three rudimentary fingers, Lucinda's range of motion was severely limited. She functioned at grade level in her academic subjects and appeared to have good visual memory. During an art assessment (Troeger-Clifford, 1981) the art therapist observed that the child cut with difficulty and manipulating clay was laborious for her. Lucinda was successful in handling a paint brush and very spontaneous when drawing. Despite normal intellectual and emotional development, the human figures portrayed in her art work were atypical.

From a **personality theory** perspective, Lucinda's drawings might be described as expressive with a direct linear quality typical of a child's work. It could be surmised that Lucinda's body image was reflective of the way she feels about human form. In the drawings of the family (Figure 1), the people appear closely linked, with Lucinda in the foreground and the baby slightly disconnected from the group. The drawing of the man, woman, and self (Figure 2) are depicted as father, mother and Lucinda. The schema for the figures reflect more detail and the bottom of the page serves as the baseline. The two female figures are clothed in transparent dresses. In the drawings of the cowgirl (Figure 3) Lucinda projects the female figure in vest, jeans, and boots, with holster and gun and a cigarette dangling from her mouth. A smile is a consistent feature in all of the drawings. From this theoretical orientation, no instruction in figure drawing would be necessary, but rather a supportive environment would be provided with art materials readily available where the child could draw or paint spontaneously. Verbal dialogue about the art work might be encouraged. Feelings surrounding the subjects would also be explored, but symbolic meanings would be determined by the adult.

A **developmental theory** application might include a determination of the stage of cognitive development of the artist. Lucinda would be in an early schematic stage. Generally, work progresses from scribbling to preschematic to schematic to some form of realism. These stages correspond to chronological age and an early schematic stage is compatible with Lucinda's being seven years old. The content and the organization of the child's art work are also a basis for judgement. The lack of detail in Figure 1 and Figure 2 would be viewed as an indication of immaturity. Figure 3 would represent a marked improvement with attention to detail and clothing reflecting a more complex drawing. The cowgirl theme would be associated with emerging imagery. An art intervention could consist of verbal inquiries about where the cowgirl lives, was the cowgirl indoors or outdoors, or what kind of animals might be in the picture. Motivation might include reading stories, doing improvisational exercises such as dressing in costumes and listening to music related to a theme. Efforts would concentrate on stimulating and extending the concepts the child was developing. The adult would not demonstrate any figure drawing exercises, but rather set the stage for the child to express ideas in visual form.

Theoretical concepts from the author's **synthesis** of perceptual and cognitive perspectives (Troeger, 1985) would produce yet another kind of information about Lucinda's art work. Although developmental indications of an early schematic stage would be acknowledged, more attention would be given to the atypical representation of the body image. Direct learning experiences could be initiated to extend the child's perception of the human body. Visual as well as tactile experiences often extend limited information caused by lack of instruction and awareness of human form. Lucinda's own arms were not like most other people's. She could observe human form in works of art, look at her peers as they modeled for small group drawing sessions and watch demonstrations of rendering the human figure by the therapist or teacher.

Figure 4 represents the first effort of Lucinda to draw arms and hands. She had just reached eight years of age. The upper extremities were typical of an eight-year-old's drawing capacity. Praise was given for improved attention to detail. The final drawing (Figure 5) in the series is much more complex and represents gains made over a semester of instruction. Background detail is included and overlapping is shown by a figure placed in front of a chair. Arms are extended upward depicting movement. The items on the table reflect a visual perspective while the layering of clothing on the woman is still transparent, indicating what she knows as well as what she sees. Lucinda's imagery appears richer not only because of the details, but she has expanded her images to include a cat, adding more interest to the drawing. She also labeled the cupboard in case the viewer needed further information. The base line remains at the bottom of the page but the overall composition is richer in the variety of shapes and forms. The next educational intervention could include making her aware of patterns and textures.

Lucinda's case is but one simple example of the very complex challenge of interpreting children's art based on a specific theoretical orientation. A historical perspective regarding the development of information on this subject is important when establishing an orientation for interpretation. The more recent theories of child art are clearly linked to learning while most of the theories developed before and during the middle of the 20th century are more closely associated with maturation. Maturation has been described by Bigge (1982) as a developmental process within an individual that reflects genetic "blueprints" by manifesting different traits; learning is an enduring change not heralded by genetic inheritance and occurs in insights, behavior, perception or motivation, or a combination of these. Wilson & Wilson (1982) discount the commonly held view that children's spontaneity and creativity will be destroyed if the natural process of making art is influenced by adults. From their point of view adult assistance is necessary to encourage the child's spontaneity and creativity. The timeliness of a theory must be constantly examined in terms of current practices. Rogers (1965) advocates testing theories, and, by such testing, profitable directions for action may be found.

Perhaps the final task in examining theories of child art is to establish a personal model for interpretation. Pertinent questions to build such a model could include the following:

1. What is your psychological orientation and is it compatible to a theory of child art?
2. What is the developmental level of the client?
3. What cultural considerations are to be taken into account?
4. What effects do learning about art have on image-making?
5. What physical, medical or drug-related factors distort the art process?

Rubin (1984) stated that her practice involved various ideas from different theories which she called "additive eclecticism." She now doubts the validity of such a heterogeneous mix. Art therapists need to establish criteria for judgements before making assumptions about meanings of visual images. A holistic perception of the client provides interrelated data, establish relationships, broadens conceptual bases, and expand the understanding of art as therapy.

References

Anderson, F. E. (1978). *Art for all the children.* Springfield: Charles C Thomas.

Arnheim, R. (1974). *Art and visual perception: A psychology of the creative eye.* Los Angeles: University of California Press.

Bigge, M. L. (1982). *Learning theories for teachers.* New York: Harper & Row.

Clarke, E. C. (1979). The educational evaluation of children's artistic progress: More is better, or is it? *Art Education, 32 (1),* 20-26.

Feldman, D. H. (1980). *Beyond universals in cognitive development.* Norwood, NJ: Ablex Publishing Company.

Gardner, H. (1985). *Frames of mind.* New York: Basic Books.

Gesell, A. & Ames, L. B. (1946). The development of directionality in drawing. *Journal of Genetic Psychology,* 68, 45-61.

Harris, D. B. (1963). *Children's drawings as measures of intellectual maturity.* New York: Harcourt, Brace and World.

Jung, C. G. (1964). Man and his symbols. New York: Doubleday & Co.

Kellogg, R. (1969). *Analyzing children's art.* Palo Alto, CA: Mayfield.

Lowenfeld, V. & Brittain, W. L. (1978). *Creative and mental growth (7th ed.).* New York: Macmillan.

McFee, J. K. (1961). *Preparation for art.* Belmont, CA: Wadsworth.

McFee, J. K. & Degge, R. (1977). Art, culture and environment: A catalyst for teaching. Dubuque, IA: Kendall/Hunt.

Piaget, J. & Inhelder, B. (1971). Mental imagery in the child. New York: Basic Books.

Rogers, C. R. (1969). *Freedom to learn.* Columbus, OH: Charles E. Merrill.

Rubin, J. (1984). *Child art therapy* (2nd ed.). New York: Van Nostrand Reinhold.

Schaefer-Simmern, H. (1948). *The unfolding of artistic activity.* Berkeley: University of California Press.

Troeger-Clifford, B. J. (1981). *The development of a model to include art in the individualized education programs for physically handicapped and health impaired students.* (Doctoral dissertation, North Texas State University).

Troeger, B. J. (1985). The relationship of artistic development to learning theory: an analysis and synthesis of current views. *Visual Arts Research, 11 (2),* 54-59.

Wilson, B., & Wilson, M. (1982). *Teaching children to draw.* Englewood Cliffs, NJ: Prentice-Hall, Inc.

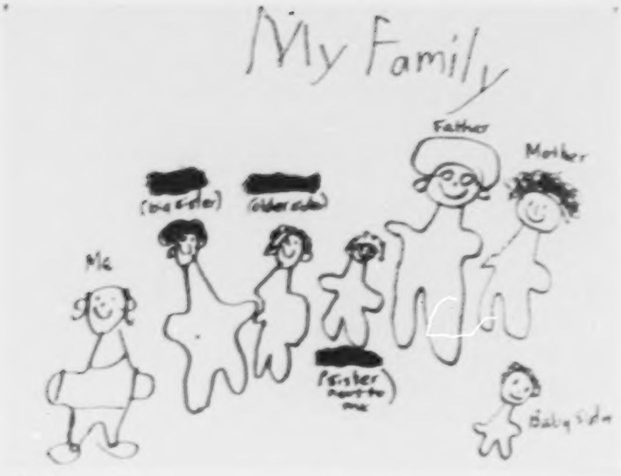

My Family
[redacted]
(one sister)
[redacted]
(older sister)
Father
Mother
Me
[redacted]
(sister next to me)
Baby Sister

Fig. 1

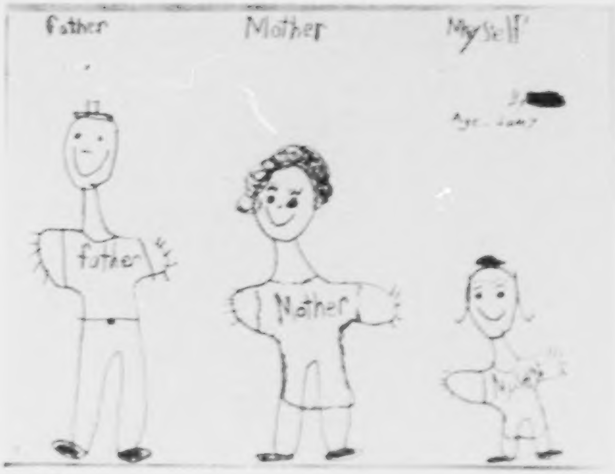

Father
Mother
Myself
[redacted]
Age
Father
Mother

Fig. 2

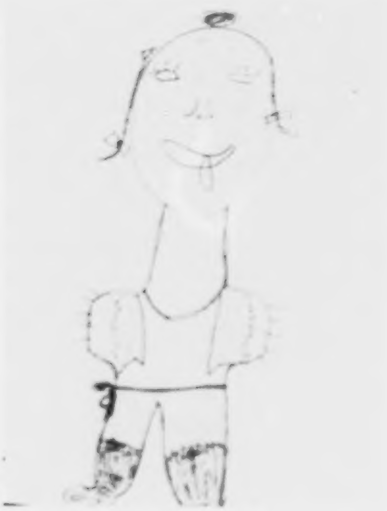


Fig. 3

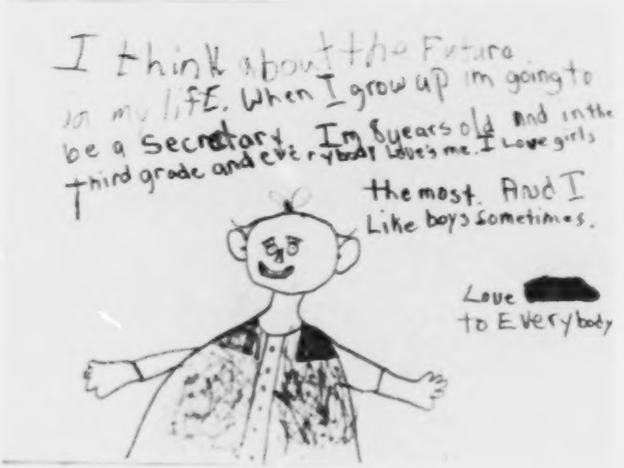

I think about the Future
in my liFE. When I grow up im going to
be a Secretary. Im 8 years old and in the
third grade and everybody Love's me. I Love girls
the most. And I
Like boys sometimes.
Love [redacted]
to Everybody

Fig. 4

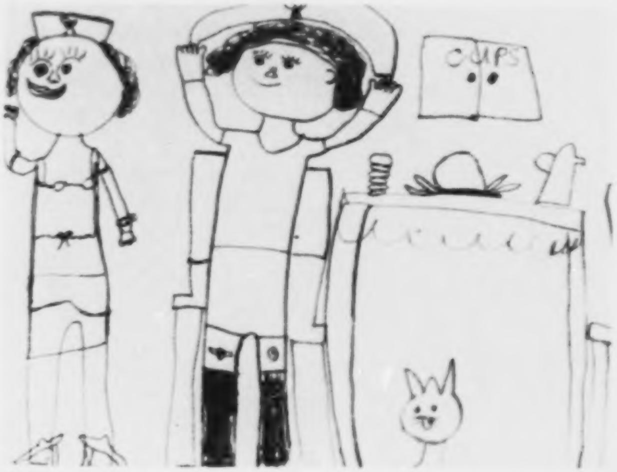


Fig. 5

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 9(1) pp. 36-41 © AATA, Inc. 1992

The Effects of Stimulant Medications on the Art Products of ADHD Children

Julie Epperson, M.A., A.T.R., University of Utah, Department of Art, Salt Lake City, Utah.

J. Lane Valum, M.S., NCSP, University of Utah, Salt Lake City, Utah.

Abstract

The present study investigated the effects of varying doses of psychostimulant medications on the expressive qualities evident in children's art products and, furthermore, considered how changes in expressive qualities corresponded to overt behavioral changes. Expressive qualities are thought to reflect a child's attention, activity level and degree of impulsiveness and were measured by a rating instrument that considered line quality, use of materials, degree of organization, integration, and completeness. The results indicate that the specific areas assessed were influenced by varying doses of psychostimulant medications. In addition, data from art products corresponded in a positive manner to data obtained from a behavioral assessment measure. The findings indicate that art therapists can contribute to the appraisal of responsiveness and treatment effectiveness of medication interventions.

It is generally estimated that 3-5% of school-age children are affected by Attention-Deficit Hyperactivity Disorder (ADHD) (Barkley, 1985). This disorder is characterized by inattentiveness, distractibility, impulsivity, and motor hyperactivity (American Psychiatric Association, 1987). In addition to these primary symptoms, children with ADHD may experience difficulties with social and academic functioning, evidenced in conflicted interactions, poor self-concept, low self-esteem, aggressive and antisocial behaviors, and a history of physical injuries related to impulsive behaviors (Frick & Lahey, 1991). Furthermore, these problems can extend into adolescence and adulthood (Barkley, 1985).

Common treatments for children with ADHD have been primarily pharmacological interventions (Dupaul, Barkley & McMurray, 1991), and secondly behavioral therapies, both directed toward management of symptoms. The three most often used medications are methylphenidate (Ritalin), dextroamphetamine (Dexidrine), and pemoline (Cylert). These drugs produce changes in behavior within one to two hours of ingestion and provide therapeutic effects for four to eight hours (Donnelly & Rappoport, 1985). Psychostimulant drugs influence concentration, attention, and may decrease impulsivity. Behavioral therapies used for the treatment of ADHD include behavior modification, parent training, self-control, and social skills training. It is recognized that using a combination of behavioral and pharmacological interventions provides greater efficacy in the treatment of ADHD (Barkley, 1985).

Approximately 30-40% of all child referrals to mental health facilities are related to ADHD (Barkley, 1982). As a result, art therapists providing intervention services to child populations in mental health facilities or in educational settings find themselves working with children affected by the symptoms of ADHD.

Art therapists may provide therapeutic services directed towards assessment and treatment of the primary symptoms of ADHD: impulsivity, inattentiveness and hyperactivity and in the treatment of the associated secondary symptoms, poor self-concept, low self-esteem, and impaired social relatedness. Furthermore, art therapists are in the position to provide valuable information on children's responses to medication due to the unique nature of art making processes. These creative processes provide a record of the child's emotional/behavioral status with the creation of a permanent product.

Wadeson and Epstein (1976) investigated the effects of stimulant medication on a child's behaviors and art productions in order to understand the intrapsychic experience as it is influenced by varying doses of the psychostimulant medication, Dexidrine. They reported significant differences in the child's expressiveness and relatedness. Epperson (1991), in a clinical case study, reported on changes in a child's art products in response to a multimodal treatment intervention including behavioral therapies, art therapy, and a medication intervention. Differences were evident in the depressive imagery represented in this child's art products. These studies are interesting and informative contributions; however, both are limited in scope due to the reliance on a single individual's response, and to varying degrees lack sufficient research controls to address the effects pharmacological interventions and dosages may have on the art products of ADHD children.

The purposes of the present research were twofold. The primary objective was to investigate children's art products in order to examine if changes in imagery were evident and could be explained by variation in medication dosages. Secondly, this study considered how changes in the art products corresponded with behaviors measured by a behavioral rating assessment.

In order to limit the scope of the research, the study was restricted to the expressive qualities of the permanent product; content was not considered. Expressive qualities evident in art products are thought to serve as a record of children's behaviors at the time they were involved in the art making process. Uhlin (1972) and Andrews and Janzen (1988) describe expressive qualities and related characteristics in the art products from children with attentional and/or learning problems. Thus, motor movement, attention, and degree of impulsivity are thought to be reflected in line quality, use of materials, degree of organization, integration, and completeness evident in the resulting art products.

Method

Participants

Eight children, ages 6 to 12 years, participated in this study. The participants were involved in an eight-week summer treatment program for emotionally and behaviorally disordered children. The program consisted of social skills training, art therapy, recreation therapy, education, and parent training. Management and reinforcement of children's behavior was assisted with a structured behavior modification program. The eight children participating in this investigation were those whose parents had requested a medication evaluation be conducted on their child. This evaluation determined whether medication had a sufficiently beneficial effect on an individual child and if it should be made a part of the child's long-term treatment. This medication evaluation was conducted during the final three to four weeks of the treatment program.

Setting

The study was conducted in a private psychiatric hospital in a large suburban area in the intermountain west. The art products for this study were collected during art therapy group sessions. The participants took part in art therapy sessions with a group of nine to ten similarly aged peers.

Data Collection Procedures and Instruments

The medication evaluation was a double-blind placebo-controlled evaluation conducted with a type and dose of medication that was appropriate for each child. For the overall evaluation, the effects of medication were evaluated by gathering information on multiple aspects of a child's functioning and comparing the data obtained on active medication days with data obtained on placebo days. For the purpose of this investigation, counselor behavioral ratings were employed. For all participants, differences were assessed between behavior on medication days and placebo days using the counselor ratings on the Abbreviated Parent-Teacher Conners Rating Scale (Conners, 1973). This questionnaire is a ten-item behavioral assessment measure of inattention, impulsivity, and hyperactivity (maximum rating 30). A higher score indicates increased ADHD symptoms present in a child's behavior. Counselors rated behaviors daily within several hours of the time art therapy sessions took place.

Art products used in this study were created during 50-minute art therapy sessions. Art tasks varied in structure and a variety of media was offered, with drawing materials most often used.

All art products were dated and photographed. Two independent raters were trained prior to being shown slides of the art products of each participant.

Raters reviewed and scored each art product using an Expressive Qualities Rating Form designed by the first author to measure the expressive qualities of the art products. This rating form is a four-item assessment measure designed specifically for this study in order to assess qualities in art products thought to be related to inattention, impulsivity, and hyperactivity. Use of scribbling, control of materials, degree of organization, and completeness was rated on a 0 to 2 scale for degree of presence. A maximum score of 8 was possible for each art product rated. A higher score was indicative of a child experiencing difficulty with expressiveness related to ADHD symptoms. Scores on the art products were tallied and means computed for each condition.

Results

In order to determine the degree of interrater objectivity on the ratings of the art products, interrater reliability was computed using correlation analyses. After being determined acceptable ($r = .72$), the raters' scores were combined to obtain a single mean for each treatment condition.

The changes in the mean expressive qualities scores across conditions were graphed and presented along with the changes in mean counselor scores. The results from all eight subjects indicate that the art products were influenced by the differing conditions when the subject demonstrated a response to medication. For those subjects responding positively to medication, mean scores on expressive qualities were lower when done while under the effects of medication. In cases where several conditions were assessed, variations were evident between dosage levels. Also, the expressive qualities scores corresponded to scores derived from the behavioral rating measure. Additionally, the scores obtained from the Expressive Qualities Rating Form were in agreement with the overall treatment recommendations derived from all data obtained during the medication evaluation.

Data from four of the eight subjects representative of the overall results are presented in graph form in Figure 1.

M2 is a 9-year-old boy with a history of ADHD being treated with Ritalin. M2 was evaluated on 10 mg. Ritalin, and placebo. Data (Fig. 1) on Subject M2 demonstrate that he experienced reduced symptoms of ADHD when under the medication condition. When under the placebo condition, an increase in difficulties as measured by both assessments was evident.

J2 is a 9-year-old male with features of ADHD. J2 was evaluated on 10 mg. Ritalin, and placebo. As the expressive qualities graph indicates (Fig. 2), J2 responded positively to 10 mg. of Ritalin. The expressive qualities assessment appears to be slightly more sensitive to changes due to medication condition than the behavioral assessment measure.

P1 is a 9-year-old boy with a history of ADHD and was being treated with Ritalin. P1 was evaluated on 7.5 mg. and 10 mg. of Ritalin, and placebo. Overall, it appears that he showed a positive response to Ritalin. The data derived from the art products depict changes that are not completely consistent with the results from the counselor observations (Fig. 3). P1 responded positively to medication, and the data from the art products supports the 7.5 mg. dosage although the data from the behavioral measure indicates that 10 mg. is more effective. However, additional data obtained during the medication evaluation not included in this study were supportive of the 7.5 mg. dose. This lower dose was ultimately recommended by the treatment team.

T2 is a 7-year-old boy with a history of ADHD. T2 was prescribed Cylert to control ADHD symptoms. T2 was evaluated on 37.5 mg. Cylert, and placebo. Results indicate that T2 did not appear to have a response to Cylert. Both rating instruments display identical patterns indicating no significant difference between conditions (Fig. 4).

Discussion

Psychostimulant medications are considered effective interventions in the treatment and management of symptoms associated with ADHD. However, a medication's intervention effectiveness is contingent on the individual's clinical response to a specific medication and to the dosage. Thus, objective assessment is important in evaluating responsiveness and is facilitated by the use of a double-blind, placebo-controlled research design.

There are a variety of methods available for monitoring responses to medication. These assessment tools consist primarily of behavioral observations measures and rating scales. However, an additional source of objective data reflecting a child's response to medication is the assessment of a child's art products. This investigation provides information indicating that stimulant medications can have a significant influence on the expressive qualities evident in art products from children with ADHD. Furthermore, these results indicate that the expressive qualities ratings are consistent with the data obtained from behavioral rating measures.

However, as the results indicate, not all subjects investigated showed a clear response to the medications behaviorally, in their art products, or with both measures. This may partially be explained by the behaviorally oriented setting in which the investigation was conducted. Hence, the influence of medication may have been less pronounced since the setting may have limited the appearance of symptoms. Secondly, unclear results are understandable when one considers that 20-30% of children do not respond or respond negatively to psychostimulant medication (Barkley, 1977).

Further study is recommended to address validity issues of the Expressive Qualities Rating Form. In addition, it would be interesting to research how the structure of the setting, art tasks, and differing media may contribute to expressive quality scores.

Summary

The results of this study indicate that art therapists can contribute valuable information to other mental health professionals and physicians regarding a child's response to medication when basing the information on the objective analyses of a child's art products. The influence psychostimulant medication has and whether it is positive, negative, or neutral appears to be receptive to objective evaluation using an assessment measure such as the Expressive Qualities Rating Form used in this study.

References

American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. revised). Washington, DC: Author.

Andrews, J. and Janzen, H. (1988). A global approach for the interpretation of the Kinetic School Drawing (KSD): A quick scoring sheet, reference guide, and rating scale. *Psychology in the Schools, 25*, 217-238.

Barkley, R. A. (1977). The effects of methylphenidate on various measures of activity level and attention in hyperkinetic children. *Journal of Abnormal Child Psychology, 5*, 351-369.

Barkley, R. A. (1982). Guidelines for defining hyperactivity in children. In: B. B. Lahey and A. E. Kazdin (Eds.) *Advances in clinical child psychology* (pp. 137-180). New York: Plenum Press.

Barkley, R. A. (1985). Attention deficit disorders. In: P. H. Bornstein and A. E. Kazdin (Eds.) *Handbook of clinical behavior therapy with children* (pp. 158-217). Illinois: The Dorsey Press.

Conners, C. K. (1973). Rating scales for use in drug studies with children. *Psychopharmacology Bulletin*, 24-29.

Donnelly, M. and Rappoport, J. L. (1985). Attention deficit disorders. In: J. M. Wiener (Ed.) *Diagnosis and psychopharmacology of childhood and adolescent disorders* (pp. 179-197). New York: Wiley.

Dupaul, G. J., Barkley, R. A., & McMurray, M. B. (1991). Therapeutic effects of medication on ADHD: Implications for school psychologists. *School Psychology Review, 20*, 203-219.

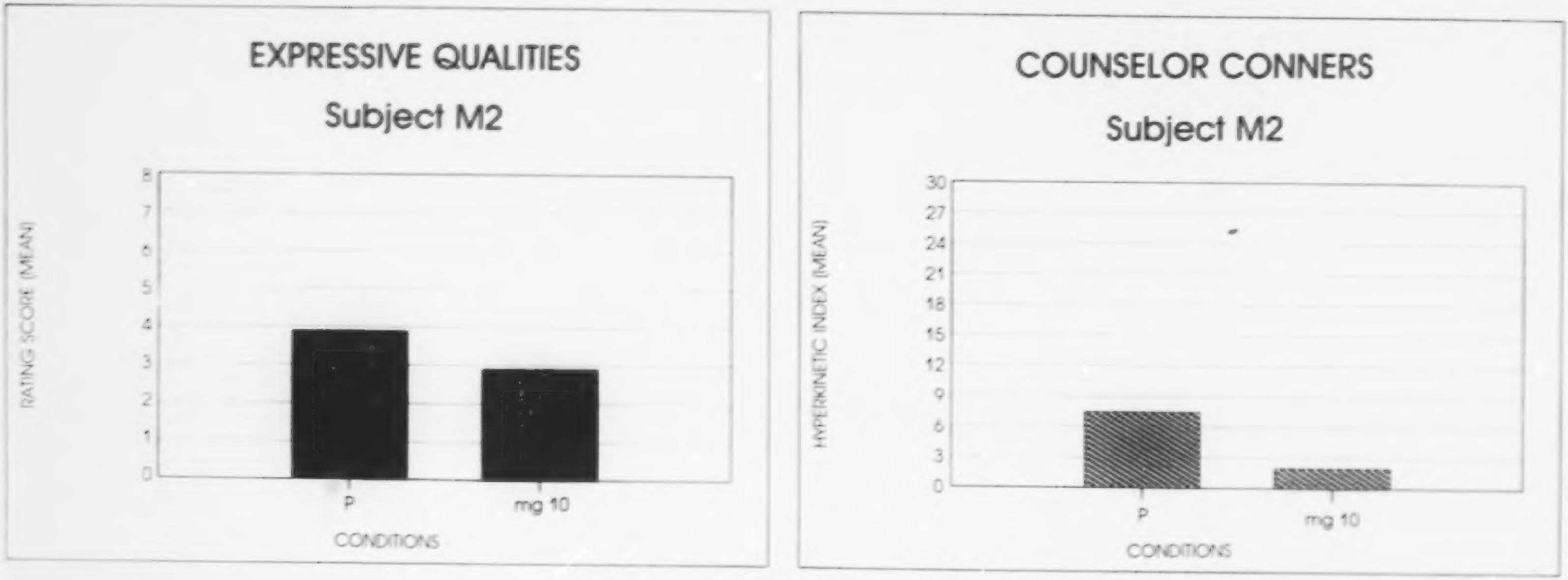
Epperson, J. (1991). *Art as healing: A record of change.* Paper presented at the Salt Lake Art Center. Salt Lake City, UT.

Frick, P. J. and Lahey, B. B. (1991). The nature and characteristics of attention-deficit hyperactivity disorder. *School Psychology Review, 20*, 163-173.

Uhlin, D. M. (1972). *Art for exceptional children.* Dubuque, Iowa: William C. Brown Company.

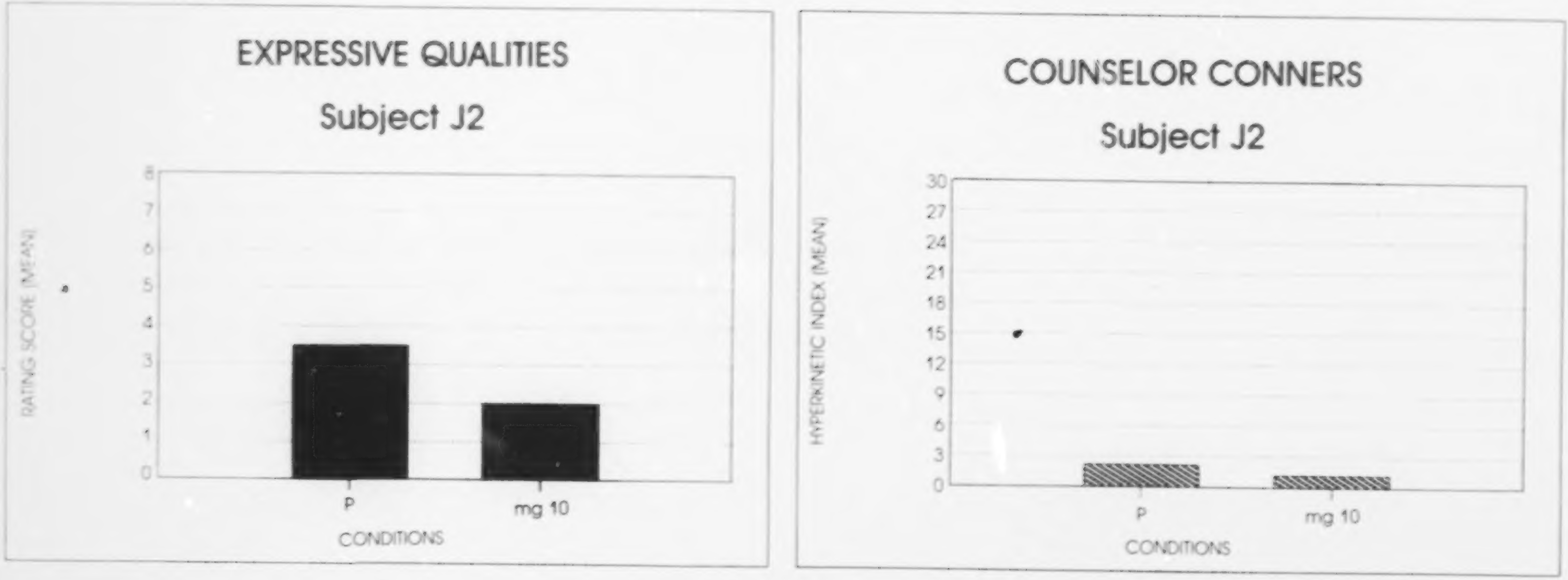
Wadeson, H. and Epstein R. (1976). Intrapsychic effect of amphetamine in hyperkinesis. In D. V. S. Sanker (Ed.) *Mental health in children* (pp. 35-60). Westbury, N.Y.: PJD Publications.

BEST COPY AVAILABLE


EXPRESSIVE QUALITIES
Subject M2

COUNSELOR CONNERS
Subject M2

Fig. 1


EXPRESSIVE QUALITIES
Subject J2

COUNSELOR CONNERS
Subject J2

Fig. 2

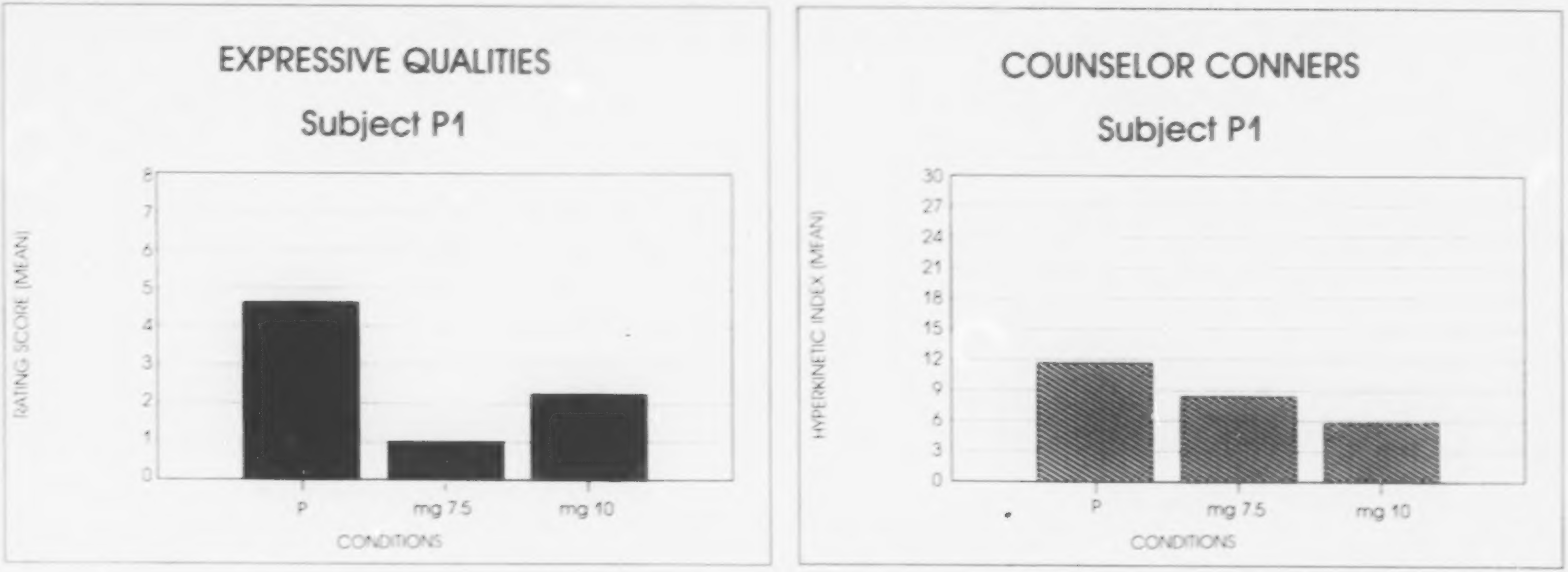

EXPRESSIVE QUALITIES
Subject P1
RATING SCORE (MEAN)
0
1
2
3
4
5
6
7
8
P
mg 7.5
mg 10
CONDITIONS
COUNSELOR CONNERS
Subject P1
HYPERKINETIC INDEX (MEAN)
0
3
6
9
12
15
18
21
24
27
30
P
mg 7.5
mg 10
CONDITIONS

Fig. 3

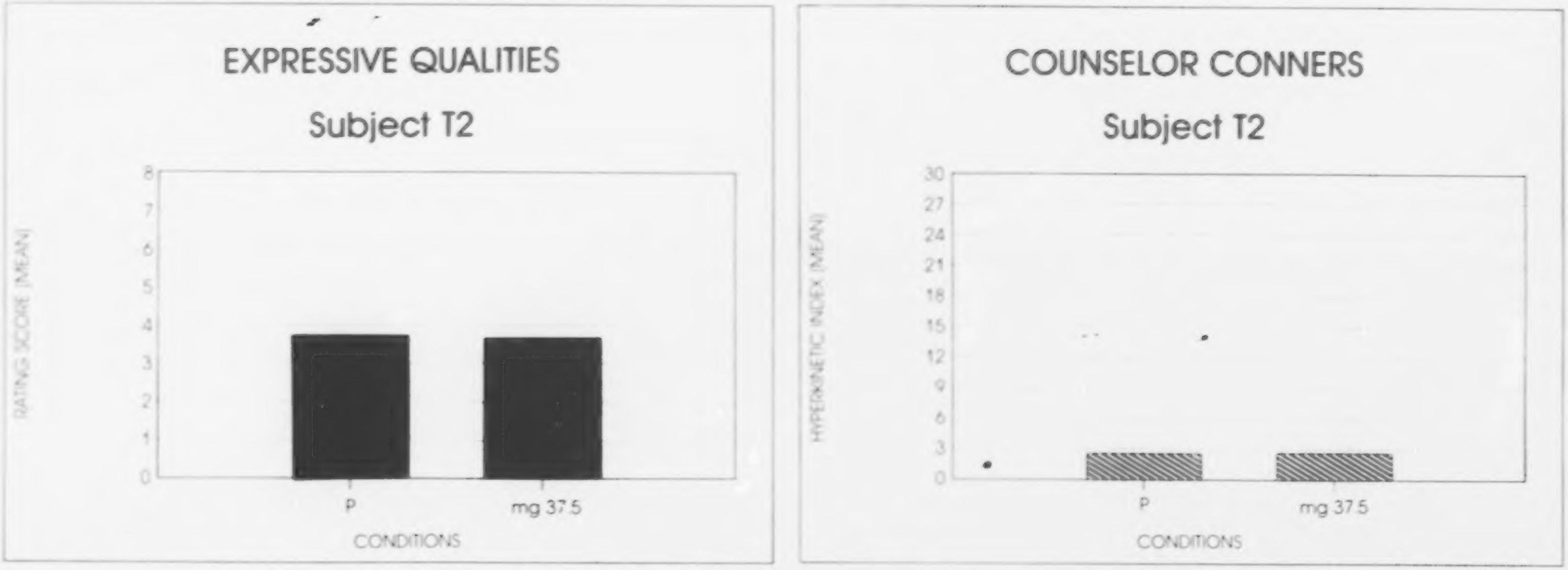

EXPRESSIVE QUALITIES
Subject T2
RATING SCORE (MEAN)
0
1
2
3
4
5
6
7
8
P
mg 37.5
CONDITIONS
COUNSELOR CONNERS
Subject T2
HYPERKINETIC INDEX (MEAN)
0
3
6
9
12
15
18
21
24
27
30
P
mg 37.5
CONDITIONS

Fig. 4

Art Therapy. Journal of the American Art Therapy Association, 9(1) pp. 42-47 © AATA, Inc. 1992

Viewpoints

Finding Light at the End of the Funnel: Working with Child Survivors of the Andover Tornado

Tamara Kay McDougall Herl, M.S., Art Educator, Andover, Kansas.

The Funnel

Since Biblical times, the rainbow has served as a sign of hope. In Genesis, Chapter 9, God tells Noah:

> Behold, I establish my covenant with you and your descendants after you. . . . When I bring clouds over the earth and the bow is seen in the clouds, I will remember my covenant.

But at 6:38 p.m., on Friday, April 26, 1991, in Andover, Kansas, there were no rainbows. Though dark clouds threatened, the town's residents were enjoying a warm spring afternoon and many were making plans for the weekend. Suddenly a devastating tornado ripped its way through the town, leaving behind a forty-acre path of destruction which will darken the lives of many for months and perhaps even years to come.

Eighty miles away, I toured an exhibit in Manhattan, Kansas, with a colleague as part of the Kansas Art Education Association spring conference. A thunderstorm raged overhead as we left the exhibit, and the bus driver mentioned that a small twister had touched down in a nearby town. It was not until much later that I heard that the town of Andover was hit by a much larger tornado—and that I realized that many of my students could be among the victims, including my own daughter, who was staying with a friend in Andover.

And so began three hours of frantic phone calls to determine what had happened. I turned on the local news in the hope of getting more information, but the news was scanty and brief. Finally, miraculously, instead of hearing a busy signal or a recording, I heard the shaky voice of my daughter telling me she was safe. I thought to myself that there must have been divine intervention at the switchboard! I wanted to return to Andover immediately, but I learned that only emergency vehicles could enter the town. News reports said that as many as 21 people had died as a result of the storm's fury.

"Were any of my students hurt? . . . they'll need food and water. . . . I can get those clothes that we were planning to take to Goodwill. . . ." These and a hundred other thoughts filled my head as, after a sleepless night, I drove toward Andover. As I traveled through the Flinthills, bits of debris dotted the hillsides like macabre wild flowers. As I neared the city itself, smashed vehicles and uprooted trees littered the ditches. And the closer I got, the more real the nightmare became.

My first thoughts were to locate my daughter, and, after a frantic search, I learned that she was at home, so I phoned her. As I heard her voice, something inside me snapped and I broke down with tears of relief. Somehow, knowing my daughter was safe helped me to move past my personal fears and to focus on the needs of others.

It was not until I rode with a group of teachers distributing food and water into the area where the twister tore its path that I realized the total extent of the destruction. People's descriptions of the area as a "war zone" were completely accurate. Mountains of twisted metal and shredded fiberglass insulation interspersed with broken glass and scraps of paper, formed a backdrop for broken trees, stripped of their bark. We watched as survivors searched through the dreary piles of rubble for bits and pieces of their lives. That night I returned home, falling into bed exhausted and emotionally spent.

Eventually, Andover teachers were called in for a special meeting to discuss how to best deal with their students' and their own feelings. I listened numbly to the counselors and speakers from organizations such as the National Organization for Victim Assistance. They advised teachers to let the students talk about and draw their experiences. About halfway through the meeting, the principal said, "And we are fortunate enough to have an art therapist on staff. Perhaps she has some ideas." I suggested that perhaps students could design a storm shelter. As the meeting turned to other matters, I wondered why I had not given any previous thought to how to use art as an intervention with the students. Finally, I realized that I had been in a stage of denial, ignoring the fact that I would be among those expected to help students piece together their broken lives.

In order to design additional art interventions, I began by making a list of the feelings the students might be having, such as fear, anger, helplessness, vulnerability, loss, shock, anxiety, denial, and guilt, and issues revolving around giving and receiving help. In reviewing art therapy and crisis intervention literature* (See editor's note at the end of this article.) I did not find anything specifically related to tornadoes, but I was able to come up with some guidelines for art activities for the teachers to use with their students.

Some Personal Observations of Art Expressions Created After the Tornado

The first part of each day at school was set aside for discussion and special activities, including art. Some children wrote in journals and others created group murals, depicting images which ranged from stereotypical art to realistic scenes of the storm (Figure 1). Other students devoted unusually careful attention to tiny details—especially in the portrayal of debris (Figure 2) and in the use of big orange "X's" which meant that someone's house had been condemned. One student created a picture called "My Grave" after hearing about a man and his son who thought they would die together in a culvert (Figure 3). While some students created fantasy scenes, others created metaphors for their experience, showing how many students perceived the crisis they had experienced (Figure 4).

When the students came to art, I told them how glad I was to see them and asked them to share their experience on paper or in modeling clay. At first, I noted that there was a great deal more copying than is normal. For example, when one class member started drawing a picture of heaven, many others turned their papers over and began using that same theme (Figure 5). I also saw some of the most expressive work these students have ever created. Many drawings showed people with tears streaming down their faces, some of them being swept up by angry black scribbles (Figure 6).

Other students depicted underground shelters and other safe places. In one class, several members depicted tepees in their art, and I was puzzled until the students explained. Just a few hours before disaster struck, classes had toured a local "Mountain Man Rendezvous," where they had been told that one reason Native Americans used tepees was because their shape made it difficult for a twister to lift the structures.

Many other pictures showed scenes of battle (Figure 7) or of someone or something facing nearly insurmountable odds. Much of the class time was spent sharing. Although many students seemed talkative and lively, I noticed that some of the students who had been hit the hardest were reluctant to share and I respected this.

Eventually, the excitement of the situation began to wear off. However, tornado images continually appeared in projects which were not related to that theme. For instance, the swirling forms of twisters appeared in response to a third grade lesson centered around texture and pattern. Students' doodles often contained swirling and spiral forms (Figure 8). Some fifth graders drew tornado pictures after seeing a video about the history of America as related to art. In a guided drawing experience, several fourth graders created imaginary creatures that fought tornadoes, had tornado bodies, or helped tornado victims.

As the school year drew to an end, some students continued to create tornado-related art. Some expressed resentment over the privileges the tornado victims received, while others complained that they were sick and tired of talking about tornadoes.

Andover's Counseling Center sent a representative to warn us that some students may need help dealing with their issues for a long time to come. He explained a plan to set up support groups over the summer.

A few days before the end of the school year, tornadoes again threatened Andover, taking almost exactly the same path as before. Teachers noted that some students ran to the window when low flying aircraft caused the glass to rattle. One student sought refuge under his desk when a classroom bell startled him.

Concluding Observations

In observing the art produced by students in response to this catastrophe, the work seems to fall into three major categories which I referred to as documentary, proclamatory, and recovery. The documentary category, which involved the children's ability to acknowledge or own the situation, had three components: denial/escape-oriented art, stereotypical art, or realistic art. The proclamatory category, which dealt with the children's vulnerability and basic needs, included art which depicted survival or safety needs and expressive/affective art. The third category of recovery included the emergence of original art, more "normal" line quality versus heavy and/or scribbly lines, and clear, clean colors versus muddy, smeared colors.

Movement through these categories seemed erratic and illogical, and not all students produced first documentary, then proclamatory, then recovery images. Immediately after the storm, some children drew pictures in the proclamatory and even the recovery stage, depending on a variety of factors including their own coping skills, their parents' coping skills, proximity to the storm, pre-existing problems, etc.

Documentary Category

In the documentary category, the children's images seemed to be saying, "It can't happen to me . . . but it did." Some students wanted to deny or escape the situation, and thus created art which helped them fantasize about a safer time or escape from the nightmare of the situation. An example of denial was provided in a creative writing experience when one student began his story fairy tale-style with the words "Once upon a time" and then listed actual numbers and names of businesses which had been destroyed, and yet gave his own family a fictitious name. Feelings of insecurity caused other students to regress to the creation of stereotypical and safe images such as "ninja turtles" or to copy themes created by their peers, as in the "heaven" pictures discussed earlier (Fig. 5). Some students were able to own the fact that this horrible ordeal had indeed happened to them, and created art which contained realistic images and excessive details (Fig. 1 & 2).

Proclamatory Category

In this category, students attempted to announce or proclaim, through their art, the desire for their basic needs to be met. The images now seemed to say, "Yes, it happened . . . now I need help and reassurance." Because the storm had left so many children feeling vulnerable, they created tepees, storm shelters, and other safe havens. Many students depicted an even more basic need—the instinct to survive—in their "against the odds" drawings and scenes of battle (Fig. 7). Some students who had formerly needed to be coaxed into adding expressive or affective details such as a curved mouth or raised eyebrows spontaneously drew details such as a screaming mouth (Fig. 3) and lines with movement (Fig. 6).

Recovery Category

Children who were fortunate enough to be in situations in which their needs were recognized and met were able to create art which falls into a third category which I call recovery. Art in this stage seemed to say, "Yes, it happened, but I survived. I have someone to take care of me." Studying changes in the content, color use, and line quality of the students' art provided clues to the artist's sense or lack of well-being.

Figures 9-12, drawn by one child over a four-week period, illustrate the progression of images toward the recovery stage; however, as previously discussed, the movement through the stages was not always sequential. In the first drawing (Figure 9), the student, in a documentary style, depicted what had happened to him in a very realistic manner. A few days later, the student created another documentary picture in an almost identical, yet less violent and chaotic manner (Figure 10). In the third picture (Figure 11), the student began creating puffy storm clouds which were almost identical to those in the first picture. He then drew creatures which rise, volcano-like, from the ground line in the center of the page. These creatures were copied from the drawing of a student sitting next to him. He had reverted back to the documentary category in which stereotypical images are created. At that point he became frustrated, scribbled through the "creatures" and attempted to draw a building below, through which he also scribbled. Even though he did not consider himself successful in this attempt, the student had gone beyond documentation and had made a move toward recovery with his attempt at the expression of an original idea (the building).

In his final picture (Figure 12), the student was able to create a drawing which did not contain the storm clouds and funnels, images which had been central to his earlier work. Though the lines of the car are heavily drawn, the theme was original. The image of the car could be seen as a symbol for escape, yet it could also represent his ability to "move on" at this point.

I feel the changes apparent in the art of these students provide evidence for the value of using art therapy in crisis intervention. Had the children not been allowed to graphically express their feelings surrounding the experience, the recovery of many may have been a much more lengthy process. The therapeutic art activities helped many students work through the crisis and served, as they continue to serve today, as indicators of how these students are coping with this horrible experience.

***Editor's note:** There are some references that art therapists may find useful when working with children who have been exposed to severe stress or crisis such as the experience the author has described. The following list contains information on the use of art expression and imagery in crisis intervention and treatment of post-traumatic stress disorder (PSTD) which may be applied to child populations who have experienced crisis in their lives:

Brett, E.A., & Ostroff, R. (1985). Imagery and PSTD: An overview. *American Journal of Psychiatry, 142*, 417-424.

Case, C. (1987). A search for meaning: loss and transition in art therapy. In T. Dalley, C. Case, J. Schaverien, F. Weir, D. Halliday, P. N. Hall and D. Waller (Eds.), *Images of Art Therapy*. London: Tavistock.

Greenberg, M. and van der Kolk, B. (1987). Retrieval and integration with the "painting cure." In B. van der Kolk (Ed.), *Psychological Trauma*. Washington, D.C.: American Psychiatric Press.

Golub, D. (1985). Symbolic expression in post-traumatic stress disorder: Vietnam combat veterans in art therapy. *The Arts in Psychotherapy, 12*, 285-296.

Howard, R. (1990). Art therapy as an isomorphic intervention in the treatment of a client with Post-Traumatic Stress Disorder. *American Journal of Art Therapy, 28*, 79-86.

Johnson, D. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy, 14*, 7-13.

Landgarten, H. (1981). *Clinical art therapy: A comprehensive guide*. New York: Brunner/Mazel.

Malchiodi, C. A. (1990). *Breaking the silence: Art therapy with children from violent homes*. New York: Brunner/Mazel.

Pynoos, R. and Eth, S. (1985). Developmental perspective on psychic trauma in childhood. In C. R. Figley (Ed.), *Trauma and Its Wake: The Study and Treatment of Post-Traumatic Stress Disorder*. New York: Brunner/Mazel.

Pynoos, R. and Eth, S. (1986a). Witness to violence: The child interview. *Journal of the American Academy of Child Psychiatry*, 25(3), 306-319.

Pynoos, R. and Eth, S. (1986b). Special intervention programs for child witnesses to violence. In M. Lystad (Ed.), *Violence in the Home* (pp. 193-216). New York: Brunner/Mazel.

Stronach-Bushel, B. (1991). Trauma, children and art. *American Journal of Art Therapy*, 29, 48-52.

Terr, L. (1981). Forbidden games: Post-traumatic child's play. *Journal of the American Academy of Child Psychiatry, 20*, 741-760.

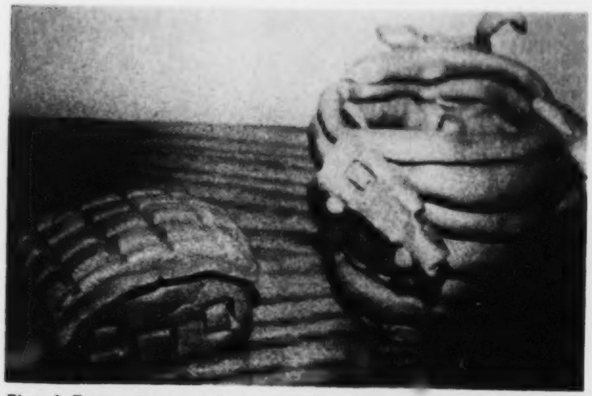


Fig. 1 Tornado sculpture created by a second grade student

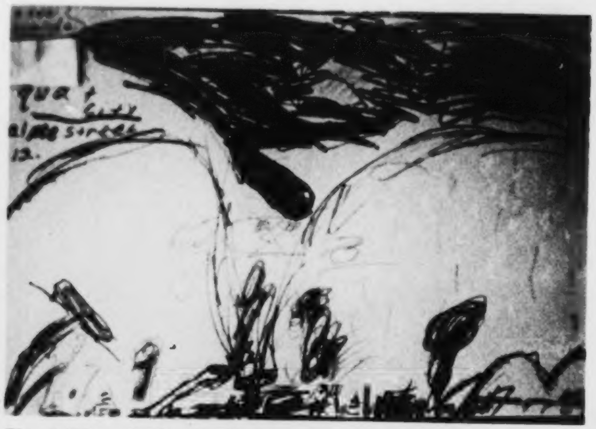

Qua t
City
street
12.

Fig. 4 "Kuwait (Quat) City," drawing by student

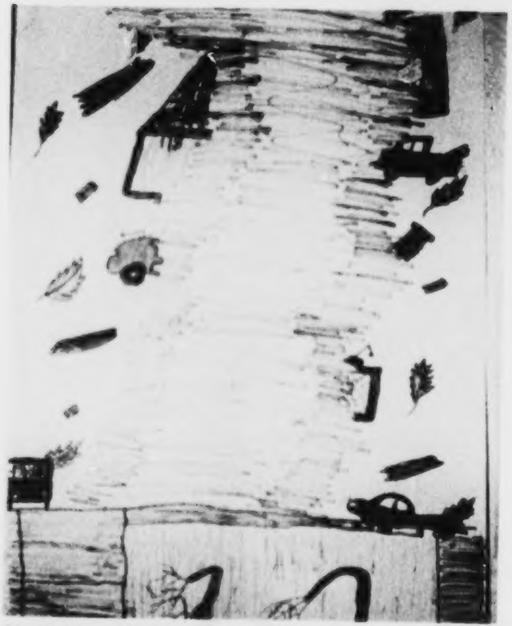


Fig. 2 Drawing by a third grade student

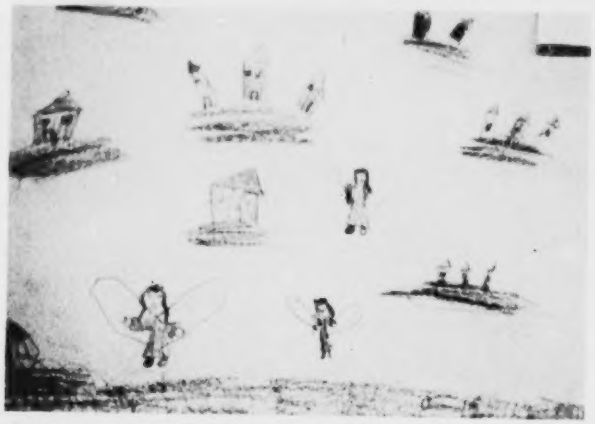


Fig. 5 Drawing of "heaven" by student

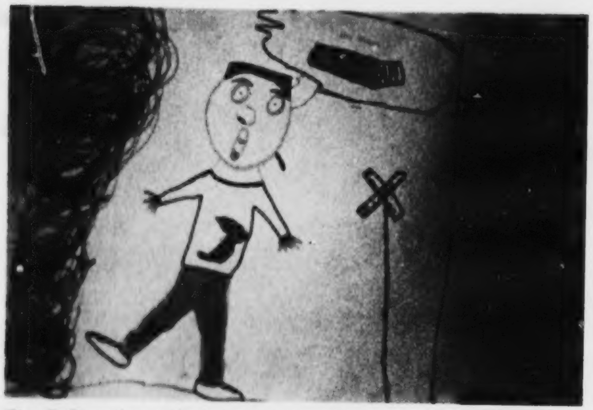


Fig. 3 Drawing with tornado images

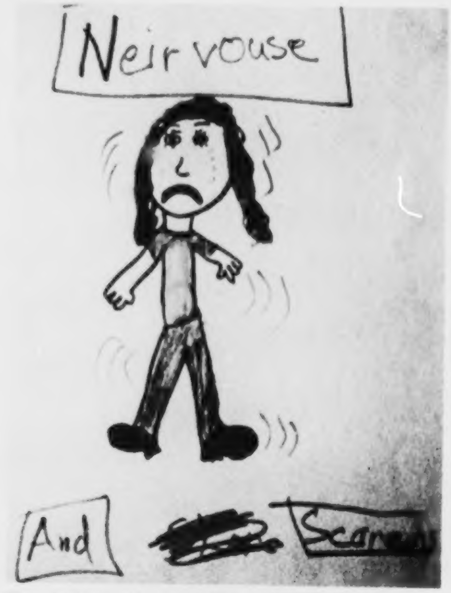

Neir vouse
And
Scare

Fig. 6 Portrait drawing

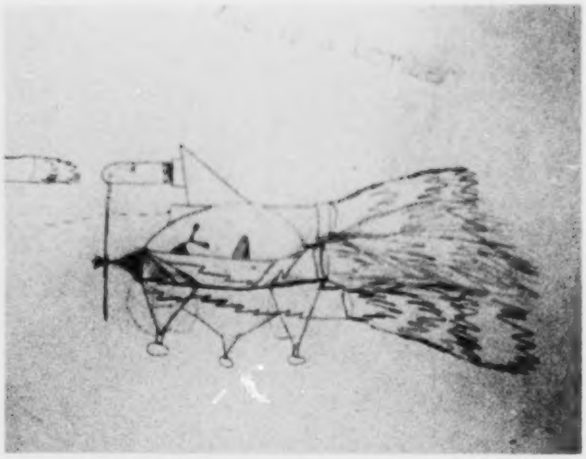


Fig. 7 Drawing of a "bomber"

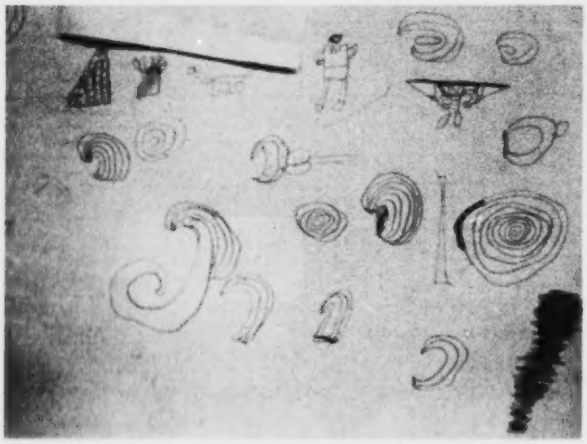


Fig. 8 Drawings containing twirling, twisting and spiral forms

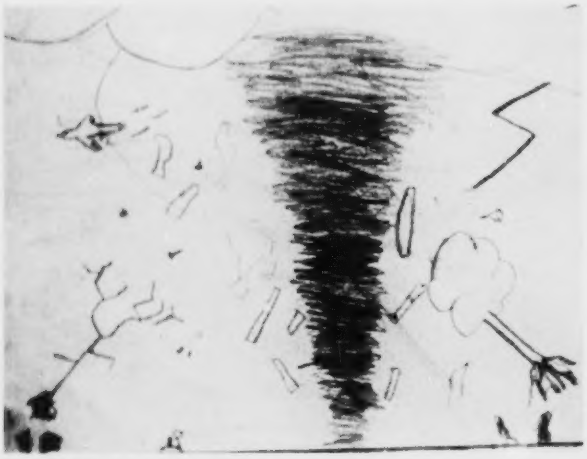


Fig. 9 Documentary category drawing

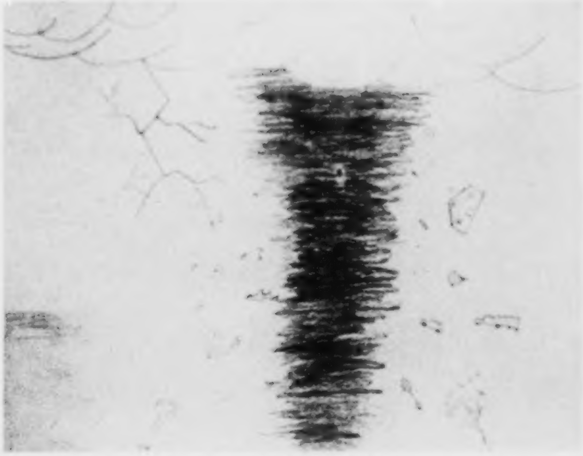


Fig. 10 Documentary category drawing

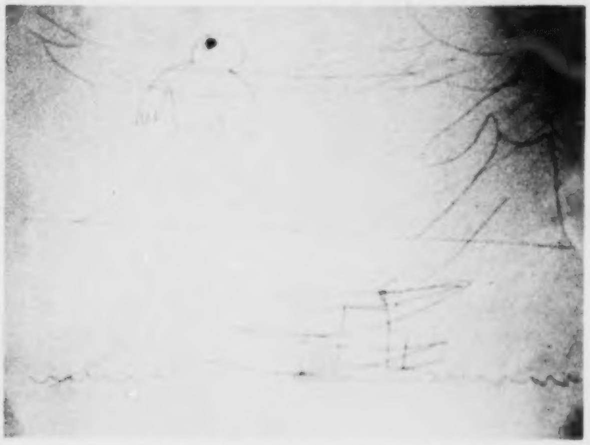


Fig. 11 Drawing with realistic, stereotypical and original images

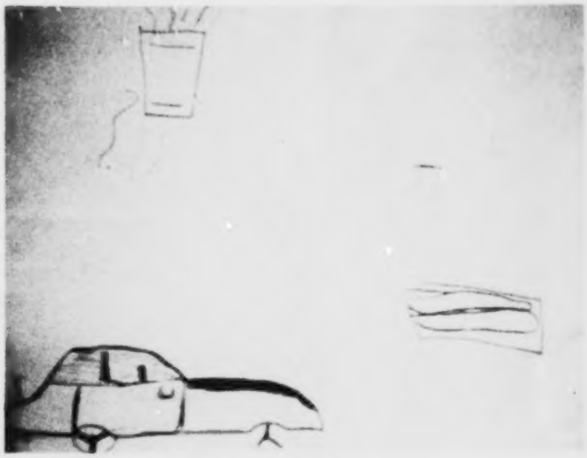


Fig. 12 Recovery category drawing

Art Therapy: Journal of the American Art Therapy Association, 9(1) pp. 48-49 © AATA, Inc. 1992

Reviews

The Art Therapist's Third Hand—Reflections on Art, Art Therapy and Society

Video by Informative Media, Inc., 761 South Blvd., Alpha, N.J. 08865-4647; produced, recorded and edited by **James Pruznick**, 1988.

Reviewed by **James J. Consoli, M.A., A.T.R., N.C.C.**, Eastern Virginia Medical School, Norfolk, Virginia.

Several years ago, as a very naive art therapy student, I recall acquiring information about one of my teachers before classes began. I was told that she was a pioneer in the field, had written several books and was traveling from New York to Washington, D.C. to teach our class. What a stage was set for our first meeting! I remember having a tape recorder in hand, ready for Ms. Kramer's first class. She turned to me and said, "Why are you taping this? I don't have a paper prepared." To me, that was irrelevant; her credibility had already been established. I was certain that whatever she had to say would have an impact on my "third hand."

The video, *The Art Therapist's Third Hand—Reflections on Art, Art Therapy and Society*, is essentially a recording of an excellent presentation by Edith Kramer at the 1986 Annual Conference of the American Art Therapy Association, Inc., in Los Angeles. I attended this presentation and remember leaving in awe of the incredible gift of insight that Ms. Kramer possesses.

Throughout the video, Kramer uses case examples and patient artwork to display the influences of the therapist's third hand as a productive intervention. Many of us are taught to avoid adding to or physically altering our client's art forms, even if solicited. To "rescue" clients in times of frustration may encourage helplessness, and breaking boundaries, however symbolic, may be contraindicated for certain populations. However, Ms. Kramer presents an intervention strategy that goes beyond the art teacher's technical assistance. Case examples she discussed included adding a border to an image that was cut off by the edge of a page, providing a different shape of paper to a mentally retarded client who was quite fixated, and the art therapist's more realistic rendering of a child who was dangerously grandiose. In these instances, the art therapist's involvement weaves together the artist, the teacher and the empathic clinician into a healing fabric that is subtle but potentially potent therapeutically.

Kramer also adds her own humorous commentary to lighten her observations of how bombarded we are by stimuli in the world around us, and of the risks involved as we develop a quasi-autism in coping or filtering assaults on our senses. Her discussion on graffiti is particularly compelling; she theorizes that the illiterate and semi-illiterate use letters (". . . the enemy") in an enlarged and aggressive manner to decorate and deface parts of a world they don't share.

Recently, Ms. Kramer was a guest speaker at

Eastern Virginia Medical School. In the workshop portion of the day we first practiced developing our third hand by taking a client's unfinished work of art and duplicating it. This gave us the opportunity to empathetically "draw a mile" with our clients' hands. I found myself looking at the drawing much differently, and knowing more about it and the client than I did before. In imagining what the drawing needed, I recognized what the client needed as well, and an opportunity to intervene therapeutically by using a metaphor was born.

The content of the 1986 presentation has been useful to me as an art therapist and as an educator. The text appears in The *American Journal of Art Therapy*, Vol. 24, No. 3, February, 1986 and I highly recommend it to others. It would be interesting to hear more about Ms. Kramer's recent work in this regard. But this video, as produced, recorded and edited by James Pruznick, does a disservice to both the content and its author.

I advocate the use of video as a compelling method of communicating to colleagues and the public about who we are and what we, as psychotherapists, can do. However, it must be accomplished in a professional manner. Just as the quality of the paper used for a written article adds to its credibility, so should the quality of a video production enhance a presentation.

Regrettably, *The Art Therapist's Third Hand* falls short in several respects. Essentially, the sound, lighting, camera angles and poor editing in this production are all as distracting as in those 16 mm high school films that flutter, slip and annoy so often. The videographer could have significantly improved the production by filming the artwork in a studio, rather than repeatedly fading and zooming in and out onto the projection screen. Images of the environment introduced in the presentation are distracting and counterproductive; if intended to highlight, they serve instead as samples of the bombardment Ms. Kramer describes and produce instead the same numbing and distancing effects in the viewer. Strategic portions of the original audio, skillfully dovetailed with a narrator's introduction, summary and closure, would have been sufficient to produce a strong film—a proper forum for Ms. Kramer's abilities and one worthwhile for the field.

At one point during her eloquent presentation, Edith Kramer likened the artistic gift to spice: "God just goes with a salt shaker or sugar shaker all over the world and spreads it out and among any 100 people you will find some gifted ones regardless of what mental level or emotional state or cultural status they happen to be." Clearly, Ms. Kramer has received several grains of insight. This video is a poor showcase for her considerable talents.

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Xerox copies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ____________________

Degrees/Credentials: ____________________

Address: ____________________

Phone #s: ____________________ **work** ____________________ **home**

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ____________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ____________________ **Date** __________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association***, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

CHARLES C THOMAS • PUBLISHER

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 206 pp. (7 × 10), 21 il., about $29.75.

☐ Gutsch, Kenneth U. & David Sisemore—**HOW TO PLAY THE RELATIONSHIP GAME: The Use of Psychological Principles to Change Human Behavior.** '91, 112 pp. (7 × 10), $24.75.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¾), 21 il., $32.75.

☐ Boy, Angelo V. and Gerald J. Pine—**A PERSON-CENTERED FOUNDATION FOR COUNSELING AND PSYCHOTHERAPY.** '90, 244 pp. (7 × 10), 2 il., $41.75.

☐ Pine, Vanderlyn R., Otto S. Margolis, Kenneth Doka, Austin H. Kutscher, Daniel J. Schaefer, Mary-Ellen Siegel, & Daniel J. Cherico—**UNRECOGNIZED AND UNSANCTIONED GRIEF: The Nature and Counseling of Unacknowledged Loss.** '90, 198 pp. (7 × 10), 7 il., $34.75.

☐ Steen, Charlene & Barbara Monnette—**TREATING ADOLESCENT SEX OFFENDERS IN THE COMMUNITY.** '89, 212 pp. (7 × 10), 61 il., $43.75.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (7 × 10), 34 il., $42.25.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $30.00.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $40.00.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 × 10), 1 table, $38.25.

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $20.00.

☐ Krauss, David A. & Jerry L. Fryrear—**PHOTOTHERAPY IN MENTAL HEALTH.** '83, 260 pp. (6¾ × 9¾), 61 il. (5 in color), 1 table, $40.00.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $46.25.

☐ Singer, Florence—**STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children.** '80, 144 pp., 33 il., $21 .25.

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $29.25.

☐ Anderson, Frances E.—**ART FOR ALL THE CHILDREN: Approaches to Art Therapy for Children with Disabilities, 2nd Ed.** '92, 486 pp. (6¾ × 9¾), 113 il., 19 tables, about $87.50.

☐ Talley, Joseph E.—**THE PREDICTORS OF SUCCESSFUL VERY BRIEF PSYCHOTHERAPY: A Study of Differences by Gender, Age, and Treatment Variables.** '92, 198 pp. (7 × 10), 25 tables, $34.75.

☐ Thorne, Elizabeth and Shirley Herscovitch Schaye—**PSYCHOANALYSIS TODAY—A Case Book.** '91, 422 pp. (7 × 10), $59.75.

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¾), 28 il., $32.75.

☐ Kissel, Stanley—**PLAY THERAPY: A Strategic Approach.** '90, 108 pp. (7 × 10), $24.75.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $42.25.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $49.25.

☐ Dennison, Susan T.—**ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents.** '88, 236 pp. (7 × 10), 36 il., 26 tables, $40.00.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $81.75.

☐ Nucho, Aina O. — **THE PSYCHOCYBERNETIC MODEL OF ART THERAPY.** '87, 248 pp. (6¾ × 9¾), 50 il., 4 tables, $42.00.

☐ Thompson, Richard H.—**PSYCHOSOCIAL RESEARCH ON PEDIATRIC HOSPITALIZATION AND HEALTH CARE: A Review of the Literature.** '85, 364 pp., 1 il., $46.50.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $21.25, spiral (paper).

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $27.25.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $44.00.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217)789-9130
Books sent on approval • Complete catalog sent on request

2600 South First Street Springfield • Illinois • 62794-9265

THE AMERICAN ART THERAPY ASSOCIATION

November 13 - 17, 1991
Denver, Colorado

"Image & Metaphor: The Practice & Profession of Art Therapy" Audio Cassettes Available

- ☐ 1. The Future of Art Therapy: A Debate / Art Therapy: Post Mortem, C. Malchiodi, MA, ATR, M. Cattaneo, PhD, ATR, P. Allen, PhD ATR / Using Creative Thinking Strategies to Image a 21st Century AATA, D. Arrington, EdD, ATR, C. Drachnik, MA, MFCC, ATR, P. Howie, MA, ATR, J. Rubin, PhD, ATR **(2 tapes)**
- ☐ 7. SYMPOSIUM - ALTERNATIVE REALITIES -- An Inquiry Into Systems of Creativity: An Alternative Realities Approach, M. Junge, PhD, LCSW, ATR / Family Art Therapy From An Alternative Realities Perspective, C. Lind, MA, J. Walter, MA, M. Junge, PhD, LCSW, ATR
- ☐ 8. SYMPOSIUM - IMAGE AS METAPHOR -- From Image to Metaphor - Why Don't You Just Say What You Mean?, D. Behnke-Marthaler, MA, ATR / Visual Metaphor: Its Role in Therapy, V. Lusebrink, PhD, ATR
- ☐ 13. SYMPOSIUM - ART THERAPY & THE ELDERLY -- Illuminations: Program Concept for Art Therapy with the Elderly, B. Callanan, MS, ATR
- ☐ 14. SYMPOSIUM - IMPACT OF RITUAL ABUSE -- Was It Schizophrenia or Ritual Abuse?, C. Drachnik, MA, MFCC, ATR / Surviving the Survivors of Ritual Abuse: Images of the Client & Therapist, K. Cox, MA, LPC, ATR
- ☐ 22. SYMPOSIUM - WORKING WITH INCEST SURVIVORS -- A Comparison of Verbal & Art Group Therapies with Adult Female Incest Survivors, C. Waller, BA, BFA, C. Malchiodi, MA, ATR / Ceramic Mural Messages From Incest Survivors, F. Anderson, EdD, ATR, HLM, K. Deske, MS
- ☐ 34. KEYNOTE ADDRESS: The Art of Dying: Images, Insights & Interventions, S. Bertman, PhD

PAPERS

- ☐ 9. Ethnicity Illuminated in Humor & Art Therapy, C. Mango, MA, ATR, J. Richman, PhD
- ☐ 10. The Use of Art Psychotherapy Evaluations of Children in Custody Disputes, S. Lyons, MS, ATR
- ☐ 15. Adventures in Short-Term Group Art Therapy: Reservations, Itineraries & Baggage Handling, P. Isis, MEd, ATR
- ☐ 16. Art Therapy Meets Hypnosis & Neurolingistic Programming, S. Zavadil, MA, ATR
- ☐ 18. Liberty & Conflict: Images From Psychologists in a War-Torn Country, M. Rosal, PhD, ATR
- ☐ 19. An Image in Transition: From Student to Professional, P. Schwartz, MA, J. Bolde, MA
- ☐ 20. Journey to Recovery: One Step at a Time, M. Miller, BA
- ☐ 21. Multiple Family Group: Art Therapy with Hospitalized Adults & Families, K. Stovall, MA, MFCC, ATR
- ☐ 26. Image as Healer, Metaphor as Helper, E. Wallace, MD, PhD
- ☐ 27. Creative Therapies for Adult Children of Addiction Recovering From Alcoholism, U. Goebels, MA, ATR
- ☐ 28. Illustrating the Family Story: Art Therapy - A Lens to Viewing the Family's Reality, S. Riley, MA, MFCC, ATR
- ☐ 29. Maybe Tomorrow: Art Therapy With AIDS Patients, W. Ferguson, PhD, ATR, D. Kronick, BA
- ☐ 31. Artistic Expression of Alzheimers in Adult Day Care, Assisted-Living & Skilled Nursing, K. Kahn, BA, ATR, M. Tarsitano, MA
- ☐ 32. Art RX: Art Expression & Physical Health, C. Malchiodi, MA, ATR
- ☐ 33. Dedication to the Contemplative Life, L. Howard, BA, M. Flemming, MA, MFCC, ATR
- ☐ 35. Images as Defense Mechanisms, V. Lusebrink, PhD, ATR, R. Gorstein, BA, M. Levick, PhD, ATR, R. Jonkers, BA
- ☐ 36. Aggression Depicted in Abused Children's Drawings: Development of an Assessment Tool, T. Manning, MS, ATR
- ☐ 39. Art Therapy - Adjunctive & Primary in a Therapeutic Community for Children, J. Duboff, MA, ATR
- ☐ 40. Deja Vu: Comparing Schizophrenic & Affective Psychotic Patients Utilizing the Bridge Projective, R. Hays, MS, ATR, S. Lyons, MS, ATR
- ☐ 43. A Three Session Package for Assessment, Confrontation & Treatment Planning, J. Consoli, MA, ATR
- ☐ 44. Hard Time Art: Creative Expression in Prison, M. Taylor, PhD, ATR, C.E. Walsh, PhD
- ☐ 45. The Effects of Stimulant Medications on the Art Products of ADHD Children, J. Epperson, MA, J. Valum, MS
- ☐ 46. Art Therapy - The Tool for Treating Multi-Abuse, N. Slater, PhD, ATR
- ☐ 47. Reality & Relationship: A Structured Art Therapy Approach with Schizophrenic Adolescent Patients, T. Manning, MS, ATR
- ☐ 48. Images of God: The Effects of Abuse on God Representatives, C. Moon, ATR
- ☐ 49. Artistic Expression of Large Mammals Confined to Zoological Institutions, D. Henley, MA, ATR
- ☐ 50. Doorways to Life: Art Interventions with Suicidal Clients, D. Conger, MA, ATR
- ☐ 51. Linking Interpretations of Children's Visual Images to a Developmental Art Scale, B. Troeger, PhD, ATR
- ☐ 52. Art Therapy Treatment of a Narcissistic Adolescent with Asthma: Case Study, R. Gabriels, MA, LPC, ATR
- ☐ 54. Exhibiting Art by People with Mental Illness: Issues, Process & Principles, S. Evans Spaniol, MA, ATR
- ☐ 55. Finding a New Niche: An Art Therapy Program in a Public School, M. Otcasek, BFA, MA
- ☐ 56. The Perception of Doors, M. Junge, PhD, LCSW, ATR
- ☐ 58. Fostering Emotional Health Through Music & Art in Primary Schools, D. Cogan, MA, M. Giles, PhD, C. Cox, MA, ATR
- ☐ 59. Idealization, Transformation & Disillusion in the Art of a Cross Addicted Transsexual, R. Obstfeld, MA, ATR
- ☐ 61. The Canvas Mirror: Images of Existential Art Therapy, B. Moon, MA, MDiv, ATR
- ☐ 62. Dying of a Broken Heart: Imagery of Eating Disorder Patients, M. Davies Cole, MA, MPS
- ☐ 63. Healing Medical Symptoms Exacerbated by Stress: Using Art Psychotherapy, G. Tartakoff, MCAT, ATR

PANELS

- ☐ 5. Art Therapy Treatment of Sexually Abused Clients: Child, Adolescent, Adult, M. Farrelly-Hansen, MA, ATR, T. Sweig, MA, ATR, H. Lock, MA, ATR
- ☐ 6. From Outside In & Inside Out: Viewing AIDS Thru Art Therapy's Window, S. White, MA, ATR, G. Fenster, MA, ATR, M. Franklin, MA, ATR, I. Rosner-David, MA, ATR, J. Weiser, MSEd, ATR, RCAT
- ☐ 11. Manifestations of Health: Art Therapists Creating Art, L. Carte- Anderson, MEd, ATR, M. Farrelly-Hanson, MA, ATR, R. Hueftle, MEd, LPC, ATR
- ☐ 12. Art by Abuse Survivors - A Lifecycle, C. Cox, MA, ATR, B. Cohen, MA, ATR, A. Mills, MA, ATR, B. Sobol, MA, ATR
- ☐ 23. Confronting Cancer Through Art: A Collaborative Effort by Hospital, Patient & Therapist, V. Minar, MS, ATR, J. Erdmann, MA, L. Kapitan, MPS, ATR, S. Richter-Loesl, MA, ATR, L. Vance, MS, ATR
- ☐ 24. Systems Approach to Art Therapy, R. Schoenholtz, MS, ATR, A. Nucho, PhD, ATR, V. Lusebrink, PhD, ATR, J. Rhyne, PhD, ATR, HLM, J. Weiser, MSEd, RCAT, ATR
- ☐ 25. My God Left Me? Spirituality, Wholism & Transpersonal in Art Therapy, R. Shoemaker-Beal, MFA, ATR, D. Frantz, MDiv, B. Moon, MDiv, ATR, S. Kopp, MS, CAC, CP, P. Dufrene, PhD, MFA, ATR
- ☐ 37. Bringing Down Additional Walls for Greater International Understanding, B. Stoll, MA, MFCC, ATR, A. Philippini, G. Troll, I. Marin, ATR, B. Nussbaum
- ☐ 38. The Dominions of Transference, D. Behnke-Marthaler, MA, ATR, A. Calish, MS, ATR, A. Canright, MAAT, ATR, S. Semekowski, MA, ATR, H. Wadeson, PhD, ATR
- ☐ 60. Comparisons of Drawings Produced by Abused Children & Survivors in Adulthood, M. Levick, PhD, ATR, HLM, K. Gomer, MS, ATR

TAPES NOW AVAILABLE: AATA's 22nd Annual Conference
November 13-17, 1991 Denver, Colorado
"Image & Metaphor: The Practice & Profession of Art Therapy"

PRICE PER TAPE: $12.00 * See list of available tapes on previous page.

Mail Order Form

NO. OF TAPES__________ X $12.00 EACH $__________
SHIPPING ($1.75 per tape to $12.00 max.) $__________
FOREIGN SHIPPING ($3.00 per tape to $30.00 max.) $__________
SALES TAX (CO Residents Only 7.3%) $__________
TOTAL OF ORDER $__________
SHIP TO (Please print clearly) ☐ RESIDENTIAL ☐ BUSINESS
NAME__________
INSTITUTION__________
ADDRESS__________
____
CITY__________ STATE__________ ZIP__________
DAYTIME PHONE__________

METHOD OF PAYMENT (Do Not Send Currency)
__________Enclosed is my check (Drawn on US Bank in US Funds)
Charge to my __________AMEX __________MASTERCARD __________VISA
CARD #__________
EXP. DATE__________
SIGNATURE ON CARD__________
MAKE CHECKS PAYABLE AND MAIL YOUR ORDER TO:
NATIONAL AUDIO VIDEO, INC.
4465 WASHINGTON STREET
DENVER, CO 80216
Phone: (303) 292-2952
QUALITY GUARANTEED - NO REFUNDS - ALLOW 2-4 WEEKS FOR DELIVERY

CALL TOLL FREE: 1-800-373-2952 (9-5 MST) • OR FAX YOUR ORDER 303-292-5629

Member ID# Required__________	**Member Postage per Item	Non-Member Postage per Item
** Educational Guidelines	30¢	$ 1.00
** Educational Program List	30¢	$ 2.00
** Standards and Procedures for Registration	30¢	$ 1.00
** Criterion for Professional Membership	30¢	$ 1.00
** Art Therapy Model Job Description	30¢	$ 1.00
** Art Therapy Media List	30¢	$ 1.00
** Standards of Practice	55¢	$ 1.00
** Ethics Document	30¢	$ 1.00
** Art Therapy Bibliography	30¢	$ 1.00
** Member Specialty List	$ 1.90	$ 2.90
** Membership Survey	75¢	$ 2.75
** Associate Student New Member Applications	—	—
Professional Membership Application	—	$ 1.00
Registration (A.T.R.) Application	—	$ 1.00

Membership Directory/Bylaws (postage $2.90) + Member: $10.00
Non-Member: $50.00 Institution: $100.00
Chapter Procedural Manual (postage $2.90) + $10.00

General Information Packet (Includes first three items) $4.00

** Available in multiples per item. 1-9, SASE ($2.00), 10-50, $5.00 (UPS), 50-100, $10.00 (UPS)

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ADVERTISING RATES

RATES	1x	2x	3x
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140

SPECIAL POSITIONS	additional
Cover #2 (Inside Front)	$130
Cover #3 (Inside Back)	130
Cover #4 (Outside Back)	165

COLOR RATES: Standard Red, Blue and Yellow (Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x
Per page additional	$90	$85	$80

INSERTS	1x	2x	3x
2 pp	$ 800	$ 700	$ 575
4 pp	1,500	1,300	1,150
8 pp	2,200	2,000	1,750

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"
Bleed Size: 8-5/8" × 11-1/4"
Inserts: 8-5/8" × 11-1/4"

SUBMISSION DEADLINES:

January 7 for March issue; April 7 for June/July issue; September 7 for November issue

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(708) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

	Members	Non-Members
Creativity and the Art Therapist's Indentity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) 110 pages	$15.00	$20.00
Art Therapy: Professionalism in Practice (1988) 127 pages	$15.00	$20.00
Painting Portraits: Families, Groups & Systems (1989) 141 pages	$15.00	$20.00
Image & Metaphor: The Practice & Profession of Art Therapy (1991)	$15.00	$20.00
Art Therapy in the Schools	$ 6.00	$10.00

*NOTE: for **Publications** postage/handling, add $3.00 for the first unit item $ .75 each additional unit

SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS.

** Foreign Orders: Require pre-payment for items and then will be billed for shipping charges as you instruct on order
Air Mail charges (1 week delivery) or Ground Services charges (2 month delivery)

10 or more copies of any single issue: 15% discount on total cost
Discounts are available when Purchasing quantities
Set of four Proceedings (consecutive years): 20% discount on total cost

Indicate Quantity of Unit Items Below **Cost/Unit** **Total**

____________________ ( ) X ________ = ________
____________________ ( ) X ________ = ________
____________________ ( ) X ________ = ________
____________________ ( ) X ________ = ________

* Publications Postage/Handling = ________ Total Publications Costs = ________

WE DO NOT ACCEPT PURCHASE ORDERS

Art Therapy: Journal of the American Art Therapy Association
Subscription Rates: Individuals — U.S. $25.00; Foreign $42.00; Institutions — U.S. $36.00; Foreign $53.00

Art Therapy: Journal - Back Issues		each	$9.00	$16.00
AATA Newsletter Subscription	Non-Member U.S.	$16.00	Foreign	$28.00

FILMS (Rental/Purchase)

Art Therapy: Beginnings (1977) color/sound. 45 minutes	16mm Rental Only:	$40.00	$50.00
	½" VHS, Purchase Only:	$50.00	$80.00
Michael (1977) color/sound, 12 minutes	16mm Rental Only:	$30.00	$35.00
	½" VHS, Purchase Only:	$50.00	$80.00
Art Therapy (1981) color/sound, 12 minutes	16mm Rental Only:	$35.00	$45.00
	½" VHS, Purchase Only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery (1978) color/sound, 32 minutes	16mm Rental Only:	$40.00	$50.00
	½" VHS, Purchase Only:	$50.00	$80.00

*NOTE: for **VHS Films Purchase** postage/handling add $3.00 for each film

*NOTE: for **16mm Rental** add $7.00 for postage/handling

Indicate Quantity of Unit Items Below **Cost/Unit** **Total**

____________________ ( ) X ________ = ________
____________________ ( ) X ________ = ________

*Films Postage/Handling = ________ Total Films Costs = ________

ORDER FORM: ***Make checks payable in U.S. funds to AATA, and mail to the above address***

SEND TO: ____________________ MBR. ID NO. ________

____

____
City State Zip Code

WE DO NOT ACCEPT PURCHASE ORDERS

The American Art Therapy Association, Inc.

1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

THE ORGANIZATION

The American Art Therapy Association (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3500 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice; AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliated Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals, information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive

Publications

- *Art Therapy*, the official journal of the AATA.
- The quarterly *AATA Newsletter*.
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- Free AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payers.
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy.

Professional Standards

- Development of model job and licensure laws.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

GENERAL MEMBERSHIP APPLICATIONS

1. The membership year is the calendar year January 1st through December 31st.

2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY. Please follow the chart below when submitting membership application.

Applications received between

Jan. 1st and May 31st—Full dues payment. Membership will expire Dec. 31st of same year.

June 1st and Sept 30th—Half year dues plus $5.00 payment, membership will expire Dec. 31st of same year.

Oct. 1st and Dec. 31st—Full dues payment, membership for the remainder of current year and the next full year through Dec. 31st.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval.

4. AATA Membership and AATA Registration (A.T.R.) each have a separate application procedure. Registration is bestowed only the Standards Committee.

5. National AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL—by application only; such members may vote, hold office and serve on committees.

Credentialed Professional Member: Individuals who have been dually approved for Professional Membership and Registration (A.T.R.) by the AATA, dues are $80 per year.

Active Professional Member: Individuals who have completed professional training in art therapy, dues are $75 per year.

CONTRIBUTING—Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $100 per year.

ASSOCIATE—Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75 per year.

STUDENT—Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Student members may not vote or hold office but may serve on the Student Subcommittee of Membership. Dues are $35 per year.

6

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

MEMBERSHIP APPLICATION

NAME ______________________________
last first middle

HOME ADDRESS ______________________________

____

PHONE (   ) ______________________________

BUSINESS ADDRESS ______________________________

____

____

BUSINESS PHONE (   ) ______________________________

EMPLOYER ______________________________

JOB TITLE ______________________________

LICENSES HELD & STATE ______________________________

PREFERRED MAILING LIST

___ HOME ___ BUSINESS

Please indicate which of the following you are applying for:

___ PROFESSIONAL MEMBERSHIP (an application packet for Professional Membership will be sent to you)

___ REGISTRATION (ATR) (an application packet for Registration will be sent to you)

___ $75 PROFESSIONAL MEMBERSHIP (after approval)

___ $80 ATR MEMBERSHIP (after approval)

___ $100 CONTRIBUTING MEMBERSHIP

___ $75 ASSOCIATE MEMBERSHIP

___ $35 STUDENT MEMBERSHIP (see student membership criterion for necessary documents to accompany this application)

PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO AATA
American Art Therapy Association, Inc.
1202 Allanson Rd./Mundelein, IL 60060

Please complete this survey:

Education (please check highest degree earned)

1 ___ Doctorate Degree
2 ___ Master's Degree
3 ___ Bachelor's Degree
4 ___ Associate/Certificate
5 ___ Other

Work Setting (please check one only)

1 ___ Hospital
2 ___ Clinic
3 ___ Day treatment center
4 ___ Rehabilitation
5 ___ Sheltered workshop
6 ___ Correctional facility
7 ___ Residental treatment
8 ___ Out-patient mental health
9 ___ School system
10 ___ Elderly care facility
11 ___ College/University
12 ___ Clinical training program
13 ___ Institute training program
14 ___ Counseling center
15 ___ Private practice
16 ___ Other ___________

Area(s) of Specialization (please check up to three)

1 ___ Addictions
2 ___ Adolescents, Hospitalized
3 ___ Adolescents, Psychiatric
4 ___ Adults, Hospitalized
5 ___ Adults, Psychiatric
6 ___ Art History
7 ___ Art Therapy Education
8 ___ Art Therapy in Schools
9 ___ Children, Hospitalized
10 ___ Children, Psychiatric
11 ___ Domestic Violence
12 ___ Eating Disorders
13 ___ Families
14 ___ Gerontology
15 ___ Hospice/Terminally Ill
16 ___ Learning Disability
17 ___ Mental Retardation
18 ___ Neurological Disease
19 ___ Prisoners
20 ___ Post Traumatic Stress
21 ___ Psychotherapy
22 ___ Rehabilitation
23 ___ Research
24 ___ Sexual Abuse
25 ___ Visual Art
26 ___ Other ___________

Voluntary Information:

Age:

1 ___ 20-24
2 ___ 25-29
3 ___ 30-34
4 ___ 35-39
5 ___ 40-44
6 ___ 45-49
7 ___ 50-54
8 ___ 55-59
9 ___ 60 +

Salary Range:

1 ___ under $10,000
2 ___ $10-15,000
3 ___ $15-20,000
4 ___ $20-25,000
5 ___ $25-30,000
6 ___ $30-35,000
7 ___ $35-40,000
8 ___ $40-45,000
9 ___ $45-50,000
10 ___ $50,000 +

Gender:

1 ___ Female
2 ___ Male

Hours Worked per Week:

1 ___ 0-10
2 ___ 10-20
3 ___ 20-30
4 ___ 30-40

THE UNIVERSITY OF UTAH COLLEGE OF HEALTH

INVITES YOU TO

MENTAL *Leisure &* HEALTH

An International Conference

A SPECIAL THREE-DAY CONFERENCE TO EXAMINE THE RELATIONSHIPS BETWEEN LEISURE AND MENTAL HEALTH FOR THE DISCIPLINES OF

• PSYCHIATRY • SOCIAL WORK • GERONTOLOGY • ARTS THERAPY • SPECIAL EDUCATION
• OCCUPATIONAL THERAPY • THERAPEUTIC RECREATION • PHARMACY
• SPECIAL TRACKS ON CLINICAL, RESEARCH AND ADMINISTRATIVE ISSUES

JULY 9-12, 1992
UNIVERSITY PARK HOTEL
SALT LAKE CITY, UTAH

FIVE INSTITUTES:

Special emphasis and full-day institutes on:
Depression: Prevention, Management, and Treatment • Psychopharmacological Intervention
• The Elderly: Activity and Mental Health • Outdoor Challenge Therapy: An Emerging Intervention Strategy
• Youth at Risk

KEYNOTE SPEAKER:

Dr. Mihaly Csikszentmihalyi
The University of Chicago
Author of *Flow: The Psychology of Optimal Experience* and *Beyond Boredom and Anxiety*

FEATURING:

Dr. M. Powell Lawton, Philadelphia Geriatric Center
Dr. Kevin Leehey, Tucson Psychiatric Institute
Dr. Thomas E. Smith, The Raccoon Institute
Dr. Pablo Stewart, Haight-Ashbury Free Clinic
+ other key international speakers

For program information contact: College of Health, (801) 581-8537, (801) 581-5580 (FAX)
For registration information contact: Conferences and Institutes (801) 581-5809, (801) 581-3165 (FAX)

UNIVERSITY OF UTAH • COLLEGE OF HEALTH

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $25 (US); $42 (Foreign). Institutions: $36 (US); $53 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9 member; $16 non-member. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1992. Enclosed is my check, payable to AATA, for $25.
Name ____________________
Address ____________________
City ____________________ State __________ ZIP __________

The interdisciplinary journal
devoted to the creative arts as healing arts.

THE ARTS IN PSYCHOTHERAPY

An International Journal

ARTS PSYCHOTHERAPY

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Associate Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

PERGAMON PRESS
Maxwell House, Fairview Park, Elmsford, NY 10523
Headington Hill Hall, Oxford OX3 0BW, England
Member of Maxwell Macmillan Pergamon Publishing Corporation

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions to the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

Editors welcome original manuscripts. Submit papers in triplicate to: Managing Editor, Sylvia Halpern, 20 Ridgecrest East, Scarsdale, NY 10583

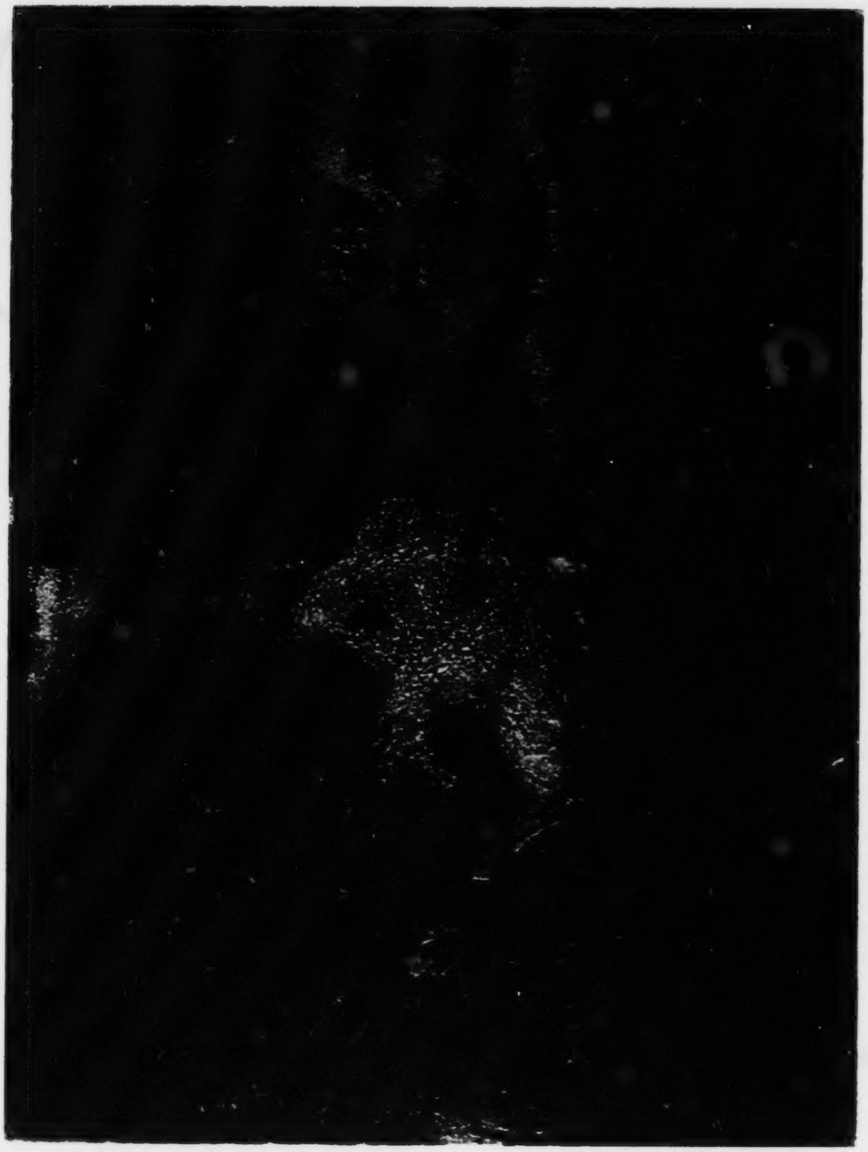
SUBSCRIPTION INFORMATION

ISSN: 0197-4556	Volume 17, 1990
Published 4 issues per annum	
Annual Institution Subscription Rate (1990)	US$130.00
Two-year Institution Rate (1990/91)	US$247.00
Professional Rate (1990)	US$ 40.00
Student Rate (1990)	US$ 16.00

BEST COPY AVAILABLE

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION



VOLUME 9, NUMBER 2, 1992

BEST COPY AVAILABLE

1184

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 36-3180580) is published triannually by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $25 (U.S.) and $42 (Foreign); institutions: $36 (U.S.) and $53 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Advertising: Please see advertising rates listed elsewhere in this journal or contact the American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 (708) 949-6064. The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, M.A., A.T.R.
University of Utah, Salt Lake City, UT

Associate Editor
Patricia St. John, Ed.D., A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor
Elizabeth Ratcliffe, M.S., MFCC, A.T.R.
College of Notre Dame, Belmont, CA

Film/Video Review Editor
James Consoli, M.A., A.T.R., NCC
Eastern Virginia Medical School, Norfolk, VA

Production Editor
Marcia May-Chambers

Editorial Board
Frances E. Anderson, Ed.D., A.T.R., HLM
Illinois State University, Normal, IL
Julia G. Byers, M.A., A.T.R.
Concordia University, Montreal, Quebec
Michael Campanelli, Ed.D., A.T.R.
Wright State University, Dayton, OH
Susan E. Cheyne-King, M.S., A.T.R.
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, M.A., A.T.R.
George Washington University, Washington, D.C.
Maxine Borowsky Junge, Ph.D., LCSW, A.T.R.
Loyola Marymount University, Los Angeles, CA
Paolo Knill, Ph.D., A.T.R., CMT-BC
Lesley College, Cambridge, MA
Wendy Lauter, M.C.A.T., A.T.R.
Oak Park, IL
Vija B. Lusebrink, Ph.D., A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, Ed.D., A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Trudy Martin Manning, M.S., A.T.R.
Eastern Virginia Medical School, Norfolk, VA
Shirley Riley, M.A., MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Paul Rodenhauser, MD
Tulane University, New Orleans, LA
Marcia L. Rosal, Ph.D., A.T.R.
University of Louisville, Louisville, KY
Lewis Shupe, Ph.D., A.T.R.
Wright State University, Dayton, OH
Sandra Ticen, M.S., A.T.R.
Canisius College, Buffalo, NY
Betty Jo Troeger, Ph.D., A.T.R.
Florida State University, Tallahassee, FL
Robert Wolf, M.P.S., A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President
Robin Goodman, Ph.D., A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Editorial

Writing About Art Therapy For Professional Publications
Cathy A. Malchiodi, M.A., A.T.R. .... ▲ 62

Man, Escapes Danger
HELP!

Commentaries

Kudos to Gary Barlow, Ed.D., A.T.R.
Roberta Shoemaker-Beal, M.F.A., A.T.R. .... ▲ 65

Articles

A Time Series Design Study of Neurologically Impaired Children
Patricia St. John, Ed.D., A.T.R. .... ▲ 67

Art Therapy and Self Esteem
Michael Franklin, M.A., A.T.R. .... ▲ 78

Brief Reports

Gender Differences in Drawings: A Study of Self-Images, Autonomous Subjects, and Relationships
Rawley Silver, Ed.D., A.T.R., HLM .... ▲ 85

Is There A 'Late Style' of Art?: Line Use in Human Figure Drawing by Elderly People
Susan Evans Spaniol, A.T.R. .... ▲ 93

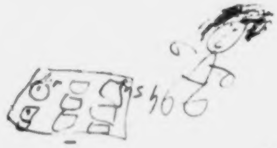
Viewpoints

Reflections: To Hell and Halfway Back
Amy F. Hendel
Introduction and Postscript, Myra Levick, Ph.D., A.T.R., HLM .... ▲ 96

Reviews

Creating Mandalas: For Insight, Healing and Self-Expression
Elizabeth Ratcliffe, M.S., M.F.C.C., A.T.R. .... ▲ 103

About the Cover: "Connect," 12" × 9", monoprint with pastel, by Mildred Lachman-Chapin, M.Ed., A.T.R. About the piece, Ms. Lachman-Chapin says: "This is one of a recent series of monoprints in which there is a figure of a woman with hand raised. Reaching to connect? To heal? To soothe? To judge? To work? To paint? In various writings and presentations of the past few years I have been investigating my role as woman engaged both as an artist and therapist. This body of art work continues the search."



VOLUME 9, NUMBER 2, 1992

Art Therapy. Journal of the American Art Therapy Association, 9(2) pp. 62-64 © AATA, Inc. 1992

Editorial

Writing about Art Therapy for Professional Publications

Cathy A. Malchiodi, M.A., A.T.R., *Editor*

Art Therapy, like other professional journals, receives a great many submissions that must either be rejected or must undergo substantial revisions before publication. Therefore, when taking the time and effort to write an article for *Art Therapy* or another peer-reviewed publication, it pays to carefully consider the following aspects in developing and finalizing a manuscript for submission.

With regard to this publication, it is extremely important for all prospective authors to first pay close attention to the "Guidelines for Submission" as outlined in each journal. Oversights such as lack of adherence to APA style and format in both the body of the text and references, failure to disguise author identity or lack of an abstract will undoubtedly slow down the processing and possible publication of a manuscript. As Editor, I see a great many manuscripts that present interesting and thoughtful information, but have not met these simple standards and are therefore returned to the author without review. This procedure is not only standard to *Art Therapy*, but to most professional journals, particularly those with competitive acceptance rates.

A thorough and accurate literature review is extremely important to building your argument if your article is theoretically based, and is a necessity if you are extending some area of research. Often manuscripts are returned to authors because there are obvious gaps in citations of current literature. Undoubtedly, a literature review is time-consuming, and a good reference library with a current collection of periodicals and dissertation abstracts must be consulted. Often a computer search is also necessary; access to CD-ROM data bases can provide periodical, dissertation abstracts and other references. It is also important to look closely at what has been published during the last five years, particularly if you are reviewing literature relevant to research.

In some ways, a literature review is often more difficult in the field of art therapy than in other disciplines. First, an author has to sift through references in a variety of subjects such as social and behavioral sciences, medicine, psychiatry, visual art, art education, special education, anthropology, etc., depending on the theme of the manuscript. This will often involve looking at material in several different data bases and perhaps even different libraries. Additionally, much of our knowledge base has been part of oral history at the Annual AATA Conferences where current professional issues, methodology and theory have been discussed and debated over the years. Also, presented in this forum are research findings, many of which have not been published in any professional journal, book or source other than self-published manuals; the latter is difficult for most individuals to obtain because they are generally only available directly from the author(s) and are not referenced for library purposes. Much of the information presented at the AATA conferences may only be available on audio tape or in the annual *Proceedings* in which short papers, synopses of presentations or, since the mid-1980's, abstracts have been published. Therefore, due to the variety of sources, it takes a special effort to explore what has already been discussed, developed or distilled in our professional field.

It is also imperative to define how observations were made and authors often neglect to identify how they specifically derived their information. There is a vast difference between clinical observations and observations made as the result of definable research methodology. Also, research methodology must be accurately described so that the reader is fully informed of how the author arrived at his/her conclusions. Again, consulting APA style, if writing for this journal, or the guidelines for submission for other journals will describe the format and content of how to present research methodology.

Clinical observations are generally those made in the course of treatment of a client and involve personal views and speculations about what has transpired. There is nothing particularly wrong with clinical observations, although it is likely that such observations are less robust than those conclusions drawn from well-designed and carefully executed research. They occur most frequently in narrative case research, which has been a traditional staple of art therapy writing. There are, as many in this profession are aware, significant drawbacks to the narrative case study approach (Rosal, 1989) and this journal discourages case studies unless a particular methodology is utilized. However, what is important is that the author identify the origin of observations so that the reader is fully cognizant of the manner in which the author derived any conclusions.

One of the greatest dangers that authors confront when they write scholarly papers is that the final manuscript may be only a collection of appropriate quotations and really nothing of their own. Many a student paper and some doctoral and masters theses have succumbed to this practice. To avoid this over reliance on quoted material, a rule of thumb when using quotations is to always move on from the quotation and continue the paragraph by developing the idea presented in the quote. By forcing a response to the quote, the author begins a dialogue with the information. This process also naturally leads to a synthesis of ideas, both those from the quoted source and the author's own developing arguments.

It is particularly important in writing to be critical. This does not mean that you have to be cruel in order to make your point, but you need to ask questions about what others have written. On one level, being critical means taking nothing for granted, e.g., not believing things because an authority figure says so or because it is in print. It also refers to the capacity to thoughtfully analyze the ideas, statements and premises of others. Additionally, you may have to examine the author's definition of terms, because the use of a term may be true when defined one way and not another.

As our profession continues to expand and become more visible, it is essential for authors to be aware of what is going on in the world outside art therapy. It is obvious that others are investigating the use and meaning of art in therapy and that their perspectives are important in defining our own. For example, one major area of investigation by professionals outside the field of art therapy that many prospective authors seem unaware of is the current debate over the use of projective drawing tests in assessment. Articles are frequently submitted to *Art Therapy* that utilize the results of some traditional projective drawing tasks as the major content of the manuscript. Although there are standard texts on projective tests readily available and this information has been taught in graduate level art therapy programs, there has been some controversy about the use of such tests for quite a few years. In fact, there are many who question the assumptions underlying projective drawings (Palmer, 1983; Cummings, 1986; Golumb, 1992, to name a few) and a great deal of published material on the pros and cons of utilizing drawing projectives in assessment. Martin (1983) went as far as calling the use of projective drawings unethical and insisted that they not be used by clinicians because of their unreliability. Although Martin's stance proved to be quite controversial in the therapeutic community, there are still recognized problems in the validity of certain projective tests (Gittleman, 1980) and the reliability of others (Kamphaus & Pleiss, 1991).

The debate over the use and meaning of projective drawings is obviously only one area that art therapists who intend to write need to be aware of. With the rapid advancement of knowledge in so many disciplines that are related to art therapy, it may seem impossible to stay abreast of current trends and developments that affect our field. However, one way to keep informed is to regularly consult professionals outside art therapy or, at the very least, peruse their professional journals. In this way, an author can at least get a "feel" for what is currently being debated or investigated and will know where to look for necessary information to develop

BEST COPY AVAILABLE

ideas for theoretical, methodological or research papers.

The need to accurately, eloquently and substantially articulate our profession is at a critical point. In recent years, art therapists have been asked to demonstrate the value of our profession from a variety of sources. Some of these sources have included insurance care providers and health service regulating bodies. Still others have involved the federal government; the formal hearing on the use of art therapy with the elderly in conjunction with the Older Americans Reauthorization Act is a recent example at this level. As we continue to be recognized as a viable professional discipline, there will be undoubtedly other hearings and other arenas in which we will have to publicly and credibly demonstrate our worth as a profession through our ability to write about art therapy both accurately and convincingly.

Additionally, in 1991, the AATA membership voted to go ahead with a national certification program for art therapists and at a subsequent business meeting at the AATA Annual Conference in Denver, Colorado, a majority indicated that they would like to see certification implemented in three years. Certification will probably involve an examination or evaluation of some sort to determine a minimum level of competency in art therapy. This idea of an examination or competency evaluation brings the profession rapidly to the question of what exactly our knowledge base consists of and how what is published supports this knowledge base. Therefore, it is paramount that writing about art therapy theory, practice and research be articulate and exacting, especially if art therapists want to demonstrate a unique knowledge base which is distinctly separate from other related disciplines. Needless to say, writing about research is particularly important, although art therapists have been squeamish to admit it and resistant to undertaking it.

Lastly, much of the writing that defines our field has appeared in *Art Therapy;* this publication contributes substantially to our identity and to directions for further exploration. Additionally, this journal often defines our profession to others in related fields. Therefore, it is essential that authors consider the power that their written words have in shaping and defining art therapy as a discipline and endeavor to contribute material to that is well-written, insightful and substantive.

References

Cummings, J. A. (1986). Projective drawings. In H. Knoff (ed.) *The assessment of child and adolescent personality* (pp. 199-244). New York: Guilford Press.

Gittleman, R. (1980). The role of psychological tests for differential diagnosis in child psychiatry. *Journal of the American Academy of Child Psychiatry, 19*, 413-438.

Golumb, C. (1992). *The child's creation of a pictorial world.* Berkeley, CA: University of California Press.

Kamphaus, R. W. & Pleiss, K. E. (1991). Draw-a-Person techniques: Tests in search of a construct. *Journal of School Psychology, 29*, 395-401.

Martin, R. P. (1983). The ethical issues in the use and interpretation of the Draw-a-Person test and other similar projective procedures. *The School Psychologist, 38*(6), 8.

Palmer, J. O. (1983). *The psychological assessment of children.* New York: Wiley.

Rosal, M. (1989). Master's papers in art therapy: Narrative or research case studies? *The Arts in Psychotherapy, 16*(2), 71-75.

Art Therapy. Journal of the American Art Therapy Association, 9(2) p. 65-66 © AATA, Inc. 1992

Commentaries

Kudos to Gary Barlow, Ed.D., A.T.R.

When one knows and lives the truth that the image is central to healing . . . when one chooses a profession where the creative visual process can tap and record the message from deep inside to serve people in their growth and healing . . . when birthing this profession takes much of our time and energy, then imagine editing the verbal message of this ever-birthing field of art therapy! Such a challenging labor of love Gary Barlow has given art therapy for eight years.

Picture the first editor of *Art Therapy*, at the end of his work day, going into a room with papers piled high on tables. Here in quiet repose, in their manila bassinets, lie the mind-children of highly creative people, waiting to be nursed into the world of print. As midwife to this process, he acknowledged the reception of each paper, telling the anxious mothers and fathers that finger- and toenails may need to be trimmed. The editor disperses the mind-children for review and perhaps re-birthing. The editor's jobs can be like the surgeon at the circumcision, for each article has a thrust, a point to make, and its unique view of our field. Each art therapist/author/parent may cringe and scream in protest at the surgery. But they usually learn that the pain of shaping an ailing child is worth the agonies of editing a professional paper.

The process of circumspection across the entire field of art therapy is not an easy one. In my editing of art therapy papers, most parents of art therapy word-children were appreciative of my work, but not all. In our work with the first AATA *Proceedings* our task was to include all papers in some form. We did not have to face telling a paper-parent that there was no room for their baby due to cost limitations, or that it was too weak to walk into print at that time. As best I can tell, Gary's midwifing did not discourage anyone from attempting another birth.

Gary stands in my mind with the great mothers and great fathers of art therapy. Elinor Ulman, my art therapy mother and first editor in the field of art therapy, gave the vision of art therapy a broad horizon—"art in therapy, education and rehabilitation." You have kept that vision in the breadth of your articles. As Dr. Bernard I. Levy and Claire Levy co-created training wheels for us all in many articles written and co-edited with Elinor, Gary has kept us rolling along for eight years, issue after issue. As Edith Wallace, MD, PhD, and Dr. Myra Levick participated in the birthing of a journal for all the creative arts therapies, so Gary brought benefits from these colleagues with him. Gary brought us a rich background in art education and from kids with special needs, supporting and extending the horizons of "art psychotherapy," as highlighted by Harriet Wadeson and others; "art as therapy," from Edith Kramer and Dr. Judith Rubin; "the arts in the service of therapy," as delineated by Dr. Don Uhlin; and, "the services of the art teacher/therapist in psychoeducational settings," documented by Dr. Frances Anderson and others. The Book Reviews and choice of book reviewers have given art therapy broad ground to walk across.

Despite the fiscal restraints that often surrounded AATA, *Art Therapy* brought us our first color pictures. As a previous member on the AATA Board, I know that they, too, are surgical teams with scissors sharpened by the limits of budget. How-

---

Editor's note: "Commentary" is a new section in which AATA members and others may discuss views about current theoretical or professional issues, express opinions or respond to articles published in *Art Therapy*. Material published in "Commentary" does not undergo peer review, but must be submitted in the style and format indicated in the "Guidelines for Submission."

ever, *Art Therapy* covers now stand as windows into our profession, glimpses into the power of the silent record, on library shelves across the country.

As Editor, Gary also nudged us in birthing our mind-children into a professional world. The issue of July 1989 comes to mind as I recall little gifts of guidance that Gary gave us, gently but clearly, in the editorials. Gary complimented Drs. Jerry Fryrear and Irene Corbit for including the format of their "confidentiality release" with their theory/research article, "Visual Transitions as Art Therapy." We were all alerted to the importance of this task specific to art therapy writers. Little feedings like this are tucked away in editorial after editorial. I go back and "digest their meals" when I need to renew my writing energies.

And art therapists *are* known to have a few viewpoints. We are so busy birthing our creative works, ourselves, our clients, and our profession that, of course, the point on which we stand has a *viewpoint*! From my standpoint of inclusionism, Gary has let us see the view from both the mountain peaks of poetry and the depths of disagreement. And, to your credit, I cannot recall any plateaus of platitudes.

Au Revoir

From one former editor to another, Gary Barlow, I say you are one of the great fathers in the field of art therapy. And it seems obvious we need to send love and appreciation to the few we have. You have midwifed us through many dark nights. You have done it with grace, humor, thoroughness and wisdom. You have brought us further into the world. We are grateful, and, though we never saw you in that room your Wright University Art Therapy staff has told me about, we appreciate all those issues delivered to our mailboxes. Your many laborious hours are now our history, and we all share it with you. Now, Gary, what would you like to birth with us next?

Roberta Shoemaker-Beal, M.F.A., A.T.R.,
Slidell, LA.

Call for Submissions to *Art Therapy*

Art Therapy: Journal of the American Art Therapy Association is considering the publication of a special issue on "Art and Medicine" for 1993. Articles may focus on the use of art expression in assessment or treatment of physical disease, theoretical, ethical or practical issues in the application of art expression in a medical setting or with physical illness, or original research in medical art therapy.

As with all submissions to *Art Therapy*, authors must submit five clear copies according to the "Guidelines for Submissions" as outlined in the current journal; please review these guidelines carefully because submissions which do not meet these requirements will not be accepted for review and will be immediately returned to the author(s).

DEADLINE for submissions is SEPTEMBER 15TH, 1992.
Please send manuscripts to:

Cathy A. Malchiodi, M.A., A.T.R.
EDITOR/ART THERAPY
% AATA National Office
1202 Allanson Road
Mundelein, Illinois 60060

Art Therapy. Journal of the American Art Therapy Association, 9(2) pp. 67-77 © AATA, Inc. 1992

A Time Series Design Study of Neurologically Impaired Children

Patricia St. John, Ed.D., A.T.R., College of New Rochelle, New Rochelle, NY; Associate Editor, Art Therapy.

Abstract

A Time Series Design, Change-Over-Time study was used to determine the usefulness of four tasks in distinguishing maturational factors and neurological characteristics of eight boys, ages 6-12, who were diagnosed neurologically impaired. Results indicate that the tasks are characterized by use of regular art materials, interest to the subjects, ability to be replicated, and allowance for expression and visuo-motor enhancement. Data on three other measures: resistance to adaptation, sensitivity to maturation, and sensitivity to neurological impairment, were collected, but are not discussed in this paper. This study has relevance to art therapists whose work is to measure the effects of treatment with heterogeneous patient populations.

A crucial issue for art therapists is finding the most effective therapeutic method for individualized patient treatment. Unlike psychologists, art therapists must confront the veracity of their methodology through small samples and heterogeneous clients. Large sample statistical findings are very difficult to attain. For many years, narrative case studies have been the dominant form for demonstrating the effectiveness of art therapy. Additionally, many art therapists use assessment procedures to determine the current functioning of the client before treatment. Over the past 20 years, numerous assessment and evaluation tools, both quantitative and qualitative, have been developed by and for art therapists (e.g., Burns & Kaufman, 1972; Ulman, 1975; Kwiatkowska, 1978; Hays & Lyons, 1981; Wilson & Wilson, 1981; Miljkovitch & Irvine, 1982; Kramer & Schehr, 1983; Silver, 1988, 1990; Cohen, Hammer & Singer, 1988; Malchiodi, 1990).

Many assessments designed by art therapists are one-session, one-activity procedures and are used to evaluate the status of the client. These assessment procedures are not repeated once treatment begins. Instead, the art work of the client is closely monitored for indicators of change in the client's disposition. Occasionally, assessments are used both before (pre-test) and after (post-test) treatment, to demonstrate change resulting from intervention; post-treatment assessments are seldom administered. The practice of administering periodic assessments during the treatment period is even less frequent.

Despite the gains in objective reporting made through assessment, many of the drawbacks of case studies identified by Rosal (1989) persist in assessment procedures. Independent and dependent variables are not described, and most assessment procedures developed by art therapists have not been tested on a large population. A recent informal survey of assessment use in child art therapy (Mills & Goodwin, 1991) indicates that a wide range of assessment procedures are used by art therapists. The majority of assessments listed, however, rely on qualitative reporting processes, thus limiting replication and generalization of results. Assessment can demonstrate the outcomes of art therapy, but it does not address the need to measure therapeutic gains during the treatment period.

All therapists ask themselves how much of their

Editor's note: This is a revised, updated and expanded version of the paper titled: "Developmental Changes in the Art of the Neurologically Impaired Child: A Change-Over-Time Study." It appeared in di Maria, A., Kramer, E., and Roth, E. (Eds.) (1983) *Proceedings of the 13th annual conference of the American Art Therapy Association* pp. 133-137. Reston, VA: American Art Therapy Association. Quantitative results of the study will appear in another paper.

BEST COPY AVAILABLE

intervention entered into the growth, or lack of growth, of their clients. If treatment is long term, the problem of distinguishing between normal maturation and intervention can be even more elusive, especially in work with children. Assessment does not address the need to measure therapeutic gains during the treatment period. It does not specify which interventions were effective and when the effects occurred.

The time-series design, an alternative to the case study narrative and to pre-treatment assessment, is a plausible approach to determine the effects of treatment. Time-series research grew out of behavioral psychology which has advocated its use since the late sixties (Kratchowill, 1979). The feature common to all time-series design in the study of groups or individuals is time. Time periods vary, but may be long enough to be considered a longitudinal study.

Additionally, time-series designs emphasize "repeated measurement under baseline and intervention conditions" (Kratchowill, 1978, p. 8). The client's behavior is observed at phase one of the study. When treatment or alternative treatment is introduced, the effects of the treatment on the client's behavior are noted (Rosal, 1989).

The time-series design is considered to be an empirical procedure particularly suited for use with an individual subject or "small group, over time, with the introduction of some intervention into the data series, and with subsequent monitoring of the series to examine effects" (Rush & Kratchowill, 1981, p. 59). Designed to examine individual variability, it allows the clinician "to establish a degree of functional relation between independent and dependent variables. . ." (Rush & Kratchowill, p. 60), to monitor the introduction of specific variables and to gauge its effect upon the individual.

It is suited to use with heterogeneous client populations. Data can be evaluated through visual and/or statistical procedures. "Visual analysis consists of judging graphic data under different conditions of the experiment" (Rush & Kratchowill, p. 63). In this case, the evaluation criteria must be quite stringent if the procedure is to have potential for success.

The single case experimental design-time series paradigm is also uniquely suited for use "in natural settings where data collection procedures necessary for true experimental designs were not feasible" (Kratchowill, 1978, p. 8). For example, it can be used in work with geriatric clients, borderline patients, and autistic children. It is characterized by repeated measurement under baseline and intervention conditions, and avoids the use of between group and between individuals comparisons. The design may be a simple ABAB format, or any combination, with intervention introduced at random or regular intervals. "A" stands for the baseline condition, and "B" indicates the intervals of intervention conditions. For example, a regular intervention interval is coded ABAB; an irregular intervention interval is coded ABBABA. Or, treatment may precede alternative treatment or intervention: BA.

Using a single subject research, time-series change-over-time model to demonstrate changes within the process of therapy, the clinician can control alternative approaches to treatment. Like the case study and assessment tools, it is used to evaluate change. The difference is that the demonstration is pre-planned, and comparatively more controlled and often quantitatively measured. Evaluation of the intervention is done during treatment, not only at the beginning or end of treatment, as in assessment. The time-series paradigm is used when the same subject is tested repeatedly. This model is compatible with art therapy because art therapists work with individuals or small groups over a period of several to many sessions, are able to pre-plan intervention, and have quantitative measures available to use when desired.

Purpose of Study

The purpose of this study was to use a modified time-series, single subject, change-over-time design to test a battery of tasks over a six-month period or longer. The tasks were designed for use with neurologically impaired children and administered on a pre-planned monthly schedule. It was hypothesized that the changes in artwork, quantitatively measured, would be due only to maturation, not to treatment intervention.

This study was designed to establish the effectiveness of the research design and methodology, and to establish the effectiveness of the task battery in seven areas. Four areas of non-quantitative measures are discussed in this paper—the tasks should: (1) use common art materials, (2) sustain the client interest, (3) allow replication, and (4) enable the child to work expressively or enhance visuo-motor skills. Three measures, which were quantitative, were tested: (5) resistance to adaptation, (6) sensitivity to characteristics of maturation, and (7) sensitivity to characteristics of neurological impairment; these will be discussed in a future paper.

Method

Subjects

The subjects were eight boys, ages 6-12, diagnosed neurologically impaired. All were enrolled in a private school in a rural section of the Northeast. The school is explicitly for neurologically impaired and emotionally disturbed children who could not be served by their public schools. All children enrolled in the school were of average or above average intelligence and none had physically handicapping conditions.

Subjects were selected by their classroom teacher on the basis of who might profit from individual art sessions, who might be able to make good use of art materials, and whose parents would be inclined to approve of their child's participation.

The age range of 6-12 years was divided as follows: age six = 1; age 8 = 2; age nine = 2; age ten = 2; and age twelve = 1.

Family constellations varied from intact families to several which were single parent families. Socioeconomic status ranged from professional (e.g., college professors) to blue collar and middle class. All children lived within a one-hour bus ride from the school in neighborhoods which ranged from urban to suburban. Children attended school on a daily basis.

One of the reasons for selecting a time-series single subject design was to accommodate the differences between children. These included a range of age, socio-economic levels, family configurations, and emotional and neurological conditions of each child. The heterogeneity of the group within the larger framework of the diagnostic category was therefore a desirable factor in this research. All subjects attended all six months of planned sessions.

Materials

Four assessment tools, plus the Bender-Visual-Motor Gestalt Test, comprised the task battery. The Bender was administered only once at the beginning of the time series. The other four tasks were administered monthly.

Each child produced six sets of the following tasks, excluding the Bender:

Bender-Visual-Motor Gestalt Test (BVMG) (Bender, 1938): The Bender is a set of nine designs, one on each card. The child is asked to copy each design onto a sheet of 8½" × 11" white paper using pencil. He is then asked to reproduce the designs from memory.

Rey-Osterreith Complex Figure Test (CFT) (Taylor, 1959): Each subject was requested to make one copy of this test, using pencil on 8½" × 11" paper. After a few minutes, a memory drawing of the same was requested.

Human-Figure-In-Action Drawing (HFIA): Subjects were asked to create a drawing of themselves or another person in action (Figure 1). 8½" × 11" paper, pencil or colored magic markers were used. This could be from memory, fantasy, or imagination.

Story-Sequence Drawing (SSD): Using pencil or colored magic markers and 8½" × 11" paper, each subject was requested to draw a story with a beginning, middle, and an end (Figure 2). It was to be sequential, and drawn within four-six frames or steps.

Clay Human or Animal: Each subject was asked to make at least one figure, using a ¼ pound stick of plasticene/oil-based clay (Figure 3).

Rational for Selection of Tests and Tasks

Lezak (1983) states: "Constructional performance combines perceptual activity with motor response and always has a spatial component. . . . The integral role of the visuo-perceptual functions in constructional activity becomes evident when persons with more than very mild perceptual disabilities experience some difficulty on constructional tasks" (p. 382).

Constructional performance is affected by location of lesion. For example:

> "Patients with right hemisphere damage tend to take a piecemeal, fragmented approach, losing the overall gestalt of the construction task. They may neglect the left side of the construction or—occasionally—pile up items (lines in a drawing, blocks or puzzle pieces) on the left . . . (they) do not benefit from having a model. Patients with left-sided lesions may get the overall proportions and the overall idea of the construction correct, but they tend to lose details and generally turn out a shabby production" (Lezak, 1983, pp. 382-383).

The selection of tests and tasks was critical for this study. Each test or task was selected to meet seven criteria: (1) *Art materials*. Materials chosen need to be commonly used in art therapy treatment; their familiarity and non-technical nature should allow for maximum *opportunities for expression*. (2) *Interest, challenge and success*. Subjects were asked to attempt each task six times. Therefore, the tasks had to hold sufficient interest. (3) *Replication*. Tasks were repeated six times using exactly the same directions. Exactly the same procedures were to be

Fig. 1. Human-Figure-In-Action Drawing. Brian, age 9: "Terra fermies looking over a hill."

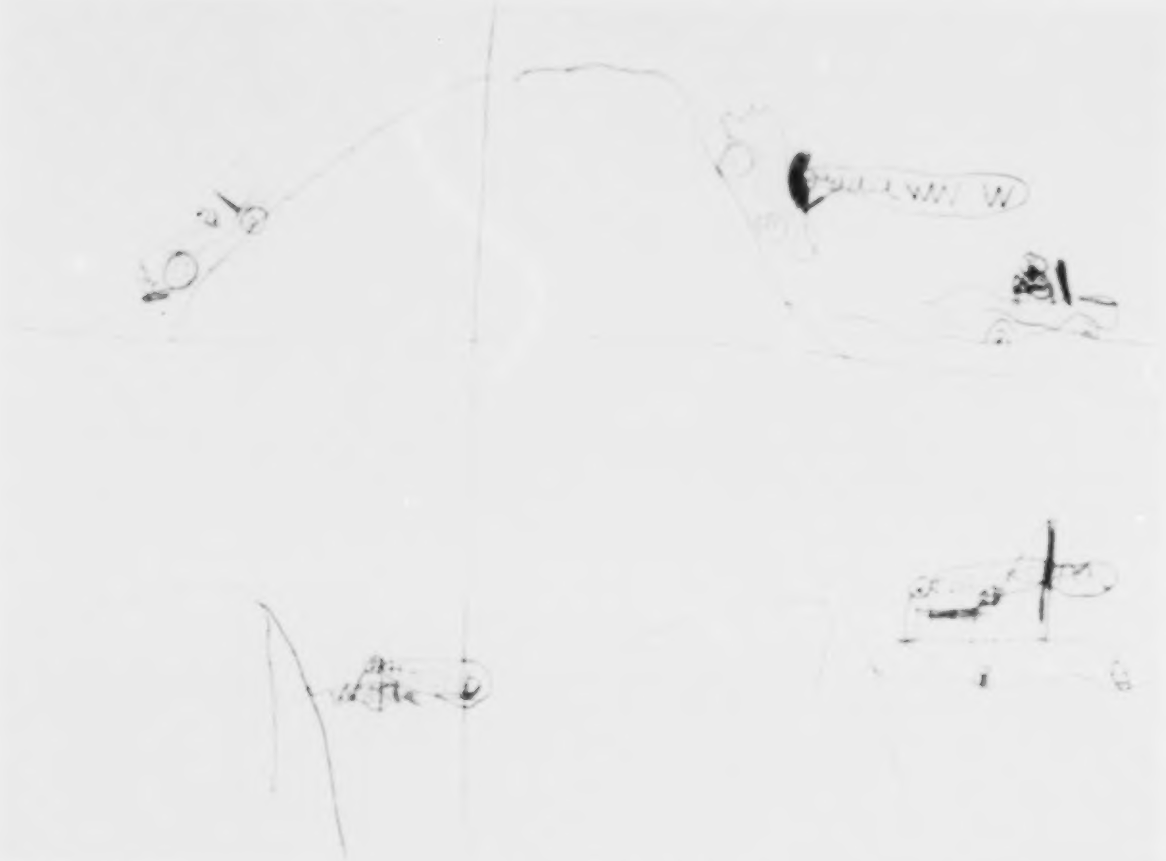


Fig. 2. Story-Sequence Drawing. Andrew, age 10: "A man drives his dune buggy over a hill and falls into the ocean. He is rescued by a ship. He says to the Captain: 'Thanks, pal.'"

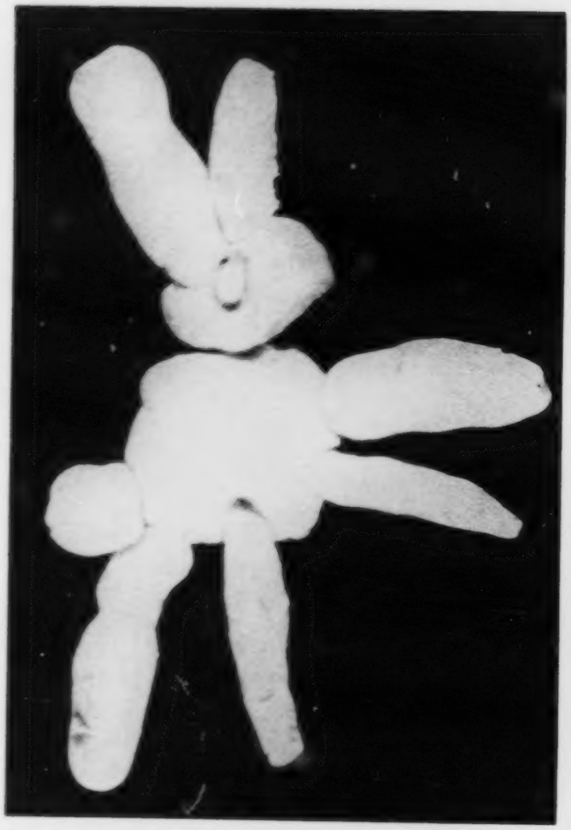


Fig. 3. Clay figure. Joey, age 6: An Easter rabbit.

followed every time with each subject to ensure uniformity from session to session. (4) *Opportunities for both expressive exploration of themes and enhancement of visuo-motor skills.* The tasks needed to include open-ended directives, allowing the child to explore themes from current life, fantasies, or memories. The structured task should allow the child to engage in a predictable, and therefore safe, activity which challenges his visuo-motor skills. The three quantitative measures were: (5) *Resistance to adaptation.* Tasks need to be resistant to learning from repeated exposure which could lead to adaptation, or mastery of the task. (6) *Sensitivity to maturation.* Tasks need to be sensitive to developmental changes in the subjects' art work which resulted from normal maturation. (7) *Sensitivity to characteristics of neurological impairment.* Tasks need to be sensitive to perceptual impairment and locus of lesions of both the left and right hemispheres.

The structured tasks, the BVMG and the Complex Figure Test, were selected because of their appropriateness for use with neurologically impaired populations. These tasks would serve as a guide or screen to consider the semi-structured tasks, the Story-Sequence Drawing (SSD), Human-Figure-In-Action (HFIA), and Clay Figure.

The Bender Visual-Motor Gestalt test is highly sensitive to characteristics of neurological impairment and is scored based on a developmental scale developed by Koppitz (1963). It is useful with children ages 5-10 and adults. The developmental scoring can differentiate between distortions "which primarily reflect immaturity or perceptual malfunctioning, and those which are not related to age or perception but which reflect emotional factors and attitudes" (Lezak, 1983, p. 5).

There are two phases of the test: copy and recall. The literature shows a reasonably high degree of consistency, over time, of the performance and scoring of the tests (Lezak, 1983).

Koppitz, testing children with brain injury, concluded that the Bender VM Gestalt could be of "considerable help in diagnosing Minimal Brain Injury (MBD), but it is not possible to determine the etiology of MBD from children's Bender Test records" (Koppitz, 1975, p. 72). She, therefore, recommended using it with other tests for diagnostic purposes. Clinically, although there were wide differences from child to child, she noted that general characteristics are often found in the tests of the MDB child:

- a lag in visual-motor integration (that is, there was a significant immaturity in the drawings of the MBD when compared to the normal child)
- marked discrepancy between IQ score and Bender test scores
- a significant number of rotations.

Adaptation to the test was not a factor in the choice of this test since it was administered once. It was found to be challenging and stressful to the subjects, and therefore not repeated after the first administration.

The Rey-Osterreith Complex Figure Test (CFT) was selected to "investigate both perceptual organization and visual memory in brain-damaged subjects" (Lezak, 1976, p. 321). This was the original intent of Rey (1941), who designed the CFT. Osterreith (1944) standardized the procedure, using 230 normal children ages 4-15, and 60 adults ages 16-60, plus "two groups of children with learning and adjustment problems (and) a small number of behaviorally disturbed adults, 43 who had sustained traumatic brain injury and a few patients with endogenous brain disease" (Lezak, 1983, p. 395).

Taylor (1959) states that:

> Children with old injuries (to the central nervous system) often show perceptual difficulties from early childhood on. The precepts which they retain are frequently distorted and poorly differentiated. Children who have developed normally up to a certain point before the injury may have retained some well structured spatial concept even though they no longer can elaborate new ones with ease (p. 396).

The Rey-Osterreith Complex Figure Test, when used with brain-injured children, often results in distorted, primitive or concretized reproductions (Taylor, 1959). Taylor suggests that more intensive study of the test's usefulness with atypical children is needed. Most errors were expected to be in organization of perceptual material in the design.

The test is made up of two subtests: copy and memory tests. In normal children, the memory drawing often nearly duplicates the flat copy drawing, but shows better organization. Brain-injured children draw poorly from memory, possibly due to an inability to coordinate previously perceived isolated details. Failure to integrate details into a larger structure means they are not easily remembered. This requires extra effort from a child who has all too often experienced failure (Taylor, 1959).

For use with neurologically impaired children in this study, the task, as originally designed, was modified. Rather than request the subject to copy the design, using a pre-arranged sequence of colored pencils, the child was simply asked to use a #2 pencil to copy the figure onto an 8½" × 11" paper. Similarly, he was offered only the #2 pencil to draw the figure from memory.

As in the original study, the steps taken to complete the copy and memory portions of the test were of interest. The errors at each step are also important sources of information about the child's perceptual strategies. A scoring system developed by Taylor (1959), adapted from Osterreith, was used to assess the drawings.

For brain-injured subjects, one would look for a wider discrepancy between copy and memory scores than is found in normal populations. This is evidence of a fragmented or piecemeal approach to copying, dealing with smaller visual units and building up the figure, bit by bit. Other characteristics include omissions, perseveration, repetition of elements which had been copied, and a design element placed in a more familiar representation, e.g., making the circle with three dots into a face (Lezak, 1983).

Few subjects in the present study were able to draw the design from memory. Specific clusters of approaches to drawing the design were noted. In general, a brain-injured subject often begins by drawing the large central rectangle and details within it (left hemisphere damage). Or, he or she might approach the task by beginning with a detail and adding the remaining details in relation to the large rectangle (right hemisphere damage) (Lezak, 1983).

Scoring of this test has not been standardized on a large sample. However, it was felt that the data gathered during this study might be useful to other research which made use of this test. Approaches to drawing the Complex Figure Test might also bear a relationship to the three semi-structured tasks in the present study. Finally, similarities and differences could be studied between the Complex Figure Test and the Bender Visuo-Motor Gestalt Test.

Standard verbal directions are used, thereby insuring that the test could be repeated exactly. The remaining criteria, adaptation and interest to the subjects have not previously been tested. Therefore, new findings were possible on these two measures.

The Human-Figure-In-Action Drawing (HFIA) is designed for this study, based upon the Harris revision of the Goodenough Draw-a-Man test (Harris, 1963), the Koppitz Human-Figure-Drawing (HFD) test (Koppitz, 1968), and the Burns and Kaufman Kinetic-Family-Drawing (KFD) test (1972).

The purpose of this task is to collect, on a regular schedule, samples of the subject's rendering of the human figure. The human figure is a sensitive indicator of body image and of the child's sense of self. Koppitz indicates that human figure drawings are very useful as part of the test battery for assessing brain-injured subjects (Koppitz, 1968).

The subject is asked to draw the figure in action "doing something" to tap into his memory and imagination, and to elicit a result having greater affective quality.

The Goodenough-Harris scoring system (Harris, 1963) measures intellectual maturation in the child (Lezak, 1983). The Koppitz scoring system is sensitive to characteristics of brain injury and emotional factors. Both scales are developmental and are appropriate for use with children ages 5-12.

With respect to brain injury, Koppitz (1968) found that there are eleven Developmental Items on HFDs which

> ". . . may have implications for brain injury at one or more age levels. These items were:
>
> Omission of body (age 6 and up),
>
> Omission of pupils (age 7 and up),
>
> Omission of neck (age 10 and up),

> Omission of two dimensional arms (stick arms) (age 7 and up),
>
> Arms not pointing downward (arms horizontal or up) (age 10 and up)
>
> Arms incorrectly attached at shoulder (age 9 and up),
>
> Omission of hands (age 6 and up),
>
> Incorrect number of fingers (age 7 and up),
>
> Omission of two dimensions on legs (stick legs) (age 8 and up),
>
> Less than two pieces of clothing (age 7 and up),
>
> Less than four pieces of clothing (age 12 and up)" (Koppitz, 1968, p. 175).

Koppitz was also able to isolate eight emotional indicators which

> ". . . were found to occur more often in the HFDs of the brain-injured boys than on drawings of the Control Subjects. These were:
>
> Poor integration of parts of figure (ages 7-12),
>
> Gross asymmetry of limbs (ages 6 and 7 and up),
>
> Figure slanting by 15 degrees or more (ages 7, 10, 11),
>
> Transparencies (ages 7-12),
>
> Omission of body (age 6),
>
> Omission of neck (ages 10-12),
>
> Tiny figure, less than 2" in height (ages 6-8, 11-12),
>
> Hands cut off" (1968, p. 176).

According to Koppitz,

> The first six of these Emotional Indicators reflect immaturity, poor integrative capacity, impulsiveness, and instability, all of which are so characteristic of so many of the brain-injured children. The last two of the Emotional Indicators seem to reflect above all the brain-injured child's poor self-concept and his feelings of inadequacy and helplessness" (Koppitz, 1968, p. 176).

She cautions, however, against making a diagnostic judgment using only these items as criteria.

To further elicit emotional factors in the development of the subjects used in the present study, the children are given a choice of using either a #2 pencil or colored markers. The mode of color usage, realism of color, and affective use of color potentially could be tapped through this revision.

Ability to replicate the directions and scoring is ensured by standard verbal directions and quantitative scoring. Adaptation is scored on a developmental scale, since the human figure is often drawn by children. This, however, needs further testing as does the criteria about interest to the subjects.

Story-Sequence Drawing (SSD). In this task, the subject is asked to draw an episode containing at least four stages (a beginning, two middle stages and an end). He can use either pencil or colored markers to draw all stages on one 8½" × 11" paper or on separate papers.

This task is adapted for this study from an unpublished task developed by Kramer and is similar to one developed by Wilson and Wilson (1981).

Wilson and Wilson (1981) state:

> ". . . (of) children who were able to tell stories (often this is not achieved before the age of five or so) (Botvin, 1976), few were unable or unwilling to draw a story in the six frames—and sometimes as few as one frame or as many as twelve—it was the amazing variety of ways with which they chose to examine the most basic of life's themes that we found most exciting" (Wilson & Wilson, 1981, p. 75).

Although their research was conducted in the United States, Japan, Finland, Egypt, Australia and New Guinea, it was not conducted with neurologically impaired children. Their findings indicate four major themes: "slice of life," development (plants, birds growing up/dying), natural process (day-night, calm-storm), and a trial (test of strength, struggle, success, combat). They summarize: "Story drawings generally provide for a fuller, more complex and consequential mirror of an individual's conception of the four realities (common reality, archeological reality, normative reality, and prophetic reality—see Kreitler & Kreitler, 1972, p. 70) than can be achieved by single images" (Wilson & Wilson, 1981, p. 79).

If the child chooses to use color, it enhances the emotional tone of the story. Degrees of consistency of theme, style, and tone are evident from session to session, and with respect to the other tasks within each session.

The study tested categories of maturation, neurological impairment, and subject's degree of interest.

To determine whether this test can be replicated, verbal directions and both quantitative and qualitative scoring are used. Resistance to adaptation was also tested.

The Clay Figure, the final task, was the only three-dimensional task required of each subject. It is intended to tap into the child's ability to model a human or an animal. This task is necessary for purposes of assessing and confirming the developmental stage of the child. Younger children tend to work in an analytic style, often making a pancake figure, while older children use a synthetic style, and produce upright figures (Lowenfeld, 1957; Golomb, 1974).

Consistency or lack of consistency between this material which invited regression and the more cognitive controlled pencil might provide information about the child's emotional development. Sometimes three-dimensional work elicits differences in subject matter and more or fewer details, or attention to detail other than that elicited by two-dimensional work. The clay medium gives additional information about subjects whose perceptual deficiencies were subtle.

The works of Golomb (1974) and Lowenfeld (1957) were used to assess the sensitivity to maturation, the developmental level of the child, and the changes which took place over time.

The subjects were allowed to work the clay in either a flat or in an upright position. The pieces could be modeled using either the analytic or the synthetic method. The analytic method seems to be useful where a lot of detail is preferred. The synthetic method gives a more solid form, which can reflect body experiences and activate knowledge (Golomb, 1974). The analytic method is useful if only a vague form concept is available to the child. He needs to watch what he is doing in order to represent the object in mind. This may have some relationship to neurological impairment, when taken in context with other tasks.

Quantitative scoring and consistent verbal directions ensured that the task would be presented exactly the same way each time. Resistance to adaptation is to be determined by this study.

Procedure

Each of eight boys, diagnosed as having neurological impairment, were individually tested over a six-month period. A quiet room within the school was used at various hours during the school day. Sessions took place on two consecutive or two alternate days of one week per month. Length of sessions were from one-half to one hour with variations determined by the child's interest span, working style, and schedule. Verbal instructions for each task were given. The sequence of each task during the session was recorded, as were comments and behavior of the child.

A word needs to be said about the sequence of the tasks. As with any diagnostic procedure, the researcher, who was also the examiner, found that in each session the sequence of the tasks had to be adjusted to the particular child. Some subjects began with the Complex Figure Test, a structured task, and moved to the semi-structured tasks. Other subjects preferred to do the opposite. The quality or validity of the products did not appear to suffer from this flexibility in session strategy.

In each session, the examiner allowed the child to choose where he would sit. This varied from directly across from the examiner to the request that the examiner move to a distant part of the room. Seating positions are usually standardized for most testing procedures. To elicit the child's cooperation and best efforts the researcher found that highly sensitive subjects and highly distractible subjects required variations in the usual testing procedure.

At the first session, the examiner introduced herself and invited the subject to sit anywhere he wished within the classroom. The examiner explained that they would have two art sessions together that week, and that both would come back next month for two more art sessions. The sessions included copying tasks, some free drawing tasks and one clay task. The subject could do each of the activities once over the two-day period. Ample materials (paper, pencils, markers and clay) were visible to the child. Design cards were hidden from the child's view until they were used.

The Bender Visual-Motor Gestalt Test was administered first, on the initial day of the six-month period. The directions are: A sheet of 8½" × 11" white paper and three pencils with erasers are placed in front of the child. The examiner says: "I've got nine of these altogether (hold up the pack of cards with the back facing the subject). I'm going to show them to you one at a time and your job is (or 'you are') to copy them as exactly as you can. Here you go." (Lezak, 1983, p. 387). Place the card in front of the subject with the length running horizontally to him. When he finishes the drawing, the second card is placed on top of the first. Continue this way until completion. (If the child draws the design very large, and needs additional paper, supply them without comment). Usually one piece of paper is sufficient (Lezak, 1983). After a brief rest, the examiner invites the child to draw all the designs from memory. "Now I'd like you to draw all the designs you can remember on this sheet of paper."

This was followed by an invitation to do another copy task or free drawing or work in clay. Instructions for the Rey-Osterreith Complex Figure Test are: A sheet of white 8½" × 11" paper is placed horizontally in front of the child. Fresh pencils are offered. The figure is presented so its length is horizontal to the subject's horizontal plane. The examiner says: "Look at this drawing and try to copy it as well as you can. Try to make sure that you do not forget anything" (Taylor, 1959, p. 396). After the child is finished copying, the figure is removed and the examiner engages the child in light conversation for about three minutes. The child is then told: "I'd like you to draw that same design again, but without looking at the card." Often this is difficult for young children. The examiner closely watches the performance. She notes the sequence by drawing the image and numbering the sequence of the units or uses a copy of the design and numbers the sequence of the units. Arrows are drawn to indicate the direction each line is drawn.

For the Human-Figure-In-Action, the child is given a fresh sheet of 8½" × 11" paper, fresh pencils and a box of eight colored markers. He is instructed: "You can use pencil or markers to draw a picture of a person doing something. This can be a drawing of yourself doing something you like to do, or of a friend, or of an imaginary person."

Directions for the Story-Sequence are: a sheet of white 8½" × 11" paper, several pencils and a box of eight colored markers are placed in front of the child. The examiner says: "I'd like you to think of a story. The story should have a beginning, middle and an end. When you have thought of a story, I'd like you to draw each part of the story. You can use one paper, and divide it into boxes (demonstrate), or you can use several sheets of paper."

Some children verbally organize their story by telling it to the examiner before drawing, while other children begin drawing almost at once. Very confused children may need to be encouraged to tell the story out loud, and, with the examiner's assistance, decide what to illustrate.

For the Clay Figure directions a stick of plasticene is placed in front of the child on a cardboard base, 9" × 12". The examiner says: "Use this clay to make a human figure. It can be a boy or girl or man or woman, or an animal. You can use all the clay for one figure or break it into pieces and make several figures." Only one stick of plasticene is allowed for each subject.

Each child is allowed to choose the order in which tasks are completed. Tasks not attempted on the first day of the two-day session are presented on the second day.

This procedure was repeated each time, except that the BVMG was not administered after the first day of the period. At the end of each two-day session, the examiner explained that she would take pictures of the subject's work and she would return the work on her next visit. After the last session of the series, she returned the artwork to the subject's classroom teacher.

Observations and Discussion

The purpose of this study was to establish a battery of tasks for use with neurologically impaired children over a period of six months. The task battery included both structured and semi-structured activities. Seven criteria were identified as essential characteristics of each task. A quantitative analysis of the results was not obtained for this section of the study; that data will appear in a future paper.

(1) *Use of art materials*. All tasks used art materials: pencil, markers, paper and clay. As stated above, children experienced these as regular art sessions using regular art materials.

(2) *Interest*. The task battery proved to be of much interest to all eight subjects. Each subject eagerly looked forward to each session, and attendance was perfect. Subjects prized their art work and looked forward to taking it home. Most subjects were confused and disappointed that they could not attend sessions weekly, following a schedule similar to that used for their art classes. This suggests that the boys experienced the sessions as regular art periods, not as testing sessions. They accepted that the examiner could come to the school only on a monthly basis. No one task was preferred over another, although the order in which tasks were completed varied according to the child's choice.

(3) *Replication*. Directions and materials for each task were easily repeated each session. The only variation necessary was for the memory subtest of the Complex Figure Test. In this test the examiner offered the opportunity to draw from memory, but did not require reluctant subjects to attempt this section of the test.

Several subjects wished to rotate the Complex Figure Test card to a vertical position. This was gently, but firmly discouraged. Typically, there were changes in size of the design and strategies for drawing the design. Many subjects placed the drawing in different parts of the paper, corners, for instance. This was particularly interesting when the quadrant selected corresponded to that chosen for the Human-Figure-In-Action drawing.

The number of sheets of paper used in the Story-Sequence Drawing varied from subject to subject, and session to session. Subjects told stories of various lengths and complexity.

(4) *Allows for expressive work or enhances visuo-motor skills*. The Complex Figure Test challenged most subjects, stimulating the need to observe, organize and graphically reproduce the figure.

Similarly, organizational skills were necessary to express ideas in the figure drawing, clay and story. These last three tasks allowed room for free choice of themes and style of expression, from cartoon characters to attempts at representation. The non-technical materials were very familiar to the children, and needed no period of mastery which might inhibit expressiveness.

(5) *Adaptation*. While subjects remembered tasks from month to month, only one subject repeated the same Story-Sequence each time. All other subjects produced new products each time. Only the Complex Figure Test offered an opportunity for learning, but the Figure was so complex, it offered little chance for mastery.

(6) *Maturation*. Scoring for the Complex Figure Test, Human-Figure-In-Action, the Story-Sequence Drawing and Clay Figure are based on developmental scales. All tasks were structured to be sensitive to allow for variations in visuo-motor skill, interest, attention span and frustration tolerance of the age levels 6-12 years. In a time-series design, the subject's products and performance are measured against his own previous performance.

(7) *Sensitivity to neurological impairment and locus of lesion*. Quantitative data on this criteria will be reported in the second part of this report.

Other factors contributed to the success of the task battery. The balance between structured and semi-structured tasks provided enough choice for each subject within the sessions. This was particularly important for those subjects who needed to move from a stressful task to one which made fewer demands. This varied with each subject, with the Complex Figure Test difficult for some, and the Figure-In-Action difficult for others. The variety of materials provided opportunities for choices, as did allowing the children to choose the sequence of tasks.

The variety of tasks allowed for the exploration of many or few ideas, changes in themes or the use of one theme. There was enough diversity to hold the children's interest over the six-month period. The Complex Figure Test remained challenging to all subjects, despite repeated administrations.

The study was not without flaws. One of the major problems was that the six-month period was too short. When looking for potentially dominant trends in the child's development, the tasks need to be highly sensitive to small changes as indicators of change or maturation. Since much of the material brought to each session could be influenced by events in the child's life at home or school, it would have been desirable to keep records of the events throughout the testing period. This might have provided clues to changes in themes, choice of materials or frustration tolerance.

Conclusions and Recommendations

This study suggests that a single subject time-series design for a change-over-time study can be a valuable and useful research tool for art therapists. It can be used with a heterogeneous population of neurologically impaired boys. A task battery of structured and semi-structured activities can sustain the interest of subjects over a six-month period, and the tasks are resistant to adaptation. This is a valid method of conducting research, and has particular application to clinical settings where art therapists work with individuals over medium to long periods.

The time-series design can be used to test the effectiveness of therapeutic intervention within the treatment period. Using the task battery as a dependent variable, we can gauge the effects of different art materials. For instance, water-based clay may be substituted for oil-based clay to gauge regression and recovery from regression, or black paper and white pencil may be substituted to gauge the effect on visual organization (Uhlin & Dickson, 1970; May, 1978; St. John, 1979).

Empirical study of the client during treatment is still necessary. The time-series design appears to be a useful addition to our methods of treatment evaluation. It is hoped that this study will stimulate interest in the time-series design not only for neurologically impaired populations, but also for any population treated by art therapists.

References

Bender, L. (1938). *A visual motor gestalt test and its clinical use*. The American Orthopsychiatric Association Research Monograph No. 3.

Botvin, G. Jr. (1976). *The development of narrative competence: A syntagmatic analysis of children's fantasy narratives*. New York: Columbia University. Doctoral dissertation.

Burns, R. & Kaufman, S. (1972). *Actions, styles and symbols in kinetic family drawings (K-F-D): An interpretive manual*. New York: Brunner/Mazel.

Campbell, D. & Stanley, J. (1966). *Experimental and quasi-experimental designs for research*. Chicago: Rand McNally.

Cohen, B., Hammer, J., & Singer, S. (1988). The Diagnostic Drawing Series: A systematic approach to art therapy evaluation and research. *The Arts in Psychotherapy, 15*(1), 11-21.

Golomb, C. (1974). *Young children's sculpture and drawings: A study in representational development*. Cambridge, MA: Harvard University Press.

Harris, D. (1963). *Children's drawings as measures of intellectual maturity: A revision and extension of the Goodenough Draw-A-Man test*. New York: Harcourt, Brace and World, Inc.

Hays, R. & Lyons, S. (1981). The Bridge Drawing: A projective technique for assessment in art therapy. *The Arts in Psychotherapy, 8*, 207-217.

Koppitz, E. (1975). *The Bender-Gestalt test for young children, Volume II: Research and application 1963-1973*. New York: Grune and Stratton.

Koppitz, E. (1970). Brain damage, reading disability and the Bender Gestalt test. *Journal of Learning Disabilities, 3*, 429-433.

Koppitz, E. (1968). *Psychological evaluation of children's human figure drawings*. New York: Grune and Stratton.

Kramer, E. & Schehr, J. (1983). An art therapy evaluation for children. *American Journal of Art Therapy, 23* (1), 3-12.

Kreitler, H. & Kreitler, S. (1972). *Psychology of the arts*. Durham, NC: Duke University Press.

Kratchowill, T. (1978). *Single subject research: Strategies for evaluating change*. New York: Academic Press.

Kwiatkowska, H. (1978). *Family therapy and evaluation through art*. Springfield, IL: Charles C Thomas.

Lezak, M. (1983). *Neurological assessment*. New York: Oxford University Press.

Lowenfeld, V. (1957). *Creative & mental growth* (3rd edition). New York: Macmillan Company.

Malchiodi, C. (1990). *Breaking the silence: Art therapy with children from violent homes*. New York: Brunner/Mazel.

Marley, M. (1982). *Organic brain pathology and the Bender Gestalt test: A differential diagnostic scoring system*. New York: Grune and Stratton.

May, D. (1978). The effects of color reversal of figure-ground drawing materials on the drawing performance of cerebral palsy and normal children. *Exceptional Children, 44* (4), 254-259.

Miljkovitch, M. & Irvine, G. (1982). Comparison of drawing performances of schizophrenic, other psychiatric patients and normal school children on a Draw-A-Village task. *The Arts in Psychotherapy, 9* (3), 203-216.

Mills, A. & Goodwin, R. (1991). An informal survey of assessment use in child art therapy. *Art Therapy: Journal of the American Art Therapy Association, 8* (2), 10-13.

Osterreith, P. (1944). Le test de copie d'une figure complexe. *Archives de Psychologic, 30*, 206-356.

Rey, A. (1941). L'examen psychologique dans les cas d'encephalopathic traumatique. *Archives de Psychologic, 28*, (112), 286-340.

Rosal, M. (1989). Masters' papers in art therapy: Narrative or research case studies? *The Arts in Psychotherapy, 16* (2), 71-75.

Rush, J. & Kratchowill, T. (1981). Time-series strategies for studying behavior change: Implications for research in visual arts education. *Studies in Art Education, 22* (2), 57-67.

St. John, P. (1982). Developmental changes in the art of the neurologically impaired child: A change-over-time study. In di Maria, A., Kramer, E., & Roth, E. (Eds.) *Proceedings of the thirteenth annual conference of the American Art Therapy Association* (pp. 113-137). Reston, VA: AATA.

St. John, P. (1979). *Effects of a remedial art program for visuo-spatial-motor skills on drawings by neurologically impaired children: A multi-case study*. Ann Arbor, MI: University Microfilms International #313130.

Silver, R. (1990). *Silver drawing test of cognitive skills and adjustment*. Sarasota, FL: Albin Press Distributors.

Silver, R. (1988). *Draw-A-Story: Screening for depression and emotional needs*. Sarasota, FL: Albin Press Distributors.

Taylor, E. (1959). *Psychological appraisal of children with cerebral defects*. Cambridge, MA: Harvard University Press.

Ulman, E. (1975). A new use of art in psychiatric diagnosis. In Ulman, E. and Dachinger, P. (Eds.) *Art therapy in theory and practice* (pp. 361-386). New York: Schocken Books.

Uhlin, D. & Dickson, J. (1970). The effects of figure-ground reversal in H-T-P drawings by spastic cerebral palsied children. *Journal of Clinical Psychology, 26*, 87-88.

Ulman, E. & Dachinger, P. (Eds.) (1975). *Art therapy in theory and practice*. New York: Schocken Books.

Wilson, M. & Wilson, B. (1981). Dimensions of meaning in children's story drawings: From theory to therapy. In di Maria, A., Kramer, E., and Rosner, I. (Eds.) *Proceedings of the twelfth annual conference of the American Art Therapy Association* (pp. 69-80). Falls Church, VA: AATA.

BEST COPY AVAILABLE

Art Therapy. Journal of the American Art Therapy Association, 9(2) pp. 78-84 © AATA, Inc. 1992

Art Therapy and Self-Esteem

Michael Franklin, M.A., A.T.R., Director, Art Therapy Program School of Art, Bowling Green State University, Bowling Green, OH.

Abstract

The impact of creating art and how this process relates to the elevation of self-esteem is often taken for granted by professionals in both art therapy and other fields. While there is little doubt concerning the validity of this relationship, there does seem to be a lack of research and a lack of understanding concerning this issue. All too often the subject of self-esteem is loosely defined, resulting in an oversimplified view of its meaning. This paper discusses ideas from literature on self-esteem that relate to both the art making process and overall treatment goals targeted in an art therapy setting. The art component of art therapy is stressed throughout since it is believed that an isomorphic relationship exists between specific features of self-esteem and this central component of our work.

Curiously enough, as a specific topic of research self-esteem has received minimal attention in the art therapy literature. Art therapists intuitively observe that a strong connection exists between art therapy, the art making process and self-esteem, but few have attempted to describe these relationships in detail. All too often art therapists seem to take it for granted that producing art is good for us and that it automatically contributes to various therapeutic goals such as the elevation of self-esteem. However, when asked to clarify these beliefs, people often struggle to define their terms. In short, there is more to the subject of self-esteem than convenient intuitive explanations.

Given the likelihood that the majority of mental health treatment facilities would almost always target self-esteem as a major goal of treatment, it is important to identify how art therapy can contribute to this universal clinical topic. Also, self-esteem issues permeate every aspect of society and go well beyond the boundaries of the clinical setting. Investigating and solving the nation's most prominent social problems almost always, in part, boil down to a discussion on the subject of self-esteem. Concern about self-esteem is growing, particularly in states like California where a massive endeavor is underway to study and implement self-esteem strategies to promote social change (Mecca, Smelser & Vasconcellos, 1989).

The ideas described in this paper will address the relationship that exists between self-esteem, creating art, and art therapy. Examining the connections between these themes will hopefully set in motion further dialogue and research on this topic.

Definitions of Self-Esteem

Endless definitions surface when investigating the meaning of self-esteem. The subject is easily complicated due to the many ideas contained within this two word title. To begin with, the term "self" has multiple interpretations, each valuable, but potentially different from the other. There is the true and false self outlined by Winnicott (1965). Jung described the central importance of the self archetype (Campbell, 1971); Kohut (1977) and other authors (Berger, 1987) have yet another viewpoint on the subject. Rather than focus on libidinal drives, they adopted the term "self object" which referred to functions that augment the development of a sense of self (Berger, 1987).

Other definitions emerge when cultural perspectives of self are considered. For example, Eastern viewpoints often conceptualize the abstraction of self in totally different terms from Western authors (Fontana, 1987; Marsella, Devos & Hsu, 1985). Purkey and Schmidt (1987) define self as the summation

---

Editor's note: This paper was presented in slightly different form at the 1987 AATA Conference in Miami Beach, Florida.

of a multi-dimensional system consisting of various learned beliefs, covering the total range of personal perceptions and self evaluations. These viewpoints are perceived as truths that ultimately define the meaning of personal existence and personality structure.

Self-esteem is perhaps the most familiar subject within the umbrella topic of the self-concept. Whereas self-concept is equated with identity, self-esteem refers to self evaluation and is often understood as a strong appreciation of oneself. Thus, trusting in personal abilities and developing an attitude of self-worth is at the core of an elevated sense of self-esteem.

Researchers generally agree that self-esteem equates with personally generated evaluations of worthiness (Coopersmith, 1967). These self appraisals can take many forms ranging from transitory to enduring. It is the well-anchored, enduring sense of belief in one's unique personal qualities that therapists hope to buttress and solidify. In general, self-esteem is viewed as a condensation of self-evaluative processes that define a sense of personal worth.

The formation of self-esteem has several sources. Making sense out of how others perceive us and value our contributions is one; for example, harsh external appraisals can create a damaged internal sense of self-worth. Observations from others of actual behavior versus personal interpretations of behavior can cause distortions in the perception of personal worthiness. Add to these factors the ingredients of social class, race and culture and the equation grows in terms of contributing factors to the formation of self-esteem.

Descriptions of self-esteem are easy to come by, however, explaining it continues to challenge researchers. Jackson (1984) describes the inherent problems associated with methods often employed in psychological research. All too often empirical research reduces personal meaning into fragments for study. Jackson strongly favors the interviewing format as a research model since it makes an effort not to reduce or distort the subjective experiences of another. Offering individuals the opportunity to tell their own stories within a carefully structured format lessens the chances for distortion of the original message. Although there are merits to this procedure, of course, there are also shortcomings. For example, observer bias could easily influence the information compiled.

According to Knapp (1973) and Coller (1971) most research instruments used to study self-esteem fall into combinations of the following four categories: behavioral trace reports, direct observations, projective techniques, and self-reports. Each has its merits and limitations. The procedure that Jackson advocates, in essence, is aligned with the work already carried out by most art therapists. When creating art one can not help but look inward and participate in decision making that is targeted at the resolution of various emotional and cognitive processes. Since projection and the subjective experience occupy a central role in the creation of art, and art therapists usually process the content of client art work through the interviewing procedures that Jackson describes, art therapy can become a forum in which to study self-esteem.

The Metaphor of Creating Art and Self-Esteem

Many authors who write about art therapy describe terms that relate to the subject of self-esteem. Landgarten (1981) talks about art as evidence of an assertive self-directed act. Rhyne (1973) describes the Gestalt art experience as allowing for the discovery of what makes people unique. Wadeson (1980) refers to art therapy as a "doing" form of therapy that activates creative potential. Rubin (1984) mentions how art serves as a concretization of the internal self. It is a way for people to say "me" or "I" or "I do" or "I can do" (p. 193). Erikson (1979) has reflected on the therapeutic merits of art materials and how they offer self-integrating experiences. Both Ulman (1975) and Kramer (1958, 1971) discuss the therapeutic opportunities for healthy self-involvement offered by active engagement with the art making process.

Additionally, there are many similarities between the topics of the art making process and life's processes. The unformed materials, much like the notion of the tabula rasa, begin to take shape as the artist engages in a decision-making process that documents change. To work with art materials is to transform their physical and symbolic potential. Thus, art may be considered a simultaneous process of reformulating the self through the active formation of an object.

Also, the art making process may be compared with the stages of human development. Working from the infancy of the empty page to the adulthood of the final product allows for the exploration of clinical and developmental themes from several perspectives. The first relates to the physical evolution of a work of art and how it parallels developmental models of growth. Another perspective can be observed when unresolved issues from the past surface during specific stages of the creative process, thus presenting a tangible means to confront those issues. Active participation in the balancing of tensions that naturally surface during this process facilitates self transformation.

Lastly, there is the opportunity to conceive, incubate and birth an idea towards conception through art making. These forces and how they operate have been discussed by various artists. For example, Paul Klee referred to art as a metaphor of the "creation." He saw an analogy between the laws governing universal processes in nature and how these same processes are reproduced in the artist (Grohmann, 1987). In addition to Klee, Max Ernst, while painting, felt as if he was a witness to a birth that he had created (Winner, 1982).

Self-Esteem, Empowerment and Art

Lack of self-empowerment is often present in the lives of people with a fragile sense of self-esteem. One of the major strategies often employed when dealing with self-esteem is helping people to become assertive and gain a sense of power over their lives (Mecca, Smelser, & Vasconcellos, 1989). Allowing clients to create their own images and participate in their unfolding contributes to the theme of empowerment. This is especially true when we consider how art objects can serve as a worthy substitute for the missing or absent "real thing" (Arnheim, 1980, p. 249).

When the process of making art is completed, a product exists that is unique and one of a kind. Reifying that which did not exist before, and will never exist in that exact same form again, validates and empowers the uniqueness of the person. Making an object out of an idea puts a powerful tool in the hands of a person who feels fragile and unworthy (Regelski, 1973). Objectifying subjective experiences creates a climate where the darkest internal events can be given form, contemplated, and eventually understood (Langer, 1964).

Art can become a safe place where the old self can be confronted and the new self rehearsed. Participating in this process, in spite of the personal pathology encountered, gives rise to a sense of accomplishment that can be affirmed by the environment (viewer), other (art therapist), and self. The narcissistic gratification that is experienced provides steam to pursue further efforts in spite of the injurious views of the self that are encountered (Kramer, 1971). In essence we are rewarded by the visual gift that we create for ourselves (Rhyne, 1973).

Art making provides the possibility to explore with clients how they value themselves by observing what is invested of themselves in their art work and how they respond to it. Confrontation with these attitudes provides a context in which to change them. People are in the unique position when in the art therapy room to experiment, to make mistakes that eventually transcend these previously held viewpoints. Within the safety of the therapeutic environment and the forgiving qualities of the materials, failures can be experienced and eventually tolerated. Readjusting perceptions of external and internal criticisms is possible due to the many safe opportunities to visually form and contain conflicts. The materials communicate reliability and possibility, while the art therapist conveys empathy, tolerance and acceptance.

Altering the many harsh internal assessments which in part are based upon perceived failures and ultimately replacing them with a new perspective is a major component of an effort to elevate self-esteem. Also, the art making process appears to be accessible to a variety of age groups and populations. It is also compatible with a high degree of pathology and people who are fragile in this area can usually participate on some level (Kramer, 1971).

Coopersmith (1967) mentions that self-esteem implies characteristics such as the ability to direct behavior, make decisions and take risks. In essence, he is describing behavior that constitutes the art making process. Goals of treatment in therapy almost always include enhancing the capacity for self mastery, individuation, empowerment, assertiveness, and participation within social support systems (Mecca, Smelser & Vasconcellos, 1989). These goals for psychotherapy mentioned typify the art making process and permeate all facets of the art therapy process. Individuation is also enhanced as one sorts out issues of self, ultimately encouraging self empowerment through the visual formation of emotionally loaded material. To create something and ultimately confront that creation, even if it represents traumatic material, allows one to reabsorb the event in a restructured form. Viewing these self-directed visual solutions demonstrates that internal chaos can be formed and redefined often without overwhelming the client. Self mastery, empowerment and assertiveness become possible as the ego recognizes victory over once elusive and frightening internal forces.

In addition to these events, audience response becomes a crucial and integral part of this process as well. Group members or staff can offer feedback; involvement of this type results in opportunities for social support and peer acknowledgement.

Self-Esteem and Relationships

Relationships, perhaps the primary area where self-esteem issues would manifest, can also be addressed through the metaphor of art. The subject of relationships is quite potent when we consider how programmed our culture is to expect immediate gratification when involved with interpersonal encounters. Between anticipating polished images to appear on drawing paper as quickly as they do on television and the inclination to change relationships as quickly as we change TV channels, youth in particular are influenced to expect unreasonable results. A double bind exists when youth feel pressed to construct personal imagery as polished as printed or electronic media. The result of such encounters produces inevitable confrontations that expose personal inadequacies and unrealistic expectations.

Additionally, dysfunctional relationships also impact self-esteem. Oates and Forrest (1985) observed that abusive parents often came from dysfunctional backgrounds, avoided other people to discuss problems with, had poor regard for their partners, abused their young and shared the major contributing factor of low self-esteem. Similarly, Oates, Forrest, and Peacock (1985) matched 37 abused children with the same number of nonabused children and found there to be a significantly low self-concept, reduced ambition, and fewer friends amongst the abused children. Self-esteem, the much needed "social vaccine," is often absent in the appropriate doses from the social structure of our culture (Mecca, Smelser & Vasconcellos, 1989). Relationships are certain to suffer, and in many cases are destined to fail when self-esteem is damaged.

While it is too much to ask that art therapy fix these societal problems, it is not beyond the scope of our field to address them. The theme of relationships, on a metaphoric level, permeates all dimensions of the art therapy process. Within the metaphor of art, rehearsal of relationship building skills can be subtlely exercised between art therapist, client, materials, product and audience. Simultaneous triadic interactions (Figure 1) engage these themes in such a way that allows for safe encounters with art products and people. Relationships are formed with the art therapist, the materials, the evolution of the art object, and the viewer concurrently.

Personal vulnerabilities will naturally affect both the metaphoric theme of relationships within the art process as well as interactions with the therapist. Pride and shame, two primary emotions currently associated with self-esteem, often dictate the terms of any fragile relationship (Mecca, Smelser & Vasconcellos, 1989). Pride equates with high self-esteem and shame with low self-esteem. Perceiving oneself in negative terms creates a context for shame to grow. Unacknowledged shame almost always evolves into anger and, ultimately, rage and violence. The mask of anger skillfully covers the felt shame. Strategies to manage anger and acknowledge shame, both strongly avoided emotions, are key elements in developing self-esteem (Lewis, 1971).

Allowing for hidden shame to be seen in the context of the art work fosters safe encounters with a potentially painful subject. Through art, safe psychic and physical distancing from the visual manifestations of shame is available to the client. As the client responds to each new art production, old patterns can be redefined and new attitudes developed which can eventually lead to a sense of personal worthiness.

Comfort in making choices can also be enhanced. Clients often express their inability to choose, feeling a paralysis of will. When sitting with clients in sessions I often count to myself the many decisions that went into their art work. Once finished, we both count the many choices that had to be made. Perceived weaknesses around the theme of making decisions are gently confronted, demonstrating their power to choose. Witnessing these themes through the challenge of the art making can then be generalized to other areas of daily living and eventually incorporated into the clients' internal resources and personal strategies.

Clinical Encounters With Art and Self-Esteem

I have witnessed repeatedly the growth enhancing possibilities inherent in the process of creating art, both in myself and with clients. Growth, as it relates to self-esteem, is usually used to define features of success and triumph. However, failure and struggle also often contribute a great deal to art work and the development of self-esteem and personal growth. The hard work and the degree of self-confrontation involved in the art making process places unusual demands on all facets of the personality (Kramer, 1971).

Internal assessments concerning choices and de-

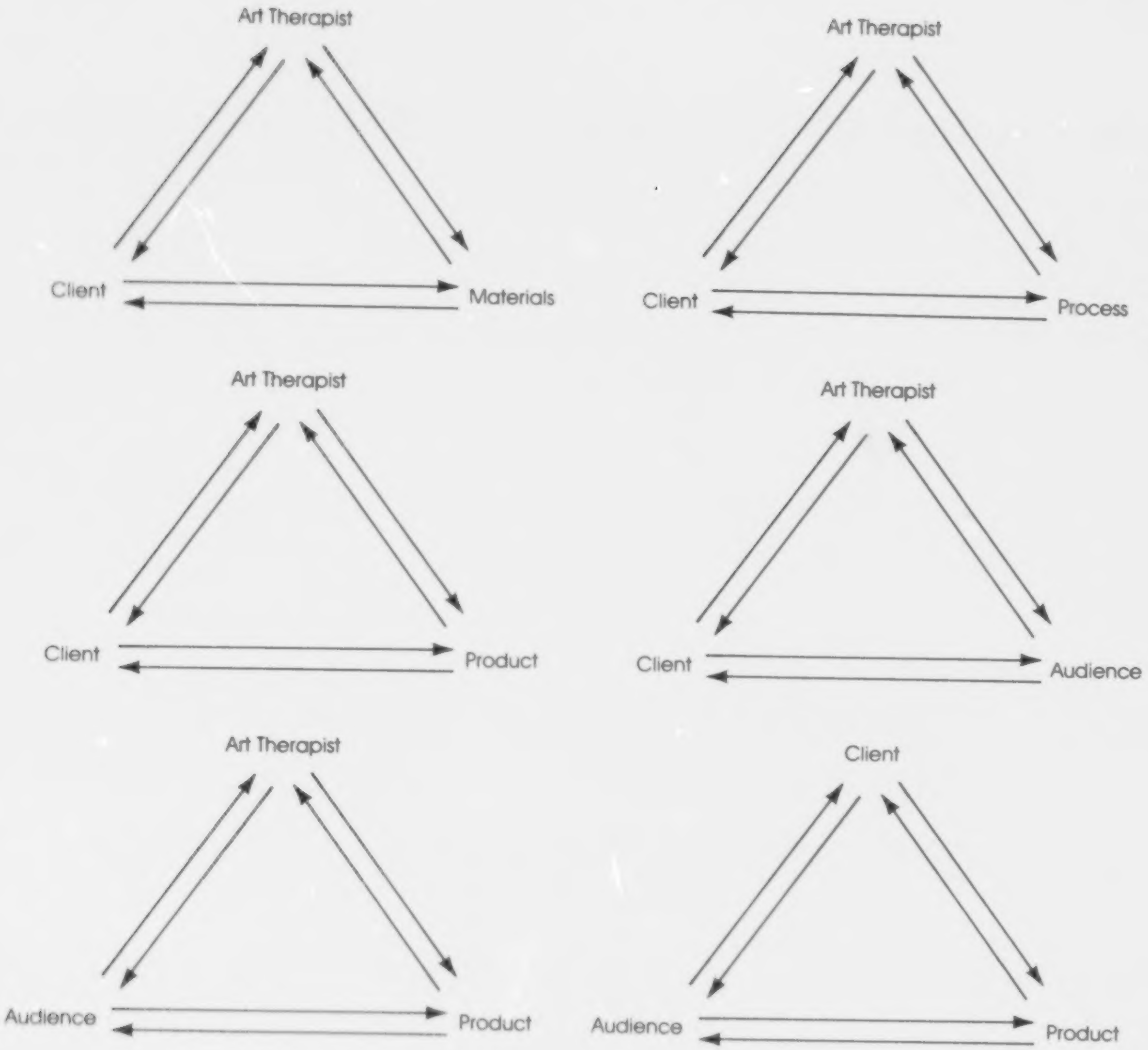

Art Therapist
Client
Materials
Art Therapist
Client
Process
Art Therapist
Client
Product
Art Therapist
Client
Audience
Art Therapist
Audience
Product
Client
Audience
Product

Fig. 1

cisions coexist with the eventual external assessments from viewer and audience. To create art is to exist in a transparent state. The self is eventually externalized through visual imagery for an audience to respond. The continuum of acceptance and rejection becomes an inescapable feature of all art work, thus creating inevitable repercussions for self-esteem issues. In short, the process invites endless opportunities for a string of encounters with success and failure, acceptance and rejection.

From a personal perspective I know several artists who have given up their work due to the pressure of their efforts to confront their visions. Clients are susceptible to the same pressures as the working artist, although it is not always apparent. They also struggle with constant self-evaluations and audience assessments. When working with clients I have found that one of my most indispensable tools as an art therapist has been my identity as an artist. It is through this lens that I can truly empathize with clients during their visual struggles to form their pain or passion (Franklin, 1990). Just like learning to become a therapist involves personal experiences in therapy as a client, so too does becoming an art therapist involve consistent encounters with art materials and their possibilities.

Case Example

Tim was a sophomore in college with a history of poor grades who struggled with relationships. He was still dealing with his anger and confusion around a turbulent divorce during his teenage years. In addition to his family problems, Tim also had difficulty with his studies due to dyslexia and problems organizing visual/spacial relationships on a printed page. All of these emotionally loaded issues developed into severe feelings of anxiety that greatly affected his school work and social life. As his grades fell in college and certain friendships began to dissolve, he decided to seek out therapeutic services at a counseling center. Traditional verbal psychotherapy was tried, but never really succeeded in meeting his needs. A couple of therapists were consulted, each finding Tim to be an unmotivated client. Between his many no-shows and what appeared to be a lack of motivation for treatment, art therapy was suggested.

I heard about his resistance, but as always, wondered how much was due to the client and how much was due to the therapist. It seemed important that I meet him at his model of the world (how he constructs meaning out of his experiences). I interviewed him during our first session about his various interests, talents, and beliefs, in short, his strengths. For the most part he denied any special abilities, except for his love of the flute. This was pertinent information since an understanding of self-esteem is usually arrived at by perceiving a synthesis of the many activities that a person participates in. One could be an average cook, excellent athlete, poor student, etc., weigh all of these experiences together, and come up with a general evaluation of personal worthiness (Coopersmith, 1967). Tim was clear that he felt inadequate in several areas, however, not with the flute. Here was my in or point of entry—the flute provided us with a context that was familiar and valued by him. If we were to be successful, then I would have to meet him through his source of pride. Balancing the pride with what often feels to be overwhelming shame, creates a forum for integrating these strongly felt paradoxical experiences. The language of the flute was to support our search.

Themes were selected each week that Tim felt strongly about; most centered around personal and family relationships. He was invited to create a musical composition which focused on each theme. Once finished Tim was then asked to make a drawing based on each flute composition. The results were astonishing. During our sessions he would play his flute compositions filling the space of the therapy room and beyond with his music. The overall quiet that regulated each of the therapy sessions was complemented by his gifted melodies.

Tim was excited at the results he was finally experiencing. By addressing his dominant auditory and visual senses and communicating through his familiar vocabulary of music, Tim started to make meaningful connections. Finding power in his ability to formulate his experiences through music and art, Tim began to experience his feelings and organize his thoughts in new ways. The pleasure of playing the flute allowed him to find strength and cross over into those hurtful areas of pain and doubt. Discovering new ways to restructure old perceptions, Tim began to develop a growing sense of confidence. Empowered by these evolving perceptions, Tim also had new tools to take charge of his life. He still had difficulties with family and personal relationships; however, he now had a new way of looking at their meaning and listening to their impact.

Conclusion

Creating art is hard work that takes courage. The shadow of failure always accompanies one along

BEST COPY AVAILABLE

the way—there are no guarantees. Through the metaphor of visual art, art therapists offer a variety of processes that are isomorphic with basic life struggles and challenges. Therefore, careful thinking about the entire art making process should be a tireless pursuit that engages all art therapists. Focusing on the points highlighted in this article is especially relevant to the practice of art therapy. Although it is difficult to prove, researchers feel that self-esteem is a significant precondition for creative work (Coopersmith, 1967). In order to participate in the art process, self-esteem, in some measure, must be present. As art therapists we need to grasp the subject of self-esteem beyond intuitive beliefs. By understanding the nature and development of self-esteem we can enhance it in our clients, in part, by offering the rich metaphor of art. Given the magnitude of self-esteem in therapy and our unique vantage point as art therapists, there is much that we can offer to this universal clinical topic.

This article is dedicated to the memory of Elinor Ulman.

References

Arnheim, R. (1981). Art as therapy. *The Arts in Psychotherapy, 7*, 247-251.

Berger, D. (1987). *Clinical empathy.* Northvale, NJ: Jason Aronson Inc.

Campbell, J. (Ed.). (1971). *The portable Jung.* New York: The Viking Press.

Coller, A. R. (1971, July). The assessment of self concept in early childhood education. *ERIC Clearinghouse on Early Childhood Education.*

Coopersmith, S. (1967). *The antecedents of self-esteem.* San Francisco, CA: W. H. Freeman and Company.

Erikson, E. (1963). *Childhood and society.* New York: W. W. Norton and Company Inc.

Erikson, J. (1979). The arts and healing. *American Journal of Art Therapy, 18*, 43-48.

Fontana, D. (1987). Self-assertion and self-negation in Buddhist psychology. *Journal of Humanistic Psychology, 27*(2), 175-195.

Franklin, M. (1990). The esthetic attitude and empathy: A point of convergence. *American Journal of Art Therapy, 29*(2), 42-47.

Grohmann, W. (1987). *Klee.* London: Thames and Hudson, Ltd.

Jackson, M. (1984). *Self-esteem and meaning: A life-historical investigation.* Albany, NY: State University of New York Press.

Knapp, J. (1973). *A selection of self-concept measures.* Princeton, NJ: Center for Statewide Educational Assessment.

Kohut, H. (1977). *The restoration of self.* New York: International Universities Press.

Kramer, E. (1958). *Art therapy in a children's community.* New York: Schocken Books.

Kramer, E. (1971). *Art as therapy with children.* New York: Schocken Books.

Landgarten, H. (1981). *Clinical art therapy: A comprehensive guide.* New York: Brunner/Mazel Inc.

Langer, S. (1964). *Philosophy in a new key: A study in the symbolism of reason, rite, and art.* Cambridge, MA: Harvard University Press.

Lewis, H. (1971). *Shame and guilt in neurosis.* New York: International Universities Press.

Marsella, A., Devos, G., & Hsu, F. L. K. (1985). *Culture and self: Asian and Western perspectives.* New York: Tavistock Publications.

Mecca, A., Smelser, N., & Vasconcellos, J. (1989). *The social importance of self-esteem.* Berkeley, CA: University of California Press.

Oates, R. K., & Forrest, D. (1985). Self-esteem and early background of abusive mothers. *Child Abuse and Neglect, 9*, 89-92.

Oates, R. K., Forrest, D., & Peacock, A. (1985). Self-esteem and abused children. *Child Abuse and Neglect, 9*, 159-163.

Purkey, W. & Schmidt, J. (1987). *The inviting relationship: An expanded perspective for professional counseling.* Englewood Cliffs, NJ: Prentice Hall.

Regelski, T. (1973). Self actualization in creating and responding to art. *Journal of Humanistic Psychology, 13*(4), 57-68.

Rhyne, J. (1973). *The Gestalt art experience.* Monterey, CA: Brooks/Cole Publishing Company.

Rubin, J. (1984). *The art of art therapy.* New York: Brunner/Mazel, Inc.

Ulman, E., & Dachinger, P. (1975). *Art therapy in theory and practice.* New York: Schocken Books.

Wadeson, H. (1980). *Art psychotherapy.* New York: John Wiley and Sons Inc.

Winner, E. (1982). *Invented worlds: The psychology of the arts.* Cambridge, MA: Harvard University Press.

Winnicott, D. W. (1965). *Maturational processes and the facilitating environment: Studies in the theory of emotional development.* New York: International Universities Press.

Art Therapy: Journal of the American Art Therapy Association, 9(2) pp. 85-92 © AATA, Inc. 1992

Brief Reports

Gender Differences in Drawings:

A Study of Self-Images, Autonomous Subjects, and Relationships

Rawley Silver, Ed.D, A.T.R., HLM, Sarasota, FL

Abstract

This paper reports a study of gender differences in drawings by 261 school children responding to a projective drawing task. Their responses are examined for concepts of self-sufficiency or connectedness with others in an attempt to find answers to three questions: Do children tend to identify with the subjects of their drawings by choosing principal subjects of the same gender as themselves? Do boys tend to represent autonomous subjects in their drawings? And, do girls tend to represent subjects interacting with others?

Drawings and titles are examined first for the genders of their principal subjects, comparing them with the genders of the children who chose them. Also, the drawings are examined for subjects acting alone or independently, and for subjects interacting with others.

A previous study by the author found significant differences in drawings by males and females across four age groups: third graders, high school seniors, adults, and the elderly. The men and boys in the sample tended to portray the world as threatening and their principal subjects were portrayed as fighting back and overcoming dangers. The women and girls, however, received nearly identical scores for the principal subjects and environments they portrayed (Silver, 1987).

The present study is an attempt to amplify and clarify the previous findings by addressing one of the four age groups, children primarily 8-9 years of age, and asking the following three questions:

1. *In responding to a drawing task, do children tend to identify with the subjects of their drawings by choosing principal subjects of the same gender as themselves?*

   It is often assumed that children and adults represent themselves, directly or indirectly, when responding to projective drawing tests. To obtain quantitative information about the degree to which principal subjects represent self-images, drawings by 261 children were examined, comparing their genders with the genders of the subjects they choose, and taking into account the subjects of sentences and the use of pronouns.

2. *Do boys tend to represent autonomous subjects in their drawings?*

   Autonomous subjects are defined as people or animals who act independently and appear self-sufficient. They may be the only subject of a drawing or appear indifferent to other subjects. In the previous study, the subjects portrayed by boys tended to live in threatening environments, but managed to escape from dangers, as illustrated in Figure 1. Scored on a rating scale ranging from 1 point (strongly negative) to 7 points (strongly positive), the mean score of their principal subjects was 4.1; environments, 2.9.

3. *Do girls tend to represent subjects interacting with others?*

Editor's note: Readers who may be interested in joining future studies are asked to contact Rawley Silver, ℅ 3332 Hadfield Greene, Sarasota, FL 34235

Although the subjects portrayed by girls in the previous study also lived in threatening environments, they tended to interact with other subjects, but not escape, as shown in Figure 2. The mean score of their principal subjects was 2.8; environments, 2.9*.

Gilligan, Ward, and Taylor (1988) find gender-related perspectives for organizing thoughts and feelings in two modes of moral judgment: the feminine mode based on concepts of care and responsibility to others and the masculine mode based on concepts of detachment and self-sufficiency. Different ways of viewing the world yield different ways of perceiving and solving problems. In our culture, the ideal of childhood development is seen from the masculine perspective, equating maturity with self-sufficiency and equating deficiency or immaturity with interdependence. These authors challenge the male ideal, suggesting a concept of morality centered on care and responsiveness to others. From the feminine perspective, there are close relationships between concepts of self and of morality as evident in the relationships of self to others. It is observed that woman's sense of self is built around connections with others, and loss of connection is experienced as a loss of self (Miller, 1976).

Procedures

The present study examines responses to a drawing task for concepts of self-sufficiency or connectedness with others. Drawings can express concepts of self and attitudes toward others, providing an additional context for assessing gender differences.

The drawings assessed here were produced in response to the *Drawing from Imagination* task of the *Silver Drawing Test of Cognitive Skills and Adjustment* (Silver, 1983, 1990). In this task, examinees are asked to choose two drawings from 15 stimulus drawings, imagine something happening between the subjects they choose, then draw a picture about what is happening. When they finish drawing, they are asked to give titles to their drawings. The stimulus drawings consist of line drawings of people, animals, and things, six of which are shown in Figure 3. The remaining stimulus drawings include sketches of a girl, man, woman, dog, cat, bug, refrigerator, TV, and bed.

Responses to the task were examined first for the genders of their principal subjects, comparing them with the genders of the individuals who chose them. Next, responses were divided into two categories: autonomous subjects acting alone or independently, and relationships, principal subjects interacting with others. Responses are scored on a 5-point rating scale adapted from a scale in the *Silver Drawing Test* as shown in Table I.

Subjects

Subjects for this study included 261 children, 145 boys and 116 girls, ages 7 to 10, selected from eight elementary schools. Previously, these children had responded to the *Silver Drawing Test* when it was administered to children and adults in order to develop normative data and determine test reliabili-

Table I

Autonomous Subjects vs Relationships: Rating Scale for Assessing Drawings

Score	Autonomous Subject	Relationships (may be implied)
1 point:	seems depressed	life-threatening or violently assaultive
2 points:	angry, fearful, unfortunate, or displeased	unfriendly, stressful, destructive, or aggressive humor
3 points:	ambiguous or ambivalent	ambiguous or ambivalent
4 points:	passive enjoyment, such as watching TV	friendly or pleasurable
5 points:	active enjoyment, such as drinking a soda	loving or caring (may include stressful situations)

---

*Editor's note: Figures 1 and 2 are from the earlier study published in ART THERAPY, July, 1987.

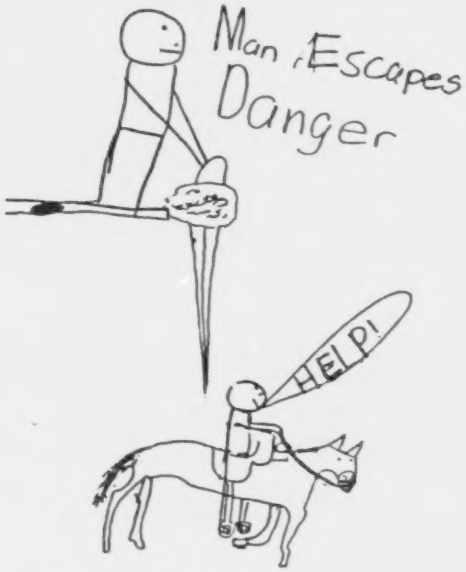


Fig. 1 Man escapes danger.

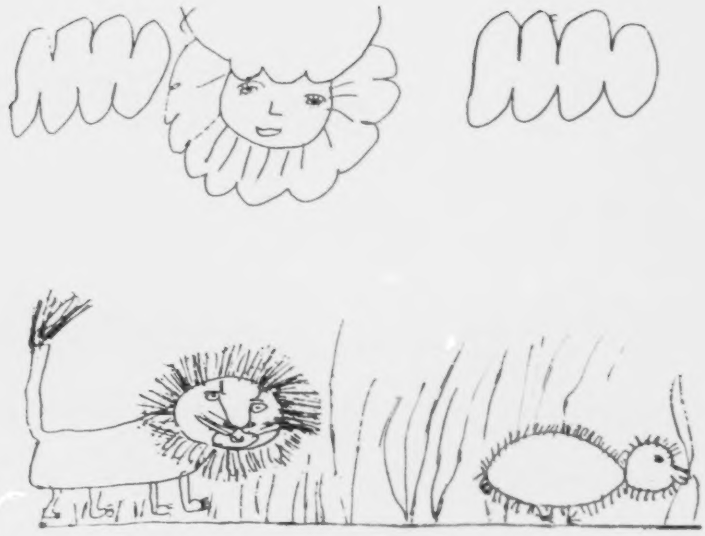


Fig. 2 "The tiger chases the chick to eat it" by Anna.

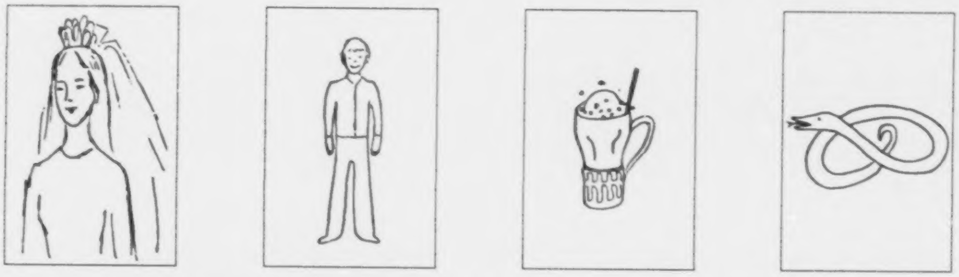


Fig. 3 Some of the Stimulus Drawings Used in the Drawing Task (reproduced with permission by the copyright owner).

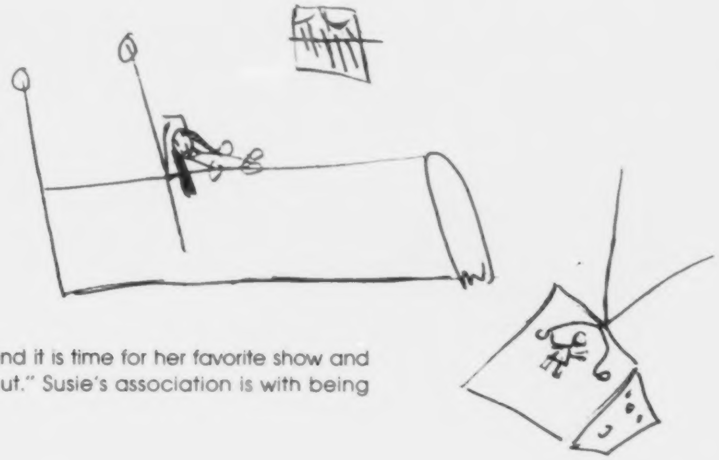


Fig. 4 By Susie, "The girl is watching the TV and it is time for her favorite show and she is scared because it is raining out." Susie's association is with being alone and afraid. Score: 2 points.

Names of children are fictitious.

ty. In the present study, responses to the *Drawing from Imagination* subtest by children in the second, third and fourth grades were reexamined for gender differences. The second graders were 7-8 years old; third graders, 8-9 years old; and fourth graders, 9-10 years old; most of the children in this study were between 8 and 9 years of age.

The schools included suburban public schools in New Jersey, Nebraska, Pennsylvania, and Ontario, Canada, as well as four schools in low to middle class neighborhoods in New York. New York schools included two suburban public schools, an urban public school and an urban parochial school.

Table II

Principal Subjects of Response Drawings by Girls

Respondents		**Principal Subjects**		
	Female	Male	Animals	X
39, Gr.2	30	3	6	
37, Gr.3	23	6	8	
40, Gr.4	20	3	17	
Total: 116	73 (63%)	12 (10%)	31 (27%)	

Table III

Principal Subjects of Response Drawings by Boys

Respondents		**Principal Subjects**		
Number	Female	Male	Animals	X
50, Gr.2	2	27	21	
54, Gr.3	5	38	11	
41, Gr.4	2	21	18	
Total: 145	9 (6%)	86 (59%)	50 (34%)	

Results

1. *Comparing Genders of the Principal Subjects of Drawings with Genders of the Children Who Drew Them.*

As shown in Tables II and III, a majority of the children drew pictures about subjects of the same gender as themselves, the boys tending to draw pictures about male subjects and the girls, female subjects. In the drawings by girls, 63% of the principal subjects were female, 10% male. In the drawings by boys, 59% of the principal subjects were male, 6% female. To determine whether these differences were significant, the *chi square* test was used. Results indicate that gender differences were significant at the .001 level of probability.

Among those who chose subjects of the opposite sex, all but four seem to identify with, or empathize with, these subjects. These four children drew fantasies about adults. In the two fantasies by boys, women appeared ridiculous as well as menacing, who threaten small animals with knives. In the two drawings by girls, one man was portrayed as a cruel scientist and the other man's behavior was ambiguous.

2. *Drawings About Autonomous Subjects*

Of the 261 children in the sample, fewer than half drew pictures about autonomous subjects. Although boys outnumber girls (46% boys, 37% girls), the differences between genders were not significant.

Table IV

Drawings About Autonomous Subjects in Responses by Girls (#1-13, Gr 4; 1-20 Gr 2)

Number			**Score**		
	1. Depressed	2. Fearful or Angry, etc.	3. Ambiguous/ Ambivalent	4. Passive Enjoyment	5. Active Enjoyment
20, Gr.2	0	1	4	13	2
10, Gr.3	0	1	2	5	2
13, Gr.4	2	2	1	6	2
43 (37%)	2 (5%)	4 (9%)	7 (16%)	24 (56%)	6 (14%)
		6 (14%)			30 (70%)

As shown in Tables IV and V, both genders had more positive than negative associations with autonomous subjects: 70% of the girls and 72% of the boys associated autonomous subjects with pleasurable experiences; 14% of the girls and 9% of the boys associated them with unpleasant experiences. The greatest difference between genders was found in drawings about autonomous subjects who appeared actively engaged in pleasurable activities, characterized by the score of 5 points. Here the boys outnumbered the girls—28% compared with 14%.

Examples of drawings about autonomous subjects are shown in Figures 4 to 6.

Table V

Drawings About Autonomous Subjects in Responses by Boys (#1-19 Gr 4)

Number			Score		
	1. Depressed	2. Fearful or Angry, etc.	3. Ambiguous/ Ambivalent	4. Passive Enjoyment	5. Active Enjoyment
17, Gr.2	0	0	5	7	5
31, Gr.3	3	2	5	13	8
19, Gr.4	0	1	3	9	6
67 (46%)	3 (4%)	3 (4%)	13 (19%)	29 (43%)	19 (28%)
		6 (9%)			48 (72%)

Table VI

Drawings About Relationships in Responses by Girls

Number			Score		
	1. Assaultive	2. Unfriendly	3. Ambiguous/ Ambivalent	4. Friendly	5. Caring/ Loving
19, Gr.2	1 (#21)	7 (#22-28)	0	8 (29-36)	3 (37-39)
27, Gr.3	1	13	3	4	6
27, Gr.4	2	9	4	9	3
73 (63%)	4 (5%)	29 (40%)	7 (10%)	21 (29%)	12 (16%)
		33 (45%)			33 (45%)

Table VII

Drawings About Relationships in Responses by Boys

Number			Score		
	1. Assaultive	2. Unfriendly	3. Ambiguous/ Ambivalent	4. Friendly	5. Caring/ Loving
33, Gr.2	9	11	4	3	6
23, Gr.3	5	5	7	3	3
22, Gr.4	1	6	6	7	2
78 (54%)	15 (19%)	22 (28%)	17 (22%)	13 (17%)	11 (14%)
		37 (47%)			24 (31%)

BEST COPY AVAILABLE

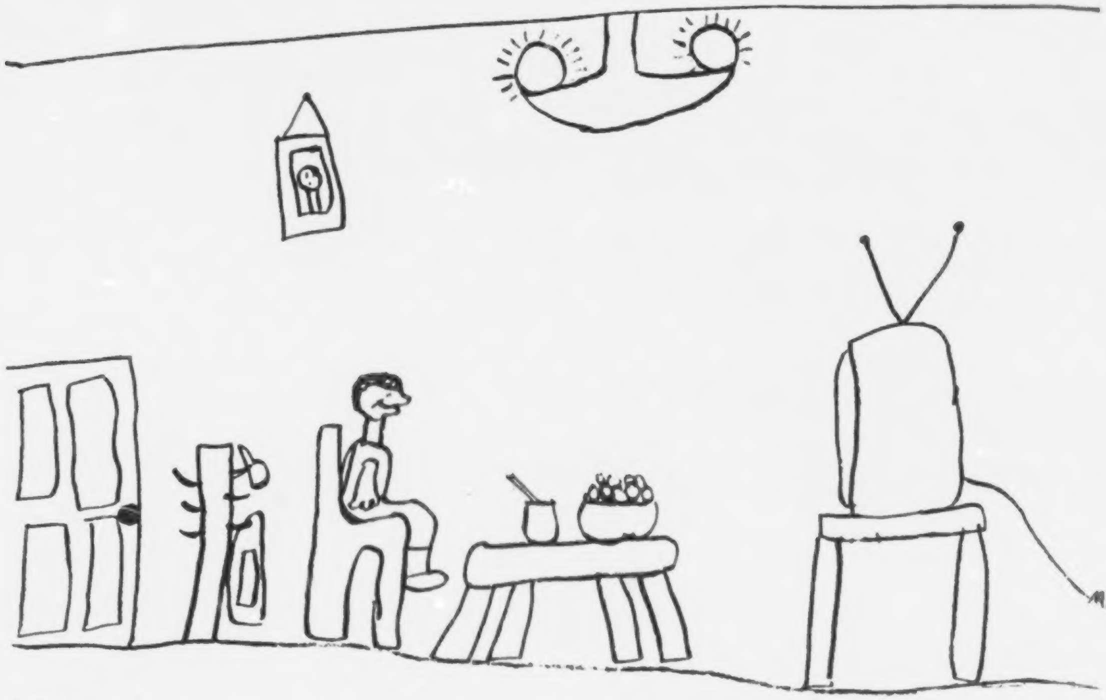


Fig. 5 By Kenny, "1. I am sitting and watching TV. 2. I bough[t] (sic) soda and popcorn. 3. I took (off my) cap and sweater."

Kenny's use of the first person singular confirms that his subject represents himself. His boy is not just passively enjoying TV, he is actively self-sufficient, having bought a snack and made himself at home in his comfortable room, a strongly positive association with an autonomous subject. Score: 5 points.

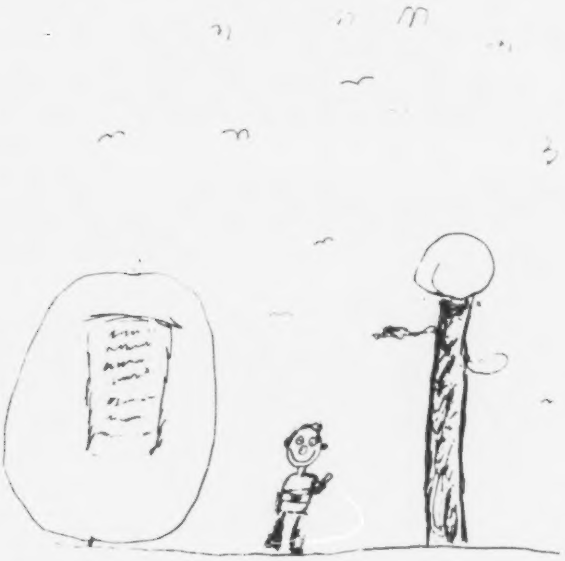


Fig. 6 By Billy, "The boy and the knife (sic)" Billy's association is with death and suicide. Score: 1 point.

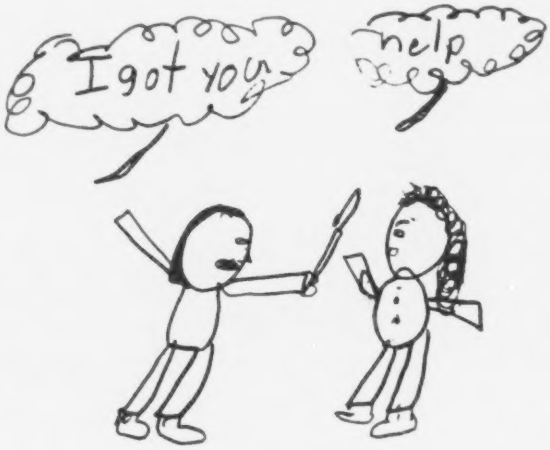


Fig. 7 "The Man with the Knife," by Ted. Assaultive and life-threatening relationship. Score: 1 point.

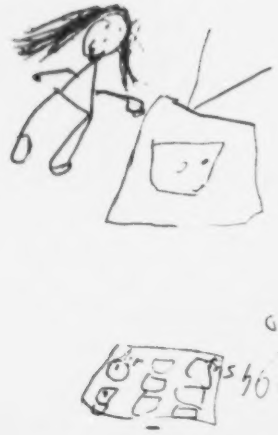


Fig. 8 "The Girl was wiching (sic) TV and playing a game but the brother came in and changed the station," by Minna. Unfriendly and stressful. Score: 2 points.

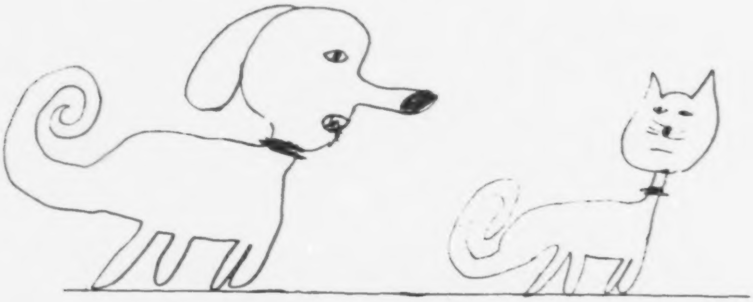


Fig. 9 "I love my pets (dog and cat)," by Danielle. Loving. Score: 5 points

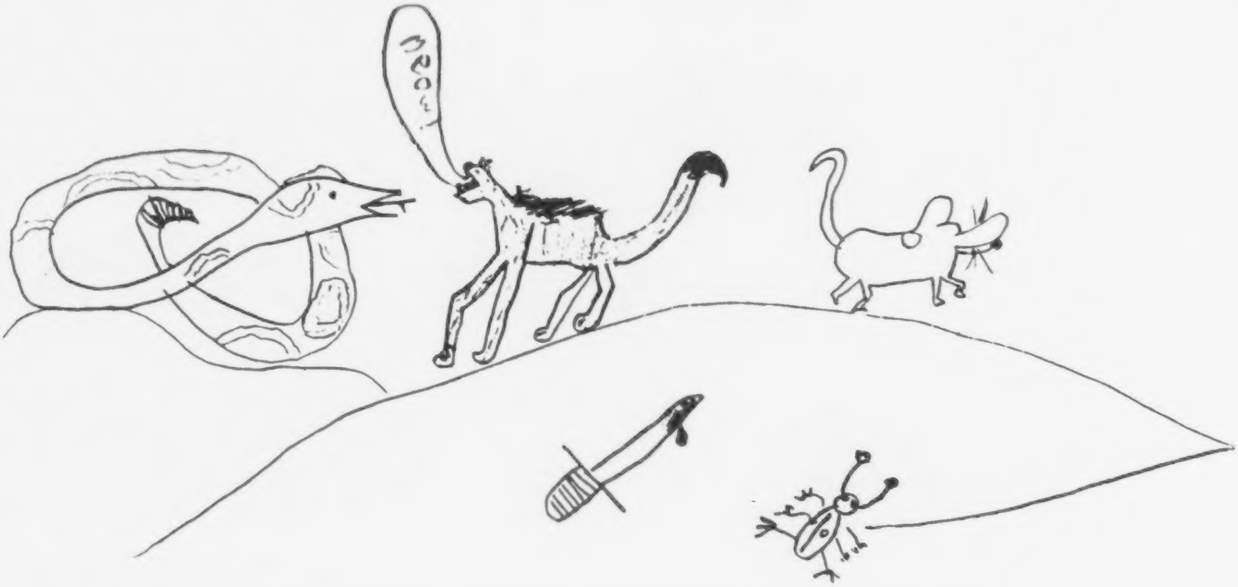


Fig. 10 "The cat who tried to save the rat," by Anthony. Caring in a dangerous world. Score: 5 points.

3. *Drawings About Relationships*

Of the 261 children in this sample, more than half drew pictures about people or animals interacting with other subjects, or implied relationships with others. Although girls outnumbered boys in drawing about relationships (63% girls, 54% boys), these differences were not significant. Again, there is a 75% probability that this is due to chance.

In the emotional content of these drawings, boys outnumber girls almost four to one, in drawing fantasies about life-threatening or violently assaultive relationships, characterized by the score of 1 point (19% boys, 5% girls), as shown in Tables VI and VII. Girls outnumbered boys, however, in portraying unfriendly or hostile relationships, scored 2 points (40% girls, 28% boys).

Examples of such drawings are shown in Figures 7 to 10.

In examining drawings about positive relationships, we find that girls outnumbered boys (girls 45%, boys 31%), but if we break down positive relationships into friendly relationships (4 points) and caring or loving relationships (5 points), there was little difference between genders in drawings scored 5 points (girls 16%, boys 14%) and girls outnumbered boys in scoring 4 points (girls 29%, boys 17%).

Discussion

The findings of this study support the assumption that children who respond to projective drawing tasks tend to identify themselves with the principal subjects of their drawings. Results indicate that most of the 261 children in the sample drew pictures about subjects the same gender as themselves to a degree that is a statistically highly significant at the .001 level of probability.

In addition to subjects the same gender as themselves, 27% of the girls and 36% of the boys chose animal subjects which also may serve to represent self-concepts. Since there was no opportunity to ask the children to discuss their drawings, the drawings about animal principal subjects were eliminated from statistical evaluations.

Also eliminated was the finding that most of the children who chose principal subjects of the opposite sex seemed to identify with or empathize with these subjects. Although 10% of the girls and 6% of the boys chose principal subjects of the opposite sex, only four children failed to represent these subjects sympathetically.

The drawings about autonomous principal subjects do not show significant differences between genders. Although the proportion of boys who represented autonomous subjects (46%) did exceed the proportion of girls who represent autonomous principal subjects (37%), this did not occur to a degree which is statistically significant.

It is interesting to note, however, that proportionally twice as many boys as girls drew pictures about autonomous subjects actively enjoying themselves: 28% of the boys and 14% of the girls drew pictures about self-sufficient subjects engaged in pleasurable activities. This finding parallels Gilligan's observation that detachment and its attendant egocentrism are associated with the masculine mode.

In drawings about relationships, again no significant difference between genders was found. Although the proportion of girls who represented relationships (63%) did exceed the proportion of boys who represented relationships (54%), this difference was not statistically significant.

When we examined the emotional characteristics of relationships portrayed, we found that 15 boys (19%) and only 4 girls (5%) drew pictures about violently assaultive relationships. Although the proportion of girls who portrayed friendly or pleasurable relationships exceeds the proportion of boys, there was virtually no difference between genders in portraying loving or caring relationships (girls 16%, boys 14%). Some of the boys associated caring relationships with living in a dangerous world while all of the girls associated caring relationships with living in a pleasant world, indicating another possible difference between genders.

The number of respondents in these rating scale categories were much too few to expect to find significant differences. It is hoped, however, that future studies with larger populations will amplify and clarify these findings.

References

Gilligan, C., Ward, D., & Taylor, J. M. (1988). *Mapping the moral domain*. Cambridge, MA: Harvard University Press.

Miller, J. B. (1976). *Toward a new psychology of women*. Boston: Beacon Press.

Silver, R. A. (1987). Sex differences in the emotional content of drawings. *Art Therapy*. 4(2), 67-77.

Silver, R. A. (1983, 1990). *Silver drawing test of cognitive skills and adjustment*. Sarasota, FL: Ablin Press Distributors.

Art Therapy. Journal of the American Art Therapy Association, 9(2) pp. 93-95 © AATA, Inc. 1992

Is There a "Late Style" of Art?

Line Use in Human Figure Drawing by Elderly People

Susan Evans Spaniol, A.T.R., Newton, MA.

Abstract

A great deal has been written about the artistic development of the maturing child; however, research in artistic development ends abruptly with adolescence. Scant mention is made in the literature of artistic transitions after adolescence, although the research on adult development in general has been growing exponentially over the past several decades.

The purpose of this pilot study was to investigate whether a distinct phase of artistic development evolves in late adulthood. Since artistic activity was a vast and complex area, this investigation was limited to a narrow, but exemplary aspect of the visual arts: line use in human figure drawings. The medium of drawing was selected because it is perhaps the most universal and immediate of the visual art forms. Similarly, the human figure was selected because it is thought to be the most frequently drawn of all subjects. Line use was singled out for study because it is the most simple and basic element of drawing, yet also one of the most variable.

This research was inspired by the relatively recent postulation of a distinct phase of artistic development positioned at the end of the lifespan of many great visual artists (Arnheim, 1986; Clark, 1981; Munsterberg, 1983). Termed the Late Style by Arnheim, this stage is described as qualitatively different from the preceding phase of middle adulthood, suggesting continuity of artistic development across the lifespan of people deeply engaged in the visual arts. According to Arnheim, the last stage of life is distinguished by contemplation, introspection and transcendence. As the aging person redirects attention inward, concern shifts from natural appearances to "underlying essentials." Looseness of style characterizes their art works, as similarities become more important than differences, objects lose their distinctness and the surface becomes diffuse.

Evidence supporting a hypothesis of a distinct artistic style in old age must demonstrate the universality of artistic development during old age. To analyze line use, it is necessary to subdivide it into its various components, including width, pressure, variability and length. Drawings by the elderly must be compared to those by younger people of all ages. This research study was designed as a beginning step in investigating the possibility of a distinct phase of artistic development in old age.

Methodology

A total of 227 subjects ranging in age from 3 to 80 years were selected to represent the decades of life from early childhood through late adulthood. The oldest group of subjects, ages 61 and above, were drawn from a special university-based study group for retired adults. Of 24 elderly persons participating, 20 were female.

The test administered was a drawing completion task consisting of several simple lines that suggest two figures facing one another (Figure 1). This task was designed to provide structure to untrained people who might otherwise feel intimidated by a blank piece of paper. Subjects were asked to identify only their age, sex and art training, if any. They were informed that the purpose of the drawing task was to examine how people draw at various ages.

The test was scored by four judges working independently without reference to information about individual subjects. The judges were selected for their expertise in art education and experience in looking at drawings. Specific criteria used on the scoring sheets were developed from other studies in which they had been successful measures of drawing skills (Burton, 1981). Classifications of lines were: continuous; broken and heavy; broken and soft; modulated (thick and thin); contour broken; and shading used for color, space, texture or mood. Categories were scored as present or absent by individual judges. In the final compilation of the data, an item was scored as present when there was agree-

BEST COPY AVAILABLE

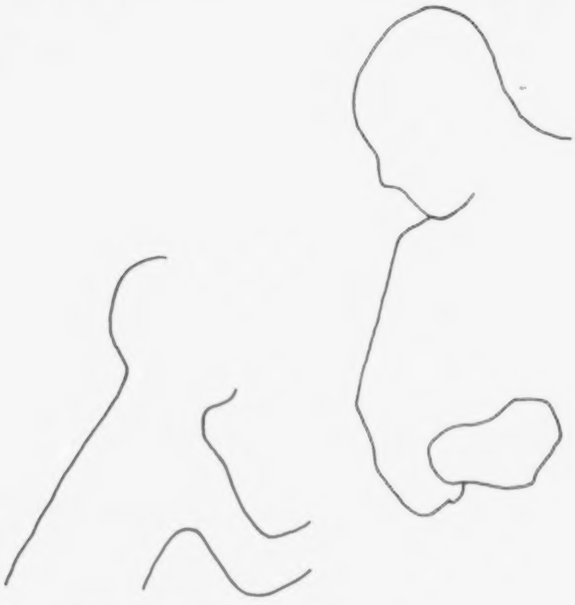


Fig. 1 DRAWING COMPLETION TEST

ment between three or more judges. Results are presented in terms of percentages representing ratios between the frequency of specific characteristics occurring in drawings by various age groups and the total number of drawings in those samples; plus or minus 10% is assumed to be significant for the purposes of this study.

Results

The results of this pilot study are equivocal in supporting the hypothesis of a distinct phase of artistic development on the basis of the analysis of line use in human figure drawing. The data describes changes in various aspects of line use across the lifespan (Figure 2). However, the statistics are not powerful enough to support a stage theory of late artistic development.

Changes in the use of continuous and broken lines suggest the possibility of the Late Age Style which Arnheim and others have observed. Analysis of the use of a continuous line indicates a fairly steady decline that seems to accelerate in old age. Conversely, analysis of the occurrence of a soft broken line shows a continuous increase until old age, when its use appears to accelerate markedly. Analysis of the heavy broken line is more ambiguous. Although its use generally follows a U-shaped curve, increasing until middle age and declining thereafter, the data suggests an accelerated decrease following middle age. The evolution of other aspects of line across the lifespan appears to be less significant. The use of a modulated line is rare across the entire lifespan, with only 10 examples out of a sample of 227, and none after age 40. Use of line as shading also occurs only ten times in the entire sample. The only use of line for shading that has potential significance is texture, which shows a marked increase in old age, although its use is infrequent. An attempt to analyze complexity as defined by multiple types of line use in a given sample indicated no significant differences across the lifespan.

Of all the linear qualities, continuity and soft broken lines show the widest range across the lifespan. Continuous lines are employed by 97% of all children under age 10, but only 21% of senior adults. While there is a 76% difference between the scores of the youngest and oldest subjects, the range of scores between the other five age groups differ by only 16%. Use of the broken soft line is almost a precise complement of continuous line use, being employed by only 3% of children through age 10, yet used by 19% of all older adults. Similarly, these scores also represent a difference of 76%, while the range of scores between them differs by only 15%. Scores for the broken heavy line approximately follow a U-shaped pattern, with least frequent use during childhood and old age. While the complementary nature of the patterns for continuous and soft broken lines suggest an obverse relationship, they do not seem to represent a continuum. Differences at the extreme age groups for each type of line use may indicate the existence of stages that are qualitatively different from those in between.

Conclusions

This pilot study demonstrated changes in line use during the later years of adult life. However, it did not discriminate whether the apparent development represents the effects of physical and mental decline, a qualitatively different stage of artistic development, or some combination of both.

The drawings of untrained persons as well as professional artists exhibit an increasing looseness of definition and decreasing differentiation between objects. During old age, broken lines predominate, boundaries dissolve and surface patterns become relatively homogeneous for artist and nonprofessional as well. The literature on the Late Style acknowledges the emotional and physical decline due to aging, yet it also attributes the style to the culmination of a lifetime of experience and wisdom (Arnheim, 1986;

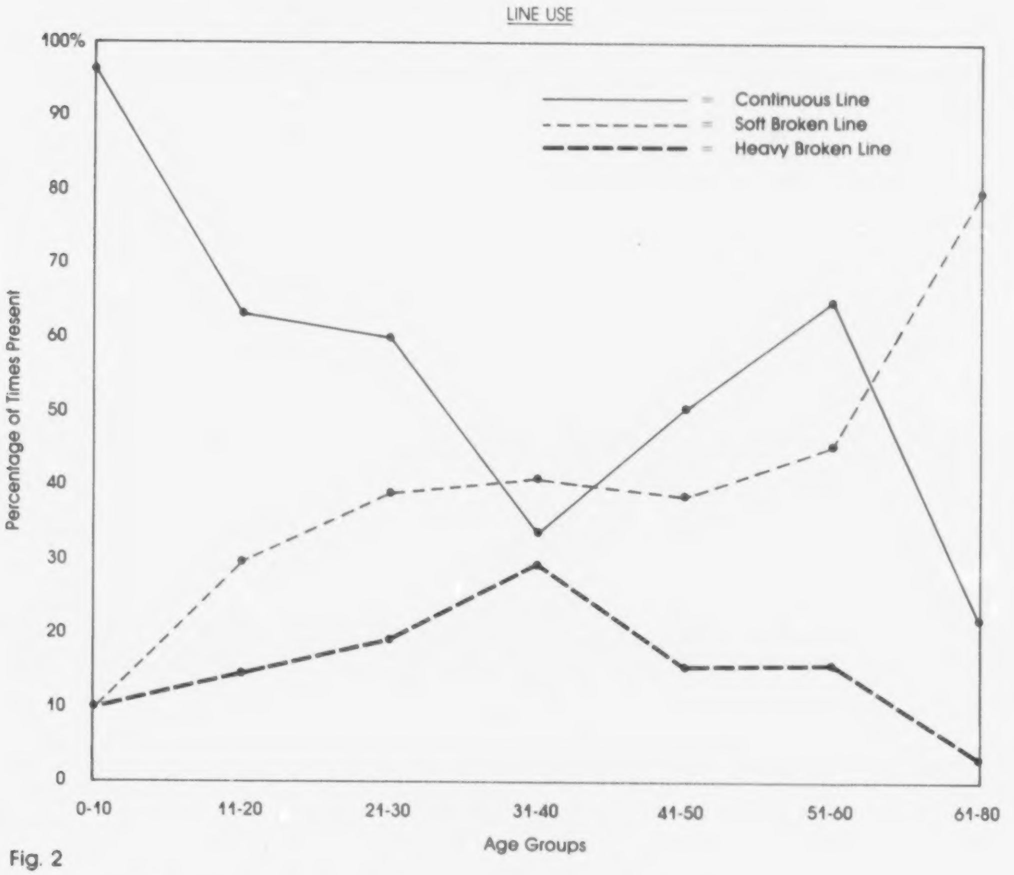


Fig. 2

Clark; 1981; Munsterberg, 1983). The art of these masters is described as a distillation of visual appearances intended to suggest underlying laws rather than to portray natural reality (Arnheim, 1986). Conventions are frequently cast aside and rationality is often devalued. Instead of studying outward forms, the artist looks inside his or herself for meaning and relies on intuition for guidance.

Unlike the artist, who often remains productive and creative throughout the lifespan, the ordinary person generally becomes less contributing, imaginative and flexible with age (Gaines, 1975). By definition, physical deterioration accompanies aging. Personality tests describe general emotional and intellectual deterioration as well, suggesting cognitive constriction, emotional instability, reduced impulse control and slowed responsibility (Panek, Wagner & Kennedy-Zwergel, 1983). The increased looseness and decreased differentiation described by the test results may certainly be attributed in part to this physical, mental and emotional decline. Whether the Late Style of untrained persons may be related to psychosocial changes as well remains to be documented.

References

Arnheim, R. (1986). *New essays on the psychology of art.* Berkeley: University of California Press.

Burton, J. (1981). *Lines, space and the organization of meaning in human figure drawings made by children eight to fifteen years.* Unpublished doctoral dissertation, Harvard University Graduate School of Education, Cambridge.

Clark, K. (1981). *Moments of vision.* New York: Harper & Row.

Gaines, R. (1975). Developmental perception and cognitive styles; From young children to master artists. *Perceptual and Motor Skills, 10,* 983-998.

Munsterberg, H. (1983). *The crown of life.* New York: Harcourt & Brace Jovanovich.

Panek, P.; Wagner, E.; & Kennedy-Zwergel, K. (1983). A review of projective test findings with older adults. *Journal of Personality Assessment, 47,* 562-582.

Art Therapy: Journal of the American Art Therapy Association, 9(2) pp. 96-102 © AATA, Inc. 1992

Viewpoints

Reflections: To Hell and Halfway Back

Amy F. Hendel*; Introduction and Postscript by: **Myra F. Levick, Ph.D., A.T.R., HLM**, Boca Raton, FL

Introduction

This paper reflects the unusual ability of a patient to articulate her struggle with her illness and journey back to health. Amy tells us what she knew and what she has learned in the therapeutic process. The record of this personal journey is followed by a postscript written by the therapist. It is illustrated with some of Amy's drawings produced during the therapeutic process. The drawings were selected by both of us.

> "God, grant me the Serenity to accept the things that I cannot change, the Courage to change the things that I can, and the Wisdom to know the difference."

The words to the Serenity Prayer, stated above, are framed on a plaque beside my bed. They are the last words I see before I go to bed and the first ones I see when I wake up. The Serenity Prayer, written by a recovering alcoholic, is the fundamental guide that all recovering addicts (alcoholics, gamblers, drug and food abusers) adhere to. Since all people who suffer from an addiction need to change basic behaviors and attitudes, the Serenity Prayer offers a viable direction to take while striving towards recovery.

My parents got divorced when I was two years old. My grandmother has Alzheimer's disease. My best friend for twelve years, my dachsund, Buster, died in my arms after a long and debilitating illness. These are things that I cannot change; I have no other alternative than to accept them. But there are things in my life that I can change, things that with a little courage and a lot of help, I can learn to deal with in a healthier, more productive fashion.

I am bulimarexic. I have had an eating disorder for the past six and a half years. For five of those years, I was a severely underweight anorexic. For the past year and a half, I have vacillated between both anoretic and bulimic behaviors. The trip has been painful. I have journeyed to hell and back. Fortunately, in the last six months, I have gathered the strength and found the help to guide myself towards recovery. It has taken over six years, but finally, I see "light at the end of the tunnel."

Because "knowing" is important to me, I learned that anorexia, or anorexia nervosa as it is formally known, is defined as the voluntary starvation resulting in a minimum loss of fifteen percent body weight. Bulimia, or bulimarexia, is defined as periodic binge eating followed by some form of purging, such as self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise.

My eating disorder activated in the summer of 1985, shortly after I graduated from Brandeis University. During that period, I was experiencing a great deal of anxiety regarding the direction I wished

---

***Editor's note:** Although it is the policy of *Art Therapy* to withhold client names, Ms. Hendel and Dr. Levick gave permission in this instance.

to pursue in terms of a career. For the first time in my life, I was no longer protected within a safe and sheltered environment (like I had at Brandeis and like I had in high school). I began to isolate myself. I accepted an unstimulating job doing phone solicitation from my house. Most of my friends from college had already moved away and I felt lonely and confused. The only human contact I had was with my neighbor, Lenny. Although he was twenty years older than me, I turned to him for companionship.

Around that time, my dog (Buster) was diagnosed with terminal cancer. The news devastated me. Buster was not "just" a dog. He was my true joy in life; he was my rock, my 'raison d'etre.' When he became ill, I felt I had to make the rest of his life as comfortable as possible. I rarely left his side. I put every ounce of energy I had into taking care of him.

In August of 1985, I had a short bout with the flu and I lost three pounds. At 5'6" and 125 lbs., I was by no means overweight. But when I saw how easy losing weight could be, I became obsessed. I began exercising for several hours a day. I stopped eating protein; then I stopped eating complex carbohydrates. Shortly thereafter, I stopped eating dairy products. Within one year's time, my diet consisted of Diet Coke, Trident Gum, and broccoli. I lost my period, I developed a heart murmur, and according to a doctor who treated me several years later, I caused irreparable damage to my internal organs.

Diary Entry—January 3, 1986

"How can I explain my eating disorder? I wish I knew. I continue to waste away, knowing damn well that I am hurting my body and jeopardizing my health. I look terrible; I feel terrible. None of my clothes fit. My eyes are sunken in. When I look in the mirror, a jaundiced, gaunt creature stares back at me. There are mornings when just getting out of bed uses every ounce of strength I have . . .

Yet, when it comes time to eat, when I finally allow my body to refuel, my good intentions peter out. I offer it some veggies, maybe a little fruit. But anything that is fatty or high caloric must stay away. They are taboo. To put such things in my body is grotesque and repulsive.

I know I need to gain weight. And I know I need to gain it soon. But for some reason, all the knowledge in the world doesn't help when it comes down to actually eating. All kinds of thoughts race through my head: tonight I won't eat anything but tomorrow I'll have something as soon as I get up . . . If I don't eat anything now, then tomorrow I won't have to exercise as hard . . . If I skip eating the apple tonight then tomorrow I can have an extra piece of gum . . . Rationalization becomes a self-induced doctrine. Every time I try and help myself, I decide to start tomorrow. The only problem with that is, tomorrow never comes."

On December 5, 1987 (a Sunday evening), Buster died in my arms. He had been in a coma for four days, and if his condition had not improved by Monday, December 6, I would have had him put to sleep. Luckily, I had already prearranged his funeral the month before. I had located and bought a plot for him in a pet cemetery in Foxborough, Massachusetts. On December 6, at precisely 10:30 A.M., I threw the last bits of dirt on Buster's grave. At the time, I weighed 82 lbs.

Four days after I buried Buster, I packed my things and moved to Florida. Because of all the weight I had lost, I was extremely sensitive to the cold weather and my body craved some warmth. Lenny also wanted to relocate, so we drove down to Miami together. Right before we left, my mother called me from Connecticut to ask why I was making such a drastic change.

Mom: "I understand it's difficult for you to stay in Waltham, but why don't you come back to New London, instead. Your room is still here for you."

Me: "I'm cold."

Mom: "That's a pretty strange reason to move 1500 miles away."

Me: "Right now, I'm wearing three sweaters, the heat is on full blast, and I'm still freezing. I need to go where it's warm and sunny."

Although my family was aware that I had a problem, they had no idea just how sick I was. Besides being grotesquely thin, I was hopelessly suicidal. It had been over a year since I had seen anyone in my family and I was doing my best to make sure it was a while before I saw them again. On my drive down to Florida, I remember literally praying that the change of scenery would help rejuvenate me. Lenny had already found adjoining apartments for us in a cheap rental complex in North Miami. He also assured me that I'd be able to find a support group to help me with my eating disorder.

After I got to Florida and settled into my apartment, the first thing I did was find a psychiatrist. A local hospital gave me the name of a doctor who was supposedly the top psychiatrist in the area. When I reached his office, a secretary had me fill out some forms. Within minutes, a short man with elevator shoes came in and escorted me into his dimly lit, extremely cold room.

Dr.: "Why are you here?"

Me: "Well, I recently lost my dog and I feel suicidal. I think I'm anorexic."

Dr.: "What makes you think that?"

Me: "Well, for one, I'm afraid to eat. For two, I've lost about forty pounds in the last two years."

Dr.: "Yes, you are rather skinny. It's hard to tell with all the layers of clothing you're wearing."

Me: "I'm cold."

Dr.: "I think we should put you on Nardil. It's an anti-depressant and it should help increase your appetite. If you don't feel any better in, let's say three month's time, call me and we'll try something else."

The doctor handed me a bill for three hundred dollars and showed me to the door. As I waited for the elevator, I remember wondering whether jumping off the sixth floor was high enough to do the job.

After this experience, I saw three other psychiatrists, two of whom were eating disorder specialists. Each one gave me a prescription for a different drug and told me to come back in three months. Needless to say, I felt discouraged. In the meantime, I tried private therapy. I tried group therapy. I tried Prozac. I tried Overeater's Anonymous meetings. I tried marijuana. I tried attending lectures. I tried vodka and tonics.

On December 5, 1989, I hit rock bottom. The only thing that I had learned about eating disorders since moving to Florida was that they were a very big business. That morning, as I was holding a bottle of sleeping pills, an advertisement for an eating disorder hospital scrolled over my television screen. I jotted down the address and got into my car. Three hours later, I was admitted.

Insurance companies rarely accept clients with pre-existing conditions. As a result, my coverage was minimal. The hospital that admitted me recommended a three month stay, but my insurance company only agreed to pay for five weeks. If I wanted to stay the extra seven weeks, it would have cost me approximately $36,000 out of my pocket. That, of course, was impossible.

In the hospital, I learned some useful things about eating disorders. I learned about control issues, about stress reduction, about dysfunctional families. I learned how dangerous starvation is to the body. To help me gain weight, the hospital put me on a 2,500 calorie a day regimen; I was not permitted to exercise. But as I was gaining the weight, I was secretly planning to go on a severe diet as soon as I left the hospital. I did not like the fact that my personal freedom was taken away, even though that was precisely what the program's primary goal was.

Unfortunately, during my fifth and final week of hospitalization, a bulimic girl named Ann became my roommate. Every night, she spent hours trying to convince me that the only way I would be able to stop gaining so much weight was to purge.

Ann: "Why bother getting depressed over all the food that they're making you eat? Just do what I do: eat whatever you want, whenever you want. Then, just as quickly as it goes down, bring it right back up."

Me: "Throwing up is disgusting. I'd rather not eat at all."

Ann: "Amy, think about the past few years of your life. Think about all the hunger pangs, all the days of being weak and listless. Don't you miss eating candy and cookies and chocolate? Don't you miss going out to dinner and spending time with friends?"

The day my insurance lapsed, I left the hospital and went back to my apartment to give it a try. I spent three consecutive days locked in my room doing nothing but eating and throwing up. When I finally came out for air, I could not handle it; I retreated back in. Eventually, what started out as an experiment turned into a nine month affair. I was totally out of control. Lenny tried to find another hospital program, but I rejected the offer. I had absolutely no faith that things would get any better. I had exhausted every possible avenue of treatment and I was getting worse.

Diary Entry—February 14, 1990

"I can't stand this anymore. I have eaten more in the past three hours than I used to eat in a whole year! My heart is beating so hard I think it's going to come out of my chest. My hands and legs are twitching. My mind is racing with thoughts of suicide, sleeping pills, machetes. All of that chocolate and pizza and cake . . . Fortunately, I threw up the ice cream. I wish I could throw up more but I can't get out of this chair right now.

God, what am I going to do? I feel so helpless, so lost. Nothing feels good to me. I have nothing to look forward to. The only thing I ever loved died in my arms. What the hell is left for me in this screwed up world? I hate it. Take me, God. Put me out of my misery. PLEASE! I just can't take this anymore!!!"

Several weeks after I left the hospital, my family (my parents, their respective spouses, and my two brothers) flew down from New England to visit me. Because I had gained so much weight, they all assumed I was "cured." What a joke! The old adage "appearances are deceiving" could not have been more appropriate. Since coming out of the hospital, I had lost all ability to manage my time. I could barely spend five minutes productively, let alone twenty-four hours. Although I looked fine, I was suffering tremendously.

While visiting, my mother and her husband decided that they wanted to rent a condominium in Florida for the rest of the winter months. That winter, my mother met Dr. Myra Levick, an art therapist who worked extensively with patients suffering from depression, addictions, and eating disorders. My mother told Dr. Levick about me and asked if she could introduce the two of us. Dr. Levick explained that she had recently retired, but occasionally, she would treat a person from her home on an outpatient basis. She gave my mother her card, telling her to have me call to make an appointment.

My mother called me six times that week, each time beginning the conversation with "Have you called Dr. Levick yet?" I decided that I could not take her nagging anymore, so I made the call. I had seen six therapists since moving to Florida; one more could not hurt. I made an appointment to meet with Dr. Levick the following Monday evening.

When I arrived at her house and rang the doorbell, a man wearing a Philadelphia Eagles' sweatshirt answered the door. He introduced himself as Myra's husband. He told me that Myra would be right with me and he escorted me into her office. The first thing I saw upon entering the room was a wall lined with diplomas. A large bookcase was built against the far wall of the office. There were books by Freud, by Jung, by Erikson. There were about fifty books on art therapy alone. As I was noting all of her books, I heard movement in the next room so I quickly sat down on the black leather couch that was adjacent to the desk I assumed was Myra's. When the door opened, a short, slender woman came in and introduced herself as Dr. Myra Levick.

Myra began our meeting by informing me of the length of each session. The fee was expected at the end of each session. We were to meet once a week and if I needed to cancel or change an appointment, she expected a call twenty-four hours in advance. Sessions involved, 1) a discussion of current issues and moods, 2) a mental voyage down memory lane, and 3) a drawing to help discover things that were not easily revealed verbally.

Our first meeting was strictly informational. Myra wanted to know the history of my family, the dynamics of my eating disorder, and my current living situation. At the end of the hour, she asked me to follow her out onto the porch. There, she had previously prepared a table with a pad, pastels, crayons, and magic markers. She then asked me to draw a picture (using any marker I wanted) of my family.

When I was finished, Myra told me that we would start our next session by evaluating my drawing. Driving home that evening, I remember thinking how interesting it was that I drew myself so much tinier than I drew the rest of my family. I also remember how difficult it had been to decide whether or not my mother's husband belonged in the picture. He has been married to my mother for over ten years and I've never felt comfortable including him in my family.

At our next session, Myra listened to my observations, and then began to list her own. She pointed out the sour expressions I painted on each face. She pointed out that my oldest brother was the only one who had most of the proper extremities attached to his body. I explained that he is the only well-adjusted member of our family. She also showed me how alike I drew the bodies on both the men and the women. This, she suggested, might reveal confusion over sexual identities. By the time Myra was through analyzing my drawing, I was astounded! She knew more about my past by that one drawing than other therapists had gleaned after months of therapy. I left that meeting feeling optimistic. Finally, someone could read through all of my "bullshit."

I have been seeing Myra for over nine months. Through intense, emotional revelations, combined with drawings of my family, my moods, and my relationships, I have made enormous strides in understanding how and why I have an eating disorder. Myra and I do not discuss food. We do not discuss diets. We talk about feelings, about self-esteem, about self-preservation.

My eating disorder is the result of a troubled childhood. Not only was I raised in a dysfunctional family, but I grew up blaming myself for my family's chaos. I felt a tremendous amount of rage towards my parents. I was angry at my mother for raising three children in a hostile and cold home environment. I was angry at my father for abandoning his family when I was only two years old. I have spent a lifetime searching for the warmth and compassion that I missed out on as a child. It is obvious that my overwhelming (and bizarre) attachment to Buster evolved from a need to receive and give love in an otherwise "loveless" environment. It is also obvious to me that my involvement with Lenny was primarily an attempt to replace the father figure I never had.

An eating disorder is a coping mechanism. It is a highly destructive form of self-punishment. Although everybody who develops anorexia or bulimia has a unique set of circumstances with unique reactions, all share at least one thing: a complete immersion of the self into a ritualistic and often, masochistic world. As I stated earlier, "knowing" is important to me so I turned to Myra for an explanation regarding how art therapy is used to treat people with eating disorders (and other addictions). She described art therapy as a nonverbal form of psychotherapy using the patient's graphic productions as a means of communication. For her, the format of examining a patient's drawings is used in the same way that the analyst and patient examine dream work.

In Myra's experience with treating anorexia and bulimia, she finds that her form of treatment helps explore the etiology as well as the symptoms and manifestations of the disorder. She said that she has found that most anorexics and bulimics are highly intelligent and will do a great deal of rationalization to explain and describe their disorder. The nonverbal form of therapy cuts through obsessive and repetitive verbalization. The drawings help explore and reveal precipitating factors and incidents that lead to an exacerbation of the symptoms. Drawings reveal specific aspects of a relationship that a patient often denies or avoids in verbal discussions.

Myra insisted that every patient she treats must be monitored by a medical physician. She told me that the recovery process depends on how much the patient is willing to give up in terms of secondary gain, like attention from the family or as an excuse for not participating in normal activity. She believes that symptoms can be put in remission, but that a person must learn to be his or her own therapist, tuning into specific familiar behaviors that might lead to a renewal of symptoms.

I accept the fact that an eating disorder is a manifestation of frustration, anger and deprivation. It is usually the result of a dysfunctional family. By understanding past traumas, a person can forgive him/herself and eventually learn to forgive others. For the past six and a half years, I have taken a painful sabbatical from "life." I have trapped myself in a world filled with severe isolation, self-abuse, and self hate. By going to therapy, I have given myself the chance to move back into the world and have some sort of decent life. I know I still have a long way to go. I am just now beginning to understand how I have masked my identity with an eating disorder, how I have used it to cover up the pain and sadness of my past. I still struggle with food. Perhaps I always will. But I now have a sense of my own self-worth. I finally believe that I deserve the chance to experience joy, and pleasure, and love.

Diary Entry—March 11, 1991

> "Last night, I flipped through my photo album of Buster. What a magnificent dog he was! So majestic, so debonair. I still miss him intensely. There isn't a day that goes by that I don't think about the way he frolicked through the snow, the way he cuddled up in my arms and licked my face.
>
> But now, I'm working on a new photo album. I'm putting together pictures of Sami (when he was a kitten), of the beautiful palm trees, of New Year's Eve with a few of my neighbors.
>
> One day, I'm going to look back at all my pictures. Instead of crying about what was, I'm going to smile at what is. One day, and it will be soon, I'm going to hold my head up high and instead of cursing at God for taking, I'm going to thank Him for giving. One day . . . One day . . ."

Postscript

You have read the personal account of a patient's struggle with a debilitating eating disorder, bulimarexia. What follows is a discussion of some of her drawings produced during the art therapy sessions. The selection of these drawings, a joint effort, is based on their reflection of and impact on the therapeutic process.

In her paper, Amy reported the different things I pointed out in her very first drawing, her family (Figure 1). In that meeting, I didn't say that she placed herself between her two brothers, with her father on one side and her mother and her husband on the other. She drew the parent figures in black, with her brothers drawn in blue and herself drawn in bright red. Everyone, except herself, is footless and attached to the bottom of the page. She has feet and is not grounded. The image suggested to me that she was suspended in space between the two families, her father's and her mother's. The need to explore this theme further led to sessions with her parents, siblings and her new sister-in-law. These meetings provided important information about the early family structure when the children were small. Amy has little memory about this period. Not surprisingly, her brothers also had very selective memories about their early childhoods. During the treatment sessions, her mother and father were not only cooperative and supportive, but corroborated the chaotic period during the dissolution of the marriage and the resulting behavior of the children.

Figure 2, produced a month later, was drawn in response to my request to depict herself in a situation with her mother, in Connecticut, and her father, in Florida. She drew herself driving the car. Her father was placed on the right, and her mother and mother's husband were drawn on the left. While somewhat isolated in both drawings, she converses with her father, but uses earphones to shut out her mother and mother's husband. This theme was explored during subsequent sessions while she prepared to visit her mother's home and attend her brother's wedding.

During this time Amy rigidly adhered to an exercise program that, she said, allowed her to eat "a certain amount of food." She developed a skin rash that she feared was from the chlorine in the pool. The amount of swimming she could do would be limited, if this was true. I suggested that she try to draw these feelings: "let it go on paper." Figure 3, she said, was the anger she felt at "not being able to keep up with her rituals." I asked her to follow through with this thought in another drawing. She drew the television, popcorn, book, visiting friend, lying in bed, telephone—all of the things she could not allow herself to do until she swam for a certain length of time. Then she promptly crossed them out (Figure 4). These were the first images in which Amy allowed herself some real freedom of expression without losing control.

Six months into therapy, Amy registered for college courses. While waiting for them to begin, she began to express her loneliness verbally and pictorially. She said she felt like a whale, and that she had gained 20 pounds. (This was not true—she had actually gained about six to seven pounds.) Using a lot of bright colors and the whole paper, she drew a whale beached and dying. This contradicted the depression she claimed. The whale, I pointed out, was reaching for the nearby water. Water represented life for it. I asked her to draw what she would like to be. She drew a dolphin jumping in the water (Figure 5). These drawings reflected more stability and energy through the grounding of the two forms and a more expansive use of space and color. Future goals

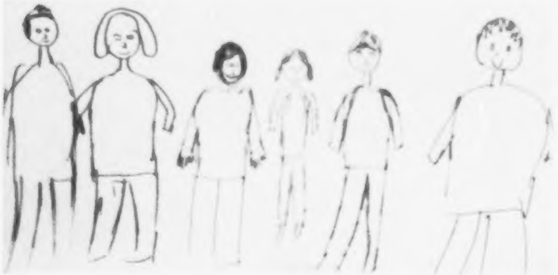


Fig. 1

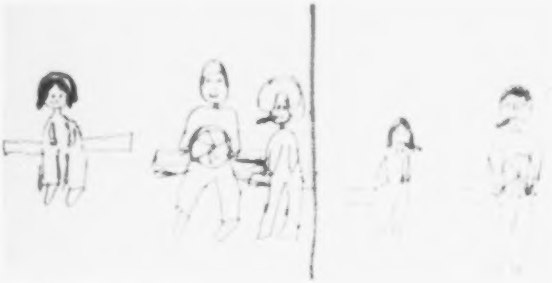


Fig. 2

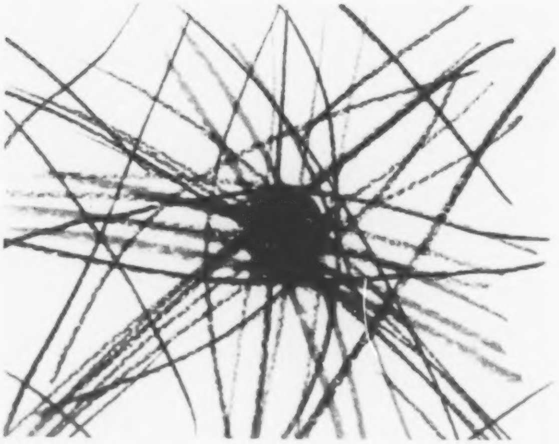


Fig. 3

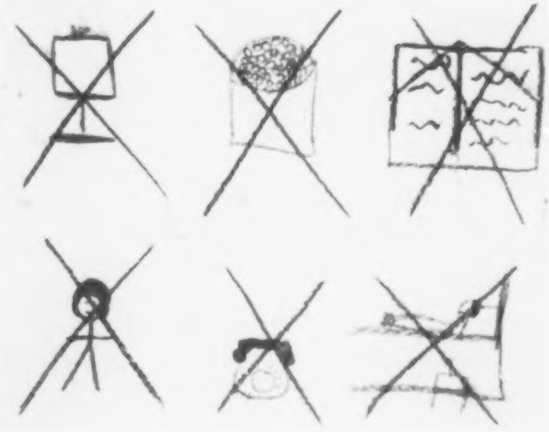


Fig. 4

were discussed which were more realistic and more optimistic than previously. She conceded, intellectually, that her eating disorder was a symptom of early childhood traumas and that she did have the ability to intellectually control her pathological responses. She agreed to plan future sessions, first with her mother and then with her father. These would provide more information about her early development.

Figure 6, produced two weeks later, is a drawing of herself with her family on the right and, on the left herself in relation to the world. She acknowledged that while she was still very separate from the family, she is "as much a person as they are." But, in relationship to the world she is no more than a dot. It was at this point that she began to see the relationships among her early traumatic experience of parents' separation and divorce, the traumatic loss of the dog she loved and cared for, and her withdrawal from friends and environment at the onset of her illness.

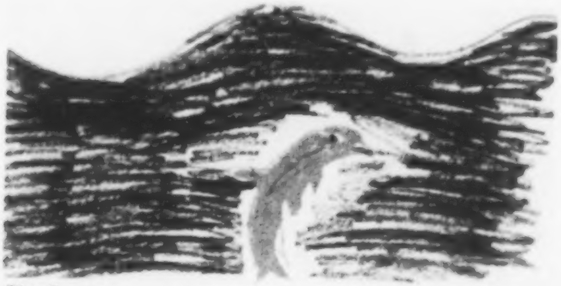


Fig. 5

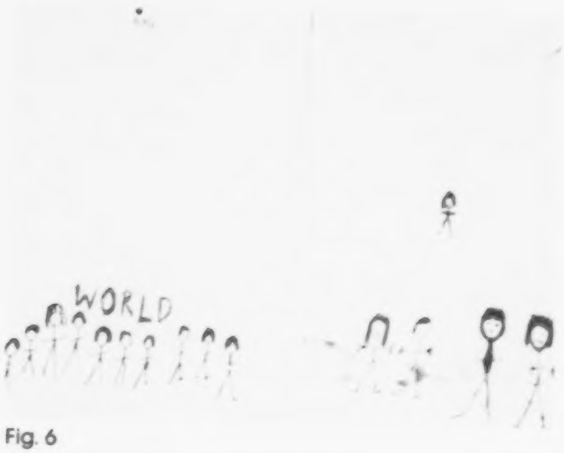


Fig. 6

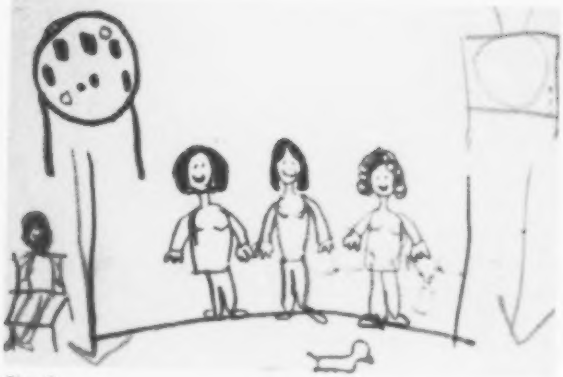


Fig. 7

The visits from her parents were helpful and productive, as were those that followed with her two brothers and sister-in-law. Early childhood and pre-illness periods were explored in depth. Figure 7 depicts Amy and her two close girl friends during her days at college. The full, grounded, clearly female figures show not only how Amy felt about herself while in college, but how she was beginning to feel about herself again.

As described in Amy's personal account, the treatment approach used was based on psychoanalytic constructs. My goal was to help her retrace her development and to explore and understand those early traumas and precipitating factors that contributed to her illness. In the process, I appealed to her intellectual ability and ego strengths. As she learned how to modify and control her ritualistic eating behaviors, she would be able to move into the real world again. Regular medical checkups and supervision of sleeping medication were required. As long as her test results indicated that she was in good health, and she could maintain her school schedule, there was no discussion of her eating habits.

Amy completed the three courses in which she was enrolled, earning good grades. Her reflections on her illness and therapy were written as a final assignment for one of these courses, and were recommended for publication by her professor and peers.

Her relationships with her parents and family members are gratifying to all of them. She is currently employed by one brother and exploring possibilities for school and continued work. The destructive relationship with Lenny has been terminated, and Amy is socially active with her neighbors and family. Physically, she has gained 50 pounds, and is now average weight for her height. She feels good about the way she looks. She has resumed menstruation regularly during the last three months after a cessation of six years. She has not engaged in binging or purging for two months.

Amy is not "all the way back." But, she has worked very hard in therapy and continues to do so.

Art Therapy. Journal of the American Art Therapy Association, 9(2) pp. 103-104 © AATA, Inc. 1992

Reviews

Creating Mandalas for Insight, Healing and Self-Expression

Susanne F. Fincher, Shambhala Publications, Boston, Mass. 1991, 192 pages paperback. $15.00 ISBN #0-87773-646-4.

Reviewed by **Elizabeth (Liz) Ratcliffe**, M.S., M.F.C.C., A.T.R., Book Editor.

Every once in a while a book appears which, right away, becomes a "classic" in its field. Until it gets into print, we don't realize how much it has been needed, because there has been nothing available to remind us that there is a gap in the existing literature. Such a book is Susanne F. Fincher's *Creating Mandalas*, published in paperback by Shambhala, 1991. The subtitle: *For Insight, Healing and Self-Expression*, suggests that personal benefit can be derived from this easily read volume. And Ms. Fincher, who discovered the healing power of creating mandalas, following the death of a child and a painful divorce, tells us that her personal recovery and subsequent fifteen-year study of the history and traditions of the mandala in many cultures, have been the impetus for this book. My reading of the work has persuaded me that besides being invaluable as a personal inspiration and resource, it may well become the single most useful professional reference for creating mandalas with clients, students or laypeople interested in knowing more about this ancient and mysterious circle form.

The word "mandala" comes from ancient Sanskrit, and was introduced to Western psychology by psychiatrist Carl Jung in the first part of this century. In Jung's medical internship at the Burgholzli Psychiatric Hospital in Zurich, he had been intrigued by his observation that frenzied schizophrenic patients would often create self-soothing by drawing circle forms. Later after his traumatic break with Freud and his own midlife breakdown, he himself found the power of self-healing by repeatedly drawing mandalas. He writes, "I sketched every morning in a notebook a small circular drawing . . . which seemed to correspond to my inner situation at the time . . . Only gradually did I discover what the mandala really is:. . . . the Self, the wholeness of personality, which if all goes well is harmonious." (p. 18).

Very early in history human beings discovered what seems to have served as the spiritual focusing power of circle forms. In prehistoric rock carvings from every continent we see the designs. Wherever they occur in art, architectural monuments, rituals and symbolic references, the circle seems to represent universal human consciousness. Sacred creation myths based on the idea of the circle occur in traditions of ancient Europe, Africa, the South Pacific and the American Indians.

Fincher says, "Ancient mandalas carved in many places around the world suggest an awe of the sun and moon. These circular heavenly bodies could have served our ancestors as natural symbols, shaping consciousness and assisting human beings to develop their thinking beyond purely instinctual levels." (p. 3). Descriptions of much prehistoric lore supply a rich and scholarly background for the author's presentation of the usefulness of making mandalas in today's world. Robert A. Johnson, Jungian analyst and author, states in his *Foreword* to her book, "Never before has mankind been in such need of the healing power of the mandala as at present. Our fractured disintegrating world cries for that cohesive force which is the great power of mandala." Ancient Tibetan mandalas, whether in sandpainting or "thangka" form, still serve Buddhist religious practice as a visual aid to meditation, and entrance into deep spiritual trance.

Fincher's section on creating and interpreting mandalas draws on the psychological theories of Jung, Neumann, Von Franz, Edinger, Rhoda Kellogg and Joan Kellogg. She credits Joan Kellogg with the precise instructions for beginning mandala work:—kinds of art materials, setting, relaxation techniques for preparation, dating each work and ordering sequence, and finally—affixing a spontaneous title. Interpretation includes careful recording of colors (and associations), listing shapes and numbers of repeated forms (and associations), and cross-referencing personal associations of color, shape and number with the spontaneous title. From this process there begins to emerge a pattern of meaning. Keeping a journal of the process becomes an invaluable part of the healing journey, which as in sandplay or dream work, takes its meaning from the sequential process rather than from any single mandala.

Chapters on color, color systems, and forms and numbers, give precise attention to these elements. In clear and direct format Fincher shares her widely researched information so that the reader has easy access to the author's rich encyclopedia of ancient and modern sources. Yet, as a contemporary scholar and experienced art therapist, she also carefully instructs the reader always to value personal preferred associations above general or historic facts. I especially appreciated this honoring of the individual, for I have come to be suspicious of theories that claim absolute answers in the increasingly complex field of human psychology. I applaud such statements as, "The color associations in this chapter are given only to stimulate your thinking about the colors in your mandala. These are not the 'right' meanings." (p. 34) And, "This chapter has been an attempt to show that colors in mandalas have another layer of meaning determined by their relationships to one another . . . (and) are not intended as hard and fast rules." (p. 90). The author has included sixteen beautiful color prints illustrating patient and other mandalas.

The chapter on numbers and forms, liberally sprinkled with sketches and drawings, provided for me one of my favorite reads, for its content provides a detailed compendium of archetypal lore. Of this vast wealth of collected source material Ms. Fincher says, "I have woven together traditional symbolism from religious liturgy, psychology and mythology. . . . This information can help you amplify the meaning of your own symbols" (p. 93). Numbers and forms are assigned several possible meanings, often contradictory in nature. For instance, ONE can stand for the single individual, or it can stand just as well for all that is potential; EIGHT represents stability and harmony as well as the divine instigator of endless change. The BULL symbolizes both the feminine (with its two crescent moon horns), and the powerful masculine god (whose bellow thunders across the angry sky). The DOG can represent the faithful friend, and in another context bestiality.

Two final chapters are given over to the Great Round of mandala forms (the twelve stages of ego-self development, or individuation) drawing on Joan Kellogg's work of the archetypal mandala series, and telling some personal stories of people whose lives have been profoundly affected by working with mandalas.

In Susanne Fincher's book *Creating Mandalas* we, as art therapists, find few final absolute answers about how to live our inner and outer lives, but many suggested possibilities about how to understand and guide our complex human selves through troubled waters. As ancient Chinese scholars (and contemporary students) of the *I Ching*, use their intuition for matching the pattern of the thrown yarrow stalks with the wisdom of the hexagrams, so can readers and practitioners of this richly rewarding book seek relief, understanding and healing for the world-weary soul of their clients and themselves.

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Xerox copies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ____________________

Degrees/Credentials: ____________________

Address: ____________________

Phone #s: ____________________ work ____________________ home

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ____________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ____________________ **Date** ____________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

CHARLES C THOMAS • PUBLISHER

☐ Anderson, Frances E.—**ART FOR ALL THE CHILDREN: Approaches to Art Therapy for Children with Disabilities, 2nd Ed.** '92, 486 pp. (6¾ × 9¾), 113 il., 19 tables, about $87.50.

☐ Jones, Carroll J.—**HUMAN FIGURE DRAWINGS OF MILDLY HANDICAPPED STUDENTS: Learning Disabled, Mildly Mentally Retarded, Emotionally Disturbed, and Speech/Language Impaired.** '92, 126 pp. (7 × 10), 70 il, $27.75.

☐ Gutsch, Kenneth U. & David Sisemore—**HOW TO PLAY THE RELATIONSHIP GAME: The Use of Psychological Principles to Change Human Behavior.** '91, 112 pp. (7 × 10), $24.75.

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¾), 28 il., $32.75.

☐ Kissel, Stanley—**PLAY THERAPY: A Strategic Approach.** '90, 108 pp. (7 × 10), $24.75.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $42.25.

☐ Jewell, David L.—**CONFRONTING CHILD ABUSE THROUGH RECREATION.** '89, 358 pp. (7 × 10), 1 il., 28 tables, $59.25.

☐ Dennison, Susan T.—**ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents.** '88, 236 pp. (7 × 10), 36 il., 26 tables, $40.00.

☐ Nucho, Aina O. — **THE PSYCHOCYBERNETIC MODEL OF ART THERAPY.** '87, 248 pp. (6¾ × 9¾), 50 il., 4 tables, $42.00.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 × 10), 1 table, $38.25.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $40.00.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $46.25.

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $29.25.

☐ Singer, Florence—**STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children.** '80, 144 pp., 33 il., $21 .25.

☐ Hammer, Emanuel F.—**THE CLINICAL APPLICATION OF PROJECTIVE DRAWINGS. (6th Ptg.)** '80, 688 pp., 360 il., $48.25.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $44.00.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 240 pp. (7 x 10), 24 il., about $43.00.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 206 pp. (7 × 10), 21 il., about $29.75.

☐ Talley, Joseph E.—**THE PREDICTORS OF SUCCESSFUL VERY BRIEF PSYCHOTHERAPY: A Study of Differences by Gender, Age, and Treatment Variables.** '92, 198 pp. (7 × 10), 25 tables, $34.75.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¾), 21 il., $32.75.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $49.25.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (7 × 10), 34 il., $42.25.

☐ Dennison, Susan T. & Connie K. Glassman—**ACTIVITIES FOR CHILDREN IN THERAPY: A Guide for Planning and Facilitating Therapy with Troubled Children.** '87, 304 pp. (8½ × 11), 203 il., 12 tables, $40.00, spiral (paper).

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $30.00.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $81.75.

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $20.00.

☐ Krauss, David A. & Jerry L. Fryrear—**PHOTOTHERAPY IN MENTAL HEALTH.** '83, 260 pp. (6¾ × 9¾), 61 il. (5 in color), 1 table, $40.00.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $21.25, spiral (paper).

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $27.25.

☐ Machover, Karen—**PERSONALITY PROJECTION IN THE DRAWING OF THE HUMAN FIGURE: A Method of Personality Investigation. (11th Ptg.)** '80, 192 pp. (5½ × 8½), 18 il., $26.50.

☐ Hart, Gordon M.—**VALUES CLARIFICATION FOR COUNSELORS: How Counselors, Social Workers, Psychologists, and Other Human Service Workers Can Use Available Techniques.** '78, 104 pp., 4 il., $18.75.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217)789-9130
Books sent on approval • Complete catalog sent on request

2600 South First Street Springfield • Illinois • 62794-9265

BEST COPY AVAILABLE

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ADVERTISING RATES

RATES	1x	2x	3x
Full Page	$300	$275	$240
One-half Page	275	250	215
One-fourth Page	200	175	140

SPECIAL POSITIONS	additional
Cover #2 (Inside Front)	$130
Cover #3 (Inside Back)	130
Cover #4 (Outside Back)	165

COLOR RATES: Standard Red, Blue and Yellow (Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x
Per page additional	$90	$85	$80

INSERTS	1x	2x	3x
2 pp	$ 800	$ 700	$ 575
4 pp	1,500	1,300	1,150
8 pp	2,200	2,000	1,750

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"
Bleed Size: 8-5/8" × 11-1/4"
Inserts: 8-5/8" × 11-1/4"

SUBMISSION DEADLINES:

January 7 for March issue; April 7 for June/July issue; September 7 for November issue

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

1233 BEST COPY AVAILABLE

The American Art Therapy Association, Inc.
1202 ALLANSON ROAD/MUNDELEIN, ILLINOIS 60060
(708) 949-6064

RESOURCES

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following Publications and Films are available from the AATA National Office.

PUBLICATIONS

PUBLICATIONS	Members	Non-Members
Creativity and the Art Therapist's Indentity (1976) 118 pages	$5.00	$7.00
Art Therapy: Expanding Horizons (1978) 142 pages	$5.00	$7.00
Focus on the Future: the Next Ten Years (1979) 151 pages	$6.00	$8.00
The Fine Art of Therapy (1980) 124 pages	$7.00	$9.00
Art Therapy: A Bridge Between Worlds (1981) 119 pages	$7.00	$10.00
Art Therapy: Still Growing (1982) 172 pages	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) 110 pages	$15.00	$20.00
Art Therapy: Professionalism in Practice (1988) 127 pages	$15.00	$20.00
Painting Portraits: Families, Groups & Systems (1989) 141 pages	$15.00	$20.00
Image & Metaphor: The Practice & Profession of Art Therapy (1991)	$15.00	$20.00
Art Therapy in the Schools	$ 6.00	$10.00

*NOTE: for **Publications** postage/handling, add $3.00 for the first unit item $ .75 each additional unit

SEE REVERSE SIDE OF THIS SHEET FOR ADDITIONAL PUBLICATIONS.

** Foreign Orders: Require pre-payment for items and then will be billed for shipping charges as you instruct on order:

Air Mail charges (1 week delivery) or Ground Services charges (2 month delivery)

10 or more copies of any single issue: 15% discount on total cost. Discounts are available when Purchasing quantities. Set of four Proceedings (consecutive years): 20% discount on total cost.

Indicate Quantity of Unit Items Below **Cost/Unit** **Total**

________________ ( ) X ________ = ________
________________ ( ) X ________ = ________
________________ ( ) X ________ = ________
________________ ( ) X ________ = ________

* Publications Postage/Handling = ________ Total Publications Costs = ________

WE DO NOT ACCEPT PURCHASE ORDERS

Art Therapy: Journal of the American Art Therapy Association
Subscription Rates: Individuals — U.S. $25.00; Foreign $42.00; Institutions — U.S. $36.00; Foreign $53.00
Art Therapy: Journal - Back Issues each $9.00 $16.00
AATA Newsletter Subscription Non-Member U.S. $16.00 Foreign $28.00

FILMS (Rental/Purchase)

Art Therapy: Beginnings (1977) color/sound, 45 minutes	16mm Rental Only:	$40.00	$50.00
	½" VHS, Purchase Only:	$50.00	$80.00
Michael (1977) color/sound, 12 minutes	16mm Rental Only:	$30.00	$35.00
	½" VHS, Purchase Only:	$50.00	$80.00
Art Therapy (1981) color/sound, 12 minutes	16mm Rental Only:	$35.00	$45.00
	½" VHS, Purchase Only:	$50.00	$80.00
Lori, Art Therapy and Self Discovery (1978) color/sound, 32 minutes	16mm Rental Only:	$40.00	$50.00
	½" VHS, Purchase Only:	$50.00	$80.00

*NOTE: for **VHS Films Purchase** postage/handling add $3.00 for each film

*NOTE: for **16mm Rental** add $7.00 for postage/handling

Indicate Quantity of Unit Items Below **Cost/Unit** **Total**

________________ ( ) X ________ = ________
________________ ( ) X ________ = ________

*Films Postage/Handling = ________ Total Films Costs = ________

ORDER FORM: *Make checks payable in U.S. funds to AATA, and mail to the above address*

SEND TO: ________________________ MBR. ID. NO. ________

____

City State Zip Code

WE DO NOT ACCEPT PURCHASE ORDERS

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

MEMBERSHIP APPLICATION

NAME ______________________
last first middle

HOME ADDRESS ______________________

____

PHONE (   ) ______________________

BUSINESS ADDRESS ______________________

____

____

BUSINESS PHONE (   ) ______________________

EMPLOYER ______________________

JOB TITLE ______________________

LICENSES HELD & STATE ______________________

PREFERRED MAILING LIST

___ HOME ___ BUSINESS

Please indicate which of the following you are applying for:

___ PROFESSIONAL MEMBERSHIP (an application packet for Professional Membership will be sent to you)

___ REGISTRATION (ATR) (an application packet for Registration will be sent to you)

___ $75 PROFESSIONAL MEMBERSHIP (after approval)

___ $80 ATR MEMBERSHIP (after approval)

___ $100 CONTRIBUTING MEMBERSHIP

___ $75 ASSOCIATE MEMBERSHIP

___ $35 STUDENT MEMBERSHIP (see student membership criterion for necessary documents to accompany this application)

PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO AATA
American Art Therapy Association, Inc.
1202 Allanson Rd./Mundelein, IL 60060

Please complete this survey:

Education (please check highest degree earned)

1 ___ Doctorate Degree
2 ___ Master's Degree
3 ___ Bachelor's Degree
4 ___ Associate/Certificate
5 ___ Other

Work Setting (please check one only)

1 ___ Hospital
2 ___ Clinic
3 ___ Day treatment center
4 ___ Rehabilitation
5 ___ Sheltered workshop
6 ___ Correctional facility
7 ___ Residental treatment
8 ___ Out-patient mental health
9 ___ School system
10 ___ Elderly care facility
11 ___ College/University
12 ___ Clinical training program
13 ___ Institute training program
14 ___ Counseling center
15 ___ Private practice
16 ___ Other ___________

Area(s) of Specialization (please check up to three)

1 ___ Addictions
2 ___ Adolescents, Hospitalized
3 ___ Adolescents, Psychiatric
4 ___ Adults, Hospitalized
5 ___ Adults, Psychiatric
6 ___ Art History
7 ___ Art Therapy Education
8 ___ Art Therapy in Schools
9 ___ Children, Hospitalized
10 ___ Children, Psychiatric
11 ___ Domestic Violence
12 ___ Eating Disorders
13 ___ Families
14 ___ Gerontology
15 ___ Hospice/Terminally Ill
16 ___ Learning Disability
17 ___ Mental Retardation
18 ___ Neurological Disease
19 ___ Prisoners
20 ___ Post Traumatic Stress
21 ___ Psychotherapy
22 ___ Rehabilitation
23 ___ Research
24 ___ Sexual Abuse
25 ___ Visual Art
26 ___ Other ___________

Voluntary Information:

Age:

1 ___ 20-24
2 ___ 25-29
3 ___ 30-34
4 ___ 35-39
5 ___ 40-44
6 ___ 45-49
7 ___ 50-54
8 ___ 55-59
9 ___ 60 +

Salary Range:

1 ___ under $10,000
2 ___ $10-15,000
3 ___ $15-20,000
4 ___ $20-25,000
5 ___ $25-30,000
6 ___ $30-35,000
7 ___ $35-40,000
8 ___ $40-45,000
9 ___ $45-50,000
10 ___ $50,000 +

Gender:

1 ___ Female
2 ___ Male

Hours Worked per Week:

1 ___ 0-10
2 ___ 10-20
3 ___ 20-30
4 ___ 30-40

The American Art Therapy Association, Inc.

1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

THE ORGANIZATION

The American Art Therapy Association (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3500 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice: AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliated Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals, information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive

Publications

- *Art Therapy*, the official journal of the AATA.
- The quarterly *AATA Newsletter*.
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- Free AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payers.
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy.

Professional Standards

- Development of model job and licensure laws.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

GENERAL MEMBERSHIP APPLICATIONS

1. The membership year is the calendar year January 1st through December 31st.

2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY: Please follow the chart below when submitting membership application.

Applications received between

> **Jan. 1st and May 31st**—Full dues payment. Membership will expire Dec. 31st of same year.
>
> **June 1st and Sept 30th**—Half year dues plus $5.00 payment, membership will expire Dec. 31st of same year.
>
> **Oct. 1st and Dec. 31st**—Full dues payment; membership for the remainder of current year and the next full year through Dec. 31st.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to the Membership Chair for approval.

4. AATA Membership and AATA Registration (A.T.R.) each have a separate application procedure. Registration is bestowed only the Standards Committee.

5. National AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL—by application only; such members may vote, hold office and serve on committees.

> **Credentialed Professional Member:** Individuals who have been dually approved for Professional Membership and Registration (A.T.R.) by the AATA, dues are $80 per year.
>
> **Active Professional Member:** Individuals who have completed professional training in art therapy, dues are $75 per year.

CONTRIBUTING—Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $100 per year.

ASSOCIATE—Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $75 per year.

STUDENT—Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Student members may not vote or hold office but may serve on the Student Subcommittee of Membership. Dues are $35 per year.

BEST COPY AVAILABLE

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ART THERAPY is published triannually by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $25 (US); $42 (Foreign). Institutions: $36 (US); $53 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9 member; $16 non-member. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1992. Enclosed is my check, payable to AATA, for $25.
Name ____________________
Address ____________________
City ____________ State ______ ZIP ______

The interdisciplinary journal
devoted to the creative arts as healing arts.

THE ARTS IN PSYCHOTHERAPY

An International Journal

ARTS PSYCHOTHERAPY

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Associate Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

PERGAMON PRESS
Maxwell House, Fairview Park, Elmsford, NY 10523
Headington Hill Hall, Oxford OX3 0BW, England
Member of Maxwell Macmillan Pergamon Publishing Corporation

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions to the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

Editors welcome original manuscripts. Submit papers in triplicate to: Managing Editor, Sylvia Halpern, 20 Ridgecrest East, Scarsdale, NY 10583

SUBSCRIPTION INFORMATION

ISSN: 0197-4556	Volume 17, 1990
Published 4 issues per annum	
Annual Institution Subscription Rate (1990)	US$130.00
Two-year Institution Rate (1990/91)	US$247.00
Professional Rate (1990)	US$ 40.00
Student Rate (1990)	US$ 16.00

BEST COPY AVAILABLE

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 9, NUMBER 3, 1992

1238

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 36-3180580) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $35 (U.S.) and $56 (Foreign); institutions: $50 (U.S.) and $70 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Advertising: Please see advertising rates listed elsewhere in this journal or contact the American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 (708) 949-6064. The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

ISBN 1-882147-02-2

Editor
Cathy A. Malchiodi, M.A., A.T.R.
University of Utah, Salt Lake City, UT

Associate Editor
Patricia St. John, Ed.D., A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor
Elizabeth Ratcliffe, M.S., MFCC, A.T.R.
College of Notre Dame, Belmont, CA

Film/Video Review Editor
James Consoli, M.A., A.T.R., NCC
Eastern Virginia Medical School, Norfolk, VA

Production Editor
Christine Fryer

Editorial Board
Frances E. Anderson, Ed.D., A.T.R., HLM
Illinois State University, Normal, IL
Julia G. Byers, M.A., A.T.R.
Concordia University, Montreal, Quebec
Michael Campanelli, Ed.D., A.T.R.
Wright State University, Dayton, OH
Susan E. Cheyne-King, M.S., A.T.R.
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, M.A., A.T.R.
George Washington University, Washington, D.C.
Maxine Borowsky Junge, Ph.D., LCSW, A.T.R.
Loyola Marymount University, Los Angeles, CA
Paolo Knill, Ph.D., A.T.R., CMT-BC
Lesley College, Cambridge, MA
Wendy Lauter, M.C.A.T., A.T.R.
Oak Park, IL
Vija B. Lusebrink, Ph.D., A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, Ed.D., A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Trudy Martin Manning, M.S., A.T.R.
Eastern Virginia Medical School, Norfolk, VA
Shirley Riley, M.A., MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Paul Rodenhauser, MD
Tulane University, New Orleans, LA
Marcia L. Rosal, Ph.D., A.T.R.
University of Louisville, Louisville, KY
Lewis Shupe, Ph.D., A.T.R.
Wright State University, Dayton, OH
Sandra Ticen, M.S., A.T.R.
Canisius College, Buffalo, NY
Betty Jo Troeger, Ph.D., A.T.R.
Florida State University, Tallahassee, FL
Robert Wolf, M.P.S., A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President
Robin Goodman, Ph.D., A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

ARTherapy
JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Editorial

Art and Loss
Cathy A. Malchiodi, M.A., A.T.R. ▲ 114

Commentaries ▲ 119

Articles

The Use of Art Therapy Following Perinatal Death
Ellen Speert, M.Ed., A.T.R. ▲ 121

Research Approaches Within Masters Level Art Therapy Training Programs
Debra Linesch, M.A., A.T.R., M.F.C.C. ▲ 129

Brief Reports

Art Therapy With Adult Female Incest Survivors
Carolyn S. Waller, M.A. ▲ 135

Viewpoints

Art Captures the Impact of the Los Angeles Crisis
Shirley Riley ▲ 139

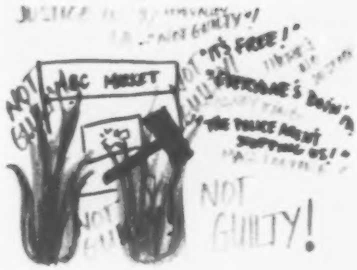
Reviews

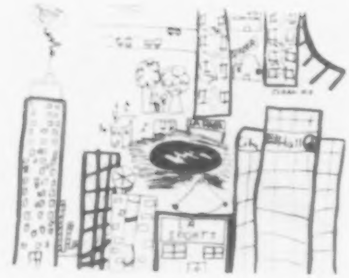
The Well-Being Journal: Drawing Upon Your Inner Power to Heal Yourself
Elizabeth Ratcliffe, M.S., M.F.C.C., A.T.R. ▲ 145

Art Culture, and Ethnicity
Howard McConeghey, Ed.D., A.T.R. ▲ 146

Mommy, Daddy, Look What I'm Saying: What Children are Telling You Through Their Art
Patricia St. John, Ed.D., A.T.R. ▲ 150

Video Review: Imagery and Grief Work: Healing the Memory
James J. Cosoli, M.A., A.T.R., N.C.C. ▲ 152


NOT GUILTY!
ABC MARKET
IT'S FREE!
THE POLICE AREN'T STOPPING US!



About the Cover: "Burning Desire," 22" H × 19" W × 6" D, translucent orange alabaster, by Robert Wolf, M.P.S., A.T.R., art therapist, psychoanalyst, photographer, and sculptor; Associate Professor, College of New Rochelle; Editorial Board Member, *Art Therapy*. About the piece, Mr. Wolf says: "My professional sculpting experience has provided a synthesis of the artist and the therapist within me."

VOLUME 9 NUMBER 3, 1992

Art Therapy: Journal of the American Art Therapy Association, 9(3) pp. 114-118 © AATA, Inc. 1992

Editorial

Art and Loss

Cathy A. Malchiodi, M.A., A.T.R., *Editor*

In this issue, Ellen Speert opens her paper on the use of art therapy with perinatal loss by stating that, "Art therapy is a modality well suited to the needs of grieving women." Most art therapists would also agree that art expression is well suited to the therapeutic needs of anyone who has experienced a loss. Additionally, it has been observed by others outside the field of art therapy that the desire to self-express through an artform is often heightened at times of mourning (Peckham, 1965; Hatcher, 1985). Hatcher (1985) describes this phenomenon from an anthropological standpoint:

> Whatever the theoretical explanation, it is clear that art somehow helps human beings cope with the trauma of death. Beauty and art forms have been part of funeral ceremonies since Neanderthal times. This universal human problem is met everywhere with symbolic solutions to satisfy the mind and esthetic solutions to release the emotions (pp. 106-107).

Judith Rubin (1980) presents a similar perspective through personal observation:

> On walking through the woods near our vacation cottage, I recently came across a self-directed use of art as a way of coping with an overwhelming event. A rural man—a laborer—had carved a powerful totem-like sculpture out of a tree trunk, as part of his mourning process following the tragic death of his young wife. His explanation of the impulse was that he "had to do something," and that the activity of creating the carving had seemed just right, perhaps filling the void left by his loss (p. 6).

The idea that art making can be helpful in processing a loss is certainly not new. In one sense, humankind may have developed art to alleviate or contain feelings of anxiety, fear, crisis, and threat (Johnson, 1987) as well as to make important events such as death "special" through the creation of visual imagery (Dissanayake, 1988). Within our professional field, art therapists have investigated the specific use of art expression in therapy with those clients who have experienced a loss (Simon, 1981; Junge, 1985; Case, 1987; Raymer & McIntyre, 1987, to name a few). Others have used art expression to help those who are seriously or terminally ill face issues surrounding their own death and to express feelings (Perkins, 1976; Fleming, 1983; Jeppson, 1983; Cotton, 1985; Minar, Erdmann, Kapitan, Richter-Loesl, & Vance, 1991, to name a few). Like Speert, these art therapists consistently observe the power and potential of art to help identify, cope with, and/or heal the pain experienced during the process of recovery from loss.

Many clinicians have acknowledged art expression as a way to work through the grief process. Art (as well as creative writing, poetry or other art forms) seems to appear spontaneously in the attempt to express the deep suffering one experiences when confronted with a significant loss. Kubler-Ross (1969; 1981), who brought discussion of the process of bereavement into the mainstream, devoted a chapter of one of her books on death and dying to the use of drawings made at a significant time (see Furth,

---

Editor's note: The editor would like to thank Tania Ottley for generously lending reference materials on the topics of grief, death, and dying.

1981). Other authors in the field of death, dying, and grief remark that expressive arts are helpful to processing a loss (Schneider, 1984, for example), although comments about why the arts are important are less specific.

Additionally, art products made at times of facing a significant loss also seem to have special meanings and content. It has been observed that art expression reveals an "inner" knowledge of impending death for the dying. British psychotherapist Susan Bach (1966; 1975; 1990) has accomplished a significant amount of research in this area, particularly with terminally ill children; both Bernie Siegel (1986) and Gregg Furth (1988) have relied heavily on Bach's research in their use of art expression with the terminally ill. Bach's work has mainly focused on the relationship between the body (soma) and the soul (psyche) in children's drawings. She has noted that visual characteristics such as the numbers of objects in a drawing, color values, and direction of movement in drawings can indicate both recovery from illness as well as downward trends in physical health. For example, according to Bach, the predominant values of colors used by a child with a life-threatening illness give direct information on prognosis.

Bach is well-known among those who are of a Jungian bent for her quadrant theory of drawing analysis, which is discussed in her early work (1966, 1975) and her more recent publication, *Life Paints Its Own Span* (1990). She has developed and tested the idea of dividing a drawing into four distinct quadrants, each of which is considered to represent an aspect of the self. For example, Bach associates the lower left quadrant with negative aspects and, therefore, with downward trends in physical health; objects in this quadrant or movement in the direction of the lower left part of a drawing may be predictive of increasingly poor health or lack of response to medical intervention. However, despite her years of data collection, Bach remains conservative in her use of the quadrant theory and cautions that professionals must also consider other elements such as color, movement, and content.

Art therapists have explored the hypotheses presented by Bach in their work with the terminally ill. Perkins (1976) conducted a preliminary study of the drawings of life-threatened children between the ages of 3 and 12 with life-threatening illnesses; the majority of these children had some form of cancer and a prognosis that was poor. She noted that death anxiety exists fairly consistently, manifesting itself in symbols "suggesting a generalized threat to the child's security" (p. 12). Perkins also used Bach's guidelines (the quadrant theory) for looking at the compositional structure of the drawings. The results of her study indicated that children with serious life-threatening illnesses demonstrated an awareness of death in the colors, symbols, and composition they chose. These findings from Perkins' small sample of children seemed to concur with those of Bach's; others have also explored Bach's concepts, arriving at similar observations (Cotton, 1985; Malchiodi, 1991).

When reading the work of Susan Bach, the transpersonal aspects of the use of art expression in therapy become clearly apparent. For example, the "soul window" has been mentioned by Bach (1966), Perkins (1976), and Cotton (1985); this term refers to a small, often round window that is placed under the eaves of a house. According to Swiss folklore, the soul of a person leaves the home through this opening. Another example which demonstrates transpersonal aspects is the association of the upper left quadrant as an area through which the spirit "goes out of life." Bach, Perkins, and Cotton have documented the depiction of paths going from right to upper left and the appearance of the setting sun in this quadrant, both predictive of impending death.

Clearly, the idea of "going out of life" through a particular space in the drawing and the term "soul window" are two concepts that have deep spiritual meaning and derivation. There are many other images which have strong connection to the spiritual realm, some more universal and some personal to the creator. When art expression is used to access the inner life of the individual who is grieving a loss of the self or loss of another, the realm of the transpersonal is inevitably touched. Profoundly spiritual imagery may emerge in client work at times of crises involving the resolution of a loss.

The first time I was struck by this phenomenon was as an art therapy intern working with a group of adolescents in an alternative program in a public school system. A 13-year-old girl in the group struggled for months with the death of her grandfather; she was extremely guilt-ridden and confused about his death because, at the time of his passing, she was not allowed to see him and speak to him one last time. Several months after the loss she came to an individual therapy session and reported that she had had a wonderful dream the previous night. I asked her to draw or paint the dream, describing as best she could what she thought the most important or memorable part was. She painted Figure 1, depicting her grandfather in the center on a large throne-

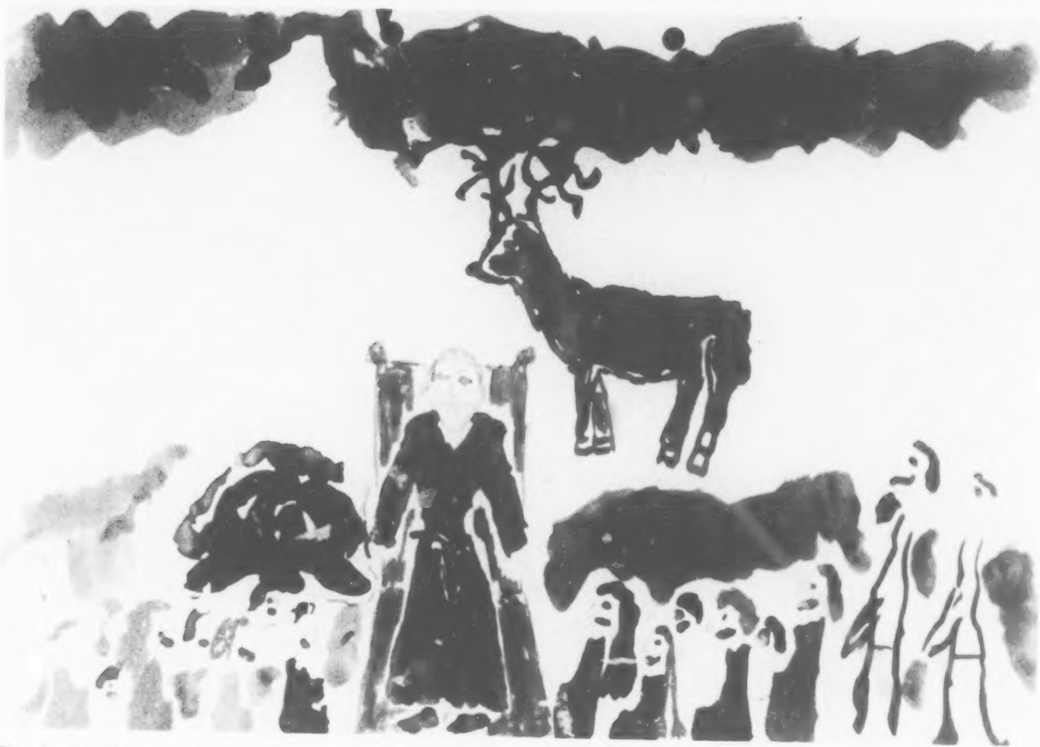


Fig. 1. "My Dream of Grandfather" by girl, 13 years; watercolor; 8½" × 11".

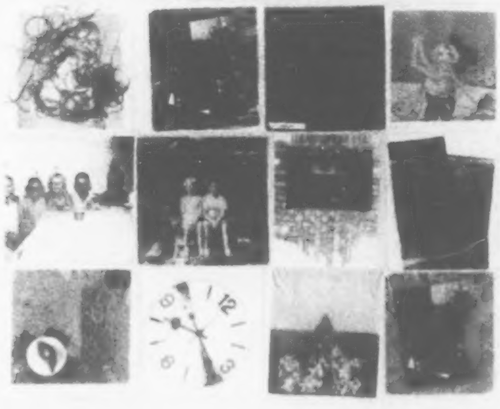


Fig. 2. "Act of Remembrance: Quilt for Ken"; mixed media including photos, transparencies, color Xerox, paint, silk habutae; 24" × 24".

like chair and herself as the person just to the right of him. She included many other people whom she indicated were various important family members.

What was most significant to her in this dream was the fact that she had the opportunity to speak with her grandfather and to hear that he remembered her and considered her to be a very important granddaughter whom he greatly missed. The part that she thought was most unusual was the ending of the dream: a reindeer came to take her grandfather away from the family to another place. Although this seemed strange, she said she was also greatly comforted by it, feeling a sense of relief when this happened in the dream.

Being a novice in my work at this point I had no real understanding of the meaning of the reindeer or the true importance of this dream in the transpersonal realm of healing a loss. Later, as I began to explore symbols, I found several references that helped me to understand the connection of the reindeer to the death of the grandfather and the beginning of the girl's emotional recovery from the loss. For example, the reindeer is a herd animal which humans have followed, or been guided by, over the centuries; in the girl's dream, the reindeer comes to take the grandfather away to another place. Also, the term "rein" is thought to signify the forces of life and the relationship of the soul to the body; to cut the "reins" is symbolically equivalent to dying (Cirlot, 1962).

This case example demonstrates that art expression is not only a way to connect with that which is lost on a transpersonal level, but also a way to remember or commemorate what has been lost. Art has often been made in memory of someone who is lost or departed. In some sense, all art expression may serve as an act of remembrance.

In times of grief many have turned to creating visual memorials to remember, record, and immortalize someone who has died. The AIDS Quilt is a powerful example of this need. When confronted with my own loss of my cousin to AIDS, I found myself deeply drawn to this process in a very personal way (Figure 2). The only way to work out his death was to create the patchwork of events that intertwined our lives, although these memories had become bittersweet with the ending of his life.

The process of creating the quilt was a long one, not unlike the process of completing my own grieving; it took me several months to complete the 12 squares which went into the final piece. It involved many hours of looking through old photo albums, collecting images, and talking to relatives to further illuminate the history of our relationship. I spent a great deal of time writing in my journal and exploring my own feelings and fears about death and dying. Finally, after all the squares were complete, there was the final process of carefully stitching the pieces together and quilting the spaces around them.

This process obviously evokes the ideas of traditional practices of quilting as a commemorative art form, however it also demonstrates the need for creating or experiencing meaningful rituals to deal with loss. The most well-known ritual involving death is the funeral where the bereaved are allowed a public forum to express grief and celebrate the life of the deceased. But rituals can also be specially constructed to address the specific needs of the bereaved. Boegel and van Morising (1991) powerfully describe the personal use of ritual involving movement, objects, and mementos in the "Carla Performance" in response to the death of a loved one. In a discussion of this piece, Gantt (1991) suggests that the art therapist can assist the grieving person in the development of an appropriate ritual, shaped by the client for his/her own situation.

There is also a certain amount of ritual in the telling of a story about an art expression; it is now known that telling others our stories in times of stress or loss can be health-giving and anxiety-reducing. Pennebaker (1990) has established that the telling of painful events is key to successful recovery, both physically and emotionally. Speert importantly observes that art making within a group context can involve both isolation in the process of creation and eventual connectedness to others through the sharing of the product. Others can respond to the product and share common symbols concerning their own losses with the group.

One of the most powerful aspects of art expression in processing loss is the ability to address fear through the art process. Loss of any kind sets up a deluge of diverse feelings—anger, depression, guilt, anxiety, and for many, fear. Once into the process, there is no fear when drawing or painting or constructing. After all, just confronting that blank paper or the untouched materials or clay can be the most courageous of acts when one is in extreme psychic pain. As 28-year-old Dori Hauri (cited in Dreifuss-Kattan, 1982) writes:

> When I paint, I feel less pain. I am still aware of my approaching death, but it loses its tangibility, the thought is not pointed any longer, nor is it blunt, it just exists. I feel that the painting is inside me like a

freshly sown plant and its fruit can grow. With my paintings I can oppose my illness. (p. 51)

Lastly, although some individuals can confront and work through many of the conflictual issues of bereavement through art forms on their own, Rita Simon (1981), British art therapist, notes that the "companionship and security of a therapeutic relationship" (p. 135) is necessary to sucessfully process a loss. The individual who is grieving and working through a loss through art expression needs a responsible witness and guide to illuminate the process and to give the appropriate and knowledgeable response to that which is expressed in visual form. In some cases, this training in both the areas of graphic communication and human emotion may be critical, such as in identifying the individual who is so troubled by loss as to consider taking his/her own life. As professionals in the field of art therapy, our knowledge about visual form, the art-making process, and the psyche is essential in assisting the individual who wishes to explore and work through the pain of loss in visual art.

This article is dedicated to the memory of Merritt Riordan, who died in May of 1992, and to his family Anne, Mike, and Stacia Riordan and Chris Pocock.

References

Bach, S. (1966). Spontaneous paintings of severely ill patients. *Acta Psychosomatica*, *8*(18), 1-66.

Bach, S. (1975). Spontaneous pictures of leukemic children as an expression of the total personality, mind and body. *Acta Paedopsychiatrica*, *41*(3), 86-104.

Bach, S. (1990). *Life paints its own span*. Einsiedeln, Switzerland: Daimon Verlag.

Boegel, K., & van Morissing, L. (1991). The healing qualities of art. *Art Therapy: Journal of the American Art Therapy Association*, *8*(1), 12-15.

Cirlot, J. E. (1962). *A dictionary of symbols*. NY: Philosophical Library.

Cotton, M. (1985). Creative art expression from a leukemic child. *Art Therapy: Journal of the American Art Therapy Association*, *2*(2), 55-65.

Dissanayake, E. (1988). *What is art for?* Seattle: University of Washington Press.

Dreifuss-Kattan, E. (1990). *Cancer stories: Creativity and self-repair*. Hillsdale, NJ: Analytic Press.

Fleming, M. (1983). Early object loss and its relation to creativity as expressed through art therapy. In A. Di Maria, E. Kramer & E. Roth (Eds.) *Art Therapy: Still Growing. Proceedings of the Thirteenth Annual Conference of the American Art Therapy Association* (pp. 53-57). Alexandria, VA: AATA, Inc.

Furth, G. (1981). The use of drawings made at significant times in one's life. In E. Kubler-Ross, *Living with death and dying* (pp. 65-94). New York: MacMillan.

Furth, G. (1988). *The secret world of drawings*. Boston: Sigo Press.

Gantt, L. (1991). Discussion. *Art Therapy: Journal of the American Art Therapy Association*, *8*(1), 15-16.

Hatcher, E. (1985). *Art as culture*. Landham, MD: University Press of America.

Jeppson, P. M. (1983). Creative approaches to coping with cancer: Art therapy and the cancer patient. In A. Di Maria, E. Kramer & E. Roth (Eds.) *Art Therapy: Still Growing. Proceedings of the Thirteenth Annual Conference of the American Art Therapy Association* (pp. 45-47). Alexandria, VA: AATA, Inc.

Johnson, D. R. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy*, *14*, 7-13.

Junge, M. (1985). The book about Daddy dying: A preventative art therapy technique to help families deal with the death of a family member. *Art Therapy: Journal of the American Art Therapy Association*, *2*(1), 4-10.

Kubler-Ross, E. (1969). *On death and dying*. New York: MacMillan.

Kubler-Ross, E. (1981). *Living with death and dying*. New York: MacMillan.

Malchiodi, C. A. (1991). Art Rx: Art expression and physical health. *Image & Metaphor: The Practice & Profession of Art Therapy* (p. 86). Mundelein, IL: AATA, Inc.

Minar, V., Erdmann, J., Kapitan, L., Richter-Loesl, S., & Vance, L. (1991). Confronting cancer through art: A collaborative effort by hospital, patient and therapist. *Image & Metaphor: The Practice & Profession of Art Therapy* (p. 77). Mundelein, IL: AATA, Inc.

Peckham, M. (1965). *Man's rage for chaos: Biology, behavior, and the arts*. Philadelphia, PA: Chilton.

Pennebaker, J. W. (1990). *Opening up: The healing power of confiding in others*. New York: William Morrow and Co.

Perkins, C. F. (1977). The art of life-threatened children: A preliminary study. In R. H. Shoemaker & S. Gonick-Barris (Eds.) *Creativity and the Art Therapist's Identity* (pp. 9-12). Baltimore, MD: AATA, Inc.

Raymer, M., & McIntyre, B. (1987). An art support group for bereaved children and adolescents. *Art Therapy: Journal of the American Art Therapy Association*, *4*(1), 27-35.

Rubin, J. (1980). Art therapy today. *Art Education*, *33*(4), 6-8.

Siegel, B. (1986). *Love, medicine and miracles*. NY: Harper & Row.

Simon, R. (1981). Bereavement art. *American Journal of Art Therapy*, *20*, 135-143.

Art Therapy: Journal of the American Art Therapy Association, 9(3) pp. 119-120 © AATA, Inc. 1992

Commentaries

Supervision and the Issue of Case Management

The traditional framework for art therapy supervision includes a discussion of theory and practice, metaphor and process, media and expression, projection and interpretation, and other issues to assist the art therapy intern to better achieve clients' goals set during the session. Many variations and special problems will arise with each person and each population engaged in treatment. All will be considered in the supervisory hour. None of these issues is foreign to our educational policies and are foundations for the supervisor/supervisee work.

However, one clinical difficulty is often ignored or purposely avoided by many art therapy training programs. Case management is the piece left out of our education in many instances. The argument is made that case management is best taught within the practicum by the clinical supervisor on site, an employee of the facility. I agree that this solution is workable if the clinic or hospital is a teaching agency and pays attention to the students' need for assistance. My concern is with the many instances when the clients' needs have been poorly handled because the instruction needed to provide them with information, or active help, has not been forthcoming.

Emotional stress is not an uncommon reaction for an intern entering a practicum. Responsibility for treatment and first-hand encounters with the wide range of human troubles appropriately causes heightened anxiety. However, additional tension which is engendered by the necessities of coping with both clinical issues and case management can be reduced by helping the student anticipate the realities of the mental health world at this time of economic cutbacks, increased crime, and abusive behaviors. Far from the creative and satisfying experiences of engaging a client in the art therapy process, exploring material and experimenting with positive change, is the experience of reporting to Children's Services the abusive activity of an adult to a child. We have to face that a good part of the practicum will not involve using inventive media to introduce movement intrapsychically—rather, it will involve using the telephone and filling out forms to satisfy legal and ethical standards.

For example, does the intern know how to proceed when the clients' art product indicates that abusive behaviors are "secretly" going on in the home? Does s/he pursue more art tasks hoping to gain clear evidence or does s/he confront the family or child verbally with her suspicions? Has the intern been briefed how to proceed with reporting to the proper authorities? Is the art product seen as confidential, priviledged communication of therapy or legal evidence that may be subpoened? When suicidal symbols emerge in the art expression where does the intern turn for help? Are needed hospitalization procedures clearly understood? If there is no sure reason to commit, does the student know how to insure around the clock protection for the patient in their home? When these crises come about has the student been advised how to precisely document all aspects of the clinical emergency in a manner that protects the intern from possible legal action? These issues only touch on some of the many situations that call for student involvement outside the focus of art therapy treatment.

We teach with pride that art therapy expressions provide a clinical tool which leads to a better understanding of the client's world. However, when the message conveyed in the art calls for immediate protective action, the therapist must deal with the larger system as it is defined legally by the state.

I don't think that this dilemma necessarily defeats the pleasure and excitement that our students feel as they learn to be professionals, but it seems to me that the idealism that they bring to the practicum could be protected if we warn them ahead about some grim realities. I have yet to have a student share with me joy and inspiration over the task of filling out a Medi-Cal form for the State.

We should give serious thought to how the socio-economic issues of our time impact the curriculum and the supervision of today's student/interns. Perhaps in some areas this is not a major problem, but those who live in California, New York, Chicago, or in the pockets of troubled areas in our country, I venture to say that our students are involved for a large percentage of their training in case management. Even if they try to avoid the problem or feel distressed by having to take on these duties, they are there.

To me, the conflict is real: art therapy thinking and case management thinking only overlap to a small degree. We have the responsibility to teach all aspects of treatment. If that is unrealistic, as I believe it is, we must address the situation and clearly define who will educate our interns when the need arises in the area of case management.

Shirley Riley, A.T.R., M.F.C.C.
Los Angeles, CA

Response to Survey of Assessment Use with Children

I am currently teaching the course, "Treatment Planning in the Creative Arts," in Lesley College's Expressive Therapy Program. In our readings I included the article published in *Art Therapy*, "An Informal Survey of Assessment Use in Child Art Therapy" (Mills, A., & Goodwin, R., 1992). In our class of 23 students, we looked at the wide variety of assessment procedures available to art therapists, ranging from projective drawing tests used by the clinical psychologist, standardized art therapy measures such as the Diagnostic Drawing Series and loosely structured sessions that respond to client initiatives. As a mid-term assignment, the students wrote a paper based on an assessment of their choice at their internship site. They were free to follow or modify existing procedures, to invent their own and/or to encourage their clients' spontaneous art activity.

In reviewing the students' assessment procedures it was fascinating to discover how similar their approaches were to the art therapists surveyed by Mills and Goodwin (1992). Like the art therapists in that survey, the students showed a great diversity in their choices of assessments. Many modified standard assessments to adapt them to their specific sites and populations. Others freely invented their own procedures. Those who used standard procedures did so in a variety of ways. Students who used the DDS obtained much information useful to their teams and some suggested modifications. Those who used the standardized House-Tree-Person seemed to be least satisfied.

The choices and attitudes of this class of Expressive Therapy graduate students provide support to the findings of Mills and Goodwin (1992) that art therapists often prefer to modify existing techniques or create their own.

Susan Evans Spaniol, M.A., A.T.R.
Newton, MA

Special Notes

THE WHITE HOUSE

May 21, 1992

Dear Ms. Malchiodi,

How thoughtful of you to send a copy of *Art Therapy: Journal of the American Art Therapy Association*.

The goal of disseminating information on art therapy looks like a worthy one. I am sure that those who deal with mental health services are grateful for this enrichment and breadth of helpful strategies for working with people who are emotionally disturbed. Thank you so for thinking of me and for sharing.

With best wishes,

Warmly,

Barbara Bush

Barbara Bush

June 25, 1992

Cathy Malchiodi, A.T.R.
Editor, *Art Therapy*
℅AATA, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Dear Cathy,

Just received your first issue of *Art Therapy* and wanted to send my commendations and best wishes on the new look, layout, and organization. I know the gigantic effort involved in a major makeover as well as the large consumption of time in editorial duties—and simply wanted to send my highest congratulations to you and the good folks involved in the production.

Sincerely,

Thomas A. Hatfield,
Executive Director
The National Art Education Association, Reston, VA

Art Therapy: Journal of the American Art Therapy Association, 9(3) pp. 121-128 © AATA, Inc. 1992

The Use of Art Therapy Following Perinatal Death

Ellen Speert, M.Ed., A.T.R., Encinitas, CA

Abstract

Art therapy is a modality well suited to the needs of grieving women. During the bereavement period following a miscarriage, stillbirth, or abortion, complex emotional responses are often difficult to verbalize, leaving grieving women isolated and confused. This paper presents information on perinatal death and the usefulness of group art therapy as an intervention within the framework of the new psychology of women. Client art expressions illustrate how women have used art therapy to work through their grief and move toward a deeper sense of personal empowerment and connection with other women.

For years, the issues of the death of a baby due to miscarriage, stillbirth, or abortion surfaced in numerous art therapy groups which the author facilitated. Due to the frequency of this occurence, a four-part, one-day workshop to specifically address perinatal death through art therapy was developed. Each part of the workshop was designed to address the various phases of the grief cycle. Simple art materials were used to: provide a spontaneous art expression as a graphic, metaphoric representation of the self; symbolically explore personal loss; work with the theme of reclaiming "the girl within", and express connection and wholeness through creating group art expressions.

Perinatal Loss

Each year in the United States about 33,000 babies are stillborn (about one in 100) according to the National Center for Health Statistics. According to Friedman (1982), stillbirth occurs at the rate of 12.6 in 1000. A much higher percentage (about one in 10 pregnancies) ends in miscarriage and an unknown number in abortion.

Despite the large number of perinatal deaths, the mother's need for mourning often goes unmet (DeFrain, 1986). Perinatal death brings together two of the most emotional of human experiences: birth and death. Although women come together in the joy of the former, they are often left isolated in the grief of the latter. Friends and family generally feel uncomfortable and ill-equipped to address the subject, leaving the woman alone in her grieving. Furthermore, the mother may be left in "medical limbo" as her obstetrician views her/his job as finished and the pediatrician has no infant to attend (Peppers, 1980). Common medical and lay responses include: "You can have another one," "It's a freak of nature," and "It's nature's way of getting rid of defects." Doctors and nurses may further distance themselves from the emotional reality of this loss of a life by referring to the baby as the "product of conception," a sanitized term to go along with the medical procedures following miscarriage or abortion. These responses overlook the woman's need to grieve her loss and may inadvertently increase her sense of isolation.

With the suppression of grief, the mourning process is prolonged and may trigger compounding emotional problems. In addition to symptoms seen during bereavement (sadness, anger, depression, emptiness, and blaming), the mother often experiences guilt inadequacy and a sense that the perinatal death reflects her failure as a parent. There may also be serious behavioral ramifications including sleep disturbance, suicidal thoughts, marital turmoil, increased rate of divorce, substance abuse, family violence, and overprotection of surviving children (DeFrain, 1986). Also, with perinatal death there are no shared life experiences or memories, so a woman is left with a sense of unreality, further disconnecting her from others.

Physical symptoms are also present and are similar to those experienced following the death of an adult. However, women often speak of deep physical pain, aching arms and/or chest during the months following the perinatal loss. These symptoms differ in some respects from those experienced following the death of an older person.

The Psychology of Women and Perinatal Loss

Even if a woman who has experienced a perinatal death is in therapy during the time of loss, traditional psychological constructs may not meet her needs. During the last decade, women have begun to study the ways in which their own psychology differs from that of men. Historically, men were not only the ones to construct the theories of human development, but they also served as the only subjects studied. It is perhaps because of this limited research population that Freud (1938), Erikson (1950), and Levinson (1978) all saw life as a struggle toward achievement and separation. It was assumed that when female clients did not mature along these lines they were deficient and, by definition, abnormal. Hancock (1989) writes that Freud assessed psychological development of the male by his separation from his mother and "thus he conceptualized development in terms of male norms and female deficiencies and pronounced women inferior in maturity" (p. 230). For this reason it was generally believed that the measurement for psychological and emotional maturity rested on the degree of separation and individuation one achieved.

Stiver (1991) points out that "the inflexible application to female development of a concept derived from male development, without sufficient attention to the quality and nature of women's experience, leads to a significant misunderstanding of women" (p. 86). Stiver, along with Jordan, Kaplan, Miller, Surrey and others at the Stone Center at Wellesley College, have brought to light new perspectives concerning the psychology of women. As a result, affiliation and connectedness are now considered important components of female maturity (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). Their perspectives redefine what constitutes psychological health, taking into consideration the unique aspects of female growth and development.

Surrey (1991), in what she calls the "self-in-relation model of development," postulates a female-centered theory of maturation. She traces the development of identity through specific relational networks and uses the term "relationship differentiation" in place of separation-individuation. Surrey uses the concept of differentiation in the sense of an embryonic cell becoming more highly developed. She states that "this is a process that encompasses increasing levels of complexity, choice, fluidity and articulation within the context of human relationship" (p. 60). Thus, development of relationships is central to female maturation and identity.

Surrey's concept is of particular importance in understanding women who are grieving a perinatal loss. This loss severs relational connection and cuts down the sense of choice, fluidity and articulation. Fortunately, these very qualities may be enhanced and nurtured within the art therapy process.

Specific Uses of Art Therapy with Perinatal Loss

Carol Gilligan (1982) observes that a woman's identity is threatened by separation. Art expressions created at the time of perinatal loss, and for months afterwards, often graphically express a lost sense of self; Figure 1 is an example of this lost sense of self, a collage figure with the head removed and arms outstretched. The creator stated that "it feels like I'm reaching for something or someone, like I need to connect." Thus, in creating this figure, the woman could express her loss and, in seeing similar symbols created by others, reduce her sense of isolation.

With the loss of a fetus, clients express a sense of being cut off from their own bodies (Figure 2). This woman, whose mother took diethystibestrol (DES) when trying to conceive her, now finds herself unable to carry a baby to term and has had repeated miscarriages. She shows graphically the blocks she has in experiencing a sense of her own body. Due to the visual and kinesthetic richness of color, texture, scent, and sound, clients' senses are often stimulated. They frequently feel more connection to their bodies through the process of pounding, tearing, painting, and gluing.

Because women tend to fuse their sense of identity with intimacy and connectedness, their assessment of self is measured by the standard of their relationships. Miller (1976) observes that a "woman's sense of self becomes very much organized around being able to make, and then maintain, affiliations and relationships. . . . Disruption of connections is perceived not as just a loss of a relationship, but as something closer to a total loss of self" (p. 83). This is expressed in the repeated hand-print motifs (Figure 3) as women speak of not only being unable to touch their babies, but also of not feeling real themselves. The hand symbolically says, "this is me." Several cli-

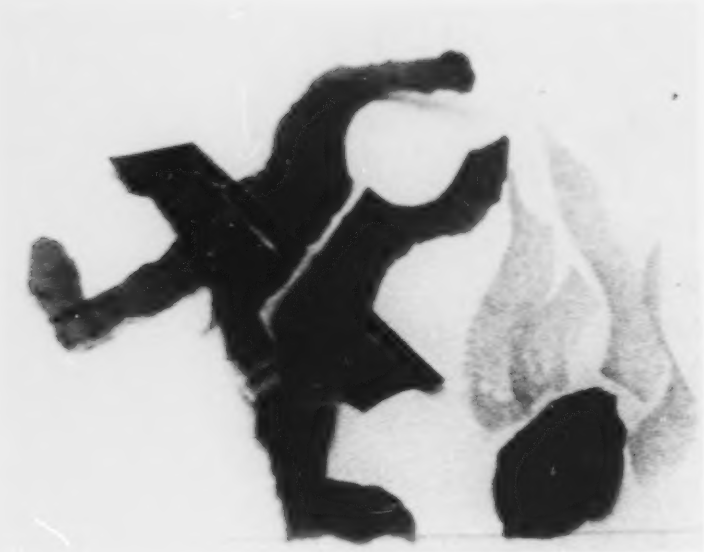


Fig. 1

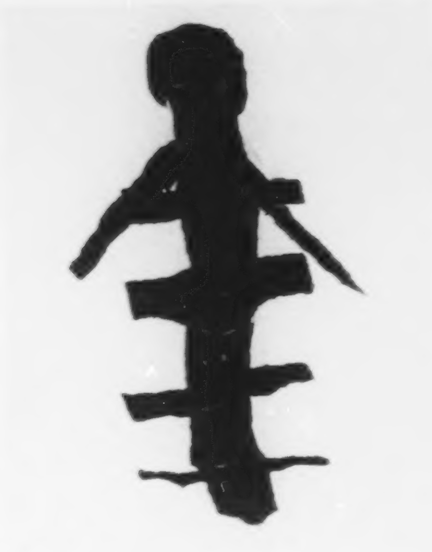


Fig. 2

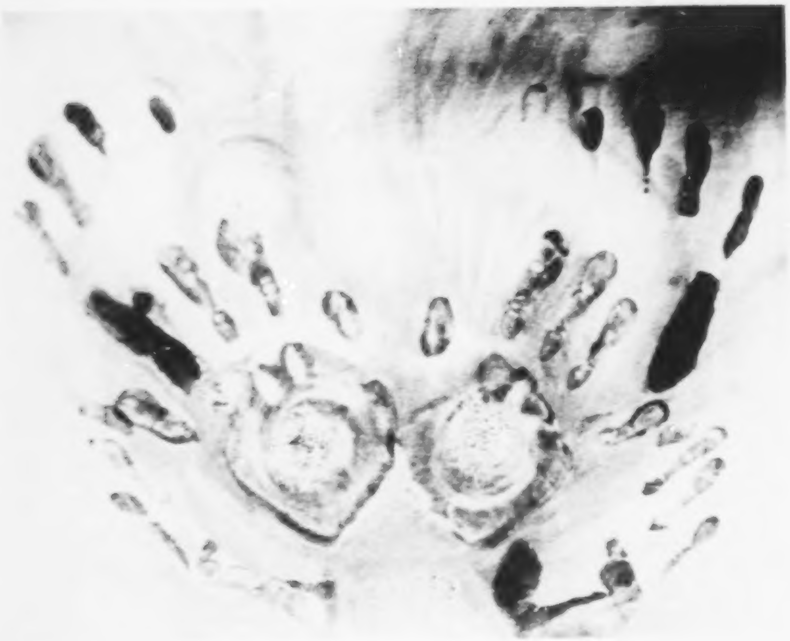


Fig. 3

BEST COPY AVAILABLE

ents also told of making impressions of their stillborn babies' hands to create a tangible object to preserve.

A woman who has lost her fetus naturally experiences a feeling of confusion over her loss. Art expression provides her with containment for this often chaotic outpouring (Figure 4). For example, the tearing of paper and flinging of paint provides an avenue of release while simultaneously structuring the chaos. Background paper had been placed inside a large tray which served to contain and give a tangible boundary to the flood of emotion.

In contrast, feelings of depletion and isolation are expressed. Many women speak of feeling lonely, isolated, and empty and use the art to fill this internal void. Surrey (1991) observes that "if the connection feels severed, there can be a sense of deadness, blackness, and even terror; some have described this experience as a 'black hole'" (p. 172). Figures 5-7 illustrate the working through of emptiness and vulnerability. A clay body was ripped open and brightly colored tissue pieces were first placed inside the womb/wound, then removed and later were again placed inside. As this woman worked through her loss, she felt a need to cover and protect her clay self using dryer lint and the shredded tissues from her tears. She also added "a brain to help understand it all." Finally, removing the protective blanket and acknowledging the pain as part of herself, she used the tissues to surround rather than cover herself.

Lost babies are created over and over again in a wide variety of media (Figures 8 & 9). Clay, plasticene, and cloth can have soothing qualities, due to their tactile richness and the ability to form an object product which can be held. With the art product, there can be a feeling of connectedness to the lost babies, keeping them a part of the woman's life. The women in the perinatal loss groups often speak of the need to have a tangible and lasting part of their lost child. One woman stated that the plasticene baby (Figure 8) which she now keeps in a visible place at home helps to say to others, "You might not be dealing with it (the stillborn baby), but I am."

As previously stated, for many women there is not only a need to be in a relationship in order to experience a complete sense of self, but they may also need to feel competent and in control. The death of a fetus may create a feeling of incompetence and loss of control which can be addressed through art therapy. Because of the contained, concrete quality of art making in a structured, therapeutic context, women are able to take risks, practice new behaviors, gain control, and develop a sense of mastery. The art product may then be placed at a distance and viewed more objectively. Although alone in the art making, the woman has allies in reviewing the art expression and can try out new ideas with the encouragement of others in the group. For example, the various changes the artist made in the sculpture (Figures 5-7) provided her with a greater sense of control.

Art expressions often reveal rage (Figure 10); clay, as a resistive medium, is helpful in releasing this rage. The outpouring of anger may be a response to the unfairness of life, a woman's feeling of incompetence, her inability to control what has happened within her own body, the lack of sensitive medical response, or other frustrations. After creating the piece, the woman stated, "I am pushing myself up out of the block and screaming." The block is styrofoam, which she stated is, "fake and cold, but the clay is warm and real . . . my rage is helping me push out."

Clay is also effective in relieving some of the pain in the chest and arms which mothers complain of following a stillbirth. With the force necessary to form clay, clients reduce the somatic component of their pain directly through body movement. Arms are now productively active rather than passive, at least during the session. Additionally, women speak of experiencing greater energy and less depression during art making, despite the sad content of their work.

Hancock (1989) observes women's needs to meet "the culture's expectation of the perfect weight, the perfect curl, the perfect makeup, the perfect orgasm, perfect childbirth, perfect children. . . . The demand for perfection is yoked to that for nuturance in the ideal of perfect nuturance that drives us all" (pp. 187-188). The creative process provides the opportunity to express a woman's authentic self, lifting the layer of external, social expectations for perfection and conformity to roles. Art making allows the grieving woman to focus inward and to express and release emotions that family, friends and others have been unable to accept.

Lastly, the loss of a fetus is often experienced as the loss of the (pro)creative self. This shift in the sense of self from full and creative (as during a wanted pregnancy) to loss of the creative potential may mirror an earlier loss of confidence.

Miller (1976), Gilligan (1982), and Hancock (1989) have studied the diminished sense of autonomy and self-confidence during normal female adolescent development. Hancock (1989) discovered that confident, self-assured nine-year-old girls often became conformist, hesitant and self-doubting only a

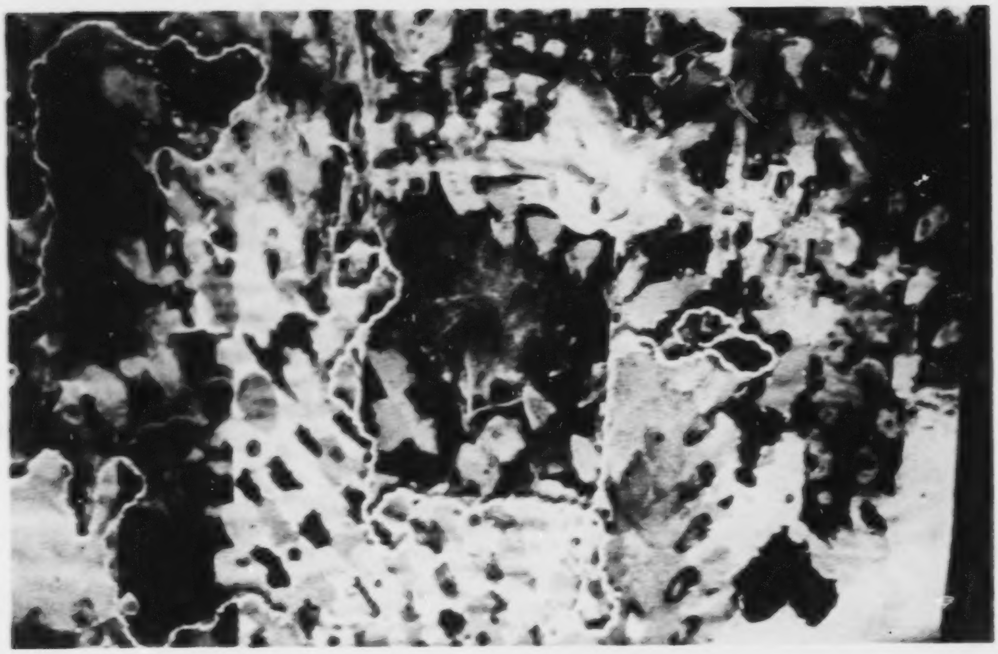


Fig. 4

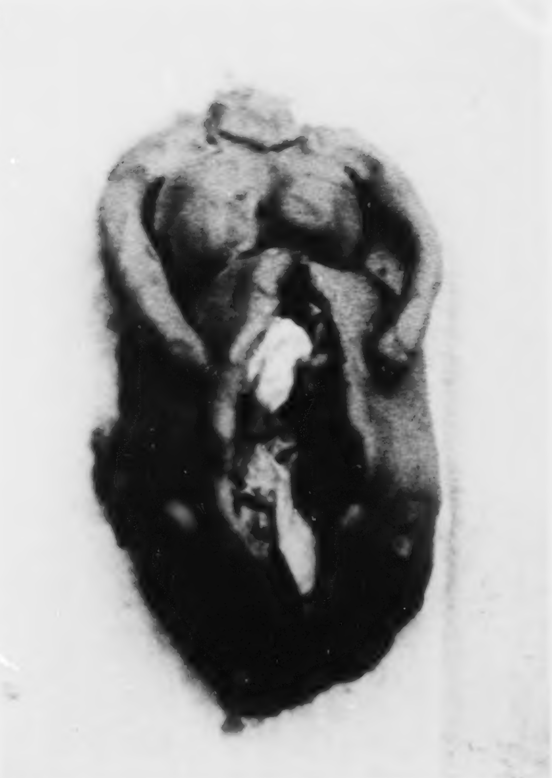


Fig. 5

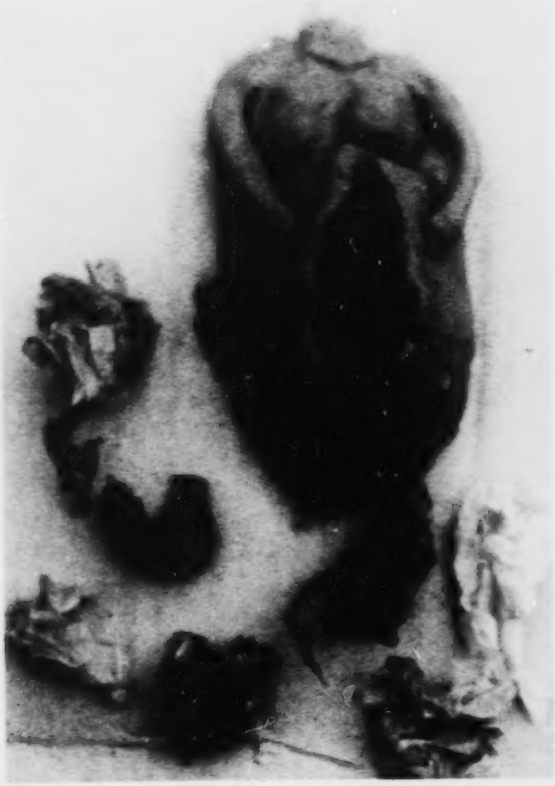


Fig. 6

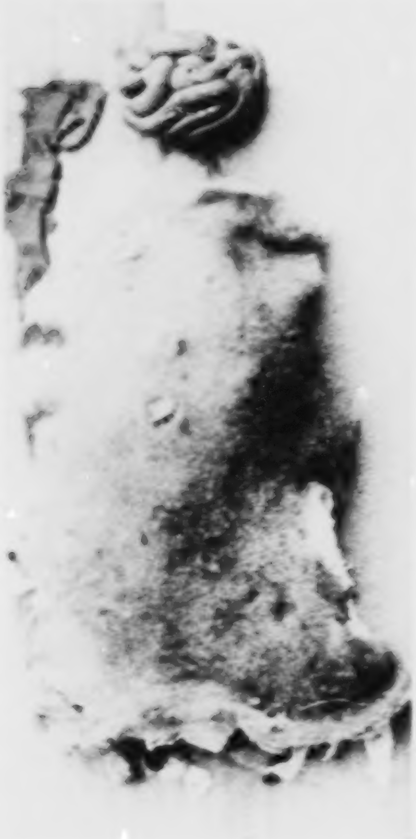


Fig. 7

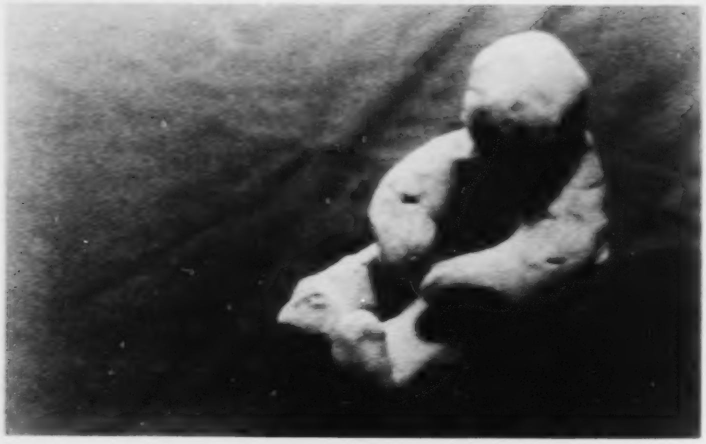


Fig. 8

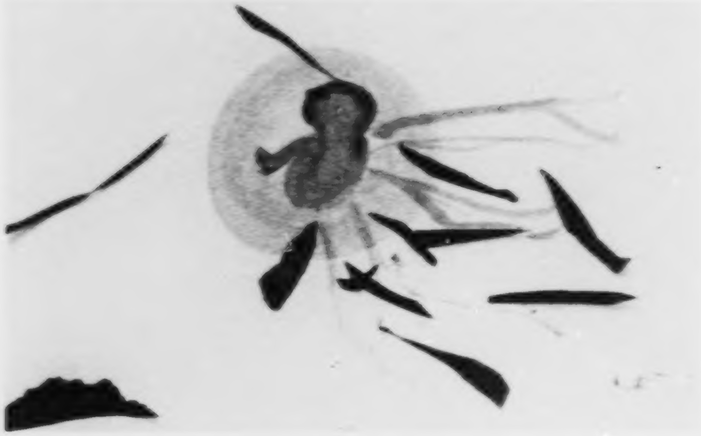


Fig. 9

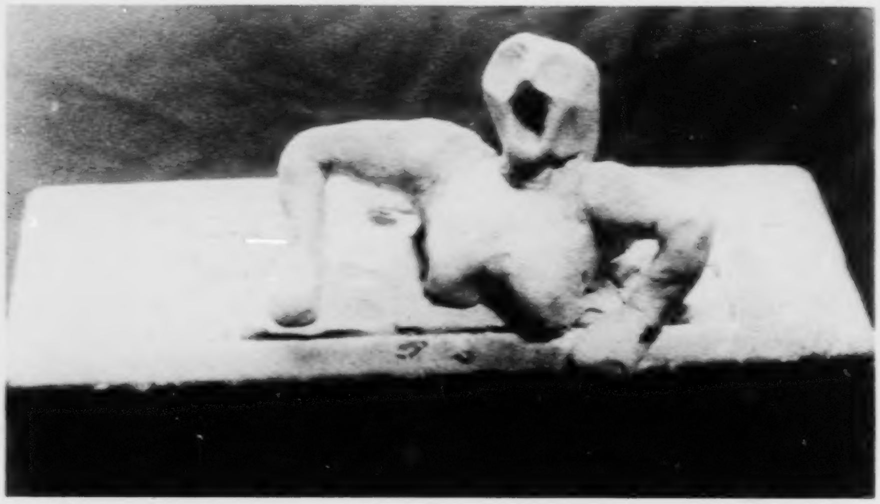


Fig. 10

few years later. Something in society gives females the message that creativity and confidence is no longer to be trusted or valued after age 12 or 13. Hancock refers to this creative, confident individual as the "girl within."

The creative process can enhance self-esteem and revive a personal sense of purpose. Art making may symbolically rekindle this "spark" as women again see themselves having the capacity to create. The creative process can renew the "girl within" while simultaneously working through the grief process.

Loss → Creativity Workshop: Techniques

In the workshops conducted by the author, simple art materials are introduced first. One of several warm ups is presented: wet paper and paint technique (finding an image to develop out of paint dropped on wet paper), wrinkling up paper and developing an image out of the fold lines, or simply finding an image to develop out of a scribble. During this warm up there is often talking, sometimes even laughter. This may be due to the newness or awkwardness of the art making, as many clients state they have not made art since grade school.

Next a process is used which the author developed. First, each woman is asked to tear a shape to represent herself from a color that feels right for her. Fadeless paper is provided because of its wonderful colors and the deckel edge produced when torn. Second, she chooses a color to represent her loss and tears it into an appropriate shape. Third, she uses rubber cement or glue stick to attach these, in their appropriate relationship, onto an 18" × 24" piece of white cardboard or heavy paper. Lastly, she draws with oil pastels what is needed to bring comfort, wholeness, or peace to the torn-paper images.

During this process the room is silent, in contrast to the warm up which preceded it. Women often comment later that they had forgotten they were in a group and that they felt totally alone as they worked. The group then spends as long as is needed talking about the process and product.

The third phase of the workshop is designed to focus on the creative "girl within." Each woman talks of a time when she felt free to explore and express herself. An individual collage is then created by each participant using a variety of materials such as feathers, cloth, glitter, nature objects, tissue, paint, etc. The wide selection of art materials encourages exploration and evokes early feelings of creativity and freedom.

After talking about these individual collages, a group mural is assigned, incorporating each woman's sense of her own child within. This process puts the women in connection with others in the group. There is often a visual interconnection of symbols and lines, and the process is far from silent. By this stage in the workshop, the women have established connection and intimacy with others in the group.

Art making, by the nature of its two-step process of expression and reflection, allows both the isolation of internal focus and the connectedness with others. As the visual symbols of loss are shared with others in the group, they also promote deeper self understanding as well as connection.

Summary

The creative experience of using the art for self exploration during the time of traumatic loss provides a tremendous opportunity for growth. It is the author's experience that connection (the female voice of "we" rather than the male voice "I") is a critical factor in the shift to a sense of empowerment and eventual growth. The trauma of a fetal death may be healed by a new sense of relatedness both with others as well as with the self.

Miller (1976) states that there is the ". . . absolute necessity of, and absolute existence in human beings of, the potential for both cooperation and creativity . . . the intense personal creating that we each must do all through life. Everyone repeatedly has to break through to a new vision if he is to keep living" (p. 44). Indeed, clients demonstrate these elements of cooperation, creativity and the re-creation of their personal vision by struggling with the art media. Through this work each woman fashions a stronger identity.

Perhaps female clients can be better served by framing interventions and the entire structure of their treatment in terms of a relationship model, supporting connection rather than autonomy. As Surrey (1991) observes, "the joining of visions and voices creates something new, an enlarged vision . . . thus the sense of connection and participation in something larger than oneself does not diminish, but rather heighten the sense of personal power and understanding" (p. 172). This author increasingly utilizes the workshop and group format of treatment in place of individual therapy. As Kohut's view of treatment is to help patients feel that "the sustaining echo of emphatic resonance is indeed available in the world" (1984, p. 78), so this writer finds the group therapy format provides more reflective surfaces to both contain and mirror each women's experience of loss and validate her sense of self. The echos, in this way, can be heard not only through the therapist and the artwork, but through the other group participants. The feminist psychological approach of mutual empowerment and connection continues to be studied at the Stone Center (Jordan et al. 1991), and further research based on this work is needed on group art therapy models.

The Loss → Creativity Workshop is designed to stimulate a deeper, more personal response in working with women experiencing perinatal death. As Johnson (1989) writes of our role as therapists that we "are constrained by the greater value our society places on control versus empathy, external versus internal concerns, managing versus caring. . . . In this sense our struggle is part of a larger, even more important struggle, not merely that of the women's movement, but supporting the values women have come to represent" (p. 236). These feminine values of empathy and connectedness are enhanced by the process of creating art together in a group format.

Further support for the group therapy approach comes from DeFrain (1991), who has spent many years observing and working with families suffering perinatal loss. He states, "The death of a baby is clearly not an individual loss . . . though individual treatment is on occasion warranted, we believe that in most cases it would be wise to encourage group solutions to many of the dilemmas the death imposes" (p. 229).

As health professionals, art therapists must support the need to express and creatively transform the issues of grief and loss with our clients to prevent some of the psychological, sociological and behavioral problems resulting from unresolved grief. We must not shy away from connecting with this pain and loss. As we are learning from the new psychology of women, a sense of connection is an essential part of addressing the needs of grieving women, particularly those experiencing the unique trauma of perinatal loss.

References

DeFrain, J. (1986). *Stillborn, the invisible death.* Lexington, MA: Lexington Books.

DeFrain, J. (1991). Learning about grief from normal families: SIDS, stillbirth and miscarriage. *Journal of Marital and Family Therapy, 17*(3), 215-232.

Erikson, E. (1950). *Childhood and society.* New York: N.W. Norton.

Freud, S. (1938). Three contributions to the theory of sex. In *The Basic Writings of Sigmund Freud* (pp. 553-629). New York: Random House.

Friedman, R. (1982). *Surviving pregnancy loss.* Boston: Little, Brown.

Hancock, E. (1989). *The girl within.* New York: Fawcett Columbine.

Johnson, D. R. (1989). Introduction to special issue on women and the creative arts therapies. The *Arts in Psychotherapy, 16,* 235-238.

Jordan, J. V., Kaplan, A., Miller, J. B., Stiver, I., & Surrey, J. L. (1991). *Women's growth in connection: Writings from the Stone Center.* New York: The Guilford Press.

Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.

Levinson, D. J. (1978). *The seasons of a man's life.* New York: Alfred A. Knopf.

Miller, J. B. (1976). *Toward a new psychology of women.* Boston: Beacon Press.

Peppers, L. (1980). Adjustment to perinatal death. *Psychiatry, 43,* 155-159.

Art Therapy: Journal of the American Art Therapy Association, 9(3) pp. 129-134 © AATA, Inc. 1992

Research Approaches Within Master's Level Art Therapy Training Programs

Debra Linesch, M.A., A.T.R., M.F.C.C., Los Angeles, CA

Abstract

A research project was conducted as a preliminary exploration of the attitudes and approaches toward research within Master's level art therapy training programs. The results of a questionnaire that was sent out to the research methodology instructors of graduate programs in art therapy are discussed. Comparative information regarding the ways in which the research process is prioritized, conceptualized and taught within different training approaches is offered by the author.

The constellation of issues that surrounds the teaching of art therapy research methodologies is a growing concern to art therapy education. Consequently, an investigation was begun into the ways in which Master's level art therapy training programs integrate research components. The focus was on concerns inherent in the process of research and the approaches utilized by programs to teach and integrate research with the program. This paper outlines the research procedure utilized, presents a summary of the results and discusses patterns that emerged from the data.

This project was based on the following three assumptions, or presuppositions, affecting process of inquiry:

1. Within the field of art therapy, a tension has existed between systematic rigor and creative research. This has affected both scholarly process and the teaching of research methodology.
2. Students may enter art therapy training programs with the bias that research is both quantitative and a foreign, incomprehensible experience.
3. The expanding scope of research methodologies offers art therapists new opportunities to engage in research that can be compatible with art therapy methodology.

Research has been only infrequently debated in the art therapy literature (Junge, 1989; Kwiatowska, 1978; McNiff, 1986; Rosal, 1989; Rubin, 1984; Wadeson, 1980). In the earliest of the writings that discuss methodological approaches, Kwiatowska (1978) articulates the prevailing attitude that careful observations and systematic organization could support solid research conclusions based on the art work produced in art therapy. Questioning the behavioral science approach, Wadeson (1980) addresses the complexity of art therapy research and emphasizes the need to refine and modify existing behavioral science research methods, perhaps even invent new ones. Rubin (1984) adds to the discussion, pointing out the unique problems in doing art therapy research and suggests alternate methodologies that might offer more compatible approaches. McNiff (1986) expands this discussion in his text on art therapy education, suggesting non-traditional forms of research that could best support and relate to the essentially creative character of the art therapy process. In an interesting published dialogue, Junge (1989) and Rosal (1989) share their disparate views regarding future directions for art therapy research. Although Rosal (1989) argues for an emphasis on single case research and Junge (1989) argues for expansion of methodological approach, in many ways they are in agreement, expressing the important idea that the field of art therapy needs to evolve methodologies of scholarship that are consistent with its methodologies of clinical practice. Nowhere in the literature, however, was there discussion of how art therapy research was being taught in training programs.

Editor's Note: The author wishes to thank Susan Reichmann for her invaluable help in constructing the questionnaire.

Procedure

A questionnaire was sent out to all Master's level art therapy training programs listed in the American Art Therapy Association's *Art Therapy Education Program List* (AATA, 1990). The questionnaire was designed to provide art therapy educators with an opportunity to portray the format and philosophy of their approach to research. The questionnaires were mailed to the individual designated by the program as the instructor of the research methodology course. A follow-up letter was sent shortly thereafter and telephone calls were used to pursue those individuals who did not respond.

Once the questionnaires were returned, the data was approached systematically, and thematic categories were developed to organize and understand the information. Although the research was essentially quantitative in approach, an attempt was made to integrate an open-ended approach to the data. As a result, despite categorical treatment of the survey results, the sequence was based on one outlined in Taylor and Bogdan (1984), *Introduction to Qualitative Research Methods*, (pp. 130-144). Attempting to treat the questionnaires as qualitative text, themes were tracked, hunches, interpretations and ideas were followed, typologies constructed, concepts and theoretical propositions developed and data viewed contextually. This mix of methodologies was a major deterrent throughout the data analysis and interpretation, and became a major limitation in this study.

Results

A large number (25/32) of the questionnaires were returned. This high response rate (78%) may suggest that art therapy educators were eager to take advantage of this opportunity to discuss research within their graduate training programs.

Goals

Table 1 presents a summary of the answers regarding the programs' goals for their required research project. The most frequent response to the question about goals was an answer combining mastery in area of concentration (A) and synthesis of studies and clinical experience (B). This may reflect the widely held opinion that the research component of a Master's level training program supports the acquisition of clinical skills.

Professional contribution to the field (C) was of secondary importance and attainment of scientifically sound research skills (E) seemed to be important to fewer instructors, notably within those programs attached to medical or research institutions. Two respondents who selected (E) questioned the word "scientifically," implying that sound research skills, but not necessarily scientific ones, can be a goal. Innovation and creativity in research design (D) was generally held to be a very high expectation at the Masters level, but was included by many as a goal.

Two interesting additions (write-ins) added to the data. The first, "to attain artistically sound research goals," represented the request for new ways of understanding art therapy research. The second, "to examine the vicissitudes of the clinical experience," seemed to offer further support for the belief that research is understood primarily as a resource for the development of clinical skills.

Relative Value of Research Within Training

Table 2 presents the results of a question asking for relative ratings of research compared to other components in Masters level art therapy training programs. Respondents typically had strong opinions about this question and used the form to express their values about research. As indicated in the chart, most programs rated research second to the clinical or practicum experience, although several attested to a desire to move in the direction of increased attention to the research component. No respondents indicated that research was more

TABLE 1

PROGRAMS' GOALS FOR MASTER'S PROJECTS

Goals	Number of times selected
A. Gain mastery in areas of concentration	22
B. Synthesize studies and clinical experience	21
C. Professional contribution to the field	19
D. Innovation and creativity in research design	14
E. Attain scientifically sound research skills	12
F. Other	2

TABLE 2

RELATIVE IMPORTANCE OF RESEARCH IN MASTER'S TRAINING PROGRAMS

	Number of times research valued as more important than x:	Number of times research valued as equally important as x:	Number of times research valued as less important than x:
x = clinical/practicum	0	4	19
x = studio art/art process	7	8	8
x = personal growth	4	6	13
x = academic/theoretical	1	11	12

important than clinical experience. Only one program felt strongly that research was much less important than all other aspects of its program.

The data indicate agreement that research is less important than practicum and academics, but there is less consensus about its priority over personal growth and the studio art process. It is interesting that the largest discrepancy in opinion occurs in the relative rating between research and the studio art process. This may be one of the indicators of the perceived tension between creativity and research scholarship.

Research Methods Introduced

Table 3 presents the research approaches introduced to art therapy Master's level students. The returned questionnaires indicated that most of the programs provide overviews of the main categories of traditional research, particularly case study, descriptive and quasi-experimental. Interestingly, several include at least an introduction into alternative research approaches, particularly phenomenological and ethnographic.

Table 4 presents a summary of responses to a question regarding the ways in which these methodologies are introduced to the students. The data reveal a diversity of approaches. Nine programs indicated they had developed a research methodology class specifically for their program, and seven of these discussed ways in which they had designed this to be uniquely compatible with the art therapy process. However, it appears that instruction in research methodologies is often embedded in other courses, i.e., assessment courses, case study courses, etc. Typically, in programs attached to medical or research institutions, art therapy students study research methodology in other human service departments, sometimes by program requirements, sometimes as an elective.

TABLE 3

RESEARCH APPROACHES

Name of research approach	Number of times identified as introduced to students
Case or Field	21
Descriptive	19
Quasi-Experimental	19
Historical	17
Correlational	16
Developmental	16
True Experimental	15
Action	14
Casual-Comparative	14
Naturalistic & Ethnographic	8
Phenomenological & Hermeneutic	8
Cybernetic	3

TABLE 4

FORMS OF RESEARCH METHODOLOGY INSTRUCTION

Ways in which research methodology instruction is provided	Number of times identified
SPECIFIC COURSE IN RESEARCH	
In art therapy program	9
Location unspecified	6
External to program	4
Material imbedded in other courses	6
No instruction offered	3

Although research methodology classes were typically described as one semester long, the length of time given to students to complete their research projects varied from one semester to two years. Thirteen programs indicated that completion of the required research project took approximately one academic year. The most frequently (18/25 respondents) mentioned way of providing ongoing support for the student engaged in research was a combination of semester long seminars and individual tutorials. Only one program claimed the structure of a research committee and extra faculty thesis advisors.

Research Options Offered

When asked about what kinds of research the students were actually doing (as opposed to what kinds of research they were learning about), the respondents presented a slightly different profile; most students engaged in either case study or quasi-experimental research. Table 5 presents a summary of the programs' responses.

It is important to mention that the list of approaches offered as options in this section of the questionnaire was developed from the programs' own curriculum descriptions. It was thought that these categories, offered in the language of those who would be responding to the questionnaire, would be most easily comprehended. However, problems emerged as it became clear that respondents were utilizing different definitions of the research approaches in their responses.

In response to the question, the case study was repeatedly the research method of choice. Although empirical/quantitative projects were mentioned as frequently (18), these approaches typically had a smaller percentage of the program's students participating in them. Irrespective of whether the program rated research as a priority or not, the case study repeatedly was the research approach in which the majority of students were engaged (ranging from 40% to 100% of students). Many programs indicated that at least some of their students were involved in empirical research projects, typically programs associated with medical or research institutions.

TABLE 5

OPTIONS FULFILLING RESEARCH REQUIREMENT

Options	Number of times this option identified as fulfilling research requirement
Case Study	18
Extra clinical experience	9
Audio-visual project	13
Clinical program development	13
Empirical/quantitative	18
Other (please specify)*	9

*specific options mentioned one time:
- qualitative, hermeneutic
- art historically based research
- various kinds of clinical experiences
- exploration of indepth media applications
- single case study designs
- oral examination
- spiritual and personal development
- theoretical reviews
- student ideas making significant contribution
- grant
- published journal article

In contrast, one respondent displayed a strong preference for the quasi-experimental single case study indicating that 90% of their students used this particular methodology to design their research project. Also, nine programs included research options that are not typically understood as research in other human service training programs, i.e., clinical program development, audio-visual projects, extra clinical experience, spiritual and personal development and grant writing. Two programs indicated that the research options available to their students were in a state of flux, in one case shifting toward new evolving paradigms and in a second case, encouraging more scientific empirical research.

Encouragement for Presentation/Publication

When asked if they encouraged formal presentation or publication of student research, all but one of the respondents replied in the affirmative. The implication here seems to be strong support for fostering student participation in the dialogues and scholarly discussions of our field.

Expression of Concerns

This category of results reflects the fact that respondents frequently added their own narrative comments. In an attempt to accurately portray the flavor of these comments the content is categorized and summarized and conveys some of the passion, interest, delight and anger that was expressed. Two respondents expressed concerns with the questionnaire itself, describing it as "overly black and white" and "limit(ing) the inquiry to the behavioral/science bias/perspective." In many ways respondents expressed their belief that the manner in which research education is integrated within art therapy training programs is complicated and needs to be considered, discussed and debated. The written concerns ranged from diverse opinions regarding research philosophy:

> Is art therapy at the M.A. level a terminal degree? (and) should the in-depth question of M.A. research be in part dependent upon answering this question?
>
> The purpose of the research training is to help students become more questioning and insightful clinicians.
>
> We discourage research study at the M.A. level and focus on clinical training.
>
> I believe that most M.A. programs do not really teach research.
>
> Our base goal is the inclusion of the artistic tradition in research/scholarship.
>
> We are encouraging more empirical/quantitative (work).
>
> Research is conducted on many levels throughout the program.
>
> Plans are underway to design a course in research which would be taught by art therapists who are doing or have done research in art therapy.

Discussion

The questionnaire suggested a profile of the diversity of approaches used to educate art therapy trainees in the research process. Although the respondents were generally in agreement about clinical training having priority in Master's level programs, there seemed to be differences of opinion about the relative value of research instruction. Two dissimilar emphases emerged: one, strong and clear, that described the research component of training programs as support for clinical development and the other, weaker and much less cohesive, that described the research component of training programs as an important endeavor on its own. This suggests that there is an escalating need to reconsider the role of research within our training institutions.

The questionnaires also suggested an interesting profile of the ways in which art therapy students are introduced to and engage in the research process. The data indicated that trainees typically receive an overview of traditional research approaches, but that this instruction rarely correlated with the actual research endeavors they design. The data repeatedly suggested the following scenario: although introduced to many research methodologies, the art therapy student found the case study most compatible with the creative psychotherapeutic process in which s/he is immersed. This is a tentative speculation based on the patterns that emerged in the data, but severely limited by the questionnaire design which did not adequately provide clear definitions for the research categories.

Although a growing number of programs have already designed or are in the process of designing specific instruction in art therapy research, overall the questionnaires reflected a lack of specific methodologies for art therapy research. This suggests that art therapy educators may benefit from some exploration of the kinds of inquiry processes that emerge from our own field.

This study was essentially limited by the very struggles which motivated it. As described in the introduction, my own presuppositions about research in the field of art therapy point to a disciplinary inclination toward qualitative methodologies. Yet the methodologies that support this research were predominantly quantitative in both philosophy and tools of inquiry. The lack of consistency between data gathering (quantitative) and data analysis (qualitative) did not enrich, but rather limited the endeavor. Consequently, the research potential that a statistical analysis of the survey might have yielded was hampered by not using an appropriately sensitive tool for the textual analysis. In effect, a mix of methodologies and a general lack of expertise about the inquiry process limited this study.

It became apparent throughout the data analysis that different programs have developed very different resolutions to the complex interplay between clinical training, creativity, and scholarship. In some situations, these resolutions have become stances or postures, i.e., to minimize research, to make research more empirical or to isolate one particular research methodology.

It is my belief that a wide range of research methodologies offers exciting opportunities for art therapy inquiry. Such a range will allow art therapists to maintain a fundamental commitment to the creative process while engaging in rigorous scholarly work. Also, a spectrum of approaches will enable art therapy educators to introduce a variety of methodologies that will be compatible with creative needs and with the ongoing scholarly needs of our field.

Conclusion

Much more work needs to be done in support of the questions that were preliminarily addressed in this research project. Questions about research scholarship in our field and within our training institutions are complex. The diversity of opinion regarding the goals, values and methodologies of Master's level art therapy research became apparent throughout the process of this research project. It seems imperative that those of us who are concerned about art therapy research within our field acknowledge the complexity of the issues and utilize the diversity for growth rather than rigid divisiveness.

References

Junge, M., (1989). CoPerspective: The heart of the matter. *The Arts in Psychotherapy, 16*, 77-78.

Kwiatkowska, H. Y. (1978). *Family therapy and evaluation through art.* Springfield, IL: Charles C Thomas.

McNiff, S. (1986). *Educating the creative arts therapist.* Springfield, IL: Charles C Thomas.

Rosal, M. (1989). CoPerspective: Master's papers in art therapy: Narrative or research case studies? *The Arts in Psychotherapy, 16*, 71-75.

Rubin, J. A. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Taylor, S. and Bogdan, R. (1984). *Introduction to qualitative research methods.* New York: John Wiley & Sons.

Wadeson, H. (1980). *Art psychotherapy.* New York: John Wiley & Sons.

Call for Submissions to *Art Therapy*

Art Therapy: Journal of the American Art Therapy Association is currently seeking submissions in the form of full-length articles and brief reports on theoretical, methodological, and research for two special theme issues:

1. **Art and Medicine.** Articles may focus on the use of art expression in the assessment or treatment of physical disease; theoretical, ethical, or practical issues in the application of art expression in a medical setting or with physical illness; original research in medical art therapy.

2. **Professionalism in Art Therapy.** Articles may focus on current professional issues in the field of art therapy such as, but not limited to, licensure, credentialling, job development and governmental affairs. Theoretical, historical, methodological, or research articles focusing on these themes will be considered.

Submissions must adhere to the "Guidelines for Submission" which are outlined in *Art Therapy;* please review these guidelines carefully because manuscripts which do not meet these guidelines will be returned to authors without review.

DEADLINE for submission of manuscripts is December 15th, 1992. Please send manuscripts to:

Cathy A. Malchiodi, M.A., A.T.R.
EDITOR/ART THERAPY
℅ AATA National Office
1202 Allanson Road
Mundelein, Illinois 60060

Art Therapy: Journal of the American Art Therapy Association, 9(3) pp. 135-138 © AATA, Inc. 1992

Brief Reports

Art Therapy with Adult Female Incest Survivors

Carolyn S. Waller, M.A., Hyde Park, Utah

Abstract

"Very little systematic research has compared different types of treatment for adult victims of sexual assault" (Resick & Schnicke, 1990, p. 488). Art therapy research in the treatment of sexual abuse has mainly been concerned with the content of art expressions produced by clients (Spring, 1984; Ticen, 1990). Therefore, comparative studies of art therapy and group verbal therapy have the potential of aiding therapists in treating this population.

Fifteen adult female incest survivors participated in this study which employed a control group and two experimental groups. Participants rated the significance of the curative factors of catharsis, cohesion, and insight in their treatment. The results of this study indicate that group art therapy, using a series of structured tasks, increased the value assigned to each of these curative factors.

Reports of successful programs for treating sexual assault victims have been published, but few are empirically based. One exception is a study carried out by Roth, Dye and Lebowitz (1989) on the effectiveness of group psychotherapy intervention with adult women who were assault victims. The treatment of adult female incest survivors is equally lacking in controlled studies although numerous authors have described treatment models for clients from this population (Courtois, 1988; Sgroi, 1988, 1989; Spring, 1990; Ticen, 1990). Research concerning incest has concentrated on prevalence or symptomatology (Briere & Runtz, 1988; Bryer, Nelson, Miller & Krol, 1987; Herman, Russell & Trocki, 1986; Russell, 1986) in an attempt to predict the aftereffects of sexual abuse by a family member (Lindberg & Distad, 1985). Herman and Schatzow (1984) developed an empirically based, time-limited group treatment for women who had a history of incestuous abuse. However, few studies have compared different therapeutic modalities (Roth, Dye & Lebowitz, 1989).

Research into the use of art therapy with sexual abuse has been concerned with the elements included in the art produced by clients and patients (Spring, 1985; Ticen, 1990), but the process of art therapy and clients' responses to this modality have been neglected. This study compared verbal group therapy and group art therapy in the treatment of adult female incest survivors. The Curative Climate Instrument (Fuhriman, Drescher, Hanson, Henrie & Rybicki, 1986) was used to determine the participants' ratings of the curative factors of catharsis, cohesion, and insight as helpful in their therapy.

Method

A total of 15 adult female incest survivors took part in this study. The control group consisted of three women who participated in eight weekly individual psychotherapy sessions during the study. Two experimental groups of incest survivors met for eight weeks in 90 minutes sessions; a group of seven women using only verbal techniques and an art therapy group of five women that used the process of drawing, painting and verbal processing. Both experimental groups addressed issues common to women who have been sexually abused: social isolation, betrayal, lack of trust, guilt, shame, anger, and wish to confront the perpetrator or care giver.

Participants completed a demographic questionnaire at the beginning of the study. After two weeks and eight weeks all participants completed The Curative Climate Instrument (Fuhriman, 1986). This instrument is a 14-item, five-point Likert Scale that measures subjects' ratings of the curative factors of catharsis, cohesion, and insight as significant in their treatment. It was developed by Fuhriman based on Yalom's Q Sort (1975).

The Kruskal-Wallis one-way analysis of variance by ranks was used to compare the control and experimental groups' ratings of these factors at the end of the second and eighth weeks. The Sandler's A-Statistic was used to determine changes in each group's ratings of the subscales after the six-week period. In both statistical methods, $p<.05$ was considered significant.

Results

Mean ages for the groups range from 32–38, an indication that the negative aftereffects of incest are present in these women's lives years after the abuse occurred. The mean number of years of abuse duration were 9.61 and 10.1 respectively for the verbal and art therapy groups. However, these numbers may be inaccurate due to participants' repression of memories or understanding of the term *abuse*.

Hypothesis 1 stated that art therapy will increase the value of insight in adult female incest survivors. Women in the art therapy group increased their value of insight after eight weeks. (Sandler's $A=.215$, $DF=4$, $p<.005$).

The art therapy group increased its value of insight significantly over the six-week interval between testings. There was little change in either the control or the verbal group's rating of this curative factor (see Figure 1).

Hypothesis 2 stated that art therapy will increase the value of catharsis in adult female incest survivors. Participants in the art therapy group valued catharsis more after eight weeks. (Sandler's $A=.282$, $DF=4$, $p<.025$).

The art therapy group increased its value of catharsis significantly over the six-week interval between testings. The control group's value of catharsis remained unchanged and the verbal group increased its value of catharsis after eight weeks of therapy (see Figure 2).

Hypothesis 3 stated that art therapy will increase the value of cohesion during the course of therapy. Cohesion was valued more after eight weeks by participants in the art therapy group. (Sandler's $A=.261$, $DF=4$, $p<.025$).

The art therapy group showed a significant increase in its valuing of the cohesion factor after eight weeks in therapy. The control group increased its value of cohesion while the verbal therapy group decreased its value of the same factor (see Figure 3).

Hypothesis 4 stated that the art therapy group would value insight more than either the control or the verbal group after eight weeks. This hypothesis was not accepted. Although the data showed a trend, it was not at a significant level (see Figure 1).

Discussion

Two important limitations must be noted concerning this study: the small sample size and the method used to recruit participants for the verbal group. It was not feasible to have large numbers of participants in either of the experimental groups if participants were to experience optimum therapeutic results. Adequate time for participants to engage in discussion and interaction with therapists and other group members was a major consideration in structuring the groups. Recruiting clients from mental health agencies rather than advertising for subjects limited the number of prospective participants for this study, but prevented the inclusion of women who were in crisis. The decision to recruit in this manner was based on ethical considerations of the possible risks to participants and insured the availability of emergency therapeutic services to participants in the event of severe emotional distress.

The verbal group was an ongoing open group that had been meeting for two years. Some of the participants had been members of this group for two years and others for only a short time. It is possible that the length of time in the group prior to the study was a factor in the clients' ratings of the curative factors. In contrast, the art therapy group participants met for the first time when the research began.

Art therapy used with a group of adult female incest survivors increased their value of catharsis, cohesion, and insight as curative factors in their treatment. Experiencing these factors may have caused them to value them higher, even when clients have not consciously put a name to those factors. In the art therapy group catharsis was performed in two ways: through the use of the art medium and through the verbalizations of strong and long repressed emotions. Cohesion may come about through the sharing of art materials as well as the sharing of common problems and experiences. The knowledge that another woman shares a similar history may be cause for bringing about closeness in members of a therapy group. Insight into the origins and present effects of serious problems can be accelerated by sharing the insights of another woman with a similar problem. Examining a problem becomes a concrete event through the visual expression of the problem, its possible solutions, and feedback from others whom the person has grown to trust.

Art therapy group participants commented that the art product, or paper on which they drew, acted as some sort of buffer or barrier between themselves and the world. This barrier can be lowered or raised at will by the artists depending on how threatening the contents are to them. Persons and animals can be disguised, symbols whose meanings are unknown to others can be used in complete safety. They can deny the interpretations of others, erase, paint over, tear or fold, and put away any material which is too affect laden for that moment. Several of the women stated that talking during the process of artmaking seemed to give them ideas for changing their drawings by the use of either additional media or colors.

Sharing of materials by therapists and group members can be an important part of trust and cohesion building in a group. Requesting additional supplies by participants may have been a way of testing both the therapist and other members of the group at the beginning of this study. Some women were continually giving up supplies to others even when they were using that particular crayon, pencil, or pair of scissors. These same women reported being "caregivers" and "rescuers" in their lives outside the group. The women who asked for supplies or ideas for drawings often spoke of needing more emotional support from family and friends than they were willing or able to provide. Caring for each other through the sharing of materials seemed to mirror the verbal support evident in the conversations.

Freedom in the use of art materials may reinforce to clients that they are trusted to have good judgment. It may also encourage the clients to feel free to express themselves in other unique ways with less fear of criticism or negative results. This is contrary to what the incest survivors have usually learned in their families of origin. The women talked about strict rules surrounding their use of art materials when they were children. Participants were reassured that they were allowed to work in any way they chose as long as everyone was safe.

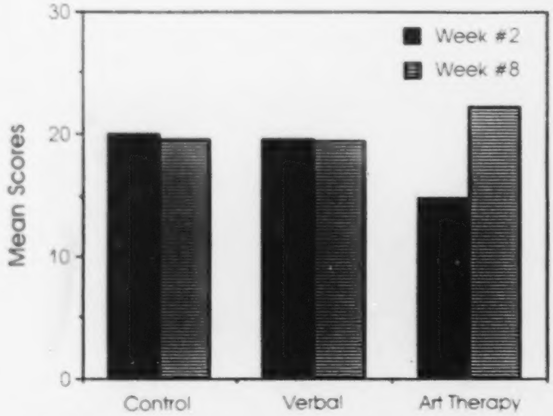


Fig. 1 Comparison of Therapy Groups Mean Scores for Insight Subscale

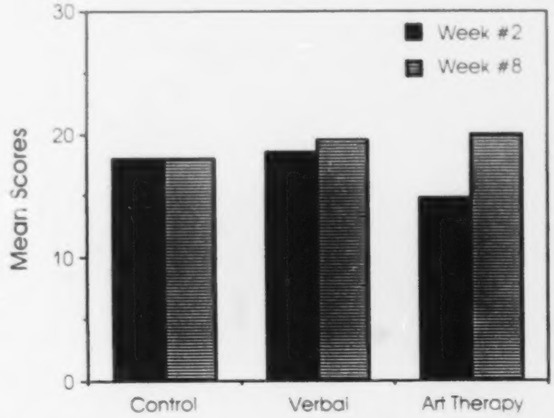


Fig. 2 Comparison of Therapy Groups Mean Scores for Catharsis Subscale

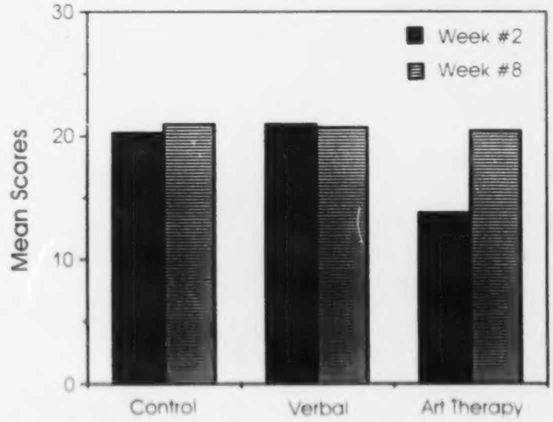


Fig. 3 Comparison of Therapy Groups Mean Scores for Cohesion Subscale

Clients in both of the experimental groups were constantly urged to find the connection between past adaptive behavior and the maladaptive behavior used in their present lives to deal with the memories and effects of abuse. It appears that the opportunity to draw a situation and see it in some concrete form allows a client to examine the causes and effects more directly than when using words. The artwork can also serve as a prompter to clients in keeping the discussion focused on the discussion topic.

Group art therapy is cost-effective because several clients can be treated at the same time. It also provides a more democratic forum where clients may participate at the same moment and on their own level during the artmaking part of the sessions (Liebmann, 1985). The art therapy group creates a safe place for clients who do not trust words or hide behind them. Incest victims were often lied to, threatened, and misled with words from their abusers and family members. The clients in art therapy report that the use of art feels safer as a medium of communication.

Conclusion

The results of this study suggest that a structured series of art therapy interventions can be useful in the treatment of the long-term effects of incest in adult women in out-patient group therapy. Appreciation and valuing of the curative factors of insight, catharsis, and cohesion may be enhanced thus preventing premature termination of therapy when only catharsis has been achieved. Further research can aid clinicians in formulating additional treatment interventions and understanding more about how the process of art therapy functions.

References

Briere, J., & Runtz, M. (1988). Symptomatology associated with childhood sexual victimization in a nonclinical adult sample. *Child Abuse and Neglect, 12*, 51-59.

Bryer, J. B., Nelson, B. A., Miller J. B., & Krol, P. (1987). Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry, 144*(11), 1426-1430.

Courtois, C. A. (1988). *Healing the incest wound*. New York: W. W. Norton.

Fuhriman, A. (1986). *The Curative Climate Instrument*. Salt Lake City, UT: Author.

Fuhriman, A., Drescher, S., Hanson, E., Henrie, R., & Rybicki, W. (1986). Refining the measurement of curativeness: An empirical approach. *Small Group Behavior, 17*, 186-201.

Herman, J., Russell, D., & Trocki, K. (1986). Long-term effects of incestuous abuse in childhood. *American Journal of Psychiatry, 143*(10), 1293-1296.

Herman, J., & Schatzow, E. (1984). Time-limited group therapy for women with a history of incest. *International Journal of Group Psychotherapy, 34*(4), 605-616.

Liebmann, M. (1985). Art games and group structures. In T. Dalley (Ed.), *Art as therapy: An introduction to the use of art as a therapeutic technique*. New York: Tavistock.

Lindberg, F. H., & Distad, L. J. (1985). PTSD in women who experienced childhood incest. *Child Abuse and Neglect, 9*, 329-334.

Roth, S., Dye, E., & Lebowitz, L. (1989). Group therapy for sexual-assault victims. *Psychotherapy, 25*, 82-93.

Russell, D. E. H. (1986). *The secret trauma: Incest in the lives of girls and women*. New York: Basic Books.

Sgroi, S. M. (1989). Healing together: Peer group therapy for adult survivors of child sexual abuse. In S. M. Sgroi (Ed.), *Vulnerable populations, Vol 2.* (pp. 131-166). Lexington, MA: D. C. Heath and Company.

Spring, D. (1985). Symbolic language of sexually abused, chemically dependent women. *American Journal of Art Therapy, 25*, 13-21.

Ticen, S. (1990). Feed me . . . Cleanse me . . . Sexual trauma projected in the art of bulimics. *Art Therapy, 7*(1), 17-21.

Yalom, I. (1975) *The theory and practice of group psychotherapy*. New York: Basic Books.

Art Therapy: Journal of the American Art Therapy Association, 9(3) pp. 139-144 © AATA, Inc. 1992

Viewpoints

Art Captures the Impact of the Los Angeles Crisis

Shirley Riley, M.F.C.T., A.T.R., Mindy Newborn, Yoko Takasumi, LCSW, A.T.R., Jane Walter, M.A.

On April 29 of this year, long-standing unresolved frustrations, angers, and inter-racial tensions erupted into violence, fire setting, and rioting in the city of Los Angeles and across the nation. Triggered by the court decision concerning the police handling of Rodney King, protest and unlawful and destructive actions were set in motion. Involvement in the crisis was brought home to every citizen in a more personal way than ever before. Most of us were overwhelmed and traumatized by the unbelievable actions of the police seen in the countless TV reviews of the Rodney King beating video. When the riots began, the media gave 24-hour exposure on every channel and brought into every home the fires, looting and the angry despair of the crowds. Criminal and outraged reactions, positive and negative actions by citizens, deeds of bravery and cowardice were all before our eyes for four days and nights of curfew and restricted activity. However one judges this extraordinary event, what is undeniable is that everyone felt as though they were on the frontline of this revolution.

We therapists were particularly disturbed by the feelings of emotional stress, helplessness and confusion experienced by our clients. For example, children were encouraged to loot with their parents, and those who did not saw others gain desired goods in this manner. The conflicting messages and the fear of danger and violence were beyond the life experience of the young and evoked old terrors and despair from the elderly.

Words cannot express the impact of the images evoked by this crisis: the fires, the mobs, the beatings, the angry faces of the crowds. For a fortunate few, the opportunity to place these images and find some words that helped make some of the stress more manageable was provided by the art therapists and art teachers in the schools and in the clinics. In addition, the city responded to volunteers who came into the community and offered some workshops and time for expressive arts. The need still continues and the interest in the art healing process has not been forgotten, although as always, there is the denial and repression of a large system that has turned away from long-term resolution of the heart of the problem.

A selection of drawings done by children and adults after the L.A. riots is offered along with brief commentaries by each therapist.

Shirley Riley, M.A., A.T.R., M.F.C.T., Private Practice, Los Angeles, CA

Figure 1 is a drawing by a 50-year-old woman who suffered many days of serious depression and dissociative reaction, when the riots evoked in her the feelings of attack, fear and lack of security that paralleled similar feelings experienced in her youth. For her, red is rage and green is abandonment; hence, the fire and burning houses were experienced on an external and internal level.

Mindy Newborn, Graduate Intern, Poseidon School, West Los Angeles, CA

Figure 2 was drawn by a 14-year-old Black/Hispanic boy. He has spent most of his life in juvenile hall and foster homes. Both his parents have been in and out of jail for as long as he can remember. He has expressed his anger at being a poor Black male in a White society in which he feels victimized.

The day after the L.A. riots the boy was extremely angry because, he said, "I wanted to go looting, but my aunt wouldn't let me." He was also angry about the police and their violent reaction toward African Americans in Los Angeles. He was asked to do a drawing about how he was feeling about the riots. Without hesitation, he drew a road leading to a burning city; on one side of the road there are signs warning, "At this point turn back," and "Welcome to L.A." In the distance is South Central L.A. burning with people running away. The other half of the page is Beverly Hills; there are no fires burning and many armed police are guarding the area. He put himself in the center of the page on top of a sign warning, "Risky." He explained that, "the rich people in Beverly Hills get protected by the police just because they're White and rich, even though their buildings weren't on fire. The poor minorities in South Central get no help from the police while all their buildings burn down." There was a disgusted resignation and a sadness in his voice as he spoke about the riots. When I asked him about the Black first rising out of the burned building, he responded by saying, "We're fighting back. Just wait."

Figure 3, the boy's collage of a child floating through the sky, responds to his feelings of helplessness during the riots. When I asked him how that child might feel, he replied, "scared and alone." All of his drawings about the riots indicate feelings of isolation and sadness.

Figure 4 illustrates the work of an 18-year-old White male who has experienced physical and sexual abuse from the time he was three. He was placed in foster homes from the age of four and has been in and out of juvenile hall. He is extremely verbal and responded to the riots with feelings of outrage and anger directed toward the police. He was very proud of being able to get away with looting merchandise from some stores in Los Angeles during the riots. He said, "I looted because it was a chance to get a hold of things that I never get a chance to get a hold of. It had nothing to do with Rodney King. It was about, 'let's get what we can get and get out.'" His drawing (Figure 4) shows Hollywood before and after the riots. His depiction of "During" shows his experience of looting at a Radio Shack, fires raging and blunt written descriptions of death and destruction. He said, "I feel hurt by it (the riots) but I also feel good because people were striking back."

Yoko Takasumi, LCSW, A.T.R., Regional Program Director, El Nido Services, Los Angeles, CA

Figures 5 through 10 were drawn by adolescent girls during a crisis intervention session at Gardena Riley High School, a part of L.A. Unified Schools for pregnant minors. The teacher reported that these girls did not have much to say when she attempted to talk to them that morning; however, given the opportunity to express their feelings and impressions through images, they were able to express themselves dramatically. The art also stimulated verbal expression and discussion in the group. The students were asked to draw their impression of the crisis, including what they saw and how they felt. When they were finished, they were asked to title their drawings.

Figure 5, "Simi Valley vs. LA" drawn by an 18-year-old expresses her disbelief and anger over the "not guilty" verdict for the Rodney King case. She also commented that because everyone was looting, it almost seemed O.K. to steal. The group related to her feelings of confusion and her mistrust of the justice and police systems. Some offered the explanation that they believed that the jurors were bribed.

Figure 6, created by a 17-year-old girl, is a composite of images which impressed her the most about the whole crisis. "There were fires and lootings everywhere. The news crew was busy televising. All the markets in South Central LA were destroyed." A White truck driver was beaten brutally by Black gang members and became a representative of racially oriented violence. On the upper left corner is an image of Rodney King who spoke on television pleading for peace. His words, "Can we get along" serves as the title.

Figure 7 titled "Corner of Western & Florence," drawn by another 17-year-old girl, focuses on the same man who was beaten. The brutality and lack of response from the law enforcement officers frightened her.

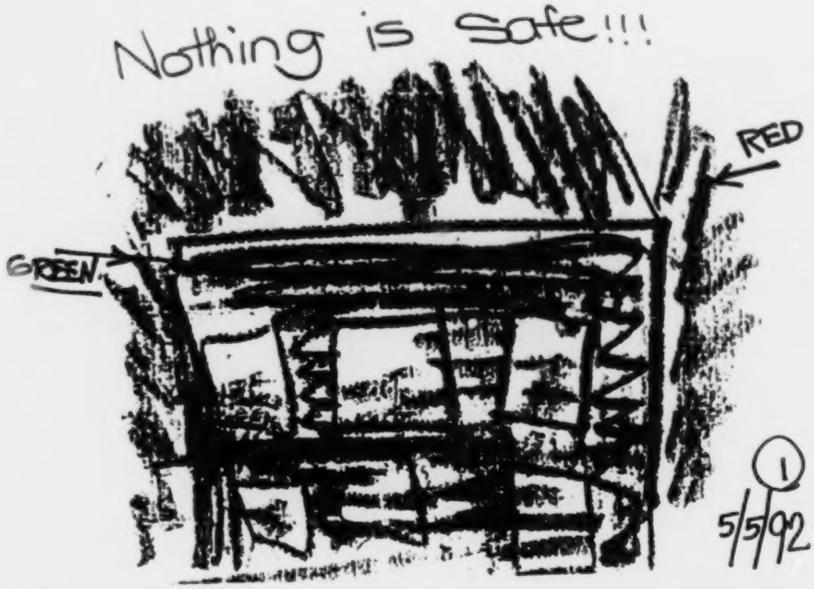

Nothing is Safe!!!
RED
GREEN
①
5/5/92

Fig. 1

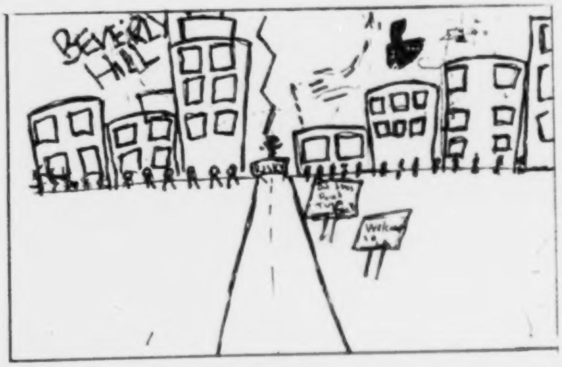

BEVERLY HILL

Fig. 2

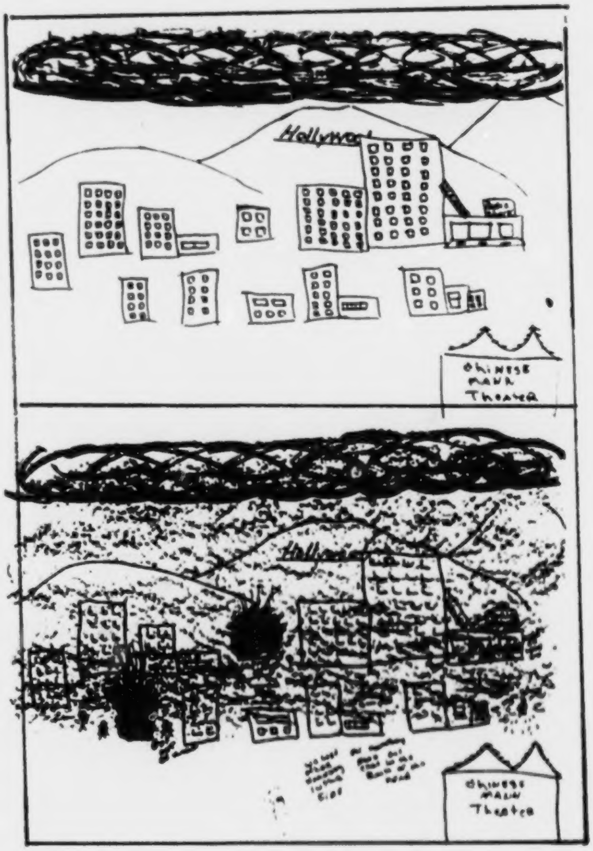

Hollywood
Chinese Mann Theatre
Hollywood
Chinese Mann Theatre

Fig. 4

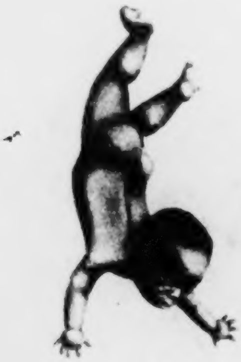


Fig. 3

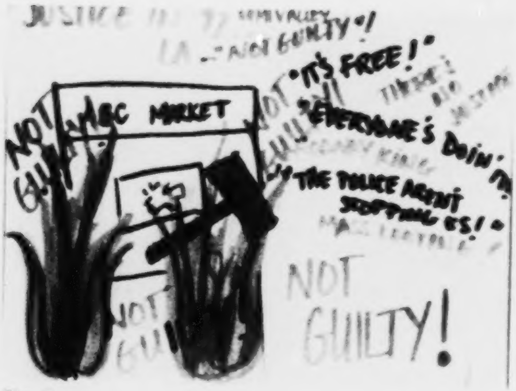


Fig. 5

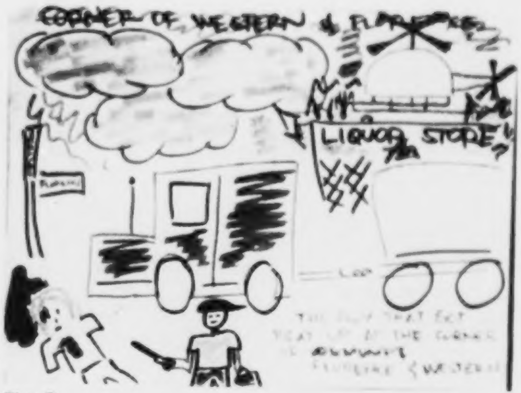


Fig. 7

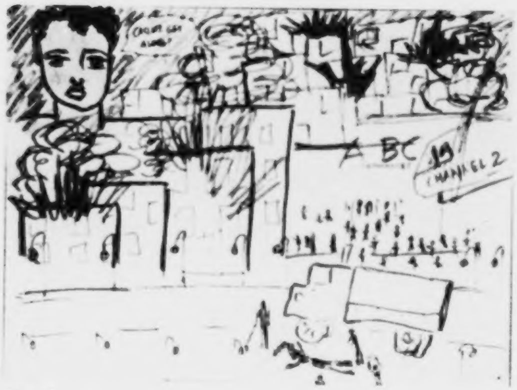


Fig. 6

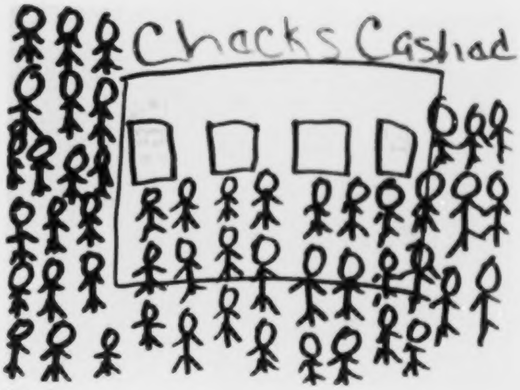


Fig. 8

Figure 8, drawn by a 16-year-old student, makes a distinct statement about what it was like for people depending on welfare checks and food stamps. The government checks were not delivered on time because of the disruption of the postal service. When a few check cashing businesses reopened after the riot, everyone rushed to cash their desperately needed checks. The result was a big crowd and long lines. This picture reminded some group members of the feelings of panic they experienced while standing in long lines in markets miles away from their homes.

Figure 9, titled "Black Community is Now Burnt, Reconstruction Begins: We All Learn," was drawn by a 16-year-old girl. The police vehicle arrives too late and trash and money are scattered about a ruined building while more fires are burning in the background. Her imagery does not match her cognitive awareness of beginning reconstruction efforts. The group talked about how some store owners offered the looters whatever they wanted in exchange for protecting the building.

Figures 10 and 11 are samples from a second grade orthopedically handicapped class at 153rd Street School in Gardena. Most of the children in the class suffer from neurological damage and are functioning below grade level. The teacher was very relieved when art intervention was offered to deal specifically with the riot because she was unsure of how to help the children talk about their feelings. The children were asked to draw what they saw or how they felt about the unrest.

A 7-year-old boy saw the fire at the mall when he went to Burger King with his uncle (Figure 10). He kept repeating, "This is fire burning, y'all." He did not stop until the entire mall was filled with the color of fire as if he needed to discharge anxious energy. He finished off with the blue, which he said was water.

Figure 11 is done by another 7-year-old from the handicapped class. He pictured the blackened figure as the bad man who sets the house on fire, and himself as crying with tears. He kept laying colors heavily for a long time, unlike his usual simple

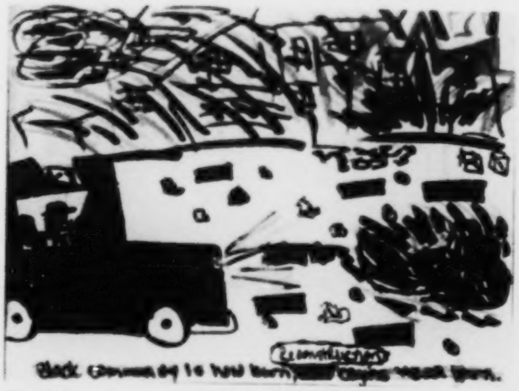

Black Community is now burn

Fig. 9

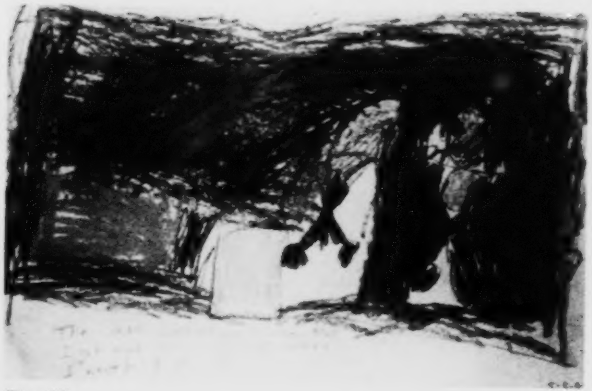


Fig. 10

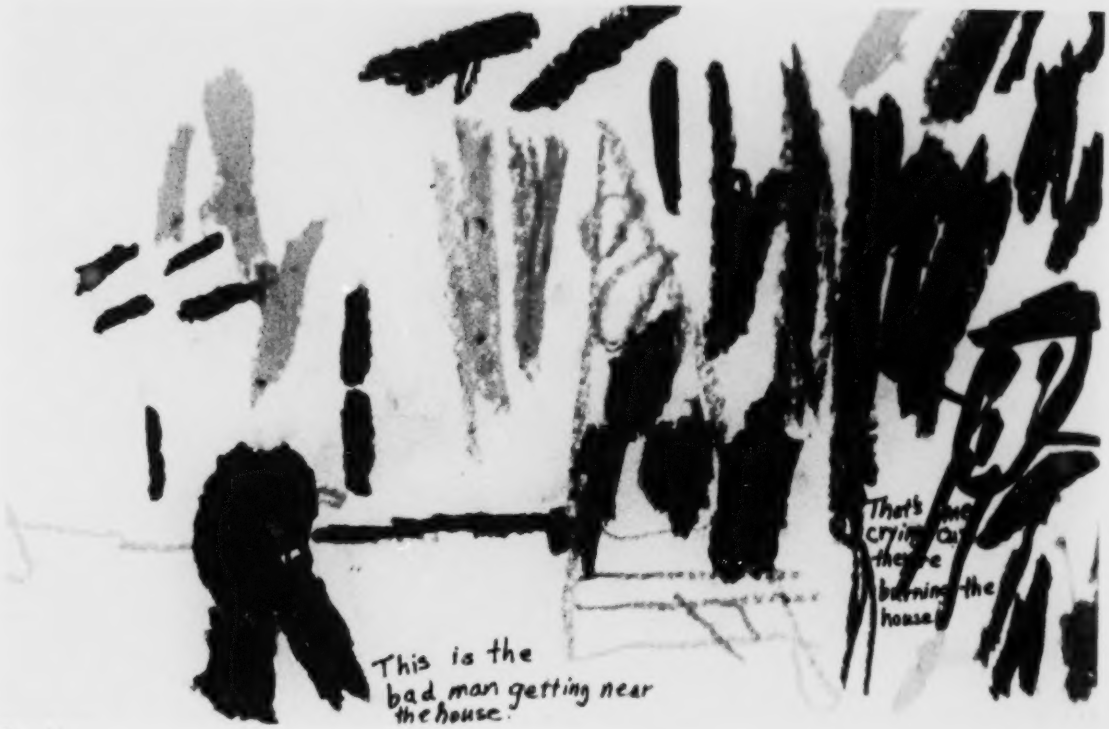

That's
cryin
the e
burning the
house
This is the
bad man getting near
the house.

Fig. 11

drawings with happy stories. The layers of color may have reflected his layers of anxiety.

This population of vulnerable children tended to personalize the trauma more readily than others, tending to internalize external events. Both of the boys imagined themselves as being in the fire. Art was helpful in this circumstance in externalizing their fears and separating their feelings from reality.

Jane Walter, M.A., Didi Hirsch Community Mental Health Center, West Los Angeles, CA

Both Figures 12 and 13 were drawn in a community mental health center during the time of the uprising. This culturally diversified clinic experienced its share of the devastating effects of the riot's turmoil, looting, smoke-filled skies and tensions. One client, on her way to the clinic, was terrorized by a mob while they entered her bus with baseball bats, breaking windows and wounding a passenger. The damage and violence spread far beyond the inner cities; the tension and fear were experienced by all of Southern California.

Figure 12 was drawn by an art therapy group of adult clients in an outpatient community support setting for the chronically mentally ill, during day three of the uprising. Typically, this population experiences great difficulties joining with one another through art. The residual symptoms of their illnesses and side effects of medications are often evidenced in withdrawal, rigid defenses and disconnected thought processes which impede their abilities to link feeling states to internal and external stimuli.

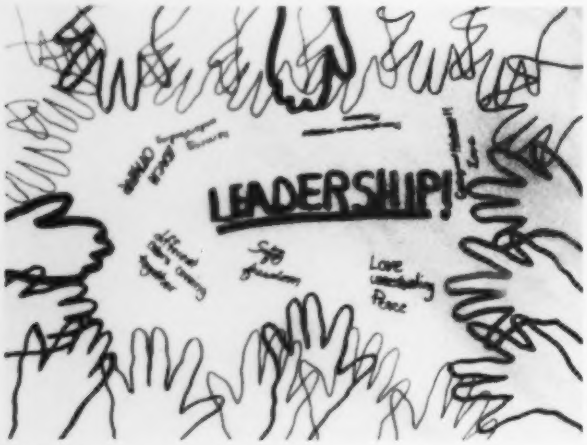


Fig. 12

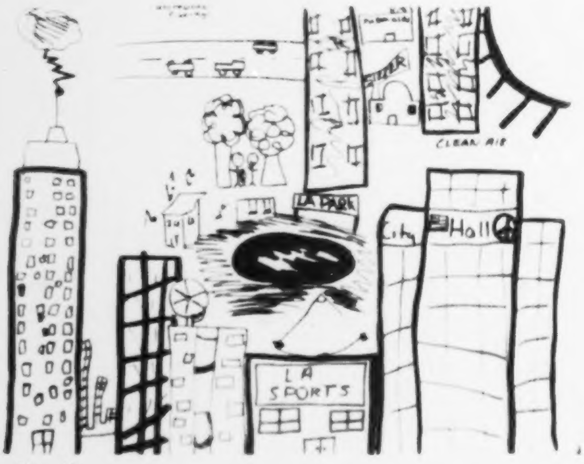


Fig. 13

This group drawing reflects the degree of anxiety felt over the riots; this otherwise detached and withdrawn group attempted to bind together in a supportive circle of hands in order to provide comfort and create a safe place and to make sense of all that was happening in their lives. Words were later added to the art experience and stimulated a discussion about the riots. One group member finished the group by verbalizing, "It's too bad that everyone can't come to the same conclusion about what our communities need to do."

Figure 13 was drawn on the sixth day after the riots during a children's group treatment program. This culturally diverse group was comprised of boys, ages 10 to 12, experiencing behavioral difficulties related predominately to attention deficit, hyperactive disorders, and oppositional defiance.

The group of boys was directed to "draw how the city should be rebuilt after the riots." The children took the directive one step further by offering solutions as to how the city could prevent future incidents of this nature from occurring. All group members unanimously agreed that City Hall was the most important building in the drawing. They reported, "It should be there to help people with problems and for keeping the peace." Another group member retorted, "City Hall should also allow people to come anytime during business hours to discuss the problems they are having in their communities." Lastly, a boy commented, "Yeah, but City Hall also needs to listen and do something about the problems before riots happen again."

Postscript—Shirley Riley, A.T.R.

My motivation for gathering these examples of crisis-art expressions was based on my continued amazement and respect for the impact of artwork from clients who normally have great difficulty in communicating their inner experiences. Through clinical contact and supervision, I observed how successfully my colleagues utilized the value of the image during times of crisis. It seemed important to me to share these drawings with art therapists outside of our sadly torn community of Los Angeles. It brings to mind the many other crises that have impacted the people with whom we work which have been more clearly understood when seen through their eyes in their art. If we art therapists ever need confirmation of how important our services are in the therapeutic world, moments like these reconfirm the unique contribution we make to our field.

Art Therapy: Journal of the American Art Therapy Association, 9(3) pp. 145-149 © AATA, Inc. 1992

Reviews

The Well-Being Journal: Drawing Upon Your Inner Power to Heal Yourself

Lucia Capacchione North Hollywood, CA: Newcastle, 1989

xii + 155 pp., paperback, $10.95. ISBN 0-87877-141-7

Reviewed by **Elizabeth Ratcliffe, M.S., M.F.C.C., A.T.R.**, Book Editor

I recommend Lucia Capacchione's *Well-Being Journal* to people who seek self-renewal and are willing to take the time to nurture themselves by going through its pages. This book is appropriate for use by both individuals and groups.

What I had intended to be a critical reading of the book in preparation for this professional review became a personal experiencing of it when physical problems overtook me this Spring. I was debilitated by an unexpected operation for a detached retina followed by a grade II sprained ankle. With upper and lower extremities essentially useless, my sense of well-being took a nose dive into the enforced expanses of immobilized time and house-bound space.

Although I had no unused journal books on hand, plenty of 8½ × 11 loose paper, craypas and felt pens provided tools for a test run of Capacchione's process. I supplemented my reading through active involvement with her chapter suggestions. Gradually, colorful pages of non-dominant-hand chicken scratched drawings and writings began to replace eye patches, ace bandages and crutches in the bedroom's clutter. Focusing on *The Well-Being Journal*'s sequential exercises, my attention shifted from the depressing confines of sick bay to the alive inner world of my unconscious. This reminded me that my body might be telling me something useful. The message is familiar to those overtaken suddenly by illness: SLOW DOWN AND PAY ATTENTION TO THE NEEDS OF YOUR BODY, EMOTIONS, AND YOUR SPIRIT.

The single most rewarding experiential exercise in Capacchione's journal turned out to be the "dialogic" alternate-hand work. Although by nature highly intuitive, my family of origin bestowed upon me a tendency to favor reasonableness over feelings. It appeared that when my nondominant left hand began to "create answers" to my dominant right hand's questions, surprising inner wisdom was revealed which could begin to enlarge my universe by adding or uncovering new dimensions and potentials. Creating these dialogues together with their accompanying drawings gave me a profound sense of discovery and excitement. The frustrations of having to cope with physical problems receded into a quieter place involving acceptance and building nursing chores into my daily life.

Instead of feeling frustrated by my incapacities, I could begin to see positive value in my current state. Out of my childlike pictures and alternate hand dialogues there emerged, like secret codes from invisible ink, constructive positive messages about my ability to take charge of what was happening to me. What had originally promised to be only an exercise in reading and critiquing someone else's self-help book had turned into a personal experience of self-healing and growth. Paraphrasing M. P. Follett's *Creative Experience* in Marion Milner's 1950s classic *On Not Being Able to Paint*, concepts by themselves mean nothing until they are knitted into the structure of my being, and this can only be done through my own activity. By putting into practice

Capacchione's admonition regarding *The Well-Being Journal*, "It works only if you use it" (p. 19), I had found a working tool to reaccess my own well-being.

Although my use and appreciation of *The Well-Being Journal* grew out of my having been physically incapacitated during the time I had planned to read and review it, many other motivations exist for exploring its contents. Useful information and creative exercises supply assistance for readers interested in such things as eating patterns, body-mapping food and moods, efficient use of time, problems with relationships, and remembering and recording dreams as tools for inner healing.

Of the seven chapters in the book, only three specifically concern themselves with the physical body. In the first the author presents her philosophical and psychological background for writing this book. In Chapters Two, Three, and Four body awareness, image and self-care are her concern. The last three chapters focus on relaxation and recreation, supportive relationships, and healing from the inner self. The final 15 pages are devoted to an appendix titled, "Finding a Health Professional," and a detailed bibliography and discography. The bibliography, divided into categories such as "Body/Mind," "Healing, Massage and Bodywork," "Diet, Nutrition and Weight Control," and "Male and Female," consists only of books published up to 1989.

Noticing this reminded me how many new volumes dealing with self-care and holistic health have been published in the 1990s. Since 1979, when Capacchione published her first book, *The Creative Journal: The Art of Finding Yourself*, she has produced five other journals. They focus on different aspects of creativity as an agent of healing and are intended for various populations. As a consumer as well as an art therapist and psychotherapist, I am grateful to Lucia Capacchione for her contributions to the growing body of literature in a rapidly growing field now entitled psychoneuroimmunology.

References

Capacchione, L. (1979). *Creative journal: The art of finding yourself.* North Hollywood, CA: Newcastle.

Follett, M. P. (1930). *Creative experience.* New York: Longmans, Green & Company.

Milner, M. (1957). *On not being able to paint.* New York: International Universities Press.

Art, Culture, and Ethnicity

Bernard Young (Ed.) Reston, VA: The National Art Education Association, 1990

xii + 278 pp.; 42 black-and-white ills., 12 tables. $19.00. ISBN 0-937652-54-7

Reviewed by **Howard McConeghey, Ed.D., A.T.R.,** Professor Emeritus, University of New Mexico, Albuquerque, New Mexico

Of the 20 chapters in this book, more than half concern a single ethnic group: African-Americans. This may be the result of the greater amount of resource material readily available on Black art and aesthetics, and of the political emphasis on civil rights and African-Americans in the United States. Nonetheless, it is a disappointment to this reviewer that as late as 1990 no chapters are devoted to Hispanic or Asian minority groups, and only two chapters concern Native Americans: Northwest Coastal Indians and an Eskimo village in Southwest Alaska. No other Native American groups are represented.

The book, written by and for art educators, may be of little interest to art therapists except the possibility of ethnic, cultural, and aesthetic differences. These may suggest differences in the psyche of various ethnic groups and therefore the need for unique therapeutic approaches.

This review is organized according to chapters with similar or related themes, rather than the chronological order of presentation in the book. The Black aesthetic is the primary focus of the book, and several chapters speak directly to this question.

"The Black Aesthetic: An Empirical Feeling," by Adriene Walker Hoard, presents research suggesting there is a certain rhythmical, flowing quality which is composed not only by solid forms, but also by the voids between forms. In the visual arts this rhythm is similar to the syncopated musical beat in jazz which fills in the tones in and around the main beats. In addition to this rhythm of solids and voids the Black aesthetic includes a depth of feeling and physical responsiveness to affective stimuli and, referring to the work of Fouda (1988), a "deep-felt cooperative consciousness" (p. 157). She says this is an ancestral group experience. Hoard surmises that at the base of Black aesthetic lies "an instinctual response to form" (p. 157), thus suggesting a relationship between visual structure and ethnicity.

To test this hypothesis, Hoard presents a research study in which "90 non-objective or abstract paintings collated to isolate the stylistic attribute of visual structure" (p. 159), were presented to adults both formally trained and untrained in the visual arts. The results of the study suggest corroboration with the hypothesis of a cultural Gestalt.

Chapter Four, by Pamela Gill Franklin and Patricia Stuhr, presents a similar study of Black people's responses to paintings by Black artists Jacob Larence and Faith Ringgold. Participants were asked to indicate the degree to which the paintings reflected the Black experience. Value was placed on those works which conveyed social and political concerns.

An historical background begins Robert L. Adams' "Alain Locke Revived: The Reconsideration of an Aesthetic." Locke (1886-1954), a Black philosopher and prime mover in the Harlem Renaissance, was spokesperson for a "New'Negro Formulation" of racial values. It charted a strategy for achieving freedom through the arts for the African-American. Locke believed that art can be a tool for advancing Black social causes. According to Adams, five aesthetic tenants were central to Locke's views. Artists should:

1. employ propaganda in their art;
2. know that African art is the fountainhead source of modern art;
3. not be restricted to racial subject matter;
4. embody the particular and the universal;
5. have rootage in a cultural soil (p. 233).

Two chapters later, we encounter Oscar Logan's "Concepts and Values of Black and White Instructors Affecting the Transmission of the Black Visual Aesthetic in Historically Black Colleges and Universities." Logan suggests that Black art can be distinguished by an interdependent triad consisting of ***Black Culture, Black Aesthetic,*** and ***Black Art.*** These refer to various attitudes and styles of contemporary Black artists. The ***Black Art Movement*** (activists), a part of the group of Black Culture, emphasizes propaganda, particularly in subject matter. ***Mainstream artists*** belong to the group called Black Aesthetic. They conform to international stylistic trends (mostly non-objective). ***Blackstream*** artists (Trans-African), considered to be a part of the Black Art Movement, use symbols, colors and techniques of African art, but with generally accepted aesthetic standards.

Logan's study indicated "race had a lot to do with how instructors rated most of the value statements" about Black aesthetic issues, "and, to a lesser degree, their ability to identify the artists' works" (p. 263). The statements were drawn from five categories which supposedly shape the Black aesthetic: 1) historical perspective; 2) call and response; 3) improvisation; 4) representational balance; and 5) balance intensity in color.

While focusing on the Black historical culture, Murry Normal Depillars emphasizes the importance of the image in "Multiculturalism in Visual Arts Education: Are America's Educational Institutions Ready for Multiculturalism?" "Art is not passive," he tells us (p. 115). He quotes Lerone Bennett, Jr. concerning the "image-situation":

> It acts because it is the image which is the ground of man's acts. This is a point of enormous importance, for men act out of their images. They respond not to the situation but to the situation transformed by the images they carry in their minds. In short, they respond to the image-situation, to the ideas they have in themselves in the situations (p. 115).

Depillars suggests that Black culture was dominant in the world before classical Greek and Roman cultures developed, and that this fact has been distorted by the white Greco-Roman tradition. He propounds the theory that the Egyptian civilization and the Egyptian Pharoahs were Black. Imhopet, called the "Father of Medicine," was also a respected builder, magician, philosopher, astronomer, and physician (p. 122). "The Greeks worshipped Imhopet, and roughly 2500 years after his death,

BEST COPY AVAILABLE

changed his name to Asklepios" (p. 122). Since Greek ascendancy a "Dis-Africanization" has replaced the original perspective.

Likewise, in "Linking the Legacy: Approaches to the Teaching of African and American Art," Paulette Spruil-Fleming presents the same historic perspective: the Black world is the true initiator of the "Western" civilization. This position is "flaunted before the eyes" of Afro-Americans today (Diop, 1974, p. xiv). Fleming urges that this African-American cultural experience be communicated to Americans, who have been significantly influenced by several centuries of negative information. This is the task, she says, of global multicultural art education.

Eugene Grigsby calls this negative information the "White Ghetto." "Afro-American Culture and the White Ghetto" defines a mental attitude of White people who are unaware of the rich African-American culture that surrounds them.

"The Depiction of Black Imagery among the World's Masterpieces in Art" by Lee A. Ransaw, gives substance to this claim. Of 30,000 paintings in the Louvre, fewer than 50 include Black figures. With 20,000 in the National Gallery of London, fewer than 30 paintings depict Black figures. And in the Metropolitan Museum of Art, only 23 paintings depict Black figures. Blacks, in these paintings, are usually seen as kind and gentle servants. The clearest summary of this survey is that Blacks have been observed with friendly eyes by European masters, but not with too much respect.

Turning to multiculturalism and multicultural education, Judith Mariahazy presents Ralph Smith's four categories of multicultural art educators. *Exegetal multiculturalists*, "interpret foreign cultures on the basis of their own personal viewpoints, primarily to criticize the society of which they are members" (p. 193). *Dogmatic multiculturalists*, maintain that their own culture is superior. *Agnostic multiculturalists* are interested in "exotic artifacts," but have only shallow interest in other judgments based on their own cultural values. *Dialectical multiculturalists* avoid any judgments based on their own cultural values and are willing to learn from alien cultural traditions. "Multiculturalism and Art Education" does include a very short mention of Native Americans and Mexican Americans, but the focus is on Blacks.

Carmen Armstrong, in "Teaching Art in a Multicultural/Multiethnic Society" believes that art teachers need to reconsider the pervasive mainstream notions of formalism that differ from other systems of organization. She urges the art educator to reconsider the prevailing Greco-Roman aesthetic if they are to become "more sensitive to the culturally diverse value systems operating in art and possible culturally based semantic barriers to student receptivity" (p. 97).

The book opens with "Teaching Art to Disadvantaged Black Students: Strategies for a Learning Style." Leo F. Twiggs stresses that teaching art as an extension of life experiences may be the only value in an otherwise hostile and alien environment. To achieve this, teachers must begin to perceive art as an humanistic endeavor. Creativity and innovation must be encouraged rather than promoting "tried and proven methods" (p. 8).

Similarly, Mary Stokrocki, in "A Portrait of a Black Teacher of Preadolescents in the Inner City: A Qualitative Description," suggests that the primary goals of art education are to relate art to students' everyday life and heritage, and to improve their inner confidence and comprehension.

An Eskimo village school is described by Joanne Kurz Guilfoil. Implications for the study of other cross-cultural settings are suggested, such as, cooperative planning to include ethnic representatives, and soliciting student opinions.

Ester Page Hill decries a "Shattered Fantasy: Minority Access to Careers in Art Education." She finds that the most critical barrier to access to careers in art education is financial.

Art therapists may be particularly interested in cultural and racial issues of the family. However, "The Minority Family as a Mediator for Their Children's Art and Academic Education," offers nothing new for art therapists or art educators.

W. Lambert Brittain studied the developmental stages in the drawings of children from New York and compared them to drawings by Aboriginal children in Australia. While he found little difference in the drawings of four and five year olds, in children over six years old the difference in baseline usage provided a striking contrast between the two groups. The Aboriginal children almost never employed a baseline.

"Ancestry and Aristocracy: Indigenous Art of the Northwest Coast" is an interesting discussion by Barbara Loeb of the art and culture of that region. No specific reference is made to multicultural education.

Can technology be used in education to address cultural and racial issues? In "Art and Culture in a Technological Society" Vesta A. H. Daniel's main point is that:

> What artists can garner from artificial intelligence, such as computer science, is how to share more effectively (and efficiently) the mysterious nature of art, the effect of experience on sensibilities, and the evidence that culturally, temporally, and geographically distant and ostensibly different societies may be advancing toward significantly similar conclusions (p. 95).

She appears to be opposing the idea of ethnic diversity because technology, particularly the computer, offers the possibility of cross-referencing data from art history and anthropology on a global scale. This would allow essential rudimentary aspects of art and aesthetics of the various cultures of the world, she says, to be considered on a broader base—"intuitive, spiritual, mystic, and unspoken"—to be presented (presumably via computer data) in formats that can be shared by greater numbers of individuals from differing cultures (p. 86). The high road to expanding a world-view and sharing a system of knowledge that "suits the needs of the current social-cultural situation," lies, she says, in harnessing the use of technological tools (pp. 94-95).

Art therapists, I presume, would be less willing to accept Daniel's concern for "official knowledge" or a system of knowledge because of a deep concern of the ideosyncratic aspect of the unique individual psyche. This reviewer believes that art educators should have the same concern.

Another chapter which suggests assimilation rather than cultural and aesthetic difference is by Bradley Smith. Titled "Assimilationism: Learning How to Learn the Beauty of It All" it is the most extreme example of the chief weakness noticed throughout the book: generalities and Romantic simplification. Smith's chapter is filled with grandiose sentimentalism. While it is poetic, it is sentimentally so. An example of the truisms presented in this short (five pages) chapter will clarify my point. Smith asks, "Teachers of the world—What should we be cognizant of as we toss the pebble of awareness into the pond of focus and cause ripples of transformation and change?" (p. 247). He proceeds to offer three "tools of learning how to learn." First "we must in truth recognize the unintellectuality and unperceptiveness of too many human beings from the four corners of the globe" (p. 242). Second "we must bring world issues to a point of concentration with the microscopic visionary of the greatest dreamers of all time" (p. 243).

"The third tool of learning how to learn," he says, "is the most exciting and most difficult to achieve. It is a search for a new tomorrow, after researching the best and worse (sic) of an unacceptable today" (p. 243). Change, Smith admits, causes friction. "However, friction does not have to come in the form of war; it can come in the form of love, just as fission may result in new life" (p. 243).

The final chapter, "A Chronological Minority Bibliography," is a listing of articles on the subject in the National Art Education journal, *Art Education*, since its beginning in 1951.

While there is considerable information in this book, it could hardly be said to break new ground or to present a full and courageous view of *Art, Culture, and Ethnicity* in the late 20th century.

References

Diop, C. A. (1974). *The African origin of civilization: Myth or reality*. New York: Lawrence Hill & Company.

Fouda, B. J. (1968). Negro-African oral tradition. In *Colloquium: Function and significance of African Negro art in the life of the people and for the people*. Senegal: Editions Presence Africaine.

SPECIAL ANNOUNCEMENT

Art Therapy is pleased to announce that the publication, *INNOVATIONS & RESEARCH in Clinical Services, Community Support, and Rehabilitation*, will be including our journal in their abstracting services, beginning with Vol. 9, No. 1. *INNOVATIONS & RESEARCH* is published by the National Alliance for the Mentally Ill (NAMI) and the Center for Psychiatric Rehabilitation. NAMI is a family advocacy and support organization of over 135,000 members nationally, with an additional 10,000 associate members. The Center for Psychiatric Rehabilitation is a research, training, and consultation center co-funded by the National Institute of Mental Health and the National Institute on Disability and Rehabilitation Research.

Publication of abstracts from *Art Therapy* in *INNOVATIONS & RESEARCH* will bring our journal to the attention of researchers, mental health professionals, librarians, students, and consumers. *Art Therapy* is extremely pleased to be invited to participate in this valuable resource.

—EDITOR

6

Art Therapy: Journal of the American Art Therapy Association, 9(3) pp. 150-151 © AATA, Inc. 1992

Mommy, Daddy, Look What I'm Saying: What Children Are Telling You Through Their Art

Myra Levick, Ph.D., A.T.R. with **Diana S. Wheeler,** New York: M. Evans and Company, Inc., 1986, 192 pp.; 80 black & white ills.; $17.95, ISBN 0-87131-462-2

Reviewed by **Patricia St. John, Ed.D., A.T.R.**

Myra Levick has written a one-of-a-kind book about art therapy for parents and teachers. Based on her book for professionals (*They Couldn't Talk and So They Drew*, 1983), this volume is intended to guide those "who are primarily involved in caring for children" (p. 9) into a portion of the art therapist's complex practice.

This book does not claim to transform parents and teachers into art therapists; it does assist the reader in knowing when to seek professional help. Dr. Levick begins with a statement of the problem: children do not always tell us when they are troubled. With less highly developed verbal skills, their artwork can alert us to their emotional needs. Their emotional needs change as children develop. Likewise, characteristics of drawings change. Cries for help may take the form of a change from the child's typical behavior and typical drawing style.

Dr. Levick organizes her book into two major sections: the first section includes preliminary information about children's drawings, including 10 "common warning signals" (p. 17). At this point, she lays out her theory of art psychotherapy (p. 46), and how to "inspire creative expression" (p. 62). The second section, Chapters Four through Eight, provides a detailed, profusely illustrated discussion of normal child development observed through behavior and artwork. Within each chapter she points out "warning signals" common to each age level from numerous cases out of her own practice. Child development and psychoanalytic theories are skillfully interwoven with assessment and treatment plans.

An example of Levick engaging her lay readers is her analysis of the drawing of a troubled child. A small house is drawn by a five-and-one-half-year old boy. The house looks typical for such drawings, but Levick alerts us to clues that indicate the house is atypical. The usual chimney with smoke is missing; there are no people or other objects. The house appears to be "floating." These are warning signals "for someone to stop and pay attention" (p. 12). Discussed in a later chapter are the clues to recognizing these signals and how to interpret them. In several other case presentations, Levick demonstrates artfully how to gather information from family and teachers. Involved are the careful assessment of drawings and extensive talks with the children. The techniques of the trained professional reveal there is no magic to understanding these drawings.

The most valuable chapters are those that explore child development in artwork, emotionally and socially. Understanding typical child development is prerequisite to identifying the atypical. Delineated are four typical stages/sequences. The first is the Babble/Scribble lasting from 18 months to two-and-one-half years. Second is Word-Shape which occurs typically at about two-and-one-half to four years, followed by the Sentence-Picture Stage/Sequence at four to seven years. The final stage of childhood, Fact-Fantasy, appears at about seven to 11 years. All age groupings are approximate. Each stage/sequence has its own specific characteristics, its own "warning signals" and appropriate methods for understanding the child within that stage/sequence.

For example, by age five, during the Sequence-Picture Stage/Sequence, children are making recognizable drawings. Some objects may have "realistic" coloring. Typically, a baseline hugs the bottom of the page. Children progressively notice differences between boys and girls, and identify with mommy or daddy. Drawings can reflect feelings about family members and the child. Sometimes this is represented symbolically. "... three related objects in drawings are one of the ways a child symbolizes a mother/father/child relationship ..." (p. 114). In the instance of one boy, Daddy is symbolized by a complete drawing of a clown, while the child's representation of himself is incomplete. "Clowns are awesome—they do all kinds of amazing tricks that make children laugh and cry and even feel scared. Around this age fathers can also be awesome, especially when little boys are trying to be like them" (p. 114). Warning signals at this stage may include lack of a baseline, failure to represent people, and omission of the distinction between male and female figures.

In another case, Levick describes a very shy, adopted child who was in therapy. At home, he was *made* to draw by his mother, who was often critical of his drawings. Through careful intervention, Levick established a therapeutic relationship with the child, and found that he was having trouble adjusting to a new country. She also determined that he was intellectually bright, ruling out developmental delay. The reader had already seen his house drawing on page 12. The house reflected his emotional state: lonely, isolated and depressed. After consultation, the parents agreed to enter therapy to learn how to help him grow emotionally.

This excellent book has its flaws. Levick makes a distinction between the art therapist and art psychotherapist by distinguishing between two schools of thought: "Art as therapy" and "Art in therapy" (p. 29). Art as therapy (read art therapist), she explains, "assumes that the very act of creating something artistic is healing" (p. 29). Art in therapy, (read art psychotherapist) has goals which are "very similar to the goals of psychoanalysts who encourage patients to discuss dreams and childhood memories ... helping the artist become aware of all the parts of the image, and of the thoughts and feelings that produced that image" (p. 30). She briefly, and almost offhandedly, acknowledges that a third group uses both approaches, depending on the needs of the client. It is apparent that she identifies herself as an "art psychotherapist." There is a not so subtle implication that the art psychotherapist is superior and is therefore similar to a psychoanalyst. There is no description of how art therapists work. Ironically, she does not maintain strict use of these terms throughout the book. This false dichotomy can be confusing to the reader. The incorrect impression given is that the art psychotherapist is more rigorously trained than the "regular" art therapist.

A minor quibble is that although Levick encourages parents and teachers to allow children to produce spontaneous artwork, she does include some examples of directed artwork. It is not clear why a directive approach is warranted, or what might be the difference between directed and spontaneous artwork. On the positive side, she points out concisely when parental intervention is indicated. For example, parents might be useful in assisting groups to identify a topic for a mural or other group project.

Other detractions may have more to do with the publisher rather than the author. Levick gives many more examples than are illustrated. On occasion the reader must visualize the artwork. Undoubtedly, inclusion of all the artwork would have been too costly for the publisher. However, this reviewer was frustrated by not having the artwork at hand. One can imagine the resulting confusion for the untrained parent or teacher for whom the book was conceived. The same concern relates to the total lack of color illustrations. Color can be a key element in identifying warning signals.

Despite these criticisms, this is a very valuable book. It may be written for teachers and parents, but should be on the shelf of every art therapist (or psychotherapist, if you like). Levick's methodology, her careful probing and pragmatic interventions are thoughtful and thought-provoking. The very simplicity of her methods is deceptive. This is art therapy in the hands of a very experienced professional. Parents and teachers reading this provocative book will discover that art can be the open sesame in deciphering the mysteries of child behavior.

Reference

Levick, M. (1983). *They could not talk and so they drew.* Springfield, IL: Charles C Thomas.

Art Therapy: Journal of the American Art Therapy Association, 9(3) pp. 152-153 © AATA, Inc. 1992

Video Review

Imagery and Grief Work: Healing the Memory

Mary S. Cerny, Ph.D.

Produced and directed by **James M. Rovaris**, Topeka, KS: Menninger Video Productions, 1989.
42 minutes. Color. Rental: $45. Purchase: $135.

Reviewed by **James J. Consoli, M.A., A.T.R., N.C.C.**, Film and Video Editor, and Instructor, Eastern Virginia Medical School Graduate Art Therapy Program, Norfolk, VA.

For of all sad words of tongue or pen,
The saddest are these:
It might have been.

John Greenleaf Whittier, 1856

This quote which begins both the video and the accompanying discussion guide, succinctly expresses the regret we experience in our own personal lives. Yet our histories, experiences, memories and internal imagery are unique to each of us. As I stare at my computer monitor or you at your journal, we absorb the images that are external to ourselves. As we pause for a moment and explore our reactions, we look also at the internal images that are "for our eyes only." It is this idiosyncratic internal view that we must respect as we address imagery work.

Imagery work is a powerful form of healing. As art therapists, we are fully aware of the healing potential of images in our work. Of the three modes of communication (lexical, kinesthetic and image), imagery has been punished the least in our experiences and is therefore less vulnerable to censorship (Shorr, 1978). We are aware also of how limiting are other treatment modalities that neglect this form of communication for a verbal approach.

Dr. Cerny willingly makes an intuitive leap with this video. She demonstrates the effectiveness of imagery work in addressing conflicting issues of grief by using imagery to tap a deeper level—the unconscious or preconscious. She explains how a person may *know* that he or she is not responsible for a loved one's death, yet may *feel* guilty, and how it is at that deeper level that effective treatment needs to occur. She describes the process and presents a live session with a young woman suffering from unresolved grief following the untimely deaths of her sister and father. Five years after the initial imagery intervention, Cerny had the unique opportunity to conduct a follow-up interview to assess its benefits.

The process Cerny incorporates is very similar to the work of Anees A. Sheik, Ph.D., of the American Imagery Institute in Milwaukee, Wisconsin. In this method, the imagery work is created internally only, not in a two or three dimensional form, and often without employing hypnotic induction techniques. The client is discouraged from maintaining eye contact with the therapist. In the video session the client is asked to close her eyes, and to form a picture in her mind of a specific image, her deceased father. She is asked to describe the image and encouraged to confront related conflicts.

Cerny cautions the viewer not to push the client too fast. It may be premature to encourage the client to work with imagery immediately or to say goodbye to someone before dealing with unresolved anger. Cerny quotes Horowitz (1983), who cautions: "Image formation is one kind of thinking, a mode that is close to emotion. A psychotherapist listens for image experiences, but any exclusive focus on image formation is an unbalanced approach."

Although I was attracted by the casualness and informality of Cerny's style, I perceived a need for a more disciplined approach. My concerns center on certain interventions she used while her client was in the trance-like state. For example, when the client said she felt scared, Cerny responded by saying, "Why are you scared?" This invites an *intellectual* response, not the initial goal when using imagery intervention.

Another more potentially damaging intervention includes imagery of the client's father, whose history included alcoholism and abusive behavior. The client did not feel close to him. In an attempt to resolve the conflict between them, Cerny stated: "He is coming over to you and giving you a big hug. . . . Does that feel good to you?" Grimacing, the client replies, "Not really."

This last example demonstrates that resolution needs to come from within the client. Otherwise, the solutions are contaminated by the therapist's "germs." This type of intervention is analogous to psychological surgery, during which the client is quite vulnerable and less protected. Destructive infections and further trauma can occur in the name of therapy. Therefore, by incorporating what Groves (1989) calls "clean language," the therapist, while keeping all surgical instruments sterilized, empowers the client to resolve conflicts independently.

In general, this video provides a very good example of how internal imagery can be used in therapy. The video's production quality is adequate for the consumer market it serves. Typical of Menninger video productions, packaging is professional. The discussion guide is an excellent resource. The content of the video is a challenge to all art therapists to explore further the realm of imagery work, without art materials.

As we continue to address issues of our professional identity, we need to explore imagery beyond the art room. Imagery and therapy include much of our identity and function as art therapists. Who, then, is more qualified?

References

Grove D. (1989). *Healing the wounded child within.* Unpublished manuscript, David Grove Seminars, Edwardsville, IL.

Horowitz, J. J. (1983). *Image formation and psychotherapy* (Rev. Ed. of *Image formation and cognition*, 1978). New York: Jason Aronson.

Shorr, J. E. (1978). Clinical use of categories of therapeutic imagery. In J. L. Singer & K. S. Pope, (Eds.) *The power of human imagination: New methods in psychotherapy* (pp. 95-121). New York: Plenum.

Now Available from the American Art Therapy Association

A GUIDE TO CONDUCTING ART THERAPY RESEARCH

●

Price: $24 Members $35 Non-members
Shipping/handling included
Orders of 10 or more copies: 10% discount

●

Please send your written request, along with payment, to:

American Art Therapy Association
1202 Allanson Road
Mundelein, IL 60060

●

We do not accept purchase orders or credit cards

✶ ✶ CALL FOR PAPERS ✶ ✶

2nd ANNUAL ART THERAPY CONFERENCE

"ART, CREATIVITY AND HEALTH"

University of Utah Conferences and Institutes

The University of Utah Conferences and Institutes invites program proposals for the 1993 Art Therapy Conference, "Art, Creativity and Health," to be held in Park City, Utah on June 18-20, 1993. Proposals must be made according to the guidelines listed below.

●

CATEGORIES

Paper: Oral presentation of written material on theoretical, methodological, or research topics related to the conference theme.

Workshop: Experiential format designed to engage participants in a technique or method to gain mastery over material covered.

GUIDELINES FOR SUBMISSION

1. All proposals must be typed (single spaced) and must describe the scope, nature and content of the presentation. It should also contain goals and objectives as well as references to relevant literature. The proposal should be no longer than one page in length (approximately 250 words).
2. A separate reference list should accompany each proposal; this list should contain the citations for all references made in the text of the proposal.
3. The title of the proposal should not exceed 12 words.
4. A 50-word abstract should accompany the proposal; this abstract may be used to describe the presentation in conference materials.
5. All proposals must include the presenter's name, degrees, address, and phone number on a separate sheet. Please indicate which type of format (paper or workshop), the level of presentation (basic, intermediate, or advanced) and the number of participants (no limit or state specific number).
6. Please submit **five (5) clear copies** of all materials.
7. Proposals which do not meet these guidelines will automatically be disqualified.

●

DEADLINE FOR SUBMISSION:

Postmarked no later than December 5, 1992.

●

Send all material to:

1993 Program Committee
Art, Creativity and Health Conference
Conferences and Institutes
University of Utah/2174 Annex Building
Salt Lake City, Utah 84112

ARTherapy
JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

COLOR RATES: Standard Red, Blue and Yellow
(Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x	4x
Per page additional	$90	$85	$80	$75

INSERTS	1x	2x	3x	4x
2 pp	$ 800	$ 700	$ 575	$ 425
4 pp	1,500	1,300	1,150	1,000
8 pp	2,200	2,000	1,750	1,450

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-page Horizontal	7"	4-7/8"
Half-page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"
Bleed Size: 8-5/8" × 11-1/4"
Inserts: 8-5/8" × 11-1/4"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue; July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

THE AMERICAN ART THERAPY ASSOCIATION

November 13-17, 1991
Denver, Colorado

"Image & Metaphor: The Practice & Profession of Art Therapy" Audio Cassettes Available

- ☐ 1. The Future of Art Therapy: A Debate / Art Therapy: Post Mortem, C. Malchiodi, MA, ATR, M. Cattaneo, PhD, ATR, P. Allen, PhD ATR / Using Creative Thinking Strategies to Image a 21st Century AATA, D. Arrington, EdD, ATR, C. Drachnik, MA, MFCC, ATR, P. Howie, MA, ATR, J. Rubin, PhD, ATR **(2 tapes)**
- ☐ 7. SYMPOSIUM - ALTERNATIVE REALITIES -- An Inquiry Into Systems of Creativity: An Alternative Realities Approach, M. Junge, PhD, LCSW, ATR / Family Art Therapy From An Alternative Realities Perspective, C. Lind, MA, J. Walter, MA, M. Junge, PhD, LCSW, ATR
- ☐ 8. SYMPOSIUM - IMAGE AS METAPHOR -- From Image to Metaphor - Why Don't You Just Say What You Mean?, D. Behnke-Marthaler, MA, ATR / Visual Metaphor: Its Role in Therapy, V. Lusebrink, PhD, ATR
- ☐ 13. SYMPOSIUM - ART THERAPY & THE ELDERLY -- Illuminations: Program Concept for Art Therapy with the Elderly, B. Callanan, MS, ATR
- ☐ 14. SYMPOSIUM - IMPACT OF RITUAL ABUSE -- Was It Schizophrenia or Ritual Abuse?, C. Drachnik, MA, MFCC, ATR / Surviving the Survivors of Ritual Abuse: Images of the Client & Therapist, K. Cox, MA, LPC, ATR
- ☐ 22. SYMPOSIUM - WORKING WITH INCEST SURVIVORS -- A Comparison of Verbal & Art Group Therapies with Adult Female Incest Survivors, C. Waller, BA, BFA, C. Malchiodi, MA, ATR / Ceramic Mural Messages From Incest Survivors, F. Anderson, EdD, ATR, HLM, K. Deske, MS
- ☐ 34. KEYNOTE ADDRESS: The Art of Dying: Images, Insights & Interventions, S. Bertman, PhD

PAPERS

- ☐ 9. Ethnicity Illuminated in Humor & Art Therapy, C. Mango, MA, ATR, J. Richman, PhD
- ☐ 10. The Use of Art Psychotherapy Evaluations of Children in Custody Disputes, S. Lyons, MS, ATR
- ☐ 15. Adventures in Short-Term Group Art Therapy: Reservations, Itineraries & Baggage Handling, P. Isis, MEd, ATR
- ☐ 16. Art Therapy Meets Hypnosis & Neurolinguistic Programming, S. Zavadil, MA, ATR
- ☐ 18. Liberty & Conflict: Images From Psychologists in a War-Torn Country, M. Rosal, PhD, ATR
- ☐ 19. An Image in Transition: From Student to Professional, P. Schwartz, MA, J. Bolde, MA
- ☐ 20. Journey to Recovery: One Step at a Time, M. Miller, BA
- ☐ 21. Multiple Family Group: Art Therapy with Hospitalized Adults & Families, K. Stovall, MA, MFCC, ATR
- ☐ 26. Image as Healer, Metaphor as Helper, E. Wallace, MD, PhD
- ☐ 27. Creative Therapies for Adult Children of Addiction Recovering From Alcoholism, U. Goebels, MA, ATR
- ☐ 28. Illustrating the Family Story: Art Therapy - A Lens to Viewing the Family's Reality, S. Riley, MA, MFCC, ATR
- ☐ 29. Maybe Tomorrow: Art Therapy With AIDS Patients, W. Ferguson, PhD, ATR, D. Kronick, BA
- ☐ 31. Artistic Expression of Alzheimers in Adult Day Care, Assisted-Living & Skilled Nursing, K. Kahn, BA, ATR, M. Tarsitano, MA
- ☐ 32. Art RX: Art Expression & Physical Health, C. Malchiodi, MA, ATR
- ☐ 33. Dedication to the Contemplative Life, L. Howard, BA, M. Flemming, MA, MFCC, ATR
- ☐ 35. Images as Defense Mechanisms, V. Lusebrink, PhD, ATR, R. Gorstein, BA, M. Levick, PhD, ATR, R. Jonkers, BA
- ☐ 36. Aggression Depicted in Abused Children's Drawings: Development of an Assessment Tool, T. Manning, MS, ATR
- ☐ 39. Art Therapy - Adjunctive & Primary in a Therapeutic Community for Children, J. Duboff, MA, ATR
- ☐ 40. Deja Vu: Comparing Schizophrenic & Affective Psychotic Patients Utilizing the Bridge Projective, R. Hays, MS, ATR, S. Lyons, MS, ATR
- ☐ 43. A Three Session Package for Assessment, Confrontation & Treatment Planning, J. Consoli, MA, ATR
- ☐ 44. Hard Time Art: Creative Expression in Prison, M. Taylor, PhD, ATR, C.E. Walsh, PhD
- ☐ 45. The Effects of Stimulant Medications on the Art Products of ADHD Children, J. Epperson, MA, J. Valum, MS
- ☐ 46. Art Therapy - The Tool for Treating Multi-Abuse, N. Slater, PhD, ATR
- ☐ 47. Reality & Relationship: A Structured Art Therapy Approach with Schizophrenic Adolescent Patients, T. Manning, MS, ATR
- ☐ 48. Images of God: The Effects of Abuse on God Representatives, C. Moon, ATR
- ☐ 49. Artistic Expression of Large Mammals Confined to Zoological Institutions, D. Henley, MA, ATR
- ☐ 50. Doorways to Life: Art Interventions with Suicidal Clients, D. Conger, MA, ATR
- ☐ 51. Linking Interpretations of Children's Visual Images to a Developmental Art Scale, B. Troeger, PhD, ATR
- ☐ 52. Art Therapy Treatment of a Narcissistic Adolescent with Asthma: Case Study, R. Gabriels, MA, LPC, ATR
- ☐ 54. Exhibiting Art by People with Mental Illness: Issues, Process & Principles, S. Evans Spaniol, MA, ATR
- ☐ 55. Finding a New Niche: An Art Therapy Program in a Public School, M. Otcasek, BFA, MA
- ☐ 56. The Perception of Doors, M. Junge, PhD, LCSW, ATR
- ☐ 58. Fostering Emotional Health Through Music & Art in Primary Schools, D. Cogan, MA, M. Giles, PhD, C. Cox, MA, ATR
- ☐ 59. Idealization, Transformation & Disillusion in the Art of a Cross Addicted Transsexual, R. Obstfeld, MA, ATR
- ☐ 61. The Canvas Mirror: Images of Existential Art Therapy, B. Moon, MA, MDiv, ATR
- ☐ 62. Dying of a Broken Heart: Imagery of Eating Disorder Patients, M. Davies Cole, MA, MPS
- ☐ 63. Healing Medical Symptoms Exacerbated by Stress: Using Art Psychotherapy, G. Tartakoff, MCAT, ATR

PANELS

- ☐ 5. Art Therapy Treatment of Sexually Abused Clients: Child, Adolescent, Adult, M. Farrelly-Hansen, MA, ATR, T. Sweig, MA, ATR, H. Lock, MA, ATR
- ☐ 6. From Outside In & Inside Out: Viewing AIDS Thru Art Therapy's Window, S. White, MA, ATR, G. Fenster, MA, ATR, M. Franklin, MA, ATR, I. Rosner-David, MA, ATR, J. Weiser, MSEd, ATR, RCAT
- ☐ 11. Manifestations of Health: Art Therapists Creating Art, L. Carte- Anderson, MEd, ATR, M. Farrelly-Hansen, MA, ATR, R. Hueftle, MEd, LPC, ATR
- ☐ 12. Art by Abuse Survivors - A Lifecycle, C. Cox, MA, ATR, B. Cohen, MA, ATR, A. Mills, MA, ATR, B. Sobol, MA, ATR
- ☐ 23. Confronting Cancer Through Art: A Collaborative Effort by Hospital, Patient & Therapist, V. Minar, MS, ATR, J. Erdmann, MA, L. Kapitan, MPS, ATR, S. Richter-Loesl, MA, ATR, L. Vance, MS, ATR
- ☐ 24. Systems Approach to Art Therapy, R. Schoenholtz, MS, ATR, A. Nucho, PhD, ATR, V. Lusebrink, PhD, ATR, J. Rhyne, PhD, ATR, HLM, J. Weiser, MSEd, RCAT, ATR
- ☐ 25. My God Left Me? Spirituality, Wholism & Transpersonal in Art Therapy, R. Shoemaker-Beal, MFA, ATR, D. Frantz, MDiv, B. Moon, MDiv, ATR, S. Kopp, MS, CAC, CP, P. Dufrene, PhD, MFA, ATR
- ☐ 37. Bringing Down Additional Walls for Greater International Understanding, B. Stoll, MA, MFCC, ATR, A. Philippini, G. Troll, I. Martn, ATR, B. Nussbaum
- ☐ 38. The Dominions of Transference, D. Behnke-Marthaler, MA, ATR, A. Calish, MS, ATR, A. Canright, MAAT, ATR, S. Semekowski, MA, ATR, H. Wadeson, PhD, ATR
- ☐ 60. Comparisons of Drawings Produced by Abused Children & Survivors in Adulthood, M. Levick, PhD, ATR, HLM, K. Gomer, MS, ATR

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

RESOURCES

1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following publications and films are available from the AATA National Office

PUBLICATIONS

	Members	Non-Members
Conference Proceedings:		
●Creativity and the Art Therapist's Identity (1976) 118 pages (ISBN 1-882147-04-9)	$ 5.00	$ 7.00
●Art Therapy: Expanding Horizons (1978) 142 pages (ISBN 1-882147-05-7)	$ 5.00	$ 7.00
●Focus on the Future: The Next Ten Years (1979) 151 pages (ISBN 1-882147-10-3)	$ 6.00	$ 8.00
●The Fine Art of Therapy (1980) 125 pages (ISBN 1-882147-12-X)	$ 7.00	$ 9.00
●Art Therapy: A Bridge Between Worlds (1981) 119 pages (ISBN 1-882147-11-1)	$ 7.00	$10.00
●Art Therapy: Still Growing (1982) 172 pages (ISBN 1-882147-06-5)	$10.00	$14.00
●Art Therapy: New Directions in the '80s (1987) 110 pages (ISBN 1-882147-13-8)	$15.00	$20.00
●Professionalism in Practice (1988) 127 pages (ISBN 1-882147-08-1)	$15.00	$20.00
●Painting Protraits: Families, Groups & Systems (1989) 141 pages (ISBN 1-882147-07-3)	$15.00	$20.00
●Image and Metaphor (1991) 143 pages (ISBN 1-882147-09-X)	$15.00	$20.00
Resource Packet: ●Art Therapy in the Schools	$ 6.00	$10.00

NOTE: Postage and handling for above publications: $3.00 for first item, $.75 each additional item

SEE OTHER SIDE FOR LIST OF ADDITIONAL PUBLICATIONS **Foreign Orders:** Pre-payment of items required. Shipping charges, per your instructions, will be billed separately. Air Mail: 1 week delivery; Ground Service: 2 months delivery

10 or more copies of any single issue: 15% discount on total cost. Set of four Proceedings (consecutive years): 20% discount on total cost.

WE DO NOT ACCEPT PURCHASE ORDERS

ITEM	Qty.	Cost/Unit	Total
________	( ) x	______ =	______
________	( ) x	______ =	______
________	( ) x	______ =	______
________	( ) x	______ =	______
TOTAL: PUBLICATIONS/POSTAGE & HANDLING			$______

Art Therapy: Journal of the American Art Therapy Association: Subscription Rates:
Individuals: US: $35 Foreign: $56; Institutions (US): $50 Foreign: $70
Back Issues: Members: $9 Non-Members: $16

AATA Newsletter: Subscription:
Non-Member: $16 Foreign: $28

FILMS (Rental/Purchase)

		Members	Non-Members
●Art Therapy: Beginnings (1977) - color/sound, 45 minutes: 16mm	Rental Only	$40.00	$50.00
	½" VHS Purchase Only	$50.00	$80.00
●Michael (1977) - color/sound, 12 minutes: 16mm	Rental Only	$30.00	$35.00
	½" VHS Purchase Only	$50.00	$80.00
●Art Therapy (1981) - color/sound, 12 minutes: 16mm	Rental Only	$35.00	$45.00
	½" VHS Purchase Only	$50.00	$80.00
●Lori: Art Therapy & Self Discovery (1978): 16mm	Rental Only	$40.00	$50.00
Color/sound, 32 minutes	½" VHS Purchase Only	$50.00	$80.00

NOTE: Postage/Handling for Films: $3.00 each VHS; $7.00 each 16mm

ITEM	QTY.	COST/UNIT	TOTAL
________	( ) x	______ =	______
________	( ) x	______ =	______

FILMS Postage/Handling = $______** **TOTAL COST OF FILMS:$______

WE DO NOT ACCEPT CHARGES OR PURCHASE ORDERS

●MAKE CHECKS PAYABLE TO: AATA
MAIL ORDER TO ABOVE ADDRESS

SHIPPING INFORMATION:

Name______ **MemberID#**______

City______ **State**______ **Zip**______

TAPES NOW AVAILABLE: AATA's 22nd Annual Conference
November 13-17, 1991 Denver, Colorado
"Image & Metaphor: The Practice & Profession of Art Therapy"

PRICE PER TAPE: $12.00 * See list of available tapes on previous page.

Mail Order Form

NO. OF TAPES________ X $12.00 EACH $________
SHIPPING ($1.75 per tape to $12.00 max.) $________
FOREIGN SHIPPING ($3.00 per tape to $30.00 max.) $________
SALES TAX (CO Residents Only 7.3%) $________
TOTAL OF ORDER $________
SHIP TO (Please print clearly) ☐ RESIDENTIAL ☐ BUSINESS
NAME________
INSTITUTION________
ADDRESS________
____
CITY________ STATE________ ZIP________
DAYTIME PHONE________

METHOD OF PAYMENT (Do Not Send Currency)
________Enclosed is my check (Drawn on US Bank in US Funds)
Charge to my ________AMEX ________MASTERCARD ________VISA
CARD #________
EXP. DATE________
SIGNATURE ON CARD________
MAKE CHECKS PAYABLE AND MAIL YOUR ORDER TO:

NATIONAL AUDIO VIDEO, INC.
4465 WASHINGTON STREET
DENVER, CO 80216
Phone: (303) 292-2952

QUALITY GUARANTEED - NO REFUNDS - ALLOW 2-4 WEEKS FOR DELIVERY

CALL TOLL FREE: 1-800-373-2952 (9-5 MST) • OR FAX YOUR ORDER 303-292-5629

MEMBER ID # ________	MEMBER	NON MEMBER
▲Educational Guidelines	$ .30	$ 1.00
▲Educational Program List	$ .30	$ 2.00
▲Standards and Procedures for Registration	$ .30	$ 1.00
▲Criterion for Professional Membership	$ .30	$ 1.00
▲Art Therapy Model Job Description	$ .30	$ 1.00
▲Art Therapy Media List	$ .30	$ 1.00
▲Standards of Practice	$ .55	$ 1.00
▲Ethics Document	$ .30	$ 1.00
▲Art Therapy Bibliography	$ .30	$ 1.00
▲Member Specialty List	$ 1.90	$ 2.90
▲Membership Survey	$ .75	$ 2.75
▲Associate/Student Membership Application	N/C	N/C
Professional Membership Application	N/C	$ 1.00
Registration (A.T.R.) Application	N/C	$ 1.00
National Registry of Master's These/Practicum Papers	$15.00	$25.00
***NEW* GUIDE TO CONDUCTING ART THERAPY RESEARCH**	$24.00	$35.00

GENERAL INFORMATION PACKET:
Includes first three items at left:
$ 4.00

▲Available in multiples:
1-9 copies
$2.00 with SASE
10-50 copies
$5.00 with SASE

ADDITIONAL PUBLICATIONS

Chapter Procedural Manual
$10.00 + $2.00 postage

Membership Directory/By-Laws

Member:	$ 10.00
Non-Member:	$ 50.00
Institution:	$100.00

($2.90 postage for above)

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3500 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice: AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliate Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive:

Publications

- *Art Therapy*, the official journal of the AATA
- The quarterly *AATA Newsletter*
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory
- Free AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice
- Mailings of professional interest

Services

- Insurance, including professional liability, major medical, life and disability
- Access to national experts in art therapy

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring
- State legislative and regulatory activities
- Promotion of recognition and reimbursement of art therapists by third-party payors
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy

Professional Standards

- Development of model job and licensure laws
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists

GENERAL MEMBERSHIP APPLICATIONS

1. The membership year is the calendar year, January 1 through December 31.
2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY: Please follow the chart below when submitting membership application.

   Applications received between:
   Jan.1 and May 31: Full dues payment. Membership expires Dec. 31 of same year.
   June 1 and Sept.30: Half year's dues plus $5 payment. Membership expires Dec. 31 of same year.
   Oct. 1 and Dec. 31: Full dues payment. Membership valid for remainder of current year and next full year.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to Membership Chair for approval.
4. AATA Membership and AATA Registration (A.T.R.) each have a separate application procedure. Registration is bestowed only by the Standards Committee.
5. National AATA membership required for Chapter Membership. Please contact AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL - by application only. Such members may vote, hold office, and serve on committees.

- Credentialed Professional Member: Individuals who have been dually approved for Professional Membership and Registration (A.T.R.) by AATA; dues are $80 per year.
- Active Professional Member: Individuals who have completed professional training in art therapy. Dues are $ 75 per year.

CONTRIBUTING - Individuals, organizations, institutions or foundations which contribute annually to AATA. Such members may vote, hold office or serve on committees. Annual dues are $100.

ASSOCIATE - Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. Such members may not vote, hold office or serve on committees. Annual dues are $75.

STUDENT - Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution indicating full-time status and coursework content. Student members may not vote, hold office but may serve on Student Subcommittee of Membership. Annual dues are $35.

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

MEMBERSHIP APPLICATION

- Name ______________________________
  Last First Middle
- Home Address ______________________________
  ____
- Phone(_____) ______________________________
- Business Address ______________________________
  ____
- Business Phone (_____) ______________________________
- Employer ______________________________
- Job Title ______________________________
- Licenses Held/State ______________________________
- Preferred Mailing Address: ____Home ____Business
- Please indicate under which category you are applying:
- _____**A.T.R. REGISTRATION** (a corresponding application packet will be sent to you)
- _____**$80 A.T.R. MEMBERSHIP** (after approval only)
- _____**PROFESSIONAL MEMBERSHIP** (a corresponding application packet will be sent to you)
- _____**$75 PROFESSIONAL MEMBERSHIP** (after approval only)
- _____**$100 CONTRIBUTING MEMBERSHIP**
- _____**$75 ASSOCIATE MEMBERSHIP**
- _____**$35 STUDENT MEMBERSHIP** (see student membership criterion for necessary documents to accompany this application)

**PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO: AATA**

American Art Therapy Association
1202 Allanson Road
Mundelein, IL 60060

Please complete this survey:

EDUCATION (highest degree earned)

1_______Doctorate Degree
2_______Master's Degree
3_______Bachelor's Degree
4_______Associate/Certificate
5_______Other

(Please indicate exact degree earned, e.g., BA, BS, MA MS, PhD, etc.)

WORK SETTING (please check one only)

1___Hospital
2___Clinic
3___Day Treatment Center
4___Rehabilitation
5___Sheltered Workshop
6___Correctional Facility
7___Residential Treatment
8___Outpatient Mental Health
9___School System
10___Elderly Care Facility
11___College/University
12___Clinical Training Program
13___Institute Traning Program
14___Counseling Center
15___Private Practice
16___Other_______________

AREA(S) OF SPECIALIZATION (please check up to three)

1___Addictions
2___Adolescents, Hospitalized
3___Adolescents, Psychiatric
4___Adults, Hospitalized
5___Adults, Psychiatric
6___Art History
7___Art Therapy Education
8___Art Therapy in Schools
9___Children, Hospitalized
10___Children, Psychiatric
11___Domestic Violence
12___Eating Disorders
13___Families
14___Gerontology
15___Hospice/Terminally Ill
16___Learning Disability
17___Mental Retardation
18___Neurological Disease
19___Prisoners
20___Post Traumatic Stress
21___Psychotherapy
22___Rehabilitation
23___Research
24___Sexual Abuse
25___Visual Art
26___Other_______________

VOLUNTARY INFORMATION

Age

1___20-24
2___25-29
3___30-34
4___35-39
5___40-44
6___45-49
7___50-54
8___55-59
9___60+

Salary Range

1___under $10,000
2___$10-15,000
3___$15-20,000
4___$20-25,000
5___$25-30,000
6___$30-35,000
7___$35-40,000
8___$40-45,000
9___$45-50,000
10___$50,000+

Gender

1___Female
2___Male

Hours Worked per Week

1___0-10
2___10-20
3___20-30
4___30-40

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Xerox copies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

BEST COPY AVAILABLE

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone #s: ____________________ work ____________________ home

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ______________________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ______________________________ **Date** ____________

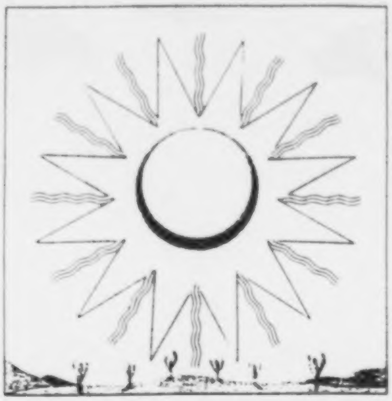
Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association***, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

1289

THE AMERICAN ART THERAPY ASSOCIATION, INC.
23rd ANNUAL CONFERENCE



THE ART THERAPIST:
Artist,
Teacher,
Clinician,
Healer

NOVEMBER 4 - 8, 1992
THE RIVIERA
LAS VEGAS, NEVADA

This year's Conference will feature:

- Day-long preconference courses with graduate credit option
- Keynote speaker John MacGregor, Ph.D., author of *The Discovery of the Art of the Insane*
- 120 presentations on a wide variety of art therapy topics, such as: special populations, abuse, spirituality and the arts therapies, professional issues, and assessment
- Experiential workshops
- New Masters Supervision Groups
- Special events

AATA members will receive additional information and full registration packages by mail. Other interested parties should contact:

AATA, Inc.
1202 Allanson Road
Mundelein, IL 60060
708-949-6064

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ART THERAPY is published quarterly by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $35 (US); $56 (Foreign). Institutions: $50 (US); $70 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $9 member; $16 non-member. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1992. Enclosed is my check, payable to AATA, for $35.
Name ______________________________
Address ______________________________
City ____________________ State __________ ZIP __________

The interdisciplinary journal
devoted to the creative arts as healing arts.

THE ARTS IN PSYCHOTHERAPY

An International Journal

ARTS PSYCHOTHERAPY

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief:
David Read Johnson, PhD, RDT
Associate Clinical Professor, Department of Psychiatry, Yale University; Clinical Psychologist, Veterans Administration Medical Center, West Spring Street, West Haven, CT 06515, USA

THE ARTS IN PSYCHOTHERAPY is a quarterly, international journal for professionals in the fields of mental health and education. The journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines. There are no restrictions on philosophical orientation or application.

PERGAMON PRESS
Maxwell House, Fairview Park, Elmsford, NY 10523
Headington Hill Hall, Oxford OX3 0BW, England
Member of Maxwell Macmillan Pergamon Publishing Corporation

SPECIAL RATES AVAILABLE FOR MEMBERS OF QUALIFYING SOCIETIES!
Members of qualifying societies can receive a discount on one-year Professional subscriptions to the THE ARTS IN PSYCHOTHERAPY. Please write for further information.

Editors welcome original manuscripts. Submit papers in triplicate to: Managing Editor, Sylvia Halpern, 20 Ridgecrest East, Scarsdale, NY 10583

SUBSCRIPTION INFORMATION

ISSN: 0197-4556	Volume 17, 1990
Published 4 issues per annum	
Annual Institution Subscription Rate (1990)	US$130.00
Two-year Institution Rate (1990/91)	US$247.00
Professional Rate (1990)	US$ 40.00
Student Rate (1990)	US$ 16.00

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 9, NUMBER 4, 1992

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $35 (U.S.) and $56 (Foreign); institutions: $50 (U.S.) and $70 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern*.

Advertising: Please see advertising rates listed elsewhere in this journal or contact the American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 (708) 949-6064. The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

ISBN 1-882147-15-4

Editor
Cathy A. Malchiodi, M.A., A.T.R.
University of Utah, Salt Lake City, UT

Associate Editor
Patricia St. John, Ed.D., A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor
Elizabeth Ratcliffe, M.S., MFCC, A.T.R.
College of Notre Dame, Belmont, CA

Film/Video Review Editor
James Consoli, M.A., A.T.R., NCC
Eastern Virginia Medical School, Norfolk, VA

Production Editor
Christine Fryer

Editorial Board
Frances E. Anderson, Ed.D., A.T.R., HLM
Illinois State University, Normal, IL
Julia G. Byers, M.A., A.T.R.
Concordia University, Montreal, Quebec
Michael Campanelli, Ed.D., A.T.R.
Wright State University, Dayton, OH
Susan E. Cheyne-King, M.S., A.T.R.
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, M.A., A.T.R.
George Washington University, Washington, D.C.
Maxine Borowsky Junge, Ph.D., LCSW, A.T.R.
Loyola Marymount University, Los Angeles, CA
Paolo Knill, Ph.D., A.T.R., CMT-BC
Lesley College, Cambridge, MA
Wendy Lauter, M.C.A.T., A.T.R.
Oak Park, IL
Vija B. Lusebrink, Ph.D., A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, Ed.D., A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Trudy Martin Manning, M.S., A.T.R.
Eastern Virginia Medical School, Norfolk, VA
Shirley Riley, M.A., MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Paul Rodenhauser, MD
Tulane University, New Orleans, LA
Marcia L. Rosal, Ph.D., A.T.R.
University of Louisville, Louisville, KY
Lewis Shupe, Ph.D., A.T.R.
Wright State University, Dayton, OH
Sandra Ticen, M.S., A.T.R.
Canisius College, Buffalo, NY
Betty Jo Troeger, Ph.D., A.T.R.
Florida State University, Tallahassee, FL
Robert Wolf, M.P.S., A.T.R.
College of New Rochelle, New Rochelle, NY

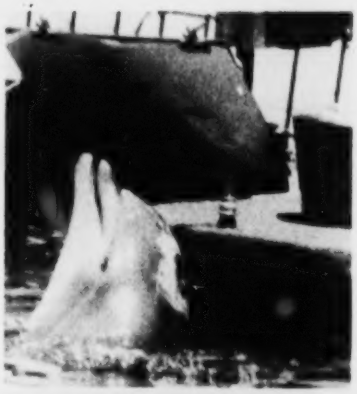
AATA President
Robin Goodman, Ph.D., A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

1293

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION



Editorial

Introduction to Special Issue: Biological and Anthropological Bases of Art Expression
Cathy A. Malchiodi, M.A., A.T.R. 166

Commentaries 168

Articles

Art for Life's Sake
Ellen Dissanayake 169

Commentary
Linda Gantt, Ph.D., A.T.R. 176

Facilitating Artistic Expression in Captive Mammals: Implications for Art Therapy and Art Empathicism
David R. Henley, M.A., A.T.R. 178

Brief Reports

Psychoaesthetics Dolphin Project
Barbara Ann Levy, M.F.A., M.P.S. 193

Viewpoints

Ritual and Art Making
Eva Wasilewska, Ph.D. 198

Reviews

Homo Aestheticus
Elizabeth Ratcliffe, M.S., M.F.C.C., A.T.R. 201

The Aesthetic Experience: An Anthropologist Looks at the Visual Arts
Patricia St. John, Ed.D., A.T.R. 203

Video Review: Psychoaesthetics Dolphin Project
Linda Gantt, Ph.D., A.T.R. 206

Noteworthy 209

Annual Index, Volume 9 211

About the Cover: "Uneasy Sleep," 15" × 12", oil on sheet metal mounted on wood, by Edith Kramer, A.T.R. About the piece, Ms. Kramer says, "The painting is one of a series of paintings on sheet metal based on colored pencil drawings done while riding the New York subways. The paintings on metal are part of an extensive group of drawings, paintings, collages and sculptures representing various aspects of the New York subways."

VOLUME 9 NUMBER 4, 1992

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 166-167 © AATA, Inc. 1992

Editorial

Introduction to Special Issue: Biological and Anthropological Bases of Art Expression

Cathy A. Malchiodi, M.A., A.T.R., *Editor*

In *Shadows of Forgotten Ancestors: A Search for Who We Are*, Carl Sagan and Ann Druyan (1992) critically examine the connections between humans and other species and ask the question, "What does it mean to be human?" By reviewing what we know about the origins of life and evolution, the authors reflect on some of the fundamental questions of human existence. They also carefully consider many characteristics thought to be the sole domain of humankind, finding that there are strong overlaps in both human and animal characteristics.

In the realm of the arts, Sagan and Druyan briefly touch on the notion that art, dance and music traditionally are thought to be uniquely human activities; however, among animals, there are strong indications that this is not completely true. For example, the authors cite the bower birds' decoration of their nests, chimpanzees' pleasure in drumming and gibbons' gratification in song. Morris's seminal studies of the chimpanzee Congo (1958a; 1958b; 1961; 1962), Beach, Fouts and Fouts (1984) and their work with chimpanzees, and the research of art therapists David Henley and Barbara Ann Levy in this issue, all demonstrate that this aspect of cultural life may not be solely limited to our species.

My first real exposure to the idea of a biological basis of art expression occurred several years ago when I was given a copy of Desmond Morris's *The Biology of Art* (1962) which describes his study of picture-making in apes and its relationship to human art. In 1953, Morris became acquainted with Schiller's (1951) work with chimpanzee drawings and, as a consequence, was determined to continue this work with apes. He eventually was able to study nearly four hundred drawings and paintings by Congo, a chimpanzee at London Zoo. As a result, Morris recorded the picture-making behavior of Congo and other primates for many years, comparing similarities to human art making (also see Morris, 1958a; 1958b; 1961).

At the time of Morris's study, Congo's art expressions became the subject of great public interest in England and a television program featured the chimp's paintings, including an actual demonstration of his skills. Eventually, a two-chimp show of paintings by both Congo and a second painting chimp, Betsy, was held at the Institute of Contemporary Arts in London in 1957. Morris (1962) recounts the skepticism that many expressed upon seeing an exhibition of chimpanzee paintings held at a London art gallery:

> The average Englishman loves animals and hates abstract art. It is not surprising therefore that an animal which paints abstract pictures produces a rather irritating mental conflict. Should one praise the animal or curse the pictures?

> The press, along with many of the visitors to the exhibition, took one extremist view or the other. The pictures were either viciously attacked as an insult to human dignity, or wildly praised as heralding a vital new art form. A few discerning eyes saw them for what they were—a series of unique documents, records of a new and biological approach to art. (p. 13)

According to Morris, human art has been examined in the past from one of several reference points—prehistory and prehistoric art, folk art of so-called primitive peoples, the art expressions of the mentally insane, and children's developmental process in art. In no one of these categories are the biological principles of picture-making adequately established. For this reason, Morris's study of the work of Congo and other great apes focused on the development of biological principles of art expression. As a result of his work with primates, Morris determined six biological principles which he believed could be universally applied to both humans and apes or, as he put it, to "everyone from Leonardo to Congo" (1962, p. 158).

In addition to the idea that art making may have biological roots, there is another question related to this theme that may intrigue art therapists—is art making a necessity to life itself? To respond to this question, by special arrangement with the National Art Education Association, we are able to bring you the 1991 keynote address, "Art for Life's Sake," by noted scholar Ellen Dissanayake. Dissanayake's ideas are both intriguing and challenging because the biological and anthropological aspects of art expression and art making are central to her conceptual base, as well as psychological and art historical underpinnings. She attempts to look at art in the broadest possible perspective—one she refers to as "palaeoanthropsychobiological" or "species-centered." The guiding premise of this view is that art is "a fundamental human species characteristic" and is "a normal and necessary behavior."

Dissanayake's thoughts on the role of art making in human life will likely have great appeal to art therapists who believe that art making is an essential and accessible experience to all individuals. But other issues raised in this edition of *Art Therapy* may challenge you to reconsider some fundamental principles of our field or, at the very least, view picture-making from a different perspective. Before you dismiss the fact that chimpanzees, apes, monkeys, elephants, and dolphins have only a laughable relationship to the picture-making activities of humankind, give some serious thought to how strong our biological connections are to these species and how compelling our own similarities are to our animal relatives. To fully understand and accept these relationships may, as Sagan and Druyan point out, be important to our understanding of our own species, and perhaps the ultimate survival of our human selves.

References

Beach, K., Fouts, R. & Fouts, D. (1984). Representational art in chimpanzees. *Friends of the Washoe*, *3*(4), 2-4.

Dissanayake, E. (1989). *What is art for?* Seattle: University of Washington Press.

Dissanayake, E. (1992). *Homo aestheticus*. New York: Basic Books.

Morris, D. (1958a). *The story of Congo*. London: Batsford.

Morris, D. (1958b). Pictures by chimpanzees. *New Scientist*, *4*, 609-11.

Morris, D. (1961). Primate aesthetics. *Natural History*, *70*, 22-29.

Morris, D. (1962). *The biology of art*. London: Methuen.

Sagan, C. & Druyan, A. (1992). *Shadows of our forgotten ancestors: A search for who we are*. New York: Random House.

Schiller, P. (1951). Figural preferences in the drawings of a chimpanzee. *Journal of Comparative and Physiological Psychology*, *44*, 101-111.

AATA CALENDAR OF EVENTS

MARCH 19-20, 1993
Regional Symposium: MPD
Minneapolis, MN

NOVEMBER 18-21, 1993
Annual Conference
Atlanta Hilton

NOVEMBER 16-20, 1994
Annual Conference
Palmer House - Chicago

NOVEMBER 9-12, 1995
Annual Conference
Town & Country - San Diego

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 168 © AATA, Inc. 1992

Commentaries

Response to Book Review

As a founding member of the Association of Teachers of Mandala Assessment, Inc., I read with great interest Elizabeth Ratcliffe's review (Vol. 9, No. 2) of Suzanne Fincher's book, *Creating Mandalas for Insight, Healing, and Self-expression*. This book is indeed a valuable contribution to the field of art therapy as a reference book on the mandala. Fincher credits many sources, her primary one being art therapist Joan Kellogg, with whom she studied in the 1970's and whose insights, she acknowledges, opened up the possibilities of the mandala for her. Fincher's material, particularly on creating and interpreting the mandala and on colors and forms, is an elaboration of the information taught by Joan Kellogg in her training courses in mandala assessment. She also expands upon Kellogg's work by investigating additional forms and the significance of numbers in the mandala. Although Fincher presents this material in a clear, organized format and has contributed insights from other authors (in addition to the ones Kellogg cites in her work), there are serious oversights.

A classic, it may be, as Ms. Ratcliffe suggests; however, it is a flawed classic. In the beginning of the chapter, "The Great Round of Mandala Forms," Fincher gives Kellogg full credit for developing the system for identifying archetypal stages in a cyclical pattern, which has been the essence of Kellogg's life work. Fincher goes on to explain in detail twelve of the archetypal stages of the great round, but is guilty of one major omission: she does not include stage 0, an important stage which Kellogg included in the second edition (1984) of her book, *Mandala: Path of Beauty*. Fincher's bibliography refers only to the first version of Kellogg's work (1978). Stage 0 is an integral part of Kellogg's theory. Prior to her discovery of it, her description of stage 1 incorporated many aspects of stage 0, thus making stage 1 complex and difficult to understand. Fincher presents this outdated material from fourteen years ago.

If Fincher takes it upon herself to write about someone else's work, she has a responsibility to do her homework and reference her source's most recent material. She has done a disservice not only to Joan Kellogg, but to all students of the mandala who may not be aware of Kellogg's fully evolved theory. I still recommend Fincher's book as useful, especially her thorough review of various color theories. However, I do want to emphasize that if people wish to understand Kellogg's theory they should go directly to the source (MARI® Course in Mandala Assessment or Kellogg's book) rather than rely on Fincher's poorly researched rendition thereof.

Carol T. Cox, M.A., A.T.R.

24th ANNUAL CONFERENCE
AMERICAN ART THERAPY ASSOCIATION

COMMON GROUND:
The Arts, Therapy and Spirituality

November 18-21, 1993
Atlanta, Georgia

Keynote Speaker: James Hillman, Ph.D.
Call for Papers Deadline: February 1, 1993

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 169-175 © AATA, Inc. 1992

Art for Life's Sake

Ellen Dissanayake, New York City, NY

I don't know which is greater—the pleasure, honor, or privilege of being invited to address the members of the NAEA. I hope that the title of my lecture, "Art for Life's Sake,"—like the question of the title of my book, *What Is Art For?*—will stimulate you to think about art in a new way, as well as to appreciate why thinking about art in a new way is important.

I intend to give a brief history of Western art—not the usual "art history" of the *practice* of art but rather a history of the Westen *idea* of art—and then present my own view of art for life's sake. This arises from an unfamiliar perspective, one that is so different, in fact, that it doesn't have a name. In order to call it something, I have occasionally called it "palaeoanthropsychobiological"—an adjective that is quite literally stunning—to suggest several things. First, that the idea of art encompasses all of human history (i.e, as far back as the Palaeolithic or even earlier); second, that it include all human societies (i.e., is anthropological or cross-cultural); and third, that it accounts for the fact that art is a psychological or emotional need and has psychological or emotional effects. Most people would probably agree that their personal "idea of art" includes all these things, but I will show you that as presently practiced and taught in the West, art is a conceptual ragbag or casserole full of the most incompatible and confusing notions.

My palaeoanthropsychobiological view is that in order to include human history, human cultures, and human psychology, art must be viewed as an inherent universal (or biological) trait of the human species, as normal and natural as language, sex, sociability, aggression, or any of the other characteristics of human nature.

Before beginning, I would like to tell you how I came to develop this view, why it came to seem mandatory. While a graduate student in art history, writing my thesis on 19th-century French symbolist art, I had the unexpected opportunity to travel to Sri Lanka, the small island nation off the southern tip of India, formerly known as Ceylon. Eventually I returned there to live and married a Sri Lankan man. For 15 years I lived abroad, and during that time also spent a year in Nigeria, two and a half years in Papua, New Guinea, and three months in India. Living in non-Western countries permits, indeed demands that you look afresh at all the cultural truths and beliefs that you have grown up with and taken for granted. Among these of course was my idea of art.

Living in another culture also makes you realize that different as other people's beliefs may be from one's own, we are all still recognizably *people*—and so you wonder what is *universal*. My way of approaching these questions came to be biological or evolutionary—looking at all humans as members of one species and then thinking of art as a kind of behavior that developed as they evolved, to help them survive. It took many years of reading and thinking and writing to address the different aspects of this approach. I am still finding new paths to follow and new things to incorporate. In 1988 I published a book, *What Is Art For?*, that set out my general ideas, and a second book which is called *Homo Aestheticus: Where Art Comes From and Why* (1992). I think these ideas have revolutionary implications for how we as a society think of art. Indeed, one of the major insights to come from my studies was just how peculiar our Western concept of art is—unprecedented in human history, and I think it is extremely important to understand this in order to see why a new view of art is required.

Editor's note: Ellen Dissanayake earned her B.A. in Humanities from Washington State University and has her M.A. in Art History from the University of Maryland. In 1977, she received a grant from the Guggenheim Foundation to pursue research at Oxford University on the evolutionary significance of art. She has recently received a Fullbright Lecturing/Research Fellowship to continue her studies in Sri Lanka.

Dissanayake's work has been significantly influenced by the years she has spent in such places as Sri Lanka, India, New Guinea, and Nigeria. Currently, she lives in New York City where she is a lecturer for the New School of Social Research. She has published two books, *What is Art For?* and *Homo aestheticus* (which is reviewed in this issue of *Art Therapy*).

Thus I will first outline how our peculiar or anomalous Western concept or idea of art has developed over the past two centuries, before setting out my palaeoanthropsychobiological view of the human species, a species that deserves to be called *aestheticus* or artistic as much as it deserves to be called *sapiens* or wise.

Development of the Western Concept of (Fine) Art

It is true that we can read about the word and concept "art" in early treatises from Greek and medieval times. But it must be realized that these are translations and that the authors may not have meant the same thing by the word "art" as we do. In fact, Plato did not discuss "art," but rather beauty, poetry, and imagemaking; Aristotle dealt with poetry and tragedy. They used a word, *techné*, which we have translated as "art," but this word was applied equally to fishing, chariotdriving, and other mundane activities. It meant "having a correct understanding of the principles involved," rather as we understand the "art" of salmon cookery or of motorcycle maintenance.

In medieval times, the arts were in the service of religion, as they have always been, but were not regarded "aesthetically," if this means separately from their revelation of the Divine. Renaissance artists gradually replaced God-centered with man-centered concerns, but their works continued to portray a recognizable world, whether actual or ideal, and the "art" was in accurately representing that subject matter, using craftsmanlike standards of beauty, harmony, and excellence.

The eighteenth century is recognized today as having been a focal point in which a number of social and intellectual trends came together, intertwined and influenced one another, and eventually became in combination and intensity what is now called "modernity." Among these trends I will mention—and I hope you will forgive the rather breathtaking oversimplification—five important and unprecedented changes. (1) A gradual secularization of society, whose aim became life, liberty and the pursuit of happiness for individuals rather than acquiescence to a humanly unknowable Divine plan. (2) The rise of science which not only fostered questioning and dissent but made possible the development of technology and industrialization. (3) The social or interpersonal changes that resulted as the emotional and affective ties of feudal and kin loyalty were replaced by instrumental relationships based on the exchange of money. (4) an emphasis on reason as the best means for understanding and controlling the matters of life, and (5) the great political revolutions in America and France with their subsequent division of society into workers and bourgeoisie and gradual weakening of the nobility and clergy.

What we now call "the Romantic Rebellion" was a reaction to the goods and evils inherent in these great changes. For example, while individualism became possible and people could be freed from tradition, custom and authority, they also became more alienated from their work and from other people. New possibilities for thought and experience were accompanied by an unprecedented loss of certainty and security about one's place in the world. New comforts and conveniences arose, but people also became more regimented in their work and gradually removed from the world of nature. While reason and critical analysis encouraged objectivity and fairness, earlier visionary and mythopoetic modes of thought were devalued, being nonlogical, although their expression in communally shared traditional practices had given great emotional satisfaction.

To artists, as to everyone, the new order brought both liberation and insecurity. As the nineteenth century advanced, their primary patrons were no longer the Church and the court. Instead it became necessary to please the public—multiform, faceless, swayed as today by hype and novelty—in what was to become an art market. Aspiring artists no longer were apprenticed in a guild system, but learned what standards were acceptable from newly-established national academies and collections in national museums. Private dealers and galleries appeared to intercede between artists and the public. Professional critics who wrote for newspapers and newly-established magazines of art contributed to the new milieu as did schools of art and scholars of art who established their field as a sequential and developing history of particular works of art that every well-educated person should know. The words or concepts of "art," "genius," "creativity" and "imagination" took on their modern meanings.

Modernism: Art as Ideology

Included in the many new approaches and subjects that 18th century thinkers turned their attention to was a subject that came to be called "aesthetics"—a concern with elucidating principles such as taste and beauty that govern all the arts and indeed make them not simply paintings or statues but examples of (fine) "art."

As the subject developed over the next century, a startling and influential idea took hold that, like the concept of "art," was unprecedented. This was that there is a special frame of mind for appreciating works of art—a "disinterested" attitude that is separate from one's own personal interest in the object, its utility, or its social or religious ramifications. The work of art became a world-in-itself, made solely or primarily as an occasion for this kind of detached aesthetic experience, which was considered to be one of the highest forms of mentality.

"Disinterest" implied that viewers could appreciate any art, even the artwork of eras or cultures far removed from their own, whether or not they understood the meaning the works had for the people who made and used them. In this sense, art was "universal." Another corollary was that works of art in themselves, apart from their subject matter, gave a special kind of knowledge—a knowledge which, with the waning of religious belief, often took on the spiritual authority once restricted to the Church. Still another was the idea of art for art's sake (or even life for art's sake), suggesting that art had no purpose but to "be" and to provide opportunities for enjoying an aesthetic experience that was its own reward, and that one could have no higher calling than to open oneself to these heightened moments.

As paintings became less and less like mirrors held up to nature, so that viewers could no longer decipher or naively admire them, critics as mediators increasingly had to explain to the public what made an artwork good or bad and even what a work "meant." In England, in the early decades of the twentieth century, Clive Bell and Roger Fry were extremely influential as they invoked "formalist" criteria for appreciating the puzzling new work of Post-Impressionists such as Cézanne, or the Cubists—work that could not be understood with the serviceable old standards (that anyone could recognize) of beauty of conception, nobility of subject matter, representational accuracy, or communication of valued truths. Art had become if not a religion, an ideology whose principles were articulated by and for the few who had leisure and education enough to acquire them.

In the mid-twentieth century, more elaborate and abstract formalist standards were developed in America by critics like Clement Greenberg and Harold Rosenberg in order to justify abstract expressionism, a school of painting that affronted sensibilities and challenged what had previously been acceptable as art. "Flatness," "purity," and "picture plane" became the verbal tokens of the transcendent meanings viewers were told they could find in the skeins and blobs and washes of paint. Because these values were not easily apparent to the untutored observer, appreciating art became more than ever an elite activity, requiring an apprenticeship and dedication not unlike that of the artist. Never in question was the "high" art assumption that works of art—no matter how strange they looked or unskilled they seemed to be—were conduits of transcendent meaning, of truths from the unconscious, expressions or revelations of universal human concerns that the artist was uniquely endowed to apprehend and transmit.

As the "isms" proliferated and art became more esoteric and outrageous, the role of the critic became not only helpful but integral to the reception of works of art. Looking back, it seems inevitable that an "institutional" theory of art arose to explain what art is. As formulated by philosophers of art like George Dickie and Arthur Danto (who were describing what was the case, not advocating or defending it), an artworld (one word) composed of critics, dealers, gallery owners, museum directors, curators, art magazine editors, and so forth, was the source of conferring the status "work of art" onto objects. What artists made were "candidates for appreciation," and if the artworld bought and sold them, wrote about them, displayed them, they were thereby validated as "art"—not before.

Implicit in this account is a recognition that what is said (or written) about a work is not only necessary to its being art, but is indeed perhaps more important than the work itself. There is no appreciation of art without interpretation. We can tell that a pile of stones or stack of gray felt in a museum is different from a pile of stones on the pavement near a construction site or a stack of felt in a carpet store because those in the museum are viewed through a lens of knowledge of their place in a tradition. "To see something as art at all," proclaimed Danto, "demands nothing less than this, an atmosphere of artistic theory, a knowledge of the history of art." In this view, there are no naive artists or naive art. Today's artists can both explain the theories behind the works that are to be seen in museums and galleries and place their own works in these traditions.

Postmodernism: Art as Interpretation

The assumption that interpretation is indispensable to appreciating and even identifying artworks has opened a Pandora's box that is now called "postmodernism," a point of view that calls into question two centuries of assumptions about the elite and special nature of art. While the term "postmodern" is used (and abused) as indiscriminately as "modern" was before, postmodernists are united in repudiating the "high" art (or modernist) view I have just described. They stress that theirs is not just one more "ism" or movement but rather a declaration of the end of all isms and movements. Theirs is a radical change of consciousness, they claim, that challenges the entire "modernist" ideology.

Rather than assuming that art reflects a unique and privileged kind of knowledge, postmodernists point out that any "truth" or "reality" is only a point of view—a "representation" that comes to us mediated and conditioned by our language, our social institutions, the assumptions that characterize individuals as members of a nation, a race, a gender, a class, a profession, a religious body, a particular historical period. Artists, just like everybody else, do not see the work in any singularly privileged or objectively truthful way, but rather—like everybody—interpret it according to their individual and cultural sensibilities. What has been enshrined as "high" art is then to the postmodernist view a canon of works that represent the worldview of elite, Western European, white males. Hence "taste" and "beauty" and "art for art's sake" are constructions that express class interests. To claim that one can appreciate works from alien cultures is an imperialistic act of appropriation—molding them to one's own standards while blatantly dismissing or ignoring the standards of their makers and users. Art is not universal, but conceptually constructed by individuals whose perceptions are necessarily limited and parochial.

Finding that modernist aesthetics masked chauvinistic, authoritarian, and repressive attitudes towards uneducated, non-Establishment and non-Western people, and towards women, postmodernist artists have thus set out deliberately to subvert or "problematize" the old "high" art standards, often parodying or otherwise flouting them. For example, enduring "timeless" works of art are replaced by intermittent or impermanent works that have to be activated by the spectator or cease to exist when the performance is over. Or, challenging the aura of exclusiveness and religiosity of the museum, art is created on the street, in remote deserts, or found in humble or trivial objects and materials. Postmodernist artists deny the integrity of individual arts by using hybrid mediums—sculptures made of painted canvas, or paintings made of words and numbers. The uniqueness, authority, ideality and originality of high art is challenged by borrowing (copying, photographing or otherwise appropriating) images from past art to be used in new works, or by making many repetitions or reproductions of an image or construction. Pastiche and collage are popular postmodern media in which works are composed of fragments that have no apparent relation to one another except for their juxtaposition.

Although the art praised by postmodern critics is puzzling, if not shocking and offensive, the social problems and cultural predicaments it reflects cannot be denied. The works and ideas that are called postmodernist can be lamented or ignored, but like modernism's works and ideas, they certainly reflect the society that spawned them. After the political calamities and barbarisms of the twentieth century, the Enlightenment and Victorian faith in human intelligence and goodness or in the progress and perfectibility of human existence seem as antiquated and untenable as medieval theology. Socialism and, more recently, other underclass movements have challenged pretensions to achieving objective, universal justice, law, and morality—as have the recurrent scandals at the very heart of government. After Freud it is hard to believe that objective rationality alone could drive human affairs, a hope also laid to rest more mundanely by the success of glossy advertisements that effectively persuade us to overspend on ever new and tantalizing non-necessities. Relativity theory in physics at least suggests the theme of relativity elsewhere. The polluting fungoid spread of the automobile and its concrete accoutrements of freeway and parking lot over city and landscape, not to mention other even worse environmental ills, certainly calls into question the wisdom of human technological domination over nature. The proliferation of images in advertisement and on television makes all events—from an exciting new dentifrice or room freshener to a fire in the Bronx, a missile attack on Tel Aviv, Johnny Carson's monologue, a famine in Africa, the Super Bowl, or an earthquake in Peru—appear equally real (or unreal), occurring as they do in succession, compressed in time and space and significance. The postmodernists' exposure of the rigid, exclusive and self-satisfied attitudes that often lay behind the rhetoric of modernist ideology is, in large measure, welcome, as is their preparing the way for the liberation and democratization of art.

But I find postmodernist aesthetics troubled and inadequate when it proclaims that there are a multiplicity of individual realities that are infinitely interpretable and equally worthy of aesthetic presentation and regard. The question arises: if everything is equally valuable, is anything worth doing? Is sprawling promiscuity really an improvement on narrow elitism? Is absolute relativism a more credible position than absolute authority? Postmodernism abandons the crumbling edifice of modernist authority for an equally uninhabitable and esoteric antistructure of relativism, cynicism, and nihilism that I claim does not have to be the inevitable outcome of the matter.

Art for Life's Sake

One way to begin to understand and resolve the perplexing contradictions, inadequacies, and confusions of both modernist and postmodernist aesthetics is, I believe, by considering art in the broadest possible perspective—the palaeoanthropsychobiological view that I mentioned—as a universal need and propensity of the human species.

Let me now jettison that tongue-twisting phrase and introduce a synonym, "species-centered." As medieval society and art was God-centered, that of the Renaissance man-centered, and ours perhaps best described as profit- or commodity-centered, I hope that a more human future society and art will be species-centered—that is, will regard all humans as alike in having the same fundamental needs.

For my purposes here with you as art educators, I would like to point out that one of the most striking features of human societies throughout history and across the globe is a prodigious involvement with the arts. Even nomadic people without permanent dwellings and with few material possessions usually have elaborate poetic language or dance styles; more settled people generally decorate their dwellings, objects of daily or ritual use, or themselves. There is no known society that does not practice at least one of what in the West we call "the arts," and in many groups art-making is among their most important endeavors.

I find it significant that the word "art" acquired its modern meaning and its existence as a concept as the arts themselves became practiced and appreciated by fewer and fewer members of society. In small scale, unspecialized, premodern societies, individuals can generally make and do everything that is needed for their livelihood. There, while there is no abstract concept of "art," everyone may be an artist—decorating their bodies and possessions, dancing, singing, versifying, performing—even when some persons are acknowledged as being more talented or skillful than others. In these technologically simpler societies, the arts are invariably and inseparably part of ritual ceremonies that articulate, express, and reinforce a group's deepest beliefs and concerns. As the vehicle for group meaning and a galvanizer of group oneheartedness, art-conjoined-with-ritual is essential to group survival—quite literally art for life's sake.

In a highly-specialized society like ours, the arts are also specialties and may exist for their own sake apart from ritual or any other purpose. This separation, peculiar only to modernized or "advanced" societies, makes art a problem. Art's heritage of specialization and self-proclaimed irrelevance permits it to be dismissed by school and governmental budgetmakers as a "frill," while its aura of sanctity and privilege remains as a reproach to those whose upbringing has not included exposure to "fine" arts. Dismissal, ignorance, irrelevance, and exclusivity of art are all artifacts of our own peculiar cultural predicament and not inherent in arts anywhere else.

The species-centered view of art combines modernism's proclamation that art is of supreme value and a source for heightened personal experience with postmodernism's insistence that it belongs to everyone and is potentially all around us. It does this by thinking of artmaking and experiencing as a human *behavior*. Let me explain.

In the evolution of the human species, not only did we gradually acquire certain characteristic physical and physiological adaptations—such as upright posture, an opposable thumb, relative hairlessness, a nine-month gestation period—but behavioral adaptations as well. Even though we no longer live in a hunter-gatherer milieu, these behavioral predispositions still characterize us as a species in their high degree of development and interrelatedness: tendencies to be sociable, to acquire and use language, to make and use tools, to impose conceptual order, to attempt to control or regularize the forces of nature, to join with our close associates in mutual endeavor. Among these tendencies, I claim, is also the behavior or propensity to "make special," particularly things that one cares deeply about or activities whose outcome has strong personal significance.

Something that is "special" is different from the mundane, the everyday, the ordinary. It is extraordinary. Now all animals can tell the difference between the ordinary or routine and the extraordinary or unusual. They would not survive if they were oblivious to the snapping twig or sudden shadow that means a predator may be nearby. But when joined with the other abilities that evolving humans had—intelligence, resourcefulness, emotional and mental complexity, the ability to plan ahead—the "special" could take on a significance that was more than simply alertness to possible danger.

We have to speculate about how early this propensity to recognize specialness arose, but it was at least 250,000 years ago—more than ten times earlier than the cave paintings that are usually called the "beginning of art"—in *Homo erectus* and early *Homo sapiens*.

The crucial factor for claiming the beginning of a behavior of art, I believe, would have been the ability not just to recognize that something is special, but deliberately to set out to make something special. This also seems to have occurred at least 250,000 years ago. In a number of sites from that long ago, and thereafter, pieces of red coloring material have been found, far from the areas in which they naturally occur. It is thought that these were brought to be used for coloring and marking such things as bodies and utensils (which would have now of course perished without trace), as people continue to do today—to make them special. There is also evidence of cranial deformation as early as 70,000 B.C. and toothfiling and tooth decoration were also practiced. These may not seem like "art" but they do show the wish to use form and color to "make special."

I suggest that to our ancestors it was essential not only to make good tools—spears and arrows for the hunt—but to make sure they worked by making them and the activities that were concerned with them special. In hunting societies that we know of today, behavior made special (or "controlled" behavior) is as much a part of preparation for the hunt as readying spears or arrows. Before the hunt, hunters may fast, pray, bathe, obey food or sex taboos, participate in special rituals, wear special adornment.

This control of their behavior and emotions can be interpreted as a way of vicariously demonstrating the control they desire in order to successfully achieve their goal. And although "behavior made special" need not be aesthetic or artistic, when one exerts control, takes pains, and uses care and contrivance to do one's best, the result is generally what is called artistic or aesthetic.

Along with control of one's behavior—making it special by shaping or elaborating it—would go making important tools and implements special, showing one's investment in their working properly, one's regard for their importance. Weapons and tools would be prime candidates for being made special.

It is in ritual ceremonies where one sees the arts most profusely in traditional societies and where I believe the nascent tendency to make special would have had the opportunity to diversify and flourish. Ritual ceremonies are group efforts to control the important things that people care deeply about—not only acquiring food but averting evil, curing illness, securing safety and prosperity, and resolving conflict. While rituals are unique in form and content in each society, they occur in response to strikingly similar circumstances—times of uncertainty, often of transition between one material or social state and another (e.g., plenty and want; disease and health; childhood and sexual maturity; unmarried and married; life and death).

I believe it is no accident that the arts are found prodigiously in ceremonial rituals and the paraphernalia associated with these ceremonies. In fact, I claim that the shaping and elaborating of behavior and of the material world that we today call the arts were *necessary* to the performance of ritual ceremonies. First, they made the ceremonies pleasurable so that people wanted to do them and would continue to do them, and they also made them compelling and memorable so that they "worked." The group participation in a common endeavor and the communally-shared emotion would strengthen the general cooperation and feeling of affiliation that was essential for small bands of people to survive in a violent, unpredictable world.

One can then say that to begin with art was not for its own sake at all, but for the sake of the performance of ritual ceremonies. What was important to the survival of early human society is not that decorating bodies or dancing in imitation of an ostrich would bring rain or create more game—although the group members certainly would have thought that was what they were doing. Rather it was the emotional bonding of the participants that gave the ceremonies survival value. The making special, the touching of or entering an extraordinary realm that making special encouraged and allowed, the unifying self-transcendent emotions that were called forth, demonstrated the likemindedness, the oneheartedness of the group so they would work together in confidence and unity. As human life evolved and became more complex, ceremonies and arts would become more complex as well. They would be used to assist the transmission of group tradition and information, as John Pfeiffer has so brilliantly shown in his book, *The Creative Explosion*, which deals with the emergence of Stone Age art.

For these reasons—unification, passing on cultural knowledge—individuals in human societies where ceremonies were performed would survive better and leave more off-spring than those who did not. And being crucial and intrinsic to ritual ceremonies, the arts were crucial and intrinsic to human survival—art for life's sake.

To think of art as a behavior of making special is truly a change of paradigm. Usually art refers to objects—paintings, pictures, dances, musical compositions, *works* of art that are the *result* of artistic behavior. Or the appellation "art" is given to objects that possess some quality—of beauty, harmony, excellence—and denied to those that do not. Yet if art is regarded as a behavior, making things special, emphasis shifts from the object or quality or commodity to the activity (the making or doing and appreciating), as we see in premodern societies where the object is essentially an occasion for or an accoutrement to ceremonial participation.

"Making special" is a fundamental human proclivity or need. We can see it in such simple things as when we cook special meals and wear special garb for important occasions, and find special ways of saying important things. Ritual ceremonies are occasions when everyday life is shaped and embellished to become more than ordinary. What artists do, in their specialized and often driven way, is an exaggeration of what ordinary people also do, naturally and with enjoyment—transform the ordinary into the extra-ordinary. Looked at in this way, art, as making the things one cares about special, shaping and elaborating the ordinary to make it more than ordinary, is fundamental to everyone and, as in traditional societies, deserves to be acknowledged as normal—encouraged and developed.

To suggest that art is more common and widespread than has usually been supposed does not have to mean that all standards fly out the window and anything goes. (Indeed, even with the idea that art is uncommon and rare, that has already happened.) Nor does it imply that it is trivial and careless. To make something special, after all, generally implies taking care and doing one's best so as to produce a result that is—to a greater or lesser extent—accessible, striking, resonant, and satisfying to those who take the time to appreciate it. This is what should be meant when we say that via art, experience is heightened, elevated, made more memorable and significant. Thus everything is not equally meaningful or valid. The reasons that we find a work accessible, striking, resonant, and satisfying are biologically endowed as well as culturally acquired. They are not merely a matter of playful and shifting interpretations.

Although "*Art*" as a concept seems to have been born of and sustained by a commercial society, is therefore only roughly two centuries old, and hence is relative, even discardable, it should not be forgotten that *the arts* have always been with us. So have ideas of beauty, sublimity, and transcendence, along with the verities of the human condition: love, death, memory, suffering, loss, desire, reprieve, and hope. These have been the subject matter of and occasion for the arts throughout human history, and it is a grievous lapse when contemporary thought assumes that because art is contingent and dependent on "a particular social context" that abiding human concerns and the arts that have immemorially been their accompaniment and embodiment are themselves only contingent and dependent.

The species-centered view of art I have developed here claims that there is valid and intrinsic association between what humans have always found to be important, and certain ways—called the arts—that they have found to manifest, reinforce, and grasp this importance. That the arts in postmodern society do not do this, at least to the extent that they do in premodern societies, is not because of some deficiency or insubstantiality of an abstract concept but because their makers inhabit a world—unprecedented in human history—in which these abiding concerns are more often than not artificially disguised, denied, trivialized, or banished.

Adopting the species-centered view of art allows us personally to better appreciate the continuity of ourselves and our artmaking with nature. Art is not confined to a small coterie of geniuses, visionaries, cranks, and charlatans—indistinguishable from one another—but is instead a fundamental human species characeristic that demands and deserves to be promoted and nourished. Art-like activities exist in all societies and all walks of life.

If you are to carry one idea away from my talk I hope it will be this: art is a normal and necessary behavior of human beings that like talking, exercising, playing, working, socializing, learning, loving and nurturing should be encouraged and developed in everyone.

Editor's note: *Art Therapy* would like to thank the author and the National Art Education Association for permission to reprint this article. The article originally appeared in *What is Art For? Keynote Addresses of the 1991 NAEA Convention*, Karen Lee Carroll (Ed.), pp. 15-26.

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 176-177 © AATA, Inc. 1992

Commentary

Linda Gantt, Ph.D., A.T.R.

Ellen Dissanayake's meticulous scholarship and careful thinking [I refer here to her two books as well (Dissanayake, 1988; 1992)] can teach us several important lessons. Perhaps the first and most sobering one is that art therapists must be humble about the claims we make as to what art and, by extension, art therapy, is and what it does for people unless and until we can claim command of such a body of literature and experience as she has.

Second, we should recognize that her "species-centered" emphasis provides a keystone to what ultimately could be an over-arching theory of art making far more encompassing than psychodynamic theory. Such a synthesis could tie together the work of Langer, Cassirer, Arieti, Freud, Jung, Dewey, and Kramer with Dissanayake's "palaeoanthropsychobiological" approach to provide a diachronic and synchronic perspective on the importance of the arts as the embodiment of human affective experience. My hope is that this admixture would provide solid reasons for the philosophical promotion and financial support of the arts with special populations as well as in the educational system.

Third, Dissanayake's mastery of anthropological and historical ideas should serve to wrest us from the grasp (some might justifiably say imprisonment) of Western concepts and biases and give us an impetus for a meta-analysis of our field. Her historical survey of the concept of art in Western culture should remind us that the intellectual and social climate in which psychotherapy and therefore art therapy developed was quite different than that of other centuries. To what extent are our ideas about acceptable goals and techniques influenced by an undue stress on individual expression and fulfillment at the expense of group values? Our susceptibility to a culturally-induced blindness has implications not only for theory but for practice, especially for those who work with newly arrived immigrants. Only recently have there been art therapy articles dealing with the influence of cultural mores on clinical practice (Geraghty, 1985; Lofgren, 1981; Lomoe-Smith, 1982; Moreno & Wadeson, 1986; Steinhardt, 1986); rarer still are those with specific comments on what other cultures teach about art. While describing her 1987 trip to China, Cathy Malchiodi stated, "Unlike our culture, which encourages children to be spontaneous in their art, particularly during the preschool and early elementary years, little emphasis is placed on free, creative thought or expression in China" (Malchiodi, 1988, p. 55). This implies that the very foundation of art therapy may be fundamentally incompatible with contemporary Chinese social thought.

When we can see our field from the perspective of other cultures and other ages we will be able to question and evaluate those principles which presumably guide our clinical practice. For example, are we biased in favor of a particular type of art so that we consciously or unconsciously regard any other type in a perjorative way? Are we so unfettered by the lack of rules in contemporary art that we blithely accept the most unformed and unfinished work as satisfactory?

Dissanayake's reinforcement of the importance of standards in art is echoed by at least three other notable writers of interest to art therapists—Sarason (1990), Arnheim (1992) and Kramer (1961; 1966), each of whom recognize the psychological importance of art making to all people, not just the especially talented. Their voices, added to hers, affirm the idea that art is for life's sake, for the fulfillment of fundamental human needs, and for human survival. According to Sarason, ". . . what needs to be challenged are axioms which, if they continue to remain unexamined, will have a negative impact on our society's future. At stake is not art in any conventional sense but the ways in which people can experience satisfaction over their lifetimes from the ordered expression of their imagery, thoughts, and feelings. The satisfaction that comes from making something, and being made and formed by it, is missing in the lives of most people" (Sarason, 1990, p. ix).

Kramer maintains that in contemporary art there is "an indiscriminate acceptance of any and every product that avoids the very concept of standards. Awareness of unwelcome feelings and facts is prevented by avoidance of intelligible statements and preference for amorphous, incoherent expression" (Kramer, 1961, p. 13). Arnheim agrees, "As its least attractive symptoms we notice an unbridled extravagance, a vulgarity of taste, and a triviality of thought. There is too much readiness to make do with too little, to be satisfied short of the ultimate effort, without the engagement of the full resources that used to be the *conditio sine qua non* of respectable art. The insufficiency shows up in the poor level of much of the work produced and the low standard of what is critically accepted in the mass media" (Arnheim, 1992, p. viii). But Arnheim does offer some solutions which are in accord with Dissanayake's perspective: "What needs to be done . . . is to revive and explore the principles on which all productive functioning of the arts is based. If one believes that art is indispensable as a psychological and, indeed, as a biological condition of human existence, it must be assumed to grow from the very roots of our being" (Arnheim, 1992, p. ix).

In her closing paragraph Dissanayake states that "art is a normal and necessary behavior of human beings that . . . should be encouraged and developed in everyone." By showing what has been important in the past to human survival and evolution she intimates what we must do to survive in the future. She gives us a coherent rationale for funding broadly based arts programs. Our ability to survive as a discipline will be directly related to our capacity to use theoretical material such as hers for analyzing our conceptual base and placing our work into historical and cultural context. In doing so we can argue forcefully and persuasively for the development and sustenance of programs which provide "art for life's sake"—art that as Arnheim (1992, p. 170) says serves as "a helper in times of trouble, as a means of understanding the conditions of human existence and of facing the frightening aspects of those conditions, [and] as the creation of a meaningful order offering a refuge from the unmanageable confusion of the outer reality."

References

Arnheim, R. (1992). *To the rescue of art: Twenty-six essays*. Berkeley, CA: University of California.

Dissanayake, E. (1988). *What is art for?* Seattle, WA: University of Washington.

Dissanayake, E. (1992). *Homo aestheticus: Where art comes from and why*. New York: Basic Books.

Geraghty, B. (1985). Case study: Art therapy with a native Alaskan girl on a pediatric ward. *American Journal of Art Therapy, 23*, 126-128.

Kramer, E. (1961). Art and emptiness: New problems in art education and art therapy. *Bulletin of Art Therapy, 1*, 7-16.

Kramer, E. (1966). Art and craft. *Bulletin of Art Therapy, 5*, 149-152.

Lofgren, D. (1981). Art therapy and cultural difference. *American Journal of Art Therapy, 21*, 25-30.

Lomoe-Smith, J. (1982). Cultural influences in art therapy with Hispanic patients. In L. Gantt & A. Evans (Eds.), *Focus on the future: The next ten years* (Proceedings of the 10th Annual Conference of the American Art Therapy Association). Falls Church, VA: American Art Therapy Association.

Malchiodi, C. (1988). Bringing art therapy to China. *American Journal of Art Therapy, 27*, 54-60.

Moreno, G., & Wadeson, H. (1986). Art therapy for acculturation problems of Hispanic clients. *Art Therapy, 3*, 122-130.

Sarason, S. (1990). *The challenge of art to psychology*. New Haven, CT: Yale University.

Steinhardt, L. (1986). Art therapy in Israel. *Art Therapy, 3*, 115-121.

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 178-192 © AATA, Inc. 1992

Facilitating Artistic Expression in Captive Mammals: Implications for Art Therapy and Art Empathicism

David R. Henley, M.A., A.T.R. Chicago, IL

Abstract

A two-year pilot study involving the pre-art and proto-artistic behavior of high functioning animals was conducted. Focusing upon apes, elephants and dolphins, art activities were facilitated by both the author or through trainers in various zoological institutions around the country. Through first-hand practice and field observation, the author attempted to gauge both therapeutic and aesthetic responses to art media, as well as study artistic development in these animals.

Introduction

After months of art therapy, Shanti, an Asian elephant, had progressed to a phase I dubbed "playful destruction": tearing, smearing and ingesting her art materials with a joy and exuberance that often occurs in two year olds or those with special needs. Her coordination remains as yet unformed, her attention short, her strength and quickness virtually unregulated; Shanti's art process is a challenge to contain. Though at times she uses sensory activities to self-soothe (gently purring while nudging and blowing gently upon the paper), such self-absorption is usually short-lived. Soon her arousal levels again escalate, particularly when she wants the attention of others. She then literally climbs inside the drawing box to stand atop her Arches Papier, insuring that the others in the group can not avoid noticing her antics. In response, her mother would most patiently trace around her baby's feet, until her craving for attention is momentarily satiated.

During one memorable session, Shanti startled us all by making her first semi-controlled mark. Without the usual mouthing of her materials, Shanti took up her charcoal and began thrashing it upon the paper, swinging the burnt wood in great figure eights, all the while trumpeting and wiggling her ears.

Witnessing such fascinating mother-child dynamics and developmental achievements is most satisfying for those working with the very young or special needs—observing it in Asian elephants has been extraordinary. Thus began my third season with populations as yet unserved by the field of art therapy: the elephant, ape, and dolphin. Aside from the pleasures I have derived from working with these remarkably intelligent and feeling creatures, I hoped to learn more about the psychodynamics of very early artistic behavior. Sliding backwards along the developmental continuum, toward preverbal and presymbolic beginnings, would perhaps illuminate the evolutionary pathways that lead to true art expression.

This paper attempts to summarize three years of data, in which I have only begun to appreciate and understand the complexities of this topic which have been narrowed down to two lines of inquiry:

The first concerns providing art therapy services, which recognizes the affective, intellectual, and expressive needs of intelligent animals who must cope with protracted periods of captivity. In human culture, institutionalization usually occurs when someone is so severely debilitated that functioning in the community is impossible. In zoological settings, wild animals capable of natural behavioral responses are housed in artificial environments which can only approximate, at best, a normalized existence. This can sometimes result in sensory deprivation leading to neurotic behavior: pacing, listlessness, stereotypy, aggressiveness, etc. Many modern zoos now attempt to minimize these reactions by offering more natural environments as well as introducing enrichment techniques as part of management programs (Schanberger, 1991a; Collins, 1991). It is in response to these initiatives that I offered my services to several zoos as a facilitator and consultant, to implement art programs that sought to engage and enrich these creatures' lives.

The second intention was to research to what extent these animals have the capacity to learn art making and express affect through the art process. I observed the animals in the act of mark making to detect whether motoric activity could give way to intended marks or perhaps eventually, become configurations that suggest concepts have been formed and are being represented. Part of this question involved whether or not aesthetic viability could be assigned to animal-made markings. This issue requires consideration of an aesthetic criteria which may be applied not only to the art of animals, but can be generalized to others who create at an infantile or regressed level of development.

To plot their development, the art process was notated (Figure 1) using an outline developed by Wilson (undated) and others at New York University. Analysis of process notations enabled me to plot the animals' affective responses, particularly their motivational levels. This was a major question that emerged during the study, one that echoed Dissanayake's "What is Art For?" (1989). Two elements of motivation were examined: that of primary gain, the internally driven artistic impulse, done for purely self-gratification and that of secondary or environmentally reinforced satisfaction. These elements were charted, allowing me to discern when the art activity was self-initiated, done without cues, without audience, done for food rewards and so forth. In this way I sought to measure the authenticity of the artistic impulse or whether, as some have charged, it is merely a clever form of behavioral training practiced in circuses and zoos.

Indeed, the field of animal behavior (ethology) has traditionally belonged to that of behavioral sciences, in which behavior is shaped and data are gathered empirically according to strict scientific protocols. Subjective, anecdotal or affective interpretations of behavior have long been considered taboo. Any reference to personality or mind invited a charge of anthropomorphizing, which asserts that human attributes are wrongly ascribed to animal behaviors. It was Goodall (1990) who through the sheer brilliance of her studies with wild chimpanzees, forced a change of attitude within the scientific establishment. Her findings confirmed the richness of primate personality and social dynamics. Now that ethology has progressed beyond purely statistical inquiry to include anecdotal methodologies, the field may now be more receptive to the contributions of other professions. It is only a matter of time that art therapists may too share their insights regarding psychological development, behavioral dynamics and creativity of animals.

Literature Review: Great Apes

The chief source of literature on art-making with apes can be found in Desmond Morris's *The Biology of Art* (1962). Morris cites chimpanzees who progressed in the scribbling stage of drawing, from random mark-making to one of increased control and "design making."

In 1952, Hediger (1968) introduced the art process to the gorilla, who had been avoided as subjects in these experiments given their contrary nature and perceived inferior intelligence. Out of 32 art-making apes, only two were gorillas. According to Morris, the graphic capability of the gorilla was certainly equal to that of chimpanzees, with their strongest efforts being equal to the ordered scribblings of a 30-month-old human child. It was noteworthy that the authors report high levels of motivation and attention to task. Morris's chimp, Congo, demonstrated single-minded intensity to an extent that any interruption often brought on tantrums. Goja's chimp, Jonny, would become stimulated to the point of sexual arousal (cited in Morris, 1962). Goja saw Jonny's art experience in these instances as an available form of displacement activity providing pleasurable and productive release of drive energy.

Several investigators, as well as trainers, point to the quality of their relationship with the animals as a determinant in maintaining motivation and investment (Roberts, 1991; Schanberger, 1991a, Collins, 1991; Sass, 1991). Morris comments: ". . . it was essential for the relationship between the experimenter and the ape to be established to the point where there was perfect rapport, a complete trust and understanding" (p. 22).

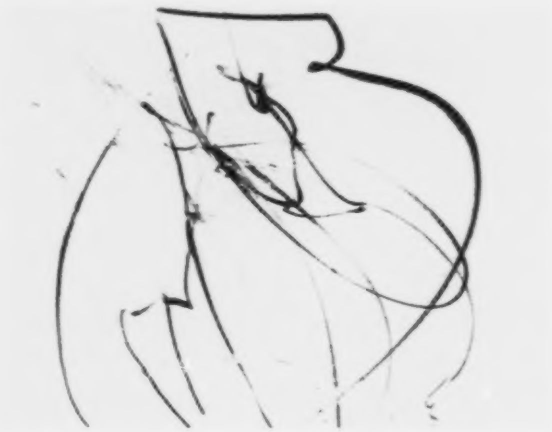
The artistic development of apes did not progress beyond controlled and elaborate scribbles, until experiments in sign language training began in the 1960's. The chimpanzee Moja demonstrated that once the rudiments of language (via sign language) were achieved, that indications of concept formation also developed. Gardner and Gardner (1969) found that the marks made by this lingual chimpanzee pos-

Process Notations: Modified for Large Mammals Adapted from Laurie Wilson, Ph.D., A.T.R., New York University

Client: Ivory: African Elephant, female, 9 yrs.

Day & Date: 5/10/91 **Time:** 11:00 am **Media:** Charcoal

Significant note. First visitation. Trainers allow us *into* Ivory's pen! Commotion with five elephants milling around us, very curious, much eye contact. Very relaxed atmosphere.



1. *Observations of General Behavior*

Ivory is very interested in me, touching my armpits, crotch and other "scented areas." Much eye contact with trunk exploration. Ivory is calm, seemingly relaxed but very alert and engaged.

2. *During Session*

A. Response to Media

Ivory responded to trainers cue to "paint." She manipulated pencil, tasted, smelled, then handed it to trainer. Handed back from trainer, began to make marks with robust movements. Does not overwork—stops on own accord. Work time elapsed 18 minutes.

B. Response to Facilitator (or educator, trainer or therapist)

Ivory constantly looked to both the trainer and myself for approval during the drawing activity. She occasionally required cues to stay on task and to keep her from sucking on the charcoal. She accepted all interventions with compliance while remaining spirited and engaged throughout.

C. Interventions

Ivory took verbal cues without requiring physical prompts with the ankus. Trainer's cues were low-key: soft spoken, reassuring, with responses to her drawings celebratory and enthusiastic. Food reinforcers were administered (peanuts) after each artwork was completed. Media was minimally adapted by adjusting easel at differing heights to discern optimum position. Different charcoal and chalks were offered to discern preferences or "tastes."

3. *Art Production and Process*

A. Detailed Description of Object or Image

Ivory's strongest work; utilized trunk movements resulting in a figure eight configuration punctuated by flowing sweeps and zig zags. Contour drawing, no shading. Composition is full bodied, utilizing the whole of the pictorial field in varying degrees of pressure and angles of charcoal application. Some trunk sweeps noted and saliva blowing. Dexterity excellent (African subspecies with prehensile upper lip.) Developmentally: clearly controlled scribble (approx. 28 months equivalent). Affect reflected; calm yet energetic. Responsive to spectator attention.

B. Pertinent Dialogue (vocalizations) or Body Language

Body language robust, curious, relaxed. Vocalizations included throat gurgles (favorite self-stimulation) and trumpeting (very loud!). Ritualized head weaving noted when Ivory waited for art activity to begin (anticipatory gesturing).

4. *Summary or Analysis of Session*

Initial session was highly relaxed and productive. Ivory is a nine year old African, wild born, who displays precocious drawing behavior. She is cooperative, even tempered and well habituated to human presence and intervention. Ivory worked productively despite being stimulated by the special visitation. She was curious and outgoing, seemingly enjoying my attention and salutations. Despite the use of food-based reinforcers, Ivory seems intensely invested in drawing activity. Whether this investment is internally or externally driven is open to question; potential for continued drawing development is exceedingly positive. Recommendation: continue arts programming with gradual diminishing of food reinforcers.

Fig. 1 Process note outline developed by Laurie Wilson, A.T.R.

sessed a sensitivity toward spatial relations and balance (cited in Winner, 1981). Marks also became less motoric and scribbly when symbolic significance was assigned to the image. Moja's "unnamed" pictures for instance, were on par with most of the other apes random kinesthetic scribblings. However, when the chimpanzee focused on creating an image which conceptually stood for an object, the change in pictorial organization was dramatic: the contours and spatial relationships were dramatically enhanced (Beach, Fouts & Fouts, 1984). Patterson has duplicated these findings with her work with KoKo, a lowland gorilla who has received one-to-one educational and language training for over eighteen years (1981).

Literature Review: Elephants

Mark-making in elephants has been documented by Gucwa and Ehmann (1985), who studied a fourteen-year-old female Asian elephant named Siri. Their account is noteworthy in that Siri's drawing was evidently a spontaneous untaught and unsolicited behavior. Isolated during the night, the following morning Gucwa would find pebble scratchings etched into the concrete floor of her paddock. Though this behavior has been reported by other trainers and observers in the wild, those scratchings were created in the sand or dirt using sticks or other implements and were subsequently lost to the elements or the animal's own trampling (Douglas-Hamilton, 1975; Hediger, 1968; and Moss, 1988). Hediger observed what he termed "trunk tracks," as a kind of graphology that betrayed the wild elephants' emotionality through various styles and rhythms, made as they moved their trunks in the sand during their travels.

Most ethologists viewed Siri's art making as a "fooling around behavior" which relieved her unrelenting boredom and isolation of captivity. When Gucwa began eliciting drawing as part of their weekly regimen, the behavior was attributed to the positive reinforcement of the trainer's increased attention. Others suggested that Siri became skilled at manipulating the trainers into increasing the quantity of other reinforcers such as food, exercise, and spectator attention. In a more positive vein, Schmidt (cited in Gucwa & Ehmann, 1985) saw Siri's behavior as an attempt to alter her environment in a bid for self-enrichment, either as a cognitive game, a display of territoriality or sexuality.

Schanberger's (1991a) ongoing work at the Phoenix Zoo has incorporated art making as both enrichment and research activity. Ruby, an eighteen-year-old Asian (Thai) elephant has demonstrated the initiative to draw without trainer intervention. When food and art materials are simultaneously presented, Ruby often chooses to draw rather than eat. Furthermore, Ruby has actually left food when researchers set up the easel. A degree of concept formation seems to have been demonstrated by Ruby, as she is able to choose those colors that correlate to objects in her environment, particularly those in which she seems to be emotionally invested (see the fire truck vignette in the discussion).

Literature Review: Dolphins

While there are voluminous studies on the intelligence of dolphins (Norris, 1966), language (Herman, 1987) and social behavior (Nathanson, 1989), few reports of dolphin art making activity have been published. One study by Barbara Ann Levy (1990) correlated art therapy principles of psychoaesthetics and object relations of Robbins (1988), with Laban Movement Analysis (Hand, 1986). Levy analyzed the art making behaviors, social interactions and body language on an integrative continuum. She reported correlations between art activity and movement of "bonded" dolphins and that a more unique expressivity existed in those animals who remained unpaired. She also correlated the possible connection between the dolphins' signature whistles and other sounds to their painting rhythms and patterns.

Quayle (1988) reports on research that explores the social aspects of dolphin behavior. She cites Norris and Johnson (Quayle, 1988) who maintain that dolphins exhibit altruistic behavior (such as injured human swimmers being protected from sharks). Nathanson (1989) takes this idea further, asserting that dolphins possess a kind of empathy. Nathanson uses dolphins to interact with mentally retarded, psychotic and other handicapped people, to facilitate their learning and interpersonal relating. Roberts (1991) reports observing sessions whereupon a dolphin who was sometimes intolerant of being handled during encounters with normal people was being worked over by a deaf/blind child who probed the dolphin's every orifice. Rather than resist, the animal held still and actually rotated himself so that the child could reach every part in the most accommodating way, much to everyone's surprise. In this case and others, the dolphin might be seen as a kind of transitional object—whereby the client can establish a relationship with a comforting, yet benign object that sets the stage for more normative and demanding relations eventually with humans.

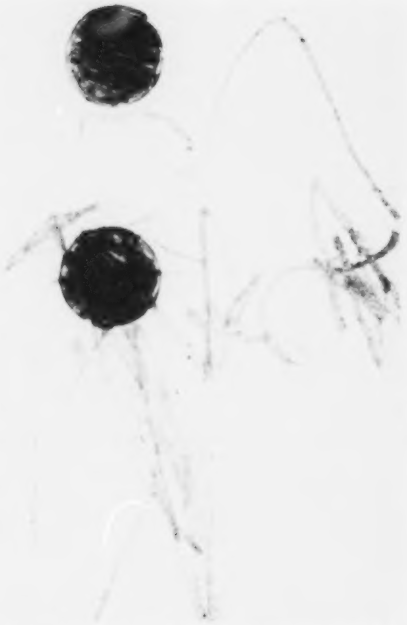


Fig. 2 Work by June of the Lincoln Park Zoo, who has interacted with the two circles pre-drawn by the author.

Fig. 3 June strikes a thoughtful pose while drawing.

Fig. 4 June and habitat-mate Donna (photographed through glass) collaborate on a scribble.

Case Accounts: The Apes

In 1989 Sara Reitz (1990), then an art therapy graduate student at the School of the Art Institute of Chicago, accepted an internship at the Gorilla Foundation in California, to work with KoKo, a twenty-year-old female lowland gorilla (*Gorilla gorilla*). KoKo is well known as one of the ten great apes to have learned some American sign language. During her years of one-to-one training with Francine Patterson, KoKo has developed extensive receptive and expressive language which enables her to express her needs, ideas, and feelings with almost unbelievable articulation. Patterson asserts that KoKo has developed a sense of self-consciousness given her mirror recognition experiments (Patterson, 1991).

During her year's residency, Reitz viewed over thirty hours of videotape and engaged KoKo directly in over a dozen sessions that involved drawing with pen, pencil, and crayon. This activity took place in a huge outside pen, with the art materials being handed to KoKo through openings in the mesh.

One of Reitz's objectives was to investigate the degree of intentionality that KoKo brought to her scribbling activity. She employed Morris's "interference patterns," which are comprised of shaded shapes that are preprinted on the drawing paper (Figure 2). Used concurrently with blank paper as a control, Morris envisioned these patterns as being stimulating to the apes' innate sense of design. He observed whether they attempted to complete an unfinished shape, balance an offset composition, or otherwise embellish, replicate or deface the forms in a kind of pictorial dialogue between pattern and ape. Of the twenty-eight works that Reitz collected, KoKo marked upon the interference patterns in 16 instances, with most markings being random scribblings in the general proximity of the pattern. On some occasions KoKo brought a verbal (sign) association to a scribble (such as "corn there"). However, Reitz found no appreciable advances in the control, placement, or configuration when the scribble had been "named." Nor did Reitz find an increase in KoKo's investment in the work when she attached a concept to it. However, in one of the parting sessions, KoKo appeared unusually absorbed as she embellished a drawing of a gorilla and her baby, that Reitz had sketched for her. (Reitz used this sketch as a kind of interpersonal interference pattern.)

Reitz's research eventually concentrated upon mirroring artistic and rapport behaviors for KoKo in an attempt to advance her schemas and cement a greater bond between the art therapist and her "client." This modeling process entailed having KoKo observe Reitz (over her shoulder) sketching prior to presenting her with the art materials. This mirroring, or dialoguing process appeared to be increasing KoKo's motivation, lessening her constant requests for food reinforcers. Unfortunately, Reitz had to terminate before more data could be collected to support this possibility.

At Lincoln Park Zoo, June (*Pan troglodytes*) has been drawing since the age of two with the same keeper, Pat Sass. Now close to twenty-five, June continues to draw, in both a kinesthetic scribbling mode as well as a more schematic style (Figure 3). During my bi-monthly sessions, June has appeared to consistently display spontaneous drawing behavior with little concern for food rewards. She unhesitatingly takes her poster board and crayons and finds a remote perch in her habitat, where hand propped thoughtfully upon her brow, colors for usually 10 minutes before climbing down to hand the work to her keeper. On other occasions, June will seek out her peers for conjoint drawing sessions (Figure 4). During these instances, the chimps seemingly take great interest in each other's work, judging by their focused and unwavering attending behavior.

As part of the primate project at Lincoln Park Zoo, I have also been conducting infant stimulation sessions with a male and female chimpanzee who are each two years of age. Both babies play with crayon, tempera paint as well as soap bubbles and other toys as part of their sensory activities (Figure 5). What is most striking about their behavior is how closely the chimps follow Mahler's stages of relating (1968).

For instance the female would cling to her keeper for most of the initial sessions, only engaging the paint brush while enveloped in her protector's arms (working over the keeper's shoulder). She displayed classic approach/avoidance conflicts (Tinbergen, 1961) with intense stranger anxiety and withdrawal, being offset by an equally powerful urge to investigate this new creature introduced to her world. By the fifth session she began reaching out to me tentatively, eventually overcoming her trepidation by climbing on to me, clinging like an infant. Needless to say, therapist/client parameters had become hopelessly blurred, her attachment eliciting powerfully paternal transferences within me. The satisfaction that came with finally being not only accepted, but coveted in the most lovingly infantile way, was sufficient to send me scrambling for the nearest supervision. In any event, both babies have developed an attachment that associates me with a pleasant break in their routines. Upon my entry they unfailingly begin to rummage through the art supplies, flailing wildly when they find the brushes. That the art activity is robust is an understatement, as they splash, and smear the paint—a free-for-all made all the more chaotic by their possessing not two, but 'four' very hyperactive hands! Upon the termination of each session, an increase in clinging behavior in the female and an escalation of acting out has been observed in the male—reactions familiar to those who work with young children with special needs, who react strongly to loss and other changes in interpersonal care.

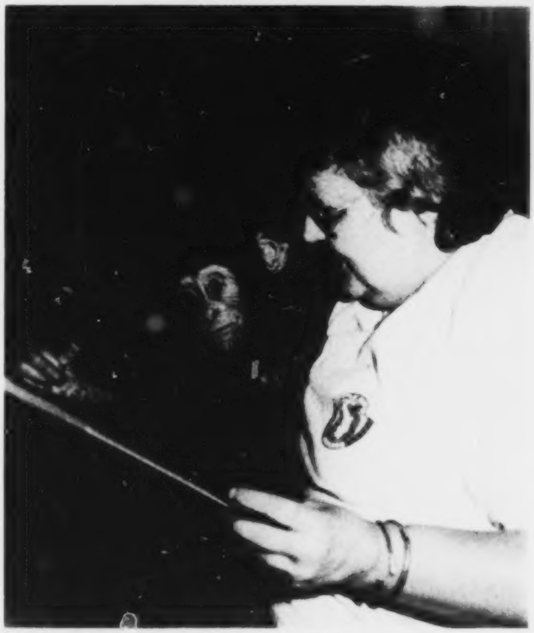


Fig. 5 Cheri's first successful scribble.

Case Vignette: Natua, Atlantic Bottlenose Dolphin

Natua was a sixteen-year-old Atlantic Bottlenose dolphin who was born at the Dolphin Research Center (DRC) and died last year of liver failure. He was considered among the brightest of the dolphins at the center, having descended from one of the original "Flippers" of television fame. Natua has appeared in numerous films, TV shows, and commercials as well as being one of the center's premier research subjects, including participation in Levy's Psychoaesthetics Project (1990).

Natua was seen with two other males: Delphi, an adult in his twenties, and Kibby, a teenager. There were six sessions over the course of three days which lasted each about an hour. All three animals had formally gained experience in painting on T-shirts that were stretched over a board and held by the trainer.

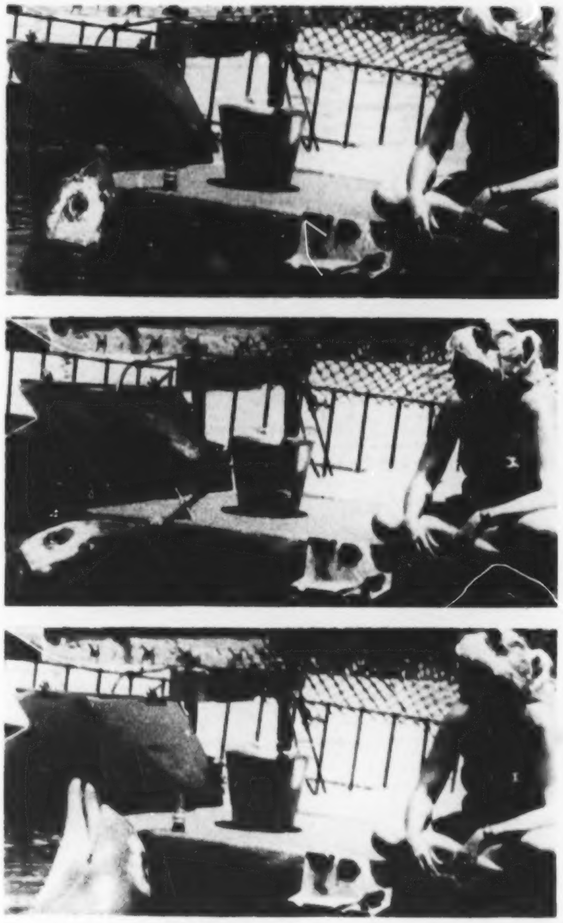
Working with the dolphins required an approach similar to those used with orthopedically handicapped clients. These individuals often have limited motor control, but possess both intelligence and a fierce determination to be successful despite their disabilities. These traits also held true for the dolphins at the DRC, who displayed remarkable motivation and problem-solving ability during the art making sessions.

Since the dolphins lack a prehensile appendage, they are by default, mouth painters. This situation required an adaptive paint brush comprised of unfinished wood, and a short flat handle (to keep the brush from sliding down the mouth). Stiff bristles were effective at absorbing hard strokes and swipes against the paper.

The easel was also a crucial adaptation. I mounted a board made of tempered Masonite on a pipe-fitting frame which was cantilevered over the water and angled downward 20 degrees. By inserting different lengths of pipe, I could adjust the height allowing the dolphins to work comfortably while they tread water (Figures 6, 7, and 8).

The media was comprised of heavy weight Arches watercolor paper which was clipped to the Masonite easel, and acrylic paint in blue, yellow and green. These colors were applied to a palette which mounted vertically onto the face of the dock, allowing for clear visibility of the color choices. A shelf underneath supported the paint brushes, half of which rested on the wood, with the other half of the handle floating on the water. This arrangement encouraged the dolphins to grasp and release the brushes with optimum independence.

From the first session, Natua demonstrated a keen interest in the new easel and paint set-up. With a burst from the trainer's whistle, Natua rose awesomely out of the water and picked up the brush from the palette shelf. He then stood poised before the expanse of the white Arches paper on the easel. After a moment of hesitation (or contemplation?) he dabbed at the paper, then with a jerk of his head, dragged the brush across the pictorial plane (Figures 6, 7 and 8). Approximately six strokes were completed in yellow and green before Natua handed the brush back to the trainer and relished his reward of a whole mackerel.



Figs. 6-8 The dolphins required an orthopedic set-up which enabled them to tread water comfortably while attending to the art materials. This sequence illustrates a few of Natua's head and brush strokes while his trainer supports his efforts.

After completing six sessions, Natua had become fully acclimated and comfortable with the new painting procedures. His last work particularly bears this out, as it appears the strongest in terms of control and diversity of brushstrokes.

Natua painted Figure 9 while remaining unusually low in the water. Whether this positioning enabled him to increase his control or simply kept exposure to the tropical sun to a minimum (note the protective zinc oxide on Natua's head in Figures 6-8) is open to question. In any event he concentrated on the lower right area, working with unusual deliberation and control. The first strokes began as concentrated dabs that became wispy as the drying color

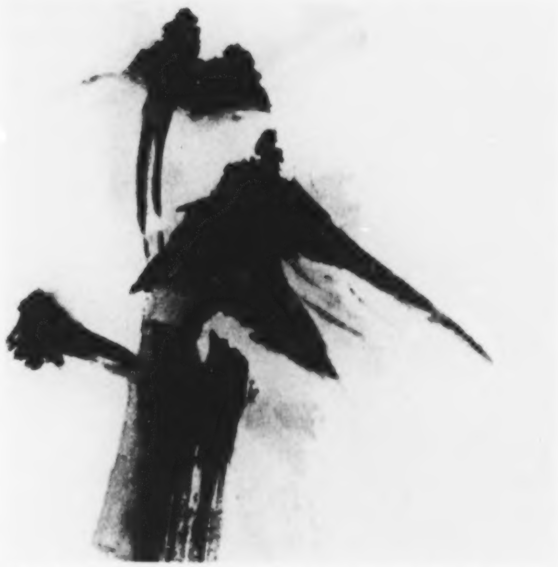


Fig. 9 A watercolor painted by Natua. This work utilized several controlled strokes creating a delicate design of balance, movement and sensitivity.

trailed off. This changed however when Natua submerged with loaded brush in mouth, which diluted the acrylic to watercolor and resulted in bands of veil. Adding to the composition were brushmarks of contrasting straight and curved trajectories registered according to Natua's head movements. A yellow circle was created when Natua did a pirouette beneath the easel, rotating 360 degrees all the while keeping the brush in constant contact with the paper—a particularly delicate maneuver.

It is significant that during this painting, Natua made the first attempts at reloading his brush between paint strokes. As he returned to the palette, his trainer thought he was finished and mistakenly asked for the brush. Natua refused, however, and proceeded to "paint" the palette instead. Painting of a palette is a familiar occurrence with special needs children. This activity often acts as a bridge between using the palette as a supplier of paint as opposed to being worked on as the art object itself.

Natua closed the session with a ritual that is common in special education—a celebration. Accompanied by the whistles and clapping of his trainer and other onlookers, Natua shot out of the water, backpedaling and screaming in excitement. This sharing of mutual joy was followed by a victory lap around his pen. With brush in mouth, Natua dove and splashed in a celebrating display of dolphin grace and power.

Case Vignette: Bozie, an Asian Elephant

For the past two years, I have conducted drawing activities with three elephants at the Lincoln Park Zoo. Bozie, a 17-year-old Asian female, her two-year-old baby, Shanti, and Binte, a 14-year-old African female. All three of these animals had been taught by the zoo staff to "finger" paint with their trunks and thus had the rudiments of working a pictorial plane prior to my intervention. Sessions are held every other week for as long as the elephants show interest (usually about 10-15 minutes per activity) during a time period which they associate with their leisure time (playing ball, running through the sprinkler, etc.). There is no behavioral modification attached to this program beyond recreation and the elephants are free to refuse the activity altogether.

The elephant's trunk is a superb prehensile appendage which functions as a primary sensory organ, through which the animal smells, breathes, touches, communicates, and manipulates. Its fine motor control, particularly among the African species, is so finely tuned, that one elephant I observed drawing in chalk immediately broke the piece in two, a preference that is common among those who often use this material.

In an attempt to offer media that was "species appropriate," I chose charcoal, a material that they might encounter and use in the wild, as well as being non-toxic and aesthetically pleasing. These elephantine pencils were constructed of 1" of hardwood dowels that I charred at both ends in a kiln. The elephants drew on deckle-edged drawing paper which was taped securely into a 30" × 48" shadow box (see Figure 10). This arrangement presented the elephants with a sturdy object that withstood rough treatment while also providing a sense of structure or "territory" which helped define the activity space. As with handicapped children, the elephants respond to consistency and ritualization. By always presenting them with the same sequence, materials, props and verbal cues, I communicated a sense of structure while also providing a trigger that cued the elephants that it was time to explore and manipulate these familiar materials.

Throughout the drawing project, the elephants displayed remarkable curiosity, with the art materials and props being subjected to the most minute examination and manipulation. The drawing box was explored thoroughly before any manipulation of the media was initiated, with every thread, splinter or scrap of tape being picked over, smelled or ingested.

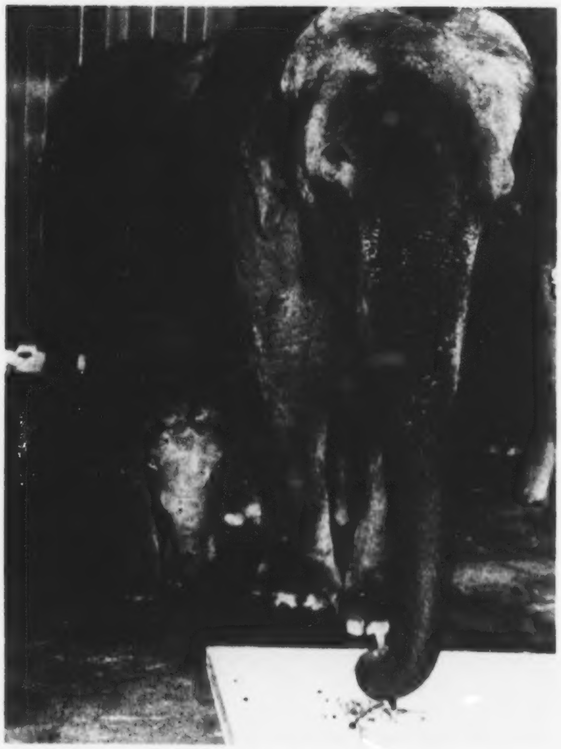


Fig. 10 Bozie working at her drawing board with charcoal. Shanti, her baby, follows her activities closely.

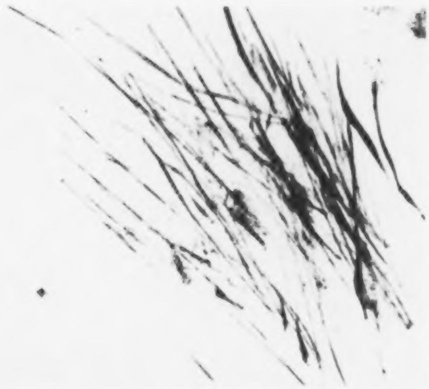


Fig. 11 Many of Bozie's drawings utilize verticle formats that are relatively controlled and organized.

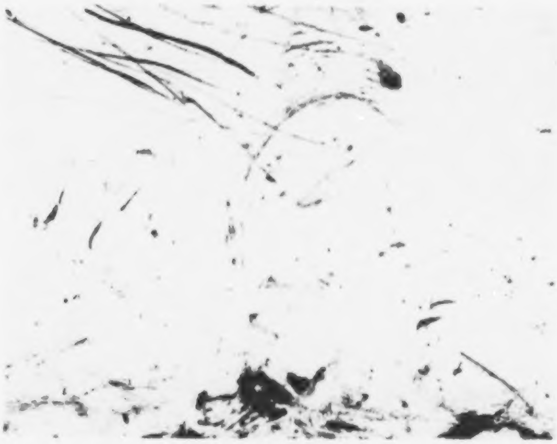


Fig. 12 In some instances Bozie works more robustly in a play or perhaps haptic mode. Here the other elephants joined in trampling, blowing and smearing their dung, charcoal or saliva.

Then the media itself was probed, usually to test the durability of the paper and charcoal. For instance, once I had neglected to tape the entire perimeter of the paper to the board, securing instead only the corners. The elephants spent the entire session peeling up the tape and destroying the paper. Once the elephants are convinced that all is secure and durable, they turn their attention to the charcoal. With a few cues to grasp the charcoal, Bozie will begin to make marks.

Drawing consists of a range of trunk movements, whose motions register as different marks on paper. The mainstay is a vertical motion that translates into a series of fairly controlled lines that are reminiscent of bundles of grain or straw (Figure 11), and are quite organized. Bozie also uses more chaotic daubing, tapping or smearings in works such as Figure 12. These robust and playful scribblings are essentially multi-media pieces, with Bozie dropping straw or dung on the paper, blowing saliva, vacuuming bits of charcoal and other earthly embellishments that record her kinesthetic and tactile experience with the media. In some instances, I invite all the elephants up to the board to assist Bozie, resulting in a elephant free-for-all of marking, smearing, tearing and even trampling. When it is evident that Bozie was working in a more controlled mode, however, she was allowed to work unfettered by the others. Figure 13 from session seven is such a piece. The charcoal was applied with great concentration and density. Strokes are strong and deliberate, with an array of vertical, horizontal and diagonal lines. Even the smearing appears to be less impulsive and more integral to this particular composition.

Since the inception of the drawing project, Shanti, Bozie's child, has observed her mother in the mark-making process. During these formative years, Shanti habitually traced her tiny trunk over the mother's drawing, faithfully replicating the

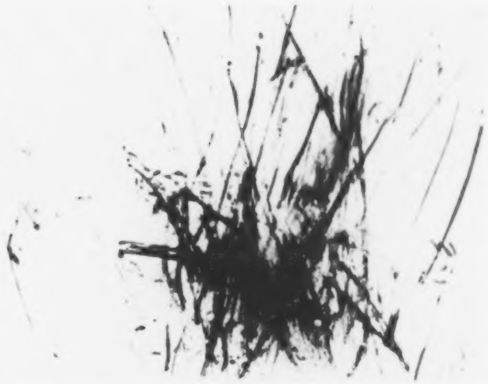


Fig. 13 After seven sessions Bozie's work incorporated both kinesthetic and haptic involvement, with multi-directional linework created by stroking and smearing.

mother's movements. At this time she was too immature to actually manipulate the charcoal without ingesting it. Recently, however, she has begun drawing at 2 years of age. Her strokes are surprisingly controlled. She smacks the charcoal up and down, creating the tiniest of dots upon the paper, which are situated alongside of the mother's more varied linework. While her attention span is brief (as the opening vignette attests), what she lacks in attending is made up by the sheer joy she brings to the process. Viewing such a scene, I gladly succumb to the worst case of anthropomorphization and picture just another two year old preschooler scribbling away, at one with herself and her art.

Discussion

The Benefits of Artistic Expression

Much of this paper questions whether captive animals can benefit from art activity. Based upon current ethological thinking, we know that environmental stimulation must be provided if these high functioning animals' emotional/cognitive equilibrium is to be maintained without the opportunities for natural life occupations of feeding, defending territory or mating. Substitute activities must be forthcoming that provide an outlet for learned and instinctive needs. The question remains, however, whether art can arise to fulfill such requirements.

Sensory Stimulation

The adage "use it or lose it" is very much in operation with high functioning animals. For instance, a major rationale of performing captive dolphins is that such "showing off" fully engages their physical and mental faculties—just as dance, gymnastics or wrestling engages those in humans. With regard to visual art, one need only observe the anticipation behavior of elephants that includes purring, trumpeting, squealing and other displays of excitement when art materials are presented. These responses vary, according to each individuals' varying needs for certain stimulation. These can often be categorized between visual and haptic modes of processing stimuli. For example, Binte, an African elephant at Lincoln Park, tends toward a tactile approach to media and design. She smears dung into her drawings, blows on saliva making a kind of sauce with the bits of charcoal, all the while flapping her ears and shuffling from side to side. In contrast to such a mixed media approach, her roommate Bozie is decidedly visual in her drawing behavior. She can be observed cocking her head to one side so as to make constant eye contact with her drawing. Ruby of Phoenix points to each of her color preferences and can successfully match color to sample. Occasionally, her keepers attempt to trick the elephant by giving her a different color, which invariably results in trumpeting and trunk jerking responses to such teasing (Schanberger, 1991b).

Needs for sensory stimulation also can be tempered by gender. Both Levy (1990) and I found that the male dolphins responded with greater physical robustness in their painting, while the female worked in a diminutive style. The infant chimps also appear of different temperaments according to gender. The male's rough and tumble treatment of paint and crayon contrasted sharply with the more serene and focused activity of the female.

Sensory stimulation that came with art activity ceased to be stimulating, however, when presented too frequently, with too much structure, or in competition with other "easier" activities. In all three species, motivation dropped off if the activity was offered more than once a week. For programs with many opportunities for enrichment, art activity did not elicit strong preference, though in those settings with limited opportunities for stimulation, art was a preferred choice (Collins, 1981). These observations corroborate to the findings of others who point to the need for novelty as a motivation stimulus (Humphrey, 1980, cited in Dissanayake, 1989). Such an insight can be well appreciated by the art therapist who may use novel materials (such as glitter or fluorescent glue) on occasion to perk up lagging creative energies in his or her students.

Social Behavior and Art Making

Much of my art program has made use of group interaction and participants of animal families or cohabitants. Subsequently, many fascinating group dynamics emerged during the art sessions.

When for instance the chimps visit each other while drawing, often marking upon each other's work, their keeper reports incidents of pacification and reconciliation of group conflict (Sass, 1991). During such potentially charged encounters the art process might have played a part in redirecting or dissipating aggression through the ritualization of the art process (Lorenz, 1966). Seen as a displacement behavior, the art process allows approach/avoidance conflicts to be negotiated through the channelling of affect (Tinbergen, 1961). Chimps who were lower in the habitat hierarchy could appear with lessened chance of retribution by their superiors during the drawing activity. The curiosity generated by each chimp's drawings overcame long-standing feuds between cohabitants, with numerous truces appearing throughout the months of art programming (Sass, 1991). Such conflict resolution might be due to the propensity of the art process to deflect raw affects as a buffering agent for direct confrontation.

Social bonding was also observed in group behavior, with the elephants particularly taking advantage of opportunities for herding around the drawing box. They often mark each other's foreheads with charcoal, smear each other's marks and feed each other bits of charcoal (particularly between mother and baby). The dolphins were usually kept separate, though on occasion they were able to observe each other in which they took great interest. Much of this curiosity, particularly among the adolescent males, probably stems from wondering what special treat their cohabitant was receiving while they stood deprived. Often they would display for one another after a session as was described in the case vignette. Such self-proclaimed displays of physical power contrasted with the delicate touch needed to hold their paint brush triumphantly above their heads.

I sometimes became an unwitting participant in the displays as well, with one instance pitted in a hierarchical struggle with a silver back gorilla. After finishing the crayon drawing, the animal spent minutes posturing until he settled upon a particularly striking and intimidating pose. Staring me down, he then thumped his chest (which reverberated with tremendous volume) finally exploding toward the bars of his enclosure—all the while throwing leaves and making a wild ruckus. Almost instinctively I lowered by body, averted my eyes and psychologically submitted to this creature. Evidently satisfied at my passivity he nonchalantly lumbered off.

Aside from the social interactions between cohabitants, caretakers and observers, I believe that the animals developed a kind of relationship with the art materials as well. Such thoughts often came to me as I observed the elephants probing the perimeters of their drawing boxes prior to drawing. They seemed to be reacquainting themselves with a familiar, perhaps important place—a mark making place where something "made special" occurred (Dissanayake, 1989). The animals came to associate this place as uniquely their own—free to explore, destroy or create as the spirit moved them. I have witnessed similar responses in the most severely handicapped child, where the art room was associated with almost completed freedom to make an impact upon their otherwise sheltered environments.

Art as Therapy

Though we can never step outside our humanness and truly empathize with an animal's emotions, several anecdotes have been reported that infer a therapeutic relationship with both the keepers and art process.

Throughout the literature and my visits with the animals, I found that the degree of investment in the art process was inextricably tied to the quality of the animal/trainer relationship, with greater intensity displayed when the preferred trainer facilitated the art experience. (Though in instances where the relationship between trainer and animal was overly enmeshed or otherwise dysfunctional, the relationship could hinder the process as profoundly as in any art therapy session.) In most instances, however, the bond between trainer and animal was a healthy one with limit setting, mutual respect, security and empathy supporting the relationship. Given the early childhood nature of this relationship, one could view the animals' performances as providing opportunities for narcissistic pleasure that arise from pleasing the mothering agent or "significant other."

Without such opportunities for social bonding, psychopathology often occurs. Schanberger (cited in Gilbert, 1990) reports that when Ruby was the only elephant at the Phoenix Zoo she often lured the waterfowl toward her by using her trunk to dribble grain as bait. Once within range, Ruby would sometimes trample the birds to death. Schanberger reports that since introducing art and other enrichment activities, this sadistic behavior has all been eliminated. Art activity also appears to displace or perhaps even sublimate sexual acting out behaviors.

Schanberger also reports that Ruby is often sexually stimulated by large vehicles that sometimes work by her habitat (I would assume a preference for well-endowed backhoes, though this has not been confirmed). Exposure to these vehicles would send Ruby to her favored masturbation tree trunk which she used assiduously. Painting activity was reported to not only lessen this behavior, but also increased a preference for bold red patterns in her paintings (Gilbert, 1990).

Problem Solving and Learning

In the literature review I cited several examples where research has proven high learning capacities in these animals, particularly in the chimps and dolphins. While I believe that art making certainly can and has contributed further to the problem-solving capacities of these animals, I tend to minimize an emphasis upon skill acquisition as part of my project. This is because I believe the place of education in therapy should remain minimized—that the animals should acquire sufficient skills in order to effectively engage the art process and maximize self-expression, but not become overly bogged down in developing a precosity that borders on being unnatural. Consider the ape who functions perfectly without an ego as we know it, and instead is governed by superbly evolved instinctual and learning mechanisms shaped by eons of natural selection. Should we overly develop the processes of self-awareness, cognition, reflection and other ego functions? Might this not constitute an intrusion upon the animal's mind every bit as devastating as primary process intrusions are to the human psyche? In observing some of these heavily programmed creatures, I was first struck by their amazing cognitive abilities, though this gave way eventually to the realization that such giftedness was pervaded by a disturbing sense of neurosis. In these cases, the effects of over stimulation were just as pathological as those caused by sensory deprivation. Hence, one must remain objective with regards to one's intentions and not allow research to exploit clients who are vulnerable in this way.

Aesthetic Sensibility

Reports of aesthetic sensibility are few in the literature, though I have heard some seemingly fantastic, yet plausible, anecdotes in which the animal in question was able to approach "formed" art expression. This entails the symbolization of personal experiences and affects which are comprehensible in their communication and display an evocative command of formal art elements (Kramer, 1971; 1992).

Such an act of integration was perhaps achieved by Patterson's male gorilla, Michael, in a work done in response to the recent earthquake of 1989 (1991). Deeply upset by the quake, Michael refused to touch the ground for days after the incident. His first painting session after the quake took the form of a series of horizontal undulating lines painted in thick brown paint. The brown was then covered by streams of red. After scrubbing the surface with increasing agitation, Michael signed to Patterson "earth-shake-bad." The finished work which I had the pleasure of seeing in photographs possessed a structurally powerful composition which was complemented by its emotionality. But, however lovely and moving this expressionistic painting appeared, ascribing aesthetic viability to it remains a clouded issue to which I now turn.

Aesthetics: A Matter of Intentionality and Critical Empathy

The aesthetic outcomes of these creatures' efforts may be considered to be academic. It is probable that, even the most accomplished animal artist cares less about its work's formal elements than the stimulation afforded by the process. However, this does not negate the potential for aesthetically rich outcomes from these and others from the "outside." Many critics have drawn attention to those art makers who may not be able to conform to the accepted aesthetics preferred by their culture, or incorporate artworld influences. Dubuffet (1987), Cardinal (1972) and MacGregor (1989) all exhort the critic not to dismiss the eccentric or psychotic art maker on the grounds of bizarre content or style, in which pictorial communication may be autistic or obscure by nature.

However, the academic issue of aesthetics, even in outsider art, requires working criteria that guide the critic in his/her arguments. The models often cited that recognize those marginal areas of creativity are Alland (1977), Kris (1952), Winner (1982), and Prinzhorn (1972). All of these writers commonly cite one criteria as being essential for aesthetic viability: that of "intentionality."

Intentionality refers to the degree of purposefulness that one brings to the creation—for example, a client who, after spilling her paint in frustration, decided to mat the splattered newspaper and pass it off as a masterpiece. While we might accept this as outpouring of emotion and part of a therapeutic experience, it has little to do with aesthetics. Consider the painting student who also decided to display not his paintings, but the splattered drop cloth instead. During his critique, however, he was able to conceptualize (or rather rationalize) that he was unconsciously attending to the space surrounding his canvases, all the time subliminally working those areas more intently than the paintings themselves. Such linguistic gymnastics are commonplace in art schools where students constantly probe the limits of art, though all too often conceptualization is used as a means of shorring up works that are weak in substance. It is interesting, however, that some aestheticians such as Dissanayake (1989) would consider the splattered drop cloth, or to use her example, an act of masturbation as part of a performance as art—only because they are acts "made special" by deliberation. Hence, she views the work of children, psychotics or precocious elephants as being more akin to acts of nature than the result of artistic license. I find this view to be limited, however, since I have found in my experience, severely retarded (Henley 1986), psychotic (Henley, 1991), autistic (Henley, 1989) or very young individuals (Henley, 1992) with seemingly no awareness of aesthetic expectation, able to create images of great power. It appears that naiveté, psychopathology or even retardation can act as a fuel that drives imagery to extraordinary levels.

To appreciate the efforts of such outsiders requires a critical stance that is undeterred by obscure artistic vision, regardless of how impenetrable the artist's communication may be. I consider this process to be more a matter of empatheticism than criticism, whereby the intentions of the artist are approached without any preconceptions or expectations. Cardinal (1989) expresses this article stance beautifully in his account of viewing petroglyphs in the rocks of Northern Italy:

> If I were to bend to the task of drawing some further lesson out of these sensations, I would have to say that what the marks were asking me to adduce was my own vulnerability. I begin to divine that the way to grasp the Primitive Scratch must be to advance without inhibition, to participate in its presence as generously as possible. To establish a dialogue across thousands of years, I must open my own sensibility as fully as possible to the transaction. Camunnus artifex hic fuit. Now I am here. The authentic apprehension of Otherness is perhaps grounded in some form of self-knowledge; or rather, knowledge of the Other is indissociable from the knowledge we concurrently gain of ourselves. (p. 125)

Art therapists are uniquely positioned to appreciate such an empathetic approach to art, given their experience in lending support to and deciphering the often covert or opaque intentions of our clients. However, empathizing with images which are not intended for two-way communication, challenges even the art therapist to respond and interpret with informed caution.

To illustrate some of this point, I begin by presenting one of Bozie's most appealing images (Figure 14). Responding to its formal elements, one can make a case for aesthetic viability: variations of hard/sharp and soft flowing lines, subtle forms that appear misty, lyrical sweeping in calm yet forceful rhythms, etc. Before I take this description further, I should say that the piece was created after Bozie had expended her creative energies for the day. Urged on by her keeper (much to my disapproval), Bozie listlessly cut a few lines, then, hastily swept her trunk over the paper to feed on bits of broken charcoal. It is this kinesthetic movement of gathering food that registered as the feathery wing forms that prompted my initial poetic waxing. Though it is perhaps a lovely movement in nature, its intentions lay not within the realm of art making but with feeding, hence the viewer is misled.

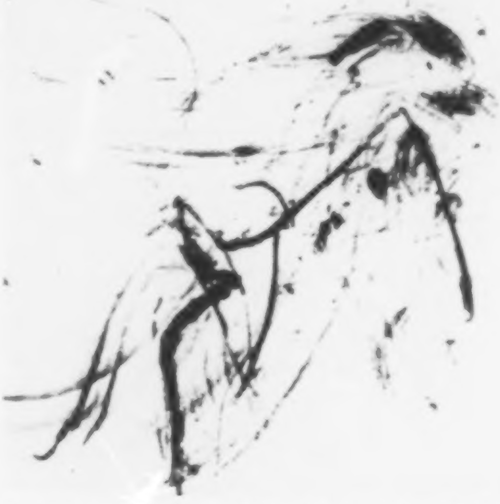


Fig. 14 Although one of Bozie's more interesting compositions, this image is purely a record of the elephants feeding movements.

On the other hand, we can cite examples in the animal kingdom of impressive artistic intentionality, although aesthetic integrity remains questionable. Diamond (1991) recounts his observations of the bowerbird, a relatively nondescript, jay-sized bird that displays art-like behavior. Bowers weave circular huts that are decorated with natural objects that are installed with great care. Colorful flowers, fruits, fungi, butterfly wings which are all collated according to color, creating a most impressive "multimedia" installation. The purpose of this display however is to woo a female into courtship. Despite such intentionality, it falls somewhat short of aesthetic sensibility, since its purpose is aimed at manipulating the viewing female by being resourceful and impressive. Although the bower is instinctually programmed in its manipulative behavior, it is reminiscent of those less than noble intentions of some art-stars of the 80's whose sensationalism or commercial savvy enabled them to tap the trendy tastes of an affluent art market.

While artists and their art can certainly prosper with deserved recognition and patronage, aesthetic integrity begins to falter when secondary gain eclipses the primacy of the creative act. By primal I refer to those internally driven forces that motivate one to sublimate instinctual yearnings and give form to matters of the soul. When exposed to the environment, these forces must somehow act in synthesis with the ego without diluting or perverting original vision. Kramer refers to such integration as "formed" expression (1971).

Imbalances between primal and secondary reinforcers occur, however, throughout the literature and field observations in both my work with humans and animals. Morris's chimps actually lost interest in painting when food reinforcers were introduced. Reitz observed KoKo signing "nut-give" even before a single line was produced. On the other hand, motivation and intention also falter when narcissistic pleasures that come with audience response are not forthcoming. It is clear that much artistic motivation is tied to these significant others (i.e., trainers, mothering agents, respected critics or instructors). Indeed, I cannot imagine the dolphins bringing as much intensity and animation to their art without the approving support of an enthusiastic audience.

What I am seeking then, is not so much learning toward one form of motivation over the other as much as a healthy, productive relationship between the two. This relationship can be best fostered by informed, sensitively administered interventions that promote formed art expression through integration. To adequately assess the aesthetic outcomes of such a process requires an informed analysis that recognizes the spirit of authenticity in art despite the likelihood that it may be cloaked in obscurity, alienation or incomprehension. Because such art criticism or clinical assessment is culturally driven, prejudice will occur, particularly when the viewer confronts a visual or conceptual vocabulary that is foreign to his or her orientation. This commonly occurs when Western analytical thought collides with the more non-linear, metaphysical reality of Eastern or indigenous cultures. And while it is true that we cannot step outside our humanness, when viewing the work of an adult elephant, it is possible to acknowledge that perhaps 30 years of rich life experience are reflected in this image; that joy, boredom, exhilaration, loss, pain and pleasure might all contribute to its quality of line, its smeared forms, its untouched space; that just because we can never fully comprehend or identify with the forces that brought such an image into being it should not simply be written off as a "curiosity." I deeply believe there are lessons taught by these and all creatures should we pause long enough to pay attention.

References

Alland, A. (1977). *The artistic animal: An inquiry into the biological roots of art.* Garden City, NY: Anchor Books.

Beach, K., Fouts, R.S., & Fouts, D.H. (1984). Representational art in chimpanzees. *Friends of the Washoe*, 3(4), 2-4.

Cardinal, R. (1972). *Outsider art.* New York: Praeger.

Cardinal, R. (1986). Ars sub rosa: Thoughts on the disposition to secrecy in the work of certain autistic artists. Paper presented at the Annual Forum of the Champernowne Trust. London, England.

Cardinal, R. (1989). The primitive scratch. In A. Gilroy and T. Dalley (Eds.), *Pictures at an exhibition: Selected essays on art and art therapy.* London, New York: Tavistock / Routlage.

Collins, D. (1991). Personal communication.

Diamond, J. (1991) Art of the wild. *Discover, 12*(2), 78-85.

Dissanayake, E. (1989). *What is art for?* Seattle and London: University of Washington Press.

Douglas-Hamilton, I, & Douglas-Hamilton, O. (1975). *Among the elephants.* New York: Viking Press.

Dubuffet, J. (1987). *Asphyxiating culture.* New York: Far Walls, Eight Windows Press.

Erb, L. (1991). Personal communication.

Gilbert, B. (1990, December). Once a malcontent, Ruby has taken up brush and palette. *Smithsonian*, 40-57.

BEST COPY AVAILABLE

Goodall, J. (1990). *Through a window. My thirty years with the chimpanzees of Gombe.* Boston: Houghton Mifflin Company.

Gucwa, D. & Ehmann, J. (1985). *To whom it may concern: An investigation of the art of elephants.* New York: W. W. Norton and Company.

Hediger, H. (1968). *The psychology and behavior of animals in zoos and circuses.* New York: Dover.

Henley, D. (1986). Approaching artistic sublimation in low functioning individuals. *Art Therapy: Journal of the American Art Therapy Association*, 3(2), 67-73.

Henley, D. (1989, a). Artistic giftedness in the multiply handicapped. In H. Wadeson (Ed.), *Advances in Art Therapy.* New York: John Wiley and Sons.

Henley, D. (1989, b). Nadia revisited: Regression in the autistic savant syndrome. *Art Therapy: Journal of the American Art Therapy Association*, 6(2), 43-56.

Henley, D. (1991). Facilitating the development of object relations through the use of clay in art therapy. *American Journal of Art Therapy*, 29(3), 69-76.

Henley D. (1991). *Exceptional children, Exceptional art.* Worcester, MA: Davis Publications.

Herman, L. (1987). *Cetacean behavior.* New York: John Wiley & Sons.

Kramer, E. (1971). *Art as therapy with children.* New York: Schocken Books.

Kramer, E. (1991). *The evolution of human perception: Implications for the understanding of the visual arts and of the visual products of art therapy.* Unpublished manuscript.

Kramer, E. (1992). Reflections on the evolution of human perception: Implications for the understanding of the visual arts and of the visual products of art therapy. *American Journal of Art Therapy*, 30(4), 126-142.

Kris, E. (1952). *Psychoanalytic explorations in art.* New York: International Universities Press.

Lachman-Chapin, M. (1987). A self psychology approach to art therapy. In J. Rubin (Ed.), *Approaches to Art Therapy.* New York: Bruner/Mazel.

Levy, B. (1990). *Psychoaesthetics and dolphin personality.* Unpublished master's thesis. New York, NY: Pratt Institute.

Lilly, J. (1978). *Communication between man and the dolphin.* New York: Jullian Press.

Lorenz, K. (1966). *On aggression.* New York: Harcourt Brace.

Lowenfeld, V. (1957). *Creative and mental growth.* (3rd Edition) New York: Macmillan.

MacGregor, J. (1989). *Discovery of the art of the insane.* Princeton, NJ: Princeton University Press.

Mahler, M., Pine, F., & Bergman, A. (1975). *Psychological birth of the human infant.* New York: Basic Books.

Morris, D. (1962). *The biology of art.* London: Methuen.

Moss, C. (1988). *Elephant memories.* New York: William Morrow.

Nathanson, D.E. (1989). *Using Atlantic nose dolphins to increase cognition of mentally retarded children.* Marathon Shores, FL: Dolphin Research Center.

Norris, K.S. (1966). *Whales, dolphins and porpoises.* Berkeley, CA: University of California Press.

Patterson, F. and Linden, E. (1981). *The education of Koko.* New York: Holt, Rinehart and Winston.

Patterson, F. (1991). Self-awareness in the gorilla Koko. *Gorilla: Journal of the Gorilla Foundation*, 14(2), 2-4.

Prinzhorn, H. (1972). *Artistry of the mentally ill.* New York, Berlin: Springer-Verlag.

Quayle, L. (1988). *Dolphins and porpoises.* New York: Gallery Books.

Reitz, S. (1990). *Process notes.* Unpublished manuscript. Chicago, IL: School of the Art Institute.

Reitz, S. (1990). *Artistic expression in the great apes.* Unpublished manuscript. Chicago, IL.

Roberts, K. (1991). Personal communication.

Robbins, A. (1988). A psychoaesthetic prospective on creative arts therapy and training. *The Arts in Psychotherapy*, 15, 95-100.

Sass, P. (1991). Personal communication.

Schanberger, A. (1991, a). *Enrichment techniques for elephants at the Phoenix Zoo.* American Association of Zoological Parks and Aquariums—Regional Conference Proceedings, 1991.

Schanberger, A. (1991, b). Personal communication.

Tinbergen, N. (1961). *The herring gull's world.* New York: Basic Books.

Vigorio, J.H. (1986, January). *Introduction to Laban movement analysis.* Paper presented at the Labora Bartenseff Institute of Movement Studies. New York City, NY.

Wilson, L. (undated). Art therapy process notation outline. Unpublished manuscript. New York, NY: New York University.

Winner, E. (1981). *Invented worlds: Psychology of the arts.* Cambridge, MA: Harvard University Press.

Winnicott, D.W. (1965). *The maturational process of the facilitating environment.* New York: International Universities Press.

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 193-197 © AATA, Inc. 1992

Brief Reports

Psychoaesthetics Dolphin Project

Barbara Ann Levy, M.F.A., M.P.S., New York City, NY

Abstract

Four Atlantic Bottlenose dolphins' artwork and body and brush movement were the primary focus of this pilot study. Research was conducted by the author at the Dolphin Research Center, Marathon Shores, Florida, in June 1989. Psychoaesthetics (Robbins, 1989), child art developmental theory (DiLeo, 1970) and Laban movement analysis (North, 1975) were used to consider the dolphins' painting behavior. Personality and individual graphic style of the dolphins were also noted.

Introduction

From June 19th to June 25th, 1989, I conducted a pilot study with four Atlantic Bottlenose dolphins trained to paint at the Dolphin Research Center (DRC) in Marathon Shores, Florida. At the DRC, dolphins were taught to paint on t-shirts by holding a brush in their mouths as a trainer held a t-shirt stretched on a piece of cardboard over the dolphins' heads at an accessible angle (Figure 1).

The theory of psychoaesthetics (Robbins, 1988; 1989) was used to consider the dolphins' artwork. Psychoeasthetics combines object relation theory and aesthetics to formulate a unique understanding of both the interaction between client (in this case, dolphin) and therapist and the quality of the resultant artwork. Art developmental theory (DiLeo, 1970) and Laban movement analysis (North, 1975) were also used to consider the dolphins' painting behavior.

The Dolphins

Natua, a male dolphin, was born in December 1974 in captivity at the Dolphin Research Center. He is the son of one of the original "Flipper" dolphins. Natua has performed in television commercials and films and was recently featured in the film, "The Big Blue." He has participated in research experiments on langauge acquisition, oil detection, and metal differentiation.

Kibby, a male, was brought to DRC from another facility where he was kept in a concrete tank and had developed stress related ulcers.

Delphi, a male, was nicknamed "The Fox" and has fathered many calves at DRC. He was brought to the research center from a facility where he was kept in a feeder pool: a pool at which the public may feed and pet dolphins. He was allowed no privacy and became aggressive. Delphi and Kibby bonded as has been observed with some dolphins of the same sex in the wild.

Misty, the only female in the study, came to DRC from an aquarium in St. Petersburg, Florida. Misty's trainers report that she has a Janus personality. "When she is good she is very very good, and when she is bad she is horrid" (Dolphin Research Center, 1989). At one moment she is a willing participant, at another, she may boycott a routine.

Data Collection

For seven days I observed the dolphins paint and videotaped many of the sessions. I observed the dolphins paint on t-shirts, 18" × 24" gessoed canvases, and paper of different sizes and shapes. At the end of the week, I discussed each of the dolphins with their trainers.

Editor's note: This brief report is a synopsis of the author's master's thesis (Levy, 1990) completed through Pratt Institute, Brooklyn, NY.

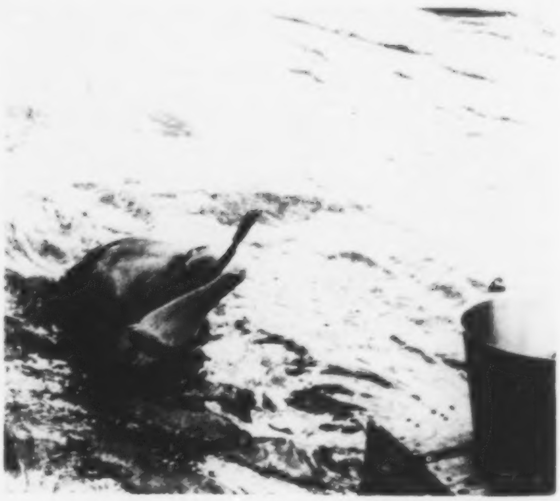


Photo Credit: B. A. Levy

Fig. 1 Dolphin painting at Dolphin Research Center, Marathon Shores, Florida

An early childhood educator, DRC volunteers and staff members assisted in observations. We worked on the docks with the dolphins three times a day for approximately thirty minutes. Two types of exercises were administered to the dolphins as well as experimental variations of both. The dolphins were presented with cut-out paper shapes and were asked to imitate these by painting the shapes on a canvas. They were also shown cut-out wooden shapes held by a trainer underwater.

At one point, a trainer held a canvas as she walked along the dock and Natua followed her and painted on the moving canvas. Additionally, Delphi and Kibby were given one canvas to share. In another instance I imitated Natua by holding a brush in my mouth. I was given my own trainer, fish bucket, and canvas and treaded water next to Natua at the dock. I imitated Natua. Natua's response to this was to inch his way over to my canvas replacing my position at the dock. He then proceeded to paint on my canvas.

Two Laban movement analysts were enlisted to study the videotapes of the dolphin and trainer to investigate a possible correlation between trainer and dolphin movements, and dolphin graphics. Movement analysts watched nine sections of videotape of the dolphins painting. Each analyst looked at dolphin and trainer movement and described them using the Laban system of analysis. To my knowledge, this is the first time Laban movement analysis has been used to evaluate animal movement. One analyst described movement in terms of body, space, shape, and effort. She focused on the relationship of dolphin to trainer.

The second movement analyst spent most of her time viewing the dolphins' movements and described the effort factors of weight, space, time, and flow. She compiled a quantitative chart for each dolphin. This process was used for observation of trainers as well. The analyst also looked at how each dolphin used combined effort factors in movement sequences.

Observations: Structured Exercises

As a structured exercise, the dolphins were asked by a trainer to imitate a geometric shape. In some of the paintings, a trainer or myself painted a geometric shape on one side of the canvas and the dolphin painted on the other side. In four of the paintings (Figures 2, 3, 4, & 5) the dolphins inverted the trainers' shapes, providing the viewer with a mirror image. for example, in Figure 2, Kibby attempted to copy a vertical bar shape and a horizontal bar shape painted on the left side of the canvas. The trainer's vertical shape is placed to the right of a horizontal bar shape and the horizontal is placed perpendicular to the center of the vertical bar. The dolphin placed a vertical shape, a horizontal shape, and some extraneous markings on the right side of the canvas. He also painted a horizontal bar shape in a semi-perpendicular direction to the right of the vertical bar.

In painting Figure 3, Natua attempted to imitate a trainer's vertical and horizontal bar shapes. The human's vertical bar shape is located on the left side of the canvas with a horizontal bar painted at its center to the right. Natua attempted to copy the trainer's marks and placed a large mark on the right side of the canvas and a smaller one to its left mirroring the trainer's mark's relationship, a large shape in relation to a smaller one.

In Figures 4 and 5, Kibby inverted the triangle that he was asked to imitate and, in both paintings, he partially covered the trainer's triangle. In painting Figure 4, it seems that he used the edge of the trainer's triangle as a bottom for his triangle.

In painting Figure 5, Kibby attempted to imitate the scale and configuration of a triangle painted by the trainer. Again, it appears that Kibby inverted the triangle.

Laban movement analysts who observed the dolphins hypothesized that the dolphins not only followed commands by the trainers, but may have mir-

1323

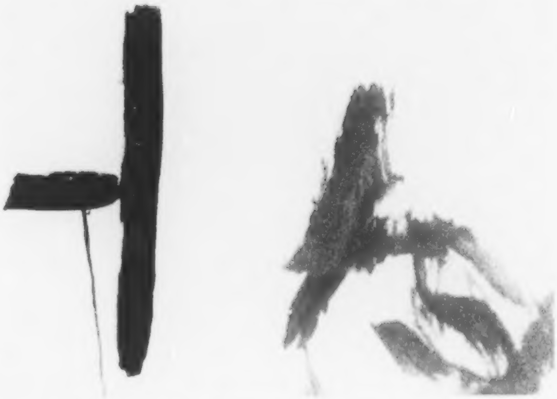


Fig. 2 1989. Fabric paint on canvas, 18" × 24". Left: Human mark. Right: Dolphin mark.

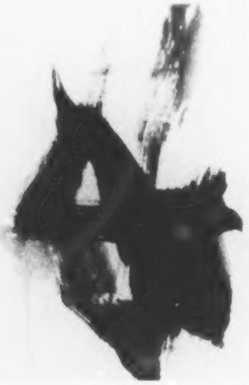


Fig. 3 1989. Fabric paint on canvas. Left: Human mark. Right: Dolphin mark.

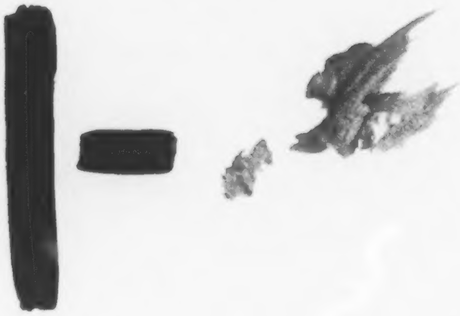


Photo Credit: D. James Dee

Fig. 4 1989. Fabric paint on canvas, 18" × 24". Left: Human mark. Right: Dolphin mark.

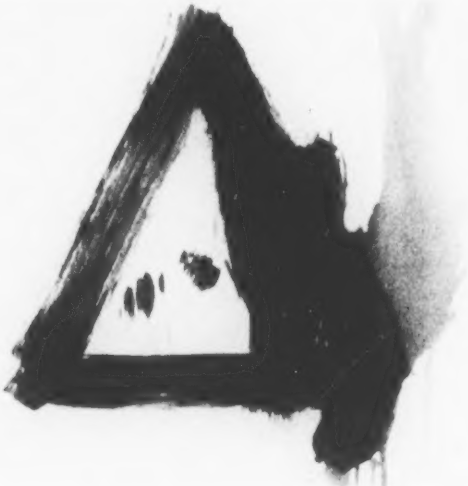


Photo Credit: D. James Dee

Fig. 5 1989. Fabric paint on canvas, 18" × 24". Left: Human mark. Right: Dolphin mark.

rored the aesthetic of each trainer's movements in the performance of a task (Levy, 1990). One movement analyst found a correlation between "time effort" in the trainers with "free flow" in the dolphins. ". . . when . . . (a trainer) . . . incorporates more time in relating to Misty . . . and Natua . . . than he did in working with Natua . . . there is definitely more 'free flow' in the dolphin's movements" (Levy, 1990, p. 51). In other words, when a trainer's attitude toward the dolphin is relaxed, the dolphin's movement also seems relaxed. When a trainer worked with Delphi in "quick time," Delphi responded with less free flow and was more tense.

As I view the canvases, especially Figures 4 and 5, the dolphins' marks seem to be a mirror of the dolphins' reaction to the trainer's movement toward the dolphin. The movements by the trainer may be reflected in the dolphin's painted response to them. The dolphin may experience phenomena similar to a human viewer if the human scanned canvases like a zoom lens advancing and retreating.

Natua and Misty were asked to paint on the same canvas, to imitate a human's painted geometric shapes. In Figure 6, a trainer painted a pink circle. The dolphins attempted to mirror the circle with a series of dots and slashes that form two superimposed circles, a violet one and a green one. When imitating the circle the dolphins would, intermittent with painting, squeal and click as they swam in large circles.

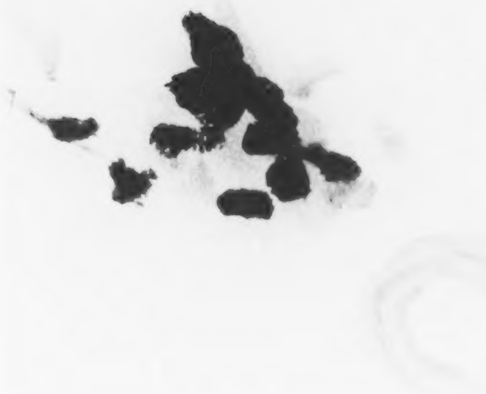


Fig. 6 1989. Fabric paint on canvas, 18" × 24". Left: Dolphin mark. Right: Human mark.

Observations: Unstructured Exercises

In an unstructured exercise, Natua and Misty painted circular shapes (Figures 7 and 8). Both of these painting sessions were recorded on videotape. In watching their movements, the circular shapes seem visually controlled by both dolphins; however, when compared, individual differences are evident. Natua and Misty both painted circular shapes by using a sequence of marks like "connect the dots." However, Natua closed his shape by using slash-marks, whereas Misty used dots to define her shape. Misty, the only female in the study, is the only dolphin who consistently used dot or dab-like strokes; the three male dolphins use slash marks. Further study is needed to determine a possible correlation between sex differences and aesthetic differences in dolphin movement and painting. Vigario, a Laban movement analyst, discusses a possible correlation between movement and sex differences:

> The first thing I notice is that I am seeing more indirecting (a flexible attitude toward space) from her than I saw from the other three dolphins. Could this possibly mean she is more flexible in her approach to life? Is this a feminine trait? My own bias? (Levy, 1990, p. 51)

Delphi and Kibby had a similar painting style. When compared to Misty and Natua, their marks were layered and covered more of the painting surface than did Natua's or Misty's slashes and dabs. Delphi's and Kibby's marks seemed more an extension of gesture, were less developed, and more slash-like than Natua's and Misty's canvases. Unlike Delphi and Kibby, Natua's and Misty's marks suggest form. According to DiLeo (1970), circular forms appear in children's artwork at about age three. Using DiLeo's structure to view the dolphins' artwork, one could speculate that Natua and Misty are the human equivalent of three years of age or older.

Throughout the week of observations, each dolphin repeated patterns of marks. For example, Natua commonly used sweeping petal-like marks. Misty typically juxtaposed a larger cluster of dab-like marks with a smaller one, both located in close proximity to the top edge of the canvas. In two other paintings Misty repeated what appeared to be a human-like form. Kibby repeated an arch-like shape in several paintings. Delphi, in several paintings on

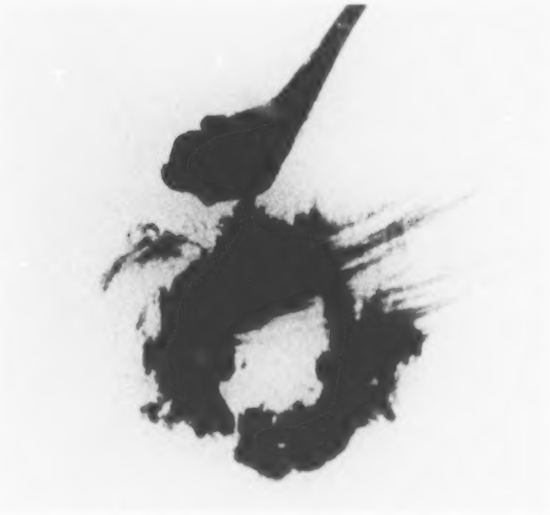


Fig. 7 1989. Fabric paint on canvas. Dolphin marks; spontaneous painting by Natua.

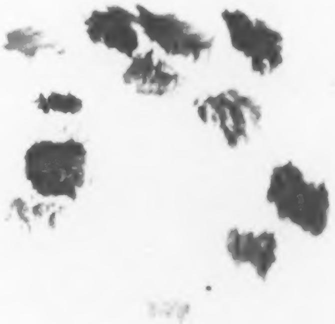


Fig. 8 1989. Fabric paint on canvas. Dolphin marks; spontaneous painting.

paper and one on canvas, repeated three vertical brushstrokes that seemed to hug one side of the surface.

Conclusion

In terms of style, it seemed that each of the dolphins had an individual style of painting; however, a pair of bonded dolphins, Delphi and Kibby, had a similar graphic and movement style and by the end of the week, the female dolphin, Misty, began to mirror Natua's sweeping bold style. The initial observations also suggested that the dolphins looked at the canvas more often than they missed it which may indicate a degree of visual control over their movements. In general, the dolphins used more multiple strokes than single strokes and more vertical strokes than horizontal or diagonal strokes.

I speculate that the dolphins not only imitate their trainers, but may mirror them when performing a task. Mirroring is defined by Stern (1985) as "affect attunement," the reflection of an inner state, the ". . . sharing or alignment of internal states . . ." (pp. 143-144). Mirroring is known to be important to the human infant's sense of self. Through mirroring: ". . . the mother is helping to create something within the infant that was only dimly or partially there until her reflection acted somehow to solidify its existence" (p. 143).

Mirroring is distinct from imitation. Imitation ". . . maintains the focus of attention upon the forms of the external behaviors" (p. 142). (Mirroring or attunement behaviors) ". . . recant the event and shift the focus of attention to what is behind the behavior, to the quality of feeling that is being shared. Imitation renders form; attunement renders feeling" (p. 142).

Michael Bright (1985), in *Dolphins*, suggests an affinity between man and dolphin. "Some claim dolphins have ESP and telepathically understand a man's thoughts and moods" (p. 6). Perhaps what Bright calls ESP is, far more simply and less dramatically, a case of mirroring.

The dolphins' artwork was also compared with early child art development. Dolphins are thought to possess individually distinct whistles which may be used to identify self and neighbor. Young children make marks called "instinctive signatures" (Distler, 1978, p. 12). Captive dolphins that paint may have graphic signatures as well. Unique repetitions of patterns, painting rhythms and distinctive painting styles were found for each dolphin.

Sex differences as seen in the dolphins' painting and movement were also explored. Misty, the only female in the study, used a controlled and contained style of painting. The three male dolphin marks covered more space on the canvases, used bolder marks, were less contained. However, it was impossible to draw any conclusions about sex differences due to the small population sample. Further research is needed in this area as well as the individual graphic style and painting behavior of dolphins in general.

References

Bright, M. (1985). *Dolphins*. London: Multimedia Publications.

DiLeo, J. (1970). *Young children and their drawings*. New York: Brunner/Mazel.

Distler, B. (1978). *Art through the ages and stages of development*. Unpublished master's thesis. Brooklyn, NY: Pratt Institute.

Dolphin Research Center. (1989). *Delphi, Kibby, Misty, and Natua*. Marathon Shores, FL: Author.

Levy, B.A. (1990). *Psychoaesthetics and dolphin personality*. Unpublished master's thesis. Brooklyn, NY: Pratt Institute.

North, M. (1975). *Personality assessment through movement*. New York: Plays.

Robbins, A. (1988). *A psychoaesthetic perspective on creative arts therapy and training. The Arts in Psychotherapy, 15*, 95-100.

Robbins, A. (1989). *The psychoaesthetic experience*. New York: Human Sciences Press.

Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Vigario, J. (1989, January). *Introduction to Laban movement analysis*. Class presented by the Laban/Bartenieff Institute of Movement Studies, New York City, NY.

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 198-200 © AATA, Inc. 1992

Viewpoints

Ritual and Art Making

Ewa Wasilewska, Ph.D., Salt Lake City, UT

In the catalog of the exhibition "Dreams and Shields: Spiritual Dimensions in Contemporary Art," curator, Frank McEntire, frequently refers to similarities between art making and performing rituals (1992). In fact, the process of art making was, is, and always will be associated with specific rituals that are deeply rooted in ourselves and our cultural traditions. These traditions, through their expression, go back to prehistoric times and so-called less complex societies.

In contrast, the modern concept of art, especially of "art-for-art's-sake," is a relatively new phenomenon which surfaced during the last two hundred years. The purpose of art works was not aesthetic in so-called primitive or less-complex societies. Instead, these works were, and are, primarily concerned with practical (from a religious point of view) functions. They were, and are, part of a larger concept, that of ideology, which often was and is equated with religion. Consequently, there would be no religion without rituals because religion, as a concept, may be reduced to two main areas: belief and ritual.

Rituals are absolutely necessary to every religion because they reflect and reinforce beliefs. Anthony Wallace wrote, "Ritual is religion in action" (1966, p. 102). Religious rituals would not make any sense if they were not supported by beliefs which explain, rationalize, and interpret their existence and necessity. On the other hand, beliefs would not make any sense if they were not supported by actions that proved and reinforced them, and, in fact, stimulated them.

The same reasoning can be applied to the concept of art, which can be divided into two main components: the idea to be expressed through art and the process of art making. Here, the art making process is the ritual: art in action. This action would not make any sense if it were not supported by an idea that would explain, rationalize, and interpret the necessity and existence of the whole process of art making. Furthermore, this idea for the final product would not make any sense if it could not be expressed, reinforced, and stimulated by the process itself.

But what is the purpose of rituals? What do people try to achieve when performing them?

In general, the main purpose of each and every ritual is communication between the world of the profane and of the sacred, between the surrounding reality and the unknown, between believers and the object(s) of their beliefs, between public and seemingly unapproachable entities. The reason for this communication may vary from a simple worship intended to bring both sides together, to requests for a better life and its assurance, to requests for wisdom, power, healing. The basic premise of each ritual is that this communication is possible, and through proper performance of a ritual, supernatural powers, the unknown, the unapproachable, can be somewhat "manipulated" by those on the other side. In other words, the sacred can be persuaded to share its knowledge and power.

Any ritual requires the presence of three elements: time, space, and performers. Time for performing rituals may be strictly prescribed among each society: for example, Sunday mass, New Year's, Christmas. A ritual can also be performed in a time of personal and/or social crisis. It often fulfills a need to express one's feelings: for example, in a time of physical or mental sickness, drought, and war. Finally, it can be performed as an indication of an individual's status change within his/her society. These so-called rites of passage are celebrated by all of us, and include graduation, marriage, promotion. Any rite of passage goes through three general stages: separation, transition, and incorporation. These three stages are nothing other than the division of all human actions: separation as preparation: setting up the goal, gathering necessary information and materials in order to perform an intended act properly; transition as the actual performance of this act, ritual in process; and finally, incorporation—the final product, something which is finished, and adds a new dimension to an individual and/or to a group.

Thus, ritual time can be perceived in two ways: as setting aside time for the performance of a ritual and as the division of time with regard to different stages within the ritual itself. In fact, only one of these stages is considered to be sacral. This is the transition stage, the actual performance which connects two worlds: the sacred and the profane. In art, the equivalent is the actual process of art making in which an artist makes the link between the world of reality and his or her ideas set up for communication.

Due to the purpose of a ritual, communication with the unknown, the space that is required for performing a ritual action must be determined, too. This is because during this performance, two worlds, that of the profane and that of the sacred, are meeting. Some rituals, especially those that are performed frequently, may require permanent structures such as modern churches, mosques, or an artist's studio. Some other rituals may be performed almost anywhere but the place must be specially prepared for the type of behavior that is included in a planned ritual. But, no matter where this place is, it becomes sacred during the actual performance of a ritualistic act simply because the powers are there. In many cases, a space becomes sacred forever as a final product of specific rituals. Here, we can use again the example of modern churches that are consecrated through special rituals as well as art works that are the result of the ritual of art making. A specific communication between different dimensions can be repeated each time these spaces and objects are approached. They emanate their "sacrality" since this link between the sacred and the profane is enclosed within their boundaries.

Finally, performers are necessary for each ritual. The number of performers may vary due to the type of ritual, tradition etc. There are always special people who can make this communication possible. Such people are more qualified to establish the contact between the world of the profane and the one of the unknown. They can be born with such powers or educated in order to establish them. They can properly prepare the rituals and interpret their performance as well as their results. According to Ellen Dissanayake, "There is no appreciation of art without interpretation" (1991, p. 19). Thus, the role of special performers and religious functionaries can be easily ascribed to artists. Religious practitioners who specialize one way or another in mediating the relations between people and their supernatural/spiritual/unknown world, generally can be divided into two categories: shamans and priests/priestesses. Shamans engage in practices relating to individuals; that is, they are curers who use supernatural powers. Priests are religious functionaries who serve a group's ritual activities. Sometimes both roles may be played by the same person. This double role is often played in modern societies by artists, who are both curers and vehicles for transmission of the past, the present, and the future, through the rituals of art making.

The comparison of artist with shaman is well founded. A shaman is a religious practitioner who has power to contact the supernatural, i.e., the world of the unknown. Artists are spiritual, whether secular or religious, practitioners, who have power for creative expression that connects various dimensions both in time and space. A shaman's powers come from a personal experience such as a soul loss or even education toward this "profession." An artist's ability to express his or her self and the surrounding world originates from very similar sources. And, finally, a shaman performs various ceremonies, mostly curing rites, during which he or she puts himself/herself into a trance state. That is exactly what art performers are doing. In order to communicate with two worlds, they have to put themselves into a sort of trance.

Artists are curers, too. Art therapy interventions can easily be included in this category of rituals whose goal is to maintain human health. In the modern Western world, most of us will ascribe our health miseries to natural causes or bad luck. Because of our medical knowledge we believe that we have the means to deal with most sicknesses and that we can explain their natural source. However, many other, often considered less-complex, societies do not look at the matter of their own health this way. Sometimes so-called natural causes seem not to exist. The causes of illness and death are often seen in the actions of other people (e.g., evil eye, witchcraft, voodoo), or supernatural phenomena (e.g., offending a spirit).

In spite of these cultural differences, the treatment is rather similar in both cases. First, the cause of the disease has to be found and made objective, so a proper cure can be chosen. Here, a shaman-diviner is a big help. If a sickness is caused by magic, a more powerful magician, sorcerer, or shaman is sought who can perform the magical rituals required to heal a patient. When illness results from a human action such as offending a spirit, undoing this action is the cure. Also, there is possession which is the cause of mental illness and can be cured only with the help of exorcism. Of course, everybody knows that instead of battling and/or driving the disease out, it is much better to take preventive action such as wearing a talisman or amulet or constructing special charms. In the modern world this might take the form of quitting smoking or having your mammogram at the proper time. But, no matter what the cause, a shaman is the one who provides a satisfying cure. The cure is suggested or revealed to him during special rituals that are focused on proper communication with spiritual forces.

Apparently, shamans are successful in their healing practices. otherwise their advice would not be sought. However, from a medical point of view, often their identification of the causes for various diseases is absolutely wrong. Thus, it seems that the main function of a shaman during rituals of therapy and anti-therapy is to convince a patient that he or she can be cured through and thanks to the ritual itself. Such a realization is possible due to the presence of a deep belief that contact with the unknown world was made, and the wisdom of the past, the powers of the present and the hope of the future will come together through the shaman and his/her work. Shamans help their patients to express themselves through direct or indirect participation in the ritualistic act, thus making them feel better by bringing more understanding to their actions.

Isn't that what art therapy interventions are all about? Through the process of art making, which is the equivalent of ritual, an artist and/or art therapist, as a modern shaman, helps people to express themselves and to release their deeply encoded emotions, sometimes even fears, in art forms. These may take forms that the client never before thought about. As modern shamans, artists connect the past, the present and the future through their art making. This is a ritual of communication between the artist's or patient's conception of the surrounding world (the world of the profane), and its perception expressed through its material "recreation" (the world of the sacred). Finally, artists and their works, as well as shamans, are not easily comprehended by the "profane" public, although they are admired for their ability to communicate with the unknown. We seek their works when we want to understand ourselves; we seek their works when we need visual, vocative, or musical expressions of the surrounding world. We seek them to teach us how to express ourselves; we seek their help when we are down, and enjoy their works when we are happy.

Today, we need artists with their rituals as much as so-called "primitive" societies need their shamans. Without them our world would be limited to the profane domain of the present. With them, we can cross boundaries and learn more about ourselves and our heritage from both the past and the future. As long as we do so, we are living in the human world which is continuously perceived, in spite of scientific achievements, the same way as in the eyes of "primitive" societies: in the world in which

> . . . all things, real and ideal, of which men think [are classified] into two classes or opposed groups, generally designated by two distinct terms which are translated well enough by the words profane and sacred. (Durkheim, 1972, p. 29).

In such a world, there is, and always will be, a place for the shamans and/or artists who can help us to bring our "sacred" selves to the every day "profane" world. And this is what makes us all so human.

References

Dissanayake, E. (1991). Art for life's sake. Address to National Art Education Association Convention.

Durkheim, E. (1972). The elementary forms of the religious life. In W. A. Lessa & E. Z. Vogt (Eds.), *Reader in comparative religion: An anthropological approach.* (pp. 28-36) New York: Harper and Row.

McEntire, F. (1992). *Dreams and shields: Spiritual dimension in contemporary art.* Provo, Utah: PROLITHO.

Wallace, A. (1966) *Religion: An anthropological view.* New York: Random House.

Acknowledgements: The author wishes to thank Jennifer Graves for reading and editing the text.

Associate Editor's Note: This paper was the Keynote Address at the opening of the exhibit and conference "Dreams and Shields: Spiritual Dimensions in Contemporary Art," 1992, Salt Lake Art Center, Salt Lake City, Utah.

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 201-202 © AATA, Inc. 1992

Reviews

Homo Aestheticus: Where Art Comes From and Why

Ellen Dissanayake, New York: The Free Press, A Division of Macmillan, Inc., 1992.

295 pp., 17 black and white photographs. $24.95 cloth. ISBN 0-02-907885-7.

Reviewed by **Elizabeth (Liz) Ratcliffe, M.S., M.F.C.C., A.T.R.,** Book Editor

Ellen Dissanayake's book is one of the most stimulating and exciting that I have read in a long time; also, one of the most scholarly and difficult to encompass. Her style is complex and dense, her material vast, and her references (chosen as authoritative backup for her radical thesis), nearly overwhelmed me by virtue of the fact that I was not acquainted with either the authors named or their work. In spite of the above, I highly recommend this volume for its brave new adventuring. Under her stewardship, we go into the unchartered waters of late 20th Century confusion, the result of the age of left-brain, literate, rational thought. Dissanayake explores new ways of seeing the significance of art-making behavior in our evolutionary process; she even suggests there may be hope for the future of humankind.

Embedded in her title, *Homo Aestheticus*, lies the meaning of her thought-provoking thesis: just as our biological species has been described as *Homo sapiens*, *Homo erectus*, and *Homo faber*, human beings are biologically endowed with aesthetic abilities, and could, therefore, be called *Homo aestheticus*. Similar to the species' unique evolutionary development attributed to possessing a large and complex brain, an upright stance and tool-making abilities, aesthetic ability has played an important part in our evolution since we emerged from pre-history's darkness 40,000 years ago.

Dissanayake writes from the perspective of ethology, a branch of anthropology which studies animals in their natural habitat in order to understand what traits and behaviors have brought about their evolutionary adaptations. Her focus on *Homo Aestheticus* is on the human animal and how certain universal human traits and behaviors have contributed to our present level of civilization. Contemporary scholars acknowledge that throughout their existence, species *Homo sapiens* has exhibited art-making behaviors. However, the author tells us that although she consulted twenty-four of the "most acclaimed, comprehensive, or otherwise most noteworthy books on human behavior written or edited during the past twenty years by professional academic ethologists, anthropologists, sociobiologists, and others" (p. 9), only seven gave serious space in their texts to a consideration of the role of the arts in human evolutionary change.

Throughout the book, Dissanayake springboards the reader into the deep seas of her provocative ideas by interweaving and elaborating upon research from many related fields. The table of contents lists seven chapters, headed by such inviting titles as *Why Species-Centrism?; Biology and Art: The Implications of Feeling Good; Dromena: Reconciling Culture and Nature; "Empathy Theory" Reconsidered: The Psychobiology of Aesthetic Responses* and *Does Writing Erase Art?* Step by step, the author unravels her unconventional thesis. She says that it is through the making of art (in one form or another), that, when faced by unpredictable natural or human disasters, early human creatures were able to transform their feelings of overwhelming chaotic confusion into useful and good feelings about their own ability to surmount threatened catastrophe.

In the first chapter, Dissanayake introduces "species-centrism," which she tells us she will be using interchangeably with "Darwinism." In her usage, both terms refer to Darwin's original 19th Century theory of natural selection, rather than to the modern "Social Darwinism." The latter emphasizes the importance of cultural influences in the resulting differences among human beings. Her differentiation between the original century-old theory and its modern interpretation is based on her thesis: all humans are more alike than different, and our evolution as a species unifies us as much or more so than our cultural differences divide us.

Chapters on "Making Special" and *Dromena* present the reader with the author's belief that universal human predispositions exist for making art and creating rituals. These have contributed to the survival of our species. In contrast to other species, early *Homo sapiens* (or *Homo aestheticus*) decorated their pots, their homes, themselves as ways of "making special," and transforming everyday ordinary reality into extra-ordinary. The Greek word *dromena* means ritual or "things done." By creating ceremonial rituals (which involved actively doing things as a group), early humans were able to transform untidy Freudian primary process feelings of powerless insignificance into a heightened sense of transcendent oneness and *communitas* or tribal merging. Aesthetic experience, even today, often involves a sense of boundary dissolution and reunion with "the other." The author sees this inborn ability of humankind as providing the sense of being able to control disorienting emotions or disturbing events, rather than just blindly reacting to them.

In *"Empathy Theory": Reconsidered*, she discusses some of the recent neuroscientific findings on how people perceive, think and feel, which seem to indicate that empathy involves a physical body-mind experience. Conceding that the research in this new and complex field is, as yet, marked by controversy and disagreement, Dissanayake states:

> The presumption of a nonspecialist who chooses to graze among competing theories may seem rash to specialists in the midst of the research who are aware of the difficulties. . . . (However), I believe that (my theory) will eventually fit coherently into the total puzzle and thus substantiate my belief that the kinds of feelings comprising aesthetic empathy arise from our natural being-in-the-world and thus have a "natural history." To biologists, such a statement will be self-evident. But nonscientists have probably never even considered the matter. Therefore, I invite them to think in a new way about how the arts, using our sensory-cognitive-emotional equipment, access and express the world and ourselves in it. (p. 148)

Contrasting with her impressive valuing of humankipd's aesthetic endowments is Dissanayake's evaluation of modern and post-modern over-refined reliance on hyperliteracy. She points out that over the 40,000 years since human beings emerged, there have been some 1600 generations. About 4000 B.C., some 150 generations ago, pictographs were invented for special groups, like priests and scribes, to preserve records and enforce laws. However, it was only twenty generations, or 500 years ago, that the invention of the printing press provided the possibility that reading and writing could play a significant role in general society. By necessity, when preliterate people communicated, they were in face-to-face contact with each other. Oral communication permits personal communion and a sense of shared experience. In today's world, where so much communication is done on the printed page, detachment and isolation are promoted. The neatly separated words are only references for something other than themselves. As readers shut themselves off from other living beings, loneliness and anxiety beset the human spirit. In our literate, post-modern era, with its stress on intellectual and technical advancement, knowledge replaces belief and impersonal exactness replaces warm, messy human interaction and emotional commitment.

In spite of Dissanayake's dour views on how post-modern hyperliteracy, technology and commercialism have eroded and erased the intrinsic valuing of art and art-making, her theory of biological, species-centered aesthetics, seems, in the end, to provide a potentially hopeful beam of light. She says,

> Perhaps it is (with) these precultural needs—for community and reciprocity, the extra-ordinary and transcendent . . . for attachment and bonding . . . that art is, and must in the West start again to be concerned: with what is not accessible to verbal language . . . but nevertheless exists to be perceived by nonverbal, nonliterate *pre*modern ways of knowing. (p. 215)

Among those of the healing professions who read this book, it seems to me that it is the art therapist who will most truly understand, through what the author calls "premodern ways of knowing." By this, Dissanayake means art's potential for binding up the gaping wounds inflicted on humankind by the evils of modern technological living.

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 203-206 © AATA, Inc. 1992

The Aesthetic Experience: An Anthropologist Looks at the Visual Arts

Jacques Maquet, Ph.D., New Haven: Yale University Press, 1986.

272 pp., 167 black and white illustrations, $19.95 paper, $45.00 cloth.
ISBNs 0-300- 04143-9 pbk., 0-300-03342-7 cloth.

Reviewed by **Patricia St. John, Ed.D., A.T.R.**, Associate Editor,
New Rochelle, NY

One of the inherent difficulties of aesthetics, and specifically, in building aesthetic theory, is that what is put forward as "art" by critics, galleries, or government grants, is forever in flux. German philosopher Alexander Baumgarten first used the term in 1744; he was referring to "the science of the beautiful." Formerly, the Greeks had used it *(aesthetikos)* to mean "pertaining to sense perception." Today, it means simply "having to do with art" or "What is art?" (Crawford, 1987, 1991, p. 18). Margaret P. Battin (1986; 1991) reflects that the task of aestheticians is to examine "art and beauty" (p. 50), but the result often makes for "dreary" reading about a field that is ambiguous and constantly changing. Typically, to present a new aesthetic theory, the aesthetician will examine existing theory, pointing out deficiencies, articulate the new theory, and cite to works of art or experience with art objects to confirm the new claims (Battin, 1991, p. 51)—or, in short, explication and destruction, construction, and confirmation.

Anthropologists have other methods that they bring to their work. Anthroplogy is "the science that deals with the origins, physical and cultural development, racial characteristics, and social customs and beliefs of mankind" (*The Random House College Dictionary*, 1975, p. 57). Its research methods follow the format of construction of theory, development of hypotheses, and testing of the hypotheses by observation. Aesthetic anthropology, according to Jacques Maquet, "is in continuity with anthropology as a social science and as a discipline of the humanities" (1986, p. 243). His ideas go back some years when he was studying traditional African Art. He used typical anthropological questions to discover aesthetic properties:

> What were the functions of the stunning Baga headdresses, the elegant Baule figurines, or the impressive Dogon statues in the societies in which they had been carved? Were they only perceived as ceremonial objects by the members of these societies, or were they also considered art objects by the users? Why were the Bambara and Senufo styles of sculpture different when Bambara and Senufo, both millet farmers, lived in similar environments and in the same region? I approached African artifacts as cultural phenomena, and it proved to be a fruitful perspective. (1986, p. 2)

His inquiries into "anthropology of art, art and culture, and cross-cultural aesthetics" were published in his *Civilizations of Black Africa* (1972a, French ed. 1962).

The differences among aesthetics, anthropology, and aesthetic anthropology come from the placement of art or aesthetic objects within the context of the culture while looking at them as would an anthropologist. Art is not separated out of context, nor are objects considered without recognition of their aesthetic importance or value to the society.

In *The Aesthetic Experience*, Maquet guides us into this new discipline through his first-hand experience with aesthetic objects—objects that may be termed art or artifacts. The resulting text is a long, complex essay abundantly illustrated with nearly every object discussed. In fact, we see his personal collection of photographs of art works and artifacts throughout the book. Likewise, the text is a lively, often personal description of his encounters with, for example, a ritual figurine from Teke, Congo, a cup from Kuba, Zaire, Piet Mondrian's *Broadway Boogie Woogie* (1942-43), or the startling photograph by Robert Capa, *Death of a Republican Volunteer, Spain* (1938).

The book is divided into three sections: "Art in Human Experience," "The Aesthetic Object as Symbolic," and "The Aesthetic Object as Cultural." In the first section he asks the questions, "What is art and what is the experience of it; what is contemplation and how does it differ from cognition and affectivity?" (p. 242). Anthropology, like art therapy, is an interdisciplinary field. Aesthetic anthropology extends the scope of inquiry, integrating, for example, law, philosophy, sociology, Marxism, Freudianism, existentialism, phenomenology, surrealism, counterculture, and consciousness movements. Maquet also claims that living during the 20th century has shaped his questions, exploration, and conclusions. Like art therapists, he says: "Anything that is relevant should be taken into account" (p. 1).

The "field," we find, is determined by the culture. If we are looking at art in Los Angeles, we consult the yellow pages, radio and television to determine what is meant by "art" in everyday reality. Likewise, we apply this approach to every time and culture. What is an "art object" to the Cokwe of Angola? A parallel term is *hamba*, meaning a category of material things which are valued (p. 17).

What is it that makes us value an object? It is something in the composition that strikes the viewer. When we are in an art museum, we say to our companion: "This painting is art, I mean good art. I don't know why this other painting is here; it is not art!" Maquet holds that an internal awareness of what is "good" and "not good" is intrinsic to all human beings, across time and cultures.

To explore this question further, he asks, what experience do you have when looking at an art object? He describes his encounter with Alexander Calder's *Les Renforts* (1963):

> . . . I first saw the stabile from a distance. It is erected among trees with a light-colored foliage—silver birches, I believe. There stood huge, nonfigurative forms in black steel plates, very much in contrast to the green and sunny environment. Their presence imposed on my attention. Moving closer, I stopped where I could best see the stabile and I looked at it for some time, not being aware if the time was short or long. Later, I did not remember if I was standing or sitting: I was just looking. The image of the stabile is very clear in my mind; I still see the general shape as well as some details of the metal surface. Though I was looking with intensity, I did not try to analyze the different shapes of the plates, nor to figure out the height or the weight of the stabile. In fact, I did not think at all while I was looking, nor did I pay attention to my companions. I did enjoy the experience, but I became aware of the enjoyment only later, after the actual encounter was over. During the experience, I was not in an introspective mood, and I did not even notice my affective state: pleasure or absence of pleasure. In fact, "I," my usual self, was not in the foregound of my awareness; the visual experience of that sculpture was filling all my consciousness. (p. 29)

Later, he found he had little to say to his companions about the stabile, but he remembered the experience as being very intense and that he had, for some time, been "outside of (his) usual stream of thoughts, worries, and feelings" (ibid). He recalled the emotional impact of the sculpture: "powerful, but latent and contained, energy . . . a non-threatening force, friendly, reassuring, not explosive or destructive" (ibid). In preparing his text for this book, he discovered the title of the stabile, which translates to "the reinforcements" (ibid).

Anthropologists intellectualize their experience of viewing objects. It can take the form of making notes, sketches, reasoning and analyzing, very much as do art historians. Maquet looks at old snapshots differently from, for instance, the way he looks at a map of Los Angeles, searching for a street. So do all of us. With these examples, he demonstrates that the "aesthetic experience" is different from "just looking." It is closer to the Eastern idea of meditation and contemplation. It has potential to help us separate art objects from non-art objects, by making us aware that some objects hold our attention for a long time and others do not. If we doubt our experience, we can check with authorities: art critics, gallery dealers, collectors and the listing of government grants to artists.

Part Two further explores this experience by searching for meaning in art objects and artifacts. The example of old snapshots is problematic. While the photographs hold a lot of meaning for me, the composition is not particularly aesthetic. You look at the snapshots and find no meaning. The difference lies in the universal quality of the experience. There must be meaning for more than just me. Aesthetic objects are "symbolic." They have meaning besides what they represent. Maquet demonstrates this by looking at Mondrian's ***Broadway Boogie Woogie***. Literally, it is a composition of horizontal and vertical bands of color, intercepted with small squares of color and peppered with larger rectangles of color. Everything is at right angles. It looks busy but orderly, like a grid map of city streets. As with the Calder, Maquet was captivated by the painting. The aesthetic experience was the result of his associations to the lines, colors and energy of the painting. It corresponded to a part of his own life experience in Manhattan, at 42nd Street, and his discovery of jazz. These forms, not a photograph or photorealistic painting, elicits meaning in this painting. He uses this, and many other examples, to demonstrate the place of meaning in aesthetic experience.

A second point, equally important to understanding aesthetic experience, is that it requires the viewer to be ready for an "aesthetic encounter." By this he means, ready for contemplation of the object. We have all experienced the need to change our attitude when entering an art museum or gallery. We prepare ourselves by slowing down and assuming an attitude of receptivity. Maquet describes the actual face-to-face encounter between viewer and object as detached or disinterested concentration on the object. This state is similar to what happens during the therapeutic process when the therapist allows herself to "merge" with the client as a method of gaining empathy. She then disengages, returning to herself as a disinterested (objective) listener or observer. Similarly, it happens in the process of making art: we merge with our painting or collage or sculpture, and then disengage, step back, and look at it. If it "looks good," we continue working.

The theme of meaning in aesthetic form is explored in his discussion of aesthetic quality. Some objects are more compelling, more full of meaning, than others. What is the meaning in Pablo Picasso's ***Guernica*** (1937)? Does it come through with compelling force? Maquet believes that aesthetic excellence is determined by the degree of ". . . internal congruence of forms, with the strength and clarity of expression, and with the presence of the object which compels and sets it apart" (p. 142). This reflects Edith Kramer's criteria for "true art": inner consistency, economy of form, and evocative power (1971, p. 67).

Part Three, to my mind, is Maquet's most illuminating chapter for the non-anthropologist. Titled "The Aesthetic Object as Cultural," it discusses aesthetic form within the context of the societal group. Three levels of culture are considered: the material culture, the social culture, and the mental culture.

An example of material resources is wood (trees). The objects made from trees will be oriented vertically, have vertical linear designs, grouped in a symmetrical composition. In a pre-industrial society, tools limit and determine the types of designs that can be carved into the surface. Techniques for production will be limited, and these will be produced by few craftsmen. Few objects will be made, but each will be relatively unique, for example, totems. In contrast, in an industrial society, where many materials are available, many tools are used, and production is abundant, the use of machines will yield uniform, mass-produced objects. Consider the impact of new materials on aesthetic forms and shapes. When acrylic paint became available, artists were able to exploit its quick drying and malleable properties to experiment with color in new ways. The earlier restrictions of oils to line, shape, texture and light and shade diminished in importance. Compare a Rembrandt with the color staining of Helen Frankenthaler. Compare a Michelanglo marble with a David Smith welded steel.

The material culture (what materials are available and are used) have an impact on the social culture, and this, in turn, influences mental (or, here, aesthetic) culture. Maquet cites the work of art historian, Jean Laude (1971), to demonstrate the intimate connection among material, social, and mental (aesthetic), cultures. Laude compared carved wood doors of the Dogon, Senufo, and Baule to molded or cast bronze plaques of the Dahomey and Benin. The Dogon, Senufo and Baule doors are characterized by "a nonsequential (placement) of figures carved on the surface, and an absence of depth," (pp. 232-234) and low relief. The Dogon, Senufo, and Baule groups were farmers, maintaining a subsistence level of production (they produced only for themselves), lived in small villages ruled by a lineage of patriarchs which was determined by kinship and descent. The Dahomey and Benin bronze plaques are characterized by a sequential representation of historical events, and an attempt to render perspective by the use of high relief and "by placing the more distant (figures) at the higher part of the plaque . . ." (p. 234). The Dahomey and Benin lived on large plantations ruled by powerful rulers, a government based on power and coercion, and a surplus economy based on long distance trade networks and economic prosperity. The relationship between aesthetic object characteristics and the material, social, and mental culture is not accidental. The two, Maquet asserts, are intimately bound together.

This complex, provocative book challenges us to think about ourselves, our culture, and certainly, other cultures. At a more intimate level, it allows us to examine our own involvement in the aesthetic experience and process, whether as artists, viewers, or art therapists. In its broadest sense, it impels us to take the anthropologist's objective, observational stance when we are encountering other cultures. In many ways, the joining of aesthetics and anthropology parallels the art therapist's clinical methods, and demonstrates research methodology we can apply to our work.

Maquet's well reasoned explorations into aesthetic process, meaning, and a culture's impact on aesthetic objects, demands many readings. The book has only two drawbacks: first, although many examples of art and artifacts are pictured and described, few are by women artists. Second, Maquet's use of jargon, and some invented words, can be confusing and "dreary." However, the copious use of examples and art objects combats this tendency, creating an exciting, dynamic presentation. Despite these criticisms, I strongly recommend this book to all who seek to better understand their own aesthetic experience, that of their culture and the cultures of others.

References

Battin, M. (1986). The dreariness of aesthetics (continued) with a remedy. *Journal of Aesthetic Education, 20,*(4), 11-14.

Battin, M. (1991). Case problems in aesthetics. In R. A. Smith and A. Simpson (Eds.) *Aesthetics and arts education*, (pp. 50-54). Chicago: University of Illinois Press.

Kramer, E. (1971). *Art as therapy with children*. New York: Schocken Books.

Laude, J. (1971). [French ed. 1966] *The arts of Black Africa*. Berkeley and Los Angeles: University of California Press.

Maquet, J. (1972a) [French ed. 1962]). *Civilizations of Black Africa*. New York: Oxford University Press.

Related reading

Fisher, J. L. (1971, 1961). Art styles as cultural cognitive maps." In C. F. Jopling (Ed.) *Art and aesthetics in primitive societies*. (pp. 171-192). New York. E. P. Dutton.

Parsons, M. J. (1987). *How we understand art: A cognitive developmental account of aesthetic experience*. New York: Cambridge University Press.

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 206-208 © AATA, Inc. 1992

Video Review

Psychoaesthetics Dolphin Project

Barbara Ann Levy, M.F.A., M.P.S.

Produced and directed by **Barbara Ann Levy**, 1990. Edited by **John Ricardo**. Sound by **Scott Wynn**. 5 minutes, color. Purchase only: $50. Available from: **Barbara Ann Levy**, 140 Charles Street, Apt. 16E, New York, New York 10014.

Reviewed by **Linda Gantt, Ph.D., A.T.R.**, Bruceton Mills, WV

In 1989, Barbara Levy spent a week conducting pilot studies with four Atlantic Bottlenose dolphins at the Dolphin Research Center at Marathon Shores, Florida. This brief videotape shows snippets of "art" sessions conducted three times a day for approximately 30 minutes during which dolphins were given paintbrushes loaded with paint. The dolphins were asked to copy shapes and to make free-form marks on various drawing surfaces including canvas, paper, and T-shirts stretched on a frame which the trainers held at an angle over the pool.

The entire tape (with the exception of a quick pan of the researchers and trainers and a visual sweep of some completed canvases) consists of scenes in which the dolphins perform according to their trainers' commands. A voice-over narration by Ms. Levy describes the various experiments and the type of data she and others collected. Some of the scenes are played in slow motion when she describes the possible correlation between dolphin and trainer movements. At these points the videotape becomes blurry, a probable result of the slower speed but nonetheless a distracting technical glitch.

Two basic types of exercises (copying specific geometric shapes and "free style" painting), with experimental variations, were given to the dolphins. Ms. Levy studied the resulting "paintings" and at the end of the week discussed the dolphins' personalities with the research center staff. Two movement analysts used Labanotation to describe and quantify the movements of both trainers and animals. This system of movement notation, first published by Rudolf Laban in 1928, is widely used by a variety of movement researchers including dance therapists. Some of the variables analyzed under this system are termed weight, shape, time, effort, and flow (Laban, 1974). Labanotation makes it possible to construct a permanent record of any movement event, to quantify it, and to compare it with other such events.

At the end of the tape Ms. Levy comments, "The findings suggest the dolphins looked at the canvas more often than they missed it which may indicate visual control over their movements. They used more multiple strokes than single strokes, and more vertical strokes than horizontal or diagonal strokes." (I wondered if the vertical strokes might possibly be an artifact of the way the canvas was held or the manner in which dolphins must partially rise out of the water in order to reach the canvas.) Ms. Levy concluded that the painting dolphins might have "graphic signatures" like those of children. "Unique repetitions of patterns, painting rhythms, and distinctive painting styles were found for each dolphin." The veracity of this statement must be taken for granted by the viewer since the narrator gives neither supporting data nor an indication of how the styles were classified (ex., whether people who did not see the dolphins paint could match the paintings to a particular dolphin). Also, Ms. Levy contrasts the painting styles of the three males with the one female. However, I felt that this sample was too small to permit such generalizing about sex differences. Perhaps the differences were due to age, previous training, or some other variable rather than sex.

Along with the videotape I was given a paper which elaborated on the research project (which also was the subject for Ms. Levy's Master's thesis). The narration was excerpted from this report. Given the brevity of the tape, much information such as the background of the dolphins, the number of paintings analyzed, and a graphic description of the majority of the paintings was omitted. Also missing from both the videotape and the paper was any definition or explanation of the term psychoaesthetics. It was unclear to me whether the paper was intended to be a companion to the videotape or the tape was designed to stand alone.

I found the dolphins' behavior intriguing—they did indeed seem to be making purposeful movements with the paintbrushes. However, there is no information given on how this behavior was initially shaped. (I presumed that the animals were rewarded with fish from the buckets sitting on the dock next to the trainers and that behavior from previous training routines had been incorporated into the art making process. But, this was not explicitly stated.) Especially fascinating to me were two small sequences—one in which a trainer presented a canvas with a black circle to a dolphin who then swam in a circle holding the paintbrush aloft and one in which a dolphin made a slight lateral roll and bubbled air out his/her blow hole. I was reminded of a child playfully experimenting with various sounds that could be made by blowing air through water.

Despite my interest in seeing the actual behavior (how many art therapists will ever get the opportunity to work with such a special group of intelligent non-humans?) I cannot recommend this videotape to others. The problems are two-fold: (1) technically, it is unfinished, and (2) it provides no context for understanding the import of such proto-art behavior. There is no formal introduction or conclusion, no titles or credits, and no change of pace or view (such as showing the narrator's face or using different camera angles) to set off the central points. The narration seems divorced from the visual material. Furthermore, it is impossible to tell the intended audience. Was this piece made to show beginning art therapists, other researchers, or the general public? What connection does it have to art therapy theory or research? The videotape does not present enough information for it to be judged as a piece of research since a literature review, explication of the methods, and a detailed analysis of the paintings are missing. Granted, Ms. Levy does state at the beginning that she was conducting a pilot study. But this small vignette is not anchored to

BEST COPY AVAILABLE

larger concepts so that the videotape will be truly useful except as documentation.

There is a hint that the other researchers and Ms. Levy attempted to connect the dolphins' behavior to theoretical issues and to compare the art with that of children. However, Ms. Levy's characterization of the dolphins' duplication of their trainers' movements as "mirroring" seems tenuous at best. She states "I speculate that the dolphins not only imitate their trainers but may mirror them when performing a task" and that Stern (1985, p. 143-144) defines "mirroring" as "affect attunement"—the "sharing or alignment of internal states." Here Ms. Levy goes too far afield. I do not see that the substitution of "mirroring" for imitation adds anything to the understanding of the animals' behavior and, in fact, may serve to cloud some important issues by unnecessary anthropomorphizing. To guard against such a tendency is the most difficult aspect of any study with intelligent mammals (and I must admit that some people may charge that my description of the dolphin appearing to be experimenting with making sounds falls into that very trap).

As it stands now, this videotape resembles a stone that might be used in a piece of jewelry. However, it is neither polished nor properly mounted. A proper setting would place it within the matrix of other work on the biological and adaptive precursors of art and art-like behavior (Alland, 1977; Dissanayake, 1988; Morris, 1962) for it to have any implications for art therapists. Such comparative work, not only with animals but with other cultures and other ages (such as Dissanayake's article in this same issue), is vital and must be encouraged. But in addition to the problem of anthropomorphizing, there are technical difficulties to consider. For example, since the dolphins must hold large brushes in their mouths, they are hampered by the lack of real control over the brush. In the videotape one can see what appear to be purposeful strokes mixed with what appear to be accidental ones. Was the second type of stroke coded differently in the analysis of the end product? Also, the trainers did not seem to be consistent in the manner in which they held the canvasses over the water and one could not tell from the brief segments how a trainer knew when a picture was finished. All of this leads to problems with scoring, interrater reliability, and proper interpretation. The use of Labanotation obviates some of these troubles when studying movement and similar rating instruments could be developed for the art.

I find this preliminary work reminiscent of the early attempts to teach oral speech to chimps. Until researchers finally realized that primates lacked certain vocal apparatuses necessary for the range of phonemes required for human speech, these experiments were doomed to failure. When they began teaching the animals sign language, they were successful (Harris, 1980, p. 83). Perhaps there are better methods of finding out what dolphins can do with art and/or symbolic communication without inadvertently introducing unwanted artifacts. I hope Mr. Levy will refine her methods, do some further work, and present them in a better setting.

References

Alland, A. (1977). *The artistic animal: An inquiry into the biological roots of art.* Garden City, NY: Doubleday (Anchor Books).

Dissanayake, E. (1988). *What is art for?* Seattle: University of Washington Press.

Harris, M. (1980). *Culture, people, nature: An introduction to general anthropology* (3rd ed.). New York: Harper & Row.

Laban, R. (1974). *The language of movement: A guidebook to choreutics* (L. Ullman, Ed.). Boston: Plays.

Morris, D. (1962). *The biology of art.* London: Metheun.

Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology.* New York: Basic.

Associate Editor's Note: Dr. Gantt makes her observations and evaluation of this unique video from the perspective of her expertise in Communications and Anthropology. She received her doctorate in Interdisciplinary Studies from the University of Pittsburgh.

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 209-210 © AATA, Inc. 1992

Noteworthy

The Art of Healing Trauma

The Southern California Art Therapy Association (SCATA) in association with the City of Los Angeles Cultural Affairs Department has created a monograph titled "The Art of Healing Trauma: Media, Techniques and Insights." This publication was produced both in response to the Los Angeles riots in April 1992 and also as a guide to the appropriate use of both art products and processes with people in crisis.

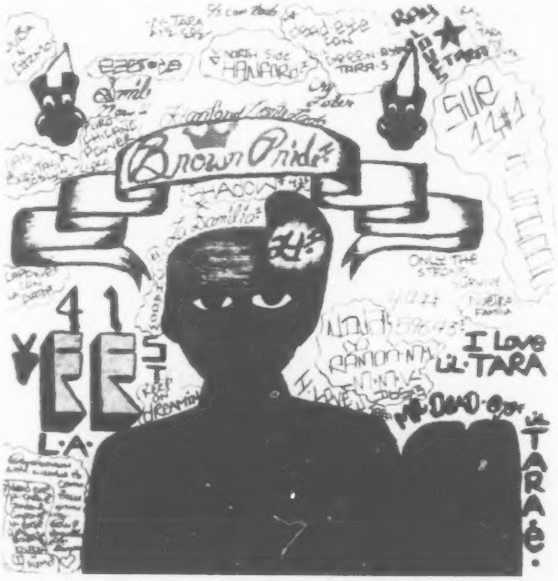
Geared to elementary and secondary classroom teachers, this monograph takes a proactive stance in promoting the value of art therapy by sharing basic information on media, process and materials used in art therapy. A chart on the possible psychological effects inherent to art materials is featured in a concise and attractive format. Cautions are offered throughout the text to emphasize the inappropriate use of the art process and image interpretation. General suggestions are also given for how to accept and respond to art images, what to note in the art product, and how to support the process of recovery from trauma.

The monograph was prepared by Evelyn Virshup, Ph.D., A.T.R., SCATA President, Shirley Riley, M.A., M.F.C.C., A.T.R., and Dorothy Shepherd, M.A., M.F.C.C., A.T.R. Additional copies are available from the Southern California Art Therapy Association, Box 4455, Sunland, CA 91041-4455.

The Art of Healing Children

"The Art of Healing Children" is an art engagement calendar which features the images and poetry of children who have participated in a joint venture between the Napa State Hospital Children's Art Therapy Program and the Arts in Mental Health Program. Al Friedman, M.A., A.T.R., Coordinator of the Children's Art Program and Sally Denman, M.A., A.T.R., Artist Facilitator with the Arts in Mental Health Program, have spearheaded this project for the last several years, demonstrating a unique collaboration between art therapists and artists-in-residence. The calendar has received critical acclaim throughout California, highlighting both the emotional power of the children's work as well as the importance of the arts and art therapy in the children's psychiatric treatment and education. In a 1991 resolution from the Senate of the State of California, the calendar project was observed to have improved "the children's self-esteem and increased the public's awareness of the benefits of arts and art therapy in treating troubled children . . . and has stressed the important role art therapy has played in treating, educating, and enhancing the children's quality of life."

Funds from the project go to hiring additional creative arts therapists and artists-in-residence to work with the children at Napa State Hospital. In recent years, a poet-in-residence, a Japanese Taiko drummer, a sculptor, an actor as well as an additional art therapist and drama therapist have been hired as a result of the proceeds from calendar sales. Funding sources have included such broad-based support as Chevron, the Gasser Foundation, the Lef



"Brown Pride" by Ray, 17 yrs. and Ramon, 17 yrs.; acrylic and marker on plywood; 48 × 46 in. From "The Art of Healing Children" art engagement calendar.

BEST COPY AVAILABLE

Foundation, Pacific Gas & Electric Company, the Doctors' Company and Beringer Winery.

The calendar now is marketed nationally and is being sold in bookstores throughout the country. It has also been in museum shops such as the Phillips Collection in Washington, D.C., the Crocker Museum in Sacramento, and at the San Francisco Museum of Modern Art where it has been a best seller among engagement calendars. If you are interested in receiving more information about this project or obtaining a copy of the calendar, please contact either Al Friedman, A.T.R. or Sally Denman, A.T.R. at Napa State Hospital, 2100 Napa-Vallejo Highway, Napa, California 94558.

International Networking Group of Art Therapists to Hold First International Conference

The International Networking Group of Art Therapists (ING) was founded in 1989 in San Francisco during the 20th Annual Conference of the American Art Therapy Association as a forum for the exchange of information among art therapists around the world and to encourage professional enrichment at a global level. As a result of this collaboration and the subsequent expansion of the group, ING will hold its First International Conference in Vilnius, Lithuania from September 4-5, 1993. The theme of the meeting will be "Art Therapy/Art Therapists: Cross-Cultural Exchange" to encourage a wide range of topics including media, symbolism, professional practice, ethics, publications, and diagnostic and treatment applications from a variety of settings and theoretical orientations.

Proposals for this conference are now being accepted for review by an international program committee. Proposals must include title, format of presentation; name, address and brief biography of presenter(s); a one-page abstract; and requested time allotment. Proposals or questions about this conference may be addressed to: Isolde Martin, A.T.R., Program Chair, Werstr. 21b, 8059 Oberding-Schwaig, Germany. Art therapists or others interested in joining ING may contact Bobbi Stoll, A.T.R., MFCC, 8020 Briar Summit Drive, Los Angeles, CA 90046.

Editor's note: *Noteworthy* is a new section to the journal whose purpose is to highlight the collective efforts of art therapists and others in successfully promoting and making visible the profession in unique and newsworthy ways.

Call for Submissions to *Art Therapy*

Art Therapy: Journal of the American Art Therapy Association is currently seeking submissions in the form of full-length articles and brief reports on theoretical, methodological, and research for two special theme issues:

1. **Art and Medicine.** Articles may focus on the use of art expression in the assessment or treatment of physical disease; theoretical, ethical, or practical issues in the application of art expression in a medical setting or with physical illness; original research in medical art therapy.

2. **Professionalism in Art Therapy.** Articles may focus on current professional issues in the field of art therapy such as, but not limited to, licensure, credentialling, job development and governmental affairs. Theoretical, historical, methodological, or research articles focusing on these themes will be considered.

Submissions must adhere to the "Guidelines for Submission" which are outlined in *Art Therapy*; please review these guidelines carefully because manuscripts which do not meet these guidelines will be returned to authors without review.

DEADLINE for submission of manuscripts is December 15th, 1992. Please send manuscripts to:

Cathy A. Malchiodi, M.A., A.T.R.
EDITOR/ART THERAPY
℅ AATA National Office
1202 Allanson Road
Mundelein, Illinois 60060

Art Therapy: Journal of the American Art Therapy Association, 9(4) pp. 211 © AATA, Inc. 1992

ANNUAL INDEX: VOLUME 9

Index A. ARTICLES

Allen, P. B. Artist in Residence: An Alternative to "Clinification" for Art Therapists 22

Dissanayake, E. Art for Life's Sake 169

Epperson, J. & Valum, J. L. The Effects of Stimulant Medications on the Art Products of ADHD Children 36

Franklin, M. Art Therapy and Self Esteem 78

Gantt, L. Commentary (on "Art for Life's Sake") 176

Henley, D. Facilitating Artistic Expression in Captive Mammals: Implications for Art Therapy and Art Empathicism 178

Linesch, D. Research Approaches Within Masters Level Art Therapy Training Programs 129

St. John, P. A. Time Series Design Study of Neurologically Impaired Children 67

Speert, E. The Use of Art Therapy Following Perinatal Death 121

Troeger, B. J. Application of Child Art Theories to the Interpretation of Children's Art 30

Index B. BRIEF REPORTS

Levy, B. A. Psychoaesthetics Dolphin Project 193

Silver, R. Gender Differences in Drawings: A Study of Self-Images, Autonomous Subjects, and Relationships 85

Spaniol, S.E. Is There a 'Late Style' of Art? Line Use in Human Figure Drawing by Elderly People 93

Waller, C. S. Art Therapy with Adult Female Incest Survivors 135

Index C. DEPARTMENTS

Viewpoints

Hendel, A. (with M. Levick). Reflections: To Hell and Halfway Back 96

Herl, T. K. M. Finding the Light at the End of the Funnel: Working with Child Survivors of the Andover Tornado, Andover, Kansas 42

Riley, S., Newborn, M., Takasumi, Y. & Walter, J. Art Captures the Impact of the Los Angeles Crisis 139

Wasilewska, E. Ritual and Art Making 198

Book Reviews

McConeghey, H. Art, Culture, and Ethnicity 146

Ratcliffe, E. Creating Mandalas for Insight, Healing and Self-Expression 103

Ratcliffe, E. Homo-Aestheticus 201

Ratcliffe, E. The Well-Being Journal: Drawing Upon Your Inner Power to Heal Yourself 145

St.John, P. The Aesthetic Experience: An Anthropologist Looks at the Visual Arts 203

St. John, P. Mommy, Daddy, Look What I'm Saying: What Children are Telling You Through Their Art 150

Video Reviews

Gantt, L. Psychoaesthetics Dolphin Project 206

Consoli, J. Imagery and Grief Work: Healing the Memory 152

Consoli, J. The Art Therapist's Third Hand—Reflections on Art, Art Therapy and Society 48

Editorials

Malchiodi, C. A. Art and Loss 114

Malchiodi, C. A. Beginnings and Endings 2

Malchiodi, C. A. Introduction to Special Issue: Biological and Anthropological Bases of Art Expression 166

Malchiodi, C. A. Writing About Art Therapy for Professional Publications 62

Special Features

Agell, G. Elinor Ulman 12

Gantt, L. In Memory of Elinor Ulman 6

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

COLOR RATES: Standard Red, Blue and Yellow
(Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x	4x
Per page additional	$90	$85	$80	$75

INSERTS	1x	2x	3x	4x
2 pp	$ 800	$ 700	$ 575	$ 425
4 pp	1,500	1,300	1,150	1,000
8 pp	2,200	2,000	1,750	1,450

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-page Horizontal	7"	4-7/8"
Half-page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"
Bleed Size: 8-5/8" × 11-1/4"
Inserts: 8-5/8" × 11-1/4"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue, July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

THE AMERICAN ART THERAPY ASSOCIATION, INC.
23RD ANNUAL CONFERENCE
The Art Therapist:
Artist, Teacher, Clinican, Healer
November 4-8, 1992 • Las Vegas, NV
AUDIO CASSETTES AVAILABLE

- ☐ 1. Artist, Teacher, Clinician, Healer: Advancing the Dialogue, M. Lachman-Chapin, MEd, CCMHC, ATR; R. Ault, ATR, HLM; H. McConeghey, ATR; M. Junge, PhD, LCSW, ATR
- ☐ 12. SYMPOSIUM - ON INTERPRETATION: The First Step in Teaching Interpretation: Sorting Sign From Symbol, L. Gantt, PhD, ATR / The Problem of Interpretation: Implications and Strategies for the Field of Art Therapy, M. Franklin, MA, ATR; R. Politsky, PhD / Interpretation in Art Therapy Practice and Research: The Hermeneutic Circle, D. Linesch, MA, MFCC, ATR **(2 Tapes)**
- ☐ 14. SYMPOSIA - MULTICULTURAL ISSUES: Multicultural Issues in Treatment, C. Anderson, MA, ATR; P. Dufrene, PhD, MFA, ATR; A. Hiscox, MA, AT; F. Smith, MA, ATR; G. Short, MA, ATR / We Come for Freedom: Southeast Asian Refugees in the U.S., R. Marano-Geiser, MA, ATR **(2 Tapes)**
- ☐ 16. SYMPOSIUM - ART THERAPY WITH ELDERS: Life Review and Reminiscence: Adult Day Care Center Clients, C. Waller, MA / Organic Mental Syndrome: Diagnostic Drawing Series Research with the Elderly, J. Couch, MA; T. Kress, MA
- ☐ 31. KEYNOTE ADDRESS: Achilles Tectonic Exhibit: The Architecture of Hallucination, J. MacGregor, PhD; D. Henley, ATR
- ☐ 47. AATA & Quality: A Tribute to Elinor Ulman, L. Wilson, PhD, ATR; P. Howie, MA, ATR; E. Kramer, ATR, HLM; M. McGraw, MA; K. Williams, PhD; G. Agell, PhD, ATR
- ☐ 51. SYMPOSIUM - ART THERAPY WITH THE CANCER PATIENT: Living with Cancer: Images of the Hurter and the Healer, V. Minar, MS, ATR / Terminal Images of a Pre-Diagnosed Cancer Patient, C. Mango, MA, ATR

PAPERS

- ☐ 2. The Talented Client: A Case Study in Countertransference for the Artist/Therapist, G. Klorer, MA, ATR
- ☐ 3. Pathology That is Not Pathological (Therapist's Post-Stress Caused by Treating Traumatic Stress), D. Spring, PhD, ATR
- ☐ 4. Beyond the Guise of Grandiosity: Art Intervention with Bipolar Children, D. Cogan, MA; M. Eife, MA, ATR
- ☐ 5. Ethical Considerations for the Group Art Therapist, M. Haeseler, MA, ATR
- ☐ 6. Painting a Field of Dreams: Art Therapy with Closed Head Injured Patients, H. Feen, MAT, ATR
- ☐ 8. Art, Play, and Games in Therapy: What's the "BIG" Difference, R. Hays, MS, ATR
- ☐ 9. Therapist Heal Thyself: Observations About a Peer Supervision Group, L. Eisenhauer, MA, MA
- ☐ 15. A Touching Sight: Art Therapy with Blind Children, L. Furman, MA, ATR
- ☐ 18. Revelation Through Repetition: Images in Adolescent Art, K. Stovall, MFCC, ATR
- ☐ 19. Painting My Way Home, B. Moon, MACE, MDiv, ATR
- ☐ 20. Classical Feminism: A Concept of Self as Woman and Artist, B. Troeger, PhD, ATR
- ☐ 21. Sharing the Silence - Art Therapists and the Homeless, P. Prugh, MA, ATR
- ☐ 22. Easing Children's Transitions into Protective Care, J. Fryrear, PhD, ATR; K. Price, MA, LPC, ATR
- ☐ 23. Exploring the Secret Underground Within the Siblings of Pediatric Cancer Patients, E. Leeuwenburg, MPS, CCLS, ATR
- ☐ 24. Art Therapy with Juvenile Arthritis Patients, V. Lusebrink, PhD, ATR; L. Turner-Schikler, MA, ATR
- ☐ 26. The Circle: Symbol of Wholeness, L. Rhinehart, MA, MFCC, ATR; P. Englehorn, MA, ATR
- ☐ 27. The Body Poem: Embracing the Image as Practice in Forgiveness, E. McNeil, MS, PhD, RN, ATR
- ☐ 28. The Art of Relationships, K. Jackson, MA, ATR
- ☐ 29. The Absent Father: Gender Identity and the Artwork of Adolescent Males, M. Haeseler, MA, ATR
- ☐ 32. Using Expressive Journals to Measure Feelings in an Adolescent Group, J. Hannah, MA; M. Rosal, PhD, ATR
- ☐ 35. A Three Step Systemic Approach for Assessment, Confrontation and Treatment Planning, J. Consoli, MA, ATR
- ☐ 36. Approaches to Art Therapy for Children with Disabilities, F. Anderson, EdD, ATR, HLM
- ☐ 37. Cultural Sublimation: Artistic Responses to the AIDS Crisis, M. Franklin, MA, ATR
- ☐ 38. Making Music: The Art of Dr. Karl Menninger, R. Ault, MFA, ATR, HLM
- ☐ 39. Creative Organizational Consultants by an Art Therapist, J. Bosky, MA
- ☐ 40. Images of Crisis: Art Therapy Process with Women in Domestic Violence Shelters, S. Lehti, BSW, ATM
- ☐ 41. Art Therapists as Exhibiting Artists: Messages from Joseph Beuys and Suzi Gablik, M. Lachman-Chapin, MEd, CCMHC, ATR
- ☐ 42. Enhancing the Range of Self-Expression Using Clay, S. Barton, BFA, MA, ATR
- ☐ 44. Object Relations and Addictions: Artwork and Bonding Patterns of Polydrug Abusers, R. Obstfeld, MA, ATR
- ☐ 45. Aesthetics in Art Therapy: Theory into Practice, D. Henley, MA, ATR
- ☐ 46. Introducing the Art Therapist as Advertising Researcher and Developer, J. Bailey, MCAT, ATR
- ☐ 48. The Shared Journey From Present to Unknown for Client and Therapist, B. Cooper, MPS, ATR
- ☐ 49. Screams From Hell: A Ritual Abuse Survivor Begins Art Therapy, C. Mullenioux, BS, MA, ATR
- ☐ 50. Drawing Out the Forgotten, the Fragmented, the Feared: A Case Study of an MPD Client, C. Rosa, MA, PLC, CAC III, ATR
- ☐ 55. The Diagnostic Drawing Series & Multiple Personality Disorder: A Validation Study, T. Kress, MA
- ☐ 57. The Clinical Underworld: Art Therapy and Sandplay with Survivors of Ritual Abuse, T. Sweig, MA, ATR
- ☐ 58. Surviving the "Other" Media in the Promotion of Art Therapy, R. Hays, MS, ATR; M. Levick, PhD, ATR, HLM
- ☐ 59. Art and Childhood Dissociation: Research with Sexually Abused Children, B. Sobol, MA, ATR; C. Cox, MA, ATR
- ☐ 60. Photo Art Therapy: A Jungian Perspective, J. Fryrear, PhD, ATR; I. Corbit, PhD, ATR

PANELS

- ☐ 11. Gregory Bateson's Relevance to Art Therapy: A Conversation with Janie Rhyne, R. Shoenholtz, MS, ATR; J. Rhyne, PhD, ATR, HLM
- ☐ 13. ETHICS IN ART THERAPY: The Roles and Goals of AATA in Setting the Pace for Our Profession, D. Wilson, PhD, ATR; G. Gibson, ATR; M. Bernier, MCAT, ATR; J. Carrigan, PhD, ATR
- ☐ 33. Coming Out: Being Lesbian and Gay, J. Treacy, BA, MAT; B. Levy, MFA, MPS; D. Addison, MFA; W. Brewer, BA, MA
- ☐ 34. Artist/Teacher, Artist/Clinician, Artist/Healer: A Dialogue with Identity, C. Malchiodi, MA, ATR; P. Allen, PhD, ATR; M. Cattaneo, PhD, ATR
- ☐ 52. A Model for Educating Interdisciplinary Staff: Limit Setting in Art Therapy, D. Wolfe, MA, ATR; L. Shulkin, MA, ATR; K. Maxwell, MA; A. Hous, BA, MA
- ☐ 53. A Compassionate Discourse: On Non-Art Therapists Doing Art Therapy, A. Mills, MA, ATR; M. Dougherty, MFA, MAAT, ATR; N. Humber, ATR; J. Rubin, PhD, ATR, HLM; R. Schoenholtz, ATR
- ☐ 54. Art Therapists Identify Transitional Stages and Treat Children in Catastrophic Trauma, D. Arrington, EdD, ATR; V. Appleton, EdD, MFCC, ATR; C. Arrington, MS; L. Chapman, MA, ATR; K. Mendenhall, PhD

BEST COPY AVAILABLE

PRICE PER TAPE $12.00

144-92 A

Mail Order Form

NO. OF TAPES____________ X $12.00 EACH $ ____________
SHIPPING ($1.75 per tape to $12.00 max.) $ ____________
DENVER RESIDENTS ADD 7.3% SALES TAX $ ____________
CO RESIDENTS ADD 3.8% SALES TAX $ ____________
IF TAX EXEMPT, INCLUDE COPY OF TAX CERTIFICATE
FOREIGN SHIPPING ($3.00 per tape to $30.00 max.) $ ____________
NEW YORK RESIDENTS ADD LOCAL SALES TAX $ ____________
ON TOTAL ORDER. IF TAX EXEMPT, INCLUDE COPY OF TAX CERTIFICATE
TOTAL OF ORDER $ ____________
SHIP TO (Please print clearly) ☐ RESIDENTIAL ☐ BUSINESS
NAME ____________
INSTITUTION ____________
ADDRESS ____________
____
CITY ____________ STATE ____________ ZIP ____________
DAYTIME PHONE ____________

METHOD OF PAYMENT (Do Not Send Currency)
________Enclosed is my check (Drawn on US Bank in US Funds)
Charge to my ________AMEX ________MASTERCARD ________VISA
CARD # ____________
EXP. DATE ____________
SIGNATURE ON CARD ____________

MAKE CHECKS PAYABLE AND MAIL YOUR ORDER TO:
NATIONAL AUDIO VIDEO, INC.
4465 WASHINGTON STREET
DENVER, CO 80216
Phone: (303) 292-2952

QUALITY GUARANTEED - NO REFUNDS - ALLOW 2-4 WEEKS FOR DELIVERY

CALL TOLL FREE: 1-800-373-2952 (9-5 MST) • OR FAX YOUR ORDER 303-292-5629

MEMBER ID # ____________	MEMBER	NON MEMBER
▲Educational Guidelines	$ .30	$ 1.00
▲Educational Program List	$ .30	$ 2.00
▲Standards and Procedures for Registration	$ .30	$ 1.00
▲Criterion for Professional Membership	$ .30	$ 1.00
▲Art Therapy Model Job Description	$ .30	$ 1.00
▲Art Therapy Media List	$ .30	$ 1.00
▲Standards of Practice	$ .55	$ 1.00
▲Ethics Document	$ .30	$ 1.00
▲Art Therapy Bibliography	$ .30	$ 1.00
▲Member Specialty List	$ 1.90	$ 2.90
▲Membership Survey	$ .75	$ 2.75
▲Associate/Student Membership Application	N/C	N/C
Professional Membership Application	N/C	$ 1.00
Registration (A.T.R.) Application	N/C	$ 1.00
National Registry of Master's These/Practicum Papers	$15.00	$25.00
***NEW* GUIDE TO CONDUCTING ART THERAPY RESEARCH**	$24.00	$35.00

GENERAL INFORMATION PACKET:
Includes first three items at left:
$ 4.00

▲Available in multiples:
1-9 copies
$2.00 with SASE
10-50 copies
$5.00 with SASE

ADDITIONAL PUBLICATIONS

Chapter Procedural Manual
$10.00 + $2.00 postage

Membership Directory/By-Laws

Member:	$ 10.00
Non-Member:	$ 50.00
Institution:	$100.00

($2.90 postage for above)

The American Art Therapy Association, Inc.

1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3800 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice: AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

Purpose:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

Chapters:

Affiliate Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive:

Publications

- *Art Therapy,* the official journal of the AATA
- The quarterly *AATA Newsletter*
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory
- AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice
- Mailings of professional interest

Services

- Insurance, including professional liability, major medical, life and disability
- Access to national experts in art therapy

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring
- State legislative and regulatory activities
- Promotion of recognition and reimbursement of art therapists by third-party payors
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy

Professional Standards

- Development of model job and licensure laws
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists

GENERAL MEMBERSHIP APPLICATIONS

1. The membership year is the calendar year, January 1 through December 31.
2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY: Please follow the chart below when submitting membership application.

   Applications received between:
   Jan.1 and May 31: Full dues payment. Membership expires Dec. 31 of same year.
   June 1 and Sept.30: Half year's dues plus $5 payment. Membership expires Dec. 31 of same year.
   Oct. 1 and Dec. 31: Full dues payment. Membership valid for remainder of current year and next full year.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to Membership Chair for approval.
4. AATA Membership and AATA Registration (A.T.R.) each have a separate application procedure. Registration is bestowed only by the Standards Committee.
5. National AATA membership required for Chapter Membership. Please contact AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL - by application only. Such members may vote, hold office, and serve on committees.

- Credentialed Professional Member: Individuals who have been dually approved for Professional Membership and Registration (A.T.R.) by AATA; dues are $95 per year.
- Active Professional Member: Individuals who have completed professional training in art therapy. Dues are $85 per year.

CONTRIBUTING - Individuals, organizations, institutions or foundations which contribute annually to AATA. Such members may vote, hold office or serve on committees. Annual dues are $120.

ASSOCIATE - Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. Such members may not vote, hold office or serve on committees. Annual dues are $85.

STUDENT - Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution indicating full-time status and coursework content. Student members may not vote, hold office but may serve on Student Subcommittee of Membership. Annual dues are $35.

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.

1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

THE FOLLOWING ARE 1993 DUES RATES

MEMBERSHIP APPLICATION

- Name ______________________
  Last First Middle
- Home Address ______________________
- Phone (____) ______________________
- Business Address ______________________
- Business Phone (____) ______________________
- Employer ______________________
- Job Title ______________________
- Licenses Held/State ______________________
- Preferred Mailing Address: ____ Home ____ Business
- Please indicate under which category you are applying:
- ____ **A.T.R. REGISTRATION** (a corresponding application packet will be sent to you)
- ____ **$95 A.T.R. MEMBERSHIP** (after approval only)
- ____ **PROFESSIONAL MEMBERSHIP** (a corresponding application packet will be sent to you)
- ____ **$85 PROFESSIONAL MEMBERSHIP** (after approval only)
- ____ **$120 CONTRIBUTING MEMBERSHIP**
- ____ **$85 ASSOCIATE MEMBERSHIP**
- ____ **$35 STUDENT MEMBERSHIP** (Student membership eligibility requires a current statement or transcript from the institution of learning indicating full-time status (6 graduate semester units, 12 undergraduate semester units, or equivalent of either with coursework content).

PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO: AATA

American Art Therapy Association
1202 Allanson Road
Mundelein, IL 60060

Please complete this survey:

EDUCATION (highest degree earned)

1 ________ Doctorate Degree
2 ________ Master's Degree
3 ________ Bachelor's Degree
4 ________ Associate/Certificate
5 ________ Other

(Please indicate exact degree earned, e.g., BA, BS, MA MS, PhD, etc.)

WORK SETTING (please check one only)

1 ___ Hospital
2 ___ Clinic
3 ___ Day Treatment Center
4 ___ Rehabilitation
5 ___ Sheltered Workshop
6 ___ Correctional Facility
7 ___ Residential Treatment
8 ___ Outpatient Mental Health
9 ___ School System
10 ___ Elderly Care Facility
11 ___ College/University
12 ___ Clinical Training Program
13 ___ Institute Traning Program
14 ___ Counseling Center
15 ___ Private Practice
16 ___ Other ____________

AREA(S) OF SPECIALIZATION (please check up to three)

1 ___ Addictions
2 ___ Adolescents, Hospitalized
3 ___ Adolescents, Psychiatric
4 ___ Adults, Hospitalized
5 ___ Adults, Psychiatric
6 ___ Art History
7 ___ Art Therapy Education
8 ___ Art Therapy in Schools
9 ___ Children, Hospitalized
10 ___ Children, Psychiatric
11 ___ Domestic Violence
12 ___ Eating Disorders
13 ___ Families
14 ___ Gerontology
15 ___ Hospice/Terminally Ill
16 ___ Learning Disability
17 ___ Mental Retardation
18 ___ Neurological Disease
19 ___ Prisoners
20 ___ Post Traumatic Stress
21 ___ Psychotherapy
22 ___ Rehabilitation
23 ___ Research
24 ___ Sexual Abuse
25 ___ Visual Art
26 ___ Other ____________

VOLUNTARY INFORMATION

Age

1 ___ 20-24
2 ___ 25-29
3 ___ 30-34
4 ___ 35-39
5 ___ 40-44
6 ___ 45-49
7 ___ 50-54
8 ___ 55-59
9 ___ 60+

Salary Range

1 ___ under $10,000
2 ___ $10-15,000
3 ___ $15-20,000
4 ___ $20-25,000
5 ___ $25-30,000
6 ___ $30-35,000
7 ___ $35-40,000
8 ___ $40-45,000
9 ___ $45-50,000
10 ___ $50,000+

Gender

1 ___ Female
2 ___ Male

1345

Hours Worked per Week

1 ___ 0-10
2 ___ 10-20
3 ___ 20-30
4 ___ 30-40

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Xerox copies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

BEST COPY AVAILABLE

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone #s: ______________ work ______________ home

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ______________________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ______________________________ **Date** ______________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

MARI®
Course in Mandala Assessment ®

30-Hour Course with
Certification of Completion

ATMA, Inc. Approved Instructors
Association of Teachers of Mandala Assessment

Carol A. Bush, LCSW	(804) 498-7220
Carol Thayer Cox, M.A.,A.T.R.	(703) 371-4534
Jonna Douglas, A.A.M.F.T.	(813) 942-1151
Paula Engelhorn, M.A.,A.T.R.	(707) 539-7745
Phyllis Frame, M.A.,A.T.R.	(804) 973-7543
Bonnie Smith-May, M.A.,A.T.R.	(301) 576-8034
Lillian Rhinehart, M.A., A.T.R.	(707) 539-0153
Deborah Glik, Ph.D.	(213) 525-0917
Pat Morini, M.A., A.T.R.	(207) 547-3291

For information on courses and
MARI® Card Test, call one of the above or
ATMA, Inc. (703) 371-4534.

EMBRACE
YOUR INNER CHILD

Workshops with

Lucia Capacchione, Ph.D.

Author:
Recovery or Your Inner Child

- Art Therapy
- Voice Dialogue
- Creative Journal
- Power of Your Other Hand

3/21-28	Mexican Riviera Cruise
April	Charlottesville, VA • Residential Training
6/4-13	Central Italy • Retreat "Path to Wholeness"
7/9	San Francisco • Lecture
7/17-18	Encino, CA • Retreat
7/24-31	So. Cal. • Professionals Training
9/11-18	So. Italy • Training

Information: (310)281-7495

Now Available from the
American Art Therapy Association

A GUIDE TO CONDUCTING ART THERAPY RESEARCH

●

Price: $24 Members $35 Non-members
Shipping/handling included
Orders of 10 or more copies: 10% discount

●

Please send your written request, along with payment, to:

American Art Therapy Association
1202 Allanson Road
Mundelein, IL 60060

●

We do not accept purchase orders or credit cards

BEST COPY AVAILABLE

CHARLES C THOMAS • PUBLISHER

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 402 pp. (7 × 10), 32 il., 9 tables, about $72.00.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 x 10), 24 il., $44.75.

☐ Anderson, Frances E.—**ART FOR ALL THE CHILDREN: Approaches to Art Therapy for Children with Disabilities, 2nd Ed.** '92, 398 pp. (6¾ × 9¾), 113 il., 19 tables, $59.75.

☐ Hardy, Richard E.—**GESTALT PSYCHOTHERAPY: CONCEPTS AND DEMONSTRATIONS IN STRESS, RELATIONSHIPS, HYPNOSIS, AND ADDICTION.** '91, 136 pp. (7× 10), $27.75.

☐ Thorne, Elizabeth and Shirley Herscovitch Schaye—**PSYCHOANALYSIS TODAY—A Case Book.** '91, 422 pp. (7× 10), $59.75.

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¾), 28 il., $32.75.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¾), 21 il., $32.75.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $42.25.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $49.25.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (7 × 10), 34 il., $42.25.

☐ Dennison, Susan T. & Connie K. Glassman—**ACTIVITIES FOR CHILDREN IN THERAPY: A Guide for Planning and Facilitating Therapy with Troubled Children.** '87, 304 pp. (8½ × 11), 203 il., 12 tables, $40.00, spiral (paper).

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $30.00.

☐ Nucho, Aina O. — **THE PSYCHOCYBERNETIC MODEL OF ART THERAPY.** '87, 248 pp. (6¾ × 9¾), 50 il., 4 tables, $42.00.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 × 10), 1 table, $38.25.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $46.25.

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $22.75.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $35.75.

☐ Breer, William—**DIAGNOSIS AND TREATMENT OF THE YOUNG MALE VICTIM OF SEXUAL ABUSE.** '92, 328 pp. (7 × 10), 5 il., about $59.75.

☐ Talley, Joseph E.—**THE PREDICTORS OF SUCCESSFUL VERY BRIEF PSYCHOTHERAPY: A Study of Differences by Gender, Age, and Treatment Variables.** '92, 198 pp. (7 × 10), 25 tables, $34.75.

☐ Lester, David—**PSYCHOTHERAPY FOR SUICIDAL CLIENTS.** '91, 150 pp. (7× 10), 2 il., $29.75.

☐ Gutsch, Kenneth U. & David Sisemore—**HOW TO PLAY THE RELATIONSHIP GAME: The Use of Psychological Principles to Change Human Behavior.** '91, 112 pp. (7 × 10), $24.75.

☐ France, Kenneth—**CRISIS INTERVENTION, Second Edition.** '90, 276 pp. (7 × 10), 3 il., $47.25.

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $46.50.

☐ Gutsch, Kenneth Urial—**PSYCHOTHERAPEUTIC APPROACHES TO SPECIFIC DSM-III-R CATEGORIES: A Resource Book for Treatment Planning.** '88, 276 pp. (7 × 10), $44.50.

☐ Dennison, Susan T.—**ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents.** '88, 236 pp. (7 × 10), 36 il., 26 tables, $40.00.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $81.75.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 236 pp. (7 × 10), $40.00.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $21.25, spiral (paper).

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $27.25.

☐ Hart, Gordon M.—**VALUES CLARIFICATION FOR COUNSELORS: How Counselors, Social Workers, Psychologists, and Other Human Service Workers Can Use Available Techniques.** '78, 104 pp., 4 il., $18.75.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $44.00.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ART THERAPY is published quarterly by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $40 (US); $64 (Foreign). Institutions: $57 (US); $80 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $10 member; $18 non-member. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1993. Enclosed is my check, payable to AATA, for $35.
Name ______________________________
Address ______________________________
City ____________________ State __________ ZIP __________

"Each issue of ***The Arts in Psychotherapy*** *is a seasonal enlightenment indispensable for the many who want to stay up to date on the professional and theoretical aspects of the creative arts therapies."*
-Rudolf Arnheim, Ph.D., Professor Emeritus of the Psychology of Art, Harvard University

THE ARTS IN PSYCHOTHERAPY
An International Journal

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief: Robert J. Landy, Ph.D., Director, Drama Therapy Program, New York University, New York, NY
European Editor: David Aldridge, Ph.D., Music Therapy, Universitat Witten, Herdecke, Germany
Managing Editor; Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, NY 10583

THE ARTS IN PSYCHOTHERAPY is an international journal for professionals in the fields of mental health and education. The Journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines.

In an effort to expand the Journal's focus to include more international articles, the new Editor-in-Chief, Robert J. Landy, has appointed a European Editor, David Aldridge, and has also updated the Editorial Boards.

PERGAMON PRESS
USA: 660 White Plains Road, Tarrytown, NY 10591-5153
UK: Headington Hill Hall, Oxford, OX3 0BW, England
A member of the Elsevier Science Publishing Group

The Editors welcome original manuscripts. Submit papers in triplicate to: Sylvia Halpern, Managing Editor, 20 Ridgecrest East, Scarsdale, NY 10583.

Submissions from Europe should be sent in triplicate to: David Aldridge, Ph.D., Music Therapy, Universitat Witten, Beckweg 4, D5804 Herdecke, Germany.

Subscription Information

ISSN: 0197-4556 Volume 20, 1993 5 issues per annum
Annual Institution Subscription Rate (1993) *£ 140.00/US$266.00
Professional Rate (1993) *£ 37.00/US$ 70.00

*Sterling Prices quoted are definitive and apply worldwide. US Dollar prices are quoted for convenience only and are subject to exchange rate fluctuation. Prices include postage and insurance. A special rate is available to members of qualifying societies. Please contact Pergamon Press for details.

BEST COPY AVAILABLE

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 10, NUMBER 1, 1993

1351

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Advertising: Please see advertising rates listed elsewhere in this journal or contact the American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 (708) 949-6064. The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

ISBN 1-882147-15-4

Editor

Cathy A. Malchiodi, MA, A.T.R.
California State University, Sacramento, CA

Associate Editor

Patricia St. John, EdD, A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor

Elizabeth Ratcliffe, MS, MFCC, A.T.R.
College of Notre Dame, Belmont, CA

Film/Video Review Editor

James Consoli, MA, A.T.R., NCC
Eastern Virginia Medical School, Norfolk, VA

Production Editor

Christine Fryer

Editorial Board

Pat B. Allen, PhD, A.T.R.
River Forest, IL
Frances E. Anderson, EdD, A.T.R., HLM
Illinois State University, Normal, IL
Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec
Michael Campanelli, EdD, A.T.R.
Edith Cowan University, Perth, Australia
Susan E. Cheyne-King, MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R.
The George Washington University, Washington, DC
Julie Epperson, MA, A.T.R.
Salt Lake City, UT
Janice Havlena, MA, A.T.R.
UNM Children's Psychiatric Hospital, Albuquerque, NM
Maxine Borowsky Junge, PhD, LCSW, A.T.R.
Loyola Marymount University, Los Angeles, CA
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Paolo Knill, PhD, A.T.R., CMT-BC
Lesley College, Cambridge, MA
Vija B. Lusebrink, PhD, A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, EdD, A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Trudy Martin Manning, MS, A.T.R.
Eastern Virginia Medical School, Norfolk, VA
Shirley Riley, MA, MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Marcia L. Rosal, PhD, A.T.R.
University of Louisville, Louisville, KY
Susan Evans Spaniol, EdD, A.T.R.
Lesley College, Cambridge, MA
Betty Jo Troeger, PhD, A.T.R.
Florida State University, Tallahassee, FL
Evelyn Virshup, PhD, A.T.R.
California State University, Los Angeles, CA
Robert Wolf, MPS, A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President

Robin Goodman, PhD, A.T.R.

AATA Executive Director

Edward J. Stygar, Jr.

ARTherapy
JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Editorial

Reflections on the 1992 Annual Conference: Are Courage and Excellence Enough?
Cathy A. Malchiodi, MA, A.T.R. 2

Commentaries

23rd Annual Conference Overview 6
HLM Award Acceptance by Harriet Wadeson, PhD, A.T.R., HLM 10
DSA Award Acceptance by Virginia Minar, MS, A.T.R. 14

Articles

Journey Toward Integration: The Use of Collages to Assess the Separation and Individuation Process of an Adult Identical Twin
Susan Neece Malone, M.A. and Marcia L. Rosal, PhD, A.T.R. 16
Profile of the Artist: MARI® Card Test Research Results
Carol Thayer Cox, MA, A.T.R. and Phyllis Frame, MA, A.T.R. 23

Viewpoints

Making the Unknown Visible: Panel Rounds at Franklin County Medical Center 30
Art Therapy in Mexico: Five Perspectives
Phoebe Dufrene, PhD, A.T.R. 39

Reviews

Exceptional Children, Exceptional Art: Teaching Art to Special Needs
Betty Jo Troeger, PhD, A.T.R. 44
Assessment Review: Silver Drawing Test of Cognitive Skills and Adjustment: Drawing What You Predict, What You See, and What You Imagine
Anna R. Hiscox, MA, A.T.R. 46
Video Review: Psychimagery: Healing the Child Within
Mindy Jacobson, MCAT, A.T.R. 48
Response to Video Review
James Consoli, MA, A.T.R., NCC 50
1993 AATA Media List, ... 52
Noteworthy 58

Together!
WE HEAL

About the Cover: "The Rock Lady," 5′ × 5′ oil painting photographed in environment, by Helen B. Landgarten, M.A., A.T.R., HLM, art therapist, educator, author, and artist; Professor Emeritus of the Clinical Art Therapy Program Master Degree Program at Loyola Marymount University, Los Angeles, California; former coordinator of Art Psychotherapy in the Family/Child Department of Psychiatry at Cedars-Sinai Medical Center, Los Angeles, California. About the piece Landgarten says, "My environment has made a major impact upon my psyche. Often, without any conscious intent, the elements of nature appear in my work."

VOLUME 10 NUMBER 1, 1993

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 2-4 © AATA, Inc. 1993

Editorial

Reflections on the 1992 Annual Conference: Are Courage and Excellence Enough?

Cathy A. Malchiodi, MA, A.T.R., *Editor*

This year's Annual Conference theme, "Artist, Teacher, Clinician, Healer," sought to address aspects of professional life that art therapists have often struggled to integrate in their work. Certainly, the problem of maintaining an identity both as an artist and therapist has been a subject for debate in many past conferences (Ault, 1977; Landgarten, 1989; Rosenberg, et al., 1982; Wadeson, Landgarten, McNiff, Free, & Levy, 1977, to name a few), and will probably continue to be debated at future meetings. The past annual conference expanded on this theme, exploring the roles of artist, teacher, clinician, and healer in the opening general session (Ault, Lachman-Chapin, McConeghey, & Junge, 1992). This topic is of interest to most art therapists, both because of the inherent diversity in art therapy practice as well as because of the reality that many art therapists find their livelihoods from working in two or more of these roles as therapist/healer, educator, and/or visual artist.

Although I had a personal interest in this theme, an additional highlight of the conference for me was a panel presentation called "The AATA and Quality," given by Laurie Wilson, Paula Howie, Edith Kramer, Katherine Williams, and Gladys Agell (1992). This presentation was dedicated to the memory of Elinor Ulman; however, it took on a significance far greater than that of a memorial tribute, addressing diversity in our work from another perspective. In listening to the panelists, qualities such as dedication, ethical practice, standards, diligence, and honesty came to mind, intertwined with our roles as writers, academicians, educators, clinicians, and supervisors.

Early in the presentation, one of the panelists observed that the word "quality" should be replaced by the word "excellence," a characteristic that Elinor Ulman embodied and demanded of herself, her students, and the profession. A second characteristic, courage, was identified by panelist Paula Howie, who offered the following quote from Ulman's (1974) work:

> Perhaps the quality most needed by the art therapist is courage. The frantic effort to plan elaborate art therapy procedures reflects the therapist's timidity, his need to attempt the impossible—that is, to chart in advance a voyage of discovery. (p. 14)

In response to the theme of the panel and this quote, Howie raised the question, "Are courage and excellence enough?" With this question and her own courageous self-searching, Howie articulately and passionately brought to light a variety of issues, further exploring the sense of disillusionment with the field of art therapy expressed in the 1991 panel "Art Therapy: Post Mortem" (Malchiodi, Cattaneo, & Allen, 1891). Howie observed that ". . . art therapists, quite frankly, are hurting. We are losing jobs, programs, (and) we are being squeezed by demands to objectify care. . . ." She also noted that health care is undergoing many changes: for example, diagnostically related groups (DRGs) mean there is less time to work with patients and the emergence of managed care will radically change how the patient's needs are met. As art therapists, in her words, "we are at the mercy of" insurance companies and regulating bodies. I would also add to Howie's list that we are losing academic training programs in art therapy at an alarming rate and are in danger of losing more before this decade is over.

Considering these realities, are courage and excellence enough? In response to the latter, there are many ways each of us can contribute excellence to our profession and association. For example, one area we can all focus on in terms of excellence is our annual conference. It is fair to say that we look to the annual conference for excellence in theory, methodology, and research to inspire us in our work. However, it is discouraging to seasoned professionals to return year after year to the conference only to be less than stimulated by repetitive or basic material on such perennial topics as geriatric life review or to listen to someone pointing out one more phallic symbol in clay. What I often hear in conference presentations makes me feel like an unwilling time-traveler going back to a previous AATA conference 5, 10, or more years ago when the same information was presented in a slightly different form. To glance over a conference program or to attend many of the sessions is often a *déjà vu* experience to a well-remembered past life.

These topics and others which are resurrected year after year certainly warrant further investigation, discussion, and formal presentation. However, many conference papers often lack rigorous research into what has been previously written and presented on these topics or, in the case of most, present no new material. This occurrence is not the fault of the conference planners or the program committee, who I believe have consciously tried to provide stimulating and contemporary programs. It is a responsibility for excellence that each of us who is accepted to make a presentation must take seriously by doing the extensive preparation necessary to present a scholarly paper or workshop to our peers.

On the other hand, the past conference did provide some surprises in areas of excellence the profession is actively striving to address. A study group on doctoral programs was extremely well-attended, attesting to the interest of art therapists in obtaining higher degrees and in contributing to our knowledge base through research. The open forum on the AATA journal was also surprisingly well-attended, by both professional members and students with questions about contributing to the field through writing. Art therapists are also striving to bring excellence to clinical work by understanding the multicultural needs and diversity of our clients as demonstrated by the symposium on multicultural issues, the Mosaic Committee Open Forum, and the Gay, Lesbian and Bisexual Caucus.

Lastly, excellence in one's personal work as well as the profession as a whole also means sharing a responsibility for the future direction of the field of art therapy. Panelist Laurie Wilson eloquently observed that "standing for quality (excellence) often, but not always, means standing for the more difficult solution." This means taking a longer view of a situation, whether it be training, standards of practice, ethical dilemmas, or certification, and looking at the given situation with the larger picture in mind.

Although excellence requires high standards, energy, and perseverance, the question of courage may be more difficult to address. Courage involves not only these qualities, but also the added elements of risk, honesty, and integrity. If courage is, as Ulman said, a quality needed by art therapists, then maybe it is something we should actively discuss with students in our training programs. More than 12 years ago, Doris Arrington, program director and professor at my alma mater the College of Notre Dame, gave the first small group of graduates from the masters in art therapy program a red badge with a ribbon bearing the word "courage" on it. Although we never discussed courage in the classroom, we all knew we would need it when we left the nest of our training program as the first graduating class to go forth and hopefully prosper as art therapists.

Since then I have kept that badge in a prominent place where I can see it each day. It was not easy to be an art therapist when I graduated, nor is it easy for today's graduates. In response to a dialogue at the conference examining the identities of artist, teacher, clinician, and healer, Conference Chair Randy Vick commented that even if our jobs were difficult at times, no one of us would ever settle for being a "shoe salesman." The obvious attraction of being a shoe salesman is that one does not have to describe what one does, nor does one need a lot of in-depth training; in comparison to being an art therapist, maybe one does not need as much courage either. Although thoughts of joining the ranks of retail sales have crossed my mind in moments of frustration, I would agree that I cannot give up my work and interest in this field, despite the drawbacks.

In her Honorary Life Membership Award address, Harriet Wadeson observes about her life and professional career that "art therapy has been a generous provider." There is a great deal that our professional lives provide each of us if we are willing to look for it; it may be in the long run what gives each of us the courage to continue. We are privileged as professionals to be able to witness what is unseen to others in the art of our clients. To view images from the human psyche is an experience that brought many of us into this field and keeps us in it. On the whole, most of us are willing to risk a little in terms of job security or stature to make this experience a central part of our lives and work.

One part of me is an idealistic dreamer, wanting to believe that courage and excellence are enough to keep the profession of art therapy alive and flourishing. I also know what Paula Howie said is true—that art therapists must actively think about licensure, certification, and achieving third-party payments, and work with health care professionals, insurance companies, and government. Despite any amount of courage and excellence, we cannot ignore these very real issues that affect the course of our development. We are a small group in comparison to related professions that are competing for health care dollars. The AATA has 4,000 members, while psychologists, social workers, and others have tens of thousands in their ranks. When considering this fact, each of us may have to have more than courage and excellence in the '90s to keep our professional lives afloat in a sea of health care providers.

But something more is needed than these practicalities—something that comes from both heart and mind if we are to survive as a profession. As Howie noted, our early educators were teaching us something more important than interpretation and technique. They were showing us that excellence, "courage, and vision" are necessary, for without these qualities we are indeed empty as individuals and as a profession. Without these qualities, there is no life, no soul, and possibly no future in our work as art therapists.

References

Ault, R. (1977). Are you an artist or a therapist? A professional dilemma for art therapists. *Creativity and the Art Therapist's Indentity: Proceedings of the 1976 Annual AATA Conference* (pp. 53–56). Baltimore, MD: AATA.

Ault, R., Lachman-Chapin, M., McConeghey, H., Junge, M. B., & Vick, R. (1992). Artist, teacher, clinician, healer: Advancing the dialogue (Audio Cassette Recording No. 1–144). Denver, CO: National Audio Video.

Landgarten, H. (1989). Art therapy's influence on my artistic and personal development. *American Journal of Art Therapy, 27*, 106.

Malchiodi, C. A., Cattaneo, M., & Allen, P. (1991). Art therapy: Post mortem (Audio Cassette Recording No. 1–135A). Denver, CO: National Audio Video.

Rosenberg, H., Ault, R., Free, K., Gilbert, Joseph C., Landgarten, H., & McNiff, S. (1982). Visual dialogues: The artist as art therapist, the art therapist as artist. *Art Therapy: Still Growing, Proceedings of the 1982 Annual AATA Conference* (pp. 124–125). Baltimore, MD: AATA.

Ulman, E. (1974). Innovation and aberration. *American Journal of Art Therapy, 14*, 14.

Wadeson, H., Landgarten, H., McNiff, S., Free, K., & Levy, B. (1977). The identity of the art therapist: Professional self-concept and public image. *Creativity and the Art Therapist's Indentity: Proceedings of the 1976 Annual AATA Conference* (pp. 38–42). Baltimore, MD: AATA.

Wilson, L., Agell, G., Kramer, E., Howie, P., & Williams, K. (1992). The AATA and quality: A tribute to Elinor Ulman (Audio Cassette Recording No. 47–144). Denver, CO: National Audio Video.

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 5 © AATA, Inc. 1993

Commentaries

Letter to Associate Editor

Dear Dr. St. John:

You have been most generous in your comprehensive and positive review of my book, *Mommy, Daddy, Look What I'm Saying*. Thank you.

Permit me to take this opportunity to respond to some of your concerns. The least of these, "the many more examples than were illustrated" were, indeed, the result of the publisher's last minute editing. This was very disappointing to me, but the editors at M. Evans & Co. maintained that the cost would be too high with all of the illustrations included. But I agree with you—I was frustrated and it is frustrating to visualize the images. And color could not even be discussed.

The inclusion of directed artwork, in spite of my obvious encouragement toward spontaneous creativity, was in many instances pragmatic. I was fortunate in being able to obtain many artworks produced by children in a variety of settings here and abroad. In so many of these settings the artwork was often directed, supporting my premise that there is a need to encourage children to produce spontaneous artwork. And, in looking at the drawings, I agree, there is no difference whether it is directed or spontaneous.

I sincerely regret your impression that I imply the "art psychotherapist is superior and is therefore similar to the psychoanalyst." The text you quote on page 29 regarding the two schools of thought—"Art as Therapy" and "Art in Therapy"—is historical fact and appears in many texts by other art therapists discussing the field of art therapy. But on pages 30 and 31 I report how our numbers have grown, and that we, as a group, "have become more sensitive to the fact that some people benefit more from one approach than from the other, and more often mix the two approaches." I also point out that the "qualified art therapist today is able to provide the best means of artistic expression for a particular patient, regardless of which approach is recommended." The many ways and many facilities in which art therapists work are described briefly in this section.

However, while this work is intended to reflect my perspective, which is psychodynamic, and I do describe in more detail the ways in which I practice art therapy, the intent is to convey an approach that meets the needs of the individual patient, not to adhere to a particular approach. These schools of thought are different but in my view are equal parts of a whole that is art therapy.

Myra F. Levick, PhD, A.T.R., HLM
Boca Raton, FL

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 6-9 © AATA, Inc. 1993

THE AMERICAN ART THERAPY ASSOCIATION
23rd ANNUAL CONFERENCE

Riveria Hotel/Las Vegas, Nevada

NOVEMBER 4–8, 1992

November 4

Preconference Courses

Using Art Therapy in the Treatment of Violent Families/*Cathy Malchiodi, Shirley Riley*

Art Therapy for Children with Disabilities/*Frances E. Anderson*

The Kwiatkowska Evaluation Revisited: New Perspectives for the Therapist/Researcher and Therapist/Artist/*Carol Cox, Barbara Sobol*

Looking Back Art/*Linney Wix*

Finding Working Symbols: The Sharing and Exploring of Client Symbols in Treatment/*Leonie Reisberg, Barbara Faith Cooper*

Process and Product: The Levick Emotional and Cognitive Art Therapy Assessment/*Myra Levick, Janet Bush*

A Deep Breath: Art Therapy and Spirituality/*Catherine Moon, Bruce Moon*

November 5

Opening Ceremony/*Robin Goodman*

Welcoming Remarks/*Rene Bouchard*

Artist, Teacher, Clinician, Healer: Advancing the Dialogue/*Mildred Lachman-Chapin, Robert Ault, Howard McConeghey, Maxine Junge, Randy Vick*

Poster Sessions

Rebuilding and Restoration: The Healing Process Explored Through Recovery Images/*Cam Busch, Sally Cornwell*

Art Therapy Groups for Adult Incest Survivors: Description and Evaluation/*K. Wands, L. Marcy*

Study Groups

Doctoral Programs for Art Therapists/*Linda Gantt*

Spirituality and the Arts Therapies; The Dialogue Continues/*Roberta Shoemaker-Beal*

Study Group on the Diagnostic Drawing Series/*Anne Mills*

Gay, Lesbian and Bisexual Caucus: An Agenda for the Future/*Barbara Ann Levy*

Open Forums

Certification/*Joan Phillips*

International Networking/*Bobbi Stoll*

Public Relations/*Kay Stovall*

Niche for the 90s/*Patricia Isis*

Standards/*Leslie Thompson*

Education/*Mary St. Clair*

Papers

The Talented Client: A Case Study in Countertransference for the Artist/Therapist/*P. Gussie Klorer*

Pathology That Is Not Pathological (Therapist's Post-Stress Caused by Treating Traumatic Stress)/*Dee Spring*

Beyond the Guise of Grandiosity: Art Intervention with Bipolar Children/*Deirdre M. Cogan, Margaret Eife*

Ethical Considerations for the Group Art Therapist/*Martha Haeseler*

Through the Flames: Art Therapy with Adult Burn Patients/*Margaret Everett*

Art, Play, and Games in Therapy: What's the "Big" Difference?/*Ronald Hays*

Therapist Heal Thyself: Observations About a Peer Supervision Group/*Letty Lou Eisenhauer*

A Touching Sight: Art Therapy with Blind Children/*Lisa Furman*

Artwork of Hospitalized Children: Gateway to Accurate Understanding of Thoughts and Feelings/*Anne Prager*

The Fire Within: The Use of Art Therapy with a Psychophysiologic Disorder/*Jeanie Sutcliffe*

The Integration of Visual Tasks in a Structured Inpatient Therapy Group/*Vivian Banish*

Transition from Trauma: Art Therapy with Adolescent and Young Adult Burn Patients/*Valerie Appleton*

Revelation Through Repetition: Images in Adolescent Art/*Kay Stovall*

Painting My Way Home/*Bruce Moon*

Classical Feminism: A Concept of Self as Woman and Artist/*Betty Jo Troeger*

Panels

The Practice of Art Therapy with AIDS/HIV Clients/*Bill Bryant, William Brewer, Noel Silver, Judy Weiser*

Gregory Bateson's Relevance to Art Therapy: A Conversation with Janie Rhyne/*Robert Shoenholtz, Janie Rhyne*

The Roles and Goals of AATA in Setting the Pace for our Profession/*Dean Wilson, Gwen Gibson, Matthew Bernier, Jeanne Carrigan*

Art Therapists Identify Transitional Stages and Treat Children in Catastrophic Trauma/*Doris Arrington, Valerie Appleton, Linda Chapman, Christian Arrington, Kristen Mendenhall*

Symposium: Interpretation

The First Step in Teaching Interpretation: Sorting Sign from Symbol/*Linda Gantt*

The Problem of Interpretation: Implications and Strategies for the Field of Art Therapy/*Michael Franklin, Rosalie Politsky*

Interpretation in Art Therapy Practice and Research: The Hermeneutic Circle/*Debra Linesch*

Symposium: Multicultural

Multicultural Issues in Treatment/*Charles Anderson, Phoebe Dufrene, Anna Hiscox, Floyd Smith, Gwendolyn McPhaul Short*

We Come for Freedom: Southeast Asian Refugees in the U.S./*Rose Marano-Geiser*

Symposium: Elderly

Life Review and Reminiscence: Adult Day Care Center Clients/*Carolyn Waller*

Organic Mental Syndrome: Diagnostic Drawing Series Research with the Elderly/*Janet Beaujon Couch, Teresa Kress*

November 6

Papers

Sharing the Silence: Art Therapists & the Homeless/*Patricia Prugh*

Easing Children's Transitions into Protective Care/*Jerry Fryrear, Karen Price*

A Three Step Systematic Approach for Assessment, Confrontation and Treatment Planning/*James Consoli*

Art Therapy with Juvenile Arthritis Patients/*Vija Lusebrink, Lisa Turner-Schikler*

Subjectivity, Circularity and Honesty in Therapist's and Client's Communications/*Jamie Rhyne*

Self Exploration Through Contour Drawing: A Student Perspective/*Shirley Gerstenberger, Laurie Lougury, Jill Steiner*

The Circle: Symbol of Wholeness/*Lillian Rhinehart, Paula Englehorn*

The Body Poem: Embracing the Image as Practice in Forgiveness/*Evadne McNeil*

Art Therapy Faces Its Shadow/*Rene Bouchard*

The Art of Relationships/*Katherine Jackson*

The Absent Father: Gender Identity and the Artwork of Adolescent Males/*Martha Haesler*

An Art Therapy Exploration of the Imagery, Issues and Implications of Exogamous (Interracial) Marriage/*Paige Asawa*

Painting a Field of Dreams: Art Therapy with Closed Head Injured Patients/*Holly Feen*

Using Expressive Journals to Measure Feelings in an Adolescent Group/*Jennifer Morgan Hannah, Marcia Rosal*

Seeing and Believing: Projective Phototherapy Techniques for Exploring Values and Personal Constructs/*Judy Weiser*

Approaches to Art Therapy for Children with Disabilities/*Frances Anderson*

Cultural Sublimation: Artistic Responses to the AIDS Crisis/*Michael Franklin*

Making Music: The Art of Dr. Karl Menninger/*Robert Ault*

Creative Organizational Consultation by an Art Therapist/*Joan Bosky*

The Therapeutic Functions of Folk Art/*Kristin Congdon*

Training Art Therapists in the Scientist/Practitioner Tradition/*Julie Epperson*

Images of Crisis: Art Therapy Process with Women in Domestic Violence Shelters/*Sandra Lehti*

Art Therapists as Exhibiting Artists: Messages from Joseph Beuys and Suzi Gablik/*Mildred Lachman-Chapin*

Enhancing the Range of Self Expression/*Suzanne Barton*

Workshops

Using Visualization to Enhance Expressive Drawing and Writing Skills/*Margaret Sands, Rochana Koach*

Contemporary Revisioning of the Shamanic Tradition: The Talisman Workshop/*Pat Allen*

Stepping Out of Grief with Art Therapy for the Suicide Survivor/*Linda Goldman, Judith Rothschild*

Developing Trust Through Rapport and Therapeutic Trance/*Sandra Zavadil, Gayle Bodine*

Exploring the Relationship of Ritual to Art Therapy/*Randy Vick*

Study Groups

Mandala Study Group/*Carol Cox*

AIDS Related Study Group/Sharing Networking About Helping HIV Clients and Families/*Judy Weiser*

Splash Studies in Phenomenological Language and Symbolic Healing (Dissociative Disorder)/*Dee Spring, Debbie Good, Trudy Manning, Cappi Lang, Lynn Sawyer*

Poster Sessions

Funding Light at the End of the Funnel: Working with Tornado Survivors/*Tamara McDougall Herl*

Open Forums

Publications/*Frances Anderson*

Getting Involved with AATA: Questions and Answers/*Bobbi Stoll*

Research/*Vija Lusebrink*

Governmental Affairs/*Robin Gabriels*

Keynote Address

Achilles Tectonic Exhibit: The Architecture of Hallucination/*John MacGregor*

Panels

Coming Out: Being Lesbian and Gay/*John Treacy, Barbara Levy, Donna Addison, William Brewer*

Training for Therapeutic Artistry/*Arthur Robbins, Vicky Youngman, Laurel Thompson, Sarah Banker, Mary Cole, Barbara Cooper, Allison Gigi, Leonie Reisberg, Joel Vogt, Erika Leeuwenberg*

Artist/Teacher, Artist/Clinician, Artist/Healer: A Dialogue with Identity/*Cathy Malchiodi, Patricia Allen, Mariagnese Cattaneo*

Master Supervision Groups

Adult Incest Survivors/*Bobbi Stoll*

Substance/Alcohol Abuse/*Holly Feen*

Elderly/*Madeline Rugh*

November 7

Papers

The Ulman Personality Assessment Procedure Revisited/*Gladys Agell*

Object Relations and Addictions: Artwork and Bonding Patterns of Polydrug Abusers/*Renee Obstfeld*

Aesthetics in Art Therapy: Theory into Practice/*David Henley*

Introducing the Art Therapist as Advertising Researcher and Developer/*Jennifer Bailey August*

The Shared Journey from Present to Unknown for Client and Therapist/*Barbara Faith Cooper*

Screams from Hell: A Ritual Abuse Survivor Begins Art Therapy/*Carol Mullenioux*

Drawing Out the Forgotten, the Fragmented, the Feared: A Case Study of an MPD Client/*Cynthia Rosa*

Symposium: Art Therapy with the Cancer Patient

Living with Cancer: Images of the Hurter & the Healer/*Virginia Minar*

Terminal Images of a Pre-Diagnosed Cancer Patient/*Christina Mango*

General Session

AATA and Quality: A Tribute to Elinor Ulman/*Laurie Wilson, Paula Howie, Edith Kramer, Mary McGraw, Katherine Williams, Gladys Agell*

Master Supervision Groups

AIDS/HIV/*Paula Howie*

Children/*Judith Rubin*

Study Groups

Working with Gay, Lesbian, Bisexual Clients/*Tih Penfil, William More*

Campaign Against the Gratuitous Use of Violence in the Visual Media/*Laurie Wilson*

Posters

Video Art Therapy/*Paula Lima*

Satanic Art and Human Evil: Don't Let Yourself be Deceived/*Cathy Hanson*

Open Forums

Clinical/*Patricia Isis*

Governmental Affairs/*Robin Gabriels*

AATA Board/*Robin Goodman*

Art Therapy Journal/*Cathy Malchiodi*

Workshops

Countering Children's Fears: A Photo Art Therapy Workshop/*Irene Corbit, Jerry Fryrear*

The Kinesthetic Experience of Art/*Arthur Robbins, Laurel Thompson*

Case Consultations on Dissociative Disorders and Clinical Misadventures/*Patty Churchill, Trudy Manning, Debbie Good, Cappi Lang, Dee Spring*

Psychopuppetry/*Matthew Bernier*

November 8

Workshops

Creative Art Interventions in Psychoanalytic Psychotherapy/*Robert Wolf*

Spontaneous Art with Children/*Krista Soste, Betsy Shapiro*

The Power of Symbolization in the Interface Between Client and Art Therapist/*Barbara Faith Cooper, Leonie Reisberg*

Marketing Yourself in Gorillaland/*Mary Ellen McAlevey*

Educator's Convocation/*Shirley Riley*

Panels

A Model for Educating Interdisciplinary Staff: Limit Setting in Art Therapy/*Delores Wolfe, Lori Shulkin, Kevin Maxwell, Amy Hous*

A Compassionate Discourse: On Non-Art Therapists Doing Art Therapy/*Anne Mills, Mary Dougherty, Nancy Humber, Judith Rubin, Heidi Lack, Robert Schoenholtz*

Papers

The Diagnostic Drawing Series & Multiple Personality Disorder: A Validation Study/*Teresa Kress*

Constructing a Session: Doing Art Therapy as a Constructivist/*Robert Schoenholtz*

The Clinical Underworld: Art Therapy and Sandplay with Survivors of Ritual Abuse/*Terri Sweig*

Applying Different Theoretical Models to Facilitate Therapeutic Process/*Arthur Robbins, Barbara Faith Cooper*

Surviving the "Other" Media in the Promotion of Art Therapy/*Ronald Hays, Myra Levick*

Art and Childhood Dissociation: Research with Sexually Abused Children/*Barbara Sobol, Carol Cox*

Photo Art Therapy: A Jungian Perspective/*Jerry Fryrear, Irene Corbit*

Post-Conference Courses

The Diagnostic Drawing Series in Clinical Practice/*Barry M. Cohen, Anne Mills*

Looking at Pictures to Study Case Dynamics and to Establish Treatment Goals/*Kay Stovall*

Special Topics in Adolescent Art Therapy: Satanism and the Occult/*Joan Phillips*

AATA Calendar of Events

MARCH 20-21, 1993
Regional Symposium: MPD
Bloomington, MN

MAY 7-9, 1993
Regional Symposium: MPD
New York, NY

NOVEMBER 18-21, 1993
Annual Conference
Atlanta Hilton

NOVEMBER 16-20, 1994
Annual Conference
Palmer House - Chicago

NOVEMBER 9-12, 1995
Annual Conference
Town & Country - San Diego

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 10-13 © AATA, Inc. 1993

American Art Therapy Association Honorary Life Member Award—

Harriet Wadeson, PhD, A.T.R., HLM

Awarded at the 23rd Annual Conference of the American Art Therapy Association, Inc., Las Vegas, Nevada on November 7, 1992

Figure 1. Harriet Wadeson (r) at 1st AATA Conference at Airlie House.

Dr. Wadeson began her art therapy career more than 30 years ago (1961) at the National Institute for Mental Health where she was one of the first art therapists to work and conduct research with groups, couples, and families, as well as to work with such challenging individuals as those diagnosed with schizophrenia, depression, and bipolar disorders. In addition to her three major publications, Art Psychotherapy, The Dynamics of Art Psychotherapy, *and* Advances in Art Therapy, *she has contributed five chapters on art therapy in psychology texts and five chapters in other texts. She has also published 45 articles in scientific journals and given 157 presentations at scientific meetings and universities. Dr. Wadeson developed an awareness of the field of art therapy through her national and international presentations, but most notably through her professional contact with the American Psychiatric Association. She has been the subject of national media coverage via the radio in Washington, D.C., Finland, and Australia.*

Dr. Wadeson has taught art therapy at 15 colleges and universities, and created and directed two art therapy graduate programs—University of Illinois, Lindenwood-4 College and the art therapy program at the University of Illinois. In addition, she created the University of Illinois Annual Art Therapy Summer Institute. She has been an invited guest faculty at many colleges and universities, and has refereed articles for psychiatric journals and reviewed art therapy proposals for publishing houses.

Dr. Wadeson has been a member of the AATA since its inception, serving on the Executive Board for six years. She chaired the Ad Hoc Committee on Funding and the Committee on Ethics and Professional Practice. She was Publications Chair when the

Newsletter was revised and again when the Art Therapy Journal was started. She also served as Research Chair where she edited the Guide for Conducting Art Therapy Research. *She served as Newsletter Editor and on the search committee for the* Journal *editor.*

Dr. Wadeson won the AATA's first prize for research in 1975. In addition, she has won the American Psychiatric Association Benjamin Rush Bronze Medal Award for Scientific Exhibits and the State of Illinois Resolution of Commendation for training art therapists who serve the citizens of the state. She has received 10 art awards, including first prize from the Smithsonian Institute in Washington, D.C. In addition, she has been curator for a variety of art exhibits. She has performed original poetry readings since 1983, and in 1991, she performed a poetry/karate and solo performance.

Dr. Wadeson began private practice in 1967 and continues to see clients privately to the present. Currently, she specializes in abuse and multiple personality disorders.

"The Happy Accident"

My most joyous moments in creating art are happy accidents—running paint or an unintended smudge—that change the direction of the work. My career in art therapy has that same sort of feel—meeting Hanna Kwiatkowska at the National Institutes of Health (NIH) 30 years ago and asking her what art therapy was. And when she told me, then asking, "How can I get training?" "I'll train you," she replied, and so I began 13 years of work at NIH that afforded me many "happy accidents." The artist finds new possibilities in the work as one color bleeds randomly into another. I have been fortunate in the many opportunities that were afforded me in this way. So in thanking you for this most high honor, I feel grateful that life has provided me an abundance of creative opportunities, many of which I did not seek. It has been an exciting privilege to develop my professional career in an emerging profession. Art therapy has been a generous and challenging provider.

In reaching this important pinnacle in my career, Honorary Life Member of the American Art Therapy Association, my mind wanders back, not only to that fateful meeting with Hanna 30 years ago, but also to other images from our collective professional past. For example, when I first visited Elinor Ulman to observe her art therapy groups at D.C. General Hospital, Elinor had blonde curls! With pictures like that in my mind, I thought it would be fun to try to collect some to share with you.

Thanks to the generosity of a number of friends and colleagues whose visages you are about to view, "Art Therapy Productions" brings you "The Way We Were."*

Our first conference was in 1970 at Airlie House outside Washington, D.C. Figure 1 shows me outside. The local arrangements for the conference were made by my mentor, Hanna Kwiatkowska. I'm not sure when Figure 2 was taken of some of the early, active members of AATA, but from the hippie get-up of Ron Hayes, I suppose it was the early '70s. With him are Helen Landgarten, Bob Ault, Mickey

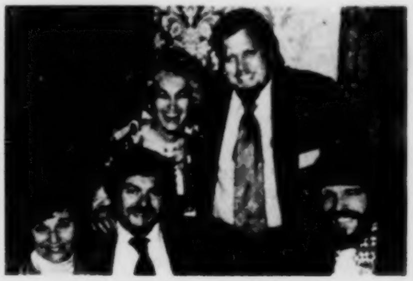


Figure 2.

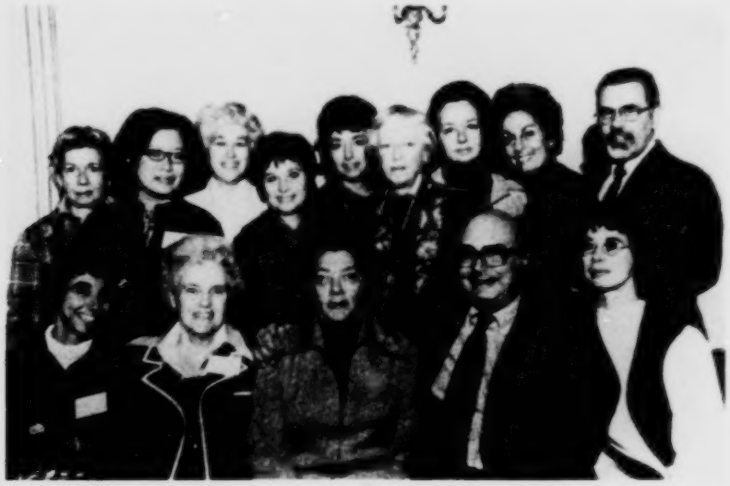


Figure 3.

---

*The actual presentation included 30 pictures, of which five are reproduced here.

Figure 4.

Figure 5.

Rosen, and Mickey's husband. In 1974 Felice Cohen was president. Here she is (Figure 3) surrounded by her Board. In 1980 the Art Therapy Educators Convocation was held in a castle in New Palz, N.Y. One of the big thrusts of that meeting was the formation of a Competencies Task Force. Figure 4 is one of its meetings. Myra Levick and Shirley Riley look pretty stymied to me. Finally, in 1985, there was a "Meet the Ol' Timers" event at the New Orleans Conference. I had completely forgotten it until Aina Nucho sent me this picture (Figure 5). I had now become an "Ol' Timer."

It's natural to feel nostalgic for the old days, remembering the laughs and good times more than the fights and acrimony. I've been around a long time, and I can tell you we've had both. But we can't bring back the times captured in those old pictures. And I don't think we want to. We've come a long way since then, thanks to both the old timers we just viewed in their younger days and the many newer timers who have worked hard for our profession.

It was a different world 20 years ago. Back-then, the initial reaction an art therapist was likely to get was "What's art therapy?" We tried to define ourselves, our work, and our place in the world, striving to balance ourselves with one foot in the world of art and the other in the world of therapy.

Those worlds seem more complex now, particularly in this period of economic instabilty and shrinking budgets. The opportunities afforded me at NIH, where I worked for 13 years with almost unlimited art materials, research support, and professional mentoring, that enabled me to publish in psychiatric journals with only a BA degree, would not be possible for a beginning art therapist today. Our creative endeavors now must be more fully conceptualized, more rigorously planned, less dependent on a benevolent fate to afford us a "happy accident" here and there.

For example, we pursue licensure for art therapists. In Illinois where I live, art therapists are looking into counselor licensing, following art therapists in other states who have already paved the way for inclusion of art therapists in the counseling license. Counseling licensure raises the question of the centrality of art in art therapy. Art therapy licensure raises questions of art therapy theory, cannons, dogma, diversity versus uniformity in training. We remain a hybrid profession, straddling as we do, art and therapy. Where do we belong? I believe we are at a crossroads. Twenty years from now when we look back will we cite licensure as a pivotal turning point in our profession's development? I think it is likely.

Our present shrinking job market challenges the art therapy profession to become essential rather than fringe—essential to the ever increasing needs within our society, of substance abusers, homeless people, battered women and children, more recently recognized needs of survivors of childhood sexual abuse, people with AIDS and their families, and on and on. So it behooves us to ask ourselves again at this time: "Who are we and whom do we want to become?"

My hope is that we look long and hard at the steps we are about to take so that as we continue to evolve as a profession, we will become the art therapists we want to be. The artist in us maximizes the "happy accident." She or he also recognizes the unwanted smudge. The nature of our special creativity in art therapy is the art of synthesis. We work whole cloth, a human life, a community, our culture. We run amuck when we forget to be whole and split ourselves into factions, artists or therapists, licensed professionals adhering to training standards or freer healers, and so forth. We understand that a work of art is more than the sum of its parts. It is a creative synthesis of form and content, line and shape, color and texture. I hope a model of artistic synthesis can serve us as we continue to create ourselves as art therapists and to mold the shape of whom we will become. I believe that we who are so creative in our art, in our work with our clients, in our development of training, in the many accomplishments of our extraordinary professional association, will continue to maximize the possibilities for the creative growth of art therapy.

In accepting this Honorary Life Membership in AATA, I feel an overwhelming sense of gratification. There are many honors possible to attain. But to be honored by my peers touches more deeply than any other. If we're fortunate, our parents may cherish us and our children may appreciate us, but rarely do our sisters and brothers do us honor. They see us for who we truly are, not for what they need us to be. For me, it is a deeply moving moment to be honored by you, my art therapy sisters and brothers, and it is with deep appreciation that I recognize you as my professional family, a group of people for whom I feel great admiration and affection.

Thank you for honoring me. Thank you for constituting a wonderful profession that has added immeasurably to my life. With all its ups and downs, good times and bad, AATA has felt like family. Art therapy has felt like home.

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 14-15 © AATA, Inc. 1993

American Art Therapy Association Distinguished Service Award—

Virginia M. Minar, MS, A.T.R.

Awarded at the 23rd Annual Conference of the American Art Therapy Association, Inc.,
Las Vegas, Nevada on November 7, 1992

Virginia M. Minar, MS, A.T.R., is currently an associate instructor in the Graduate Art Therapy Program at Mount Mary College, Milwaukee, Wisconsin. Her private practice is with cancer patients. Virginia retired in 1986 from the West Allis-West Milwaukee School District after 15 years as an art-exceptional education teacher/therapist. For 11 years, she was also an instructor in the undergraduate Art Therapy Program at Alverno College, Milwaukee, Wisconsin.

Virginia has held numerous positions with the Wisconsin Art Therapy Association, including 10 years on its Executive Board. Since 1978, she has served the AATA on the following committees: Finance, Art Therapy/Art Education, Appeals Study, Governmental Affairs, Nominations, Art for the Disabled, Education, and Standards, Ethics and Professional Practice; and has chaired the Registration Qualifying Board Central Division, the Honors Committee, and the Finance Committee.

Virginia has just completed three years as Treasurer of the AATA and has been elected to a two-year term as a Director of the association. She has been the Board liaison to the Membership Committee for two years and the Publications Committee for one year, and in 1993 will be the liaison to the Governmental Affairs Committee.

Remarks Upon Receiving the AATA Distinguished Service Award

I believe in magic—the magic of the creative process—the magic of the creative process as an agent of change unique to the creative therapies in general and to the art therapy profession in particular.

This is a magic moment for me. Because there are so many people in this organization who have given their time and energy to further the growth of our profession, I am deeply touched at being selected by the Honors Committee to receive this award. To know that the Board of Directors approved the selection, makes this moment more precious, for to be publicly recognized by your familiars is a rare occurrence.

I have often been asked why I have become so involved in this organization; why I have volunteered my services. It is because I believe so strongly in that mysterious, magical change in behavior that occurs when individuals can release their images and recognize their meaning. I have seen it happen for both children with developmental disabilities and adults living with cancer. In my own artwork, I am repeatedly awed by the experience of allowing the creative process to work—of finding answers to both recognized and unrecognized feelings and problems.

To those of you whom I have had the privilege of working with throughout my 17 years of membership in this organization, I thank you for your companionship on this journey toward wider recognition of our profession. To all of you who believe in the magic of the creative process, I ask you to use some of that energy and commitment in actively serving this organization. Winston Churchill, who painted to relieve the pressures of his leadership responsibilities, once said, "We make a living by what we get. We make a life by what we give." I have given a part of my heart, my head, and my hands to art therapy; in return, it has given me many magic moments. In this magic moment, I sense the warmth of your embrace. Thank you.

A Symposium

ART THERAPY IN THE TREATMENT OF POST-TRAUMATIC STRESS DISORDER: Sexual Abuse and Multiple Personality Disorder

- March 20 - 21, 1993
  Holiday Inn Airport #2
  Bloomington, MN

- May 7 - 9, 1993
  Days Inn - 57th Street
  New York, NY

Presented by the American Art Therapy Association, Inc.
Co-Sponsored by the Minnesota Art Therapy Association and the New York Art Therapy Association
Advance registration is advised.
Please call the AATA National Office for registration information.

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 16-22 © AATA, Inc. 1993

Journey Toward Integration: The Use of Collages to Assess the Separation and Individuation Process of an Adult Identical Twin

Susan Neece Malone, MA, and Marcia L. Rosal, PhD, A.T.R.
University of Louisville, Louisville, KY

Abstract

In this paper, a single case study using art therapy to facilitate the separation-individuation process of an adult identical twin is presented. The client was self-referred to a university counseling center. After initial crisis intervention sessions, the problems of dependency and identity were addressed through art therapy. The uniqueness of this study rests with its innnovative measurement tool, an inner circles collage which allowed the therapist to chart the client's intrapsychic move toward separation from her identical twin. The client used collages as a means of discovering differences between herself and her twin sister and to identify her own separate and unique sense of self.

Introduction

Thornton Wilder, himself a twin, described the pain of separation in *The Bridge over San Luis Rey* (1927). When Manuel dies, his twin brother, Esteban, cries, "I'm alone, alone, alone." For an adult exploring the issues of separation-individuation in therapy, the cries of Esteban can truly be understood. What awaits the client involved in the separation-individuation process may be one of the most painful experiences a twin will undertake, "for when self is part of another and another is part of self, self-identity is fragile and separation may bring fears of loss of self" (Siemon, 1980, p. 391).

This study is about Sally (a pseudonym), a 25-year-old identical twin, whose unresolved issues of separation and individuation from her twin sister, Sandra (a pseudonym), became the major focus of art therapy. Sally's concerns over her identity led to an examination of the literature on the issues of separation and individuation in the psychological life of twins. Thus, it is the purpose of this paper to examine the separation-individuation process in adult twins and to explore implications for treatment.

The Psychological Issues of Being a Twin

In a literature review on the separation-individuation process in same-sex twins, Terry (1975) provided psychological insight into the early development of twins. First, Terry theorized that twins never experience being the sole recipient of mother's attention. During the early months when children develop an early emotional attachment to mother, a twin develops two early attachments simultaneously: one to the mother and one to the twin. While the strong bond is developing between twins, a single child is experiencing the symbiotic phase with the mother. At the phase of differentiation, the twins are experiencing the feeling of not being alone.

Lassers and Nordan (1978) agreed that twins often substitute each other as surrogate symbiotic objects during separation from the mother. The twins may not struggle toward individuation, but replace mother by each other. The substitution of the twin for the mother interferes with intrapsychic separation which includes differentation, distancing, boundary formation, and disengagement from the symbiotic object. Terms used to define this close association between twins include twinning reaction, we-self, mutual interidentification, complementarity, and twin symbiosis (Terry, 1975).

Terry (1975) explored the ways that mutual dependency in twins is reinforced. First, the demanding work involved in caring for twins often calls for many modes of care. Thus, the one constant factor in the life of a twin may be the co-twin. When parents realize that each twin has a soothing effect on the other, they may frequently leave them together, depriving them of opportunities to relate to an adult. Therefore, being an identical twin offers a person a sense of security which may lead to a lack of individuation.

Mutual dependency may also develop due to imitation. One twin imitates the emotional reactions of the other, thus minimizing competition, conflict, and individuality. The more twins look alike, the harder it is for others to relate to them as individuals. Thus, Terry stressed the need for twins to be regarded as individuals. Parents need to develop an intimate relationship with each child by spending time with each child separately, thus encouraging individuality. Popular twin-rearing practices such as alike dressing, calling them twins, and praising or disciplining them as a pair should be avoided.

Siemon (1980) also saw the problems inherent in the development of identity as a twin as a substitute for identity as an individual. Siemon stated that as twins reach adolescence, the separation-individuation process becomes much more difficult than single children experiencing this at a very young age. Some responses to this later separation may be anxiety, denial, anger, and grief.

Siemon (1980) explored the issues of separation-individuation as they relate to the formation of other relationships as well. Problems with other relationships may be disturbed object relations, isolation, fear of intimacy, competition, mutuality, and psychology of the exception. In adulthood, having a child may pose a threat to self-identity. A relationship with a child may serve as a constant reminder of the kind of dependence a twin grows up with. Twins may also find it difficult to socialize because they have always relied on each other for support.

Ainslie (1985) referred to the "psychology of twinship" in presenting his theoretical framework for understanding the complications in twin identity formation and psychological development. Like Terry (1975) and Siemon (1980), Ainslie agreed that the problems in the psychology of twins are identity confusion, separation and dependency issues, and role complementarity. Through life history research of adult twins, Ainslie explored the fate of the twin relationship in both adolescence and adulthood. His research supports the hypothesis that early twin relationships continue to play an important role in the psychological life of adult twins.

Therapeutic Interventions

Intervention strategies for helping twins complete the separation-individuation process are reported in the literature. The need to treat twins as individuals is reinforced in an article by MacLean and Jones (1987). In work with a family with twins, MacLean and Jones helped the parents to treat the twin boys as individuals because one twin used acting out behavior as a means to assert his own identity. They suggested that therapy be focused on helping the child to express feelings in two ways: (a) to express anger at parents for not treating the child as an individual, and (b) to help the child express ideas which were different from his twin's ideas and from the family norms. Terry (1975) also supported helping parents to treat the twins as individual children.

Siemon (1980) offered three intervention strategies for adult twins. First, information on the psychological dynamics of twinship should be provided so that twins can begin to see themselves as individuals and reduce the trauma of separation. In addition, reinforcing the positive aspects of intimacy, closeness, and security will help a twin struggle with the negative aspects of such closeness. Thus, the focus of therapy rests on "resolving the grief of separation as well as on working through the twinship by developing a better individuated self" (p. 398). Finally, twins should not be seen together in therapy as this sets up the old pattern of seeing them as one unit.

Adelman and Siemon (1986) discussed the need for therapists to help adult twins make a relational shift. Relational shift is the term used by Adelman and Siemon when a twin changes the psychological meaning of being a twin. Thus, a twin is still able to be close with the sibling, but the ability to be separate is achieved. To address this issue, the use of "I" is stressed rather than using "we" which is so common among adult twins. The use of "I" in talking about the relationship with the twin helps the client begin to discuss the relationship, share feelings about separation, and affirm affection for the other.

Knowledge of early twin development is vitally important in understanding the separation-individuation issues of adult twins (Ainslie, 1985; MacLean & Jones, 1978). Certainly, understanding the unique psychological issues of being a twin was helpful in working with Sally. Also, the following intervention strategies found in the literature were incorporated into Sally's treatment plan: (a) providing information on the psychological dynamics of twinship (Siemon, 1980), (b) resolving the grief of separation (Siemon, 1980), (c) using the word "I" rather than "we" to assist in the relational shift (Adelman & Siemon, 1986), and (d) assisting the client in talking with the twin about the relationship (Adelman & Siemon, 1986).

Method

The hypothesis of this study was that art therapy would facilitate the separation and individuation process of an adult identical twin as measured by the weekly movement on a client-made inner circles collage. The main goal was to observe if the client became less enmeshed with her twin sister at the intrapsychic level. A secondary goal was to observe if the client became less enmeshed with other family members.

Design

An AB single case design was employed (Behling & Merves, 1984). This design included a baseline phase which was one session. In this session, the client created the inner circles collage, consisting of a drawing of concentric circles on 12" × 18" white paper on which collage symbols of significant others could be placed, but not affixed. The entire treatment phase covered a period of 11 weekly sessions.

Subject

Sally, an identical twin, was self-referred to a university counseling center. Her unresolved issues of separation and individuation became a major focus in her psychotherapy. She presented with feelings of depression, sadness, dejection, and self-blame.

Developmental Background. Sally described her home of origin as a "rather rigid, controlling, intellectual environment" in which there was an emphasis on thinking and doing and little importance placed on intuition and feeling. Affection was shown sparingly in the family.

At an early age, the twinship had a tremendous impact on Sally's growth and development. Although Sally's twin, Sandra, provided Sally constant attention and companionship, feelings of dependency began to form. The twins were expected to maintain and take care of themselves thus leading to distance and isolation from other family members, particularly the parents. They were often dressed in the same outfits although the colors were different. Sandra was often dressed in bold, bright colors such as red or orange while Sally was dressed in cooler shades of blue or green.

A traumatic situation regarding separation issues occurred during Sally's early adolescence when Sandra chose to move out of the bedroom they had shared since infancy. School friends told Sally that Sandra was acting strangely because she loved other girls. Sally remembered being devastated by this suspicion of her sister's homosexuality and she became the keeper of this secret. It wasn't addressed until the college years when Sandra confided in Sally that it was indeed true that she was homosexual.

Sally and Sandra chose to attend different colleges and Sally recalled the pain of separation during that period and considered the idea of transferring to Sandra's college. While Sally was dealing with the separation anxiety from her sister, she met her husband. It is possible that Sally married him to fill Sandra's role in her life. Sally reported feeling unsure about her decision to marry. She carried these doubts into her marriage and felt unfulfilled and uncertain during the first two years of the marriage. She became romantically involved with another man and admitted that her involvement was to sabotage herself, cause a crisis, and thus force herself to confront the problems in her marriage.

Treatment Prior to the Study. Twelve sessions of therapy were conducted before the research study which served to address immediate crisis-oriented concerns and to assess the client, identifying issues appropriate for longer term therapy.

The first five sessions were spent working on Sally's immediate concerns. When asked to identify her presenting problem on the personal information form, she stated she was pregnant, possibly not by her husband, and that the situation was causing her great distress. The therapist's role was a supportive one as Sally discussed several important decisions which needed to be made regarding her pregnancy, marriage, and extramarital relationship. It became evident that marital therapy was needed so that important joint decisions could be made about the pregnancy as well as the future of the marriage. Sally and her husband were referred to another therapist at the counseling center for this purpose.

Sally reported that both marital and individual therapy sessions helped her to make several important decisions. First, Sally asked her doctor to pinpoint the time of conception. The doctor was able to identify her husband as the father. Second, she decided to continue the pregnancy and keep the baby. Finally, she decided to end her affair and concentrate on making her marriage work. Once these decisions were made, emphasis was placed on identifying and assessing Sally's other needs.

Assessment. Sally was given several assessments including the House-Tree-Person drawing test (HTP) (Buck, 1981) and the Kinetic Family Drawing (KFD) (Burns & Kaufman, 1972). The person portion of the HTP and the KFD indicated that Sally was dealing with fears surrounding her own sexuality and identity. Some ambivalence regarding her sexual identification was indicated when she struggled to define the gender of the first person drawing. It seemed as though Sally struggled with the person drawings in her effort to picture them alike as well as different. When asked to identify herself in the KFD, Sally pointed to two figures and replied, "these two" and made no distinction between herself and her twin. It was at this point that she seemed to understand the impact of the twinship on her life.

From information accessed through the assessment drawings, it was hypothesized that Sally was unable to view herself as a separate individual and had concerns that she may be homosexual. The assessment sessions clearly laid the groundwork for beginning the separation work which Sally needed to do in order to individuate.

Inner Circles Collage as a Measure

Throughout the assessment sessions, it became evident that Sally had an affinity for collage work. The collages she created in therapy helped her to discuss issues and identify problems and solutions. It was hypothesized that using collage to evaluate therapy outcome was appropriate for this client and, therefore, the idea for the inner circles collage was developed to assess the process of separation and individuation. The client was directed to make an inner circles collage representing both herself and her significant others. On 12" × 18" white paper, Sally drew concentric circles representing each layer of herself with the smallest circle in the center representing her most intimate core self. Then Sally drew and cut out a symbolic shape which represented each significant person in her life. The symbolic shapes were then placed on the circles representing herself according to her perception of intimacy. The symbolic shapes were not affixed to the self-circle drawing.

During each session, Sally was asked to replace the symbolic shapes on the collage so that it could be referred to during the session. The client was not aware that the collage was a measurement tool and nothing else was said to avoid biasing the project in any way. After each session, the distance between the intimate core self and the symbol representing each significant person in her life was measured. Thus, the collage provided a means for measuring the separation-individuation process. Although the client was asked to place all significant people in her life on the collage, only the symbolic shapes of her twin sister and her husband were measured for the purposes of this paper.

Collage as a means of assessing therapeutic change is unique and not well-researched in the literature. However, it seemed the best approach to use as a measure of individuation because the symbolic shapes could be easily manipulated by the client within the concentric circles format and measured by the researchers. Also, the client showed a preference for this medium in treatment, as previously mentioned.

As stated above, the main goal of therapy was to assist the client to become less enmeshed with her twin sister as well as with other family members, including her husband. Therapy would also help Sally become aware of the need to discuss being a twin with her sister. Thus, art therapy themes focused on separation and individuation issues.

Results

Sally's movement of the shape symbols on the collage reflected the separation which was taking place (see Figure 1). When Sally completed the inner circles collage for the first time, her twin and her husband were overlapping and placed on Sally's inner core circle (see Figure 2).

The shape symbol (which was orange) repre-

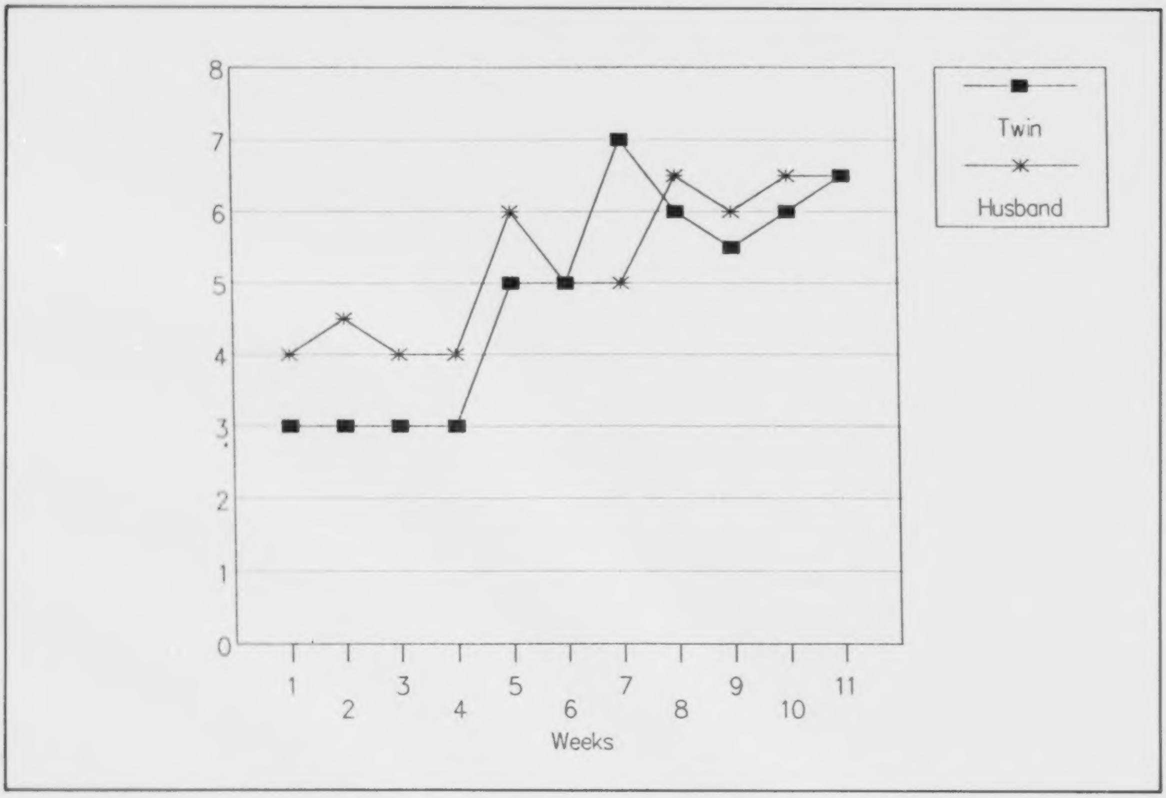


Figure 1. Movement of symbolic shapes of the twin and husband from the inner core circle of the client as measured in millimeters.

senting Sandra moved a total distance of 4.5 mm from the beginning of the study to the end, which seemed to be a major change. It took four weeks for Sandra's symbol to begin moving and once it did begin to move, the husband's shape symbol moved as well allowing the observer to see Sally's inner core circle. The husband's shape symbol (which was red) moved a total distance of 2.5 mm (see Figure 3).

The fact that Sally overlapped the shape symbols of her twin and her husband at the beginning of the study supported the concern that the husband was a replacement for Sandra during Sally's college years. In addition, Sally used warm, bright colors (orange and red) for the shape symbols for both her twin and her husband. Sally identified Sandra with the warm, bright colors from her dress in childhood. Sally's choice of red for her husband further supports the hypothesis that Sally's husband was someone to replace Sandra.

Perhaps the most interesting result of the study was that as Sally became less enmeshed with her twin, she became less enmeshed with other family members as well. This can be observed by comparing Figures 2 and 3 and noting the separation and distancing of the other shape symbols.

Treatment Overview

During processing of the inner circles collage in the second session, fears regarding homosexuality were discussed. Sally recalled that homophobia had developed over the years since Sally's discovery that Sandra was a homosexual. She stated that in order to deal with these fears, it was important for her to separate in order to understand her own identity. An article on twin separation and individuation (Adelman & Siemon, 1986) was given to her to read as homework.

In the following session, Sally chose to discuss the twin article and reported that she really identified with the author who was a twin. She said that she felt relieved and understood. She talked about how devastated she was at age 12 when Sandra had

1372

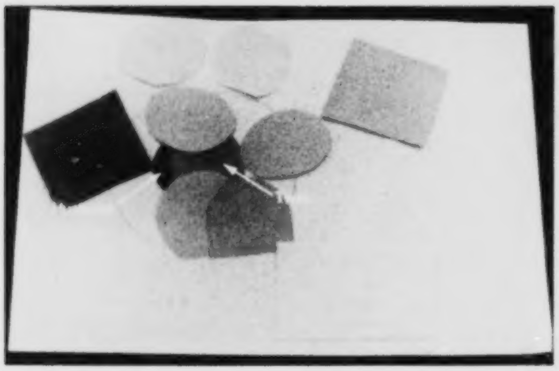


Figure 2. The placement of symbolic shapes on the first inner circles collage completed.

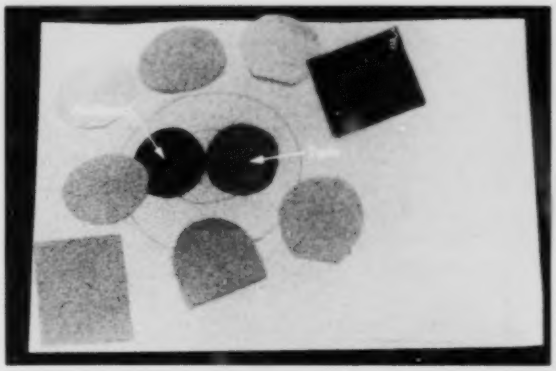


Figure 3. The placement of the symbolic shapes on the inner circles collage completed in the final session of the treatment phase.

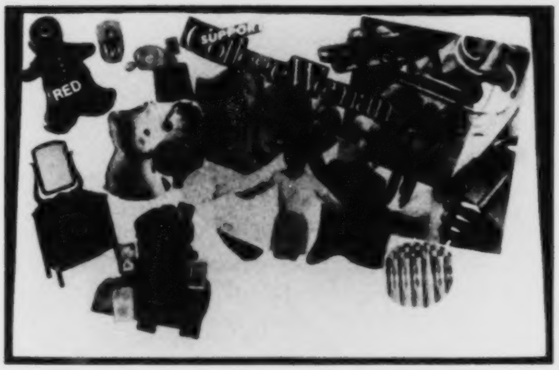


Figure 4. The client's collage in response to, "Who is my twin?" The client represented her twin as a red gingerbread figure.

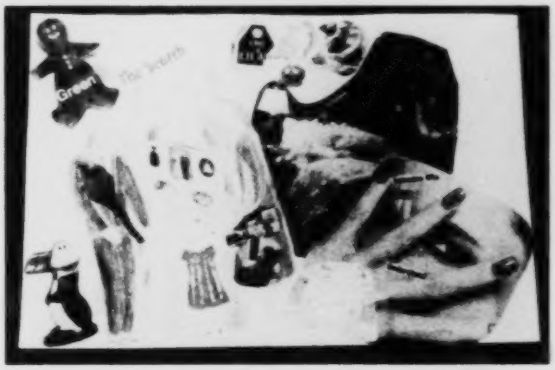


Figure 5. The client's collage in response to, "Who am I?" The client represented herself as a green gingerbread figure.

chosen to be physically separate from her. Feelings of abandonment and isolation were buried within her, and she connected her need to "latch onto others" as a consequence of this past traumatic event. She constructed two collages: one answering the question, "Who is my twin?" and the other answering the question, "Who am I?" (see Figures 4 and 5) which she processed in the fourth session.

She chose to process the collage about Sandra first (Figure 4), followed by the collage about herself (Figure 5). She used a red gingerbread person to represent Sandra's burning intensity and a green one to represent her own reserve. There was a strong division between the masculine and the feminine in the two collages. The collage about Sandra was filled with images representing the more masculine qualities of the personality. Sally was aware that she gave Sandra's collage a car, sports items, and a sense of physical activity. In contrast, feminine qualities of the personality were represented by the images in Sally's self-collage. In discussing the collage about herself, Sally noted the emphasis on passive, nurturing items and was aware of the opposite nature of the collages. As she placed the collages side by side, she stated that together they represented a whole; apart each collage was incomplete. Thus, the collage activity was very beneficial for Sally to identify her need to activate the more masculine side of her personality.

It was in session 5 and after the production of the self/twin collages that Sally began to move the shape symbols of both her twin and her husband away from her inner core circle (see Figure 1). The self-twin collages were referred to again in session 9. Sally commented that sad feelings caused her to feel less whole and stated that it was important for her to stay in touch with the "red" within her. Sally stated, "I've spent my life looking at Sandra and trying to figure her out and now it's time for me." She continued by saying, "We are both whole . . . we both have gifts, some alike and some different."

During session 11, Sally initiated a discussion about the realization that she had not fully separated from Sandra. She identified the importance of talking with Sandra explicitly about their relationship. Sally also realized the importance of saying good-bye in therapy so that she could learn to say good-bye to the wounded part of the self. In addition, she acknowledged that it had never been difficult to say good-bye before because she had never allowed herself to become invested. She stated, "I can feel my feelings for the first time in my life. After Sandra burned me, I became guarded and protected. I don't have to be any more."

Sally's realization that she needed to discuss her relationship with her twin was the final goal of therapy. As Adelman and Siemon (1986) stated, it is important for the twins to discuss their relationship in order for identity separation to occur.

Discussion

It was the expectation of this study that art therapy would facilitate the separation-individuation process of an adult identical twin. Art therapy touched Sally in a way that verbal therapy alone could not because of her ability to think metaphorically through the art therapy process. It was through her collages that she was able to integrate thought with feeling.

It became obvious that Sally developed a more integrated self. This was evident through the movement of shape symbols in the inner circles collage as well as through her growing ability to assert herself and to identify the more masculine side of her personality.

There is a need for more research regarding adult twin individuation-separation as illustrated by the limited literature found for this study. There are many questions left unanswered such as: (a) How do twins negotiate their relationships in later life? (b) How do relationships with significant others impact on the twin and vice versa? and (c) Is intimacy between twins critical in decisions to marry and divorce? The single case study presented here only begins to answer some of these questions. There is a need to replicate this research and to research other aspects of the use of art therapy with twins.

The collage as a tool to measure the individuation-separation process was an integral part of the study and served to support the efficacy of art therapy. The inner circles collage was adapted specifically for use with this client and was easy to administer. Although the inner circles collage was not tested for validity or reliability, it proved to be a valuable tool to measure clinical changes. The specific use of collage to measure therapeutic change in this study demonstrates that it should be investigated as an assessment tool in art therapy.

As the present study indicates, art therapy provided a unique opportunity for a twin to move toward wholeness. Through art, the therapist was able to identify that the client had not psychologically separated from her twin and continued to see herself as part of a unit. The artwork reflected the divided, yet enmeshed, personalities of both Sally and her twin. The client eventually worked toward acceptance of personality traits which she had given over to her twin. Art facilitated Sally's journey to find the other half within herself. The use of collage as a tool for assessing therapeutic change in the separation-individuation of twins was exciting and presents possibilities for future use.

References

Adelman, M., & Siemon, M. (1986). Communicating the relational shift: Separation among adult twins. *American Journal of Psychotherapy, 40*, 96–109.

Ainslie, R. (1985). *The psychology of twinship*. New York: Academic Press.

Behling, J. H., & Merves, E. S. (1984). *The practice of clinical research*. New York: University Press of America.

Buck, J. (1981). *The House-Tree-Person technique*. Los Angeles, CA: Western Psychological Service.

Burns, R. C., & Kaufman, S. H. (1972). *Actions, styles, and symbols in Kinetic Family Drawings: An interpretive manual*. New York: Brunner/Mazel.

Lassers, E., & Nordan, R. (1978). Separation-individuation of an identical twin. *Adolescent Psychiatry, 6*, 469–478.

MacLean, G., & Jones, B. (1987). The psychological development of a twin: A case study of the importance of a symptom. *Canadian Journal of Psychiatry, 32*, 588–594.

Siemon, M. (1980). The separation-individuation process in adult twins. *American Journal of Psychotherapy, 34*, 387–400.

Terry, G. (1975). The separation-individuation process in same-sex twins: A review of the literature. *Maternal-Child Nursing Journal, 4*, 121–127.

Wilder, T. (1927). *Bridge over San Luis Rey*. New York: A. & C. Boni.

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 23-29 © AATA, Inc. 1993

Profile of the Artist: MARI® Card Test Research Results

Carol Thayer Cox, MA, A.T.R., Washington, DC and **Phyllis Frame, MA, A.T.R.**, Charlottesville, VA

Abstract

The authors are approved MARI® instructors in mandala assessment and Board members of the Association of Teachers of Mandala Assessment, Inc. who have been using the MARI® Card Test developed by art therapist Joan Kellogg, MA, A.T.R., in their clinincal work. After several years of testing artists and/or art therapists, the authors observed specific patterns unique to this population. Thus, the question was raised: Is there a personality profile for the artist? A research project was designed to test the authors' hypotheses about the creative personality. The MARI® Card Test was administered to an artist group (70 subjects) and a control group (70 subjects). Results yielded significant differences in card and color choices.

The MARI® Card Test, developed by art therapist Joan Kellogg in 1978, is a projective psychological instrument that is now being researched and validated in various parts of the country. The test is based on the archetypal imagery found in mandala drawings, or drawings in a circular form. According to Jung's theory, the images or archetypes found in the collective unconscious contain ancient memories of the development of human consciousness, common to all humankind (Jung, 1965). Each archetype reflects a psychological process or instinct, with the mandala representing the most powerful archetype of all, ". . . the ultimate unity of all archetypes" (Storr, 1983, p. 292).

The ritual mandala has ancient roots in Eastern religious tradition as a form of visual meditation and as a symbol of wholeness and perfection. The personal mandala, on the other hand, reflects one's psyche at any given moment, one's inner struggles, the light and the dark, many levels of consciousness, and the potential for change.

Mandala is a Hindi word derived from Sanscrit meaning "circle." Jung considered the mandala to be an archetypal symbol representing wholeness. He said that drawn mandalas were like "cryptograms concerning the state of the self" (1965, p. 196). During his many years as a psychotherapist, numerous mandalas were described as dream images and often drawn, painted, modelled, or danced by his patients during moments of crisis or transformation. They were symbols for the process of individuation which he defined as, "the coming to self-hood or self-realization," a drive toward psychic wholeness (1979, p. 78).

Joan Kellogg's work has deepened our understanding of the archetypal images found in many personal mandalas. She has worked with psychiatrists in clinical settings with a variety of patients. In her consultant work at the Maryland Psychiatric Research Center near Baltimore, mandala drawings were used as a monitor of change and progress during treatment. Patients would be asked to color with oil pastels a pencil outlined ten and one half inch diameter circle. Having only demographic information about the patients, Kellogg interpreted these mandalas on the basis of color, movement, and symbols.

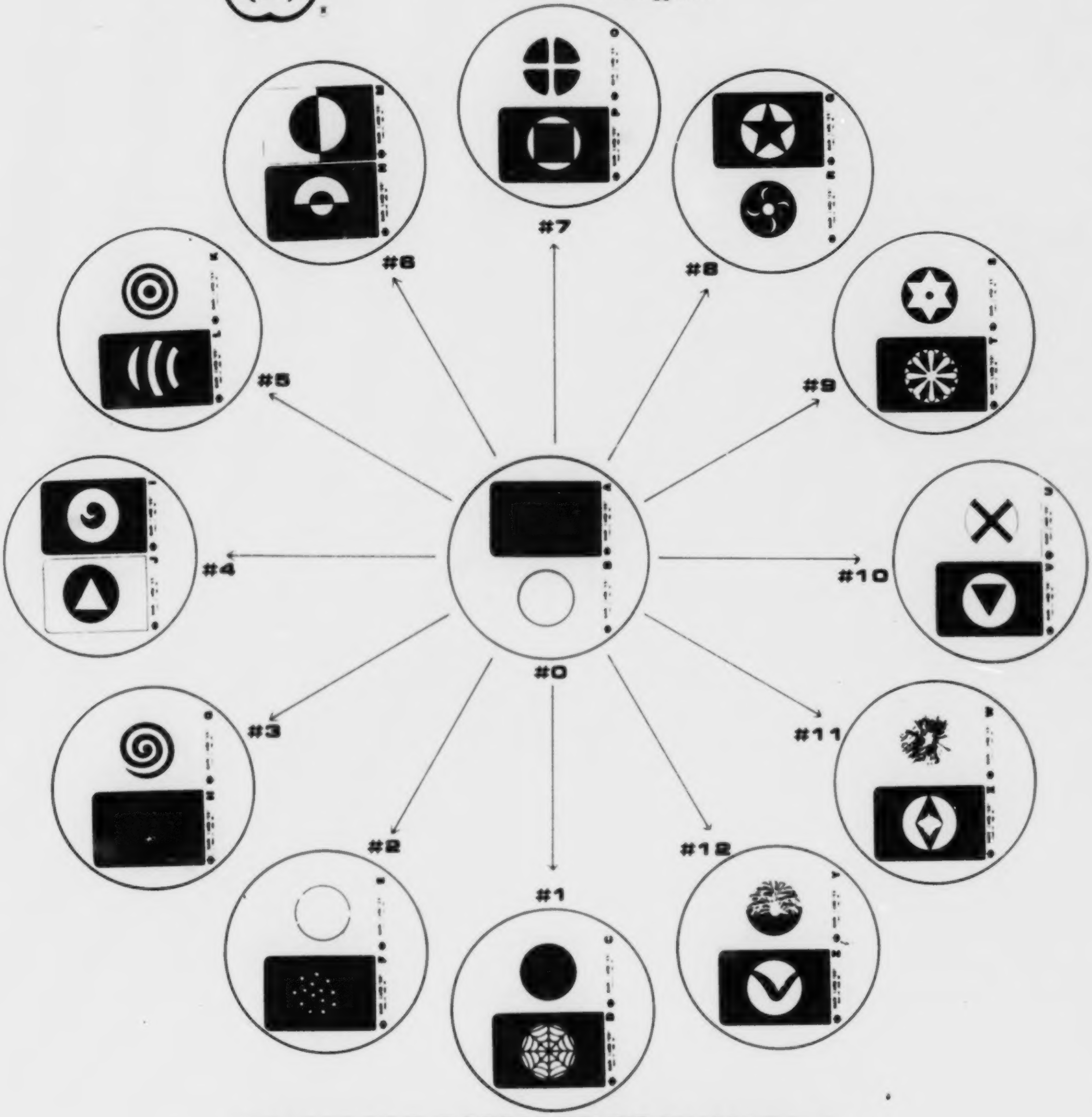
Beginning in 1969, after reviewing hundreds of drawn mandalas at different institutions and in private practice, she began to notice recurring images, patterns, and shapes depicted in the drawings. She

---

Editor's note: The authors wish to express their appreciation to David Cox, B.S., for his technical knowledge and assistance in computing the data and tabulating the results.

MARI® Card Test

Joan Kellogg 1991



STAGES OF THE GREAT ROUND OF MANDALA.

0. **Clear Light**
1. **The Void**
2. **Bliss**
3. **Labyrinth, Spiral**
4. **Beginning**
5. **The Target**
6. **The Dragon Fight**
7. **Squaring of the Circle**
8. **The Functioning Ego**
9. **Crystallization**
10. **Gates of Death**
11. **Fragmentation**
12. **Transcendent Ecstasy**

Joan Kellogg 1991

MARI® (Mandala Assessment and Research Instrument)
JOAN KELLOGG, M.A., ATR P.O. Box 463 Lightfoot, VA 23090

Figure 1.

BEST COPY AVAILABLE

organized these images into a circular design with 13 basic structures which she calls the "Archetypal Stages of the Great Round of the Mandala" (1978) (Figure 1). Out of this theoretical work she developed in 1978 the first version of the Mandala Card Test, which has since been renamed the MARI® Card Test (1991). (MARI® is the registered trademark for the Mandala Assessment Research Institute.)

The test, in its present revised version, is composed of 26 design cards, representing the 13 archetypal stages (2 versions in each stage). For research purposes, a letter of the alphabet is assigned to each card. There are 38 colored cards and one in foil. A number is assigned to each color card. The designs are embossed in black on clear plastic cards. The color cards are on paperstock. The colors in the test match the oil pastels Kellogg used in her study of the mandala drawings. All the patients' mandalas were drawn using a standard set of Holbein oil pastels. Kellogg selected matching color stock for the test.

The client is asked to select five design cards which appeal to him/her and is then asked to select a color card for each design chosen. The color card is placed under the transparent design card. The resulting five design cards, each with an appropriate color, is ranked according to preference. Art therapist Phyllis Frame has included an additional request, the choice of a sixth card which she calls the rejected card. She has the client choose the design card which appeals to him/her the least along with a color card which best matches his/her feelings about the design card. In her clinical work, Frame also has the client select a second color card that seems to make the rejected card more acceptable.

The MARI® Card Test is a nonverbal test which assesses an individual's present state. It tends to be situational; subsequent test choices may be influenced by time, treatment, and significant life events. From clinical observation it seems that over time, the more healthy subject will choose a variety of stages and colors. Less healthy subjects tend to be more restricted, and repetition in either designs and/or colors is common. It has been observed that some movement reflected in a change in design and color choices can be generated through therapy. A choice selected repeatedly over time warrants investigation of its significance for the client, however, and might indicate ongoing psychological and/or physiological issues and/or basic personality traits.

The MARI® Card Test gives clues as to different psychological processes at work within the individual at any given moment and assesses the person's current state. The stages are cyclical and should not be thought of in terms of one being more significant than another. All reflect a continuing process of change and growth.

Brief Description of the 13 Stages

0	Clear Light: Source of all being
1	Void: Deep unconscious
3	Bliss: Passive/receptive, generative space
3	Labyrinth, Spiral: Focused movement of energy
4	Beginning: Symbiotic, narcissistic space
5	Target: Defense, boundary setting
6	Dragon Fight: Struggle, ambivalence, separation
7	Squaring the Circle: Integration, union of opposites
8	Functioning Ego: Self-identity, autonomy
9	Crystallization: Socialization, completion
10	Gates of Death: Acknowledgement of loss
11	Fragmentation: Ego disintegration
12	Transcendent Ecstasy: Change of consciousness

Advantages in using this test are ease of administering, unattended self-testing (although the process of selection is always interesting to observe and may contribute to an overall understanding of the client), use with clients unfamiliar with the English language, and with inarticulate and nonverbal clients, as well as with those who may be psychologically defended. The test is generally perceived as acceptable and nonthreatening. It has not been validated and is currently considered a research instrument. It is important to note that this is a potential projective test, developed by an art therapist, that uses both color and form whereby results can be quantified for purposes of statistical analysis.

Interpretation of the MARI® Card Test is based on Kellogg's theory of the stages and her theory about color from the perspective of the Great Round of Mandala. Kellogg's hypotheses about color are derived from many interdisciplinary sources and theories, including anthropology, biology, physics, and psychology. Continuing research on the MARI® Card Test will not only determine the validity of Kellogg's theories, but will also expand the theoretical base for its use as a projective test.

Research Design

The authors decided that it might make an interesting research project to take advantage of the art therapists gathered at the 1985 AATA Conference in New Orleans and to devise a systematic study using the MARI® Card Test with this population. The purpose of this research project was to determine if artists and art therapists differ as a group from the general population in choice of symbolic stages and colors, using criteria developed by the MARI® Card Test. For purposes of simplicity, the artists and art therapists shall heretofore be referred to as the artist group. It was assumed by the authors that art therapists have had training in visual art and have an understanding of the creative process.

A demographic form was devised with questions relating to age, sex, ethnic background, education, art education, current physical or emotional problems, and sexual abuse. Current feeling states were assessed by the selection of two descriptive words for each stage. Participants were asked to circle the words which seemed applicable to them at the time of completing the form. The MARI® Card Test was administered by art therapists familiar with the test and who were certified in Mandala Assessment (i.e., having taken Kellogg's 30-hour basic MARI® Course in Mandala Assessment). Fifty percent of the testing of art therapists was done at the AATA Conference. The others were tested later in Washington, D.C., Maryland, and Virginia, and included artists who were not art therapists. Participants who elected to be part of this research were asked to take the MARI® Card Test and complete the demographic form.

The control group was given the test after the data from the artist group had been gathered. The control group consisted of a nonpsychiatric population of individuals who had no art beyond grammar school and were not actively involved in any type of creative activities. This criterion was determined from the demographic questionnaire and a personal interview.

The following hypotheses were formulated:

1. That there is a significant difference in color and stage preference between the artist and control group.
2. That the artist group more often selects the axis 6-12, with the implication that creative struggle precedes a new level of artistic inspiration.
3. That colors and stages that Kellogg has noted to be sometimes associated with somatic distress are more significantly chosen by those under a doctor's care for physical problems.
4. That certain stages or colors are more significantly chosen by individuals who are currently seeking professional help for emotional problems.
5. That certain colors and stages are more significantly chosen by sexually abused persons.
6. That the feeling state word choices correlate significantly with the stages selected on the MARI® Card Test.

Of the 140 people who participated in this study, 119 were females and 21 were males. This is due to the fact that the majority of art therapists tested at the conference were females. The age distribution ranged from age 18 to 80, with the largest distribution in the 30–40 age range. The respective ages of the artist group and the control group were fairly equally distributed.

The SPSS-X®, a statistical program for social sciences, was used to analyze the data. After running a frequency distribution of colors and stages by both the artist group and the control group, a basic chi square level of significance interpretation was done. A null hypothesis was established. For example, the artist group shows no preference for color (i.e., colors are selected with equal frequency). This hypothesis was then tested against the research hypothesis, that is, that the artist group shows a preference for color (i.e., colors are selected with unequal frequencies). The typical research chi square level of significance of .05 or less was used. A significance level of .01 was considered to be highly significant. The Yates correction for continuity was used for all chi square levels of significance.

Results and Discussion

The completed results turned out to be highly significant, that stages and colors were selected by preference and not randomly chosen. These results, of course, are what would be expected, but research procedures indicate the necessity for establishing this basic level of significance for preference.

I. The following stage selections were significant: Stage 0 (.0045 significance), Stage 6 (.0201), and Stage 7 (.0201) were chosen by the artist group rather than the control group. Stage 9 (.0006) was chosen by the control group.

   Possible explanation for stage selections:

   - Selection of Stage 0 by the Artist Group—Artists by the nature of their work are often in touch with the universal source of creativity stemming from the deep unconscious.

- Selection of Stage 6 by the Artist Group—Creative struggle is a necessary part of the artistic process. Artists often address conflicts, opposites, and dichotomies in their work in order to achieve a sense of harmony in what they do.
- Selection of Stage 7 by the Artist Group—The creative struggle is often followed by a sense of unification and integration. Fully functioning artists need to utilize both right and left hemispheres of the brain.
- Selection of Stage 9 by the Control Group—The energy of the control group may be more focused on the here and now, socialization, and their lifetime goals rather than on struggle, the unconscious, and personal growth.

II. The five most popular stages for both groups combined were 3, 8, 9, 11, and 12. Stage 12 was the most popular stage choice for each group. The only significant difference in color choice for these particular stages was that in Stage 12 the artist group selected aqua, turquoise, and yellow, and the control group selected azure blue and royal blue (.0269).

Possible explanations for stage and color selections:

- Popularity of Stage 12 for Both Groups—Stage 12 suggests the longing for wholeness and renewal. Both feelings are common to most people at various times in their lives.
- Selection of Aqua, Turquoise, and Yellow for Stage 12 by the Artist Group—Aqua and turquoise in Stage 12 imply energy directed toward healing and growth, while yellow in Stage 12 brings consciousness into the renewal process.
- Selection of Azure Blue and Royal Blue for Stage 12 by the Control Group—Blues on Stage 12 speak to trust in the process, use of intuition, and support for change.

III. The following color choices of the two groups compared to one another were found to be significant:

1. Azalea, a very hot pink, was highly significant in that it was more frequently chosen by the control group (.0062).
2. Chartreuse was found to be significant in that it was more frequently chosen by the control group (.0198).
3. Turquoise was found to be significantly chosen by the artist group (.0150).

In other words, a significant relationship existed between the selection of these colors and whether or not a person was an artist or a member of the control group.

Possible explanations for color selections:

- Selection of Azalea by the Control Group—Azalea is a color which reflects high energy and anxiety. Its significant selection by the control group suggests a higher level of anxiety for this group than for the artists who have more chance to express these feelings through their art.
- Selection of Chartreuse by the Control Group—The choice of this color is mainly significant due to the fact that fewer artists (2) chose it than did the control group (11). Chartreuse is a color that sometimes represents burnout. This could mean that fewer artists feel burned out on their jobs than the nonartist. Although these numbers are small, it is an interesting difference to note.
- Selection of Turquoise by the Artist Group—As stated previously, turquoise is a healing color. It is often used by people who have experienced early wounding. Perhaps artists engage in creative endeavors to help heal themselves.

IV. The axis choice which was found to be the most significant for the artist group is axis 6–12 (.0273). The axis choice most significant for the control group is axis 2–8 (.0484).

Possible explanations for stage selections:

- Selection of Stages 6–12 for the Artist Group—It was previously theorized by Kellogg that the artist's axis would be stages 3–9. Stage 6, struggle, versus Stage 12, transcendence, may reflect the creative process for many artists. Rollo May so aptly describes this inner process: "A dynamic struggle goes on within (an artist) between what he or she consciously thinks on the one hand and, on the other, some insight, some perspective that is struggling to be born" (1975, pp. 62–63). ". . . the struggle with limits is actually the source of creative productions. . . . Creativity arises out of the tension between spontaneity and limitations" (May, 1975, p. 137). Suzanne Langer also speaks of this tension: "A work of art is a composition of tensions and resolutions, balance and unbalance, rhythmic coherence, a precarious yet continuous unity" (1957, p. 8).

- Selection of stages 2–8 for the Control Group—This was an unexpected finding. This axis choice speaks to the control group's need for a sense of self-identity which may be attained through career (Stage 8, functioning ego) along with the need to let go, relax, and escape the demands of everyday pressure (Stage 2, bliss).

V. In a cross-tabulation of color choice and people who indicated they were under emotional or physical care by a physician, it was found that people under care significantly chose peach (.0373), but significantly avoided dark rose (.0426). Another significant finding was that people under care did not tend to choose Stage 3 (.0151).

It is interesting to note that 15 out of 70 in the control group indicated they had problems (3 emotional and 12 physical). There were a total of 24 artists out of 70 who indicated they had problems (16 emotional and 8 physical). There was no significant difference between the stages or colors chosen for emotional versus physical problems.

Possible explanations for color selections:

- Selection of Peach and Avoidance of Dark Rose by People Under Emotional and Physical Care—This population selected peach, a body color, raising issues around the body/feeling state as being important. This choice implies a sense of vulnerability and/or a need for positive touch or a positive body/feeling state. The avoidance of dark rose, a color suggesting wounding on an emotional or physical level, may be an unconscious avoidance reaction to these negative states. Both of these colors are sometimes considered somatic indicators in Kellogg's hypotheses on color.
- Avoidance of Stage 3 by People Under Physical and Emotional Care—This population may be unwilling to move into the unknown because of a high level of anxiety and fear related to their problems. They already are in a state of uncertainty and Stage 3 would make this state even more intense.

VI. With the sexual abuse question, the hypothesis was that the abused and the nonabused would differ in their preference for stages and colors. Out of the 70 control group members, only 7 people indicated that they were sexually abused. However, of the 70 artists, 22 people indicated sexual abuse. When abuse by color and stage for the artist group only was cross-tabulated, the results showed that those who had been sexually abused did not choose Stage 7 (.0310). Another finding was that those who were abused significantly chose magenta (.0284).

Possible explanations for stage and color selections:

- Avoidance of Stage 7 by Sexually Abused People—Those who had been abused did not select Stage 7, the stage of uniting of opposites, the masculine and the feminine. This stage correlates with Freud's genital phase. A person who has experienced sexual abuse would not necessarily be attracted to a stage reflecting sexual issues.
- Selection of Magenta by Sexually Abused People—This color relates to anxiety and inflammation and perhaps a call for help. It also may reflect a positive desire for self-assertion, all of which relate to abuse.

VII. There was no correlation between feeling words and stages. This may be due to reaction-formation or the fact that many people are not consciously aware of how they are feeling. Also, the forms and colors of this test tend to elicit unconscious material which may be preverbal and not linked at all to actual words.

Conclusion

Artists seem to have a propensity for dealing with conflict and unresolved issues and tend to go inward for inspiration and healing in their process of integrating dichotomous aspects of their creative struggle. Healing self and/or others seems to be a motivating force for artists/art therapists.

People who are not engaged in creative pursuits seem to be more involved with their roles in society and family, accept outward circumstances with a certain amount of trust and sense of support, and seem to be less apt to address inner struggle and conflict. The anxiety level of these people seems higher than artists, perhaps because they have no usual means of discharging inner tensions as artists do through their artistic process.

More of the artists acknowledged emotional problems which may reflect a higher level of psychological wounding. The choice to create may relate to their need for self-expression and healing. The nonartists acknowledged a higher percentage of physical problems and very few emotional problems. One might question whether these people may somaticize emotional problems as they have fewer outlets for creative self-healing. People who are under emotional or physical care seem to feel vulnerable and are trying to repress their anxiety about their condition. They seem to want body contact, physical reassurance, and support in a safe context from their caretakers.

Artists reported more frequent incidence of sexual abuse than the nonartists, which raises questions about the validity of the control group's response since recent statistics reveal that approximately one out of three women have been molested by the age of 18 (Russell, 1988, p. 25). People who have been sexually abused tend to avoid intimate relationships or to seek a sense of power or control within a relationship in order to allay their anxiety.

The results of this study support the assumption that the person who actively creates functions differently from the person who does not. Artists have long known of their uniqueness and their differences from the norm. One of the hopes of this study is that these unique traits of the artist can be elucidated and understood more fully.

This study focused on the visual artist only. Future studies are recommended to test other kinds of artists, such as musicians, poets, and dancers, to see if they fulfill the criteria established by this study for the profile of the artist or if there are other profiles for different types of creative artists. Further research is also warranted to see if there are differences between visual artists who are art therapists and visual artists who are not art therapists. The MARI® Card Test appears to be an excellent tool for these types of study, since it tests for many levels of functioning, both conscious and unconscious.

Carol Thayer Cox, MA, A.T.R., is on the faculty of The George Washington University, Graduate Art Therapy Program, Washington, D.C. Phyllis Frame, MA, A.T.R., is the Director, Round Oaks Creative Center, Charlottesville, Virginia. Correspondence concerning this article may be directed to either Ms. Cox or Ms. Frame.

References

Jung, C. G. (1959). *Mandala symbolism*. Princeton, NJ: Bollingen Series.

Jung, C. G., von Franz, M. L., Henderson, J. L., Jacobi, J., & Jaffe, A. (1964). *Man and his symbols*. Garden City, NY: Doubleday.

Jung, C. G. (1965). *Memories, dreams, reflections*. (A. Jaffe, Ed.). New York: Vintage Books.

Jung, C. G. (1979). *Word and image*. (A. Jaffe, Ed.). New York: Vintage Books.

Kellogg, J. (1977). The use of the mandala in psychological evaluation and treatment. *American Journal of Art Therapy, 16*, 123–134.

Kellogg, J. (1992). Color theory from the perspective of the great round of mandala. *The Journal of Religion and Psychical Research, 15*(3), 138–146.

Kellogg, J. (1978, 1981, 1984, 1987, 1991). *Mandala: Path of beauty*. Clearwater, FL and Lightfoot, VA: MARI.

Langer, S. (1957). *Problems of art*. New York: Charles Scribner & Sons.

May, R. (1975). *The courage to create*. New York: Bantam Books.

Russell, D. (1988). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. In L. Walker (Ed.), *Handbook on sexual abuse of children* (pp. 19–36). New York: Springer Publishing Co.

Storr, A. (1983). *The essential Jung*. Princeton, NJ: Princeton University Press.

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 30-38 © AATA, Inc. 1993

Viewpoints

Making the Unknown Visible:
Panel Rounds at Franklin County Medical Center East Spoke Psychiatric Unit, Greenfield, MA, March 17, 1992

Panelists:

George S. Patrick, MD, Medical Director, Mental Health Services, Franklin Medical Center; **James R. Shortell, PhD,** Chief Clinical Psychologist, Franklin Medical Center; **Nicholas Fleisher, MSW, LICSW,** Social Work and Group Program Manager, Franklin Medical Center; **Victoria J. Wilk, RN, MS,** Program Manager, Inpatient Mental Health Services, Franklin Medical Center; **Gwen Brown, BFA, MA,** Candidate in Art Therapy, Recreation Therapist, Franklin Medical Center; **Elizabeth Zemelka, BA,** Art Therapy Intern, Franklin County Medical Center.

Introduction
by Victoria J. Wilk

Mental health, like other medical treatment modalities, is struggling with a mandate to provide good care in the shortest time possible. The unit manager is charged with bringing the talents of her team to prevail on the ubiquitous nature of mental illness in as rapid and cohesive a fashion as possible.

Our 20-bed psychiatric unit is housed within a general hospital in a predominantly rural setting. As a generic psychiatric unit, it admits patients ages 14 to the elderly, with no upper age limit or limitation due to physical illness.

Art therapy has been part of the treatment modalities since Summer 1991. During that period the artwork of one psychotic patient was particularly powerful and allowed the team to interact with him when there seemed to be little hope for his progress. This confirmed the multidisciplinary team's belief in the usefulness of artwork in this setting. It culminated in this collaborative presentation.

An Introduction to Art Therapy
by Gwen Brown

The connection between art and healing has existed throughout history. Shamans from many cultures have used carved figures in their healing rituals. Native American Navajo shamans heal with sand paintings. In Tibet, a tanka or scroll painting might be given to a patient as a prescription for meditation.

In Western Europe, an interest in the art of psychiatric patients began in the 1800s when Hans

---

Associate Editor's Note: Art therapy is relatively new to Western Massachusetts' treatment programs. In this paper, the treatment team describes how they used their recently formed art therapy program in diagnosis and treatment. The Panel Rounds provided a public forum for sharing their work and giving art therapy a wider audience. This was a first in the history of the hospital. Portions of the panel discussion have been edited for the purposes of publication.

Prinzhorn, a German psychiatrist and art historian, collected many works by patients. At about the same time, Freud was studying dreams and Jung was exploring archetypal symbolism. Both generated interest in the imagery of the unconscious. Children's art was given serious attention for the first time during the 1880s, resulting in the identification of developmental stages in children's art.

Art therapy as a distinct practice was born during the 1940s. Margaret Naumburg and Edith Kramer applied psychoanalytic theory to their work in art education and therapy with children. Naumburg used art in addition to verbal therapy, while Kramer viewed the process of artmaking as therapy. The field of art therapy expanded in these two directions and now is approached from many philosophical perspectives and used with individuals and groups in a wide variety of settings.

We are familiar with the powerful way art can communicate feelings. Artists themselves have been both admired and ostracized. I believe people react strongly to artists because art taps the unconscious of the artist, who communicates with the viewer on many levels through his/her artwork. This both intrigues and scares us. When we encounter a nonrepresentational painting or sculpture we may think, "I don't understand this." What we *feel* is different. There is a level of recognition that is difficult to describe with words; it is an emotional, even visceral response. John Berger wrote, "Seeing comes before words. The child looks and recognizes before it can speak" (1972, p. 7).

Art's ability to tap the unconscious can be useful in diagnosis. For example, the Ulman Assessment (Ulman, 1975), designed for use in art therapy, is a series of four drawings that provide the therapist with visual information about a patient or client. As a series, the drawings provide a wealth of information about a client's use of materials and time. The therapist can observe attitudes, behavior, verbalization, and body language or movement while the client is drawing. The formal elements of the drawings (line, shape, color, composition, for example) and the content reveal much about the individual's feelings, self-perception, wishes, weaknesses, and strengths. The art therapist can use this information during sessions and share it with other members of the treatment team.

During individual art therapy, the patient engages in direct interaction with art materials. He or she learns that choices are plentiful and decisions have direct results. One can also learn from mistakes, start over, try again, and witness concrete evidence of internal changes by reviewing the artwork. In artmaking we are confronted with the same challenges we find in our lives. Similarly, we persist at improvement until we are satisfied. In these ways art therapy can be practice for life. If a patient uses the work for self-reflection, further insight can be achieved. Art products provide a tangible record of the patient's progress or regression.

Group therapy is the most common mode of treatment in inpatient settings. In group art therapy, clients find nonverbal as well as verbal ways to communicate, and participate simultaneously, at their own levels. Art can be enjoyable, leading to an experience in positive sharing. Verbal discussion of art products provides an opportunity for self-reflection and feedback from others. The art can also be used to explore group dynamics. For example, we might discuss which roles people played in the creating of a mural, and what it was like for them to be in those roles.

The art therapist's role is that of a guide through both the artmaking and the verbal processing of the artwork. The art therapist also interprets visual language for members of the treatment team.

The Patient: Donald

by Nicholas Fleisher

The patient is a 42-year-old man whom I will call Donald. We chose Donald because his art was especially useful to our understanding of him. Painting, drawing, and sculpture were important outlets for Donald; and they were also important to our continued ability to interact with him, especially during a period when he was extremely paranoid and psychotic.

For most of his hospitalization, Donald was an enigma to staff because he refused to talk. He is a large, stocky man, with long, disheveled hair. On the unit he was predominantly quiet and reclusive. Typically, I would find him alone in his room, staring into space. Sometimes his roommate was present, but they did not talk. Despite Donald's silence, he attended therapy groups and activities where he listened, but would not participate. His standard response was "No comment."

My initial information on Donald was sketchy and came from an intake report. It described an incident that Donald said he did not remember. It reads:

> Donald is a 42-year-old married, white male, who was brought to the Emergency Room last eve-

> ning by local police department after he was found to be randomly discharging his rifle in the air at trees in the context of rather rambling and incoherent speech while he was hunting yesterday afternoon in the woods near his house (sic).
>
> Donald described the incident as "being taken completely by surprise," that for reasons that are unclear to him, he began shooting wildly thinking he must protect someone else, someone (whose) identity he could not recall. He said that at the time, he had rather racing thoughts thinking that perhaps he was back in Vietnam, that other people might be shooting at him, or that he was hearing helicopters. He was not aware of any similar incidents. He says that he was able to "look at himself" with some small part of himself not involved in the action and "wonder what this was all about." He denied any other participants. He used one tablet of Ibuprofen for left calf discomfort the morning of the incident. He denied any drug or alcohol use. He denied any other physical symptoms.

Donald had no history of hospitalizations or of psychiatric treatment. His mother suffered from periodic bouts of depression and had been hospitalized several times in the past. No other family members were known to have psychiatric problems.

Donald's wife of 12 years contributed additional background information. Donald was the second of three brothers. He lived with his parents until he married at about age 30. The couple have no children. After graduation from high school he immediately entered the service. His duty in Vietnam did not directly involve him in combat and was not thought by his family to be traumatic. After completing his military duty, he became a taxidermist through a mail-order course and practiced taxidermy for several years. Becoming tired of this for reasons he could not explain, he moved on to a series of maintenance jobs where he has a successful employment record.

Donald continues to be close to his brothers and parents, but apparently has not sustained any friendships on his own. He is described as always having been awkward socially, preferring solitary activities such as hunting. He and his wife work different shifts, allowing for considerable time apart.

You can imagine some of the questions we had because Donald did not remember clearly and spoke minimally. I wondered about the possibilities. Was he having a reaction related to his experiences in Vietnam? Was this a new manifestation of an affective illness like his mother's depression? Had he sustained a head injury or ingested a toxic substance? I especially wondered about the presence of a crisis in his marriage or his family, given his exceptionally isolated lifestyle.

My initial goal was to find something safe for Donald and me to talk about, but this was not to happen easily. We were able to have brief discussions with superficial friendliness, but when I asked anything about his hospitalization, he would quickly end the meeting. I did learn a few things from these talks.

He said that he liked "STAR TREK" and that being on the unit was a bit like being in a STAR TREK movie. He also said that he felt as though he were in outer space without a space suit. Then I thought we were starting to make progress. These were images worth pursuing, but he would go no further. In one session he appeared more relaxed and gave me an even clearer statement of his fear. He asked me, "How do you do all of this?" and added, "One person couldn't be in charge of it all!" Finally I began to understand the extent of his fear and isolation. His world had become a totalitarian state where virtually everybody was included except himself. This helped me understand why, several days later, he began refusing visits from his parents. It also clarified why, when his wife visited, he returned his wedding ring and sent her away. I also understood why he began refusing medication that he had previously taken through the encouragement of his family.

Not knowing Donald raised my anxiety as I tried to work with him. He was there for all of my projected fears and confusion. I wondered what he was thinking, and how much to ask of him. Was he angry with me? I found myself wondering if he could be violent. The incident which resulted in his hospital admission was an ambiguous one, and I still didn't know why he had been shooting his gun.

Two factors at that time were particularly helpful in containing my own anxiety. The little information he had given me suggested he wanted some contact, although not too much. The other factor which helped us was his artwork.

Donald's art reflected enormous depth and sensitivity, as well as inborn talent. These positive qualities helped to balance my fears. The art was so different from my apprehensions that it challenged anything that I might have been thinking about this man. At the time, it was this kind of information that told me to suspend any conclusions I might have.

While I was doing a fine job of managing my own anxiety, Donald was not improving. In fact, he appeared to be getting increasingly more hopeless. When I tried to talk with him about planning, he told me that he did not expect ever to leave the unit. He was having more difficulty meeting with me and said that for him, things (sic) were worse. At a staff meeting, we decided to press the issue of medication even harder with greater insistence. Dr. Patrick and I had a particularly unpleasant meeting with Donald. We threatened to force medication with a court order if he refused to comply voluntarily. We explained our reasons to him. Donald showed no reaction or willingness to compromise at this meeting and appeared to be farther away than ever. To my surprise, several hours later, he approached the nursing staff and began a trial of Haldol.

The medication was significantly helpful. After several days, I could see Donald's mood changing very gradually. He did not talk much, but he no longer appeared to carry the weight of the world. He began to discuss the possibility of going home and even returning to his job.

I have had the opportunity to see Donald several times since he left the hospital, resumed his life at home, and returned to work. I have come to know Donald in a different way. I now know him as an extremely open and talkative person with a dry sense of humor. I also perceive him as a person who is acutely sensitive and aware of other people—so much so, that he is sometimes too vulnerable. He deliberately keeps to himself much of the time because he worries about being hurt. I now realize he is a person who cares very much about relationships.

Donald has been able to tell me about his hospitalization. His descriptions have been remarkable, although not surprising. His experience, he reports, was a darkness that is beyond description. The hospital unit often felt like a concentration camp with the nurses, Dr. Patrick, and me as Nazi collaborators. This image helps me understand why he thought he would never leave. My office was a place of enormous power; he says I was more powerful than I could ever know. He does not still see me this way, but he gasps when he describes the memories.

I was relieved to hear Donald describe the positive aspects of his experience as equally powerful. He knew there was a complete division between his inner experience and external reality. He would hear us talk to him, but our words made no sense, adding to his confusion and fear.

When Donald began to recover, his inner and outer experiences began to integrate. He felt relief as people started to make sense again. The initial experience of integration was fragile. He described objects and events as interconnected in the same magical way as before, but at this point, with positive intentions. The unit took on qualities of perfection, with staff and patients conspiring to be helpful. While not yet normal, this was a period of rapid progress. After discharge, Donald initially continued this idealization and felt strongly that everyone should have at least one experience on an inpatient mental health unit.

More recently, Donald has returned to work. He paints as a hobby and spends leisure time with his family. His idealization of the unit is diminishing as is his fear of recurrence of a psychotic episode. An important aspect of his progress is that he no longer dwells on his hospital experience. Now his thoughts are focused on the present and his daily activities and responsibilities. He is more grounded and personally more enjoyable. He remains a very intense person who enjoys and usually prefers solitude to a more sociable existence.

Art as Therapy with Donald

by Elizabeth Zemelka

We all have ideas about what art is. My definition is instrumental in how I understand people as well as myself.

Seeing is more than a way of identifying—it is a very real way of feeling and knowing. It is about light and space and a dialogue with materials or matter. It is a way of comprehending and showing me to myself and to others. Artmaking makes me visible. Moreover, it is very difficult for me to talk about my own work, so I understood what Donald meant when he said to me "it's all in the picture." He was not facile with words, but he left a wealth of information about himself in a large collection of drawings and several sculptures and paintings. Out of 65 works, there are 56 drawings, 6 sculptures, and 3 paintings. Only six pieces are not concerned with landscape or animal life. Of these six works, three are very sparsely detailed interior scenes. Pencil drawing was Donald's preferred medium, and he favored depicting outdoor space.

Space Track

His first drawing shows outer space and a traveling star ship. He calls this drawing "space track—the last fronteer" (sic).

The first image is significant. I wondered if Donald conceived of himself as a frontiersman pushing the borders of space. I thought about the theme of wilderness and what it might mean for him in the

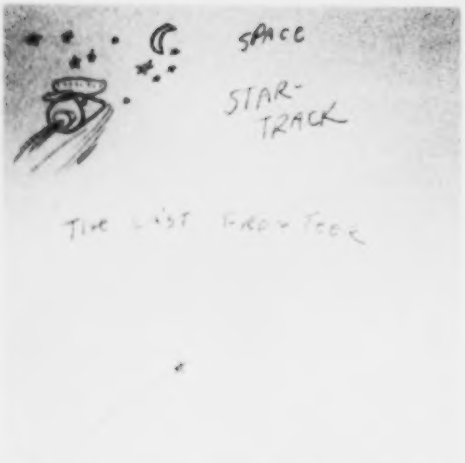


Figure 1. Space-Track—The Last Fronteer (sic)

context of his art. Space is explored in several subsequent pieces.

Butterfly

Distance shrinks dramatically, almost reversing itself in touching closeness to this butterfly, with its wings made of glitter and its antennae made of wire. This was Donald's second drawing.

Cabin in Landscape

Then space reappears but it is the familiar space of a landscape. As Donald explored the effects of paint and pastels, he made many drawings of a solitary house in the country.

When I first looked at this painting I did not see the house, with its front porch facing the sunset. The house, which actually looks like a cabin, is private and camouflaged by the foliage and the mountains. It is separated completely from the viewer by a body of water, and the viewer is prevented from entering the scene.

The house image underwent several transformations over several drawings. In one pastel, stairs began to appear, suggesting access. In another drawing, when he used red paper, the whole picture seemed to warm up. The house was big and looked more like a lodge. This particular work was one of Donald's more dramatic uses of color. His work often reflected low light. By that I mean pigment value and saturation were kept to a minimum.

The house at sunset appeared to be a cabin—or was it a shed? Who is outside looking at these houses? What is this outsider feeling? Who is inside?

One of the objectives of art therapy is to give the patient the opportunity to bring some words to the picture as a final *product*: Is it successful? And to the *product*: How was it made? This goal was not realized because Donald made many of his drawings privately in his room. When he handed me a stack of 30 drawings, not only was he unable or unwilling to say much about the work beyond the titles, but he was also unable to recall the order in which they were made. He had difficulty distinguishing between drawings he copied from magazine pictures and his own original work. I was taken aback by this because, as an artist, I am keenly aware of what is my own work and what is not. He leaves us guessing.

In addition to landscape drawing, another striking aspect of Donald's work are his many animals. He often used them to "tell stories" or portray "heartfelt" feelings.

Yellow-eyed Wolf

For example, while this wolf pays close attention to us, by looking and listening, another wolf calls out in the distance (bottom right hand corner of the drawing). This call was magnified and amplified in further drawings by using a similar body position in other drawings to convey loss and confusion.

Dog

A variety of animals appeared in his work, from tigers and lions to chipmunks, mice, buffalo, deer, and dogs. Donald's clay sculpture received the most applause and his sudden eminence spurred him on. He was inventive though not concerned with permanence, using chalk over clay on this deer's head to achieve the suede-like texture of its coat. He used hair for the whiskers and beads for the eyes, as though he were constructing a model.

This dog has distinct visual focus appearing to look up at Donald, while he gave the dog palpable form. Donald often said that if he could not see the form in his mind, he could not make it. His visual and tactile memory is remarkable.

Not Caged

Donald presented an affinity for the outdoors and animals. If this is true, then how does this next drawing make sense? He titled this picture "not caged" showing the buzzing life of beaver, moose, chipmunks, squirrels, and birds. We see debris in the foreground: beer cans and cigarette stubs.

The dichotomy of freedom and control is pre-

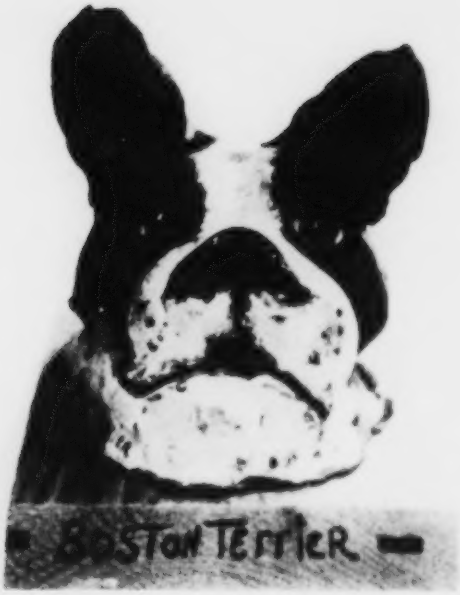


Figure 2. Dog

Figure 3. Not Caged

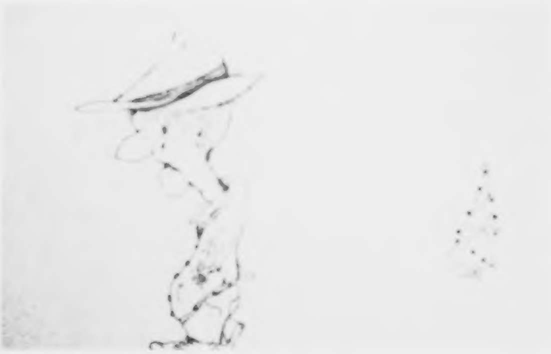


Figure 4. Christmas

sented in this drawing. Is this dichotomy a part of his belief structure, or is it a statement about his being on the unit? Even if this is Donald's sardonic sense of humor about the carelessness and disrespect of humanity, what could inform me that this picture did not include Donald as part of humanity? It is unmistakable that Donald was suffering loss of control, craving freedom, and angry about being caged.

What about Donald's control? When we look at the art that he made on the unit we see his distinct preference for pencil drawing. Pencil drawing allows for the highest degree of cognitive and motor control, in comparison to other media, like paint: the more fluid it is, the more it can have a mind of its own. Paint is more difficult to control. In each case the dialogue with material is very different.

Christmas

Fear, anger, and sadness often dance together. Donald expressed sadness on Christmas Day when he chose not to see anyone, or be seen by anyone.

Taxidermist

A similar self-image appears in "Two Taxidermists Chining" (sic).

As his discharge date approached, his fears of being retained intensified. After all, he thought he was in a concentration camp.

Donald with His Psychiatrist and Social Worker

In these last two drawings, each on the reverse side of the other, Donald expressed concern. On one side of the paper he stands between a quick exit

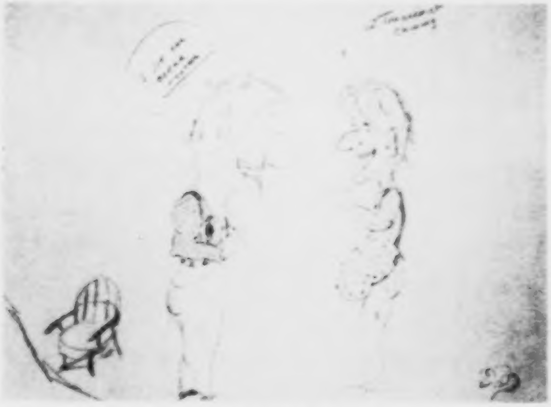


Figure 5. Two Taxidermists Chining (sic)

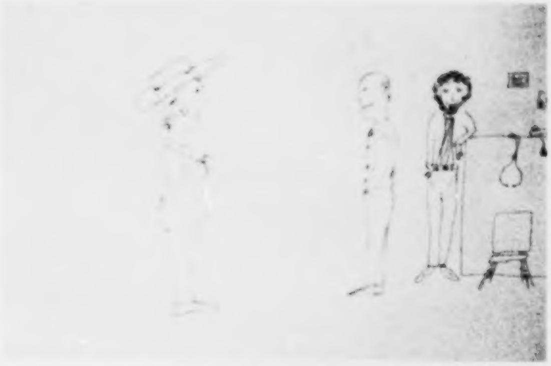


Figure 6. Donald with His Psychiatrist and Social Worker

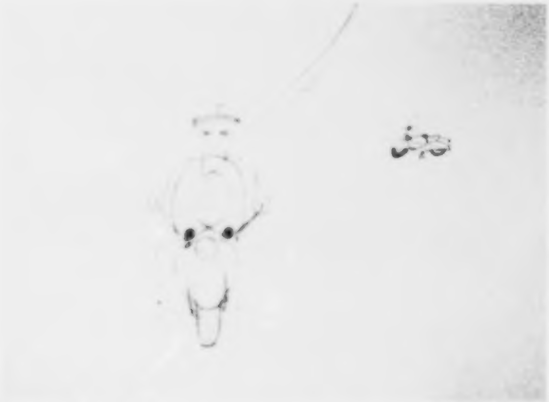


Figure 7. Police

door at the left and his psychiatrist and social worker on the right. The psychiatrist is smiling, his head is beaming, and his hands are in his pockets. Donald is frowning and pointing to himself. I wonder what the psychiatrist has just said to Donald?

Police

We flip the paper over and see the police riding toward us. Who is speeding off into the distance in the opposite direction? Has Donald made a quick exit?

Art as a Catalyst in Group Therapy

by James R. Shortell

As the clinical psychologist, one of my duties is to conduct group therapy three times a week on the Inpatient Unit. Although this does not relate directly to art therapy or a patient's artwork, a particular group session in which Donald was a participant came to mind.

This group consisted of five patients, of which only one was particularly verbal. The group included a 75-year-old, significantly depressed man who was quite withdrawn and relatively nonverbal; a 65-year-old woman, who, likewise, would generally sit and remain almost uncommunicative; a recently reconstituted psychotic woman who was very concrete; and a 45-year-old woman who had been suicidal at the time of admission, but who was now quite verbal. She was the one person in the group who would volunteer spontaneous conversation.

A major goal for one session was to initiate conversation in which each of the members could participate. This was a formidable task, since most members were relatively withdrawn.

The session began by my focusing on the patients' plans after discharge, particularly on activities they might pursue to maintain any positive momentum generated in the hospital. Donald volunteered that he had enjoyed artwork. Group members who recently had observed his sculpture and some drawings responded with a good deal of praise, and Donald appeared pleased to hear others compliment him on his artwork, enabling him to feel a valued member of the group.

The discussion turned to other areas of interest. The depressed gentleman mentioned that until recently he had gone dancing with a female partner. He missed this activity. Other members of the group asked him where he used to dance. A good deal of discussion ensued concerning which big bands had appeared and whether group members had been involved. The 65-year-old woman began to brighten up a good deal, and with a sparkle in her eye, confided that she used to be much slimmer than she is now, had been quite a good dancer and had won some prizes. The discussion soon included everyone who shared previous experiences involved with music and dancing. The tone was quite positive with everyone feeling included.

When the ability for insight in such groups is limited, a worthwhile goal is simply to enable group members to feel included and valued. This goal was clearly met. A valuable stepping-stone to our discussion had been the mention of Donald's artwork and the enthusiastic response of group members.

Donald remained relatively nonverbal, although he did make comments at times. It was clear that his artwork had been a means for him to communicate his feelings to others. His art enabled me to become an active participant during this session. The group was able to reexperience past positive feelings, thereby countering their current emotional distress.

Donald, Art, and the Inpatient Unit

by George S. Patrick

As I was thinking about how to talk about the artwork and its effects on the unit, particularly in relation to our patient Donald, my wife's description of our daughter Jenny, when she was about 14 months old, kept coming to mind. She described sitting and calming Jenny, who had just awakened, crying, in her dark room. Suddenly, Jenny became excited, pointed to the moon, and said over and over in her beginning-to-talk way, "POON in the sky! POON in the sky!" Jenny seemed to want to leap from Josie's lap and touch the moon.

How does this story make sense in relation to the artwork, the inpatient unit, and Donald? The inpatient unit is a powerful place, particularly if you are locked in with patients and staff. Implicit in the patient's need for hospitalization is his or her inability to handle strong feelings: hate, envy, rage, lust, love, and the potential consequences of these feelings: murder, self-mutilation, suicide, psychosis, for example. The trained staff often know something of the terribleness of the feelings, but, in contrast to the patients, are able to be ordinarily defended against these feelings.

Most of our patients employ rather *extra-ordinary* defenses such as splitting, denial, projection, and projective identification. These defenses are about "disowning" feelings and leave their mark. As George Valliant says: "You know when you are near someone with a character disorder; it is like being on an elevator with a person smoking a cigar. You can't disregard the effect" (1977).

Psychosis is worse. One way of conceptualizing psychosis is that the person has no defenses, and has nothing to cushion any sensation from the environment, including intrapsychic events. The fear that this unmediated contact with reality provides must be awesome. Nick's evocative description of Donald conveys this. It is what Donald means when he says, "East Spoke is a powerful place." Anyone experiencing psychosis can be a potent transmitter of fear, perhaps terror. It is similar to being near a tuning fork: You see no motion, but the resonance can be searing. In my imagination, the fear is secondary to experiencing complete abandonment, or, as I heard one patient describe it, feeling "terminally lost." A corollary to this lost feeling is feeling small. In psychosis, a person faces the threat of annihilation.

I did not really want to be around Donald. Around him, I had the sense that I could be siphoned off into some remote part of the universe, or, *he* could be a Star Trek alien, trying to squash me. I wanted to go to the cafeteria, but, there, I could not eat. I wondered, "What are we going to do with him anyway? Maybe he's always been crazy. After all, this is a short-term unit. His wife could take care of him at home." When it came to Donald, I was irritable.

Then, his artwork started coming. One morning, on the table in the room where Rounds are held, I saw Donald's sculpture of the deer's head. I was looking at a delicate, vulnerable doe. I became very excited; I had to touch it. I wanted the security of contact, of possibly obtaining some of this beauty and softness for myself. At this point, I knew that we could treat Donald and the limit to which I was willing to go to provide treatment.

For several months before Jenny had found the moon, Josie and I had read the children's book, *Goodnight Moon*, over and over to her at bedtime. This book has a small child in bed saying good night to all the objects in the room before the lights are turned out. "Goodnight, mittens, Goodnight, room." Then, when the lights are turned off, "Goodnight Moon." Donald had been working with us for several weeks before we found him.

What is common to both stories that allowed Jenny to be less afraid of night, and us to be less afraid of Donald? D. W. Winnicott's description of psychotherapy contributes to our understanding.

> Psychotherapy takes place in the overlap of two areas of playing: that of the patient, and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible, then the work done by the therapist is directed towards bringing the patient from a state of not being able to play, into a state of being able to play (1982, p. 44).

Before Winnicott could formulate this idea about play he developed his concept of the transitional object. He describes this object as one that allows an infant to mediate the absence of mother. It is an object that gives the illusion of mother in mother's absence. It usually embodies some of mother's qualities, being soft and cuddly, like a piece of blanket, and can withstand all the love and hate of which the infant is capable. The illusion is created by the infant's simultaneous experience that the object is me, under my omnipotent control. It is also not me. The object is real, and also not real.

On the way to separation from mother, the infant must sustain a paradox concerning this object; no decision is made about the real absence of mother, or about the real identity of the object. This "thing" can not be only part of a blanket or a stuffed animal; it must also be partly mother. Winnicott extends this concept to assume that the task of reality acceptance is never completed, and that none of us is free from the strain of relating inner and outer reality. Release from this strain is provided by an intermediate area of experience.

Playing, then, is the activity that creates this intermediate area. Beyond infancy, when we can stand literal separation from significant others, we are constantly playing. Particular transitional objects, like art or other cultural products, are the result of playing. Since trying to come to terms with reality is universal, Winnicott is saying that the patient and therapist obtain security when they find the familiar in each other's playing. Jenny found increased security by finding the moon. We found the security to treat Donald by finding him through his art.

In my experience on the inpatient unit, patients experience safety and begin to feel secure when they can relate to and be included by other patients and staff. The phrase, "providing space for feelings," sounds like a cliche, but I think that is just what we provide. We provide a transitional or intermediate space through all of our activities on the unit: nursing contacts, psychotherapy, groups, and creating art. The transitional phenomena act as buffers to make the love and hate more palatable to everyone.

The evidence that playing leads to group relationships is all around us. Murals were created by groups of patients. These murals have changed the unit. Initially, the walls were insipid and blank, and I felt like a laboratory specimen about to be dissected. Now I actually feel warmer and included in the space. Similarly, this presentation is an example of our team's group process and how we work together on the unit.

References

Berger, J. (1972). *Ways of seeing*. New York: Penguin Books.

Ulman, E. (1975). "A new use of art in psychiatric diagnosis." In Ulman, E., and Dachinger, P. (Eds.) *Art therapy in theory and practice*. (pp. 361–386) New York: Schocken Books.

Valliant, G. (1977). Personal communication. (See also Valliant, G. (1977). *Adaptation to life*. New York: Little Brown & Company.)

Winnicott, D. W. (1971, 1982). *Playing and reality*. New York: Penguin Books.

1390

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 39-43 © AATA, Inc. 1993

Art Therapy in Mexico: Five Perspectives

Phoebe Dufrene, PhD, A.T.R., West Lafayette, IN

Introduction

A Fulbright grant enabled me to conduct research in Mexico, investigating art therapy/art education for special populations. In May 1992, I served as Visiting Professor/Researcher at the Universidad Autonoma de Nuevo Leon in Monterrey, Mexico. My responsibilities involved teaching seminars on art therapy and art education to the faculty and administrative staff and assessing the use of art therapy in various sectors of the state of Nuevo Leon. Later that summer, I assessed the use of art therapy in other Mexican cities and states by visiting and talking with professionals who use therapeutic art.

Cross-cultural studies such as this are analyzed and interpreted from the perspective of the investigator. Definitions of disciplines such as art therapy and the credentialing of the art therapist are compared to those used in the United States or Europe. This paper does not do that. Instead, it presents, through interviews, the Mexican perspective on art therapy, without interpretation or analysis.

These interviews offer the reader a brief view of how five very different professionals adapt therapeutic art to their cultural environment. The interviews were conducted in Spanish and English depending on our mutual comfort level in speaking and understanding. Responses are translated to the best of my ability and without any editing of the content.

Lic. Saskia Juarez Green, Professor of Fine Arts

I had previously met *Lic.* Saskia Juarez Green, Professor of Fine Arts at the Universidad Autonoma de Nuevo Leon, in Monterrey, Mexico, when I was a presenter at the University's Biennial Symposium. She was now enrolled in my post-graduate seminar at the University.

Recently, *Lic.* Green was involved in therapeutic art education through a collaboration with the Monterrey Special Education Department and the Department of Visual Arts at the Universidad Autonoma de Nuevo Leon. Special education teachers enrolled in her one-week experimental art program, including those who worked with her and the Fine Arts staff. Several special education teachers were physically disabled. In Mexico, handicapped students are encouraged to major in special education so they can be role models for children with similar problems. One teacher, who had one arm, was experiencing her first painting session.

P.D.: What types of students were involved in this program?

S.G.: The group consisted of the emotionally disturbed, physically handicapped, and mentally retarded (Down Syndrome). In Mexico all types of disabilities are mixed together in special education. Children with various disabilities got along well and shared materials cooperatively.

P.D.: What ages were the students?

S.G.: Seven to 15 years old.

P.D.: What art activities did you explore?

S.G.: One of the main activities was mixing the primary colors and black and white to make secondary colors, tints, and shades. The favorite color they made was "color café," a tan or light brown. The emotionally disturbed worked with paints brilliantly and the Downe's (sic) Syndrome children liked to work on tactile projects. The group was also involved in sculpture and pantomime.

P.D.: Are there plans for this experimental art program to continue?

S.G.: It all depends on funding possibilities and local politics.

Video is one of the main sources of documentation of children's art programs. The video of this program highlighted students emerging from the school bus, their awe at the university surroundings, and various instructors assisting physically handicapped children in the classroom. Exposure to art and exploration of media were emphasized, rather than assessment of individual work. Therefore, no slides or direct examples of student work were shown.

When asked about her other experiences with special education students, *Lic.* Green stated:

> A few years ago I worked in a mural program as part of an urban project for youths with psychological, social, and delinquency problems. As the art coordinator I helped the participants select mural themes, many dealing with social problems. One of our most popular themes was "Pollution." Because of the pollution theme and its health hazards, this unit had the assistance of university biology professors as well as social workers.

Lic. Green, whose background is in fine arts, has received numerous awards for her landscape painting. She has no formal training in art education, art therapy, or special education. When asked how she prepared herself to teach art to special needs children and adolescents, she said:

> In Mexico there are very few art teachers working at any level in special education or regular education. I did not receive any inservice training for either art project with special education students. For me, the ability to teach art to special populations seems to come naturally. I feel comfortable with all types of people and enjoy exposing others to art.

Yolanda M. Farias, Art Therapist in Private Practice

Yolanda M. Farias is also affiliated with the Universidad de Nuevo Leon where she will be teaching a course, "The Psychology of Art," during the 1992-93 academic year. I interviewed Ms. Farias at her private office in a suite that she shares with her psychiatrist husband and another psychiatrist. Their clients are wealthier Mexicans who can afford private therapy.

Our initial conversation dealt with Ms. Farias' plans for her upcoming course and her theoretical influences. She described the course:

> My course will discuss the history of creativity in hospitals. I'll show slides of patients' art from the 1800s in Europe, primarily from the collection of Dr. Prinzhorn. He was a psychologist and art historian who collected Swiss/German patients' art. In the course I will also teach the theories of Jung, Edith Kramer, and Laurie Wilson, as well as provide opportunities for studio exercises. My influences are primarily Freud and Jung. I am very influenced by psychoanalytic theory and have had four years of psychoanalysis. It depends on the patient's ability to benefit from long-term analysis or short-term therapy. With children, I'm more [inclined] toward a Jungian approach and use a combination of art, play, and verbal therapy.

Ms. Farias discussed the relationship between art and psychology in Mexico:

> For me it is very close because I am an artist. But the relationship of psychology to art and creativity is not promoted much in Mexican universities in our psychology or art departments. The only exposure psychology students have in the relationship between art and psychology is through courses in projective techniques where students are exposed to the D-A-P (Draw-A-Person) and H-T-P (House-Tree-Person) tests. There is not much student interest in this topic. To my knowledge, Cuba is the only country in Latin America that is involved in art therapy. Cuba is more advanced in mental health than the other Latin American countries.
>
> I am the only trained art therapist in the city of Monterrey, and there is one in Mexico City. A few psychologists in our hospitals use art therapy with their patients, but they are primarily psychologists and not trained in art therapy.

P.D.: How is art therapy used here in Mexico? For what populations? How are people in Mexico prepared to practice art therapy?

Y.F.: I use it with children, adults, and prisoners. I'm doing research on art therapy with a prisoner group because I am fascinated by the violent mind. Our prisons are not as humane as in the United States and the prisoners do not get much rehabilitation. The prisoners draw freely a subject of their choice. It is for self-expression and motivation. Prior to working in private practice and part-time with prisoners, I worked a few months with our Department of Health in a substance abuse program. We worked on posters dealing with prevention of substance abuse. I worked with families who had drug addicts or substance abusers. In the Department of Health I also used art therapy in an early stimulation program for children from infancy to age four.

P.D.: What is your educational background?

Y.F.: I have a master's degree in psychology from a Mexican university and an MA in Art from New York University. The MA from New York University involved courses in art therapy, fine arts, and art education.

P.D.: Are you interested in exchanging information with art therapists and psychologists in other countries?

Y.F.: Yes, primarily in the United States. I am returning to the U.S. in two years. I'm interested in Emmanuel Hammer's Institute of Projective Techniques. I don't have any contact with mental health professionals in other Latin American countries, but I would like to. I'm interested in the transcultural meaning of color. Through my work at the United Nations I met professionals from other countries.

P.D.: What is your personal involvement in art?

Y.F.: I also use art for myself. I am a printmaker (etching) and belong to a printmaking studio. While working at the United Nations I did a series of etchings on the Gulf War. I've had two interviews about my art in our newspapers.

Lic. Enrique Lupricio Padillo, Psychologist

Ms. Farias referred me to *Lic.* Enrique Lupricio Padillo, Chief of the Psychology Department at the Hospital Psiquiatrico del Estado (state psychiatric hospital). *Lic.* Padillo uses therapeutic art techniques in his practice.

Our interview took place at the hospital, a sharp contrast from a private office and university art studio. It was my first visit to a psychiatric facility outside the United States. Located in an urban working-class neighborhood, the hospital is a sprawling one-story structure with an inner courtyard, typical of Moorish/Spanish architecture. There did not appear to be any security guards. Only the more violent patients were on locked wards. At that time of the morning most of the patients were leisurely strolling in the courtyard and some were gardening. The area is large enough for exercise and privacy.

Unlike my interviews with *Lic.* Green and Ms. Farias, which were in a combination of Spanish and English, my interview with *Lic.* Padillo was entirely in Spanish. Due to my Spanish-speaking limitations, this interview was more formal than the others.

P.D.: Please tell me about your art therapy work at this hospital.

E.P.: My patients work with drawing media, oil, gouache, et cetera. The patients illustrate their family life, the inner self, and similar topics. Drawing is a projection of the inner self. Other psychologists and psychiatrists bring their patients to me because sometimes art is the only way they can communicate. Art is a manifestation of the patient's conduct. I also use poetry and art and have patients read a poem and illustrate it. We practice community therapy and group therapy.

P.D.: What types of patients do you work with?

E.P.: Paranoid schizophrenics, catatonics, the retarded, and chronically mentally ill adults. Schizophrenics are in their own world. Their work is perseverative as is their language.

P.D.: What are your theoretical influences?

E.P.: They are eclectic: Freud, Fromm, Jung, and Gestalt theory.

P.D.: What is the opinion in Mexico and other Latin American countries of the relationship between art and psychology?

E.P.: Here the artist is often considered insane because of the literature on famous artists. Artists are considered neurotic. Poetry therapy as an artistic modality is seen as one of the relationships between art form and psychology.

P.D.: Do any of your colleagues practice art therapy?

E.P.: No. I'm the only one in this hospital. Some of the staff practice occupational therapy.

P.D.: What is your educational background?

E.P.: I have a BA in the humanities and an MA in psychology.

P.D.: Are you interested in exchanges with psychologists or art therapists in other countries?

E.P.: Yes. Germany and the United States.

P.D.: What is your personal involvement in art?

E.P.: I recently made a video titled *Documental Picopatologia de la Pintura*. It's an animated film showing the bizarreness of artists' work like Picasso, artists inspired by strange dreams and sexuality. I'm also a painter, muralist, and licensed art teacher in Los Angeles, California. At the age of 21, I traveled the Mayan route through the Americas. My art is influenced by Mayan, Aztec, and mestizo culture. The Indian influence is strong in my work. I participated in the 1974 conference on Latino/Chicano art in California and painted a mural for Mill Valley State College in California. My murals deal with social problems such as the Vietnam War. Artists should be socially conscious. Also [I am] interested in experimental film and documentary photography. In Mexico photography is used more as criticism against societal problems, but in the United States photography is used more as a creative, artistic form without a message. In addition to working as a psychologist and art therapist here at the hospital, I'm a professor of communication at the Universidad Autonoma de Nuevo Leon where I teach aesthetics, photography, and the psychology of art.

Dr. Myrthala Juarez de Gzz, Psychiatrist

My last art therapy interview in Monterrey took place at the Universidad Autonoma de Nuevo Leon Psychiatric Hospital. Affiliated with the University, it is a teaching and research hospital. Due to time constraints, my contact with patients and staff was limited. I had a brief tour and interview with psychiatrist, Dr. Myrthala Juarez de Gzz.

P.D.: Please tell me about your work in the hospital.

M.J.: I/we provide individual, group, family, and marriage therapy for in- and outpatients from infancy to adulthood. We have art, music, play, dance, sociodrama, psychodrama, and occupational therapy.

P.D.: What are your theoretical influences?

M.J.: Freud, Mahler, Melanie Klein, and Winnicott, all of whom we are required to read in English.

P.D.: What is the Mexican and Latin American opinion of the relationship between art and psychology?

M.J.: Art is important, fluid, and easy for patients to relate to. Art is the key to the unconscious. It relaxes hyperactive patients and helps modify schizophrenic behavior.

P.D.: How is art therapy used in this hospital?

M.J.: Art therapy is once a week for the inpatients. Since none of us are trained art therapists, we read books about it to help us. We mainly use art therapy to interpret the patient's unconscious. Our chief of psychiatry is a painter and all the paintings on our walls are his, so art is very respected here. Our patients also do craft projects like embroidery, stuffed dollmaking, and small cabinetry/woodworking projects that they sell to raise money to buy more arts and crafts supplies.

P.D.: What is your educational background?

M.J.: I have an MD in psychiatry and am a trained pianist. I am very interested in music therapy.

P.D.: Are you interested in exchanges with doctors in other countries?

M.J.: Yes. England, the United States, and Argentina. Argentina is active in music therapy and psychodrama.

Ana Rosa Garcia Mayorga, Artist

In Colima, Mexico, I visited *Maestra* Ana Rosa Garcia Mayorga, director of the Taller Magistral Sobre Liberacion de la Creatividad (Masterly Studio for the Liberation of Creativity). The *taller* (studio or workshop) is housed in a designated historic building. Most of the activities take place outdoors in the inner courtyard that is open to the sky. Gallery and storage space is located in rooms surrounding the courtyard.

Ms. Mayorga is a Columbian artist currently living in Mexico. Her textile designs are based on Columbian and Peruvian traditions. She teaches art in her studio to teachers, professors, psychologists, parents, and children in both regular and special education schools. The classes usually consist of a mixture of typical and atypical populations.

Ms. Mayorga, who speaks Spanish only, explained her theories and techniques of creativity liberation. Samples of adult and children's art, gallery brochures, and her written curriculum supplemented the interview.

Her main objectives are to:

> . . . comprehend creativity as an innate part of development and to release inhibitions. I support the comprehension of the liberation of creativity as a method of communication and expression, as an essential part of the global formation of the individual. I want to improve my client's self-esteem and personal evolution.

Ms. Mayorga's methodology involves group and individual exploration, encounter sessions, sensory stimulation, perceptual exercises, communication with body gestures, motivational activities, oral and written narratives, respect for physical space, respect for the psychology of the other, exploration of individual and collective memories, and creative play as spontaneous expression.

Studio techniques include exploration of color using crayons, paint, and colored pencils, printmaking, collage, clay modeling, symmetry exercises, mask making, and scribble techniques. She uses traditional indigenous crafts of Mexico and other Latin American countries. Participants are also involved in movement and music. Exhibitions of adult and children's art are displayed at local galleries.

Ms. Mayorga would like to earn a master's degree in art therapy and wishes to collaborate with psychologists in the United States. Many of the special education students in her program are referred by psychologists. A student exhibition brochure states: *El ser humano es esencial un ser creativo.* Roughly translated, this reads, "To be human is in essence to be creative."

Conclusion

When I reflect on these interviews and many others that were conducted in mental health clinics, shelters for abused children, special education departments, and art studios, I can only admire and respect these Mexican professionals. They are using art in therapeutic settings despite limited resources and often without training. Through self-motivation and concern for clients, these professionals train themselves and use their natural creative abilities.

These five professionals demonstrate that the natural power of art can transcend limitations such as lack of training programs, job descriptions, and licenses.

The author would like to thank *Lic.* Gabriela Pendroze, Lourdes Avila, and Laura de la Mora for their invaluable assistance in arranging these interviews.

Associate Editor's Note: This impressionistic view of the practice of therapeutic art in Mexico can stimulate the reader to consider our similarities and differences. When training programs are not readily available, the therapeutic use of art forms around the background and experience of the professional and the needs of the clients. Dr. Dufrene provides us a rare glimpse of some of these configurations.

LOYOLA MARYMOUNT
UNIVERSITY

Graduate Department of
Marital and Family Therapy
(Clinical Art Therapy)

offers a

Master of Arts
in
Marital and Family
Therapy

For more information contact
Dr. Debra Linesch
Loyola Marymount University
7101 West 80th Street
Los Angeles, CA 90045
(310)-338-4562

- *Approved by AATA since 1979 (One of the first five programs in the country to be approved)*
- *Meeting California state requirements for MFCT licensure*
- *Family Systems/Psychodynamic Orientation*
- *Full-time and Part-time programs*
- *Nationally respected and distinguished faculty*
- *Committed to innovation and integration in models of art therapy and student-centered approaches to learning*

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 44-46 © AATA, Inc. 1993

Reviews

Exceptional Children, Exceptional Art: Teaching Art to Special Needs

David R. Henley, MA, A.T.R., Worcester, MA: Davis Publications, Inc. 1992.

280 pp., 271 black & white illustrations, 7 color illustrations. $34.95 cloth.
ISBN 0-87192-238-X.

Reviewed by **Betty Jo Troeger, PhD, A.T.R.,** Tallahassee, FL

David Henley presents two major challenges to art educators working with students who have exceptional needs: first, that significant art experiences are within the grasp of all children, and, second, that a studio model of mainstreamed, individualized art instruction is the best way to facilitate artistic expression. Henley builds a theoretical foundation for therapeutic art education, dividing his book into three parts: exceptional children, exceptional art, and adaptations.

In Part One, exceptional children, Henley presents the guiding principles that inform his work, crediting Viktor Lowenfeld's art education therapy (1957) as the primary source for his concepts. Henley describes art education therapy as a "philosophical perspective which promotes the art experience with sensitivity that appreciates the sheer wonder of the child artist" (p. 5). Henley's definition of art therapy falls within the parameters provided by Edith Kramer (1979), and he distinguishes art psychotherapy from therapeutic art education and from general art education. Practitioners who work within a cognitive, behavioral, or developmental model may find exceptions with Henley's psychoanalytic definition of art therapy. All other adaptive experiences are defined as therapeutic art education.

An introduction to typical and atypical children, including the artistically talented individual, provides the reader with a psychoanalytic view of child development and an understanding of individual learning needs. Brief descriptions of learning disabilities, visual impairments, hearing impairments, orthopedic impairments, retardation, and emotionally handicapping conditions are included in this first section. The omission of other exceptional conditions (i.e., the health impaired and hidden disabilities) is a significant oversight in the text. Nevertheless, Henley does maintain that each exceptional condition poses unique presenting problems and he offers multifaceted suggestions for their remediation.

Based on his interpretations of Public Law 94–142, Henley advocates providing the art experience in the least restrictive environment. In keeping with his position on mainstreaming, "(e)ach child is assessed as to his or her emotional, cognitive and aesthetic needs and each is accommodated in an environment where strengths and weaknesses are camouflaged so as not to make an issue of the disability" (p. 66). Camouflaging is defined as selecting different facets of art experiences and scaling them to different levels of complexity for each student without sacrificing the integrity of the process or product. A reasonably small teacher/student ratio is imperative to individualized teaching and learning. From this reviewer's perspective, Henley's concept of the least restrictive environment is designed for the master teacher who is working under ideal conditions.

By establishing as normal an art learning process as possible, a child's imagination and socialization can be challenged simultaneously. The therapeutic art educator motivates, nurtures, and intervenes through verbal and direct hands-on assistance with the art expression. Instruction includes reflection, which may begin with student awareness that he or she has made a product. Then, it may move to more complex cross-referencing processes involving art history and criticism. Creative expression, generated through personal experience, is Henley's ultimate goal for each learner. While motivation is based on psychodynamic phenomena, Henley's discussions of honesty, firmness, sensitivity, confidence, and concern, generally can be adapted to any art teaching perspective.

Part Two specifically addresses processes involved in drawing, painting, printmaking, sculpture, and ceramics, using case studies to demonstrate specific ways to adapt instruction to disabling conditions. In the section on drawing, Lowenfeld's (1957), developmental theory is applied. He believes children should be "encouraged to draw in the spontaneous, naive style of a child. . . . (and be left) to express what they know about, how they feel, imagine or dream. . . ." until they begin to exhibit an appropriate cognitive and perceptual level of development (p. 94). His approach emphasizes art as an academic discipline only after the child begins to work in a realistic mode. Accordingly, he does not support instruction in drawing techniques until approximately age 11.

Painting is the "most emotionally charged and expressive of all media" (p. 128), and, therefore, painting presents strong responses related to motivation and to regression. When adapting this media for a broad range of abilities and developmental levels, the therapeutic art educator is challenged to control the stimulation produced by paint's color and fluidity. Henley incorporates technical aspects of media, specific subject matter, and artists' styles into painting processes. Color illustrations enrich the verbal descriptions throughout the chapter.

Printmaking presents great potential for integrating diverse skills and providing adaptations to a variety of problems. Techniques in monoprinting, collographs, embossing, jigsaw printing, and block printing expand our perception of a least restrictive environment. For impulsive students, the cautious use of tools and equipment is often a powerful behavioral device. Therefore, the art teacher must continually assess whether the student is capable of handling particular printmaking processes.

Henley believes that sculpture begins with block play and early developmental activities such as making toys, shadow box relief, and free-standing sculpture. He suggests using large scale works and environmental constructions to entice the young and the severely disabled. The process of casting in a variety of media (clay, sand, paper, metal) can engage many levels of learners. Collage is introduced as a process that stimulates grasping, placing, and arranging elements into sculptural compositions. Carving is a useful technique for students who have proven their capabilities for handling tools, by moving from simple to more complex operations.

Clay is "among the most therapeutically dynamic art media" (p. 172). Henley describes the ceramic studio: furniture, tools, equipment, and the hazardous dust and fumes generated through the art process. Specific properties of clay are discussed to help the therapeutic art educator make wise and safe choices when selecting materials. He describes figure modeling and methods of constructing (hand building, slab building, coiling, molding) and throwing on the potter's wheel in terms of their suitability for individual achievement. Glazing and firing procedures are also included.

The final section of this text addresses adaptations. Henley states, "Art expression becomes the first step in actually mastering behaviors, by virtue of working through emotions instead of simply acting upon them or—the other extreme—oppressing them" (p. 200). He advocates an empathic stance rather than behavior modification techniques when dealing with problems. Special problems presented by psychotic and autistic behavior, self-stimulation, and compulsive behaviors are also addressed in this section. Additionally, he discusses attention deficits, mood swings, fearful reactions, defeatism, depression, and anxiety reactions. His examples of personal responses to behavioral issues provide the reader with a glimpse into the relationship between understanding issues and overt behavior.

Henley convinces the reader that the artwork of children can convey some aspect of the child's state of mind. Through brief, anecdotal examples of specific problems, a clearer understanding of the messages contained in art and dialogue emerges. Detailed models for assessment notation are provided in five domains: motivation, behavior, skill acquisition, aesthetic/expressiveness, and affect. He gives examples of process notes, individualized educational plans (IEPs), and a rationale for the use of video in assessment. Finally, Henley implores us to "suspend preoccupation with rational analytical thought and perception . . . and acknowledge that there are other ways of seeing, feeling and expressing" which may run contrary to a viewer's parameters of Western aesthetics (p. 275).

Exceptional Children, Exceptional Art is a welcome addition to the growing body of literature that addresses the artistic expression of children who have special needs. Henley joins Edith Kramer (1979), Judith Rubin (1984), and Frances Anderson (1978), as a major contributor to the knowledge base for work with this population. The text clearly demonstrates the author's devotion to children of all ages and abilities, a passion for the art process, and an abiding belief in the power of the therapeutic art experience. The major strength of the book lies in the many challenges the author offers for experiencing the art processes. The major problem with the book is the questionable practice of camouflaging the child's level of aesthetic response. It provokes questions about teacher adaptations of the learning process that are made at the expense of an opportunity to learn to appreciate similarities and celebrate differences. Nevertheless, Henley's views provide a conceptual basis for an informed dialogue about practices in art therapy and therapeutic art education.

References

Anderson, F. (1978). *Art for all the children*. Springfield, IL: Charles C Thomas.

Kramer, E. (1979). *Childhood and art therapy*. New York: Schocken.

Lowenfeld, V. (1957). *Creative and mental growth*. (3rd ed.) New York: Macmillan.

Rubin, J. (1984). *Child art therapy*. New York: Van Nostrand Reinhold.

Silver Drawing Test of Cognitive Skills and Adjustment: Drawing What You Predict, What You See, and What You Imagine

Rawley Silver, EdD, A.T.R., HLM Sarasota, FL: Albin Press, 2nd ed., 1990.

92 pp., 30 black & white illustrations, paper. $40, complete test battery (includes 10 test booklets); $28, manual only; $16, expansion set (includes 10 test booklets, 10 scoring forms, and one layout sheet). ISBN 0-9621429-1-3.

Reviewed by **Anna R. Hiscox, MA, A.T.R.**

The new edition of the *Silver Drawing Test* (SDT) is a must for any professional interested in obtaining information that may be bypassed using standardized tests. Silver concurs with Piaget (1968), who asserts:

> the roots of logical thought are not to be found in language alone, even though language coordinations are important, but are to be found more generally in the coordination of actions, which are the basis of reflective abstraction (p. 18).

Clinicians will find this revision of the SDT a precise and effective measurement tool of cognitive and affective development. As art therapists we are inundated with assessment measures from other disciplines. Our viability depends on developing tools with retest reliability. In refining the SDT, Silver has paved the way for novices as well as pioneers.

The introductory chapter of the manual is important to understand the author's sensitivity and empathy when obtaining cognitive and emotional measures from language-impaired children. Silver describes her relationship with Charlie, a child who is deaf, who was instrumental in encouraging her research. Silver's work with Charlie culminated in a task that would assist not only with the evaluation of latency age children, but also with adolescents and adults.

The SDT is a five-point scale instrument containing three primary scoring measures: the ability to order sequentially and conserve by using a predictive drawing test; the ability to associate and represent concepts by drawing from imagination; and the ability to perceive and represent concepts of space by drawing from observation. It enables the assessor to identify cognitive skills that are independent of verbal skills, depression, and at-risk individuals.

The SDT has no time limit, but generally the test can be administered to groups or individuals in 18–20 minutes. The recommended age range for use of the SDT is five years to adult. It can be used as a pre/post evaluation tool. The SDT is not, however, a tool that should be used by a lay person. Although this assessment is easy to administer, it should not be utilized without a thorough understanding of psychological and artistic development. Art therapists, school counselors, psychologists, and other professionals who implement assessments and evaluations will find that the SDT is an invaluable addition to their repertoire.

Silver postulates, "Drawing takes the place of language as the primary channel for receiving and expressing ideas" (p. 3). This statement is validated by significant correlation between the SDT and other accepted measures such as the Otis Lennon School Ability Test, the Iowa Test of Basic Skills, the Canadian Cognitive Abilities Test, the Wechsler Intelligence Scale for Children, the Metropolitan Achievement Test, and the SRA Mathematics Achievement Test (p. 21).

While significant correlations have been found when the SDT is compared with other standard assessment instruments, limitations are observed in the SDT percentile ranks and T-score conversions. The standard deviation and the cumulative normal probabilities for children in the ninth, eleventh, and twelfth grades are omitted and must be estimated. Although the SDT has been administered to adults, the small number of subjects provides insignificant data, thus decreasing the validity and reliability of data for adult subjects.

The second edition of the SDT provides a comprehensive, easy-to-read guide to the author's hypothesis and her rationale for scoring each subtest. Silver notes that scores on projection (emotional content) are excluded from the total score because the rating scale does not reflect a cumulation or progression from emotional disturbance to mental health (p. 17). Conversely, Silver postulates that the emotional content of the projective component offers clues to the emotional state of the individual.

The current edition of the SDT contains many of the same illustrations as the previous edition. The most significant revision occurs in the language of the scoring guide which, in fact, modifies the scoring criteria. This change increases pictorial clarity and reliability, and greatly decreases subjectivity.

Another improvement is found in scoring the test of predicting verticality. Silver does a nice job of describing how one would achieve the maximum number of points. Here she demonstrates what constitutes adequate support for a house, thus assisting in determining a score of four or five. Under the section "Drawing from Observation—Horizontal Relationships," Silver gives a specific description, thus eliminating the need for the assessor to ponder the difference between a score of four or five. Another noted distinction between the original SDT and the current revision are the simplified instructions for measuring relationships in depth (front-back). In order to receive the maximum score of five points, "the relationships in depth are accurate and the layout sheet is included in the drawing" (p. 41). In the original publication, the examinee received a score of five points if "all four objects are related; fine discriminations" (p. 31).

The many semantic changes in the guidelines for administering the SDT render the current edition superior to the previous version. The 1990 edition also has a concise format for "Drawing from Imagination" and "Drawing from Observation." This revision of the SDT provides tighter scoring guides and eliminates many of the ambiguities of the original test.

Compared to other disciplines, art therapists have been on the periphery in developing, implementing, and researching assessment tools. Silver has advanced the field of art therapy by her continued research to refine the SDT. This is a positive step for the advancement of art therapists as quantitative clinicians. Our work with clients is always

BEST COPY AVAILABLE

evolving. This evolution includes the tools we use to implement change. The 1990 revised SDT provides art therapists and other professionals with a bridge with which to link standardized assessment tools and nonverbal measurements.

References

Silver, R. (1983). *Silver drawing test of cognitive & creative skills.* Seattle: Special Child Publications.

Silver, R. (1990). *Silver drawing test of cognitive skills and adjustment.* Sarasota, FL: Albin Press.

Piaget, J. (1968). *Genetic epistemology.* New York: Columbia University Press.

Editor's note: *Art Therapy* is planning to offer reviews of art-based assessments in coming issues. If you are interested in reviewing an assessment or have an assessment you would like to have reviewed, please contact Dr. Patricia St. John, A.T.R., through the AATA National Office.

Video Review

Psychimagery: Healing the Child Within

James J. Consoli, MA, A.T.R., NCC Executive Producers: **Trudy Manning, MS, A.T.R.** and **James Consoli, MA, A.T.R., NCC**, Norfolk, VA: EVMS Psychimage Productions, 1991

30 minutes, color. Purchase only: $80

Available from: **James J. Consoli, MA, A.T.R., NCC**, Eastern Virginia Medical School, Graduate Art Therapy Program, P.O. Box 1980, Norfolk, VA 23501

Reviewed by **Mindy Jacobson, MCAT, A.T.R.**, Philadelphia, PA

Psychimagery: Healing the Child Within introduces the viewer to the language of art and the application of imagery techniques in exploring childhood traumatic experiences. The videotape begins with a melodic interlude and a man drawing, thereby setting the stage for what is to follow.

The narrator states:

> The language of art, the imagery of the child within. There is healing in these images as the hopes, fears and emotions of the inner child are recognized and honored. But the child may be reluctant, traumatized beyond expression by pain, fear or guilt. A wall is thrown up against memory and the language falls silent.

Consoli, the pioneer of a technique known as Psychimagery, is introduced as an art therapist who can break through to the inner child. In discussing the case of "Anne," a woman who is blocked and who uses intellectualization as a defense, Consoli outlines the initial treatment issues of trust and performance anxiety. Such issues are not uncommon in the treatment of individuals who have been sexually abused (Jacobson, 1985), but Consoli does not identify the relationship of these issues to Anne's traumatic childhood until later.

The video traces the progress of Anne's treatment through narration, artwork, and a demonstration of two sessions. Issues surrounding the treatment of abuse victims are brought to the forefront, thus exposing the viewer to the "healing powers" of the image and its use in uncovering repressed traumatic material. Provided we listen carefully and read between the lines, we are subtly introduced to the dissociative spectrum. The process of art therapy is

1400

complex, however. It would have been helpful if Consoli mentioned that this type of work may traumatize the inexperienced therapist (Chu, 1988; Kluft, 1989).

The major intent of the video is to demonstrate the technique of Psychimagery. After multiple viewings, however, I found it difficult to define Psychimagery, and surmised that the use of spontaneous imagery to explore unconscious material constitutes Psychimagery. Referring to the work of Margaret Naumburg (1966), Consoli suggests that Psychimagery is an original technique. Based on the text, however, I did not find this to be the case. Instead, the analytic framework developed by Naumburg and expanded by Wadeson (1980), Rubin (1984), and others, seems to be at the core of Consoli's work.

A lack of integration of the various methods used contributes to the confusion in defining Psychimagery. Consoli suggests that he relies on systematic desensitizing and relaxation techniques to reduce Anne's agoraphobia, and employs hypnotic interventions to reach the inner child. The viewer is left to wonder if these techniques are part of Psychimagery or if Consoli's pioneering work is a combination of imagery and hypnosis.

David Grove's hypnotic methods are highlighted when Consoli uses the technique to return the wounded child to "T-1," the moment just prior to the trauma. Like Grove, Consoli uncovers details surrounding the trauma, moves the patient through it, and processes the material, thereby dissolving the developmental arrest. Essentially this process, known as abreaction, is used by most therapists when working with abused patients. It is well documented in the literature on Post Traumatic Stress Disorder and Dissociation (Cooper, 1983; Kluft, 1988).

The film raises several diagnostic and treatment issues and the viewers are left with questions. For example, why doesn't Consoli use the images produced by Anne to reach her "other parts"? Anne's artwork is richly symbolic, containing the answers Consoli needs to break through her amnestic barriers. Is the "inner child" actually a dissociated part of Anne that developed in response to severely traumatizing childhood events? Consoli does not choose to explore this. Neither does he explore nor mention the variations within Anne's artwork which suggest dissociative phenomena, despite her suggestion that she dissociates.

Because the video is generously illustrated with Anne's artwork, we have numerous opportunities to see images and phenomena which suggest dissociative processes. For example, there are consistent changes in handwriting, numerous references made to "fading out," self-portrayals which intimate various age states, elevated perspectives which suggest floating, and disconnections between the head and torso. Anne reports that her father was "like two different people." Her paradoxical relationships with him and Mother are consistent with the histories presented by patients who dissociate.

Anne's treatment with Consoli terminated after one year, leaving the diagnostic issues clinically unresolved. If this patient was dissociating, and this was not explored in its entirety, what may we surmise about Anne's recovery? Although her initial symptomotology was resolved and traumatic material was processed, might there be other dissociated aspects of the self which were left to fester?

Despite my concerns about Anne's diagnosis and my suggestion that a more comprehensive case review might have illuminated these concerns, I found the video to be educationally beneficial. It is appropriate for use with art therapists and other clinical groups.

In terms of production, I found the video technically sound and aesthetically appealing. The artwork is dramatically alluring, the music well chosen, the videography professional, and the text inviting. Anne's interjected statements and the use of two in-session videos are ingredients that further dramatize the seriousness of this type of work. The only offensive technical element is the simultaneous elicitation of a male patient's inner child and the narration of new text. This can be disruptive and confusing.

In support of Consoli's efforts, *Psychimagery: Healing the Child Within* is a moving video which sensitizes the viewer to the artwork of the traumatized patient. Despite my concerns surrounding the lack of reference to dissociation in art therapy, I plan to use the video (in conjunction with inservice discussions of dissociation) as a training film for art therapy students. Anne's case is intellectually stimulating and raises diagnostic and treatment issues for the viewer. Consoli deserves credit for taking on such an endeavor. Certainly video is an emerging format, suitable as a means for art therapists to share their work.

References

Chu, J. A. (1988). Ten traps for therapists in the treatment of trauma survivors. *Dissociation*, *1* (4), 24-32.

Cooper, A. (1983, October). *The concept of psychic trauma.* Paper presented at the 11th Friends Hospital Annual Clinical Conference, Philadelphia, PA.

BEST COPY AVAILABLE

Jacobson, M. L. (1985). Manifestations of abuse in the artwork of an inpatient diagnosed with multiple personality disorder. In B. G. Braun (Ed.), *Proceedings of the Second International Conference on Multiple Personality & Dissociative States* (p. 113). Chicago, IL: Rush-Presbyterian-St. Luke's Medical Center.

Kluft, R. P. (1989). The rehabilitation of therapists overwhelmed by their work with MPD patients. *Dissociation, 2* (4), 243–249.

Kluft, R. P. (1988, June). *Varieties of abreactions and abreactive techniques.* Paper presented at the Philadelphia Study Group meeting of the International Society for the Study of MPD, Philadelphia, PA.

Naumburg, M. (1966). *Dynamically oriented art therapy: Its principles and practice.* New York: Grune & Stratton, Inc.

Rubin, J. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Wadeson, H. (1987). *The dynamics of art psychotherapy.* New York: John Wiley & Sons.

James Consoli responds:

Mindy Jacobson raises questions and infers that not only do the diagnostic issues remain unresolved in this case, but Anne's recovery seems questionable. I could not agree more with her statement that ". . . a more comprehensive case review might have illuminated these concerns. . . ." However, the intent of this 30-minute video was to highlight a case that visually demonstrated the therapeutic potency of imagery and to introduce the technique of Psychimagery. Incorporating a comprehensive review of this year-long case, including a more thorough description of the Psychimagery process, practically would have required a mini-series. (An instructional video is currently being considered as a follow-up to the first film.)

Psychimagery is a term developed to explain more clearly the therapeutic usefulness of imagery. Elinor Ulman (1975) wrote, "It is hard, sometimes impossible to find the ideal name for a complex and subtle discipline. The title 'art therapy' can easily be dismissed as inadequate or inaccurate, but I have not found a better one" (p. 3). Some art therapists hold that "if you are not doing art, you are not doing art therapy." Clearly, the use of art materials is a prerequisite to this theoretical approach. Other art therapists perceive themselves as psychotherapists who incorporate all three forms of communication (lexical, kinesthetic, and imagery) (Shore, 1978), to promote healing. When speaking of imagery, I am referring not only to that which is created externally, in plastic and graphic form, but also to internal creations, such as dreams or mental images, whether spontaneous or guided (Rubin, 1985). With certain populations, my theoretical position is more closely related to the latter. If this is considered to be art therapy, there is no need for a new word.

Margaret Naumburg (1928) pioneered the use of spontaneous drawings, and, as Jacobson writes, others have expanded on this approach in an attempt to make the unconscious conscious. Bernard Stone (1975), incorporating this approach, developed the technique of sequential graphic gestalt. This process takes the spontaneous renderings a step further by moving them forward in time. By creating a narrative, one can raise insight on a sequence of events rather than on a "snapshot" view, that displays only a particular moment in time. This technique more closely resembles an abreaction while incorporating art materials and metaphor or metonymy. David Grove (1989) uses what he refers to as epistemological metaphors: mental images originated by the client. He also includes clean language: a way of speaking that allows the therapist to choose his or her words carefully so as not to traumatize the client through an abreactive intervention. As in art therapy, he uses the metaphor to provide a safe distance while addressing the intrapsychic conflict. Although Groves' approach employs only the use of internal mental imagery, there are many similarities. Similar to Naumburg's approach, the client's images are spontaneous; similar to Stone, the images evolve over time.

My reason for introducing the technique of Psychimagery is twofold: to clarify the semantics of a therapeutic process that incorporates both the non-iatrogenic interventions of guided mental imagery *with* the imagery created externally in graphic or plastic form and, to demonstrate the potency of the combination of both modalities. As stated by the video's narrator, ". . . psychimagery then joins the communication with the inner child with proven art therapy techniques to create a dynamic healing process."

Regarding the "inner child," the viewer might surmise that Anne had dissociated a part of herself in response to a traumatizing event. It is my assumption that she had dissociated in an attempt to survive the emotionally overwhelming experience of the abuse. It is unfortunate that many therapists do not incorporate the use of metaphor and instead take the approach of having the client actually re-live, and re-experience, the feelings, only to be re-traumatized (in the name of therapy!). Referring to dissociative experience, Ross, Joshi, and Currie (1990) summarize that they

> . . . are common in the general population, (with a tentative prediction of dissociative disorders in the range of 5%–10%), we suspect that dissociative symptoms may occur in a wide range of psychiatric disorders, just as anxiety and depression can be components of many different entities (p. 1552).

I have many concerns about the propensity of therapists, swayed by popular mental health issues (e.g., sexual abuse and multiple personality disorders are "fashionable") to quickly diagnose and perceive their clients in a preconceived framework (Harakas, 1992). At the close of her book *Approaches to Art Therapy* (1987), Judith Rubin reminds us of an old tale of six blind wise men who come across an elephant. They try to discern its shape, each touching only a part and assuming that the animal is ". . . a spear . . . a tree . . . a rope . . . a wall . . . a fan . . . a rope!" (p. 320).

It may appear to the viewer that it was my decision to continue treatment through the behavioral technique of systematic sensitization, even after Anne had found relief from her presenting problem of agoraphobia. Or, that it was my decision to end treatment after she had developed sufficient insight into the etiology of her condition. In fact, however, it is my conviction that the client remain empowered through the therapeutic process so as to not be revictimized. Another client may have been satisfied with relaxation techniques which allowed him or her to leave home and be productive. Another may have wanted to explore further the possibility of "other parts," or more amnestic barriers. In my view the decision is the client's, and Anne stated that she was ready to terminate.

I do appreciate the comments and concerns that Jacobson addresses. I believe that it is imperative that we have open dialogue about these important issues that have an impact on the field. I invite others to do the same. I am pleased that Jacobson will find the video useful as an academic tool, and I hope others will as well, whatever the endeavor or context.

References

Consoli, J. J., Manning, T. (Producers) & Husson, E. (Director). (1991). *Psychimagery: Healing the child within.* (Videotape). Norfolk, VA: Psychimagery Productions, Eastern Virginia Medical School.

Grove, D. J. (1989). *Healing the wounded child within.* Unpublished manuscript.

Harakas, M. (1992, September 4). False memories. *The News & Observer* NC.

Naumburg, M. (1928). *The child and the world.* New York: Harcourt, Brace.

Ross, C. A., Joshi, S., & Currie, R. (1990). Dissociative experiences in the general population. *American Journal of Psychiatry, 147* (11), 1547–1552.

Rubin, J. A. (1985). Imagery in art therapy: The source, the setting, and the significance. *Journal of Mental Imagery,* 9 (4), 71–82.

Rubin, J. A. (Ed.) (1987). *Approaches to art therapy.* New York: Brunner/Mazel.

Stone, B. (1975). Sequential graphic gestalt. In Jakab, I. *Psychiatry and Art, 4,* 216–229.

Shore, J. E. (1978). Clinical use of categories of therapeutic imagery. In Singer, J. L., & Pope, K. S. (Eds.), *The power of human imagination: New methods in psychotherapy* (pp. 95–121). New York: Plenum.

Ulman, E. (1975). Art therapy: Problems of definition. In Ulman, E., & Dachinger, P. (Eds.), *Art Therapy: In theory and practice* (pp. 3–13). New York: Schocken.

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 52-57 © AATA, Inc. 1993

The American Art Therapy Association, Inc. 1993 Media List

Updated by **James Consoli, MA, A.T.R.**

This media list is provided to assist AATA members and others in locating films and tapes on art therapy and related subjects. Inclusion of a film or tape in this list does not imply endorsement by the AATA. It is the responsibility of the film/video producers, directors, and/or consultants to have obtained appropriate release forms for clients and client visual work appearing on film or tape. Descriptive information has been provided by producers and distributors; for more information on specific films/tapes, please contact them at the addresses given below.

Films, Videotapes, and Filmstrips:

Archetypal Images and Art

Produced by Emporia State University, Emporia, Kansas. The art of Peter Birkhauser is discussed from a Jungian approach. The tape focuses on Jung's concept of the archetypal basis essential to personal wholeness and the importance of the unconscious in any creative activity. Birkhauser's art is utilized to illustrate these concepts. Excellent resource for graduate-level art therapy coursework.
VHS ½"; 40 minutes. Purchase only: $40 (plus postage). Contact: Dean L. Frantz, 3831 Evergreen Lane, Ft. Wayne, IN 46815

Art and Therapy

Produced by Bronx Mental Health Council, 1983. Vera Zilzer, A.T.R., leads art therapy sessions in a hospital in South Bronx, New York, and discusses her approach to art therapy. Actual patient interchange is demonstrated and several examples of patient artwork are included. Reviewed in *Art Therapy*, 2 (2), pp. 98–99, 1985.
VHS ¾"; 22 minutes. Rental or purchase. Contact: Hughes Lavergne, Unicorn Productions, 67 East 4th Street, #14, New York, NY 11225

Art Therapy

Produced by the American Art Therapy Association, 1981. A short introduction to the field of art therapy for general use. 16mm; color; 12 minutes. Rental only: $35 (members), $45 (nonmembers).
VHS ½"; color; 12 minutes. Purchase only: $50 (member), $80 (nonmembers). Contact: American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

The Art Therapist's Third Hand

Produced by James Prunick. This video documents the lecture/presentation given by Edith Kramer, A.T.R., at the 17th Annual American Art Therapy Association Conference in Los Angeles, 1986. It refers to Kramer's article of the same name (*American Journal of Art Therapy, 24* [3], 1986). Reviewed in *Art Therapy*, 9 (1), pp. 48–49, 1992.
VHS ½"; 55 minutes. Purchase: $400; rental: $40. Contact: Recycled Images, Inc., 761 South Blvd., Alpha, NJ 08865

Art Therapy

Produced by T. Dalley, D. Waller, and J. Beacham, University of London Goldsmiths' College, 1985. An introduction to the theory and practice of art therapy featuring a student training group, a one-to-one session, work with mentally handicapped people, and case studies.

VHS, PAL, U-matic; 30 minutes. For purchase from: Tavistock Publications, 11 Fetter Lane, London EC4, England

Art Therapy: Beginnings

Produced by the American Art Therapy Association, 1977. Documentary film in which four art therapy pioneers discuss and illustrate their use of art therapy in a mental health context. Includes Margaret Naumburg, Elinor Ulman, Hanna Yaxa Kwiatkowska, and Edith Kramer. The latter three demonstrate procedures for assessing clients through art therapy.

16mm; color; 45 minutes. Rental only: $40 (members), $50 (nonmembers).

VHS ½"; color; 45 minutes. Purchase only: $50 (members), $80 (nonmembers). Contact: American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Art Therapy and Children

Produced by T. Dalley, D. Waller, and J. Beacham, University of London Goldsmiths' College, 1987. Featuring a school for disordered children and an adolescent unit, the art therapists discuss their approach. Extracts from actual sessions are shown. The role of the art therapist in a team is clearly demonstrated.

VHS, PAL, U-matic; 30 minutes. For purchase only from: Tavistock Publications, 11 Fetter Lane, London EC4, England

Art Therapy: The Healing Vision

Produced by the Menninger Foundation, 1986. This video reviews the history and methodology of art therapy and presents a conceptual framework focusing on three elements: person, process, and product. Includes an interview with Grandma Layton whose work documents her recovery from depression, historical footage from the Menninger archives, and case examples. Reviewed in *Art Therapy, 4* (3), pp. 138–139, 1987.

VHS, BETA ½", U-matic ¾"; color; 49 minutes. For rental or purchase. Contact: Menninger Foundation, Box 839, Topeka, KS 66601, or 1-800-345-6036

Art Therapy: It Is Progressive, It Is Effective

This tape educates viewers about art therapy's usefulness for aiding self-expression. Two case studies are presented (multiple personality and handicapped teenager), which take viewers deeper into the definitions and applications of this progressive therapy.

VHS; 12 minutes. Purchase only: $19.95; check or money order made payable to Kathy Gotshall-Sollars. Price includes shipping and handling. Contact: Kathy Gotshall-Sollars, P.O. Box 501049, Indianapolis, IN 46250

Art Therapy with a Group of Latency Age Girls

Produced by Mildred Lachman-Chapin, A.T.R., CCMHC, MEd, and Peter Volkert, 1970; re-edited, 1991. This video documents one year of group art therapy sessions with latency age girls in a psychoeducational facility.

VHS ½" and ¾"; black and white. Purchase only. Contact: Mildred Lachman-Chapin, 903A Waukegan Road, Deerfield, IL 60015

Art: How Does a Child Grow?

Written by Pearl Greenberg, EdD, Kean College of New Jersey. Shows the artistic growth of one child in order to offer clues to what is possible for all children.

91-frame color, two-part filmstrip with 37 minute cassette and guide. Purchase only: $45. Contact: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago, IL 60604

Art Therapy and Psychiatry

Produced by Trevor Scott, University of London, Audio Visual Centre, 1988. Program consultants: D. Waller, N. Minton, and J. Weller. Filmed in a large psychiatric hospital near London, this video shows how art therapy can be effective with a range of acutely or chronically ill patients. A panel discussion is included, chaired by Professor Christopher Conford, Professor Emeritus of the Royal College of Art, London.

VHS, PAL, U-matic. For purchase only. Contact: University of London, Audio Visual Centre, North Wing, Senate House, Malet Street, London WC1, England

Art Therapy: Releasing Inner Monsters

Produced by Cathy Malchiodi, A.T.R., University of Utah, Salt Lake City, Utah, 1987. Focuses on how art therapy can be utilized in the treatment and assessment of children from violent homes. The tape

gives a basic definition of art therapy and includes art expressions by children who have been physically abused, sexually abused, or exposed to domestic violence.
VHS ½"; 15 minutes. For purchase only: $40 (which includes study guide). Contact: Cathy A. Malchiodi, A.T.R., 2768 Comanche Drive, Salt Lake City, UT 84108

Art with Elders in Long-Term Care: A Visual Legacy

Produced by Hillhaven Convalescent Hospital, 1984. Documents an ongoing art program at a long-term care facility for the elderly. It celebrates the work of these artists and provides convincing evidence for inclusion of art programming with elderly populations. Features Mary Ann Merker-Benton, an artist, teacher, and consultant to Hillhaven Convalescent Hospitals of Northern California.
VHS ½"; 15 minutes. Purchase: $150. Rental: $35. Contact: Filmakers Library, 133 East 58th Street, New York, NY 10022

Children and the Arts

Produced by Judith A. Rubin, PhD, A.T.R., HLM. This film emphasizes the emotional and social growth possible for young children involved in music, dance, art, and drama. Self-definition, self-confidence, control, mastery, and interpersonal sensitivity are among the values shown common to all art forms.
Film 16mm; 22 minutes. Rental only. Contact: Judith A. Rubin, PhD, A.T.R., HLM, 128 North Craig Street, Pittsburgh, PA 15213

Clinical Art Therapy with the Family (three videocassettes)

Three videocassettes show the synthesis of art and psychotherapy. Intended for the educational training of mental health clinicians.

TWO HANDS. Produced by Helen Landgarten, MA, MFCC, A.T.R. A dynamic art therapist demonstrates her unique combination of theory and practice. Using simple interventions, Landgarten shows the power of the art metaphor to illuminate a father-daughter dyad.

GOING HOME. Produced by Maxine Junge, MSW, LCSW, A.T.R. A young family's struggle with a major life transition is met with therapeutic flexibility by Junge. Her sensitivity and understanding of the value of imagery helps the family to identify and explore issues of ethnicity, culture, individuation, and community.

MOTHERS & DAUGHTERS. Produced by Shirley Riley, MFCC, A.T.R. Combining systems theory and strategic intervention, Riley investigates a three-generational family's confused roles, redundant patterns, and unresolved grief. She shows understanding of adolescent and family dynamics as the art therapy illuminates issues and demonstrates the application of theory to practice.
VHS ½"; color. Purchase of complete set: $225. Purchase of individual tapes: $90 each. Rental of individual tapes: $55 each (applicable to sale price). Please state title of individual tapes. Contact: AT/VIDEO, 14008 Mira Montana Drive, Del Mar, CA 92014, (619) 481-3311

The Color Bunch

Produced by Judith Rothschild, 1982. This film demonstrates the use of film animation within a group therapy setting. It offers an introduction to the use of animation as a therapeutic technique. Reviewed in *Art Therapy, 1* (2), pp. 92–93, 1984.
16mm; color; 17 minutes. Contact: JKR Productions, 650 Midfield Lane, Northbrook, IL 60062

Creative Art Therapy with Children

Produced by Kim Pawley, A.T.R., and Terry Conheady, 1984. This tape provides an introduction to Creative Art Therapy. Artwork and movies that were made by emotionally disturbed children are shown to illustrate the way in which these chldren perceive themselves and their world. It explains the role of art therapy in self-expression, self-understanding, and personal growth.
VHS ¾"; 8 minutes. For purchase or rental. Contact: Kim Pawley, A.T.R., Convalescent Hospital for Children, 2075 Scottsville Road, Rochester, NY 14623

Creative Arts Therapies at the Pace School

Produced by Simone Alter Muri, 1987. This video focuses on how art and music therapies can be used with developmentally delayed and autistic youth. It also presents an overview of the PACE program and the value of creative arts as therapy.
VHS ½". Contact: Simone Alter Muri, A.T.R., 56 Bradford Street, Northampton, MA 01060, (413) 584-9223

Creative Expression

Produced by Pat Sandor and Pat O'Sullivan, Ridgeview Institute, 1987. This video presents specialized vehicles for expression of feelings as demonstrated by artwork and accompanying musical selections. Its purpose is to creatively present information to professionals about the progression of emotions as addressed through art and music therapies. Reviewed in *Art Therapy*, 5 (3), pp. 106–107, 1988.
VHS ½", 20 minutes. Purchase: $295; BETA ¾", Purchase: $350; Rental: $50 for seven days. Contact: Ridgeview Institute, Attention: Finance Department, 3995 South Cobb Drive, Smyrna, GA 30080

Draw from Within: An Introduction to Art Therapy

Produced by Don L. Jones, A.T.R., Harding Hospital. An introduction to the practice of art therapy using two cases in which important turning points were reached through expressive therapy techniques.
VHS ¾". Available for rental or purchase. Contact: Harding Hospital, 445 East Granville Road, Worthington, OH 43085

Expressions

Produced by R. Wieske, Adult Service Center, Inc., 1984. This tape is about people feeling good about themselves through self-expression. It documents the results of a series of workshops in literature, music, drama, and mime. The project was funded by the Michigan Council for the Arts.
VHS, BETA II ¾"; 25 minutes. Purchase or rental. Contact: Adult Field Services, Inc., 1413 Field, Detroit, MI 48214, (313) 921-6238

Gestalt Art Experience

In this film Janie Rhyne outlines the principal concepts of Gestalt art experience and leads a group through three therapeutic experiences: "Finding Your Own Rhythm Vocabulary," "Creating Your World in Clay," and "Building a World Together."
16mm; color; 27 minutes. For purchase or rental. Contact: Extension Media Center, University of California, Berkeley, CA 94720

Gravity Is My Enemy

Produced by Churchill Films, 1977. Film about Mark Hicks who is without nerve or muscle function below the neck. He demonstrates his artistic skill and techniques and discusses his life and images. Academy Award winner for Documentary Short Subject, 1977.
16mm; 26 minutes. Contact: Churchill Films, 662 North Robertson Blvd., Los Angeles, CA 90069

The Green Creature Within

Produced by Drs. Judith A. Rubin and Eleanor Irwin. A record of a two-year outpatient group for male and female adolescents using expressive modalities, with emphasis on art and drama. Included are some necessary conditions in the therapeutic environment, two individual case studies, and specific therapist behaviors that seem to facilitate such work.
¾" tape; 24 minutes. For rental. Contact: Judith A. Rubin, PhD, A.T.R., HLM, 128 North Craig Street, Pittsburgh, PA 15213

Life and Art of Peter Birkhauser

Produced by Emporia State University, Emporia, Kansas. This presentation highlights the artist's life with particular attention to his dreams and to the crisis which changed the direction of his life and art. More than 70 reproductions of his paintings are included, with comments by the artist and Jung. Valuable for art therapy graduate classes.
VHS ½"; 31 minutes. For purchase only: $40 (plus postage). Contact: Dean L. Frantz, 3831 Evergreen Lane, Ft. Wayne, IN 46815

Lonny: A Case Study in Clinical Art Therapy

Produced by Jane Shulman, MA, A.T.R., MFCC, 1985. This videotape tells the story of art psychotherapy with a six-year-old schizophrenic child. Employing the child's artwork and words, it serves as an introduction to the use of clinical art therapy with children.
VHS ½" and BETA ¾"; 28 minutes. Rental: $35. Contact: Jane Shulman, A.T.R., MFCC, 942 Embury Street, Pacific Palisades, CA 90272, (818) 796-3515

The Maze

Produced by Dr. James B. Maas, Cornell University, 1970. This film features the Canadian artist, William Kurelek, who reviews his life and years of depression. He focuses on images and symbols he

BEST COPY AVAILABLE

included in "The Maze," a large painting that he made while hospitalized in England. Interviews with three generations of the Kurelek family are included. Reviewed in *Art Therapy, 1* (3), pp. 149–150, 1984.
16mm; color; 30 minutes. Contact: Audio Visual Services, Pennsylvania State University, University Park, PA 16802

Michael: Demonstration of a Diagnostic Interview Using Art Therapy Techniques

Produced by The American Art Therapy Association, 1977. The first art therapy session with a six-year-old boy of divorced parents.
16mm; color; 12 minutes. Rental only: $30 (members), $35 (nonmembers).
VHS ½"; color; 12 minutes. Purchase only: $50 (members), $80 (nonmembers).
Contact: American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Perpetual Arts Relaxation Tape #2

This video provides stimulating and relaxing imagery which could be utilized by art therapists with individuals and groups.
Reviewed in *Art Therapy*, 5 (1), pp. 33–34, 1988.
VHS; 30 minutes; purchase or rental. Contact: Perpetual Arts, % Mr. Alma Bulkely, 9848 Wimbleton Drive, Sandy, UT 84092

Psychimagery: Healing the Child Within

Produced by Trudy Manning, MS, A.T.R. Content by James Consoli, MS, A.T.R., NCC, 1991. A video about an agoraphobic and her experiences with an innovative technique that incorporates art therapy and hypnosis.
VHS; color; 30 minutes. Purchase only: $80. Contact: James Consoli, Graduate Art Therapy Program, Eastern Virginia Medical School, P.O. Box 1980, Norfolk, VA 23501

The Shape of a Leaf

Produced by Campbell Films, 1967. This film documents an art and educational program for developmentally delayed and mentally retarded children at the Perkins School. It is helpful to the professional working in a school-based setting with these populations.
16mm; color; 29 minutes. Contact: Very Special Arts, Kennedy Center, Washington, DC 20566

Stevie's Light Bulb: Graphic Art in Child Psychiatry

Produced by Ralph D. Rabinovitch, M.D., and Francis C. Pasley, M.D. Available in either film or video, this is an illustration of the use of graphic art in child psychiatry through applications in diagnosis and treatment. It covers 35 years of involvement by the authors. Numerous case studies demonstrate the elements of art that are crucial in work with children. Reviewed in *Art Therapy*, 2 (1), pp. 45–46, 1985.
16mm; color. VHS ½", BETA ¾"; 76 minutes in two parts. Rental or purchase. Contact: Hawthorne Center Films, Hawthorne Center, Northville, MI 48167, (313) 349-3000

Suicide: A Teenage Dilemma

Executive producer and writer, Evelyn Virshup, PhD, A.T.R.; producer and director, Jim Stimpson, 1987. This Emmy-award-winning video explores why teens attempt suicide, discusses behaviors that may indicate someone is suicidal, and suggests ways to help. It stresses that teens often express suicidal feelings through writing, drawing, and painting. Virshup discusses the symbols of death in a series of drawings by a 19-year-old girl who was hospitalized after a suicide attempt. The program is accompanied by an instructional guide containing an introduction, objectives, and instructions for using the film. Reviewed in *Art Therapy, 1* (3), pp. 148–149, 1984.
VHS ½", ¾", and BETA ½"; 30 minutes. Purchase: $192 (Health Sciences Consortium Member); $385 (non-member). Contact: Health Sciences Consortium, 210 Silver Cedar Court, Chapel Hill, NC 27514

Understanding Children's Art Expression Series

Produced by Ruth M. Freyberger. Illustrates children's progress from an early object-naming scribble to the depiction of the final space concept, and the realistic portrayal and concept of figure and space in terms of basic developmental levels.
Purchase only: Set of three color filmstrips and an eight-page guide: $40. Individual filmstrip and guide: $15. Contact: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago, IL 60604

A Very Special Arts Festival

Produced by Dr. Claire Clements. More than 700 handicapped children, adults, and senior citizens from Northeast Georgia enjoyed and participated in this Very Special Arts Festival. This video illustrates a wide range of art activities and dimensions of art therapy with special needs populations.
VHS ½"; 15 minutes. Rental only. Contact: Dr. Claire Clements, 850 College Station Road, Athens, GA 30610
NOTE: Very Special Arts, John F. Kennedy Center for the Performing Arts, Washington, DC 20566, is a national/international resource for information and media on the use of arts with the handicapped. Most states have active VSAs which may also have media available.

Vision of Paradise Series

Produced by award-winning filmmakers A. Light and I. Saraf. This series consists of magical and entertaining films on folk art and native artists of differing ethnic backgrounds and styles. It is an exploration of creativity and process, intended for use by groups interested in art, aging, and creativity.
16mm (other formats available); color; 28 minutes each in a series of five films. For rental or purchase. Contact: Light-Saraf Films, 131 Concord Street, San Francisco, CA 94112

We'll Show You What We're Gonna Do!

Produced by Judith A. Rubin, PhD, A.T.R., HLM. This film shows an exploratory art program for multi-handicapped blind children. They are seen using the art experience for sensory exploration and awareness, to define their individuality, as a way of relating to each other, and as a means of expressing and coping with feelings.
16mm; color; 28 minutes. For rental only. Contact: Judith A. Rubin, PhD, A.T.R., HLM, 128 North Craig Street, Pittsburgh, PA 15213

With Eyes Wide Open

Produced by Dr. Laurence Becker and Ron Zimmerman. This film explores the life and work of Scottish artist, Richard Wawro who is described by some as "hopelessly retarded, with severely impaired vision, and an IQ of 30." The film offers a warm, personal view of a young man with joy and confidence in his work, in his world, and in himself. Reviewed in *Art Therapy*, 2 (1), pp. 46–47, 1985.
16mm; color; 56 minutes. For rental or purchase. Contact: Laurence Becker, Creative Learning Environments, 507 Park Blvd., Austin, TX 78751

Resources

For additional sources of information on films and videotapes, see:

Niswander, V. (1980). Art therapy bibliography. *Art Education, 33* (4), 36–37. Reston, VA: National Art Education Association.

Jungels, G. (1985). Film/video reviews: Twenty-two productions about art therapy. *Art Therapy: Journal of the American Art Therapy Association*, 2 (3), 141–146, 1985.

The AATA Media List will be updated on an annual basis. Members who have produced films or videos on art therapy, or who can update the above information, are asked to submit the following information to the AATA office:

Name of Film/Videotape
Producer(s)
Format—16mm, VHS, BETA, U-matic
Color or Black & White
Length
Rental price; purchase price
Address where film/tape may be rented or purchased
Brief description: 50 words or less

Send to: American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, IL 60060. Attention: Film/Video Review Editor.

Art Therapy: Journal of the American Art Therapy Association, 10(1) pp. 58 © AATA, Inc. 1992

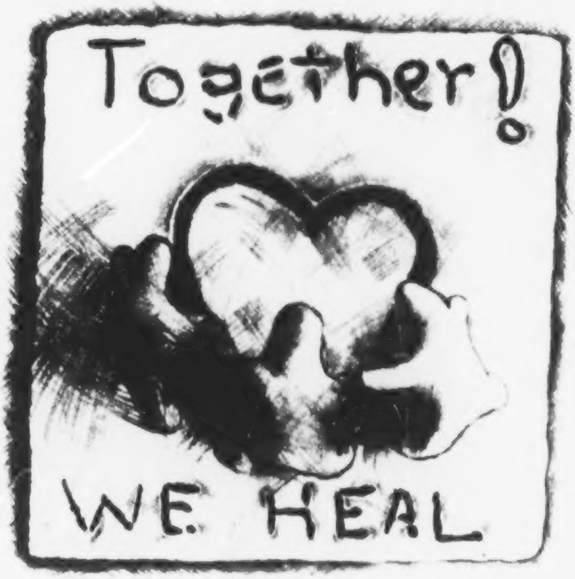
Noteworthy

Courage! Together We Heal

Courage! Together We Heal: Mural Messages from Incest Survivors is a 25-page monograph describing the development and implementation of an art therapy group for incest survivors. The monograph is authored by Frances E. Anderson, Ed.D., A.T.R., HLM, Distinguished Professor of Art, Illinois State University, who also served as a principle investigator for the project. Karen Deske, M.S., A.T.R. assisted Dr. Anderson in compiling the information and also served as a principle investigator.

The monograph provides an overview of adult incest survivors, including material on the characteristics of this population, emotional, social, somatic and sexual issues, and treatment strategies. The mural project is thoroughly described, with quotes from participants as well as black and white illustrations of group members' work. An extensive reference list is included at the end of the monograph.

The publication is part of "A Pilot Demonstration and Training Project on the Therapeutic Use of Ceramic Art with Adults Molested as Children" and was supported in part by a grant from the Peoria Area Arts and Sciences Council, and the Illinois Arts Council. Additional funding was provided by Lutheran Social Services of Illinois and Illinois State University. The project was implemented between December 31, 1989 and November 30, 1990, at Lutheran Social Services, Peoria, Illinois. For more information or to purchase copies of *Courage! Together We Heal*, please contact Dr. Frances Anderson, A.T.R., HLM, at the Department of Art, Illinois State University, Normal, Illinois 61761.



1410

CHARLES C THOMAS • PUBLISHER

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 402 pp. (7 × 10), 32 il., 9 tables, about $72.00.

This book will address the use of creative arts, play, and other modalities in the psychotherapy of victims of multiple personality disorder. A dramatic rise in the number of inpatients and outpatients undergoing treatment for multiple personality disorder makes this subject an issue of importance and urgency that has not been explored in previous publications. Although the literature on their treatment is growing rapidly, it is exclusively addressed to the concerns of the primary therapist. When these patients are referred for adjunctive therapy to art therapists, movement therapists, activities therapists, music therapists, psychodramatists, occupational therapists, and vocational counselors, these mental health professionals have little, if any, printed resources which address their specific needs when dissociative patients are referred to them, and they often work in isolation from the advice, guidance, and shared experiences of colleagues. This book helps fill the needs of these groups of therapists, who make invaluable contributions to the treatment of patients. It also presents, in toto, a comprehensive overview for the reader who wishes to understand and explore the value of the inclusion of these disciplines in a program that purports to provide adequate care to dissociative disorder patients, or even to patients with other psychiatric disorders.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $35.75.

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¼), 28 il., $36.25.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¼), 21 il., $36.25.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¼), 34 il., $46.50.

☐ Dennison, Susan T. & Connie K. Glassman—**ACTIVITIES FOR CHILDREN IN THERAPY: A Guide for Planning and Facilitating Therapy with Troubled Children.** '87, 304 pp. (8½ × 11), 203 il., 12 tables, $44.00, spiral (paper).

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $33.00.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $23.50, spiral (paper).

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $30.00.

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 242 pp. (7 × 10), 71 il., about $43.75.

This book explores the experience of the contribution of art to spirituality in recovery from codependency and/or chemical dependency. This exploration resulted in gathering together ten personal stories which are woven with many common themes, creating the powerful portrait of recovery presented in this book. Since much of the previous work in these combined areas is theoretical, there is a need for research which highlights the essence of the experience of recovery including the spiritual dimension as experienced through art and art therapy. Very little research is currently available which interfaces these areas, and spirituality is an important component in the process of recovery. Therefore, knowledge about the contribution of art to recovery is valuable. Addiction is exterior attachment, whereas recovery is finding healing and wholeness through an interior journey. This book, about the interior experience, attempts to add clarity to the literature on the recovery process.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 × 10), 24 il., $44.75.

☐ Hardy, Richard E.—**GESTALT PSYCHOTHERAPY: CONCEPTS AND DEMONSTRATIONS IN STRESS, RELATIONSHIPS, HYPNOSIS, AND ADDICTION.** '91, 136 pp. (7 × 10), $30.75.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¼), 56 il., $46.50.

☐ Dennison, Susan T.—**ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents.** '88, 236 pp. (7 × 10), 36 il., 26 tables, $44.00.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $54.25.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $90.00.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 × 10), 1 table, $42.25.

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $51.25.

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $25.25.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $48.50.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

BEST COPY AVAILABLE

A Call for Artwork and Articles

Treating Abuse Today **is interested in publishing artwork by survivors of abuse and articles by professionals in the field of abuse treatment.**

Treating Abuse Today is a magazine for clinicians working in the field of abuse survivorship. Offering articles by such renowned experts as Laura Davis, Christine Courtois, Wendy Maltz and Barry Cohen, *Treating Abuse Today* offers clinicians information on the most vital and revealing area of psychotherapy: abuse. Covering clinical issues (rage, shame, grief), multiplicity, family and partner issues, transference and countertransference, the sexual abuse of males, ritual abuse and legal issues, *Treating Abuse Today* discusses the latest phenomena and treatment strategies. *Treating Abuse Today* offers in-depth articles as well as book reviews, current events and a network of upcoming conferences. Currently, *Treating Abuse Today* offers columns on art and the expressive therapies, partners of survivors of sexual abuse, survivor litigation and male survivorship.

- *FOR SUBMISSION INFORMATION, CONTACT:*

Karen J. Karleski, M.A., Associate Editor
Treating Abuse Today
2722 Eastlake Ave. E., Suite 300
Seattle, WA 98102

- *TO SUBSCRIBE, CALL IN OR FAX YOUR ONE-YEAR ($36) OR TWO-YEAR ($60) SUBSCRIPTION TO:*

Karyn D. Hand, Managing Editor
Voice: (206) 329-9101 / FAX: (206) 329-8462
VISA, M/C, AMEX — 24 HOURS A DAY

NINTH ANNUAL SUMMER INSTITUTE IN THE HUMAN SERVICES

JULY 9–17, 1993

CONTINUING EDUCATION/GRADUATE SCHOOL OF SOCIAL WORK UNIVERSITY OF UTAH, SALT LAKE CITY, UTAH 84112

Courses in Art Therapy

Using Art in Therapy, a one-credit course on Saturday, July 17 from 9:00 a.m.–5:00 p.m. For psychologists, social workers, and mental health professionals interested in the therapeutic application of art in treatment.

Imagery as Medicine, a one-credit course on Friday evening, April 30 and Saturday, May 1, 1993. For psychologists, social workers and health care professionals who are interested in the current research on imaginal techniques with individuals who are physically ill.

For more information on these and future offerings, please call Social Work Continuing Education, (801) 581-8913.

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Xerox copies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ____________________

Degrees/Credentials: ____________________

Address: ____________________

Phone #s: ____________________ **work** ____________________ **home**

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ____________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ____________________ **Date** ____________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association***, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

ARTherapy
JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

COLOR RATES: Standard Red, Blue and Yellow
(Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x	4x
Per page additional	$90	$85	$80	$75

INSERTS	1x	2x	3x	4x
2 pp	$ 800	$ 700	$ 575	$ 425
4 pp	1,500	1,300	1,150	1,000
8 pp	2,200	2,000	1,750	1,450

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-page Horizontal	7"	4-7/8"
Half-page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"
Bleed Size: 8-5/8" × 11-1/4"
Inserts: 8-5/8" × 11-1/4"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue; July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ART THERAPY is published quarterly by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $40 (US); $64 (Foreign). Institutions: $57 (US); $80 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $10 member; $18 non-member. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1993. Enclosed is my check, payable to AATA.
Name ____________________
Address ____________________
City __________ State _____ ZIP _____

*"Each issue of **The Arts in Psychotherapy** is a seasonal enlightenment indispensable for the many who want to stay up to date on the professional and theoretical aspects of the creative arts therapies."*
-Rudolf Arnheim, Ph.D., Professor Emeritus of the Psychology of Art, Harvard University

THE ARTS IN PSYCHOTHERAPY
An International Journal

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

Editor-in-Chief: Robert J. Landy, Ph.D., Director, Drama Therapy Program, New York University, New York, NY
European Editor: David Aldridge, Ph.D., Music Therapy, Universitat Witten, Herdecke, Germany
Managing Editor: Sylvia M. Halpern, 20 Ridgecrest East, Scarsdale, NY 10583

THE ARTS IN PSYCHOTHERAPY is an international journal for professionals in the fields of mental health and education. The Journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines.

In an effort to expand the Journal's focus to include more international articles, the new Editor-in-Chief, Robert J. Landy, has appointed a European Editor, David Aldridge, and has also updated the Editorial Boards.

PERGAMON PRESS
USA: 660 White Plains Road, Tarrytown, NY 10591-5153
UK: Headington Hill Hall, Oxford, OX3 0BW, England
A member of the Elsevier Science Publishing Group

The Editors welcome original manuscripts. Submit papers in triplicate to: Sylvia Halpern, Managing Editor, 20 Ridgecrest East, Scarsdale, NY 10583.
Submissions from Europe should be sent in triplicate to: David Aldridge, Ph.D., Music Therapy, Universitat Witten, Beckweg 4, D5804 Herdecke, Germany.

Subscription Information

ISSN: 0197-4556	Volume 20, 1993	5 issues per annum
Annual Institution Subscription Rate (1993)		*£ 140.00/US$266.00
Professional Rate (1993)		*£ 37.00/US$ 70.00

*Sterling Prices quoted are definitive and apply worldwide. US Dollar prices are quoted for convenience only and are subject to exchange rate fluctuation. Prices include postage and insurance. A special rate is available to members of qualifying societies. Please contact Pergamon Press for details.

BEST COPY AVAILABLE

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 10, NUMBER 2, 1993

1417

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Advertising: Please see advertising rates listed elsewhere in this journal or contact the American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 (708) 949-6064. The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

ISBN 1-882147-15-4

Editor

Cathy A. Malchiodi, MA, A.T.R.
California State University, Sacramento, CA

Associate Editor

Patricia St. John, EdD, A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor

Elizabeth Ratcliffe, MS, MFCC, A.T.R.
College of Notre Dame, Belmont, CA

Film/Video Review Editor

James Consoli, MA, A.T.R., NCC
Eastern Virginia Medical School, Norfolk, VA

Production Editor

Christine Fryer

Editorial Board

Pat B. Allen, PhD, A.T.R.
River Forest, IL

Frances E. Anderson, EdD, A.T.R., HLM
Illinois State University, Normal, IL

Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec

Michael Campanelli, EdD, A.T.R.
Edith Cowan University, Perth, Australia

Susan E. Cheyne-King, MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA

Carol Thayer Cox, MA, A.T.R.
The George Washington University, Washington, DC

Julie Epperson, MA, A.T.R.
Salt Lake City, UT

Janice Havlena, MA, A.T.R.
UNM Children's Psychiatric Hospital, Albuquerque, NM

Maxine Borowsky Junge, PhD, LCSW, A.T.R.
Loyola Marymount University, Los Angeles, CA

Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI

Paolo Knill, PhD, A.T.R., CMT-BC
Lesley College, Cambridge, MA

Vija B. Lusebrink, PhD, A.T.R.
University of Louisville, Louisville, KY

Howard McConeghey, EdD, A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM

Trudy Martin Manning, MS, A.T.R.
Eastern Virginia Medical School, Norfolk, VA

Shirley Riley, MA, MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA

Marcia L. Rosal, PhD, A.T.R.
University of Louisville, Louisville, KY

Susan Evans Spaniol, EdD, A.T.R.
Lesley College, Cambridge, MA

Betty Jo Troeger, PhD, A.T.R.
Florida State University, Tallahassee, FL

Evelyn Virshup, PhD, A.T.R.
California State University, Los Angeles, CA

Robert Wolf, MPS, A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President

Robin Goodman, PhD, A.T.R.

AATA Executive Director

Edward J. Stygar, Jr.

ARTherapy
JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Editorial

Introduction to Special Issue: Art and Medicine
Cathy A. Malchiodi, MA, A.T.R. 66

Commentaries 70

Articles

An Art Therapy Protocol for the Medical Trauma Setting
Valerie E. Appleton, EdD, A.T.R. 71

Art Therapy with Pediatric Cancer Patients: Helping Normal Children Cope with Abnormal Circumstances
Tracy Councill, MA, A.T.R. 78

Art Therapy and Brain Dysfunction in a Patient with a Dementing Illness
Judith Wald, MS, A.T.R. 88

Viewpoints

Portrait of an Illness
Mary Lynne L. Ricci, MA, A.T.R. 96

Reviews

Art as Medicine: Creating A Therapy of the Imagination
Vija B. Lusebrink, PhD, A.T.R. 100

Creativity and Disease: How Illness Affects Literature, Art and Music
Patricia St. John, EdD, A.T.R. 103

MusicMedicine
Therese Marie West, MMB-BC 105

Video Review: Visual Arts for the Physically Challenged Person
Simone B. Alter Muri, EdD, A.T.R., LMHC 106

Response to Video Review
Barbara Ann Levy, MFA, MPS 107

Noteworthy 109

About the Cover: "Dead or Alive," 54" × 29", cardboard, sticks, plaster gauze, acrylic paint, by Pat Allen, PhD, A.T.R. "This piece is influenced by Mexican art associated with El Dia de los Muertos, the holy day which honors and welcomes back the spirits of those departed with food and celebrations. In keeping with this spirit, the piece overlooks my dining room table. An awareness of death in life and an aesthetic which incorporates the detritus of everyday life—egg cartons, toilet paper rolls, newspaper—informs the work."

VOLUME 10 NUMBER 2, 1993

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 66-69 © AATA, Inc. 1993

Editorial

Introduction to Special Issue: Art and Medicine

Cathy A. Malchiodi, MA, A.T.R., *Editor*

This special issue of the journal addresses the application of art therapy within a medical context. The high response rate to the initial "Call for Papers" on the topic of art and medicine indicates that many art therapists are investigating the unique role of art expression in the medical setting. This special issue also comes at a time when Hillary Rodham Clinton may have made public her comprehensive plan for the nation's health care. Where or if art therapy is included in this plan remains to be seen, but it is certain that art therapists have been active in providing their services to a variety of patient populations in medical settings.

The term *medical art therapy* has been applied to the specific use of art therapy with individuals who are physically ill, experiencing trauma to the body, or undergoing aggressive medical treatment such as surgery or chemotherapy. However, the exact definition of medical art therapy varies as much as the practitioner, the population, and the setting in which it is presented. Over the last few years, art therapists have contributed knowledge on the use of medical art therapy with patients suffering from cancer (Cotton, 1985; Dreifuss-Kattan, 1990; Jeppson, 1983; Mango, 1992; Minar, 1992; Minar, Erdmann, Kapitan, Richter-Loesl, & Vance, 1991; Perkins, 1977); pediatric burns (Levinson, 1986; Levinson & Ousterout, 1979); arthritis (Lusebrink, Turner-Schikler & Schikler, 1992); acquired immune deficiency syndrome (Rosner & Sagman, 1985; White, Fenster, Franklin, Rosner-David, & Weiser, 1991); and on general connections between art expression and health (Long, Chapman, Appleton, Abrahms, & Palmer, 1989; Lusebrink, 1990; Malchiodi, 1993; Tartakoff, 1991). Others outside the field of art therapy have also explored the use of art expression (particularly drawing) with physically ill individuals (Achterberg, 1985; Achterberg & Lawlis, 1978, 1984; Seigel, 1987; Simonton, Simonton, & Creighton, 1978).

There are distinct differences between art therapy conducted in a psychiatric milieu and art therapy conducted in a medical setting, due to the environment, goals, and focus of each. For example, medical settings may have different objectives than psychiatric milieus, one obviously being the primary concern for the physical care of patients. Although psychological dimensions of treatment are important in a medical setting, the first goal is to expediently treat the presenting illness or physical condition. Therefore, art interventions must be designed with the overall medical treatment of the patient in mind, and with a knowledge of the particular illness, medications, or procedures involved in each individual case.

In contrast to most psychiatric settings, hospitals provide crisis care for patients' physical needs, including urgent medical assistance such as surgery, pharmacological interventions, or emergency evaluations. Appleton (in this issue) cites the need for crisis intervention models of art therapy, models which differ from those used in long-term psychotherapy settings. In a medical setting, crisis models of treatment are more applicable to the changing needs of patients whose physical conditions may be unstable and who have to cope with issues of loss surrounding body image and self.

Additionally, it is obvious that the physical condition of the patient affects how art therapy can be presented. In some cases the patient is fragile and susceptible to infections, and the art therapist must be cognizant of maintaining the sterile environment through appropriate use of media and tools. At other times the patient may be unable to participate without physical adjustments, such as arrangements for art therapy at the bedside or creation of special devices to help the patient draw or paint. For example, Cotton (1985), in her work with pediatric cancer patients, describes her patient Sabrina as unable to hold a brush at one point because of the deterioration of her health and the damage to her hands from intravenous injections.

The circumstances under which art therapy is conducted in a medical setting may also be different than in a psychiatric setting. For example, Council (in this issue) notes that art therapy with pediatric cancer patients may be offered in the hospital waiting room where children await chemotherapy, radiation treatments, or check-ups. The family, including siblings, may be present and may become part of the art therapy. Confidentiality is not easily maintained in this open environment where patients come and go at will, and where art therapy essentially takes place in a public arena, such as a waiting room or at bedside.

In addition to the uniqueness of the application of medical art therapy with client populations, some additional questions about art therapy within a medical setting come to mind. For example, do art expressions reveal disease and/or recovery processes? A body of evidence supports the idea that the somatic aspects of a patient's condition appear in his or her art product (Bach, 1966, 1975, 1990; Cotton, 1985; Levinson, 1986; Malchiodi, 1991; Perkins, 1977). In this issue of the journal, Judith Wald presents the case of Mel whose progressive neurological deterioration may have been evident in the art expressions he made during the last several years before his death. As investigation of the somatic component in art expressions continues, it is likely that art therapists will be able to contribute to the overall medical evaluation of patients through graphic clues to regression, remission, and recovery from disease which appear in art expressions.

In addition to the material presented in this issue of *Art Therapy*, there is a larger context in which medical art therapy could become a major player in the future. The recent Public Broadcast System presentation of "Healing and the Mind" (also see accompanying text, *Healing and the Mind*, Moyers, 1993) explored the mind/body connection and the increasing interest in so-called "alternative" forms of health care. The series investigated the field of psychoneuroimmunology; the use of Eastern methods of health care such as acupuncture, Tai Chi, and meditation; and progress in understanding the role that the mind and emotions play in health and well-being.

"Healing and the Mind" highlighted the recent advancements that health professionals, including art therapists, should be cognizant of in the care and treatment of patients with life-threatening illnesses. A particularly moving segment addressed the treatment of patients with breast cancer and how group support may be a key element in prolonging the lifespan of those patients with metastatic breast cancer. Dr. David Speigel at Stanford University found that women who participated in support groups in which they expressed a complete range of their feelings about their disease lived, on average, twice as long as women who were assigned to a control group. Although Speigel agrees that this research needs further validation (he is currently conducting additional studies to verify his initial findings), there seems to be a strong connection between social support, opening up to others, and resistance to physical illness (Pennebaker, 1990; Schaefer, Coyne, & Lazarus, 1982; Spiegel, Bloom, Kraemer & Gottheil, 1989; Wortman, 1984; Wortman & Conway, 1985).

This segment emphasized the necessity for considering aspects of social support theory, resilience, and stress reduction when tailoring interventions to meet the needs of patient groups in medical settings. For example, if it is true that social support and opening up to others are beneficial to individuals who are experiencing a life-threatening illness such as metastatic breast cancer, then perhaps art therapy may be useful with this population in a group setting where talking and sharing the content of art expressions are the focus. McNiff (1992), although not specifically discussing medical populations, cites the inherent value of art therapy and art making in telling one's story to other members of a group. This type of "storytelling" about one's images may prove to be useful in providing a socially supportive way to express feelings about illness, particularly with patients whose lives are threatened by cancer or other diseases.

Although art therapy as an adjunct to medical treatment was not specifically cited in the "Healing and the Mind" series, the segment on Commonweal Cancer Help Program in Bolinas, California, showed participants engaging in art activities, along with other experiences such as creative writing and sandtray. Michael Lerner, president of Commonweal, described the program's goal as helping "individuals find their own personal pathways to healing in an effort to optimize their chances for recovery" (p. 12, Graham, 1993). In this sense, the approach of Commonweal is in sync with the goals of medical art therapy which utilizes expressive modalities to meet each person's needs for exploration of his/her disease experience in a way that is most comfortable and accessible.

A question concerning the profession of art therapy emerged from the Commonweal segment: Is art therapy a form of alternative health care? Although many art therapists do not wish to be included in the same ranks with Ayurvedic medicine, massage, biofeedback, etc., it may be that art therapy is perceived by the larger public as something less than mainstream and, therefore, part of the alternative health care movement. As the view of health care shifts during the 90s, this may not be as distasteful as it seems. Alternative forms of treatment are currently being given attention by government agencies, in particular the newly formed Office of Alternative Medicine (OAM) of the National Institutes of Health (NIH). Included on the OAM advisory panel are O. Carl Simonton, pioneer in the use of visualization with cancer patients (Simonton, Simonton, & Creighton, 1978) and Bernie Siegel, surgeon and popular author (1987, 1989), among others. It is interesting to note that both Simonton and Siegel have used drawing in conjunction with their programs, although generally as an adjunct to guided visualization and relaxation.

Lastly, does the use of art therapy with physically ill individuals present any implications for the healing process itself? The answer to this question involves many variables, including how the art process is presented, whether it is presented in a group or individual setting, the characteristics of the population, etc. Long-term outcome studies, such as Speigel's work with patients with breast cancer, may be necessary to begin to identify if there are properties of art expression which contribute to the health and well-being of a specific patient population or to physically ill individuals in general.

Fortunately, healing is not defined only by blood chemistries or the eradication of tumors. Playwright and writer Barbara Graham (1993) notes that "being healed isn't the same as being cured. Healing is a process of becoming whole—physically and psychologically . . . healing takes place even as the body weakens" (p. 12). It may be that future research in the field of medical art therapy will be in the areas of evaluation of somatic conditions and assistance in the physical recovery of some patients. However, the greatest impact of medical art therapy also could be in the art process's ability to synthesize and integrate client issues such as pain, loss, and death, and the art therapist's ability and training to help patients do this through art making. By Graham's definition of healing, the use of art expression in conjunction with a total medical treatment program may be one of the most viable avenues through which our patients can find true healing in their lives.

References

Achterberg, J. (1985). *Imagery in healing: Shamanism and modern medicine.* Boston: Shambhala.

Achterberg, J., & Lawlis, G. (1978). *Imagery of cancer: A diagnostic tool for the process of disease.* Champaign, IL: Institute for Personality and Ability Testing.

Achterberg, J., & Lawlis, G. (1984). *Imagery and disease.* Champaign, IL: Institute for Personality and Ability Testing.

Bach, S. (1966). Spontaneous drawings of severely ill patients: A contribution to psychosomatic medicine. *Acta Psychosomatica, 8,* 1–66.

Bach, S. (1975). Spontaneous pictures of leukemic children as an expression of the total personality, mind and body. *Acta Paedopsychiatrica, 41*(3), 86–104.

Bach, S. (1990). *Life paints its own span.* Einsiedeln, Switzerland: Daimon Verlag.

Cotton, M. (1985). Creative art expression from a leukemic child. *Art Therapy: Journal of the American Art Therapy Association, 2*(2), 55–65.

David, I. R., & Sageman, S. (1985). Psychological aspects of AIDS as seen in art therapy. *American Journal of Art Therapy, 26,* 3–10.

Dreifuss-Kattan, E. (1990). *Cancer stories: Creativity and self-repair.* Hillsdale, NJ: Analytic Press.

Graham, B. (1993). Wounded healers. In *Healing and the Mind with Bill Moyers: A Viewer's Guide* (p. 12). Sausalito, CA: Institute for Noetic Sciences.

Jeppson, P. M. (1983). Creative approaches to coping with cancer: Art therapy and the cancer patient. In A. Di Maria, E. Kramer, & E. Roth (Eds.), Art Therapy: Still Growing, *Proceedings of the 13th Annual Conference of the American Art Therapy Association* (pp. 45–47). Alexandria, VA: AATA.

Levinson, P. (1986). Identification of child abuse in art and play products of pediatric burn patients. *Art Therapy: Journal of the American Art Therapy Association, 3*(2), 61–66.

Levinson, P., & Ousterout, D. K. (1979). Art and play therapy with pediatric burn patients. *Journal of Burn Care and Rehabilitation, 1*, 42–46.

Lusebrink, V. (1990). *Imagery and visual expression in therapy*. New York: Plenum, New Science Library.

Lusebrink, V., Turner-Schikler, L., & Schikler, K. (1992). Art therapy with juvenile rheumatoid arthritis patients. *Proceedings of the 23rd Annual Conference of the American Art Therapy Association* (p. 82). Mundelein, IL: AATA.

Malchiodi, C. A. (1991). Art Rx: Art expression and physical health. *Proceedings of the 22nd Annual Conference of the American Art Therapy Association* (p. 86). Mundelein, IL: AATA.

Malchiodi, C. A. (1993). *Art, imagery and health: Using art and imagery for health and well-being*. Salt Lake City, UT: Art Rx Publications.

Mango, C. (1992). Terminal images of a pre-diagnosed cancer patient. *Proceedings of the 23rd Annual Conference of the American Art Therapy Association* (p. 117). Mundelein, IL: AATA.

McNiff, S. (1992). *Art as medicine*. Boston: Shambhala.

Minar, V. (1992). Living with cancer: Images of the hurter and the healer. *Proceedings of the 23rd Annual Conference of the American Art Therapy Association* (p. 116). Mundelein, IL: AATA.

Minar, V., Erdmann, J., Kapitan, L., Richter-Loesl, S., & Vance, L. (1991). Confronting cancer through art: A collaborative effort by hospital, patient and therapist. *Proceedings of the 22nd Annual Conference of the American Art Therapy Association* (p. 77). Mundelein, IL: AATA.

Moyers, B. (1993). *Healing and the mind*. New York: Doubleday.

Pennebaker, J. W. (1990). *Opening up: The healing power of confiding in others*. New York: William Morrow and Co.

Perkins, C. F. (1977). The art of life-threatened children: A preliminary study. In R. H. Shoemaker & S. Gonick-Barris (Eds.), *Creativity and the art therapist's identity* (pp. 9–12), Baltimore, MD: AATA.

Schaefer, C., Coyne, J. C., & Lazarus, R. S. (1982). The health-related functions of social support. *Journal of Behavioral Medicine, 4*, 381–406.

Siegel, B. (1987). *Love, medicine, and miracles*. New York: Harper & Row.

Siegel, B. (1989). *Peace, love, and healing*. New York: Harper & Row.

Simonton, O. C., Simonton, S., & Creighton, J. (1978). *Getting well again*. Los Angeles: J. P. Tarcher.

Spiegel, D., Bloom, J., Kraemer, H., & Gottheil, E. (1989, October 14). Effect of psychosocial treatment on survival of patients with metastatic breast cancer. *The Lancet, 2* (8668), 888–891.

Tartakoff, G. (1991). Healing medical symptoms exacerbated by stress: Using art psychotherapy. *Proceedings of the 22nd Annual Conference of the American Art Therapy Association* (p. 118). Mundelein, IL: AATA.

White, S., Fenster, G., Franklin, M., Rosner-David, I., & Weiser, J. (1991). From outside in and inside out: Viewing AIDS through art therapies' window. *Proceedings of the 22nd Annual Conference of the American Art Therapy Association* (p. 55). Mundelein, IL: AATA.

Wortman, C. B. (1984). Social support and cancer: Conceptual and methodological issues. *Cancer, 53*(10), 2339–2360.

Wortman, C. B., & Conway, T. L. (1985). Social support and recovery from illness. In S. Cohen & S. L. Syme (Eds.), *Social support and health* (pp. 281–302). New York: Academic Press.

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 70 © AATA, Inc. 1993

Commentaries

Excerpts from a letter to the Editor from Ellen Dissanayake ("Art for Life's Sake," Volume 9, No. 4)

February 19, 1993

Dear Cathy,

I do want to tell you how extremely pleased I am that someone has conceived a whole issue around the importance of biology (and anthropology) to our understanding of "art." I think Linda's (Gantt) commentary, more than anything else that has been written about my work, catches, comprehends, and clearly states the ramifications and importance of the "palaeoanthropsychobiological" approach. I am really thrilled to see it all set out—and wonder if anyone has commented. Liz Ratcliffe's review of *Homo Aestheticus* was wonderful; she really read it closely and is the first to have mentioned the psychobiology chapter, which I think is one of the most important contributions of the book.

My year here (Sri lanka) has been most enjoyable—a real change from American life . . . my very best to you.

Sincerely,
Ellen Dissanayake, Fullbright Senior Scholar
Bahirawakanda, Kandy, Sri Lanka

Letter to the Associate Editor

January 13, 1993

Dear Dr. St. John:

Thank you for inviting me to reply to the review of the *Silver Test of Cognitive Skills and Adjustment* (2nd edition) and for the opportunity to thank Anna Hiscox for her thoughtful observations.

The review criticizes, rightly, the absence of norms for students in grades 9, 11, and 12, and the inadequate number of adult norms. These norms were not developed because I did not believe they would be useful, assuming that older respondents would have acquired the cognitive skills under consideration. I was wrong.

Maggie McCready presented the *Silver Drawing Test* to a class of college students who received a mean score of 39.67 points, out of a maximum of 45. One respondent received low scores in *Drawing from Observation* together with a strongly negative *Drawing from Imagination*. (A small mouse stabbing a cat through the stomach and back with a large, bloodied knife, scored one (1) point.) Morbid responses, scored one point, were found to be associated with adolescent depression (Silver, 1988), suggesting that preoccupation with emotional problems had affected the cognitive functioning of this respondent.

Glenda Hunter, in a doctoral project at the University of New England, Australia (1992), used the *Silver Drawing Test* with 65 male and 128 female college students. She found gender differences in spatial thinking and problem-solving among 10 variables: abilities to select, combine, and represent (concept formation, creativity, and problem solving); horizontal, vertical, and depth relationships (unrestricted spatial thinking and problem-solving); predicting horizontality and verticality (conversation); and projection (adjustment). The findings suggested that females are characterized by higher performance in unrestricted spatial thinking and problem-solving.

Although I would like to expand the norms, I am now retired and no longer have access to sample populations. If any readers have used the *Silver Drawing Test* with older populations, or would like to do so, I would greatly appreciate hearing from you.

Sincerely,
Rawley Silver, EdD, A.T.R., HLM
Sarasota, FL

Associate Editor's Note: Readers who are interested in contacting Dr. Silver may write directly to her at 3332 Hadfield Greene, Sarasota, FL 34235.

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 71-77 © AATA, Inc. 1993

An Art Therapy Protocol for the Medical Trauma Setting

Valerie E. Appleton, EdD, A.T.R., Cheney, WA

Abstract

Art therapy as crisis intervention is relatively new in the field of medical trauma care, outside of the psychiatric setting. Art therapy on a trauma unit provides unique opportunities for clinical intervention and field research. This paper presents an art therapy intervention protocol developed for a burn trauma unit over a 10-year period. A research paradigm for assessing artwork and the psychosocial transition from trauma, rationales for art therapy in a medical setting, and documentation are considered. A case study illustrates the ways that art media were used to review, integrate, and express the personal experience of recovery from severe burns.

Introduction

Crisis intervention has been developed only within the past few decades. It cannot be directly related to any single theory of human behavior as all have contributed to some degree (Aguilera & Messick, 1986). At a minimum, the therapeutic goal of crisis intervention is the psychological resolution of the individual's immediate crisis and the restoration of functioning that existed precrisis (Watkins, Cook, May, & Ehlben, 1988). A larger goal is improvement of functioning above the precrisis level (Aguilera & Messick, 1986). The implementation of these goals requires an integration of allied professionals in the total care of trauma victims (Bowden, Jones, & Feller, 1979).

Lusebrink (1990) notes the body of research evidence (Achterberg, 1985; Achterberg & Lawlis, 1980; Korn & Johnson, 1983; Sheikh & Kunzendorf, 1984; Simonton, Simonton, & Creighton, 1978) supporting the notion that "imagery can be used as a healing agent to supplement conventional medical procedures" (p. 219). Also, color, line quality, and themes in artwork were observed to assist medical patients in the expression of feelings surrounding illness, hospitalization, surgery, body imagery, and medical procedures (Abel, 1953; Bach, 1966, 1975; Furth, 1973, 1988; Lusebrink, 1990; Machinsky, 1982) as well as about home and family (Landgarten, 1981; Levinson & Ousterout, 1979), and staff (Misner, 1979). A panel describing innovations in "medical art therapy" was presented at the 20th Annual Conference of the American Art Therapy Association (Long, Chapman, Appleton, Abrams, & Palmer, 1989). Art therapy functions clinically in psychosocial burn care as: (a) a projective base, (b) a diagnostic tool, and (c) a mode of treatment (Levinson & Ousterout, 1979).

As a colleague of Levinson's, the author wrote a research grant to provide art therapy with adolescent and young adult burn patients. The study ranged over a 10-year period, between 1981 and 1991. Lee's (1970) model of the salient psychosocial issues in the transition from trauma provided the foundation for the research paradigm. Artwork descriptors were found to reflect Lee's four stages as follows:

Stage 1. Impact: Morbidity was expressed in color choice, line quality, and images reviewing trauma impact.

Stage 2. Retreat: Regression was expressed through fantasy imagery, superhuman figures, sunsets, and design/abstracts.

Stage 3. Acknowledgement: Family and social interactions were reflected in images of trees, and self-concept through self-selected "healing" colors, and mandalas.

Stage 4. Reconstruction: Psychosocial issues of mastery, independence, and future goals were observed in the patients' selections of art processes and in home images (Appleton, 1989).

Intervention Protocol

The following is an overview of the protocol developed for art therapy interventions on a burn trauma unit. The interventions are based on the achievement of eight clinical objectives. Each is cited below with supporting rationale.

1. To establish a therapeutic framework for art therapy interventions with the patient.

A trust relationship that reinforces the therapeutic alliance is established with the patient through art processes. Symbolic processes are the focus of the intervention and offer ways to transcend the verbal limitations exacerbated by the trauma sequelae (Lusebrink, 1990). Furthermore, symbolized feelings and experiences can be a more powerful mechanism of expression and communication than verbal description alone, and at the same time render these feelings and experiences less threatening (Dalley, 1984).

Art therapy interventions occur at the patient's bedside with media that are chosen by the patient from a consistent selection presented by the art therapist. For instance, the art media may include dry watercolor cakes (12 colors), felt pens (wide and thin), watercolor cartridge brushes, soft pastels (24 colors), and collage materials for use on paper or boxes (magazines, colored papers, glitter, and medical supplies such as cotton swabs, tongue depressors, and syringes). Both the art therapist and the media provide the patient with a sense of continuity. In recovering from trauma, a consistent relationship with key care givers is essential, both for the quality of the therapeutic relationship and as a reality reference for the trauma survivor who suffers from a sense of depersonalization, disorientation, and loss of identity.

2. To utilize the patient's natural coping mechanisms of denial and projection through art processes.

The process of art therapy is based on the recognition that an individual's most fundamental thoughts and feelings, derived from the unconscious, reach expression in images rather than words (Naumburg, 1973). When the symbolic aspects of imagery are accessed, along with the verbal and cognitive, art therapy can provide an integrative and healing opportunity for the individual (Rubin, 1984).

The art therapist works with the patient to evaluate his or her coping capacity. Art processes are discussed and ideas and media offered to the patient. The majority of the art therapy activities are either spontaneous or impromptu. For the purposes of assessment and projection, the art therapist specifically requests that patients render the traumatic event and subsequent experience of hospitalization and administers Buck's (1978) House-Tree-Person diagnostic.

3. To clear up misconceptions regarding hospitalization, medical procedures, and/or the burn injury event.

The therapist works with the treatment team preparing patients for surgery and daily hospital procedures in burn care. Through art processes patients are observed to place the burn/trauma event into a temporal perspective. The art products provide, as Dalley (1984) describes, a concrete visual record that exists over time. The visual and symbolic images become important for both the staff and the patient, recording gains or set-backs in psychosocial adjustment.

4. To encourage mastery and creativity, enhance self-esteem, and reaffirm the patient's appropriate age-level abilities.

It is documented that burn patients who are actively involved in their own care have better prognostic outcomes than those patients who remain passive (Scanlon & Levesque, 1981). The art therapy activities provided on the trauma unit (drawing, painting, and building collages on paper and boxes) require active and creative interaction with media. The ability to control media becomes an opportunity for the projective control of the feelings of anxiety, helplessness, immobilization, and sensory deprivation common among trauma victims.

Burn and trauma victims typically regress during crisis and the stress of injury and hospitalization. Extremely regressed patients are not compliant with procedures and may become overwhelmed, exhibiting behaviors ranging from acute depression to hysteria. Art processes offer the patient a vehicle for self-expression through creative and generative activity.

5. To offer the patient emotional, physical, and social outlets to decrease stress.

As pain is directly linked to stress response, the relaxation benefits of art activities assist in pain control. The therapist can encourage more compliance with nursing staff and physical therapy by initiating activities where the focus is nonmedical. For example, art activities where the patient must reach with a paintbrush or move around a sculpture indirectly encourage the stretching of scarred areas and the getting out of bed and becoming mobile, and enhance social interaction with others. Art products in the patient's room or conjoint art-making processes between patient, staff, and family facilitate discussion and verbalization.

Art materials are offered to the patient from a full range of color and media choices. The patient's level of physical energy can be seen in his or her selection and use of the media, each of which has specific physical properties and capabilities. Media are viewed on a continuum ranging from those more easily controlled, such as sharp pencils and felt tip pens, to those more difficult to control, such as watercolor paint (Landgarten, 1981).

6. To bridge the gap between home and hospital through all phases of the recovery from trauma.

The goal is to return the patient, as much as possible, to precrisis life. Thus, predischarge planning and preparation are an important phase of care. Patients need to feel they will be cared for after they leave the hospital. After the home situation is evaluated, follow-up art therapy may be recommended. Also, the therapist may refer the patient to a social worker and/or psychiatrist for postdischarge psychotherapy, when appropriate. Patients often report that they learned through the therapeutic relationship with the art therapist that it can be appropriate to "ask for help."

7. To evaluate the premorbid family situation and to assess evidence of abuse, neglect, or family crisis in the course of ongoing art therapy and psychosocial evaluation.

The art therapist is an advocate for the patient and works with the treatment team during assessment. Abuse may not be overtly verbalized, but can appear projectively in artwork. The art therapist reports graphic representation of abuse for the legal defense of victims.

8. To provide art therapy follow-up groups and appropriate referral to support agencies in the community prior to discharge from the hospital.

Patients often experience a regression to less effective levels of coping when faced with returning home. Often the patient will be returning to the locale of the original burn trauma and will suddenly be fraught with unexpressed feelings. Art therapy facilitates the transition from the hospital to home by reinforcing the expression of feelings. With the patient's permission, the art therapist utilizes the patient's artwork in predischarge evaluation with the burn team where a plan is created to support the physical and psychosocial needs of the patient outside of the hospital. Follow-up art therapy groups or individual sessions may be indicated at this time.

Documentation

Art therapy interventions are documented in the medical chart much the same way as other treatments accorded the patient. These notes are part of the patient's records referenced by all members of the team: social workers, psychiatrists, physicians, nurses, and consultants. Charting reflects intervention protocols in the following ways:

1. The art therapist meets the patient upon admission to the hospital. As the patient proceeds through hospitalization, the art therapist continues to evaluate the interventions that might be required through consultation with patient, the medical staff, and the medical record.
2. The patient is seen for art therapy two to five times weekly at the bedside, which helps prepare the patient for surgery and other medical procedures, and for discharge.
3. Notes of the doctor, nurses, psychiatrists, social worker, and art therapist are kept in each patient's medical chart and reviewed at case rounds and meetings.
4. Artwork is dated, and the art therapy interview and interventions are documented in the medical chart according to a format designed by the author to avoid duplication of services with other members of the team. The charting format includes: Interaction, Affect, Process/Product, Observation, and Plan (IAPOP). Direct quotes and patient descriptions of art processes are recorded verbatim to preserve idiosyncratic meaning.
5. With the patient's signed permission, original artwork and/or slides of artwork are kept as part of the research data. Patients are informed that their art contributes to an understanding of the experiences of medical trauma patients.

Case Example

The following is part of a case study developed for a research dissertation (Appleton, 1989) and preserves the anonymity of the study participant. It presents the ways "Michael, patient #13," used art media to make therapeutic gains—moving from regression toward a sense of mastery over his recovery from severe burns.

While driving home intoxicated after his high school reunion, Michael, age 24, was burned after his car rolled on an exit ramp. He claimed throughout hospitalization that he was not drinking that night. Michael's medical report noted fractures to the vertebra of the spine and sixth rib, requiring a long period of immobility and physical dependency on nursing care. He was emotionally overwhelmed with his burns, exhibiting overly dependent, regressive behavior and low pain tolerance. His behavior was described by the nursing staff as "acting like a four-year-old."

Art therapy interventions were begun as soon as Michael was conscious for 24 hours, the ninth day of his 35-day hospitalization (5 weeks). He stated then "I just want to be dead. This is the worst pain I have ever had" and rendered the accident in black and red including a diagram of the highway, an image of what a passerby would have seen, and an image from his perspective pinned underneath the car (Figures 1, 2, and 3). The next day he drew a nightmare of the accident and tore it up to throw away. These images reflect the impact of trauma, and his artwork is characterized by black, orange, and red color choices often observed among burn patients (Appleton, 1989). During this period he was beset with nightmares of the accident.

After some relaxation training with the art therapist, he painted a mandala and began to explore a difficult media, watercolor. He worked slowly, was absorbed in the painting process for two hours, and called the work "the many aspects of pain" (Figure 4). He continued painting on his own throughout the week to complete the mandala. At this point in his recovery, his main concern was how people (women, in particular) would react when they saw the scars on his chest and abdomen.

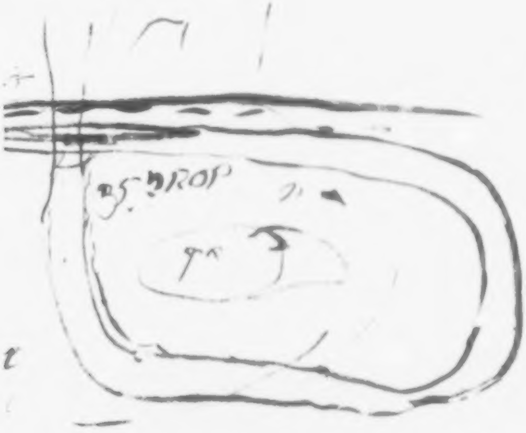


Figure 1. "Accident diagram of freeway exit."

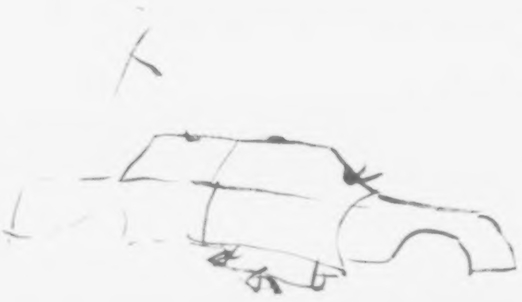


Figure 2. "Accident from my perspective."

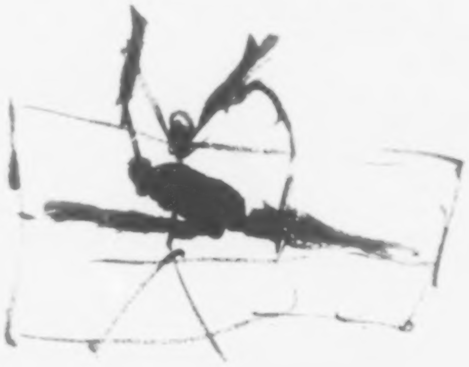


Figure 3. "What the passers-by saw."

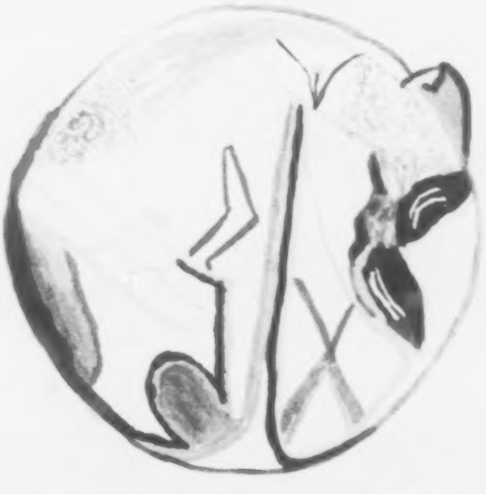


Figure 4. "The many aspects of pain."

The acknowledgement stage, as described by Lee (1970), is typified by periods of mourning and frustration when the patient realizes that his former self has been significantly altered. Michael drew an image in soft pastels which he titled "Frusteration (sic)" (Figure 5). The image includes scratchy lines, restriction of the body posture, and lack of hands and lower body, and may reflect Michael's emotions regarding his changed body as well as his physical limitations at this stage of healing. He was still immobilized in bed at this point in his care.

By the midpoint of his hospitalization, the 19th day, Michael painted a watercolor of Hawaii and was able to hold the paper without assistance from the art therapist (Figure 6). This ability pleased him and he stated, "I'm not in as much pain now." His attitude with the media was exploratory and his behavior became less demanding, regressive, and dependent. By the 26th day of hospitalization, he requested a reclarification of the art therapist's role. He stated, "I want you to know, I have my own ideas about my care, and I don't need all the help I did before. I'm accepting my burns better now." The following day he asked his mother to leave his bedside for the first time. He told her, "This is my therapy time now." During this session he created images reflecting his world travels while in the Army. The collage, called "The Old World," includes images of Europe (Figure 7).

The final stage of Michael's recovery from burn trauma was reflected in three works (Figures 8 and 9, and a clay piece; no figure available). "Spanish Galleon" with three masts was created before returning home to his three family members (Figure 8). The ship is a form of transportation, perhaps symbolic of sailing away or a way out of the hospital. However, Michael expressed ambivalence about leaving intensive care. This ambivalence may be

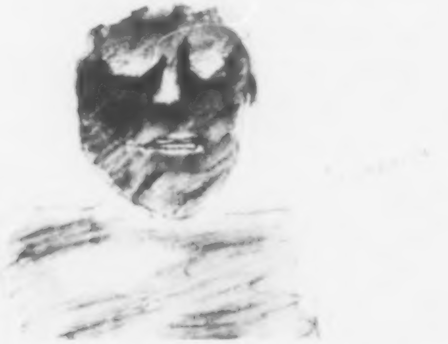


Figure 5. "Frusteration [*sic*]."

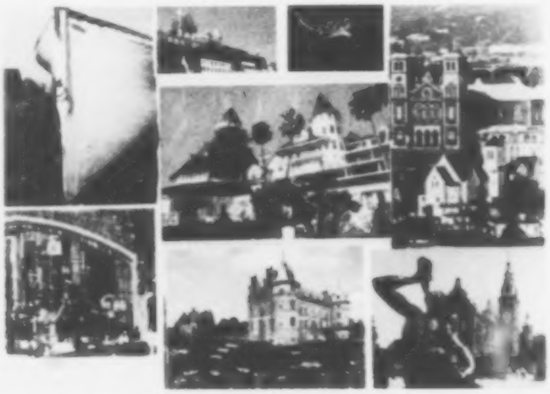


Figure 7. Collage. "The Old World."

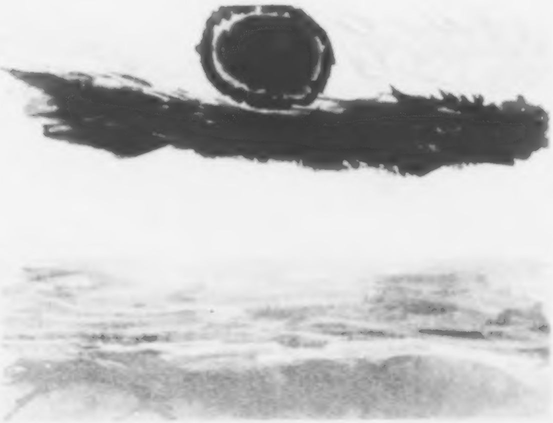


Figure 6. "Sunset."

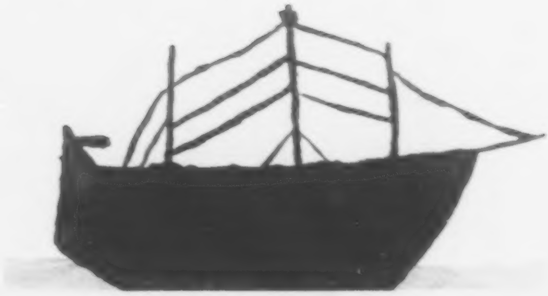


Figure 8. "Spanish Galleon, 1535."

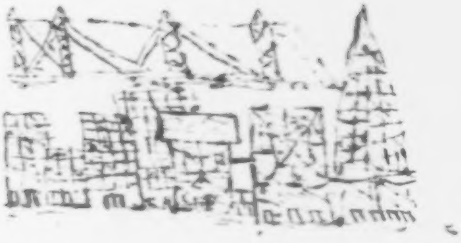


Figure 9. "The City."

seen in the fact that his sailboat has no sails. The image titled "The City" (Figure 9) leans toward the left, perhaps reflecting his stated hesitance to leave the unit and concern over his ability to care for himself. This resistance to leaving the burn unit was temporary. His last art process while an inpatient was to build a house in plasticene clay. The sides were cleverly constructed so the structure would not fall when the roof was positioned. He stated, "Notice how my house can stand without supports." Buck (1966) suggests that the house is a projection of the self; perhaps Michael was symbolically stating his ability to support the burden of his own care.

During the last session with the art therapist, Michael made numerous statements about his plans to do things for himself. He wanted to see his medical chart and arranged for in-home art therapy visits postdischarge. He stated, "I learned from this art therapy that sometimes it's O.K. to seek counseling—something I never would have done before." He had overcome the emotional and physical regressions he experienced in burn trauma through the mastery of art media and had acquired a new perspective and value of his own care.

Conclusion

Art therapy in the sterile, medical environment validates the deeply personal nature of the patient's experiences by focusing on feelings and expressive processes. In this way, art therapy supports the clinical understanding of trauma as an idiosyncratic process that is impacted by social perception, premorbid adjustment, prior psychiatric diagnoses, support systems, coping styles, cultural reference, gender, and personality (Andreason, Noyes, & Hartford, 1972; Gaines, 1986; Jacobson, 1965; Mestrovic, 1985; Peterson, 1986, 1983; Silverman, 1986; Viney, Benjamin, Clark, & Bunn, 1985).

At the burn unit, patients ranging from pediatric to geriatric age groups were extremely receptive to art therapy interventions. On a Likert-style survey developed for this research, 100 percent of the study participants reported that "art therapy has been helpful to me during my hospitalization" (Appleton, 1989).

The protocol described in this paper offers a therapeutic and educational tool for settings other than the burn trauma unit, when and wherever brief therapy and/or trauma assessment and counseling services are required. Such services may include crisis and emergency housing, disaster intervention, abuse recovery counseling, pediatric surgery units, emergency rooms, intensive care units, oncology units, and rehabilitation units. Examining the artwork of trauma survivors contributes to the understanding of the complexities of their adaptations. Thus, art therapy allows the exploration of the many ways individuals make the transition from trauma to recovery, a most beneficial process for all concerned.

References

Abel, T. M. (1953). Figure drawings in facial disfigurement. *American Journal of Orthopsychiatry, 23,* 253–264.

Achterberg, J. (1985). *Imagery in healing: Shamanism in modern medicine.* Boston, MA: New Sciences Library.

Achterberg, J., & Lawlis, G. F. (1980). *Bridges for the bodymind: Behavioral approaches to health care.* Champaign, IL: Institute for Personality and Ability Testing.

Aguilera, D. C., & Messick, J. M. (1986). *Crisis intervention theory and methodology* (5th ed.). St. Louis, MO: The C. V. Mosby Company.

Andreason, N. C. J., Noyes, R., & Hartford, C. E. (1972). Factors influencing adjustment of burn patients during hospitalization. *Psychosomatic Medicine, 34* (6).

Appleton, V. E. (1989). Transition from trauma: Art therapy with adolescent and young adult burn patients. Doctoral dissertation, University of San Francisco (University Microfilms International No. 9027812).

Bach, S. R. (1975). *Spontaneous pictures of leukemic children as an expression of the total personality, mind, and body.* New York: Schwabe.

Bach, S. R. (1966). Spontaneous paintings of severely ill patients. *Acta Psychosomatica,* (8). Basel, Switzerland: Giegy.

Bowden, M. L., Jones, C. A., & Feller, I. (1979). Psychosocial aspects of a severe burn: A review of the literature. *International Bibliography on Burns, 1979 Supplement.* Michigan: National Institute for Burn Medicine. (Library of Congress No. 79-89259).

Buck, J. N. (1978). *The House-Tree-Person diagnostic technique: Revised manual.* Los Angeles: Western Psychological Services.

Furth, G. M. (1973). Impromptu paintings by terminally ill, hospitalized, and healthy children: What can we learn from them? Doctoral dissertation, Ohio State University, 1973.

Furth, G. M. (1988). *The secret world of drawings: Healing through art.* Boston, MA: SIGO.

Gaines, A. D. (1986). Factors determining trauma vulnerability. Trauma: Cross cultural issues. In L. G. Peterson, & G. J. O'Shanick, (Eds.), *Advanced psychosomatic medicine: Psychiatric aspects of trauma, 16,* (pp. 1–16). Basel: Karger.

Jacobson, G. (1965). Crisis theory and treatment strategy: Some socio-cultural and psychodynamic considerations. *Journal of Nervous Mental Disorders, 141,* 209.

Kagen, S. L., & Lusebrink, V. B. (1978). The expressive therapies continuum. *Art Psychotherapy, 5*(4), 171–179.

Korn, E. R., & Johnson, K. (1983). *Visualization: The uses of imagery in health professions.* Homewood, IL: Dow Jones-Irving.

Landgarten, H. B. (1981). *Clinical art therapy: A comprehensive guide.* New York: Brunner/Mazel.

Lee, J. M. (1970). Emotional reactions to trauma. *Nursing Clinics of North America, 5*(4), 577–587.

Levinson, P., & Ousterout, D. K. (1979). Art and play therapy with pediatric burn patients. *Journal of Burn Care and Rehabilitation, 1,* 42–46.

Long, J., Chapman, L., Appleton, V., Abrahms, E., & Palmer, S. (1989). Innovations in medical art therapy: Defining the field. *Proceedings of the 20th Annual American Art Therapy Association Conference* (p. 84). Mundelein, IL: AATA.

Lusebrink, V. B. (1990). *Imagery and visual expression in therapy.* New York: Plenum.

Machinsky, W. J. (1982). An examination of the pre-operative and post-operative drawings of children experiencing surgery. *Proceedings of the 13th Annual Conference of the American Art Therapy Association* (p. 146). Alexandria, VA: AATA.

Mestrovic, S. G. (1985). A sociological conceptualization of trauma. *Social Science Medicine, 21*(8), 835–848.

Misner, S. J. (1979). Using art techniques for staff and patient education. *Nursing Outlook, 27,* 536–539.

Naumburg, M. (1973). *An introduction to art therapy.* New York: Teachers College.

Peterson, L. G. (1986). Behavioral responses to trauma: Acute responses to trauma. In L. G. Peterson & G. J. O'Shanick, (Eds.), *Advanced psychosomatic medicine: Psychiatric aspects of trauma.* (pp. 84–92). Basel: Karger.

Peterson, L. G. (1983). The psychological impact of trauma: Recognition and treatment. *American Journal of Emergency Medicine, 1,* 102–106.

Read, H. (1956). *Education through art.* (rev. 3rd ed.) New York: Pantheon Books.

Rubin, J. A. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Scanlon-Schlipp, A. M., & Levesque, J. (1981). Helping the patient cope with the sequelae of trauma through the self-help approach. *Journal of Trauma, 21*(2), 135–139.

Sheikh, A. A., & Kunzendorf, R. G. (1984). Imagery, physiology, and psychosomatic illness. In A. A. Sheikh (Ed.), *International review of mental imagery* (pp. 95–138). New York: Human Sciences.

Silverman, J. J. (1986). Post-traumatic stress disorder. In L. G. Peterson & G. J. O'Shanick, (Eds.), *Advanced psychosomatic medicine: Psychiatric aspects of trauma* (pp. 115–140). Basel: Karger.

Simonton, O. C., Simonton, S., & Creighton, J. (1978). *Getting well again.* Los Angeles: J. Tarcher.

Viney, L. L., Benjamin, Y. N., Clark, A. M., & Bunn, T. A. (1985). Sex differences in the psychological reactions of medical and surgical patients to crisis intervention counseling: Sauce for the goose may not be sauce for the gander. *Social Science Medicine, 20* (11), 1199–1205.

Watkins, P. N., Cook, L., May, S. R., & Ehlben, C. M. (1988). Psychological stages in adaptation following burn injury: A method for facilitating psychological recovery of burn victims. *Journal of Burn Care and Rehabilitation, 9*(4), 376–384.

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 78-87 © AATA, Inc. 1993

Art Therapy with Pediatric Cancer Patients: Helping Normal Children Cope with Abnormal Circumstances

Tracy Councill, MA, A.T.R., Washington, DC

Abstract

Art therapy with pediatric cancer patients addresses the emotional and developmental needs of an essentially normal population under extreme stress. Assessment and intervention must be made in response to the unique emotional impact of cancer and its treatment on young patients. This paper reviews the literature on the problems likely to be encountered by the pediatric cancer patient and presents case examples to illustrate the emergence of these issues and their management in art therapy.

Introduction

Art therapy with pediatric cancer patients presents a set of diagnostic and theoretical challenges distinct from those encountered in working with psychiatric populations. Traditionally, art therapists have used artwork to identify psychopathology and to resolve internal conflicts. The medical patient, in contrast, may not only need to resolve internal conflicts, but also to negotiate physical illness and/or disability so that she or he can continue to grow and develop as a person.

In the medical setting, art therapy may be considered as an adjunctive treatment, since patients come to the hospital primarily for medical treatment. However, when the art therapist is part of the overall treatment team, she or he can provide a uniquely humanizing influence in the midst of an experience that threatens the child's sense of self and trust in the world (Rollins, 1990). Also, the art therapist's evaluative skills can help the medical team identify psychiatric and behavioral problems that can affect a child's response to diagnosis and medical intervention.

Literature Review

Psychosocial intervention with pediatric cancer patients is predicated on the notion that the diagnosis of cancer and the treatment that follows represent stressors that warrant intervention. Even without expressions of distress, such as noncompliance with treatment, school refusal, or self-destructive behavior that typically result in requests for psychological or psychiatric intervention (Tovian, 1991), pediatric cancer patients may benefit from early psychosocial support. Sanger, Copeland, and Davidson (1991) suggest that screening pediatric cancer patients for adjustment problems is worthwhile, given that psychological sequelae of illness and treatment may extend well beyond the treatment period. Glazer (1991) and others have suggested that bone marrow transplant patients may experience symptoms of post-traumatic stress disorder, and thus extensive psychosocial support for such patients and their families is in order.

Many authors have described the following problems likely to be encountered by chronically ill children: (a) separation anxiety (especially in preschool children), (b) the belief that illness and/or treatment is a punishment for some misdeed or bad thought (in school-age children), and (c) conflicts over dependency versus autonomy (Pfefferbaum, 1989; Schowalter, 1970). Depression, anxiety (both situational and generalized), and disturbances of body image and self-esteem are reported to occur widely in cancer patients (Lesko, Massie, & Holland, 1987; Pfefferbaum, 1989; Sanger, 1991). Bull and Drotar (1991), in a study of coping mechanisms used by pediatric cancer patients, report that children use different coping mechanisms when encountering cancer-related stressors than they do for other life stressors. Rather than problem-solving strategies they describe more intrapsychic, emotion-management coping devices for cancer-related stressors. In general, much of the literature suggests that children who were preschoolers at the age of diagnosis are most successful in adapting, while children who were adolescents at diagnosis have the most difficulty (Koocher & O'Malley, 1981).

Art therapists have identified several potential applications of art therapy intervention with medically ill patients. Jeppson (1982) describes how to use art therapy to reduce symptoms of depression and anxiety, increase patients' sense of control and autonomy, and facilitate communication with family and the health care team. She also notes that art therapy can promote effective coping strategies outside the hospital and therapeutic session, including relief of pain through distraction. Crowl (1980) describes how art therapy can be used to help a child master his or her anxiety regarding impending surgery. Cotton (1985) presents a case analysis based on the work of Perkins (1977) that highlights the value of nonverbal communication through artwork and suggests methods of interpreting pictures specific to life-threatened children. Bach (1990) emphasizes the interpretation of artwork as a preconscious expression of a patient's physical condition while Jessee (1992) measures body-image in burn patients through art assessment. Themes of helplessness, anxiety, isolation, and body-image emerge in Geraghty's (1985) work with a hospitalized Alaskan girl. Numerous authors have written about their work with the terminally ill: Kern-Pilch (1980) emphasizes the value of choice and control, Rudloff (1985) describes the therapeutic process, and Fenster (1989) explores the search for meaning.

Overview of the Art Therapy Program with Pediatric Cancer Patients

The author works as an art therapist and member of the Pediatric Oncology treatment team at a medium-sized cancer treatment and research center where art therapy is available to all patients, from toddlers through young adults. Since much of the children's chemotherapy is given on an outpatient basis, they spend many hours in the waiting room. Thus, art activities are provided in the waiting room on clinic days. In this very public setting, the traditional boundaries of therapy—a separate room, a closed door, an uninterrupted hour—are unavailable. Parents, siblings, and friends sit close by and sometimes participate. During therapy, patients are called to exam rooms to undergo medical procedures and often return hooked up to IV poles; nausea, aches and pains, or fatigue often disrupt participation. Even when sessions take place in the relative privacy of an inpatient hospital room, the primacy of medical procedures and the child's physical limitations supersede the therapeutic process.

Though all patients are encouraged to participate, as both in- and outpatients, the child decides whether he or she is able or willing to participate on a given day. It is believed that this measure of choice, given the innumerable procedures over which the patient has no choice, is essential to building a therapeutic alliance in this setting. Hans Peter Weber, the "clinical artist" who collected many pictures for Susan Bach's study of the artwork of medically ill children, emphasizes the element of choice in working with the medically ill. "Children under medical treatment have few opportunities to choose what they do, so I find it not only important but also necessary to allow the child to choose if, when, and what he will draw for me" (Bach, 1990, p. 13). A child's choice not to do artwork may represent a general sense of isolation and social withdrawal that often accompanies cancer treatment, or it may be the result of anxiety over an upcoming procedure, lack of interest, or simply a chance to exert control by saying "no." Thus, every attempt is made to assess the child's behavior in the clinic to help parents and staff support the child effectively.

Case Material

The case material presented reflects work accomplished during the first year and a half of the art therapy program. In the examples that follow, themes of separation anxiety, alienation, anger, aggression and fear, and body-image and self-concept, beliefs about disease and treatment, and images that may represent concepts of death itself are observed. The use of art therapy in the beginning phase of diagnosis and treatment, during middle or maintenance phase of therapy, and following relapse or in advanced stages of disease with poor prognosis are grouped together in order to pinpoint interventions that may be particularly useful at these stages of treatment.

Diagnosis and Early Treatment

The earliest phase of cancer treatment assaults children's body image, identity, and self-esteem. Embarrassment, anger, and social withdrawal may accompany the child's sudden loss of self. Children may try internally based coping strategies, resulting in depression, withdrawal, self-blame, and alienation. A supportive, client-centered, and at times nonverbal approach can help the patient both express troubling feelings and regain some sense of bodily integrity and self-worth. The active presence of the art therapist in both inpatient and outpatient encounters and the relative safety of art materials for displaced expression can afford valuable psychosocial support.

Bonnie

Bonnie, a five-year-old diagnosed with an extremely large abdominal tumor, was immediately hospitalized for evaluation and possible resection of the tumor. I was urged by medical staff to visit her as soon as possible and to begin preparing her for surgery that might be both disfiguring and disabling due to the size and location of the mass. It was expected that the surgery would take place within the next few days.

At our first session I offered play-doh, and she chose to make Easter eggs which we took turns hiding and finding. The hiding and finding game may have expressed Bonnie's efforts to find her own hidden tumor. Though invisible without x-rays and special scans, this mysterious thing had brought Bonnie into the baffling new world of the hospital. Bonnie was so delighted with our game that she used it to begin every subsequent session while she was an inpatient. In our daily sessions, she also created preschematic representations of "Barbie" and used glitter with enthusiasm.

Although I could see the trust-building value of these early sessions, I felt compelled to raise the issue of Bonnie's tumor because of the potentially imminent surgery. I asked Bonnie to make a picture about herself in the hospital. She frowned at first, but proceeded to draw two tadpole figures, a small one with a frowning expression to represent herself and a larger one with what appears to be two smiling mouths to represent her mother (Figure 1). The self-figure is interesting in that the area below the neck is suggested only by a series of dots, which Bonnie indicated represented her tumor. No body outline is used, and a strong horizontal line suggesting bedcovers separates the head from the rest of the figure. Bonnie commented that she felt better when her mommy was with her in the hospital. She abruptly concluded our discussion of her tumor by saying she did not like to talk about it, that it made her feel like she had "glitter on [her] head," and she wanted to hunt Easter eggs again. When I wondered aloud what it felt like to have glitter on your head, Bonnie giggled, then looked sad, and said that "people would look at you funny."

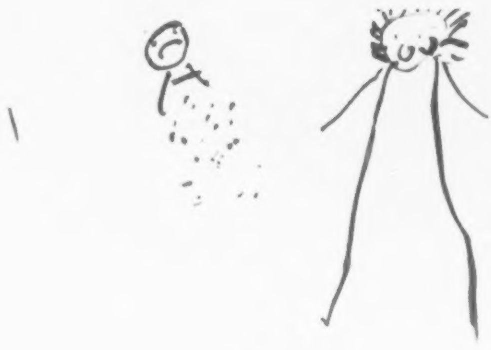


Figure 1.

Bonnie seemed to express a mix of curiosity, anxiety, and embarrassment about her tumor. Her early work with me seemed to encapsulate the struggle with body image and self-esteem that a cancer diagnosis can bring. Faced with being looked at and monitored by many new people and strange machines, Bonnie used indirect play (hiding and finding eggs) to search metaphorically for her tumor. She drew "Barbie" repeatedly, rehearsing her premorbid identification with an ego-ideal that seemed to represent a fantasy of grown-up femininity. Also, Bonnie used drawings to work out her ideas about her tumor, its appearance, and location within her body.

Bonnie's surgery was subsequently delayed in favor of a period of chemotherapy. As a new surgery date approached some months later, Bonnie again drew her tumor. In the second figure, there is a boundary around the dot-filled tumor; the figure has two-dimensional arms with fingers, a smiling head, and indications of two internal organs, the lungs and the heart. Bonnie made this picture, again at my suggestion, to illustrate the "ultrasound" findings on a doll during a medical play session. Bonnie expressed pride in her drawing, saying that at first she wasn't sure how to draw it, but she thought she did pretty well. Medical staff commented that her depiction placed her tumor rather accurately within her abdomen.

A client-centered approach was employed to sensitively follow Bonnie's lead and allow her feelings to emerge without overwhelming her fragile defenses. Bonnie did not ask many questions or attempt to assign blame. Rather, she sought to work things out within herself, using metaphoric play and representations of her own body and an ideal female form in artwork.

Benjie

Benjie was a quiet boy who sometimes mystified me. Although he liked art and seemed to connect well with me during his initial inpatient stay, his participation in art activities in the clinic was infrequent. Many days he sat in the hallway with a family member, far away from the art table, declining invitations to participate. One day Benjie came into the clinic, smiling, and presented me with an illustrated story (Figure 2). The story tells of a boy who "went to a boat," which was painted red by some "men" and then looked "as good as new." The illustration shows the newly painted boat on a calm sea, with a jumping dolphin beside it and a wealth of marine life under the water. A large half sun is attached to the left edge of the page. This picture was followed by many pencil drawings of dolphins, boats, and marine life of many kinds.

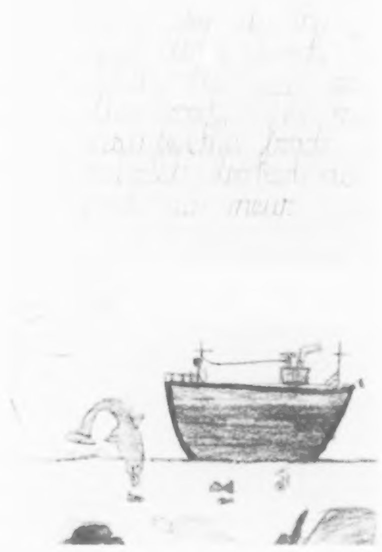


Figure 2.

Although Benjie's initial phase of treatment was completed without further hospitalizations, he did experience hair loss from chemotherapy and temporary weight gain due to steroids. His burst of marine pictures and renewed communication with me came during a time when his hair had grown back and his weight had returned to normal. The content of his story suggests hope that the doctors would make him "as good as new." His use of the color red for the boat is interesting in the light of Bach's work, which suggests that in leukemic children the absence of red may represent the profusion of white cells within their blood (Bach, 1990, p. 45). Within Bach's framework, his red boat may relate his own perception that his health is being restored by his treatment.

In this early phase of cancer treatment, Benjie withdrew from an activity and an expressive outlet he enjoyed. The work of Koocher and O'Malley, in reporting the insights of childhood cancer survivors, makes a case for the adaptive value of denial and suppression of feelings during active cancer treatment (1981). It may be that such denial and withdrawal, rather than representing pathological depression, allow the child to conserve his or her emotional resources for the concrete hurdles ahead. It was only when Benjie felt better physically that he rejoined the art therapy group. The constant availability of art therapy in the waiting room seems to have significant value for children like Benjie, who may withdraw as the cancer and its treatment attack their bodies and change their outward appearance and rejoin when they are physically able.

Arthur

Arthur, a 12-year-old boy, had surgery to remove a tumor immediately upon diagnosis and hospitalization. Though I visited him during inpatient treatment, his initial artwork was created at his first outpatient clinic visit. He used clay to create a human head with a gaping mouth, upturned eyes, exaggerated ears, and a large scar on the side of his face (Figure 3). After creating this head, Arthur pointed out his own scar, at the back of his head, from removal of his tumor.

After he was hospitalized for a course of chemotherapy, Arthur began a series of clay heads, which he described as "space aliens." Each of the figures has a gaping mouth and some combination of human, animal, and insect-type features. In one notable session, Arthur said he wanted to make an alien that was "really scary." After several attempts, he made two creatures, the first a bell-shaped head

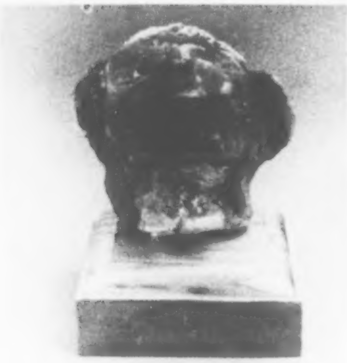


Figure 3.

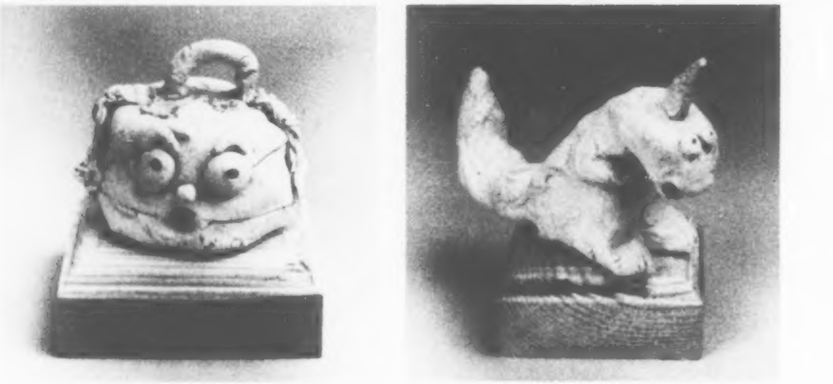


Figure 4.

with round eyes and an open, round mouth (Figure 4). Next, he completed a dinosaur-like creature with one sharp horn, a scar on his face, and a wide-open mouth. Expressing frustration with his work, Arthur finally blurted out, "I think they look more scared than scary." During this time, Arthur was experiencing many painful side effects of chemotherapy and was having difficulty complying with treatment, especially swallowing pills and adhering to daily routines. Arthur stated that he just wanted to sleep and kept his drapes closed and the lights off most of the day. He often would not acknowledge the presence of staff members in his room, pretending to be asleep. I offered clay, a material Arthur enjoyed, and a chance to interact without talking unless he chose to. Participation in art therapy was one of the few avenues of communication with hospital staff that Arthur kept open.

Arthur seemed overwhelmed by the disfiguring and disabling aspects of his treatment. Hair loss, scars, pain, fear, and social isolation may have left him feeling like an alien creature. His forced regression to dependence on his parents and staff for daily care and the fear of death caused Arthur to become depressed. Arthur's work in art therapy allowed medical staff to better appreciate the roots of his withdrawal and to regard him as a young man with complex emotions rather than simply an uncooperative and unappreciative adolescent. The clay figures also gave Arthur a way to express his feelings in the safe displacement of artmaking.

Middle Phase of Treatment

In the middle phase of treatment, intervention is aimed at supporting the patient through the long-term stress of treatment. Denial may be an important ingredient of the patient's defenses. During this phase, careful attention must be given to helping restore the patient's sense of self. Often, the cancer treatment team becomes a primary social support. Art therapy can provide a valuable outlet for reflection of feelings about loss and self within a supportive environment.

Jason

Five-year-old Jason was forced to undergo a series of scans requiring ingestion of a thick, chalky barium liquid prior to the test. Jason had great difficulty swallowing enough of the substance to suffice, and several times had to have tubes placed to force-feed him the substance. Jason and his mother worked closely together to devise strategies that might help him drink the liquid, but these visits most often ended in trauma and humiliation as he was forced to have tubes placed. Before and during much of this period in his treatment, Jason had drawn a figure on nearly every clinic visit. His schema included a squarish yellow head (Jason had blond hair), smiling face, a rectangular body, and two-dimensional arms and legs, and was generally placed in the center of the page. Sometimes Jason placed himself beside another similar figure representing his brother or his dad. His repetitive schema appeared to be a self-image. As the frequency of invasive procedures increased, Jason began to come to the clinic armed with various toy weapons such as armor, a knife, a bow and arrow, and a water pistol.

Once, when Jason had been through the ordeal of tubes and completed the scan, he insisted on returning to the clinic to see the art therapist before going home. Upon entering the room, he requested materials and created Figure 5. He said this image

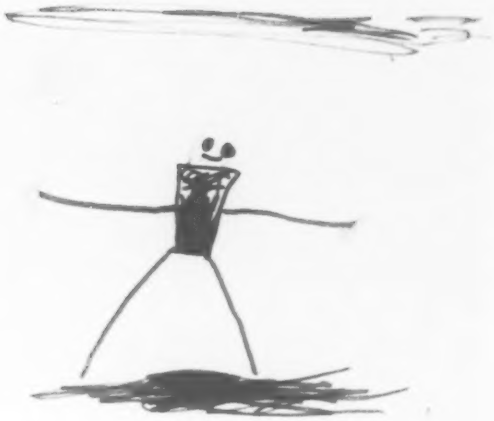


Figure 5.

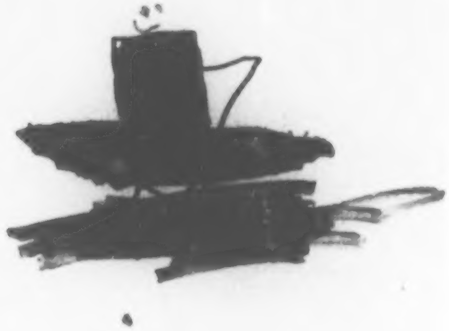


Figure 6.

represented himself, and he left it in the clinic for display. His strong need to create this image seemed to represent his efforts to maintain bodily integrity and a concept of himself in the face of necessary but traumatic violation of his body boundaries.

As Jason neared the end of his treatment protocol, with the invasive procedures limited to periodic but comparatively infrequent monitoring, a greater expressiveness evolved in his self-representations. After a family fishing trip, Jason depicted himself rowing a boat (Figure 6). He also began to draw deer and other animals, places, and vehicles he had encountered in his life outside the clinic, suggesting both renewed energy and an appropriate focus on life events.

Frank

Frank was a nine-year-old boy who had suffered many impairments as a result of his treatment. In addition to temporary side effects, he was left with visual impairment, motor difficulties, and premature signs of puberty. He had visited many doctors at various hospitals, and his approach to the clinic staff was that of an "old hand." He was outgoing and cheerfully demanding in eliciting support from care givers, sometimes resembling a little old man in his sophisticated banter, and other times behaving like a demanding two-year-old. He had an articulate, engaging, and supportive family.

Frank was always willing to relate to a new patient how frightened he himself had been upon first coming to the clinic. Frank's family had moved to America from another country to obtain treatment for Frank, and he did not know English on arrival at the hospital. Frank reported that art therapy helped him feel less anxious about upsetting treatment procedures, especially blood drawing. Despite his apparent adjustment to the treatment setting, Frank one day drew a very messy, smeared, and layered picture of the clinic (Figure 7). He labeled it "Hospital Map," and marked several "exits" along the bottom of the page; Frank included no entrances to the hospital. In commenting on his picture he laughingly said that if he owned the hospital none of the kids would ever have to get shots, and they would all get well. Frank adamantly did not draw himself in the "clinic" picture, and he never pursued themes of feelings about his illness when they arose, saying it made him feel "too sad" to think about his cancer. Frank seems a salient example of the adaptive use of denial in coping with cancer diagnosis and treatment during a middle phase, when the outcome is uncertain.

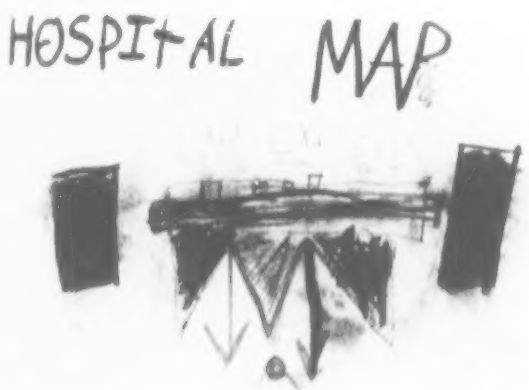


Figure 7.

Eugene

Eugene was diagnosed with cancer during college. Because of his age and the type of cancer, he was classified a pediatric patient though he was in his early twenties. An introspective and artistically talented young man, Eugene resisted participating in the art therapy program, perhaps because the predominant clinic population were young children. Eugene became more engaged in the art process when invited to prepare a canvas for a patient art exhibition. Following that event, which brought him in contact with other older patients, Eugene occasionally ventured some artistic expression.

Figure 8 represents a tiny painting of a "parade" of assorted characters and animals making their way along a narrow, serpentine precipice surrounded by a black void. By applying Bach's quadrant method of analyzing artwork, the path along the precipice leads into what she terms the "minus-minus" quadrant, described as the place of darkness and the unknown (Bach, 1990). According to Bach's method, this aspect of the painting and its overarching darkness may be a poor prognostic sign. Eugene explained that the inspiration for his painting came from a song by the Doors, but he did not explain what the song meant to him.

Some months later, Eugene again produced a tiny painting (Figure 9), this one shows an aerial view of a streetcorner in a deserted cityscape dominated by red and grey. Though this second painting is more firmly grounded than the first, the mood of isolation and danger is profound. After a staff member expressed an interest in purchasing the first painting, Eugene appeared to gain some confidence and questioned the therapist about artists whose work he had seen in museums. Then he produced a sketch (Figure 10) showing a hermaphroditic figure dominating the page, with a bald, bespectacled figure behind him on one side and a tall palm tree on the other. A small, multicolored sun is placed above. Eugene laughed and made self-effacing remarks about this drawing. His artwork alludes to late-adolescent identity concerns, with an overlay of rather brooding and perhaps death-related imagery. It is impossible to know whether Eugene's artwork expresses concerns related to an individuation process, but he certainly expresses significant worries about himself, his potency, and his capacity for relatedness discussed in the literature on cancer survivorship.

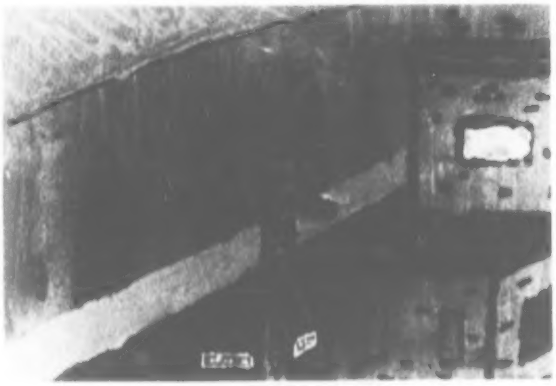


Figure 9.

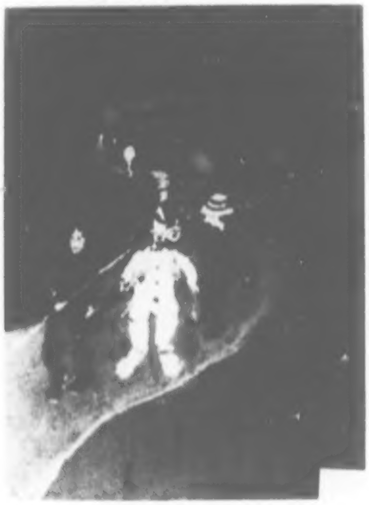


Figure 8.

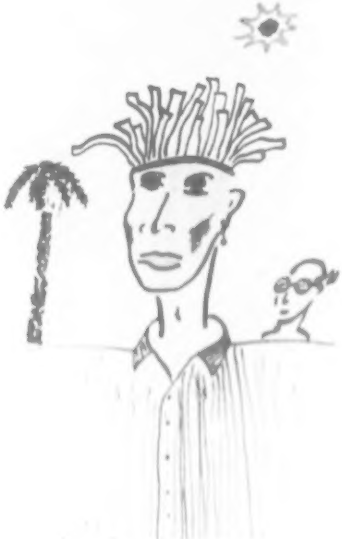


Figure 10.

Relapse and Palliative Care

During relapse or palliative care, heightened uncertainty replaces the now-familiar routines of treatment. Anger and isolation may resurface, and communication with family members and staff may break down (Kubler-Ross, 1969). Art therapy may be especially helpful in facilitating communication at this difficult time. Parents and staff members may feel their decisions about treatment are responsible for the patient's imminent death; e.g., if only some different route had been chosen, perhaps it would not have come to this.

The transition from working to save the patient's life to allowing him or her to die is extremely difficult for care givers. Often, it is the patient who first senses that death is imminent, and that isolation becomes painful if it cannot be expressed somehow. The power of art to give expression to profound existential themes and the relationship with the art therapist can be a strong support to the patient when words are too difficult either to say or to hear.

Paul

Six-year-old Paul was considered in remission and then suddenly relapsed. Following the recurrence of his disease he did many paintings and drawings directly focusing on issues of loss and death. When first hospitalized after relapse, Paul's play often related to hearses, and he drew pictures about burglars and a "16-year-old boy" who had died of AIDS. Shortly after his relapse was diagnosed, Paul asked the doctor straightforwardly, "Am I going to die?" Paul displayed none of the denial associated with other cases, but rather a disarming awareness of his own mortality.

Paul's best hope was a bone marrow transplant at another center after several rounds of chemotherapy. He was hospitalized several times during a three-month period. His parents were unable to be with him for long stretches of his inpatient stays, though they kept in close touch by phone. On one occasion, when Paul was particularly lonely and angry with his parents and acting out with staff and other patients, he was asked to draw a picture to show how he felt. Paul painted a simple schematic figure in red watercolor, surrounded by slash-marks in green. He called the figure "Freddy Krueger" (Figure 11) and explained that Freddy was angry because "people keep bothering him."

Hoping to help Paul accept his own intense feelings while conveying that I accepted them, I asked Paul to draw another picture, this time showing Freddy with someone who understands him. Paul then produced Figure 12, a representation of a smiling "Freddy" alongside a larger female figure. Both figures are shown with upraised arms. Paul related that Freddy's friend was a girl, older than he, who understood how he felt. After producing this picture, Paul said he would like to "just rest," and he busied himself in bed with a favorite toy. Paul's work in art therapy seemed to relieve his anxiety at being separated from his loved ones, and to give him a vehicle for expressing both anger and trust of adult care givers.

Paul sailed through his bone marrow transplant with flying colors, only to relapse again. This time his cancer progressed rapidly despite aggressive chemotherapy. Around the time of his second relapse, Paul created a picture of a person picking an apple from a tree. It shows a tree that is completely overtaken in red, possibly the "tumor red" identified by Bach (1990) which symbolizes the burning, pain-

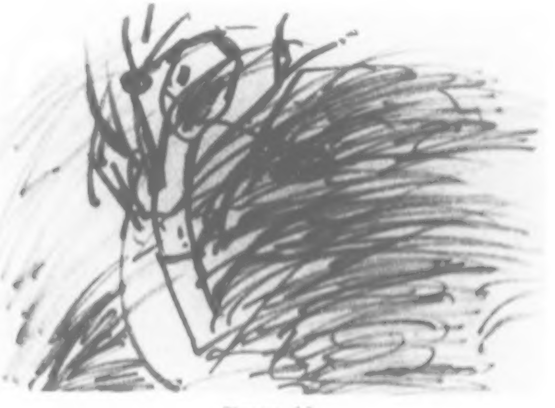


Figure 11.

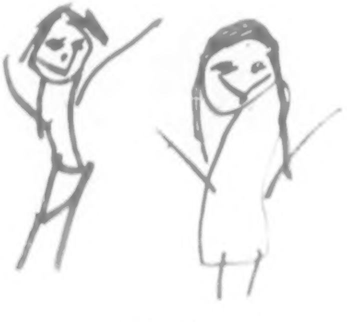


Figure 12.

ful force of disease. The tree holds five large apples, the sixth about to fall, a poignant suggestion that Paul's sixth year might be his last.

Wanda

Wanda was a young woman in her early twenties first diagnosed and treated at age 12. Failure to achieve remission had resulted in prolonged treatment and eventual failure of her immune system; eventually she chose a course of palliative care over prolonged chemotherapy with no likelihood of cure. Wanda's youth had been disrupted by her illness and treatment. She was in some ways immature and had made few moves toward individuation. Wanda strongly resisted talking about her feelings and had difficulty trusting anyone outside her family, but she was engaging toward staff members and quite talented in art. She related to me, asking my advice on materials, techniques, and subject matter, but preferred to work at home and bring her artwork in to discuss it.

Her first major work in this context was the large painting she created for the patient art show. This image (no photograph is available) is of a light blue mask-like face floating in a watery green atmosphere, with long, vertical tendrils of seaweed in the background. Within the mask, several goldfish swim. Following this image, Wanda began to do many more creative projects at home and to sell her handcrafted jewelry and items of painted clothing to staff members.

Several months later, she produced the "Firebird" image (Figure 13). In this dramatic, crisply articulated image, the firebird rises over a moonlit lake hidden within a grove of trees. It is surrounded by iridescent paint, giving the bird an ethereal presence. The patient clearly articulated the meaning of the Firebird story as having risen up from the ashes. She did not, however, relate the image to herself. It is my opinion that Wanda used artwork effectively to sublimate her concerns about the meaning of her own impending death. The bird, placed centrally and ascending in the landscape, unmistakably announces that Wanda will soon leave this world, though she was not to speak of her death in words until the very end. She visited our clinic for the last time only a few days before her death, but she did not say goodbye until she asked her mother to telephone us just hours before she died.

Bertman (1991), Kubler-Ross (1969), and many others have written of the existential aloneness that surrounds the time of death. Wanda's way of preparing for her death was not to talk about her life and her leaving, but rather to allow images to arise from within. When she began the Firebird image, she told me it was something she had always wanted to paint. My role as her art therapist was to provide technical advice, materials, and encouragement, so that in the context of our relationship her innermost experience could find expression.

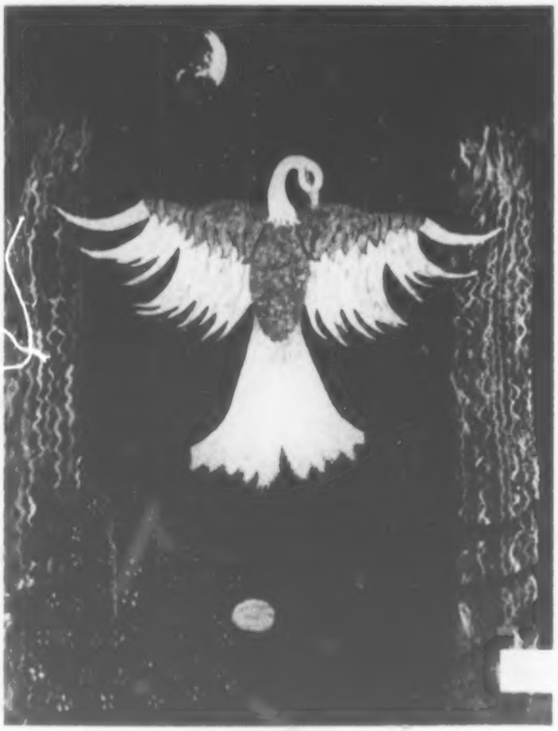


Figure 13.

Conclusion

The preceding discussion and case material illustrate psychological characteristics, issues, and coping mechanisms of pediatric cancer patients. The efficacy of art therapy intervention with medically ill children is demonstrated, especially through the following therapeutic benefits:

1. Patients control their own choices of art materials, subject, and verbalization regarding their artwork, enabling them to experience themselves as active creators as opposed to victims of a disease or helpless recipients of treatment.
2. Patients maintain communication with the treatment team through art expression at times when relationships are strained by anger, withdrawal,

fatigue, and feelings that are too emotionally charged to be said with words.

3. Patients continue the process of development through visual communication, supporting social and mental growth and mitigating the isolation of the hospital experience.
4. Patients rehearse troubling events and work out concepts of self in art expression, supporting a sense of mastery over feelings about illness and treatment.

As art therapists, we are well acquainted with the value of artistic expression in communicating what is not spoken and in marshalling psychic energy to support the work of life. In medical centers, where science and technology bring about the miracles of modern medicine, the image making along with careful listening can support the work of healing. Familiarity with the emotional consequences of diagnosis and treatment, sensitivity to patients' graphic messages, and trust in the value of open-ended creativity allow the art therapist to be a valuable support to physically ill children.

Editor's note: This research was funded by a grant from the Cancer Research Foundation of America, Alexandria, Virginia.

References

Bach, S. (1990). *Life paints its own span.* Einsieden, Switzerland: Daimon.

Bertman, S. (1991). *Facing death.* New York: Hemisphere Publishing.

Bull, B. A., & Drotar, D. (1991). Coping with cancer in remission: Stressors and strategies reported by children and adolescents. *Journal of Pediatric Psychology, 16*(6), 767–782.

Cotton, M. A. (1985). Creative art expression from a leukemic child. *Art Therapy: Journal of the American Art Therapy Associatoin, 2*(2), 55–65.

Crowl, M. (1980). The basic process of art therapy as demonstrated by efforts to allay a child's fear of surgery. *American Journal of Art Therapy, 19*, 49–51.

Fenster, G. M. (1989). Art therapy with HIV positive patients: Mourning, restitution and meaning. *Proceedings of the 20th Annual Conference of the American Art Therapy Association* (p. 95). Mundelein, IL: AATA.

Geraghty, B. (1985). Art therapy with a native Alaskan girl on a pediatric ward. *American Journal of Art Therapy, 23*, 126–128.

Glazer, J. P. (1991). Psychiatric aspects of cancer in childhood and adolescence. In M. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (pp. 964–977). Baltimore: Williams and Wilkins.

Jeppson, P. (1982). Creative approaches to coping with cancer: Art therapy and the cancer patient. *Proceedings of the 13th Annual Conference of the American Art Therapy Association* (pp. 45–47). Mundelein, IL: AATA.

Jessee, P. O. (1992). Perception of body image in children with burns, five years after burn injury. *Journal of Burn Care and Rehabilitation, 13*(1), 33–38.

Kern-Pilch, K. (1980). Anne: An illustrative case of art therapy with a terminally ill patient. *American Journal of Art Therapy, 20*, 3–11.

Koocher, G. P., & O'Malley, J. E. (1981). *The Damocles syndrome.* New York: McGraw-Hill.

Kubler-Ross, E. (1969). *On death and dying.* New York: Macmillan.

Lesko, L. M., Massie, M. J., & Holland, J. C. (1987). Oncology. In A. Stoudemire (Ed.), *Principles of medical psychiatry* (pp. 495–520). New York: Harcourt, Brace, Jovanovich, Grune & Stratton, Inc.

Perkins, C. F. (1977). The art of life-threatened children: A preliminary study. *Creativity and the Art Therapist's Identity: Proceedings of the American Art Therapy Association* (pp. 9-12). Mundelein, IL: AATA.

Pfefferbaum, B. (1989). Common psychiatric disorders in childhood cancer and their management. In J. C. Holland & J. H. Rowland (Eds.), *Handbook of psychooncology* (pp. 544–561). New York: Oxford University Press.

Rollins, J. H. (1990). Helping children cope with hospitalization. *Imprint, 37*(4), 79–83.

Rudloff, L. (1985). Michael: An illustrated study of a young man with cancer. *American Journal of Art Therapy, 24*, 49–62.

Sanger, M. S., Copeland, D. R. & Davidson, E. R. (1991). Psychosocial adjustment among pediatric cancer patients: a multidimensional assessment. *Journal of Pediatric Psychology, 16*(4), 463–474.

Schowalter, J. E. (1970). The child's reaction to his own terminal illness. In A. C. Schoenberg, D. Carr, & D. Peretz (Eds.), *Loss and grief* (pp. 51–69). New York: Columbia University Press.

Tovian, S. M. (1991). Integration of clinical psychology into adult and pediatric oncology programs. In J. Sweet (Ed.), *Handbook of clinical psychology in medical settings* (pp. 331–352). New York: Plenum Press.

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 88-95 © AATA, Inc. 1993

Art Therapy and Brain Dysfunction in a Patient with a Dementing Illness

Judith Wald, MS, A.T.R., South Salem, NY

Abstract

The clinical course of a patient whose dementing illness defied DSM III (APA, 1980) diagnostic labeling is followed. Through the patient's art therapy work, the author attempts to corroborate the patient's behavior and performance with clinical and medical tests. This information is then related to present-day knowledge of brain dysfunction and impairment and to the autopsy findings. Art therapy served a special role for the patient, providing him with self-esteem, grounding, and boundaries, as well as with an emotional outlet and means of communicating the realities of his disease. While his well-drawn houses somewhat disguise his impairments, his drawings of people clearly illustrate aspects of the organic disease—regression, depression, and psychotic ideation.

Introduction

Mel was a patient in a Dementia Day Treatment Program for two years. His dementing illness followed a unique course, defying *DSM III** (APA, 1980) diagnostic labeling. Attempts to characterize his dementia were made, and changed, as his clinical and morphological symptoms evolved. This paper describes the interesting clinical course of Mel's dementing illness, particularly through his art therapy work, and attempts to corroborate his behavior and performance with clinical and medical tests. This information is then related to present-day knowledge of brain dysfunction and impairment. Finally, findings from the patient's autopsy are described in order to clarify his case.

The Case of Mel

Mel was 80 years old when he was brought to the Geriatric Evaluation Service of a rehabilitation center with complaints of memory impairment and disorientation. Past medical history included bilateral hernias operated on 30 years ago, pneumonia twice in his 20s, pancreatitis, hearing loss (he wore a hearing aid), and heart disease. His medications were Lasix, Lanoxin, Isordil, Potassium Chloride, Hydergine, five vitamins, and Mylanta. Formerly a successful, sociable, hard-working professional, Mel had become withdrawn, uncommunicative, agitated, and increasingly forgetful. His wife reported episodes of nocturnal confusion, odd behaviors such as abruptly leaving the phone, and disorganization in ADL (activities of daily living) skills such as leaving clothes about the house and losing them.

It was noted that since sustaining a head injury with concussion in a car accident a year previous to the evaluation, Mel had failed noticeably. At the time of the accident, the attending physician felt that the patient had a mild to moderate organic mental syndrome. For that reason a CT (Computerized Tomography) scan was performed to rule out subdural hematoma (swelling or mass of blood located beneath the outer membrane of the brain). Indeed, there was no subdural hematoma on the CT scan, but cerebral atrophy (decrease in size of the cerebrum) was noted. Progressive degenerative disease involving cerebral structures was diagnosed. He was put on Elavil to help in the management of dementia.

***Editor's note:** This case took place during the time of *DSM III*; the *DSM III-R* (APA, 1987) added a "catch-all" category of Organic Mental Disorder NOS (not otherwise specified) which could apply to the client described by Ms. Wald.

Cerebral atrophy causes a pathological state characterized by a breakdown in the stability of dynamic processes; wakefulness and memory disorganization result. These marked behavior changes, as well as others, result from a weakened cortex that becomes easily distracted and unable to discriminate between significant and insignificant stimuli. Mel's altered sleeping patterns, reduced behavioral spontaneity, lack of initiative, and reduced interpersonal exchange pointed to the possibility of frontal lobe damage or depression, which can be masked in dementia-like behaviors. The evaluation team signed out Mel with a diagnosis of cognitive impairment with depression, noting the medical condition of arteriosclerotic cardiovascular disease. It was recommended that Mel attend a Dementia Day Treatment Program. The patient was put on Trazodone, due to suspected depression.

The Dementia Day Treatment Program emphasized memory retraining and socialization through a multidisciplinary approach to manage patients with dementing illnesses. When Mel entered the program, he presented as pleasant, articulate, and eager to participate in all activities. Though abrupt and with a mechanical affect, he was also capable of real humor.

Because Mel was a former architect, a person with previously developed art skills, art therapy served a special role in his treatment, management, and diagnosis. In addition, Mel was considered an interesting case because his failings were so irregular. Although he signed each drawing with his name and the date, scored well on the Kahn-Goldfarb Mini-Mental Status Test (9 out of 10), and brought up current events, he also perseverated endlessly on a topic or theme. While able to hide his failings with a witty remark, his artwork revealed the realities of his disease. For example, in art therapy Mel produced a well-conceived self-portrait as his first drawing (Figure 1). However, his failing perceptions were apparent in his simplified, awkward representation of the chest, arms, and stick fingers. Subsequent portraits similarly revealed good organization for the head, but with increasing disorganization on the rest of the figure. In addition, Mel tended to work impulsively in art therapy without awaiting directives; by providing him with additional subjects and paper, his excessive energy was channeled in a productive manner.

Mel's art was a source of pride and accomplishment to himself and to others. Both patients and staff frequently complimented his ability and encouraged further production. His drawings of realistic scenes demonstrated a good sense of proportion and perspective, although confusion appeared in the perseveration of repeated arches (Figure 2). Premorbidly hard-working and productive, Mel was able to reinforce these traits in art therapy, which seemed to give him a sense of security. He always sat in the "best pupil seat" (next to the teacher) and got his own apron. However, even though the art room was also used for other programs, Mel would instinctively get an apron and sit down in "his" seat whenever he entered the room, no matter what the activity.

In other parts of the program, Mel showed declines in social behavior. He exhibited a voracious appetite for food, his movements were impulsive and ill-considered, and he showed a strong sexual

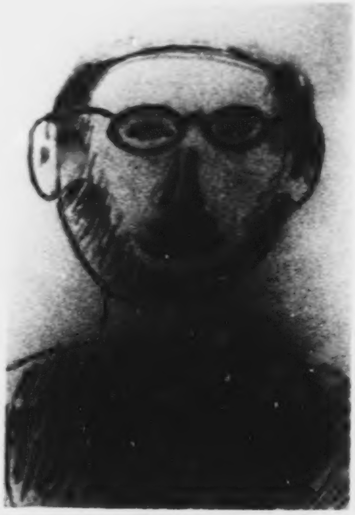


Figure 1. Self-portrait executed in early stage dementia.

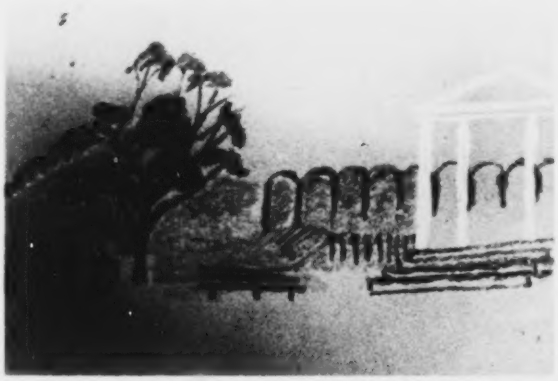


Figure 2. Drawing skill retained in proportion and perspective, but confusion appears in the perseveration of arches.

preoccupation. Altered sexual behavior and impulsiveness are typical of frontal lobe patients who lose the mechanism to monitor and regulate behavior and actions. Mel was presenting generally as more disabled than had been revealed in the evaluation testing.

At one point in his treatment, Mel was away from the program for two months on a vacation in Florida. His wife encouraged him to paint, and he brought back attractive watercolor scenes, but as she said, "not like he used to paint." A change in environment often proves difficult for dementia patients, who respond best to as few changes in environment as possible. Upon returning to the program, Mel was more difficult to manage. Trazodone was discontinued as it didn't seem to effect any notable behavioral change. Because his impulsiveness and belligerence were increasing at home and in the program, Mel was placed on Haldol; he responded well to this medication.

A follow-up GES (Geriatric Evaluation Service) evaluation changed his primary diagnosis from cognitive impairment with depression to mixed-type dementia. Certain behaviors revealed Mel's continuing behavioral status decline: he would forget to zip his trousers; his eating habits deteriorated; and he misidentified his clothing. Sexual confusion became apparent in his choosing to dance with a male. In art, he painted breasts on a figure he described as a male (Figure 3). (Also, note the ears on the face, the mustache below the mouth, the awkward body, and sideways feet—all contained within a clock going to numeral 24, with a Roman numeral 12, nevertheless, in the appropriate place.)

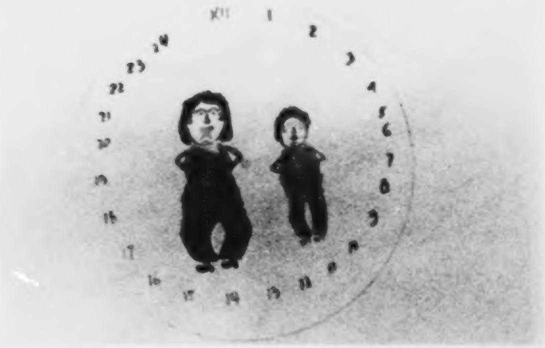


Figure 3. A "24-hour clock," containing two figures of confused sexual identity and facial feature placement.

Mel's perseverations were particularly interesting. For example, unlike most dementia patients, he was able to bring up current events topics; however, he would bring up the same topics week after week and showed a lack of true understanding or the ability to express himself on a deep level. In addition, learning to put his hands on the shoulder of the person in front of him in group dance therapy caused him to put his hands on another patient's shoulders outside the dance therapy sessions, too. Also, in a poetry therapy session, he repeated the same phrase five times.

In art therapy, Mel would repeat a subject for weeks, no matter what new instructions the art therapist gave. When a staff member became a father, Mel perseverated on "Joe, his wife, and their baby." Very concrete and unable to abstract, he added a figure to a group abstract mural. Using art to orient him to task and to get him to notice what others were doing, Mel finally contributed balanced, wavy lines. These wavy lines in turn became a new source of perseveration to add to his future artworks. In one session to get him started the art therapist drew a triangle on a sheet of paper. Mel filled it in with a person and surrounded it with wavy lines. During the next session five days later, he drew a triangle before the art therapist had a chance to explain the lesson; his ability to remember the previous session was remarkable and pointed to a unique variety of "intrusions." To a certain extent it was possible to redirect him to the general topic, after he had completed his first idea. Such inflexible perseverative behavior reflects impaired response inhibition, which is common in frontal lobe patients whose sequencing and organization of elements are disturbed. Unable to shift response strategies, modify or stop a sequence, these individuals endure the lingering sensory experience of previously viewed material. This "pathological inertia of an image" (Luria, 1973, p. 241) results in lack of spontaneity in drawings, intrusions, or omissions.

For a period of time, Mel developed a peculiar behavior—compulsively washing his hands every few minutes in art, especially during clay sessions. Therefore, "messy" media proved to be of little therapeutic value. Instead, his compulsiveness was appropriately channelled with more controlled pencil drawings (see the house, Figure 4. Note how he represented each brick until time ran out. Though well drawn, this three-sided view of a house reflects his organic brain damage). Similarly, Mel would paint pictures of people at the art table, compulsively including every square of the checkboard-patterned tablecloth.

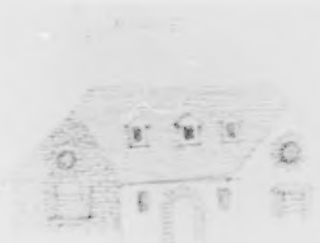


Figure 4. Compulsivity channelled in a pencil drawing of a house.

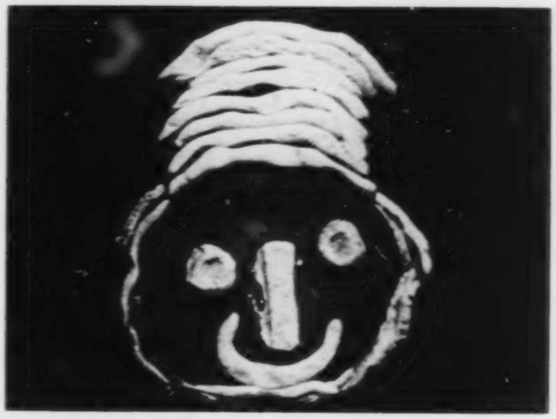


Figure 5. Simplification and perseveration in a clay sculptured face.

Mel responded best when art therapy was structured; he needed the focus and boundaries of a specific task. Always a willing contributor to group murals of a realistic nature, Mel drew happily from the concrete suggestions of others. For example, his distractibility and impulsiveness in trying to leave the room could be redirected by handing him a magic marker with a suggestion for a contribution. Moreover, classical music played in the background helped Mel to relax. In this atmosphere, with topic suggestions such as "draw memories of a pleasant vacation" and concrete redirections when he got distracted or blank, Mel was able to paint lovely scenes from his trips. Art projects which drew on memory helped offset his memory losses and gave him a sense of pride in his past accomplishments as well as in his immediate art product.

Though productive, Mel's figure representations showed increasing deterioration—arms originating from the head, ears within the face, and awkward proportions. At times he attached legs to arms, represented women as men or vice versa. One time he gave a girl four legs, noting after he had drawn the figure with straight, standing legs that they were actually bent and seated. Hair on a sculptured clay face multiplied to eight layers (Figure 5). Often he would omit the head, working in an unusual manner from the bottom up. Although Mel continued to enjoy drawing and produced three to four drawings a session, he did not react to graphic errors (another sign of increased dementia). These disconnected and misconnected drawings graphically mirror descriptions of disjointed behavior in frontal lobe patients.

Mel's social discoordination continued. As he became more and more restless in the program, he developed odd clinical symptoms such as snorting, buccal movements, and tongue thrusting (possible tardive dyskinesia associated with Haldol). Another neurological examination was given to see if neurological changes accompanied his progressive memory deterioration and disorientation: Mel had gotten lost in his community, had deteriorated in self-care, and had difficulty remembering conversations from moment to moment. However, he scored 9 out of 10 on the Kahn-Goldfarb orientation scale, with the same neurological results as originally. A CAT scan showed some cerebellum atrophy, but no other change. It was primarily on the behavioral scale that deterioration occurred. The attending physician noted that progressive deterioration in behavior suggests progressive dementia—not Alzheimer's disease or depression—a degenerative disease of the central nervous system.

Although failing intellectual capacity was noted in his lack of input in current events discussions, Mel continued to sign his pictures with the correct date. Of note in his figure drawings was a new angular rendition of both arms and legs, perhaps symbolically representing his further loss of ability to reach out and maintain effective control. Asked to make an animal in art, he made bizarre constructions of men and beasts combined, with angular arms and legs (Figure 6). In addition, figures had faces within their rounded bodies (Figure 7). Angular arms and ears became confused and interchanged and mouths were eliminated (coinciding with his failing speech). Representation of an additional face within a body revealed psychotic ideation (Wald, 1984) and drawing skeletons within the body outline in x-ray-like vision revealed his confusion in distinguishing the inside from the outside and generally recognizing boundaries (Figure 8). One theory of schizophrenia postulates that psychotic symptoms are due to abnormal dopamine activity. Another theory describes pseudopsychotic behavior in right frontal lobe dysfunction. This psychotic ideation was transient in Mel, lasting a month.

Mel became more eccentric socially, more difficult to control, and more aggressive and determined. Also, his drawing ability continued to regress. He drew a disproportionate tree with a too thick trunk, thin spike-like branches, isolated leaves. Noses became triangles, bodies became ovals. Mel became more machine-like in his movements and in his drawings. He relied on a stereotyped manner of drawing himself—even a snowman became a self-portrait. His figure drawings became "humpty dumpty"-like and feet were omitted. Mel drew a confused version of a face, although he did notice an extra ear and wanted to erase it. Reality orientation was reinforced through artwork by asking him if he noticed anything wrong or missing in his picture and if he wanted to add anything he may have forgotten. Failing vision and hearing appeared to compound decreasing sensory input. Although he drew an excellent three-dimensional house, it took him the entire session to notice and correct a missing wall and to add steps to connect the doors to the base.

Although Mel originally initiated his own drawing ideas, at this point he took them from others. Having drawn a logical portrait, Mel noticed a pattern in another person's drawing of a circle and illogically (except that the face was a circular shape) painted the same pattern over his portrait (Figure 9). He even mimicked another neighbor by drawing stick-like hair and by signing the neighbor's name to

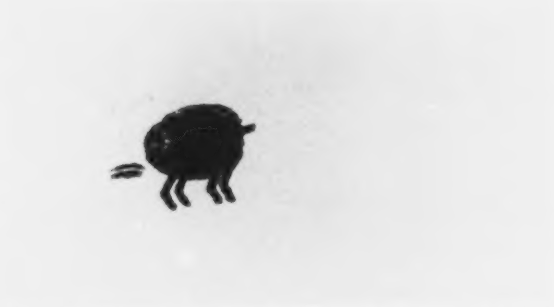


Figure 6. Bizarre drawing of a man and beast combined. Note glasses from earlier self-portrait (Figure 1).

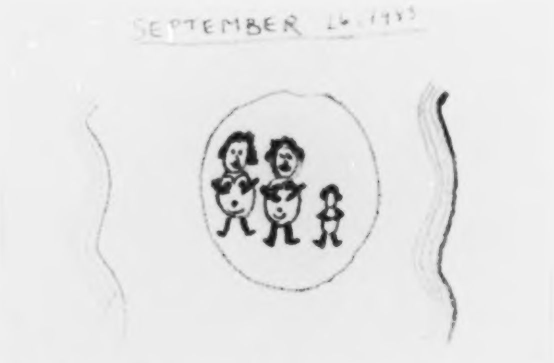


Figure 7. Intrusions from former art therapy sessions and faces within bodies.

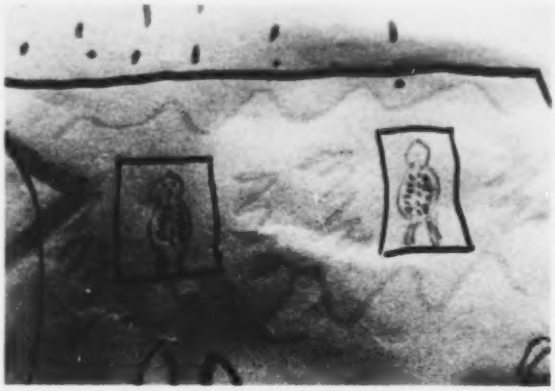


Figure 8. Psychotic ideation also appears in skeletons drawn within the body outline, not knowing the inside from the outside.

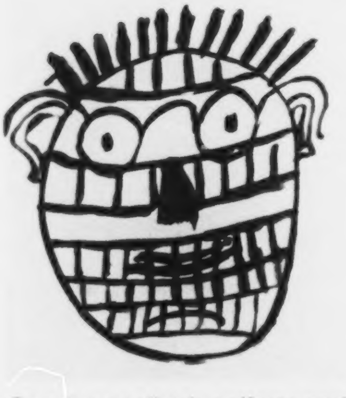


Figure 9. Copying another's patterns and signing a neighbor's name to his painting, Mel needed to literally "draw support" from another patient.

his own painting. When the art therapist pointed this out to Mel, he painted over the wrong name with his own name. Symbolically losing more of his own self, Mel needed to draw support from another patient.

Further merging is evidenced in his house drawings, with the appearance of stick arms on their side walls and simplified grinning mouths and chins at the base. (Mel described them as such without any notice of their incongruity.) Though usually drawn as simplistic frontal views, the houses were sometimes accurately drawn three dimensionally. This high skill level reflected the former architect's training in drafting. This graphic merging, seen in Rorschachs in percept contamination, can be viewed as Mel's symbolic need to merge psychologically with another to help take over his failing ego or cortical functioning (Wald, 1986).

At this time, noting a deterioration of verbal skills (including misdating his drawings), Mel was once again tested clinically. Surprisingly, he produced a perfect MSQ score and high MMS score (27 out of 30), placing him within normal, not demented, intellectual range. However, his behavioral score decreased from 5 to 17. The neuropsychologist reported Boston Diagnostic Aphasia Examination results similar to an anomic aphasic (inability to remember names of objects, impairment in ability to communicate), noting that Mel's auditory comprehension was lower than expected for this disorder. Although his comprehension of single words was good, he was unable to follow two-step commands. He answered only two questions correctly on complex ideational material. He read difficult material out loud fluently, but gave little evidence of understanding what he read with multiple choice responses. On the Boston Naming Test, his score of 34 placed him at the level of an aphasic, showing moderate deficits. The neuropsychologist concluded that his scores on formal language assessment presented a pattern compatible with organic dysfunction, suggesting in particular memory and frontal dysfunction.

In sharp contrast to his well-drawn houses, which somewhat disguised his impairments, Mel's drawings of people clearly showed his regression and symbolic merging with others. They illustrated sexual confusion, fused men-beasts, psychotic skeletal structures, and faces within bodies. Confused perceptions appeared in awkward proportions, arms originating from the head, misconnected and disconnected arms and legs. Regressed drawing ability was represented in angular arms and legs, a body becoming an oval, a nose becoming a triangle. Body parts were multiplied or omitted. The ears in particular underwent a transformation—drawn within the face, angular renditions, interchanged with arms, merged with eyeglasses. The left ear was omitted and later, the ears became increasingly elephant-like. Though emphasis on ears can often indicate possibilities of paranoia or auditory hallucinations, in Mel's case it could be largely attributed to his increasingly failing hearing (he wore a hearing aid) and his increasing loss of auditory sensory input.

Mel's pictures eventually became more bizarre and his simplified smiling mouths turned downward. Asked if he felt sad he replied, "Joe is sad," again identifying with another staff member (who, ironically, actually appeared happy). These sad mouths perseverated up to nine mouths. Depression was one of Mel's original diagnoses, but antidepressant drugs had been discontinued early in his treatment when no affective or behavioral improvement was noted. Depression may be due to underactive norepinephrine; Mel's sadness could also be attributed to a psychological reaction to his failing abilities.

Mel further deteriorated in ADL skills, with incidents of urinary incontinence. He now needed supervision in the bathroom and needed to be seated on the toilet. Mellaril medication was necessary so he would remain calm and nonviolent. An NMR (Nuclear Magnetic Resonance) portrayed his brain as showing diffuse cortical and cerebral atrophy. The physician attributed the results to Alzheimer's disease with a rather unusual course.

In the last months of his life, Mel's behavior was so regressed and disturbing to his wife that he was placed in an SNF (skilled nursing facility). He continued to come to the Dementia Day Treatment Pro-

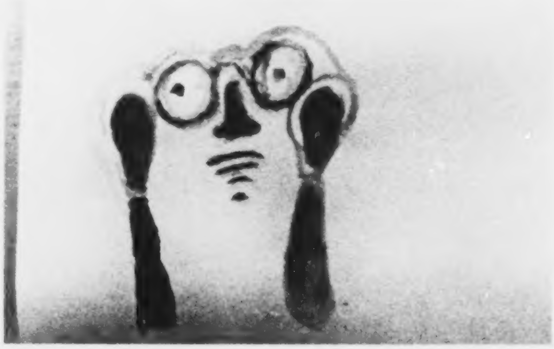
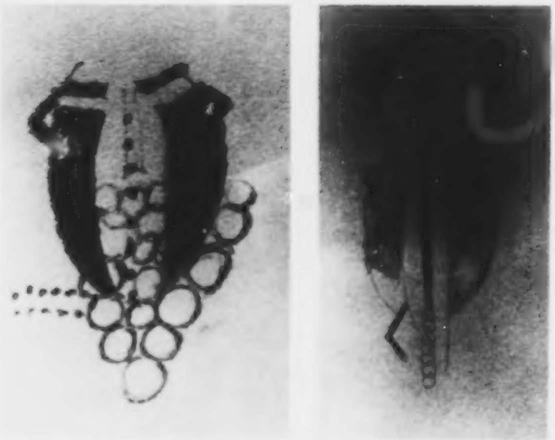


Figure 10. Loss of structure and boundaries; feeling the weight of failing speech and hearing, resulting in a depressed affect.

BEST COPY AVAILABLE



Figures 11, 12. Omissions, confusion, simplification, depression, disturbed bowel function as patient declines.

gram twice a week, but appeared sleepy and inattentive, with possible hallucinations, he became more active in the program when his Mellaril was reduced. His drawings (Figure 10) had multiple sad mouths (depression and loss of speech), multiple buttons (dependency needs), and multiple stripes on the body (possible feelings of imprisonment). The facial features at times lacked outlines to contain them and sometimes lacked a head (Figure 11), as his brain no longer functioned properly. Instead, new emphasis was placed on disturbed bowel control by multiple balls emitting from the bottom of his body (Figure 12).

Results of Mel's Autopsy

Mel passed away four months after his SNF placement, just prior to his 82nd birthday. His general autopsy revealed changes expected in an older man with a severe dementing illness: bronchopneumonia, collapse of lungs, heart disease in atherosclerosis and enlarged heart with scarring, enlarged prostate, gallstones, and mild kidney infection.

Results of the brain autopsy presented an opportunity to correlate behavioral, clinical, and medical findings. Before the microscopic results were available (due to the time required for fixation of the brain), the physician described the patient's brain as within the normal size range, with the two hemispheres of nearly equal size. The gross structure was consistent with the latest medical impression of mixed dementia (both Alzheimer's disease and some cerebrovascular disease). However, a microscopic neuropathological examination of Mel's brain did not lead to a simple diagnosis. Neuronal losses were noted; focal loss and neuronal atrophy were noted in the cerebral cortex. The hippocampus showed focal atrophy and spongiosus (swelling and excessive fluid in the tissue spaces).

The attending physician at the Dementia Day Treatment Program explained that Mel's loss of nerve cells occurred in the area characteristically affected by Alzheimer's disease, the cholinergic nucleus basalis. Nerve cells were also lost in other areas, notably in the locus ceruleus, which is frequently affected by Alzheimer's disease, and in the substantia nigra, which is affected in Parkinson's disease. The diagnostic plaques and tangles of Alzheimer's disease were not found, nor was any evidence of strokes.

These pathological findings explained Mel's mental and behavioral deterioration. Focal atrophy and neuronal loss in the cerebral cortex were noted in x-rays as well as in the autopsy. Indeed, its function as main coordinator and regulator of thinking and behavior had become disorganized. This correlated with the staff's and the art therapist's notation of the continued deterioration in Mel's behavior, and later in his cognitive abilities.

Frontal lobe deterioration, as suspected, accounted for the personality, social, and behavioral changes, sexual confusion and disinhibition, intrusions, perseverations and omissions, loss of spontaneity, and possibly pseudodepression. Swelling and fluid in the hippocampus accounted for Mel's memory loss. While memory is stored in many areas, the hippocampus plays a significant role in the process of memory formation, particularly in memory consolidation, storage, and retrieval of new memories.

Marked neuronal loss damaged the nucleus basalis, which has a modulatory effect on neurotransmitters and appears to play important roles in learning, memory, and attention—all of which had become dysfunctional in Mel. In addition, Mel's artwork at times showed psychotic ideation in skeletal structures and merged and fused percepts. The substantia nigra, the locale of dopamine production, showed marked deterioration. While Mel had no Parkinsonian physical symptoms, such as a stumbling gait or facial rigidity caused by insufficient dopamine production, excessive dopamine activity has been implicated in schizophrenia. Moreover, neuronal loss in the locus ceruleus could account for Mel's depression. As the main site of norepinephrine production, depression may be due to its underactivity. It is also hypoactive in Alzheimer's disease, thus the patient was unable to put current sensory information together with past experience.

The final evaluation of Mel particularly noted degeneration of the substantia nigra, locus ceruleus, and nucleus basalis consistent with Parkinson's disease. Although morphologically the findings pointed to Parkinson's disease, clinically Mel did not present with Parkinsonian symptoms. It has been noted that "movement disorders, especially Parkinson's disease, produce symptoms that are similar to those of frontal-lobe lesions—most particularly, reduced spontaneity of behavior, changed social behavior, and impaired corollary disease" (Kolb & Whishaw, 1980, p. 304). Parkinson's disease patients can behave much like depressed or schizophrenic patients, and the presence of neurochemical abnormalities in schizophrenia and depression implicates the neurotransmitters noradrenaline, dopamine, serotonin, phenylethylamines, and endorphines. The substantia nigra and the locus ceruleus are significant sites for the production of some of these neurotransmitters.

Conclusion

The pathological findings did not clearly point to a simple diagnostic label to apply to Mel's dementing illness. Since medical literature does report other patients with a degenerative disease with many characteristics of Alzheimer's disease but without plaques and tangles (Heilig, Knopman, Mastri, & Frey, 1973), the physician concluded that this may prove to be an emerging syndrome not yet accepted in medical literature. Whatever the diagnosis, Mel's art paralled the degenerative course of his disease, providing an additional avenue for understanding the complexities of a dementing illness.

References

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: Author.

Heilig, C. W., Knopman, D. S., Mastri, A. R., & Frey, W. (1973). Dementia without Alzheimer pathology. *Neurology*, 35, 762–765.

Kolb, B., & Whishaw, I. (1980). *Fundamentals of neuropsychology*. New York: Freeman Press.

Luria, A. R. (1973). *The working brain*. New York: Basic Books.

Wald, J. (1984). Graphic representation of regression in an Alzheimer's disease patient. *The Arts in Psychotherapy*, *11* (3), 165–175.

Wald, J. (1986). Fusion of symbols, confusion of boundaries: Percept contamination in Alzheimer's disease patients. *Art Therapy: Journal of the American Art Therapy Association*, 3(2), 74–80.

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 96-99 © AATA, Inc. 1993

Viewpoints

Portrait of an Illness

Mary Lynne L. Ricci, MA, A.T.R., Baltimore, MD

This is the story of my own debilitation, survival, and ultimate rehabilitation from the often devastating and potentially fatal disease, lupus. Emphasis in this paper is on the art experience. The artwork presented evolved long before I understood the art therapy process or appreciated the therapeutic impact that process had on my life.

I had just completed my sophomore year of college, majoring in physical education. Following a difficult separation from my parents at the beginning of the fall semester, I felt that I had finally reached a level of growth that allowed me to look forward to returning to school. Soon after I moved home for the summer, I was stricken with lupus.

The Columbia University College of Physicians and Surgeons Complete Home Medical Guide (1985), defines lupus as:

> Systemic Lupus Erythematosus, also referred to as SLE or simply lupus, is one of the most serious of all rheumatic diseases because it can involve the kidneys or other vital organs. Like rheumatoid arthritis, lupus occurs predominantly in women, but the reasons for this are not known. It may strike at any age, from childhood into the sixties and seventies, but most patients with lupus will develop it when they are young adults. The symptoms largely depend upon the organs involved, and as the disease runs its course, usually over a period of years, different target organs may be affected. The degree of disease activity varies from potentially life-threatening flare-ups to complete recovery.
>
> The cause of SLE is not known, but certain facts have emerged as a result of years of intensive research. It appears that patients with SLE have a defect in their immune system, particularly with the regulation of the production of antibodies, the protein substances that normally help to defend against infections (pp. 583–584).

The high doses of steroids used to treat the disease have many side effects, one of which (steroid myopathy) caused me to lose the use of my arms and legs. In essence, I found myself slowly becoming paralyzed. I was transported over 200 miles from my home to a hospital for specialized care. My parents were able to accompany me and remained with me over the next three months.

Ultimately, the drug therapy overtook my body. Only my left (nondominant) hand could move, and then, only a few inches above the mattress. I felt robbed of my dignity as I lay there, helpless, my body violated by tubes and needles. I identified with babies I saw on television, sadly envying them because they could crawl. During periods of steroid-induced psychosis, I desperately tried to understand how they managed to crawl, when I could not move. Much of the time I felt like an infant—innocent, vulnerable, and frightened. I was a young adult trapped inside the totally dependent body of an infant. I understood the incredible fear children must experience, the fear of not being nurtured and of being abandoned in their state of helplessness. I was not only unable to do anything for myself physically, but also could not raise my voice to call for help, due to a failed medical procedure that had damaged by vocal cords. I had a new perspective on the frustration a child must feel when attempting to communicate unmet needs.

My thinking and behavior took on primary process features. I could not separate my unconscious

1459

fantasies from current reality, and I expected immediate gratification. Not only did I make unrealistic demands of my caretakers, but I paid scant attention to the requirements of the external environment. The intense conflict within surfaced, and I exhibited little control over my impulses. What little verbal output I had was, at times, most repugnant! As I attempted to gain control to foster more organized thought, my chaotic, unorganized impulses emerged to diminish my sense of self. My ego functions were limited and, therefore, I was incapable of postponing immediate gratification or of regulating my behavior.

I experienced great ambivalence about my situation. Many times I simply wanted the struggle to end; I wanted to die. My parents were with me most of the time. I appreciated their attentiveness, but frequently resented their looming over me. Their ability to move without restraint frustrated me greatly. I also discovered that the nurses were putting crushed medications in my jello, so I refused to eat. My depression intensified as I began to turn my anger inward. My raging anger and frustration became a destructive force within my limp, voiceless body. The days seemed endless.

I frequently experienced delusions and hallucinations as a result of the steroids. My interpretation of reality became very distorted. For example, I was convinced that I heard family members talking in the hallway, and I was convinced that a team of doctors spied on me from inside the light above my bed. I was certain that mouse-sized cockroaches scurried across the floor. (At the city hospital where I was staying, those cockroaches certainly had the greatest potential for being reality-based!)

After 2½ months in the hospital my condition stabilized and I was able to attend physical therapy. The steroid doses were gradually lowered and I was beginning to feel more hopeful about my survival. The physical therapists exercised my limbs to prevent muscle atrophy. One day I worked with a physical therapist who was new to the department. As she seemingly abruptly moved my arms and legs, she said, "You know, you'll probably never walk again, but at least you have your brains." Her statement catapulted me into a state of deep depression. I stopped eating, would not communicate, and refused to return to physical therapy. A few days after this incident a psychiatrist visited me. I was able to express my feelings and share my interest in art. She wrote orders for me to attend occupational therapy.

The hospital did not employ an art therapist, but the occupational therapy department was equipped with some art materials. I sat in my wheelchair at the end of a long table and watched stroke survivors place pegs in holes. The physical therapist's words echoed in my mind. The sights and sounds of the occupational therapy department left me quite unmotivated; I felt trapped both physically and emotionally and needed, but was unable, to communicate my deepest fears and raging anger.

The occupational therapist, aware of my interest in art, devised an apparatus to suspend my barely functional left arm from a rubber sling, thereby allowing me to paint. I finally had an outlet; my creative needs were being met and I regained hope. I felt a surge of determination to prove the physical therapist wrong. Now I believe that her threat of what I perceived to be eternal imprisonment may have been the spark that ignited my motivation to regain both mental and physical health. Further, I suspect that my depression and resignation following her comment represented my need to return to more infantile patterns before I could progress. I identified with the infant's natural tenacity to survive and its relentless determination to have its needs met.

Now I wonder how my experience would have been different had I worked with an art therapist. My path, perhaps, would have been less rocky and unclear, my journey less lonely. Although it represented only a fraction of my premorbid autonomy, regaining the freedom to paint was a cathartic experience. My aggressive energy finally found a constructive outlet in artwork. Initially I feared failure because I was working with my left hand. However, I soon learned to view that as just one more hurdle to clear.

The Artwork

The image I created developed slowly as I became more comfortable manipulating the swinging apparatus. At first I struggled to steady my hand to accumulate paint on the brush. Working slowly, I applied broad blue strokes across the center of the paper. I became invested in the art process. Each brush stroke became a conquerable challenge, a giant leap toward freeing my body and mind from the heavy physical and emotional burden each had endured.

It took me several minutes to wash the blue paint out of the brush. Then I applied a light wash of yellow-green around the blue. My image suddenly became alive, bringing me comfort as the representation of a pond emerged. My painting began to develop into a landscape (Figure 1). I tested my skill

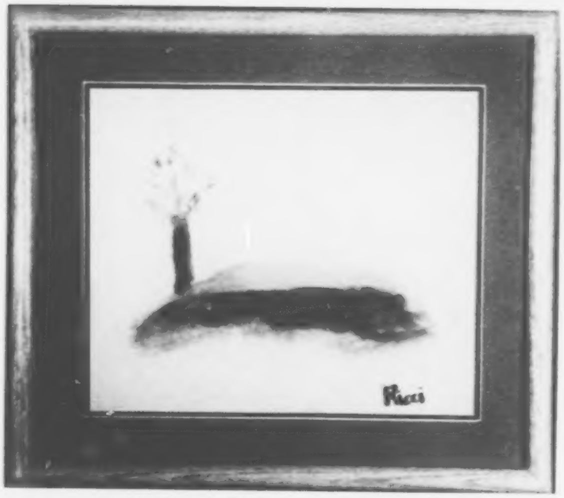


Figure 1. Water, sun, and tree.

and depicted an almost vertical tree trunk. I reinforced the trunk several times with brown paint, and then lightly painted a few tree branches with the drying paint that remained on the brush. I was tired but felt that the picture was incomplete. My resolve intensified when I decided to further challenge myself to create a round sun. This was a frustrating process, requiring even more control. At one point, when my sling took an unexpected bounce, a drop of orange paint fell to the side of the sun. It looked like a sun burst! I added yellow inside the circle to soften the intensity of the bright sun. Using a dry brush technique I had learned in high school, I added orange leaves to the bare branches. Although somewhat sparse, the leaves seemed to reflect the sun's rays, illuminating the scene. This "simple" painting took 1½ hours to complete. I recall the excitement of my parents who noticed a positive change in me when I returned from that therapy session.

The Symbolic Content

Unconscious symbols emerged spontaneously. Only now do I realize they stood for something quite complex. Blue was my favorite color, so it was appropriate that both my first application of color and my initial outlet of deep inner turmoil reflect a form of self-nurturing. After I applied the yellow-green wash and realized that a pond had formed, I felt in control. The yellow-green seemed to add support, provide boundaries for the water, and suggest new life. I believe that I reinforced the trunk with brown paint to provide the tree with the physical and emotional stability I was yet unable to feel.

Typically, I strive for perfection; therefore, allowing the unexpected "sun burst" to remain may have been part of the process of acceptance. Slowly, my sense of self was restored. I was able to abandon some of my old patterns and enjoy this new experience. Perhaps, on some level, the bright burning orange sun corresponded to my anger. The yellow, added possibly to subdue the rage I felt, softened the intensity of the sun's rays. Sun can be particularly harmful to lupus patients.

The painting appears to have three main elements: water, sun, and the tree. Unconsciously, these may have represented my parents and myself. Water represented my mother; the sun, my father; and I, the tree, receiving nurturing from both. Spatially, the tree is closer to the water; I am generally more dependent on my mother. My father (sun) oversaw my care in the hospital; likewise, I feel he always had a clear view of my situation.

The stable, upright tree may have indicated my need to stand alone, but it also confirmed my continued dependence and need for nurturing. Further, it suggested two strong urges: the need to venture out into the world and the need for safety. The sparsely covered branches may have reflected both my unhealthy mental state and my underlying doubts about my ability to overcome paralysis. Autumn leaves may have suggested death, but, more appropriately, they depicted a constructive destruction of something old (dying leaves), necessary to build something new (spring blossoms). The heavily painted tree trunk suggested the tree had enough strength to survive the winter and bloom in the spring. Highlighting the leaves of the tree with colors of the sun may have suggested my relationship, on some level, to my father. A final addition to my painting was to carefully paint my last name, using the blue of the water. Again, this suggested another tie to my mother. While the landscape was sparse, located in empty space, it could suggest an element of the unknown.

I believe these symbols fit between my fantasy to be healthy and individuated and the reality of this happening only after a long recuperation. The artwork enabled me to make sense of my world, albeit on an unconscious level, and to separate fantasy from reality by achieving some level of mastery.

I felt some peacefulness; the artwork provided a healthy way to deal with my conflicting feelings and supplied previously unachievable pleasure by constructively redirecting my energy. This increased energy resulted from healthier ego-functions as I moved out of the steroid-induced psychotic state.

My creativity increased. Slowly, as the steroid doses were gradually lowered and I engaged in physical therapy, I regained the use of my limbs. A little over one year from the beginning of my bout with lupus I graduated from using a wheelchair to ambulating with a walker.

During my rehabilitation I was constantly involved in creating art. The art experience served several functions. While I was ill the art process was my therapy, albeit on an unconscious level, it provided inner peace. Now, as an art therapist I use it at a cognitive level. Training has allowed me to interpret the symbolic content of the artwork; it confirms the catharsis I felt. In addition, it has helped me be more sensitive to what my patients may be experiencing. My experience of the intense frustration of being unable to communicate has increased my empathy for patients who struggle for expression, either verbally or artistically. The difficulty I had manipulating art materials has helped me understand those patients who feel frustrated when using unfamiliar art materials.

It has been more than 14 years since the onset of my illness; I have been in remission for almost 12 years. At times my memories of the illness are vivid, as though it had just occurred. Persistent dreams about that time suggest that I continue to repress thoughts and feelings related to my illness. On a more positive note, I can say that being able to express my thoughts and feelings through artwork always brings back memories of the enormous pleasure of overcoming seemingly unconquerable challenges. As an art therapist, I hope my patients can reach a similar level of peace in their journeys toward mental health.

Reference

Tapley, D. F., Weiss, R. J., & Morris, T. Q. (Eds.). (1985). *The Columbia University College of Physicians and Surgeons complete home medical guide*. New York: Crown Publishers.

The American Art Therapy Association
24th Annual Conference

Common Ground:
The Arts, Therapy, and Spirituality

November 18 - 22, 1993® Atlanta, Georgia
Atlanta Hilton and Towers

AATA members will receive program information as it becomes available. All other interested individuals are invited to contact the AATA National Office for Conference information.

AATA
1202 Allanson Road / Mundelein, IL 60060
(708) 949-6064 Fax: (708) 566-4580

® Preconference Courses and Opening Reception will both occur on Thursday, November 18, 1993. Conference activities continue through Monday, November 22, 1993.

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 100-102 © AATA, Inc. 1993

Reviews

Art as Medicine: Creating A Therapy of the Imagination

Shawn McNiff, Boston & London: Shambala Publications, Inc., 1992.

235 pp., 38 black & white illustrations. $16.00 paper. ISBN 0-87773-658-8.

Reviewed by **Vija B. Lusebrink, PhD, A.T.R.**, Louisville, KY

In his fourth book on art therapy Shawn McNiff sets out to further describe and substantiate his approach to art therapy. The approach is a composite based on the creative arts, parts of James Hillman's archetypal psychology, Jungian philosophy and the concept of active imagination, his observations from his leadership of "art therapy studios," and introspection on his own images.

As in his previous books, McNiff writes in the first person and weaves his own experiences with a discussion of ideas and quotes from various sources, including a number of poems. This results in an uneven text. However, at the same time, it gives a taste of the creative process whereby the personal becomes interwoven with general knowledge and archetypal intuitive generalizations. Nevertheless, this book is McNiff's most mature work on the importance of the role of arts and images in art therapy. Similarly, his rendering of the images that illustrate part of the book shows a new richness, expressiveness, and intuitive aesthetic quality.

Art as Medicine is divided into three parts: *Context*, *Dialoguing and other methods*, and *Demonstration*. In the introduction McNiff defines his approach as a psychology that "desires to activate and move soul by striving to speak its own language" (p. 1). He differentiates this from approaches that explain "the artistic emanations from soul" (ibid). The basic principles underlying his approach are dialogue and interplay between the image and its creator, and an emphasis on increased awareness rather than on a specific image.

The first part of the book, *Context*, comprises eight subsections. In *Simple Beginnings*, McNiff covers the evolution of his work in art therapy from the beginning of his work as an artist in a state hospital to his leadership of internationally offered "art therapy studios," where the main components are relaxation and watching "the flow of painting from the soul" where "deep movements of psyche are made visible through paint" (p. 14). This process constitutes art as medicine.

The *shamanistic continuities* inherent in this approach are ascribed to images that emerge through engagement in the expressive arts' therapeutic rituals. This process counteracts the loss of soul or detachment from feelings and estrangement from others and nature that results in bodily and mental illness. Involvement with materials and the subsequent freedom of expression "embrace soul's varied expressions" (p. 23), without the classification of its pathology.

According to McNiff, the *attuning to the archetypal* dimension is achieved in the act of painting through "responding" instead of "strategic planning." He illustrates this with a personal account of a transformation in his perspective when he encountered difficulties while renovating his house. McNiff also describes the retreat environment of the art therapy studios where he is a co-painter. He emphasizes that his approach is in opposition to science and that his commitment is "to liberating art and art therapy from the narrow perspectives of scientism which have discouraged artists from realizing their potential as *psychological savants*" [italics mine, VBL] (p. 43).

McNiff discusses surrealism and its psychic automation as art therapy's clearest *link to the "art world"* of the 20th century. The art therapist is a witness and guide who participates in the shared group experience and its affirmation of the presence of soul in images and personal interactions. McNiff perceives the soul as the *psyche's movement* or kinesis. This movement is present during interaction with paint. By "(s)ticking with the image" we experience a "sustained communion" with the "image or painting" (p. 55), in transformations and "transmigration of soul from one phase of the product to another" (p. 60). A sense of presence of soul first is evoked through attuning to the perceptual and structural elements of the image.

McNiff assumes an intimate collaboration between artist and images which he sees as the artist's "psychic offspring" (p. 64). *Imaginal realism* directly represents the life of the artist's imagination. The artist's own reflections upon the manifestations of the psyche in images and direct dialogue with images are seen as the best research method for in-depth art therapy.

McNiff sees artistic images as angels that affirm "the painting's existence as a living, expressive phenomenon" (p. 75). The ensuing dialogue thus becomes one between *the artist and angel*. McNiff bases this approach on Henry Corbin's concept of images as angels that represent an archetypal dimension of self that always is a guide, leading the person. For example, McNiff elaborates on Neitzsche's Zarathustra as a guide to his soul. The subsequent discussion of the *daimonic tradition* is based on Greek daimones who, as autonomous figures, guided human actions.

The second part of the book, *Dialoguing and other methods*, briefly covers loquent meditations, creation stories elucidating the images, responding, talking with images, and the value of dialogue.

In *loquent meditations* the creator silently explores the visual aspects of the image which, in turn, elicit responses in the viewer. This visual meditation is followed by *creation stories* about the images, which treat the images as "ensouled" with the corresponding "enactment of feelings and psychological tensions" (p. 100). The *responding* component of this process focuses on feedback by the therapist and other participants in the group as they consider the image and feelings aroused by it.

Exploration of the work culminates in *talking with images* or dialogue that "is based on acceptance of the autonomous life of pictures within a world of interactions and multiple perspectives" (p. 105). The images thus become "angels of transformation" as the creator explores and speaks with various images and their distinct physical and aesthetic attributes. *The value of dialogue* refers to recognizing the autonomous nature of the image and articulation of its "plural qualities." This dialogue may be elaborated upon, taking the form of a *performance* of the imagination through movement, voice, dramatic action, and costumes. *Dreaming* and exploration of dream images become part of the process of healing through the images or "art as medicine." McNiff rejects the notion of gestalt therapy, that every part of the dream is part of the dreamer. In his opinion this view results in "the loss of the daimonic world," and he prefers to see images as "partner," with whom the dreamer establishes relationships (pp. 128–129).

The last third of the book, *Demonstrations*, consists of McNiff's own *image dialogues* with 26 oil pastel paintings. These expressive images depict development of a theme that begins in ancient Babylon with associations to the recent Persian Gulf War. They end with a "Yankee house," presumably McNiff's own. The essential difference between his discussion of his personal expressions in *Depth Psychology of Art* (1989) and the present book is that the latter presents an evolution and elaboration of his previous more descriptive approach.

The focus of the dialogues is on the interaction between the masculine and feminine aspects of the creator's psyche, elaborated through the presence of images of animals, trees, house, and walls. McNiff's image dialogue is, for the most part, cerebral and reflective. He describes the sensory and pictorial aspects of the images, but, curiously, emotions are missing from the dialogue. The representations of the images have depth in moods created and in the immediacy of their presence, but the dialogue has a tendency to become overly intellectual and repetitious, thus contradicting McNiff's own assertion about the independence and "daimonic" nature of images.

My synopsis of *Art as Medicine* reflects McNiff's crystallization of a personal style and his approach to art therapy. It is based on the Jungian method of active imagination. McNiff is a facile writer, offering many sensitive and insightful observations on the interaction of the psyche, or soul, the image, and the intellect of the creator during the process of art therapy. The archetypal intimacy of the subject, however, carries its own dangers, to which McNiff is not immune. Treading on the interface between the archetypal psyche and the ego inflated by identification with the archetypal psyche, he succumbs, in a number of instances, to the latter.

One of the biggest shortcomings that appears throughout the book are frequent derogatory, inaccurate, and undocumented statements about art therapy. Outside of McNiff's previous work, the only reference to art therapy is Helen Landgarten's and Darcy Lubbers' *Adult Art Psychotherapy* (1991), and then, only within the context of McNiff writing a forward for this book.

Among the undocumented comments regarding art therapy and art therapists are the following: *diagnostic perspective that dominates their work* [italics mine, VBL] (p. 39), "diagnostic labeling [in art therapy] that does not permeate the other creative arts therapies to the same degree" (p. 41), "egocentric assumptions that the image fits into the *a priori* theoretical bias of the interpreter" (p. 53), "practices of art therapy that attempt to 'fix' the work in definitions offend the imago" (p. 80), "prepackaged conclusions that are all too often associated with the psychological interpretation of art" (p. 151), "the hierophants who will tell us that the doorways are vaginal openings that the man desires" (p. 172), "(i)nterpreters are apt to make assumptions about an artist's psyche on the basis of one picture" (p. 173). These comments culminate in: "I enthusiastically and graciously say 'Thank you' to all of the interpretive *confabulators* [italics mine, VBL], labelers, and their fleet of diagnostic tests, handbooks, and outrageous statements about the motivations of artists" (p. 219). From a Jungian perspective one can make the observation that the above generalized statements are a negative anima's comments. They are not a valid representation of the field of art therapy, nor of the approaches to the theory of art therapy used by most art therapists (Rubin, 1987).

McNiff presents as his original thought the inquiry into and meditation on perceptual aspects of the image, as well as the dialogue with those images. The focus on perceptual aspects has been discussed in art therapy literature (Betensky, 1973; Lusebrink, 1990), and the dialogue has been used in different approaches to therapy that involves imagery.

Another shortcoming is the lack of elaboration of terms, such as "art studios" (which are apparently weekend or week-long workshops) and "art as medicine." McNiff never fully credits James Hillman or the concept of "daimons" or "daemones." In regard to the illustrations, it would have been helpful to number them in the first two-thirds of the book.

In summary, McNiff's latest book is an important contribution to the understanding of the role and dynamics of visually depicted images on the function of the psyche. If one is willing to overlook the shortcomings discussed above, it offers an elucidation on a depth aspect of art therapy from the viewpoints of philosophy and art. Application of McNiff's approach appears to be most appropriate for a clientele similar to himself—intelligent and functional individuals who have the personal means to attend international self-exploratory workshops. This approach is less useful to art therapists who work with individuals who have serious impairments and psychopathology, given the constraints of time limits and reimbursement through insurance.

Despite its shortcomings, *Art as Medicine* contributes to the literature a valid, in-depth, and vital view of one of the many aspects and uses of art therapy.

References

Betensky, M. (1973). *Self-discovery through self-expression*. Springfield, IL: Charles C Thomas.

Landgarten, H. B., & Lubbers, D. (1991). *Adult art psychotherapy*. New York: Brunner/Mazel.

Lusebrink, V. B. (1990). *Imagery and visual expression in therapy*. New York: Plenum Press.

McNiff, S. (1989). *Depth psychology of art*. Springfield, IL: Charles C Thomas.

Rubin, J. A. (Ed.). (1987). *Approaches to art therapy: Theory and technique*. New York: Brunner/Mazel.

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 103-104 © AATA, Inc. 1993

Creativity and Disease: How Illness Affects Literature, Art and Music (7th edition)

by **Philip Sandblom, MD, PhD.** New York: Marion Boyars Publishers, 1992.

207 pp. 84 black & white and 12 color illustrations. $17.95 paper. ISBN 0-7145-2941-9

Reviewed by **Patricia St. John, EdD, A.T.R., Associate Editor**

In his preface to Philip Sandblom's *Creativity and Illness: How Illness Affects Literature, Art and Music*, Carl Nordenfalk, director emeritus of the Swedish National Museum, warns, "Once you start reading, you will not easily put the book aside. . ." (p. 8). Readers be forewarned. This seamless, elegant essay, delivered with grace and power, is the marriage of a skillful surgeon and a sagacious humanist. Written with warmth and humor, Philip Sandblom's inquiry into the effects of illness on art and artists never patronizes the artist nor dismisses the potent effects of pain. Sandblom bases his thesis on the assumption that "art is always founded on experience; one cannot create from nothing" (p. 11). Illness inevitably affects art, but how, when, and where are cause for examination.

Frida Kahlo, who had the congenital defect *spina bifida*, painted her illness countless times. At the other extreme is Matisse whose bout of appendicitis turned him from his plan to be a lawyer to painting, as a diversion, and then as a career. Illness visitied him again in the form of bronchitis, causing him to move to Nice for a cure. At the age of 70, he developed colon cancer. This left him partially bedridden for much of the rest of his life. Sandblom interviewed Matisse, who admitted that illness had altered his life and art. He believed art should give happiness; he was "so convinced of the beneficial radiation of his colour and its power to heal that he hung his pictures around the beds of ailing friends" (p. 33).

Illness can both stimulate and enrich creativity. The text is generously laced with testimony from artists. Edvard Munch stated that "(w)ithout illness and anxiety I would have been a rudderless ship" (p. 20). While Sandblom has gathered no statistical evidence of a link between creativity and illness, he accepts the position that a link often does exist. He bases this position on "many excursions through the provinces of art I have collected" (p. 19).

Sandblom explores those features of the creative personality that set the artist apart from the typical person. "Are artists . . . at all to be counted among the mentally normal?" he asks, and answers, "No, 'one is not a genius because one is mad' but it may help!" (p. 35). Bipolar depression, schizoid personality, the neurotic, depressed and paranoic, may successfully seek relief or resolution of life's tensions and conflicts through creative pursuits, including the arts. To rank among the world's great creators it takes more than the trauma of illness. The ability to "see everything with innocent eyes," a desire to share and communicate deepest feelings, the "urge to seek new and personal means of expression," a pioneering attitude that risks going into unknown territory without "fans or followers," a sense of one's own individual identity, and a complete dedication to pursuing art, despite handicaps, disease, isolation, or old age, are some of the characteristics of the creative personality (pp. 38–39).

Many artists used artificial substances to stimulate creativity. A comparison of two versions of the

BEST COPY AVAILABLE

windmills of Montmartre by Utrillo illustrates the long-term effects of alcohol. Sandblom selected two examples, one dated 1912 when the artist was using alcohol slightly, and the second, dated 1953 when the artist was alcohol dependent. The subtle whites, blues, and greens of the earlier painting have changed to harsh, expressive brush strokes of predominantly oranges, reds, and bright greens. The delicacy and refinement of the 1912 work has evolved to a vigorous and rough application of paint. Opium was a popular stimulant during the 19th century; it was also used medicinally. Keats, Berlioz, Coleridge, and Piranesi used it. Piranesi's "Prison of Imagination" "convey(s) . . . feelings of desperate helplessness" as the effects of the drug wore off. The use of opium combined with the artist's manic-depressive tendencies so that Piranesi's engravings evoke dark, fantastic, and terrifying visions.

Sandblom also explores the effects of mental illnesses on creativity. Giving support indirectly to art therapy, Sandblom writes: "Works of the insane have provided fundamental insight into certain manifestations of mental disorder, and in certain cases can even help us to reach a diagnosis" (p. 67). Sandblom traces "prints" of the schizophrenic in Charles Meryon's etching. Ernst Josephson, a Swedish artist, painted while in sound health, and later, when he became schizophrenic (p. 76). His later work is considerably more expressive, although the composition has suffered.

For the combined effects of physical and mental illness, Sandblom discusses epilepsy and how it affected the work of Van Gogh, with its periods of "terrible anxiety, confusion and aggression" (p. 87). In an exploration of defects of sight, Sandblom recounts how cataracts obscured Claude Monet's vision, causing him to complain, "I see everything in a fog" (*Ibid*). After a cataract operation, Monet changed the color in some of the cataract-influenced paintings and destroyed others. A period during the 1890s demonstrated the combined effects of disease and operation in his series *The Japanese Bridge*. Sandblom presents four of Monet's paintings of the Japanese bridge executed at different times: in health, disease, and pre- and postoperation. Tinted glasses and further recovery were captured in his final series, the water-lilies. The tranquility of these paintings reflects Monet's regained peace.

For other examples, Sandblom explores the role of deafness on Goya, Swift, and Beethoven. Congenital malformations affected Henri de Toulouse-Lautrec, and the impact of old age can be traced in the work of Cezanne. Marc Rothko became obsessed with death, exploring it in the murals of Rothko's Houston chapel "where light and life fade away in the almost black purple, predicting his suicide" (p. 101). At the close of the book, Sandblom concludes: "In great artists, the passion to create generates a willpower strong enough to defeat the worst disease" (p. 180).

Sandblom treats his topic with care and a keen eye. His observations are astute, and he supports each hypothesis with well-chosen examples. The book's value lies in its breadth of scope, rather than in long, detailed examinations of artists' lives and works. Sandblom has left to the scholar the task of a fully developed historical examination of life and disease. As a starting point for study of one or several artists with similar afflictions, this book cannot be equaled. Were another edition written, Sandblom would undoubtedly include the effects of HIV on creativity. Although Sandblom does not mention art therapy, outside of the context of William Styron's (1990) recollections (p. 147), his work eloquently supports the efforts of art therapists and demonstrates possibilities of creativity within the clutches of illness.

Reference

Styron, W. (1990). *Darkness visible: A memoir of madness*. New York: Random House.

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 105-106 © AATA, Inc. 1993

MusicMedicine

by **Ralph Spintge, MD** and **Roland Droh, MD, Editors.** St. Louis: MMB Music, Inc., 1992.

411 pp., $29.92 paper. ISBN 0-918812-72-0.

Reviewed by **Therese Marie West, MMB-BC,** Concord, CA.

These are exciting times for the expressive arts therapist. As the United States faces the daunting task of bringing about major reforms in our system of health care, we observe trends which point towards a new place for the arts in modern medicine. Not merely a renaissance of ancient healing arts, this change is a sign of human development, a coming together of art and science to meet human needs at the most basic levels of personal and societal survival.

MusicMedicine is a timely and valuable resource for anyone exploring the role of music in this dynamic arena. It contains the proceedings of the Fourth International MusicMedicine Symposium sponsored in 1989 by the International Society for Music in Medicine.

This book will be valuable to all those working and doing research in any of the creative arts and medicine because its contributors explore theoretical and practical issues facing all medical arts practices. Recurrent themes point to the problems, obstacles, and opportunities facing us as we attempt to bridge the long-established separation between creative art and scientific medicine. As clinicians and researchers attempt to understand the language of science and art and to comprehend works published in foreign languages, the need for many kinds of improved communication becomes clear.

The reader of *MusicMedicine* quickly gets a sense of the scope and volume of work currently being done in "musicmedicine," and the international energy fueling the movement. Its contributors explore the growing need for an international database of research and publications in allied fields. At a practical level the reader is provided with suggestions and valuable information on already existing resources.

Technological advances in communications and medical research, specifically in neuroscience, have provided methods to assess the effects of music and sound vibrations on physiological, psychological, and social functioning. What in the past were considered as only subjective and elusive experiences can now be brought to light through scientific methods. What was once the domain of esoteric practices of healing arts is coming out of hiding to the potential benefit of humankind. This growing momentum of interest, along with dedicated efforts to uphold the highest possible standards of research and clinical practice, ultimately serves the consumer. Today's consumer wants safe, reliable, and cost-efficient treatments and is ready to participate actively in regaining and maintaining good health.

The arts therapies stand in a unique position to contribute to the rehumanization of medicine. They not only offer methods which support existing medical treatments, but also provide newly acknowledged potential as recognized and medically prescribed treatments in themselves. The writings of the physicians and researchers of *MusicMedicine* clearly suggest that this rehumanization of medicine is already taking place, and they point out there is much work yet to be done to bring this about.

Many of the 57 authors contributing to this instructive new volume are nationally and internationally recognized leaders in this rapidly developing field. They are physicians, musicians, music therapists, educators, researchers, scholars, and movement and physical therapists. Their common ground is music. The 36 articles are grouped into six areas:

I. General Considerations, where definitions and models are proposed for integrating music and medicine; II. Aspects in Physiology and Physics, which is often highly technical but well worth the reading; III. Applied Research, which represents work in pain reduction, psychoneuroimmunology, immune-related disorders, and social and emotional development; IV. Therapeutic Applications and Workshop Transcriptions, which span a broad range of traditional and innovative practices and health issues; V. Aspects of Occupational Health Care, where the focus is on areas of concern to the performing musician; and VI. Toward Standards of Research in MusicMedicine and Music Therapy, which concludes the book with articles which should stimulate thinking and dialogue among all interested parties.

MusicMedicine is a fascinating compendium of the current state of research in the role of music and medicine. Although it raises many more questions than it answers, that is the nature of human investigation and problem solving. As food for thought, it is a feast.

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 106-108 © AATA, Inc. 1993

Video Review

Visual Arts for the Physically Challenged Person

Produced by HVS Productions for the Young Artist Workshops Programs, St. Norbert College, De Pere, WI, and the Agency for Instructional Technology with support from the National Endowment for the Arts Artists-in-Education program, 1989.

25 minutes, color. Rental: Basic program rate of $47, plus school enrollment rates depending on enrollment populations. For more information, call the Agency for Instructional Technology in Bloomington, IN (800) 457-4509.

Reviewed by **Simone B. Alter Muri, EdD, A.T.R., LMHC,** Springfield College, Springfield, MA

Visual Arts for the Physically Challenged Person is designed to assist visual arts teachers in involving students who have disabling conditions. A strength of this video is its strong argument for the importance of art to all children, especially those with special needs. At the close of the video, Professor Charles Peterson sums up this position: "Within a medically impaired body, there can be a highly creative and intellectual mind." We need to work with individuals according to their unique capabilities in order to overcome disabling situations.

The video incorporates a humanistic approach that emphasizes self-realization and the attainment of individual goals. It covers work with two- and three-dimensional materials, photography, and state-of-the-art computer graphics.

The major focus is on the adaptation of art materials for physically challenged individuals and individuals with communication disorders. These adaptations, which draw on the expertise of occupational and physical therapists, are geared to increase students' ranges of motion, grasping skills, and ability to work with materials. Several devices are demonstrated including styrofoam balls on paintbrushes, rubber spatulas as extensions of mouth guards, hand levers on potter's wheels, and computer hardware and software. The range of examples is good, but I question the implicit assumption that art teachers and therapists would not be trained to adapt materials for the physically challenged.

Another strength of the video is its application to classroom teaching. College students unfamiliar with federal special education laws P.L. 94-142 and the Education for All Handicapped Children Act (1975) will gain an understanding of the current legal requirements. Considerable attention is given to the importance of mainstreaming and working within a multidisciplinary team. However, the video could do more to demonstrate how a special needs child's weaknesses could be camouflaged in an integrated classroom, through careful choices of art activities that emphasize the child's strengths (Henley, 1992).

From a technical perspective, the producers did an excellent job of incorporating voice over narration, clear visuals, and special editing techniques. The video comes with an excellent facilitator's guide that classroom teachers can use as a follow-up to the program. Detracting from the overall technical excellence is background music that is sugary, reminding one of a dental office. Some of the cuts, including one of an individual in a wheelchair with a sticker on the back stating, "I brake for sexy women," are in questionable taste and have no relevance to the arts.

The art therapy audience will also be frustrated with the video's focus on product as opposed to process. Within the first few minutes of viewing, an art teacher repeats to a deaf student and her interpreter, "I want all the white spots covered. I don't want to see any white spots showing." Though the video stresses the importance of art activities that feature built-in success, designed to increase the self-confidence of physically challenged people, this product-oriented approach goes against the grain of a developmental approach to art (Lowenfeld & Brittain, 1987).

Visual Arts for the Physically Challenged Person is a good starting point for classroom teachers. However, restricting the scope of the video to the adaptation of art devices also limits the audience who might benefit from its message. While I am pleased that the video makes no pretense of being art therapy, it is time for a video by art therapists on this topic. Such a video would go beyond the adaptation of materials and deal with the psychological and developmental issues that often manifest during the process of creating art.

Note: The target audience for this video is K–12 students and teachers.

References

Agency for Instructional Technology. (1989). *A facilitator's guide to 'Visual arts for the physically challenged person.'* Bloomington, IN: Agency for Instructional Technology.

Henley, D. (1992). *Exceptional children, exceptional art.* Worcester, MA: Davis Publications.

Lowenfeld, V., & Brittain, W. L. (1987). *Creative & Mental Growth* (8th ed.). New York: Macmillan.

Response

Barbara Ann Levy, MFA, MPS, responds to Linda Gantt's review of *Psychoaesthetics Dolphin Project, Art Therapy, 9*(4), 206–208.

Dr. Gantt raises a point about the "anthropomorphic objection" when she states, "I do not see that the substitution of 'mirroring' for imitation adds anything to the understanding of the animals' behavior and, in fact, may serve to cloud some important issues by unnecessary anthropomorphizing" (1993, p. 208). I believe she misses the point and makes the assumption that animals do not have mental experiences. Others have written on this topic. I refer the reader to Donald R. Griffen's response to the "anthropomorphic objection" in *The Question of Animal Awareness* (1981). He describes the argument as conceited and compares it to ". . . the Pre-Copernican certainty that the earth must lie at the center of the universe," a species-centric view. He warns of the dangers of circular reasoning whereby the accusation reiterates the original objection (pp. 124–125).

Mental experiences have been documented by ethologists in a variety of species. Honeybees and some species of birds have been found to use elaborate rituals to communicate. Denise Herzing, in her presentation *Social Interactions Between Humans and Dolphins* (1989) (Delta Society 8th Annual Conference) discussed anthropomorphism as a useful tool.

In recent years, a paradigm shift has occurred in the dolphin-human interspecies interaction and communication field. Previously, the emphasis was on teaching research dolphins to be like us so that we

BEST COPY AVAILABLE

might communicate with them. An example of this is John Lilly's dolphin studies (1967), where human language was taught to Bottlenose dolphins. Today, interspecies interaction is studied in the dolphins' environment at sea and on their terms. Dolphins come to research boats, swim with the research participants at will, and are unintrusively videotaped and documented. Researchers from The Oceanic Society of San Francisco, California, and Denise Herzing of the Wild Dolphin Project in Jupiter, Florida, collect interspecies interaction data in the wild as well as conduct more traditional longitudinal wild dolphin population studies.

In my study (1990), I used a psychoaesthetic framework to describe what I experienced when viewing dolphin-human interaction and dolphin marks or "paintings." I did not shape or participate in training sessions where the animals' behavior was shaped, but conducted my study within the system that was already in place.

Psychoaesthetics is a way to view artwork and human interaction through the lens of psychology, specifically using object relations theory and aesthetics. Artwork is seen as a container for the art therapeutic matrix and a reflection of the quality of the therapeutic relationship (Robbins, 1987, p. 67). Two dolphins' interactions were recorded through the aesthetic qualities of a painting that I discuss in *Psychoaesthetics and Dolphin Personality* (1990):

> Misty . . . interacted with Natua's marks. Her yellow marks intercept and extend his. They change and pull a viewer's eye from right to left, balancing the painting and acting as a stabilizing force that allows a viewer's eyes to stay within the boundaries of the canvas. As a result, I ask myself the question: Does Misty have a calming effect on Natua? (p. 29)

Anthropomorphism has been confused with aesthetic understanding. Artists have something unique to offer observers of animal behavior: "Empathy for the object" is a necessary ingredient in fine arts studio training. Aesthetic sensibility or "connoisseurship," a way of seeing according to Elliot Eisner (1991), is necessary for the construction of a reality that is called "art." An artist's reconstruction of a still life, for example, is only part of the art equation. The expressive quality of the marks made by an artist in the reconstruction of a still life completes the picture. The artist's self and subjectivity inform the viewer about the qualities of the perceived reality. This is similar to the "process recording" format used in social work training, where students record the dialogue between themselves and their clients to determine the "gist" or phenomena of a session or interview. In addition, this is useful in finding their voice within the session. In this way countertransference issues and the therapist's style are illuminated and documented.

Since the dolphins made marks that mirrored the trainer's marks, special relationships, and placement, it is possible that the dolphins were "creative." A dolphin could have reconstructed a triangle in a variety of ways that would not have reiterated or reversed the trainer's special orientation or the scale of the marks made on the page. "Imitate" was the command made by the trainer, not "Imitate the trainer's marks by painting your mark in a position under the trainer's mark and upside down." More work is needed in this field, using a larger sample to determine a dolphin's creative capabilities.

At the University of Hawaii, Lou Herman (1988) found that dolphins could conceptualize. In the Kea Language Study, it was determined that the dolphins generalized commands given by a trainer. For example, "Fetch" was a command given to a dolphin. The dolphin generalized the concept, fetching whatever object was requested, and used whatever body part it found appropriate to complete the task (p. 413). The painting dolphins at the Dolphin Research Center in Grassy Key, Florida, may "create" when they reverse the order of the trainer's configuration or composition. A composition is similar to the creation and use of syntax.

References

Eisner, E. (1991). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice.* New York: Macmillan.

Griffen, D. R. (1981). *The question of animal awareness: Evolutionary continuity of mental experience.* Los Altos, CA: William Kaufmann.

Herman, L. M. (1988). *Cognitive characteristics of dolphins, Cetacean behavior, mechanisms and functions.* Malabar, FL: Robert E. Krieger.

Herzing, D. (1989). *Social interactions between humans and dolphins.* Delta Society 8th Annual Conference, November, 10–12.

Levy, B. A. (1990). *Psychoaesthetics and dolphin personality.* Unpublished master's thesis. Brooklyn, NY: Pratt Institute.

Lilly, J. C. (1967). *The mind of the dolphin: A nonhuman intelligence.* New York: Doubleday.

Robbins, A. (1987). *An object relations approach to art therapy.* In J. A. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (pp. 63–74). New York: Brunner/Mazel.

Art Therapy: Journal of the American Art Therapy Association, 10(2) pp. 109-111 © AATA, Inc. 1993

Noteworthy

In memory of Elizabeth "Grandma" Layton, 1909–1993

by Robert E. Ault, MFA, A.T.R., HLM

A cold wind was blowing across the flat Kansas prairie on March 17th, as friends and family huddled together for warmth and comfort. They had come to say their goodbyes to Elizabeth "Grandma" Layton, an extraordinary woman who had died two days earlier. The Wellsville cemetery, a field dotted with trees and stone markers, seemed strangely similar to the other open fields that surrounded it. One was keenly aware of the seasons and rhythms of life so important to the people of the small rural community where Elizabeth was born and where she died. Out of the earth had come life that had struggled, flourished, given life, withered and died and was now replanted. Following a ceremony, mercifully made brief because of the bitter cold, we gathered at the local VFW hall where cake and hot coffee were served by church women, and people could greet the family, express their sympathy, reconnect, and partake of the age-old ritual of healing grief.

Two weeks later there was a different type of gathering in Lawrence, Kansas, where several hundred friends, admirers, and some family members came together for a memorial service. They brought drawings she had given them and hung them from floor to ceiling in the auditorium, forming a backdrop for the many friends who spoke of their relationship with her and her art. There was the sharing of stories, some laughter and tears, and thankfulness for the simple but profound gift and message of her life. A reception was held afterwards at which pink lemonade and oreo cookies were served, as I'm sure Elizabeth would have wanted.

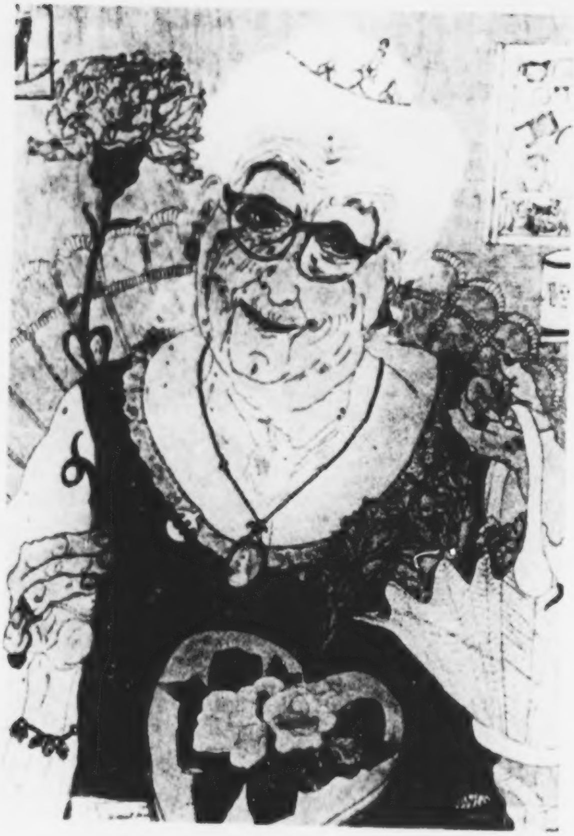
I was asked to be one of the speakers and shared the following comments with the group: "How do you summarize many years of contact, study, sharing, caring, and love in a couple of minutes? It is so personal. But that was what her life and her art were about. Everyone who knew her or saw her art felt something personal. She opened her life in a way that was very rare, not only in personal relationships but especially so in the arts. There were an honesty and openness and lack of pretense that were like a breath of fresh air—air the public eagerly gasped.

As an art therapist I have always been interested in not only the product of art but also the process. These two elements contribute to the meaningfulness of an art experience. Elizabeth was a gold mine for study, for she had experienced firsthand the healing power of art and was willing to open her life for examination. She enthusiastically participated in the studies that we did in trying to understand what happened to her that made her well. The research was done, and we have now been able to reproduce in others the process of healing that she experienced. It is now being practiced across the United States.

Last summer Elizabeth participated with us on behalf of the American Art Therapy Association to present testimony to the U.S. Senate in support of the inclusion of art therapy in the Older American's Reauthorization Act. At the same time, she was having a one woman show at the Smithsonian Institution's Gallery of American Art.

Elizabeth loved art therapy and art therapists, since she knew from her own experience about the healing power of art. She was like a beacon of inspiration and a validation of our belief in our profession. She showed us the direction to new territories that needed exploration and encouraged us to proceed. Through that she left a legacy equal in importance to her art for which we will be forever grateful.

Finally, I wanted to take a moment to share my own personal experience. It is ironic that she taught me a process of dealing with loss and grief that I was able to use in dealing with my loss of her. I did a drawing last week and felt much better afterwards. It is of myself with Glenn and Elizabeth, still a part of my thoughts and feelings. She places her hand on mine and quiets the pain. I am surrounded by her



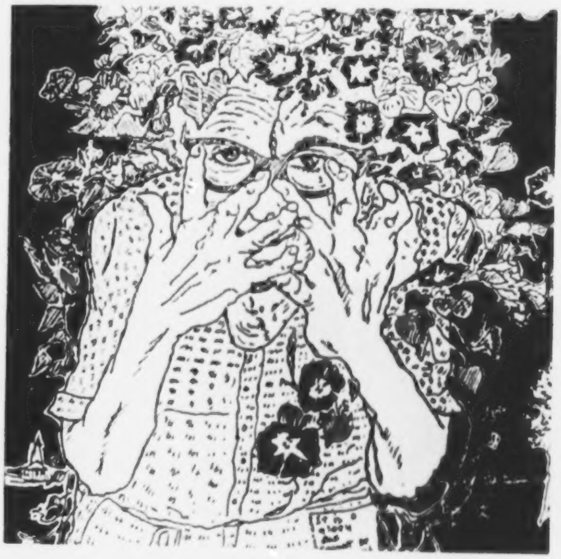
images of flowers and her thoughts on art therapy. I am wearing one of her "I am loved" buttons. She was a safe zone and indeed an affection connection.

Elizabeth Hope Layton died Monday, March 15, 1993 at the Olathe Medical Center. Her death was the result of a stroke suffered February 17th. She was born October 27, 1909, in Wellsville, Kansas, the daughter of Asa Finch and May (Frink) Converse. Her father was the editor of the Wellsville *Globe* and her mother, a Poet Laureate of Kansas in the 1920s, wrote a column and front page poem for the *Globe* each week.

Elizabeth grew up in Wellsville, where she lived the rest of her life. She completed two years of college, married young, and had five children before her marriage failed. When her father died, she became responsible for the paper which she ran until 1957 as a single working mother in the 1940s, long before such a status became more commonplace. For 40 years she experienced depressions that became more cyclic, with alternate states of agitation. She sought out treatment and was given psychotherapy and medication. She was also hospitalized and underwent 13 electroshock treatments in an attempt to modify her violent mood swings. She married Glenn Layton in 1957, and became a full-time wife, mother, and grandmother continuing to struggle with her illness.

At the age of 69, following the death of her son, she again experienced severe depression and decided, instead of seeking more psychiatric help, that she would take an art class at a nearby university. The only class available was one in contour drawing. Not knowing what to draw one night, she got out a mirror and drew herself, the first of over 1,200 drawings she was to complete in her remaining years. She drew herself as others—in different moods and fantasies, grieving, loving, dressed up, and nude. She examined her values, her sexuality, and her multitude of relationships. After a while a "miracle," as she called it, occurred. Her bipolar type symptoms ceased and she remained symptom-free the rest of her life.

Her drawings, done with colored pencils on cardboard bought at the local drugstore, began to receive attention from people in the art world. Don Lambert, a journalist for the local newspaper, while writing a review of a student art show at Ottowa University saw for the first time contour drawings of an older woman. She signed her name as "Grandma," the way the younger students in her class referred to her. Don was taken by the images and thus began his journey to promote her work, acting as her friend and agent. One of her first shows was held at Menninger's in Topeka, following his attempt to get



the Topeka Public Library and the Mulvane Art Center of Washburn University to exhibit the drawings. They had refused him on the basis that she had been a patient and they weren't interested in that type of art. In more recent years both places have had one woman shows of her work.

Elizabeth Layton's art has now been viewed by people all over America via shows that have traveled extensively. She has never sold any of her work although it was in great demand, but gave it freely to friends and charitable organizations. A book about her life and art, *Through the Looking Glass*, was published, as well as countless articles. Several plays have also been written about her life and she has appeared on national television programs and on the National Public Radio. In all of these forums she proclaimed the value of art therapy and her conviction art could be done by anyone and it would make you feel better. She opened her life for examination and was most generous with her time to all who asked. She became something of a grandmother for the country.

At her show last summer in the Smithsonian, hundreds of people wrote pages of letters to her in the gallery books. These were sent to Elizabeth. She read and enjoyed them greatly, answering many of the people. One such letter said:

> "Dear lady. . . . Your heart must be as beautiful as your great green eyes. You are more than 'The Grandmother of us all.' You are our conscience, the voice from within our hearts that reminds us of what is right and good and true. Thank you so much."

The cold prairie winds have diminished now and the season is starting to change. The yellow daffodils that she loved so much are beginning to bloom and the earth stirs again. The fields surrounding the cemetery are showing the first touches of green. A rich legacy has been left by this extraordinary woman who described herself as a "drawer of pictures" and a "one word poet." We might add, "a creator of wonderful visual poetry" and "giver of unconditional love." She will be missed.

MARI®
Course in Mandala Assessment

30-Hour Course with
Certification of Completion

ATMA, Inc. Board of Directors
Association of Teachers of Mandala Assessment

Carol A. Bush, LCSW (804) 498-7220
Carol Thayer Cox, M.A.,A.T.R. (703) 371-4534
Jonna Douglass, M.A., L.M.F.T. (813) 784-7907
Paula Engelhorn, M.A.,A.T.R. (707) 539-7745
Phyllis Frame, M.A.,A.T.R. (804) 973-7543
Bonnie Smith-May, M.A.,A.T.R. (410) 576-0834
Lillian Rhinehart, A.T.R., M.F.C.C. (707) 539-0153
Deborah Glik, Ph.D. (310) 206-9548
Patty Morini, A.T.R., L.C.P.C. (207) 547-3291

For information on courses and
MARI® Card Test, call one of the above or
ATMA, Inc. (813) 784-7907.

BEST COPY AVAILABLE

CHARLES C THOMAS • PUBLISHER

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $49.75.

This book explores the experience of the contribution of art to spirituality in recovery from co-dependency and/or chemical dependency. This exploration resulted in gathering together ten personal stories which are woven with many common themes, creating the powerful portrait of recovery presented in this book. Since much of the previous work in these combined areas is theoretical, there is a need for research which highlights the essence of the experience of recovery including the spiritual dimension as experienced through art and art therapy. Very little research is currently available which interfaces these areas, and spirituality is an important component in the process of recovery. Therefore, knowledge about the contribution of art to recovery is valuable. Addiction is exterior attachment, whereas recovery is finding healing and wholeness through an interior journey. This book, about the interior experience, attempts to add clarity to the literature on the recovery process.

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $62.75.

☐ Sopchak, Andrew L., Andrew M. Sopchak & Robert J. Kohlbrenner— **INTERPERSONAL RELATEDNESS FROM PROJECTIVE DRAWINGS: Applicability in Diagnostic and Therapeutic Practice.** '93, 320 pp. (8½ × 11), 166 il., 46 tables, about $64.75.

☐ Plach, Thomas A.—**RESIDENTIAL TREATMENT AND THE SEXUALLY ABUSED CHILD.** '93, 144 pp. (7 × 10), 3 tables, about $28.75.

☐ Talley, Joseph E.—**THE PREDICTORS OF SUCCESSFUL VERY BRIEF PSYCHOTHERAPY: A Study of Differences by Gender, Age, and Treatment Variables.** '92, 198 pp. (7 × 10), 25 tables, $38.25.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¾), 34 il., $46.50.

☐ Dennison, Susan T. & Connie K. Glassman—**ACTIVITIES FOR CHILDREN IN THERAPY: A Guide for Planning and Facilitating Therapy with Troubled Children.** '87, 304 pp. (8½ × 11), 203 il., 12 tables, $44.00, spiral (paper).

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $48.50.

☐ Hart, Gordon M.—**VALUES CLARIFICATION FOR COUNSELORS: How Counselors, Social Workers, Psychologists, and Other Human Service Workers Can Use Available Techniques.** '78, 104 pp., 4 il., $20.75.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $35.75.

Central to the author's approach is the manner in which the mentor and the beginning art therapist come together in their efforts to learn and grow. The author demonstrates the deep, intimate, alive and complex training relationship that can lead to the awareness of meaning in the lives of both. The concern for authentic engagement in the training relationship enhances the beginner's ability to use the self to help clients learn to use art and artistic expression to identify and integrate new insights in their lives. The book is ultimately concerned with the use of art and the artistic relationship to promote human growth. The author's deep understanding of both art and existentialism makes this book a high point in the ever-evolving fields of existential psychotherapy and art therapy. It is an important contribution to the development of creative, effective psychotherapists who value human growth. It will be of particular interest to those involved in art, art therapy, existential psychotherapy and the development of a future generation of psychotherapists.

☐ Breer, William—**DIAGNOSIS AND TREATMENT OF THE YOUNG MALE VICTIM OF SEXUAL ABUSE.** '92, 236 pp. (7 × 10), 5 il., $43.75.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 × 10), 24 il., $44.75.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¾), 21 il., $36.25.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $46.50.

☐ Dennison, Susan T.—**ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents.** '88, 236 pp. (7 × 10), 36 il., 26 tables, $44.00.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $44.00.

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $51.25.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $23.50, spiral (paper).

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $30.00.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

CRACOM Corporation presents:

A Child's Story is a riveting autobiographical, and pictorial account of the process of recovering from the devastating effects of childhood sexual abuse. The author—artist, survivor, and activist—tells her personal story in three voices, corresponding to her stages of recovery:

- THE WORDLESS VOICE OF INTENSELY PERSONAL ART (33 color plates)
- THE VOICE OF A WOUNDED SURVIVOR STRUGGLING TO HEAL, expressed in poems and personal journal entries
- THE CALM VOICE OF KNOWLEDGE AND INSIGHT, expressed in the objective essays that synthesize scholarship from over 30 experts

Book Excerpts

"One day I told my therapist that, for me, 'some feelings just don't have words.' What I painted or drew became my voice, my way of speaking those unspeakable feelings.
Art is a means in which emotions can be retrieved before the survivor can verbalize the experience. After visual communication is accomplished, the story can be put into words, thus beginning the healing process."

Pat Harris, Author, artist, incest survivor and activist.

Reviewer Statement

"One of the few books written which allows an analysis of the trauma of sexual abuse to be made by a journey through a survivor's pictorial images. These memory images probably are less adulterated than those embellished by linguistic maturities made when adult survivors recall their stories only through language. The art is raw and painful: the text is instructive and teaches healing."

Bernice L. Collins, Ph.D., Clinical Psychologist, East St. Louis, Ill.

To order your copy of ***A Child's Story*** mail your check for **$29.95** (plus appropriate sales tax) to :

CRACOM Corporation • 12131 Dorsett Road, Maryland Heights, MO 63043
Credit card orders (MC/VISA) please call **(1) 800-880-3988**
Discounts available for associations and fund raising events

BEST COPY AVAILABLE

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Xerox copies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

1468

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone #s: ____________________ **work** ____________________ **home**

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ______________________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ______________________________ **Date** ____________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

ARTherapy
JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

COLOR RATES: Standard Red, Blue and Yellow
(Available Cover #4 Only)

Black & white plus one color	$130 additional
Black & white plus two colors	260 additional
Black & white plus three colors	360 additional
Other colors and special inks	260 additional per color

BLEED	1x	2x	3x	4x
Per page additional	$90	$85	$80	$75

INSERTS	1x	2x	3x	4x
2 pp	$ 800	$ 700	$ 575	$ 425
4 pp	1,500	1,300	1,150	1,000
8 pp	2,200	2,000	1,750	1,450

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-page Horizontal	7"	4-7/8"
Half-page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"
Bleed Size: 8-5/8" × 11-1/4"
Inserts: 8-5/8" × 11-1/4"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue; July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount. 10% discount offered if total cost of advertising and exhibit space for the year is $800 or more.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

The American Art Therapy Association, Inc.

1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 3800 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice: AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films and awards.

PURPOSE:

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

CHAPTERS:

Affiliate Chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network of people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive:

Publications

- *Art Therapy*, the official journal of the AATA
- The quarterly *AATA Newsletter*
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory
- AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice
- Mailings of professional interest

Services

- Insurance, including professional liability, major medical, life and disability through Maginnis & Associates
- Access to national experts in art therapy

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring
- State legislative and regulatory activities
- Promotion of recognition and reimbursement of art therapists by third-party payors
- National liaison with related professional organizations for recognition and promotion of the profession of art therapy

Professional Standards

- Development of model job description and recommendations for licensing standards
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists

GENERAL MEMBERSHIP APPLICATIONS

1. The membership year is the calendar year, January 1 through December 31.
2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY: Please follow the chart below when submitting membership application.

   Applications received between:
   Jan.1 and May 31: Full dues payment. Membership expires Dec. 31 of same year.
   June 1 and Sept.30: Half year's dues plus $5 payment. Membership expires Dec. 31 of same year.
   Oct. 1 and Dec. 31: Full dues payment. Membership valid for remainder of current year and next full year.

3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to Membership Chair for approval.
4. AATA Membership and AATA Registration (A.T.R.) each have a separate application procedure. Registration is bestowed only by the Standards Committee.
5. National AATA membership required for Chapter Membership. Please contact AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL - by application only. Such members may vote, hold office, and serve on committees.

- Credentialed Professional Member: Individuals who have been dually approved for Professional Membership and Registration (A.T.R.) by AATA; dues are $95 per year.
- Active Professional Member: Individuals who have completed professional training in art therapy. Dues are $85 per year.

CONTRIBUTING - Individuals, organizations, institutions or foundations which contribute annually to AATA. Such members may vote, hold office or serve on committees. Annual dues are $120.

ASSOCIATE - Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. Such members may not vote, hold office or serve on committees. Annual dues are $85.

STUDENT - Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution indicating full-time status and coursework content. Student members may not vote, hold office but may serve on Student Subcommittee of Membership. Annual dues are $35.

BEST COPY AVAILABLE

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

MEMBERSHIP APPLICATION

•Name______________________________
Last First Middle

•Home Address______________________________

____

•Phone(_____)______________________________

•Business Address______________________________

____

•Business Phone (______)______________________________

•Employer______________________________

•Job Title______________________________

•Licenses Held/State______________________________

•Preferred Mailing Address: _____Home ____Business

•Please indicate under which category you are applying:

- ______**A.T.R. REGISTRATION** (a corresponding application packet will be sent to you)
- ______**$95 A.T.R. MEMBERSHIP** (after approval only)
- ______**PROFESSIONAL MEMBERSHIP** (a corresponding application packet will be sent to you)
- ______**$85 PROFESSIONAL MEMBERSHIP** (after approval only)
- ______**$120 CONTRIBUTING MEMBERSHIP**
- ______**$85 ASSOCIATE MEMBERSHIP**
- ______**$35 STUDENT MEMBERSHIP** (see student membership criterion for necessary documents to accompany this application)

PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO: AATA

American Art Therapy Association
1202 Allanson Road
Mundelein, IL 60060

Please complete this survey:

EDUCATION (highest degree earned)

1________Doctorate Degree
2________Master's Degree
3________Bachelor's Degree
4________Associate/Certificate
5________Other

(Please indicate exact degree earned, e.g., BA, BS, MA MS, PhD, etc.)

WORK SETTING (please check one only)

1___Hospital
2___Clinic
3___Day Treatment Center
4___Rehabilitation
5___Sheltered Workshop
6___Correctional Facility
7___Residential Treatment
8___Outpatient Mental Health
9___School System
10___Elderly Care Facility
11___College/University
12___Clinical Training Program
13___Institute Traning Program
14___Counseling Center
15___Private Practice
16___Other______________

AREA(S) OF SPECIALIZATION (please check up to three)

1___Addictions
2___Adolescents, Hospitalized
3___Adolescents, Psychiatric
4___Adults, Hospitalized
5___Adults, Psychiatric
6___Art History
7___Art Therapy Education
8___Art Therapy in Schools
9___Children, Hospitalized
10___Children, Psychiatric
11___Domestic Violence
12___Eating Disorders
13___Families
14___Gerontology
15___Hospice/Terminally Ill
16___Learning Disability
17___Mental Retardation
18___Neurological Disease
19___Prisoners
20___Post Traumatic Stress
21___Psychotherapy
22___Rehabilitation
23___Research
24___Sexual Abuse
25___Visual Art
26___Other______________

VOLUNTARY INFORMATION

Age

1___20-24
2___25-29
3___30-34
4___35-39
5___40-44
6___45-49
7___50-54
8___55-59
9___60+

Salary Range

1___under $10,000
2___$10-15,000
3___$15-20,000
4___$20-25,000
5___$25-30,000
6___$30-35,000
7___$35-40,000
8___$40-45,000
9___$45-50,000
10___$50,000+

Gender

1___Female
2___Male

Hours Worked per Week

1___0-10
2___10-20
3___20-30
4___30-40

The 1993
American Art Therapy Association, Inc.
Membership Directory
is now available

Members: US$13.00 Non-Members: US$55.00
Please add postage and handling:
U.S. Orders: $2.90
Canada and Mexico: $3.25
Foreign: $10.00

Orders may be placed in writing, with appropriate payment enclosed, to:

The American Art Therapy Association, Inc.
1202 Allanson Road / Mundelein, IL 60060

ARTherapy
JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

ART THERAPY is published quarterly by the American Art Therapy Association. Members of AATA receive the journal as a membership benefit. Non-members may subscribe at the following annual rates: Individuals $40 (US); $64 (Foreign). Institutions: $57 (US); $80 (Foreign). A discount of 10% is available for 10 copy minimum orders. Single copies are available at $10 member; $18 non-member. Printed in the U.S.

Make checks payable to AATA and return with application to:
American Art Therapy Association, 1202 Allanson Road, Mundelein, IL 60060

Please enter my subscription for 1993. Enclosed is my check, payable to AATA.
Name ______________________________
Address ______________________________
City ____________________ State __________ ZIP __________

"Each issue of **The Arts in Psychotherapy** *is a seasonal enlightenment indispensable for the many who want to stay up to date on the professional and theoretical aspects of the creative arts therapies."*
– Rudolf Arnheim, Ph.D., Professor Emeritus of the Psychology of Art, Harvard University

THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

Editor-in-Chief: Robert J. Landy, Ph.D., Director, Drama Therapy Program, New York University, New York, NY
European Editor: David Aldridge, Ph.D., Music Therapy, Universitat Witten, Herdecke, Germany
Managing Editor: Sylvia M. Halpern, 20 Ridgecrest East Scarsdale, NY 10583

Highly acclaimed in the field, **THE ARTS IN PSYCHOTHERAPY** presents innovative research in artistic inquiry and expression, and its use in the treatment of mental disorders.

THE ARTS IN PSYCHOTHERAPY is an international journal for professionals in the fields of mental health and education. The Journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines.

In an effort to expand the Journal's focus to include more international articles, the new Editor-in-Chief, Robert J. Landy, has appointed a European Editor, David Aldridge, and has also updated the Editorial Boards. These changes will allow the Journal to offer even more diverse coverage while opening up a dialogue among creative arts therapists all over the world.

The Editors welcome original manuscripts. Submit papers in triplicate to: Sylvia Halpern, Managing Editor, 20 Ridgecrest East, Scarsdale, NY 10583.

Submissions from Europe should be sent in triplicate to: David Aldridge, Ph.D., Music Therapy, Universitat Witten, Beckweg 4, D5804 Herdecke, Germany

SUBSCRIPTION INFORMATION
ISSN 0197-4556 Vol. 20, 1993
Published 5 issues per annum
Institutional Rate (1993) *£140.00/US$224.00
Professional Rate (1993) *£37.00/US$59.00

*Sterling prices quoted are definitive and apply worldwide. US dollar prices are quoted for convenience only and are subject to exchange rate fluctuation. Prices include postage and insurance.

Members of qualifying societies can receive a discount on personal subscriptions. Please write for further information.

FREE SAMPLE COPY AVAILABLE UPON REQUEST!

PERGAMON PRESS
USA: 660 White Plains Road, Tarrytown, NY 10591-5153 **UK:** Headington Hill Hall, Oxford, OX3 0BW, England
A member of the Elsevier Science Publishing Group

BEST COPY AVAILABLE

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 10, NUMBER 3, 1993

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Advertising: Please see advertising rates listed elsewhere in this journal or contact the American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 (708) 949-6064. The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

ISBN 1-882147-19-7

Editor

Cathy A. Malchiodi, MA, A.T.R.
California State University, Sacramento, CA

Associate Editor

Patricia St. John, EdD, A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor

Elizabeth Ratcliffe, MS, MFCC, A.T.R.
College of Notre Dame, Belmont, CA

Film/Video Review Editor

James Consoli, MA, A.T.R., NCC
Eastern Virginia Medical School, Norfolk, VA

Production Editor

Christine Fryer

Editorial Board

Pat B. Allen, PhD, A.T.R.
River Forest, IL
Frances E. Anderson, EdD, A.T.R., HLM
Illinois State University, Normal, IL
Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec
Michael Campanelli, EdD, A.T.R.
Edith Cowan University, Perth, Australia
Susan E. Cheyne-King, MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R.
The George Washington University, Washington, DC
Julie Epperson, MA, A.T.R.
Salt Lake City, UT
Janice Havlena, MA, A.T.R.
UNM Children's Psychiatric Hospital, Albuquerque, NM
Maxine Borowsky Junge, PhD, LCSW, A.T.R.
Loyola Marymount University, Los Angeles, CA
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Paolo Knill, PhD, A.T.R., CMT-BC
Lesley College, Cambridge, MA
Vija B. Lusebrink, PhD, A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, EdD, A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Trudy Martin Manning, MS, A.T.R.
Eastern Virginia Medical School, Norfolk, VA
Shirley Riley, MA, MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Marcia L. Rosal, PhD, A.T.R.
University of Louisville, Louisville, KY
Susan Evans Spaniol, EdD, A.T.R.
Lesley College, Cambridge, MA
Betty Jo Troeger, PhD, A.T.R.
Florida State University, Tallahassee, FL
Evelyn Virshup, PhD, A.T.R.
California State University, Los Angeles, CA
Robert Wolf, MPS, A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President

Robin Goodman, PhD, A.T.R.

AATA Executive Director

Edward J. Stygar, Jr.

BEST COPY AVAILABLE

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Editorial

Introduction to Special Issue on Art Therapy and Professionalism: Is There a Crisis in Art Therapy Education?
Cathy A. Malchiodi, MA, A.T.R. 122

Commentaries 129

Articles

Ethical Considerations in a Supervisory Relationship: A Synthesis
Jeanne Carrigan, OSF, PhD, A.T.R. 130

The History of Art Therapy Licensure in New Mexico
Deborah A. Good, MA, A.T.R. 136

The Art Therapist as Exhibiting Artist: Messages from Joseph Beuys, Suzi Gablik, and Donald Kuspit
Mildren Lachman-Chapin, MEd, A.T.R. 141

The Art Therapist as Social Activist: Reflections and Visions
Maxine Borowsky Junge, PhD, LCSW, A.T.R., Janise Finn Alvarez, MA, A.T.R., Anne Kellogg, MA, A.T.R., and Christine Volker, MA, MFCT 148

Brief Reports

Art Therapy Faculty Survey
Vija B. Lusebrink, PhD, A.T.R. 156

Age and Gender Differences Expressed Through Drawings: A Study of Attitudes Toward Self and Others
Rawley Silver, EdD, A.T.R., HLM. 159

Viewpoints

Art Therapy in Private Practice: Legal and Insurance Issues
Gail Wirtz, MAT, MPS, A.T.R. 169

Full Circle
Mury Rabin, PhD, A.T.R. 171

Reviews

Essentials of Art Therapy Training and Practice
Matthew Bernier, MCAT, A.T.R., and Trudy Manning, MS, A.T.R. 173

Therapy? Unmasking the Fears, Shattering the Myths, Finding the Path to Wellness
Betty D. Jones, MA 175

A Child's Story: Recovering Through Creativity
Two Reviews: Margaret L. Smart, MSW, LCSW, A.T.R. and P. Gussie Klorer, MA, A.T.R. 176

Response to Book Review
Bruce Moon, MACE, MDiv, A.T.R. 179

Noteworthy 180

About the Cover: "The Artist's Studio," 25" × 31", watercolor, by Cay Drachnik, MA, A.T.R., MFCC, HLM, past President of the American Art Therapy Association. "This represents my return, after 20 years of practicing art therapy, to my first love—painting. What better way to symbolize this than to paint the clutter of my studio!"

ART SAVES LIVES
ART THERAPY PROGRAM
C.S.U. SACRAMENTO 1993

VOLUME 10 NUMBER 3, 1993

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 122-128 © AATA, Inc. 1993

Editorial

Introduction to Special Issue on Art Therapy and Professionalism: Is There a Crisis in Art Therapy Education?

Cathy A. Malchiodi, MA, A.T.R., *Editor*

This issue of *Art Therapy* focuses on the broad topic of professionalism in the field of art therapy. Many topics in our discipline are connected with professionalism; in this issue of the journal several important ones are addressed, including licensure of art therapists (Good), ethical aspects of supervision (Carrigan), malpractice insurance (Wirtz), and our identities as art therapists (Lachman-Chapin; Junge, Finn Alvarez, Volker, & Kellogg; Rabin).

As major players in the evolution of the theory and practice of art therapy, art therapy educators have an important influence on professionalism, both as teachers and as role models. However, it appears that art therapy education may be floundering in its ability to address certain professional aspects of the field. An article in the Spring edition of the *AATA Newsletter* (Riley, 1993) reported that a small group of art therapy educators met to discuss issues critical to the development and survival of graduate level art therapy training, identifying several areas that they felt needed some immediate attention for the overall health of the profession. These areas included networking, sharing professional skills, and decreasing isolation among art therapy educators; supervision and development of supervisory guidelines for art therapists; examining the current process of approval of art therapy training programs; reviewing and updating the content of art therapy education; and the impact of recent closures of approved art therapy training programs.

It is fair to say that these are anxious times for art therapy educators and art therapy education. This past year, three AATA-approved programs have closed their doors to new applicants (Wright State University, Dayton, OH; State University College at Buffalo, NY; and the University of Utah, Salt Lake City, UT), with others threatened, but stabilized (see discussion of California State University Sacramento, later in this editorial); still others may be in jeopardy over the next few years. One general observation that has been linked to program closures is the sluggish economy, and the fact that limited tax dollars have had a direct effect on the ability of state-supported programs to survive. Although tax dollars do have an effect on both the quality and quantity of education funded through the public domain, it would be simplistic to say that this is the only problem that affects art therapy education or program closures. We need to acknowledge that there may be intrinsic weaknesses in art therapy education that put it at particular risk.

In the course of writing this editorial, I polled various art therapy educators across the United States to get their input on what they considered problematic in art therapy education. Although this polling was not very "scientific," many similar observations were expressed; from these observations, the following topics emerged as prominent contributors to the overall problems in art therapy education.

Art Therapy: Modality or Field?

The age-old question of whether art therapy is actually a bona fide discipline or merely a modality still lingers. Is art therapy a separate discipline (albeit a hybrid), or is it a modality such as various frameworks of psychology (cognitive, rational-emotive, Jungian, etc.)? When Janie Rhyne, PhD, A.T.R., HLM, entertained this thought several years ago (1989), more than a few art therapists were upset:

> I've said this to lots of top-notch art therapists and you might as well know it, too: we don't even know that art therapy is a separate field or will it last as a separate field. Quite a few of us are doing other things more than we're doing art therapy. Should it be a separate field? I'm one of the ones who think it probably should not be. Gradually we'll become a part of other fields: psychologists and social workers who use art therapy. (1989, p. 12)

Rhyne's observations raise fundamental issues about our field. If art therapy is truly a modality rather than a distinct discipline as she says, then it is dubious that it will be able to survive within colleges and universities unless it is incorporated within other fields of study. Rhyne supports her premise with the fact that many who have studied art therapy with the intent to practice it, often end up doing things other than art therapy (casework, verbal therapy, etc.). This may become more of a truism as increasingly large numbers of art therapists become licensed under job titles such as counselor, marriage and family therapist, or psychologist.

Our body of art therapy literature may also be a contributing factor in whether or not we are considered to be a bona fide discipline. Although we have a great deal more literature on art therapy than we did 10 to 15 years ago, the available literature that has been generated often lacks rigor or relies heavily on the foundations of other fields. In this sense, the articulation of art therapy as a separate discipline has not yet been fully accomplished.

Additionally, as one educator observed, we are still not able to explain exactly what it is that we do in a way that is convincing to other professionals. For this reason, we often lack credibility among professionals in related fields such as psychology, art education, visual art, etc., largely because we have not succeeded in defining ourselves. We are also utilizing models of theory and practice that have not been informed by ongoing developments in other disciplines. Our inflexibility or unwillingness to incorporate new paradigms into instruction severely compromises our own vitality as a profession. Art therapy education's ability to adjust curricula to the times will likely play a major role in whether art therapy departments are retained in academic environments in the future.

The Role of Visual Art in Art Therapy

Mildred Lachman-Chapin states in her article in this journal issue that "we . . . as art therapists are seen as lesser or not quite real artists. . . . Perhaps this reflects the art world's rejecting response to artist-as-healer." Art therapy has struggled for recognition by the visual arts; training programs housed in art departments at universities or art schools have most acutely felt this strain. Often, art therapy is seen by studio art faculty as not quite art, and is even looked upon with outright disdain by the art world in general.

Some of this disdain comes from the fact that the basic philosophy of art therapy does not generally encourage individuals with whom we work to make art in the true sense of the word. What is created during an average art therapy session is generally rudimentary visual expression; according to Allen (1992), such "art may reflect the impoverishment of the environment which is ill equipped to sustain the production of more realized work" (p. 22). It is easy to see why studio artists find art therapy difficult to understand, and fail to grasp why it is called "art" therapy at all.

Additionally, the role of visual art in art therapy training still haunts our profession. Some years ago, the AATA decided to forego requesting that applicants for the A.T.R. submit a slide portfolio of visual art. Although it was obviously difficult to judge art portfolios as part of the registration process, the decision not to request them was symbolic of our trend to minimize the value of visual art skills and training as professional requirements. The *Guidelines for Academic, Institute and Clinical Art Therapy Training* (AATA, 1993) also clearly spell out that studio art courses at the graduate level are not acceptable. As state licensure becomes a requirement to practice therapy in some states, training programs often adapt curricula to meet these guidelines; any remaining art courses are generally the first things to go to make way for the clinical courses needed for eventual licensure. Granted, this is an economic reality and a difficult decision that a training program must make for its students; however, such decisions are often made in tandem with the exclusion of art from the core curriculum.

The Purpose of Art Therapy Education

Determining the purpose or goal of art therapy education consistently plagues art therapy educators. What is it exactly that we are educating students for in the workplace? Is it to work in a traditional mental health setting such as a hospital? Is it to do inpatient or outpatient work, or both? Are we educating students for adjunctive or for primary roles as mental health professionals? Are we educating artists who use art in therapy? Are we educating psychotherapists to use art as a modality? Art therapy educators are constantly confronted with addressing these and other questions in their teaching and curriculum development. Then, there is the really scarey question that art therapy educators have to face—Are there really any art therapy jobs out there for graduating students? Telling students that they have to be creative and develop their own positions may still hold true, but it is getting repetitive to rely on this old saw. As programs in higher education, particularly at the graduate level, become more accountable for the placement of their graduates in jobs, art therapy educators may have to deal directly with exactly how they are educating their students to find viable employment after graduation.

In terms of employment outcome, licensure has had a dramatic inpact on education, particularly in states where licensure is a necessity to practice privately, to make a livable wage, or to obtain or retain a position in a mental health facility. In states where licensure in a related mental health field is available, training programs perform a dual task: educating an individual to be an art therapist while preparing him/her for licensure as a counselor or marriage and family therapist. Although this is a practicality for many art therapy training programs, it does impact the field by placing a significant amount of attention on related coursework other than pure art therapy. Add to this the necessary infusion of the diverse requirements of the AATA guidelines for training (1993), such as research, multicultural issues, and the like, and the task of designing effective art therapy curricula seems daunting at best.

Art Therapy Educators: A Strength or a Weakness?

Art therapy educators are, in essence, an elite group; when compared to other professional groups, they are extremely small in number. This has had an impact on art therapy education in a variety of ways, some of which are problematic. First, although there are very few job openings at any given time in higher education for art therapy educators, often there are also very few applicants from which to choose. In comparison to an opening for an assistant professor in visual art or psychology which, depending on the college or university, may draw hundreds of qualified applicants, art therapy training programs in need of an instructor may attract less than 20 applicants, many of whom are not qualified for the position because they lack the appropriate degree, registration, or previous experience. Although the applicant pool may contain several good candidates with solid records in teaching and/or administration, the pool is nonetheless limited in scope and dimension.

When a job offer is made to a good candidate, the candidate may not take the position for one of several reasons. First, the position may offer no advantage over the teaching/administrative assignment that s/he already has. Also, gender becomes an issue as most art therapy educators (and art therapists) are female; it is still the norm in our society that a male is more likely to relocate himself and his family for a career change than a female. A single female without children may make the move, but a married female or a single parent with concerns about moving children may not be as adaptable to relocation. Many programs, therefore, end up hiring a local individual who minimally fills job requirements such as a Master's degree and an A.T.R. This person is often entry level, with little teaching experience and has little or no experience in the overall development or knowledge of the field. Also, the individual may not really have the optimal qualifications for the position nor the depth necessary to perform the wide continuum of tasks (academic advising, administration, research, clinical supervision, as well as teaching) required to keep the program viable over the long haul.

In some cases, it is more important that the potential applicant for an art therapy educator position have a clinical license in the state where the position exists. In the final analysis, a lack of licensure can override the other aspects of an applicant's resumé, as stellar as it may be in terms of past teaching records, presentations, research, or scholarly publications. Although it may be vital to the institution and the program's existence to hire someone with the required state licensure, this practice does bring up the question of how such hiring affects the vitality of the field of art therapy. Because of such practice, the candidate with the most commitment to art therapy—an individual who has chosen to follow a path involving commitment to the development and practice of art therapy rather than pursuing a license or related clinical track—may not be hired.

Lastly, the type of terminal degree an applicant holds may affect possible hiring. Doctoral degrees are often required if the academic position also involves administration. With very few traditional academic settings offering doctoral studies in art therapy, many individuals choose a nontraditional or external degree program to obtain a doctorate degree. These programs allow for in-depth study of a field of interest not available at most colleges and universities; thus, an individual can pursue advanced study specifically in art therapy. However, as several educators observed, some colleges and universities may be unwilling to hire someone with an external degree. One educator noted that in one instance an art therapy educator was denied tenure because her doctorate was from a nontraditional training program.

The Superwoman/man as Art Therapy Educator

There is another phenomenon intrinsic to the art therapy educator that can be potentially problematic. It seems that in order to be an art therapy educator and/or program director, one must literally have superhuman skills and capabilities. Within art therapy educational programs, there are many of these superhumans who singlehandedly carry out all the necessary functions of the training program: teach, advise, administrate, supervise both clinical internships and research, and do much of their own secretarial work.

Frances Anderson, EdD, A.T.R., HLM, shared the following "job description" with colleagues at the 1990 Art Therapy Educators Convocation:

> **Wanted:** Art therapy educator to direct art therapy program. Responsibilities include, but are not limited to: Administration of graduate program, fundraising including grants and scholarships and financial aid for students, directing master's theses, teaching four art therapy courses per semester, practicum site development and supervision. As director you will serve on all major department and university-wide committees and author the upcoming National Association of Schools of Art and Design 7-year self-study document and the AATA Education and Training Program Approval document. Applicant qualifications include: doctorate in art therapy or closely related field; A.T.R. status; 7 years clinical work, including work with special populations, geriatrics, and clients with eating disorders, chemical dependence, physical and sexual abuse; 5 years administrative experience; publications sufficient to qualify for university graduate faculty status; and an exhibition record as an artist. Also needed is more energy than a speeding locomotive, ability to leap tall buildings with a single bound, ability to repel bullets and colleagues' slings and arrows, x-ray vision, mind reading capacity for dealing with academic administration and students, ability to walk on water, live with no sleep, write like Shakespeare, paint like Picasso, the luck to land grants and pick winning lottery numbers, the political acumen of a Boss Tweed or Richard Daley, the diplomatic skills of a Henry Kissinger. It would also help if the applicant is independently wealthy as we have no resources for student help, secretary or travel, etc. Applicants with no family responsibilities are encouraged to apply (there will be no time for family on this job). This is a 12-month appointment. Salary: $12,000 per year. Timbuckto University is located in the beautiful countryside in the far outskirts of Civilization City, the state's cultural center, which is 2 hours away by airplane or 2 days by mule. (Anderson, 1990)

This description is both simultaneously funny and sad; it is funny because no one person could do all the aspects mentioned and sad because there are many art therapy educators who actually do almost all the things Anderson noted. Most art therapy educators are continuously exhausted by an overwhelming gamut of responsibilities that go beyond mere teaching. In addition to instruction, they are heavily committed to outside activities which support the profession: serving on the AATA Board or Committees, serving on Boards of Affiliate Chapters, participating in governmental affairs in their state, giving in-service presentations to publicize the field, etc. These activities are in addition to the expected clinical work, community service, university service (sitting on various institutional committees, department committees, and ad hoc committees), publication, research, and, in some cases, exhibition of visual art.

The problem with superwoman/man art therapy educators is that many have not been able to keep up the frenetic pace, forcing some to opt for different paths after experiencing academia for a few years. Art therapy education suffers when this happens, because of the potential loss of individuals whose academic work allowed them to contribute to the development of the field through research or writing. Also, Wadeson (1989) noted that some academics leave art therapy education for higher pay, in addition to the burnout experienced on the job.

Programs in Jeopardy: Some Observations

At the start of this editorial, the closure of three AATA-approved, state university programs was mentioned. A fourth program, California State University Sacramento (CSUS), was jeopardized by a series of events earlier this year. The program faced being phased out due to budgetary restraints within the California system of higher education.

Art therapy training programs in state universities have, in some ways, been considered the profession's flagships. The awarding of graduate degrees in art therapy from state institutions has given the profession a degree of equality with related mental health professions, such as psychology, counseling, and social work, all of which have graduate programs at public universities in most states. Art therapy training programs in state universities have access to more facilities, large libraries, and data bases, and the interactive atmosphere of a diverse academic environment. These advantages can contribute to the learning experiences of students who greatly benefit from the variety and depth of training. The lower tuition also has afforded individuals with limited resources the opportunity to obtain art therapy training at a significantly lower cost; this has been extremely important to single women, single parents, and nontraditional students who may be older and/or have limited financial resources. For these reasons, the closure of state-supported training opportunities hurts the entire field of art therapy, beyond the community and state in which the program was housed.

Before its threatened closure, CSUS's program has had, as many art therapy training programs, a bumpy history. In the 70s, the program was directed by the late Dr. Donald Uhlin, A.T.R., and was housed in the school's Art Department; later, after a series of events, it was placed in the Department of Counselor Education where, until recently, it was directed by Nina Denninger, MA, A.T.R. Denninger further developed the Master's degree program in art therapy at CSUS to enable students to become both registered art therapists and licensed marriage and family therapists in California.

During the 1992–1993 academic year, CSUS's program became vulnerable to the budgetary problems that have plagued the State of California for the last several years. Higher education was placed in particular jeopardy because public education was greatly subsidized by tax dollars. Cuts were recommended at all state institutions of higher education, pending passage of the state budget. In order to meet these cuts, the Department of Counselor Education and the School of Education (in which Counselor Education is housed) recommended that the Art Therapy program be phased out. The main reason given for phaseout was that art therapy did not meet the mission statement of the School of Education. The general mission of the School of Education was to serve school-age children in the public school system and to educate students to work within that system. Although most art therapy graduates from CSUS went on to work primarily with children, the School of Education felt that funds should go first to teacher education rather than art therapy education.

In response, students, faculty, and art therapists in the immediate community and Northern California embarked on a letter-writing campaign; additional help was requested from the AATA and other art therapy educators to provide support. A group of art therapists, faculty, and students went to the state legislature to meet with a prominent legislator who also sent letters to the university administration on behalf of art therapy.

However, the students at CSUS took the process one important step further; they became visible to the rest of the university and to the community in a proactive way. They analyzed the system (e.g., the School of Education and the university) that had told them their program could be phased out and they established a series of strategies to deal with it. They set up booths at both the university and at the state capital to publicize the threat to the art therapy program and to disseminate information on the field; they formulated petitions to solicit signatures in support of the program's retention; they created a media campaign that included talking to local television and radio stations and creating T-shirts (see Figure 1). The students also set up meetings with administrators within the university to express their concerns, ask questions, and become visible. These efforts, created in a very short amount of time, had a substantial effect on the system that sought to phase out their program of study. As a result, the program has been given a reprieve, with attention to moving it to a different department which can financially support it.

One could attribute the situation at CSUS to the budget crisis in California, but that does not explain all the issues involved. The program is robust, having approximately 45 students, and has established a solid reputation in the community. It has an excellent track record for service to the Sacramento area and provides thousands of children, adults, and families with no-cost art therapy services each year. When the phaseout was announced, CSUS was in the middle of review by the AATA Education and Training Board for approval of its training program, a process which was supported by the Department of Counselor Education and the School of Education. It also has the only combined art therapy/marriage and family degree in the state system, making it afford-

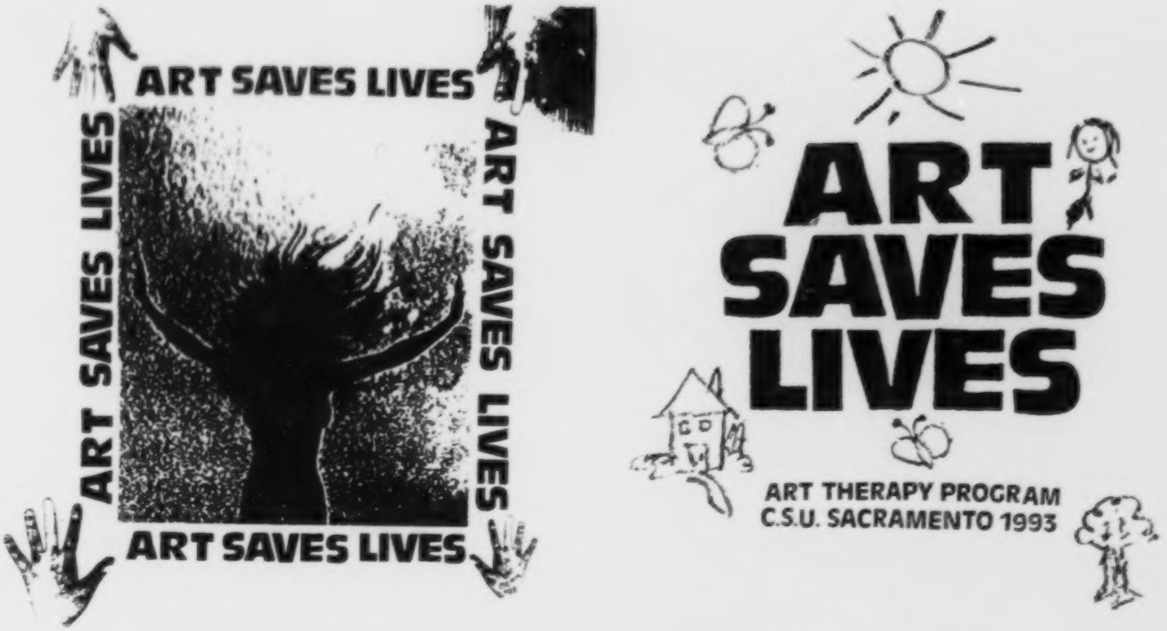


Figure 1: T-shirt designs by CSUS graduate student, Lynne Okun, with help from Jennifer Robins.

able to women and minorities who might not otherwise be able to undertake such training in a private setting. Additionally, there were other programs in the School of Education which have smaller enrollments and have much less impact on the community than does the art therapy program. Yet, the art therapy program became threatened despite its robustness and its contributions to the immediate community and the state system. Such a situation is indicative of the possibility for any art therapy training program to become threatened at any time.

Conclusion

In this issue of the journal, Junge, Volker, Kellogg and Finn Alvarez call for art therapists to become social activists, with clients and in life. In this spirit, what the students at CSUS, art therapy professionals, and others in the community did concerning the threat to their training program could have far-reaching implications for other programs and for art therapy education in general. Of utmost importance is how the Sacramento students actively handled their situation; they did not roll over and play dead. They formed a network, analyzed the situation, established a plan of action, and pursued it. Most of all, they handled difficult circumstances with a great deal of creativity as well as professionalism.

Like the students at CSUS, we are going through a time in our collective history as a profession and association when we need to reexamine how we can work together. Art therapy educators especially need to consider how to do this, since they are, in many ways, the glue that holds the field together. Unfortunately, this is also a time when art therapy educators are feeling overwhelmed not only by their institutions, but also by our own ranks; many educators are feeling isolated in their schools, unsupported by other educators, and uneasy with the current process of approval by the Education and Training Board (ETB). If we do not honestly confront and deal with these feelings, we most certainly will self-destruct at our own hands before any budgetary or other societal influences reach us.

It is important to remember that when a training program folds, it affects not only the immediate community where the program existed, but the entire professional community of art therapists. When state university programs fold, the problem is critical because these programs are affordable and can support those students who could not otherwise afford to undertake the expense of art therapy education in a private college. Also state programs often can support art therapy research, which directly influences, nurtures, and hastens the development of our field. It is also likely that the first successful bid at art therapy licensure (see article by Good in this issue) was partly due to the dynamics of having a program of study at the major public university in that state.

Many of the topics discussed in this editorial are not new to the field, but they are important to both art therapy educators and art therapists if art therapy is to survive in the coming years. In the light of what is happening both in higher education and society in general, it is important to revisit these issues and to reconsider their effect on the overall health of the field of art therapy.

This editorial is dedicated to the graduate students in the Art Therapy/Marriage and Family Counseling Master's Degree program at CSUS who demonstrated a great deal of intelligence, integrity, courage, and professionalism in response to a difficult situation.

References

Allen, P. (1992). Artist-in-residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association*, 9(1), 22–29.

American Art Therapy Association, Inc. (1993). *Guidelines for academic, institute and clinical art therapy training.* Mundelein, IL: Author.

Anderson, F. (1990). *Qualifications for art therapy educators.* Unpublished manuscript presented at the International Convocation of Art Therapy Educators, University of New Mexico, Albuquerque, NM, on March 11, 1990.

Jordan, H. (1989). An interview with Janie Rhyne. *American Journal of Art Therapy*, 28, 5–12.

Riley, S. (1993). Attention art therapy educators, students and supervisors. *American Art Therapy Association Newsletter*, 26(2), 20.

Wadeson, H. (1989). Art therapy education at the crossroads. *Art Therapy: Journal of the American Art Therapy Association*, 6(3), 103–105.

4th Annual Southwest Regional Conference on Abuse and Dissociative Disorders

Pre-Conference Institute – September 30, 1993
Conference – October 1-3, 1993

Keynote and Pre-Conference Speakers Include:

Christine Courtois, Ph.D.
Eliana Gil, Ph.D.
Judith Peterson, Ph.D.
Roberta Sachs, Ph.D.

Held at the Sheraton Hotel, Tyler, TX

For more information or to receive registration forms, please contact Kay Earhart, Family Violence & Sexual Assault Institute, 1310 Clinic Drive, Tyler, TX 75701 (903) 595-6600 or Fax (903) 595-6799.

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 129 © AATA, Inc. 1993

Commentaries

Letter to Editor

Dear Ms. Malchiodi:

After reading the recent review by Vija Lusebrink of Shaun McNiff's *Art as Medicine*, I wondered if she and I had read the same book. The image of a waspish schoolmarm, lips pursed, ruler at the ready, formed in my mind while reading the first page-and-a-half of the review. I plowed through the workmanlike dissection of what I had found to be a text of rather passionate scholarship, full of literary and philosophical allusions which enlarge the context of art therapy.

On page three, the ruler comes down. Dr. Lusebrink complains about McNiff's unattributed characterization of art therapists as "interpreters and diagnostic labelers" as she labels him ego-inflated and archetype-identified, "in a number of instances," none named. Far more damning and personal criticisms, these. She unwittingly supports his point by continually labeling him a Jungian, a claim he never makes, for using the method of dialoguing with an image, a method that predates Jung by many centuries. Barbara Hannah, in *Encounters with the Soul: Active Imagination as Developed by C. G. Jung* (1981), tells us that this method has been in use since the dawn of history. The oldest example she cites is of Egyptian origin, a 4,000-year-old text whose title translates as "The world-weary man and his soul."

Not content to complain about art therapists supposedly getting short shrift from McNiff, Dr. Lusebrink complains on behalf of James Hillman. Judging from Hillman's comments printed on the book jacket, he read a prepublication copy of the manuscript and could have raised concerns himself, if he had any. In any event, Hillman didn't create the concept of "daimons" any more than Jung created active imagination.

In getting mired in measuring imaginary violations of intellectual property rights, Dr. Lusebrink has taken, in my opinion, a decidedly low road. I would like to focus on the fact that *Art as Medicine* is a lively and inspirational work illustrated with rich paintings that, even in black and white reproductions, show that at least one art therapist remains committed to his art. Additionally, this book, issued in trade paperback and distributed worldwide, appears on the shelves of more bookstores than any other recent art therapy publication.

One of Margaret Naumburg's last and unfortunately unrealized wishes was to write a book about art therapy that would bring its ideas into the mainstream. Shaun McNiff has accomplished this and I think we ought to be grateful. The exposure of this book benefits all art therapists.

I must take issue with another point regarding the art studio approach. Dr. Lusebrink claims that:

> Application of McNiff's approach appears to be most appropriate to a clientele similar to himself—intelligent, functional individuals who have the personal means to attend international self-exploratory workshops. This approach is less useful to art therapists who work with individuals who have serious impairments and psychopathology, given constraints of time and reimbursement through insurance.

In my experience I have found that one thing the art studio approach has taught me unequivocally is that **all** people are "like myself," regardless of their income, I.Q., or social status. When I make art alongside another person, it is our common humanity that is revealed. It is when we sit apart from and judge that our eyes focus on psychopathology or other categories of difference.

In recent years, my students, inspired by McNiff's ideas among others, have created art studio programs in the most unlikely places. Deborah Gadiel's open studio work with poor Hispanic outpatient clients continues; Denise Colletti, a 1993 grad of the School of the Art Institute, carried out collaborative studio work with chronic schizophrenics in a sterile state hospital. Carol Kiendel-Ringer, also a 1993 grad, created a studio program with inner city adolescents in a day hospital under terrible conditions. These students have consistently taken the powerful idea of art making beyond my wildest dreams. In every case it has been students whose own art making is central to themselves who have been able to move beyond what most would see as insurmountable roadblocks and creatively see and effect new and exciting solutions to problems inherent in the practice of art therapy.

The waspish schoolmarm is an archetype that lurks within each of us, especially tender perhaps in those concerned about establishing the validity of the clinical approach to art therapy, those fearful of wholly trusting the art. McNiff, who seems to have worked out an enviable balance in his life as global ambassador of art therapy, prolific writer, and accomplished painter, may easily evoke the scold in art therapists who perceive their livelihood eroding day by day. To those art therapists I would suggest putting down the ruler and taking up the paintbrush, even if only for a few moments a day. It is in the exercise of our creativity, which is after all our spiritual force, that answers can be found, even to seemingly pragmatic questions. There is nowhere more than within our own profession that art as medicine is desperately needed.

Sincerely,
Pat B. Allen, PhD, A.T.R.

Editor's note: Another response to Dr. Lusebrink's review of *Art as Medicine* appears in the Book Review section of this issue.

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 130-135 © AATA, Inc. 1993

Ethical Considerations in a Supervisory Relationship: A Synthesis

Jeanne Carrigan, OSF, PhD, A.T.R., Tucson, AZ

Abstract

Some of the most prominent ethical concerns presently being reviewed by psychologists, counselors, and other helping professionals focus on issues related to supervision and training of interns in clinical professions (American Association for Counseling and Development, 1991; Kitchener, 1988; Stadler & Paul, 1986). This movement stems from the increasing number of formal complaints interns have filed with their respective professional organizations (Slovenko, 1980). These claims range from sexual harassment to supervisors acting in dual or multiple roles with interns. The art therapy profession has not been exempt from such complaints. During the past years, the Committee on Ethical and Professional Practices has dealt with similar supervision-related issues.

The purpose of this paper is to examine the nature of the supervisory relationship and the roles of each participating member as they are discussed by theorists from other mental health professions. It is hoped that the following ideas will be of interest and assistance to both interns and supervisors.

Introduction

Some of the most prominent ethical concerns presently being reviewed by psychologists, counselors, and other helping professionals focus on issues related to supervision and training of interns in clinical professions (Kitchener, 1988; Stadler & Paul, 1986). This paper will attempt to synthesize important elements of the supervisory relationship as described in studies and codes of professional conduct from: the American Association for Counseling and Development (AACD), the American Psychological Association (APA), the American Association for Marriage and Family Therapy (AAMFT), and the National Association of Social Workers (NASW).

Increasing interest in the supervisory relationship stems from the growing number of formal complaints filed by interns with their respective professional organizations (Slovenko, 1980). These claims range from sexual harassment to supervisors acting in dual or multiple roles with interns. The art therapy profession has not been exempt from such complaints. During the past years the Committee on Ethical and Professional Practice has dealt with similar supervision-related issues.

These issues are not to be confused with the violation of an educational institution's code of academic integrity. Matters concerning grades, academic performance, cheating, and/or the quality or content of lectures are concerns that can be addressed directly to the professor teaching the class, to the department head of the academic unit, or to a higher administrative body by means of a formal grievance. The ethical conduct examined in this paper does not necessarily occur in the classroom, but rather lies within relationships formed between interns and supervisors.

The purpose of this paper is to examine the nature of the supervisory relationship, and the roles of each participating member as they are discussed by theorists from other mental health professions. It is hoped that the following ideas will be of interest to members of the American Art Therapy Association as well as be of assistance to both interns and supervisors during the difficult time of internship.

The Nature of the Relationship

The supervisory relationship is best described as complex (Whiston & Emerson, 1989). It is ". . . an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facili-

1486

tate the development of therapeutic competence in the other person" (Loganbill, Hardy & Delwork, 1982, p. 14). Although it is therapy-like in character, clinical supervision must remain focused on the professional growth of the interns and not become involved in providing counseling to them (Corey, Corey, & Callanan, 1987; NASW, Standard III-9, 1980; AAMFT, Standard 6.3, 1985; APA, Principle 7-C, 1992; AACD, Section B-11, 1981; Kurpius, Gibson, Lewis, & Corbet, 1991). At first, the novice supervisor may believe this is a reasonable expectation, but soon discovers how difficult it is to keep counseling out of supervision. In fact, some theorists believe that this kind of separation is impossible (Ryder & Hepworth, 1990).

Why are Clinical Supervisors Tempted to Counsel Their Interns?

In part, the answer may lie within the very nature of the relationship, for it is both a personal and an intensive experience. It requires an in-depth level of communication between both parties at frequent intervals, resembling counseling sessions (Sherry, 1991). To further confuse matters, many supervisors are therapists, and that is what they do best. Some supervisors simply want to counsel and believe it is their role as a supervisor to do so, while others turn to counseling because they need to "fall back on training as a counselor" due to their lack of training in supervisory methods (Whiston & Emerson, 1989). Also, interns may unknowingly elicit counseling by presenting unresolved personal problems while being supervised, thus introducing the opportunity for a supervisor's therapeutic intervention.

What do Professional Codes of Ethics Recommend Concerning the Supervisory Relationship?

The following excerpts are taken directly from the professional codes of ethics of four associations (AACD, APA, AAMFT, and NASW). These excerpts provide guidelines concerning the professional conduct of association members while in a supervisory role.

The American Association of Counseling and Development—"When the member has other relationships, particularly of an administrative, supervisory, and/or evaluative nature, with an individual seeking counseling services, the member must not serve as the counselor but should refer the individual to another professional" (AACD, B-11, 1981).

The American Psychological Association—"Psychologists who employ or supervise other professionals or professionals in training accept the obligation to facilitate the further professional development of these individuals. They provide appropriate working conditions, timely evaluations, constructive consultation, and experience opportunities" (APA, 7-C, 1992).

"Psychologists do not exploit their professional relationships with clients, supervisees, students, employees or research participants, sexually or otherwise" (APA, 7-D, 1992).

The American Association for Marriage and Family Therapy—"Family therapists who provide supervision assume responsibility for defining the relationship as 'supervisor-supervisee' and for clearly defining and separating supervising and therapeutic roles and relationships" (AAMFT, 6-3, 1985).

The National Association of Social Workers—"The social worker who serves as an employer, supervisor, or mentor to colleagues should make orderly and explicit arrangements regarding the conditions of their continuing professional relationship" (NASW, III-9, 1980).

Why is Counseling Interns Not Recommended by Most Codes of Ethical Conduct?

First, supervision is an unequal relationship in which interns have little freedom to make choices. It is a relationship in which one member has all the status, power, and expertise, while the other member has little or none (Stolenberg & Delworth, 1987). Difficulty arises from this imbalance of power. Upchurch (1985) cautions supervisors to beware of potential enticements such as: the misuse of power and authority; the creation of a relationship where the trainee becomes overdependent; the possibility of negative transference and countertransference; and the development of intensive emotional reactions both positive and negative toward the supervisor. In short, supervisors must be alert to the inequity of the supervisor-intern relationship and provide means to compensate for it. It is also suggested that interns be responsible for choosing their own practicum sites and supervisors (Sherry, 1991).

These choices are incidental, however, compared to the choice made by the supervisor to engage in counseling the intern. If this occurs, interns, because of the inequity of the relationship, often have little choice but to participate, even though they did not contract for counseling. If they choose not to participate, their supervision could be discontinued. Placing an intern in a situation of "diminished consent" or "lack of consent" may have ethical ramifications. Of course, this situation is not to be confused with those times when interns need to periodically articulate "What is going on with them?" Lack of consent occurs when the focus during supervision is primarily on the well-being of an intern rather than his/her professional development (Corey, Corey, & Callanan, 1988).

Second, the addition of the counselor role to the supervisor's job expectations only complicates a relationship that already involves multiple roles. In most instances, supervisors are expected to teach, evaluate, consult, monitor client welfare, and facilitate the intern's self-awareness (Sherry, 1991). Conflict emerges when the roles become incompatible, such as that of the counselor and teacher (Kitchener, 1988). This conflict can develop into a dual relationship problem if the supervisor "explicitly" conducts two different relationships with an intern over a prolonged period of time (Cormier & Bernard, 1982). An example of a problem arising from a dual relationship is illustrated by Ryder and Hepworth's observations: "We ask supervisees . . . to be open and relatively undefended with us, and may assure them of our benevolence; but then we grade their performance. A student who is too open with us may live to regret it" (1990, p. 130). This can happen when the classroom instructor also serves as the clinical supervisor. Supervisors need to be aware that there is a difference between the style and rapport of supervision versus the "control-oriented" quality of a classroom. Even with this knowledge, it is difficult to be objective while evaluating interns' performances when the supervisor is engaged in two distinctly different roles.

Finally, there is a third person involved in all supervisory relationships—the client. The welfare of the client is paramount and no aspect of the supervisory process should jeopardize it (Pope & Vasquez, 1991). Unfortunately, a popular grievance made in malpractice suits today deals with the failure of supervisors to adequately supervise the work of their interns (Sherry, 1991). It is the supervisor who is ultimately responsible for the treatment of the client, and therefore must sometimes make difficult decisions when an intern is not competent or skilled in handling a therapeutic situation. When interns are engaged in therapy with their supervisors, decisions concerning the interns' competence may become awkward and blurred, leaving the client in a precarious and perhaps dangerous situation.

Even with all the difficulties inherent in the supervisory relationship, internships can provide experiences that are growth-producing for interns as well as opportunities for professional development for supervisors (Corey, Corey, & Callanan, 1987). According to Stolenberg and Delworth (1987), the success of this relationship depends on the presence of a competently trained supervisor, well-defined roles in the supervisory relationship, the delineation of the intern's rights, professional expectations and training objectives, and respect for interns. These components are referred to as "due process" or the rights of supervisees. In the remaining paragraphs these components will be discussed in relation to the roles played by each participant.

What is the Role of the Supervisor?

The ideal supervisor is a competent clinician who has taken advantage of continuing educational opportunities on an ongoing basis and has been trained in supervisory techniques (Corey, Corey, & Callanan, 1987; Pope & Vasquez, 1991). Besides possessing these prerequisites, the supervisor is able and willing to formulate and define the supervisory relationship.

This delineation of the supervisory process is extremely important for it provides the intern with a clear understanding of the nature of the supervisory relationship, the expectations of the internship, and the criteria for evaluation (Cormier & Bernard, 1982). Although each internship site will have varying expectations of its interns, some common factors may include fees, internship objectives, assessment criteria, confidentiality, choices of internship supervisors, and grievance procedures (Upchurch, 1985). Interns also need to be informed early in the internship that it is the responsibility of the supervisor to ensure work performed by the intern meets the standards of the profession. If these standards are not met, then it is the responsibility of the supervisor to request that the intern seek counseling or possibly discontinue the internship.

After establishing parameters of the supervisory relationship, the single most important task of the supervisor is timely feedback. Communication between intern and supervisor needs to take place on a regularly scheduled basis. During these sessions, interns are encouraged to express their professional concerns, while supervisors can "clearly, frankly, and promptly communicate" their observations of the intern's development (Pope & Vasquez, 1991). Serious matters that involve the intern's professional and/or clinical abilities need to be brought to the attention of the intern early in the supervisory process. After discussing the problems, the content of the conversations needs to be documented in writing by the intern as well as the supervisor. This kind of early intervention can prevent further complications in the supervisory process. According to Keith-Spiegel and Koocher, "Lack of timely feedback is the most common basis of ethics complaints regarding supervision" (1985, p. 172). When there is cause for questioning the possible fairness of a particular resolution, the supervisor should seek consultation from others (Upchurch, 1985).

What is the Role of the Intern?

Interns must be theoretically and experientially prepared to participate in particular internships (Sherry, 1991). Just as supervisors are ethically obligated to recognize their own limitations and areas of competence (APA, Principle 2-a), it is the intern's responsibility to select an internship site that is in keeping with the individual's academic background and abilities. This takes some introspection and honesty on the part of the intern. If this factor is ignored, frustration may follow for all parties involved: supervisor, intern, and client. For instance, an intern who has no knowledge of special populations should not be interning in a school setting where planning and providing appropriate interventions for students with disabilities is a priority. This is unfair to the intern and certainly may place students with disabilities in emotional jeopardy.

As previously mentioned, it is the right of the intern to receive clear expectations of the internship before or early in the supervisory relationship. For many interns these expectations come in written form in a contractual agreement followed by a detailed verbal orientation by the supervisor. In all the excitement of beginning a new job, sometimes these expectations become blurred. The phrase "I didn't know that" then becomes a common expression. Taking notes during the orientation, reviewing all written documentation, and then asking clarifying questions are the responsibility of the intern.

Interns who are aware of personal problems that may affect the quality of their work performance should seriously consider obtaining counseling. As in the case of academic readiness, emotional health is a crucial factor in the mental health professions. When interns are simultaneously coping with their own problems while involved in an internship, many times the only manifestations of that experience are stress and confusion.

Also, interns often act as extensions of their supervisors in various professional capacities. In many cases, interns may replace the supervisor in providing services to particular clients, may interface with other professionals as a representative of the supervisor, and may participate in various clinical meetings where they are asked to speak on behalf of the supervisor. In all these circumstances, interns should demonstrate respect and consideration for their supervisors (Stolenberg & Delworth, 1987).

What are Some of the Views of Art Therapy Educators Regarding the Supervisory Relationship?

Before providing art therapists' viewpoints on this question, it is important to consider what the present Code of Ethics for Art Therapists (1992) states concerning the supervisory relationship adapted from the American Psychological Association (APA, 7-c):

> "Art therapists do not exploit their professional relationships with clients, supervisees, students, employees, or research participants sexually or otherwise."

This statement provides minimal direction to clinical supervisors, who, over the past decade have been requesting more formal guidelines. In response, Wilson, Riley, and Wadeson (1984) wrote a "mini-manual" on art therapy supervision. The article defines and develops the three stages of art therapy supervision by providing detailed descriptions of students' skill development, by giving examples of how theory and practice are integrated during internship, and by describing the changing nature of the supervisory relationship throughout the different stages of supervision.

In the first section, called "Beginning Phase," Wilson discusses the importance of well-defined roles for both members of the supervisory relationship. She states that the supervisor's role is one of "teaching students how to ask questions." These questions serve as a form of self-examination whereby students can delve into the changing dynamics of the therapeutic process. On a cautionary note, Wilson clearly distinguishes the self-examination of the art process from the self-examination that transpires in one's own personal therapy. It is her belief that the role of the supervisor is to assist the supervisee in identifying personal difficulties which may later become obstacles in his or her clinical work. It is not, however, the role of the supervisor to engage in a therapeutic relationship while in the supervisory setting.

Five years later Calisch (1989) created a supervisory model which she labeled "eclectic blending." In this approach, Calisch attempts to integrate four clinical models of supervision: psychodynamic, interpersonal, person-centered, and behavioral. Her rationale for this new formulation stems from the unique nature of art therapy. Since art therapy includes a variety of theoretical orientations, a model for supervision needed to be created which would ". . . fit its multiple parts." As Calisch defines the nature of supervision, she describes a different kind of supervisory relationship:

> From the very start the supervisor must communicate that attention to interpersonal issues is not only permissible but is a very important component of the supervisory relationship. (p. 41)

She admits that this position is nontraditional, but after personally experiencing positive results from this approach, Calisch believes that fostering a collaborative spirit through interpersonal explorations can be profitable to both supervisor and supervisee.

Lastly, a third model, described by Durkin, Perach, Ramseyer, and Sontag (1989), again addresses the unique needs of the art therapy supervisory relationship. It employs art making and journal writing as a means of communication throughout the supervisory process. Bringing ". . . the tools of the trade into the supervisory relationship . . ." (p. 391) is the essence of this model. In it, supervisory sessions become opportunities where both the supervisor and supervisee exchange insights and ideas as they create art and prose describing their supervisory relationship. Art therapy supervisors who have used this model state that it enables both parties to "zero in on issues" before they are consciously formulated. They assert it assists in fostering better understanding of the dynamics of their relationship, providing a visual format in which there can be an exchange of ideas on issues. They also credit this model for promoting integration of cognitive theory into the affective domain. However, the authors admit it is personally risky, crossing over the bouadaries of traditional supervision and closely paralleling the therapeutic relationship.

Conclusion

Supervison is a relationship full of complexities and ambiguities that does not offer professional counseling to the intern even though one of its primary goals is to promote self-awareness in the intern. It is an intensive personal relationship, yet communication between the two parties must remain on a supervisory level which sometimes results in an unequal relationship that allocates most of the responsibilities and power to the supervisor, while the intern may be in danger of being disempowered. Because of these seemingly paradoxical characteristics, supervisors must be either experienced or seek instruction on how to supervise effectively.

Counseling educators are finding that supervision requires different skills than teaching or counseling (Ellis, 1991; Kurpius, Gibson, Lewis, & Corbet, 1991). For this reason they are beginning to create special training programs for supervisors, and many of them foresee establishing a certification for supervisors. The reader may believe that this additional process is not appropriate for art therapists. However, unless art therapy supervisors are knowledgeable about the ethical and legal issues involved in supervision, their interns will experience poor quality supervision while the supervisors become prime targets for unpleasant legal confrontation.

It is now time for our profession to closely examine how interns are being supervised and later mentored. We need to support those persons willing to supervise by providing regularly scheduled workshops that specialize in supervisory techniques. As a profession, we must assure our students that we are doing everything possible to provide them with opportunities for quality supervision.

Jeanne Carrigan, OSF, PhD, A.T.R., teaches art therapy at the University of Arizona and is currently Chair of the Board of Ethics and Professional Practice. Inquiries about this article may be directed to her at: 10464 North Fair Mountain Drive, Tucson, AZ 85737.

References

American Association of Art Therapy. (1990). *Code of ethics for art therapists*. Mundelein, IL: Author.

American Association for Counseling and Development. (1981). *Ethical standards*. Washington, DC: Author.

American Association for Counseling and Development. (1991). Report of the AACD Ethics Committee: 1989–1991. *Journal of Counseling and Development, 70*, 278–280.

American Association for Marriage and Family Therapy. (1985). *Code of ethical principles for marriage and family therapists*. Washington, DC: Author.

American Psychological Association. (1992). *Ethical principles of psychologists*. Washington, DC: Author.

Calisch, A. (1989). Eclectic blending of theory in the supervision of art psychotherapists. *The Arts in Psychotherapy, 16*, 37–43.

Corey, G., Corey, M., & Callanan, P. (1988). *Issues and ethics in the helping professions*. Pacific Grove, CA: Brooks/Cole Publishing.

Cormier, L. S., & Bernard, J. M. (1982). Ethical and legal responsibilities of clinical supervisors. *The Personnel and Guidance Journal, 60*(8), 486–491.

Durkin, J., Perach, D., Ramseyer, J., & Sontag, E. (1989). A model for art therapy supervision enhanced through art making and journal writing. In H. Wadeson, J. Durkin, & D. Perach (Eds.), *Advances in Art Therapy* (pp. 391–432). New York: John Wiley.

Ellis, M. V. (1991). Critical incidents in clinical supervision and in supervisor supervision: Assessing supervisory issues. *Journal of Counseling Psychology, 38*(3), 342–349.

Keith-Spiegel, P., & Koocher, G. P. (1985). *Ethics in psychology*. New York: Random House.

Kitchener, K. S. (1988). Dual role relationships: What makes them so problematic? *Journal of Counseling and Development, 67*, 217–221.

Kurpius, D., Gibson, G., Lewis, J., & Corbet, M. (1991). Ethical issues in supervising counseling practitioners. *Counselor Education and Supervision, 31*, 48–57.

Loganbill, C., Hardy, E., & Delwork, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist, 10*(1), 3–42.

National Association of Social Workers. (1980). *Code of ethics*. Washington, DC: Author.

Pope, K. S., & Vasquez, M. J. (1991). *Ethics in psychotherapy and counseling: A practical guide for psychologists*. San Francisco: Jossey-Bass Publishers.

Ryder, R., & Hepworth, J. (1990). AAMFT ethical code: "Dual relationships." *Journal of Marital and Family Therapy, 16*(2), 127–132.

Sherry, P. (1991). Ethical issues in conduct of supervision. *The Counseling Psychologist, 19*(4), 566–584.

Slovenko, R. (1980). Legal issues in psychotherapy supervision. In A. K. Hess (Ed.), *Psychotherapy supervision* (pp. 453–473). New York: John Wiley.

Stadler, H., & Paul, R. D. (1986). Counselor educators' preparation in ethics. *Journal of Counseling and Development, 64*, 328–330.

Stolenberg, C. D., & Delworth, U. (1987). *Supervising counselors and therapists: a developmental approach*. San Francisco: Jossey-Bass Publishers.

Upchurch, D. W. (1985). Ethical standards and the supervisory process. *Counselor Education and Supervision, 75*(2), 90–98.

Wilson, L., Riley, S., & Wadeson, H. (1984). Art therapy supervision. *Art Therapy: Journal of the American Art Therapy Association 1*(3), 100–105.

Whiston, S. C., & Emerson, S. (1989). Ethical implications for supervisors in counseling of trainees. *Counselor Education and Supervision, 28*, 318–325.

CALL FOR PAPERS

Art Therapy is calling for papers on **Multicultural Issues in the Theory and Practice of Art Therapy**.

Authors are encouraged to submit full-length articles, brief reports, viewpoints, and book reviews which relate to or discuss the interface of multicultural issues with the theory and/or practice of art therapy. Also, submissions which discuss multiculturalism with regard to ethical and professional issues, gender issues, and education/supervision are encouraged.

Please send all submissions to:

Cathy Malchiodi, MA, A.T.R.
Editor, *Art Therapy*
1202 Allanson Road / Mundelein, IL 60060

Deadline for submissions for this special issue is October 15, 1993. Please read the Guidelines for Authors published in each issue of *Art Therapy* regarding the specifics of format and style.

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 136-140 © AATA, Inc. 1993

The History of Art Therapy Licensure in New Mexico

Deborah A. Good, MA, A.T.R., Albuquerque, NM

Left to right: Deborah Good, MA, A.T.R., Dr. James Morris (AMFT), Governor Bruce King, Pam Micker (NMMHCA), and Dr. Rob Sharp (AMHCA).

Abstract

This article traces the historical roots of the creation of the first art therapy licensure bill to be written and entered into the state legislative system. Five years after the introduction of this legislation, the state of New Mexico passed into law the first licensure bill in the United States to govern the practice of art therapists.

The original concept development, the process of writing the actual legislation, how the bill was introduced during three legislative sessions, the transformation and evolution to an omnibus bill, and the factors pertinent to the final passing of this legislation during the 1993 New Mexico Legislative Session are explained to the reader in detail. Personal reflections from the author are incorporated to familiarize the reader with this legislative experience.

Introduction

New Mexico is a state of diverse cultural backgrounds. The people enjoy the idea of getting things done "mañana," tomorrow. The pace is slow, and people take their time to adapt to change.

Paula Banek, A.T.R., was the first registered art therapist to move to the state in 1978 and was active in educating people about art therapy. For this reason, it is not surprising that Paula became the first Governmental Affairs Chair (GAC) for the New Mexico Art Therapy Association (NMATA). During the early 1980s, Paula worked on the development of a state job description. She met with local legislators and set the groundwork for what would become the first art therapy licensure bill in the United States.

While interning under Paula's supervision, I became aware of her determination and admired her dedication to the field. We discussed the needs of our profession and agreed that there was a need for a state job description. I was sure that the political scene was boring and not of interest to me, so through the next few years, Paula continued to meet with state committees and individuals who might support the need for a job description as an art therapist.

In 1987 the governmental affairs position was passed on to me. It seemed fitting that when Paula declined to be NMATA's GAC that someone who had worked with her behind the scenes should take over. I began attending to the AATA Governmental Affairs meetings at the national conferences to find out what other people were doing around the country. The central theme seemed to be that art therapists needed licensure. At that time there was no model licensure bill for art therapists available. The National Coalition of Creative Art Therapists had created a legislative packet, but it was not specifically geared to art therapy. I felt that art therapists needed more than a title bill, we also needed to describe our scope of practice in order for licensure to be effective.

I was baffled as to where to start. The whole idea of licensure seemed overwhelming. Although I didn't know anything about state government, I am good at asking questions and finding the right people in order to accomplish what I want to do. I knew one state legislator who agreed to let me use his name as support in order to access the state Legislative Council Services. At this point, I really didn't think that anyone, including myself, ever thought that licensure for art therapists would become a reality.

The Legislative Council Services provided an outline that was used as a guideline for writing all licensure legislation. This outline was taken to the University of New Mexico where Howard McConeghey, PhD, A.T.R., and Josie Abbenante, MA, A.T.R., and I created a composite of art therapy information. After this work was completed, a representative from the Legislative Council Services drafted the first copy of the Art Therapy Practice Act which was reviewed by a group of art therapists that made up the NMATA Governmental Affairs Committee. Among this group was Kristina Sly-Linton, A.T.R., past AATA Clinical Chair, who was active in the early stages of the development of this legislation. After several revisions, the Art Therapy Practice Act was ready to be presented to the 1989 New Mexico Legislative Session.

It is important to know how each individual state conducts its legislative sessions. Each state has certain times that it meets each year in addition to particular sessions that deal only with isolated concerns. The state of New Mexico holds a 60-day session on odd-numbered years, and a 30-day session on even-numbered years. Special sessions may be called by the governor at any time to deal with concerns that cannot wait until the next scheduled session. For example, the New Mexico 30-day session deals with financial concerns of the state; additionally, bills may be introduced which were not completed from the prior session upon the Governor's recall.

House Bill 184

Our sponsor, Rep. Raymond Sanchez, was unable to carry the bill through the legislative session alone and a co-sponsor had to be found who was willing to introduce and represent NMATA's concerns. We had decided to enter the bill in the House of Representatives since we already had support in that body. Rep. Cisco McSorley agreed to sponsor our licensure efforts. He remained our chief sponsor throughout the 1989, 1991, and 1993 legislative sessions.

House Bill 184 was introduced during the last week of January 1989. The bill was assigned to two committees in the House: Business and Industry, and Appropriations and Finance. At this point, our work had only begun. It was important to meet with every member of each committee prior to the committee hearing. This meant catching legislators between 7 a.m. and 8 a.m., at lunchtime, or when they took a break and left the floor or committee. We waited for them outside their offices and walked them to their next meeting, or left notes in their offices hoping that they would read them.

I met with most of the Representatives. Nearly every day I drove 60 miles from Albuquerque to Santa Fe and back; on some days it was necessary to make two trips. Rep. McSorley's office kept in touch with me on a regular basis, helping me track the bill and notifying me at 7 a.m. if it was scheduled for a committee hearing that day, although we didn't know if the bill would be discussed in committee or not. Several times Santa Fe art therapists activated a phone tree and sat with me while I waited hours to testify, often only to be postponed. At this time, Dr. Robert Waterman, president of Southwestern College in Santa Fe, became involved and remained involved until the bill's eventual passage five years later.

HB184 passed the House Business and Industry Committee on February 14, 1989 and the House Appropriations and Finance Committee on February 27. The passage was a direct result of personally speaking to as many legislators as possible. We became one of several licensure bills to be introduced that year: social workers, psychologists, and counselors also were seeking licensure.

On March 2, 1989, HB184 was heard on the floor of the New Mexico House of Representatives. New Mexico art therapists sat in the balcony and watched as Rep. McSorley introduced the bill and entertained questions from his peers. One Representative asked him if art therapy "was like silly putty at lunch time." Fortunately, he never wavered in his testimony, and he was always respectful and polite. The bill passed the floor of the House splitting party lines: Democrats in favor, Republicans against.

That evening the bill moved into the New Mexico Senate. It was assigned to two Senate committees: Public Affairs and Finance and Appropriations.

Rep. McSorley followed it into the Senate with the support of Sen. Shannon Robinson, a life member of the New Mexico Art Therapy Association. Sen. Robinson was a freshman in the Senate that year. He had an impressive understanding of art therapy because his legal secretary, Gail Bell, A.T.R., was studying to be an art therapist at the University of New Mexico. He also donated time on his computer for NMATA usage and willingly supported our licensure efforts.

On March 14, 1989, HB184 successfully passed both Senate committees. During this time I wrote guidelines for legal testimony which later became part of the legislative packet created by AATA GAC Robin Gabriels, A.T.R.

As the 60-day session came to a close, HB184 was heard on the floor of the Senate, passing 32–8, on March 17, 1989. It then made its way to the Governor's office for his approval or veto. Cay Drachnik, A.T.R., then president of the American Art Therapy Association, made a special visit to New Mexico upon my request. We tried to speak with the Governor but were unable to do so. However, it was a good feeling to be supported by the AATA on the state level, and it was that kind of support that encouraged me to reach for this dream. I was an unknown art therapist in New Mexico. What an honor for the president of AATA to personally visit and try to help me! I am eternally grateful for Cay's vision and her ability to see mine.

The politics at this point became particularly interesting. New Mexico had a predominately Democratic House and Senate; but, the Governor was a Republican. He vetoed HB184 30 days later, stating that the penalty section was too broad; he also vetoed the counselors bill.

It is the right of all concerned to discuss with the Governor's attorney the reasons for a veto, so I scheduled an appointment and met with him weeks later. It is also a right to be able to see the file that went with HB184 to the Governor's desk. The NMATA had implemented a forceful letter-writing campaign from art therapists, employers of art therapists, and concerned citizens. We knew that we should have approximately a hundred letters in our file, but there were only three. When I asked the Governor's attorney what the real reason for the veto was, he replied, "The Governor was tired. Your bill happened to reach him within the last 24 hours that he had to sign or veto all bills."

There were many lessons to be learned from this brief interchange. We needed to keep a master file of all letters sent to all legislators and the Governor. We needed to find a way to get our bill to the Governor's office more quickly after passage on the floor of the Senate. It was difficult to have this kind of momentum and have to wait two years to try again.

House Bill 641

During the rest of 1989 and 1990, we continued to educate legislators on the art therapy profession. The necessity for licensure was not felt as strongly by some art therapists as it was by those who were aware of the preference in employment that was granted to those professionals who could hold a state license. It was with this in mind that we worked toward the 1991 legislative session. The original licensure bill had now gone through many hands in the AATA. Suggestions for revisions were included, and strategies formulated.

With the legislative session approaching in mid-January 1991, we were informed that the counselors were also returning with their licensure bill. The marriage and family therapists had joined efforts with the counselors, and they were working on a bill to license both professions individually. The question was put to the NMATA members whether or not they wanted to join efforts with the counselors and marriage and family therapists. The pros and cons were weighed and a decision was made to unite in a way that would make all of us stronger and still maintain our original goals. Knowing that the decision for the marriage and family therapists to join with the counselors had already been made, we realized the strength in numbers of professionals who could be licensed through their bill would outweigh ours. An argument could be made that the state of New Mexico would save money licensing three to four separate disciplines under one board. We began to work with the Legislative Council Services to combine our bills into what we called the Counselors and Therapists Practice Act.

Historically, the counselors in New Mexico had made attempts at licensure for approximately 15 years. The title "counselor" stirs up conflict when dealing with state agencies, group home situations, dorm counselors, etc. Questions were asked about how we define our professions and still allow job descriptions to exist that do not equal our specifications. Licensure's main consideration always must be "to protect the public." Therefore, a licensure bill must appear to alleviate harm and not produce additional stress on the existing systems in place. These are issues that we continued to battle for the three years that art therapists joined with counselors and marriage and family therapists.

The 1991 legislative session with opposition from a group of counselors in the northern part of the state. They threatened to openly oppose the bill unless there were changes made in the language. It seemed that some of their requests could be dealt with easily, while others would sacrifice the integrity of the projected law. Negotiations ensued and our bill was not introduced due to compromises that continued to develop. However, the art therapy and marriage and family therapy sections of the bill remained untouched. Finally, 30 days into the session HB641 was introduced in the New Mexico House of Representatives. We were getting a late start and timing was crucial.

Two main differences in support occurred during the 1991 session. An art therapist who worked for a state agency, Aviva Ariel, offered to maintain direct computer contact with the legislative tracking of HB641; this was an incredible help. It eliminated my daily long-distance phone calls at 7 a.m. Also, the three professions raised money to hire a lobbyist to help the bill get through the legislature.

HB641 was assigned to three committees in the House of Representatives: Consumer and Public Affairs, Judiciary, and Appropriations and Finance. Not only were we cut to 30 days, but now we had an extra committee hearing to go through. Fortunately, Rep. Cisco McSorley was Vice Chairman of the Judiciary Committee. As the state GACs from all three professions waited to be heard in committee, I began to work on the members of the Judiciary Committee to see if our bill could be given a due pass without a hearing. After HB641 passed Consumer and Public Affairs, we headed for Judiciary. Our due pass was granted, and HB641 moved to the House Appropriations and Finance Committee.

At this point each committee was overloaded with bills to be heard; hearings were going on into the middle of the night, and starting again at 7 a.m. before the floor session. No time could be lost. We decided to remove the request for appropriations from the bill and passed Appropriations and Finance. Then HB641 moved to a full floor vote of the House of Representatives. Again, our bill split party lines and with a Democratic majority we passed the House and entered the Senate. At this point, there were less than 10 days left in the session.

In the Senate, HB641 was assigned to two committees: Consumer and Public Affairs and Corporations. Sen. Robinson helped us again in the Consumer and Public Affairs Committee. We were heard, passed, and sent to the Corporations Committee where the insurance lobbyists came out in full force. Another compromise had to be made: The mandatory third-party reimbursement was taken out of the bill. Actually, we were surprised that we had gotten so far without more opposition in this area. Originally, the bill had been written with prioritized components that could be eliminated in committee hearings, if necessary. We wrote the bill asking for everything, and then tailored it as we went from hearing to hearing, knowing that we would maintain the priorities of the bill even if we had to sacrifice the frills.

HB641 waited until the last three days of the session to be brought up on the Senate floor for a full, and final, vote. The last day of the legislative session is always a Saturday and the session officially closes at noon. What bills remain unheard, die. After Friday night HB641 still had not been heard. The Senate was working through the night to make its way through the backlog of bills that remained. I got up at 3 a.m. and made my way to Santa Fe, 60 miles in a snow storm. I found my GAC colleagues in the gallery above the New Mexico Senate. The Senate was in the midst of a filibuster and HB641 was behind the filibuster. We sat and watched as the time ran out; there was nothing that could be done.

This 1991 legislative session left us all drained. I questioned the decision to join the counselors. After all, weren't they the reason for the majority of opposition? Why didn't they work out their conflicts prior to the session? If only we had started earlier. Working with two other GACs seemed to be slowing us down, rather than helping.

I devoted my energy to negotiating a reduction of the final lobbying fee. The three state associations hadn't received much for the large sum of money that we were paying. We confronted the lobbyist who said that he tried hard. He told us of all his conquests and said that we were one of the unfortunate losses. I held my ground and recounted the lack of professionalism with which we were treated. In response, he reduced our final fee. The following year, before the 1992 30-day session, I received a letter from this lobbyist granting the NMATA free lobbying for any concern that came up during that session. Of course, we had to wait another year to introduce our bill again, but this was an interesting turn of events.

The loss of HB641 was felt deeply by many professionals in New Mexico. The consensus of support became unified throughout the art therapy community. The art therapists in New Mexico used this time to unite their efforts and begin to look at licensure as a plan, rather than a possibility.

House Bill 234

During the summer of 1992, the GACs met again. Janice Havlena, MA, A.T.R., 1992 president of NMATA, joined in those meetings. As Janice left the presidency, Elaine Giovando, MA, the NMATA 1993 president became a major supporter. The decision was made to stay with the counselors and marriage and family therapists due to the number of professionals who would benefit from licensure and the positive effect of those numbers on committee hearing votes. Money was raised for a lobbyist, who was carefully selected. We were not going to go through the same scenario a second time.

HB234 was introduced into the House of Representatives on January 28, 1993, by Rep. Cisco McSorley. The counselors still maintained their opposition in committee hearings. I decided to take a firmer role and work with the lobbyist, proactively confronting opposition. Elaine Giovando, Dr. Robert Waterman, and I spent a considerable amount of time meeting with the counselors who expressed opposition and the legislators. Since this was the third session in which I had played an active role, legislators knew me, spoke to me openly, and mentioned ideas that might help to get our bill passed.

HB234 successfully passed the House Business and Industry Committee on February 16 (unanimously), the House Finance and Appropriations Committee on March 1 (unanimously), and a full House floor vote on March 4 (58–1). House Bill 234 arrived in the New Mexico Senate on Friday, March 5. Sen. Shannon Robinson, chairman of the Senate Public Affairs Committee, heard HB234 on Monday, March 8. Again we passed committee with a unanimous vote. Sen. Robinson carried HB234 to the floor of the Senate on Wednesday, March 10, where it passed the full Senate by a vote of 26–4. After a final concurrence in the House of Representatives the next day, HB234 made its way to the Governor's office.

On Thursday, March 18, 1993 at 3:00 p.m., Governor Bruce King signed the Counselors and Therapists Practice Act into law creating the first state licensure for art therapists. Officially, HB234 became law on July 1, 1993. Between July 1, 1993 and July 1, 1994, the Counselor and Therapists Practice Act Board will be developing application forms, accepting A.T.R.s for grandparenting into licensure, and creating all the necessary documents and rules from which the Board will operate. Governor King will appoint one art therapist, one marriage and family therapist, one mental health counselor, one clinical counselor, and four public members to the Board. By July 1, 1994, licensing of art therapists will be a reality in New Mexico.

Reflections

I believe that the most important thing that I learned from this adventure is that all things really are possible. If you have a vision, you can bring it to maturation. It is easy to become discouraged, but determination and perseverance are worth all their effort and energy to achieve a successful end result.

I matured during this process too. Before I began working toward art therapy licensure, I had no concept of how effective one person could be with regard to state regulations. I had no idea that the government was really here to serve me. As a voting member of my community, I have a right and an obligation to monitor legislation that affects me and my environment. The elected officials are here to serve the public; that concept totally negates the idea that legislative figures are untouchable or unreachable. Now, I look differently on my rights as a citizen and carefully consider whom I vote into public office. As new candidates show up at my door requesting signatures of support, I speak to them about art therapy and my needs as a voter.

Art therapy licensure in New Mexico is only the beginning. I have no doubt that many states will follow and that art therapy will grow in recognition because of these efforts.

Deborah A. Good, MA, A.T.R., is in private practice and directs the Art Therapy degree program at Southwestern College in Sante Fe, NM. Ms. Good has served both on the AATA Board of Directors and on the interim Art Therapy Credentialling Board. Inquiries concerning this article may be directed to her at: 2449 Pueblo Bonito, NW, Albuquerque, NM 87104.

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 141-147 © AATA, Inc. 1993

The Art Therapist as Exhibiting Artist: Messages from Joseph Beuys, Suzi Gablik, and Donald Kuspit

Mildred Lachman-Chapin, MEd, A.T.R., Chicago, IL

Abstract

The inquiry begins with questions arising from an attempt to integrate the identities of the art therapist and the exhibiting artist. Are they fundamentally opposite: the art therapist functioning to serve others and the exhibiting artist functioning to serve or express himself/herself? This discussion deals with the views of Suzi Gablik, an art historian, Joseph Beuys, an artist, and Donald Kuspit, an art critic.

The art world is talking about a new identity for the artist, one of healing and relationship. This paper examines the implications of the art therapist's message for the art world of today. Until now we have addressed ourselves almost exclusively to the mental health world. Now it may be time to address the art world from which we came.

Several years ago Mari Fleming and I spoke at the AATA conference about our concerns about being both art therapists and exhibiting artists (Fleming, 1993; Lachman-Chapin, 1993). Afterwards, I was propelled to continue to integrate these two identities, finding in the writings of Suzi Gablik and Donald Kuspit and in the artwork and theories of Joseph Beuys one of the great art debates of our time: How do we value the aesthetic in art as opposed to social activism?

After 20 years as an art therapist, I was pretty clear about my identity, goals, and aspirations. As an exhibiting artist, however, I was not so clear, so I asked myself some questions. As an artist what can I accomplish—money, fame, the love of men? These are the motivations Freud listed. Or can the artist accomplish healing or teaching—something closer to what motivated me as an art therapist? Or, can the artist expect to accomplish social change?

Also, what is driving me as an artist—my unresolved psychic conflicts, a narcissistic wish for fame, a wish for money? (Fat chance!) Am I driven by wanting to help individuals or to change society?

And lastly, what does success as an artist mean to me? This is, in fact, the question that Suzi Gablik in her recent book, *The Reenchantment of Art* (1991), starts with, as she examines the present state of art and makes her own impassioned pitch for change.

Suzi Gablik

As I tackle these questions, my more familiar identity as an art therapist is what I keep referring to. Thus, this was the basis for my initial response to Gablik's ideas when I heard her speak two years ago and later when I read her book. I wasn't so much interested in seeing if I could agree with her ideas about the function of art, as I was in justifying the role of art therapy to the art world. This would, in a personal sense, help integrate my two identities. I was also looking for a new way for our field to be viewed.

Following up on her earlier book, *Has Modernism Failed?* (1988), which criticizes the aesthetics, intentions, and morals of modern art, Gablik tries in this current book to prescribe a treatment. She rails against the material, object-oriented, aggressive, cold, confrontational, expensive, imposing nature of the present art world, looking instead to return art to its rightful place in the realm of magic, enchantment, and social usefulness. To accomplish this she envisions an art world in which compassion, nur-

BEST COPY AVAILABLE

turance, dialogue, and giving primacy to relationship and interaction are paramount. She wants artists to create a meaningful connection between art and society and is especially concerned with caring for the environment. What captured my attention was that in talking about art as interaction, healing, dialogue, and helping, Gablik was describing some of the essential and inherent qualities of art therapy.

Gablik goes on to equate these qualities of art with the feminine, describing the present art scene as masculine, with patriarchal, destructive, deconstructive, rational, and inhumane elements. She says the present patriarchal art world is a "dominator system" in which the self is central.

> Power is associated with authority, mastery, invulnerability and a strong affirmation of ego-boundaries—which is precisely what the modern artist's 'self' came to convey. Autonomy disregards relationships, however; it connotes a radical independence from others. By contrast, in the partnership model, relationships are central, and nothing stands alone, under its own power, or exists in isolation, independent of the larger framework, or process, in which it exists. Within the dominator system, art has been organized around the primacy of objects rather than relationships, and has been set apart from reciprocal or participative interactions. What I shall argue is that it has become trapped within a rigid model of insular individuality. To reverse this priority, giving primacy to relationships and interaction, is also to reverse the way that artists see their role, and implies a radical deconstruction of the aesthetic mode itself. (1991, p. 62)

While Gablik seems to be describing the kind of art making that we do as art therapists, she goes further in two important ways. It is these ways I question. First, she clearly wants the artist to become involved, not especially with individuals as we do, but with social change. She is saying that through art we should attempt to correct threatening social evils (threats to the environment in particular). Second, she strongly suggests that we *can* effect such change. This implies giving up the essentially self-centered, aesthetic approach that has been developing throughout much of art history since the Renaissance: that we each make art to express our own vision and that we try to make it as aesthetically "good" as we can.

As examples of what Gablik would have us do instead, she notes various artists and their projects: Dominique Mazeaud, cleaning up the Rio Grande River; Mierle Laderman Ukeles, shaking hands with garbagemen in the five boroughs of New York City; and Krzysztof Wodiczko, making mobile homes for the homeless. She also praises Tim Rollins for his work with learning disabled children in New York City, inspiring collaborative projects derived from classic works of literature. She claims that all these art projects involve actions, sometimes ritualized, which give a spiritual dimension to the artists' works.

Certainly, the art world has witnessed a great burst of social activism in recent years. Caught in the attacks against the art world by the fight against funding for the National Endowment for the Arts, artists have left their isolated studios to join in concerted political action. But aside from these self-defensive activities, the rise in earth works, conceptual, performance, and installation art is a clear indication of the trend away from the object-oriented and commercialized art world.

This year's Whitney Bienniel, which features artists whose works have been shaped by social, cultural, and political concerns, is further evidence that these concerns have emerged. As Sozanski reports in a recent article in the *Chicago Tribune*, "This year's edition (of the Whitney Bienniel) can certainly be considered 'au courant' for the way it engages sociopolitical issues that have emerged at the forefront of current art-making. . . . Its premise—that the politics of individual and group identity define the current zeitgeist and thus should be a primary concern of art—might be challenged" (1993, p. 12). These kinds of problems, he goes on to say, "artists are well-equipped by experience and temperament to illuminate. If they don't, who else will?" (1993, p. 12)

Joseph Beuys

As I began to examine the question of artist as social healer, I came across Donald Kuspit's article entitled "Joseph Beuys: the Body of the Artist" (1991b). Kuspit is a distinguished art critic, professor of art history and philosophy at the State University of New York at Stony Brook and A. D. White professor at large at Cornell University. He is the author of many articles and books, as well as a regular contributor to *Art in America* and *Artforum*. He is extremely knowledgeable about psychoanalysis and self-psychology and, for this reason, his art crticism is often enriched by his psychological insight.

Joseph Beuys, born in 1921, was a member of the Hitler youth and served as a combat flyer during the war. Shot down over Russia, he was rescued by Tartars who brought his nearly frozen body back to

1498

life by wrapping him in fat and felt. Later, these two materials became very prevalent in his sculpture works. "In 1947, he turned to art as part of his healing process, enrolling in the Dusseldorf Academy of Art. He not only became a professor at the Academy but became known as one of the pre-eminent figures in postwar German art" (Killian, 1993, p. 11). In 1979, he was given a show at the Guggenheim Museum in New York City. He died in 1986, after his sculptures, drawings, and especially his performances brought him international fame. Presently, New York's Museum of Modern Art is having a major exhibition of his drawings, to be shown later in Los Angeles, Philadelphia, and Chicago.

In many of his writings and interviews, Beuys spoke of his intent to help cure the sickness of the German people through his art and his theories about creativity. Kuspit observes that Beuys' narcissistic traumas in early childhood resulted in an art that was essentially psychosocial, that is, "it derived as much from his unhappy childhood experience and fantasy" as from the psychological needs of the German people. "His art," Kuspit says, "was a dialectic between childhood dream and adult social healing" 1991b, p. 82). He did this by "using art to undo the life-denying traumas that had been inflicted on him, without denying their reality (it is this kind of activity that constitutes art's so-called 'spiritualization of life,' its fundamentally reparative task)" (*Ibid*, p. 84).

Beuys was a teacher and a healer. He attempted to "teach other sufferers the lesson of his wound and its cure by warmth." . . . "He understood that the personal is, indeed, the political, that is, that one's attitude to other people profoundly informs, even creates, sociopolitical reality" (*Ibid*, 1991b, p. 86). "The idea that individual and social health are inseparable is crucial to this concept. For Beuys, art was a process of simultaneous self- and social healing" (*Ibid*, 1991b, p. 82). He felt that every man had creative possibilities. He was reaching to connect with every man, to hold out hope for him to express himself through art (as Beuys conceived art to be), and to make social changes through his art. Beuys made exhibition "a sacred social service rather than simply self-serving. . . . Beuys' exhibition of himself and his art—of his body self as art—was a profound act of giving" (*Ibid*, 1991b, p. 86).

In a recent lecture Kuspit referred to Beuys as being "the last gasp" of the idea of the artist as healer. Kuspit, in his recent book, *The Cult of the Avant Garde* (1993a), also speaks at length about Beuys as shaman. "Beuys represents the most strenuous avant garde attempt to reconcile the roles of artist and healer, to make art a kind of healing and to make healing artistic" (1993a, p. 97).

I was happy to have found many similarities between art therapy and the goals of Gablik and Beuys. I rejoiced that the art world, like Moliere's character discovering "prose," might be about to rediscover art's healing function—so fundamental to our role as art therapists. But as I read more and thought more carefully about some of the issues raised by both Gablik and Beuys, further questions arose.

Activist and Aesthetic Modes

Ortega y Gasset wrote a famous essay back in 1925 called *The Dehumanization of Art*. He talked about what he saw as the essential difference between the new, modern, "unpopular" art, and the art of the past. The essential difference, as he saw it, was that art of the past dealt with lived, human reality, while modern art was distanced, objective, stylized, aesthetic, and dehumanized. In talking about the new arts of the period he said, "Wherever we look we see the same thing: flight from the human person" (1956, p. 30). The new artist, he says, repudiates reality, places himself above it. "Being an artist means ceasing to take seriously that very serious person we are when we are not an artist" (*Ibid*, p. 45). He characterizes this modern artist's stance as self-mockery and distancing.

Shusterman (1992) expresses similar statements by redefining aesthetics as basic to the practical concerns of everyday experience as it must reach out to a broad audience. In effect Beuys says the same thing. In a 1980 video interview, in connection with his show at the Guggenheim Museum, Beuys explains that for him art is a social tool. He says, "aesthetics doesn't exist for me . . . the human being is aesthetics in itself." Beuys goes on to talk about "social sculpture," saying that the essential qualities of this sculpture are thought and feeling embedded in the materiality of the human body. He speaks of language and thinking as more important to sculpture than the end product. Transcendence in the invisible world is what he is after, "not just material beings." He talks about the joy for life, related to everyone's needs in society, as a molding power of the soul which will not necessarily lead to any physical form in art.

These writers ask that art become meaningful and relevant to human concerns. But in Gablik's writings there is an additional moral and ethical imperative. She, like Beuys, is saying, in effect, that we as artists should devote ourselves to being *activists for change*. And much as we may agree with her wish to develop an art world that is more compassionate, relational, spiritual, etc., and to prevent through our work the continued destruction of our ecosystem, must we make the choice to give up our aesthetic strivings? Should we commit ourselves to an active moral and aesthetic program following Beuys' example?

Kuspit (1991a) spells out what he sees as the essential difference between two kinds of art making. The activist artist, he says, is not only careless about producing aesthetically "good" art, but is also morally against art that is not socially oriented. He goes on to make a psychological differentiation between the two: The activist artist is tied to a super-ego moral stance, seeking to confront and overthrow the existing authority, while "the aesthetically oriented artist experiences the world as disappointing but desirable . . . a hopeful if realistically difficult place" (1991a, p. 22). The aesthetically oriented artist, Kuspit says, is motivated by "desire," a mysterious life force that revitalizes art, history, and the self; the moralizing artist, he says, is motivated by a wish to overthrow the "parental" status quo, deeming the aesthetic promise of pleasure a seductive illusion.

Others speak out for the importance of the aesthetic quest. Weins says, "While art's social and political functions are gaining the limelight, however, we must also keep in mind such (currently dubious) things as mystery and beauty—the things that make art art. . . . A wholesale dismissal of aesthetic, philosophical, and formal issues which have been built over time would be detrimental. It is often through such elusive constructs as beauty and mystery that art attains its impact, its ability to profoundly inform us about who we are and what we feel" (1993, p. 7).

Carol Becker, associate dean of the Art Institute of Chicago, speaks about the despair of post-modernism and the new emphasis on extending art to a larger audience. She calls this "community based" art. She examines Marcuse's work, expecting to find support for political activism, but finds instead that he wrote that "the political potential of art lies only in its own aesthetic dimensions" (1978, pp. xii–xiii). Becker says, "For Marcuse the need to make formally effective work is more than an abstract idea. . . . Within his system, it is the idea essential to the meaning of art itself" (1993, p. 26). It becomes, in Marcuse's words, "the cosmos of hope" (1978, p. 52). "Art challenges the monopoly of the established reality," Marcuse writes, by creating 'fictitious worlds' in which one can see mirrored that range of human emotion and experience that does not find an outlet in the present reality" (1978, p. 66).

Johnston, in reviewing Gablik's latest book, says that she proposes that artists give up "the most important thing they possess—their individuality, their power to define themselves" (1993, p. 41). She goes on to say, "The artist as child, a figure who transcends the childhood abuse endemic to the modern family, has been a hallowed entity in our culture. The artist as dissident remains a valuable model" (1993, p. 41). She urges more autobiography—in fact shared autobiographies—"uncovering in greater detail, with more piercing scrutiny, the actual sources of dissent in society" (1993, p. 41).

Another question emerges: Can we, as artists, actually effect change to any important degree by being activists in our art? This has not been the case historically. Can't our searches in the realms of self and style make an important statement about society? I think of the imprint of Cubism, Dada, Impressionism, Abstraction, the array of recent fads such as Pop, Appropriation, Deconstruction, Minimalism. Each helped us look around and see the world differently. Becker says, "Those who actually desire a revolutionary message cannot grasp the degree to which innovations in form can also be radical in terms of how they change the scope of what people are able to see" (1993, p. 26).

There are certain things that motivate people to become artists in the first place. First, there is often some need to express and exhibit the self in an attempt at self-healing. Like Beuys, some area of hurt calls for attention in those of us who choose to devote ourselves to art making. Beuys clearly wanted his exhibitionism to heal himself as well as society.

I do question whether it is possible for artists to forego our expression of "desire" for the sake of promoting changes in society. Kuspit would say that the activist artist does forego this, having given up on the hope of achieving this "desire." Instead, the activist artist would adopt an optimistic guise of hope for social progress. Kuspit (1993a) is in fact dubious about Beuys' attempts to be of "reparative service to pathological society" (p. 96), post-war Germany in particular. He says that Beuys' performances, in fact, lost their meaning as healing events. He was, in Kuspit's view, solving his own narcissistic problems rather than giving to or healing his audience.

Personal Conclusions

For myself, I chose the aesthetic artist alternative, much as I would like to further the kind of art world environment and goals to which Gablik exhorts us. I have a need to teach, to heal; this is clear from my long career as an art therapist. The art I am driven to make, though, must come from my own inner needs, from the impact of the world on my sensibilities, and from my need to dialogue with my audience. I contribute my art to causes I believe in. I am active socially and politically, but not essentially through my art. Like Beuys, but in a very different way, for me the personal is the political. As Goldberg (1986) says in her book on writing, painting is my way of "facing the world. It is a deeply political act, because you are not just staying in the heat of your own emotions. You are offering up some good solid bread for the hungry" (1986, p. 47).

My personal art may not affect many people. If it were "better" (whatever that means), perhaps it would have more soul shaking responses from others; I would wish it so. But unless I exhibit it, this cannot happen at all. So an important element of what motivates me is this vague, but strong, wish to express, but also to share my own traumas with others, affecting them in some way. Kuspit says, "More than is realized, the artist's attitude toward his audience, emblematic of the kind of reciprocity he wants to establish with it, is the fundament of his art" (1993, p. 83). He goes on to say, ". . . the art will not be compelling unless the audience believes it is deliberately addressed to it, the audience, rather than made for the artist's narcissistic edification as a sign and proof of his creativity. In short, the audience must feel the artist's will to relate to it in order to find elementary value in his art" (1993, p. 84).

Is my work political? That is a question of numbers—how many people I can affect. It is also a question of relevance to current, deeply felt cultural issues. For me these include loneliness and alienation, deconstruction of a feeling of personal wholeness, and fear of destruction, both personal and environmental. Gablik points out that "for the first time in recorded history, the certainty that there will be a future has been lost; this is the pivotal psychological reality of our time" (1991, p. 19). Gablik also observes that a new way of seeing or understanding brings a new way of acting. Forces of idea and spirit do produce action; any study of history demonstrates this. The material world—economics, geography, technology, the chronology of events—is not the only decisive factor in change. So therefore the personal can be political.

We need hope in this threatening and cynical world. Perhaps my art, in a small way, can give hope to others and encourage them to speak from their own creativity. Perhaps my art can speak of the kind of relationships, the magic and enchantment of connection which Gablik refers to. Perhaps I can bring the outer world—other people touched by my art—to my inner world, making *me* more whole. Gablik says, "Healing is the most powerful aspect of reconstructive modernism" (what she is urging) (1991, p. 25). She contrasts this with current artists who would have us believe that art can only deconstruct. She also refers to Heinz Kohut, the psychoanalyst and originator of self-psychology, who wrote that "those artists who are in touch with the necessary psychological tasks of a culture prepare the way for the culturally supported solution to a conflict to emerge, or for the healing of a psychological defect" (1991, p. 24).

There has been a considerable movement in the art world to counter the object-oriented and commercial system. Most of this work is indeed social activist in intent. However, this will never replace the individual's yearning for the vague and diffuse desires for the aesthetic which fires the artist. Perhaps this is the "image of humanness . . . the liberated human psyche" which art can communicate (Becker, 1993, p. 25). Also, social goals can be equally or better served by the artist who digs deeply into the human condition as she or he knows it from his or her own experience. Becker speaks of this need to "reclaim the importance of subjectivity—not as an end in itself, but as a way to understand the particularities of individuals, and therefore of the collective" (1993, p. 27).

Ramifications for the Field of Art Therapy

What are some of the ramifications for our field? First, we have to acknowledge how we are viewed by the art world, and how we see ourselves vis-à-vis them. I work in an art school, the Art Institute of Chicago. My experience has been that we (both faculty and graduate students) as art therapists are seen as lesser—or not quite real—artists. This is evidenced, in one way, by our struggle to have our graduate students' artwork included in the school's graduate show at the end of the year. Not being "studio artists," our students are sometimes deemed not as qualified as graduate level artists. Happily, we usually succeed.

In many other more subtle ways we also get the message that because we use our art for something, because we "interpret" art, we are in a different category. This undercurrent exists, despite the fact that our art therapy graduate students' portfolios have to pass muster with the faculty for entrance, and that nine credits of studio courses in classes with art students are required in the Art Institute art therapy program. Perhaps this reflects the art world's rejecting response to artist-as-healer. Beuys may be the "last gasp"—accepted and revered—but art therapists are no Beuys.

Is it about time that we, as art therapists, reach more directly into the current dialogue in the art world? We need to discuss the issues raised by Gablik and Kuspit, explaining that our art involvement is indeed activist within our own parameters. That is, we are being all the things that Gablik asks of artists. We do it not to change society directly, but to help change the people with whom we work. This is an essential difference. We work, as did Beuys, with the personal, spreading the effect through society as good teachers and shamans do.

As artists, art therapists enter the arena of artists as equals. This means that we compete and are willing, therefore, to be judged in some aesthetic way. I was surprised and chagrined recently to see that in two shows of artwork by art therapists, there was a real resistance to being juried or judged. In both cases the final decision was to accept all submitting artists. In a discussion afterwards at one show, most of the audience of art therapists expressed strong opposition to exhibiting their work in "commercial galleries." They talked with disdain about the terrible art world and about being judged.

Is there a three-way split between (1) being an art therapist; (2) making art for self-expression just for oneself; and (3) making art as part of the art world, seeking exhibition, dialogue with a broad audience, and recognition? As I have moved more into being an exhibiting artist, while continuing to be an art therapist, I sense an uncomfortable hostility from some of my colleagues. Is it envy? Are art therapists disappointed artists? (Agell, 1986) Is it because there is a vague feeling that by emphasizing exhibiting, we are giving up some of the ideals of the quiet, interpersonal creativity of art therapists? Is there a pejorative, moral stance relating to what is seen as the narcissism of exhibition? I don't know the answers to these questions, but I think they are worth thinking about by our profession. This analysis has led to what seems to be an opposition between the human, subjective, healing kind of artist—Beuys, Gablik's artists, we art therapists on the one hand—and the aesthetic, object-oriented, desire-driven ones on the other. As art therapists, we are clearly both. As artists, we must find our own way in an art world earnestly searching for answers.

I think it is time to address the art world with a statement about who we are and where we stand with regard to the dialogue I have been describing. I see us as being *both* activist and aesthetic artists. We help, therefore we act. But we also deeply value the aesthetic concerns that make us artists, and which we can impart in our activist role to our clients. We can also substantiate and confirm the roots of art activity in the primal psychological and spiritual wellsprings of the mind and soul, thereby making clear that one of the functions of art is to heal. Perhaps it can only be to heal oneself, to help others to heal themselves. Perhaps we can, by "reaching out to an audience greater than the art world . . . offer some vision for developing a less alienated future" (Becker, 1990, p. 26).

Finally, we can hope that our clarified identity and our activities both as therapists and exhibiting fine artists—joined with other artists in the art world—will have some power to effect some of the social changes we want. Until now we have related almost exclusively to other mental health fields. That is where our jobs have been. Now we need to build bridges to the art world. That is where we came from.

Mildred Lachman-Chapin, MEd, A.T.R., is an art therapist in private practice, a member of the adjunct faculty at the Art Institute of Chicago, and an exhibiting artist.

References

Agell, G. (1986). "Comment" on Rosenblum, B. (1986). "A sociological consideration of alienation in artists." *American Journal of Art Therapy, 25*, 51–52.

Becker, C. (1990). *Social responsibility and the place of the artist in society*. Chicago: Lakeview Press.

Becker, C. (1993). Subtle subversion. *New Art Examiner, 20*(7), 25–27.

Beuys, J. (1980). Interview with Kate Horsfield. Produced by Lyn Blumental.

Fleming, M. (1993). From clinician to artist; from artist to clinician, Part I. *American Journal of Art Therapy, 31*, 70–75.

Gablik, S. (1991). *The reenchantment of art*. New York: Thames & Hudson.

Gablik, S. (1988). *Has modernism failed?* New York: Thames & Hudson.

Goldberg, N. (1986).*Writing down the bones*. Boston: Shambala Press.

Johnston, J. (1993, February). The artist as social worker. *Art in America*. 39–41.

Killian, M. (1993, March 11). Art as healer. *Chicago Tribune*. Section F, 11.

Kuspit, D. (1991a). Art and the moral imperative. *New Art Examiner, 18*(5), 18–25.

Kuspit, D. (1991b). Joseph Beuys, the body of the artist. *Art Forum*, 80–86.

Kuspit, D. (1993a). *The cult of the avant-garde artist.* Cambridge, MA: University Press.

Kuspit, D. (1993b). The end of creative imagination. *New Art Examiner, 20*(9), 16–29.

Lachman-Chapin, M. (1993). From clinician to artist; from artist to clinician Part II. Another perspective. *American Journal of Art Therapy, 31*, 76–80.

Marcuse, H. (1978). *The aesthetic dimension.* Boston: Beacon Press.

Ortega y Gasset, J. (1956). *The dehumanization of art and other writings on art and culture.* New York: Doubleday & Co.

Shusterman, R. (1992). *Pragmatic aesthetics: Living beauty, rethinking art.* Oxford, U.K.: Blackwell.

Sozanski, E. (1993, March 28). Taking sides. *Chicago Tribune.* Section 13, 12.

Wiens, A. (1993). Editorial. *New Art Examiner, 20*(7), 7.

American Art Therapy Association
24th Annual Conference

Common Ground:
The Arts, Therapy, and Spirituality

November 18-22, 1993
Atlanta Hilton and Towers
Atlanta, Georgia

Special events include -

- Keynote Speaker, JAMES HILLMAN
- Exhibition of drawings by Elizabeth Layton, "Through the Looking Glass"
- Master Supervision Groups exploring a wide range of issues
- Art Therapy Educator's Convocation
- Awards Banquet

Interested individuals are invited to contact the AATA National Office
1202 Allanson Road / Mundelein, IL 60060
(708) 949-6064 Fax: (708) 566-4580

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 148-155 © AATA, Inc. 1993

The Art Therapist as Social Activist: Reflections and Visions

Maxine Borowsky Junge, PhD, LCSW, A.T.R.; Janise Finn Alvarez, MA, A.T.R.; Anne Kellogg, MA, MFCT, A.T.R.; and Christine Volker, MA, MFCT, Los Angeles, CA

Abstract

From a systems perspective, the role of the art therapist as social activist at a time of deep and crucial change for our clients, mental health systems, our country, and the world is discussed. Despite the fact that art therapists, through our artists' identities, are natural agents of change, our education and strivings for professional acceptance mediate against our natural proclivities in this direction. Case examples of their experiences as change agents are presented by three art therapists: two write in dialogue about their participatory research project with Central American refugees, and another writes about her work as a trade union activist.

Maxine Junge: Art Therapists and the Paradoxical Gift of Sight

Art therapists are particularly talented at seeing; it is our stock in trade. As the dictionary states, seeing is "perceiving, coming to know, forming a mental picture of, and understanding the meaning of something."* Seeing, we come to profoundly understand our clients. Visible in their art expression are the depths of their terrors, the joys of their inner worlds, and their efforts to change these worlds. The art therapist's and the client's engagement with the process of creativity as a method of inquiry and a way of knowing, pictorially reveals and externalizes reservoirs of memory and deeply felt implicit and tacit awarenesses hidden from consciousness.

Art expression takes us to unknown places beneath the silences of words and brings the terrors of the dark into the light where they may be tamed. All human beings are paradoxically both cursed and blessed by the darkness of not seeing. What do we look at when we see? We cannot bear to look upon mountains of corpses, faces from the Holocaust, or images of the evil of African-American slavery and oppression. Such imagery assaults our eyes and threatens to burn them out. By seeing too much we go blind; we close our eyes to defend against our own powerlessness in the face of horror. But by closing our eyes to shut off what is too terrible to know, we may go blind to what is before us.

What do we see when we look? Thirty-five thousand people die of starvation each day; the majority are children. The images of Somalia haunted us and, finally, led to United Nations' and American intervention, but many died and will still die before help arrives. The great plague of AIDS confronts us daily; there are two or three listings each day in the Los Angeles obituaries. Already lost are many of our best and our brightest. The violence of the cities explodes daily, in particular against and within minority groups. Recently, we rejected as President a man who advocated a "kinder, gentler world" and in a condition of astounding denial refused until the end to see beyond his office walls to the desperate realities in which many people live.

What do we see when we look? A decade of denial when we allowed ourselves to be lulled to sleep by a handsome, forgetful Hollywood actor and his

---

*Websters Ninth New Collegiate Dictionary

Editor's note: A different version of this paper was presented at the Annual Conference of the American Art Therapy Association, San Francisco, California, November 1989.

successor. We see a country where in most places the sale of fireworks is illegal, but the sale of machine guns is not. In the Los Angeles rebellion or "riot" (as you may choose to call it), we saw the faces of despair and desperate, encroaching poverty and racism. We saw the logics of pain unraveling identity. In the year since that cataclysmic event which altered the consciousness of our nation, not much of a concrete nature has happened to "rebuild L.A." How can we come to know the truth in Krishnamurti's words: "You are the world and the world is on fire"? This image that lies before us is what we must see.

Artists as Those Who Help People See

We who come to the profession of art therapy embrace the tradition of artists as those who help people see. We resonate with the idea of the artist as outsider, observer, social critic. Imagine the images of Bosch, Goya, Daumier, Ben Shahn, Picasso's "Guernica," Maya Lin's Vietnam memorial in Washington, her civil rights memorial in Montgomery, Alabama with Martin Luther King's words on it, "Until justice rolls down like water and righteousness like a mighty stream," and the AIDS quilt. Let these images glide through your mind and speak their truths to your heart.

As these images move through your mind, you cannot avoid feeling the sweeping power of the arts for change . . . you *feel*. And it is that word—"feeling"—that is the problem. Feeling requires that we open our eyes to break through our denial. It leads to deep questioning about ourselves and our world, intense discomfort, possibly despair and possibly joy. Feeling lets us know what we try hard not to see: that we do not have control over much. Feeling leads to opening the windows so that the unknown comes in and the winds of change blow through, so that we can see.

The Role of Imagination

The great painter Goya told us that "the sleep of reason produces monsters." The key to sight and, beyond it, to change is the power of the imagination. To paraphrase Goya: The sleep of the imagination produces, even in life, death. Imagination is the essence of hope—and of the potentialities of the creative process. However, the word "imagination" does not appear in the indices of many of the books about creativity written in the last 20 years. Additionally, dictionary definitions hold within them the intriguing duality of imagination as creativity and change on the one hand, and, on the other, as something not real, devoid of truth, as in "imaginary." But it is the act of imagination that offers a vision of something different, better, and the resulting hope that can impel us to action. The power of the imagination gave rise to the dream of democracy, in China for example, and the tumbling of the Berlin wall and the national boundaries which have tossed Eastern Europe into so much chaos. These examples prove that change seldom comes when or as we expect it to, nor in a necessarily orderly or predictable fashion. The concept of planned change is, indeed, an oxymoron.

Psychotherapists, Art Therapists, and Social Change

Psychotherapists, unlike artists, have not tended to be activists, but rather agents of social control. As the mental health system has crumbled around us and our clients in the last 10 years, we must wonder if our twin identities of artist/therapist—the artist awake to change and the therapist holding on to containment—force us into some impossible double bind.

At first therapists saw the individual and his or her intrapsychic problems, but not beyond the boundaries of the person's psychic skin. Most therapists sat in the protected havens of their offices and waited for clients. A powerful conceptual leap occurred when we widened our view of the individual's struggles to also include the family system. However, most therapists have not yet taken to the streets or viewed our territory to include the community, society, and the larger world environment. All too often therapists heal what is already wounded and do not attend to the milieu which wounds and re-wounds again and more deeply.

Suggested by Jung, Rank, and others, people project outwardly the dark sides that cannot be tolerated within. For example, in the 12th and 13th centuries, at a time of denial of the body, leprosariums isolated lepers so that they would not have to be seen, to infect others with the awareness of bodily reality and mortality. At the beginning of the Renaissance, a time of renewed worldly sensuality and the birth of rationality, leprosy died out and the leprosarium buildings became insane asylums. Insanity, thus, became the disavowed projection of the age of science and rationality—insanity which must be locked away from view.

In more recent times psychotherapists have embraced the notion of themselves as scientists, objectivists, rationalists of the psyche. They focused on examination of the individual mind, with social adaption as a goal—let us not forget the era of lobotomies. The value of conformity to the culture was, and to a large extent still is, the norm within the white male medical hierarchy; the labeling of deviance as psychopathology had as its intention the reification of control. If deviance and irrationality are incarcerated, they become invisible, and safety of the status quo can be maintained.

That our ideas are culturally and socially constructed is not news. Even in the short 20 years I have been in the mental health field I can remember when mothers were blamed for all problems in their children, particularly boys. (This mother-blaming era, of course, is not over yet!) Schizophrenia was thought to be caused by families, particularly schizophrenogenic mothers. Autistic children were a result of "ice box" or very distant parents. Father/daughter incest was not all that bad and could even be helpful for a girl. The dominance of women in single-parent black families was destroying black men and children, and a patient who was unable to get to the clinic with her six children because she could not afford the bus fare was considered resistant to change. Although paradigms and pendulums shift, we retain within the new, habits of the old. Thus, many of these ideas remain today in barely disguised forms.

O'Connor, in his article "Therapy for a Dying Planet" (1989), writes of an incident which occurred in Frieda Fromm-Reichmann's practice before she left Germany to come to the United States:

> A young woman with numerous irrational fears came to her for help. During the course of psychoanalysis, the patient gradually overcame her fears, and after three years, the therapy was successfully ended. A few weeks later the young woman, who was Jewish, was picked up by the Gestapo and sent to a concentration camp. (p. 70)

The message is obvious: In the words of a social psychologist friend, "Are we missing the forest for the clouds?" As art therapists are we too often helping people adjust to a destructive society? Are we ourselves co-opted by the status quo and, understandably, yearning to be inside, adapt, make do, and continue to cope with a fatally injured mental health system?

Art Therapy Education and Activism

What about the art therapist's education as education for activism? Does our education help us see?

A part of our history as art therapists that may impede us is that we have been trained as "appreciators" of art, as reflectors, supporters, explorers of the intrapsychic landscape rather than pro-activist, co-creators engaged together with our clients in their struggle, which is ultimately also our own. Typically, we are not trained as advocates or revolutionaries, not as social and cultural analysts or critics, but as those who through the art therapy process help people cope and adapt.

As the director of a masters program, I confess to you my belief that all too often education is not authentically based. The process of professionalization itself initiates the student into the community through a series of formalistic rituals which deaden the senses and overinflate the thinking processes to the exclusion of feeling and imagination. As art therapists, we learn many unforgettable lessons about change. Unfortunately, when student therapists graduate into the professional world and seek to enter the ranks of employed and respected practitioners, in the words of Pogo, "They see the enemy and the enemy they are us." Quite naturally, with student loans on our backs, we embrace the status quo, strive to climb the hierarchical ladder, and forget everything we ever knew about the artist's mission to make waves.

As example, a few years ago our masters program engaged in deep changes in the system which included not only the department, but also the university, the mental health community, and the state. On the face of it, a simple issue of licensing was at the core. We all are aware that there are political and economic tides that arise out of complex struggles and exert enormous pressures on our lives. In addition, themes of the artist, the arts, and therapy as outsiders in the academy and in the mental health professions were apparent along with art therapy emerging as the projected dark side of rational, scientific, behavioral psychology.

In this circumstance, people, particularly students, refused to accept the status quo. They found that the answers were in themselves and empowered them to action. Touching the strength in themselves was education at its best, and in an extraordinary way helped them understand the meaning of empowering their clients as human beings. In our profession we need this kind of systems observation, reflection, and social change, and must undertake this willingly, with our eyes wide open.

I propose that it is time for art therapists to take another conceptual leap—an activist leap. To begin, we must recognize ourselves and those with whom we do therapy as deeply interrelated. Next, we must acknowledge that we and our clients are part of larger systems in which life and work can go on or may end in despair. And we must see that struggle clearly and engage in it strategically and effectively beyond the boundaries of office walls and the psychic limitations of our own consciousness and denial.

Art Therapists as Activists: Three Stories

Following are the experiences of three art therapist/activists. Christine Volker and Anne Kellogg speak in a dialogue about their participatory research project with Central American refugees. Janise Finn Alvarez was also part of the work. She writes about her participation and work as a trade union activist.

Christine Volker and Anne Kellogg: A Dialogue

Christine Volker:

I come from the tradition of the artist/activist. In art school I found myself drawn to the work of Kathe Kollwitz, the German Expressionist artist. Although Kollwitz's work was inspired by a great spirit of social activism, I could never make that leap in my own artwork. An axiom of the formalist school of painting prevalent in my art education strictly stated that one did not mix politics with art. As a result, I kept my political activism and my art separate throughout the 1980s.

New political activism eventually led me to Nicaraqua in 1986. I celebrated New Year's Eve with the campesinos of the state-run coffee farm cooperative where we had been picking coffee beans high up in the mountains. Later, I drank a toast with Luis, a Commandante of Sandanista troops stationed there to guard us from Contra attack. Our four-mile radius was protected, but nightly I heard the shooting and saw the helicopters flying the wounded to the hospital in nearby Matagalpa. As a result, I returned to the United States a changed person.

In 1987, I enrolled in the art therapy program at Loyola, where I was astonished to meet another social activist, Maxine Junge, who also happened to be the director of the program. In my first semester when I talked about my trip to Nicaraqua, a fellow student, Anne Kellogg, stated, "I feel very connected to you." From this connection began our joint clinical research project.

Anne Kellogg:

When Chris and I discovered each other, we realized we had both been previously active in social justice work with the Central American community. We decided to integrate our past and our present, developing a project we called "Going Through the Journey with Central American Refugees" which explored the conditions of uprooting, migration, and relocation through family art therapy.

Our project examined the family drawings and dynamics of Salvadoran and Guatamalan refugees who migrated to the Los Angeles area. Particular attention was paid to the psychological effects of premigration conditions, the migration process, and postmigration relocation in the United States.

CV: This work with refugees from El Salvador and Guatamala provided for us an integration of activism, art, and psychology. Our multiple personae have finally become one. This is partly what we hoped to accomplish with our interventions with the refugees: An integration of their past identity in their country of origin with their present reality as they adjusted to a new culture and country—an integration which involved an acceptance of self. For only in realizing our pain, can we heal.

AK: In the early '80s I became involved in housing Central American refugees as part of what was called "The Underground Railway." This movement helped to shelter, feed, and find work for Central Americans. As part of a church peace group, I became active in educating my parish about U.S. involvement in Central America and the conditions refugees experience after their arrival in the United States. My parish supports a sanctuary house in Los Angeles called Casa Grande which gives short-term shelter to arriving Central Americans. One million Central American refugees have arrived in the United States in the last 10 years, largely due to increasing violence and oppression in their countries. While many of these people now receive amnesty under the 1986 Immigration Control and Reform Act, hundreds of thousands have illegal status and, if returned to their country of origin, could be subject to political reprisal, torture, or death.

CV: Our art therapy project was accepted by the committee at Casa Grande. The house is a temporary shelter which provides a safehaven and community for Central American refugees who have arrived in this country in the last one to five months. While staying in the house, refugees may apply for political asylum and search for work and more permanent living conditions.

AK: We hoped artwork would provide a safe place for containment of the multiple traumas experienced by these people during their uprooting, migration, and relocation. It was thought that the art process could facilitate grief and mourning, capitalize on family strengths, and begin to integrate past experiences with present reality. Perhaps most importantly the art product could create an historical document to be used as a touchstone marker in the defense of these peoples' human rights.

CV: We held two presession meetings with the families in the house before obtaining permission to do the therapy. We found our values as "gringo" psychotherapists challenged. We were questioned and rightfully so. "How could drawing pictures possibly help?" they asked. "Didn't we realize that these were painful issues better left alone?"

AK: As we attempted to address these questions, we felt an overwhelming respect for these people who had gone through so many traumatic experiences to reach our country. We also knew that our own country was responsible for fueling much of the violence with our military aid to El Salvador. We realized that this project was as much for our own healing as theirs. While it was difficult to establish trust and respect under these circumstances, we received approval to proceed with the group.

CV: The multifamily group consisted of 12 people, including two intact families. The others were single members of families who had come to the United States hoping to bring other members of their families later. Since families usually arrived in stages, many felt fragmented and experienced grief for absent members. Following are case examples of representative themes or issues which came up during group therapy.

The Chibarras were a reconstituted family consisting of Father, Esteban, Mother, Ana, two sons, Gustavo, 9 and René, 7, and one daughter, Estralita, 3.

Esteban fled to a refugee camp in Honduras when his village in El Salvador was ambushed by government soldiers. The soldiers would often come to the village looking for evidence of guerilla activity. When the soldiers came, the villagers would flee, taking specially prepared boxes of provisions which would sustain them in their hiding places until a scout informed them that the soldiers were gone. On one such occasion the returning villagers were met by a surprise ambush attack. A massacre ensued. Esteban was one of the returning villagers. He escaped the soldiers by diving into a lake and emerging behind a bush with just his nose and eyes above water. He watched while his village was burned and his neighbors slaughtered. He watched while his four children were butchered. He watched while his wife was raped and then shot to death.

After the soldiers left, Esteban ran to the nearest refugee camp. There he met Ana who had lost her husband in similar circumstances. Together they reconstituted a family, migrated to the United States, and found sanctuary at Casa Grande.

The artwork of this family depicts various intrusive themes—the bombs, soldiers with guns, helicopters flying overhead machine-gunning the people below. One drawing showed four children and a wife sitting at a table eating. The father, Esteban, is standing in the corner of the page. Esteban explained that he had returned to the village from the refugee camp in Honduras to get a table which had been left behind when he fled. Esteban had built this table for his family and retrieving it was important to him; it served as his transitional object. A border was drawn encircling the family, symbolically containing the anxiety stirred by this memory. Esteban said that the border represented a map of Honduras, yet he placed himself outside the family. Esteban's present family with his new wife Ana had only three children, yet here were drawn four children. Could Esteban have unconsciously drawn the family he had lost in the massacre?

In his drawing, René, age 7, showed two helicopters. One was black signifying the death helicopter shooting people on the ground below. A person was shown lying on the ground dead. Two donkeys looked on, one with a black death head. Three trees were drawn, all uprooted from the ground. One of the trees, like the person, is lying on its side, perhaps also dead, signifying that the life force itself was also dying. The house was depicted with people standing in the doorway, seen through the walls. The rendered Coca-Cola machine was a visible reminder of American involvement in El Salvador. René spoke about his drawing: "Here's the helicopter, here's the dead person, here's a fallen tree."

René was asked to draw something about the United States. He drew a helicopter shooting a figure holding a machine gun pointed upward outside Casa Grande in Los Angeles. People were inside the house, sitting at the table and two figures stood at the entrance. The recurring theme of the shooting helicopter was seen in many of the children's drawings and seemed to symbolize the common trauma of war they experienced. The children were also aware of helicopters in the skies over Los Angeles since on many evenings a helicopter could be heard flying over Casa Grande. For René the black image of the shooting helicopter represented a threat not only from the past but also in the present. This is an example of the intrusion of thoughts and feelings associated with past traumas which are symptoms of post-traumatic stress disorder.

Esteban's and Ana's 3-year-old daughter Estralita used glue, pen, masking tape, and collage as she created what she called "La Bomba." She and the two other young boys in the group were the only ones who mentioned bombs. The adults did not respond to this or talk about it. The children seemed to have more direct access to their memories of the traumas of war. The adults seldom referred directly to the conditions of the war relevant to their uprooting.

A collage by Esteban illustrated the conditions in El Salvador. There were four images: two men riding horses signifying life in the country; a scene of the desert representing the crisis in El Salvador; an old woman and her granddaughter, symbolizing love and respect for the elderly; and a perspiring boy with a thermometer in his mouth, representing the sick ones and the sickness of the country.

Predominant in the children's drawings were destructive weapons of warfare. The helicopters firing down, the man with the machine gun, and the bomb. These represented intrusion into their present reality of the past traumas of war. The floating houses, which we found in many of the drawings, symbolized the loss of home and country and current rootlessness. • Casa Grande is only a temporary shelter. Floating houses without any baseline represented the insecure existence of these refugees in a foreign country.

The floating house, the uprooted tree, and the running man occurred repeatedly in the artwork and seemed to symbolize the trauma of the uprooting, the migration, and the relocation. The multi-family art therapy was brief crisis intervention work and did not allow for addressing the many losses in depth. But the project was a gesture of healing in the context of incomprehensible wounds.

AK: During our work at Casa Grande, we came to admire and respect the strength and courage of the men, women, and children we met. Through the art process and product we tried to validate this strength and normalize the natural responses that come from going through such out-of-the-ordinary experiences, to contain the pain in the context of the art.

CV: From individual statements presented by the refugees at the final evaluation meeting, the art therapy process helped more than any other kind of therapy that had been done at Casa Grande. Visual imagery allowed for the confrontation of painful past events. The refugees told us that this was not easy for them, but they said it was necessary.

AK: The creation of symbols to explore the uprooting, the migration, and the relocation offered the people the opportunity to address their traumas and to integrate them. But monumental wounds continue. People arrive with images of murder, rape, torture, and the loss of loved ones. When they first arrive, they are preoccupied with survival, but as time goes on the images return as nightmares. How can we provide healing in this overwhelming context? We believe the art helps; the people we have worked with say that it does.

Janise Finn Alvarez:

I was fortunate to have the opportunity to be the translator and the art therapist for the project described by Christine Volker and Anne Kellogg. The experience of working with the refugees was as empowering in its own way and as moving as anything that I have done. These people have courage and have been through things that even speaking of cannot give them their full weight.

I am Central American in heritage—Central American and Irish. My mother comes from Nicaragua, and my father comes from Ireland. There aren't too many Central American art therapists around. And I am bi-lingual—I was born in Los Angeles, but Spanish was my first language. I learned English in school.

Also I feel a kinship to many of the Salvadorans since one of the groups most persecuted there are trade unionists. It's up there with being a Jesuit priest in terms of the mortality rate. As disheartened as I often am by the attitude in the United States toward labor unions, I think most people have been successfully brainwashed by the forces of major business which Ronald Reagan personified and to which George Bush was handmaiden. It is powerful and deeply moving when I think of my trade unionist counterparts in El Salvador who are killed.

When I graduated from a masters program in art therapy, I was thrilled and grateful to have a job, especially the job I wanted working with families in the Hispanic community in East Los Angeles. But I started to get a little uncomfortable about the fact that art therapists and dance therapists were paid less than other M.A.-level therapists. Being an activist is first having pride. When you're a trade unionist, you have pride in your work. You feel you must be taken seriously and be listened to. I had a good sense of what I was and felt my training was good. I also believed that my specialty as an art therapist was very important and that I should actually be paid more than other therapists. But at first I didn't even try to get that across to others.

I mentioned my sense of injustice about the situation to people, and someone suggested that I run for the union negotiating team because we had a contract coming up in the agency. So I did. It was an empowering experience to achieve what I wanted, which was parity. The sense of sitting down across the table from your employer as an equal was also empowering.

Suddenly, I had changed the job. I didn't beg for it; I didn't plead for it. We just sat down and got what we asked for. I thought this was really wonderful: People's lives change this way. I helped myself, but I was also helping others. My dance therapist sisters on the staff were crying they were so excited with our success. They had been beaten down with the idea that we're just lucky to have a job. "Creative arts therapy—what is that? You're so lucky to get what you can get—whatever little crumb . . . five dollars an hour . . . ten dollars an hour . . . hey, you're doing well!"

That experience changed me. I went on and ran for president of the union chapter, and I continued to inform myself about labor history. It certainly dispelled a lot of the myths that I had heard over the years. I became the treasurer of the Local, which is a state-wide Local, representing social service workers throughout the state of California.

I also had a wonderful experience when I attended a women's conference. For one week I was surrounded by other union women from all over the western United States—rural women, urban women, professional, highly degreed women, and also sheet metal workers—all different colors, all different shapes. I'd never seen a less racist situation in my life. And we were all representing workers.

The strike that occurred at my agency was remarkable for me. After we resolved the strike, I went back to work at the clinic, and it was tough. I had to go back and deal with harrassment and the things that make people afraid of being in a union. One of the most effective methods that employers have when they wage a campaign against a union organizing drive is to say that it's going to be different—it's going to be nonadversarial. It *is* adversarial. It's not a question of morality. It's a question of each person looking out for his or her own interests, and if you're not looking out for yours and you're thinking that your boss is doing it for you, you're really in a dangerous, victimized situation. If you're leading your clients to believe that the world is basically okay and it will always take care of you, because you believe that, you're leading them into some dangerous situations.

A strike is, of course, the most adversarial of situations. We went out on strike and stayed out for 12 weeks. Even though the economic issues were settled in a week, management wanted to keep every scab they'd hired. If we had accepted that contract and gone back to work at that time, that would have been selling out so we stayed out for 12 weeks in solidarity. We were able to triumph. I'm very proud of that. It's a special moment in my life, though it was painful being without a paycheck for 12 weeks.

I am an artist and a labor activist, and I think there's a connection. An important social realist art tradition most of us are familiar with is the WPA work that came out in the '30s and how strong that was. It was the artists' responsibility then and now to speak out. As an art therapist/activist, I believe I have a responsibility to take what my clients are telling me and discern what is theirs and what is the chaos and injustice of the world they live in. If I say the responsibility is mainly the client's, then I am doing something that is not unlike what a bad boss does to her or his employee. I am causing the client to be weakened. A therapist may even wrongly think she or he is empowering the client by giving him or her a sense of an unrealistic idea of what the world is—the sense that it's all their doing. It is not. Children in Central America saw bombs dropping. They didn't imagine that. The devastation that occurred in their lives wasn't their choice. It was die or leave—it was that simple. And so they did leave. Now they are in pain, and there's a realistic reason for that. They should be in pain and they should be angry as hell. And we should be angry as hell, too.

I see my roles as an art therapist and activist intertwined. I can't just think of that person in front of me as my client for one hour. I must consider what that person goes home to, what that person's life is about. If I am not doing something to rectify the injustice that's creating the problem in that person, then I'm just hand-holding and frankly I don't want to be a part of it. If you do not act, you become accepting of all that happens to you.

The Challenge: Toward Community

The art therapist has had a proud tradition as a pioneering individualist. But we believe the time is now to move away from individualism toward community, to break through and look at the world we and our clients live in, and to work to change it. A colleague, a Korean who grew up in this country, went back to Korea recently. The Koreans he met said to him, "Do not come to help us. Come in solidarity. We do not need your help. We need community with you." We must look to each other, to other creative arts therapists, to other people to form a community—a global community in which human growth is prized. Together we must find the courage to take the actions to ensure this vision.

Joanna Rogers Macy, a peace activist, has written:

> When we face the darkness of our time openly and together, we tap deep reserves of strength within us.

> Many of us fear that confrontation with despair will bring loneliness and isolation. But—on the contrary—in the letting go of old defenses and our denial, truer community is found. In the synergy of sharing comes power. (1983, p. 75)

With our eyes wide open, as art therapists/activists in the human community we must cherish the transcendant dream of a just and creative society and using our imaginative hopes, nurture it into being by our actions. As art therapists we have unique talents to offer in this regard.

In Maya Angelou's words from her inaugural poem (1993) for President Bill Clinton:

> History, despite its wrenching pain,
> Cannot be unlived, and if faced
> With courage, need not be lived again . . .
>
> The horizon leans forward
> Offering you space to place new steps of change.
> Here, on the pulse of this fine day
> You may have the courage
> To look up and out. . . .

Finally the challenge:

> Lift up your eyes upon
> This day breaking for you.
> Give birth again
> To the dream . . .
>
> Lift up your hearts
> Each new hour holds new chances . . .

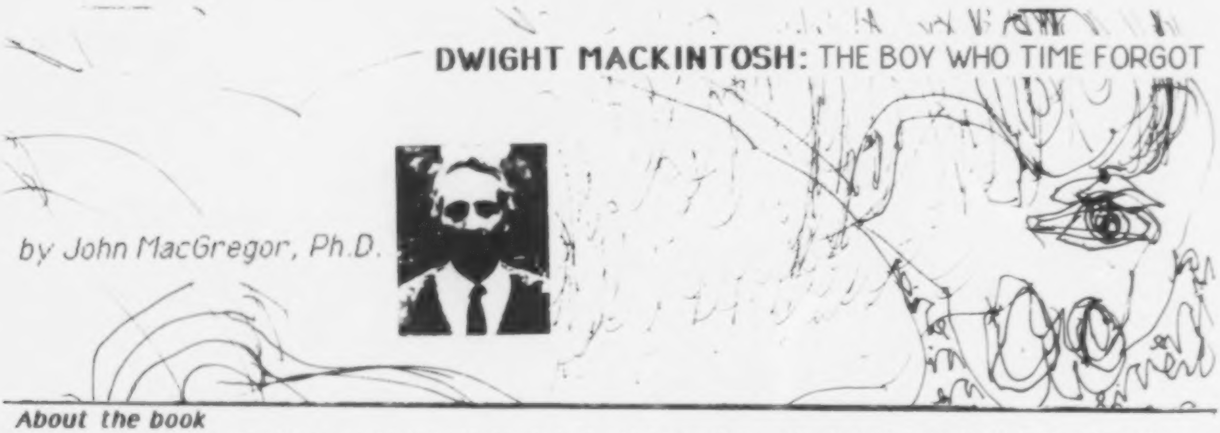
Correspondence concerning this article may be directed to: Maxine Junge, PhD, A.T.R., Director, Clinical Art Therapy Masters Program, Loyola Marymount University, 7101 West 80th Street, Los Angeles, CA 90045.

References

Angelou, M. (January 17, 1993). "Inaugural Poem" printed in *USA TODAY*, 7.

Macy, J. R. (1983). *Despair and personal power in the nuclear age.* Philadelphia: New Society Publishers.

O'Connor, T. (1989). Therapy for a dying planet. *Family Therapy Networker*, *13*(5), 69–72.



DWIGHT MACKINTOSH: THE BOY WHO TIME FORGOT

by John MacGregor, Ph.D.

About the book

Dwight Mackintosh: The Boy Who Time Forgot is the result of a unique collaboration between author/scholar John MacGregor, Ph.D., Creative Growth Art Center, a studio and gallery for mentally and physically disabled adults; and Coleman Souter, a San Francisco design firm.

The book follows a 15-year obsession with image making by elder Dwight Mackintosh, working a remarkable artistic environment in downtown Oakland, California. The inner world of an Outsider artist is revealed in Mackintosh's exquisite drawings, and made accessible to the reader by the poetic prose of author John MacGregor.

Retail Price

Hardcover $18.50, Softcover $11.00, Shipping & Handling $1.00, add 50 cents for each additional copy. California residents add 8.25% sales tax. Dealer inquiries are invited.

CREATIVE GROWTH ART CENTER 355 24TH ST., OAKLAND, CA 94612 Tel (510) 836-2340

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 156-158 © AATA, Inc. 1993

Brief Reports

Art Therapy Faculty Survey

Vija B. Lusebrink, PhD, A.T.R., Louisville, KY

Abstract

A survey of 29 graduate and undergraduate faculty in art therapy showed that both graduate and undergraduate programs rely heavily on part-time faculty. The part-time faculty do only teaching and do not receive any benefits, except for a couple of instances. The full-time faculty's duties, in addition to teaching, include research and service requirements which range from 0–25%. They all receive medical insurance, but only two-thirds of the programs offer retirement benefits for their full-time faculty.

As Chair of the 1992 Research Committee, I conducted a survey of art therapy faculty in different institutions of higher learning. The survey focused on the following areas: number of full- or part-time faculty, salary range, teaching load and other job-related assignments, benefits, and whether a doctoral degree was necessary for the position. In addition, information was collected in regard to the necessity for doctoral degrees and programs in art therapy in the future.

A total of 73 survey forms were mailed to different graduate-level and undergraduate programs, including those offering only some courses in art therapy. This information was based on the AATA 1990 brochure on programs in art therapy. Of the 29 replies received, 10 were from accredited graduate programs, two from graduate institutes, and two from clinical training programs. Other replies received were from the following: a program offering an area of concentration in art therapy for doctoral studies; two programs in graduate studies with 21 credit-hours in art therapy; one program offering both an undergraduate and graduate program; an Extension program offering both a post-master's certificate and an External Degree program option in art therapy; one graduate program offering a survey course in art therapy.

Of the eight replies received from undergraduate programs, three stated that their respective programs were either terminated or not in existence.

Faculty Status

One of the outstanding features of both graduate and undergraduate programs is the reliance on part-time faculty.

Of 10 approved graduate programs:

- 1 program has four full-time faculty;
- 3 programs have three full-time faculty;
- 2 programs have two full-time faculty;
- 4 programs have one full-time faculty.

The number of part-time faculty in the graduate programs ranged from 2 to 16 with a mean of 7.4 part-time faculty. For the undergraduate programs only one program had three full-time faculty; two programs had full-time directors; the number of part-time faculty in the undergraduate programs ranged from none to four.

Salary

The salary ranges of graduate university-based programs are represented in Table 1.

Table 1
Salary Ranges of Full-Time Graduate Faculty

	Range	Mean
Director/Professor	$55,000–$60,000 +	$57,500 +
Director/Associate Prof.	$50,000–$55,000 +	$52,500 +
Director/Assistant Prof.	$32,000–$50,000 +	$39,250
Professor	$40,000–$58,000	$51,000
Associate Professor	$40,000–$50,000	$46,700
Assistant Professor	$28,000–$42,800	$37,200

Table 2
Part-Time Salary Range as Adjusted for a Three Credit-Hour Course (N = 80)

	Range	Mean
Professor and Associate Prof.	$2,800–$5,000	$3,900
Assistant Professor	$1,500–$4,000	$2,640
Instructor	$1,500–$3,000	$2,310

Institute faculty were paid by the number of students enrolled in classes. Clinical internship program directors' salaries ranged from $30,000–$40,000, with the mean of $37,000. The salary ranges for part-time faculty in graduate programs are represented in Table 2.

In all the undergraduate programs, the directors' salary range was $30,000–$40,000, with a mean of $32,500. As already indicated, only one undergraduate program had two full-time faculty members, in addition to the director, at the assistant professor level; their salary was $25,000.

The pay for undergraduate instructors for a three credit-hour course ranged from $1,160–$1,200.

Duties

The survey questionnaire specified the following categories for faculty duties: teaching, administration, research, and service. The duties of the full-time faculty of approved programs are represented in Table 3.

The part-time faculty did only teaching, except in a couple of instances where they had some administrative, service, or research duties. The number of courses taught by part-time faculty ranged from one to three.

The duties of the directors of institutes and clinical internship programs are represented in Table 4 and undergraduate programs in Table 5.

Table 3
Duties of the Full-Time Faculty of Approved Graduate Programs (N = 10)

	Directors		Full-Time Faculty	
Duties	Range	Mean	Range	Mean
Teaching	20–60%	45%	25–80%	64.25%
Administration	20–65%	37.5%	0–25%	10.12%
Research	0–25%	7.12%	0–25%	11.25%
Service	5–25%	13.5%	0–25%	14.37%

Table 4
Duties of Directors of Institutes (N = 2) and Clinical Internship Programs (N = 2)

	Institutes		Clinical Internship Programs	
Duties	Range	Mean	Range	Mean
Teaching	25–50%	37.5%	25–65%	45%
Administration	25%		25%	
Research	0–25%	12.5%	0–10%	5%
Service	25%		5–50%	22.5%

Table 5
Duties of Directors of Undergraduate Programs (N = 2)

Duties	Range	Mean
Teaching	25–40%	32.5%
Administration	40–50%	45%
Research	0–5%	2.5%
Service	15–25%	20%

Benefits

In all university-based programs, full-time faculty received medical insurance, as did those in one institute program and in one clinical internship program.

Other benefits received by full-time faculty were:

- Retirement (10 out of 16 reported data);
- Free tuition for course(s) (7 out of 16 reported data);
- Life insurance (6) and disability insurance (6).

One of the institute programs offered its faculty medical insurance, and the other tuition remission. Of the clinical internship programs, both offered retirement, and one also offered medical insurance and tuition remission.

The biggest difference between full-time faculty and part-time faculty was the fact that part-time faculty did not receive any benefits, except for one program which offered medical insurance and tuition remission, and another program which offered tuition remission.

Faculty with Doctoral Degrees

All or part of the faculty (12 out of 19) in university-based programs or departments offering art therapy courses have doctoral degrees. Seven of the universities which either have graduate programs or offer courses in art therapy already require their faculty to have doctoral degrees, and five will require a doctoral degree in the future.

Presently, only one university offers a doctoral program, which is in art education with the option of an area of concentration in art therapy. Five programs are planning to start doctoral programs within 5 to 10 years.

Of the 19 university-based responders, 12 indicated the need for doctoral-level programs in art therapy especially to prepare individuals for teaching positions and to obtain a base of knowledge in art therapy. One correspondent pointed out that "art therapy disparately needs systematic research, and doctoral research is a way or means to extend the knowledge base of art therapy." Five other respondents were undecided about this need. One respondent did not see a need for doctoral degrees for researchers/practitioners and clinicians.

Conclusion

The present sample of the surveyed programs in art therapy reiterates the fact that most of the graduate and undergraduate programs depend to a large extent on part-time faculty. This necessity provides some benefits to students, such as offering a wide range of approaches to art therapy, especially in the clinical area. The benefits to institutions of higher learning are obvious since part-time faculty are less expensive, they draw lower salaries, and do not receive benefits. Unfortunately, relying on part-time faculty can be detrimental to the field of art therapy in the long-range view, since part-time faculty are not involved in research.

The difference in salary of the various levels of graduate faculty range from $10,000–$18,000. The present survey did not ask for the length of employment, which would account for some of the differences. The salary for the undergraduate faculty is low, especially at the assistant professor level. Hopefully, the present survey will provide some supportive data for the AATA in this area.

In regard to research, the percentage of time devoted to research by the faculty is low. Development of doctoral programs would not only prepare art therapists for teaching, but also offer them the opportunity to engage in systematic research. As pointed out by several respondents, the field of art therapy needs to increase its base of knowledge.

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 159-168 © AATA, Inc. 1993

Age and Gender Differences Expressed Through Drawings: A Study of Attitudes Toward Self and Others

Rawley Silver, EdD, A.T.R., HLM, Sarasota, FL

Abstract

This study investigated gender and age differences in attitudes expressed in response to a drawing task. Subjects included 531 respondents in five age groups: children ages 7–10, younger adolescents ages 13–16, older adolescents ages 17–19, younger adults ages 20–50, older adults ages 65 and older.

Although proportionally more females than males drew pictures about relationships, and more males than females drew pictures about solitary subjects, these differences did not reach statistical significance. However, when the attitudes expressed *toward self and others were taken into account, significant differences were found.*

1. *Respondents tended to choose and draw subjects the same gender as themselves to a highly significant degree.*
2. *Males expressed positive attitudes toward solitary subjects, negative attitudes toward relationships to a highly significant degree.*
3. *Females expressed positive attitudes toward solitary subjects, both positive and negative attitudes toward relationships to a highly significant degree.*
4. *Males showed significantly higher frequency than females in drawing about assaultive relationships. However, age and gender differences interacted resulting in a significant age variability in assaultiveness for females but not for males. The proportion of older women who drew pictures about assaultive fantasies exceeded the proportion of older men who did so, as well as the proportion of all other female age groups.*
5. *A converse age and gender interaction was found for caring relationships. Males showed significant age variability whereas females had significant frequency of caring relationships across all age groups. The proportion of younger men who drew pictures about caring relationships exceeded the proportion of younger women who did so, as well as the proportion of all other male age groups.*

Introduction

This study asked whether responses to a drawing task can express attitudes toward self and others, whether males and females have characteristically different attitudes, and if so, whether attitudes change from youth to maturity to old age.

Although these questions are not usually asked by art therapists, answers may provide useful norms for evaluating emotional needs as well as more accurate expectations. For example, several studies have found that males focus on independence and competition, that females focus on connectedness and caring for others, and that our school systems favor the male point of view (Gilligan, Ward, & Taylor, 1988; Tannen, 1991; *The American Association of University Women Report*, 1992). These studies based their findings on academic achievement and verbal communication.

Editor's note: This research study received the 1992 Research Award of the American Art Therapy Association. It is included in this special issue of *Art Therapy* to highlight Dr. Silver's professionalism and commitment to art therapy research.

This paper presents an expansion of a study of gender differences in drawings by children (Silver, 1992). It considers the same questions but expands the inquiry and includes adolescents and adults. The underlying theory—that drawings can yield information about differences between genders and age groups—received some support in another previous study (Silver, 1987). Differences between genders were found in the emotional content of drawings across four age groups: third graders, high school seniors, younger adults, and older adults. The male groups consistently portrayed more negative environments inhabited by positively seen subjects; female groups seemed to relate subjects to environments, portraying fortunate subjects in pleasant worlds and unfortunate subjects in unpleasant worlds. These differences were significant across the four age groups. To the extent that the principal subject of a drawing reflects the self-image of the person who draws it, and the environment reflects the way that person perceives the world, the findings suggested that boys and men tend to see themselves as fighting in a dangerous world, while women and girls tend to see themselves as part of the world rather than opposing it.

The case for unconscious representation of the self in human figure drawings has not been firmly established, according to Harris (1963). He suggests that the concept defies objective validation and questions the theories of Machover (1949) and Buck (1948). Harris also cites studies of gender differences by Jolles (1952) who found that 80% of children ages five to eight drew their own sex first, and by Schubert and Wagner (1954) who found that a smaller proportion of women drew the female figure first than the proportion of men who drew the male figure first.

The present study is an attempt to clarify previous findings by asking three questions:

1. Do respondents to a specific drawing task choose same-gender subjects to a significant degree, supporting the view that the subjects of drawings reflect self-images?
2. Do women and girls respond to a specific drawing task with drawings about interpersonal relationships, while men and boys respond with drawings about solitary subjects?
3. Can responses to a drawing task provide information about age and/or gender differences in expressing attitudes toward solitary subjects and relationships, and if so, can this information clarify expectations and identify emotional strengths and weaknesses?

Methodology

In response to the first question, the genders of respondents were compared with the genders of principal subjects in their drawings. For answers to the second question, genders were compared after dividing responses into two groups: those portraying solitary subjects and those portraying relationships. For answers to the third question, responses were assessed on a five-point rating scale (see Figure 1).

Attitudes Toward Solitary Subjects

1 point: Strongly negative: for example, solitary subjects who are sad, helpless, or dead; the future seems hopeless.
2 points: Moderately negative: for example, solitary subjects who are angry, frightened, dissatisfied, or unfortunate.
3 points: Intermediate level: neither negative nor positive (unemotional) or both negative and positive (ambivalent or ambiguous).
4 points: Moderately positive: solitary subjects associated with passive enjoyment, for example, watching TV or being rescued.
5 points: Strongly positive: solitary subjects associated with active enjoyment, accomplishment, for example, drinking soda or escaping.

Attitudes Toward Relationships

1 point: Strongly negative: for example, life-threatening or assaultive relationships.
2 points: Moderately negative: for example, stressful, hostile, confrontational, or unpleasant relationships.
3 points: Intermediate level: neither negative nor positive (unemotional) or both negative and positive (ambivalent or ambiguous).
4 points: Moderately positive: for example, friendly or pleasurable relationships.
5 points: Strongly positive: for example, caring or loving relationships.

Figure 1. Rating Scale for Assessing Attitudes Toward Solitary Subjects and Relationships Expressed in Response to the Drawing Task

Age and gender groups were then compared in terms of percentages and mean scores.

Subjects

Subjects for the study included 531 children and adults, 257 male, 274 female. Five age groups were sampled: children ages 7 to 10, young adolescents ages 13 to 16, older adolescents ages 17 to 19, younger adults aged 20 to 50, and older adults ages 65 and older.

The children included 116 girls and 145 boys attending grades 2, 3, and 4 in urban and suburban elementary schools in New Jersey, New York, Pennsylvania, and Ontario, Canada. Seven schools were public and one was parochial. The young adolescents included 28 females and 37 males attending grades 8 to 10 in three public urban and suburban schools in Pennsylvania and New York. The older adolescents included 38 females and 22 males attending 12th grade classes in New York urban and suburban public high schools, as well as a class of college freshman in Nebraska.

The sample of younger adults included 61 women and 25 men who attended lectures or workshops and responded to the drawing task anonymously. The older adults included 28 men and 31 women over the age of 65 who lived independently in their communities and responded anonymously to the drawing task while attending recreational programs or social occasions.

The Drawing Task

Respondents were asked to choose two drawings from the array of *Silver Drawing Test* (SDT) stimulus drawings, imagine something happening between the subjects they chose, then draw a picture of what they imagined. They were encouraged to change the stimulus drawings and to add their own ideas. When drawings were finished, they were given titles and discussed, whenever possible, so that meanings could be clarified. Examples of stimulus drawings are shown in Figure 2.

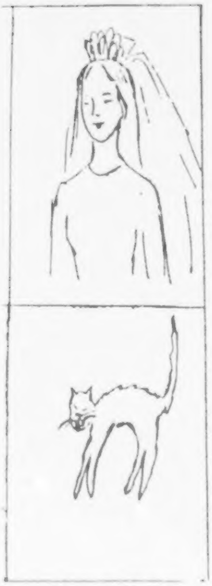


Figure 2. Examples of stimulus drawings.

The Assessment Instrument

The assessment instrument (Figure 1) was adapted in part from a scale in the *Silver Drawing Test* (*SDT*, Silver, 1990), a five-point continuum ranging between strongly negative and strongly positive themes. It was also adapted from the scale in *Stimulus Drawings and Techniques* (Silver, 1991) which was used in the 1987 study. Relationships between the two previous scales have been examined in a study of interscorer reliability in which 12 of the 24 scored drawings were responses to the *Stimulus Drawing* task and 12 were responses to the *SDT* task. No significant differences in mean ratings were found ($t(22) = .8$). Thus, there appears to be consistency of measurement between the scales. In addition, the new scale was developed from the scale used in the 1992 study (which was based on the two previous scales), but, in addition, distinguished between autonomous subjects and relationships.

Procedures

Responses were divided into two groups: drawings about solitary subjects and drawings about relationships between subjects. These were then examined for gender differences and similarities. It was theorized that respondents who drew solitary subjects thought of themselves as alone while those who drew relationships thought of themselves as part of a group. A solitary principal subject was defined as a person or animal acting autonomously, either the only living subject of a drawing or, if several living subjects are portrayed, they act independently or appear indifferent to one another. Drawings about relationships were defined as drawings of people or animals interacting with one another. The relationships may be visible in the drawing, verbalized in the story, or else implied.

Because the sample of children was considerably larger than any other sample, it was felt that an additional perspective on gender differences would be gained by equalizing the number of subjects in each group and obtaining mean scores on the five-point rating scale. With this in mind, 20 subjects from each of the age and sex groups were selected at random (N = 200) and mean scores of the 100 males and 100 females were compared. Although these numbers are too small for a reliable statistical analysis, they provided interesting information and raised questions for further research.

Results

Question 1. Do respondents to a specific drawing task choose same-gender subjects to a significant degree, supporting the view that the subjects of drawings reflect self-images?

Most respondents chose same-gender subjects. Among the 257 males in our sample, 54% chose male principal subjects, 11% chose female subjects, as shown in Table 1. Among the 274 females, 52% chose female subjects, 11% chose male subjects, as shown in Table 2. To determine whether they drew same-gender subjects to a significant degree, a 2 × 2 chi square (X^2) was calculated utilizing those males and females who clearly drew human subjects in their response drawings (N = 338). Results indicated that respondents who drew human subjects, drew same-gender subjects to a degree significant at the .001 level of probability ($X^2 = 145.839$ $p < .001$; $\phi = .657$). The phi coefficient (ϕ) was calculated on the chi square to determine the strength of the relationship. The phi coefficient ranges from ϕ, a weak or nonexistent relationship, to 1, a very strong, definitive relationship.) This finding seems to support the assumption that responses to projective drawing tasks tend to be self-gender images.

Another similarity between genders was found in the choice of animal subjects (34% males, 31% females) which seemed to serve as human symbols, consciously or unconsciously disguised. This observation was illustrated in the response of an older man who apparently drew an analogy: man chases women as dog chases cats (Figure 3).

The tendency to choose same-gender subjects peaked in childhood (63% girls, 59% boys) and reached its lowest level among adults. A surprising difference between genders also appeared. Among younger adults, the tendency to choose same-gender subjects declined to virtually the same level (40% men, 39% women). Among older adults, however, the decline continued among older women, but reversed among the older men, most of whom, like the sample of boys, chose male subjects (boys 59%, older men 54%).

Only 19% of the older women chose same-gen-

Table 1
The Gender of Principal Subjects in Drawings by 257 Men and Boys

Age, Number	Male Subjects	Female Subjects	Animal Subjects	Unclear
7-10, N = 145	86 (59%)	09 (6%)	50 (34%)	0
13-16, N = 37	17 (46%)	03 (8%)	17 (46%)	0
17-19, N = 22	10 (45%)	04 (18%)	08 (36%)	0
20-50, N = 25	10 (40%)	06 (24%)	05 (20%)	4 (16%)
65+, N = 28	15 (54%)	05 (18%)	07 (25%)	1 (4%)
257	138 (54%)	27 (11%)	87 (34%)	5 (2%)

Table 2
The Gender of Principal Subjects in Drawings by 274 Women and Girls

Age, Number	Male Subjects	Female Subjects	Animal Subjects	Unclear
7-10, N = 116	12 (10%)	73 (63%)	31 (27%)	0
13-16, N = 28	05 (18%)	16 (57%)	07 (25%)	0
17-19, N = 38	05 (13%)	23 (61%)	10 (26%)	0
20-50, N = 61	06 (10%)	22 (39%)	26 (43%)	05 (8%)
65+, N = 31	03 (10%)	06 (19%)	09 (29%)	13 (42%)
274	31 (11%)	142 (52%)	83 (31%)	18 (7%)

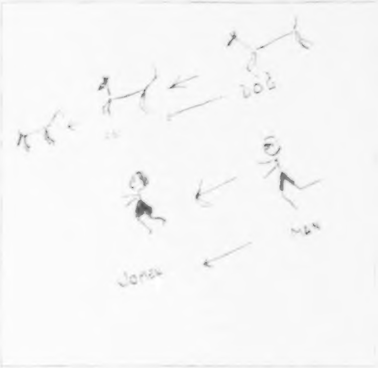


Figure 3. Drawing by an older man.

der subjects, a proportion smaller than any other age or gender group. It should be noted, however, that 42% of the older women, a proportion larger than any other age or gender group, drew genderless human subjects. By comparison, all the children and adolescents who drew human subjects drew them as male or female.

Question 2. Do women and girls respond to a specific drawing task with drawings about interpersonal relationships, while men and boys respond with drawings about solitary subjects?

Although proportionally more females than males drew pictures about relationships, and more males than females drew pictures about solitary subjects, these differences did not reach statistical significance. As shown in Table 3, of the 257 men and boys in the sample, 44% drew solitary subjects, 56% drew relationships. Of the 274 women and girls, 39% drew solitary subjects, 61% drew relationships. Both genders drew more relationships than solitary subjects

These findings may seem to deny that males tend to focus on self-sufficiency and females on responsibility and care, but when *attitudes* were taken into account, as in the third question, significant differences were found.

Question 3. Can responses to a drawing task provide information about age and/or gender differences in expressing attitudes toward solitary subjects and relationships, and if so, can this information clarify expectations and identify emotional strengths and weaknesses?

Proportionally more men and boys expressed positive attitudes toward solitary subjects (63% positive, 17% negative), negative attitudes toward relationships (57% negative, 26% positive) as shown in Tables 4 and 5. These differences were significant at the .001 level of probability ($X^2 = 46.971$, $p < .001$; ø = .474).

Proportionally more women and girls also expressed positive attitudes toward solitary subjects (68% positive, 17% negative) as shown in Table 6. Their drawings about relationships, however, were both positive and negative (46% negative; 41% positive, as shown in Table 7. These findings, too, were significant at the .001 level of probability ($X^2 = 25.32$, $p < .001$; ø = .327).

In addition, chi-square analyses were conducted on the frequency of particular attitudes expressed by males and females in the five age groups. The data on this analysis were limited to the frequencies of four attitudes: assaultive relationships, caring relationships, active solitary pleasures, and passive solitary pleasures.

Males showed a significantly higher frequency than females of drawings about assaultive relationships (X^2 (1) = 9.38, $p = <.01$). However, gender and age differences interact ($X^2(4) = 13.07$, $p < .05$), resulting in a significant age variability in assaultiveness for females ($X^2(4) = 11.89$, $p < .05$), but

Table 3
Comparing Genders in Drawings About Solitary Subjects and Relationships

Drawings by 257 Males			Drawings by 274 Females		
Age, Number	Solitary S.	Relationships	No.	Solitary S.	Relationships
7-10, N = 145	67 (46%)	78 (54%)	N = 116	43 (37%)	73 (63%)
13-16, N = 38	15 (39%)	23 (61%)	N = 28	09 (32%)	19 (68%)
17-19, N = 21	06 (29%)	15 (71%)	N = 38	16 (42%)	22 (58%)
20-50, N = 25	12 (48%)	13 (52%)	N = 61	22 (36%)	39 (64%)
65 +, N = 28	14 (50%)	14 (50%)	N = 31	16 (52%)	15 (48%)
N = 257	114 (44%)	143 (56%)	N = 274	106 (39%)	168 (61%)
M + F = 531	114* = 21%	143 = 27%		106 = 20%	168 = 32%

Table 4
Attitudes Toward Solitary Subjects in Responses by Boys and Men

Age, Number	Score				
	1. Sad or Helpless	2. Frustrated or Frightened	3. Ambivalent, Unemotional or Unclear	4. Passive Pleasure	5. Active Pleasure
7-10, N=67	3 (4%)	3 (4%)	13 (19%)	29 (43%)	19 (28%)
13-16, N=15	0	3 (20%)	3 (20%)	3 (20%)	6 (40%)
17-19, N= 6	0	2 (33%)	1 (17%)	2 (33%)	1 (17%)
20-50, N=12	0	5 (42%)	1 (8%)	2 (17%)	4 (33%)
65+, N+14	0	3 (21%)	5 (36%)	3 (21%)	3 (21%)
Total N=114	3 (3%)	16 (14%)	23 (20%)	39 (34%)	33 (29%)
	Negative: 19 (17%)			Positive: 72 (63%)	

Table 5
Attitudes Toward Relationships in Responses by Boys and Men

Age, Number	Score				
	1. Assaultive	2. Stressful	3. Ambivalent, Unemotional or Unclear	4. Friendly	5. Caring
7-10, N=78	15 (19%)	22 (28%)	17 (22%)	13 (17%)	11 (14%)
13-16, N=23	8 (35%)	6 (26%)	6 (26%)	2 (09%)	1 (04%)
17-19, N=15	7 (47%)	5 (33%)	1 (7%)	0	2 (13%)
20-50, N=13	2 (15%)	4 (31%)	0	1 (8%)	6 (46%)
65+, N=14	3 (21%)	9 (64%)	1 (7%)	1 (7%)	0
Total N=143	35 (25%)	46 (32%)	25 (17%)	17 (12%)	20 (14%)
	Negative: 81 (57%)			Positive: 37 (26%)	

not males. In other words, female assaultiveness appeared to change with age, whereas male assaultiveness remained stable.

The converse age and gender interaction was found for caring relationships ($X^2(4)=12.52$, $p<.05$). Males showed significant age variability (X^2 $(4)=13.10$, $p<.05$), whereas females had similar frequency of caring relationships across age groups.

No significant age or gender effects occurred for passive and active pleasures.

When attitudes toward relationships and solitary subjects were examined in greater detail some intriguing differences appeared:

1. Negative Attitudes Toward Relationships

Strongly negative (assaultive, 1 point). Proportionally more older women than older men responded with fantasies about aggressiveness (27% females, 21% males), the only age group in which females surpassed males, as shown in Tables 5 and 7. The least difference between genders was found among older adults; the greatest difference was found among children and younger adults. Five times as many younger men as younger women drew pictures about assaultive relationships (15% men, 3% women) and approximately four times as many boys as girls (19% boys, 5% girls). In both adolescent groups, about twice as many males as females drew pictures about assaultive relationships. The fantasies about assaultive relationships followed similar patterns with both genders, increasing with age from third graders to younger adolescents and to older adolescents, dropping to their lowest levels with younger adults, and rising with older adults.

Moderately negative (stressful relationships, 2 points). Although little difference between genders was found in drawing about stressful relationships (males 32%, females 36%), noteworthy differences appeared when age groups were examined.

Proportionally more older men expressed fantasies about stressful relationships (64%), than any other age or gender group. Also high was the proportion of younger adolescent girls (53%). An example is shown in Figure 4. The smallest proportion (14%) was found among older adolescent girls.

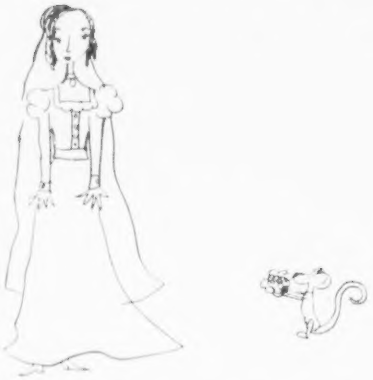


Figure 4. Drawing by a girl, age 11.

2. Positive Attitudes Toward Relationships

When caring and friendly relationships were combined, the female age groups excelled (41% females, 26% males). Differences appeared, however, when caring and friendly relationships were examined separately.

Strongly positive (caring relationships, 5 points). Almost no gender differences were found in drawings about caring relationships (15% females, 14% males); age differences, however, were found. The younger men produced the largest proportion of drawings about caring relationships (46%), a proportion surpassing all other male and female age groups (Figure 5). By comparison, only 10% of the younger women drew pictures about caring relationships. Among female age groups, the greatest disparities were found among adolescents (27% older adolescents, 5% younger). Among male age groups, the

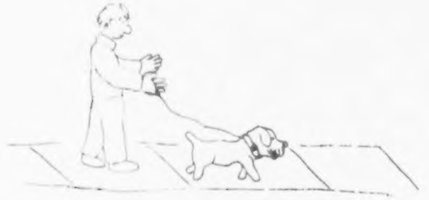


Figure 5. Walking my dog, by a young man.

Table 6
Attitudes Toward Solitary Subjects in Responses by Girls and Women

Age, Number	Score				
	1. Sad or Helpless	2. Frustrated or Frightened	3. Ambivalent, Unemotional or Unclear	4. Passive Pleasure	5. Active Pleasure
7-10, N = 43	2 (5%)	4 (9%)	7 (16%)	24 (56%)	6 (14%)
13-16, N = 9	1 (11%)	0	0	6 (67%)	2 (22%)
17-19, N = 16	0	3 (19%)	2 (13%)	8 (50%)	3 (19%)
20-50, N = 22	1 (5%)	4 (18%)	1 (5%)	10 (45%)	6 (27%)
65+, N = 16	2 (13%)	1 (06%)	6 (38%)	2 (13%)	5 (31%)
Total N = 106	6 (6%)	12 (11%)	16 (15%)	50 (47%)	22 (21%)
	Negative: 18 (17%)			Positive: 72 (68%)	

Table 7
Attitudes Toward Relationships in Responses by Girls and Women

Age, Number	Score				
	1. Assaultive	2. Stressful	3. Ambivalent, Unemotional or Unclear	4. Friendly	5. Caring
7-10, N = 73	4 (5%)	29 (40%)	7 (10%)	21 (29%)	12 (16%)
13-16, N = 19	3 (16%)	10 (53%)	2 (11%)	3 (16%)	1 (5%)
17-19, N = 22	5 (23%)	3 (14%)	2 (9%)	6 (27%)	6 (27%)
20-50, N = 39	1 (3%)	16 (41%)	6 (15%)	12 (31%)	4 (10%)
65+, N = 15	4 (27%)	3 (20%)	4 (27%)	2 (13%)	2 (13%)
Total N = 168	17 (10%)	61 (36%)	21 (13%)	44 (26%)	25 (15%)
	Negative: 78 (46%)			Positive: 69 (41%)	

smallest proportion was found among younger adolescents (4%).

Moderately positive (friendly relationships, 4 points). Approximately twice as many females as males drew pictures about friendly relationships (26% females, 12% males), and all age groups followed this pattern of gender differences.

3. Negative Attitudes Toward Solitary Principal Subjects

When strongly and moderately negative attitudes were combined, no gender differences were found (17% of both males and females). When they were separated, however, differences again appeared.

Strongly negative (sad or helpless, 1 point). Although few respondents drew pictures about sad or helpless principal subjects, the proportion of females doubled the proportion of males (6% females, 3% males) as shown in Tables 4 and 6. When age groups were examined, the largest proportions were produced by the sample of older women (13%) and younger adolescent girls (11%) (Figure 6). None of the older adolescent girls and only 5% of the children and younger women drew sad or helpless solitary subjects. Only three of the 114 male respondents drew sad or helpless solitary subjects, and all three were boys ages 7 to 10.

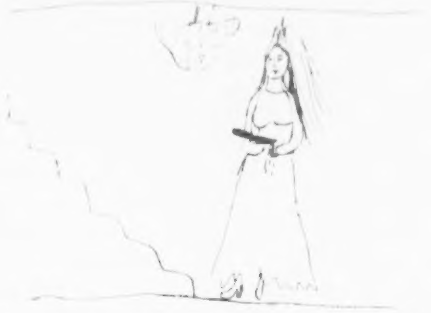


Figure 6. "The Dying Bride," by a girl, age 14.

Moderately negative (frustrated or frightened, 2 points). A larger proportion of males than females drew angry or frightened solitary subjects (14% males, 11% females).

4. Positive Attitudes Toward Solitary Subjects

Strongly positive (active pleasures, 5 points). Larger proportions of males than females associated solitary subjects with active pleasures (29% males, 21% females), except for the older women who reversed the tendency. A large proportion of older women than older men associated solitary subjects with active pleasures (31% women, 21% men).

Moderately positive (passive pleasures, 4 points). Larger proportions of females than males associated solitary subjects with passive pleasures (47% females, 34% males). The largest proportion was found among younger adolescent girls (67%); the largest male proportion among boys (43%).

In comparing mean scores, the females expressed more positive attitudes toward relationships than did males; males expressed more positive attitudes toward solitary subjects than did females, as shown in Table 8. Except for the sample of younger men, age groups among both genders had higher mean scores for solitary subjects than for relationships. The spread was greater for males than for females. The younger men received mean scores of 3.70 in both categories.

In attitude toward relationships, the younger men received a higher mean score, expressing more

Table 8
Comparing Mean Scores of 100 Males and 100 Females for Age and Gender Differences in Attitudes Toward Solitary Subjects and Toward Relationships

Age Group (N = 20)	Responses by 100 Males		Responses by 100 Females	
	Solitary Subjects	Relationships	Solitary Subjects	Relationships
1. 7-10	4.0	2.0	4.0	3.08
2. 13-16	4.5	2.25	3.59	2.62
3. 17-19	3.69	2.0	3.86	2.62
4. 20-50	3.70	3.70	3.33	3.27
5. 65+	3.50	1.92	3.25	2.42
Total Scores	19.39	11.87	18.03	15.16
Mean Scores	3.88	2.37	3.61	3.03

positive attitudes than any other age or gender group. The older men received a lower mean score, expressing more negative attitudes than any other age or gender group.

In attitudes toward solitary subjects, the younger male adolescents received a higher mean score expressing more positive attitudes than any other age or gender group. The older women received a lower mean score, expressing more negative attitudes than any other age or gender group.

Discussion and Summary

The findings of this study, built on previous findings, seem to support the assumption that the principal subjects of projective drawings tend to represent self-images. Respondents who drew human subjects, drew same-gender subjects to a degree that was highly significant at the .001 level of probability. For art therapists, this finding provides evidence that looking for overt and covert self-images in projective drawings is appropriate and productive. It should be noted, however, that even though comparatively few respondents drew principal subjects of the opposite sex, this finding may also have useful implications. These respondents, particularly the adults, tended to express *negative* attitudes toward opposite-gender subjects. Although the numbers were too small for statistical analysis, this observation suggests that further study with additional respondents would be worthwhile.

The study did not find that females draw pictures about relationships and that males draw pictures about independent solitary subjects. Although proportionally more females than males drew relationships, and more males than females drew solitary subjects, these differences were not statistically significant.

When responses were examined for particular attitudes, significant differences were found between age groups as well as gender groups. Males showed a stable and significantly higher frequency of drawings about assaultive relationships, as might be expected. It was surprising, however, to find that females showed significant age variability in drawings about assaultiveness. Female fantasies about being assaultive appeared to change with age. The proportion of women age 65 and older not only surpassed the proportion of older men as well as all other female age groups, but also surpassed the proportion of all male age groups combined.

When drawings about caring relationships were evaluated, it was surprising to find that males showed significant age variability. The proportion of younger men ages 20 to 50 not only surpassed the proportion of younger women as well as all other male age groups, but also surpassed the proportion of all female age groups combined. Again, the numbers were too small for statistical analysis, but hold promise for future studies.

The findings of this study raise questions about traditional expectations regarding ages and genders. It is usually expected that males are more aggressive and that females are more caring. Some investigators attribute these differences to social pressures and the way children are raised. Others look to biological causes, such as hormones which program males for aggression and competitiveness and females for caring and nurturing. One explanation for the finding about men age 20 to 50 fantasizing about caring relationships could be that they are biologically programmed to protect and care for their families. An explanation for the finding about older women fantasizing about aggression could be the effect of menopause on the production of estrogen and progesterone.

In any event, the findings seem to suggest that drawings can serve to identify age/gender differences in attitudes. If expanded, the findings may eventually provide norms on which to base more accurate expectations as well as information about emotional needs. For example, the older adults expressed more negative attitudes than any other age group. These findings suggest a need for thorough follow-up when drawings about sad, solitary subjects or stressful relationships are found.

On the other hand, it is important to note that many of the negative responses by older adults were characterized by sardonic or self-disparaging humor. The implication seems to be that art therapists who work with the elderly can expect to find not only frailties, but also wit and resilience.*

I hope some readers will be interested in joining this ongoing study by presenting the drawing task to additional respondents. If the sample populations can be expanded, some of the tentative findings reported here could be clarified.

References

The AAUW Educational Foundation. (1992). *How schools shortchange girls.* Joint publication of the AAUW Educational Foundation and National Education Association.

---

*For further details about the study of older adults, see Silver, in press.

Buck, J. N. (1948). The H-T-P technique: a qualitative and quantitative scoring manual. *Journal of Clinical Psychology, 4*, 151–159.

Gilligan, C., Ward, J. V., & Taylor, J. M. (1988). *Mapping the moral domain*. Cambridge, MA: Harvard University.

Harris, D. B. (1963). *Children's drawings as measures of intellectual maturity*. New York: Harcourt, Brace & World, Inc.

Jolles, I. (1963). A study of the validity of some hypotheses for the qualitative interpretation of the H.T.P. for children of elementary school age. *Journal of Clinical Psychology, 8*, 245–255.

Machover, K. (1949). *Personality projection in the drawing of the human figure*. Springfield, IL: Charles C Thomas.

Miller, J. B. (1976). *Toward a new psychology of women*. Boston: Beacon Press.

Schubert, H. J., & Wagoner, M. E. (1954). Sex differences in figure drawings by normal late adolescents. *American Psychologist, 9*, 467.

Silver, R. A. (1987). Sex differences in the emotional content of drawings. *Art Therapy: Journal of the American Art Therapy Association, 4*(2), 67–77.

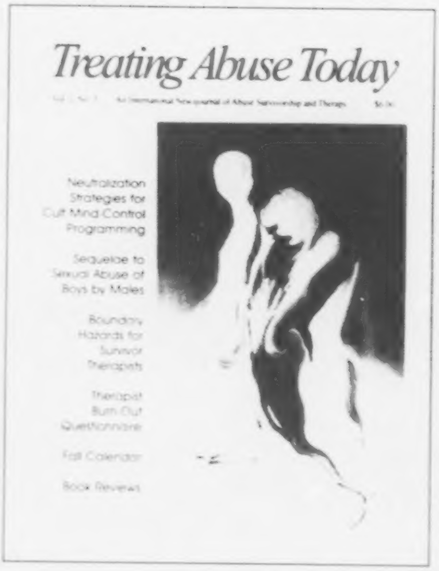
Silver, R. A. (1983, 1990). *Silver drawing test of cognitive skills and adjustment*. Mamaroneck, NY: Ablin Press.

Silver, R. A. (1991). *Stimulus drawings & techniques*. Sarasota, FL: Ablin Press Distributors.

Silver, R. A. (1993). Assessing the emotional content of drawings by older adults: Research findings and implications. *American Journal of Art Therapy*. In press.

Silver, R. A. (1992). Gender differences in drawings: A study of self-images, autonomous subjects, and relationships. *Art Therapy: Journal of the American Art Therapy Association, 9*(2), 85–92.

Tannen, D. (1990). *You just don't understand*. New York: Ballantine Books.


Treating Abuse Today
Neutralization Strategies for Cult Mind Control Programming
Sequelae to Sexual Abuse of Boys by Males
Boundary Hazards for Survivor Therapists
Therapist Burn Out Questionnaire
Fall Calendar
Book Reviews

UNIQUE RESOURCE DISK OFFER

With any two-year subscription ***Treating Abuse Today*** will enclose a **RESOURCE DATABASE©** disk for your IBM compatible computer — *FREE*. Three easy-to-use and valuable database programs are featured: extensive bibliography of publications pertaining to sexual abuse and recovery; listing of state, regional and national organizations providing services in the field of abuse survivorship; and index of state crime victim compensation agencies. This diskette also contains information regarding Clinical Training Publications, Inc., its newsjournal *Treating Abuse Today*, subscription details, author guidelines, and advertising information.

SUBSCRIBE TODAY!

NAME ______________________________
ORGANIZATION ______________________
ADDRESS ___________________________
CITY/STATE ________________ ZIP ________
COUNTRY ___________________________
PHONE _____________________________

☐ ONE YEAR INDIVIDUAL SUBSCRIPTION (6 ISSUES PER YEAR) — **$36**
☐ TWO YEAR INDIVIDUAL SUBSCRIPTION (*INCLUDES DISK BONUS*) — **$69**
☐ INSTITUTIONAL SUBSCRIPTION (ANNUAL) — **$66**

PAYMENT: ☐ VISA ☐ MASTERCARD ☐ AMEX ☐ CHECK

CARD NUMBER: ______________________
EXP. DATE _________________________

Make Checks Payable to Treating Abuse Today

FOR FURTHER INFORMATION OR TO ORDER, PLEASE CALL, WRITE OR FAX:
Treating Abuse Today
2722 Eastlake Ave. E., #300, Seattle, WA 98102
Phone (206) 329-9101, FAX (206) 329-9462
Compuserve ID#76430,2614

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 169-170 © AATA, Inc. 1993

Viewpoints

Art Therapy in Private Practice: Legal and Insurance Issues

Gail Wirtz, MAT, MPS, A.T.R., Chicago, IL

Unforeseen issues of litigation and insurability pose a potential threat to art therapists in private practice. Unlike social workers or psychologists, art therapists are not licensed by the state. This lack of certification jeopardizes our legal credibility and insurability. Frequently, art therapists must fight for any rights they might expect from the judicial system. We should be aware that this may be costly. Current association-sponsored insurance coverage falls far short of the needs of the art therapist in private practice.

For 10 years I have owned and operated an art therapy-art education business with a staff of six and an exposure of approximately 100 clients weekly. The center services families within a Chicago middle-to-upper-class community. Creative development classes serve parents and children, and individual art therapy is provided for children. Because of volume, I have had greater contact with the public, leaving me more exposed to legal and insurance issues than many art therapists.

During its operation, the center has been a viable and valuable asset, both to me and the community. However, several events caused me to reexamine the role of art therapy within the framework of legal and insurance issues. During the past three years, I have twice been involved in legal matters. Although different issues were addressed, the combined financial and professional impact led me to question the viability of private practice for art therapists.

The first case concerned a child who was allegedly abused by a janitor at her school. I worked with the child for three years. Ten years later I was subpoenaed to testify in the case as the child's therapist. Providing therapy for the child was not the most difficult aspect of the case; the difficulty arose in going to court as her therapist. I was not trained to give depositions, nor was I knowledgeable about my own malpractice liability, had I unknowingly crossed the defined role of art therapist. Aware of my lack of training in these areas, I chose to have a lawyer present in the deposition, for support and to assure that I would be defended.

I was informed that I would be an expert witness, compensated for the numerous hours of preparation and days of deposition. After two days of deposition, however, it became evident that the judicial system did not recognize art therapists as professionals, and, therefore, I was not eligible for compensation. At my lawyer's request, the judge clarified my status as an expert witness and my right to payment. The judge also reinstated my legal right to have written questions in advance for review with my attorney. Prior to this point, however, I was not paid for my work.

The intricacies of the sexual abuse case alerted me to examine my own vulnerability to sexual abuse charges. Now concerned with liability, I began investigating my own insurance policy which was through the association-sponsored company furnishing group rates for art therapists. An insurance broker who reviewed it was unable to get a clear answer regarding coverage for sexual abuse. The policy offered no obvious coverage for sexual abuse; it stated that abuse is excluded if an adverse judgment were found against the insured. The underlying message appeared to be: "We will not insure you, but we might if you are found *not* guilty."

My second legal exchange concerned a lawsuit in which I was sued by an employee for discrimination. The before-trial costs were great; I followed my lawyer's advice to settle with no admission of guilt. This painful learning experience took valuable time from my business and family. Again, I looked to my insurance carrier for help, but discovered that discrimination is a separate policy which it does not offer.

Many art therapists in private practice may be under the misconception that they are covered by insurance. My experience has been that this is not the case. Lawyer's fees for protecting our rights in court frequently are not paid by insurance companies, nor are many additional costs. The obtuse language used in the policy can allow insurance companies to withhold payment while unsuspecting art therapists believe they have coverage. Art therapists can avoid problems through careful preparation in several specific areas:

1. *Malpractice and the boundaries of the art therapist.* Going beyond the boundaries of the job description for art therapists can result in charges of malpractice. This can precipitate lack of coverage through the association-sponsored company and other carriers. A review of the literature reveals that 13.2% of the "total claims against psychologists [are for] psychologists undertaking work in areas for which they are not qualified by education, training, and experience" (Pope & Vasquez, 1991, p. 28).
2. *Alleged sexual abuse.* Accusations of alleged sexual abuse can rob an art therapist of professional and personal integrity and impose economic hardship. At this time the association-sponsored insurance company states they do not cover allegations of sexual abuse, particularly if the court rules against the insured. The literature reveals that "53.2% of the costs of malpractice are for sexual impropriety" (Ibid.). More insurance money is paid for sexual abuse allegations than any other area. This is a high-risk area that warrants genuine concern for coverage.
3. *The definition of art therapist.* The insurance company I now use defines an art therapist "like the state." The state, I informed them, has no definition. However, nothing in writing elucidates the company position; yet, they were unwilling to assist me in clarifying who could be hired under the job title "art therapist."

To address this dilemma, I am seeking a new policy. My insurance broker recommended changing the corporation to not-for-profit, thereby increasing eligibility with insurance companies that deal with not-for-profit agencies. One carrier has been found who uses clear language, particularly in the areas discussed above; sexual abuse coverage is clearly stated within the policy, giving me greater confidence.

My experience highlights many legal concerns facing the art therapist in private practice. For example:

1. Is it safe for Registered Art Therapists (A.T.R's), with no other professional affiliation, to be in private practice?
2. What are the specific guidelines for art therapy practice that state the limitation of our training? In our work, boundaries frequently overlap with duties commonly attributed to social workers and other therapeutic professionals, for example home visits or recreational work. Do we need to clarify our professional boundaries and limit our practice to art therapy only?
3. If the association-sponsored insurance carrier knew that we were not state-recognized, would it continue to insure us?
4. Could the association set up private practice guidelines or offer a legal ethics course that would be available to art therapists?

I believe we need to tread very carefully, acting before we must react. Legal issues are easier to prevent than to fight. Faced with our litigious society, these issues are critical to the future of our field. Clarity in defining our legal rights may be dependent on state recognition. We need education concerning liability. Perhaps most importantly, we need to be supported by insurance companies that will defend our rights as policyholders, without leaving us with unanswered questions when litigation rears its ugly head.

Reference

Pope, K., & Vasquez, M. (1991). *Ethics in psychotherapy and counselling: A practical guide for psychologists.* San Francisco, CA: Bass.

Art Therapy: Journal of the American Art Therapy Association, 10(3) pp. 171-172 © AATA, Inc. 1993

Full Circle

Mury Rabin, PhD, A.T.R., Hastings-on-Hudson, NY

Fifteen years of observing the effects of their artwork on patients in treatment has convinced me of the authentic power of art therapy. Without doubt, it helps the sick get well, certainly healthier. It confronts the patient with truth, both the dark and light sides. Also, it addresses the intellect from another perspective: Patients' drawings depict conscious thoughts in the manifest quality of expressive work. Simultaneously, latent qualities that seem to emerge mysteriously from the unconscious are revealed in the artwork. On paper, patients present their dreams to themselves.

Art therapy works. The therapy of art therapy works. Yet, the mechanism of how the unconscious and conscious become visible remains elusive. Why particular colors have meaning to the individual, why the patient chooses a particular image as most significant, why the art may predict future happenings—getting healthier, sicker, suicidal thoughts and actions, playing it out in images, aggressive and abusive actions, feeling sad, joyous, angry, depressed, empty and full—these questions still intrigue us. Like the template of a bird's song, art therapy is awesome. It is potent; it is always authentic. The patient always knows it is truth (Rabin, 1987).

Art can help well people be healthier. Art can invite passions to yield to their highest potentials. Art can be beautiful, soothing, inspiring. However, it is just as often the catalyst for disturbing feelings. It can evoke compassion, revulsion, anger, depression, love, and despair. The artist may succeed in conveying his/her intent to the viewer. Art speaks to the viewer, often evoking a personal response different from the artist's intentions.

Given time, nonverbal communication through art has an impact on the healthy person much the same as art produced in therapy. For the patient struggling to regain health, art serves to complete that process of healing and growth. For the well person who either produces his/her own art or views that of others, the effect is one of reaching a higher level of wellness, of activating his or her creativity. As an exercise in assisting the communicating functions of both brain hemispheres, it increases intellectual activity (Taylor, 1960).

The functioning person bears the stresses of life in a verbal culture. Nonverbal symbolic messages support the well person in efforts to bear responsibilities in a society that suffers from creative malaise. It is not enough to smell the roses; we need to stop and feel them, study them, find the differences within the flower and its leaves, and acknowledge the thorns. What is its neighboring plant, the earth beneath, the effect of weather on its color and stability? Does it smell different from time to time?

Art has to become a passion that is pursued daily, through nature as well as through formal art productions. We can develop a respect for and an unselfconscious attitude toward art. Childlike activities inviting creativity should not be confused with childish busyness.

Creative people make creative societies, make smarter societies, make better places, make ethical societies. Kramer (1971) writes:

> There is, in my opinion, evidence that the lack of active art experiences and the concomitant saturation with pseudo-art among large segments of the population constitute a pathogenic condition. (p. 5)

Henri (1960) observes:

> Art when really understood is the province of every human being. . . . When the artist is alive in any person, whatever his kind of work may be, he becomes an inventive, searching, daring, self-expressing creature. He becomes interesting to other people. He disturbs, upsets, enlightens, and he opens ways for a better understanding. Where those who are not artists are trying to close the book, he opens it, shows there are still more pages possible. The world would stagnate without him. . . . Museums of art will not make a country an art country. But where there is the art spirit there will be precious works to fill museums. Better still, there will be the happiness that is in the making. Art tends toward balance, order, judgment,

> of relative values, the laws of growth, the economy of living—very good things for anyone to be interested in. (p. 15)

A culture hospitable to art will be more likely to receive art therapy as a serious profession and provide equal status with other therapeutic disciplines. I look forward to a time when art therapists will finally have an identity. We are still reading news articles about pictures used in treatment by a variety of health professionals without a single mention of art therapy or art therapists. An example follows:

> Prosecutors in the Glen Ridge sex assault case today used drawings made by a mildly retarded young woman to press their argument that the four young men on trial here forced her to perform sex acts. . . . The witness, Ann Burgess, a psychiatric nurse and researcher with expertise in sexual assault cases, asked the young woman to do the drawings, a standard psychological testing tool. . . . Twelve weeks into the trial, the drawings could well be the last impression the jury receives of the prosecution's case. . . . (Sullivan, January 8, 1993, p. 45)

Art therapy has been the best kept secret in the therapeutic community. Art therapists often do the work but seldom receive recognition for accomplishments. When I was hired to head a section of a psychiatric unit of a hospital, I was told the psychiatrist agreed to hire me "because she has her PhD, and in spite of the fact that she is an art therapist." My training and skills were, of course, used and welcomed, indeed considered to be essential to treatment.

I know many credentialed art therapists and other creative art therapists who have had to continue their academic training after completing degrees and credential procedures. Only by acquiring a more acceptable credential, i.e., social worker, psychologist, family counselor, could they be assured employment at a decent economic level. There is still little chance of moving up in the hospital setting. One student, prior to graduation, was offered the same position at the same salary I was receiving. So much for my master's and doctoral degrees and the coveted A.T.R.!

Cross-fertilization with other therapies may be needed to promote art therapy as a profession whose standards match other disciplines. Research following traditional methodologies will bring recognition among professions that acknowledge only scientific approaches. More training in accepted research methodologies would benefit the cause of art therapy. It is no more difficult to design a study that will yield results that have meaning across disciplines. Single case studies that do not provide some means of assessment will no longer be useful for the purposes of increasing the credibility of art therapy.

When art is nurtured and valued by our society, when it is respected and even revered, art therapists may then be able to flourish in their own right. Many art therapists are artists, indeed were artists before becoming art therapists. A portfolio of quality art is required for admission to many art therapy programs. It is important for art therapists to continue to work at their art and allow their art to develop as they grow as an individual. The artist-therapist must become one. Just as one works to increase health in clients, one must find a way also to keep an identity as an artist. S/he must plant art seeds everywhere. Working to help the well person develop creativity may be an avenue to explore, where art therapy will be honored and its influence widened.

References

Henri, R. (1960). *The art spirit.* New York: J. B. Lippincott Co.

Kramer, E. (1971). *Art as therapy with children.* New York: Schocken Books.

Rabin, M. (1987). *Phenomenal and nonphenomenal body image tasks in the treatment of eating disorders.* Ann Arbor, MI: University Microfilms International.

Sullivan, J. (1993, January 9). "Abuse case focuses on drawings by woman." *The New York Times*, Metro.

Taylor, H. (1960). *Art and the intellect.* New York: Museum of Modern Art.

Who is Art Therapy?

She's a stroke of paint
from a loaded brush

She's clay pounded and staged
Graphite caressing the page

She's paper scrolled in a hush
Never revealing too much

She's the revealer of secrets
A painter of terrors and fears
And of dreams buried in years

Captive her spirit frees
Releasing the bars within me

She's a sculptor of hearts
A magic touch of a collage
A mandala of new starts
Emancipating the lodged

By Karen Wilkie

Reviews

Essentials of Art Therapy Training and Practice

by **Bruce Moon, MACE, MDiv, A.T.R.**, Springfield, IL: Charles C Thomas, 1992.

188 pp., 21 black & white Illustrations. $35.75 cloth. ISBN 0-398-05794-X.

Reviewed by **Matthew Bernier, MCAT, A.T.R.**, and **Trudy Manning, MS, A.T.R.**, Norfolk, VA

Bruce Moon presents us with a text generously filled with poems, dialogue, and illustrations. Moon writes eloquently and comments on a variety of topics: image, metaphor, creative encounters, intern/supervisor relationships, love, work, assessment, and language. His pieced-together sequence of chapters reads like separate notes, articles, essays, and commentaries.

The title of this book is somewhat misleading; it probably should be retitled *Essentials of Existential Art Therapy Training and Practice.* Moon offers art therapy educators at least 25 "essentials" of art therapy training and practice. These are based on his own approach to art therapy and his internship and training program at Harding Hospital, both of which are based on existentialism and humanistic psychology. The book effectively serves as a sequel to Moon's previous book *Existential Art Therapy: The Canvas Mirror* (1990), and not as an overview of the current diverse approaches to art therapy training and practice.

Despite the existential orientation of the book, many ideas presented are useful to all training programs regardless of theoretical approach. Moon's description of the art therapy student's process is right on target and worthwhile as it reflects an educator's journey with students. Chapter III, "Beginner's Chaos," is designed to decrease the anxiety and overwhelming feelings of the entering student. Chapter IV, "The Journey Metaphor in Training," demonstrates the struggles and risks taken by the art therapy intern. Chapter XI, "Gifts of the Young," and Chapter XII, "Gifts of the Male and Female Student," remind us to be aware of the differences among our students and to appreciate and honor these differences as gifts to training and to the profession.

However, we disagree with Moon's apparent "loose" approach with students, described in Chapter V, "The Mentor Supervisor." Here it appears the supervisor should allow students to *discover* proper/appropriate expectations at the clinical site. A structure, or at least a boundary, sets out the path of acceptable codes of conduct, ethics, and proper attire for the student. The student must still struggle to assert his/her own individuality and, angrily or sadly, discover himself/herself in the midst of overwhelming expectations. Expectations, clearly expressed, can avoid needless wounding of the novice interns' already delicate sense of themselves as they enter into the profession of art therapy.

Moon discusses imagery, symbolism, and

assessment. He criticizes "cookbook" approaches to interpretation of artwork, and encourages art therapists not to attempt to use formulas or systems to analyze images. He encourages us to "regard images as living things" (p. 4), and states that "the image cannot be measured or verified" (p. 9). He describes his humanistic approach of mutual exploration of meaning in art and the art-making process.

On the topic of professional identity, Moon believes "our professional prestige must come from our own profession" (p. 56). He cautions educators not to train students to be "as-if psychologists or pseudo psychiatrists" (Ibid).

Moon presents strong opinions about the essentials of the core curriculum in art therapy training. Although he states that creative arts therapies professions "must develop standards of education that are both meaningful and diverse" (p. 21), he clearly describes and supports training and practice based in existentialism and humanistic approaches. He believes the core curriculum should include the humanities such as philosophy, theology, and literature, in addition to the "arts processes" (p. 154), "relationship skills, communication skills and psychotherapeutic techniques" (Ibid). Throughout the book he is most adamant that studio art coursework be included in training programs and he attacks the AATA educational guidelines for "not support[ing] continued engagement in studio art coursework" (p. 49). He expresses his belief that "arts-making is soul-making" (p. 66), and that in order to be art therapists we "must engage in the art process at a deep level" (Ibid) or else "we art therapists will eventually dry up and be blown away like dust" (p. 52). We question his description of his course "Studio Methods Seminar" which sounds like group art therapy.

Moon criticizes the AATA training guidelines and current art therapy training programs, methods, and philosophies. At times his attacks on the AATA guidelines sound more like the whining school boy who is angry at his teacher about a grade, as though the AATA has wronged him and/or his training program in some way. An example is his attack on guidelines for 600 hours of practicum. Reasoning that, spread over the course of training, the practicum amounts to only two hours per day, he complains that learning can not "be done in brief, inconsistent clinical exposures" (p. 64). He "urge[s] that clinical field work experiences be enriched by classroom instruction" (p. 63). Has he done his homework? Research into curricula of other programs would reveal that some do include enrichment and exposure to other disciplines, milieu, and various skills through coursework, group supervision, and the practicum experience itself.

We note that in 1989, the AATA members voted not to "alter" but to step forward with requiring a master's degree as the clear path for registration. To join our ranks, other paths to registration must demonstrate rigorous study and internship. We do not perceive the AATA to have taken away our creativity nor the "art-part" of us. Preserving it is the responsibility of art therapy educational programs and the student.

We applaud Moon's admonitions to educators to continue in their own art and clinical work in order to practice what we preach. Moon's mixture of teacher, supervisor, clinician, and artist, is a strong role model that is, we think, common to most art therapy educators. It keeps us in touch, and thus we are most useful to our students and clients.

Moon continually stimulates us to think about how we train our students. As educators we owe it to our students to require a diverse theoretical clinical and creative experience. It is our job to foster their growth to become self-actualized therapists by nourishing their creativity, challenging these notions through experientials, and actively encouraging them to explore their issues in therapy (outside of the educational program). Our students also need to know the *language*, not the job, of the psychiatrist and psychologist to carve out their unique piece of the job market as professional art therapists.

In the practical world, art therapists need to be similar to other mental health professionals as much as they need to be different. Just as Bruce Moon cautions us not to over analyze or project onto the art creation, we ask him not to pigeon-hole each "master's degree" program and other art therapy training methodologies. We, as art therapists, use different media, different "language," and different metaphors. It is the diversity we all bring to the field of art therapy that is truly creative.

Reference

Moon, B. L. (1990). *Existential art therapy: The canvas mirror.* Springfield, IL: Charles C Thomas.

Therapy? Unmasking the Fears, Shattering the Myths, Finding the Path to Wellness

Joyce Houser Ward, MFCT, Tarrytown, NY: Wynwood Press, 1992.

192 pp. $10.00 paper. ISBN 0-922066-75-2.

Reviewed by **Betty D. Jones, MA,** Boulder City, NV

Respectful of the healthy ego that is in pain, Joyce Houser Ward outlines the sequential stages of the therapeutic process. She speaks to the myriad of people who have sought therapeutic help because it was the healthy choice.

As therapists we often forget how mysterious and sometimes frightening the world of the psyche is to the novice client. Ward has not forgotten. She writes to the client, supporting his or her courage and determination to be in therapy. Her words are empathic:

> This healing process is a journey chosen by relatively few people. If you are one of those, credit yourself as courageous, wise, and fortunate. You'll never regret the choice. The beginning might be frightening and arduous, but it gets easier as you go along. (p. 183)

Ward is to the therapeutic process what Kubler-Ross has been to the grieving process. She has clarified the pattern of therapy. Her chapter titles chart the steps of therapy: Facing the Unknown, Pain's Purpose, Fears and Feelings, Resisting Change: Fight or Flight, Shame and Self-exposure, Becoming Real: Opening the Emotional Floodgates, From Despair to Hope, Therapy in Recovery, The Healing Relationship, Rebirth, and Transformation. She sets goals and gives hope by describing what life can be like after therapy ends. "Healing emotionally frees you to be more of who you want to be and to do" (p. 181). The end of therapy is "a place where you meet yourself free of masks; where you touch the spiritual skin of life, taste its flavor, and breathe its breath" (p. 182). She continues:

> You can never return to the place of not knowing, to the unconsciousness of earlier days. Sometimes you may wish you could return, because the journey gets painful and the old days seem simpler in your memory. But you can't go back, and even if you could, ultimately you wouldn't choose to. It's like having been blind all your life; suddenly you're able to see: movement, colors, and shapes pour in, more than you even imagined. Much of what fills your vision is beautiful and miraculous, but ugliness enters in too, uninvited, along with the grotesque and horrifying. You don't like everything in life's mixture of joy and pain, yet having experienced it, you wouldn't want to go back to blindness. (pp. 183-184)

Ward emphasizes, encourages, enlivens, and enlists the strengths of the client. For clients who range from grandiose to battered, from self-sufficient to fearful, for all those "normal neurotics" who come to therapy in emotional pain, or at the point where they have just begun to see unpleasant or disruptive patterns in their lives, this is the book of choice. Therapists will want to have this book in their lending libraries.

An artful therapist, Ward clothes hard reality in poetically attractive language; her words are easily quoted. She is a mentor to us all.

A Child's Story: Recovering Through Creativity

Pat Harris with **Jeanette Batz,** St. Louis, MO: Cracom Corporation, 1993.
154 pp., 33 color illustrations, $29.95 hardcover. ISBN 0-9633555-2-X.

Reviewed by **Margaret L. Smart, MSW, LCSW, A.T.R.,** Palo Alto, CA

A Child's Story is two books in one. First, it is a primer of child abuse, including definitions, theories of cause, and the consequences and requirements for recovery. Embedded within the first book is Harris' story of abuse and, more importantly, her path to recovery. The author shares excerpts from her journal, poetry, and art. The two books are interwoven, alternating between informational material and her story. This format, however, detracts from the important message of the book.

Designed for a newcomer to the field of abuse, much of the current thinking on causes and consequences of abuse is presented in straightforward, simple language. However, Harris does not inform us that this material is only an introduction to an extremely broad and most complicated subject. An example is found in her discussion about perpetrators. Many theories have been raised regarding cause of abuse, motivations of perpetrators, and classes of perpetrators. Harris offers only limited coverage on these topics and draws conclusions too quickly. At this point in our knowledge about child abuse a presentation of the many questions we need to address would have been preferable.

Harris is sometimes glib and one-sided. When she discusses the role of the survivor's partner she misses the point that the partner is also a victim who requires support to withstand living with the survivor's pain. While survivors can learn to give and take within the now healthy, nonabusing relationship, it is not realistic to expect that the nonabused partner will always provide strength and understanding.

No book on abuse is complete without a discussion about treating children of suspected abuse. Behavior, previously thought to be conclusive evidence of abuse, is now open to question. Specific physical evidence previously connected with physical abuse is now seen as normal for children of certain ages. In some cases, suspicions have been raised that therapists may unwittingly influence what the child tells them. None of these issues are addressed.

The true power of this book is in the author's own story of abuse and recovery. Her engrossing journal entries provide a chronology of pain, conflict, and discovery. She has the courage to seek information and confront those who might help her find the truth. In the face of disappointment, she struggles on. Her perseverance and unshakable faith in the outcome are awe-inspiring. She expresses the experience of the abused child and speaks authoritatively on coping with the terror of abuse.

Poetry and art enable her to reach inner pain. Poetry opens the door to her child. The adult forms the words, but we hear, clearly, the child's voice, allowing us to experience her pain. Her deepening understanding about the consequences of abuse moves from theoretical material to written thoughts of the survivor, and from poetic expressions of memories and feelings to the ugliness of pain in her artwork. She found increasingly more potent vehicles to release her pain. Of these, art is the most potent. As she journeys through these levels, she is healed by her own process and by allowing others to join her.

If ever there was a book that validated the use of art as therapy, this is it. Harris, whether knowingly or not, demonstrates what art therapists have long known: Art enables the abuse survivor to reach the depths of hidden pain and bring it to the surface to be viewed, understood, and, eventually, mastered. Art taps the strengths of the abused, assisting in healing the wounds. For this reason, I highly recommend this book.

A Child's Story: Recovering Through Creativity

Pat Harris with **Jeanette Batz.** St. Louis, MO: Cracom Corporation, 1993.

152 pp., 33 color illustrations, $29.95 cloth. ISBN 0-9633555-2-X.

Reviewed by **P. Gussie Klorer, MA, A.T.R.**, Edwardsville, IL

If a book about incest can be considered beautiful, this one is in its physical appearance and in the message it conveys to therapists and their survivor clients. Written from the perspective of an incest survivor, Pat Harris speaks powerfully about pain and healing. Her raw honesty about her abusive past is illustrated through art and journal entries. Sensitive questioning, relentless searching, and her strong need to survive are apparent throughout.

This is not art produced in the context of art therapy. Harris is a professional artist who never intended to put her story in her art, but found the images "interrupted work I was preparing for a one-person show and startled me with their revelations" (p. 3). The reader is privy to the process of uncovering many layers of memories which did not emerge until Harris was in her thirties and had run the gamut of somatic symptoms and therapy. Psychoanalysis was integral to her (the book is dedicated to her therapist), but it goes far beyond merely recording the process of expressing her pain. The issue of pain is approached through three "voices": the wounded survivor struggling to heal, the nonverbal voice of her art, and a strong voice of knowledge and insight gained through research. Ms. Harris' purpose was not only for her own self-empowerment but also to help other survivors gather the courage, patience, and energy needed to heal.

She organizes the book into chapters interfacing her art and journal entries with information about child abuse, perpetrators, survivors, consequences of abuse, the recovery process, and a section on expressive therapies. Harris has researched her topic well and is able to juxtapose and balance emotionally laden material with intellectual discussion. She has relied on experts for documentation and does not pretend to be an authority on anything other than her own process. Consequently, the reader senses her as a generous and humble, yet immensely courageous and talented, woman.

In the section on expressive therapies, Harris interviewed two St. Louis art therapists, Carol Lark and Sharyl Thode Parashak. She gives examples of how art therapy might be used with adult and child survivors and makes a strong case for survivors to seek professional help rather than trying to self-heal. Harris asks,

> Why not just sit home with some Crayolas? Because you need a witness, someone to help you maintain some structure while your whole emotional world is

> falling apart and coming back together in new ways. This other person makes things safe and proves to you that your view of reality is valid. (p. 143)

Harris makes another strong case for the importance of looking at one's imagery and thinking about possible meanings. As she gains new insights, meanings change over time. Therapists who believe they can interpret art and assign diagnostic assessments to pictures without understanding the artist or client's own interpretations should reconsider their methods.

A Child's Story can help survivors understand some dynamics of the recovery process. Placed in the waiting rooms of art therapists, the book can serve as a quiet inspiration to clients who are struggling with their own imagery. I have lent my copy to clients when I felt they needed to feel less alone in their struggles.

Concurrent to the publication of the book, Harris exhibited her paintings at the St. Louis Design Center, a gallery in St. Louis. The exhibit included all the paintings in the book along with sculpture and an installation of a child's room. Viewer participation and feedback were invited by providing mural paper for graffiti commentaries. To further educate the public, statistics and factual information about child abuse are provided. Harris appears to be making a bridge between fine art and therapy, a bridge not always welcomed in the fine arts community. Perhaps recognizing this, Harris embraced the art therapy community by providing a special viewing and gallery talks for area art therapists. It is difficult to review this book without including insights gleaned from the gallery talk and discussion.

The exhibit raises many questions for artists and art therapists: Is this art? Or is this too similar to that which is produced in therapy? Ulman (1975) addressed this issue years ago when she reminded us that the definition of art therapy is closely intertwined with the definition of art. Ulman stated, "The spontaneous projections encouraged in therapy-oriented art therapy are not art in the complete sense, but neither are they anti-art. They are vital fragments of the essential raw material from which art may evolve" (Ibid, p. 13). Ms. Harris considers her art not only a documentation of her healing process, but valid as art objects. Some images, particularly a book of drawings titled "A Child's Story," appear raw and unresolved as art objects. Yet other series of paintings, such as the "Wounded Women" and "Self-Bound Women," classify as art objects. Her work represents a necessary challenge to the fine arts community who historically perceive fine art and art therapy as separate entities. Throughout art history, however, there has been an overlap between the two. The difference appears to be that Harris is talking about it.

Ms. Harris relates an incident when a former teacher from art school came to her studio and criticized her use of art to express troubles. The instructor "suggested that I start over and draw things in my studio. She said the windows with the heart mobile in front of them seemed more like me" (p. 82). Later, Harris resolves this issue for herself when she writes in her journal.

> The teacher who told me to paint things in my studio and that art was not therapeutic was wrong. Art can be therapeutic for both the creator and the viewer. Political art disturbs and moves people. When an artist has something to say and does not wish to entertain, then she must not follow those rules of pleasing by subverting the emotions into a still life. I don't wish to paint life the way people want to see it. I want my art to tell people how life is. (p. 127)

Clearly, Harris' intention is to be educational; she writes to heighten awareness about abuse and to help other abuse survivors heal. Her role is one of an advocate. By choosing to exhibit this work, she confronts the fine arts community who resist and dismiss this bridge between art and therapy. She has demonstrated that the art community do not know what to do with her work, and consequently they ignore it.

As an educational tool this is a potent book both for therapists and survivors of incest who will be moved by the blunt emotionality of her art. Readers who have not been abused will gain greater understanding of the complexities of abuse cycles. Artists may have difficulty with the distraction of explanations and rationalizations and may dismiss the art because of the dual intent of education and expression.

This book should be a welcome addition to art therapists' libraries. Harris has put her soul into this book, and it is a beautiful testament to the strength she has gained through her creative outlets.

References

Harris, P. (May 11, 1993). Gallery talk. St. Louis Design Center. St. Louis, MO.

Ulman, E. (1975). *Art therapy: Problems of definition.* In E. Ulman and P. Dachinger (Eds.), *Art therapy in theory and practice* (pp. 3-13). New York: Schocken Books.

Book Review Response

A response by **Bruce Moon, MACE, MDiv, A.T.R.**, to Vija B. Lusebrink's review of *Art as Medicine: Creating a Therapy of the Imagination* by Shaun McNiff. Reviewed in *Art Therapy: Journal of the American Art Therapy Association,* Volume 10, Number 2.

Dear Book Editor:

I have just finished reading Dr. Lusebrink's review of Shaun McNiff's most recent book, *Art as Medicine*. As I put the review aside, I couldn't help but wonder if Vija and I had read the same text. I feel compelled to write to you and offer an alternative view.

I regard *Art as Medicine* as one of the most significant works ever to emerge from the profession of art therapy. While each of McNiff's previous books has made articulate and thought-provoking philosophical and theoretical contributions to our body of knowledge, this new effort exhibits a depth and existential integrity that surpass the earlier texts. Contrary to Lusebrink's pronouncement that "quotes from various sources, including a number of poems . . . result in an uneven text," I found the interweaving of ideas from Corbin, Hillman, Nietzsche, Ferrini, Magritte, and D. H. Lawrence to be evocative and absoring reading.

I was troubled by Lusebrink's implication that McNiff's approach to art therapy is "in opposition to science." In fact, McNiff states, ". . . my mission has *not* been in opposition to science." He does express displeasure with what he terms "scientism." This is an idea akin to the "Clinification Syndrome" described by Pat Allen, PhD, A.T.R., in Volume 9, Number 1, of this journal. There are many art therapists who are equally concerned with this aspect of the profession.

As I read the *image dialogues* section of the book, I was engrossed by the passion and artistic commitment conveyed in Shaun's reflections on his paintings. In my view this book works because of its unique blend of imagination, intimacy, and solid intellectual inquiry.

Lusebrink cites as one of the biggest shortcomings of the book its "frequent, derogatory, inaccurate, and undocumented statements about art therapy." I found McNiff's references to the profession to be provocative, insightful, and deeply respectful. I have heard many presentations at conferences which validate his concern with those in the field who analyze and dissect the life out of images, in effect committing "imagicide." McNiff attributes 14 art therapy colleagues as having intimately collaborated in the development of the book. I suspect they, and many more, share his concerns with the directions of the profession.

Dr. Lusebrink asserts that "this [McNiff's] approach is less useful to art therapists who work with individuals who have serious impairments and psychopathology, given the constraints of time limits and reimbursement through insurance." At one level Vija may be correct. At a deeper level, however, *Art as Medicine* has been of great use to me in the clinical setting in which I work. I treat individuals who have severe emotional and mental disturbances and limited resources. The reading of McNiff's book has served to refresh my faith in the art process. It has fed my soul and, thus, has been of immeasurable help to the patients I serve.

Shaun McNiff serves our profession as a mentor therapist whose primary mission at this time is to take care of us art therapists. I believe that this book should be welcomed as a terribly important and positive contribution to a field desperately in search of grounding theory and philosophy.

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue; July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

Noteworthy

An Exhibition of Art by Edith Kramer

Edith Kramer, noted artist/art therapist, exhibited paintings and sculptures at the College of Notre Dame Weigant Gallery, Belmont, CA, June 5–9, 1993. The exhibit was arranged through the joint efforts of Marilyn Halevi, A.T.R., Annette McGarr, Rebecca Ratekin, Doris Arrington, EdD, A.T.R., the CND Graduate Student association, and college staff.

Edith Kramer was born in 1916 in Vienna, Austria. She was educated in Vienna and studied drawing and painting in Prague from recognized members of the Bauhaus. She emigrated to the United States in 1938 and became a citizen in 1944. She practiced and taught art until 1950 when she began her work as an art therapist with emotionally disturbed and economically deprived children in the New York area. Since 1959 Kramer has taught in art therapy training programs and presently serves as an Adjunct Professor at New York University. She has authored three books: *Art Therapy in a Children's Community*, *Art as Therapy with Children*, and *Childhood and Art Therapy: Notes on Theory and Application*.

EDITH KRAMER
ARTIST / ART THERAPIST

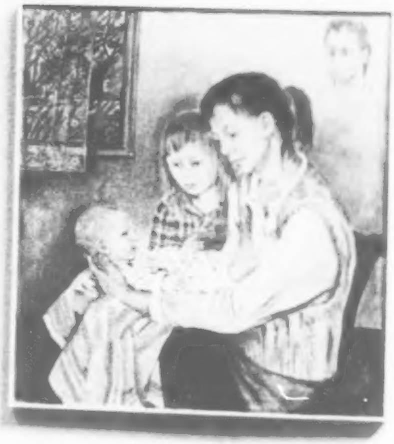


Figure 1. Painting by Edith Kramer at recent Weigant Gallery exhibition, College of Notre Dame, Belmont, CA.

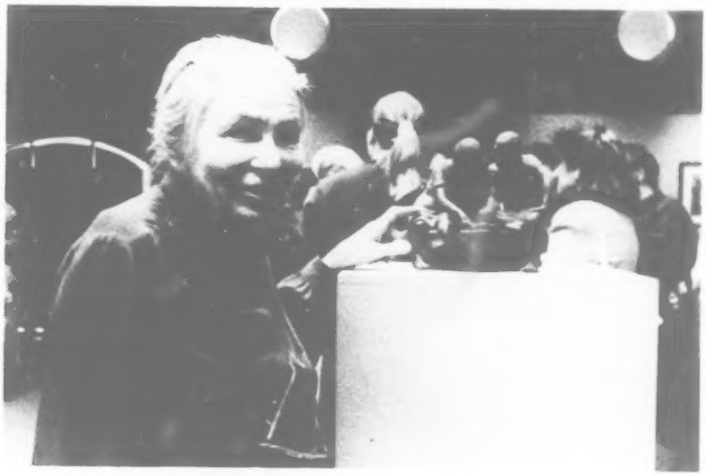


Figure 2. Edith Kramer and sculpture.

Dwight Mackintosh and the Creative Growth Center

The Creative Growth Center in Oakland, CA, provides creative art programs, educational and independent living training, and counseling and vocational opportunities for adults who are physically, mentally, and emotionally disabled. A professional art studio has been developed for clients who are especially gifted and who have the potential for becoming partially or fully self-supporting through their art. Drawing, painting, printmaking, graphic arts, and ceramic sculpture are included in a program designed to suit the talents and needs of individual clients. The program is further enriched by field trips to museums, art galleries, and artists' studios. Whenever possible, clients are taken "on site" for drawing and painting experiences. The Creative Growth Gallery professionally exhibits the work of Creative Growth clients, as well as the art of emerging and well-known artists.

Someone who has benefited from this remarkable program is Creative Growth artist Dwight Mackintosh. More than 10 years ago, Mackintosh began coming to the Creative Growth Art Center, spending his days churning out work after work, many of which consisted entirely of wavy lines that resembled secret writing or elaborate scribbles. Irene Ward Brydon, A.T.R., director of the center, observes that "drawing is a compulsion for him . . . from the first day he came here, we knew he was a significant artist."

Noted scholar John McGregor has recently published a book on Dwight Mackintosh titled *Dwight Mackintosh: The Boy Who Time Forgot*. The book follows the artist's 15-year obsession with image-making while working in the Creative Growth Center. The compelling inner world of this outsider artist is revealed in both Mackintosh's exquisite drawings and John McGregor's poetic prose about the artist.

For more information on Creative Growth or to purchase this book, please contact Irene Ward Brydon, A.T.R., at 355 24th Street, Oakland, CA 94612, (510) 836-2340. (A review of McGregor's book on Mackintosh will appear in the next issue of *Art Therapy*.)

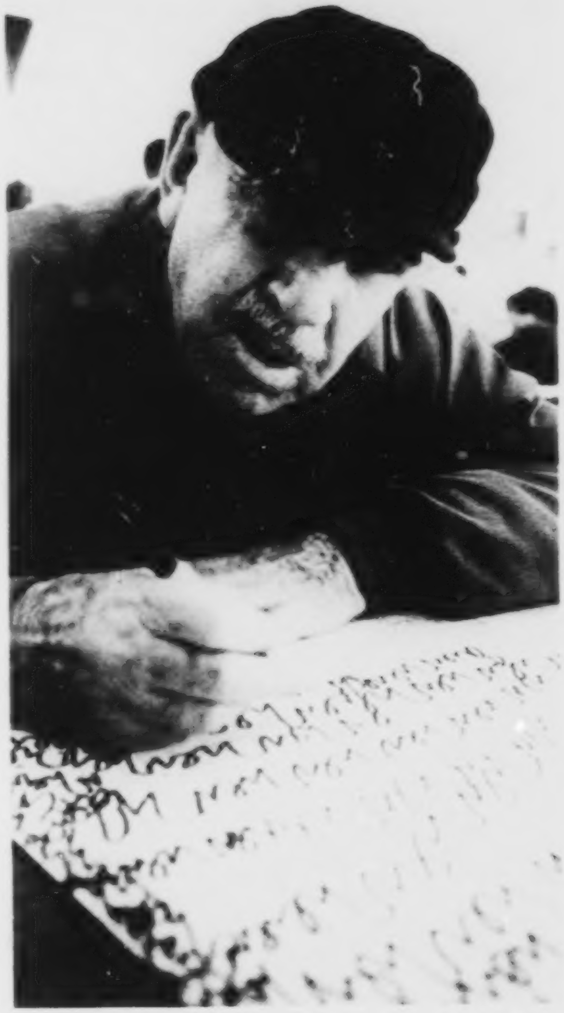


Figure 1. Dwight Mackintosh: The artist in the Creative Growth studio (1993).

Photo credit: Julie Polunsky.

BEST COPY AVAILABLE

THE AMERICAN ART THERAPY ASSOCIATION, INC.

CODE OF ETHICS FOR ART THERAPISTS APPROVED BY MEMBERSHIP BALLOT

September 1990

Art therapists are members of a larger community of professionals providing services in the mental health field. As such members, art therapists subscribe to the basic ethical standards accepted by other organizations representing such professionals. With due respect and where applicable, part of the following ethical standards is based upon those developed and adopted by the American Psychological Association Ethics Committee.

Art therapists believe in the dignity and worth of the individual human being. While demanding for themselves freedom of inquiry and communication, art therapists accept the responsibility this freedom confers: objectivity in reporting findings, high standards of competence, and consideration for the best interests of all persons for whom services are rendered.

Responsibility

Art therapists place high values on objectivity and integrity, maintain high standards of professional competence and service, and are responsible for the consequences of their actions.

A. Art therapists have the responsibility to attempt to prevent distortion, misuse, or suppression of art therapy findings by the institution or agency of which they are employees.

B. As members of governmental or other organizational bodies, art therapists remain accountable as individuals to the highest standards of their profession.

C. As art therapist educators, art therapists recognize their primary obligation to help others acquire knowledge and skill and maintain high standards of scholarship.

D. As practitioners, art therapists know that they bear a heavy social responsibility because their recommendations and actions may alter the lives of others. They are alert to personal, social, organizational, financial, or political situations or pressures that might lead to misuse of their influence.

E. Art therapists recognize that personal problems and conflicts may interfere with professional effectiveness. They refrain from undertaking any activity in which their personal problems are likely to lead to inadequate performance or harm to a client, student, colleague, or research participant. If engaged in such activity when they become aware of personal problems, art therapists seek professional assistance to determine whether they should suspend, terminate, or limit the scope of their professional activity.

Competence

The maintenance of high standards of competence is a responsibility shared by all art therapists in the interest of the public and the profession as a whole. Art therapists recognize the boundaries of their competence and the limitations of their techniques. They provide only services and use only techniques for which they are qualified by training and experience. In those areas in which recognized standards do not yet exist, art therapists take whatever precautions are necessary to protect the welfare of their clients. They maintain knowledge of current professional information related to the services they render.

A. Art therapists accurately represent their competence, education, training, and experience. The AATA recognizes that individuals who have achieved Professional Membership status in the Association may call themselves art therapists. Those members who have met the additional criteria as set forth in the Standards of Registration of the AATA may call themselves Registered Art Therapist and may utilize the initials A.T.R.

B. As art therapy educators, art therapists provide instruction based upon careful preparation and are accurate, current, and scholarly.

C. Art therapists recognize the need for continuing education and are open to new procedures and changes in expectations and values over time.

D. Art therapists recognize differences among people, such as those that may be associated with age, gender, socioeconomics, sexual preferences, and religious and ethnic backgrounds. When necessary, they obtain training, experience, or counsel to assure competent service or research relating to such persons.

Moral and Legal Standards

An art therapist's moral and ethical standards of behavior are a personal matter to the same degree as they are for any citizen, except as these may compromise the fulfillment of their professional responsibilities or reduce the public trust in art therapy and art therapists. Regarding their own behavior, art therapists are sensitive to prevailing community standards and to the possible impact that conformity or deviation from these standards may have upon the quality of their performance as art therapists. Art therapists are also aware of the possible impact of their public behavior upon the ability of colleagues to perform professional duties.

A. As art therapy educators, art therapists are aware of the fact that their personal values may affect the selection and presentation of instructional materials. When dealing with topics that may give offense, they recognize and respect the diverse attitudes that students may have toward such materials.

B. As employees or employers, art therapists do not engage in or condone practices that are inhumane or that result in illegal or unjustifiable actions. Such practices include, but are not limited to, those based upon considerations of race, handicap, age, gender, sexual preference, religion, or national origin in hiring, promotion, or training.

C. In their professional roles, art therapists avoid any action that will violate or diminish the legal and civil rights of clients or of others who may be affected by their actions.

Public Statements

Honesty, caution, and due regard for the limits of present knowledge characterize statements of art therapists who supply information to the public, either directly or indirectly.

Public statements include, but are not limited to, communication by means of a publication, directory, television, radio, or films.

A. When announcing or advertising professional services, art therapists may list the following information to describe themselves and the services they provide: name, relevant academic degrees earned from an accredited institution, date, type and level of certification or licensure, AATA membership status, address, telephone number, office hours, a brief listing of services offered, an appropriate presentation of fee information, and policy with regard to third party payments. Any additional relevant information may be included if not prohibited by other sections of these Ethical Standards.

B. In announcing or advertising the availability of art therapy services or publications, art therapists do not present their affiliation with AATA or any other organization in a manner that falsely implies sponsorship or certification by that organization. Art therapists do not state AATA membership, professional or otherwise, in a way to suggest that such status implies specialized professional competence or qualifications.

C. Public statements made by art therapists do not contain (1) false, misleading, or unfair statement, (2) a misrepresentation of a fact or statement likely to mislead or deceive because it makes only a partial disclosure of relevant facts, (3) a testimonial from a client regarding the quality of the art therapist's services, (4) a statement implying unusual or one-of-a-kind abilities, (5) a statement intended or likely to create false expectations of favorable results, (6) a statement comparing offered services to those of other professionals, (7) a statement likely to appeal to a client's fears, anxieties or other emotions concerning the possible results of failure to obtain the offered services, (8) a statement which directly solicits individual clients.

Confidentiality

Art therapists have a primary responsibility to respect client confidentiality and safeguard verbal and visual information about an individual or family that has been obtained in the course of their practice, investigation, or teaching.

A. Information shall be revealed only to professionals concerned with the case. Written and oral reports only disclose data relevant to the purposes of the inquiry. Every effort is made to avoid undue invasion of privacy.

B. Art therapists are responsible for informing their clients of the limits of confidentiality.

C. Art therapists obtain written permission from clients before any data, visual or verbal, is divulged. All identifying information about the individual is adequately disguised.

D. Art therapists reveal information without the consent of their clients when there is clear and immediate danger to any individual or to society, or as mandated by law. Such information is revealed only to the appropriate professional workers, public authorities, or others designated by law.

E. Art therapists make provisions for maintaining confidentiality in storage and disposal of records and art expressions.

Welfare of the Art Therapy Client

Art therapists respect the integrity and protect the welfare of the person, family, and/or group with whom they work, and they understand that the art expression is the privilege of the client.

A. Art therapists terminate or transfer clients when it is reasonably clear that the client is not benefiting from a therapeutic relationship.

B. Art therapists make financial arrangements that are clearly understood by their clients and that safeguard the best interests of the client and the profession.

C. Art therapists employed by another person or agency suggest clientele of the employer or agency leave to come to their private practice only when there is mutual agreement between the art therapist and the employer or agency. Such a change is made only in the best interest of the client.

Professional Relations

Art therapists act with integrity in regard to colleagues in art therapy and in other professions.

A. Art therapists do not offer professional services to a person receiving art therapy from another therapist except by agreement with the other therapist or after termination of the client's relationship with the other professional.

B. Art therapists assign credit to those who have contributed to publication and in proportion to their contribution.

C. Art therapists understand areas of competence in related professions and make use of all professional, technical, and administrative resources to best serve their clients.

D. Art therapists secure appropriate authorization when conducting research in institutions and organizations. They insure that the institution or organization receives adequate information about the research and proper acknowledgement of their contributions.

E. Art therapists do not exploit their professional relationships with clients, supervisees, students, employees, or research participants sexually or otherwise.

F. When art therapists know of ethical violation by another art therapist, they informally attempt to resolve the issue by bringing the matter to the attention of the art therapist in question. If the misconduct is minor in nature, such an informal solution is usually appropriate and is made with sensitivity to any rights of confidentiality involved. If the violation cannot be resolved informally or is of a more serious nature, art therapists bring it to the attention of the Board of Ethics and Professional Practice of the AATA.

Public Use and Reproduction of Client Art Expression

Art therapists are responsible to their clients for any public use and reproduction of client art expression.

A. The identity of the client is protected by withholding the name, address, date of hospitalization or treatment, and other specific information which may disclose the person's identity to the public. Any part of the art expression which may reveal client identity is disguised.

B. Art therapists display client art expression with the written consent of the cuent or his/her legal representative. Consent is obtained with the recognition of the client's freedom of choice and appraisal of conditions that may limit freedom of choice.

C. Art therapists display client art expression in a manner upholding the dignity of both the client and the profession.

D. Art therapists have the responsibility to interpret client art expression fairly and accurately in a manner that minimizes the possibility of misleading the public and other professionals.

Family Violence & Sexual Assault Bulletin

The *FVSAB* is an innovative publication dealing with the issues in family violence and sexual assault. Specific topics include: spouse/partner abuse, sexual assault/incest survivors, child physical abuse & neglect, & elder/parent abuse.

Topics appearing in each Issue Include:

◆ current classified references ◆ research & treatment articles ◆ resource networking ◆ conference calendar ◆ book/media reviews ◆ book releases ◆ legislative issues ◆ announcements

To order this 52-page quarterly bulletin, please fill out form below and send to
FVSAI • 1310 Clinic Drive • Tyler, TX 75701 • (903) 595-6600 • Fax (903) 595-6799

Method of Payment: ☐ Check made payable to FVSAI ☐ Visa ☐ MasterCard

Name____________________
Address____________________
City/State/Zip____________________
Phone (W)__________ (H)__________
Profession____________________

☐ U.S. Individuals, Shelters, Crisis Centers **$25.00**
☐ Institutions, Libraries, Other Agencies **$40.00**
☐ Canada/Mexico **$30.00**
☐ International/Other **$45.00**

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone #s: ____________________ work ____________________ home

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ______________________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Black and white photos of original artwork plus 4 photocopies of each.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ______________________________ Date ______________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association***, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

CHARLES C THOMAS • PUBLISHER

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 x 10), 24 il., $44.75.

PHOTO ART THERAPY: A Jungian Perspective illuminates and guides the reader through new possibilities for art therapy practice, approached by the authors as a creative interaction with different artistic media and therapeutic methods. Although the book is based on Jungian theory and practice, the authors carefully explore co-operation with other therapeutic perspectives, all of which are in keeping with Jung's belief in transcendent universals and multifaceted therapeutic practices. The book is divided into four sections: Self-Understanding, Alleviating Distress and Symptoms, Group Therapy, and Discussion. Wherever possible and practical, photo art therapy work done by clients as illustrations of the concepts is included. The text not only demonstrates innovative ways of combining artistic media but allows clients to articulate the inner workings of the therapeutic process through an engaging series of dialogues and narrations. The book establishes a twofold landmark in elucidating art therapy's close and vital connections to both phototherapy and the discipline of Jungian psychotherapy.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 x 10), 21 il., $35.75.

Central to the author's approach is the manner in which the mentor and the beginning art therapist come together in their efforts to learn and grow. The author demonstrates the deep, intimate, alive and complex training relationship that can lead to the awareness of meaning in the lives of both. The concern for authentic engagement in the training relationship enhances the beginner's ability to use the self to help clients learn to use art and artistic expression to identify and integrate new insights in their lives. The book is ultimately concerned with the use of art and the artistic relationship to promote human growth. The author's deep understanding of both art and existentialism makes this book a high point in the ever-evolving fields of existential psychotherapy and art therapy. It is an important contribution to the development of creative, effective psychotherapists who value human growth.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ x 9¾), 56 il., $46.50.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 x 10), 1 table, $42.25.

☐ Singer, Florence—**STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children.** '80, 144 pp., 33 il., $23.50.

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 x 10), 71 il., $49.75.

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 x 10), 32 il., 9 tables, $62.75.

☐ Sopchak, Andrew L., Andrew M. Sopchak & Robert J. Kohlbrenner— **INTERPERSONAL RELATEDNESS FROM PROJECTIVE DRAWINGS: Applicability in Diagnostic and Therapeutic Practice.** '93, 292 pp. (8½ x 11), 166 il., 46 tables, $59.75.

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ x 9¾), 28 il., $36.25.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ x 9¾), 21 il., $36.25.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ x 9¾), 34 il., $46.50.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 x 10), 11 il., 38 tables, $90.00.

☐ Nucho, Aina O. — **THE PSYCHOCYBERNETIC MODEL OF ART THERAPY.** '87, 248 pp. (6¾ x 9¾), 50 il., 4 tables, $46.25.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 x 10), $44.00.

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $22.00.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $51.00.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ x 11), $23.50, spiral (paper).

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $51.25.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $30.00.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $48.50.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

BEST COPY AVAILABLE

"Don't tell" was a constant threat, but no one ever said, "Don't draw a picture."

A Child's Story: Recovering Through Creativity by Pat Harris is the personal story of an adult child-abuse survivor who finally is able to tell. Using her talent as an artist and with the help of a professional writer/friend, she reveals the steps of her recovery, from victim to survivor to activist.

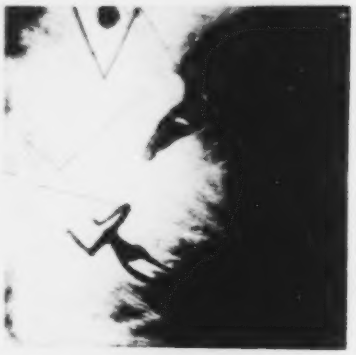
KEY FEATURES

- Thirty-three full color reproductions of the artists work…
- Personal art, journal entries including poetry…
- Integration of professional insights through background essays on aspects of abuse, recovery and expressive therapies.

REVIEWER'S COMMENT

A Child's Story provides the reader with an opportunity to view the intense images of sexual abuse and the artists healing journey. The book demonstrates the connection between the imagery of early traumatic memories and the healing power of creative expression. Pat's discussion of sexual abuse literature provides a frame of reference for the emotional experience of interacting with the images, making it an excellent reference for therapists, educators and survivors.

— MARY N. ST. CLAIR, MAT, ATR, LCSW
St. Louis Institute of Art Psychotherapy-Director

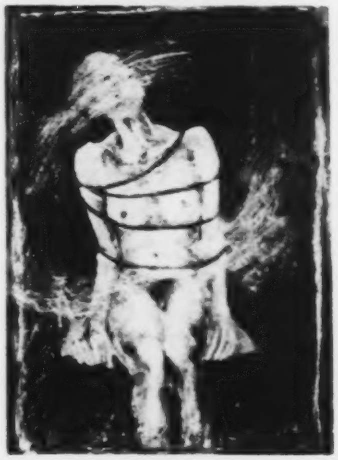


Intrusion
Oil and wax on canvas
(47" x 47")
1990

BOOK EXCERPT

"What I painted or drew became my voice, my way of speaking those unspeakable feelings. Art is a means in which emotions can be retrieved before the survivor can verbalize the experience. After visual communication is accomplished, the story can be put into words, thus beginning the healing process."

— PAT HARRIS



Isolation
Oil pastel and paintstick on paper
(35" x 47")
1990

A Child's Story: Recovering Through Creativity
by Pat Harris with Jeannette Batz
10 / x 8 /, 154 pages, $29.95, hard cover, 4-color
ISBN 0-9633555-2-X
© 1993 copyright CRACOM Corporation

For MasterCard or Visa orders outside Missouri, call **1-800-880-3988.** Missouri residents call 314-291-3988; ask for extension 100. Mail check for $29.95 (Missouri residents add 5.725% sales tax) to CRACOM Corporation, 12131 Dorsett Rd., Suite 109, Maryland Heights, MO 63043. Shipping and handling will be added to all orders not prepaid. Discounts available for associations and fund raising events.

For information on sponsoring Pat Harris's art exhibit entitled "A Child's Story" in your area, please fax (314) 991-3332.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 10, NUMBER 4, 1993

1545

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Advertising: Please see advertising rates listed elsewhere in this journal or contact the American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 (708) 949-6064. The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

ISBN 1-882147-20-0

Editor

Cathy A. Malchiodi, MA, A.T.R.
California State University, Sacramento, CA

Associate Editor

Patricia St. John, EdD, A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor

Elizabeth Ratcliffe, MS, MFCC, A.T.R.
College of Notre Dame, Belmont, CA

Film/Video Review Editor

James Consoli, MA, A.T.R., NCC
Eastern Virginia Medical School, Norfolk, VA

Production Editor

Christine Fryer

Editorial Board

Pat B. Allen, PhD, A.T.R.
River Forest, IL
Frances E. Anderson, EdD, A.T.R., HLM
Illinois State University, Normal, IL
Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec
Michael Campanelli, EdD, A.T.R.
Edith Cowan University, Perth, Australia
Susan E. Cheyne-King, MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R.
The George Washington University, Washington, DC
Julie Epperson, MA, A.T.R.
Salt Lake City, UT
Janice Haviena, MA, A.T.R.
UNM Children's Psychiatric Hospital, Albuquerque, NM
Maxine Borowsky Junge, PhD, LCSW, A.T.R.
Loyola Marymount University, Los Angeles, CA
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Paolo Knill, PhD, A.T.R., CMT-BC
Lesley College, Cambridge, MA
Vija B. Lusebrink, PhD, A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, EdD, A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Trudy Martin Manning, MS, A.T.R.
Eastern Virginia Medical School, Norfolk, VA
Shirley Riley, MA, MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Marcia L. Rosal, PhD, A.T.R.
University of Louisville, Louisville, KY
Susan Evans Spaniol, EdD, A.T.R.
Lesley College, Cambridge, MA
Betty Jo Troeger, PhD, A.T.R.
Florida State University, Tallahassee, FL
Evelyn Virshup, PhD, A.T.R.
California State University, Los Angeles, CA
Robert Wolf, MPS, A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President

Robin Goodman, PhD, A.T.R.

AATA Executive Director

Edward J. Stygar, Jr.

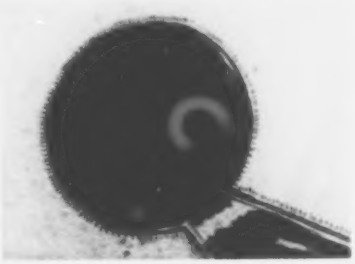
ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Editorial

Art Therapy: Journal of the American Art Therapy Association—The First 10 Years
Cathy A. Malchiodi, MA, A.T.R. 190

Commentaries 192



Articles

The Effects of Art-History Enriched Art Therapy on Anxiety, Time on Task, and Art Product Quality
Carol L. Miller, MA, A.T.R. 194

Using Visualization and Art to Promote Ego Development
Frances F. Kaplan, DA, A.T.R., and Joan Bloomgarden, MA, A.T.R. 201

Resistance in Art Therapy: A Multi-Model Approach to Treatment
Arthur Robbins, EdD, A.T.R., and Barbara Cooper, MPS, A.T.R. 208

Countertransference: A Theoretical Review and Case Study with a Talented Client
Gussie Klorer, MA, A.T.R. 219

Brief Reports

Survey of Doctoral Work by Art Therapists
Vija B. Lusebrink, PhD, A.T.R., Marcia L. Rosal, PhD, A.T.R., and Michael Campanelli, EdD, A.T.R. 226

The Effects of Directed Art Activities on the Behavior of Young Children with Disabilities: A Multi-Element Baseline Analysis
Susan Banks, Pat Davis, Vikki F. Howard, and T. F. McLaughlin, PhD 235

Viewpoints

The Ear of the Physician
Shirley Low Gerstenberger, MS 241

Reviews

Facing Death: Images, Insight, and Interventions. A Handbook for Educators, Healthcare Professionals, and Counselors
Hannah Sherebrin, RN, A.T.R. 243

Freeing the Creative Spirit: Drawing on the Power of Art to Tap the Magic and Wisdom Within
Vija B. Lusebrink, PhD, A.T.R. 245

The Creative Journal for Teens: Making Friends with Yourself
Marcia L. Rosal, PhD, A.T.R. 247

Dwight Mackintosh: The Boy Who Time Forgot
Elizabeth (Liz) Ratcliffe, MS, MFCC, A.T.R. 248

Response to Book Review
Bruce Moon, MACE, MDiv, A.T.R. 250

Video Review: Creative Arts Therapies at the PACE School
Carmello Tabone, MA, A.T.R. 251

Annual Index, Volume 10 253

VOLUME 10 NUMBER 4, 1993

About the Cover: "Bleeding Saint," 96" × 72", 1992, oil, fabric, and beeswax on canvas, by Mari Marks Fleming, MA, A.T.R., MFCC. "Through the juxtaposition of form and image, textural ground, encrusted and sewn fabric patches, covering and uncovering, I seek to evoke sensation and memory. I am interested in the histories we construct, the new stories each of us creates to find meaning in the disparate elements in our lives."

Art Therapy: Journal of the American Art Therapy Association, 10(4) pp. 190-191 © AATA, Inc. 1993

Editorial

Art Therapy: Journal of the American Art Therapy Association—The First 10 Years

Cathy A. Malchiodi, MA, A.T.R., *Editor*

This issue of *Art Therapy: Journal of the American Art Therapy Association* marks an important turning point: Ten years ago, in October 1983, *Art Therapy*, Volume One, Number One was published. The American Art Therapy Association announced in the *AATA Newsletter* early in 1983 that it would "be producing a new professional journal, published solely by the association" (AATA, 1983a, p. 1). At that time, a subcommittee of the Publications Committee was appointed, including the following individuals: Barbara Katz Mandel, Georgiana Jungels, Frances Anderson, Mildred Lachman-Chapin, Linda Gantt, Ruth Obernbreit, Susan Michal, Judith Rubin, Harriet Wadeson, and Robert Wolf. This subcommittee worked to establish the journal's first editorial policies, the criteria for selecting an editor, and the style and format for publication.

The first issue of *Art Therapy* was coordinated by Linda Gantt and Mildred Lachman-Chapin, two past AATA Publication Chairs, and Barbara Katz Mandel, 1983 AATA Publications Chair; Linda Gantt served as Interim Editor until a permanent Editor was found. In June 1983, a search committee was formed, consisting of Barbara Katz Mandel, Harriet Wadeson, Vija Lusebrink, Sandra Packard, and a professional consultant, Anita DeVivo, then Director of the American Occupational Therapy Association (AATA, 1983b). A job description for the first Editor of *Art Therapy* was announced (*Ibid.*); subsequently, Gary Barlow was appointed Editor for a four-year term, and continued in the capacity of Editor until 1991.

The emergence of *Art Therapy* as the official journal of the American Art Therapy Association came at an uneasy time in the organization's history. The December 1983 issue of the *AATA Newsletter* reported, among other things, that the association faced a deficit for fiscal year 1983, the executive director had resigned, and the Annual Business Meeting was viewed by many members as less than congenial (AATA, 1983c). Apparently, there was also concern about protecting the journal from political influence within the association, as evidenced by a motion at the Annual Business Meeting that requested the "[AATA] Bylaws be revised to ensure the Journal's independence from the Publications Committee" (*Ibid.*, p. 2). Members' rights to express divergent points of view in the *AATA Newsletter* were also reaffirmed through a motion from those in attendance (*Ibid.*).

Despite the apparent upheaval in the AATA, *Art Therapy* was underway with a spectacular inaugural issue. Not only was the publication of an AATA-sponsored journal impressive in and of itself, but the articles in that first issue also have major significance for the field today. Both Judith Rubin's and Pat Allen's observations on the life of Margaret Naumburg (who died earlier that year) provided moving accounts that have become standard readings on the history and foundations of the field. Don Jones' verbal and visual reflections on being an art therapist also provided another important piece of history from a personal perspective, capturing the institutional world of several decades ago. He also articulately described the isolation experienced while practicing art therapy. Although the AATA has greatly expanded opportunities for communication with other art therapists, many of us can still relate to feeling isolated in the agency or hospital within which we work, just as Jones did in the '40s.

Readers were also treated to a preview of John MacGregor's forthcoming book, *The Discovery of the Art of the Insane* (1989), which would later become a highly respected text on psychiatric art. Frances Anderson provided an extensive analysis of the published research literature in arts for the handicapped, giving the reader an invaluable list of research studies related to the visual arts. Rawley Silver wrote the first of many articles for *Art Therapy* on her investigation of how drawing tests can be useful in identifying and understanding children whose intellectual abilities may not have been apparent in traditional intelligence tests. Both Harriet Wadeson and Shaun McNiff provided personal perspectives on the art in art therapy (Wadeson) and a studio approach to art therapy (McNiff) in the first Viewpoints section of the journal.

Both Mildred Lachman-Chapin and Interim Editor Linda Gantt highlighted the importance of words in our work as art therapists. Lachman-Chapin raised questions about how we communicate with our clients and how we describe our work as art therapists to others, citing the need for articulation in both endeavors. Gantt explored the importance of the written word in another way, calling for a reexamination of the work of early writers and a continuous reevaluation of previously published art therapy literature:

> Our Janusian look must not be reserved for the beginning of new projects but must be our customary stance as we take stock of our successes and failures, always with an eye to improving the published literature, the foundation of our field. (1983, p. 3)

In some ways, the profession of art therapy has come a long way since the publication of the first issue of *Art Therapy*; in other ways it has remained the same. The isolation experienced by art therapists in a mental health setting that Jones observed still exists to some extent, although not as acutely as when he first practiced. Anderson's observation that art therapists must begin to utilize research methodology in addition to the traditional case study if they are to expand the field and be accepted by both professionals and political bodies which regulate mental health services, still holds true today. Additionally, the role of art in art therapy explored by both Wadeson and McNiff continues to resurface as art therapists redefine their roles with client populations and with other professionals.

Gantt made the following observation concerning the field of art therapy and the profession in general in the first *Art Therapy* editorial:

> The 1980s will be a critical period in our profession's development. We will be forced to show how art therapy is both distinct from and similar to allied fields, for on such distinctions rests our future, our training programs, our positions, and our prestige. (1983, p. 3)

It seems that the 1990s will provide the profession with challenges similar to those that Gantt spoke of over a decade ago. On this, the tenth anniversary of the first publication of *Art Therapy*, it is fitting to reconsider Gantt's observation with an eye toward improvement not only of our published literature, but our overall profession.

References

Gantt, L. (1983). Editorial. *Art Therapy: Journal of the American Art Therapy Association*, *1*(1), 2–3.

MacGregor, J. M. (1989). *The discovery of the art of the insane*. Princeton, NJ: Princeton University Press.

American Art Therapy Association. (1983a). AATA to begin new journal. *American Art Therapy Assocation Newsletter*, *13*(1), 1.

American Art Therapy Association. (1983b). AATA journal progresses: Search for editor begins. *American Art Therapy Association Newsletter*, *13*(3), 2.

American Art Therapy Association. (1983c). Association's Annual Meeting. *American Art Therapy Association Newsletter*, *13*(6), 2.

Articles from *Art Therapy*, Volume One, Number One, referred to in this Editorial:

Allen, P. B. (1983). The legacy of Margaret Naumburg. *Art Therapy*, *1*(1), 5–6.

Anderson, F. E. (1983). A critical analysis of "A review of the published research literature in arts for the handicapped: 1971–1981," with special attention to the visual arts. *Art Therapy*, *1*(1), 26–39.

Gantt, L. (1983). Editorial. *Art Therapy*, *1*(1), 2–3.

Jones, D. L. (1983). An art therapist's personal record. *Art Therapy*, *1*(1), 22–25.

Lachman-Chapin, M. (1983). Making verbal the nonverbal: A commentary. *Art Therapy*, *1*(1), 47–49.

MacGregor, J. M. (1983). Paul-Max Simon: The father of art and psychiatry. *Art Therapy*, *1*(1), 8–21.

McNiff, S. (1983). The art therapy intensive. *Art Therapy*, *1*(1), 51–52.

Rubin, J. A. (1983). Dayenu: A tribute to Margaret Naumburg. *Art Therapy*, *1* 1), 4–5.

Silver, R. A. (1983). Identifying gifted handicapped children through their drawings. *Art Therapy*, *1*(1), 40–46.

Wadeson, H. (1983). The art in art therapy. *Art Therapy*, *1*(1), 50–51.

Commentaries

Response to Commentary by Pat Allen, PhD, A.T.R.

In my review of Shaun McNiff's *Art as Medicine* I tried to give an objective view of the introspective nature and richness of McNiff's writing and images, while objecting to some of his subjective generalizations about other art therapists and their approaches.

McNiff's book is a very good example of the heuristic method of inquiry. At the same time it points out the drawbacks of this method, which are further brought into focus by Pat Allen's commentary in *Art Therapy: Journal of the American Art Therapy Association, 10*(3), p. 129. First, the subjective approach is valid when used to describe the individual's experiences, but it raises problems if used to address issues pertaining to the public domain, namely in McNiff's case, to make personal judgments about approaches used by other art therapists. As we can see in Allen's commentary, the subjective nature of heuristic studies may evoke different perspectives from different readers, depending on the reader's viewpoint, and render the repsonses too personal and subjective instead of creating a dialogue.

The second drawback of the heuristic approach is the possible overemphasis on a singular approach. In this case, the emphasis is on a particular view of imagery and the use of art therapy, instead of a more objective recognition of the evolving nature of the latter.

Art therapists have already fought the battle of art as therapy versus art as psychotherapy in the past. Hopefully, the present duality of the art studio approach as emphasized by Allen and the diagnostic and analytical perspectives that presumably dominate all other art therapists' work as defined by McNiff will not precipitate a conflict repeating the past in regard to the exclusiveness of a particular approach as the only acceptable one.

The sequential duality in the development of concept formation has been eloquently described by Arnheim:

> Percepts are generalities from the outset, and it is by the gradual differentiation of those early perceptual concepts that thinking proceeds towards refinement. However, the mind is just as much in need of the reverse operation. In active thinking, notably in that of the artist or the scientist, wisdom progresses constantly by moving from the more particular to the more general. (1969, p. 186)

Similarly Wolfflin (1950), in his treatise on the development of style in later art, pointed out that in occidental art there were changes from linear, planar, and closed forms to painterly, recessive, and open forms, and from multiplicity and absolute clarity of the subject to unity and relative clarity of the subject. These changes were "recommenced" again around 1800 and replaced by a new "linear" mode of vision.

Wolfflin stated that "a closer inspection certainly soon shows that art even here did not return to the point at which it once stood, but that only a spiral movement would meet the facts" (1950, p. 234).

These descriptions of the development of percepts, concepts, and artistic styles could be taken as similes for the development of art therapy.

The earlier implied duality in this view can be accepted as another evolutionary step in art therapy. Such a larger view does not need to deny the validity of different approaches nor the existence of the multiple components of art therapy.

Vija Lusebrink, PhD, A.T.R.
Louisville, KY

References

Arnheim, R. (1969). *Visual thinking*. Berkeley, CA: University of California Press.

Wolfflin, H. (1950). *Principles of art history. The problem of the development of style in later art*. NY: Dover Publications.

Letter to Editor

As former chair of AATA's Publications Committee, I certainly encourage debate in the pages of AATA's publications and applaud *Art Therapy* for printing Pat Allen's disagreement with Vija Lusebrink's review of *Art as Medicine* by Shaun McNiff. I was in McNiff's place a number of years ago, and was appreciative of a reaction letter to a review of one of my books (Arthur Robbins and Donna Bassin. (1980). *American Journal of Art Therapy*. (20) 78.)

I am writing this letter, however, not to applaud but to decry. Healthy debate is one thing; inflammatory characterization of a colleague is another. I am referring to Pat Allen's letter's opening paragraph in which she conjures an image of Lusebrink as "a waspish schoolmarm, lips pursed, ruler at the ready." In the next paragraph she states, "the ruler comes down" (*Art Therapy*, 1993, 3(10), 129). Although seven paragraphs later Allen states that "the waspish schoolmarm is an archetype that lurks in each of us," the characterization of Lusebrink sticks as Allen objects to many of her points throughout the letter. In the same issue, a letter from Bruce Moon offers another reaction to Lusebrink's review. Moon makes points similar to Allen's; however, in contrast to Allen, Moon does not couch his arguments in unflattering imagery, but states them in a forthright manner. (It is curious to note that Allen's letter is placed after the editorial at the beginning of the issue under Commentaries, whereas Moon's letter is placed near the end of the journal.)

It is ironic that the same issue of the journal contains AATA's Code of Ethics: "Art therapists act with integrity in regard to colleagues in art therapy" (p. 184). At best Allen's characterization of Lusebrink is unprofessional. This sort of imagery regarding a colleague perpetuates an ugly aspect of AATA's history that has been besmirched by inflammatory name-calling. One prominent art therapist called another a Nazi in a widely circulated letter; I was labeled "a true master of double think and newspeak . . . foretold by Orwell in *Nineteen Eighty-Four*" in the *AATA Newsletter*, 1984, (XIV)1; a prominent art therapist accused another of having his hand in AATA's till in a local publication; and on and on.

I believe it is the responsibility of *Art Therapy's* Editor and Editorial Board to urge contributors to write in a professionally responsible manner if their submissions are to be published. Although inflammatory imagery is sure to draw reactions (I doubt this letter will be the only response), it's a cheap way to inspire debate.

Harriet Wadeson, PhD, A.T.R., HLM
Chicago, Illinois

Editor's note: Two points are in need of clarification regarding Dr. Wadeson's commentary. One concerns the placement of submissions to *Art Therapy*. Dr. Allen's observations on Lusebrink's book review were addressed as a letter to the Editor; therefore, they were published in the Commentaries section which is designed for this purpose. Bruce Moon's piece was submitted as a response to a Book Review; such responses are regularly published in the Reviews section of the journal.

The second point concerns two principles fundamental to all journalism: the right of freedom of speech and freedom of the press. It is the policy of the journal to allow for such freedom within the Commentaries section of this publication and to uphold the legal right of the individual to express an opinion.

Letter to Editor

Superlative! Bravo! Timely! Provocative! Honest! Challenging! All these words were on my lips at some time during my reading of the current issue of *Art Therapy* (Volume 10, Number 3, 1993). I just received the journal in the mail today and all other mail waited as I couldn't stop until I'd read every word! First time that's ever happened! The theme—Professionalism—couldn't be more appropriate at this time and is a topic sorely needed in the ranks of art therapists.

Your Editorial hit the nail on the head making it increasingly difficult to continue to ignore the need for professionalism. Jeanne Carrigan's article on ethics challenged us further to get our act together. Debbie Good's history of New Mexico's licensing was an inspiration and goal to strive for in many other states—one true success story. Millie Lachman-Chapin's dilemma of the identity conflict between art therapist and exhibiting artist is familiar to us all and seemed to mirror the dilemma of our professional existence and behavior as does Maxine Junge, et al. (although "The Challenge: Toward Community" with which this article concludes reinforced ING's work in building ". . . a global community in which human growth is prized." I have just witnessed the most generous sharing and exchange at our conference in Vilnius, Lithuania with plenty of courage and vision to ensure ongoing expansion and growth). Rawley Silver's research study set a fine example of professional achievement—a model for us all. Gail Wirtz's cautions to art therapists in private practice definitely needed to be said, more importantly they need to be heeded. This seems to be an area of enormous ignorance and elective blindness among art therapists. Ms. Wirtz gave us a much needed eye-opener!

I appreciated the dual reviews of *A Child's Story: Recovering Through Creativity* and found the response to a previously published review of Shaun McNiff's book to be refreshing in offering an alternative viewpoint.

Congratulations on a job very well done. Don't lose your looking glass into the future. There will be much more need for it with the issues ahead! Keep up the good work!

Bobbi Stoll, MFCC, A.T.R.

Art Therapy: Journal of the American Art Therapy Association, 10(4) pp. 194-200 © AATA, Inc. 1993

The Effects of Art History-Enriched Art Therapy on Anxiety, Time on Task, and Art Product Quality

Carol L. Miller, MA, A.T.R. Glen Oaks, NY

Abstract

The effects of an art history enrichment art therapy task on anxiety, time on task, and art product quality among chronic adult psychiatric day hospital patients were investigated using a repeated-measures, quasi-experimental design. State-anxiety was measured with the* State-Trait Anxiety Inventory *(Spielberger, 1983). Art product organization level was assessed with the* Art Description Scales *(Miller & Miller, 1992). The results indicated the art history enrichment task reduced anxiety* ($p < .05$) *and increased time on task* ($p < .002$)*. Art organization level tended toward a significant increase* ($p = .075$) *compared with a control condition. The findings are congruent with the literature concerning supportive art therapy and suggest that the use of art history enrichment in art therapy may be helpful with this population.

Introduction

Chronic psychiatric patients in a long-term day hospital present a number of challenges to the art therapist. Patients in the art group often complain about the difficulty of concentrating on the art task; they frequently lack the motivation to continue, show signs of restlessness, and sometimes express negative feelings about art.

In a research paper written in 1975, Young concluded that supportive art therapy which uses the creative process and instruction in art techniques to enhance self-esteem and self-identity was a successful approach with chronic psychiatric patients, particularly those suffering from schizophrenia, who were short-term inpatients. Using supportive art therapy with a day hospital adult population, what specific kinds of art tasks would be most helpful to reduce anxiety and thereby encourage sustained participation in the art activity?

Art therapists have developed structured art directives found to be therapeutic with schizophrenic patients (Honig & Hanes, 1982; Landgarten, 1981; McNiff, 1976; Moriarty, 1973). I have developed an art directive which seems to engage patients in the creative process—the use of art history as an introduction to the art task. Art history, which includes anecdotal biographical material as well as discussion of the artistic style, seems to validate the art task as an adult activity. The art task presented to the group includes selected elements derived from the art. I have also observed clinically that art history enrichment appears to result in better patient attendance, more sustained participation during art therapy sessions, and higher quality artistic products. The research reported in this article explores this approach quantitatively by examining the effects of art history enrichment before the art task on patients' levels of anxiety, the time they spend on the art task, and the

---

Editor's Note: The author wishes to thank Frances Kaplan, Coordinator of the Creative Arts Therapy Program at Hofstra University, for her thoughtful help in preparing this manuscript, and the author's husband, Michael, for his assistance with the data analysis and scale construction.

Requests for reprints or inquiries concerning the *Art Description Scales* should be sent to Carol L. Miller, Department of Psychiatric Rehabilitation, Long Island Jewish Medical Center, Hillside Hospital Division, Glen Oaks, NY 11004.

quality of their artwork. The findings of this study could be helpful to art therapists who wish to reduce patient anxiety among their chronic psychiatric patients, increase patient involvement and participation in the artistic process, and improve the quality of patients' art products (Kramer, 1971).

Review of Related Research

A search of the literature revealed no quantitative research in the area of art therapy and anxiety reduction. Young (1975) found, in a primarily observational study of chronic schizophrenic inpatients, that structured, supportive art therapy gave patients "a sense of security in working towards a definitive goal—that of improved technique and mastery of art skills" (p. 115). She compared three treatment and control groups and found that the schizophrenic patients "were not able to relate actively to an insight-oriented art therapy program" (p. 101).

Drawing upon Young's work, in two reports about the same experiment, Borchers (1985) and Green, Wehling, and Talsky (1987) explored the effectiveness of supportive art therapy with chronic psychiatric patients attending an aftercare clinic in an experimental, quantitative study. Patients in the art therapy group showed significant improvement on two measures of the *Progress Evaluation Scales*: "Getting Along with Others" and "Attitude Toward Self" (Ihilevich & Gleser, 1982), with $p < .05$ on both, but not on the Rosenberg Self-Esteem Scale (1965). "Seventy percent of the subjects reported feeling relaxed after the sessions" (Green, Wehling & Talsky, 1987, p. 990).

Honig (1977), writing about her structured work with schizophrenic patients, stated that "the loose, permissive, creative, or spontaneous approach often increased anxiety and confusion" (p. 100). Honig and Hanes (1982) discussed how the art therapist can intervene to alleviate such confusion and fear with a series of tasks that address specific areas of psychopathology. These authors mention relaxation and anxiety reduction as possible benefits from using a structured art therapeutic approach. The research reported here attempts to document in a quantitative, experimental study whether this symptom reduction is an objective, observable, therapeutic outcome when art history is used to enrich and structure the art task, as compared with a low-structured control condition. In addition, I observed the art history-enriched condition's effect on the time patients spent on the art task and the level of organization of their art products.

Hypotheses

Research groups were formed and data were collected and analyzed to prove or disprove the following hypotheses.

1. There will be a significant reduction of anxiety under the art history experimental condition, while anxiety reduction under the control condition will not be significant.
2. The time spent on the art task under the art history experimental condition will be significantly greater than under the control condition.
3. The level of organization of the artwork will be significantly greater under the experimental art history condition than under the control condition.

Method

Research Participants

The sample consisted of 13 adult, day hospital patients, eight females (61.54%) and five males (38.46%). Their ages ranged from 24 to 58, with a mean of 35.23 and standard deviation of 9.97. The patients' primary diagnoses included five with Affective Disorder (38.46%), five with Paranoid Schizophrenia (38.46%), and three with Schizoaffective Disorder (23.8%). Patients had been participating in the art therapy group from 1 week to 52 weeks, with a mean of 16.46 weeks and standard deviation of 13.97. All but one patient had been in the group 24 weeks or less.

Instruments

The Spielberger *Self-Evaluation Questionnaire*, also known as the *State-Trait Anxiety Inventory* (STAI, Form Y-1) (1983), was used to measure participants' anxiety. Form Y-1 is a 20-item scale that evaluates how respondents feel "right now, at this moment," as it was designed to measure the patient's current state of anxiety. The State form (Y-1) is more sensitive to small changes than the Trait form (Y-2), which measures the more enduring trait of anxiety. The S-Anxiety scale has shown high internal consistency; alpha reliability is 0.92. Because it was developed to be sensitive to fluctuations in situational stress, reported test-retest correlations are low, as would be expected. "The S-Anxiety scale has been found to be a sensitive indicator of changes in transitory anxiety experienced by clients and patients in counseling, psychotherapy, and behavior-modification programs" (Spielberger, 1983, p. 2). Spielberger states that "to assess changes in anxiety over time, it is recommended that the S-Anxiety scale be given on each occasion for which the measure is needed" (pp. 3–4). The scale has been shown to have good validity, both with psychiatric and normal populations and has been used in research and clinical practice for over 20 years.

In addition to being psychometrically sound and well-developed, the S-Anxiety scale has the advantage of being brief and easy to administer within 5 or 10 minutes to a group. In addition, the scale does not contain upsetting content, which could have negative effects on disturbed patients.

Time spent on the art task was obtained by observing how long individuals took to complete their artwork. Because I was concurrently involved with art materials, helping patients, giving directions, and administering the anxiety pretests and posttests, time spent on task was estimated to the closest 5-minute interval.

The *Art Description Scales* (ADS) (Miller & Miller, 1992) were used to assess the quality of the artwork. Arnheim (1980) felt that "a person's best achievement bears therapeutic fruit, not obtainable from a lesser effort" (p. 249). The ADS were developed for this study to measure the level of organization in the artwork, i.e., use of clear forms, structure, organization, closure, etc. The instrument contains 10, seven-point, semantic-differential scales emphasizing cognitive control and organization. The 10 items are summed to yield a total score which can range from 10 to 70. Internal consistency coefficient alphas range from 0.975 to 0.982 for the three raters: an activities specialist, a PhD counselor, and myself. Inter-rater reliability coefficients ranged from 0.779 to 0.922, with a mean of 0.841. The scales appeared reliable and internally consistent enough to use in research.

Each rater independently assessed the 26 paintings (13 control group, 13 experimental) which were intermixed and presented in the same randomized sequence. To obtain as unbiased a measure as possible, the total scores of the three raters were summed for each painting. Organization level scores for this study could range from 30 to 210.

Procedure

The research design used was a single-group, time series (Cox & West, 1982), which is a quasi-experimental design, similar to Campbell and Stanley's equivalent time-samples design (1966).

The research took place on two successive Wednesday morning sessions of 1½ hours each. Although I believe a greater separation between group sessions could counteract the "practice effect," time constraints required the experiment to be done in two consecutive weeks.

Seventeen patients (the low-structured control group) were given the *Self-Evaluation Questionnaire* at the beginning of Session I. The patients were identified by research numbers on the scale, rather than by patient names, to provide anonymity. After collecting the questionnaires, I asked the group to do an art task by saying, "Paint freeform shapes" (the temperas were placed on the work table, 12″ × 18″ paper was distributed as well as brushes). The patients were therefore given some structure since the present research focuses on art history enrichment rather than unstructured versus structured art tasks.

It was announced at the beginning of the session that patients should not leave before submitting their artwork and receiving another questionnaire. After patients finished work on their paintings, the time spent on the art task was noted, and they received the posttest questionnaire.

At Session II, the art history-enriched experimental group, the same procedure was followed in administering the pretest, this time to 15 patients of whom 13 were in Session I. The same art materials were used, but the art directive included an introductory mini-lecture about Kandinsky, his career, and the beginning of nonobjective art, together with illustrations of his work. In addition, I gave information about how to structure the painting—by drawing three curving lines across the paper that intersected with each other at a few points. At the end of Session II, patients submitted their work and completed the posttest questionnaire. Again, the time patients spent on the art task was noted.

Method of Data Analysis

The anxiety scores, time spent on the art task, and ratings of the art organization level were analyzed by using both paired-comparison *t* tests and Wilcoxson signed-rank tests (nonparametric tests) since the sample size was only n = 13 and assumptions about normality and equal variances required in the *t* test may not have been warranted.

For the anxiety data, a comparison of pretest versus posttest scores was made—first, for the control condition, and then for the experimental condition.

Results

Hypothesis 1 stated that there would be a significant reduction in anxiety under the art history experimental condition, while anxiety reduction under the control condition would not be significant. The results of the data analysis for anxiety are shown in Figure 1.

In the low-structured control condition, the mean anxiety score dropped from a pretest of 39.154, $SD=12.453$, to a posttest of 36.615, $SD=12.790$, $t(12)=1.26$, $p=.1158$ (one-tailed test), or nonsignificant. Although patients' anxiety levels dropped during the low-structured, control condition, the decrease was not significant.

In the experimental condition, using art history enrichment, the mean anxiety score was reduced from a pretest of 38.846, $SD=13.24$, to a posttest of 35.692, $SD=11.426$, $t(12)=1.814$, $p=.0474$ (one-tailed test), significant at the .05 level. The observed decrease in patients' anxiety levels during the experimental condition was significant.

To ensure that these results would remain significant under nonparametric tests, the Wilcoxson signed-rank test showed for the control group $Z=-1.112$, corrected for ties, $p=.1331$ (one-tailed test), or nonsignificant. For the experimental group, $Z=-1.931$, corrected for ties, $p=.0268$ (one-tailed test), significant at the .05 level. Both the *t* tests and Wilcoxson tests support hypothesis 1.

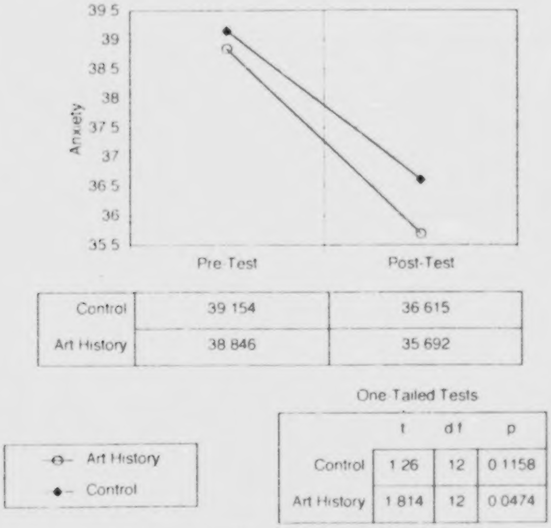
Hypothesis 2 stated that the time spent on the art task under the art history experimental condition would be significantly greater than under the control condition. The results of the data analysis for time spent on the art task are shown in Figure 2.

Figure 2 shows that the mean time spent on the art task during the control condition was 33.077 minutes, $SD=17.505$, with the mean time under the experimental condition being 47.692 minutes, $SD=9.04$. The *t* test showed $t(12)=3.916$, $p=.0011$, significant at the .002 level. The Wilcoxson signed-rank test showed $Z=-2.675$, corrected for ties, $p=.0038$ (one-tailed test), significant at the .005 level. Patients working under the experimental condition spent a significantly greater amount of time on the art task than they did under the low-structured, control condition. The results supported hypothesis 2.

Figure 3 shows frequency distributions of the time spent on the art task under the control and experimental conditions and graphically indicates the increase in time spent on the art task when art history introductory enrichment was used as compared with the low-structured control condition.

Hypothesis 3 stated that the level of organization of the artwork would be significantly greater under the experimental art history condition than under the control condition. Figure 4 shows the sum of the three raters' assessments of the art products under the control and experimental conditions using the *Art Description Scales*.

The mean of the summed ratings of art organization level for the control group was 127.077, $SD=48.82$, while the mean rating for the experi-

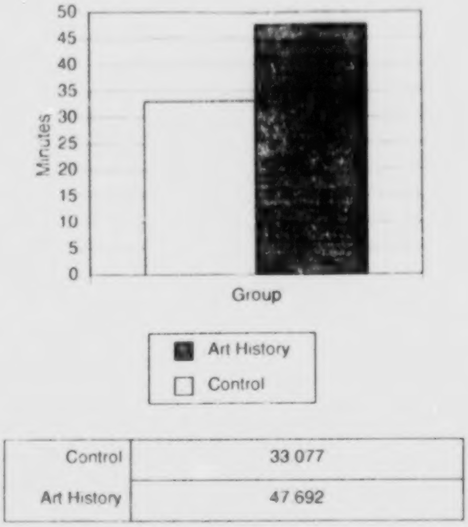


	Pre Test	Post-Test
Control	39 154	36 615
Art History	38 846	35 692

One Tailed Tests

	t	d f	p
Control	1 26	12	0 1158
Art History	1 814	12	0 0474

Figure 1. Art History Effects on Anxiety.



Control	33 077
Art History	47 692

Figure 2. Art History Effects on Time on Task.

BEST COPY AVAILABLE

mental group was 147.231, $SD = 40.803$, $t(12) = 1.546$, $p = .074$ (one-tailed) test. A Wilcoxson signed-rank test showed $Z = -1.433$, $p = .076$ (one-tailed test). The mean global ratings of artwork organization level increased under the experimental condition. Since $p < .10$, the increase tended toward significance.

Hypothesis 3 received some support: The increase in level of organization from the control to the experimental condition tended toward significance.

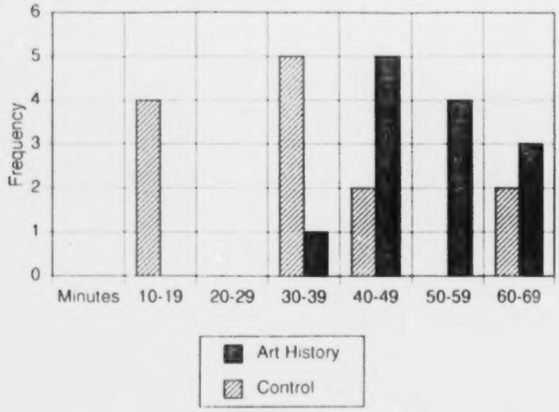
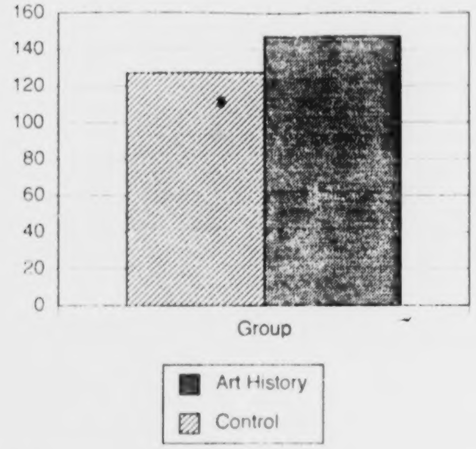


Figure 3. Time on Art Task Frequency Distributions: Control vs. Art History.



Control	127 077
Art History	147 231

Figure 4. Art Organization Level Control vs. Art History.

Discussion

Hypothesis 1 stated that anxiety reduction under the art history experimental condition would be significant, while anxiety reduction under the control condition would not be significant. The results of the data analysis lend support to this hypothesis, as there was a statistically significant reduction observed in the experimental condition. Although the anxiety decreased in the control condition, it did not decrease significantly.

Hypothesis 2 stated that art history enrichment would result in patients becoming more involved in the art task and therefore spend more time on it than under the control condition. This hypothesis was strongly supported by the data. Patients spent an average of 15 minutes more on the art task in the experimental group than in the control.

Hypothesis 3 predicted that the art history enrichment would be associated with higher levels of organization in patient artwork. The results of the ratings on the *Art Description Scales* tended to support this hypothesis. Although the organizational level of artwork was higher in the experimental condition, it did not quite reach the .05 level of significance ($p = .074$). Even in the control condition, many patients produced art at fairly high levels of organization, possibly because some structure was provided. Also, many of the patients had been in the group for several months and may have increased their art organizational level before the experiment was conducted.

Overall, the hypotheses of this study were generally supported. The use of art history enrichment appears to have a beneficial effect on chronic adult psychiatric day hospital patients' emotional states (anxiety) and behavior (time spent on the art task, involvement in the art process). Also, there is some suggestion that quality of artistic output may have increased, although this only tended to reach significance. The impact of these observations may be that patients' self-esteem also increased, although this was not measured.

While Honig and Hanes (1982) have developed a detailed series of art therapy tasks to enhance mental functioning with chronic patients in long-term residential treatment and Young's use of a teaching approach was beneficial to chronic patients in a short-term psychiatric unit (1975), the art history enrichment of the present study was developed for stabilized, but chronic, day hospital adults who need to build interpersonal skills and strengthen ego development over a 6- to 12-month time span. In order to achieve this, they need to become involved with the art activity, as well as the group. Among this population, art history enrichment reduces anxiety and involves the patients with their work so that they are better able to develop skills and improve concentration. As with any therapeutic treatment, the age, socioeconomic class, diagnosis, time in program, and capabilities of the patient (Young, 1975) are factors to be considered when deciding if art history enrichment is an appropriate therapy.

Green, Wehling, and Talsky (1987) reported that patients felt more relaxed after art therapy sessions. The present study supports these authors' observations with a standardized measure of anxiety. A number of writers have discussed the value of the addition of art education to art therapy with particular patient groups (Arnheim, 1980; Erikson, 1979; Kramer, 1971; Talerico, 1986) as being supportive to ego development and a sense of identity by helping the patient focus on his or her strengths and abilities through the "creative problem solving process . . . from interactions with art products and processes" (Congdon, 1990, p. 19).

Beyond anxiety reduction and task involvement are broader goals: (a) the creation of a valued art product through which the patient can integrate elements of his/her personality through line, shape, and color; McNiff (1976) and Arnheim (1980) believe that quality of the artwork can help in the healing process; (b) learning to manipulate a variety of art materials that are an "extension of the self" (Erikson, 1979, p. 79); and (c) becoming part of a community with fellow artists when artwork is displayed and discussed, as well as becoming part of the larger community in hospital and community exhibits.

Although the reduction of anxiety in the control condition was not significant, it was observed to decrease somewhat by the end of the session. This may be because some structure, although not a great amount, was provided by the therapist. For some patients, the art activity itself may have had a modest effect on reducing their anxiety.

It was expected that patients would spend more time on the task in the art history enrichment group than the control group, but it was surprising to see how little time patients spent in the low-structured control group. Many patients were uninvolved and eager to leave the art therapy studio. A possible explanation for this observation is that patients may have been used to more structure from previous experience in art therapy groups. It should be noted, however, that art therapists agree that in comparable settings, low task involvement and consequently short time spent on the art task are typical responses from chronic psychiatric patients in an art therapy group.

Questions raised by this study include: (a) Would the art therapy reduction of state-anxiety (Spielberger, 1983) over a longer period of time, i.e., several sessions, result in measurable reductions in trait-anxiety, which is defined to be a more enduring characteristic (Spielberger, 1983)? (b) Does the art history enrichment which improves the quality of the patient's art product then lead to enhanced patient self-esteem? (c) Can the assessment of the art product examined in this study (art organizational level) be used to monitor and assess patients' overall response to the art therapy program?

The findings of this study may contribute to the practice of art therapy by providing empirical support for using an intervention of art history enrichment to promote symptom reduction, patient involvement, and higher quality art products. For this reason, it might be important for art therapists in training to have an art history course in addition to studio work.

As with all research, this study has many limitations: mixed diagnostic categories in the group, which may moderate results, the nonrandomness of the sample (for external validity), the small sample size (n = 13), possible practice effects from frequent test repetitions, and not observing anxiety reduction over a greater period of time, so as to make the findings more useful in treatment planning. Although there was not a separate control group, some researchers feel a group can serve as its own control, ensuring that it is comparable to the control group, thereby reducing error variance (Winer, 1962). Some confounding variables that were not controlled include the number of weeks patients had attended the group and the time patients' took their medication in relation to the time the art group met (as some patients get very sleepy from their medication, while others get restless). Since I served both as art therapist and researcher, I may have acted in a way to bias results. Also, a small number of patients asked questions about the meaning of words in the *Self-Evaluation Questionnaire*. Suggestions for further research include addressing the questions raised and the concerns about the limitations just stated and further developing and refining the *Art Description Scales*, which could be useful in evaluating other art therapy approaches.

Conclusion

The structured art therapy program with art history enrichment is successful in helping patients who do not respond easily to other art interventions to spend a sustained period of time at a task and to be satisfied and pleased with their art products, according to their verbal accounts. They are observed to be more connected to the group because of the greater time spent in the group and evidence more joy while in the process, when a lack of affect is the norm. Their voluntary attendance usually results in a "full-house," and patients are shown a way to use their time enjoyably and productively by becoming connected to the larger world of artistic traditions and culture generally.

Ulman (1977) correctly forecast: "Looking ahead, it appears that art education therapy, thus far used mainly with younger people, may find a growing currency in work with adults. It has been predicted that what I termed 'the therapeutically oriented art class' may become a part of the treatment offered adults in the growing numbers of community mental health centers" (p. 16).

Finally, an art educative approach seems to communicate to patients that the staff has not given up on them. The very act of teaching information, concepts, skills, and techniques with seriousness and care imparts the unspoken belief and hopefulness that the patient can learn to join the larger world of people and events.

References

Arnheim, R. (1980). Art as therapy. *The Arts in Psychotherapy, 7,* 247–251.

Ba, G. (1988). Strategies of rehabilitation in the day hospital. *Psychotherapy and Psychosomatic Medicine, 50,* 151–156.

Borchers, K. K. (1985). Do gains made in group art therapy persist?: A study with aftercare patients. *American Journal of Art Therapy, 23,* 89–91.

Campbell, D. T., & Stanley, J. C. (1966). *Experimental and quasi-experimental designs for research.* Skokie, IL: Rand McNally.

Congdon, K. G. (1990). Normalizing art therapy. *Art Education, 19,* 21–24, 41–43.

Cox, R. C., & West, W. L. (1982). *Fundamentals of research for health professionals.* Rockville, MD: RAMSCO.

Erikson, J. M. (1979). The arts and healing. *American Journal of Art Therapy, 18,* 75–80.

Green, B. L., Wehling, C., & Talsky, G. J. (1987). Group art therapy as an adjunct to treatment for chronic outpatients. *Hospital and Community Psychiatry, 38,* 988–991.

Grossman, F. G. (1981). Creativity as a means of coping with anxiety. *The Arts in Psychotherapy, 8,* 185–192.

Honig, S. (1977). Art therapy used in treatment of schizophrenia. *Art Psychotherapy, 4,* 99–104.

Honig, S., & Hanes, K. M. (1982). Structured art therapy with the chronic patient in long-term residential treatment. *The Arts in Psychotherapy, 9,* 269–289.

Ihilevich, D., & Gleser, G. C. (1982). *Evaluating mental-health programs: The Progress Evaluation Scales.* Lexington, MA: Lexington Books, D. C. Heath.

Kramer, E. (1971). *Art therapy with children.* New York: Schocken Books.

Landgarten, H. (1981). *Clinical art therapy: A comprehensive guide.* New York: Brunner/Mazel.

McNiff, S. (1976). The effects of artistic development on personality. *Art Psychotherapy, 3,* 69–75.

McNiff, S. (1973). A new perspective in group art therapy. *Art Psychotherapy, 1,* 243–245.

Miller, M. F., & Miller, C. L. (1992). *Art Description Scales.* Unpublished manuscript.

Moriarty, J. (1973). Collage group therapy with female chronic schizophrenic inpatients. *Psychotherapy: Theory, Research and Practice, 10,* 153–154.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Spielberger, C. D. (1983). *Manual for the State-trait Anxiety inventory (Form Y).* Palo Alto, CA: Consulting Psychologists Press.

Talerico, C. J. (1986). The expressive arts and creativity as a form of therapeutic experience in the field of mental health. *The Journal of Creative Behavior, 20,* 229–247.

Ulman, E. (1977). Art education for the emotionally disturbed. *American Journal of Art Therapy, 17,* 13–16.

Winer, B. J. (1962). *Statistical principles in experimental design.* New York: McGraw-Hill.

Young, N. A. (1975). Art therapy with chronic schizophrenic patients of a low socioeconomic class in a short-term treatment facility. *Art Psychotherapy, 2,* 101–117.

Art Therapy: Journal of the American Art Therapy Association, 10(4) pp. 201-207 © AATA, Inc. 1993

Using Visualization and Art to Promote Ego Development: An Evolving Technique for Groups

Joan Bloomgarden, MA, A.T.R. and Frances F. Kaplan, DA, A.T.R., Hofstra University, NY

Abstract

A technique was devised for promoting specific aspects of ego development in groups. In its current form, this procedure employs two visualization and art experiences and is guided by two therapeutic models, transactional analysis and existential therapy. Loevinger's conception of ego development provides a larger framework in which to place the experiences and their accompanying models and offers a hierarchy of treatment goals. Details of the procedure, along with the supporting rationale—including a description of Loevinger's scheme—are presented. Examples from applications of the procedure are also discussed, and directions for further investigation are indicated.

Introduction

The purpose of this report is to present a group art therapy procedure, our experiences in using this procedure, and a supporting theoretical framework. Designed to promote specific aspects of ego development, the procedure has the primary goals of enhancing self-esteem, improving interpersonal relating, and increasing awareness of personal values. Two therapeutic models, transactional analysis and existential psychotherapy, are used to inform a process that involves two visualizations with accompanying art expressions. Our procedure is in a preliminary form, and conclusions regarding its efficacy should be considered highly tentative. We offer it as work in progress that exemplifies one direction in which the boundaries of art therapy can continue to expand.

The Ego Development Scheme

Our aim is to promote optimum mental health rather than to address psychopathology. We assume that the more mature the individual, the more resources that person will have to deal with life's problems—including mental illness. Marie Jahoda (1958) has discussed how "positive mental health" goes beyond adjustment, normality, or absence of mental illness, and Jane Loevinger (1976) has identified this definition of mental health as consistent with the highest level on her ego development scale. To fully appreciate the benefits of coming as close as possible to this ideal, it is necessary to examine Loevinger's formulation.

Building upon an existing body of developmental theory and informed by empirical study, Loevinger devised both a theory of ego development and a means for measuring this concept (Loevinger, 1976; Loevinger & Wessler, 1970; Loevinger, Wessler, & Redmore, 1970). In her scheme, ego development is defined as a hierarchy of 10 invariant stages and transitional levels. Passage through these stages results in changes in impulse control, moral style, interpersonal relations, conscious preoccupations, and cognitive complexity (see Table 1).

After early childhood, the ego-development

Editor's note: In a somewhat different form, portions of this paper were presented in a workshop at the 22nd Annual Conference of the American Art Therapy Association, Denver, CO, November 1991.

Table 1
Loevinger's Ego-Development Scale

Stage	Code	Capsule description
Presocial-Symbiotic	I-1	Earliest stage, largely preverbal (not used in scoring Loevinger's ego-development measure)
Impulsive	I-2	Dependent and demanding, fears retaliation, dichotomized thinking, frequent conceptual confusion
Self-Protective	delta	Opportunistic, manipulative, and power oriented, fears being caught; externalizes blame; views life as zero-sum game
Ritual-Traditional (transition from Self-Protective to Conformist)	delta/3	Concerned with concrete aspects of cleanliness, physical appearance, and traditional sex roles; desires respectability
Conformist	I-3	Conventional and rule bound, moralistic and sentimental; seeks acceptance by group; concern for appearances; thinks in stereotypes.
Self-Aware (transition from Conformist to Conscientious)	I-¾	Painful self-criticism, elementary awareness of individual differences, multiple alternatives, and exceptions to rules; concern for appropriateness of actions
Conscientious	I-4	Responsible; guided by inner standards; achievement oriented; psychologically minded and conceptually complex; empathic and self-respecting
Individualistic (transition from Conscientious to Autonomous)	I-⅘	Values interpersonal relations and appreciates their complexity; sees paradox instead of polar opposites; aware of conflicting emotions; distinguishes between appearance and reality; truly tolerant
Autonomous	I-5	Copes with inner conflict; rich inner life; cherishes individuality; aware of complex psychological causality; values self-realization more than achievement; concern for broad social perspectives
Integrated	I-6	Reconciles inner conflict; involved in search for identity; values justice and idealism; broadly empathic

Note. Beginning with the I-4 stage, descriptions are cumulative. Content of table based upon material found in Holt (1980), Loevinger (1976), and Loevinger and Wessler (1970).

stages are relatively independent of age. That is, individuals can cease development at almost any point on the scale, and there is evidence that many do not progress very far. For example, research using Loevinger's sentence completion test of ego development strongly suggests that the Self-Aware (I-¾) level is the modal level for adults in our culture (Holt, 1980). Characteristics of this level, such as "painful self-criticism," clearly stand in the way of optimal psychological functioning.

More favorable characteristics are found as we inspect the higher levels. Note that self-respect (I-4), true tolerance (I-⅘), concern for broad social perspectives (I-5), and being broadly empathic (I-6) are located in succession at the upper end of the scale. This suggests that healthy ego development involves a gradual consolidation of a sense of self along with a progressive decrease in egocentricity and a turn toward altruism. For therapists who wish to promote ego development, a complex approach that includes self-esteem building, interpersonal skills training, and values clarification seems indicated. For art therapists working in this area, visual tools that facilitate psychological differentiation and integration are required. Previous work (Lusebrink, 1990) suggests that mental imagery may well be such a tool.

Visualization as a Tool for Art Therapy

Visualization is the formation of a mental picture. This working definition involves the conscious creation of an image or images. Visualizations have been created for the purpose of healing disease (Epstein, 1989), for the purpose of relaxation and stress reduction (Fanning, 1988), and for the remediation of depression (Epstein, 1989; Fanning, 1988). Visualizations have been used to enhance sports performance and for the purpose of increasing self-esteem. Although images are best chosen by the individual (Siegel, 1986), combining self-chosen images with directed images has been used to good effect (Fanning, 1988).

Visualization was our method of choice because of the powerful results imaging has reportedly produced in recent years (Korn & Johnson, 1983). Epstein (1989) states that research has not examined the phenomenon of healing through imagery in a methodical way, but drawing upon clinical experience, imagery has been found to reinforce healing of both the mind and the body. There are a variety of ways to construct visualizations, which makes them very adaptable to particular needs. One is *receptive visualization* (Fanning, 1988). After the initial relaxation stage, the participants retrieve their own set of feelings and images. There are minimal prompts, and the participant's mind is allowed to wander and seek its own place. Another approach is *programmed visualization* (Fanning, 1988). Here the individual responds to guided imagery—either self-directed or guided by another. Programmed visualization is used to help a person accomplish something specific, such as more effective public speaking, increased assertiveness, or athletic achievements. Our visualizations use a combination of receptive and programmed visualization. This seemed most appropriate for our purposes because we wished to achieve a specific, yet broadly defined, goal.

Visualization and Art Experiences

Practitioners of growth-promoting therapy have recommended use of more than one therapeutic model (Corey, 1985; Wadeson, 1987; Wilber, Engler, & Brown, 1986). For this reason, we have chosen two models consistent with our philosophies and experience.

Transactional Analysis Visualization

Both transactional analysis (TA) and art therapy use action-oriented techniques which coincide with their respective principles. Often art therapists will use an art directive and then discuss the production (Landgarten, 1981). Therapists using TA are concerned with communication within the patient's system of relationships. They analyze interactional patterns and teach the principles to the patient (Berne, 1961). Combining the two therapies seemed natural and appropriate for our purposes.

The concept of ego states—adult, parent, child—is the cornerstone of TA theory. Keeping this in mind, we designed the directives and visualization to be given while participants are in the adult, or mature self, state. TA also teaches that people are motivated by the need for "strokes." Thus, we developed an art directive with the intent of creating a positive feeling, a positive image, and eventually a positive stroke. Berne (1961) has proposed that promoting such positive interactions is ego-building. It would appear to follow, then, that this encourages movement toward a higher developmental stage.

A short relaxation is used to prepare for this visualization. This relaxation exercise is given in the style of Epstein (1989), who differentiates between relaxation that induces a semisleep state for the purpose of lowering stress and relaxation in which the participant actively works on the imagery. The directives for the relaxation and visualization are as follows:

> This art expression has a few steps to it. For this exercise you will be working with a partner. You will be choosing someone from this group who you do not know and will be spending time conversing together. One of you will begin speaking about anything of interest to you at this time—why you are here, your professional interests, personal goals, personal history—just anything you feel like sharing. Your partner will begin by listening but is invited to ask questions and join you whenever appropriate. Then you will reverse the process. You will have approximately 3 minutes each. I will alert you when to switch. You may find your partner now.
>
> [Following completion of the conversation] Relax in your chair, and if you feel comfortable, close your eyes while we start with deep breathing. First exhale, with the exhale being long and relaxing. It should be twice as long as the inhale. Now inhale, exhale, inhale, exhale. Now think of the partner you were talking with and think about one of the qualities you noticed that was positive—something you noticed about that person that made you feel good, that you admired, that you recognized as special. Now, still breathing and relaxing, feel that good quality, that trait that you liked, or the positive aspect of your partner's personality. Take it inside you and feel it while you notice how it looks. Notice the shapes of it, the colors, the lines, if there are patterns. Feel it and notice the special imagery that is coming to mind. Stay with the imagery and feel it as you see it. Still relaxing, enjoy the imagery. When you have that imagery and when you feel it, then, still staying relaxed and seated, you may open your eyes. When you are

> ready, you may begin your artwork. Begin to portray the positive quality, trait, aspect of your partner that you just pictured. You will have 15 [or longer] minutes for the artwork.
>
> [Following completion of the artwork] You are going to give your partner the artwork. Give your artwork and describe what the quality is and how it looks to you. When you give it to your partner, your partner will receive it and state the quality by saying "I am . . ." and briefly describe the images using "I am." Then you will receive your partner's artwork. When you have finished, we will have time for a discussion.

Existential Therapy Visualization

The primary focus of the existential approach to therapy is dealing with ultimate concerns: freedom, isolation, meaning, and death (May, 1983; Yalom, 1980). Assuming responsibility for one's own existence is of primary importance for this process—as is the development of values. It is through connections with others and with the world that personal values are discovered and refined.

We contend that the tenets of existential therapy offer an orientation for helping clients achieve the ego-transcending traits of the higher levels of the ego-development scale. (It is a paradox of ego development that, in a sense, one has to lose oneself in order to find oneself.) More a philosophy than a set of techniques, the existential approach provides a world view that can guide the art therapist in creating growth-promoting activities (Moon, 1990). It is just such a viewpoint that has inspired the following visualization:

> Imagine that you are taking a journey—a journey into space. Imagine the space capsule here in the center of the room. You make your preparations and climb into the capsule. Now the roof is rolling back and the capsule is ready for flight. Now you begin ascending into space. You are seated by a window and, as you ascend, you enjoy the changing view. You see the [school, hospital, workshop setting] getting smaller and smaller. You see the [city, town, surrounding countryside] spread out before you. It is very beautiful. You ascend still further—up and up—until you can see the curvature of the Earth and then the entire earthly sphere that we call home. As you look, images of what means the most to you about our world begin to appear. Slowly, your spacecraft begins to circle the Earth. Slowly the images of what means the most to you become clearer. As you travel, you are entranced as you view the shapes of the continents passing beneath you, and you are struck by the observation that there are no discernable boundaries between countries—that each merges into the other—that each is a part of the whole. As you continue to circle the Earth, you think of the world's troubles and you begin to see images of how you would like the world to be. As you continue on your journey these images of how you would like the world to be become more and more vivid. Slowly you complete the circle—slowly you begin to descend—slowly you return to this room, bringing with you memories of the beauty of the Earth, bringing with you the images of what means the most to you, bringing with you the images of how you would like the world to be.
>
> When you are ready, make a picture about this experience. You will have 15 [or longer] minutes to complete your artwork. We will then discuss your experiences.

Discussion of Examples

We have applied our procedure in a number of different contexts: a graduate course for art therapy majors; an elective undergraduate art therapy course; a workshop at an art therapy conference; and a treatment setting (TA visualization portion only). But before presenting examples from these applications, a few general observations are in order.

First, although both visualization experiences are highly involving, the TA experience was generally considered more powerful by participants. This might well be due to a sense of increased intimacy and self-esteem evoked by the personal affirmations. Therefore, when the experiences are used together, it appears to feel more satisfying to conclude with the TA activity. (Indeed, feedback recommending this order was given by the graduate students.)

Second, our experience suggests that the TA visualization is appropriate for both patient and nonpatient groups. The existential visualization, on the other hand, has not been tried with psychiatric patients and is probably not as appropriate for them—or for those whose development has been arrested at a low level of ego functioning.

Third, we consider collage to be the medium of choice. All kinds of paper, magazine pictures, and materials of various colors and textures can be effectively used. In our opinion, the additional sensory stimulation provided by these materials facilitates the translation of the visualizations into concrete form. Also, collage can result in a satisfying end product even for those with minimal art skills.

Specific Examples

Because the TA visualization offers a "here and now" interpersonal experience, it is suitable for an inpatient setting where the groups are always changing. One of us used it in the 20-bed psychiatric unit of a community hospital with the goals of increasing interpersonal contact and promoting the feeling of general well-being. Overall, the experience was reported as pleasurable by the group. The patients were generally supportive of each other and, when paired off, became active participants relative to their level of functioning. They remarked how often their focus dwells on negativity and problems, thereby overlooking opportunities to become aware of and nourish positive aspects of themselves and others.

The remaining examples are from our joint session with an undergraduate class in art therapy for which one of us was the instructor. Ten students participated in both the existential and TA experiences, presented in that order. Following the session, the students wrote brief reactions to the experiences in their class journals that supplied us with additional information. We are aware that the student-teacher relationship probably introduced a certain amount of bias. Whether this significantly influenced our conclusions can only be determined by further investigations.

The student artwork provides indications of current levels of ego functioning. Figure 1 depicts the personal goals of a male student that relate to sports and body building. This self-focused response to the first visualization was in marked contrast to the more altruistic responses of the other students. The work of a woman student also departed from the norm—but in a different manner (see Figure 2). Her collage, with complementary images symbolizing balance, represented an attempt "to break from the stereotypical images of peace, love, and happiness" (quote from journal). The narcissism of the one student's response and the creativity of the other student's response suggest divergent levels of ego development.

More to the point, there are also hints of ego-advancement in this set of examples. The young man who desired physical strength was able to put aside his self-preoccupation and reflect on the qualities of another as part of the TA experience (see Figure 3). In his journal he remarked, "I drew a sunbeam as a portrayal of the girl I worked with, because I always thought of her as a 'spaced out' person, but she really isn't." In another instance, a student responding to the existential visualization appeared to reinforce high ego-level values while depicting a frequently occurring theme—respect for nature (see Figure 4). She wrote, "Not only did I show society's negative characteristics but I also showed the way I wish

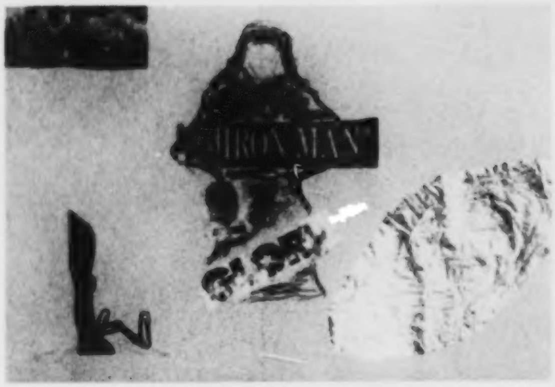


Figure 1.

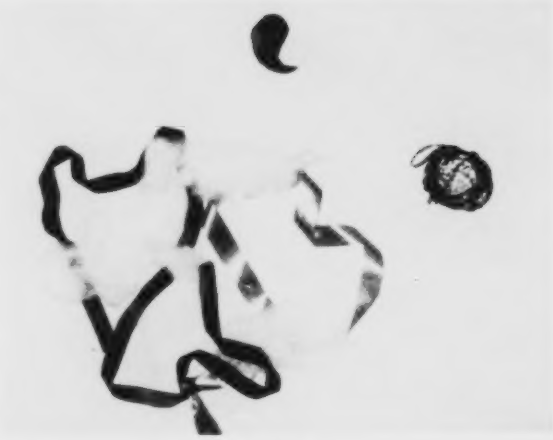


Figure 2.

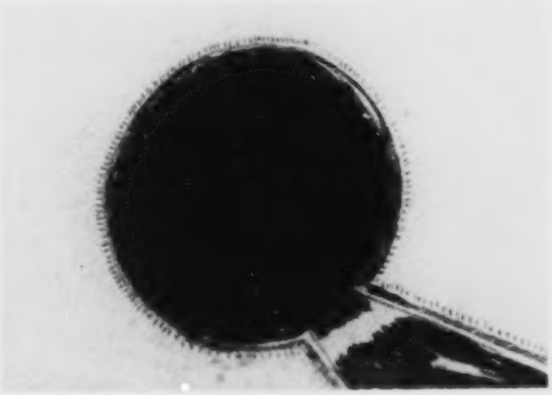


Figure 3.

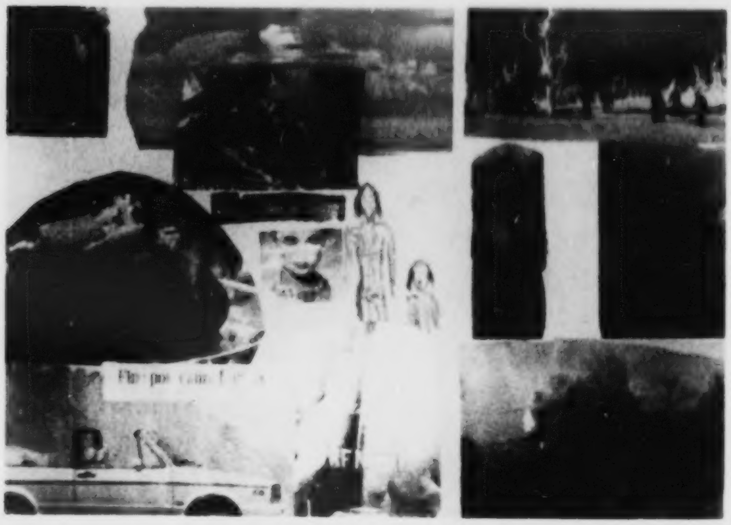


Figure 4.

things were such as: enjoying nature rather than exploiting it, and enjoying the simpler things in life rather than material possessions."

It should be noted, however, that any steps forward were probably fleeting and may have been little more than normal fluctuations in ego level. Loevinger (1976) has stated, "Ego development is growth, and there is no way to force it. One can only try to open doors" (p. 426). Although we cannot aspire to more, we do assume that each additional "door opening" has value and might, in the long run, produce a lasting cumulative effect.

Finally, the procedure appears to have some general assessment value. Suggestions of typical defense mechanisms—which may or may not be indicative of ego level—were revealed by the artwork and accompanying interactions. For example, one young woman's collage contained a cotton mandala with a silver smiling face labeled a "puffy cloud" (see Figure 5). Her journal indicated that it made her feel good to create this for her male partner. He, however, expressed feeling puzzled as to what it meant. It is possible that the puffy cloud represents the artist's projection of her own internal world. On the other hand, her partner may have been denying that, as a male, he could be associated with an image of "feminine" softness. In any case, possibilities for further exploration were presented.

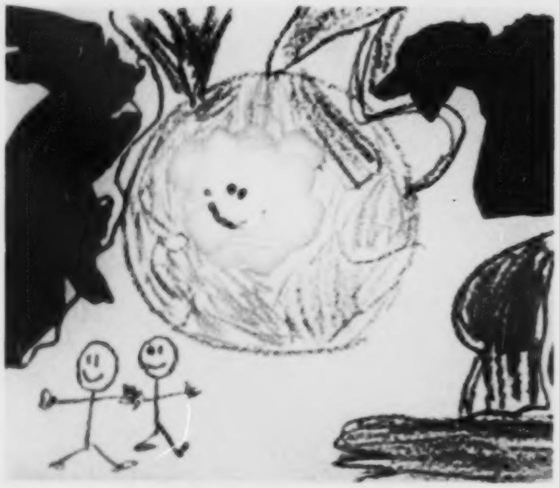


Figure 5.

As a concluding example, another young woman's description of the same visualization experience revealed the defense of healthy narcissism. She wrote, "It felt good to give someone something that I had made myself and was my creation and I felt special having something presented to me about myself. That is the best gift that you can give someone else." With this statement, she also gave evidence of nonmaterialistic values worthy of emulation and provided an endorsement for the art therapy process in general.

Conclusion

The examples presented in this article exhibit some emerging patterns relevant to ego development. We believe these are sufficiently supportive to warrant the expenditure of effort needed to conduct objective studies. Quantitative research using Loevinger's ego-development measure in a pretest/posttest design is a logical next step. Positive findings from this research would, in turn, provide encouragement for the development of companion procedures. As a consequence, a therapeutic program of several sessions could be put together with the aim of promoting the enduring increases in ego level that are unlikely to result from a single exposure. Our study, then, represents only an initial step down a long road—but suggests that the journey is worth undertaking.

Questions regarding this article may be directed to Joan Bloomgarden, MA, A.T.R., and Frances F. Kaplan, DA, A.T.R., Hofstra University Creative Arts Therapy Program, Hempstead, NY .

References

Berne, E. (1961). *Transactional analysis in psychotherapy*. New York: Grove Press.

Corey, G. (1985). *Theory and practice of group counseling* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Epstein, G. (1989). *Healing visualizations: Creating health through imagery*. New York: Bantam Books.

Fanning, P. (1988). *Visualization for change*. Oakland, CA: New Harbinger Publications.

Holt, R. R. (1980). Loevinger's measure of ego development: Reliability and national norms for male and female short forms. *Journal of Personality and Social Psychology, 39*, 909–920.

Jahoda, M. (1958). *Current concepts of positive mental health*. New York: Basic Books.

Korn, E. R., & Johnson, K. (1983). *Visualization: The uses of imagery in the health professions*. Homewood, IL: Dow Jones-Irwin.

Landgarten, H. B. (1981). *Clinical art therapy*. New York: Brunner/Mazel.

Loevinger, J. (1976). *Ego development: Conceptions and theories*. San Francisco: Jossey-Bass.

Loevinger, J., & Wessler, R. (1970). *Measuring ego development: Vol. 1. Construction and use of a sentence completion test*. San Francisco: Jossey-Bass.

Loevinger, J., Wessler, R., & Redmore, C. (1970). *Measuring ego development: Vol. 2. Scoring manual for women and girls*. San Francisco: Jossey-Bass.

Lusebrink, V. B. (1990). *Imagery and visual expression in therapy*. New York: Plenum.

May, R. (1983). *The discovery of being: Writings in existential psychology*. New York: W. W. Norton.

Moon, B. L. (1990). *Existential art therapy*. Springfield, IL: Charles C Thomas.

Siegel, B. S. (1986). *Love, medicine and miracles*. New York: Harper & Row.

Wadeson, H. (1987). An eclectic approach to art therapy. In J. A. Rubin (Ed.), *Approaches to art therapy* (pp. 299–313). New York: Brunner/Mazel.

Wilber, K., Engler, J., & Brown, D. P. (Eds.). (1986). *Transformations of consciousness: Conventional and contemplative perspectives on development*. Boston: New Science Library.

Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.

The Editorial in Volume 10 #3 neglected to mention that, as of July 1993, the art therapy program at California State University Sacramento is now approved by the American Art Therapy Association. Persons wishing to contact the CSUS program for additional information may direct correspondence to: Art Therapy Masters Program, Department of Counselor Education, 6000 J Street, CSUS, Sacramento, CA 95819-6079.

Art Therapy: Journal of the American Art Therapy Association, 10(4) pp. 208-218 © AATA, Inc. 1993

Resistance in Art Therapy: A Multi-Model Approach to Treatment

Arthur Robbins EdD, A.T.R. and **Barbara Cooper MPS, A.T.R.**, New York, NY

Abstract

Four treatment models are discussed with reference to working with resistance in art therapy—drive psychology, object relations theory, self psychology, and ego psychology. Each of these models imagines resistance in its own way. Working with these four models of treatment, art diagnosis, therapeutic interventions, and the transference/countertransference relationship are considered with particular attention to resistance issues. Four cases are presented.

Introduction

Therapeutic models of treatment roughly fall into four major categories (Pine, 1990): drive psychology, object relations, self psychology, and ego psychology. Each theory attempts to organize therapeutic data under a central principle that not only helps therapists understand each case but also offers a methodology of interaction with patients. If therapeutic communications stall into a period of stagnation characterized by stereotypy or repetition, interventions are required to improve the therapeutic flow and processing. Each model offers clues and guidelines to help therapists remove these resistances. The organization of patient art, along with transference and countertransference phenomena, lends itself to a particular model of treatment. This paper attempts to clarify the variety of differentiations that lead to adapting different therapeutic models and the variety of therapeutic interventions that are associated with this understanding.

The Multi-Model Approach

The multi-model approach to treatment has been extensively elaborated by Pine (1990), who divides models of treatment into drive theory, ego psychology, object relations, and self psychology. Lazarus (1976) also uses the term "multi-model," but his orientation is heavily behavioral and cognitive. The authors of this paper recognize that different models of treatment and their particular languages may speak more or less eloquently to each therapist, depending on his or her particular personality. Yet, regardless of the therapeutic orientation of the therapist, all patients may at some time during the therapeutic process demonstrate resistances to treatment. The intent of this paper is to present a broad framework for resistance work that is not embedded in one particular therapeutic school.

Four Models of Resistance

Resistance can be viewed as any psychic obstacle that interferes with the therapeutic process. The concept of resistance was originally developed in drive psychology and remains fairly central in each psychoanalytic framework, having taken on new meanings in the contexts of object relations theory, self psychology, and ego psychology.

1. Drive Psychology: Drives are energetic expressions of sexual and aggressive tensions. Patient communications are funneled toward the expression, organization, and mastery of drives and/or their equivalents. Affects of guilt, shame, and anxiety that are associated with defensive operations lead to resistances; they are lowered through therapeutic interventions. Integration of drives in one's functioning becomes the central theme of this treatment model.

From a drive psychology perspective, the therapist works with the patient to make resistance ego-alien, and thus lessens the obstacles to the treatment process (Fenichel, 1934). Within a drive psychology framework, the focus is on the patient's integration of drive material into his or her everyday functioning. Resistance occurs when the patient feels overwhelmed and frightened by drives and becomes defensive. But the pioneers of treatment did not foresee that resistance work could, on occasion, be experienced by the patient as critical and unacceptable. Direct confrontative resistance work can cause even more pronounced resistance. Perhaps in reaction to the limited classical appreciation of resistance, Moustakas (1974) reframes resistance as the psychological protection developed by a patient to preserve an inner sense of ego integrity. Consequently, a respect for the adaptive importance of resistance enters the treatment process.

2. Object Relations: Therapeutic work is organized around issues of internalized relationships (objects) that are associated with fears, longings, or conflicts around attachment, loss, and the process of separation and individuation. Interventions are focused in the area of abandonment and loss. The constancy of the real relationship and the structure of art making become an important piece of the reparative process.

From an object relations perspective, resistance calls for a variety of holding environments which, it is hoped, increase the patient's ability to tolerate the vagaries of object attachment and loss (Kernberg, 1976). Personality is organized by a series of early relationships that are internalized, both unconsciously and consciously. These relationships are constantly repeated in the present, and therapeutic challenges to these embedded patterns create fears of abandonment. In an object relations framework, the therapist creates a "good enough" holding environment, within which the patient can internalize both the strength and perspective of the therapist, thus becoming more able to withstand the problems of change. Defensive patterns of resistance to treatment are resorted to when fears of abandonment become overwhelming.

3. Self Psychology: Under the psychic construct of the self that represents our interests, values, and attitudes, interventions are directed toward affirming self cohesion. Anxiety represents a threat to the self and interpretations are organized around mirroring and supporting the self.

From a self psychology perspective, appropriate mirroring or empathy reduces resistance and facilitates treatment (Kohut, 1971). By mirroring, we reflect back to the patient the dissociated parts of the patient's self. This mirroring is both cognitive and affective. It is expected that the patient may go through an idealization process, perhaps creating a transference/countertransference relationship marked by "twinship." ("Only you and I understand each other.") When treatment bogs down, the problems can often be traced to a lack of empathy on the part of the therapist. Resistance is ameliorated when the therapist responds to the patient's communications with appropriate empathy or mirroring.

4. Ego Psychology: The therapeutic focus is placed on reinforcing the adaptive abilities of the patient that are consistent with his or her developmental maturation. Interventions are directed toward enhancing the patient's ego resources that are intimately related to self-esteem issues. The ego represents a series of functions that integrate for the patient's inner and outer reality demands.

Ego psychology can encompass both behavioral therapy and cognitive therapy and offers a developmental perspective on the patient's ego adaptational conflicts with reality. Treatment centers around the management of reality and the reinforcement of more effective ego-based coping mechanisms. Included in this orientation are such techniques as offering therapeutic contracts, supporting and improving ego skills, and creating models of identification which improve social effectiveness. In working with art, the specific skills necessary to make meaningful art are reinforced and supported by the therapist. Within the context of ego psychology, resistance occurs when the therapist demands behavior or relatedness that is inappropriate to the patient's developmental level (Hartmann, 1939). In these instances, the patient's competent functioning and self-esteem are considered pivotal in treatment. Supplying appropriate developmental tasks and emotional support becomes the therapist's goal. Resistance occurs when the patient feels overwhelmed by developmental tasks that are inappropriate to his or her skills or cognitive and emotional integrative ability.

Art Diagnosis

The challenge for the art therapist within a multi-model approach is manifold. First, an assessment of the artwork in terms of its developmental level and defensive organization is necessary. Second, the meaning of this organization within the context of the transference/countertransference relationship must be considered. Third, a series of interventions that lessen the patient's resistance and increase his or her ability to be therapeutically present in the treatment relationship must be developed.

Psychoaesthetic organization in artwork informs a diagnostic perspective with therapeutic implications. The authors' assessment is based on their subjective experience with the patients' art; that is, their internal visual experience upon viewing the artwork. This appraisal is admittedly a subjective one, but is consistent with an intersubjective notion of psychotherapy, a therapeutic assumption that the subjectivity of both the patient and therapist are always present and that both are interrelated in any given therapeutic engagement. These subjective interpretations of art are based, however, on 40 years of clinical experience with patients and their art expressions.

For example, in Figure 3, the art expression lacks grounding and does not seem connected to the outside. There are problems in creating a gestalt and a tendency toward fragmentation. Such skills as judgment, planning, and the capacity for symbolic abstraction are not apparent in this artwork. The material seems obvious and, at times, stereotyped. This visual organization in fact parallels the behavior of patients who are overwhelmed by reality and present to the therapist feelings of inadequacy and low self-esteem (ego psych).

An object relations framework will prove useful when the structure of the art form shows enmeshment of two forces "fighting" one another. The viewer's focus moves to the center and then is bound or trapped by an outside force. The usual oscillation of the eyes' movement from inside to outside and back is inhibited. In contrast, when there is true object constancy, a fairly clear flow of in and out in the artwork is observed. From the artwork's perspective, the flow of energy toward the center is thought to represent the self, while the horizontal and vertical axes represent the object. The flow of energy in the artwork—horizontally, vertically, and from inside to outside and back—tells the story of the patient's internal object relations.

When a patient's artwork pulls our eyes toward the center, or when there is no pull at all toward the center, the self psychology model is also relevant. Sometimes there is relatively little movement back and forth from the inside to the outside and no great enmeshment of self and object. Focus moves toward the inside of the artwork and remains there. Often the material is shallow and expansive, or at times small and limited. One experiences the viewing of this artwork as being enmeshed in the center, or of not being able to find the center.

When a patient has worked through the basic issues of object constancy, he or she may produce artwork featuring a relatively stabilized organization of movement from inside to outside. In this case a drive psychology framework is useful. There may be evidence of strong defenses around drive material, with the flow of energy being stopped either on the horizontal or longitudinal axis. For instance, there may be a heavy overbalance of horizontal art activity that stops the flow of energy upward, or tight obsessional forms that interfere with the movement or flow of the artwork as a whole. The viewer's attention is then directed to where the flow stops. Does he or she see strong, emotional, affective colors being overly contained with strong lines either in a horizontal or vertical direction? Sometimes the artwork will be overly elaborated or overly structured, as a way of muffling or restricting strong emotional engagement with the viewer. The opposite may also be present with a chaotic display of emotional coloration, primitively organized. Here therapeutic interventions will be directed to create a flexible structure that facilitates patients' affective connection with the therapist, without overwhelming or overly restricting them.

Transference and Countertransference

Although the scope of this paper precludes extensive discussion of transference and countertransference as understood within each model of treatment, it does emphasize that different models of treatment offer different means of processing the communications of patients and that different models of treatment tend to create different transference and countertransference reactions. For instance, working from an ego psychology perspective, the therapist will be very active and structuring, creating a very powerful authority transference. Within an object relations framework, the therapist adheres to firm boundaries, while the patient is constantly struggling against "falling into a dark pit" and may go through a number of provocative maneuvers. In this case art serves as a transitional object and holds the patient in spite of the transference and countertransference machinations that may go on between therapist and patient. When approaching cases from a self psychology viewpoint, however, the experience is one of being present for and with the patient. In this instance the patient enters into either an idealizing or self object transference relationship with the therapist. Building the patient's sense of self through mirroring and empathy is the main thrust of this treatment. Finally, the therapist working from a drive psychology perspective will attempt to maintain a fairly neutral and separate therapeutic stance with the patient. A variety of drives and fears may be projected onto the therapist which ultimately are either interpreted or confronted. As there is less use of the therapist's personal resources as a holding or healing agent, countertransference responses are associated with the traditional notions of countertransference: past conflicts of the therapist getting in the way of treatment process.

Treatment Interventions

We have already discussed in some detail the interventions that are typically indicated by these four models of therapy. In an ego psychology model, structure, support, and reinforcement are basic underpinnings of treatment intervention. In self psychology, mirroring and empathy are the basic tools to work with resistance. In an object relations framework, the art form becomes the transitional object that deals with object loss and a need for holding. Finally, in drive psychology terms, defenses are constantly encouraged as well as interpreted and/or confronted as seen in the art form to effect greater synthesis and ego integration.

The implementation of these four models of therapy can flow from one to another. They often overlap and become central for one phase of treatment and peripheral to another. The artwork itself usually offers the diagnostic clue as to how the therapeutic material may best be understood and treated. Following are four clinical sketches that illustrate how to apply the four models of treatment to different clinical problems and manifestations of resistance. Cases 1 and 2 are by Arthur Robbins; cases 3 and 4 are by Barbara Cooper.

Case 1

Joan, a married woman of 40, without children, enters treatment with complaints of loneliness and depression. In her capacity as theatre director, she views herself as unsuccessful and frustrated, in spite of the fact that from time to time she has directed important pieces that have received good reviews. Her husband, a busy professional in the medical field, works long hours and is not always available either physically or emotionally. On the surface he is supportive, but he feels uncomfortable in any intimate dialogue. With their busy professional schedules, they rarely spend time with one another except on vacations. Joan's parents were also busy professionals, leaving the children to surrogate caretakers. Private school beginning at age 8 afforded Joan some structure in which she felt cared for and secure. Joan describes an overly anxious and infantile mother, who, out of her own sense of insecurity (rather than concern), was both overprotective and neglectful. Now in her third year of treatment, Joan has moved from a very distant and unrelated connection to the therapist to one in which she feels far more connected and emotionally grounded. Mirroring, empathy, and reflection have been important modes of intervention. Joan brings her loneliness and sadness to the session; she can be very elusive and difficult to reach. At times her relationship to her mother is referred to as being repeated in the transference, though the focus has been basically on her self. Joan rarely refers to her father, who was largely absent and emotionally disengaged from his daughter. The treatment is basically verbal in nature though on occasion the patient works with art to clarify a particular issue.

In a recent session, Joan speaks about her dissatisfaction with her job. She feels unappreciated and unrecognized and despairingly complains about her inability to do much about her situation. She admits that her colleagues view her as competent, but she gets no gratification or pleasure from this. Joan speaks of a secret place inside of her that even she does not know very well. This juncture in our dialogue seems to be an excellent place to move into a nonverbal mode. I ask her if she can draw this place, and she says she will try. She chooses a soft pink pastel that she says represents some vague far-off place in herself. She asks me if I will accompany her in her drawing, and I agree. The closeness and intimacy are consistent with the self psychology approach. I would be far more hesitant to accompany my patient if there were issues around boundaries or regression. In the following interaction there is a mutual mirroring process. This technique seems most applicable in cases where the object attachment needs firming up. Mirroring occurs on conscious and unconscious levels, in both participants. The relationship has a symbiotic quality. Out of this rhythm of give and take, the patient develops a new perspective on the self.

Joan draws a half-circle and I complete the other half with sharp angular lines (Figure 1). This intervention comes fairly spontaneously, though I am subliminally aware that I want to offer her a framework in which she can feel held and yet have something to bounce up against. I am also trying to

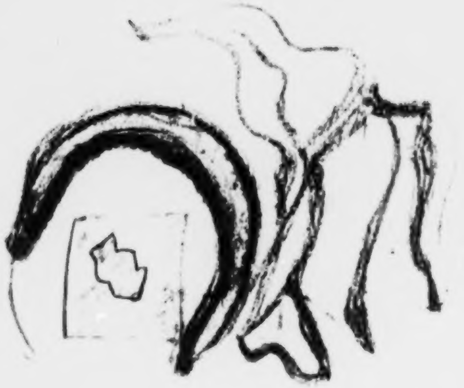


Figure 1.

mirror the masculine and feminine elements of the self so that she has a frame for exploration. She chooses brown and orange pastels and transforms my harsh lines into something more flowing and soft. We both recognize that she would like me to hold and recognize the soft flowing part of her. I then draw a box, as my representation of the missing object, and then she fills it with a pink color. She proceeds to draw a green outline inside the box, and I fill it in with green. I say to myself that her emptiness can be filled, even though I hear, somewhere, her green envy. Once again, I mirror her wish to be filled, and at the same time suggest perhaps that envy is something that can be accepted without judgment. Perhaps this secret place may be the envy and hunger in my patient, but I do not feel it necessary to verbally articulate these impressions. The simple nonverbal mirroring is all that seems required. I then draw a circle and she shades half of it with green pastels. I outline one part of it with red, and she softens it with a red flow. She comments on the empty spaces and wonders if that's what's really inside of her. I comment that perhaps the empty space feels too enclosing and she needs to express the flowing part of her without being entrapped. She smiles to herself as she observes that her flow of brown lines has its own entrapment. "I guess," she says, "I'm a woman of the '90s; I want softness, I want to be held, I want to feel strength, and I want freedom." Here, in visual dialogue, the soft parts of the patient's self encounter the firm straight line of the therapist, and the sense of flow resonates with the soft flowing part of the patient. In this mirroring dialogue, I mirror her need for closeness and intimacy, as well as her desire to make her own art structure. We both participate in, share, and observe this complicated mirroring. The paradoxical nature of the self becomes highlighted in this mirroring. The wish for freedom interposes and interfaces with the need for softness and holding. In this session the patient takes some risk in being close while at the same time expressing her need for freedom.

The therapeutic engagement is directed at the patient's sense of self. To be sure, she wants freedom from encroachment, but most important, she wants to be seen. There are many sessions of this nature. Gradually the patient evolves into a more defined and definitive woman who addresses her needs both in work and with her husband. There are of course many regressions, particularly when the therapist takes his vacation. However, slowly the patient has become more organized and clear, as well as related to an I-thou therapeutic dialogue. The mirroring techniques of self psychology have been especially helpful to this patient.

Case 2

Mary, a married woman of 35, mother of two young children, a girl of 4 and a boy of 6 months, has been in intensive psychotherapy for approximately 6 years. During one 3-year period, Mary was seen three times a week. She is currently worked with once a week. Initially, the patient was a very lost and confused woman, but slowly she discovered herself, fell in love, married a very supportive husband, and prepared herself for the profession of medicine. A good deal of therapeutic emphasis has been placed on the self and object loss during the main part of treatment. Mother, viewed as infantile and immature, and Father, all too busy with his business, left much of the parenting to a live-in nanny. The mother was fairly warm and caring when the patient was preadolescent, but the teen years created for the patient a good deal of alienation and estrangement from the family. The mother was seen as a very poor role model and as a woman whose interest in sexual matters was minimal. Currently, Mary has little to do with her mother. Mary's father died 2 years ago from a sudden heart attack.

During the most recent stage of treatment, Mary has grown very articulate in addressing her problems. Treatment is basically verbal in nature though the patient on occasion works with art to clarify a particular issue. She also works with collages in an art class and often shares her newest creation with the therapist. Her sexual life has improved, but now, after the birth of her latest child, she once again wants little or nothing to do with sex.

This has caused problems between her and her husband. Mary is visibly upset over her inability to deal with her sexual problems. She considers her body ugly and unappealing. She hates her round hips and hairy body. (Most people, I believe, would view her as very pretty.)

In this reported session she states that she wants to take a breather from talking about sex. She is concerned about her daughter, Donna, who hates wearing pretty clothing and prefers the torn jeans that adolescents commonly wear. Donna hates bathing and is generally oppositional toward any suggestions that Mary makes about her clothing. The mother laments that her daughter is turning out to be like herself. While Donna exhibits oppositional behavior, she is also very concerned about showing favoritism to either parent: after spending time with her father, she reassures her mother that she really cares about her, and in turn, when she spends time with her mother, she then reassures her father that she cares about him as well. The patient laughs and comments that it looks like her daughter is in the middle of the oedipal phase. "What does this have to do with you?" I ask. The patient shrugs her shoulders, and I suspect that we are ready to move to another level of expression. I ask her if she would like to draw her mother, her father, and herself. She readily agrees, but draws a small box-like figure for her mother, a long straight line for herself, and an even longer line for her father (Figure 2). I comment that she could at least add some meat and substance to her representations. I feel, however, that any more interpretation would not be useful at this point. She calls her mother "the fecal baby" and says there is nothing she can add to it. What she really wants to do is rip and tear.

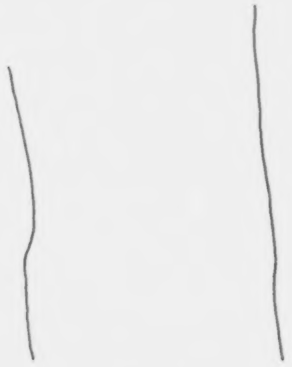


Figure 2.

I encourage her to do so and she takes the side of the paper with the fecal mother and tears it in pieces. She complains that she does not have brown paper, which would be far more appropriate to accompany her affect. I proceed to give her some brown paper and she proceeds to make a pile of pieces of paper. "What would you like to do now?" I say, and she comments that she would like to burn the pieces. "Shall we?" I say, and she breaks into tears and says, "My poor mother. She has been mean to me in many instances, but I can't hold it against her that she is so inadequate." I reflect back, "It is very hard to be furious at such an inadequate mother, for she was such a pushover and does not know how to fight back. Do you really think that your anger can be so destructive to your mother?" "Well, if this is what's holding me back, I'm going to do something about it," she says. I remind her that her most creative work in a recent art class dealt with collages. The patient decides to take the pieces home and bring back a creative work of the cut-up pieces of her mother. "Maybe," I say to myself, "the patient can find some transformational qualities in her rage that can truly lead to a separation from her mother and a more adequate notion of the female image."

Though there are issues around separation from the mother, the overwhelming thrust of the material deals with defenses against rage and guilt, and the reintegration of these impulses into a more organized picture of the female self. In this therapeutic instance the toleration of rage, as well as a creative reorganization of this drive material, becomes the focus of treatment. Subsequently, the patient entered a rather protracted period of loss and depression that seemed to be precipitated by problems with her child. However, it also became apparent that after the period of rage toward her mother, she was able to externalize the object of her mother, which set the stage for feelings of loss and abandonment. So, at this particular juncture of therapy, the therapist moves from a drive psychology framework of processing to an object relations model that is more appropriate to work through object loss.

Case 3

Rose, a 30-year-old woman, came into the Harlem-based clinic for help. She claimed to feel angry and depressed much of the time and the precipitating factor was a fight with her mother. Rose is a welfare recipient with a seventh grade education and has been employed only once in her life for 6 weeks. Rose has a 13-year-old daughter who lives with her mother. When Rose was 5 she witnessed her father stab her mother. She was assaulted as well and was hospitalized briefly for a concussion. Rose is married to Joseph, now serving a prison sentence for selling drugs. They met through a friend of Rose's while Joseph was in prison for assault. They married while Joseph was still in prison. They lived together for a year before Joseph was reincarcerated. During that year, Joseph was physically abusive with Rose. She was hospitalized for a head wound after she was thrown against the refrigerator.

When I met Rose she was both abrasive and tearful—pleading for help. She attached to me in a positive way immediately, almost too quickly. Her case history, coupled with her immediate attachment, led me to believe that Rose was a borderline personality. A few months passed and Rose continued to become more attached to our sessions. She identified with me in a profound way. During this time I asked her to do some drawings. She complied, though reluctantly. Her drawings gave a crucial indication as to the direction of treatment.

In Figure 3, her drawings are childlike, exhibiting a floating, empty, simple quality of expression. The emptiness has a more organic quality than is usually associated with the borderline personality. (The organic factor was later ruled out by psychological tests.) I tended to be confrontative, addressing any acting out and encouraging a search for the self, assuming that this self, when emerging early in life, had been treated harshly, negatively, and/or with ambivalence by the mother. I was working with Rose assuming that she was a borderline patient; however, Rose's responses to my interventions were uncharacteristic of the borderline patient. My confrontation of her acting out was not met with rage, but with appreciation, a deepening of trust, insight, and change.

Figure 3.

I recommended vocational training for Rose, as well as a group that met at the clinic once weekly. In addition, I scheduled a brief second weekly session with me. She responded positively and came to the next session wearing glasses (that I had never seen her wear) claiming: "I'm going to be going to school soon, and I need to see!" She received much encouragement and support for this. Unfortunately, I went away for 2 weeks shortly thereafter. I hoped Rose would attend the group to keep some continuity with the clinic, but when I returned, I found that Rose had not attended the group. She missed our first session as well. When she called to say she was ill and couldn't come in, I suggested we have our session over the phone. We talked for 45 minutes. Apparently, Rose hadn't left her apartment since I had gone away and she was extremely depressed. She cried that when I went away she realized that she had nobody. She threatened not to keep her appointment with the Office of Vocational Rehabilitation that week because of her depression. I gave her a "pep" talk about getting out and being with people. I asked her to picture myself on her shoulder saying, "Go for it!" She laughed at this and promised to go.

Up until now, my countertransference reactions to Rose varied from anger at her ability to love the husband who abuses her, to compassion for her, to admiration for her strength and fearlessness in seeking treatment, having come from a street culture that views therapy in a negative light. Now, my countertransference response was overwhelming to me. I detested being needed in this way, knowing that without me she couldn't function. I understood my response and where it came from in my life, but felt paralyzed in my role as therapist for Rose. I presented this case to my weekly supervision group to gain some insight and clarity. My supervisor diagnosed Rose as an inadequate personality, which required different treatment than that recommended for a borderline personality.

I had been approaching Rose from an ego psychology viewpoint, becoming quite involved in her life, structuring her time, etc., yet I had believed this to be erroneous, nonpsychoanalytic, a crossing of boundaries that ought not be crossed. Through presenting this case, I could see that my approach with her was actually on target. I also came to see that I needed to set Rose up with more structure, perhaps in a day hospital. The feelings of dread subsided as I began to feel hopeful about Rose's treatment once again.

When Rose came in for our next meeting, she arrived uncharacteristically early. I heard her speaking in a loud rapid voice in Spanish to the receptionist and to another caseworker. (She knows that I don't speak Spanish.) The therapist told me that she was "badmouthing" me, claiming that I expect so much from her (groups, vocational training, etc.), and that she felt like killing herself. When Rose came into my office, she wept and talked about how glad she was to see me and how much she missed me. I asked about her anger. At first she denied being angry. I told her that the other therapist had told me what she said. Coupled with her missing her first session back with me last week, I said, her behaviour amounted to this: I held up my middle finger. She laughed and poured out her anger at me for leaving her. Her "heavy" affect became brighter and more energetic. We talked about what was now going on with her and what our immediate goals were. As treatment progressed, within an ego psychology framework, Rose felt increasingly grounded and effective in handling reality demands.

Case 4

Betty, a 43-year-old woman, was admitted to the inpatient unit of a private psychiatric hospital after a very serious suicide attempt. She had sent her husband and two teenage sons off to the movies and taken an overdose behind her locked bedroom door. During the movie, the older son "had a funny feeling," left the theatre, rushed home, and found his mother nearly dead. She recovered in a medical hospital for about a week. Reportedly, upon regaining consciousness, she spotted a plastic knife on a food tray near the bed, grabbed it, and tried to stab herself. When she was admitted to the inpatient unit, she spent a few days in her room with constant, 24-hour "suicide" watch. Her first group as a patient in the unit was in my "Visual Journal" group, in which the whole unit (15 patients) participates.

Her first drawing in the Visual Journal group was of a tree with a black hole with blood dripping out of the hole. She shared with the group her ambivalence as expressed in the tree: Is it shedding leaves for fall (to bloom again in spring), or is it dying? She admitted to feeling suicidal, although not as violently as before.

When she presented that first drawing to me, she was well aware of the effect of the black hole with the blood running out of it (Figure 4). She sought my attention outside of the group and asked for individual sessions. I declined her request because I did not conduct individual sessions at the clinic. However, I would have refused in any case, so as not to feed her need for special treatment; also, she was currently seeing a primary therapist. Betty agreed to continue with the group treatment that I felt was appropriate for her.

In the first art therapy group that she attended, I spoke about the tree she had drawn and asked her if she could crawl into the hole and experience the blackness there. She was quite willing to do this. She closed her eyes as I sat with her and talked her through the experience. I then asked her to draw what came clear as her eyes adjusted to the darkness. The second drawing is her image of the rage in the darkness (Figure 5). She then told her

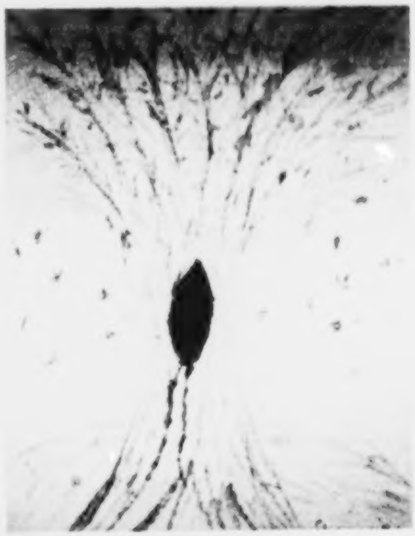


Figure 4.

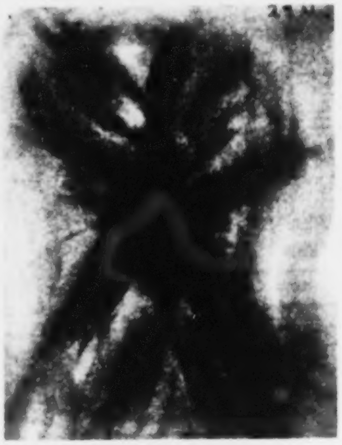


Figure 5.

story: She had been having an affair with another counselor at her work place, and he had left her. She believed that without him there truly was no air for her to breathe in this world, so she attempted suicide. After this session, she began bringing me poetry from her journal which exhaustively described her symbiotic attachment to this man and her rage and despair at the abandonment. Her next drawing was a further exploration of the black hole, which takes more form than the first, and again describes ambivalence: the death-mask and the rage (Figure 6). This drawing also brings to light her delight in shocking the group. I think she believed she was shocking me as well.

The next drawing was another expression of her rage, also disguised as a question mark (Figure 7). Her work was quite contained even as a statement of rage; Betty was a model of control and perfection in her personal habits, appearance, poetry, and artwork.

She brought me a clay piece she had done on her own and of which she was very proud. A woman in the fetal position is unsure if she is going to stay curled up and die, or unwind and give birth to herself. Betty's choice of pink (flesh) for the glaze was, she reported, a clue that this figure would give birth. This "psychologizing" of her own work was, I believe, part of her continuing campaign to impress me.

The next drawing (Figure 8) is one which she had done in her journal, again on her own, and exemplifies her drawing style when in control. Again, the theme of life or death is apparent. Also, there is seductiveness here—the beautiful flowers detract from the horror of their being uprooted. Are they going to be repotted and live, or starved and left for dead? Betty wouldnt' say.

The next drawing was done during group time when the assignment was to "take a picture from inside you and put it outside of you to look at." As she finished drawing this, she gasped and jumped out of her seat. She hadn't intended the red mass of blood that dripped from the wound to be a figure and had just noticed its shape (Figure 9). This truly frightened her and prevented her from talking about the picture in any detail. She did say that it accurately described how she felt. She responded with anger when I made a comment about "the good breast and the bad." This was followed by the next drawing of a black door with blood running out from underneath it. She sobbed as she talked about her relationship with her father and how there was always a wall between them. The only way he would validate or notice her would be if she cut herself and let the blood run out under the door. She was enraged at him and, in response, I gave her clay, suggesting that she "wedge the hell out of it" as she shouted resentments at him. For all her drama, I felt that this was one of our genuine times, when she truly felt and her feelings were truly processed. The next drawing was produced the following morning in Visual Journal group: a peaceful, calm drawing. The last drawing came a few weeks later and represents her moods and feelings as she prepared for discharge (Figure 10). Her last artwork was a drawing of herself looking out into the future.

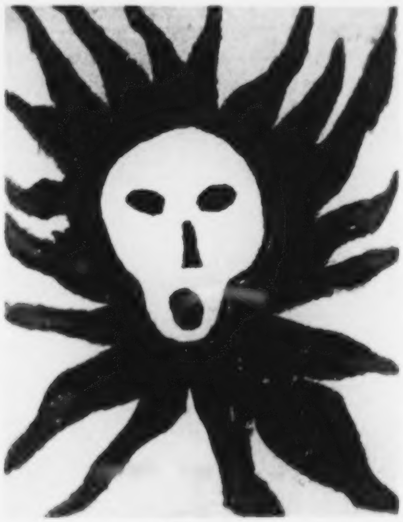


Figure 6.

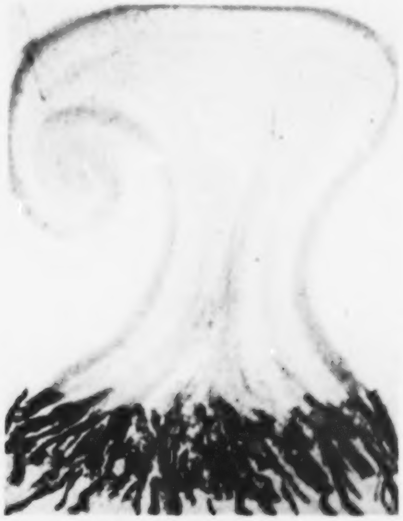


Figure 7.

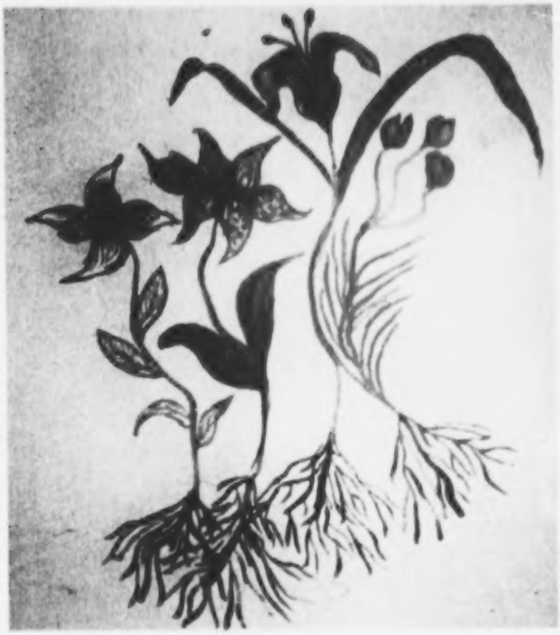


Figure 8.

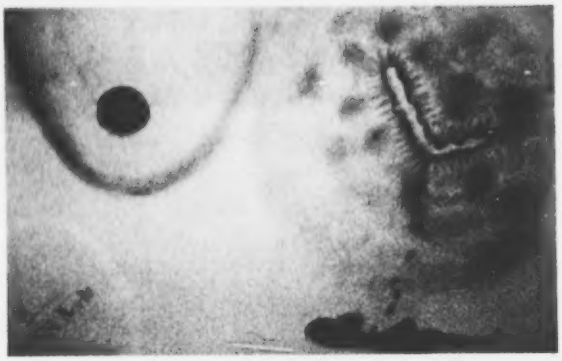


Figure 9.

Figure 10.

In this series of artworks, the outside object seems to be choking off the inside self of the patient. In her life Betty acts this out with her former lover. She cannot leave this object and is constantly hounded by its presence, yet she dances around this conflict, not really getting into the pain of loss for she cannot face feelings of abandonment. On brief occasions, however, she does move into a very authentic place and starts to deal with her problems. Betty uses art to impress others and to present a false self. This manipulative controlling behavior is commonly part of the borderline. There is obviously a good deal of splitting in her searching for the good object while at the same time subtly acting out the introject, and ultimately repeating her abandonment anxiety.

My countertransference toward Betty ran the gamut. I liked her; her artwork was quite seductive, an art therapist's dream and she knew this. The times that real growth took place, I believe, occurred when I consistently confronted her grandiose/false self for a few sessions. She would then be enraged at me and withholding. I would validate her angry stance and provide materials for the expression of this. She was then able to use the materials for authentic expression. Clay and pastels proved to be the best media for her. (They both defied control to the extent that would challenge her without over-frustrating.) At these times she allowed her clothing to become soiled with the materials; she "played" with them. She let herself cry, thus letting her makeup run off, which was uncharacteristic of her style.

Unfortunately, time wasn't available to work through a synthesis of the bad/good breast within Betty. I felt that my role with her was to stand back, and yet be firm in setting boundaries; to be the voice of truth confronting a false self; to provide the means for her to ground herself and through this, to discover herself. I believed she had a rich, creative, intelligent, very funny, wonderful self somewhere deep inside. I let her know this in many ways—most importantly in the way I confronted her phoniness.

Summary

Patients can and do resist therapeutic process. Treatment is concerned with the problems of patients being out-of-process and the variety of interventions necessary to help patients regain therapeutic process. Indeed, when patients are in charge of their process and have acquired the ability to regain their process upon losing it, they are very close to the terminal phase of treatment.

As with any creative endeavor, problems are often intensified when therapists have only one way of seeing patients' communications. In all the above cases, it is the structure of the art form that gives diagnostic clues as to the treatment intervention. Yet art diagnosis must always be viewed within the context of the transference/countertransference relationship. In the first case, the mirroring became very complex and symbolic. Here, mirroring involved the play of hidden shadows and nuances within the patient's personality that the therapist represents and which become reflections for the patient to feel, touch, and reintegrate. Attachment issues, as well as mirroring, are illustrated in the therapeutic dialogue.

In the second case under discussion, Mary's three brief lines were not truly a representation of her inner world, but an acting out of her contempt for her parents. The resistance that was manifested in the art form did not prevent the patient from processing her therapeutic material. On a very profound level, albeit in a very simple and direct form, she informed the therapist that they were not worth that much involvement. However, the direct expression of her rage became the pivotal point in the shift toward a new level of painful therapeutic engagement—that of depression and loss.

In the case of the third patient, it can be observed how knowledge of a therapeutic model of treatment helps the therapist understand what is needed in treatment. On the surface the patient acted like a borderline, yet her artwork offered a true representation of her condition. Structure and reinforcement worked with this patient. Trying to be a holding agent and reflect the self simply would not be enough to contain this patient in treatment. In short, survival and functioning were far more important at this stage in treatment than going through the various stages of mirroring.

In the fourth case, the variations in ego states that are so prevalent in the borderline condition are reflected in the artwork. In Figure 10, the sublime fused quality of her representation is apparent as she retreated from any real struggle of self object differentiation. Figures 4 and 5 represented the inner black self trapped in the surrounding object, while Figure 9 demonstrated the split of good object and bad object. In the latter, the patient's passive self was connected with a very frightening introject. The artwork seems to have contained this very difficult representation of a bad object, and perhaps gave the patient some room for a reorganization before she left the hospital. On other occasions, her artwork seemed too pretty and false. Thus, the slippery and fast-moving ego states often move in and out of the patient's artwork; yet her language was rarely connected to the symbol except in Figure 9.

Questions may be raised concerning the subjective appraisal of the patients' art representations. The authors believe that there is no such thing as one truth in art or in therapy. The mutually interacting personalities of patient and therapist will determine many subjective/objective realities. The therapist's evaluation of the resistance will set the course of the therapy. Interventions arise out of a given diagnostic appraisal and are shaped by a therapeutic model.

Verbal dialogue can be elusive, and the same can be said for representations in artwork. Both types of expression offer an important means of understanding the composition and organization of the patient's personality. From this understanding, a way of working with patients can be derived that may be of help to therapists who are lost in the quagmire of therapeutic resistance. Obviously, therapists will be drawn to one therapeutic model or another, but in stormy times, when the resistance is high, a multimodel approach will offer an additional compass to navigate through muddy therapeutic waters. Each therapeutic model offers a mode of intervention for coping with resistance. Each can become an indispensable tool for organizing therapist/patient communications.

References

Fenichel, O. (1934). *Outline of clinical psychoanalysis.* New York: Norton.

Hartmann, H. (1939). *Ego psychology and the problem of adaptation.* New York: International University Press.

Kernberg, O. (1976). *Object relations theory and clinical psychoanalysis.* New York: Aronson.

Kohut, H. (1977). *The restoration of the self.* New York: International University Press.

Lazarus, A. (1976). *Multimodel behavior therapy.* New York: Springer.

Moustakas, C. E. (Ed.) (1974). *The self: Explorations in personal growth.* New York: Harper & Row.

Pine, F. (1990). *Drive, ego, object, and self.* New York: Basic Books.

Art Therapy: Journal of the American Art Therapy Association, 10(4) pp. 219-225 © AATA, Inc. 1993

Countertransference: A Theoretical Review and Case Study with a Talented Client

Gussie Klorer, MA, A.T.R., Edwardsville, IL

Abstract

It is our dual identity of artist and therapist that can be particularly problematic for the art therapist. Transference and countertransference issues are complicated by these roles. In this theoretical review and case study, my role as artist, and my narcissism at seeing a talented young client blossoming under my direction, complicated the therapeutic process greatly. Fourteen-year-old Carlos was the "dream client." He was motivated, prolific, talented, enthusiastic, and was dramatically improving behaviorally as a result of art therapy. This article points out serious complications which are attributed to problems of transference and countertransference.

Introduction

When supervising novices or students of art therapy, it is important to create an environment where they feel free to share, not only their triumphs and glories, but their failures and mistakes as well. It is from our mistakes that the most profound learning takes place. In looking back over an art therapy practice of 13 years, many of my own mistakes come to mind. I recall a case very early in my career which was important enough to influence the direction of my research during the last few years. I hope, through this paper, to stimulate discussion and thought about two very complicated issues, transference and countertransference in art therapy.

The lack of art therapy supervision is an important issue in this case study which, 10 years ago in the Midwest, was a common occurrence. Additionally, there were problems unique to the child residential treatment setting which complicated the transference and countertransference issues. Nell (1988) discussed this phenomenon as it is experienced in a residential treatment center. In traditional therapy, the client becomes completely known to the therapist, but the therapist can remain anonymous to the client, which contributes to the transference. In residential treatment, where the therapist and client share working/living space for 40 hours per week and more, the countertransference of therapist to client can be stronger than the transference of client to therapist.

Nell noted three factors that intensify and nourish the countertransference, all of which were identifiable as factors in this particular case. First, the treatment staff were at times socially involved with residents, eating meals together, sometimes planning and attending parties for them, and occasionally serving as crisis intervention staff when acting out behaviors interfered with daily interactions. Second, the amount of time and the interest shown to residents truly represented the therapists' personal investment and created hopes and expectations for the residents' success. Third, in a situation such as this, the therapist and supporting staff are not just a parental symbol—they are functioning in the role of parent, despite the fact that there may still be involvement with the actual parent.

Literature Review

Art therapists have studied, discussed, and debated transference and countertransference issues for many years (Allen, 1988; Agell, Levick, Rhyne, Robbins, Rubin, Ulman, Wang, and Wilson, 1981; Wolf, 1985; Robbins, 1987, 1988). Although there is a continuum of opinion ranging from a strictly traditional psychoanalytic approach to advocates of techniques that allow for the unique aspects of art making, all agree that transference and countertransference are relevant to art therapy. Rubin (1984) has stated that although remaining as anonymous as possible is useful for the therapeutic process, an art therapist cannot maintain an analyst's total neutrality. Through interaction with the client and art materials, the art therapist may be perceived as the nurturer, the teacher, the seducer, the good or bad parent, the policeman, the helpful guardian. She further sees differences in countertransference: "As with transference, there are factors peculiar to the art therapy situation. Since the art therapist is also an artist, she [or he] must be careful not to let her [or his] enthusiasm for the quantity or quality of a person's art products influence her [or him] unduly" (Rubin, 1984, p. 57).

Agell (Agell et al., 1981) reminds us that the art material bears the brunt of the transference, allowing the art therapist the freedom to explore the art with the client from a more detached and cooperative position. More recently, Allen (1988) questions the usefulness of transference in the art therapy arena, where providing a situation of psychological safety and creative stimulation is different from that of psychoanalysis. She urges therapists to decline the power that a therapist has in a transferential relationship, and direct the client to use the art as a container, thus promoting the art process.

Countertransference issues also will pose unique problems for the art therapist. Wilson, defending the classical psychoanalytic position of countertransference, declares it to be a potential impediment to therapy and makes a strong argument against art therapists adopting the current popular therapeutic techniques of using countertransferential feelings as a source of information and as a means of active intervention with the client (Agell et al., 1981).

However, both Robbins (1987) and Wolf (1985) do just that in their work with clients. Wolf, influenced by Kernberg, Masterson, Racker, Robbins, Roland, Searles, and Winnicott, believes that "less emphasis should be placed upon viewing this phenomenon as the analyst's deficiency, but should be seen instead as a new and unique tool with which we can better understand the patient's transference projections and early object, or self-object experiences" (p. 129). He suggests that rather than repressing countertransference feelings and "inductions," the therapist use them to better understand what is happening with the client.

Robbins sees countertransference as unavoidable and suggests that both the therapist and the client are in treatment within the art therapy relationship. Robbins states, "It is hoped that the therapist will be more in charge of the process than the clients, but the therapist should not fool himself [or herself] with false notions of professionalism or objectivity" (1987, p. 150). Robbins advocates an active use of countertransference and recognizes that art and creativity can be used to mask countertransference reactions and keep the therapist at a distance.

It should be noted, as recognized by Wilson (Agell et al., 1981), that therapists such as Robbins and Wolf advocate techniques which are solidly based in their extensive and additional training as psychoanalysts. This is not the case with many art therapists. It is hoped that art therapy training programs impart to their students an understanding of the limitations of their training so they do not borrow techniques unwisely. Yet, because of the relative newness of our field, we often need to go to psychoanalytic sources when we struggle with theoretical issues in our work with clients. The difficulty arises when we attempt to adapt ideas and techniques when we do not have the training from whence these ideas emerged.

Within the psychoanalytic field, there is a continuum of opinion on countertransference which ranges from Freud, who saw it as an indicator that the analyst needs further therapy, to those who accept countertransference as inevitable, to those who actively encourage using countertransference feelings in therapy (Hedges, 1987; Little, 1981; Scharff, 1992). If one were to take the most conservative position, that is, to recognize its existence as inevitable, but not to actively respond to it, one might be missing an important communication from the patient.

Scharff (1992) describes the process of projective identification as being a communication from the projector (client), who expels part of the self onto an object (therapist). Duncan (1981) suggests that the therapist will commonly experience a thought, sensation, or feeling in response to the client's material that is a reflection of the projective and introjective processes. At the moment of object induction, that is, when the therapist experiences the same feeling state as that of the projector, countertransference feelings which can be useful to the therapy are experienced by the therapist. It is important that the analyst not be damaged, hurt, or changed by the projection, but rather be able to contain it for the client, so that it can become neutralized. Both Robbins and Wolf recommend the use of artwork for this containment (Robbins, 1987; Wolf, 1985).

A further complication when looking at the issue of transference and countertransference is the nature of the population. Very little is written about the application of these issues to the child population (Berlin, 1987). Marshall (1979) found only 10 references to countertransference in 25 years of *The Psychoanalytic Study of the Child*. Notable in this area are writings from Klein and Anna Freud, who both recognize difficulties with the child population because the transference reactions are altered with the existence of actual parents in the child's present life. Klein felt transference was observable through play, verbalizations, and behaviors. She saw transference as the result of experiences with the early mother image, not necessarily the current real mother. Anna Freud saw the presence of parents in the child's life as allowing for transference reactions, but not a real transference neurosis (Freud, 1946).

Bollas: "The Unthought Known"

It is useful, when searching for a theoretical framework, to find someone whose work and ideas parallel one's thinking, despite the difference in training and technique. Bollas (1987), who works with autistic children from an object relations perspective, has thoughts which are important for art therapists. He recognizes the difficulties clients have in expressing thoughts and longings into words when they may have no cognitive memory of the infant's longing. The search for the transformational object enacts a preverbal memory. His term *the unthought known* refers to reliving early memories of being and relating through language of that which is known, but not yet thought. Further, he sees the unthought known as being stimulated by the aesthetic moment, such as through a painting, a poem, or music.

Bollas believes that the aesthetic moment constitutes part of the unthought known. "The aesthetic experience is an existential recollection of the time when communicating took place primarily through this illusion of deep rapport of subject and object. Being with, as a form of dialogue, enabled the baby's adequate processing of his [or her] existence prior to his [or her] ability to process it through thought" (Bollas, 1987, p. 22). Within the clinical situation, because the client cannot express his or her conflict in words, the full articulation of preverbal transference evolves in the therapist's countertransference.

The transference/countertransference interaction is an expression of the unthought known, according to Bollas, and the therapist will assist in bringing the unthought known into thought through the experience of transference and countertransference. Bollas addresses the difficulty of making material available to a client when the therapist does not as yet know the unconscious meaning. Bollas states: "Were the analyst to wait until that time when he [or she] knew what the patient was communicating . . . through the transference, it might well be months before he [or she] could speak. . . . The analyst must be prepared to be subjective in selected ways in the presence of the patient in order for the patient to use his [or her] own nascent subjective states. How does one do this? To some very considerable extent it is a question of the analyst's relation to his own feelings and thoughts" (Bollas, p. 205). Bollas defends Little's position that the analyst should be asking herself/himself how she/he is feeling and why now. Analysts in the British School see a continuous interplay between the client's transference, analyst's countertransference, and projective identification.

For art therapists, the ability to stimulate the aesthetic moment Bollas speaks of through the client's use of art materials is a provocative one, although this presupposes that the therapist will understand the unconscious meaning projected in the pictures. We can only dream that interpreting pictures is so accessible to us. This is where art therapists can, as suggested by Robbins (1987), Wolf (1985), Allen (1988), and others, use the art process themselves to understand their countertransference reactions. This also underscores the need for good supervision, specifically art therapy supervision, as opposed to supervision by a supervisor who has little experience with the power of the visual image.

Case Study

Carlos was an attractive biracial 14-year-old who was a difficult child to engage in therapy. Our first sessions were noted by an initial flirtation, followed by distrust, disrespect, and belittling comments directed toward me. It was not surprising that his drawings also reflected a rage toward women. Because of his guarded behavior and propensity for aggressive outbursts, I approached Carlos tentatively and began working with him on art techniques, offering art instruction as a nonthreatening means of getting close to him. This approach, although not typical of my normal working style, worked quite well with Carlos since he fancied himself an artist and sought out the teachings of someone whose talents he appreciated, even if she was a female. Using this approach I was able to establish a relationship with Carlos which grew to be much more positive than he had with most women staff and ultimately allowed us to deal with issues surrounding his fear of closeness and abandonment. However, because of this approach, the transference and countertransference issues became particularly complicated. During the course of a therapy that lasted approximately two years, one drawing dramatically and embarrassingly revealed the countertransference to me, which necessitated a change in the direction of the therapeutic process.

Carlos had a history of abuse and neglect, not unlike many of the children at this placement. He was a twin, and his twin was the more disturbed of the two boys, exhibiting paranoid and confused thinking at an early age. Carlos exhibited more stable and controlled behavior, although he, too, had an angry and at times violent streak.

The boys were placed into foster care at age four by the child protective agency due to abuse and neglect by the mother. The father regained custody 4 years later, despite his own history of intoxication, burglary, paranoia, and child abuse. Three years later, the boys were again taken into custody because of alleged sexual abuse by the father. After a year of residential treatment for both boys, Carlos' behavior stabilized, and he was placed back with his mother. Mother then kidnapped his twin from placement and hid him in the attic for 2 months, until Carlos finally told the police. Mother's rage and rejection toward Carlos were so great that it became impossible for him to live there any longer. Both boys were placed back in residential treatment at that time, aged 13. As is typical for children who have received mixed messages from a parental figure, the boys continually longed to be with mother and never accepted the rejection. They made her cards and pictures and waited anxiously each holiday for her to come to pick them up, only to re-experience again the anguish of rejection when she would fail to show up.

Carlos was initially suspicious of me. He tested the minimal behavioral parameters I set forth in the art room. He had leadership potential, and the success or failure of a group frequently revolved around his attitude. Carlos knew how to dissolve whatever group process I had going by sudden outbursts of malicious, explicitly sexual comments directed toward me. This would, of course, send the other boys in the room into peels of laughter, and it would be all I could do to maintain control of the group. After disrupting a group art session, Carlos would linger at the art room door, not wanting to leave. He seemed intrigued by the possibilities the art room might hold for him. His disruptiveness and need for attention were such that early on I decided to see him individually for art therapy. I also saw him in a verbal therapy group of nine boys which I co-led with a female social worker.

Carlos appeared to have some talent in art. He most often drew female figures, and I felt some of his pictures related to adolescent identity issues. He seemed to be struggling with sexuality and his racial identity (Figures 1 & 2). As he continued to show a preoccupation with his portraits of women, I felt he was working through feelings for his own mother on a deep and unconscious level (Figure 3). Distortions

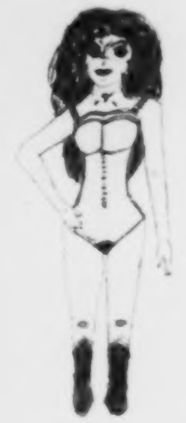


Figure 1.

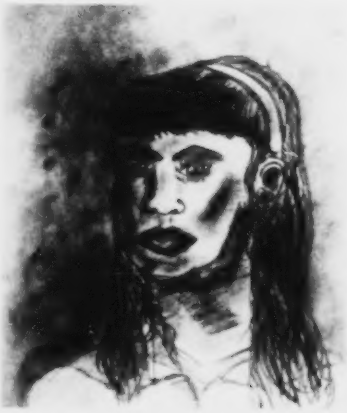


Figure 2.

in color, proportion, and form made his portraits appear angry and grotesque (Figure 4).

Simultaneously, Carlos would make sculptures for his mother; his excitement over his gifts was touching. He always made sure that he carved his name into the clay figure prior to firing so that his mother would believe he made it. Somehow, he never acknowledged the fact that his mother never came to receive the gifts. A sculpture of a mermaid he made for her was given to me. I was willing to take on the role of the good, nurturing mother at this time. Our relationship was becoming one that Carlos could trust: the provider, teacher, nurturer. Carlos was also beginning to accept the role of artist. I loaned him books on drawing, gave him professional art materials with which to work, and we talked the language of art. He was beginning to receive campuswide recognition for his art.

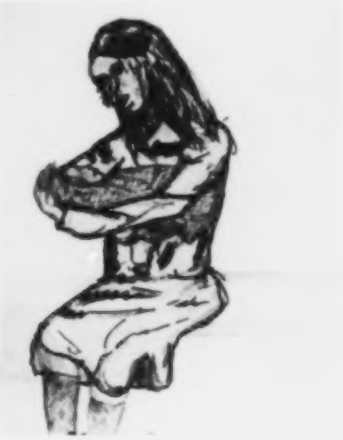


Figure 3.

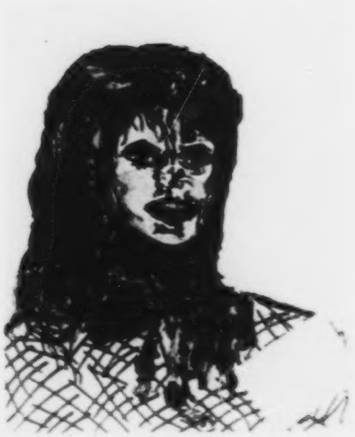


Figure 4.

Despite the good relationship we had in the art room, Carlos presented another side in his verbal group. Here, he was nasty and malicious toward the cotherapists, to the impediment of any group process. After one particularly horrendous group, where he was belligerent and disruptive during the entire session, he then waltzed into his individual art therapy session 20 minutes late, and I had had enough. I confronted him and told him how I personally was affected by his behavior since I spent so much positive time with him in art. He could not handle the confrontation and instead began talking about a painting he was doing, a sad, depressed, dark picture of a person on a horse. He talked about the aesthetics and technicalities to avoid the real issue. Again, I brought up his behavior and he said angrily, "I know what you want me to think. You want me to think that this painting is about my feelings or something dumb like that." Gradually, he came to accept the idea. Then, when confronted again about his group behavior he said, "Well that's the trouble with getting close to people. You see me down here in art and then you expect that everywhere I have to act like that." This was the first time that he acknowledged his fear of closeness and his closeness to me. Subsequent sessions continued along these themes.

In art, Carlos spent hours studying proportion and movement. He wanted to understand the structure of the human figure and would ask peers or me to hold an arm or leg a particular way when he was struggling with drawing a particular pose. It was interesting that he always started with the feet and drew his way up the figure, sometimes omitting the head. According to Machover (1949) this may suggest a difficulty in interpersonal relationships and a reluctance to undertake emotional commitments, which certainly seemed true of Carlos.

The staff saw art as the arena where Carlos could experience success and used it as a reward for appropriate behavior. He was allowed extra time in the art room for "independent study" as a reward when he was doing well in other areas of the program. This, in addition to Open Art Studio and his individual art therapy session, potentially gave him quite a bit of time in the art room, and behavioral changes were quick to follow.

Carlos' improved behavior sparked the narcissistic gratifications and assurances I needed at that time. I was eager to prove, through Carlos, the effectiveness of art therapy to a sometimes skeptical staff. Since his artistic gains resulted in noticeable behavioral improvements, there developed a specific form of countertransference which Reich (1973) terms the "Midas touch," wherein the therapist's gratification for the therapeutic success becomes intertwined with the client's needs. My role as artist, and my narcissism at seeing a talented young client blossoming under my direction, complicated the neutrality which I needed to strive for in a therapeutic sense. I was particularly invested in this child's therapy and was missing the obvious.

When Carlos drew the following picture I realized what should have been apparent earlier. Carlos had come to his individual art session late again, a testing pattern which had become more frequent. This session was followed by Open Art Studio, at which time several other children came in to work on on-going projects. I was engaged in conversation with two other children, and Carlos began drawing my portrait. I could not see his easel. When he was finished I looked at the drawing, titled, "Gussie When She Is Tired" (Figure 5). The obvious sexualization of the portrait was a shock to me, and I realized that I had inadvertently supported this love-transference. My countertransference feelings, had I been more cognizant of how much I enjoyed his presence in the art room, could and should have been used as a measure for where our therapy was headed. Contained within this single image was such a multitude of emotions and "unthought knowns." I wondered immediately about his relationship with his mother, the mixed messages, and his unfailing devotion to her. I was also frightened of my own feelings and humiliated that I had missed something so blatant. Looking back through his drawings, I discovered that he had added my head to some of his unfinished nudes.

I made a decision then to diffuse the transference by separating the art instruction from our therapy sessions. I felt the intensity of working with the female figure had become too personal. I was able to arrange for Carlos to join a figure drawing class at Washington University for talented high school students. In this way, he was able to draw female and male live models without the stimulation of my presence (Figure 6). I also introduced him to the idea of using magazine pictures as models.

In our sessions, we talked about boundaries and I attempted to define our relationship for him more clearly. We were also able to explore other issues in art therapy, most notably, a series of losses. His brother was discharged to a more intensive treatment center due to increased pathological behaviors, and his social worker of two years was moving out of state. With each of these losses, there was a deterioration and regression in his behavior, and then an obvious retreat into art to process the feelings.

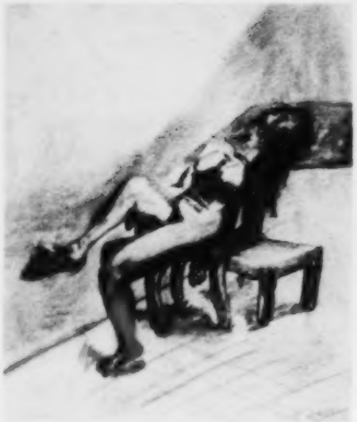


Figure 5.

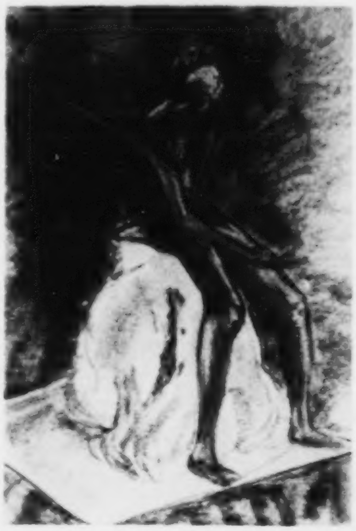


Figure 6.

Carlos gained immeasurably from the art instruction, and his pictures became less overtly sexualized and more balanced as he and I worked through our issues. I introduced him to acrylic paint and encouraged him to put his figures into an environment. This led to an interest in landscape painting. Something that we were never able to work through was that "unthought known," that undefinable longing for a mother who in actuality could not be there for him in any healthy way.

Throughout his two years in treatment, Carlos requested to go back home numerous times. He believed that if he could be reunited with his mother, they could live happily ever after. Finally, at age 16, he and his brother ran away to live with their mother. She moved them to another state, where she abandoned them again.

Conclusion

It should be emphasized that, when the client cannot express the conflict in words, the transference/countertransference interaction can be an expression of the "unthought known." Bollas feels that the infant element in the client speaks to the therapist through object usage that is revealed through the therapist's countertransference, and the therapist should, in fact, allow the client to affect him or her. He states, "This inevitably means that the analyst must become disturbed by the patient. . . . Each analyst, working with, rather than against, the countertransference must be prepared on occasion to become situationally ill" (Bollas, 1987, p. 204).

Only in retrospect do I see that my feelings of humiliation and embarrassment were based upon an induction which may have specifically related to a projective identification with Carlos' own experience of humiliation when his mother rejected him. He was able to get me to understand his humiliation on an affective level, and it made me feel ill.

According to Little (1981), the greatest danger and difficulty in countertransference is a paranoid or phobic attitude toward the therapist's own feelings. "The very real fear of being flooded with feeling of any kind, rage, anxiety, love, etc., in relation to one's patient and of being passive to it and at its mercy leads to an unconscious avoidance or denial" (p. 45). I hid the drawing this client made from myself so that I would not have to confront the issues. I wish now that I had stayed with my discomfort, felt it more deeply, and perhaps drawn something in response to it.

The other point to be underscored is the importance of continued self-exploration, processing, supervision, and study. I was driven to learn more about these issues because I suddenly found myself at such a loss and knew that I had made a mistake. Little (1981) notes that all therapists make mistakes, but because they are painful to us, we tend to avoid talking about them. I hope, through example, to encourage a process of sharing mistakes or failures so that a deeper understanding of therapeutic issues can take place and so that clients can reap the benefits of our lifelong struggles to provide what they might need when we do not know what that might be.

Gussie Klorer, MA, A.T.R., is the Director of Graduate Art Therapy at Southern Illinois University at Edwardsville, School of Fine Arts and Communication, Department of Art and Design, Edwardsville, IL 62026-1764.

References

Agell, G., Levick, M., Rhyne, J., Robbins, A., Rubin, J., Ulman, E., Wang, C., & Wilson, L. (1981). Transference and countertransference in art therapy. *American Journal of Art Therapy, 21*, 3–23.

Allen, P. B. (1988). A consideration of transference in art therapy. *American Journal of Art Therapy, 26*, 113–118.

Berlin, I. (1987). Some transference and countertransference issues in the playroom. *Journal of the American Academy of Child and Adolescent Psychiatry, 26*, 101–107.

Bollas, C. (1987). *Shadow of the object: Psychoanalysis of the unthought known*. New York: Columbia University Press.

Duncan, D. (1981). A thought on the nature of psychoanalytic theory. *International Journal of Psycho-Analysis, 62*, 339–349.

Freud, A. (1946). The role of transference in the analysis of children. In *The psychoanalytical treatment of children*. London: Imago Publishing Co.

Hedges, L. (1987). *Interpreting the countertransference*. New Jersey: Jason Aronson, Inc.

Kernberg, O. (1988). Object relations theory in clinical practice. *Psychoanalytic Quarterly, 57*(4), 481–504.

Little, M. (1981). *Transference neurosis and transference psychosis*. New York: Jason Aronson.

Machover, K. (1981). *Personality projection in the drawing of the human figure*. Springfield, IL: Charles C Thomas.

Marshall, R. J. (1979). Countertransference in the psychology of children and adolescents. In L. Epstein & A. J. Feiner (Eds.), *Countertransference: The therapist's contribution to treatment*, (pp. 595–628). New York: Jason Aronson.

Nell, R. (1988). Transference and countertransference in a therapeutic community. *Dynamic Psychotherapy, 6*(1), 61–66.

Reich, A. (1973). *Psychoanalytic contributions*. New York: International Universities Press.

Robbins, A. (1987). *The artist as therapist*. New York: Human Sciences Press.

Robbins, A. (1988). *Between therapists: The processing of transference/countertransference material*. New York: Human Sciences Press.

Rubin, J. (1984). *The art of art therapy*. New York: Brunner/Mazel.

Scharff, J. S. (1992). *Projective and introjective identification and the use of the therapist's self*. New Jersey: Jason Aronson.

Wolf, R. (1985). Image induction in the countertransference: A revision of the totalistic view. *Art Therapy: Journal of the American Art Therapy Association, 2*(3), 129–133.

Art Therapy: Journal of the American Art Therapy Association, 10(4) pp. 226-234 © AATA, Inc. 1993

Brief Reports

Survey of Doctoral Work by Art Therapists

Vija B. Lusebrink, PhD, A.T.R., Louisville, KY; **Marcia L. Rosal, PhD, A.T.R.**, Louisville, KY; **Michael Campanelli, EdD, A.T.R.**, Perth, Western Australia

Abstract

A survey of art therapists with doctoral degrees was conducted to obtain information on the types of doctorates received by art therapists and the research topics and methodologies of the dissertations. The 78 responses received showed that there has been a rapid increase in the number of art therapists with doctoral degrees in the last several years. The dissertation topics were diverse; the predominant topics were studies of art therapy assessment tools, identification of abuse, and the use of art therapy in the treatment of serious illness/grief. Art therapists equally utilized quantitative and qualitative research methods.

A mentor and resource pool, based on the information gathered in this survey, is recommended to assist art therapists conducting research.

Introduction

The field of art therapy is growing and expanding. Every year graduates with master's degrees in art therapy enter the mental health work force. As more art therapists are trained, seasoned registered art therapists continue their education by obtaining doctorates in disciplines related to art therapy. By investigating different aspects of the field through doctoral studies, art therapists enrich and enliven our profession. In addition, the array of dissertation topics add needed knowledge to the research base of art therapy.

This paper presents the results of a survey of art therapists with doctoral degrees and the topics of their dissertations. Vija B. Lusebrink, Chair of the American Art Therapy Association, Inc. (AATA) Research Committee for 1992, conducted the research. Michael Campanelli, who independently compiled information on dissertations with topics in art therapy or related areas, supplemented the survey with his data.

The purpose of the survey was twofold: (a) to obtain information on the types of doctorates received by art therapists, and (b) to survey the research topics and methodologies of dissertations. The research from art therapists' doctoral dissertations is rarely published or may be published in journals outside the field of art therapy. Thus, the valuable information obtained through doctoral research is not easily accessible to other art therapists. The information garnered from the survey will provide a resource for art therapists who are thinking about doctoral studies and the research uncovered may impact the knowledge base of the field.

Method

A total of 143 questionnaires were mailed to art therapists with doctoral degrees. These art therapists were identified through three sources: (a) by the AATA membership survey (Gordon & Manning, 1991), (b) by the 1990 AATA *Membership Directory*, and (c) by responses to an announcement placed in the *Art Therapy Newsletter* soliciting information from art therapists with doctoral degrees.

Respondents were asked to provide the following information: (a) name of institution, discipline studied, degree type, and year of degree; and (b) title and abstract of dissertation. Respondents were also asked to send a brief discussion of how the research may benefit the field of art therapy. If the dissertation was published, respondents were asked to send the appropriate reference.

Seventy-two (50%) questionnaires were returned. In addition, six art therapists who did not respond to the AATA survey were identified by Campanelli, making a total of 78 responses. All but eight of the art therapists surveyed were Registered Art Therapists (A.T.R.s).

Results

The results of the survey are presented in five areas: (a) types of degrees earned, (b) the trend of art therapists earning doctorates, (c) types of institutions granting degrees, (d) dissertation topics, and (e) research methodologies used by art therapists in dissertations.

Types of Degrees Earned

The 78 art therapists who obtained doctorates received four types of degrees: (a) 60 received Doctor of Philosophy (PhD) degrees, (b) two obtained Doctor of Psychology (PsyD) degrees, (c) 15 hold Doctor of Education (EdD) degrees, and (d) one earned a Doctor of Arts (DA) degree. Of the 72 respondents of the AATA survey, the largest number of doctoral degrees by discipline were in psychology including clinical psychology (22), followed by art education (9), educational and counseling psychology (8), and art therapy (8). (See Table 1.) Unfortunately, there were no data about the type of degree earned on the six doctorates from Campanelli's survey.

The Trend of Art Therapists Earning Doctorates

There has been a rapid increase in the number of art therapists who hold doctoral degrees. Only five art therapists received doctoral degrees from 1966 to 1969; similarly, only nine art therapists obtained doctoral degrees from 1970 to 1979. However, there was a rapid increase during 1980 through 1989 when 49 art therapists obtained doctoral degrees. From 1990 through 1992, 17 art therapists received doctoral degrees, indicating an increase in the number of art therapists working on doctoral degrees in the 1990s.

Table 1
Doctoral Degrees by Disciplines

	PhD	EdD	Total
Art Education	3	6	9
Art Therapy	8		8
Behavioral & Human Sciences	2		2
Counseling and Ed. Psych.	4	4	8
Creative Arts	1		1
Education	5	2	7
Fine Arts (DA)	1		1
Health Administration	1		1
Human Development	2		2
Human and Organic Systems	1		1
Interdisciplinary	3		3
Marriage and Family Counseling	1		1
Psych./Clinical Psych. (2 PsyD)	22		22
Psychology/Art	2		2
Psychology/Art Therapy	2		2
Social Sciences	2		2
Total	60	12	72

Institutions Granting Degrees

Sixty-nine of the doctoral degrees received by art therapists were from universities, professional schools, and external degrees accredited by agencies recognized by the Council on Postsecondary Accreditation (COPA) as listed in the *Accredited Institutions of Postsecondary Education* (1991–1992). Five degrees were from professional schools in psychology. Eighteen art therapists (23%) obtained external degrees from The Union Institute, formerly The Union of Experimenting Colleges and Universities; seven of these degrees were obtained before The Union Institute was accredited. Of the 18 degrees completed by art therapists through The Union Institute, eight degrees have *art therapy* as part of the degree title.

Four additional degrees were from external programs: three art therapists hold doctorates from the Fielding Institute and one from Saybrook Institute. (The degree obtained from Saybrook was prior to its accreditation.) Three art therapists completed degrees from nonaccredited institutions of higher learning which are not listed in *Peterson's Guide to Graduate and Professional Programs: An Overview* (1993).

Dissertation Topics

Fifty-four (69%) of the 78 dissertation topics developed by art therapists related to the field of art therapy. The survey of dissertations reveals a wide diversity of topics grouped around particular subject areas derived from terms, topics, or concepts found in the titles of the dissertations. Table 2 is alphabetically arranged by subject area and shows the number of dissertations within each subject. When a topic could not logically fit into a category, a new subject area was created. The selection of categories is arbitrary to some degree; thus, it is important to keep in mind that the choice of subject areas listed here does not preclude the possibility of arranging the references into other feasible categories.

Studies of art therapy assessment tools, art education, and art therapy as a means of treatment for serious illness/grief were the predominant areas investigated. It is interesting to note that six dissertations were about women's/men's studies. Only seven studies researched the efficacy of art therapy (outcome studies).

Table 2
Dissertation Subject Areas

Abuse/physical/sexual	6	Multicultural	3
Addiction	1	Nursing	1
Art/art education	12	Physical disability	4
Art therapy	7	Research	1
Assessment	12	Schizophrenia	2
Career	1	Serious illness/grief/ death	8
Children/adolescents	6	Symbols	2
Creativity	4	Systems theory	1
Depression	1	Transpersonal/ spiritual	3
Eating disorders	3	Trauma	3
Expressive therapies	4	Women's/men's studies	6
Healing/recovery	1		
Imagery in art therapy	3		
Mental Retardation	3		

Research Methodologies Used in Dissertations

The classification of the types of research was divided into two areas: (1) basic or applied research, and (2) the methodology utilized in the dissertation. The categorization of basic or applied research was based on the definitions stated by Cates (1985): Basic research (sometimes called pure research) explores or expands our knowledge of theory, and applied research studies how theory relates to practice. The classification of research methodologies used in the dissertation survey was based on categories discussed by McLaughlin and Carolan (1992) and Rosal (1992). The types of research paradigms encompass six quantitative methods (survey, assessment, outcome, correlational, comparative, and descriptive) and four qualitative methods (naturalistic-ethnographic, phenomenological-hermeneutic, historical, and cybernetic). A category designated as "other" included the development and writing of books and journals and was considered a qualitative study. The classification of the different methodologies used in dissertations was based on the information available in the dissertation abstracts. The classification of methodologies is not to be regarded as absolute, but as indicating general trends of the approaches used. Abstracts were available for 74 dissertations.

Art therapists equally utilized quantitative research methods and qualitative research methods (37 in each classification). Table 3 indicates that a wide variety of research methodologies were used. By far, the most popular method used in dissertations by art therapists was the phenomenological-hermeneutic methodology (21 dissertations).

Discussion

The survey of doctoral work by art therapists highlights several exciting trends and may offer the field some guidelines for future thinking about research in art therapy. First, the survey found that the number of art therapists who earned doctoral degrees increased dramatically in the 1980s. It appears that this trend will continue at a more rapid rate in the 1990s. Additionally, despite the fact that there are no doctoral programs in art therapy, art therapists are obtaining degrees in fields related to art therapy such as psychology, art education, and counseling psychology.

The art therapy profession has long struggled with when and how to teach research to art therapists. Teaching research on the master's level versus the doctoral level has been debated. Now, teaching research as a part of master's level art therapy education is mandated by the AATA, Inc. (*1993 Guidelines for Training*). To help understand what programs teach on the master's level, Linesch (1992) surveyed art therapy programs concerning the format and philosophy of approaches to research education. She found the main goals for master's research projects were to gain mastery in an area of concentration and

Table 3
Dissertations by Art Therapists

		Related to	Basic or Applied Res.		Granting Institutions		Methodology/Type of Study**											Degree
							Quantitative						Qualitative					
Name	ATR	Art Therapy	Basic	Appli	Univ/ Colle	Insti/ Other	Survey	Assess ment	Out come	Corre lation	Compar ative	Descrip tive	Natur alistic	Phen. Herm.	Histor ical	Cyber netic	Other	Year
Allen, P. B.	X	X	X			X								X				1986
Allinder, R. M.	X		X		X						X							1987
Appleton, V. B.	X	X	X		X							X						1989
Arrington, D.	X	X	X		X		X											1986
Bjork, M.	X	X		X		X			X									1986
Bowker, C. A.	X	X		X	X			X			X							1990
Campanelli, M.	X		X										X					1985
Capacchione, L.	X	X		X		X											Book	1977
Catchings, Y.	X			X	X				X									1981
Chickerneo, N.	X	X		X		X								X				1990
Cockrum, C.	X		X		X									X				1989
Cooper, G.	X		X		X						X							1970
Corbit, I. E.	X	X		X		X								X				1985
Dempsy-Polan,L.	X			X	X		X					X						1990
Dobrin, B.	X	X				X												1980*
Drake, L. M.	X		X		X						X							1985
Dufrene, P.	X	X	X		X		X				X							1988
Egger, B.		X		X		X								X			Book	1988
Etherington, A.	X	X	X			X						X						1991

**See references on last page for Methodology/Type of Study

Table 3 (Continued)

		Related to	Basic or Applied Res.		Granting Institutions		Methodology/Type of Study** Quantitative						Qualitative					Degree
Name	ATR	Art Therapy	Basic	Appli	Univ/ Colle	Insti/ Other	Survey	Assess ment	Out come	Corre lation	Compar ative	Descrip tive	Natur alistic	Phen. Herm.	Histor ical	Cyber netic	Other	Year
Gantt, L.	X	X		X	X			X										1990
Garrett, A.D.	X	X		X		X											Journ	1984
Gilliland, I	X	X	X			X								X				1981
Golub, D.	X				X													1979*
Goodman, R.F.	X	X		X	X			X		X	X							1989
Graves, S.	X	X		X	X			X			X							1982
Grégoire, P.A.	X	X	X		X					X								1969
Gruter, A.	X		X			X					X							1989
Hiltunen	X	X			X					X								1983
Junge, M.B.	X		X			X								X				1991
Kaplan, F.F.	X	X	X		X					X								1985
Katz, F.R.			X		X										X			1986
Kelner, H.	X	X	X			X					X							1988
Kent, R.B.				X	X				X									1968
Knill-Cattaneo, M.	X					X							X					1982
Kunkle-Miller, C.	X	X	X		X		X											1985
Lang, M.C.	X		X		X								X					1984
Leavitt, C.G.	X	X		X		X		X										1988
Leonard, K.M.	X		X		X									X				1990

		Related to	Basic or Applied Res.		Granting Institutions		Methodology/Type of Study**											Degre
							Quantitative						Qualitative					
Name	ATR	Art Therapy	Basic	Appli	Univ/ Colle	Insti/ Other	Survey	Assess ment	Out come	Corre lation	Compar ative	Descrip tive	Natur alistic	Phen Herm	Histor ical	Cyber netic	Other	Year
Levick, M.	X	X	X		X			X				X						1982
Linesch, D.	X	X	X			X								X				1992
Lovell, S.	X	X				X								X				1990
Lusebrink, V.B.	X	X	X		X					X								1984
Marlin, W.			X		X									X				1984
Martin, G.	X					X												1981*
McCarthy, J.	X	X	X			X							X					1983
McIntyre, B.B	X	X	X			X								X				1987
McNeil, E.	X	X	X			X								X				1984
McNiff, S.	X	X	X			X								X				1977
Muri, S.A.	X			X	X				X									1990
Nucho, A.O.	X		X		X							X						1966
Ochipa, D.T.	X	X	X		X								X					1991
Peck, J.				X	X													1983
Pines, S.	X		X		X									X				1979
Rabin, M.	X	X		X	X				X									1987
Rappaport, L.	X	X	X			X								X				1986
Reed, L.C.	X		X			X					X						Book	1990
Rhyne, J.	X	X	X		X							X						1979

Table 3 (Continued)

		Related to	Basic or Applied Res.		Granting Institutions		Methodology/Type of Study**											Degre
							Quantitative						Qualitative					
Name	ATR	Art Therapy	Basic	Appli	Univ/ Colle	Insti/ Other	Survey	Assess ment	Out come	Corre lation	Compar ative	Descrip tive	Natur alistic	Phen. Herm.	Histor ical	Cyber netic	Other	Year
Richardson, J.F.			X		X									X				1986
Rosal, M.L.	X	X		X	X				X									1986
Rubin, J.	X	X		X	X												Book	1976
Rugh, M.M.	X	X	X		X									X				1990
St. Thomas, B.C.	X	X		X	X			X										1976
Scholnick-Cohn, R.	X	X	X			X								X				1984
Sidun, N.M.	X	X		X	X			X										1986
Silver, R.	X	X		X	X			X				X						1966
Slater, N.	X	X	X			X	X					meta-analy						1988
Speck, G.C.	X	X	X		X									X				1968
Spring, D.	X	X		X		X					X	X						1988
Steinberger, E.	X	X		X	X				X									1987
Stuart, J.P.	X		X			X								X				1990
Tritell, S.	X	X				X												1988*
Troeger, B.J.	X	X		X	X												Model	1981
Venture	X	X		X		X											Book	1977
Virshup, E.	X	X		X		X											Book	1983
Wadeson, H.	X	X		X		X											Book	1978
Waller, D.	X	X		X	X												Book	1990

to synthesize clinical experience. The case study was the research methodology utilized most often in the master's projects.

Some art therapy educators hypothesized that the critical thinking skills necessary to conduct research can begin on the master's level (Junge, 1989; Rosal, 1989). However, there is evidence that in order to become a critical thinker and builder of theoretical models of any substance one needs training beyond the master's level (Junge, 1989). The authors of this article agree that development of new research paradigms and theories is beyond the scope of master's level training since master's programs in art therapy focus on the development of clinical skills. Thus, teaching and training in research methodologies commensurate with the development of clinical skills may be most appropriate on the master's level. As Linesch (1992) found in her survey, most master's programs have opted to teach research skills which enhance clinical practice and, thus, the majority of master's projects or papers are based on case studies.

The use of both quantitative and qualitative research methodologies utilized by art therapists for their doctoral studies reflect the dual nature of our field as being from both behavioral sciences (quantitative focus) and fine art (qualitative focus). Both types of research are important, timely, and necessary for our nascent field. In addition, the need for art therapists to find alternative research paradigms and to develop unique methodologies is vital and has been discussed by several authors (Gantt, 1986; Junge, 1989; Junge & Linesch, 1993; McNiff, 1987). The development of new research paradigms is worthy and exciting. Again, this type of intensive work cannot be expected from master's level students who are grappling with obtaining clinical expertise and is more appropriate for doctoral level inquiry.

It should be noted that all but eight of the surveyed art therapists with doctoral degrees are A.T.R.s. Holding an A.T.R. implies that the individual had at least one year of clinical experience beyond the master's degree prior to beginning doctoral studies. Therefore, it is possible that clinical experience contributed to the types of research and dissertation topics art therapists chose. In fact, the use of clinical case study research was popular in doctoral work. Of the types of methodologies used in doctoral studies, the descriptive case study was utilized in 29.5% of the dissertations.

Art therapists need to be challenged and supported in their quest for conducting research. An en-

		Related to	Basic or Applied Res.		Granting Institutions		Methodology/Type of Study**											Degree
							Quantitative						Qualitative					
Name	ATR	Art Therapy	Basic	Appli	Univ/ Colle	Insti/ Other	Survey	Assess ment	Out come	Corre lation	Compar ative	Descrip tive	Natur alistic	Phen. Herm.	Histor ical	Cyber netic	Other	Year
Whitney, J.D.	X	X		X		X										X		1983
Witlin, R.	X	X	X		X		X											1987

*Abstracts are not available

**Methodology/Type of of Study:
Quantitative: Survey, Assessment, Outcome, Correlation, Comparative, Descriptive
Qualitative: Naturalistic Ethnographic, Phenomenological-Hermeneutic, Historical, Cybernetic, and Other (book, journal, model)

1595 BEST COPY AVAILABLE

vironment where peers and mentors are available for advice and consultation is a must. The following is a proposal for an Art Therapy Research Mentor and Resource Pool (MRP) based on the information gathered in this survey. The MRP would have two components:

1. The mentor pool would include art therapists who are familiar with particular research methods and topics and would be willing to consult with and mentor novice art therapy researchers.
2. The resource pool would initially include information compiled from the present doctoral degree survey of art therapists. This compilation of dissertation abstracts would be the primary resource and could be expanded as more therapists engage in research.

Also, it is evident from this survey that art therapists are multidisciplinary thinkers and have conducted doctoral studies in several areas. A continuation of multidisciplinary research may enrich and enliven our field. As McNiff (1987) stated, in the field of art therapy "interdisciplinary cooperation has been the norm rather than the exception" (p. 285)—let us hope this continues!

Conclusion

An increasing number of art therapists are obtaining doctoral degrees. The topics investigated and the approaches and methodologies used in the dissertation studies are diverse. The majority of art therapists use qualitative (specifically phenomenological-hermeneutic) types of research in doctoral work.

Three general recommendations can be drawn from the present survey. First, it may be timely to develop doctoral degree programs in art therapy. This conclusion is based on the information garnered from this survey and from a survey of art therapy educators about the development of doctoral programs (Lusebrink, 1993). Second, strong support from within the professional organization for individuals seeking doctoral degrees is recommended in view of the lack of programs offering degrees in art therapy. A rich pool of information regarding doctoral dissertation research for prospective doctoral students is now compiled and should be available for use by future art therapy doctoral students. Finally, a meta-analysis of the doctoral studies conducted may illuminate both strengths and weaknesses in art therapy research and may highlight areas for future research emphases.

Vija B. Lusebrink, PhD, A.T.R., is Professor of Expressive Therapies, University of Louisville; Marcia L. Rosal, PhD, A.T.R., is Associate Professor of Expressive Therapies, University of Louisville; Michael Campanelli, EdD, A.T.R., is Professor of Art Therapy, Edith Cowan University, Perth, Western Australia. Inquiries about this survey may be directed to Dr. Vija B. Lusebrink, A.T.R., Expressive Therapies, University of Louisville, Louisville, KY 40292.

References

Accredited Institutions of Postsecondary Education: Programs, Candidates. (1991–1992). Washington, DC: American Council of Education.

Cates, W. M. (1985). *A practical guide to educational research.* Englewood Cliffs, NJ: Prentice-Hall.

Gantt, L. (1986). Systematic investigations of art works: Some research models drawn from neighboring fields. *American Journal of Art Therapy, 24*(4), 111–118.

Gordon, R. A., & Manning, T. (1991). 1990–91 membership survey report. *Art Therapy: Journal of the American Art Therapy Association, 8*(2), 20–29.

Junge, M. B. (1989). The heart of the matter. *The Arts in Psychotherapy, 16*(3), 77–78.

Junge, M. B., & Linesch, D. (1993). Our own voices: New paradigms for art therapy research. *The Arts in Psychotherapy, 20*(1), 61–67.

Linesch, D. (1992). Research approaches within Master's level art therapy training methods. *Art Therapy: Journal of the American Art Therapy Association,* 9(3), 129–134.

Lusebrink, V. B. (1993). Art therapy faculty survey. *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 156–158.

McLaughlin, D., & Carolan, R. (1992). Types of research. In H. Wadeson (Ed.), *A guide to conducting art therapy research* (pp. 53–59). Mundelein, IL: American Art Therapy Association.

McNiff, S. (1987). Research and scholarship in the creative arts therapies. *The Arts in Psychotherapy, 14,* 285–292. New York: Pergamon Press.

Peterson's guide to graduate and professional programs: An overview (27th ed.). (1993). Princeton, NJ: Peterson's Guides.

Rosal, M. (1989). Master's papers in art therapy: Narrative or research case studies? *The Arts in Psychotherapy, 16*(3), 71–75.

Rosal, M. (1992). Illustrations of art therapy research. In H. Wadeson (Ed.), *A guide to conducting art therapy research* (pp. 63–72). Mundelein, IL: American Art Therapy Association.

Art Therapy: Journal of the American Art Therapy Association, 10(4) pp. 235-240 © AATA, Inc. 1993

The Effects of Directed Art Activities on the Behavior of Young Children with Disabilities: A Multi-Element Baseline Analysis

Susan Banks, MEd, Pat Davis, MEd, Vikki F. Howard, PhD, and T. F. McLaughlin, PhD, Gonzaga University, Spokane, WA

Abstract

The effects of directed art activities on the behavior of two preschool children and one kindergarten child with disabilities in a rural classroom were examined. A multi-element baseline design across participants was used to compare directed art activities with typical preschool art activities. The behaviors measured were aggression, eye contact, and social initiation. Each art activity directed by the teacher focused on an affective concept such as anger or happiness. The control condition used the same art materials as the directed art activity, and the children chose how they would use the materials. The results indicated that the directed art activity had a larger effect than the control condition on the social behavior of two children, while the control condition generated little effect. Neither art activity had a measurable effect on the targeted behavior of the third child. Implications for use by preschool and other teachers were suggested.

Introduction

Art, as a part of child development, has been studied in terms of creative expression, psychosocial development, and cognitive development (Silver, 1978). Art activities have traditionally been included in preschool programs for children with developmental delays as they "provide the opportunity for creative expression; practice of fine and gross motor skills; and the application of language concepts relating to form, shape, color, texture, and spatial relationships (Bailey & Wolery, 1984, p. 124). These activities have also provided a "conduit for responding to experience and expressing the change that occurs at every developmental stage" (Ferrara, 1991). Through art, children are able to express feelings of aggression and anger, fear and anxiety as well as expressions of love (Salant, 1975). Preschool children have been particularly vulnerable to disruptions in family life. When these children have been unable to express feelings of anger, fear, and pain, behavior problems and learning difficulties have often resulted. Naumburg (1973) suggested that the procedures of art therapy could be used in art education for both normal and emotionally disturbed students.

Recently, Swenson (1991) illustrated the relationship between art education, art therapy, and special education. Aspects of art education have provided value as therapy. These include participation in group projects which have encouraged cooperation as well as reduced competition and feelings of isolation encountered by most children in special education. Kramer (1979) stated that when children with emotional and behavior problems have inner

---

Editor's note: Preparation of this manuscript by the first two authors was in partial fulfillment of the requirements of a Master of Education in Special Education from Gonzaga University. The help and assistance of Diane Gemmill, Kathy Brown, and Jenny Carter in the project was greatly appreciated. Requests for reprints should be addressed to T. F. McLaughlin, Department of Special Education, School of Education, Gonzaga University, Spokane, WA 99258-0001.

conflicts, they are often inaccessible to education through normal teaching practices.

Art therapy has a long history of application for children with serious behavioral, intellectual, and emotional problems. However, there is very little empirical evidence to support such applications. Furthermore, since practices vary widely depending on the theoretical foundations of the practitioner, no single method can be viewed as "art therapy." The present study relied primarily on Kramer's viewpoint that art therapy does not need to involve interpretation or assumption of underlying pathology. Rather, art can be a form of communicating emotions which might then be healing. This study was developmental in nature as great care was taken to incorporate materials, activities, and discussions to facilitate emotional responses at the children's developmental levels (Silver, 1978). Behavioral techniques used throughout the activities included modeling, contingent reinforcement, and prompting (Roth, 1987).

This study was designed to measure the direct effects of art therapy. Its purpose was to evaluate the effects of directed and nondirected art activities utilizing some strategies of art therapy within a behavioral context on high-risk, preschool and primary grade students with developmental disabilities. Directed art activity was selected to attempt to facilitate an emotional outlet which would then allow the children to be ready to experience a successful peer encounter.

Method

Participants and Setting

Three children were chosen as participants. A kindergarten child with attention deficit disorder was selected for the study because of excessive aggression resulting in poor social interaction with peers. The two other children were preschoolers and were selected because of delays in social development and poor interactions with peers as observed by the classroom teacher. The children attended a combination preschool/kindergarten program consisting of nine kindergarten children with and without disabilities as well as six preschoolers who were all classified as developmentally delayed. The Vineland Adaptive Scale (Sparrow, Balla, & Cicchetti, 1984) was used to determine delays in social skills for each child. A social skills subscale composite score of 70 (below-2 SD) indicates a delay in social skills and qualifies a child for preschool services.

Subjects

Jack was a 6-year-old child enrolled in the combination preschool/kindergarten program. Jack's cognitive skills were not a concern as he appeared to be developing normally. Since he had not been referred for services, his IQ scores were not available. The Vineland Adaptive Scale (Sparrow, et al., 1984) showed a social skills composite standard score of 47 (3 SD below the mean) with a composite score of 70. The child frequently displayed sensory integration problems (inability to screen out stimuli, unable to complete tasks), aggression, and psychosocial coping skill loss as observed by the classroom teacher. His mother reported that he had a history of experiencing violence within the family.

Jerry was a 4-year-old boy with significant cognitive delays. His IQ composite score was 64 according to the Stanford-Binet Intelligence Scale (Terman & Merrill, 1973; Thorndike, Hagen, & Sattler, 1986). The Vineland Adaptive Behavior Scale indicated a social skills composite standard score of 70 (2 SD below the mean). He also showed significant delays in speech and language, gross and fine motor skills, and social development. Jerry was noncompliant and displayed frequent temper tantrums. His mother reported that he had been a victim of physical violence within his family.

Andy was a 4-year-old boy with an IQ score of 121 on the Stanford-Binet Intelligence Test. The Vineland Adaptive Behavior Scale showed a composite social skills standard subscale score of 85. Although his social skills subscale composite score was too high to qualify him for developmental delay in social skills, he had difficulties playing cooperatively with his peers. He qualified for the preschool special education program because of delays in gross and fine motor skills.

For the first half of the study, the children's classroom was located in the basement of a 61-year-old school building. The remainder of the study took place in a new preschool/kindergarten through sixth grade school building in a small rural community. The entire population of the school included 110 students. Approximately 25% of the students received special education or related services. A large portion of the community was comprised of families of lower socio-economic status.

Materials

Selected art materials were appropriate to the developmental levels of the children and included watercolors and paintbrushes, play dough, chalk, crayons, fingerpaints, and paper and glue.

Behavior Definition and Measurement Procedures

Target behaviors were selected based upon the classroom teacher's observation and consultation with various support service providers. Physical aggression, the behavior under study for the first child, was defined as hitting, kicking, choking, pushing, or grabbing toys from a peer. Prior to the study, Jerry initiated interactions primarily with adults. A determination was made to attempt to increase the frequency of self-initiated peer interaction. The third child had poor attending skills, lack of impulse control, and eye contact. Eye contact was chosen as the targeted behavior in an attempt to increase overall attending skills. Since he rarely engaged in even fleeting eye contact, frequency of eye contact was selected rather than duration.

The three target behaviors were selected with the overall goal of increasing adaptive social skill interactions with peers. These students had developed no sustaining peer relationships, although each verbally expressed a desire to have a friend.

For ease of classroom management, all target behaviors were measured by a frequency count. Data collection lasted for an interval of 5 minutes. Two data collection periods per day were conducted during center time: the first immediately after the treatment probe and the second 30 minutes later. Center time consisted of free exploration with toys, games, puzzles, and books and peer social contact within a small group (three to four children). Two observations were carried out to assess possible generalization of effects across time.

Experimental Design and Experimental Conditions

A multi-element baseline design (McLaughlin, 1983; Ulman & Sulzer-Azaroff, 1975) replicated across individuals was chosen to evaluate the use of various art activities. This design calls for alternating conditions so that contrasts between the two treatment probes could be examined. The condition in effect was first determined by a coin toss. An alternating pattern was followed throughout the remainder of the study (Kazdin, 1982).

Baseline: Baseline data were collected in absence of either treatment condition. Data were collected during center time which usually lasted 1 hour per day. This condition was in effect for 5 school days.

Control condition: During the control condition, art materials were provided along with the verbal statement, "Boys and girls, you have 15 minutes for this activity." During this phase the entire class participated in the activities, but data were collected on the targeted subjects only. No adult direction was given to the students except when inappropriate behaviors were observed. Teachers observed the activity. The art media were preselected to maintain consistency with the directed art activity. Each child determined how the materials would be used and what product they developed. Target students did not receive special attention during the activity. Data were collected 5 minutes after the art lesson, and again 30 minutes later.

Directed art activities: The second phase consisted of directed art activities utilizing preselected media which matched the corresponding control condition and a period of 5 minutes in which the teacher directed the children to focus on a "feeling" word or concept (mad, happy, love). The "feeling" word was written on the board and the teacher then asked, "What makes you (feeling)? A 15-minute period for execution of the art activity followed. Verbal cues to refocus on the concept were given as needed during the activity; for example, "(Child's name), think about what (feeling) means to you" or "How do you feel when you're (happy, sad, etc.)?" When the time period ended, each child was asked to describe how his/her artwork reflected the focus concept. The class discussion lasted 10 minutes. The following script was used:

1. "(Child's name), tell us about your (picture)."
2. "How do you feel about your (picture)?"

Data were again collected immediately after the directed art activity and 30 minutes later during center time as the target behaviors were more likely to occur at that time.

Interobserver Agreement

A paraprofessional was trained to observe the target behaviors of each child. These data were taken twice for each child. Reliability of measurement was calculated by dividing the smaller number by the larger number and multiplying by 100. Interobserver reliability was 93% (range 83% to 100%). Reliability data were taken during initial observation (the first 5 minutes of center time).

Independent Variable

After she had been verbally informed of the methodology for the procedures to note for which type of art activity (directed or control condition) was being conducted, an outside observer randomly visited the classroom following baseline. The paraprofessional observed the class three times. Agreement as to the implementation of the independent variable was 100%.

Results

Visual analysis of the data indicated that both experimental and control art activities resulted in therapeutic improvement of social behaviors across individuals. Furthermore, social behavior following directed art activities was more improved than following control art activities. Of the three subjects, Jack's data showed the most marked improvements. Overall, the mean rate of aggression per session was 7.2 for baseline (range 3–10), 5.0 after control art activities (range 0–9), and .75 after directed art activities (range 0–2). During baseline, Jack emitted aggressive behaviors an average of 7.8 times (range 7–10) at the beginning of circle time, and an average of 6.6 times (range 3–9) 30 minutes later (see Figure 1). A comparison of aggression at 5 and 30 minutes following treatment conditions showed means of .5 and 1.0 respectively after directed art activities (ranges: 1–2 at 5 minutes; 0–2 at 30 minutes) and means of 5.0 and 5.2 respectively after control art activities (ranges: 3–9 at 5 minutes; 0–8 at 30 minutes).

In an overall comparison of social initiations, Jerry emitted a mean of .2 responses per session (range 0–1) during baseline; a mean of 1.6 responses per session (range 0–4) following control art activities; and a mean of 3.4 responses per session (range 1–5) following directed art activities. The data showed that in circle time Jerry emitted an average of .2 responses during both the first 5 minutes and 30 minutes later (see Figure 2). Directed art activities were followed by increased social initiations means of 3.6 (range 2–5) and 3.2 (range 2–5). By contrast, self-initiated responses were emitted an average of 1.7 times (range 0–3) and 1.5 times (range 0–4) respectively at 5 minutes and 30 minutes following control art activities.

Differences across conditions were less marked for Andy than for either Jack or Jerry. An overall comparison revealed a mean of .6 eye contacts (range 0–2) per session during baseline; a mean of 1.5 eye contacts (range 0–3) per session following control art activities; and a mean of 1.9 eye contacts (range 0–3) per session following directed art activities. During baseline, Andy was observed establishing eye contact an average of .8 and .4 times (ranges 0–2) respectively for the first 5 minutes and then 30 minutes later. Mean number of eye contacts following directed art activities were 1.5 (range 1–3) and .8 (range 0–2) respectively at 5 and 30 minutes following treatment. Similarly, eye contact was observed an average of 1.5 (range 1–3) at 5 minutes and 1.0 (range 0–2) 30 minutes later following control art activities.

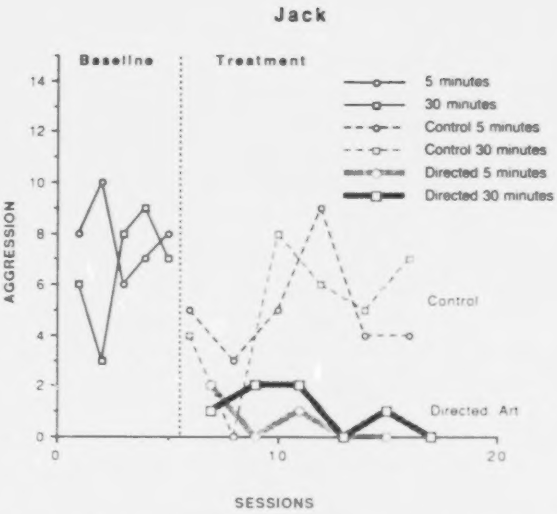


Figure 1. The frequency of aggressive behaviors during each of the various experimental manipulations.

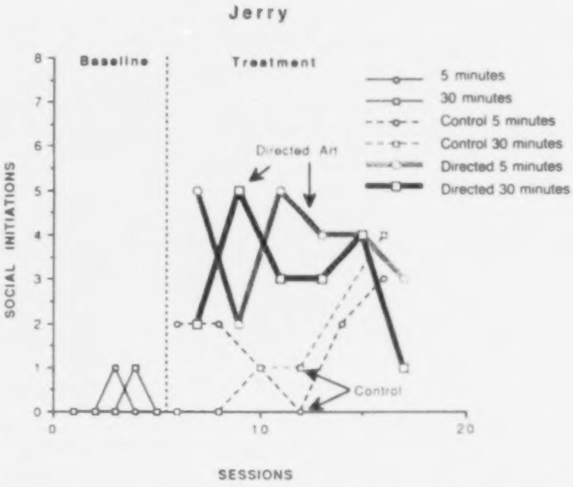


Figure 2. The frequency of social initiation during each of the various experimental manipulations.

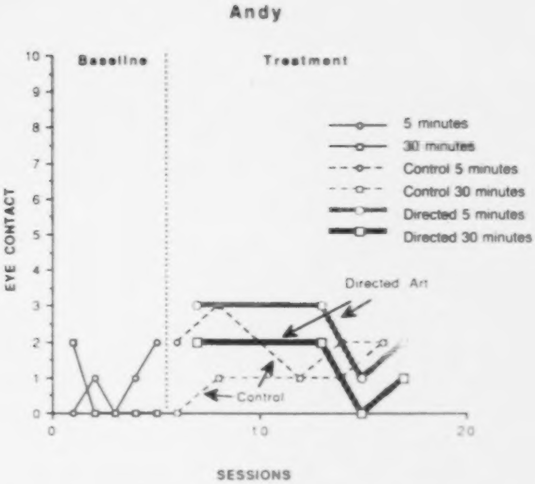


Figure 3. The frequency of eye contact during each of the various experimental manipulations.

Discussion

The results of this study indicate that directed art activities may be effective for improving social behaviors for children. The process of pairing manipulation of selected art materials and activities with communication between children and the teacher seems to be an effective outlet of emotional expression, particularly for students who have a history of repression and violence. Although the data for Andy were not as dramatic, some change was found. Halfway through the study this pupil was also absent a large percentage of the time. Later, it was determined that due to his type of sensory motor problems, he was not capable of engaging and maintaining eye contact without physical and verbal prompts.

The changes noted in the students' behaviors after the nondirected activity may have resulted from a whole group activity as opposed to small group art activities that were previously conducted in the class. A large group may also have stimulated students' expressive output (Thompson, 1990). The outcomes here appear to support strategies used in the work of Malchiodi (1990) [facilitating emotional responses], Roth (1987) [behavioral techniques], and Silver (1978) [child development].

It is possible that when students are exposed to directed art activities for a period of months rather than weeks, the impact would be more enduring. Though there was an immediate impact on all children, the results were not sustained from day to day. Thus, the length of time spent in art therapy is a factor which warrants further investigation to determine the real potential of art therapy in the classroom.

Using directed art activities seemed practical, cost-effective, and manageable in an integrated setting where all children could benefit in individual ways. In further studies, it would be advantageous to collect data on the entire class using videotape. The tape could be analyzed, target behaviors selected, and permanent data records kept. Moreover, the child who made the greatest gains in the study was behaviorally involved (aggressive), and further replication with a target population of children exhibiting aggression may further validate the results or reveal some comparison data.

Although most early childhood special education teachers are not trained art therapists, their education has typically included a good background in the psychology of younger children as well as research methodology. Provided that they work closely with school psychologists and counselors to refer cases to trained specialists when necessary, knowledge of art therapy techniques could be invaluable as a preventative measure with children who are developmentally delayed and at risk for developing emotional and behavioral problems.

Though the current study revealed that art therapy could be effective, additional research is warranted to establish the generalizability of these findings to other populations. A study contrasting the combination of art and discussion with just a discussion of emotions would be advantageous in establishing the critical elements involved in the behavior changes. The maintenance and effectiveness of employing various types of art activities also warrant further study; for example, whether or not the medium employed in the art activity would produce different rates of behavior and if behavior changes could be maintained over time. Finally, the use of methodology from applied behavioral analysis allows one to evaluate and make appropriate data-based judgments as to the effectiveness of new interventions, including art-based interventions, for children with disabilities.

References

Bailey, D., & Wolery, M. (1984). *Teaching infants and preschoolers with handicaps*. Columbus, OH: Charles E. Merrill Publishing.

Ferrara, N. (1991). Art as a reflection of child development. *American Journal of Art Therapy, 30*, 44–50.

Kazdin, A. E. (1982). *Single case research designs: Meth-*

BEST COPY AVAILABLE

ods for clinical and applied settings. New York: Oxford University Press.

Kramer, E. (1979). *Childhood and art therapy*. New York: Schocken.

Malchiodi, C. (1990). *Breaking the silence: Art therapy with children from violent homes*. New York: Brunner/Mazel.

McLaughlin, T. F. (1983). An examination and evaluation of single subject designs used in behavior analysis research in school settings. *Educational Research Quarterly, 7*, 35–42.

Naumburg, M. (1973). *An introduction to art therapy*. New York: Teachers College Press.

Roth, E. A. (1987). A behavioral approach to art therapy. In J. A. Rubin (Ed.), *Approaches to art therapy* (pp. 213–232). New York: Brunner/Mazel.

Salant, E. G. (1975). Preventative art therapy. *American Journal of Art Therapy, 14*, 67–74.

Silver, R. A. (1978). *Developing cognitive and creative skills through art*. Baltimore, MD: University Park Press.

Sparrow, S. S., Balla, D. A., & Cicchetti, D. V. (1984). *Vineland Adaptive Behavior Scales*. Circle Pines, MN: American Guidance Service.

Swenson, A. B. (1991). Relationships: Art education, art therapy, and special education. *Perceptual and Motor Skills, 72*, 40–42.

Terman, L. M., & Merrill, M. (1973). *Stanford-Binet Intelligence Scale: 1973 Norms Edition*. Boston: Houghton Mifflin.

Thompson, C. M. (1990). "I make a mark": The significance of talk in young children's artistic development. *Early Childhood Research Quarterly, 5*, 215–232.

Ulman, J. D., & Sulzer-Azaroff, B. (1975). Multi-element design in educational research. In E. A. Ramp & G. Semb (Eds.), *Behavior analysis: Areas of research and application* (pp. 377–391). Englewood Cliffs, NJ: Prentice-Hall.

"Each issue of **The Arts in Psychotherapy** *is a seasonal enlightenment indispensable for the many who want to stay up to date on the professional and theoretical aspects of the creative arts therapies."*
– Rudolf Arnheim, Ph.D., Professor Emeritus of the Psychology of Art, Harvard University

THE ARTS IN PSYCHOTHERAPY
AN INTERNATIONAL JOURNAL

Editor-in-Chief: Robert J. Landy, Ph.D., Director, Drama Therapy Program, New York University, New York, NY
European Editor: David Aldridge, Ph.D., Music Therapy, Universitat Witten, Herdecke, Germany
Managing Editor: Sylvia M. Halpern, 20 Ridgecrest East Scarsdale, NY 10583

Highly acclaimed in the field, **THE ARTS IN PSYCHOTHERAPY** presents innovative research in artistic inquiry and expression, and its use in the treatment of mental disorders.

THE ARTS IN PSYCHOTHERAPY is an international journal for professionals in the fields of mental health and education. The Journal publishes articles (including illustrations) by art, dance/movement, music, poetry and drama psychotherapists, as well as psychiatrists and psychologists, that reflect the theory and practice of these disciplines.

In an effort to expand the Journal's focus to include more international articles, The new Editor-in-Chief, Robert J. Landy, has appointed a European Editor, David Aldridge, and has also updated the Editorial Boards. These changes will allow the Journal to offer even more diverse coverage while opening up a dialogue among creative arts therapists all over the world.

The Editors welcome original manuscripts. Submit papers in triplicate to: Sylvia Halpern, Managing Editor, 20 Ridgecrest East, Scarsdale, NY 10583.

Submissions from Europe should be sent in triplicate to: David Aldridge, Ph.D., Music Therapy, Universitat Witten, Beckweg 4, D5804 Herdecke, Germany

SUBSCRIPTION INFORMATION

ISSN: 0197-4556	Vol. 20, 1993
Published 5 issues per annum	
Institutional Rate (1993)	*£140.00/US$224.00
Professional Rate (1993)	*£37.00/US$59.00

*Sterling prices quoted are definitive and apply worldwide. US dollar prices are quoted for convenience only and are subject to exchange rate fluctuation. Prices include postage and insurance.

Members of qualifying societies can receive a discount on personal subscriptions. Please write for further information.

**FREE SAMPLE COPY
AVAILABLE UPON REQUEST!**

PERGAMON PRESS
USA: 660 White Plains Road, Tarrytown, NY 10591-5153 **UK:** Headington Hill Hall, Oxford, OX3 0BW, England
A member of the Elsevier Science Publishing Group

Art Therapy: Journal of the American Art Therapy Association, 10(4) pp. 241-242 © AATA, Inc. 1993

Viewpoints

The Ear of the Physician

Shirley Low Gerstenberger, MS, Topeka, KS

Three decades ago, as a sociology student, I received an assignment to design and implement a research problem relevant to my discipline. The in-depth study I attempted with a university drawing class was qualitative, using participant-observation, interview, questionnaire, and sociogram techniques. Just what insights this vast array of collected data brought me were somewhat ambiguous, but I polished it off with descriptive statistics and felt certain that the results were more promising than tables of numbers replete with complex statistical manipulations. Part of my methodology was based on naivete, but part was grounded in a discipline that did not subscribe to the theory that quantitative is always better! I had the freedom to investigate my subjects from many perspectives, to organize, reorganize, and enhance my information in varying ways, and to recognize that to generalize my findings was overstepping boundaries, inviting bias.

Indeed, President Johnson at the nation's helm seemed eager to hand out grant funding and encouragement for a wide range of research topics and methodologies among the social sciences. Social science research seemed a ready opportunity, and one not necessarily constrained by the rigors of experimental methodology. Behaviorism flexed its muscles but did not eliminate qualitative approaches. Accountability was to one's academic doctrine.

Many years later, after employment in data collection and other areas of research in psychology/psychiatry and the completion of graduate training in art therapy, I find myself sorting through a morass of possibilities for teaching a one-semester graduate course in research problems and art therapy. My sociology background exerts a fundamental influence on my perception of individuals and their behavior. I find myself pulled toward a methodology that will focus on the unique aspects of the individual, and not to an approach that strains out those special characteristics of humanness. Furthermore, my propensity to view the total context of the person, a need to climb with empathy into another's world and experience its complexity, is ever stronger. How can we hear an individual speak through art without being part of the process, participating in the dialogue, responding to the drummer who stirs both client and self?

It is natural to speak strongly for phemenological or hermeneutic research models, any model that allows the process of treatment itself to be the mother of the research method. However, just as there is necessity to study people within their own ecosystem, it is equally necessary to conduct research within our current sociopolitical context. Today's health care is one based on a medical model. Psychological treatment is addressed and made legitimate, albeit often in the back closet, within the confines of our health care system. With burgeoning costs of medical care and growing expectations for health care provision, we look for the discipline of art therapy through an ever more confusing maze of reimbursement issues.

Art therapy exists in a tenuous position within psychiatric treatment; its credibility generally does not reach the hallowed doors of the reimbursement agencies. Perhaps its destiny is a specialized treatment, available only to people able to finance service out-of-pocket. Even given that destiny, its healing potential must be touted, and with rigorous, professional support, its potential made apparent to the public. Better yet, why surrender to the exclusion from the insurance system and limit the population for whom art therapy might find a responsive chord? With either position, it seems obvious that to herald art therapy as a treatment of good choice we must promote research and we must publish our findings. To gain appropriate acknowledgment and recognition of our potential, we must know the audience to whom we first speak.

Our reimbursement system, both public and private, is based on a medical model. Our access to that system is through the door of the physician. Discourse on the pros and cons of the medical model can continue at length. Battles can be fought for wholistic treatment that springs from a psychological or spiritual framework. However, the final arbitrator in our pragmatic society is the person or institution that pays the bill. Mainstream treatments are those that public and private reimbursement agencies have deemed cost-worthy.

Consulting physicians in specialty areas are contracted for review and consultation by reimbursement agencies. Such a procedure carries with it the assumption and responsibility that the physician-consultant is a knowledgeable resource on any treatment modality. Should a query on the effectiveness of a proposed art therapy treatment reach the desk of such a physician, a decision crucial to our discipline lies in the hands of the psychiatrist. It is incumbent upon us to deliver our information, our research data, into such powerful hands. Even such a contact may not be possible if the reimbursement agent is not sufficiently cautious to check for medical opinion, but rather dismisses a request perfunctorily. And, as often is the case, such a claim may never be filed.

To successfully work the system we need to conduct research and supply findings in a professional manner, one comfortable to the psychiatrist. Recently, a psychiatrist of many years called upon me for published research that would support an art therapy program. A large insurance company had requested his opinion. Clearly, the physician was not interested in theory or anecdotal material. Case histories were not solicited. The limited research world to which the psychiatrist subscribed was couched in such concepts as control and experimental groups, pretests and posttests, and quantitative findings. His experience was based on medication studies. To him, expressive therapy referred to a verbal psychotherapy aimed at insight. The basic potential of imagery and its dynamic interplay with the unconscious was linked to dreams, not art therapy. I was not well-prepared to provide concise, supportive data for art therapy treatment.

While the media, both televised and in print, currently appears to be giving more attention to the use of art therapy, the scope of the discipline is not well-understood. It may be more easily acknowledged as an assessment tool, a crisis technique, or a leisure activity primarily suited to children. Unfortunately, diagnostic indicators or reports of childrens' art created after national disasters do not justify the effectiveness of art therapy treatment to reimbursement agencies psychiatrists.

The psychiatrist with whom I spoke wanted evidence, empirical data, for treatment success using art therapy. The message was clear. Regardless of treatment approach we must actively promote research in art therapy that incorporates measurement tools that quantify change. It would be advantageous to maintain a central file that contains reliable and valid measurement tools. Certainly a graduate course in research methodology has vast ground to cover with little or no time to explore instruments or become skilled in the administration of psychological assessment. Outcome studies based on control groups are needed. Using such control and experimental groups, the psychiatrist has no need to delve into the actual procedure of art therapy, but can give a cursory yet endorsing glance at quantitative results. Though I balk at moving from a qualitative model, and fear the loss of special data that our client art and its context yield, it appears that acceptance of the profession of art therapy lies in such a move.

Research for our own edification can be conducted in whatever method is most fruitful. Research to bring us to the awareness of reimbursement agencies must speak the language of the psychiatrist. Our health care system may be in the midst of great change as its complexity and troubles mount. Art therapy needs to purposefully locate its position in the health care arena at this time. A portfolio of data is a resource to which all art therapists need access. It is a resource all art therapists need to promote, vigorously and assertively.

Reviews

Facing Death: Images, Insight, and Interventions. A Handbook for Educators, Health Care Professionals, and Counselors

by **Sandra L. Bertman, PhD,** Washington: Hemisphere Publishing Corporation, 1991.

214 pp., 190 black & white illustrations. $20.00 paper. ISBN 1-56032-223-3.

Reviewed by **Hannah Sherebrin, RN, A.T.R.,** London, Ontario, Canada

When the lights dim and the audience is asked to sit through yet another slide presentation at a conference, often one can observe people discreetly nodding off. Not so when Dr. Sandra Bertman shows her double-slide presentation "Facing Death." I first saw the images two years ago at the International Conference on Death and Dying at King's College, London, Ontario, Canada. Bertman's original and provocative juxtaposition of literary, artistic, pop culture, photography, and cartoon images depicting death made the audience sit up and take note. Faced with images that challenged our own mortality, we were emotionally moved and forced to re-evaluate our previously held impressions. When familiar paintings were presented side-by-side with unexpected cartoons or a literary quotation, we were provoked to discover new meanings, new insights. Among the many thought-provoking examples, a humorous one comes to mind. Jacque Louis David's painting *The Death of Socrates*, in the collection of the Metropolitan Museum of Art, is fairly well-known. It depicts the elderly philosopher, surrounded by his distressed students. As he is handed the cup of hemlock, he speaks, punctuating his words with an upheld finger. We typically ascribe to Socrates the example of willingness to die for an ideal; here death is the ultimate expression of virtue. Another interpretation was suggested by an oncology patient: It looks like Socrates is "giving God the finger!"

The freshness of the slide presentation is beautifully preserved in book format. Although the illustrations, unlike the slides, are not in color, the impact is extremely strong throughout the book's four chapters. The first chapter is an introduction to terminal illness in contemporary society and a discussion of the value of using the arts to stimulate dialogue. Medical staff have been trained to be detached, scientific, and analytical in their views of illness and death; Bertman finds both patients and medical personnel can benefit from another approach. She offers this insight: "The arts uncover realities that lie outside the quantifiable or statistically measurable. They invite us into the world of dying persons in a manner different from, but not less penetrating than, scientific analysis" (p. 6).

In the second chapter we are challenged to explore critical themes through a selection of writings and images. The themes cover a wide span, from loneliness, facing the moment of death, sorrow of the survivors, the art of dying, to depictions of afterlife. The selection of images is based on three criteria: their relevance to the theme and the concerns they identify, their ability to elicit an emotional response, and their implicit humanistic bias. This nonthreatening sequence of poetry, imagery, and letters is designed to aid disclosure of beliefs and fears. For example, Woody Allen's words, ". . . the fear that there may be no afterlife—a depressing thought, particularly for those who have bothered to shave. Also, there is fear that there is an afterlife but no one will know where it is being held" (p. 26).

The third chapter is dedicated to validity research on this tool and presents responses from various populations with whom the images were used. Bertman, who is professor and director of the Program in Medical Humanities at the University of Massachusetts Medical Center, Worcester, tested this teaching method on her nursing and medical students. Images were also experimentally used with 54 West Virginia junior and senior high school students, Lesley College students in Cambridge, Mass., and hospice volunteers who were attending a statewide conference in Massachusetts. The Death Attitude Questionnaire and a form for discussing the "Most Memorable Image" are included as appendices. Readers can duplicate her research and collect additional data. To further validate her method for teaching and therapy, the Death Attitude Questionnaire can be administered several weeks after the presentation to detect changes in attitude.

Both similarities and differences in attitudes and choice of images are apparent when responses of the five populations are compared. Commonly held attitudes dealt with difficulty in communciation about the subject, concerns about physical and emotional pain, control, and desire for a dignified death with some form of immortality. These concerns have been recognized in existing clinical literature and this study supports their validity. Most significant from a therapeutic perspective is the impact of particular images on each group. The junior/senior high school group identified more with pop culture images and literal or symbolic depictions of afterlife. College students also frequently selected symbolic images of afterlife, whereas the medical and nursing students tended to select realistic or photographic portrayals of death. Both nurses and palliative care volunteers identified with depictions of loneliness, communications, or lack of communication, at the deathbed.

The photographs of Mark and Dan Jury, titled "Gramp," were the most emotionally charged for me. Simultaneously viewing the photograph of the grandfather, Mark, holding his grandson Dan, a baby, in his arms, and then Dan carrying his fragile, diapered grandfather, was a moving and loving experience. It brought back memories of diapering my mother before her death. The goal in all presentations was "to enable participants to relate to the images in personal terms" (p. 159). Bertman certainly achieves this goal.

The fourth chapter further explores and develops the instrument, providing us with guidelines for using the book effectively in death education and counseling. Readers are challenged to go beyond the book and create images of their own. With the use of the arts, and through the arts, we are encouraged to broaden our experience of death. Dr. Bertman's aim is to support front line staff who continue to "be there" for the dying and their families. The book does much more. It is a sensitive document which evokes laughter and tears and provokes us to rethink our attitudes. "Art, presented in a sensitive, nonthreatening format with a carefully directed focus, can evoke deeply personal understanding and can provide a sort of emotional vaccination that induces protection and a sense of empowerment, community, and humaneness" (p. 168).

As a unique teaching tool, this book merits a place of honor. It is rich with examples and provides excellent reference lists and an extensive bibliography. Because loss and bereavement are central issues in therapy, this volume could well be included in the curriculum of art therapy programs. *Facing Death* is a welcome addition to any art therapist's library, for it is a true reflection of art therapy values.

Freeing the Creative Spirit: Drawing on the Power of Art to Tap the Magic and Wisdom Within

by **Adriana Diaz**, San Francisco: Harper San Francisco, 1992.
223 pp., 12 color illustrations. $16.00 paper. ISBN 0-06250-182-8.

Reviewed by **Vija B. Lusebrink, PhD, A.T.R.**, Louisville, KY

In *Freeing the Creative Spirit*, Diaz, a teacher of painting and pottery, presents a mixture of philosophical, expressive, and instructive advice for novices in art and self-exploration. This volume of "how-to-do" offers 20 art experiences and instructions in the use of art materials, five pages of reflective questions, and two meditative descriptions. Interwoven within are personal comments, references from artists, various philosophical approaches, and basic advice on obtaining and using art materials. On page margins selected quotes from artists, poets, and others enliven the text. The author's own pen sketches are interspersed throughout the book.

The introduction briefly covers the concept of *creative meditation* as "a prayerful integration of play, self-discovery, community building, and aesthetic spirituality" (p. 3). Diaz conceptualizes her approach through a diagrammatic schema of six concentric rings expanding outward from "the core of divinity, exploring the realms of the ancestral, personal, social, and universal selves through creative experiences, rituals, meditations, and reflective questions" (p. 7). These rings are surrounded by "divinity." A flow of creative energy is presumed to permeate and traverse the separate parts.

The first chapter deals with the "Ancestral Self." Diaz combines some thoughts on creativity and play with personal comments and anecdotes from observation. In the experiential section of this chapter, she briefly introduces the components of ritual: smudging or herb burning, a text for meditation, and the yoruba blessing. Simple directions are given for building an altar from a cardboard box. An exploration of paint and simple art experiences, coupled with reflective questions, conclude the chapter.

Chapter 2, "Reflections in the Inner Well," gives suggestions for using sensation and paint colors to explore emotions related to others. Additional art experiences focused on the self are discussed along with self-exploratory questions.

The third chapter, titled "The Reverential Eye," is the most integrated in the book. It includes a guided meditation and exercises in drawing from observations. Emphasis is on empathy and sensory exploration of the drawn object. An introduction to the color wheel concludes this chapter.

Chapter 4 explores the social self and briefly discusses play, autonomy, and trust. Trust is examined from five viewpoints: trust in teacher/facilitator (i.e., author), oneself, medium, process, and the divine creative force. Healing of relationships and personal healing are illustrated with brief anecdotes from the author's experience. Art experiences in this chapter incorporate the mandala, nonverbal communication, and conversation painting preceded by the "Machine," a synchronous group movement experience (pp. 139–140).

The artist as witness, prophesy, and the universal self are explored through collage exercises related to home, neighborhood, and city, in Chapter 5. The last chapter, titled "The January Time," is a period of transition between the past and the future. Diaz suggests reviewing one's visual expressions and gives suggestions for personal and public view of the work created. She includes short descriptions of the elements of formal expression, such as style, line, texture, force, and balance. One of the exercises is rewriting the Ten Commandments in the form of "I shall" rather than "Thou shalt not."

The author's concluding thoughts speak to a "New Renaissance." "Our descendants," she writes, will "read about how we began to carry pencils and sketchbooks everywhere. They'll learn how we healed ourselves and our cities by painting murals together and sculpting monuments out of recycled materials" (p. 183).

The book includes a section on resources, including descriptions of supplies, the "Five Minute-Teaching-Anybody-How-to-Draw Anything" guide, brief instructions on how to look at pictures, and working with groups. Her bibliography covers a fair list of readings in art, philosophy of art, and self-exploration. The most glaring omission is that of any art therapy references, especially Lucia Capacchione's *The Creative Journal: The Art of Finding Yourself* (1979), since the present work covers similar material. The only reference even somewhat related to art therapy is Margaret Frings Keyes' *The Inward Journey: Art and Therapy for You* (1974); this work is mentioned in the context of Jung's concept of the mandala.

After reading *Freeing the Creative Spirit* I could appreciate Diaz' intention to share her creative experiences and her basic structure of concepts related to self. The leaps of thought from brief glimpses on art and philosophical musings to self-exploration to detailed basic descriptions on where to obtain art materials and how to use them, however, appeared disjointed. Diaz' simplistic editorial comments throughout the book are annoying despite her assertion that the concepts shared "are not a Pollyanna philosophy. Reading ominous newspaper headlines and walking past the homeless on the streets takes me into the dark recesses of life's mysteries" (p. 181).

As an art therapist, I bristle at statements such as "working in groups . . . ensures everyone's emotional safety" (p. 115). My question is, "If it is a self-exploratory group, then who guides it?" Several times Diaz asks us to "trust me," but the above statement along with the nature of most of her art experiences makes me cautious. I hesitate to recommend this book to persons without previous training either in art or counseling, for whom this book is apparently geared. The 12 colored reproductions of visual expressions provide examples of the various art experiences; from these it is obvious that the author is talking about art experiences in art therapy and not artistic expressions. Another weakness is in the format and organization of the book. Different print sizes obstruct an easy flow from one part of the book to the next. On the positive side, however, the section related to art education is the strongest in philosophy and instructions. Specifics for supplies for each experience reflect the author's teaching experience.

Nevertheless, a few basic drawing experiences do not make one an artist or a creative individual, nor do a dozen and a half basic art experiences offer one deep and safe insight into one's personality. Art therapists with the appropriate training will benefit little from this volume. The book, however, dangerously has the power to create "creative meditation" instructors/therapists who use art therapy methods without the appropriate background training in art or counseling.

References

Capacchione, L. (1979). *The creative journal: The art of finding yourself.* Chicago, IL: The Swallow Press.

Keyes, M. F. (1974). *The inward journey: Art as therapy for you.* Milbrae, CA: Celestial Arts.

MARI®
Course in Mandala ® Assessment

30-Hour Course with
Certification of Completion

ATMA, Inc. Board of Directors
Association of Teachers of Mandala Assessment

Carol A. Bush, LCSW (804) 498-7220
Carol Thayer Cox, M.A.,A.T.R. (703) 371-4534
Jonna Douglass, M.A., L.M.F.T. (813) 784-7907
Paula Engelhorn, M.A.,A.T.R. (707) 539-7745
Phyllis Frame, M.A.,A.T.R. (804) 973-7543
Bonnie Smith-May, M.A.,A.T.R. (410) 576-0834
Lillian Rhinehart, A.T.R., M.F.C.C. (707) 539-0153
Deborah Glik, Ph.D. (310) 206-9548
Patty Morini, A.T.R., L.C.P.C. (207) 547-3291

For information on courses and
MARI® Card Test, call one of the above or
ATMA, Inc. (813) 784-7907.

The Creative Journal for Teens: Making Friends with Yourself

by **Lucia Capacchione, PhD, A.T.R.**, North Hollywood, CA: Newcastle Publishing Company, Inc., 1992.

170 pp., 48 black & white illustrations. $12.95 paper. ISBN 0-87877-175-1.

Reviewed by **Marcia L. Rosal, PhD, A.T.R.**, Louisville, KY

What do Anne Frank, Anais Nin, and a teen in your life have in common? According to Capacchione, they all have a need to express themselves privately, confidentially, and safely. Capacchione recommends the adolescent be given a journal. I couldn't agree more! Creative journal-keeping (Capacchione's term) can help teens discover who they are, how they feel, and what they need and want from others and the world around them.

This book about the creative journal-keeping process is written for teens. The text is simply worded in a down-to-earth style; yet, it is elegant and comprehensive, explaining why journalling can be enriching and describing the range of issues that can be addressed by regular use of a journal. Capacchione augments her recommendations for working in a journal with excellent examples from the *Diary of a Young Girl* by Anne Frank (1952), *Linotte: The Early Diary of Anais Nin 1914–1920* (1978), and examples from teens with whom she has worked.

Capacchione begins with an example of how creative journal-keeping helped her through a serious illness. This personal story links creative journal use to her inquisitive, curious, 15-year-old self. She observes how much adolescents know instinctively without being conscious of the range and depth of their understanding of the world. The short story ends with an endearing photograph of the author energetically learning to ride a skateboard!

Next, Capacchione helps the adolescent get started by discussing the basics of creative journal-keeping. She succinctly defines and describes the uses of pictures and words as journalling expressions, dispelling the myth that drawing and writing are only for those who possess talent or are creative. Talent and creativity are not prerequisites for this work. She sets guidelines for the journalling experience and discusses when journalling can be useful. Journalling requires honesty; Capacchione carefully creates a link between honesty and the need to feel the journal is sacred and private. The teen is assisted in setting guidelines and boundaries for maintaining this privacy.

Chapters 2 through 7 are devoted to helping teens use the journal. Exercises are presented under six main topics: (1) what's happening, (2) more about me, (3) getting it all together, (4) me and others, (5) my world, and (6) creating my future. The first three topics help the teen focus on the self and get in touch with feelings, thoughts, and ideas. Helping the adolescent to relate to others, including family, friends, heroes, significant others, and enemies at home and school, is the thrust of "me and others" and "my world." Exercises in Chapter 7 help teens to focus on their futures (hopes, dreams, and plans). Throughout the book, teens are encouraged to create their own journalling exercises.

The developmental plan of exercises is excellent and in concert with cognitive psychologists' view of treatment strategies for troubled teens. Capacchione confirms what I have experienced in working with preadolescent and adolescent clients—they need assistance in getting in touch with who they are before dealing with others and thinking about the future.

Particularly with troubled teens, focusing on the future can be especially useful. Often they feel stuck in time and sense that growth and change are beyond their reach. By helping them through a developmental sequence such as is outlined in Capacchione's book, even troubled teens can begin to sense some power and control over their destinies.

As in her previous books (1989a, 1989b), Capacchione does not claim this book to be a comprehensive text on creative journalling. Rather, it is a workbook for "hands on" journal-keeping by teens. In this regard the book is stimulating and may energize the teen in your life to begin a life-long commitment to creative journalling and self-discovery.

References

Capacchione, L. (1989a). *The creative journal: The art of finding yourself.* Hollywood, CA: Newcastle Publishing.

Capacchione, L. (1989b). *The creative journal for children.* Hollywood, CA: Newcastle Publishing.

Frank, A. (1952). *Diary of a young girl.* New York: Modern Library.

Nin, A. (1978). *Linotte: The early diary of Anais Nin 1914–1920.* Niles, IL: Harcourt, Brace, Jovanovich.

Dwight Mackintosh: The Boy Who Time Forgot

John MacGregor, PhD; Forward by **Irene Ward Brydon.** Oakland, CA: Creative Growth Art Center, 1992.

Monograph, paperback, 96 pp., 50 plates, $11.00 + ship/tax, from Creative Growth, 355 24th St., Oakland, CA 94612.

Reviewed by **Elizabeth (Liz) Ratcliffe, MS, MFCC, A.T.R.,** Book Editor

Just as John MacGregor's 1989 *Discovery of the Art of the Insane*, challenged long held attitudes about the aesthetic value of art produced by mentally ill and psychotic people, so his present little volume persuades the reader that the creative work of retarded people can represent aesthetic productions of high quality. MacGregor's monograph is focussed on a man named Dwight Mackintosh.

Dwight Mackintosh, christened here "the boy who time forgot," is not easily forgotten by any serious reader of this generously illustrated monograph on a still-living 86-year-old California outsider artist. Today, a silent shuffling old man, withdrawn under a Greek sailor's cap, Dwight is unaware of his surroundings unless they include paper, markers, and a familiar place to sit and lose himself in his uniquely expressive art work. Virtually unable to communicate with speech, his days are spent between a warm and caring board and care home in nearby Berkeley, and Oakland's Creative Growth Center for severely disabled adults.

Spurred on by his long-term interest and research in art of the mentally disturbed, author John MacGregor spent some two years as consultant, advisor, and friend helping Creative Growth's director Irene Brydon put together a 1992 symposium on Outsider Art. During those two years scholar-author-researcher MacGregor occupied many hours observing artist-client Mackintosh hunched over his table at Creative Growth obsessively producing his uniquely expressive art. Of this art MacGregor comments:

> His need to draw is clearly obsessional: when interfered with he manifests very marked anxiety and distress . . . powered by intense fantasy, he explores his inner world in endlessly varied drawings. . . . He is

> unmistakably compelled by forces beyond his control . . . drawing has, by chance, become his chief mode of communication; a means of establishing contact between himself and his environment, and beyond that with a world of which he is completely unaware. (p. 14)

In 1978 at age 72, Dwight Mackintosh was brought by his older brother Earl to Creative Growth, which in that era of massive mental patient evacuation from California state institutions, provided a friendly open environment for transition into community living. The Oakland center had been established with six artistically inclined clients in 1974, as a part-time community program, and was a natural choice for Dwight, who, recently discharged from Stockton State Hospital, had shown interest and talent in the Alan Short Center art classes there.

Prior to his six years at Stockton, Dwight had spent 25 years at each of two California state hospitals. His first admission had occurred in 1922 when he was 16. There are no records from that hospitalization, but later ones indicate that for 56 of his 86 years, his life experience had revolved around the loneliness and humiliation of institutional warehousing.

The fact that Dwight Mackintosh has survived into old age at all is near miraculous, let alone that his art increasingly is shown and collected in the U.S. and abroad, commanding prices from $500-$4,000 (Brydon, 1993). This financial bonanza has not affected his sense of self since he is unable to grasp the connection between his art making and its selling. At one point, when first his work began to bring in money through the Center's gift shop, the staff bought him a cornet in which he had expressed interest, thinking it might revive some past musical involvement. At first Dwight seemed entranced with his shiny new instrument and attempted for a full day to blow sounds on it; then, taking it home, apparently he forgot it, although in a few works he does include musical instruments.

Dwight's graphic style is essentially calligraphic, with rangy tendrils of undecipherable writing intimately married with the drawn scene into a distinctly personal statement. His major choice of subject matter, from the earliest known work to the present, has remained restricted: people (usually boys), motor vehicles, and buildings. In the early years vehicles were school buses (with or without faces in the windows); buildings were large structures (with cupolas, bells, or flags); and people were groups of boys (usually naked and with gigantic erect penises, perhaps involved in masturbation). It would seem that wellsprings for his graphic presentations were fed by past memories of adolescent institutional living and masturbatory fantasies. In keeping with starkly etched memories of teen-age male rituals involving motor vehicles, group living, and sex, black line was his chosen medium in his early pictures.

Gradually over Dwight's 14 years of productive work, changes have appeared, with colored pencils and chalk on pastel paper seriously entering his aesthetic repertoire around 1988. At that time his obsession with curvilinear writing also began to be replaced by perseverated strokes of color producing a warmly tinctured emotion overlay, previously lacking in his black and white work. MacGregor sees these changes as perhaps physically set in motion by a 1986 seizure, followed by neurological damage, and a series of small strokes. However he maintains that to

> suggest that Mackintosh's final phase is influenced by neuropathology can all too readily be assumed to imply that his work has been damaged. . . . While the changes in his physical and mental state are naturally reflected in his drawings, his graphic images have, paradoxically become freer, more powerful, and in purely linear terms, richer and more consistent. While he may be in decline, his art emphatically is not. Rather, an event rare in the history of art is occurring: the development of a true "late style." (p. 41)

Besides learning a great deal about the work of Dwight Mackintosh, author MacGregor was able to observe the other Creative Growth variously impaired artist-clients, making some intriguing observations to do with creativity and retardation. Staffed by 25 caring practicing artists, the Center's open happy atmosphere encourages the 120 clients' ability to concentrate for many hours without interruption, and to return to their work day after day with no loss of intensity. The author states, of the "possible effects of inhibited intellectual development on the image-making impulse. . . . It appears that even severe limitations in functioning do not interfere with creativity . . . may even enhance it" (p. 15).

Although the overall quality of art produced by Creative Growth clients is amazingly high, MacGregor sees Dwight's work as clearly having a place of its own: inside the camp of Outsider Art. Though less disabled than many clients, Dwight is without a doubt intellectually impaired: on the Goodenough Draw-A-Man test in 1974, he scored at the 8-year-old level; a year later in 1975, his I.Q. was found to be 56, mildly retarded. Yet Dwight is less able to function on his own than would be predicted from these results. The author attributes his low functioning, as well as the unique aesthetic quality of his art to a powerful natural artistic talent, which demanded to give expression to the endless years of institutional isolation where he experienced extreme physical and psychological deprivation and, quite likely, periodic withdrawal into psychosis. Thus marked, today his aloneness is profound.

> He has no strong emotional attachment to anyone. Beneath the shadow of his cap, he has withdrawn into a world of his own. Almost all of his mental experience now seems to originate from deep within and from long ago. He lives for the most part in a subjective realm of recurring images, memories and fantasy, into which it is but rarely possible to intrude. . . . Given his profound isolation and inward focus, what impresses one most is the urgency of his need to create. (p. 19)

These are the kinds of experiences MacGregor's research has shown to be contributing factors in the production of Outsider Art, sometimes called Art Brut. MacGregor quotes French artist Jean Dubuffet, originator of the term, "Two criteria are essential in identifying Art Brut: intensity of expression and freedom from cultural influences. . . . (These) works arise from spiritual states of a truly original kind, profoundly different from those to which we are accustomed" (1989, p. 301).

Surely for creative people of any sort, especially practitioners of art therapy, MacGregor's ideas and discoveries are not entirely new. However, at times we all welcome a powerful reminder of the healing truth which we ourselves have experienced and in which we are professionally trained. We do not all work with either psychotics or retarded people, nor do we need to discover outsider artists among the clients we see daily. But to turn the pages of John MacGregor's beautifully printed, compassionate monograph on Dwight Mackintosh supplied for me the thrill of a true success story, as well as a personal aesthetic tonic and a professional inspiration.

References

Brydon, I. W. (1993, October). Personal communication.

MacGregor, J. (1989). *The discovery of the art of the insane*. Princeton, NJ: Princeton University Press.

A response by **Bruce L. Moon, MACE, MDIV, A.T.R.**, to Matthew Bernier and Trudy Manning's review of *Essentials of Art Therapy Training and Practice, Art Therapy: Journal of the American Art Therapy Association*, Volume 10, Number 3.

I have been asked to respond to the review of my book, *Essentials of Art Therapy Training and Practice*. I find the process of reading reviews of my work to be both interesting and challenging. Generally, I am pleased by the supportive comments Bernier/Manning made, as well as stimulated by the constructive criticisms they offered.

Disturbing, however, are their repeated misrepresentations of what they describe as my, "attacks on the AATA degree guidelines." In the book I say, "It is of great concern to me that the guidelines generated by AATA for Master's Degree programs do not support continued engagement in studio art coursework" (p. 49). This is a fact. The Guidelines mention studio art courses only as possible electives. Many graduate students from programs throughout the United States have shared their worries that they have no time to make art while they are in art therapy educational programs. My concern is born of my love for the profession. This is not an attack. Surely this must be a matter of ethical concern for all art therapists.

The reviewers also question a passing reference made to a course, Studio Methods Seminar, that I taught at the Clinical Internship in Art Therapy at Harding Hospital. This refers to the last chapter of the book in which I share my artistic process of working through my mother's stroke and eventual death in 1991. Their comment is, "sounds like group art therapy." This comment seems to hold a mysterious edge of derision that I fail to understand. Bernier/Manning's misunderstanding of this chapter reflects other significant shortcomings of their review.

The final paragraph of their review begins, "In the practical world. . . ." This seems to suggest that *Essentials of Art Therapy Training and Practice* may not be a pragmatically applicable text. I remind the reader that I spend 40 hours a week in a psychiatric hospital filled with real patients who have significant emotional problems. I don't know how I could possibly write from a more practical perspective.

Video Review

Creative Arts Therapies at the PACE School

Produced by **Simone Alter Muri, EdD, A.T.R., LMHC**

25 minutes, color. Purchase: $60; rental: $40, from Simone Alter Muri, 56 Bradford Street, Northampton, MA 01060.

Reviewed by **Carmello Tabone, MA, A.T.R.,** Morgantown, WV

It may be necessary to view this video several times to truly appreciate what it has to offer. Hidden between the pictures, music, and rapidly moving narration is a valuable message about using the creative arts therapies, principally art and music therapy, with a predominantly autistic and mentally retarded adolescent and adult population. My first impression of the video was that it was little more than a promotional tape for the PACE School. However, upon closer scrutiny, I was able to recognize its potential value to art therapists, especially those who are contemplating work with the developmentally disabled. It not only provides the opportunity to see this population in action, but also demonstrates the effectiveness of arts therapies.

The video's narrative focuses almost exclusively on the creative arts therapies, broken only by comments by the school's director and various therapists employed by the school. Scenes from art and music therapy sessions demonstrate how the therapies are used and the goals they achieve. The happy faces of the clients involved in creative arts therapies should be more than enough to establish the effectiveness of this intervention.

The initial scenes explain the meaning of creative therapies and state they are used to help clients "discover new aspects of themselves or make changes in their minds." The narrator says these nonverbal therapies "encourage both the expression and resolution of conflict" and "encourage individual skill development and social interaction." The meaning of therapy, as it applies to this population, is defined as:

> an ongoing relationship between a trained specialist and a client that fosters acceptance, ability to share, trust, ability to make choices, skill acquisition, learning, ability to symbolize, self-esteem, release of tension, independence, and expression of pent-up emotions.

At this point, focus on the creative arts therapies stops, and an introduction to the PACE School is provided by its director. He gives essential background information about the clientele who are developmentally delayed adolescents and adults, ages 12 to 22 years. Most clients are autistic or mentally retarded. Many have behavioral problems at home and school, difficulty interacting with others, and communication deficits. The director also discusses the school's overall goals; this section seems quite unrelated to the arts therapies.

Switching back to the creative arts therapies, goals for music and art therapies are established. There are four main groups: (1) the need to develop better social or interpersonal skills, (2) the need for better developmental skills, such as improved fine muscle and gross motor skills, (3) the need for a strengthened sense of self, and (4) the need for a creative outlet which allows the expression of emotions or pent-up feelings. Later in the video, the first three goals are explored in depth. However, the one goal I consider most important to art therapists is the need for a creative outlet; unfortunately, an expansive discussion of this goal is omitted.

The next topic is on assessment of client strengths, weaknesses, and needs. Consultations with staff, evaluations of behavior, and an initial evaluation by the creative arts therapist are used to accomplish this task. At this point, the video would have been enhanced by a discussion and demonstration of specific evaluation methods used by the creative arts therapists.

The narration once again is interrupted by several short segments. The director provides details on funding the creative arts therapies program and the "crux of the program," and speech, art, and music therapists talk about their roles at the school. The art therapist discusses her successful work with three clients, providing this section's most interesting segment. A similar presentation is made by the music therapist. Although this review is aimed at art therapists, I must admit I was impressed with the work of the music therapist. She certainly seems to be a valuable asset to this program and easily demonstrates what an important role music therapy plays with this population.

Concluding the video is a comparison between art conducted in an "education system" versus that at the PACE School. We learn that "at the PACE School both the process and product are important." This contrasts with other programs for special needs children where emphasis is on production of stereotyped artwork.

This video's strength is the vast amount of information it offers on using creative arts therapies with the developmentally disabled. Its weakness is a lack of organization and formatting. An introductory segment that would provide an overview is missing. Several segments seem to be out of sequence; for example, clients are shown in therapy long before the population is identified. This could have been corrected by careful sequencing. Viewers who are unfamiliar with autistic and mentally retarded clients then would not wonder why apparently typical looking young adults were scribbling and communicating with difficulty. Several pieces of information seem unrelated to the film's intent; these include many comments by the school's director and the speech therapist's segment.

Technical quality also needs some attention. In some segments the volume of the background music detracts from the narration; in other places the sound quality is poor. Color varies from segment to segment, and a few scenes are out of focus.

Overall, I find *Creative Arts Therapies at the PACE School* has accomplished its mission. At this writing it is the only video that I know of devoted entirely to art and music therapies with autistic and mentally retarded clients. Just seeing this population in action is in itself valuable, particularly for the uninitiated who have never worked with the developmentally disabled. After reviewing this video, I am convinced it contains sufficient information to establish and justify a creative arts therapies program. I feel confident the video will encourage other art therapists to work with the developmentally disabled.

LOYOLA MARYMOUNT
UNIVERSITY

Graduate Department of
Marital and Family Therapy
(Clinical Art Therapy)

offers a

Master of Arts
in
Marital and Family
Therapy

For more information contact
Dr. Debra Linesch
Loyola Marymount University
7101 West 80th Street
Los Angeles, CA 90045
(310)-338-4562

- ***Approved by AATA since 1979 (One of the first five programs in the country to be approved)***
- ***Meeting California state requirements for MFCT licensure***
- ***Family Systems/Psychodynamic Orientation***
- ***Full-time and Part-time programs***
- ***Nationally respected and distinguished faculty***
- ***Committed to innovation and integration in models of art therapy and student-centered approaches to learning***

ANNUAL INDEX: VOLUME 10

Index A. ARTICLES

Appleton, V. E. An Art Therapy Protocol for the Medical Trauma Setting ... 71

Bloomgarden, J., & Kaplan, F. F. Using Visualization and Art to Promote Ego Development ... 201

Carrigan, J. Ethical Considerations in a Supervisory Relationship: A Synthesis ... 130

Councill, T. Art Therapy with Pediatric Cancer Patients: Helping Normal Children Cope with Abnormal Circumstances ... 78

Cox, C. T., & Frame, P. Profile of the Artist: MARI Card Test Research Results ... 23

Good, D. A. The History of Art Therapy Licensure in New Mexico ... 136

Junge, M. B., Alvarez, J. F., Kellogg, A., & Volker, C. The Art Therapist as Social Activist ... 148

Klorer, G. Countertransference: A Theoretical Review and Case Study with a Talented Client ... 219

Lachman-Chapin, M. The Art Therapist as Exhibiting Artist: Messages from Joseph Beuys, Suzi Gablik, and Donald Kuspit ... 141

Malone, S. N., & Rosal, M. Journey Toward Integration: The Use of Collages to Assess the Separation and Individuation Process of an Adult Identical Twin ... 16

Miller, C. L. The Effects of Art-History Enriched Art Therapy on Anxiety, Time on Task, and Art Product Quality ... 194

Robbins, A., & Cooper, B. Resistance in Art Therapy: A Multi-Model Approach to Treatment ... 208

Wald, J. Art Therapy and Brain Dysfunction in a Patient with a Dementing Illness ... 88

Index B. BRIEF REPORTS

Banks, S., Davis P., Howard, V. F., & McLaughlin, T. F. The Effects of Directed Art Activities on the Behavior of Young Children with Disabilities: A Multi-Element Baseline Analysis ... 235

Lusebrink, V. B. Art Therapy Faculty Survey ... 156

Lusebrink, V. B. Survey of Doctoral Work by Art Therapists ... 226

Silver, R. Age and Gender Differences Expressed Through Drawings: A Study of Attitudes Toward Self and Others ... 159

Index C. DEPARTMENTS

Viewpoints

Patrick, G. Shortell, J. R., Fleisher, N., Wilk, V. J., Brown, G. & Zemelka, A. Making the Unknown Visible: Panel Rounds at Franklin County Medical Center ... 30

Dufrene, P. Art Therapy in Mexico: Five Perspectives 39

Gerstenberger, S. L. The Ear of the Physician ... 241

Rabin, M. Full Circle ... 171

Ricci, M. L. Portrait of an Illness ... 96

Wirtz, G. Art Therapy in Private Practice: Legal and Insurance Issues ... 169

Book Reviews

Bernier, M., & Manning, T. Essentials of Art Therapy Training and Practice ... 173

Jones, B. D. Therapy? Unmasking the Fears, Shattering the Myths, Finding the Path to Wellness ... 175

Klorer, P. G. A Child's Story: Recovering Through Creativity ... 176

Lusebrink, V. B. Art as Medicine: Creating a Therapy of the Imagination ... 100

Lusebrink, V. B. Freeing the Creative Spirit: Drawing on the Power of Art to Tap the Magic and Wisdom Within ... 245

Ratcliffe, E. Dwight Mackintosh: The Boy Who Time Forgot ... 248

Rosal, M. L. The Creative Journal for Teens: Making Friends with Yourself ... 247

Sherebrin, H. Facing Death: Images, Insight, and Interventions. A Handbook for Educators, Healthcare Professionals, and Counselors ... 243

Smart, M. L. A Child's Story: Recovering Through Creativity ... 176

St. John, P. Creativity and Disease: How Illness Affects Literature, Art, and Music ... 103

Troeger, B. J. Exceptional Children, Exceptional Art: Teaching Art to Special Needs 44

West, T. M. MusicMedicine 105

Assessment Reviews

Hiscox, A. R. Assessment Review: Silver Drawing Test of Cognitive Skills and Adjustment: Drawing What You Predict, What You See, and What You Imagine. 46

Video Reviews

Jacobson, M. Psychimagery: Healing the Child Within 48

Muri, S. A. Visual Arts for the Physically Challenged Person 106

Tabone, C. Creative Arts Therapies at the PACE School 251

Editorials

Malchiodi, C. A. Art Therapy: The First Ten Years 190

Malchiodi, C. A. Introduction to Special Issue: Art and Medicine 66

Malchiodi, C. A. Introduction to Special Issue on Art Therapy and Professionalism: Is There a Crisis in Art Therapy Education? 122

Malchiodi, C. A. Reflections on the Annual Conference: Are Courage and Excellence Enough? . . . 2

Special Features

1993 AATA Media List 52

Call for Papers

Art Therapy is seeking submissions for two special issues:

✓ **STUDIO APPROACHES TO ART THERAPY**

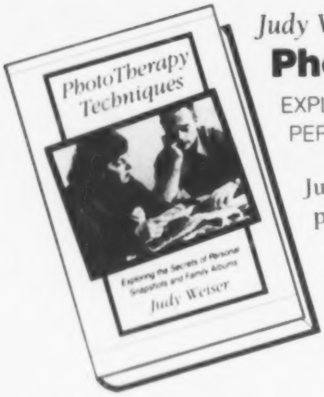
Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to applications of art therapy occurring in a studio setting or where the therapy takes place primarily through in-depth art making. Submissions may focus on any population. Of particular interest are the pragmatic, logistical, and political issues involved in applying art therapy to a studio environment. Theoretical papers are welcome, provided they are grounded in direct experience.

✓ **ETHICS IN ART THERAPY**

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to ethics and art therapy. Submissions may focus on, but are not limited to, ethical issues specific to the practice of art therapy, pedagogical considerations in the incorporating ethics in art therapy, training, ethics in art therapy research, and ethical dilemmas in exhibiting client art expressions.

DEADLINE FOR SUBMISSION IS APRIL 1, 1994. Please refer to "Guidelines for Authors" in this journal for specific requirements regarding style and format. All manuscripts should be submitted to:

Cathy A. Malchiodi, MA, A.T.R., Editor
c/o AATA, Inc.
1202 Allanson Road / Mundelein, IL 60060


PhotoTherapy Techniques
Exploring the Secrets of Personal Snapshots and Family Albums
Judy Weiser

New from Jossey-Bass Publishers

Judy Weiser

PhotoTherapy Techniques

EXPLORING THE SECRETS OF
PERSONAL SNAPSHOTS AND FAMILY ALBUMS

Judy Weiser shows how mental health professionals can use clients' personal photos and family albums as catalysts for therapeutic communication.

> *"We live in a world of photographic images, and it is time to engage them psychologically. Judy Weiser's wide-ranging ideas and methods will expand and deepen the creative arts professions."*
> —Shaun McNiff, author of *Art as Medicine*

August 1993 $38.95

Also available

Lourene A. Nevels, Judith M. Coche
Powerful Wisdom
VOICES OF DISTINGUISHED WOMEN PSYCHOTHERAPISTS
August 1993 $26.95

Jeffrey A. Kottler
On Being a Therapist
REVISED EDITION
July 1993 $14.95

James I. Kepner
Body Process
WORKING WITH THE BODY IN PSYCHOTHERAPY
A GESTALT INSTITUTE OF CLEVELAND PUBLICATION
July 1993 $26.95

To order call (415) 433-1767 or Fax (415)433-0499

A GUIDE TO CONDUCTING
ART THERAPY RESEARCH

Published by the American Art Therapy Association, 1992
261 pp., $35/$24 ISBN 1-882147-03-0

Highlights include -

- Art Therapy Research in Perspective: Before You Begin
- Basics in Research
- Methodological Challenges Specific to Art Therapy Research
- Resources for Art Therapy Research

ORDER FORM

Name__________ Member ID#__________

Street__________

City/State/Zip__________

Enclose corresponding payment: $35 (non-AATA members) or $24 (AATA members). Members must supply AATA membership number. Sorry, no credit card or purchase orders. Total price includes shipping/handling. Mail completed form and payment to:

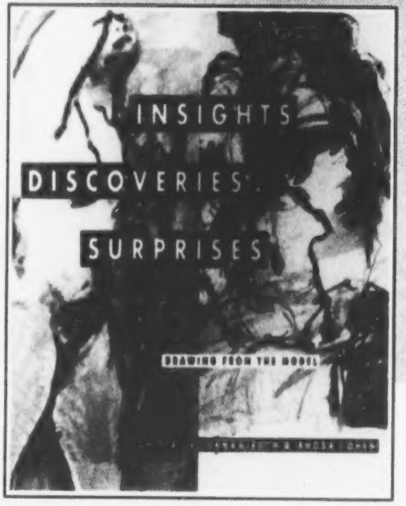
AMERICAN ART THERAPY ASSOCIATION
1202 Allanson Road / Mundelein, IL 60060

BEST COPY AVAILABLE

INSIGHTS, DISCOVERIES, SURPRISES

Drawing from the Model

Ghitta Caiserman-Roth and Rhoda Cohen



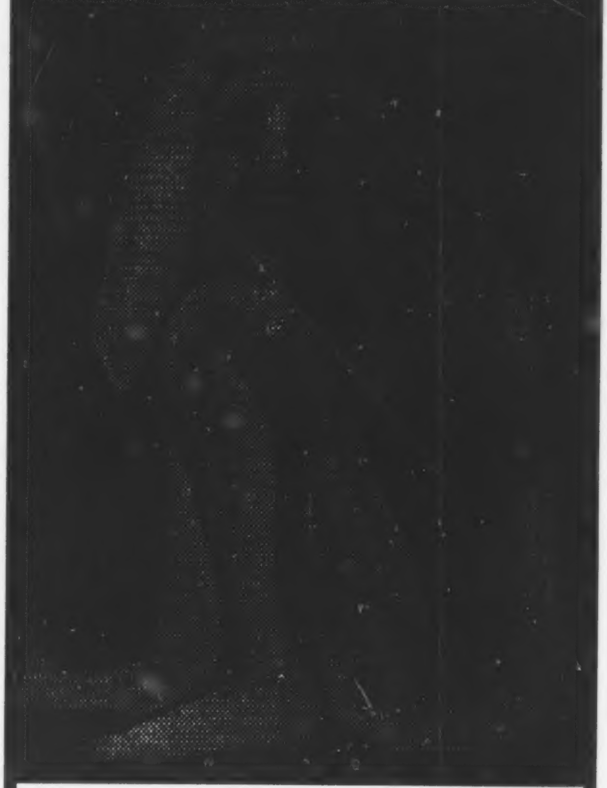
The authors, one a psychoanalyst-artist and the other an artist-teacher, reveal their struggles with the creative process. Combining candid dialogue, reproductions of their drawings, and practical teaching notes, the unique structure of this book allows the authors to share their creative approach to the subject-matter. The frank and personal disclosures and highly individual artistic styles of the authors will stimulate and encourage a diverse audience. Specialists in the psychological or psychoanalytical facets of creativity will be fascinated with this approach.

8 ½ x 11	26 colour illustrations	
Cloth	ISBN 0-7735-0993-3	$24.95

McGILL-QUEEN'S UNIVERSITY PRESS

Distributed in the US by:
University of Toronto Press,
340 Nagel Dr., Buffalo, NY 14225-4731
Telephone orders: 416-667-7791
(VISA and Mastercard accepted; postage will be added)

PSYCHIMAGERY



"TRAPPED" by J. Consoli

ANNOUNCING A NEW FILM

BY JIM CONSOLI, M.A., A.T.R.
DEMONSTRATING AN EFFECTIVE
FORM OF PSYCHOTHERAPY THAT
MINIMIZES RETRAUMATIZATION
AND INCORPORATES THE
DYNAMIC USE OF ART AND
"USHERED" IMAGERY.

Send for a free brochure or order now
*by mailing your name, address and a check for $80.00 + *$5.00 shipping/handling per tape in Continental U.S. (Virginia residents add 4.5% sales tax) *$10.00 per tape outside U.S. payable to:*

Medical College of Hampton Roads,
c/o The Graduate Art Therapy Program,
P.O. Box 1980, Norfolk, VA 23501

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone #s: ______________ work ______________ home

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ______________________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Black and white photos of original artwork plus 4 photocopies of each.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ______________________________ **Date** ______________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions**; a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

CHARLES C THOMAS • PUBLISHER

☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 242 pp. (7 × 10), 16 il.

It is the author's goal to completely introduce the complex and diverse field of art therapy as it is now practiced in the United States. This text touches the major themes and issues of the profession. This should be the first book, or one of them, which students new to the field read about art therapy. There is provided clinical service to many specific patient populations; the basic tenets are applicable to all human beings. For the past twenty years the author has worked with mentally ill patients and makes reference in a readily understandable manner of experiences with patients, colleagues and students. Art therapy can be used with the very young through the very old. No one is disqualified on the basis of gender or sexual orientation. Art therapists work with persons from all races, creeds and religious traditions. Art therapy is effective with individuals, couples, families and groups. It works well with the intellectually gifted and the learning impaired. It can be used with the chronically mentally ill, the terminally ill, the vision impaired and the deaf. It is a safe assumption that patients admitted to psychiatric hospitals have already tried to alleviate their emotional distress with traditional verbal psychotherapy without significant relief. It is the creation of an objective thing that separates art therapy from the work done by psychologists, social workers, psychiatrists and counselors. Art therapy is particularly effective with posttraumatic stress disorder—from aftereffects of war, physical, sexual or emotional abuse. This book describes the essential elements of the process of facilitating therapeutic change in forming a foundation from which art therapists construct treatment plans and philosophies.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 × 10), 24 il., $44.75.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $35.75.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¾), 34 il., $46.50.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 × 10), 1 table, $42.25.

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $32.25.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $23.50, spiral (paper).

☐ Lipton, Merrill I.—**POSTTRAUMATIC STRESS DISORDER—Additional Perspectives.** '94, 248 pp. (7 × 10).

☐ Anderson, Frances E.—**ART-CENTERED EDUCATION AND THERAPY FOR CHILDREN WITH DISABILITIES.** '94, 314 pp. (6¾ × 9¾), 100 il., 14 tables.

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $49.75.

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $62.75.

☐ Anderson, Frances E.—**ART FOR ALL THE CHILDREN: Approaches to Art Therapy for Children with Disabilities, 2nd Ed.** '92, 398 pp. (6¾ × 9¾), 113 il., 19 tables, $59.75.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¾), 21 il., $36.25.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $46.50.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $54.25.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $33.00.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $90.00.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $44.00.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $51.00.

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $51.25.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $30.00.

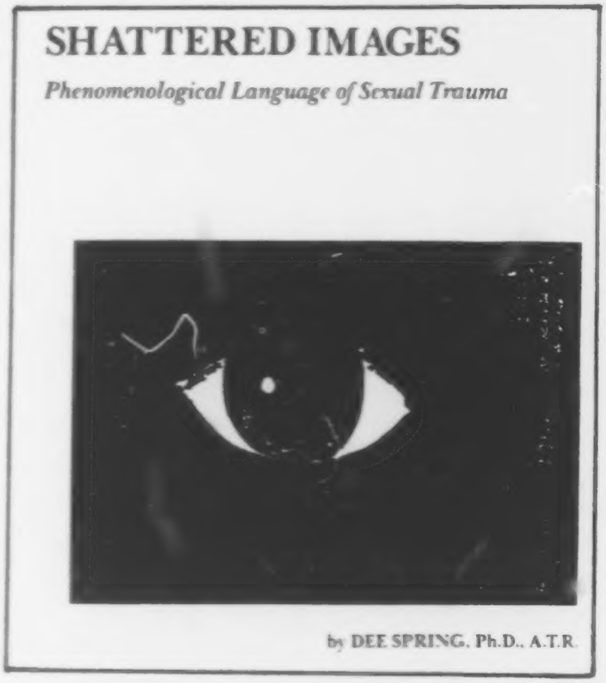
☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $25.25.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $48.50.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

MAGNOLIA STREET PUBLISHERS
— PRESENTS —



SHATTERED IMAGES

Phenomenological Language of Sexual Trauma

by DEE SPRING, Ph.D., A.T.R.

SHATTERED IMAGES: Phenomenological Language of Sexual Trauma

Dee Spring, Ph.D., A.T.R.

Dee Spring has specialized in the treatment of Post-Traumatic Stress and Dissociative Disorders for twenty years. Her pioneering efforts in this field have gained international recognition because of her unique treatment style which includes art therapy, imagery and hypnosis. This book presents a treatment model that simultaneously helps the therapist stay on track amid the myriad crises encountered with sexual trauma victims and creatively explains the complex, multi-level treatment process.

Featured throughout are 57 drawings by adult victims of sexual trauma. These drawings are at once disturbing, dramatic and hopeful, representing an intense private testimony that unwraps individual secrets.

ISBN: 0-9613309-2-9
Paper **$36.00**

GESTALT ART EXPERIENCE—Creative Process & Expressive Therapy, Janie Rhyne — Paper **$18.95**

DYNAMICALLY ORIENTED ART THERAPY: Its Principles and Practice
Margaret Naumburg — **$32.95**

— FORTHCOMING FALL 1993 —

ART AS THERAPY WITH CHILDREN, Edith Kramer

Second Edition. New updated material included. Available Fall '93.

prepublication price
Paper **$19.95**

CALIFORNIA ART THERAPY TRENDS, ed. Evelyn Virshup

A collection of articles and exercises by leading California art therapists. Available Fall '93.

prepublication price
Paper **$19.95**

MAGNOLIA STREET PUBLISHERS • 1250 W. Victoria • Chicago IL 60660 USA

Individual orders to:
STERN'S BOOK SERVICE
2004 W. Roscoe St.
Chicago, IL 60618
312-883-5100
Fax 312-477-6096

All major credit cards and checks accepted.
Add $4.00 shipping & handling per book.

Celebrating
AATA's 25th Anniversary
1969 - 1994

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 11, NUMBER 1, 1994

1623

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064, FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

ISBN 1-882147-22-7

The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue, July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, MA, A.T.R.
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Patricia St. John, EdD, A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor
Barbara Sprayregan, Psy.D., A.T.R.
Arlington, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Philadelphia, PA

Production Editor
Christine Fryer

Editorial Board
Pat B. Allen, PhD, A.T.R.
River Forest, IL
Frances E. Anderson, EdD, A.T.R., HLM
Illinois State University, Normal, IL
Doris B. Arrington, EdD, A.T.R.
College of Notre Dame, Belmont, CA
Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec
Mariagnese Cattaneo, PhD, A.T.R.
Lesley College, Cambridge, MA
Susan E. Cheyne-King, MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R.
The George Washington University, Washington, DC
Julie Epperson, MA, A.T.R.
Salt Lake City, UT
Janice Havlena, MA, A.T.R.
UNM Children's Psychiatric Hospital, Albuquerque, NM
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Vija B. Lusebrink, PhD, A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, EdD, A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Shirley Riley, MA, MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Susan Evans Spaniol, EdD, A.T.R.
Lesley College, Cambridge, MA
Betty Jo Troeger, PhD, A.T.R.
Florida State University, Tallahassee, FL
Evelyn Virshup, PhD, A.T.R.
California State University, Los Angeles, CA
Robert Wolf, MPS, A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President
Bobbi Stoll, MFCC, A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

1624

Celebrating AATA's 25th Anniversary — 1969 - 1994

VOLUME 11

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 1, 1994

Editorial

The 1993 Annual Conference: Rediscovering Our Common Ground — Cathy A. Malchiodi, MA, A.T.R. 2

Commentaries 4

Special Conference Section

24th Annual Conference Overview 7
HLM Award Acceptance by Gwen L. Gibson, MA, A.T.R. 10
DSA Award Acceptance by Deborah A. Good, MA, A.T.R. 12
Images as Angels by Shaun McNiff, PhD, A.T.R. 13
Soul and Spirit: The Image Instructs by Pat B. Allen, PhD, A.T.R. 17
Mystery: The Guiding Image by Cathy Moon, MA, A.T.R. 18

Special 25th Anniversary Section

Introduction 23
The First AATA Conference Program 24
AATA Award Winners—1970-1993 25
How Will the Profession of Art Therapy Change in the Next 25 Years? Responses by Past Award Winners — Harriet Wadeson, PhD, A.T.R., HLM, Gladys Agell, PhD, A.T.R., HLM, Virginia Minar, MS, A.T.R., and Janet Bush, EdS, A.T.R. 26
Photo Gallery 33

Special Section: Sexual Abuse and Dissociative Disorder

Articles

Diagnosis or Dilemma: Drawings of Sexually Abused Children — Maralynn M. Hagood, MFCC, A.T.R. 37
The Contribution of Art Therapy to the Dissociative Disorders — Patricia S. Murphy, PhD, A.T.R. 43
Abreacting and Assimilating Traumatic, Dissociated Memories of MPD Patients Through Art Therapy — Mindy Jacobson, MCAT, A.T.R. 48
An Application of Art Therapy to the Trauma of Rape — Karen Hargrave-Nykaza 53

Brief Reports

The Tongue as a Graphic Symbol of Sexual Abuse — Cay Drachnik, MFCC, A.T.R., HLM 58

Viewpoints

Looking In—Looking Out: An Artist's Journey Through Childhood Sexual Abuse — Jane Orleman 62

Reviews

Shattered Images: Phenomenological Language of Sexual Trauma — Susan Cristantiello, MCAT, A.T.R. 66
Casualties of Childhood: A Developmental Perspective on Sexual Abuse Using Projective Drawings — Barbara Faith Cooper, MPS, A.T.R. 67
Video Review: The Box: A Guide to an Interactive Film Project for use with the Arts Therapies — James J. Consoli, MA, A.T.R., NCC 68
Video Review: Archetypal Images and Art — Matthew Bernier, MCAT, A.T.R. 70
Video Review: The Life and Art of Peter Birkhauser — Matthew Bernier, MCAT, A.T.R. 70
Response to Book Review — Ellen G. Horovitz-Darby, MA, A.T.R. 71
Response to Video Review — Simone Alter-Muri, EdD, A.T.R. 71

About the Cover: "Isolation," oil pastels and paint sticks on paper, 35" × 47"; by Pat Harris, visual artist, Associate member of the AATA; author of *A Child's Story*. "'Isolation' is one piece in a series of four called 'Self-Bound Women.' The series depicts the loss of identity and voice, self-victimization, and feelings of isolation people experience as a result of surviving the trauma they experience from sexual abuse."

Editorial

The 1993 Annual Conference: Rediscovering Our Common Ground

Cathy A. Malchiodi, MA, A.T.R., *Editor*

When the title of the 1993 Annual Conference, "Common Ground: The Arts, Therapy, and Spirituality," was announced over a year ago, art therapists expressed a variety of preconceptions about the theme. Some connected it with the transpersonal or contemplative psychologies; others saw the theme as relating to religion; some felt it might be an attempt to replicate the success of the "Common Boundary" conferences which focus on the connections between psychotherapy and spirituality; and others worried that the AATA and art therapy might be stepping too far into the "weird."

However, as it turned out, the annual conference was much more than its theme may have implied from any of these perspectives, and was much different than many could have imagined. First, it was the most well-attended conference in recent AATA history (almost 950 registrants), which lent an energy that has not been present in the past few years. Also, despite the negative trends in the economy, the talk of art therapy positions being eliminated, and the threat to the future of the profession within the changing health care system, a hopeful and positive feeling gradually emerged that has not been present for quite sometime at AATA conferences.

Beginning with the well-orchestrated opening ceremony and presentation led by Cathy Moon, Program Chair, several themes which became pervasive throughout the conference were initiated. One theme which many found particularly stimulating was the important role visual art played in the opening session of each day. The use of a formal gallery-like slide show of art therapists' work at the beginning of two of the general sessions was both artistically impressive and inspiring, and demonstrated the importance of the central position of art in our work. There was also a great deal of sharing of personal art and art process in both the general sessions and individual presentations that followed, reinforcing the idea that personal art making can indeed be a valuable way of researching and clarifying theoretical and methodological issues in our field.

Additionally, the idea of unity was initiated during the opening session through many aspects, including a performance which encouraged audience participation. Although some people may have felt uncomfortable with group participation, it did indeed force a connection with others in the space (e.g., through the symbolic tying of pieces of string and yarn, among other aspects). The discussion groups which followed provided another forum for connection with others as well as a comfortable and humanizing environment for people to reflect on issues presented in each general session. Since the annual conference serves as a place for people to reconnect with each other each year, to get support for their often difficult and isolating work as art therapists, and to exchange ideas, this opportunity to meet and talk in such an intimate space was both congenial and collegial.

A third theme that emerged as the conference unfolded was a feeling of diversity. Although many art therapists initially saw the conference theme of arts, therapy, and spirituality as restrictive, it seemed to have no obvious effect on the diversity of presentations. There were numerous stimulating presentations, some related to the designated conference theme and others quite divergent in theoretical perspectives and philosophies. Attendees could find well-designed research studies and clinical applications as easily as heuristic explorations of the art making process and personal perspectives on the arts and spirituality. Additionally, there were a number of presentations that emphasized interdisciplinary themes (anthropology, feminism, art history, medicine, performance art, etc.) which were both refreshing and provocative.

In this 25th anniversary year of the AATA, it is important to remember that within the field of art therapy diversity has been our common ground. It is the diversity within the profession that has served as a stimulus and has given us vitality, it is also our diversity that sometimes bewilders us, inflames us, and often creates chaos within our ranks. As Editor, I am often confounded by the diversity in opinions informally expressed to me concerning the journal: some think the journal is too research-oriented, others say there is not enough research and that more rigorous research papers, particularly empirically based, should be encouraged, some readers feel there is too much emphasis on art and the language of art over principles of psychotherapy, managed care, and diagnostically related groups (DRGs), while others are left feeling the journal does not adequately represent art-based theories of practice; others would like to see more current paradigms (e.g., transpersonal, feminism, mind/body, social constructivism, etc.) presented, in contrast to those who find such thinking dangerous and controversial, and would like to see more emphasis on traditional theories and methodologies of psychotherapy.

16[illegible]6

This diversity of opinion can obviously be quite healthy; it is our collective ability to make connections between these diverse ideas that will see art therapy through the years ahead. Our ability to connect diversity within our field, allowing it to emerge as a strength rather than a disabling factor, will be necessary if we expect to survive as a profession with any life into the next century. There is plenty of room in our profession for art, quantitative research, spirituality, managed care, heuristic inquiry, psychotherapy, standards of practice, contemplation, licensure, studio work, and certification, as diverse as they sound; needless to say, there is room for all these topics and more on the pages of this journal. We must also remember that it is also our history of passion, of being for or against one or more of these diverse topics, that often has propelled us forward to new vistas and terrain, resulting in the growth of the field.

Lastly, although we may feel vehement about a certain theory or methodology and angered by another, we need not fear arguing with each other about what gives each of us the passion to continue on as art therapists. The point is that we need not be afraid of any of these ideas which make us diverse, nor do each of us have to embrace all of them simultaneously. The point is that as long as we allow for all of them and are willing to continue a dialogue with our diversity, we will have the stimulation and tools we need not only to survive as a profession, but also to keep our souls alive in the workplace and in life.

Art Therapy IS SEEKING SUBMISSIONS FOR TWO SPECIAL ISSUES

Studio Approaches to Art Therapy *Art Therapy* is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to applications of art therapy in a studio setting or where the therapy takes place primarily through in-depth art making. Submissions may focus on any population. Of particular interest are the pragmatic, logistical, and political issues involved in applying art therapy to a studio environment. Theoretical papers are welcome, provided they are grounded in direct experience.

Ethics and Art Therapy *Art Therapy* is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to ethics and art therapy. Submissions may focus on, but may not be limited to, ethical issues specific to the practice of art therapy, pedalogical considerations in the incorporation of ethics in art therapy training, supervision, and practice; ethics in art therapy research; legal aspects of art therapy practice; and ethical dilemmas in exhibiting client art expressions. Potential authors are reminded to consider the topic of ethics as specifically related to the field of art therapy, not counseling, psychology, or other related mental health fields. Submissions will be reviewed for publication in part on the ability of the author to make this connection.

Art Therapy is also seeking full-length articles, brief reports, and viewpoints for a **second special issue devoted to the use of art in relation to medicine.** Submissions may focus on, but may not be limited to, theory and application of art therapy to medical settings; the use of art therapy with specific populations (cancer, AIDS, chronic physical conditions); the relationship of art therapy to changes in healthcare delivery and the forthcoming national healthcare plan. Submissions which explore the connections between the art process and mind/body concepts and psychoneuroimmunology are also welcomed.

Deadline for submission for Studio Approaches to Art Therapy and Ethics and Art Therapy is April 1, 1994. Deadline for submissions for Art and Medicine is June 1, 1994.

Please refer to Guidelines for Authors in each Journal issue for specific requirements in terms of style and format. Please send all manuscripts to **Cathy Malchiodi**, A.T.R., Editor, *Art Therapy*, c/o AATA, 1202 Allanson Road, Mundelein, IL 60060.

Commentaries

Response to Dr. Lusebrink

I wholeheartedly agree with Dr. Lusebrink that a fruitful dialogue can occur between adherents of various approaches to art therapy, and I appreciate her engaging in dialogue on these pages with me. As Suzi Gablik (1992) notes: "Contradictions in beliefs offer not only the greatest depth of field, but also project clear alternatives from which to choose" (p. 27). However, as I have written previously (Allen, 1992), this dialogue requires consciousness in order for it to be useful. Art therapists, I suggest, need to choose how to practice based on clear intention rather than allowing ourselves to be wholly shaped by outside forces such as the health care system, insurance underwriters, or even our own beloved AATA as it evolves into an ever larger and more bureaucratic entity. While certainly many art therapists practice in a more clinical manner from both natural affinity and the conscious choice to work in clinical settings, too many believe they have no choice but to do so at the bidding of an institution.

We are co-determining factors in the making of reality. To again quote Gablik:

> What we are learning is that for every situation in our lives, there is a thought pattern that both precedes and maintains it so that our consistent thinking pattern creates our experience. By changing our thinking we also change our experience. . . . **The basic step is to confront what we actually believe. . . . (p. 27)** (emphasis mine)

To confront what one actually believes is no small matter. It is worthwhile to examine our deeply held attitudes for we are not the sole creators but are co-creators of our own reality. We share the creation of our work-reality with doctors, mental health and insurance professionals, administrators, and not least of all, those whom we serve as art therapists. Among this host of co-creators, if we are not the clearest voice for working through the art, who will be?

Dr. Lusebrink correctly identifies my approach to knowing as heuristic. This is a method of knowing which requires the taking within one's self of ideas, concepts, and feelings in order to discover meaning. Through the heuristic process, one discovers the fears, fantasies, and projections associated with an idea or feeling and over time thoroughly digests these in order to arrive at the essence or meaning. There is a recognition that there is no way to step outside one's self and be, in some detached way, "objective." Rather, the element of the subjective self is used in a rigorous manner towards the end of deriving meaning. Clark Moustakas (1981) quotes Polanyi (1958, pp. viii–6) in *Personal Knowledge*: "Into every act of knowing there enters a passionate contribution of the person knowing what is known, and . . . this coefficient is no mere imperfection but a vital component of his knowledge."

Sincerely,
Pat B. Allen, PhD, A.T.R
River Forest, IL

References

Allen, P. (1992). Artist-in-residence: An alternative to clinification for art therapists. *Art Therapy: Journal of the American Art Therapy Association, 9*, 22–30.

Gablik, S. (1992). *The reenchantment of art*. New York: Thames and Hudson.

Moustakas, C. (1981). Heuristic research. In Reason and Rowan (Eds.), *Human inquiry: a sourcebook of new paradigm research*. Chichester: John Wiley.

Polanyi, M. (1958). *Personal knowledge: Towards a postcritical philosophy*. London: Routledge and Kegan Paul.

Letters to the Editor

I wish to respond to your excellent editorial discussing Art Therapy and Professionalism in *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 122–128. My view is that art therapy must build on its own interdisciplinary roots. You made the point that art therapy is not fully articulated as a separate discipline in the sense that the body of literature is lacking vigor and relying heavily on the foundation of other fields. I wish to extend this argument with the help of the metaphor of amalgamation. My goal is to articulate a position that protects and develops the interdisciplinary values of art therapy.

If we look at the very structure of the name for our professional field, we see that art therapy is *interdisciplinary*, reflecting the combination of two fields of process—art and therapy. Let us consider a metaphor for art therapy as an amalgam, the admixture of metals. In art therapy, similarly, two processes, art and therapy, are combined.

As the literature of art therapy has developed, it seems that another metaphor has been misapplied—the metaphor of the alloy, a process in which metals are also combined. However, in the alloy process, a metal having a lesser value is generally used to reduce the purity of the mixture. The arguments for either "art" or "therapy" in art therapy seem to me to have been similarly alloyed by implying the "other" to contain the nature of an inferior. I hope we can leave behind the metaphor for art therapy as an inferior blend of either art and therapy or therapy and art. In its place I offer the metaphor of the amalgam, the intermixture of art and therapy. I further call for this interdisciplinary endeavor to be valued as a strong foundation for art therapy to build upon.

In looking ahead, if we are committed to the idea that art therapy is an interdisciplinary field, the new literature must reflect this interdisciplinary nature. While the literature has adequately, and at times painfully, reflected the growth of art therapy to its present stature, we must remember that the field is not fully grown, and for art therapy to be recognized as a fully functioning, mature, and unique field, rigorous literature must be produced. Our growth as a field has been reflected in literature that "relies heavily on the foundation of other fields," which has not been inappropriate. However, we must now move ahead and develop rigorous literature that does not neglect our interdisciplinary roots.

Your editorial made the valuable statement that we are "utilizing models of theory and practice that have not been informed by ongoing developments in other disciplines. Our inflexibility or unwillingness to incorporate new paradigms into instruction severely compromises our own vitality as a profession." I agree that new paradigms are needed to give continued potency to our development. And this points toward growth through incorporating ongoing developments in other fields that will enhance our own interdisciplinary development.

We must not discount the accomplishments of our profession that have brought us to the point of licensure and inclusion in the Older Americans Act. We are accepted as a separate discipline. Art therapy has been hardened in the fire of the growth process. However, for art therapy to move ahead and to function as an articulated field we must continue with the amalgamating process that has brought us this far. We must continue to develop as an interdisciplinary field.

Roberta Toby Pashley, MA, A.T.R
Marietta, GA

I am writing in response to your recent editorial in *Art Therapy: Journal of the American Art Therapy Association*.

My primary concern is whether art therapy can survive as a discipline. Your editorial underscored my fear that we are rapidly becoming a modality when you observed that "increasingly large numbers of art therapists become licensed under job titles such as counselor, marriage and family therapist, or psychologist." My predicament (as an art therapist trained at New York University) leaves me in the position of not being able to be licensed unless I go back for another degree, despite the fact that my coursework overlaps with MFCC requirements in California.

More worrisome to me, however, is that certificate programs are popping up to prepare applicants to become A.T.R.s in 21 credits if the applicant already possesses a Masters degree. It is my firm belief that art therapy is a discipline and that a Masters program in art therapy should be required because of the extent of the training involved. Certificate programs promote the idea of art therapy as a modality.

The irony is that my degree is not sufficient training in the eyes of the Board of Behavioral Science Examiners in California to be allowed to sit for licensure as an MFCC (even if I take 21 additional units). However, an MFCC could take 21 units and become an A.T.R. When I was accepted into a social work program, the requirement was to complete an MSW in order to be a social worker, regardless of whether or not I had a Masters degree. Why? It is because social work is a discipline, not a modality. The same should be said for art therapy. How can we expect to be taken seriously when we allow certificate programs? The training one would receive in a certificate program would be inferior to that which is provided in an MA art therapy program.

Furthermore, I am opposed to combining art therapy within MFCC programs. The discipline of art therapy seems to get too diluted and the focus seems too broad. I feel that instead of becoming MFCCs, we should push for state-by-state licensure as art therapists, define our field, and not blur the boundaries between us and other professions. We are separate but equal, with knowledge specific to our art therapy training.

Allison Brooks, MA, A.T.R.
Napa, CA

The Fall issue of *Art Therapy: Journal of the American Art Therapy Association* included your editorial which addressed the question, "Is there a crisis in art therapy education?" The editorial noted that during the foregoing year three AATA-approved programs have sealed their doors to new applicants and still other educational programs are in possible jeopardy. The paper linked this occurrence with several factors, yet, I feel your most significant observation is the question of whether art therapy is a discipline or a modality. The editorial contends that if art therapy is viewed as a modality, then it is unlikely it will survive within institutions of higher education. As a modality, art therapy will undoubtedly become embraced within other fields of study, where it will be assimilated into their scholarly pursuits.

It is reasonable to state there is a crisis in art therapy education; unfortunately, it may be our own striving to obtain state licensure that has contributed to this precarious turning point. Many training programs have adapted curricula in order for graduate students to obtain licensure in other fields of study. Granted this arrangement does allow students to obtain licensure which has become a requirement to practice therapy in many states, however, it may also give credence that art therapy is a modality rather than a discipline. By adapting art therapy curricula for the acquisition of professional licensure in other disciplines or to create indirect avenues of employment, we may be diluting our identity as a legitimate and distinct discipline. It is understood that licensure is a professional reality; however, obtaining licensure in other fields of study is a short-term solution and may impede our ability to secure recognition as a distinct discipline.

The recent licensing of art therapists in the state of New Mexico is monumental in the establishment of art therapy as a distinct discipline. It should serve as a model from which we can begin to build a strong educational foundation that will prepare our students for licensure as art therapists! Art therapy education may find it more advantageous to direct its attention to strengthening and expanding curricula which pertains to the students' professional skills and models of theory and practice. We must be careful not to presume that art therapy's survival is contingent on licensure from other fields of study as we struggle to obtain our own licensure. Let us not lose our identity as art therapists in the quest for professional licensure; rather, let us build our selfhood which will bring about licensure as an art therapist.

Michael J. Hanes, MAT, A.T.R.
Ada, OK

As an art therapy educator, I read your editorial, "Introduction to Special Issue on Art Therapy and Professionalism: Is There a Crisis in Art Therapy Education?", with great interest. I, too, have struggled with the question of whether art therapy is a modality—albeit a powerful, effective one—like behavioral, family, and play therapy, or a truly separate field for which we should offer distinct training programs. As a consultant to The Sage Graduate School, Albany, New York, I was asked to help develop a curriculum for a graduate art therapy program. The question of the value and efficacy of training art therapists was a difficult one.

As a new graduate of Pratt Institute's program in the late '70s, I was, at times, very angry at an institution which trained me for a career in which there were few jobs. Like many of my classmates, over the years, I created a variety of positions for myself and always did more than art therapy work. I provided numerous in-service training sessions and became skilled at networking. However, job mobility was always severely limited, and with the souring of our economy, the situation has worsened. I watched many of my peers return to school for social work or special education degrees. Most put art therapy on a back burner in their work with clients. Our journals continued to be authored by A.T.R.s with doctoral degrees. This left me confused and saddened.

In my work with clients and in case conferences, I was often struck by the sheer power of the medium of art and by the skills that I had acquired during my training as an art therapist. The frustration of working in such a clinically effective modality, which was so rarely understood or taken seriously by other mental health professionals, was never far from the surface. The issue of recognition among other mental health professionals will be an even more daunting one as our health care system changes.

With some reluctance, I recommended to the Sage committee that they develop a masters degree program in community counseling with a specialization in art therapy. I felt that such a degree would offer graduates greater job diversity, security, and mobility. I also made the decision to return to school in counseling psychology. I have found some of my coursework a review, and I am stunned by the absence of the creative therapies among the recommended interventions. This absence represents a real loss for the future clients whom these student therapists will encounter.

I hope that the AATA will continue to encourage the use of this modality. However, it is my opinion that in the coming years graduate art therapy program directors will be forced to take a hard look at the world of work into which they are sending their graduates. They will have to ask themselves how well their students are armed for success. While I would deplore the loss of art therapy training for mental health practitioners, I would prefer the development of training institutes similar to those for family therapists. I feel that every teacher has a responsibility to his or her students. Were I advising my own child, I would recommend a more generic, marketable degree, in concert with additional training in art therapy. I can offer no different advice to my students.

Lucille C. Larney, MPS, A.T.R.
Slingerlands, NY

The Interchange for Mental Health Professionals, a newsletter published by the Institute for Psychosocial Studies, is available to help art therapists be heard and make their profession known. This dynamic, new eclectic publication offers -

- a variety of strategies and techniques from a variety of different perspectives and disciplines for clinicians to use with clients.
- interaction among mental health professions so you have a chance to learn about different approaches to problems
- a boost in your morale:
  - overcome burnout
  - keep in touch with colleagues
  - survive supervision
  - tap into your creativity
  - advance your career
  - learn to stay objective
  - deal with hard-to-reach clients
  - develop fresh insights
  - renew a sense of faith in your profession

The Interchange for Mental Health Professionals is published monthly at a subscription rate of $39 for one year or $72 for two years. Please contact us at:

2300 Computer Road
Building C, Suite 3
Willow Grove, PA 19090

THE AMERICAN ART THERAPY ASSOCIATION
24th ANNUAL CONFERENCE

Atlanta Hilton and Towers/Atlanta, Georgia

NOVEMBER 18–22, 1993

November 18

Preconference Courses

Creativity/*Joan Bloomgarden*

Practically Speaking: Special Topics in Art Therapy with Severe Dissociative Disorder Clients/*Barry M. Cohen, Carol T. Cox, Anne Mills, Mary-Michola Barnes, Suzanne Des Marias*

The *Draw-A-Story* Instrument in School, Hospital, and Private Practice/*Elizabeth Conley, Peggy Dunn-Snow, Rawley Silver, Christine Turner, Mary Waterfield, Ky Wilson*

Sandtray Wordplay Therapy: Healing Body, Heart, Mind, and Soul/*Gisela Schubach De Domenico*

Knowing the Art Process: The Ground of Art Therapy/*Mari M. Fleming*

Introduction to Jungian Art Therapy/*Ethne J. Gray*

Addressing Societal Violence Through Family Art Therapy/*Cathy A. Malchiodi, Shirley Riley*

Magic and Metamorphosis: Firing the Imagination Through Stories and Art/*Joanne Ramseyer*

The Interplay of Transference, Countertransference, and Self Expression/*Annette Shore*

November 19

General Session:

Welcome/*Robin Goodman, Bobbi Stoll, Randy Vick, Cathy Moon, Comer Rudd-Gates, Christine Turner*

Mystery, the Guiding Image/*Cathy Moon*

Poster Sessions

Sentenced to Death: The Spiritual Journey Through Art of AIDS Patients and Their Families/*Beth Gonzalez-Dolginko*

A Correlational Study of Children's God-and-Self Drawings and Self-Concept/*Susan Patrick, Sarah P. Hite*

The Resilient Soul—A Case Study/*Lois Mirkin*

Study Groups

Working with Lesbian/Gay/Bisexual Clients/*William More, Tih H. Penfil*

Surviving the Conference: Tips and Information for Students/*Donna M. Addison, Meg Brumfield, Nataunya Kay, Julia Kuberka*

Issues Confronting the Pediatric Art Therapist/*Anne Prager, Valerie E. Appleton, Kathryn Bard, Erika Leeuwenburg*

Open Forums

International Networking Group of Art Therapists/*Patricia H. Grajkowski*

Certification/*Joan Phillips*

Education/*Mary St. Clair*

Meet the Board/*Robin Goodman*

Papers

The Scarlet Letter: Dual Relationships in the Supervisory Setting/*Jeanne Carrigan*

Nest Building: Children Recovering Themselves Through Art/*Debra DeBrular*

The AIDS Memorial Quilt—Art Therapy and Spirituality on Common Ground/*Judy Weiser*

The Arts/Therapy/Spirituality: Evolution, Impact, Responsibility, and Opportunity/*Evadne McNeil*

Art for Empathy in Adult Sex Offender Treatment/*Randall Overdorff*

Trauma Rages Without Boundaries: The Cross-Cultural Effects of War/*Rose Marano-Geiser, Marti Ising*

"Homecoming," or "I'll Draw Until I Have a Voice"/*Ursula Goebels*

Childhood Schizophrenia: Still Present But Not Accounted For/*David Henley*

Psyche and Soma: Considerations for the Pediatric Art Therapist/*Anne Prager*

Right From the Horse's Mouth: Interaction with Imagery in Art Therapy/*Robert Schoenholtz*

Presenting a Case Study for Art Therapy Supervision/*Bobbi Stoll*

An Archetypal Approach to Art Therapy/*Howard McConeghey*

A Contemplative Approach to Art Therapy: The Art of Healing and Authenticity/*Bernie Marek*

Art and MPD: Uncommon Realities/*Barry M. Cohen*

"The Rebels": Development of an Art Group with Resistant Sex Offenders/*Joy Ackerman, Marcia Rosal*

The Volcano Drawing: A Technique for Assessing Levels of Affective Tension/*Carol Thayer Cox*

Group Art Therapy with Attention Deficit Hyperactivity Disorder Children/*Katherine Jackson, Susan Carney*

Mainstreaming Art Therapy for Children with Disabilities/*Frances E. Anderson*

Art Therapy, Feminism, and Archetypal Psychology: Something's Rumbling in the Swamp/*Josie Abbenante*

Creativity: The Heart of an Ageless Spirit/*Judith Niemet*

Documenting Our Story: Art Therapy History/*Joan Phillips*

Panels

Homosexuality 101: What Every Art Therapist Needs to Know/*Donna M. Addison, Judy Weiser, Mary Hammond, Mike Barbee, Selvy Thiruvengadam*

Are There Doctors in the House? Does Art Therapy Need a Cure?/*Robin F. Goodman, Gladys Agell, Linda Gantt, Katherine Williams*

Workshops

Drive-Through Art Therapy: A Response to the Challenges of Brief Hospitalization/*Cecily R. Mermann*

Levels of Consciousness: Opening the Door/*Barbara Faith Cooper, Leonie Reisberg*

Adolescents: Creating a Challenge to Meet the Challenges/*P. Gussie Klorer*

Symbolism Explored from a Meditative/Spiritual and Object Relations Perspective/*Arthur Robbins*

November 20

Master Supervision Groups

Jungian Art Therapy/*Ethne J. Gray*

Art Therapy with the Elderly/*Drew Conger*

Art Therapy in the Schools/*Audrey Di Maria*

BEST COPY AVAILABLE

Medical Art Therapy/*Irene Rosner-David*

Multicultural Issues in Art Therapy/*Charles Anderson*

Art Therapy and the Treatment of Addictions/*Holly Feen, Lynn Jones*

Art Therapy and the Treatment of Eating Disorders/*Myra Levick*

Art Therapy with Very Young Children/*Ellen Horovitz-Darby*

Family Art Therapy/*Shirley Riley*

General Sessions

Award & Ceremony

Images as Angels/*Shaun McNiff*

Soul and Spirit/*Pat Allen*

Poster Sessions

Liberian Children Draw Their World at War/*Martha P. Haeseler, Gloria Small*

The Installation of a Geriatric Patient's Art/*Bernadette Callahan*

The Imagery of Unsanctioned Grief in Women Who Experience an Elective Abortion/*Kely J. Doolan*

Study Groups

Mandala/*Phyllis Frame*

AIDS: Sharing and Networking About Helping HIV+ Clients/Families/*Judy Weiser*

No Shallow Curriculum: Keeping the Soul in Art Therapy Education/*S. Kathleen Burke, Amy Jacobs, Gail Rule Hoffman, Richard Hoffman*

The Diagnostic Drawing Series/*Anne Mills*

Optimism, Realism, and Disillusionment: Conflicting Issues for the Experienced Clinician/*Shirley Riley, Judith Rubin*

General Session for Students

Open Forums

Public Relations and Art Therapy: Short-Term and Long-Term Goals/*Nancy Knapp*

Mosaic Committee/*Charles Anderson*

Research/*Nancy Sidun*

Papers

Art Therapy Research: New Models, New Understandings/*Debra Linesch*

An Art Therapy Group for Children of Divorce/*Barbra McIntyre, Julie Adams*

Video Art Therapy and Chronic Illness: Towards Evoking and Preserving Imagination/*Kimberly Bush, Diane Rode*

Transforming Vicarious Trauma with Therapists Through Art, Psychodrama, and Group Therapy/*Molly H. Guzzino*

Hard Time Art: Growing Old in Prison/*Marcia Taylor, Joan Castle*

The Use of the Mandala with Older People/*Janet Beaujon Couch*

Assessing the Emotional Content of Drawings by Adolescents/*Rawley Silver*

Art: Body and Soul/*Bruce L. Moon*

Shadow and Spirituality: Images of Trauma Survivors in Art Therapy and Sandplay/*Terri L. Sweig*

Art Therapy Treatment of Sexual Abuse Both Explicit and Implicit/*Judith Duboff*

Heuristic Inquiry—A Passionate, Personal Research Method Honoring to Art and Spirituality/*Nancy Barrett Chickerneo*

The Children's Diagnostic Drawing Series/*Elizabeth Leigh Neale*

Exploring Enlightenment of the Body Through the Use of Plaster Casting Material/*Sharon J. Robertson*

Art Therapy with Pediatric Cancer Patients: Helping Children Cope/*Tracy Councill*

Art Therapy in Jail: Doing Time, Sublimination, and Resistance/*Letty Lou Eisenhauer*

Group Art Therapy with Older Adults/*Judy Smethurst*

Betrayal: The Loss of the Guiding Image/*Lynn Kapitan, Lori Vance*

Panels

The MARI Card Test: Reflections on the Past, Considerations for the Future/*Joan Kellogg, Carol T. Cox, Kenneth D. Feigenbaum*

Exploring the Common Ground: Contributions from Related Fields/*Linda Gantt, Louis W. Tinnin, Katherine Williams*

A Continuing Dialogue on Non-Art Therapists Doing Art Therapy/*Anne Mills, Nancy Humber, Janie Rhyne, Wendy Vernon*

Art Therapy Supervision from Three Perspectives: Bioenergetic, Object Relations, and Spiritual Healing/*Arthur Robbins, Elaine Rapp, Sandra Robbins, Mary Cole*

Certification Is Coming (But I Hate Taking Tests)/*Leslie Buchanan, Anne Parker, Madeline Gray*

Workshops

Art, Bridging Psychotherapy and Healing—How to Get from There to Here/*E. Carbery Neal*

Witness of the Soul: Image as Teacher, Healer, Transformer/*Cam Busch, Susan Iorio*

The Construction of a Healthy Environment for Gay Men, Lesbians, and Bisexual Clients/*Barbara Ann Levy*

Buddhism and Archetypal Psychology: Mindfulness and Metaphor in Art Therapy/*Barbara A. Falconer*

Use of Film to Explore Countertransference Issues Towards Borderline Clients/*Abby Calisch*

November 21

Keynote Address

You Can't Fix It—and Besides, It Ain't Broke/*James Hillman*

Poster Sessions

The Personal Constructs of Depressed Men/*Michael Barber*

The Bridge as a Metaphor of Connection for Latency Age Boys/*Julianne Hertz*

Foundations of Creativity: Creativity Studies for the Art Therapist/*Sarah P. Hite*

Study Groups

Doctoral Study Group for Art Therapists/*Linda Gantt*

Spirituality and the Arts in Therapy: The Dialogue Continues/*Roberta Shoemaker-Beal*

Research in Academic Training and Professional Practice/*Nancy Knapp*

Open Forums

Governmental Affairs/*Terry Towne*

Standards Committee/*Sr. Mary Duffy*

Publications/*Audrey Di Maria*

Long-Range Planning/*Myra Levick*

Papers

Why Hast Thou Forsaken Me? Spiritual Abandonment Experienced by Victims of War/*Marty K. Ising, Marcia L. Rosal*

Conflicts and Triumphs of Co-Leadership of Expressive Therapy Groups for Abused Children/*Lori Shulkin Lowinger*

Parting the Veil Between Personal and Professional Identity: Integrating Spirit into Work/*Suzanne Lovell*

St. Francis of Assissi: A Twelfth Century Expressive Therapist/*Jeanne Carrigan*

Languaging: Examining the Verbal Component of Art Therapy Treatment/*Shirley Riley*

Group Art Therapy: Towards an Articulation of Theoretical Principles/*Laurel Thompson*

A Dynamic Duo: Art Therapist/Employee Assistance Professional/*Kathy Dowling, Stephanie Peterson*

A Three Step Family Systems Approach for Assessment, Confrontation, and Treatment Planning/*James J. Consoli*

Transpersonal Aspects of Art Expression in Processing Grief and Loss/*Cathy Malchiodi*

November 22

Papers

An Art Therapy Group Intervention to Address Chronic Career Dissatisfaction/*Ursula Goebels*

New Images for an Ancient Paradigm of Spirituality/*Nancy Barrett Chickerneo*

Drawings as Acceptable Evidence of Sexual Abuse: A Court of Appeals Ruling/*Sandra L. Graves*

Art, Therapy, and the Creative Spirit: Developing Inclusive Treatment Programs for Children/*Betty Jo Troeger*

The Creativity Continuum: Common Ground for Arts, Therapy, and Spirituality/*Evadne McNeil*

The Myth of Inanna and Ereshkigal: An Initiation Rite for Women/*Janne M. Wenzke*

Objectification of Self: A Study of Self-Image with Attention Deficit Hyperactivity Disorder (ADHD) Children/*Katherine Jackson*

Non-Dominant Handwriting as a Technique in Art Therapy: Creating Experience/*Joan Ritchie*

Finding the Sacred in Sandtray Therapy/*Phyllis Frame*

Psychology of the Artist: Piet Mondrian and Primal Scene Traumatization/*Ani Stern Buk*

Self-Esteem Enhancement Through Art Therapy/*Jerry L. Fryrear*

The Typology and Symbolism of Windows in Visual Expression/*Vija B. Lusebrink, Lisa Turner-Schikler, Joy Ackerman*

Art Therapy with Incest Survivors: Emotional, Cognitive, Spiritual, and Research Aspects of Treatment/*Frances E. Anderson, Marian B. Deitz, Cynthia R. West*

Images of Surviving: Art Ritual as Intervention with Sexually Abused Adolescent Females/*Linda Darrah Reynolds*

National Practice Study of Art Therapists/*Nancy Hall, Joan Knapp*

Feminine Identity/Spiritual Growth in a Father's Daughter Using Art/Sandplay Therapy/*Donna M. Johnson*

The Art Therapist as Expert Witness in Child Sexual Abuse Litigations/*Marcia Sue Liebman*

The Healing Power of Art: The Transporter Series/*James Torrenzano*

Art of the Soul: An Artist/Therapist Reflection on St. Hildegard's Imagery/*S. Kathleen Burke*

Wild Nature: The Gift of the Image/*Ginger Mongiello*

Spiritual Life of the Child: Robert Coles and Beyond/*Mimi Farrelly*

Identification with the Agressor as Seen in Children's Drawings/*Tiffany M. Groves*

From Sensation to Form: The Process Observed/*Mari M. Fleming*

Psychology, Art History, Art and Education, and Anthropology Contributions: New Perspectives for Art Therapy/*Janie Rhyne*

Assessing Attachment Patterns with the Bird's Nest Drawing in Family Art Evaluation/*Donna Kaiser*

Idiosyncratic Religious and Demonic Themes in Art Therapy: Implications for Treatment/*Elyse Capell*

Hypomania vs. Hyperactivity: Using Art as an Instrument for Differential Diagnosis/*Deirdre M. Cogen, Margaret Eife*

Healing Through Art: The Native Indian Way/*Nadia Ferrara*

The Art of Anger: Imagery, Anger Management, and Conflict Resolution/*Frances F. Kaplan*

Panels

Art Exhibiting for Building Awareness of the "Human Condition" by Art Therapists/*Julia Byers, Abby Calisch, Leland Peterson*

Death and Wilderness in the Creative Process: The Importance of Remembering/*Josie Abbenante, Debra Vetterman, Ginger Mongiello*

Documentation in Art Therapy/*Martha P. Haeseler, Lani Gerity, Carol Greenlaw, Edith Kramer*

Workshops

Mining Our Inner Wisdom: Exploring Emptiness/Space as a Spiritual Reality/*Marianne Hieb*

Women in the Tower: Theatre for Psychospiritual Growth/*Roberta Pashley*

Not Everything Is Good in Genesis One/*Jo Milgrom*

Thirsting for Wholeness/*Leonie Reisberg, Linda Siegel*

Spiritual Wounds and Vicarious Trauma/*Molly H. Guzzino*

Exploring the Relationship of Ritual to Art Therapy/*Randy Vick*

Art Therapy Educators' Convocation

Follow Through: Art Therapy Style

Gwen Locke Gibson, M.A., A.T.R.

1993 Honorary Life Member, awarded at the 24th Annual Conference of the American Art Therapy Association, November 20, 1993, Atlanta, GA

Gwen Locke Gibson, MLA, A.T.R., HLM began working as an art therapist at the Baltimore City Psychiatric Day Treatment Center in 1968 in pioneer capacity. In 1972, Gwen earned the A.T.R. under the regulations at that time; she could have received the grandfather clause but chose to establish her credentials. She earned her BA in 1967 at Towson State University, her MLA in 1975 at Johns Hopkins University. Gwen has a certificate in Family Therapy Training from the University of Maryland Medical School. (Gwen received a certificate as medical laboratory technician in 1943 from the University of Pennsylvania, worked in that field while her husband completed medical school until the birth of Robert W. Gibson, Jr. in 1950.)

Gwen assisted in the early organization of the Maryland Art Therapy Association. She is well respected for her countless hours of teaching and supervising students, also for supporting and organizing art therapy positions in her home region. Nationally, Gwen held numerous offices in AATA beginning in 1972: chairing research on initiating local chapters, Treasurer, President-Elect, Chair of 1976 Conference Program, Co-Chair of overall planning of 1976 Annual Conference, President 1979–81. As President, Gwen distinguished herself by taking on and resolving many organizational conflicts. During this time, the decision was made to obtain a management office for extended services. Gwen singlehandedly established the "art therapy registered" privilege with the United States Department of Patents and Trademarks for AATA use only! Gwen was AATA's Chairperson with the National Coalition of Creative Arts Therapy from 1979–81; was a participant and co-planner of the June 1979 Coalition Conference sponsored by the Falk Foundation through the American Psychiatric Association. Her leadership, judgement, and character helped guide AATA through a very important period of history, achieving a unity of purpose.

Gwen has published numerous papers on art therapy practice, has spoken in a variety of forums to educate art therapists and the public on the uses of our special talents. This includes radio and T.V. interviews plus regular appearances in sociology, psychology, and art classrooms in college and graduate school settings.

Since her presidency, Gwen has served on various AATA committees. Most recently, she chaired the Committee on Ethics and Professional Practice; this is a heavy responsibility requiring careful evaluation of cases, consultations with legal counsel, setting up procedures and forms for committee use, practicing strictist confidentiality. Gwen guided this committee through its first years with her usual quiet, diplomatic manner. Her wisdom, problem-solving skills, professionalism, understanding, clinical expertise, reliability, dedication to art therapy, and willingness to serve AATA many hours out of a single week make her an outstanding role model for all art therapists.

Gwen is now 70 years old. She retired from full-time employ at the Psychiatric Day Hospital, Francis Scott Key Medical Center, a Johns Hopkins Institution in Baltimore. The Day Hospital persuaded Gwen to return 2 days a week. Gwen has also consented to serve AATA this year as member of the Long Range Planning Committee. She is current chairperson of the Maryland Art Therapy Ethics Committee.

Gwen considers her greatest joy and pride to be her beloved family: Gibby, his wife Chris, and children Rob and Caroline; Christopher; Peggy, her husband Irv, and children, Molly and Evan Klein. She and Robert Gibson, MD divorced in 1982 after 37 years of marriage.

The Honorary Life Member award is the highest, tangible expression of gratitude that one can receive from peers of the American Art Therapy Association. I thank all of you who forwarded my name as a candidate. I thank the Honors Committee and AATA Directors whose first appraisal found me to be deserving of acclaim. I thank the AATA members for the ballot vote of final approbation.

With modesty, I accept this gift in the company of all the "angels which sit upon my shoulders." These angels are AATA members past and present who have labored with me to make the practice of art therapy a viable profession. Some are in the audience today. They are the committee members, pioneers, practitioners, teachers; not the least of the angels are my three kids: Gibby, Christopher, and Peggy who shared me during times when "I owed my life to the company store." Ex-spouse Bob Gibson encouraged and supported my involvement, as well.

Taking part in the growth and development of a profession has greatly influenced my personal strength and maturity. I used to be painfully shy. When I was a youngster, my head rested more often upon one shoulder in vain efforts to hide it under one of my arms. Parents and teachers pushed me into action, because they had more faith in my potential than I did. In elementary school days, my stomach would get queasy when I was pressed into a new undertaking. Even my successes bred more stress. For example, my beloved, long-time violin teacher decided to switch me to study with a violin "master." I upchucked first, and then auditioned. I passed the audition; however, I did not wish to make a serious commitment to this one instrument. Why follow through on a path which was not of consuming interest to me? I learned to go with "gut reaction" (excuse the pun), and assert the space comfortable for me. I enjoyed my role as member of the orchestra rather than aspiring to be a solo performer. Team participant, not the star.

"Follow through" became a personal pursuit when the task was important to me. Another sample of increasing self awareness began in 1939 when I joined a group of Quakers who shared my need to make efforts for world peace. We toiled all summer with workshops for children, helping them to design anti-war posters. We met with the parents to raise their consciousness to seek alternatives to global disputes. In the process of championing the ideal of world harmony, I discovered my shy voice was changing to bold and authoritative speech. Further, in the mid-1940s, our Quaker activities involved interracial volunteers who organized weekend work crews in the Philadelphia area (sort of like Habitat); we also shared once-a-week art lessons at an interracial "Y." During the AATA Conference in Denver, I skipped out to join Friends (upper case and lower case "F") in a silent vigil in the height of noon-time hustle around the War Memorial Square re: issues of U.S.A. intrusion in Central America. My commitment to peaceable negotiations continues; the follow-through felt good.

My immediate family has always been the #1 cause for me, and will always be. In 1968, art therapy became the #2 cause worthy of my time and efforts. I loved the career I launched in 1967; I vowed to learn more ways to help patients; I wanted to become an able teacher and supervisor; serving AATA was the way.

By the year 2020, I hope many more art therapy pioneers will emerge. It is true we appreciate Naumburg, Kramer, Kwiatkowska, et al., and celebrate their contributions to revive and redirect the ancient connections between art and healing. The ideal is that pioneers should not be frozen in past times. At this moment, an art therapist pioneer is traveling the birth canal. If we do not believe in this continuity and fail to nurture "new blood," the American Art Therapy Association will stagnate. Let us not deify the founders to the exclusion of acknowledging the contributions of the young.

This 70-year-old brain has 25 years of AATA history among the incised trails of memory. May I share some personal concerns? The Presidents of AATA come and go; historically, management firms and lawyers have come and gone. (I hasten to say I have no current knowledge of change, for the relationships appear mutually agreeable.) We must keep a continually up-dated text of past and present obligations to give to incoming leaders to assist them in the performance of duties. For example, as Treasurer and member of the 1975–1977 Finance Committee, upon the advice of a bank president friend, I established a "rule of thumb" to maintain in our treasury the dollar amount equivalent to one year of the association's operating expenses. This regulation assures a safety net for unforeseen budget demands and/or emergency funds; otherwise, AATA could go bankrupt after one year's disaster. Follow through on this advice.

As President in 1980, I applied to the Patent and Trademark Office in Virginia to register AATA's A.T.R. for registering art therapists. Every 10 years, this official record must be reconfirmed in writing, accompanied by a required stipend. The United States Government does not send reminders or bills, so our AATA leadership must note the due date and take responsibility to communicate the association's goals and purposes plus assurance of the continued use of A.T.R. We need a "red letter" document or manual like a "hot line" listing when the date confirmation is due. Follow through is vital for our registry trademark; otherwise, we lose it.

It concerns me that not all AATA members realize the distinctions of business management's functions as compared with the association's professional leadership. Too often, I have heard art therapists say, "I called AATA Office about a great idea—or—about my complaints. They gave me names of other persons to call. I didn't call, because I thought it was enough to give my message to the office." Some members view the Mundelein site as "Big Daddy" or "Big Momma"; some believe the staff is made up of art therapists. This inability to make a distinction must pose a headache for Stygar Associates also. The individual with the distorted perception fails to communicate with appropriate Directors or Committee Chairs. Is there a way to clarify naiveté? To increase direct communications?

AATA has made great strides: setting educational guidelines, more schools offer art therapy training, an increased number of hiring persons recognize the effective results of art therapy interventions, procedures for ethical practice are in place, etc. Setting up testing and the credentialing board activities will be costly, although valuable to assure competent clinicians. Further, I hope we can afford to create our own computer data base discs to inform the public about the many uses of art therapy. Directors and managers of psychiatric, medical, educational, and penal institutions rarely have knowledge of our existence. Some who express a desire to read art therapy papers and research projects have searched information data bases with little or no success. The same dead end is met by students of art, social work, nursing, and others who want to survey our modality to discover ways in which we can work together. Could AATA's Public Information and Publication Committees study ways to make possible this important source of exchange? I believe we were once listed in psychiatry's data base; but there may not have been the necessary follow-through to maintain the connection. Are we testing and credentialing persons who may not find employment placements, because sufficient agencies have not discovered us? Let us not keep secret our creative abilities to make a positive difference in relieving the suffering of patients and clients. Similar to the practice of wholistic medicine, we must demonstrate wholistic attention to association development.

You might ask, "Were you cured of your shyness, Gwen?" My response is that I get "flashbacks" from time to time, however, commitment to a cause bigger than self is the "medicine." I believe in art therapy, I love my colleagues. It is exciting to stand shoulder-to-shoulder with you. When standing shoulder-to-shoulder, you can't hide your head under your arms even if you wanted to.

More AATA members must become personally involved. Some may be waiting for a colleague to invite them into service. Don't hesitate, please write or phone the president or president-elect to announce your willingness to carry a baton in a committee of your special interest. Follow through, and make this profession the best you could wish it to be. My greatest reward is the friendships, the support, and caring; it could be your reward, too.

Post Script: I promise not to rest on my laurels. I will serve AATA as long as destiny permits. Thank you for my HLM.

1993 Distinguished Service Award

Deborah A. Good, MA, A.T.R.

24th Annual American Art Therapy Association Conference

November 20, 1993, Atlanta, GA

Deborah Good is currently the department chairperson for the art therapy masters degree program at Southwestern College in Santa Fe, New Mexico. She has a private practice which includes contract work with Family Therapy of Albuquerque, Albuquerque Public Schools and New Vistas. She is also a doctoral student in the Counseling Department at the University of New Mexico.

Debbie has worked extensively in numerous hospital and outpatient settings. She has served on many state and national committees, including: AATA Cinical, AATA Governmental Affairs, AATA Registration and Standards, NMATA Governmental Affairs, NMATA Conference Program Committee, Co-Chairperson for the Four Corners Expressive Therapy Conference, NMATA Board of Directors, NMATA president, and the Biopsychosocial Task Force for JCAHO. Debbie also was elected to the AATA Board of Directors from 1989–1992, where she served as AATA Board liaison for the Clinical and Governmental Affairs Committees. Currently, she is the Chair of the AATA Nominating Committee.

Her teaching history includes receiving the "Outstanding Teacher," Univeristy of New Mexico Student Evaluation Award while a graduate student in art therapy. More recently she received "A Friend of Music Therapy Award" from the southwestern region of NAMT, Distinguished Service Award from NMATA, "Extraordinary Support Award" from Webster University, and "The 1993 Outstanding Faculty Award" from Southwestern College. She has been a visiting instructor at Mount Mary College and the University of Utah.

Debbie has been a speaker for the AATA Regional Symposium on Sexual Abuse and PTSD. Recently, she became the head of that team. Her list of presentations are extensive, ranging from clinical issues to legislative concerns. In 1988, she wrote the first state legislation to license art therapists. Debbie lobbied and testified for this bill during the 1989, 1991, and the 1993 New Mexico legislative sessions. The bill was successfully passed, and officially signed into law in the state of New Mexico as of July 1, 1993.

Thank you! I am honored to have been chosen as the fifth recipient of the AATA Distinguished Service Award. I am also honored today to have two very important people in my life here. They are responsible for molding me into the person that I have become. They taught me:

. . . to have respect for others and their opinions, but to develop my own by trusting my intuition,

. . . to have passion in what I do for a living always remembering that all I do affects others, not only myself,

. . . to make decisions after weighing all the options;

. . . to admit to being wrong, as well as, being right;

. . . and to make a difference in the world by being myself.

I'd like to introduce to you my parents, Benny and Polly Good. Thank you for being here for me today.

As I thought about what I wanted to say to you, I remembered myself in 1973, 20 years ago, as an art educator in an alternative prison program for young adolescent males. There I realized that what I was doing was more than art education. I realized that there was a therapeutic encounter happening between these disturbed young men and their art making. I remember, like it was yesterday, the first time that I pushed paper and crayons under the door to the lock-up security room. Minutes later drawings were slid back to me expressing more than this troubled teen could put into words.

I grabbed everything I could find that was written on art therapy and began to work toward my career as an art therapist. A year later, I was involved in a debilitating automobile accident that left me with a seriously injured spine and partial paralysis. After going through a cervical fusion and three years of physical therapy, I moved to New Mexico and pursued my Master's degree in art therapy at the University of New Mexico.

I have a history of starting things. I guess we all do as art therapists. I had already learned that time waits for no one and that today is what is most important in life. (A serious illness will teach that very quickly.) In keeping with our spiritual theme for this conference, I can tell you that I lived through a broken neck for some reason.

I was the first true art therapy student at the University of New Mexico and the first student from that program to receive my A.T.R. Along with the other art therapy graduates, we started art therapy programs across New Mexico, creating our own internships, job descriptions . . . and our future employment.

I quickly realized how volatile and precious my relationships with my clients were when I watched people prepare to die as life forms left their pictures and spirit guides appeared in the upper left-hand corner of the paper. Deaf adolescents told of date rape through their artwork because they couldn't verbally communicate; an autistic child learned to focus through gross body movements while painting on a wall, homicidal prisoners created a wall mural through which they could visualize and problem solve; and severely abused clients retrieved and processed memories through sequential drawings that enabled them to become empowered in their lives.

Our training to be registered art therapists is rigorous, and rightfully so. We interact with people through the unconscious images that they create with so much trust, in our presence. We meet them on a soul level. It is our strength and our vulnerability. And with this connection comes an immense responsibility, that has too often become violated by counselors and therapists. This is the reason we need licensure—for our protection and for the clients'. I decided a long time ago that if and when I became licensed, it would be as an art therapist because that is what I am.

I saw that art therapists were lagging behind other professions in state and national regulations. We are *gifted* practitioners, and we had no choice but to mold into other professional categories in order to become licensed and recognized as legitimate. I felt that we deserved to be recognized for who we are and what we are trained to do. This was the impetus behind the creation of the first art therapy licensure practice act.

Rev. Francis Rath said once that "today depends on the vision one has for the future. Historically, without a vision, people perish. The future creates the present rather than the present creating the future." Our dreams make us who we are. Acting on those dreams gives purpose to the here and now. I believe in the power of art therapy and through the spread of state licensure, art therapy will not perish. We need to keep abreast of the times and current, if not ahead of, other helping professions.

For me the Counselor and Therapists Practice Act, regulating art therapists as Licensed Professional Art Therapists (LPAT), which officially became the first law of its kind on July 1, 1993, has been the highlight of my year and professional career. It will affect many people, not only New Mexico art therapists. This state licensing law does not require residency in New Mexico. It is possible for art therapists living in other states to become licensed in New Mexico and practice in their home state. Time will provide the answers to the impact that this will have on the art therapy profession.

I want to leave you with a quote from George Bernard Shaw's play *Back to Methuselah* that seems to bring summation to what I have been trying to say, and what I want you to remember. The serpent speaks in the garden of Eden and says, "You see things as they are and say why? But, I dream things that never were and say why not?"

Thank you very much.

Images as Angels

Presented at General Session, 24th Annual AATA Conference

Shaun McNiff, PhD, A.T.R. Cambridge, MA

The figures we know as angels have many names—daemons, spirits, jinii, faeries. They are a way of looking at things, a perspective, a poetic view, or what Jung would call a "psychological fact." Japanese rituals acknowledge the ghost of the teapot, and Native communities everywhere imagine spirits inhabiting hills, rocks, and trees.

When I view my creations as angels, imagination is welcomed. Reason is not abandoned, but it steps aside and invites other participants.

The classic scenario when a person is ready to acknowledge an image as a living thing and dialogue with it for the first time sounds something like this: (Speaking to a picture) "I don't know what you mean. You're a puzzle I can't solve. What do your symbols and colors mean?" James Hillman who will be speaking to you tomorrow says, "Do you ask the person who arrives at your door, 'What do you mean?'"

In extending hospitality, we greet the person, spend time together, talk, enjoy each other's company, and afterwards feel enriched or ensouled by the visit. Isn't this a perfectly adequate way to practice art therapy?

I realize that uninvited and disturbing guests also arrive at our doors and I will speak about them shortly. For now, let's stick to the image that our artist found puzzling.

Solving a picture is not likely to open the soul. As Jung said, when I try to explain an image, the birds fly away. The "puzzle perspective" on art gets all of the energy stuck somewhere in the head, and even when it moves, the process is euphemistically called "mental gymnastics."

There was tension in the face, around the eyes and mouth, of the woman with whom I was working. I suggested welcoming her image and simply reflecting on the energies of its expression, telling it how she feels about its qualities. Whenever someone begins to talk with pictures in this more intimate way, the conversation slips down to the heart.

I imagine the images loving these engagements. They say, "Art therapy, put your heads aside for awhile, keep our mysteries, feel our vibrations, our visual qualities, our beauties and provocations. Dance with us in different ways."

We are so intimidated by the "touchy-feely" label that we have overcompensated with the analyzing mind, repressing the feeling function which is the way art heals the soul's wounds.

When images express themselves and act upon us, they are behaving in ways that correspond to figures we call angels. If art therapy can accept a correspondence between a picture of a lawnmower and castration fear, then it is not too far fetched to liken images to angels. Science could be an unlikely ally in that experiencing images as angels may be closer to the new physics of interacting energies than we realize. We need an advanced physics of art therapy which expands our reflections on the interaction between matter and energy, and not the labeling of images that assumes the guise of science. I must emphasize science's role as ally rather than director. Our discipline is the artistic imagination, and it welcomes cooperation with other fields.

Approaching images as angels suggests new ways of relating to them and implies that they carry medicine. I am not endowing images with "powers" in the sense of idols, what we have in effect done to medical technologies. The angelic nature of an image transmits its medicine through cultivation and relationship. Everything depends upon how we engage the image and the values guiding our actions. In his Italian Renaissance *Book of Life*, Marsilio Ficino, one of archetypal psychology's inspirations, said cultivation warms up the image so that it "penetrates the flesh of someone touching it."

Here's how I began my reflections on artists and angels in *Art as Medicine*: "If we imagine paintings as a host of guides, messengers, guardians, friends, helpers, protectors, familiars, shamans, intermediaries, visitors, agents, emanations, epiphanies, influences, and other psychic functionaries, we have stepped outside the frame of positive science and into the archetypal mainstream of poetic and visionary contemplation."

Angels are having a Renaissance throughout popular culture in bookstores, cardshops, garden centers, theaters, and mail order catalogs. The images of angels that we see are anthropomorphic cherubs and Botticelli-like female figures with rosy cheeks, strawberry blonde hair, and flowing garments, all displaying idealized Northern and central European racial characteristics. I love Botticelli, but I also hear D. H. Lawrence howling from the other side about "this angel business," the pretty and vaporized spirits masking the soul's dark and sensual life. Our contemporary culture of angels is exclusively oriented to light figures. I do not negate, or even dislike, aerial spirits. I am simply reflecting on a one-sided imagination which neglects the earth angels, the spirits of matter, fire, stone, and darkness.

Art therapy has been my spirit guide and its influence grows stronger and clearer every year, as I witness the wisdom of the cliché, "Trust the process," and as I let go of my need to control and let the angels step forward, focusing all of my energies on holding the space, the *temenos* of the studio, where art's unexplainable transformations occur. Upsetting images are always vital agents of this medicine. If they are not welcomed and respected, we sense, perhaps even smell, that the space is not safe for an opening of the soul. The images in art and dreams may show where we hurt, but they never come to harm us. Year after year I see how the deepest conflicts of the soul are transformed through the making of art, if we can stick to the images and let them cook in our sanctuaries, always trusting the art to provide the unexpected remedy.

Outside contemporary Western culture, in India, ancient Greece, and old Europe, the dark angels, troublesome and sinister figures, live alongside the sweet and proper ones in a healthy ecology of spirits where figures like Madonna and, yes, even Howard Stern, are essential to soul's pantheon.

In my personal experience I find that what bugs me the most usually has the most to offer. Demons dig deep into avoided depths and feelings. The disturbing image is typically my guiding angel, the one who delivers the most important messages. It wants to be seen and respected. If I deny its efforts to communicate, it either ups the ante and increases the pressure in order to burst through, or it may patiently wait around for years, appearing in recurring dreams and paintings until I am ready to engage it. Typically, it furthers my compassion for the places in myself and others where the soul is wounded, suffering, or confused. I call these images "angels of the wound" like the AIDS icons Judy Weiser (1993) and Michael Franklin (1993) help us see.

Again, *these images want to be felt* and not fixed, as James Hillman will no doubt illustrate in his keynote lecture. This is the defining quality of art therapy practiced as a spiritual discipline. The unsettling image is an ally of the soul who helps me reframe how I am looking at life and living it. The dream dog gently biting at my back wants me to turn around and pay attention, to look in all directions, to see immediate things, while my gaze is fixed on a distant desire. My tendency is to brush aside the biting dog, tie it up, cure its biting, make it submit to my control. So it intensifies its grip and I increase my resistance, perhaps taking a pill, and it comes again and again, becoming more monstrous and nightmarish, trying to break through repression, this messenger I make into an adversary.

Classical philosophy maintains that every thing has an essential "substance" that constitutes its being (Aristotle). The spirit or quality of a thing is the basis of its character, something that emanates from its material nature, what Rudolf Arnheim today describes as the expression of objects. Things present themselves to us and expression, as Arnheim says, is embedded in their structures. Depth is on the surface we do not fully see. This is my sense of the angel.

The arts affirm that every object or gesture has a spiritual as well as physical nature which depends upon one another. Henry Corbin, my guide to the psychology of angelic phenomena, has described the angel as the person in everything—"beneath the appearance the apparition becomes visible to the Imagination" (1977, p. 29). Active imagination is the faculty through which "beings and things" are transformed "into their subtle state." It is a process of interpretation which is essentially meditation or prayer.

Esoteric doctrines have a profoundly practical application to art therapy where matter, body, and consciousness are infused with spirit and transformed into new forms, stories, and experiences. As colors and forms are moved and changed, our psyches experience corresponding effects. The materials and movements are shaping us. When will we see this and access its resources rather than banish soul to the shadow world through our attempts to establish art therapy as an "exact" technology?

There is a paradox at work in Corbin's reference to the spirit of an image "beneath the appearance," because the angelic nature of an image is experienced through reflection on its physical form. The angelic perspective affirms both the immediate form and its spiritual counterpart. They appear simultaneously. This is different from believing that the "true" or "deep" meaning is hidden behind a form. Deep-down is right now. If I look for something underneath, I overlook what is here.

The angel is the uplifting feeling I get when looking at Charlotte Salomon's colors and imaginary scenes and the mysteries of Frida Kahlo's faces, spirits that fly out to the viewer. Last night a dream told me there were angels in the sweeping gestures of Franz Kline's big, black strokes. "The spirits are in the motions," the dream said. "They're in there for those with the sensitivity to see and feel them when they look at a picture and when they're making one."

Interpretation is an ongoing active imagination, and creative transformation is the energy of healing. The purpose of art therapy becomes an infusion of imagination into life with a trust that a revitalized spirit will treat disorders of the spirit.

In my studios I drum to help people paint from the lower body, from the back and shoulders, to physically enact imagery from the feet and thighs as well as the fingers, arms, and head. The angel is a spirit moving through us, never fixed, a force of transformation that is healing. My studio participants love to engage finished images, but the primary experience is always art making. Do you see why I have always felt that art therapy cannot be separate from movement, drama, performance, and the sounds of creating? The angelic perspective does not fit into tidy specializations. Spirits are forever crossing disciplines within the fields of imagination.

Since we are not painting together today, I must return to reflecting on established images. As I say in *Art as Medicine*, I need ways to respond to pictures which correspond to their spirits. I repeatedly learn from our emphasis on *gesamtkunstwerk* (total expression), how the imagination is stimulated and renewed by fresh, nonhabitual expressions, like singing or moving the feeling. The angel is the surprise, the infusion of spirit, that arrives unexpectedly. For many of us talking is the most effective avoidance, the essential mode of control. Angels are more likely to arrive when we get up out of our chairs, out of our controlling heads, shutting off talk for awhile and finding new ways of engaging pictures.

I am sure there are people on the edges of their chairs, screaming silently, "My patients are hallucinating constantly, suffering from delusions. Your methods encourage this. It's crazy making. It will make them worse."

If a person talks to a specific color, picture, or texture, empathizing with its nature, isn't he or she making contact with the immediate and physical world? Maybe it's safer to talk to a painting than to a person. And even if there is an element of poetic madness involved, why not consider the homeopathic maxim, "The toxin is the anti-toxin." Imagination offers new versions of old stories and forms an unlikely alliance with cognitive therapies. But as in creative problem solving, the linear mind relaxes its grip and allows spontaneous expression to form itself into fresh structures.

Many people find it easier to respond viscerally with their bodies to the raw energy in a painting. There is a direct expression conveyed by the painting to the body of the viewer, a charge that stimulates an equally physical countercharge, that usually corresponds to the movement and energy that shaped the painting. People are often speechless before their image, sometimes overwhelmed and even afraid. I frequently see people who fear the energy in their pictures and sculptures. They say, "You're all over the place, too _______ much." Or, "You have so much power, no boundaries, chaotic. I'm afraid if I take you into me, I'll lose control. I'm afraid of what I'll do. I'm afraid of your power."

Talk alone doesn't work in these situations. When the artists communicate with the energy of the images with the expressions of their bodies, the situation becomes more organic, contained within their movements and within the structures of the images, as contrasted to fears without tangible embodiments.

Another artist dreamed of a frightening figure coming at her. She talked about the dream and painted it repeatedly. But only through physically enacting the experience, getting behind the mask of the figure as contrasted to having it come at her, could she know in her body that the dream demon was coming to help her accept the forcefulness of her expression rather than have it constantly turned against herself.

Physical movement helps us take the spirits of our pictures into our bodies. As we interpret the gestures of our paintings through movement, we go through yet another phase of making them our own as contrasted to the intellectualizing, disassociation, distance, and fear that we sometimes have in looking at our own pictures.

But the most basic move we make in my art therapy studios is talking *with* the image rather than talking *about* it. A woman made a small clay angel with an open chamber that contained a heart. She held the figure lovingly in the palm of her hand but did not speak directly to it.

She said, "It has a heart and an open space. I feel the emptiness now and that troubles me."

She felt stuck and the talking did not go further.

I said, "Do you want to try a different way of talking?"

She said, "Yes."

I said, "Rather than speak about the image as an 'it,' speak to the angel as a person, as a 'you.' You can repeat what you said, but just try saying it in this more intimate way."

She continued, "You have a heart and open space. I feel the emptiness in you and it troubles me. I like the way you feel in my hand, and your heart, it's so open. It wants company. There's space in you for others. I wish I could close you."

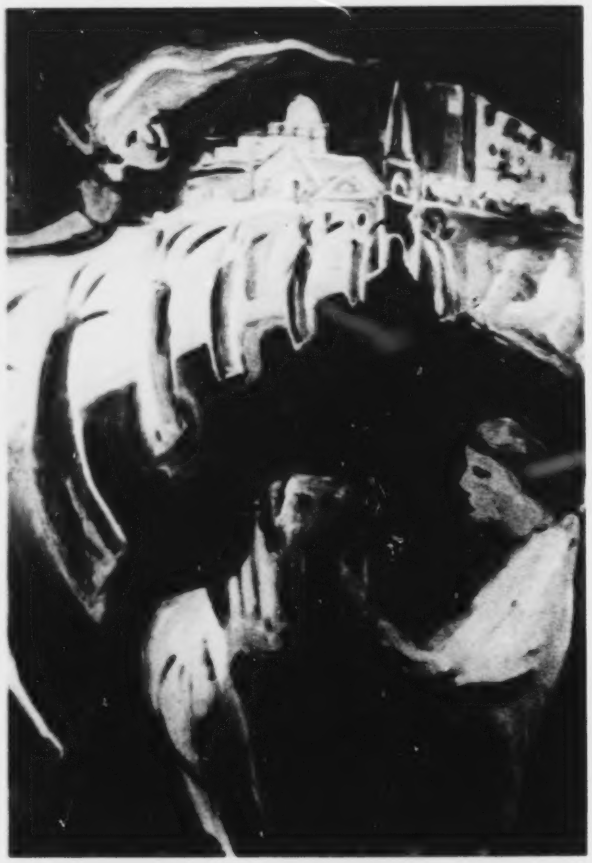
I said, "You can."

She tenderly closed the flap opening over the angel's chest and massaged its edges. "I close you," she said, "but in a way that you can be opened again."

I've got a picture that wants attention.

Picture speaks, "So you've got a problem with fair-haired feminine angels flying in space?"

I say, "I like you but I want to see the spirit in everything, in the animal, the person under the tree, the odd



trees., the imaginal city, the red cloud, the dark sky, the paint, the colors, every gesture, the movement of the trees, the wind blowing through you."

Now something personal to the picture. "I didn't put you in *Art as Medicine*. I wasn't comfortable with you. You seemed strange. I didn't want to show you, yet you're the one I hang in my house on the biggest wall.

"You disturbed me because you brought something new . . . so red, the bleeding door, menstruating streets and skies, those weird trees dancing. My wife liked you immediately and our daughter said, 'There's magic in the red cloud and the girl knows how to find it.'"

The human figure, the man or woman, sits with the animal. Still right now.

The crazy trees whisper, "Everything will move if you can sit still."

As I settle down, and stick with the painting it feels like a vortex of energy. I begin to lose me and spin in its world, its imagination.

I ask myself: "The painting is a magical environment, but am I safe here in the place from where I look? Can I let go in front of these people? The more I look, the more I am penetrated by your color, movements, and spaces. If I'm going to travel into you, I need to relax and feel safe, protected."

"Come," the girl says. "All you have to do is sit and you will travel. Listen to the trees. They will guide you."

I begin to identify with the seated figure and feel one of my daughters hovering above. The picture is reframed from the perspective of the girl, *Annie Hall* style. "I can't believe he's sitting still. I can go to him, but will he get up the minute I arrive and say that he has work to do? He may be ready for me today, and the intimacy I bring."

The animal says nothing and just feels the presence of the person and comes close, smelling, looking, and sensing.

But now the animal feels like my dog who says, "Hey dude, sit . . . sit, SIT. Isn't that what you're always telling me? You need it more than I do."

The trees speak, or do they sing?

They move and make sounds.

I hear words now. "Play for us. Watch and play. Hold the space for us. Play."

The human figure says, "Yes. I sit and play, drumming and making rhythms on a mbira for the painters and dancers."

"Play," the trees say. "It's time to stop talking."

I respond with music.

This is what we do in my studios—cultivating the spirits of the image, more imagination and less explaining. Letting go in a safe place, always returning to the images, immersing ourselves in them and soul's speech which transforms everyone involved. Today I identify with the seated figure. Next time it may be the girl, or the animal, or the red. Every day I have a new relationship with the image.

When I hold the space for an artist and the images, others sit as witnesses. They are invited to respond after the artist's dialogue, but there is an essential rule—no questions and all statements are to come from the heart. If the image disturbs someone, of course he or she can express this. But the sanctuary is maintained when the upheaval comes authentically from a personal feeling as opposed to an analysis or judgment that avoids its bias. The sacred lies in the exchange of feelings and soulful expressions within the space where the work is done—this is what distinguishes a spiritual art therapy. The witnesses expand imagination and its medicine by speaking to the image, as the image, or to the artist. Artistic responses through movement, sound, or ritual enactment are welcomed, and they always seem to give the most to soul and the most satisfaction to the artist. Perhaps the angels of art therapy feel the same way.

"More art they say, feed our souls with images."

This is what you have done here in Atlanta, transforming art therapy by showing your art, infusing our community with soul and the divine influx of imagery. The angels are always a step ahead of the reflecting mind so who knows what changes are happening through these acts. As my guiding daemon says, "Let's see where it takes us."

Before I even finish I can hear the polarizing responses, insisting that I am opposing analysis, intellect, professional standards, and the rest. Please understand that I am not asking the thinking mind to leave art therapy, but only to relax its controlling grip, to step back in order to progress.

Pat Allen, who has a gift for "naming" (1992), has celebrated your imagery shown here in Atlanta, and she has proclaimed us a tribe of artists who have come out from our tents. Art therapy is appropriately transforming itself through art and bringing art's medicine to others through example, by living the discipline of art, influencing those who look and become involved as co-creators. The stream will carry us. What a difference from being asked to draw a house, a person, or a birdbath by a tester with an interpretive agenda for whatever you do. Where is our discussion of the ethics of these covert manipulations of imagery? Do we need a Miranda ruling for images?

I am drawn to the image as angel because this "metaphor of a metaphor" (Bachelard, 1987) affirms the poetic basis of creative imagination. Why not imagine images as angels for awhile and see what happens as contrasted to calling them pieces, works, graphic indicators, pictures. It's an exercise, an interpretation, just language, where metaphors try to feel, but never grasp, the untranslatable essence of a thing, *das ding*. If you don't like words such as spirit, soul, and angels (Schoenholtz, 1993), cast them aside and use your own language, your indigenous speech, what Owen Barfield calls the "speaker's meaning" (1967). Articulate your offense and your longing and these expressions will open to the soul, the mystery (Moon, 1993), or whatever you call the source of creation and feeling. Carve it out for yourself and I will try to listen to your expression. The last thing I want is someone to adopt my speech. That's a disturbing echo I hear too often within associations and professions. I hunger for art's individuation of your voice, your way, into a full spectrum of colors and forms. And today we realize that art is, and will forever be, our mainstream. It speaks many languages but we have a common method, love of images.

References

Allen, P. (1992). Artist-in-residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association*, 9(1).

Bachelard, G. (1987). *On poetic imagination and reverie*. Dallas, TX: Spring.

Barfield, O. (1967). *Speaker's meaning*. Middletown, CT: Wesleyan University Press.

Corbin, H. (1977). *Spiritual body and celestial earth.* Princeton, NJ: Princeton University Press.

Ficino, M. (1980). *Book of life.* (G. Boer, Trans.) Dallas, TX: Spring.

Franklin, M. (1993). AIDS iconography and cultural transformation: visual and artistic responses to the AIDS crisis. *The Arts in Psychotherapy, 20*(4), 299–316.

McNiff, S. (1993). *Art as medicine.* Boston: Shambhala.

Moon, C. (1993). *Mystery: The guiding image.* *Opening Session, American Art Therapy Association 24th Annual Conference,* Atlanta.

Schoenhholtz, R. (1993). Personal communication.

Weiser, J. (1993). *PhotoTherapy techniques.* San Francisco: Jossey-Bass.

Soul and Spirit: The Image Instructs

Presented at General Session, 24th Annual AATA Conference

Pat B. Allen, PhD, A.T.R., River Forest, IL

This presentation was inspired by a piece of writing by James Hillman called "Soul and Spirit" which appears in *A Blue Fire,* a collection of his selected writings. Hillman draws a distinction between soul and spirit, partly to clarify the difference between spiritual disciplines and psychotherapy. Spirit, he says, makes clear distinctions and is about refinement and purifications. Soul, on the other hand, is confusion and richness. Spirit takes the better part and seeks to make all one, while soul accepts all diversity, is contrary to category, and is messy.

The common definitions of soul and spirit are simpler; they are actually interchangeable according to Webster. Each word is used to define the other, both having to do with the ineffable, the immaterial. This would seem to reflect the bias toward spirit, pristine and transcendent, and an ignorance of soul as Hillman is using the term. While soul in our culture is marginalized, soulful is painful, and soul food and soul music are born of the suffering of the marginalized.

I was caught by Hillman's essay because he struck a chord for me when I reflected on the title of the conference and my experience with images. It is soul more than spirit that I encounter in my images. I guess to split hairs, I would have been more comfortable with a conference entitled "Arts, Therapy and Soul" and with a figure sitting in the mud rather than flying through the sky.

Hillman associates soul with feminine and spirit with masculine and at first that annoyed me. But there is something to that, I thought, after reading about the lives of 13th century women mystics who were soulful even in their extreme spirituality. Starving themselves on one hand, the sooner to become one with their God, yet managing, like Catherine of Sienna, to give advice to Popes and to have people constantly asking for advice on daily life and living in the most chaotic profusion yet finding the divine there.

There are points where soul and spirit converge and it seems to me that this mingling occurs in extraordinary human beings who live most fully in soul (most soulfully). Then spirit, which is part of the divine, rushes in itself and cannot resist. What I am saying is that soul is our place, our job, our lot as human beings. And there can be a wish to avoid soul and try for spirit, which is more orderly, focused, clear, and light.

Thomas Moore says that the emotional complaints of our time, complaints we therapists hear every day in our practice, include "emptiness, meaninglessness, vague depression . . . all these symptoms reflect a loss of soul and let us know what the soul craves" (Moore, 1992). What does the soul crave?

Soul is a cauldron, huge and dark. It is our job to keep the fire burning underneath, to replenish the contents within, and to stir and stir, endlessly. Under some cauldrons, the fire has long since burned out. The curve of the kettle is caked with rust; the stuff inside is desiccated. The stirrer has gone off to other tasks and forgotten the sacred duty: to keep things cooking, as the jazz musician says.

What goes on in the cauldron is the transformation of human suffering, the distillation of our sorrow. If our sorrow isn't cooked, it stays alive and raw, eating us instead of us eating it, and it chases us, or so we imagine, away from our cauldron, our fire, to other places until we are so weak we die inside. We can forget that the fire and the cauldron are essential, are our source, our job.

Art making is an act of remembrance—remembering that soul is our place, remembering about starting fires, combustion, cooking, and throwing everything into the cauldron and stirring it up, transforming the raw into the sweet. "Soul sticks to the realm of experience and to reflections within experience" (Hillman, 1975). It is from everyday experiences—sorrow, annoyances, jealousy, rage—that soul cooks and spirit rises. The path to spirit is through soul and soul takes all, the dark, the dirty, the indiscreet, the mundane, and the marvelous. Everything feeds the fire.

The images in this presentation show the instruction of the image, a path that begins with an image of rage and betrayal and pain and carries through to a spiritual insight. "Art is a process of ensoulment" (McNiff, 1989). The image instructs to let go of judgment, of analysis, to follow instead, to trust, to dance along the path laid out for each of us, the path of the individual soul.

Why in the world do I want to show you these images?—messy and indiscreet about messy feelings, rage, and betrayal. I guess because these images said something to me about soul. I was angry with someone, felt betrayed, and tried to reason with myself about it, look at the dynamics, let it go. I made some nasty little sketches in my sketchbook and tried to let it go. But it wouldn't; she wouldn't go away. I found my thoughts kept turning to this person, her treachery, and I resented her intrusion. It wasn't even me she had betrayed anyway, but her husband of 10 years whom she had announced she was divorcing, summarily, after 10 years with no discussion, no angst. She was excising him from her life. She felt fine about it, she said. Something about this shocked and sickened me. I felt cold, unbearably cold. But I was mad, too. I had art I wanted to be working on, and it was being pushed out by images of her. In a fit of anger, I drew an image of her, an exorcism, and painted with old smelly tempera paints (see if I waste anything good on her). I painted in a frenzy wanting nothing more than to be rid of her cold and nasty visage. I drew a bird cage with a heart in it and scratched her a scar where her heart should have been. Why so emotional? Why so hot about this? I painted her and her husband. I collaged her mouth and eyes from magazines, betrayer, liar, false. I sat with these images feeling scared, powerful, dangerous. These would surely kill her if she saw them. I did one more her, locked into a metal collar that prevented feeling, that allowed her to be exposed, 3-D glasses on her eyes and a Pinnochio nose. Exposed as what? As an anorexic of the soul.

That insight stopped me. An anorexic of the soul. No fire under her cauldron, no mess, no feeling, just rational decisions. I had vented my feelings, expressed my resentment at all the trouble she was causing me, distracting me from my work, yet, all this feeling can only mean I am in here too—not just the pain of betrayal but more.

The denial of feeling, of the messiness of life is for me life threatening. The pretense of order, the denial of disorder, pain and suffering are life threatening. The fantasy of needing no one, of self-sufficiency, is life threatening. She embodied that for me. She had simply made an executive decision—his services were no longer required. I felt that emptiness, impoverishment of empathy, that the lust for order demands. I recognized it in myself. I had struggled with it in my rage at her. I didn't want this messy inconvenient suffering. I had a plan, work I had planned to do. The soul doesn't plan.

The next series came shortly after, quirky images done quickly in pencil, without a plan, then washed over in watery acrylic. A figure about to punch a child or bless it, a two-faced, empty-eyed figure. Then a figure going into the water, a submerged figure, barely visible, a fetal form. Is the figure going in to save it, to rescue this suicidal or unborn form? The denied self?

The rescue of the suffering and incomplete self, and an angel appears on cue. Angels as representatives of the work of the soul, mediators of soul and spirit. "A particular image is a necessary angel, waiting for a response," Hillman says.

In the soul, reunion takes place, the denied is affirmed, all prodigal daughters and sons are welcome. Spirit cannot help but arrive, newly held and protected, the small being. (I won't say child, because this is about smallness in all sorts of ways.) It is always in our smallness that we suffer.

Soul is like the dog seeking out, sniffing out the dark, small, the denied. Angels are ever in waiting, as witness, even in our sense of falling, and falling, companions are there, whether we see them or don't. The small dark self, eyeless and incomplete, can be found and reclaimed, honored and rejoiced over, even when tempted to despair in feelings of isolation. I felt compassion for my anorexic of the soul, her and me. The angels are there, whether we see them or not. I don't think she knows that; she thinks she has to do it all alone. But actually, spirit is all. We can't fall out of it, though we can imagine such a falling.

Simultaneously, a series of sculptures came—wrapped silent figures, anonymous and held within spaces. There is no chronological, no linear progression here. I have had to create one and it is by necessity false. All images are simultaneous, holographic, facets of a wholeness that we are, even as we misperceive ourselves as fragmented.

The work of the soul is to take all within the dark places, to find and sniff out all that is wrapped and silent, its cry muffled, to reclaim, rejoice, hold, and affirm—all the suffering, all the isolation, everything—to grow it, and cook it, and eat it. And a final quote from Hillman, "Our images are our keepers, as we are theirs."

References

Hillman, J. (1975). *Revisioning psychology*. New York: Harper Collins.

Hillman, J. (1989). *A blue fire*. New York: Harper Collins.

McNiff, S. (1989). *A depth psychology of art*. Springfield, IL: Charles C Thomas.

Moore, T. (1992). *Care of the soul*. New York: Harper Collins.

Mystery: The Guiding Image

Cathy Moon, MA, A.T.R., Opening Session, 24th Annual Conference of the American Art Therapy Association

The theme of the 1993 American Art Therapy Association Conference in Atlanta was "Common Ground: The Arts, Therapy and Spirituality." The opening session of the conference was a creative integration of movement, visuals, and vocals with a more traditional, verbally presented, text. This article contains the "text" part of the opening session. The intent of the whole performance was to put forth some of the questions raised by the conference theme and to set a tone of openness to diverse ideas and viewpoints.

The basis for the opening session was provided by responses to a questionnaire sent to about 75 AATA members. The questions addressed areas of interest and concern related to the conference theme. References to the responses of those questioned are contained in this article.

guided
by grace or gusts of wind
that wind
around and around our lives
lifting us here, dropping us there
to form the furrows
and twists and knots and nicks
of who we are
of how we stand
curved into the wind as if straining to hear

guided
by unseen unspoken understood
wordlessness—
the time my mother found
the rosary beads in the drawer
of her nightstand
curled up, a coiled snake
she did not put there
had never seen
picked up without question nonetheless

guided
by nebulous, nagging, snagging
visions
and whispers that waft through the air
only to be shared over coffee
in hushed tones
with my friend who will nod and cluck her tongue
not to say she understands
but only
that she believes.

guided
by unspoken images, unseen words
uncovered
in the rooms where people paint
and pray with hands rough and raw
from molding clay
into the stories they cannot speak
dare not say
do not see
until they are formed before them.

guided
by unformed informed strangely formed
twitches of understanding
that carry me beyond what I think I know
a drawing done in chalk
on brown paper
the shock of it when I see it complete
"I did not know
I could do that"
looking around as if to find who did.

I had a dream about kittens . . . slipping through my house at night, startling me. Wondering where these unfamiliar creatures came from, I followed them, down tilted wooden steps to the basement of my house where they lay suckling, nuzzled up against the body of their mother . . . 6, 8, 10 of them! And there were more . . . large cats, full grown, slipping in through crevices in the old stone foundation, clambering down and around the mounded rocks in the cave-like place. They found warmth and the freedom to move as they wished between the inside and the outside world. the otherI thought at first. I saw them as invaders and wanted to get rid of them. But then I looked again and knew I could not bring myself to throw them out. It was the connection of the kittens to the mother cat that held my eye. And the way this formed the centerpiece around which the others wove to and fro, went inside and outside, with ease. I thought that I would have to feed them and care for them and contain them. But they were doing just fine without me. So I climbed back up the tilted wooden steps, closed the basement door so that it was open just a crack, and let them be.

What, then, is the connection between kittens clambering around in my dream, and a gathering of art therapists who are climbing in and around questions of the spiritual in our work, trying to find the common ground? Perhaps the connection is the feeling of being startled by something unexpected and the need to understand the source. Perhaps the connection is the urge to be rid of this invasion, this complication full of need and potential infestation and propensity to multiply. Maybe the connection is the understanding that what was there before I ever even knew about it does not need me, or you, to give it life, to contain and control it or to protect it. And maybe, just maybe, the connection is the text of the story itself. Maybe we will find the common ground only through the stories we tell and the images we share, replete with all the head-scratching, "now-what-does-that-have-to-do-with-anything" kind of responses that stories and images engender.

This is not to suggest that this topic grants us the permission to be vague or muddle-headed or to abandon the searching questions stimulated by our intellect. Spirituality is not a distinct category of human experience, it is a quality that pervades all of our experiences. If we are to examine the spiritual in our work we have to bring along not only our intuition, artistic sensibilities and passionate beliefs but also the piercing, prodding questioning of intellects that seek to understand and that recognize what we do not know.

Now that I've said all that (and those of you who are not so sure this conference theme is a good idea, get ready to roll your eyes) I propose that *mystery* be our guiding image in this search for understanding. Mystery, from the Greek word "mystos," meaning keeping silence. And from the Latin "mysterium," having to do with ministerium service, or occupation, or ministering. Silent ministry. By proposing that mystery be our guiding image I am not suggesting that we be led by some loose, vague, inarticulate notion of the meaning of our work. Instead, I am suggesting that we plant ourselves firmly and humbly in the reality of the work we do, knowing that it is, at its most fundamental level, a silent ministry. Now, don't take me too literally here. I don't mean that art therapists do not talk. The silence refers instead to the ineffable nature of our work, the inability we have to ever completely capture in words, to point to with certainty, to know without question, why engagement in art making helps people to heal.

We all know this can cause us problems as professionals in a health care system which is increasingly demanding of proof that the dollars invested will result in beneficial outcomes. So we respond, as we should for our professional survival, with research which demonstrates the validity of our work. We struggle to find research methods which are congruent with our identities as artists and art therapist clinicians. We look to anthropology, biology, and art history as well as psychology to aid us in establishing a basis for the work we do. We write articles and books, give lectures, make videos, and present workshops in attempts to articulate what it is that we do and how and why. And still, we are taken aback, startled, awed, humbled, amazed by the power of art to participate in the creation and deepening of human life. We experience this as artists and as those who bear witness to the work done by our patients. There is something going on in art making which eludes us. We are left staring, mouths hanging agape, speechless. We are in the presence of mystery.

Kirk Varnedoe (1992), director of the department of painting and sculpture at New York's Museum of Modern Art, said it this way:

> . . . art's strong suit is not delivering specific messages and inciting concrete deeds. Art may instead be at its most powerful . . . when it orchestrates perplexity, fails to confirm what you already know, and instead sends you away temporarily disoriented but newly attuned to experience in ways that are perhaps even more powerful, *because* they are vague, rogue, and indeterminate.

BEST COPY AVAILABLE

Many years ago I went to a presentation by a local artist who talked about and showed slides of her work. I cannot recall with clarity the appearance of her artwork. I only have in my mind vague images of sticks . . . lined up in rows, bundled together with string, arranged in patterns, given places of honor. For many years these vague remembrances of art pieces hovered around inside me, waiting, gestating.

Then life handed me some troubled times. In the midst of loves and losses entwined, while I became thin from what was eating away at me emotionally, and my father was slipping away piece by piece, claimed by cancer and Alzheimer's disease, and my marriage was stripped to the bones, in that vulnerable, shivering state of readiness to be reconstructed . . . then it was time for the sticks to be born again.

I found them laying by the side of the road, someone's discards from a spring pruning. They were cut and broken at one end. At the other end tiny buds still appeared full, ready to bloom, as yet unaware. I cradled these sticks in my arms, took them back to my studio. I loved them, and nursed them with oil paints squeezed out in violets, blues, umbers . . . deep, nourishing colors. I swathed them in soft colored twines, wrapped around and around their wounds. I laid them in the cradle of my paintings, tucked them to sleep with the swish-swish of my brushstrokes, back and forth, back and forth. At night I sat up with them, in the darkness of my studio, played music to soothe them. When it was time for them to be born again, it was-I who cried, giving sound to the pain of their breathing.

I can tell you this. I cannot explain all that it meant to me. Nor can I explain why I still have sticks clustered in the corner and laying in bundles on the floor of my studio. It certainly is not because I need something to fill up the space! All I know is that they say something to me about the way life is . . . broken, discarded, utterly ordinary, potentially special, there to be disregarded or taken in hand and created anew. Out of respect, I give these sticks a home, a place of honor in my studio. They still act as guides for me though I'm not sure how or toward what.

Willingness to be guided by something not entirely known or knowable and, in so doing, to become more attuned to the way life is. Certainly this is something we ask of our patients in therapy. There is profound mystery to human suffering. This mystery cannot be tested or theorized or medicated or explained or therapized away. We don't promise our patients a problem-free life. Instead, we offer to wade with them, knee deep in the way life is . . . inexplicable, undeserved suffering and all.

Jan, a patient I have worked with, has reminded me many times of the mystery of human suffering. She has had very few words to put to it in the time that I have known her, but her artworks have been stunning testimonials to the painfulness of life. On one sunny afternoon I joined Jan and a few other patients in the kitchen of the inpatient unit for our art therapy group. We all set about the task of creating self symbols. Jan used the materials at hand . . . a plastic surgical glove, red food coloring, an aluminum baking pan, water, straight pins. When it came time to share her piece, she placed the pan, now filled with water, on the kitchen counter. She then floated the surgical glove, full of red-colored liquid, in the pan. Carefully she arranged the art pieces of the other group members on the counter, forming a half circle around her piece. She placed mine on the edge of the pan, then took it off. Too close I stood with the other group members, our bodies echoing the position of the art pieces on the counter, forming a half circle around Jan. Slowly she picked up a straight pin and held it above the floating glove. She moved her hand down, the sharp point of the pin barely puncturing the surface of the glove. I winced as red droplets appeared. Then she brought the pin down, and down again, and again, not roughly but with intent. And the blood red color ran in rivulets, staining the water pink, while the rest of us gave a silent witness to her suffering. No one moved. No one spoke. For a while we just stood with her. And when it was time, we helped her put these ordinary hospital kitchen things away.

It is out of the ordinary things of life, the things at hand . . . the dreams and sticks and straight pins, paints and pans, that new life is made. And in the art rooms of the hospitals, schools, jails, geriatric centers, private practice offices, psychiatric facilities, and other places where art therapists work, there are people who are making art, and in so doing they participate in the making of themselves.

But is this an inherently spiritual act, this participation in creation?

I asked art therapists this question. Is there an inherent relationship between spirituality and making art? They said "yes" and "no" and "sometimes" and "if." It was a more complicated question than I realized at first. It followed on the heels of a question about their personal definition of spirituality, but it became apparent that their answers also were intimately tied with their definitions of art.

To summarize, and of necessity generalize, the "no" responses were tied to a view of art that is pragmatic picture-making, arising from purely human endeavors and based on intellect and training. The "yes" responses were connected to a view of art which holds that art making is an encounter with being, a response to the threat of nonbeing, contact with authenticity, a connection with a higher creative source, a willingness to be affected by life, a bridging relationship between inner and outer, an inexplicable urge to reach beyond the superficial, a flicker of the divine within, a surrender to that "something" that takes one to new levels of understanding, an honoring of connections with others and the world around, and an act that brings meaning.

The responses leaned heavily toward the side of acknowledging if not an inherent connection between art therapy and spirituality, then at least an interrelationship. Yet this same group of people articulated many potential dangers in the integration of a spiritual focus in art therapy practice.

This is what a dangerous spiritual art therapist would be like: This therapist would not have developed sufficient trust in his or her potency as a human being, and would desperately seek a narcissistic fusion with an omnipotent other. The dangerous spiritual art therapist might wish to function as a pseudo-god and thereby undermine the clients' ability to find the resourcefulness, the art, within themselves. In the desire to become god, this therapist would be grandiose, guru-like, inflated and vague. Art making would be used as an opiate, a way of avoidance for therapist and client alike. The reality of the physical and psychological aspects of the client would be avoided and the practice would be vague and unformed, without a clear theoretical base. "Faith" would be substituted for sincere attempts to explore and come to new understandings.

And, perhaps most grievous of all, the practice of art therapy would be used to preach the therapist's own dogmatic spiritual or religious views.

Several months ago, at the time I was working on the writing of this opening session for the conference, I did a drawing during one of my art therapy sessions. I drew myself floating in what looked like a womb-like environment with a sort of umbilical cord running off the edge of the page. I sat back and smiled at the image I had created, feeling rather smug that I was able to just float and be ready for the birthing of this conference, congratulating myself on keeping this whole thing in perspective and not getting riddled with anxiety. One of the patients looked at it and without hesitation said, "She looks inflated." Zing! Almost immediately, though barely perceptible, a s-s-s-s-s-s-s-s-s-s-s-s-s sound could be heard in the room and I was again grounded in some healthy, earthy anxiety!

Spiritual concerns deal with a part of life that is hard to get a firm hold on. Questioning in this area brings us to the edges of self identity and cohesion. Our response to this precarious position CAN be to revert to extreme doctrine, to use doctrine as a sort of "glue" to keep ourselves intact. We might also go in the other direction and become "unglued," so to speak . . . regress to an undifferentiated state where we lose focus and merge with what feels good, abandoning critical thinking. We are all susceptible and vulnerable to this.

In spite of these dangers, the art therapists I questioned also were able to articulate many benefits to the integration of a spiritual focus in art therapy practice.

In contrast to the dangerous spiritual art therapist, let me now present you with a composite image of the beneficent spiritual art therapist:

The beneficent spiritual art therapist would remain firmly grounded in the reality of the tangible world while acknowledging the intangible, ineffable aspects of life. In practice, the making of art would provide such a grounding for therapist and patient alike. Clients would be assisted in exploring, identifying, and expressing the clients' own personally meaningful belief systems, viewing spirituality as an inherent quality of being human. The therapist's approach would be flexible enough to encompass the needs of clients, whether that be to address directly pointed themes like "faith" and "God" or to explore spiritual questions via themes like "creative force" or "healing power." The spiritual basis of the therapist's practice would reinforce the ability to be genuine and authentic, congruence with a value system, and awareness of limitations as a therapist. The therapist's knowledge base would not be limited by the literalism of Western medical or pathological theories of illness and treatment but would also include worldwide wisdom traditions and healing methods as areas of study.

I suspect that the qualities described in this composite image of a spiritual art therapist are not troubling to the majority of people here, even those who are opposed to the theme of this conference. The basis of the controversy surrounding the conference theme does not seem to stem from a repudiation of the spiritual in life. Nor does it seem to rise primarily from a rejection of art as a point of access to the spiritual, though certainly we could not claim art to be the singular point of access. The controversy seems to arise instead from the multiplicity of responses and reactions to the word "spirituality," and to the images this conjures up relative to how it would become manifest in the practice of art therapy.

I have done a great deal of thinking about, reading about, and talking to others about this theme over the past year. At times this has meant taking brief dips into the bizarre, the unusual, and the humorous. Several months ago, Randy Vick, the Conference Chair, sent me something in the mail. It was a magazine article about performance art happenings. The article was a description of an "anything goes" kind of event where people proposed to do such things as jump nude into a vat of jello and staple beef jerky to their bodies while singing the national anthem backwards! Randy's quip at the top of the Xerox read, "Perhaps something like this for our opening ceremony?"

Not long after I read this article I had a dream about the opening ceremony. I don't remember it clearly, but it was smoky, weird, dark, and swarming with people. No one had beef jerky stapled to their body, but Randy was running around, sending wafts of incense into the room with the priestly presence of a celebrant in the Roman Catholic church. The religious, the ridiculous, the bizarre, and the reverent all collided in this dream image. Parts of my Catholic upbringing, which are imbedded in the bones of who I am, surfaced and mingled with the unfamiliar and disturbing fringe element expressions.

"Spirituality" is a loaded word. It is loaded with ancient history and trendy New-Ageism. It is loaded with the reactions of a scientific, methodological culture and the reactions of a people hungry for something to fill the void they feel. It is loaded with the good and bad of religion. It is loaded with hope and meaning and mistrust and cynicism.

It's easy to make assumptions and to jump to conclusions about what the inclusion of a spiritual focus in art therapy practice means. The challenge will be to listen past our prejudices and misconceptions and fears without losing hold of our passionate beliefs.

It seems like this should be easy for us. As artists and art therapists we have often been on the other side of this struggle for understanding. We have been perceived as unnecessary, as one of the frills to be disregarded or discarded. We have been perceived as dangerous voodooists, and met with mistrust and suspicion. We have been perceived as artsy-craftsy people who keep clients busy between the times when they have real therapy. We have been perceived as extraordinarily gifted people whose magical abilities as artists make us people to be in awe of and intimidated by. Misconceptions of art therapists have been and continue to be abundant.

It seems that this would make it easy for us to listen past our fears, prejudices, and misconceptions as we discuss the common ground between art, therapy, and spirituality, but it's not easy. "Spirituality" is such an imprecise word, so prone to misinterpretation, so difficult to define. It's a lot like "art," so prone to misinterpretation, so difficult to define. I'll say it again. . . . Maybe we will find the common ground only through the stories we tell and the images we share.

When I was a little girl my family would make yearly trips to a place called Conneaut Lake Park, an amusement park. My parents had 10 children, with an age span of about 20 years from oldest to youngest. To make these visits to Conneaut Lake Park bearable my parents would allow the older children to go off on their own while they stayed with the younger children. In that magical year when it was determined that I was "old enough," I was allowed to roam the park with my sister Liz, who was a year younger than I. Our meanderings led us to a ride called the "Blue Streak." We could see that it was a ride where a series of cars attached to one another entered into a dark tunnel. It looked like fun to us so we eagerly got in line. It was not until the car we were in turned a corner and the end of the tunnel was in view that we realized we were on the roller coaster. The BIG roller coaster. I will never forget the look on my sister's face as she grabbed my arm, face as white as a sheet, and said, "Cathy, it's the roller coaster!" Being the big sister that I was, I said "It'll be okay, Liz." It was meant as a lie. But in fact, it ended up being the truth. We were okay. In spite of being carried away on something we never intended to get on in the first place, we were okay.

I am not going to stand up here and tell you that "It'll be okay" with the intention of fooling you into believing that I am calm, cool, and collected about this whole conference theme. I have been, I am, scared. I offer you my arm but, as the sign says, "Ride at your own risk." This look at mystery as a guiding image for our profession takes us into risky territories where passion runs high, individuals feel threatened, and longstanding taboos are touched upon. Fear is called for. And yet, I do not regret being program chair, or orchestrating this opening session, any more than I regretted riding the "Blue Streak." I stepped off that ride with face flushed, fingers stiff with hanging on, and stomach rolling just like the ride. I also stepped off with the understanding that it was my willingness to be guided by something not entirely visible or known that accounted for my renewed sense of being alive.

What is it that will give this professional organization of art therapists a renewed sense of being alive?

It seems that, in recent years, we have spent much of our time, effort, and energies trying to renew our professional organization's sense of aliveness through a focus on pragmatic concerns. We have fought to protect our professional identity by obtaining exclusive national trademark rights to the initials "A.T.R." We have been actively involved in legislative issues which affect whether or not art therapy services are reimbursed by third-party payers. We are in the process of developing a national certification test with the hope that the validity of our profession will be further solidified. We have attempted to adapt our educational programs and clinical practices to the expectations of a shifting health care system which demands that we provide treatment in less and less time. We have worked hard to gain public recognition and political clout. Given the general economic conditions in the United States, and the current state of health care in our country, it is understandable why we have worked so hard on these things. Is this work necessary? Absolutely! Is this work enough to give our profession a renewed sense of being alive? Absolutely not!

I suggest that this conference theme was chosen, voted on, and approved by the membership because concern with the pragmatism of our professional identity is necessary but not enough . . . because we have a need to connect with the mystery, the awe, and the faith we have that art therapy helps people to heal, whether or not we can prove it, legislate it, certify it, or be reimbursed for it . . . because we know that it is our willingness to be guided by something not entirely visible or known that leads to a deeply renewed sense of being alive as professionals.

Lynda Sexson, author of *Ordinarily Sacred*, talks about "the human impulse to preserve the world as we know it, to make rigid its walls, secure its borders" as a religious activity. She says:

> Religions reassure, reacquaint, realign us with the known and keep us safe from the chaos of new perception. But other religious activities break down walls, rearrange the borders, celebrate chaos by writing its programs and discovering its resemblances (and hence order) to ourselves. The religion of preservation tells us who we are; the religions of disorientation force us to create ourselves.
>
> (Sexson, 1992, p. 86)

We have been working hard of late on identifying and preserving who we are. It is time to risk the disorienting experience of allowing mystery to be our guiding image, of allowing mystery to force us to create our profession anew.

References

Sexson, L. (1992). *Ordinarily sacred*. Charlottesville: University of Virginia Press.

Varnadoe, K. (1992, September). Entering the software century. *ARTnews*, pp. 57–58 and 142.

The American Art Therapy Association, Inc.: Twenty-Fifth Anniversary (1969–1994)

Volume 11, No. 1 of *Art Therapy: Journal of the American Art Therapy Association* inaugurates the first of four special sections celebrating the history of the American Art Therapy Association in its 25th anniversary year (1969–1994). In this issue, some historic material on the first Annual Conference of the American Art Therapy Association, Inc., is presented, including a transcript of the first conference program and the personal invitation extended by then Secretary, Felice Cohen, A.T.R., HLM, to members in 1970. Special thanks go to Rawley Silver, EdD, A.T.R., HLM, for providing the journal with copies of these documents.

The second section presents a record of the winners of the AATA awards from 1970 to 1993, including Honorary Life Member, the Distinguished Service Award, and the Art Therapy Clinician Award. Following this section, four AATA award recipients have responded to a request by the journal to answer the following question: **1994 marks the 25th Anniversary of the American Art Therapy Association. How will the profession of art therapy change in the next 25 years? In other words, what is your vision of the 21st century art therapist?** In the three remaining issues of this volume of *Art Therapy*, other award recipients will respond to this question; we hope that their commentaries will provoke a lively dialogue on subjects both salient and controversial to the professional field.

Lastly, a photo gallery of art therapists is presented; special thanks go to Bobbi Stoll, MFCC, A.T.R., who collected the photos reprinted in this issue.

AMERICAN ART THERAPY ASSOCIATION

Dear Member:

You are cordially invited to attend, and participate in, the first conference of the American Art Therapy Association.

It is to be held at Airlie Foundation, Warrenton, Virginia, on Friday and Saturday, September 25 and 26, 1970. This lovely hotel is providing us with rooms, 3 meals a day and conference rooms. In addition it is surrounded by beautiful grounds with recreational facilities and is close enough to Washington, D.C. for those who wish to tour our capitol.

For your convenience we are enclosing a list of our board members who are acting as committee members for Mrs. Christine Wang, our reservation chairman. For further information and reservations contact that member nearest you geographically.

The format being planned is a morning and afternoon session on Friday, with a luncheon break. During both sessions papers will be presented and immediately prior to the afternoon session there will be a short business meeting. The focus of the papers will be on Techniques of Clinical Practice. The evening will be free for socializing.

On Saturday we plan to have only a morning session during which there will be workshops. Those who wish to tour Washington Saturday afternoon will be free to do so.

If you wish to present either a paper or conduct a workshop, fill in the enclosed form and return it immediately to Myra Levick, Hahnemann Community Mental Health Center, 314 North Broad Street, Philadelphia, PA 19102. As we wish to make this as diversified as possible we are requesting that all participants send their papers and workshop formats to her also, to be received no later than June 30. Any arriving after that will not be considered. This is to insure ample time to print programs and mail them to those registered by September 15.

The board joins me in expressing the wish that you will join us in this "FIRST."

Very sincerely yours,

(Mrs.) Felice Cohen
Secretary

FC:del

AATA EXECUTIVE OFFICERS

President: Mrs. Myra Levick
The Hahnemann Medical College
Community Mental Health Center
Hotel Philadelphia–314 N. Broad Street
Philadelphia, PA 19102

President Elect: Mr. Robert Ault
C.F. Menninger Memorial Hospital
A.T. Department–Box 829
Topeka, KS 66601

Secretary: Mrs. Felice Cohen
Child Guidance Center of Houston
3214 Austin Street
Houston, TX 77004

Treasurer: Margaret C. Howard
Children's Medical Center
Box 7362
Tulsa, OK 74105

BEST COPY AVAILABLE

AMERICAN ART THERAPY ASSOCIATION
Scientific Program

Morning Session — Friday, September 25, 1970

8:30 a.m.	***Welcoming of the Guests***
9:00–9:30	Michelle Flesher Art Therapy at a Small Psychiatric Hospital
9:30–10:00	Frances Purdy Encounter Principles as Applied to Art Therapy
10:00–10:30	Margaret Naumburg Importance of Training Art Therapists in the Adequate Use of the Psychiatric Interview
10:30–10:45	Break
10:45–11:15	Dr. Arthur Robbins A Psychoanalytic Prospective Toward Inter-relationship of Creative Process and Functions of an Art Therapist
11:15–12:00	General Discussion
12:00–1:00	LUNCH

Afternoon Session — September 25, 1970

1:00–2:00	Business Meeting
2:00–2:30	Miriam Dergalis Use of Art Therapy Test to Increase Accuracy in Determining Differential Diagnosis and Contributing to Team Approach to Treatment
2:30–3:00	John Herring, MD Family Art Therapy in Day Hospital Setting
3:00–3:30	Edith Zeirer
3:30–4:00	General Discussion
4:00–4:15	Break
4:15–4:45	Kay Pellock Creative and Free Expression Techniques, Applications for Mental Retardation
4:45–5:15	Judith Rubin Mother-Child Art Therapy Treatment Group
5:15–5:45	Rawley Silver The Transfer of Attitudes and Intellectual Abilities from Art to Other School Situations and Visa-Versa
5:45–6:15	General Discussion

Morning Session — Saturday, September 26, 1970

9:30–11:30	Workshops — *Helen Landgarten* — Art Therapy Methods Utilized in Clinical Out-patient Environment *Sandra Kagin and Myra Levick* — Techniques Used to Train Psychiatric Art Therapists *Harriet Wadeson* — Techniques for Treating Couples *Janie Rhyne, MA* — Therapeutic Art Expression *Marge Howard* — Current Diagnostic Evaluative Techniques Utilized with Short Term Hospitalized Children *Don Jones* — Helping Patients to Experience Feeling *Viola Dovell and Theresa Roach* — Free Expressive Techniques *Carol Johnson* — Art as a Tool in Education of Emotionally Disturbed Children *Bert Ramsey, Dr. William Shapiro, and Miss Judith Lombard* — A Demonstration of Technique and Therapeutic Value of a Large Group Drawing
11:30–1:00	General Discussion

AATA Award Winners: 1970–1993

Recipients of Honorary Life Membership in the American Art Therapy Association:

The **Honorary Life Membership** (HLM) is the AATA's most prestigious award and is conferred upon Professional members of the AATA in recognition of major contributions which have had a broad influence on the field of art therapy. The award was established in 1970 when Margaret Naumburg was presented with the first HLM; since then 18 additional HLMs have been awarded by the AATA:

1970	Margaret Naumburg
1971	Edith Kramer
1972	Elinor Ulman
1973	Hanna Yaxa Kwiatkowska
1974	Myra Levick
1975	Helen Landgarten
1976	Elsie Muller
1977	Bernard Levy
1980	Janie Rhyne
1981	Judith Rubin
1983	Rawley Silver
1986	Robert Ault
1987	Gladys Agell
1988	Don Jones
1989	Felice Cohen
1990	Frances Anderson
1991	Cay Drachnik
1992	Harriet Wadeson
1993	Gwen Gibson

Recipients of the American Art Therapy Association Distinguished Service Award:

The **Distinguished Service Award** (DSA) is conferred on a Professional member of the AATA in recognition of significant contributions to the field of art therapy specifically in the area of the AATA's internal development as well as its relationship with other organizations. As of 1993, five DSAs have been awarded:

1988	Lewis Shupe
1989	Suzanne Canner Hume
1991	Cathy Malchiodi
1992	Virginia Minar
1993	Deborah Good

Recipients of the American Art Therapy Association Art Therapy Clinician Award:

The **Art Therapy Clinician Award** (ATCA) is conferred on a Professional member of the AATA who demonstrates outstanding achievement in clinical service. There are four categories: (1) Adult Services, (2) Adolescent Services, (3) Child Services, (4) Family Services. There have been two ATCAs given:

1990	Shirley Riley (Family Services)
	Janet Bush (Child Services)

Other Awards:

The **Other Awards** category was developed for long-term productive involvement in the AATA and the profession of art therapy. Outstanding art therapists who have retired or who are about to retire are considered appropriate candidates for this award; the category also includes posthumous awards. Posthumous awards have been given to Clara Jo Stember and Donald Uhlin.

1994 marks the 25th Anniversary of the American Art Therapy Association. How will the profession of art therapy change in the next 25 years? In other words, what is your vision of the 21st century art therapist? Four AATA Award Recipients Respond.

Question: Will Art Therapy Survive Universal Health Coverage Reform?

Harriet Wadeson, PhD, A.T.R., HLM

Harriet Wadeson, PhD, A.T.R., HLM, began her art therapy career at the National Institute of Mental Health in Bethesda, Md., in 1961 under the mentorship of Hanna Kwiatkowska; she remained on the NIH staff until 1975. While there she published numerous papers in psychiatry journals and produced several exhibits for scientific conferences. One of them, "Portraits of Suicide," won the American Psychiatric Association's Benjamin Rush Award.

Toward the completion of her tenure at NIH, Harriet received a Masters Degree in Art Therapy and Psychology from Goddard College. This was followed by a Masters in Social Work from Catholic University and a PhD from Union Graduate School in 1978.

Harriet's teaching career began at NIH at its Foundation for Advanced Education in the Sciences and continued at Montgomery Community College and Lindenwood-4 College. In 1978 she moved to Texas to direct the Art Therapy Graduate Program at the University of Houston, and in 1980 transferred to the University of Illinois at Chicago to direct its Art Therapy Graduate Program, a position she has currently held for the past 13 years. Ten years ago she established its Annual Summer Institute which she continues to direct.

Harriet has been active in AATA since its inception, having served on its Executive Board for six years as Publications and Research Chair. She has also chaired its Funding Committee, Status of Women Committee, Ethics Committee, and edited the Newsletter. In 1979 she received AATA's Research Award. She is the editor of AATA's first book-length publication, A Guide to Conducting Art Therapy Research.

Other books she has published include Art Psychotherapy, The Dynamics of Art Psychotherapy, *and* Advances in Art Therapy, *the latter also an edited book. To date Harriet has published 50 journal articles, 14 chapters in scholarly texts, and contributed to five other published works. She has given 76 presentations at scientific meetings, 44 invited guest lectures (many of them abroad), 68 workshops, and she has held 17 visiting professorships. She has received 10 art awards (including a First Prize from the Smithsonian) and been awarded a Resolution of Commendation from the Illinois State Legislature. Her most cherished honor, however, is the HLM from AATA. Harriet's work has been highlighted in newspaper and magazine articles as well as on radio and television, in this country and abroad.*

Answer: YES, NO, MAYBE! President Clinton's health care revolution spearheads the double thrust of both humanitarian and economic reform. Most art therapists, particularly those of us who work with disadvantaged populations, would support health care for all, recognizing not only its inherent humanitarianism, but also its far-reaching impact that would ripple-effect into many other areas of society.

On the other hand, the restructuring of the health care system and its economic imperatives raise questions among many. Both health care administrators and economists argue over whether the President's "managed competition" can in fact pay for the health coverage he proposes and whether the "regional health alliances" through which care would be delivered might not add an unwieldy bureaucratic superstructure to the system.

From my perspective of an individual art therapist in private practice as well as a director of an art therapy graduate program, I puzzle over the future of my profession under the President's plan. Certainly, Clinton's current proposal will undergo heavy hammering as well as detailed refining on the anvils of Congress and its lobbyists before a final version is adopted. Nevertheless, from my limited viewpoint as an individual provider and consumer, some issues spring immediately to mind. Although my knowledge of societal economic possibilities is almost nil, I do have the benefit of colleagues' experiences in today's managed health care systems to project a view of an enlargement of that format to future health care. Unfortunately, all the reports I have received have been negative. One report is from a neurologist working in a smaller HMO that has been bought out by Humana. The physicians there have been required to buy into the organization at $20,000 or to get out. Other reports have come from a hospital bought out by Humana from a psychologist and an art therapist. They spoke of mass lay-offs and despairing morale. Apparently, Humana's expansion is part of an ongoing trend. According to the *New York Times*:

> *MEDICAL NETWORKS WITH BIG DREAMS*
>
> Big health maintenance organizations are likely winners in a new system in which capitation payments would finance most medical care, replacing fees for each service (September 19, 1993, Sec. 3, p. 6). (The article cites the Humana buy-out of the HMO mentioned above, as well as others.)

According to David Himmelstein, M.D., a professor at Harvard University Medical School:

> This is an incredible Rube Goldberg-type structure. Essentially what they want to do is push people into HMOs and save money on that. . . . What they will succeed in doing is putting the Aetnas and Prudentials in charge of the system, giving them ownership of health care (*Chicago Tribune*, September 19, 1993, section 1, p. 19).

The most impactful personal report I have heard has come from an art therapist who for 10 years directed an expressive therapies department of a private hospital operated by a managed health care organization. Recently she resigned, telling me that she could no longer abide the frustrations of trying to provide patient services in a system driven primarily by economic considerations to the exclusion of attention to patients' needs. As a 10-year veteran of this system, she was certainly no starry-eyed innocent idealist. She had been successful in her work and had developed an excellent reputation for her program. Her resignation raises significant questions for me about the place for art therapists in managed care.

The *New York Times* article quoted above is titled "Changing the Fortunes of the Medical Business." As the lead article of the Sunday Business Section, it focuses on the winners and losers under the President's proposed health plan. Among the losers are specialists: "Cost-conscious medical networks make fewer referrals to specialists and entirely exclude specialists they don't need or want" (September 19, 1993, section 3, p. 6). The article is referring to medical specialties and does not cover mental health care at all. (Its absence speaks to its insignificance in the overall plan.) Nevertheless, it is clear that mental health benefits will be limited and referral for additional treatment by an art therapist unlikely. Additional losers will be hospitals (the job source for many art therapists), but the good news is that the *Times* sees nursing homes and home care as winners as patients are moved to less expensive settings as soon as possible. Certainly the former offers art therapy possibilities.

It appears clear that individual art therapists and art therapy training programs are ill-advised to look to the traditional fee for service medical model to fund art therapy positions. Those of us who are in private practice, and the many art therapy students and beginning practitioners who would like to develop a private practice, are well advised to recognize changing realities. For example, some of my private clients now receive substantial insurance reimbursement for my fees. Many art therapists look to licensure (either of art therapists or as counselors) to enable them to qualify for third-party payment. Yet it is likely that insurance coverage of private practice art therapy will become obsolete very soon. With such a realization in mind, I contacted the insurance system that manages the State of Illinois health insurance that provides my own coverage. The concreteness of the justifications for treatment and its constant concrete monitoring appeared antithetical to the ways in which I work and view my clients. I did not pursue the contact further. I believe that art therapy services will be difficult to justify for many clients in the kind of accountability that will drive the cost containment provisions of the future health alliances. The goals of art therapy treatment are more often directed toward life enhancement realms than toward "fixing" a particular ill.

For the many art therapists who work at hospitals, prospects are also questionable. There have already been substantial lay-offs in both private and not-for-profit facilities. If hospitals will lose out further, as the *Times* suggests, art therapists may be considered nonessential staff and given the gate. The 10-year veteran director of expressive therapies in a managed private hospital, discussed above, upon seeing her staff dwindle from successive lay-offs, decided to leave before the ax reached her position as well.

Given the grim prospects for art therapy support under "managed competition," what creative alternatives are possible? One possibility applies to a very small segment of society. The Clinton proposal retains the option of fee-for-service treatment by a private practitioner with greater out-of-pocket expense to the consumer. Therefore, as is now the case, some clients with the financial wherewithall will continue to see art therapists on a private basis. Those art therapists (like myself) who now are covered by third-party payment will probably have to reduce their fees to accommodate the loss of insurance coverage. The days when psychotherapists can bill a session from $75 (social workers) to $150 (psychiatrists) are rapidly drawing to an end. How private art therapy fees will be influenced by the fees of other private mental health practitioners remains to be seen.

Very few art therapists derive the major portion of their income from private practice, however. Most private practice work is conducted by those who work in a facility's art therapy program as well. And for most art therapists, work at a facility is their sole source of income. Where the essential mission of such a facility is to provide medical care or education, art therapy may be perceived as nonessential and therefore may be eliminated in the service of cost-cutting. On the other hand, where the mission is rehabilitative in nature, art therapy may be an essential component in promoting positive change. Examples of such programs might include shelters for the homeless, battered women and children, ex-prostitutes, survivors of violence and abuse, and aftercare facilities. Art therapy might also be integral to programs for care of individuals who are not expected to improve, such as AIDS units, hospices, facilities for the elderly. Another nonpsychiatric area, education, offers possibilites for art therapists. In some communities, such as Dade County, Fla., art therapy has become a part of the public school system. Many other school systems, however, reject any service labeled therapy. Special schools, on the other hand, often offer therapy as a major component of their programs.

Art therapy in these kinds of facilities is usually long-term in nature. Most art therapists would probably agree that

BEST COPY AVAILABLE

art therapy, like other nonpharmaceutical mental health modalities, is most effective on a long-term basis, providing greater opportunity for growth and integration of change. Art therapy for short-term care, such as seen on psychiatric units, may be on the way out.

Finally, there is the great grey area of personal growth. Certainly our profession has generated more heat than light around viewing art therapy as creativity- rather than as pathology-oriented. Those of us who practice and teach art therapy have known the benefits of experiencing our own art for personal exploration, healing, growth, and joy. We have done so on our own, in art therapy classes, and in workshops directed toward that end. Some of us have even received remuneration from providing such experiences for others. Few of us, however, have made a living from it. Nevertheless, this is an arena in which many art therapists would like to work. Perhaps there are creative possibilities to explore and develop in this realm.

I have written this article in order to prompt myself to come to grips with the imminent challenges that face my profession, both to help me to formulate my own directions, as well as to prepare art therapists of the future whom I train. In doing so, it appears to me that the soil for art therapy's growth (or maybe its survival) is likely to be most fertile in the fields of social, rather than in the more traditional psychiatric, needs. Even prior to Clinton's proposal, I have noticed a shift in our training program. More of our practicum sites are shelters, AIDS units, programs for survivors of violence and abuse. A course in art therapy for specific populations in which each class is taught by a guest art therapy lecturer expert in a specific area, has changed in recent years. The syllabus now includes more areas of social ills, such as homelessness, sexual abuse, cross-cultural problems, and AIDS.

Although art therapy has come a long way in becoming a recognized and respected profession, in the current climate of health care cost-cutting, it is essential that we become essential if we are to survive health care reform. Some of the graduates from the program I direct furnish impressive models: One is part of a staff of three that provide a day shelter for homeless women. Art is all over their community space, and the women can make art whenever they want. Two graduates run programs at aftercare day facilities. Art in groups and individual sessions make up a significant component of these facilities' services. Another has created an innovative art program at a day care center for the elderly. All these art therapists have directed these programs for five to 10 years. Recently a program for women surviving violence and sexual abuse has hired several of our graduates and is seeking art therapy interns. Art therapy is increasingly becoming recognized as a major modality in tapping into experiences of violence and abuse that may not be accessible by words. Three years ago an art therapy intern set up an art therapy program on a hospital AIDS unit. The program became indispensable and has been generously funded to the extent of building and bountifully equipping a special art room with adjoining solarium, headed by the intern/graduate. These are but a few examples of art therapy's movement into realms of acute social need.

To return to my initial question on the survival of art therapy and its three-part answer: NO, I don't believe art therapy will survive if our heads are in the sand and we proceed with business as usual as the winds of change blow us away. YES, I believe we will survive and grow if we become essential providers in the realms of great need in our unfortunately needy society. And finally, I reserve a MAYBE for those gray areas of great interest to art therapists, private practice and personal growth. Perhaps they must remain sidelines for most of us.

Art Therapy: The Future

Gladys Agell, PhD, A.T.R., HLM

Gladys Agell, PhD, A.T.R., HLM, is the director of the Graduate Art Therapy Program of Vermont College of Norwich University and the editor of the American Journal of Art Therapy. She enjoys a private practice as both an art therapist and a clinical psychologist. Since joining the American Art Therapy Association in the very early days, she has been an active member of the Education Committee, in addition to serving as Education Chair, Chair of the Nominating Committee, President-elect and President, and in the recent past as Secretary.

Gladys Agell has been an active art therapist since 1967. For most of the ensuing years, she has paired the roles of educator and clinician. Clinical work has included art therapy with children, adolescents, and adults. As an educator, Dr. Agell has designed and developed the program that has been housed at Vermont College of Norwich University for over 10 years. Believing that responsible political activity is part and parcel of participating in a developing field, Dr. Agell was a founding member of both the New York Art Therapy Association (NYATA) and the Art Therapy Association of Vermont and the founding chair of the NYATA. In addition, she has served on both the Education and Nominations committees of the American Art Therapy Association, Inc. (AATA); she has chaired both committees; is a past-president and of course was president-elect of the association. AATA awarded her the Honorary Life Membership. As editor of the American Jour-

nal of Art Therapy. Agell has made an effort to follow in the tradition of Elinor Ulman, who brought to the profession a publication that was contemporary, thought-provoking, and well-written.

Agell has been interested in greater membership power and participation in the Association. She has stated, "For too long AATA has been an organization that has operated behind closed doors. It is time that members are well-informed and have the opportunity to influence decisions made by the executives. I have been advocating this for some time and there has been a marginal response to this notion. I would certainly like to see this become a practice of our association rather than an exception. This includes but is not limited to being informed about how members of the Board vote on issues.

I was sitting with Margaret Naumburg just before she received the first Honorary Life Membership from Myra Levick, the first president of the American Art Therapy Association. I thought Margaret would be pleased that the fruits of her labor resulted in the establishment of a national association . . . and that she was about to receive AATA's highest accolade. Not so. Margaret bemoaned what she predicted would become a plebeian field rather than an elysian landscape peopled by a handful of gifted art therapists. Margaret was an intellectual and her notion of art therapy was elitist. There were, in her view, only a few people suited to becoming art therapists. I wonder what she would say if she were alive today.

The present foreshadows the future, laying the foundation for what is to come. Though originating in psychoanalytic theory, contemporary art therapy is comprised of people who hold diverse beliefs and variously define ways they work. Diversity, to my way of thinking, produces vibrancy . . . vitality. However, a framework must be established to prevent diversity from declining into chaos. At one time the guiding documents of AATA provided that framework.

However, past editing of Guidelines for Art Therapy Training and Education, Standards and Procedures for Registration, have mutilated what were once erudite, lucid documents. In addition, the AATA ethical code, criteria for professional membership, and criteria for clinical practice reflect our lack of linguistic precision and sophistication. Documents become mandates before those affected are fully informed of their meaning. Furthermore, the lack of consistency between documents and contradictory criteria due in some measure to careless grammar, syntax, and bewildering organization presents a profile lacking in professional polish.

Educators who neglect the art in art therapy seem unaware of the danger inherent in this kind of misguided training. Quick, crude art making has been supported and the emphasis on talking about the picture or sculpture made central to the session. In the interest of encroaching on psychiatric prestige, the artwork is disregarded. However, psychiatrists, psychologists, social workers, and mental health counselors talk better than we do. If we want to enter that assembly, we should abandon brushes, pastels, and clay tools and concentrate fully on words . . . talk, talk, talk . . . because, as it is presently, we're up against some pretty stiff competition. Not only are we outclassed, we're outnumbered.

The slides of members' artwork at the Atlanta conference clearly demonstrated that we are artists. We're good with art materials. If we can relinquish our promotion of questionable idolatry, our self-image of being healers and shamans; if we can take pride in helping people discover something about themselves by pushing pigment or pulling graphite across a surface or forming clay in an effort to elicit "Eureka," only then do I see a viable future for art therapy that is not subordinate to mental health counselors, family therapists, or special educators. If talk can succeed the experience instead of replacing it, if we can learn more about what we're looking at and acknowledge that it has meaning beyond a mere storyline; or in other words, if we can look deeply and balance our psychiatric beliefs with our art knowledge, only then can we make a credible contribution to others.

A Time for Growth

Virginia M. Minar, A.T.R., recipient of the 1992 Distinguished Service Award

Virginia M. Minar, MS, A.T.R., is currently an associate instructor in the Graduate Art Therapy Program at Mount Mary College, Milwaukee, Wisconsin; her private practice is with cancer patients. She retired in 1986 from the West Allis-West Milwaukee School District after 15 years as an art-exceptional education teacher/therapist.

Ms. Minar has held numerous positions with the Wisconsin Art Therapy Association, including 10 years on their Executive Board. Since 1978, she has served the AATA on more than 14 different committees. On the AATA Board, she has served as Treasurer, as Director, and is presently the President-Elect.

Virginia Minar has received the following awards and honors: a Wisconsin Art Education Association Award in recognition of outstanding contributions to the arts and service to the Community; the WATA Honorary Life Member Award; Very Special Arts service awards; the 1992 AATA Distinguished Service Award; Kappa Delta Pi and Phi Kappa Phi honors. She has appeared on local television programs and

BEST COPY AVAILABLE

been interviewed for local newspaper articles regarding her work with special needs children and cancer patients. As an artist, her early artwork was in painting and photography; she now works primarily with oil pastels, drawing, and rubbing with cloth to achieve subtle blending of colors.

Organizations, like people, go through stages of development in which events and experiences bring about changes in personal and public relationships as well as professional goals and objectives. As we celebrate our 25th year we are ready to enter Erikson's Stage Seven, adulthood. In this stage, concern is

> with establishing and guiding the next generation. . . . Productivity in work and creativity . . . are important concepts in this period. Having a sense of accomplishment . . . depends on giving loving care to others and regarding one's own contributions to society as valuable. Merely producing children does not give . . . a sense of generativity; one must see one's role in rearing them as a contribution to humankind and the larger society. Dangers are self-absorption and a sense of stagnation, a sense of going nowhere, doing nothing important. (Schell & Hall, 1979, pp. 39–40)

For this discussion, I am substituting the word "growth" for "development." As an organization, we have been steadily developing. We are now ready to grow, not only in size, but also in weight and power. Our membership has increased 35% since 1989. We have been recognized by some legislative bodies at both the federal and state levels. We have established working relationships with certain allied professions and are investigating alliances with others. We need to continue to grow in all of these areas if we want to secure our place in the ever-changing health care environment. Using each letter of GROWTH, I will expand on the meaning of the word as it relates to the next 25 years of the American Art Therapy Association (AATA).

"*G*" stands for GENERATIVITY: Art therapy educators are producing the next generation of art therapists. As these students graduate and enter the profession, we, the elders of this organization need to embrace the role of mentor by sharing our contributions to the field with them, and by guiding these new collegues without expecting them to mirror our images. While we should continue to honor our history, we must be receptive to their ideas and allow that new energy to generate further growth.

"*R*" represents RESEARCH: While some valuable research has been done by art therapists as documented in *A Guide to Conducting Art Therapy Research* (Wadeson, 1992), it is imperative that we continue to encourage and support research that demonstrates what we do and how it effects those to whom we provide services. Because creativity is primary in the practice of art therapy, many of us have been reluctant to conform to the requirements of clinical research. Rubin (1984) cautions that research is

> rarely as flexible as any of the other roles [art therapists assume], because of the necessary control of important variables. Research allows creativity primarily in its design and analysis, but hardly ever in the actual implementation of the study. (p. 179)

We need to find solutions to the problem of doing empirical studies without sacrificing the "art" of art therapy. The AATA has established a Research Fund to which members are encouraged to contribute, but this fund needs to increase substantially before it can support the implementation of innovative art therapy research. Recently, we have been granted a new tax status "enabling the AATA to solicit and accept tax-deductible contributions" including grant monies (Goodman, 1993, p. 1). The Research, Clinical, and Governmental Affairs committees will be able to collaborate on "researching" those foundations that make grants available to qualified charitable organizations.

"*O*" stimulated two choices: OBJECTIVES and OBLIGATION. Although our objectives may change from year to year, they must always be selected to meet contemporary challenges. In 1994, four of the board's major objectives are: (a) to offer Continuing Education Credits at the annual conference and at regional symposiums, (b) to implement revisions to our Educational Guidelines and the Education Training Board's approval process, (c) to strengthen Ethics and Professional Practice policy and procedures, and (d) to engage a legislative consultant to help us prepare testimony for various committee hearings on Health Care Reform. While the AATA's initial obligation is to meet the professional needs of its members, the ultimate obligation is the protection of the public we serve by continuous reassessment of the growing field of art therapy.

"*W*" suggests WISDOM: The use of wisdom is essential for art therapists. Wisdom is to know which of the various theories and methods will work best for you in your practice. Corey, Corey, and Callanan (1993) advise that:

> We do not advocate that you subscribe to one established theory, because you can find ways to draw on therapeutic techniques from many theoretical approaches. . . . Ideally, practitioners' theoretical orientation will serve as a basis for reflecting on . . . goals and techniques that are most appropriate with specific clients in resolving a variety of problems. (p. 236)

AATA's role is to use the wisdom and expertise of its members in providing educational opportunities through our symposiums and conferences that offer programs and courses about contemporary topics, for example current trends in health care provision, specific treatment groups (e.g., cancer, HIV, Alzheimer's), ethics and professionalism, private practice management, and service guidelines. Such offerings will allow participants to increase their knowledge and skills in particular areas of interest. Wisdom is recognizing what theories and techniques you are comfortable using in your private practice, or within your institution of employment.

"*T*" represents two seemingly oppositional concepts, TENACITY and TOLERANCE. Tenacity is the ability to firmly hold on to the belief that art therapy, as a treatment modality, is distinctly different from other human service professions. That difference is the use of art materials and the creative process to allow images to emerge that can be explored by the individual or group with the guidance of the art therapist. As discussed before, there are, within the profession, various art therapy theories and techniques, but the one thing they have in common is the "art part." That is the part which requires tenacity, not a particular theory or technique. Tolerance of the various art therapy procedures used by our colleagues is essential. Our organization cannot grow if we are expending our energy championing one particular method over another.

Tenacity and tolerance must work together when presenting art therapy to allied professions, governmental agencies, health care institutions, and the public.

"*H*" is the last, but most important letter of GROWTH since it represents the **HEALTH** of the organization, the public we serve, and ourselves as providers of service. In order to function effectively in our increasingly complex society, we must seek to attain and maintain health in mind, body, and spirit.

What does that mean for the AATA? The Board of Directors as representing the mind needs to, at all times, make decisions that protect and benefit the body, the membership. The body needs to take an active part in questioning those decisions, suggesting alternatives, and supporting the work of the board and the committees. Both the board and the membership need to nurture the spirit of the association by exhibiting their commitment to, and belief in the profession of art therapy. The spirit should be neither narcissistic in nature nor completely altruistic in application.

Except for our responsibility as members of the society-at-large, we are not accountable for the presenting health of the public we serve. Once we have accepted a client, treatment should deal with mind, body, and spirit as a total gestalt. While many art therapists adhere to a particular theory and methodology, others use a more eclectic approach in their practice. What works for one patient may not work for another. Flexibility should be coupled with commitment to finding the most effective methodology for meeting the needs of specific clients.

Finally, we must take care of ourselves. Before we can function effectively as art therapists, we need to strive for wholeness in mind, body, and spirit. How can we help others, if we do not first help ourselves? Helping ourselves includes being active in both local and national art therapy organizations. These groups can serve as a support system, particularly for those who feel isolated in their place of employment.

Maslow (in Good, 1974, p. 143) believed that few people attain complete self-actualization in their lifetime, but that "in practically every human being there is an active will toward health, an impulse toward growth, or toward the actualization of human potentialities." The American Art Therapy Association is made up of human beings, and I would hope that we never reach the point where we feel we have attained all of our goals and objectives. We must avoid the dangers of self-absorption and stagnation. We will only remain vital if we experience on-going GROWTH. The time will always be NOW!

References

Corey, G., Corey, M. S., & Callanan, P. (1993). *Issues and ethics in the helping professions*. (4th ed.). Pacific Grove, CA: Brooks/Cole.

Good, P. (1974). *Human behavior: The individual*. New York: Time-Life Books.

Goodman, R. (1993, Fall). Report of the president. *American Art Therapy Association Newsletter*, p. 1.

Rubin, J. (1984). *The art of art therapy*. New York: Brunner/Mazel.

Schell, R. E., & Hall, E. (1979). *Developmental psychology today*. (3rd ed.). New York: Random House.

Wadeson, H. (Ed.). (1992). *A guide to conducting art therapy research*. Mundelein, IL: American Art Therapy Association.

My Visualization for 21st Century Art Therapy

Janet Bush, EdS, A.T.R.

Recipient of the 1990 Art Therapy Clinician Award/ Child Services

Janet Bush, EdS, A.T.R., was the founder of clinical art therapy in the Dade County Public Schools, Miami, Fla. She began the art therapy program as a pilot undertaking, and soon demonstrated the potential that is inherent in an art therapy approach. She is presently serving as Department Chairperson in the Division of Exceptional Student Education, where she directs a program of 18 master art therapists who provide services to over 400 emotionally disturbed students.

She began her career as an art educator, having received a BA degree in art and psychology from The Ohio State University. Graduate art therapy studies at Hahnemann University, in Philadelphia, led her to work in a public school setting, and she pioneered the application of art therapy to public schools in her graduate thesis. At Dade County Public Schools, she coordinated the first full art therapy program in a public school setting in the nation.

Ms. Bush is a registered, practicing art therapist, a founding member of the Florida Art Therapy Association, a university instructor, and a nationally known speaker and lecturer on art therapy in the schools. She has written numerous articles, and has served as a consultant in many clinical and educational settings. She made a major contribution to the field of art therapy with the establishment of a model program for public schools which the American Art Therapy Association recognized. She subsequently received a distinguished clinical services award for her work with children. As a result of Ms. Bush's efforts, art therapy in the public schools has become a nationwide practice in recent years.

I was the recipient of the AATA Art Therapy Clinician Award at the 1990 NCATA Conference in Washington, D.C.

BEST COPY AVAILABLE

The award was in recognition of my work in implementing a school system program for severely emotionally disturbed youth, in Miami, Fla. The program, which has been operating in the Dade County Public Schools since 1979, is staffed by 18 full-time master art therapists. It has served over 400 children each school year. I am encouraged to look forward to the time, during the 21st century, when art therapy may be available in every school district in the nation.

The profession of art therapy has evolved to encompass a wide range of applications. Although the field was traditionally part of the intervention for psychiatric patients, its horizons have expanded to school settings—both for the so-called normal youngster and for the youngster experiencing problems. The introduction of art therapy in the schools represents new ideas, healthy controversy, and fresh challenges. The expectation is that the 21st century will make it possible to extend the benefits of the growing sophistication of the profession and its interface with other fields—particularly, education—to a variety of new operations.

The multiplicity of training approaches has already led to numerous models of functioning not only in the clinically oriented hospital settings, but also in the schools. There has been an endless historical debate over the philosophy and the proper role and function of the art therapist in clinical settings. It is likely that as programs and art therapy services grow within education, the philosophical debates will carry over to education.

In essence, the history of art therapy has been the history of a profession seeking an acceptable identity. Thus one of the issues needing exploration and closure is the role of the art therapist in the 21st century. I do not see the art therapist as an outside consultant who delivers services to an educational setting, but rather as a professional functioning within the educational system as part of that setting. The lag between the development of appropriate training for utilization of art therapy in the schools and the beginning of professional school art therapy programs and services remains incomprehensible. There is no doubt that public agencies, parents, children, and other consumers of school art therapy services do not have an understanding of the nature of art therapy. To meet the demands of human needs in the coming century, the time has come to organize a practical implementation model and to define the role and function of the school art therapist so that both parents and public agencies know what art therapy can do for a child.

Business communities and the public are demanding change in our entire education system, wanting our schools to become more "customer focused." And who are our customers? Many students are emotionally distraught and unable to cope. More disturbing than ever is the fact that even those students who succeed in school and who score well on conventional tests have not been educated to cope successfully with the demands foreseen for the personal, vocational, and civic life of the near future. If the schools do not meet the needs of our general student body, the response to what is perceived as school system failure may lead to a demand for the inclusion of intensive art therapy in the schools to counter the downhill learning curve. Educators must convince community members that unless we ensure the educational achievement of all students, the overall quality of life will be affected for generations to come.

Traditional educational values and well-established programs will continue to meet intense scrutiny. Public expectations have never been higher. The push for accountability, measured by student performance outcomes, is increasing. Perhaps the greatest challenge now facing educators is the question, Can you truly marshal the elements of proof that the education system can respond to public pressure in a positive way and improve the performance of the schools and of the children served by the schools?

It is no longer fair or productive simply to point to our schools and say they are failing. It is time to join forces to bring about the changes so sorely needed throughout our educational system, changes that may involve the entire community of art therapists, for they are equipped to help meet the challenge of the 21st century. Art therapy procedures used for diagnostic and screening purposes can identify youngsters at risk. When used for treatment, art therapy procedures can help individual students to better understand themselves. Art therapy in the 21st century will be equipped to offer children opportunities to work through obstacles impeding their educational success. It will facilitate appropriate social behavior and promote healthy affective development through which these children can become more receptive to academic involvement, and it will maximize their social and academic potential.

Countless numbers of children have gone unnoticed and unheard of through the years because art therapy has not been available to assist them. I invite you to join me in building a productive educational frontier with the aid of art therapy.

To those who continue to share my conviction that children deserve our best efforts, thank you for believing as I do. Let's meet in the 21st century and compare notes.

PHOTO GALLERY

President Robin Goodman, 1992 Spring Board Meeting, Chicago, IL.

John MacGregor, Keynote Speaker, Bob Ault at 1992 Conference, Las Vegas, NV.

Cay Drachnick & Jaynie Rhyne at 1992 Conference, Las Vegas, NV.

Felice Cohen, Irene Corbit, May 1987.

1992 Conference—Las Vegas: Janet Bush, Barbara Fish, Debbie Good, & Mary St. Clair.

Shirley Riley, Helen Landgarten, Suzanne Silverstein-Chiramonte and Bobbi Stoll at 5th Annual Conference, 1974.

Art Therapy: Journal of the American Art Therapy Association, 11(1) pp. 34-36 © AATA, Inc. 1994

Introduction to Special Section on Sexual Abuse and Dissociative Disorder

Cathy A. Malchiodi, MA, A.T.R., Editor

This special section of *Art Therapy* highlights the use of art therapy with clients who have been sexually abused or who are experiencing dissociative disorder. Included in this section is a research report on the contribution of art therapy to dissociative disorders (Murphy), observations on the clinical applications of art therapy with MPD clients (Jacobson), the use of art therapy with a victim of rape (Nykasa-Hargrave), and a review of published research on the use of drawings to determine child sexual abuse (Hagood). A unique personal perspective from an artist who experienced sexual abuse as a child is described through both words and art (Orleman), and this issue's cover art is by a survivor of sexual abuse (Harris).

The investigation of the unique connections between art therapy and the assessment and treatment of sexual abuse in particular has had a long history. Naumburg (1953) devoted an entire book to her study of a woman sexually abused as a child, observing that the abuse was repressed until her art released the traumatic memories. Howard and Jacob (1969) examined the art productions of sexually abused children, noting some similarities in the graphic indicators present in their limited sample. In the late 70s, Clara Jo Stember, an art therapist who worked as part of a sexual abuse treatment team, wrote of her experiences in developing art therapy programs with abused children (1978) and her observations of graphic indicators of sexual abuse in children's drawings (1980); later, Naitove (1982) described and expanded Stember's work with sexually abused children. More recently, art therapists and others have developed research to systematically examine specific graphic indicators of sexual abuse in various drawing tasks (Cohen & Phelps, 1985; Kelley, 1984; Riordan & Verdel, 1991; Sidun & Rosenthal, 1987; Spring, 1985a, 1988; Yates, Beutler, & Crago, 1985, to name a few).

Additionally, the use of art therapy in the assessment and treatment of sexual abuse has been a cutting edge topic at many of the annual AATA conferences. At the AATA 15th Annual Conference, many art therapists may remember the well-attended presentation by Felice Cohen (1984) who discussed her comprehensive study of the graphic indicators of sexual abuse in children's drawings; this landmark study was later published in the following year (Cohen & Phelps, 1985). In recent years, the annual conference has continued to provide a forum for discussion of sexual abuse in relation to adult treatment issues (Anderson, Deitz, & Ward, 1993; Anderson & Deske, 1991; Cox, Cohen, Mills, & Sobol, 1991); family art therapy (Cox, 1988); developmental issues across the lifespan (Farrelly-Hansen, Lack, Safran, & Sweig, 1991); ritual abuse (Cox, 1991; Drachnik, 1991; Sweig, 1992); sex offenders (Overdorff, 1993; Spring, Hurd, & Churchill, 1988); and other topics and presenters too numerous to list. During these years, a study group on the symbolic language of sexually abused clients was formed and led by Dee Spring, PhD, A.T.R. and others, to more closely examine treatment issues (child, adolescent, adult, and perpetrators), to discuss clinical observations and research, and to share case material.

In the mid 80s up until the present, a topic related to sexual abuse rose to prominence at the annual conference: dissociative disorder or multiple personality disorder (MPD). In 1985, Christine Sizemore (of "The Three Faces of Eve" fame) discussed her own multiple personalities and shared her paintings at the 16th Annual AATA Conference. Since then art therapists and others have been active in presenting both clinical material and research data, contributing to the area of dissociative disorders. (Cohen & Cox, 1988; Spring, 1985b; Swieg, 1988, to name a few), and in writing comprehensive texts on the topic (Kluft, 1993; Spring, 1993). One of the most requested AATA Regional Symposia has been on the topic of multiple personality disorder, reinforcing the continuing interest of art therapists in this area of study and practice.

Art Therapy, Sexual Abuse, and Dissociative Disorder: Some Unanswered Questions

Despite all the contributions by art therapists and other professionals to the body of knowledge on art-based assessment and treatment of sexual abuse and dissociative disorders, there are still many questions that remain unanswered. One area that continues to confound art therapists is the reliability of drawings in identifying sexual abuse and dissociative disorder. Despite the best research efforts, can drawings ever be utilized with reliability in such circumstances? In this issue of the journal Hagood and Drachnik pose some questions about the reliability of graphic indicators of sexual abuse in children's drawings. Hagood's overview of the literature on the graphic indicators of sexual abuse in children's drawings concludes that a great many more studies are needed to arrive at a comprehensive list of graphic indicators with this population. She also points out that developmental level must be carefully taken into account in the examination of children's drawings. Currently, Hagood is conducting a large-scale research project in Great Britain examining the art expressions of children who have been sexually abused to determine if such art expressions can be utilized with any degree of reliability and under what circumstances.

Drachnik, in her discussion of the tongue as a possible graphic indicator of sexual abuse in children's drawings, cites the fact that there may be indicators in art expressions that researchers and clinicians have not yet recognized or formally investigated. Her brief report on her clinical observations of the drawings of sexually abused children points to the need to continue research into graphic symbols with open minds to additional possibilities in this area.

Another topic of interest to art therapists who work with sexually abused or traumatized clients is the current debate over what has been coined "false memory syndrome" (Wylie, 1993). False memory syndrome may include inaccurate recollections of past traumatic events, including those which susceptible individuals adopt at the suggestion of someone else; for this reason, therapists who work with clients to bring forth repressed memories have come under fire. Currently, clinicians and researchers who work with adult clients who state that they were sexually abused as children are investigating the reliability of such accounts. There are also questions being raised concerning the amount of and type of abuse reported by clients; in particular, the areas of cult and ritual abuse have become controversial in the eyes of both professionals and the public.

Additionally, there have been questions raised about the benefits of uncovering traumatic memories in clients (Yapko, 1993) and that repressed memory therapies are actually harming clients, rather than helping them (Jaroff, 1993). With regard to the field of art therapy which utilizes art expression and imagery to uncover or surface traumatic memories, it is interesting to speculate as to whether the use of drawings or other visual art expressions, under certain circumstances, may be more reliable than verbal accounts. Given the scrutiny that strictly verbal accounts have received over the last few years, the use of art expression may also be viewed critically by those who doubt the accuracy of traumatic memories; therefore, additional studies of the reliability of art expression in surfacing repressed memories are undoubtedly needed to increase clinical confidence in its use as a therapeutic tool with traumatized clients.

Lastly, will art therapists be increasingly called upon to share their unique knowledge as expert witnesses in courts of law in cases involving sexual abuse? At the recent AATA conference two interesting presentations were given on the subject of the use of drawings in court. Graves (1993) illustrated methods of introducing drawings as evidence and discussed the acceptability of art therapy in testimony. Liebman (1993), building on the work of Levick, Safran, and Levine (1990), established and clarified the role of the art therapist as an expert witness in child abuse litigation. Both presenters underscored the important role of the art therapist as an expert witness in cases involving sexual abuse.

The use of art expression has become an important and recognized tool in both the assessment and treatment of both children and adults who have experienced sexual trauma. However, working with sexual abuse and dissociative disorders in a clinical environment, private practice, or as an expert witness is probably some of the most difficult and challenging work for any professional. For art therapists it also may be some of the most exciting work, due to the unique modality we have available to communicate with and treat our clients, and the increasingly rich body of knowledge on the use of art expression with traumatized populations that art therapists have contributed to over the last decade.

References

Anderson, F., Dietz, M., & West, C. (1993). Art therapy with incest survivors: Addressing emotional, cognitive, spiritual and research aspects of treatment. In *Common Ground: The Arts, Therapy, & Spirituality* (p. 129). Mundelein, IL: AATA.

Anderson, F., & Deske, K. (1991). Ceramic mural messages from incest survivors. In *Image & Metaphor: The Practice and Profession of Art Therapy* (p. 76). Mundelein, IL: AATA.

Cohen, B. (1993). Art and MPD: Uncommon realities. In *Common Ground: The Arts, Therapy, & Spirituality* (p. 74). Mundelein, IL: AATA.

Cohen, B., & Cox, C.T. (1988). Breaking the code: Identification of multiplicity through art productions. In *Professionalism in Practice* (p. 105). Mundelein, IL: AATA.

Cohen, F., & Phelps, R. (1985). Incest markers in children's art work. *The Arts in Psychotherapy, 12*(4), 265–283.

Cohen, F. (1984). *Incest markers in children's art work.* Unpublished paper presented at the 15th Annual Conference of the American Art Therapy Association, Washington, DC, November 2.

Cox, C. T. (1988). Family art therapy: A case study involving three sexually abused sisters. In *Professionalism in Practice* (p. 90). Mundelein, IL: AATA.

Cox, C. T., Cohen, B., Mills, A., & Sobol, B. (1991). Art by abuse survivors: A life cycle. In *Image & Metaphor: The Practice and Profession of Art Therapy* (p. 63). Mundelein, IL: AATA.

Cox, K. (1991). Surviving the survivors of ritual abuse: Image of the client and therapist. In *Image & Metaphor: The Practice and Profession of Art Therapy* (p. 67). Mundelein, IL: AATA.

Drachnik, C. (1991). Was it schizophrenia or ritual abuse? In *Image & Metaphor: The Practice and Profession of Art Therapy* (p. 66). Mundelein, IL: AATA.

Farrelly-Hansen, M., Lack, H., Safran, D., & Sweig, T. (1991). Art therapy treatment of sexually abused clients: Child, adolescent, adult. In *Image & Metaphor: The Practice and Profession of Art Therapy* (p. 54). Mundelein, IL: AATA.

Graves, S. (1993). Drawings as acceptable evidence of sexual abuse: A court of appeals ruling. In *Common Ground: The Arts, Therapy, & Spirituality* (p. 120). Mundelein, IL: AATA.

Howard, M., & Jacob, I. (1969). Case studies of molested children and their art productions. In I. Jacob (Ed.), *Art Interpretation and Art Therapy. Vol. 2. Psychiatry and Art* (pp. 72–89). New York: Karger.

Jaroff, L. (1993). Lies of the mind. *Time, 142*(23), 52–59.

Kelley, S. (1984). The use of art therapy with sexually abused children. *Journal of Psychosocial Nursing, 22*, 12–18.

Kluft, E. S. (1993). *Expressive and functional therapies in the treatment of multiple personality disorder.* Springfield, IL: Charles C Thomas.

Kluft, R. (1987). An update on multiple personality disorder. *Hospital and Community Psychiatry, 38*(4), 363–373.

Levick, M., Safran, D., & Levine, A. (1990). Art therapists as expert witnesses: A judge delivers a precedent-setting decision. *The Arts in Psychotherapy, 17*, 49–53.

Liebman, M. (1993). The art therapist as expert witness in child sexual abuse litigation. In *Common Ground: The Arts, Therapy, & Spirituality* (p. 133). Mundelein, IL: AATA.

Naitove, C. (1982). Art therapy with sexually abused children. In S. Sgroi (Ed.), *Handbook of Clinical Intervention in Child Sexual Abuse* (pp. 269–308). Lexington, MA: Lexington Books.

Naumburg, M. (1953). *Psychoneurotic art: Its function in psychotherapy.* New York: Grune & Stratton.

Overdorff, B. (1993). Art for empathy in adult sex offender treatment. In *Common Ground: The Arts, Therapy, & Spirituality* (p. 66). Mundelein, IL: AATA.

Riordan, R., & Verdel, A. (1991). Evidence of sexual abuse in children's art products. *The School Counselor, 39*, 117–121.

Sidun, N. & Rosenthal, R. (1987). Graphic indicators of sexual abuse in Draw-A-Person tests of psychiatrically hospitalized adolescents. *The Arts in Psychotherapy, 14*, 25–33.

Spring, D. (1985a). Symbolic language of sexually abused, chemically dependent women. *American Journal of Art Therapy, 24*(1), 13–21.

BEST COPY AVAILABLE

Spring, D. (1985b). *The visual language of multiplicity.* Unpublished paper presented at the 16th Annual Conference of the American Art Therapy Association, New Orleans, LA, October 26.

Spring, D. (1988). *Sexual abuse and post-traumatic stress reflected in artistic symbolic language.* Ann Arbor, MI: UMI Dissertation Information Services, Pub. #9008293.

Spring, D. (1989). From "way below" to the "light side": Identifying alters in MPD. In *Family Portraits: Families, Groups & Systems* (p. 92). Mundelein, IL: AATA.

Spring, D., Hurd, S., & Churchill, P. (1988). The lifelong effects of sexual abuse: Male victims and victim turned offender. In *Professionalism in Practice* (p. 114). Mundelein, IL: AATA.

Spring, D. (1993). *Shattered images: Phenomenological language of sexual trauma.* Chicago: Magnolia Street Publishers.

Stember, C. J. (1978). Change in maladaptive growth of an abused girl through art therapy. *Art Psychotherapy, 5*(2), 99–109.

Stember, C. J. (1980). Art therapy: A new use in the diagnosis and treatment of sexually abused children. In B. McComb Jones, L. L. Lenstrom, & K. MacFarlane (Eds.), *Sexual Abuse in Children: Selected Readings* (pp. 59–63). Washington, DC: U.S. Government Publications.

Swieg, T. (1988). Is showing telling? Art therapy and sandplay as treatment for dissociative disorders. In *Professionalism in Practice* (p. 116). Mundelein, IL: AATA.

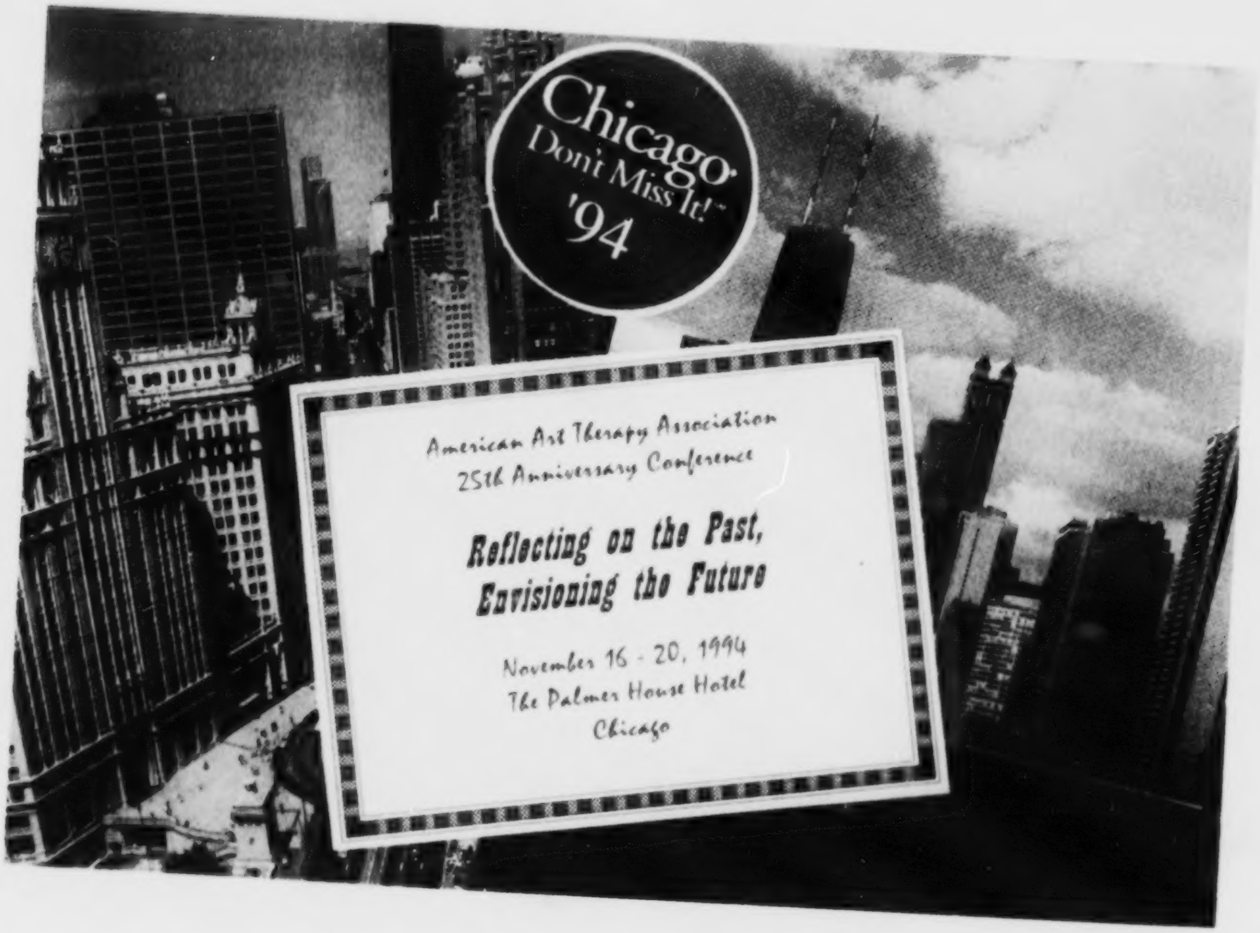
Swieg, T. (1992). The clinical underworld: Art therapy and sandplay with survivors of ritual abuse. In *Artist, Teacher, Clinician, Healer.* Mundelein, IL: AATA.

Wylie, M. S. (1993). The shadow of doubt. *The Family Therapy Networker, 17*(5), 18–29.

Yapko, M. (1993). The seductions of memory. *The Family Therapy Networker, 17*(5), 31–37.

Yates, A., Beutler, L. E., & Crago, M. (1985). Drawings of child victims of incest. *Child Abuse and Neglect, 9,* 183–189.

Editor's note: Due to space, this reference list presents a very limited selection of presentations and papers on the topics of art therapy, sexual abuse, and dissociative disorder. Those interested in additional references are advised to consult the yearly conference *Proceedings* of the American Art Therapy Association, Inc., and books and journals in the fields of art therapy, family violence, sexual abuse, trauma, and dissociation.



Art Therapy: Journal of the American Art Therapy Association, 11(1) pp. 37-42 © AATA, Inc. 1994

Diagnosis or Dilemma: Drawings of Sexually Abused Children

Maralynn M. Hagood, MFCC, A.T.R. Edinburgh, Scotland

Abstract

The incidence of child sexual abuse in both the United States and Great Britain has been reported in increasing numbers over the past 20 years (American Humane Association, 1984; Miles, 1989). In Cleveland, England, in 1987, a national scandal arose (The Cleveland Incident) from the reporting of a large number of alleged cases of child sexual abuse by two pediatricians ("Cleveland Inquiry," 1988). This resulted in the traumatic and, in some cases, inappropriate removal of many children from their homes by child protection authorities. The National Society for the Prevention of Cruelty to Children (NSPCC) released figures which reflected twice as many cases reported from April 1988 to April 1989 as were reported in the preceding year (Miles, 1989). The alleged case of ritual sexual abuse in the Orkney Islands in Scotland currently is being investigated in a hearing which will continue through June 1992. The need for better diagnostic tools on behalf of sexually abused children in the United Kingdom has become increasingly apparent.

Psychotherapists and art therapists working with children identified as having been sexually abused have noticed certain graphic indicators seemingly peculiar to the artwork of these children. The use of art therapy in the treatment of sexually abused children has been well substantiated. Studies have been carried out to determine what characteristics appear more frequently in the drawings of children who have been sexually abused.

Research Into Drawings of Sexually Abused Children

Goodwin (1982) carried out 19 consecutive interviews with girls age 5 to 16 who were suspected incest victims. The drawings were of diagnostic value in understanding the child's fears and anxieties, her view of her family, and her self-image. Images of male phalluses were incorporated into more "acceptable" subjects, such as phallic trees. Goodwin described an 8-year-old girl's depiction of a dream in which she was camping inside a zipped-up tent with a phallic-appearing tree intrusively overlapping the tent. Some children with whom Goodwin worked who were known to have been sexually abused drew the perpetrator with an obvious phallus, but identified it as a "decoration" or said it was "nothing." Goodwin developed the Draw-the-Perpetrator task where she observed that children refused to draw about the sexual abuse as frequently as they refused to talk about the event. Frequently the victim crossed out his or her repeated attempts to draw the perpetrator and finally gave up or drew a figure with an obvious phallus. Goodwin found the use of drawings helpful in evaluating sexual abuse with children under 12. She did not find as much success in using drawings with adolescents. She nevertheless concludes her article by stating:

> Such drawings, by themselves, are not sufficient to make a diagnostic decision. It is the child's increasing sense of being able to communicate and her experience of being understood that are helpful to the clinician in reconstructing what is happening in the family. The discovery of a workable avenue of communication is also helpful in reducing the anxiety of a child whose enmeshment in family secrets has often blocked verbal means of asking for help. (Goodwin, 1982)

Kelley (1984) examined 120 pictures drawn by 10 sexually abused children. Analysis showed that, of the self-portrait drawn, 20% portrayed prominent genitalia, 40% placed an added emphasis on the pelvic region, 43% emphasized the upper portion of their bodies, and 30% drew themselves without hands. A major problem with this study was that only 10 subjects were used, which is too small for generalization to other groups.

Koppitz (1968) found that Human Figure Drawings of normal children ages 5 to 12 rarely included genitalia. Conclusions were based on the drawings of over 1,800 school children in this age range. In examining body parts drawn by 5 to 12-year-old "normal" school children, Koppitz reported that only two of 925 girls (one 7-year-old and one 9-year-old) and nine of 931 boys (six aged 5 and one each 6, 7, and 9 years old) included genitalia. These conclusions also were based on only one drawing from each child.

DiLeo (1973) noted after reviewing thousands of ordinary children's figure drawings that the representation of genitalia was rare and reasoned that it was because the child had been made precociously aware of the high emotional charge invested in the sex organs due either to surgery or seduction by adults or older children.

Silvercloud (1982) unsystematically listed several features reoccurring in the artwork of children known to be sexually abused from her clinical experience. Items such as stab marks, crossed out windows, heavy lines, red houses, and so on, were discussed.

Stember (1980) used art therapy extensively with sexually abused children and found that drawings sometimes revealed the possibility of sexual abuse which was substantiated upon further assessment. Sexually abused children often created disorganized drawings and clown images. Horizontal scribbling frequently changed to vertical scribbling and then drawings became more organized through the process of therapy.

Editor's note: This article was originally published in the *British Journal of Projective Psychology*, 37(1), June 1992. *Art Therapy* wishes to thank Dr. Zahid Mahmood, editor of the *BJPP*, and Maralynn Hagood for permission to reprint this article on this occasion. Questions about this article may be directed to Maralynn Hagood, University of Edinburgh, Psychology Department, 7 George Square, Edinburgh, Scotland EH8 9JZ.

Kelley (1984) noted that pictures drawn by sexually abused children in the early phases of therapy were often below expected developmental levels, but that during the later stages of therapy children drew more age-appropriate pictures. Burgess, McCausland, and Wolbert (1981) believed that sexual abuse should be suspected in children whose drawings markedly shift from age-appropriate figures to disorganized objects or show repeated sexual figures. However, these conclusions were not systematically validated. Hibbard, Hoekelman, and Roghmann (1990), however, found no significant differences in the developmental levels of sexually abused children compared with those of nonabused children as measured in Human Figure Drawings.

Johnston (1979) evaluated 10 sexually abused children ages 5 through 11 using the Kinetic-Family-Drawing and found that the drawings revealed dysfunctional family systems. Two of the 10 children included representations of the male sex organ. Isolation was manifested by the drawing of the family members in separate compartments on the paper and role reversal was interpreted in the drawing when the child made herself larger than the mother figure. Other possible causes of size differences, such as level of anxiety, importance, or self-esteem (Thomas & Silk, 1990) were not discussed.

Empirical studies have been carried out comparing artwork between groups of sexually abused children and those who were in psychiatric treatment for other emotional problems. Cohen and Phelps (1985) compared sets of drawings of 166 children, aged 4 to 18 years, 89 of whom were known to have been sexually abused and 77 of whom were children who were being treated for other emotional problems. Statistically significant differences were found in the frequency of rated graphic indicators between the two groups on both the House-Tree-Person Test and the Kinetic-Family-Drawing. Poor interrater reliability, however, made the results inconclusive, and developmental differences in the subjects were not taken into account. Again, the comparison group consisted of psychiatrically hospitalized children, and it was suggested that the use of a "normal" comparison group be incorporated into future studies.

In an archival study, Sidun (1986) along with Chase (1987) developed a coding manual for artwork of sexually abused children from existing literature. They rated and compared Human Figure Drawings of 30 known sexually abused adolescents with drawings of 30 adolescents being treated for emotional disturbance with no known history of sexual abuse. A wide range of intelligence was represented with subjects in one group having IQ scores of 75 to 118 and the other group having IQ scores ranging between 75 and 123. Both groups were matched for IQ but possible effects of differences in intelligence on the artwork was not accounted for. Sidun hypothesized that the abused group would draw more over-sexualized and undifferentiated figures, with more indicators of anxiety and more indicators of poor self-esteem. No statistically significant differences were found, however, in measuring these characteristics.

It was further hypothesized that drawings of the sexually abused group would contain a greater frequency of wedges, phallic-like objects, and circles than drawings of the nonabused group. In a composite analysis of the data, a greater number of such characteristics was found in artwork of the sexually abused group. When these characteristics were analyzed independently, however, the only characteristic found to be statistically significant was the use of enclosed circles, which was interpreted as indicative of "oral regression." The use of enclosed circles is also a developmental characteristic in drawings of very young children (Kellogg, 1969; Lowenfeld & Brittain, 1982). Results also indicated that line pressure was heavier in drawings of sexually abused adolescents than in drawings of nonabused subjects. Another graphic indicator expected in drawings of sexually abused subjects was exaggeration of trouser flies. Nonabused adolescents actually drew trouser flies more often than the abused group. The investigator reasoned that adolescence is a natural time for heightened concern for sexuality and therefore not specific to abused subjects. It was concluded, however, that the strongest graphic indicators seen as possible sexual abuse in adolescence were omitted hands, omitted fingers, head only, enclosed circles, and heavy line pressure. A major problem with using these graphic indicators as clues to possible sexual abuse is that they may also reflect feelings of anxiety and helplessness (Koppitz, 1968) which would very likely exist in emotionally disturbed adolescents whether or not they had been sexually abused.

Yates, Butler, and Crago (1985) compared drawings of a group of 18 girls who were incest victims and 17 girls who were disturbed but not incest victims. The age range of the first group was 3.5 to 17 years old, and the age range of the second group was 4 to 17 years old. The list of characteristics to be rated were derived from the clinical literature and consisted of 15 dimensions. These were hyposexualization (failure to attend to sexual features), hypersexualization (overelaboration of sexual features), degree of immaturity, level of anxiety, control of impulse, amount of confusion between love and anger, quality of somatization, quality of denial, quality of repression, and quality of sublimation. The only two dimensions measured which proved to be statistically significant were measures of impulse control and repression, which suggested that incest interferes with the child's ability to utilize repression and to control impulses. The issue of developmental differences between this wide age range also was not addressed, nor were any correlations with intelligence made.

Two studies have been done to date using normal children assumed not to have been sexually abused as controls.

Chase (1987) compared the Human Figure Drawings and Kinetic-Family-Drawings of 34 female subjects, ages 5 to 16, who were victims of incest with those of 26 matched emotionally disturbed subjects and 34 matched subjects with no known adjustment disorders. One drawing per subject was collected for each projective drawing instrument. Using the same scoring manual as was used in Sidun's study (Sidun, 1986), significant differences were found in drawings between sexually abused subjects and emotionally disturbed subjects, as well as sexually abused subjects and nonabused subjects. There were also differences in developmental scores using Koppitz' developmental rating method with sexually abused children having significantly lower developmental scores than either normal nonabused or emotionally disturbed children.

Hibbard, Roghmann, and Hoekelman (1987) compared the drawings of 57 children, ages 3 to 7, referred for alleged sexual abuse with the drawings of 55 nonabused children matched for age, sex, race, and socioeconomic background.

Subjects were asked to draw two Human Figure Drawings, one of each sex, and asked to complete a human figure outline. Drawings were scored for the inclusion of five body parts: eyes, navel, vulva/vagina, penis, and anus. The results were that sexually abused children were 6.8 times more likely to draw genitalia than were comparison children. They concluded that few children drew genitalia and those who did were likely to have been sexually abused. However, while a drawing may alert one to the possibility of sexual abuse, it does not prove it. Because genitalia were drawn more often in the completion drawing, it is strongly recommended that such a drawing be used in future studies.

Hibbard et al. (1990) replicated their earlier study. They compared drawings of 109 children alleged to have been sexually abused with drawings of 109 children with no known history of sexual abuse. They collected two Human Figure Drawings drawn in the same session, and one Complete-A-Man drawing per subject. Matched comparison groups consisted of children ranging from ages 3 to 8. In this second study, the developmental maturity of these children was measured by the Goodenough-Harris Draw-A-Man Test and the Peabody Picture Vocabulary Test. Correlations of scores from these two tests were high in the nonabused children's group, but low with the children who allegedly had been sexually abused. Six out of 109 children allegedly sexually abused drew genitalia on the completion drawings. Only one child in the nonabused group did so. The conclusion, on such meager evidence, that sexually abused children were six times more likely to draw genitalia in drawings than were nonabused children seems inconclusive. Hibbard et al. made similar sweeping conclusions in their earlier study.

In several of these studies, graphic indicators have been compared between groups of sexually abused children and those who were in psychiatric treatment for other emotional problems. The latter groups are likely to be contaminated with a good possibility of emotionally disturbed subjects being victims of undisclosed sexual abuse. Few comparisons with normal children judged to be nonabused have been published to date. Most studies have been based on only one drawing per subject.

Variability of children's drawings on a day-to-day basis, discussed at length by Kellogg (1969), has not been accounted for in most studies. Kellogg found in her collection of 200,000 children's drawings, that a child's rendition of the human figure varied considerably when drawn on a daily basis. Rubin (1984) similarly found considerable variations in drawings created at different times, and that these variations also increased and decreased at certain age levels of the children whose drawings were studied. Interestingly, studies on drawings of sexually abused children continue to use one or very few drawings, and none has been longitudinal to date.

Measurements of mental maturity made with instruments which are known and respected for their validity and reliability, such as the WISC, Stanford-Binet, and Ravens were not used to correlate the effects of mental maturity on children's drawings in the vast majority of the studies discussed above.

Vast differences in drawing abilities of children at each age level assessed, for example, drawings of 3-year-olds versus 8-year-olds, or even 15-year-olds, were not taken into account in most studies using matched groups. Frequencies measuring certain characteristics, such as no pupils in eyes, no mouth, transparencies, no hands, heavy lines, etc., were calculated without taking into consideration the fact that young children may include these characteristics in their drawings, not as an element of abuse, but rather as the course of normal development.

An American book recently published is full of lengthy accounts of children's drawings without adequate discussions of developmental aspects of these children's artwork (Wohl & Kaufman, 1985). Particular attention is focused on drawings of children from abusive homes and again sweeping analytic interpretations are made. Developmental phases of these children's creations are only superficially discussed and interpretations commonly used for adults are used in assessing drawings of young children.

Problems with Projective Drawing Instruments

Projective drawing instruments are widely used by clinical psychologists, educational psychologists, social workers, art therapists, and other professionals who work with children. Drawing tests are used as a preliminary assessment tool and are often interpreted on an analytic basis. Frequently only one drawing is used. Drawings are often discussed with other professionals on their own merit without corroboration by the child. Problems of validity and reliability abound and are a major drawback in using children's drawings as an accurate assessment instrument.

The fact that the Human Figure Drawing (HFD), used most often in these studies, was developed in years prior to 1968 has not been taken into consideration. The level of exposure of children to sexually explicit material in the many years following the development of the HFD, as well as other projective drawing tests, is not addressed in most of these studies. The effects of sex education, "modern" parenting methods, films, videotapes, and so on are discussed only by Hibbard et al. (1990). What is now reflected in children's drawings as "normal" in 1992 might be considerably different than what was typical of children's drawings at an earlier period of time when the establishment of many children's projective drawing tests was carried out. The use of old projective drawing tests as a valid measure of children's drawings today regarding assessment of child sexual abuse becomes highly questionable.

Analytic Theory as Related to Drawings of Sexually Abused Children

Sigmund Freud's seduction theory and oedipal complex have influenced the thinking and training of psychotherapists including art therapists throughout the world (Masson, 1984). Problems arise in assessing phallic images in children's artwork in view of the currently debated issue of Freud's seduction theory and his revision of his original belief that female patients suffering from hysterical symptoms usually had been sexually abused as children. Freud presented his seduction theory in a group of three papers entitled "The Aetiology of

BEST COPY AVAILABLE

Hysteria" (Freud, 1896) in which he publicly challenged the notion that hysteria was hereditary and identified excitement of the genitals resulting from sexual abuse in childhood as the trauma that brought on hysteria.

One year after Freud proposed his theory, he began to doubt that actual sexual abuse in childhood was the basis for hysterical symptoms (Rosenfeld, 1987). Masson (1984) argues that Freud's reversal of opinion and creation of the oedipal complex was due to Freud's cowardice in dealing with a doubting medical community. This debate still reverberates among mental health professionals.

Edith Kramer, one of the early founders of art therapy, was trained extensively in Freudian psychoanalytic theory subsequently influencing the training of art therapists in the United States, Great Britain, and those involved in the early development of art therapy in many other countries in the world. Kramer (1969) worked with a child whose drawings depicted genitalia and claimed that the child had not been molested because her artwork was well organized. This case study is described on several pages of graphic detail of the repeated phallic imagery of the 9-year-old child's work. Kramer's book was the standard textbook in art therapy training programs across the United States in the mid-1980s. In the clinical experience of this writer, the artwork of vast numbers of children known to have been sexually abused was frequently not fragmented and chaotic, but for the most part was well-organized.

Carl Jung developed his theory of the transcendent function describing it as a process whereby the unconscious is revealed in artwork and becomes integrated with the conscious (Jung, 1935). Jung had his patients paint and draw their dreams in an effort to help them to become aware of unconscious symbols and to bring them into their conscious understanding (Jung, 1933).

Margaret Naumburg (1987), another major contributor to art therapy theory, draws from psychoanalytic theories of both Freud and Jung. She defines art therapy as a process whereby thoughts and feelings are derived from the unconscious and often reach expression in images rather than in words.

> By means of pictorial projection, art therapy encourages a method of symbolic communication between patient and therapist. Its images may, as in psychoanalytic procedures, also deal with the data of dreams, fantasies, daydreams, fears, conflicts, and childhood memories. The techniques of art therapy are based on the knowledge that every individual, whether trained or untrained in art, has a latent capacity to project his [or her] inner conflicts into visual form. . . . (p. 1). Art therapy accepts as basic to its treatment methods the psychoanalytic approach to the mechanisms of repression, projection, identification, sublimation, and condensation. (Naumburg, 1987, p. 2)

Naumburg (1953) dedicated an entire book to a case study of a woman who had been a victim of sexual abuse in her childhood. Anatomically correct male genitalia appear repeatedly in the paintings and drawings of the patient whose recollections of such abuse were repressed until her imagery unlocked her memories.

A phenomenon which frequently occurs in the paintings, drawings, and sculptures of young sexually abused children is the depiction of anatomically correct male genitalia. Such artwork sometimes includes ejaculation and is created at a level of realism far beyond developmental appropriateness. These children usually name the genitalia as some other object, such as a tree, a cloud, a heart, a rainbow, etc. (Goodwin, 1982; Uhlin, 1979). However, the size, shape, and proportions of these "sublimated" genitalia leave little to the imagination (Figures 1–4). This particular characteristic in children's artwork may be one which would arouse a high level of suspicion of sexual abuse. To depict such realism at so young an age seems highly unusual. The naming of these phalluses as some other object might be due to two explanations. The first might be that the child is conscious of what he or she has drawn but attempts to disguise this knowledge. The second possibility might be that the phallus as the traumatic object is unconsciously portrayed. A considerable amount of further investigation needs to be done to understand this phenomenon and to learn whether it occurs in drawings of nonabused children as well.

Additional Problems in Assessment of Children's Drawings

Sweeping statements are frequently made about children's drawings without considering the following phenomena:

Effects of Immediate Prior Events

What has gone on in the child's life immediately prior to doing the drawing? For example, does a particular flower the child draws have deep significance, or has he or she just come from an art class in nursery school where everyone was painting daisies?

Effects of Therapeutic Treatment versus Ordinary Developmental Maturing During the Process of Therapy

It is easy to assume that changes in artwork are due to therapy, but in actual fact may be due to developmental maturation which would occur without therapy. For example, a child may draw legs apart at the initial phase of therapy, but later draw them together. Is this due to resolution of the trauma of sexual abuse or to mental development?

Projection into Children's Drawings—The Child's Intention versus Our Own Projection

It is important to get a description from the child wherever possible. When a clinician suspects sexual abuse, it is easy to project "evidence" into children's drawings. The problem in working with sexually abused children is that these children are very often unable to verbalize such a trauma, and it is easy for an overanxious clinician to read more into the artwork than may actually be there. On the other hand, it is equally easy to overlook clues that may indeed indicate that sexual abuse has occurred.

Psychoanalytic Interpretations Appropriate for Adults Carried over to Children's Drawings

Can psychoanalytic symbols commonly used with adult patients be similarly used in working with children? For example, are interpretations commonly made by users of the

House-Tree-Person Test (Buck, 1948) which may apply to drawings of adults appropriate for drawings of young children? Existing literature on case studies suggests that this is often the case.

Implications for Clinicians Working with Sexually Abused Children

The British Psychological Society recently expressed its concerns regarding the ability of psychologists to assess child sexual abuse lest British psychologists have their own Cleveland (Howitt, 1990). The dilemma in using children's drawings as indicators of possible sexual abuse is apparent. Caution and common sense cannot be overemphasized as British clinicians treat children who are alleged to have been sexually abused on an ever-increasing basis.

Many variables must be taken into account. Indicators listed in the literature as characteristics of artwork of sexually abused children are frequently seen at various stages of development in the ordinary nonabused population. They also appear in drawings of children with other emotional problems, perhaps suffering from forms of abuse other than sexual. Analytic interpretations used in working with adults or older children cannot be generalized to younger children's drawings. Knowing events which may have occurred immediately prior to seeing a child may help clarify why the child depicted certain elements in his or her drawing. Listening to what the child has to say about a drawing is important, but one must take into account the reluctance of most children to disclose sexual abuse. The child may be trying to communicate indirectly and be unable to verbally describe what could be happening.

The development of more valid and contemporary projective instruments using children's drawings is essential. Methodologically sound studies must be carried out to better understand differences in drawings of nonabused and sexually abused children.

The theoretical dilemma currently faced by mental health professionals as to whether phallic images in children's artwork are normal oedipal fantasies or images reflecting actual sexual abuse is in need of resolution. Such a major theoretical question will not be easily answered. Meanwhile, we are faced with the immediate task of adequately protecting the children with whom we come into contact.

At the present time, it has been consistently demonstrated that drawings alone cannot be used as evidence that sexual abuse has occurred. Hopefully, with time, the use of children's artwork will become increasingly valuable in detecting sexual abuse and we will become better equipped to protect children from the long-term psychologically damaging effects of such abuse.

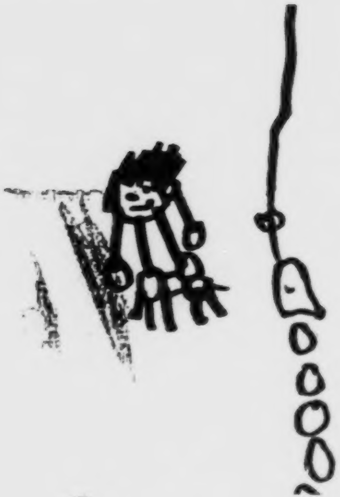


Figure 1.
4 years old
"A Girl and a House"

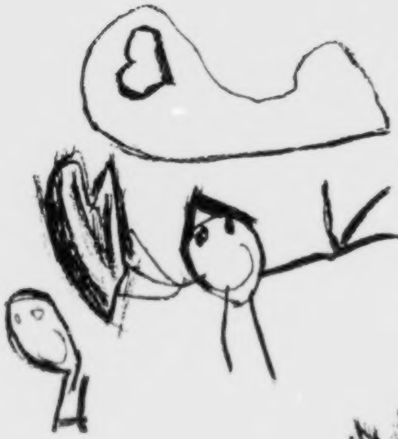


Figure 2.
5 years old
"A Cloud"

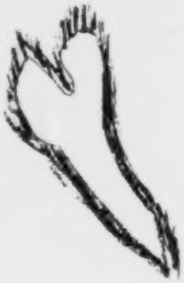


Figure 3.
5 years old
"A Cloud"

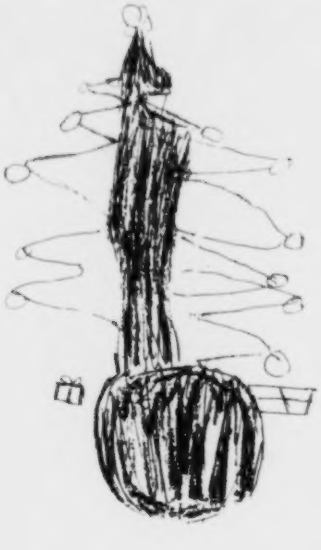


Figure 4.
4 years old
"A Christmas Tree"

References

American Humane Association. (1982). *National analysis of official child neglect and abuse reporting.* Denver, CO.

Buck, J. N. (1948). The House-Tree-Person test. *Journal of Clinical Psychology, 4,* 151–159.

Burgess, A. W., McCausland, M. P., & Wolbert, W. A. (1981). Children's drawings as indicators of sexual trauma. *Perspectives in Psychiatric Care, 19*(2).

BEST COPY AVAILABLE

Chase, D. A. (1987). An analysis of human figure and kinetic family drawings of sexually abused children and adolescents. Dissertation Abstracts International (University Microfilms, No. 87-10434).

Cleveland Enquiry (1988, July 7). *London Times*, p. 5.

Cohen, F. W., & Phelps, R. E. (1985). Incest markers in children's artwork. *The Arts in Psychotherapy, 12*, 265–283.

Di Leo, J. H. (1973). *Children's drawings as diagnostic aids*. NY: Brunner/Mazel.

Freud, S. (1986). The etiology of hysteria. *The standard edition of the complete psychological works of Sigmund Freud, (Vol. III). London: Hogarth Press.*

Goodwin, J. (1982). *Sexual abuse: Incest victims and their families.* London: John Wright.

Hammer, E. F. (1958). *Clinical application of projective drawings.* Springfield, IL: Charles C Thomas.

Howitt, D. (1990). Expert opinion: Risky sexual abuse diagnosis. *The Psychologist, 3*, 15–17.

Johnston, M. S. K. (1979). The sexually mistreated child. Diagnostic evaluation. *Child Abuse and Neglect, 3*, 943–951.

Jung, C. G. (1933). *Modern man in search of a soul.* New York: Harcourt & Brace.

Jung, C. G. (1935). Collected works (The transcendent function), 8, Par. 168.

Kelley, S. J. (1984). The use of art therapy with sexually abused children. *Psychosocial Nursing, 22*(12), 12–18.

Kellogg, R. (1969). Analyzing children's art. Palo Alto, CA: National Press Books.

Koppitz, E. M. (1968). *Psychological evaluation of children's human figure drawings.* New York: Grune & Stratton.

Kramer, E. (1975). *Art as therapy with children.* New York: Schocken.

Lowenfeld, V., & Brittain, W. (1982). *Creative and mental growth* (7th ed.). New York: MacMillan.

Masson, J. M. (1984, February). Freud and the seduction theory. *The Atlantic Monthly*, 33–60.

Miles, T. (1989, April 9). Child abuse move as cases rise again. *London Observer*, p. 6.

Naumburg, M. (1953). *Psychoneurotic art: Its function in psychotherapy.* New York: Grune & Stratton.

Naumburg, M. (1987). *Dynamically oriented art therapy.* Chicago, IL: Magnolia Street.

Rosenfeld, A. (1987) Freud, psychoanalysis, and incest. *Child Welfare, 66*, 485–496.

Rubin, J. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Sidun, N. M. (1986). *Graphic indicators of sexual abuse in adolescent Draw-A-Person Test.* Unpublished Doctoral Dissertation. Illinois School of Professional Psychology, Chicago.

Silvercloud, B. (1982). Using art to express the unspeakable: A tool for intervention and therapy with the sexually abused. *The Proceedings of the Thirteenth Annual Conference of the American Art Therapy Association*, Philadelphia.

Stember, C. J. (1980). Art therapy: A new use in the diagnosis and treatment of sexually abused children. In: *U.S. Department of Health and Human Services, Sexual Abuse of Children: Selected Readings* (pp. 59–63.). Washington, DC: U.S. Government Printing Office.

Thomas, G. V. & Silk, A. M. J. (1990). *An introduction to the psychology of children's drawings.* London: Harvester Wheatsheaf.

Wohl, A. & Kaufman, B. (1985). *Silent screams and hidden cries.* New York: Brunner/Mazel

Uhlin, D. L. (1979). *Art for exceptional children.* Dubuque, IA: Wm. C. Brown.

Yates, A., Beutler, L. E., & Crago, M. (1985). Drawings of child victims of incest. *Child Abuse and Neglect, 9*, 183–189.

Call for Programs

The 5th Annual Texas Conference on Trauma and Dissociation
September 22-25, 1994 - Dallas, Texas
Sponsored by the Texas Society for Study of Trauma and Dissociation

PROGRAM SUBMISSIONS: For those working, studying, or involved with trauma and dissociative disorders, including psychologists, counselors, marriage & family therapists, physicians, social workers, and nurses.

THEME: The conference will focus on intervention techniques and clinical issues concerning trauma and dissociation. Sample topics include ritualized abuse, childhood abuse, dissociative disorders, symbolic ventilation, creative arts, hypnotic techniques, "false memory" syndrome, male victims, adolescent treatment, integration and post-integration techniques.

CONTENT OF SUBMISSION

- 25-word summary
- 5 copies of one-page abstract
- Curriculum Vitae
- One-page credentials and experience
- Four copies of abstract without author's name

PROPOSAL FORM

Title ______
Presenters ______
Objectives ______
Your Name ______ Degree ______
Address ______
City/State/Zip ______
Phone (H) ______ (W) ______

Please check all that apply:

AV	☐ Slide	☐ Overhead	☐ Video
LEVEL	☐ Beginning	☐ Intermediate	☐ Advanced
TOPIC	☐ Trauma	☐ Dissociation	
GROUP	☐ Child	☐ Adolescent	☐ Adult
TIME DESIRED	☐ ¾ Hour	☐ 1½ Hours	☐ 2 Hours

Send materials to: FAMILY VIOLENCE AND SEXUAL ASSAULT INSTITUTE, 1310 Clinic Drive, Tyler, TX 75701, (903) 595-6600

DEADLINE FOR PROGRAM SUBMISSIONS: POSTMARKED BY APRIL 1, 1994.
Notification will be made by June 1, 1994

Art Therapy: Journal of the American Art Therapy Association, 11(1) pp. 43-47 © AATA, Inc. 1994

The Contribution of Art Therapy to the Dissociative Disorders

Patricia S. Murphy, PhD, A.T.R., Moscow, Idaho

Abstract

Research has shown that childhood trauma is a critical component in dissociative disorders (Putnam, 1989). Traumatic imagery and frightening emotions are right brain functions (Brende, 1984). In order to explore concepts of brain hemispheric lateralization and distinct right brain functioning in extensive dissociation, the Dissociative Experiences Scale (DES) scores of 114 engineering students were compared to the DES scores of 92 drawing students on a university campus. The DES measures the level of dissociative experiences. The engineering curriculum was presumed to require more analytical, left brain skills while the drawing class tasks were assumed to utilize more visual, right brain skills. The data were separated into three levels of scoring. A chi-square calculation found differences in dissociative scoring levels between the groups that approached significance at the .05 level. This suggests that brain lateralization may play a role in dissociative processes. Since art therapy may employ the right hemisphere through visual imagery, it may be a useful tool in accessing dissociated states.

Introduction

The usefulness of art therapy in working with persons with dissociative disorders, especially those with multiple personality disorder (MPD), has been noted (Kluft, 1984). Many art therapists can attest from personal experience that many dissociative clients have been able to use art in their healing process in ways that they have not been able to use other modalities. As an art therapist working with clients who have dissociative disorders, one cannot help but be struck with the highly evocative and traumatic imagery that often evolves from that process. Is there something specific about dissociative clients that makes them so amenable to art therapy? One answer may be found in an examination of the literature about dissociation and brain hemispheric lateralization found in MPD.

The resurgence of interest in dissociative processes and the findings of increased numbers of people with MPD in the last decade has stirred research into dissociation and its functioning. This research has provided convincing evidence that dissociation is a naturally occurring phenomenon (Wolff, 1987), and that it is common in children and diminishes with age (Ross, Ryan, Anderson, Ross, & Hardy, 1989). Thus, in a normal developmental process, dissociation usually declines over time. When this does not happen and the individual continues to experience considerable dissociation, that person may be at risk for a dissociative disorder.

The dissociative disorders, which include MPD, have as their two principal characteristics disturbances in memory and disturbances in identity (Kluft, 1988). A third principle characteristic that has emerged from large case studies of individuals with MPD is that dissociation is invariably correlated with childhood trauma (Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Miller, Reagor, Bjornson, Fraser, & Anderson, 1990). Additionally, the greater extent of the trauma, the more dissociation (Sanders, McRoberts, & Tollefson, 1989). Some theorists maintain that victims parcel out the trauma in order to accommodate it. It then becomes the conflicting memories and effect that keep the system from integration.

Research in recent years, in a number of fields, has focused on exploring a better understanding of how mental processes in dissociation are presumed to operate. Efforts to develop theoretical models to explain dissociative phenomena include trance-state models, neurologic models, psychological models, learning and memory models, and split brain models (Putnam, 1984). Putnam (1984) points out that these models provide a frame of reference within which specific research questions can be asked. It should be noted that the models do not necessarily contradict each other; they simply offer a way to conceptualize a research question.

The context for this paper focuses on a model of hemispheric lateralization in dissociation. It has been well established that the right and left hemispheres of the brain differ in their influence on specific brain functions. The left hemisphere controls language and uses sequential thought while the right hemisphere governs spacial arrangements and uses visual thought (Gregory, 1987). Thus, the use of art therapy may employ the right hemisphere to a greater extent than more traditional "talk" therapies.

Because dissociation is linked to childhood trauma, and traumatic imagery is located primarily in the right brain, as is visual imagery, it is suggested that there might be associated links between visual imagery, right brain functions, and dissociation. It is known that particular emotional states are related to specific areas of the brain. For example, the right hemisphere of the brain has also been associated with emotional expression, depressive affect, in addition to traumatic imagery (Brende, 1984). Studies using electrodermal responses (EDR) have further suggested that left hemisphere functioning appears to be linked to hypervigilance and aggressive outbursts (Brende, 1984). Evidence that different alter personalities have specific characteristics and/or emotional content such as anger or depression supports concepts of brain lateralization in MPD (Putnam, 1989). Brende (1984) found evidence of hemisphere-specific functioning in an MPD patient. Other studies describe handedness changes among alter

---

Editor's note: The basis for this article comes from the author's doctoral dissertation, conducted at the University of Idaho, January through May, 1992. Requests for reprints should be sent to Patricia S. Murphy, PhD, A.T.R., 1207 Nearing Road, Moscow, ID 83843.

BEST COPY AVAILABLE

personalities which further suggest brain lateralization in MPD (Putnam et al., 1986).

Thus it would appear that individuals with dissociative disorders may have either greater access to more right hemispheric areas of mental functioning. Those areas are more highly elaborated by the trauma experience and/or the usual integrative function of left and right brain has been compromised. These additional capacities are usually offset, however, by the inability of the system to operate in unity and by the memory difficulties that individuals with dissociative disorders experience.

As part of a larger study to explore the prevalence of dissociative disorders in a university setting, the dissociative experiences of two groups of students were compared. One hypothesis was that those attracted to the fields which employ visual imagery would have more dissociative experiences than those attracted to fields that utilize the more analytical and logical process of the left brain, such as engineering. In an effort to provide some elucidation, a segment of the student population for this study were drawing students. The rationale was that drawing classes utilize spacial arrangements and require more right brain skills and would appeal to individuals whose interest and skills are primarily in that arena. The comparison group was comprised of engineering students who were presumed to use more left brain skills. The engineering curriculum places heavy emphasis on mathematical and analytical skills which rely mainly on left brain functions.

Method

Subjects

The subjects were a selected sample of 415 undergraduate students at the University of Idaho. The Dissociative Experiences Scale (DES) was used to measure the extent of the participants' dissociative experiences. There were six different sources for completed DES forms used for the study. They were (a) drawing classes in the College of Art and Architecture (92 students, 4 different classes), (b) basic engineering classes in the College of Engineering (114 subjects, 4 different classes), (c) a child development class in the Home Economics school in the College of Agriculture (64 subjects), (d) a cognitive psychology class in the College of Arts and Letters (42 subjects), (e) clients using the Student Counseling Service at the University of Idaho (71 subjects), and (f) users of the Student Health Service (32 subjects). Students gave written informed consent at the time of administration of the DES and also indicated if they were willing to participate in a later, personal interview.

A total of 27 participants were later interviewed using a diagnostic instrument for dissociative disorders called the Dissociative Disorder Interview Schedule (DDIS).

Although some of the broader findings of the study will be discussed, the focus of this paper is on the comparison between the 92 drawing students and the 114 engineering students.

Measures

The two instruments which have been the most widely used in studies of dissociative phenomena are the Dissociative Experiences Scale (DES) and the Dissociative Disorders Interview Schedule (DDIS) (Bernstein & Putnam, 1986; Ross, Heber, et al., 1989). In 1986, Carlson and Putnam designed and validated a self report scale of dissociative experiences (Bernstein & Putnam, 1986). The scale was called the Dissociative Experiences Scale (DES) and was one of the first instruments that attempted to measure dissociative experiences. Reliability testing showed that the scale had good test-retest reliability (.84) and strong split-half reliability. The DES describes 28 different dissociative experiences and asks the respondent to indicate the extent to which he or she has that experience (Bernstein & Putnam, 1986). The range of possible scores, 0 to 100, is the mean of all the questions. Thus, it attempts to measure the level of dissociative experiences.

The authors of the DES were testing the hypothesis that the number and frequency of experiences and symptoms attributable to dissociation lie along a continuum where normal individuals would have fewer and less frequent dissociative experiences than those with dissociative disorders or disorders with a significant dissociative component (i.e., post-traumatic stress disorder—PTSD). It was further hypothesized that individuals with nondissociative psychiatric disorders would fall somewhere in between the two extremes. The results of this study showed a steady progression in the median DES scores from normal subjects to multiple personality patients. The scale was able to differentiate between subjects with and without clinical diagnoses of a dissociative disorder. The authors concluded that the dissociative process does make a considerable contribution to the psychopathology of some psychiatric disorders and that the DES is a reliable and valid instrument that is able to distinguish subjects with a dissociative disorder from those without (Bernstein & Putnam, 1986).

Most of the studies to date have examined the DES scores of established clinical populations in comparison to other clinical and/or nonclinical groups. In those clinical groups, high scores on the DES are correlated with dissociative pathology. Scores over 30 on the DES have been found to be indicative of a dissociative disorder in clinical populations (Bernstein & Putnam, 1986; Coons, Bowman, Pellow, & Schneider, 1989). Ross, Norton, and Anderson (1988) maintain that scores above 30 are almost always associated with DSM-III-R diagnosis of MPD or PTSD while scores over 50 are rarely achieved in persons without MPD. Putnam (1991) reports on a multicenter study of 1,300 patients that demonstrated a blind hit-rate of 89% correct classification of MPD versus non-MPD subjects by using a cutting score of 30 on the DES.

More recent studies have suggested that this may hold true in nonclinical populations as well (Ross, Ryan, Voight, & Eide, 1991). A two-part study by Sanders, McRoberts, and Tollefson (1989) reported that individual differences in dissociation in college students are positively related to differences in self-reported stressful or traumatic experiences in youth. The authors feel that these studies have demonstrated a clear and consistent correlation in a normal population between stressful events in youth and later tendencies toward dissociation.

The Sanders and colleagues study (1989) is only part of a larger effort to examine dissociative experiences in nonclinical populations. A major question raised in studies of nonclinical groups is whether high scores on the DES are indicative of pathology in normal populations. Although the DES has been shown to reliably differentiate patients with dissociative disorders from patients with other disorders and nonpatient groups, it is a screening device for dissociative experiences and not a diagnostic instrument. It does appear quite likely, however, that high scorers experience severe symptoms which include amnesias and identity problems and therefore could experience considerable difficulties in negotiating in the world.

The first of the diagnostic interviews to be developed and the one most widely used to date is the Dissociative Disorders Interview Schedule (DDIS) developed by Ross, Heber, Norton, Anderson, Anderson, and Barchet (1989). The DDIS is a structured interview designed to make diagnoses of the dissociative disorders, somatization disorder, major depressive disorder, and borderline personality disorder. There are 16 sections and 131 questions. The DSM-III criteria for the disorders mentioned above are incorporated into the instrument. Questions also include information about substance abuse, childhood physical and sexual abuse, Schneiderian first rank symptoms, extrasensory experiences, and secondary features of multiple personality.

In the original study, the DDIS was administered to 80 psychiatric patients: 20 MPD, 20 schizophrenic, 20 panic disorder, and 20 eating disorder patients (Ross, Heber, et al., 1989). The results found an inter-rater reliability of .68 (*Ibid.*). The authors state that the DDIS has excellent validity with a specificity of 100% and sensitivity of 90% for the diagnosis of MPD. The "specificity" relates to the fact that none of the patients in the categories other than MPD met the criteria for MPD. The "sensitivity" refers to the fact that two of the 20 MPD patients did not meet the criteria for MPD.

The DDIS can be administered in 30 to 45 minutes and is designed to be used by a variety of mental health professionals. Ross and colleagues claim that used together the DES and DDIS provide a rich source of information on clinical subjects.

In this study the DDIS was used to determine whether the individual met the criteria for one of the dissociative disorders.

A final qualitative measure used was a debriefing interview offered to each DDIS participant. During that interview the researcher discussed concepts of dissociation and each person's individual responses to the DES and DDIS. It provided an opportunity to observe and discuss dissociative experiences and thus served as a validation of the diagnoses and as a way to see how dissociation was experienced on an individual level.

Procedure

Approval for the project was received by the University Institutional Review Board of the University of Idaho. For the drawing classes, permission to elicit participation in the project was received by the head of the Art Department and the three instructors who taught the four classes from which the forms were obtained. Since the study was interested in those students who were primarily art students (rather than those taking art as an elective), it was decided to primarily use drawing classes that were above the beginning level. This group consisted of individuals who were actually doing artwork and were likely to be Art and Architecture majors. The classes represented were Drawing I, Drawing II, Drawing III, and Drawing IV.

As previously stated, the primary reason for the selection of engineering classes was that the engineering curriculum places heavy emphasis on mathematical and analytical skills and was presumed to appeal more to left brain thinkers. In the case of the engineering classes, permission was received from the Associate Dean of Engineering and the three instructors who taught the four classes from which the forms were obtained. The four classes represented all the sections of a basic engineering course which is required for all engineering majors. In all, 114 students from the engineering classes completed the DES.

Since the completion of the DES was a voluntary and confidential process, no tallies were kept on those who did not complete the DES. However, virtually everyone in every class completed the DES.

Once permission was received, the DES was explained briefly by the researcher and administered during class time along with the informed consent and agreement for a personal interview. The responses were then analyzed for differences between groups. Parametric statistics were used and significance was set at .05.

In the second phase of the project, the DDIS was administered to 18 people who scored above 30 on the DES and a stratified random sample of nine people who scored less than 30 on the DES. The interviews were conducted by four graduate students in the Counseling program at the University of Idaho. The interviewers were trained by the researcher on dissociation theory and the administration of the DDIS. They met weekly as a group to discuss the interviews and to reach consensus on the diagnoses. They were blind to the DES scores of the subjects.

Following the administration of the DDIS, participants were offered the opportunity to meet with the researcher to discuss dissociation and their individual responses to the DDIS. Only one person, a low scorer, did not participate in this process.

Results

Distribution of DES Scores

The distribution of DES scores was positively skewed with 37 people (8.9%) scoring above 30 on the DES. The mean score for the sample was 14.69 (*SD* 10.77). Although among the groups, the art students exhibited the highest mean score of 16.36 (*SD* 11.23), an analysis of variance revealed no significant differences in mean scores between the DES scores obtained from different sources, $F(5, 409) = .69$, $p =$ N.S. Figure 1 displays the distribution of DES scores for the entire sample, the art classes, and the engineering classes.

Differences Between Art and Engineering Students

In order to ascertain if there were significant statistical differences between art and engineering students in scoring, the data were separated into three levels of score (high, medium, low) using the students from the two groups. Low scorers were those who scored below 7 on the DES. They represented 25.2% (52 people) of this group. Medium scorers were those who scored between 7.1 and 29.9 on the DES; there were 135 people (65.5%) in this category. The high scorers were those who scored 30 and above on the DES. They represented 19 people or 9.2% of this sample. A high score of 30 was chosen because this is the level, in clinical populations, that is indicative of a dissociative disorder (Bernstein & Putnam, 1986).

There were approximately the same number of students in the art and engineering groups and assumptions of homogeneity were met. Table 1 displays the result of the cross-tabulation, χ^2 (2, N = 206) = 5.73, p = .0569. This result approaches significance at the .05 level and suggests some differences between these two groups of students. The art students had four fewer low scorers and four more very high scorers than would be expected. The engineering students had the reverse situation, four more lower scorers and four less very high scorers than would be expected.

The art classes contributed 35% of the very high scorers compared to only 22% of the entire sample. By contrast, the engineering students comprised 16% of the very high scorers and 27.5% of the entire sample.

Dissociative Disorders in Very High Scorers

Of the 18 very high scorers who were interviewed, 16 met the criteria for one of the dissociative disorders as determined by the DDIS (89%). The other two very high scorers both had considerable dissociative experiences and one of them later told the researcher that he had not been totally honest with the male interviewer about the extent of his sexual abuse or his symptoms.

Of those who scored above 25 on the DES, 19 of 21 met the criteria for a dissociative disorder while no one who scored below 25 (and was interviewed) met the criteria for a dissociative disorder.

Discussion

The main question for this paper has been whether there is evidence of brain hemispheric lateralization in individuals with dissociative disorders. Specifically, do persons with dissociative disorders have more access to, or more highly elaborated, right brain hemispheres? If the answer is yes, it provides further support for the use of art therapy with dissociative clients. Since it is assumed that drawing and visual perception are more right hemispheric activities, use of art media and the process of creating graphic images may provide a way to access the traumatic imagery associated with dissociative disorders. The release and processing of these traumatic images can have a cathartic and healing effect. Likewise, the art product may be a way to describe a traumatic event that cannot be described verbally for any number of reasons. Because of the memory difficulties experienced by those with dissociative disorders, art productions may serve as clues or as a way to begin to access those memories.

The main focus of the entire study was to examine the prevalence of dissociative disorders in a nonclinical popula-

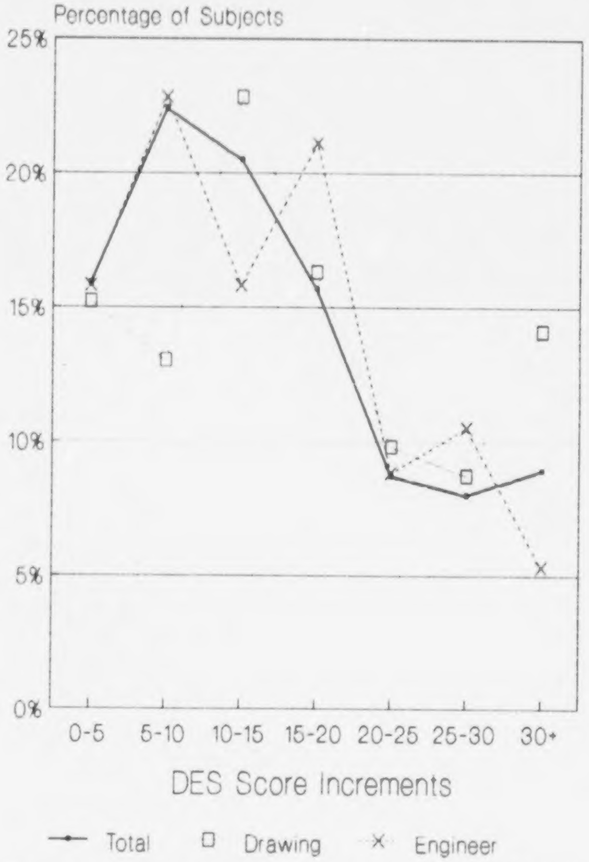


Figure 1. DES scores by total students, art students, and engineering students.

Table 1
Differences in Range of DES Scores Between Engineering and Drawing Classes

Count Exp Value Col Pct Residual	Drawing Classes	Engineering Classes	Total
Low Scorers	19	33	52
(0–7)	23.2	28.8	
	20.7%	28.9%	25.2%
	−4.2	4.2	
Medium Scorers	60	75	135
(7.1–29.9)	60.3	74.7	
	65.2%	65.8%	65.5%
	−.3	.3	
Very High Scorers	13	6	19
(30 and over)	8.5	10.5	
	14.1%	5.3%	9.2%
	4.5	−4.5	
Total	92	114	206
	44.7%	55.3%	100.0%

Note. χ^2 (2, N = 206) = 5.73, $P < .0569$

tion. The results indicated that almost 9% (37 students) of 415 students scored above 30 on the DES and that 89% of those very high scorers met the criteria for one of the dissociative disorders, including four who were positive for MPD. These figures may be quite conservative because, in clinical samples, 15% of people with MPD score below 20 on the DES (Ross, Miller, et al., 1990). At a minimum, these results suggest that extensive dissociation is a problem for a considerable number of individuals.

One question that evolved from this process was whether art students would evidence more extensive dissociative experiences than students who are presumed to use more left brain skills, such as engineering students. In fact, there were differences that approached significance. If one can support the premise that, generally, engineering skills differ from artistic skills in the use of brain hemispheres, the findings support the idea that dissociated states are associated with activity in different parts of the brain, and/or a lack of connection between brain hemispheres.

Does this mean that those in the arts have more dissociative experiences than those in more pragmatic fields? Perhaps, because dissociation can be a positive source of creativity and focus. It should be remembered that virtually everyone has dissociative experiences, and they are a normal and important aspect of human functioning. Likewise, for most people the right and left hemisphere of the brain work in concert to create our experience of the world. For some, perhaps that balance is weighed more heavily in one direction or the other. But it is when overwhelming trauma is experienced and dissociation exacerbated that people are at risk for a dissociative disorder. This study was focused on those people who are at the extremes of the dissociation scale. The very high scorers comprised 14% of the art students and 5% of the engineering students. This in no way implies that most artists are more emotionally troubled than others. It more likely appears that people who have been traumatized seek to express their trauma in some tangible way. High-scoring art students may be the most fortunate in that they have access to a socially acceptable and potentially healing expression of the traumatic events that shaped their lives. With appropriate therapy, perhaps they can come to understand and integrate their experience.

The debriefing interviews offered an opportunity to observe some of the characteristics of the high dissociators. First, it appeared that the art students were more willing to discuss their dissociative experiences, 10 of 13 very high scorers in the drawing classes came in for interviews compared to three of six engineering students. The two very high scorers who did not meet the criteria for one of the dissociative disorders were drawing students. Some clearly felt that their dissociative experiences served their artistic expression and made them better artists.

Perhaps the engineering students did not have the vehicles for release that were available to the drawing students. Since all of the interviewed engineering students were male (compared to three males of 10 drawing students), this may account for some of the perceived differences between the groups.

This paper provides evidence that 5% to 10% of a nonclinical population may experience dissociation to the extent of meeting the criteria for one of the dissociative disorders. It further suggests that there may be a connection between the use of right brain functions and dissociative disorders. It may be that those who experience extensive dissociation seek ways in which they can express their trauma, namely, in the expressive arts. Those who use artistic productions to express themselves may, in fact, be using their art to help heal their trauma. (This should come as no surprise to art therapists.) Others, who do not have access to suitable means of expressing their trauma, may be more at risk for serious pathology.

We are coming to understand that many emotional disorders are rooted in trauma. Art can be a helpful and useful way to express that trauma. Likewise, a focus on creativity can help the client find new ways to resolve intrapersonal and interpersonal difficulties. This speaks persuasively for the continued and expanded use of art therapy in treating the dissociative disorders and other emotional difficulties with a posttraumatic component.

References

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *The Journal of Nervous and Mental Disease*, *174*, 727–735.

Brende, J. O. (1984). The psychophysiologic manifestations of dissociation. *Psychiatric Clinics of North America*, *7*, 41–50.

Coons, P. M., Bowman, E. S., Pellow, T. A., & Schneider, P. (1989). Post-traumatic aspects of the treatment of victims of sexual abuse and incest. *Psychiatric Clinics of North America*, *12*, 325–335.

Gregory, R. J. (1987). *Adult intellectual assessment*. Newton, MA: Allyn and Bacon.

Kluft, R. P. (1984). Aspects of the treatment of multiple personality disorder. *Psychiatric Annals*, *14*, 51–55.

Kluft, R. P., (1988). Dissociative disorders. In Talbott, J. A., Hales, R. E., & Yudofsky, S. C. (Eds.), *Textbook of psychiatry*. Washington, DC: American Psychiatric Press.

Putnam, F. W. (1984). The study of multiple personality disorder: General strategies and practical considerations. *Psychiatric Annals*, *14*, 58–61.

Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford Press.

Putnam, F. W. (1991). Recent research on multiple personality disorder. *Psychiatric Clinics of North America*, *14*(3), 489–501.

Putnam, F. W., Guroff, J. J., Silberman, E. K., Barban, L., & Post, R. M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry*, *47*(6), 285–293.

Ross, C. A., Heber, S., Norton, G. R., Anderson, D., Anderson, G., & Barchet, P. (1989). The dissociative disorders interview schedule: A structured interview. *Dissociation*, *2*, 169–188.

Ross, C. A., Miller, S. D., Reagor, P., Bjornson, L., Fraser, G. A., & Anderson, G. (1990). Structured interview data on 102 cases of multiple personality disorder from four centers. *American Journal of Psychiatry*, *147*, 596–601.

Ross, C. A., Norton G. R., & Anderson, G. (1988). The dissociative experiences scale: A replication study. *Dissociation*, *1*, 21–22.

Ross, C. A., Ryan, L., Anderson, G., Ross, D., Hardy, L. (1989). Dissociative experiences in adolescents and college students. *Dissociation*, *2*, 239–242.

Ross, C. A., Ryan, L., Voight, H., & Eide, L. (1991). High and low dissociators in a college population. *Dissociation*, *4*, 147–151.

Sanders, B., McRoberts, G., & Tollefson, C. (1989). Childhood stress and dissociation in a college population. *Dissociation*, *2*, 17–23.

Wolff, P. H. (1987). *The development of behavioral states and the expression of emotions in early infancy*. Chicago, IL: University of Chicago Press.

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 11(1) pp. 48-52 © AATA, Inc. 1994

Abreacting and Assimilating Traumatic, Dissociated Memories of MPD Patients Through Art Therapy

Mindy Jacobson, MCAT, A.T.R., Philadelphia, PA

Abstract

When used to treat patients diagnosed with multiple personality disorder (MPD), art therapy aids in translating unspeakable memories into a visual format, which may be used for psychotherapeutic exploration and mastery. As anger is sublimated, associations to artwork may be actuated to bridge affective states and memories. "Stepping in," a drawing process developed by the author, may then be used to promote "cross alter associations" to the imagery drawn by other personalities. Consequently, new feeling states may be experienced through abreaction and cognitive awareness, the comprehensive expansion of memories, and the lessening of self-destructive ideation. This process may be utilized to break down amnesic divisions, and ultimately to diffuse personality barriers originally created to ensure the survival of the severely traumatized child. This paper addresses the recovery of traumatic material (metabolizing the trauma) and its subsequent resolution and integration.

Introduction

Art therapy is a nonverbal treatment modality which facilitates verbalization through the art process and lends itself to the treatment of patients who dissociate. Art serves as a visual record of the personality system or inner group created by dissociative individuals, reducing denial through permanent inscription on the page for both the patient and therapist to discover together (Jacobson, 1986, 1989). At the core of art therapy is creativity, the invitation to generate imagery for restoration and growth (Wadeson, Durkin, & Perach, 1989).

In working towards crisis resolution, art activates an alternative form of communication in contrast to verbalization, the latter typically forbidden by the perpetrators of abuse. Art productions which embody the affective memories related to trauma bridge the gap between nonverbal and verbal ideation. Cathartic expression, therefore, takes place through the externalization of previously repressed material onto an art form which is safe and diminishes the potential for acting out (Fink, Levick, & Goldman, 1973).

Multiple personality disorder (MPD) has been directly linked to severe and enduring abusive experiences originating in childhood (Kluft, 1984). The abused child, fearing the expression of feelings related to trauma, may find alternative modes for coping with them. Dissociation and the symptomatic formation of alternate personalities are the most dramatic defensive maneuvers in response to these overwhelming and horrifying experiences (Coons, 1984; Kluft, 1984). The emergence of alternate personalities allows the individual to survive both psychologically and physically. Dissociation may preserve comfort and safety in response to stress, guilt, and rage. It also enables one to take revenge, gratify narcissistic and masochistic needs, partially repeat or reenact earlier traumas, experience secondary gain, and display the fixation or arrest from previous developmental stages (Ellenberger, 1970; Kluft, 1984).

One of the art psychotherapist's roles is to provide the dissociated patient with appropriate channels for the expression of feelings and integration of deeply repressed material (Cohen & Cox, 1990; Jacobson, 1986, 1990, 1991; Jacobson & Mills, 1992). In working with patients diagnosed with MPD, the invitation to draw or sculpt typically leads to the presentation of personal nightmares related to previous abuse. This information, dissociated from the birth personality, must be externalized and integrated in order to restore psychological health (Comstock, 1986; Kluft, 1988). Similarly, the management of anger and destructive impulses is critical to the therapeutic process and survival of the individual as the phases of treatment evolve (Jacobson, 1986, 1990; Putnam, 1989; Wadeson, 1980).

Through the promotion of visual personality, the patient learns how to access parts of the internal system of alters for expressive purposes and mastery. As the investment in art productions expands, however, affective issues may become increasingly charged due to the magnification of feelings by alters conjointly expressing themselves. This includes the expression of rage towards the self and others, and concomitant feelings of grief. The expression of these feelings is crucial in setting the foundation for subsequent personality unification, although often it can also lead to an increase in suicidal and homicidal feelings.

Managing Abreactions

Abreaction, the process of bringing into consciousness, recalling, and affectively reliving previously unconscious material, has been consistently viewed as central in the treatment of multiple personality disorder (Braun, 1986; Comstock, 1986; Hammond, 1992; Hicks, 1988; Kluft, 1985, 1987; Wilbur, 1984). Kluft (1988) described a traumatic experience and the corresponding affective component as an abscess waiting to be drained. Similarly, Comstock (1986), Hicks (1988), and Spiegel (1986) report that memory is a reconstructive process, and that the abreaction of traumas is essential and painful.

During abreaction a duality may exist in that some individuals demonstrate a "co-presence" between the past and current reality (Comstock, 1986; Hicks, 1988; Kluft, 1988; Spiegel, 1986). A misrepresentation of current reality based on former traumatic or conflictual relationships, known as transference, is similar to abreaction as the person reverts in time and loses partial connection with present reality. Minor degrees of this are not considered to be pathological (Hicks, 1988).

In more severe cases, as in MPD and Post Traumatic Stress Disorder (PTSD), there may be a total loss of contact with the here and now. The misinterpretation or misperception of interpersonal dynamics or environmental stimuli may occur, and the potential for reexperiencing the past as a current phenomenon becomes likely (Comstock, 1986; Hicks, 1988; Kluft, 1988; Spiegel, 1986).

The literature reports parallels between MPD and PTSD in that psychic trauma implodes the mind with an inordinate degree of stimuli which cannot be assimilated in normal ways, which leads to a posttraumatic stress response, and which may mobilize dissociative processes (Cooper, 1983; Kardiner, 1959; Kolb, 1983; Spiegel, 1984). The ego constriction which victims of massive trauma experience reduces the potential for adaptation and requires the active reliving of the stressful events. With sustained therapeutic support, mastery may be achieved through abreactive techniques, personality disturbances may diminish or dissolve, and internal controls may improve (Cooper, 1983; Kolb, 1983; Spiegel, 1984).

According to Comstock (1986), abreactions always serve a purpose. Although initially unclear, a variety of reasons for abreactive experiences include: (a) to inform or present information; (b) to educate, reeducate, or modulate distorted thinking patterns which occurred during a trauma; (c) to complete and release repressed affect, content, and somatic material; and (d) to add details and information surrounding recollections (Braun, 1986; Comstock, 1986; Hicks, 1988; Kluft, 1988). Abreactions may be unabridged and contain autonomic, physiologic, affectual, and intellectual representations of previously repressed material. In partial abreactions, the abreactive experience does not go through to completion and only segments of the memory are reexperienced.

Signals that an abreaction is about to occur may include: (a) intense hallucinations; (b) flashbacks; (c) an increased expression of anger or self-mutilation; (d) burning, anesthetic, or new somatic sensations (body memories); (e) inexplicable emotions which are evasive, pervasive, and new; (f) behavior reenactment of a scenario; (g) startle responses or hyperalertness; (h) problematic dreams or nightmares; (i) increased fears of being alone or with others; (j) newly emerged obsessive-compulsive behaviors; and (k) passive influence experiences (Comstock, 1986; Hicks, 1988; Kluft, 1985, 1987; Putnam, 1989).

As abreactive experiences are inherently regressive, the therapist's responsibility is to provide a safe environment in which to allow abreactions to occur and to estimate the time frame needed to accomplish the necessary work (Hicks, 1988; Kluft, 1988). According to Kluft (1988), this is not always possible as many abreactive experiences are spontaneous and result in the patient's leaving the session in a compromised position (i.e., with controls but without completing or fully addressing the abreative experience). Sometimes traumas require repetitive abreactions in order to be fully understood and to desensitize the current stimuli which precipitated a flashback.

Patients should be evaluated as to when they are able to handle full abreactions. If this is not possible, internal distancing from the actual memory may be used to allow alters to view the scene from a removed position. The use of fractionated abreactions, as defined above, may prevent the escalation of acting out behavior and emotional or physical exhaustion. Therapeutic interventions such as art therapy, movement therapy, or hypnosis may also increase one's understanding of the personality system in conjunction with traumatic events and distressing relationships (Kluft, 1987; Spiegel, 1986).

In the literature on the therapeutic use of imagery, McKinnon (1984), Grigsby (1987), and Brett and Ostroff (1985) state that the role of visual imagery in the symptomatology of PTSD requires further attention. These authors hypothesize that the use of therapeutically structured visual imagery may preclude the need for hypnosis and decrease resistance, although they warn that an overly direct approach may result in the patient viewing the therapist as sadistic.

It is this author's opinion that the process of art therapy increases the potential for abreaction in MPD patients as censorship tends to decrease when nonverbal modalities are utilized in psychiatric treatment. As the therapeutic alliance progresses and art enables the patient to connect with previously repressed material, spontaneous abreactive experiences may similarly increase. Art may be therapeutically structured, however, which may circumvent the need for hypnosis to access traumatic memories.

The art process promotes the unraveling of layers existing in complex MPD patients, which leads to the provision of visual information. Through this mode of information gathering, alters may communicate and compare histories and also modify previously learned responses to foster mastery of original traumata. Art expression bridges various components of memory including behavior, affect, sensation, and knowledge (Braun, 1988).

Abreactive sessions may be orchestrated in response to imagery in drawings, and they may also occur spontaneously (i.e., triggered by art media or content in previous drawings). Safety is a priority when doing abreactive work as the patient relinquishes distance between the present and past and may lose control unexpectedly. For this reason, pre-abreactive work should be done in the initial phases of treatment and prior to planned abreactive sessions. This includes delineating the abreactive process within sessions, formulating a safety plan in the event the abreaction becomes unmanageable, and addressing the possibility of inpatient treatment to explore material which might compromise safety. The necessity of developing a therapeutic alliance with the patient and personality system is obviously paramount with this type of therapeutic work.

Case Example

Rachel was referred for individual outpatient art psychotherapy due to increased blocking in her verbal psychotherapy sessions. After several months of art therapy treatment, she began to experience pain in her buttocks, which proved to be inconclusive upon medical examination. In a subsequent collage which she had been working on independently (Figure 1), it was determined that the bridge in the

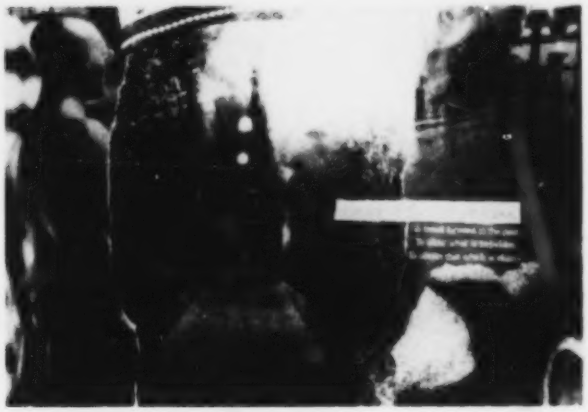


Figure 1.

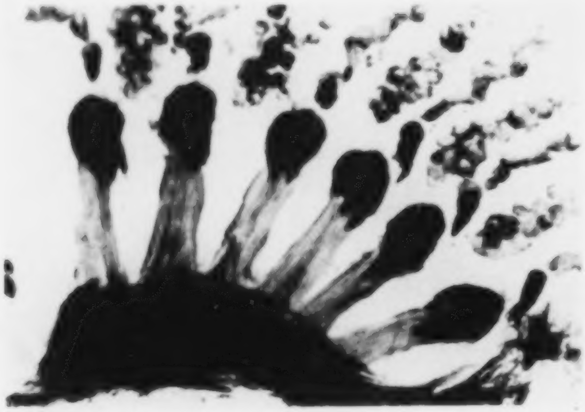


Figure 2.

upper right-hand corner appears to be leading to the screaming young girl. The latter is connected to an underground tunnel within which a man stands; to the left of the tunnel is a disrobed figure with buttocks bared.

In conjunction with this collage, a younger alter emerged and asked to work with fingerpaint (Figure 2). Although unable to verbalize the meaning of the images, Rachel noted six phallic shapes with darkened material on the tips, an oozing substance emanating from them. Subsequently, a drawing was completed in which a portion of the cognitive memory was depicted (Figure 3). In exploring this memory through a series of fractionated abreactions, another alter named Anna drew herself and the therapist in the rafters of a barn. Her perpetrator is seen as ready to penetrate, as she lies atop several bales of hay. In the final picture (Figure 4), drawn following a complete abreaction of the memory, several personalities "wail and scream" as the corresponding affect is released from the wooden plank which previously contained them. Following this series of pictures and the acknowledgement of repetitive anal rapes by father, the body memories and pain Rachel experienced were resolved.

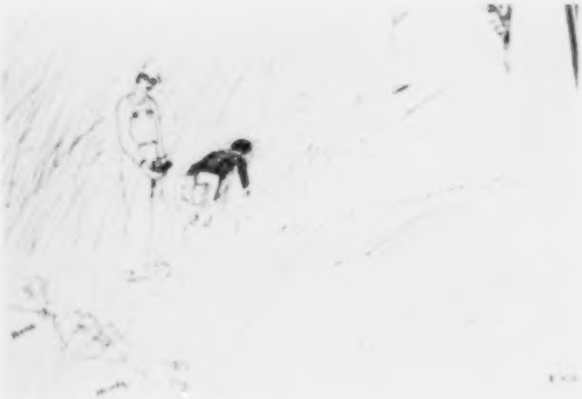


Figure 3.

Assimilating Traumatic Material

As the therapist investigates memories, the foundation for bridging affective states is laid and the dissociated material may emerge. Repressed material held by personalities may surface, enabling the recognition and understanding of particular incidents. This data may be used to abreact a traumatic experience and expose affective fragments, allowing alters to bring forth memories and to enhance their comprehension of varying perspectives surrounding them. This last therapeutic endeavor, a process developed by this author, explicitly utilizes artistic imagery as a vehicle for sensitizing alters to thoughts and feelings other than their own. This method, called "stepping in," involves free association plus assimilation, which may lead to resolving issues surrounding traumatic events.

Free association to art productions offers the patient and therapist text which directly relates to personal images. Through the work of Naumburg (1966), the integration of psychoanalytic theory and free associations to spontaneous art

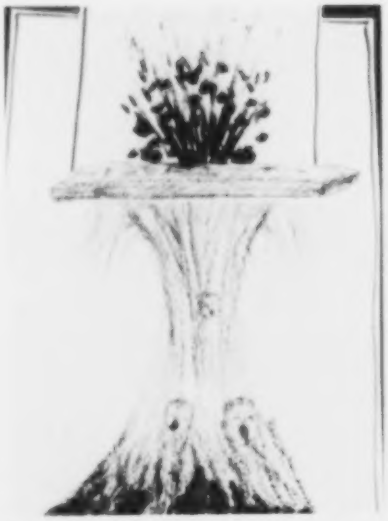


Figure 4.

productions yielded one use of art expressions as a therapeutic modality. In this tradition, "stepping in" is a term coined by the author to describe a therapeutic technique incorporating free association that has developed in her clinical work with alters. It is a process in which several alters are asked to free associate to the same drawing. The alters may have participated in drawing the image; however, alters who have not drawn are also asked to "step in" to an area of the image or align with another alter who has been drawn. Through this process, alters who initially denied awareness of a traumatic event may find connections to the traumatic material presented in the image. Consequently, it can be a first step toward assimilating and integrating memories, as the personalities "stepping in" may recognize some aspect of the event being explored.

The major difference between the technique of "stepping in" and traditional free association is that visualization techniques and simple hypnotic interventions are utilized to facilitate the process. Additionally, nonintegrated aspects of the self are associating to the same image.

Case Example

In examining the original dissociative split resulting in the development of alters Sarah, Dan, and Nicole, this drawing was elicited (Figure 5). The drawing depicts Daddy and three adult friends sexually violating a child (Sarah/Nicole) on a table. A young boy with arms bound is depicted to the right of the table (Dan), and another tiny figure watches from outside the shed door.

The original personality, the one near the door, reported that she was not involved in this incident and that she enjoyed laying in the grass. After reaccessing the memory depicted by the three alters in this picture, this therapist asked the observing personality to step into the body on the table for several counted seconds—to see "if it fit." Following an affirmative nod of her head, she was asked to step out of the picture. For the next few months her grief and illusion of immunity, which distorted reality in order to preserve psychological safety, were addressed. Dan's and Nicole's rage offered another affective component related to this trauma, as her therapy continued to explore what the group would say to Daddy if he were alive (Figure 6).

Over time it was learned that personality Dan evolved and was mute as a result of being bound and gagged during

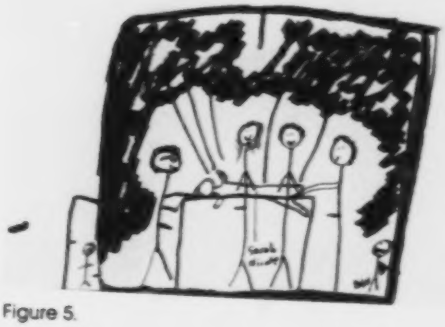


Figure 5.

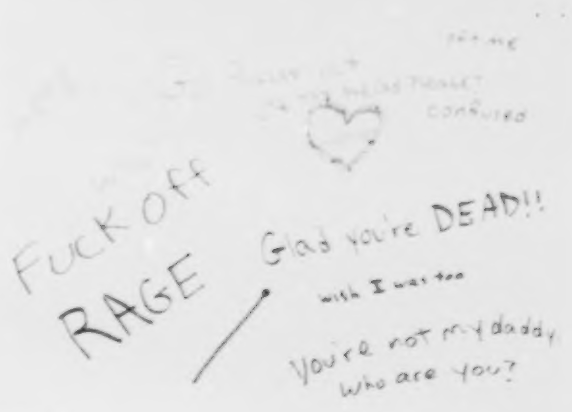


Figure 6.

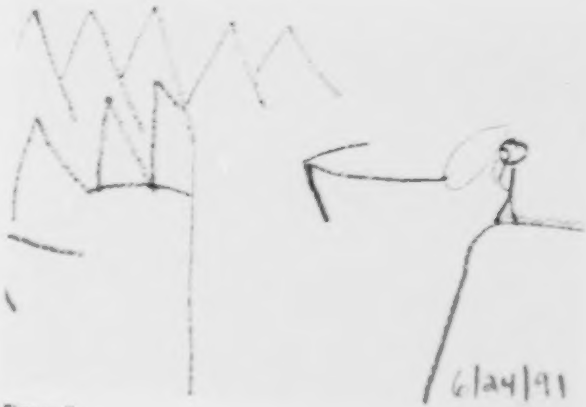


Figure 7.

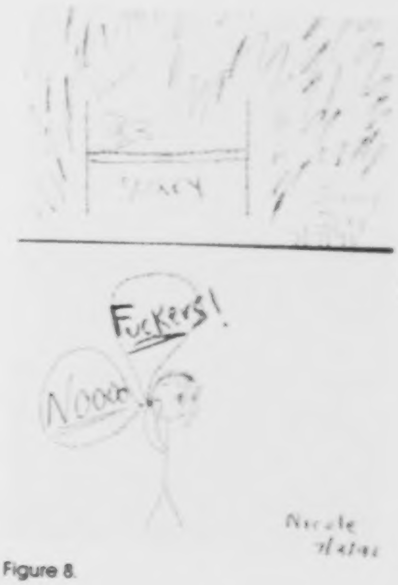


Figure 8.

BEST COPY AVAILABLE

the abuse. In therapy he gradually accepted being taught how to speak (Figure 7), and the corresponding feelings of fear and grief were retraced. Currently, the accommodation of previously assimilated schema is being addressed in order to understand the patient's personality system, which has led to decreased personality tension and increased personality communication within the system at large (Figure 8).

Conclusion

When repetitive traumas occur, the child often revises and reformats reality in a new way in order to safeguard his/her psyche. As the ability to comprehend recurring traumas becomes impossible, the assimilation of such trauma may result in internal fragmentation.

The use of visual imagery to recover traumatic memories offers the MPD patient a developmentally flexible modality for resynthesizing past experiences through artistic externalization. Through abreactions, and the corresponding processing of them, maladaptive accommodating and self-correcting mechanisms may be identified and relearned. In conjunction with relearning truths through "stepping in," dissociated material may be shared among alters within the personality system. This may reduce the need for separateness and support the development of an integrated psyche.

In conclusion, art psychotherapy may offer diagnostic information and aid in uncovering psychodynamic data in patients diagnosed with multiple personality disorder. Through abreactive techniques and others, a nonverbal, comprehensive mode for both accessing and reprocessing dissociative information is available. As illustrated in the brief case examples, this modality is effective in the recovery, resolution, and integration of the traumatic material presented by patients who dissociate.

References

Braun, B. G. (1986). Issues in the psychotherapy of multiple personality disorder. In B. G. Braun (Ed.), *Treatment of Multiple Personality Disorder* (pp. 3–28). Washington, DC: American Psychiatric Press.

Braun, B. G. (1988). The BASK model of dissociation. *Dissociation, 1*, 4–15.

Brett, E. A., & Ostroff, R. (1985). Imagery and post-traumatic stress disorder: An overview. *American Journal of Psychiatry, 142*(4), 417–424.

Cohen, B. M., & Cox, C. T. (1990). Breaking the code: Identification of multiplicity through art productions. *Dissociation*, 2(3), 132–137.

Comstock, C. M. (Speaker). (1986). *The therapeutic utilization of abreactive experiences in the treatment of multiple personality disorder* (Cassette Recording No. IVc-303-86). Alexandria, VA: Audio Transcripts.

Coons, P. M. (1984). The differential diagnosis of multiple personality disorder: A comprehensive review. *Psychiatric Clinics of North America*, 7, 51–65.

Cooper, A. (1983). *The concept of psychic trauma*. Paper presented at the 11th Friends Hospital Annual Clinical Conference, Philadelphia.

Ellenberger, H. (1970). *The discovery of the unconscious*. New York: Basic Books.

Fink, P. J., Levick, M. F., & Goldman, M. J. (1973). Art therapy: A diagnostic and therapeutic tool. *International Journal of Psychiatry, 11*(1), 104–118.

Grigsby, J. P. (1987). Single case study: The use of imagery in the treatment of posttraumatic stress disorder. *The Journal of Nervous and Mental Disease, 175*(1), 55–59.

Hammond, D. C. (Speaker). (1992). *Clinical hypnosis in the treatment of multiple personality disorder* (Cassette Recording No. 37-742-92A-D). Alexandria, VA: Audio Transcripts.

Hicks, R. E. (1988). *Abreaction*. Unpublished manuscript.

Jacobson, M. L. (Speaker). (1986). *Managing anger in the multiple personality patient: Therapeutic approaches through art therapy* (Cassette Recording No. ID-303-86). Alexandria, VA: Audio Transcripts.

Jacobson, M. L. (Speaker). (1988). *From isolation to abreaction: An intrinsic process in art psychotherapy with multiple personality/dissociative disorder patients* (Cassette Recording No. IXB-436-88). Alexandria, VA: Audio Transcripts.

Jacobson, M. L. (1989). *Enhancing communication across alters through art therapy* (Cassette Recording No. 25-494-89). Alexandria, VA: Audio Transcripts.

Jacobson, M. L. (1990). *At risk: Indices of suicide in the artwork of patients with multiple personality disorder* (Cassette Recording No. VIIId-595-90). Alexandria, VA: Audio Transcripts.

Jacobson, M. L. (1991). *Art, association and assimilation: The sensitization of enraged alters to the system at large* (Cassette Recording No. IIId-693-91). Alexandria, VA: Audio Transcripts.

Jacobson, M. L., & Mills, A. (1992). *A survey of art therapy in the identification and treatment of MPD* (Cassette Recording No. 34-742-92A-B). Alexandria, VA: Audio Transcripts.

Kardiner, A. (1959). Traumatic neurosis of war. In S. Arieti (Ed.), *American Handbook of Psychiatry: Vol. 1* (p. 252). New York: Basic Books.

Kluft, R. P. (1984). Aspects of the treatment of multiple personality disorder. *Psychiatric Annals, 14*(1), 51–55.

Kluft, R. P. (1985). The treatment of multiple personality disorder (MPD): Current concepts. *Directions in Psychiatry*, 5(24), 3–9.

Kluft, R. P. (1987). An update on multiple personality disorder. *Hospital and Community Psychiatry*, 38(4), 363–373.

Kluft, R. P. (1988). *Varieties of abreactions and abreactive techniques*. Paper presented at the Philadelphia Study Group meeting of the International Society for the Study of Multiple Personality Disorder, Philadelphia.

Kolb, L. C. (1983). Return of the repressed: Delayed stress reaction to war. *Journal of the American Academy of Psychoanalysis, 11*(4), 531–545.

McKinnon, J. A. (1984). Brief psychotherapy of the Vietnam combat neurosis. In H. J. Schwartz (Ed.), *Psychotherapy of the combat veteran* (pp. 125–151). New York: SP Medical and Scientific Books.

Naumburg, M. (1966). *Dynamically oriented art therapy: Its principles and practice*. New York: Grune and Stratton.

Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: The Guilford Press.

Spiegel, D. (1984). Multiple personality disorder as a posttraumatic stress disorder. *Psychiatric Clinics of North America, 7*(1), 101–110.

Spiegel, D. (1986). Dissociation, double binds, and post traumatic stress in multiple personality disorder. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 63–77). Washington, DC: American Psychiatric Press.

Wadeson, H. (1980). *Art psychotherapy*. New York: John Wiley and Sons.

Wadeson, H., Durkin, J., & Perach, D. (1989). (Eds.). *Advances in art therapy*. New York: John Wiley and Sons.

Wilbur, C. B. (1984). Treatment of multiple personality. *Psychiatric Annals, 14*(1), 27–33.

Art Therapy: Journal of the American Art Therapy Association, 11(1) pp. 53-57 © AATA, Inc. 1994

An Application of Art Therapy to the Trauma of Rape

Karen Hargrave-Nykaza, BS, Watertown, NY

Abstract

This paper explores the personal violation of rape in terms of specific trauma usually experienced after a rape: PTSD, rape trauma syndrome, and permanent life changes. The purpose of this paper is to explore the ways in which art therapy can help a rape victim engage herself in the healing process. A study of one rape victim is reviewed along with the current literature as an example of the life-altering effects of rape and the importance of art expression in their treatment.

Rape: Definition and Overview

A formal definition of rape according to common law reads:

> "A man commits rape when he engages in intercourse with a woman not his wife; by force or threat of force; against her will and without her consent." (Estrich, 1987, p. 8)

The act of rape is connected with aggression. Society associates sexuality with violence and these contextual beliefs are not easily altered (Fonow, 1992). Others observe that "men are socialized to be aggressive while women are socialized to be victims" (Chapman & Gates, 1978, p. 29). Hall (1986) found that images of male dominance and female passivity allow this culture to support rape-tolerant attitudes. Male supremacy seems to be upheld at whatever cost. For women, this cost is often rape, sexual harassment, physical abuse, emotional abuse, and living in constant fear of being attacked (Chapman & Gates, 1978).

According to Chapman and Gates (1978), sexual exploitation begins at an early age when children are exposed to fairy tales, cartoons, TV programs, and commercials. It seems that before anything can be done about rape specifically, society has to change the exploitation that has become so accepted in our social mores. Vona Evans (1992) found that these exploitive stereotypes are engrained in children's minds very early and not easily erased.

Twenty-five percent of the women who report their rapes have been raped by their husbands. According to the common law definition of rape cited above, violating one's wife sexually may not be considered rape. In a televised report a woman spoke about being raped by her husband. She had the entire attack on videotape, including her being tied to her bed. Even with this evidence, her husband was found innocent. If modern law does not yet recognize rapes by acquaintances as "real" rapes, it is not surprising that the issue is rarely raised when the rapist is the victim's husband (Estrich, 1987).

The Effects of Rape

There are emotional effects following a rape. These include grief and loss, depression, guilt and self-blame, rage, terror, mistrust, low self-esteem, fears about control, body image distortion, intimacy and sexual difficulties, and self-destructive behaviors (Quina & Carlson, 1989). Most women who have been raped experience all of these emotional effects at some point; many are experienced for several years following the rape. One victim expressed, "I have gotten over the physical trauma of what he did to me, but I live every day with the emotional trauma" (Kantrowitz, 1991, p. 32).

One of the most dangerous outcomes of rape occurs when the victim blames herself (Quina & Carlson, 1989). Reilly (1992) found that less than half of the women in a category of highly victimized women acknowledged that they had been raped. According to Remer and Witten (1988), most women do not even discuss the experience of being raped with their significant other. This type of shame can only perpetuate a negative cycle and enhance an atmosphere where rape myths are perpetuated (*Ibid.*, 1988).

Often in cases of sexual trauma involving rape, victims are told that they are to some degree responsible for being victims (Ochberg, 1988). In many cases, the woman feels like a criminal herself as lawyers present a case against her to make it look as if she asked to be raped (Hazelwood & Burgess, 1987). A woman's entire past is scrutinized, especially if she is claiming she got AIDS from her rapist (Salholz, 1990). It is also very difficult for a victim to try to recover from rape while a defense lawyer is presenting her sexual history to a jury (*Ibid.*). If a defendant knows the victim's sexual history, it could be argued that such knowledge is relevant to determining what her rapist thought at the time of intercourse (Estrich, 1987). Self-blame and projected responsibility by others seem to be a pervasive problem according to Sundberg (1991). All too often the public considers the circumstances surrounding the attack rather than the victim's feelings.

Additionally, rape is the most intimate of crimes; it is the dark terror in a woman's heart as she crosses an empty parking lot. It is also the only violent crime that tarnishes the victim and the criminal (Kantrowitz, 1991). Fear of rape is one of the strongest fears reported by women and is thought by women to be worse than murder (Quina & Carlson, 1989). A common attitude among women who fear rape is that if they were attacked, they would fight the attacker because they would rather die than live the kind of life they believe they would have after such a trauma (*Ibid.*).

A result of the rape is the appearance of the rape trauma syndrome (Chapman & Gates, 1978). Some of the emotions described by victims who have experienced this syndrome are extreme psychological shock, fear or terror, anger, shame, guilt, anxiety, revenge, powerlessness, and humiliation (*Ibid.*). "Victims of criminal harm experience a special kind of trauma cre-

---

Editor's note: The author wishes to express her appreciation to Kevin, Allen, Laura, and Alice for their valuable contributions to this article. Reprints or questions about this article may be directed to Karen Hargrave-Nykaza, 218 Barben Avenue, Watertown, NY 13601.

ated by the intentionality of the criminal act" (Quina & Carlson, 1989, p. 26). A sexual crime has additional meaning for its victim because it is such a personal violation (*Ibid.*). "Rape trauma syndrome can help corroborate the victim's assertion of lack of consent and also help the jury understand the typical reaction of rape victims" (Block, 1990, p. 309).

A diagnostic category that has several symptoms in common with rape trauma syndrome is posttraumatic stress disorder (PTSD). According to the DSM-III-R (1987), symptoms of PTSD include difficulty sleeping, outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle response, and physiological reactions when exposed to events that symbolize an aspect of the traumatic event. "The DSM-III-R (1987) defines PTSD as a response to a significantly traumatic event outside the range of usual human experience, markedly distressing to almost anyone, and usually experienced with intense fear, terror and helplessness" (Howard, 1990, p. 79).

The Use of Art Therapy with Trauma

Howard (1990) noted that art therapy is a visual process that has great potential in accessing traumatic memories which may have been visually encoded. Thus, the art process may be useful as an intervention for PTSD and also provide a needed distance from this traumatic material (*Ibid.*). "By dissociating the self from the content of the picture, the patient's sense of personal control and integrity is protected" (*Ibid.*, p. 81). The victim uses denial to work through the traumatic imagery to discuss a picture of a feeling rather than the feeling itself.

Art therapy is also valuable to the rape victim because victims of psychological trauma have difficulty expressing their experiences directly and effectively through words (Johnson, 1987). At times of overwhelming terror, the cognitive system is bypassed and the event is recorded in photographic form. Memory may be blocked, but the visual images of art therapy may offer a unique way for traumatic memories to come to consciousness. The control of traumatic memories through the use of art materials seems to be essential to the victim at this point (Johnson, 1987). Johnson also states that "the need to disown and deny the affect and memories of the trauma, and to remain in control of them are more effectively accomplished when these images arise on paper" (p. 11).

Another purpose of art therapy is to restore a sense of order to the sensory modalities that an emotional crisis and stress have fragmented (McNiff, 1981). McNiff explained how angry the client's early pictures were and "how they allowed her to release her feelings in a way that would not harm anyone" (p. 164). Her artwork became a visual enactment through which she could free herself of anger and fear. This type of experience obviously could be useful in processing traumatic memories and the feelings surrounding them.

Horowitz (1971) found that repressed memories are accessible to consciousness in image representations that are inexpressible in words. Art therapy seemed helpful to the rape victim in this way because it used images to represent ideas and feelings. The images were less threatening to the victim when verbal expression became too difficult.

Art therapy is a particularly effective mode of treatment for the recovering victim. One strength found in the literature on the use of art therapy with rape victims is that it is thought to be a less threatening mode of expression (Burgess, 1979). The graphic images which haunt rape victims often require an alternative outlet to verbal therapy. Howard (1990) suggested that the images can place the victim in a life-threatening situation, yet the illustration can depict the victim seeking help or escaping rather than being victimized. The art therapy process and product seem to help victims restore some continuity between image and feeling.

Peacock (1991), in a study of postsexual abuse trauma, found that art therapy enables a client to identify, acknowledge, and express feelings. Her hypothesis also proposed that art therapy enhances the client's self-esteem, decreases anxiety, and decreases depressive symptoms.

Art therapy may be effective because it is directed at the essence of image trauma (Burgess, 1979). The rebuilding of the self as separate from the attack may take a different length of time for each victim. Some of the factors that influence how long the rebuilding process takes are the severity of the abuse, the strengths and weaknesses of the victim, and the support she receives from various sources. Art therapy keeps the focus on the image, keeping in mind that the rebuilding process is different for each victim.

An article by Yates and Pawley (1987) discusses one woman's struggle with sexual abuse. The woman's internal conflict is described as the struggle between her will to remember being sexually abused by her brother and the terror of remembering. As a child she denied this ongoing abuse, but as an adult she felt that she must resolve this conflict by allowing herself to feel what she had previously denied. She accomplished this partially through the use of her own artwork. Once she was prepared to accept the images she created, she understood the meaning behind them. "By creating art and being involved in psychotherapy, she learned about the healing process. Through this imagery, psychotherapy, and perseverance, she has worked toward resolution of difficult emotional issues" (p. 41). In experiencing her own art therapy, this woman expressed her own growth regarding her sexual trauma. "I have a new enthusiasm for creating art, and I will continue to explore the relationship between my unconscious and creative self. It is through expression in imagery that I have been healed."

The Symbolism of Sexually Abused Women

According to Spring (1985), women who have been sexually violated often draw wedges and eye forms. Posttraumatic stress also causes an increase in the frequency and sharpness of this wedge symbol. Spring noted that these symbols can be used for several related reasons: (a) use of the wedge shape to protect the vagina from penetration; (b) use of the wedge shape to equate penetration with threat, and (c) use of the eyes to symbolize guilt, being watched, and vigilance (such as watching for the rapist's return). Some of Rhyne's research (1979) suggests that subjects attach vigilance to drawing eyes. The wedges seem to appear when the victim is expressing threatening situations (Spring, 1985).

Horovitz (1988) found that triangular shapes were used to represent the vagina in a woman who had been sexually assaulted. She concurred with Spring's findings (1985) and also discovered that illustrations of the perpetrator were often devoid of body and contained an overly aggressive smile.

Spring (1985) stated that as the sexual abuse victim begins to make progress, the wedge and eye forms may be incorporated in the artwork in a more positive manner. These symbols may assist in the woman's growing ability to gain mastery over her victimization. For some, drawing provided a relief from the pain; for others, it gave a sense of control.

Spring (1985) also found that chemical dependency may arise in victims of sexual assault as a way to self-medicate against unbearable emotional pain. The author found this to be true when she interviewed a rape victim about her experience. The interviewee explained that she took drugs to escape the pain of being raped. "Drugs and alcohol can create a self-induced altered state of consciousness that provides an escape from emotional pain on a continuing basis" (p. 20).

Case Example

The rape victim interviewed by the author is an art therapist as well as an artist. She found that simply realizing the attack had occurred, working on it through art, and later writing about it were tremendous steps toward rebuilding, though she feels her issues are still somewhat unresolved. The victim observed that she experienced many symptoms of PTSD including difficulty sleeping, difficulty concentrating, and a physiological reaction when exposed to events that symbolize an aspect of the traumatic event. Through this woman's self-examination through art, like others who experience PTSD, the traumatic event was persistently reexperienced. As this victim turned to art to express her pain, she was shocked by some of the images she found in her work. In addition, she found the physical activity of painting allowed her pent-up emotions to be released. According to Bauer (1992), nonthreatening imagery is important to find and diffuse negative and aggressive feelings. Art therapy also provided this woman with an opportunity for nonthreatening and nonverbal self-expression.

This victim explained to the author that she was not violently attacked, and for this reason it was difficult for her to acknowledge the incident as a rape. She tried to ignore the incident, perhaps pretending that it didn't happen at all. During the time this victim tried to block out the incident, she found her feelings of self-worth beginning to erode. She engaged in many self-destructive behaviors, as if to surround herself with anything that would help block out the rape.

This woman explained to the author how her own art therapy helped her work through the many changes she was experiencing. She also shared a passage from a literary work that she felt expressed her feelings regarding her own work:

> Upon completion of the first draft, I found myself trying once again to leave the rape behind me. I would look for ways to avoid going back to the manuscript, fearing that other feelings and issues would resurface as I reread and reworked the manuscript. Finally one year later I developed the impetus to complete the final draft. My fears that the wounds would reopen did not hold true. As I reread the manuscript, however, I gained new insights into my own healing process. I found that I described the rape as "my" rape. Somehow I was still owning being raped, that is, taking responsibility to some degree that I had been raped. Now I find the degree of anxiety has lessened. I also discovered that the issues related to the long-term process of healing were clearer to me when I returned to the second draft. This only points out how very long it takes to integrate the experience into one's life. Even when I thought that I had fully integrated the rape, I relearned how deep the wounds really are. (Katz, 1984, pp. 100–101)

The rape victim shared several samples of the artwork she created during her own healing process. She did not interpret them but explained that the process of doing the work was in itself therapeutic. She did not work with a therapist throughout the process, as she did not feel ready for verbal exploration of her feelings. She still feels unable to interpret her feelings and the content of her artwork, so a description of the work by the artist and some interpretation by this author will be included.

Figure 1 is an etching and was her first artistic undertaking after the rape. It seems to reflect a tragic feeling of self-blame, common among rape victims. Shame is apparent with the woman covering her face. The eyes are masked which could suggest the victim's unwillingness to accept or deal with what has happened to her. The victim expressed feelings of denial about the occurrence of the attack along with her refusal to cope with her feelings since the attack. She seems to be concealing her identity, afraid of the stigma attached to rape in addition to her own feelings of shame. Ironically, the victim chose to etch this image in stone, which could be a metaphor for the permanent effects of the rape.

Figure 2 is the result of the previous illustration being soaked in acid. It seems that for this victim, after she created these images, she was desperate to remove them from her memory. According to the DSM-III-R (1987), recurrent distressing dreams of the event are normal. This woman expressed that she was haunted by reliving the experience while she was both awake and asleep. This might reflect her inability to accept how vulnerable she was at the time of the attack. Again the face has been covered to conceal the woman's identity, and the mesh seems to be used as a de-

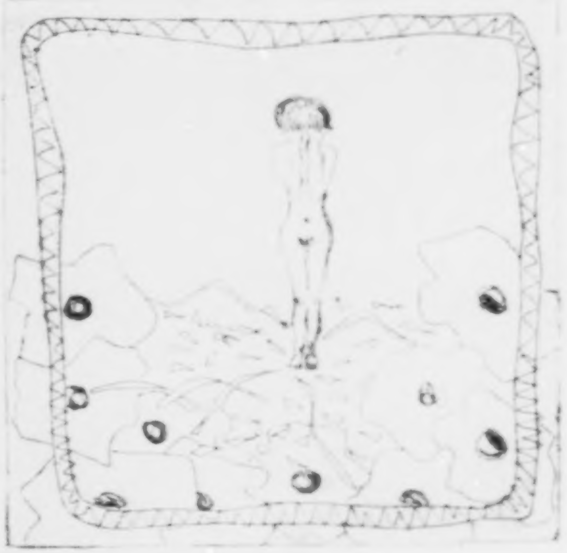


Figure 1.

BEST COPY AVAILABLE

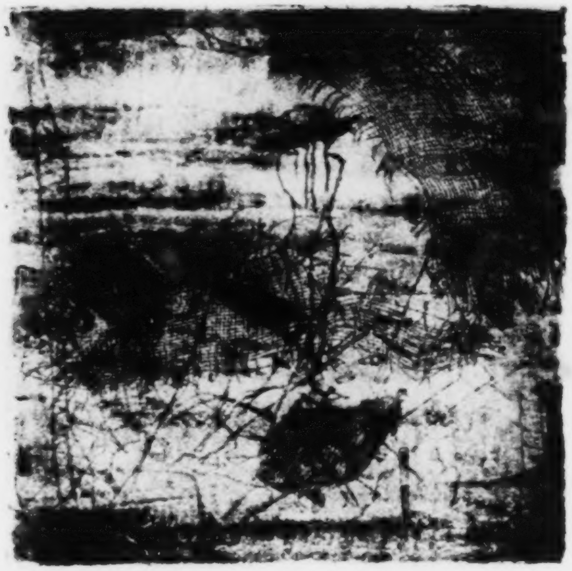


Figure 2.

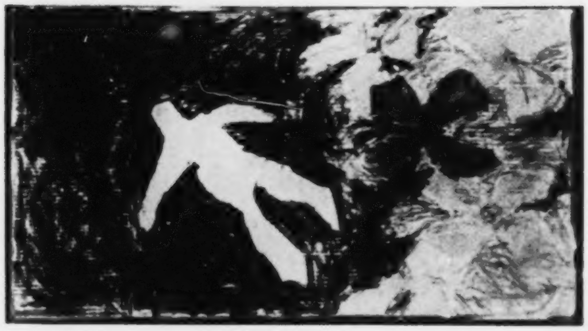


Figure 3.

fense to protect the body. This may be her last effort to protect herself from the emotions resulting from her rape by putting an actual physical barrier between herself and the rapist.

Figure 3 was her first painting in a series and again raises the issue of being deflowered. In fact, flowers and deflowering are recurring themes in her artwork. The ghostlike figure in this painting appears to illustrate the victim's feelings of being continuously haunted by her attacker. The combination of the deflowering imagery, the woman's depressed background, and the ghostlike attacker may reflect a woman's life that has been permanently altered by rape.

Figure 4 was painted next. It contains bold purples and reds to represent the victim's anger both at herself and the attacker. When looking at this monumental painting (6′ × 8′), the viewer gets a sense of the rage that is suggested by the victim's work. This painting appears to be the combination of the victim's anger and depression resulting from the attack. The large size of the painting might reflect the overwhelming feelings the victim experiences through these emotions.

Figure 5 was done on top of a fiberglass screen. The victim chose this material because the transparent quality allows for reflections of the past to be seen. In this painting, the many layers of paint previously used have been lifted indicating the artist's feelings about regrowth. The possibility for light to show through the screen may be a sign of a lifting depression. The colors used are yellows, oranges, and greens, again suggesting a lifting of the victim's depression. Flowers recur again as a possible metaphor.

As Spring (1985) suggested, Figure 6 shows how prevalent the eye forms were in the artwork of this rape victim. According to Spring's research, the eye forms may have been used by this victim to symbolize guilt, being watched, and vigilance. The sharpness of the shapes in this painting seems to suggest the victim's harsh feelings about the attack, feelings that remain even after beginning to work through them. She chose to use red, blue, yellow, white, and black. The colors also contribute to the contrasting feeling of the painting.

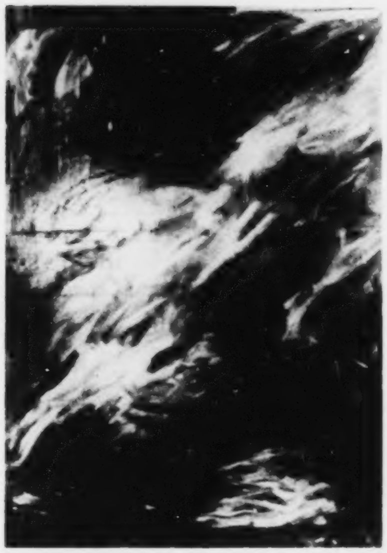


Figure 4.

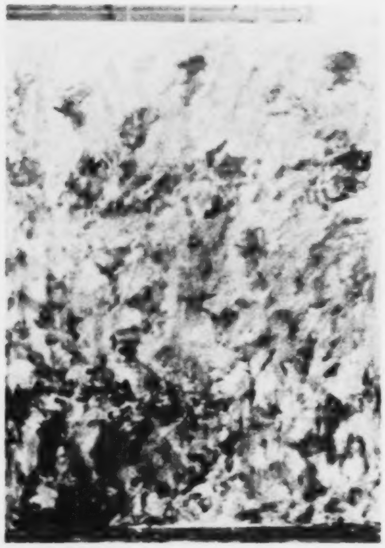


Figure 5.

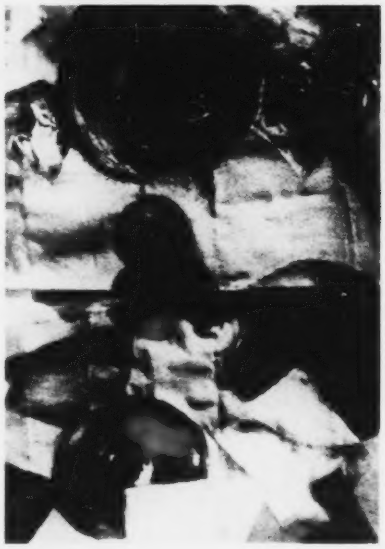


Figure 6.

The wedge shapes used were also noted by Spring (1985) to indicate a need to protect the vagina or a connection between penetration and threat.

Conclusion

There are many ways that rape victims can be helped via verbal techniques suggested by Quina and Carlson (1989). The techniques mentioned in this paper were those that are used by art therapists, including McNiff, Howard, Spring, and Horovitz. The power of art therapy in the recovery process of a rape victim has been illustrated in this paper with a discussion of recurring symbols used by victims of rape and sexual abuse in general. These symbols seem to provide these women with a voice when they have otherwise lost their ability to verbalize their emotions.

The permanence, symbolism, and sense of control that is provided through art is of great value to the rape victim. Art seems to provide a nonthreatening modality and a safe space for the rape victim to express the emotions that otherwise might remain unexpressed.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed.). (Rev. 1987). Washington, DC: Author.

Bauer, L. (1992). Unpublished thesis. New York.

Block, A. P. (1990). Rape trauma syndrome as scientific expert testimony. *Archives of Sexual Behavior, 19*(4), 309–322.

Burgess, A. W. (1979). *Rape: crisis and recovery*. New Jersey: Prentice-Hall.

Chapman, J. R., & Gates, M. (1978). *The victimization of women*. Arizona: Sage Publications.

Estrich, S. (1987). *Real rape*. Cambridge, MA: Harvard University Press.

Fonow, M. M., Richardson, L., & Wemmerus, V. A. (1992). Feminist rape education: Does it work? *Gender and Society, 6*(1), 108–121.

Funk & Wagnalls. (1976). Dictionary. New York: Funk & Wagnalls.

Hall, E. R., Howard, J. A., & Boezio, S. L. (1986). Tolerance of rape: A sexist or antisocial attitude? *Psychology of Women Quarterly, 10*, 101–118.

Hazelwood, R. R., & Burgess, A. W. (1987). *Practical aspects of rape investigation*. New York: Elsevier Science.

Holmstrom, L. L., & Burgess, A. W. (1983). Rape and everyday life. *Social Science and Modern Society*, 33–40.

Horovitz, E. G. (1988). Short term family art therapy: A case study. In Watson, D., Long, G., Taff-Watson, M., & Harvey, M. Adara (Eds.). *Two decades of excellence: a foundation for the future*, Chapter 11.

Horowitz, M. J. (1971). The use of graphic images in psychotherapy. *American Journal of Art Therapy, 10*(3), 153–162.

Howard, R. (1990). Art therapy as an isomorphic intervention in the treatment of a client with post-traumatic stress disorder. *American Journal of Art Therapy, 28* 79–86.

Johnson, D. R. (1987). The role of the creative arts therapies in diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy, 14*, 7–13.

Kantrowitz, B. (1991). Naming. *Newsweek*, April 29, 26–32.

Katz, J. H. (1984). *No fairy godmothers, no magic wands: The healing process after rape*. California: R&E Publishing.

McNiff, S. (1981). *The arts and psychotherapy*. Springfield, IL: Charles C Thomas.

Ochberg, F. M. (1988). *Post-traumatic therapy and victims of violence*. New York: Brunner/Mazel

Peacock, M. E. (1991). A personal construct approach to art therapy in the treatment of post sexual abuse trauma. *American Journal of Art Therapy, 29*, 100–109.

Quina, K., & Carlson, N. (1989). *Rape, incest, and sexual harassment*. Connecticut: Praeger.

Reilly, M. E. (1992). Tolerance for sexual harassment related to self-reported victimization. *Gender and Society, 16*(1), 122–137.

Spring, D. (1985). Symbolic language of sexually abused, chemically dependent women. *American Journal of Art Therapy, 24*, 13–20.

Sundberg, S. L. (1991). Victim blame and the disinhibition of sexual arousal to rape vignettes. *Violence and Victims, 6*(2), 103–117.

Vona Evans, G. (1992). Personal communication. June 26.

Yates, M., & Pawley, K. (1987). Utilizing imagery and the unconscious to explore and resolve the trauma of sexual abuse. *Art Therapy: Journal of the American Art Therapy Association, 4*(1), 36–41.

PLEASE NOTE CORRECTION TO THE FOLLOWING ANNOUNCEMENT

On page 36 of the most current issue of the AATA *Newsletter* (Winter 1994) the correct dates for the South Florida Art Therapy Institute's *Special Topics in Art Psychotherapy* are:

May 20 - 22, 1994

Questions should be addressed to the AATA National Office.

Brief Reports

The Tongue as a Graphic Symbol of Sexual Abuse

Cay Drachnik, MFCC, A.T.R., HLM, Sacramento, CA

Abstract

Art therapists and other professionals have explored and identified many graphic symbols in children's drawings indicative of sexual abuse (Cohen & Phelps, 1985; Howard & Jacob, 1969; Sidun & Rosenthal, 1987). Yet many art therapists and other professionals who work with children have identified graphic symbols which they believe are indicative of sexual abuse, but have not been verified in thorough research. One such symbol which has not been substantiated by research is the protruding tongue. This paper traces the history of this symbol from ancient times to the present in an attempt to explain the tongue's appearance in the drawings of children who have been sexually abused. Also included is an informal study by the author of the tongue symbol in the art expressions of children who have experienced sexual molestation.

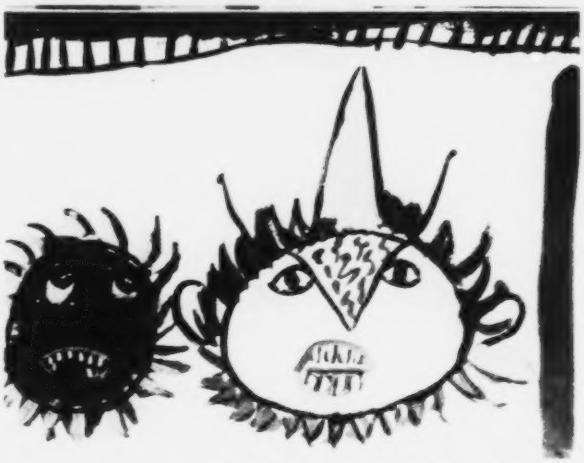


Figure 1. From the book, "Art Interpretation and Art Therapy."

Introduction

In reviewing the literature on symbols of sexual abuse noted in the art expressions of children since 1970, no mention was found of a protruding tongue as a possible indicator of molestation. Yet in my work with children in an outpatient setting, I have clinically observed the appearance of the tongue repeatedly in the drawings of sexually abused children.

In a study of sexually molested children, Chase (1985) suggested that an emphasis on the mouth in a human figure drawing might indicate sexual abuse, but the tongue itself was not mentioned. Additionally, Howard and Jacob (1969) present 11 illustrations of art expressions by sexually abused children and in two of the drawings tongues are prominent (Figures 1 and 2); however, there is no mention of these tongues within the text. Lastly, Uhlin (1972a) makes reference to a drawing by a sexually abused boy, observing ". . . notice the exhibiting of the phallic tongue . . ." (p. 112). Because Uhlin (1972b) had observed the tongue as a "phallic symbol" in addition to my clinical observations of a tongue in a number of drawings by sexually abused children, I became interested in researching anthropological and art historical information that might support the idea of the tongue as a symbol of sexual abuse.

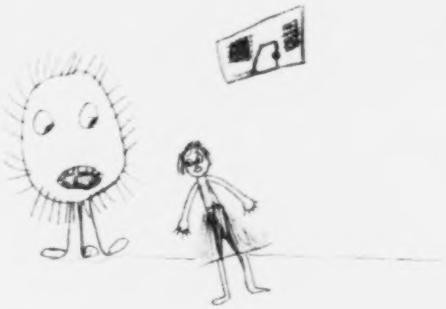


Figure 2. From the book, "Art Interpretation and Art Therapy."

A Brief History of the Tongue Symbol

The tongue as a graphic symbol, as other symbols, has more than one connotation which can be positive or negative or both. It can also have several meanings simultaneously.

Salmony (1954), in his book *Antler and Tongue*, observes that the tongue has been seen in statues, masks, and paintings of many cultures throughout history.

There are numerous examples of the tongue in art from ancient times until the present. One of the earliest recorded appearances of the tongue in art was in Egypt where the god Bes was often portrayed with a protruding tongue. His many roles included that of protector against evil spirits. This same god was later found in Asiatic and Greek civilizations.

Another example of the tongue symbol appeared in southern China about 400–200 B.C. on wooden busts (Figure 3). These busts also contained stag horns, which came out of the top of the head. The tongue was extremely elongated, reaching almost to the base of the stand. Also, K'uei, a Chinese deity in the Han Period, had the characteristic of a very long tongue.

In Greek art, the protruding tongue appears to have had both a divine attribute and a fearful element. This is evident in the face of Medusa, the female demon slain by Perseus. Medusa's face (Figure 4), with its hair of snakes and protruding tongue, turned men who looked at her to stone (until Perseus looked into his mirror-like shield and cut off her head). Walker (1988) noted that Medusa appeared in antiquity as a warning to men to keep away. Campbell (1959), discussing American Northwest totem poles, observed that the faces on the poles with their protruding tongues were similar to the Greek Medusa.

A few examples of symbolic tongues attached to animal profiles were found later in the Etruscan civilization and in Yugoslavia about the fifth century B.C. Buddhist texts also made frequent use of tongue symbols in connection with animals. For example, in Cambodia the Garuda, a bird-like figure, is shown with a pendant coming out of its mouth (Salmony, 1954). This same creature is used in southern Asian countries on the corners of homes to drive away evil spirits.

Kushan Mathura art dating from the second and third centuries A.D. depicts female demons with long undulating tongues, shown ready and eager to devour their mates. Rangda, a Balinese witch who stole children, is shown with a protruding tongue (Figure 5). Neuman (1963) also notes that Kali, an Indian goddess with her elongated tongue and bloody breasts, is shown dancing on the prostrate Shiva (Figure 6). Kali is described by Jobes (1961) as a blood thirsty avenger; she is also known as the supreme mother goddess, having a dual role of both benefactress and ogress.

Although the protruding tongue appears to have many sexual connotations, it has other meanings as well. For example, in Mexico the protruding tongue was often a symbol of wisdom (Bayley, 1951). In some parts of India, it is sometimes a symbol of great respect, and in Tibet it is still used as a favorable salutation (Walker, 1988). The Maori of New Zealand stick out their tongues to impress the spirits. However, in our Western culture the protruding tongue may be a symbol of insult (Figure 7).

Later, in medieval Europe, tongues appeared on carved heads on cathedrals in Norway, Germany, France, England, and other countries. Walker (1983) observes that "this was distinctly related to the exposure of sexual organs" (p. 1003). Exposing the genitals was thought to keep evil forces at bay. Also, in medieval times, creatures with protruding tongues indicated that the cathedral was dedicated to a pantheon of both pagan and Christian deities. By Renaissance times, however, the older deities with their protruding tongues were declared to be devils. For example, in 975 A.D., a Spanish manuscript illustrated one of the earliest images of this devil, depicting him as a naked man with an ox head and a long tongue (Figure 8). From that time on, images of Satan appeared frequently with elongated tongues.

Walker (1983) noted that at this time in history, "Pictures of lusty devils showed long phallic tongues, and sticking out

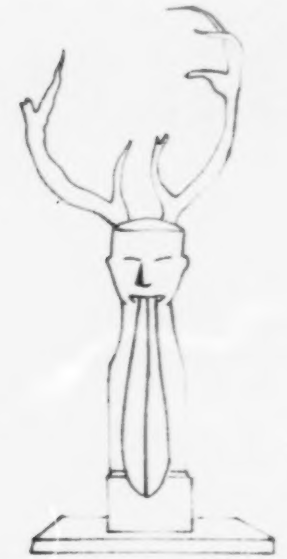


Figure 3. Drawing of a painted wood sculpture. China 400–200 B.C.

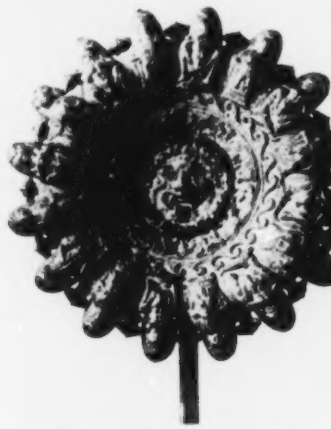


Figure 4. Lamp with Medusa head.

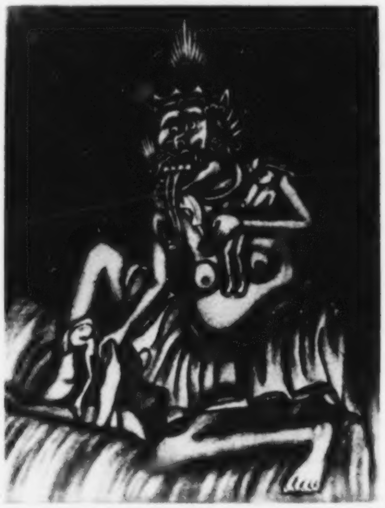


Figure 5. Rangda, a Balinese witch.

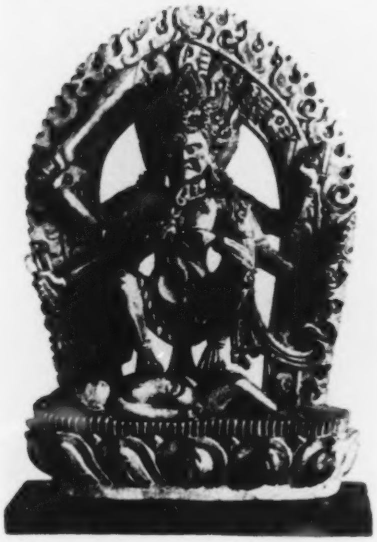


Figure 6. Kali.

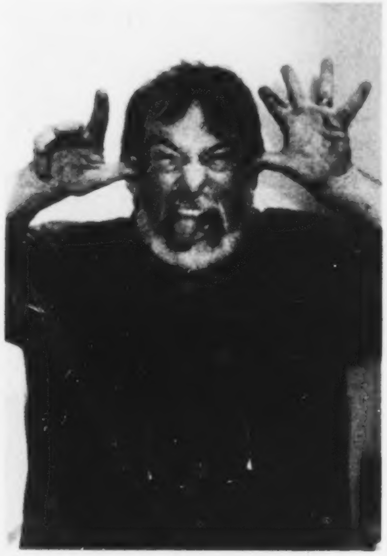


Figure 7. Artist Jerald Silva making an insulting gesture.

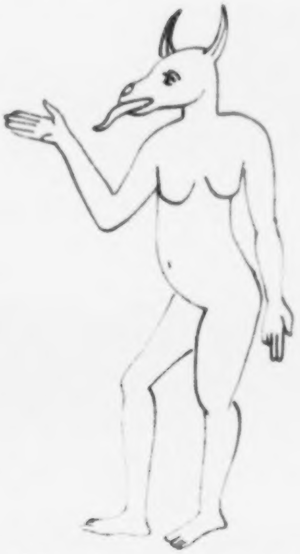


Figure 8. Drawing from an illustrated page in the Beatrea of the Cathedral of Gerona, Spain, dated 975 A.D.

the tongue at someone became a favorite gesture of insult. . ." (p. 1003). She added that "it was because of the tongue's sexual connotation that medieval devils were usually depicted with protruding tongues" (1988, p. 327).

Lastly, noted scholar Desmond Morris in his book *Body Watching* (1985) reported that the tongue is ". . . an echo of the male penis" (p. 103). He observes that an invitation from a prostitute is often a protrusion of the tongue between open lips, and that South American males may invite sexual encounter with the "slow wagging of the tongue from side to side within the half opened lips" (*Ibid.*, p. 103).

Clinical Observations

Because of the number of tongues I had seen in the drawings of sexually abused children and the numerous references to the tongue as a symbol connected with sexuality throughout art history and anthropology, I decided to review my collection of drawings that I had accumulated over the past 15 years. I examined the drawings of 263 children between the ages of 2½ and 18 years who had been seen for three or more sessions of therapy. Fifty-seven of these children had been identified as having been sexually abused. Another 12 children were identified as suspected victims of sexual abuse. Fourteen of the children identified as sexually abused were under the age of four; therefore, their drawings were mostly scribbles and had to be eliminated from this informal study.

Of the remaining 43 previously identified as sexually abused, the drawings of 14 children displayed one or more tongues (Figures 9 and 10 are two examples), which is only a little less than 25% of the sample. Of the 12 children who were suspected of sexual abuse, only three displayed tongues. However, of the other 194 clients (not known to be sexually abused) seen over this 15-year period, only two drawings displayed a protruding tongue.

Additionally, the appearance of a tongue has been informally noted by students under my clinical supervision in the drawings of sexually abused children. Although their observations are also clinically rather than empirically based, these observations do support the idea that the tongue symbol may in some way be related to the occurrence of sexual abuse in children.

Conclusion

Many art therapists are expected to make assessments of children's drawings, particularly in the area of sexual abuse; for this reason, it seems that there is a great need for more research in the area of sexual abuse symbols in general. Empirical research on the tongue symbol could prove helpful, since clinical observations seem to indicate that this symbol may be related to sexual abuse. Also, additional research on the meaning of the tongue symbol from anthropological and art historical perspectives could amplify why children who have been abused may include it in their drawings.

If the tongue is a graphic symbol of sexual abuse in children's drawings, what is its purpose? Could children be using this symbol to work through the sexual abuse? Could they be unconsciously communicating the abuse to the therapist? Or could they be using the symbol as a protective device (as some cultures relate the tongue to protection or a way to ward off danger) to prevent further sexual abuse? These are interesting questions that might be explored by art therapists who continue research in this area and with this particular symbol.

Lastly, due to the nature of this informal study, therapists are cautioned in their interpretation of this graphic sym-

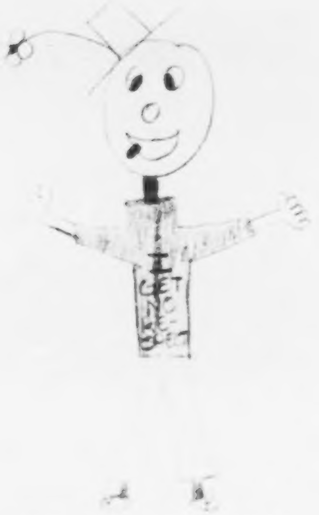


Figure 9. Drawing by a 15-year-old sexually abused girl.

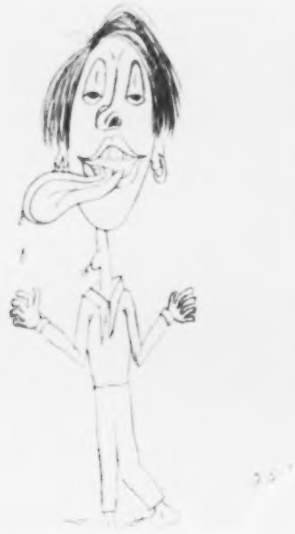


Figure 10. Drawing by a 15-year-old sexually abused boy.

bol in children's drawings. It is obvious from this small sample that not every drawing by sexually abused children contains the tongue symbol. However, there is enough evidence that the appearance of the protruding tongue in a child's drawing may be a possible clue worthy of further investigation.

References

Bayley, J. N. (1951). *The lost language of symbolism.* New York: Barnes & Noble.

Campbell, J. (1959). *The mask of God. Primitive mythology.* New York: Viking Press.

Chase, D. (1985). *An analysis of human figure and Kinetic Family Drawings of sexually abused children and adolescents.* Unpublished manuscript.

Cohen, F., & Phelps, R. (1985). Incest markers in children's artwork. *The Arts in Psychotherapy, 12*(4), 265–283.

Howard, M., & Jacob, I. (1969). Case studies of molested children and their art productions. In I. Jacob (Ed.), *Art Interpretation and Art Therapy* (pp. 72–89). Basel, Switzerland: S. Kargen.

Jobes, G. (1961). *Dictionary of mythology, folklore & symbols.* New York: Scarecrow Press.

Neumann, E. (1963). *The great mother: An analysis of the archetype.* New York: Pantheon.

Morris, D. (1985). *Body watching: A field guide to the human species.* New York: Crown.

Salmony, A. (1954). *Antler and tongue.* Zurich, Switzerland: Artbus Asiae.

Sidun, N., & Rosenthal, R. (1987). Graphic indicators of sexual abuse in Draw-A-Person tests of psychiatrically hospitalized adolescents. *The Arts in Psychotherapy, 14*(1), 25–33.

Uhlin, D. (1972a). *Art for exceptional children.* Dubuque, IA: William C. Brown.

Uhlin, D. (1972b). Unpublished class lecture notes on art and psychology. California State University, Sacramento.

Walker, B. (1983). *The women's encyclopedia of myths and secrets.* San Francisco: Harper Collins.

Walker, B. (1988). *The women's dictionary of symbols and sacred objects.* San Francisco: Harper Collins.

Viewpoints

Looking In—Looking Out: An Artist's Journey Through Childhood Sexual Abuse

Jane Orleman, Artist, Ellensburg, WA

I have been a painter for 25 of my 52 years. In the mid-1980s, I began to paint less and less. By 1989, my production diminished from an average of 20 paintings a year to only one. It was as though all of my vital energy and interest in life was draining from me. I filled the void with endless games of solitaire and science fiction.

My mother died in 1989; this seemed to release me from my stupor. I began working with a clinical psychologist in March of 1990, with the hope of overcoming my creative block. As we discussed my early life, I came to realize that it still held a powerful grip on me. I found it very hard to talk about it out loud. I whispered a lot.

I started to do one or two paintings a month. These images were inspired by subjects discussed in therapy sessions. In November, I started a series of small paintings from the point of view of myself as a child. These child-view images have allowed me to say in paint what I have found so hard to say in words. I am now doing six to eight paintings a month. About one-third of these are in the child-view. The rest reflect my feelings, as an adult, about the past abuse and about the process of therapy.

All these paintings are oils on canvas. The earlier ones are painted with small brushes. In June 1991, in response to a dream, I started using a palette knife. In August, at my therapist's suggestion, I began painting with a butcher's knife, an expressive and invigorating tool. Recently, I have been using two-inch wide brushes which afford me a flowing sense of freedom.

My earliest memories are of being molested. Between the ages of 3 and 8, this happened often. From 9 to 12 years, I was subject to almost daily physical or sexual assault. Rarely did a day go by when my father did not beat one of us children or my mom. I had assumed the attitude that this had all happened in a long, dead past. Painting these images has helped me to accept the memories. They continue to have a strong impact on how I feel about myself. I am grateful that I have been supported during this process by love and encouragement from my husband and two of my brothers.

I consider my paintings a dialogue with myself and approach the canvas with thoughts brought up in therapy. The painting is my deeper self telling me what I feel, think, or sometimes, remember. Very often these are feelings and thoughts of which I am not consciously aware. The comments accompanying the paintings are my attempt to understand the images on a conscious level. Often I have included dreams which seem to connect with the paintings.

The 10 images in this portfolio are from an ongoing series of over 200 paintings. My first step in the creative process always is to decide on the size of the canvas. Sometimes it is necessary to put a half dozen canvasses on the easel before I sense that I have the right one. The small child-view paintings usually deal with events; the larger ones are expressive of feelings. For this article I have paired event images with expressions of feelings relating to those events.

Figure 1A. "I Was 11 When My Brother Brought His Friends Home." 14" × 18"

This happened. The boys were 15 to 17 years old. I remember some of their names. This image shows my soul withdrawn to the corner of the room while another part of me turns into pure rage.

The night after I started the painting, I had this dream:

> I was being attacked by huge worms, and I was stabbing them with a hunting knife. It was an overhand stab—using all of my force. I felt that I hadn't really hurt them much because they were too stupid to feel it.

Figure 1B. "Guilt" 28" × 22"

This week my therapist suggested a revolutionary idea to me—to paint from my own life experience. He said, "What else do you have if not that?" The idea of painting my life was repellent and frightening to me.

However, all of the other wells were dry, so I decided to try it. We had talked about my feelings of guilt associated with being a victim and this became the first image in a narrative of my early life. The secrets that I have kept until now have bound and contained me like this bottle of poison. The skull and crossbones marks the spot where all of the painful emotions have been stored. I think it may be common to feel that one would never have been beaten or raped unless it was deserved.

Figure 2A. "Memories of Mother" 12" × 24"

When I was 35, my parents moved to the town which had become my home. Until then I had kept 3,000 miles between us. As a child I had begged mother to stay. As an adult I begged her to leave. I don't know which was more painful. It took 5 years to get my parents to move away.

Figure 2B. "Banished" 36" × 30"

This image is symbolic of an event that occurred at the end of this week's therapy session. Since I had just shown these revealing paintings for the first time, I was feeling very exposed. All of my feelings of rejection came to the surface and overwhelmed me. Anger was also a big part of this experience. I seldom become angry, and it was frightening to me as I felt possessed by the anger.

One of my responses was to go to the library and read three books about therapy so as to understand what was happening. Reading about transference made me realize that this "way out of proportion" reaction was in some way useful to the growth process. It didn't make me feel any better, but the knowledge did allow me to return the next week. It took six months to work through these intense feelings.

I had this dream the night after the therapy session. The man with the knife was Dr. W.

> I was in an underground labyrinth. There was ice everywhere including underfoot. I was surrounded by thin ice. I could tell where the ice was thicker because it was more white than the thin ice. There were some pathways that had the thicker ice, and I was running along them as fast as I could. There was a man with a knife chasing me. He kept hollering at me to stop, and he would guide me to safety. I knew I was surrounded by 25,000 miles of thin ice, but he seemed the larger threat. I kept running.

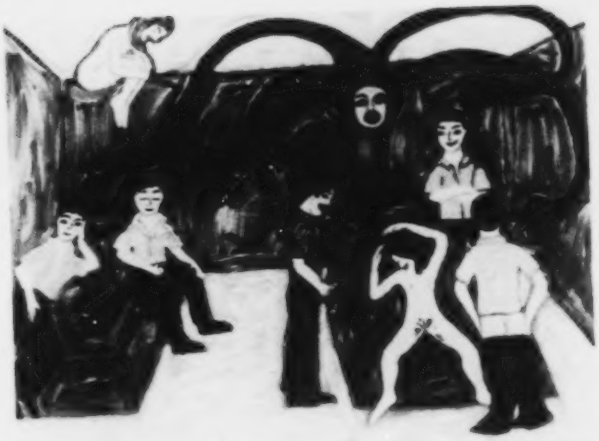


Figure 1A.

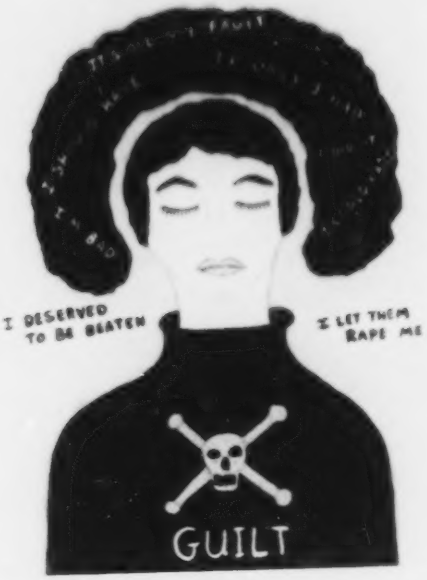

I DESERVED TO BE BEATEN
I LET THEM RAPE ME
GUILT

Figure 1B.

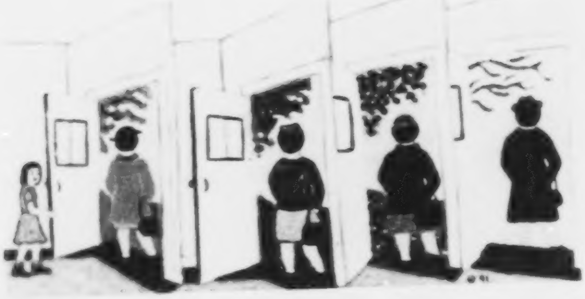


Figure 2A.

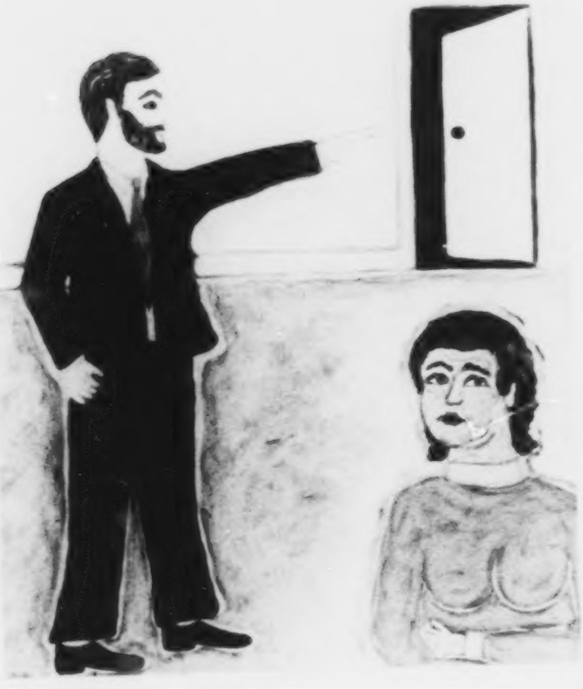


Figure 2B.

Figure 3A. "Go Make Your Daddy Happy." 11" × 14"

Those were the words Mom said when she sent me into the lion's den. When I began this painting, I was thinking of doing an image relating to my mother. I always wanted her love and protection, but what I felt from her was not only neglect, but also betrayal. No one could make Daddy happy, but I was the one assigned to the job.

Figure 3B. "Unacknowledged Feelings" 50" × 54"

At this time I was experiencing a feeling of a heavy nameless weight pressing in on me. I couldn't identify what was getting me down so I decided to paint the feeling itself. In doing that I realized I couldn't identify feelings I refused to acknowledge.

The night before I painted this image I had the following dream. I think it is the dirt, bugs, and mice in the house of my soul which I have refused to acknowledge.

> I found that my house had great holes in the inner walls and floors, leaving it open to the dirt and bugs and mice which are found in basements. Even on the second story this was true. The house needs a lot of work.

Figure 4A. "Monsters in the Night" 16" × 20"

I find this image very disturbing. I think that in relationship to this memory I am still hiding on top of the closet. It is reasonable that I would rather think a monster had gotten me in the night rather than my own father.

The following dream puts this image into words.

> I was a young girl. I went into my bedroom to take a nap. My father was there. After I fell asleep a dog started licking my vulva. I couldn't wake up but I was sure it was a dog and was afraid it would bite me and eat me. It felt physically exciting—mentally repulsive and very frightening. After a while Dick [my husband] came in the room. I was afraid he would be repulsed by what he saw. (I knew he was there even though I couldn't wake up.) But he just lay down beside me and put his arm around my shoulders. As he held me the dog melted away.

Figure 4B. "The Bones Remember What the Mind Forgets." 52" × 58"

Shortly before I started this painting I had experienced a devastating memory involving my father. It released intense feelings which I spent the next 2 months trying to put a lid on. I was unable to return to the unknowing state although, to be honest, a large part of me still wants to forget. I feel like my bones have been picked clean of all pretense, and I am left with the naked truth. It is ironic that the bones have more vitality than the fully fleshed figure.

Figure 5A. "Learning to Fly" 10" × 14"

My therapist had made a remark which caused me to question myself, my process of painting, and, then, my trust in him. If he could be so wrong about something I felt was important, could I really trust him? My way of discovering how I felt about him was to trust my process first—which means that I stood before the easel and asked my inner self how she felt about Dr. W. Does she trust him?

In this image I perceive that he sees where I am now and where he would like to see me someday. This means that he is not just sitting there recording. He has a vision. I do trust him.

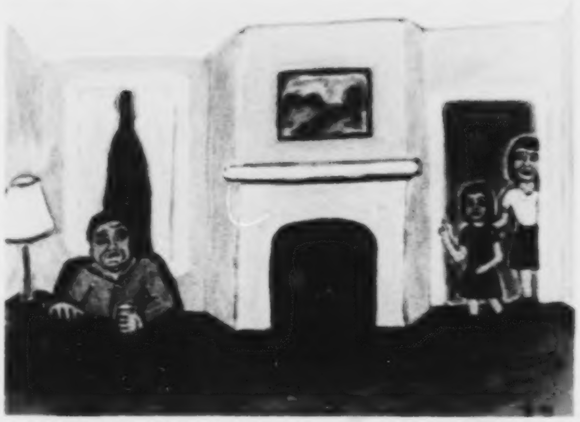


Figure 3A.

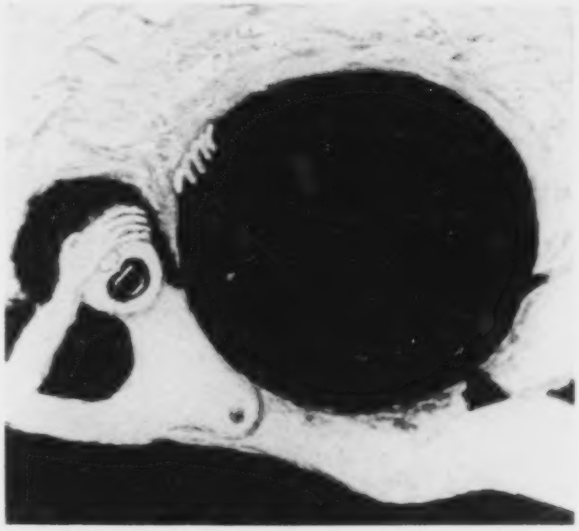


Figure 3B.

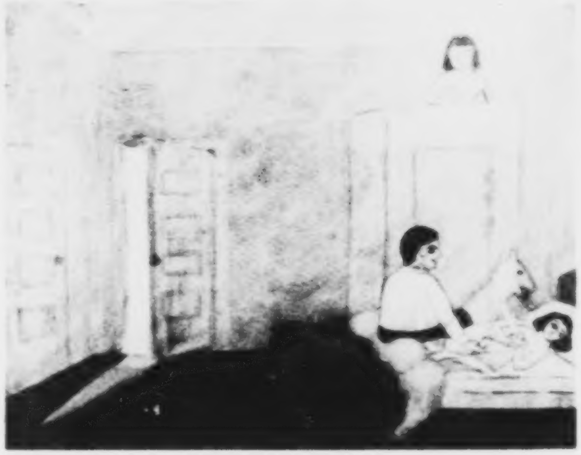


Figure 4A.

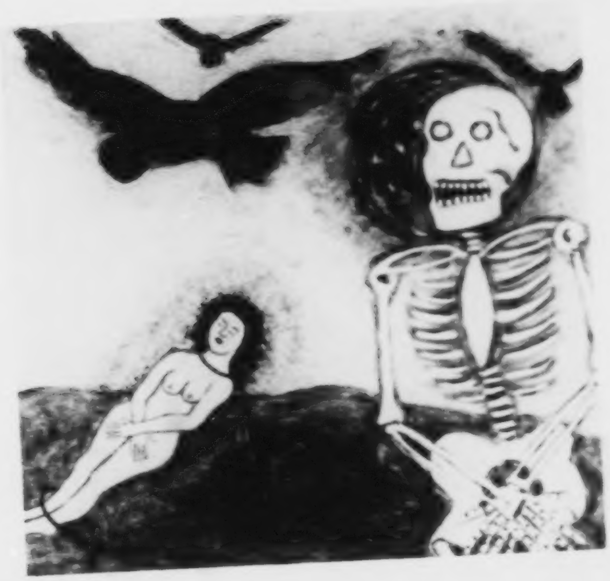


Figure 4B.

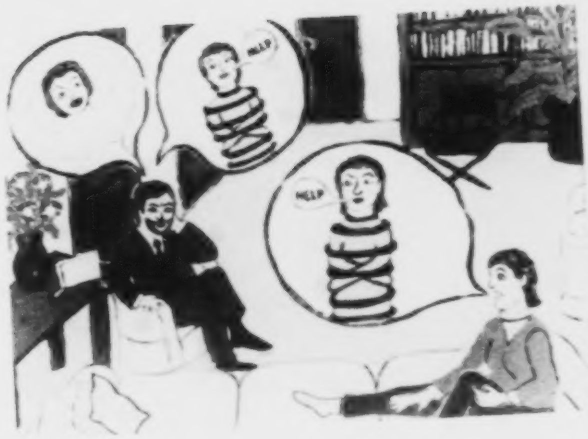


Figure 5A.

Figure 5B. "Metamorphosis" 42" × 36"

After seeing Dr. W's winged vision in "Learning to Fly," I realized that I am not tied up in that image. I am in a cocoon. My struggles will eventually lead to a "Metamorphosis."

The night after painting this I dreamed about using the past to build a future.

> A man was asking a fraternal organization to give him a book. It was the only one on their bookshelf. I was trying to convince them not to give away their heritage. I told the man he should borrow it, read it, and bring it back to be the first one in the library. I said he would be just the man to build the library.

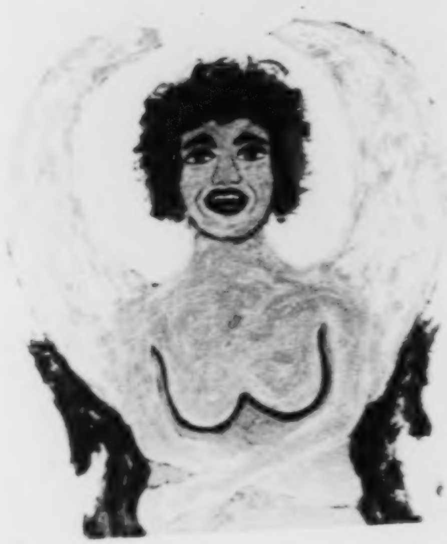


Figure 5B.

Biographical Note: Jane Orleman was born in Oneonta, New York, in 1942. In 1971, she married Dick Elliott, also an artist; they reside in Ellensburg, Washington. From their studio, *Dick and Jane's Spot*, Ms. Orleman has produced these paintings and many others. A recognized artist, she has received grants from Art Matters, Inc., New York (1989 and 1992), and the Artist Trust GAP, Seattle (1989). Her numerous one-woman exhibits in the Pacific Northwest include, most recently, "Telling Secrets" at the Whitman College Gallery in Walla Walla, Washington, and "An Artist's Journey: Looking In & Out," at the Northlight Gallery, Everett, Washington. During the past three years she has exhibited in Seattle and Ellensburg, and this year she was invited to exhibit at the Larson Museum in Yakima, Washington. Her work has been seen in juried exhibits in Los Angeles, Wisconsin, Oregon, Chicago, and New Mexico, and she has been the recipient of many awards. Her artwork has received very positive reviews in many Northwest newspapers. In addition to her exhibits, she is an articulate spokesperson. This year she was invited to lecture to offenders in Walla Walla, Washington and for the Women's Caucus for Art, National Conference in Seattle. She has presented to the American Association of Sex Educators and many other professionals who work with victims of incest and abuse. Her numerous publications, such as in *Treating Abuse Today*, focus on issues of sexual abuse.

Her exhibit, "Telling Secrets: An Artist's Journey Through Childhood Sexual Abuse," will be available through the National Exhibit Touring Services. Call 1-800-356-1256 for information.

Reviews

Shattered Images: Phenomenological Language of Sexual Trauma

Dee Spring, PhD, A.T.R., Chicago: Magnolia Street Publishers, 1993.

305 pp., 57 black & white illustrations, $36.00, paper. ISBN 0-9613309-2-9.

Reviewed by **Susan Cristantiello, MCAT, A.T.R.**, Mt. Vernon, NY

In language both metaphorical and didactic, Dee Spring makes vivid a difficult subject while providing information of indispensable value to clinicians working with victims of sexual abuse. Her work contains three main areas of expertise: first, the phenomenological rationale for the symbolic language of victims; second, the mechanisms of victimization (such as the crisis-violence cycle and mastery issues); and third, a generous section on treatment stages of restoration and special therapeutic methods and strategies. The only addition I would have liked would have been the inclusion of an index to help locate the multiple references to original terms and procedures.

Shattered Images is unique in that it focuses on the common aspects of sexual trauma. According to Spring, the effects of such trauma are the same whether it is perpetrated through incest, rape, or ritualized abuse. The effects are also lifelong—only the degree of trauma varies. It is this common experience shared by all victims, and the lack of permission to speak of it, which creates a common symbolic language—the phenomenological language of sexual trauma.

This is a crucially important synthesis since clinicians working with victims frequently find a combination of forms of abuse in a single case and must often address a combination of relationships between victims and abusers. This overlapping of forms of abuse leads Spring to define sexual trauma as a "category of experience" (p. 32). Each traumatic experience is reproduced in the "form of symbolic images which are coded messages" (p. 31).

As a result of her research, Spring concludes that the artwork of women who were sexually abused, regardless of form, showed a significant depiction of highly stylized eyes along with wedge-type configurations. These were among the most consistent coded messages found in victims' art. She contends that the eye symbols seem to be related to the victims' feelings of guilt, hypervigilance, and dissociation, while the wedge symbols seem to be related to fear and pain. She devotes a chapter to these phenomena and includes many helpful examples of artwork and an especially useful glossary of terms.

Too often sexual trauma remains unidentified, kept secret through the original fear of threat and society's attitude of blame and rejection. Victims internalize these messages and lose touch with their own histories of abuse. Consequently, victims seek treatment for a variety of spurious reasons, and receive a variety of misdiagnoses, while the real problem remains hidden, intact, and toxic. Spring's work provides an opportunity for any perceptive clinician to recognize the hidden message of trauma in victims' artwork and to appreciate the implications for specialized treatment.

A majority of the book is devoted to a thorough discussion of her treatment model. Her "orientation is gestalt, flavored with a transpersonal overview. The course of therapy is psychodynamic carried out in a cognitive manner through art, hypnosis, imagery, metaphor, and analogy. Techniques of reality therapy, bibliotherapy, and journalizing carry weight in this model" (p. 185). This intricate blend of the verbal with the nonverbal utilizes the creativity of both the therapist and the client and is worked on individually and in groups, including couples work and sex therapy where appropriate. Her complex, variegated approach takes place over a two-year period and addresses the whole person.

Interestingly, Spring's approach to writing and treatment is similar. The treatment plan, she warns, must be clear and systematic and shared with victims since they need to regain control and have cognitive awareness of what is to come. Intuitively, Spring seems to sense that the reader also requires glimpses of what is to come. When you are reading about the horrors of sexual trauma, it is reassuring to know that the author will shortly be discussing clinically tested methods of treating it. She takes us gently but firmly through layers of information, weaving a blend of theory, metaphor, poetry, technique, and visual and case material to create a work of great breadth, creativity, and relevance.

She also has ideas about the qualities and attitudes needed in therapists working with victims. Her insights are a valuable guide to those considering this type of work and an important review for those already engaged in it. She provides art therapies with an astoundingly organized and plentiful number of creative activities designed for individual, group, and couples work and closely relates them to specific treatment issues. The 65-page appendix contains assessment and worksheets, directions for use, and task checklists. Although the book contains basic information on art therapy and the benefits of creativity in healing, art therapists likely will not find this boring. It is precisely her blend of the old with the new that makes the material so digestible and which validates one's own professional struggles in this challenging work. Clinicians in other disciplines who work with victims will find familiar information too, but presented in a new way. They will have the opportunity to gain new insights and rethink the old, equipped with a visual language of sexual trauma and the most detailed, multifaceted translation of victims' experience to date.

Although at first glance it may seem traditional, Spring has a new way of looking at abuse issues. She uses the term "victim" rather than "survivor" throughout her book. She wants us to be aware that survival is only one stage to be passed through on the way to victory. While acknowledging the strength inherent in being a survivor, Spring encourages further development of one's full potential to become a victor. She presents a comprehensive view of restoration rarely seen in the literature, stressing the practical skills which must be learned to manage the trauma's life-long effects.

The promise of a chance for true victory over trauma is made much more powerful by the addition of her own story of abuse and restoration. She courageously practices the honesty and intimacy she "preaches" for victims. Her personal revelation colored my previous reading with more vivid hues and proved, as nothing else could, how the therapeutic successes found through restoration can truly turn a victim's life around.

Metaphors and analogies are used throughout the text to help readers first understand the symbolic language and later the effects of abuse and the process of restoration. But if you are someone who balks at detailed metaphorical usage as perhaps too elemental and removed from a traditional way of looking at psychodynamics, be patient. It becomes clear that this model is evidence of Spring's creative ingenuity—her ability to picture the psyche and the spirit and reflect it back to us, and her clients, in a new and unique visual form. One of the most useful concepts emerging from her metaphorical paradigm is her description of internal Victim Roles, which she elaborates with scripts, diagrams, and practical instructions for use in therapy.

Spring challenges our own creativity and flexibility, and one gets the impression that if we rise to the challenge we will arrive at a more efficient form of treatment and a heightened empathy for victims. This can at times be a difficult population to work with and at times *Shattered Images* is a difficult book to read because of the powerful feelings stirred within us. Yet Spring reignites our own enthusiasm for working with victims partly by providing us with workable metaphors and treatment tools and partly by the contagion of her own enthusiasm, generous self-revelations, and compassion for victims.

Casualties of Childhood: A Developmental Perspective on Sexual Abuse Using Projective Drawings

Bobbie Kaufman & Agnes Wohl, New York: Brunner/Mazel, 1992.

176 pp., 152 black & white illustrations, 6 tables; $29.95, cloth. ISBN 0-87630-652-0

Reviewed by **Barbara Faith Cooper**, MPS, A.T.R., New Salem, NY

Art therapists in a variety of clinical settings frequently encounter evidence of sexual abuse. At times clients are forthcoming with their histories; more often they are not.

Casualties of Childhood is a welcome addition to the increasing literature on this subject. It offers a developmental perspective of the projective drawings (House-Tree-Person, and Kinetic Family Drawing) of latency age children and of adults who were abused during latency. Latency is defined as

> . . . the period during which youngsters are normatively venturing out into the world, taking what they have learned about relating to others and generalizing this to the environment at large . . . for child-victims of incest this becomes an arduous task. (p. 100)

The purpose of this book is to discuss why "generalizing to the environment at large" becomes an arduous task and how this is seen in the artwork.

Using widely-known projective drawing research (e.g., Buck, DiLeo, Hammer, Jolles, Machover, and others), and their own clinical findings, Kaufman and Wohl discuss 96 drawings by children and 56 drawings by adults in terms of symbolic language of the sexually abused. The book is filled with valuable, well-documented inter- and intrapsychic effects of sexual abuse on the latency age child. In the Introduction trauma is defined based on analytic and self-psychology literature, with the focus on sexual abuse. Chapter 1, "Paradigms of Trauma and Sexual Abuse," differentiates between child sexual abuse and Post Traumatic Stress Disorder. A review of the literature on child sexual abuse and a description of symptom formation are clearly written. Chapter 2, "General Principles in the Analysis of Projective Drawings," is a comprehensive synopsis of the history, reliability, and validity of projective drawings. It includes the developmental aspects of drawings skills and general principles used in the analysis of drawings. Each projective test used is described in detail. This chapter also contains the authors' pilot study using projective drawings with 54 children. Chapter 3 discusses "The Projections of Ego Functions of Sexually Abused Children," focusing on alterations in ego functions, mastering of affects, sublimation of drives, utilization of play and fantasy, identification with the aggressor, altruistic surrender, inhibition of self-caring functions, cognitive dysfunctions, and case vignettes. Chapter 4, "Aberrations in the Superego of Sexually Molested Youngsters," discusses guilt, identification with delinquent values, absence of anticipatory guilt, faulty identifications, guilt displacement, rigid superego functioning, and case studies. In Chapter 5, we encounter "The Incestuous Family's Influence on the Development of Object Relations During Latency." We read about the child within the family system, specifically, the relationships to the abusive parent, the silent parent, development of object relations, the child's relationships outside the family, and case vignettes. Last, the artwork of adults is discussed in Chapter 6: "Adult Survivors: the Long-Term Effects of Childhood Sexual Abuse."

Case studies support the points discussed at the beginning of each chapter. Drawings and histories of the children and adults are clearly presented and cover a wide spectrum of types of abuse and drawing styles.

As an adjunct faculty member and clinician, I find this book a valuable and welcome addition to the field. It comprehensively, clearly, and concisely brings together the work of many distinguished authors/clinicians. I have recommended it to graduate students and colleagues.

Only two related concerns come to mind. It appears that the case examples and artworks were done by children and adults who disclosed sexual abuse before the projective tasks were undertaken, and therefore, many of the indicators in the artwork seem obvious. My clinical experience, however, is that often, particularly with latency age children, no disclosure is made, yet many of the indices of sexual abuse are present in the artwork. This places the art therapist in a highly sensitive position.

In a paragraph near the beginning of the book the authors warn clinicians of possible misuse of the symbols seen in the artwork:

> We must emphasize, however, that there is danger in using projective drawing without serious consideration of the artist's age, developmental stage, cognitive strengths, liabilities, and possible neurological impairments. Moreover, while we will shortly review the general areas used in understanding the assertion a drawing makes, we again caution the reader that a drawing or painting must always be assessed within the context of the client's history, behavior, and other evaluative data. (p. 17)

This reviewer feels that *more* emphasis should be placed on this point, especially for students/interns and non-art therapists. It is indeed within the treatment relationship with a client that assessments of this nature need to be made. The danger is that clinicians, particularly novices, could use this text as a "cookbook" for sexual abuse identification. This would be an unfortunate misuse of a very well-written book.

In recommending this book, I see its strength in the enlightenment of clinicians to symbols in the artwork and psychodynamics of sexually abused clients. Kaufman and Wohl have done this extremely well.

Video Review

The Box: A Guide to an Interactive Film Project for Use with the Arts Therapies

Written by **Karen Wakeley, MPS**. Designed by **Michael J. Kennedy** and **Karen Wakeley**. Produced by Manna Films, 1993.

½" VHS, 30 minutes, color. Purchase: $300, from Manna Films, 309 5th Avenue, Box 497, Brooklyn, NY 11215.

Reviewed by **James J. Consoli, MA, A.T.R., NCC**, with **Jane Bushman, MS, A.T.R.**, Virginia Beach, VA.

A former supervisor who had an extremely dry sense of humor once stated, "I'm going to teach you a new form of art therapy. The therapist does the drawing and the clients watch." The organizing concept behind this film is along similar lines; its primary goal is to elicit a reaction and stimulate discussion.

After seeing this avant-garde video, my reaction was exactly that. I attempted to make sense of what I had seen, and felt the urge to contact colleagues to ascertain their impressions from symbolic, clinical, and practical perspectives. Their reactions will be presented following a discussion of the content of the film and accompanying the 97-page user's manual.

It is ambiguous who this video serves and what qualifications are necessary for group facilitators. The manual suggests using it with populations such as college students training in helping professions, corporate sensitivity training programs, developmentally delayed adults, inner city teens, victims of abuse, homeless people, the withdrawn and depressed, substance abusers, the medically ailing, and artists. Some abstract reasoning ability is necessary, but the suggested age range begins at 5 years. The intent is that through reaction and discussion people will be helped ". . . to realize their potentials and to develop self-confidence . . . gain insight in the realm of communications, understanding, healing, and spiritual enrichment (pp. 3, 8).

The video is designed to be used in therapy. Unlike television, the film does not allow viewers to be passive. In the manual Michael Kennedy writes:

> People are certainly affected by this one-sided presentation. The biggest fault of television is that it presents an overload of information and image serving only to congest the mind. . . . Through this constant conditioning to absorb, few individuals get an opportunity to participate or react to what they see. (pp. 3,4)

The use of this narrative film without dialogue is an attempt to fill this gap.

The film opens with the central figure, a female character, inside a box, the central symbol. We see them throughout the four segments of the film: winter, spring, summer, and autumn. At the beginning of each segment, the box, usually containing the female character, is placed in four environments. Without the benefit of the usual introduction of characters and formation of plot and dialogue we watch the female character struggle with her ambivalence about leaving the box and exploring her environment. We are forced to develop our own impressions or project our own issues onto this individual and her situation. This metaphoric state provides a context for discussion and/or activities that follow the viewing. The viewer must attempt to integrate what is observed with his or her own current or past areas of difficulty.

Winter begins at evening in an alley. The girl inside the box finds herself among boxes and garbage. She explores a variety of objects around her and collects things she seems to like, bringing them into her box. The scene dissolves and we next see her walking through a spring forest. Her clothes are torn. She explores the environment, coming upon a rabbit and a small box. Placing some objects inside the box, she clutches it to her heart and leaves through a sunny opening in the trees.

On a sunny day in summer, she crosses a field and comes upon a fence and a child playing by a table spread with food. This is her only interaction with other individuals. She crawls through the fence and hungrily grabs some food, but is frightened away by an angry man. She encounters another group, where a smiling man begins to pay attention to her. But the angry man approaches and she runs back to her box. She appears to think about the events and returns to the smiling man who introduces her to the group, offering her food and drink. They embrace and go their separate ways.

In autumn, she is inside the box with the lid secure, totally withdrawn from the outside world. She rips a hole in the box, looks outside, and moves the box. It rolls downhill and the lid pops open. Beautiful leaves are outside and she brings them in only to discover they lose color inside the box. She becomes angry, appearing to throw a tantrum. Eventually she abandons the box, gathers leaves in her skirt, returns to the box, touches it, and then kicks it away. At the end she smiles, picks up leaves, and looks at them in the bright sunlight.

The user's manual is extremely comprehensive. It gives a synopsis of each season, provides lists of feeling words that may be evoked during group discussion, offers clues to the symbolism, provides topics to discuss, questions that can be asked by the group facilitator, projects to use with discussion, and includes a section for "advanced questions and projects."

The manual clearly states that how the film is used is determined by the group facilitator. It cautions against not doing your homework prior to presenting the video. It encourages the group facilitator to be an "enthusiastic" leader and strongly recommends the audience view one season at a time before proceeding with appropriate projects and discussion. The manual is an excellent resource for the novice group leader, containing many ideas for drawing, journal-making, poetry, psychodrama, and suggested group activities that may be directly or indirectly related to the film (e.g., the trust walk). A paper titled "The Box: An Interpretive Journey" describes in more clinical terms concepts that support the film as a therapeutic tool.

After viewing this film, I contacted colleagues and asked them to watch it and discuss their impressions. Because the user's manual refers to "archetypes" contained in the film, one of my contacts was Timothy Sanderson, MD, a Jungian analyst (personal communication, June 9, 1993). The film, he felt, was "too contrived"; he was caught with the feeling that he was "supposed to respond rather than just responding or reacting." The same kind of symbolic material can be used, he felt, in a less manipulative way, as in simply presenting a story. Using the story and its metaphoric material, one could explore issues and raise insight through discussion. He wondered, however, if his impressions were biased, given that most of the special populations who would be viewing this video may be less psychologically sophisticated. Perhaps they could reap the intended benefits of this modality.

Another colleague, Jane Bushman, MS, A.T.R., director of expressive therapies for an inpatient psychiatric unit, also viewed the film. She reported:

> *The Box* was presented to an inpatient psychiatric adult group on May 26, 1993. The group consisted of nine patients (two men, seven women), with various diagnoses, including depression (some with suicidal ideation), chemical dependency, bipolar, and schizophrenia. Ages ranged from 19 to 56 years. The idea of "the box" was perceived by the group as the primary theme, representing protection and entrapment. One client referred to the box as a "shell," a metaphor for "being trapped in his depression," and that "internal fears are a negative force that keep (him) boxed in." Another client suggested that audience members should hold a box while watching the film in order to enhance the experience.

The seasons were perceived generally to represent their own cycles of change and growth. Winter imagery evoked a sense that even in times of despair ("bleakness"), one could create—that there was hope. Spring generated the feeling that one could find beauty in simple things, that life needed to be basic for them. The summer imagery evoked little discussion to the actual seasonal symbology. It did, however, engender a significant reaction to the two male characters, i.e., "good father/bad father." The group members generally perceived the autumnal sequence as a metaphor for being able to break out of their shells and learn (gather) new ways of dealing with issues.

One group member saw the rips in the actress' shirt as representing "past wounds." The inconsistency between the actress' ragged appearance and her relatively well-groomed hands, adorned with watch and ring, seemed to be a source of disbelief or distraction for several patients. They appreciated the lack of verbal interactions in the film, sharing that the nonverbal expression allowed them to interject their own issues and also forced them to make connections in their own lives.

The technical quality of the film created negative impressions. Sound effects were exaggerated and distracting and at times comical. The acting seemed amateurish and awkward and failed to transport the audience beyond the limits of the medium itself.

> Overall, the patients viewed the film as a positive medium in their treatment. They perceived it as being vague enough, symbolic enough, that it afforded them the opportunity to interject their own specific issues and to identify with someone else (the actress). One woman shared that the film "reinforced the importance of imagery in the process of healing."

Conclusions

In general I found the quality of the film production to be very good and the packaging very professional. Although the user's manual is impressively comprehensive, I had some concerns. Glaringly missing is how a group facilitator can frame an introduction to this film. How the film is presented can have a lasting impact on how it is perceived. A common reaction was, "I don't get it . . . I feel stupid," and "If there's something that I'm supposed to get, I don't get it." The abstract quality can be confusing and intimidating, just as art materials can have a negative and intimidating impact on adults who have not drawn since their elementary school years. This film could benefit from an introduction that provides a disclaimer, such as "everyone has different reactions to this film and there are no right or wrong impressions. As you view it, pick one or two impressions that make sense to you and we'll discuss them following the film." This may relieve viewers' anxieties and encourage them to consider a specific impression rather than attempt to understand the entire segment or series. Each segment is rich with symbolism and behaviors that do, in fact, provide that metaphorical slate necessary for projection.

I commend the writer and producers in their endeavor. The project is creative and original and challenges the one-sided passivity of television watching. Like drugs, one can take in television, sit passively, and allow it to alter thoughts and feelings. The film purposely frustrates viewers; they cannot remain passive. The lack of dialogue and plot forces their active involvement in making sense of each scene. I am certain I could conduct an insightful discussion with a group of adults after showing them Dr. Seuss' *Horton Hears A Who* (1970). But in contrast to *The Box*, does the completeness of *Horton* . . . put the viewer too much at ease? Does the incompleteness and abstract quality of *The Box* succeed in encouraging viewers to become active, to get up from their recliners (or boxes), and find sense in this film? Rather than stating my opinion, I purposely leave my conclusions ambiguous so you may more easily "project" your own.

References

Jones, C. (Director & Producer), & Geisel, T. (Dr. Seuss) (Writer & Producer). (1970). *Horton hears a who.* [Film]. New York: MGM/UA.

Video Review

Archetypal Images and Art

Written by **Dean L. Frantz, BA, MDiv,** Produced by The Division of Psychology and Special Education, The Teachers College, Emporia State University, KS, 1988.

VHS ½", 40 minutes: 33 seconds, color. Purchase: $43, from ART, P.O. Box 15712, Ft. Wayne, IN 46885-5712.

Reviewed by **Matthew Bernier, MCAT, A.T.R.,** Norfolk, VA

Jungian analyst Dean Frantz delivers scholarly lectures on the relationship between archetypal images and art. He discusses these within the context of Carl Jung's concept of archetypes, the unconscious, and Peter Birkhauser, a Swiss modern artist "whose paintings are a prime example of the way in which art can reflect the archetypal background of the psyche." Observers report that Birkhauser's paintings have a healing power, a "medicine for the soul."

Frantz reviews Jungian concepts such as archetypes of transformation, transcendence, numinous experiences, and the individuation process. Archetypes are archaic remnants or primordial images. They are "mental forms whose presence cannot be explained by anything in the individual's own life and which seem to be aboriginal, innate, and inherited shapes of the human mind" (Jung, 1964, p. 67). Frantz states, "Anything rooted in the archetypes may have healing power." He explains transformation as a "growing awareness of inner archetypal background" which "brings a growing enrichment and completion of the personality." He defines numinous experiences as "events or experiences which can be felt but not described in words." Jung believed that real therapy involved approaching and exploring the numinous as in dreams and art, and noted that art frequently anticipates psychological changes before they come to the surface of collective consciousness.

Frantz explains there are two kinds of art. The first serves to entertain, please, or portray realism. The second "springs from within the unconscious" of the creator who is the "translator of eternal" and an "instrument of realizing purpose." The artist creates not only about himself but expresses collective statements or messages on behalf of everyone. As a result the artist is often misunderstood, thought of as mad, and ridiculed. Frantz states, "If the artist is able to endure the suffering which is his inevitable lot, he too may be a means of bringing healing and renewal to his society." He explains that archetypal art leads us to transcendence by "opening gates to a world not limited by time and space," putting "us in touch with our own depths," providing "new depths of meaning," and enriching "our experience of being alive."

The archetypal nature of Birkhauser's paintings allows them to serve not only as an expression of our collective inner stories as they "translate unconscious images in the language of the present." They "portray dimensions of life beyond the here and now" and they are "in touch with the infinite." Frantz explains that some observers of archetypal paintings cannot tolerate seeing them, while "others are fixed on them," "caught in an archetypal theme." Observers of Birkhauser's paintings have said.

> It's "as if I had been here before . . . as if I had always known these paintings."
> "There is a mutual message here. I want to run away but I cannot. I am compelled to confront what these paintings are saying to me."
> "These paintings gave me a new insight into life."

According to Frantz, "The artist's job is to create art" but he or she is "not expected to interpret it." The "interpretation is left to us who observe it. We must let a work of art work on us to shape us." The art "reminds us of parts of our lives neglected or forgotten." Art is a "path toward wholeness."

The text is scholarly and interesting while the images are compelling. Unfortunately, the style of the video is boring and distracting. Frantz stands at a podium and lectures before a single camera. Throughout the video the picture switches to static images of Birkhauser's paintings, which are intriguing and require attention and contemplation, but are often unrelated to the text. Frantz speaks slowly and clearly, but the language of the text is lofty and poetic, forcing us to listen carefully. This makes it difficult to attend to both the text and the images. Nevertheless, the content of this video, which should be made available in written form, is important and worthwhile.

Reference

Jung, C. G. (Ed.). (1964). *Man and his symbols.* New York: Doubleday.

Video Review

The Life and Art of Peter Birkhauser

Written by **Dean L. Frantz, BA, MDiv,** Produced by The Division of Psychology and Special Education, The Teachers College, Emporia State University, KS, 1988.

VHS, 30 minutes: 54 seconds, color. Purchase: $43, from ART, P.O. Box 15712, Ft. Wayne, IN 46885-5712.

Reviewed by **Matthew Bernier, MCAT, A.T.R.,** Norfolk, VA

This video is a sequel to *Archetypal Images and Art* (Frantz, 1988). While it follows the same lecture format of *Archetypal Images . . .*, this video is a little more engaging since the focus is on Birkhauser and his paintings. The images, including art and photographs, are related to the text.

Peter Birkhauser, a Swiss modern artist, attracted the attention and appreciation of Carl Jung because his artwork provided outer representations of inner archetypal images of the psyche. Birkhauser's early art training focused on details of the outer world. Around the age of 30 he was plagued by depression, lost enthusiasm for painting the outer world, and began to record his dreams. He entered Jungian analysis which eventually brought him in contact with Carl Jung.

Birkhauser realized that he needed to listen to his unconscious and inner messages. He changed his orientation in art in order to fulfill his task of making the contents of his unconscious visible. He allowed his artwork to be led by his unconscious, especially through dream imagery as he began to paint only images of his inner world, his dreams, fantasies, and visions.

Typical of archetypal artists, Birkhauser's art was not accepted by critics. Today, as Frantz discusses, his images are seen as having healing powers because they express archetypal forces related to our collective consciousness. Birkhauser was called from within to express universal themes such as spiritual and creative forces, renewal, wisdom, and transformation which are connected to the individuation journey.

While we view the more than 70 slides of Birkhauser's paintings, Frantz delivers comments by the artist and Jung as well as his own interpretations of the artwork. The content and images are fascinating. However, they are weakened by the less interesting presentation format, a single camera angle of Frantz lecturing at a podium, interspersed with static slides of artwork.

For a more in-depth review of Birkhauser's artwork with interpretive commetaries by Marie-Louise von Franz, and an essay on "Analytical Psychology and the Problems of Art" by Peter Birkhauser, I recommend reading *Light from the Darkness: The Paintings of Peter Birkhauser*.

References

Birkhauser Verlag (1980). *Light from the darkness: The paintings of Peter Birkhauser*. Basel, Switzerland: Birkhauser Verlag.

Emporia State University (Producer), & Frantz, D. L. (Author). (1988). *Archetypal images and art* [Videotape]. Ft. Wayne, IN: ART.

Book Review Response

Ellen G. Horovitz-Darby, MA, A.T.R., responds to the Book Review by Matthew Bernier, MCAT., A.T.R., and Trudy Manning, MS, A.T.R. of *Essentials of Art Therapy Training and Practice* by Bruce Moon, MACE, MDiv, A.T.R., *Art Therapy: Journal of the American Art Therapy Association,* Volume 10, Number 2.

In Bernier and Manning's review of Bruce Moon's latest opus, they rightly acknowledge Moon's gift for writing. Indeed, the hallmark of this book is the manner in which Moon's ideas are presented. Examining the contents of this text is comparable to reading poetry and literature. Moon's work must be savored, occasionally put aside, and pondered. His profundities weave a tapestry of soul-filled anecdotes and life experiences. We have much to learn from the way Moon embraces life, learning, and teaching. The reader needs to tread carefully lest his or her thinking be challenged, provoked, and perhaps transformed. Moon's ability to stir up the homeostatic cobwebs of the mind is uplifting, refreshing, and far reaching.

Yet there are some who may take umbrage with this and do not embrace the theosophy that Moon proposes. Moon is quite opinionated and strongly disputes the notion of training students "to be as-if psychologists or pseudopsychiatrists" (p. 56). His desire to delineate the profession of art therapy as one chiseled and forged with art materials is aligned with the teachings of our greatest and most diverse pioneers such as Edith Kramer, Shaun McNiff, Harriet Wadeson, and Rawley Silver. Instead of hammering and pigeon-holing Moon's approach as suggested by Bernier and Manning, it would be a welcome change if educators could embrace Moon's passion for espousing the importance of hanging on to our heritage and, most importantly, our art.

Moon's vision is not a rejection of verbiage. He suggests a "metaverbal framework," a therapy that goes "beyond words" (p. 111). He implores the art therapy educator to counsel the myriad questions and struggles about art raised by incipient art therapists. This approach is akin to that of my greatest teacher and mentor, Edith Kramer. Always she returned me to my art. And, through this tutelage I had my greatest breakthroughs as I struggled through the maze of graduate training.

Alas, Moon's pitch for accepting our art is not the whining of an "angry school boy," as suggested by Bernier and Manning, but our ancestral lot and birthright. His viewpoint does not contradict or attack AATA's principles or guidelines. It underscores the importance of maintaining and upholding our identity and profession. His plea for approaching clinical training from a "perspective of soul" (p. 66), indeed makes this work of ours both sacred and passionate. For the sake of our future and our profession, I hope we can take heed and, as Moon so ardently demands, listen to our senses.

Video Review Response

Simone Alter Muri, EdD, A.T.R., responds to Carmello Tabone's review of *Creative Arts Therapies at the PACE School, Art Therapy: Journal of the American Art Therapy Association,* Volume 10, Number 4.

This video was originally intended to educate mental health and special education professionals about the value of art therapy with autistic and developmentally delayed populations. What also emerged after several screenings was its applicability to beginning art therapists interested in working with these clients.

I agree with Mr. Tabone that a verbal introduction to the population could be beneficial, and hope to develop a written introduction that can be included with the video. I am distressed with Tabone's comment: "Viewers who were unfamiliar with autistic and mentally retarded clients then would not wonder why apparently typical looking young adults were scribbling and communicating with difficulty." I cannot believe that any serious student of art therapy would not immediately sense from viewing the video participants that this was a special needs population.

The video was not created to be a promotion for the PACE program (which folded in 1986), but as a promotion of the value of art therapy within this setting. The goal was to encourage administrators to hire more art therapists for their programs.

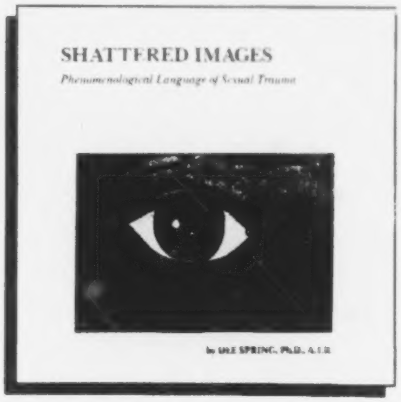
MAGNOLIA STREET PUBLISHERS

CALIFORNIA ART THERAPY
TRENDS
Edited by
Evelyn Virshup, Ph.D., ATR

A thought and creativity provoking collection of essays and exercises by more than thirty California art therapists. pa. 29.95

Art as therapy with children
by Edith Kramer

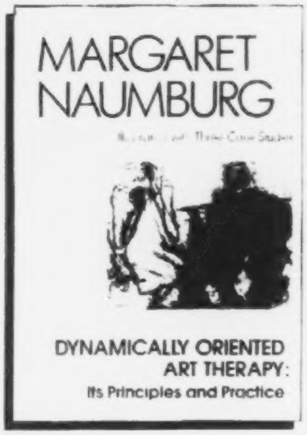
One of the most widely read textbooks by a pioneer in the field. Now updated and back in print. pa. 19.95


SHATTERED IMAGES
Phenomenological Language of Sexual Trauma
by DEE SPRING, Ph.D., A.T.R.

This book presents a unique treatment model incorporating art therapy, imagery and hypnosis. pa. 36.00

JANIE RHYNE
THE GESTALT ART EXPERIENCE

This popular author presents simple directions for art activities designed for individuals and groups. Widely used as a textbook. pa. 21.95


MARGARET NAUMBURG
DYNAMICALLY ORIENTED ART THERAPY:
Its Principles and Practice

Naumburg's classic pioneering work, presenting three illustrated case studies of women dealing with alcoholism and depression. hd. 32.95

MAGNOLIA STREET PUBLISHERS • 1250 W. Victoria • Chicago IL 60660 USA

Individual orders to:

STERN'S BOOKS
2004 W. Roscoe St.
Chicago, IL 60618
312-883-5100
Fax 312-477-6096

All major credit cards and checks accepted.
Add $4.00 shipping & handling for first book,
.50 @ additional book.

AMERICAN ART THERAPY ASSOCIATION, INC.

24th Annual Conference

COMMON GROUND:
THE ARTS, THERAPY, SPIRITUALITY

November 18-22, 1993 • Atlanta, Georgia

AUDIO CASSETTES AVAILABLE

☐ 1. WELCOME / Mystery, The Guiding Image, Cathy Moon, MA, A.T.R.
☐ 2. The Scarlet Letter: Dual Relationships in the Supervisory Setting, J. Carrigan, OSF, PhD, A.T.R.
☐ 3. Nest Building: Children Recovering Themselves Through Art, D. DeBrular, BFA, A.T.R.
☐ 4. The AIDS Memorial Quilt - Art Therapy and Spirituality on Common Ground, J. Weiser, MScED, A.T.R.
☐ 5. The Arts/Therapy/Spirituality: Evolution, Impact, Responsibility and Opportunity, E. McNeil, PhD, A.T.R.
☐ 6. Art for Empathy in Adult Sex Offender Treatment, R. Overdorff, MA, LPC, A.T.R.
☐ 7. Trauma Rages Without Boundaries: The Cross-Cultural Effects of War, R. Marano-Geiser, MA, A.T.R.; M. Issing, MA, A.T.R.
☐ 8. "Homecoming" or "I'll Draw Until I Have a Voice", U. Goebels, MA, A.T.R.
☐ 9. Childhood Schizophrenia: Still Present But Not Accounted For, D. Henley, MA, A.T.R.
☐ 10. Right From the Horse's Mouth: Interaction with Imagery in Art Therapy, R. Schoenholtz, MS, A.T.R.
☐ 11. Presenting a Case for Art Therapy Supervision, B. Stoll, MA, MFCC, A.T.R.
☐ 12. An Archetypal Approach to Art Therapy, H. McConeghey, EdD, A.T.R.
☐ 13. A Contemplative Approach to Art Therapy: The Art of Healing and Authenticity, B. Marek, MFA
☐ 14. Art & MPD: Uncommon Realities, B. Cohen, MA, A.T.R.
☐ 15. "The Rebels": Development of an Art Group with Resistant Sex Offenders, J. Ackerman, MA; M. Rosal, PhD, A.T.R.
☐ 16. The Volcano Drawing: A Technique for Assessing Levels of Affective Tension, C. Cox, MA, A.T.R.
☐ 17. Group Art Therapy with Attention Deficit Hyperactivity Disorder Children, K. Jackson, MA, ATR; S. Carney, MA, A.T.R.
☐ 18. Art Therapy, Feminism and Archetypal Psychology: Something's Rumbling in the Swamp, J. Abbenante, MA, A.T.R.
☐ 19. Creativity: The Heart of an Ageless Spirit, J. Niemet, MA, A.T.R.
☐ 20. Homosexuality 101: What Every Art Therapist Needs to Know, D. Addison, MS; J. Weiser, MsEd, RCAT, A.T.R.; M. Hammond, A.T.R., M. Barbee, MA; S. Thiruvengadam, MAAT
☐ 21. Certification is Coming (But I Hate Taking Tests), L. Buchanan, BSN, MA, A.T.R., A. Parker; M. Gray; N. Hall
☐ 22. Are There Doctors in the House? Does Art Therapy Need a Cure? R. Goodman, PhD, A.T.R.; G. Agell, PhD, A.T.R., HLM; L. Gantt, PhD, A.T.R.; K. Williams, PhD, A.T.R.
☐ 23. Images As Angels, S. McNiff, PhD, A.T.R.
☐ 24. Soul and Spirit: The Image Instructs, P. Allen, PhD, A.T.R.
☐ 26. Art Therapy Research: New Models, New Understandings, D. Linesch, PhD, A.T.R.
☐ 27. An Art Therapy Group for Children of Divorce, B. McIntyre, PhD, LPC, A.T.R., J. Adams, RN
☐ 28. Video Art Therapy and Chronic Illness: Towards Evoking and Preserving Imagination, K. Bush, MFA; D. Rode, MPS, CCLS, A.T.R.
☐ 29. Hard Time Art: Growing Old in Prison, M. Taylor, PhD, A.T.R.; J. Castle, MA
☐ 30. The Use of the Mandala with Older People, J. Couch, MA
☐ 32. Art: Body and Soul, B. Moon, MA, MDiv, A.T.R.
☐ 33. Art Therapy Treatment of Sexual Abuse Both Explicit and Implicit, J. Duboff, MA, A.T.R.
☐ 34. Heuristic Inquiry, A Passionate Personal Research Method Honoring to Art and Spirituality, N. Chickerneo, PhD, CADC, A.T.R.
☐ 35. The Children's Diagnostic Drawing Series, E. Neale, MA
☐ 36. Exploring Enlightenment of the Body Through the Use of Plaster Casting Material, S. Robertson, BS, OTR/L, MPS, A.T.R.
☐ 37. Art Therapy with Pediatric Cancer Patients: Helping Children Cope, T. Councill, BFA, MA
☐ 38. Art Therapy in Jail: Doing Time, Sublimation and Resistance, L. Eisenhauer, MA, MA
☐ 39. Group Art Therapy with Older Adults, J. Smethurst, MA
☐ 40. Betrayal: The Loss of the Guiding Image, L. Kapitan, MPS, A.T.R.; L. Vance, MS, A.T.R.
☐ 41. The MARI Card Test: Reflections on the Past, Considerations for the Future, J. Kellogg, MA, A.T.R.; C. Cox, MA, A.T.R.; K. Feigenbaum, PhD
☐ 42. Exploring the Common Ground: Contributions from Related Fields, L. Gantt, PhD, A.T.R.; L. Tinnin, MD;
☐ 43. A Continuing Dialogue on Non-Art Therapists Doing Art Therapy, A. Mills, MA, A.T.R.; N. Humber, MA, A.T.R.; J. Rhyne, PhD, A.T.R.; W. Vernon, MA, A.T.R.
☐ 46. Why Hast Thou Forsaken Me? Spiritual Abandonment Experienced by Victims of War, M. Ising, MA, A.T.R.; M. Rosal, PhD, A.T.R.
☐ 47. Conflicts and Triumphs of Co-Leadership of Expressive Therapy Groups for Abused Children, L. Lowinger, MA, A.T.R.
☐ 48. Parting the Veil Between Personal and Professional Identity: Integrating Spirit Into Work, S. Lovell, PhD, A.T.R.
☐ 49. St. Francis of Assisi: A Twelfth Century Expressive Therapist, J. Carrigan, OSF, PhD, A.T.R.

- ☐ 50. Languaging: Examining the Verbal Component of Art Therapy Treatment, S. Riley, MA, MFCT, A.T.R.
- ☐ 51. Group Art Therapy: Towards An Articulation of Theoretical Principles,
  L. Thompson, MPS, ADTR, A.T.R.
- ☐ 52. A Three Step Family Systems Approach for Assessment, Confrontation and Treatment Planning,
  J. Consoli, MA, A.T.R.
- ☐ 53. Transpersonal Aspects of Art Expression in Processing Grief and Loss, C. Malchiodi, MA, A.T.R.
- ☐ 55. New Images for an Ancient Paradigm of Spirituality,
  N. Chickerneo, PhD, CADC, A.T.R.
- ☐ 56. Drawings as Acceptable Evidence of Sexual Abuse: A Court of Appeals Ruling, S. Graves, PhD, CPGC, A.T.R.
- ☐ 57. Art, Therapy & The Creative Spirit: Developing Inclusive Treatment Programs for Children,
  B. Troeger, PhD, A.T.R.
- ☐ 58. The Creativity Continuum: Common Ground for Arts, Therapy, and Spirituality, E. McNeil, PhD, A.T.R.
- ☐ 59. Objectification of Self: A Study of Self-Image with Attention Deficit Hyperactivity Disorder (ADHD) Children,
  K. Jackson, MA, A.T.R.
- ☐ 61. Non-Dominant Hand Writing as a Technique in Art Therapy: Creating Experience, J. Ritchie, RN, BUS
- ☐ 62. Self-Esteem Enhancement Through Art Therapy,
  J. Fryrear, PhD, A.T.R.; C. Gill, MS
- ☐ 63. The Typology and Symbolism of Windows in Visual Expression, V. Lusebrink, PhD, A.T.R.;
  L. Turner-Schikler, MA, A.T.R.; J. Ackerman, MA
- ☐ 64. Art Therapy with Incest Survivors: Emotional, Cognitive, Spiritual and Research Aspects of Treatment,
  F. Anderson, EdD, A.T.R., HLM
- ☐ 65. Images of Surviving: Art Ritual as Intervention with Sexually Abused Adolescent Females,
  L. Reynolds, MA, LMFT, A.T.R.
- ☐ 66. National Practice Study of Art Therapists,
  N. Hall, MA, A.T.R.; J. Knapp, PhD
- ☐ 67. The Art Therapist as Expert Witness in Child Sexual Abuse Litigations, M. Liebman, MA, MCAT
- ☐ 68. The Healing Power of Art: The Transporter Series,
  J. Torrenzano, A.T.R.
- ☐ 69. Art of the Soul: An Artist/Therapist Reflection on St. Hildegard's Imagery, S. Burke, PhD, LPC, A.T.R.
- ☐ 70. Wild Nature: The Gift of the Image, G. Mongiello, BFA
- ☐ 71. The Spiritual Life of Children: Robert Coles and Beyond, M. Farrelly, MA, MAT, A.T.R.
- ☐ 72. Identification with the Agressor as Seen in Children's Drawings, T. Groves
- ☐ 73. From Sensation to Form to Self: The Process Observed, M. Fleming, MFCC, A.T.R.
- ☐ 74. Psychology, Art History, Art & Education, Anthropology Contributors: New Perspectives for Art Therapy,
  J. Rhyne, PhD, A.T.R.
- ☐ 75. Assessing Attachment Patterns with the Bird's Nest Drawing in Family Art Evaluation, D. Kaiser, MS
- ☐ 76. Hypomania vs Hyperactivity: Using Art as an Instrument for Differential Diagnosis, D. Cogan, MA, A.T.R.;
  M. Eife, MA, A.T.R.
- ☐ 77. Healing Though Art - The Native Indian Way,
  N. Ferrara, MA, A.T.R.
- ☐ 78. Shadow and Spirituality: Images of Trauma Survivors in Art Therapy and Sandplay, T. Sweig, MA, A.T.R.
- ☐ 79. The Art of Anger: Imagery, Anger Management, and Conflict Resolution, F. Kaplan, DA, A.T.R.
  A. Calisch, PsyD, A.T.R.; L. Peterson, MA, A.T.R.
- ☐ 81. Death and Wilderness in the Creative Process: The Importance of Remembering, J. Abbenante, MA, A.T.R.;
  D. Vetterman, MA, A.T.R.; G. Mongiello, MFA
- ☐ 82. Documentation in Art Therapy, M. Haeseler, MA, A.T.R.;
  L. Gerity, MA, A.T.R.; C. Greenlaw, MA, A.T.R.;
  E. Kramer, A.T.R., HLM
- ☐ 83. Psyche and Soma: Considerations For The Pediatric Art Therapist, A. Prager, RN, MA
- ☐ 85. Finding The Sacred In Sand Tray Therapy,
  P. Frame, MA, A.T.R.
- ☐ 86. Psychology of the Artist: Piet Mondrian and Primal Scene Traumatization, A. Buk, MFA, MA, A.T.R.

PRICE PER TAPE - $12.00

143-93 A

Mail Order Form

NO. OF TAPES ____________ X $12.00 PER TAPE $ ______________

SHIPPING ($1.75 per tape to $12.00 max.) $ ______________

DENVER RESIDENTS ADD 7.3% SALES TAX $ ______________

CO RESIDENTS ADD 3.8% SALES TAX $ ______________
IF TAX EXEMPT, INCLUDE COPY OF TAX CERTIFICATE

FOREIGN SHIPPING ($3.00 per tape to $30.00 max.) $ ______________

NEW YORK RESIDENTS ADD LOCAL SALES TAX $ ______________
ON TOTAL ORDER. IF EXEMPT, INCLUDE CERTIFICATE

TOTAL OF ORDER $ ______________

SHIP TO (Please print clearly) ☐ RESIDENTIAL ☐ BUSINESS

NAME ______________________________

INSTITUTION ______________________________

ADDRESS ______________________________

____

CITY ____________ STATE ____________ ZIP ____________

DAYTIME PHONE ______________________________

METHOD OF PAYMENT (Do Not Send Currency)
(Foreign customers must pay by credit card or pre-paid Purchase Order)

________ Enclosed is my check (Drawn on US Bank in US Funds)

Charge to my ________ AMEX ________ MASTERCARD ________ VISA

CARD # ______________________________

EXP. DATE ______________________________

SIGNATURE ON CARD ______________________________

MAKE CHECKS PAYABLE AND MAIL YOUR ORDER TO:

NATIONAL AUDIO VIDEO, INC.
4465 WASHINGTON STREET
DENVER, CO 80216
Phone: (303) 292-2952

QUALITY GUARANTEED - NO REFUNDS - ALLOW 2-4 WEEKS FOR DELIVERY

CALL TOLL FREE: 1-800-373-2952 (9-5 MST) • OR FAX YOUR ORDER 303-292-5629

American Art Therapy Association, Inc.

RESOURCES

◆CONFERENCE PROCEEDINGS

	Members	Non-Members
Creativity and the Art Therapists Identity (1976) (ISBN 1-882147-04-9)	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) (ISBN 1-882147-05-7)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) (ISBN 1-882147-10-3)	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) (ISBN 1-882147-12-X)	$ 7.00	$ 9.00
Art Therapy: A Bridge Between Worlds (1981) (ISBN 1-882147-11-1)	$ 7.00	$ 10.00
Art Therapy: Still Growing (1982) (ISBN 1-882147-06-5)	$ 10.00	$ 14.00
Art Therapy: New Directions in the 80's (1987) (ISBN 1-882147-13-8)	$ 15.00	$ 20.00
Professionalism in Practice (1988) (ISBN 1-882147-08-1)	$ 15.00	$ 20.00
Painting Portraits: Families/Groups/Systems (1989) (ISBN 1-882147-07-3)	$ 15.00	$ 20.00
Image and Metaphor (1991) (ISBN 1-882147-09-X)	$ 15.00	$ 20.00
The Art Therapist: Artist, Teacher, Clinician, Healer (1992) (ISBN 1-882147-14-6)	$ 15.00	$ 20.00
Common Ground: The Arts, Therapy, and Spirituality (ISBN 1-882147-21-9)	$ 15.00	$ 25.00

NOTE: **Ten or more copies of any single Proceeding: 10% discount on total cost. Set of four Proceedings (consecutive years): 20% discount on total price.** POSTAGE AND HANDLING FOR PROCEEDINGS: $3.00 **first item; $.75 each additional Proceeding.**

◆OTHER PUBLICATIONS

	Members	Non-Members
A Guide to Conducting Art Therapy Research (ISBN 1-882147-08-0)❶	$ 24.00	$ 35.00
National Registry of Masters Theses and Practicum Papers ❷	$ 15.00	$ 25.00
AATA Chapter Manual	$ 10.00	N/A

NOTE: ❶ Postage included on all orders for this publication. Ten or more copies - 10% discount.
❷ Chapter Manual: Add $2.90 for postage/handling.

◆TRAINING LITERATURE

	Members	Non-Members
Educational Guidelines	$ .30	$ 1.00
Education List (colleges & universities offering art therapy programs)	$ .30	$ 1.00
Standards and Procedures for Registration	$ .30	$ 1.00
Criterion for Professional Membership	$ .30	$ 1.00

NOTE: **General Information Packet - $4.00 - consists of first three items above.** These pamphlets are available to **members only in multiples: 1-9 copies - $2.00 plus SASE;** 10-50 copies - $5.00 plus SASE.

◆APPLICATIONS

	Members	Non-Members
A.T.R. (Registration) Application	N/C	$ 1.00
Professional Membership Application	N/C	$ 1.00
General Membership Application	N/C	N/C

◆ MEMBER INFORMATION

	Members	Non-Members
Member Specialty List	$ 1.90	$ 2.90
Membership Survey	$ .75	$ 2.75
Membership Directory	$ 13.00	$ 55.00

NOTE: **Postage and handling for** AATA Membership Directory: U.S. - $2.90; Canada Mexico - $3.25;
Foreign - $10.00

BEST COPY AVAILABLE

◆OTHER LITERATURE

	Members	Non-Members
Art Therapy Model Job Description	$ .30	$ 1.00
Art Therapy Media List	$ .30	$ 1.00
Bibliography: Books Authored by Members of AATA	$ .30	$ 1.00
Standards of Practice Document	$ .30	$ 1.00
Ethics Document	$ .30	$ 1.00

NOTE: **Above items are available to members only in multiples**: 1-9 copies - $2.00 with SASE; 10-50 copies -

◆SUBSCRIPTIONS

Art Therapy: Journal of the American Art Therapy Association	Individuals:	U.S. - $40	Foreign - $64
	Institutions:	U.S. - $57	Foreign - $80
	Back Issues:	Members - $10	Non-Members - $18
AATA Newsletter	Non-Members:	U.S. - $16	Foreign - $28

◆FILMS

	Type	Members	Non-Members
Art Therapy: Beginnings 1977 (color/sound/45 minutes)	16mm - RENTAL ONLY	$ 40.00	$ 50.00
	One-half inch VHS - PURCHASE ONLY	$ 50.00	$ 80.00
Michael 1977 (color/sound/12 minutes)	16mm - RENTAL ONLY	$ 30.00	$ 35.00
	One-half inch VHS - PURCHASE ONLY	$ 50.00	$ 80.00
Art Therapy	16mm - RENTAL ONLY	$ 35.00	$ 45.00
	One-half inch VHS - PURCHASE ONLY	$ 50.00	$ 80.00

NOTE: **Postage and handling for films**: $3.00 each VHS; $7.00 each 16mm

ORDERING INFORMATION:

1. **WE DO NOT ACCEPT** credit card or purchase orders. All orders must be accompanied by payment in cash, check, or money order in U.S. funds.
2. **FOREIGN ORDERS:** Shipping will be made per your instructions (surface or air). Please specify method of shipment with your order. Additional postage, above amount remitted, will be billed to you if necessary.
3. **RETURNS ARE NOT ACCEPTED** for refund on shipped items.

Mail completed order form and payment to:

AMERICAN ART THERAPY ASSOCIATION
1202 Allanson Road
Mundelein, IL 60060

TITLE	Quantity	Price	Total

SHIPPING INFORMATION

Name____________________________ Member ID#__________

Street____

City/State/Zip__________________________________

Total ____________

Postage ____________

Applicable Discount ____________

TOTAL ENCLOSED $ ____________

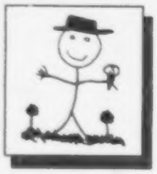
Please allow 2-4 weeks for delivery

MAKE CHECKS PAYABLE TO AATA

LUCIA CAPACCHIONE, PH.D., A.T.R.

1994 WORKSHOPS/LECTURES:

4/8-10 **SANTA BARBARA, CA** • Inner Child Retreat
4/22-23 **LOUISVILLE, KY** • Art Therapy Assn. Lecture/Workshop
4/30-5/1 **HOUSTON, TX** • 2-day Workshop
6/17-19 **SANTA BARBARA, CA** • Inner Family & Relationships
11/13-20 **GHOST RANCH, NM** • Week-long Inner Family Training
12/9-11 **SANTA BARBARA, CA** • Inner Child Retreat



NEW !!!

AUDIOTAPE: *The Wisdom of Your Other Hand* five-tape set from Sounds True Recordings

BOOK: *Creating a Joyful Birth Experience* Coming this summer from Simon & Schuster

BOOKS:
- *The Creative Journal*
- *Recovery of Your Inner Child*
- *The Power of Your Other Hand*
- *The Well-Being Journal*
- *The Creative Journal for Children*
- *The Creative Journal for Teens*
- *Lighten Up Your Body, Lighten Up Your Life*
- *The Picture of Health* (also on audiotape)

TAPES:
- *Intuitive Thinking with Lucia Capacchione*
- *The Power of Play (on the Inner Child)*

For information, call: (310)281-7495

COLLEGE OF NOTRE DAME

OFFERS:

- Master of Arts in Art Therapy (37 units)
- Master of Arts in Marital & Family Therapy (50 units)
- Graduate Art Therapy Certificate Program (21 units) for those already holding a Master's degree"

- Systems & Jungian oriented art therapy
- AATA-approved
- Meets California state requirements for MFCC licensure
- Afternoons & evenings
- Summer Program
- Located in the beautiful San Francisco Bay Area

Art Therapy Program
COLLEGE OF
NOTRE DAME
1500 Ralston Avenue
Belmont, CA 94002-1997

For program specifics call (415) 508-3556

For an application call (415) 508-3523

NASCO Arts & Crafts...
Your Palette to Creativity!

Nasco
ARTS & CRAFTS

NASCO's 1994 Arts & Crafts Catalog has over 10,000 arts and crafts supplies available—Everything you need to inspire your students to discover the freedom and joy of self-expression through art. We offer materials for painting, drawing, sculpting, jewelery making, ceramics, art history, and much more. Many items are available exclusively from NASCO including: NASCO Print Drying Racks, NASCO's Safety-Kut print making blocks, NASCO Country School Tempera, and NASCO's highly acclaimed Bulk-Krylic.

Write Dept. EAE405, for your free 1994 NASCO Arts & Crafts Catalog today, or call our free phone order service.

Free Phone Order Service: 1-800-558-9595
FAX: 1-414-563-8296

Nasco
Fort Atkinson, WI 53538-0901
Modesto, CA 95352-3837

SIUE

Southern Illinois University at Edwardsville

Art Therapist / Art Studio Generalist

Assistant Professor. Full Time. Tenure Track. Salary & benefits competitive. To teach three courses per semester in graduate Art Therapy and/or undergraduate Art Studio or Introduction to Art (lecture). Start Aug. 16, 1994.

Qualifications: MA or MFA, ATR Certification. Three years of adult clinical experience in Art Therapy with studio background preferred.

Application: Submit letter of application, three letters of reference, 20 slides of own work. A/D March 15, 1994. AA. EOE. WMA.

Art Therapy Search, Box 1774, Art & Design, Southern Illinois University at Edwardsville, Edwardsville, IL 62026.

CHARLES C THOMAS • PUBLISHER

☐ Moon, Bruce L. — **INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 16 il., $45.75

It is the author's goal to completely introduce the complex and diverse field of art therapy as it is now practiced in the United States. This text touches the major themes and issues of the profession. This should be the first book, or one of them, which students new to the field read about art therapy. There is provided clinical service to many specific patient populations; the basic tenets are applicable to all human beings. For the past twenty years the author has worked with mentally ill patients and makes reference in a readily understandable manner of experiences with patients, colleagues and students. Art therapy can be used with the very young through the very old. No one is disqualified on the basis of gender or sexual orientation. Art therapists work with persons from all races, creeds and religious traditions. Art therapy is effective with individuals, couples, families and groups. It works well with the intellectually gifted and the learning impaired. It can be used with the chronically mentally ill, the terminally ill, the vision impaired and the deaf. It is a safe assumption that patients admitted to psychiatric hospitals have already tried to alleviate their emotional distress with traditional verbal psychotherapy without significant relief. It is the creation of an objective thing that separates art therapy from the work done by psychologists, social workers, psychiatrists and counselors. Art therapy is particularly effective with posttraumatic stress disorder—from aftereffects of war, physical, sexual or emotional abuse. This book describes the essential elements of the process of facilitating therapeutic change in forming a foundation from which art therapists construct treatment plans and philosophies.

☐ Moon, Bruce L. — **ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $35.75.

☐ McNiff, Shaun — **EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $44.00.

☐ Landy, Robert J. — **DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 × 10), 1 table, $42.25.

☐ Landreth, Garry L. — **PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $51.25.

☐ McNiff, Shaun — **THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $30.00.

☐ Espenak, Liljan — **DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $32.25.

☐ Machover, Karen — **PERSONALITY PROJECTION IN THE DRAWING OF THE HUMAN FIGURE: A Method of Personality Investigation. (11th Ptg.)** '80, 192 pp. (5½ × 8½), 18 il., $29.25.

☐ Anderson, Frances E. — **ART-CENTERED EDUCATION AND THERAPY FOR CHILDREN WITH DISABILITIES.** '94, 314 pp. (6¾ × 9¾), 100 il., 14 tables.

☐ Sopchak, Andrew L., Andrew M. Sopchak & Robert J. Kohlbrenner — **INTERPERSONAL RELATEDNESS FROM PROJECTIVE DRAWINGS: Applicability in Diagnostic and Therapeutic Practice.** '93, 292 pp. (8½ × 11), 166 il., 46 tables, $59.75.

☐ Chickerneo, Nancy Barrett — **PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $49.75.

☐ Kluft, Estelle S. — **EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $62.75.

☐ Fryrear, Jerry L. & Irene E. Corbit — **PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 × 10), 24 il., $44.75.

☐ Moon, Bruce L. — **EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¾), 21 il., $36.25.

☐ McNiff, Shaun — **DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $46.50.

☐ Radocy, Rudolf E. & J. David Boyle — **PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $54.25.

☐ McNiff, Shaun — **FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¾), 34 il., $46.50.

☐ Peters, Jacqueline Schmidt — **MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $33.00.

☐ Bruscia, Kenneth E. — **IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $90.00.

☐ Levick, Myra F. — **THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $51.00.

☐ Fürrer, P. J. — **ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $23.50, spiral (paper).

☐ Plach, Tom — **THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $25.25.

☐ Hammer, Emanuel F. — **THE CLINICAL APPLICATION OF PROJECTIVE DRAWINGS. (6th Ptg.)** '80, 688 pp., 360 il., $53.25.

☐ Kwiatkowska, Hanna Yaxa — **FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $48.50.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone #s: ____________________ work ____________________ home

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ______________________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Black and white photos of original artwork plus 4 photocopies of each.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ______________________________ **Date** ____________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

1703

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

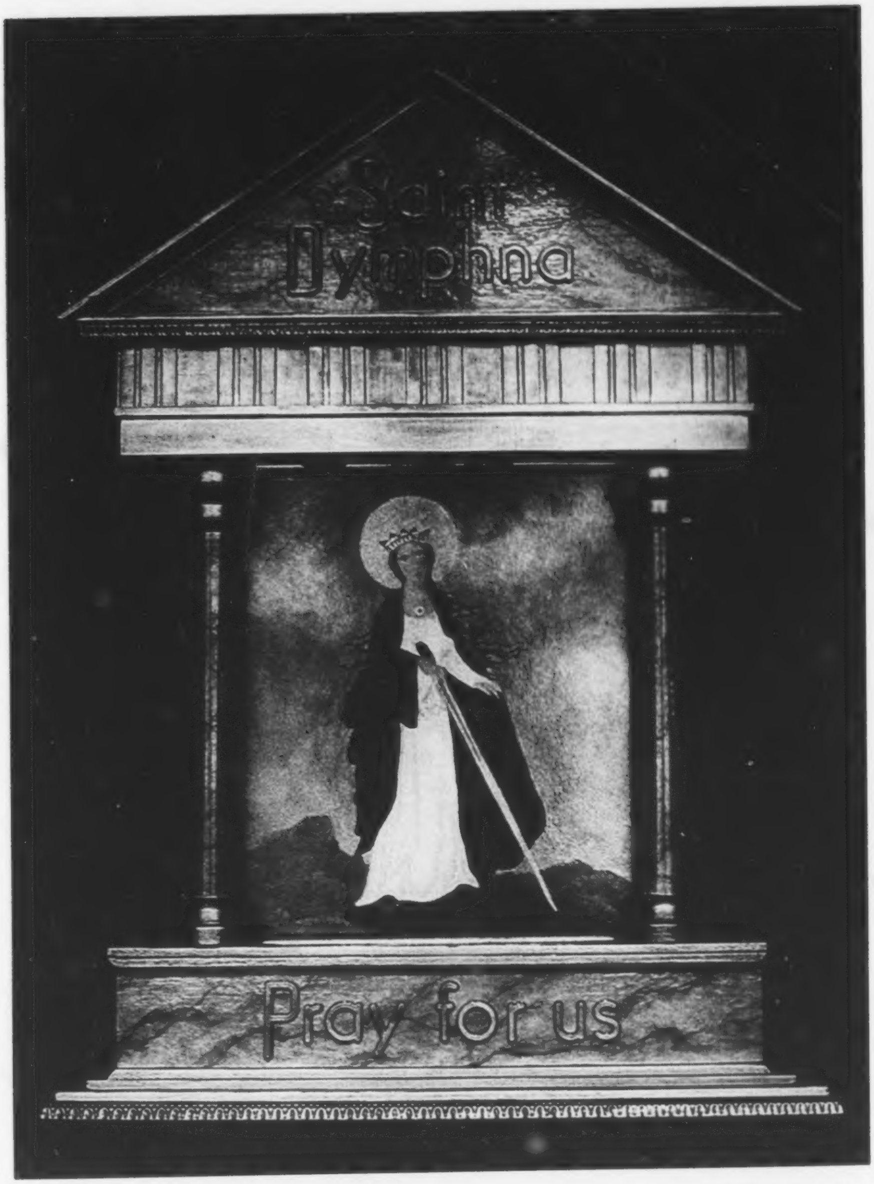
1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Celebrating
AATA's 25th Anniversary
1969 - 1994


Saint
Dymphna
Pray for us

VOLUME 11, NUMBER 2, 1994

1705

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue; July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, MA, A.T.R.
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Patricia St. John, EdD, A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor
Barbara Sprayregan, Psy.D., A.T.R.
Arlington, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Philadelphia, PA

Production Editor
Suzan B. Soto

Editorial Board
Pat B. Allen, PhD, A.T.R.
River Forest, IL

Frances E. Anderson, EdD, A.T.R., HLM
Illinois State University, Normal, IL

Doris B. Arrington, EdD, A.T.R.
College of Notre Dame, Belmont, CA

Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec

Mariagnese Cattaneo, PhD, A.T.R.
Lesley College, Cambridge, MA

Susan E. Cheyne-King, MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA

Carol Thayer Cox, MA, A.T.R.
The George Washington University, Washington, DC

Julie Epperson, MA, A.T.R.
Salt Lake City, UT

Janice Havlena, MA, A.T.R.
UNM Children's Psychiatric Hospital, Albuquerque, NM

Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI

Vija B. Lusebrink, PhD, A.T.R.
University of Louisville, Louisville, KY

Howard McConeghey, EdD, A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM

Shirley Riley, MA, MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA

Susan Evans Spaniol, EdD, A.T.R.
Lesley College, Cambridge, MA

Betty Jo Troeger, PhD, A.T.R.
Florida State University, Tallahassee, FL

Evelyn Virshup, PhD, A.T.R.
California State University, Los Angeles, CA

Robert Wolf, MPS, A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President
Bobbi Stoll, MFCC, A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

VOLUME 11

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 2, 1994

Editorial

Sorting Out Certification — Cathy A. Malchiodi, MA, A.T.R. 82

Commentaries 84

Tribute to Suzanne Canner Hume 86

Special 25th Anniversary Section

How Will the Profession of Art Therapy Change in the Next 25 Years? Responses by Past Award Winners — Edith Kramer, A.T.R., HLM, Cay Drachnik, MA, A.T.R., MFCC, HLM, Frances E. Anderson, EdD, A.T.R., HLM, Helen B. Landgarten, MA, A.T.R., HLM, Myra F. Levick, PhD, A.T.R., HLM, and Shirley Riley, MA, A.T.R., MFCC 91

Gallery by Rawley Silver, EdD, A.T.R., HLM 102

Special Section on Art-Based Assessment 104

Articles

An Introduction to the Diagnostic Drawing Series: A Standardized Tool for Diagnostic and Clinical Use — Barry M. Cohen, MA, A.T.R., Anne Mills, MA, A.T.R., and Adrienne Kwapien Kijak, MSW, A.T.R. 105

Diagnostic Drawing Series: Research with Older People Diagnosed with Organic Mental Syndrome and Disorders — Janet Beaujon Couch, MA, A.T.R. 111

A Study of the Diagnostic Drawing Series with Eating Disordered Patients — Kathie Kessler, MA 116

The Children's Diagnostic Drawing Series — Elizabeth Leigh Neale, MA, A.T.R. 119

Tree Drawings and Trauma Indicators: A Comparison of Past Research with Current Findings from the Diagnostic Drawing Series — Anita Rankin, MA 127

Research with Diagnostic Drawings for Normal and Alzheimer's Subjects — Nancy M. Knapp, PhD, A.T.R. 131

Brief Reports

The Imagery and Expression of Anger: An Initial Study — Frances F. Kaplan, DA, A.T.R. 139

Art Therapy and Alexithymia — Marilyn Heiman, MA, A.T.R., Diane Strnad, MA, Wendy Weiland, MA, A.T.R., and Thomas N. Wise, M.D. 143

Report on the National Art Therapy Practice Analysis Survey — Joan E. Knapp, PhD, Lenora G. Knapp, PhD, and Joan Phillips, MA, MS, LMFT, LPC, A.T.R. 146

Commentary on the Assessment Portion of the Art Therapy Practice Analysis Survey — Joan Phillips, MA, MS, LMFT, LPC, A.T.R. 151

Viewpoints

Diving and Snorkeling: The Depths and Shallows of Therapy— Harriet Wadeson, PhD, A.T.R., HLM 153

A Review of Two Art Assessment Tools in an Adult Day Treatment Center — Piyachat Ruengvisesh Finney, MA, A.T.R., CP .. 154

Reviews

Instant Images: A Guide to Using Photography in Therapy — Julia Gentleman Byers, A.T.R. 157

Tactile Graphics — Betty D. Jones, MA 158

Portraits of Spirituality in Recovery: The Use of Art in Recovery from Co-Dependence and/or Chemical Dependency — Carol Ann Bomberger, MA, A.T.R. 159

Video Review: Art Therapy with a Group of Latency Age Girls — Gussie Klorer, MA, A.T.R., LCSW 160

Noteworthy 161

About the Cover: "The Saint Dymphna Allegory," 29" × 19" × 3", acrylic painting on masonite sculpture; by Randy M. Vick, MS, A.T.R., Director of Expressive Therapies, Michael Reese Hospital, Department of Psychiatry, Chicago, IL; this piece tells the story of the 7th century martyr and was originally presented as part of a larger installation (please see Noteworthy section of this Journal for more information).

Editorial

Sorting Out Certification

Cathy A. Malchiodi, MA, A.T.R., *Editor*

This 25th year of the American Art Therapy Association, Inc., not only commemorates the silver anniversary of the organization, but also marks the beginning of the long-anticipated certification program for art therapists. The question of certification within the profession of art therapy and the AATA itself has had a long history, almost as old as the association itself. The underpinnings of certification began with initial attempts to define competencies in art therapy (Lusebrink, 1981; Lusebrink & McNiff, 1979; Lusebrink, Nucho, Riley, & Ault, 1980), and various committees were formed throughout the 70s and 80s to explore the idea of certification for art therapists. In 1989, an ad hoc committee was appointed to once again explore the idea of a national certification program for art therapists (AATA, 1989). Subsequently, in 1991, the membership voted by ballot to proceed with the development of a certification program (AATA, 1991) and at the general business meeting at the annual conference that year a majority of those in attendance voted to complete the process of developing a certification within three years.

Although the implementation of certification and a competency examination is an important historic milestone, few AATA members seem to be openly talking about it in the pages of our publications aside from those members on the Art Therapy Credentials Board (ATCB) or those involved with actual Certification Committee work. During my tenure as Editor I have yet to receive one commentary, letter, or viewpoint that addresses the subject. Recently, a letter to the *AATA Newsletter* Editor made a plea for A.T.R.s with a certain amount of experience to be "grandparented," citing that the examination process may be more appropriate for less experienced A.T.R.s, new, or unregistered therapists (Buchalter, 1994). Other than this brief comment, opinion within the pages of our publications has been noticeably absent.

Meanwhile, the process is moving forward and some practical aspects of certification have already been determined by the ATCB over the last year. The first examination has been scheduled and will be held during the time of the 1994 annual conference; the price of taking the examination has been set at $230; and grandparenting will be limited to a very select group of art therapists. A recertification program is currently being developed, to be in place after the initial group of art therapists becomes certified. A practice analysis survey was sent last year to professionals in the field to identify the tasks entry-level art therapists must perform in practice and the knowledge necessary for such performance. Currently, the Certification Committee, along with guidance from Knapp & Associates, is gathering material from professionals in the field and working toward the actual development of an examination.

The development of a certification examination is one of the most complex and heady tasks of the entire process, and one that may have the most profound and lasting effects on the direction of the profession. I must admit that when I was asked to write 10 questions for possible inclusion in the certification exam, I immediately felt very respectful of what I might put to paper. Simultaneously, I also felt stymied about what I could honestly design as test questions. Some areas of knowledge such as the *AATA Code of Ethics* or *Standards of Practice* came to mind, but frankly after that I became confused about what art therapy resources could actually be utilized to develop sound questions, given the requisite multiple choice format.

My confusion stemmed from several problematic aspects of the development of the field of art therapy, particularly our literature. One major problem with utilizing our publications to design exam questions is in viewing much of what is published as "truth," particularly truth on which to design multiple choice exam questions. First, much of our literature, particularly books, has not had to pass any particularly rigorous standards in order to be published. Many publishers (many of which are well-known to art therapists) are eager to print anything about art therapy and will send a contract out to a prospective author who has what sounds like a marketable topic on paper without seeing the actual manuscript. Often no request is made of the author to submit the final manuscript to objective reviewers in the field for verification and criticism of content, a practice standard in many fields and with many publishers. There is also straight-out vanity press where a publication goes to press either self-published or published under circumstances without editing. These types of practices result in publications that often have flaws in factual areas as well as theoretical and methodological areas.

Also, although less problematic, publications in the field of art therapy have tended to be based more on clinical and philosophical observations, rather than on research and hard data. Obviously, psychology, counseling, and other clinically-based disciplines have had to contend with developing examinations, given some similarities in knowledge areas. However, these disciplines have been around longer than the field of art therapy, and thus have produced literature that has withstood time as well as undergone a much more rigorous scrutiny. Additionally, another characteristic of art therapy to be considered is the infusion of art within its literature. Art is a discipline that is based in human creativity (at best, an elusive subject) and that has very little in the way of rules; when there are rules, they often are broken.

Art-based assessments are another area of ambiguity and controversy in both our literature and knowledge base. Fortunately, many art therapists in the field are respectful of the use of art in assessment and the use and misuse of interpretation, understanding the limitations of making strict interpretations of client art expressions. In this issue of the journal, Joan Phillips, current Chair of the Certification Committee, comments on other areas of concern, particularly on the conflicting opinions art therapists express about art-based assessments through the National Practice Analysis Survey (also published in this issue). On one hand, many feel that art-based assessments, particularly "free art assessments," are intrinsic to the practice of art therapy; on the other hand, art therapists find little or no consensus on how to go about defining exactly what free art assessments are.

Another area of concern is the oral history that has abounded concerning assessment protocols. This oral tradition has generated protocols that have often been regionally-based or connected to some specific training program, and almost always never written about in depth. Once in a while the profession gets a glimpse of these assessments at a session at the annual conference, but that limited viewing does not provide the necessary data on how to implement these assessments nor their application with specific populations. Given the status of art-based assessments in the field of art therapy in addition to the conflictual feelings about utilizing art expressions as interpretative data, it is easy to understand the Certification Committee's decision not to place a focus on them in the development of the examination.

Those who were asked by the Certification Committee and Knapp & Associates to develop test questions were also asked to reference where each proposed test question was cited. Considering the varying quality of our published literature, the lack of previous peer review, and oral traditions, this will likely pose some problems in the overall process of exam development. The Certification Committee has undertaken the enormous responsibility of selecting and developing the final questions for the examination from the material submitted; however, the accompanying responsibility of verifying facts will be difficult at best, given the inherent problems previously mentioned.

A final matter regarding the actual examination is, given the previously mentioned aspects, will what is developed really be an art therapy certification exam or basically a counselor exam disguised as an art therapy exam? In thinking about designing test questions, some authors of potential questions may have passed up the art therapy literature, going to texts outside the field for references. If the majority of questions on the examination are culled from literature outside the field (e.g., questions about group therapy from Yalom or Corey & Corey, from the DSM III-R, from standard texts on family therapy such as the Goldenbergs, psychotherapy with children from the writings of Winnicott, to name a very few possible examples), then we may have missed our mark. This trend would bring the field rapidly back to the question of whether or not art therapy is a bona fide discipline in its own right, or merely a modality that is an appendage of another profession such as counseling, psychology or the like (Malchiodi, 1993).

Lastly, some would observe that the purpose of certification at present is limited, given that only one state has achieved art therapy licensure. It is obvious that by creating a certification process we are basically preparing ourselves for possible future scenarios when other states may achieve art therapy licensure and regulations our profession must meet, given possibilities of new standards for health care. However, the verdict is not in on if certification will protect the field given a national health care program that includes managed care or other similar plans. With these unknowns and other variables, the effect of certification for art therapists will not be realized for many years.

Undoubtedly, the real impact of certification at this point in time is the articulation of an art therapy knowledge base, one that truly defines our profession and distinguishes it from others in the health care arena, whether or not certification will be successful in clarifying and refining the definition of art therapy as a field also remains to be seen. The movement to define ourselves through certification also brings to mind another question for which an answer may not be immediately evident: will certification make the field of art therapy credible? This search for authenticity has dogged this profession since day one, as both the association and its members have struggled to define themselves to hospitals, governmental agencies, health care professionals, and the public. Whether or not certification will help us achieve a sense of being "real," either psychologically or otherwise, is the real question that remains to be answered.

References

American Art Therapy Association. (1989). Summary of motions passed at the Fall 1988 Board of Directors meeting. *American Art Therapy Association Newsletter, 21*(1), 14.

American Art Therapy Association. (1991). AATA 1991 election results. *American Art Therapy Association Newsletter, 23*(4), 14.

Buchalter, S. (1994). Letter to the editor. *American Art Therapy Association Newsletter, 27*(4), 17.

Lusebrink, V. B. (1981). *Discussion of art therapy competencies.* Unpublished manuscript, Art Educators Conference, Shakertown, KY.

Lusebrink, V. B., & McNiff, S. (1979). *A survey of art therapists' responses to the competence evaluation checklists and self-evaluation.* Unpublished manuscript.

Lusebrink, V. B., Nucho, A., Riley, S., & Ault, R. (1980). *Report on the evaluation of art therapists' competencies.* Unpublished manuscript.

Malchiodi, C. A. (1993). Introduction to special issue on art therapy and professionalism: Is there a crisis in art therapy education? *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 122–128.

Commentaries

Letters to the Editor

I write in appreciation of your editorial, "Introduction to Special Issue on Art Therapy and Professionalism: Is There a Crisis in Art Therapy Education?" (*Art Therapy: Journal of the American Art Therapy Association*, Volume 10, Number 3, 1993). You presented issues relative to our various philosophies and to the pragmatics of making decisions most beneficial for the survival of our profession, seeking unity without uniformity. You also posed other questions and avoided the trap of easy answers.

Though I realize that there is a crisis in art therapy education, I do not know enough of the details to give informed answers. However, regarding "art therapy and professionalism," I do have experience, knowledge, and beliefs. So, I write here in response to the section in your editorial entitled, "Art Therapy: Modality or Field?" (Malchiodi, p. 122). In this section you include a paragraph taken from a long interview with me recorded by Henrietta Jordan (*American Journal of Art Therapy*, Volume 28, Number 1, 1989). From what I said, you drew conclusions relating my thoughts to your implication that art therapy must be either a "bona fide discipline or merely a modality" (Malchiodi, p. 122). I did not, and would not, use that wording nor that kind of either/or thinking in defining art therapy. Instead, I used the words "a separate field" (Jordan, p. 12). I think we all know that in the present overcrowded milieu of therapies, no one discipline can claim to be totally distinctive. Each field incorporates positions and practices advocated in related fields. Art therapy educators and practitioners wisely include in our knowledge base tenets originating in more established disciplines. Professional philosophers, educators, scientists, and artists have always done so in an ever-interactive process of reactive and proactive development of ideas and understandings. Individuals can ignore ideas inimical to their own; cultists thrive on such denial. I am wary when someone claims a direct source to power and truths unavailable to ordinary mortals. When professional responsibilities are blurred, I grow uneasy. Further, I would never label art therapy as "merely a modality." Historically art expression has been practiced as therapeutic experience for millennia. In a cultural context art experience has been and still is central in enlivening all cultures known to anthropologists. Culturally specific rituals involve art making and experience as far back as our Neolithic ancestors up to and including our present. In the wide context of humankind, art as therapy has been and will continue to be for life's sake. No person or profession can cordon off this universal urge and claim the right to delimit its potentialities.

Too often we take for granted our right to freedom and give little thought to the fundamental and necessary principle that having freedom assumes being responsible. In the interview to which you refer and in the context of AATA's concerns as an organization, I spoke unthinkingly. In retrospect, I am embarrassed by the paragraph quoted. I spoke so offhandedly. I expressed my personal opinion, and by implication those of other art therapists. I referred to a serious matter as if I did not recognize or even care about the reality and complexity of the problems. The interview was recorded almost five years ago. Since then AATA membership has approved changes affecting the professional status of our members. The actual outcome of this move has yet to be determined. I read that the Art Therapy Credentials Board, far more politically informed than I, is working toward devising standards and measures of who we are and what we do. If they can do this while respecting the diversities among us, and if this can provide art therapists with more security in status and income, I applaud their efforts and wish us well.

Janie Rhyne, PhD, A.T.R., HLM

Healthy egos are both well differentiated and well integrated. Placed in this framework, the collective "ego" of professional art therapists is rich in the former attribute and deficient in the latter. We represent a diversity of opinions, viewpoints, and approaches that we articulate with emphasis (and, sometimes, a disregard for the sensitivities of others) in the pages of this journal and elsewhere. However, we have difficulty when it comes to unifying our diversity. The controversy surrounding the theme of our most recent annual conference, "Common Ground: The Arts, Therapy, Spirituality," is a case in point.

Cathy Moon's beautifully poetic opening address for the conference was moving and persuasive. But it takes more than a good speech to unite those who embraced the theme, those who value spirituality but think it should be kept separate from professional life, and those who are nonbelievers. (So that you know where I stand, I include myself among the last.) And it also takes more than majority rule—an imposition of the will of the largest group on all the rest.

My point is that we as art therapy professionals need to find better ways to interrelate. We need to work harder at understanding our diverse viewpoints, at finding ways to benefit from what each has to offer, and at devising resolutions to the inevitable conflicts that take into account our shared interests. In regard to the conference, for example, a theme such as "The Search for Meaning," developed to include separate sections on spirituality, theory, research, etc., might have bridged our differences.

We do not want to stifle debate (small chance of success in any case!) because this is one way we clarify and develop our ideas and concepts. But when we are able to come up with creative and satisfying solutions to our major conflicts with some consistency, we will be able to say that we as a profession have reached "ego" maturity—and we will have *truly* found common ground.

Frances F. Kaplan, DA, A.T.R.
Morris Plains, NJ

Thank you for publishing the survey by Lusebrink, Rosal, and Campanelli; this survey is a valuable asset to the art therapy research archives.

For the record, I need to point out an error in the analysis of data regarding my doctoral dissertation topic. Although my topic did not have art therapy mentioned in the title, the body of research and the context within which this research was conducted, subscribed to art therapy principles and practices. I would not be surprised if this is also true of other researchers and if more doctoral dissertations than the survey indicates are related to the field. Art therapy is totally integrated into my life and was an extremely important part of my doctoral studies.

Simone Alter Muri, EdD, A.T.R.
Northampton, MA

A belated but heartfelt congratulations to you and the American Art Therapy Association for editing and publishing the special issue of *ART Therapy* on art and medicine (Vol. 10, No. 2, 1993).

Your own editorial was an excellent introduction to the issue and raised some central issues, not the least of which was the outstanding Barbara Graham quote that "being healed isn't the same as being cured. . . ."

As you know, we in the International Arts-Medicine Association (IAMA) refer to our "movement" as arts-medicine and note your term "medical art therapy." All of us in this field must continue to discuss basic definitions and terminology, and we look forward to those discussions.

Suffice it to say, it is inspiring for many of us to note that individuals and institutions around the world are increasingly and successfully utilizing arts interventions in a wide variety of medical settings.

We noted this phenomenon in our recently signed 1993 Tokyo Declaration on Arts-Medicine, on which we would like you to comment. Also of note is a six-point Rationale for the Increased Utilization of the Arts in U.S. Health Care which I published as president of IAMA in July of 1991.

More importantly, however, is that the special issue of *ART Therapy* is a stunning achievement, and all of us who believe in the healing power of the arts are in your debt. We are very pleased to note that the current president of AATA, Bobbie Stoll, is on the Board of Directors of IAMA.

Again, congratulations on this wonderful achievement. We very much look forward to working with you.

Richard A. Lippin, M.D., President
International Arts-Medicine
Association
Philadelphia, PA

CALL FOR PAPERS

Art Therapy is seeking submissions for the following special issues:

Gender Issues in Art Therapy

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to gender issues in the theory and practice of art therapy. Submissions may focus on any topic or population related to this theme. Of particular interest are: the effect of gender on clinical practice, professionalism, ethics, and/or training, feminist theory and its relationship to art therapy, and gay and lesbian issues in clinical practice.

Ethics and Art Therapy

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to this and art therapy. Submissions may focus on, but are not limited to, ethical issues specific to the practice of art therapy, pedagogical considerations in incorporating ethics with art therapy training, supervision, and practice; ethics in art therapy research; legal aspects of art therapy practice; and ethical dilemmas in exhibiting client art expressions. Potential authors are reminded to consider the topic of ethics as specifically related to the field of art therapy, not counseling, psychology or other related mental health fields. Submissions will be reviewed for publication in part on the author's ability to make this connection.

Deadline for submission for "Gender issues and Art Therapy" is December 1, 1994. The deadline for "Ethics and Art Therapy", has been extended until September 1, 1994. Please see "Guidelines for Authors" in the journal for specific requirements in terms of style and format. Please send 5 copies of all submissions to:

Cathy A.Malchodi, A.T.R, Editor
Art Therapy, c/o AATA, 1202 Allanson Road, Mundelein, IL 60060

Tribute to Suzanne Canner Hume, MEd, A.T.R.
1952-1994

On February 16, 1994, the field of art therapy experienced a tragic loss with the death of colleague, educator, teacher, and clinician Suzanne Canner Hume. Suzanne's accomplishments and contributions to the field of art therapy were many. She was a graduate of Radcliffe College and the first student to graduate in art therapy from Lesley College, later to receive her A.T.R. in 1976. She was extremely active in governmental affairs, advocating for recognition of art therapists in her home state of Massachusetts. Her untiring work in this area resulted in the passage of the Massachusetts Mental Health Counselor Bill in 1990, which included art therapists in the legislation.

Suzanne also left her mark on art therapy education. She developed and directed an art therapy program at Dean Junior College, and later designed and directed a summer art therapy institute at Simmons College in Boston; both programs were carried out while she was still in her twenties. Suzanne also served on the AATA Education and Training Board, chairing the ETB from 1985–87. She received the Distinguished Service Award from the AATA in 1989 for her achievements on the ETB and in governmental affairs.

In honor of Suzanne, a collection of letters was gathered from Suzanne's friends and colleagues. These letters extoll not only the accomplishments of Suzanne Canner Hume, but also characterize the exceptional quality of her contributions and her extraordinary spirit. They are presented as "Letters to Erika," in honor of Suzanne's daughter and husband, and respectfully as a celebration of Suzanne's life.

Letters to Erika

Dear Erika,

I knew your mother as a friend and colleague through our work in the field of art therapy. I remember when I first moved to Massachusetts, your mother came to a lecture I gave at Lesley College for the New England Association of Art Therapists. I felt quite honored that she would come to my presentation, and after I finished my lecture, I remember how she made me feel welcome in my new home. This was many years before you were born, but I can remember talking with your mother in the months after about how much she wanted to have a child, and later, how happy she was when she give birth to you.

Suzanne was an extraordinary human being and I hope that these letters will honor her memory in an extraordinary way. But this is not the only purpose that I had in mind in collecting these letters. I know Suzanne would want you to know the story of her life as you grow up and become a young lady, because your arrival on this planet was the most important thing in the world to your mother. So I thought that if I asked some of your mother's special friends to write their memories of her for you that this could be my gift to you as you grow and want to know more about the extraordinary person Suzanne was to many, many people.

There are many words that flood my mind when I think of your mother: kind, gentle, intelligent, thoughtful, gracious, beautiful. It is still hard for me to believe that she is gone because she was so filled with life and vitality. I know that everyone who has written a letter to you feels the same way. I also know that as you grow up, everyone who has written a letter to you would be glad to personally share their memories of your mother with you. This is a treasure that we would all be honored to give you in the years to come.

Cathy A. Malchiodi
Salt Lake City, UT

Dear Erika:

I remember Suzanne well. We worked together between 1980 and 1988. Her contributions to the New England Association of Art Therapists, the American Art Therapy Association Education and Training Board, and her successful pioneering work for licensing for art therapists in Massachusetts have affected all of us. She changed our lives. She changed my life.

My earliest association with Suzanne was in our work on the New England Association of Art Therapists. She invited me to attend a meeting in 1980; I think in late Spring. I was intrigued with her position on the Board. While it did not seem that she held elected office, she was clearly a vital part of the organization, probably as a "member-at-large." Her efforts and energy were behind numerous conferences and membership drives. These all were done with her inevitable professional abilities, with no detail overlooked, from signs to meals, from flowers to greeting each speaker and conference goer. She knew everyone, and everyone knew her at these conferences, and she had kind and caring words for each. When she left NEAAT to form the Massachusetts Coalition of Creative Arts Therapists and work for licensing legislation,

Figure 1. AATA Education & Training Board meeting in Rockport, MA at the home of Suzanne Canner Hume and Ed Hume. From left to right, Julia Byers, Bob Ault, Mari Fleming, Suzanne Canner Hume, Patricia St. John, and Mary St. Clair.

the organization went into hibernation for about two years. Her energy and abilities to bring people together were impossible to duplicate.

The success of Suzanne's work for licensing came to fruition only recently, when the Massachusetts legislature approved licensing for art therapists under the umbrella of Mental Health Counselors. Her work, along with others, allowed us to apply for licensing under a grandfather clause. We all were indebted to her for this. Along the way, she coordinated the First New England Joint Creative Arts Therapies conference, held at Lesley College on March 15, 1986. She brought together creative arts therapists from all over the region, for one of the most inspirational celebrations of our profession. Suzanne knew how to work hard and how to celebrate and play in style!

Not the earliest, but perhaps one of my most vivid memories of Suzanne dates to March 1987. Suzanne, then Chair of the AATA Education & Training Board, called to tell me that my appointment to the post of Secretary of ETB had been approved, and we had better get to work, fast. The former ETB Secretary had left the post suddenly for health reasons. Meanwhile, boxes and boxes of applications for approval had been submitted by art therapy programs, and the deadlines for responding to the materials had come and gone. The applications had been sent to my home and, when they arrived, Suzanne and I scheduled a meeting for a Sunday (the only day both she and I were free).

In her typically energetic style, she rose early and made the three-hour drive from Rockport, Massachusetts, at the eastern end of the state, to my home in Amherst, in the west. I had worked previously with Suzanne for the New England Association of Art Therapists and briefly, on the licensing project, so I knew her drive and energy level were boundless. She would work until the job was done. Sure enough, she arrived ready to dive into the mountains of paper work. She carefully and thoroughly trained me, going with meticulous attention through one program. A checklist guided us. We had something like a half dozen more programs to inventory. It would be a long day. We divided the remaining pile and got down to work. Suzanne not only reviewed her stack of materials, but often stopped to help me orient myself to this new task. She would have worked without a break, but my husband insisted we take lunch. Anyone who has worked with Suzanne knows that the work continued as we sat down to eat. And the work continued well into the evening, without a break, until it was done. Around eight o'clock, Suzanne declined dinner and an invitation to stay the night. She drove the three hours back to Rockport. To this day I wonder where her energy came from; I went to bed! Oddly enough, it actually had been a fun day—such was Suzanne's ability to make heavy work into serious play.

The next day we began to work together, by phone and mail; we wrote letters to each program. She taught me the art of the gentle, but firm, request for missing or deficient materials, and, most importantly, how to write with clarity and respect. She was most sensitive to the feelings and perception of the program director who would be receiving the letter. At the same time, she was thorough and careful. Her letters were perfectly worded; I had much to learn. She knew so much!

This style of working continued throughout our association, and we were on the phone several times a week until her term on the ETB was completed in Fall 1987. Actually, she stayed on the Board an additional year to ease the transition to a new Chair. The photograph accompanying this letter was taken after the Spring 1987 ETB meeting in Rockport. Suzanne had arranged for us to stay in a nearby house for the Friday through Sunday meeting. She arranged for meals, a walk through the marshes, and some magnificent views from the huge picture window overlooking the Atlantic. The house was set on a rock, directly above the ocean, and we ETB'ers sat among piles of papers, with one eye on the crashing waves. Suzanne somehow kept our attention on work, and deftly negotiated us through discussions of the programs being reviewed for approval. As secretary, I took notes and then drafted letters during our infrequent breaks. Suzanne guided us through an insurmountable amount of work, remaining fresh and open to each new problem. At the same time, she arranged lunch, and later, dinner. Before the meeting started, she and your father made several trips to Boston's Logan airport to pick up ETB members—whose flights, of course, were at all different times. By Sunday afternoon, she had served us a sumptuous lobster dinner, and the reverse trip to the airport was underway. Fortunately, I knew my energy level was no where near that of Suzanne's, and my husband drove me home. My admiration for Suzanne's indefatigable energy grew with each week. Clearly, she would be hard to replace.

When you were born, Suzanne brought you to the AATA Conference. She was full of her old energy, and had begun to pursue doctoral studies at the Fielding Institute in California. I know I was not alone in looking forward to her return to "active duty" with AATA. I sorely miss her clear thinking and ability to include everyone. Her broadmindedness, generosity, and her unending dedication to the cause of art therapy, has enriched all of us. She will be sorely missed—she will not be forgotten.

Rest well, Suzanne.

Patricia St. John
Amherst, MA

Dear Erika,

I knew your Mom for a really long time, long before you were born and even before she married your Dad. We met in Boston when we were both still students. There were half a dozen of us who were friends, all deciding on careers, all involved in one way or another in art therapy. Of the whole group, only your Mom and I decided to stick with art therapy. The rest went into counseling, social work or other fields. I mention this because it shows her determination to follow her own instincts and keep to her own path.

Those were exciting days. We worked together planning an art therapy conference, one of the first ones in Boston. I remember how thorough Suzanne was, from taking care of the smallest detail like coffee and donuts, to giving an excellent presentation herself. Everything she did was done well.

One of my favorite memories is of when I met you. You were about two years old. I came to Boston from Chicago with my daughter Adina and we drove up to Gloucester to visit your family. You and Adina played together and your Dad videotaped you both. Your Mom was very beautiful, she always dressed with lots of style and usually wore a rather serious expression. Whenever she smiled or laughed, she became even prettier. I remember thinking that day how she never stopped smiling and how her beauty lit up the room. She obviously loved you so much and was so filled with joy watching you play that she glowed.

I feel very lucky to have known Suzanne, to have been her friend and to have grown up together with her in art therapy. I just wanted to share these memories with you.

Love,

Pat Buoye Allen
River Forest, IL

Dear Erika,

Two telephone calls came that terrible day from colleagues that knew and loved your mother and who knew I would want to be informed of her passing. I thought surely there had been a mistake as the defense of disbelief worked its ways to lessen the loss and grief. It was only gradually that the news began to sink in and become a reality. My heart screamed it wasn't possible, yet my head nodded the truth, we had lost a very special colleague and friend. My heart argued it wasn't fair; Suzanne was young and vital; she was one of the good people who makes the world better and I searched for a logical or just explanation. There simply wasn't any, for the world isn't always a place of justice or logic, it just is. It is a hard reality we not only die by but more importantly live by. I continue to seek meaning out of it all, and I hope someday my words will help you to know and love your mother as those of us that worked with her did.

Some years ago I had the good fortune to be appointed to the Education and Training Board of the American Art Therapy Association for four years and became part of a very special team of colleagues that included your mother. Of all of the committees, boards, task forces, and teams that I participated in over the years, this one was the most special. Not only was it composed of very special people, but our task demanded we struggle mightily together to find fairness and order in the education of future generations of art therapists. When people struggle together with respect and a sense of caring as we did, and bring to resolution difficult problems, a great depth of connection is felt with each other. I would like to refer to it as an affection connection. I will retain it the rest of my life, and when I think of our times together, I smile and my heart is reassured of the rightness of life.

I did not know Suzanne before our work on the ETB, but let me share a few of my impressions from our years together. She was a thin, wiry young woman from the East Coast that ran every day and always brought her running clothes with her to our meetings. She was so friendly and warm and although seeming casual on the outside, when we got down to the task of understanding volumes of materials on graduate programs she was like a corporate lawyer in her quickness, sharpness, and amazing accuracy of analysis. She was dedicated to the task of making the work fair and through her example and leadership she molded the ETB into a politically free body that demanded and was given respect by the membership of our organization. I always felt so proud to be a part of the process and to be an art therapist, as well as exhausted after one of our three-day marathon meetings.

One time we met at your home overlooking the ocean there in Massachusetts. I loved the place. We could watch the lobster fishermen check their traps, observe the light house on the island, and smell the salty air that is special to those of us that grew up on a coast but live in the middle of America. I still have sea shells that I picked up on the rocks below your house. As we concluded our meeting that Sunday, your father brought each of us huge lobsters for lunch and we feasted. I still remember well the bright pink shells, the juice running down our arms, the wonderful tasting meat and the cracking of jokes as well as shells, and laughing together. It was a very special time.

The group was always very affectionate with each other and as we gathered or parted there would always be a round of greetings and goodbys and hugs. I wanted to tell you about one such event related to saying goodby that was especially meaningful to me and that I believe illustrates something very important about Suzanne. I don't remember what meeting it was, but she drove me to the airport to catch my plane home. That weekend had been difficult for me as I was struggling with some personal issue that I don't even remember now and that I did not share with the group. To my knowledge it had been kept private. We arrived at the airport and unloaded my bag and as in the past embraced and said goodby, but your mother hesitated an extra couple of seconds in letting go. She hugged me tightly for a moment longer than usual, and I will always remember her with a deep sense of affection for it. Standing there in the bustle of the airport, she communicated her sensitivity to my pain and let me know she knew and cared about it. It was a very healing moment for me and I will always love her for it. I tell you this story because it wasn't just with me, it was with the world and everybody she came in contact with. She loved her family most of all and wanted to have and love you so greatly. She also loved her clients, her profession, and her colleagues.

It is hard to think about how much we will all miss our future years together. I prefer to think about how much I appreciate our time we did have as friends. She was very special and will long be remembered. Like the lighthouse there by your home she helped many of us find our way in the dark and safely manage our lives and the direction of our beloved profession. My deepest sympathy to you and Ed and the rest of your family.

Bob Ault
Topeka, KS

Dear Erika:

As I sit at my desk remembering your mother, I am aware of my sorrow and sense of loss. I am saddened by the loss of my personal relationship with Suzanne, of our annual dinners in Cambridge and our friendship. I also grieve the loss of a valued colleague, her professional support, and our frequent collaborations. Your mother and I had been planning a presentation on ethical issues related to art therapy and I was eagerly anticipating continuing our work together. However it will remain forever in the planning stage.

Suzanne and I often talked together on the phone. We discussed our profession, our work, and our teaching, but we also supported each other. Whenever I left a message, I knew she would respond as soon as she could. I last spoke to her over a year ago. We had an unspoken ritual of dining together on a day when Suzanne taught at Lesley. Although Suzanne had taken a leave of absence from the college due to her doctoral studies and internship, she called to say she would like to meet at an ethnic restaurant in Cambridge. We chose Passage to India in Porter Square. It never occurred to me that this would be the last time we would see each other. We discussed a paper she had written about ethical issues working with children, and she shared her newest picture of you, Erika, saying, "One is only a mother once in a lifetime." She told me what a great pleasure it was to see you growing up. She spoke of the importance of devoting quality time to you and her family, and described her search for a balance between mothering, family life, doctoral studies, an internship, and private practice. That evening, as at other times, I was touched by her modesty and care for others. These are my memories of that night at the Passage to India.

Suzanne was a role model for me in her commitment to excellence and caring. She was a leader in establishing the profession of art therapy. She gave visibility to art therapy in the Commonwealth of Massachusetts. Due to her perseverance, consistent lobbying, educating the public, and organizing various groups of creative arts therapists, the creative arts therapists in Massachusetts are now eligible to become Licensed Mental Health Counselors.

Suzanne always aimed for the highest quality in her work. As an adjunct faculty member at Lesley College in the Expressive Therapies Program, she influenced the training of future art therapists. Her rich knowledge and numerous resources were highly valued and appreciated by her students. Her clear and supportive teaching enabled them to approach and examine their work critically and with high standards. She was able to identify the potential strengths and abilities that each student and professional could bring to their work. Her effort, her caring, and her commitment to excellence in art therapy was always a source of inspiration. She taught me about the importance of maintaining high quality and avoiding mediocrity in our profession, while remaining caring and supportive. She was a role model and mentor for many of us in the field of art therapy, professionals as well as students.

Now when I walk by the Passage to India, I am reminded of Suzanne, of what she taught me and the importance of her legacy of excellence and commitment to the art therapy profession. I feel fortunate that I was able to know and work with Suzanne, that she touched my life. It is this—her spirit—that will stay with me. I am grateful that we were able to walk together on this life path for a while.

Mariagnese Cattaneo
Lesley College
Cambridge, MA

Dear Erika:

The last time we were together you were not yet two. Your mother and I strolled with you along the palisades in Santa Monica. It was a lovely day—no smog because a breeze was blowing in from the ocean. Sometimes you ran around and your mother had to chase after you and keep you safe; other times you were content to be in the stroller nibbling a treat. When you looked at your mother, you both laughed and gave each other "mommy/daughter" loving looks. By this age you were a "big girl" and to me, looked so much like your mother that it was "Little Suzanne" and "Big Suzanne" with whom I walked.

As always, your mother had delightful stories to tell about her travels with your Dad and the vacations they planned with you. There was no doubt that you were the best thing that ever happened and taking care of you was a joy.

I wish I had the ability to send you the colors of your mother. She wore soft silken clothes that often combined marvelous colors that contrasted with her pale skin and black hair. As with everything she did, her artistry was apparent.

I remember that same day I was so attracted to the perfume she was wearing. She told me it was Esteé Lauder

"Knowing" and I rushed out and bought it. When I wear it I always feel that I am sharing the scent of Suzanne.

We didn't do much more than laugh that day. We went for coffee and a sweet and you weren't the least bit interested in our conversation. You visitied lots of people in the restaurant, and many people remarked on your likeness to your mother and how lovely you both were. Your mother was very proud of you.

In the past I had visited your parents' home in Rockport when they lived on the big rock by the sea. I had come to give a class nearby, and it made the trip more fun staying with your parents. Your mother had hurt her back so we spent a good deal of time lying around and talking about therapy and life. It never was just the "usual" theory conversation. Suzanne had an inventive mind and ways of putting things together that made something new out of used ideas. She spoke a good deal about supervision, since we both do that, and how she cared about the students she taught and supervised. We also wandered off into stories of our families and children. That visit was before you "were" and your mother told me how much she hoped to have a little girl. Shortly after that visit she called and told me how wonderful it was to be pregnant.

In thinking about my time with your mother, I realize, Erika, that the time didn't count up to very many hours in relation to actual time spent, but her delightful spirit and brilliant mind impacted me more in those limited hours than longer time spent with others.

I first knew Suzanne when she was involved with education. Her efforts to bring form to a newly created committee that evaluated educational standards was a lasting contribution. She worked many extra hours to put together the basic manual and did so with the full cooperation of her committee. Suzanne was able to demonstrate her dedication to education in a manner that inspired others to emulate her vision to raise standards of training. She was honored with the Distinguished Service Award from the American Art Therapy Association for her efforts.

I hope when you read this that you do not imagine that I suggest you should "be" your mother. Her greatest gift to her friends, and I imagine much more to you, was to respect and enjoy individuality and independent thinking. She would have wanted that for you, I believe. She was indeed a complete individual, a creative thinker, a person who could give and receive affection and understand laughter and tears. We miss her very much.

Fondly,

Shirley Riley
Los Angeles, CA

Dearest Erika,

Your mother was my beloved friend and I want to tell you about some of my memories of her.

First of all, she was always "Suzanne." She was never Sue or Susie or any other nickname. The completeness of her and her depth and seriousness as a person were reflected in her name. But she was not *only* serious. When I received my PhD, Suzanne gave me a pair of earrings as a gift. They are the most wonderful and silly earrings I own. (I would never have thought earrings could be silly, but these are.) I treasure them, because they remind me so of her. Like your mother, they have many apparently contradictory elements magically made into a work of art.

Each earring is an abstract bouncing human figure with a big head and beads for arms. Contradictory to the shape, the colors are subtle—blues and greens with a gold zig-zagged line, and they are textured with gold embossed lines. They remind me of your mother's many faceted temperament and her playfulness. Each time I wear them, someone tells me how beautiful or unusual they are (like she was). Each time I wear them, they bounce up and down on my ears and catch on my clothes or hair. So they are not easy earrings to wear—they demand and invite attention and interaction—they get me tangled up, delightfully; they make me laugh (like she did).

Suzanne's seriousness and intelligence were tempered by a highly sensitive pragmatism and informed by a commitment to action. She worked long, hard, and courageously to develop legislation in Massachusetts which included art therapists. For the American Art Therapy Association, she fought to shape documents and policies for educational programs which encouraged variety, creativity, and quality. In her years on the Education and Training Board, her honesty and fairness gave an integrity to a process which had sometimes been lacking. Her stamp will be felt in many ways on art therapy education for years to come.

She wanted always to learn more and to probe deeper in her understanding of people in order to be of more help to them—and just for the sheer pleasure of learning. Your mom learned from everything she did. (She could have learned from a rock!) This was what led her to take on studies toward a PhD in Psychology at the Fielding Institute, where I was also a student at the time. And then not long after she began Fielding, she was surprised by becoming pregnant with you.

I remember her as slim and angular in her jogging clothes, looking like a marathon runner. I remember her, after a trip to Baja California with your father, tanned and looking like a gypsy princess in an intense purple blouse, blue skirt, and huge hoop earrings. The very last time we were together, you were with us. As we ate our way through huge breakfasts at a restaurant by the Pacific Ocean, you sat in your high chair grinning and playing and occasionally banging spoons. You were a wonderful child, smiley and full of life—glowing in the California morning sun. Your mom looked at you with such delight and love. You gave her a tremendous amount of pleasure and she loved her exceptional daughter exceptionally.

I look forward to knowing you, Erika, through the years to come and telling you my stories about your lovely mother. (Come to California and we'll sit by the sea and chat endlessly.) I'll keep the earrings for when you're older—I'm saving them for you. And each time I take them out, I'll think about your mom and you and about how much she loved you. Keep in touch. (Feel free to call collect!)

Much love,

Maxine Junge
Los Angeles, CA

How Will the Profession of Art Therapy Change in the Next 25 Years? Responses by Past Award Winners

We Cannot Look into the Future, Without Considering the Past and Present

Edith Kramer, A.T.R., HLM

1916	*Born, Vienna, Austria.*
1934	*Graduated from Realgymnasium, Vienna.* *Attended art classes at the Kunstgewerbeschule in Vienna. Studied sculpture with Fritz Wotruba, Vienna, drawing and painting in Vienna and Prague with Friedl Dicker (Bauhaus, died 1944 at Auschwitz, attained posthumous recognition in Europe).*
1938	*Arrived as a refugee in the United States, citizenship 1944. Continued to pursue the practice of art in the United States.*
1938–41	*Art and shop teacher at the Little Red School House, New York City.*
1943–44	*Machinist during World War II.*
1950–57	*Initiated and conducted art therapy program at Wiltwyck School for Boys, a residential treatment home for emotionally disturbed, culturally and economically deprived city children, ages 8–13.*
1960–63	*Initiated and conducted therapeutically oriented art program at the Leak and Watts Children's Home, Yonkers, NY (home for dependent children of both sexes, ages 7–17).*
1963–74	*Art therapist at the Albert Einstein College of Medicine, Dept. of Child Psychiatry.*
1964–74	*Art therapist at the Guild School of the Jewish Guild for the Blind, school for the blind and visually limited children who have learning and behavioral difficulties.*
1974–78	*Consultant in art therapy.*

Participated in art therapy training programs from 1959 onwards.

At present, Adjunct Professor of Art Therapy at New York University and professorial lecturer of Art Therapy at George Washington University, Washington, DC.

Author of three books:
Art Therapy in a Children's Community
Charles C Thomas, 1958
Art as Therapy with Children
Schocken Books, 1971
Childhood and Art Therapy: Notes on Theory and Application
Schocken Books, 1979

One Woman Shows:
USA, Austria, Germany, Argentina, Sweden, Belgium

The pedagogic methods of the Bauhaus have been formative in the artist's development and remain an essential element of her understanding of the visual arts. However, her style has remained consistently representational. Personal expression remains subordinate to the task of interpreting the subject with respectful comprehension.

The Past

When I initiated my first art therapy program at the Wiltwyck School for Boys in 1950, the profession did not exist, nor was any training available. However, Margaret Naumburg had already used the term.

As preparation for my task, I could count on experience as an art teacher, as well as the Freudian psychoanalysis I had completed. Formative for my understanding of art, children, and psychotherapy was my acquaintance with ideas burgeoning in the Vienna of my youth. Working with the blind, Victor Lowenfeld was developing theories on child development in art and on ways of fostering children's sense of self. Fredrick Itten (later at the Bauhaus) was training artists. Anna Freud, August Aichhorn, Erik Erikson and others were practicing psychoanalytically oriented childcare, education, psychotherapy, and social work. I integrated these concepts with the informal training which came to me on the job. As I attended case conferences and rounds, my comprehension of my own work and of my function within the team was broadened. I formed concepts that constituted the foundation for ideas I subsequently developed. I published my first book in 1958 and taught my first course in art therapy in 1959. In course of time, my understanding was enriched by interchanging with a growing body of practitioners, who had also come to the field without formal training. All of us were ill-paid and looked upon as somewhat suspect newcomers in the field of social services.

The Present

Now, in 1994, art therapy is an established profession. Universities, institutes, and clinical settings offer training on a graduate level. It is possible to obtain a doctorate in art therapy. Income from the profession, although still low, has risen. Membership with the American Art Therapy Association (AATA) is constantly increasing. The areas in which art therapy are practiced, and the populations it serves are broadening.

It seems to me that the advent and growth of art therapy is linked to the absence of art in daily life, in our industrialized society. A sense of emptiness, a hidden hunger, makes people ready to respond to art therapy when offered in the artificial milieus which society (grudgingly) provides for its severely troubled members. However, the sterility which pervades society does not halt at the doors of such institutions. Increasingly, art therapists are forced to comply with conditions inimical to art—short-term treatment, reliance on drugs. Art therapy is often considered not as an aid to individual treatment, but as a substitute for it, this limits and diminishes our work.

The Precarious Future

It is tempting to see in the achievements of the past only prospects for a bright, expansive future. But we cannot divorce the destiny of art therapy from the fate of society as a whole. We see our world poised between the road to disaster, through environmental destruction, and depersonalization of work and life, and the concommitant disintegration of the social fabric, and hope for the reversal of those trends. We hope that the industrial juggernaught will be tamed and made to serve mankind instead of destroying it.

Even today, the practice of art therapy is stultified by the limitations of a shortsighted revolving door policy, bent on reducing symptoms rather than effecting inner change. Concommitant demands to devise day-by-day treatment goals threaten to blind art therapists to the surprises inherent in making art, to finding unforseen strengths, talents, buried troubles, unexpected solutions. The check-off lists many practitioners are required to follow lack provision for recording the essence of psychotherapy. This entails periods of increased vulnerability, periods of rebellion, and times of chaotic turmoil heralding inner change. If the present trends continue, if art therapy which belongs to the humanities is made to conform to a narrow medical model, I forsee increasing devitalization and the loss of *art* in art therapy.

However, there are hopeful signs. Experiments with half-way houses and therapeutic communities show that society may finally be ready to realize that there are large numbers of individuals who need sheltered environments for very long periods, or permanently, so that they may live a dignified and productive life even though their psychic organization remains fragile and subject to breakdown. In such environments art therapy can have an essential cohesive function.

The rise of holistic medicine gives hope that there will be doctors ready to combine the vast resources of modern medicine with individual care.

Neither art nor art therapy can be midwife to society. The fate of our profession depends on forces beyond our control. Within our narrow field, however, we must be valiant. The necessity to establish art therapy as a respected treatment modality inevitably entails adjustment, even compromises. However, we must not lose our identity. As we fight for recognition, we must uphold the laws inherent in making art. Art needs space for improvisation, openness to the unexpected, acceptance of the eccentric. Artists are more often than not somewhat odd individuals. Let's strive to become respected and employable mavericks! As we lecture, write, and discuss our work, let's avoid therapese. Let's speak plain English.

I greatly hope that part-time jobs will become the rule in the future so that art therapists will not have to sacrifice their own art making as they serve others.

I expect that art therapists will increasingly engage in research. I am gratified to find that the colleagues who are at present so engaged are striving to include the elusive factor of quality in their thinking.

Konrad Lorenz writes that ethologists are always gratified when they can find behavior that can be counted. But before one begins to count, he cautions, one must have studied the total life cycle, the instinctual endowment, the environment, and all behaviors available to the species under observation. In the absence of this information, one does not know *what* one is counting. Let's keep this in mind as we investigate that mysterious human behavior of making art.

Where Will Art Therapy Be as a Profession 25 Years from Now?

Cay Drachnik, MA, A.T.R., MFCC, HLM

Cay Drachnik was a past president of the American Art Therapy Association (AATA) and served on AATA's Boards for Governmental Affairs, Standards, Ethics and Professional Practice, Long Range Planning, and Nominating Committees. As a founder and charter member, vice president, and honorary life member of Northern California Art Therapy Association, she served as its legislative representative for four years.

Cay was also a founder and charter member of the California Coalition of Creative Art Therapists.

Cay obtained a BS from the University of Maryland, and graduated with honors. She holds a California Art Teaching Certificate and an MA in Art, with emphasis in Art Therapy, from California State University, Sacramento, California (CSUS). Cay assisted Don Uhlin, PhD, A.T.R., in founding the art therapy program at CSUS and taught art therapy courses at CSUS and at University of Utah. Currently she is on the staff of the College of Notre Dame, Belmont, California.

Cay was appointed by Governor Reagan in 1975 to the State of California Health Facilities Advisory Board where she helped draft regulations for all the licensed health facilities in the state, while protecting regulations concerning art therapy. She worked on licensing for art therapists in California and she, Honey Rawlinson, and Bobbi Stoll (current president of AATA) were the first three art therapists to be licensed as MFCC's in California.

Cay worked as a clinician at Psych West Counseling Center for 18 years until county funding was cut and the clinic closed June 31, 1993. She supervised students, worked in private practice, and consulted with schools and agencies in the Sacramento area. She has lectured widely, written about art therapy, and her manual, "Interpreting Symbols in Children's Drawings," is to be published in 1994. Currently, she is consulting in art therapy and winning awards for her watercolor paintings. She is listed in a number of "Who's Who's," among them, "Who's Who in the World" and "Who's Who Among Human Services Professionals."

I was not one of art therapy's founding mothers; however, I did enter the field early-on and have devoted a great many years to my chosen profession. As I have watched our field grow, I have been proud of our progress, but at the same time I have been concerned about its future.

I believe that 25 years from now art therapy will either have ceased to exist as a separate profession or it will be an even more vital, exciting, and dynamically functioning profession. It will depend on how progressive our leadership is and how hard we, the members of the AATA, are willing to work to keep our organization on track. It also depends on how smart we are politically and especially how we, as members of the organization, work together.

I feel we have some especially far-thinking, brilliant, and talented members and that we are doing the right things, but we are not doing them fast enough. With national health care breathing down our necks, we should by this time have our certification examinations in place. Yet there were some members of our organization who saw no reason to speed up this process. I realize that changes should not be made hastily, and our membership should be educated about new proposals, but to set no time limit for implementing important policy changes means that we may be left behind in the end. Credentials, I believe, are vital to our survival. It gives credence to our educational programs and demonstrates to other health professionals and legislators our competency to practice.

Another roadblock to survival is numbers. We have only about 4,000 members, while other health professionals have organizations with 30, 40, and 50 thousand members. For about 14 years, the AATA has been associated with the National Coalition of Arts Therapists Associations (NCATA), composed of music, dance, drama, and poetry therapists. One problem with that group was that we had different levels of terminal education. Dance and art require a masters degree, while Music requires only a BA. Poetry and drama function more or less as modalities, their members having mostly degrees in related mental health fields but additional course work in drama or poetry. There are, to my knowledge, no masters degrees in poetry or drama therapy. Supposedly, we were to work together on legislative issues, and for a while, we did. Together, we had 10,000 members which we thought would make an impact.

However, the Coalition began to fall apart when, in 1991, the National Association of Music Therapists mounted independent legislation on behalf of music therapists in the Older American's Act. When writing about the coalitions in the Fall 1993 AATA Newsletter, Bobbie Stoll (our current president) stated, "There seems to be ongoing distrust of, or at least resistance to, full cooperation and collaboration. . . ." She goes on to say, "it will be time for the AATA to very seriously evaluate our investment versus the value received. . . ."

I personally feel that the time has come to leave the NCATA and to explore going under the protective umbrella of the American Association of Counselors, which has approximately 60,000 members, is located in Alexandria, Virginia (the outskirts of Washington, D.C.), and has a number of divergent counseling groups, such as vocational counselors and rehabilitation counselors associated with it. It has experienced lobbyists, and with its large membership, a far more powerful voice in Congress than the 10,000-strong NCATA. Also, we already have some common ground with this group. In states where art therapy is considered an equivalent degree by licensing laws, art therapists are usually licensed as counselors. The exceptions are in New Mexico, where art therapy is listed as a *degree title* under a generic licensing bill, and California, where art therapists can be licensed as Marriage and Family Counselors, but *only* if they complete *all* the required courses for marriage and family counseling. The American Association of Marriage and Family Therapists made it quite clear to us during our struggles in California that they did not want art therapy listed as a degree title under their licensing law. Historically, I should point out that art therapy, along with at least a dozen other degree titles, were considered equivalent degrees and were allowed to take the California MFCC licensing exam until 1985. Then, most of the degree titles were legislatively eliminated. This could happen in all other states where art therapy currently is listed as an equivalent degree. There was no counseling or generic counseling licensing law in California at that time, so art therapists had no other option if they wanted the benefit of a license.

While I was president of the AATA, Linda Gantt, Ed Stygar, and I went to Alexandria, Virginia, and explored with the American Association of Counselors the idea of joining their association. At that time they welcomed us. But there were certain disadvantages, such as setting up our national office in Alexandria under their auspices, and, also, at the time we were already committed to NCATA. However, we felt this alliance should be looked into at a later date.

I now feel this later date has arrived. Many art therapists work as counselors, but many also work as activity therapists in hospitals or other facilities. However, many activity therapists would like to eventually be in private practice and receive reimbursement from HMOs, PPOs, or whatever the new health plan would designate. Now, in most states, only licensed therapists may receive such reimbursement. We, as art therapists, need to be included in the new health plan and we will need reimbursement, otherwise others, less knowledgeable in art therapy will be taking over our jobs. If we have a powerful organization such as the American Association of Counselors behind us and an examination to demonstrate our competency, then licensing in all states should be available to art therapists.

With such a scenario, I most certainly see art therapists and our organization thriving 25 years from now. We will be serving those that need us—especially the children of this world. We have something unique that we know works, and we must see that it continues to benefit mankind.

Art Therapy in the 21st Century

Frances E. Anderson, EdD, A.T.R., HLM

Frances E. **Anderson** *is a founding member of both the American and Illinois Art Therapy Associations, the first AATA Regional Standards Chairperson for the Midwest, and has served on numerous AATA committees over the past 25 years. A member of the committee that founded* Art Therapy: Journal of the American Art Therapy Association, *she has served on its Editorial Board since its inception in 1983. In 1992, as publications chair, she oversaw the publication of AATA's first monograph:* A Guide to Conducting Art Therapy Research. *She has just completed six years of service on the Education and Training Board.*

She received her BA degree in Art and Psychology from Agnes Scott College, Decatur, Georgia, and her Master's and Doctoral degrees in Ceramics and Art Education from Indiana University, Bloomington, Indiana. Dr. Anderson taught ceramics and craft design at the University of Tennessee, Knoxville, prior to joining the Art Department faculty at Illinois State University in 1970. She has authored 40 articles, three chapters for books, 11 monographs, and eight books. In 1991, Dr. Anderson was the 16th faculty member in the history of Illinois State University to be named Distinguished Professor.

Dr. Anderson has participated in 22 AATA national conferences and has given 12 keynote addresses at related conferences here and overseas, as well as participating in over 200 workshops, panel discussions, and presentations. An exhibiting ceramic artist and photographer, her artwork is represented in galleries and collections throughout the United States and in Australia and China. Dr. Anderson has been a Visiting professor at the University of Illinois; the University of Arizona; Boston University; College of Notre Dame; Bunting Institute of Radcliffe College (Harvard University); the University of Texas, Austin; Burwood College, Melbourne, Australia; and Florida State University. She also teaches courses for five graduate art therapy training programs around the country.

For the past 25 years, Dr. Anderson has worked with children with disabilities. In 1978, based on this clinical work with children, she published Art for All the Children, *with a second edition of this seminal work published in 1992. Early this year, her eighth book,* Art-Centered Education and Therapy for Children with Disabilities *was published by Charles C Thomas.*

Dr. Anderson also has had 35 grants funded including, most recently, five grants that have supported her work with incest survivors including a newly completed, year-long outcome study of using art therapy in the treatment of incest survivors. Two grants from the Illinois Arts Council have supported both the publication of a monograph (Courage! Together We Heal) *and a videotape documenting her approach to the treatment of incest survivors. One of the outcomes of these grants has been the production of several clay murals composed of messages of terror, rage, and hope from the clients.*

There are trends and issues today which will greatly impact on art therapy in the next century. I want to identify these issues and make a case for addressing them now because if we do not, the field of art therapy will be substantially diminished in the future.

Need to Affiliate with Other Professional Mental Health Associations

The membership of AATA is about 4,000, a very small number. We need to form strong coalitions with other related professional organizations. One of the largest groups that offers such an arrangement is the American Counseling Association. This group permits affiliations with other groups while allowing each group to maintain their own identity and autonomy. This and other similar affiliations may well be one of the only ways that art therapy can acquire the political clout needed to survive in the 21st century.

Expanded Job Opportunities

Today, the two largest employers of art therapists are the Miami, Dade County Public schools, which employ 15 art therapists, and Napa State Hospital in Sonoma, California, where 14 art therapists are employed. I predict that the trend toward greater employment of art therapists will continue (in spite of the current money crunch). The public schools will continue to be inundunated with children with serious emotional disturbances. The numbers of children with fetal alcohol syndrome and with addiction to crack and other drugs will continue to increase. Already public schools are struggling to deal with students with all kinds of disabilities. A part of this struggle surrounds a growing trend in special education called *inclusion* (Anderson, 1994). Inclusion advocates the placement of all children, regardless of the nature or severity of their disability, into regular education classrooms. Special services for these children will be provided by special consultants. If the schools do not already have art therapists on staff, art therapists could become one of the groups of consultants needed to provide educational services.

Now is the time to demonstrate to special educators at all levels the benefits that art therapy offers not only children with emotional and behavior problems, but all children with disabilities. And how can this be done? One way is to lobby for a special classification category at the state level so that students trained as art therapists do not also have to have a state-issued teachers certificate before they can work in public schools. Occupational, physical, and speech therapists already have this special designation. It is time for art therapists to be so designated.

Documentation/Justification of Art Therapy

We need research that documents what we as art therapists know about the power of art to heal, motivate, and remediate the emotional, physical, and educational problems of children with disabilities. To generate this kind of research we need to address the issue of providing the skills so that art therapists can conduct this research. This research must include other methodologies besides the case study method. Further, art therapists need the skills to comprehend, critique, and analyze research done in related fields that can enhance our field. In 1981, Very Special Arts in Washington, D.C. invited me to conduct the first comprehensive literature review of all the published studies in all the arts for children with disabilities (Anderson, Ash, & Gambach, 1982). We examined over 400,000 articles and identified 52 studies that met the project criteria (studies that were experimental and resulted in hard data). Of this number, 19 were visual arts studies. In 1983, I analyzed these studies and noted some of the issues that art therapy needed to address (Anderson, 1983).

> Art therapists believe strongly that art is a major means of treatment. The profession must document this belief in terms that laypersons and scholars from other disciplines can understand and accept. If art therapists lack the research skills and training to do this kind of investigation, then it is important that they acquire this expertise or interest scholars and researchers from other disciplines in collaboration with them to do the needed research. (Anderson, 1981)
>
> There is also a gap in systematic research in most studies being undertaken in art therapy. This research is necessary to provide standardized information for building the knowledge base of art therapy and for replication of important studies. With this need in mind it is interesting to note that the most widely used form of research reporting, the case study, has no generally accepted, systematic format for conveying information. . . .
>
> If art has value as a treatment modality, and if this value is supported by evidence obtained from case studies, then the use of art as a treatment and assessment tool will stand the test of other types of research methods. Art therapists must begin to use other research methodologies, in addition to the traditional case study, if they are to expand knowledge and justify the discipline to scholars and policymakers outside the field. (Anderson, 1983, pp. 37 and 38)

Well, we are not yet there. For the past two years I have been engaged in updating this literature review to cover the period between 1981 and 1992. A perusal of over 400,000 articles in the ERIC and PsyInfo Data bases (and hand searches of journals) have identified 60 studies in the visual arts which met the criteria of empirical research resulting in hard data (Anderson, Kolano, & de la Cruz, 1993). There were only five reports which could be considered outcome studies documenting the benefits of art therapy. One of the largest grouping of studies was on projective drawing techniques. This body of research shared many of the problems identified by Neale & Rosal (1993) in their analysis of 17 studies on projective drawing techniques with children. They noted a failure of many of these studies to cite related research, the inconsistent reporting of criteria used, and often inadequate reporting of statistical analyses of the data. Six of the 17 studies were authored or co-authored by art therapists. So, although other researchers also are remiss in their reporting, this does not exonerate our field.

What concerns me is that some research is being done in a largely naive manner without solid research training. For example, the field needs valid and reliable art-based assessments. But before art therapists go out and reinvent the wheel, we must be aware of what has already been done not only in our field but in related fields of psychology, art education, anthropology, medicine, sociology, and criminal justice. We also need to have an understanding of psychological assessments, including statistical knowledge and a thorough comprehension of how assessment instruments are constructed, field tested, and refined (i.e., made reliable and valid). To date, our field has not adequately addressed this problem partly because many of our educational programs do not place a priority on this type of training, and partly because so many other areas need to be addressed in a Master's level course of study.

Without an understanding of both qualitative and quantative research methodologies, art therapists cannot fully understand those research studies that employ such methodologies. Therefore, the possibility exists that the research conducted in art therapy may indeed be "reinventing the wheel," instead of building on work that has already been done. I am not advocating that art therapists be research experts. I am advocating that art therapists be trained sufficiently in a range of research methodologies (including basic statistics and psychology of assessments) so that they can cogently read the literature both in art therapy and in related fields.

If we cannot justify what we do in a systematic way using a variety of research methodologies, then our future as a profession is not very bright. The way art therapy will be healthy and thriving in the 21st century will be intimately tied to this justification question. We believe in what we do—but that may not be enough because we are often funded by agencies and enterprises that will demand more evidence than a strong belief in the art therapy process.

References

Anderson, F. E. (1994). *Art-centered education and therapy for children with disabilities.* Springfield, IL: Charles C Thomas.

Anderson, F. E. (1992). *Art for all the children: Approaches to art therapy for children with disabilities.* Springfield, IL: Charles C Thomas.

Anderson, F. E. (1983). A critical analysis of A *review of the published research literature on arts for the handicapped: 1971–1981, with special attention to the visual arts.* *Art Therapy: Journal of the American Art Therapy Association, 1*(1), 26–39.

Anderson, F. E., Ash, L., & Gambach, J. (1982). *A review of the published research literature on arts for the handicapped: 1971–1981.* Washington, DC: National Committee: Arts for the Handicapped.

Anderson, F. E., Kolano, M., & de la Cruz, R. (1993). *A review of the published research literature on arts for persons with disabilities, 1981–1992.* Illinois State University, Normal, IL.

Neale, E. L., & Rosal, M. L. (1993). What can art therapists learn from the research on projective drawing techniques for children: A review of the literature. *The Arts In Psychotherapy, 20*(2), 37–49.

Art Therapy in the 21st Century

Helen B. Landgarten, MA, A.T.R., HLM

In 1967 Helen B. Landgarten pioneered art psychotherapy on the West Coast at Cedars-Sinai Medical Center in the Family Child Department of Psychiatry, where she introduced art therapy for diagnosis and treatment. As founder and director, in 1973 she instituted the first Clinical Art Therapy Master's degree program, and is a Professor Emeritus at Loyola Marymount University. She served on the first AATA board and in numerous board positions thereafter, as well as on several committees. She was the sixth person to receive the Honorary Life Member Award. Landgarten is currently a research associate at Harbor UCLA Medical Center, in the Research and Education Institute.

Recognized worldwide for her contributions to the field of mental health, Helen has been invited to lecture and give paper-presentations in a large number of countries. Her biography appears in over 40 national and international "Who's Who" directories.

The following books are among her long list of publications: Family Art Psychotherapy: A Clinical Guide and Casebook *(1987);* Clinical Art Therapy: A Comprehensive Guide *(1981);* Adult Art Psychotherapy: Issues and Applications *(1990), co-editor and chapter author on "Termination." These books have been translated into numerous foreign languages. Her current book,* Magazine Photo Collage: A Multicultural Assessment and Treatment Technique *(1993), has been applauded by therapists from the Asian, Black, Caucasian, and Hispanic cultures. According to Chester Pierce, MD from Harvard Graduate School of Education, it is "well suited for conducting research that should enhance racial amity."*

Helen's paintings, sculptures, and etchings have been exhibited in museums and galleries throughout the country. Aside from lecturing, she continues to contribute chapters on art therapy, most recently for the Handbook of Child Psychiatry *and* Family Play Therapy. *Landgarten continues to paint and writes fictional short stories for relaxation.*

My predictions for art therapy in the next century are contingent upon continued quality Master's degree programs. However, during the 21st century, our profession will blossom because in this century we have prepared fertile ground for future growth. In many states art therapists have planted their seeds in every type of institution that is concerned with individuals' mental health.

I predict that in the future the government will realize that the early prevention of problems is more economical than eventually working with people in clinics and hospitals to solve problems. Already, art therapy has been instituted in a number of public school systems. In the future, the federal government will mandate that art therapy be placed in all the public schools, from elementary through high schools, since, in relation to purely verbal therapy, it is less threatening and less stereotyping for the children who attend.

Art therapists have always been able to acclimate their skills to treat whatever diagnosis is currently popular. For instance, during the last 10 years a great deal of attention has been paid to the following diagnoses: post traumatic disorder, drug and alcohol abuse, anorexia nervosa, and bulimia nervosa. Recently, the limelight has been on multiple personality disorder, sexual abuse, and attention deficit disorder. As time goes on people in our profession will continue to adjust their practice to "new" or "renewed" disorders as they take center stage.

Outpatient work in clinics and private practice will grow in strength. We now have a collection of worthwhile publications that educate practitioners from various related fields. At one time, clinicians from other disciplines were leery of "those art therapists," where now, we are frequently embraced.

Medically related work will thrive because the health care providers will find it economically sound. They will see that art therapy, combined with a physician's treatment, will reduce the recidivation rate. Further, the current trend toward "outpatient surgery" will undoubtedly continue leaving some patients feeling neglected if they believe their recovery should take place inside the hospital. For such patients, a set of art therapy sessions would help to prevent them from feeling abandoned and encourage a more positive attitude toward regaining their health.

There are many innovative and current surgeries such as organ transplants and lengthening limbs of dwarfs that result in dramatic body changes. In such cases patients should receive art therapy because their mental adjustment to a new body image is essential. Although some surgeons may not want their patients treated by a therapist, they are beginning to see that without this dimension, the physical results of surgery may be a success, but the patients' postsurgery disappointments and depression may hold them back from enjoying their positive physical results. Along these medical lines, pain centers will use far more art therapists in the future. Insurance companies will recognize that helping persons cope with pain through art therapy is cost-effective because repeated doctor visits will lessen.

Alternative medicine is slowly, but continually, gaining more ground, and in the 21st century, it is possible that it will become an accepted and standardized mode of treatment. Art therapists who already are engaged in this philosophy will be at a premium.

Court evidence regarding art products is beginning to be recognized. Numerous art therapists (in different states) are testifying as "expert witnesses." The utilization of these services by lawyers will increase.

The health care providers will recognize that it is cheaper for them to pay for family art therapy (when appropriate) than to treat each family member individually. Art therapists trained in this direction will find that their private practice is vastly increased.

There will be a continuance of group therapy, since this modality is cost-effective. The popularity of thematic treatment that deals with people who suffer like-symptoms or like-circumstances will increase. In the 21st century, as the world experiences new types of illnesses, lifestyles, and traumatic events, art therapy will flourish because it can be catered to fit into any type of future caseloads.

Currently in the 1990s, a big search is on for the "inner child." In the late 1990s, undoubtedly the hunt to find the "adolescent" will be popular. During the next century, art therapists in private practice will be doing their part to help people *finally* grow up and gain greater satisfaction from life by climbing into "adulthood." These art therapists will give their clients "hope," by encouraging them to give up past expectations and grief, not from real losses, but from what was lost in their fantasies. The slate will be wiped clean. Clients will begin therapy by drawing what is both positive and possible for their life from now on. Therapists will help clients look for, and examine, their positive role models in order to be motivated and to integrate some of these characteristics into their realm of being. As someone once said, "if you don't have a dream, then how can it come true?" I would like to alter that to, "if you don't have a good role model, then how do you know how to aspire to a greater life."

Art therapists who adhere only to the Freudian, Jungian, Adlerian, or any other theory will find that they will fuse these schools of thought to match the needs of the times. The hardcore clinicians who refuse to advance and stay loyal to their ancient theories will become therapeutic dinosaurs. Already changes are taking place; for instance, the therapy word "eclectic" originally had a pejorative flavor. It was believed that art therapists, who indulged in a combination of theories did not have a solid psychological frame of reference and, thus, resorted to treating their clients in a variety of ways. However, the word "eclectic" has been replaced by "integrative," and is accepted as a means of treatment.

Now, in the 1990s our profession is appearing everywhere as an accepted means of treatment. Art therapy has been recognized by the media; it is often discussed in the newspapers across the country and on television newscasts as a crisis intervention mechanism, and as a diagnostic and healing instrument. A number of movies both in the theaters and on videotapes show a protagonist in the art therapy process. I have discovered our work in novels; even the soap opera, *Santa Barbara*, displayed the books "Clinical Art Therapy" as a prop on a doctor's desk.

Pessimistic art therapists are our most serious enemy because their negative attitude is a self-fulfilling prophesy. They should not be allowed to contaminate our future in the 21st century.

I am optimistic about our profession; for what we have sown in this century will be reaped in the next century. Art therapists, THE BEST IS YET TO COME.

To Be or Not To Be

Myra F. Levick, PhD, A.T.R., HLM

Myra F. Levick postponed pursuing her own art career education to work while her husband, Leonard, was in medical school. In 1958, when their third and youngest daughter was in second grade, her husband encouraged her to resume her studies. She obtained a Bachelor of Fine Arts degree from Moore College of Art in Philadelphia. While planning to continue graduate study for a Master's degree in the History of Art, Dr. Levick became intrigued by the idea of working in the psychiatric unit at the Albert Einstein Medical Center, a *general hospital in Philadelphia. The late Dr. Morris Goldman was the director of this unit, the first unlocked ward in a general hospital, and was convinced of the value of having an artist work with mentally ill patients. While Dr. Levick employed her art skills in working with the patients, she also studied psychiatry and psychology, obtaining a Master's degree in Educational Psychology (MEd) from Temple University in Philadelphia.*

During 1963 and 1967, Dr. Levick, Dr. Goldman, and Dr. Paul J. Fink, a psychoanalyst on the Einstein staff, published journal articles about their experiences in art therapy, stimulating the interests of art students, art teachers, and practicing artists in the area to pursue training in this growing field. In 1967 Dr. Fink, then director of education in the Department of Psychiatry at Hahnemann Medical College & Hospital, and Dr. Goldman, then director of the Hahnemann Mental Health Community Center, received approval for developing a graduate art therapy program in that institution. Dr. Levick was invited to join the staff, develop a course outline, and coordinate this first graduate program in art therapy, actively training students in didactic and clinical work.

Attracting the interest of practicing art therapists all over the country, a guest lecture series was sponsored by Hahnemann in 1968. This led to the establishment of an ad hoc committee to form the American Art Therapy Association. In 1969, in Louisville, Kentucky, the AATA became a fact and Dr. Levick was elected its first president. She continued to broaden her knowledge, studying family and group psychotherapy while continuing her academic position and private clinical practice. In 1974, she became a licensed psychologist to practice art psychotherapy in Pennsylvania.

In 1976, Dr. Levick was asked to design and coordinate a program at Hahnemann to provide training for art, dance/movement, and music therapists. Initially supported by a three-year grant from the National Institutes of Mental Health, this became the model program for training creative arts therapists together in a graduate program within a medical school. Dr. Levick was named director of the program, the Master's Creative Arts in Therapy Program (MCAT), and became a professor in the Department of Mental Health Sciences and in the medical college.

In 1982 Dr. Levick earned a PhD in education and child development from Bryn Mawr College in Pennsylvania. In 1984, she resigned from her position as director of the MCAT program to continue writing, and in 1986 retired, maintaining her current position as professor and consultant to the program. Dr. Levick published numerous articles in journals here and abroad and wrote two books, They Could Not Talk and So They Drew *(1983) and* Mommy, Daddy, Look What I'm Saying *(1986). She is editor-in-chief emeritus of* Arts in Psychotherapy, *an international journal.*

She now lives with her husband in Boca Raton, Florida, where, in December 1993 they celebrated their 50th wedding anniversary. Enjoying the freedom to paint again, she also continues to write, lecture, maintain a small private practice and teach psychology for the New York Institute of Technology on the Lynne University campus in Boca Raton.

Twenty-five years ago the American Art Therapy Association was born. And I was one of the midwives. As the association grew, this initial role became broadened to include positions on the Executive Board, from president down, and subsequently serving on several committees. Given this longstanding relationship, I was naturally very pleased to receive Cathy Malchiodi's invitation to write a response to her question "How Will the Profession of Art Therapy Change in the Next 25 Years?—What Is Your Vision of the 21st Century Art Therapist?" I am still pleased to have this opportunity, but as I began to formulate my answer, the realization dawned on me that this is really two questions. As you will see, these two questions evoke more questions. I consider it nearly impossible to even suggest how the profession will change over the next quarter of a century. And the vision I have for the next century, at this point in time, remains a wish. So faced with these ambiguities and limited space to cogitate about them, I focus this presentation on the training of the art therapist as I see it now, and how that impacts on the role of the art therapist in the field of mental health now and in the future.

The view that we maintain "quality in training" (Levick, 1978, 1989) is by no means mine alone. There are so many professional art therapists who are strong advocates for high standards of training and practice. Again and again the officers and directors of the AATA have revised our standards for practice and approval procedures for programs. A Master's degree will soon be a requirement for new professional membership. We have a Credentials Board working toward national certification. But the problem arises from the interpretation of those "high standards of training and practice." Directors of training programs may meet the criteria for approval. Their course offerings and supervised clinical hours appear to be consistent with the requirements of the Education and Training Board.

But there is no consistency! Before you incur umbrage at my statement, I ask for your patience. Bear with me a little longer as I give evidence, not criticism, of how our diversity has fragmented our image. We meet and we do not speak the same language. How is this possible? .

Looking back, I recognize my own readiness to contribute to the current state of our profession. With other midwives and subsequent caretakers, I strongly supported the need for different orientations to make our child strong. That child has grown and multiplied and in some ways bears no resemblance to the original conceptualization of the nascent art therapist. Art therapists who, regardless of orientation, see themselves as "professionals, regardless of license or ability to prescribe medicine, having the same moral obligations to the people we treat as any professional in the field of mental health" (Levick, 1979, 1989). Above, I noted we often speak a different language; I was confronted with this contretemps several years ago while working on a project with Janet Bush, Director of the Clinical Art Therapy program at Dade County school system. In another paper, (Levick, 1989) I discuss this project in some detail. For here, let me say briefly, Janet was charged with developing an art therapy evaluation instrument for the then 11 art therapists on her staff. She engaged me as the consultant to this project, using my work on cognitive and emotional indicators manifested in children's drawings as a basis for what is now known as the *Levick Emotional & Cognitive Art Therapy Assessment* (Levick et al., 1989). It was only a few short months before we realized that to move forward, we needed to retreat and teach the staff a theoretical construct only a few were even a little familiar with. It is important to report that in doing this we emerged as a small cadre of highly trained art therapists, not only able to speak the same language, but also able to communicate this knowledge to colleagues from different disciplines in the school system.

There are many examples that could be cited to describe where, what was at first glance a difference in orientation, is in fact a fragmentation of a singular concept. I have come to know the many faces of art therapy in practice. But now there are new faces that, in addition to speaking differently, bear little resemblance to the images I know of art therapy as a therapeutic process in mental health. Nowhere have I felt this more acutely than at the AATA conference in Atlanta.

The theme of the conference was "Common Ground, the Arts, Therapy, Spirituality." This immediately suggests to me that there is a question regarding the relationship between the arts and therapy and something else, spirituality, that heretofore had not been identified in the process of art therapy. I had naively believed that after 24 years, we recognized that art as therapy and art in therapy were equally valid approaches insofar as the needs of our patients were met. And this raises another question. Are we training our students to recognize the needs of our patients? Some of what I saw and heard in Atlanta appeared to meet and gratify the needs of the therapist, not the patient. But now another separation appears on the horizon, with yet another dimension to incorporate. The very compellation of our field, art therapy, signifies an irreproachable relationship between the arts and therapy. Yet, there are those among us who would add something else, abstract and highly personal, when we are still unable to come together on basic theoretical constructs. In looking at the AATA program in Atlanta, it is interesting to see that some presenters totally ignored the theme, discussing familiar topics in old and new ways, while others totally embraced it in an ingenuous form, an artless form, or instinctive form. This dichotomy continues to reinforce the division in our ranks.

But the most revealing and disturbing experience for me was listening to our keynote speaker, James Hillman, and then leading a discussion group on his presentation. Hillman is brilliant, provocative, and curiously ambivalent about his own teachings. It is not the intent here to critically review Dr. Hillman's words, but rather to try to convey his message and the impact it had on many who heard him. Because of my role as a discussion leader, I took copious notes. While what I refer to is obviously taken out of context, I make every effort to maintain the spirit of his speech. On the one hand he spoke eloquently of the difference between criticism of art versus the interpretation of art: Plato versus Freud. We all agreed he did not approve of looking at art and translating what's there into what is not there. His discussion of good form in art reflecting that the artist was in good shape and that this is the primary task of the soul was esoteric and sometimes difficult to follow. But the message was clear—interpretations, vis á vis art therapy, is not acceptable. This was not fair. Responsible art therapists do not interpret artwork. They make connections and facilitate their patients to make these interpretations, if that is the goal for that patient. And in the middle of these dynamically presented maxims was the statement that, consistent with the medical model he denigrated, we retain the title of therapist for ourselves and patient for the people we work with. He treats "patients" who are suffering and have pathology. He sees the title "client" as a power word (Hillman, 1993).

I presume James Hillman was invited because he is a well-known, controversial figure, into soul, and suggests we hold on to some piece of the medical model that helps us identify ourselves, while engaging in a therapeutic process that releases "imaginative possibilities" (Hillman, 1993). And most of the people that heard him were awed and inspired. When I asked how we could translate what he said into practical application, the impression was that all one needed to do was "listen to the paintings." Psychotherapy as a basis for art therapy was definitely out. And there were other presentations that awed and inspired the younger people that were present. They were titillated by ideas that have little to do with the practice of art therapy. These ideas are magical and mystical and spiritual. They distort our identity and confuse our colleagues from other disciplines in mental health. THEY CAST SUSPICION ON OUR PROFESSIONAL INTEGRITY.

We are not alone in this search for identity. Psychiatry as a field and psychiatrists have been struggling to redefine their problems and reconceptualize their domain in mental health (Michaels & Marzuk, 1993). In the conclusion of two lengthy articles on *Progress in Psychiatry*, Michaels and Marzuk refer to psychiatry as "the battered child of medicine, born in witchcraft and demoniacal possession." They go on to say "the battered child has been transformed by a tumultuous adolescence into a vigorous and successful young adult" (Michaels & Marzuk, 1993). In 1974, I gave the commencement speech to the first graduating class of art therapists at Eastern Virginia Medical School. For that speech I wrote an analogy of the training of art therapists to the first six stages of man from the Eight Stages of Man developed by Erik Erikson (Levick, 1977). In the 6th stage, intimacy and solidarity versus a sense of isolation, I consider the graduating art therapist in the adult stage professionally, having survived the preceding chaotic period (of adolescence in training) and the search for identity as an art therapist.

At age 25, like the psychiatrists, art therapists are young adults. But as for all young adults, that is just the beginning. How will the profession of art therapy change in the next 25 years? The answer is the reader's response to my question: Are we to be or not to be art therapists? To be, we must truly become adults. We must take professional responsibility for reconceptualizing our role in the field of mental health. We must redefine our training objectives, learn a common language, and require accountability of our members. From this sound structure, we must build unique and individual styles of treatment. My hoped-for vision of the 21st century art therapist is that of a respected member of the professional force who treats those young and old individuals in society suffering from some form of mental illness, and who respects the creativity in each of us.

References

Hillman, J. (1993, November). *You can't fix it—and besides it ain't broke.* Paper presented at the AATA 24th Annual Conference, Atlanta, GA.

Levick, M. (1977). The creative arts therapists: Their stages of development during their professional training—an analogy. *The Arts in Psychotherapy, 4,* 3–4.

Levick, M. (1989). Reflections: On the road to educating the creative arts therapists. *The Arts in Psychotherapy, 16,* 57–60.

Levick et al. (1989) *Levick emotional & cognitive art therapy assessment.* Miami, FL: Dade County Public Schools.

Michaels, R., & P. M. Marzuk. (1993). Progress in psychiatry. *New England Journal of Medicine,* 329(8), 552–558.

Art Therapy in the 21st Century

Shirley Riley, MA, A.T.R., MFCC, Recipient of the 1990 Clinician Award for Family Services

A long time ago, as starts all the fables, I was my parents' daughter, my husband's wife, and my children's mother. That was the baseline of my life. Then life did interesting things to me. One of my sons was born disabled, and so I became an expert on disabilities and how to raise money to help their causes. When my other sons grew up, demonstrated fine abilities and, in due time, the capacity to find wonderful mates, my status shifted in our relationships. My marriage endured the many changes of a long-term relationship and gave me freedom to find a different view of myself as a woman. My art education at UCLA continued to stimulate my need to make art, but it was not enough.

So one day I took daughter, mother, wife, artist, fundraiser, and educator of the disabled into a new arena—that of student. This arena was one that seemed to make all those women happy and able to engage in a kind of art that I had always wanted to produce and which never reached my critical standards. I became an art therapist.

Clinical work became my fascination, teaching and supervising clinical art therapy students became my pleasure, and arranging internship placements satisfied my curiosity about how the world worked with people needing mental health assistance. Therapy felt like the most creative process I ever experienced.

Along the way my clients helped me make theory real, colleagues challenged my notions about therapy, and students made me think more carefully about the field of art therapy. Being involved with the American Art Therapy Association gave me the wider picture and an opportunity to make some contributions.

At this date I can say my family is proud of my clinical and published work, my clients continue to make positive changes, I am still enthusiastic about my choice of art therapy as a career, and I wonder where it will take me next. I've made great friends in our field and ruffled a few feathers, but it's been a wonderful 20 years in the field that was invented, so my fantasy says, just for me. I'm grateful that I have lived during the years that this profession became a respected vehicle for creative work in psychotherapy.

My vision of art therapy in the coming years is opaque. My lenses are obscured because the world in general, and the mental health world in particular, is in a major period of transition. With change comes uncertainty, anxiety, and often a search for a new identity. It is in this area of renewing our own concepts of ourselves as clinicians in the professional world that we must be flexible and without fear.

In this postmodern world where so many basic values and attitudes are being deconstructed, it is to be expected that our art therapy foundations will also be in flux. However, to react to this global instability in a paranoic manner that personalizes the instability as a threat solely to ourselves is unhealthy.

The fear that we entertain, as I see it, is one that is focused on our identity. Intense anxiety is aroused when it is perceived that we may be facing dissolution or absorption into another professionally named group. Many fear this would result in the disappearance of art therapy. The reality points to the fact that what we do, in its many forms and in many settings, has gained respect and is requested by a growing number of agencies and hospitals which include art therapy in their basic treatment planning.

If we are to take our place in the new mental health system we must deal with this fear of a loss of identity. We will not disappear just because we add "counselor" or "MFCC" to our major title of art therapist. Practical solutions are a necessary part of change; psychological change is a personal matter. As a group, I feel, we should not be afraid to test our new ways of naming ourselves. As individuals, I believe, we cannot *not* be art therapists. It is an essential part of our world view and our training which we cannot shed, even if tempted to do so. We do not lose "art therapist" if we add a license to keep us alive.

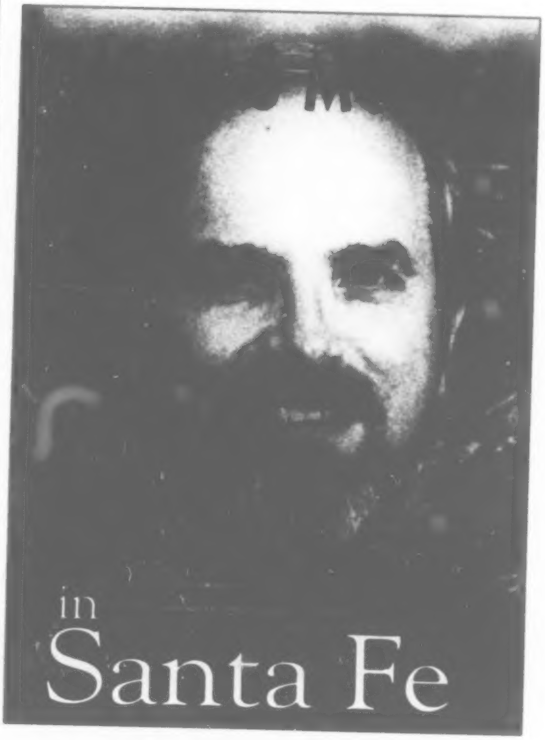
I have been so impressed with the realization that what we do as routine treatment is in the vanguard of most of the current thinking in family therapy. Countless respected theorists are discussing externalization of problems focusing on narratives, discussing families' symbolic knowing, deconstructing or dissolution of problems, and other examples that are too numerous to list here. The striking concept that runs through all of these discussions is the obvious reference to concrete imagery to aid in problem resolution.

Let me give an example. When Michael White and his cohorts help a client-family externalize and "fight the enemy problem," i.e., temper tantrums, encopresis, etc., by imagining the problem as a personality that controls the family, the concretizing of this "problem person" cries out for an art therapy approach. How much easier it would be to fight an enemy that has become real through the art expressions of the client(s). The visualization of the problem adds greater maneuverability to the therapist's plan. The art representation is an intimate, unique look at the "problem-enemy" which invites an attack and uncommon solutions, helping the family to return to a more functional relationship.

This is only one flight of clinical fancy that I had when reading a prominent author in the family field. Everywhere in the literature one can find new exciting ways of conceptualizing treatment; in almost every case the addition of our abilities to introduce the nonspeaking knowing to the therapeutic discourse begs to be utilized. We art therapists in the family field have been illustrating the families' stories for a long time. We need now to share our abilities with other therapeutic disciplines by presenting papers at their conventions and publishing in their journals. Imagine the surprise when psychologists, social workers, counselors, and the like find that we are all doing the same thing! We, too, can appreciate the gender-defined roles, socio-economic pressures as well as the multicultural difficulties stressing our society. The profession of art therapy stands on its own feet with the added strength of the creative, visual process. We are capable of incorporating and joining with theories from other fields and still retaining the magic of turning silent knowing into visible products that invite verbal exploration. How art therapy offers a vehicle to the complex human capacity to know ourselves and our world is a skill that others admire and we proudly offer to the mental health community.

Reaching our 25th year is an entrée into maturity. A developmental milestone that marks our ability to give up attachments to old family myths and rituals and create a new stance toward our profession. Moving away from our family of origin conflicts, while still retaining their strength and pioneering spirit, is an exciting opportunity. I certainly welcome the younger generation who can meet the coming 21st century with courage and the inventiveness of youth. Reinventing the family story of art therapy by preserving the unique qualities and strengths, giving up the conflictual patterns that have repeatedly lead to discord, and inter-marrying with new families with clear boundaries and contractual agreements will lead, I believe, to a healthy future.

My hope is that we become political activists—expansive, fearless, aggressive, and convinced that our true image will dominate any modifications that may be necessary to adopt in order to survive in the new mental health system. We who believe in creativity must be willing to be creative in every way the future presents to us.



SOUTHWESTERN COLLEGE presents a day with Thomas Moore at our Thirteenth Annual Transformation and Healing Conference in beautiful Santa Fe, New Mexico. Author of best selling titles, Care of the Soul and Soul Mates, Dr. Moore will focus on the "re-enchantment of every day life" in this keynote presentation. We invite you to join us in exploring ways to spiritualize life and bring greater meaning to our existence.

August 27th, 10:00 am to 5:00 pm $65

For reservations and further information on this and other offerings of Southwestern's Transformation and Healing Conference, please call or write.

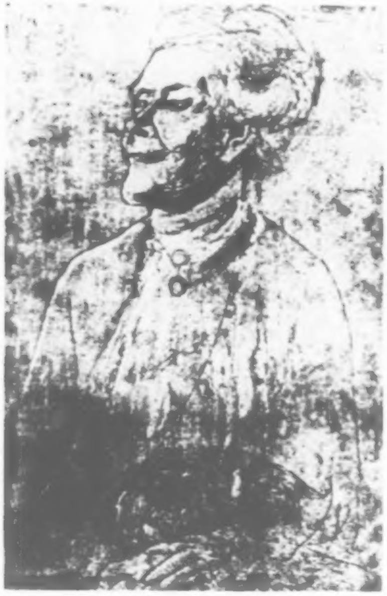
SOUTHWESTERN COLLEGE
P.O. Box 4788 • Santa Fe, NM 87502
(505) 471-5756

GALLERY

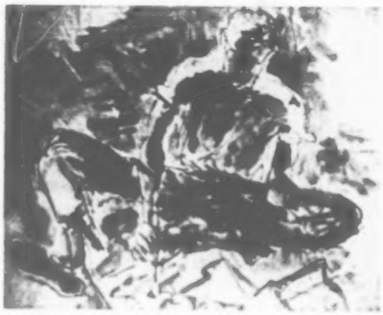
drawings by Rawley Silver, EdD, A.T.R., HLM

Artists, Poets, and Other Writers

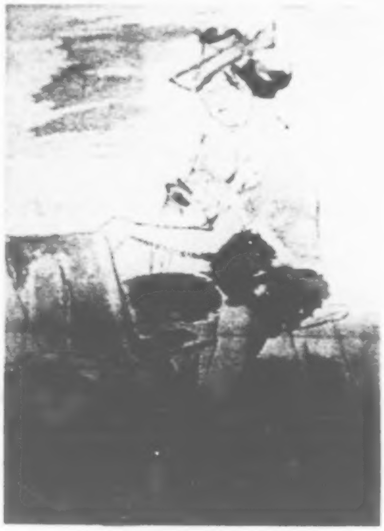
Who is an artist?
Who will agree
on Mary Cassatt



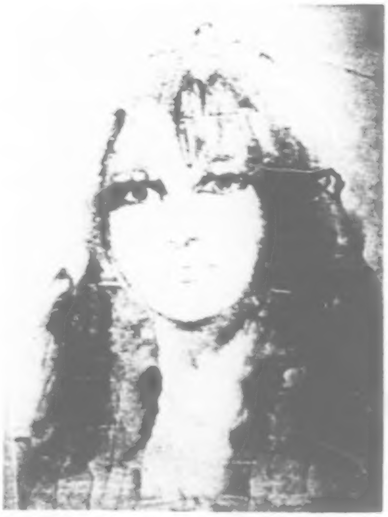
or Robert P.?



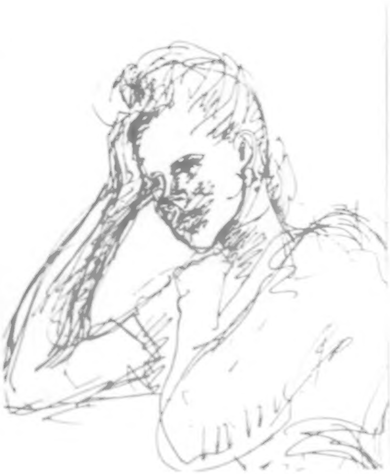
Alice N.



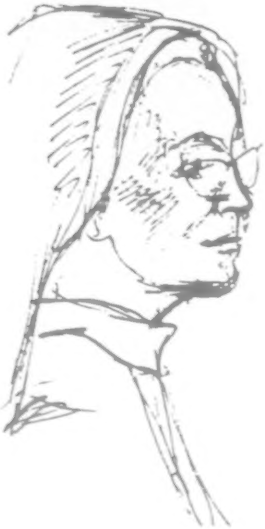
or Ellen K.?



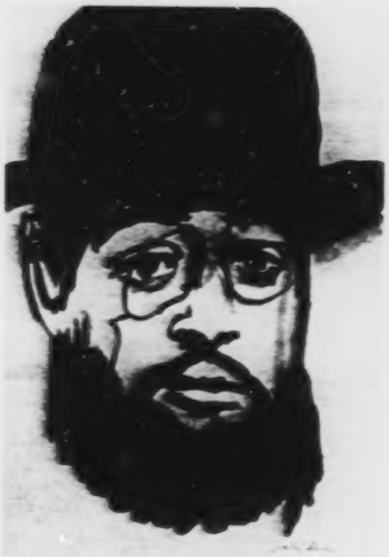
Gracie P.



or Sister J.?



Toulouse L.



or Tania K.?

Niru T.?

JoAnn O'B.?

or those who practice Therapy?

Art Therapy: Journal of the American Art Therapy Association, 11(2) p. 104 © AATA, Inc. 1994

Introduction to Special Section on Art-Based Assessments

Cathy A. Malchiodi, MA, A.T.R., *Editor*

This special section of *Art Therapy* focuses on research in the area of art-based assessments. The first part of this section highlights research and recent developments in the use and application of the Diagnostic Drawing Series (DDS), featuring an introduction to the assessment (Cohen, Mills, & Kijak), research on organic mental syndrome (Couch), indicators of trauma in tree drawings (Rankin), applications to child populations (Neale), and research with eating disorders (Kessler). The second part of this section features the research of several art therapists who are exploring the application of art in the assessment in a variety of ways, including the use of diagnostic drawings with Alzheimer's subjects (Knapp), relationships between art expression and alexithymia (Heiman, Strnad, Weiland, & Wise), and connections between imagery and anger (Kaplan).

This brief introduction cannot cover the multidimensional aspects of the development and current trends in art-based assessments in the field of art therapy. However, readers who wish to know more about this topic are referred to a comprehensive description and history of art-based assessments presented in *A Guide to Conducting Art Therapy Research* (Wadeson, 1992) in a chapter by Linda Gantt (1992). Gantt traces the historical precedents of contemporary art-based assessments, identifies areas that have been problematic in assessment in general, and suggests ways that art therapists can contribute to the future development of art-based forms of evaluation.

Two additional chapters in the AATA research guide give a partial listing of art-based assessments developed by art therapists and others (Arrington, 1992; Knapp, 1992). From a quick review of these lists, the use of the term *art-based assessment* may be a misnomer since many of the tasks listed are basically art directives which have the possibility of someday becoming what might be called an "assessment." Also, for many of these so-called assessments, no interrater reliability or extensive validity studies have been conducted, and no reliable scoring systems exist; therefore, readers are cautioned to fully investigate these aspects when formulating an opinion or using them in clinical or research settings. Eventually, these protocols may become bonafide art-based assessments through further research on their applications and through specific attention to the concepts of standardization, reliability, validity, and bias.

Lastly, a commentary on art-based assessments written by Joan Phillips (following the special feature on the Art Therapy Analysis Practice Survey) sheds some light on the inherent problems the field faces in regard to art-based assessments and their use in clinical settings. As a result of her work with the practice survey and the Certification Committee, Phillips concludes that the need for more rigorous investigation of assessment tools in the field of art therapy continues, especially if any of these tools are to be considered part of the overall knowledge base of our discipline. She also observes the ambiguity that art therapists have expressed through the Art Therapy Practice Analysis Survey concerning art-based assessments, noting that although the majority of art therapists see assessment as important, they are not in agreement about what constitutes an art-based assessment.

When thinking about the concept of assessment in art therapy, many art therapists become queasy upon hearing words such as standardization, experimenter bias, statistical analysis, and validity. However, those who are interested in pursuing the development of reliable art-based assessments realize that these and other obstacles must be systematically addressed in order to develop respectable forms of art-based evaluation in our field. Given the inherent qualities of art coupled with the variety of clients and clinical settings, this is a daunting task at best, but also one that offers a great many research possibilities to demonstrate how art-based assessments might be effectively used in the evaluation of specific populations.

Special thanks are extended to Anne Mills, A.T.R., who provided editorial assistance on the DDS submissions and whose research expertise as well as knowledge of art-based assessments was greatly appreciated.

References

Arrington, D. (1992). Art-based assessment procedures and instruments used in research. In H. Wadeson (Ed.), *A Guide to Conducting Art Therapy Research* (pp. 157–178). Mundelein, IL: American Art Therapy Association.

Gantt, L. (1992). A description and history of art therapy assessment in research. In H. Wadeson (Ed.), *A Guide to Conducting Art Therapy Research* (pp. 133–156). Mundelein, IL: American Art Therapy Association.

Knapp, N. (1992). Tabulation of drawing assessments for assessment. In H. Wadeson (Ed.), *A Guide to Conducting Art Therapy Research* (pp. 179–191). Mundelein, IL: American Art Therapy Association.

Wadeson, H. (1992). *A guide to conducting art therapy research.* Mundelein, IL: American Art Therapy Association.

Art Therapy: Journal of the American Art Therapy Association, 11(2) pp. 105-110 © AATA, Inc. 1994

An Introduction to the Diagnostic Drawing Series: A Standardized Tool for Diagnostic and Clinical Use

Barry M. Cohen, MA, A.T.R., Anne Mills, MA, A.T.R., and Adrienne Kwapien Kijak, MSW, A.T.R., Washington, DC

Abstract

The Diagnostic Drawing Series (DDS) is unique among art therapy assessments in that it is a standardized evaluation supported by extensive research. The DDS combines art therapy's attention to materials, task, and process with the research methodology of the social sciences. Not predicated on any one model of art therapy or verbal psychotherapy, the DDS has proven to be a versatile resource for clinicians in the decade since its inception. The DDS, its administration, and its usefulness in clinical practice are described in the context of a structural approach which can be taught effectively to students and enhance accountability to clients and colleagues alike.

Introduction

Issues of identity and survival are of continuing concern to art therapists, as evidenced in the published and audiotaped literature of the field (Allen, 1992; Hodnett, 1973; Jordan, 1989; Kreitler & Kreitler, 1978; Malchiodi, Cattaneo, & Allen, 1991; McNiff, 1992; Mills, 1986; Mills, Dougherty, Rubin, & Schoenholtz, 1992; Ulman, 1961). Although many thoughtful suggestions have been given about what practitioners could do to help ensure the field's future, every art therapist must choose for her/himself those which s/he is willing to implement.

In responding to this call for action, it is essential to recognize and respect the philosophical differences that American art therapy encompasses. For instance, one task that we all share as art therapists, regardless of theoretical approach, is to be "able to explain exactly what it is that we do in a way that is convincing to other professionals" (Malchiodi, 1993, p. 123). A group of art therapists, working in collaboration during the last 10 years, has chosen to contribute to this goal through the development of the Diagnostic Drawing Series.

A three picture assessment tool, the Diagnostic Drawing Series supports the growth of the knowledge base of art therapy by fostering extensive cumulative research (Cohen, 1986b, 1990). For example, studies have been completed that employ large numbers of DDSs to establish norms, or graphic profiles, for different groups (Cohen, Hammer, & Singer, 1988; Couch, 1992; Gulbro-Leavitt & Schimmel, 1991; Kress, 1992; Mills, 1989; Mills & Cohen, 1993; Neale, 1991). The breadth of this work, in addition to other studies currently in progress, spans the continuum from health to illness among adolescents and adults in a variety of art therapy venues. With these findings as a foundation, a clinician can decrease reliance on intuition in the reading of pictures, and make comparisons between clients and among clinical populations with confidence. This approach can promote greater objectivity in assessing client artwork and more clarity in communicating conclusions verbally and in writing.

Use of the DDS and its structural approach can strengthen practitioners' skill in articulating "what it is that we do." The clinical acumen of art therapists is supported when founded on research rather than "the hunches of talented judges" (Levy & Ulman, 1974, p. 25). This systematic approach can be taught effectively to students and can aid art therapists in becoming more accountable to colleagues and clients alike.

The Diagnostic Drawing Series

The Diagnostic Drawing Series was originally developed by art therapists Barbara Lesowitz, Shira Singer, Anna Reyner, and Barry Cohen and tested in the inpatient psychiatric facilities of the Fairfax Hospital Association in Virginia in 1982. The graphic profiles of the drawings in the Series are correlated with concurring diagnoses assigned by psychiatrists and psychologists at the time of the collection of the pictures; it is from this correlation that the name Diagnostic Drawing Series is derived. The original sets of standardized pictures were solicited nationally; the pictures were collected primarily on inpatient psychiatric units within three to five days of admission. The reader is directed to the DDS Handbook for the current research protocol guidelines (Cohen, 1985).

The DDS combines art therapy's attention to materials, process, and individuality with the research methodology of the social sciences. This approach is particularly valued within institutions that emphasize intake, triage, diagnosis, treatment and discharge planning, charting, and medication management (Mills, 1986).

The DDS was crafted according to the assumption that a well-designed art therapy assessment tool should address the following concerns:

Process

- elicit the maximum amount of information in a single brief session, but involve more than one picture (Gantt & Howie, 1979)
- employ materials and techniques compatible with the philosophy and practice of art therapy
- reflect the affective and behavioral changes of the client throughout the session

Organization

- be standardized in all aspects of materials, administration, and record keeping
- include a protocol that controls for medication use and time period of collection (Kramer & Iager, 1984)
- have a standardized rating system with clearly defined structural criteria (Ulman & Levy, 1967)
- be supported by the foundation of normative and other research (Mills, Cohen, & Meneses, 1993)
- have a central clearinghouse for disseminating information (MacFarlane, 1942)

Versatility

- be compatible with the variety of theoretical and research approaches espoused by art therapists
- be comprehensible to a wide variety of mental health professionals
- be useful to clinicians in a variety of ways
- be compatible with medical and psychiatric diagnostic research

Once the Series was designed, a standardized rating system was developed by a group of art therapists headed by the first author. They sought to compile objective, measurable criteria from the literature of art theory, art therapy, and art education (Dondis, 1973; Gantt & Howie, 1979; Kreitler & Kreitler, 1972; Rhyne, 1979). Definitions of such basic terms as *line*, *blending*, *shape*, and *abstraction* had to be created in order to be used as criteria in the rating process. The reader is directed to the rating guide itself for precise definitions of the descriptive art terms used in this article (Cohen, 1986).

Materials and Procedure

The Series employs 12 colors of soft chalk pastels that are flat-sided and have no paper wrappers around the sticks. Alphacolor is a widely available brand that fits this description. A single box may be used for many administrations.

Chalk pastels were chosen because of their versatility of application. They can be used to draw lines with their tips, as well as shapes with their broad, flat sides. They can be used to produce light to heavy pressures, fade to saturated color, and can be blended to create new colors.

The Series requires 18" × 24", 70 lb. white drawing paper with a slight texture, or tooth, to the paper surface (Cohen, 1985). The large format and the good quality white paper communicate respectfulness to the client; the grey paper used in another assessment procedure has sometimes been perceived by individuals as cheap or dirty. The large size of the DDS paper allows variety in the placement of images on the page and tends to amplify unusual scale or compositional relationships between image and page. The tooth allows the art therapist to ascertain how much pressure has been applied with the pastel to the surface of the paper.

The DDS is designed for tabletop administration, since using an easel or wall is not practical in all situations. The association of the easel with art education or lessons can be either beneficial or detrimental in the art therapy context. Clients lacking such formal training seem to feel more comfortable at a desk or tabletop, as it is the typical working space at home, on the job, and for most inpatient art therapy groups.

When the session begins, the client is advised by the art therapist that:

1. s/he may orient the paper in any direction
2. s/he has as long as 15 minutes to work on each drawing
3. s/he will be asked to produce three pictures, one per page, and that the directions for each picture will be given one at a time
4. the pictures will be discussed afterwards, when all three drawings are complete

For the initial (often called the "free") drawing, the client is asked to "make a picture using these materials." When presenting the second sheet of paper, the art therapist directs, "draw a picture of a tree." The final task is to "make a picture of how you're feeling using lines, shapes, and colors." In order to sound less abrupt, some art therapists say, "the instruction for the first picture is to make a picture using these materials," and so on.

Elements of the Series

To understand how each part of the Series contributes to the assessment tool as a whole, we must first look more closely at the nature of each drawing in the Series. Bolander (1977) codifies assessments into several classes with subcategories. One class—gestalt sampling techniques—tests a moment in the life of the artist from the complex whole of his or her personality, illness, transference, mood, and cognitions. Each of the three drawings of the DDS corresponds to a particular subcategory within this class.

The First Picture: Free Picture

"Make a picture using these materials."

The first picture of the DDS is the unstructured task of the Series. It corresponds to the category Bolander lists as "subject free to choose theme; materials supplied" (p. 25). The nonspecific nature of this task can evoke a variety of responses ranging from enthusiasm and spontaneity to resentment and hostility. The resulting drawing may be viewed as particularly significant inasmuch as it functions as a first picture or dream might in therapy (Shoemaker, 1977). From it we may gauge the amount and type of information the individual is initially willing to share. The theme and style of the first picture may be regarded as a graphic representation of the client's defense system.

A simple drawing of flowers in a vase, conveyed by light outlines and the use of several colors, was created as a first picture in the DDS of a mildly depressed woman. In this case, the art therapist might wonder about the woman's use of denial in defending against her depression by using the stereotypic image of flowers. Some clients, in fact, plan a picture before the session (if they have advance knowledge of it) or use an overlearned image from childhood, like a sun, house, and tree schema (Lowenfeld & Brittain, 1975).

The graphic message that is communicated may reflect the coping mechanism that is being employed by the client in response to the stressful request to draw a picture. It also indicates what kind of first impression the client wishes to make. A troubled, intelligent, and highly defended 16-year-old boy drew careful arcs of the colors in a spectrum, beginning with black and ending in red, and explained, "I was just trying out the chalks."

When a client with a history of severe early trauma is overwhelmed or flooded by feelings, sensations, or memories, he or she has lost the ability to modulate internal states and sometimes also behaviors. Often the only option in response to the first picture is a blatantly direct expression of his or her inner turmoil. In her first art therapy session, a woman with a dissociative disorder who alleged she had experienced multi-perpetrator, multivictim abuse made a line drawing of a robed figure holding a knife dripping blood, surrounded by dead babies.

Free pictures range from concrete to abstract, from remote or impoverished to direct and boldly expressive. Content, too, varies in relation to defensive style.

The Second Picture: Tree Picture

"Draw a picture of a tree."

The second drawing is most like the category Bolander describes as "instructions are highly specific" (p. 25). The dictated task as well as the subject of this drawing is especially welcomed by adults who insist they "cannot draw" or "cannot think of anything to draw" in response to the first picture. Defenses seem to quickly lower as a result of shifting to a directive task immediately following the free picture, and so a less guarded response may emerge.

Everyone has seen a tree and most people believe they can draw one; the tree is among the first recognizable images drawn by children (Kellogg, 1970). Not surprisingly, many adults revert to their own preadolescent tree schemas when confronted with this task.

Trees have been studied extensively in relation to projective drawings (Buck, 1948; Hammer, 1958), and it is said this subject matter provides the deepest tapping of the psyche in the realm of projective drawings (Bolander, 1977; Koch, 1952). The tree can be viewed as a symbolic self-portrait, displaying one's vegetative and/or psychic state (Jung, 1967). The inclusion of the tree drawing in the Series constitutes a link with the drawing tests and symbol-based art analyses of the past. As such, it affords an opportunity to reexamine the work of previous investigators. The introduction of colored chalk pastels and the large-sized paper, however, enhances the potential for free, expansive self-expression.

Early DDS research suggested that people diagnosed with schizophrenia often create trees that look most like those of the nonpatient research sample—complete, connected, and recognizable. This finding was particularly surprising in light of traditional notions of the split and impoverished schizophrenic tree (Hammer, 1958; Koch, 1952). This level of integration stood in contrast to the first and third pictures in the Series drawn by these individuals (Cohen, Hammer, & Singer, 1988). Perhaps people with schizophrenia draw visually coherent second pictures because this task is both directive and concrete, suggesting the way a task can structure and organize performance. On the other hand, some nonschizophrenic clients decompensate graphically despite, or perhaps because of, the structure inherent in the directive (Mills, 1988).

It appears that the structure of the task in the second picture elicits strengths in some clients while identifying weaknesses in others. For instance, if individuals diagnosed with borderline personality disorder and post-abuse syndromes draw a tree in the first picture, they often present themselves graphically with a well-organized facade. Within the more structured format of the second picture, however, underlying pathology and disorganization may be revealed by disfigured, falling apart, and floating trees (Cohen, 1989; Mills, 1989; Mills & Cohen, 1993).

A self-mutilating patient diagnosed with borderline personality disorder, who was also artistically skilled, responded to the instruction for the second picture by saying, "Oh, good—*structure*!" She made a drawing that was, at first, unrecognizable as a tree. After a moment it became clear that it was a cross-section of a trunk from an aerial perspective—a view of a tree that had been lopped off. In this case, the structure of the task provided the client with an artificial sense of control that allowed an image reflecting severe disturbance to arise.

Even if a client draws a tree in the first picture, the therapist should still give the proper instruction (i.e., request a drawing of a tree) for the second picture. It is important clinically to observe the difference between two trees drawn by the same client in consecutive pictures within a single series (Creekmore, 1989). In viewing the difference between any first and second pictures, the therapist becomes aware of the interaction between task, process, and pathology.

The Third Picture: Feeling Picture

"Make a picture of how you're feeling using lines, shapes, and colors."

The third picture belongs to Bolander's category of gestalt sampling techniques in which the "directions are specific for theme only" (p. 25). This task allows great latitude of expression for the participant despite the specificity of its wording. Certain clients, when asked to "make a picture of how you're feeling, using lines, shapes and colors," will respond literally to the instructions, drawing some lines and shapes in color. Others, more capable of abstract thought, will draw geometric or biomorphic forms, creating abstractions based upon their feeling states. A third group of clients will draw a scene, still-life, or portrait, reasoning that all images are made up of lines, shapes, and colors. So it is that clients, in response to this instruction, may draw images ranging from abstract to representational, from highly personal to stereotypic or mundane.

Up to this point in the Series, the clients might be performing expressly for the therapist. In the third picture, the request for a depiction of feelings invites the clients first to reflect, then to assert themselves through graphic self-expression. Compared to other drawing assessment procedures, this task is uniquely direct. A straightforward invitation is made in search of a candid answer. Patients are rarely fooled by the artifice of projective tests, which are now part of our popular culture. If we want to know about the patients' experience or self concept, why not simply ask?

The conceptual complexity of this task seems to encourage thoughtfulness and control by some clients on a more conscious level than the second picture. However, the position of the feeling picture as the final drawing of the Series (after a two-picture warmup) also offers the opportunity for emotional release. Clients whose therapeutic issues cluster around intense feeling states, such as individuals diagnosed with affective disorders or personality disorders, seem to welcome this opportunity. These clients lavish what appears to be intense effort on the third picture. A wide range of colors is employed and a high percentage of page space is often used by individuals from both the affectively and characterologically disordered groups (Cohen, Hammer, & Singer, 1988; Mills, 1989).

In addition to providing valuable clues regarding the patient's capacity and willingness for expression on an affective level, this final drawing may show a change in energy level or mood from the initial picture. For example, a recently retired 64-year-old man was admitted for the first time to a psychiatric hospital with a diagnosis of major depression. His first two pictures were monochrome and used little space. His third drawing filled the page with a landscape featuring tiny houses and a huge storm cloud overhead. The progression of formal elements across the pictures in this Series is telling; increase in color and space usage in the feeling picture of depressed patients, while not typical, is clinically noted. The instruction for the feeling picture is purposefully phrased to encourage abstraction and can, therefore, function like a measure of cognitive capacity. Low IQ clients and those with organic brain syndrome may therefore have difficulty with this task, but generally complete the picture nonetheless. Concrete responses or stereotypic images are frequently noted in the third picture by these groups. For example, a moderately mentally retarded 36-year-old woman drew a picture of the hospital bounded by a rain cloud on the left and sun above her on the right, and stated, "I hope the sun will shine on me!"

A related response is seen in the third pictures of psychotic patients and those diagnosed with schizophrenia. In these drawings, words are often used in combination with concrete elements or highly idiosyncratic symbols. Such responses can be attributed to the inability of these clients to identify or express feelings (as noted in individuals with alexithymia), compounded by an inability to translate feelings into abstract images.

This final picture in the Series can also provide patients with an opportunity for closure on the experience of completing the Diagnostic Drawing Series and the material it stimulates. In this case, a picture of how they are feeling might communicate a specific response to drawing the DDS itself.

Special Considerations in Administering the DDS

Although unusual, a client's refusal or inability to complete any picture in the Series represents important information and is a valuable part of that patient's total response. If this does occur, the clinician should simply retain a blank page at the appropriate place in the Series once it has been assembled for storage.

Refusal to complete the first picture is uncommon, and rarely have clients left the session at this point after declining to draw. Even if the first picture is refused, advancing to the second picture is usually possible—probably because it is structured and therefore less threatening—and the remainder of the Series is then completed. It should be noted that refusal of the first picture may signal passive-aggressive or acting-out tendencies in the client, in the observation of these authors.

It has never been reported, to date, that a client balked at the second picture. Floridly psychotic, organic impaired, and moderately retarded individuals have all executed tree pictures. These same clients—for whom feelings are difficult to conceptualize or abstract—are, however, more likely to have difficulty executing the third picture. On the other hand, clients with disorders in which affect plays a strong role are unlikely to have any difficulty completing the third picture.

Some clients may not be able to respond at all to the directions for the third picture. In this situation, ending the art-making part of the session and turning to discussion of the first two pictures is appropriate. In all cases, it is important that the art therapist normalize the experience and provide closure for the client in the session.

In certain clinical situations the art therapist may need to encourage a resistant or recalcitrant client to start or continue to draw the DDS. Such an intervention should be governed by the personal style of the clinician and be as nonspecific as possible. One popular intervention to getting started is asking the client to look over the selection of colors, and to then pick up the color that is most appealing and begin to make a mark with it.

Some clinicians feel awkward discouraging clients from dialogue until the Series is complete. This guideline was created to control for the possibility that discussion would contaminate ensuing drawings. It is true that clients are often eager to discuss their products as they work. The authors, however, have found that clients readily accept the request to delay talking; some clients even seem to gain from the experience by devoting more attention to their art making. Discussions at the end of the session typically yield more honest and thoughtful explorations of the images.

Clinical Use of the Series

The DDS is especially useful to keep in mind when planning a first outpatient art therapy session for which one has little information about the client. It allows the art therapist to assess the client's issues, defenses, and strengths, while the client can explore media typical of an art therapy experience. Clinicians using the tool for the first time frequently express surprise at the amount of information elicited in a brief session. Clients frequently report enjoying the tasks and materials.

Inpatient uses of the DDS include assessment, group therapy, treatment and discharge planning, as well as multidisciplinary education. Although it is designed for single subject administration, the DDS has also been administered as a task in inpatient art therapy groups. The Diagnostic Drawing Series became part of the initial evaluation on one psychiatric unit, and one of the art therapy groups became a weekly DDS session. This helped to triage new patients into high-

and low-functioning teams. Intersubject contamination was examined through close observation of process and product; however, influence of picture content among group members did not seem to occur (Creekmore, personal communication, 1989).

The DDS can serve as an effective aid in educating multidisciplinary staff in case conferences, in-service presentations, and treatment planning meetings. By familiarizing colleagues with this standardized format, recognition of variations among the Series of different clients is facilitated. In fact, clinicians employing the DDS have reported increased interest in, respect for, and sophistication about client art therapy productions from their co-workers after introducing this tool. Findings from DDS research are available to substantiate clinical or diagnostic observations, which enhance the art therapist's value as a member of the treatment team.

The DDS has also been used as a discharge assessment tool and is well-suited for outcome studies. A DDS review session can also be a very potent format, as there is no denying the changes that manifest in a number of Series drawn over the course of treatment or across several hospitalizations by the same client.

Using the DDS regularly for inpatient evaluation makes it possible to compile a library of DDSs. It also allows the therapist to compare DDSs of recidivist clients across time. Changes such as the intensification, amelioration, or diversificiation of symptoms may be evidenced in the art.

When very specific thematic material must be elicited, other tasks may be used in conjunction with the DDS. For instance, in cases that involve family dynamics, the DDS can be completed, discussed, then followed by a Kinetic Family Drawing (Burns & Kaufman, 1970) modified by the use of DDS art materials. In such cases, neither tool alone could supply the full range of information necessary, and each tool enriches the other.

Creativity may be the culprit that causes art therapists to modify assessment techniques infinitely to suit the client, the therapist, or the setting. The authors, having found benefit in keeping the tool as constant as possible to best recognize the differences in patterns of response between clients, strongly encourage consistency. For instance, we recommend maintaining the 15-minute research limit per picture in clinical work as well. Experience shows that many patients do not require the full 45 minutes to complete a Series, so that a client who uses the full allotment of time is clearly communicating a special need.

Changing paper size, re-ordering tasks, or inserting an additional picture somewhere within the Series would result in something that is not a DDS and cannot legitimately be compared with the DDS research findings. This point cannot be overemphasized.

Research by Clinicians? The Benefits of Collaboration

Collaboration between clinicians and researchers has been very important in the development of the DDS. When a Series is collected according to the research protocol, it can be submitted to the DDS Archive in Washington, DC. There it can be used by interested student and professional investigators. Inquiries from those interested in conducting research are welcomed. All may contribute to and use the archive which now contains more than 1000 Series. In fact, without art therapists' contributions of correctly collected Series to the archive, there would be no research.

Busy art therapists or those working in isolation often find it difficult to launch solo research projects. The collaborative nature of the DDS research offers clinicians the special opportunity to pool ideas, resources, and energies. For instance, the authors have established a communication network among researchers and clinicians through the DDS Newsletter (Cohen, 1985b) that links those with similar investigative interests.

Conclusion

Selecting an appropriate assessment technique for clinical use is a complex judgment which should involve consideration of factors such as: professional acceptance, evidenced by reputation, conference presentations, and journal articles; tests of reliability and validity; the support of research; and the legal/ethical right to employ that tool. These matters are of particular importance when there is the possibility of litigation related to a case.

Sadly, the primary factor influencing most clinicians' choice of assessment techniques is their familiarity with a tool. Any assessment that is used routinely will become the one with which the clinician feels most skilled, and will become the tool on which s/he will tend to rely, regardless of the aforementioned factors.

The authors have presented the rationale for the design and use of the only assessment tool in art therapy that is supported by extensive diagnostic and procedural research. Although systematic investigations of the Diagnostic Drawing Series have been the focus of DDS presentations and publications since its inception 10 years ago, the advantages of using the DDS in clinical practice are many. They can be summarized as follows:

- simple design allows quick set up, administration, and completion
- pastels and large paper invite an experientially richer encounter than pencil-and-paper projective drawing tests
- varied task structure facilitates a wide range of responses
- format can be used effectively at any point during clinical treatment and,
- multi-center research builds clinical knowledge base

In addition, the DDS is the only published art therapy assessment tool linked to the standards of the DSM III-R (APA, 1980). As it is not predicated on any one particular model of art therapy or verbal psychotherapy, it can be used by all art therapists as a sort of *lingua franca*. It is hoped that this examination of its rationale and components will contribute to a fuller understanding of the DDS as an assessment tool, as well as its utility in clinical practice. Clinicians accustomed to intuitive work with art may take note that the DDS can be an affirming supplement to their approach.

By standardizing the complex process of diagnostic assessment in such a way that all aspects of it can be articulated, recorded, studied, and taught, we advance the theory, practice, and integrity of art therapy. Building upon each others' work, we help to ensure our survival within the increasingly embattled and competitive health care environment.

Editor's note: The authors wish to express their appreciation to Barbara Lesowitz, MA, A.T.R., Anna Reyner Blaustein, MFCC, A.T.R., and Shira Singer, MA, A.T.R., without whose efforts this paper would not have been possible. Much of this paper is based on discussions with students and colleagues about their experiences with the DDS. We are grateful for their considered thoughts.

Requests for reprints should be sent to Barry M. Cohen, P.O. Box 9450, Washington, DC 20016.

References

Allen, P. B. (1992). Artist in residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association*, 9(1), 22–29.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

Bolander, K. (1977). *Assessing personality through tree drawings*. New York: Basic Books.

Burns, R. C., & Kaufman, S. H. (1970). *Kinetic Family Drawings*. New York: Brunner/Mazel.

Cohen, B. M. (Ed.). (1985). *The Diagnostic Drawing Series handbook*. (Available from Barry M. Cohen, P.O. Box 9853, Alexandria, VA 22304).

Cohen, B. M. (Ed.). (1985b). *The Diagnostic Drawing Series Newsletter*. (Available from Barry M. Cohen, P.O. Box 9853, Alexandria, VA 22304).

Cohen, B. M. (Ed.). (1986). *The Diagnostic Drawing Series rating guide*. (Available from Barry M. Cohen, P.O. Box 9853, Alexandria, VA 22304).

Cohen, B. M. (1986b). Een Nieuwe Tekentest (A new diagnostic test). *Psychologie*, Amsterdam.

Cohen, B. M. (1989). *The Diagnostic Drawing Series in the integration process of multiple personality disorder* (Cassette Recording No. B291-43). Garden Grove, CA: InfoMedix.

Cohen, B. M. (1990). Diagnostic Drawing Series. In I. Jakab (Ed.), *Stress management through art: Proceedings of the International Congress of Psychopathology of Expression* (pp. 123–130). Boston: ASPE.

Cohen, B. M., Hammer, J. S., & Singer, S. (1988). The Diagnostic Drawing Series: A systematic approach to art therapy evaluation and research. *The Arts in Psychotherapy*, *15*(1), 11–21.

Couch, J. B. (Speaker). (1992). *Organic mental syndrome: Diagnostic Drawing Series research with the elderly* (Cassette Recording No. 16). Las Vegas, NV: American Art Therapy Association.

Creekmore, J. (1989). *The Diagnostic Drawing Series Tree Scale*. Unpublished manuscript.

Dondis, D. A. (1973). *A primer of visual literacy*. Cambridge, MA: The MIT Press.

Gantt, L., & Howie, P. (1979). Diagnostic categories & art work. *Proceedings of the Tenth Annual Conference of the American Art Therapy Association* (pp. 120–121). Alexandria, VA: American Art Therapy Association.

Gulbro-Leavitt, C., & Schimmel, B. (1991). Brief report: Assessing depression in children and adolescents using the Diagnostic Drawing Series modified for children (DDS-C). *The Arts in Psychotherapy*, *18*(4), 353–356.

Hammer, E. F. (1958). The House-Tree-Person projective drawing technique: Content interpretation. In E. F. Hammer (Ed.), *The clinical application of projective drawings* (pp. 165–207). Springfield: Charles C Thomas.

Hodnett, M. L. (1973). A broader view of art therapy. *Art Psychotherapy*, *1*, 75–79.

Jordan, H. (1989). An interview with Janie Rhyne. *American Journal of Art Therapy*, *28*(1), 5–12.

Jung, C. G. (1967). The philosophical tree. In H. Read, et al., *Vol XIII. The collected works of C. G. Jung: Alchemical studies*. Bollingen Series XX. New Jersey: Princeton University Press.

Kellogg, R. (1970). *Analyzing children's art*. Palo Alto: Mayfield Publishing.

Koch, K. (1952). *The tree test: The tree-drawing test as an aid in psychodiagnosis* (2nd ed.). (English translation). Berne: H. Huber.

Kramer, E., & Iager, A. (1984). The use of art in assessment of psychotic disorders: Changing perspectives. *The Arts in Psychotherapy*, *11*(3), 197–201.

Kreitler, H., & Kreitler, S. (1972). *Psychology of the arts*. Durham, NC: Duke University Press.

Kreitler, H., & Kreitler, S. (1978). Art therapy: Quo vadis? *Art Psychotherapy*, 5(4), 199–209.

Kress, T. (Speaker). (1992). *The Diagnostic Drawing Series and Multiple Personality Disorder: A validation study* (Cassette Recording No. 55). Denver, CO: National Audio Video.

Levy, B. I., & Ulman, E. (1974). The effect of training on judging psychopathology from paintings. *American Journal of Art therapy*, *14*(1), 24–27.

Lowenfeld, V., & Brittain, W. L. (1975). *Creative and mental growth*. New York: Macmillan.

MacFarlane, J. W. (1942). Problems of validation inherent in projective methods. *American Journal of Orthopsychiatry*, *12*, 405–410.

Malchiodi, C. A. (1993). Introduction to special issue on art therapy and professionalism: Is there a crisis in art therapy education? *Art Therapy: Journal of the American Art Therapy Association*, *10*(3), 122–128.

Malchiodi, C. A., Cattaneo, M., & Allen, P. B. (Speakers). (1991). *Art therapy: Post mortem* (Cassette Recording No. 1-135A). Denver, CO: National Audio Video.

McNiff, S. (1992). *Art as medicine: Creating a therapy of the imagination*. Boston: Shambhala.

Mills, A. (Speaker). (1986). *The art therapist and the anti-psychiatry movement* (Cassette Recording No. S303-22). Garden Grove, CA: InfoMedix.

Mills, A. (Speaker). (1988). *The Diagnostic Drawing Series: The borderline personality disorder sample* (Cassette Recording No. W327-39). Garden Grove, CA: InfoMedix.

Mills, A. (1989). *A statistical study of the formal aspects of the Diagnostic Drawing Series of Borderline Personality disordered patients, and its context in contemporary Art Therapy*. Unpublished master's thesis, Concordia University, Montreal.

Mills, A., Dougherty, M., Rubin, J., & Schoenholtz, R. (Speakers). (1992). *A compassionate discourse: On non-art therapists doing art therapy* (Cassette Recording No. 53-144). Denver, CO: National Audio Video.

Mills, A., Cohen, B. M., & Meneses, J. Z. (1993). Reliability and validity tests of the Diagnostic Drawing Series. *The Arts in Psychotherapy*, *20*(1), 83–88.

Mills, A., & Cohen, B. M. (1993). Facilitating the identification of Multiple Personality Disorder through art: The Diagnostic Drawing Series. In E. Kluft (Ed.) *Expressive and functional therapies in the treatment of multiple personality disorder*. Springfield, IL: Charles C Thomas.

Neale, E. L. (1991). *The Children's Diagnostic Drawing Series*. Unpublished master's thesis, University of Louisville, Louisville, KY.

Rhyne, J. (1979). *Drawings as personal constructs: A study in visual dynamics*. Dissertation prepared for University of California, Santa Cruz, California.

Shoemaker, R. H. (1977). The significance of the first picture in art therapy. *Proceedings of the Eighth Annual Conference of the American Art Therapy Association*, (pp. 155–162).

Ulman, E. (1961). Art therapy: Problems of definition. *Bulletin of Art Therapy*, *1*(2), 10–30.

Art Therapy: Journal of the American Art Therapy Association, 11(2) pp. 111-115 © AATA, Inc. 1994

Diagnostic Drawing Series: Research with Older People Diagnosed with Organic Mental Syndromes and Disorders

Janet Beaujon Couch, MA, A.T.R., Alexandria, VA

Abstract

This paper describes the use of a standardized three-picture art interview, the Diagnostic Drawing Series, with older people. Artwork was collected from 24 patients diagnosed with Organic Mental Syndromes and Disorders as defined by the DSM III-R criteria. The formal aspects of the art were rated using the Drawing Analysis Form (Cohen, 1985), the Content Checklist (Cohen & Cohen, 1990), and the Tree Scale (Creekmore, 1989). Results were analyzed statistically and compared to the ratings of art done by a control group of older people with no apparent neurological dysfunction. The results of an interrater reliability study are examined.

Introduction

Art therapy has proven to be a viable modality with older people, providing an avenue of creative expression, increased self esteem, socialization, and the possibility of personal growth. The field of geriatric practice in art therapy is an emerging one and at present there is a relatively small body of written work about this population. Much of the literature describes art programs designed as an activity for older people. Media choices, suggested artistic projects, the use of art as a life-review process, and case studies have presented the possibilities that art therapy and art education can offer in both community and institutional settings (Conger, 1979; Dewdney, 1975; Jungles, 1979; Rugh, 1985; Wald, 1983, 1986; Zieger, 1976; to name a few). However, with few exceptions (Andrews, Brocklehurst, Richards, & Laycock, 1980; Fischer & Fischer, 1977; Silver, 1976, 1981; Weiss, Schafer, & Berghorn, 1977), the literature has lacked systematic analysis of graphic qualities seen in the art of cognitively impaired older adults. Research can be difficult due to the variations within the population and the training of those working with them. This lack of valid and reliable research can have a significant impact on how art therapy is seen as a treatment modality. Art therapists working with cognitively impaired older people often have to combat the impression that art therapy is merely a pleasant recreational activity.

The art of older people diagnosed with Organic Mental Syndromes and Disorders (OMS/D) appears to have similar characteristics. These characteristics can be difficult to research since art-based assessments often need to be adapted due to visual, physical, and cognitive impairments. The Visual-Motor Gestalt Test, developed by Bender in 1938, shows how a person uses his or her perceptual system to organize configurational wholes. Organicity is apparent in test results from brain-damaged patients; however, this test does not score for art productions (Berg, Franzen, & Wedding, 1987, pp. 89–97).

Early signs of organicity have been observed and documented by art therapists working with older adults. Wald (1983, 1986) describes characteristics of art done by patients diagnosed with Alzheimer's disease as: perceptual distortion, tendency for simplification, perseveration (repetition of lines, shapes, or forms on the same drawing or from drawing to drawing), rotation of paper, and short, sketchy lines. Cronin and Werblowsky (1979) observed the additional features of disconnections, static affect, and difficulties in comprehension. A chart of observable characteristics seen in the art of patients diagnosed with OMS/D (all age groups) was compiled by Gantt and Howie (1984). Color was found to be unconventional (due to brain damage), limited, and used for outlining. Two-dimensional form characteristics were found to include the following: flat rendering of forms, relative size distortion, line quality sketchy or broken, one side blank (in stroke patients), bizarre rendering, incomplete forms, rotation of paper, and perseveration. Disorganization and figure/ground merging appeared, and content was idiosyncratic due to short-term memory impairment.

Cheyne-King (1990) has found that art products of young patients with brain injury show evidence of neglect of one side of the page. Images are often unrecognizable and may appear fragmented and unorganized. These characteristics are also seen in the art of older stroke patients. Andrews, et al. (1980) tested older adults with an art-based assessment (copy a picture of a house and draw a man and a clock from memory) to determine whether drawings by stroke patients had prognostic value. They found that left-brain damaged patients demonstrated more perseveration, and right-brain damaged patients had more structural abnormalities in their artwork. Some form of sensory integration abnormality was found in all tested. Art done by brain damaged older adults tends to be more expressive in higher functioning patients. Those with severe damage continue to make art that is more stereotypical and less expressive (Fischer & Fischer, 1977).

Method

A total of 24 older people, aged 67 through 93, diagnosed with OMS/D participated in this study. There were 16 females and 8 males. Each subject was diagnosed by physi-

---

Editor's note: The author wishes to thank Theresa Kress, MA, for her invaluable help in collecting drawings for this study.

cians on the basis of separate interviews. Half of the subjects live in a continuing-care retirement facility, the other half attend a day treatment center and live in the community. The sample was mixed racially and socioeconomically.

The control group consisted of 10 older people with no history of apparent neurological dysfunction. There were nine females and one male, aged 77 through 100. All live independently. This sample was not mixed racially or socioeconomically and is thus heavily skewed.

The Diagnostic Drawing Series (DDS) (Cohen, Hammer, & Singer, 1988) was administered to all participants in the study. The DDS was chosen because no adaptation was necessary, it is easily administered, and it is a "systematic research design that investigates the relationship between the various DSM III-R psychiatric diagnoses and graphic styles" (pp. 11–12). The DDS is especially useful as the "clinical data . . . can be communicated to other mental health professionals. The most recently analyzed interrater reliability of the DDS shows an overall percentage of agreement of 95.7%, . . . which exceeds many comparable studies in the field" (Mills, Cohen, Meneses, 1992, pp. 83–88).

Participants were given 18″ × 24″ white drawing paper, a box of 12 chalk pastels, and then asked to draw three pictures: "Make a picture using these materials. Draw a picture of a tree. Make a picture of how you're feeling, using lines, shapes, and colors" (Cohen, et al., 1988, pp. 12–13). The client's way of responding to the task was noted, as well as the progression or regression in the pictures across the series.

Organic Mental Syndromes and Disorders are medical diagnoses and, as such, this study is different from previous DDS research. Most participants had been placed in their respective facilities before the study began; therefore, it was not possible to assess patients within the first five days of admission, as requested in the DDS protocol. Also, it was not possible to control for medications and the influence they may have on the art produced; the course of treatment in relation to the disease process is not addressed.

Half of the DDS in the OMS/D sample were administered in a group setting while the other half were done individually. Artwork produced in a group did not appear to be influenced by the presence of others. This conclusion is based on participant's comments and the observation of those who administered the assessment. Due to the nature of the disease process, i.e., decline in cognitive functioning and verbal skills, the patient becomes, and often remains, isolated even in the presence of others.

The drawings were rated by the two art therapists trained to administer the DDS. The DDS Rating Guide (Cohen, 1985) was used to rate all three pictures.

The first and third pictures were rated according to the DDS Content Checklist (Cohen & Cohen, 1990). This Checklist is a 111-item list which includes: figure elements, body elements, structural elements, symbols and signs, things, animals (real or fantasy), substance use, celestial, and landscape elements. Several items were added in order to rate the content of the OMS/D sample. To the category "structural elements," line fragments, background fill-in, unrecognizable shapes, radial designs, perseveration, and floating image were added. To the category "things," "other" was added.

The first pictures containing trees and the second pictures (the tree picture) were rated according to the Tree Scale (Creekmore, 1989). This is a 61-item list of structural and content elements to which were added: "other deciduous trees" to the "kind of tree category," and "floating." An "other" category was added to this scale, containing: writing, floating images, perseveration, and unrecognizable objects.

Results

The purpose of this study was to investigate the graphic qualities of art produced by people diagnosed with the various DSM III-R categories of Organic Mental Syndromes and Disorders.

Hypothesis 1 stated that images would be representational and floating; perseveration, limited use of space, and unusual placement would be found. Perceptual distortion, simplification, perseveration, short, sketchy lines, rotation of paper, fused images, boundary confusion, and disconnections would also exist. (Characeristics noted by Wald (1983, 1989) and Cronin & Werblosky (1979).

Hypothesis 2 stated that there would be little or no blending and an inability to abstract; the art would become less organized in the progression from Picture One to Picture Three; the directives would cause anxiety; and the images would be classified as impoverished according to the DDS Rating Guide.

Tabulation of the percentage of occurrence/nonoccurrence of the criteria was done using the Drawing Analysis Form (DAF). All categories in the OMS/D scores do not add up to 100% because of the blank pictures occurring in Picture One and Picture Three in this sample. In the OMS/D sample, lines tended to be longer than expected, although short, sketchy lines do appear. Idiosyncratic use of color was not found to be common, and space usage was fuller than expected (34% to 66%). Findings were as follows:

1. Monochromatic use of color
2. Use of blending rare
3. Use of line predominates
4. Impoverished pictures
5. Representational images
6. Single images
7. Lack of enclosures
8. Lack of groundlines
9. Minimal inclusion of animals
10. Minimal inclusion of people
11. Light line pressure
12. Most trees unrecognizable
13. Unusual placement

Content and quality of the images done by those diagnosed with OMS/D became more unorganized from the first picture through the third. Otherwise there was little change across the series throughout the DDSs produced for this study. Floating images were common and trees in the third picture are indicative of perseveration (see Figures 1–3).

The Content Checklist (Cohen & Cohen, 1990), designed for use in conjunction with the rating guide, was employed to rate the number of items in each picture. When any item is repeated more than once on a single picture, only one tally mark is recorded on the Checklist. Therefore, it was not possible to rate perseveration, an "other" category was added

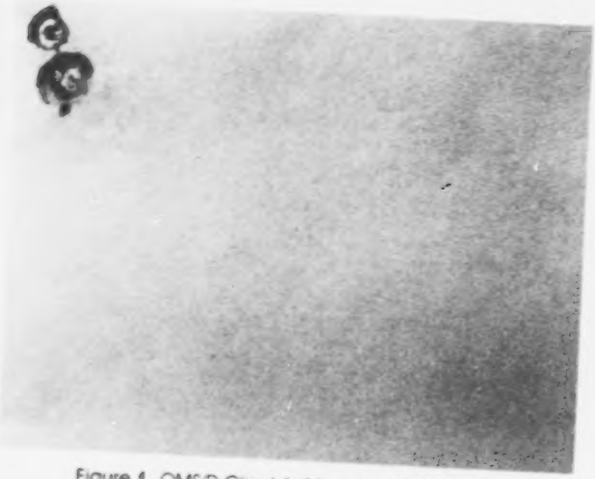


Figure 1. OMS/D Client A/ 85 years old: Picture 1

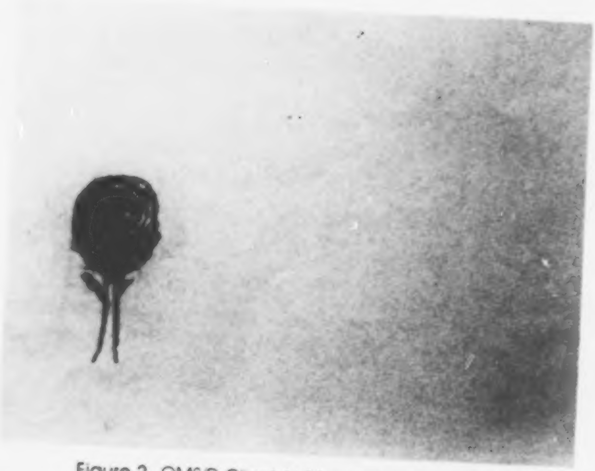


Figure 2. OMS/D Client A/ 85 years old: Picture 2

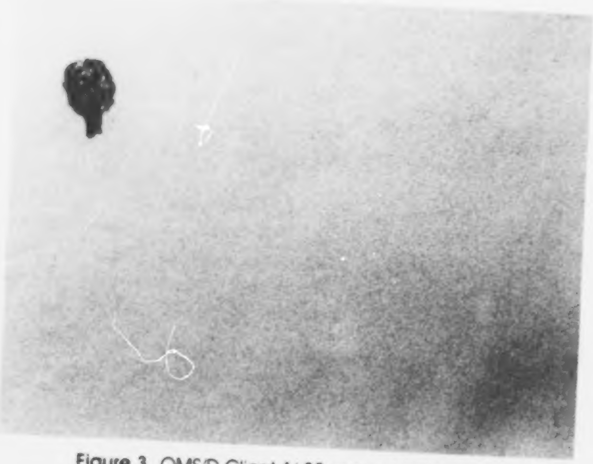


Figure 3. OMS/D Client A/ 85 years old: Picture 3

containing line fragments, perseveration, unrecognizable shapes, and floating images.

Seventeen (70.8%) patients produced representational images on Picture One, with 12 (50%) on Picture Three. Fifteen (62.5%) pictures contain floating images, which can be added to the "commonality" list (see Figures 4, 5, & 6). Due to the disintegration of images, the "structural elements" section of the Checklist contains the largest number of items scored in the OMS/D sample. Recognizable images tended to be concrete. In the Control sample, most responses were in the categories named "things," "celestial," and "landscape elements."

The Tree Scale (Creekmore, 1989) was designed to rate trees in the first and second pictures of the DDS. In the OMS/D sample, paper orientation tended to be horizontal (91.7%), whereas the Control sample tended to orient the paper vertically (60%). When the OMS/D sample was given a choice as to orientation of paper, usually no choice was made. Rotation of paper was not noted, perhaps due to the large paper size. Writing appears in many pictures from this sample, possibly a way of reducing anxiety. Flowers and animals are absent in tree pictures from both samples.

All trees in the Control sample fulfilled the criteria for "recognizable." Of the OMS/D sample trees, 50% were rated as unrecognizable, 8.3% had "chaotic branch structure," and 16.7% were rated as "falling apart" (see Figure 7).

Discussion

Limitations of this research must be noted. Although the Control sample was small, the demographics (predominantly women) seems to represent the general population of older people at this time. The Controls are all from one socioeconomic, cultural, and racial group which may skew the results. The raters were not blind to the diagnoses, so results may be biased.

Of the rating tools used in this study, the DDS Rating Guide was the easiest to use and score. The Content Checklist and the Tree Scale did not have categories to rate all the elements found in the OMS/D art. The challenge of abstracting seemed too difficult for those in the OMS/D sample and the number of blank pictures (25%) on Picture Three seems to confirm this.

Perseveration of lines, shapes, or forms on the same picture (see Figure 8), as well as from picture to picture (e.g., trees in Picture Three), was seen but was not as prevalent as hypothesized. The Content Checklist and the Tree Scale had to be adapted to include this category.

Floating images, limited use of space, and unusual placement were found in the OMS/D sample, but not in the Controls. Structural qualities identified by other writers, i.e., simplification, perceptual distortion, fused images, boundary confusion (Wald, 1983), and disconnections (Cronin and Werblosky, 1979), could possibly be measured in the DDS categories "impoverished" and "disintegrated." Although the above qualities of simplification, etc., are commonly observed in the art of this population, standardized rating criteria are needed for measurement.

Concern about the paper size (18" × 24") was observed in both samples. The first directive caused anxiety in both

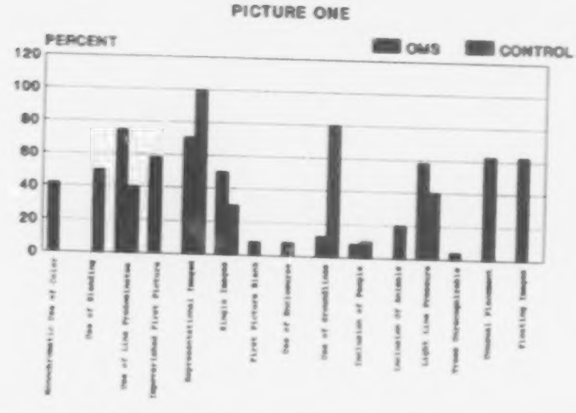


Figure 4. Results of DDS Research Comparison of Data OMS and Control Samples

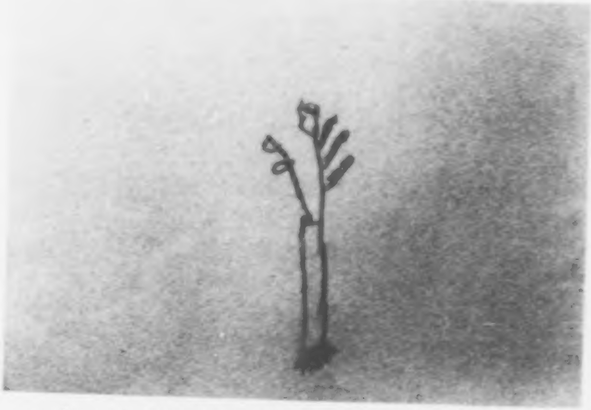


Figure 7. OMS/D Client B/ 81 years old: Tree Picture 2

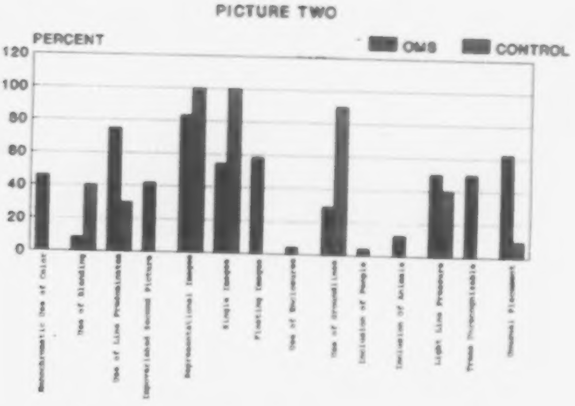


Figure 5. Results of DDS Research Comparison of Data OMS and Control Samples

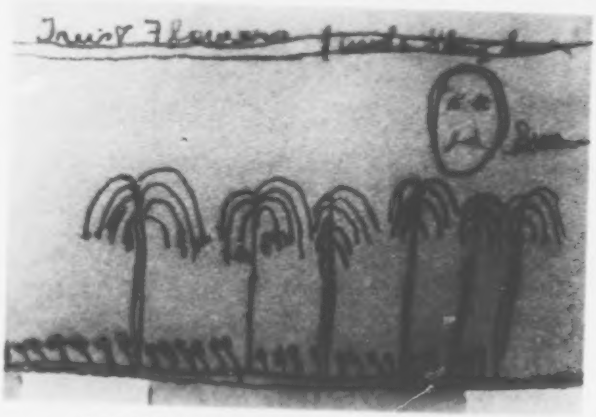


Figure 8. OMS/D Client C/ 82 years old: Picture 1

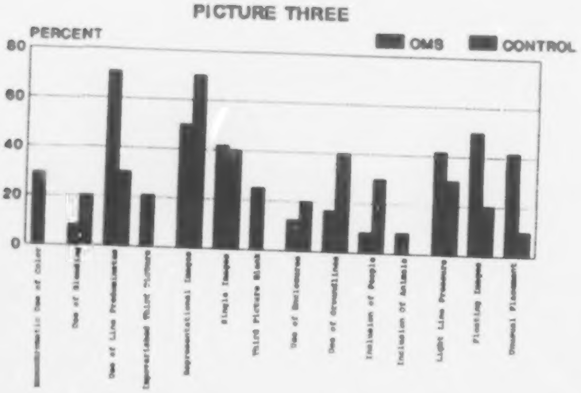


Figure 6. Results of DDS Research Comparison of Data OMS and Control Samples

samples; however, all directives seemed generally difficult for those diagnosed with OMS/D. This could be described as "static affect and difficulty in comprehension" (Cronin & Werblosky, 1979), both qualities observed with these clients.

Attempting to mask deficiencies in cognition by continual verbalization is often seen when working with OMS/D clients. Most of the OMS/D sample tried to talk around the task, repeating the instructions several times before attempting to make a mark on the paper. Those unable to draw (blank pictures) spoke throughout the task.

There was little blending noted in the pictures produced in the OMS/D sample: 0% in Picture One, 8.3% in Picture Two and Picture Three, whereas the Controls had blending in 50% of their pictures. There were no blank pictures in the Control sample; the OMS/D sample had 8.3% blank for Picture One, and 25% for Picture Three, indicating difficulty both in abstraction and comprehension of the directives.

Individuals in both samples did more representational pictures than abstractions, and people, animals, and enclosures were not common. Long or continuous lines were also found in the art of both samples (50% in the OMS/D sample) which is an interesting contrast to Wald, Cronin, and Werblosky's observations.

Pictures done by the Control sample (Figures 9–11) were integrated (100%) and the OMS/D pictures tended to be impoverished or disintegrated. Everyone in the study attempted to draw the second picture, the tree. All trees were rated as integrated and recognizable in the Control sample and 50% of the trees in the OMS/D sample were rated as unrecognizable. Groundlines were found in the pictures from the Control sample, but there were few in the OMS/D sample.

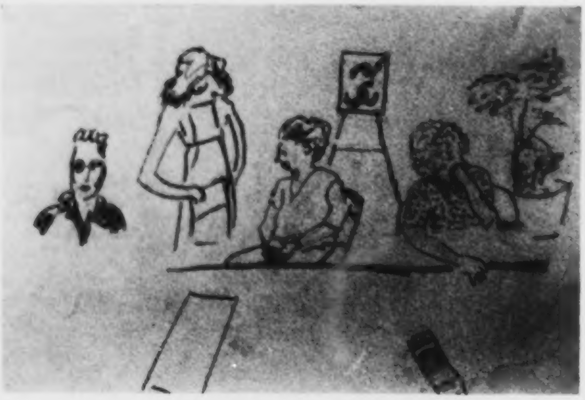


Figure 9. Control Client A/ 76 years old: Picture 1

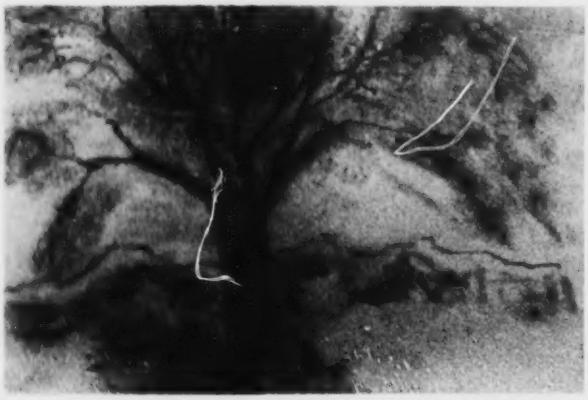


Figure 10. Control Client B/ 100 years old: Picture 2

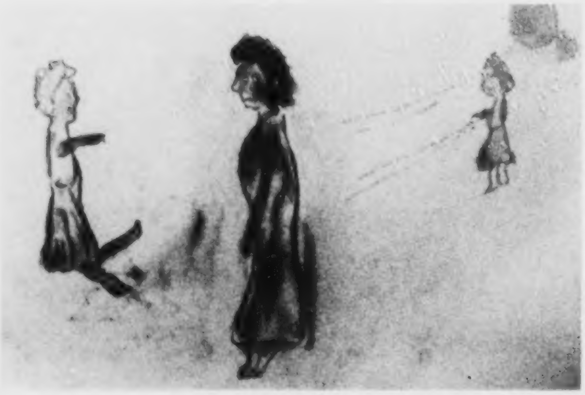


Figure 11. Control client B/ 100 years old: Picture 3

Conclusion

Structural qualities found in art done by clients diagnosed with Organic Mental Syndromes and Disorders have been identified using the Diagnostic Drawing Series. Observation of these qualities may aid in the early diagnosis of OMS/D and help educate medical and mental health professionals working with this population. A study of the DDSs of younger people (under age 65) diagnosed with OMS/D is recommended. Development of additional scales is needed to rate qualities seen in the art of older people with OMS/D such as perseveration, boundary confusion, and floating images.

References

Andrews, K., Brocklehurst, J. C., Richards, B., & Laycock, P. J. (1980). The prognostic value of picture drawings by stroke patients. *Rheumatology and Rehabilitation*, *19*, 180–188.

Berg, R., Franzen, M., & Wedding, D. (1987). *Screening for brain impairment: A manual for mental health practice*. New York: Springer.

Cheyne-King, S. E. (1990). Effects of brain injury on visual perception and art production. *The Arts in Psychotherapy*, *17*, 69–74.

Cohen, B. M. (Ed.) (1986). *The Diagnostic Drawing Series Rating Guide*. Available from Barry M. Cohen, P.O. Box 9853, Alexandria, Virginia, USA 22304.

Cohen, B. M., & Cohen, R. (1990). *Diagnostic Drawing Series Content Checklist Rating Guide*. Unpublished.

Cohen, B. M., Hammer, J. S., & Singer, S. (1988). The Diagnostic Drawing Series: A systematic approach to art therapy evaluation and research. *The Arts in Psychotherapy*, *15*(1), 11–21.

Conger, D. K. (1979). Art therapy with elderly stroke survivors. *NYSATA Bulletin*, *11*, 5–13.

Creekmore, J. (1989). *Diagnostic Drawing Series Tree Scale*. Unpublished.

Cronin, S. M., & Werblosky, J. H. (1979). Early signs of organicity in art work. *The Arts in Psychotherapy*, *6*, 103–108.

Dewdney, I. (1973). An art therapy program for geriatric patients. *American Journal of Art Therapy*, *12*, 249–254.

Fischer, T., & Fischer, R. (1977). Nonverbal dialogue with the brain-damaged elderly. *NIH Library*, 61–79.

Gantt, L., & Howie, P. (1984). *Diagnostic categories and pictorial characteristics*. Unpublished chart.

Jungles, G. (1982). *To be remembered: art and the older adult in therapeutic settings*. Buffalo, NY: Potentials Development for Health and Aging Services.

Mills, A., Cohen, B. M., Meneses, J. Z. (1993). Reliability and validity tests of the Diagnostic Drawing Series. *The Arts in Psychotherapy*, *20*, 83–88.

Rugh, M. (1985). Art therapy with the institutionalized older adult. *Activities, Adaptation, and Aging*, *6*, 105–120.

Silver, R. A. (1976). Using art to evaluate and develop cognitive skills. *American Journal of Art Therapy*, *16*, 11–19.

Wald, J. (1983). Alzheimer's disease and the role of art therapy in its treatment. *American Journal of Art Therapy*, *22*, 57–64.

Wald, J. (1986). Fusion of symbols, confusion of boundaries: Percept contamination in the artwork of Alzheimer's disease patients. *American Journal of Art Therapy*, *3*, 74–80.

Weiss, W., Schafer, D. E., & Berghorn, F. J. (1989). Art for institutionalized elderly. *Art Therapy: Journal of the American Art Therapy Association*, *6*, 10–17.

Zieger, B. (1976). Life review in art therapy with the aged. *American Journal of Art Therapy*, *15*,(2), 47–50.

Art Therapy: Journal of the American Art Therapy Association, 11(2) pp. 116-118 © AATA, Inc. 1994

A Study of the Diagnostic Drawing Series with Eating Disordered Patients

Kathie Kessler, MA, E.D.S., C.H.t., Peoria, AZ

Abstract

This study is based on the etiology, phenomenology, diagnosis, and treatment of eating disorders. There has become an increasing awareness and prevalence of eating disorders in our culture today. Literally, "eating disorders" implies "disordered eating." The most common eating disorders are Anorexia Nervosa/self-starvation, Bulimia Nervosa/binge eating, and Eating Disorders Not Otherwise Specified (NOS)/symptoms of both (Emmett, 1985). The combined sample for this study included women from all three diagnostic categories.

The purpose of this study was to examine the possible existence of structural and content elements in the Diagnostic Drawing Series (DDS) significant to an Eating Disorder population and to discover if there were recognizable or identifiable differences between the profiles of Anorexic, Bulimic, and Eating Disorder NOS individuals. Previous studies of the DDS have been conducted with other mental disorders in the areas of schizophrenia, depression, dysthymia (Cohen, Hammer, & Singer, 1988), borderline personality disorder (Mills, 1989), organic mental syndrome (Couch, 1992), and Multiple Personality Disorder (Mills & Cohen, 1991; Kress, 1992; Heijtmajer & Cohen, 1993). This additional study with eating disorders provides a broader application of the use of the Diagnostic Drawing Series instrument along with increased reliability and validity.

Method

This investigation uses a descriptive research method which draws attention to the degree of two events, an eating disorder and the artist's renderings of the DDS, and how they are related. This methodology produces data that is accurate and representative, describing "what is, and allowing for the study of relationships or events as they happen in human life" (Cohen, Hammer, & Singer, 1988).

The sample subjects were obtained from one source, an inpatient eating disorder program for women in the Wickenburg, Arizona area. Subjects ranged in age from 15 years to 54 years. The sample included 55 women diagnosed with Bulimia Nervosa, 17 women diagnosed with Anorexia Nervosa, and nine women diagnosed with an Eating Disorder NOS. The source of these diagnoses was the Axis I and II diagnosis made by one psychiatrist and one psychologist in accordance with the DSM-IIIR categories recorded in the charts of each individual patient as a part of his or her legal record.

The instrument used for measurement in this research work was the Diagnostic Drawing Series (DDS) (Cohen 1988). Clients are given three 18" × 24" pieces of white drawing paper and a box of 12 chalk pastels. They are then asked to "make a picture using these materials" on the first piece. When this is complete they are then asked to "draw a tree" on the second one and once completed, to "make a picture of how you're feeling using lines, shapes, and colors" on the third one (Cohen, Hammer, & Singer, 1988).

The collection of the drawings by each patient in this study was obtained within the first five days following psychiatric admission to the treatment facility. The drawings were obtained during the first group art therapy contact. Upon admission to the facility, patients were advised that they would be scheduled for an initial group art therapy session with the art therapist.

The characteristics of the drawings, that is, 36 elements in 23 categories, were reported on the Drawing Analysis Form (DAF) by this researcher, the resident art therapist at this treatment facility. There are 183 choices for the three drawing series, and it is important to note that although there is a blank category for all three pictures, in this study there were no blank occurrences, therefore, all the categories on the DAF add up to 100%. The data were then separated according to eating disorder diagnosis, Anorexia, Bulimia, and Eating Disorder NOS.

Results

Tabulation of the percentage of occurrence/nonoccurrence of the descriptive criteria on the Drawing Analysis Form (DAF) was completed. When the tabulations of the Combined Eating Disordered sample were studied, and a greater than 50% occurrence of elements was determined, a profile of elements for each picture emerged (see Table 1).

The profiles of this research were compared with control group data initially obtained by Cohen, Hammer, & Singer in 1988. The profiles of eating disorders did not vary from the control group profiles (Cohen, 1993b) except for two elements: groundline and falling apart trees. The Combined Eat-

---

Editor's note: Kathie Kessler graduated with a Bachelor of Arts in Human Resources Professional Counseling/Art Therapy from Prescott College, Prescott, Arizona and a Master of Arts in Advanced Professional Counseling from Ottawa University, Phoenix, Arizona. She is a Graduate/Specialist in Eating Disorders from Remuda Ranch Center for Anorexia and Bulimia. She is currently completing her Master's Level Marriage and Family Specialty. She may be contacted at: 18981 N. 96th Lane, Peoria, AZ 85382.

Table 1
Combined Eating Disorder Sample: DAF Findings Elements with a Greater Than 50% Occurrence

Picture 1	Picture 2	Picture 3
Four or more colors	No blending	Four or more colors
No blending	No idiosyncratic color	No blending
No idiosyncratic color	Line/shape mix	No idiosyncratic color
Line/shape mix	Integrated	Line/shape mix
Integrated	Representational/curvilinear	Integrated
Representational/curvilinear	Single image	Abstract mix (Geometric/biomorphic)
Multiple image	No enclosure	Multiple image
No enclosure	No groundline	No enclosure
No groundline	No people	No groundline
No people	No animals	No people
No animals	Inanimate objects	No animals
No abstract symbols	No abstract symbols	Inanimate objects
No word inclusion	No word inclusion	No word inclusion
Medium line/quality	Medium line/quality	Medium line/quality
Long/continuous lines	Long continuous lines	Long continuous lines
Movement/neither	Movement/neither	Movement/neither
Space usage/67–99%	Space usage/67–99%	Space usage/67–99%
	No tilt	
	No unusual placement	

ing Disorder sample resulted in 72.5% with no groundline (see Table 2), whereas, according to Cohen (1993b), 70.4% of the control group had groundline occurrence. The individual group samples of this study paralleled those of the Combined Eating Disorder sample on this element. Cohen (1993b) also confirmed that the 21.3% of the falling apart tree element of the Combined Eating Disorder sample was significantly higher than the control group's 7.4% of falling apart tree element. The individual group samples of this study also paralleled those of the Combined Eating Disorder sample on this element (see Table 3).

Recently Cohen (1993b) reported that in relation to the tree scale, there was a 20% occurrence of knot holes in the control group. In the Combined Eating Disorder sample group, there was a 55% occurrence of knot holes, but in the Bulimia Nervosa sample group a 70.8% occurrence of knot holes, making this significant in these sample groups. However, in the Anorexia Nervosa sample group there was a 82.4% nonoccurrence of knot holes and a 66.7% nonoccurrence of knot holes in the Eating Disorder NOS Sample group (see Table 4).

At the time of this study, published material on the content check list was unavailable.

Discussion

While these elements ("no groundline," "falling apart trees," and "knot holes") are not in themselves indicative of the presence of an Eating Disorder, they may add to the accumulation of data in support of a tentative Eating Disorder diagnosis.

Table 2
Percentage of Occurrence/Non-Occurrence of Groundline Element in Picture one of the DAF

	Combined ED Group	Bulimics	Anorexics	ED/NOS
Groundline				
no	72.5%	70.8%	76.4%	77.8%
yes	27.5%	29.7%	23.6%	22.2%
	Control Group			
yes	70.4%			

Table 3
Percentage of Occurrence/Non-Occurrence of Falling Apart Tree Elements in Picture Two of the DAF

	Combined ED Group	Bulimics	Anorexics	ED/NOS
Falling Apart	21.3%	14.8%	41.2%	22.0%
	Control Group			
	7.4%			

Table 4
Percentage of Occurrence/Non-Occurrence of Knot Hole Element in the Tree Scale

	Combined ED Group	Bulimics	Anorexics	ED/NOS
Knot Hole				
no	45.0%	29.6%	82.4%	66.7%
yes	55.0%	70.8%	17.6%	33.3%
	Control Group			
yes	20.0%			

Although the Combined Eating Disorder sample was relatively large, the individual Bulimia Nervosa sample was nearly three times that of the Anorexia Nervosa sample and six times that of the Eating Disorder NOS sample. Additional studies with larger sample sizes in these specific diagnosis groups may yield additional diagnostic data.

With the high correlation of knot holes in the Combined Eating Disorder sample, in the individual Bulimia Nervosa sample and the Dissociative samples, a specific study of dual diagnosed individuals with Bulimia Nervosa and Dissociative Disorders may yield further data which could correlate with these individual studies.

References

Cohen, B. M., Hammer, J. S., & Singer, S. (1988). The Diagnostic Drawing Series: A systematic approach to art therapy evaluation and research. *The Arts in Psychotherapy, 15*, 11–21.

Cohen, B. (1993a). Tenth International Conference on Multiple Personality and Dissociative States, in conjunction with The American Society of Clinical Hypnosis and held in conjunction with the Tenth Annual Meeting of the International Society for the Study of Multiple Personality and Dissociation.

Cohen, B. (1993b). Personal communication. October 10, 1993.

Couch, J. B. (1992). *Patients diagnosed with Organic Mental Syndrome compared with elderly people with no apparent neurological dysfunction*. Unpublished master's thesis, George Washington University.

Creekmore, J. (1989). *Diagnostic Drawing Series Tree Scale*. (Unpublished).

Emmett, S. (1985). *Theory and treatment of anorexia nervosa and bulimia*. New York: Brunner/Mazel.

Kress, T. (1992). *A study of the content of drawings from the Diagnostic Drawing Series of Patients with Multiple Personality Disorder*. Unpublished master's thesis, George Washington University.

Mills, A. (1989). *A statistical study of the formal aspects of the Diagnostic Drawing Series of Borderline Personality disordered patients, and its context in contemporary Art Therapy*. Unpublished master's thesis, Concordia University, Montreal.

COLLEGE OF NOTRE DAME

OFFERS:

- Master of Arts in Art Therapy (57 units)
- Master of Arts in Marital & Family Therapy (50 units)
- Graduate Art Therapy Certificate Program (21 units) for those already holding a Master's degree

- Systems & Jungian oriented art therapy
- AATA-approved
- Meets California state requirements for MFCC licensure
- Afternoons & evenings
- Summer Program
- Located in the beautiful San Francisco Bay Area

Art Therapy Program
COLLEGE OF
NOTRE DAME
1500 Ralston Avenue
Belmont, CA 94002-1997

For program specifics call (415) 508-3556

For an application call (415) 508-3523

Art Therapy: Journal of the American Art Therapy Association, 11(2) pp. 119-126 © AATA, Inc. 1994

The Children's Diagnostic Drawing Series

Elizabeth Leigh Neale, MA, A.T.R., Louisville, KY

Abstract

This study investigated the Children's Diagnostic Drawing Series (CDDS). The first hypothesis was that the variables of the DDS Rating Guide applied to the CDDS would significantly discriminate between children in the treatment group (with a DSM-III-R psychological disorder) and children in a control group. The second hypothesis was that a cluster of variables of the DDS Rating Guide applied to the CDDS would emerge as criteria for diagnosing children with adjustment disorders. There were 90 subjects total, ages 5–17, who had various SES backgrounds. Twenty-eight of the children in the treatment group were diagnosed with Adjustment Disorder (DSM-III-R). Seven out of 23 objective variables of the DDS Rating Method significantly discriminated between children currently being seen in therapy and children not in therapy. Six of those seven variables had an inter-rater reliability of Kappa ≥ 0.50. Of the 23 variables of the DDS Rating Guide, 20 had categorical clusters for children in the treatment group diagnosed with adjustment disorder.

Method

Hypothesis

There are two hypotheses investigated by this study. The first hypothesis is that the variables of the DDS Rating Guide, applied to the CDDS will significantly discriminate between children in the treatment group (with a DSM-III-R psychological disorder) and children in a control group without a diagnosis. Thus, children with a diagnosis will be distinguished from children without a diagnosis by their performance on the CDDS. The second hypothesis is that a cluster of variables of the DDS Rating Guide applied to CDDS will emerge as criteria for diagnosing children with a DSM-III-R diagnosis of an adjustment disorder.

Subjects

Subjects in the control group attended local private schools in a large Midwestern metropolitan area and came from varying socioeconomic backgrounds. The treatment group subjects were referred by a state-funded, outpatient, mental health treatment facility in the same city. All subjects included in the treatment group were currently being seen in psychotherapy by one of the therapists at the mental health facility. None of the subjects terminated therapy while this study was being conducted. For a subject to be included in the control group, she or he must not have been in therapy at the time of the study, and did not enter therapy while the study was being conducted.

There were 160 children in the subject pool, ranging in age from 5 to 17. Of the 113 subjects in the control group, 50 were randomly chosen to participate in the study. Forty of the 47 subjects in the treatment group were randomly chosen for the study. Of this 40, 28 carried a diagnosis of Adjustment Disorder. There were 11 black children and 39 white children in the control group. In the treatment group there were 19 black children, 20 white children, and one Hawaiian child. There were 26 females and 24 males in the control group and 18 females and 22 males in the treatment group (see Table 2).

Table 1
Table of Age Totals Within Groups

Age	Group		Totals
	Control	Treatment	
NA	1	1	2*
5	3	3	6
6	3	2	5
7	4	3	7
8	6	2	8
9	12	7	19
10	4	3	7
11	7	3	10
12	2	4	6
13	7	4	11
14	1	3	4
15	0	2	2
16	0	1	1
17	0	2	2
			90

* There were two subjects for which an age was not given.

Table 2
Table of Race and Gender Totals Within Groups

Group	Gender		Race		
	Males	Females	White	Black	Hawaiian
Control	24	26	39	11	
Treatment	22	18	20	19	1

Table 3
Table for DSM-III-R Diagnoses

Diagnosis	Number Ss
300.40 Dysthymia	2
309.00 Adjustment disorder with depressed mood	5
309.23 Adjustment disorder with work or academic inhibition	1
309.28 Adjustment disorder with mixed emotional features	11
309.30 Adjustment disorder with disturbance of conduct	2
309.40 Adjustment disorder with mixed disturbance of emotions and conduct	7
309.90 Adjustment disorder not otherwise specified	2
311.00 Depressive disorder not otherwise specified	2
312.00 Conduct disorder: Solitary aggressive type	1
312.90 Unspecified disturbance of conduct	1
313.81 Oppositional defiant disorder	4
314.01 Attention deficit disorder with hyperactivity	2
	Total = 40

Adapting the DDS for Children

The DDS has been modified for children in two ways: (a) there was a change in the medium used, and (b) there was a change in the DDS verbal instructions (Sobol & Cox, 1991).

The original medium, a soft, square chalk pastel, was changed due to the messy nature of the pastels. Harder pastels used in the CDDS created less chalk dust and less mess while providing a similar range of expressiveness.

For this study, the data collection was conducted both individually and in groups. Due to the group format a change in the administration of the DDS was initiated; administration was simplified and instructions were made more concrete. Children need simple instructions which often must be repeated. For example, instead of "make a picture using these materials" the children were told "make a picture using the pastels and the paper." Otherwise, the instructions for the pictures did not change.

Administration Procedure for the CDDS

The procedure for data collection for the control group and the treatment group was the same. For the treatment subjects, the data were collected both in groups and individually. Data from the control group were collected only in groups. The author was the test administrator for all subjects.

Measuring Device

The CDDS consists of three drawings: (a) the free picture, (b) the tree picture, and (c) the feeling picture. Instructions for the administration of the CDDS are the same as the DDS instructions with the above-mentioned exceptions. (See the reference list for obtaining these instructions, Cohen, 1985.)

The Rating Format

The drawings are rated on 23 variables that are precisely defined in a manual which guides the rater when rating the drawings (Cohen, 1985). The Rating Guide examines many objective factors of drawings such as color type, blending colors, representational or abstract, and the inclusion of groundlines, animals, people, symbols, and words (see Table 4).

This same manual was used to rate the CDDS drawings. Exact requirements are given for variables such as line length, tilt, unusual placement, and space usage. The factors eliciting subjective responses are integration, movement, line pressure, and line or shape content. However, even these variables have clear operational definitions for rating.

Interrater Reliability

Interrater reliability was established between the author and two trained DDS raters who were blind to the nature of this study. The statistic used to define the interrater reliability was a Kappa measure of reliability. The Kappa statistic is the appropriate interrater reliability measure for the rating of categorical data. The boundaries of Kappa are −1.0 to 1.0. A value greater than + or −0.5 can be interpreted as a strong measure of reliability.

A statistical program was created to calculate the interrater reliability for this study (Vogel & Joshua, 1991). Interrater reliability was established by the three raters for each variable. There were 12 variables for which significant interrater reliability was established.

Table 4
List of Variables for CDDS

1. Color type: monochromatic, two-three, four or more
2. Blending
3. Idiosyncratic color
4. Line/shape: line only, shape only, mixed
5. Integration: disintegrated, integrated, impoverished
6. Abstraction: geometric, biomorphic, mixed
7. Representational: angular, curvilinear, mixed
8. Image: single, multiple, blank
9. Enclosure
10. Groundline
11. People
12. Animals
13. Inanimate objects
14. Abstract symbols
15. Word inclusion: yes, no, words only
16. Landscape: land only, with water, water scene
17. Line quality/pressure: light, medium, heavy
18. Line length: short & sketchy, broken, long
19. Movement: implied, virtual, neither
20. Space usage: 0–33%, 34–66%, 67–99%, full
21. Tree picture only: unrecognizable, chaotic branch structure, minimal trunk, falling apart
22. Tilt
23. Unusual placement

Statistical Procedures for Analysis of Data

The statistical procedure chosen for analyzing the data for hypothesis one (discriminating between the control and the treatment group) was the logistic regression model. The rationale for choosing this statistic was that: (a) the data are categorical, (b) the distribution of the errors for categorical data is binomial and not based on a normal distribution, and (c) because of the categorical nature of the data, the constraint of the regression equation is that the equation must be formulated to be bounded between zero and one. The logistic regression equation for this study was: $E\ [y = 1/x]$.

The statistical procedure chosen for analyzing the data for hypothesis two (identifying the cluster variables for children diagnosed with adjustment disorder) was the Chi-Square statistic for each variable. For each variable that was significant a percentage of responses per category was calculated to determine the trend for that variable.

Results

Interrater Reliability of Significant Variables

Six of the seven variables which significantly discriminated between the treatment and control groups were variables which had an interrater reliability (Kappa value) greater than 0.5: color type (1.00), line/shape (0.58), integration (0.68), groundline (0.86), inanimate objects (0.61), and space usage (0.77). This further validates using these six CDDS variables to discriminate between the treatment and the control group. The variable, "abstract symbols" was difficult to rate as noted by the low interrater reliability.

Hypothesis One

The first hypothesis investigated by this study was that there would be variables of the CDDS which would significantly discriminate between children in the treatment group and children in the control group. This hypothesis was supported by the data. There were seven (out of 23) variables that discriminated between the treatment and the control group: color type, line/shape, integration, groundline, inanimate objects, abstract symbols, and space usage (see Table 5).

Color Type

The variable "color type" significantly discriminated between treatment and control groups when its three categories (monochromatic, two to three colors, or four or more colors) were examined. However, when each category was compared to the other two categories, only one comparison (monochromatic as compared to four or more colors) was significant. Therefore, the control group was significantly more likely to have four or more colors in their CDDS than the treatment group.

Line/Shape

The variable "line/shape" significantly discriminated between the treatment group and the control group across its categories (line only, shape only, and mixed line and shape). However, when each category was compared with the other two categories, only "mixed line and shape" when compared to "line only" significantly discriminated between the treatment and control groups. Children in the control group were more likely to use "mixed line and shape" than children in the treatment group when "line only" was the alternative.

Table 5
Probability Table for Hypothesis One

Variable	Confidence Interval for Odds Ratios for Coefficient	*p* value
Color type	$1.7 \leq \times \leq 22.8$	$p \leq .05$
Line/shape	$4.8 \leq \times \leq 33.9$	$p \leq .05$
Integration vs. Disintegration	$1.8 \leq \times \leq 6.9$	$p \leq .05$
Integration vs. Impoverished	$5.1 \leq \times \leq 58.8$	$p \leq .05$
Integration vs. Disintegration and Impoverished combined	$2.3 \leq \times \leq 7.9$	$p \leq .05$
Groundline	$1.2 \leq \times \leq 3.6$	$p \leq .0001$
Inanimate objects	$1.3 \leq \times \leq 3.5$	$p \leq .0054$
Abstract symbols	$1.6 \leq \times \leq 5.9$	$p \leq .0013$
Space usage	$1.6 \leq \times \leq 18.5$	$p \leq .05$

Integration

The variable "integration" significantly discriminated between the treatment and control groups across its three categories (disintegrated, integrated, and impoverished). When the two categories, "disintegrated" and "integrated," were analyzed, children in the control group were significantly more likely to have an integrated CDDS than a disintegrated CDDS. In addition, when the comparison was made between "integration" and "impoverished," the control group was significantly more likely to have an integrated CDDS than an impoverished CDDS. Finally, when the two categories, "disintegrated" and "impoverished," were combined, and compared to "integrated," children in the control group were significantly more likely to have an integrated CDDS than either a disintegrated or an impoverished CDDS.

Groundline

The variable "groundline" significantly discriminated between the treatment and the control group. For developmental reasons, only children age seven and above were included in the statistical analysis of this variable. The control group was significantly more likely to include a groundline in the CDDS than the treatment group.

Since the treatment group was less likely to include a groundline, the objects in the CDDS would be either paper based or free floating.

Inanimate Objects

The variable "inanimate objects" significantly discriminated between the treatment group and the control group. The control group was significantly more likely to include inanimate objects in the CDDS than the treatment group.

Abstract Symbols

The variable "abstract symbols" may significantly discriminate between the treatment and control groups. Significance cannot be certain due to the low interrater reliability. Children in the control group were more likely to include abstract symbols in the CDDS than the treatment group.

Space Usage

The variable "space usage" significantly discriminated between the treatment group and the control group across its categories: 0–33%, 34–66%, 67–99%, and 100%. However, only the 0–33% category when compared to the 100% category was significant in discriminating between groups. The control group was more likely to utilize the entire page when the alternative was the use of 0–33% of the page.

Summary of Hypothesis One

Of the 23 variables in the CDDS rating form, seven variables were found to significantly discriminate between the treatment group and the control group.

Inanimate objects were more likely to be found in the drawings of the control group. The variable, "inanimate objects," was defined in part as "concrete, immobile objects including food items, plant items, nature images . . ." (Cohen. 1985, p. 4). Cohen also stated that "mundane signs are included: stop signs, dollar signs, flags, peace signs, smiley faces, question marks, exclamation points, arrows" (1985, p. 4).

Children in the control group were more likely to include abstract symbols in their drawings. This variable was difficult to rate as is evident by the low interrater reliability. Therefore, the discriminatory value of this variable is weak. The definitions given in the rating guide for abstract symbols and "inanimate objects" are similar and the several examples are interchangeable. More often than not, when a child's drawing was categorized as having an abstract symbol, the drawing was also categorized as having an inanimate object.

Hypothesis Two

The second hypothesis investigated whether a cluster of variables of the CDDS would emerge as criteria for diagnosing children with adjustment disorders. When the statistical program was implemented, the data available for each diagnostic category within the entire group of adjustment disorders were insufficient, and therefore, could not be analyzed specifically (see Table 3). However, when all children diagnosed with particular types of adjustment disorders were collapsed into one set and analyzed as one group, there was sufficient data.

The data support the hypothesis. A cluster of 20 variables (out of 23 possible variables on the CDDS) was found to significantly ($p \leq .02$) describe the drawings of the 28 children with the DSM-III-R diagnosis of adjustment disorder. The statistical information on each of the 20 cluster variables is presented. The variables not in the cluster, "enclosure" and "tree" are not discussed (see Table 6). Only six of the 20 cluster variables significantly discriminate between groups and have significant interrater reliability.

Some drawing patterns emerged for several of the 20 variables that clustered for subjects diagnosed with an adjustment disorder. While not every picture drawn by a child with adjustment disorder will meet all the characteristics, this profile gives a general idea of what to expect (see Table 7).

Characteristics of pictures drawn by children diagnosed with adjustment disorder seemed to parallel characteristics of both the treatment group and the control group. Of the DSM-III-R diagnoses for children, adjustment disorder is the mildest and least chronic. Thus, these children's drawings were most like the drawings by children with no diagnosis. As stated under hypothesis one, children in the treatment group were less likely to use four or more colors in their drawings. However, of the children in the treatment group who did use four or more colors, the majority were diagnosed as having an adjustment disorder (see Figure 1).

Children diagnosed with adjustment disorder used either line only or a mixture of line and shape in their drawings (see Figure 2).

As stated under hypothesis one, children in the treatment group were less likely to have integrated drawings. However, the majority of the children in the treatment group who had integrated drawings were diagnosed with an adjustment disorder (see Figure 3).

As stated under hypothesis one, the variable "groundline" significantly discriminated between the treatment and control groups. The children with a diagnosed adjustment disorder followed the pattern of not using a groundline (see Figures 4 and 5).

"Space usage" was a significantly discriminating variable and had a high interrater reliability. Children diagnosed with adjustment disorder were most likely to use 67–99% of the space (see Figure 6).

For 20 of the 23 variables on the CDDS rating form, there was a significant difference in the distribution of responses across categories. Drawings of children diagnosed with adjustment disorder have the following characteristics: use of four or more colors, use of either line only or line and shape mixed, integrated, representational mixed (angular and curvilinear), multiple images, land only (if depicting a landscape), medium pressure, long lines, and use of 67–99% of the space.

The variables which are most important in characterizing the drawings of children with adjustment disorder are: (a) variables with high interrater reliability, and (b) variables which also discriminate between the treatment and control groups. For example, the variable "groundline" seems to be a vital characteristic to look for in the drawings of children with adjustment disorders. Children with adjustment disorders do not tend to use a groundline.

Table 6
Chi-square Table for Hypothesis Two

Variable	Category	% Ss	Chi Square	DF	*p* value
Color type	monochromatic	10%	40.22	2	0.0001
	two/three colors	25%			
	four or more colors	65%			
Blending	no blending	86%	42.96	1	0.0001
	blending	14%			
Idiosyncratic color	no idiosyncratic color	95%	65.79	1	0.0001
	idiosyncratic color	5%			
Line/shape	line only	44%	38.74	2	0.0001
	shape only	1%			
	mixed	54%			
Integration	disintegrated	26%	34.67	2	0.0001
	integrated	63%			
	impoverished	11%			
Abstract/representation	abstract/geometric	2%	102.78	5	0.0001
	abstract/biomorphic	6%			
	abstract/mixed	5%			
	representation/angular	10%			
	representation/curvilinear	20%			
	representation/mixed	57%			
Image	single	14%	101.19	2	0.0001
	multiple	86%			
	blank	0%			
Groundline	no groundline	68%	10.38	1	0.0001
	groundline	32%			
People	no people	86%	42.97	1	0.0001
	people	16%			
Animals	no animals	86%	42.98	1	0.0001
	animals	16%			
Inanimate objects	no inanimate objects	63%	5.44	1	0.02
	inanimate objects	37%			
Abstract symbols	no abstract symbols	90%	52.16	1	0.0001
	abstract symbols	10%			
Word inclusion	no words	68%	52.52	2	0.0001
	words included	30%			
	words only	2%			
Landscape	land only	95%	38.27	2	0.0001
	with water	5%			
	water scene	0%			
Line quality/ pressure	light	1%	73.41	2	0.0001
	medium	77%			
	heavy	22%			
Line length	short & sketchy	2	144.52	2	0.0001
	broken	1%			
	long	97%			
Movement	implied	19%	32.00	2	0.0001
	virtual	19%			
	neither	63%			
Space usage	0–33%	9%	42.80	3	0.0001
	34–66%	15%			
	67–99%	56%			
	100%	21%			
Tilt	no tilt	96%	69.44	1	0.0001
	tilt	4%			
Unusual placement	no unusual placement	85%	38.30	1	0.0001
	unusual placement	15%			

Table 7
Characteristics of Drawings of Children Diagnosed with Adjustment Disorders

Variable	Category
Color type*/**	4 or more colors
Blending	no blending
Idiosyncratic color**	no idiosyncratic color
Line/shape*/**	either line only or line and shape mixed
Integration*/**	integrated
Abstraction/representational	representational mixed (angular & curvilinear)
Image**	multiple images
Groundline*/**	no groundline
People**	no people
Animals**	no animals
Inanimate objects*/**	no inanimate objects
Abstract symbols*	no abstract symbols
Word inclusion**	no words
Landscape	land only
Line quality/pressure	medium pressure
Line length	long
Movement	no movement
Space usage*/**	67–99%
Tilt	no tilt
Unusual placement	no unusual placement

*Variables which significantly discriminated between the treatment and control groups

**Variables with interrater reliability with Kappa $\geq .50$

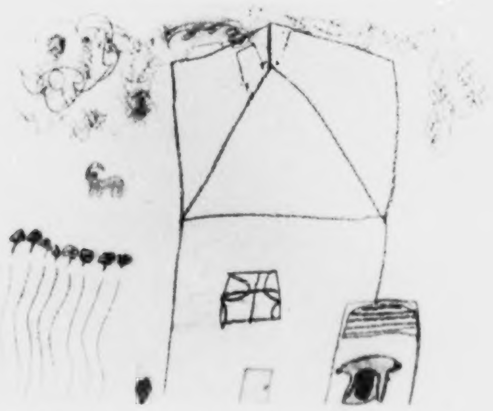


Figure 1. Free picture, subject diagnosed with adjustment disorder. (Characteristics include: four or more colors, no blending, no idiosyncratic color, mixture of line and shape, integrated, representational mixed, multiple images, no groundline, no people, no abstract symbols, no words, land only, medium pressure, long line length, 67–99% space use, and no tilt.)

Discussion

Both hypotheses were supported by the data. First, there were six variables of the CDDS which significantly discriminate between children in therapy and children not in therapy. Secondly, there were 20 variables that characterize the drawings of children with adjustment disorders. The results must be carefully interpreted. Furthermore, the inclusion of all factors affecting the outcome must be taken into account.

In the discussion of the results, an attempt will be made to explore the interactions between the three parts of the CDDS study: (a) interrater reliability, (b) the use of the

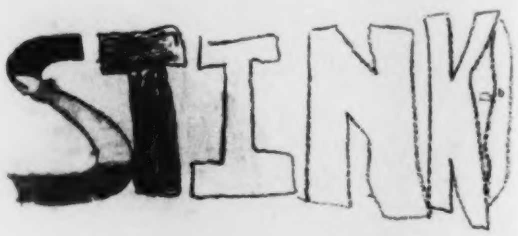


Figure 2. Free picture, subject diagnosed with adjustment disorder. (Characteristics include: four or more colors, no blending, no idiosyncratic color, line only, integrated, representational mixed, multiple images, no groundline, no people, no animals, no inanimate objects, no abstract symbols, medium pressure, long line length, no movement, 67–99% space use, and no tilt.)

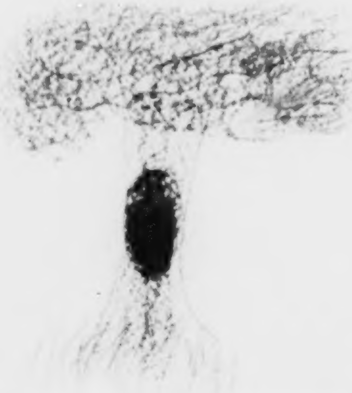


Figure 3. Tree picture, subject diagnosed with adjustment disorder. (Characteristics include: four or more colors, no blending, no idiosyncratic color, mixture of line and shape, representational mixed, multiple images, no groundline, no people, no animals, no abstract symbols, no words, medium pressure, long line length, no movement, 67–99% space use, and no tilt.)

CDDS to discriminate between the treatment and control groups, and (c) the characteristics of the CDDS of children with adjustment disorders.

There were six variables of the DDS Rating Guide which had high interrater reliability and significantly discriminated between the treatment and control groups: "color type," "line/shape," "integration," "groundline," "inanimate objects," and "space usage." All six variables were also important in the discrimination of children with adjustment disorders from their CDDSs.

The analysis of "color type" suggests that there may be a relationship between the number of colors used and whether or not a child is in treatment for psychological reasons. One possible relationship that could be explored is the one between restriction of affect and number of colors utilized with the assumption being that the more restricted the affect the fewer colors used.

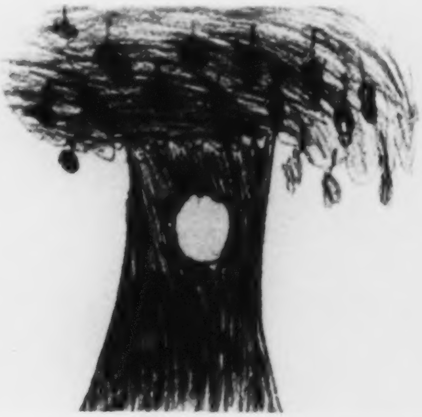


Figure 4. Tree picture, subject diagnosed with adjustment disorder. (Characteristics include: four or more colors, no blending, no idiosyncratic color, line only, integrated, representational mixed, multiple images, no groundline, no people, no animals, no abstract symbols, no words, medium pressure, long line length, no movement, 67–99% space use, and no tilt.)

Children in the control group have a tendency to utilize a combination of line/shape possibilities. In comparison, children in treatment seem to use one style of expression. Children in the control group draw with greater integration and embellishment than do children in the treatment group.

The use of the groundline in the control group CDDS is congruent with what is normally expected for graphic representation according to Lowenfeld and Brittain (1987).

While not a calculated statistic, it was noted that children in the control group used symbols and objects of various sorts in most of their pictures. Children in therapy were more likely to have impoverished drawings, and it is possible that it is difficult for a rater to recognize distinct objects.

In a comparison of the drawings of children with adjustment disorders to the control group and to the treatment group, the drawing characteristics of two variables are similar to the control group and the drawing characteristics of four variables are similar to the treatment group (see Table 8). A diagnosis of adjustment disorder is temporary (problems began six months ago or less) and is attributed to a known stressor. Based on these criteria, the problems of adjustment disorder children are less severe and more temporary, if treated, than other children with DSM-III-R diagnoses. Therefore, if children's drawings are a reflection of their current mental health, then the drawings of children with adjustment disorders should be similar to drawings of both the control group and the treatment group. The results of the CDDS study support this assumption.

Limitations of the Study

The results of hypothesis one (the CDDS can be used to discriminate between children in therapy and children not in

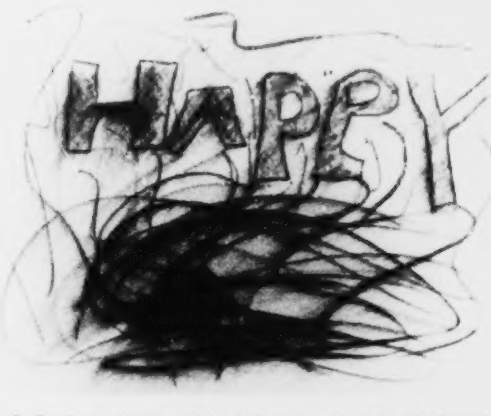


Figure 5. Feeling picture, subject diagnosed with adjustment disorder. (Characteristics include: four or more colors, no blending, no idiosyncratic color, mixture of line and shape, integrated, representational mixed, multiple images, no groundline, no people, no animals, no inanimate objects, no abstract symbols, medium pressure, long line length, 67–99% space use, no tilt.

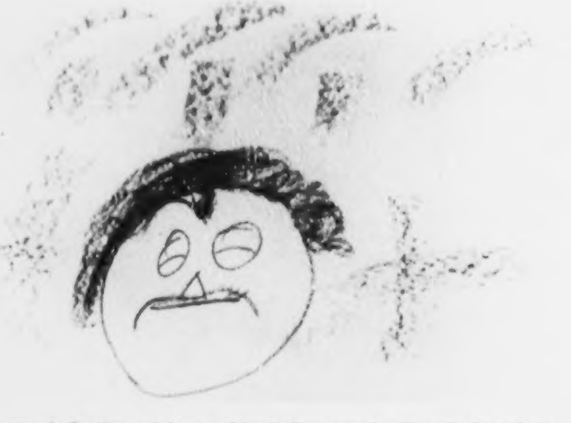


Figure 6. Feeling picture, subject diagnosed with adjustment disorder. (Characteristics include: no blending, no idiosyncratic color, mixture of line and shape, integrated, representational mixed, multiple images, no groundline, no animals, no inanimate objects, no abstract symbols, no words, medium pressure, long line length, 67–99%, and no tilt.)

BEST COPY AVAILABLE

Table 8
Drawing Patterns of Control, Treatment, and Adjustment Disorder Groups

Variable	Control	Treatment	Adjustment Disorder
Color type	4 or more	3 or less	4 or more
Line/shape	mixture	line only or mixture	line only or mixture
Integration	integrated	disintegrated or impoverished	integrated
Groundline	present	absent	absent
Inanimate objects	present	absent	absent
Space usage	>33%	<99%	67–99%

therapy) can be generalized to a similar population for the following reasons: (a) a large subject pool was used, (b) from the population pools of both the treatment and the control group, a random sample of subjects was chosen, (c) a control group was used, and (d) consistent data collection and administration procedures were used.

The results of hypothesis two (a cluster of variables of the DDS Rating Guide applied to the CDDS can be used to identify children with adjustment disorders) may not be strong enough to generalize outside of the sample population for the following reasons: (a) a small number of subjects was used, (b) a comparison to other diagnostic categories was not possible, and (c) 14 of the 20 variables that clustered for children with adjustment disorders did not significantly discriminate between the treatment and control group and did not have strong interrater reliability.

In addition to the problems mentioned above, four other limitations of the study were noted. First, the data were collected both individually and in groups. It was not possible to uncover differences which may be attributed to the two methods of data collection, adding a new dimension to the test results.

Second, previous reported use of the DDS was with adults. Because the DDS was developed for adults, the variables in the DDS Rating Guide were developed for adult drawings and some of the variables may not be appropriate for children's drawings (Cohen, 1985). The questionable appropriateness of some of these variables for children's drawings may contribute to the low number of variables which discriminated between the treatment and control groups. Third, one aspect of the study was to include a racial balance. Due to time limitations it was not possible to collect an adequate number of CDDS profiles from both black and white children. Therefore, in the control group there was not an equal number of black and white children. Finally, there was potential experimenter bias since the primary investigator also collected and rated the data.

Recommendations for Future Research

There are four recommendations for future research. First, additional replication studies on both the DDS and the CDDS are needed. Second, the Drawing Analysis Form and the Rating Guide may need revision. Because of the categorical nature of the rating format, statistical analysis of the data is extremely complicated. For a less complicated analysis, the rating format should be comprised of variables rated on a continuous data scale. By using a continuous data scale, the distribution of errors would be normal and use of a statistical analysis with more power would be possible.

Third, the total number of subjects and the number of subjects in each diagnostic category should be increased. The total number of subjects in the control group should be equal to the total number of subjects in the combined diagnostic category groups.

Finally, it would decrease potential experimenter bias if the administrator of the drawings, rater of the drawings, and the author of the research were not the same person.

Conclusion

This CDDS study was designed and conducted with standard research principles in mind. Two hypotheses concerning the CDDS were proposed and the data supported both hypotheses. Through the implementation of the CDDS study, important research questions were uncovered. The study of the CDDS presented here is a starting point for continued investigation into the use of drawing assessments for children.

References

American Psychiatric Association (1987). *Diagnostic and Statistical manual of mental disorders* (3rd ed.). Washington, D.C.: Author.

Cohen, B. M. (1985). *The Diagnostic Drawing Series Rating Guide.* (Available from Barry M. Cohen, P.O. Box 9853, Alexandria, VA 22304).

Cohen, B. M., Hammer, J. S., & Singer, S. (1988). The Diagnostic Drawing Series: A systematic approach to Art Therapy evaluation and research. *The Arts in Psychotherapy, 15*(1), 11–21.

Sobol, B., & Cox, C. (1991). *Art and childhood dissociation: A pilot study.*

Vogel, R., & Joshua, M. (1991). *KAPPA.* (Computer Program to calculate Kappa statistics). Louisville, KY: University of Louisville.

Art Therapy: Journal of the American Art Therapy Association, 11(2) pp. 127-130 © AATA, Inc. 1994

Tree Drawings and Trauma Indicators: A Comparison of Past Research with Current Findings from the Diagnostic Drawing Series

Anita Rankin, MA, Washington, DC

Abstract

An enduring hypothesis is that knotholes, broken branches, damaged trunks, and leafless trees are indicative of traumatic episodes in an individual's life. This paper reviews selected past research which does not definitively confirm or deny the basic hypothesis and reports a current study based on tree drawings from the Diagnostic Drawing Series Archive. Suggestions for possible further areas of research on this topic utilizing the Diagnostic Drawing Series are presented.

Introduction

In 1945, C. G. Jung wrote that the most common symbolic meanings of the tree image are "growth, life, unfolding of form in a physical and spiritual sense, development, growth from below upwards and from above downwards, old age, personality, and finally death and rebirth" (Jung, 1967, p. 272). In short, Jung believed the tree image to be a "projection of the individuation process" (p. 341). Several other authors have agreed with Jung's statement, presenting hypotheses that would support the assumption that tree drawings may represent the life history of an individual, including developmental processes, past experiences, and hopes for the future (Buck, 1948; Bolander, 1977), as well as characterological aspects (Koch, 1952; Hammer, 1958). Tree drawings may allow for a greater possibility of unconscious projection of repressed or avoided material as compared to the human figure (Hammer, 1958).

An inpatient on a dissociative disorders unit wrote a powerful statement about her personal perspective of tree symbols and trauma:

> I look out the window and the trees are speaking to me—losing their limbs, leaves, branches, contorted, barren—so vulnerable against the clear blue sky, so lost amongst the crowd of cars and buildings—the glut of city. Some will bloom again in spring, some now cry the beauty of orange, red, and yellow sleep, but others will bear their scars forever. The missing limbs will not return in spring; the leaves that come on nearby branches may disguise or hide, but cannot deny the loss. How do you tend to such a tree?

The idea that a tree image can indicate presence or absence of psychic trauma has generated both interest and controversy among art therapists, psychologists, and other mental health professionals over the past 40 years. Several research studies have evaluated the basic relationship between trauma markings on trees and traumatic life episodes; associated hypotheses have also been developed from this initial concept. This article will first review some of the important research studies, followed by observations of tree drawings from the archive of the Diagnostic Drawing Series (DDS).

Published Hypotheses

Three years after the publication of Jung's essay, John Buck published his initial description of the House-Tree-Person (H-T-P) projective drawing technique. In this article, Buck wrote, "Scars, broken branches, and the like, seem to symbolize traumatic episodes which the subject feels were scarring" (Buck, 1948, p. 390). Buck stated that the time of the trauma may be estimated by the location of the scar on the trunk, where the base of the trunk represents the birth of the person and the top of the tree the current age. He also wrote that well-adjusted people will rarely state that the tree they have drawn is dead. Buck suggested that a dormant tree is not the same as a dead tree, and that a totally dead tree may indicate a greater degree of maladjustment than one that is only partially dead. Buck and Hammer (1969) stated that a leafless tree represents "inner barrenness" and also a "lack of ego organization" (p. 186), preventing a person from being able to formulate a sense of the future.

Bolander (1977) echoed Buck's initial hypothesis when she wrote, "Some of the scarring marks may represent objectively traumatic occurrences, such as the death of loved ones, serious accidents or illnesses, rape, or dramatic changes in life circumstances" (p. 285). Bolander suggested that scarring marks could refer to subjectively traumatizing events or to unconscious preoccupations. Her conclusions suggested that specific marks have specific meanings. Bolander's interpretation of dead trees was somewhat different than Buck's: "People who draw dead trees often feel that they are completely victimized by external forces. Their defenses have deserted them, for one reason or another" (p. 117).

Research Studies

Several research studies have tested these hypotheses related to tree imagery, including the work of Levine and Galanter (1953); Lyons (1955); Bolin, Schneps, and Thorne (1956); MacCasland and Judson (1960); Moll (1962); Devore

---

Editor's note: Additional information regarding this article may be obtained from Anita Rankin, MA, Center for Abuse Recovery & Empowerment, The Psychiatric Institute of Washington, DC, 4228 Wisconsin Avenue, NW, Washington, DC 20016.

and Fryrear (1976); and Torem, Gilbertson, and Light (1990). A brief description of the methods and relevant findings of these studies follows.

Levine and Galanter (1953) collected tree drawings from 27 persons who had experienced the amputation of an arm or a leg. In this study, it was assumed that substantial body trauma would produce associated psychic trauma. Only seven of the subjects drew a scar on the tree image; the majority of the participants in this research study did not indicate their traumatic experience through the drawing of an injured tree. Observations of the placement of the seven scars on the tree images indicated there was no correlation between scar placement and the established date of the amputation.

In a subsequent study (Lyons, 1955), 50 individuals were asked to draw a tree, assume the tree had been hit by lightning, and mark an "X" on the tree where the lightning would have struck. They were then interviewed to determine the worst thing that had happened to them in their lives and when that event had occurred. No significant correlation was found in this study to indicate that placement of a tree scar is related to the date of the trauma.

Another important study to question the tree/trauma hypothesis was conducted by Bolin, Schneps, and Thorne (1956). A total of seven spontaneous scars or broken branches were observed in the tree drawings of 51 mental patients and 31 nurses/psychiatric aides-in-training. Four of the scars were drawn by the patients, and three by the staff. These results indicated no significant differences in the number of occurrences of injured tree drawings between known mental patients (who are suspected of having experienced a higher degree of trauma) and a more generalized population. These authors also studied the relationship of the placement of tree injury to the date of reported trauma. Thirty-nine mental patients were instructed to draw an "X" on an image of a standardized tree provided by the researchers. Several days later the patients were asked to ascertain the date of the worst event of their lives. These dates were compared with the placement of the "X" on the tree image. No relationship between the date of the worst event and the placement of the "X" was found.

Two research studies (Judson & MacCasland, 1960; Moll, 1962) addressed the relationship of the weather and seasonal influences on the drawing of a tree. In the first study, 20 House-Tree-Person (H-T-P) sets for each month of the year were collected and observed to determine the presence or absence of leaves. The 240 tree drawings were created by patients (120 men, 120 women) with a range of psychiatric diagnoses. The drawings of the women patients showed a seasonal influence, with a significantly higher percentage of bare trees drawn in winter months. However, this was not true for the male population. Judson and MacCasland concluded, "Less significance should be attached to the drawing of a bare tree in winter than in summer" (p. 173). The follow-up study (Moll, 1962) considered the lack of significance in the male tree drawings. H-T-P drawings were collected from 269 male students. This author concluded that the time of the year was in fact significantly related to whether male subjects drew more or less leaves on tree drawings.

Devore and Fryrear (1976) studied a total of 1,844 H-T-P sets drawn by "juvenile delinquents." They found 228 tree drawings (12.36%) which contained tree holes or scars, in a population that they expected to have a high level of abuse history and subsequent trauma. The researchers randomly selected 76 samples from drawings that included a tree hole and 76 samples that did not include a tree hole. The individuals who drew these trees were compared on the basis of 22 variables. Devore and Fryrear concluded that there may be certain personality variables (increased intelligence and hyperactivity) that cause a person to express psychic trauma through tree drawings which are not found in other individuals who do not draw scarred trees. No follow-up studies have been conducted to verify these results.

In a more recent study (Torem, Gilbertson, & Light, 1990) the researchers instructed 215 individuals not identified as mental health patients and 56 mental health patients to draw a tree and complete a questionnaire surveying their physical, verbal, and sexual abuse histories. Sixty-four percent of 138 subjects reporting past abuse drew trees with scars, knotholes, or broken branches. Twenty-seven percent of 133 individuals not reporting abuse also drew knotholes, scars, or broken branches. This would indicate that anyone drawing a tree with the above mentioned indicators would be suspect for having experienced previous psychic trauma, but not all knotholes, scars, or broken branches are necessarily indicative of trauma. Although there was a slightly higher percentage of trauma indicators present in the drawings of the mental health patients reporting past abuse as compared to the other group of subjects reporting past abuse, the difference was not shown to be significant. The study did not find any significance for the correlation of the placement of the traumatic indicator to the date of the trauma. These researchers also reported an association between duration of physical abuse and instances of injury markings on the tree drawings, in that the individuals abused over longer periods of time drew more numerous scars and broken branches on their tree drawings.

Study Methods

Most of the tree drawings which have been previously studied and reported in the research literature were obtained through either the administration of an established projective drawing technique or a simple directive to draw a tree. Included in the projective drawing techniques which incorporate the drawing of a tree are the Koch Tree Test (Koch, 1952), The House-Tree-Person Test (H-T-P) (Hammer, 1958), and the Diagnostic Drawing Series (DDS) (Cohen, Hammer, & Singer, 1988). The Koch Tree Test is not widely known or used in the United States, since revised editions of the original publication have not been translated into English. Published tree drawing research in English has primarily used either the "draw a tree" directive or the H-T-P to provide the tree images used in the studies; the H-T-P has probably been the most frequently used of the two.

The tree drawings accumulated in the DDS archive in Washington, D.C., provide an additional resource to aid in the study of tree images as diagnostic indicators of trauma (Mills & Cohen, 1993); there are currently over 1000 samples of tree drawings in the collection, including tree images collected from various diagnostic populations located in different parts of this country and other regions of the world. The

DDS is a standardized art interview (Cohen, Hammer, Singer, 1988) in which the individual is instructed to draw three pictures, the second of which is a tree.

For this study a total of 60 tree drawings were selected from the DDS archive. Thirty drawings were created by adults consecutively admitted to a post-traumatic dissociative disorders unit in a psychiatric hospital. Tree drawings of this patient population were selected because this is a population in which there is a high frequency of reported childhood trauma; the majority of therapists working with this population believe in the existence of a causal relationship between dissociative disorders and trauma (Putnam, 1989). As a control, the remaining 30 drawings were randomly selected from a collection of 50 drawings created by staff members at another psychiatric facility.

Tree drawings were observed for the presence of knotholes, broken branches, damaged trunks, and the absence of leaves. (Scars were found to be indistinguishable from tree bark texture or shading.) An independent rater viewed the tree drawings. There was 96% agreement between the primary observer and the independent rater as to the occurrences of knotholes, broken branches, damaged trunks, and bare trees. Criteria for the identification of knotholes, broken branches, and leafless trees were obtained from the Diagnostic Drawing Series Tree Rating Scale Definitions (Creekmore, 1989).

Findings from the DDS

Sixty percent of the tree drawings created by individuals diagnosed with dissociative disorders contained at least one instance of either a knothole, a broken branch, a damaged trunk, or were leafless. Twenty-seven percent of the tree drawings of the control group showed one of the above indicators. These percentages seem on the surface to reflect differences in these populations; however, on closer study of each category of tree injury, the significance diminishes in some categories.

In a comparison of the occurrence of knotholes observed in the tree drawings of the two populations, almost an equal amount of trees with knotholes were observed in each, as shown in Table 1. This suggests that the presence of knotholes is not indicative of trauma. One tree drawing created by an individual from the psychiatric population was notable as it contained a total of 12 knotholes. This may suggest that large numbers of knotholes on a single tree may indeed reflect historical trauma.

Broken limbs or damaged trunks were observed in 30% of the tree drawings of the population diagnosed with dissociative disorders, whereas no broken branches or injured trunks were observed in the control group. This may indicate a correlation between the presence of broken limbs or damaged trunks and traumatic events in the life of the artmaker.

Thirty percent of the tree drawings of those diagnosed with dissociative disorders lacked foliage, whereas only 7% of the trees were leafless in the control group. A closer review of the seasons in which the trees were drawn by the psychiatric population indicated strong evidence of seasonal influence. Seventeen percent of the trees drawn in summer/spring were leafless; whereas 50% of the trees drawn in fall/winter were leafless.

Table 1
Numbers of Trauma Indicators Observed in DDS Tree Drawings

	Tree drawing groups	
Trauma indicators	Inpatient n = 30	Control n = 30
Knotholes	8	7
Broken limbs	5	0
Damaged trunks	4	0
Leafless trees	9	2

Five (17%) of the tree drawings created by the dissociative population contained more than one instance of a broken branch, damaged trunk, or lacked foliage. (Knotholes were not included in the calculation of multiple indicators because they are more likely to be indicative of stereotypic schemas.) None of the tree drawings created by the control group showed more than one trauma indicator. This would imply that the presence of multiple indicators may be more suggestive of a trauma history than are single indicators.

Overall differences in the comparison between a group of tree drawings created by the psychiatric population with those created by the control group are very apparent; the dissociative group's tree drawings include images of severely damaged trees, whereas the degree of overall tree injury in the latter group is quite minimal. However, when comparing individual tree drawings there is not always an obvious difference. Fifty-seven percent of trees drawn in the inpatient setting did not show any broken limbs, damaged trunks, or bareness. This implies that more than half of the tree drawings in a dissociative population may not indicate a history of trauma as evidenced by the above indicators, and, therefore, may not reflect a self-image which reflects historical material; the trauma experience is not projected onto the tree drawing.

The results of this small study have limited generalizability. The findings are based on a small sample, and many additional tree drawings by both groups of subjects would need to be examined to validate the findings. Obtaining accurate trauma histories for subjects in each group would aid in the overall validity of the results, although this may not be possible as some trauma instances may be repressed or dissociated. Also, the sample of participants was skewed as to gender (inpatients and staff were primarily female) and ethnicity (Caucasian).

Discussion

Studies published to date do not consistently support or refute the basic hypothesis that the presence of scars, knotholes, broken branches, or leafless trees are indicators of traumatic experience. Nor has research proven that the absence of these indicators means that an individual has never experienced unusual levels of trauma. However, both the current study and that of Torem, Gilbertson, and Light (1990) strongly suggest that the presence of multiple tree injury markings on one individual's tree drawing is related to past traumatic experience in the life of that individual. The majority of studies do not support the idea that the date of the trauma can be determined by the placement of a scar on a tree drawing. Tree/trauma research also indicates that a tree without foliage may be drawn as a response to seasonal factors, and not necessarily be representative of the aftereffects of trauma. The presence of one or two knotholes in a tree drawing did not prove to be suggestive of past trauma in this current study.

The acceptance of tree drawings as a valid and helpful tool in the assessment of trauma is based on the assumption that a tree drawing is a representation of self. It is important to acknowledge that not all tree drawings are self-images. A tree image may symbolize someone the individual has known in the past or present, or a mythical figure. A drawing may also depict a tree which a person has actually seen at some time during his life. In this case, it may be argued that the tree an individual remembers and portrays was chosen due to projective identification; however, this hypothesis has not been validated through research. A tree drawing may reflect a person's feelings, needs, or wants in the specific moment that the tree image is being created. This tree image would be representative of self, but would not necessarily include historical information. In any random sample of tree drawings, some will be self-images, others may represent someone other than the imagemaker; some will reflect the individuation process of the person, some will not; some will include representation of past and present experiences with future possibilities, others will depict only a single timeframe. The statistical probability that a tree image represents the life experience of the individual is unknown; this should be considered when tree drawings are being used for trauma assessment.

Finally, although it is interesting and potentially productive to attempt to identify patterns in tree drawings, it must be remembered that each drawing is produced by a complex individual, and the imagery used is a product of that individual's biological make-up, history, and response to that history. The meaning of any image is in many respects unique to that individual.

Suggestions for Further Study

The tree drawings collected in the DDS archive provide an excellent resource for future study of the tree/trauma relationship and its potential use in assessment as well as measuring treatment outcome. Possibilities for further DDS research in the tree/trauma debate include continuing and broadening this study, examining the hypothesis that knotholes are not trauma indicators and that they may represent conventional tree schemas. A comparison of tree drawings created by inpatients and outpatients diagnosed with Posttraumatic Stress Disorder (PTSD) might help distinguish between trauma indicators related to crises resulting in hospitalization and indicators related to chronic PTSD symptoms. A more in-depth study of seasonal influences on tree drawings could be conducted that compares diagnostic groups and control subjects. A cross-cultural comparison of differences in tree drawings created by control subjects and individuals within diagnostic categories which are suggestive of trauma would be helpful to diminish false diagnostic indicators which might be specific to particular cultural and/or geographic groups. Observations of the tree drawings of patients known to engage in self-injurious behavior would be interesting to see if they differ in any way from individuals who do not inflict self-harm. Longitudinal studies of patients' tree drawings over the course of several years of treatment are also a possibility through the use of the DDS archive. It would be interesting to see if the effects of treatment are reflected by specific changes in the tree drawings over time.

Other possible indicators of trauma have been suggested by Mills and Cohen (1993) through the study of tree drawings from the DDS. These include "chaotic branches, unrecognizable trees and trees with trunks of minimal length" (p. 46) as well as tilted trees. Further study and observations of these possible indicators in additional tree drawings may prove to reinforce the idea that there are additional indicators of trauma which have not been previously identified.

References

Bolander, K. (1977). *Assessing personality through tree drawings.* New York: Basic Books.

Bolin, B. J., Schneps, A., Thorne, W. E. (1956). Further examination of the tree-scar-trauma hypothesis. *Journal of Clinical Psychology, 12,* 395–397.

Buck, J. (1948). The house-tree-person technique: A qualitative scoring manual. *Journal of Clinical Psychology, 4,* 317–396.

Buck, J., & Hammer, E. (1969). *Advances in the house-tree-person technique: Variation and applications.* Los Angeles, CA: Western Psychological Services.

Cohen, B. M., Hammer, J. S., & Singer, S. (1988). The diagnostic drawing series: A systematic approach to art therapy evaluation and research. *The Arts in Psychotherapy, 15,* 11–21.

Creekmore, J. (1989). *Diagnostic Drawing Series Tree Rating Scale Definitions.* (Available from Barry M. Cohen, P.O. Box 9853, Alexandria, VA 22304)

Devore, H. E., & Fryrear, J. L. (1976). Analysis of juvenile delinquents' hole drawing responses on the tree figure of the house-tree-person technique. *Journal of Clinical Psychology, 32,* 731–736.

Hammer, E. F. (1958). *The clinical application of projective drawings.* Springfield, IL: Charles C Thomas.

Judson, A. J., & MacCasland, B. W. (1960). A note on the influence of the season on tree drawings. *Journal of Clinical Psychology, 16,* 171–173.

Jung, C. G. (1967). *Volume 13 of the collected works of C. G. Jung, alchemical studies.* New Jersey: Princeton University Press.

Koch, C. (1952). *The tree test.* New York: Grune & Stratton.

Levine, M., & Galanter, E. H. (1953). A note on the "tree and trauma" interpretation in the HTP. *Journal of Consulting Psychology, 17*(1), 74–75.

Lyons, J. (1955). The scar on the HTP tree. *Journal of Clinical Psychology, 11,* 267–270.

Mills, A. & Cohen, B. M. (1993). Facilitating the identification of multiple personality disorder through art: The Diagnostic Drawing Series. In E. S. Kluft (Ed.). *Expressive and functional therapies in the treatment of multiple personality disorder* (pp. 39-66). Springfield, IL: Charles C Thomas.

Moll, R. P. (1962). Further evidence of seasonal influences on tree drawings. *Journal of Clinical Psychology, 18,* 109.

Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder.* New York: The Guilford Press.

Torem, M. S., Gilbertson, A., & Light, V. (1990). Indications of physical, sexual, and verbal victimization in projective tree drawings. *Journal of Clinical Psychology, 46*(6), 900–906.

Art Therapy: Journal of the American Art Therapy Association, 11(2) pp. 131-138 © AATA, Inc. 1994

Research with Diagnostic Drawings for Normal and Alzheimer's Subjects

Nancy M. Knapp, PhD, A.T.R., Emporia, KS

Abstract

This study designed and tested a battery of drawing techniques with a scoring methodology appropriate for investigation of Alzheimer's disease (AD). The battery was adapted from previous experience in the field of projective drawings and the scoring was developed from characteristics hypothesized to be present in an Alzheimer's population. The variables as a whole and most of the hypothesized drawing features provided significant discrimination between the age-matched controls and Alzheimer subjects ($p < 0.0001$). The relative importance of individual variables were interpreted as they might describe AD deficits. Capability to discriminate was also provided at $p < 0.0001$ by objective measures of use of space and size of the drawn objects. This might suggest a possible graphic process analogous to micrographia. The interrater reliability as measured by the Kappa Coefficient was in excess of 90%.

Introduction

A blank paper is virgin territory on which people leave their marks in individual ways with seemingly infinite variety. However, if researchers use a structured format to collect drawings under controlled circumstances, they may detect a pattern of variables between certain patient/client groups. If the differences in such a pattern are statistically significant, the drawing procedure has potential for use in diagnosis and treatment.

Art tasks are commonly used in medical settings to assess functional and physical impairment. Three basic paradigms have dominated the use of art for these purposes: (a) art presented as a stimulus to be observed, described, or responded to by the subject, (b) visual images or tangible objects to be copied by the subject, and (c) verbal or written requests given to the subject to draw a particular picture. Each model challenges different skills and sensory responses, and the results of each require different evaluation or scoring systems.

The use of drawing tasks for diagnosis and research in medical settings support the premise that a person's drawings relate to his or her general intellectual and cognitive functioning. Drawings have been linked closely with studies of perception and brain dysfunction since the mid-19th century.

In 1985, Benton reviewed what he called the "huge literature" on hemispheric inattention and injuries with brain patients. He listed art tasks for performance discrimination in brain diseases of visuoperceptual, visuospatial, and visioconstructive disorders. Although the consensus of the authors Benton reviewed seems to be that the value of art tasks is uneven, neurologists continue to use a variety of drawing techniques and exercises in their examinations. Similarly, Roeltgen (1985) cited effects of agraphia during clininical evaluations. He included art tasks to explore the subtleties of specific deficits with combined linguistic and motor components.

Heilman, Watson, and Valenstein (1985) cited spontaneous drawings as useful because they do not require afferent stimuli, and Sacks (1985) stated that he nearly always asks a patient to draw, "partly as a rough and ready index of various competencies, but also as an expression of their 'character' or 'style'" (1985, p. 215). Bogen (1985) used art tasks for assessing callosal syndromes. He suggests using felt pens rather than pencils, starting with simple figures, and progressing to more complex.

Kramer and Iager (1984) concluded their review of art used in the assessment of psychosis by summarizing advances in neurobiology, including complex neuropsychological and standardized psychometric tests, the computerized axial tomography (CT scan), brain electrical activity mapping (BEAM) and other brain imaging techniques, positron emission tomography (PET scan), cerebral blood flow and progress in neuropathology and psychopharmacology; they claimed that these techniques "are changing perspectives about the phenomenology of psychosis. It is not unlikely that there may exist artistic correlates of new diagnostic categories" (1984, p. 198).

Major portions of research on brain dysfunctions have focused on patients with Alzheimer's disease (AD), a progressive brain disease which is the diagnosis of one-half of all demented adults. Early phase AD may include memory and attention defects, general confusion and disorientation, apraxia, and gait and movement disturbances due to ephemeral weakness and rigidity of muscles. Second stage patients may demonstrate complete disorientation, purposeless hyperactivity with perplexity and agitation, spastic contractures, disrupted speech, dullness, and apathy. The terminal phase includes profound dementia and vegetative existence. Traditionally, AD has been seen as progressive, irreversible, and untreatable because of generalized brain atrophy, especially in the frontal and occipital lobes.

Hollinder, Mohs, and Davis (1985), Reisberg, Ferris, and Franssen (1985), Cummings and Benson (1986), and the *Diagnostic and Statistical Manual of Mental Disorders III-R* (1987) have detailed criteria for the diagnosis of AD. Because symptoms of constructional apraxia, dyspraxia, or difficulties of visual spatial integration have long been identified as part of the clinical presentation with AD, diagnosing physicians frequently request patients to copy geometric figures or to draw cubes or clocks. Additionally, tasks such as the Rey-Osterrieth Complex Figure Test (Peck, Stephens, & Martelli, 1987) are part of a complete neuropsychological evaluation and might be included in a diagnostic work-up for AD.

Research with projective drawings for this population is sparse. There is none dealing exclusively with AD patients although two published studies (Plutchik, Conte, Weiner, & Teresi, 1978; Moore & Wyke, 1984) used variations on the D-A-P and house drawing techniques with subjects including demented patients who would probably be currently diagnosed as having AD. In 1978, Plutchick, et al. cited the lack of data on the use of projective drawings with the elderly population as a whole when they addressed several measures of body image for the geriatric population. They found that drawings could distinguish significant differences between young adults and a geriatric population but not between normal elderly and psychotic elderly or psychotic young adults. They also found a tendency in older people to draw simpler, smaller, and less sexually differentiated or integrated figures.

Moore and Wyke (1984) used house and cube drawing tasks to test patients with senile dementia. They found that, when compared to drawings by elderly controls and patients with focal brain lesions, spontaneous drawings by demented patients were grossly impoverished, missing in essential features, small, cramped, perseverative across items, and randomly labeled. In copies of drawings they included more details although they were often wrongly placed.

AD patients are frequently evaluated with traditional intelligence and neuropsychological tests, which include art tasks. The results are characteristically uneven. Selective sensory deficits among the AD population, the erratic but progressive course of the disease, and the fact that it affects a wide variety of people with a wide range of prior functioning, all complicate research measures and contribute to complex findings. To illustrate the clinical and biological heterogeneity of AD, Friedland (1988) presented six very different house drawings from six patients with probable AD. Houses drawn by patients with left temporoparietal hypometabolism were vastly better integrated than those by patients matched in severity of dementia but with right temporoparietal hypometabolism.

Wald (1983, 1984, 1986) presented specific case histories, treatment, techniques, and characteristics of the art from patients with AD. She found that art reflected the progressive course of the disease and deterioration in neuropsychological abilities.

Cummings and Zarit (1987) described similar impairment in a drawing series by a semiprofessional artist with probable AD. These drawings of windmills from the artist's homeland track the sequential impairment of the artist, even though he was performing a familiar task with a familiar subject.

Method

The purpose of this study was twofold, to test a battery of projective drawings under highly controlled circumstances and to test whether such a drawing battery can differentiate a population of patients with diagnosis of early stage AD from an age-matched control group. The first goal was prompted by the simultaneous existence of sustained, enthusiastic use of projective drawing techniques and equally sustained, well-founded doubt and criticism. The second goal seemed supported by the fact that the list of identified symptoms common to AD includes constructional difficulties which have been observed in drawings of AD patients. Several facts contribute to the press to investigate the use of drawing with an AD population. There is a paucity of research with either spontaneous or directed drawings with this group despite long-term recognition of constructional difficulties in this population. Simultaneously, there now exists technology which allows more reliable diagnosis of AD.

The methodology grew from my earlier experience as a clinical art therapist and an amalgamation of ideas and work from other theoreticians, clinicians, and others with interest in quantification of artistic expression for the understanding of emotion and behavior. The research design was a Static-Group Comparison Design, technically a preexperimental model according to Campbell and Stanley's definition (1966).

Subjects

Subjects were recruited primarily from an ongoing treatment and research population from Harbor/UCLA Research and Education Institute, Inc. They represented two independent groups: the first, healthy controls without major psychiatric or medical disorders or head trauma; the second group, Alzheimer's patients, relatively early in the course of illness but with demonstrated pathology, manifested in behavioral change, or evident in brain imaging studies. Inclusion criteria for the second group required a diagnosis of AD, made and confirmed by a psychiatrist and a neurologist in accordance with the *Diagnostic and Statistical Manual III-R* (1987). A total of 84 subjects were assigned random code numbers and administered protocols. Of 35 control subjects, aged 45 to 83, three were eliminated after pathology was discovered during preliminary testing. Eleven of the 42 AD patients included, aged 51 to 89, were eliminated because they presented additional diagnostic questions or confounding additional diagnoses such as schizophrenia and alcoholism. Subjects in each group were matched by age, to yield 25 pairs of the closest range for analysis; this required eliminating the youngest of the controls and the oldest of the AD subjects. Of the 50 age-matched subjects, the mean age for controls was 69.0 with nine males and 16 females, the mean age for AD subjects was 71.2 with 10 males and 15 females.

Instrumentation

The core of the design consists of a systematic drawing test protocol which can be replicated readily. Projective techniques were chosen to provide a range of stimuli embracing both ambiguity and structure. The battery is based upon the most apparently useful parts of traditional drawing techniques and related research. The four drawing tests have been used as a series since 1982 by art therapists at Harbor/UCLA Department of Psychiatry. These techniques were: Name Embellishment (NE); a modification of the House-Tree-Person (H-T-P-M); a modification of the Kinetic Family Drawing (K-F-D-M); and a Free Choice, Titled (FC-T). Each technique seeks different information and was arranged sequentially to complement other procedures.

The researcher designed a 14-page *Instruction Manual and Protocol for the Projective Drawing Test Battery* to guide methodical administration. A booklet *Define It Before You Count It* provided operational definition for critical terms. A

Response and Inquiry Form was designed to be attached to each of the four drawings, and score sheets were designed based upon a graphic indicator list of 39 variables which were hypothesized as more likely to appear in drawings by AD subjects than drawings by nondemented elderly. These 39 variables were extrapolated from DSM III-R for AD and from published descriptions of art from AD patients. This form, the Graphic Indicator List, is included as Figure 1 and comprised the major hypothetical construct for differentiating the control from AD subjects in this study. Scores of graphic indicators may be examined as a total, separately according to the four tasks, #1 NE, #2 H-T-P-M, #3 K-F-D-M, or #4 FC-T, or

Checklist for graphic indicators **Code #**

Please check for apparent characteristics in each of the four drawings.

	CHARACTERISTIC	NE#1	H-T-P-M#2	K-F-D-M#3	F-C-#4	
A. APPROACH TO DRAWING TASK	Lag Time #					
	Drawing time					
	Inappropriate to task					
	Refusal of task					
	Abstract response					
	Concrete response					
	Confused response					
	Excessive response					
	Impulsive response					
	Minimal response					
	Derailing from goal					
	Destruction of material					**A SUB TOTAL**
B. DRAWING ORGANIZATION	Distorted perspective					
	Distorted proportion					
	Bird's eye view					
	Worm's eye view					
	Fragmented gestalt					
	Dominance R L T B					
	Specific area neglect					
	Incongruity					**B SUB TOTAL**
C. DRAWING QUALITY	Ambiguous shapes					
	Flattened shapes					
	Paucity shapes/form					
	Apparently aimless lines					
	Gaps between lines					
	Overlapping lines					
	Perservation line/form					
	Reinforced lines					
	Shakey lines					
	Unintelligible essentials					**C SUB TOTAL**
D. DRAWING CONTENT	Omission of essentials					
	Overemphasis on details					
	Irrelevant/extra letters					
	Evidence of faulty recall					
	Evidence of suspicion					
	Bizarre content					
	Morbid content					
	Paucity in content					
	Personalized content					
	Perservation in theme					
	Fused or Hybrid images					**D SUB TOTAL**
	SUB TOTALS	**1**	**2**	**3**	**4**	**TOTAL**

Figure 1. Graphic Indicator List

separately according to four subcategories of the measures: A. Approach to Drawing, B. Drawing Organization, C. Drawing Quality, or D. Drawing Content. This form was modified to compare independent scoring by the three judges. A supplementary modified mental status form was also designed. Each segment of this procedure sought to ensure accurate and standardized administration in order to assess the utility of the battery in distinguishing drawings from the two populations.

Other Tests

Prior to and in addition to the procedure for this study, the following tests were administered by the research staff at Harbor/UCLA to all control subjects: Structured Clinical Interviews for DSM III-R, Hamilton Depression Rating Scale (HAM-D), Brief Psychiatric Rating Scale (BPRS), Thought Disorder Rating Scale (TDRS), Mini Mental State Examination (MMSE), Hachinski Scale (HS), as well as a complete physical exam and standard laboratory tests. A neuropsychological battery included Wechsler Adult Intelligence Scale-Revised (WAIS-R), Wechsler Memory Scale, Rey-Osterrith Complex Figure Test, Wisconsin Card Sorting Test, Stroop Test, Consonant Trigrams, Thurstone Controlled Oral Word Association Test, and the Recognition Memory Test. Neuroimaging and brain mapping were also done with the following techniques: Computerized Axial Tomography (CAT), Magnetic Resonance Imaging (MRI), Computerized Electroencephalogram (EEG), and Single Photon Emission Computerized Tomography (SPECT). The purpose of these procedures was to assure that the control subjects had no abnormalities which might contaminate research or confound comparative studies.

Procedure

Before the administration of the drawing procedures, all subjects or their legal conservators signed the Human Subjects Consent Form; also, they were given a copy of *Experimental Subject's Bill of Rights* and a question and answer sheet which described the nature and purpose of the research. The researcher emphasized the voluntary nature of participation and the option of being unable or unwilling to complete the series of drawings. This procedure also guaranteed confidential and anonymous handling of results. Subjects were informed that people who do not draw regularly sometimes feel awkward or uncomfortable with the process and that drawings may stir up feelings or memories. It was established that it was appropriate to express any reservations or discomfort experienced. All informed consent papers are part of the author's permanent file.

Administration of the Battery

The drawing battery was administered with uniform procedure to all subjects as specified in the *Instruction Manual and Protocol for Projective Drawing Test Battery* with standardized arrangement of identical materials. At the time of administration specific diagnostic information about individual subjects was not available to the examiner who also was blind to the results of the additional tests listed above. Drawing performance and behavioral observations from the research sessions were recorded on the Response and Inquiry Forms which were attached to the drawings as stipulated in the protocol. Each series was then coded with a random number so that the age, gender, and code number were the only identifying information on the forms throughout scoring and statistical analysis.

Validity

A panel of three independent judges with established expertise in the field of art therapy and no other connection with the project scored the drawing protocols. Although all three were professionally experienced in using art with diagnosis, they were oriented to the operational definitions of terms used for the 39 variables in the Graphic Indicator List as part of the process to provide a uniform base for terminology and to control reliability of categories. Any terminology for which there was not 100% agreement of meaning was rephrased, discarded, or put into a separate category for independent analysis.

For initial scoring, the three judges chose a random sample of nine drawing batteries from the 50 study protocols. To test both interrater reliability and the validity of the system, they scored these nine samples individually on single Graphic Indicator Lists without knowledge of the results from other judges. Following this, the individual scores were tallied on a three-way sheet so that percentage of agreement could be checked. For the 39 variables judged this way, point by point unanimity was sought for what *was scored* and for what *was not scored* 90% of the time. For the 50 age-matched subjects included in the study, a total of 195 drawings were scored; an overall 90% criterion of agreement was required for a scoring to be retained.

All variables were counted individually for four drawings from each subject, therefore, the maximum possible total was 4 × 39 or 156 scorable points. For a 90% agreement, judgment had to coincide on 140 of the 156 points. It was considered a disagreement *if one judge only* marked any given variable or *if one judge did not* mark a variable when the other two did. Agreement or disagreement was counted point by point with each variable. In the initial scoring all three judges agreed in excess of the 90% criterion. Therefore, scoring was divided among them for the remainder of the drawing to be evaluated by one judge. The research had every sixth protocol scored by two judges without sharing prior scores as an additional check. The Kappa Coefficient was used to provide a measure of agreement among the three judges. This statistical process accounts for frequency of positive and negative scores to eliminate the chance of random agreement, thereby avoiding artificial inflation of results.

Criterion-related validity was provided by establishing the 39 variables in the Graphic Indicator List from diagnostic criteria from the DSM III-R for Primary Degenerative Dementia of the Alzheimer Type, since that constellation of symptoms distinguished the AD group of subjects from the control subjects.

Characteristics initially hypothesized from the literature on AD were analyzed and subjected to theoretical scrutiny as part of the content validity to establish which if any of the characteristics occur more frequently in the drawings from

AD patients than controls. Further analysis also searched for patterns and clusters of related characteristics to aid in future exploration of graphic indicators of AD.

Results

Findings from the study are presented in the following order: first, analysis of the scoring process by three independent judges for 50 comparable protocols; second, presentation and statistical analysis of the scores from the judgment of graphic indicators hypothesized as potentially differentiating the drawings of AD and control subjects; and third, presentation and analysis of additional objective measures from the general protocol.

Scores from the judging of the pictures can be accessed from the graphic indicator total, separately according to the four tasks, # NE, #2 H-T-P-M, #3 K-F-D-M, or #4 FC-T, or separately according to the subcategories of the measures: A. Approach to Drawing, B. Drawing Organization, C. Drawing Quality, or D. Drawing Content. For judgment criterion, this study sought 100% agreement, 90% of the time. To meet that target, unanimity had to occur in 420 of the potential 468 points for each protocol scored in common.

The mean point disagreement in the process of judging the drawings was 29.8 (± 11.7). This can also be expressed as a percentage of agreement of (100% − 6.4%) = 93.6% so that the goal of 90% unanimous agreement was exceeded. Because some of these scores represented a count of absence or presence of an item, the scores were also corrected to the level of agreement which can be assigned to chance by using the Kappa Coefficient. In this study the three judges each making a two-valued judgment would be expected to reach random agreement 25% of the time, agreement for these judges with the Kappa Coefficient was 0.915, thereby exceeding chance. Throughout the judging process, interrater reliability was maintained at over 90%.

Graphic indicator scores for 50 AD and control subjects exhibit similar variances and their skewness and kurtosis fall within the range expected for normal distributions for 95% confidence levels. There was a significant difference between the mean score for control subjects ($M = 16.84 \pm 6.71$) and that for AD subjects ($M = 42.12 \pm 7.42$), $t(24) = 12.6$, $p \leq .0001$. The scattergram in Figure 2 illustrates these results. The scores show a separation of performance in which none of the control subjects scored above 29 and none of the AD subjects scored below 32.

Table 1 displays score data for each separate drawing task. Differences were noted in responses to different elements of the battery and from different subjects. Although no control subject refused any of the four tasks, three AD subjects declined #3, the family drawing, and two declined #4, the free choice.

Student's *t* tests performed for all four of the individual tasks show significant differences between the two groups of subjects. Although all tasks produced significant results, the strongest raw score difference was from task #2 ($t = 12.57$, $p \leq 0.0001$) which asks the subjects to draw a picture including a house, a tree, and a person, whereas task #1, the request for name embellishment, elicited the smallest difference in raw score. ($t = 5.89$, $p \leq 0.0001$)

```
                 60-61 -                  X
                       -
                       -                  X
                       -
                       -
                 50-51 -                  X
                       -                  XX
                       -                  XXX
                       -                  XX
                       -                  XXXX
                 40-41 -                  XX
                       -                  X
                       -                  XX
                       -                  XX
                       -                  XXX
SCORE            30-31 -                  X
                       -  XXX
                       -
                       -  X
                       -  XXX
                 20-21 -  XX
                       -
                       -  XXXXX
                       -  XXX
                       -  XXX
                 10-11 -  X
                       -  XX
                       -  X
                       -  X
                       -
                   0-1 -

             SUBJECTS:    CONTROL         AD
```

Figure 2. Graphic Indicator Scores

Table 1
Means and Standard Deviations of Scores and t test by Drawing Tasks

Test	Means & SD Controls	Means & SD AD	*t*	*p*
#1 NE	3.48 ± 2.49	7.88 ± 2.86	5.89	≤ 0.0001
#2 HTPM	4.24 ± 2.01	12.16 ± 2.56	12.57	≤ 0.0001
#3 KFDM	5.16 ± 2.59	11.36 ± 2.08	8.73	≤ 0.0001
#4 FCT	3.96 ± 1.79	10.24 ± 3.28	11.07	≤ 0.0001
All tests*	16.84 ± 6.72	41.95 ± 8.00	11.45	≤ 0.0001

*In this treatment, five AD subjects for which either Task #3 or Task #4 were not obtained have been eliminated for consistency. Overall graphic indicator scores included average values for the missing data.

BEST COPY AVAILABLE

Table 2
Means and Standard Deviations of Subject's Scores and t tests According to Graphic Indicator Categories

	Controls	AD	t	$p\leq$
A. Approach to Drawing	1.68 ± 1.75	11.56 ± 3.98	10.87	0.0001
B. Drawing Organization	2.28 ± 2.46	6.89 ± 2.83	6.06	0.0001
C. Drawing Quality	7.16 ± 3.09	11.17 ± 5.91	3.42	0.0013
D. Drawing Content	5.64 ± 2.64	11.89 ± 3.10	7.41	0.0001

Table 2 shows the subtotals of subject's scores according to drawings categories, A, B, C, and D. Although AD subjects were significantly higher than control subjects in all general categories shown in both Tables 1 and 2, the greatest overlap of individual scores occurred in Category C of Table 2, a finding confirmed in the results of *t* tests performed according to categories. Variables in Category C measured drawing quality.

Possible interplay between scores and the ages of the subjects was explored by evaluating ranked ages and graphic indicator scores for both of the study groups. Figure 3 provides the configuration of the scores and ages for control subjects; Figure 4, contains the same information for AD subjects. For control subjects, there was a positive relation between age and high scores; an F-test shows a large ratio of the Means Squared for controls (212.449), the probability of this being a random occurrence is .0257. For AD subjects, the results were different; no relation was apparent. Means Squared was much smaller (5.19), and there was a .7511 probability that the effects of age on scores is random.

Results were also analyzed according to the individual variables from the Graphic Indicator List. There were several differences in response patterns between control and AD groups. No single variable was scored for all control subjects, but two variables, Minimal response and Paucity in content appeared at least once for all AD subjects. Six variables were scored in more than 60% of the batteries from Control subjects: 16 variables were scored for 60% or more AD subjects. Frequency by percentage of responses to the 39 variables was tabulated. Clusters and divergences in the incidence of individual variables was also examined for analysis by stepwise regression.

The 11 variables identified as the strongest by stepwise regression were compared to the 11 variables with the greatest raw frequency. They overlap in seven variables: Concrete response; Confused response; Specific neglect/dominance; Omission of essentials; Evidence of faulty recall; Bizarre content; and Perseveration in theme.

Objective measures of findings included several features in addition to the graphic indicators. They include the use of time and material.

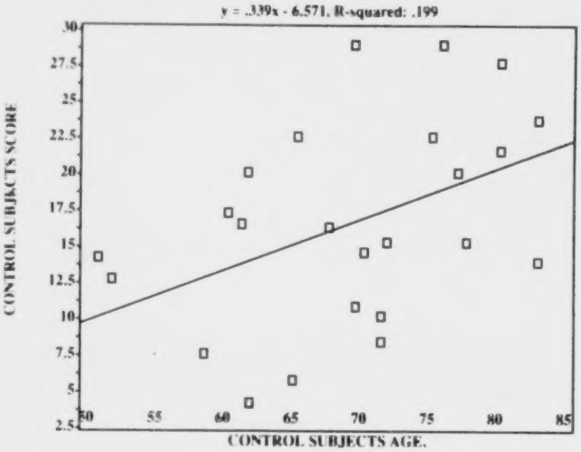


Figure 3. Relationship of Age and Graphic Indicator Scores of Control Subjects

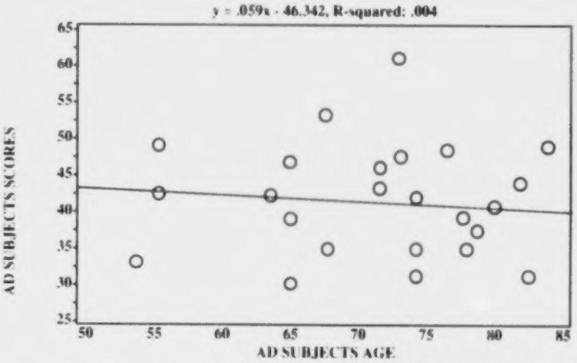


Figure 4. Relationship of Age and Graphic Indicator Scores of AD Subjects

The mean time for control subjects to complete the battery of four drawings was 42.2 minutes while AD subjects took an average of 30 minutes. Within the measures of each group there were sizable variances, the SD for controls was 17.3, for AD subjects it was 9.6. Control subjects took one-half minute lag time before starting each drawing while AD subjects took slightly more than one minute for each. The actual drawing time for separate tasks was close for the two groups, control subjects spent 4.6 minutes per drawing and the AD subjects spent 4.2 minutes. Neither difference was significant when subjected to a *t*-test.

Drawing Materials

All subjects had identical opportunity to choose from the same materials which were displayed in a consistent position. The materials included thick and fine markers, oil pastels, a #2 pencil with an eraser, and a pen. Results appeared to indicate that many of the subjects were indifferent or at least casual about materials. Ten control subjects (40%) and 11 AD subjects (44%) chose to use the same single tool throughout for all four drawings. One subject from each group elected to use his personal pocket pen. A larger disparity was evident in the way the remainder of the two groups responded to choices of materials; only 10 of the 95 drawings from AD subjects had two to four colors and none had more than four. Control pictures which had more than one color usually had many; more drawings included five more colors than the medium range of two to four.

Three categories were used to gauge individual use of material: (a) use of a single implement or color, (b) use of two to four colors or materials, (c) use of five or more colors. One hundred drawings from control subjects were rated and 95 from AD subjects. Table 3 illustrates the results.

Table 3
Materials Chosen and Used for Each of Four Drawings According to Groups

	Control Subjects Number of Materials Used			AD Subjects Number of Materials Chosen			
Drawing:	1	2–4	5/more	1	2–4	5/more	declined
#1 NE	14	5	6	24	1	0	0
#2 HTPM	14	2	9	22	3	0	0
#3 KFDM	14	5	6	20	2	0	3
#4 FCT	13	6	6	19	4	0	2

Use of Space

All subjects used white 8″ × 10″ paper, presented horizontally. Nineteen control subjects drew on the paper as it was presented, three vertically and three mixed positions throughout the four drawings. Among AD subjects, 17 drew horizontally, five vertically, and three mixed the positions. These findings indicated that for this measure the two groups of subjects were comparable.

The amount of space used by the drawings was measured by a transparent template according to whether the drawing used less than one-third of the page, between one-third and two-thirds of the page, or more than two-thirds of the page. Again, 100 samples from the control subjects and 95 samples from the AD subjects were measured showing clear differences in the use of space between the two groups: 7% of control subjects used less than one-third of the space compared to 54% of the AD subjects. At the opposite end of the spectrum, 79% of control subjects used more than two-thirds of the page compared to 22% of AD subjects. These data are also presented in Table 4 and the difference between control and AD subjects is significant ($x^2(2) = 70.3$, $p \leq 0.0001$.)

Table 4
Observed Frequency Table for Use of Space

Area	Control	AD
Less than ⅓	7	52
Between ⅓ and ⅔	15	23
More than ⅔	78	20
Totals	100	95
DF = 2	Total Chi-Square = 70.3	$p \leq 0.0001$

House Drawings

For research purposes, house drawings were the most common configuration which could be readily quantified for statistical analysis. To facilitate comparison, a linear measure of the area of the house pictures was developed. First, the gross area covered by a house was calculated by multiplying the overall vertical and horizontal dimensions. The house was then quantified as the length of a side of the equivalent square. A total of 25 houses drawn by control subjects were measured; the mean length of the side of an equivalent square was 3.77 ± 1.43 inches. Nineteen house drawings by AD subjects were measured; the mean length of a side of an equivalent square was 1.94 ± 1.00 in. The t statistic measuring the significance of the difference between these data is $t = -4.76$, $p < 0.0001$, a value clearly indicating a significant difference. These data provided a simple example of the projective drawing analog of micrographia.

Discussion

Two current and widely publicized concerns are the "graying of America" and the high cost of healthcare. These well-documented phenomena heighten the potential usefulness of a relatively simple method of differentiation among the aging population. Results from the drawing battery were consistent throughout with test results for the same population of standardized psychological tests and high-tech medical procedures.

Replication of the procedure with other populations and with larger numbers would be potentially useful. The same procedure might be tested with a different assortment of graphic indicators designed for the anticipated characteristics of any clinical population. Levin and Benton (1988) discussed the relative merits of fixed batteries versus flexible or adjustive strategy in neuropsychological assessment. Their conclusions are useful in any work with a clinical population. The contrasting needs of research and treatment can be addressed starting from a similar battery of techniques if the clinician is flexible. During the course of the above research, several potential subjects demonstrated needs beyond the boundaries of the study. Such individuals were responded to in a supportive, therapeutic way and were not included as subjects. Provisions for appropriate response in similar contingencies should be incorporated in all research design.

The attempts by art therapists to understand people, their strengths, and their pathology by way of their art processes and products will continue to be a challenge. For research, many models and the admixture of many resources is demanded. The rewards of crisp and useful results are possible and certainly within the purview of well-trained art therapists.

References

American Psychiatric Association. (1987). *Diagnostic and Statistical Manual of Mental Disorders III-R*. Washington, DC: Author.

Benton, A. (1985). Visuoperceptual, visuospatial and visuoconstructive disorders. In K. M. Heilman & E. Vensten (Eds.), *Clinical Neuropsychology*. (2nd ed.) New York: Oxford University Press.

Bogen, J. (1985). The callosal syndromes. In K. Heilman & E. Vensten (Eds.), *Clinical Neuropsychology*. (2nd ed.) New York: Oxford University Press.

Campbell, D. T., & Stanley, J. (1966). *Experimental and quasi-experimental designs for research*. Boston: Houghton Mifflin.

Cummings, J., & Benson, D. F. (1986). Dementia of the Alzheimer Type/An inventory of diagnostic clinical features. *Journal of the American Geriatric Society, 34*, 12–19.

Cummings, J., & Zarit, J. (1987). Probably Alzheimer's Disease in an artist. *Journal of American Medical Association*, November, 258.

Friedland, R. P. (moderator). (1988). Alzheimer's Disease: Clinical and biological heterogeniety. *Annals of Internal Medicine, 109* (15), 298–311.

Heilman, K., Watson, R. T., & Valenstein, E. (1985). Neglect and related disorders. In K. Heilman & E. Vensten (Eds.), *Clinical Neuropsychology*. (2nd ed.) New York: Oxford University Press.

Hollander, E., Mohs, R. C., & Davis, K. L. (1986). Review: Antemortem markers of Alzheimer's Disease. *Neurobiology of Aging, 7* 367–387.

Kramer, E. S., & Iager, A. C. (1984). The use of art in assessment of psychotic disorders: Changing perspectives. *The Arts in Psychotherapy, 11*, 197-201.

Levin, H. S., & Benton, A. L. (1988). Neuropsychological Assessment. In R. Joynt (Ed.), *Clinical Neurology*. (Vol 1, rev. ed.). Philadelphia: J. B. Lippincott.

Moore, V., & Wyke, M. (1984). Drawing disability in patients with senile dementia. *Psychological Medicine, 14*, 97–105.

Peck, E., Stephens, V., & Martelli, M. (1987). A descriptive summary of essential neuropsychological tests. In L. Hartlage, et al. (Ed.), *Essentials of Neuropsychological Assessment*. New York: Springer Publishing.

Plutchik, R., Conte, H. R., Weiner, M. B., & Teresi, J. (1978). Studies of body image. IV. Figure drawings in normal and abnormal geriatric and non geriatric groups. *Journal of Gerontology, 33*(1), 68–75.

Reisberg, B., Ferris, S., & Franssen, E. (1985). An ordinal functional assessment tool for Alzheimer's-Type Dementia. *Hospital and Community Psychiatry, 36*(6), 593–595.

Roeltgen, D. (1985). Agraphia. In K. Hellman & E. Vensten (Eds.), *Clinical Neuropsychology*. (2nd ed.) New York: Oxford University Press.

Sacks, O. (1985). *The man who mistook his wife for a hat and other clinical tales*. New York: Harper & Rowe.

Wald, J. (1983). Alzheimer's disease and the role of art therapy in its treatment. *American Journal of Art Therapy, 22*(1), 57–64.

Wald, J. (1984). The graphic representation of regression in an Alzheimer's disease patient. *The Arts in Psychotherapy, 11*, 165–175.

Wald, J. (1986). Fusion of symbols, confusion of boundaries: Percept contamination in the art work of Alzheimer's patients. *Art Therapy: Journal of the American Art Therapy Association, 3*(2), 74–80.

THE 5TH ANNUAL CONFERENCE ON TRAUMA AND DISSOCIATION
SEPTEMBER 22 - 25, 1994 - DALLAS TEXAS

Sponsored by the Texas Society for Study of Trauma and Dissociation

CONFERENCE THEME: The conference will focus on intervention techniques and clinical issues concerning trauma and dissociation. Topics will include ritual abuse, childhood abuse, dissociative disorders, symbolic ventilation, creative arts therapies, hypnosis, "false memory" syndrome, male victims, and integration and post-integration techniques. Also featured:

✓ Pre-conference Institute on Art Therapy and Family Violence

✓ Sessions on "Using Drawings in the Assessment of Children from Violent Homes" & "Forensic Art Therapy"

For a conference brochure, please contact: Family Violence and Sexual Assault Institute, 1310 Clinic Drive, Tyler, TX 75701 (903) 595-6600.

Brief Reports

The Imagery and Expression of Anger: An Initial Study

Frances F. Kaplan, DA, A.T.R., Hofstra U., NY

Abstract

This study, the first in a projected series, investigated the relationship between anger and anger imagery and between anger and positive action. In addition, the colors, themes, and formal elements used to depict anger were explored. Forty-six college students completed a social action questionnaire, a drawing representing anger, and Spielberger's State-Trait Anger Expression Inventory. A significant positive correlation ($p < .05$) was found between intensity of anger imagery and State Anger, and the correlation between Anger Expression scores and social action tended toward significance ($p < .10$). A qualitative analysis of the drawings indicated that there are common signs and symbols used to express anger in drawings and suggested a therapeutic technique for further development. Overall, the results support clinical experience in art therapy.

Introduction

Our ideas about anger are changing. We view it as both more positive and more complicated than we once did. Advice columns in the newspaper tell us that it can be a positive force. Popular self-help books have alerted us to the dangers of the denial of anger, on the one hand, and its inappropriate expression, on the other (Lerner, 1985; Tavris, 1989). Turning to the professional literature reveals studies that cast doubt on earlier conceptions of the psychology of anger. For example, watching aggressive sports has been shown to increase hostility rather than to reduce it through catharsis (Goldstein & Arms, 1971). Further, there is evidence that verbal expression of anger is ineffective in ameliorating aggression—unless it is combined with a reinterpretation of the stimulating event (Green & Murray, 1975).

Our changing viewpoint has had implications for the practice of therapy. The realization that there are optimum levels of experiencing anger and preferred modes of expressing it has led to the development of anger management programs to assist clients in recognizing and harnessing anger. The techniques for this process are still evolving, but relevant findings suggest that visual modalities have a role to play. Consider research in the areas of imagery and color. Imagery interventions have been shown to have potent therapeutic utility (Korn & Johnson, 1983; Sheikh, 1984). More to the point, imagery has been found to enhance the effectiveness of verbal cognitions in altering unpleasant moods (Means, Wilson, & Dlugokinski, 1986–87). In regard to color, art therapy research (Levy, 1980) has provided support for one of the field's primary assumptions: that a consistent relationship exists between color and emotion. These developments suggest that art therapy can make an important contribution to the process of anger management—either as part of a specialized program or within the context of a more comprehensive course of treatment.

Finally, there are indications that anger, social activism, and optimum psychological functioning are linked. In their work on moral commitment, developmental psychologists Colby and Damon (1992) speculate that "people . . . who spend their lives fighting for social justice, need the harder edge that anger provides" (p. 128). A previous study supports this conjecture. As part of an investigation of imagery and nuclear attitudes (Kaplan, 1988–89), antinuclear activists produced more vivid images of anger. Similarly, a connection between activism and healthy functioning can be inferred from current formulations of ego development (Loevinger, 1976). In these, concern for social problems is generally a characteristic of the higher developmental stages.

The larger purpose of this study, then, was to increase our understanding of how art expression relates to anger so that it can be more effectively used for dealing with this complex emotion. More precisely, this study was designed to investigate the relationships between anger, images, and positive social action and to explore typical themes, colors, and formal elements used to express anger in drawings.

Method

Research Participants

The sample consisted of 46 undergraduate students. The participating students—37 women and nine men—were members of an introductory course in art therapy and two sections of a course in educational psychology. They had a mean age of 21.3 years and reported their ethnic origins as white (39), Hispanic (4), and black (2); one person did not indicate ethnic group.

Frances F. Kaplan, DA, A.T.R., is a coordinator of the Creative Arts therapy program at Hofstra University, NY.

Measures

The research tools were an activity questionnaire, an anger imagery drawing procedure, and Form HS of the State-Trait Anger Expression Inventory (Spielberger, 1988). The activity questionnaire, considered a measure of positive action, and the anger imagery drawing procedure were developed for the purposes of this study. As mentioned above, previous research (Kaplan, 1988–89) had found a relationship between anger imagery and social activism. Thus, I devised a brief questionnaire to determine whether participants had ever been involved in or financially supported the work of any social action groups (see Table 1). The imagery drawing procedure was a modified version of one used in the same study. Participants were instructed as follows: "If anger were something you could see, what would it look like? Draw a picture and give it a descriptive title."

The State-Trait Anger Expression Inventory (STAXI) is a research instrument that measures the experience and expression of anger. It contains six scales that assess amount of current anger (State Anger), propensity toward anger (Trait Anger), tendency to turn anger inward (Anger-in), tendency to direct anger outward (Anger-out), degree to which anger is prevented (Anger Control), and a general index of the frequency with which anger is expressed (Anger Expression). Individuals rate themselves on four-point Likert-style scales for each of the 44 STAXI items. Examples of these items are "I am quick tempered" and "I control my angry feelings." Studies reported in the STAXI manual (Spielberger, 1988) indicate good concurrent validity and internal consistency reliability. Normative data is available for the college population used in this investigation.

Table 1
Social Action Questionnaire

1. Have you ever been involved in or supported the work of any social action group?

☐ **Yes** ☐ **No**

If "yes," complete 2. and 3.

2. Type of group (check all that apply)

- ☐ **Environmental protection**
- ☐ **Human needs (dealing with hunger, housing, etc.)**
- ☐ **Human rights (women/minority rights, opposing apartheid, etc.)**
- ☐ **Animal rights**
- ☐ **Peace/disarmament**
- ☐ **Other** ____________________

3. Type of involvement (check all that apply)

- ☐ **Gave money**
- ☐ **Signed petitions**
- ☐ **wrote letters to officials**
- ☐ **Participated in demonstrations**
- ☐ **Attended meetings**
- ☐ **Did volunteer work**
- ☐ **Worked for pay**
- ☐ **Other** ____________________

Procedure

The participants were administered the research instruments during one of their regularly scheduled class sessions. They were given self-rating research packets containing a demographic data sheet, the social action questionnaire, a sheet for the anger imagery drawing, and the STAXI item booklet. Each participant was also supplied with a pencil, a small box of cray-pas, and a packet of assorted markers. So that the anger imagery would be as spontaneous as possible, participants were directed to complete the drawing before responding to the anger inventory. No time limit was imposed for completion of the research measures.

Drawing Analysis

The drawings were subjected to both a quantitative and qualitative analysis. For the quantitative analysis, the drawings were ranked in regard to anger intensity. An independent rater scored the drawings on a three-point scale based on a global assessment of expressed anger. As a reliability check, I also rated the drawings. Comparison of the two sets of scores resulted in a satisfactory interscorer correlation of .75. However, in order to minimize bias, only the other rater's scores were used in the calculations.

The qualitative analysis involved a careful examination of the artwork to determine typical colors, themes, and formal elements. This analysis was conducted by myself with the assistance of an art therapist in training. First, I sorted the drawings to derive categories of themes and colors. The student then sorted the drawings using my categories. This resulted in 98% and 80% agreement, respectively, for color scheme and content classification. Again, to minimize bias, the student's ratings were the ones used. The analysis of formal elements focused on the characteristics of the "angriest" drawings. The student and I independently noted our impressions. Because there was a general concurrence on characteristics, those reported represent a summary of the two responses.

Results

Quantitative Findings

As one indicator of the relationship between anger and positive action, Anger Expression (AX/EX) was statistically compared with social action. Since the scores for the STAXI scales are considered to be in the normal range if they fall between the 25th and 75th percentiles (Spielberger, 1988), AX/EX scores were sorted into three categories—low, average, and high—based on their percentile rankings. Social action was treated as a dichotomous variable reflecting whether or not participants reported involvement in social action groups.

Table 2
Bivariate Frequencies for Anger Expression and Social Action ($N = 46$)

Social action	Anger Expression score categories Low	 Average	 High
Yes	5	16	5
No	5	8	7

Table 3
Bivariate Frequencies for Image Intensity and Social Action ($N = 46$)

Social action	Anger image intensity ratings 1	 2	 3
Yes	7	8	11
No	2	12	6

Table 4
Bivariate Frequencies for Drawing Themes and Anger Expression ($N = 46$)

Anger Expression categories	Drawing themes Face	 Scribble	 Fire	 Explosion	 Misc.
Low	6	1	2	1	0
Average	6	8	4	4	2
High	5	3	2	2	0

(The remainder of the information on the social action questionnaire served as confirmation of this involvement.) A frequency distribution for AX/EX categories versus social action is presented in Table 2. Inspection of this distribution suggests a curvilinear relationship between the two variables. Although the chi-square value was nonsignificant ($\chi^2 = 2.25$, $p > .10$), combining the high and low AX/EX category scores and computing a Pearson correlation coefficient produced a marginally significant result ($r = .21$, $p < .10$, one-tailed test) in the predicted direction. This provides some tentative support for the notion that *moderate* levels of anger facilitate actions leading to change.

A similar analysis of the relationship between image intensity and social action was conducted. (See Table 3 for a frequency distribution of these variables.) Calculations yielded a larger but still nonsignificant chi-square ($\chi^2 = 4.33$, $p > .10$) and a significant correlation ($r = -.29$, $p < .05$, one-tailed test). The negative direction of the correlation seems to contradict the results of the preceding analysis. However, calculation of correlation coefficients for image intensity ratings and the raw scores for the six STAXI scales produced only one significant result—the value for the correlation between State Anger and image intensity ($r = .26$, $p < .05$, one-tailed test). This suggests that image intensity reflects current angry feelings rather than a general tendency to experience anger. Nevertheless, it is of interest that those expressing a moderate amount of angry feelings were less likely to have engaged in social action. (A possible explanation for this is offered in the Discussion section of this article).

Qualitative Findings

Inspection of the drawings yielded information concerning colors and themes used to depict anger. The association between anger and the colors black and red/orange appeared strong. Fifty-two percent of the artwork displayed this color combination—sometimes with small amounts of other colors. For another 33%, either black alone or the hot colors (red, yellow, orange) were the predominate colors. The remaining drawings (15%) had relatively cool color combinations or were rendered in pencil.

The most common themes, accounting for 95% of the drawings, were as follows: faces of monsters, devils, or humans—some disembodied, some with a portion of the upper torso (37%); scribbles representing confusion, chaos, or an abstraction of anger (26%); fire, by itself or consuming a person or thing (17%); and explosions (15%). (Figures 1-4 present examples of these themes, in order.) An attempt to differentiate themes used by participants with different anger tendencies revealed some interesting trends. Table 4 displays the distribution of themes in relation to AX/EX scores. Note that the face theme is the most frequently occurring one in the lowest score category. Also note that themes suggesting spontaneous expression—scribbles, explosions, flames—predominate in the higher categories. An additional bit of information is pertinent. Upon review, the faces drawn by low scorers appeared more anxious than angry (see Figure 1 for an example).

Finally, the drawings were examined to determine the characteristics that contributed to the global assessment of anger intensity. In general, drawings rated the "angriest" filled up more of the page, were more intensely colored, appeared more dynamic, and had heavier line pressure. When faces were the theme, their expressions seemed decidedly angry.

Discussion

The results of this study offer varying degrees of support for the following conclusions:

1. There is a relationship between normal levels of anger and action to promote change. Although this conclusion received only tentative support, it is in line with both clinical and everyday experience. Stronger findings might have resulted if another action variable, such as assertive behavior, had been used. Indeed, there are indications that this would be the case. Doyle and Biaggio (1981) found that asserters expressed more anger than nonasserters. However, they used

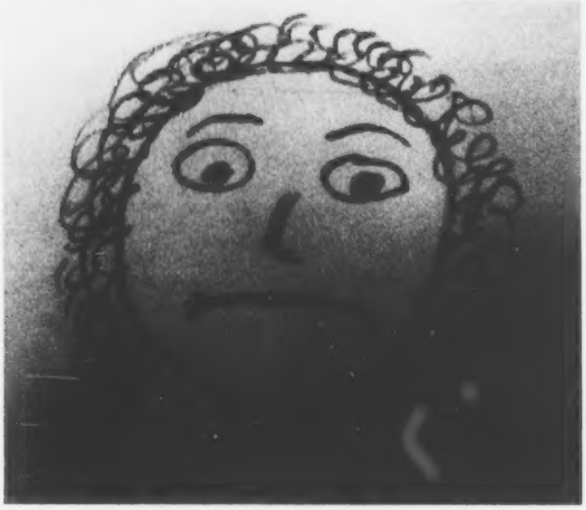


Figure 1.

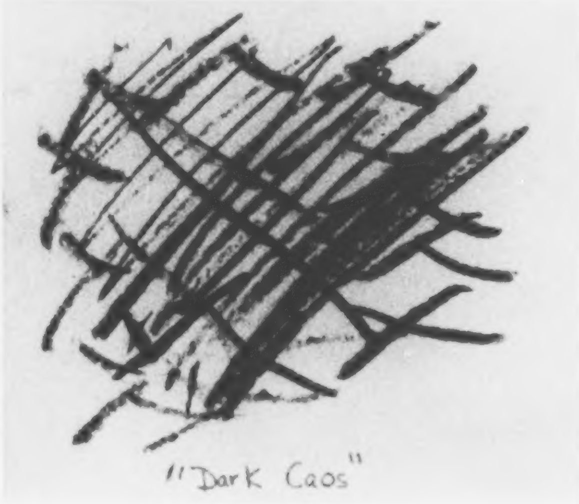


Figure 2.

Figure 3.

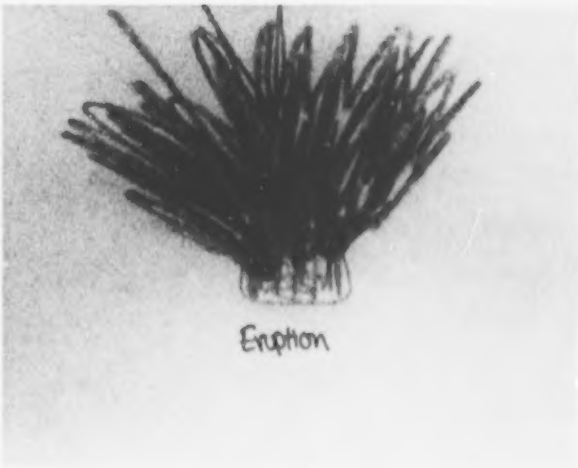


Figure 4.

different measures of anger and, hence, somewhat different constructs than those used in this study.

2. There is a relationship between how angry a drawing looks and how angry the artist feels. The evidence suggests that this applies more to state than to trait anger. However, in regard to the latter, the qualitative results point to drawing content as a promising area for further investigation.

3. There are certain colors, themes, and formal elements that are commonly used in depicting anger. The qualitative findings that lead to this conclusion could be considered "soft" evidence. But these findings are reinforced by a particular aspect of the quantitative analysis. The rater for the drawings was not an art therapist; yet he readily differentiated drawings in respect to anger intensity and received validation of his rating through the significant correlation with the State Anger scale. This suggests a degree of universality, at least within our culture, for the graphic signs and symbols of anger.

4. Individuals producing moderately intense images of anger are less likely to engage in social action. Although the evidence is insufficient to rule out the possibility that this conclusion results from error, a plausible explanation can be offered. Perhaps those who experience anger unequivocally are more likely to have it available for constructive use. If this is so, another dimension is added to the relationship between anger and positive action. That is, for the two to be strongly linked, it may be necessary to have a moderate propensity to express anger along with a strong tendency to experience it fully when it occurs.

As a final point, the therapeutic implications of this study deserve attention. It is no revelation to art therapists that drawings can be used to deal with anger. However, the possible relationship between drawing content and trait anger suggests a novel approach to anger management. Should the association between drawing content and trait anger prove strong, those who experience too much or too little anger might be guided toward moderation through gradual changes in their anger imagery.

References

Colby, A., & Damon, W. (1992). *Some do care: Contemporary lives of moral commitment.* New York: The Free Press.

Doyle, M. A., & Biaggio, M. K. (1981). Expression of anger as a function of assertiveness and sex. *Journal of Clinical Psychology, 37*, 154–157.

Goldstein, J. H., & Arms, R. L. (1971). Effects of observing athletic contests on hostility. *Sociometry, 34*, 83–90.

Green, R. A., & Murray, E. J. (1975). Expression of feeling and cognitive reinterpretation in the reduction of hostile aggression. *Journal of Consulting and Clinical Psychology, 43*, 375–383.

Kaplan, F. F. (1988–89). Imagery, ego development, and nuclear attitudes. *Imagination, Cognition and Personality, 8*, 105–120.

Korn, E. R., & Johnson, K. (1983). *Visualization: The uses of imagery in the health professions.* Homewood, IL: Dow Jones-Irwin.

Lerner, H. G. (1985). *The dance of anger.* New York: Harper & Row.

Levy, B. I. (1980). Research into the psychological meaning of color. *American Journal of Art Therapy, 19*, 87–91.

Loevinger, J. (1976). *Ego development: Conceptions and theories.* San Francisco: Jossey-Bass.

Means, J. R., Wilson, G. L., & Dlugokinski, L. J. (1986–87). Self-initiated imaginal and cognitive components: Evaluation of differential effectiveness in altering unpleasant moods. *Imagination, Cognition and Personality, 6*, 219–229.

Sheikh, A. A. (Ed.). (1984). *Imagination and healing.* Farmingdale, NY: Baywood.

Spielberger, C. D. (1988). *State-Trait Anger Expression Inventory: Research edition.* Odessa, FL: Psychological Assessment Resources.

Tavris, C. (1989). *Anger: The misunderstood emotion* (rev. ed.). New York: Touchstone.

Art Therapy and Alexithymia

Marilyn Heiman, MA, A.T.R., Diane Strnad, MA, Wendy Weiland, MA, A.T.R., and
Thomas N. Wise, MD, Falls Church, VA

Abstract

This study investigated the effect of alexithymia upon a person's art production. Subjects were 100 patients, 24 men and 76 women, hospitalized on an inpatient psychiatric unit. The Toronto Alexithymia Scale and 100-mm analog scales for depression and anxiety were administered. Each subject was asked to draw, then identify his/her illness. Verbatim associations were recorded. Artwork was rated as concrete, abstract, combination of the two, or symbolic. Number of colors used and presence or absence of body parts were noted. No significant correlations were found. All subjects, even those quantified as alexithymic, were able to graphically communicate their illness using these instructions. These results suggest the possibility for art therapy to contribute significantly to the multidisciplinary milieu.

Introduction

This paper reports a study done by art therapists in collaboration with the chairman of the department of psychiatry at a community-based teaching hospital. It was conducted on the 34-bed inpatient psychiatric unit, which is unlocked and treats voluntary adults and adolescents. All patients are managed by private psychiatrists who refer patients to creative arts and group therapies.

The study investigates the effect of alexithymia, an empirically measurable personality trait, on a patient's diagnostic art production done in response to the direction, "draw your illness." It, therefore, combines an objective instrument with artwork, which is subjective and less quantifiable. Past art therapy research that combines empirical measures with artwork includes authors Cohen, Hammer, and Singer (1988); Gantt (1990); Miller (1989); and Silver (1976, 1982, 1988).

Alexithymia

The term *alexithymia* was coined by Sifneos (1973) from Greek origins meaning absence of words for emotions. Bagby, Taylor, and Parker (1991) include the following features in defining alexithymia: (a) "difficulty in identifying and discussing feelings, (b) difficulty in distinguishing between feelings and the bodily sensations of emotional arousal, (c) constricted imaginative processes as evidenced by a paucity of fantasies, and (d) an externally oriented cognitive style" (p. 155).

Because of these characteristics, the presence of alexithymia has been shown to reliably predict difficulty using verbal psychotherapy (Bagby et al., 1991). It can be identified and measured through a variety of instruments; for the pur-

---

Editor's note: Requests for reprints or questions about this study may be directed to Marilyn Heiman, MA, A.T.R., Creative Arts Therapy, Fairfax Hospital, 3300 Gallows Road, Falls Church, VA 22046.

pose of this study, the Toronto Alexithymia Scale (TAS) was used. The present study investigates the relationship of alexithymia to an individual's ability to utilize art therapy.

We hypothesized that patients who score high on their TAS will: (a) respond to "draw your illness" with concrete imagery, (b) use three or fewer colors, and (c) somatize their illness by depicting human figures or parts of figures (somatize defined as mental illness manifested in the human body, excluding brain/mind). We further hypothesized that patients who score low on their TAS will: (a) respond to "draw your illness" with abstract imagery, (b) use more than three colors, (c) not depict the body, and (d) likely combine abstract and concrete imagery.

Method

Subjects

The subjects for this study were 100 patients hospitalized within a community-based, open inpatient psychiatric unit. Patients excluded from participation included those too psychotically disorganized to cooperate with the protocol as well as those with significant cognitive impairments due to delirium or dementia.

Measures

Alexithymia was measured dimensionally utilizing the TAS. The TAS is a 26-item self-report instrument demonstrated to have internal consistency, good reliability, and construct and criterion validity that measures alexithymia characteristics. A global score based upon the method reported by Bagby, Taylor, and Atkinson (1988) was used.

Depressed and anxious affects were individually assessed utilizing a 100-mm visual analog scale with greater values indicating more dysphoric affects. These scales have been demonstrated to provide a valid and reliable assessment of global affect (Morrison, 1990). The subject also was asked if he/she was color blind.

Each subject was asked to draw a graphic representation of his/her own illness. The materials used were 18" × 24" paper and a 24-color box of pastels.

It was decided to minimize the number of measurable variables by using only one drawing. Drawing the patient's illness was used because it:

1. Required the patient to conceptualize and graphically communicate his/her view of the illness;
2. Helped bypass defenses such as avoidance, intellectualization, and denial by acknowledging the reason for hospitalization;
3. Elicited whether the patient viewed his/her illness as psychiatric or somatic;
4. Served as a symbol which could be modified as the patient progressed in treatment.

After completing the drawings, each subject was asked to identify the illness drawn. Verbatim associations were recorded by the art therapist. This art production was scored as to whether it was abstract, concrete, combination of abstract and concrete, or symbolic. We defined these terms as follows:

Concrete: A literal response reflected in representational or realistic imagery (Figure 1).

Abstract: "The reducing of the visual statement down to the basic elements, bearing no connection to any representational information drawn from experience of the environment." (Dondis, 1971) (Figure 2)

Symbolic: "A simplified image that represents an idea or concept known to many, such as musical notes, numbers and words." (Dondis, 1971) (Figure 3)

Other considerations included the number of colors used and the presence or absence of actual body parts. Each of these parameters was judged independently by three of the authors. In cases where there were differences, a consensus was reached. Statistical analysis was performed using the SPSS Statistical package. Both demographic and inferential statistics were utilized. As the data distributed in a normal

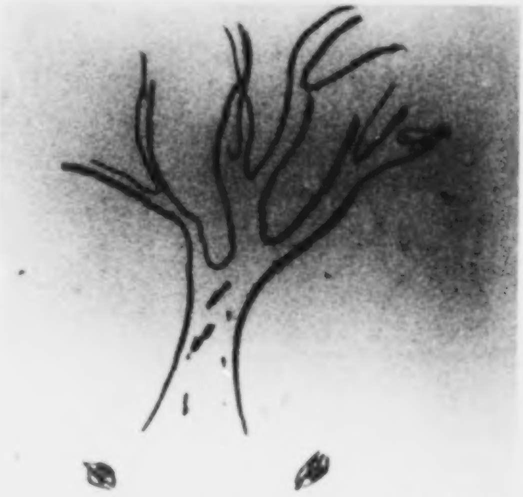


Figure 1. "Manic depression" drawn by nonalexithymic female (TAS 66).

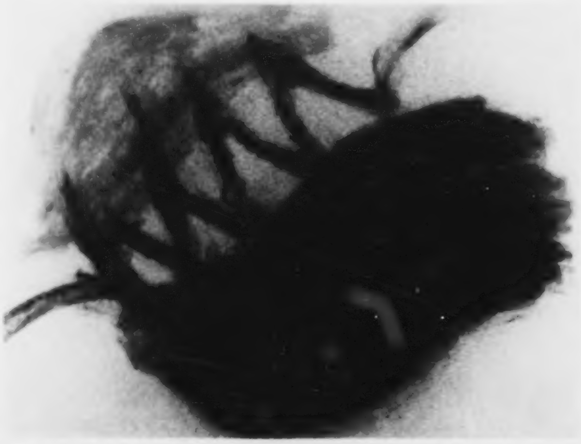


Figure 2. "Depression" drawn by alexithymic female (TAS 85).

Figure 3. "Anxiety and confusion" drawn by nonalexithymic female (TAS 58).

fashion, parametric as well as nonparametric approaches were utilized.

Results

The subjects included 24 men and 76 women. The diagnostic categories of the study sample were similar to the general psychiatric population during the two years prior to the study. Sixty-three subjects had a mood disorder, 15% presented with substance abuse and a dual diagnostic mood disorder, 7% had schizophrenia, 10% had a brief psychotic reaction, and 5% had other diagnoses. Analyses of variance revealed no difference between the alexithymia scores for patients with dual diagnoses, mood disorders, or psychotic states and thus the cohorts were aggregated for subsequent analyses. The median age for the total group was 38.26 (s.d. 14.43). As the males did not differ from females in respect to age, alexithymia score, or anxious or depressed affects, the total 100 subjects were considered together irrespective of gender. The mean TAS score for males was 70.125 (s.d. 14.094) and for females 71.7895 (s.d. 12.783). This group was thus significantly more alexithymic than a normative sample reported elsewhere (f = 1.547, p = .049) (Wise, Mann, & Sudy, 1992). Significant correlations were found among anxiety, depression, and alexithymia.

The subjects were partitioned via median split into those individuals above the median in alexithymia and those below. Analyses were then run to see if there was a significant association between a variety of the dichotomous variables. Chi-square analyses revealed no significant associations between alexithymic characteristcs and the presence of concrete elements, abstract elements, number of colors, body parts, or presence or absence of both concrete and abstract elements.

Due to the lack of significant correlations, the drawings were rescored for the presence or absence of symbolism. This did not yield significant association with the designation of alexithymic characteristics. Similar lack of significant association was found between the presence or absence of depression and anxiety utilizing the median split. Similar analyses were run by partitioning patients into very alexithymic subsets above 72, and very nonalexithymic below 62.

Discussion

The majority of patients in this study are suffering from major mood disorders. Given the high incidence of this diagnosis on psychiatric units (approximately 60%), the findings from this study are useful. No significant correlations were found among the TAS, 100-mm lines for depression and anxiety, and variables measured in the artwork. Thus the findings refute our hypothesis. Also, patients with high TAS scores sometimes were able to abstract and use three or more colors. One reason for this may be the use of the TAS versus other instruments which measure alexithymia. Concern was raised about the validity of the TAS because some patients who clinically appeared alexithymic scored low on the TAS. However, this may be related to the state effect of depression (Wise, Mann, & Sudy, 1992). Other considerations that may affect the use of abstraction and colors include diagnosis, talent, IQ, or past exposure to art therapy.

The "draw your illness" picture combined with the TAS and 100-mm line proved a useful assessment with psychiatric patients. When obtained early in a patient's stay, the drawing helped establish a therapeutic alliance. It provided an understanding of the patient, which was useful when formulating art therapy interventions. The data of the research package has been well-received at multidisciplinary staff conferences and clinical rounds since it offers a blend of quantifiable data with artwork. Although no correlations were found, it is nonetheless significant that all patients, even those clearly alexithymic, were able to graphically communicate their illness with these instructions.

Future research might include examininig color preferences, measuring primary or secondary alexithymia, rating size of self when drawn, and perhaps requesting a second drawing of health. This research series also could be compared with 100 drawings from medically hospitalized, nonpsychiatric patients.

We believe that art therapy can be used successfully with alexithymics to promote exploration of emotions. The merits of "concurrent group and individual psychotherapy" for such patients is addressed by Swiller (1988), and we suggest that group art therapy can offer yet another therapeutic dimension. Art therapy offers a richly symbolic visual means for alexithymics to begin to express, recognize, and discuss feelings within a supportive setting.

References

Bagby, R. M., Taylor, G. J., & Atkinson, L. (1988). Alexithymia: A comparative study of three self-report measures. *Journal of Psychosomatic Research*, 32(1), 107–116.

Bagby, R. M., Taylor, G. J., & Parker, J. (1991). The alexithymia construct: A potential paradigm for psychosomatic medicine. *Psychosomatics*, 32(2), 153–164.

Cohen, B., Hammer, J., & Singer, S. (1988). The diagnostic drawing series: A systematic approach to art therapy evaluation and research. *The Arts in Psychotherapy*, *15*, 11–21.

Dondis, D. (1973). *A primer of visual literacy.* Cambridge: MIT Press.

Gantt, L. (1990). *A validity study of the Formal Elements Art Therapy Scale (FEATS) for measuring diagnostic information through assessing formal variables in patients' drawings.* Unpublished dissertation, University of Pittsburgh, Pittsburgh, PA.

Miller, R. (1989). *The art therapy process in the context of the psychosomatic syndrome and alexithymia.* Unpublished master's thesis, Concordia University, Montreal, Quebec.

Morrison, D. P., & Peck, D. F. (1990). Do self report measures of affect agree? A longitudinal study. *British Journal of Clinical Psychology*, 29, 395–400.

Sifneos, P. (1973). The prevalence of "alexithymic" characteristics in psychosomatic patients. *Psychotherapy & Psychosomatics*, *22*, 255–262.

Silver, R. (1976). *Stimulus drawings and techniques.* New York, NY: Albin Press.

Silver, R. (1988). *Draw-a-story: Screening for depression and emotional needs.* Mamoronek, NY: Albin Press.

Swiller, H. (1988). Alexithymia: Treatment utilizing combined individual and group psychotherapy. *International Journal of Group Psychotherapy*, 38,(1), 47–61.

Wise, T., Mann, L., & Sudy, L. (1992). Alexithymia and the Five-factor Model of Personality. *Comprehensive Psychiatry*, 33, 147–151.

Report on the National Art Therapy Practice Analysis Survey

Joan E. Knapp, PhD, Lenora G. Knapp, PhD, and Joan Phillips, MA, MS, LMFT, LPC, A.T.R.

Introduction

In 1993, the American Art Therapy Association, Inc. established the Art Therapy Credentials Board, Inc. (ATCB) to oversee the development and administration of a certification program for art therapists. As the first step in this process, the ATCB contracted with Knapp & Associates of Princeton, New Jersey, to conduct a practice analysis of the art therapy profession to identify the tasks entry-level art therapists must perform in practice and the knowledge necessary for competent performance. The definition of the field, provided by the practice analysis, lays the foundation for developing examination specifications and content and guides the examination development process. Linking the examination to practice analysis data establishes the content validity of the examination and helps to ensure that the examination accurately reflects the profession of art therapy as it is performed in actual practice settings.

Method

The first phase of the practice analysis consisted of a review of literature and documents related to the profession of art therapy. This review included membership reports, journal articles from *Art Therapy: Journal of the American Art Therapy Association*, AATA Code of Ethics and General Standards of Practice Document, art therapy competency lists developed by educators, and academic curriculums and course descriptions from art therapy graduate programs across the country.

Based on information obtained during the literature/document review, a semistructured telephone interview was designed to identify the responsibilities, techniques, procedures, and knowledge essential for competent performance in the practice setting. Interviews were conducted with 11 art therapists representing diverse geographic locations, theoretical orientations, and practice settings.

Data from the practitioner interviews and literature/document review were used to develop preliminary lists of the major responsibilities of the profession of art therapy, the tasks subsumed within these responsibilities, the major knowledge areas required for competent performance of the responsibilities and tasks and the specific knowledge included in these areas. These lists were formatted into a draft practice analysis survey. For the responsibilities section, each task was accompanied by a five-point Likert scale with which to rate the importance of competence in the task for an entry-level art therapist. Each specific knowledge area was accompanied by two 5-point rating scales: importance (how important is an understanding of the knowledge area in order for the art therapist to adequately serve and protect clients?) and the extent of knowledge that is necessary to adequately serve and protect clients (i.e., basic concepts, application, in-depth mastery).

After review and revision by the Certification Committee, the draft survey was piloted on a small sample of art therapists ($N = 12$) to determine whether the directions, rating scales, and items were clear and if the survey and content were both accurate and complete. Feedback was discussed with the Certification Committee and revisions to the survey

---

Editor's note: Please direct all correspondence to Joan E. Knapp, PhD, Knapp & Associates, 217 South Harrison Street, Princeton, NJ, 08540, or Joan Phillips, A.T.R., % Art Therapy Credentials Board, 1202 Allanson Road, Mandelein, IL 60060.

were made. The final list of major responsibility areas is presented in Table 1. Table 2 shows the major and specific knowledge areas included in the survey. The survey was mailed to all current Registered Art Therapists (A.T.R.s) (N = 2500).

Table 1
National Art Therapy Practice Analysis Survey: Major Responsibilities of Art Therapists

Creating a therapeutic environment
Client assessment
Treatment planning
Provision of art therapy services
Documentation
Professionalism and ethics

Table 2
National Art Therapy Practice Analysis Survey: Major and Specific Knowledge Areas

I. Psychological and Psychotherapeutic Theories and Practices
A. Human development
1. Cognitive
2. Social
3. Psychosexual
4. Language
5. Perceptual-motor
6. Developmental stages of art
B. Theories of creativity
C. Group dynamics
D. Models of psychotherapy (theory, techniques, and application to art therapy)
1. Psychodynamic/psychoanalytic
2. Gestalt
3. Family systems
4. Humanistic/Existential
5. Cognitive
6. Behavioral
E. Treatment strategies (concepts, techniques, and application to art therapy)
1. Crisis intervention
2. Brief therapy
3. Individual therapy
4. Marital/couples therapy
5. Family therapy
6. Group therapy
7. Counseling
8. Impact of treatment context on therapeutic approach

II. Art Therapy Assessment
A. Art therapy assessment and techniques
1. Diagnostic Drawing Series
2. Kramer Art Therapy Evaluation Scale
3. Kwiatkowska Family Art Evaluation
4. Levick Emotional and Cognitive Art Therapy Assessment
5. The Silver Drawing Test of Cognitive and Creative Skills
6. Ulman Personality Assessment Procedure
7. Free art evaluation
B. Standardized projective drawings
C. Analysis and interpretation of process, form, and content of art

III. Art Therapy Theory and Practice
A. History of art therapy
B. Continuum from art as therapy through art psychotherapy
C. Difference between verbal therapy and art therapy
D. Difference between art therapy and art education
E. Impact of art process on individuals
F. Feelings and behaviors evoked by various art media
G. Meaning conveyed by formal elements and principles of art
H. Metaphor, symbolism, and symbolic behavior

IV. Client Populations
Developmental characteristics and application of art therapy to:
A. Children
B. Adolescents
C. Adults
D. Elderly
Characteristics of population and application of art therapy to:
E. Developmentally disabled
F. Physically disabled
G. Physical rehabilitation clients
H. Chemcially dependent clients
I. Clients with acute or chronic medical illness
J. Clients with acute or chronic psychiatric illness
K. Inpatient clients
L. Day treatment clients
M. Long-term institutionalized clients
Application of art therapy to DSM-III-R diagnostic categories:
N. Disorders usually first evident in infancy, childhood, or adolescence
O. Organic mental disorders
P. Psychoactive substance use disorders
Q. Psychotic disorders
R. Mood disorders
S. Anxiety disorders
T. Somatoform disorders
U. Dissociative disorders
V. Sexual disorders
W. Sleep disorders
X. Impulse control disorders not elsewhere classified
Y. Adjustment disorders
Z. Psychological factors affecting physical condition
AA. Personality disorders
Racial, ethnic, and gender differences in:
BB. Concept of self, family, and community
CC. Interpersonal relationships and social interactions
DD. Cultural meaning and approach to art
EE. Perceptions of psychotherapy

Table 2
(Continued)

- V. Psychopathology
  - A. Abnormal psychology
  - B. Etiology of psychiatric disorders
  - C. Mental status
  - D. DSM-III-R diagnostic categories
- VI. Art Theory and Media
  - A. Art history, appreciation, and aesthetics
  - B. Elements and principles of design
  - C. Mechanics of the preservation and display of art
  - D. Role of symbolism and art in the history of society
  - E. Art Media
    - 1. Types of media—Two dimensional
    - 2. Types of media—Three dimensional
    - 3. Physical qualities (e.g., brightness, texture, density)
    - 4. Preparation and use
    - 5. Safety guidelines, hazards, and toxicity
- VII. Research Methods
  - A. Qualitative analysis and case studies
  - B. Quantitative analysis
  - C. Reliability and validity (for research and psychometric instruments)
  - D. Guidelines governing the use of human participants in research
- VIII. Professionalism and Ethics
  - A. AATA Code of Ethics
  - B. AATA General Standards of Practice Document
  - C. Confidentiality regarding client records and artwork and its limits
  - D. Conditions under which client should be referred to another professional
  - E. Related disciplines
    - 1. Occupational therapy
    - 2. Therapeutic recreation
    - 3. Education
    - 4. Speech and language
    - 5. Creative arts therapies
    - 6. Addiction counseling
    - 7. Social work
    - 8. Clinical psychology
    - 9. Psychoanalysis
    - 10. Psychiatry
    - 11. Physical therapy
    - 12. Other health professions (e.g., nursing)
  - F. Institutional/organizational cultures
  - G. Continuous quality assurance and improvement
  - H. Local reporting laws pertaining to abuse/neglect of children and the elderly and agencies involved in enforcement of the laws
  - I. Laws regarding client harm to self and others
  - J. Limitations of privilege in the client-therapist relationship in legal proceedings
  - K. Federal, state, and local laws regarding educational rights
  - W. Universal precautions regarding body fluids

Results

The practice analysis survey was completed by 1,125 A.T.R.s for a return rate of 45%. Based on experience with similar surveys, Knapp & Associates considered this to be an excellent return rate for a practice analysis survey and an indication of the strong commitment of A.T.R.s to the advancement of the art therapy profession.

Demographics

As can be seen from Figure 1, the survey sample included representation from all major geographic regions of the United States. The overwhelming majority of respondents were female (94%) and Caucasian, non-Hispanic (91%) (see Table 3 for further detail on racial/ethnic representation in sample). Eighty-two percent of the sample was age 35 years or older (see Figure 2).

With respect to education and professional experience, the majority of survey respondents were graduates of Master's degree programs in art therapy (66%) (see Figure 3) and had

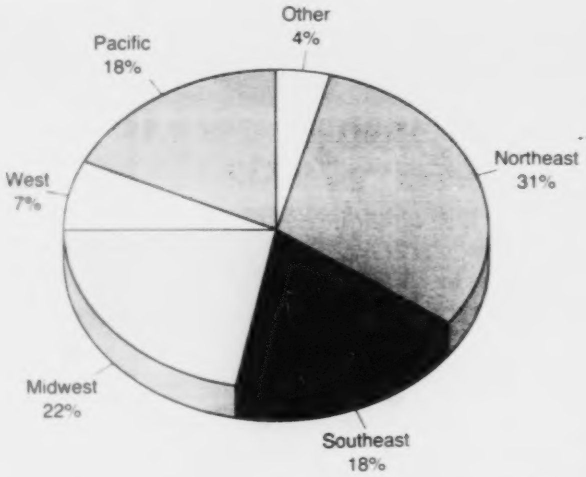


Figure 1.

Table 3
Racial/Ethnic Representation in Survey Sample

Race/ethnicity	Percent of sample
Caucasian, non-Hispanic	91
African American	1
Asian American	1
Native American	1
Puerto Rican American	<1
Chicano/Mexican American	<1
Spanish American	<1
Other	6

been practicing art therapy for six or more years (77%) (see Figure 4). As shown in Figure 5, on average, the therapists surveyed reported spending nearly half of their professional time engaged in direct client service. Survey respondents practiced in one or more of a variety of settings, with the largest percentage of professional time spent working in psychiatric hospitals (25%) (see Table 4).

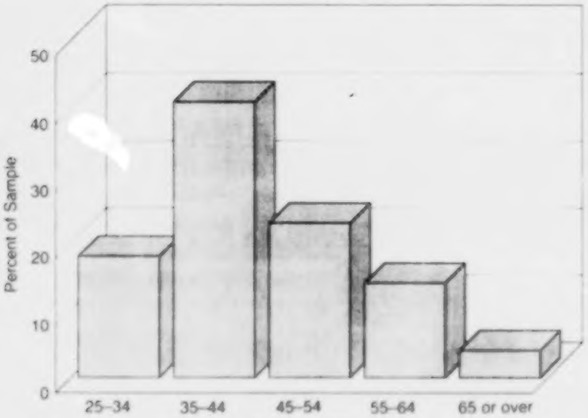


Figure 2.

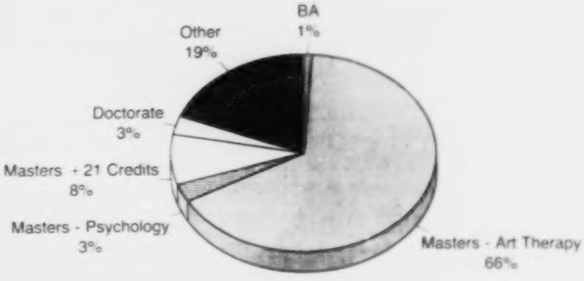


Figure 3.

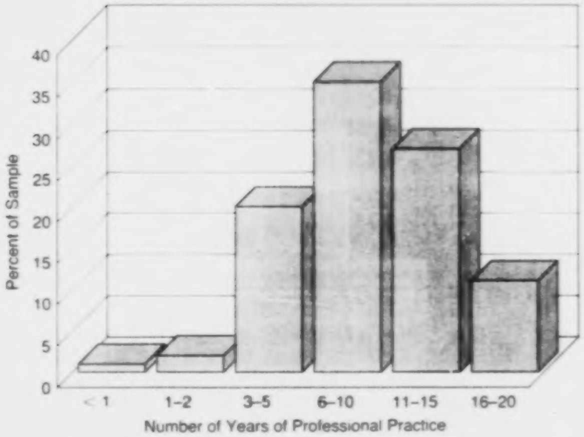


Figure 4.

Practice Dimensions

Table 5 presents the rank order of mean importance ratings for the major responsibility areas. The rankings indicate that the A.T.R.s sampled rated "creating a therapeutic" environment as the most important major responsibility of entry-level art therapists. Other major responsibilities that lay a

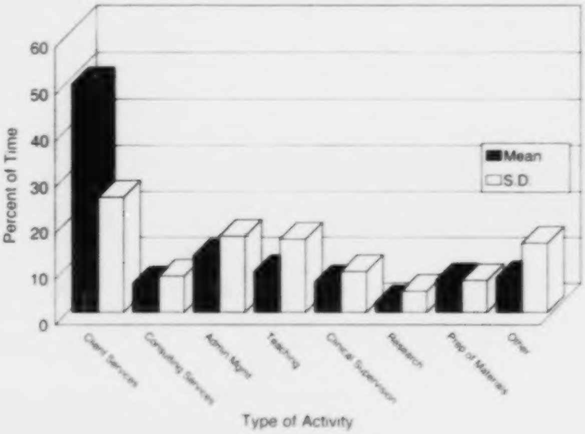


Figure 5.

Table 4
Mean Percent of Professional Time Spent in Various Practice Settings

Practice setting	Mean percent of professional time
Hospital—psychiatric	26
Private practice	18
Outpatient mental health	18
Public or private school (K-12)	10
Academic institution	6
Hospital—medical	3
Rehabilitation center	3
Extended care facility	3
Business/industry	<1
Other	12

Table 5
Rank Order of Mean Importance Ratings of Responsibilities (Descending Order)

Creating a therapeutic environment
Professionalism and ethics
Documentation
Provision of art therapy services
Treatment planning
Client assessment

foundation for competent practice, such as professionalism and ethics (e.g., recognizing professional limitations, participating in continuing professional education) and documentation, were rated as the next most important. Finally, the responsibilities determined to be the least important for entry-level art therapists were those related to specific forms of art therapy services (e.g., client assessment).

The rank order of mean importance ratings of the major knowledge areas suggests that the areas rated as most crucial to adequately serving and protecting clients are those that most directly determine how the entry-level art therapist will conduct and plan treatment (e.g., art therapy theory and practice, psychotherapeutic practices, client populations) (see Table 6). Knowledges less relevant to day-to-day practice (e.g., research methods) were perceived as less important.

As shown in Table 7, the rank order of mean extent of knowledge ratings closely parallels the mean importance ratings, indicating that the A.T.R.s surveyed believe the knowledge areas most directly related to the delivery of client services must be mastered at a greater depth than areas that have a less direct impact on the provision of art therapy services.

Table 6
Rank Order of Mean Importance Ratings of Major Knowledge Areas (Descending Order)

Art therapy theory and practice
Psychopathology
Psychological and psychotherapeutic theories and practices
Client populations
Art theory and media
Professionalism and ethics
Art therapy assessment
Research methods

Table 7
Rank Order of Mean Extent of Knowledge Ratings (Descending Order)

Art therapy theory and practice
Psychological and psychotherapeutic theories and practice
Psychopathology
Client populations
Art theory and media
Art therapy assessment
Professionalism and ethics
Research methods

Conclusions

Demographic data from the practice analysis survey was consistent with that of the 1990–1991 Membership Survey Report (Gordon & Manning, 1991), confirming that the survey sample was representative of the population of registered art therapists. In addition, the responsibilities and knowledges derived from the practice analysis project were similar to art therapy competencies developed by art therapy educators (Lusebrink & McNiff, 1979; Lusebrink, 1979, 1981; Lusebrink, Nucho, Riley, & Ault, 1980). Given the excellent return rate for the survey, the representativeness of the sample, and the consistency of the data with previous studies of the art therapy profession, it is believed that the survey captured the diverse perspectives that exist with respect to art therapy and provided accurate information with which to define the profession as it is actually practiced in the field.

Implications for Examination Development

Data obtained from the practice analysis survey will assist the ATCB in determining the content of the art therapy certification examination and ensuring that the content is consistent with professional practice. A panel consisting of ATCB Certification Committee members and other subject matter experts will link each specific knowledge (e.g., confidentiality regarding client records and artwork and its limits) to appropriate knowledge area(s) (e.g., client assessment, provision of art therapy services), thereby producing a matrix of examination specifications. This is accomplished by determining, through group consensus, whether the knowledge is crucial to competent performance of the responsibility. Next, operational definitions will be developed for the responsibilities and knowledges in the examination specifications matrix. These definitions expand upon the specifications by citing the actual situations and knowledge to be tested. Thus, the operational definition for confidentiality of records and its limits might include reference to how the reporting of child abuse impacts confidentiality. Operational definitions serve as detailed guidelines for writing examination questions and assembling the examination. The process outlined above conforms with professional standards and legal requirements for the development of professional certification examinations and will enable the ATCB to link the examination to actual practice by relating its content to the definition of the profession provided by the practice analysis survey.

References

Gordon, R. A., & Manning, T. (1991). 1990–91 Membership survey report. *Art Therapy: Journal of the American Art Therapy Association, 8,* 20–29.

Lusebrink, V. B., & McNiff, S. A. (1979). *A survey of art therapists' responses to the competent evaluation checklists and self-evaluation.* Unpublished manuscript.

Lusebrink, V. B. (1981). Discussion of art therapy competencies: Art educators conference. Unpublished manuscript. Shakertown, KY.

Lusebrink, V. B., Nucho, A. O., Riley, S. S., & Ault, R. E. (1980). *Report on the evaluation of art therapists' competencies.* Unpublished manuscript.

Commentary on the Assessment Portion of the Art Therapy Practice Analysis Survey

Joan Phillips, MA, MS, LMFT, LPC, A.T.R., Chair, Certification Committee, Art Therapy Credentials Board, Inc.

Art Therapists and Assessment

It is ironic that the general public often views art therapy as dealing with the use of drawings in a diagnostic manner, while within the field of art therapy little consensus has developed over the years as to what types of assessments are legitimate and which ones (if any) should be taught to students of art therapy. In summarizing and presenting the findings of the *Art Therapy Practice Analysis Survey*, assessment emerged as an area of ambiguity. Assessment was rated as "very important" by a majority of art therapists, yet little agreement was found on what specific techniques and methods are necessary for the entry level art therapist to have working knowledge of. Discussions surrounding this issue have raised perennial questions that our field continues to give lip service to; the need for rigorous research to validate assessment methods, as well as questions about the overall validity of assessing. Not surprisingly, in the context of examining who we are as a profession, we find out we have a wide range of views about how we assess others.

In reviewing the research literature on projective drawing techniques used with children, Neale and Rosal also reviewed the major positions and questions raised by art therapists in relation to using drawings in assessment: "The question of using drawings for diagnosis has always divided art therapists into two camps—one fears that objectivity is lost if art is used for diagnosis and the other fears that the richness of art is lost if specific indicators are examined" (Neale & Rosal, 1993). Responses to the task analysis survey point to far more than two camps, and much complexity and "fear" does surround the issue of assessment and using drawings diagnostically.

Another survey of child art therapy assessments found that art therapists surveyed cited use of many different techniques—some were modifications of existing projective techniques and others self-developed. "A question that is begged by the proliferation of assessments . . . is the difference between subjects or themes for drawings, and evaluations or assessments." They also note that "The presence of a number of assessments with which the authors were unfamiliar seems evidence of an 'oral tradition' operating in the field of art therapy" (Goodwin & Mills, 1991). Several art therapists have worked hard in developing and studying specific assessment tools. However, the current availability of information in published format about these assessments is limited, as is the range of expertise reflected in research done on these tools. Most art therapists appear to train themselves in assessment as they grow professionally and do not enter the field with a very wide working knowledge of specific assessment tools and studies.

The General Standards of Practice Document prepared by the Clinical Committee of AATA defines assessment as "the use of any combination of verbal, written, and art tasks chosen by the professional art therapist to assess the individual's level of functioning, problem areas, strengths, and treatment objectives" (1989). The problem, from a certification viewpoint, is what particular "verbal, written and art tasks" should an entry-level art therapist have knowledge of and be able to apply in a practice setting. Consumers of art therapy should be able to expect some basic level of competency in assessment from an art therapist—yet how are we to define this competency?

Given that assessments involve the use of art, will we EVER have fully validated instruments utilizing standard scientific and quantitative methods of establishing validity and reliability? There is a precedent with such work, e.g., Exner's scoring system for the Rorschach. However, such a comprehensive system is not currently available for most art therapy assessments.

Practice Analysis Survey Development and Results Regarding Assessment

Even before the initial draft of the survey instrument was finished, the Certification Committee of the ATCB had debated which, if any, particular assessments to include on the survey. Many committee members felt they had been out of school a long time and thus were not familiar with particular assessments; however, the feeling was that "new" art therapists probably know a lot about these. Talking with "new" art therapists later I found they held assumptions that "other" art therapists might know specific assessment tools, but they frequently commented that "my school didn't teach that." Another discussion in the committee had to do with whether we could ask about projective drawings such as the K-F-D or D-A-P since these projective techniques were more solely the province of psychologists or other professionals and we might be legally liable somehow if we even implied (via a question on the survey) that art therapists administer these projective devices. It is true that specific training in the use of standardized projectives is a prerequisite to using them; indeed, however, no one profession can lay sole claim to this territory and an art therapist trained to administer them is not limited by the test itself. (Apparently some states have tried to limit who uses such techniques through specific licensure and scope of

BEST COPY AVAILABLE

practice language; but it is not the technique itself that "belongs" to any one profession at this point.) Related to this issue is the ethical issue of art therapists using tests or techniques for which they have only gone to one workshop. This latter issue may really be the area where we should focus our concern.

In facing what specific assessments we might include on the survey, Knapp and Associates commented that it appeared our field had many assessments bearing the names of their creators. Goodwin and Mills in discussing this trend of individually developed or modified techniques note that, "This may be testimony to our professional identity as artists and innovators. It may also indicate widespread unfamiliarity with or rejection of published assessments."

When the actual survey went out and was answered by almost 50% of the current A.T.R.s, the main trend was that "free art assessment" (which the survey did not define) was important along with "standardized projective drawings" such as the House-Tree-Person or Draw-a-Person. The highest area rated in the assessment section was the "analysis and interpretation of process, form and content in art." "The latter suggests that we as art therapists do a lot of assessment, but the other data indicate we all do it in our own way at this point. Thus, we noted that the responses to the survey items about assessment agreed in the main that art therapy assessment is an important area, yet when specific assessment "tools" were listed, the importance ratings dropped and no one or two assessments were agreed upon as applicable knowledge or skills we should expect of an entry level art therapist.

As professional art therapists we often tout the diversity of our field as an asset and indeed the assessment portion of the survey was quite diverse and yielded the least consensus of any area on the survey. Comments fell into three major areas: (a) "I never do assessments" (either out of choice or the setting doesn't require them); (b) "I am always doing assessment, I just don't separate it out as such", and, most frequently, (c) "I use my own assessment." Comments from a variety of art therapists indicated they felt alarmed to see art therapy assessments and/or projective assessments listed that they either were not taught in school, don't feel are being taught now, or don't feel should be taught. Conversely, others commented that particular assessments (such as the DDS) were of paramount importance and should be part of any assessment issues tested in a national exam for art therapists.

Implications of the Survey Results in Exam Development

Do any of the currently available assessment methods developed by art therapists have sufficient research to support their use by the entry level art therapist? What art therapy assessment methods are and/or should be taught to graduate students of art therapy? Lacking answers to these questions: What does all this mean in relation to the development of a certification exam? It means that for now, any test items about assessment will reflect general knowledge of projective techniques and of assessment issues—NOT knowledge and application of specific assessment tools. While this relieves some and disappoints others, it is the only defensible action that will reflect our profession's current position regarding assessment. The absence of a lot of items about specific assessments on the certification exam is not a statement that specific assessments are not important; it reflects the lack of consensus about assessment and to what extent assessment is viewed as an essential part of the repertoire of the entry level art therapist.

As the dialogue deepens regarding assessment, and as educators consider the utility and empirical validity of particular assessments, future certification examinations will reflect more focus on this area. Until then, it is my opinion that much more discussion, research and dialogue needs to take place, and as professionals we must all address individually and then collectively our position regarding assessment. We must also realize pragmatically the importance of assessment in this era of "gatekeepers," managed care and the like. Most, if not all, clinical settings mandate "assessment" as the basis of and justification for specific treatment plans. On a meta-level as well, we are being "mandated" into licensure as a basis for inclusion of art therapy as a valid service. One can quite reasonably argue the utility and humanity of these trends; yet we must respond in some manner to this context. The development of the certification exam from within our own field is one response to these mandates.

"We attempt to confirm, moderate and predict the outcome of our treatment process through the fervent study of client artwork. Yet we must do so cautiously and in reverence to the artwork, which tells us so much more than we can describe" (Henley, 1987). Similarly, in our move toward certification and study of ourselves as art therapists, we must realize that who we are is much more than what can be described and tested for, yet we proceed cautiously toward validating our profession through describing the essential tasks that link us in our valued diversity.

References

American Art Therapy Association, Inc. (1989). *General Standards of Practice Document*. Mundelein, IL: American Art Therapy Association.

Art Therapy Credentials Board, Inc., & Knapp & Associates. (1993). *Art Therapy Practice Analysis Survey*. Princeton, NJ: Knapp & Associates.

Henley, D. (1987). Art assessment with the handicapped: Clinical, aesthetic and ethical considerations. *Art Therapy: Journal of the American Art Therapy Association*, *4*(2), 57–66.

Mills, A., & Goodwin, R. (1991). An informal survey of assessment use in child art therapy. *Art Therapy: Journal of the American Art Therapy Association*, *8*(2), 10–13.

Neale, E., & Rosal, M. (1993). What can art therapists learn from the research on projective drawing techniques for children? A review of the literature. *The Arts in Psychotherapy*, *20*(1), 37–49.

Viewpoints

Diving and Snorkeling: The Depths and Shallows of Therapy

Harriet Wadeson, PhD, A.T.R., HLM, Evanston, IL

Many years ago when I first glimpsed the under water world through my snorkel mask, I felt I had traveled to a different planet. That watery world that had been all around me as I saw it from the land, suddenly revealed itself in a dazzling brilliance of colors, exotic formations, muffled sounds, and movement that rocked me in its rhythm. Entering a client's world is like that. The sights, the sounds, and the rhythms sway differently from my own.

But diving into the wreck goes far beyond snorkeling. It is dark and foreboding down there. Vestiges of destruction are everywhere, the safety of air more distant. No wonder clients, and sometimes therapists, prefer to stay just below the sunlit surface.

Surface swimming sometimes makes me feel that I am not doing my job. A psychotherapist, and especially an art therapist, should dive deep into the wrecks of psychic disasters, not merely skim the surface to look down from a distance at the barnacled, dismembered vessels on the bottom of the sea. Often, however, I find myself splashing the surface with clients as they wrestle with their daily antagonists—spouses, bosses, co-workers. I will be reminded of their repeated patterns and childhood ghosts, but the clients may be too besieged by their current encounters to pay much heed to my reminders.

For example, Jane, a survivor of incest by older brothers and cousins, feels used by her supervisor and co-workers. Together, we develop strategies. They work. She has learned to reflect instead of immediately agreeing to extra work which previously left her feeling resentful and used. I remind her that her family life had trained her to be a passive victim (*victim* is her word); her childhood depended upon it. But now she can stand up for herself. I do not know whether she hears me or not. What is important is that she is changing her life.

Some years ago, I worked with Janet, a patient with ulcerative colitis. Frequently her pain, nausea, and diarrhea made it impossible for her to go to work. After seeing several physicians and undergoing a number of tests, she was told her problems were completely emotionally based. I saw her once a week for nine months in outpatient therapy. This was her only treatment. She dealt very little with her past except to inform me that she had been adopted and that whenever she was bad, her parents threatened to send her back to the orphanage. In therapy she focused on her current work situation, where she was a perfectionist, and friendships, most of which revolved around the workplace. At the end of nine months she had learned to relax her work efforts, had received a promotion, and made friends elsewhere. But of most significance, her colitis symptoms had vanished. At our last session I asked her what she thought had helped. She said this was the first time in her life she had a relationship in which she did not feel judged. She never explored her past.

I am reminded of yet another client, Marcia, a middle-aged woman who I began seeing six years ago, and now see only every several months. She was referred to me after her second serious suicide attempt. While hospitalized, she expressed her feelings for the first time in response to a drawing she made. It took a long time in our work together for her to get in touch with her anger and sadness and to express them. For the first several years, it often seemed nothing was happening in our sessions. Looking back to that period, she said, to my surprise, that if I had moved to another part of the country at that time, she would have had to follow me. Unfortunately, twice while I was on vacations she became quite depressed, and her husband worried about suicide. During one of these vacations, she hospitalized herself. Eventually, her artwork began to show her sadness and anger, the latter especially in relation to her husband. Her focus was her marriage, her children, and her current care of her parents. Like Jane and Janet, little attention was given to her childhood. Nevertheless, Marcia changed her life. She relates to her husband differently and is content with her marriage and values herself more. She is generally happy and has been for several years. Once again, snorkeling, not diving. Still, Marcia has become a strong swimmer.

Psychoanalyst Hilde Bruch writes:

> I have observed over and over again that therapists who focus on their patient's daily lives, and how they feel about and get along with people, have better treatment results. . . . For uncovering and correcting underlying causes, it is more helpful to begin with the immediate relevant aspects of a patient's malfunctioning. . . . (1974, p. 38)

Connie, another incest survivor, does dive deeply into the wreck and surfaces with paintings of fury, despair, and imprisonment. Sometimes she cries inconsolably. Yet, the movement in her life is more of a surface water swim than an underwater plunge. Like Marcia and Janet, she is learning to become aware of her current feelings, especially her interpersonal reactions, to assert herself, and to set limits. Once again, my attempts to draw connections between the past and the present receive polite attention. I do not know if they help Connie to feel understood or enhance insight.

I have borrowed the phrase "diving into the wreck" from a poem by Adrienne Rich (1984). Its imagery and meaning speak to me of the delicate and dangerous work I do with clients:

> the thing I came for. . . .
> the drowned face always staring
> toward the sun
> the evidence of damage
> worn by salt and sway into this threadbare beauty
> the ribs of the disaster
> curving their assertion
> among the tentative haunters. . . .
> We circle silently
> about the wreck
> we dive into the hold.
> I am she: I am he
> whose drowned face sleeps with open eyes. . . .
> we are the half-destroyed instruments
> that once held to the course. . . .
> We are, I am, you are
> by cowardice or courage
> the ones who find our way
> back to this scene. . . . (p. 164)

I have written elsewhere of the lure such wreckage holds for me (Wadeson, 1990), and I must confess the barnacled treasures that Connie salvages from her deep dives into the shipwreck of her childhood intrigue me more than the life she explores just beneath the surface. Her paintings dredge up images of the ghoulish faces of her fears, the iron bars of her prison, the unutterable loneliness of her burial place, and the helplessness and vulnerability of a tiny baby in a rageful world. Sometimes she gives the baby a voice and dissolves in tears as its feelings wash over her. But she cannot stay in that dark and treacherous place for long and rises to the surface to say in her adult voice, "The boss responded to my memo."

So, I have had to learn to become agile in the water. Sometimes I try to dive, but find I have left the client on the surface. Sometimes the client dives, and I cannot find her. More often, we swim together, varying our depths. I have come to see that the currents of therapy are unpredictable. Some clients sweep the ocean bottom. Others barely touch it. Its dark mystery is so frightening to some, they do not even acknowledge there may be personal detritus there. Perhaps the point is not how deep they dive or how thorough the salvage, but rather that a strong swimmer is near.

References

Bruch, H. (1974). *Learning psychotherapy*. Cambridge, MA: Harvard University Press.

Rich, A. (1984). *The fact of a door frame*. New York: W. W. Norton & Company.

Wadeson, H., et al. (1990). Through the looking glass: I. When clients' tragic images illuminate the therapist's dark side. *Art Therapy: Journal of the American Art Therapy Association, 7*(3), 107–110.

A Review of Two Art Assessment Tools in an Adult Day Treatment Center

Piyachat Ruengvisesh Finney, MA, A.T.R., CP, Cambridge, MA

Introduction

Several articles by art therapists describe, review, and evaluate various assessment tools (Hiscox, 1993; Neale & Rosal, 1993; O'Neill, 1991; Rubin, 1991; Silver & Carrion, 1991; and Wadeson, 1992). Based on my experience, it is important that: (a) the clinician consider the client's mental status when selecting an art assessment tool, (b) evaluation tools are periodically evaluated, (c) the tool's effectiveness with the specific population is evaluated, and (d) the timing is appropriate for each tool.

One of the most important factors when working with any population within the mental health field is the clinician's sensitivity to a client's emotional fragility, defenses, and needs. In most settings, an art therapist takes various roles. One is that of an evaluator, meeting with a client when she or he is first admitted to a program and implementing an initial art intake, either for diagnostic purposes or for gathering therapeutic information. Thereafter, she or he may administer a periodic art assessment to evaluate a client's psychological progress. Here the clinician's sensitivity lies in selecting an art assessment tool for use with the client. She or he needs to take into consideration the appropriateness of the tool, the purpose, and the timing of the evaluation process, in the treatment beginning phase (pretest), middle phase (periodic review), and end phase (posttest). My experience in a day treatment center demonstrates this point.

Setting

The Lawrence F. Schiff Day Treatment Center serves adults who have chronic major mental illnesses. Diagnoses include Affective Disorder, Schizophrenia, Dual Diagnosis, and Post Traumatic Stress Disorder. Ages range from early 20s to late 50s. The program consists of traditional verbal psychotherapy groups and both verbal and nonverbal expressive therapy groups. The Center is well staffed, with five social workers, a psychiatrist, a mental health worker, four trainees, and one expressive therapist. The expressive therapist assumes various roles: an evaluator who implements an initial art evaluation and periodic art evaluations; a group leader, leading expressive art therapy groups; a supervisor, training a graduate level art therapy intern; a consultant, offering inservice training to a staff group as well as sharing pertinent information that arises during an expressive art therapy group or from an individual session; and a case coordinator for five clients.

During my four years at the Center, I have used two art therapy assessment tools, the House-Tree-Person Technique (Buck, 1966), and the Stimulus Drawing and Techniques (Silver, 1981). One is used for an initial evaluation and the other as part of a case conference, periodic review.

An initial art evaluation is done to assess the client's cognitive ability and to gather presenting therapeutic issues for appropriate group art therapy placement. The art evaluation for a case conference periodic review is to reassess the client's psychological progress and changes in her or his coping skills, affect management, therapeutic issues, and treatment progress.

House-Tree-Person Technique

The House-Tree-Person (H-T-P) is ". . . a technique designed to aid the clinician in obtaining information concerning an individual's sensitivity, maturity, flexibility, efficiency, degree of personality integration, and interaction with the environment, specifically and generally" (Buck, 1966, p. 1). Results of the assessment provide the clinician "with diagnostically and prognostically significant data concerning Ss [the subjects] which otherwise might take much more time to acquire" (*Ibid.*, p. 2).

A subject is provided with an H-T-P drawing form (white paper, each page 7" × 8½") and a Number 2 pencil. Each page is consecutively labeled at the top "House," "Tree," "Person." The evaluator says:

> I want you to draw me as good a picture of a house as you can. You may draw any kind of house you wish; it's entirely up to you. You may erase as much as you like; it will not be counted against you. And you may take as long as you wish. (*Ibid.*, p. 18)

Using the same format, the client is asked to draw a picture of a tree and a picture of a person. After each drawing is finished, the client is asked questions about details and representational meanings. Buck states, "Each drawn whole—the House, the Tree, and the Person—is regarded as a psychological self-portrait of the S (subject) . . ." (*Ibid.*, p. 3). The House represents associations of home and the interpersonal relationships with those who live with the subject. The Tree represents associations of the person's "life-role" and his ability to obtain satisfactions in and from his environment. The Person represents associations of different interpersonal relationships, whether in the past, the present, or the future. The assessment provides part of an in-depth psychological profile of the client. The technique can be administered by a trained, licensed psychologist, a certified projective techniques administrator, or an art therapist under supervision by a licensed psychologist.

Originally, the H-T-P was designed to assess level of intellectual functioning and to detect personality maladjustment. A sample of 120 adults at six intelligence levels were selected (imbecile, moron, borderline, dull average, average, and above average). Later, a group of 20 superior intelligence subjects was added. In looking at these 140 sets of drawings, researchers identified and listed the items which might serve to differentiate subjects on the basis of intelligence. These included both the presence and the absence of the listed items. "As a result of this analysis it was found that items of detail, proportion, and perspective appeared best to differentiate between the Ss at the various levels" (*Ibid.*, p. 10). An attempt was made to identify items which would differentiate between drawings by people who did not exhibit major personality maladjustment and drawings by people who were maladjusted, psychopathic, psychoneurotic, prepsychotic, or psychotic (*Ibid.*). "[D]etails, proportion, perspective, time, comments (spontaneous and induced), associations, line quality, self-criticism, attitude, drive, and concept" best differentiated between the two groups of drawings (*Ibid.*, p. 14).

In administering the H-T-P to adults who suffer from mental illnesses, I have found results from this assessment tool to concur with other psychological tests used to measure the client's personality adjustment and level of intellectual functioning.

Stimulus Drawings and Techniques

Stimulus Drawings and Techniques/The Silver Drawing Test (SDT) was developed by Rawley Silver in the early 1970s. It was copyrighted in 1974, and published as an abridged manual in 1981 (Rubin, 1991, p. 118). A revised, fourth edition was published in 1989. The test evolved from Silver's work with deaf children. Although evidence of cognitive skills was apparent, she noticed that traditionally language-oriented intelligence tests did not measure these skills (Silver & Carrion, 1991).

When administering the test, the client is asked to select four pictures from 50 picture cards, categorized by people, places, animals, and things. Then, she or he is asked to draw:

> Try to think of something happening between the drawings you choose. Then when you are ready, draw a picture of your own. Make your drawing tell a story. Show what is happening. Feel free to change these drawings and to use your own ideas. (Silver, 1981, p. 2)

Silver states, "These 50 drawings can be used as a therapeutic technique, a developmental technique, or as an assessment technique for evaluating emotional needs, cognitive skills, and progress in therapeutic or educational programs" (*Ibid.*, p. 1). She postulates, "The emotional content of the projective component offers clues to the emotional state of the individual" (Hiscox, 1993, p. 47). O'Neill (1991) suggests that in therapy, "SDs (Stimulus Drawings) are valuable for gaining access to fantasies and clues to self-image or interpersonal relationships. . . . In assessment, SDs can be effective for evaluating emotional, cognitive, and creative skills" (p. 87). In most cases, I have found the client's pictures and stories accurately reflect his struggles and life issues and are consistent with his history.

Discussion of the H-T-P and SDT

When I first began working at the Center, I used the House-Tree-Person Technique for the initial evaluation. At the time, I felt the tool gave me brief but essential therapeutic information on a client in the first session. After a year, I had tested about 25 to 30 clients. From this experience I learned a valuable lesson. Some clients had difficulties with the assessment process; all, however, completed the session. Two major difficulties were apparent: (a) a few clients became overwhelmed by the issues that emerged and were flooded with affect; (b) some clients attempted to use the initial assessment session as a therapy session. They needed to be refocused, provided with containment, and, because this session was not intended to be a therapy hour, helped to bring closure to their issues. The assessment was usually administered on the first day of a client's arrival, before the client had developed a therapeutic alliance with the clinician. I needed to rethink my selection of assessment techniques. Clients are potentially fragile on the first day; material raised by the H-T-P resulted in clients becoming overwhelmed by their issues. This was counterproductive. I decided to use the Silver Drawing Test for the initial assessment.

The Silver Drawing Test evaluates a client's cognitive ability (abilities to select, combine, and integrate pieces to make a whole), therapeutic themes in the client's life, and her or his use of fantasy and creativity. Newly admitted clients usually feel safe with this assessment tool. The task is semistructured; they choose from predrawn cards. For some clients, these cards decrease performance anxiety and few clients say: "I hate art. I don't know how to draw. I only draw stick figures." Sometimes, the cards help them tap into underlying issues. When the client is asked to tell stories after completing the drawings, she or he can choose to disclose at a personal level, or project her or his feelings onto the picture card characters chosen. In the latter case, the client does not have to fully own the issues and feelings she or he describes. A client who is vulnerable can regulate distance and closeness and maintain defenses during this first meeting. It is crucial to respect a client's defenses especially in the first phase of a therapeutic relationship; defenses serve a purpose.

In the middle phase of treatment, I implement the House-Tree-Person Technique. It can give an in-depth picture of a client's intrapsychic issues, and symbols can reflect coping skills. It is appropriate to evaluate the client's progress just before the periodic case conference. Trust and a therapeutic alliance have been established between the client and me and, in most cases, clients are willing to discuss their pictures openly on both projective and personal levels. They often make references to pertinent life issues and show some insight into their behavior and interaction with others. They also appear to enjoy the postinterview interrogation that includes talking about their pictures on an abstract level, and may make an attempt to address their conflicts via metaphor.

Both the SDT and H-T-P can also be administered near the end phase of treatment. The purpose of a posttest is to evaluate changes that occurred as a result of therapy. This is an opportunity for the client to review coping skills mastered and issues addressed. The session also provides a closure to treatment. By comparing the pretest and the posttest, the client may see concrete evidence of progress in the pictures. This last session is often quite touching. Clients feel sad about leaving and good about the changes they have made.

Over time I have found these two tools to be appropriate in work with adults with chronic mental illnesses. The Silver Drawing Test is suitable for use as an initial assessment and as a posttest, whereas the House-Tree-Person Technique is appropriate for the middle or end phase of treatment to evaluate progress made by the client.

Conclusion

This paper has discussed two art assessment tools and the importance of making a periodic review of assessment tools. A tool may appear to be suitable at one point in your practice, but it is recommended that you periodically review the benefits and possible counterproductive effects of the assessment tool. An art therapist needs to be sensitive to her or his client's mental status and symbolic language. These serve as guides in her or his selection of assessment tools that are integral to her or his work.

References

Buck, J. N. (1966). *The House-Tree-Person Techniques: Revised Manual.* Beverly Hills, CA: Western Psychological Services.

Hiscox, A. R. (1993). Review of Silver Drawing Test of cognitive skills and adjustment: Drawing what you predict, what you see, and what you imagine. *Art Therapy: Journal of the American Art Therapy Association, 10*(1), 46–48.

Neale, E. L., & Rosal, M. L. (1993). What can art therapists learn from the research on projective drawing techniques for children? A review of the literature. *The Arts in Psychotherapy, 20*(1), 37–49.

O'Neill, S. (1991). Review of stimulus drawings and techniques: In therapy, development, and assessment. *The American Journal of Art Therapy, 29*(3), 87–88.

Rubin, J. A. (1991). Review of Silver Drawing Test of cognitive skills and adjustment: Drawing what you predict, what you see, and what you imagine. *The American Journal of Art Therapy, 29*(4), 118–119.

Silver, R. (1981). *Stimulus drawings and techniques.* New York: Trillium Books.

Silver, R., & Carrion, F. (1991). Using the Silver Drawing Test in school and hospital. *The American Journal of Art Therapy, 30*(2), 36–43.

Wadeson, H. (Ed.). (1992). *A guide to conducting art therapy research.* Mundelein, IL: The American Art Therapy Association.

Reviews

Instant Images: A Guide to Using Photography in Therapy

by Jerry L. Fryrear, PhD, A.T.R., Irene E. Corbit, PhD, A.T.R., and Sandra Mason-Taylor, MA, LPC, LCDC.
Dubuque, IA: Kendall/Hunt Publishing Company, 1992.

112 pp., 17 illustrations. $11.95, paper, text edition.
ISBN 0-8403-8182-4.

Reviewed by **Julia Gentleman Byers, A.T.R.**, Montreal, Quebec, Canada

Instant Images is the first manual to use only Polaroid 600 instant "snapshot" images for specific sequential psychotherapeutic assignments. It is not a book about the therapeutic value of using photographic methodologies in therapy and does not offer specific therapeutic interventions to address clinical issues for various client populations. Given these limitations, the reader can readily pursue its contents with appropriate expectations.

This outwardly simple recipe book provides a well thought out series of therapeutic tasks that aim to aid in therapy and personal growth. The authors assume the reader is knowledgeable about therapy and personality theory. They borrow many ideas from Jungian concepts, such as the Shadow and the Persona. Familiar art therapeutic directives are used from theories and practices of contemporary art therapy authors and practitioners.

Two clients, Sandra and Irene, provide examples for each assignment. Their verbatim commentaries are frequently quoted after they have gone through processes of reflection and interaction and production of their final collage. Although many black and white illustrations of the artwork are provided, the authors do not give interpretations of the clients' metaphors.

In the first section, a therapy format is used to present an overview of the complete program. The manual is intended to be used in ". . . logical progression and the later assignments are built on earlier ones" (p. 7). The issue of confidentiality is raised. A commitment to the 16-week program is expected. Supplies include multimedia arts and crafts materials. One assumes that color Polaroid film is used, although this is not stated. Enough film for at least 35 snapshots per client, with 10 exposures per pack, is recommended.

The sequence begins with a rhetorical question, "Who am I?" (p. 19). It is explored through exercises with themes of nature and other people. In keeping with the building development of the psychological journey, partners are encouraged to explore ways to let go of personal blocks. Ideally, this leads to depicting and resolving immediate conflicts within brief therapy. Towards closure, the partners are encouraged to define their relationship and develop an awareness of their present needs and future goals. The final assignment integrates a review and summary of the project.

The authors clarify their use of directed themes and issues. They begin by attempting to answer, "Why photo therapy?" (p. 3). It may be more apt to ask, "Why *Polaroid* art therapy?" At this point, the book would have benefited from a theoretical debate. The authors could have discussed how Polaroid images differ from magazine photo collage or experimental photography in multimedia collages used by authors and practitioners such as Helen Landgarten (1980, 1993), Harriet Wadeson (1980), and Judy Weisler (1993). Instead, the authors encourage us to use art media, taking into consideration limitations of instant images, since the format, size, and structure of the first task of each assignment is constant. Fryrear, Corbit, and Mason-Taylor caution, "[t]he Polaroid corporation advises against cutting apart the photographs because the developing chemicals within the layers of the photograph are mildly irritating to the skin" (p. 22). The metaphoric implication here is very powerful. However, the book does not explore this or other metaphors, such as attaching filters, looking at different perspectives, focusing brightness or contrast, time of exposure, soft focus, outdoor or indoor lighting effects, and distorted elements. These are tools of the photographic trade. The instant image process could also be explored. Because this is a manual, the authors should specify that the therapist/reader needs artistic knowledge about the properties of the photographic medium itself.

Landgarten (1980) stated that photo pictures can initially lend structure, assisting expression for the client whose defense mechanisms are strong. In Polaroid instant images, is this more or less apparent? When setting up a scene for exposure of the snapshot, does it overlap with principles of drama therapy?

During the initial intense and challenging period of brief therapy, visual images and/or collages can be used to acknowledge that change is very difficult. In addition to using photo media to work through initial resistances, this is an optimum time to integrate the media itself as a communication tool, thereby giving credibility to the modality of "photo art therapy." The photographer's pallet is different than the painter's: color plasticity changes according to the held focal position. The sense of using a camera as equipment to express emotions is fundamentally different than wet paint and the immediacy of blending and reblending.

A Polaroid color photo is a prisoner of the moment of exposure. Delicate tone differences are generally lost, because of the greatly reduced size of the picture and the accuracy ratio of the equipment itself. In "instant" Polaroid, there is one chance for one image. The issue of duplication or imitation is avoided. The media itself provides enormous opportunities for self-exploration through metaphor.

Within the brief treatment approach of this book, there are opportunities for clients to explore issues of intimacy and trust through individual or group processes. Given the protective vehicle of the photographic medium, clients can explore various levels of psychological awareness because the modality itself holds symbolic content. This is apparent as Sandra and Irene express their immediate reactions to the exercises.

A strength of Fryrear, Corbit, and Mason-Taylor's book is the closure they provide for assignments and exercises that explore the role of expectations in relationships. Irene, the business partner of Sandra, states that the complete program was a ". . . voyage . . . a celebration of life. . . . This real journey has been full of joy, beauty, excitement and sometimes pain and frustration" (p. 101). This brings Hillman's words to mind:

> [I]t is not the conceptual tool or specific language that makes soul, but the manner and purpose with which the tool is employed. Psychological faith begins in the love of images and its flow mainly through shapes of persons in reveries, fantasies, reflections and imaginations. Their increasing vivification gives one an increasing conviction of having and then of being an interior reality of deep significance transcending one's personal life. (p. 150)

The potential depth and use of "instant images" demonstrates the need to review patterns of meaningful relationships. This short-term therapeutic program can provide enrichment beginning from the instant the client absorbs the photo, and attaches personal meaning to it. Some of us think of photography as a fisherman would; we get caught up in the ideal of having to go out and get an image. In having that very strong goal, some of us lose sight of the experience—the most important part.

Instant Images, although too recipe-like in wordage and precise application, is an innovative contribution to the few available manuals on creative media for therapy and personal growth. It integrates Jerry Fryrear, Irene Corbit, and Sandra Mason-Taylor's areas of expertise and practice. Still, I remain perplexed about the fundamental differences, in the final productions, between magazine photo collage and instant images, using photography in therapy. Both can be beneficial additions to the therapeutic armament.

References

Hillman, J. (1983). *Re-visioning psychology*. New York: Harper Collins.

Landgarten, H. (1980). *Clinical art therapy*. New York: Brunner Mazel.

Landgarten, H. (1993). *Magazine photo collage: A multi-cultural assessment and treatment technique*. New York: Brunner Mazel.

Wadeson, H. (1980). *Art psychotherapy*. New York: John Wiley & Sons.

Weisler, J. (1993). *The secret lives of personal snapshots and family albums: Phototherapy techniques useful for art therapists*. New York: Jossey-Bass.

Tactile Graphics

by **Polly K. Edman**, New York: American Foundation for the Blind, 1992.

525 pp., 242 black & white illustrations and 832 sketches, diagrams, and photographs. $80.00, cloth. ISBN 0-89128-194-0.

Reviewed by **Betty D. Jones, MA**, Boulder City, NV

How is it possible for a sightless person to "see" the black and white stripes of a zebra, the charming freckles on a face, or the beautiful patterns of a butterfly's wing? Polly Edman, in *Tactile Graphics*, shows us how. In her more than three decades of work with blind children, Edman developed ways to make this possible. Using the tactile sensory channel, she conveys purely visual images of striped fur, freckled skin, and delicate wing, without distorting the smooth surfaces of zebra, face, and butterfly.

Edman, a graphic artist, designer, author, and illustrator, served as head of production graphics at Sweden's National Center for Educational Aids for the Blind for 12 years. The many and varied techniques described in this long and copiously illustrated book demonstrate her creativity and inspiration.

Ten chapters cover topics such as theory, production and materials, pictures, children's drawings, maps, mathematics, graphs, and evaluation criterion. In the Appendices she lists basic materials and their sources, information sources, references, and a glossary.

Grounded in the physiology of learning, Edman's training is evident in her philosophy:

> I believe all seeing is a learning process, whether it is done with your eyes or with your fingers. Gathering information and sorting out impressions is a mental activity that allows you to "see" things the way you do. Each one of us sees things differently. (p. 4)

She speaks specifically to the art therapist who works with blind children. "Children the world over enjoy drawing pictures. Just because a child cannot see does not mean that he or she cannot achieve artistic expression through pictures" (p. 6). She shows us how blind children read their raised-line drawings:

> Give a child a drawing board—a rubber pad covered with a thin sheet of plastic. Draw a line across the surface with a ball point pen. A welt is formed as the pen is pressed against the plastic. Let the child scribble on the page, and to his or her surprise, the wiggly lines will rise to form a relief . . . place the child's hand on the sheet and help him or her draw around it. Then ask, "What's that?" as you feel the drawing together. "My hand" will be the reply. You may now say, "Oh no, your hand is still on the end of your arm." Both of you feel the page again. And you repeat, "What's that?" Most often, the answer is the same: "My hand." "No, it's not your hand," you reply. "It is a *picture* of your hand." The look of surprise and then delight that will appear on the child's face has happened the world over. This is a picture! You have just filled an often-heard word with *new* meaning. (pp. 6–7)

Edman believes "A picture is only one way to organize the mind" (p. 8). She is interested in giving children knowledge of the world. For example, in three drawings by a young Ethiopian boy, he distinguishes a "quiet" sun, an "intensely

BEST COPY AVAILABLE

hot" sun, and a "cool" sun. "The sun is important to this young boy from Ethiopia, and it is definitely personal" (p. 183).

How do you demonstrate the flight of a bird on a page, using only touch? The principle is the same as the old 1920s flicker movies, or the little books you thumb quickly. Repetition of the same picture, or form, with slight variations, depicts the object in movement. The child pulls his fingers down the column of repeated bird images and feels the movement of wings in flight. Edman's solutions to such problems are ingenious, simple, and inspirational. In the sensory receptive area of the brain, more area is dedicated to the fingers and tongue than to any other part of the body. The crawling infant explores the world using this sensory channel, gathering memories and impressions. As adults, we have been trained to look and not touch. The blind child *must* touch; so must many of our clients. In this art therapy, touch is an essential part of the healing process.

Edman's ideas can easily be adapted for clients with learning disabilities or cerebral palsy. If we remember our senses are paths to pleasure and paths of expression, we will find ways to use the sensory channel in psychodrama, music, dance, and poetry. We know how essential "warm fuzzies" are to infant development; this book reintroduces us to the experience of soothing memories associated with silk, satin, and downy softness.

Glimpsing how the blind child perceives has raised questions about art produced by my clients. When is a transparency not a transparency? Blind children draw smoke starting way down inside the chimney (p. 176); this is logical. The sighted child knows the source of the smoke, but only "sees" it after it leaves the chimney. The blind child draws what he knows, rather than what is visually perceived. Is he drawing a transparency without boundaries, or is he expressing a deeper knowledge? Edman gives very concrete (tactile) forms and methods of reaching one specific population, yet her book is broadly philosophical and stimulates self-examination.

It is difficult to justify spending a lot of money on one book, unless the book is one of a kind in its field, comprehensively covers the subject, contains numerous practical applications, and will contribute significantly to the field. *Tactile Graphics* does all of the above. This book is literally an art instructor's manual, a creative thinker's touchstone, and a therapist's bible. It is an encyclopedia on the subject of tactile information gathering.

Portraits of Spirituality in Recovery: The Use of Art in Recovery from Co-Dependence and/or Chemical Dependency

Nancy Barrett Chickerneo, PhD, A.T.R., CADC.
Springfield, IL: Charles C Thomas, 1993.

241 pp., 70 black & white illustrations. $49.75, cloth.
ISBN 0-398-05845-8

Reviewed by **Carol Ann Bomberger, MA, A.T.R.,**
Belmont, CA

Chemical dependency, co-dependency, and recovery are popular topics. Spirituality is an important dimension in the recovery process for those in recovery and those professionals who work with them. This is especially so for those who use the 12 Steps of Alcoholics Anonymous. Much has been written on these topics. What is unique about Nancy Barrett Chickerneo's book is her focus on the use of art to facilitate spiritual growth in recovery. Chickerneo states, "Very little research is currently available which interfaces these areas, and spirituality is an important component in the process of recovery. Therefore, knowledge about the contribution of art to recovery is valuable" (p. vii).

Chickerneo's thesis, "New Images, Ancient Paradigm: A Study of the Contribution of Art to Spirituality in Addiction Recovery" (1990), provided the basis for this book. She noticed themes and similarities in her own life and work with clients and students, and became interested in "a more formal exploration of the experience of the contribution of art to spirituality in recovery" (p. vii). Divided into three parts, Part I: Introduction to the Problem and the Method of Study; Part II: Stories of the Co-Researchers; and Part III: Themes, Literature, and Realizations), the book has the sound and feel of formal research. At the same time, it contains personal accounts of the effect of art making on the lives of the "co-researchers," (her term for subjects), and herself. By choosing "Heuristic Inquiry" as her method of study, she can include personal, subjective material.

Unlike the "scientific method" of quantitative research involving objective, reductive reasoning, heuristic inquiry is a qualitative method that "offers opportunities to study both subjective and objective data in a deductive manner" (p. 15). Her choice of the heuristic method is bold and controversial. In *Beyond Science, Beyond Therapy: A New Model for Healing the Whole Person* (1992), Anne Wilson Schaef argues extensively and vehemently against the quantitative scientific method as a product of a dysfunctional, control-addicted society. Unlike Schaef, Chickerneo does not defend her choice of heuristic inquiry by denigrating the scientific method. Rather, she explains and defends heuristic inquiry by tracing its existential roots, outlining its humanistic evolution, and explaining the phases of the heuristic process. By explaining and defending her choice of method she adds a substantial argument to the debate. However, those who have difficulty accepting heuristic inquiry as a valid research methodology will probably have trouble accepting this book.

The data for this study comes from nine "stories" (or case studies), of her co-researchers and her own life. The stories fill the bulk of the book. Largely verbatim, they are generously illustrated with photographs of artwork. These interviews were nondirective and unstructured with two exceptions, when each co-researcher was asked to give "a brief personal and family history including any memory of childhood spirituality as well as an addition history," and an answer to the question, "How has art contributed to the spiritual part of your recovery?" Sifting through the answers, Chickerneo notes the "possible themes and generalizations" that emerged (p. 31).

In the book's last section, Chickerneo charts and discusses the themes, surveys the literature on art, spirituality, and addiction, discusses how her study relates to earlier published literature, and then attempts a synthesis of all that has gone before. She attempts to see the experience of spirituality through art "in a new way," and concludes, "For the co-researchers of this study, art, which was accessed on the interior of their beings, has proven to be a way back home to them and their higher power" (sic) (p. 236).

Chickerneo says, "the book is designed to be enjoyed by general readers, professionals, and/or researchers in the fields of study" (p. vii). In a way, this is true. For general readers in recovery, reading the stories is similar to going to a 12-step meeting. Professionals and researchers who can accept heuristic inquiry, or at least be open to it, can benefit and learn from the wealth of information provided. However, as an art therapist, I was hoping to find useful information and ideas about, as the subtitle implies, the use of art with clients in recovery from co-dependency and/or chemical dependency. Since this is an area I have researched (1990), I am always looking for more ideas. Practical suggestions which an art therapist can use in daily practice are not available in this book.

The heuristic method allows for the biases of the researcher. Her bias is evident in the religious flavor of her work, which at times, takes on a righteous tone. For example, she asserts, "addiction counseling professionals and art therapists working in the field of addiction need to take seriously a holistic approach to recovery that honors spirituality" (p. 235). In my opinion, counseling professionals and art therapists do not need to be told what they need to do. When I closed the cover of Chickerneo's book, I was left with the impression that she had spent a lot of energy trying to persuade readers to her way of thinking. In her discussion, "Ancient Paradigm," she points out how the themes in her study relate to the beatitudes in the Bible. Even though she states that this "paradigm" is "just one ancient source which comes out of my own reflections and tradition," (p. 232), the fact that she adds these personal reflections to her study, no matter how interesting, raises a question about her real intent.

Chickerneo has obviously given much time and thought to topics she knows and cares about. Her book is rich with ideas, her research is extensive, and the stories are fascinating. However, in her efforts to prove the value of art to facilitate the growth of spirituality in recovery, Chickerneo has pinned the butterfly to the board. The formal style of her language and the structure of the research format are ponderous and weighty. The religious bias and righteous tone detract, and it is doubtful that research will convince skeptics of the value of art and spirituality. Perhaps the problem with the book stems from trying to do too much. Instead of designing her book "to be enjoyed by general readers, professionals, and/or researchers in the fields of study," writing for a delimited audience might have provided focus.

References

Carroll, C. A. (1990). *Use of the twelve steps of Alcoholics Anonymous in art therapy groups with substance abusers.* Unpublished master's thesis, College of Notre Dame, Belmont, CA.

Chickerneo, N. B. (1990). New images, ancient paradigm: A study of the contribution of art to spirituality in addiction recovery. *Dissertation Abstracts International, 51*, 11-A, p. 3781. Ann Arbor, MA: University Microfilms. No. AAD91-10801.

Schaef, A. W. (1992). *Beyond therapy, beyond science: A new model for healing the whole person.* San Francisco, CA: Harper Collins.

Video Review

Art Therapy with a Group of Latency Age Girls

by **Mildred Lachman-Chapin, A.T.R.** Produced by **Peter Volkert**, 1970; re-edited 1991.

VHS ½" and ¾", 55 minutes, black and white. $80, purchase only from Mildred Lachman-Chapin, 903A Waukegan Road, Deerfield, IL 60015; 708-940-8134, or to Fax an order, phone number plus #1.

Reviewed by **Gussie Klorer, MA, A.T.R., LCSW**, St. Louis, MO.

Art Therapy with a Group of Latency Age Girls offers an inside look at five girls and three therapists over the course of one year. The setting is a school for emotionally disturbed girls.

The children are introduced through their artwork and the viewer quickly senses each girl's individual personality. Over the year, changes within each child and the group allow the viewer to watch group dynamics unfold. For example, scapegoating is seen when a Caucasian child is rejected because of her skin color. She attempts to physically escape only to have her movement blocked by a therapist. Pairing is seen when an older child takes on a protective, bossy role with a smaller child, effectively excluding a third child. The therapist responds by allying herself with the third child. Triangulation is noted when three children team up, excluding a fourth child. In each situation the viewer is able to observe the therapists' not-always-successful interventions.

Therapists demonstrate a highly structured, theme-centered style that is obviously necessary with this population. Group boundaries are established early and the importance of establishing group rituals is demonstrated through songs that begin and end each group. Therapists are interactive in their approaches to the children, recognizing the girls' mothering issues; physical touch and holding are part of the group process. When a child becomes confused and asks the therapist, "Are you her mama?", the therapist establishes an important boundary for the child.

The therapists' approaches to the children and interaction with the artwork will stimulate discussion and controversy among art therapists-in-training. Students may wonder about the therapists' quickness to draw on the children's artwork or may question some of the interventions. There are many points where I, as an instructor, would want to stop the film and invite students to discuss possible alternative interventions. For example, when three girls begin name-calling and are extremely disruptive, one of the therapists attempts to talk about the problem with this extremely resistant group. This provides an opportunity to invite students to think of appropriate consequences for the behavior, in contrast to allowing it to escalate.

The video offers a view of child group art therapy that is strikingly different from what can be achieved through the printed word where behaviors are described but not experienced. The video format brings to life problems inherent to this population, giving a realistic portrayal. When the children mutiny and escape, laughing and screaming, from the art room to the playground, the therapists are challenged to quickly find an appropriate therapeutic response. I cringed when I saw this scene; these are the groups we all like to forget. By including it in the film we can observe the calm response of the therapists. This is a useful teaching tool for students who too easily feel they have failed when group behavior is erratic. Lachman-Chapin is honest about the errors therapists make. When three children team up against a fourth, she admits that aligning herself with the fourth child "turned out to be a bad mistake." The viewer is privy to what happens next and observes the therapist's struggle with the resulting behavior. It is a valuable lesson.

For all its useful points the video falls short at the technical end of production. It is, at times, disjointed, jumpy, and difficult to hear, suggesting that distribution of the film for teaching purposes was an afterthought. The age of the video and technical flaws distract from the content. Nevertheless it can evoke group discussion in a child art therapy course and certainly paints a realistic picture of latency-aged, emotionally disturbed girls.

Noteworthy

The Saint Dymphna Altarpiece

Cover by Randy Vick, MS, A.T.R., Chicago, IL

(28" × 19" × 3", painted wood construction with acrylic painting on masonite)

The legend of Saint Dymphna states that she was the daughter of a 7th century Celtic chieftain and his devout Christian wife. When she was 14 her mother died and her father Damon, driven mad with grief, sent envoys to find a noblewoman resembling his late wife for him to marry. When none was found, his advisors suggested he marry his daughter. Upon hearing of her father's plan Dymphna fled with her friends, the court jester and his wife, and her confessor, Saint Gerebernus.

Damon was able to follow them by tracing their use of foreign coins. His men killed her companions, and when she refused to return with him he cut off Dymphna's head with his own sword. Their bodies were buried at the site near the town of Gheel, Belgium. Many miraculous cures of persons afflicted with epilepsy, mental illness, and demonic possession are reported to have occurred at the shrine (Hoever, 1989).

Eventually a church was built nearby and later an asylum known for its humane care and tradition of integrating patients into the community. Saint Dymphna is the patroness of sufferers of nervous and mental disorders. Her feast day is May 15th (White, 1991).

This altarpiece was part of a larger environmental installation entitled, "The Saint Dymphna Allegory" produced in collaboration with Isabel Rafferty, MAAT, A.T.R. and was presented at the opening of the Illinois Art Therapy Association's annual conference on St. Dymphna's Eve, 1993. Also included were the story of the saint's life, eight small votive paintings dealing with mental illness, music, candles, flowers, and incense in an environment which evoked a medieval church. The work was conceived as a performance/experiential which invited viewers into another place and time in order to gain a new perspective on their current time and place. After viewing the objects the participants created artwork in response to the experience and to the clients they serve.

References

Hoever, H. (1989). *Lives of the saints.* New York: Catholic Book Publishing.

White, K. E. (1991). *A guide to the saints.* New York: Ivy Books.

In the "Survey of Doctoral Work by Art Therapists," *Art Therapy, 10*, 4, 1993, Jane Ferris-Richardson, Ph.D., A.T.R., was incorrectly alphabetized under R for Richardson, instead of under F for Ferris-Richardson. Table 3. should list Dr. Ferris-Richardson, A.T.R., as a Registered Art Therapist.

BEST COPY AVAILABLE

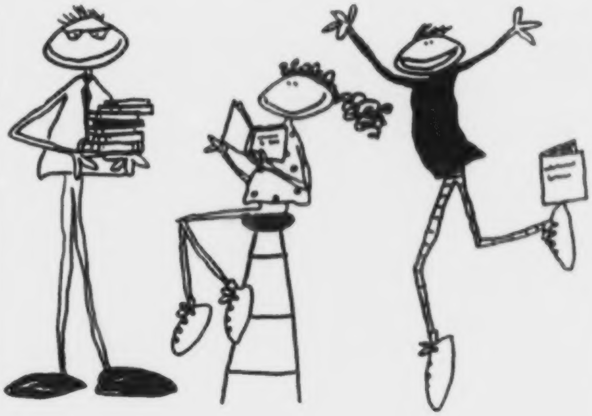
JEAN
BARNES
BOOKS

IF YOU'VE NEVER MET US BEFORE, WE ARE A GENERAL BOOKSTORE WITH A 30 YEAR HISTORY OF CARRYING ONE OF THE BEST PSYCHOLOGY BASED SELECTIONS IN THE COUNTRY. WE HAVE A STRONG, SERVICE ORIENTED BACKGROUND THAT OFFERS THE KNOWLEDGE & ABILITY TO HANDLE RESEARCH

AND YOUR SPECIAL ORDER REQUESTS.

WE HAVE BIBLIOGRAPHIES OF THE MANY TITLES AVAILABLE IN OUR INVENTORY INCLUDING ART THERAPY

CALL US
WE'LL SEND YOU ONE



1-800-678-0621
VISA / M/C / DISCOVER / A/E
ACCEPTED

Coming in Summer 1994

A new, exciting concept magazine !

Creative Lifelines

An international quarterly magazine written by and for survivors and professionals exploring the links between the creative arts and healing.

Help us take shape.

- ✧Submit copies of original art and articles.
- ✧Encourage your clients to submit samples of their work, with your notations. (Artwork can be submitted on an anonymous basis.)
- ✧Send us your subscription before April 1 and receive a special prepublication price of $20 for one year or $40 for two years. (Regular annual subscription rate is $29.95. International subscribers add $10.)
- ✧Complete our magazine content survey.
- ✧Send us names of other potential subscribers or contributors.

PLEASE FILL OUT FORM BELOW:

I need more information.

☐ Please send magazine content survey

☐ Please send Guidelines for Submissions

☐ Please send information concerning advertising.

Name________________________________

Address______________________________

____

Enclosed is my check in the amount of $__________ (plus appropriate MO sales tax for MO residents) for a subscription reservation.

Return completed form to:

Creative Lifelines
Attention: Publisher
4579 Laclede Avenue
Suite #154
St. Louis, MO 63108-2103

American Art Therapy Association, Inc.

RESOURCES

♦CONFERENCE PROCEEDINGS	Members	Non-Members
Creativity and the Art Therapists Identity (1976) (ISBN 1-882147-04-9)	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) (ISBN 1-882147-05-7)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) (ISBN 1-882147-10-3)	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) (ISBN 1-882147-12-X)	$ 7.00	$ 9.00
Art Therapy: A Bridge Between Worlds (1981) (ISBN 1-882147-11-1)	$ 7.00	$ 10.00
Art Therapy: Still Growing (1982) (ISBN 1-882147-06-5)	$ 10.00	$ 14.00
Art Therapy: New Directions in the 80's (1987) (ISBN 1-882147-13-8)	$ 15.00	$ 20.00
Professionalism in Practice (1988) (ISBN 1-882147-08-1)	$ 15.00	$ 20.00
Painting Portraits: Families/Groups/Systems (1989) (ISBN 1-882147-07-3)	$ 15.00	$ 20.00
Image and Metaphor (1991) (ISBN 1-882147-09-X)	$ 15.00	$ 20.00
The Art Therapist: Artist, Teacher, Clinician, Healer (1992) (ISBN 1-882147-14-6)	$ 15.00	$ 20.00
Common Ground: The Arts, Therapy, and Spirituality (ISBN 1-882147-21-9)	$ 15.00	$ 25.00

NOTE: Ten or more copies of any single Proceeding: 10% discount on total cost. Set of four Proceedings (consecutive years): 20% discount on total price. POSTAGE AND HANDLING FOR PROCEEDINGS: $3.00 first item; $.75 each additional Proceeding.

♦OTHER PUBLICATIONS	Members	Non-Members
A Guide to Conducting Art Therapy Research (ISBN 1-882147-08-0)❶	$ 24.00	$ 35.00
National Registry of Masters Theses and Practicum Papers ❷	$ 15.00	$ 25.00
AATA Chapter Manual	$ 10.00	N/A

NOTE: ● Postage included on all orders for this publication. Ten or more copies - 10% discount
● Chapter Manual: Add $2.90 for postage/handling.

♦TRAINING LITERATURE	Members	Non-Members
Educational Guidelines	$ .30	$ 1.00
Education List (colleges & universities offering art therapy programs)	$ .30	$ 1.00
Standards and Procedures for Registration	$ .30	$ 1.00
Criterion for Professional Membership	$ .30	$ 1.00

NOTE: **General Information Packet - $4.00 - consists of first three items above.** These pamphlets are available to **members only in multiples: 1-9 copies - $2.00 plus SASE;** 10-50 copies - $5.00 plus SASE.

♦APPLICATIONS	Members	Non-Members
A.T.R. (Registration) Application	N/C	$ 1.00
Professional Membership Application	N/C	$ 1.00
General Membership Application	N/C	N/C

♦ MEMBER INFORMATION	Members	Non-Members
Member Specialty List	$ 1.90	$ 2.90
Membership Survey	$ .75	$ 2.75
Membership Directory	$ 13.00	$ 55.00

NOTE: **Postage and handling for AATA Membership Directory:** U.S. - $2.90; Canada/Mexico - $3.25;
Foreign - $10.00

◆OTHER LITERATURE

	Members	Non-Members
Art Therapy Model Job Description	$ .30	$ 1.00
Art Therapy Media List	$ .30	$ 1.00
Bibliography: Books Authored by Members of AATA	$ .30	$ 1.00
Standards of Practice Document	$ .30	$ 1.00
Ethics Document	$ .30	$ 1.00

NOTE: **Above items are available to members only in multiples:** 1-9 copies - $2.00 with SASE; 10-50 copies -

◆SUBSCRIPTIONS

Art Therapy: Journal of the American Art Therapy Association	Individuals:	U.S. - $40	Foreign - $64
	Institutions:	U.S. - $57	Foreign - $80
	Back Issues:	Members - $10	Non-Members - $18
AATA Newsletter	Non-Members:	U.S. - $16	Foreign - $28

◆FILMS

	Type	Members	Non-Members
Art Therapy: Beginnings	16mm - RENTAL ONLY	$ 40.00	$ 50.00
1977 (color/sound/45 minutes)	One-half inch VHS - PURCHASE ONLY	$ 50.00	$ 80.00
Michael	16mm - RENTAL ONLY	$ 30.00	$ 35.00
1977 (color/sound/12 minutes)	One-half inch VHS - PURCHASE ONLY	$ 50.00	$ 80.00
Art Therapy	16mm - RENTAL ONLY	$ 35.00	$ 45.00
	One-half inch VHS - PURCHASE ONLY	$ 50.00	$ 80.00

NOTE: **Postage and handling for films:** $3.00 each VHS; $7.00 each 16mm

ORDERING INFORMATION:

1. **WE DO NOT ACCEPT** credit card or purchase orders. All orders must be accompanied by payment in cash, check, or money order in U.S. funds.
2. **FOREIGN ORDERS:** Shipping will be made per your instructions (surface or air). Please specify method of shipment with your order. Additional postage, above amount remitted, will be billed to you if necessary.
3. **RETURNS ARE NOT ACCEPTED** for refund on shipped items.

Mail completed order form and payment to:

AMERICAN ART THERAPY ASSOCIATION
1202 Allanson Road
Mundelein, IL 60060

TITLE	Quantity	Price	Total

SHIPPING INFORMATION

Name______________________________ Member ID#__________

Street____

City/State/Zip____

Total ____________

Postage ____________

Applicable Discount ____________

TOTAL ENCLOSED $ ____________

Please allow 2-4 weeks for delivery

MAKE CHECKS PAYABLE TO AATA

BEST COPY AVAILABLE

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone #s: ____________________ work ____________________ home

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ______________________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Black and white photos of original artwork plus 4 photocopies of each.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ______________________________ **Date** __________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

CHARLES C THOMAS • PUBLISHER

☐ Makin, Susan R.—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 116 pp. (7 × 10).

The author has written a most interesting guide for those who are curious about art therapy. The book provides information and references which she wishes she had been familiar with before embarking on a new career in art therapy. It discusses art therapy theory, practice and instruction from a variety of perspectives, and will be just as useful for prospective employers and clients of art therapists as it will be for art therapy students and new art therapists. In addition to providing background history and information, the author focuses on the major questions she has wrestled with, and the answers she has found. She offers a unique perspective on the process of learning to be a clinician since she has had the rare opportunity to study in rather different kinds of training programs—she comes from Great Britain and has studied in both Canada and the United States, providing a distinctive view of the history, development and present state of the profession in these three areas.

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $62.75.

☐ Anderson, Frances E.—**ART FOR ALL THE CHILDREN: Approaches to Art Therapy for Children with Disabilities, 2nd Ed.** '92, 398 pp. (6¾ × 9¾), 113 il., 19 tables, $59.75.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¾), 21 il., $36.25.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $46.50.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $54.25.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¾), 34 il., $46.50.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $90.00.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts and Practices.** '86, 262 pp. (7 × 10), 1 table, $42.25.

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $51.25.

☐ Singer, Florence—**STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children.** '80, 144 pp., 33 il., $23.50.

☐ Anderson, Frances E.—**ART-CENTERED EDUCATION AND THERAPY FOR CHILDREN WITH DISABILITIES.** '94, 314 pp. (6¾ × 9¾), 100 il., 14 tables.

☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 16 il., $45.75

☐ Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 110 pp. (7 × 10), 12 il.

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $49.75.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 x 10), 24 il., $44.75.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $35.75.

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¾), 28 il., $36.25.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $33.00.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $44.00.

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $22.00.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $51.00.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $23.50, spiral (paper).

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $32.25.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $30.00.

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $25.25.

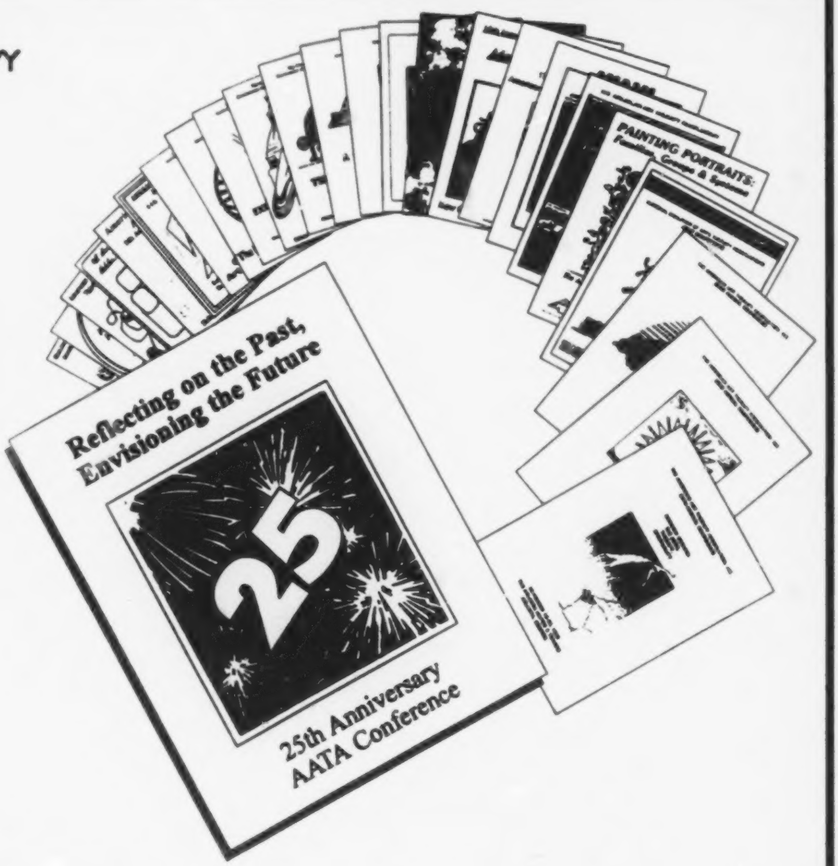
☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $48.50.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130

Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

THE AMERICAN ART THERAPY ASSOCIATION INC.


Reflecting on the Past, Envisioning the Future
25
25th Anniversary AATA Conference
PAINTING PORTRAITS

25th ANNIVERSARY CONFERENCE
REFLECTING ON THE PAST, ENVISIONING THE FUTURE

NOVEMBER 16-20, 1994
THE PALMER HOUSE
CHICAGO, ILLINOIS

This years conference will feature:

- Day long pre-conference courses
- Keynote speaker ELLEN DISSANAYAKE, author of Homo aestheticus and What is Art For?
- Experiential workshops, oral presentations and networking forums
- General sessions on ethics and highlights from the history of the Association
- Public exhibit of artwork by area art therapists and other special events

AATA members will receive additional information and full registration packages by mail. Other interested parties should contact:

AATA, Inc.
1202 Allanson Rd.
Mundelein, IL 60060
708-949-6064
Fax: 708-566-4580

(The next AATA Conference will be held November 8-12, 1995 in San Diego). Contact AATA for information regarding the submission of proposals.

PLEASE POST OR PASS ALONG - - - - - PLEASE POST OR PASS ALONG

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Celebrating
AATA's 25th Anniversary
1969 - 1994

VOLUME 11, NUMBER 3, 1994

1795

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue, July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, MA, A.T.R.
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Patricia St. John, EdD, A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor
Barbara Sprayregan, Psy.D., A.T.R.
Arlington, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Philadelphia, PA

Production Editor
Suzan B. Soto

Editorial Board
Pat B. Allen, PhD, A.T.R.
River Forest, IL
Frances E. Anderson, EdD, A.T.R., HLM
Illinois State University, Normal, IL
Doris B. Arrington, EdD, A.T.R.
College of Notre Dame, Belmont, CA
Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec
Mariagnese Cattaneo, PhD, A.T.R.
Lesley College, Cambridge, MA
Susan E. Cheyne-King, MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R.
The George Washington University, Washington, DC
Julie Epperson, MA, A.T.R.
Salt Lake City, UT
Janice Havlena, MA, A.T.R.
UNM Children's Psychiatric Hospital, Albuquerque, NM
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Vija B. Lusebrink, PhD, A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, EdD, A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Shirley Riley, MA, MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Susan Evans Spaniol, EdD, A.T.R.
Lesley College, Cambridge, MA
Betty Jo Troeger, PhD, A.T.R.
Florida State University, Tallahassee, FL
Evelyn Virshup, PhD, A.T.R.
California State University, Los Angeles, CA
Robert Wolf, MPS, A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President
Bobbi Stoll, MFCC, A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

VOLUME 11

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 3, 1994

Editorial

Certification: In Search of Accountability — Cathy A. Malchiodi, MA, A.T.R. 170

Commentaries 173

Special 25th Anniversary Section

The Formation of the American Art Therapy Association — Maxine B. Junge, PhD, A.T.R. 175

An Informal Interview with Edith Kramer — Bardi Koodrin, BA, Gail Caulfield, MA, and Annette McGarr, MA 180

Special Section: Art Therapy and Multicultural Issues

Articles

Addressing Culture and Values in the Training of Art Therapists — Mariagnese Cattaneo, PhD, A.T.R., LMHC 184

Art Therapy with Culturally Different Clients — Cynthia A. Westrich, MA 187

Art Therapy with Native American Clients: Ethical and Professional Issues — Phoebe M. Dufrene, PhD, A.T.R. and Victoria D. Coleman, EdD, NCC 191

Transcultural Responses to Aesthetic and Therapeutic Experience: An Ethological Approach — David R. Henley, MA, A.T.R. 194

An Interview with Joan Kellogg — John Alden Thayer 200

Brief Reports

American Art Therapy Association, Inc. 1992-93 Membership Survey Report — Gwynne La Brie, BA and Cindy Rosa, MA, A.T.R., LPC, CAC III 206

Viewpoints

A Note on Ethnicity in Humor and Art Therapy — Christina Mango-Hurdman, MA, A.T.R. and Joseph Richman, PhD 214

Native American Experience of Healing through Art — Nadia Ferrara, MA, A.T.R. 216

Magazine Photo Collage as a Multicultural Treatment and Assessment Technique — Helen B. Landgarten, MA, A.T.R., HLM 218

Psychopathology of Expression and the Therapeutic Value of Exhibiting Chronic Clients' Art: A Case Study — Simone B. Alter-Muri, EdD, A.T.R. 219

Being Different: A Theoretical Perspective — Judy Weiser, R.Psych., A.T.R. 224

Reviews

Understanding Race, Ethnicity, & Power: The Key to Efficacy in Clinical Practice — Martha P. Haeseler, MA, A.T.R. 229

Creative Art in Groupwork — Erika Cleveland, MA, A.T.R., LMHC 230

Response to Video Review — Karen L. Wakeley, MPS 231

About the Cover: "Swiss Soldier II," 12" × 8" × 4" by Mariagnese Cattaneo, PhD, A.T.R., Professor, Lesley College. "The day the Gulf war broke out I was travelling from Switzerland to Boston. The plane was half empty, the airports in Europe deserted; people avoided travelling. I felt angry and disappointed. The following day I went to my studio. I remembered a series of Swiss crosses I had formed a year earlier from newspaper, cheesecloth, and gesso. At that time I had put them aside because, after the initial inspiration, I did not know how to continue with these forms. Now I started painting them, one layer of paint after the other, adding sticks, slowly these crosses became soldiers, faceless mercenaries. 'Swiss Soldier II' is one of a series of seven."

Editorial

Certification: In Search of Accountability

Cathy A. Malchiodi, MA, A.T.R., *Editor*

As the AATA approaches its 25th anniversary celebration this fall, the efforts to implement a national certification program for art therapists continue to solidify, becoming an issue of conversation by both those inside and outside the professional ranks. In a recent issue of *Common Boundary*, an article titled "Art Therapy's Growing Pains" (Baker, 1994) described our profession's current struggle with developing and implementing a certification program for art therapists, bringing the debate into the public eye. Through a variety of interviews and viewpoints, the article presented the pros and cons of the AATA's move toward certification of art therapists, highlighting both the hopes and fears of prominent art therapists in our field concerning the long-range effects of certification on the profession.

The development of a certification program for art therapists has been a long and often difficult venture (Malchiodi, 1994). Whether or not to implement certification in addition to the current registration process has included a great deal of impassioned discussion and debate, criticism as well as support, and even confusion and ambiguity among our most noted clinicians, educators, and scholars. In contrast to the complexity of the profession's struggle, the *Common Boundary* article portrays the AATA's move toward certification as a more-or-less black and white issue, with diagnostic-type art psychotherapists who support certification in one camp, and creative or expressive arts therapists who support the arts and art process in the other. Certainly, it is not that easy to pigeonhole the parties in question and most see the development and implementation of certification as a much more complex issue. Many art therapists and expressive arts therapists feel that certification deserves their support, but simultaneously want to protect the multidimensional aspects of the profession that differentiate it from other related fields. On the whole, we generally agree that certification for art therapists is important, but also deeply value our rich connections to visual arts as well as our interface with related creative arts therapies.

Concurrent to the *Common Boundary* article, the summer issue of the *Art Therapy Credentials Board Review* (1994) was published and additional details of the actual certification process were made public. A "Bulletin of Information" describing the purpose, scope, and application procedures is now available and all A.T.R.s will have received this material by the time this editorial goes to press. A separate study guide for an additional fee is also offered; the intent of this guide is to give more specific information on the details of the areas of knowledge as determined by the National Practice Survey. Other important decisions have been made by the ATCB, including the grandparenting of the current Honorary Life Members of the AATA and the tightening of eligibility requirements for certification after the year 2000 (see the bulletin for specific details).

The bulletin provides the first real opportunity for art therapists to review the aspect of certification that they have been most curious about: the contents of the examination and the resources that were used to develop the test. The publication offers some eye-opening information in that respect, particularly in the area of references. With regard to the reference list, the ATCB states that these "references may be helpful in reviewing for the examination. This list is intended for use as a study guide only. [The] ATCB does not intend the list to imply endorsement of these specific references, nor are the test questions taken from these sources" (p. 13, 1994). That statement is noticeably ambiguous concerning what actual references will be used within the examination, leaving the reader to assume that the list provided in some way covers the material on the test. Although actual endorsement is denied, it still leaves one with the feeling that the materials listed were specifically selected by someone or some group (one assumes that the list did not generate itself), thus implying some sort of "endorsement" on an unofficial level.

Within the published reference list, the book list provided is particularly worrisome for several reasons. First, the amount of titles written before 1975 is astounding—29 of the 49 titles—with many written during the 1950s and 1960s. I was personally shocked to see titles such as Machover's *Personality Projection in the Drawing of the Human Figure* (1949) and Hammer's *Clinical Application of Projective Drawings* (1958). It is common knowledge that the information published in these types of publications has come under severe criticism over the last decade (Cummings, 1986; Gittleman, 1980; Golumb, 1992; Kamphaus & Pleiss, 1991; Martin, 1983; Palmer, 1983, to name a very few). Another example is the listing of Blos (1962, 1970, 1979) who has written several texts on adolescence; however, numerous texts and articles exist that describe more contemporary societal issues and influences in adolescence. Other surprises were the inclusion of Bender's *Child Psychiatric Techniques* (1952) and books by Anna Freud (1965, 1966), in contrast to the lack of listing any of the many current texts on childhood disorders, intervention strategies, and the DSM that might be more relative to today's short-term clinical practices of art therapy with children.

At any rate, even if one wanted to study the writings of the authors on the book list, in many cases it would be extremely difficult or impossible to obtain some of these titles, due to the fact that they are either out of print or only available through large university libraries. This may also hold true for some of the journal articles listed, as the standard art therapy journals are not always available even in the best library systems; older issues (pre-1980) are even more difficult to find. One wonders why the Certification Committee was not advised by the testing firm to locate more current, edited texts or journal articles that highlight the works they wanted to emphasize, rather than list the original publications. This is a standard practice in other fields to include the materials of authors whose work is more foundational than contemporary. For example, a seminal text such as *Family Therapy* (Goldenberg & Goldenberg, 1991) might be referred to in lieu of citing an original Minuchin (1981), or an edited text such as *Psychiatric Disorders of Children and Adolescents* (Garfinkel, Carlson, & Weller, 1990) might be used to cover a variety of basic theories on childhood pathology. (These are obviously just a few suggestions, since there are many other titles that could be considered.) This major oversight has resulted in a book list that makes the field of art therapy look, at the very least, out of touch and archaic. As one art therapy colleague observed, "I would be laughed out of a graduate course or professional seminar if I used these [out-dated] references in a scholarly paper."

Another interesting aspect of the book list is that most of the titles were written by non-art therapists—33 of the 49 titles, which is roughly more than two-thirds of the published list. Granted, titles of works such as those by Lowenfeld and Brittain (1957) and Gardner (1980) on the developmental levels of artistic expression, as well as those on art, counseling, etc., would come from outside the field of art therapy. However, when more than two-thirds of the book titles are by authors from outside the field of art therapy, one is left to wonder exactly what is going on.

So what is going on? It is interesting to speculate on how the Certification Committee arrived at this reference list. Supposedly, these resources were derived from consultation with art therapy educators and other experts in the field, with final decisions made by the Certification Committee members. A real concern is that this antiquated list is what educators are teaching their students; the publication of such a list implies, at least on some level, that this is the case. The low percentage of books authored by art therapists also was baffling. This brings me back to my previous question: Is it because our own literature does not hold up to scrutiny (Malchiodi, 1994)? Another question also comes to mind: Are we as educators and clinicians resistant to using the works of our own authors in the training of students? At any rate, in the Certification Committee's review of the reference list, it may have been wise to do some additional cross-checking with experts in the field as to the final contents.

These observations take me back to the *Common Boundary* article (Baker, 1994) that portrayed those in favor of certification as mostly in the psychoanalytic, diagnostic camp of art therapists. In some respects, the article may have been more accurate than I had originally wished to believe. When reading the reference list provided in the ATCB document, I am left with the impression of a field basically embedded in psychoanalysis and diagnostics, and, unfortunately, not even reliable diagnostics. I still have hope that the actual examination will be more broadly based, contemporary, and multidimensional; however, the psychoanalytic sway of the literature list certainly has dampened that spirit.

Finally, it is interesting to note that in the summer issue of the *ATCB Review* (1994), the "Certification Committee News" report suggests that the entire profession has been an influence on the evolution of certification, answering the self-reflective question.

> WHO is preparing this exam for art therapists anyway? . . . from the inception of the move toward certification, art therapists have been the sole driving force in this project. This exam is not written by other professionals, state regulators or outside "testing experts." It is developed and written by art therapists. By now close to 100 art therapists have participated in some aspect of development or writing of the exam, even more are . . . [currently] working to write questions for use on the exam. (p. 2)

While it is true that a large group of art therapists was consulted through the National Practice Survey and a smaller group was asked to write questions for possible inclusion in the examination, that part of the process is over and the final version rests in the hands of the Certification Committee (with advice from the firm Knapp & Associates). At this point there is not a lot of consultation with the larger group of professionals, partly due to reasons of confidentiality in the development of the exam and partly due to apparent deadlines for publication of a candidate bulletin and study guide.

So, who is really accountable for the certification examination—the ATCB, the Certification Committee, the consultants, or the entire professional population of art therapists? I can only respond to this question from my own experience as the editor of the Association's journal, a position which entails a great deal of accountability to my peer professionals. The Editorial Board and I are accountable to not only the authors who submit material for possible publication, but we also bear a more serious accountability to the entire field of art therapy. We regularly make important decisions to accept, revise, or reject papers through the process of peer review. We also copy edit, proofread, and finally verify content of accepted papers to the best of the journal staff's ability. Our decisions result in the publication of what we hope represents not only the best of our scholarly endeavors, but also the diversity of art therapy practice, methodology, and theory.

The journal's accountability to the field of art therapy is to conduct the process of peer review with an openness that results in the publication of a variety of philosophical and methodological approaches. Our prime directive is to honor all ways of thinking and to encourage and protect the freedom of writers in our field to express diverse opinions. To do this we call on the very best experts we have on hand to contribute to the process and to protect the diversity of the profession. However, the protection of the tremendous diversity of this profession does have its limits: we can only address what is received to be reviewed by this publication and we can only eventually publish what we receive from the members and other professionals through due process and according to procedures of peer review.

The Certification Committee has a similar and equally serious accountability to the field of art therapy in developing a test which will conceivably measure a level of basic competency among art therapists, and that will support our credibility as providers of mental health services. Like the journal, the Certification Committee also bears the weighty responsibility for the representation of the field to the larger public and for the future direction and growth of the profession of art therapy. They have been empowered with tasks of soliciting, editing, revising, rejecting, accepting, and verifying the material that has been submitted to them through the National Practice Survey and the potential examination questions submitted by the pool of experts. Like the journal, the committee has endeavored to encourage many art therapists to participate in the process and to have a voice. However, also like the journal, the committee is a relatively small group of individuals who must attempt to accurately represent and reflect the larger profession. And like the journal, they can only process the material that they receive from the larger profession, whether it be test questions, input on surveys, or letters of suggestions or advice.

As many who have been in this profession for a while, I am still sorting out my feelings about this tremendous undertaking to create and implement a certification program. I see reality on one side: a movement toward health care plans that may exclude or at the very least severely limit the ability of art therapists to practice. Competency and credentials are a reality for those who work in clinics, hospitals, and other agencies, with licensure becoming a standard requirement. Whether or not one is for or against certification, it is important to note that the first art therapy licensure in New Mexico would not be in existence if the profession had not undertaken to create a certification exam. After June 30, 1994, according to the *Counselor and Therapist Practice Act*, all art therapists who apply for art therapy licensure will have to take the examination (p. 145, 1994). This was not a choice, but was a necessary component of the proposal to license art therapists. It is a standard practice that all professions which achieve licensure on the state level have an examination in place to use for testing the competency of those who apply for licensure.

On the other hand, my idealistic side worries about our knowledge base, our roots in visual art, and our collective strength in our diversity. These are potential areas on which a misguided certification program might have serious ramifications, ramifications that could have long-lasting effects on education, training practices, and development of the field. Certification, on one hand, is necessary to our survival in a precarious job market and health care arena; on the other hand, like the journal, our publications, our professional conferences, and educational standards, it must be inclusive of the entire field and feel comfortable to the members of this association or we as art therapists will professionally wither and die. We are a small and struggling group of individuals, and each and every effort, decision, and direction we take is important to our ultimate survival.

What this all boils down to is accountability. Each professional who undertakes the responsibility of serving on an AATA or ATCB Committee or Board is accountable for the profession's growth rather than limitation, continued achievements rather than restrictiveness, and inclusiveness rather than exclusiveness. These concepts are at the root of our continued survival as a profession. Certification may be one avenue to the protection and advancement of the profession, but art therapy's future will always be embedded in our collective ability to encourage continued growth, openness, and intellectual advancement, while remaining inclusive of the many dimensions that have enriched this field. These are ideals to which each and every one of us must remain accountable.

References

Art Therapy Credentials Board. (1994a). *Art Therapy Credentials Board Review, 1*(3), 1–3.

Art Therapy Credentials Board. (1994b). *Certification examination in art therapy: Bulletin of information.* Mundelein, IL: Author.

Baker, B. (1994, July/August). Art therapy's growing pains. *Common Boundary*, 42–48.

Bender, L. (1952). *Child psychiatric techniques.* Springfield, IL: Charles C Thomas.

Blos, P. (1962). *On adolescence: A psychoanalytic interpretation.* New York: The Free Press.

Blos, P. (1970). *The young adolescent.* New York: The Free Press.

Blos, P. (1979). *The adolescent passage.* New York: International Universities Press.

Cummings, J. A. (1986). Projective drawings. In H. Knoff (Ed.), *The assessment of child and adolescent personality* (pp. 199–244). New York: Guilford Press.

Freud, A. (1965). *Normality and pathology in childhood.* New York: International Universities Press.

Freud, A. (1966). *The ego and the mechanisms of defenses.* New York: International Universities Press.

Gardner, H. (1980). *Artful scribbles.* New York: Basic Books.

Garfinkel, B., Carlson, G., & Weller, E. (1990). *Psychiatric disorders of children and adolescents.* Philadelphia, PA: Saunders.

Gittleman, R. (1980). The role of psychological tests for differential diagnosis in child psychiatry. *Journal of the American Academy of Child Psychiatry, 19*, 413–438.

Goldenberg, I., & Goldenberg, H. (1991). *Family therapy: An overview.* Pacific Grove, CA: Brooks/Cole.

Golumb, C. (1992). *The child's creation of a pictorial world.* Berkeley, CA: University of California Press.

Hammer, E. (1958). *The clinical application of projective drawings.* Springfield, IL: Charles C Thomas.

Kamphaus, R. W., & Pleiss, K. L. (1991). Draw-a-Person techniques: Tests in search of a construct. *Journal of School Psychology, 29*, 395–401.

Lowenfeld, V., & Brittain, W. (1957). *Creative and mental growth.* New York: MacMillan.

Machover, K. (1949). *Personality projection in the drawing of the human figure.* Springfield, IL: Charles C Thomas.

Malchiodi, C. A. (1994). Sorting out certification. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 82–83.

Martin, R. P. (1983). The ethical issues in the use and interpretation of the Draw-a-Person test and other similar projective procedures. *The School Psychologist, 38*(6), 8.

Palmer, J. O. (1983). *The psychological assessment of children.* New York: John Wiley & Sons.

State of New Mexico Counseling & Therapy Practice Board. (1994). *Counselor and Therapist Practice Act.* Santa Fe, NM: Author.

Commentaries

Letters to the Editor

I read your editorial, "Sorting Out Certification," with considerable interest as I have been involved with the process of developing a certification program for art therapists for nearly 10 years. Most of the activity in support of certification has taken place in the past three years, beginning with the AATA Certification Committee's search for a testing agency to help us develop our examination and culminating in the formation of the Art Therapy Credentials Board (ATCB) and the administration of our first exam.

With all that has been written about why we need certification, there is one question which has not been given enough consideration. That is the question of accountability.

The reason we feel compelled to fortify our credentials is that we are being asked to be accountable for the quality of the work we do. Clients, employers, insurance companies, and regulators are the ones doing the asking. If we fail to respond, it will become increasingly difficult to find anyone willing to allow us to practice or to pay us to be art therapists.

In order to be accountable, we must establish standards of competence and devise a means for measuring compliance with these standards. This is the purpose, and the only purpose, of the certification examination. Our Registration program has served us well for many years, but it is no longer enough. Registration requires review of credentials, not a demonstration of competence. At the moment, formal testing is the most widely accepted measure of competence and will, therefore, be the most useful. Registration of art therapists will remain an essential part of our credentialing program, but it will be supplemented with a certification exam and a recertification program.

The relationship between certification and licensing is confusing to many art therapists, and we have received quite a few letters, many rather irate in tone, asking why we are wasting our time developing a certification program when licensing is what we really need.

It is essential to keep in mind that licensing is mandatory, government-imposed regulation of a trade or profession. When a state licenses members of a profession, it may become impossible for an unlicensed individual to practice. In some cases, it may be illegal. We have no control over how states regulate professional activity, although we are free to lobby in support of legislation we view as favorable.

Certification programs are developed by professional groups for the purpose of assessing the competence of those practitioners who choose to become certified. The current trend in the state licensing of counselors and therapists is to require candidates for licensing to pass the national certification exam for their profession. This is happening because the state licensing boards want to see evidence of competence before they will issue a license to an individual, but they will not undertake exam development when there is little chance that revenue from licensing fees will be sufficient to allow them to recoup costs.

Licensing is imposed as a consumer protection measure, but it may also benefit members of the licensed profession because it implies that those who earn their licenses have demonstrated competence in the process. This has become important to us because insurance companies generally accept a license as proof of competence and are more likely to reimburse payments to a therapist who is licensed than they are to one who is not.

The advantage to developing our own program is that we set the standards for measuring an art therapist's competence ourselves and the resulting credentialing program will give us something tangible to bring to legislators or licensing boards when they are considering licensing art therapists. If we do not have a certification program of our own to offer, we are likely to find that we are either unable to achieve favorable legislation or that the bodies wishing to regulate our practice will establish their own standards to evaluate what we do. We cannot afford to let this happen.

Returning to the question of accountability, I would like to say that the most disturbing undercurrent in much of what I have read on the subject of the certification of art therapists is the suggestion that we are either so hopelessly confused about what it is that we do that we cannot be held accountable, or that because creativity and spontaneity are the hallmarks of our work, we cannot be expected to be accountable. What does this say about our sense of responsibility to those we profess to serve?

Regardless of our individual philosophies and techniques, we are representing ourselves as experts in the application of artmaking as a vehicle for healing and personal growth. How can we expect people to trust us to do this with competence and sensitivity when we do not believe, ourselves, that we can define what we do, how we do it, and what the outcome should be.

Having made these observations and asked these questions, I would like to add that I do not agree that finding the commonality in our profession and devising a way to measure it is an impossible task. The Certification Committee of the ATCB set about doing this three years ago and you are about to see the result. I believe that they have succeeded and that this exam, developed for art therapists by art therapists, will reassure most, if not all, of you that it is a true reflection of who we are and what we do.

Nancy Hall, A.T.R.
President
Art Therapy Credentials
Board (ATCB)

I am writing in regard to your Editorial in the most recent Art Therapy regarding the process of certification, specifically as it pertains to "grandfathering."

Throughout the discussions about certification, I assumed that experienced art therapists would be given an opportunity to be grandfathered. This is a process I have observed in psychologists, physicians, and social workers and was certain ATCB would follow suit.

When I first found out there would be no grandfathering, I wrote to the credentials board asking for an explanation. In response I recently received a letter from Nancy Hall, President, stating that grandfathering would weaken the credential. She did not explain how. Then she stated that because all A.T.R's would be able to sit for the exam during the first five years "without further qualification" a form of grandfathering is occurring to "allow those whose professional preparation predated today's training programs." Finally, she explained that only Honorary Life Members would be grandfathered.

I still cannot imagine how grandfathering will weaken the credential. The idea is based upon the belief that experience deserves respect and that much of what we learn as clinicians occurs in the professional work occurring after graduate school through practice and the assimilation of theory. If such procedures weaken credentials, why have other mental health professionals embraced grandfathering as their credentialing processes became more stringent?

I thought that the A.T.R. after my name demonstrated that I have documented to AATA's satisfaction that my training and experience are at least adequate. Now it seems ATCB is questioning the qualifications of those already registered as art therapists. I find I can only respond to this personally; my own professional organization appears to question the standards by which I became registered and won't consider my experience and years of support to the field of art therapy in creating a new level of art therapist.

I was pleased to learn that our pioneers of art therapy will be respectfully grandfathered. I was expecting that practitioners such as myself with substantial experience would also be shown similar professional respect.

I recently read the article in the journal *Common Boundary* about art therapy and certification. From that article, I understand that a result of certification, for better or worse, will be a more homogeneous organization of art therapists who are more clinical in orientation and less art-based. It is a sad comment on our organization if we are finding it necessary to weed out the more art-based art therapists now rather than waiting for the certification process to achieve that end over the next 20 years or so. Those A.T.R.s whose backgrounds are more art-based and less clinical have long been a part of the financial and membership base of AATA. I do not want those A.T.R.s to be treated disrespectfully, nor do I want experienced clinical art therapists treated in a similar manner.

I write this letter respectfully, but with significant concerns about the current direction we appear to be taking.

Rebecca Thomas, A.T.R.
Mountain Lakes, NJ

Letter to the Associate Editor

RE: 11:2, 1994, "A Review of Two Assessment Tools in an Adult Day Treatment Center," Piyachat Ruengvisesh Finney

I am writing to correct an error in the journal and to dispel confusion between two assessment instruments: 1. *Stimulus Drawings and Techniques in Therapy, Development and Assessment;* and 2. *Silver Drawing Test of Cognitive Skills and Adjustment: Drawing What You Predict, What You See, and What You Imagine (SDT).*

The author of the journal article seems to refer to both as though they were a single instrument. She seems to have used only #1, however, because she refers to 50 stimulus drawings and a date of publication. On the other hand, the author also refers to #1 as the *SDT*, which is the acronym for #2, and cites reviews and an article concerned with #2 (Rubin, 1991; Hiscox, 1993; O'Neill, 1991; Silver & Carrion, 1991).

This confusion, shared by others, is understandable because both instruments begin with the same initials. Nevertheless, the instruments are quite different. The *Silver Drawing Test* (#2) includes three tasks: Predictive Drawing, Drawing from Observation, and Drawing from Imagination—a stimulus drawing task in which examinees are asked to select two from a set of 15 stimulus drawings, imagine something happening between them, then draw what is happening. They are encouraged to change the subjects they chose and add their own, then write a title or story. The test manual includes normative data so that a particular individual may be compared with others, as well as seven studies of test-retest and interscorer reliability. In addition, scores on the *Silver Drawing Test* are correlated with scores on 12 traditional tests of intelligence or achievement. This instrument is being translated into Portugese by art therapists in Brazil. First published by Special Child Publications in 1983, a revised edition was published by Ablin Press in 1990.

Stimulus Drawings and Techniques (#1) consists of a single drawing task and includes 50 stimulus drawings. Although it reports several studies, it is concerned primarily with techniques for access to fantasies and cognitive skills, as well as with findings about individual differences, consistency of selections, the use of humor, and the range of emotional content. First published by Trillium Press in 1981, and reprinted in 1982 and 1986, revised editions were published by Ablin Press in 1989 and 1991.

Adding to the confusion is a third stimulus drawing instrument: *Draw a Story: Screening for Depression and Age or Gender Differences.* Fortunately, it begins with different initials.

Rawley Silver, EdD, A.T.R., HLM
Sarasota, FL

Special 25th Anniversary Section

The Formation of the American Art Therapy Association

Maxine B. Junge, PhD, A.T.R., Los Angeles, CA

The details about the formation of the American Art Therapy Association are presented in this excerpt from the forthcoming publication* A History of Art Therapy in the United States *by Maxine Borowsky Junge, PhD, A.T.R. with Paige Pateracki Asawa, MA. The events which led up to the organization's founding, the primary organizers, and the controversies surrounding the development of professional standards for art therapists are discussed.

This monograph will be published later this year by the American Art Therapy Association in conjunction with its 25th anniversary.

Introduction

By the mid-1960s, the formation of a professional organization for art therapists was an idea whose time had come. In the early 1960s, Don Jones and Robert Ault, a young art therapist from Texas, were working at the Menninger Clinic, dreaming together over endless cups of coffee about a national society. As early as 1966, art therapists attended the meeting of the International Society for Psychopathology of Expression in Washington, D.C., and talked about forming a group. These art therapists included Sandra Kagin, then living in Oklahoma and working with retarded chlidren. Marge Howard, also from Oklahoma, who had worked in mental health for some years and had done studies on sexually abused children and their artwork. Elinor Ulman, the founder and editor of the *Bulletin of Art Therapy*,[1] and Tarmo Pasto, a psychologist from California.

The International Society for Psychopathology of Expression focused its scholarly interests on the pathology evident in artwork. It had been formed in 1959 and included a wide variety of disciplines related to psychopathology and psychology of the arts, although it tended to be dominated by psychiatrists. The American Society had been incorporated in 1966 in Topeka, Kansas. Some of the conference papers from these two groups were published in books edited by Irene Jakab (Jakab 1971, 1969, 1968).

The art therapists who talked together about the possibility of their own group envisioned an organization that would be responsive to their needs and would address questions of treatment as well as pathology and diagnosis. However, it is clear from reading the tables of contents of Jakab's publications that art therapists were regular presenters and involved participants. One volume (Jakab, 1969) includes papers by Margaret Howard, Elsie Muller, Bernard Stone, Donald Uhlin, Tarmo Pasto, and Harriet Wadeson. At one time or another, Pasto, Howard, and Muller were officers in the Society. All became active in the new professional organization for art therapists.

One must wonder why the need for a separate organization was so strongly felt. The 1960s in America was an era of tremendous civil rights activity led by Dr. Martin Luther King, Jr. It may be speculated that in an organization such as the International Society of Psychopathology of Expression dominated by psychiatrists and in a mental health community still hierarchical and based on the medical model, art therapists had the political foresight to recognize that in order to achieve acknowledgement as respected mental health professionals, they would have to separate themselves out. They needed to band together to set up principles of practice and, most essentially, to establish a sense of professional identity. This kind of separatism of a minority group is sometimes an unwanted result of prejudice, but is also a much-practiced strategy and a recognizable first step of minority groups of all kinds in their efforts to achieve equality.

Don Jones described the Society as having something of a "caste system" in which the art therapists were "invited guests." The art therapists wanted to talk about using art as treatment, rather than just a measure of pathology, and this was a reason for another organization (D. Jones, telephone call with Linda Gantt, September 9, 1993).

When Margaret Naumburg's book *Dynamically Oriented Art Therapy* was published in 1966, it provided an important impetus to the new movement. In it, she formally defined the theoretical assumptions that had been presented in her previous books and which she had discussed in presentations throughout the country. In May, 1968, a group of East Coast art therapists[2] coincidentally exhibited artwork of hospitalized psychiatric patients at the meetings of the American Psychiatric Association (APA) in Boston.[3] Later, a panel was presented on art therapy, organized and moderated by Mardi J. Horowitz, MD, at the American Psychiatric Association meetings in Miami Beach. Naumburg, Ulman, Edith Kramer, Hanna Yaxa Kwiatkowska, Carolyn Kniazzeh,[4] and Myra Levick made presentations which were discussed by Paul Jay Fink, MD, and Lyman C. Wynne, MD. This event proved to be extremely significant. Myra Levick writes:

> The separate exhibits were impressive, professional, and reflected different approaches within a relatively new modality for the diagnosis and treatment of mentally ill populations—art therapy. . . . During this conference we were all invited to lunch by Paul J. Fink, MD, then coordinator of Education and Training at Hahnemann Medical College, now Hahnemann University. . . . Over lunch we agreed that in order to define this discipline as a recognized profession, a national art therapy association needed to be established. (Levick, 1985, p. 28)

BEST COPY AVAILABLE

The First Organizational Meeting

The first formal attempt to form a national organization for art therapists took place in 1968, under the auspices of Hahnemann Hospital in Philadelphia. Dr. Fink was tremendously interested in art therapy and he, along with Morris Goldman, MD, Director of Hahnemann's Community Mental Health Center, began what was the first graduate-level art therapy training program (called "Psychiatric Art Therapy") since an earlier art therapy program in the 1950s at the University of Louisville had become inactive. Myra Levick was hired as Director. Levick, Fink, and Goldman (1967) published an article in the *Bulletin of Art Therapy* called "Training for Art Therapists." Elinor Ulman acknowledged Levick as "the founding spirit of the association" (Ulman, in Jordan, 1988, p. 108).

Levick had attended Moore College of Art in Philadelphia and later earned her doctorate from Bryn Mawr College:

> I was trained as a professional artist—having gone back to school after marriage and children. . . . I have painted all my life . . . At the time I graduated Moore College, I had been considering going on for a Master's degree in the history of art. In fact, I had been accepted and there was a little notice on the bulletin board that a psychiatrist was looking for an artist to work with emotionally disturbed patients in the first inpatient unit in a general hospital in Philadelphia. I was absolutely fascinated. He said that he thought an artist had a great deal to offer in working with emotionally disturbed patients and if I would bring my art skills, he would teach me how. He told me there were art therapists in the country about which I knew nothing. I gave up the History of Art Master's and he took me on. (Levick, 1975)

So, in 1963, she:

> . . . had the opportunity to utilize my talent and training as a painter in a 29-bed inpatient unit for adults suffering from moderate neurosis to severe psychosis . . . My job title was "art therapist" and one of my first tasks was to learn what that implied. (Levick, 1983, p. 11)

Although many had talked of the need for a national association, it was Myra Levick's energy (along with Paul Fink's encouragement) which brought about the necessary steps to create the organization. Levick's role in the formation of the American Art Therapy Association irrevocably changed the course of art therapy in the United States by emphasizing art therapy as a separate discipline (as had been defined by Naumburg) and thereby fostering the emerging sense of the art therapist's identity as a special kind of mental health practitioner. Levick was the American Art Therapy Association's first president[5] and has been actively involved with its progress since then. She eventually became Director of the Creative Arts in Therapy Program at Hahnemann, which included dance and music therapies as well. She published widely and became the editor of the second journal in the field, *The Arts in Psychotherapy* (originally called *Art Psychotherapy*). In 1983, Levick published *They Could Not Talk and So They Drew*, which dealt with defense mechanisms as they were expressed in art. She wrote:

> My own particular interest and expertise evolved around ego mechanisms of defense . . . how these elements are manifested in drawings of children and adults in a therapeutic milieu. (Levick, 1983, p. xviii)

She is now retired and living in Florida while continuing to consult as an art therapist.

In December, 1968, Myra Levick and Paul Fink hosted an organizational meeting and invited as many art therapists as they could find.[6] About 85 people (including 50 art therapists) attended, and an *ad hoc* steering committee was elected. The committee consisted of Elinor Ulman, Don Jones, Felice Cohen, Robert Ault, and Myra Levick. (Robert Ault was hired by Don Jones at the Menninger Foundation in 1960 and had been trained by Jones.) The steering committee was given the task of developing a constitution for the new organization.

From the beginning, there was considerable and sometimes acrimonious controversy over whether to form an organization at all. Although many art therapists saw the need for a forum to bring people together for the purposes of education and identity and to achieve recognition as a new profession, a few, such as Elinor Ulman, felt that it was too soon and that art therapy should develop further on its own.[7] She and Edith Kramer urged that a broader territory be carved out for the field, one which went beyond psychiatric settings.

While some were trying to slow what they felt to be a premature definition of the field, others were convinced that forming a national association was urgent. Don Jones remembers:

> I went to Philadelphia with a sense of frustration. Having written to art therapy people and others saying we must get together . . . at that time my impression from them was that we can't form an organization. This is a very special kind of thing. It can only be taught by selected practitioners. Myra Levick . . . told me her impression of my coming to Philadelphia which was: I walked into her office, thumped my fist on her table . . . and said either we get it together *now* or forget it! I felt the urgent need. If we were going to grow at all we needed to get together. (Jones, 1975)

Of the meeting in Philadelphia, Robert Ault says:

> Don Jones and I spent years working together and sitting in a back room drinking coffee and talking about someday maybe creating a national organization. We had dreamed about that and shared [that dream] for a long time. . . . Don left Menninger's very shortly before the first meeting. If Don had still been at Menninger's, one of us would have had to stay home to cover at the hospital. As it was, we both went to Philadelphia to work on a project that we had both wanted as our big life project. (Ault, 1975)

Ault continues about the Philadelphia meeting:

> [That first meeting was] very heated. Margaret Naumburg was there. She was a very old woman with a hearing loss. She would sit with her cane and every time someone said something she didn't want to hear, she would knock her cane on the floor. She was nominated [to the steering committee] but lost and stomped out saying "I'm not through with you!" I had several warm pleasant letters from her later, but those initial days, they were something else! (Ault, 1975)

Rawley Silver from New Rochelle, New York, attended the Philadelphia organizational meeting; her feeling about it was shared by a number of others. "As someone working in an isolated situation," she said, "I was delighted to meet others who shared my interests and concerns" (Silver, 1985).

The steering committee worked for several months and then set up a meeting at the University of Louisville, Kentucky, on June 27, 1969. Naumburg was unable to attend.

BEST COPY AVAILABLE

and there were several disagreements on key issues. There were opposing opinions on the form the association should take. In Washington, Ulman worked on a constitution for the new organization, while in Kansas, Robert Ault consulted with Bill Sears of the Music Therapy Department at the University of Kansas. In 1954, Sears had helped create the National Association for Music Therapy. Ault also collected constitutions from the American Speech and Hearing Association, the American Occupational Therapy Association, and the Wisconsin Art Therapy Association, a state art therapy organization:

> I concluded the best structure to follow was one emphasizing a strong federal organization with the possibility of eventual state or local chapters or units.
>
> The day before attending the committee meeting in Louisville, I drafted a constitution and had copies made to take along. As it turned out, Elinor had also brought copies of a constitutional model she had put together, . . . that of a rather weak national alliance composed of strong state units. The discussions of the committee were long and difficult, ending at 4 a.m. The next day a constitution was read to the assembled group and adopted. (Ault, 1975)

The First Executive Board

Having adopted a constitution based on the model of a strong national body, the members of the new organization elected officers and committee chairs: Myra Levick, President; Robert Ault, President-Elect, Margaret Howard (Oklahoma), Treasurer; Felice Cohen (Texas), Secretary, Elsie Muller (Missouri), Constitution; Sandra Kagin (Kentucky), Education, Helen Landgarten (California), Public Information; Don Jones (Ohio), Publications, Ben Ploger (Louisiana), Professional Standards; Bernard Stone (Ohio), Membership, and Hanna Yaxa Kwiatkowska (Washington, D.C.), Research.

Many on the original Executive Board such as Levick, Kagin, and Landgarten went on to contribute to the field as authors and/or as directors of training programs. However, in an evolving clinical discipline it is natural that many would put their primary energies into clinical work. Ben Ploger had begun teaching art in Houston in 1935. He became professor and chair of the Department of Fine Arts at Delgado College in New Orleans. There, according to Levick, he was asked to "volunteer time to teach art to mentally disturbed nuns cloistered in the religious unit of the De Paul Hospital" (Levick, 1981, p. 5). He began to practice art therapy throughout the hospital and became director of art psychotherapy there in 1966. Margaret Howard was also treasurer of the American Society of the Psychopathology of Expression. Having studied with Naumburg, she was the art therapist at the Children's Medical Center in Tulsa for many years. Sandra Kagin trained with Howard. Elsie Muller, a social worker by training, had also studied with Naumburg; she worked at the Gillis Home for Children and later the Ozanam Home for Disturbed Adolescent Boys in Kansas City, Missouri, and published a ground-breaking article, "Family Group Art Therapy: Treatment of Choice for a Specific Case" (Muller, 1968).

Robert Ault is now retired from the Menninger Foundation. He initiated the undergraduate and graduate art therapy programs at Emporia State University in Emporia, Kansas, and has been a tireless presenter. He is fond of talking of what he calls "the art therapy movement." In recent years, he has helped bring to light the artwork of Elizabeth Layton and pioneered the use of art therapy with corporations and organizations. His contributions to AATA have been numerous.[8] In 1985, he was chosen Kansas State Educator of the Year. Felice Cohen later became a President of AATA and continued to work as an art therapist and researcher in Houston.

Because of the efforts of Marge Howard, the American Association of Art Therapy was chartered in Oklahoma in 1969, which was also the site of the first Executive Board meeting. Dues were set at $15.00. A roster dated in 1969 showed 20 members in good standing. Robert Ault, with the help of a graphic artist, designed AATA's logo.

The first *Newsletter* of the American Art Therapy Association, edited by Don Jones, contained the following "President's Message" from Myra Levick:

> For the past twenty years artists have been involved in using their skills to aid in the diagnosis and treatment of psychiatric patients and in more recent years have not only begun to speak and write about their experiences, but have been recognized for their contributions.
>
> It is an established fact that an organization must be formed in order to attain professional recognition. And it is with great pleasure that we announce that the AATA was voted into being on June 27, 1969, in Louisville, Kentucky, by a representative group of art therapists from all over the country and Canada. The goals of this new group go far beyond merely formalizing that which has already been achieved. It is hoped that Art Therapy and its relation to mental health and education will be more clearly defined and further developed. (Levick, 1970, p. 1)

The First Conference

One hundred people attended AATA's first conference, held at Airlie House in Warrenton, Virginia, September, 1970. Margaret Naumburg was unanimously designated as the first recipient of an Honorary Life Membership[9] by the new AATA Executive Board. According to Ault, this was an effort to say: "We honor you, we respect you, we want you to be a part of us, but you cannot have control of us. We want you to join us" (Ault, 1975).

Even though she had stalked out of the organizational meeting in Philadelphia, Naumburg's warm acceptance of the Honorary Life Membership implied an endorsement of the new organization. Levick said:

> The highlight of the meeting [at Airlie] was Ms. Naumburg's memorable acceptance speech . . . it was especially meaningful to many of us who knew this was the first and only professional group Ms. Naumburg openly supported. Her words were insightful, professional, and inspiring. I treasure personal letters from her (sent to me as President of AATA) in which she stated how pleased she was with the directions we were taking to establish a field she had been committed to for many, many years. (Levick, 1975)

From its inception, the American Art Therapy Association has been an organization of vital individualists with strong opinions and loud voices. The arguments through the years have been substantive, vocal, and, at times, difficult and divisive. Judith Rubin, a past President of the Association, has written: "The early meetings were so full of passion and discord that I wondered whether I really wanted to be a part of this noisy group" (Rubin, 1985, p. 30). Harriet Wadeson put it this way:

> I attended the preliminary meeting in Philadelphia and the first conference at Airlie House outside Washington in 1970. I recall

> disagreeing with Margaret Naumburg on both occasions. . . . From the outset, I could see that we are certainly a group of "characters." (Wadeson, 1985, p. 31)

Elinor Ulman's account of that first annual meeting in the *American Journal of Art Therapy* (Volume 10, No. 1, 1970) elicited a number of angry letters from board members such as Felice Cohen (1970a) and Bob Ault (1970) who felt that she presented a distorted view of what transpired. Myra Levick's letter was printed in the *Journal*:

> I have read your [EU's] account of the first annual conference . . . and must say that I am appalled by your biased subjectivity and gross distortions. . . . I cannot begin to comprehend what your editor's note, 'The Association is 14 years ahead of its time' means. I do know that for many years the possibility of forming a national art therapy organization has been discussed to no avail. Now, thanks to many people too numerous to list here, who are dedicated, involved, and energetic, this organization has finally come about.
>
> I hope this organization will continue to welcome constructive criticism and diversified viewpoints. However, your particular criticism of the organization and its officers has been destructive in its attempt to delay progress. (Levick, 1971)

There were, however, letters taking Ulman's side. Wayne Ramirez, president of the Wisconsin Art Therapy Association, wrote to agree with her reporting (Ramirez, 1971a, p. 74; 1971b, p. 130). Herschel Stroyman (1971, pp. 130, 143–144) said he "found Miss Ulman's impressions . . . free of sycophancy, to the point, and unanswered."

Developing Professional Standards

After the stormy sessions surrounding the formation of AATA, one of its first major battles concerned the question of registration. Social workers, with no available licensing in many states, had long awarded a national certification of competency by examination designated by the letters ACSW (Academy of Certified Social Workers). Many other organizations also certified practitioners. At Warrenton, AATA voted to begin awarding registration[10] to those art therapists who could prove they met certain standards. The service mark would be A.T.R. for "Art Therapist, Registered." As President, Myra Levick wrote in the *AATA Newsletter*:

> The American Art Therapy Association took a giant step forward at its very first meeting in Warrenton, Virginia. The decision to certify art therapists under the Grandfather's Clause, who have been working in psychiatric settings for five years, was passed and the first registry will be published this year.
>
> An organization is recognized by the professional standards it maintains and aspires to. The decision to establish certification lays the groundwork for the development of these professional standards. It need not follow that every person using art in either education or psychiatric milieu would want to be certified. It is, however, important that the organization identify itself with specific goals. (Levick, 1970, p. 1)

But the requirement of having worked in a psychiatric setting was one of the sticking points with some members who saw it as a premature narrowing of the field. In a letter to the editor in the *Journal*, Arthur Robbins stated that the Pratt Institute art therapy staff "recognize[d] the problems inherent in drawing up a certification for a discipline that has not yet crystallized" (Robbins, 1971, p. 100). By the time of the publication of the 1970 *AATA Newsletter*, 52 of the 61 art therapists who qualified had written and accepted. However, Edith Kramer wrote to say she did not want certification.[11] In a letter published in the *Newsletter*, Kramer stated her objections:

> There seem to be several reasons why certification is being sought. Important before all is the hope of enhancing the art therapist's bargaining power on the labor market. However, it seems to me unlikely that certification of art therapists by other art therapists would carry much weight in any struggle for better pay or for respect and recognition on the job. Attempts at obtaining certification from the outside, on the other hand, would entail a great deal of preparatory work on our part in defining the profession. It seems to me that any ill-prepared moves in this direction would be likely to jeopardize our ultimate goal.
>
> I therefore see no other reason to rush to certification other than the desire to quickly establish standards of excellence amongst art therapists. Certification, however, seems to me to be apt to induce premature rigidity within a field that must remain flexible and open to experimentation if it is to grow and to prove its worth.
>
> . . . As a member of the editorial board of the *American Journal of Art Therapy*, I have had the often painful duty to read manuscripts written by persons without academic titles as well as by others who had obtained the right to add all kinds of letters to their names, including "PhD" and "MD." This experience has taught me that the possession of degrees of any kind constitutes no guarantee whatever of the ability to think clearly or to write grammatically. . . .
>
> To summarize, I am of the opinion that in order to obtain the right to establish standards and to invent titles, art therapists must give themselves more time to discuss, experiment, and learn. (Kramer, 1970)

In her argument, Kramer neglected to recognize the model of most professional groups, including doctors and lawyers, which set up their own qualifying exams and enforce quality control. Felice Cohen, AATA's Secretary, answered Kramer's letter by stating:

> The rationale behind certification and registration was precisely to remove rigidity within the field. Up to this time, art therapy has been quite rigid. There have been so few who were included into what was a rather small group of art therapists. Those art therapists were mostly located in the East. There has been only one publication for art therapists, the *American Journal of Art Therapy*. Now, there is another publication, the *AATA Newsletter* . . . there is now diversification in the field . . . more people can be heard. Since the formation of AATA, we have qualified art therapists from practically every state in the country and Canada. This can be construed as flexibility. (Cohen, 1970a, p. 2)

Not only had there been a tremendous battle at the conference on the question of having professional standards for registration, but there were also major differences in what kind of standards to have and how to determine them. The two groups collided with each other philosophically and with vehemence. Judith Rubin remembers:

> [Kramer and Ulman] were worried that what they (and Naumburg) had conceptualized would be prematurely narrowed. There were no villains or heroes, but everyone was very passionate and wanted to insure the survival of the profession to which they had given their life's blood. But they had different ideas of how to get there. Somewhat later, in Houston at a meeting of the American Society for Psychopathology of Expression, a group of us had lunch and Sandra Graves (Kagin) came up with a wonderful compromise[12] which made it possible for people pursuing alternative avenues in art therapy education and experience to be considered to meet standards for registration and the argument was resolved. (J. Rubin, personal communication, January 14, 1994)

BEST COPY AVAILABLE

What has held the organization together during its wars and its relatively short life has been the overriding commitment on the part of the pioneers to the development of art therapy as a therapeutic discipline. Like a vital, opinionated, competitive family, the members argued. But like a family, they pulled their covered wagons into a protective circle to fight the important battles necessary to carry the profession forward. Whatever else might be said about the American Art Therapy Association, it could never be called dull!

Endnotes

1. The *Bulletin of Art Therapy* was first published in 1961 and was the only professional journal in the field until 1973. In 1969, Ulman changed the name to the *American Journal of Art Therapy*.
2. Those art therapists included Naumburg, Jane Gilbert, Lynn Berger, Carolyn Refsnes Kniazzeh, Hanna Yaxa Kwiatkowska, Miryam Dergalis, and Myra Levick.
3. Boston was the site of the "first all-day conference" on art therapy, January 15, 1966, organized by Carolyn Refsnes and Vernon Patch, MD. Three hundred people attended (News, *Bulletin of Art Therapy*, 5, 116–121, 1966).
4. Née Refsnes.
5. Levick served in that capacity from 1969 to 1971.
6. Much of the following information has been collected from the archives of the American Art Therapy Association housed at the Menninger Foundation, Topeka, Kansas.
7. To further her argument, Ulman published an article by Stern and Honoré (1969) on the problems and questions entailed in the formation of an association entitled, "The Problem of National Organization: Make Haste Slowly."
8. In addition to being AATA's second President (1971–1973), Ault was the Chair of the Education and Training Board.
9. Later recipients of the Honorary Life Membership Award honoring significant contributions to the field were Edith Kramer, Myra Levick, Elinor Ulman, Bernard Levy, Helen Landgarten, Elsie Muller, Hanna Yaxa Kwiatkowska, Rawley Silver, Judith Rubin, Janie Rhyne, Gladys Agell, Robert Ault, Don Jones, Felice Cohen, Frances Anderson, Cay Drachnik, Harriet Wadeson, and Gwen Gibson.
10. Registration is one of the lower levels of professional credentialling since it is based on education and experience but not on demonstrated competencies. A more stringent level of credentialling is based on a national examination. In all professsional organizations, the requirements for credentialling are gradually tightened as the discipline develops.
11. Others who were offered registration under a grandparenting arrangement but originally refused were Janie Rhyne and Arthur Robbins.
12. Graves' suggestion was to award applicants for registration Professional Quality Credits (PQCs) based on their education and training, with different experiences being given a different number of points. One had to amass a total of 12 PQCs in order to be granted registration.

References

Ault, R. (1970). Unpublished letter to Elinor Ulman, December 8, 1970. Topeka, KS: Archives of the American Art Therapy Association, Menninger Foundation Library.

Ault, R. (1975). *An oral history, art therapy pioneers* (Audio tape). Louisville, KY: Department of History, University of Louisville.

Cohen, F. (1970a). Unpublished letter to American Art Therapy Association Executive Board, December 3. Topeka, KS: Archives of the American Art Therapy Association, Menninger Foundation Library.

Cohen, F. (1970b). Letter. *AATA Newsletter, 1*(4), 2.

Jakab, I. (Ed.). (1968). Psychiatry and art. *Proceedings of the IVth International Colloquium of Psychopathology of Expression*, Washington DC, 1966. New York & Basel: S. Karger.

Jakab, I. (Ed.). (1969). Art interpretation and art therapy. *Proceedings of the Vth International Colloquium of Psychopathology of Expression*., Los Angeles, California. New York & Basel: S. Karger.

Jakab, I. (Ed.). (1971). Psychiatry and art, Vol. 3. *Proceedings of the 4th annual meeting of the American Society of Psychopathology of Expression*. New York & Basel: S. Karger.

Jones, D. (1975). *An oral history, art therapy pioneers* (Audio tape). Louisville, KY: Department of History, University of Louisville.

Jordan, H. (1988). An interview with Elinor Ulman. *American Journal of Art Therapy, 26*, 107–112.

Kramer, E. (1970). Letter. *AATA Newsletter, 1*(4).

Levick, M. (1970). President's message. *AATA Newsletter, 1*(4).

Levick, M. (1971). Letter in the Reader's Forum. *American Journal of Art Therapy, 10*(74), 98–99.

Levick, M. (1975). *An oral history, art therapy pioneers* (Audio tape). Louisville, KY: Department of History, University of Louisville.

Levick, M. (1981). Art therapy: An overview. In R. Corsini (Ed.), *Handbook of innovative psychotherapies*. New York: John Wiley & Sons.

Levick, M. (1983). *They could not talk and so they drew: Children's styles of coping and thinking*. Springfield, IL: Charles C Thomas.

Levick, M. F. (1985). Meet the ole timers, perspectives on the American Art Therapy Association. Messages in Art. *Program of the 16th Annual Conference for the American Art Therapy Association*, New Orleans, LA.

Levick, M., Goldman, M., & Fink, P. (1967). Training for art therapists: Community mental health center and college of art join forces. *Bulletin of Art Therapy, 6*, 121–124.

Muller, E. (1968). Family group art therapy: Treatment of choice for a specific case. In I. Jakab (Ed.), Psychiatry and art. *Proceedings of the IVth International Colloquium of Psychopathology of Expression*, Washington DC, 1966. New York & Basel: S. Karger.

Ramirez, W. (1971a). Letter in the Reader's Forum. *American Journal of Art Therapy, 10*, 74.

Ramirez, W. (1971b). Letter in the Reader's Forum. *American Journal of Art Therapy, 10*, 130.

Robbins, A. (1971). Letter in the Reader's Forum. *American Journal of Art Therapy, 10*, 99–100.

Rubin, J. (1985). Meet the ole timers, perspectives on the American Art Therapy Association. Messages in Art. *Program of the 16th Annual Conference for the American Art Therapy Association*, New Orleans, LA.

Silver, R. A. (1985). Meet the ole timers, perspectives on the American Art Therapy Association. Messages in Art. *Program of the 16th Annual Conference for the American Art Therapy Association*, New Orleans, LA.

Stern, R., & Honoré, E. (1969). The problem of national organization: Make haste slowly. *Bulletin of Art Therapy, 8*, 91–95.

Stroyman, H. (1971). Letter in the Reader's Forum. *American Journal of Art Therapy, 10* (130), 143–144.

Wadeson, H. (1985). Meet the ole timers, perspectives on the American Art Therapy Association. Messages in Art. *Program of the 16th Annual Conference for the American Art Therapy Association*, New Orleans, LA.

BEST COPY AVAILABLE

An Informal Interview with Edith Kramer

Bardi Koodrin, BA, Gail Caulfield, MA, and Annette McGarr, MA

In June, 1993, G.A.T.S.A., the graduate art therapy student association of the College of Notre Dame (CND) hosted a month long exhibit of Edith Kramer's paintings and sculptures. On May 31, when Miss Kramer arrived at CND's Wiegand Gallery to install her artwork, several students requested an interview.

Born in Austria in 1916, Kramer emigrated to the United States in 1938 to escape Nazi persecution: She made her way first to Prague, Czechoslovakia in 1934, where an American friend on the Jewish rescue committee eventually was able to get her an affidavit to travel via Poland to America. She remembered the years spent with Friedl Dicker who later died in Auschwitz.

E. K.: . . . what I did in Prague . . . between 1934–38 tied in [with art therapy] because my teacher, Friedl, also did some art teaching with some of the refugee children. Czechoslovakia, at that time, was still a liberal state in which the government accepted refugees from Germany; some of them were political refugees, some of them were workers, some were Communists, some were Social Democrats—working families that fled Hitler but weren't allowed to work because of the Depression. They were not given a permit to work and were put into camps that were not anything like concentration camps, but still places to hold this influx of families, people for whom there wasn't any space in the world. They waited there to emigrate somewhere else, to South America, to various places. And there were children there who were uprooted and traumatized by this change and by what happened to their parents, though not traumatized in the way that children would be traumatized during the war and in the concentration camps. There was no war yet. But we worked with these kids, and I got to know a little bit about disturbed and traumatized children.

B. K.: Did you learn how to read their art, in the process of teaching them?

E. K.: Well, a little bit. How to see, particularly, the identification with the aggressor. We saw drawings of Hitler and people . . . who identified with Hitler, who was, after all, the most powerful person; he was evil and powerful, and the way to bind the anxiety was to be like him. We saw some of the rigidity, the messiness, and the fragmentation that you see in traumatized children. I got to know a little bit of that. . . . I arranged an art exhibition at a Montessori nursery school that one of the refugee people started, and I figured out, let's put all the houses together, all the people together, and all the different subjects together, and we did something that was much more educational than just hanging up kids' nice work. And, so I was, I think, already somehow systematically thinking about things with a bit more organization and more thought. At that time already there were lots of psychoanalysts in Prague . . . coming from Germany, some from Austria later on, refugee Jewish psychoanalysts. You could get psychoanalysis for very little money, and they were also offering many courses, and since I was in those circles, I was allowed to sit in on some courses in child development.

G. C.: Was your training in psychoanalytical art therapy?

E. K.: Well, eventually, I had psychoanalysis in this country. I started in Prague, and then everybody had to leave Prague; after the *anchluss* we knew our time was very limited and you had better get out of Europe as fast as you could, at least out of the German area of Europe. . . . So I started in analysis there [in Prague], but it was just a few months, and then we decided we'd better meet in America, if we got there. They got to America; the analysts, if they had good connections they could leave. So, I had kind of a promise that this would continue if I got there. . . . That was a clinical analysis, not a training analysis . . . for three years and then I took off for eight years of living. Then I went back for two more years of analysis.

Miss Kramer remembered her early years in America and the beginnings of her career as an art therapist.

E. K.: . . . I did some teaching and I supported myself and it was a good moment, I think, for a person my age in my situation to come to the United States; . . . for me as a painter, it was the right moment and actually probably easier to somehow live on a part-time job in the United States than it would have been in Austria. . . .

B. K.: What was your emphasis and subject matter in your paintings?

E. K.: I was always a representational painter, never anything else. I was always somehow in opposition against what was going on in art at this time. Even my friend Friedl, who started as a Bauhaus person with a lot of experimentation, went somehow back to nature during the time I knew her, and while I still use a great deal of the Bauhaus methods of teaching and of separating various elements in art, I was always representational. I've always really liked the world and what I see in the world, but I certainly found here a new world that was very fascinating, very wonderful to try to make some statements about it. So, I did. I could always support myself somehow.

B. K.: Weren't you hired to be a shop teacher, more of a carpenter and jack of all trades?

E. K.: Yes, I had to learn a lot more about carpentry than I knew, but I learned it on the job, and after all, you taught kids from 6 to 12, not grown-ups or adolescents and at that time there was no machinery; you had hand tools only and kids learned to use a cross-cut saw, hand-drill and things like that, and so you worked really, everything by hand. . . . It was much simpler then, you could let kids build benches and tables, bookshelves, anything. . . .

A. McG.: Could you talk about the beginning of art therapy and what you encountered in New York?

E. K.: What I encountered in New York about art therapy? Well, there wasn't such a thing. There was Margaret Naumburg whose books I did read eventually! But otherwise there was really no such thing. But there was of course progressive art teaching . . . in 1938 the Walden school already existed and the art teaching that was done at the Little Red School House where I was a shop teacher. I also did some art teaching and did some clay work with the kids that was already the kind of art teaching that was influenced by Florence Cane and Victor Lowenfeld. It was very free and respected the childrens' developmental stage and worked within that stage, and I think it was very good art that was given at the Little Red School House.

G. C.: When you work with children and they make drawings or sculptures, do you then talk with them about what they have done?

E. K.: No!

G. C.: So, what is your feeling about that?

E. K.: I think sometimes there might be a conversation, but I certainly don't formalize. First you draw and then you talk about it? I think that's all wrong. I think one of the wonderful things is that you needn't talk. You could talk, you're allowed to talk, nobody is going to say, "Shut up because I'm not your talk therapist," but, there is a door opened to a kind of communication with yourself and others that is, indeed, nonverbal and is symbolic and need not be necessarily translated into words. And, after all, any good work that anybody does, the image tells you more than words could tell, and this is after all the hallmark of good art—that it says more than you could say about it.

G. C.: My feeling has always been that art is in itself a healing process. In your book, *Art as Therapy with Children* (p. 219), you wrote: "Art cannot remove the cause of tension or directly help resolve conflict, it serves as a model of ego functioning." Are you saying there that art in and of itself does not heal?

E. K.: I would say, if you are really a very sick person and you just have nothing but art therapy, it probably won't be enough. It might be the central thing; it might be the thing that prepares you for talk therapy; it might be the thing that you can continue by yourself after your therapy is over, but it is certainly something different. . . . I don't know how much I've changed my opinions about this since I wrote this book in '71, but I would say that there are certain people who profit much more from doing art than from any kind of talk you could do with them, no doubt. But, in general, we sustain, support, and help the sick and we cure the healthy. It's very seldom we have the wonderful chance of curing a healthy person, right? So, in this sustaining work, you work on many, or most, people who need that kind of support from many different directions. One person alone, or one access to man alone will not do; it really always needs a team. What our own part in this team will be will differ greatly. . . . It might be the most important element of this team. Here, I'm the one person whom this man does not assault and for whom he even produces something, right? It might be if he's done some art, he may be more ready to talk to me; or he has talked, and now he wants to do a picture about what he has talked about. What's going to happen will be very different, and one has to take it as it comes and not insist, "I am the big person who can do it all" or "I am the underdog who is only the helper of the big shots, the eggheads who do the talk therapy." It's neither one nor the other.

A. McG.: What about doing both, for the art therapist to be well-versed in both art and talk therapy?

E. K.: Somebody like Judy Rubin, who is a trained analyist, or my friend Laurie Wilson, who also has gone through real psychoanalytic training, can do certain things in art therapy that I would not dare to do because I'm not trained. Nor do I have a healthy desire to be so trained, because I'm perfectly happy with my status and my function in this field, and I don't want another function added to it because it takes still more away from my own art; . . . and neither Judy nor Laurie do art anymore.

G. C.: Exactly! I wonder about that, because people who are both psychotherapists and art therapists talk longingly about the art they used to do, that they have no time to do anymore.

E. K.: That they no longer do. Right! I want to take three or four months vacation. If you are somebody's primary therapist you can't do that, that person is going to commit suicide during that time. So, I want to have a position in which I can write this kid a postcard while I'm away, and when I used to work I wrote special postcards and really selected them for each kid. When I got back they said, "Oh, I got your card, . . . I still have your card," and they're glad now they're going to have art again. That's fine. If you had been the primary therapist, and the person said, "I nearly committed suicide and where have you been and you've destroyed me by being away." I don't want to be in that position because I'm an artist. On the other hand, I think because I'm an artist I can get something from these people in art that those people who have abandoned their art don't get.

B. K.: I've read when you write a book, your art seems to get put aside because you have to focus on your writing; that's something you don't seem to like very much, in the sense that it takes you away from your art.

E. K.: No! That's a sacrifice. For those 30 years [of Kramer's professional book writing period], every 10 years, I'd have enough to say and I figured I should spend some time doing that. So then in the summer I would always paint, but in the winter I'd say, "You're not allowed to paint, you have to write this book!" Then I would lock myself in and write the book. . . . I said, "I can't do three things; I can't paint and work and write a book" so then I would get a little money (from grants) so I could write a book. But I found that if I painted I wasn't going to write, so I would stop painting in order to make myself have only the satisfaction of finding the right words rather than the right colors or shapes. But this was not easy for me to do and it was a sacrifice, but had great compensations because it both gave me status in the world of art therapy and also because I wrote certain things that I felt. . . . Art does not require much intellectual work, . . . if you have a fairly good mind, you need to exercise that mind also, from time to time.

A. McG.: It's interesting that you say your art is not an intellectual pursuit.

E. K.: No, it isn't. . . . If you're a painter, I think that it does not exercise your conceptual mind in the way in which writing a book exercises your conceptual verbal mind. And if you have a good mind that is quite well-equipped, you want to use it from time to time.

B. K.: I know what you're saying, because when I'm in my writing mode, my art gets put aside, and vice-versa. When you were writing your books and felt you had to sacrifice your art, did you find that you needed to use psychoanalysis?

E. K.: No, no. The analysis helped me very much. I don't think you can understand what's going on unless you have some personal therapy, and you also have to learn what you should stay away from because that's where your unresolved conflicts will get into the way of what you're supposed to be doing. I think you learn where you have inclinations for countertransference, mistakes, and disturbances, and either control it or stay away from it. For all of that you need to be in analysis. But I needed the analysis much more in my personal life than in my professional life, except for understanding. But for conducting my personal life, I needed the analysis. That was a private thing.

G. C.: In your book, *Art as Therapy with Children*, you addressed the meaning of art, and what art is in relation to what art therapy is. I haven't found much in the professional writings that addresses those concerns, the importance of art and what makes something art or not art—"anti-art" or "pseudo-art."

E. K.: *Childhood and Art Therapy*, the next book I wrote, addresses that also. . . . *Art as Therapy with Children* addresses the whole problem of transference in art therapy.

B. K.: You said you worked very little with adults. What about the parents of the children you worked with. Did you ever get involved with the family?

E. K.: Well, no. You see, the places [where] I worked were all places the parents were not accessible. In the Wiltwyck School for Boys, the parents were not accessible, and at the Jacobi Hospital, I sat in on some interviews with parents and children together, and in the rounds I got to know some of the parents and what they were like. I think you can do wonderful work with parents and children together. I know some who do it and I supervised or observed some of this, but I really never have done it myself.

G. C.: There's a wonderful story about you working with the blind boy who made that bird. . . .

E. K.: Yes, he's now 40 years old and I still see him. There's a very interesting story about him. . . . He became a Pentacost preacher. He had periods of great violence. He did some beautiful sculpture with me; I continue to work with him. He still comes from time to time; he works still with wax. He is highly gifted, and that is someone who ran out of every therapy, and could not be in therapy. I think that the stabilizing factor of religion is one of the things that he certainly needs. He has really done very little art; he does art when he comes to me, but the gift is there, and it was very important in his adolescence and his young adulthood.

M. H.: Have you stayed in touch with Angel?

E. K.: Yes, he is in the Navy. He still does art. He has sold a few pictures and got a price. He's still interested in art, but he no longer needs to be a famous artist. He's married, a stable marriage; there's a teenage daughter and a little boy now, and he writes to me.

G. C.: Do you think that cultural differences made any difference in your ability to work with American children?

E. K.: . . . I was very lucky because if you land in Greenwich Village among a parents group who send the children to a progressive school . . . they probably are more similar to you than a group of farmers or business people in Austria if you come from a Bohemian environment. I landed again in a Bohemian environment, so it was not that much of a culture shock. I mean, certain things shocked me terribly. . . . In Austria swearing is anal or by sacrilege, but not by anything sexual . . . that anybody could use [a word for] lovemaking as an ugly assault, that shocked me. So there were certain cultural things that were different, . . . it wasn't that different except more liberal. . . . Mr. and Mrs. Roosevelt were the father and mother of the country; . . . it was a very different atmosphere than it is today; . . . it was a very wonderful time in America. It was a time that was much more open; there was much more generosity.

B. K.: You started as an art therapist 50 years ago. Now in the '90s, we as therapists certainly have different issues to deal with, such as gangs, drugs, and guns.

E. K.: Gangs and guns were there, but there weren't that many drugs, and that makes a great difference. It was easier then; I was young, I lived on streets and in tenement buildings that today would be dangerous for a young woman. And when it was hot, I . . . slept on the roof. You wouldn't dare to sleep on the roof now.

B. K.: Yes, I have to say it is different, that women in particular can't be as free.

E. K.: You can't! I could go home at 2 o'clock in the morning. I wasn't afraid; there was no need to be afraid.

B. K.: When you were working back in the '50s and '60s, did you find the issue of sexual abuse as prevalent as it is now?

E. K.: No, it wasn't. Now, maybe there was hidden sexual abuse which we didn't know about. I think also there really is an increase because people [are getting] more and more infantile. If you need an infant to sexually satisfy you, that means that you yourself are so frightened of adult sex that you have to get somebody who is totally helpless. And what you do are fantasies that every 3- or 4-year-old develops, but gets over. I think the lack of maturity is increasing, that makes for more sexual abuse. Adults are like 4-year-olds. There are more of them now, I think, than there used to be. Adults were more like ages 6 or 7 in the Oedipal stage, rather than in the anal stage.

M. H.: But I wonder also, how come incest taboos are common?

E. K.: It's very often the stepfathers who seduce their stepdaughters, right? I think before there was certainly emotional seduction; there always was, but it was not acted out physically. There is a difference between the father of Elizabeth Barrett Browning, who made her into an hysteric, and the father today who really puts his penis into his daughter's mouth. . . . In both cases the father is possessive of the daughter and destroys, somehow devours, the daughter. But it is a much worse devouring when it's so physical. For a little child to unchain that sexual passion, the physical sexual passion of an adult, that is just absolutely intolerable.

B. K.: Now we have the wide-scale ritualistic abuse stories that are apparently coming to the surface.

E. K.: In the *New Yorker* . . . there was this rampant fantasy that really wasn't true.

B. K.: That's a good question right now. Is it true, or is it not true?

E. K.: I think that probably both occur. There are real things happening, I know of such horrible [stories], and then also, there really are fantasies that become a kind of reality. . . . And this type of fantasy is universal. Every child at some point develops those fantasies; that is something which Freud found out–the power of fantasy, which is also an enormous power. Those hysterics that Freud worked with probably did have fantasies of a seduction that didn't occur. Among them probably there were also some psychotics indeed [with whom] sexual seduction had occurred. And we'll never know which one was which.

M. H.: There's a natural stage in development, at age 4 or 5, where children want to possess their parent in that certain way, but it seems these are [adults] who never grew up emotionally, and so they're still at that stage.

E. K.: But then again, you've got those who continue to have these wild fantasies, and they might be pushed to act out that fantasy. Still two different people. You'll encounter both.

G. C.: How do you see the place of the spiritual in terms of art and art therapy?

E. K.: Well, I am not a spiritual person. I really don't know. I'm still sustained by the secularized Judeo-Christian moral code and it suffices me. I think . . . people need something of that sort. . . . Whatever we get now is so jerry-built—it's not cooked by a culture, so usually it is really very frail and has not much substance. I don't know what to do about that. . . . I know there is a need for some sense of right and wrong, and some sense of virtue and evil in the world, and that there is retribution for sin against the holy spirit. . . . But there is no system today for all that since the churches . . . no longer have power, and the secularized element seems not sufficient for many people. So I really don't know what to say to young people about that . . . where to find that kind of moral gyrator, the moral thing that keeps you from going in all directions and doing any old thing, and having no sense of self and no sense of what you're doing in the world. . . . I think really what we need is new sins—new sins against the environment.

A. McG.: Or a new moral code for new sins?

E. K.: Right!

M. H.: How about the role of spirituality in relation to death? It seems like religion plays a very big role in helping people.

E. K.: Helping people to die . . . or cope with death. Certainly, denial of death is the worst you can do—which our culture does. You have to figure that life is not forever and that eventually you'll die and you better make good use of the time you have on this earth because it's the only time you're going to have. There are some people who think there is life after death. This to me seems absurd, but it's not absurd to everybody and I certainly wouldn't stop anybody from such a belief if that belief sustains him. I don't know for sure whether I'm right, or who is right, but prepare yourself to live as good a life as you can because it's not forever. I think that's necessary. Because [if] you die and you feel you've wasted your time, that's about the worst thing that could happen to you. How short, or how long that time is, nobody can foresee, so every day you must live as if it were the last day, in a sense, not to do the unspeakable.

B. K.: So every day is just a process in itself; it could be your last day.

E. K.: You have to do what you can do to be a mensch [Yiddish word for a good person], and hope for the best. No?

G. C.: I guess I see the spiritual and the creative as one, and if somebody is experiencing a creative process, then [he or she is] also experiencing some essential truth in some way, and that this is somehow connected.

E. K.: Art is certainly concerned with truth. The lie is the deadly sin in art; there's no doubt about it. So if you call truth spirituality, then yes. To me, it's foreign, this way of thinking, but then I'm an old woman. We were all agnostic, and very assimilated . . . but on the other hand, we knew the Bible. . . . I know the Bible better than any one of you probably. . . .

B. K.: Edith, what advice would you give new art therapists who are about to go out into the world?

E. K.: Fight for part-time work! [There was much laughter at this point from the students. Kramer smiled broadly, and pointed to the collection of her paintings stacked in neat piles on the gallery floor.] Because if you're full-time, you really don't have time to do your art. You need a part-time job. It's as simple as that. You need time for everything else! Try to get into places where there's not this total short-time revolving-door work with patients, so that you have time to do art therapy. . . . I think you should try to get into long-term work. . . . There are tremendous opportunities working with the physically ill and the handicapped, and all such people that are not psychiatric patients. . . . I think you can do a tremendous amount with people who are physically ill in hospitals and in hospices, and in old age homes, and in many places where the rejects or the temporarily confined people are kept. It's very satisfying work because you may be working with someone who is dying but is emotionally intact. There is more hope there in every session than with someone who is maybe physically very, very healthy, but emotionally a permanent cripple. So, I think you have more satisfying work very often if you can work with people who are more intact and very much in need of symbolic living, because direct living is for some reason or other cut off and impossible. . . . And the prisons! . . . I worked a little with prisoners. Actually, those were adults I worked with for two semesters at Riker's Island, and it was very interesting and very satisfying, and they were just like grown up little boys. . . . So, there is a very wide field. Try not to stay only in psychiatry. Figure how broad this could be.

B. K.: I guess that goes back to what you said earlier about how art therapy doesn't always heal the mentally ill versus the people who are emotionally stuck in developmental stages.

E. K.: Mmm, there are others. There are the blind, there are the deaf. There is an enormous amount of people who really need symbolic living and need to feel that there is a door open where they can feel like a human being even if in some way or another something is missing. Art can make you feel like you're a mensch, and maybe that's the most important thing. . . . It can reassure you and confirm to you that you're a human being.

B. K.: Have you found that a lot of people really are afraid to start the art therapy process; they might say, "I'm not an artist" or "I don't know how to be creative"?

E. K.: Yes, but I think that's overcome fairly quickly, usually, because you find out that you surprise yourself. I think that is one thing [where] treatment plans are wrong, because there are surprises, and if you have already a plan . . . you're going to shut off this possibility that it might be something completely different. You must be open for it and ready to pick it up. If you have your treatment plan all cut up and sealed, you're not going to see it.

M. H.: That sounds like the artist in you talking because that's what we learn from painting.

E. K.: Right! You don't know. You can't foresee. You must be open to the unexpected. If you, as a practitioner are no longer surprised, you know something is wrong with what you are doing. Be open to surprises!

Art Therapy: Journal of the American Art Therapy Association, 11(3) pp. 184-186 © AATA, Inc. 1994

Addressing Culture and Values in the Training of Art Therapists

Mariagnese Cattaneo, PhD, A.T.R., LMHC, Cambridge, MA

Abstract

This article discusses the importance of addressing culture, values, and aesthetics in the training of art therapists. It illustrates how students can be guided to discover and examine the influence which culture has on their own and on others' perceptions of different modes of artistic expression. Students should be given the opportunity to gain an awareness of their personal and cultural backgrounds with their attendant values and biases. Also, they should explore culturally based differences in aesthetics which deemphasize the role of universality in artistic expression. This newly gained sensibility can give direction to their therapeutic work with clients.

Introduction

I was raised in a very small country. But even growing up in such a small country as Switzerland, I became conscious at a very early age of the dynamics of cultural diversity. Within its narrow borders, Switzerland has four language groups: German, French, Italian, and Rhaeto-Romance—each with its own distinct culture.

As a Swiss-Italian, I spent my childhood in the German-speaking part of the country. In school, the Swiss-Italian culture was neither valued nor acknowledged, while in my home the Swiss-German culture was similarly discredited. I remember my kindergarten teacher telling my mother that I was a stubborn child. She did not realize that I often behaved inappropriately because I could not understand her directions in the Swiss-German language. This personal experience of living between two cultures made me sensitive to differences of culture and values, and to the impact that these differences can have on people.

When I moved to the United States, what stood out most for me during my first contacts with the people was this country's great diversity of race, ethnic background, and class, and what struck me most was that this diversity was ignored in education and in clinical work.

Although as art therapists we deal with all the factors that shape an individual personality, our special facility is our fluency in visual expression and communication. Since culture is a powerful influence on visual language, the focus of this article is on the impact that culture and its attendant values and aesthetics have on the work of art therapists. As art therapists, we must always be keenly and constantly aware of the cultural differences that exist between, and even within, seemingly similar groups of people. As educators of art therapists-in-training, we must promote this awareness in our students.

Culture and Values

Culture defines the life of a specific group of people, its history, its adaptation to the physical environment, its artistic expression and appreciation, its verbal and nonverbal expression and means of communication. It refers to a shared pattern of beliefs, feelings, and knowledge. "Culture is the collective expression of the group's personality—its wishes, values, and ideology. It is the sum total of knowledge and attitudes, a vast accumulation of ways of thought, of action, and of emotional expression" (Tseng & McDermott, 1981, p. 6).

Although people in different societies and cultures may share similar basic needs, emotions, feelings, and perceptions of the world, how they express themselves and interact with each other may be very different. These differences are the product of both individual development and cultural dynamics. Cultural values and beliefs guide individual communication, behavior, and action. Any deviation from the cultural norms is not sanctioned by the dominant cultural group and, therefore, is often labeled as inappropriate. Also, each culture has its own value system which supports the cultural beliefs and acts as a guardian of culture. "The very nature of culture is that it establishes and defines certain patterns of behavior that exist in, and are unique to, one group but are different between groups. The customs are shared and sanctioned by the group" (Tseng & McDermott, 1981, p. 6).

While the dominant culture in this country is defined by middle and upper class white male values, the reality is that our society consists of a multitude of cultures and subcultures. These subcultures can vary considerably. They can be defined by characteristics such as race, ethnicity, religion, class, gender, sexual orientation, education, and age. They can be more or less organized. Each one can have specific norms of behaviors—ways of living and use of language, both verbal and nonverbal. Their values can vary and be substantially different from the dominant culture.

As art therapists, we never work in a culturally homogeneous situation. Rather, we are constantly confronted with a vast variety of cultures and subcultures. It is important to be aware of a clients' personal and cultural backgrounds and their attitudes toward their values. To understand the relevance of what a client brings into therapy, it is important for the therapist to be aware of her or his own cultural background and personal value system and to understand how one's own attitudes can interfere with constructive interactions. These understandings are important prerequisites for becoming an effective art therapist—one who is respectful and considerate of the differences clients bring to the therapeutic process.

Art Expression, Aesthetics, and Culture

As therapists we must be aware of issues of oppression and power differentials based on class, race, ethnicity, gender, and sexual orientation. As art therapists we must also be aware of internalized cultural imperialism as it may be expressed in the different arts and media. We must be alert to our culturally bound aesthetic values and tastes.

In art therapy, the creative process and its expression are integral parts of the therapeutic work. Visual expression is part of everybody's life, although it may not be recognized as a conventional "art form." This expression takes many forms and can be seen in various ways, such as how we decorate our homes and gardens, how we dress, the colors we choose to wear. These everyday choices are all part of our visual expression. Through our visual expression, we communicate who we are, how we feel, and how we identify with our particular culture, subculture, or group. This visual expression is part of our identity.

Expression through visual images, artifacts, music, and dance is common to all cultures and is an integral part of life and living. Because we are shaped by our culture and its values, expression through art and its subsequent meaning are interwoven with cultural attitudes. Therefore, the basic attitude of the artist and of the beholder are determined not only by personal taste, but also by the culturally conditioned situation in which an individual's aesthetics develop.

I still remember when I was in fourth grade and the knitting teacher brought yarn of different colors for us to choose for knitting a small bag. A girl who lived on one of the poorest streets chose blue and green. The teacher scolded the girl, saying, "Your choice of color really shows where you come from!" This remark strongly influenced my future aesthetics by affecting how I reacted to certain color combinations. I internalized that blue and green together were "vulgar," and it has taken me a long time to overcome this indoctrinated value judgment.

Diverse Versus Universal Expression

Art therapists often emphasize the universality of artistic expression and use this as an argument for its effectiveness in working with various populations. But we must be very cautious in applying the term "universal" to artistic expression and communication. We must critically examine what we mean by the term "universality." The universal may be defined as that which fits into the framework of the dominant culture. This is a Eurocentric approach of Western culture through which the universal is defined. But art is not value free. We must acknowledge that how we see the world and its cultural expression derives from our cultural contexts, which shape our values and aesthetics. In art therapy, both the therapist and the client bring their subjective aesthetic experiences to the therapeutic encounter.

Cultural expression is common to all people. But how and what is expressed is very specific to cultural background, class, race, ethnicity, gender, beliefs, and value systems. We are shaped by our culture and its values. Expression through the arts and its subsequent meaning are interwoven with cultural attitudes. The basic attitude of the artist and of the beholder are not only a matter of personal taste, but also come from a culturally conditioned situation in which individual aesthetics and taste develop. We are conditioned by historical frameworks of education that are both formal and informal as well as the controlling cultural industry (Adorno, 1975), that mandates its own criteria in formulating what is cultural, "universal," and appropriate. This ethnocentricism in the arts is balanced on a notion of quality that "transcends boundaries—and is identifiable only by those in power" (Lippard, 1990, p. 7). It is this idea of quality that guides education in the arts. "The conventional notion of good taste with which many of us were raised and educated was based on the illusion of social order that is no longer possible (or desirable) to believe in" (Lippard, 1990, p. 7).

Personal taste is so determined by these conditions that it is often very hard to see beyond one's own limited viewpoint. It can be difficult to appreciate and respect what does not conform to our personal experience, except for its novelty and exoticism. In our society every age, social, and ethnic group has its own tendencies in taste. It is essential for art therapists to develop insight into the cultural complexities that we encounter in our work with clients. Like any mental health worker and psychotherapist, we must have a cultural awareness and knowledge. However, we must also be aware of the personal and culturally bound aesthetic frameworks and taste that we bring to the therapeutic work as well as our clients' cultural expression through the arts. This brings an additional important dimension to the training of a culturally aware art therapist. Unfortunately, this essential aspect of our work often does not receive enough attention.

By abandoning the stance of universality of artistic expression, the art therapist must abandon old values, beliefs, and judgments in the arts. One must instead learn to value the subjective experience and aesthetics of each individual. This learning can enable honest communication and interaction.

Implication for the Training of Art Therapists

Lofgren (1981) says, "In order to be able to work with culturally different clients in a spirit of well-informed cooperation, the art therapist must take responsibility for becoming culturally aware. This means learning all one can about the client's lifestyle outside of the therapy session. What one learns directly from the clients is not enough. Culturally different clients cannot be expected to be conversant enough with another culture to impart to therapists all they need to know of cultures foreign to them" (pp. 29–30). It is essential for art therapy students to have the opportunity to gain insight into the cultural complexities that they will encounter in their work as therapists. Campanelli (1991) suggests that "art therapists need to examine issues of ethnocultural diversity and learn how they apply to art therapy theory and practice" (pp. 34–35).

As mentioned earlier, we are influenced by the cultures in which we were raised with their values, aesthetics, norms, and taste. We are all part of larger systems such as family, community, and the larger society. In our work as art therapists, we encounter not only our own cultural system and subsystem, but also the cultural systems of our clients with their norms and values as well as the cultural norms and the values of the dominant culture. We interact with these systems, and it is in these interactions that cultural conflicts can arise.

Students are often personally confronted with these conflicts. In the process of becoming art therapists, they are faced with their own cultural system with its values and beliefs, those of their peers, their teachers, their supervisors, their practicum and internship placements, as well as those of their clients. Being surrounded by all these different value systems forces students to examine and question their own. This examination is often painful, especially during the beginning phase of training, when old values start to erode and new ones are still vague and underdeveloped. Because it is such a vulnerable time, students require much support and understanding from teachers, supervisors, peers, and others. As educators, we need to provide a safe environment in which students can examine their personal and cultural identities, their values and beliefs, and their biases and assumptions. Students should be encouraged to explore how these cultural factors have impacted their individual development.

The college at which I teach emphasizes diversity in its training of teachers and therapists. Cultural issues and diversity are addressed in the context of the seminar topics. In the core seminar in art therapy, gaining awareness of multiplicity and diversity starts with students sharing their cultural background, their values, and their belief systems. For the students, this becomes a discovery of the vast spectrum of differences that exist within a group which, at a superficial look, might seem homogeneous. We draw from a wealth of experience within the group of students. This often is a painful process in which internalized societal messages, bruising experiences, a sense of powerlessness, fears, anger, and guilt surface and are externalized. Through storytelling and art making, students reconnect with their own history and the feelings it arouses. For example, students are asked to represent in an artwork how they see that their personal development was shaped by race, ethnicity, class, religion, gender, and sexual orientation. At the same time, they consider how each of these influences has shaped them into who they are today. Historical, societal and cultural biases become contextualized through readings, discussions of their personal experience, and artwork.

Pinderhughes (1989) suggests teaching methods for training clinicians through an experiential groups model. This understanding of the multifaceted complexities involved in intercultural and intracultural work is "developed by exploring within a group format the participants' own feelings, perceptions, and experiences vis-a-vis ethnicity, race, and power. As they identify and acknowledge their predispositions and biases in these areas, grappling with them privately and within the group, they discover the origin of the feelings and perceptions that influence their behavior with culturally different others" (p. 211). Important to this process of critical learning is accepting and embracing one's own revisited traditions that can provide a source of strength as well as a sense of pride and beauty. It is the esteem and love for one's own cultural background and identity which form an important base for valuing the diversity in other people's experiences. Diversity and multiculturalism can be celebrated and promoted, not feared, resisted, or rejected.

Since all expression—visual, verbal, nonverbal, formal and informal—reflects a complexity unique to each person but fashioned by cultural influences and values, the art therapist needs to be aware of the impact culture has on images, colors, forms, and symbols. "Personal associations, education, political and environmental contexts, class and ethnic backgrounds, value systems and market value, all exert their pressure on the interaction between eye, mind, and image (Lippard, 1990). To understand the impact of this socially internalized perception, I encourage students to explore their exposure to the different arts, the meaning they had for them as they were growing up, and how art influenced their present sense of aesthetics. This leads to an examination of their criteria for acceptance or rejection of certain works of art. For this experience the students bring to class reproductions of their favorite works of art. Using an existing piece of art is a safer way of looking at one's aesthetics than trying to elicit culturally different reactions to personal works. Students share their personal responses to specific works of art, which refer to previous personal experiences and the feelings they provoke. They are also encouraged to look for the cultural content and context of the artworks. Students begin to realize how diverse reactions to specific works of art can be, and they begin to develop an understanding of culturally based differences in visual communication, aesthetics, and taste.

Conclusion

Through personal exposure to differences in culture, values, and aesthetics, students gain a broader understanding of differences that clients bring to the therapeutic relationship. This awareness of the client's history, lifestyle, and experience with art, and the role the client's culture has within the dominant culture, help to prevent miscommunication and misdiagnosis. With this awareness, the art therapy student starts to develop an understanding of the roles that culture, subculture, values, beliefs, and aesthetics have in the therapeutic relationship and is prepared to identify existing cultural differences and respect them. With this understanding of the cultural complexities that both client and therapist bring to the therapeutic relationship, the art therapist can hopefully prevent the misinterpretations and misunderstanding that could be detrimental to the therapeutic process. These understandings can also aid in mobilizing all possible resources toward a positive outcome for the well-being of the client.

Editor's note: Mariagnese Cattaneo, PhD, A.T.R., LMHC, is a Professor at Lesley College Graduate School, Cambridge, MA.

References

Adorno, T. W. (1975). *Gesellschaftstheorie and Kulturkritik*. Frankfurt am Main: Suhrkamp.

Campanelli, M. (1991). Art therapy and ethno-cultural issues. *American Journal of Art Therapy*, 30(2), 34–35.

Lippard, L. (1990). *Mixed blessings*. New York: Pantheon Books.

Lofgren, D. E. (1981). Art therapy and cultural differences. *American Journal of Art Therapy*, *21* (1), 25–30.

Pinderhughes, E. (1989). *Understanding race, ethnicity and power*. New York: Free Press.

Tseng, W. S., & McDermott, J. F. (1982). *Culture, mind and therapy: An introduction to cultural psychiatry*. New York: Brunner/Mazel.

Art Therapy: Journal of the American Art Therapy Association, 11(3) pp. 187-190 © AATA, Inc. 1994

Art Therapy with Culturally Different Clients

Cynthia A. Westrich, MA, Edwardsville, IL

Abstract

To create a therapeutic alliance with a client, the art therapist needs to be sensitive to the cultural differences which can bias the relationship. The purpose of this paper is to present a literature review of specific cross-cultural therapeutic principles to be considered during treatment. Furthermore, it defines how barriers such as language, diagnostic errors, and others may influence the treatment and possibly contribute to a client's early termination from therapy. The author also considers the use of art materials and gives attention to products and/or to processes during art therapy with the client. It is by exploring these issues that art therapists can possibly discover an individualized technique which will best benefit their clients who may have different cultural values, beliefs, and traditions.

Introduction

Art therapists should pay particular attention to populations with cultural differences and how these differences may affect the therapeutic relationship. By understanding elements of cross-cultural therapy, art therapists may prevent projection of their own ideas and beliefs onto clients. This is essential in preventing problems which can occur when the art therapist may apply a western clinical approach to people from other cultures. Also, imagery can serve as a useful aid to communicate and to integrate feelings for the culturally different client (Wadeson, Durkin, & Perach, 1989). Therefore, art therapy, more so than traditional verbal therapy, may have the "potential to transcend some of the more dangerous barriers in cross-cultural communication in an innovative way because it may adapt itself strikingly well to divergent values" (Lofgren, 1981, p. 29).

Characteristics of Cross-Cultural Therapy

To better serve the client whose ideas, beliefs, and/or cultural traditions may seem unfamiliar, art therapists should become aware of the field of cross-cultural therapy. Cross-cultural therapy refers to therapy in which the therapist and the client are "culturally different because of socialization acquired in distinct cultural, subcultural, racio-ethnic, or socio-economic environments" (Jackson, 1987, p. 66). It is important for art therapists to acknowledge that cross-cultural therapy depends on both real and perceived cultural differences and similarities in the therapeutic relationship. Even if *the therapist and the client are culturally similar, but perceive each other as culturally different*, then the relationship may be considered cross-cultural (Jackson, 1987). McNiff (1984) notes in his cross-cultural art therapy experiences that cultural differences are perceived within age groups, genders, races, people of different sexual preferences, and within political and religious values.

Cultural differences can best be understood by examining four of the following characteristics of cross-cultural therapy: degree of fit, existential therapy, transcultural care, and pluralistic therapy. The degree of fit between cultures may be across lines of social class, region, race, and ethnic background. It may also be associated with similarities and differences in cultural history and economic development. Thus, when there are more cultural characteristics that the therapist and the client share, then there will be a closer degree of fit. However, if the therapist and the client share few cultural characteristics, cross-cultural psychotherapy may require two collaborating therapists and consultation with specialists in the language and customs of the client's country (Bolman, 1968).

Because of the ambiguities and the degrees of fit which may occur between the client and the art therapist, the art therapist may also want to rely on an existential approach to therapy. "Existential therapists relate to clients, whoever they are, as members of the human species sharing the universal culture. This is based on the principle that all individuals are worthy of respect and appreciation because they are human beings" (Vontress, 1988, p. 76). If art therapists can discover the universals which they share with clients through existential therapy, there is a common ground on which clients and art therapists can communicate (Golub, 1989).

After finding a common ground, the art therapist can begin to "transculturally care" for his/her client. Transcultural caring refers to knowing the client's cultural beliefs, values, and lifestyles. This approach can be used to assist culturally different clients in helping them live in a changing or foreign environment (Leininger, 1985). The model of transcultural care does not "seek to replace any valid method for practice; it encourages [art therapy] practitioners to be aware of ethnicity and to begin to incorporate that awareness into practice" (Devore, 1985, p. 97). Art therapy can and should be provided to people in ways which are culturally acceptable and familiar to them.

Transcultural care may also include assistance from others who are familiar with the cultural practices of the client. "A model for cross-cultural therapy suggests that at least two therapists, one representing each culture, be used to 'bridge' people. This may include peasant-scientists, traditional native healers, and even so-called witch doctors" (Bolman, 1968, p. 1240). In this dual-therapist role, "components of folk healing . . . [can be] integrated with accepted psychological or psychiatric treatment. This method does not fuse two belief systems, but rather uses them in tandem" (Lefley, 1984, p. 159).

BEST COPY AVAILABLE

The use of folk healing has been discussed as an adjunct to art therapy (Golub, 1989; Schmais, 1988). For example, in Golub's use of art therapy with Cambodian survivors of war, Kroue Khmers, traditional healers, are sought for common somatic complaints. The healer performs "coining," a system of rubbing a smooth coin with oil along the outside lines of the body, related to the specific complaint. Golub feels that, as an art therapist, her "interest and respect for traditional healing practices . . . [seems] important to the clients, who in many cases, . . . [feel] that they . . . [have] to hide traditional beliefs from Americans in order to be accepted" (Golub, 1989, p. 19). Furthermore, her clients report their dreams to her as another form of healing. Understanding that the Cambodians believe that their missing parents come to them in dreams, Golub further views these "dream spirits" as "primary therapists to whom she and the clients listen as guides for treatment" (Golub, 1989, p. 19).

Golub (1989) also reports using outside resources in the community as healing agents for her refugee clients. "A Khmer Institute is held twice a year in which surviving Khmer artists, musicians, dramatists, dancers, writers, and historians teach intensive courses" (p.19). This institute also provides a reunion for the refugees. Furthermore, "American staff . . . [participate] as co-learners . . . or as assistants to the teachers. On the request of the Cambodian organizers of the Institute, the art therapist also . . . [provides] an open group for . . . [refugees] to engage in the spontaneous use of art materials" (Golub, 1989, p. 19).

Lastly, art therapists must consider their roles as "pluralistic" therapists. "The pluralistic therapist's goal is to help clients clarify their personal and cultural standards." (Diaz, 1988, p. 339). To accomplish this, "the pluralistic therapist needs to understand both the patients' ethnic group and the dominant group's culture and to know the points of contact between the two cultures and the process by which the cultural standards of each influence the patient" (Diaz & Griffith, 1988, p. 339).

According to Diaz and Griffith (1988), the pluralistic therapist actively fosters patient identification with his or her ethnocultural origin through three major therapeutic functions: reflection, education, and mediation. Furthermore, culturally effective pluralistic therapists have at least five characeristics: they recognize their own values and assumptions, " . . they are aware of generic characteristics of therapy that influence the therapeutic process. . . .", "they understand the socio-political forces that influence the attitudes of culturally different minorities . . .", and they are truly eclectic in their own therapeutic style (Marsella, 1982, p. 341).

These characteristics may result in rapport, empathy, interest, and appreciation of the culturally different client (Marsella, 1982). "What one learns directly from his/her client is not enough. Culturally different clients cannot be expected to be conversant enough with another culture to impart to therapists all they need to know of cultures foreign to them" (Lofgren, 1981, p. 30). Therefore, the "pluralistic" art therapist "must become more [culturally] aware of the history, art experiences, cultural values, and of the life styles of . . . [his/her] culturally different client" (Lofgren, 1981, p. 129). This means that art therapists should be dedicated to learning all they can about the client's lifestyle outside of the therapy sessions. "The deeper the art therapist's knowledge of one cultural group in particular and the wider the range of groups about whom the art therapist has some special knowledge, the more effective he or she can be" (Lofgren, 1981, p. 29).

Barriers in Cross-Cultural Therapy

Even the most knowledgeable art therapist may be confronted with several barriers in his/her therapeutic relationship with the culturally different client. If these barriers are not addressed, the client may terminate art therapy early (Marsella, 1982). Some of the cultural barriers that may hinder the formation of a good therapeutic relationship may include language, incorrect assessment of the client, emphasis on individualism, neglect of the client's support system, and dependency on linear thinking.

The use of standard English to communicate with a client may be discriminatory (Sue & Sue, 1977). The heavy reliance by therapists on verbal interaction to build rapport "presupposes that the participants in a [therapeutic] dialogue are capable of understanding each other. Yet, . . . [therapists] fail to understand the client's language and its nuances sufficiently so as to make rapport building possible" (Atkinson, Sue, & Morten, 1979, p. 14).

While verbal language obviously presents cultural differences, the visual arts, because of their universal elements and principles, are more interchangeable. For instance, Moreno and Wadeson (1986) observe that in offering art therapy to Hispanic immigrants, art expression acts as a useful modality in addressing images and feelings for the population when verbalization could pose a problem. Thus, art therapy has a "unique potential to construct a cross-cultural theory of psychotherapy based on universal properties of the creative process . . . because common qualities consistently present themselves in imagery and in the process of making art" (McNiff, 1984, p. 126).

Another barrier of cross-cultural therapy can occur with diagnostic errors when "using definitions of normality generated from the perspective of one culture with people of a different culture" (Usher, 1989, p. 63). Thus, normality and abnormality must be considered within a cultural context especially during an art therapy assessment.

It is obvious that art therapists should not conclude that behavior patterns, which may appear strange, unfamiliar, and different, fit into the category of pathology. However, one "cannot avoid evaluating the appropriateness of a client's behavior, but he or she should always do it from within the client's cultural or social frame of reference" (Draguns, 1985, p. 60). Thus, art therapists must "develop a standard of normality with reference to the culture itself, as a means of controlling an uncritical application of the criteria, that . . . [he/she] brings with . . . [him/her] from . . . [his/her] civilization" (Marsella, 1982, p. 363).

Many art therapists have observed that the use of art therapy assessment may be beneficial when there is a language barrier. For instance, Burch and Powell (1980) were successful using Silver's art therapy assessment to assess the mental status and progress of a Vietnamese refugee who cannot speak English. They conclude that since the Silver assessment demonstrates the value of using art therapy in the evaluation and development of cognitive skills in children with organic disorders of communication and learning, the same rationale may apply to patients with cross-cultural language difficulties.

On the other hand, Lofgren (1981) presents an example of a Navajo Indian client who was diagnosed as schizophrenic based on assumptions that do not take into account her cultural background. She was admitted to an inpatient psychiatric unit for evaluation of acute schizophrenia because a doctor, giving her a physical examination as required by her employer, became alarmed when she sat in his office for 45 minutes without speaking to him. He in turn notified a psychiatrist who had her hospitalized for two-and-one-half weeks.

Silence plays an important role in all facets of Native American life, especially with authority figures; the doctors did not take this into consideration. Instead, this Navajo Indian woman was hospitalized based on a false assumption and was diagnosed as "schizophrenic." As Lofgren learned more about her art therapy client's Native American culture, her behavior first seen as bizarre became more reasonable. Lofgren notes her initial mistake in evaluating the client's drawing. After the client drew a sandpainting of a woman, Lofgren concluded that it represented her inability to integrate mind and body. Yet, after learning of the significance of sandpainting as it relates to the Navajo Indian culture, Lofgren learned that her client communicated a great deal through what she omitted as well as through what she included. By further review of her artwork through her client's eyes and culture, Lofgren was able to understand her client's feelings, symbols, and expressions of spirituality.

Considering the client's acculturation process may further prevent diagnostic errors. Moreno and Wadeson (1986) describe the use of acculturation in their art therapy assessment with Hispanic immigrant clients.

> The acculturation process has two major variables: the antecedent, having to do with the level of the individual's functioning in his or her country of origin, and the intervening variables . . . [having to do with] how well the individual can integrate his or her previous level of functioning into the host culture. . . . The sensitivity to the acculturation process enables a more accurate diagnosis, identification of significant issues, and an appropriate treatment planning and therapist assignment. . . . [Furthermore], through the use of art and themes, related to the process of acculturation, many relevant feelings and memories can be disclosed . . . and explored in ongoing art therapy. (p. 126)

Art therapists must also give consideration to their stance on individualism while working with culturally different clients. For example, Waller (1989), after teaching art therapy in Bulgaria, found that art education tended not to be about self-expression. She found self-expression was alien to Marxist-Leninist philosophy and to Bulgarian traditions in art. This is in contrast to the Western concept of self-expression which implies individualism. Instead, art in Bulgaria arises from the folk arts where families and villages can be identified by their traditional art expressions (Waller, 1989, p. 181).

The importance of family and its effect on individualism is also noted in Moreno and Wadeson's (1986) study of Hispanic clients in art therapy. The images of family and friends appear as a predominant motif in the client population studied. They noted that in their art therapy Hispanic clients reveal a cultural value that the family is a source of support and acceptance. They state, "for this reason, it is not uncommon for an Hispanic individual faced with a problem first to seek help or advice from a family member, and only in extreme cases turn to a mental health professional" (Moreno & Wadeson, 1986, p. 123).

Art therapists should consider their clients' natural support systems, such as families, in an effective treatment plan for therapy. In many cultures the notion of formal therapy is preferred less than nonformal or informal alternatives available to a client. The idea of sharing "intimate family secrets to a stranger is not allowed in many, if not most, of the world's cultures. These problems are dealt with inside the family or in a group context with little or no outside involvement" (Pedersen, 1987, p. 21). Thus, wherever possible, the natural support systems surrounding a client should be utilized.

A final cultural barrier which deserves consideration is the client's thought process. It is important for art therapists, who may be used to thinking in a linear fashion, to understand that their clients' thinking may be in a nonlinear format. While psychotherapy tends to be distinctly analytical, rational, and verbal, this logic may contrast with other cultures that may also view the world with holistic thinking (Sue & Sue, 1977). Because not all persons are socialized to think in the same way, it is important "to change not just the content of a message for . . . [therapy], but also the way of thinking through which that message is being expressed" (Pedersen, 1987, p. 22).

An example is presented by Lofgen (1981) whose client divides a large sheet into quarters and begins drawing scenes of her life history. While Lofgren is expecting her to work in a left to right fashion on a long piece of butcher paper, she is surprised at her client's attempt to depict a time line in a different format. Unsure if her client understands, she repeats the directive. However, by allowing her client to work in her own fashion, she learns the Navajo way of depicting one's life history in quadrants in a clockwise direction to represent the orderly movement of the earth around the sun. The four quadrants are symbolic of the four ages of man: infancy, youth, maturity, and the transition of age. More importantly, as the art therapist begins to overcome cultural barriers and begins to understand the dynamics between herself and the client, she discovers a way to communicate that will best benefit her client.

Consideration of Process, Product, and Structure in Cross-Cultural Art Therapy

Art therapists should identify materials, processes, and the use of structure that will lead to a constructive therapeutic art session. For example, to better understand their Hispanic clients, Moreno and Wadeson needed to regain a sense of unity which was important to their culture; they used collage in a group format. The task involved a series of steps appropriate to the Hispanic way of socializing. Art therapists may also want to learn more about the traditional art and traditional art materials which their culturally different clients use. For example, Golub (1989) offered Cambodian refugees materials similar to those used in their culture: wood-carving tools, clay, markers, oil and water pastels, colored pencils, inks, charcoal, tempera, and watercolor with bamboo pens and assorted brushes.

Regarding product and process, art therapists may also want to consider their clients' traditional use of the art media. For instance, in Golub's work with Cambodian refugees, she noted that the refugees preferred to work in miniatures, filling in the detail in the entire space and adding poetry as seen in traditional Cambodian art. The refugees adhered to tradition by following the sequence of first drawing the picture in pencil, then applying paint sequentially from the background to the foreground. "This process is reinforced at the Khmer Institute where refugees relearned the traditional drawing process from some of the few surviving Cambodian artists" (Golub, 1989, p. 28). Lofgren's client also relied on her traditional background by making a sandpainting image which is ritually significant to her (Lofgren, 1981).

Art therapists should consider the use of structured or unstructured tasks as intervention with culturally different clients. For instance, by allowing their Hispanic immigrant clients to work in an unstructured fashion while making collages, Moreno and Wadeson noted that their clients spontaneously discussed their own work or commented on the work of others. "This appears to facilitate communication and set a very relaxed atmosphere where a variety of topics can be discussed" (Moreno and Wadeson, 1986, p. 127). On the other hand, Lofgren discovered that her usual open-ended, unstructured approach to the art therapy session was not appropriate for her Native American client whose class-value system showed a preference for a "concrete, tangible, and structured approach" (Lofgren, 1981, p. 29).

Conclusion

Overall, once art therapists understand the characteristics of cross-cultural therapy, they will gain a better awareness of their clients. Culturally sensitive art therapists consider the degree of fit between themselves and their clients and acknowledge that clients do indeed share basic human universal drives. Art therapists can transculturally care for a client by understanding cultural beliefs and values from the client's perspective; if necessary, they seek assistance from an alternative therapist who may be knowledgeable in traditions used in the client's culture. Finally, art therapists may act as pluralistic therapists who help clients clarify their personal and cultural standards, and are aware of how these standards relate to the more dominant culture's standards. By taking the time to educate themselves about their clients' cultures and backgrounds, art therapists may also avoid, or at least be aware of, some potential cultural barriers that may contribute to a client's possible early termination of therapy.

By becoming more familiar with a client's culture the art therapist may also discover new ideas on how to utilize materials, products, and processes in an individualized format that best meets a client's needs. The client may present traditional uses of media and art products to work through issues in therapy that may only be evident to the art therapist who is willing to explore the client's culture. These may lead to motivation, curiosity, and sincere humanistic interest between therapist and client.

References

Atkinson, D. R., Sue D. W., & Morten G. (1979). *Counseling American minorities: A cross-cultural perspective.* Dubuque, IA: William C Brown.

Bolman, W. M. (1968). Cross-cultural psychotherapy. *American Journal of Psychiatry, 124*(9), 1237–1244.

Burch, E. A., & Powell, C. H. (1980). The psychiatric assessment of a Vietnamese refugee through art. *American Journal of Psychiatry, 137*(2), 236–237.

Devore, W. (1985). Developing ethnic sensitivity for the counseling process: A social-work perspective. In P. Pedersen (Ed.), *Handbook of Cross-Cultural Counseling and Therapy* (pp. 93–98). Westport, CT: Greenwood Press.

Diaz, L., & Griffith, E. (1988). Cross-cultural mental health treatment. In L. Diaz & E. Griffith (Eds.), *Clinical Guidelines in Cross-Cultural Mental Health* (pp. 337–361). New York: John Wiley & Sons.

Draguns, J. G. (1985). Psychological disorders across cultures. In P. Pedersen (Ed.), *Handbook of Cross-Cultural Counseling and Therapy* (pp. 55–61). Westport, CT: Greenwood Press.

Golub, D. (1989). Cross-cultural dimensions of art psychotherapy: Cambodian survivors of war trauma. In H. Wadeson, J. Durkin & D. Perach (Eds.), *Advances in Art Therapy* (pp. 5–42). New York: John Wiley & Sons.

Jackson, M. J. (1987). Cross-cultural counseling at the crossroads: A dialogue with Clemmont E. Vontress. *Journal of Counseling and Development, 66,* 20–23.

Lefley, H. P. (1984). Delivering mental health services across cultures. In P. Pedersen (Ed.), *Mental Health Services: The Cross-Cultural Context* (pp. 157–171). Beverly Hills, CA: Sage Publications.

Leininger, M. M. (1985). Transcultural caring: A different way to help people. In P. Pedersen (Ed.), *Handbook of Cross-Cultural Counseling and Therapy* (pp. 107–115). Westport, CT: Greenwood Press.

Lofgren, D. (1981). Art therapy and cultural difference. *American Journal of Art Therapy, 21*(1), 25–30.

McNiff, S. (1984). Cross-cultural psychotherapy and art. *Art Therapy: Journal of the American Art Therapy Association, 1*(3), 125–131.

Marsella, A. J. (1982). Culture and mental health: An overview. In A. Marsella & G. White (Eds.), *Cultural Conceptions of Mental Health and Therapy* (pp. 359–388). Dordrecht, Holland: D. Reidel.

Moreno, G. P., & Wadeson, H. (1986). Art therapy for acculturation problems of Hispanic clients. *Art Therapy: Journal of the American Art Therapy Associaton, 3,* 122–130.

Pedersen, P. (1987). Ten frequent assumptions of cultural bias in counseling. *Journal of Multicultural Counseling and Development, 16*(2), 16–24.

Schmais, C. (1988). Creative arts therapies and shamanism: A comparison. *The Arts in Psychotherapy, 15,* 281–284.

Sue, D., & Sue, D. W. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology, 24*(5), 420–429.

Usher, C. H. (1989). Recognizing cultural bias in counseling theory and practice: The case of Rogers. *Journal of Multicultural Counseling and Development, 17*(2), 62–71.

Vontress, C. E. (1988). An existential approach to cross-cultural counseling. *Journal of Multicultural Counseling and Development, 16,* 73–83.

Wadeson, H., Durkin, J., & Perach, D. (Eds.). (1989). *Advances in art therapy.* New York: John Wiley & Sons.

Waller, D. (1989). Musing cross culturally. In A. Gilroy & T. Dalley (Eds.), *Pictures at an Exhibition: Selected Essays on Art and Art Therapy* (pp. 179–188). New York: Tavistock.

Cynthia Westrich is currently an art therapist at Catholic Children's home in Alton, IL and is completing her MA in Art Therapy at S. Illinois Univ. at Edwardsville.

Art Therapy: Journal of the American Art Therapy Association, 11(3) pp. 191-193 © AATA, Inc. 1994

Art Therapy with Native American Clients: Ethical and Professional Issues

Phoebe M. Dufrene, PhD, A.T.R. and Victoria D. Coleman, EdD, NCC, West Lafayette, IN

Abstract

This article briefly discusses how art therapists can best serve Native American populations. Contemporary Native Americans are a product of both the dominant culture and their indigenous culture. History, coupled with racial biases, has led the authors to identify ethical and professional issues that should be addressed with Native American clients. Traditional healing, ethical and professional considerations, and implications for art therapists are highlighted in order to introduce professionals to the specific needs of this population.

Introduction

For art therapists working with Native American clients, a knowledge of some of the basic elements in the Indian philosophy of health and medicine may help to overcome cultural barriers between therapists and clients. With mutual respect for both cultures, art therapists and Native American clients can facilitate a therapeutic relationship.

Sometimes therapists who work with multicultural populations encounter barriers. Consequently, to overcome these barriers, therapists must recognize that values differ significantly from one culture to another. For example, the Eurocentric or American concept of success includes individualism, hard work, and perseverance. However, Native American clients may have difficulty fitting into this "winner" stereotype. These values may also be antagonistic to the values of their own cultures, *i.e.*, those valuing cooperation over individualism (Coleman & Barker, 1991).

Background

The revival of Indian customs and traditions began between the mid 1950s and the late 1960s, an era of global decolonization and geopolitical retreat by Western powers. In this changing climate, Native Americans turned to their own heritage, and Eurocentric-trained health professionals came to recognize the value of Native American therapeutic resources (Dufrene, 1991). After many decades of suppression, religious ceremonies such as ritual dancing, sweat bath purification, peyotism, and vision quests re-emerged during the 1950s. Native Americans began to rediscover their own culture, and since that time tremendous interest in tribal religion has manifested itself. Activist movements in recent years are attempts to recoup lost ground and return to the culture, outlook, and values of the old days.

Before the passage of the 1978 Freedom of Religion Act, many Native Americans had difficulty obtaining access to Native American healers due to laws prohibiting the practice of traditional religion and medicine. Indian healers were generally considered to be superstitious magicians by missionaries and government officials, and segments of the healing arts were lost to many of the tribes (Halifax, 1981).

Traditional methods of healing continue to remain a major strength of tribal religion. This approach is currently being recognized by organizations such as the Public Health Service and the National Institutes of Health. Special grants have been awarded to provide training of more medicine men/women, and to have them work closely with health professionals (Meyers, 1987).

Relationships with the federal government continue to affect Native American tribes tremendously. Art therapists need to be aware of the impact of the government on tribes and on mental health care. During the colonization of the United States, the government signed treaties with tribes that were recognized as sovereign nations. However, most of these treaties were ignored during U.S. expansionism, and many tribes were either exterminated or forced onto reservations. As a result, Native Americans became dependent on the federal government through agencies such as the Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS). Most Native American experiences with Eurocentric mental health care originated with the IHS. Native Americans seeking mental health services are frequently forced into the position of trusting health care providers employed by the same federal agencies that are responsible for some of their psychological stress (Sage, 1991).

Geographical and Racial Issues

Art therapists need to be aware of the geographical and regional differences among Native Americans. These differences affect ceremonial beliefs and practices, Indian language use or nonuse, the degree of acceptance or rejection of mixed-blood Indians, urban versus rural environments, and reservation versus nonreservation status. The above differences all impact Native Americans' mental health and well-being (Sage, 1991).

With the migration from reservations to urban communities, there has been an increase in intertribal and interracial marriages. Today, more than 60% of all Native Americans are of mixed heritage, the result of interracial marriages with African Americans, Hispanic Americans, Asian Americans, and Caucasians. These recent demographics refute the stereotype

BEST COPY AVAILABLE

that all Native Americans live on isolated reservations (Peregoy, 1993). Often, the mixed-blood urban Indian is in a position to be the most vulnerable to mental illness and alcohol/drug abuse. These individuals are often asked to accept the culture of one parent and reject the culture of the other parent (Dufrene, 1990). Depending on tribal matrilineal/patrilineal descent, Native Americans may be denied tribal enrollment and be ineligible for IHS benefits. Although rejected for tribal status, they are still not fully accepted into the dominant culture because of physical appearance. Indians whose mixed ancestry is Hispanic-American or African-American are the victims of double discrimination as a "double minority."

The authors (a Native American art therapist and an African American psychologist) have collaborated on several cases with urban Native Americans with biracial backgrounds. It is their observation that minority therapists have a more comprehensive understanding of cross-cultural issues. For example, one of their male clients, a product of an interracial marriage and in the process of divorcing a non-Indian woman, had previously received counseling from a white therapist. He had difficulty expressing himself verbally and was reticent with respect to identifying his feelings. Having minority therapists as role models was instrumental in facilitating his self-actualization. Minority therapists, because of their experiences with racism and discrimination, may have a unique understanding of the idiosyncrasies and nuances of American life.

The federal government has established several criteria for determining the eligibility of Native Americans for educational, mental health, housing, and other services. In most cases, in order to receive mental health or other health-related services, a Native American must have a minimum of one-quarter Indian heritage. This undoubtedly prevents many mixed-blood Indians from receiving free- or low-cost mental health services (Peregoy, 1993). Thus, art therapists may find themselves in an ethical dilemma with respect to providing therapeutic services in federally funded facilities.

Ethical Considerations

Some important ethical considerations for art therapists to remember when working with Native Americans are the extenuating nature of minority status and the less advantageous social conditions faced by many in this population. Most Native Americans must choose between two paths, Native or non-Native. Those who are most likely to avoid social deviance are well-grounded in both cultures. The question facing therapists is how to encourage and enhance such development in both traditional and modern societies.

Art Therapy and Native American Healing

Native Americans encounter frustrations in their daily lives as they are forced to interact with non-Native individuals. There is a general suspicion of the non-Native population by Native Americans, consequently, any therapeutic orientation or approach will be recognized as an intrusion. Native Americans prefer not to disclose personal or family matters with outsiders.

Some contemporary Western therapeutic techniques have similarities with traditional Native American healing. For example, the role of the group leader or facilitator can be compared to an elder, clan leader, or medicine person leading a Native American group. In the Native American culture, group discussions are held in a circle with each person having an opportunity to participate. Assuming that the art therapist or psychotherapist has examined his or her own value system with respect to the Native American culture, the use of a variety of mechanisms, including traditional techniques, may be helpful in resolving psychological concerns.

As a result of the historical experience, contemporary racial biases, and frustrations discussed above, the authors have identified specific ethical and professional issues that they recommend should be followed when providing therapeutic services to the Native American population.

Ethical and Professional Considerations for Native American Clients

1. Art therapy for Native Americans must respect the spiritual dimensions of the Native American culture.

   While it is acknowledged that spirituality in the Native American culture is prominent, specific practices are determined by individual tribal values, beliefs, and customs.

2. Sessions may begin and end with a prayer that would be acceptable to the Native American individual.

   A prayer indicates acknowledgment of higher powers that play a role in our physical and mental well-being. Native Americans believe that healers can be successful only if they seek the aid of spiritual forces.

3. It is preferable that art therapy be conducted by a Native American mental health professional.

   Native American counselors will probably better understand the issues, needs, and concerns of this population.

4. In circumstances where a Native American mental health professional is unavailable, the non-Indian therapist should have background knowledge of the particular tribe that will be served.

   Non-Indian art therapists should be familiar with the values, beliefs, customs, and traditions, and have an overall appreciation and understanding of the idiosyncrasies and nuances peculiar to Native Americans.

5. In the pursuit of understanding the Native American culture, persons outside of the culture must not be deluded by profit-making enterprises in shamanism, vision quest, sweat lodge bathing, etc. These commercial attempts to train instant medicine healers are damaging to participants as well as to Native Americans.

   There is no expeditious way to acquire information about the Native American culture, and involvement in "quick fix" activities will only have a deleterious effect on the therapist and the client.

6. Western therapeutic techniques may or may not be appropriate; however, the art therapist must determine the efficacy of a given approach based on consultation with the individual.

   Art therapists must critically examine the philosophy of Eurocentric therapeutic techniques, *i.e.*, purpose of counseling, role of therapist, function of individual or group members, etc., to assess if there is (in)congruence with the values and beliefs of the Native American culture.

7. To facilitate the optimum therapeutic process, a blend of traditional and Eurocentric approaches to mental health may be the best solution for Native Americans interacting in two worlds (Indian and non-Indian).

   Based on the information presented, art therapists must determine, in consultation with Native American clients, what approaches (Eurocentric and/or Native American) will be appropriate.

8. Non-Indian therapists need to be aware of their own cultural biases when counseling transculturally.

   When counseling individuals from different cultures, it is imperative initially that individuals understand their own values, beliefs, attitudes, and biases, etc.

9. Art therapists working in Native American communities must actively seek opportunities for interaction with this population.

   Therapists must make special efforts to become involved with family, community, and social activities involving Native Americans in order to facilitate an understanding of the culture.

Implications

There are significant implications for art therapists who want to affect the success of Native American clients. Implications related to training, research, and program development are discussed below.

Training: Higher education must train mental health professionals to provide mental health services for Native Americans. Courses in anthropology, history, sociology, and political science, as they relate to Native Americans, are needed. In some instances, Native American therapists can more adequately understand and address the needs of their constituency. The recruitment and retention of Native Americans into art therapy and other human development training programs will help to alleviate this difficulty. Consultation with tribal and other community leaders will encourage Native Americans to pursue careers in this field.

Research: Most of the literature and research conducted on Native American mental health has been done by non-Native Americans. This will be rectified as more Native Americans acquire training in research methodology and enter professions in the social sciences.

Program Development: Most of the health care for Native Americans is provided by the federal government. Given the negative historical experiences of Native Americans with the federal government, it is imperative that more Native Americans design and implement their own mental health programs. Mental health professionals must carefully examine their role in designing counseling programs for Native Americans.

Summary

Art therapists and other mental health professionals should be cognizant of the skills and knowledge necessary to work effectively with Native American clients. As the 21st century approaches and multicultural and diverse populations increase, we will be required to adapt to several roles. One of these roles will be assuming responsibility for the success of equitable mental health opportunities for Native American clients.

Editor's note: Phoebe M. Dufrene, PhD, A.T.R., is an assistant professor of visual and performing arts at Purdue University, West Lafayette, Indiana, and maintains a private practice as an art therapist. She is a member of the Powhatan Nation.

Victoria D. Coleman, EdD, NCC, is an associate professor of vocational education at Purdue University. She maintains a management consulting firm and private practice as a counseling psychologist.

References

Coleman, V. D., & Barker, S. A. (1991). Barriers to the career development of multicultural populations. *Educational and Vocational Guidance*, 52, 25–29.

Dufrene, P. (1991). A comparison of the traditional education of Native American healers with the education of American art therapists. *Art Therapy: Journal of the American Art Therapy Association*, 8, 17–24.

Dufrene, P. (1990). Exploring Native American symbolism. *Journal of Multicultural and Cross-Cultural Research in Art Education*, 8, 38–50.

Halifax, J. (1981). *The shaman*. New York: Crossroad.

Myers, W. M. D. (1987). Cross-cultural medicine. *Behavioral Sciences Exchange*, 8, 113–119.

Peregoy, J. J. (1993). Transcultural counseling with American Indians and Alaskan Natives: Contemporary issues for consideration. In J. McFadden (Ed.), *Transcultural Counseling* (pp. 163–191). Alexandria, VA: American Counseling Association.

Sage, G. (1991). Counseling American Indian adults. In C. C. Lee & B. O. Richardson (Eds.), *Multicultural issues in counseling: New approaches to diversity*. Alexandria, VA: American Association for Counseling and Development.

Trottier, I. (1989). Prevention of child sexual abuse requires increased awareness, education. *NIHB Health Reporter*, 4(13), 14–16.

Art Therapy: Journal of the American Art Therapy Association, 11(3) pp. 194-199 © AATA, Inc. 1994

Transcultural Responses to Aesthetic and Therapeutic Experience: An Ethological Approach

David R. Henley, MA, A.T.R., Clinton, New Jersey

Introduction

In keeping with the current emphasis on multiculturalism in contemporary society, the approaches explored in this article call for the recognition of the common artistic and therapeutic needs of minority clients. Given the current political climate which supports the tenet of "separate but equal," art therapists are well-positioned to appreciate and foster a client's self-esteem through cultural identification. However, those who support an emphasis on separatism should consider Lippard's (1990) statement that "understanding the intercultural process is perhaps evenly divided between understanding differences *and* sameness" (p. 20). She points out also that although solidarity, coalition building, and social pride were building in the '80s, the multicultural art movement failed to develop a theory of multiplicity that was either assimilative or separative, or, above all, relational. Although Lippard sees no advantage in advancing "one more universalist concept," the position of this paper considers that multiplicity might best be understood by exploring those forces which bind us as a common species: that it is by first acknowledging the kindredness of the world's peoples that we may come to appreciate our differences.

The transcultural view in this paper makes use of the concepts of ethology and phenomenology. Ethology is the study of animal behavior, which considers animal characteristics that have evolved over millennia in dynamic interaction with their environment (Lorenz, 1962). Human ethology attempts to understand our species by making comparative analogies between species as a method of understanding the underpinnings of both innate and cultural behavior (Berger, 1974). Phenomenology is a philosophical method that bases knowledge on the perception of phenomena. Applied to ethological practice, it specifies those perceptions which make up the organism's self-world. The concept of "self-world" assumes that the organism is both creator and judge of its own private universe by virtue of its sensory systems that filter the flow of ideas and affects.

As techniques of observation and interpretation, both ethology and phenomenology mesh with psychoanalytic theory because all three emphasize significant events in early mental development—events which may become fixed and thereby influence the future course of one's personality (Candland, 1993). As with archetypal psychology, both ethology and phenomonological systems draw upon those forces which function beyond the realm of consciousness and which may find expression in imagery that could be considered collective in nature. The collective psyche may be viewed ethologically as a form of sollverte or innate (evolved) template which guides sensory experience in ways that maximize our adaptation to the environment (Wilson, 1975).

Such sollverte are routinely encountered during art therapy as they are given form through the art process in such manifestations as early attachment behavior, motivational ambivalence, control of instinctual drives, and the quality of play or exploratory behavior. These dynamics can be viewed as forming the essential building blocks of art making behavior which Dissanayake (1989) has termed "making special." She views art making as a universal desire to transform aspects of one's world, by virtue of the aforementioned dynamics, into a realm that is different from the everyday—an alternative reality where the senses and drives become shaped, ritualized, elaborated, and symbolized. Dissanayake claims that "making special" in humans is a universal behavior that possesses adaptive value and, as such, has contributed to the survival of our species.

In previous studies I have explored the dynamics of "making special" with nonhuman populations including several species of captive animals. I found that through facilitated play, ritual, and sensory stimulation, proto-artistic activity could develop (Henley, 1992). In this article the analogy will be reversed. Rather than discuss the early psychodynamic processes of animals or special child populations, I will focus instead upon the group dynamics of multiethnic peoples who are interacting with an installation sculpture by Jean Dubuffet. I will endeavor to identify those dynamics that become activated when responding to an aesthetic stimulus. The resulting behaviors will then be considered within an ethological/phenomenological framework and eventually applied to the practice of art therapy.

Literature Review: Ethology and Art Therapy

The application of ethological constructs to art therapy has been explored by Edith Kramer. In her article "Play and Art Therapy" (1977), she discusses early attachment behavior, relating it to Leyhausen's observations of captive felines who become intensely possessive of certain objects in their environments. Highly prized, resistant to change, and defended as a kind of personal territory in both animals and humans, "transitional objects" (Winnicott, 1965) foreshadow the evolution of artistic motivation and investment. Kramer writes:

> Thus we could venture to suggest that even art has some roots in prehuman behavior. It seems that the human infant's propensity to endow inanimate objects with a wealth of emotional significance that endures over a considerable length of time stands in a precursory relationship to the capacity to create new objects that lastingly embody meaning to their creator and to his audience. (p. 5)

At the root of transitional phenomena is the cementing of attachments between mother and infant. It was Bowlby (1983) who drew upon attachment dynamics in both human and animal species, acknowledging its adaptive value. Bowlby posits the behavior's origin as being a protective measure from predators: those who are isolated and without attachments would be more vulnerable to attack. Kramer (1992) discusses how the attachment process develops through sensory experience, with first tactile, then visual incorporation of the mother's face and breast schema. Hence, the earliest precursor of aesthetic experience is perhaps the infant's capacity to search out protection and sustenance by the visual recognition of these significant forms. The infant's powerful response to visual configuration also applies to other creatures in nature. Kramer cites Lorenz (1962) who pointed out that prey animals must quickly and unerringly recognize the essential characteristics of predators or the results could be fatal. The prey must possess in its collective memory a schema of the predator—one that allows for quick, accurate recognition and elicits a powerful response, purely on the basis of its visual elements and composition. Such configurations are termed by ethologists "super-normal objects." These abstract, abbreviated configurations combine simple elements (such as two exaggerated circles for eyes) in order to elicit strong measures which are adaptive in that they further an organism's chances for survival.

Aside from fostering attachment responses or predator identification, super-normal objects can trigger sexual receptivity, such as displaying breeding plumage in birds, or, in the case of humans, through suggestive clothing or body painting that accentuates sexually significant features. Defensive measures occur in moths whose wing design patterns take the form of frightening predatory facial schema. Kramer has found parallels to moth markings in the designs of certain tribal masks which use moth-like abstractions and ominous features to prompt magical powers of defense, fertility, death rites, etc. Feeding responses are also stimulated by super-normal configuration, such as the nestling birds who trigger parental feeding by the triangular, colorful targets of their gaping mouths. Indeed, certain parasitic birds exploit super-normal attraction by placing their own offspring into the nests of lesser birds. With their larger, more powerful targets, they receive a major share of the food, insuring their own survival at the expense of others.

Edwards (1987) theorizes that such innate responses to form may constitute the evolutionary forerunner of archetypes, giving particular style to the basic instinct. It was Gombrich (1951), however, who first made connections between Lorenz's observations of super-normal phenomenon and proto-artistic behavior. For example, when a child's ordinary broomstick is transformed into an object of play, the resulting "hobby horse" exists mainly through one's imagination. According to Gombrich, the capacity to transform and symbolize is based on responses to "biologically significant form" which includes two components: the first is the "real" or manifest motif; the second, and perhaps even more crucial, is that which is absent from form but is provided by the viewer. He refers to this as the "Et Cetera" principle:

> for those "privileged" objects which play their part in the earliest layers of image-making recur—as was to be expected—in that of image-reading. The more vital the feature that is indicated by the context and yet omitted, the more intense seems to be the process that is started off. (p. 166)

Gombrich's (1992) seminal theory of art as "illusion" is in line with Dissanayake's requirement for an "alternative" reality and Kramer's belief in the magical effectiveness of certain signs, gestures, and rituals that are projections rooted in experience.

A second major dynamic of human behavior applicable to ethological and art therapy theory is rooted in play or exploration, a process which is involved in both the creating and experiencing of aesthetic experience. Morris (1967) explains that the drive toward exploration is based on the quality of novelty that is promised by the stimulus. During play, the process of "investigation-reward" usually dictates that a substantial payoff (of novelty) is obtained from a disproportionate expenditure of comparatively little engery—which he terms "magnified reward." However, as play leads to more goal-oriented exploration (such as aesthetic experience), these proportions change as greater rewards require greater risks. Kramer writes:

> We see that behavior motivated by curiosity is akin to play in being energized by an urge for pure experimentation rather than by any immediate physical need. It is, however, more stressful than play, for it has the power to propel the animal into dangerous situations. (1977, p. 5)

It is this drive toward novelty which co-exists with the need for caution when taking risks that creates a state of motivational conflict which is negotiated both in art and life.

Approach/avoidance dynamics were first articulated by Tinbergen (1961), who observed the ambivalence of gulls during mating when pairing intimacy generated much anxiety and conflict. He subsequently applied approach-avoidance dynamics to autistic individuals or others with delicate dispositions, pointing out that the task of exploring the world and establishing relationships are occasions for both curiosity and inhibition (1983). For clients for whom sensory perception is distorted or reality testing is impaired, inhibition over exploration, or indeed, autistic withdrawal, may constitute an adaptive response which favors the autistic person's survival.

As Tinbergen found with gulls and Fossey (1983) and Goodall (1971) found with primates, it is often the process of ritualization which may lessen or bind the anxiety that arises when confronting a stimulating yet potentially harmful stimulus. One such ritualized behavior is "redirection" (Tinbergen, 1983). Goodall (1971) observed chimps whose display behaviors made use of throwing feces, leaves, tree branches, and other raucous behaviors when they felt threatened. Rather than striking out or potentially harming someone, the chimps unloaded their affects upon inanimate material so as to absorb frustration and redirect aggression. Tinbergen also identifies "displacement" behavior which differs from redirection in that it implies further transformative measures in which tension or aggression gain release without overt reference to the conflict. Tinbergen gives the example of sipping cocktails at a party—such behavior has little to do with gaining liquid nourishment though it does absorb and express tension in ways that are socially appropriate. The "formalization" or "regularization" (Dissanayake, 1994) of these rituals is the individual variant or repertoire of different displacement behaviors, i.e., beard stroking, key jingling, nail biting, etc. Applied to visual expression, formalization often takes the form of stereotypy or other inflexible schema that may characterize inhibited responses to artistic expression. For although the arts stimulate much curiosity, exploration, and sensory

BEST COPY AVAILABLE

arousal, they also require boldness and risk-taking which sometimes result in defensive postures that strive to maintain a balance between these conflicts (Henley, 1989).

To illustrate these dynamics further, I now turn to a case account in which super-normal response, exploratory behavior, and approach/avoidance conflict are analyzed in ethological terms.

The Case: "The Jardin d'Email" by Jean Dubuffet

Dubuffet's monumental sculpture appears as an apparition among the misty woods in the garden of the Kroller-Muller Rijksmuseum in the Netherlands. Its massive presence is strangely offset by an encircling, featureless high wall which guards any hint of the sculpture's internal features. For those approaching this work, the curiosity displayed among a range of international patrons appeared consistent—all seemed aroused by the presence of this mysterious colossus. However, Dubuffet deftly taxes this curiosity as the pilgrims are forced to walk almost completely around the bare exterior before finally arriving at a discernable feature: a nondescript slit-like opening in the otherwise white concrete wall. When one observed patrons negotiating this entrance, it became immediately apparent that in concert with their curiosity, discernable caution and ambivalence were also being displayed. And while almost everyone overcame this ambivalence (having placed their trust in the hands of the Rijksmuseum as well as some pragmatism "we walked all this way we might as well . . ."), there were some who opted to pass up the experience on several park benches probably set out for the purpose.

Upon entering Dubuffet once again raises the anxiety levels, as the tunnel is narrow and convoluted, requiring uncomfortably close contact with the countercurrent of exiting patrons. Finally, one passes up and through another slit-like doorway which is part of the sculpture's main element—a towering, whimsical affair which most patrons interpreted in organic terms (i.e., a tree, toadstool, etc.) (Figure 1). This and another lesser protuberance on the far side constitute the most dominant stylistic elements in the work. The rest of the internal composition was essentially featureless with understated contours and elevations that were delineated by a network of painted black lines (Figure 2). This linework forms cellular patterns that either interlocked like jigsaw puzzle pieces or meander about the plateaus like river currents.

Interviews were conducted with approximately 40 American, German, Dutch, Italian, Nigerian, Belgian, Japanese, Greek, British, Czech, Kuwati, and other patrons who could describe to me their experiences in English. Most evoked associations from childhood, of having secret hideaways or imaginary kingdoms similar to those imagined by Lewis Carroll. For some, ethnic customs involving meeting grounds, English gardens, Italian piazzas, or Greek coffeehouses were evoked; where interactions with others were enriched and mediated by architectural elements. Carl Sandburg came to mind for one Japanese man who recited his "Mending Wall," where "fences make good neighbors"—again alluding to boundary issues and territoriality.

However ethnically diverse their responses were, patrons more often reacted in decidedly consistent patterns of behavior. First, the two dominant phallic objects generated the strongest responses among both children and adults. This was perhaps due to the paucity of other arousing elements in the pictorial field. As a "stimulus pattern," the two protruding elements were related to as focal points of orientation as well as centers of congregation in the rest of the space. This dynamic is consistent with other stimulus response investigations, such as those involving chimpanzees (Morris, 1962), gorillas (Reitz, 1992), and elephants (Henley, 1992), whereby pictorial fields that included preprinted circles always seemed to precipitate an interaction with these elements. They were often drawn upon, mirrored, or continued, much in the same way the patrons used the towers to dialogue with the rest of Dubuffet's sculpture.

As patrons set out to walk the sculpture, several other patterns of exploration emerged. First, Dubuffet's use of static, jigsaw forms, together with his modeling of small plateaus, appeared to trigger mild territorial responses particularly within family or adolescent peer groups. These elements were often utilized as tables or benches for group activities such as eating, playing, and other behaviors that cemented and reinforced group bonds. Although these personal territories weren't actually defended, they were clearly claimed for

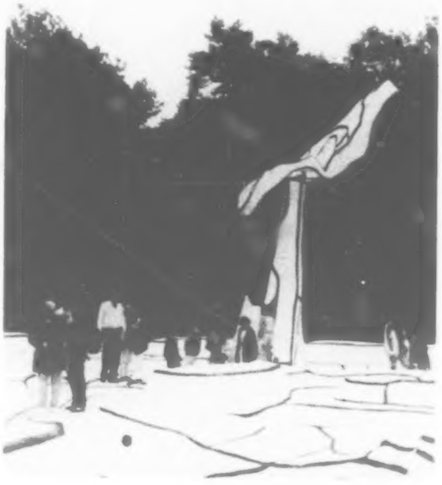


Figure 1.

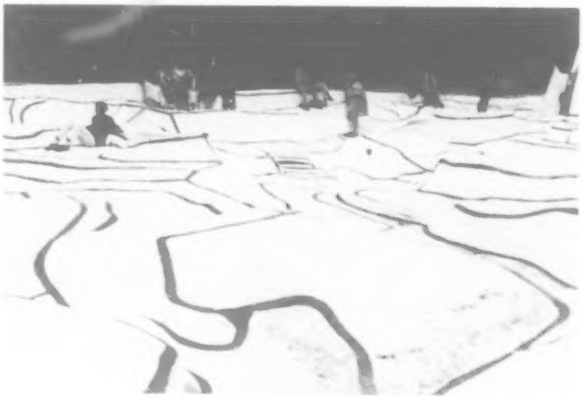


Figure 2.

the duration of the visit. Others sought out less prominent spaces as they migrated to the outer edge to walk the perimeter of the work, then situated themselves on the wall (usually in couples) allowing an overview perspective of the entire sculpture (Figure 2). Here they often discussed and reflected upon the work. Eventually, however, verbal exchanges gave way to resting, sleeping, or, on occasion, using the perimeter wall to become physically intimate, as their interest in the space yielded to interest in one another.

Among children, however, activity levels were vigorous throughout their visit. Novelty was sought at every turn as they investigated every aspect of the work. There was evidence that the children fell into the two categories proposed by Gardner (1980). The "patterners" seemed taken up with the formal elements of the piece, responding to the configurations of lines, for instance, through games of hop-scotch or hide-and-seek. Most of these children reacted to manifest patterns and 3-D elements without a great need to involve others in their introspection. Sharply contrasted to the "patterners" were the "dramatists" who displayed a marked preference for pretend play, acting out, storytelling, and social exchanges that thrived upon vigorous action, adventure, and conflict. Storr (1988) views these two characterizations as being transcultural in nature and being closely aligned with Jung's system of introverted/extroverted personality types. In any event, among both types of children, incidents involving overstimulation were noted, with arousal levels escalating until parents were compelled to set limits. Here the greatest extent of culturally diverse responses were noted, as one could make fairly informed generalizations as to the ways in which tantrum or overheated behaviors were dealt with depending upon nationality—from hushed urgings to be calm, to raucous shouts and threat displays. Younger children displayed only minor variations of attachment, exploratory, and "checking back" behavior. For most young children, the parents remained the dominant object of stimulus response and orientation rather than any elements Dubuffet offered. Again, cultural orientation appeared to play a part as to the degree to which parents would permit independent exploration in their children. Concerns ranged over the dirtiness of the sculpture, its crowdedness, the hardness of its surface, its limitlessness, and other considerations that modulated child interaction with the space.

Stimulation levels among all participants appeared to be linked to the density of population. When several tour buses emptied, simultaneously flooding the *Jardin* with tourists of every nationality, there seemed a marked escalation of tension. Displacement behavior increased as people pushed back to the perimeters became increasingly agitated; while some vaulted over the walls to escape the crush, others laughed nervously, paced, groomed, and engaged in other behaviors that vented tension. A decrease in exploratory behavior meant an escalation of territoriality, particularly in adolescents, as groups staked out areas with several male members visibly posturing in subtle threat displays to preserve their space. Incidents of overcrowding were short-lived, however, as most tour groups appeared to be so overstimulated that they tended to march in, take a perfunctory look around, pose for pictures, and then, seemingly, exit in relief. Their visits were shorter than unorganized tours or individuals. Some tour group members displayed high levels of displacement behaviors as well (perhaps because they realized the effects of their intrusion upon the ecology of the space). Their brief attending behavior, distracted concentration, and lack of exploratory or animated behavior supported Lorenz's (1962) tenet that identical stimuli can arouse markedly different responses if the quantity of stimulation reaches saturated levels.

Habituation to the space also prompted a decrease in play and exploration. Once the possibilities for novelty were seemingly exhausted, most participants utilized the space to relax, reflect, and, most commonly, "people watch." Only when it came time to exit did the spector of traveling the constricted tunnel-way again arouse a degree of animation or tension in the participants. It was noteworthy that while most took the expected route, a number of patrons (particularly males) opted to jump the wall. The many black scuff marks on the white exterior wall indicated that this was a popular means of avoiding the forced intimacies of the tunnel exitway.

Discussion

Within its guarded walls, Dubuffet's sculpture has given form to a landscape "made special." By modulating levels of stimulation, suspending rules of perception, and dissolving familiar approaches to structure, he succeeds in transporting us into Dissanayake's "other realm." Amadie (1976), writing for the Pace catalogue, considered it a "premeditated attack on our senses that occurs in a field specifically to continue action." This critical observation implies that Dubuffet intentionally limited the elaboration and embellishment of his ideas so as to force the viewer into closer proximity with his or her own perceptions. Dubuffet seems intent upon supplying only enough visual information so as to stimulate an intensely personal phenomenological experience. One recalls the "significant form" of Gombrich's "Hobby Horse," where only the barest essential elements are needed to transform the mundane into the magical. As a work of phenomenology, it is up to the participant to contribute imagination, fantasy, or perceptual impressions to activate this otherwise inanimate environment. Dubuffet skillfully sets these perceptual and imaginative processes into motion by his careful introduction of elements—from the intriguing first view of its colossal form, to its sparse interior where a patchwork of random, perhaps unconscious, doodles provides what little structure there is to guide our interactions. The limited color and its erratic, "nervously delineated" (Glimcher, 1969) lines, tend to flatten, rather than describe, the forms. The breaking up of interior space into plateaus and depressions creates maps to nowhere, inviting random exploratory interactions that seem most akin to play. Here Dubuffet's contempt for the conventions of "high art" is most evident as his affinity for the playful vocabularies of child or naive artmakers is clearly referenced. Dubuffet also makes clear his wish that we approach his work without informed aesthetic preconception, disarming us to be co-creator and judge of this world of our own making.

He presents us with a magnificent "hobby horse," which frees us to exercise our own capacities for play, ritual, and associations that maximize personal response. That Dubuffet aims for a depth of phenomenological response is apparent in his statement, quoted from the Pace Gallery catalogue, which first showed the macquette for this sculpture: "We are invited to attend the sinking of cultures as wreckers of our own boat in order to reconquer those instinctual values long since lost" (Glimcher, 1969).

Here Dubuffet seems taken up with what Winnicott (1965) terms the "authentic self." For those patrons conditioned to compliance and mannerly appreciation of aesthetic objects, Dubuffet invites subversion and action, providing an arena where the conventions of culture yield to more authentic yearnings which Dubuffet views as requisite for "pure" aesthetic experience. Yet, in his largely successful bid for a potent phenomenological, even therapeutic experience, it can be argued that Dubuffet sabotages the work's potential as a powerful object of art. This is due not to the scarcity of elements as much as to their failure to evoke super-normal responses from a majority of viewers. While the towers certainly influenced patron orientation and congregation, they seemed not to trigger responses of intense attachment: few seemed mesmerized by these objects' power—most in fact seemed only to be amused by their tilting and squatting postures, like "drunk old men—one listing ready to topple, the other already down and snoring," as one clever German put it. This decidedly masculine association regarding the two main elements was consistent among those polled—few found the element's phallic nature sensually inviting as they might a Henry Moore or Isamu Noguchi sculpture (both of whom make dominanf use of circular/mandala motifs). There seemed little magnetic "holding" to these two elements, and thus, viewers were left to extract meaning in objects that essentially held little totemic power. The "maximum reward" called for by Morris during acts of play seems also not to have been achieved. The two elements' lack of novelty in terms of texture, form, theme, etc. seemed to explain their incapacity to sustain any extended viewer explortion.

Although the *Jardin* may fall short as a compelling work of art, its value perhaps applies more significantly to the realm of therapeutic discourse, which art therapists may attempt to emulate in their own clinical practice. For instance, Dubuffet's deft balance between providing a powerful motivational stimulus while also cultivating a therapeutic "blank slate" is not unlike Winnicott's (1971) use of squiggles or Cane's (1983) use of scribbling exercises. Each of these provides the viewer/participant with a vigorous open-ended guide from which associations are aroused and given spontaneous form through facilitated expression.

In concert with environmental artist James Pruznick, I have made use of interactive designs for prompting both aesthetic and therapeutic response. Figures 3 and 4 depict large-scale interactive sculptures that were created to evoke responsivity in clients within a range of racial, socioeconomic circumstances.

Clients were invited to interact with the work from both inside and outside. From inside, facilitators encouraged them to recognize extra awareness to their senses and perceptions in a phenomenological sense. With greater "intent" (Betensky 1987), clients noted subtle fluctuations of billowing movements caused by changes in air pressure as more clients entered and exited. They touched the internal elements which hung and draped against their faces and bodies, noting textures and forms. Different kinds of movement were pointed out, as some sat meditatively still while others had brisk "run-throughs." Once outside, clients observed the shadowy movements of others inside and how their forms and movements created a composition.

Conceptually, the work drew upon architectonic form to invite interaction and evoke associations of both "inner and outer" approaches to home territory. This "dwelling" association opens the way for clients to tap into their needs for exploration, habituation, and interaction—processes that are naturally occurring in most environmental installations and are both conducive to universal and cultural identification. The works make use of Kramer's (1986) "Third Hand" mode of intervention, whereby clients engage their clinical issues mainly through the art media and technique rather than through verbal analysis—essentially an "art as therapy" experience. This implies that materials are chosen for their propensity to elicit maximum therapeutic and aesthetic response. For instance, where Dubuffet uses concrete, Pruznick chose cotton muslin, gauze, parachute silk, and polished aluminum—materials closer in spirit to original transitional objects in which the intensity of attachment is most often prompted by tactile responsivity. Hence, the most basic need for sensory stimulation and attachment were met much in the same way that Harlow's Rhesus monkeys found solace in terry-cloth clad surrogate mothers (far more so than their cold and hardened realistically modeled counterparts). Since the material were both soft and translucent the more insecure clients were able to see their support staff through the sculpture's walls—thus bridging inner and outer through a sheer stimulus barrier.

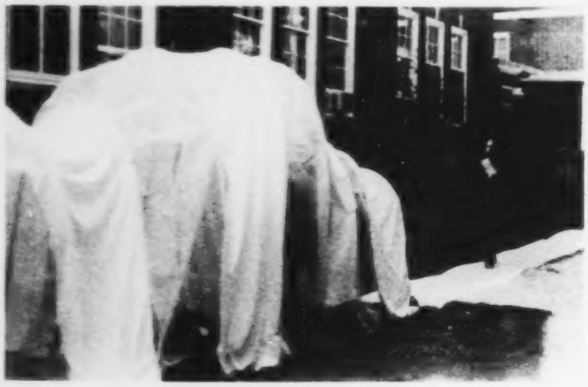


Figure 3.

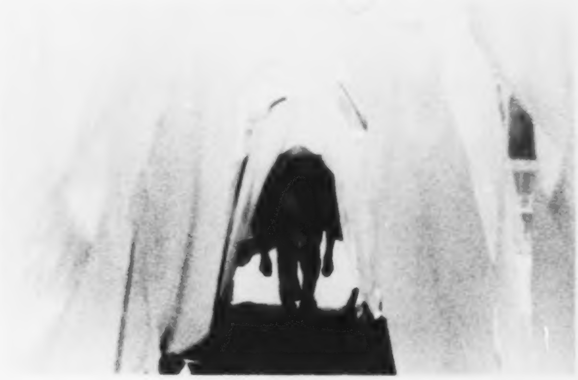


Figure 4.

Pruznick's structural designs took into account the need for different levels of relating and activity. His use of a cotton cloth "track" in Figure 3 induced both directed and robust interaction while reducing instances of ambivalence or anxiety through the balanced use of directive and open-ended structuring. The internal forms invited both vigorous and reflective interaction, with draping, woven tunnels of material and hanging strips, all lending sensory stimulation and novelty; yet their open compositions seemed to minimize tactile or sensory inhibition. The large, visible tunnels aroused participation and minimized stress by presenting the child with an archetypal experience in which instances of regression were accommodated and supported. Client associations to the works: caves, tornadoes, a mother's scarf, a bird's nest, ocean waves, billowing clouds, etc., all speak to the work's universal sensibility. That even the most resistent blind child entered these forms speaks to the need to stimulate without threatening, where opportunities for risk-taking are rewarded by judicious portions of novelty, nurturance, sensuality, and security.

While the prospect of being engulfed by these works was perhaps daunting to some (as "Jonah was engulfed by the whale" remarked one archetypal enthusiast), it was perhaps these works' super-normal qualities: larger than life, softened mandala formats, that in the end, signaled to the client that the rewards of exploration were well worth the risk.

In conclusion, this article suggests that ethological techniques of observation can provide the artist, critic, and clinician with a valuable tool for discerning the most basic and profound aspects of psyche. Ethology contributes theoretical and practical insight that may enhance aesthetic and therapeutic effectiveness. In no way does it suggest a biological "determinism" which undermines the power of a free will, nor does it overshadow cultural identification or diversity. For it is generally accepted, even by those of a sociobiological orientation, that cultural evolution has far surpassed biological evolution as a force of change. However, the endless debates over nature vs. nurture (or in this case, culture) need not be viewed as a dichotomy or mutually exclusive. The hostility with which the multiculturalist Lippard views universality of expression seems to be more a matter of political or civil pride than of professional criticism. For the ubiquity of drive energy, of motivational conflict, and transitional or Gestalt phenomena provide a firm footing upon which one can begin to layer the myriad of cultural variations that define the full dimensions of the artist and his/her art.

Editor's note: The author gratefully acknowledges Ellen Dissanayake and Edith Kramer for their helpful comments in preparing this manuscript.

References

Amadie, D. (1976). *Jean Dubuffet: Mires.* New York: Pace Gallery Editions.

Berger, L. (1974). *From instinct to identity.* Englewood Cliffs, NJ: Prentice-Hall.

Betensky, M. (1987). Phenomenology of art expression and therapy. I J. Rubin (Ed.), *Approaches to Art Therapy.* New York: Brunner/Mazel.

Bowlby, J. (1983). *Attachment.* New York: Basic books.

Candland, K. C. (1993). *Feral children and clever animals: Reflections on human nature.* New York & Oxford: Oxford University Press.

Cane, F. (1983). *The artist in each of us.* Craftsbury Common, VT: Art Therapy Publications.

Dissanayake, E. (1994). Personal communication.

Dissanayake, E. (1989). *What is art for?* Seattle & London: University of Washington Press.

Edwards, M. (1987). Jungian analytic art therapy. In J. Rubin (Ed.), *Approaches to Art Therapy.* New York: Brunner/Mazel.

Fossey, D. (1983). *Gorillas in the mist.* Boston: Houghton Mifflin.

Gardner, H. (1980). *Artful scribbles:* The significance of children's drawings. New York: Basic Books.

Glimcher, A. (1969). *Jean Dubuffet: Simulacres.* New York: Pace Gallery Editions.

Goodall, J. (1971). *In the shadow of man.* Boston: Houghton Mifflin.

Gombrich, E. (1951). Meditations on a hobby horse. In L. L. Whyte (Ed.), *Aspects of Form.* London: Parson Press.

Henley, D. (1992). Facilitating artistic expression in captive mammals: Implications for art therapy and art empathicism. *Art Therapy: Journal of the American Art Therapy Association,* 9(4), 178–192.

Henley, D. (1989). Stereotypes in childrens art: Art therapeutic interventions using Lowenfeld's motivational techniques. *American Journal of Art Therapy,* 27(4), 116–125.

Kramer, E. (1992). Reflections on the evolution of human perception: Implications for the understanding of the visual arts and of the visual products of art therapy. *American Journal of Art Therapy,* 30(4), 126–142.

Kramer, E. (1986). The art therapist's third hand: Reflections on art, art therapy, and society at large. *American Journal of Art Therapy,* 24(3).

Kramer, E. (1977). Art therapy and play. *American Journal of Art Therapy,* 17(1).

Lippard, L. (1990). *Mixed blessings: New art in a multicultural America.* New York: Pantheon Books.

Lorenz, K. (1962). *On aggression.* New York: Harcourt, Brace & World.

Morris, D. (1967). *The naked ape.* New York: Crown.

Morris, D. (1962). *The biology of art.* London: Metheun.

Reitz, S. (1992). Unpublished manuscript.

Storr, A. (1988). *Solitude.* London: Flamingo Editions.

Tinbergen, N. (1983). *Autistic children: New hope for a cure.* Winchester: Allen & Unwin.

Tinbergen, N. (1961). *The herring gulls world.* New York: Basic Books.

Wilson, E. O. (1975). *Sociobiology: The new synthesis.* Cambridge: Harvard University Press.

Winnicott, D. W. (1971). *Therapeutic consultations in child psychiatry.* New York: Basic Books.

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment.* New York: International Universities Press.

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 11(3) pp. 200-205 © AATA, Inc. 1994

An Interview with Joan Kellogg

John Alden Thayer, New York, NY

Abstract

Joan Kellogg is probably best known to art therapists for her investigation of the mandala and her development of the concept of the Great Round. As a result of this work, she has published the book* Mandala: Path of Beauty *and numerous articles on mandala symbolism. Kellogg's other accomplishments include the establishment of the Mandala Assessment Research Institute (MARI) and collaboration with Dr. Stanislov Grof. In this special interview Joan Kellogg discusses her thoughts on the theory and practice of art therapy, the mandala, and her life.

Joan Kellogg has become somewhat of a legend in her own time. And, like most legends, she is surrounded by myths and rumors which lend her an aura that both exalts and obfuscates her. Perhaps no one will ever know the real Joan Kellogg, but it was certainly worth making an attempt by spending a memorable day during the summer of 1993.

As the cicadas revved up and wound down in the late summer heat, Joan switched on the recorder and began her story. A woman in her early seventies, she still has eyes that sparkle and grow round with awe at the pure excitement of ideas. They can also narrow to slits that scorn naivete or plain old ignorance. Not a person to put up with fools gladly (or to educate interviewers not yet up to speed), she can vacillate in a heartbeat from ecstatic poet of the transcendent to tough realpolitik critic. Some of her more scathing observations are reserved for the fields of psychology and art therapy in particular. Unaware of the roller-coaster ride that awaited me, I was lulled by the deceptively calm banality of the setting, an expansive kitchen in a suburban Virginia home, her patient husband, Russ, pouring the coffee. Joan began in a biographic mode.

"Although I showed professionally in the mid-sixties, I considered myself more a student of art rather than an artist. While living in Wykoff, New Jersey, I had a one woman show at Franklin Lakes Gallery, a three woman show in Paterson, N.J. and exhibited in several juried shows in the Northeast, but I had grown disenchanted with my peers in art circles. One tends to think of artists in an ideal sort of way, and I assumed because I was thrilled when other artists won an award or sold a picture or when they showed in a prestigious show that the same feelings would be projected from them to me. I found that not to be true. Since that generosity was not shown, I decided I would rather not pursue working in my own art and showing my own work. I began to think of teaching, and I read a lot of Carl Jung's work—those beautiful books that came out of Princeton in the Bollinger Press series. And—I began to paint in the form of mandalas."

As she spoke I had to remind myself that in 1969 very few people even knew who Carl Jung was, no less read his works. And fewer still, at least in the West, were painting in mandala form. (Mandala is the Sanskrit word for circle, and a mandala is what results when using the circle as the primary frame of reference in a painting.) What rendered her casual statement even more extraordinary was the fact that Joan Kellogg had graduated from high school in St. Petersburg, Florida and joined the WAVES during World War II. Having married Russ in 1946 just after the war, she began a family like so many other veterans and, following her husband's corporate transfers through six different cities, her family grew by six children. Joan Kellogg was a very busy suburban housewife and mother. Not the sort of matrix one would expect to produce the remarkable discoveries to come.

Joan continued, her large dark eyes twinkling with the recollection. "I read a newspaper article about Hahneman Hospital in Philadelphia and how they were using art in psychiatry. Suddenly it all came together and I thought, that's what I want to do! I didn't even have a name for it. It was simply that THAT was what I wanted to do! So I bundled up my portfolio, newspaper articles and such, and I went to the Christian Sanatorium in Wykoff, met with the director, Richard Rosendale, MD, told him about Hanhneman, asked him who is doing that kind of work here, and where can I go to learn?

"And he said, 'You're not going anywhere. You're going to stay right here. I'll introduce you to people who will be helpful, and you'll get all the information you need. You just come here. You will not work with the auxiliary volunteers, but in the occupational therapy department directly under me.'

"So I began my own educational process in familiarizing myself with how various disorders were mirrored in the art process. It was here that art therapy with mandala began for me."

"What was it like to be doing art therapy without knowing that this was what you were doing?" I asked.

"These were long-term patients. I didn't know anything. After each art session I would write up a formal report on each patient. And I would relate the art done that day to the previous time and maybe to the time previous to that, and I would look for a continuum. It became apparent that this form of communication was very direct. Some of the nurses began to think I was getting into the files because the intuition that resulted was like ESP and it would be very frightening to some people. 'How is she getting this information? She has no access to any of these files!' And I didn't know anything. I just knew I was connecting with the artwork. And it was teaching me. I wasn't imposing anything on it. It was a nonverbal form of communication and a gestalt about the total well-being of that person."

"And at that time you probably did not even know what the word 'gestalt' meant."

"No, but I learned later. My umbrella is art therapy, but I don't perceive myself as a therapist. I'm interested in the product and always have been. And what the product will do. You don't learn a lot about developmental stages from working with the product of chronic patients. For many patients merely to participate in art or occupational therapy may require various medications which may, in turn, interfere with expressed creativity. The highs are blunted. The lows are prevented. The patients are kept suspended. Again, I'm not a therapist. What I'm saying is that I'm interested in the product. If the medication interferes with the telephone through which I am communicating, it interferes with the product.

"Unfortunately, institutions may not encourage or even allow staff art therapists access or even input to the treatment team which usually consists of physicians and psychotherapists. The skilled sensitivity to nuances and subtleties in both color and form which the art therapist could bring to interpreting the state of a patient is thus often totally lost to the treatment team.

"To make matters worse the art therapist may not even be informed of the medication being used, and thus may find it hard to discriminate how medication may affect the art product. My interest is primarily in product, so this exclusion from the treatment team seriously impeded my own work.

"So I accepted an offer from the Psychiatric Department of St. Joseph's hospital in Paterson, N.J. where I could work with short-term patients who were not heavily medicated and who showed some progression and change in their continuum. It was during these three years in New Jersey hospitals that I began to amass the vast number of mandala drawings which would result in the concept of The Great Round.

"I would continue to gather many more after moving to Maryland where I was invited by Dr. Stanislov Grof to work as a consultant in the Art Therapy Research Project in the Catonsville, Maryland Psychiatric Research Center. But it was during those early years that I stayed awake at night for hours. I still have all the old scratch pads that I'd fool around with in the middle of the night trying to figure things out. By 1977 I had seen enough over time to know that I could divide all these people's drawings up into only 12 categories.

My heart skipped a beat. "You did what? Wait a minute! Run that past me again," I thought.

"When did it come to you that it was even possible to do such a thing? And what gave you the inspiration to divide up the vast myriad of possible pictures into groups?" I asked breathlessly. The cicadas droned their intertwining tales into the oppressive summer haze. A storm lurked somewhere down the Tidewater.

Joan paused and looked at me. Then she said, simply, "I could not imagine there not being order."

I thought of other great minds faced with the numbing enormity of new raw data, such as Mendeleev who, out of the vast morass of chemical facts, dreamed forth the genius of The Periodic Table of Elements, by which our understanding of nature at the atomic level is still interpreted. Or Newton who insisted on there being a law to explain the seemingly unrelated vicissitudes of gravity. Here I was in the steamy vintage sixties kitchen of an elderly woman whose husband was beginning to think about lunch and whose work could easily turn out to be of similar magnitude.

If what Joan Kellogg had discovered about human ideation was true, she may well have stumbled upon the schema for the hard wiring of the human mind. If this is so, and the 12 piles into which she originally divided the thousands of mandalas she had seen over the years bring forth and encapsulate all the attributes of the human brain, then every emanation of our brains, from childhood play toy to schemes for city planning, coming as it would from the same hardware, will bear unmistakable characteristics which can be traced back to the same mainframe architecture. Joan Kellogg, in her suburban kitchen, may well have given us a new way to understand the world, and us in the world.

The enormity of her discovery cannot be explained by the mere search for order, noble as that rational scientific trait is. After all, accountants search for order. Bean counters usually do not change mankind's understanding of the world. So I pressed Joan futher by chiding her about her claim to an ostensibly nonlinear mind, when she evinced such a heroic urge to order. She ignored my comment. But her eyes blazed as she unexpectedly launched into an extraordinary free association discourse on the nature of the categories, which she later came to refer to as the Stages of the Great Round. Thunder growled in the distance as a storm approached, and the closer it came, the faster Joan talked. Her voice lost the detached and almost military clip it had when discussing chronological events, and took on a broader register of tonality that ranged freely from rapture to chortle.

"Look here! Stage Two! [represented in Joan Kellogg's iconology by a Jackson Pollock-like plethora of floating bloblets]. This is where the Fertility Goddess lives. She is very busy there. That's where you have seeds. In other words we fructify ourselves mentally. I mean, that's a difficult concept to understand, but we do. This [Stage 12, depicted by a fountainlike image or a Fourth of July sparkler] is the Male Orgasm, and this [Stage 2] is the Female Orgasm. Between them lies Stage 1 at the bottom of the Great Round. It's the Beginning, the Void [represented by an empty black circle]. We fertilize ourselves in the deep unconscious, of course. We fertilize ourselves in the mind, the mind! So Stage 2 can be represented, for example, by pollen, as in the American Indian tradition, the Golden Seeds. Rice at a wedding, winnow-

BEST COPY AVAILABLE

ing wheat. See how many images the symbol I have chosen for Stage 2 can show you? It's the Blissful Receptive, the Ocean. Or the pagan goddess who loves frogs and snakes. In other words it doesn't say no, it just says, Yes!, Yes!, Yes! More!, More! More of living this, of being this! More. There's no judgment, as there is in stages on the upper side of the Great Round.

"Then this [Stage 12, represented by a gushing sparkler fountain] is an eruption of the mind, a new idea. Stage 11, immediately preceding this one [and represented by a symbol that looks like subway graffiti] is a terrible time of disintegration and chaos. Things have fallen apart. Writers and poets experience this particularly. 'Who am I? It's over. The book's done and now who am I?' And they go down and down and down and suddenly what happens? Miraculously they become inspired again. Look here, in Stage 12! In antiquity the 'creator god' was envisioned as a phallus who ejaculated his essence, emptying himself to create worlds of beings, and things. And the space of his activity was seen as a womb. That's how the world was made. And I think it's sort of basic, these two fructifying elements [in Stage 12 and Stage 2] on either side of Stage 1, the Void. There are many cultural images which sanctify the rejuvenating power of stage 12. Fountains, or for that matter, the Resurrection. Even that is basically physiological. Death and Resurrection may reflect physiological events—thus the early pagan worship of the phallus and awe at its spontaneous tumescence."

Joan looked out the window at the softly falling rain and mused, "What appears as closure in Stage 12, the explosion of new insight and inspiration, yields the seed of what is to come, a seed pod that travels its night sea journey to the emptiness of Stage 1 where it readies itself for insemination in Stage 2.

"So those are all metaphors for the way our consciousness works. They are true at a certain mundane level. Or taken as true in early attempts to explain how things happen. But they are still very, very much active in the mind. And nobody knows death and resurrection like an artist. They die daily. Have you ever met an artist on the street and said 'Oh, Jim I just loved that painting!' and he looks at you like you're crazy and says, 'You haven't seen what I'm doing now!' He has died to his progeny. That's dying well. Saying, 'I did it. It's gone. It's walking. It's in school. I don't have an umbilical cord on it. This one—the Now! That's what I think is important.' And he'll die to that one too. Just as gracefully as he died to the other one. So I think our role model for a healthy mind is the creative mind. Creativity, if conceived of as an emotional or mental pursuit rather than physical reproduction, could be described in terms of the pineal gland—an anatomical representation of the phallic impulse, inseminating the pituitary gland as womb. Thus creativity can be accomplished in one mind. This reverberates in the present exploration of the collaborating hemispheres of the brain. I think the Great Round of Stages is a fair reflection of the healthy life process."

"Religions have always said, 'Go forth and multiply.' Catholicism has taken that rather literally, but in the abstract perhaps they were on to what you were talking about," I offered.

"Of course you have probably not even read *Mandala: Path of Beauty*," she glared.

I was surprised at this sudden turn. In fact I had read her thesis submitted to Antioch for her Master's degree in Art and Psychology in Counseling in 1978, which was published in 1981. This was the seminal work in which her initial concept of The Great Round with its 12 stages was first presented. I sensed a resentful frustration at being broadly misunderstood, a theme I wanted to follow up on later, although I was sure it would surface again. But for the moment I was still under the spell of her lusty grasp of metaphor, a spell I did not want to break. So I assured her I had indeed read it and went on as if nothing had happened.

"It's interesting that Stage 2 could also be viewed as inchoate matter, space gas, the raw material of the universe, while in Stage 3 [represented by a pinwheel-like icon] there begins a swirling such as one finds in galaxies, and in Stage 4 [represented by a homuncular form] the swirling has condensed into an actual planetary body," I offered.

"If you are into energies, which I never got into, you can very easily connect these Stages to a theory of matter. This is not my field. I'm not a physicist. I don't pretend to be one," she snapped, apparently not satisfied with my dodge. But she couldn't resist adding, "But in Stage 1, the Void, you can connect the heaviness, the inertness, the density of the condensed matter. . . ."

"Like the Black Hole, where matter is so dense that gravity falls in upon itself!" I added.

"And in catatonia, where you take up the least space, rigid. All that feeling of metal, lead. And then in Stage 2 you have the spilling forth of all these stars. . . ."

"Like the Big Bang!"

"Yes, absolutely, absolutely; it's the same. Incidentally, on a cellular level certain shining bodies which manifest themselves in the multiplication process are called asters, stars."

"Is it true that every Stage has a flip side, so to speak, a negative aspect for a positive aspect? Is there a kind of yin/yang dualism in the universe which your Stages reflect?" I asked. I had already been warned that Joan does not always

answer questions in so many words, and so it was with her response.

"Take Stage 1 [the Void, represented variously in Joan's iconology by a black circle or a weblike structure.] You're talking about the egg, about insemination. The egg is coming down a thread, just like a spider, and it's going to latch onto the uterine wall. Now if there's any problem there—the uterine world is a participatory universe—when that egg comes down, the wall also reaches out and grabs it, and if it doesn't, if it does not welcome the egg in some way and the egg is left—'Oh my God! I don't belong in this world. I have been cast out. I have been orphaned!' Such people dream dreams, they read children's fairy stories, and they are always the abandoned one. The roots go back that far. It's a biological memory of not being wanted. Of hanging on for nine months by your fingernail. It's a terrible burden. It has nothing to do with your father or your mother and who hit whom. It's your biological memory of not being enveloped with universal warmth—a wonderful place—but of hanging there like a clock! And nothing's coming up. Nobody is meeting your train. It's a horrible experience. So many alienated people have had an experience like that."

"I think I know about the flip side of Stage 2. Maybe it's the imp of the perverse in me, but when you were talking about the multiplicity of stars in Stage 2, I was thinking about a box of dead fish I saw at the South Street Seaport. As I walked past I noticed that the entire cardboard box was seething with maggots . . . ."

"That's right. Maggots are also very much Stage 2. Even death is fertile. Oh, it's so fertile! And then you have the dissociation of 2. When you're just falling all over the place, you have no boundaries, and you're fearful of engulfment. That's a negative 2, the one you run into with the fecundity of swamps and flies, and all these voices. Every culture has figured out how to correct the worst of it by exorcism. That's pretty incredible, you know, that no one has ever taken this seriously. The doctors will say, 'Well, they're just real bad schizophrenics.' Guess what! They get exorcised and they're back at work and their marriage is working and everything is fine a week later. What happened to the schizophrenia? Nobody ever asks."

"They don't dare," I ventured.

"That's right, their whole world view would change. We're dealing here with the transpersonal. Transpersonal, of course, is in the world of archetypal realities. It's a world of shamans and holy men, and some women have been privileged to know about it. And what little I know about it would convince me that it is a totally different level we're talking about. Our mistake is in our inability to address both worlds in treatment. They should be integrated because they were artificially sliced apart anyway—at one time the medicine man was also the spiritual director. Well we started to professionalize things and we split them apart."

"The witch doctor was both a priest and a doctor."

"Absolutely. Just as Einstein said, "Energy and Matter are the same thing. When you slice them apart you've got a whole new can of worms."

Joan suddenly pulled back, perhaps afraid that our free floating conversation would look ridiculous in print, and added, "Remember, I'm not too smart. I'm not an intellectual. I was just working from what I know. There's so much you can't talk about. This is a very mundane, practical subject, this art therapy stuff. Art therapists don't get into this, because they work for the Recreation Department. They're not supposed to develop ways of looking at the world. They're not supposed to think. Which is pretty limiting. And if an art therapist does discover something new about the world, she's not allowed to talk about it. There's a masculine initiative we don't have. We don't go into the hospital and say, 'This is what I want to do. Sign here and please see that all the schizophenics are sent to my office.' Instead we stand and salute. Meantime the other professions are dividing up the spoils. This one is getting funding for this, and that one for that, and the art therapist is left standing in the hall wondering what happened because no one taught her what to do. And, alas, many of us are not Nancy Drew. No curiosity."

We had returned to her dissatisfaction with a vengeance. I knew we would have to deal with it, but I was not ready yet. I wanted more poetry, more amazine connections, more of that versatile mind that could jump from idea to idea like a lithe young boy crossing a rocky stream. I hoped I could deflect her into her funny rapturous reveries again.

"When you first developed the concept of The Great Round, you posited 12 Stages. And with one glaring exception, you have never varied from that number," I said. "What made you designate the 13th Stage? And why?"

"I found that all the mandalas I saw over the years could be classified as reflective of one of the 12 Stages. Sometimes a mandala incorporated aspects from two or even three Stages, but there were never any surprises, except for Stage 1. Certain mandalas which initially appeared as Stage 1 evinced a luminous quality which was beyond the concerns of Stage 1. Beyond and yet before. So I created Stage Zero, and placed it at the center of The Great Round. Stage Zero dealt with something that was not personal. It transcended the personal. Psychology didn't really hit it. It hits the others. But when you get to Stage Zero psychology has nothing to do with what's going on there. It's more like that's a place from which you witness your own life. Part of you lives there anyway and witnesses you going around The Great Round again. And it kind of makes jokes every now and then, like 'Oh God! You're doing it again! Kind of cosmic-y jokes. This is the part of us that is transcendent, that knows life is a game, but that is not really caught up in the game. And to us it's home. And people who have been imprinted very hard in Stage Zero are forever homesick. You can't fix it. And you just gotta tell them, look, you're just homesick! Do you 'remember' a place the expectation of which nothing in this world has ever come up to? Yeah? Well, you're homesick for it."

"A kind of cosmic home," I suggested.

"Yes, exactly. And it's the part of you that says everything is okay. I mean, my teeth are rotting, I have b.o., I caught cancer yesterday, and my hair is all turning white, but, you know, it's really all okay. And mean it. It's from that kind of place that this comes. I added Stage Zero in 1984, and called it Clear Light. For a while I did not want to call it a Stage at all, since it represents the ultimate mystery and because, in a sense, it represents no mandala at all. However, it symbolizes an absolute point, mind, or state of consciousness which we take to be the origin and end of all form. It is the empty void, or the Plenum, the Nirvana principle of Eastern psychology, the state of pure mind beyond every conceivable duality. Beyond light and darkness, form or no form, beyond time and space, beyond concepts and logic. It has no beginning and no end. It is conceived as the very ground of all existence. It is the ultimate aim, psychologically and experientially of both the Western and Eastern mystic."

"I can see why the average art therapist finds you a bit hard to take," I said. What the hell, I thought. We might as well get it over with. "In fact," I added, "from a scientific point of view, Stage Zero is a hard pill to swallow. Let's face it. This is pretty controversial stuff."

"That's why I rarely discuss it. Stage Zero is the most controversial, but it is also the most important. Yet, except for one paper I wrote with Dr. Francesco Di Leo, I never mention Stage Zero. Not one word. Because it doesn't have its place in an art therapy course. If it were a conference on religious and scientific interfacing, it would be another story, depending, of course, on the maturation of the crowd. Most of the art therapists are so young. I am not a saint or something to the young art therapists. I don't even know them. I don't go to the conferences. I don't have a great deal in common with them. I am no model. I am a maverick. I was always just slightly beyond the pale. I was not academic. I was strictly clinical. I came up through the hospital, sanitarium, drug research center, not the Ivory Tower. I'm like a flyer who learned to fly by the seat of his pants. I never went to school for it."

Joan Kellogg was granted membership in the AATA via a grandfathering clause in 1974, since what she had already been doing in the field predated the founding of the AATA by quite a few years.

"Then I committed the ultimate crime of going to Antioch and getting an MA in Psychology rather than in Art Therapy. I was neither fish nor fowl. I had no sorority. It was all experience. Run by me. I didn't have any boss over my head. I was the boss and also the cleaning lady. I was independent and I did what I wanted. At Antioch we attacked all the taboos. We played hardball. There was passion, interest, enthusiasm. Passion is usually bled out of graduate school. Art therapists have their own agenda; I don't know, sticking silver foil on paper or something. 'It's a great tool. We will show you how to do it. You cut it up and you glue it. Oh, it's wonderful and you get the whole family involved.' And I think, 'OH GOD! DELIVER ME!!!!!'"

"It strikes me that in this field what you are faced with is that you are a mystic who is being shot down by a bunch of clerics."

""Hah! That's cute! I like that. But there is no use putting them down. This mandala thing was born in the wrong building. Not that it will be accepted anywhere else either. I mean, I don't think the average linear psychologist could have dealt with it any better. Study of The Great Round involves symbols which have to do not only with culture but with profound psychological and emotional issues. I deal with them in an irreverent yet passionate way. Ultimately, I salute reverence. This stuff is genuinely transcendent. Talk about the Grail! I mean, man, you are there! People can catch that! They can get a glimpse! They want more of this because they know it is of ultimate importance. That is very upsetting to academics. Our academic world is interested in technique. They remind me of missionaries who want to cure the natives without loving them. People are whole beings, with a spiritual side as real as their material side. But don't for one minute assume I'm just some New Age nut. You asked me what inspired me or what kept me on the trail, so to speak, of trying to develop Order out of Chaos. I couldn't believe it was my magical insightfulness without there being an underlying order that I just happened to trip over. If I was right, then it needed to be researched. And I realized that it's very difficult to do research with mandalas. They are too soft. By that I mean they are too subjective. There has to be a better way to do this, more scientific. And that's why I developed the MARI cards."

MARI stands for Mandala Assessment Research Institute, a legal entity which Joan established to encompass the development, production, and appropriate use of the MARI cards as a testing tool. They currently consist of three translucent plastic symbol cards for each Stage, for a total of 39, as well as 38 color cards and two foil cards. The subjects are asked to choose five symbol cards and place them on color or foil cards in descending order of preference. They are often asked to draw a mandala at the same time, but it is this constellation of card/color combinations which represent the raw test result data. Since the cards and colors are standardized, the subject's choices can be accurately compared to the choices of other subjects and compared to the results of other standardized tests. The MARI cards constitute a method of rationally organizing and representing the information and connections embodied in The Great Round.

"What is the primary function of the MARI Card Test in today's world?" I naively asked.

"It has two major uses. Personality assessment in therapy and use as a standardized test in group studies intended to advance a particular scientific theory or proposition. The MARI Card Test is a superb research tool."

"So despite the discomfort some may feel in dealing with The Great Round, the MARI Card Test offers something beyond a belief system. It's eminently quantifiable," I suggested.

"Everything is numbered or initialed so it can be easily stored in a computer. We're not talking about subjective or impressionistic kinds of things. When we use the cards we're using scientific methods. I did what I set out to do, which was to find the order in what appeared to be randomness. And I've developed the instrument to measure that order. I found that I could teach it to others. I developed the instrument as a research tool and as a tool for use in therapy, an effective means of communication between client and therapist. There will be something beyond this. Everything transforms itself, including card tests. It may be around for fifty years—that's likely—but it will transform itself into something else, just as the mandalas transformed themselves into cards. But I do think we have an instrument that is worthy of being offered to scientific study and research, and I think it will add something to what is already there. I don't think it is the universal test. No test is the universal test. But it comes close because of its nonverbal nature. You can take it into any culture or subculture. I think that is very attractive."

"What does one discover or measure about someone else in administering the MARI Card Test? Can you spot suicidal tendencies? Can you spot a compulsive personality, the traces of multiple personality disorder, manic depression, schizophrenia, the evidence of child abuse?"

"Mandalas done by subjects with specific disorders are frequently consistent with these disorders, as perceived by art therapists, but diagnosis is more likely to be accurate when performed by a therapist familiar with a particular disorder. Of course, diagnosis of specific emotional disorders is dependent on the competency of physicians or licensed professionals, based on interviews, history, and behavior, plus tests of one kind or another. Our knowledge of the use of the MARI Card Test has expanded exponentially since its inception. What we lack is independent research to verify what we have already observed and publications to spread the word. We also lack a spectrum of observations on the MARI Card Test results with healthy populations. We all have repertoires of card choices. Unless you have a roaring headache, there are some card/color combinations you would never pick outside your normal repertoire of states and experiences. We all have our repertoire of states of consciousness which we visit often, and maybe only one or two which we would choose to visit voluntarily only under the direst of circumstances. The sick, on the other hand, have a very small repertoire, depending on the illness."

"Can I assume, then, that the healthy person travels The Great Round many times during his life and perhaps. . . ."

"During the year, during the week! But in different octaves, if you will."

I added, "For example, the coming to the end of something, evinced by Stage 11, Disintegration, could be the end of a love affair, the completion of a project, coming to the last page of a great book, the closing night of a play, or even the presaging of your own death—the same note but in different octaves, right? Maybe that is what is meant by saying, 'We die a thousand deaths.'"

"Yes, and your choice of MARI Cards will reflect each of those in slightly different ways depending on what colors you choose with Stage 11 and what other Stage/Color combinations you choose at the same time."

"It strikes me that to read the results of a MARI Card Test takes a certain amount of training. How do you insure that inept neophytes such as myself don't misuse the instrument?"

"That's where ATMA comes in. The Association for Teachers of Mandala Assessment. In 1989 I signed a contract with a group of nine people who had taken a number of my courses and wished to spread the word about MARI Cards. I gave the new group the power to accept and set requirements for new teachers. I gave them the power to structure the content of the course. They still teach the course in a 30-hour format over an intensive four-day weekend, designed to create a kind of sensory, experiential, and intellectual overload."

"I understand that your life has centered around the research, the development, and the teaching of your theories. Which area has given you the most satisfaction and in which have you experienced the most success?"

"I guess the ability to teach what I have learned. Without the exhaustive research necessary to document statistically the correlations and significance we have discovered in our practices, we must learn to trust our intuition more. That is often an anathema to psychologists, but it is like asking mother, 'How do you know the stew's ready?' She's been making stew since year one and she knows when it's ready. If you ask a linear person he'll give you an answer in hours and minutes, but mother will say, 'Well, it's just going to feel a certain way when you stick the fork in.' It's process orientation as opposed to 50-minute hours. Not only does the factual information have to be transmitted from the teacher art therapist to the student art therapist, but this change in attitude also has to be conveyed to make this work."

"Have you ever considered yourself a healer?"

"No, not at all. My goal is understanding, not healing. I'll leave that to those nurturing souls who deal directly with patients. I only interact with art products. If in teaching about this any healing happens, it is due to personal insight gained by the student. Of course I am interested in the personality related to the product. That is central. I think, as a matter of curiosity, I am more of the mediumistic receptive personality, which is different from someone who sends rays out. I'm just a bowl who takes it in."

"Where is mandala theory and the MARI Test going now?"

"Training, practice, and research must all go on simultaneously. It's not enough to say that you are doing something. You have to know if it's working, and only research will show you if you are really accomplishing something or if you are just whistling dixie. We art therapists have to tell the institutions we are working for that we want to do a particular project. We are perfectly empowered to do that; it's just that a lot of us have not grasped that if you work for an institution, that is the umbrella under which you thrive, and if it means that you will thrive by doing necessary research you will, in turn, help the institution. So apply! Why not? If it is not a profession, then we might as well pack up our things and go home!"

The sun sloped in through the early evening windows and glistened on the storm-soaked leaves. "I don't have to climb another mountain. I've climbed this one. I've done the best I could, and I am quite ready to leave the Teachers of Mandala Assessment with my work. I've taken it as far as I can take it. They must take it from here. That requires that they really begin to start thinking in terms of grants, funding, and serious scientific studies which will document what we have already found out and what we are still continuing to discover. Seventy years! Enough already! I am ready to say, 'Here's what I've done. I'm proud of it. Take it from here!'" *As the sun began to sink through the swirling lowland mists, Joan Kellogg looked at me and said, "I'm happy."*

BEST COPY AVAILABLE

Brief Reports

American Art Therapy Association, Inc. 1992–93 Membership Survey Report

Gwynne La Brie, BA, Emporia, KS, and Cindy Rosa, MA, A.T.R., LPC, CAC III, AATA Membership Chair, Denver, CO

Abstract

Since 1988, AATA has sent out a biannual survey every other year to all its members along with annual membership dues. The survey consists of a variety of questions dealing with different aspects within the field of art therapy and AATA membership. Over the past years, changes have been made within the survey, but the overall information requested has remained the same. The survey asks that members provide information regarding their areas of specialization, populations, major activities, salary, and optional demographic information. The information collected from the returned 1992–93 survey is presented in this article, and a general graphic picture of the field of art therapy and AATA membership is provided.

Since the American Art Therapy Association's development 25 years ago, the field of art therapy has continued to change and grow. It has become an increasingly recognized field in the area of mental health, and there are now more art therapists employed not only in the United States, but in the entire world. Also, more art therapists are employed in a variety of settings, and overall AATA membership continues to grow.

In 1992–93, AATA mailed out a demographic survey to all members along with a billing for annual membership dues. The survey included questions pertaining to employment, specialization, types of populations, and optional demographic information. Over 3,000 surveys were sent out, and a total of 1,988 surveys were returned. The information collected from these surveys is presented in this report with a summary of both the practice of art therapy as well as the status of AATA members.

As seen in Table 1, there has been an increase in total AATA membership from 1991 to 1993. These statistics show an 18.4% increase in membership from the last survey in 1990–1991. The most notable increase occurred in the number of Professional A.T.R.s. This membership category was the only group that increased significantly, while the majority of the other membership groups decreased or did not change at all.

Table 1
AATA Membership

MEMBERSHIP	07/31/91	05/31/93	INCREASE	%
TOTAL AATA MEMBERSHIP	**3492**	**3777**	**285**	**18.4**
PROFESSIONAL A.T.R.	1893	2296	403	21.2
PROFESSIONAL	182	151	N/A	N/A
ASSOCIATE	747	674	N/A	N/A
STUDENT	605	591	N/A	N/A
LIFE MEMBER	15	15	0	0
HON. LIFE MEMBER	13	14	1	7.6
CONTRIBUTING	9	8	N/A	N/A
RETIRED	28	28	0	0

Table 2
Respondents' Educational Degree

DEGREE	1990-91	%	1992-93	%
MASTER'S DEGREE	1335	81.8	1598	82.8
BACHELOR'S DEGREE	186	11.4	212	11
DOCTORAL DEGREE	111	6.8	92	4.8
ASSOCIATE/CERTIFICATE	5	0.3	15	0.8
OTHER	92	5.6	6	0.3
NONE	35	2.1	N/A	N/A

In looking at the educational level of survey respondents, Table 2 shows that the Master's degree continues to be the most often reported level of education; however, those who responded with Bachelor's degrees often stated that they were currently working on their Master's degree, and a small majority of respondents with Master's degrees indicated that they were currently candidates for a PhD program.

Areas of Specialization: As noted in the 1988–89 and 1990–91 survey, the specialties listed by AATA members reflect current trends in mental health as well as other areas where art therapists are employed. The first three areas reported as specializations are included in Figure 1, however, these figures may be an underestimation of actual specialization. Many respondents selected anywhere from 3 to 10 or more areas, but survey instructions indicated that they list them in order of most frequent to least frequent. Therefore, Figure 1 shows the first three most often selected.

In selecting area of specialization, many respondents chose the category of "other." The most frequently listed areas written in were women's issues, depression, hearing impaired, intercultural, education, sexual offenders, children at risk, homeless, oncology, and juvenile detention.

Primary and Secondary Work Settings: Figures 2 and 3 show only the first setting selected for both primary and secondary jobs. As illustrated by the figures, there appears to be a diversity within job interests as well as employment.

Population Types: In Figures 4 and 5, only the first two populations listed by respondents are displayed. Respondents, however, often listed anywhere from three to seven different populations.

Age of Population: Figure 6 shows the age ranges of clients with whom respondents work within their primary and secondary jobs.

Major Job Activities: Figures 7 and 8 illustrate the major activities that respondents perform within their primary and secondary jobs; and only the respondents' top three major job activities are displayed.

Salary by Job Title: This question was answered by 1,510 for a primary job and 594 for a secondary job. Often those who did not respond indicated that it was a personal question and, therefore, left it blank. Tables 3 and 4 show the breakdown of salary into $5,000 increments for primary and secondary job titles.

Figures 9 and 9a represent the respondents' salary ranges broken down into hours worked each week for primary jobs and Figures 10 and 10a show the ranges for secondary jobs. So that the information can be clearly represented and understood, two figures are presented for both primary (9 and 9a) and secondary (10 and 10a) jobs. The two figures for each job category show the same information broken down in two ways.

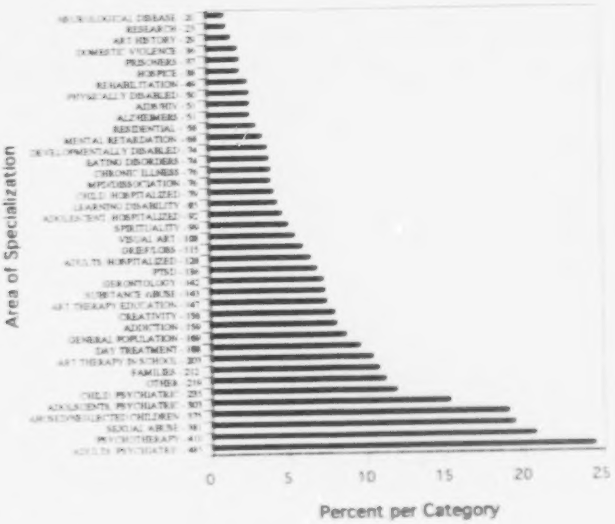


Figure 1. Areas of Specialization

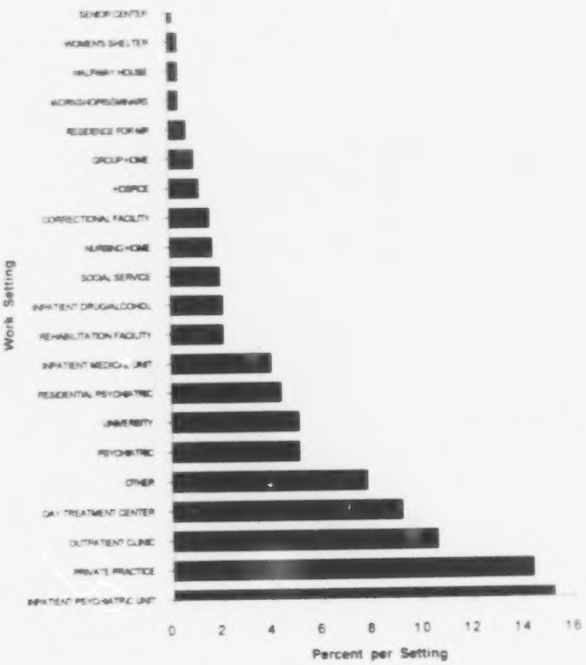


Figure 2. Primary Work Setting

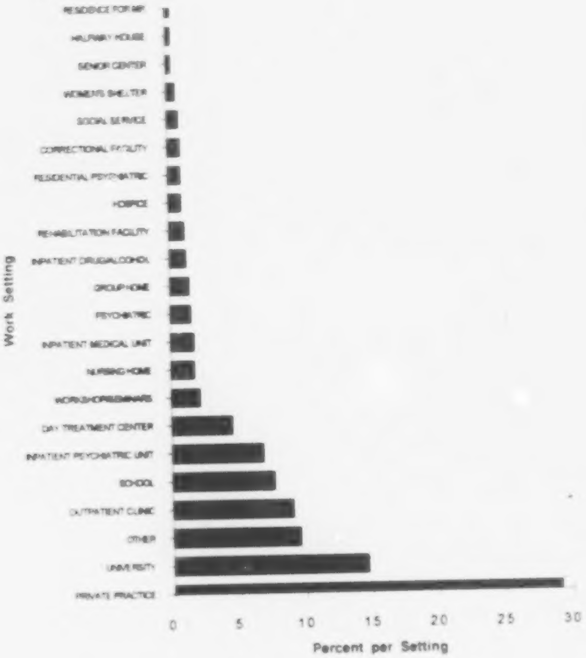


Figure 3. Secondary Work Setting

BEST COPY AVAILABLE

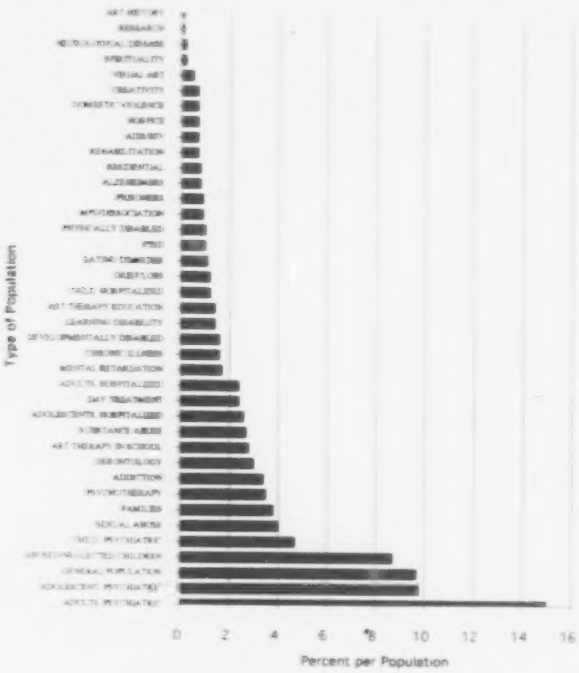


Figure 4. Populations of Primary Job

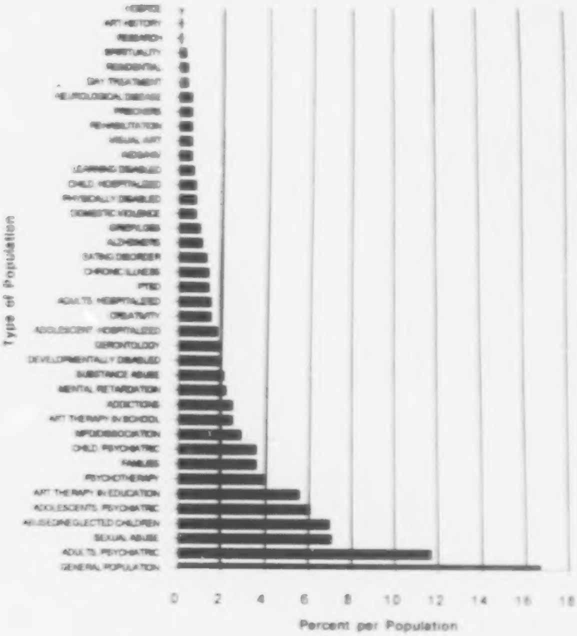


Figure 5. Populations of Secondary Job

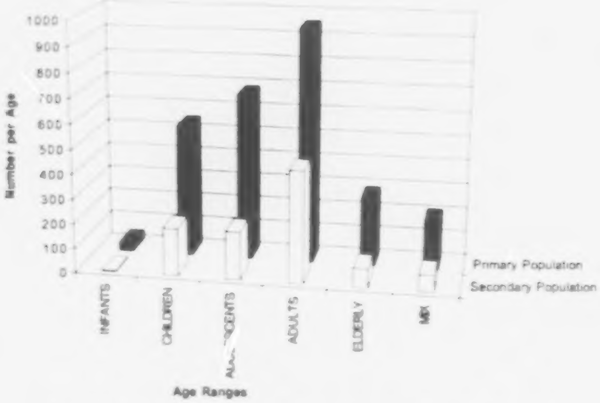


Figure 6. Ages of Populations for Primary and Secondary Jobs

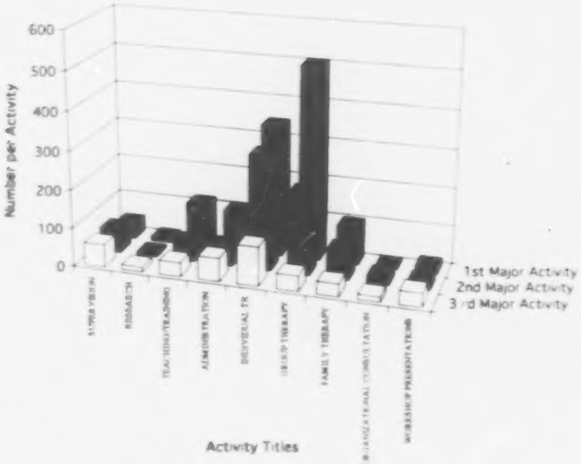


Figure 7. First 3 Major Activities of Primary Job

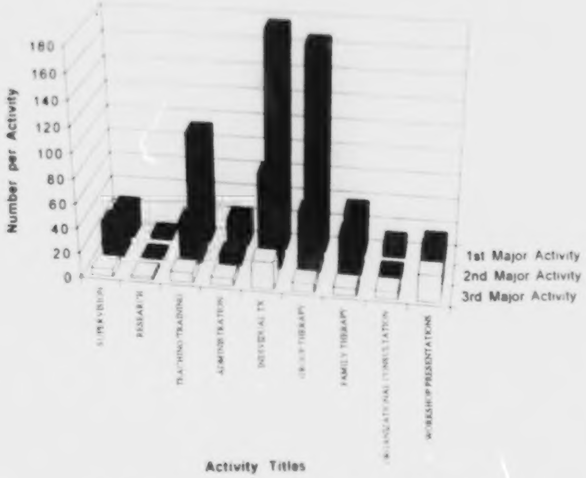


Figure 8. First 3 Major Activities of Secondary Job

Table 3
Detailed Summary of Salary by Primary Job Title

Salary Range	Job Title											
	Director		Art Therapist		Consultant		Counselor/Clinician		Mental Health		Other	
	#	%	#	%	#	%	#	%	#	%	#	%
<10K	2	1.7	78	10.5	6	19.4	11	5.0	1	3.7	51	13.7
10-15K	3	2.5	82	11.1	7	22.6	18	8.2	6	22.2	28	7.5
16-20K	2	1.7	98	13.2	4	12.9	30	13.7	4	14.8	34	9.1
21-25K	9	7.6	129	17.4	4	12.9	35	16.0	5	18.5	40	10.7
26-30K	21	17.8	134	18.1	2	6.5	40	18.3	6	22..2	62	16.6
31-35K	28	23.7	128	17.3	2	6.5	44	20.1	1	3.7	45	12.1
36-40K	23	19.5	55	7.4	1	3.2	19	8.7	3	11.1	49	13.1
41-45K	10	8.5	13	1.8	1	3.2	5	2.3	--	----	28	7.5
46-50K	9	7.6	11	1.5	2	6.5	4	1.8	--	----	19	5.1
>50K	11	9.3	12	1.6	2	6.5	13	5.9	1	3.7	17	4.6
Total N	118		740		31		219		27		373	

Table 4
Detailed Summary of Salary by Secondary Job Title

Salary Range	Job Title											
	Director		Art Therapist		Consultant		Counselor/Clinician		Mental Health		Other	
	#	%	#	%	#	%	#	%	#	%	#	%
<10K	6	46.2	159	58.2	32	58.2	34	40.5	--	---	105	63.3
10-15K	2	15.4	48	17.6	8	14.5	18	15.4	1	50.0	26	15.7
16-20K	2	15.4	20	7.3	2	3.6	13	15.5	--	---	13	7.8
21-25K	1	7.7	13	4.8	4	7.3	6	7.1	--	---	6	3.6
26-30K	--	---	4	1.5	2	3.6	5	6.0	--	---	3	1.8
31-35K	--	---	13	4.8	1	1.8	4	4.8	1	50.0	7	4.2
36-40K	--	---	6	2.2	4	7.3	1	1.2	--	---	5	3.0
41-45K	--	---	4	1.5	1	1.8	1	1.2	--	---	1	0.6
46-50K	2	15.4	2	0.7	1	1.8	1	1.2	--	---	--	---
>50K	--	---	4	1.5	--	---	1	1.2	--	---	--	---
Total N	13		66		55		84		2		166	

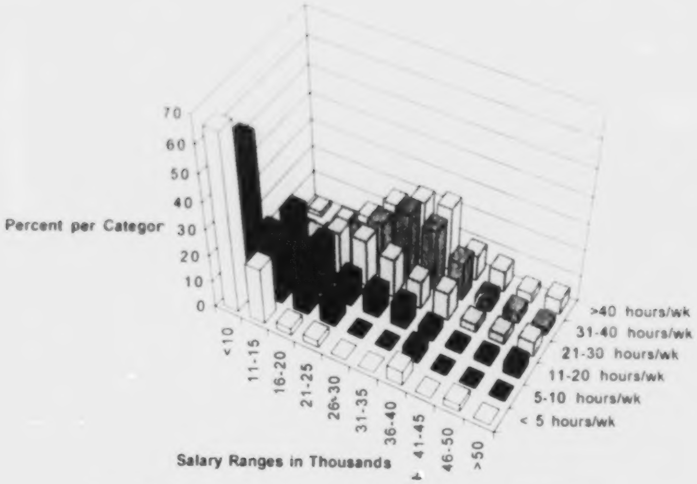


Figure 9. Salary of Primary Job by Hours Worked Each Week

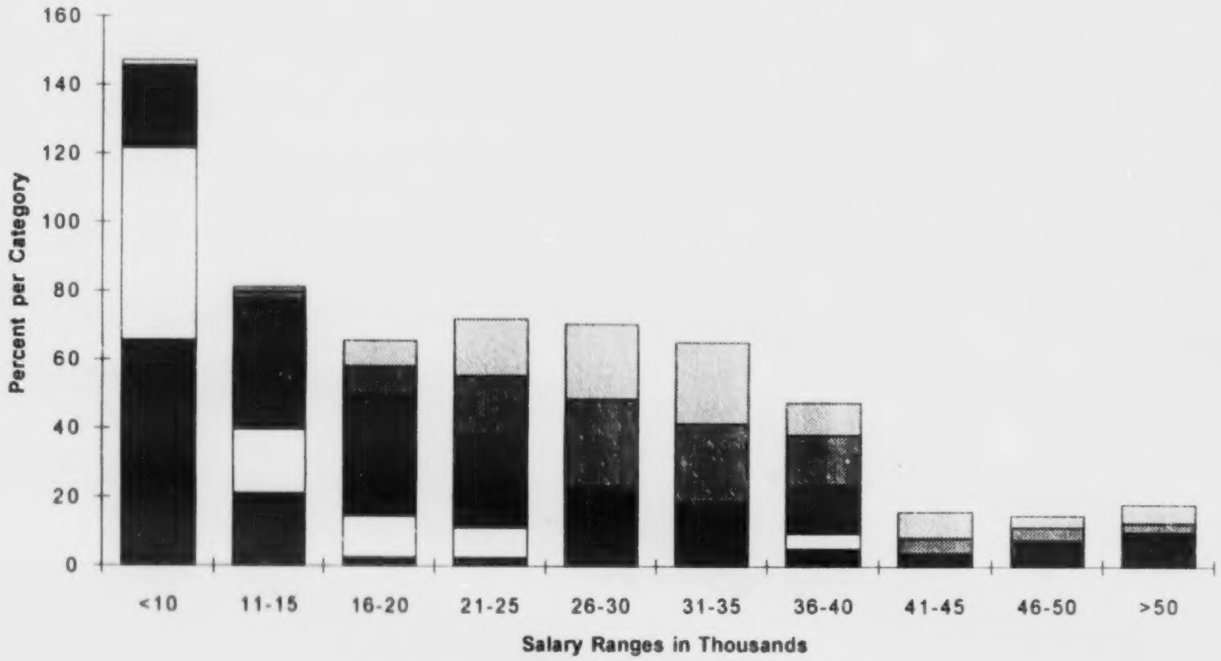


Figure 9a. Salary of Primary Job by Hours Worked Each Week

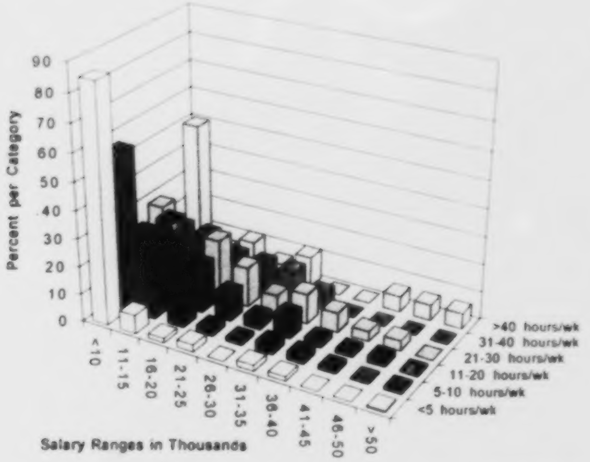


Figure 10. Salary for Secondary Job by Hours Worked Each Week

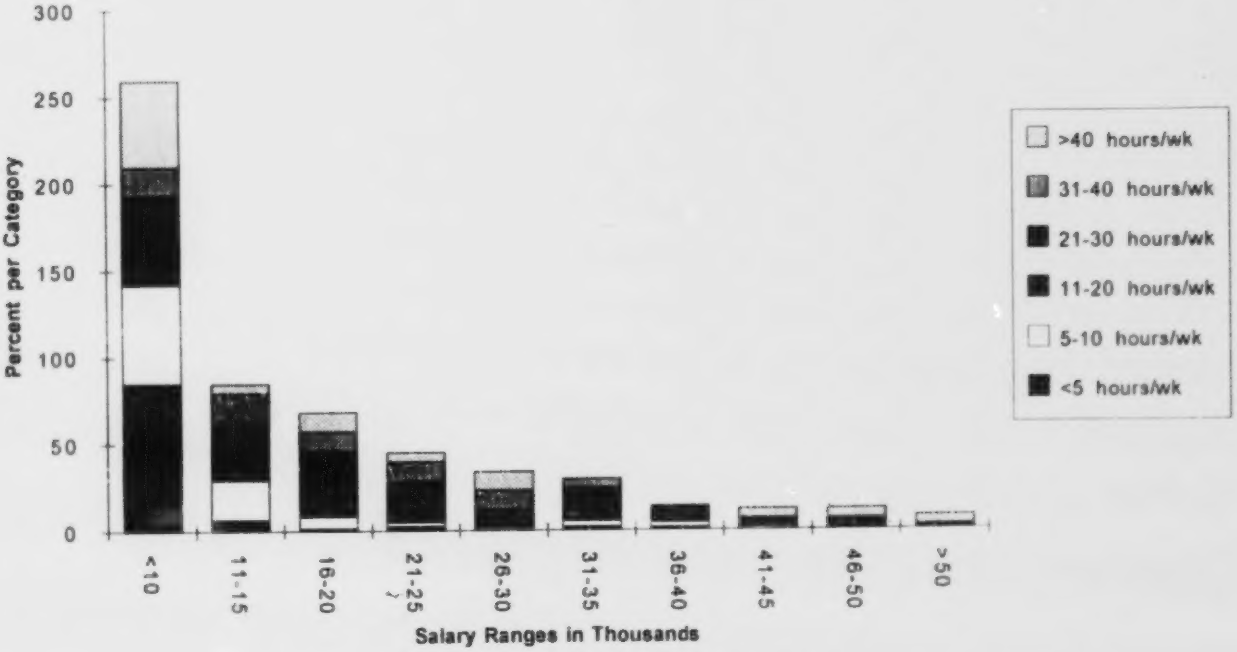


Figure 10a. Salary for Secondary Job by Hours Worked Each Week

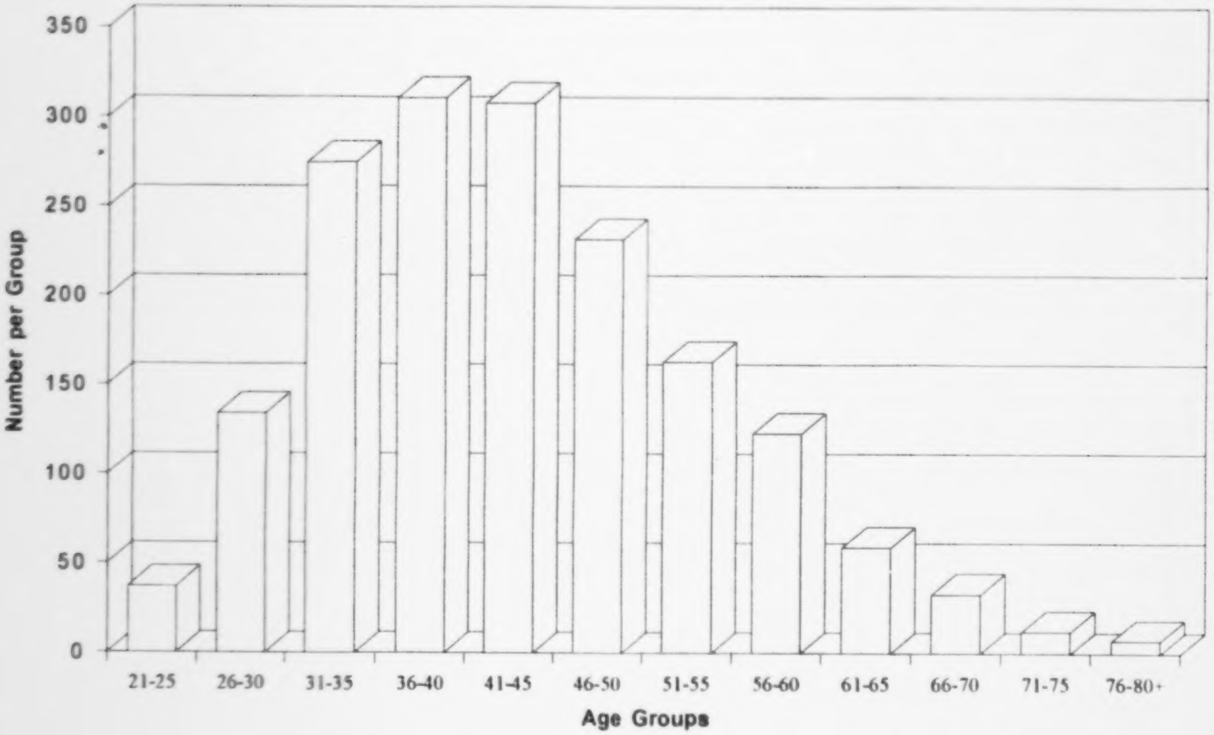


Figure 11. Age of Respondents

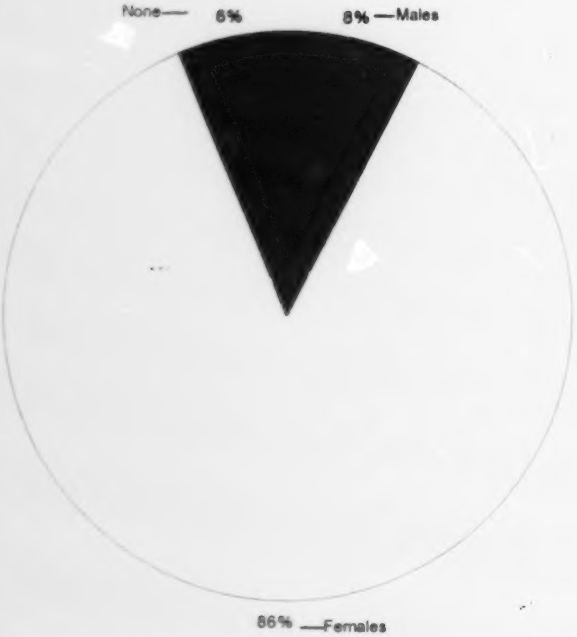


Figure 12. Gender of Respondents

Age, Gender, and Ethnicity: The background information of each respondent was optional. for this reason, some did not fill in this portion of the survey. Figure 11 provides the information concerning the age distribution of respondents of AATA. Figure 12 provides data concerning the gender of AATA members, and Table 5 shows the ethnic background of respondents.

National and International Membership: Illustrations A and B give the breakdown of AATA members nationally and internationally.

Table 5
Summary of Racial Background

	1990-1991		1992-1993	
RACE	#	%	#	%
AFRICAN AMERICAN	10	.6	33	1.9
ASIAN AMERICAN	10	.6	14	.8
CAUCASIAN	1512	92.6	1642	93.6
HISPANIC	13	.8	25	1.4
OTHER	28	1.7	40	2.3

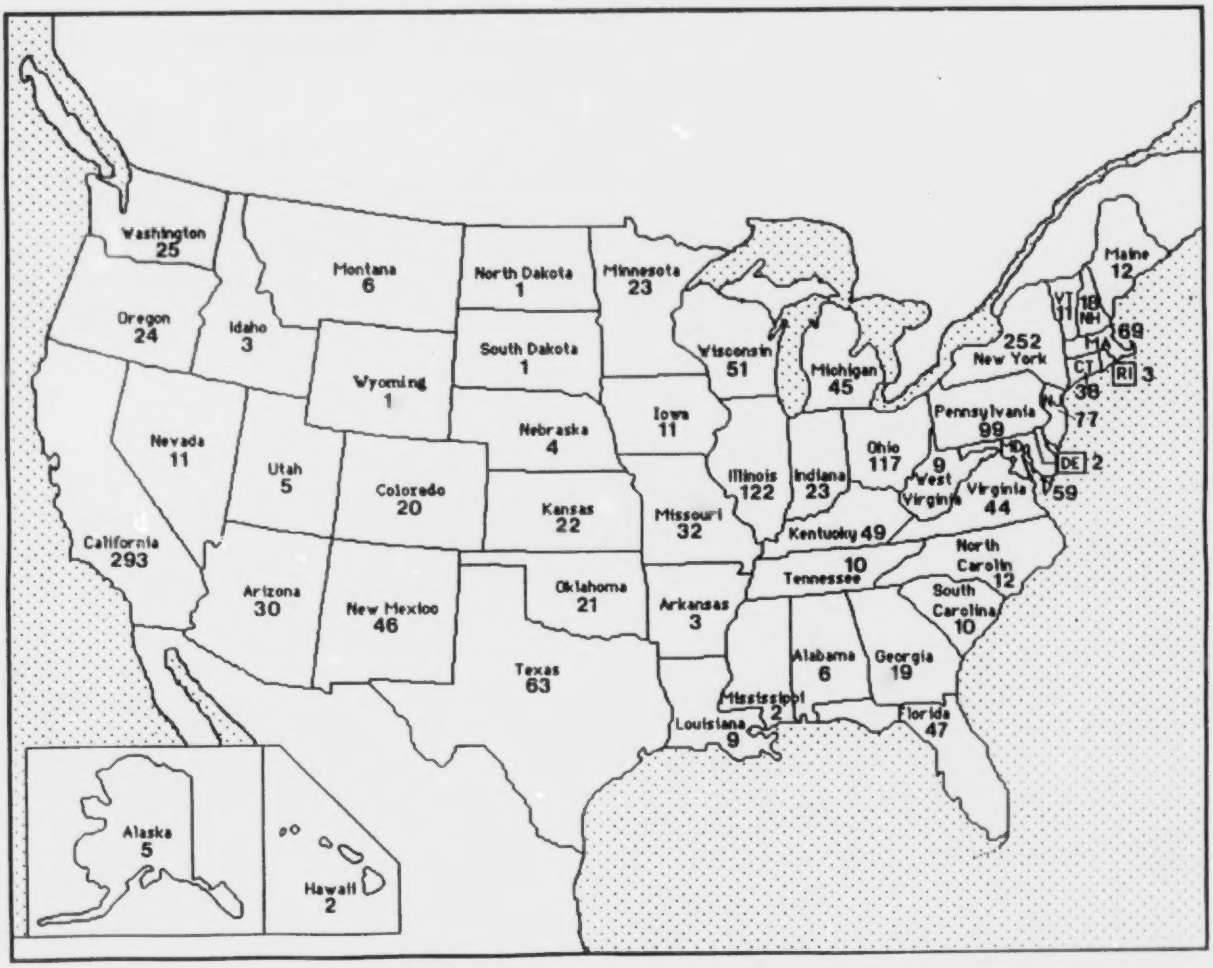

Washington
25
Montana
6
North Dakota
1
Minnesota
23
Maine
12
VT
11
18
NH
69
MA
Oregon
24
Idaho
3
South Dakota
1
Wisconsin
51
Michigan
45
252
New York
CT
RI
3
38
77
Wyoming
1
Nebraska
4
Iowa
11
Pennsylvania
99
Nevada
11
Utah
5
Colorado
20
Illinois
122
Indiana
23
Ohio
117
9
West
Virginia
MD
DE
2
59
Virginia
44
Kansas
22
Missouri
32
Kentucky 49
California
293
Tennessee
10
North
Carolin
12
Arizona
30
New Mexico
46
Oklahoma
21
Arkansas
3
South
Carolina
10
Alabama
6
Georgia
19
Texas
63
Mississippi
2
Louisiana
9
Florida
47
Alaska
5
Hawaii
2

Illustration A: AATA U.S. National Membership

Australia	2
Austria	2
Canada	45
France	2
Germany	6
Israel	4
Italy	4
Japan	3
Netherlands	1
Norway	1
Scotland	1
Spain	1
Switzerland	4
Taiwan, ROC	1
United Kingdom	1

Illustration B: AATA International Membership

Viewpoints

A Note on Ethnicity in Humor and Art Therapy

Christina Mango-Hurdman, MA, A.T.R. and
Joseph Richman, PhD, Bronx, New York

In an earlier study (Mango & Richman, 1990), we describe the therapeutic effect of humor assignments during art therapy with a heterogeneous group of psychiatric inpatients. Both the art and humor productions expressed the patients' isolation, impaired interpersonal relationships, and the pain of mental illness. The participants valued the group because they could share these difficulties and problems and because the combination of modalities amplified the social cohesiveness of the group.

Art Therapy Group

Art therapy group treatment with African American or Hispanic patients was conducted by the senior author, a Caucasian woman. The patients were in the discharge phase of treatment and remained in this group for up to six months. The average group size was six patients. All patients had been treated in a variety of different groups, including open-ended art therapy where they could create whatever they chose. In this study, topic (theme-based) art therapy is used; the therapist presents a theme and patients respond with a drawing. Meetings were held once a week and every other week the topic was humor.

In the humor group, patients first tell jokes as a warm-up procedure. Provided with pencil and 9 × 12 white drawing paper, they are asked to draw something funny that happened to them or to someone else, or to make up something funny. Following the task, they display and share their work through discussion. The therapist never tells jokes nor directs the content of the patient's humor. "Ethnic" humor emerges spontaneously from the patients.

A 27-year-old African American dual-diagnosed schizophrenic and polysubstance abuser spontaneously told the following joke.

> There was a white guy, an Oriental guy, a black guy and a haunted house with a room for rent. The white guy goes to see the room and hears, "I got you, now I'm going to eat you!" He runs away. Next, the Oriental guy goes to the haunted house to see the room and hears the same thing. "I got you, now I'm going to eat you!" He becomes afraid and runs away. The black guy goes to see the room and he too hears, "I got you, now I'm going to eat you!" He says, "Let me investigate," then turns on the light and sees a little boy sitting in the corner, picking his nose, saying, "I got you, now I'm going to eat you!"

In contrast to the white and Asian, the black man is depicted as superior because he does not run away. By overcoming fear he shows there is nothing really to fear. This is a counterphobic joke pointing to the joke teller's desire to master the situations she fears. The joke also depicts an oral fantasy of taking in bad food or "snot."

The personal implications behind this joke are striking. The patient had been abandoned by her mother, who also was a substance abuser, and raised by her grandmother. During a chaotic childhood, the patient became prematurely autonomous, feeding herself. Following in her mother's path, she is also a substance abuser. The patient abuses coke, "feeding" her head by snorting cocaine through her "nose."

The good organization of the joke indicates ego strength and positive resources for recovery. The content suggests the severe anxiety behind her psychiatric illness and substance abuse which can be dealt with fruitfully in treatment.

The next example illustrates how ethnic jokes tap identity and social role problems and conflicts. A 49-year-old African American man spontaneously drew the following picture during one of the sessions (Figure 1).

The patient said his picture, which he titled "Ajax Messenger," is about a "black typical messenger, who is really a con artist, and not in college." The picture shows a black man, riding a bicycle, listening to a "ghetto blaster" playing a popular black group on the radio. The man has a menial job, which (as the sign reads) requires no experience, no high school, no brains, no polygraph test. He speaks black slang, is unable to spell, and lies to the viewer about being in college.

This drawing is a complex, condensed creation, depicting the life situation prevailing among many inner city inhabitants in general, and the members of the therapy group in particu-

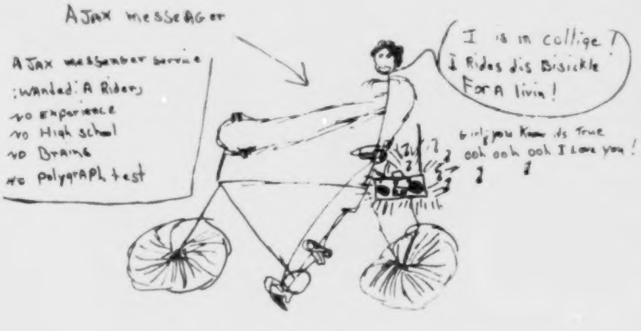


Figure 1.

BEST COPY AVAILABLE

lar. His image portrays a caricature of black inferiority that is so extreme as to reduce it to absurdity. First, the patient is laughing at the stereotype of blacks as stupid and dishonest. Second, he addresses how blacks have historically held low-paying jobs and have been unable to attend college. Third, he depicts the status needs that are frustrated. Fourth, he presents the development of covert, manipulative, "conman" behavior, characteristic of oppressed minorities.

The patient was a very bright man who never finished high school, but planned to obtain his GED and attend college one day. The picture, on a personal level, shows the patient's ambivalence and anxiety concerning his ability to succeed in his schooling and job goals. The hesitant line quality of the drawing and the thin man with an erect penis suggest problems in self-identity especially about maleness and potency. These problems in self-identity may directly contribute to ambivalence around achievement. Once again, the patient's ethnic humor offered the therapist a greater understanding and contributed to accurate empathy.

In another case, a 20-year-old African American group member shared a series of "playing the Dozens" (Abrahams, 1964), as told by one rap singer he had heard:

> "Your mother's so poor, she went to McDonald's and put a shake on lay away."
> "Your mother's hair is so nappy she needs to take pain killers to comb her hair."
> "Your mother's so old she was around when they planted Central Park."

These expressions are part of the folk culture of the black community, presenting African Americans in their historical position as poor and deprived. On a more personal level, the patient grew up in a single parent family with his mother, with sporadic contact with his father. The themes of his "Dozens" include a mother's lack of attractiveness, her age, and her poverty. These can be understood as his efforts to distance himself as young men do in their striving to individuate.

Discussion

These spontaneous examples of ethnic humor told during therapy depicted the patient's struggle to establish his or her own identity and to be confirmed as a worthwhile and separate person. They condensed a great deal that was helpful in understanding the individual, whatever the cultural background, and provided important personal information.

Creative art therapies engage the patient and touch upon deep and often unconscious thoughts, fantasies, and life tasks in an accepting and relatively nonthreatening manner. Humor is one such form of self expression, and the graphic arts another. When used in combination, they help patients feel free to bring up ethnic material, which otherwise might remain unexpressed. The ethnic humor which emerged offered opportunity for the therapist to understand and make contact with the patients.

We conclude that whatever the content of the therapy, humor can be a unifying force when it brings out similarities in culture, problems, experiences, and areas of stress. As Freud (1905), and Zwerling (1955) emphasize, humor expresses the needs, striving, attitudes, and life situations of the person telling the joke and the person who laughs.

A cohesive outcome was particularly true of the humor therapy group where social bonding develops because people who laugh together form a community of good will. As Goodchilds (1972) said, "Humor is a phenomenon preeminently interactive, immanent, impromptu" (p. 176).

Our clinical observations suggest that ethnic material surfaces in the patients' art and humor especially when there are unresolved issues of identity. Ethnic humor provides an opportunity to explore the patient's self-esteem and self-identity.

References

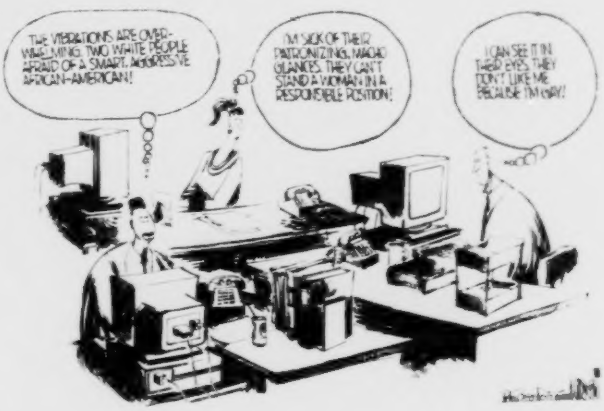
Abrahams, R. D. (1964). *Deep down in the jungle . . . negro narrative folklore from the streets of Philadelphia.* Philadelphia, PA: Folklore Associates.

Freud, S. (1905). *Jokes and their relation to the unconscious.* Standard Edition Vol. 8. London: Hogarth.

Goodchilds, J. D. (1972). On being witty: Causes, correlates, consequences. In J. H. Goldstein & T. E. McGhee (Eds.), *The psychology of humor* (pp. 173–193). New York: Academic Press.

Mango, C., & Richman, J. (1990). Humor and art therapy. *The American Journal of Art Therapy, 28*(4), 111–114.

Zwerling, I. (1955). The favorite joke techniques in diagnostic and therapeutic interviewing. *Psychoanalytic Quarterly, 24,* 104–115.


THE VIBRATIONS ARE OVERWHELMING. TWO WHITE PEOPLE AFRAID OF A SMART, AGGRESSIVE AFRICAN-AMERICAN!
I'M SICK OF THEIR PATRONIZING, MACHO GLANCES. THEY CAN'T STAND A WOMAN IN A RESPONSIBLE POSITION!
I CAN SEE IT IN THEIR EYES. THEY DON'T LIKE ME BECAUSE I'M GAY!

Native American Experience of Healing through Art

Nadia Ferrara, MA, A.T.R., Montreal, Quebec

While working in Northern Quebec, a Native American Cree elder shared with me his belief that art therapy was actually created for Natives. In my attempts to pioneer the development of crosscultural art therapy, I have witnessed a high rate of success because Native clients respond positively to art therapy (Ferrara, 1991). Expression through art is closely linked to the Native American culture. They believe that through this process thoughts and emotions are more naturally accessible, as compared to a talking-out process. They speak in images, their oral traditions are filled with metaphor, and the shamans and medicine people use imagery and metaphoric language for the purpose of healing (Young, Ingram, & Swartz, 1989).

I have been working with various tribes, among them the Cree, Mohawk, and Ojibwa. My services include assessment, brief and long-term therapy in hospitals, residential treatment and social service centers. The arts, spirituality, and healing are so closely linked that they naturally come together during therapy with these Native American groups.

Very little has been written about working with these groups. In 1989, when I was working with a Cree Indian boy, I desperately sought art therapy literature about this population. I found only one article addressing cultural differences and art therapy (Lofgren, 1981), and her case illustration was with a Navaho girl. The need for research on crosscultural issues is apparent.

My work with Native Americans has been aided by their acceptance of me, based on the fact that I look Native. In my frequent travels to different villages across Quebec and Ontario, I am always faced with Natives greeting me in their mother tongue. My dark skin, dark-brown hair, and almond-shaped eyes have helped me go beyond barricades and checkpoints on certain reserves. My physical presence has aided in developing a positive therapeutic alliance, since clients usually perceive me as a member of their cultural group. In some cases, when they discovered that I am not Native, they felt empowered to teach me some Native words. In one community I was given some caribou meat, which is viewed as a spiritual gift from the Creator. When offered to another, the meat symbolizes acceptance and a strong sense of trust. Clear boundaries exist regarding what is acceptable behavior within and outside of the reserve. The non-Native game warden enforces the rule that non-Natives may not bring any meat outside of the Cree villages.

Working with Native Americans requires a significant amount of patience and cultural understanding. Crosscultural art therapists must be aware of not imposing their own values which may be antagonistic to those held by the client (Campanelli, 1991). Often I need to talk slowly, be more articulate, and accept one hour sessions filled with silence. If the therapist shows a capacity to be silent with Native American clients, the clients will understand this as validation of who they are and their view of the healing process.

When I speak of silence I do not mean that the therapist becomes stoic and stonefaced. It is during "silent sessions" that body language is used or, in specific cases, the therapist engages in the art-making process. In other words, the only language used in such sessions is nonverbal. This helps to bridge the gap between the therapist as a "white person" and the Native American client, because "white" people are viewed as "babblers" by Natives. In the Cree's eyes, the white man's personality is superficial (Preston, 1976). By our silence and reticence, we demonstrate that we accept their style of communication.

Reticence plays a significant role in healing, for example in sweat lodge rituals. Also, it has a positive facilitating function and meaning in the Cree's cultural milieu (Preston, 1976). My work with 15-year-old Jay, an Ojibwa, illustrates the use of silence and reticence in art therapy. Jay was sexually abused when he was a young child. Although he was referred for therapy for acting out behavior, during our first six sessions he was silent and did not engage in the art-making process. Validating his silence by just being present and occasionally making eye contact helped to establish a strong therapeutic relationship.

One of Jay's first drawings (Figure 1) was a portrait of his stepfather, a Vietnam War veteran. Jay was experiencing great difficulties in his relationship with his stepfather and often expressed his anger by defying house rules. This drawing suggested Jay's guardedness. Pressured lines on the jaw area indicate his need to be reticent and contain his emotions.

In Figure 2, depicting his own cartoon creation, "Firestar," Jay's anger and aggressive instincts are more apparent. In later sessions Jay became more comfortable and involved in art making and interpretive processes which allowed him to address his inner conflicts and unresolved issues. In most of his pictures, he had difficulty drawing the full figure. This

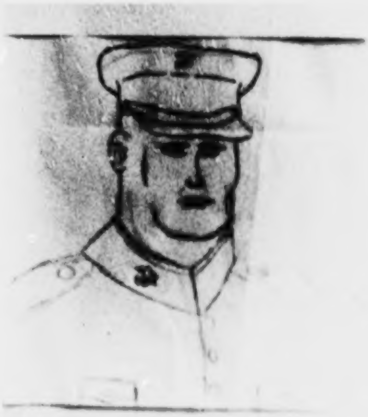


Figure 1

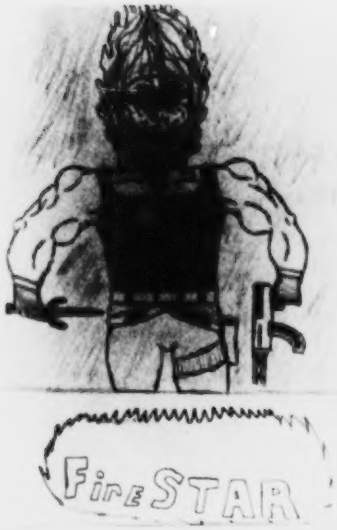


Figure 2.

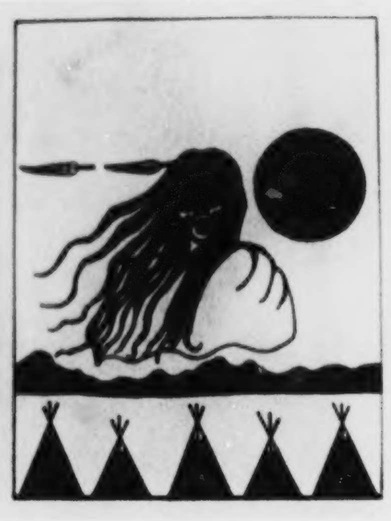


Figure 3.

indicates his anxiety around the genital area related to his past experience of abuse. Jay's long-term goal in art therapy was to develop an alternative form of communication and move towards sublimating his thoughts and feelings.

Some of the art therapy techniques I use include reading from the cultural legends and asking the client to draw, paint, or sculpt, using the legend as a theme. Native American music and guided imagery are introduced to help establish a relaxed atmosphere and encourage reconnection to their culture.

Working with dreams through art by recreating or recording them is a significant aspect of the Native American culture and its traditions (Speck, 1977). In Figure 3, Tom, a 38-year-old deaf Cree, shows how the night spirit protects the sleeping bush people and their prey. This drawing was motivated by a dream Tom had while living in the bush camp.

My work with Native counselors has resulted in methodological changes and a better understanding of the culture. I bring cultural symbols and metaphors into sessions to promote the formation of a cultural identity. The therapist also needs to create a repertoire of the symbolic cultural rituals that are prevalent in traditional communities.

Although my work has focused on Native Americans, I believe all art therapists are involved in crosscultural psychotherapy because our pluralistic society demands it. The idea of one culture, the Western-cosmopolitan culture, may be on the verge of annihilation. Native elders have taught me that we all have different origins, and these should be respected and maintained. The concept of an ethnocentric Western culture does not exist; the reality is that North America is a cultural mosaic.

Although Native Americans have been forced to assimilate and, in the past, tribes were decimated, they and their cultures continue to survive. The Natives have begun to look towards the values and beliefs of their own culture and traditions, taking into consideration their ability to survive. In addressing their conflicts and issues, Natives are reconsidering and incorporating the healing power of art that inherently stems from their roots and way of life.

References

Campanelli, M. (1991). Art therapy and ethno-cultural issues. *American Journal of Art Therapy, 30*, 34–35.

Ferrara, N. (1991). Luke's map of the journey: Art therapy with a Cree Indian boy. *Journal of Child and Youth Care, 6*, 73–38.

Lofgren, D. (1981). Art therapy and cultural difference. *American Journal of Art Therapy, 21*, 25–30.

Preston, R. J. (1976). Reticence and self-expression: A study of style in social relationships. In W. Cowan (Ed.), *Papers of the 7th Algonquian Conference (1975)*, (pp. 450–494).

Speck, F. (1977). *Naskapi*. Oklahoma: University of Oklahoma Press.

Young, D., Ingram, G., & Swartz, L. (1989). *Cry of the eagle: Encounters with a Cree healer*. Toronto: University of Toronto Press.

Reprints of this article may be requested from the author by writing to: Nadia Ferrara, A.T.R., 12674 26 Avenue, Montreal, Quebec Canada H1E172

Magazine Photo Collage as a Multicultural Treatment and Assessment Technique

Helen B. Landgarten, MA, A.T.R., HLM, Los Angeles, CA

Crosscultural counseling is in a state of crisis. A large influx of immigrants is now treated by a small number of therapists who can converse with them in their native languages. To address this discrepancy, better methods of crosscultural treatment must be considered.

I began seeking resolutions to this problem in 1967, when working with clients from Asian, African American, and Hispanic cultures. At Cedars-Sinai Thalians outpatient Mental Health Center, I found that involving these clients in art therapy was not always an easy task.

African Americans often were angry that they were assigned for treatment by a Caucasian, middle-class therapist. Perhaps they thought I would lack empathy or could not understand them. A number of these clients were overtly resentful and/or prejudiced against white people.

Hispanic clients did not object to me for those reasons. They generally worried about the language barriers and problems with communication.

Asian clients tended to be polite, and if they had objections to being assigned to me, it was never voiced. Their resistance usually was to revealing personal information.

To improve my work with minority clients, I introduced collage into treatment, making a point to use pictures that matched my clients' cultures. Collage was integrated with other art therapy methods, as drawings, paintings, construction paper art, and plasticene sculpture always remained the primary media.

Magazine photo collage often triggered comments and free associations that would not have happened otherwise. It was particularly valuable with clients who were resistant to art therapy. The photographs served as a warm-up and eased them into involvement with the usual art therapy materials.

Because the self-identifying magazine images were so effective, I began a serious search for pictures of women and men from numerous cultures that depicted them in a variety of ages, emotions, and situations. During the 1960s and 1970s, this was difficult to manage because magazine advertisements almost never used minority individuals as models. By the 1980s, positive messages, such as "black is beautiful," were well-known and advertisements began to include African Americans in catalogues, magazines, and newspapers. Also during that period, the number of African American magazines had increased. However, for my purposes, a new problem arose. The images appropriately represented upwardly mobile role models, but, in doing so, they failed to show anything other than pictures of smiling black people.

Magazines such as *Business Week* and *Money* contained many images of Asian men, but seldom women. Only recently Asian women have begun to appear in some advertisements. To resolve the Asian picture shortage in our United States publications, I went into the Asian communities. There, on newsstands and in book stores were a large number of daily and weekly magazines sent over from Japan. In Korean and Vietnamese shopping areas, free advertising newspapers were available with pictures of Asian people.

The photographs of Hispanics were, and still are, more difficult to find. A large number of magazines printed in Spanish are found on the international newsstands and in the Mexican, Central American, South American, and Cuban communities in Los Angeles. Unfortunately, they are translations of American publications such as *Life, Redbook, Cosmopolitan, Newsweek,* etc. They carry no Hispanic advertisements or articles. Again, I found pictures in the free advertising community newspapers only in Spanish-speaking shopping areas.

National Geographic, Time, Life, and *Newsweek* carry photographs of people from around the world. They provide an excellent source of photographs for clinicians who work with clients of almost any ethnic group.

The use of the multicultural people images had a positive therapeutic payoff. Therapy progressed at a faster pace because this approach was a means to bridge the gap between my clients and me, hastening a positive transference. My clients saw that I cared enough about them to provide a personal visual language that aided communication. For example, African American clients were more comfortable with images that were like themselves and often portrayed how they felt. On some level they understood this as a symbolic gesture. It indicated my wish to assist them in the context of their culture, rather than implying that therapy was coming from a position that was white, middle class, and, therefore, denigrating.

Asian clients who used images from their cultural group found it easier to divulge their secrets. Their reticence was lessened because they directed their therapy by selecting pictures. The short time it took to complete a collage delayed the humility of having to share their problems with a stranger; the imagery clarified issues and aided them to stay focused.

Hispanics found that magazine pictures of their own people made it easier to communicate difficulties. They often were impressed by all the photographs that expressed their own concerns, at times, explicitly so. Spanish-speaking clients learned that any problem was appropriate to bring into the session.

In the last six or seven years mental health funding has been cut noticeably, insurance companies now allot a briefer time for assessment and treatment, and it is imperative that we reach clients within a shorter period of time. Multicultural photo collage can be used in assessment as well as treatment, especially since it is not unusual for assessment and treatment to occur simultaneously.

It is questionable to assess minority children's intelligence quotients using tests standardized on middle-class, Caucasian Americans. Similarly is the current use of projective tests as the basis for diagnosing immigrant clients, especially when these tests have not been standardized for these cultural groups. In my work, it appears that these assessment results may not be valid for cultures other than middle-class Caucasian Americans. To address this discrepancy, I examined collages made by my multicultural clients and developed a systematic four-task assessment method (Landgarten, 1993).

Crosscultural therapy is now a popular subject. Art therapists have a decided advantage when working with a variety of people. Magazine photo collage has a place in treatment. It compliments, but does not replace, the drawings, paintings, and sculptures that we request of our clients. It is particularly useful when we use "people" pictures that match our clients' cultural group. As ethical practitioners, we owe our clients opportunities for the most positive therapeutic results. Multicultural magazine photo collage is an effective technique for attaining multicultural goals with ethnically diverse clients.

Reference

Landgarten, H. (1993). *Magazine photo collage: A multicultural assessment and treatment technique.* New York: Brunner/Mazel.

Psychopathology of Expression and the Therapeutic Value of Exhibiting Chronic Clients' Art: A Case Study

Simone B. Alter-Muri, EdD, A.T.R., Northampton, MA

L'art brut, literally translated "raw art" or "The Art of Outsiders," refers to the "Art of the Insane" (Phyllis Kind Gallery, 1993) (MacGregor, 1989). Included in this group are the thousands of artworks found in closets of art therapists, hospital records, or personal portfolios of the mentally ill. Rejected by the art establishment, it is condescendingly called, "the art of children, primitives and the insane" (Dubuffet, 1967).

Seventy years ago, in *Ein Geisteskranker als Kuenstler*, (A Mental Patient as Artist), Swiss psychiatrist Morgenthaler presented the copious work of Adolf Woelfli. Woelfli's alleged explosive and dangerous temper was treated through harshly controlled isolation. He had few opportunities to use paper and pencil until his psychiatrist directed the hospital to supply art materials. For 30 of his 35 years of psychiatric hospitalization, Woelfli documented his experience in an elaborate series of compulsive drawings, writings, collages, and paintings, developing a system to survive the threat of escalating depersonalization and fragmentation. During his lifetime, Woelfli's art was exhibited, and he became the first schizophrenic artist to achieve fame in the mainstream art culture.

For 70 years the art world has given increasing attention to "The Art of Outsiders." Although most art therapists resonate deeply with this interest, publishing the art of mentally ill clients outside of professional journals is restrained and limited. While restraint is sometimes warranted, if carefully handled, exhibiting client work can have therapeutic value, especially when exhibition is part of a talented client's therapeutic plan.

Exhibitions of art by psychiatric patients are not much more original, more inventive, or more interesting than artwork commonly produced by "normal" people. Yet, while mental illness does not preclude talent in art, a client's innate potential or a genuine, intense drive to create art is not always apparent early in treatment. Genuine artists are almost as rare among the mentally ill as in the general population (Dubuffet, 1967).

We are faced with questions: What contributes to the amazing talent and deeply touching expressiveness of those few talented clients? What allows imagery to arise from a few mentally ill clients? Artisitic training and exposure to art appreciation do not appear to play a major role.

The Case of Mr. Q.

Mr. Q., diagnosed with chronic schizophrenia, was hospitalized for 23 of his 44 years. He was considered one of the most regressed patients on the wards of three major psychiatric hospitals. As his artistic expressiveness developed, he recovered the ability to make social connections and resumed work within the community. During the three years I worked with Mr. Q., he was able to channel his aggressive impulses into highly original and productive artwork that yielded several exhibits. At first, exhibiting his art induced a period of regression, but later he recovered and reached a higher level of personality organization. His case demonstrates the use of exhibiting artwork as part of the therapeutic plan.

Mr. Q. was first hospitalized at age 20 when he attempted to leave his family home after a fight with his older brother. Clinicians at the community mental health center had met him the week before when he had thrown objects from a window and run naked in the street. He insisted he heard the Pope's voice. Six months earlier, his family reported he often was found in a confused state wandering in the streets and sleeping in junkyards and churches.

Mr. Q.'s parents were strict Catholics, born in Ireland, and educated through the elementary level. His mother's work as a scrub woman for the hospital supported the family. His father, a retired railroad worker, died from the physical effects of alcoholism. Mr. Q. developed a close relationship with his father and often accompanied him to church several times each day. The family consisted of seven children. Mr. Q. was the youngest. Several of his siblings had physical or mental illnesses, and three died in childhood. Mr. Q. was close to one of his brothers who was placed in a state school for the developmentally delayed. Family life was marked by tension and fighting, particularly between his father and oldest brother.

Hospital records show that Mr. Q. performed poorly in elementary school. At age 10 he was described as moody and withdrawn, refusing to play with other children. At 12 he expressed an interest in the priesthood, but was discouraged from joining. At 15, while in a violent rage, he assaulted his mother and was sent to a Youth Detention Center. He completed the first year of high school then left school to work, intermittently, at various jobs. Employment never lasted more than 2 months.

Treatment History

Mr. Q. was diagnosed with Schizophrenic Reaction, Acute Undifferentiated Type, and admitted to a state hospital. His condition remained unimproved, and after one year he was transferred to a second and third state hospital. After 2 years he was discharged and sent home where he was able to obtain a job, but was fired after several months. For the next 2 years he lived at home. His family reports he paced the floors and fought with his oldest brother. At their request he was rehospitalized and remained institutionalized from age 22 to 37.

His treatment plan consisted of chemotherapy and psychotherapy. For 3 months he participated in group therapy sessions with his mother, but he assaulted her during a session and the therapy was discontinued. After this episode, he stopped talking in sentences, became incontinent, and, for hours, would lie under a piano. He hallucinated and had delusions of being a high religious figure, the Pope, Jesus Christ, Saint Francis, Moses, God, Krishna, and Buddha. He was quite flirtatious with women patients and nursing staff. After he was treated for syphilis, he expressed fears of being homosexual and was nearly mute for long periods.

When he was 37, plans were made for him to move to a group home to comply with major administrative changes in the state hospital system. His older brother sabotaged these plans. As acting head of family, he requested that Mr. Q. be transferred to a psychiatric hospital. After 3 years of hospitalization, Mr. Q.'s behavior was more socially acceptable; he appeared more aware of his environment and spoke in coherent full sentences. But, his difficulties with personal hygiene and religious delusions continued. Auditory hallucinations stemmed from voices he heard on radio and television. However, he was improved enough to be transferred to an unlocked milieu therapy unit.

The milieu therapy unit was designed to treat chronic schizophrenic clients in residential and day treatment rehabilitiation programs. It was located in a large hospital ward. To prepare for community reintegration in half-way house placements and part-time jobs, clients were taught independent living skills through role models and practice. The therapeutic program was divided into three components: activities of daily living, recreation and prevocational skills, and intra/interpersonal therapy, which included art therapy.

Art Therapy Sessions

During transition from the back ward to milieu therapy, Mr. Q.'s case administrator referred him for art therapy. Mr. Q. was very angry and resistant to staff; he exhibited poor social skills, uncontrollable outbursts of anger, and self destructive behavior. His odor was offensive due to poor personal hygiene. He often would sexually harass staff. Despite this, staff often described him as "a charming personality."

From his first sessions, Mr. Q. appeared to be interested in art. In group art therapy he avoided the group. He used his own ideas for artwork, and preferred religious themes and the Renaissance. His art was fragmented, a characteristic in work by chronic schizophrenic and day treatment clients (Figure 1). Landgarten (1981) distinguishes between the art of acutely psychotic, hospitalized patients, and the art of day treatment clients. She suggests that day treatment clients tend to produce pictures depicting complete, realistic illustrations. Mr. Q.'s fragmented, but illustrative imagery could be found in art by clients in both day treatment and hospital settings.

Mr. Q. rejected assistance with art materials and he refused to talk about his art. This was not unusual. Schizo-

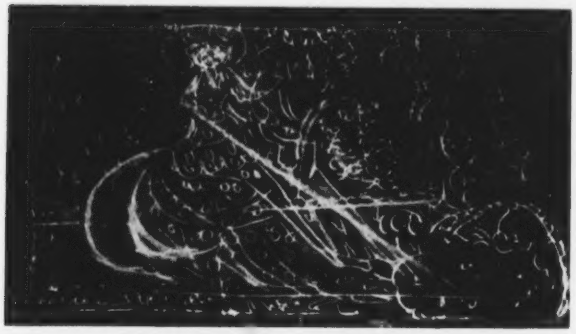


Figure 1. St. George slaying the dragon

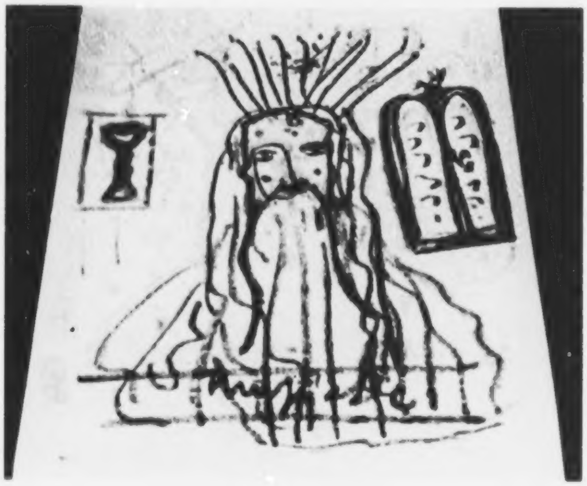


Figure 2. Moses

Figure 3. Jesus

Figure 4. Moses

phrenic clients may regress from verbal to nonverbal communication when attempting to establish a relationship in therapy through their drawings (Jakob, 1969, & Amos, 1982).

A humanistic-oriented art therapy treatment plan, designed to assist with reality issues by focusing on current themes, was successful only a few times. Mr. Q. typically chose his own subject matter, even when structured art experiences were suggested. After several individual sessions, he appeared to trust the art therapist, and began to describe his pictures. Amos (1982) explains: "At least a part of the schizophrenic's motivation for producing art lies in the establishment (sic) of some kind of communicative tie with others" (p. 132).

The Art Exhibits

During 3 years of art therapy, Mr. Q. came to view himself as an artist. When he drew himself as the Pope, Jesus, Moses, and Krishna, his acting out behavior diminished markedly. The art therapist assisted him in presenting his work in several art exhibits. These ranged from a random sampling of art on the program's walls to an exhibition in the hospital lobby, and a show in a large public municipal building where hundreds of viewers passed daily.

When his artistic talent was appreciated and admired, Mr. Q. gained a sense of importance and his self-image as an artist grew. He stopped relying on the delusional sense of mastery and grandeur, and no longer needed to claim to be God.

Perhaps the most important outcome of art therapy was his trusting relationship with the art therapist. He also increased his level of verbal communication and formed relationships with staff members. In art therapy sessions, he was able to use visual images to deal with unconscious thoughts and conflicts (Figure 5).

Making visual images can increase the ability to differentiate reality from fantasy (Wilson, 1987). According to Cohen (1981), mentally ill clients can use their art as a point of equilibrium and balance between the world of fantasy and reality.

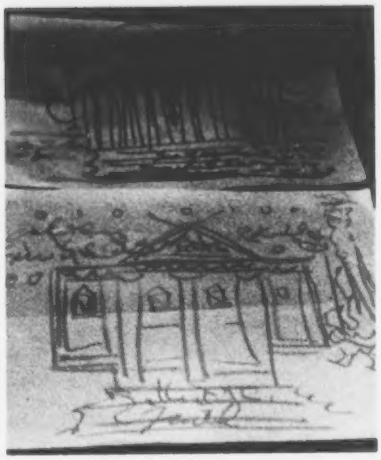


Figure 5. Temples of justice

Mr. Q.'s artistic style and artistic approach are innovative and unusual. With no formal training he would draw and integrate a few random lines to make a distinguishable figure. This brings to mind Jakob's cases where the art of the schizophrenic was directed by the images in the art itself (1969). Lusebrink (1990), Arieti (1976), Weiner (1966), and Machover (1949) described the typical favor of schizophrenic art: floating images, symbolic imagery, stylization, heavy ornamentation, repetition of forms, and static faces with few gender differences. These features can be seen in Figures 1, 2, and 3. Mr. Q's paranoid delusions may be observed in his emphasis on the figure's eyes. His tendency to overwork resulted in muddy colors, and he crossed out figures in drawings that con-

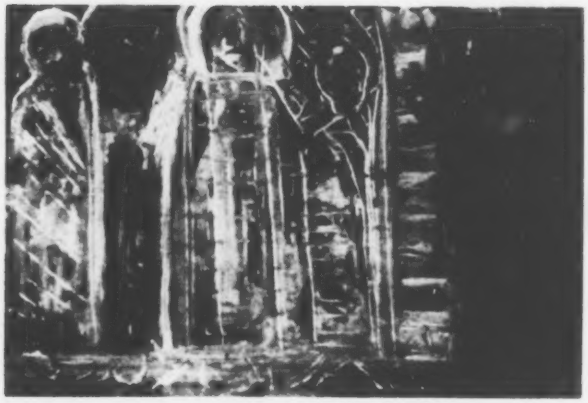


Figure 6. Guardians of the temple of justice

tained beautiful images (Figures 6 and 8). His work includes "word salad calligraphy," but it does not show what Landgarten (1981), Cohen (1981), and others describe as "art salad." Unlike many artists with schizophrenia, Mr. Q.'s symbolic images remain whole.

Mr. Q. enjoyed the process of creating art. He often created a rapid succession of works, repeating the same theme. When creating art every day his assaultive behavior decreased, suggesting, on some level, sublimation of aggressive impulses (Kramer, 1971).

Despite his recovery, he experienced major setbacks along the way. Just before the opening of his first exhibit, his hygiene began to deteriorate. Although he appeared interested in the show, his offensive odor allowed him to keep his distance from staff and clients. In staff meetings, the issue of Mr. Q. enjoying his odor was debated. His odor made him more aware of his physical presence and isolated him from others. He did not want to examine his behavior. When staff pressed the issue of his hygiene, his artwork regressed (Figure 7).

This outcome is consistent with the observations of Lusebrink (1990), Landgarten (1981), and Cohen (1981)—that acutely psychotic clients reveal disintegration through their poignant artwork. On the day of the exhibition we discovered that most of the art had been destroyed by urine. Mr. Q. explained he had to spray them with "holy water." Art done during sessions now contained abstract phallic symbols. Mr. Q. became physically assaultive and sexually abusive to staff; he was transferred to the hospital back ward.

Once stabilized, Mr. Q. reentered the milieu program and resumed art therapy sessions. We discussed the issue of exhibiting art during individual art therapy. Six months later, he said he wanted to show his work to others, and was given permission to hang it in various rooms on the unit. Staff and clients admired his work, and he asked the art therapist to help him get an exhibit. Over the next 3 months, he discussed the process, feelings, and reality of having an art exhibit with his psychiatrist and during individual art therapy. The process took time because Mr. Q. fluctuated in his commitment; he was not always lucid. Eventually, all parties agreed to launch the exhibit, and it was held at a large public facility for state services.

The exhibit was announced only within the hospital and an invitation was sent to Mr. Q.'s family. On the day of the opening Mr. Q. appeared slightly nervous; supportive staff were available to take Mr. Q. back to the hospital or administer additional medication, if necessary. At the opening, his delusions changed from a religious figure to a famous artist, and he introduced himself as Michelangelo. Mr. Q.'s mother and sister attended the opening. He approached his mother in a positive manner, and inquired about her health and the house. After the exhibit, she visited him almost every Sunday.

Not only was Mr. Q. able to remain at the exhibit without regressing to psychotic behavior, he was also able to accept positive feedback. Acknowledgment of his strengths allowed Mr. Q. to relate more appropriately to the staff. After the exhibit his behavior improved and his lucidity increased. He spent more time on his art, and he was given permission to use the art room during the evening. Gradually, hospital staff became interested in his work, and he sold some pieces to social workers and psychiatrists.

Following this period of marked improvement, Mr. Q. became more attached to the art therapist; he followed her as often as possible. His references to his mother and fantasy relationships with women increased, and his romantic transference to the art therapist intensified. Unfortunately, the art therapist announced her upcoming 3-week vacation. In response, Mr. Q. became increasingly more tense over the next few weeks, and finally, assaulted the art therapist. Again, he was hospitalized. After 4 months he returned to the milieu program where his attendance in art therapy sessions diminished, and he rarely created art at his leisure.

Three months later, Mr. Q. again began creating art and attending individual art therapy sessions. When he learned that the Pope was scheduled to visit Boston, Mr. Q. entered a phase of enormous struggle; he believed himself to be the Pope. He produced several artworks depicting his struggle.

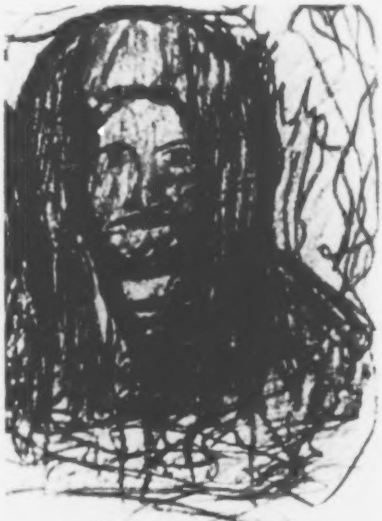


Figure 7. St. Jude

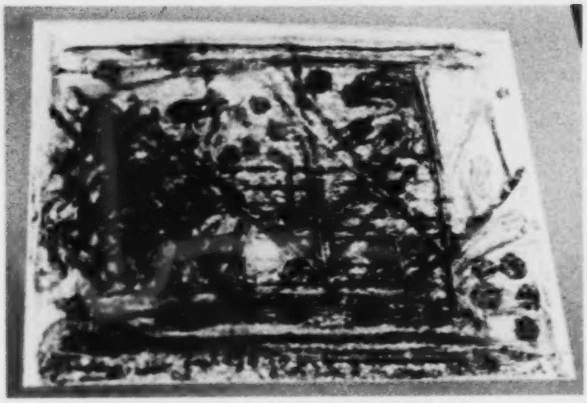


Figure 8. An Italian boat lost in an Irish sea

In Figure 8, an Italian boat is lost in an Irish sea. As the struggle intensified, he was hospitalized for another violent episode. During this hospitalization, his regression was temporary but identity issues intensified and continued to provide the material for his artwork. Eventually, he again returned to the milieu program and art therapy treatment.

Summary of Treatment

The focus of work with Mr. Q. took two directions. To encourage Mr. Q. to nourish his creativity as a means of self-expression (Figures 9 and 10), the art therapist assured him that his art was an appropriate way to receive positive attention. The finished art product provided the means to build his sense of self-worth, self-confidence, and identity as an artist. As Mr. Q. began to view himself as an artist, his delusional thoughts of being a religious figure decreased.

The other direction of treatment regarded relationships. Mr. Q. continued to have difficulties behaving appropriately with people he liked. He did not know the difference between friend, lover, staff member, or therapist. Although relational issues were explored in his artwork, his behavior continued to require staff to place strict limits.

Mr. Q. had shown definite improvement during art therapy treatment. His increased ability to view himself as an artist rather than a delusional religious figure indicated increased self-esteem. He saw people appreciate, praise, and purchase his artwork. His psychological growth, however fragile, parallels the unfolding of his artistic talent. Eventually, he was able to work and more appropriately interact with others in the community.

Exhibiting Client Artwork

The issue of exhibiting client artwork is raised by Mr. Q.'s case. Exhibiting art is not appropriate for all clients. The risks of unknown reactions to something as personal as one's artistic expression can be a major setback in treatment. Ethical issues of continuing the process toward an art exhibit after a major regression must be discussed with the primary therapist and treatment staff. Galleries must understand that an exhibit may be canceled if the client is unable to manage the experience, and hospital staff should be on hand should the opening be too stressful. The exhibit should not be widely publicized. Ethical questions arise in the labeling of the artist as mentally ill. Haeseler (1987) and Spaniol (1990) address the importance of protecting both the dignity and confidentiality of clients.

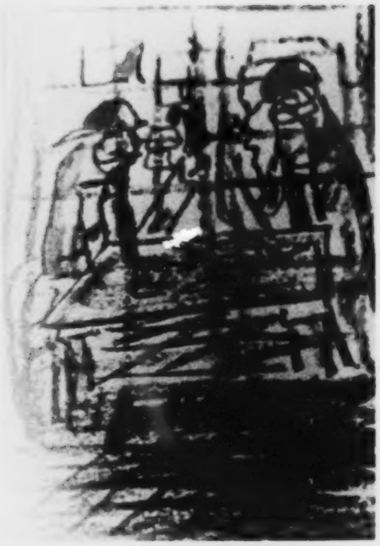


Figure 9. Friends having coffee at a cafe (Note that Mr. Q. included the bars of the hospital windows in his drawing.)

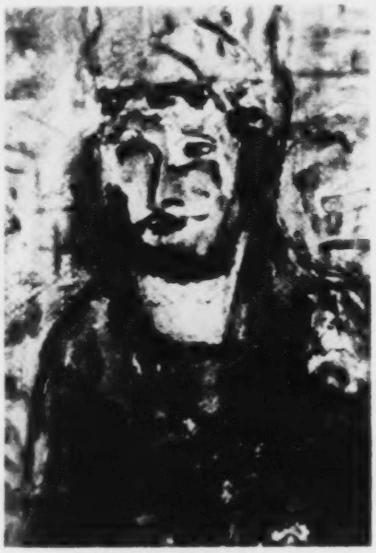


Figure 10. St. Jude

This raises the issue of public reaction. Is the art accepted because it is fascinating to explore the myth of the "crazy" artist? Is Mr. Q. a Van Gogh for our times? Is this recent resurgence of interest in exhibitions of client art a fad (Johnson, 1993)? Is it politically correct? Or is it an integral step in an art therapist's treatment plan?

BEST COPY AVAILABLE

Sass (1990) and Plokker (1965) have posited that the artistic styles of people with mental illnesses might be compared with trends and styles of modern art. But, as is evident in this case study, the art of the mentally ill can be considered valid in its own right. The *Musee de l'Art Brut* in Lausanne, Switzerland, opened its doors to the public in 1976 to display thousands of artwork by people with mental illnesses and artwork by so-called "outsiders." Inspired by Dubuffet (1976), this collection has become a landmark in the movement to allow the public to share in the intensity and originality of art by the mentally ill. This museum also allows artists to benefit from public interest without being stigmatized by their illnesses. Similar collections, small museums, and exhibits across Europe are increasingly gaining public appreciation (MacGregor, 1977). In the United States, ample room exists for progress in exhibiting, validating, and publicizing *L'Art Brut*—"The Art of Outsiders," or, simply, art by people with mental illness (MacGregor, 1989, Spaniol, 1990). The time has come for the art therapy community to consider integrating exhibition of artwork within the treatment plan. This can be an important expansion of the intrapsychic and interpersonal course of development, healing, and growth of clients.

References

Amos, S. (1982). The diagnostic, prognostic, and therapeutic implications of schizophrenic art. *The Arts in Psychotherapy*, *9*, 131–143.

Arieti, S. (1974). *Interpretation of schizophrenia*. (2nd ed.). New York: Basic Books.

Cohen, F. (1981). Art therapy: Psychotic expression and symbolism. *The Arts in Psychotherapy*, *8*, 15–23.

Dubuffet, J. (1967). *Prospectus et tou les ecrits suivants* (Vol. 1). Paris.

Gotthold, D. (1983). Neutralization of drives through art therapy: Treatment of an assaulting patient. *Pratt Institute Creative Arts Therapy Review*, *4*, 1–11.

Haeseler, M. (1988). Censorship or intervention, "But you said we could draw whatever we wanted." *American Journal of Art Therapy*, *26*, 11–20.

Jakob, I. (Ed.) (1969). *Psychiatry and art: Art interpretation and art therapy* (Vol. 2). New York: Karger.

Johnson, K. (1993). Significant others. *Art in America*, 84–91.

Kramer, E. (1971). *Art as therapy with children*. New York: Schocken Books.

Landgarten, H. (1981). *Clinical art therapy*. New York: Brunner/Mazel.

Lusebrink, V. B. (1990). *Imagery and visual expression in therapy*. New York: Plenum Press.

MacGregor, J. (1977). European collections of psychiatric art. *Confina Psychiatricia*, *20*, 1–9.

MacGregor, J. (1989). *The discovery of the art of the insane*. Princeton, NJ: Princeton University Press.

Machover, K. (1949). *Personality projection in the drawing of the human figure*. *Springfield, IL: Charles C Thomas*.

Plokker, J. H. (1965). *Art from the mentally disturbed*. Boston: Little, Brown.

Sass, L. (1990). Surrealism and schizophrenia: Reflections on modernism, regression, and the schizophrenic break. *New Ideas in Psychology*, *8*, 275–297.

Spaniol, S. (1990). Exhibiting art by people with mental illness: Issues, process, and principles. *Art Therapy: Journal of the American Art Therapy Association*, *9*, 70–78.

Weiner, I. (1966). *Psychodiagnosis in schizophrenia*. New York: John Wiley & Sons.

Wilson, L. (1987). Symbolism and art therapy: Theory and clinical practice. In J. A. Rubin (Ed.), *Approaches to art therapy* (pp. 44–62). New York: Brunner/Mazel.

Being Different: A Theoretical Perspective

Judy Weiser, R.Psych., A.T.R, Vancouver, British Columbia, Canada

"You're Jewish, aren't you?" asked the friendly secretary from the office next door. "Yes, at least culturally, though not very religiously," I replied, trying to explain that I definitely was Jewish, although I had not set foot into a synagogue to worship in the 20-plus years since I moved here. "Oh, good," she responded, "I need a Jewish minister to say grace at our interfaith banquet next month, and there aren't any Jewish churches here in town."

I told her that although I had not been in any of them, I was sure there were several synagogues in town. When I suggested she try the yellow pages, she said she had already looked: "That's how I knew there weren't any," she said smugly. I borrowed her telephone book and looked up "synagogues" and found a listing for five. I gently suggested that perhaps the spelling had proven difficult.

She complained that she had looked under "churches" ("where they all should be") and demanded to know why "Jewish churches" weren't in there among all the others. When I tried to explain that churches were for Christians and that Jews were not Christians, at least not any more(!), she said it made no sense, and seeming dismayed, pouted, "Why couldn't they put their list in with all the others rather than confusing people by keeping apart?"

She, the friendly secretary from next door, who I truly like and who I am certain meant me no personal harm, had absolutely no idea what her words precipitated in me, based on my own childhood years of suffering and later adult anger in reaction to taunts, caution, fears, and, at times, physical pain based on living in Ku Klux Klan territory, where Jews were considered Blacks-with-white-faces, and treated just as horribly. She of prejudice-by-innocence, ignorance-by-default, and "attitude"-by-accident, had no idea how I had suddenly grown chilled inside and was quickly jolted back to early survival patterns of feeling that I had to be cautious and "on-guard" and other feelings that she, the nice Christian lady who really, honestly, means no harm to Jews, had unknowingly caused to surface in me. She who was trying to be liberal in the first place.

Our actual conversation continued without any break. All the above happened in the microsecond it took for me to feel pushed to the outside edge of her boundary of what was usual, normal, and expected, regardless of her not intending this, while she never knew it had happened. This exclusion-through-dominant-group-marginalization often happens without the "do-er" knowing they have done anything at all. They think they are just having a conversation, but if you, the reader, are "different" in any way (i.e., not part of the mainstream culture), you know exactly what I am talking about, and you know exactly how it feels.

Ordinary conversations, which can appear to one party to be a mutually shared communication (while the other party may be recoiling in horror), may sometimes result in just such consequences. For those of us who use verbal interactions as our means of helping others, it is crucial to understand what it means to be different in ways that we may not be sensitive to, as well as the kind of feelings that arise outside our awareness in response to our innocently delivered words. These reactive feelings are part of the therapeutic reality, whether or not we are aware of them.

Being "different" means simply that one *is* different from others, somehow. Sometimes both parties agree that actual difference is there and has differential meaning and thus consequence. Sometimes one person knows it and the other remains oblivious; and, even more difficult, sometimes significant difference is causing dissonance at unconscious levels without either party being aware that it is an activating part of a problem. Whether this difference automatically signals a "right-versus-wrong" bipolar forced choice, or whether this difference makes something better or worse, resides within each perceiver and his or her underlying values. These values are by no means universal or conscious.

But regardless, it is perception itself upon which reality is based. Reality is consensus of agreement about experiences and their meaning, shared understandings upon which further interactions occur. Basic existential theory teaches that as you perceive, you literally bring into existence that which you believe to be real. Differences you perceive will be those you notice and pay attention to (consciously or unconsciously), while those differences which do not make any difference to you will not be noticed, and thus are not accepted as existing in the first place. Very simply, those differences that don't matter, don't.

Differences which selectively make a difference can have a powerful impact on those forced to the margins of mainstream society (Hall, 1969, 1973; Henley, 1977; Mayo & Henley, 1981; Weitz, 1976). Many recent postmodernist theorists have addressed how the deconstruction of meaning from a stimulus event or person, or category of being, mandates consequences beyond mere behavior (Burgin, 1989; Carr-Harris, 1984; Watney, 1987).

Both postmodernist and phenomenological theory deal with how meaning is constructed into that which we think we are seeing "as it already is." We encounter something, and what we "get" is not just there on its own; rather, we contribute a great deal to the meaning which we think we are getting from that stimulus object or person; we actually "construct" its meaning. As we discover something new we try to make sense of it, we mentally take it apart, "deconstructing" it to see how it makes sense to us. This is a human trait embedded in all of us.

One particular application of these theories has appeared in numerous writings about the construction of gender, the meaning of what it is to be a woman or man, and expectations about what males or females can or should do. From the moment of birth, boys and girls are enculturated into roles that society defines as appropriate for them, based on their genital configuration. It only gets worse as they grow older. Several current feminist-based theorists discuss the construction of gender and sex-based roles (Benjamin, 1984; Frieze & Ramsey, 1976; Gilligan, 1982; Hare-Mustin & Marecek, 1988). They consider women and homosexuals from the contexts of power and family dynamics that have grown out of cultural, religious, and societal assumptions, which themselves may have evolved from basic fear or threat of that which is unfamiliar or uncommon. *Being* and *acting* are not the same thing. Holding beliefs and attitudes based on underlying values can mandate behaviors which may not be acceptable in mainstream society simply because they are uncommon ones rather than right or wrong ones.

We often notice difference and do not quite know how to evaluate it. If we already have a preestablished framework within which to examine it for meaning and value, we use that framework. But if there is something new encountered with which we have no previous experience, human instinct warns us to be careful, to be suspicious, and to find out if this new thing is some sort of threat or danger. Anthropologists say this is a primal instinct for protection or survival. The same theorists also discuss how primal habits, such as urinating on others' territory or fighting to the death over mating rights, have evolved into more civilized and socialized habits which mask those earlier drives into more socially acceptable behaviors (Hall, 1969, 1973; Morris, 1967).

Those whose values are in the majority usually dominate the rules by which society is run; those who write the rules usually win the arguments. If something new or unexpected appears, it is always examined from the viewpoint of what already exists. What already exists serves as the current standard for evaluation. If it is different, and therefore thought to be a threat, it is usually ostracized, disempowered, excluded, deemed wrong/bad/immoral, or even worse.

An excellent example of this in North America is the routine murder by Christian explorers of those "two-spirited" native peoples whose identities did not fit with what they knew about how people "ought to be" (Tafoya, 1993; Williams, 1986). It is interesting to note that today some of those same cultures still include the possibility of seven separate genders instead of what most of us have been raised to believe. It is just that they have learned not to discuss this with outsiders who would not understand—for example, that "two-spirited" is *not* the same as the non-Native convenient label of "bisexual." Rather, it is something completely different, a lot more complex, and worthy of understanding for its own value (especially by those individuals who find themselves not quite fitting the current triumvirate of being either "gay," "straight," or "bisexual," as the *only* choices available).

Who one is inside (identify, self-concept) is also partially defined externally by social guidelines that assign values to that identity based on surrounding societal and cultural norms. Whether or not we fit into these norms, our identity is also partially formed in response to these externalized attitudes. Some of the earliest writings about stigma (Goffman, 1963) suggest that people who are "invisibly different" may be able to "pass" without being known to be different. However, they nevertheless encounter stereotyping and prejudicial reactions much the same as those who are visibly different minorities, such as racially or physically challenged people.

Growing up Jewish in Texas was a quick lesson in being different, knowing I was definitely different, yet not necessarily looking or acting different from those around me. I had a privileged difference, one which could be kept invisible unless I trusted enough to let it out to those who I knew would judge me for myself, rather than preconceived prejudices. This "passing" made life easier in many ways, but left me baffled about consequent complications such as how I then should react when hearing others' anti-Semitic remarks.

Inner beliefs, values, attitudes, and assumptions form the definition of who we are inside. If these are different from those held by the surrounding society, the "norm," they are seen as not normal. But being different from the majority does not automatically equal abnormal, whether we are talking about homosexuals being hated by others or whether we are referring to those others being judged by their own victims via reverse stigmatization.

Being marginalized (pushed out of the mainstream) usually means also being disempowered from rightful participation in society. Becoming the "other" who has been sectioned off into a category of difference also forces a generalization syndrome whereby all in that category are reduced to stereotypes and simplistic reductionistic characterization. In the case of racial minorities or physically challenged people, such differences are visible. But, for those who can pass if they choose (such as Texan Jews, especially my red-haired, blue-eyed cousin, who always confounded the Klan), there is a complicating factor of self-hate, which is internalized from outsiders, that can also result in shame and disguise.

I have explained above my viewpoint that all facts exist only in cultural and situational contexts; all truth is relative to the reality filters used by each person perceiving it. This becomes significant when trying to figure out how it is that people do happen to voluntarily change their minds. It is even more relevant for those of us whose work occasionally involves trying to get them to do so, assuming we have the right to decide they should! The following example illustrates such a situation.

To this day, my father thinks that African Americans are a separate race halfway between humans and apes. No amount of logical reasoning, scientific fact-producing, or first-hand introductions to my Black friends, who obviously do not fit his stereotype, has managed to change his mind one bit, though he has learned not to express those views out loud when I am around. What do I do with him? Do I try to force him to change his mind, to overpower his will by greater force? As a psychotherapist, I do not believe in trying to force mind-changes. I learned long ago that this does not work. Instead, it only produces resistance equal to the force being externally inflicted.

Cognitive dissonance theory (Festinger, 1957) repositions personal change from behavioral to cognitive and value-based contexts. It suggests that in order to change internally, people must come to that change through natural process. This can happen by encountering internal, and usually initially unconscious, dissonance between two simultaneously held conflicting views. More often, it happens by encountering new behaviors which then produce new perceptions that alter inner beliefs and the deeply unconscious, nonverbal values which underlie them.

People often react to others who are significantly different by feeling threatened by something which is simply new and out of the ordinary to them. But this does not automatically mean that the person who appears to be different actually intends to signal any threat by their presence (Moustakas, 1972).

Phenomenological theory suggests that meaning is created within each perceiver in response to a sensory catalyst and that different people can have radically different interpretations of an identical stimulus. For example, the value of a photograph lies not in the visual "facts" inside its borders, but rather in what these mean in the mind of each viewer. Its value lies more in what it is a photograph *about* than what it is a photograph *of* (Weiser, 1993). Similarly, what a word signals (for example: "suitcase," "AIDS," "bald," "dog," "menopause") is much more than its specific physical parameters. Regarding a phenomenological perspective about any kind of difference, including, and especially, homosexuality, it is not *being* and *acting* physically or culturally different that seems to be the issue, but rather what this difference *means* in the minds of both that person and those others encountering her or him.

From this it is simple to grasp that, objectively, being different does not automatically mean being wrong or being bad. *Being* different is not the issue, but rather how that difference affects others. Far too often we forget that the responsibility for our reactions lies in ourselves, not the person to whom we are reacting. There is a difference between significant and insignificant differences (i.e., differences that matter and those that do not). Therein lie the roots of stigma, phobia, prejudice, marginalization, and, ultimately, disempowerment and hatred. For example, does it matter to you that "homophobia" does not appear as a legitimate word in the dictionary of Microsoft Word's spelling-checker? Should it? Why or why not?

It is sometimes easier and more acceptable for those in the mainstream of society to be liberal about demanding full human rights for those who are visibly handicapped or racially different from themselves. This is because their view of "those people" is from an outside, privileged, and "safe" perspective. Not coincidentally, this position is also one from which they can clearly be seen as *not* belonging to that group of marginalized/excluded "others" (outsiders) because they do not look like those people.

However, if there are "invisible" groups who are perceived as possibly threatening (Jews, gays, lesbians, Nazi sympathizers, Mennonites, non-Caucasion people who happen to look Caucasian, Northern Irish, whatever—i.e., those people who are different in personally significant, yet nonvisible, ways), then the mainstream may not be quite so strident in its willingness to publicly support these "others." Why? Simply because there is less clear distinction between themselves and those others, and, heaven forbid, someone hearing about it might think the new supporter has just self-declared as *being* one of "those."

Associating with those deemed less desirable, or supporting their rights as invisible minorities, can "taint" the helper-with-good-intentions. it can be an interesting shift for them to suddenly be perceived by their own dominant culture as being one of those outsiders they are trying to help. When the difference matters and they are suddenly shifted in perceived identity, liberal intentions are quickly tested for their strength.

If we are suddenly perceived to be a part of the very group we have been trying to help from the outside, things can become much different from the inside looking back out. For gay men and lesbians, for example, this is another type of homophobia, albeit of the liberal kind ("I think they are okay, but I don't want to be perceived as one; it's fine to be that way, but, oh god, don't let my kid turn out that way"). It is a different situation to be tolerant when people of your own kind suddenly move you into the "invisible outsider" group, thinking that you must be one and it just does not show, that you must just be covering it up by "passing."

It is extremely important for all therapists, of any sexual orientation and any culture, to work from operational perspectives based on understanding of complexities such as those mentioned above. It is particularly interesting to add these concepts to our already-complicated travels through issues of transference and countertransference, particularly when it is the therapist who is part of the minority group.

At some time all of us will be involved in multicultural therapy situations. Therefore, it becomes imperative to have a basic grounding in humanistic, phenomenological, and existential theories which regard the perception of difference from a model of perceiver-based construction of reality (Moustakas, 1992). Similarly, it is equally essential to have a thorough grasp of the basic concepts of systems/cybernetics theory. Particularly important are those components of it which provide a framework for difference and differentness to be regarded as enriching and empowering rather than threatening or destructive, and thus necessary to the healthy balance of human interaction (Bowen, 1966, 1972; Jackson, 1957; McGoldrick, Anderson, & Walsh, 1989; Weiser, 1990).

A better understanding of these concepts can help us become more sensitive to nuances which previously might have passed unnoticed and to become more tolerant of other colleagues and clients who are different from ourselves. I think the therapeutic goal is not necessarily one of changing the inner beliefs of people, but rather to arrive at a position from which they can permit others to be different without that difference automatically signaling threat. I do not think any of us would take away others' rights to hold personal beliefs; that is itself unethical. Rather, this paper attempts to re-position personal opinion, and even personal prejudice, into a state of having-a-right-to-exist-*inside*-a-person (if for some reason necessary) but clearly acknowledged as being just one of many alternate attitudes possible—and definitely disempowered from any right to inflict pain and injustice on others who may not share that belief.

I want to close by way of a personal anecdote which I think encompasses all the above into a real-life situation that can be reconsidered from the conceptual framework just described:

Two years ago I joined a local community choir with a friend of mine. He and I had sung Christmas carols together for several years, and I really enjoyed how I felt after an evening of singing. So, when he said he had decided to join this choir, and that I was welcome to join with him (the choir took anyone interested who was willing to be a part of their group), I gladly agreed, knowing we would have fun. Perhaps I should clarify here that it is the Vancouver Lesbian and Gay Choir we joined. That did not matter to me; most of my friends are gay and lesbian (it just evolved that way, much the same as you have friends whose hobby or work interests parallel your own). I went with him to the first rehearsal and had a great time.

Now, I have been careful thus far in this paper to not give readers any clues about my sexual orientation (a lot of people live this way all the time). Obviously with the first name of Judy, I am female, but was I always? Yes, I am happily married, but have I said yet to which a partner of which gender? I have a husband, so "of course" I am not lesbian (or am I? Is this a marriage of convenience?). If I tell you I am not lesbian, is it then a simple, "Well then, she is straight (heterosexual)"? But what if I am "bi" (bisexual), or "two-spirited"? By this point *do readers care* about what I am in my private life? Is it at all relevant to authoring this paper? To doing art therapy? Does the sexual orientation of the professional matter to their nonbed life? This is one of those yes-and-no kinds of answers.

But, back to me. For the record, I am straight (or, as my friends prefer to label me, "slightly bent"). I do not often go out banner-waving or shouting forceful demands, but neither will I silently witness injustices without making public statement when I encounter something I believe to be wrong. I will not hide, though I may not flaunt; and thus, we return to me and my choir. I joined the Vancouver Lesbian and Gay Choir because I wanted to sing and because my friend Terry, who is gay, wanted to, and because we wanted to sing together. I joined this group whose motto is "For people who like to sing: gay, lesbian, and straight friends or relatives thereof who are gay-supportive." This seemed fine to me. I saw no reason to need to label my sexual identity in order to prove I could sing well. Since there was no question on the membership application asking who I had sex with, I saw no reason to offer comments that were unnecessary. I was there, I wanted to sing, obviously, I was gay-supportive. So, I sang, and it gave me great enjoyment.

During the first few months I realized that although who I "really" was did not need to be kept a big secret, neither was it relevant to what we were doing. I was a bit concerned that those who found out my secret heterosexuality might pre-judge me as an outsider who could never really truly fit in and belong, and so I thought it best not to mention it unless asked directly. (I will not lie.) I was asked out by a couple of the women, who I turned down because I was "married", but since this is a term also used among the group for commitment of two same-sex partners, this gave nothing away. I occasionally went out socially with the group, and went on retreats where the dorm housing was quite rowdy and playful. During all of this, I was just myself, me, my own way of being, without hiding or faking, but just being me, at ease with the jokes and banter. This was not new to me and my medium-radical feminist values.

As our first concert approached and formal evaluations drew near, I checked the constitution to make sure I was still legally "okay" for membership. Reassured, I auditioned. I passed. Then, I asked the director if it was true that straight people were welcome. He nodded agreement and asked me, "Why? Do you know of any who want to join? They're quite welcome, you know!" I giggled and waved a "hello" to him. His reaction was one of total shock, "But you can't be—you don't look it and certainly don't act it!" followed immediately by, "Oh my god. Look what I've just said—generalized just like those people who stereotype us. Sorry. . . ."

I asked him to keep it a secret, to let me stay in the closet until my identity became known naturally. Slowly, as one event or another came to pass, my "passing" came out. I was not "outed" (which would not have mattered, except, it might have). I simply was a person who was slightly different from the others and I noticed that, yes, I had been watching my gender pronouns, neutering them or turning them plural. I was being careful to not give things away unless I was certain the person would not think I had some other agenda for being in the choir.

For me, all this was rather lighthearted, and there would have been no terrible consequence had I been discovered and "outed" at the very first rehearsal. It would have either mattered or not. I could have easily gone on with my life without this choir had they decided there was something perverse about me. ***But, there is no way I ever would want to have to live all my life*** with these safeguards and protections and worries and "what-ifs."

There is absolutely no way I would ever want to be part of a society that makes anyone who is different, in whatever way, have to live their lives under those nonnatural conditions. I support homosexuals not because I am a "wanna-be," (in this case, if I wanted to be, I easily could be!) but because I cannot conceive of living a life where they, or any other people, do not have an equal right to exist even while being different from my way.

Standing by in silence while injustices are done to others not like me is not part of my reality. As systems theory so clearly explains, an advanced system or society is one where differentness and differences are seen as enriching and adding complexity rather than threatening or to be denied.

An old Doonesbury cartoon shows an African American man telling a gay Caucasian colleague that he is not sure he can continue working with him because he heard the colleague is gay. The colleague replies, "Yeah, and I hear you're black." When the man responds, "Yeah, but that's different," the colleague reminds him, "Yeah, but it didn't used to be. . . ."

Writing this paper as both a woman and a Jew, both of which seem to be acceptable because you are still reading this, I want to close by reminding you that these may be okay today, ***but they sure didn't used to be***! Let us consider a future where other invisibly different people find such previous prejudices equally outdated.

References

Benjamin, J. (1984). The convergence of psychoanalysis and feminism: Gender identity and autonomy. In C. Brody (Ed.), *Women therapists working with women* (pp. 37–45). New York: Springer.

Bowen, M. (1966). The use of family theory in clinical practice. *Comprehensive Psychiatry, 7*(5), 345–374.

Bowen, M. (1972). Toward the differentiation of a self in one's own family. In J. Framo (Ed.), *Family Interaction—A Dialogue between family researchers and family therapists* (pp. 32–55). New York: Springer.

Burgin, V. (1989). *The end of art theory: Criticism and postmodernity.* Atlantic Highlands, NJ: Humanities Press International.

Carr-Harris, I. (1984). Sex and representation. *Vanguard, 10,* 22–26.

Festinger, L. (1957). *A theory of cognitive dissonance.* Stanford, CA: Stanford University Press.

Frieze, I. H., & Ramsey, S. J. (1976). Nonverbal maintenance of traditional sex roles. *Journal of Social Issues, 32*(3), 133–141.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity.* Englewood Cliffs, NJ: Prentice Hall.

Hare-Mustin, R. T., & Marecek, J. (1988). The meaning of difference—Gender theory, postmodernism, and psychology. *American Psychologist, 43*(6), 455–464.

Hall, E. T. (1969). *The hidden dimension.* Garden City, NY: Doubleday Anchor.

Hall, E. T. (1973). *The silent language.* Garden City, NY: Doubleday Anchor.

Henley, N. M. (1977). *Body politics: Power, sex, and nonverbal communication.* Englewood Cliffs, NJ: Prentice-Hall.

Jackson, D. D. (1957). The question of family homeostasis. *Psychiatry Quarterly, 31*(1), 79–80.

Mayo, C., & Henley, N. M. (1981). *Gender and nonverbal behavior.* New York: Springer-Verlag.

McGoldrick, M., Anderson, C. M., & Walsh, F. (Eds.). (1989). *Women in families: A framework for family therapy.* New York: Norton.

Morris, D. (1967). *The naked ape.* London: Jonathan Capes.

Moustakas, C. (1992). Firebrand—The experience of being different. *The Humanistic Psychologist, 20*(2), 175–188.

Tafoya, T. (1993, August 23). *Two-spirited people—another way of being.* Paper presented at the meeting of the American Psychological Association, Toronto, Ontario, Canada.

Watney, S. (1987). *Policing desire: Pornography, AIDS, and the media.* Minneapolis: University of Minnesota Press.

Weiser, J. (1990). Round things don't have any straight lines—Or, looking for the feminist requires "systems" thinking. *The Arts in Psychotherapy, 17*(3), 265–267.

Weiser, J. (1993). *Phototherapy techniques—Exploring the secrets of personal snapshots and family albums.* San Francisco, CA: Jossey-Bass.

Weitz, S. (1976). Sex differences in nonverbal communication. *Sex Roles, 2*(1), 175–184.

Williams, W. L. (1986). *The spirit and the flesh—Sexual diversity in American Indian culture.* Boston: Beacon Press.

Reviews

Understanding Race, Ethnicity, & Power: The Key to Efficacy in Clinical Practice.

Elaine Pinderhughes, New York: The Free Press, 1989. 269 pp., $32.95 cloth. ISBN 0-02-925341-1.

Reviewed by **Martha P. Haeseler, MA, A.T.R.**, Guilford, CT

While the recent focus on cultural and racial diversity in our profession has been sorely needed and useful, no one has asked us to take a look at ourselves as thoroughly as does Elaine Pinderhughes, an African-American professor of Social Work. She not only raises our awareness about cultural diversity and teaches us new ways of working with clients who are different from ourselves, she also asks us to take a hard look at issues such as racism in the United States and power in the therapy relationship.

Although many therapists try to be sensitive to whatever biases they may unwittingly bring to the therapeutic relationship, issues such as racism and the dynamics of power are frequently overlooked or addressed only with pain and a sense of disorientation. When the author reminds us that these issues inevitably touch all our lives, however privileged, well-meaning, diversified, or monocultural, scales fall from our eyes.

She points out that differences between people frequently give rise to feelings of anxiety, fear, and discomfort. She attributes the origin of these feelings to the earliest experiences between mother and infant, to the narcissistic injury that occurs when the infant experiences self as imperfectly mirrored by mother, and comes to the painful realization that self is separate (different) from mother. The remnants of infantile narcissism in all of us might lead to fear of difference or fear of sameness, as a defense against the wish to merge. Typical defenses against such fears and discomfort include distancing via cultural or racial stereotyping, projecting onto the other the powerlessness and rage we feel, and denial of differences.

For us to become more aware of our fears, biases, and projections, Pinderhughes asks us to look at our experiences with differences. How did our families and culture teach us to view differences between people? Which of these teachings fit with our current experiences and conceptions of ourselves? What typical defenses do we erect to ease the discomfort produced by differences?

To help clients explore feelings about ethnic and racial identity, she asks us to look at and sort out our own possibly conflicted feelings towards the values and customs of the culture(s) which shaped us and within which we now live. As we become more comfortable with our cultural identities we can help clients become more comfortable with theirs. If we acknowledge racism, we can better understand the projections and assumptions we and our clients make.

To fully empower our clients, she asks us to acknowledge our own feelings of pain and powerlessness, understand our own power needs and responses, and become aware of the dynamics of power in the clinical process. We can then help clients focus on strengths and successes without feeling our power is threatened.

This book is full of wisdom. Here are a few points worth emphasizing:

1. "Cultural differences are not deviances" [*sic*] (p. 17). People from minority cultures demonstrate enormous strength in negotiating two sometimes opposing cultures.
2. Symptomatic behavior may be adaptive to a disadvantaged client. For example, a client's manipulative or aggressive behavior may be seen not as a personality disorder but as a strength developed to use an oppressive system to advantage. Such strength should be acknowledged while therapists teach clients to empower themselves in proactive, rather than reactive ways.
3. Be careful not to attribute all symptomatic behaviors to cultural problems. Developmental problems and psychodynamic conflict must also be taken into consideration.
4. While finding commonalities in cultures, beware of stereotyping or making assumptions. Each individual's adaptation to culture, race, and ethnicity is unique.

Pinderhughes has conducted workshops and ongoing groups in schools and health-care facilities to promote awareness of these issues. The book is enriched by quotes from participants. In an appendix on the author's teaching methods, she stresses that her approach is educational: ". . . the goal centers on growth in terms of self-understanding and development of attitudes and ways of thinking that will enhance functioning as a service-provider" (p. 235).

In reading this book, I found myself reacting to some generalizations made about white middle-class Anglo-American culture (my cultural background). For example, Pinderhughes contrasts "American values [which] emphasize competition, winning, and being number one" (p. 22), with "autonomy and independence" (pp. 160–161), with values of "pre-American cultures, [such as] . . . affiliativeness, collaterality in relationships, and interdependence" (p. 160). I ask, "Whose America is she referring to?" Recent literature has suggested that there are differences in psychological development between men and women. Men's development is characterized by competitiveness, separateness, and independence, while women's is characterized by relationships and connection (Gilligan, 1982; Belenky, Clinchy, Goldberger & Tarule, 1986). As a white middle-class American woman, I felt that Pinderhughes' generalizations did not relate to me. I then realized that Pinderhughes would probably ask me to ponder my identity as a woman in a society which displays

BEST COPY AVAILABLE

values different from my own, and another scale fell from my eyes.

References

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). *Women's ways of knowing: Development of self, voice and mind.* New York: Basic Books.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Creative Art in Groupwork

Jean Campbell, Bicester, United Kingdom: Winslow Press, 1993.

194 pp., 21.95 pounds sterling, paper. ISBN 0-86388-118-1.

Reviewed by **Erika Cleveland, MA, A.T.R., LMHC**, Boston, MA

In the United States, managed care has resulted in shorter and shorter time periods for patient treatment. Thus, the arrival from the United Kingdom of Jean Campbell's *Creative Art in Groupwork* is a refreshing addition to the art therapists' armament of short-term work.

The book is divided into four parts: two brief introductory areas covering background and theory, an extended activities section, and a short conclusion that includes lists of art materials and resources. While the book is aimed at beginners and more experienced clinicians, additional background information would have provided a more meaningful text for those with limited art therapy experience. For example, although references are made to theorists such as D. W. Winnicott and Herbert Read in a section entitled *Art as Therapy*, no mention is made of any art therapists. I would have liked to have read about pioneers such as Edith Kramer or contemporaries such as Judith Rubin, particularly since the book is aimed, as it appears to be, at a broad audience that includes art educators, social workers, and all those in the field of health care. This book may be their only exposure to the field of art therapy.

Campbell presents her background material in a positive tone, clearly grounded in a belief in the importance of creativity and expression for encouraging therapeutic progress in clients. Examples come from her experiences with an African Caribbean senior citizen's group and a fertility support group. She makes a distinction between art as activity and art as healing and touches very briefly on some clinical issues in groups such as transference, boundaries (physical and emotional), and confidentiality. Care in selecting a group leader is also mentioned as a concern, and she emphasizes the importance of clinical training, stating, "This is definitely one of those careers where you can never learn too much!" (p. 23).

The handbook style of the book offers 142 art activities for use with a wide variety of populations. Campbell acknowledges that there are drawbacks to structured art tasks. She prefaces her description of prestructured group work with the comment, "It can limit the creative life of the group . . . the needs of the individual may get lost . . . (and it) . . . can limit the development of the group leader's skills" (p. 27). However, I would have appreciated more discussion about the necessity for preplanned art activity groups with particular populations and settings. As Merman (1993) states, there is clearly a need for a more structured approach within short-term hospital stays which demand that "We must prevent regression, avoid uncovering repressed material, and raise no issues that cannot be dealt with in a two week or less hospitalization" (p. 35).

The core of this book is the activities section in which group art activities are "warm ups," "core exercises," "linkage" (or various ways in which art activities can be combined with other modalities), "discussion and feedback," and "closure and endings." Core exercises are further differentiated into general themes, relating and relationships, celebration and ritual, professional and experiential learning, and focus on issues.

Each activity is presented on a separate page with specific parameters such as recommended age group, time, and group size clearly spelled out. The activity is described and warnings are given about emotionally provocative themes. Ideas for further development including follow-up activities or ways in which the material can be enriched by expanded discussion are also suggested. Most of the ideas presented here will be familiar, in some form, to art therapists who have worked in the field for a longer period of time. However, because the material is presented in a clear, organized way it can provoke thought about how these ideas can be implemented.

Activities are presented for use with a wide range of populations with more extended focus on particular areas. Work with couples, families, and senior citizens are given a special focus, with specific issues devoted to these populations. Gender and sexuality and racial issues are also explored in a series of exercises that could theoretically be presented as a sequence in a short-term workshop. Alternative approaches to each task are thought-provoking and the relevance to particular populations is outlined. A section on "professional and experiential learning" could be used with a variety of professional populations to promote reflection and learning about aspects of career and personal development. For a "well" population, a series on "celebration and ritual" provides exercises to promote self-reflection and enjoyment.

There are not many books about art therapy that present such simple, direct, and easily applicable ideas for use with groups. Among those that do suggest specific ideas for groups, as part of a larger context, are Robbins and Sibley (1976), Paraskevas (1979), and Landgarten (1981). Rubin (1984), advocates a more open-ended approach while recognizing the need, at times, for structured activities. In comparison with books that offer more lengthy rationales for use with particular populations or theoretical background, Campbell offers limited theory and rationale. Her book is most useful as a stimulus to generate ideas for approaches to groups.

With this in mind, *Creative Art in Groupwork* can clearly be helpful to art therapists who use it as a spring board for developing their own approaches to groups. It may be particularly relevant to those who work in short-term settings and those who offer training and workshops to "well" populations.

References

Furrer, P. J. (1982). *Art therapy activities and lesson plans for individuals and groups.* Springfield, IL: Charles C Thomas.

Landgarten, H. B. (1981). *Clinical art therapy.* New York: Brunner/Mazel.

Merman, C. R. (1993). Drive-thru art therapy: A response to the challenges of brief hospitalizations. *American Art Therapy Association 24th Annual Conference, Common Ground: The Arts, Therapy, Spirituality* (p. 35). Mundelein, IL: The American Art Therapy Association.

Paraskevas, C. B. (1979). *A structured approach to art therapy methods.* New York: Collegium.

Robbins, A., & Sibley, L. B. (1976). *Creative art therapy.* New York: Brunner/Mazel.

Rubin, J. A. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Video Review Response

A response by **Karen L. Wakeley, MPS,** to James Consoli's review of *The Box.* Reviewed in *Art Therapy: Journal of the American Art Therapy Association,* Volume 11, Number 1

> *"I say," murmured Horton. "I've never heard tell of a small*
> *speck of dust that is able to yell.*
> *So you know what I think? . . .*
> *Why, I think that there must*
> *be someone on top of that small speck of dust!"*
> (Dr. Seuss, 1954)

I ask from *The Box,* in the voice of Who, "Hey, Horton! How's this? [Are our images] coming through?"

In the last paragraph of his review of *The Box,* Consoli compares the video to Dr. Seuss' film *Horton Hears a Who* (1970), asking if,

> . . . in contrast to *The Box,* does the completeness of *Horton* . . . put the viewer too much at ease? Does the incompleteness and abstract quality of *The Box* succeed in encouraging viewers to become active, get up from their recliners (or boxes), and find sense in [*The Box*]? (p. 69)

While *Horton Hears a Who* is an excellent metaphoric story with great potential for therapeutic use, *The Box* is markedly different in that it is devoid of any verbal utterances. The creation of dialogue, internal dialogue, and verbal narrative reference is left to the viewer's projection. He may project his own scenario or associate it with an actual situation or memory. He can alter the story to fit his conscious and unconscious needs. Even those who do not consciously imagine dialogue fill in the sensory information they need to be able to relate to the story by identifying or denying identification.

The characters' actions and facial expressions reveal loneliness, anger, fear, curiosity, and anticipation without verbal explanation or labeling, thus allowing and encouraging identification on a preverbal, gut level. The verbal fairy tale uses distancing through character formation and setting, and includes conflict and an outcome. The visual story of *The Box* also contains these elements but during processing, the facilitator and client(s) may work with conflicts on a metaphoric level, or bring the story closer through conscious identification. The vagueness of the story line enhances opportunities for identification. While conflict is presented and explored, it is left to the viewer to accept it at face value or to further define it. Even taken at face value, the viewer makes the situation his own by providing the narrative to accompany it.

Who Does *The Box* Serve?

Anyone with the capacity to watch and respond to a short video story can benefit from *The Box.* People who have intrapsychic or interpersonal difficulties and can identify with the character can be guided to explore their situations through *The Box.* Although children as young as 5 years can use this tool to learn to name and describe feelings, we recommend a mental age of at least 8 years for in-depth use.

The Box is well-suited for work with substance abusers. Its short segments, flexibility, distancing properties, and capacity to provoke interaction make it appropriate for use in short-term treatment centers. Two of its four seasonal segments suggest "gaining control" and "breaking out of ruts."

Psychiatric treatment centers can find many uses for *The Box.* The video has short segments and varied follow-up activities which allow it to be continually used as the client population rapidly turns over. Groups can be completed in under one hour. Further exploration of one segment may be contained with different follow-up activities to intrigue both new members and provide continuity to clients who attended the previous group. In long-term settings, issues may be explored in depth, with the distancing factors altered to fit the treatment situation.

Children and adolescents in well-health groups can use *The Box* to explore feelings, actions, reactions, and changes in their lives. Children and adults, including those who are withdrawn or resistant to treatment, respond to the visual images in *The Box.* This makes the video an ideal tool for exploring feelings and situations for those who are medically ailing or experiencing emotional difficulties. The video is a tool to help people identify and share feelings and situations, work creatively alone and with others to solve problems, and become aware of ways in which they can gain control of difficult aspects of their lives.

Students in the helping professions may use *The Box* both as an instrument for learning to adapt a therapeutic tool for various populations, and as a tool for enhancing self-awareness and sensitivity. The video can be a tool for corporate sensitivity training programs, to encourage employees to be more empathic, self-aware, and improve their abilities to work with others.

By including archetypal symbols and eliminating verbal narrative, *The Box* can reach a greater audience, including persons who are deaf or speak languages other than English. This therapeutic tool is used primarily with groups, but it is also used with individuals.

What Qualifications Are Necessary for Group Facilitators?

Leadership is a pivotal factor in determining the benefits a group can derive from the use of *The Box.* Group facilitators should be creative therapists, psychologists, social workers, or other professionals with strong backgrounds in psychology and human development. A skilled teacher can use *The Box* as long as a psychologist is available for consultation, if needed. The facilitators should have good group leadership skills. They must be active listeners of word, body language, and picture, and be accepting of all responses. They must not pressure or seek a desired response but be able to judge when a client needs more distance or more in-depth follow-up work. It is essential that the leader be able to facilitate discussion of any material that may come up for the student or client, since *The Box* may reach people on a deep unconscious level as well as on a superficial level. It may bring up material that is both repressed and frightening.

Introduction: How Can the Facilitator Frame *The Box* for a Group?

Consoli states that "(g)laringly missing is how a group facilitator can frame an introduction to this film" (p. 69). Although some guidelines are given within the text of the User's Manual, we agree with the need for conspicuous guide to introducing the video, and have added one to the manual. It can be summarized as follows:

> You are about to see a short story about a girl and a box. Everyone has different reactions to this film and there are no right or wrong impressions. As you watch, pick one or two feelings, images, or ideas that have meaning for you and we will discuss them after we see the film.

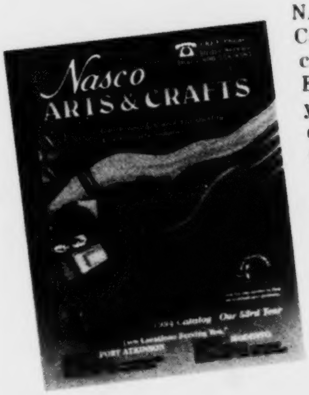
Short, introductory videotapes showing *The Box* in use with children, adolescents, and adults are available for free 10-day viewings.

References

Consoli, J. (1994). Video Review. The Box: A guide to an interactive film project for use with the arts therapies. *Art Therapy: Journal of the American Art Therapy Association, 22*,(1), 68–70.

Geisel, T. (Dr. Seuss). (1954). *Horton hears a who.* New York: Random House.

Jones, C. (Director & Producer), & Geisel, T. (Dr. Seuss) (Writer & Producer). (1970). *Horton hears a who.* [Film]. New York: MGM/UA.



NASCO Arts & Crafts...
Your Palette to Creativity!

NASCO's 1994 Arts & Crafts Catalog has over 10,000 arts and crafts supplies available—Everything you need to inspire your students to discover the freedom and joy of self-expression through art. We offer materials for painting, drawing, sculpting, jewelery making, ceramics, art history, and much more.

Many items are available exclusively from NASCO including: NASCO Print Drying Racks, NASCO's Safety-Kut print making blocks, NASCO Country School Tempera, and NASCO's highly acclaimed Bulk-Krylic.

Write Dept. EAE410, for your free 1994 NASCO Arts & Crafts Catalog today, or call our free phone order service.

Free Phone Order Service: 1-800-558-9595
FAX: 1-414-563-8296

Nasco
Fort Atkinson, WI 53538-0901
Modesto, CA 95352-3837

FROM THE PUBLICATIONS COMMITTEE:

***Look for the these new and exciting resources* available this Fall!**

The AATA Membership Survey Report, by Gwynne La Brie, BA

The History of Art Therapy, by Maxine Junge, PhD, A.T.R.

Oral Histories by the Pioneers of Art Therapy

The Continuous Quality Improvement Manual, prepared by Paula Howie, A.T.R., and Kathy Gilmartin Gutierrez, A.T.R.

The Guide to Conducting Art Therapy Research, edited by Harriet Wadeson, PhD, A.T.R.

American Art Therapy Association, Inc.

RESOURCES

Available through the National Office

♦CONFERENCE PROCEEDINGS	Members	Non-Members
Creativity and the Art Therapists Identity (1976) (ISBN 1-882147-04-9)	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) (ISBN 1-882147-05-7)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) (ISBN 1-882147-10-3)	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) (ISBN 1-882147-12-X)	$ 7.00	$ 9.00
Art Therapy: A Bridge Between Worlds (1981) (ISBN 1-882147-11-1)	$ 7.00	$ 10.00
Art Therapy: Still Growing (1982) (ISBN 1-882147-06-5)	$ 10.00	$ 14.00
Art Therapy: New Directions in the 80's (1987) (ISBN 1-882147-13-8)	$ 15.00	$ 20.00
Professionalism in Practice (1988) (ISBN 1-882147-08-1)	$ 15.00	$ 20.00
Painting Portraits: Families/Groups/Systems (1989) (ISBN 1-882147-07-3)	$ 15.00	$ 20.00
Image and Metaphor (1991) (ISBN 1-882147-09-X)	$ 15.00	$ 20.00
The Art Therapist: Artist, Teacher, Clinician, Healer (1992) (ISBN 1-882147-14-6)	$ 15.00	$ 20.00
Common Ground: The Arts, Therapy, and Spirituality (ISBN 1-882147-21-9)	$ 15.00	$ 25.00

NOTE: Ten or more copies of any single Proceeding: 10% discount on total cost. Set of four Proceeedings (consecutive years): 20% discount on total price. POSTAGE AND HANDLING FOR PROCEEDINGS: $3.00 first item; $.75 each additional Proceeding.

♦OTHER PUBLICATIONS	Members	Non-Members
A Guide to Conducting Art Therapy Research (ISBN 1-882147-08-0)❶	$ 24.00	$ 35.00
National Registry of Masters Theses and Practicum Papers ❷	$ 15.00	$ 25.00
AATA Chapter Manual	$ 10.00	N/A

NOTE: ❶ Postage included on all orders for this publication. Ten or more copies - 10% discount.
❷ Chapter Manual: Add $2.90 for postage/handling.

♦TRAINING LITERATURE	Members	Non-Members
Educational Guidelines	$ .30	$ 1.00
Education List (colleges & universities offering art therapy programs)	$ .30	$ 1.00
Standards and Procedures for Registration	$ .30	$ 1.00
Criterion for Professional Membership	$ .30	$ 1.00

NOTE: General Information Packet - $4.00 - consists of first three items above. These pamphlets are available to members only in multiples: 1-9 copies - $2.00 plus SASE; 10-50 copies - $5.00 plus SASE.

♦APPLICATIONS	Members	Non-Members
A.T.R. (Registration) Application	N/C	$ 1.00
Professional Membership Application	N/C	$ 1.00
General Membership Application	N/C	N/C

♦ MEMBER INFORMATION	Members	Non-Members
Member Specialty List	$ 1.90	$ 2.90
Membership Survey	$ .75	$ 2.75
Membership Directory	$ 13.00	$ 55.00

NOTE: Postage and handling for AATA Membership Directory: U.S. - $2.90; Canada/Mexico - $3.25;
Foreign - $10.00

♦OTHER LITERATURE	Members	Non-Members
Art Therapy Model Job Description	$ .30	$ 1.00
Art Therapy Media List	$ .30	$ 1.00
Bibliography: Books Authored by Members of AATA	$ .30	$ 1.00
Standards of Practice Document	$ .30	$ 1.00
Ethics Document	$ .30	$ 1.00

NOTE: Above items are available to members only in multiples: 1-9 copies - $2.00 with SASE; 10-50 copies -

♦SUBSCRIPTIONS			
Art Therapy: Journal of the American Art Therapy Association	Individuals:	U.S. - $40	Foreign - $64
	Institutions:	U.S. - $57	Foreign - $80
	Back Issues:	Members - $10	Non-Members - $18
AATA Newsletter	Non-Members:	U.S. - $16	Foreign - $28

♦FILMS	Type	Members	Non-Members
Art Therapy: Beginnings	16mm - RENTAL ONLY	$ 40.00	$ 50.00
1977 (color/sound/45 minutes)	One-half inch VHS - PURCHASE ONLY	$ 50.00	$ 80.00
Michael	16mm - RENTAL ONLY	$ 30.00	$ 35.00
1977 (color/sound/12 minutes)	One-half inch VHS - PURCHASE ONLY	$ 50.00	$ 80.00
Art Therapy	16mm - RENTAL ONLY	$ 35.00	$ 45.00
	One-half inch VHS - PURCHASE ONLY	$ 50.00	$ 80.00

NOTE: Postage and handling for films: $3.00 each VHS; $7.00 each 16mm

Introducing the

25th Anniversary Commemorative Poster

"Three Art Therapists"
1989

poster reprint of the
34" X 45" oil painting
by artist Edith Kramer

Limited Edition — only 1,000 prints available!

available at the National Conference

for further information please contact
the AATA National Office

Call for Papers

Mandala: The Sacred Circle
Honoring the Life and Work of
Joan Kellogg
Johns Hopkins University,
Baltimore, MD
June 4,5 & 6, 1995

Sponsored by ATMA, INC.
Association of Teachers of
Mandala Assessment

For information, call (813) 581-0786

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone #s: ____________________ work ____________________ home

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ______________________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Black and white photos of original artwork plus 4 photocopies of each.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ______________________________ **Date** ____________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association***, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions**; a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

THE AMERICAN ART THERAPY ASSOCIATION INC.

25th ANNIVERSARY CONFERENCE

REFLECTING ON THE PAST, ENVISIONING THE FUTURE

Reflecting on the Past, Envisioning the Future
25
25th Anniversary AATA Conference
PAINTING PORTRAITS

NOVEMBER 16-20, 1994
THE PALMER HOUSE
CHICAGO, ILLINOIS

This years conference will feature:

- Day long pre-conference courses
- Keynote speaker ELLEN DISSANAYAKE, author of Homo aestheticus and What is Art For?
- Experiential workshops, oral presentations and networking forums
- General sessions on ethics and highlights from the history of the Association
- Public exhibit of artwork by area art therapists and other special events

AATA members will receive additional information and full registration packages by mail. Other interested parties should contact:

AATA, Inc.
1202 Allanson Rd.
Mundelein, IL 60060
708-949-6064
Fax: 708-566-4580

The next AATA Conference will be held November 8-12, 1995 in San Diego. Contact AATA or see the Fall Newsletter for information regarding the submission of proposals.

CHARLES C THOMAS • PUBLISHER

☐ Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 206 pp. (7 × 10), 33 il.

In *Spiritual Art Therapy: An Alternate Path*, the author proposes that, on one level or another, each person is a seeker of spiritual transcendence although most hide this need even from themselves. She perceives this search to be a critical element in attempts to cope with life's traumata, specifically loss and grief, when people face the emotional work of accepting the inevitable. In this book, therapists are urged to take into account the existence of spiritual aspects of personality, both in terms of making proper assessments and more focused treatment plans for the people under their care. Although addressing itself chiefly to art therapists, the thrust of this opus is an attempt to sensitize all clinical practitioners to the spiritual dimensions of art therapy. By drawing on sources in the literature of religion, psychodynamics, systems theory, sociology, art and ethics, the author lays a foundation for her mission, namely, to find a way of discovering and, if possible, measuring clients' spiritual sensibilities and search for personal meaning of their relationship to God. In addition to art therapists, it will be useful to mental health workers, social workers, educational therapists, pastoral counselors, psychologists, psychiatrists, and other creative arts therapists.

☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 16 il., $45.75.

☐ Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 × 10), 12 il., $33.75.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $35.75.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $54.25.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $33.00.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $44.00.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $51.00.

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $51.25.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $30.00.

☐ Rich, John Martin & Joseph L. DeVitis—**THEORIES OF MORAL DEVELOPMENT. (2nd Ed.)** '94, 180 pp. (7 × 10).

☐ Makin, Susan R.—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 116 pp. (7 × 10).

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts, Theories and Practices. (2nd Ed.).** '94, 310 pp. (7 × 10), 1 table.

☐ Westmeyer, Paul M.—**A GUIDE FOR USE IN PLANNING, CONDUCTING, AND REPORTING RESEARCH PROJECTS. (2nd Ed.)** '94, 148 pp. (7 × 10), 15 il.

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $49.75.

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $62.75.

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¾), 28 il., $36.25.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¾), 21 il., $36.25.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $46.50.

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $22.00.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $23.50, spiral (paper).

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $25.25.

☐ Singer, Florence—**STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children.** '80, 144 pp., 33 il., $23.50.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $48.50.

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $32.25.

☐ Benenzon, Rolando O.—**MUSIC THERAPY MANUAL.** '81, 178 pp., 20 il., $28.25.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

Call for Papers

Art Therapy is seeking submissions for the following special issue:

Gender Issues in Art Therapy

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to gender issues in the theory and practice of art therapy. Submissions may focus on any topic or population related to this theme; of particular interest are: the effect of gender on clinical practice, professionalism, ethics and/or training, feminist theory and its relationship to art therapy, and gay and lesbian issues in clinical practice.

Deadline for submission for "Gender Issues and Art Therapy" is December 1, 1994.
Please see "Guidelines for Authors" in the Journal for specific requirements in terms of style and format. Please send five copies of all submissions to:

Cathy A. Malchiodi, A.T.R., Editor
Art Therapy, c/o AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060

Errata:

On pages 157 and 158 of Volume 11, Number 2, Judy Weiser's name and reference to her work are incorrect. The corrected reference should read: Weiser, J. (1993). *PhotoTherapy techniques: Exploring the secrets of personal snapshots and family albums.* San Francisco, CA: Jossey-Bass, Inc. We apologize for this error.

Call for Papers

Art Therapy Association of Florida Conference

The Image Speaks: Trusting the Process of Art Therapy
The Dolphin Beach Resort
St. Petersburg Beach, Florida
May 5, 6, & 7

Attention Art Therapists, Creative Art Therapists, Mental Health Professionals, Allied Professionals and Educators: CALLING ALL PAPERS, PRESENTATIONS, PANELS, WORKSHOPS

Please submit an abstract of three hundred words, double spaced and typed.

Mail three copies to:

Lin Carte-Anderson M. Ed., A.T.R.
123 E. Tarpon Avenue
Tarpon Springs, Florida, 34689

Due: October 10, 1994

Qualifying Materials needed from each presenter:
Resume, course synopsis, bibliography, goals/objectives, and means of evaluating participation;

CEUs for psychologists, medical professionals, social workers and mental health counselors are being arranged.

BEST COPY AVAILABLE

Magnolia Street Publishers

presents

Integrative Approaches to
FAMILY ART THERAPY
By Shirley Riley, MFCC, A.T.R.
with observations by Cathy A. Malchiodi, MA, A.T.R.

Integrative Approaches to

FAMILY ART THERAPY

By Shirley Riley, MFCC, A.T.R.
with observations by Cathy A. Malchiodi, MA. A.T.R.

This important new book by noted family art therapist Shirley Riley is designed for both the beginning practitioner as well as the advanced family therapist. An important source of ideas, this text provides not only examples of integrative approaches to family art therapy, but also offers practical ways to utilize art therapy with individuals, families and couples. The volume emphasizes the integration of current thinking in family therapy and the application of art therapy in family treatment. Chapters cover a wide range of theoretical viewpoints, including structural, systemic, narrative, family of origin and social constructionism. Riley brings these theories to life through case examples as well as commentaries on contemporary socio-economic and cultural aspects of family art therapy in the '90s.

This will be an invaluable resource in both art therapy and family therapy courses. Suggestions for utilizing the material in the classroom as well as in clinical settings are included, making this book a practical guide for students, educators and therapists.

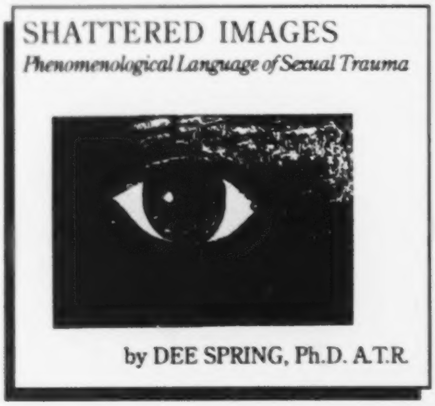
available in November —pa. $29.95

CALIFORNIA
ART THERAPY
TRENDS

A creative and timely collection of essays and excercises by more than 30 California art therapists. pa. **$29.95**

ART as therapy with children
by Edith Kramer

One of the nost widely read textbooks by a pioneer in the field. Now updated and back in print. pa. **$19.95**


SHATTERED IMAGES
Phenomenological Language of Sexual Trauma
by DEE SPRING, Ph.D. A.T.R.

A unique treatment model for sexual trauma victims incorporating art therapy, testing, imagery and hypnosis. pa. **$36.00**

MAGNOLIA STREET PUBLISHERS•1250 W. VICTORIA ST.•CHICAGO, IL 60660•312-561-2121

individual orders TO:

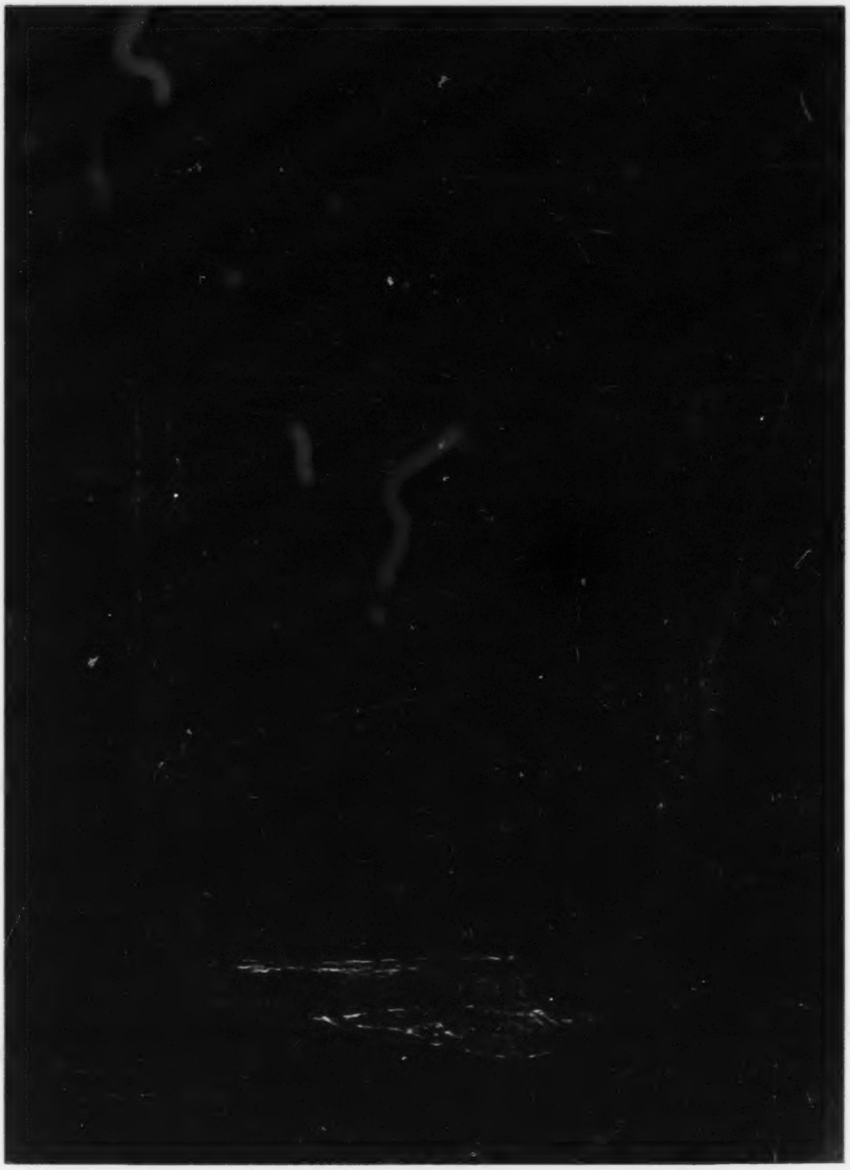
STERN'S BOOKS
2004 W. Roscoe St.
Chicago, IL 60618
312-883-5100 or Fax 312-477-6096

All major credit cards and checks accepted. Add $4.00 UPS for first book, .50 @ additional book, USA.

Celebrating
AATA's 25th Anniversary
1969 - 1994

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION



VOLUME 11, NUMBER 4, 1994

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue; July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, MA, A.T.R.
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Patricia St. John, EdD, A.T.R.
College of New Rochelle, New Rochelle, NY

Book Review Editor
Barbara Sprayregan, Psy.D., A.T.R.
Arlington, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Philadelphia, PA

Production Editor
Heather R. Jurczyk

Editorial Board
Pat B. Allen, PhD, A.T.R.
River Forest, IL
Frances E. Anderson, EdD, A.T.R., HLM
Illinois State University, Normal, IL
Doris B. Arrington, EdD, A.T.R.
College of Notre Dame, Belmont, CA
Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec
Mariagnese Cattaneo, PhD, A.T.R.
Lesley College, Cambridge, MA
Susan E. Cheyne-King, MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R.
The George Washington University, Washington, DC
Julie Epperson, MA, A.T.R.
Salt Lake City, UT
Janice Havlena, MA, A.T.R.
UNM Children's Psychiatric Hospital, Albuquerque, NM
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Vija B. Lusebrink, PhD, A.T.R.
University of Louisville, Louisville, KY
Howard McConeghey, EdD, A.T.R.
University of New Mexico (Emeritus), Albuquerque, NM
Shirley Riley, MA, MFCT, A.T.R.
Loyola Marymount University, Los Angeles, CA
Susan Evans Spaniol, EdD, A.T.R.
Lesley College, Cambridge, MA
Betty Jo Troeger, PhD, A.T.R.
Florida State University, Tallahassee, FL
Evelyn Virshup, PhD, A.T.R.
California State University, Los Angeles, CA
Robert Wolf, MPS, A.T.R.
College of New Rochelle, New Rochelle, NY

AATA President
Bobbi Stoll, MFCC, A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

VOLUME 11

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 4, 1994

Editorial

Introduction to Special Issue on Ethics and Professional Issues: Professional Courtesy — Cathy A. Malchiodi, MA, A.T.R., LAT, LPCC 242

Commentaries 244

Special 25th Anniversary Section

Interview with Felice W. Cohen, A.T.R., HLM — Irene Corbit, PhD, A.T.R. 246

How Will the Profession of Art Therapy Change in the Next 25 Years? Responses by Past Award Winners — Jayne Rhyne, PhD, A.T.R., HLM, Robert E. Ault, MFA, A.T.R., HLM, Judith A. Rubin, PhD, A.T.R., HLM, Rawley Silver, EdD, A.T.R., HLM, Deborah A. Good, MA, A.T.R., and Cathy A. Malchiodi, MA, A.T.R., LAT, LPCC 250

Articles

The Art Therapist as Expert Witness in Child Sexual Abuse Litigation — Marcia Sue Cohen-Liebman, MA, MCAT 260

The Power of Language in the Art Therapeutic Relationship — Susan Spaniol, EdD, A.T.R., LMHC and Mariagnese Cattaneo, PhD, A.T.R., LMHC 266

The Art of Art Therapy May be Toxic — Jennifer Jacobs, MA, A.T.R., and Ilo Milton, MPS, MSW, A.T.R. 271

Brief Reports

Legal and Ethical Issues Impacting Unlicensed Art Therapists and Their Clients in California — Marybeth Webster 278

Viewpoints

Progress or Politics — Dee Spring, PhD, A.T.R., MFCC 282

Politics and Poetics: The Acquired Wisdom of the Art Therapist — Maxine Junge, PhD, A.T.R. 288

Essential Legal Issues for Art Therapists in Private Practice — Gail Wirtz, MAT, MPA, A.T.R. 293

Photography and Confidentiality — Jennifer L. Jacobs, MA, A.T.R. 296

Patterns — Mildred Lachmann-Chapin, A.T.R. 297

Reviews

Stories for Children with Problems and Wishes: A Therapeutic Workbook for Turning Problems into Gifts — J. D. Ball, PhD 299

The Way of the Journal: A Journal Therapy Workbook for Healing — Susan E. Cheyne-King, MS, LPC, A.T.R. 299

Noteworthy 301

Annual Index, Volume 11 302

About the Cover: "Airless," 6" × 9", 1994, Mixed Materials, by Don Seiden, A.T.R., Professor, Art Education and Art Therapy, School of Art Institute of Chicago. "The fear of suffocating in an airless space is the theme of this wall sculpture. A union of horror and humor in collision create the uneasy quality of the image."

1871

Editorial

Introduction to Special Issue on Ethics and Professional Issues: Professional Courtesy

Cathy A. Malchiodi, MA, A.T.R., LAT, LPCC, *Editor*

This issue of *Art Therapy* features several articles focusing on the broad topic of ethics and professional practice. Contributions include a review of the role of the art therapist as expert witness in child sexual abuse litigation (Cohen-Liebman); an exploration of the impact of language in art therapy (Spaniol & Cattaneo); information on art materials that every art therapist should know (Jacobs & Milton); legal and ethical issues impacting unlicensed art therapists (Webster); and several viewpoints including two on politics and professional issues (Spring; Junge), legal issues in private practice (Wirtz), and photography and confidentiality (Jacobs).

As editor of this journal one ethical issue that has intrigued me is the concept of professional courtesy. Professional courtesy is the respect extended to colleagues, peers, teachers, and supervisors when utilizing their original work in one's written publication or oral presentation. In publications, it may be in the form of citing the work of another in a reference list or it may be as simple as making an acknowledgement in a footnote of a person's contribution to the development of the work.

A very common instance where professional courtesy is extended is in the preface to a master's thesis or doctoral dissertation. It is a tradition for the author to note the people who contributed to development of the work, particularly teachers, supervisors, committee chairs and members, and mentors. This is a formal and effective way of acknowledging the information conveyed throughout the student's program of study as well as the time teachers, committee members, and others have put into the student's learning experience. In oral theses or dissertation presentations, the acknowledgement may be less formal, with the speaker briefly noting any individuals who inspired, provided professional communications, or helped to develop the ideas presented in the talk.

Unfortunately, lack of professional courtesy in publications and presentations in our field is a fairly common occurrence. Earlier this year I was stunned to see my exact words and original ideas from a graduate class I had taught at the local university in print in a magazine and credited to a former student, but with no reference to me included as the source for these concepts. It gave me pause to think how often I have heard art therapy educators observe that former students or supervisees used the original materials they have so carefully provided them in the classroom without acknowledging them as the source for these ideas. I think part of the reason for this is that students see their professors with consumers' eyes; they may believe what they receive in the classroom is something that they have purchased through tuition, and therefore becomes theirs to utilize in any manner. They are often naive in their understanding of what their mentors have put into their lectures, experientials, and course outlines in terms of time and research. Therefore, they may assume that they do not need to give reference to original material that is conveyed to them in an educational or supervisory setting. In the same vein, they may also usurp the ideas of fellow students, neglecting to acknowledge them as the source of inspiration, collegial advice, or communication.

Educators and supervisors also need to be wary of their inappropriate use of student work accomplished under their tutelage. It is not news that professors have used graduate students' work as their own in both publications and professional presentations. Therefore, the same courtesy must be considered when including the work of students within a paper or other scholarly presentation.

Professionals in our field are often guilty of not giving appropriate credit to others. Many papers are submitted to the journal with inadequate references to the original ideas developed by other art therapists. Some of this is due to lack of library research on the topic of the paper and certainly, the author has the choice to reference or not reference another author within the development of his/her topic. However, when ideas are presented that approximate the original work of another individual, then credit in some form must be given, either in the reference list (when cited within the text of the article or presentation) or in an acknowledgement (when a mentor, teacher, supervisor, or colleague has significantly contributed to paper/talk or advised the author/presenter).

As this journal goes to press the Ethics Committee of the American Art Therapy Association has developed a revised *Code of Ethics* for art therapists, to be presented at a general session of the 25th Annual Conference. Related to the topic of professional courtesy with regard to publications and other printed materials, "Responsibility to the Profession," Section 7, states:

> 7.2 Art therapists shall attribute publication credit to those who have contributed to a publication in proportion to their contributions and in accordance with customary professional publication practices.

> 7.3 Art therapists who author books or other materials which are published or distributed shall appropriately cite persons to whom credit for original ideas is due. (AATA, 1994)

Others in the field of art therapy have examined this issue as well. In the document, *The Diagnostic Drawing Series Style Guide*, Mills (1994) suggests the following courtesy concerning citation of work derived from the DDS:

> When presenting work which derives from the DDS Archive, it is good form to acknowledge by name (verbally if presenting, in a footnote or author's note if publishing) the contributions of those who assisted by collecting the Series or by helping you on site. Extensive consultation with others about your work should also be acknowledged in this manner.

Professional courtesy in the field of art therapy is a subject that should be discussed with our students in their graduate training and with interns we supervise. It is also a practice that professionals should be cognizant of in their own writing and conference presentations. Aside from the obvious ethical aspects of the professional courtesy, there is an added benefit involving respect and affirmation of other's work. These are concepts that support art therapists in continuing to share their work either through publication or presentation, and affirm the value of one's original contributions to the field.

Editor's note: In the spirit of professional courtesy, I would like to thank Cay Drachnik, A.T.R., HLM, for her communication on the revised *Code of Ethics*, Anne Mills, A.T.R., for sharing *The DDS Style Guide* and her cogent thoughts on authorship, and Jeanne Carrigan, A.T.R., for many stimulating conversations on ethics in general, that contributed to the formulation of this editorial.

References

American Art Therapy Association. (1994). *Code of ethics*. Mundelein, IL: Author. (in press as of this writing)

Mills, A. (1994). *The Diagnostic Drawing Series style guide*. Unpublished document available from the author.

For additional information on authorship and style see:

American Psychological Association. (1994). *Publication manual of the American Psychological Association* (4th ed.). Washington, DC: Author. (Potential authors should obtain a copy of this newest edition of the APA publication manual in order to prepare manuscripts for submission to this journal)

Art Therapy
is seeking submissions for the following special issues:

1. Gender Issues in Art Therapy

Art Therapy is seeking full-length articles, brief reports, and view points for a special issue devoted to gender issues in the theory and practice of art therapy. Submissions may focus on any topic or population related to this theme. Of particular interest are: the effect of gender on clinical practice, professionalism, ethics, and/or training, feminist theory and its relationship to art therapy; and gay and lesbian issues in clinical practice.

2. Art Therapy & Addictions

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to the use of art therapy in the treatment of addictions. Submissions may focus on any aspect of art therapy or population related to this theme; of particular interest are specific applications of art therapy to clients with addictions, research in the area of art therapy and addictions, and issues in clinical practice with clients with addictions.

3. Art Therapy in the Schools

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to the use of art therapy within schools. Submissions may focus on any aspect of art therapy or population related to this theme; of particular interest are specific applications of art therapy to clients/students in school settings, research, ethical and professional issues, and issues in providing art therapy services within an educational milieu.

Deadline for submissions for "Gender Issues in Art Therapy", "Art Therapy & Addictions" and "Art Therapy in the Schools" is *March 15th, 1995*. Please see "Guidelines for Authors" in the *Journal* for specific requirements in terms of style and format; submissions which do not follow these requirements will be returned without review. Please send five (5) copies of all submissions to:

Cathy A. Malchiodi, A.T.R., Editor
Art Therapy
c/o AATA, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Commentaries

Letters to the Editor

Protecting the Integrity of Art Therapy

Since its formation in 1971, the American Art Therapy Association, Inc. (AATA) has moved steadily toward its goal of achieving consistently high standards in the mental health profession. This has been accomplished through the adoption of standards for the practice of art therapy, implementation of a registration process to signify attainment of high professional status, and continual education and information sharing among members. Moreover, with our firm's assistance as legal counsel, AATA has adopted a code of ethics and a grievance procedure to enforce those ethical precepts available to both members and their patients.

Despite the enormous growth in the art therapy profession and widespread use of art therapy, not all mental health professionals who incorporate the discipline of art therapy into their practice are knowledgeable about the standards adopted by AATA. As AATA's legal counsel, we have encountered an increasing number of general mental health professionals who incorporate art therapy into their practice. Many of these individuals refer to themselves in their letterhead, business cards, and other materials as "art therapists." A significant number of these mental health professionals are believed to have very minimal art therapy background, perhaps as little as having completed a one- or two-day seminar focusing on art therapy. The growing use of the term *art therapy* among general mental health professionals has created some confusion among AATA members and the general public as to precisely who is entitled to hold himself or herself out as an "art therapist."

For several years, AATA had the exclusive right to enable qualified art therapists to hold themselves out as being a Registered Art Therapist and to use the designation A.T.R. in connection with their professional practice, thereby signifying that they meet the high standards established by AATA. That registration process is now the responsibility of AATA's sister organization, the Art Therapy Credentials Board, Inc. As counsel, we actively assisted AATA in protecting the integrity of the A.T.R. title and of the term *Registered Art Therapist* when others have attempted to use or confer those designations without authority. We have even obtained judicial enforcement of AATA's rights when challenged.

The right to control the use of the terms *A.T.R.* and *Registered Art Therapist* is not, however, to be confused with the ability to regulate use of the broader terms *art therapy* and *art therapist* in conjunction with the general practice of therapy. Simply stated, AATA has no right to regulate or impose conditions on the use of those general terms, and very few states regulate the use of those terms. The practice, the use of art therapy by a generalist is a matter of competency to be determined by patient and therapist. Regarding professional credentials, holding oneself out as an art therapist may approach the level of misrepresentation, but absent state regulation, it is also a matter between patient and therapist.

The question here is what may AATA do directly and through its members to address the need for clarity and to maintain high professional standards in this area. As an association, AATA has contacted nonmember therapists identified as using the term *art therapist* and/or *art therapy* to inform them of AATA's organizational concerns about art therapy as a discipline, as well as to introduce AATA to them and encourage membership. By promoting AATA membership and participation in professional conferences and programs sponsored by AATA, the association hopes to encourage adherence to its professional standards and ethical guidelines while facilitating continuing education within the art therapy profession. As members, you can help work toward these objectives by spreading the word about AATA and working within your local chapters to better inform your fellow mental health professionals of the importance of maintaining uniformly high standards in the art therapy field. It is equally important, however, to work within your own communities to educate the general public about the unique benefits of art therapy and the high professional standards which AATA members are required to meet. In this way, you will be promoting the organization and what it stands for, the art therapy profession as a whole, and the competency of you and your fellow members as indicated by your participation in AATA and adherence to its high standards in your professional field.

Jonathan Braverman,
Rivkind, Baker & Braverman, P.C.,
Braintree, MA

It is always a pleasure to find the techniques of PhotoTherapy receiving attention through various articles or book reviews in professional journals, and thus I am delighted that Julia Byers took the time in a recent issue of *Art Therapy: Journal of the American Art Therapy Association* (Vol. 11, No. 2) to provide a detailed evaluation and comprehensive discussion of Fryrear and Corbit's 1992 book, *Instant Images—A Guide to Using Photography in Therapy*.

However, there were a few small errors made in that review, and I write today to ask you to print the correct information. Both in the text of the review, when Fryrear and Corbit's book was contrasted with others written on similar topics, as well as in its reference section, mistakes were made regarding the title of a recent book about various PhotoTherapy techniques, as well as the name of its author and publisher.

I am Judy Weiser, *not* Weis*l*er, and the title of my book, published in 1993 by Jossey-Bass in San Francisco (*not* Brunner/Mazel in New York City!) is: *PhotoTherapy techniques—Exploring the secrets of personal snapshots and family albums.* Since Ms. Byers has also recently written a lovely review of my book for the Canadian Art Therapy Association Journal without making these rather basic errors, I doubt that she was responsible for making those noted above in the Fryrear and Corbit review. Therefore, I can only assume it was a typesetting error through the editing process, and thus I'm expecting that you will not mind printing these corrections.

I might add that the incorrect title listed in the review's reference section *does* sound really interesting! It is, in fact, actually the title of one of my presentations at a past AATA conference(!), and although this is not the title of anything I have yet published, perhaps I will someday!

Thank you in advance for correcting these mistakes—and I'm looking forward now to seeing reviews of other books dealing with using client snapshots and albums as helpful adjuncts for art therapy practice, or, perhaps a special issue some day on this topic?

Judy Weiser, R Psych, MScEd, A.T.R.,
Vancouver, BC, Canada

Editor's note: An errata appeared in the previous issue of *Art Therapy*, Volume 11, No. 3.

Cathy Malchiodi's editorial (1994) and Rebecca Thomas' letter to the editor (1994) inspired me to voice my concerns about credentialing, especially "grandfathering." Grandfathering is a method of certifying professionals who have been working in the field without requiring them to be tested.

According to the State of Arizona Board of Behavioral Health Examiners, the object of certification is "To protect the public by maintaining and enforcing certification standards for behavioral health professionals in the fields of social work, counseling, marriage and family therapy, and substance abuse counseling" (Rules and Laws, State of Arizona, 1993). As the Governmental Affairs chairman of the Kachina Art Therapy Association, I investigated state certification and was informed that the potential for harm would need to be established before any consideration of certification/licensure would be looked into. There were two areas of concern. First, was it harmful or potentially harmful for counselors, and other mental health providers to use art therapy if they have not had the proper training? This could lead to the need for licensure, because licensure can make it impossible for other professionals to use art therapy without proper training. I have been concerned about this practice since 1989 when, as a volunteer at a psychiatric hospital, I saw counselors (untrained in art therapy) using art therapy with patients. The counselors utilized art directives that were contraindicated, they interpreted patients' artwork, they had no art training, and were not familiar with art media. Today, I am still concerned when I hear counselors, who are untrained in art therapy, say they use art therapy in school settings, private practices, and mental health agencies. There is no licensure to prevent this dangerous practice.

Secondly, does art therapy pose a potential danger? In my opinion, art therapy has the same risks as other mental health professions, so the answer is yes.

The object of certification is NOT so that art therapists can be accountable to insurance companies, or so that art therapists have more job opportunities. As a professional, those reasons are quite appalling to me. It is apparent that the profession of art therapy is growing and we will need the government's help to make sure the public is protected. In the past our Ethics, Education, and Standards Committes, and our own policing policies were in effect. Our A.T.R. status was an indication of our professional training.

Grandfathering is a respected, valuable and utilized method of certifying professionals who have been following all ethical practices, who had the required training at the time, and who wish to become certified. Are there others of you who think grandfathering should be utilized for all A.T.R.'s? What might we do to have an impact on this decision?

Lola Hickert, MEd., A.T.R., CPC
Litchfield Park, AZ

References

Malchiodi, C. A. (1994). Sorting out certification. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 82–83.

Thomas, R. (1994). Letters to the editor. *Art Therapy: Journal of the American Art Therapy Association, 11*(3), 173–174.

Special 25th Anniversary Section

Interview with Felice W. Cohen, A.T.R., HLM

Irene Corbit, PhD, A.T.R., Houston, TX

Felice W. Cohen was one of the founders of the American Art Therapy Association. She served as its first Secretary, third President, and on the committee that wrote the original association bylaws. She also served on numerous AATA committees, both as Chairperson and member.

Felice has been honored as a Distinguised Fellow with the American Society of Psychopathology of Expression, and as an Honorary Life Member of the Buckeye (Ohio) Art Therapy Association, the South Texas Art Therapy Association, and the AATA in 1989. She is retired from clinical practice and from the University of Texas Mental Sciences Institute where she worked as a clinician and served as Chief of Art Psychotherapy.

Felice has written numerous articles and given countless presentations on the clinical applications of art therapy. She is best known for her research on graphic indicators of child sexual abuse, publishing a paper on this topic in 1985. She has also developed video presentations of her work with abused populations. They include: Child at Risk, *which won an Emmy award, and* Breaking Silence.

The following interview of Felice Cohen, A.T.R., HLM, was conducted by Irene Corbit, PhD, A.T.R., student and friend of Felice, during April 1994. Videotaped by Jerry L. Fryrear, PhD, A.T.R.

Irene Corbit (IC): *I'm here today with Felice Cohen, you have been quite an important person in my life—a mentor, a teacher, and a colleague. You were the first secretary of the American Art Therapy Association, and . . .*

Felice Cohen (FC): President-elect.

IC: . . . president-elect, and then the third president of the American Art Therapy Association. So you go way back; you are one of the pioneers in the field.

FC: As I said to you earlier, I think I need a wagon. It's time for a wagon for the pioneers.

IC: *To begin with, why don't you let us know how you started as an art therapist.*

FC: Alright. I really started as a Sunday artist and a psychologist. That was my start. And I knew that the two together were important. And so I found a place through Baylor Medical School, the College of Psychiatry here in Houston, that would let me come and work for free and study for free. And I did that for about 2 or 3 years. Then we moved into what is now one of the largest medical centers in the country, and I was an associate at a place called TRIMS which means Texas Research Institute of Mental Sciences.

I wasn't paid for any of this, but one of the psychiatry residents who graduated received a job as medical director of the Houston Child Guidance Center, so she asked me if I would come over and start a program there. How much? For free—it's the same story. So, I did, and then one day she said, why don't you write a proposal to get a grant.

A well-known woman philanthropist in Houston by the name of Miss Hogg started the Child Guidance Center. I wrote to the Hogg Foundation at the University of Texas, but in those days, people were not writing grants. So, I said how will I do this? And my mentor, Dr. Pierce, said, "Well, just start off saying what you want." So my papers started—here come the judge, literally, here come the judge. And then I said, "I need money. I want to start a program here, and I can't continue to do it for free. I'd appreciate anything you could do." And the next day the letter was received by the Hogg Foundation, and I had a phone call inviting me up that day. They gave me a check right then and there. It lasted for 3 years, and that started my being paid.

In the meantime, I would speak for free anywhere and to anyone who asked, trying to spread the word about what art therapy was. There were only two art therapists in the city spreading the word, but before long, people knew what art therapy was about. We received calls from schools and churches—people wanted to learn about art therapy.

Then I received a job at TRIMS after the grants ran out, and I was there for 20+ years as Chief of Art Psychotherapy. When TRIMS was no longer funded by the state of Texas, the University of Texas took it over, and I was invited to continue my work. I stayed for 2 more years, but the bureaucracy was more than I could tolerate so I left. They gave me a farewell party which I thought would backfire because you're not supposed to drink on state property and they served mixed drinks. I thought this is one way of getting rid of me! Anyhow, that's how it started, and I've been in private practice ever since.

IC: *Now, I know you've worked with a number of interns, art therapy interns.*

FC: Yes, I worked with a number of art therapy interns; however, I really worked with more psychiatry residents than I did with art therapy interns.

IC: *I know one thing about you that maybe the rest of the audience, or not too many of them, know—you were the first Honorary Member of the South Texas Art Therapy Association.*

FC: I was also the first Honorary Life Member of the Buckeye Association.

IC: *And also an Honorary Life Member of the American Art Therapy Association.*

FC: That's right. Thank you. So I have three, and I consider that a real honor. To have your peers think this of you is just really great.

IC: *How about the future of art therapy? How do you feel about licensure? How do you feel about ongoing training and further education in the field? What are your thoughts about that?*

FC: Well, as you said, I'm a pioneer, so I did very well for my time. But like all things, times change, and I would probably have a very difficult time getting a job now, even with the amount of background I have, the amount of work I've done, and the amount of publications I've contributed to.

I think licensure is the most important issue. In fact, 10 years ago I wrote a proposal for licensure for art therapists, and Linda Gantt, who at that time was the Head of Governmental Affairs, came to Houston so that we could present it to the Senate. That was at the time that an organization called the "Killer Bees" . . .

IC: *I remember them well . . . .*

FC: Just skipped town . . .

IC: *That was all the legislators.*

FC: All the legislators went down to the border and played poker. And Linda and I were left there.

I knew licensure was very important to have and I hoped that with luck I'd get in under the grandfather clause. But, nevertheless, it's not new to me. I think art therapists need to broaden our field and need to train much longer than 2 years. I think they should certainly get LPCs (Licensed Professional Counselors) in Texas; I don't know what the rules are in other places.

IC: *They're different in other places.*

FC: But here in Texas, I think they definitely should. They can't have too much education as far as I'm concerned.

IC: *How about your thoughts for the future? Say into the 21st century?*

FC: Well, as a pioneer, I think you might leave this question to someone much younger than I who could answer it much better. I'll pass on that one.

IC: *Going back to you being a pioneer, I know that you were very instrumental in the beginning of the AATA. Please tell us a little bit about that first meeting. How did it come about and who was involved?*

FC: Oh, I'd be delighted. I think this is something that I hope the people who see this interview enjoy reading it as much as I do telling it. Dr. Paul Fink, who was Chief of Psychiatry at Hahnemann Medical College in Philadelphia, was very interested in starting an art therapy program. As a matter of fact, one of the first ones in the country was there. While I was at the Child Guidance Center, I received a letter from Myra Levick saying that she was inviting some people to Philadelphia as guests of Hahnemann for the purpose of determining whether or not we should have an association. Just that simple.

IC: *How do you think she got your name?*

FC: I don't know. But I do know at that time we were on a "Mrs." basis—Mrs. Levick and Mrs. Cohen. It's no longer that way at all. Anyhow, she not only got my name, but other names. I did a lot of speaking in Houston—perhaps Paul may have heard of me—I really don't know how it happened.

It was a very cold day in February in 1967, and this Houstonian had never been to Philadelphia. The occasion started with Elinor Ulman giving a presentation. When the presentation was over, there was nothing formal written anywhere about anything. Then we went into another room and met.

Now, I didn't know anyone there, not anyone. That's where I met Bob Ault, Don Jones, Myra, and Elinor Ulman. There were 40 or 50 people from all over the United States who were all interested in art therapy. You see, Don Jones had been doing something called art therapy; we'd all been doing something called art therapy, but we didn't know it. And Don Jones had been working at the Menninger Foundation with Bob Ault; they knew each other. Anyhow, Elinor Ulman was there, Hana Kwiatkowska, the founder of family art evaluation, Margaret Naumburg, whose name does not have to be explained, I think. Edith Kramer was there—and I felt like I was sitting between my bookends. Those were the only books I had, the only articles I possessed had been written by these women.

IC: *By Kramer and Naumburg, right?*

FC: No, Kwiatkowska had already published her book. All of them had published.

So, to make a long story short, we had a discussion, a lively discussion. It seems that Elinor Ulman, Margaret Naumburg, and Edith Kramer thought that there was no need for any art therapy association because they were the art therapists of the United States. And there was no problem with that because they were. Well . . . .

IC: *So they had already carved their niche in the field of art therapy.*

FC: Yes. I couldn't tolerate that. Those who know me know I sometimes do something called "running off at the mouth." And I did it there: I stood up and I talked a lot about how I felt. The outcome of this whole thing was that we took a vote to elect five people to help found an art therapy association, including the original founders that I've already named.

Now this did not sit well with Edith, Hana, and Margaret. Didn't sit well with them at all. . .

IC: *It really impressed you, didn't it?*

FC: So then in 1968, we founded the American Art Therapy Association.

IC: *Who was the first president?*

FC: Myra (Levick).

IC: *Myra was the first president.*

FC: Let me say this to you. The more things change, the more they stay the same. There was a terrible fight at that first meeting in Louisville. If it hadn't been for several important people, there would never be an American Art Therapy

Association, because false names were brought in as proxies to vote against it. It was an incredible situation. The anger was everywhere. And I saw that when I was active in AATA and throughout my presidency. The only thing that changed were the faces.

IC: *There certainly has been a division in the Association.*

FC: Absolute split. Real fracture there, and it was at that first meeting that Marge Howard became Treasurer. I would like to add at this point that I received a call last night from the Director of the Children's Hospital in Tulsa, where Marge had one of the first art therapy programs in the country. One of her students, Sandra (Kagan) Graves, called to say that Marge had died. She lived a full life; she was 90 years old.

When I was President and Marge was Treasurer we had about $150 maybe, in the treasury, and Marge counted every postage stamp that we paid for ourselves. We all had our jobs; we had no help. I wrote 40 to 50 letters a week to answer inquiries, because so many people wanted to become art therapists at that time. This also happened to everybody else who was on the board. We did it all. And there were no Xerox machines come to think of it, so we had to use carbon paper. A lot of things come to mind as I think about it. It never got to be too much because we always knew that there would be an American Art Therapy Association, and it would work. And I also think that because there was this faction that was fighting so diligently to keep it from happening that we worked harder and harder to make it happen.

I can recall one more thing. I felt that we were in such bad shape when board meetings lasted until 2, 3, or 4 o'clock in the morning. I said we have (and I think he was the vice president then) Don Jones, a nondenominational minister, and I would like him to lead us in a prayer so that we can do this beautifully. And I want you to know that the faction on this side vetoed prayer, and we had no prayer because they were the majority, and that was very significant to me.

I recall the experience of a funny kind of thing, but then a not so funny kind of thing. When I was Secretary, we knew that Margaret Naumburg would receive the first Honorary Life Membership. And as Secretary it was my job to have the plaque made. The first plaque that I had made, I spelled her name wrong, so I had to have another one made. I took it to Philadelphia, and my husband and I and Myra Levick and her husband went together to Airley House, which is where we had our meeting.

IC: *Was this the first conference?*

FC: First conference. So anyhow, we had been driving about 3 hours I suppose when I asked Myra, "You have the plaque?"

IC: *You do have the plaque?*

FC: Myra said to me "You do have the plaque, don't you?" And I said, "What are we going to do?" And she said "We're going to get off this turnpike and turn around and go back and get the plaque." Then, when we got the plaque, and it was my duty to present it to Margaret Naumburg, I couldn't remember her name and I just said, "Here, this is yours." That's it!

IC: *How about any other memories? I know you have loads of memories of those times.*

FC: I remember newsletters that Don Jones used to write. They would come out on one piece of paper.

IC: *And those were the first newsletters.*

FC: First newsletters. I remember how hard we worked to make this thing work, really, and there was, I can't explain, still this friction always, always. I can remember in New York, when I was President once more, we had a large stack of names voting against an amendment that we wanted passed, but they were not legal (votes).

IC: *They were proxy votes?*

FC: Proxy votes—not legal. So it didn't change at all, and as I say, the names have changed.

Today, unfortunately, I can't make many of the meetings. I do regret that we can't have more cohesion. However, I suppose that having competition is a very good thing. It makes us stop and think. The only thing that I regret is that it makes us stop and fight, and we could use that energy more productively.

IC: *The AATA has really grown in spite of the fact that there have been differences of opinion throughout the years. Any other old memories?*

FC: All of my memories are old! I have a nickname, "Buzz." And I remember that at the last meeting that I chaired, which was in Louisville, we went out to the Kentucky Derby. I bet on a horse called "The Nutty Bee" and I won!

Looking back there was a wonderful man, but I can't think of his name. He hand-carved a gavel for me; I have it here, and I know I'll keep it here forever.

IC: *So that's what you brought the meetings to order with, I'm sure.*

FC: Absolutely, I brought my own gavel. As we grew, we knew we had to have licensure 10 years ago. We saw it then—it had to be done. . . . Oh, I'll tell you one other thing I did that I'm quite proud of. I started having a parliamentarian at the meetings.

IC: *Oh, you're the one who did that.*

FC: And the reason I did that, and I don't want to sound like I'm bragging, was because of the constant friction. It got to the point where some of the people were complaining about Robert's Rules of Order, saying that we were not following that. I said I would have none of that—we'll have somebody who will make sure we follow Robert's Rules of Order. So, during my term in office, we had our first parliamentarian, and I feel quite proud of that.

IC: *And that's been carried on since then.*

FC: That's been carried on. We needed it because we couldn't fight each other anymore. But that cut down on an awful lot of the fun.

IC: *How about memories with Myra (Levick). I know you two became very close.*

FC: Oh, gosh. I remember we always shared a room, and we always had wonderful times. She came to Houston and presented, and I went up to Philadelphia at Hahnemann and presented. We had great times together, and we learned a lot, I think, from each other. Through her I met Paul Fink, and that's been a high spot in my life. Myra continued on teaching, as you know, in Florida, and now she's retired from the profession. We have some pretty fine memories and fond memories. We miss the old people like ourselves, who don't

BEST COPY AVAILABLE

come to the meetings anymore. Ever wonder why that is? It can't be because we're old, or maybe it is, but the subject matter never changes.

IC: *No, it's still art therapy.*

FC: Still art therapy and the papers are amazingly alike—same subjects, primarily. There are some differences—gender subjects that we didn't touch on—but otherwise, there's really no difference, and I kind of wish we could get together again. I remember Gwen Gibson who just received Honorary Life Membership. She worked so hard for the organization. If I start naming people, I'm going to leave people out, and I don't want that to happen.

IC: *There have been a lot of people who have worked very hard.*

FC: They all worked very hard. Elsie Muller is a wonderful, wonderful woman who was a social worker as well as an art therapist and was in charge of a school for boys in Kansas City. I'm troubled that so many people don't know about such important people who started in our organization.

Herb Rosenberg, who is now completely an artist, was an incredible art therapist, incredible.

IC: *I know you did some special research while you were at TRIMS. Maybe you'd like to tell us about the research?*

FC: Well, if you have a little luck doing something in particular, you become an authority on a subject. You understand that. The world calls you an authority. I had two, three, or four children who had been victims of incest. I was working quite closely with the Children's Protective Services, so, a psychologist named Dr. Randy Phelps and I did this research together and it was the first research of its kind. As a matter of fact, the word "incest" was not being used at that time and Randy and I were asked to go on a lot of TV shows, including Public Broadcasting. We were very frightened that people would misunderstand.

Now, I mentioned Public Broadcasting. I would like to get something to read to you, if I might do that. I should tell you that I participated in a film called "Child at Risk."

IC: *I recall that film.*

FC: I worked very closely with the staff at the local PBS for this show. It dealt with the children that I deal with in "Child at Risk" and I'd like to share it with you.

IC: *This is dated September 16, 1986 [sic] and it's to Mrs. Felice Cohen at UTMSI, 1300 Morrison, Houston, Texas 77030.*

Dear Felice: Just to let you know that "Child at Risk" has won an Emmy Award. The ceremony was held in New York on August 25, and out of 187 entries and 16 national finalists, the National Academy of Television Arts and Sciences selected our program as the one to receive its highest honor in community service for the year. The show wouldn't have been the same without your help; your professional advice and forthright explanations of child sex abuse provided viewers a close look at a child's perspective after being sexually abused. The case histories you offered testified to the emotional struggles faced by the entire family. And for many, your interview was an introduction to the help a child may receive in the professional community. Thank you for speaking up on behalf of the children who cannot speak for themselves about an all too common problem. An Emmy Award is a rare honor. Ours is the first presented to a Texas station in the local community service category and one of only three in Public Television. The honor is shared by you. Thank you for helping increase awareness about this sensitive subject. Most sincerely, Carla C. Reed, Associate Producer.

IC: *That's quite an honor.*

FC: Thank you, I really treasure this. All our names are on the Emmy.

IC: *So, do you ever go to visit it?*

FC: I went to see it once. I just wanted to see it once and that was enough. But I'm very proud of it.

IC: *I'm sure you are. We're proud of it, too.*

FC: I think someplace in the house I might have an extra copy of the film that may be of value for the American Art Therapy Association library.

IC: *Good idea. Well, anything else? Any closing remarks? Any words of wisdom for young art therapists?*

FC: I think we need to have, if I had my way, more cohesiveness among the schools that are teaching art therapy. I think there needs to be a clarification of the courses that are necessary. I'd like to see the American Art Therapy Association have an examination for registration.

IC: *Well, you know that certification will be coming into effect before too long, and there will be an examination.*

FC: But I think that it's been the most rewarding experience for me in my life, besides my children, husband, and grandchildren. But really, it's been my life.

IC: *Well, you know one thing I need to tell you is those of us in the art therapy profession in Houston really look at you as the wise old woman of the art therapy field here in Houston.*

FC: Thank you, thank you very much.

Editor's note: This is an edited version of the actual interview.

How Will the Profession of Art Therapy Change in the Next 25 Years? Responses by Past Award Winners

The Future of Art Therapy: In What Context?

Janie Rhyne, PhD, A.T.R., HLM

From teenage time into the now of my 81st year, I have chosen diversity in my education and lifestyle. In 1935 I received a BA degree from Florida State University with a double major in Art and Social Sciences. In 1938 I studied at the University of Heidelberg, but when I realized what Nazi Germany was about I left in a hurry. I settled in a suburb of Philadelphia for 10 years with my husband and children. I taught art to kids in a Jewish settlement house, to patients in a Veterans' Hospital, and to well-to-do members at a community center and to puberty-aged kids in a private school who were labeled "problem children," using art media and my meager knowledge of psychology therapeutically.

After two years in psychoanalysis and a divorce, my children and I moved to Florida where I was again a student earning an MA for my work relating Art and Cultural Anthropology. With a new husband, we lived mostly outside the U.S.A.—in Mexico, Spain, and in a commune in Canada. After a second divorce in 1964, I chose to live in the Haight Ashbury area of San Francisco, becoming a part of the turbulent sixties. With two year's training as a therapist, I led groups of "hippies," rebellious students, and puzzled parents. In private practice, my clientele came with all sorts of hopes and fears—both pragmatic and mystical. In 1973 I returned to academia at the University of California, Santa Cruz. I taught courses as a teaching fellow in Aesthetics, led training groups, and maintained a private practice. In 1979 I received a PhD in Academic Psychology.

From 1978–1980 I was Assistant Professor, Institute of the Expressive Therapies, University of Louisville. Since 1980 I have taught Visual Language Communications to graduate students in the School of Social Work at the University of Iowa as Adjunct Associate Professor. From 1979 to 1992, I was visiting faculty in the Vermont College Graduate Art Therapy Program. I teach yearly courses in the Marylhurst Art Therapy Program and the British Columbia School of Art Therapy. I joined AATA in 1969 as an A.T.R. and was awarded Honorary Life Membership in 1980. I have served on a number of committees: Honors, Professional Standards, consultant to Education and Training, and as Chair, Research Committee from 1981 to 1985.

I have led more training groups than I can remember, including those for the Association of Humanistic Psychology, Gestalt Therapy, and many art therapy groups in the U.S.A., Canada, and Europe. I am currently conducting a series of small workshops for personal and professional development here in Iowa City. I have published one book, The Gestalt Art Experience *(recently revised), numerous chapters in edited books, and articles in the* American Journal of Art Therapy.

The Future of Art Therapy

I view the question asked as requiring two answers, related certainly, but separable. The first part of the question concerns future changes in the profession of art therapy, and implies the involvement of our American Art Therapy Association in a context of an existent entity: an organization determining qualifications, standards, boundaries, and approval for the legitimacy of practitioners of art therapy. The second part of the question concerns the 21st century art therapist in a context of individual options and choices of those who practice art therapy with various orientations and affiliations: personal beliefs, preferences, education, and goals would direct selections of how, when, and where art therapy would be a legitimate practice.

Within AATA, diversification has multiplied exponentially in the last 25 years. We ask, "How far can diversity expand within any association before the organization comes apart at the seams?" And then, there is the question of our vocabularies and descriptions of perceptions and performances in the context of art therapy. How far apart can our ideation move before the distances among us become too wide to bridge our gaps in understanding? Have varied concepts already moved us into disassociations too disparate to allow for honest conversations, recognizing and respecting differences and disagreements? Twenty-five years ago art therapists differed and disagreed, but there was an accepted vocabulary for discussion of most of our issues. Can we go back and establish that vocabulary? I think not. Can we, instead, construct and accept a definition of the art therapists' roles whose boundaries include each of us, from psychoanalysts through shamanists? I don't see how.

I know there are some people in our field with whom I can't even imagine conversing in mutual appreciation. One of those is James Hillman, Keynote Speaker for our 1993 National Conference. Through the years I have read a good bit of his writings because good friends thought he had something to say. He did—about 20 years ago. But his writing has changed, and in his recent books and articles I find little of interest to me. His kind of spirituality seems too abstract and conceptual, enticing us away from experiencing our human nature—more provocative than evocative. As I listened to him speak, I admired his presentation and his erudition. But, as he continued I became aware, to my bemusement, that images of Ross Perot lecturing on the TV screen were drifting around in my mind. Hillman's and Perot's subject matter is very different, of course. But, I was seeing the professorial role each man adopted to teach us what we ought to know with surety of their knowledge and of our ignorance. They do it with dedication, and I am impressed, but do I want to learn what they want to teach? For many people the answer is "yes." Obviously my answer is "no," or my mind would not have wandered away from the content of Hillman's lecture as it does from those of Perot. They are each human beings, dedicated to their causes. But, their causes are not my causes, so I tune them out. I also tune out would-be, self-selected shamans' claims to all-knowingness and power and recounted dramas of soul retrieval just as I do TV Evangelists. They profess to know all the answers, while I am still living with the questions. I can't imagine tuning out our 1994 conference speaker, Ellen Dissanayake, who speaks in an inclusive language that makes sense to me.

I am only one art therapist among our 4,000. Yet, we all live and work in the mid-1990s in our era of ideational overload. TV talk shows chat about therapy and sometimes they claim to "do it." Even if we tune out TV's dramas, there are hundreds of self-help books loading shelves in bookstores and filling the minds of troubled people. There are journals, arriving monthly, telling us the latest techniques for dealing with patients and brochures advertising curative sessions and the addiction groups . . . and so on, and so on. Psychiatrists, psychologists, social workers, counselors, and educators are all assailed by this overload of new knowledge of how-to-do-it in the mental health field. As art therapists we are not alone. Perhaps we are pressed too closely in the crowding, maybe there are too few art therapists to get the benefits we want. If so, we should encourage affiliations with larger organizations. On the other hand, we are in the process of credentialing registered members of our present association. How many art therapists want to or even can pass the certification exam? Will we lose members as we gain quality in our national standards? In aiming for standardization, we shall certainly lose some of our diversity. Is that what most of us want?

I don't know—and I know that I don't know—any right answers to these questions. I do know for sure we cannot go back to where we were in 1969. We must live and work in this era, from the mid-1990s and into the 2000s. In the midst of ideational overload, we must reach for wisdom in deciding which ideas to attend and which not to. Tuning out TV programs is easy; it's harder to do in real, life experiences. When we speak of the future, I can't see any details that far away; my eyes are myopic. Yet, in my mind, I know that whatever art therapists may be doing will be in a context of ever-shifting configurations of parts within the whole of our multicultural society. I know, too, that whatever we do now, as individuals and as an association, is and will be a part of patterns that connect our past, present, and future.

In Search of the Wisdom of a Vision

Robert E. Ault, MFA, A.T.R., HLM

Robert Ault, born and raised in Corpus Christi, Texas, was voted into the South Texas Art League at the age of 14, the youngest artist ever admitted into the group. He went on to Texas University where he earned his BFA in painting and a fellowship to Wichita University in Kansas, where he completed an MFA in art. His introduction to art therapy was in organizing an art therapy program for handicapped children while in graduate school. Upon graduation in 1960, he became a staff member at Menningers in Topeka, where he continued his training, receiving advanced training in psychotherapy and psychoanalysis. He worked as an art therapist, a psychotherapist, and as a faculty member of the Menninger Management Institute for 32 years. Following early retirement in 1993, he is currently in private practice, runs the Ault's Academy of Art, and works half time as an assistant professor at Emporia State University, where he organized a Master of Science in Art Therapy degree program in 1973 and has continued to teach.

He served on the Organizing Committee for the American Art Therapy Association, was elected its first President-

Elect, and served as its second President. He also has served as Chair of the Standards Committee, two terms on the Education and Training Board, on the Editorial Board, and through the years, in many other capacities with the organization. In 1960 he helped organize the Kansas Art Therapy Association and has served that association in many capacities.

He was awarded the 10th Honorary Life Membership by AATA in 1986, was named the outstanding faculty in the College of Education at Emporia State in the area of scholarship in 1985, and again in the area of service in 1986. In 1983 he was appointed by the Governor of Kansas to serve a term on the Kansas Arts commission, and in 1985 he was named the Kansas Outstanding Educator of the Year.

. *Through the years, he has published many articles on art therapy and co-authored and helped produce* Art Therapy: A Healing Vision, *a videotape that has received widespread distribution. He continues to present and teach throughout the country. He represented the AATA before the United States Senate in 1992 regarding the Older Americans Authorization Act and served on a granting committee for the Department of Aging after the act was passed. He continues to be active as a professional artist, having over 45 one-man shows, and his work is in collections throughout the Midwest.*

Wisdom

I thought wisdom came with age, like arthritis or nearsightedness, but I haven't found that to happen. Maybe it did and I just can't remember where I put it. As one of the elders invited to write a piece for the Journal, I have procrastinated in hope that wisdom or inspiration would shine its light but have decided now the wisest thing to do is reflect out loud on where we have been and where I hope and/or fear we might collectively go. As I think of these matters here in Kansas, an image forms in my mind. It is as follows.

Standing on the crest of a rise in the prairie, the scout would peer in all directions for signs he had learned from experience. He knew a lot rode on his readings, and he felt the responsibility keenly. Knowing the capabilities of the wagons and people, the changeable and violent weather, or hostile forces, all went into his thoughts and he acted at last on his feelings and gave advice. He did not order the direction as that was the job of the trailmaster. His job was to look back as well as ahead and know what was both wise and possible.

Wisdom descends to us from the Anglo-Saxon word which means: "the irreversible process of becoming from within." It's not such a bad definition of art therapy, since it is of prime concern if life is to have meaning and is the "stuff" we try to teach our children, our students, our patients, and ourselves.

What was it like in the early 1960s when several of us around the country began to identify ourselves as art therapists? I remember well the joy and pain that went into the birth and early years of the AATA. I also remember the bonding of people joining in a creative act that was far greater than any of us alone could muster. I reflect back on the extreme tension and division we endured and our need for each other's understanding and support as we felt our way along, attempting to do what was wise at the moment. None of us had been trained in organizational matters and as the old saying goes, "Experience is something you get right after you need it." We did find common ground though and shared the fever and a common vision about this thing we called art therapy.

The "vision" we shared that allowed us to work and create together was composed of several ingredients. Coming from our experience as artists and treaters, the first and foremost ingredient was our absolute belief in the value and importance of using art making and imagery in the treatment of patients. It was understood that one also needed a foundation of psychology and clinical skills, but the art was central to the process, not an adjunct technique. Regardless of what it was called, we knew it worked when other traditional forms of treatment or rehabilitation didn't. In those days we usually worked successfully with people whose treatment from highly trained psychologists and psychiatrists failed. As art therapists, we often differed on the how's, but never the should's.

Second, was our conviction that this belief should be acted upon, expanded, and made available to as many people as possible, and it was worth the energy and sacrifices required.

Third, was our recognition that we had brothers and sisters of like mind and heart that understood what we were about. This recognition helped us deal with the professional isolation most of us felt at that time, and to have respected colleagues was a blessing. Can you imagine being an art therapist today without a national organization, conferences, a newsletter and journal, or other art therapists you could talk to?

Fourth, was our determination that in spite of our differences in orientation, we would proceed with an organization and trust that a structure for the exchange of ideas would pay great dividends and bring peace among our own ranks. Finally, we wanted art therapy to be recognized, available, and the treatment of first choice rather than last choice—a reality that is now beginning to occur across our country.

I have never envisioned art therapy as a profession but rather as a set of ideas. Of course there are professional concerns and things that need to be done, but thinking of it only in terms of our professional needs was too limiting. Like all ideas that are worth their salt though, they would be utilized by others in related professions and even by amateurs at times. Standards of practice, education, and all the ins and outs of the association's business would preoccupy us for years, and it has been hard to keep to our vision and to our primary responsibility—that of helping people. Maybe our real wisdom is in the balance of ideals and the practical realities of life.

For generations people have used religion to help come to grips with life and its problems and mysteries. Finally, we discovered the scientific method, and it brought not only a revolution of change, but often compounded our problems and led us to even greater mysteries. It is my belief that the next great change will be the rediscovery of the arts as a primary civilizing and healing agent. There is no group of people better equipped to lead this way than those of us in the creative arts therapies.

What have we done with the first 25 years of the AATA? First, we learned we could not achieve our vision alone, but rather needed each other and were strengthened by both our similarities and differences. We put together a viable organizational structure that has made these connections possible via conferences and publications. As these connections were made we developed a much clearer identity as legitimate professional art therapists. Our role models changed from those outside our profession to those within our ranks and there occurred an internalization of that process. Now it is easier for us to say with clarity, meaning, and pride that we are indeed art therapists.

We also took steps to identify and organize a body of knowledge that could be taught, insuring future generations of art therapists better trained than ourselves. In so doing we took a dangerous step in introducing into our "vision" the institutional demands of higher education. This added an element of business, demands for systemizing and organizing information so it could be taught, the promotional needs of the teachers, research skills, publishing, regulating, etc. All of this may be necessary, but it goes against the natural grain of many of us identified as art therapists, and it had little relevance to our daily clinical interactions. In so doing we tended to psychologize the art therapy process since it was easier to research and teach and fit with the institutional model. As academics we could really sink our teeth into it and search for truth as we had the tools of science and the models of psychology and psychiatry. In these first 25 years we were highly successful in developing our knowledge base and the profession, but what about the art side of the equation? In that area the "vision" often blurred and our faith in the art process was shaken. I have never met an art therapy professor who didn't proclaim the therapeutic need for making art. I have also never met one who didn't wish they had more time for their art. The folks in clinical-based training seem to have been more successful with this than the academics, I believe, because it was a part of their daily creative interactions.

Where will we go during the next 25 years? We do have choices but we have to get past our philosophical crisis to make them wisely. We must not lose our understanding of and faith in the art process. We can't go off into some hocus pocus of spirituality, or the rigidity of scientific research, or be swallowed up in some larger political organization, but must continue to focus on what brings meaning and joy to life and address the issue of human suffering, of which there is plenty to go around. We must remind ourselves again and again of our "vision" and make plans accordingly. Certainly we must all deal with the realities of political power, integration into health care packages, the need to be a part of the university systems, and the desire to have an identity as art therapists. But my dream is that the insights, the understandings, and the healing that takes place in all our studios and offices will be embraced by the art world and find application not only in health care, but in health promotion. As therapists we still deal with only a small fragment of the population. It is the general population that can benefit greatly from adaptations of the art therapy experience. We know that all children can find and honor themselves through making art and music or dance. Families can learn to deal with each other with respect and without violence. Communities can also come to understand each other's differences and find commonalities for connecting and exchange as we return to the widespread use of the oldest civilizing agent of all, the arts.

It is also my dream that our government can lead the way in redesigning our offensive budget into a true peace-making machine using the power of the arts rather than guns and explosives. It certainly would be cheaper and easier to make peace through the arts than to settle our differences with war. There is evidence of this already as the cold war ends and the military is being used to help fight famine or forest fires rather than to fight people. Maybe art therapists can also have a significant role in teaching how it is possible to make peace between peoples through understanding and acceptance.

Perhaps some of these dreams can come about if we can see and feel and hold to the "vision." Art therapy is worthy of our love, energy, and dedication, and we should never underestimate its value or lose faith in the healing it brings about.

My Wishful Vision of Art Therapy in the Next 25 Years

Judith A. Rubin, PhD, A.T.R., HLM

I was born during a "Great Depression," ironically also a time of tremendous hope. My recently unearthed teenage diaries are full of words like "swell" and "neat" and, though hopefully more realistic, I remain an optimist. I had always wanted to be an artist, but since my talent wasn't spectacular, I shifted to another love—working with children. First art teacher, then art therapist—a discovery made serendipitously, but like the duckling and the swans, once found I knew it "fit."

I feel fortunate having had to design my own training—psychoanalysis with children and adults plus a doctorate in counseling. Entering the field during its beginnings also provided an opportunity to create procedures and programs in many settings with various populations. Working in a university-affiliated child guidance center and psychiatric hospital enabled me to grow as a psychotherapist, supervisor, teacher, *researcher, consultant, and program developer. By 1985 I realized I preferred doing therapy and went into full-time private practice, a daily delight and constant challenge.*

It is gratifying to have started programs in different places which have survived and even grown, and to have written books and made films that others find useful. Even being president of AATA with no central office was worth the work, especially helping to shape the direction of the profession and its organization.

Now I plan to gradually decrease my clinical work and increase time for writing books, making videos, working in the community, and traveling. My tolerant, supportive family—husband and three children—has expanded to include two in-laws and one grandchild, with whom I anticipate more time as well.

The loveliest fringe benefit of involvement with AATA has been the friendship of colleagues I like and respect. Art therapy has been a marvellous matrix for me, both personally and professionally, and I feel extremely fortunate.

My Vision

I anticipate that the profession of art therapy will continue to expand and to grow in ever-new directions during the next 25 years, as it has in the past. Art itself is so versatile that it can be therapeutic for an even wider range of people than those already served. Because it is also cost-effective, I expect the field to continue to develop in breadth as well as in depth.

From the most to the least restrictive setting, art therapy is one of the most powerful tools available for those with mentally disabling conditions of all kinds, both chronic and acute. One of my wishful visions is that by the next quarter of a century, there will be one or more art therapists in every psychiatric setting, including long-term, short-term, and partial hospitals, as well as all kinds of outpatient clinics.

In addition, there is tremendous room for growth in the role of art therapy in rehabilitation, care, and education. Hopefully, there will someday be an art therapist in every setting where people can be helped to get back on a functional track. This would include all kinds of rehabilitation centers, corrective facilities, nonpsychiatric hospitals and clinics, and shelters of every sort. For those whose ills cannot be cured, but must be borne, art therapy can provide relief and solace—whether the loss is of a limb, a life, or a loved one. Another of my fondest wishes is that there will be an art therapist in every school, day care center, and residential institution—not only for those who are "exceptional" but also for those who are "normal"—and at every age level, from the toddler to the elderly.

By the time the next 25 years have passed, I expect that most people will have heard of the profession of art therapy and of the therapeutic potential of art. If we are open to sharing and collaborating with other disciplines, we can facilitate an amazing expansion of opportunities for therapeutic involvement in art and other expressive modalities. If we pursue alliances and communication abroad as well as at home, we may also assist in the growth of art therapy around the world. I hope that we have reached a more mature stage of development as a group, and that we need no longer be suspicious or stingy with others. If we are able to engage in genuine dialogue, the benefits will be as much professional as political. We have nothing to lose and everything to gain, in spite of the anxieties of some. Energies devoted to cooperation must be more productive and constructive than those spent on competition. We don't "own" either art or therapy. We surely have much to learn as well as to teach.

My deepest wish is that more and more people will receive the benefits of art in, for, and as therapy. In order for that to happen, the profession would do well to deepen as well as to broaden and above all, to avoid the twin traps of restrictiveness and rigidity. It is my hope that the deepening will occur as we become ever more thoughtful and reflective about our work. Theories that are less often borrowed and more often isomorphic with art are one likely outcome. Research, too, can become more sophisticated, as well as more relevant and applicable. The development of doctoral programs in art therapy will probably be a stimulus in both areas, as well as for the creation of more tools for training students in our own and related fields.

The technological miracles that are rapidly transforming our world have yet to be fully harnessed by art therapy. Not only can there be more and better teaching tapes of the traditional kind, there also can be more creative uses of computers and video, especially the exciting new interactive modalities. As a technological illiterate, I can hardly imagine the possibilities, except to sense that they already offer a dazzling array of potential applications by the next generation of art therapists. At the very least, we should be able to greatly expand the repertoire of visual creativity for the most severely impaired and immobilized among us. At best, it should be possible to widen and extend artisitic horizons for everyone.

Perhaps most vital to the survival of our civilization and our world, art therapy can play a central role in enlivening the spiritually barren desert in which we now wander. The social and environmental ills of our time are awesome, and require immediate "treatment" if there is to be a future at all for our children and the planet. Art therapists can and must help to channel energies now wasted on violence and destruction into healthy and constructive creativity. I envision therapeutic art activities being made available in such places as malls, libraries, churches, community centers, and other settings where the disillusioned of all ages might (re)discover a vision of life and themselves as hopeful and worthwhile. We have a most valuable resource to share. We can and should contribute to healing the soul of the community, as well as the psyche of the individual. Perhaps another way of expressing my most heartfelt wish is to pray that swords may not only be beaten into plowshares, but into paintbrushes, pastels, and pottery as well.

Expanding the Role of Art Therapy

Rawley Silver, EdD, A.T.R., HLM

AATA: *A.T.R. registration 1970; Annual Research Award: 1976, 1980, 1992; Honorary Life Member, 1983. Honorary Life Member, Art Therapy Association of Florida, 1988. Committees: Art with Handicapped, Program, Honors.*

Education: *Cornell University, BA, 1939; Columbia University, MA, 1964; EdD, 1966 (Fine Arts and Fine Arts Education); Smith School of Social Work, 1940; Art Students' League, 1961.*

Publications: *51 journal articles, assessment instruments, research reports, book chapters, reviews, art catalogues, and a book.*

Teaching: *Adjunct Associate Professor, Graduate School, College of New Rochelle, 1974–1980; schools and institutions for deaf and language-impaired children and adults, 1961–1973.*

Research grants: *U.S. Office of Education, 1967; NY State Dept. of Education, 1972; National Institute of Education, 1979.*

Exhibitions: *painting: Invitational: Hudson River Museum, 1976, and elsewhere; one-person shows: 1992, 1986, 1981, 1977, 1976, 1970, 1969, 1961, 1960, 1959, 1956, 1955. Smithsonian Institution Traveling Exhibitions:* Shout in Silence, *1969–1976;* Art as Language: *1979–1983.*

Papers, Workshops, Talks: *70+ conferences, colleges, universities, 1970–1993.*

The Next 25 Years

Before offering some thoughts on how art therapy may change during the next 25 years, I would like to mention an issue of great concern when the AATA was being formed 25 years ago. There were two divergent points of view: that art therapy should lean toward psychiatry, or that art therapy should lean toward education and rehabilitation. As I recall, Myra Levick and Felice Cohen were leaders of the "art psychotherapy" position while Elinor Ulmann and Edith Kramer were leaders of the "art as therapy" position.

We seem to be returning to this issue. To celebrate our 25th anniversary, *Art Therapy: Journal of the American Art Therapy Association*, has asked some of us how we see the future. The first to respond, Harriet Wadeson (1994), has warned that health care reform may have a disastrous effect, and suggested that growth and perhaps the survival of art therapy may depend on moving toward social rather than psychiatric needs. The second respondent, Gladys Agell (1994) warned against making talk central to the art therapy session. "In the interest of encroaching on psychiatric prestige, the artwork is disregarded." These observations by directors of two education programs suggest that in the future, art therapists are less likely to work in psychiatric hospitals than in schools, rehabilitation centers, and other agencies that address social needs.

If so, training and skills could be expanded in several ways. Art therapists might become qualified to administer, score, and analyze assessment instruments like the WISC and WAIS which, I believe, are still restricted to qualified psychologists.

In addition, training might expand to include the biological bases of psychology. With our special access to normal populations of all ages and both genders, as well as those with diseases of the mind, we are in a unique position to study abilities and disabilities, similarities and differences. We have access to the unconscious as well as the conscious mind—which Edelman (1992) calls "the remembered present"—and are in a unique position to contribute to the discoveries that have emerged from neuroscience, such as diseases of consciousness that accompany changes in intentionality.

We might also explore the brain functions that underly the ability to perceive and interpret nonverbal messages expressed through art forms. In discussing the healing process, Louis Tinnen (1990, 1993, 1994) has examined the role of unconscious mimicry. As he observes, mimicry uses ancient brain functions inherited from reptiles and early mammals and underlies the cooperation seen in schools of fish, flocks of birds, and herds of animals. Mimicry belongs to the realm of "primary process" thinking and is inaccessible to consciousness. Furthermore, aesthetic sensibility, empathy, and emotion are rooted in mimicry. The special capacities of the nonverbal brain are generally unknown to the dominant verbal mind which adopts them as its own. The nonverbal therapies give us access to these mechanisms that consciousness is blind to.

Does mimicry function in assessment as well as treatment? As artists with psychological training, we may be using mimicry unconsciously, identifying with others who draw, paint, or model clay. Through empathy, we may receive graphic messages that are inaccessible to the conscious mind, but claimed by conscious assessments of fantasies, moods, and attitudes toward self and others. We start with the particularities of an individual's graphic expression, then analyze, abstract, generalize, and assess changes that occur over periods of time.

References

Agell, G. (1994). Art therapy: The future. *Art Therapy: Journal of the American Art Therapy Association, 11*, 28–29.

Edelman, Gerald M. (1992). *Bright air, brilliant fire*. New York: Basic Books.

Tinnen, L. (1994). Transforming the placebo effect in art therapy. *American Journal of Art Therapy, 32*, 75–78.

Tinnen, L. (1993). Art therapy mobilizes self-healing. *Presentation at the 24th annual American Art Therapy Conference.*

Tinnen, L. (1990). Obligatory resistance to insight. *American Journal of Art Therapy, 28*, 68–70.

Wadeson, Harriet. (1994). Will art therapy survive universal health coverage reform? *Art Therapy: Journal of the American Art Therapy Association, 11*, 26–28.

Art Therapy and Changing Times

Deborah A. Good, MA, A.T.R., LAT, LPCC, recipient of the 1993 Distinguished Service Award

Deborah Good, MA, A.T.R. is the author of the first art therapy legislation passed in the state of New Mexico in 1993. She is currently working on her dissertation at the University of New Mexico in the Counseling Department. She teaches at Southwestern College and is on the adjunct faculty of several colleges throughout the United States. Debbie has a private practice which includes contract work with Family Therapy of Albuquerque, Albuquerque Public Schools, and the state of New Mexico.

Debbie is licensed in New Mexico as an art therapist (LAT) and a Clinical Counselor (LPCC). She has worked extensively in numerous hospital and outpatient settings. She has served on many state and national committees, including AATA Clinical, Governmental Affairs, Standards, NMATA Governmental Affairs and Conference Program Committee, Co-Chairperson for the Four Corners Expressive Therapy Conference, NMATA Board of Directors, NMATA president, and the Biopsychosocial Task Force for JCAHO. Debbie also was elected to the AATA Board of Directors from 1989–1992, where she served as AATA Board liaison for the Clinical and Governmental Affairs committees. She was elected to the AATA Nominating Committee in 1992 and served as chair of that committee for the past two years.

Last year, Debbie received the 1993 AATA Distinguished Service Award for her work on art therapy licensure legislation. She has also been honored with "The 1993 Outstanding Faculty Award" from Southwestern College, "Extraordinary Support Award" from Webster College, Distinguished Service Award from NMATA, "A Friend of Music Therapy Award" from the Southwestern Region of NAMT and the "Outstanding Teacher" recognition from the University of New Mexico.

Debbie has been a speaker for the AATA Regional Symposium on sexual abuse and Post Traumatic Stress Disorder (PTSD), and is currently the head of that team. Her list of presentations are extensive, ranging from clinical issues to legislative concerns.

Art Therapy

Recently, during my doctoral comprehensive exams, I was asked to explain my philosophy of counselig and art therapy. My answer became more of a self-questioning process than I anticipated. I know that in this field we are required to be constantly changing our views, our approaches to the therapeutic arena, and our acquisition of knowledge. Without this constant change and growth we become stagnant, ineffective, focused on the past, and lose our sense of the true nature of our work and passion . . . the art.

Many art therapists have been forced to fit into standards of other helping professions, job titles other than art therapist, and mold to the requirements of the employing institution rather than follow their training as an art therapist. Art therapists have become licensed in many states by names other than art therapist. I hold two licenses: one as an art therapist (LAT) and one as a clinical counselor (LPCC). My doctoral studies are in counseling with a minor in art therapy. I view this as an expansion of my skills, rather than a compromise. It became very clear to me as I sat in front of my doctoral program committee, that I am, and always will be, an art therapist. It is my foundation and belief system. It doesn't matter what other titles I may go by. I remain an art therapist in the way that I think and view the human experience.

We are trained how to interact, be still, dialogue, and live with the images that are created through art expression. Other helping professionals may use art material in therapeutic sessions, but they are not skilled in the ability to think and see as an art therapist. Being an art therapist is the development of a way of living in this world that sees things from an image and aesthetic point of view. There is a sense of being truly involved in life when in the midst of creative expression. What is developed is a way of looking at the world that cannot be re-created in any other way. I teach and believe that to become an art therapist a person must learn how to see art and humanity in a different manner than the rest of the world.

Because we are art therapists, we have a definite advantage over verbal therapists. Through the process of art making and creativity, we have direct access to the soul. Isn't soul making what life is about? The art process cuts through verbal defenses and naturally awakens the true purpose of our being. We are action-oriented therapists and are able to witness personal transformation that occurs within the context of creating art. The world is craving the healing qualities inherent in art therapy. Society has talked itself sick of dealing with the superficial world of words. My clients are looking for a new way to communicate with themselves, others, and their environment. They are looking for a way to achieve deeper meaning out of their existence. Art therapy provides them with a reconnection to their purpose in life, and confronts them with personal images needed for growth.

While we work toward continuing to keep pace with other helping professions, we must not lose sight of the real goal. We are working through licensure, congressional hearings, art exhibits, and health care accreditation bodies to continue to have jobs where we are able to provide the services that we so deeply believe in. We cannot afford to verbally argue about the way things are, or should be. These are the trappings of futility. If we become distracted from our original goals of becoming art therapists, we enter into an inner organizational battleground of opinion bashing. This will keep us from growing within the world, due to lack of cohesiveness within. It is important for us to work together, support each other for the common goals that we share, and learn to disagree with respect in order to move on. We must continue to expand, keep up, and stay ahead professionally, maintaining our vision of the inherent healing powers in the process of making art.

Art therapy, because of its fundamental beliefs, can only become more valuable in the next 25 years. Time has taught us well the damage that humans create when they try to live through verbal communication only. We have become a disconnected community that lives in its head, cut off from the essential messages that the body and soul bear. We have learned to intellectualize our way through life and to value this above all other forms of self-evaluation. But, for the most part, it's not working any more. People are seeking other means of self-discovery and the yearnings of the soul are becoming louder. The creating of art answers this call. It is that basic, that simple.

As artists and art therapists, we know that we create to live. Creativity is essential to our life. We cannot afford to forget the power of our own creative being. We ask our clients to create art as a method of healing, but do we remember to continue to heal ourselves in the same manner? The survival of art therapists depends on their continued lives as artists. The creative spirit, the artistic connection, and the healing results will not go away in the future. But we must remember to nourish the source of our convictions. By living our lives through our passion we can bring compassion to the world.

There is a strong future and hope for art therapy, providing we believe in ourselves and in the ideals that we bring to this profession.

Looking Ahead

Cathy A. Malchiodi, MA, A.T.R., LAT, LPCC, recipient of the 1991 Distinguished Service Award

Cathy A. Malchiodi, MA, A.T.R., LAT, LPCC, is a graduate of the Boston Museum School/Tufts University and the College of Notre Dame. She is the Editor of Art Therapy: Journal of the American Art Therapy Association *and author of* Breaking the Silence: Art Therapy with Children from Violent Homes *(Brunner/Mazel, 1990) and co-author of* Integrative Approaches to Family Art Therapy *(Magnolia Street Publishers, 1994). She served on the Executive Board of the American Art Therapy Association (AATA) for four years and as Chair of various AATA committees, including Membership, Ethics, Certification, and Publications. In 1991 she received the Distinguished Service Award for her work with the AATA and contributions to the field of art therapy; she has received additional honors from Very Special Arts, Kennedy Center; Hong Kong Association for Arts for the Handicapped; China Fund for the Handicapped; and the Art Therapy Pioneer Award, among others. She currently serves on the Editorial Boards of the* International Journal of Arts Medicine, ONLINE Journal of Alternative Medicine *and the* Journal of Child Sexual Abuse. *Ms. Malchiodi is widely published in professional journals, particularly in the use of art expression with trauma victims, multiple personality disorders, child physical and sexual abuse, and physical illness; she has served as an expert witness in legal cases, particularly those involving the use of drawings to identify physical and sexual abuse. Her private practice and consultation services spe-*

cialize in forensic and medical art therapy with children, adults, and families.

Ms. Malchiodi has an international reputation as an educator and has taught at universities, colleges, and institutions throughout the United States, Canada, Europe, and Asia. She has worked as a Master Teacher for Very Special Arts International and was selected to represent them in China, the first educational exchange of its kind. She has served as the Interim Director of the Art Therapy/Marriage and Family Counseling Degree program at California State University, Sacramento and is the former Director of the Art Therapy Graduate Program at the University of Utah; she has been a visiting professor for the University of North Texas, Florida State University, Mount Mary College, University of Illinois, University of Oklahoma, Lesley College Department of Counseling Psychology and Expressive Therapies, and Southwestern College, among others. She is also the Director of the Institute for the Arts & Health, in Salt Lake City, UT, a national training and research institute devoted to the development of the expressive arts as an adjunct to a total wellness program. Currently, she is investigating the role of the arts in the comprehensive medical care of individuals with cancer and other illnesses, as well as continuing her clinical consultation and research with children and families from violent homes.

Art Therapy in the Future

Since I am both a dreamer and a pragmatist, I see the future of the profession of art therapy as having many possibilities for success, but equally as many for demise. Many things have been cited as intrinsic to the survival of art therapy into the 21st century—certification, licensure, alliance with other professional groups, recognition by state and federal governments, and research. But I think there are more basic factors and influences that will affect the viability of the profession over the next several decades.

As pragmatic and as boring as it sounds, what we are paid as art therapists will probably have an impact on the future of art therapy. Over the years I have seen many colleagues drop out from the field because they cannot find work or they simply cannot afford the luxury of being an art therapist. Since most of our profession is female (and still paid less than males in our current society) and either single and/or supporting a family, money is a definite factor and I believe, will be closely related to the vitality of the profession.

Being an art therapist, male or female, can also be an expensive venture, including the costly registration fees for annual conferences/symposia, increased expenses of maintaining of credentials (registration, certification, licensure, etc.), and additional costs of continuing education and malpractice insurance. The salary of the average art therapist (art therapist, as opposed to professionals who hold additional credentials in related fields) does not always rise to meet these expenses. The results may be: lower attendance at our conferences and therefore, less sharing of clinical observations, research, and programming; art therapists choosing licensure in an allied field over art therapy credentials, due to costs of keeping both and their comparative value in the job market; art therapists maintaining certification and/or registration, but dropping membership in the AATA and therefore, no longer receiving the journal, newsletter, and other materials that keep one abreast and involved in the field.

In a more academic vein, our ability to incorporate new paradigms within our field will also be related to our vitality as a profession. We often seem to be hung-up on some ideas that are outdated and archaic, even if these theories contradict both gender and multicultural issues and the movement toward short-term treatment. The 90s have shown us that multicultural and gender issues and brief therapy are obviously areas that we must be knowledgeable about. I don't think that relying heavily on psychoanalytic theories, which have been a tradition in the field of art therapy, will continue to serve us much longer in light of these current trends. Also, utilizing outdated materials from 40-year-old tomes on projective testing does not effectively apply to our work as art therapists, particularly with women, gay and lesbian clients, and people of color, among others. The time is now to begin to dialogue and rework our ideas about art expression and art making to reflect these client populations in preparation for the next several decades.

I think the real test of our strength and future as a profession will come from our ability to really include art in what we do. The word "art" gets a lot of lip service in our field, but rarely truly gets addressed. Most of our training programs negate the importance of studio art experiences in their curricula. Educational standards require only the equivalent of a semester's worth of art courses for those with no art background. The AATA itself has contributed to this trend; it was not that long ago that the portfolio was dropped from the AATA requirements for professional registration.

A constant lament of art therapists is the old saw that "I just don't have enough time to make art," often coupled with the excuse that "My creativity is reflected in how I do therapy, so I really don't need to make art." We seem to have come to the convenient conclusion that quick sketches of feelings and badly cut and pasted magazine pictures can approximate art, and that art making is a 50-minute process without much depth. I know well the realities of working with clients within short-term mileus, but we art therapists have reduced the scope of art therapy through the neglect of our own art making and our lack of knowledge of the field of visual art. This has resulted in our disregard for the importance of art in our training, our profession, and our lives. If we are not careful about this, the effects of it may be quite negative and detrimental to the profession as a whole.

The last idea I wish to present is that if we truly wish to grow into the next century, it is time to let go of the past. This is the year that we have celebrated our silver anniversary, honoring and remembering people who founded our field. But we sometimes get caught up in remembering the past and recalling the old days so much that what is going on in the here and now is lost or devalued. It is easy to understand because the past is easy to recall and as they say, hindsight is twenty-twenty. It is easy to do so because the tasks, decisions, and challenges we have ahead of us are often difficult to face and reminiscing is not.

The individuals we are honoring in this anniversary year are what might be called the first generation art therapists. By and large these are the people who made ready the way, formed training programs, and taught the next generation.

I'm part of that latter group, the second generation. We enjoyed the mentoring of the profession's founders, but no longer have the benefit of being perceived as something unique or novel as they did in their time. We have to prove our worth under much more critical conditions, under ever-tightening health care parameters, demonstrate the outcome of what we do, and grapple with the unanswered questions as well as the debatable aspects of the field of art therapy.

For this reason I think it is particularly important to honor and consider the achievements of this second generation, in addition to the first. Some names that come to my mind include: Pat Allen and her articulate observations on studio approaches to art therapy and the role of artist as therapist; David Henley and his work interfacing art therapy, art education, developmental theory, and visual art; the expertise, fortitude, and commitment of Carol Cox, Barry Cohen, and Anne Mills to doing long-term research studies on art expression; Michael Franklin and his explorations of the art process and commentaries on contemporary topics such as the AIDS crisis; Janet Bush and her tremendous achievement in developing a comprehensive and model program placing art therapists in the public schools; Debbie Good and her seminal work in envisioning and developing the first licensure act specifically for art therapists. There are other individuals who come to mind who have kept our art therapy training programs together with their own dedication, sacrifice, and initiative, contributions that are the backbone of our continued growth in numbers. There are many others who work in clinical settings and many whose names I don't know because they work in isolation and cannot afford to come to conferences to share their achievements or do not have the time to write for publication. These are individuals who have tackled some of the most difficult problems, both theoretical and practical, and created and implemented solutions that will pave the way for the continued growth of art therapy into the next century.

The 25th year of the AATA has been one of reflection on the achievements of the past, particularly the founders of the profession. In honor of them we have put our energy into making special attempts to commemorate these individuals. However, in doing so let's not forget the vital energy of the second, third, and upcoming generations of art therapists who are in hospitals, schools, and agencies doing the work, blazing trails, and still defining the field of art therapy. Perhaps we should be honoring and recording the efforts of these individuals, too, because what they are doing and saying now is just as important to the future of art therapy as the memories and foundations our pioneers have to share.

Art Therapy: Journal of the American Art Therapy Association, 11(4) pp. 260-265 © AATA, Inc. 1994

The Art Therapist as Expert Witness in Child Sexual Abuse Litigation

Marcia Sue Cohen-Liebman, MA, MCAT, Cherry Hill, NJ

Abstract

Basic judicial tenets regarding expert witness status and testimonial capacity are examined in an effort to educate the art therapist about the rules and regulations that govern participation in child sexual abuse litigation. Legal, mental health sciences, and art therapy literature as it pertains to the qualification of the art therapist as an expert witness and the admissibility of novel scientific evidence in the form of drawings is reviewed. The synthesis of this material is an attempt to ascertain and define how basic judicial tenets are applicable to and can be adhered to by the art therapist in the capacity of an expert witness in child sexual abuse litigation.

Introduction

The law in the area of child sexual abuse litigation is in a formative stage of development. It can take years for courts to achieve consensus regarding basic principles and applications when complex new subjects are introduced in the law of evidence (Myers et al., 1989). Expert testimony regarding child sexual abuse allegations falls into this category. Art therapists can support this newly emerging area of litigation by providing evidentiary material that is substantially validated. Drawings enable art therapists to offer information that is not otherwise accessible to the court. Since art therapy is not a precise science and in the eyes of the law it is not quantitative or experimentally verified, the art therapist involved in legal proceedings has to justify that the probative value of the use of art expressions outweighs the prejudicial effect. In the future the legal usefulness of art expressions will depend less on scientific precision than on the wisdom that is imparted by the art therapist in the guise of an expert witness.

The intent of this paper is to educate art therapists about basic judicial tenets that govern expert witness status, specifically in child sexual abuse litigation. Legal, mental health sciences, and art therapy literature as it pertains to the qualification of the art therapist as an expert witness and the admissibility of novel scientific evidence in the form of art expressions will also be reviewed. The synthesis of this material is an attempt to ascertain and define how basic judicial tenets are applicable to and can be adhered to by the art therapist in the capacity of an expert witness in child sexual abuse litigation.

The material presented in this paper was gathered from a variety of resources outside the field of art therapy due to the paucity of literature regarding the role of the art therapist within the judicial system. Expert mental health testimony is increasingly incorporated into judicial proceedings necessitating an awareness of basic courtroom policies and procedures by art therapists in anticipation of possible courtroom involvement.

This paper provides art therapists with a basic comprehension of judicial protocol and expert witness status including: a definition of expert witness status with an overview of basic judicial procedures, rules, and regulations; a brief historical overview highlighting the interface between the judicial and mental health professions; a discussion of how art therapists may qualify as expert witnesses; and consideration of a landmark case in which the field of art therapy was accepted as reliable and an art therapist was qualified as an expert witness.

The Adversary System

The modern use of expert testimony developed in the 18th century out of the adversary system of trial (Ladd, 1952). The witness in the adversary system provided the trier of fact with knowledge rather than opinion. Exercising opinions and conclusions to determine a verdict became the sole province of the jury. The function of the witness was to state the facts of which he or she had personal knowledge (Ladd, 1952). The adversary system is founded on the belief that the most effective way to arrive at just results in litigation is for each side of a controversy to present the evidence that is most favorable to its position and to let a neutral judge or jury sift through the conflicting evidence and decide where the truth lies (Myers, 1992).

The adversary system is not without criticism. It has been evaluated as not conducive to the fair evaluation of objective testimony. "The adversary system presupposes that the most effective means of determining the truth is to place upon a skilled advocate for each side the responsibility for investigating and presenting the facts from a partisan perspective" (Poythress, 1977, p. 216). Ideally, the adversary system insures informed, unbiased expert opinion. Invariably, the adversary system forces the expert witness to align himself or herself with the party that engages his or her testimony, thus allowing the testimony to be biased. An antibiased device known as cross-examination, which tests competency and credibility, exists within the adversarial system (Slovenko, 1987).

Interdisciplinary Interface

Psychiatrists and mental health professionals provide evidence in more than 1 million cases a year (Yuille, 1989; Smith, 1989). Psychologists provide expert testimony on two major types of evidence. The first is clinical evidence in which testimony focuses on some type of clinical assessment. The second is derived from social science research from which generalizations are made. This is referred to as research evidence (Yuille, 1989).

Psychiatric expert testimony consists of three distinct areas. The first is identification and reporting of suspected cases of sexual abuse. The second involves basic knowledge of child cognitive and psychosexual development, psychopathology, and interviewing skills to aid in the determination of competence as well as the assessment of reliability and consistency of allegations. The third consists of an evaluation of the psychiatric status of the complainant and recommendations for treatment (Abright, 1986).

Although mental health professionals testify on a multitude of issues related to both civil and criminal matters, the psychiatrist is often a preferred expert witness (Perlin, 1977). Medical expert testimony is weighed as more credible than nonmedical expert testimony even in mental health litigation (Bolocofsky, 1989). An implied hierarchy exists with regard to the credentials of a practitioner. A doctorate degree or a medical degree confer greater respect with regard to testimony than a master's or bachelor's degree. This is attributed to the belief that the more training and experience an individual has substantiates greater reliability and credibility. Currently, there is no empirical data to support this claim and mental health professionals continue to combat misperceptions about their testimonial capabilities. They have found it necessary to educate their legal counterparts about their unique skills and techniques which prepare them to testify in the legal system.

Basic Judicial Tenets

American courts are divided into criminal and civil cases. Civil litigation includes divorce, child custody proceedings, personal injury litigation, and proceedings in juvenile court to protect abused and neglected children (Myers, 1992). There are two distinct although sometimes overlapping court systems: federal courts and state courts. Every state has a system of trial and appellate courts. Laws vary in detail from state to state and between one law enforcement agency and another (Myers, 1992). Although federal rules and regulations are addressed in this article, it is important that mental health professionals be familiar with local and state legislation.

Court participation is often initiated through a subpoena. A subpoena is a command that is normally issued by a court at the request of an attorney (Myers, 1992). It mandates that the professional go to court; however, it does not mean that the individual has to disclose privileged information (Myers, 1992). It is prudent and wise to contact the attorney that signed the subpoena in an effort to ascertain the reason and rationale for being asked to appear and testify in court.

Child Sexual Abuse Litigation

Allegations of child sexual abuse may manifest in eight different types of proceedings: criminal prosecutions; juvenile delinquency litigation; juvenile court proceedings; child custody and visitation litigation; proceedings to terminate parental rights; civil suits brought by victims against the perpetrator; civil litigation against child protective service agencies for failure to protect children from sexual abuse; and administrative proceedings (Myers et al., 1989).

Child sexual abuse cases may be handled through the child protective system or the criminal justice system. The former allows the state to intervene when parents are not protecting their children or if they are actively abusing them. The latter defines certain behaviors towards children as crimes. Cases in child protective services are handled in family or juvenile courts, whereas cases reported through the criminal justice system are routed through the criminal courts. In family courts, decisions may be based on a "preponderance of evidence" that the child has been abused. It is not necessary in these cases to identify the perpetrator. In criminal courts, the alleged abuse must be proved "beyond reasonable doubt." It must be proved that the alleged perpetrator committed the crime and that he or she did so with "unlawful intent" (Abright, 1986). In family courts, the aim is to protect the child while in criminal courts, the accused is found to be innocent or guilty. In the criminal system, witnesses are required to give their testimony in a public courtroom in the presence of a jury, the judge, and the defendant and be subjected to cross-examination by the defense attorney (Bulkley, 1989). In some cases, litigation will be pursued in both systems.

The right to cross-examine is not unlimited, and judges have the authority to impose limitations upon the examiner. Cross-examination has two purposes: to elicit favorable testimony and to undermine direct testimony by challenging its content by impeaching the witness's credibility (Myers, 1988).

The jury in a criminal proceeding does not determine if the accused is guilty or innocent but rather that the accused is guilty or not guilty (Everstine & Everstine, 1989). If found not guilty, it has not been proven beyond reasonable doubt that the accused committed the crime. A finding of not guilty indicates that a crime could not be proven as explicitly required by the law. It does not indicate that the jury could not believe that the defendant did the crime (Everstine & Everstine, 1989).

Expert Testimony

The basic principle governing admission of expert testimony is established in Rule 702 of the Federal Rules of Evidence. Rule 702 states:

> If scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training or education, may testify thereto in the form of an opinion or otherwise. (Myers et al., 1989, p. 6)

This rule establishes that testimony must be relevant to a matter that is in dispute. To be reliable the testimony must also have scientific or some other basis. Finally, it must not be otherwise available to the average juror. The probative value must be greater than the prejudicial effect (Smith, 1989).

Federal Rules of Evidence 703, 704, and 705 permit experts to base their opinion on information that would not ordinarily be admissible as evidence, to testify to ultimate issues (eg., whether or not the abuse has occurred), and to express opinions without first having disclosed the underlying facts that gave rise to the opinion. With regard to the ultimate issue, many scholars believe that mental health experts should not be allowed to provide an opinion regarding ultimate legal issues. An opinion that a child has been sexually abused mirrors the legal issue that is before the court. It is not within the jurisdiction of the expert to speak to the ultimate issue that is before the court in the manner of an opinion.

An expert can also testify about the sexual abuse of the child through alternate means without resorting to an opinion. For instance, in child sexual abuse litigation, an expert can discuss inapproprite sexual knowledge possessed by the child. In most states experts are allowed to state their opinions as being of "reasonable certainty" due to the belief that the jurors will be able to weigh appropriately opinions and information entered as evidence.

The trial judge determines if the proffered testimony meets the requirements of Rule 702. Admissibility of the testimony is determined with regard to whether the testimony will assist the trier of fact. In cases without a jury, the judge is the trier of fact. In a jury trial, the jury assumes the role of the trier of fact. The jury is comprised of a body of ordinary people who provide judgment in determining the ultimate issue. Elimination of technical jargon and scientifically worded testimony or expressions is important if the jury is to use the testimony to decide the issue in question.

The federal rules allow that expert testimony need not be limited to subject matter that is beyond the knowledge of the average juror. Experts can offer depth and insight to subjects of familiarity, and their testimony can be admitted to refute misconceptions about commonly held subjects.

Rule 703 of the Federal Rules of Evidence stipulates the permissible basis for expert testimony:

> The facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert at or before the hearing. If of a type reasonably relied upon by experts in the particular field forming opinion or inferences upon the subject, the facts or data need not be admissible in evidence. (Myers et al., 1989, p. 8)

Child sexual abuse experts base their opinions on a variety of sources. Judges have the jurisdiction to determine what types of facts and data are "reasonably relied upon" by experts in the field of child sexual abuse in order to permit experts to formulate admissible opinions on the basis of inadmissible evidence (Myers et al., 1989).

To serve as an expert mental health witness, an individual must qualify under the rules of evidence and belong to a legally recognized mental health profession (Bolocofsky, 1989). These requirements in and of themselves do not ensure that an individual is a competent witness. Discretion resides with the court in determining the competency of a mental health professional as an expert. Three critical factors determine one's qualification as an expert on child sexual abuse: extensive firsthand experience with sexually and nonsexually abused children; a thorough and up-to-date knowledge of the professional literature on child sexual abuse; and objectivity and neutrality about individual cases (Myers et al., 1989). Techniques and skills employed by the expert are as important to consider as is admissibility.

The party that offers the testimony has the responsibility to establish the qualifications of the witness. The experience through which an expert has gained specialized knowledge is important to the weight of the testimony as well as for admissibility. Witnesses establishing expert qualification are questioned on the witness stand with regard to education, specialized training, and relevant experience. Advanced degrees, membership in professional organizations, and publications regarding child sexual abuse are additional areas that are explored. Previous expert status in prior cases of child sexual abuse litigation is another consideration in the qualification process as is current employment and past internships. Prior experience working with sexually abused children will be questioned as well. Expert witnesses are not required to be the foremost authority on a particular subject nor must they be knowledgeable about all aspects of the issue.

Mental health professionals may testify in two different capacities. The first is as a "fact" witness and the second is as an "expert" witness. The former does not garner special status while the latter is awarded certain privileges. Fact or lay witnesses may not testify as to matters of opinion while expert witnesses may testify in the form of an opinion. The testimony provided by a lay witness is based on personal knowledge rather than opinion or inference. Prior to the establishment of the Federal Rules of Evidence, neither type of witness was allowed to express an opinion on the matter before the court in order not to usurp the function of the jury.

Whenever the trier of fact is confronted with issues which cannot be determined intelligently on the basis of ordinary judgement and practical experience gained through the usual affairs of life, the benefit of scientific or specialized knowledge or experience may be provided by use of expert testimony (Ladd, 1952, pp. 418–419). The expert provides an opinion "that is a reasonable probability rather than conjecture or speculation" (Ladd, 1952, p. 419). A lay witness expresses his/her opinion as an expression of his/her observations which are otherwise difficult to state. The expert witness expresses his/her scientific knowledge through his/her opinion. However, only an expert witness may address a hypothetical question.

Another form of expert testimony that is utilized in child sexual abuse cases consists of a combination of lay and expert testimony. Behaviors observed in sexually abused children as a group are discussed by the expert in combination with lay testimony establishing that the complainant demonstrates such behaviors. This type of expert testimony does not focus specifically on the child involved in the case; rather, it speaks to sexually abused children as a group. Expert testimony that a child demonstrates behaviors commonly associated with sexually abused children is distinct from expert testimony that a particular child was sexually abused. In this capacity, the expert is not offering an opinion on the ultimate question of whether abuse occurred.

Criticisms Associated with Mental Health Expert Testimony

Disagreement about the legal value of mental health professionals in the judicial system has persisted since the introduction of mental health expert testimony (Yuille, 1989).

Criticism about the ethics and appropriateness of mental health testimony has been and still is prevalent. The inherent issues in this debate manifest in the following areas: weak scientific basis for psychology and psychiatry; the questionable measurement techniques employed by mental health professionals; and the absence of substantive requirements for who may serve as an expert mental health witness (Bolocofsky, 1989).

Critics argue that the mental health profession has little to offer the judicial system. One particular area of difficulty is the lack of scientific data regarding human behavior. Some members of the legal profession contend that psychological assessments are not reliable or valid and that courts rely on inaccurate or unreliable data and thereby reach incorrect decisions (Smith, 1989). One of the chief areas of criticism rests with the assumption that the mental health expert derives his or her testimony from a theoretical base (Bolocofsky, 1989).

Criticism regarding psychological tests and techniques revolves around the methodology used to evaluate the data generated (*Maryland Law Review*, 1979); that is, the selection of the specific assessment techniques may alter accuracy and objectivity of results. Other criticisms focus on the following factors: inadequacy of standardization; low reliability or insufficient data on reliability; and low validity or insufficient data on validity (*Maryland Law Review*, 1979). In particular, projective techniques have been criticized for several reasons. These include questionable theoretical rationale foundation, evidence that alternative explanations may account as well or better for the individual's responses to unstructured test stimuli, and inadequacy when evaluated in accordance with test standards (*Maryland Law Review*, 1979).

Novel Scientific Evidence

Drawings are considered to be novel scientific evidence in the court system. To be admitted as evidence, the admissibility of drawings or novel scientific evidence is determined through specific principles and is subjected to a special admissibility test. A hearing may be conducted to evaluate the admissibility of such evidence. The special admissibility test is applicable when expert testimony is judged by the court to be less accessible to lay analysis than other types of evidence. The special admissibility test is applicable when expert testimony is based on scientific principles of questionable reliability (Myers et al., 1989).

The court decides if evidence is novel or scientific. The issue of concern is reliability and there are different tests that can be used by the court to determine reliability. The Frye test is considered the general acceptance test. It requires that scientific evidence must be sufficiently established to have gained general acceptance in the field in which it belongs. Although it is increasingly criticized, a majority of courts continue to adhere to the Frye Rule. The Frye Rule has been "the dominant standard for determining admissibility of novel scientific evidence at trial" since its inception approximately 70 years ago (*Daubert v. Merrell Dow Pharmaceutical*, 1993, p. 46).

Most courts do not require scientific certainty of psychological data; however, they do insist upon some level of acceptance for new or novel psychological data. The Frye Rule has generated much debate and scholarship. In *Daubert v. Merrell Dow Pharmaceutical* (1993), the Supreme Court evaluated the continuing authority of the Frye Rule. An opinion was offered that the Frye Rule was superseded by the adoption of the Federal Rules of Evidence (*Daubert v. Merrell Dow Pharmaceutical*, 1993, p. 46). Federal Rule 702 does not advocate that general acceptance be established as a precondition to admissibility. Rule 702 does "assign to the trial judge the task of ensuring that an expert's testimony both rests on a reliable foundation and is relevant to the task at hand" (*Daubert v. Merrell Dow Pharmaceutical*, 1993, p. 54).

Courts do not agree on the application of the Frye Rule with regard to psychological evidence. Critics cite four flaws inherent in the Frye test that deem it unsuitable for novel forms of psychological testimony (McCord, 1986). The first concerns the application of the rule. It is not always evident whether evidence is scientific or not. Another flaw is the determination of what constitutes general acceptance by the field of experts on the specific issue. This concept is difficult to define concretely. Some legal scholars suggest that the definition of general acceptance be "widespread, though less than universal acceptance premised on documentation in the relevant professional literature" (Myers et al., 1989, p. 26). This is criticized because general acceptance offers no assurance that the information is reliable and valid (*Maryland Law Review*, 1979). A final flaw relates to whether or not general acceptance of the underlying principle as well as the application should be established. Without proof of accuracy, scientific expert testimony is thought merely to reflect the personal opinions and beliefs of the expert (*Maryland Law Review*, 1979). The underlying principles of medicine and the mental health sciences are generally accepted and courts take just notice of these foundations. Some advocates of the test feel that the Frye Rule should be invoked when expert testimony is based on novel applications of the accepted underlying foundations (Myers et al., 1989).

If the Frye Rule is invoked, four sources of evidence can be used to establish general acceptance. The first is informed testimony. Witnesses may be called to testify regarding general acceptance. The quality of the testimony rather than the number of witnesses aids in the establishment of acceptance. The witness should possess significant expertise regarding the scientific principle at issue. Knowledge about the status of the principle among other qualified professionals is important information for the witness to present. An informed witness will have comprehensive knowledge of published literature on the topic as well as materials presented at professional conferences including unpublished data. The informed witness will also be aware of the views of leading authorities in the field. The witness should not present as an advocate for the principle; rather, she or he should be neutral and provide information assessing the position of the scientific community.

The other three sources of evidence used in the establishment of general acceptance include the introduction of relevant literature, guidelines from professional organizations, and prior court decisions. Guidelines from professional organizations provide the court with a consensus of the members of an organization. Moreover, the status of the sponsoring organization may be a prominent factor in establishing general acceptance.

An alternate to the Frye Rule is relevance analysis. This is a two-step process. Once reliability is assessed, the court balances the reliability and probative value of the evidence against mitigating factors including causing unfair prejudice to the opposing party or misleading the jury. Relevance analysis is considered well suited to expert behavioral science testimony regarding child sexual abuse (Myers et al., 1989).

Expert testimony can be presented in one of four ways in child sexual abuse cases: expert diagnosis to prove that abuse occurred; vouching for the child's credibility regarding the allegation; explanation of unusual behavior; and explaining the capabilities of children as witnesses (McCord, 1986).

Qualification of Art Therapists as Expert Witnesses

Federal Rule 702 states that an individual qualifies as an expert by virtue of knowledge, skill, experience, training, and education. To serve as an expert mental health witness, an individual must qualify under the Rules of Evidence and belong to a recognized, national mental health profession.

The field of art therapy is a recognized mental health profession. The field is regulated by a national organization, the American Art Therapy Association, Inc. (AATA) which is recognized by the American Psychiatric Association (APA). The AATA has developed guidelines for the training, membership, and practice of art therapists. The AATA designates and establishes professional standards and criteria for its membership regarding training and education. Specific goals govern the organization. These include the progressive development of the therapeutic use of art, the advancement of research, the improvement of standards of practice, the development of criteria for training art therapists, and the exchange of information and experience through publications, meetings, and seminars (Rubin, 1979, p. 14). Association documents include a Code of Ethics, Standards and Procedures for Registration, and Guidelines for Art Therapy Training. Professional qualification for entry into the field requires a master's degree from an accredited academic institution and completion of required course work from an accredited institute or clinical program (Levick, 1983; Lusebrink, 1989). Graduate training programs are required to include practicum experience in addition to didactic training.

Wilkerson v. Pearson

A precedent setting case in New Jersey in 1985 established the credibility of art therapists as expert witnesses as well as the validity of drawings as judiciary aids. The case *Wilkerson v. Pearson* (1985) involved a mother trying to stop supervised visitation between her daughter and the child's natural father due to allegations of sexual abuse. The child was being treated by a registered art therapist who was originally qualified as an expert. The art therapist's expert status and her testimony were later challenged on the basis that neither met the standards and criteria established in New Jersey rulings that govern the admissibility of expert testimony. Under New Jersey Rule 56(2)(b) expert testimony is admissible only if the expert has sufficient expertise to offer the intended testimony and the testimony itself is sufficiently reliable (*State v. Cavallo*, 1982). Relevant evidence is defined as evidence having any tendency in reason to prove any material fact (*State v. Cavallo*, 1982). It was noted that once the proper foundation is established, expert opinion testimony is admissible. Scientific evidence is admissible if the proposed technique or mode of analysis has sufficient scientific basis to produce uniform and reasonably reliable results and will contribute materially to the ascertainment of truth. Thus, New Jersey's standard of acceptability for scientific evidence was an important issue in *Wilkerson v. Pearson* (1985). In *State v. Cavallo* (1982) the following was included:

> The Frye test recognizes that most judges are experts in few, if any, fields of scientific endeavor. Judges are not well suited to determine the inherent reliability of expert evidence, but they can decide whether the proffered evidence has gained "general acceptance" in the scientific community. The proponent of scientific evidence can prove its "general acceptance" and thereby its reliability by the three methods of proof that have been recognized by the courts: expert testimony, scientific and legal writings and judicial opinions. (*State v. Cavallo*, 1982, p. 521)

Through the utilization of these three methods of proof, general acceptance of art therapy within the scientific community and its reliability was established in this case. Before accepting the art therapist as an expert witness, experts in the fields of child psychiatry and art therapy were introduced to the court. These individuals, Dr. Allen Levine, a child psychiatrist, and Dr. Myra Levick were presented as duly qualified experts in their respective fields (Levick, Safran, & Levine, 1990). In their proffered testimony, each referred to relevant literature in his or her respective fields and relevant judicial opinions were consulted during the proceedings.

The judge, the Honorable Harvey Sorkow, followed the three basic requirements for the admission of expert testimony as established by Chief Justice Robert Wilentz in *State v. Kelley* (1984). The Chief Justice wrote:

> In effect, this Rule imposes three basic requirements for the admission of expert testimony: (1) the intended testimony must concern a subject matter that is beyond the ken of the average juror; (2) the field testified to must be at a state of the art such that an expert's testimony could be sufficiently reliable; and (3) the witness must have sufficient expertise to offer intended testimony. (Levick, Safran, & Levine, 1990, p. 52).

The judge accepted the testimony provided by the art therapist in the guise of an expert witness and the art therapist was qualified as an expert in the field of art therapy. The opinion written by the judge set a precedent in the State of New Jersey, making it a landmark case in the state.

The judge discussed the acceptance of art therapy and its reliability in his opinion by stating:

> This court is satisfied that art therapy has a sufficient scientific acceptance and basis. It is not a test such as a breathalyzer that establishes a result given certain facts. Rather, art therapy is a modality of treatment that is subjective in nature but has within its discipline fundamental criteria that if found to exist lead to certain inferences and conclusions. To this extent such evidence is reliable. (*Wilkerson v. Pearson*, 1985, p. 338)

Conclusion

This paper is intended to serve as a reference for the art therapist who is or who may become involved in child sexual abuse litigation. Salient information regarding expert witness status and testimonial capacity as well as the qualification of novel scientific evidence was presented. The purpose was to educate art therapists about basic judicial tenets that are pertinent to qualification and participation as expert witnesses in child sexual abuse litigation.

Mental health expert testimony is just emerging in the opinion of some researchers. In many cases expert testimony is helpful while in others it is essential and required. The prospect for the future is more rather than less expert testimony. The future promise for contributions from the field of art therapy is promising, particularly in the area of child sexual abuse litigation.

Editor's note: Marcia Sue Cohen-Liebman holds a Master of Arts in Art History from Rutgers University and a Master of Creative Arts in Therapy from Hahnemann University. She is an art therapist at the Children's Advocacy Center in Philadelphia, Pennsylvania and a trainer for the National Training Program on Effective Treatment Approaches in Child Sexual Abuse. Correspondence concerning this article may be directed to her at 1172 Barbara Drive, Cherry Hill, NJ 08003.

References

Abright, R. (1986). Psychiatric aspects of sexual abuse. *Bulletin American Academy of Psychiatry and Law, 14*, 331–342.

Bolocofsky, D. (1989). Use and abuse of mental health experts in child custody determinations. *Behavioral Sciences and the Law, 7*, 197–213.

Bulkley, J. (1988). Legal proceedings reforms and emerging issues in child sexual abuse cases. *Behavioral Sciences and the Law*, 6(2), 153–180.

Comment: The psychologist as expert witness: Science in the courtroom. (1979). *Maryland Law Review*, 38, 539–601.

Daubert v. Merrell Dow Pharmaceutical, 113 S. Ct. 2786 (1993).

Everstine, D. S., & Everstine, L. (1989). *Sexual trauma in children and adolescents: Dynamics and treatment*. New York: Brunner/Mazel.

Fink, P. J., Levick, M. F., Dulicai, D., Briggs, C., Hays, R., & Johnson, D. R. (1984). Creative arts therapies. In T. B. Karasu (Ed.), *The Psychiatric Therapies* (part 2). Washington, DC: APA Commission on Psychiatric Therapies.

Ladd, M. (1952). Expert testimony. *Vanderbilt Law Review, 5*, 414–431.

Levick, M. F. (1983). *They could not talk and so they drew*. Springfield, IL: Charles C Thomas.

Levick, M. F., Safran, D., & Levine, A. (1990). Art therapists as expert witnesses: A judge delivers a precedent-setting decision. *The Arts in Psychotherapy, 17*, 49–53.

Lusebrink, V. B. (1989). Education in creative arts therapies: Accomplishments and challenges. *The Arts in Psychotherapy, 16*, 5–10.

McCord, D. (1986). Criminal Law Expert Psychological Testimony about child complainants in sexual abuse prosecutions: A foray into the admissibility of novel psychological evidence. *The Journal of Criminal Law and Criminology, 77*, 1–68.

Myers, E. B. (1987–88). Examining the young witness: Paint the child into your corner. *Family Advocate, 10*(3), 42–47.

Myers, E. B., Bays, J., Becker, J., Berliner, L., Corwin, D. L., & Saywitz, K. J. (1989). Expert testimony in child sexual abuse litigation. *Nebraska Law Review*, 68(1–2), 1–145.

Myers, E. B. (1992). *Legal issues in child abuse and neglect*. Newbury Park, CA: Sage.

Perlin, M. L. (1977). The legal status of the psychologist in the courtroom. *The Journal of Psychiatry and Law*, 5(1), 41–54.

Poythress, N. G. (1978). Psychiatric expertise in civil commitment: Training attorneys to cope with expert testimony. *Law and Human Behavior*, 2(1), 1–19.

Rubin, J. (1979). Art therapy: An introduction. In *Conference on Creative Arts Therapies* [Monograph] (pp. 12–14). Washington, DC: American Psychiatric Association.

Slovenko, R. (1987). The lawyer and the forensic expert: Boundaries of ethical practice. *Behavioral Sciences and the Law*, 5(2), 119–147.

Smith, S. (1989). Mental health expert witnesses: Of science and crystal balls. *Behavioral Sciences and the Law*, 7, 145–180.

State v. Cavallo, 88 New Jersey, 508 (1982).

State v. Kelley, 97 New Jersey, 178 (1984).

Wilkerson v. Pearson, 210 New Jersey. Super. 333, 335. Chancery Division. (1985).

Yuille, J. C. (1989). Expert evidence by psychologists: Sometimes problematic and often premature. *Behavioral Sciences and the Law*, 7(2), 181–196.

Art Therapy: Journal of the American Art Therapy Association, 11(4) pp. 266-270 © AATA, Inc. 1994

The Power of Language in the Art Therapeutic Relationship

Susan Spaniol, EdD, A.T.R., LMHC and Mariagnese Cattaneo, PhD, A.T.R., LMHC, Cambridge, MA

Abstract

This article examines language usage in art therapy and its impact on the art therapeutic relationship. It is intended to raise critical awareness of how biases become imbedded in language, how language usage maintains differences in power, and how to monitor language use in professional practice. The article begins by looking at the cognitive, social, and cultural roots of language development. It then explores the complexity of communication systems used by art therapists, which include clients' visual and verbal communications, the language of the treatment team, and art therapy terminology. It looks at how our verbal interactions with clients affect our relationships with them, and it raises awareness of the impact of language usage when talking and writing about their artworks. Finally, it offers specific suggestions for improving our written and verbal communications as art therapists.

As art therapists, we respect the power of the image. We guide our clients' use of that power so they can experience their lives more fully. We encourage their imaginative use of line and color to give form to their feelings and thoughts, to connect with others and to explore their relationships with their worlds. Although the use of images is the distinctive hallmark of our trade, words are also essential tools because language is the basic medium of everyday exchange between people. The purpose of this article is to examine the use of language in art therapy and its impact on the relationship between the art therapist and client.

This article views language as a dynamic social instrument that absorbs and reflects all aspects of human experience. Because language is molded by people's experiences, cultural characteristics of groups become imbedded in its sounds, syntax, and meaning. And since language reflects cultural differences, its standard, acceptable usage is determined by the language habits of the dominant culture. It is especially important for art therapists to be aware of the language they use when communicating with and about clients because the relationship between therapist and client is traditionally, and inherently, asymmetrical.

Language Development

Speech is a uniquely human social event. The development of speech helps children adapt to their social worlds because it enables them to communicate their feelings, needs, and thoughts to others. Infants' early cries, coos, and babblings motivate their caretakers to tend to their needs. Over time, young children gain control of their speech. Their vocabulary and grammar expand exponentially until, by around age 3 or 4, they have usually mastered the profoundly complex skill of language communication.

Despite the universals of human development, each child's use and understanding of language is also determined by his or her personal and cultural history. Language is dynamic, not static, changing its form over time and place. Similarly, word meaning is relative, not fixed, varying with individual circumstances. How children learn to speak and how they understand what they hear are influenced by their families, their neighborhoods, and their schools. Likewise, how adults comprehend and use language is affected by a complex mosaic of factors that include education, economics, class, occupation, age, gender, and politics.

Language usage is a critical issue because it shapes how we feel, think, and act. It is the basis for our sense of existence and identity because it is a tool for developing self-awareness and self-concepts. The words we hear early in life become our first units of thoughts, and our structures of speech shape the patterns of our thoughts (Vygotsky, 1972). Language enables us to name, define, and organize our inner worlds of feelings, sensations, and thoughts. It allows us to externalize these interior phenomena by translating them into signs and symbols that communicate meaning to others. It also directs our actions because language is integral to anticipating, planning, and problem-solving.

Language and Culture

Power is a social fact that exists whenever a person's role allows him or her to exert control, influence, or authority over someone else. Language is a social instrument that is *shaped by* culture and also *shapes* culture. Its proper usage reflects the speech and writing of those in power. It is the domain of the dominant culture.

In the United States, for example, standard English reflects the speech and writing habits of educated people. White middle- and upper-class professionals shape, define, and name ideas, feelings, things, and people. People who are disenfranchised in our culture due to their race, ethnicity, class, or gender often have language habits that are not considered standard English. Therefore people in nondominent cultures are defined and named by the dominant culture; they are often silenced because they do not speak or write the language of privilege.

People in our society are seen and heard when they use the words and syntax of the dominant culture. If they do not use standard language, they remain silenced and invisible whether they speak or not. When Hegel (1964) examined the dialectic relationship between the consciousness of the "master" who does the naming and that of the "oppressed" who is named, he wrote, "The one is independent, and its essential nature is to be for itself, the other is dependent, and its essence in life or existence is for another" (pp. 236–237). Members of a nondominant culture can become trapped in their own silent world. If they choose to speak the language of the dominant culture, they risk disavowing their own identity in the process. According to Adrienne Rich (1977), "In a world where language and naming are power, silence is oppression, is violence" (p. xv).

Standard English is an idiom of the privileged class. It is inclusive of values of the dominant culture and exclusive of those outside the circle of power. It contains overt and subliminal messages that exclude those who are disenfranchised. This use of language can cause people in the disempowered group to feel unworthy, inadequate, and/or inferior. The growing awareness of the politics of language focuses attention on its latent sexism and racism.

While fine distinctions about language usage may sound blandly academic, their effects can be deep, tragic, and enraging. In her book, *Lost in Translation* (1989), Hoffman observes, "Linguistic dispossession is a sufficient motive for violence, for it is close to the dispossession of one's self. Blind rage, helpless rage or rage that has no words—rage that overwhelms one with darkness. And if one is perpetually without words, if one exists in the entropy of inarticulateness, that condition itself is bound to be an enraging frustration" (p. 124).

The Use of Language in Art Therapy Treatment

The foundation of any interaction is shared meaning. This is especially true in a therapeutic relationship because empathy, support, and trust are essential to building and maintaining an alliance. In our work as art therapists we are required to mediate between a multitude of idioms, including the visual and verbal communication of our clients, the diagnostic categories of the clinical team, the vocabulary of the art world, and the terminology of art therapy. We are trained to respond to the subtleties of visual imagery, but we are not always attuned to the complexities of the many verbal systems we use as art therapists.

Like any therapeutic relationship, the art therapy relationship is an artificial construct that is based on an imbalance of power. As such, it is inherently unequal, even when clients come to us voluntarily. When clients are referred to us, it is not uncommon to assume that they have a mental illness and conduct initial interviews with the intention of identifying symptoms and diagnosing pathology. It is a human tendency to notice information that confirms initial assumptions and to ignore contradictory or paradoxical evidence.

Distinctions of roles are emphasized from the beginning of treatment in order to "set the therapeutic frame." Therapists are usually trained to be relatively reticent while encouraging their clients to disclose as much as possible. This imbalance in verbalization is designed to evoke powerful transference reactions which may manifest themselves in dependency or idealization of the therapist. It is not uncommon for clients to attribute their therapists with magical qualities such as omniscience and healing powers, or to feel strong regressive tugs in their presence. While transference feelings may be a useful and inevitable aspect of the therapeutic relationship, art therapists must sensitize themselves to how the quantity, as well as the quality, of the language they use creates an imbalance of power.

Talking and Writing About Mental Illness

Language also exerts power over the client when it includes technical terminology unfamiliar to laypersons. Technical and scientific expressions can be useful among professionals because they create an interdisciplinary vocabulary, but they are usually alienating in conversing with clients. Using exclusive language is a way of talking above clients, even while talking to them; it tends to make them feel anxious, intimidated, and inferior. Coleman (1983) observes, "At the heart of the matter lies a struggle for control—the use of symbols to guide, manage, dominate, direct or regulate the perceptions of others" (p. 401).

Art therapists should take care to remain sensitive to words that could "type" or label someone. Like scientific terminology, accurate diagnoses can advance treatment. They organize quantities of complex information into a form that can be understood by the various disciplines of a treatment team. They may help determine appropriate treatment goals and medication, and they are a "necessary evil" in applying for reimbursement from insurance companies. However, art therapists should remember that scientific terminology derives from a medical model that diagnoses pathology rather than describing functioning. Therefore, it should be reserved only for those occasions when it is required, and even then scientific terminology should be used sparingly.

Obviously, there is potential risk in labeling people. The risk is that we will identify people with their illnesses rather than view them as individuals. When we label people, we put them into categories and tend to interact with them on the basis of those categories instead of providing individualized care based on their particular needs. Rather than *working with* a person who happens to have a disorder called schizophrenia or post-traumatic stress, for example, we *treat* "a schizophrenic" or "a trauma victim."

Deegan (1993), a clinical psychologist and a former psychiatric patient, describes the perils of being labeled by an illness. She cautions that when people identify with their illnesses, they often give up control of their lives, passing the responsibility on to their therapists. Remembering when she was first labeled with chronic schizophrenia, she recalls her deep sense of loneliness and worthlessness. In an imaginary conversation with herself as a young woman, Deegan underscores the negative language used to reinterpret normal human behavior when someone is labeled with a mental illness.

> Almost everything you do gets understood in reference to your illness. You used to have days when you had "ants in your pants" but now they say you are agitated. You used to feel sad sometimes but now you are said to be depressed. You used to disagree sometimes but now you are told you lack insight. You used to act independently but now you are told that your independence means you are uncooperative, noncompliant, and treatment resistant. You used to take risks. You learned from your failures as you were growing and learning. But now that you have been labeled with a mental illness the dignity of risk and right to failure have been taken from you. No wonder you get angry. Normal people get to make many stupid choices over and over again in their lives. Nobody tells them that they need a case manager. (p. 9)

Just as language is culturally relative, so are concepts of mental illness. People are most apt to label those they know least well. Szasz (1970) cautions against "manufacturing madness" and notes that what we identify as mental illness may actually be problems of everyday living. Giving psychiatric labels to those who are unconventional or different from the dominant culture may be a way of trying to control those we fear or do not understand.

In a pluralistic society, art therapists need to be aware that all aspects of their relationships with clients are influenced by cultural assumptions about wellness and illness. Before rushing to label a person's illness, we should remind ourselves that each society has different notions of the causes, diagnoses, course, and cures of mental illness. We should try to familiarize ourselves with their cultural beliefs, practices, and worldview so we can understand how they experience their worlds.

We might also consider the possibility that eagerness to label people with mental illness is a form of xenophobia. It is commonly accepted that everyone feels threatened by people who are *different* from them. However, it is also possible that what some professionals fear most about their clients are their *similarities*. Labeling clients may be a means by which some clinicians reassure themselves that they are indeed different from people who have a mental illness. It is important to remind ourselves that what separates us from our clients with mental illness are merely accidents of time, place, or circumstances.

Talking and Writing About Clients' Art

The familiar proverb, "A picture is worth a thousand words," suggests the complexities of translating visual imagery into spoken and written language. Art therapists face this dilemma when they encourage clients to explore and clarify the images they create in art therapy sessions. They face it again when they discuss their clients with other members of the treatment team, and also when they participate in professional activities such as teaching, presenting, and writing.

The language used by art therapists is a highly refined synthesis of their multidisciplinary education and training with their cultural backgrounds and experiences. In discussing artworks with clients, it can be tempting to use our own familiar art therapy discourse or the medical culture's convenient system of diagnostic categories. Hoping to facilitate their recovery, we encourage clients to translate their images into words and to decode the meaning of their creations. However, talking to clients about their art can be like conversing in different tongues. While we often describe art as a "universal language" accessible to all, many clients have not had opportunities to develop vocabularies or concepts related to art. We may have unrealistic expectations when we encourage clients to translate the visual into the verbal and to explore what their creations mean to them.

Similarly, significant nuances of clients' artwork may "get lost in the translation" when we write about it, interpret it, and discuss it with fellow professionals. In presenting clients' art, we usually edit or rephrase their words for the sake of clarity and brevity. In so doing, however, we may also dilute both the meaning of their products and the intensity of their subjective experiences. Even more troublesome, we may translate their creative expressions into symptoms of diseases, evaluating their images in terms of the medical culture's definition of what is appropriate and inappropriate, healthy and unhealthy, normal and deviant, or functional and dysfunctional.

Those of us who are members of the dominant Western culture are apt to make assumptions about client artworks based on Eurocentric definitions and standards we think are universal. It is only natural that these assumptions become imbedded in the language we use when talking and writing about our clients' images. All art therapists are expected to have a solid grounding in the history of art. However, the aesthetics of most were formed in white, middle-class households, nurtured by slides of art by Old Masters shown in darkened college classrooms, and cultivated through museum trips to contemplate masterpieces of Western civilization. Lippard (1990) notes, "Within the artworld, few cases of overt censorship due to racism are recorded or reported because personal taste and individual selection (called curating) rule for the most part unchallenged. The people doing the 'caring' for art are overwhelmingly white, middle-class, and—in the upper echelons—usually male" (1990, p. 7).

We all know that art, like language, is fashioned from the fabric of our lives, woven from the threads of our social, emotional, and intellectual beings. Yet we may not be fully aware of our cultural conditioning when we look at art by our clients. We may have difficulty separating which aspects of their images are determined by their unique personalities and which are affected by the "ways of seeing" of their particular cultural groups. As art therapists, we have the responsibility of developing awareness of our own subjective aesthetics that we bring to the therapeutic encounter. Awareness of our culture-bound aesthetic values and taste is necessary in order to comprehend the subjective aesthetics of another person. Once we recognize our own artistic sensibilities and their roots in our personal and cultural experiences, we can begin to see beyond the limits of our particular perspectives to appreciate the diverse aesthetics of our clients. This new understanding will naturally be incorporated into our verbal and written communications, providing a more accurate reflection of our clients and their art.

Suggestions and Recommendations

Before exploring and modifying our language usage as art therapists, we should take time to examine whether aspects of our personal biases, professional assumptions, and clinical theories interfere with our ability to perceive what our clients show and tell us.

In considering the "art" of art therapy, we can begin to look at our assumptions about artistic expression. We might ask ourselves questions such as: Do we assume that the arts are always therapeutic and universally accessible? Do we value spontaneity of expression over more cognitive approaches? Do we differentiate between self-expression and an authentic work of art? We can also examine our assumptions about mental illness. We can reflect on the influence of the medical profession's disease model of mental illness, which focuses on pathology rather than strengths and transformation. We can wonder under what conditions diagnoses advance treatment, and when they become stigmatizing, disenfranchising, or dehumanizing. And we can wonder if we ever make assumptions about chronicity, unemployability, and dangerousness based on our fears of our clients rather than our hopes for them.

A Phenomenological Approach to Language Usage

What people do, say, think, know, make, and use constitutes culture, and attempts to describe culture, or aspects of culture, are called ethnography (Bogdan & Biklen, 1982). Ethnographers believe that reality is a social construction. One way to avoid using culture-bound language is to adopt the attitude of an ethnographer, or anthropologist, who seeks a subjective understanding of the lives and behavior of other peoples. Before actually writing or talking about clients and their art, it is useful to try to gather a generous amount of data over an extended period of time. We can try to approach clients with as few preconceptions and judgments as possible, listening to them attentively, observing their art intently, and interacting with them respectfully. Like anthropologists studying an unfamiliar culture, we can try to spend time documenting observations of clients and recording their words as accurately as possible. Rather than using clinical terminology, we can create vivid descriptions by allowing our clients to "speak for themselves" by using their words in our verbal and written presentations.

Art therapy literature provides concrete guidelines for helping clients find words to describe the subjective meaning of their artworks. Based on their beliefs that the meaning of an artwork is constructed by its maker, Betensky (1987) describes a phenomenological approach to art therapy and Nucho (1987) describes what she calls "ipsomatic seeing." Betensky's phenomenological approach outlines a highly structured sequence of motivating, viewing, describing, and integrating artworks. Once an art piece is created, the art therapist guides the client in a process called "phenomenological intuiting," which is a close examination of the work followed by an objective description of its formal elements. The key phrase repeated by the art therapist during the viewing process is simply, "What do you see?"—which prompts a detailed verbal description of the phenomenon, or artwork. Next, the art therapist guides the client in "unfolding" and integrating its private meanings. By emphasizing an unbiased understanding of artworks, this methodology can aid the art therapist in viewing clients' art from their perspective and can also provide the language for talking and writing about it.

Nucho's ipsomatic approach provides a similar structured process for helping clients describe and decode their artwork phenomenologically—without any preconceived notions. She details a structured dialoguing phase which takes place when an artwork is completed. In talking about their art, clients are guided through a three-step inquiry based on an inventory of the shapes and/or objects in the artwork, an exploration of its affective components, and an intellectual elaboration of its meaning. As in Betensky's method, the ipsomatic approach encourages clients to construct the meaning of their own art, giving us language that respects their experiences of their worlds.

An approach to using less biased language is to exercise our empathy by imagining what clients might say if they described themselves or their artworks. Another resource rarely used is our clients themselves. There may be cases when it is appropriate to consider consulting with them for corroboration or corrections of our written reports. When we write assessments, we can present our findings as tentative hypotheses rather than conclusive diagnoses. We can try to paint an expressive word-picture of their everyday experiences, portraying as closely as possible how it feels to inhabit their world, what their joys and sorrows are, and what gives their lives meaning.

Nonjudgmental Language

It takes vigilance to use language that conveys our meanings accurately and objectively. Many words and phrases commonly used in the mental health field imply judgment and too often become disparaging labels. When clinicians communicate about their clients, they frequently use terms that imply polarities, such as low-functioning and high-functioning, overachieving and under-achieving, appropriate and inappropriate, and normal and abnormal. But human behavior is rarely so extreme. Rather than describe people in terms of black and white, it is often more accurate and less judgmental to use more specific words to represent the gray area that lies in between.

Another language habit that encourages labeling is the use of words that indicate facts rather than inferences. This occurs most often when the communicator uses a variation of the verb *to be* (Hatfield, 1986). Facts have objective reality that can be verified, while inferences are, at best, educated guesses. When we make statements about clients, it is important to use qualifying terms such as *perhaps*, *might be*, *possibly*, or *seems to be*. For example, consider the difference between stating, "He is obsessed," and remarking, "He seems to be obsessed," and then describing the client's observed behavior.

Sometimes mental health professionals use language that has negative or fatalistic implications. For example, a term used frequently is the adjective *chronic*, which implies that a person can never recover. It is more accurate and less harmful to use words such as *prolonged*, *persistent*, *serious*, or *severe* because no one can predict the certain course for any individual. Several long-term studies of the course of psychiatric disorder show that one-half to two-thirds of people with severe mental illness recover sufficiently to function well in the community (Frances, 1990; Harding, Zubin, & Straus, 1987; Huber, Gross, Schuttler, & Linz, 1980). Similarly, when communicating about clients, we can choose to emphasize strengths rather than weaknesses and abilities rather than disabilities, because negative characterizations can become self-fulfilling prophecies.

One of the best resources for language describing a nondominant culture is the group itself. Just as most of us try to identify racial and gender groups by names they prefer, we can also identify the people we treat by terms they choose. Chamberlain, a vocal advocate for people with mental illness, who has lectured worldwide and advised President Clinton, refers to "former patients, psychiatric survivors, mental clients and consumers. She askes her audience to 'note the multiplicity of terms . . . [as] there is no single term we are all comfortable with. We choose to call ourselves by many different names. I prefer to call myself a psychiatric survivor'" (In Bachrach, 1992, p. 867). "Survivor" is the most radical term used by people in the mental health system. Writing for a publication called *The Disability Rag* (1991), Rosen describes the rationale for this term: "Those of us who are involved in the struggle to end our oppression are, simply, survivors. There is no better word to define the reality that belongs uniquely to us. . . . Until we define our existence, in a word we ourselves have chosen, we will never be free" (pp. 6–7).

"People First Language"

Although there is no universal agreement on terminology at this point in the evolution of mental health terminology, the consensus favors what is called "people first language." *Guidelines for Reporting and Writing about People with Disabilities* (1993) is a pamphlet published by the University of Kansas to inform professionals from various fields about preferred language usage and to suggest straightforward terminology for portraying people with disabilities. These guidelines were endorsed by over 100 national disability organizations and are used by the Associated Press. The updated American Psychological Association's *Publication Manual* (1994) has added a new chapter on language bias to help authors avoid "perpetuating demeaning attitudes that are biased assumptions about people." It emphasizes the importance of using language that maintains the integrity of people as human beings.

As the term suggests, "people first language" puts people first, not their disability. For example, according to the guidelines we should refer to "a person with schizophrenia" or "a person who has experienced schizophrenia," rather than give someone a generic label such as "a schizophrenic." This way, the person, rather than his or her functional limitations, becomes the subject of the sentence and focus of the statement. Preferred terms for talking about people who are mentally ill include "people with emotional disorders, psychiatric illness, or psychiatric disabilities." The guidelines also suggest that diagnostic terms, such as psychotic and schizophrenic, be used only when medically and legally accurate and should never be used out of context.

Conclusion

Using respectful but accurate language when speaking and writing about clients and their art can have a favorable impact on the outcome of art therapy treatment. Language can be empowering. Just as our attitudes are imbedded in the language we use, so the language we use can affect attitudinal change. It is possible that addressing and discussing clients in respectful terms will increase their self-esteem and help build a more positive sense of identity. It may be that hearing themselves talked about in respectful terms can help clients think about themselves in more respectful terms, causing a shift in self-perception from one who is stigmatized, disenfranchised, and disempowered to one who is valued, respected, and empowered.

A newsletter called *Pathways to Promise: Interfaith Ministries and Prolonged Mental Illness* (1994) recently published the poem "Beyond Programs: A Parable," which gives voice to some of the sentiments this article seeks to convey:

> **I don't want** to be a client, I want to be a person.
> **I don't want** a label, I want a name.
> **I don't want** services, I want support and help.
> **I don't want** residential placement, I want a home.
> **I don't want** a day program, I want meaningful, productive things to do.
> **I don't want** to be programmed all my life.
>
> **I want** to learn to do things I like and go where I want to go.
> **I want** to have fun, to enjoy life and have friends.
> **I want** the same opportunities as all of you (p. 2).

References

American Psychological Association. (1994). *Publication Manual.* (4th ed.). Washington, DC: Author.

Bachrach, L. (1992). "The chronic patient": In search of a title. *Hospital and Community Psychiatry, 43*(9), 867–868.

Betensky, M. (1987). Phenomenology of therapeutic art expression and art therapy. In J. Rubin (Ed.), *Approaches to art therapy* (pp. 149–166). New York: Brunner/Mazel.

Bogdan, R., & Biklen, S. (1982). *Qualitative research for education.* Boston: Allyn and Bacon.

Coleman, W. (1983). The struggle for control in health care settings: Political implications of language usage. *Et Cetera, 40,* 401–409.

Deegan, P. (1993). Recovering our sense of value after being labeled. *Journal of Psychiatric Nursing, 31*(4), 7–11.

Harding, M., Zubin, J., & Strauss, J. (1987). Chronicity in schizophrenia: Fact, partial fact, or artifact? *Hospital and Community Psychiatry, 38*(5), 477–486.

Hegel, G. (1964). *The phenomenology of mind.* New York: Humanities Press.

Hoffman, E. (1980). *Lost in translation: A life in a new language.* New York: Penguin Books.

Huber, G., Gross, G., Schuttler, R., & Linz, M. (1980). Longitudinal studies of schizophrenic patients. *Schizophrenia Bulletin, 6*(4), 592–605.

Interfaith Ministries and Prolonged Mental Illness. (1994). *Pathways to promise.* St. Louis, MO.

Nucho, A. (1987). *The psychocybernetic model of art therapy.* Springfield, IL: Charles C Thomas.

Lippard, L. (1987). *Mixed blessings.* New York: Pantheon.

Research and Training Center on Independent Living. (1993). *Guidelines for reporting and writing about people with disabilities.* (3rd ed.) Lawrence, KS: University of Kansas.

Rich, A. (1977). Introduction. In S. Ruddick, & P. Daniels (Eds.), *Working it out* (p. xv). New York: Pantheon Books.

Stone, S. (1991). Survivor. *The Disability Rag,* May/June, 1–7.

Szasz, T. (1970). *The manufacture of madness.* New York: Harper and Row.

Vygotsky, L. (1972). *Thought and language.* Cambridge, MA: Institute of Technology Press.

Editor's note: Correspondence should be addressed to Susan Spaniol, EdD, A.T.R., LMHC and Mariagnese Cattaneo, PhD, A.T.R., LMHC, Lesley College Graduate School, Counseling Psychology and Expressive Therapies Division, 29 Everett Street, Cambridge, MA 02138-2790.

Editor's note: For free copies of the *Guidelines for Reporting & Writing about People with Disabilities*, or a 14" × 20" poster about disability writing style, contact: Research and Training Center on Independent Living, 4089 Dole Bldg., University of Kansas, Lawrence, KS 66045, or phone: 913-864-4095 (voice/TDD) or fax (913-864-5063).

Art Therapy: Journal of the American Art Therapy Association, 11(4) pp. 271-277 © AATA, Inc. 1994

The Art of Art Therapy May Be Toxic

Jennifer Jacobs, MA, A.T.R., and Ilo Milton, MPS, MSW, A.T.R, Brooklyn, NY

Abstract

Art therapists may or may not be aware of the potentially harmful ingredients that are found in art materials which are the tools of our trade. The purpose of this paper is to educate art therapists on the complexities in the process of toxicity warnings on materials. This is necessary so that we do not inadvertently endanger the health of our patients while striving to promote change, growth, and/or development. The inadequate government regulations and laws that dictate labeling of art materials are described to illustrate how art therapists must take it upon themselves to provide preventive measures in order to minimize potential hazards.

Introduction

What is the Materials Labeling Act? What does a warning label mean? What does it mean to art therapists when they see labels or *do not* see labels on art materials? As art therapists, we often are too busy thinking about a patient's creations and the artistic process to give a second thought about the tools of our trade. When our art therapy department was approached by a safety inspector in the hospital, we looked into our cabinets and said, "What is *really* in here?" We found that most materials do not have the ingredients listed on the labels. So how are we to guarantee our patient's safety when using these materials? What happens if a child eats a box of crayons or an adult stabs another person with a colored pencil? Does it make a difference if the pencil is yellow or blue? What is in these materials that we so blindly put into our patients' hands?

LHAMA-Public Law 100-695

In November 1990 a federal law called the Labeling of Hazardous Art Materials Act (LHAMA-Public Law 100-695) went into effect. This law is an updated version of the 1988 Federal Hazardous Substance Act (FHSA) (United States Congress, 1988). LHAMA amends FHSA by addressing chronic health hazards. Its purpose is to protect users of art materials from unknowingly exposing themselves to potentially dangerous materials for appropriate and foreseeable uses related to art making. This 38-page law gives specific guidelines (in complex jargon) for determining when an art material may be a carcinogen, neurotoxicant, or developmental/reproductive toxicant when used in the making of art over a lifetime of use. The methods of exposure of the art material to the body explored in the guidelines are injection, inhalation, or skin contact.

These guidelines are applicable to materials intended for use by children or in a household. A toxic label not only means that the product should be handled with care, but also that children under Grade 6 should not even use it. Products marketed only to schools or businesses where only adults will use them, do not need to comply with this ruling. Therefore, if a professional silk screen shop donates some ink to your art program, the materials may be toxic and not labeled as such.

The concern about toxic ingredients in art materials was initially raised by the American Society for Testing and Materials (ASTM). The ASTM developed a standard for labeling, called Designation D-4236. Most art supplies, both toxic and nontoxic, refer to this designation with a quote, "Label conforms to ASTM D-4236 Standards." While the ASTM brought the issue of toxicity to light, it did not define toxicity completely. The LHAMA developed a definition for toxicity and methods for testing for toxicity.

LHAMA's guidelines are for determining a positive toxicity; they do not completely rule out toxicity. When there is no label, this means only that there is no evidence to prove a risk at the present time, or that the manufacturers have known about a material's potential danger for under a year (the time alloted to properly label a product that has been found to be toxic). Art therapists, therefore, must remember that there is always a risk involved when using materials with unknown ingredients.

The law also distinguishes between a "hazard" and a "sensitization." A hazard is a strong risk, whereas a sensitization is a risk of a risk. It is best to assume that all art materials are sensitive and need to be handled properly and with care. We must feel confident in our knowledge of the risks and dangers when using a particular material so that we can instruct and supervise our patients' safe use of various materials.

As of November 1990, any art materials initially introduced into commerce on or after the day LHAMA went into effect are liable for proper warning labels. "If an art material producer or repackager becomes newly aware of any significant information regarding the hazards of an art material or ways to protect against the hazard, this new information must be incorporated into the label after 12 months from the date of discovery" (1991, p. 15710).

The LHAMA represents a big victory for safety when dealing with materials bought after November 1990, but what about that jar of paint that has been in your cabinet for as long as you have been employed? Prior to 1983, manufacturers did not have to tell anyone anything about the content or effects of their products. In 1983, several concerned groups advocating for artists' safety, such as the Center for Safety in the Arts and the Committee for the American Society of Testing Materials, pressed for voluntary labeling of art materials. This was only mildly successful because manufacturers could choose whether or not to label their products. As a result, the manufacturers who labeled their products were punished unknowingly by the consumer. When given two labels on a shelf at an art store, the consumer often chose the unlabeled one over the labeled one, even though both contained the same ingredients. The government was finally persuaded to make labeling mandatory in 1988 under FSHA. This was then superseded by the LHAMA in 1990.

Federal regulations define *toxic* as "any substance which has the capacity to produce personal injury or illness to man through ingestion, inhalation, or absorption through any body surface" (1991, p. 15672). Carcinogens are defined as cancer-causing materials. Determining carcinogens is difficult because of the long latency period between exposure and appearance of tumors, as well as the multiple sources of carcinogenic exposure. Discrepancies due to lack of evidence or controversies are settled case by case by the Consumer Product Safety Commission.

Neurotoxicity is an adverse effect to the nervous system due to exposure to a toxin. The effects can be immediate, delayed, reversible, or irreversible. Characteristics of neurotoxicity are side effects due to overdosing, functional or structural responses which render the nervous system unable to compensate and restore the normal functioning, or any alteration in one's normal functioning. Neurotoxicity damage happens in both the central and peripheral nervous systems. Chemicals enter the nervous system through nerve endings or the blood-brain barrier. Since neurotoxicity can produce a variety of symptoms, it is difficult to trace it to a specific cause. "Major difficulties encountered in studies in humans are the delayed neurotoxic effects, exposure to mixtures of chemicals, and the lack of information on the effects of acutely nontoxic low-dose levels of neurotoxicants over a long period of time" (1991, p. 15680).

Reproductive and developmental toxicity addresses potential effects during the growth of children or hazards that may affect the ability of adults to reproduce healthy offspring. As with carcinogens and neurotoxicants, so many possible causes of defects besides a certain art material make it difficult to prove conclusively that one specific cause or art material is responsible. Although the law is worded to cover every little detail, in the end it is too vague to be effective.

Under the LHAMA, manufacturers or repackagers are required to have any materials they market as art supplies tested by a board-certified toxicologist of their choice. (The term *art supplies* was never defined and seems to be a term placed on the product by the manufacturer.) If the product's ingredients are found to be toxic, the manufacturers or repackagers must submit information regarding the criteria and findings to the Consumer Product Safety Commission (CPSC), and the proper labeling must be placed on the product within 12 months. If the product is found to be nontoxic by the toxicologist, the CPSC need not be notified. In either case, the CPSC does not see the actual recipe for the material unless the Commission requests to see it to settle a dispute. All recipes are confidential and kept by the toxicologist along with documentation of the procedure used to test the material, the criteria for a "toxic" determination, and the findings on that particular product. It is the responsibility of the manufacturer or repackager to check all art materials and notify the CPSC in the event of a toxic finding.

Proper labeling is checked at random with materials bought at retail by a certifying board made up of users or their representatives and manufacturers' chemists, and may be funded by manufacturers. The manufacturer is also required to have the recipe tested every time the ingredients are changed or once every 5 years. After a product has been deemed toxic, the manufacturer has one year to put a warning on its label. The law is geared to place the major burden of informing the public on the manufacturer or repackager.

The manufacturer or repackager does not have to obtain prior approval from the CPSC to market a new product, but all new products developed after the LHAMA went into effect must be tested and properly labeled within 12 months. Warning statements must be in bold capitals with the lettering size equal to or greater than other lettering on the box or bottle. The warning must also be in English and located prominently in legible type in contrast to other parts of the label. Toxic labels must include the name and address of the producer or repackager, a working telephone number in the United States, and a warning statement. If the product's size is one ounce or less, the package must contain an insert with warning information. Products that are found to be hazardous must be labeled and their marketing must be limited to adults or children above Grade 6.

Practical Application of the LHAMA

To test the law and the level of manufacturers' compliance, we took inventory in our supply cabinets. (Some materials in our cabinets were purchased prior to the law going into effect, so we estimate a ± 10% degree of error.) Regarding a complete address on the label, our inventory found 84% in compliance, 11% listing no address, and 5% having incomplete addresses. However, only 7% of the suppliers had a telephone number. Only 5% of our materials made no reference to the law or warnings of any kind. While manufacturers seem to follow the rules when it comes to a warning statement, they rarely are in total compliance with the LHAMA guidelines. For example, we looked at Duco Cement packaging and found an incomplete address and no telephone number. On the other hand, Krylon Workable Fixatif did have a complete address and the verbiage even mentions calling poison control for more information; however, this product did not display the manufacturer's telephone number.

In our inventory gold stars went to Binney and Smith products (Crayola, Liquitex, Aritista) and Weber Costello (Alphacolor Char-kole) for not only being in compliance with federal regulations, but also for having "800" numbers on some products and for being certified by the Arts and Crafts Materials Institute as nontoxic. We found the products that had nothing on their labels regarding toxic warnings, etc., tended to be manufactured in other countries and/or were old materials. Imports, to our knowledge, are not required to be in compliance with U.S. laws and are not checked by import agents.

Consumer Product Safety Commission

The Consumer Product Safety Commission (CPSC places the responsibility for enforcing guidelines on interstate com-

1992

merce agencies. The Commission's responsibility is to make regulations and specify tests for determining toxicity. The Commission will also intervene in instances where there is uncertainty about a product and no solution can be determined. When we called the Commission, a representative vividly described the overwhelming task of monitoring the regulations, because of limited staff and the large geographical locations each person is assigned to monitor. An endless supply of products, each with its own recipe, makes the job of total awareness impossible. Another hurdle is toxic quantity. A product may contain toxic chemicals, but not enough to deem the art material toxic. So each ingredient that comprises the thousands of colors and types of art materials has to be analyzed, and the results read by employees of the Commission.

Considering that there is only a small staff of CPSC employees assigned to large parts of the United States, only a minimum number of products are actually monitored. The first page of the American Society of Testing and Materials standards practice for labeling says it best: "Since knowledge about chronic health hazards is incomplete and warnings cannot cover all uses of any product, it is not possible for precautionary labeling to ensure completely safe use of an art product" (1988, p. 1).

The Process of Labeling a Material as Toxic

The process of labeling a material toxic is important because it illustrates just how detailed and time-consuming testing is. To summarize, the LHAMA outlines three types of intake and two types of analysis. The types of intake are oral ingestion, inhalation, or skin contact. Studies are done using animals and humans (where available and permissible). Human data are obtained from studies of exposure and previous data. If positive information on humans is available, then the substance is considered toxic. If limited information on humans is available (which means all outside factors cannot be eliminated), along with sufficient evidence on animal studies, then a toxic ruling is also concluded. If animal studies alone generate conclusive information but no human data can be found, then the material will be determined nontoxic. "While it is not mandatory that persons (toxicologists) follow these guidelines in making their determination of chronic toxicity, the commission intends to bring individual enforcement actions against improperly labeled products, or against manufacturers, distributors, or retailers of such products" (1991, p. 15674).

The toxicologist must first determine whether or not the substance is toxic. He or she then decides what risk is acceptable over a lifetime of use so that there is no effect on the individual. This testing process uses initial data from testing to guide testing of specific effects.

The Commission can also rule based on default, which assumes the product is dangerous by assuming the person will be exposed to the highest risk. This is needed in cases of suspected danger so an art material will have some kind of warning label. Later, the material may be thoroughly tested and the label will be adjusted accordingly. Not only can dangerous materials be unlabeled, but labels may incorrectly name a nontoxic material toxic.

In an attempt to be as complete as possible, the Art Materials Labeling Act has several types of warnings. One aspect that the guidelines address is ***bioavailability***, which is defined as the "ability of a substance to be absorbed into the body" (1991, p. 15688). Manufacturers try to get around a toxic labeling by stating that a toxic material is not soluble and therefore cannot be absorbed into the body. However, a material may not be hazardous during one contact, but will become dangerous over time. Hazardous substances cannot simply be labelled toxic. Much depends on factors such as the amount of exposure, the chemical nature of the substance, the metabolism of the person exposed, the distribution through the body, and other unique factors that differ each time a substance is used. What makes bioavailability especially difficult is that it takes into account an individual's physiology, which can vary according to age, sex, race, body build, etc. That is why, for example, some warnings may be specific to women or children. Bioavailability testing is complicated and time-consuming since bioavailability is adjusted as necessary to account for species, sex, and race.

Sensitization, another type of warning defined in the Art Materials Labeling Act, describes a product that has the potential to be dangerous but a definite ruling of toxicity cannot be made due to a lack of data. Sensitization means there is a potential for harm if the products are not handled carefully. Therefore, we must always be sure our patients are using materials in a properly ventilated room and are equipped with protective gear if necessary.

Conclusion

Are we, as art therapists, going to harm our patients and/or ourselves in treatment? To respond in the negative, we must be aware of the possible dangers of the materials which are essential to our work. The best possible way to keep our patients and ourselves safe is to keep our eyes open. We must carefully choose our art materials and keep the type of population with whom we work in mind when ordering supplies. We must become familiar with nontoxic substitutes (*Art Hazard News* publishes such a list) and use materials bought after 1990 (or know from where the older supplies come). When in doubt, we should refrain from using an unlabeled material. It is especially important to post the poison control center's telephone number in our art rooms. When we are unsure of a material, we can also call the CPSC or any organization that researches art materials and their safety. We must keep in mind that there is always a risk, but that watchful art therapists will be able to prevent harm or injury by being knowledgeable about the materials we use with our clients.

Editor's note: Jennifer Jacobs, MA, A.T.R., is an art therapist and child counselor in the Program for Adolescent Development at Kings County Hospital, Brooklyn, NY. Ilo Milton, MPS, MSW, A.T.R., is in private practice and is the Acting Director of the Art Therapy Department in the Division of Child & Adolescent Psychiatry at the State University of New York Health Science Center at Brooklyn, NY.

Inquiries about this article may be directed to Ilo Milton at 30 Lincoln Plaza, New York, NY 10023.

References

Consumer Product Safety Commission. (1991). Labeling of Hazardous Art Materials Act (LHAMA-Public Law 100-695). *Federal Register*, 56 (74):15672–15710.

United States Congress (1988). *Federal Hazardous Substance Act*. (U.S. Public Law 100-695. 102 Statute 4569.) Washington, DC: U.S. Government Printing Office.

Resources

American Society for Testing & Materials. (1988). *Standard practice for labeling art materials for chronic health hazards*. Annual Book of the American Society for Testing & Materials Standards. Philadelphia, PA: Author. 1–4.

American Society for Testing & Materials, 1916 Race Street, Philadelphia, PA 19103.

Arts & Crafts Materials Institute, 715 Boylston Street, Boston, MA 02116, Telephone 617-426-6400.

Arts & Crafts Safety Hotline, Telephone 212-777-0062.

Art Hazard News, Center for Safety in the Arts. A newsletter published 10 times per year. Available from Center for Safety in the Arts, 5 Beekman Street, 10th Floor, New York, NY 10038. Telephone 212-227-6220.

Brooks, V. F. (1984, October). Artist's materials: A new generation for the 80's. *Art News*, 83, 137–143.

Consumer Product Safety Commission, Telephone 301-492-6800 or 301-492-6400.

Kessler, P. (1989, March). Read the label. *ArtNews*. 88:40.

McCann, M. (1992). *Artist beware*. New York: Lyons & Burford.

McCann, M. (1985). *Health hazards manual for artists*. New York: Foundation for the Community of Artists.

Rossol, M. (1990). *The artists complete health and safety guide*. New York: Allworth Press.

Shaw, S. & Rossol, M. (1991). *Overexposure: Health hazards in photography*. New York: Allworth Press.

Appendix

Safer Substitutes in Art

By Angela Babin, MS

Waste Reduction

Artists and art students work with many materials to create art. Certain art materials can be hazardous both to the students and to the environment. The best way of eliminating waste art materials is through source reduction, the elimination of hazardous or nonhazardous wastes before they are created. Reuse and recycling are also good methods of reducing waste. Several ways that art students and teachers can address this issue are:

▶ Substitute art materials that are less toxic to the environment—and also less toxic to the students.
▶ Completely use up art materials. Purchase in container sizes that do not leave lots of residue.
▶ Reuse or recycle art materials whenever possible.
▶ Treat hazardous waste art materials by neutralization (see photography section) or other methods when possible to reduce the toxicity of the waste stream.

Understand that substitutions may involve using alternative art materials and techniques. It may take a little time getting used to these alterations. Also, remember that the safety of all recycled materials should be determined before use. This poster contains general recommendations and very specific ones for safer substitutes in art.

Elementary School Students

Some art materials are dangerous for young children to use. Basically, young children should only use art materials that are nontoxic. This poster recommends that young children use art materials that do not have any warning labels and carry the statement "Conforms to ASTM D-4236" or similar wording. Products that have been approved by a toxicologist and carry the Certified Product (CP) or Approved Product (AP) seal of the Arts and Crafts Materials Institute are generally approved for young children.

This poster shows safe art materials that can be SUBSTITUTED for the more hazardous ones in elementary school classes. Young children should not use any processes discussed under secondary schools unless also approved for elementary school students, at the top of each arts category.

Secondary School Students

Art materials that are used in the junior and senior high school levels are often more toxic. This poster shows safe and less toxic art materials that can be used to replace more hazardous materials. Please remember that sometimes the substitute materials can still be hazardous—just less so! Make sure that the label carries the statement "Conforms to ASTM D-4236" or similar wording, indicating that the warning label conforms to the requirements of the Labeling of Hazardous Art Materials Act of 1988.

Since many art materials recommended here still might be hazardous, although to a lesser degree, secondary school students and teachers may still need to take health and safety precautions while using art products. These precautions may include types of ventilation, gloves, respirators (face masks), and other safety precautions. Remember to take the right safety precautions!

CERAMICS

Elementary School Students

Clays	Use only wet, premixed clays.

White clays	Use only talc-free clays.
Glazes	Paint finished pieces with acrylics or tempera instead of glazing. Use CP/AP lead-free liquid glazes.

Secondary School Children Through Adult

Clays	Use only talc-free, premixed clays.
Glazes	Use only lead-free glazes. Use premixed liquid glazes, not powders.
Colorants	Use glazes that do not contain carcinogenic nickel, cadmium, uranium, chromates, or talc.
Waste clay	Cut into small pieces and place in barrel of water for recycling.
Waste glazes	Combine residual glazes and reuse.

PAINTING AND DRAWING

Elementary School Students

Paints	Use CP/AP water colors, tempera, and acrylic paints, not adult paints.
Scented markers	Do not use because they teach children to smell and eat art materials.
Permanent markers	Use CP/AP water-based markers.
Pastels, chalks	Use CP/AP oil sticks, crayons, chalks, and colored pencils.
Spray fixatives	Use CP/AP clear acrylic emulsion to fix drawings.
Rubber cement	Use glue sticks or double-sided tape.

Secondary School Students

Painting

Pigments	Use pigments that do not contain lead, cadmium, mercury, arsenic, or chromates.
Pigments	Use premixed paints.
Oil paints	Use water-based paints. Replace turpentine washes with acrylic underpainting.
Spray paints	Brush or spatter paints.
Solvent cleaning	Use baby, vegetable, or mineral oil instead of solvents to clean hands and brushes.
Turpentine	Use turpenoid, odorless paint thinner, or odorless mineral spirits.
Waste solvents	Reuse solvents by allowing to settle, and then filtering or decanting.

Drawing

Pastels	Use oil pastels instead of dry pastels.
Drawing inks	Use water-based inks not solvent-based inks.
Permanent markers	Use CP-AP water-based markers. Use alcohol-based markers instead of markers based on toluene or methyl isobutyl ketone.

COMMERCIAL ART

Elementary School Students

Scented markers	Do not use because they teach children to smell and eat art materials.
Permanent markers	Use CP/AP water-based markers.
Rubber cement	Use glue sticks or double-sided tape.
Glues	Use CP/AP glues for collage.

Secondary School Students

Paint/Drawing materials	Use water-based paints and inks instead of solvent-based ones.
Airbrushing	Use a tooth brush to spatter paint. Don't airbrush solvent-based dyes or inks.
Permanent markers	Use water or alcohol-based markers instead of markers based on toluene or methyl isobutyl ketone.
Rubber cement	Use waxers or double-sided tape instead of rubber cement or spray adhesives. Use kneaded eraser to remove wax from mechanicals. Use heptane-based adhesives instead of hexane-based types.

PHOTOGRAPHY

Elementary School Students

Photochemicals	Use polaroid cameras, without transfer manipulation.
Photochemicals	Send film out to be developed. Do sungrams with blueprint paper and sunlight. Do photocopier art.

Secondary School Students

Black and White Processing

Developers	Use only metol/hydroquinone developers or the less toxic phenidone/hydroquinone developers. Use replenishment solutions to reuse chemicals. Neutralize with stop bath or critic acid before disposal.
Stop bath	Use water only, instead of acetic acid.
Fixers	Use low acid fixers instead of high sulfur dioxide rapid fixers. Recover silver from fixer if using large amounts.
Reducers	Use only Farmer's reducer (potassium ferricyanide).

Intensifiers	Do not use intensifiers because of their high toxicity.
Toners	Do not use toners because of their high toxicity.
Hypo eliminators	Use water or hypo clearing agents for washing.

Color Processing

Color developers	Do not use phenylene diamine developers.
Solvents	Use only low solvent color processes.
Formaldehyde stabilizers	Do not use formaldehyde.

Blue Printing

Fixer	Use diluted hydrogen peroxide instead of dichromates for fixing.

METAL WORKING

Elementary School Students

Jewelry	Bend metal wire instead of soldering.
Stained glass	Use colored cellophane and black paper to imitate colored glass and lead came.

Secondary School Students

Jewelry

Silver solder	Use cadmium-free silver solders.
Fluxes	Use borax instead of fluoride-based fluxes.
Pickling baths	Use sodium hydrogen sulfate (Sparex) instead of sulfuric acid. Neutralize bath with baking soda (sodium bicarbonate) before pouring down sink with lots of water. Test with pH paper.

Enameling

Enamels	Use only lead-free enamels.
Enamel colorants	Use enamels that do not contain nickel, cadmium, uranium, arsenic, or chromates.
Waste enamels	Combine and reuse.

Metal Casting

Lead	Do not cast lead or lead-containing metals.
Sand blasting	Use glass beads or alumina instead of silica sand.
Asbestos	Use asbestos-free insulation.
Silica Investment	Use plaster and sand mixture.

Stained Glass

Lead came	Use copper foil technique.
Lead solders	Use lead and antimony-free solders.
Fluxes	Use acid-free and rosin-free fluxes.
Glass paints	Use colored glass or lead-free paints.

Welding

Metals	Weld metals like mild steel that are not galvanized, or do not contain lead, nickel, chromium, or cadmium. Use only found metals of known composition. Do not use metals coated with lead paint.
Fluxes	Do not use fluoride fluxes.
Degreasing	Degrease metals with detergents or odorless mineral spirits instead of chlorinated hydrocarbons.

PRINTMAKING

Elementary School Students

Screen printing	Use CP/AP water-based inks. Use cut paper stencils.
Relief printing	Use linoleum cuts instead of woodcuts. Use CP/AP water-based inks.

Secondary School Students

General

Pigments	Use pigments that do not contain lead, cadmium, mercury, chromates, or arsenic. Use premixed inks.
Cleaning solvents	Use odorless mineral spirits instead of turpentine, kerosene, or gasoline.

Screen Printing

Inks	Use water-based inks instead of solvent-based inks.
Stencils	Use cut paper, contact paper, etc., instead of lacquer stencils.
Screen mounting	Use staples or tape instead of solvent-based glues.
Photoemulsions	Use diazo photoemulsions or presensitized photo film.

Intaglio

Acids	Use ferric chloride (iron perchloride) instead of Dutch mordant. Neutralize nitric acid baths with baking soda before pouring down sink. Test with pH paper.
Cleaning solvents	Scrape inking slab and press with palette knife to reduce amount of ink, remove remaining ink with vegetable, baby, or mineral oil, and wipe oil film with cotton ball and rubbing alcohol for cleanup.
Photoetching	Use presensitized plates or xerox transfer/screen process instead of techniques that use highly toxic solvents.

Lithography

Acids	Use premixed gum etches instead of using concentrated acids.
Vinyl lacquers	Do not use because of high toxicity.
Dichromates	Use fountain solutions based on water and gum arabic. Use citric acid as counteretch.
Hydrofluoric acid	Do not use because of extreme toxicity.
Talc	Use asbestos-free talcs (e.g., baby powder).
Phenol	Use mechanical cleaning of stones.
Photolighography	Use positive/negative presensitized offset plates.

WOODWORKING

Elementary School Students

Woods	Use only common soft woods.
Glues	Use CP/AP glues.
Paints	Use CP/AP water-based paints.

Secondary School Students

Preserved	Do not use woods treated with chromated wood copper arsenate (CCA), pentachlorophenol, or creosote. Use ordinary woods.
Particle board and plywood	Use ordinary woods to avoid formaldehyde.
Tropical woods	Use nonallergenic and nonirritating woods.
Leftover wood	Recycle into new projects.
Glues	Use white glues, hide glues, and other water-based glues instead of epoxy, formaldehyde, or solvent-based glues. Use small containers to minimize drying out of glue.
Paints and coatings	Use water-based products instead of solvent-based ones. Use lead and mercury-free paints.
Shellac	Use shellacs containing denatured alcohol not methyl alcohol.
Oil and solvent-soaked rags	Recycle by drying or sending to recycling laundry

SCULPTURE

Elementary School Students

Modeling clays	Use premixed clay or CP/AP modeling materials.
Papier mache	Use black and white newspaper with CP/AP pastes or CP/AP instant papier maches made from cellulose.

Secondary School Students

Clay	See Ceramics.
Plastics	
Plastic resins	Do not use polyester, epoxy, acrylic, or polyurethane resins because of high toxicity.
Solid plastics	Use saws instead of hot wire or torches.
Stone	
Soapstone or steatite	Carve alabaster or cast plaster.
Wax	
Waxes	Use beeswax or petroleum waxes, not chlorinated waxes.

TEXTILE AND FIBER ARTS

Elementary School Students

Synthetic dyes	Use vegetable dyes (spinach, tea, onion skins, etc.) or food dyes.
Synthetic fibers	Use fibers that have not been treated with formaldehyde sizings.
Textile remnants	Left-over textile scraps can be used for stuffing pillows or soft sculpture projects.

Secondary School Students

Fibers	
Animal fibers	Use hair and wool not imported from Mid or Far East because of anthrax.
Dyeing	
Mordants	Use nondichromate mordants.
Fiber-reactives	Use liquid fiber-reactives, not powders.
French dyes	Use water-based dyes.
Vat and azoic dyes	Use other classes of dyes.
Leather dyes	Use leather dyes containing denatured alcohol rather than other solvents.
Batik	
Wax	See Sculpture, wax.
Dyes	See Dyeing.
Solvents	Boil out or iron out wax instead of using solvents.
Papermaking	
Woods, plants	Use nonallergenic and nonirritating materials.
Lye	Recycle used paper and cardboard, or use rotten or mulched plant materials to avoid boiling in alkali. Use soda ash (sodium carbonate) not lye.
Dyes and pigments	Use liquid dyes and pigments instead of powders. See also Dyeing.

Permission was granted to reproduce this article from the Center for Safety in the Arts, New York, NY.

Legal and Ethical Issues Impacting Unlicensed Art Therapists and Their Clients in California

Marybeth Webster, Grass Valley, CA

Abstract

A confusion about who and what is an art therapist is examined via the exclusionary California state licensing laws. Comparison of the training and job descriptions of art therapists with psychotherapeutic disciplines with licensed degrees reveals few discernable differences, yet the restriction prohibiting private practice to unlicensed art therapists limits full use of their skills. Ethical issues (such as advertising, expert witness, duty to warn and report, malpractice, etc.) are discussed as they affect the unlicensed art therapist. It is the purpose of this article to further efforts to legitimize the profession and to move toward removal of ethical and legal constraints on unlicensed art therapists via state-recognized certification, exemption, or formal licensure.

Introduction

In California art therapists who have qualified for registration (A.T.R.) with the American Art Therapy Association (AATA), and even persons who meet the California requirements for the job title of art therapist or art rehabilitation therapist, are barred from private practice by state licensing laws. Unless the art therapist holds a license as a social worker; psychologist, or marriage, family, or child counselor (MFCC), s/he may not practice privately in California.

The California State Personnel Board specifies art as one of the rehabilitation therapist specialties for state hospitals. The job description says . . . "assess individual needs, . . . determine objectives; . . . conduct various forms of group and individual therapy; . . . evaluate and document patient/resident response and progress. . . ." Additionally, the description states that an art specialist "uses art media as a means of expression and communication to promote preceptive, intuitive, affective, and expressive experiences which lead to growth or reintegration of personality" (California State Personnel Board Specifications, 1972). I interpret this as giving unlicensed art rehabilitation specialists the right to do psychotherapy (which the Psychologist Licensing Law prohibits!) but only in a state rehabilitation setting under supervision.

Also, art therapists are used as clinicians in state licensed health facilities where they may serve on a treatment team. Art therapist is a job listing in the California Department of Health and Personnel Services and is currently defined in the California Administrative Code of Health Regulations as follows: "Art therapist means a person who has a master's degree in art therapy or in art with emphasis in art therapy, including an approved clinical internship from an accredited college or university; or a person who is registered or eligible for registration with the American Art Therapy Association." (Title 22, Division 5, 1973).

A legal memo written especially for this paper analyzes existing California state laws regarding licensure of psychologists, clinical social workers, MFCCs, and educational psychologists and finds that the differences among authorized functions may be in form, not substance. The memo goes on to say:

> Under the existing licensing schemes, psychologists, clinical social workers and MFCCs all do counseling. Clinical social workers "explain psychosocial aspects" of situations to clients, whereas MFCCs "provide psychosocial explanations of relationships" to clients. Psychologists "modify behavior which is socially ineffectual," whereas clinical social workers "help people achieve more adequate social adjustments." Psychologists "diagnose and treat emotional disorders" whereas clinical social workers "modify behavior, emotions and thinking."
>
> To avoid conflict with other professions, an art therapy licensing statute must set forth art therapy methods that are distinguishable from the "psychological" methods used by a psychologist, the "psychosocial" methods used by a clinical social worker, and the "applied psychotherapeutic techniques" used by an MFCC. In addition, the art therapy licensing statute must describe the practice of art therapy in language that is different from the other professions—even if they may be doing substantially the same thing.
>
> Discussion among art therapists would disclose a broader rationale for licensing art therapists and such reasons should be included in the legislative intent section of the statute.
>
> However, it seems to me that art therapy's amenability to the diagnosis and treatment of child abuse victims may more readily distinguish it from the work of psychologists, clinical social workers and MFCCs, whose methods are ineffective if the client has not developed sufficient language ability to benefit from the treatment. Child abuse is no longer considered to be a private problem but a public problem affecting the public interest. Therefore the time may now be right to seek licensing for art therapists to serve a public interest in ameliorating a public problem. (Enright, 1992)

Public Protection

The public is not protected by law from the many who claim to be art therapists or who say they do art therapy but who do not have the proper academic background or necessary clinical experience to work with the people served by state-licensed health facilities (Drachnik, 1991). In defending certification and/or licensure of professionals, protection of the public is paramount, with the ideal being technical competence and professional accountability (Johnson, 1970).

Regional art therapy associations are receiving complaints from consumers and agencies about people claiming to be art therapists* who do not have appropriate education or supervised practical training. Some of these individuals are artists with no clinical education or supervision who work with severely disturbed adults and children. This kind of practice is potentially dangerous for patients and certainly now helpful for the reputation of the profession.

Quacks, defined as a "pretender to skill which he does not possess; one who practices as a licensed mental health professional," (Cohen, 1979) abound, perhaps especially in California. Alternative "therapies" are rampant. The popular inclination of Californians to seek improvement or repair in mental, emotional, and spiritual realms makes people vulnerable to these pseudo-therapists. Proving that art therapy is not just another form of quackery includes efforts to professionalize and regulate the discipline on a par with licensable mental health professions.

Art Therapy Licensure and Certification

Addressing professional and ethical concerns about protection of the public form unqualified or unscrupulous practitioners, as well as accountability for competence, is underway within the profession of art therapy with the creation of national certification requirements and an examination. It is hoped that certification will lead eventually to licensure in the State of California, thereby exempting licensed art therapists in the Psychology Licensing Law along with other exempted professionals such as MFCCs, MSWs, psychologists, etc. (Gregory & Paine, 1984).

The California Board of Behavioral Science Examiners oversees licensure, investigates ethical issues, and determines and enforces sanctions for those therapies comparable to art therapy. It is to that board that California art therapists might apply for regulation under a licensing bill.

The Board of Psychology under the Medical Board of California oversees clinical psychologists' licensure and, through its Central Complaints and Investigation Control Unit, investigates and disciplines ethical infractions by psychologists. This body would presumably have the power to exempt art therapists from legal restrictions prohibiting practice of what psychologists define as psychotherapy.

Definitions of Psychology vs. Art Therapy

The Psychology Licensing Law defines the practice of psychology as "rendering or offering to render for a fee to individuals, groups, organizations, or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations" . . . including "but not restricted to: diagnosis, prevention, treatment, and amelioration of psychological problems and emotional and mental disorders of individuals and groups" (Business & Professions Code, 1990).

Language describing what art therapists do could include all of the above but with variations, since art therapy includes a wide variety of techniques and theoretical bases. Examples of possible definitions can be found throughout art therapy literature:

> An art therapist uses the process of art expression and its exploration to effect her [or his] client's positive growth and the amelioration of [her or his] suffering" (and then writes many books about how this is done). (Wadeson, 1980, 1987)

> Art therapy is a human service profession providing opportunities to develop physical, emotional, and/or learning skills through art experiences. It provides for the exploration of personal problems and human potential through both verbal and nonverbal expression. . . . Through observation and analysis of art behaviors, art products, and the client's communications, the art therapist formulates diagnostic assessments and treatment plans as part of a total therapeutic program. The focus may be on growth experiences, rehabilitation, psychotherapy, prescriptive treatment, remediation, adaptation, and/or personality enhancement. . . . the art therapist creates a supportive environment by organizing the art materials and other resources, by inviting participation appropriate to the client's devleopmental stage of art expression; by accepting the client's willingness to share thoughts and feelings; and by encouraging the client to recognize and extend these insights beyond the art therapy session. (Jungels, 1979)

> What the creative arts therapist has brought to the mental health field in particular is the notion that psychodynamics and principles of aesthetics are intricately interwoven and that by tapping the artist within ourselves and our patients we have an invaluable treatment tool. . . . We need to develop our own language and theoretical framework, but we must also be conversant in the language of other professionals. We must seek legal protection for our unique skills while continuing to remain receptive to the contributions of our colleagues. Ultimately, if we are to grow as professionals, we must develop concepts and formulations to match the complexities and depths of our therapeutic experiences. (Robbins, 1987)

Who May Practice in California?

Recognized professional groups licensed to practice in the State of California include physicians, clinical social workers, educational psychologists, MFCCs, optometrists, psychiatric technicians, registered nurses, attorneys, persons utilizing hypnotic techniques by referral, persons licensed to practice medicine, dentistry or psychology, persons utilizing hypnotic techniques which offer avocational or vocational self-improvement and do not offer therapy for emotional or mental disorders; duly ordained members of the recognized clergy; duly ordained religious practitioners doing work of a psychological nature consistent with the laws governing their respective professions provided they do not hold themselves out to the public by any title or description of services incorporating the words "psychological," "psychologist," "psychology," "psychometrist," "psychometrics," or "psychometry," or that they do not state or imply that they are licensed to practice psychology. Exempted persons are licensed under Article 5 . . . i.e. educational psychologists, etc. (Business and Professions Codes, 1990).

---

*Editor's note: Please see the commentary by Jonathan Braverman on p. 244 regarding this issue.

Current Status of Unlicensed Art Therapists

In addition to work in agencies or hospitals, unlicensed art therapists in California report that they currently:

- teach art techniques, experiences, or art processes
- conduct expressive, communication, or self-esteem groups
- conduct in-service trainings
- lead expressive workshops
- do art assessments as a consultant to an agency or licensed therapist
- do art therapy under supervision of a licensed therapist in private practice
- use art therapy techniques as part of career guidance
- use art therapy as part of structured mediation
- act as personal consultants
- teach or supervise (with an A.T.R.) art therapy trainees

One art therapist advertises her individual and group work as "Gestalt Art Experiences", another as "Art as a Second Language." Workshop titles I have used include "Self-esteem Through Self-expression" and "The Me Nobody Knows." In the opening orientation and/or on the informed consent forms given to new clients, care must be taken to state that the unlicensed art therapist who is not supervised is not doing psychotherapy.

Ethical Issues

Ethical issues faced by an unlicensed art therapist include but are not limited to: advertising and other representation to the public; privacy; privilege and confidentiality; serving as an expert witness; duty to warn; reporting abuse; supervisory liability as employee/consultant to a licensed therapist; malpractice; informed consent; and release of art materials for lectures, exhibit, or publication.

Advertising and other representation to the public. Art therapists may list their name, relevant academic degrees earned from accredited institutions, date, type and level of certification, AATA membership status, address, phone, office hours, services offered, and, if not otherwise prohibited, appropriate fee information (AATA, 1990).

Representation to the public in the form of fliers, brochures, listings in resource directories, newspaper interviews, etc., must follow the limitations listed above with special care not to give the appearance of being a psychologist or other licensed practitioner. One may not refer to oneself as a "therapist," "psychotherapist," or "counselor," although it is correct to say "Registered Art Therapist" (A.T.R.) or "Board Certified" (BC) if in fact one holds the A.T.R. and BC. One may say, "I have degrees in psychology," if that is true, but not "I am a psychologist." However in California my degrees in Educational Psychology and Community Psychology do not qualify me to say I am a psychologist.

Privacy, privilege, and confidentiality. Clients need to know that what they share is always theirs to limit, and that all confidences will be vigorously protected from being revealed to any outsider. Since it is the client who holds privilege, he or she has the right to release his or her privilege to allow records or testimony in court. Exceptions to confidentiality include danger to self or others and abuse. Another exception is that parents have the legal right to information about their offspring under most circumstances (Rinas & Clyne-Jackson, 1988).

Serving as an expert witness. Clients must be made aware that an unlicensed art therapist qualifying in California as an expert witness will have less clout than would a licensed therapist. The possible exception to this is the growing respect of legal and law enforcement personnel for the revelations in artwork of children in abuse cases as interpreted by competent art therapists.

Duty to warn. Although not required of unlicensed persons in the Tarasoff ruling (Corey, Corey, & Callanan, 1992), it is morally and ethically necessary for the unlicensed art therapist to notify authorities and potential victims.

Reporting of abuse. Reporting abuse or suspected abuse to Child or Adult Protective Services is also ethically required. Although not specified, an unlicensed art therapist who works with minors or elders, like a dance teacher or anyone who deals professionally with children, is considered a mandated reporter.

Supervisory liability as employee/consultant to a licensed therapist. The law does not permit licensed practitioners to delegate their responsibilities *in toto* to an unlicensed person; also, the assistant, employee, or supervisee must be competent to perform the services she or he is delegated to perform. The unlicensed art therapist must not function in a way so as to get the "cloak" of being a licensed professional by reason of association with the supervisor/employer. Where a client could reasonably confuse the employee with being a licensed professional, the professional may be subject to disciplinary action for "lending out" his or her license. Usually the "master" is required to respond for, and is seen as responsible for, the "tortious conduct" of his or her employees. This would not absolve the unlicensed individual from the consequences of his or her actions, and the supervisor/employer might sue to recover damages (Cohen, 1979).

Likewise, participating in institutional teams may create added risk for the professional members of the team. As more persons participate in decision-making conferences concerning patients, the risk of suit for breach of confidentiality and/or defamation becomes greater. It is possible, lacking specific law, that an unlicensed art therapist could be seen as an "un-authorized" team member with questionable rights to information about a client (Cohen, 1979).

Malpractice. Unlicensed persons cannot be sued for malpractice. Cohen (1979) says,

> Malpractice is a civil offense subsumed under tort law. A tort is "a harm done to an individual in such a way and of such a type that the law will order the person who did the harm to pay damages to the injured party." . . . torts can be intentional or unintentional. Technically malpractice is an unintentional tort (negligence).

Quacks and unlicensed art therapists can be sued for ordinary negligence, assault, battery, intentional or unintentional causing of emotional distress, and other torts such as breach of contract. With the exception of sexual abuse of clients, malpractice insurance covers both intentional (assault, battery, defamation, etc.) and unintentional (breach of duty of due care, duty to prevent suicide or assault to third parties, misrepresentation, causing emotional distress, or invasion of privacy, etc.) acts (Cohen, 1979).

Informed consent. Oral orientation in early client sessions and written contracts must include accurate and complete information on the services to be offered (goals, techniques, rules, and procedures), limitations and risks, right to withdraw from treatment, and confidentiality and its limits. Minors or persons unable to give consent must have guardian/parental consent. Qualifications of the art therapist, financial arrnagements, obligations around scheduling/missing appointments, probable length of therapy and termination plans, whether a supervisor will be involved, how interruptions in the work will be handled, and an explanation of uses made of case notes, also need to be included (Corey et al., 1992).

Ownership and release of art materials or photographs of artwork for lectures, exhibit, or publication. Clients should be informed of one's intent to use their materials in public, the purpose thereof, and to only do so with their signed release, with the understanding that client identity will be concealed and that the display and interpretation of the works will be "fairly and accurately in a manner that minimizes the possibility of misleading the public and other professionals" (AATA, 1992). However, there are no laws that specifically govern disposition of art expressions created while in art therapy.

Conclusion

It is hoped that within the foreseeable future the issue of ethical and legal constraints on unlicensed art therapists will be moot via state-recognized certification and exemption or by formal licensure. Until then, art therapists who are not licensed in their respective states must be cognizant of laws and regulations governing their professional practice.

References

Acute Psychiatric Hospital Regulations. (1973). *Title 22*. Sacramento, CA: Department of Health.

American Art Therapy Association, Inc. (1990) *Code of Ethics*. Mundelein, IL: Author.

Business and Professions Code, Psychology Licensing Law. (1990). Medical Board of California.

California State Personnel Board Specifications. (1972). *Rehabilitation therapist, state hospitals*. Sacramento, CA: Author.

Cohen, R. J. (1979). *Malpractice: A guide for mental health professionals*. New York, NY: The Free Press.

Corey, G., Corey, M.S., & Callanan, P. (1992). *Issues and ethics in the helping professions*. Pacific Grove, CA: Brooks/Cole Publishing.

Drachnik, C. (1991 & 1992). Personal correspondence files released to the author.

Enright, M. (1992). State license law for art therapists: A legal memo written for the author.

Gregory, B. M., & Paine, E. L. (1984). Legislative Counsel of California letter to Senator Jim Nielsen.

Johnson, D. (1970). Legal regulation of the social work professional. *Social Casework*. *51* (9), 473–484.

Jungels, G. (1979). The use of the creative arts in therapy. *Proceedings of the Conference on Creative Arts Therapies*, June 28–30." Washington, DC: The American Psychiatric Association.

Rinas, J., & Clyne-Jackson, S. (1988). *Professional conduct and legal concerns in mental health practice*. San Mateo, CA: Appleton & Lange.

Robbins, A. (1987). *The artist as therapist*. NY: Human Sciences Press.

Wadeson, H. (1980). *Art psychotherapy*. New York, NY: John Wiley & Sons.

Wadeson, H. (1987). *The dynamics of art psychotherapy*. New York, NY: A Wiley-Interscience Publication, John Wiley & Sons.

Viewpoints

Progress or Politics

Dee Spring, PhD, A.T.R., MFCC, Ventura, CA

"To rise out of suffering is to view the past from another angle" (Spring, 1993).

Recently, as I toured England, I became overwhelmed with its antiquity and the years of struggle for control by various countries. The history of sacrifice and sabotage is written on the faces of the buildings and monuments, such as Stonehenge, which date to 3000 BC. I was in awe of the many historical statements preserved in the visual arts, the collection of artifacts, and the strong differing opinions of the people I encountered and engaged in conversation. Regardless of the differences in opinion or the variance in tales about historical figures and incidents, I observed one element which was constant—a continuous thread of respect and acceptance for historical contributions.

During my wanderings, I realized how powerful the components of respect and acceptance are for uniting people whether it concerns a country or an association such as the American Art Therapy Association. Upon my return, as I began to write this article, I became aware that these two elements are missing from AATA's history. The original civil war created by Naumburg and Kramer is still very much alive and carried on by followers of each grande dame. Most members have forgotten what created the war in the first place. It is this piece of history that underlies the adversarial position of many art therapists and continues to be stored in the "suitcase of the past" (Spring, 1993).

Civil War and the Sacrifice-Sabotage Principle

The war was predicated on the sacrifice-sabotage principle. Both Naumburg and Kramer were saying the same thing about the results of art therapy and benefits to the patient, but argued which was most important, psychotherapy or art expression. It was as though one had to be sacrificed for the other rather than accepting the value of blending both elements. However, both discussed the phenomenological occurrence of conflict being reexperienced, resolved, and integrated in artwork as well as the idea that inner experience must be retranslated from an image to verbal communication. Yet, they were unable to resolve their own conflicts, thus providing the original environment for AATA.

In the beginning, along with the argument about what made art therapy a discipline, was the idea of sacrifice. Art therapists were considered economically deprived. Today, belief in this monetary deprivation continues to invade the classroom and conferences. Rather than preparing art therapy students to earn a living, they are led to believe that choosing art therapy is a sacrifice. Thus, "poor art therapists" adopt the ancient philosophy and develop a sense of entitlement rather than a drive to reframe the image. When professional members are forced to pay for students' food at conferences through increased conference fees, it is evident that the principle is still operating. Older members must sacrifice to pay for the students. Are we once again sabotaging the natural process of struggle which builds character and breeds appreciation for personal and collective accomplishment? It seems this new "mothering" concept is providing students with the benefits that older members have earned by their own hard work and struggle. Such decisions lead to the type of conflict that sabotages the philosophic health of the Association and causes resentment within the membership.

If we are to consider the health and progress of AATA, our history cannot be dismissed. The history brings into focus our current behavior and attitudes, our response to each other, plus the lack of respect and adversarial contempt for the contributions of contemporaries. It seems that we continue to fight the same battles over again rather than adopting a new philosophy of what art therapy is and can become.

Naumburg and Kramer were both grand women in their era and we owe much to their pioneering efforts. Their argument was over method and procedure as related to what was most important, psychotherapy or art expression. However, their conflict should not continue to be our conflict in the 1990s. We have more challenging problems to confront.

After years of members participating in and evaluating the argument, without any research to prove which method works best, we can concede that all art is spontaneous, that there must be a direction for therapy, that treatment plans and the manner in which art expression is used to accomplish the goals of therapy is of utmost importance. It seems that art therapists are so busy attempting to convince each other that their way is the best, depending upon which ancient leader they are following, that the major point of our professional existence has been missed. The major point is to prove what it is that we do. I am not sure we know what we do as we have no outcome studies and have a serious deficiency in empirical research.

The Concept of Terminal Uniqueness

Perhaps our deficiencies are directly related to the concept of terminal uniqueness. Art therapists refer to themselves as "unique" but are unable to define what that means. If it means waving feathers, dangling crystals, and chanting, then we are unique! It seems we are more interested in the verbal definition of "uniqueness" than what we do that moves therapy along in a unique manner. Being defined as unique will not bring us favor in the professional community. We can no longer afford the luxury of just being unique and creative; we must also be qualified to be licensed so that we can make money. Yet, the political environment is such that there are those who defy changing their educational programs to prepare the student for licensure or making money. There are those who want art therapy to stand alone in its uniqueness rather than piggy back as a specialization on another license. This attitude is another article in the "suitcase of the past."

Education

I remember while teaching some years ago that I was asked what changes I thought the program should make. At that time, this program had one 3-week course in group therapy which was supposed to qualify the art therapist to do therapy. I suggested that in the future, as the field moved toward certification and licensure, art therapists would be called upon to know more psychopathology and have more training in psychotherapy techniques. My response met with an avalanche of contempt for my suggestions and several reasons why such change would not be tolerated. I was firmly told there was no need to do anything different since this school was primarily concerned with art expression, not therapeutic skill. Most students who graduate from that program do not work in the field of art therapy. In order to maintain the field of art therapy, such archaic attitudes cannot continue in our educational programs.

It is now recognized that our educational programs must be drastically changed to meet the current educational demands. The sacrifice-sabotage principle has been at work in our education approval process as in other areas. The idealistic values and antique methods of evaluation used in the past by the Educational and Training Board (ETB) are finally being streamlined and simplified by a new generation of art therapists. Hopefully, the proposed changes will attract more universities that have an interest in promoting an art therapy program. Old art therapy programs cannot continue to be rubber stamped, nor allowed to take the students' money without making the required programmatic changes. Until about 6 years ago, the policies, procedures, and inner workings of the ETB were kept secret, even from the Board of Directors. While I served on the AATA Board, the first meeting between the ETB and the AATA Board was held. This meeting began the process to implement needed changes and lift some of the secrecy that had existed for many years. Such elitist philosophy prevented educational programs from moving forward, and the past idealistic philosophy of the ETB prevented us from attracting colleges and universities that could offer art therapy programs to a wider audience at less expense to students. Recently (November, 1993), I received feedback on the approval process from a major university. This is a program that I have worked on for 8 years, one class at a time. They let me know that "the AATA approval process was idealistic and crazy"; that they could "inaugurate a medical program easier than seek approval for an art therapy program." The new Education Standards were recently published in the *AATA Newsletter* (Staff, Summer, 1994). However, this publication does not address the approval process, nor the policies and procedures used by the ETB. Members are not privy to this information. The rationale for the secrecy in the past was to keep the approval process out of the political arena. Did this happen?

In terms of education and professional status, we cannot stand alone as "unique" creatures. We have to comply with the rules of other professional entities which are involved with up-to-date educational programs and approval, along with continuous involvement in empirical research and outcome studies. We need to define what professional traits are rather than just throwing the word "professionalism" around and pretending that we have it. The "suitcase of the past" contains many articles about education and what constitutes professionalism.

Professional Traits

Professional traits which breed respect are connected with sharing knowledge. This appears to be very threatening to those art therapists who want to maintain the status quo of the 1960s. Sharing knowledge is professional; keeping knowledge to one's self or one's own group is a betrayal. Praise and respect of one's contemporaries is honorable; disrespect for professional contributions is an injustice. Openness and truthfulness builds trust; secrecy and underhandedness is abusive. Rigidity and insecurity breed defensiveness. These primary elements separate professionalism from destructiveness.

Being professional does not include attempting to undermine or characterologically assassinate those members who have made contributions that are worthy of acknowledgment. When I served on the Honors Committee, a few members of the Executive Board underhandedly attempted to overturn a decision made by the Honors Committee. Why? Because someone outside their group, who did not like the choice of the Committee, made an outstanding contribution to the field of art therapy. There is no question in such instances that the sacrifice-sabotage principle is alive and well. Such tactics also indicate that the sacrifice-sabotage principle is more important than respect or progress. I was first infuriated, then embarrassed, that such a maneuver had been considered. What does this say about our leadership?

It seems that the members of AATA are stingy and withholding when it comes to awards. What a shame! From 1970–1993, 19 Honorary Life Memberships and nine other awards were bestowed. There seems to be pressure to give a yearly HLM award, which is very competitive and political. It takes only one nomination for an individual to be considered for any award. There have been five Distinguished Service Awards and two Clinical Awards. There were two posthumus awards. This makes a total of 28 awards in 23 years (Malchiodi, 1994). Out of 4,000 members, we must have more than 28 outstanding members over a period of 23 years. To reward one's fellows brings positive energy, healthy competi-

BEST COPY AVAILABLE

tion, praise, and acknowledgment for achievements and hard work. Everyone gets to share in the excitement. Giving awards is a special communication of gratitude, respect, and acknowledgment of dedication to the field. This is part of building a gracious and respectful community.

If we look at our history in this area, we find that the Clinical Award is seldom given. Is this part of the civil war fallout? Does clinical mean psychotherapy versus art expression, thus the awarding of this distinction is to be avoided? Are we so threatened, so jealous, and so fearful that to reward others makes us less than the recipients? Awards are given every year; many members can be recipients. The awards are not going to disappear because they are given. Do we withold our appreciation because that would mean sharing the power? Or is it that the sacrifice-sabotage principle is so ingrained that we must not acknowledge efforts because of our own insecurities? Perhaps such positive endeavors are too anxiety provoking; most of us will do anything to avoid anxiety and use denial as the antidote. Since sharing and acknowledging contributions is another element of being a professional, I think we are seriously lacking in this area. Are we professionals, or do we throw the word around in hopes that it will light on us and we will be magically transformed? Perhaps our concept of professionalism is another one of our quiet crises. I have begun to realize that the negative side of what we refer to as professionalism creates a crisis cycle to which AATA is addicted.

The Crisis Cycle

During my long affiliation with AATA, I have watched the sacrifice-sabotage principle and the push to power and control by particular individuals operate to create ongoing crises within AATA. A good example of such a destructive crisis and the creation of invisible wounds is the 1982 AATA Conference in Chicago, which I attended. At the business meeting, a fight occurred between proponents of the *American Journal of Art Therapy*, published by Elinor Ulman, and supporters of a new journal, to be published by AATA. The management of this professional problem was devastating to many members because of its personal nature. It was a drama of both intrigue and horror, centered around control issues. The membership voted to publish a new journal titled *Art Therapy*. The first edition was published in October 1983, and continues today as the major trade journal in the field. *The American Journal of Art Therapy* is published by Norwich University in Vermont. The invisible wounds from that crisis have not healed. Instead the wounds have continued to fuel present crises. Most members are unaware of the provoking history, thus do not understand some of the nonsensical crises about power, control, and politics that erupt from time to time.

At times I have been disgusted and discouraged with the political mechanics that continue to operate out of a civil war environment. At other times my passion for fairness and respect for others has engaged me in controversy as a means to quell the destructive energy that seems to be ever present when a new idea or concept is presented. At times I wonder if we have achieved progress, or just more sophisticated politics based on the status quo of ancient leaders. I have attempted to decipher whether AATA operates from a base of jealousy or graciousness, and if the need for control by some individuals is so important that the sacrifice-sabotage principle cannot be comprehended.

It is apparent that AATA has many invisible wounds. These wounds may be healed by moving out of a 25-year-old pattern of crisis based on the abuse model. I believe that respectful controversy over professional problems is educational and healthy, but the need to control defines the insecurity and narcissism of members who want power. As long as there is an adversarial environment, unity cannot be established, nor can advancement to earning respect as professionals by other fields be attained. As long as there is disrespect for the contributions of all members, art therapy will continue to be disregarded rather than embraced by other professional groups. Since history infiltrates both present and future, we need to view it from a different angle and re-form our philosophy. Our history cannot be changed, but we can use the historical learning experiences to manage the future and discontinue the addiction to the crisis cycle. We do not need to reinvent the wheel.

If we look at the "crisis-violence cycle" (Spring, 1993), we can begin to understand how we need to change for the future. The crisis-violence cycle is an unusual system with particular phases and components which operate together, overlap, and co-mingle. The pattern is kept operational both

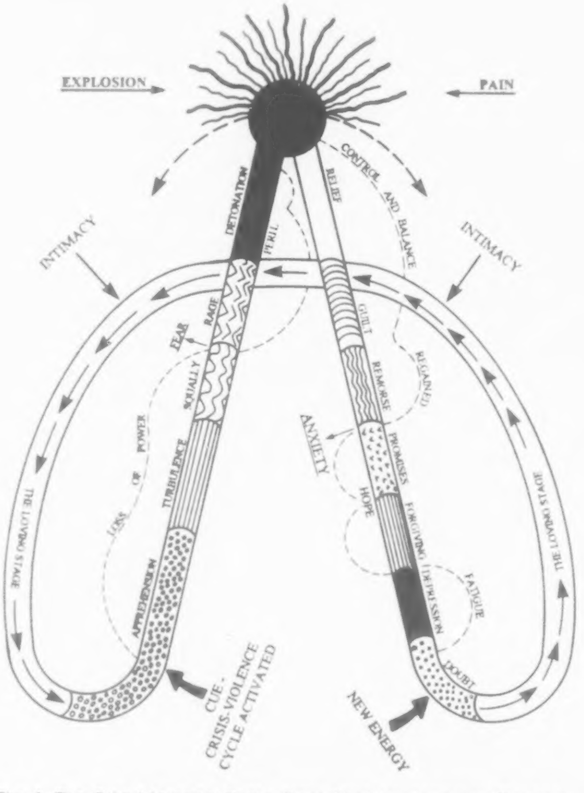


Fig. 1. The Crisis-Violence Cycle. From *Shattered Images: Phenomenological Language of Sexual Trauma* (p. 99) by D. Spring, 1993, Chicago: Magnolia Street Publishers. Copyright 1993 by Magnolia Street Publishers. Reprinted by permission.

by passivity and aggression. The components of the cycle are adversarial and conflictual. Feeling powerless, placing blame, and lacking respect starts the cycle and the "loving stage" recycles it. Adversarial roles, lack of boundaries, and control issues keep the cycle operational. During the building of the crisis there is an emotional disturbance resulting from a clash of opposing impulses, or the inability to reconcile impulses with realistic or moral considerations. The "explosion" follows, coupled with pain for the participants. These elements are a part of the addiction carried in "the suitcase of the past" and apply to the crises in AATA.

In order for this system to be ongoing, nine elements must be present: passivity, aggression, frustration, a feeling of powerlessness, loss of control and the desire to regain it, spontaneous rage, relief gained through the use of force (emotional or physical), a search for intimacy, and the hope of change which couples with magical thinking about the outcome. The cycle begins and ends in the "loving stage." In AATA's case, the loving stage is the annual conference in which the casual observer thinks that everything is wonderful. The undertow of the cycle is seldom recognized by the general membership since in any abusive situation, there is the public appearance and the hidden reality. The fuel for the crisis-violence cycle is the metaphorical roles which are adversarial in nature and can be observed within the membership. We can all find ourselves among the list of characters in the drama of the civil war.

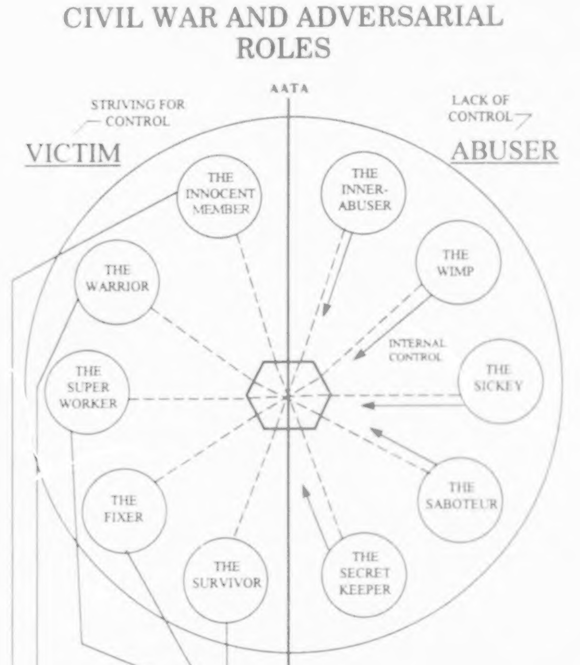


Fig. 2. Civil War and Adversarial Roles. From *Shattered Images: Phenomenological Language of Sexual Trauma* (p. 122) by D. Spring, 1993, Chicago: Magnolia Street Publishers. Copyright 1993 by Magnolia Street Publishers. Adapted by permission.

1. The Innocent Member who is naive but willing versus the Secret Keeper who only tells the member bits and pieces to get the Innocent Member involved in the push to power. The conflict is honesty versus secrecy.

2. The Warrior who fights for justice and fairness versus the Saboteur who wants to keep the status quo and fights in underhanded ways to maintain it. The conflict is good versus evil.

3. The Superworker who is concerned with acceptance through defensive competence versus the Sickey who exaggerates problems, complains, and has little motivation. The conflict is success versus failure.

4. The Fixer who is constantly involved with fixing many members, many projects, and many problems and jumps to the rescue in a crisis versus the Wimp who is indecisive and has learned how to be helpless to gain control. The conflict is control versus lack of control.

5. The Survivor who endures no matter what happens and acquires a martyr-like philosophy versus the Abuser who creates crises where non exists through impulsive behavior and irresponsive acts and strives to keep others in a confused crazy-making situation as a means of control. The conflict is emotional life versus death in terms of gaining attention to feel powerful.

These roles represent the political behavior that creates invisible wounds. They are historical, along with the original civil war and the ongoing crisis-violence cycle. These historical elements are contained in the "suitcase of the past." As we move into the next 25 years, it seems reasonable to clean out the suitcase in order to gain a new perspective for the future. We are now at the age of 25 ready to move away from parents. It is time to stop our adolescent crisis-oriented behavior as we ready for mating. It is time to make wedding preparations for uniting history and current events with the prospect of a new life. Will the new family manage the next 25 years by the rules inaugurated by the ancient leaders to continue the civil war, or will they use the knowledge of past mistakes to create a new environment? Will the new family roles incorporate a philosophy that art expression and therapeutic skill must be an equal blend to create the synthesis which is art therapy?

A Model for Change

Instead of carrying on the civil war, we need to cherish what Naumburg and Kramer stood for and extract the knowledge they gave us as a birthright. We do not need to continue their argument; we have too many vital challenges to address and too many important matters to resolve. Opposing views can be combined into a single strength that can unify AATA regardless of the argument over method and what is more important, art expression or therapeutic skill. Both elements have to be present if art therapy is to advance. Both Naumburg and Kramer were dedicated to the patient's therapeutic success. Does it matter whether therapy skills are more prominent than art expression? If art expression and clinical skills are not integrated and used simultaneously then we just have one or the other, but not art therapy.

Since all art is spontaneous (how can it be otherwise?), it seems that the importance is the use of art therapy for the power it exhibits in healing, the effect that it has on the patient, and how the patient incorporates the insight and awareness gained from the combination of art and psychotherapeutic skills. How the patient manages life after art therapy determines whether the tool was used successfully. I surmise that if we had outcome studies this would strengthen the idea that method is not the real argument. The real argument is about power and control disguised by opposing claims of how to do art therapy. We must move from verbal claim to written proof.

Resolution Is Connecting the Past to Current Events

As we move toward the year 2000, attitudes and performance need to be adjusted to meet the challenges of a technological world, more crowded space, and less personal expression. The demand for art therapy services should increase as people will thirst for individual expression. As we enter the next phase of a more mechanized and technological environment that swiftly engulfs an international community, we must consider scripts for success, common goals, and healthy controversy rather than continuing the sacrifice-sabotage principle.

Viewing the past from a different angle means cleaning out "the suitcase of the past," rearranging some articles, and deleting others. It means incorporating a change in roles to diminish destructive conflict. Rather than continuing the adversarial nature of the AATA, we might consider establishing roles that flow and compliment each other rather than separating and fighting. Real power and control is always within the individual. Collective power and control can only be acquired through teamwork, equality, and respect within a resonating community. We have to give up something to get something. In the context of this article, this means giving up the old destructive ways and creating a new drama that leaves the audience feeling good about AATA. The drama is about us, each of us, not some phantom-like presence. We must own the role we play. We must own our participation in the sacrifice-sabotage principle and our own addiction to the communal crisis-violence cycle which reverberates with a distorted excitement.

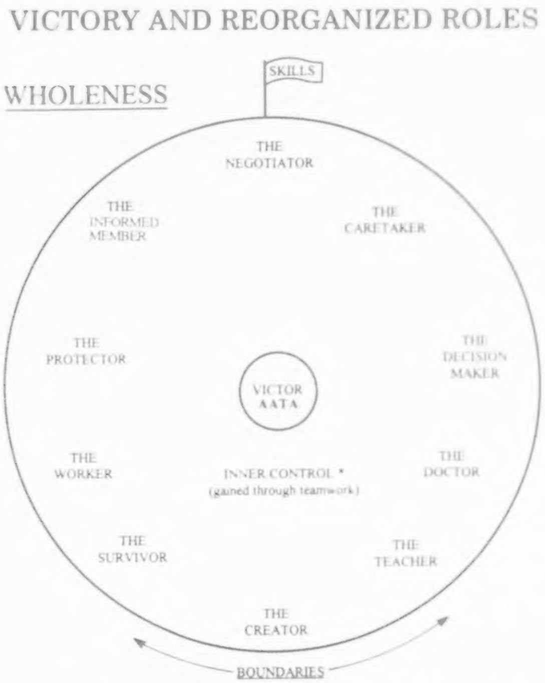


Fig. 3. Victory and Reorganized Roles. From *Shattered Images: Phenomenological Language of Sexual Trauma* (p. 194) by D. Spring, 1993, Chicago: Magnolia Street Publishers. Copyright 1993 by Magnolia Street Publishers. Adapted by permission.

The new drama is a rewrite, not a rerun, of the adversarial roles. The metaphorical roles can be modified to flow and compliment each other as conflict resolution is achieved.

1. The Innocent Member becomes the well-informed, involved member.

2. The Secret Keeper becomes the teacher and shares knowledge.

3. The Warrior becomes the protector and guards honesty and justice.

4. The Superworker becomes the worker who does a competent job.

5. The Survivor becomes the victor who meets challenge with knowledge.

6. The Saboteur becomes the negotiator who listens and compromises.

7. The Sickey becomes the doctor who promotes a healthy community.

8. The Fixer becomes the caretaker of advancement and achievements.

9. The Wimp becomes the creator who can design or create opportunities.

10. The Abuser becomes the decision maker who negotiates and looks for logical solutions to problems.

The new drama incorporates a new backdrop, the same actors with different roles, and the plot is about a group of people who rescued their community. The final act is a community celebration involving all the inhabitants in a folk dance where all move to the same rhythm.

Reflections

From the time I began studying art therapy, I could not understand the reasons for an either-or approach to the field. I have not been able to understand why being a good clinician and a good artist, which includes exhibition, are not compatible; why psychotherapy seems to be tainted in some way that takes away from art expression and vice versa. Yet, this argument continues in full force as presented by Lachman-Chapman (1993).

> The inquiry begins with questions arising from an attempt to integrate the identities of the art therapist and the exhibiting artist. Are they fundamentally opposite: the art therapist functioning to serve others and the exhibiting artist functioning to serve or express himself/herself? (p. 141)

Perhaps it is not so much the either-or concept, but rather the fallout from the civil war in which each side purported to be right rather than blending and synthesizing art expression and psychological theory. I believe that at some point in our maturation we must accept that there is no either-or approach. Art therapists are multifaceted. They are a composite of clinical skills and artisitc talents who use both art expression and psychotherapy to bring forth unconscious material. Their work is a unique combination of skills and creative thinking that other modalities cannot claim. Art therapy cannot exist if one or the other element is missing from the process. This is the terminal uniqueness!

I found the composite of skills and creativity to be very important when I began making a living in the art therapy field. My art therapy degree did not qualify me for a job, nor did it qualify me for any type of licensure. It took a second Master's degree in Clinical Psychology to gain employment in the field and to qualify for licensure. The combination of two Master's degrees in differing fields did not diminish my composite of skills nor my creative abilities. In fact, my knowledge, skills, and expertise were intensified and embellished. However, in order to conduct empirical research in art therapy, I had to complete a PhD in clinical psychology. The terminal degree broadened my skills and my theoretical base, enhanced my creativity, and generally increased my investment in the art therapy field because of the results of my research.

Following the completion of the research, I felt hostility from some of my colleagues that I did not understand. It became evident that there were those who chose to assassinate the research rather than accepting it as a contribution to the field or conducting follow-up research to disprove my findings. Without any foundation or proof that the research was not valid, verbal attacks and one written denouncement ensued. Most of the attacks come from colleagues who had not pursued a PhD and who had never done empirical research in any field, certainly not in art therapy. In addition, my education was attacked and denounced as not being legitimate, that my sample was too small, and my pursuit of a specialization in art therapy was dishonorable. Today, Educational Standards state there must be "opportunities for specialization" (Staff, Summer 1994).

It took five years of answering the *Call for Papers* for the annual AATA conference to be permitted to present my work. During this time, I presented my work across the nation and taught it in universities. It was as though my research in the field of art therapy was alien to the Association who had previously rewarded me for the concept. The mixed message that I received about the research still rings in my ears. I was given the research award in 1978 for material that became the dissertation, but was not allowed to present any of the material for 5 years. I was told that the topic was "not appropriate conference material." It took another 5 years to be allowed to present the final outcome of the research.

Such stories are the invisible wounds that I alluded to earlier. Such stories are rampant within the Association, but the stories are kept secret as members suffer in silence or withdraw from participation. Since research on trauma resolution was a completely new area of art therapy at that time, who were the judges? The shame and ego destruction that such political maneuvers perpetrate cause deep scars. Such unprofessional response to contributions of members breeds distrust, resentment, and a withdrawal from the mainstream of the business of AATA. We have lost talented members' expertise and vision because of the same type of professional abuse.

Would I manage this political situation which revolved around the sacrifice-sabotage principle differently? Yes, I would tell the story in a written forum where it could be addressed in a professional manner and perhaps censored. At

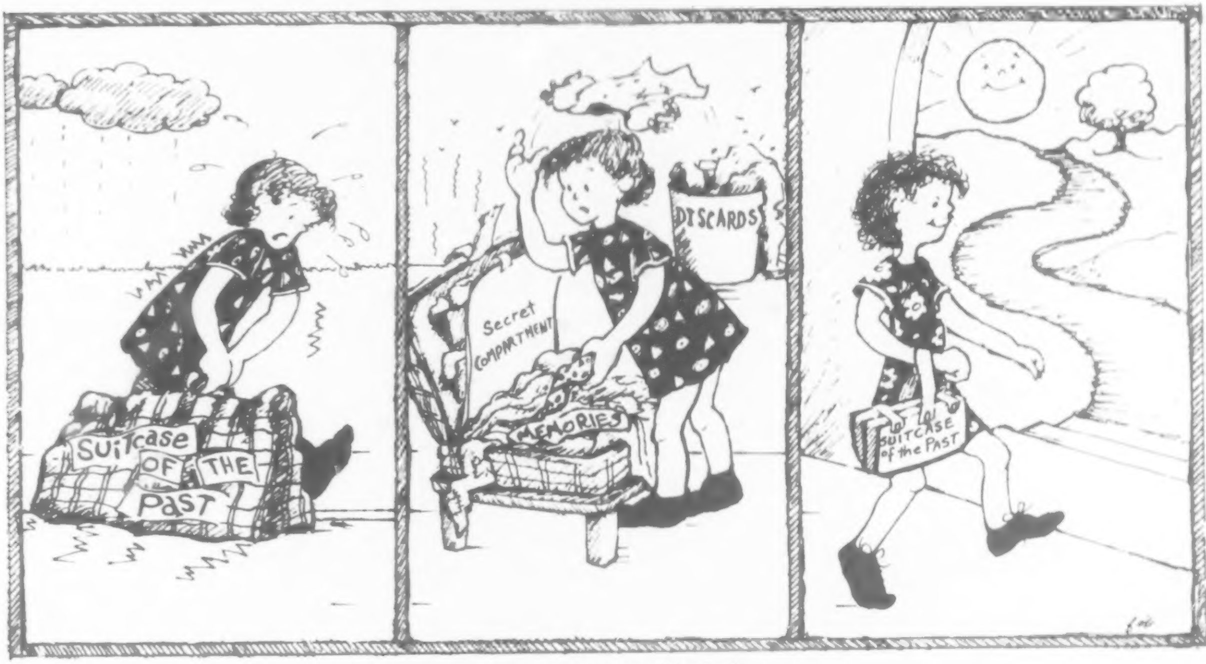


Fig. 4. The Suitcase of the Past

that time I was so shocked by the response that I succumbed to being another victim of AATA's political system. I resigned myself to accept that my work was not worthy, and I had wasted my time. Professionally, I was devastated with shame. Later, I was angry.

It was at the Denver Conference in 1991 that I gained final resolution on whether my research was vital to the field of art therapy. At that conference two-thirds of the presentations were related to trauma resolution. I finally felt rewarded for my pioneering efforts in the specialization in art therapy that had so many years ago been discredited. Obviously, it took me several years to recognize that my contributions were worthwhile; that other art therapists and professionals from all over the country were seeing the same thing within a specialized population that I saw.

I continue to try to understand the dynamics that operate in similar situations that occur too frequently within the AATA political system. Was the discrediting of my work an act of professional jealousy, a threat to the old guard, or a political maneuver to squelch a new dimension of art therapy? What are the motives for annihilating new knowledge? Who takes it upon themselves to be the demolition squad? It is this type of behavior that must be curtailed if art therapy is to prosper in the professional community. We must allow innovative empirical research and outcome studies to define what it is that we do or do not do. Our response to contemporaries must be respectful rather than destructive if we expect to collect a body of knowlege that includes proof, not just words or case studies. We must be supportive of fragile attempts to promote art therapy as a viable modality that other professions can acknowledge as grounded in accepted and proven methodology. We must nurture the creative and analytical minds that can bring respect to the field of art therapy by moving out of the 1960s mentality.

Would I become an art therapist if I had to do it over again? Yes, but with a different approach. Following my degree in Art I would pursue a Master's degree in Clinical Psychology, then attend a post-graduate program in art therapy. Why? Because I now know the value of having strong underpinning in art expression and psychological theory in order to comprehend the powerful tool that is defined as art therapy. Without respect for the fine blending of theory, psychotherapy, and art expression, I believe we miss the target. It is this balance which is the most vital aspect of art therapy along with being the artists we were trained to be. Our art, however, cannot be confined to the visual arts; it must include research and proof of what it is that we do, not just a claim to fame because we are unique.

Alvarez (Junge, 1993, p. 154) sums up my thoughts and intention for writing this controversial article: ". . . the time is now to move away from individualism toward community, to break through and look at the world we and our clients live in, and to work to change it." It is possible to gain inspiration from each other, give up secrecy and denial, recover from the addiction of the crisis cycle, and resort to positive behavior rather than the negativity of the sacrifice-sabotage principle.

As we clean out our "suitcase of the past," we become more authentic and intrigued with what we can accomplish as a community in the next 25 years. The challenge to myself and my colleagues is that we acknowledge and respect each other's fragile attempts to light the darkness with a magic flashlight and gain in the ability to distinguish image from mirage.

References

Junge, M., Alvarez, J., Kellogg, A., & Volker, C. (1993). The art therapist as social activist: Reflections and visions. *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 148–155.

Lachman-Chapman, M. (1993). The art therapist as exhibiting artist: Messages from Joseph Beuys, Suzi Gablik, and Donald Kuspit. *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 141–146.

Malchiodi, C. (1993). Introduction to special issue on art therapy and professionalism: Is there a crisis in art therapy education? *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 122–128.

Malchiodi, C. (1994). (Ed.). AATA award winners: 1970–1993. *Art Therapy: Journal of the American Art Therapy Association, 11*(1), 25.

Naumburg, M. (1987). *Dynamically oriented art therapy: Its principles and practice.* Chicago: Magnolia Street.

Spring, D. (1993). *Shattered images: Phenomenological language of sexual trauma.* Chicago: Magnolia Street.

Staff. (1994, Summer). Education Standards. *American Art Therapy Association Newsletter, XXVII*(3).

Ulman, E., & Dachinger, P. (Eds.). (1975). *Art therapy in theory and practice.* New York: Schocken Books.

Politics and Poetics: The Acquired Wisdom of the Art Therapist[1]

Maxine Junge, PhD, A.T.R., Los Angeles, CA

The poet T. S. Eliot wrote:

> *Where is the life we have lost in living?*
> *Where is the wisdom we have lost in knowledge?*
> *Where is the knowledge we have lost in "information"?*
> Choruses from "The Rock"

Art therapists bring gifts of imagery and symbol making and ritual. They help meaning to be made and understood because through the art media we see the hidden chambers of inner worlds we inhabit and which inhabit us. Making visible the invisible is a first step toward change. From the magician's empty, dark, and even dangerous top hat of the unconscious, art therapists help us to pull the bouquets of multicolored flowers we have created. These flowers are symbols offering dreams and realities of nurturing, sustenance, continuity in the face of despair and tragedy—of permanence in the face of whirlwinds, of transformations and, above all, of hope. The magic wand is created of art materials, of the art therapist's sensitive consciousness and intelligence, her/his compassion with her/his sustaining presence which lights the client's journey. The wand is shaped by the art therapist's heart and put into clients' hands so they may create the colors that are the shape and magic of meaning and of change. Visual metaphor and symbol are the flowers of transformation and, remarkably, the means to reform one's world.

Howard Gruber (1989) writes:

> Creative work must be in some ways kindred to the world, if not the world as it is, then the world, as it will or might be. It flows out of the world back into it. Thus the creative person, to carry out the responsibility to self, the responsibility for inner integrity, must also in some way be responsive to the world. (pp. 280-281)

I want to speak to you about ideas and questions that have been preoccupying me for a long time. More than ever in our history as art therapists the questions seem unanswerable. The easier ones are over. Perhaps it has to be enough that we continue to ask the questions, to challenge the assumptions, to seek truth and meaning.

I speak to you with the heart of an art therapist actively engaged in the development of the profession for more than 20 years. I am an educator, clinician, organizational consultant, writer, and painter. I am someone who after all those years still thinks that art therapy is the most fascinating work there is. I am currently finishing a history of art therapy in the United States, to be published in the next few months by the American Art Therapy Association. So, I also speak to you as an historian of our field and one convinced that while the past cannot always define our vision of the future, understanding its meaning can help us give the future shape.

To situate where we are today, it is useful to look back at the historical cultural tides of this century which helped create and propel the new profession of art therapy forward and from which it gained imagination and energy. These particular tides are the Great Depression and the Works Progress Administration (WPA), Freud and Dewey, Psychoanalysis and Progressive Education, Art Therapy as a Women's Movement, and the Mental Health Climate.[2]

The Great Depression and WPA

Art therapy was born into a climate in which, for the first time in this country, the arts and artists interfaced with social and economic purposes in an important way.

On April 8, 1935, during the despair of the severe economic depression, one of the most remarkable social experiments of our national history was born. This was the Works Progress Administration, created by Henry Hopkins under Roosevelt's New Deal. The WPA was a relief project through which people of various skills were salaried. The visionary Hopkins insisted that artists were as deserving of help as other indigent people; it was assumed that poverty-level artists, including actors, would be pleased to work for a subsidy, and that the American people would be happy to enjoy the results of their labor if it was at a price they could afford. Less than 1% of the WPA budget was devoted to the arts, but the WPA arts project, which included the Federal Theater, Federal Music Project, Federal Art Project, and Federal Writers Project, employed 40,000 artists by the end of 1935.[3] Although, as one congressman said, "The object of the WPA is to relieve distress and prevent suffering by providing work. The purpose is not the culture of the population"—develop culture it did. For example, many playwrights, actors, and technicians, later central to the American theater, received their initiation and vital experience in the Federal Theater. Orson Welles was one of these.

From 1934–1938, Mary Huntoon was director of the Kansas Federal Art Project. She had returned to her Topeka, Kansas home in 1931 after 10 years as an artist in Europe. In 1946, at Karl Menninger's invitation, Huntoon established the Department of Art, Physical Medicine, and Rehabilitation at Winter Veteran's Hospital and began her practice, research, and writing in art therapy. We can safely speculate that Huntoon's experience and background in the arts which was integrally wedded to the necessities and realities of the social milieu, had a deep impact on her. She brought this to her work at Winter Hospital. Her own history as an early-day artist/social activist in the Federal Art Project provided Huntoon a model from which to develop her art therapy. This crucial formative discovery and experience of social applications of the arts and their profound possibilities for change is a touchstone echoed by many art therapists. It often motivates others to join the profession. We hear it repeated today by a new generation of students in art therapy programs who proclaim, "I want to develop my art to help people."

Freud and Dewey: Psychoanalysis and Progressive Education

The emergence and evolution of psychoanalysis in the United States in the beginning years of the 20th century provided fertile ground for the therapy which offered a remarkable method for contacting the unconscious and an imagistic picture of that internal and often deeply hidden landscape. In 1909, Freud was invited to the United States to speak at Clark University. His writings, translated by A. A. Brill, began to be published and the first translation of *The Interpretation of Dreams* appeared in 1913. Freud's conviction that the images and symbols of our dreams had meaning and were the disguised messages of the unconscious provided a powerful conceptual *raison d'etre* for art therapy. Moreover, as interest in psychoanalysis spread in this country and its advocates in the intellectual community increased, more people, including artists, became convinced of its usefulness and intrigued with the products elicited through the method of free association. Margaret Naumburg, known as the mother of art therapy, was born in 1882, 26 years after Freud's birth. In 1914, one year after the publication of *The Interpretation of Dreams* in the United States, Naumburg founded the Children's School, later called the Walden School, in New York City. The school espoused a progressive educational philosophy based on psychoanalytic principles. Naumburg underwent Freudian and Jungian analyses, and many New York analysts, including A. A. Brill, sent their children to the school.

Through Naumburg and others, progressive education, based on John Dewey's philosophy, was another important touchstone for early art therapy.[4] Dewey believed that the problems of education are interconnected with social, political, economic, and cultural problems. He believed in a relationship between school and society where school becomes not a place pupils go to acquire knowledge, but to carry on a way of life. He saw school as an ideal democratic community in which students practice cooperative interaction and self-government and intelligence is applied to problems that arise. A progressive school is viewed as a working model of democracy. Eschewing the Cartesian mind/body split and favoring a total person approach, Dewey postulated an education based on meaningful experience and creative expression rather than rigid intellectual methods. Its form was pragmatic, related to life, and process oriented. Dewey's philosophy remains an important educational thrust in the national educational armament of philosophies and most recently appeared prominently in the widespread education movements of the late 1960s and 1970s stressing the "whole child" in "the open classroom" and the pragmatic relevance of education. Education as related to society and as experiential and process based became relevant to art therapy.

Art Therapy as a Women's Movement

While there is little, if any, direct acknowledgment in the literature or research that the field understands itself as such, I believe that art therapy's evolution has shadowed a centrally important movement of this century, the Women's Movement. It has been largely created and developed by women and has suffered from many of the oppressive external and internal constraints inherent to sexist conditions. Art therapy has a relevant predecessor in the Social Work profession with its commitment to solving social problems of the individual and society and by development primarily by women. When the question arises why there are so few men in the field, the answer typically offered is that men do not tend to venture into low-paying professions with relatively low prestige. It is also suggested that the large numbers of women in the art therapy profession serve to keep away men who might enter it. They perceive a "women's profession" as less powerful and important. Surely there is truth in those ideas, but I believe the reality to be more complex and more interesting. If women are the relational creatures that writers and researchers would have us believe, it stands to reason that women quite naturally (and perhaps inherently) understand the connection of all they do with the social and relational worlds around them and are driven to use their talents and skills in this way. Whether this is genetically or culturally determined, women are in the nurturing business and, as a matter of course, use their talents toward that end. It is not surprising, therefore, that women artists or women with an artistic bent should choose to use their skills working with people.

The early art therapists had their own nurturers, mentors who were male psychiatrists fascinated with visual art and with the potential of imagery within therapeutic work. Mary Huntoon had Karl Menninger, Margaret Naumburg had Nolan D. C. Lewis, Myra Levick had Paul Fink, and Helen Landgarten had Saul Brown. The men "discovered" them, taught them, and helped them attain positions of importance and prominence. It is not surprising that in the male medical hierarchy of mental health, art therapists would have a long, hard struggle to establish a level of equality of practice standards, education, and pay scale with other mental health professions. The struggle to be perceived as equal professional colleagues is certain to continue in a social and political climate in which the arts are discounted and in which women and their nurturing roles are devalued.

The formation of the American Art Therapy Association (AATA) was characterized by ongoing arguments built on deep and passionate ideological convictions. But it should not be overlooked that, without a doubt, AATA gave the creative, energetic women who began it an arena in which to test themselves and to gain organizational skills and experience which would hold them in good stead as they initiated educational and clinical programs across the country.

While the originators of the American Art Therapy Association often battled each other strenuously, they also served as an important source of support and connection for each other. Therefore, another way in which the development of art therapy should be viewed as part of the evolution of women in this country is through the important role models who have emerged and who have been mentors to new generations of art therapists who are predominantly women. Second generation art therapists often have had the privilege of women mentors. Art therapist writers courageously presented their work openly in professional communities and wrote about their ideas in books and articles. In their roles as educational program developers, teachers, supervisors, and clinical colleagues, art therapists in all regions of the country have offered fledglings the support and encouragement necessary to grow. They also have provided a compelling model of competent, successful, and creative professionals seeking to develop themselves and to establish themselves and their profession in an important way.

Women in our society, even today, often remain invisible. But precisely because they are ignored and hidden outsiders, they may be uniquely free to find their own voices. They are also intrinsically linked through their experience of difference with the marginal outsiders of the culture. To a great extent, art therapists still remain the outsider at the gate of mental health professionals. They share this outsider position with artists. But for the woman art therapist, the evolution of the practice and profession of art therapy provides confirmation of the essential meaning of the struggle. As she sought to change herself, she changed the world around her. As she demanded more respect for herself and her work, she gained more respect within the systems around her. As she establishes her work as a visible and visual force to be reckoned with she can be threatening and threatened. She can also prevail. It has been said that the personal is the political; there is no one for whom this must be more clearly in the forefront of her consciousness than the woman art therapist.

Evolving Mental Health Climate

Beneath all these influences during the second half of the 20th century, a central motivating factor giving impetus and drive to the new profession was the changing national climate in mental health philosphies and treatment. With the notable exception of Margaret Naumburg, most early art therapists found work in psychiatric hospitals as part of a treatment team or as a special kind of art teacher with children. Freud's ideas, imported from Europe and associated with the past in the transplanted new life, took on an American pragmatism in the psychotherapies which evolved after World War II. These new therapies, including group therapy, were developed to treat returning veterans. From this treatment more and varied forms were developed.

With the stunning advent of the major tranquilizers in 1954, a whole new perception of psychiatric illness and treatment became possible. Psychiatric patients who had spent years warehoused in institutions were rehabilitated and able to return to their home communities. In those communities outpatient services were to be established to provide humane and cost-effective forms of psychotherapy and treatment. The Mental Health Act of 1963 was the federal government's action to establish community centers and storefronts for services, most of which were short-term and crisis oriented. Often funding was withdrawn from long-term treatment programs. Another idea that developed and began to grow in the 1960s was that of systems theory. Family therapy was first discussed at a national meeting in 1957. The individual was no longer the only unit of treatment; the defining importance of the social context and interpersonal relationships gained increasing prominence.

From the beginning of the release of patients from the hospitals into the community, even in the halcyon days of the new philosophy and what seemed like sufficient funds, there were never enough relevant services. However, the air was filled with remarkable hopefulness and optimism that a new day had dawned. Staffing the centers created employment for many newly trained therapists, including art therapists, and a ready and expansive job market. These developments gave art therapists of the 1960s and 1970s important clinical experience and the impetus to start the first academic training programs.

Today, in many areas of the United States, we are in an era of economic despair, a country rife with problems emerging from our great Democratic experiment. Cutbacks, mental health budget slashings, low morale, increasing violence in the lives of many Americans and in what remains of mental health systems, portend the worst. While we face the uncertainties of managed care, a mental health philosophy which focuses on the etiology of biological determinism of mental illness and tends to discount psychotherapy may well threaten art therapy's very survival. At a time of such economic and moral challenge, there is the tendency to become rigid and to overstructure in an effort to ward off chaos and maintain balance. This threat can come from outside or from within. In its history, organized art therapy has had to be ever mindful of its relationship to other mental health professions and outside accrediting bodies and commissions. As a "new kid on the block," it has needed to find a way to be accepted and acceptable while retaining its heart and spirit. This has never been an easy marriage. For example, for many years there has been encouragement to establish professional credibility through quantitative behavioral research, resembling the behaviorism of academic psychology which, in itself, is a discipline striving to establish itself as a science. This has been done at the same time we have discounted and underappreciated our core as therapeutic artists and our more natural proclivities toward imaginative interpretive work and research. On the other side of the coin, a few years ago, when art therapy educational programs in California found it necessary to address themselves to the vastly changing and more rigidly structured state licensing laws to stay viable in the job market, the cries within the profession were loud about how the California programs had abandoned their art. Closer examination showed this not to be the case. Where is our community? I believe we need to redefine and redevelop our sense of an art therapy community.

Having taken an historical look at the profession, I would like to share with you some thoughts about the state of art therapy today.

The State of Art Therapy Today

I am concerned that not enough art therapists are pursuing doctoral programs. Academic institutions increasingly require the doctoral degree, and this lack of doctorates means that we may not be producing new generations of art therapists. We must have the necessary union cards to enter the system and, in this case, the halls of academe. Art therapy training not attached to accredited institutions can be valuable and of high quality, but it does not give the graduate art therapist nor the evolving profession the stamp of legitimacy that I believe we must achieve.

In academic institutions across the country, even with long-time art therapy training programs, there are few tenure track or tenured positions and those few have seldom reached the rank of full professor. When an instructor is an "adjunct" or "visiting" professor, this means the job is not institutionalized and the academic institution is not visibly committed to maintaining the job, and perhaps the program. When the adjunct instructor goes, the program may go. Over time have we not paid enough attention to internal and institutional politics and situating our programs within the accepted academic framework? I think not. In the last few years, three American Art Therapy "Approved" programs have closed.

I also worry that many art therapist do not consider their education a lifelong endeavor. I have seen too many master's level art therapists who, in the understandable struggle to survive and make ends meet, do not continue learning in any consistent and rigorous way. I do not mean an occasional workshop here and there, but a thoughtful indepth course of study providing a structure through which their work can be understood and expanded leading to increased skills, new insights, and a deepening of individual meaning.

I am deeply concerned about the numbers of art therapy certificate programs springing up. A year or so ago a young woman, a friend of a friend, thrilled with her discovery of the new world of art therapy, called me to ask what I knew about a particular certificate program. I was surprised to hear that, although the program advertised that it took only people with Master's degrees in Mental Health, in reality it admitted just about anybody, such as this woman who had a Master of Fine Arts (MFA) degree. However fine the quality of education provided might have been, I am worried about two issues.

First is the "false advertising" problem. A person with an MFA and a Certificate in Art Therapy has spent much money, time, and effort acquiring a credential which, in today's mental health marketplace and in managed care of the future, is all but worthless. Secondly, the more we credential other mental health professionals, the more we do ourselves in. Having worked long and hard to develop quality educational programs of 48 units, or more, AATA now is willing to say that an art therapy education of 21 units is sufficient. Many already consider that art therapy is merely a string of techniques or recipes easily learned and applied, an idea which we as professionals support as we minimize what is necessary to become an art therapist. Why should I, as an employer, hire an art therapist if I can send the mental health worker I already have on staff to take a crash course and learn the techniques?

As for the art therapists who direct and staff these programs, they say, "Well if I don't do it somebody else will. Why shouldn't I make a living too?" This dilemma speaks to the important moral question that each of us must ask and answer over and over again: How am I contributing to the strength and life of my profession?

There is no question, however, that we must spread the word to other mental health professionals. Too many art therapists are satisfied never to present their work or to publish except for other art therapists. If each one of you presented one time this year to a conference or a group which was not predominantly art therapists, the word would continue to spread. We are our own best public relations experts and the power of the visual image continues to present a compelling case for what we do.

Interactive with the above issues, I am concerned about art therapists remaining viable in the job market. This year a survey was conducted of job experiences of the last 5 years of graduates of a particular program.[5] The data was compared with experiences from 5 years ago with the expectation that things were a lot worse. The results were surprisingly hopeful. The numbers of graduates working in fulfilling jobs had not diminished. What had changed was that there were fewer full-time jobs. The bad news was that the pay was still dismal. In the current (May 1994) graduating class, half had jobs before graduation. How well art therapists are trained will have an impact on the life course of the profession.

As educators, we must also look to the numbers of art therapists trained; there is the potential to flood a changeable market. Not too long ago, at a Board of Behavioral Science Examiners meeting, I met a man who was director of a California MFCT program that graduated 250 people a year! I was astounded. "How do they find jobs?", I asked. "We're not responsible for that. Most of them don't," he said. "The cream rises to the top." I find this position reprehensible and immoral. Art therapy education is only as good as its graduates' future's. I believe that no matter how fine a program, if graduates cannot put their skills into practice, it does not matter. As educators *we are responsible*. We must face the moral imperative that we cannot merely teach in isolated ivory towers, but must strive to develop a mental health system that is enhancing to clients and to workers. The students we help grow must learn about how to create growth in themselves, their clients, and in the institutions and organizations of which they are a part, including the art therapy profession.

You will, of course, notice the systematic implications and linkages of these issues. They are irrevocable, intertwined, and interrelated. As one changes, they all change. You can never do just one thing. But something is abundantly clear: We can no longer indulge ourselves in micro-level, individualistic thinking; it is simply not sufficient nor powerful enough to address the complex questions we face today.

I would like to close by talking to you about wisdom. Wisdom is not a word commonly bandied about at art therapy conferences nor among art therapists. But I think it essential that we consider it, for, I believe, above all, we will need wise leadership as we shape the vision and actuality of our future together as art therapists. Sievers (1994) writes:

> Instead of regarding wisdom as a human quality which, similar to maturity, potentially all human beings are capable of and which as such can be applied to our social life and work in organizations (*cf.* Winnicott, 1950), we more and more tend to put wisdom into the wheelchairs of those people who because of their age and their social role, no longer are supposed to have a reasonable impact on our lives. (p. 323)
>
> Wisdom in this sense is the learning that comes through experience; it is the crucial dimension . . . through which a life and life experience finally obtain quality for a mature adult. . . . [Wisdom is] a qualifying process which reflects one's individual and collective experience in order to provide [him or her] with meaning. (p. 287)

I believe that life is inevitably tragic. It is bounded by the frame of birth and death. Within this frame, mortality must be squarely faced to create individual and societal meaning. At the same time, we must maintain and acknowledge the dialectical relationship that every person, every art therapist, is inevitably mortal and that the institution of art therapy itself is supposed to survive and is, therefore, hopefully, immortal. Sievers (1994) writes:

> The management of wisdom could also be perceived as the explicit attempt to face inevitable tragedy in life . . . that life and work necessarily have to include tragic experiences, if life is to be taken seriously. (p. 279)
>
> In the context of leadership, wisdom can be conceptualized as the mature quality of the process through which individual and collective meaning is given to the human experience. (p. 280)
>
> [We must not] relinquish the hope that wisdom may finally contribute to the exploration of more mature solutions for overcoming the battle and facing the future. (p. 280)

As we approach the new century, in the years to come, art therapists will need to be particularly nimble contortionists to continue to be players in the mental health arena, and yet, also, retain enough of their defining freedom which gives spirit and heart to the endeavor of therapy.

In a time when the walls often seem to be closing in or crumbling down altogether, art therapy needs wise visionary leaders to lead the way. I speculate that although they may appear radically different from the pioneering visionaries of art therapy's history, they will hold dear, as did their forebears, the qualities of creativity, innovation, and commitment to the bettering of the human condition in a time of profound difficulties.

In conclusion, I want to leave some wise words with you. When he was Secretary of Health, Education, and Welfare, John Gardener said:

> Life is full of golden opportunities hidden underneath seemingly unsolvable problems. (Unknown source)

And, the educator Horace Mann declared:

> Refuse to die until you can leave some gifts for humanity. (Unknown source)

Elie Wiesel, writer and Nobel Prize winner, imagines therapy as a "moral quest," not the process of objectively weighing moral factors, but actively taking sides on behalf of those who suffer. Although there will never be any final answers to the quest for moral certainty, it is the search itself which gives human life both its meaning and its unfathomable mystery.

> We are all in a quest—all partners in a quest for truth, for friendship, for meaning, for hope, for humanity. . . . The moment the question stops, our humanity stops. (Unknown source)

I wish us all good luck and courage!

Footnotes

1. This paper is a revised version of the Opening Speech of the First California Art Therapy Conference, June 4, 1994, Asilomar Conference Center, Monterey, CA.
2. Parts of this section are excerpted from *History of Art Therapy in the United States* (in press).
3. Information for this section was culled from J. O'Conner and L. Brown, (Eds.) (1978). *Free, adult, uncensored: The living history of the Federal Theater project.*
4. The source for some of this information is J. Johnson, H. Dupuis, & Y. Johansen (1973). *Introduction to the foundations of American education.*
5. Survey conducted on graduates of the Loyola Marymount University graduate program in Marital & Family Therapy/Clinical Art Therapy.

References

Gruber, H. W., & Wallace, D. B. (Eds.). (1989). *Creative people at work.* New York: Oxford University Press.

Junge, M. (in press). *History of art therapy in the United States.* Mundelein, IL: American Art Therapy Association.

O'Conner, J., & Brown, L. (Eds.). (1978). *Free, adult, uncensored: The living history of the Federal Theater project.* Washington, DC: New Republic.

Sievers, B. (1990). Thoughts on the relatedness of work, death, and life itself. *European Management Journal, 8*(30), 321–324.

Sievers, B. (1994). *Work, death, and life itself: Essays on management and organization.* New York: Walter De Gruyter.

Whylie, M. S., & Griffin, K. (1994 May/June). Family Therapy. *Networker, 10.*

Essential Legal Issues for Art Therapists in Private Practice

Gail Wirtz, MAT, MPA, A.T.R., Chicago, IL

An art therapist in private practice today is faced with the possibility of being sued for malpractice. Although an art therapist merely wants to conduct art therapy with a client, it is prudent to consider carefully the legal implications of practice in each case we accept. This article reflects my own experience in facing the reality of litigation and proposes ways to manage the risk.

Art Therapists and Courts

Given the current litigious climate throughout the United States, every art therapist should be aware of potential legal issues because they affect insurance, licensing, and American Art Therapy Association (AATA) guidelines. Only one state, New Mexico, has specifically licensed art therapists. It is clear that laws are changing rapidly and that art therapists must understand state and federal laws regulating their profession.

Three years ago I noticed a marked change: I realized that I could find myself involved in litigation, and the reality has altered my practice. I believe that in order for art therapists to practice safely today, they must take proactive steps to manage the risk of being sued. This article will focus on two specific questions and the conclusions to be drawn from their answers: Why would an art therapist ever be called to court? And, what is an art therapist's best defense?

Why Would an Art Therapist Ever Be Called to Court?

I am an art therapist holding Master's degrees in Education and in Art Therapy. I have 18 years of art therapy experience, and, for the past 10 years, I have been in private practice. Several years ago I was served a subpoena in a case involving one of the children in my practice. The subpoena required my presence at a deposition because I was the child's art therapist and had supported the finding that the child had been sexually abused.

It is important to note that in this case no one was suing me. Rather, the defendant's attorney wanted to undermine the process by which I had concluded that the child had been abused. On the other hand, the plaintiff's attorney wanted me to testify as an expert on the evaluation of abuse. An expert witness is someone with special knowledge of the subject about which s/he is to testify. An expert witness is needed to aid the jury members in their understanding. This contrasts with a fact witness who testifies merely to what s/he witnessed.

When I was subpoenaed, I had no idea what an expert witness was, let alone the fact that, as an art therapist, I could be called as one. Moreover, I was unaware of the unpaid time commitment this process would entail.

Art therapists need to be prepared to be expert witnesses. When I speak of an art therapist, I am referring to a person registered with an A.T.R., but not necessarily certified by the state as a social worker, clinical psychologist, or counselor. Legally, psychiatrists (MDs), psychologists (PhDs), and social workers (MSWs) have been viewed by our society as experts on issues of mental health and have been called to give expert testimony (Turkat, 1993, p. 36). However, my experience suggests this is already changing.

A witness qualifies as an expert by virtue of any of the following factors: knowledge, skill, experience, training, or education. As art therapists become more qualified, their testimony is also being accepted as that of expert (Wirtz, 1993, p. 169). When I was subpoenaed to testify by deposition, I answered questions for 2 days about my qualifications. The questions were as specific as, "How many children between the ages of two and two-and-a-half did you work with before 1983 who had been sexually abused?" During questioning, there was a great deal of exploration about the courses I had taken which were relevant to the case as well as questions about qualifications needed to become an art therapist. Essentially, the lawyers wanted to know, "Can you legally do what you are doing?" This further confirmed for me that to act professionally was not enough; I had to be certain of my legal status.

Levick, Safran, and Levine (1990) noted that once the questions about the art therapist's qualifications have been answered, the "witness [art therapist] must be prepared to present documentation of [his/her] statements with published literature or clinical data that can be submitted as evidence" (p. 49). The battle between lawyers is always whether the art therapist is an expert or a lay person. Ultimately, the trial judge decides whether a witness qualifies as an expert, but the battle between the lawyers sometimes perpetuates even through appeals.

The lawyer, advocating for her/his client who does not want the art therapist's testimony to be considered expert, can be very tough in cross-examination. It is important for the art therapist to know "the basics of cross-examining an expert, addressing credentials, reviewing facts that the expert has relied upon, challenging sources of authority, and questioning the expert's grasp of the operative facts of your case" (Mulroy, 1993, p. 27). When lawyers talk about the basics, this can mean: "How can I make the professional sound like s/he doesn't know what s/he is talking about, or sound unprofessional?" The article "How to Cross-Examine a Psychologist in a Custody Case" (Mulroy, 1993) is evidence of this. I found the article to be very realistic. Lawyers spend considerable time on the therapist's "credentials, licensing, experience, specific courses/specific training in a particular area" (p. 68). In my own case, I was questioned over a 2-day period for 14 hours of unpaid time.

The case of the abused child involved the issue of whether an art therapist qualified as an expert, but there is another way an art therapist may become involved in a lawsuit: The art therapist may be a defendant accused of malpractice.

> While most clinicians believe that they practice within legal guidelines, they then also believe they are at no legal or liable risk. It is truly unfortunate when some clinicians learn that this is not the case and find themselves in a lawsuit. (Stout, 1993, p. 1)

Malpractice is the legal term to denote the negligent or unskilled performance of professional duties (Gifis, 1984). Negligence is cited when the therapist has omitted something s/he should have done, or by doing something s/he should not have done. Lawsuit "causes of action reflect acts of negligence or substandard care for which any health care provider could be found liable" (Manisses Communications Group, 1993, p. 5). The areas specifically cited include abandonment, breach of confidentiality, failure to obtain informed consent, and certain intentional torts, such as assault and battery (Manisses Communications Group, 1993).

The question of malpractice is important to a jury. The jury determines whether someone performed malpractice by comparing the defendant's performance with that of the profession's standard of care. The standard of care varies, of course, depending on the profession. For example, a doctor's standard is different from a nurse's standard. If a state actually licenses a professional, the standard is outlined to some extent by the licensing or practice act passed by the state's legislature. If a profession is not licensed in a particular state, the standard is obtained from another source, most often the profession's highest national organization's practice guidelines and codes of ethics. The more unclear the standard, the broader the battleground for the laywers involved.

Lawyers, in their advocacy, will discuss the standard of care; the less well-defined, the more room for interpretation. They want to know if your testimony is credible and how it compares to that of your colleagues (both other art therapists and other mental health professionals). "Codes of ethics provide a standard of practice that invariably underlines the importance of protecting confidences. However, they do not have the force of law. But in litigation they may be used to define the standard of care" (Manisses Communications Group, 1993, p. 22).

It is no surprise, then, that the most common question for an art therapist in a legal proceeding is, "Do you have guidelines for your profession, and do you follow these?" A clear concurrence of guidelines for our profession was never as important as at this moment.

The Art Therapist's Best Defense

Whether art therapists are called as experts or charged with malpractice, specific tools can aid them in presenting their expertise or presenting their defense. These tools include, but are not limited to, a clear, well-articulated standard of practice, knowledge of the laws within the state, and adequate record keeping. The standard of care was identified above as the point of departure for an expert witness and first in the line of defense for an art therapist.

With the frequency of litigation today, art therapists must be informed about licensing laws and must maintain a working knowledge of the laws that apply in the state in which they practice. Practicing without a license can be malpractice, depending on the requirement of the specific state. And even if a state does not specifically license, certify, or register art therapists, it is not safe to assume that no law can be violated.

The language of other professional licensing acts can impinge on whether an art therapist can be accused of practicing a licensed profession other than art therapy. In Illinois there has been concern recently regarding the exclusionary language in the Clinical Psychologist Licensing Act of 1989, as amended, and how it may have an impact on art therapists and their practice.

Art therapists who want to practice safely must maintain adequate records. Consistent, reliable record keeping aids the art therapist in managing the risk of a law suit. But, what constitutes adequate record keeping? The American Art Therapy Association's General Standards of Practice (1989) defined the record keeping procedure needed when working with clients, noting "Registered Art Therapists are expected to follow these guidelines." The standard is shown in Table 1. However, based on experience and on further reading, I believe these guidelines are too narrow for art therapists in private practice and need to require a greater breadth of documentation.

A Legal Primer for Psychologists and Counselors (Manisses Communications Group, 1993) cites a study by John Paddock, Robert Remar, and Patricia Maykuthth of the record keeping practices of psychotherapists. Most psychotherapists in the study believed that "thorough clinical records can provide an excellent defense against malpractice claims" (p. 39), yet about two-thirds did not have sufficient records to afford them even minimal legal protection. The researchers made the following recommendation:

> . . . organize and standardize records, organize client information into the following categories: intake sheet, history (psychosexual/developmental), evaluations (mental status examination, psychological tests, etc.), diagnosis, specific treatment objectives and methods used to reach these goals; progress notes, termination summary, supervision/consultation notes, medication record (current/historical), correspondence, billing record, legal documents (e.g., release of information). (pp. 39–40)

The researchers also recommended that the therapist

> . . . be concise, self-monitor, document treatment in a timely manner, never, ever fudge a clinical record, know the psychotherapist's risk areas, have a standard procedure for evaluating suicide/homicide risk, base interventions on well-established theory, use clear behavioral descriptions, and keep records secure. (pp. 40–42)

Table 1

Standard V: Documentation from the American Art Therapy Association Guidelines

---

2.5.0. The frequency of documentation shall be established so that the most recent art therapy progress notes reflect accurately:

a. Current level of functioning.
b. Current goals and treatment plan.
c. Content and graphic features related to problem.
d. New changes in affect, thought process, behavior.

2.5.1. Art therapy discharge/transfer summary of progress note shall be written, including response to treatment and recommendations.

2.5.2. Each art therapy service unit follows an established policy for the retention and disposition of record.

The American Psychological Association (APA) Committee on Professional Standards and Practice (1993) stated that professionals should keep at least the following information: "(a) identifying data; (b) dates of service; (c) types of service; (d) fees; (e) any assessment, plan or testing reports and supporting data as may be appropriate, and (f) any release of information obtained" (p. 985).

I propose that at a minimum the recommendations above be adapted as necessary and incorporated into AATA's Guidelines for Private Practice. However, art therapists should consider other factors regarding record keeping. First, because art therapists—unlike other mental health professionals—use art media, the art therapist's patient records should include facsimiles or copies of clients' art. Second, there are some things that therapists should never write down or include in a patient's record: "Hunches, value judgments, emotional statements, personal opinions, illegal behavior (that is not homicidal in nature), sexual practices (irrelevant to clinical picture), 'sensitive information' that holds little clinical utility and could embarrass or harm the patient or others" (Stout, 1993, p. 3).

It is noteworthy that the Illinois Mental Health and Developmental Disabilities Confidentiality Act makes a distinction between personal notes kept by a therapist (740 I.L.C.S. 110/3) and record keeping. Personal notes may be data, for example, which the art therapist catalogues for professional case presentations or drawings which help the art therapist with difficult countertransference material. Specifically, the Act states:

> a) All records and communications shall be confidential and shall not be disclosed except as provided in this Act.
> b) A therapist is not required to but may, to the extent that he determines it necessary and appropriate, keep personal notes regarding the recipient. Such personal notes are the work product and personal property of the therapist and shall not be subject to discovery in any judicial, administrative or legislative proceeding preliminary thereto. (740 I.L.C.S. 110/2)

Other states may also distinguish between personal notes and record keeping. Stout (1993) recommends that personal notes be placed under a separate code and stored in a different location from case notes. This distinction allows therapists to use notes to separate out personal thoughts and feelings from the clients' records. Because it is not legal to go back to change records, records must be completely accurate from the beginning.

Another example of a documentation problem surfaced when a client's father asked me to tape and transcribe the session I had with his child. Before I taped the session, I sought legal advice from two lawyers and found their advice contradictory. One lawyer commented that he did not see how it could hurt; the other lawyer felt it was better not to transcribe a session because, in his opinion, it could complicate the evidence.

In the case I described, I was the therapist who had been paid by the state to work with the child who was suspected of having been abused. I transcribed notes I had taken on each session and had them typed. There were 52 sessions and approximately 200 pages of notes. After 3 days of deposition, we had completed an examination of only the first three sessions. Most statements the client made and the therapeutic responses were examined. At times I regretted having taped the sessions; it felt like every response I made was questioned, and I was asked why I responded the way I did. Other times I was pleased to have transcribed the sessions because I could identify which statements made by the client and acted out with art materials led to my conclusion that the child had been abused.

Conclusion

As an art therapist, my goal is to provide an opportunity for clients to express nonverbally what may be difficult to express verbally and to provide the therapeutic environment for patients to grow from that expression. It is not my goal to prove or disprove abuse allegations.

It is not enough for art therapists to depend upon statements and comments from colleagues or art therapy associations regarding our practice. We must be sure that the information we are receiving about our rights to practice is legally correct. It also seems imperative that art therapists working with high-risk clients (identified as suicide, child abuse, and child custody by Caudill, 1992) be especially careful. When trying to help a client, a therapist may be exposed to considerable risk which can jeopardize the therapist's own family.

I keep reminding myself that my therapeutic responsibility is to help the client in therapy, not to help prove or disprove allegations of abuse. My responsibility is also to myself. The more information a therapist gives the prosecution, the more the therapist is questioned and potentially made less credible.

I am pleased to see ethics retained as a requirement under the new AATA core curriculum (Approved Educational Guidelines, 1994, p. 11). I also am pleased that we are beginning to see the need to learn legal procedures as part of the practice of art therapy. I hope guidelines for art therapists in private practice can also be established to help art therapists practice safely within the legal system. It is my beleif that, in order to practice privately, an art therapist should have a minimum of 5 years of experience and a state license.

It is incorrect for art therapists to feel they are at no legal risk. The AATA is trying to stay informed legally, but the job is too great for one organization to track all local, state, and federal legal requirements. It takes each of us, researching and writing about our own experiences and informing each other as to the potential dangers of liability. It is imperative that we keep abreast of changes regarding our risk: What we learned yesterday about our rights may change tomorrow.

Note: The author wishes to acknowledge the assistance of Susan L. Kennedy, attorney, for her legal advice in preparing this article.

References

American Art Therapy Association. (1993). *General standards of practice*. Mundelein, IL: Author.

Approved Educational Guidelines. (1994). *American Art Therapy Association Newsletter*, *27*(3), 11.

Caudill, O. B. (1992). Retaliation suits. *National Psychologist*, *1*(2), 33.

Clinical Psychologist Licensing Act, 225 I.L.C.S. 15/1, *et seq.* (1989). State of Illinois.

Committee on Professional Practice and Standards. (1993). Record keeping guidelines. *American Psychologist*, *48*, 984–986.

Gifis, S. H. (1983). *Law dictionary* (2nd ed.). New York: Barron's.

Levick, M., Safran, D. S., & Levine, A. J. (1990). Art therapists as expert witnesses: A judge delivers a precedent setting decision. *The Arts in Psychotherapy*, *17*, 49–53.

Manisses Communications Group. (1993). *A legal primer for psychotherapists and counselors*. Providence, RI: Author.

Mental Health and Developmental Disabilities Confidentiality Act, 740 I.L.C.S. 110/1-, *et seq.* (1983). (West).

Mulroy, T. M. (1993). How to cross-examine a psychologist in a custody case. *American Journal of Family Law*, *7*, 65–72. Reprinted in S. C. Haddad, E. Hubbard, & J. L. Rubens (Eds.), *Family law, custody and placement issues* (pp. 27–34). Eau Claire, WI: Lorman Education Services.

Stout, C. (1993, October). *Risk management: Enhancing clinical practice while decreasing liability*. Paper presented at Illinois Art Therapy Association Symposium, Chicago, IL.

Turkat, I. D. (1993). Questioning the mental health expert's custody report. *American Journal of Family Law*, *7*, 175–179. Reprinted in S. C. Haddad, E. Hubbard, & J. L. Rubens (Eds.), *Family law, custody and placement issues* (pp. 35–39). Eau Claire, WI: Lorman Education Services.

Wirtz, G. (1993). Art therapy in private practice: Legal and insurance issues [Viewpoints]. *Art Therapy: Journal of the American Art Therapy Association*, *10*, 169–170.

Photography and Confidentiality

Jennifer L. Jacobs, MA, A.T.R., New York, NY

In recent years art therapy has included photography as a tool in therapy. Since photography can be a very precise and revealing art form, it raises new questions about confidentiality. It is difficult to hide our clients' identity when their pictures are part of the artwork. Staff can be wary of cameras on the unit and often are hesitant to encourage taking photographs on site. How can we, as art therapists and clinicians, use this form of expression without breaching confidentiality rules?

In my work with emotionally disturbed children and adolescents, I find that both black and white and instant photography is a valid form of expression. It can be beneficial in building self-esteem, encouraging planning skills, teaching mastery of step-by-step processes, and strengthening the ego.

Photography enables my clients to plan and manipulate their artwork without starting from scratch or relying on prefabricated materials such as magazines. Phototherapy allows the client access to ready made subject matter and enables direct manipulation of images.

Working with children and adolescents in a hospital setting limits subject matter to the hospital grounds. At first, in an effort to expand opportunities for other images, I encouraged clients to take film home. I discovered that, because of their family's economic status, many did not own 35mm cameras. Clients who did own photography equipment rarely returned the film. Most often they said, "I lost it."

Clients often find the most exciting subject for their pictures is themselves. Latency children compete to be, simultaneously, the photographer and the photographed—to make faces for the camera. Adolescents are concerned with their appearance and identity. They enjoy posing and critiquing their images; this has relevance to identity formation, a task of adolescence.

The best way to enforce ethical standards is to obtain release forms from clients before they enter the group. However, this often is difficult when working with minors. Parents or guardians are often unavailable or hard to reach. This raises a second ethical question: Is it fair to exclude a client who may greatly benefit from photography because a parent is rarely available? To allow a child to attend sessions, I make the rule that the client who is photographed, who is the subject of the photograph, owns the picture. Secondly, pictures cannot include more than one client, unless, of course, consents are signed for all clients in the photographs. Any artwork that uses the photographs is the property of the client and cannot be given to anyone without consent from the parent or guardian.

Displaying artwork containing photographs is another issue. An important part of art therapy is the praise and pride a client receives when his or her artwork is displayed. It imparts a sense of importance many clients have never felt. When proposing to show artwork that includes photographs, staff often balks, as well they should. Concern for the clients' rights to confidentiality is paramount. In lieu of a consent, displaying artwork is still possible, but must be restricted to the art room or the ward, places not readily accessible to the general public, but where the client and staff can view it. The client can reap the benefits of displaying artwork while treatment remains confidential.

Since photography is an exact image of the client, and may reveal his or her identity, special consent forms should be signed if the artwork ever is to be used for presentations, lectures, or papers. The consent must be fully explained to the client's parent or guardian and specify that photographs that identify the client are being used. For presentations, avoid using artwork with photographs of clients, even when consents are signed. If this is unavoidable, make a loose sketch of the photograph and superimpose it on the slide reproduction. The audience will still get a flavor of the artwork but the identity of the client will not be exposed. I believe that even with consents, photographs should not be shown outside the hospital.

Art therapy's success is increased when we are very cautious about confidentiality issues. Art is a tangible record of a client's treatment issues; it is as unique to each individual as is a signature. It is our responsibility to ensure that anonymity be preserved.

Patterns

Mildred Lachmann-Chapin, A.T.R., Deerfield, IL

Geometric

To decorate. My body. My house. My clothes. My house objects.

To make boundaries, borders.

To reassure me about the order of things. I can expect the repetition, know the rhythm, feel safe.

To tell me I feel stifled, rigid. That I must change the order. Shake up what is expected of me.

Break the pattern of my life.

Small, sneaky breaks. Until the music shifts gently to a new key while harmony continues. Suddenly they notice.

Or sudden breaks. A noisy clatter. Dishes drop and break, households split. Departure with no comforting goodbyes.

Biomorphic

The curve takes over.

Flowers and growing forms prevail.

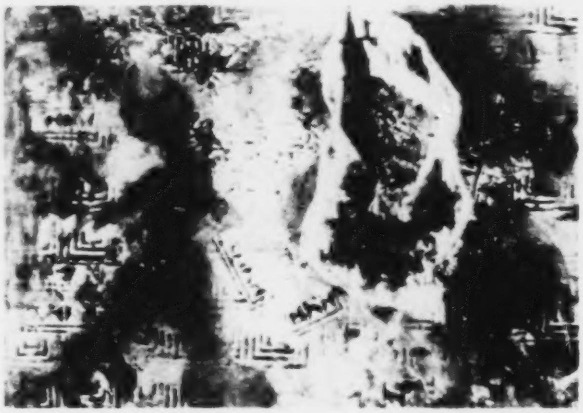


Fig. 1. Pattern & Destruction. Monoprint and pastel, 18" × 22".

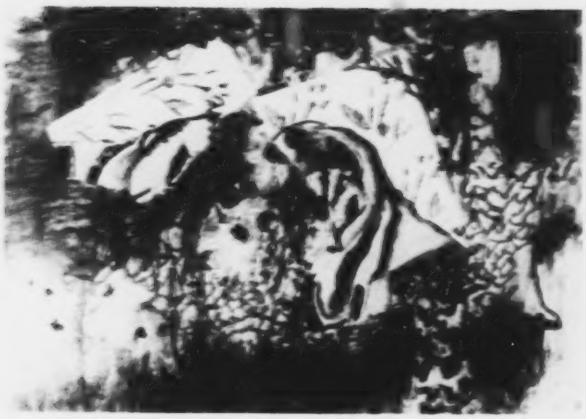


Fig. 2. Broken. Oil on paper with collage, 22" × 30".

Sky, earth and water lend me their cadences, their ideas to draw.

I have space to breathe.

I can pleasure in their moving adventures, flowing this way and that, making me feel wet, warm, sleepy.

Sometimes confused, disordered, lost in the profusion of possibility.

Representational

I make the world's forms mine,

Control and describe them.

They are my signs.

Sign language, symbol,

Infinity of meaning locked in each. I see the world, hold it in my power and keep all my secrets.

Except the ones that leak out.

Sometimes I want some leaks.

Sometimes I don't know I want some leaks, but I do. A secret hope that the leaks will find reverberations.

Which ones leak out?

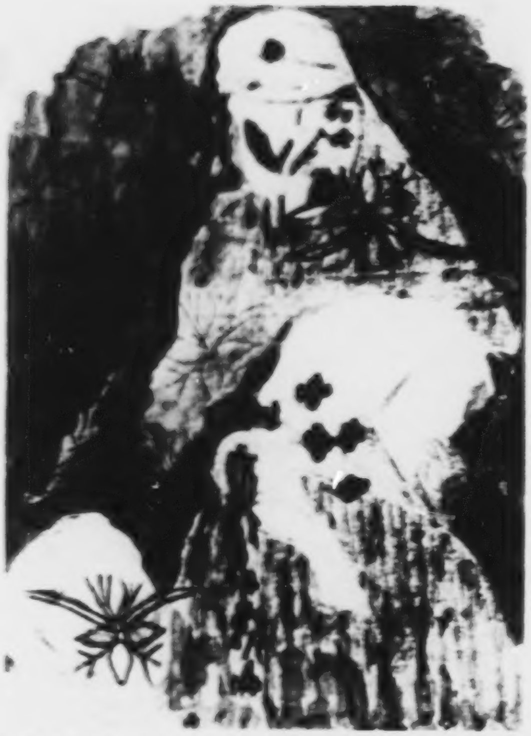


Fig. 3. Patterned Women. Monoprint mixed media, 23" × 17".

Some secrets stay shut in . . . but maybe they send promising vibrations, mysteries to be unfolded.

Editor's note: The poems and images are Lachmann-Chapin's new book called *Reverberations: Mothers & Daughters*, Evanston Publishing, Inc.

Reviews

Stories for Children with Problems and Wishes: A Therapeutic Workbook for Turning Problems into Gifts

by Burt C. Wasserman, Minneapolis, MN: Educational Media Corporation, 1994.

80 pp. $9.95 paper. ISBN 0-932796-62-1.

Reviewed by **J. D. Ball, PhD,** Norfolk, VA

Burt Wasserman's therapeutic workbook for child psychotherapists provides clinicians with creative and helpful interactive aids. In a series of separate exercises, Wasserman introduces first a therapeutic cartoon and then some probing questions to elicit childrens' art. This insightful path to children's imagery is based in Neurolinguistic Programming (NLP), and Wasserman's intervention tools combine aspects of Richard Gardner's *Therapeutic Communication with Children: The Mutual Story Telling Technique* (1971) with time-tested art therapy approaches. There is a significant cognitive therapy focus that is apt to be better recognized and more easily employed by most readers than are the principles of NLP. Many of the cartoon stories in the workbook are the products of Wasserman's own clinical use of children's art. With this approach, he has reported elsewhere (Wasserman, 1992; 1993) on how his patients visualize effective solutions and shift visual imagery of life problems. Part II of the workbook illustrates how therapists might teach clients to set goals, shift feelings, change behavior, and rethink a problem.

This workbook offers creative tools for helping children express and reason through life problems from within a psychotherapeutic relationship that is responsive to the individual needs and creativities of specific children. I agree with Wasserman's view that this approach is most effective for 6 to 12 year old children, as it uses stories and directive art therapy to introduce cognitive concepts that are often essential to ego supportive psychotherapy. The reader is encouraged to become familiar with underlying theory through references in the workbook's bibliography. The wise child therapist can derive much help from Wasserman's workbook by selectively choosing exercises that are best suited to a particular child's personal needs. This will enhance the treatment plan and provide helpful structure to the child therapist's work. For example, using just one of Wasserman's suggested exercises, children who are struggling with feelings of helplessness might be encouraged to draw a picture showing what they have done or might do to change a problem.

Art therapists are particularly likely to find Wasserman's workbook syntonic with their own training and talents, but this is a good reference source for child therapists of all persuasions.

References

Gardner, R. A. (1971). *Therapeutic communication with children: The Mutual Storytelling Technique.* New York: Jason Aronson.

Wasserman, B. G. (1992). Helping children challenge unwanted behaviors. *Anchor Point.* Franktown, CO: Cahill Mountain Press.

Wasserman, B. G. (1993). Integrating NLP with Art Therapy. *Anchor Point.* Franktown, CO: Cahill Mountain Press.

The Way of the Journal: A Journal Therapy Workbook for Healing

by Kathleen Adams, MA, Lutherville, MD: The Sidran Press, 1993.

79 pp. $15.95 paper. ISBN 0-9629164-2-0.

Reviewed by **Susan E. Cheyne-King, MS, LPC, A.T.R.,** Providence Forge, VA

Journaling can be a healing and empowering experience and a way to nurture oneself. After discovering that most clients with Post Traumatic Stress Disorder wrote in journals but that most of them had negative feelings or experiences associated with their journals, Kathleen Adams decided to develop a system that incorporates structure into journal writing. *The Way of the Journal* consists of exercises to be done a day at a time (less than 30 minutes each) for 10 days in addition to dialogues with the journal, feelings worksheets, and various imaging worksheets. The exercises move from short and highly structured to more open-ended and loosely structured. The design of the workbook is to "minimize the risk of overstimulation or flooding" (p. 4).

Adams begins by describing what she calls "the developmental continuum of journal therapy" or her "Quick and Easy method" (p. 2), then addresses therapists briefly. She goes on to describe how to use the workbook, how to prepare to write, and how to reward yourself for writing. The bulk of her book (51 pages) consists of worksheets. These begin with sentence completions and move on to exercises such as clustering and, finally, free writing. The end of the book offers suggested readings, tells why to use the journal writing as an adjunct to therapy, and explains how it can be used as an intervention with various populations.

This workbook is similar to Capacchione's books, *The Creative Journal: The Art of Finding Yourself* and *The Creative Journal: A Handbook for Teens.* Both review methods and use and provide space to complete exercises. Unlike Cappachione's book, Adams' book does not utilize art expression. *The Way of the Journal* is fairly intense and obviously more for therapeutic use, although some exercises such as the poetry exercise could be used for more casual self-exploration.

BEST COPY AVAILABLE

According to Adams, this book provides a "quick and easy" method of journal writing. The format of the exercises, however, makes it appear less quick and easy and more cumbersome and annoying. Each exercise begins with "So, how was it?" but the directions for the exercise are on the following page(s), thus making it necessary to flip back and forth between the entry and recording feelings. Artwork could have been suggested for some of the exercises such as "Create a Shield" and "Bridging Back to the Present." These minor criticisms should not detract from what could be a fundamental part of healing, particularly for individuals who have survived trauma.

References

Cappachione, L. (1989). *The creative journal: The art of finding yourself.* Santa Monica, CA: Hayhouse.

Cappachione, L. (1990). *The creative journal: A handbook for teens.* Santa Monica, CA: Hayhouse.

RdWing
LEVYB

Contact Art Therapy On-Line!

Get in on the Information Superhighway! If you have a modem you can send e-mail to **ART THERAPY** on-line. Subscribers to the America Online service can send messages to the Editor, Cathy Malchiodi, A.T.R. by contacting the code name **"RdWing"**; those with e-mail can send messages to **"rdwing@aol.com."** Another onliner, Barbara Levy, A.T.R. can be contacted through America Online **"LEVYB"**, through e-mail **"levyb@aol.com."** or through the Delphi Custom Art Therapy Forum. Barbara hosts this online forum through which art therapists can network and communicate nationwide. To get more information about joining either Delphi or American Online services, please contact **Art Therapy, c/o AATA National Office, 1202 Allanson Road, Mundelein, Illinois 60060**

NEW!

From the
American Art
Therapy Association,
Inc.

A HISTORY
OF ART THERAPY
IN THE UNITED STATES

Maxine Borowsky
Junge
with Paige Pateracki
Asawa

Members: $35.00
Non-Members: $50.00

C.Q.I.

Continuous
Quality
Improvement
Manual

Paula Howie
Kathy Gilman
Guiterrez

Members: $25.00
Non-Members: $37.00

"I'm Into Art
Therapy"

Full color poster
by
Elizabeth "Grandma"
Layton

Members: $25.00
Non-Members: $35.00

"Three Art
Therapists"

Full color poster
by
Edith Kramer

Members: $25.00
Non Members: $35.00

Art Therapy and Expressive Interventions

for Trauma Victims and Survivors

Cathy Malchiodi, M.A., A.T.R.

Friday, March 24, 6pm to 9:30pm

Saturday, March 25, 10am to 6pm

Tuition for Course: $145

- Course will provide an overview of applications of art therapy with individuals, groups and families who have experienced trauma, domestic violence, and/or physical and sexual abuse.
- Emphasis will be on how to use art therapy and expressive modalities effectively in interventions using didactic, experiential and group process.

Can be matriculated for one AT Studio unit. Application for CEU's in process.

Southwestern College maintains a non-discriminatory policy

To Register Contact:

SOUTHWESTERN COLLEGE

P.O. Box 4788 • Santa Fe, New Mexico 87502
(505) 471-5756 • Fax (505) 471-4071

Noteworthy

Beyond the Drawing Room: The Art of Mary Huntoon

Almost 25 years after her death, the story of Mary Huntoon's life, art, and work as an art therapist was publicly chronicled for the first time in an exhibit at the Salina Art Center, September 12th through October 28th. This exhibition of 49 paintings, drawings, and prints traces the life of Kansas artist Mary Huntoon from her entry into the Art Student's League of New York in 1920, to Paris in 1926, through four marriages and a 16-year career as a pioneering art therapist at Winter Veterans Hospital in Topeka, Kansas, under the guidance of Dr. Karl Menninger.

Curator Joyce Fent pulled together prints, drawings, and paintings from five decades of the artist's work. Huntoon was born in 1896 into one of the first families of Topeka, Kansas. Her odyssey from the prairies of the Midwest to New York, the salons of Europe, and back to Kansas where she capped a career as an artist with a second career as a pioneer in the field of art therapy is traced in this exhibition. Organized for the Kansas Reciprocal Art Touring Exhibit Service (known as KRATES), the show will travel to the Spenser Museum of Art at the University of Kansas, the Menninger Archives in Topeka, the Carnegie Arts Center in Goodland, and the Topeka and Shawnee County Public Library after its debut in Salina, and it will be available to galleries and arts groups throughout the region. Fent spent 2 years collecting works for the exhibit, which have been borrowed from four important Kansas institutions and three individuals, and researching Huntoon's life through archival sources and numerous interviews across the country.

Huntoon's prints—lithographs, etchings, aquatints, engravings—display a remarkable spontaneity and versatility. During post-graduate work at the Art Student's League in New York, she was a student of Joseph Pennell, and Robert Henri. Her paintings also won awards and were shown in important exhibitions in the United States and Europe. But perhaps her greatest contribution was to the early development of art therapy. Huntoon was invited to teach drawing at the Menninger Clinic in 1934, an association that would result in the 1946 announcement by Dr. Karl Menninger that she would join the staff at Winter General Hospital, where she worked as an art therapist for the next 12 years. Doctors sought her advice, and copies of her first paper about her work in the creative arts as therapy were internationally reprinted and distributed widely.

A catalogue containing Fent's essay about Huntoon's life and work (the first comprehensive piece ever produced) and reproductions of 50 works of art will accompany the exhibition. For more information, or to arrange tours or KRATES venues for this exhibition, contact the Salina Art Center, 242 S. Santa Fe, Salinas, KS, (913) 927-1431.

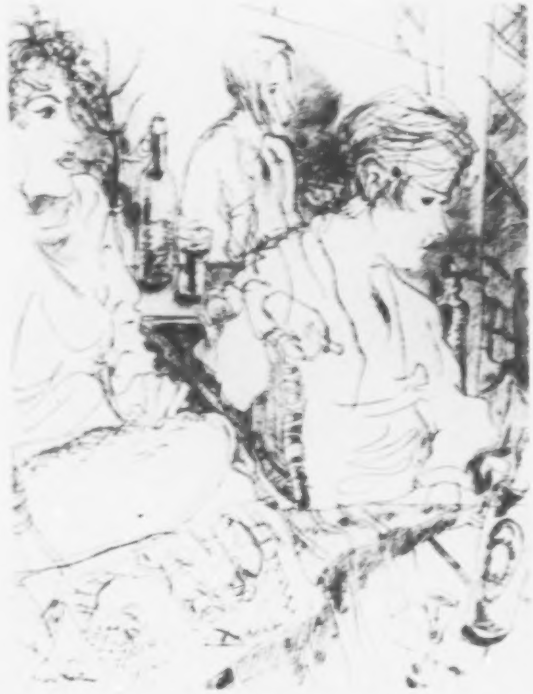


Fig. 1. "The Three Women," (1931); Etching—11.7/40, by Mary Huntoon

EXHIBITION VENUE LISTING

**"Beyond the Drawing Room:
The Art of Mary Huntoon (1896–1970)"**

Salina Art Center Salina, Kansas	Sept. 11–Oct. 28, 1994
Goodland Arts Council Goodland, Kansas	Feb. 1–Mar. 10, 1995
Spencer Museum Lawrence, Kansas	June 4–July 20, 1995
Menninger Archives Topeka, Kansas	Nov.–Jan., 1995
Topeka Public Library	Jan., 1996

ANNUAL INDEX: VOLUME 11

Index A. ARTICLES

Cattaneo, M. Addressing Culture and Values in the Training of Art Therapists 184

Cohen, B., Mills, A. & Kwapien Kijak, A. An Introduction to the Diagnostic Drawing Series: A Standardized Tool for Diagnostic and Clinical Use 105

Cohen-Liebman, M. S. The Art Therapist as Expert Witness in Child Sexual Abuse 260

Couch, J. B. Diagnostic Drawing Series: Research with Older People Diagnosed with Organic Mental Syndrome and Disorders 111

Dufrene, P. M. & Coleman, V. D. Art Therapy with Native American Clients: Ethical and Professional Issues 191

Hagood, M. M. Diagnosis or Dilemma: Drawings of Sexually Abused Children 37

Hargrave-Nykaza, K. An Application of Art Therapy to the Trauma of Rape 53

Henley, D. R. Transcultural Responses to Aesthetic and Therapeutic Experience: An Ethological Approach 194

Jacobs, J. & Milton, I. The Art of Art Therapy May be Toxic 271

Jacobson, M. Abreacting and Assimilating Traumatic, Dissociated Memories of MPD Patients Through Art Therapy 48

Kessler, K. A Study of the Diagnostic Drawing Series with Eating Disordered Patients 116

Knapp, N. M. Research with Diagnostic Drawings for Normal and Alzheimer's Subjects 131

Murphy, P. S. The Contribution of Art Therapy to the Dissociative Disorders 43

Neale, E. L. The Children's Diagnostic Drawing Series 119

Rankin, A. Tree Drawings and Trauma Indicators: A Comparison of Past Research with Current Findings from the Diagnostic Drawing Series 127

Spaniol, S. & Cattaneo, M. The Power of Language in the Art Therapeutic Relationship 266

Thayer, J. A. An Interview with Joan Kellogg 200

Westrich, C. A. Art Therapy with Culturally Different Clients 187

Index B. BRIEF REPORTS

Drachnik, C. The Tongue as a Graphic Symbol of Sexual Abuse 58

Heiman, M., Strnad, D., Weiland, W. & Wise, T. N. Art Therapy and Alexithymia 143

Kaplan, F. F. The Imagery and Expression of Anger: An Initial Study 139

Knapp, J. E., Knapp, L. G. & Phillips, J. Report on the National Art Therapy Practice Analysis Survey 146

La Brie, G. & Rosa C. American Art Therapy Association, Inc. 1992-93 Membership Survey Report 206

Phillips, J. Commentary on the Assessment Portion of the Art Therapy Practice Analysis Survey 151

Webster, M. Legal and Ethical Issues Impacting Unlicensed Art Therapists and Their Clients in California 278

Index C. DEPARTMENTS

Viewpoints

Alter-Muri, S. B. Psychopathology of Expression and the Therapeutic Value of Exhibiting Chronic Clients' Art: A Case Study 219

Ferrara N. Native American Experience of Healing Through Art 216

Finney, P. R. A Review of Two Art Assessment Tools in an Adult Day Treatment Center 154

Jacobs, J. Photography and Confidentiality 296

Junge, M. Politics and Poetics: The Acquired Wisdom of the Art Therapist 288

Lachmann-Chapin, M. Patterns 297

Landgarten, H. B. Magazine Photo Collage as a Multicultural Treatment and Assessment Technique 218

Mango-Hurdman, C. & Richman, J. A Note on Ethnicity in Humor and Art Therapy 214

Orleman, J. Looking In—Looking Out: An Artist's Journey Through Childhood Sexual Abuse 62

Spring, D. Progress or Politics 282

Wadeson, H. Diving and Snorkeling: The Depths and Shallows of Therapy 153

Weiser, J. Being Different: A Theoretical Perspective 224

Wirtz, G. Essential Legal Issues for Art therapists in Private Practice 293

Book Reviews

Bomberger, C. A. Portraits of Spirituality in Recovery: The Use of Art in Recovery from Co-Dependence and/or Chemical Dependency 159

Byers, J. G. Instant Images: A Guide to Using Photography in Therapy 157

Cleveland, E. Creative Art in Groupwork 230

Cooper, B. F. Casualties of Childhood: A Developmental Perspective on Sexual Abuse Using Projective Drawings 67

Cristantiello, S. Shattered Images: Phenomenological Language of Sexual Trauma 66

Haeseler, M. P. Understanding Race, Ethnicity, & Power: The Key to Efficacy in Clinical Practice 229

Horovitz-Darby, E. G. Response to Book Review 71

Jones, B. D. Tactile Graphics 158

Wasserman, B. C. Stories for Children with Problems and Wishes: A Therapeutic Workbook for Turning Problems into Gifts 299

Video Reviews

Alter-Muri, S. Response to Video Review 71

Bernier, M. Archetypal Images and Art 70

Bernier, M. The Life and Art of Peter Birkhauser 70

Consoli, J. J. The Box: A Guide to an Interactive Film Project for Use with the Arts Therapies 68

Klorer, G. Art Therapy with a Group of Latency Age Girls 160

Wakeley, K. L. Response to Video Review 231

Editorials

Malchiodi, C. A. Certification: In Search of Accountability 170

Malchiodi, C. A. Introduction to Special Issue on Ethics and Professional Issues. Professional Courtesy 242

Malchiodi, C. A. The 1993 Annual Conference: Rediscovering Our Common Ground 2

Malchiodi, C. A. Sorting Out Certification 82

SPECIAL SECTIONS

24th Annual Conference

24th Annual Conference Overview 7

HLM Award Acceptance by Gwen L. Gibson 10

DSA Award Acceptance by Deborah A. Good 12

Allen, P. B. Soul and Spirit: The Image Instructs 17

Moon, C. Mystery: The Guiding Image 18

McNiff, S. Images as Angels 13

25th Anniversary

Introduction 23

The First AATA Conference Program 24

AATA Award Winners (1970-1993) 25

How Will the Profession of Art Therapy Change in the Next 25 Years? Responses by Past Award Winners - Wadeson, H., Agell, G., Minar, V. & Bush, J. 26

How Will the Profession of Art Therapy Change in the Next 25 Years? Responses by Past Award Winners - Kramer, E., Drachnik, D., Anderson, F. E., Landgarten, H. B., Levick, M. F., & Riley, S. 91

How Will the Profession of Art Therapy Change in the Next 25 Years? Responses by Past Award Winners - Rhyne, J., Ault, R. E., Rubin, J. A., Silver, R., Good, D. A., Malchiodi, C. A. 250

Interview with Felice W. Cohen, A.T.R. - I. Corbit 246

Junge, M. B. The Formation of The American Art Therapy Association 175

Koodrin, B. An Informal Interview with Edith Kramer 180

Silver, R Gallery 102

Photo Gallery 33

The American Art Therapy Association

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 4,500 professionals and students. It is governed and directed by a nine-member Board elected by the membership. The AATA has established standards for art therapy education, registration and practice: AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films, and awards.

PURPOSE

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education, and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

CHAPTERS

Affiliated chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network for people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a Chapter member. Information on locating the chapter nearest you is available from the AATA office.

MEMBER BENEFITS

Individual members receive:

Publications

- *Art Therapy*, the official journal of AATA
- The Quarterly *AATA Newsletter*.
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and membership directory.
- AATA Literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability through Maginnis & Associates.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.
- Nationwide Advocacy
- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payors.
- National liaison with related professional organizations for recognition and promotion of art therapy.

Professional Standards

- Development of model job description and recommendations for licensing standards.
- Develoment and implementation of national guidelines for approval of Master's Degree and training programs in art therapy.
- Development and implementation of nationally recognized Standards of Registration of Professional Art Therapists.

MEMBERSHIP APPLICATIONS

1. The membership year is the calendar year January 1st through December 31st.
2. Contributing, Associate and Student applicants for NEW MEMBERSHIP ONLY: Please follow the chart below when submitting membership application:
   Applications received between:
   Jan. 1st - May 31st - Full dues payment; membership expires Dec. 31st of same year.
   June 1st - Sept. 30th - Half year dues plus $5.00 payment; membership expires Dec. 31st of same year.
   Oct. 1st - Dec. 31st - Full dues payment; membership for the remainder of current year and the next full year.
3. Professional Member applicants must meet Criteria for Professional Membership. Formal application with documentation is submitted to Membership Chair for Approval.
4. AATA Memberships and AATA Registration (A.T.R.) each have a separate application procedure. Registration is bestowed only by the Standards Committee.
5. NATIONAL AATA membership is required for Chapter Membership. Please contact the AATA office for information on AATA Chapters.

CATEGORIES AND FEES

PROFESSIONAL - By application only; such members may vote, hold office and serve on committees.

- **Credentialed Professional Member:** Individuals who have been dually approved for Professional Membership and Registration (A.T.R.) by the AATA; dues are $95 per year.
- **Professional Member:** Individuals who have completed professional training in art therapy; dues are $85 per year.

CONTRIBUTING - Individuals, organizations, institutions or foundations which contribute annually to the AATA. Such members may not vote, hold office or serve on committees. Dues are $120 per year

ASSOCIATE - Individuals interested in the therapeutic use of art who support the purposes and objectives of the AATA. Such members may not vote, hold office or serve on committees. Dues are $85 per year.

STUDENT - Individuals who do not meet the qualifications of Professional Membership and are currently taking coursework in art therapy or related fields. Requires a current statement from the institution of learning indicating full-time status and coursework content. Members may note vote or hold office, but may serve on the Student Sub-Committee of Membership. Dues are $35 per year.

The American Art Therapy Association

MEMBERSHIP APPLICATION

NAME :

HOME ADDRESS :

PHONE: ( )

BUSINESS ADDRESS:

PHONE: ( )

EMPLOYER:

JOB TITLE:

LICENSES HELD & STATE:

PREFERRED MAILING LIST:

☐HOME ☐BUSINESS

Please indicate under which category you are applying:

- ☐A.T.R. REGISTRATION (A Corresponding application packet will be sent to you)
- ☐$95 CREDENTIALED PROFESSIONAL MEMBERSHIP (after approval only)
- ☐PROFESSIONAL MEMBERSHIP (a corresponding application packet will be sent to you)
- ☐$85 PROFESSIONAL MEMBERSHIP (after approval)
- ☐$120 CONTRIBUTING MEMBERSHIP
- ☐$85 ASSOCIATE MEMBERSHIP
- ☐$35 STUDENT MEMBERSHIP (see student membership criterion for necessary documents to accompany this application)

PAYABLE IN U.S. DOLLARS
MAKE CHECK PAYABLE TO:
AATA - American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, IL 60060
(708) 949-6064 Fax: (708) 566-4580

Please complete this survey:

Education (please check highest degree earned).

1☐ Doctorate Degree
2☐ Master's Degree
3☐ Bachelor's Degree
4☐ Associate/Certificate
5☐ Other

(Please indicate *exact* degree earned, e.g., BA, BS, MA, MS, PhD, etc.)

Work Setting (please check only one).

1☐Hospital
2☐Clinic
3☐Day treatment center
4☐Rehabilitation
5☐Sheltered workshop
6☐Correctional facility
7☐Residential treatment
8☐Out-patient mental health
9☐School system
10☐Elderly care facility
11☐College/University
12☐Clinical training pro.
13☐Institute training pro.
14☐Councelling center
15☐Private practice
16☐Other

Area(s) of Specialization (please check up to three).

1☐Addictions
2☐Adolescents, Hospitalized
3☐Adolescents, Psychiatric
4☐Adults, Hospitalized
5☐Adults, Psychiatric
6☐Art History
7☐Art Therapy Education
8☐Art Therapy in Schools
9☐Children, Hospitalized
10☐Children, Psychiatric
11☐Domestic Violence
12☐Eating Disorders
13☐Families
14☐Gerontology
15☐Hospice/Terminally Ill
16☐Learning Disability
17☐Mental Retardation
18☐Neurological Disease
19☐Prisoners
20☐Post Traumatic Stress
21☐Psychotherapy
22☐Rehabilitation
23☐Research
24☐Sexual Abuse
25☐Visual Art
26☐Other

Voluntary Information

Age:
1☐ 20-24
2☐ 25-29
3☐ 30-34
4☐ 35-39
5☐ 40-44
6☐ 45-49
7☐ 50-54
8☐ 55-59
9☐ 60+

Salary Range:
1☐under $10,000
2☐$10-15,000
3☐$15-20,000
4☐$20-25,000
5☐$25-30,000
6☐$30-35,000
7☐$35-40,000
8☐$40-45,000
9☐$45-50,000
10☐$50,000+

Gender:
1☐ Female
2☐ Male

Hours worked/week:
1☐ 0-10
2☐ 20-30
3☐ 10-20
4☐ 30-40

RESOURCES

The American Art Therapy Association Serves as a clearinghouse for information about the field of art therapy. The following publications, films and training literature are available from the AATA National Office

The American Art Therapy Association, Inc.
1202 Allanson Road / Mundelein, Illinois 60060
(708) 949-6064 Fax: (708) 566-4580

PUBLICATIONS

CONFERENCE PROCEEDINGS	MEMBERS	NON-MEMBERS
Creativity and the Art Therapist's Identity (1976) ISBN 1-882147-04-9	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) ISBN 1-882147-05-7	$ 5.00	$ 7.00
The Use of Creative Arts in Therapy (1979 Joint Conference)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) ISBN 1-882147-10-3	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) ISBN 1-882147-12-X	$ 7.00	$ 9.00
Art Therapy: A Bridge Between Worlds (1981) ISBN 1-882147-11-1	$ 7.00	$ 9.00
Art Therapy: Still Growing (1982) ISBN 188214-06-5	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) ISBN 1-882147-13-8	$15.00	$20.00
Professionalism in Practice (1988) ISBN 1-822147-08-1	$15.00	$20.00
Painting Portraits: Families/Groups/Systems (1989) ISBN 1-882147-07-3	$15.00	$20.00
Image and Metaphor (1991) ISBN 1-882147-09-X	$15.00	$20.00
The Art Therapist: Artist/Teacher/Clinician/Healer (1992) ISBN 1-822147-14-6	$15.00	$20.00
Common Ground: The Arts, Therapy & Spirituality (1993) ISBN 1-822147-21-9	$15.00	$25.00
Reflecting on the Past, Envisioning the Future (1994) ISBN 1-882147-24-3	$15.00	$25.00

NOTE: Ten or more copies of any single Proceeding: 10% discount on total. Set of four proceedings (consecutive years): 20% discount on total. POSTAGE/HANDLING: $2.90 first item; $.75 each additional.

OTHER PUBLICATIONS

A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0[1]	$24.00	$35.00
Art Therapy in Schools[3]	$ 6.00	$10.00
National Registry of Masters Theses and Practicum Papers[2]	$15.00	$25.00
Addendum to National Registry[3]	$12.50	$22.50
AATA Chapter Manual[2]	$10.00	N/A
Applying for Funds from Your Area Agency on Aging[3]	$ 7.00	$14.00
Aging Artfully: Health Benefits of Art and Dance[2]	$ 7.00	$10.00

NOTE: [1]Postage included on all orders for this publication. Ten or more copies 10% discount. [2]Add $2.90 for postage. [3]Postage included on all orders for these publications.

TRAINING LITERATURE

Educational Guidelines	$ 0.30	$ 1.00
Education List (Colleges and universities offering art therapy programs)	$ 0.30	$ 1.00
Standards & Procedures for Registration	$ 0.30	$ 1.00
Criterion for Professional Membership	$ 0.30	$ 1.00

NOTE: General Information Packet - first three items above ($4.00). These pamphlets are available to members only in multiples: 1-9 copies - $2.00 plus SASE; 10-50 copies - $5.00 plus SASE.

OTHER LITERATURE

Art Therapy Model Job Description	$ 0.30	$ 1.00
Art Therapy Media List	$ 0.30	$ 1.00
Bibliography: Books Authorized by Members of AATA	$ 0.30	$ 1.00
Ethics Document	$ 0.30	$ 1.00
Standards of Practice Document	$ 0.30	$ 1.00

NOTE: Above items are available to members only in multiples: 1-9 copies - $2.00 plus SASE; 10-50 copies - $5.00 plus SASE

APPLICATIONS

A.T.R. (Registration) Application	N/C	$ 1.00
Professional Membership Application	N/C	$ 1.00
General Membership Application	N/C	N/C

MEMBER INFORMATION

Member Speciality List	$ 1.90	$ 2.90
Membership Survey	$ 0.75	$ 2.75
1994 Membership Directory[2]	$ 14.00	$ 55.00

NOTE: [1]Postage and handling for AATA Directory: U.S. - $2.90; Canada, Mexico - $3.25; Foreign - $10.00

SUBSCRIPTIONS	MEMBERS		NON-MEMBERS	
Art Therapy: Journal of the American Art Therapy Association	Individuals U.S.	$ 40.00	Foreign	$ 64.00
	Institutions U.S.	$ 57.00	Foreign	$ 80.00
Back Issue	U.S.	$ 10.00	Foreign	$ 28.00
AATA Newsletter	U.S.	$ 16.00	Foreign	$ 28.00

FILMS	MEMBERS	NON-MEMBERS
Art Therapy: Beginnings (1977) (color/sound/45 min.)		
(16mm - Rental only)	$40.00	$50.00
(1/2" VHS - Purchase Only)	$50.00	$80.00
Michael (1977) (color/sound/12 minutes)		
(16mm - Rental only)	$30.00	$35.00
(1/2" VHS - Purchase only)	$50.00	$80.00
Art Therapy (1981) (color/sound/12 minutes)		
(16mm - Rental only)	$35.00	$45.00
(1/2" VHS -Purchase only)	$50.00	$80.00

NOTE: Postage & handling for films: $3.00 each VHS; $7.00 each 16mm

---

1. **WE DO NOT ACCEPT CREDIT CARDS OR PURCHASE ORDERS.** All orders must be made in writing, accompanied by payment in cash, check or money order in U.S. funds.
2. **FOREIGN ORDERS**: Shipping will be made per your instructions (surface or air). Please specify method of shipment when ordering. Additional Postage, if necessary, will be billed separately.
3. **RETURNS ARE NOT ACCEPTED** for refund on shipped items.

TITLE	Quantity	Price	Total

SHIPPING INFORMATION

NAME: ____________________

MEMBER I.D.# ____________________

STREET: ____________________

CITY/STATE/ZIP ____________________

Total: $ __________

Postage: $ __________

Applicable Discount: $ __________

TOTAL ENCLOSED: $ __________

Allow 2-4 weeks for delivery
MAKE CHECKS PAYABLE TO AATA

AATA REGIONAL SYMPOSIA

SEXUAL ABUSE

Presenters: Deborah Good (Two presenters to be added at a later date)

Description of this symposia will be announced at a later date.

ADDICTIONS

Presenters: Lynn Jones, Holly Feen and Katie Webb

Participants will receive the latest information on the use of art therapy in the treatment of addiction and dual diagnosis. Art therapists will be able to identify specific non-verbal approaches for working through resistance and denial in the treatment of substance abusers. Counselors will be able to identify specific ways in which to coordinate treatment efforts with art therapists in their facilities.

FAMILY ART THERAPY

Presenters: Mari Fleming, Shirley Riley and James Consoli

The Kwiatkowska Family Art Evaluation is a procedure for interviewing and assessing families which have been carefully developed and researched which can readily be taught to professionals, particularly those with training in other art therapy evaluation procedures. The Family Art Evaluation provides an efficient means of introducing family therapy and systemic thinking into treatment settings. The intensive workshop will present family systems theory emphasizing the family life cycle and family system as seen in the Kwiatkowska Family Art Evaluation. Participants will be trained in the administration and interpretation of the evaluation and in modification of the procedure.

ART THERAPY IN THE SCHOOLS

Presenters: Janet Bush, Sarah Hite and Rebecca Taulbee

The objectives of this symposium will provide the participants with understanding the administrative procedures for implementing and art therapy program in a large, urban school system, become familiar with the uses of art therapy for students in a public school system, become aware of techniques and strategies used in the training and preparation of school personnel; utilize the information they have gained to initiate discussion on approaches and practices of art therapy in public schools; and to be prepared to transfer techniques and strategies for implementing art therapy services to other public schools systems.

ART THERAPY WITH THE OLDER ADULT

Presenters: Larry Barnfield, Bernadette Callanan and Judith Wald

The symposium will cover general views on aging, relevant facts and new research, the role of art therapy with elders and settings in which art therapists practice and the special advantages of art therapy with the aging. It will cover the goals of treatment, treatment issues; and consideration of the clinical treatment of three groups of vulnerable aging and case studies.

RESEARCH AND GRANTS IN ART THERAPY

Presenters: Frances Anderson, Vija Lusebrink and Doris Arrington

The participants of this symposium will be introduced to research concepts and will be assisted in the development of art therapy research proposals. Basic information about research will be covered including hypothesis formulation, choosing appropriate research designs, selection of measures, subject selection, data collection, processing and analysis, and how to critique research articles. The goal of the symposium will be to offer participants a solid foundation for building research projects in the field of art therapy.

ART THERAPY WITH CHILDREN AT RISK

Presenters: Cathy Malchiodi, Julie Epperson and Deborah Good

This symposium proposes to fill the need for advanced art therapy training focusing on theory, interventions, methodology and research with children at risk. "Children at risk" are defined as those who are directly affected by family violence, physical and sexual abuse, neglect, homelessness, and various disabilities such as attention deficit hyperactivity disorder, learning problems, and physical limitation which put them at further risk for abuse and neglect. Emphasis will be on how the clinician can develop both short and long term art therapy interventions, effectively assist the child in crisis and appropriately utilize art expression in assessment of current level of psychological functioning.

ART AND MEDICINE

Presenters: Cathy Malchiodi and Anita Mester (third presenter to be added at later date)

The symposium will focus on the unique dimensions of art therapy within a medical context with people who have experienced life-threatening chronic illness, particularly cancer and HIV. the special role that art expression plays in the assessment and evaluation of both the somatic and psychological status of the individual will be discussed, supported by the current research of both art therapists and clinicians in related fields. Special emphasis will be on paradigms for the use of art therapy within the context of psychoneuroimmunology and mind/body healing. Theories of imagery from current research by Achterburg, Simonton, Bach and others will be covered to assist the participants in integrating the use of art expression with physically ill clients will be presented so that participants acquire an understanding of the practical aspects of adapting art therapy to specific disease conditions. Lastly, emotional and transpersonal issues of grief and loss which are intrinsic to the experience of physical life threatening illness will be addressed.

ADDRESSING DOMESTIC VIOLENCE THROUGH FAMILY ART THERAPY

Presenters: Cathy Malchiodi and Shirley Riley (third presenter to be added at a later date)

This symposium will focus on art intervention and treatment with families who have experienced domestic violence, with the notion that such intervention can be helpful in addressing a larger scope, including social violence. The first half of the symposium will address the use of art expression as intervention for the immediate effects of family violence, with an emphasis on what the art therapist can accomplish in a time-limited setting; focus will be on the unique role of the art therapist in crisis care in shelters, safe houses, and other short term, crisis-oriented facilities. The second half of the symposium will be devoted to how art therapy may be utilized in treatment, focusing on issues of family reconstruction, role adjustments, and post-traumatic separation and loss. The use of art tasks to assist the family in re-thinking gender roles and assigned relationships and to experiment with new modes of interpersonal and intrasocietal communication will be presented.

These Symposia are offered at no charge to the participating Chapter

• • • • • • • • • • • • • • • • •

For further information regarding the context or scheduling of these symposia, please contact the AATA National Office at

1202 Allanson Road ❖ Mundelein, Illinois ❖ 60060
(708) 949-6064
Monday through Friday 9:00 a.m. to 5:00 p.m. Central Standard Time

CHARLES C THOMAS • PUBLISHER

☐ Rugel, Robert P.—**DEALING WITH THE PROBLEM OF LOW SELF-ESTEEM: Common Characteristics and Treatment in Individual, Marital/Family and Group Psychotherapy.** '95, 280 pp. (7 × 10), 2 tables.

☐ Lipton, Merrill I.—**POSTTRAUMATIC STRESS DISORDER—Additional Perspectives.** '94, 258 pp. (7 × 10). $48.75.

☐ Makin, Susan R.—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 112 pp. (7 × 10), $29.95.

☐ Locke, Shirley A.—**COPING WITH LOSS: A GUIDE FOR CAREGIVERS.** '94, 238 pp. (7 × 10), $46.75.

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $62.75.

☐ Hardy, Richard E.—**GESTALT PSYCHOTHERAPY: CONCEPTS AND DEMONSTRATIONS IN STRESS, RELATIONSHIPS, HYPNOSIS, AND ADDICTION.** '91, 136 pp. (7× 10), $30.75.

☐ Steen, Charlene & Barbara Monnette—**TREATING ADOLESCENT SEX OFFENDERS IN THE COMMUNITY.** '89, 212 pp. (7 × 10), 61 il., $48.25.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $54.25.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $33.00.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $44.00.

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $22.00.

☐ Krauss, David A. & Jerry L. Fryrear—**PHOTOTHERAPY IN MENTAL HEALTH.** '83, 260 pp. (6¾ × 9¼), 61 il. (5 in color), 1 table, $44.00.

☐ Fūrrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $23.50, spiral (paper).

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $51.25.

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $25.25.

☐ Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 186 pp. (7 × 10), 33 il. $41.95.

☐ Soukup, James E.—**UNDERSTANDING AND LIVING WITH PEOPLE WHO ARE MENTALLY ILL: Techniques to Deal with Mental Illness in the Family.** '95, 136 pp. (7 × 10).

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts, Theories and Practices. (2nd Ed.).** '94, 294 pp. (7 × 10), 1 table. $58.95.

☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 16 il., $45.75.

☐ Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 × 10), 12 il., $33.75.

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $49.75.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 x 10), 24 il., $44.75.

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¼), 28 il., $36.25.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¼), 21 il., $36.25.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¼), 56 il., $46.50.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $90.00.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $51.00.

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $32.25.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 258 pp., 54 il., $30.00.

☐ Singer, Florence—**STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children.** '80, 144 pp., 33 il., $23.50.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $48.50.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Art Therapy, the official journal of the American Art Therapy Association, is a quarterly journal for professionals and students who are interested in the use of art in the fields of mental health, psychotherapy and human development. The purpose of the *Journal* is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. ***Art Therapy*** publishes refereed articles, including illustrations, by art therapists, psychologists, family therapists, and others that reflect the latest advances in theory, research, professional issues, and practice. An emphasis is placed on the use of visual arts in therapy, but articles in related disciplines of interest are considered for publication. *Art Therapy* is an important source for news and summaries of national conferences, book reviews, media, and commentaries.

Recent articles published in ***Art Therapy:***

✱An Application of Art Therapy to the Trauma of Rape

✱The Use of Art Therapy Following Perinatal Death

✱The Children's Diagnostic Drawing Series

✱Art Therapy with Native American Clients: Ethical and Professional Issues

✱Diagnosis or Dilemma: Drawings of Sexually Abused Children

Art Therapy is available to AATA Members as part of their membership. Non-Members may subscribe at the following annual rates:

Individuals: $40.00 (U.S.) - $60.00 (Foreign)
Institutions: $57.00 (U.S.) - $80.00 (Foreign)

Single Copies are available at:

Members: $10.00 - Non-Members:$18.00

Make checks or money orders payable to AATA and return with this subscription order form to:
American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois
60060

Please enter my subscription for 1995. Enclosed is a check in the appropriate amount:

Name: ______________________________

Address: ______________________________

City: ____________________ State: ____________________ Zip: ____________

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone #s: ____________________ work ____________________ home

Type of Submission (check one):

___ Article

___ Brief Report

___ Viewpoints

___ Book Review

___ Film/Video Review

Title of Submission: ______________________________

____

Checklist:

___ Five copies, typewritten on 8½" × 11" paper.

___ Black and white photos of original artwork plus 4 photocopies of each.

___ Paper and references adhere to *Publication Manual of the American Psychological Association* (Third Edition).

___ Abstract of 75-125 words (for articles and brief reports only).

___ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

___ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

Author's signature ______________________________ **Date** __________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

____

___/___/___/

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

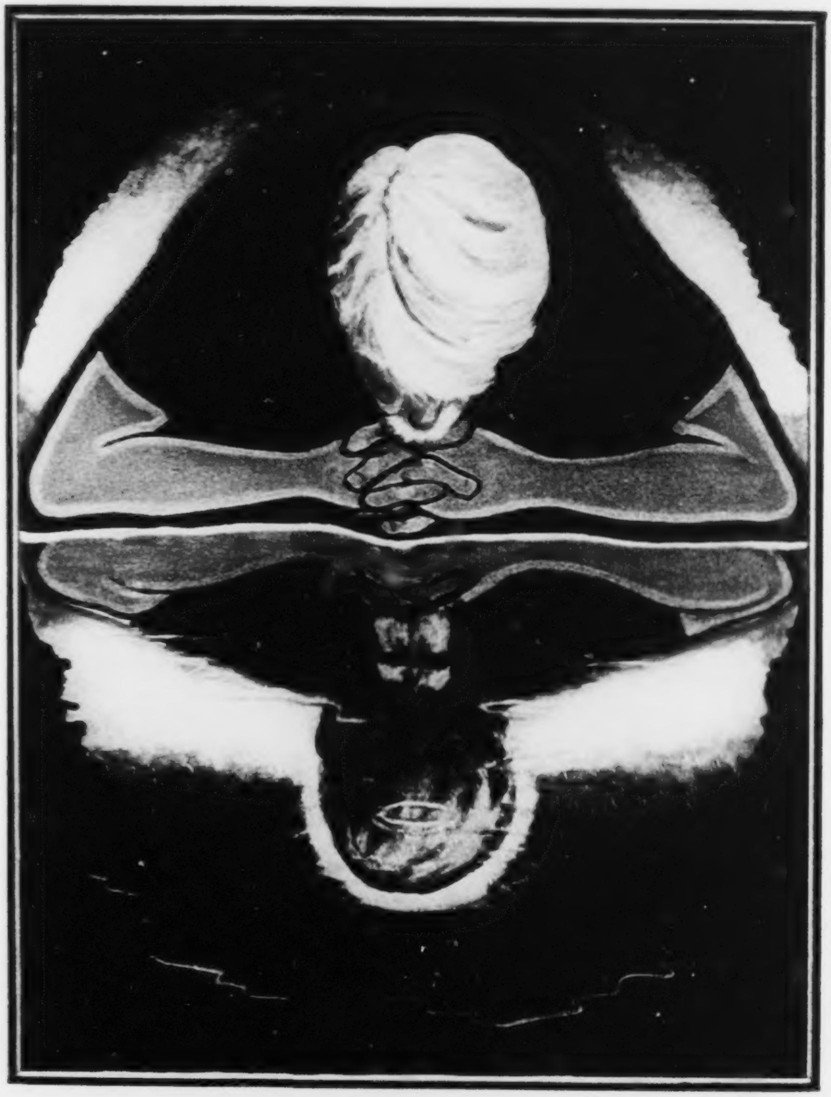
Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Cathy A. Malchiodi, A.T.R., Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8½" × 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Third Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication Manual* for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" × 7" and black and white glossy prints, preferrably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. It is the **author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION



VOLUME 12, NUMBER 1, 1995

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Psychological Abstracts, INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern*.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue; July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, MA, A.T.R., LAT, LPCC
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Patricia St. John, EdD, A.T.R.-BC
College of New Rochelle, New Rochelle, NY

Book Review Editor
Barbara Sprayregan, PsyD, A.T.R.
Stoney Brook Counseling Center, Chelmsford, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Friends Hospital, Philadelphia, PA

Production Editor
Heather R. Jurczyk

Editorial Board
Pat B. Allen, PhD, A.T.R., LAT
School of the Art Institute, Chicago, IL
Doris B. Arrington, EdD, A.T.R.-BC
College of Notre Dame, Belmont, CA
Janet Bush, EdS, A.T.R.
Dade County Public Schools, Miami, FL
Julia Byers, MA, A.T.R.
Concordia University, Montreal, Canada
Mariagnese Cattaneo, PhD, A.T.R., LMHC
Lesley College, Cambridge, MA
Susan Cheyne-King MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R., LAT
George Washington University, Washington, DC
John Goff Jones, PhD, ABPP, A.T.R.-BC
Oklahoma City, OK
Julie Epperson, MA, A.T.R., LPCC
YWCA of Salt Lake City, Salt Lake City, UT
Deborah A. Good, MA, A.T.R., LAT, LPCC
Family Therapy of Albuquerque, Albuquerque, NM
Anna Hiscox, MA, MFT, A.T.R.
McAuley Neuropsychiatric Institute, San Francisco, CA
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Frances F. Kaplan, DA, A.T.R.
Hofstra University, Hempstead, NY
Carol Lark, MA, A.T.R.
Art Therapy Center of St. Louis, MO
Vija B. Lusebrink, PhD, A.T.R.
University of Louisville, Louisville, KY
Patricia Engle Murphy PhD, A.T.R.
Private Practice, Moscow, ID
Mary Ellen Peacock, MA, A.T.R.
St. Francis of Assisi School, Louisville, KY
Leslie P. Knowles, A.T.R., LMHC
Whitney Academy, East Freetown, MA
Shirley Riley, MA, A.T.R., MFCT
Loyola Marymount University, Los Angeles, CA
Irene Rosner David, MA, A.T.R.-BC
Bellevue Hospital Center, New York, NY
Nancy M. Sidun, PsyD, A.T.R.
The Chicago School of Professional Psychology, Chicago, IL
Susan Spaniol, EdD, A.T.R.
Leslie College, Cambridge, MA
Evelyn Virshup, PhD, A.T.R., MFCC
California State, Los Angeles, CA
Judith Wald, MS, A.T.R.
New York Hospital - Cornell Medical Hospital Center,
White Planes, NY

AATA President
Bobbi Stoll, MFCC, A.T.R.-BC

AATA Executive Director
Edward J. Stygar, Jr.

1944

VOLUME 12

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 1, 1995

Editorial

Who Owns the Art?— Cathy A. Malchiodi, MA, A.T.R., LAT, LPCC 2

Commentaries 4

Special Conference Section

25th Annual Conference Program 9
Time Capsule Contributions 12
HLM Award Acceptance by Linda Gantt, PhD, A.T.R. 13
DS Award Acceptance by Doris B. Arrington, EdD, A.T.R.-BC 14
Clinical Award Acceptance by Dee Spring, PhD, A.T.R.-BC 16
1994 Keynote Address by Ellen Dissanayake 17

Special Issue on Art and Medicine

Articles

Tuberculosis: Art Therapy with Patients in Isolation — Irene Rosner-David, MA, A.T.R.-BC and Shereen Ilusorio, MA, A.T.R.-BC 24
Pediatric Art Therapy: Strategies and Applications — Anne Prager, RN, MA, A.T.R. 32
Art Therapy on a Hospital Burn Unit: A Step Towards Healing and Recovery — Johanna Russel, MS, A.T.R. 39
The Use of Art Therapy in Treatment Programs to Promote Spiritual Recovery from Addiction — Holly Feen-Calligan, MAT, A.T.R.-BC 46

Brief Reports

Terminal Stage Leukemia: Integrating Art Therapy and Family Process — Emily Scudder Teufel 51

Viewpoints

Art & Endometriosis (From an Artist's Sketchbook) — Jane C. Berstein, MA, A.T.R. 56
Taking Inventory in the Age of AIDS — Emily Piccirillo, MA, A.T.R. 62
Let Me Wipe My Tears So I Can Help with Yours — Audrey Elkinson-Griff, MA, A.T.R. 67
Healing Through Art — Darcy Lynn 70
TB, the Mask, and Me — Susan Conlon, MA 72

Reviews

Cancer Stories: Creativity and Self Repair — Susan E. Cheyne-King, MS, A.T.R., LPC 73
California Art Therapy Trends — Mari M. Fleming, A.T.R.-BC, MFCC 74
The Creative Journal for Children: A Guide for Parents, Teachers and Counselors,
Recovery of Your Inner Child: The Highly Acclaimed Method for Liberating Your Inner Self,
Lighten Up Your Body—Lighten Up Your Life: Beyond Diet and Exercise—the Inner Path to Lasting Change,
The Picture of Health: Healing Your Life with Art — Marcia L. Rosal, PhD, A.T.R.-BC 76

About the Cover: "Who, What, Where, How?," 30" × 40", mixed media on canvas by Don Jones A.T.R., HLM. "This is my graphic response to Cathy Malchiodi's invitation to comment on the future of the art therapy profession, which of course, is my personal future and continuity as well. The painting is based on an art therapy drawing exercise of dividing the paper into four parts: WHO am I? WHERE will I be? WHAT blocks me? and HOW to get there? To conceive of the future is to first look backward and inward, then to envision a goal, next to confront the barriers, and finally to use the perspective to plan strategies for success. I believe art therapy's future is in art therapy, not social work, counseling, psychology, education, or an adjunct to some other discipline. I think that we will, however, find ourselves exploring 'imagery' more and 'art' less. Our new colleagues may be neurologists and brain anatomists. It promises to be a creative challenge for those with the vision. But, as one can see, I'm still meditating on 'Who are we?' Our profession needs to answer this first."

Editorial

Who Owns the Art?

Cathy A. Malchiodi, MA, A.T.R., LAT, LPCC, *Editor*

The 25th Annual AATA Conference not only marked the silver anniversary of the association, but also the introduction of a new ethics document for art therapists. The AATA Ethics Committee Chair Cay Drachnik, AATA Board member Jeanne Carrigan, and AATA legal counsel, Jonathan Braverman, presented an overview of the new document at a general session of the conference. Many of the topics presented were of no surprise: confidentiality and privacy, responsibility to patients, research subjects, students and supervisees, and professional integrity and competence. However, the issue of what to do with client art made in therapy was one topic which captured the interest of many who were in attendance and concerns began to emerge, some of which have been expressed by Spring (1994) and Neustadt (see Commentaries this issue), among others.

Possibly one of the most confusing and controversial aspects of the practice of art therapy has been the maintenance, storage, and disposition of client art expressions. AATA ethics documents have addressed this issue in different ways. The 1990 version of the *Code of Ethics for Art Therapists*, under the section titled "Confidentiality" states:

> Art therapists make provisions for maintaining confidentiality in storage and disposal of records and art expressions. (AATA, 1990)

The latest draft of what is now referred to as *Ethical Standards for Art Therapists* (AATA, 1994) is somewhat more explicit, stating:

> Art therapists shall maintain patient treatment records for a reasonable amount of time consistent with state regulations and sound clinical practice, but not less than seven-years from completion of treatment or termination of the therapeutic relationship. Records are stored or disposed of in ways that maintain confidentiality. (Section 2.6)

This more recent document uses the term "patient treatment records" and stipulates that such records must be retained for a period of seven years from termination. It is difficult to say from reading this statement whether art expressions are considered "treatment records" per se, or if they are, that they must be retained for the seven year period stipulated. The language seems noticeably vague, although it is reported to be compliant with laws that stipulate that records must be kept for a minimum amount of time (Braverman, 1995).

The issue of who "owns" client art expressions has come up in Ethics Committee discussions over the last several years. Legal counsel Braverman notes that the "recovery of art and treatment records, and the inability or refusal of therapists to return patient artwork. . . have been one of the more common areas of complaints to the committee on Ethics and Professional Practice (CEPP)" (p. 15, 1995). It seems that some art therapists have very definite feelings that the client owns the art created within art therapy, while others see the situation quite differently, preferring to retain the original work as a record of treatment. Braverman also notes, however, some art therapists feel strongly that the client owns the art made in therapy, "in many instances artwork constitutes a medical record" (p. 15, 1995). The legal implication seems to be that art therapists should keep records of art made in the course of therapy, preferably in a visual form.

Record-keeping involving art expressions (as opposed to descriptive notes on client art) in the form of slides, photographs, or photocopies or the actual artwork can be problematic. The difficulty with these strategies comes in determining not only how much photography or photocopying is legally required, but also how much is necessary and feasible. Consider, for example, those art therapists who see a great many clients; how to take and store photographs/slides of every piece that a client creates has boggled my mind on occasion, particularly when working with adults or children who have been abused, situations that necessitate accurate record-keeping. But there are other situations that can create problems for maintenance of complete visual records of client art. Fantasize if you will the hyperactive child who goes through a half-ream of computer paper, filling up an endless series of pages with scribbles. The groups I lead also give me pause in this regard, when there may be up to 15 people in a group, the physical machinations required to either photograph or store work for later photography is literally exhausting. In these cases, a real problem faced by art therapists is a cost-effective means of maintaining records of all art created in the therapeutic setting as well as the space to physically store such material.

Although the issue of ownership of client art may seem to be obvious to many art therapists, it is also fair to say that the issues of ownership are complex and that this is a topic that members should be actively encouraged to provide input on and be heard. Spring points out in a recent statement on ownership that what is legally required may in fact be different from our clients' as well as our individual ethical beliefs. In a recent issue of the *AATA Newsletter*, (1994) she notes the following:

> I do not believe the storage, retrieval and disposal of the clinical art record has had sufficient debate to make quick, uninformed

> decisions. The return of artwork to the patient, without any visual clinical record being kept by the therapist, has not been challenged in court. As art therapy becomes more widely used, and more artwork is brought into criminal and civil litigation, we will probably be forced to face the issue. A decision may be made for us by a judge or a jury. (p. 28)

The outcome of this dilemma may not only be rooted in medical regulations, but also may involve laws that effect artists and their works. (The latter is an area of law in and of itself; for more information see Duboff, 1993; Crawford, 1994.)

Additionally, in retaining client art in any form, we also have some more subtle aspects to consider. By definition, art therapists are characteristically more sensitive in how we view art expression and subsequently in how the client sees the art s/he creates. The latter is one of many ethical questions that we must ask ourselves with regard to the disposition of art made in therapy. A client's perspective may depend on many variables: the type of art therapy, the agency/facility in which the therapy takes place, the style of the practitioner, as well as the client's own view of art and art making. Children, for example, often have a difficult time perceiving art therapy as something other than an art class, although it has been explained to them that the purpose of the art activity is therapeutic (Malchiodi, 1990, 1991); this may hold true for some adult clients as well. Also, the type of task assigned to the client may have an impact on whether or not the art expression is important for the client to keep. When asked to do a projective drawing series such as drawings of a house, tree, and person, I have rarely seen a client who didn't realize that I might be using these art expressions in evaluation; they often choose not to keep these drawings. On the other hand, my adult clients with AIDS or cancer who are working on issues involving life review, grief, and death are engaged in making personal, meaningful art that they want to keep, share with others, or leave to someone as a visual legacy. Other issues that relate to the topic of ethics and artwork, but are too numerous to mention, include cross-cultural perspectives on art expression (Cattaneo, 1994) client abandonment of art (Moon, 1994), and a regard for images in general (McNiff, 1991).

As a profession, art therapists are possibly the only group that makes reference to art expression in their ethics document. Many health professionals (social workers, counselors, psychologists, etc.) use art directives in their clinical work with patients; however, ethical codes governing these professionals do not, to my knowledge, have rules about the disposition of art expressions. As registered, certified and/or licensed art therapists, we have made a special commitment to follow the ethical standards as set forth by the AATA to respect the art of our clients. We also must remember that those of us who are members of the AATA are bound by whatever our association determines to be the guidelines for disposition of client art. Spring (1994) and Neustadt note that if a decision is going to be made on this vital question, it should be a decision made by the members after there has been sufficient published debate. However, unlike the previous 1990 ethical code for art therapists, this newest draft was not voted on by the membership and was adopted by the AATA Board of Directors with the advice of legal counsel*. Despite this decision, the importance of this topic is one that all art therapists must continue to examine. Granted, an ethical code must be compliant with existing laws and regulation; most art therapists are not well-versed in these areas. However, we as a profession are knowledgeable about and dedicated to the importance of art in the lives of people, and as such, must continue as a group to explore the significance, meaning and impact of art expression in the lives of our clients.

***Editor's Note:** The AATA Board of Directors recently decided to send a revised *Ethical Standards for Art Therapists* to the AATA membership for ratification during Spring 1995.

References

American Art Therapy Association. (1990). *Code of ethics for art therapists*. Mundelein, IL: Author.

American Art Therapy Association. (1994). *Ethical standards for art therapists*. Mundelein, IL: Author.

Braverman, J. (1995). Retention of treatment records under the new AATA Ethics Standards. *AATA Newsletter*, XXVII, (1), pg. 15

Cattaneo, M. (1994). Addressing culture and values in the training of art therapists. *Art Therapy: Journal of the American Art Therapy Association, 11* (3), 184–186.

Crawford, T. (1994). *Legal guide for the visual artist*. New York: Allworth Press.

Duboff, L. (1993). *Art law in a nutshell*. St. Paul, MN: West Publishing.

Malchiodi, C.A. (1990). *Breaking the silence: Art therapy with children from violent homes*. New York: Brunner/Mazel.

Malchiodi, C.A. (1991). Using drawings in the evaluation of children from violent homes. *Family Violence & Sexual Assault Bulletin*, 7 (4), 14–16.

McNiff, S. (1991). Ethics and the autonomy of images. *The Arts in Psychotherapy, 18*, 277–283.

Moon, C. (1994). What's left behind: The place of the art product in art therapy. *Reflecting on the Past, Envisioning the Future* (p. 108). Mundelein, IL: AATA, Inc.

Spring, D. (1994). Who owns the artwork? *AATA Newsletter, XXVII* (4), 26–28.

Commentaries

Letters to the Editor

I am writing out of deep concern for the profession art therapy. I survived the conference intact only because I made a commitment to myself to speak my truth, and add my voice to the growing chorus of concern.

I am quite alarmed by the new ethics code as well as the process in which it was presented. A summary of this document was presented to the membership at a general session. No one had a copy of the completed document, and members heard for the first time astonishing inclusions that have grave implications for art therapy practice. When individuals expressed concern at the general session and at the membership meeting, they were told the document had been voted on by the Board without membership even seeing it first! I am absolutely amazed that the AATA Board could vote on such a document, even a draft, without extensive membership input and discussion.

I am committed to follow an ethical code that serves my clients. However, I do not believe this ethical code is in the best interest of my clients. I work with people who have AIDS. I have facilitated an art therapy group for people with HIV and AIDS for four years. Many of my clients have died. They gave the artwork they created to family members and partners as a lasting gift from their soul to be held, touched, witnessed, and cherished. Who owns the art? It is an irrelevant question. Art is an expression of soul. It belongs to the maker. I am not a collector of souls. I will not incur yet another loss for my clients or the significant people in their lives, a loss of their very rich imagery.

It was also stated that practicing art therapy in people's homes is considered unethical. Clearly no one on this Board is aware of an agency called hospice. For 2 years I was the grief counselor and bereavement coordinator for a hospice. I traveled all over the country counseling people in their homes, helping them come to terms with their lives, say good-bye to their loved ones, and die in their own homes. Often, I would use guided visualizations and supported breathing as well as extensive use of symbol and metaphor as clients faced their final hours. I would help family members communicate with their loved ones who slipped into symbolic language as death approached. By including a "no art therapy in the home" clause in our ethical code, we are denying therapy to populations art therapists can serve.

I believe decrees like keeping client artwork and not allowing art therapy in the home are unethical and not in the best interest of our clients. In the *AATA Newsletter*, Dee Spring stated, "Ethical standards are primarily based on legal ramifications of particular acts . . ." (Spring, 1994). I wholeheartedly disagree. Ethics and law are often in conflict. Martin Luther King in "Letter from Birmingham Jail" refers to ethics appealing to a moral law above the law of the state (King, 1969). The whole point of the civil rights movement is that ethics goes beyond the law of the state and is often in conflict with it. The entire civil rights movement was about a higher ethical code challenging immoral laws. Another chilling example of the conflict of ethics and law was elaborated by Hannah Arendt in *Eichmann in Jerusalem*. She stated, "Everything the Nazis did to the Jews was perfectly legal (according to German law at the time)" (Arendt, 1963).

The role of AATA is to protect the art and the diversity of our practice. We must protect the image from being a tool of litigation. As artists, we have the ability to envision a way beyond complying with the system.

I believe the AATA Board has lost a vital connection to the membership it serves. The business meeting could have been a rich opportunity to dialogue about these and other pressing concerns. I propose next year's business meeting allows ample time for open discussion about whatever concerns the membership needs to voice. I propose the Board use its best listening skills to witness and understand its members. I propose that the ethics code needs a great deal of dialogue and reworking before it is voted on, and that it is voted on by the entire membership.

Laurie Ellen Neustadt, MS, A.T.R.
Madison, Wis.

References

Arendt, H. (1963). *Eichmann in Jerusalem. A report on the banality of evil.* New York: Viking Press.

King, M.L. (1969). Letter from Birmingham Jail. *On civil disobedience: American Essays, old and new by Abraham Lincoln ... et al.* Chicago: Rand McNally.

Spring, D. (Fall 1994). Who owns the art? *AATA Newsletter*, 27 (4), 26.

I am writing this letter out of grave concern for what is happening to our association. Having attended every AATA business meeting since 1981, I have witnessed and experienced many heated, impassioned debates about policymaking. Our membership expressed itself, votes were taken, issues were decided, and the AATA Board of Directors, of course, implemented the policies which were passed.

Our business meeting in Chicago this past November was disturbingly different from past meetings. I left the meeting with a sense that the Board was being secretive, defensive, and not leveling with its members. Furthermore, the Board was exercising powers not granted to it.

I will be specific. A new ethics document was presented as a fait accompli. My recollection is that the previous ethics document was approved by a membership vote in 1990. The content of this new document, quite different from our previous one, was never presented to the membership for discussion because, it was explained, our legal counsel required ethics revisions to be made quickly. When Gladys Agell reminded the Board that at the 1993 business meeting the membership approved her resolution (Motion No. 11 passed by the Board) that any changes in documents be published in two newsletters preceding a vote, our president informed her that the Board had rescinded that decision. This I find truly appalling!

A Board cannot rescind an action of its membership, it does not have veto power! The Board of Directors is elected as an agent of its members. It is not empowered to make policy changes without consulting the membership. Agell's resolution reflects the action of the membership and is still in effect which means that the new ethics document, which the Board presumed to adopt without any authority from the membership, is, in fact, void. I believe that the Board owes us an explanation and an apology.

We need to remind the Board of Directors that their job is not to make policy, but to implement policy made by the membership. Our members need to be aware that anything done by the Board of Directors can be rescinded or changed at a meeting of the members (but not vice-versa!).

Carol Thayer Cox, A.T.R., LAT
Fredricksburg, Va.

I have many concerns regarding the certification issue. First is the implied negation of the competency of the professional membership of AATA, those who have by training, practicum, supervision, and recommendation achieved A.T.R. status. That the A.T.R. membership should be examined further to prove competency is ludicrous. Isn't this like "biting the hand that feeds you"? Regarding the New Mexico licensure procedure, it reads that those applying *after June 30th, 1994 will be required to take the exam.* **Not** those before June, 1994. In California, when the Board of Behavioral Science Examiners added an oral exam to the requirements for licensure, all MFCCs were not required to take the oral exam to further prove competency. I have difficulty understanding why the ATCB has grandparented (excused) the Honorary Life Members from the testing procedure. Are HLMs more competent as art therapists than A.T.R.s?

I also have a concern about the narrow scope of the reference list. The only Jungian text listed is the one written for the general public (of which Jung wrote little). His *Archetypes and the Collective Unconscious, Two Essays on Analytical Psychology, The Structure and Dynamics of the Psyche, The Practice of Psychotherapy, Psychology, and Alchemy,* to mention a few, are not listed, while Freud and Freudian works are generously represented. In Jung's volume on *Archetypes and the Collective Unconscious,* he has given our particular field the most extensive information on the Mandala as a symbol and its relationship to the process of individuation. In *Memories, Dreams, Reflections,* Jung reports on his extensive involvement in drawing mandalas and the insights he gained from that experience, resulting in the development of the process of individuation. Works by other Jungians are also omitted such as Marie-Louise von Franz on fairytales, von Franz and Hillman on Jungian typology, Hillman on archetypal psychology, Ann Ulanov on the feminine and Neumann on the great mother, to mention a few. Where is Joseph Campbell and his work on mythology? These works clearly relate to our field in imagery, graphics, art, and the process of art as therapy. Why are they not listed? I know some of these references were submitted. The analytical process and the process of individuation are represented in these texts and are as valid a healing process as that of psychoanalysis.

I know I am not alone in my concern and disappointment with the Certification Committee on its lack of recognition of the competency of Registered Art Therapists. Alienating the membership that supports AATA is not a good move. At this point in the game, it seems to me the only fair and correct action for the committee to take is to grandparent in all the professional members of the Association.

Lilliam M. Rhinehart, MA, A.T.R., MFCC
Santa Rosa, Calif.

After being in private practice for almost 20 years and a member of AATA since 1974, I feel betrayed. Suddenly, I find that A.T.R. is no longer sufficient for professional recognition and that the 20 years I worked in the field, pioneering acceptance of the tools of nonverbal and art therapy modalities, are not recognized as being sufficeint to qualify me to be "grandfathered" into the credential program. Without examining the merits and propriety of "grandfathering," or the gross inequities and pernicious result of a politically selective and highly subjective application of the concept, one recent editorial (Malchiodi, 1994) stated the following: ". . . grandfathering will be limited to a very select group of therapists." That is the essence of my feelings of betrayal. I do not question the achievements of the so-called select group, but I do take issue with the fact that years of clinical experience and pioneering do not count for certification.

In fact, the dismissal of "grandfathering" and the endorsement of such an approach by the AATA contradicts the very ideals long espoused in the pages of *Art Therapy.* For example, in another editorial (Malchiodi, 1993) Paula Howie is quoted as saying that art therapy teaching should encompass more than interpretation and techniques. She advocates the position that "excellence, courage and vision are necessary, for without these qualities we are indeed empty as individuals and as professionals. "The editorial further states:

> Although excellence requires high standards, energy, and perseverance, the question of courage is more difficult to address. Courage involves not only those qualities, but also added element of risk, honesty, and integrity . . . . (p. 3)

Indeed, these are the qualities needed when one leaves the nest of the learning program to enter the real world. It is the "courage" needed to be a pioneer art therapist in private practice in a somewhat unfriendly environment, to say the least; the "vision" in the future to sustain the lone art therapy practitioner; and the professional "excellence" necessary in order to prove not only the therapist but art therapy itself.

I seek no reward for courage and excellence, but merely recognition. I simply demand that my rights not be denied and that all I have accomplished for myself and for my profession not be stripped away by my own professional organization. As long as "honor for life" is an internal organization honor, it has place and is quite appropriate. Certification, however, is the credentials presented to the outside world, the arena in which my professional activities, and those of others in private practice, take place. An internal organizational honor, by its very nature being somewhat political, is certainly not a better indicator of worthiness for "grandfathering" status than 20 years of private practice experience.

While I was not active in the AATA, I consider myself as a pioneer in the field. I was the first art therapist in the Louisville area to open an independent private practice. Is this not comparable to those who were active in the political leadership arena or organizational level of AATA who are "honored for life" and are to get "grandfathered" into the credentials program? They well deserve the honor the recognition. However, they should not be excused when it comes to certification. It would not surprise me if most of them are, or were, affiliated with university teaching in one way or another where different criteria of excellence and performance are required. Research, publications, and conferences are not at the top of the list in private practice. It has a different set of priorities and requires a different kind of excellence and different courage. It also would not surprise me if those in our organization whose main work is in the academic/teaching setting are among the most avid proponents of the certification by examination with as few "grandfathered" exceptions as possible. No doubt that they will be in the forefront in the provision of examination preparatory classes and continuing education.

Ironically, over the years I have been "grandfathered" into several credential programs or certification for other professional organizations that were more tangential to my practice. Instead AATA suggests (a) that certification based on test results should take precedence over years of clinical experience; (b) that certification which ignores years of experience can conceivably produce a higher level of art therapists, and (c) that certification which ignores years of clinical experience could conceivably result in better acceptance of the discipline. Hardly! Examinations may have some limited value, particularly as a foundation on the entry level, but they cannot be a substitute for years of clinical application and experience.

I seriously doubt that political leadership in a professional organization is more deserving of "grandfathering" status than years of clinical experience. I question the fairness to the rest of us, their colleagues. Those of us who worked in hospitals, in mental health centers, and in private practice and struggled day-to-day for acceptance and recognition. For AATA to totally disregard all this, and to declare that I, and those like me, are not good enough unless we pass an examination, is not just unfair, it is simply outrageous.

Nira B. Riback, MA, A.T.R., LSW
Louisville, Ky.

References

Malchiodi, C.A. (1994). Sorting out certification. *Art Therapy: Journal of the American Art Therapy Association, 11* (2), 82–83.

Malchiodi, C.A. (1993). Reflections on the 1992 Annual Conference: Are courage and excellence enough? *Art Therapy: Journal of the American Art Therapy Association, 10* (1), 2–4.

Response to "A Note on Ethnicity in Humor and Art therapy"

I found this article to be tasteless, insensitive, racist, and on the peripheral of ethical accountability. It is difficult to believe that supremacist ideologies remain in the clinical arena under the disguise of humor, art, and psychotherapy.

I am appalled that the authors utilized the artwork of psychiatric patients to define the cultural norms of African-Americans. If this article was statistically sound, Mango-Hurdman and Richman would have shoddy data because it is unimportant that their clients are African-American or Hispanic. The authors also have erroneously utilized psychodynamic theory and applied this hypothesis to the global cultural view of African-Americans.

Humor can be a good interventive tool as a motivating technique and an anxiety reducer when used constructively. The viewpoints made in this article are dangerous and exploitative examples of the worst type of therapy. Ethnic jokes perpetuate stereotypical, racist ideology and should not be mistaken for sound clinical judgment to increase group cohesiveness.

I am shocked and saddened that the journal found this article worthy of printing. Shame on you! It is mandatory to have the Mosaic Committee so that art therapists of color can correct, educate, and be our own advocates to protect against writers like Mango-Hurdman and Richman. Since these authors continue to write about rappin and cappin, language within the Black community, I suggest they read "Assertive Black, Puzzled White" by Cheek, D. (1976).

Anna Hiscox, MA, A.T.R., MFT
Mosaic Committee, Chair

Responses to Anna Hiscox' Response to the Article, "A Note on Ethnicity in Humor and Art Therapy"

I was surprised to hear Ms. Hiscox' reaction to my article since it was written with the purpose of being more sensitive and empathic with culturally diverse groups. I would like to stress the point that the clinical examples presented in the article were all spontaneously generated by the group members. I in no way elicited the cultural material that was produced. Therefore, my clinical position was to utilize this material as important expressions of the client, which the client felt safe enough to draw or express within the group. Racial issues are potentially explosive issues in today's climate. However, they remain issues we must deal with in therapy if we are to treat the person in total.

Nothing to date has been written about art therapy with African-Americans or Hispanics, with a psychodynamic understanding. However, others have written or lectured about African-Americans, Hispanics, and psychodynamic theory. I would suggest the following additional readings: (1) Da Concecao Dias, C.G., De Lyra Chebabi, W. (1987). Psychoanalysis and the role of black life and culture in Brazil. *International Review of Pyschoanalysis, 14*, 185–202. (2) Holmes, D. (1990). *Race and transference in psychotherapy and psychoanalysis.* Presentation at the American Psychological Association. Boston, MA. (3) Stein, H.F. (1980). Culture and ethnicity as group fantasies: A psychohistoric paradigm of group identity. *The Journal of Psychohistory, 8*, 21–51. These noted authors and many others have inspired my clinical work, thinking, and writings.

It would be helpful for me to understand the "specifics" of Ms. Hiscox' viewpoints about the material presented. This could open a dialogue of communication to empower art therapists of diverse cultural backgrounds to work together with the good of the client our primary interest.

Christina Mango-Hurdman, MA, A.T.R.
New York, NY

I am happy to reply to the letter by Ms. Anna Hiscox, since the paper she is criticizing was not the one we wrote. In addition, we may have overlooked some of the salient features of the therapy. Chief among these is the fact that Christina Mango-Hurdman is a fantastically good therapist who is warm and caring and establishes excellent rapport with her patients. As a result, there was a firm therapeutic alliance in the group that she described. The patients felt free to express themselves openly, both in the art and humor assignments and in the discussions of the materials, knowing they would be understood and helped. The relationships between the different members of the group were positive and trusting. They felt comfortable with each other and with the therapist, and felt free to express their thoughts, needs, and wishes, as well as the roadblocks to their fulfillment.

The humor exercise, in which the participants were asked to tell a joke and to draw something funny, contained not the remotest hint of bias or direction, aside from the request to be humorous. Christina has many years of experience, and has included this integration of humor and art therapy with patients of every diagnostic category and every ethnic origin. There has never been any suggestion of prejudice in any of her work. She has demonstrated over and over again that the people she works with improve symptomatically and in their relationships with others.

It was not her idea or suggestion that the patients tell ethnic jokes. The patients told them spontaneously, in the same manner and therapeutic intent they told jokes dealing with work, sex, friendship, family relationships, and many other areas. These were discussed in our first paper on humor and art therapy and were not repeated in this one. Generally speaking, the most creative humor was offered by patients who were particularly bright, thoughtful, insightful, and mature. In many of the ethnic jokes and drawings, they were expressing the barriers in society that thwart their efforts to succeed and meet their goals. The humor and art therapy led to fruitful discussions of how to overcome these difficulties.

It is the nature of humor to expose the vices and ills of society. Clearly, to expose them is not to approve of them. The ethnic humor was an effective presentation of what is wrong with society, and the discussion that ensued centered around what the victims could do about it. They expressed the struggle *against* racism and bias, and there should be more presentations of such worthy efforts.

Therefore, Ms. Hiscox' statement that, "Ethnic jokes perpetuate sterotypical, racist ideology and should not be mistaken for sound clinical judgment to increase group cohesiveness," was irrelevant, since no one requested ethnic jokes and drawings. When they did appear, they were treated like all the other art and humorous materials—to increase understanding and, yes, group cohesiveness.

Joseph Richman, PhD
New York, NY

I am writing in response to your letter of October 17, 1994, regarding Christina Mango-Hurdman and Joseph Richman's Viewpoint, "A Note on Ethnicity in Humor and Art Therapy." There is much to be learned from your letter, your concerns are real. I had no idea, as I read the article, how a very subtle racism pervaded the text. Your letter opened my eyes to my blindness in this matter. Indeed, accepting this Viewpoint as presented does represent insensitivity toward the very cultural and ethnic stereotypes that the Mosaic Committee has worked so hard to change.

Neither the journal nor Mango-Hurdman and Richman intentionally, or consciously, presented damaging material. Nonetheless, because of our ingrained lack of racial perception, the damage was done. Your letter sensitizes us to the use of "the artwork [and jokes] of psychiatric patients to define the cultural norms of African-Americans." While Mango-Hurdman and Richman clearly state that the examples are taken from a culturally and ethnically heterogeneous group of patients, no inclusion is made of other patients' contributions. Further, a truly diverse presentation of humor and artwork would come from a representative sampling of patients from various cultural and ethnic groups, socioeconomic groups, professional groups, and so forth. If the focus is limited to African-Americans, it should include representatives from all levels of health and socioeconomic standing, and not the stereotypical disadvantaged blacks. At the least, the article needs to clearly state that this is not a representative sampling, nor is it meant to represent the larger group in all its diversity and nuances.

We make mistakes, but can we learn from them? This Viewpoint may be a good starting point for discussion of racial issues in art therapy. Juxtaposed with the responses, students in training and art therapy professionals can learn much about our hidden prejudices, blind spots, and passive acceptance of the status quo. Multicultural training must become an imperative task for art therapy educators and supervision groups.

Patricia St. John, EdD, A.T.R.
Associate Editor, *Art Therapy: Journal of the American Art Therapy Association*

Response to "*Art Therapy with Native American Clients: Ethical and Professional Issues*"

I am writing to comment upon the article "Art Therapy with Native American Clients: Ethical and Professional Issues" that appeared In November's *Art Therapy* (Dufrene & Coleman, 1994). I have three years experience working with Native American clients: two were on-reservation in a tribal-run health center. I support the authors' comments that entreat art therapists to be aware of the differences among

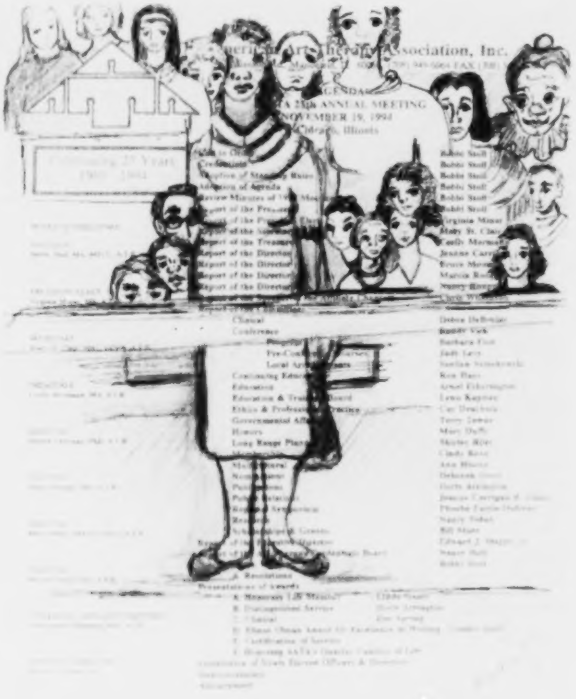
Native American people. Differences appear in language, dress, customs, ceremonial practices, traditional and nontraditional spirituality, and the degree of each tribe's acculturation. In my experience, there is often a nonexplored acceptance of the sterotypic depictions which the media have perpetrated upon us. Upon hearing that I worked with one Northeastern tribe, I received a number of comments from people who admitted that they, "didn't think about Indians being in this part of the country," and that most of their images or understanding came from Western tribes.

As we explore our assumptions and biases, I would point out that the art therapist may experience them in two ways: personal assumptions about Native American people that may be identified, and reverse-flowing assumptions that Native American people may have about non-Natives. I believe we must work dilegently to uncover and uproot these assumptions, as they impede our progress in working together. Here I must take issue with the authors' recommendation that, "It is preferable that art therapy be conducted by a Native American mental health professional." (Dufrene & Coleman, 1994, p. 192). Such a claim is unsupported by any studies that I know of, which show that the treatment outcome of Native American clients seen by Native American therapists is better than those seen by non-Native therapists. While the point is well taken that art therapists must pursue an understanding of the tribe they are serving, suggesting that only Indians can best serve Indians appears to be a segregationist viewpoint that stresses our differences, while ignoring the possibility of a good fit between client and therapist of dissimilar backgrounds. My most honored moments were experienced on the reservation when clients commented that I seemed "so Indian-like." This had to do with congruence, shared world view and empathic atunement; a color-blind perspective that celebrated our ability to understand one another despite dissimilar backgrounds. While on the reservation, I heard just as many clients express that they preferred not to see a Native American therapist, as those who did.

There is another important issue to consider. If Native American therapists see Native American clients of the same tribe, what about dual relationships? Many tribal communities are close-knit; often everyone is related somehow to everyone else. Can or should a therapist see a client who also is seen at pow wows, participates in the same sweatlodge, attends the same church or recovery group, and is one's friend, neighbor, or relative? If the Native American therapist is seeing clients from a different tribe, then the fact that Native peoples are not a homogeneous group must again be considered.

In my experience, multicultural work is a stretching, growth-producing, painful process as personal assumptions are uncovered and explored, reverse-flowing assumptions are experienced and worked through, and common ground is sought. This requires and challenges all of us to open our hearts and our minds, and reaffirm why we became art therapists to begin with.

Joy Moody, MEd, A.T.R., LCPC
Hampden, Me.



Untitled drawing by Helen Landgarden, A.T.R, HLM, Los Angeles, CA

THE AMERICAN ART THERAPY ASSOCIATION
25th ANNUAL CONFERENCE

Palmer House/Chicago, Illinois

NOVEMBER 16–20, 1994

November 16

Preconference Courses

Art Therapy Interventions for Children with Disabilities/*Frances Anderson*

The Diagnostic Drawing Series: Celebrating Ten Years of National Collaborative Research/*Barry M. Cohen, Anne Mills, Barbara Sobol*

Avoiding the "Paid Friend" Syndrome: Maximizing Your Effectiveness as a Psychotherapist/*James J. Consoli*

Work Induced Trauma and Experiential Debriefing for Therapists/*Molly Guzzino, Lucy Mitchell, Beverly Voss*

Journey Through the Expressive Arts: Illusions, Reflections and Possibilities/*Phyllis Frame, Linda Lee Goldman*

Empathic Imagination/*Mildred Lachman-Chapin*

Narrative, Externalization, Visualization: Current Trends in Family Art Therapy/*Shirley Riley*

Interaction with Imagery in Art Therapy: Introduction to Personal and Professional Use/*Robert Schoenholtz*

Neuropsychological Basis of Expressive Therapy: How Expressive Therapy is Represented in the Brain/*John Jones*

Supervising Art Therapists/*Kay Stovall*

November 17

Welcome

Bobbi Stoll, Virginia Minar, Randy Vick, Barbara Fish, Suellen Semekoski, Judi Levy

General Session

The Phantoms of the AATA: History of the American Art Therapy Association/*Harriet Wadeson, Sandra Graves*

Papers

An Art Therapy Response to Dealing with Natural Disaster/*Peggy Dunn-Snow, Donna Testa Ochipa, Janet Bush, Patricia Isis, Rebecca Taulbee*

Results of Recent Research Studies on Diagnosis and Art/*Linda Gantt, Carmello Tabone*

What do Attorneys Really Want? Art Therapists in the Legal System/*Sherry Lyons*

Sandplay Therapy and Personality Factors: Commonalities of Underlying Processes/*Vija B. Lusebrink*

Spirituality in Recovery: Overfunctioning Co-Dependent Private Practice Clients in the 90's/*Nancy Barett Chickerneo*

Art and Play Therapy in Sexual Abuse Treatment: Making Anatomically Correct Dolls/*Gussie Klorer*

Multicultural Assessment and Treatment Technique: Magazine Photo Collage (MPC)/*Helen Landgarten*

Invasive Art: Art as Empowerment for Women with Breast Cancer/*Cathy Malchiodi*

Children with Disabilities: Hard Data Research Trends over the Past Two Decades/*Frances E. Anderson, Candice Schilz, M. Kolano, Rey De La Cruz*

Essentials: Human Restoration Through Art/*Bruce Moon*

Poster Sessions

Everybody's Doing It: A Grand Celebration of the Arts/*Rose Marie Conway*

Gender Differences and the Creative Process/*Diane Kraynak*

Focus Groups

Lost in the Shuffle: Child Sexual Abuse Survivors in the Mental Health World/*Gail Roy, Victoria Polin*

The Diagnostic Drawing Series/*Anne Mills*

Ethical Concerns of Lesbian and Gay Therapists/*Debra Vetterman, Josie Abbenante*

Art Therapy in the Schools—Strategies for Implementation/*Janet Bush*

The Bridge Drawing Projective Focus Group/*Ronald E. Hays, Sherry J. Lyons*

Open Forums

ATCB Certification/*Joan Phillips*

Publications Open Forum/*Doris Arrington*

Student Orientation Session/*Mary St. Clair*

Regional Symposia Open Forum/*Phoebe Dufrene*

The Labyrinth: Art Therapists, Macro Systems and Ethnic Diversity (The Mosaic Committee Open Forum)/*Shirley Riley, Dianalee Skleen, Janet Smith, Charles Anderson, Janice Escobar, Anna Hiscox*

Papers

It's Not Fair! Art Therapy with the Grieving Child and Adolescent/*Patricia D. Isis*

Pediatric Art Therapy: The Nuts and Bolts/*Anne Präger*

Integrating Phototherapy Techniques into Art Therapy Practice—Comprehensive Overview, Including Case Illustrations/*Judy Weiser*

Making Sense: Art Therapy Groups for a Geriatric Dementia Population/*Kathleen Kahn-Denis*

Women and Art Therapy: Moving Treatment Beyond the Patriarchal Paradigm/*Ellen Speert*

The Children of Chernobyl: The Power of the Pictorial Message/*Leslee Pollakoff Goldman*

Pipes, Pimps and Prostitution . . . Dual Diagnosis in the Streets/*Patricia Prugh*

Portraits of the Artists: A Qualitative Study of Artists with Mental Illness/*Susan Spaniol*

A Picture of our Beginnings: The Artwork of Art Therapy Pioneers/*Margaret Sands-Goldstein, Holly Feen-Calligan*

Holding and Healing: Sandplay in the Ongoing Treatment of Dissociative Disorders/*Terri L. Sweig*

Images of Loss/*Katherine Jackson*

Reflecting on Process: Non Traditional Art Therapy Research/*Debra Linesch, Karen Lee, Jean Noble, Arleen Schneider, Elizabeth Yossem*

A Three Step Family Systems Approach for Assessment, Confrontation and Treatment Planning/*James J. Consoli*

Multi-Family Art Therapy Group with Schizophrenics/*Alison Gigl*

BEST COPY AVAILABLE

Realizing Archtypal Theory in the Real World Application of Art Therapy/*Debbie Simms*

Trauma to Well-Being: "The Recovery Scrapbook," A Record of Healing/*Daryl Hlavsa, Celeste Schexnayder*

Art Therapy and Transitional Phenomena in Addiction Treatment/*Renee Obstfeld*

Assessment Using Prestructured Images: A Collaborative Research Project/*Randy M. Vick, Billie S. Strauss*

Thirty Years of Art Therapy: Summing Up/*Don Seiden*

Panels

The Color Spectrum of Life: Art Therapy with Biracial Clients/*Anna Hiscox, Charles Anderson, Floyd Smith*

A Schizophrenic Woman's Treatment Through an Open Studio Approach/*Claudia Bader, Annette Hruska, Anne Reilly, Richard Lewitz*

Art Therapists: The Second Generation/*Myra Levick, Karen Levick Gomer, Doris Arrington, Chris Arrington, Irene Corbit, Sheryl Corbit*

Cauldron: Into the Pot with Thee!/*Cathy Malchiodi, Pat B. Allen, Mariagnese Cattaneo*

An Introduction to the Joint Commission/*Richard Scalenghe*

Workshops

The Belief Art Therapy Assessment: New Directions in Spiritual Art Therapy/*Ellen G. Horovitz-Darby*

Exploring the Effects of Pregnancy on Art Therapists as Clinicians and Supervisors/*Mercedes B. ter Maat, Ann D. Vandesyde*

Celebrating Differences: Learning to See by Looking Within/*Martha P. Haeseler, Lani Gerity, Andrea Ramsey*

Interaction with Imagery in Art Therapy/*Robert Schoenholtz*

Chicago Sampler

November 18

Master Supervision Groups

Adolescents/*Barbara Fish*

Art Therapy & the Elderly/*Drew Conger*

Art Therapy & Addictions/*Lynn Jones, Holly Feen*

Art Therapy & Eating Disorders/*Myra Levick*

Pediatric Art Therapy/*Robin Goodman*

Family Art Therapy/*Shirley Riley*

Short Term Art Therapy/*Cecily Mermann*

Adult Psychotherapy/*Cathy Moon*

Group Art Therapy/*Marcia Rosal*

Art Therapy & Dissociative Disorders/*Terri L. Sweig*

Slide Show of AATA Members' Artwork

General Session

After 25 Years the Beat Goes On: Introducing AATA's New Code of Ethics/*Cay Drachnik, Jeanne Carrigan, Jonathan Braverman*

Poster Sessions

Giving Voice to Image: Art Therapy with a Ritualistically Abused Adolescent/*Suzanne Bailey*

A Lasting Legacy: Photographs as Record Keepers/*Katy Tartakoff*

Monitoring the Course of Electroconvulsive Therapy (ECT) Using Art Therapy/*Carmello Tabone, Linda Gantt*

Drawing Away Hard Time: Art Expression by Senior Male Lifers-/*Marcia F. Taylor, Joan C. Castle*

Focus Groups

Lesbian, Gay and Bisexual Caucus/*Mary Brigid*

Pediatric Art Therapy/*Ann Prager*

A 25 Year Reunion: An Interview with Pioneers from the First AATA Conference/*Doris Arrington, James Consoli, Frances Anderson, Robert Ault, Don Jones, Sandra Kagin Graves, Myra Levick, Kay Martinez*

Open Forums

Continuing Education Credits Open Forum/*Ron E. Hays*

Affiliate Chapters/*Christine Wilkinson*

Education/*Arnell Etherington, Chair, Virginia Minar, Special Committee, Lynn Kapitan*

International Networking/*Patricia H. Grajkowski*

State Licensure/*Nancy Knapp*

Papers

Van Gogh to Beuys: Incorporating Art History in Art Therapy Treatment Plans/*Simone Alter Muri*

Children of Violence: Has Art Therapy Influenced Coping with Violence? What Lies Ahead?/*Beth Gonzalez-Dolginko*

Resonance and Cohesion in Art Therapy Groups/*Laurel Thompson*

I'm Not Crazy But I Have Been/*Jerry L. Fryrear*

The Dot to Dot Projective: Distinguishing Thought and Mood Disorders/*Ronald E. Hays*

What's Been Left Behind: The Place of the Art Product in Art Therapy/*Cathy Moon*

Take a Risk: Cultural Bias in the Therapeutic Profession/*Rose Marano-Geiser, Anna Hiscox*

From Downdall to Sanity/*Dee Spring*

Clinical Assessment of Children's Drawings and Stories Following a School Shooting/*Leslee Pollakoff Goldman*

Toward a More Inclusive Use of Imagery and Art in Psychotherapy/*James J. Consoli*

Group Art Therapy: What Do We Know and What Do We Still Need to Consider/*Marcia L. Rosal*

Visual Interludes: False Memories or Missing Pieces?/*Dee Spring*

Learning to Read the Visual Language of Pictures: A Structuralist Approach/*Barry M. Cohen, Carol T. Cox*

A Paradigm Shift: From Facilitating Spontaneous Expression to Developing Personal Symbol Systems/*Betty Jo Troeger*

Multiculturism and Art Therapy: Looking Back and Seeing Beyond-/*Abby Calisch*

Where Do You Draw The (Border) Line? Art Therapy with Borderline Personality Disorder/*Mary Belle Estman, Roberta Jonkers*

Panels

Inclusion Project: Opening Doors for Art Therapy in Public Schools/*Carmen Drew, Juneria P. Berges, Norma Castleberry, Susan Strickland*

The Multidisciplinary Treatment of Attention Deficit Hyperactivity Disorder Includes Art Therapy Groups/*Diane S. Safran, Frank M. Safran, Susan Finkelstein*

Breaking Through Barriers: The Advantages of Art Therapy in Forensic Settings/*David Gussak, Julie Cowie, Reid Dorwin, Nancy Hall*

The Professional Relationship: Ethics/*Gladys Agell, Linda Gantt, Robin Goodman, Katherine Williams*

Legal Issues: Can Art Therapists Stand Alone?/*Gail Wirtz, Nancy Sidun, Jean Carrigan, Harriet Wadeson, Susan L. Kennedy, Rose Marano-Geiser*

Workshops

The Box—A Versatile Video Tool to Increase Self-Esteem and Communication/*Karen Wakeley*

Hakomi and Art Therapy: New Paradigm Using Body, Imagery and Mindfulness/*Deborah Purdy, Barbara Cargill*

Back to the Future: Visions of Our Professional Identities/*Patricia D. Isis*

Photo Art Therapy: A Group Approach/*Irene E. Corbit, Jerry L. Fryrear*

Slide Making—Photographing Your Artwork/*Alexandria Elliot-Prisco*

Long Range Planning Committee Meeting with Chairs/*Shirley Riley*

November 19

Keynote Address

Reflecting on the Past: Implications of Prehistory and Infancy for Art Therapy's Future/*Ellen Dissanayake*

Poster Sessions

An Exploration of Women's Body Image Through Phototherapy/*Laura Faber*

Art Therapy to Enhance Self Expression with the Abused, Handicapped Child: A Study with Two Children from Different Cultures/*Do Hee Kim*

Individual Versus Group Art Therapy in Attention Deficit Hyperactivity Treatment/*Kate Cherrie Strazisar*

The Clothesline Project/*Mary Hamilton*

Focus Groups

Aids-Related Study Group—Sharing and Networking About Helping HIV+ Clients/Families/*Judy Weiser*

Doctoral Programs for Art Therapists/*Linda Gantt*

Failures and Wrong Thinking: Living and Learning/*Judith A. Rubin, Shirley Riley, Laurie Wilson*

Matter over Mind: The Rhinoceros/*Don Seiden*

Open Forums

Public Relations and Art Therapy/*Evelyn Virshup*

Student Subcommittee on Education/*Arnell Etherington, Rebecca Wilkinson*

Slidemaking—Photographing Your Artwork (Part II)/*Alexandria Elliot-Prisco*

Research Open Forum/*Nancy Sidun*

Ways of Elders/*Levne-Madori*

Papers

Research Curriculum: Evolution of Practical Applications for a Graduate Art Therapy Program/*Trudy Manning, Sarah Hite, Lynne C. Raymond*

Recipes for Success: New Programs in New Spaces/*Mary Krebs Smyth, Diana Nawrocki*

Humanity Behind the Offense: Group Art Therapy with Special Needs Sex Offenders/*Marcia L. Rosal, Joy Ackerman-Haswell, Laura Johnson*

Bump Wisdom: Drawing Out the Images of Pregnant Women/*Nora Swan-Foster*

HIV/AIDS: An Artful Retrospective with Images for Tomorrow/*Audrey Elkinson-Griff*

Documenting Our Story: Art Therapy History/*Joan Phillips*

The Creativity Mobilization Technique: In a "Drive-Thru" Environment/*Roberta Toby Pashley*

Creating Vacancy: Loss of Soul in the Workplace/*Linney Wix, Josie Abbenante*

The Severely Disturbed Highly Gifted Child as an Adult/*Edith Kramer*

Workshop

The Lion Roars and the Group Responds/*Arthur Robbins, Sandra Robbins*

Closing Reception and Dance for Dollars

November 20

Art Therapy Credentials Board Certification Exam

Art Therapy Films from the Archives

Films presented will be: *Art Therapy Beginnings, Brush with Life, Michael and Art Therapy*

Papers

Art and the Brain/*Don Seiden*

The Bridge: A Metaphor of Connection, Transition, and Transformation/*Julianne Hertz*

Sexually Abused Children and Their Drawings: A Composite List of Indicators/*Marcia Sue Liebman*

Infertility: A Silent Struggle Expressed Through Creativity/*Sita Isenstadt-Grossman*

The Open Art Studio as a Holding Environment for Adolescents in Day Treatment/*Carol Kiendl*

Homosexual Adolescents: Building a Bridge Towards Autonomy/*Susan Cydell Ombadykow*

The Kid with the Long Arms: Image Communication with a Lost Woman/*Trudy M.L. Maaskant*

Art Therapy with Adolescent Families/*Christine Kocen, Sarah Larson*

Finding the Hero-Heroine Within: Therapeutic Aspects of Inpatient Expressive Therapy Groups/*Connie Lichvar, Katie L. Voorhees*

Computers and Chronically Ill Children: Communicating with Images/*Kimberly Bush*

The Wounds of Sexual Assault: How Art Therapy Can Help Children Heal/*Marcia Marie Rock*

Staying on Track—Using the Train as a Structuring and Healing Metaphor/*Karen Wakely*

Alchemical Images and the Vision Quest: Into the Hell-Issues of Adolescence/*Inrid A. Von Brockdorff*

Drawings As Judiciary Aids/*Marcia Sue Liebman*

Panel

The Clothesline Project: A Feminist Vision of Art Therapy Work/*Katherine A. Meyer, Marian K. Lancaster, Suellen Hugan*

Workshops

When Is a Splitting Defense a Bridge to Reparation?/*Arthur Robbins*

The Double-Edged Image: Exploring Conflict Through the Poetry and Dance/Movement Therapies/*Lawaune Moorman, Alma M. Rolfs*

AATA FUTURE CONFERENCE DATES:

November 8–12, 1995
Town & Country Hotel
San Diego, CA

November 13–17, 1996
Adams Mark Hotel
Philadelphia, PA

November 12–16, 1997
Pfister Hotel
Milwaukee, WI

On the evening of Saturday, November 19, 1994
at the 25th Anniversary Conference of the
American Art Therapy Association
held at the Palmer House Hotel, Chicago,
Honorary Life Members, Past Presidents,
& other dignitaries placed items of
historical importance in this Time Capsule
as a gift to future generations of art therapists.

It is to be unsealed at the 50th Anniversary
Conference in the year 2019.

"TIME CAPSULE" Contributions

Ulman Memorial Issue of *American Journal of Art Therapy*
Gladys Agell, HLM (Past President)

Video Tape: "Courage! Together We Heal: Mural Messages from Incest Survivors"
Frances Anderson, HLM

Early AATA Board documents (Organizational documents, constitution and bylaw drafts); Menninger report on AATA progress; Buckeye Art Therapy Association address "The Silver Circle"
Bob Ault, HLM (Past President)

State of California Personnel Board Art Therapist Job Description (1972); Title 22 California State Health Regulations art therapist definition; California Marriage & Family Licensing Law
Cay Drachnik, HLM (Past President)

1994 Conference Proceedings "Reflecting on the Past, Envisioning the Future"
Barbara Fish (Program Chair)

Collection of documents spanning nearly 20 years of governmental affairs involvement
Linda Gantt, HLM (Past President)

Egg Timer (used to limit excess discussions at Board Meetings
Gwen Gibson, HLM (Past President)

Testimony for AATA to the Special Committee on Aging, U.S. Senate "Aging Artfully: Health Benefits of Art & Dance Therapy"
Robin Goodman (Past President)

Newspaper Article on University of Louisville MA Art Therapy Program
Sandra Graves (Past President)

First Art Therapy Certification Exam Candidates' Bulletin and Study Guide
Nancy Hall (ATCB President)

1st *AATA Newsletter* and, *Art Therapy: Journal of the American Art Therapy Association*, 1(1), "An Art Therapist's Personal Record"
Don Jones, HLM (Past President)

A History of Art Therapy in the United States
Maxine Junge (Author)

Original "*Art Therapy: Beginnings*" Film Flyer (1977) and *AATA Library Guide* (1978), Original AATA Poster (1980), Undeveloped film (for unfilmed/unpublished association contributors)
Georgianna Jungels (Past President)

Autographed 25th Anniversary Poster
Edith Kramer, HLM

Publishers flyers on her four books; Copies of historic photographs
Helen Landgarten, HLM

1st Art Therapy Graduate Training Brochure, (Hahnneman, 1967)
Myra Levick, HLM (Past President)

1994 issues of *Art Therapy: Journal of the American Art Therapy Association*
Cathy Malchiodi (Journal Editor)

"Art Therapy in the Schools" position paper; Distinguished Service Award article
Virginia Minar (President Elect)

1994 issues of the *AATA Newsletter*
Deb Paskind (Newsletter Editor)

Personal note to Judy Rubin from Janie Rhyne, HLM

Letter to Margaret Naumburg (1972); A video tape: "The Green Creature Within"; Button: "I Survived Artfully" (Received after 77–79 Presidency)
Judith Rubin, HLM (Past President)

1994 Local Arrangements items; Mayoral Proclamation
Suellen Semekoski (Local Arrangements Chair)

Shouts in Silence, catalog of Smithsonian exhibit of art by hearing impaired children
Rawley Silver, HLM

"Board Brush" autographed by the 1993–1994 AATA Board; *AATA Policy & Procedure Manual* (computer disc)
Bobbi Stoll (President)

1994 AATA Membership Directory (hard copy and computer disk)
Ed Stygar (Executive Director)

Time Capsule inventory; Robert Mondavi Cabernet Sauvignon 1989 for a celebratory toast by the 50th Anniversary Conference Chairs
Randy Vick (Conference Chair)

Guide to Conducting Art Therapy Research
Harriet Wadeson, HLM

HLM Award Acceptance

Linda Gantt, PhD, A.T.R.

Honorary Life Member awarded at the 25th Annual Conference of the American Art Therapy Association, Chicago, IL

Dr. Gantt's contributions to art therapy falls chiefly into three areas: teaching and scholarship, governmental affairs, and organizational work. She was an instructor at her art therapy alma mater (The George Washington University) for 2 years after her graduation besides being a field work and practicum supervisor for 5 years. For 13 years Linda was a visiting faculty member at Vermont College. She has lectured at a number of other graduate and undergraduate art therapy programs and at state and national art therapy conferences. Her first elected position in AATA was as the chair of the Publications Committee; when AATA launched its own journal in 1983, Linda was on the planning committee and served as the interim editor.

Art therapy literature has been a special interest for her. Most AATA members were introduced to Linda in 1974 when they received a copy of the annotated bibliography on art therapy that she and Marilyn Schmal compiled under the auspices of the National Institute of Mental Health. Linda was an editor for three Conference Proceedings, *the report of the American Psychiatric Association Conference on* The Use of the Creative Arts in Therapy *published in 1980, and the report of the Task Panel on the Role of the Arts in Therapy and Environment for the President's Commission on Mental Health in 1978. She has assisted with copy editing, layout, and desktop publishing for the* AATA Research Manual, *the* Continuous Quality Improvement Manual, *and the* History of Art Therapy in the United States. *Her original contributions include three chapters in the* Research Manual, *several articles in professional journals, and a rating scale to measure the correlation of formal elements in artwork with psychiatric diagnoses. She is currently serving on the Editorial Board of the* American Journal of Art Therapy *and was on the editorial board of* Art Therapy: Journal of the American Art Therapy Association *for 7 years.*

After she completed her Master's degree in art therapy, Linda was instrumental in organizing the Potomac Art Therapy Association and served as its first president. In this capacity, she also was the co-chair (with Susan Castellucio Michal) of the 1979 AATA Conference that had 1,000 participants. (This was when AATA did not have a national office handling the conferences.) Later, when she moved to West Virginia, she helped to organize the Appalachian Art Therapy Association. She served in a number of offices for both local chapters and AATA including a total of five terms on the AATA Board, the most recent positions being that of President and President-Elect. Some of the committees she chaired included Publications, Research, Nominating, Long-Range Planning, and a Special Committee to Review the 1983 Budget.

At the 1976 Conference, Linda made a motion to establish a committee that was to become the precursor to the current Governmental Affairs Committee. When the motion passed she was appointed the chair. It was from this committee and its liaisons with dance/movement therapists, psychodramatists and music therapists in the Washington area that the Legislative Alliance of the Creative Arts Therapies (LACAT) evolved. The National Coalition for the Arts Therapies Associations (NCATA) grew out of these legislative efforts. In 1992, Linda was the coordinator for the art therapy part of the U.S. Senate hearing on art and dance during the reauthorization of the Older Americans Act. She has always been committed to collaborative work and in that spirit she has been serving as the coordinator of Federal legislative activities for NCATA.

Feeling she needed additional training for the research and theoretical work she wanted to do, Linda went back to school to earn her doctorate in interdisciplinary studies at the University of Pittsburgh. Since finishing her doctorate in 1990, Linda has been working with Carmello Tabone at West Virginia University to extend her research on the correlation of artwork and diagnosis.

Colleagues, former students, friends . . . my sincere thanks go to Cay Drachnik and Virginia Minar for nominating me, to the Honors Committee for selecting me, and to you, the AATA membership, for voting for me. I consider it especially symbolic to be given Honorary Life Membership this year as AATA celebrates its 25th anniversary, since this year I am two times 25 years old and celebrating my own personal milestone. But I think this award is also symbolic in that I believe that I am the first person to receive an HLM who has a Master's degree specifically in art therapy. So, I represent those generations of art therapists who, instead of inventing art therapy on their own, have had someone else to blaze the path.

While I was not at the organizational meeting in Philadelphia or at the first conference, I did make it to the fourth conference held in Columbus, Ohio, in 1973, and to the Boston meeting of the American Society of Psychopathology of Expression in the same year. It was at the Boston meeting that I got my one and only glimpse of Margaret Naumburg as she received an award from that organization.

By my reckoning, I am a member of the third generation of art therapists. I count it my great, good fortune to have had as my teachers Elinor Ulman, Edith Kramer, and Hanna Yaxa Kwiatkowska. But my getting into the first class of the Master's program at The George Washington University was the end of a long chain of events which began at North Texas State University in Denton, Texas, when I was an undergraduate with a major in sociology and a minor in history, and bent on eventually becoming a social worker. A friend wanted me to take a painting class. She said she needed psychological support and asked me to enroll with her. After fighting the long registration lines, I finally got the last place in the class. The next day, much to my distress, I learned my friend had been unable to get in and I found myself quite alone as one of only two students who were not art majors.

Having decided to get a second minor in psychology, I took a class in abnormal psychology under Dr. Meryl Bonney. Dr. Bonney stated categorically that one could learn more about the human psyche from the arts than from any psychology textbook. To support this contention, he permitted his students to substitute a wide variety of projects such as paintings and poems on psychological themes for the usual spate of library papers. Our textbook for the course had some drawings by psychiatric patients. The end papers were full-color reproductions of plates from one of Ainslie Meares' books. They showed paintings by a patient who was, at first, unable to speak to her therapist because she was so disturbed. But she communicated through the art she brought to their sessions.

On Dr. Bonney's reading list was an article by Elinor Ulman and a book by Margaret Naumburg. This was in 1966, mind you. (I confess I do not recall having read either of them then.) But the idea of combining art and psychology was planted in my mind. Three years later, while I was living in Washington, D.C., a friend suggested that we take a class in art therapy together, and I readily agreed. You might guess what happened—I signed up and my friend did not. Again, I was alone in a situation not of my own making. The Washington School of Psychiatry sponsored the class and Elinor Ulman taught it. The next year, I took another class with Elinor. She had a heart attack and Hanna served as a substitute instructor. During one session Bernie Levy walked in and asked how many of us wanted a Master's degree in art therapy. He said that if he could get enough people to convince the Dean that it would be viable, the university would start a program.

It was only a little while later that I realized how much work there was to be done in the Association and how easily one is roped into doing it. I started my work in publications as an apprentice to Millie Lachman (now Lachman-Chapin) who was then the editor of the *AATA Newsletter*. We had seen each other at a lecture at the Smithsonian Institute, and she called the next week to ask me to help her with the *AATA Newsletter*. At the 1977 conference in Virginia Beach, I made a motion to establish an ad hoc committee on lobbying and Federal job classification (which eventually turned into the permanent Governmental Affairs Committee). After the conference Don Jones, who was then President, called to ask me to chair it.

Being selected for this award has given me the opportunity to reflect on my past as well as the Association's and to think how the field has grown and I along with it. But I want to speak to you about the future. We will not have to wait another 25 years to see whether art therapy remains a vital enterprise and an independent discipline. I think our collective fate will be decided in the next 5 years. To ensure that our future is a relatively happy one, I make an earnest plea to the generations that follow mine. I have no doubt that the powerful idea of combining art and therapy will outlive us all. But I am speaking to the group from which future awardees will come—the Clinicans, the DSAs, and the HLMs. I am making an earnest appeal to you to apply your best efforts in those three areas in which I have had the greatest interest and have applied most of my energy—publications, research, and governmental affairs. Relatively speaking, not many of our members are involved in these pursuits, but I am convinced that this is how we will secure our future. Each of these areas requires considerable effort for, as a group, we are more visual than verbal, more emotionally attuned to our patients and clients than research-minded, and more interested in being alone in a studio absorbed in individual creative pursuits than in the tough and sometimes brutal world of political action. Our publications must meet the standards set by the other well-known and older disciplines; our research studies must be rigorous; and our advocacy work must represent us to policymakers at both the state and Federal level.

It is ironic that we live in a time when the amount of information available to us is unprecedented, and yet there seems to be a backlash against empirical research, rational thinking, and knowledge in general. Our hybrid discipline is both art *and* science, and we must keep it that way. Our task is paradoxical in that it is both easier and harder to be an art therapist in this generation than in the ones that preceded us. Do not be afraid of controversy and debate as long as it is centered on ideas and not personalities or factions, but strive for high standards in all that you do.

I have found art therapy to be intellectually challenging because there are so many unanswered questions and emotionally fulfilling because of the many friends and colleagues I have met so far. As my friend Paula Howie said on a panel at an earlier AATA Conference, I would not want to be anything other than an art therapist. So, my heartfelt thanks go to my teachers whose accomplishments paved the way, to my students whose questions prompted me to learn more, and to all of you for considering me worthy of this honor. I am very grateful.

DS Award Acceptance

Doris B. Arrington, EdD, A.T.R.-BC

Doris Arrington is a Professor and the Director of the Art Therapy Program at the College of Notre Dame in Belmont, California. In addition, she is a National Certified Counselor, a licensed clinical psychologist and a clinical mem-

ber of the American Association of Marital & Family Therapy. She has a long history of working within the San Mateo County mental health system. She serves as a clinical consultant to a variety of agencies in the San Francisco Bay area.

Dr. Arrington has been a visiting professor at many colleges and universities. She has presented at AATA national conferences since 1979. In 1976, she co-created with Drs. Evelyn Virshup and SueAnne Eslinger Foster a major national art therapy exhibit. She has sponsored art exhibits by art therapists in the Bay area, students and alumni of the College of Notre Dame, and most recently, Edith Kramer, A.T.R., HLM, and Robert Ault, A.T.R., HLM. She continues to work as a sculptor and painter.

Dr. Arrington has published in The Arts in Psychotherapy *and* Art Therapy: Journal of the American Art Therapy Association. *She has chapters in the* Guide to Research in Art Therapy, California Art Therapy Trends, *and* Art for All the Children.

Dr. Arrington has served on many state and national committees and boards. On the state level she served as secretary in 1978 and president of the Northern California Art Therapy Association from 1979–1983 and was awarded the HLM in 1984. On the national level she served on the Standards Committee and later chaired the Western Division of the Registration Qualifying Board as well as the Nominating Committee. She was elected to the AATA Board of Directors in 1987 as Standards Chair. She was re-elected as a Director-at-Large in 1989 and 1991. She served until 1993 overseeing the Certification, Scholarship, Membership, Mosaic, and Publication committees. She was appointed as an iterim board member of the Art Therapy Credentials Board. She has served on the Editoral Board for Art Therapy: Journal of the American Art Therapy Association, *as a member of the AATA Regional Symposium Committee, and as Chair of the Publications Committee. In 1980, she received one of AATA's first research grants and since that time she has supervised art therapy grants in medical hospitals, state facilities, family service agencies, battered women's services, VA hospitals, and local school districts and colleges.*

A decade or so ago, as President of the Northern California Art Therapy Association, I sent Standards Chair Shaun McNiff a letter, telling him that California was too big and too diverse to have just one Standards Representative. His response was to be my future managerial model. *Ring, Ring.* He appointed the complainant to the task. That was the beginning of my professional life with AATA.

I am deeply honored to be chosen in this 25th anniversary year as the recipient of the AATA Distinguished Service Award. Today, I want to thank the Honors Committee, the AATA Board, and you, the members of AATA, who have elected me or appointed me to Boards and Committees in AATA.

Next, I would like to thank my number one support, my lifetime friend and husband, Bob, who answers the phone when many of you call. *Ring, Ring.* He and I learned a long time ago that by serving each other and others we were actually taking care of ourselves and we believe our three sons have picked up that little gem. I would like to introduce you today to my youngest son Christian Arrington, a school psychologist in Oakland, California and a soon to be art therapist.

Service is all about getting and giving support from and to relatives, friends, staff and co-workers, students, and clients. In the College of Notre Dame Program we teach art therapy that builds on Trust, Cooperation, and Support. I have been blessed to live and work with people who adhere to those three principles, and I greatly appreciate our continuing associations. So thank you Dr. Arnell Etherington and Dr. Richard Carolan, Jeanne Weir, Cay Drachnik, Dr. Frances Anderson, Mari Fleming, and Sr. Mary Duffy, as well as our visiting faculty, many of whom are here today.

The good news is serving AATA means that you get and give support to new acquaintances throughout the country. The bad news is your phone rings all the time. *Ring, Ring.* The good news is your life is challenged and enriched by your new circle of friends and acquaintances. The bad news is you have no time to enjoy them. *Ring, Ring.*

Webster says service is the performance of labor for the benefit of another, a duty done, or even spiritual serving as shown by obedience, good work, and love, as dedicated to the service of God. I can buy into all of the above. The volunteers that I know who serve or have served AATA do so because they believe the work of our Association is important. They come together to engage in the beauty of, and the struggle to, the service of AATA, or as Harriet and Sandy said yesterday, Conflict vs. Cooperation. The volunteers bring portfolios of professional skills and experience to accomplish the goals set by our Association. They soon find that they must leave personal agendas, excess baggage, and inflated or fragile egos outside of the Committee or Board room and take in commitment and flexibility. When the job is completed they have collaborated, negotiated, shared, discussed, maybe cussed, but definitely sacrificed. If they are lucky, they have learned to let go and forgive so that they can celebrate their accomplishments and grow from their failures. The process itself often creates a sense of trust, cooperation, and support for those involved.

Those that risk also risk criticism. However, if we refuse to risk and grow, life loses its meaning and we get lost. About the time I was first becoming an art therapist, our family was transferred to San Francisco. After five generations and 30 years of living in Texas I felt like Dante wrote in the Divine Comedy: "Midway in life's journey I was made aware that I had strayed into a dark forest and the right path appeared not anywhere." I don't transplant well. During the next 4 or 5 years in California as my roots sunk deep into the environment, I drew, sketched, etched, and painted roots, branches, trunks of trees, perhaps 200 or more in all. At one of Jayne Rhyne's workshops in the Santa Cruz mountains, she had us make a lifeline, and it was no surprise that mine turned out to be a tree and I had a significant paradigm shift. My art had been caring for my soul by making a home for the tree images as they transformed my life.

Today, imaging provides me with the light I need to see the path so that I can go deeper into the forest and meet and make friends with creatures that live there. Using art therapy, I have been honored over the last 20 years to be able, on occasion, to light forest paths for both students and clients by providing, as Hillman notes, safe spaces to explore valid images and serious rituals for the sake of the soul.

Today, I am as excited about art therapy as I was when I first understood what it was all about. Serving AATA provides

BEST COPY AVAILABLE

me with the opportunity to give back to a profession that changed not only my direction, but possibly a few others'.

Ring, Ring, Whoops, there goes the phone again. Hello. Oh, this time the AATA wants you. Thank you again and carpe diem. (For this speech, the *Ring, Ring* was a tape recording that I played of my telephone ringing.)

Clinical Award Acceptance

Dee Spring, PhD, MFCC, A.T.R.-BC

Dr. Dee Spring, an art therapist for 20 years, is recognized internationally for her treatment of sexual abuse and dissociative disorders. In 1973, she designed, implemented, and operated the first rape crisis center to specialize in art therapy for crisis intervention and treatment of sexual trauma victims. She was presented with the American Art Therapy Association's Research Award in 1978 for her pioneering research in this area. She served on the Board of Directors from 1985 to 1989 as Treasurer; designed, implemented, and served as the first Chief Instructor for the Regional Symposia Program (1985–1993), and served on various committees from 1982 to 1994. She served as the Conference Program Chair (New Orleans) in 1985. In 1985, she presented the idea of Study Groups to meet at the annual conference on specific topics and hosted the first one on sexual trauma and symbolic language. She was the founding Treasurer of the Sierra-Pacific Affiliate Chapter of AATA in Central California. She completed empirical research on the artistic symbolic language of sexual trauma victims in 1987. In 1988, she founded the first study group in the United States on Art Therapy and Multiple Personality Disorder to be affiliated with the International Society for the Study of Multiple Personality and Dissociation. She served on the Board of Directors (1985–1987) of the California Society for the Study of Multiple Personality and Dissociation and presently serves as the Society's President (1993–1995).

Her history as an artist includes being a dancer and vocalist. She began focusing on the visual arts in 1966. From 1968 to 1978, Dr. Spring exhibited her artwork which included painting, sculpture, and weaving. Her specialization in the art field is batik. She won several awards for her paintings, sculpture, and batik. In recent years, she has focused on literary and oratory art rather than the performing or visual arts, but is currently renewing her interest in sculpture and design.

Dr. Spring currently conducts a busy private practice as the Executive Director of Earthwood Center which is a specialized treatment center for sexual trauma and dissociative disorders. She is also a part-time professor at the University of California, Santa Barbara (1988–1994) where she designed and instituted a post-Master's art therapy program in 1993. She has received many recognitions and awards over the years, recently being cited in the International Who's Who of Professional and Business Women. *She is the author of* Shattered Images: Phenomenological Language of Sexual Trauma *and* Image and Mirage: The Visual Language of Multiplicity. *In addition to these publications and her dissertation,* Sexual Abuse and Post-Traumatic Stress Reflected in Artistic Symbolic Language, *she has authored two training manuals, articles and book chapters, as well as given oral presentations about her specialized work on the international level. She has been a presenter at AATA's annual conferences since 1982.*

For all of you who know me well, I must say this award was a shock! Quite frankly, I didn't know what to do with it, or what to say about it. I figured the Honors Committee had run out of names. Then I discovered that it only has been given twice before. Guess that makes it very special. I thank all of those who were involved in giving me this honor. Thanks for your consideration and respect. It has been a bit of a struggle to get to this place, and it's only taken 20 years. Now, I have 2 minutes to tell you about it!

I remember the other award I received from AATA in 1978. I was shocked then too. This award was for my research for treatment of sexual abuse using art therapy and the consistent forms which showed up in this population's art expression. Unfortunately, the Research Committee forgot to notify me and I didn't show up! During this conference in Los Angeles, I got a call from Gary Barlow wanting to know where I was. He was not happy with me. It was with this telephone call that I learned about the award. Gary met me in a dark little room in the basement of the hotel and gave me a $50.00 check. Today is very different, we have lights! I remember attending Myra Levick's presentation at this conference. She inspired me to teach what I had learned about this population's drawings.

The years have been filled with both wonderful and exasperating times in AATA. I learned to laugh often and much, and to win the respect of intelligent people. I learned about earning the appreciation of honest critics, and how to endure the betrayal of others. I remember being elected Treasurer and learning that we were $35,000 in the red and close to bankruptcy. I remember meeting Ed Stygar for the first time in Chicago in 1986 when I was attending another organization's conference. I found this strange man kneeling by my chair. We then had a meeting about AATA's finances in a dark restaurant! There must be something about lights and AATA! I got the job of being the heavy-handed treasurer, but we made it, and look at us today, a reserve account of half a million dollars.

Aside from the memories and business of AATA, what is important is what I've learned in the clinical realm of art therapy about being a pioneer in the area of traumatic and dissociative disorders since 1973. I have had extraordinary opportunities to observe this population and learn how to manage the most difficult of cases.

I learned about emotional pain, dramas of protection, memories forgotten, and fractured identities. I learned about living and re-living terrible moments, dealing with injustice, and managing incredible pain. I learned about trust and honesty, divided loyalties, deceptions, trickery, and nefarious people who harm the young. I learned about betrayals, ambushes, masquerades, and the fallacy of vision, both the patient's and mine. I learned about incredible journeys of the mind, and the nature of the human spirit to survive, adapt, grieve, and move on to the next stage. I learned about tragedy and triumph, war and peace, collapse and transformation. I learned about portraits of trauma, the reality, not the magical rescue. I learned about walking through shadows and dungeons that dampen the spirit and numb the psyche. But most of all, I learned about courage and determination to distinguish image from mirage.

I thank you.

1994 Keynote Address Reflecting on the Past: Implications of Prehistory and Infancy for Art Therapy

Ellen Dissanayake, Edinburgh, Scotland

Introduction

The past I intend to reexamine today is one that is much older than the past of the field of art therapy. In fact it goes back to the very beginnings of ourselves as a species. Such a long view is usually taken only by palaeontologists or zoologists, and you may well wonder what it can contribute to your field, which is concerned not with ancient fossils and dusty remains of dwelling sites but with flesh and blood humans and their warm, messy emotions, conflicts, and needs. I hope to suggest, however, how this 4 million year old past, as reconstructed today by evolutionary psychologists, does pervade and affect the present.

Another past I will refer to is much more short-term (and much more familiar to you as therapists and parents). That is the past we all share: infancy. Understanding something of these phylogenetic and ontogenetic pasts will, I hope, contribute to envisioning new ways to think about art therapy's future.

First, let me introduce myself. As some of you may know, my particular subject of interest is the arts and their place in human life. I began as a conventional student of Western art history, and accepted all the usual ideas of the field as it was in the 1960s—that art was a specialized activity of making "works of art," practiced by a talented few ("artists") who had responded to a kind of calling and thereby created an avenue to transcendence and spiritual insight for the rest of us, who in our spare time went to look at their works in museums and learned to understand them from classes and books.

In 1970 I married a Sri Lankan and for the next decade and a half lived in several non-Western countries—Sri Lanka, Papua New Guinea, and Nigeria. As a result of this exposure to other ways of life, my ideas about art and indeed almost everything began to change. By the time I returned to the West in the mid-1980s, with a book that I hoped to find a publisher for, I discovered an art climate that was also very different from the one I had left some 15 years earlier. My book, *What is Art For?*, was published in 1988, and after it appeared I discovered that it had relevance to two new "isms" that I hadn't even known about when I wrote it: multiculturalism and postmodernism.

Like adherents of these positions (which of course overlap), I claimed that there was more to "art" than what was now referred to as the Western high art tradition. Also like them, I wished to broaden the concept of art to include process, performance, and relevance to life. Influenced by the non-Western societies I had lived in, I thought it was important to recognize and value the multiplicity and variety of other cultures' ways, including of course their arts.

In some important respects, however, my ideas varied from the postmodern, multicultural West, and it is in these differences that I think my ideas' relevance to art therapy lies. Unlike both multiculturalists and postmodernists, I claim that while human *cultures* may be *multi-*, or many, humans as a *species* are alike in a number of important underlying characteristics and are in this sense one. Thus, while multiculturalists and postmodernists stress relativism and difference, I stress universalism and similarity.

My second book, *Homo Aestheticus*, maintains that humans are by their very nature aesthetic, and that as a species we deserve to be called "artistic" as much as *sapiens* or "wise." In other words, underlying all the manifold arts in the multiplicity of human cultures, humans are alike in making and valuing the arts.

Such a position requires a knowledge of evolutionary biology, and it is here that I part company with every postmodernist or multiculturalist that I have met. For there is a sort of reflex or "knee-jerk" antiscience bias, and especially an anti-Darwin bias, among almost everyone today, from the most politically correct to the most fundamentalist and bigoted right-wing fanatic. Science and evolution are blamed for everything from war, racism, and acid rain to abortion and godlessness. I will not defend Darwinism here today, but I do mean to show where I think an enlightened examination of our evolutionary past is the best way to begin to envision a humanly satisfying future for everyone, and that includes the field of art therapy.

Before going on to describe my view of art, I want to say a bit more about this evolutionary starting point.

Species-Centrism

Sometimes when I describe my general perspective I have used the term *paleoanthropsychobiological*. It sounds flippant or pretentious, but really encapsulates what I mean. Another term, which sounds serious but dull, is *species-centrism*. It correctly suggests that my view is neither culture-centric (which most views are, derived from the individual's own culture with which he or she is familiar) nor self-centric (which is another frequent tendency, generalizing from one's own personal abilities or biases, that are of course culturally influenced).

A species-centric or paleoanthropsychobiological view regards humans from the vantage point of prehistory (*paleo-*, paleologically), as well as cross-culturally (*anthro-*, anthropologically), individually (*psycho-*, psychologically) and, embracing all these, from an ethological (*biological*) viewpoint. While such a position no doubt arises out of Western culture, it tries as far as possible to be aware of and to avoid parochialism.

The word *ethology* may be familiar to some of you already from the work of the pioneer art therapist Edith Kramer (e.g., 1977, 1979, 1992) and her former student, David Henley (e.g., 1992, 1994). It refers to the biology of behavior. Ethologists are concerned with the normal behavior of animals, including humans. A behavior in a species is an inherited predisposition to act in a certain way in certain circumstances. All members of the species have the tendency or the potential to perform that behavior—it is part of their "species nature." For example, it is part of canine nature when meeting another dog to greet one another by sniffing head and rear, or to mark one's territory if one is a male by lifting a rear leg—whether the dog is a St. Bernard or a chihuahua.

A human ethologist, like myself, then, wishes to discern what inherited behavioral tendencies and needs are universally present in humans by virtue of their common *human* nature, apart from (or "beneath") their individual differences and particular cultures. For example, while African babies are carried on their mothers' backs in wrappers, Navajo babies are swaddled on cradleboards, and North American babies are whisked around in strollers and carseats, *all babies* have the need for developing and sustaining a predictable social relationship with their caretakers and tendencies to behave in ways that will assure that these needs will be met (i.e., they cry, smile, and otherwise compel their elders to respond to and care for them). Crying, smiling, holding the arms out in order to be picked up, and so forth are evolved behaviors, and during human evolution babies who did those things survived better than babies who did not, thus passing on this trait to their offspring.

Similarly adolescent boys and young men may go out hunting together for game, or raid nearby villages for women and other booty, or be inducted into the armed forces and fight in wars, or play team sports, or form neighborhood gangs—but all seem to have an easily encouraged behavioral tendency to join and bond with other males in groups and perform dangerous and exciting physical activities together. This behavioral tendency was adaptive in hunting societies where young active males joined together to hunt and kill for the livelihood or defense of their group.

Obviously, many human adaptations that were valuable in our hunter-gatherer days (which was 39/40ths of human existence) are maladaptive today. We live in a world very different from that in which our behavior evolved, *and* our emotions—which are what motivate us to behave (or not behave) in certain ways. At the same time, many aspects of this present world are incongruent with our nature. As therapists who deal with people who are maladapted to modern society, it is a good idea to understand that people tend to behave in ways that would be more appropriate in small-scale, face-to-face societies, or they respond inappropriately to modern life because much of what they need is not found in the kind of world we live in today, or that world requires them to do things that many humans are not easily predisposed to do. I know of one book for general psychotherapy that is written from this viewpoint, *Exiles from Eden* by Glantz and Pearce. I recommend it for an introduction to what may be a new perspective for art therapy.

Art and Human Nature

My particular species-centric interest is not in infant attachment or male bonding, but rather in the arts, or art in general. Using paleo-, anthro-, psycho-, and biological evidence I want to show how we can consider art as a common universal human tendency or need. I'll begin by looking first at *making*, using evidence from infancy and childhood, as well as paleontology.

Homo faber

It is well known that the earliest cultural artifacts of our hominid ancestors were stone and then bone tools—implements used for obtaining and preparing food and other of life's necessities, such as scraping skins to use for shelter and clothing, fashioning utensils and vessels, and making weapons. It is now believed that among the advantages of walking upright is that the already dextrous and flexible primate hand was left free and could be used for other things—to carry, to make gestures, to make tools and, unlike other animals, to use tools to make tools.

This adaptation is quite evident in infant development. Both monkey and human fetuses make reaching and grasping movements in the womb, but the human baby is born with incipient hand movements that presage its future life as a tool user and communicator par excellence. Newborns can see much better than was earlier suspected, and they make pre-reaching movements in the direction of objects that their eyes track. Around 4 weeks, babies begin to be truly sociable, responding to others' faces and sounds with social expressions and sounds of their own. Their hand movements become expressive, like conversational gestures, and pre-reaching towards a "target" temporarily declines. By 2 months these gestures have characteristics of speech: temporal patterning, emotional dynamism, and direction toward others.

But along with using its hands communicatively, a baby's drive to master the skills of tool use reasserts itself, with increasing control and coordination. In the human brain there are different paths for perception (that is, for information coming in through the senses) and for acting on the world. The baby's coordination of eye and hand (that is, his or her visual perception and motor activity) is developed first by practicing bringing his or her hands in contact with each other, then reaching out more successfully and precisely to things in the outside world, and ultimately truly grasping them.

Once babies can reach for, aim at, and grasp objects, they investigate them with mouth, tongue, and lips. Because of their importance to feeding, these have been the first action or motor areas to develop in the cerebral cortex. In fact there are twice as many nerve-endings there at this stage than in the fingertips. (It's understandable that even as adults when some of us are concentrating on a precise motor activity like threading a needle or writing, our lips or tongue may make small movements.)

Reaching, grasping, and investigating by eyes, hands, and mouth are repeated again and again, allowing us to learn not only about how things in the world look, taste, smell, sound, and feel, but also that our actions can have an effect on them. As I said, these sensory perceptions and motor skills from the very beginning have reciprocal beneficial effects on cognition. For example, at first we can only release our grip accidentally, but when we achieve the coordination to let go deliberately, dropping objects becomes as enjoyable as grasping them was earlier. Not only do we have an effect on the world, we can *plan* (to drop) and *predict* (someone will pick it up and hand it back), and these cognitive pathways in the brain become more developed. Subsequent developmental stages of motor activity include using the precision grip of opposable thumb and fingers (which is unique to humans, as is our rotating wrist) and our improved eye-hand coordination all together.

Manipulation (the word *manus* means "hand" in Latin) also is developed in person-person-object games, where babies and their partners hand objects back and forth and do things with them. Rhythmic banging is synchronized with syllable babbling at 6 months, indicating the inherent coordination and pleasure in rhythm. It is important to realize that handling and using are inextricably connected with social interaction and communication—reaching out to others as well as to the inanimate world. Both persons and objects have meaning, and the imperative to have an effect on both is mediated with the hands.

Such special anatomical and cognitive abilities, and their emotional/social correlates, indicate that surely the use and making of things manually—that is by our hands—is something we were born to do. And indeed, one could say that nothing recognizably human is achieved without hand use—building, cooking, sewing, painting, carving, molding, writing. If we haven't realized this before it is only because in our lives machines do these things for us, but until very recently, human lives were made by human hands. Early anthropologists called us *Homo faber*—the making, or toolmaking animal. The earliest humans were the earliest handiworkers: to be human was to make, to make things for life.

Homo aestheticus

What I am here to talk about today, however, is not just the universal need to handle and make things, but what I claim is also universal—a need to make them artfully, to "artify." (It's interesting that there's no verb in English for doing what we do when we do art, whatever that is.) And what *is* it to make artfully? I won't take you through all the steps of my search for the most inclusive way to characterize the human art impulse. The best way I have found to describe it is that art is a way of making ordinary experience, of whatever kind, extraordinary. When "artifying," one shapes or elaborates everyday, mundane reality, thereby transforming it into something special, different from the everyday.

Another way that I have put it is that in its most fundamental sense art can be viewed as the activity of *making things special*: decorating the natural body, shaping and embellishing objects of daily or ritual use and the natural surroundings to make visual arts; exaggerating and patterning ordinary bodily movements or the expressive features of the natural voice to make dance and song; molding, rearranging, and vivifying ordinary language to make poetry; or using all of these together in multimedia performances that excite and unify their participants. As an ethologist, or Darwinist, I have suggested that individuals and societies who made special the things they cared about would have survived and prospered better than individuals and societies that did not, and hence the tendency to make special what one cares about—rather than the reverse: not to care and not to make special—gradually became an essential inherited feature of human nature.

An evolutionist, however, must be prepared to suggest why people ever started to do these things, and even more important, what was the reason that they persisted—what real benefits did they provide so that natural selection would allow people who made the ordinary extraordinary to survive better than people who didn't bother and left the ordinary as it was.

One reason I have suggested is that if people took the trouble to make important tools special (that is, if they carefully added decorative or magical marks to their spears, shields, canoes, divining rods, firesticks, and other implements), this "special treatment" would extend to the care they took of these artifacts. The care or control required to fashion and embellish an important tool was like a metaphor for the care and control one wished to exercise in using it and the value one embued it with. People who handled their tools sloppily would use them sloppily, and thus be less successful hunters, warriors, and curers. In this sense, art or craft can be assumed as being a necessary part of the technology that actually made it work better, not a superfluous addition.

This is plausible, and is borne out by the observation that in most societies people do make important things special, but I believe there is more to the behavior than enhancement of implements. Ethologists point out that the germ of a nonordinary or "special" dimension already exists in two behaviors that humans share with other animals. The first is play, and I know that you, as therapists, are well aware that art and play share certain similarities.

For example, both play and art are what psychologists call "self-rewarding," i.e., done for their own sake rather than to achieve an external reward like real food (as at a doll's tea party), or real adventure or travel (as in playing cops and robbers, or armchair escape reading). Even dogs when playing don't bite each other hard, and cats sheathe their claws, as if they realize their fights aren't "for real." Theatre is a kind of play (as the word *play* tells us)—a world of "as if" or pretend, even when it treats of the real world. No wonder that play is a long-recognized means of dealing with uncomfortable as well as pleasurable subjects, and I am sure that some of the successes of art in therapy are related to the "make believe" dimension it shares with play—allowing exploration and trying-out without suffering the real-life consequences. Freud, of course, considered art to be a kind of play insofar as he saw both as substitutes for real life—"phantasy." In this sense then, play is "special" in that it is extraordinary, outside ordinary day-to-day life.

Another artlike behavior is ritual, which is also "outside" ordinary life but deals differently than play with real life concerns. (One can play at being married or being dead or graduating, but this is different from going through the ceremony.) In ritual ceremonies, everything—clothing, words, behavior, emotions—is "special" in some sense. In fact, if you think about it, a ceremony—every ceremony—is a one word label for what is really a whole collection or assembly of arts: song, or special voice; dance, or special movement; poetic or special language, special visual display, spectacle, and performance.

But even apart from ceremonies being made up of arts, there are similarities between the characteristics of individual arts and of any ceremony. Both are stylized: there is a kind of formal structure within which a ceremony occurs just as temporal arts like music, dance, and poetry occur in a preordained order that shapes or molds or expresses feelings. Even everyday ritualized behaviors like greetings and partings use verbal formulas ("How do you do", "Have a nice day") and stylized gestures (handshakes, kisses, waves) much as arts use (or used to use) conventions of representation and technique. Whereas some rituals are empty and almost meaningless through familiarity and repetition, most, like the arts, have been fashioned with the express purpose of directing and affecting our emotions, of heightening them. Most of us cry at weddings and feel choked with corny (or meaningful) emotions we didn't know we had at solemn patriotic or religious occasions.

As other animals play, they also have ritualized behaviors—for example, greetings and territory marking, like the dog behavior I mentioned earlier. Like other animals, when you and I meet each other we each leave our circumscribed individual space (our "territory") and both enter into a joint shared encounter. This transition seems to call for a marking that establishes our relationship to each other, our reciprocity and willingness to merge boundaries, or the reverse. If there is an agreed-upon way to behave, a ritualized set of movements or words, the transition is made smoothly and we can conduct our business in mutual space until it is time to segue out of that and back into solitude, again with a ritual.

Why do people engage in the more complex rituals that we call ceremonies? For similar reasons. There is a large and rich literature about ritual that points out how it is *liminal*, *limen* being Latin for the word *threshold*, that is, a time of transition between one state and another. Think of the nuptial threshold that used to symbolize the borderline past which the bride and groom took up ordinary married life (the period of engagement, wedding, and honeymoon all being the special ceremonial time that is outside of ordinary life). The initiate, or ill person, or dead person, for the time of a ceremony, is between the old state and the new. Transitions are times of uncertainty and danger, where everyday rules do not apply. Things can become much better or much worse: therefore, these times are treated with respect and care.

Ceremonial rituals, in humans, like ritualized behaviors in humans and other animals, are performed in order to affect an uncertain situation—to restore or assure prosperity, health, victory, successful passage to a new state of being (adult, spouse, mother, warrior, graduate), or to avert misfortune, defeat, or bad vibes. Because people care about the results, rituals are not performed casually. Words, voices, actions, movements, bodies, surroundings, and paraphernalia are made as impressive or sacred or beautiful or extraordinary as they can possibly be. And, as is the case with tools or weapons, this makes the ceremonies work better, though in a communal as well as individual way.

Ritual, play, and art are all "bracketed"—set off from everyday life. In their own ways, and in overlapping ways, they are *special* kinds of behaviors that are unlike the mundane ordinary things we do most of the time, such as sleep, eat, shop, work, housekeep, drive. The fact that art shares features with ritual and play should help us to appreciate why it can be a powerful means of engaging attention and working through disorder and uncertainty.

Implications

In the remainder of my talk, I would like to draw out, examine, and elaborate on some of the implications of these brief reflections on our individual past as infants and our species' past in prehistory. These pasts have critical implications for understanding the role that the arts can play in contemporary life, which in so many respects we are ill-equipped by nature to deal with.

1. *Importance of handling and making*

Pleasure in handling is hardwired into human nature for a very good reason: It predisposes us to be tool users and makers. The infant drive to reach, grasp, investigate with mouthing, looking, and dropping has critical biological importance. And as a critically important biological drive, it is something all babies everywhere *want* to do. You can't stop them. Handling, like walking, talking, and playing, is pleasurable.

So what about *making*? In a premodern society the pleasure infants and children receive from handling and then using objects evolves naturally into making them—implements, vessels, houses, regalia. The important universal behavior of play provides opportunities for children to imitate the activities of adults and thereby learn the ways of their society. If the adults in a society make and use tools, children will too. If adults don't, then children won't either, and their natural drive to move seamlessly from handling to making will atrophy just as surely as the predisposition to smile or share will wither if not encouraged or mirrored by positive example. At best children may say "Mommy, let's make something," but in our society we do not make very much and certainly most people make little of what they use. We buy it, or consume it, as images presented by media. Not making can be considered a deprivation of a fundamental human proclivity.

2. *Importance of making special*

Humans not only want to handle and make, but they have a natural tendency to make special. Children, when given the opportunity to draw will first scribble randomly, but with time this scribbling becomes more controlled. Geometrical shapes such as circles, crosses, and rectangles are produced accidentally at first but seem naturally attractive to children who spontaneously go on to repeat and perfect them. Their first efforts are not copies of the world about them, but autonomous shapely forms that they may label, usually with adult prompting, as members of the family, flowers, suns, or animals, all of which look remarkably alike. Children similarly like to regularize their movements in dance, and their voices and words in song and wordplay; they like to dress up and adorn their surroundings. While this can be called "play," it may easily be channeled like other imitations of adults' activities into appropriate ritual and artistic "making special."

3. *The relationship of art to important concerns and to survival*

It is important to realize that not all things are made special by humans, and those that are chosen are usually made special for a reason. Until very recently, the arts have been primarily in the service of abiding human concerns: That is, it has been natural for humans to make special what they care about. For example, as I mentioned earlier, tools for subsistence and weapons are frequently made special (by decoration or ceremonial consecration) to ensure that they work better, and ceremonies themselves are intended to ensure good outcomes to uncertainties. They concern the most important emotions and events: birth, puberty, marriage, death, loss, memory, healing, protecting from harm ensuring prosperity and victory, reconciling human wishes with powerful forces of nature. Thus I claim that the principal evolutionary context for the orgin and development of arts was in activities concerned with survival. That is, selective advantage would have accrued to those individuals with more considered use and valuation of important implements as well as to individuals who participated in ceremonies that articulated and reinforced common purpose.

4. *Relationship of art to anxiety and control*

My evolutionary reconstruction also emphasizes art's close association with anxiety, in that its earliest occasions seem to have been concerned with "something to do" in times of uncertainty—that is, as I described, transitions between one stage and another. It is interesting that humans all over the world have found that shaped, controlled, nonordinary behavior—whether in ritualized behaviors like greetings and partings, or in ceremonial rituals that also negotiate transitions—helps to relieve anxiety.

Rhythmic or patterned movement or vocalization in the self or group provides, by analogy, an illusion of control of the external situation, and thus such behavior would have been more soothing and unifying to our hominid ancestors (as well as to us today) than "natural," random, uncoordinated activity. While it does not seem likely that a society's ceremonies would have brought rain, attracted game, cured infectious disease, or protected from flood and famine—the reasons why the group performed them—it does seem likely that ceremonies mobilized, coordinated, and unified its members, ensuring that they worked together in a common cause, believing in the validity of their worldview and the efficacy of their action. And to begin with, this is how I claim that art originated and was retained.

Psychologists have specifically dealt with the fundamental evolutionary importance for humans and other animals of reducing psychological uncertainty (Kalma, 1986). Psychological studies indicate that "healthy" and "hardy" people of today have a greater sense of control over events in their lives, tend to be committed to others and to themselves, and tend to possess a belief system that includes a sense of the meaningfulness of life (Kobasa, 1979). It seems clear that throughout human evolution, groups that worked together in confidence and harmony would have prospered more than those whose members acted individually, selfishly, haphazardly, or without reference to communal purpose. And, it should be clear, the arts (the products of the human activity of making special) were vehicles for this kind of unification. They riveted joint attention, synchronized bodily rhythms, conveyed messages with conviction and memorability, and indoctrinated right attitudes and behavior.

While living in Scotland, I learned of a contemporary, continuing "traumatic event" where the arts have provided "something to do" and helped to unify people—the siege of Sarajevo. An Edinburgh composer, Nigel Osborne, has been deeply involved with the people there, and related in a newspaper article the words of one artist: "I think art did quite a lot for the city. Art gave people some energy, the feeling of still being civilised, and perhaps a little bit of self-respect." He could have been referring to one instance reported by Osborne when, after the breadline massacre in May 1992, the cellist Vedran Smailovic put on his white tie and tails and played the Albinoni Adagio in the middle of the street. According to many, this marked the start of the civil resistance movement. The image of Smailovic playing among the ruins, and in the graveyards under sniper fire, became an icon for a city that chose to see itself as dignified, cultured, and European, rather than barbaric and brutal like its assailants.

The former Obala Theatre, destroyed by shelling, became a public shortcut to avoid snipers, so its director decided to turn the ruins into an exhibition space.

> Often objects and images were created from the materials of destruction, like Mustafa Skopljak's stalagmites of shattered glass and dolls' faces buried in sand, or Ante Juric's installations of debris, mud, and water. Here it is as if the legacy of Joseph Beuys has become a dark prophecy but the processes of the work are modernism in reverse. This has nothing to do with fragmentation, deconstruction, or the atomic blast that scatters meaning and reference. It is integrative and reconstructive: an almost sacred act of nurturing and healing. (Osborne, 1994)

The "Witnesses of Existence" exhibition, as it was called, was wrecked by mortar fire on Christmas Day 1993, but the artists rebuilt it, and with the help of the United Nations, it will be exhibited in the West. In Sarajevo during the siege, there continued to be an excellent children's choir, music education went on despite everything, and the Sarajevo String Quartet gave concerts throughout, predominantly matinees and ad hoc events.

Osborne concluded his article:

> It seems to me that something very strong has come from my colleagues in Bosnia. While the world stood by and watched a holocaust on television, and while Western art floundered in a colossal imaginative recession, the artists of Sarajevo were the frontline of European civilisation, creating a new inclusive art, refined in hell-fire, tough enough to deal with anything, and absolutely necessary. (Osborne, 1994)

I hope that the foregoing four points have impressed upon you how important art has been, in my view, to human evolution. In closing, I would like to mention a few other general ideas that emerge from a species-centered view that, even though they are not directly concerned with art are, I believe, relevant to art therapy.

5. *Importance of nonverbal mentation*

"Prehistory" usually refers to human existence before the invention of writing and recordkeeping. The fact that so much of human nature is evident in children before they become verbal, and in our species before it became literate (and perhaps even before it became very verbal) suggests that nonverbal thinking and experiencing are important. This is easy to forget in contemporary logocentric society, especially academic society. We have all recently come across claims by philosophers and other masters of theory that people are "nothing but" the sum of their language and vocabulary, that words give us the ability to think and even to have experiences, that they make us what we are. Looking at infants and babies alone should suggest how inadequate such claims are.

Children, premodern and prehistoric people, and artmakers commonly and naturally use "intelligences" (Gardner, 1983) that are spatial, mechanical, musical, or kinaesthetic—that is, *non*verbal. In modern society, which exalts verbal analytic problem-solving, persons whose natural aptitudes are for these other kinds of thinking are disadvantaged. In earlier societies they would have found a valued place.

6. *Importance of emotion*

The emphasis on verbal analytic thought and hence "rationality" in Western academic tradition has further meant that the importance of emotion has been neglected. Indeed, "emotion" is typically regarded as an animal or mammalian or "female" trait that is to be guarded against as dangerous and must be repressed or controlled—an "enemy of reason." To an ethologist, emotions are biologically important indications of what is important to us positively and negatively. Colwyn Trevarthen, a psychologist and neuroscientist, considers emotions to be *regulators*, not products, of psychological activities, and *causes*, not effects, of perception and action.

> [Emotions] are not implanted in subjects by their "objects" and they are not brought into being as cognitive categories or by their perceptual or cognitive associations. Even when they react to or are triggered by stimuli in the "here and now," emotions are aimed to condition future action and future consciousness. They are a part of the dynamic generation of conscious, intelligent action that precedes, attracts and changes experiences. (Trevarthen, 1993)

Such a position suggests that as therapists, one should regard emotions less in terms of being defenses or requiring sublimation than as indicators of where values lie and where directions should be taken.

7. *Importance of culture*

Culture is an outgrowth of nature, not opposed to it, and no matter how different from one another, cultures have evolved to satisfy universal biological needs that are characteristic of our species. It is true that humans are different from other animals in having complex and varied cultures that often make it difficult for us to understand one another. Compared to other animals we have less to depend on from our own innate resources, and therefore require a long childhood in which to absorb our own particular culture. However, it is important to realize that culture is not separate from our biology but indeed is itself an adaptation, or rather is made possible by a number of other adaptations that give us the motivation and abilities to learn from our fellows and, equally important, to learn some things more easily than others. Thus all humans are born—no matter what our race or environment—with genetically endowed tendencies to become cultural, which can be seen in the first year or two of babies, who are born precultural, so to speak, yet are preprogrammed, as it were, to go on and do certain things. I will now name a few of these universal "cultural" abilities that are also universal biological propensities, some of which I have mentioned earlier in relation to art as making special.

a. **Grasping, handling, manipulating,** which will lead to using and even making the tools of one's society.

b. **Understanding and speaking a language** used by one's associates.

c. **Attaching and bonding** to one's particular caretaker(s). In Scotland, I have been working with a specialist in mother-infant interaction, Colwyn Trevarthen whom I mentioned earlier, and I have thus become somewhat familiar with the British object-relations school of psychotherapy, based on the work of Bowlby and Winnicott, among others. While you undoubtedly know more about their contributions than I, I have been struck with the obvious sensibleness of considering a person not in isolation but in relationship, and of course the early relationships between infants and their caretakers set the pattern for future interaction.

John Bowlby used ethological principles for developing his ideas. Bowlby's investigations into the biological importance of infant attachment, showing that the infant is born actively seeking engagement with another, has been a welcome antidote to Freud's earlier view of the baby as a passive receptacle whose behavior is "conditioned" by its experiences.

d. **Imitating and wishing to please** familiar persons and gradually acquiring their beliefs. It is interesting that the times of greatest emotional sensitivity in babies and young children are found to be linked to increases in imitative behavior. Apparently the baby's impetus to interact, which is of course an emotional drive, finds expression in imitation. This makes good biological sense, because imitation helps enculturate us into the ways of our social group. (You will remember earlier that I talked of both art and play as making use of imitation, and here I mention its very early emotional and psychobiological underpinnings.)

e. **Playing, engaging in make-believe** (including imitation).

f. **Imposing conceptual order**, categorizing experiences according to general mental and particular cultural templates.

I have called these things that babies do naturally "fundamental characteristics of human nature," but they can also be thought of as *needs*. Handling, making, speaking, bonding, imitating, playing, forming concepts—these are among the abilities that make us human. Babies do not have to be trained to learn them in the way that lions can be trained to jump through hoops or elephants to dance. Being a baby means wanting to handle things, imitate, bond and attach, learn to talk, play, and accept the beliefs of those around you. Babies are emotionally motivated to try to do those things: they *need* to do them or they are not normal babies and will not be normal adults in their societies.

Cultures then make use of these natural tendencies of babies and small children and produce adults whose acculturation rests on their common human nature, that is, on abilities and needs that are the same everywhere. The universals of cultures grow naturally out of these tendencies.

As I said earlier, these evolved behavioral tendencies and needs, and the motivations and emotions that empower them, evolved for a world that is very different from the one in which we now live. Premodern and traditional societies observably do better than modern and postmodern societies in providing opportunities to express such fundamental elements of human nature as:

- **Engaging in appropriate and useful activity toward one's subsistence** (e.g., making things that one will use for one's life, seeing the results of one's actions, valuing one's efforts and knowing that others value them; this, I would claim, also includes making things one cares about special).
- **Acknowledging and expressing one's social nature**—experiencing community and reciprocity (e.g., attaching and bonding to significant persons, having an acknowledged place in a group, sharing, giving and receiving, joining with a group to do things perceived as important together).
- **Accepting and affirming a world view that is shared by others** (e.g., participating in ritual ceremonies that manifest this belief, seeing evidence that this system works, (e.g., by experiencing "self-transcendent" or "oneness" states that validate one's belief).

I could name other human universals, but these can be found elsewhere (e.g., Brown, 1991; Glantz & Pearce, 1989). I think I have said enough, however, to convey that in a species-centered view the arts are not superfluous in human life. Nor are they mere sublimation or entertainment. The sources of art extend far back into our individual past as infants in handling, making, imitating, playing, even in our emotional attachments to others, and into our species' past as prehistoric hominids, i.e., in our desire to affect and control our world and to reduce anxiety and uncertainty, in our penchant for the extraordinary dimension of experience, in our need to acknowledge our emotional investment in important objects and outcomes by making things and events special, and in our need to confirm a socially shared world view.

In the infancy of our species, as well as in our individual infancy, we engaged in nonverbal and highly emotional kinds of mentation far more naturally than as adults—especially as adults in a complex, technological, highly literate society—but these nonverbal and emotion-suffused "frames of mind" are well-known to artists and can be reengaged with in the arts.

Art in the species-centric view is also more than individual expression or wish-fulfillment or creativity. It is a way of making and sharing the extraordinary with others. In envisioning art therapy's future, I as a Darwinist would encourage you to learn more about the ways the arts have been manifested and used in premodern societies so that you can appreciate (a) how art is a means of satisfying precultural needs, and (b) how aberrrant and unsatisfying contemporary Western society is in meeting these needs. The arts, as in other times and places, can go a long way in allowing our evolved species' needs to find fulfillment.

References

Bowlby, J. (1969). *Attachment and loss: Vol. I. Attachment.* London: Hogarth.

Brown, D.E. (1991). *Human universals.* New York: McGraw-Hill.

Dissanayake, E. (1988). *What is art for?* Seattle: University of Washington Press.

Dissanayake, E. (1992). *Homo aestheticus: Where art comes from and why.* New York: Free Press.

Gardner, H. (1983). *Frames of mind: The theory of multiple intelligences.* New York: Basic Books.

Glantz, K., & Pearce, J. (1989). *Exiles from Eden.* New York: Norton.

Henley, D. (1994). Transcultural responses to aesthetic and therapeutic experience: An ethological approach. *Art Therapy: Journal of the American Art Therapy Association, 11*(3).

Henley, D. (1992). Facilitating artistic expression in captive mammals: Implications for art therapy and art empathicism. *Art Therapy: Journal of the American Art Therapy Association, 9*(4), 178–192.

Kalma, A. (1986). Uncertainty reduction: A fundamental concept in understanding a number of psychological theories. In Jan Wind and Vernon Reynolds (Eds.), *Essays in Human Sociobiology.* (213–241). Brussels: V.U.B. Study Series 26.

Kobasa, S.C. (1979). Stressful life events, personality and health: An inquiry into hardiness. *Journal of Personality and Social Psychology, 37*(1), 1–11.

Kramer, E. (1992). Reflections on the evolution of human perception: Implications for the understanding of the visual arts and of the visual products of art therapy. *American Journal of Art Therapy, 30*(4), 126–142.

Kramer, E. (1979). *Childhood and art therapy.* New York: Schocken.

Kramer, E. (1977). Art therapy and play. *American Journal of Art Therapy, 17*(1).

Osborne, N. (1994 April). Playing at the very edge. *Independent, Weekend,* p. 31.

Trevarthen, C. (1993). The function of emotions in early infant communication and development. In Jacqueline Nadel and Luigia Camaioni (Eds.), *New Perspectives in Early Communicative Development.* (48–81). London: Routledge.

Art Therapy: Journal of the American Art Therapy Association, 12(1) pp. 24-31 © AATA, Inc. 1995

Tuberculosis: Art Therapy with Patients in Isolation

Irene Rosner David, MA, A.T.R.,-BC and Shereen Ilusorio, MA, A.T.R.-BC,
New York, NY

Abstract

In recent years there has been an unexpected resurgence of tuberculosis, a disease that was considered to have been conquered earlier in this century. Due to environmental, epidemiological, and behavioral factors, it is reappearing with increasing prevalence and presenting new treatment challenges. Art therapy, which partly originated in tuberculosis sanatoria, again serves to assist patients in coping with their illness and confinement. Case examples illustrate aspects of the disease and related emotions and highlight the potential for such an expressive activity to counter perceived and real isolation.

Tuberculosis—History and Resurgence

Tuberculosis (TB) is a potentially devastating disease that historically has been a leading killer. In prehistoric time it affected animals, later becoming prevalent in humans in areas with widespread poverty and in crowded cities. This produced the necessary environmental conditions for person-to-person spread of the airborne pathogen of the disease that came to be called the "great white plaque" (Dubos & Dubos, 1952). In the early 1600s the incidence of TB increased sharply, and over the next several hundred years the epidemic spread throughout western Europe. It reached colonial North America when European migrants brought the tubercle bacillus with them (Diamond, 1992).

Treatment often required surgery and a period of convalescence, based on the approved regimen of the day which was rest in quiet, pleasant surroundings with fresh air, sunshine, and good nutrition (Lerner, 1993; Rollier, 1952). Tuberculosis sanatoria arose out of a therapeutic concept of "open-air living" while separating infectious patients from the community (Wilson, 1968, 1979).

Before the era of chemotherapy for TB, 50 percent of cases reportedly resulted in death (American Thoracic Society [ATS], 1992). Since the 1950s, TB had steadily declined because of the availability of effective antituberculosis medications. Public health officials treated it as a disease that had been conquered (Bates & Stead, 1993; Boutotte, 1993; Nardell, 1993; Wilson, 1968). However, since 1985, there has been a resurgence of TB with particular treatment and control challenges related to drug-resistant strains and to noncompliance (Bloom & Murray, 1992; Menzies, Rocher, & Vissandjee, 1993; Pozsik, 1993). In the past decade the incidence of TB has increased significantly nationwide and more than doubled in New York City (Frieden et al., 1993). Due to compromised immune systems, there is a prevalence of TB among patients with HIV infection (Castro, Valdiserri, & Curran, 1992; Centers for Disease Control [CDC], 1990; Hopewell, 1992), with the highest rate of coinfection, 46 percent, from New York City (Bayer, Dubler, & Landesman, 1993; Onorato & McCray, 1992). It is thought that homelessness among urban drug users has further contributed to vulnerability and the transmission of TB (Brudney & Dobkin, 1991; CDC, 1992; Selwyn et al., 1989; Wolfe, Marmor, Moss, & Des Jarlais, 1993).

The resurgence of TB with multidrug-resistant strains poses a serious public health risk in the United States (Bloch et al., 1994). If patients do not complete a course of medication, it becomes ineffectual and requires a change to another drug. Nonadherence, therefore, has contributed to the development of treatment resistance (Bloom & Murray, 1992; Dunbar-Jacob, 1993). The major determinant of outcome is patient compliance, and an official joint statement of the ATS and the CDC (1993b) emphasizes the importance of instituting measures designed to foster adherence and to ensure that patients take prescribed drugs. Programs to improve adherence have included strong educational components, the monitoring of treatment, and behavioral approaches (ATS, 1992; Morisky et al., 1990).

An effective strategy promoting compliant behavior for outpatients has been Directly Observed Therapy (DOT) and the use of incentives. DOT requires that a heathcare provider or other designated, responsible person observe the patient ingesting anti-TB medications. The administration of medication may take place in a clinic, home, workplace, or any agreed upon location. Injecting drug users, who have reported avoiding medical treatment because of fears of detention, are more likely to participate in such a community-based program (Curtis et al., 1994). Studies have indicated that when DOT is used, treatment completion rates have increased, while drug resistance and relapse have decreased (CDC, 1993a; Weis et al., 1994).

The use of incentive schemes rewarding positive health behaviors further fosters adherence. Such enablers include providing carfare to the DOT site, food, clothes, money for child care, conveniently scheduled appointments, and follow-up for missed appointments (ATS, 1992). Although the benefits of such programs have been recognized and documented in medical literature, behavioral strategies and the use of incentive in TB treatment have not yet been studied or reported in the field of psychology. A review of the literature revealed only one related study in public health, a behaviorally oriented program that studied the value of educational counseling with incentives. Enlisting family and friend support, offering positive verbal reinforcement for adherence, and contracting an incentive scheme resulted in higher levels of compliance to medical regimens (Morisky et al., 1990). It is believed that in order to regain control over this communicable disease, DOT programs supported by inducements for compliance should be broadly implemented (ATS, 1994; Iseman, Cohn, & Sbarbaro, 1993a; Iseman, 1993b; Joseph, 1993).

The Role of Art Theapy in the Treatment of TB—Foundations in the Past

In 1938, British artist Adrian Hill was convalescing from TB in a sanatorium. During his six-month stay, he became involved in his own artwork, discovering its therapeutic value. Indeed, it was Hill who claimed to have first coined the term "art therapy" to describe his work (1945). In "Painting Out Illness" (1951), he reflected on his own restlessness and the importance of engaging in an expressive, constructive activity. "Never does the problem of free-time become so acute as in the period of long-term illness." He was intrigued as to why the act of drawing and painting seemed to help patients come to terms with their traumas and to speed up the rehabilitative process (Waller, 1991). He went on to encourage other patients and to advocate for art therapy in sanatoria and hospitals in England and other countries.

Hill was also passionate about the concept of art therapy, and his efforts contributed to the formation of the British Association of Art Therapists (Waller, 1991). It seems remarkable to note that the profession apparently had significant roots in a medical setting, with the therapeutic goal of enhancing patients' coping abilities as related to physical conditions and treatments. This had been an important but relatively rarely practiced specialized area that is only recently returning to the forefront (Malchiodi, 1993a, 1993b).

In the late 1940s, Dr. Auguste Rollier, director of a well-known European sanatorium in Leysin, Switzerland, was a strong proponent of psychological support. He emphasized the importance of healing the whole person, realizing that patients were not only physically but also emotionally sick (1953). He believed that rest alone was not enough and could contribute to depression. He encouraged the medical and nursing staff to keep their patients occupied and stimulated. A positive attitude and sense of optimism through constructive activities could made the difference in real recovery (David, 1952).

The Art Therapy Program-Bellevue Hospital

As a major municipal medical facility in a city with a high incidence of the disease, Bellevue Hospital Center serves a significant number of TB patients. As many as 40 inpatients with active pulmonary TB who are on strict respiratory isolation precautions may be present at any given time. Such isolation requires confinement in a private room, special ventilation systems, and the wearing of protective facial masks by caregivers.

As in the past, patients are prescribed long-term medication regimens and must remain in the hospital, and in their rooms, while they are actively infectious. It is generally believed that with TB "the patient does not have the right to refuse treatment for the disease and continue to expose others" (Frankel, 1992; Pozsik, 1993). In compliance with the New York City Department of Health code, patients at Bellevue who have been previously noncompliant, reluctant to take medications, or attempted to leave prematurely are under orders of detention by the Commissioner of Health. Their isolation is further enforced by the presence of security officers.

These patients' attitudes toward the hospital, disease, and treatment involve loss of control, anxiety, and anger. Control is often compromised in physical illness, and with the imposed restrictions of TB isolation and detention, it is further diminished. Under such circumstances artistic endeavor may take on even greater value. One may regain some sense of mastery in the art process, while externalizing feelings related to illness (Rosner, 1982b; Rosner David & Sageman, 1987). As stated by Hill (1951), TB patients who engaged in art were "exercising their powers of choice and criticism . . . a sense of power had now been reached, and with it a sense of well-being." Human considerations may become as important as scientific ones in the battle against TB (Grange & Festenstein, 1993), and the stage is set for a valuable and highly specialized, renewed area for art therapy.

The authors have been seeing patients with tuberculosis for art therapy sessions for approximately 4 years, with increasing incidence over the past year. Patients are referred by various members of the interdisciplinary healthcare team, most notably from the Psychiatry Liaison Service, which refers patients who are particularly anxious, depressed, or noncompliant. Patients are typically intravenous drug users, many are homeless and may have personality disorders. Lack of cooperation and maladaptive behaviors contribute to the problem of noncompliance and drug resistance (Landesman, 1993; Sageman, 1992). By referring patients to art therapy, caregivers recognize the emotions involved the engaging qualities, and the opportunity to make isolation rooms more humane. The case material presented in this article focuses on such work with patients in respiratory isolation. Their art reveals images and themes related to their disease, prognosis, and confinement. Interpretations are based on clinical observations, common patient perceptions and graphic representations in medical art therapy.

James

Upon initial contact, James was very weak physically. He could barely sit up for more than 10 minutes. He had a long history of alcohol abuse, homelessness, and a personality disorder, all of which contributed to noncompliance. During several previous hospitalizations, as well as outpatient treatment, James did not complete full courses of medication. This resulted in serious multidrug-resistant TB. He had been in respiratory isolation for a month when referred due to depression and anxiety. During the subsequent 9 months of treatment, there were numerous changes in medication in order to find a drug combination that would be effective and curative.

James was verbally very expressive about his feelings of anger, frustration, and anxiety due to his illness, confinement, and prolonged convalescence. He was able to derive positive feelings from his art that served to counteract depression, increase self-esteem, and provide an opportunity to exercise control.

Following infection control guidelines, the art therapist wore a mask. Due to risk of contagion even with this protective measure, art therapy consisted of numerous brief contacts. James preferred to work on his own, once structure for a visual composition was planned. Due to his weak physical condition, most of his artwork was done in bed, using a lapboard or tray table.

James' first drawing (Figure 1) is a view from his hospital window showing life going on outside at a distance. In the center of the water is a camouflaged, blurred area. The two-way road has a spotted, droplet-like design that is visually suggestive of germs, blood, or lesions. This spotted motif is prevalent throughout this case. In medical art therapy patients often pictorialize some aspect of their disease or treatment which usually reflects a process of confrontation and integration of bodily changes (Rosner, 1982a). The vehicles on the road are moving but do not seem to have a destination as the road, like the bridge, is cut off.

Little bright red images or spots are scattered over the next drawing (Figure 2) in the form of flowers, foliage, and various markings. This pictorialization may be seen as symbolic of the TB bacillus or blood. James had significant hemoptysis, the coughing up of blood, typically bright red, from the bronchi or lungs (Berkow & Talbott, 1977).

James sometimes worked from art reproductions which provided choice, structure, and stimulation. The use of such prints has special value, as they not only expand the repertoire of creative expression but also counteract the visual monotony of months in an isolation room. James' choices of reproductions and associations were also useful as projective techniques. It seems noteworthy that James often chose to draw landscapes, as if to bring the outside into his limited and clinical surroundings. One such drawing provided a calming and soothing effect (Figure 3). James said that it gave him a "sense of peace" and "while doing art, I can forget that I am here in Bellevue." Again, there is a blurred area in the center of the water, perhaps a symbolic blemish, and branch-like pathways that resemble bronchial airways.

All the landscapes are from a distant perspective, as if removed from life. This tone continues in the next drawing (Figure 4), but now there are figures looking across a body of water. There are houses on the other side and boats in the water, but it seems questionable whether life on the other side will be accessible. The main figure, and a miniature at its side, are seen from the rear. Primarily done in brown, they appear stiff and wooden and do not look lifelike or suggest mobility. There is a predator—like animal on the ground which James called a "crab being roasted," repeating germ imagery as well as slow deterioration.

James' first change in subject matter was a well-grounded still life (Figure 5). It is a bowl of fruit, rich in color and life. It may embody hope and nurturance; however, the banana is beginning to rot with brown spots, reminiscent of the spots of earlier drawings. There is a window and a picture on the wall, continuing the landscape and distancing elements. The indications of houses are prominent and bright red. The fruit is more than symbolic here, as it literally represents nourishment which is a significant part of the TB treatment regimen. At this time, James took on a more active role by his im-

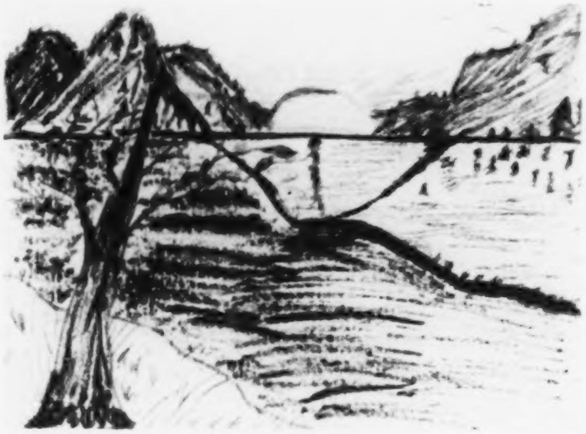


Figure 2.

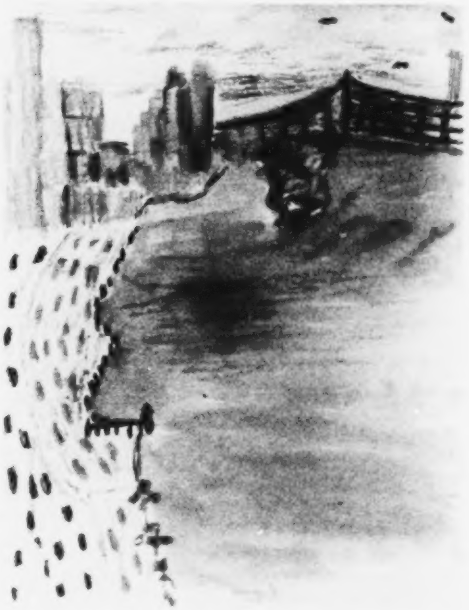


Figure 1.

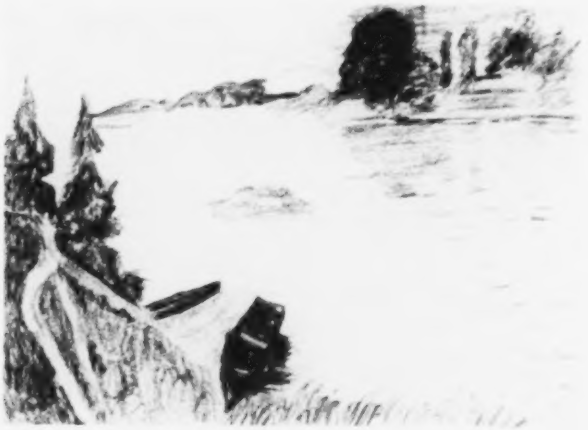


Figure 3.

proved nutrition and by requesting books on TB in order to understand his disease. This motivation seemed to be related to an effort to exercise control and resulted in greater compliance.

The ground is very precarious in the next drawing (Figure 6), and the house appears to be sinking. James commented, "The shack doesn't look right . . . it's all falling apart . . . it looks mixed up." This seems an accurate depiction of his homelessness and physical and emotional instability. James was very aware of his declining condition. Birds, pathways, and trees as symbols of germs, disease, and anatomy emerge here again. The birds are red and full-bodied and adhere to the airway-like branches.

Feelings of isolation, emptiness, and loneliness were embodied in his drawing of a person on a pathway (Figure 7). He is holding a stick for balance, appears to be on a slow, long journey, and is surrounded by vast, empty space. At this time James was attempting to maintain hope but was realistically saddened by repeated treatment failures.

Expressive landscapes gave way to greater emotion and images of the TB attack on his body. His last drawings were often more directly of himself, and a blue portrait (Figure 8) suggests an unrealistic, alien quality. In addition to conveying fear, the eyes may have exaggerated prominence since they are the only area of a caregiver's face that is visible. Due to the side effects of his medication, James was also experiencing vision and hearing impairment, which may partially account for the emphasis on the eyes and the pointed ears.

James' case of TB was unusually resistant and his prognosis was poor. He was physically deteriorating when he drew "A Path to Nowhere" (Figure 9), which was reflective of his discouragement and agitation after a long period of futile efforts to find an effective drug combination. At this stage James frequently talked about his fear of the future and the possibility of not getting better. His artistic and verbal expression of his perception of the severity of his illness was

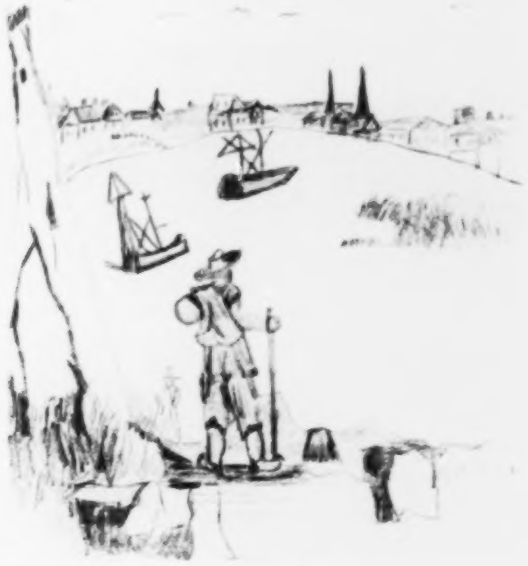


Figure 4.

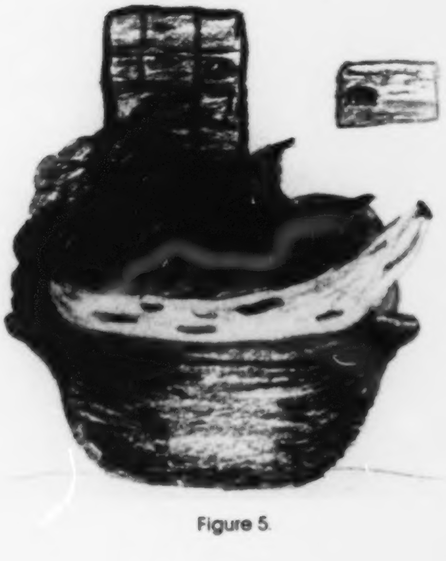


Figure 5.

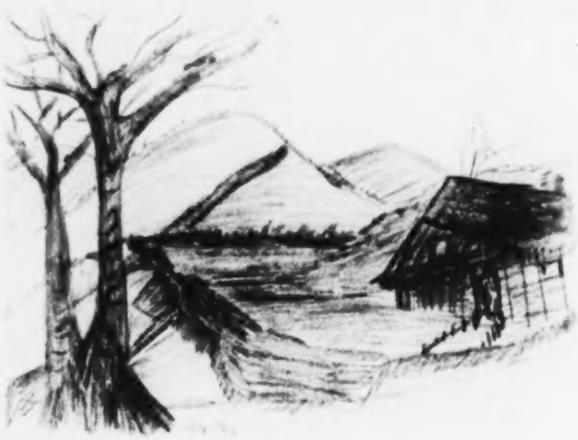


Figure 6.

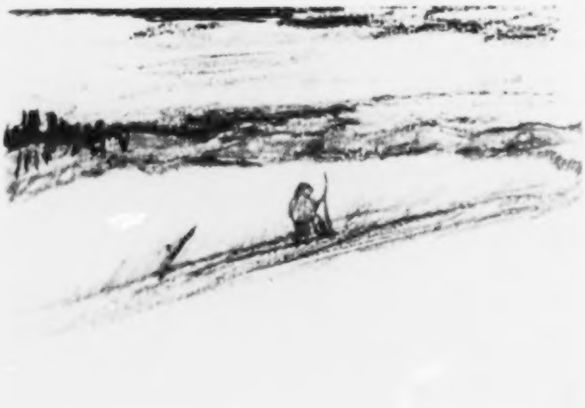


Figure 7.

honestly confronted in this drawing. Visually externalizing intense emotion provided relief as James was adjusting to the idea that his struggle was beginning to fail. The effect of this drawing is different from his previous artwork in its emotional discharge, agitated graphic quality, and loosely formed images. Pictorial elements again may relate to the body with many branches resembling bronchial airways that perhaps now reflect uncontrollable disease.

Disturbing elements prevail in the last two drawings which reflected his active decline and desperation. He drew his room (Figure 10) which had been the world around him for months with realistic items in the foreground. He rendered himself as a skeleton in the background with a sad, rather than frightened face, and indicated "TB" in his lungs. He included another figure which he said was a doctor, with a strong torso and the caption "madness," perhaps because he could not be cured. He also drew himself in the form of a chest X-ray (Figure 11) labeling "TB" and "cavities" (charac-

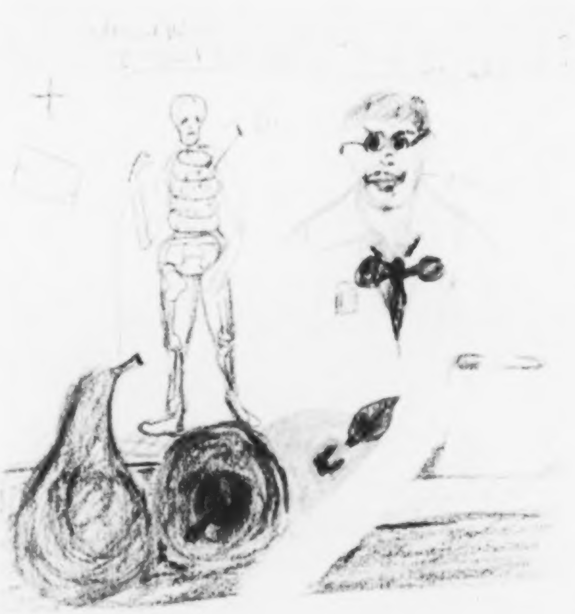


Figure 10.

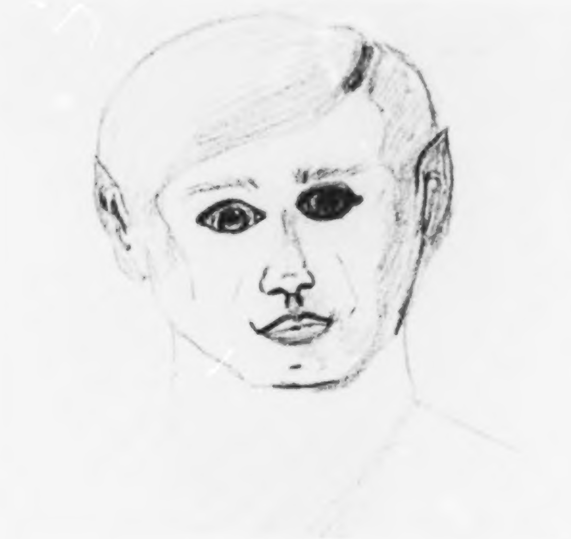


Figure 8.

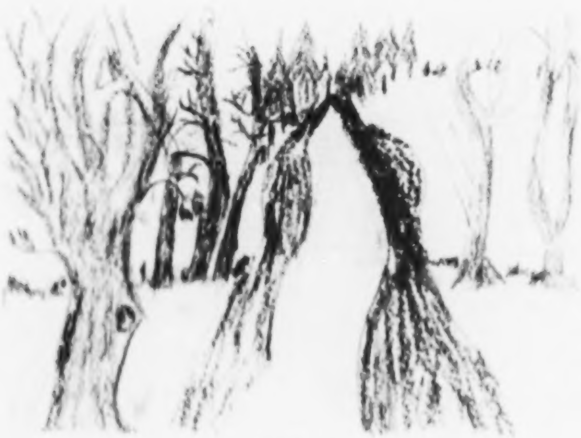


Figure 9.

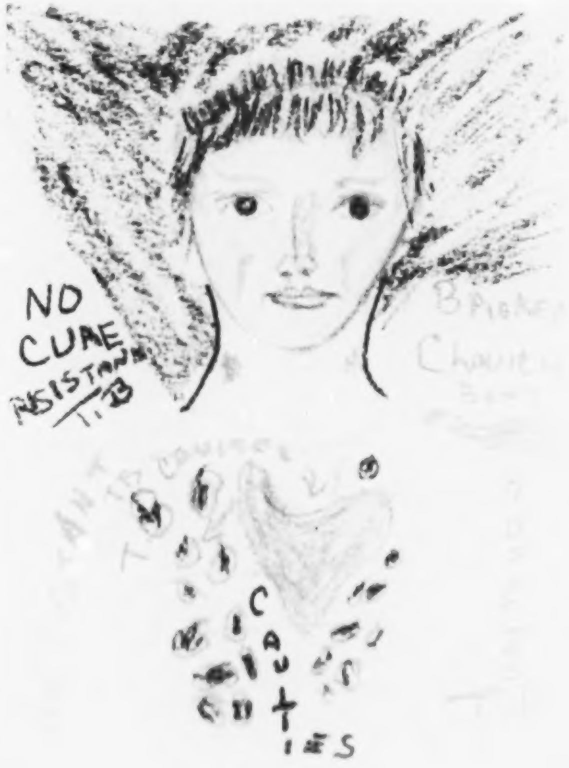


Figure 11.

1972

teristic of the lung pathology), and proclaiming "resistant," "no cure," and "hopeless." This was an accurate portrayal and confrontation with the end stage of his illness. His inclusion of words emphasizes the images and elaborates on his anguish.

In James' last several drawings a final and direct release of sadness, anger, and emotional turmoil occurred. This intense discharge and graphic representation of his fate may have aided in this transitional phase toward resignation. James' agitation subsided, and he gradually succumbed to his illness. He was receptive and appreciative of the visits that continued when art making was no longer possible. Through the course of his illness and treatment, art therapy served as a link to the outside world, as well as a safe means of emotional expression. It fortified him during hopeful periods and contributed to his compliance with the medical regimen. Through art he increasingly externalized representations of illness and, ultimately, of death.

Ramon

Ramon had been on respiratory isolation for 1 week when he was referred to art therapy. Although he was described as hostile and noncompliant, he was immediately responsive to the opportunity to draw. In the beginning of the first session he sobbed and talked openly about his medical ordeal. He allied himself to the art therapist, claiming to have been an artist for the police department, drawing faces from witnesses' descriptions of alleged criminals. He doubted his ability to continue to draw well, yet boasted about his talent for portraits, needing to look only once or twice at a subject. His statements of pride in his artistic abilities seemed to fortify his self-esteem.

While spontaneously drawing the art therapist, he indeed looked at the paper only twice. He drew the shape of the head and the hair, then looked a long time at the eyes while drawing them. He stopped when he came to the bridge of the nose, apparently realizing that the rest of the face was camouflaged by the protective mask. He appeared sad, but resigned, and completed the drawing between sessions using his imagination. Perhaps drawing the therapist was a way to bond as an artist, and also an attempt to transcend the distance that is experienced with the wearing of masks.

Ramon asked for paper and black drawing pencils and worked on his own to create a very expressive drawing of a face with a mask over the eyes (Figure 12). The mask does not camouflage but, rather, reveals sad eyes. The notion of a facial covering is critical in TB care and isolation. Indeed, this mask merges with, or is an extension of the face. Unlike an opaque respirator mask, this one appears transparent, enabling the viewer to see the eyes and tears behind the obstacle, as well as for the eyes to see outward. Perhaps this represents the partial, guarded existence he was experiencing. Like goggles, the mask provides a measure of protection. It also resembles a harlequin mask with a handle, suggesting that it can be removed to reveal the person. The handle of the mask is ribbon-like, ending in an open scissor image. The transparency may also suggest ambivalence about interpersonal contact and intimacy. Further, it may embody the reality that contact without a mask involves not only emotional risk, but also the real risk of infecting others. There must be a powerful, ominous feeling about the ability to transmit a disease by the simple and natural acts of breathing or coughing.

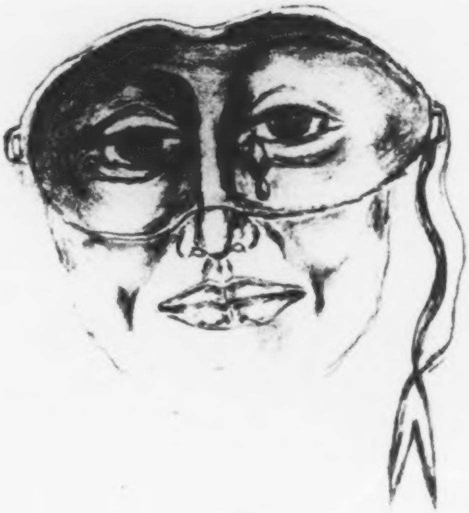


Figure 12.

The most striking aspects of this drawing are the large, teary eyes. This is a very eloquent rendition of feelings of sadness and seclusion. The crying that is apparent behind the mask seemed a valuable and safe release. Ramon did not directly verbalize any associations to the drawing; instead, he distanced himself from the emotions by focusing on the technical aspects. He asked whether the therapist had noticed how well he "got the shadows" and "wasn't it good?" It seemed he was also seeking assurance that he was good, needing validation at a time when his self-esteem had been diminished through illness and confinement.

During the course of his hospitalization, Ramon became more compliant. He remained in his isolation room and reliably took his medication. He was no longer hostile, but rather calm, while expressing a range of emotions in art appropriate to the features of his disease and prognosis. Art therapy served also to neutralize a clinical, monotonous atmosphere and, thereby, may have contributed to compliance to medical treatment. The experience enriched his immediate world, as did the supportive relationship with the therapist.

Infection Control Guidelines and Special Considerations for the Art Therapist

Caregivers have unique and real concerns when treating patients with infectious TB. Healthcare workers must take special measures to minimize the risk of becoming infected. TB infection, as indicated by tuberculin skin testing, should not be confused with TB disease. If infection occurs, in most cases immunity develops that prevents active disease. Such people are not contagious, as their immune systems also prevent transmission. Further, they may be medicated as a measure to prevent disease activation. The ATS (1992) and the CDC (1990) provide guidelines and recommendations for TB control. Bellevue Hospital follows such guidelines and educates staff regarding patient isolation and strategies to prevent airborne transmission, including environmental and personal safety precautions.

The environmental interventions recommended have been for the facility to increase ventilation and airflow according to specific standards in order to prevent institutional airborne transmission (ATS, 1992; Nardell, 1993). In the area of personal care, we have adopted the recommendation to use special filtering masks when engaged in art therapy with TB patients (CDC, 1990). These disposable "particulate respirators" are thick and fit tightly over the mouth and nose in order to protect against inhaling droplet nuclei. Greater effort is required to breathe through the masks, and it is therefore quite uncomfortable to wear one for an extended period of time. Due to such discomfort, and in order to minimize risk, we conduct brief sessions, generally no longer than 20 minutes. It is also important to be sensitive to the therapist's appearance, and the responses and issues that may be elicited from the patient. Patients may attribute the use of such a protective item to being treated like an outcast or alien. Recent studies indicate that many perceive TB as a severe social stigma (Wolfe, Marmor, Moss, & Des Jarlais, 1993), and that duration of illness may be related to feelings of alienation (Sokhey, Vasudeva, & Kumar, 1990).

Another area for consideration involves the art materials. Since organisms would have to be inhaled for TB infection to occur, no particular protective measures have to be undertaken. Following CDC guidelines, art materials fall into the category of "noncritical items," since they remain outside the body and are in contact only with intact skin (1990). However, washing materials with soap or detergent is advisable to protect against germs from dirt or secretions. The use of clay should present no problem with regard to TB, but one should always be observant. In the unlikely event that any art material becomes soiled with blood or bodily fluids, it should be discarded or left with the patient. Following such basic infection control practices, the art therapist should be able to use the full range of materials in safety.

Lastly, when working with TB patients, the emotions of the therapist should be acknowledged. Although we are well educated on infection control guidelines and diligently implement all recommendations in our work, we realize that some measure of risk does exist. We must be honest about this, as well as accompanying anxieties. In addition, we are often dealing with extremely ill patients and must be prepared to face their deterioration and possible death. To balance this, a caseload is never exclusively comprised of TB patients. This makes the work somewhat less intense and may diminish risk to some degree. Further, as with diseases such as AIDS, care for oneself is vital. The need to express and integrate emotions evoked in medical art therapy is essential, as is having many resources for support and life-enhancing, personal activities (Rosner David & Sageman, 1987; White, Fenster, Franklin, Rosner David, & Weiser, 1991; Winiarski, 1991).

Conclusion

The artwork of TB patients in respiratory isolation reflects aspects of the illness and its restrictions. In the authors' clinical experience, images related to anatomy and manifestations of the disease, and emotional themes or perceptions related to being seriously ill and set apart are prevalent.

Art therapy with TB patients clearly presents special issues for the therapist, especially since the incidence of TB is increasing and therefore offering new clinical interest and opportunity for art therapists. It is important to follow infection control guidelines which currently focus on the utilization of a respirator mask to avoid airborne transmission and TB infection.

Patients benefit from the artistic expression of their emotions not only regarding the disease and prognosis, but also regarding the unique experience of isolation. Existence within such restriction only worsens the tendency toward noncompliance. Participation in art therapy serves to decrease anxiety and to provide an opportunity to exercise control. The therapeutic gains and enriched atmosphere of their quarters help patients to confront their illness and hospitalization with greater compliance. There may, therefore, be significant implications for art therapy and similar modalities in TB care. With enhanced coping abilities and adherence to treatment regimens, such activities may contribute to efforts to control the spread of the disease.

Lastly, the evocative nature and value of artistic expression for patients with TB are echoed in the past. Throughout history, especially in the 19th century, many famous writers, musicians, and artists were thought of as being particularly creative as "consumptives" suffering from pulmonary TB. Among them, Elizabeth Barrett Browning spoke of the "butterfly within, fluttering for release" (Dubos & Dubos, 1952, p. 62). As described by René Dubos in "The White Plague" (1952) the disease:

> . . . contributed to literature a number of symbols, images and moods, of great emotional force because they were then the expression of impacts received in everyday life" (p. 46) " . . . many tuberculous individuals have dazzled the world . . . by the passionate energy with which they exploited their frail bodies . . . in order to overcome the limitations of disease. (p. 61)

Editor's Note: The authors wish to express their appreciation to art therapist Susan Conlon, MA, for her contribution of the case of Ramon for this manuscript, and to Evelyn Altenberg, PhD, Linguistics, for her assistance with translation of Auguste Rollier's paper.

Irene Rosner David, MA, A.T.R.-BC, is Director of Activity Therapy at Bellevue Hospital Center, specializing in various areas of medical art therapy. Shereen Ilusorio, MA, A.T.R.-BC, is an art therapist at Bellevue Hospital Center, specializing in rehabilitation medicine and tuberculosis.

References

American Thoracic Society. (1992). (Medical Section of the American Lung Association). Control of tuberculosis in the United States. *American Review of Respiratory Disease, 146*, 1623–1633.

American Thoracic Society. (1994). (Medical Section of the American Lung Association). Treatment of tuberculosis and tuberculosis infection in adults and children. *American Journal of Respiratory and Critical Care Medicine, 149*(5), 1359–1374.

Bates, J.H., & Stead, W.W. (1993). The history of tuberculosis as a global epidemic. *Medical Clinics of North America, 77*(6), 1205–1217.

Bayer, R., Dubler, N.N., & Landesman, S. (1993). The dual epidemics of tuberculosis and AIDS: Ethical and policy issues in screening and treatment. *American Journal of Public Health, 83*(5), 649–654.

Berkow, R., & Talbott, J.H. (1977). *The Merck manual of diagnosis and therapy.* Rahway, NJ: Merck.

Bloch, A.B., Cauthen, G.M., Onorato, I.M., Dansbury, K.G., Kelly, G.D., Driver, C.R., Snider, D.E. (1994). Nationwide survey of drug-resistant tuberculosis in the United States. *Journal of the American Medical Association*, *271*(9), 665–671.

Bloom, B.R., & Murray, C.J.L. (1992). Tuberculosis: Commentary on a reemergent killer. *Science*, *257*, 1055–1064.

Boutotte, J. (1993). TB, the second time around. *Nursing*, 93, 42–49.

Brudney, K., & Dobkin, J. (1991). Resurgent tuberculosis in New York City: Human immunodeficiency virus, homelessness, and the decline of tuberculosis control programs. *American Review of Respiratory Disease*, *144*(4), 745–749.

Castro, K.G., Valdiserri, R.O., & Curran , J.W. (1992). Perspectives on HIV/AIDS epidemiology and prevention from the eighth international conference on AIDS. *American Journal of Public Health*, 82(11), 1465–1469.

Centers for Disease Control. (1990). Guidelines for preventing the transmission of tuberculosis in health-care settings, with special focus on HIV-related issues. *Morbidity & Mortality Weekly Report*, 39(RR-17), 1–29.

Centers for Disease Control. (1992). Tuberculosis among homeless shelter residents. *Journal of the American Medical Association*, *267*(4), 483–484.

Centers for Disease Control. (1993a). Approaches to improving adherence to antituberculosis therapy—South Carolina and New York, 1986–1991. *Morbidity & Mortality Weekly Report*, *42*(4), 74–81.

Centers for Disease Control. (1993b). Initial therapy for tuberculosis in the era of multidrug resistance: Recommendations of the advisory council for the elimination of tuberculosis. *Morbidity & Mortality Weekly Report*, *42*(RR-7), 1–8.

Cornell, C. (1988). Tuberculosis in hospital employees. *American Journal of Nursing*, 88, 484–486.

Curtis, R., Friedman, S.R., Neaigus, A., Jose, B., Goldstein, M., & Des Jarlais, D.C. (1994). Implications of directly observed therapy in tuberculosis control measures among IDUs. *Public Health Reports*, *109*(3), 319–327.

David, R. (1952). Personal communication as a student of Auguste Rollier, M.D., Leysin Sanitorium, Switzerland.

Diamond, J. (1992). The arrow of disease. *Discover*, *13*(64), 64–73.

Dubos, R., & Dubos, J. (1952). *The white plague: Tuberculosis, man, and society*. Boston: Little Brown.

Dunbar-Jacob, J. (1993). Contributions to patient adherence: Is it time to share the blame? *Health Psychology*, *12*(2), 91–92

Frankel, D.H. (1992). USA: Civil liberty and control of tuberculosis. *Lancet*, *340*(8833), 1459.

Frieden, T.R., Sterling, T., Pablos-Mendez, A., Kilburn, J.O., Cauthen, G. M., & Dooley, S.W. (1993). The emergence of drug-resistant tuberculosis in New York City. *New England Journal of Medicine*, 328(8), 521–526.

Grange, J.M., & Festenstein, F. (1993). The human dimension of tuberculosis control. *Tubercle and Lung Disease*, 74(4), 219–222.

Hill, A. (1945). *Art versus illness*. London: George Allen & Unwin.

Hill, A. (1951). *Painting out illness*. London: Williams & Norgate.

Hopewell, P.C. (1992). Impact of human immunodeficiency virus infection on the epidemiology, clinical features, management, and control of tuberculosis. *Clinical Infectious Diseases*, 15(3), 540–547.

Iseman, M.D. (1993b). Treatment of multidrug-resistant tuberculosis. *New England Journal of Medicine*, 329(11), 784–791.

Iseman, M.D., Cohn, D.L., & Sbarbaro, J.A. (1993a). Directly observed treatment of tuberculosis—We can't afford not to try it. *New England Journal of Medicine*, 328(8), 576–578.

Joseph, S. (1993). Tuberculosis, again. *American Journal of Public Health*, 83(5), 647–648.

Landesman, S.H. (1993). Commentary: Tuberculosis in New York City—The consequences and lessons of failure. *American Journal of Public Health*, 83(5), 766–768.

Lerner, B.H. (1993). New York City's tuberculosis control efforts: The historical limitations of the "war on consumption." *American Journal of Public Health*, 83(5), 758–766.

Malchiodi, C.A. (1993a). Introduction to special issue: Art and medicine. *Art Therapy: Journal of the American Art Therapy Association*, *10*(2), 66–69.

Malchiodi, C.A. (1993b). Medical art therapy: Contributions to the field of arts medicine. *International Journal of Arts Medicine*, 2(2), 28–31.

Menzies, R., Rocher, I., & Vissandjee, B. (1993). Factors associated with compliance in treatment of tuberculosis. *Tubercle and Lung Disease*. 74(1), 32–37.

Morisky, D.E., Malotte, C.K., Choi, P., Davidson, P., Rigler, S., Sugland, B., & Langer, M. (1990). A patient education program to improve adherence rates with antituberculosis drug regimens. *Health Education Quarterly*, *17*(3), 253–267.

Nardell, E. (1993). Environmental control of tuberculosis. *Medical Clinics of North America*, 77(6), 1315–1334.

Onorato, I.M., & McCray, E. (1992). Prevalence of human immunodeficiency virus infection among patients attending tuberculosis clinics in the United States. *Journal of Infectious Diseases*, *165*, 87–92.

Pozsik, C.J. (1993). Compliance with tuberculosis therapy. *Medical Clinics of North America*, 77(6), 1289–1301.

Rollier, A. (1952). Der heutige stand der heliotherapie in Leysin [The current state of heliotherapy in Leysin]. *Strahlentherapie*, 88, 442–447.

Rosner, I. (1982a). Art therapy in a medical setting. In A. DiMaria, E. Kramer, & I. Rosner (Eds.), Art therapy: A bridge between worlds. *Proceedings of the 12th Annual Conference of the American Art Therapy Association* (p. 17–21). Reston, VA: AATA.

Rosner, I. (1982b). Art therapy with two quadriplegic patients. *American Journal of Art Therapy*, *21*(4), 115–120.

Rosner David, I., & Sageman, S. (1987). Psychological aspects of AIDS as seen in art therapy. *American Journal of Art Therapy*, 26(1), 3–10.

Sageman, S. (1992). *Drug resistant TB—The new and potentially fatal epidemic: A psychiatric overview of noncompliance with treatment*. Manuscript submitted for publication, Bellevue Hospital, New York University Medical Center, 1–21.

Selwyn, P.A., Hartel, D., Lewis, V.A., Schoenbaum, E.E., Vermund, S.H., Klein, R.S., Walker, A.T., & Friedland, G.H. (1989). A prospective study of the risk of tuberculosis among intravenous drug users with human immunodeficiency virus infection. *New England Journal of Medicine*, *320*(9), 545–550.

Sokhey, G., Vasudeva, P., & Kumar, L. (1990). The effect of duration of illness on the personality of allergic and tuberculosis patients. *Journal of Personality and Clinical Studies*, 6(1), 69–72. (From *PsycINFO Database*, 1991, American Psychological Association, Abstract No. 78–27963.)

Waller, D. (1991). *Becoming a profession: The history of art therapy in Britain, 1940–82*. London & New York: Tavistock/Routledge.

Weis, S.E., Slocum, P.C., Blais, F.X., King, B., Nunn, M., Matney, G.B., Gomez, E., & Foresman, B.H. (1994). The effect of directly observed therapy on the rates of drug resistance and relapse in tuberculosis. *New England Journal of Medicine*, 330(17), 1179–1184.

White, S., Fenster, G., Franklin, M., Rosner David, I., & Weiser, J. (1991). From outside in and inside out: Viewing AIDS through art therapies window. *Proceedings of the 22nd Annual Conference of the American Art Therapy Association* (p. 55). Mundelein, IL: AATA.

Wilson, J. (1968). Rise and decline of the tuberculosis sanatorium. *American Review of Respiratory Disease*, 98, 515–516.

Wilson, J. (1979). History of the American Thoracic Society. *American Review of Respiratory Disease*, *119*, 327–335.

Winiarski, M.G. (1991). *AIDS-related psychotherapy*. New York: Pergamon Press.

Wolfe, H., Marmor, M., Moss, A., & Des Jarlais, D. (1993). Tuberculosis beliefs among New York City injecting drug users. *Lancet*, *341*(8861), 1658–1659.

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 12(1) pp. 32-38 © AATA, Inc. 1995

Pediatric Art Therapy: Strategies and Applications

Anne Prager, RN, MA, A.T.R., Washington, DC

Abstract

A literature search reveals that little has been published specifically on art therapy with medically ill, hospitalized children. It also is apparent that interest in this subspecialty is growing. The author, whose approach is based on phenomenology, describes the strategies used in her practice of art therapy on the pediatric unit of a large, teaching hospital, illustrating them with case material. Assessment rounds made to evaluate which children could benefit from art therapy; the importance of staff communications; and the clinical work itself are discussed. The art materials used and the organization of products are also described. Necessary adaptations for practicing art therapy in the hospital environment are included.

Introduction

Pediatric art therapy, in general, is a term used for the application of art therapy to children and adolescents who have medical illnesses. This paper refers more specifically to practicing art therapy with children and adolescents who are hospitalized. While there are currently few practitioners in this field, there is evidence that interest is growing.

A literature search reveals very few references directly applicable to the implementation of art therapy for children in general pediatric hospital settings (Landgarten, 1981; Nadler, 1983; Prager, 1993). There are a few more articles with indirect references which: asthma (Gabriels, 1988); burns (Appleton, 1993); cancer (Bach, 1990; Councill, 1993); hearing impairment (Henley, 1987); intestinal problems (Lillitos, 1990); and trauma (Stronach-Buschel, 1990). In contrast, there is an abundance of writings, not related to art therapy, on the psychological aspects of illness in children. Some examples include Bergmann (1965), Freud (1952), Prugh (1953), and Terr (1991). Other literature includes psychiatric consultation in pediatrics (Shugart, 1991) and childhood conceptions of illness (Bibace & Walsh, 1980; Perrin & Gerrity, 1981).

The author has been employed as a hospital pediatric art therapist for 20 hours a week for 4 years and entered the field with extensive nursing experience. Her approach is based on the principles of phenomenology (Betensky, 1987). The premise of this approach is succinctly described by Junge and Linesch (1993) who relate that in phenomenology

> the inner experience of the person is focused upon, with the goal of grasping the essential nature of the phenomenon separate from the constructs of intellect and society. Phenomenologists strive to free themselves from the taken-for-granted ideas about things and attempt to get beneath the conventional ways experiences are described to the underlying structures. . . . Through empathy and a deep in-dwelling, the understanding of the experience is gained. (p. 63)

This approach works well for short-term intervention because it focuses directly on whatever problem the child may be experiencing at the moment. The openmindedness and accurate empathy provided not only elicits valuable information about the child, but also helps to alleviate fear, anger, confusion, and sorrow as the patient begins to feel understood.

Workplace and Caseload

Fairfax Hospital is an attractive, modern, 700-bed facility set in the suburbs of a major city. This private, nonprofit teaching facility also serves as a major trauma center for a wide geographic area. The pediatric art therapy position is under the administration of the Child Life Department, which is comprised of generalists in the normal, psychosocial development of children. The work I do as a specialist is independent, and I am the sole art therapist on the 60-bed pediatric unit. Fifty private and semiprivate beds are available, collectively called "peds main," with 10 additional beds in an intensive care unit. The ages of the patients range from a few days to 18 years, and the average length of stay is 3½ days.

Most of the illnesses seen are acute, either medically or as the result of trauma and accidents. Some are life threatening and others are fatal. There are also children admitted repeatedly for exacerbations of chronic diseases such as cystic fibrosis, asthma, and diabetes. The hospital has pediatric specialists in the areas of trauma, general surgery, neurology and neurosurgery, cancer, cardiology, gastroenterology, renal diseases, and plastic surgery. Because other facilities in the area specialize in HIV-positive children and burns, few of these patients are seen. The only psychiatric admissions are for medical/surgical sequelae of suicide attempts and for psychosomatic evaluations.

To begin the selection of patients appropriate for art therapy, the first task each day is to get an up-to-date computer printout of all the patients on pediatrics. The printout gives each child's name, age, sex, room number, doctor, and diagnosis. Children 5 years and older are highlighted as potential art therapy recipients because patients in this age range generally are more skilled in creating representational art and are better able to sit through group art sessions. Younger children are seen on request, usually when they are especially withdrawn or when abuse is suspected. The average number of potential art therapy patients is about 20 per day, and all of these are invited to the twice weekly art groups.

Children selected for individual art therapy sessions are those most likely to suffer psychological problems resulting from trauma and very serious illnesses and those who endure chronic illnesses. The length of stay is also a consideration; children who will be in the hospital for a few weeks (e.g., for treatment of cystic fibrosis) need not be seen immediately. Patients referred for art therapy by the medical staff and ancillary personnel almost always receive the service. Hospitalization is stressful for all children, but those who exhibit more than usual sadness, withdrawal, anger, anxiety, or confusion are prime candidates for art therapy. It is unfortunate that not all the children who could benefit from art therapy are able to do so, but there is no money available to increase the service.

Assessment Rounds

Evaluating the psychosocial needs of the patient population is a strategic element in deciding what interventions to implement. On the two days a week when art therapy groups are offered, I go to all the age-appropriate children's rooms to invite them to the group. These visits can reap a wealth of information about actual or potential psychosocial troubles. Knowledge about child and family dynamics (Kramer, 1971; Kwiatkowska, 1978; Rubin, 1984a) and acuity in visual discrimination (Arnheim, 1969) helps to identify which children will need further evaluation.

By active observation, a sense of illness severity and the child's coping methods can be discerned. Is the patient pale and listless and attached to a lot of medical equipment? Is the patient crying or demanding or placidly accepting fate?

By noting the belongings in the room, data about the child's individuality, value to others, socioeconomic status, ethnicity, religion, and so forth, can be gathered. Are there hordes of toys, flowers, and balloons? Cards from classmates? What is the quality of the belongings? Are there items from home? If so, what are they? Are religious artifacts in evidence? Untouched meal trays? Old pizza boxes? Does the room have that "lived-in" look or is it rigidly tidy? In time one learns to register these observations consciously and to organize them into beginning impressions about psychosocial circumstances.

For example, what impression would one have of the rooms drawn by children in Figures 1 and 2? In Figure 1 we see an empty environment with no people and no belongings. The small size of the image with a line drawn through the faceless head, together with the ambiguous inclusion of hands, suggests feelings of powerlessness. Noting that the patient does not fit in the bed and also that the surrounding boundary is incomplete, one could surmise that the child feels a lack of support and safety in this environment. On the other hand, in the second room (Figure 2) we notice that the child has a telephone on the table to maintain contact with others, has received some flowers, and can control her environment to some degree by adjusting her bed position and the lights included in the picture.

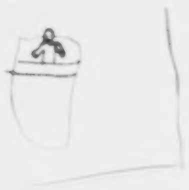


Figure 1.

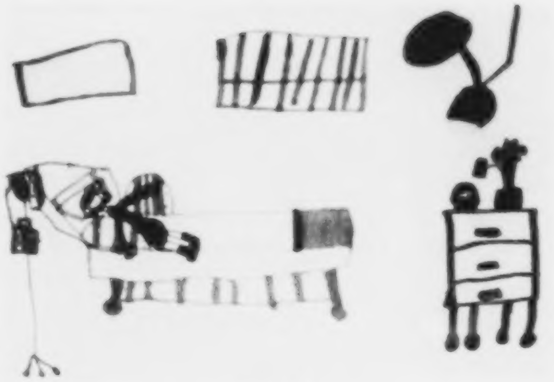


Figure 2.

As to the family, what members, if any, are there? What is the quality of the interactions? Do the parents speak for the child? Do they welcome a creative opportunity for their child when s/he is invited to group? Are they leery of me? Are they and their child willing to part company for a while? What is the overall atmosphere in the room?

While making the above observations, I introduce myself to the family. I explain that I will be offering an hour-long art group which gives the children a chance to meet each other, a chance to be expressive about what is happening to them, and a chance to have fun in a "normal" activity outside of their rooms. When talking to the parents, I introduce the concept that children in the hospital generally have very limited choices, whereas while creating art they have the opportunity to be in charge, and that this helps to maintain their independence. The children may choose what materials to use, what images to create, to whom they want to show their artwork, and what they want to do with it. I also mention that the hour with the art group offers the parents a break, which most enjoy. Educating the parents in this way helps them to separate briefly from their child. It also helps me to form an alliance with them.

Forming this alliance is crucial. One must be on guard with difficult families not to be so devoted an advocate of the child that the parents become antagonized. When it emerges either in assessment rounds or later that the parents are impeding the overall well-being of the patient, then it is wise to reevaluate the situation and include the family system as a whole in the plan of care. In these situations, family art therapy sessions can be very beneficial, and collaboration with the social work department is key.

Staff Communications

Informal communications with staff, more formal presentations in multidisciplinary rounds, and charting are important to achieve respect and acceptance for art therapy in the scientifically—oriented, medical model (Robbins, 1976; Rubin, 1984b). Informal communications occur spontaneously in the halls, the garage, the cafeteria, etc. One of the strategies used is to be readily responsive and available when communicating about the children, as this kind of interchange fosters not only good quality care for the children, but good staff relations as well.

Formal staff communications occur weekly at hour-long psychosocial rounds, held separately for the ICU and "peds main." Participating in these sessions are medical residents, an attending pediatrician, and a psychiatrist. Representatives from nursing, social work, art therapy, child life, nutrition, occupational/physical therapy, speech pathology, pharmacy, and the chaplaincy also attend, along with a host of students from various disciplines.

The purpose of these meetings is to address psychosocial aspects impinging on the healthcare and well-being of each child, which can be hampered by participants who maintain an adherence to their scientific orientations. While this may be done in an effort to defend against distressing feelings, it can result in appearing insensitive. In presenting art, thought needs to be given to its selection: generally, works that clearly prove a point, are dramatic, or are just plain charming are chosen. Showing artwork in a timely fashion that corroborates, refutes, or embellishes statements made by other disciplines underscores the unique contribution of art therapy. It is also a very effective way to capture the attention of the more technically focused staff members because the art itself has the capacity to engage their emotions directly. As an example, the painting in Figure 3 was shown after a rounds participant followed a cursory description of a little girl's tuneup for cystic fibrosis with the phrase "no psychosocial problems." (This conclusion is sometimes reached simply because the parents are noted to be at the child's bedside.) The windowless train seems blind as it careens powerfully to the left, a realm thought by Bach (1990) to be a place of "darkness and the unknown." One wonders if the "box" might refer to a coffin. The picture seems to provide vivid evidence of the child's underlying sense of the ominous progression of her fatal illness. Hospitalization always results in some psychosocial disruption and helping to increase the awareness of this is one strategy of art therapy.

The use of rounds for education about art therapy is another worthwhile strategy. One example is that of a 14-year-old boy who had intestinal disease and was nervously awaiting abdominal surgery. He said he hadn't done art in years. Nevertheless, he decided to try to draw a maze and created Figure 4. When this picture, drawn with remarkable control, was shown in rounds, everyone noticed its likeness to intestines. They could also see how this art therapy patient used the metaphor to express the fears and confusion he had about the integrity of his viscera. The need for control in patients whose bowels are out of control was also discussed.

A second educational example occurred as follows: At the time of our initial session, I did not know that the boy who drew the image in Figure 5 had some years previously undergone irradiation of his brain for a tumor. I pointed out in rounds that the confused organization of stems, flower, and leaf, plus the questionable symmetry of the vase, and the tremulous line quality, seemed to indicate organic involvement. Then the attending doctor told about the radiation, and a discussion ensued clarifying how art can reflect central nervous system impairment. We also talked about what meaning the choice of a black vessel with black flower, drawn as a gift for his mother, might have for this dying child. Everyone attending the session learned something.

The only formal, written staff communication is charting, and the method for doing so varies among hospitals. At our institution, the art therapist charts in the "Integrated Progress Notes" along with the doctors and other personnel.

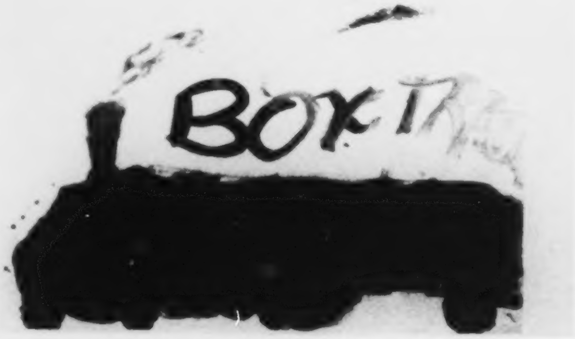


Figure 3.

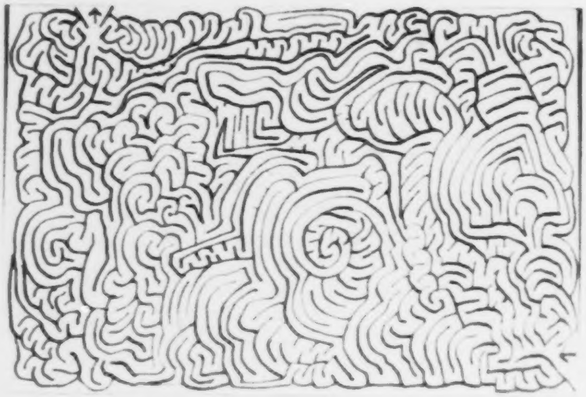


Figure 4.

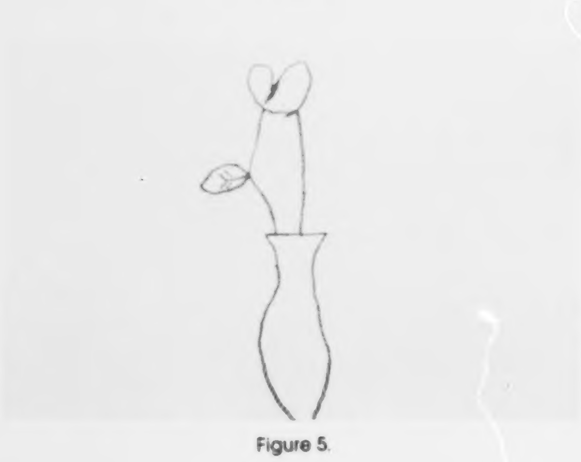


Figure 5.

Clinical Work

One-to-one art therapy at the bedside is done on an as-needed basis. Flexibility is required since appointments need to be made in consideration of medical procedures off the unit, which almost always take precedence. The length of art therapy sessions is variable and depends on circumstances. Sometimes the child does not feel well enough to work for more than just a few minutes. The nature of the illness itself, medical equipment, and interruptions can also present obstacles. When possible, the art therapist must devise strategies for creating art while circumventing these impediments.

Examples of medical hindrances are the need for cardiac and oxygen saturation monitors, nasogastric suctioning, and traction. Children with these devices must be seen at the bedside. Some kinds of leg traction require the art therapist to become a "human easel," which can add a sense of kinesthetic communication as the therapist feels the pressure applied by the drawing of the child and then responds by supplying the appropriate counter-tension. Children who cannot speak due to mouth sores from chemotherapy or new tracheostomies may take to art therapy readily as a major source of making their feelings and thoughts known. The emotions of the girl in the self-portrait seen in Figure 6 are clearly communicated. The brush stroke beneath her chin could symbolize the tracheostomy which had rendered her speechless.

Patients who have limited use of their upper limbs because of IVs, injury, or paralysis also provide challenges for the art therapist. A collage put together by the art therapist at the direction of the patient can give the child a sense of power, while a variety of feelings may also be expressed through the choice of images. When infective processes are present, it is necessary for the art therapist to wear a gown, mask, and gloves. This garb not only seems antithetical to creating art, but also seems to impair nonverbal communication. Also, some medicines interfere with the making of art. For instance, aminophylline, which is used to treat asthma, can cause tremors affecting line quality in drawing. Morphine and other drugs also can cause perceptual changes.

Interruptions to therapy, another kind of hindrance, are frequent and come in various forms. Some can be avoided by planning in advance, for instance, by talking with the child's nurse before starting a session to be sure no treatments are scheduled and the IV is filled. Unavoidable interruptions may include friends dropping by, a roommate screaming, time for medication, incoming telephone calls, housekeepers emptying the trash, doctors visiting, the arrival of lunch, and even helicopter activity outside the window. Another major interference is the TV. An effective approach (not always successful) is to suggest to the child that art and TV don't mix well, and that the TV be turned off during the session.

Sometimes it is difficult to arrange for the absence of the parents while doing bedside sessions. On arriving in the room, I attempt to form an initial rapport with the parents by encouraging them to talk about their reactions to the circumstances and by describing what I do. I mention my training as an artist, psychotherapist, and nurse, without emphasizing the psychotherapeutic role since this idea is threatening to some parents. I explain that I use art materials to help children understand and express their feelings about what is happening to them. I add that sometimes children find relief by drawing about their illnesses, and sometimes they like to escape by drawing about something entirely unrelated. The choice is the child's. Then I tell the parents that I will be with their child for *x* amount of time (depending on the situation) during which they can have a break, adding that most parents like to go to the cafeteria, take a shower, or go for a walk. Almost always, when faced with this positive approach, they are comfortable in leaving their child, and if they are not, that is telling in itself.

Valuable work can be accomplished under optimal circumstances, as illustrated by Figure 7. Here, a boy struggles with his fear of losing his foot, which was perilously injured when a truck accidentally drove onto it and stopped. In the picture, the boy and a passerby in a car yell to the truck driver to "Get off the foot." Interestingly, the artist does not make word bubbles long enough to include the word "foot." It appears that he is starting to deal symbolically with feelings about its possible amputation. Prophetically, he adds the word "foot," after elongating the bubbles. Needless to say, an interruption in the therapeutic process of venting his fears could have interfered with his beginning to cope with the threat of losing his foot and would have been counterproductive. Fortunately, his foot was saved.

Not so fortunate in the realm of interruptions was the 7-year-old child whose drawing is shown in Figure 8. She had spent many soothingly obsessive minutes, using much control, to fill in the grass and draw a sun and clouds before even

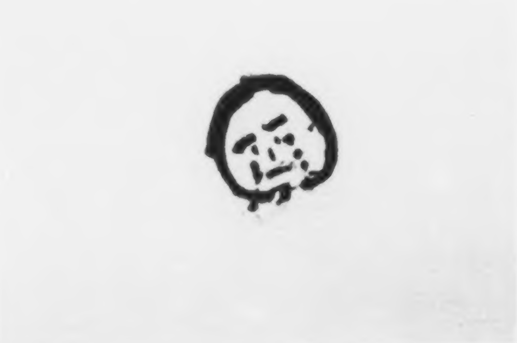


Figure 6.

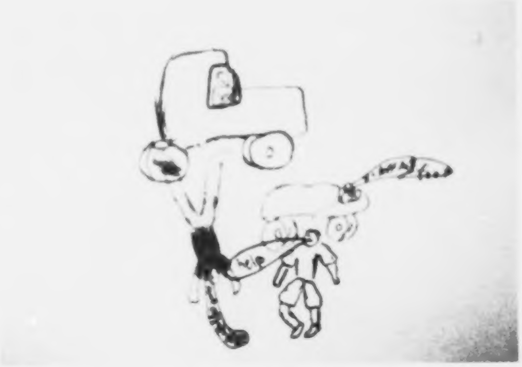


Figure 7.

Figure 8.

attempting the tree. The recent colostomy with which she had to contend seemed to emerge quite evidently in the metaphor of a tree. Because of the sudden availability of the CT scan, the art therapy session had to stop abruptly, and she did not have time to explore any resolution. The best that might have been offered was an observation about how difficult it was not to have control, implicitly referring not only to the interruption itself but also to her inability to control what had happened to her body and its functions. It is important to incorporate these interferences into the sessions for therapeutic gains.

The other major clinical activity is art group which is offered to children who are well enough to attend. Kramer (1979), Linesch (1988), Rubin (1984), and Schneider (1990) provide useful information about principles and facilitating skills used in child art therapy groups. However, additional strategies for groups in the general pediatric setting are needed. DiCowden (1987) presents one approach. The approach used on our unit follows.

The groups are held in the adolescent dayroom, which is spacious and pleasant and looks out onto an atrium. One strict rule is that no medical procedures are allowed, and this affords some sense of sanctuary for the children. A colorful sign saying, "Art Group in Session—Please Come Back at ___ O'clock" is put on the door to prevent interruptions. The children sit at a large round table surrounded by walls with electrical outlets for plugging in IVs. It is a good idea to seat those who have IVs in such a way as to avoid tangling the lines as children arrive and depart. Patients also come with oxygen tanks, in wheel chairs, and sometimes even in their beds. It is imperative to have a functioning intercom system nearby to call a child's nurse, usually for such minor things as a bathroom break or IVs which are low on fluid.

Groups bring their own set of challenges. For example, one small group included a 12-year-old girl with a recently amputated leg about which she was very self-conscious. Shortly after the group began, an 8-year-old arrived who was soon to have surgery for a badly mangled hand. The 8-year-old sat staring fixedly at the other's stump, and a therapeutic intervention was called for on the spot. Sensitivity, tact, and skill are needed when the children's appearances are frightening or repelling or perplexing due to their reasons for hospitalization.

There are other demands in these groups as well. Members seldom attend more than once because of the rapid turnover, so the composition is extremely variable and unknown until the children show up; the ones who have been invited may be unable to come at the last moment, and new admissions sometimes simply appear without having been seen before. However, by making introductions with the arrival of each new member and by giving simple guidelines, a sense of group cohesion can blossom quickly. Comments that there is no right or wrong, or good or bad in art, and that the children can make whatever they like, form a basis for an accepting and secure atmosphere. Often the children confuse this group with art class in school where they are told what to do and are graded; the difference needs to be clarified. Added to the goals of creating art, peer interaction, furtherance of autonomy, and self-expression is the children's discovery of commonalities in their hospital experiences. It is helpful to keep these goals in mind while facilitating the groups.

Clinical work with hospitalized children can become exquisitely satisfying once one gets beyond the hindrances. Although as of now only one-to-ones and groups are scheduled regularly, a rewarding aspect of the job is creating other applications for art therapy.

Recently, a 5-year-old girl with a newborn brother quite suddenly became paralyzed by a tumor pressing on her spinal cord, and, on admission, was only able to use her right hand. Only one thing, she insisted, would bring relief: "I want to go home and make a garden." That not being possible, together we made the art garden which is illustrated in Figure 9. She planted "seeds" for lima beans, flowers, corn, squash, and tomatoes in the paper flower pots which I had made and she had decorated. The "seeds" flourished under the sun she had pasted above to warm them. Between meetings I added new sprouts and leaves to which she would then attach new vegetables and flowers. When several days elapsed between meetings, I added taped-on weeds which she would then gleefully pluck off. Each session ended by her directing me to water the plants, and the garden grew and grew.

I was aware that she had been quite rigid in her control during the creation of her garden, being very decisive about what she would and would not include. When her condition improved and she was to go home soon, the control relaxed, and she was able to present more personal information on an earthier level. More specifically, she seemed better able to

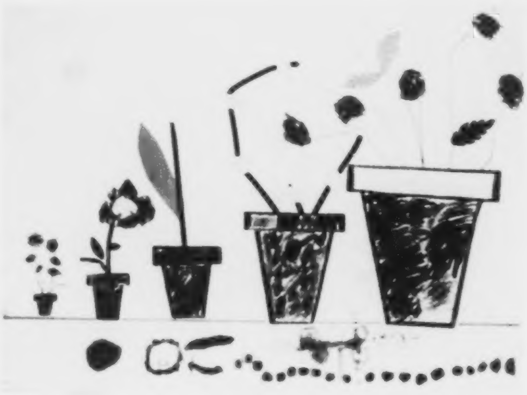


Figure 9.

express feelings in the metaphor about her paralysis and about her brother. The last addition to the garden was a family of worms drawn beneath the flower pots. She fed the worms with the vegetables she had grown. The first worm, drawn in corporal pink, called "the sister worm," is likely herself and is seen above and to the right of the face. The mother worm, drawn next, is above the lima beans at the right. The mother was described with giggles as "gassing out the bottom" and having "lots and lots of buttocks." It must have been perplexing for the patient to be aware of her own bodily odors and functions without the associated physical sensations and control. It is also possible that at this age she confused the mechanisms of bowel movements with childbirth. The child then added that "the mother is pregnant and the baby's foot is coming out of her." The brother worm, depicted beneath herself as a legless rocking horse, has a wooden pole through his head. "That's the thing you hold onto when you ride on him," she said with a smile. She seemed conflicted about his ability to walk, and perhaps she felt punished by paralysis for her hostile feelings toward her new sibling. The face belongs to the father, and for reasons unknown is the only nonworm family member.

The opportunity to create these kinds of reparative interventions goes a long way toward diminishing the impact of the devastating illnesses and trauma seen in clinical work. It is also a useful strategy for preventing burnout, because the act of creativity is empowering and regenerative.

Supplies

Another important concern for art therapists is to have high quality art supplies kept in good order; this shows respect for the making of art. Using oil pastels instead of Crayons is a subtle way to give the message that the creation of art is more than play. The basic materials for drawing, painting, and sculpture are sufficient, since a thorough exploration of any one medium is more than can be accomplished in a few sessions. While the patient may, of course, choose any medium, in keeping with the philosophy of "being where the child is," tempera paint and clay are always readily available. For the child confined to the hospital, it can be soothing to be in touch with such earthy substances. Also, these media are especially conducive to the expression of feelings.

A 9-year-old boy appeared to seek resolution of the struggle he was having with cancer solely by mixing paints. He had moved to this point after spending many sessions making nonrepresentational designs with a ruler and pencil, perhaps finding comfort in this guarding of his emotions. His many mixtures were made in tiny clear plastic medicine cups, which he anthropomorphized. One grayish-purple cupful was named Oscar. Oscar didn't fit in with the other colors because it was so different, which may have symbolized his feelings of being isolated because of his disease. Sometimes the child created potions, appearing to reenact the battle of the cancer and the chemotherapy in his body. He made potions that would render the consumer weak and helpess and potions providing vigor and longevity. Then he would mix them together, analyzing them to see which seemed to be the strongest. He engaged in a similar process, perhaps as an outlet for his anger, when he dropped little paint-blob "bombs" into the water held in a large clear plastic container. He delighted in seeing their explosive diffusion through the sides of the jar and again in creating battles as other "bombs" were dropped. While he never painted a picture, the strategy of staying empathically with his lead in the creative use of the materials seemed to be beneficial.

The availability of a kiln can be an asset for children with life-threatening illnesses. When appropriate, clay may be offered with the explanation that the kiln can make the work "become as hard as a brick and last forever." This invitation to make lasting memorials has yielded some extraordinarily moving works of art, later to be treasured by the children's families. More commonly, the children are offered the opportunity to paint their finished sculptures, which enriches the process of art making rather than emphasizing the end product.

A large canvas bag, stocked with art supplies and paper clipped to same-sized, heavy cardboards, is used for one-to-one bedside sessions. If the children feel up to it, they enjoy hunting through the bag to choose their media. Another scheme for managing a greater volume of supplies is a wheeled art cart with drawers. This is especially convenient for group use. Separate drawers can be used for drawing, painting, and sculpture materials, and paper can be stored in vertical files attached on the back. The cart is locked away when not in use.

When the children arrive for group, colored pencils, markers, tempera paints, and paper of various sizes have been set out invitingly on the table. These materials offer a range of expressive control—from tight, using pencil and small paper, to a looser style, using tempera and large paper. As the group progresses and one gets a sense of its direction and needs, other materials can be added.

There are a few special considerations about using art materials in the hospital. They are safe to use in most situations, but exceptions must be kept in mind. As an example, it is probably not wise to offer chalk pastels to asthmatics. Also, immunosuppressed children need to have clean materials, and supplies used by children who are isolated because of infections must be decontaminated. With the former patients a few new materials the child likes can be selected and left in the room; with the latter the hospital infection control policy for decontamination should be followed.

Organization of Artwork

Managing the art products of the hospitalized pediatric population is complicated because of the rapid turnover. As mentioned previously, the children have the choice of what to do with their finished artwork. Frequently, I have observed that when the work is affectively loaded, children leave it with the art therapist; in contrast, when it has more of a social, "hearts-and-flowers" nature, they keep it or give it to their parents. Portfolios are maintained for patients seen over time, special projects such as sibling and family artwork, staff artwork, and artworks used when giving inservice presentations. Two other portfolios, which can be used for educational purposes, contain art exemplifying normal developmental phases and organic impairment. The largest portfolio is a chronologic one for children who come in for short-term, acute care. Occasionally these children return at a later date, and when their old artwork is brought to them, they seem to feel a warmth from continuity. Carbon copies of chart entries are kept to refresh the memory if these children are rehospitalized.

In addition to the actual artwork, I have developed a slide library of the children's art, along with the attending parental permission forms. When asking the parents for permission, I tell them that I have a large collection of children's artwork and would very much like to be able to include their child's. Usually they are flattered by this approach rather than uneasy about my wanting to photograph the artwork for possible pathologic content. The slides are filed in plastic slide boxes, alphabetically with the child's name. A corresponding card file refers to each slide by age, sex, date, and diagnosis. Carbons of chart notes for each child in the library are also at hand for reference. In this way, when called for, it is easy to select works done by children of certain ages or diagnoses. The slide library is used for many purposes, including presentations, articles, and potential research. It can also be used to evoke memories and savor past meaningful experiences for patients, families, and myself, much as one would a family photograph album.

New strategies for using the slides emerge from time to time. Recently, I worked with a long-term patient with a grave prognosis to create a retrospective art show of her work. The occasion was overtly a celebration of her creativity in life, and covertly a review in preparation for the letting go of her life. We used the slides collected over the years and planned the exhibition together. She was wholly in charge of the guest list, selection of the artwork to show, and narration of the slides. The experience appeared to offer some resolution for all involved.

Conclusion

There are both pleasures and pitfalls in this job. Because there are no art therapy colleagues at hand for support, it is often lonely. It can also be profoundly sad, and the potential for burnout is ever-present. On the other hand, and far weightier in the balance, is the privilege of the intimacy experienced as one is included by the children in their resilient and courageous responses to adversity. I hope that the strategies presented in this article will serve to stimulate thinking about practice in this field.

References

Appleton, V. (1993). An art therapy protocol for the medical trauma setting. *Art Therapy: Journal of the American Art Therapy Association, 10*(2), 71–77.

Arnheim, R. (1969). *Visual thinking*. Berkeley: University of California Press.

Bach, S. (1990). *Life paints its own span: On the significance of spontaneous pictures by severely ill children*. Zurich: Daimon Verlag.

Bergmann, T. (1965). *Children in the hospital*. New York: International Universities Press.

Betensky, M.G. (1987). Phenomenology of therapeutic art expression and art therapy. In J.A. Rubin (Ed.), *Approaches to Art Therapy* (pp. 149–166). New York: Brunner/Mazel.

Bibace, R., & Walsh, M.E. (1980). Development of children's concepts of illness. *Pediatrics, 66*, 912–917.

Councill, T. (1993). Art therapy with pediatric cancer patients: Helping normal children cope with abnormal circumstances. *Art Therapy. Journal of the American Art Therapy Association, 10*(2), 78–87.

DiCowden, M.A. (1987). Art therapy: A therapeutic tool in pediatric acute and rehabilitation programs. *American Journal of Art Therapy, 26*(2), 52–56.

Freud, A. (1952). The role of bodily illness in the mental life of children. *Psychoanalytic Study of the Child, 7* 69–81.

Gabriels, R.K. (1988). Art therapy assessment of coping styles in severe asthmatics. *Art Therapy: Journal of the American Art Therapy Association, 5*(2), 59–68.

Henley, D.R. (1987). An art therapy program for hearing-impaired children with special needs. *American Journal of Art Therapy, 25*(3), 81–87.

Junge, M.B., & Linesch, D. (1993). Our own voices: New paradigms for art therapy research. *The Arts in Psychotherapy, 20* 61–67.

Kramer, E. (1971). *Art as therapy with children*. New York: Schocken Books.

Kramer, E. (1979). *Childhood and art therapy*. New York: Schocken Books.

Kwiatkowska, H.Y. (1978). *Family therapy and evaluation through art*. Springfield, IL: Charles C. Thomas.

Landgarten, H. (1981). *Clinical art therapy*. New York: Brunner/Mazel.

Lillitos, A. (1990). Control, uncontrol, order, and chaos: Working with children with intestinal motility problems. In C. Case & T. Dalley (Eds.), *Working with Children in Art Therapy*, (pp. 72–88). London: Tavistock/Routledge.

Linesch, D. (1988). *Adolescent art therapy*. New York: Brunner/Mazel.

Nadler, H.S. (1983). Art experience and hospitalized children. *Children's Health Care, 11*, 160–164.

Perin, E.C., & Gerrity, P.S. (1984). Development of children with a chronic illness. *Pediatric Clinics of North America, 31*, 19–31.

Prager, A. (1993). The art therapist's role in working with hospitalized children. *American Journal of Art Therapy*, 32,(1), 2–11.

Prugh, D.G., Staub, E.M., Sands, H.H., Kirschbaum, R.M., & Lenihan, E.A. (1953). A study of the emotional reactions of children and families to hospitalization and illness. *American Journal of Orthopsychiatry*, 23, 70–79.

Robbins, A., & Sibley, L.B. (1976). *Creative art therapy*. New York: Brunner/Mazel.

Rubin, J.A. (1984a). *Child art therapy* (2nd ed.). New York: Van Nostrand Reinhold.

Rubin, J.A. (1984b). *The art of art therapy*. New York: Brunner/Mazel.

Schneider, S., Ostroff, S., & Legow, N. (1990). Enhancement of body-image: A structured art therapy group with adolescents. *Art Therapy: Journal of the American Art Therapy Association*, 7(3), 134–138.

Shugart, M.A. (1991). Child psychiatry consultations to pediatric inpatients: A literature review. *General Hospital Psychiatry, 13*, 325–336.

Stronach-Buschel, B. (1990). Trauma, children and art. *The American Journal of Art Therapy*, 29,(3), 48–52.

Terr, L.C. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*(1), 10–20.

Art Therapy: Journal of the American Art Therapy Association, 12(1) pp. 39-45 © AATA, Inc. 1995

Art Therapy on a Hospital Burn Unit: A Step Towards Healing and Recovery

Johanna Russell, MS, A.T.R., Sacramento, CA

Abstract

This article describes how art therapy can benefit patients who are hospitalized due to severe burns. Burn patients typically suffer psychological as well as physical trauma due to their burn experience. This author outlines the psychological phases, identifies how burn patients typically experiences their healing process, and discusses how art therapy can assist the patient at each stage of the recovery process. Two case studies illustrate the use of art therapy with pediatric burn patients to express their trauma and cope with their burn experience.

Introduction

Patients who are hospitalized due to severe burns suffer physical and psychological trauma. Burn wounds have been described as one of the most physically traumatic injuries and hospitalizations a person may experience. Additionally, the burn incident and injury itself may be terrifying. The person may experience loss of home, parents, siblings, pets, and/or possessions. Those persons who require hospitalization endure necessary painful procedures such as daily dressing changes, debridement of dead tissue, and numerous surgical procedures. For some, disfigurement and disabilities may occur from loss of body extremities such as fingers, hands, toes, or feet. For all, scarring as a result of the burn injuries can lead to difficulties in accepting a change in body image and self-esteem.

A patient may have to return to the hospital numerous times for reconstructive surgery in order to release skin contractures which may form across joints. Burn injuries can be severe and the psychological ramifications must be dealt with for the patient to successfully adjust and adapt to his/her burn experience.

Art Therapist as Multidisciplinary Burn Team Member

Burn units that utilize a "burn team" approach recognize the need for multidisciplinary professionals who meet both the physical and the psychosocial needs of burn patients. The available literature highlights how important it is that the team include mental health professionals who are not directly involved in the physical, medical care of the patient. Nicosia and Petro (1983) recommend, a "no needle" mental health professional should be available to attend to the emotional needs of the patient. "This should be someone on whom the patient does not depend for direct medical care, and therefore to whom it is easier for the patient to express a range of feelings, including opposition and anger" (p. 108).

The author is an art therapist and a member of the multidisciplinary team at the medical center. In her work, she brings a variety of age and developmentally appropriate art materials to the bedside from which the patient can choose. The art supplies include oil pastels, felt tip pens, paints, drawing materials, paper, clay, print making and mask making materials to name a few. The art therapist purposely elicits the patients' anxieties, responds to their fears, and passes on this information, if necessary, to other medical burn team staff. Baron (1989) observes, "because the art therapist is accustomed to reading a symbolic language, he or she has the opportunity to cue into these messages and to play a central role in their understanding" (p. 152).

The art therapist can assist burn patients throughout their healing and recovery process. "From a holistic perspective, the art work provides art therapists with a much deeper level of understanding and the possibility to participate more fully with clients in their healing process" (Baron, 1989, p. 151). Mehaney (1990) in writing about the use of play therapy with a 3-year-old burn patient concurs with Levinson and Ousterhout (1980), who used art therapy with burn patients, saying "interventions to facilitate adaptation to burns, include the use of art . . . therapy" (p. 57). The art therapist is a valuable member of the burn team in being a part of the patient's therapeutic support system.

Psychological Phases in Adaptation to Burn Injuries

Of particular value to any mental health professional working with burn patients is an understanding of the stages of recovery patients may experience during the process of adapting to and recovering from their injuries. The stages appear to be similar for both children and adults. Children certainly have special needs, but "all burn patients tend to follow a similar course" (Cresci, 1982, p. 475). Not all burn patients experience every stage, and some patients experience the stages in different sequences at varying times. These stages tend to overlap and form a continuum with each stage being replaced by the next stage.

Watkins, Cook, May, and Ehleben (1988) describe seven stages of response that adult burn patients typically experience. The seven stages include survival anxiety, problem of pain, search for meaning, investment in recuperation, accept-

BEST COPY AVAILABLE

ance of losses, investment in rehabilitation, and reintegration of identity. Doctor (1993) claims these stages can be easily adapted to the pediatric patient as well. In working with burned children, I have found that Watkins' et al. stages are descriptive of the psychological adaptations children may experience. Therefore, I have incorporated these stages into this article to help describe the recovery process. A patient may pass through a stage and later in his/her recovery, may need to return to a stage and reintegrate its meaning into his/her life.

Art therapy provides an action-oriented, external outlet for hospitalized children to cope with their trauma. Steward (1993) states that there is new research to suggest that the selection and use of coping strategies changes across the life cycle, with younger children employing more action-oriented, external coping strategies while older children, adolescents, and adults increasingly employ cognitive and affective, internal coping strategies. Steward further notes that the opportunities of young patients to use developmentally appropriate action strategies in the face of stress (escaping, running away, etc.) are sharply limited by the need to administer necessary, painful medical procedures. Action strategies are further limited by the drain on children's physical energy and well-being. By manipulating developmentally appropriate art media such as paints and clay, children can make use of their action-oriented means of coping.

Use of Art Therapy in Assisting Burn Patients with Their Psychological Phases of Recovery

Stage 1: Expressing Survival Anxiety

During the initial stage, which Watkins et al. describe as "survival anxiety" where the patient wonders if he/she will survive the burn injury, the art therapist may encourage the patient to communicate his/her concerns. Cersei (1982) explains that burned children sometimes need help in clarifying their feelings. "By telling a story about a favorite animal that is sick, or drawing a picture, children will reflect their feelings and concerns" (p. 494).

Stage 2: Problem of Pain

Art therapy is an excellent tool to help burn patients express and cope with pain. McGrath and Vair (1984), in their study of the psychological aspects of pain for burned children state, "It is helpful to give children a way of expressing severity of pain. If children are given effective tools to express their pain and are listened to, they are more likely to be able to cope" (p. 83). They suggest three strategies to reduce pain "(1) enhancing predictability and control, (2) encouraging relaxation, and (3) using distraction" (p. 17). Art therapy may be used to assist patients in pain management in each of these areas.

To enhance a patient's feeling of control, a patient can choose whether or not to do artwork. The art therapist is one of the few people in the hospital to whom the patient can say "no!" If a patient does desire to participate in an art activity he/she has control over the selection of art materials. Most importantly, the child can decide what kind of mark or picture they want to draw or how they want to squeeze, pound, or mold clay. In a hospital environment where the patient has little control over what happens to him/her, art therapy offers a sense of control. In the art therapy literature, Lusebrink (1989, p. 2) summarizes that art therapy "enchances a client's sense of control and mastery through the physical manipulation of materials, reorganization of sensations and corresponding conscious thought processes."

To encourage relaxation, imagery that is soothing to the patient can be imagined and then drawn. The artistic process itself facilitates reducing tension as the patient becomes involved in the art activity. (Klingman, Koenigsfeld, Markman, 1987, p. 164). When the patient is involved in manipulating art materials and creating, he or she is focused on the artwork and, therefore, is distracted from his or her pain.

Stage 3: Search for Meaning

During this phase, the patient may need to retell the burn accident many times as he/she attempts to understand the question "Why did this happen to me?" A child, for example, may be feeling too much anxiety to verbalize this concern, but he/she may be able to express his/her fears through artwork. Roberts and Appleton (1989, p. 63) describe the use of art therapy at a hospital burn center as "a very effective outlet for expression and a basis for exploring the patient's concerns" (p. 63).

Watkins et al. (1988) emphasize the need for patients to resolve their own understanding of their injury. Patients may focus so intently on the circumstances of the injury, that they have little energy left for involvement with others and may become withdrawn or avoid situations because of an overwhelming fear of the situation recurring. Resolution of this stage is very important.

Stage 4: Investment in Recuperation

During this phase, patients move towards regaining autonomous functioning. As burn team members praise patients for small gains, patients learn to focus on their abilities rather than their disabilities (Watkins et al., 1988). By actually manipulating art materials and creating a tangible art product, patients are able to focus on their accomplishments. The art therapist can encourage and praise the patients' attempts to participate and create their own art.

Stage 5: Acceptance of Losses

The next phase of the burn patients' recovery begins when patients start to comprehend cognitively and emotionally the losses they experienced as a result of the injury (Watkins et al., 1988). Orr, Reznikoff, and Smith (1989, p. 454), who studied body image, self-esteem, and depression in burn-injured adolescents and young adults, explain, "Patients with burns may experience inordinate personal losses, such as the death of parents, siblings, or pets and the destruction of possessions, in addition to the loss of bodily functions or limbs" (p. 454). Scarring due to burns can also be devastating in terms of body image and self-esteem.

The art therapist can allow patients to express losses and, thereby, assist patients to define the losses and move toward acceptance. Cameron, Juszczak, and Wallace (1984, p. 108) used creative arts in a hospital setting to help children cope with altered body image and learned that

> . . . creative arts can be helpful as a preventative, therapeutic and assessment technique for helping children with their body

1984

> image. It is a way of allowing children to deal with potentially difficult issues at a safe distance and of providing opportunities for making choices and feeling in control. (p. 112)

Cameron et al. summarize: "Carefully selected expressive activities provide children with the opportunity to deal with their body image during hospitalization and thus help foster reintegration and acceptance" (p. 112).

Stages 6 and 7: Investment in Rehabilitation, Reintegration of Identity

During these stages patients are learning to regain as much of their pre-burn level of independent functioning as possible. As patients experience success in accomplishing even simple tasks, they feel a sense of accomplishment and gains self-confidence. However, patients may discover they are unable to resume some functions. At this point patients may feel sadness, hurt, frustration, anger, and anxiety. They may have to re-comprehend emotionally the newly recognized loss, accept it, and move again toward recovery and rehabilitation. Through art therapy, patients can express their fears and concerns and work through their anxieties and frustrations. Patients may also determine and express goals through their artwork which can facilitate their rehabilitation.

Case No. 1

Mary was 8 years old at the time an aerosol can exploded next to a wood stove in her home. She was the only one home at the time of the explosion which caused her and her home to catch on fire. She suffered 80% total body surface area burns, with 65% full thickness burns to her arms, torso, legs, and neck, and 13% partial thickness burns to her face and posterior torso. Initially, the risk of Mary's death was high due to the high percentage of her body that was burned. Her initial hospitalization was for 5 months during which she had numerous surgeries. She would need to return to the hospital for reconstructive surgery many times.

Mary was 3 months post-burn injury when I joined the burn team and began working with her. At this time she was still undergoing numerous surgeries for skin grafting, experiencing painful but very necessary procedures such as twice daily dressing changes, and learning to move and manipulate her limbs again through painful physical therapy. I worked with her for the ensuing 2 months of her hospital stay and during numerous returns to the hospital for reconstructive surgery over the next 2½ years. From the psychiatric consultation notes in her medical record charts, I noted that she initially expressed fears of mortality, the loss of her kittens in the fire, and the possibility of her deformed appearance. Through art therapy, she continued to express her concerns, losses, joys, and accomplishments as she adjusted to the phases of her burn experience.

Acrylic paints were the first art medium Mary tried. Her hands were still bandaged, yet she had enough grasp for me to slip the paint brush in between her thumb and fingers. She could then move her hand with the paint brush across the paper. She could make bright colors flow onto the paper without needing to apply pressure, which would have been difficult and painful for her to do. Most importantly, she was able to do the activity herself and see the outcome of her endeavors. Painting was initially successful and continued to be Mary's favorite art medium.

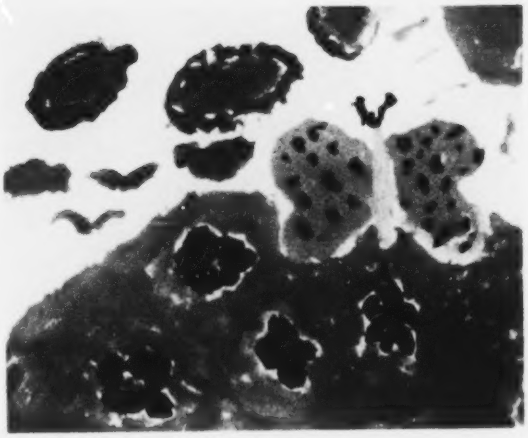


Figure 1.

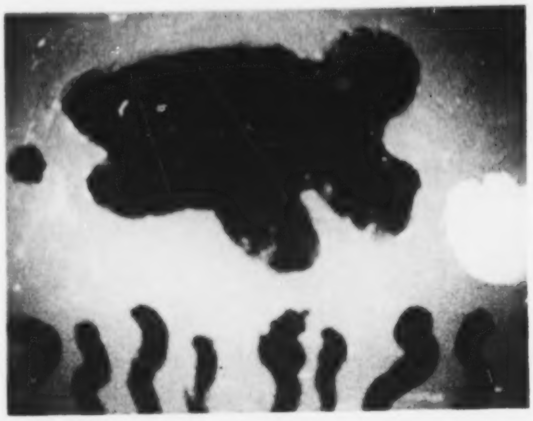


Figure 2.

Figure 1 is Mary's first painting after her burn accident. She discovered that she could manipulate the paint brush and control the color, shapes, and lines within the picture. It seemed important to her at this time to be able to create something bright and colorful, using bright red for the flowers and brilliant yellow for the butterfly with red and blue spots. She also may have been unconsciously acknowledging that she was experiencing a transformation, as does a butterfly, in adjusting to her burn injury. I praised her efforts and hung her picture on the wall of her hospital room so she could proudly show it to family, friends, and hospital staff when they entered her room. During art activities, Mary had control over her art materials; also, it was relaxing, and it was a distraction—all helpful in reducing pain.

After several other paintings on various days, she painted the picture in Figure 2, a green fish swimming in a blue sea. When she finished painting it she exclaimed, "That is the best I have ever painted!" This was a very important realization for Mary because her comment implied that here was something she could do better now than before the fire and her injuries. Mary was attempting to regain her autonomous functioning

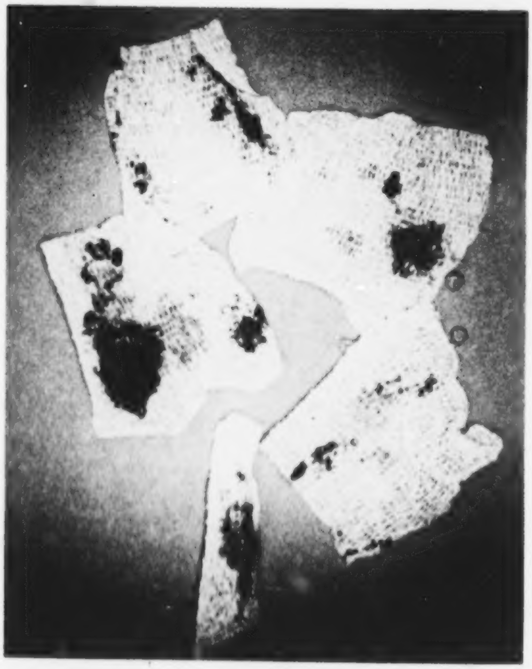


Figure 3.

which Watkins et al. describe in the stage of "Investment in Recuperation." The artwork was a tangible product that she could experience creating and in which she could take pride.

Figure 3 is a picture using the bandages from her fingers which she saved and painted. She originated the idea of painting her bandages. When I suggested she mount them on poster board, she did and labeled it, "My colorful spinning wheel." The patient was transforming her bandages which had a connection with her painful dressing changes and injuries into a colorful, playful object. She possibly was gaining control over her bandages, which in turn helped her control and diminish her pain.

Nine months elapsed from the time of Mary's discharge to our next session in the hospital. During this session, she painted a light blue figure with yellow hair and eyes extending out of its head (Figure 4). Two lavender hearts float nearby. Mary told me she wanted to paint a monster and proceeded to paint this picture. It is my speculation that this may be a self-portrait, depicting Mary's feelings about herself. Her monster appears to be a friendly, feminine monster with eyes that are out of its body. The lavender hearts, which are her favorite color, communicate friendliness and love. Her monster does not appear to have a neck, which is very similar to Mary's appearance at this time until she can have reconstructive surgery to reform her neck. Mary's monster (and Mary herself) may be very aware and seeing, and may want others to see her friendliness and not her body which may appear monsterlike. Using the metaphor of the friendly monster may have been her way of expressing feelings which were too painful or threatening to verbalize. She was attempting to accept her body image which was an appropriate response for her as a burn patient and was expressing a normal concern for her adjustment process with her world of friends, family, and school.

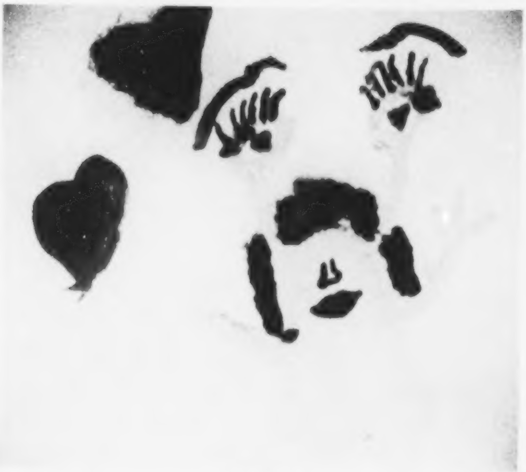


Figure 4.

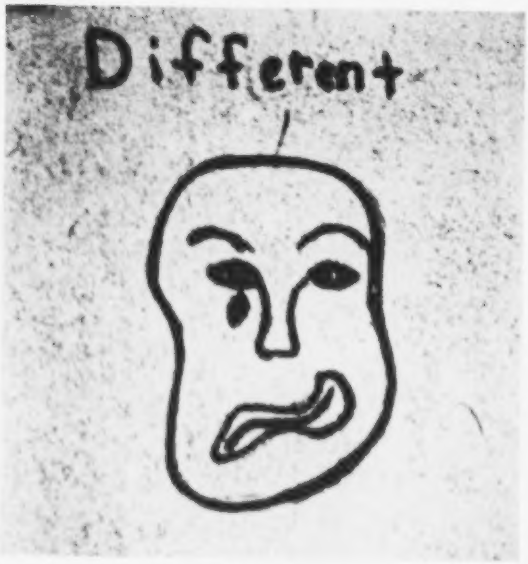


Figure 5.

Six months later, when she returned to the hospital for another reconstructive surgery, she created Figure 5, which she entitled "Different." The art medium here is print making which she had looked forward to trying for several hospitalizations. Mary, as usual, decided the subject matter. While she drew, she said she did not like the clown who smiled all the time because he laughs and jokes when the other clown is sad. She then wrote "Different" above the clown's head.

Another 9 months followed and Mary returned for yet another surgery. She told me at this time that she and her family might be moving to another state. She painted the picture in Figure 6 and spontaneously dictated to me the corresponding poem. The possibility of moving appears to have prompted Mary to re-evaluate her losses. She is returning to the phase in her adjustment process of redefining and accepting her losses. The lost paint brush may indicate that she has to say good-bye to me and our art time together. She includes

1986

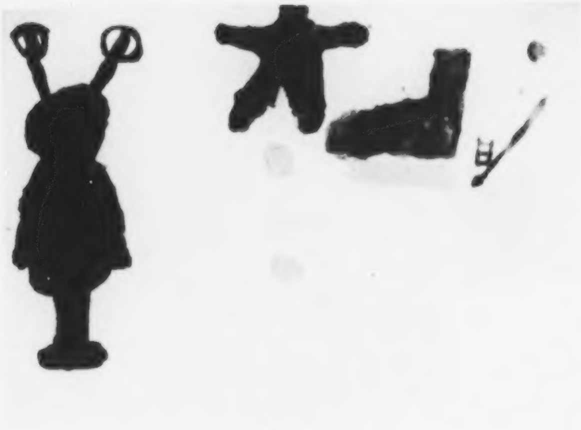


Figure 6.

LOST THINGS
I lost my jumping jacks.
I used to have a pretty little teddy, but I lost it too!
My Mom broke her wine glass but then couldn't find it.
My older brother has stinky sneakers, but we guess the dog drug them off.
At school I had a hole in my pocket—I lost all my money for pop cycles.
My baby sister took my comb and hid it away.
And while we watched an old movie, my Dad lost his cup.
While I was painting this picture for the poem, I lost my paint brush.
I met this THING—he says he knows all about it.

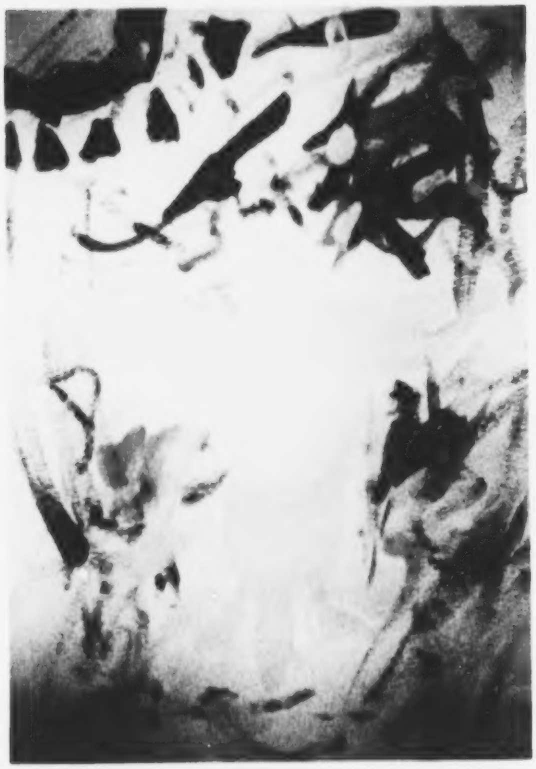


Figure 7.

all members of her family, as if indicating the "problems" of daily living that occurred in their lives. Her "Thing" is the green friendly looking monster (that is similar to her other monster). The "Thing" seems to observe all this, understand it, and accept that life is just like that.

One month later, Mary was back. She painted Figure 7 in the afternoon while she was waiting to go to surgery. She said the blue bird is sad and that the background is someplace where no one has ever been before. She was feeling very anxious about her upcoming surgery that day and told me that being busy with art helped her feel less anxious. The art gave her a way to express her anxiety as well as providing an activity she could engage in while waiting.

Art therapy assisted Mary in processing her inner concerns through the various psychological phases of her burn trauma. The artwork was a positive, expressive activity where she had control over the medium and could take pride in the resulting art products. The art was a diversion from pain and anxieties due to hospital procedures and surgeries. Through her artwork, she could express concerns about her body image due to scarring and deformities caused by her burns. She also was dealing with the losses she had suffered and portrayed these feelings through art. Moreover, whenever she came back to the hospital for surgery, she could look forward to seeing me and having our time together, as well as creating art. Art therapy provided a tangible, positive medium through which Mary could express her joys, fears, and anxieties and thereby assisted her in her healing process.

Case No. 2

Tina was a 4½-year-old female who was admitted to the burn unit with burns on her buttocks, genitalia, legs, and feet. Her injuries appeared to have characteristics similar to burns due to forced immersion in hot water and appeared to be several days old. Bruises also were evident on the patient's body. She smelled foul, had a severe case of head lice, appeared frightened, and was malnourished. Her mother, a 20-year-old single parent with two other children ages 1 and 6, first brought her daughter into an outpatient clinic for treatment of diarrhea whereupon the patient was tranferred to the burn unit. Child abuse was immediately suspected due to the type of injury, the delay in bringing the patient for medical care, the bruises evident on her body, and the mother's account of how the burn happened, which was inconsistent with the type of burn injury. When the child was admitted to the hosital, Child Protective Services was notified, and Tina was removed from the custody of her mother.

The first day the patient was admitted to the hospital and settled in her hospital room, I introduced myself to her. Since she was very frightened, tired, and hungry, I helped feed her ice cream at her nurse's suggestion. I then read to her from a children's book in which she took an interest. I felt she did not have the energy to do art this first day, but I still wanted to introduce myself and interact with her in a supportive nonthreatening manner.

At our second session, which was 2 days later, Tina appeared less frightened. When I offered her a drawing pad and crayons to use, she choose a pink-purple crayon and started spontaneously drawing members of her family (Figure 8).

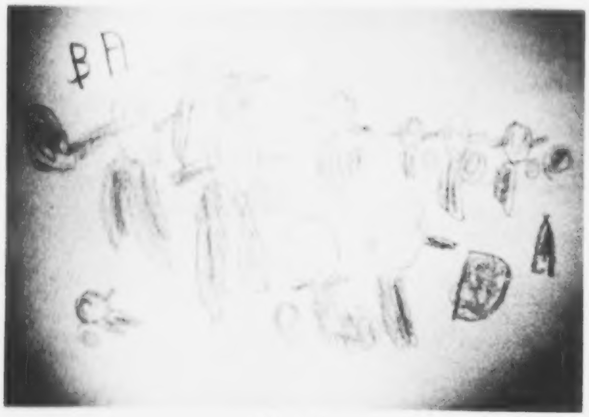


Figure 8.

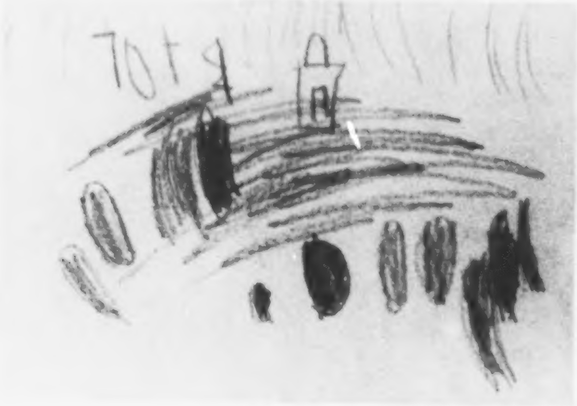


Figure 9.

While she drew, she talked softly about each person. She started with a picture of her mother with a smile on her face. She drew her dad looking sad. As she drew the figures, she talked about the illustrated behavior of different family members, such as one family member pulling out his hair. Tina said the small figure in the lower, left-hand side of her picture was "too little to get hit." The circle shapes beside each figure, she said, were cookies which her mom and dad made. However, she said that if she ate the cookies, she would throw up. Tina explained that the letters *BA* at the top of her picture meant "I love you," which she wanted to tell her mom. However, Tina became angry at this point and said she did not know how to write "I love you" because no one had taught her.

At this session, Tina was expressing many thoughts and feelings. For example, she was expressing survival anxiety (stage 1 in Watkins' et al. psychological phases); however, her anxiety seemed to be primarily because of her abusive family environment. She appeared to have angry, conflicting feelings about her mother and father which she indicated by saying she would throw up the home-baked cookies and being angry at not knowing about love. She did not complain of her pain, which is often typical of children suffering from abuse.

Through her drawing and verbal dialogue, Tina could express her situation and her feelings of anger and sadness. When she was drawing, she seemed to give herself permission to talk about aspects of her abuse. I listened carefully to her and supported her feelings that it was not right to get pushed and hit, and that she had a right to be angry.

After she finished her first drawing, she drew a second picture (Figure 9). First, she drew rain at the top of the page. Then she drew her mother's house and said the wind was blowing, as she made large, back and forth strokes across the page. She then covered her mother's house in color, which she said was frost on the windows. She drew other ovals which were other houses, such as her aunt's, which she also covered with color. Tina talked quietly as she drew and expressed herself through her story and her large sweeping strokes of color.

Tina appeared to be beginning to work through her "search for meaning" (stage 3 of Watkins' et al. psychological stages). However, at this point she did not disclose how her burn accident happened, which made it difficult for her to resolve this stage. She expressed her anxiety by drawing wind and then covered up her secret by drawing frost on the windows so one cannot see in or out. During later sessions with Tina, I learned that her mother had told her not to tell what happened, which is typical in abusive situations.

After this session, I charted the significant details of our interaction in her medical record chart. I also talked with the social worker handling this case and communicated to her what I had learned. The social worker could then make any necessary further reports.

Our third session was 5 days after the second session. The patient had received skin grafting several days prior in surgery. Her head had been shaved, which is a normal procedure when using this area as a donor site for skin to graft onto the burned areas of the body. The patient was quiet and withdrawn compared to her talkative and sponataneous manner during the previous drawing session. However, she told me she wanted to draw, and I offered her crayons. She drew one house which she said was her mommy's house. Then she put her head down on her table. She said she was hungry, but when lunch came she ate very little.

After lunch I showed her some hearts since it was close to Valentine's Day and during the second session she had told me she wanted to draw a heart. She glued the hearts onto the paper but remained subdued and quiet during this activity.

Tina's mother came into the room during this time, but Tina showed little response or reaction to her mother. She continued gluing hearts onto the paper. After about 30 minutes of very little interaction between the two, her mother said she was going to the cafeteria for awhile and left the room. Her mother did not return again that day. When her mom first left the room, Tina cried and wanted her mother to return. After about 10 minutes, Tina stopped crying and I offered her poster paints. Tina proceeded to paint her entire piece of paper red. She appeared to be absorbed in her painting and talked very little during this time. The painting seemed to give her an outlet to express in paint that which she could not verbalize.

Our fourth art therapy session was 4 days after the third session. I offered Tina the paints again because I knew she had enjoyed using the paints and had been expressive in her choice of color. During this session, she used all the colors and appeared to be excited and happily engrossed in mixing

1988

colors to discover new colors while she painted with large, circular strokes. After about 45 minutes of painting, she said she was finished and wanted to draw.

While Tina drew a large face, she said, "My daddy whips me, and I don't like it." She further said he hit her with a belt. She also said that's how her feet got hurt. Since I knew that her feet were burned, I realized there was an inconsistency in her story and that she was not telling everything. She said her mom did not want her to tell anyone, and she did not want me to tell her mom that she had told me. She then said she was finished drawing. I listened to her, validating her feelings, and told her that it was not right to get hit and that she was right in telling me.

Through painting at the beginning of the session and then drawing, Tina seemed to become more confident and, therefore, was able to begin to express more about her abuse. In addition, she seemed to be continuing to work through the psychological phase of adjustment of "searching for meaning" and beginning to be able to tell her story. By painting and drawing, Tina was able to express her emotions, to reveal aspects of her abusive home environment, and to tell secrets of her abuse which her mother had told her not to tell.

It was determined that Tina would be placed with a medical foster mother when discharged from the hospital. When I saw Tina for our fifth session, a few days before discharge, she was withdrawn and quiet. She appropriately seemed to be anxious about going to a new home and leaving the now familiar hospital surroundings and staff. She did not want to talk, paint, or draw. I then sat down next to her, put my arm around her, and read her a book. She leaned up against me and appeared to like the comforting time.

The last time I saw Tina during hospitalization, the foster mother was at the hospital to take her home. Tina was frightened and crying that she did not want to leave the familiarity of the hospital and go to a new home. The foster mother was appropriately sincere and caring in the situation. I helped them pack Tina's belonging, supported Tina's anxious feelings, transpored her to the car, and said good-bye to her.

Conclusion

In conclusion, art therapy can play an important role in a burn patient's recovery process. Since some patients, especially children, can express themselves better through nonverbal modalities, there is a need for an art therapist to assist them in working through their trauma and psychological phases of adjustment. Art therapy provides an action-oriented, external outlet for hospitalized children to cope with their trauma. When children manipulate developmentally appropriate art media, they make use of these action-oriented means of coping.

By drawing, painting, pounding clay, etc., children can express their emotions about their burn experience. During hospitalization, their participation in art allows them a distraction from their pain, offers them predictability and control, and provides them with a pleasurable, relaxing part of their day. They can look forward to seeing the art therapist, with whom they have built a relationship of rapport and trust and who is not a part of painful, but necessary hospital procedures.

As burn survivors progress toward reintegrating their body image and adjust to accomplishing tasks or being unable to resume all of their pre-burn functioning, art therapy can be an outlet for expressing their frustrations, anger, sadness, and/or joy. Art can help burn survivors comprehend their losses and gains as well as assist them in determining new goals. Their artwork is a tangible product in which they can take pride and see their accomplishments. Their art also serves as a permanent record of their thoughts and feeling that can be evaluated and used in assessment. Art therapy provides a unique means of assisting, supporting, and enabling patients to cope with their burn experiences.

References

Baron, P.F. (1989). Fighting cancer with images. In H. Wadeson, J. Durkin, & D. Perach (Eds.), *Advances in art therapy* (pp. 148–167). New York: John Wiley.

Cameron, C.O., Juszczak, L., & Wallace, N. (1984). Using creative arts to help children cope with altered body image. *Child Health Care, 12*, 108–112.

Cresci, J.V. (1982) Emotional care of the hospitalized thermally injured. In R.P. Hummel (Ed.), *Clinical burn therapy: A management and prevention guide* (pp. 475–508). Boston, John Wright & Sons.

Doctor, M.E. (1993). History of psychosocial care. *Journal of Burn Care and Rehabilitation, 14*, 267–271.

Klingman, A., Koenigsfeld, E., & Markman, D. (1987). Art activity with children following a disaster: A preventative-oriented crisis intervention modality. *The Arts in Psychotherapy, 14*, 153–166.

Levinson, P., & Ousterhout, D.K. (1980). Art and play therapy with pediatric burn patients. *Journal of Burn Care and Rehabilitation, 1*, 42–46.

Lusebrink, V.B. (1989). Art therapy and imagery in verbal therapy: A comparison of therapeutic characteristics. *The American Journal of Art Therapy, 28*, 2–3.

Mehaney, M.B. (1990). Restoration of play in a severely burned three-year-old child. *Journal of Burn Care and Rehabilitation, 11*, 57–63.

McGrath, P.J., & Vair, C. (1984). Psychological aspects of pain management of the burned child. *Child Health Care, 13*, 15–19.

Nicosia, J.E., & Petro, J.A. (1983). *Manual of burn care*. New York: Raven Press Books.

Orr, D.A., Reznikoff, M., & Smith, G.M. (1989). Body image, self-esteem, and depression in burn-injured adolescents and young adults. *Journal of Burn Care and Rehabilitation, 10*, 454–461.

Roberts, D., & Appleton, V. (1989). Psychosocial care of burn-injured patients. *Plastic Surgical Nursing, 9*, 62–65.

Steward, M.S. (1993). Children's memory of medical procedures: "He didn't touch me and it didn't hurt!" In C.A. Nelson (Ed.), *Minnesota Symposium on Child Psychology: Memory and affect in development*. Hillsdale, NJ: Lawrence Erlbaum.

Watkins, P.N., Cook, E.L., May, S.R., & Ehleben, C.M. (1988). Psychological stages in adaptation following burn injury: A method for facilitating psychological recovery of burn victims. *Journal of Burn Care and Rehabilitation, 9*, 376–384.

1989

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 12(1) pp. 46-50 © AATA, Inc. 1995

The Use of Art Therapy in Treatment Programs to Promote Spiritual Recovery from Addiction

Holly Feen-Calligan, MAT, A.T.R.-BC, Detroit, MI

Abstract

A spiritual basis for living is essential if one is to recover from addiction (Alcoholics Anonymous, 1976). Art fosters spiritual development through both the creative process itself and in contemplating a work of art which moves one to a higher level of understanding. This article illuminates the relationship between art therapy, spirituality, and recovery and offers a model in which art therapy can be used in treatment programs to facilitate spiritual recovery from addiction. Literature related to recovery, art, and spirituality is summarized. Personal and professional experiences of the author are provided as illustrations.

Introduction

Addiction is a disease that is spiritual in nature as well as physical and emotional (Alcoholics Anonymous [AA], 1976). The importance of the spiritual recovery of an individual has been underscored by many recovering people and other experts in addiction treatment (AA, 1976; Bill W., 1967, Bjorklund, 1983; Booth, 1985; Chickerneo, 1990; May, 1988). This article illuminates the relationship between art therapy, spirituality, and recovery and offers a model in which art therapy can be used in treatment programs to facilitate the spiritual recovery from addiction.

Personal Experience

I had worked in treatment programs and had taught art therapy courses on the university level at the time I married my artist-husband. As newlyweds, we began painting together. That is to say not only did we paint together in the same room, but we painted together in the same room on the same piece of paper! My husband had been working in oil paints and oil pastels for some time when he spontaneously invited me to join in. The invitation brought feelings of excitement, anticipation, and desire to paint with him, confident that this would be a special opportunity to grow close. Despite these feelings, however, I also dreaded the prospect of painting with my husband. I feared my painting proficiency or lack thereof would be revealed. In retrospect, I also believe I feared the intimacy required of working together. Later I learned that my husband had similar ambivalent feelings. Ultimately, we decided to paint together, but that decision continued to be fraught with resistance. We threw a load of laundry in, made coffee, did the dishes, and when there were no other tasks to stand in our way, the first brush strokes appeared on paper.

It seemed miraculous that we finally started to paint, but the bigger miracle was that we continued! Exhausted and frustrated, many times our painting sessions just didn't get anywhere. We kept telling one another what each painting looked like shouldn't matter as long as we continued to make the effort. Yet we were so overjoyed when what we painted looked good to us, we became frustrated when what appeared on paper did not meet with such success. Despite the failures, however, there was a great attraction to painting together. Something always pulled us back. We experienced a satisfaction in knowing that we were working, that we had made the effort, and that we were taking the steps to what we had begun to believe was essential to our well-being and creativity—a commitment to art and to our relationship. We seemed to be developing a faith that the outcome would take care of itself. We simply needed to do the work.

In addition, we were growing closer. Physically, we were close, working on an 11 in. by 14 in. canvas. Emotionally and spiritually, we were getting close. Sometimes we talked, but even if we didn't talk, we always communicated. We were becoming more familiar with one another's insecurities, talents, and comfortable ways of expression. Each of us felt a joy when the other would come up with the solution to an artistic problem that would bring the whole painting together. We felt that together we were involved in doing something that neither of us could do alone. The paintings were not my style nor his style, but a new style, our style. Was this a "power greater than ourselves" described in addiction literature?

With more and more successes, I grew so that I feared less the prospect of painting together, and trusted more the process. The fear of painting was replaced with an excitement about the adventure of wondering what would appear. I had faith that continuing, that is, daily persistence in painting was what was important. The end result would take care of itself.

I saw a connection between what we were doing, what I was encouraging patients at the treatment program to do, and with my own concept of spirituality. I became very aware of the process of "letting go"—letting go of expectations, plans, fears, and my ego. There were times when I poked along contentedly with "my side" of the painting only to watch my husband's idea override mine as he poured turpentine over the whole thing. "Powerless" over turpentine, I visually experienced a form of letting go as I watched my image disintegrate.

Yet the faith that another image equally as pleasing would appear was always there. The quiet time spent in painting helped me to connect with something both inside and outside of myself. Prior to this painting experience, I had always been a very goal-directed person who needed to be producing something tangible at all times. Painting together helped me to think differently about that. I became able to leave housework alone and not obsess over whether we would paint anything resembling art. The process was meditative, uplifting, inspiring, and creative. I had the opportunity to daydream, to fantasize, to concentrate, and to work through various little details of my life! Whether or not we liked the end product, we felt positively about the process, pleased that we had done the work, and grateful for this special closeness.

I took what I was learning to work with me. My Friday art therapy groups became "Doing By Not Doing" groups. During these groups, I encouraged relaxation, the emptying of the mind of any problems and thoughts and simply painting alone or with a partner, or being still altogether. The methods used in the art therapy groups will be described in more detail at the end of this paper.

Spirituality and Recovery

As human beings, we are spiritual creatures (Booth, 1985). Spirituality is an aspect of ourselves just as we have physical and emotional aspects (Bjorklund, 1983). Virginia Satir said, ". . . life is something inside you. You did not create it. Once you understand that, you are in a spiritual realm" (Touchstones, 1986). Bjorklund (1983) states, "Spirituality has to do with the quality of our relationship to whatever or whomever is most important in our life" (p. 3). Because of this, spirituality is closely related to values, priorities, goals, and preoccupations (Bjorklund, 1983).

When too much time and energy are spent preoccupied with drinking, then alcohol is at the center of life and has become too important. If something is important, it is given value or worth. "The process of giving worth to something is called worth-ship or worship. When we worship something, we are talking about a god-like relationship with the object of worship" (Bjorklund, 1983, p. 9). According to Bjorklund, this is the basic rationale for describing alcohol as a spiritual disease.

For the person in recovery for whom alcohol had become God, the challenge in recovery is to find God—"God as we understood Him," a "power greater than ourselves," or a new spiritual focus (AA, 1976, p. 59). The person in recovery must discover or rediscover what is most important in life. Something must replace alcohol as the center of the person's life. Recovery does not consist of simply not drinking. "Just to stop drinking without other growth or change would simply frustrate a person who had not learned any other way to meet basic human needs" (Bjorklund, 1983, p. 10). For the individual in recovery, a change, some transformation of desire and attitude, is required in order to stop drinking. This transformation (that some call God) is the spiritual experience in recovery. The hope of the person recovering from alcoholism is the maintenance and growth of a spiritual experience, according to Bill W., cofounder of Alcoholics Anonymous (AA) (1967, p. 5).

Maintaining and developing spiritual experiences involve recognizing the spiritual aspect of the self and developing it. Spiritual recovery includes discovering one's values and priorities, and learning what makes life meaningful and worth living. A friend of Bill W.'s stated his formula for spiritual recovery: "You admit you are licked, you get honest with yourself, you talk it out with somebody else, you make restitution to the people you have harmed, you try to give of yourself without stint, with no demand for reward, and you pray to whatever God you think there is, even as an experiment" (Ebby cited in AA, 1957, pp. 62–63).

Many individuals in recovery want to know how to get in touch with their spiritual selves in order to further facilitate spiritual recovery. Booth (1985) says finding spirituality is a matter of looking within: "It is what it is to be a human being" (p. 31). We are already spiritual creatures. The key to understanding spirituality is understanding ourselves. To do this we must have time evey day to nurture ourselves, to meditate and pray. We must slow down enough every day to know what it is we are looking for (Booth, 1985).

Ironically, one must live spiritually before one understands what spirituality is, for spirituality is not something that can be learned through books. Living spiritually for some may mean simply being open to spiritual questions. For others, living spiritually means daily persistence in making contact with God, praying, meditating, listening, and cultivating attitudes of gratitude and peace. Living spiritually may mean helping others or attending religious services or Twelve Step meetings. Spiritual experiences may mean being creative: making art or music, writing, walking, fishing, or camping.

The literature describes certain conditions that seem to foster spiritual growth: quiet, uninterruptd time alone, authentic sharing of the self with others as well as helping others, being still, praying, maintaining an openness to spiritual questions, and living spiritually (AA, 1976; Booth, 1985; Fox, 1983; Fossum, 1989). When one ". . . takes notice of his inner self and trusts it, when he feels a connection with the things larger than himself, he has begun his spiritual development" (Fossum, 1989, p. 43).

Spirituality has been connected with recovery from alcoholism since the founding of AA more than 50 years ago. At the beginning of AA, Bill W. found he had difficulty sobering other alcoholics. He came to understand that other alcoholics needed to arrive at a willingness to want sobriety through having had a spiritual awakening, rather than being "cured" from some outside element (AA, 1957). Bill W. recalled his own spiritual transformation that came suddenly following a period of deep depression after trying on his own to stop drinking. He found himself crying out in his hospital room, "If there is a God, let Him show Himself! I am ready to do anything, anything" (cited in AA, 1957, p. 63).

Bill W. recalled that in the 1930s, Jung told his patient, Rolland H., that his alcoholism was hopeless unless he found his way to some religious or spiritual experience (Segaller, 1989). His alcoholism was incurable, in other words, without some sort of conversion. Jung said, "His craving for alcohol was the equivalent on a low level of the spiritual thirst of our being for wholeness" (Bauer, 1982). He thought that what people sought in alcohol was in fact the spirit—that drinking was motivated by a spiritual search. Jung believed everyone had a need for elation, for specialness, for the cessation of pain, for heroism, for meaning, and to have an ecstatic dimension to our lives. He believed the need for emotional highs was universal (Segaller, 1989). Jung noted that ". . . 'alcohol' in Latin is *spiritus* . . . the same word for the highest religious experience as well as for the most depraving poison" (Bauer, 1982, p. 127).

Jung connected the spiritual quest to the metaphor of highs, or height. Jung used the example that in ancient cultures high places such as mountains and the heavens were the places of the gods: The Greek gods lived on Mount Olympus. The Pueblo Indians lived on a 6000 ft plateau close to the father, sun. When an individual seeks experiences of getting high, he does not feel high, according to Jung (Segaller, 1989). The frequency of drawings made by patients containing mountains, airplanes, and spaceships may relate to that. It is also interesting to note the frequent responses of "skydiving" or "flying" by patients in treatment programs when asked what new hobbies they plan to pursue.

Most hospital-based treatment facilities address spirituality through the context of AA—the 12-step program most credited with helping individuals maintain a lifestyle of emotional, physical, and spiritual recovery. Unfortunately other opportunities to address spiritual recovery in treatment programs such as art therapy, journal groups, relaxation therapy, and therapeutic out trips are frequently those deemed most expendable in an effort to curb costs. Patients attend AA meetings while in the treatment program and are oriented to AA's Twelve Steps through didactic therapy sessions. The first three steps generally addressed in treatment programs involve admitting powerlessness over the addiction, believing that a "power greater than ourselves" can restore sanity to life, and making a decision to "turn our will and our lives over to the care of God as we understand Him" (AA, 1976, p. 59).

Art and Spirituality

Kandinsky (1977) wrote of the value of art in feeding the spirit—that the feeling expressed in the art can deepen and purify that of the spectator. "Such works of art at least preserve the soul from coarseness; they 'key it up,' so to speak, to a certain height, as a tuning-key the strings of a musical instrument" (pp. 2–3). Kandinsky valued art if it expressed the internal life of the artist, and wrote about the importance of knowing and expressing one's inner truth.

Joseph Campbell (1986) similarly maintained the value of art is spiritual in nature. He compared the artist and the mystic, each having been exposed to the same reality. The difference, says Campbell, is that the artist has a craft. The nature of the artist and the nature of the universe are two aspects of the same reality. Creative discoveries made by the artist represent universal truths. The "proper" artist, through his inspiration, functions as a true seer and prophet (p. 132).

Evidence of a connection between art and spirituality also can be found in cultures throughout the world, throughout the ages. Carvings of protective animals and spirits in everyday objects by the Bearing Sea Eskimos (Ohno, 1985); the Hindu dance, the Bharata Natyam reminding onlookers of the supreme greatness of God (Kamuda, 1993); the culture of the Native Americans for whom art is inseparable from ritual or religion (Dufrene, 1991); Egyptian mummies and burial practices; exquisitely crafted places of worship, hymns, fables, etc., all demonstrate the interrelationship between art and spirituality. "In many cases it's the art and artifacts that remain, whether it be the Pyramids, a raku bowl, or a Raphael painting. If there is a soul, the arts are it. They're our voice, our search for meaning, our way of believing" (Halbreich, 1993). Albert Einstein said, "The most important function of art and science is to awaken the cosmic religious feeling and keep it alive" (*Touchstones*,1986).

The relationship between art and spirituality has been addressed by Matthew Fox (1983) who suggests art is a form of meditation. In the past, art as meditation occurred naturally: People were gardeners, told stories, played instruments, made their pots, etc. In our industrial society today, we must make a conscious effort to do these things, to develop our right brain, the unconscious, or our mystical lives (Fox, 1983).

Fox has maintained that Americans today operate on an introverted meditation model. We take in others' images in the form of television and the movies. We do not empty our minds, experience real quiet, and form our own images and beliefs. Eckhart said, "Whatever I want to express in truest meaning must emerge from within me and pass through an inner form. It cannot come from the outside to the inside, but must emerge from within (Fox, 1983, pp. 191–192). What emerges from within is art. "Only art as meditation reminds people so that they will never forget that the most beautiful thing the potter produces is . . . the potter" (Fox, 1983, p. 192).

Koontz (1986) noted a relationship between God and creativity: God created human beings in His likeness; therefore, we are created to be creators like God. Koontz identified a change that takes place in both art and spirituality. In art, the artist makes something new. On a spiritual level, God transforms human beings into new creations. Bailey (1993) wrote that art can be a way of honoring God. Whether they work in wood, clay, or paint, many artists spend a great deal of time recreating God's handiwork, often pondering the object they are about to reproduce, paying homage to God, sipping "the beauty of creation one detail at a time: the multicolored worn edge of an oak leaf, the expression in a duck's eye, the stories in just one groove of a maple's bark" (p. 39).

In recent years, art therapists have articulated their viewpoints related to art and spirituality (Shoemaker, 1991; McNiff, 1988; Moon, 1992). Chickerneo (1990) provided a thorough review of the literature related to addiction, spirituality, and recovery. In her study, 10 individuals in recovery identify how art has contributed to the spiritual part of recovery.

Art Therapy, Spirituality, and Recovery

Recovery, art, and spirituality share certain qualities that lend support to the use of art as therapy in addiction treatment: Recovery, art, and spirituality all require commitment and consistent effort to know them. Recovering individuals make a daily commitment not to use substances and to practice the Twelve Steps as best they can. Like recovering people, artists make a similar commitment to their art. Art requires consistent, regular, if not daily attention. Artists must consistently study and apply what they study and feel. Artists are absorbed with their ideas and with their work, and they are never far from it. There is a high "degree of absorption," investment, and continuity in their work (R. May, 1975, p. 40). This may also be true of recovery—there are no shortcuts, no instant transformations. Recovery becomes a way of life, realized with consistent, daily effort. One's spirituality likewise grows and flourishes with daily, consistent effort at living spirituality and being open to spiritual questions.

Terms such as letting go, powerlessness, and humility, understood by individuals in recovery also can be understood through making art. In art, letting go refers to the creative process, to a freedom required of working with media, or an openness to following new directions. I can remember working and reworking a portrait of the son of a friend of mine—making several finished pieces that were so close but just not right. Exhausted, frustrated, and at my limit, I humbly surrendered! I

1992

put the whole thing away to rest and ask for help. A day or so later something called me back. All at once I was able to sense the individuality and spirit of the child and to capture that spirit perfectly, almost effortlessly. The ability to admit powerlessness and let go of the work was instrumental to my ultimate success with it.

This vignette may be what Christian Koontz (1986) meant by the ability to "let go" to be able to receive the impulse or the invitation from God. "When we have acknowledged our human limitations, the problem drops into the unconscious mind . . . where Wisdom . . . makes the needed and desired connection for us. When we are ready, willing, and able to receive the insight and deal with its consequences, she allows it to pop into our conscious mind when we least expect it. Or she allows it to dawn on us so gently that one day we simply realize it is there" (Koontz, 1986, p. 37).

Koontz wrote of doing the work as best one can, and then letting go of it, simply waiting for God to do God's part. There are times when doing nothing is most productive: ". . . the more useless we allow ourselves to be, the more we find ourselves in the seed bed of genuine creativity. Just being there, inert as a seed, our roots are drawn deeper into the heart of creativity. Sooner of later the sap of life begins to flow through those roots toward the surface. Eventually a new creation—a new idea, a new artwork, a new action, a new relationship, or a new person—breaks through the underground darkness into the light of day" (Koontz, 1986, p. 12).

Letting go used in the context of recovery relates to spirituality, to faith and trust in the higher power. Recovering persons admit powerlessness over addictions, believe that a higher power can restore sanity to their lives, and decide to turn their wills and their lives over to the care of God as they understand God (AA, 1976). Recovering persons "let go and let God."

Step Three mentions "God as we understood Him" (AA, 1976, p. 59). Patients in art therapy groups have at times objectified abstract images or ideas about God in their art. In this sense, art has helped recovering persons come to terms with their understanding of God.

References to "highs" are common to art, spirituality, addiction, and recovery. Leonard (1989) found a connection between addiction and creativity in original etymological roots: "The Latin for addict, addictus, means to devote, surrender, deliver over, or give oneself up habitually. . . . Originally it had a spiritual meaning—dedication to the gods—stemming etymologically from addicere: to say. Thus, inherent in the meaning of addiction is the sense of dedication or bearing witness to creative energies" (p. 4). In recalling the advice of Jung, the recovering individual must acquire that which he is seeking through the use of alcohol or other substances—an emotional and spiritual high. The feeling artists get when dedicated to their creative process may be a sort of high. Doing art might feel good. It might provide meaning and a sense of purpose in the life of the artist.

Doing By Not Doing: Art Therapy in Spiritual Recovery

The above concepts formed the basis for art therapy "Doing By Not Doing" groups. The title of the group referred to accomplishing something by doing nothing! The need for such a group became apparent while working on a busy substance abuse inpatient unit. A rigorous schedule gave patients something to do all day. Patients were exhausted when they came to art therapy and indignant that they came into the hospital to learn about their disease, not to draw. Patients were assured that these art groups were just as necessary as other therapy groups.

"Doing By Not Doing" groups provided time to stop and listen, to get in touch with the inner self, and with the higher power. The feelings awakened, concepts learned, and awareness gleaned from the treatment program could be contemplated during this quiet group. Doing by not doing refers to achieving insight after the search for insight has been abandoned. Doing by not doing refers to the paradox identified by Koontz: "The more useless I allow myself to be the more I find myself in the seedbed of genuine creativity" (p. 12). Art allows us to lose ourselves and find ourselves at the same time (Fox, 1983).

Methods

Sessions were begun with the provision of opportunities for patients to experience powerlessness in art. This was not too difficult since most patients agreed they were powerless to draw a straight line. Group members were instructed to let go of their preconceived notions about drawing and to let go of their fears of participation. Gestures in the air were made and transcribed on paper. Drawing with eyes closed and with the nondominant hand also provided opportunities to experience powerlessness. Making a drawing together with a partner without talking also was done. Pouring odorless turpentine over the images produced with oil pastels provided an opportunity to visually let go.

At times a passage from Emmet Fox's pamphlet, *The Golden Key* (1931) was read. Fox recommended that readers "stop thinking about the difficulty, whatever it is and think about God instead" (p. 2). Following a moment of silent contemplation, individuals could make art if they so chose. Art materials were within easy access. Individuals could draw, paint, or sculpt, but they were to remain quiet whether they made art or not.

Patients were encouraged to relax and were asked to direct attention inward, to become aware of their inner selves. At times, slides of nature were shown or classical music played, but for fear of encouraging "outside/in dynamics," silence and stillness were preferable. The proper way to use the art materials was demonstrated at the beginning of the sessions: using the sides of the pastels, scraping images with the palette knives, and how to use the turpentine. Group members were encouraged not to plan anything, but to listen and to respond to any impulse they had.

Observations

A certain transformation was observed during the sessions. The art therapy groups frequently began with a lot of resistance, noise, and turmoil, and ended in a state of peace. The author cannot recall a single patient who didn't relate feeling more calm and relaxed as a result of these sessions. Even patients who were not accustomed to being quiet and were uncomfortable with being alone with their thoughts benefited from time-limited periods of quiet. Specific problems patients had were clarified through the meditative process. Objectified on paper, issues seemed to be made more manageable.

Although insights and interpretations were not the primary goal of the group, many insights were made. For example, some patients saw themselves in their artwork. One patient ended up with a "mess" of lines going in all directions. He connected this with his messed-up life and his feelings of being overwhelmed and not knowing where to turn, thus helping him to admit powerlessness. Others saw constellations of designs that appeared to them to show their lives coming together, or that there was light amidst the darkness. A patient whose concentric circles resembled a target was able to acknowledge his own role in being a target to be shot at by others.

Other patients seemed to enjoy the creative process, and in the process being able to put some ideas together. Patients were observed scraping and rubbing the colors on the canvas and finishing multiple pieces. They seemed to be getting hooked, absorbed, or possessed by the creative process. Some of their artwork contained the hallmarks of good art: evocative power, inner consistency, and economy of artistic means to use Kramer's (1971) terminology. These qualities seemed to be attained through the "integration and balance of tensions" and mirrored a "complex balance of inner forces" (Kramer, 1971, p. 67).

The presence of "Doing By Not Doing" groups on the unit in the treatment schedule communicated to patients that "not doing" is necessary to recovery. Making time to listen to one's inner voice and to God is as necessary as going to meetings, exercising, eating right, taking up new hobbies, and any of the other prescriptions in recovery from addictions.

Another observation concerns the difference in the patients' reception to the Doing By Not Doing groups versus the other art therapy groups in which patients were asked to make art consistent with milieu therapy themes of denial, recovery, and relapse, and to discuss their art in front of the group. Patients appeared fearful of what they might reveal and may have modified their drawings in an attempt to reveal less—or to keep that which was feared under wraps. But when interpretations weren't called for, when the instruction was to do nothing, more was accomplished. Artwork was more colorful and consumed a greater portion of the page. Patients were engaged for longer periods of time and left the sessions seemingly feeling better—more enthusiastic, in brighter moods—than in other sessions. Once again Jung's prescription to give patients what they sought came to mind. The author wondered if the patients liked this group better because they could "space out," relax, and fantasize or even experience emotional and spiritual highs in a way that was similar to what was sought from drugs.

Conclusion

The personal experiences of the author in making art were critical to the development of the art therapy approach described herein. While structured art therapy sessions were valuable to chemical dependency inpatients to assist with self-expression and self-awareness, of equal or greater value seemed to be the unstructured, "Doing By Not Doing" approach. As inpatient stays are becoming shorter, chemical dependency programs should provide guidance in areas that are known to promote long-term recovery. Recovery from addiction requires finding a spiritual basis of living. Art therapy, a quiet, reflective, humbling, creative, and meaningful endeavor, may provide the means to assist with this process.

References

Alcoholics Anonymous. (1976). *Alcoholics anonymous* (3rd ed.). New York: Author.

Alcoholics Anonymous. (1957). *Alcoholics anonymous comes of age: A brief history of AA*. New York: Author.

Bailey, J. (1993, February). How art heals. *St. Anthony Messenger*, 36–41.

Bauer, J. (1982). *Alcoholism and women*. Toronto: Inner City Books.

Bjorklund, P. (1983). *What is spirituality?* Center City, MO: Hazeldon.

Booth, L. (1985). *Spirituality and recovery* (rev. ed.). Deerfield Beach, FL: Health Communication.

Campbell, J. (1986). *The inner reaches of outer space: Metaphor as myth and as religion*. New York: Harper & Row.

Chickerneo, N. (1990). New images, ancient paradigm: A study of the contribution of art to spirituality in addiction recovery. *Dissertation Abstracts International*. 9110801.

Dufrene, P. (Speaker). (1991). *My God left me? Spirituality, holism, and the transpersonal in art therapy*. (Cassette Recording). Denver, CO: National Audio Video. No. 25.

Fossum, M. (1989). *Catching fire: Men coming alive in recovery*. New York: Harper & Row.

Fox, E. (1931). *The golden key*. Marina del Rey, CA: DeVors.

Fox, M. (1983). *Original blessing*. Santa Fe, NM: Bear & Co.

Halbreich, K. (1993, Winter/Spring). Fifty Americans [Commemorative issue]. *Newsweek*, 58–62.

Kamuda, A. (1993, February 10). Religious movement: Students learn Hindu dance. *Detroit Free Press*, p. 8F.

Kandinsky, W. (1977). *Concerning the spiritual in art* (M. Sadler, Trans.). New York: Dover.

Koontz, C. (1986). *Connecting creativity and spirituality*. Kansas, MO: Sheed & Ward.

Kramer, E. (1971). *Art as therapy with children*. New York: Schocken Books.

Leonard, L. (1989). *Witness to the fire: Creativity and the veil of addiction*. Boston: Shambhala.

May, G. (1988). *Addiction and grace*. San Francisco: Harper & Row.

May, R. (1975). *The courage to create*. New York: Bantam Books.

McNiff, S. (1988). The shaman within. *The Arts in Psychotherapy, 15*, 185–291.

Moon, B. (1992). *Essentials of art therapy training and practice*. Springfield: Charles C Thomas.

Ohno, D. (1985, December). From spiritual to material in the art of the Inua. *Detroit Focus Quarterly*, p. 7.

Segaller, S. (Producer/Director). (1989). *The wisdom of the dream*. Vols. 1, 2, 3. [Film]. USA: Border Television.

Shoemaker, R. (Speaker). (1991). *My God left Me? Spirituality, holism and the transpersonal in art therapy* (Cassette Recording). Denver, CO: National Audio Video. No. 25.

Touchstones: A daily book of meditations for men. (1986). Minneapolis, MN: Hazeldon Foundation.

W.B. (1967). As Bill sees it: *The AA way of life . . . selected writings of AA's cofounder*. (19th printing). New York: AA World Services.

Terminal Stage Leukemia: Integrating Art Therapy and Family Process

Emily Scudder Teufel, Cornish, NH

Abstract

Children in the terminal stages of a life-threatening illness have special emotional needs. Often, these needs cannot be met by people close to the child as they are dealing with personal feelings of their own. Through art therapy children express symbolically what they will not or cannot express verbally. Some children have the added stress of family problems that are magnified due to the situation. Refocusing the family on the child and her need for emotional support became the subject of an art therapy intervention. The resulting artwork symbolized family unity for a 9-year-old girl in the terminal stages of Acute Lymphoblastic Leukemia.

Introduction

Acute Lymphoblastic Leukemia (ALL) is a type of cancer in which the malignancy affects a particular line of blood cells. The result of the proliferation of abnormal cells is the "crowding out" of normal blood cells. This type of leukemia reflects the specific line of blood cells affected, although ALL is usually seen only in children and young adults. Patients may present with symptoms of fatigue, excessive bruising, anemia, pallor, general malaise, or loss of weight.

ALL is treated in several stages. The first and most critical stage is treated via induction chemotherapy which is used to reduce the level of leukemia cells below detection, a state referred to as remission. This is an intensely emotional time for parents and children as the child is often taken directly from the pediatrician's office to the hospital where the first phase of treatment lasts up to 2 weeks. Treatment includes invasive and painful procedures that add to the emotional stress of both child and family.

The next phase, consolidation or early intensification, consists of intensive chemotherapy for a certain period of time. The child makes weekly visits to the clinic for blood testing and is admitted bimonthly to the hospital for IV medications. On the off weeks the child could be admitted due to fevers and neutropenia (decreased numbers of infection fighting white blood cells). The hospital staff and procedures become more familiar to the child and parents at this time. Relapse of leukemia during this remission period is a very poor prognostic sign that greatly reduces the odds of a cure. After the first relapse, the child may qualify for a bone marrow transplant. This procedure can cause death and does not have a good record of success for these patients. Of children who are in their second remission, 30% to 60% have prolonged survival (Wilson, et al., 1991). After a second relapse, when there is no hope for transplant, a family can decide to continue chemotherapy, hoping for a remission, or provide palliative measures intended to make the child comfortable. The family is faced with difficult choices throughout the illness, but this may be the hardest to make. The child may be considered in the terminal stages of the disease at this point, but there is no fine line to distinguish this.

The last phase of treatment, once successful remission has been accomplished, is called maintenance. Maintenance continues for several years and consists of lower doses of chemotherapy.

Terminal Stage ALL: Implications for Art Therapy

It is difficult to assess how much children understand about their disease and what the future holds for them. Research has shown that younger children perceive death as impermanent while older children approaching age 9 or 10 view death as personal and permanent (Hodges, 1981). Bluebond-Langner (1978) worked with critically ill children and found that as children progressed through an illness to death, their self-concept changed. She described five stages: Stage 1 (seriously ill), Stage 2 (seriously ill and will get better), Stage 3 (always ill and will get better), Stage 4 (always ill and will never get better), Stage 5 (dying). Successful completion of each stage results in resolution and preparation for the next stage but also the mourning process that accompanies any change in self-concept.

Children who successfully pass through the necessary stages are better prepared to resolve unfinished business with family members. However, at this point in time, family members have often exceeded their emotional capacity during the first phase of induction. Denial and anger are among the first defenses to become evident. They may not recognize the child's changing self-concept and feelings around that particu-

1995 BEST COPY AVAILABLE

lar stage. Without appropriate support the child is left alone to cope with personal feelings. In addition to their own fears, children sense their family's feelings. They try to care for their parents and deny their own fears. Tate (1989) stated that "accumulated data indicate that dying is made easier when individuals feel understood and can express their feelings, fears, and hopes" (p. 115). Art therapy is particularly important to these children who can use art to symbolically express underlying emotion and family issues.

Case Study

Margaret, a 9-year-old girl, was diagnosed with ALL in April. She spent the summer traveling 1½ hours from her home where she lived with her father and stepmother to a children's hospital. After Margaret's parents divorced when she was 4 years old, her mother moved to Georgia. Although friction existed between her father and maternal grandparents, Margaret often stayed with them (and with her paternal grandparents) because her father and stepmother worked some night shifts. Margaret longed to visit with her mother, but these visits were infrequent. Her mother did not have a peaceful relationship with her own parents, lived at a great distance, and did not see herself as a reliable mother figure.

I met Margaret while I was working as an art therapy intern. Though she spoke very little, it was apparent that Margaret was comfortable and skilled with the art materials. After an introduction and demonstration of basic use, I let her choose what to do with the materials. Margaret carefully thought out and created pieces in a precise manner. As time went on, she became increasingly hungry for a greater array of materials. She apparently wanted to see all of her options before coming up with a unique way of putting them together. It is possible that her hunger for materials reflected her need for care and support since she spent a great deal of her own energy nurturing her family.

Margaret spoke little during our early sessions. Sometimes she gave me a sideways glance and seemed satisfied that I was attentive to her art process. Our therapeutic relationship progressed during the month of December when Margaret relapsed and consequently had longer stays at the hospital. She began to use art therapy sessions to relay verbal tidbits of information about her feelings. The content of her artwork and short bursts of speech conveyed her feelings of vulnerability and concern for her family.

On one occasion Margaret told a story about the divorce group she attended. She heard that some of the girls had been abused by new stepparents. She felt lucky that her parents had found such nice people to live with. During this time she created a house made of popsicle sticks (Figure 1). She placed a small dab of glue on each of the four corners of the foundation, carefully laying down successive layers. The tall roof posed technical difficulty for her. Together we found she could use a long thin piece of clay and glue to attach the roof to the house. The structure of the house she created was solid. It had a transparent quality due to the slats in the sides and the open roof. The house seemed to embody the strength she felt from the love of her family. However, there was no door, no color, nor anything placed inside.

On another occasion Margaret came to the hospital for a routine clinic visit and was told that she had to be admitted. She walked onto the unit, and we had an impromptu art therapy session. She chose a small square piece of wood, some short nails, and a hammer from the closet. Without a word she began to hammer the nails with great force, making a loud noise when she missed the nail and hit the wood. I helped her hold the wood and said nothing as she began to create a star pattern (Figure 2). As she hit the nails she looked towards the door and chanted softly, "This is for the doctors . . . and the nurses . . . ." Her catharsis ended before she finished the star pattern, but it was important for Margaret to vent her anger and frustration in a safe place. She was not directly angry with the doctors and nurses but frustrated with her illness and moving from Stage 2 (seriously ill and will get better) to Stage 3 (always ill and will get better). She was faced with a harsh reminder that neither she nor her father was in control of her life, and that the disease dictated what would happen each day.

I rarely suggested a theme for Margaret in art therapy. However, one interaction led me to explain how some childen had used three-dimensional materials to create a special place to keep feelings, but my introduction to this project was terribly awkward. Margaret looked at me quizzically but she must have forgiven me my fumbling. She chose a small 4½ in. high box from a large selection of materials and cut off the lid. She then used tissue paper and glue, a technique we had been working with, to apply a colorful veneer to the outside of the box. The colored tissue she used was integrated with

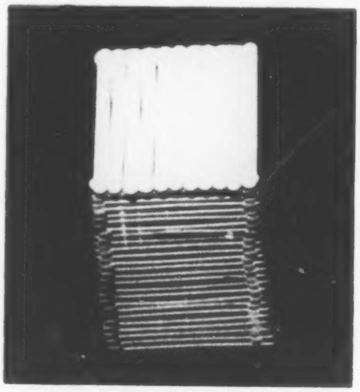


Figure 1. Popsicle Sticks, 8" X 4"

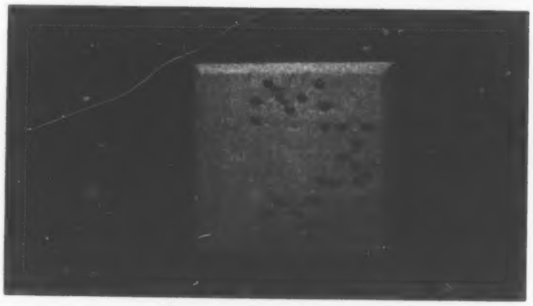


Figure 2. Wood, 3" X 3"

1996

black tissue so that the end product was fairly dark overall. In subsequent sessions she painted the surface with clear acrylic that intensified the colors. She then made a knotched piece of cardboard and chose black yarn to weave a small pouch about 2 in. wide. Without any explanation she put the pouch inside (Figure 3).

As usual, Margaret did not attribute a direct meaning or metaphor to her artwork. She did not need to because the artwork gave me clues that were confirmed later. After a few months, Margaret told me that she shared her unpleasant feelings only with her cat. She did not want to burden her family because she saw the emotional toll her illness had already taken on them. Her statement opened an avenue to discuss the energy involved with keeping feelings inside. The box she had created earlier seemed to symbolize a quiet and brooding self. The soft, delicate pouch hiding dark and hurtful feelings was kept inside to help others. The box and pouch were left open, symbolically inviting me to share her feelings and to support her. Expressing her feelings through the artwork helped Margaret learn something about herself. As a result, she also felt comfortable addressing her feelings more directly with me.

After her relapse, the medical team and her family decided to continue with intensive chemotherapy and hoped for the possibility of remission and subsequent transplant. Margaret visited doctors at a special transplant center who explained that she could die at any time during the transplant procedure. In several following art therapy sessions, Margaret produced a construction paper collage of a rainforest (Figure 4). She chose a large piece of white paper and covered it with black construction paper. She put me to work cutting out shapes from a pattern she had drawn on construction paper. I sensed that she needed support in her travel to the dark jungle she had started to create. The rainforest includes a snake and flowers among the vines and fallen trees. Perkins, quoted in Tate (1989), found that a "notable symbol in the art of life-threatened children was that of a snake, which seemed to represent a threat" (p. 115). The snake in Margaret's picture is located in the lower left part of the picture and is the only element that she cut out of white paper and colored with marker. All other pieces have been cut out of colored construction paper and glued onto the background. The pink flowers may symbolize hope, but the sunlight here does not penetrate through the dense green and brown undergrowth. The rainforest may represent Margaret's move from Stage 3 (always ill and will get better) to Stage 4 (always ill and will never get better). The jungle shows little hope for survival with the black of night, the entangled vines, and the snake in the tree. For society in general, the rainforest has come to represent the potential for extinction.

During the last session working on this project, Margaret voiced her concern that her father had taken up smoking again. She said that he did not have any other method of stress relief. Perhaps with the realization of potential death, she was unconsciously concerned that her father might not be able to go on without her. Denial of her own fear and focus on her father may have also been part of the feelings associated with the move from Stage 3 to Stage 4.

In March Margaret relapsed a second time. As her physical condition deteriorated, the family situation became increasingly complex. Her mother arrived from Georgia, and her grandparents made more visits to the hospital. With the increased contact between family members and heightened concern about Margaret's future, the tension among family members grew. Margaret wanted to spend time with her mother, but her maternal grandmother was concerned that her daughter could not handle the situation emotionally. The grandmother felt out of control with Margaret's illness and in an attempt to help both herself and the family, she unwittingly presented an obstacle in Margaret's need to resolve unfinished business with her mother. The grandmother's resentment was projected onto Margaret's father, her mother, and in part to Margaret herself. It was clear that something needed to be done to help the family come together for Margaret.

Feifel (1973) stated that "opening channels of communication tends to mitigate feelings of inadequacy and guilt not only in the dying patient, but among the professional people involved and family members as well" (p. 3). In an attempt to open up communication, prompt family support, and help Margaret resolve her concerns, I gave her white foam core petals to give to any family member or friend that she wanted. Instructions given to each family member explained various ways the petal could be decorated and that it would represent him or her. The petals would be assembled in

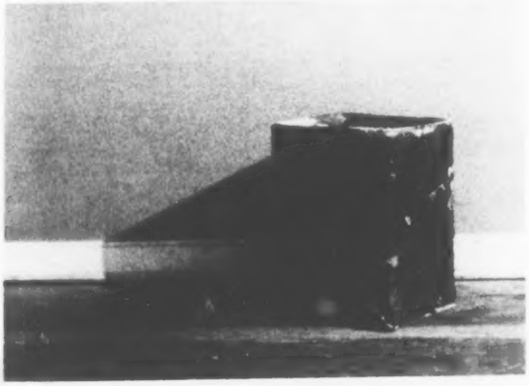


Figure 3. Cardboard Box and Tissue Paper, 5" X 3½", Black yarn pouch, 1½" X 2"

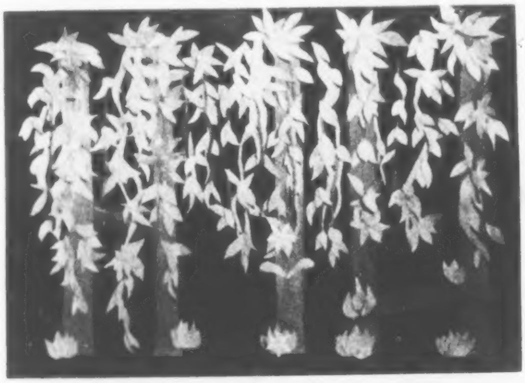


Figure 4. "Rainforest," Construction Paper, 18" X 24"

1997

Margaret's room around a circular center piece that she would complete. She could place the petals in any configuration, and petals could be added so that the flower would grow. Each petal had Velcro on the back and would adhere to a piece of magenta fabric that Margaret chose.

Margaret and her father participated in a joint art therapy session to complete the first petal and her circular piece. During the session, she worked with acrylic paints making her circle a medium pink with dark red dots on it (Figure 5). Margaret's use of pink and red seemed significant. It has been proposed that "the use of a great deal of pink can be an admission of vulnerability, fear of exposure, and a need for caring from the therapist . . ." and also that it might be used by "one who is preoccupied with disturbances of the flesh . . ." (Kellogg, MacRae, Bonny, & DiLeo, 1977). These authors also mentioned red as being " largely connected with the physical life of man . . ." (p. 124). Color usage could point to Margaret's preoccupation with her body and what was occurring within.

Her father's technique of working slowly and carefully with a small brush was similar to her own technique. He painted a light yellow-green background with the images of a duck, an owl, a leaf, and two fish (Figure 6). The yellow-green he used was the color of one of Margaret's chemotherapy drugs. Perhaps he was stuggling with the decision they had made to discontinue the chemotherapy. As father and daughter worked, a constant interchange about their life and happy memories flowed between them. Her father showed me wallet photographs of Margaret as a child and the time before her illness. He asked her questions about her artwork and explained the meaning of each symbol on his petal. This session lasted almost 3 hours.

Her mother chose to paint her petal alone with Margaret. The finished petal (Figure 7) depicts a scene from the beach symbolizing her home far away. The sun could be rising or setting, symbolizing either hope or death. The vacationlike scene might reflect her desire to escape this situation or to help her daughter escape. Other petals were completed by her stepmother, aunts, uncles, friends, and grandparents.

Eventually Margaret's condition and medication resulted in heavy sleep, but on some days she was alert for a short time. Our sessions became shorter, but we carried on the same schedule as before. Sometimes she looked up at the flower at the foot of her bed and asked me to pull off a particular petal. She remembered stories from holidays and special events and described the photos in detail. One day she told me that she would like to complete a petal. I brought her one, and she decided to use the tissue paper. She seemed to

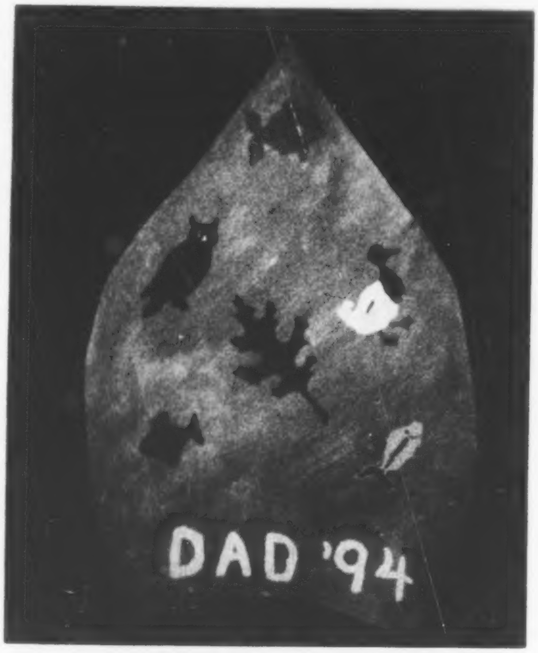


Figure 6. Acrylic, 10" long

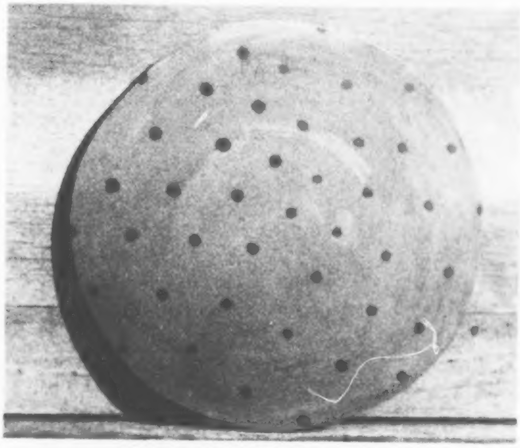


Figure 5. Acrylic, 11" diameter

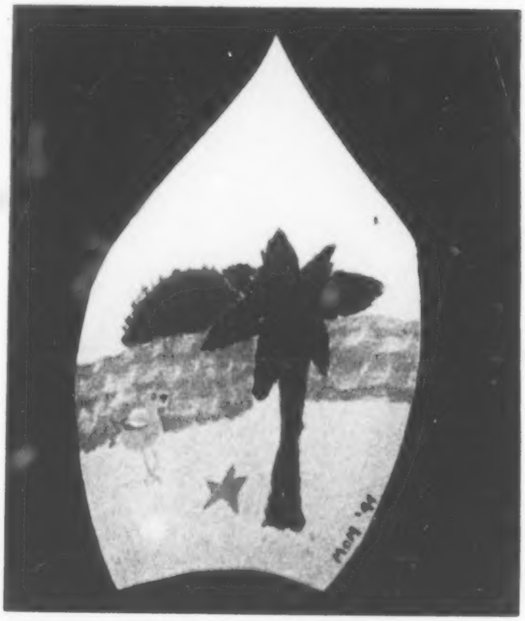


Figure 7. Acrylic, 9½" long

review our time together, thinking back to one of the media she had used to express her vulnerability. She cut out tissue paper hearts and used bright colors for the background. I felt that she was completing a petal that would remind her of the time she spent in art therapy (Figure 8).

The flower project was not easy for the family to complete (Figure 9), and it became a catalyst to bring family problems to the surface. Family members showed great personal strength as they sought to examine and resolve, as best they could, the problems that arose. The project highlighted the way in which family struggle affected Margaret. Early in the project, Margaret called her grandmother in tears saying that there were not enough petals for her to have one. When Margaret and I met for art therapy, she related this story and said that her grandmother was angry. There were more than enough petals for whomever Margaret chose, but it seemed that she was reacting to underlying family stress. She needed support to resolve unfinished business with her grandmother. Conflicts simmering under the surface became evident when the family was asked symbolically to admit that Margaret was dying. Her grandmother eventually saw the petal as a way of contributing to Margaret's happiness. She spent an entire day at home going over old photographs, crying, and remembering. She covered the petal with many small photos spanning Margaret's life.

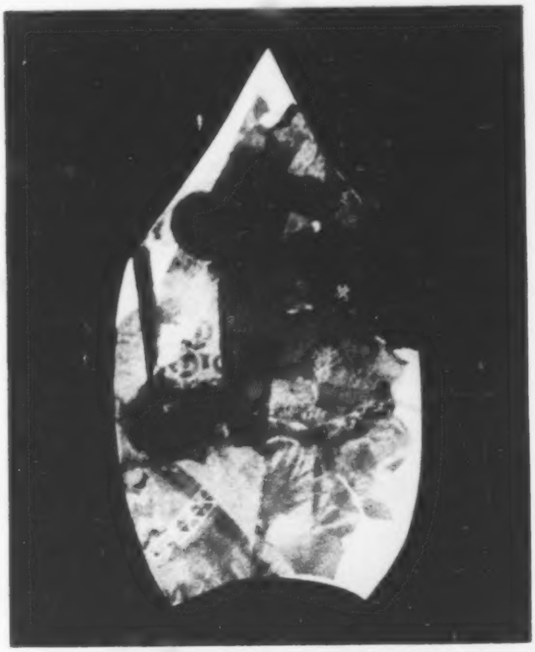


Figure 8. Tissue paper, 9½" long

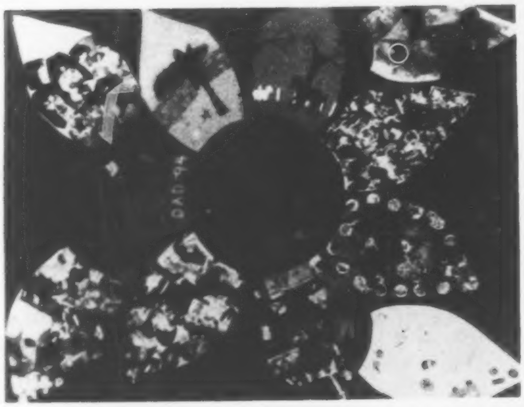


Figure 9. "Margaret's Sunflower Collage"—completed, 48" X 36"

In the end, Margaret's family created a beautiful flower for her and were able to work through their feelings about Margaret's illness, putting their personal differences aside. The family will have the artwork to remind them of the strength they had within themselves to come together for her. In the end they supported her and showed her a united front. (Margaret died the day before the 1 year anniversary of her diagnosis. She died with her mother, father, and stepmother at her side and her grandparents nearby.)

Conclusion

In this case art therapy was used to support a child through various stages of illness and a changing sense of self. Words are often inadequate and difficult to find when family and friends watch a young child die. Words are difficult for the child as well. Communication among people who were suffering both emotionally and physically was accomplished through the artwork, particularly the last intervention. This intervention helped the child resolve family issues in her mind and helped her family express their good-bye. The artwork remains as tangible evidence that the family supported Margaret and made a difference in her final days.

References

Bluebond-Langner, M. (1978). *The private worlds of dying children.* Princeton, NJ: Princeton University Press.

Feifel, H. (1973). *The meaning of dying in American society.* Los Angeles: University of Southern California Press.

Hodges, D.M. (1981). Using art and poetry with termininally ill children in the hospital. *The Arts in Psychotherapy, 8,* 55–59.

Kellogg, J., MacRae, M., Bonny, H.L., DiLeo, F. (1977). The use of mandala in psychological evaluation and treatment. *American Journal of Art Therapy, 16,* 123–134.

Tate, F.B. (1989). Symbols in the graphic art of the dying. *The Arts in Psychotherapy, 16,* 115–120.

Wilson, J.D., Braunwald, E., Isselbacher, K.J., Petersdorf, R. G., Martin, J.B., Fauci, A.S., & Root, R.K. (Eds.). (1991). *Harrison's principles of internal medicine* (12th ed.). New York: McGraw-Hill.

BEST COPY AVAILABLE

Viewpoints

Art & Endometriosis (From an Artist's Sketchbook)

Jane C. Berstein, MA, A.T.R., Mays Landing, NJ

This is a personal story about my struggle to overcome a chronic and oftentimes debilitating illness called endometriosis, and how my artwork has played a vital role. The Endometriosis Association's brochure (1987) defines endometriosis as follows:

> Endometriosis is a puzzling disease affecting women in their reproductive years. The name comes from the word "endometrium," which is the tissue that lines the inside of the uterus and builds up and sheds each month in the menstrual cycle. In endometriosis, tissue like the endometrium is found outside the uterus, in other areas of the body. In these locations outside the uterus, the endometrial tissue develops into what are called "nodules," "tumors," "lesions," "implants," or "growths." These growths can cause pain, infertility, and other problems . . . .
>
> The most common symptoms of endometriosis are pain before and during periods, (usually worse than "normal" menstrual cramps, pain during or after sexual activity, infertility, and heavy or irregular bleeding. Other symptoms may include fatigue, painful bowel movements with periods, diarrhea and/or constipation and other intestinal upset with periods. Some women with endometriosis have no symptoms. Infertility affects about 30–40% of women with endometriosis and is a common result with progression of the disease.

My purpose in sharing my experience and my artwork is to make others aware of this troubling illness. I feel it is my task as a woman/artist/art therapist to inform, educate, and share my experience about endometriosis in the hopes of helping others.

I need to provide some background information before discussing the artwork. In my struggle to get help, I have gone to many traditional medical doctors, tried traditional treatment (i.e., pain medication, hormonal therapy [including menopausal hormones and birth control pills], and two surgical procedures [laparoscopy], and I have also tried alternative medicine [accupressure, TENS Unit—Transcutaneous Electrical Nerve Stimulation System, vitamins/supplements, dietary changes, listening to relaxation tapes, prayer], and my own art therapy). At the writing of this article, I am 37 years old, single, and have never been pregnant. Most likely I will need to have a hysterectomy due to the severity of my medical condition.

Unfortunately, endometriosis is often misdiagnosed and/or underdiagnosed by the medical field, specifically gynecologists. After going to four gynecologists and after surgery (laparoscopy is usually required to prove the diagnosis), I finally was diagnosed with severe endometriosis. The endo was all over my internal organs. I remember that before my first surgery for endo (June 1990), my biggest fear, based on the way I had been treated by previous doctors, was that the surgeon would not find anything. Well, that was not the case! There was a reason for my pain and fatigue! My first surgery confirmed that there was something wrong and that my suffering was not a figment of my imagination.

In retrospect, I had suffered with endo for at least 10–12 years before receiving the diagnosis. On a gut level, I knew something was wrong, but I did not have a name for it. In looking back, I believe I was in denial in the early years of pain. In my situation, with the passage of time, the pain became worse and a daily experience. When I became aware that I might have endo, I asked two gynecologists directly if I had endo, given my symptoms. I still did not get an answer to my question. Even a few years ago gynecologists were not picking up symptoms of endo. My personal story is common to many women! It is for this reason I need to share my story to encourage better and faster diagnosis and treatment.

The importance of documenting my symptoms (i.e., the pain) through my artwork was so necessary for me—knowing that it validated my suffering and knowing that there was something wrong with my body even though the medical doctors missed the diagnosis. In essence, I was told that it was all in my head. The IT was endo. The artwork was so significant to me in my struggle to fix whatever needed fixing, that I brought my sketchbooks to the doctors' office visits and shared my artwork with the doctors I felt most comfortable with (i.e. the two gynecologists who performed my surgery, my homeopathic doctor, and my clinical psychologist).

As an art therapist, I work in a state institution; the paperwork is very important. If an incident is not documented in writing, it did not happen. For me, I considered that to be the case with my drawings—that I needed to document, to have proof that I actually went through this horrendous pain. The documentation for validation of my symptoms, specifically the pain, were in my drawings. The drawings are part of the overall picture.

From the drawings in my sketchbooks (approximately 450 drawings within a 12-year period), I selected only a sampling to discuss in this paper. It was very difficult to pick out a handful of pictures. I tried to select the most linear drawings, mindful of the black-and-white reproduction limitations. Unfortunately, the pictures cannot be viewed in the original form, in color. For this reason I have selected certain pictures that still portray the meaning/message when seen only in black and white. I have concentrated on the pictures I drew in the midst of my most painful times.

On each drawing in my sketchbooks, I have compulsively written notes such as date, time of day, time of menstrual cycle (i.e., day one of period is day one of cycle, day 14–16 is usually ovulation time, etc.). Each drawing is on 8½" x 11" paper. The materials I used were mostly Pentel markers, Crayola markers, and Schwan Stabilotones (i.e., in pencil form, which is between a pastel and a crayon). The markers were used for the most part because they were easy and quick to use with no preparation or cleanup, necessary factors when I was in pain. I kept these materials near my bed and took them with me in my travels.

As an artist I consider my artwork to be abstract expressionistic. The first picture (Figure 1) that was selected is not specifically an "endo" picture. In 1983, I went to Israel and when I returned to the United States, I was quite ill with a virus and in bed for 6 weeks. This is when I began drawing in my sketchbooks. This first picture depicts my image of being flat in bed. This image is also relevant to my suffering with endo. The endo has controlled my life, draining my energy approximately 2 weeks out of every month.

Many of the pictures selected for this article were created during the middle of the night while I was in excruciating pain, with my TENS Unit on, under the influence of pain medication and homeopathic remedies. Some of my drawings were created rapidly in a matter of minutes; others were drawn at a slower pace, 15–30 minutes, on average. For this article, due to limited space, I concentrated on my pictures from the last few years.

My drawings document my story: Drawing was a release, a way to vent my innermost thoughts and sometimes my only salvation. Who are you going to call at 2, 3, or 4 a.m. to talk to about your discomfort, the kind of pain that makes you question whether it is worth living. Some of these drawings are powerful and some are hard to look at. My own drawings helped me get through the time periods when the pain was most excruciating. It helped me survive the awful pain, especially while I was waiting for the pain medication to work, "kick in" so I would be "knocked out." At times, the pain would wake me from a sound sleep. Usually, this is when I would draw, to help ease the pain until I could rest again. I also drew at others times during my menstrual cycle. The vast difference between the drawings, use of color, and line quality during the period and PMS time of the cycle and less painful days is significant. During the pain, I would most often use red, black, and brown, not my regular colors. During the times of the month with less pain, I would use my regular palette of colors (many colors, especially pink, blue, and purple).

Before my second surgery, June 1993, I sent my medical records to the surgeon for a records review and evaluation. The surgeon asked for a brief description of my pelvic pain. The following paragraph was part of my letter to the surgeon dated 2/10/93:

> Presently I have pelvic pain in the middle of my pelvis, below or near the belly button and going out towards my ovaries/hips. Generally speaking, the whole pelvis hurts. As an artist, my description is to draw a rectangle covering the entire area of hips, ovaries, and pelvis. The pain radiates out from the middle of my pelvis towards my ovaries/hips. While the left side gets radiating cramps and pain during the period, sharp pain during ovulation is not usually present on left side. Specifically, the pain in the middle of my pelvis is usually [sic] a dull ache and/or cramps, which can be quite intense. Sometimes it comes and goes, and other times it is continuous, usually few days before and during the whole period. The cramps continue on and off. When flooding, the pain can be excruciating. The right side near ovary/hip is usually quite painful during ovulation time and right before and during the period. The pain on the right side (ovary/hip) is a sharp, stabbing, jabbing, knifelike type of pain. This pain occurs every month during ovulation time and also during my period in conjunction with the cramps. I also have soreness, tenderness, and/or pain on right side near ovary/hip after bowel movements, right before and during my period. I also experience pressure in my pelvis during and after eating right before and during my period.

The next few pictures are what I call my typical pain pictures. Figure 2 was created at 1:15 a.m. on the first day of my period, while awaiting some relief from a new pain medication. Figure 3 is a typical pain picture. Intense pain was in the middle of my pelvis radiating out towards my ovaries. The line quality is sharp like the pain.

Figure 4 shows line quality similar to Figure 3, in addition to having a triangular shape. This picture was drawn on the second day of my period. The pain would come. It did not matter where I was or what I was doing. Many times I would be out shopping or doing errands, and I would have to curtail my activities due to sudden pain.

Figure 5 is one of my favorite pictures because it has so much movement, depth, and color. However, I drew this pic-

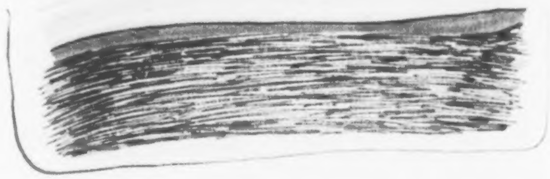


Figure 1. June 8, 1983

Figure 2. 1/16 - 1/17/92 (Thursday - Friday) 1:15 a.m. (1/16) First Day of Period. Took prescription pain medication. Waiting for some relief from the pain. (Waiting to get "knocked out.")

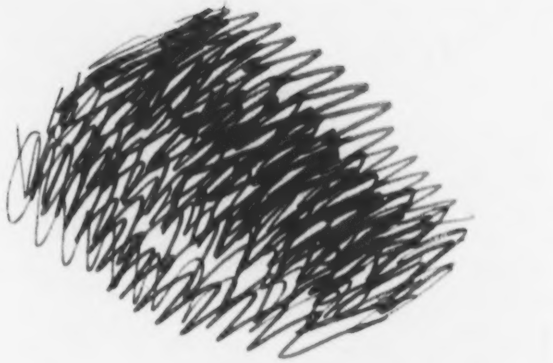


Figure 3. 3/15/92 (Sunday) 2:35 p.m. Fourth Day of Period. Pain returned with a vengeance. Took prescription pain medication and put on TENS Unit. Waiting for relief. My legs ache. The pain is intense in pelvis area and out toward ovaries. My abdomen is bloated. Yesterday, I slept most of day and night due to pain and medicine.

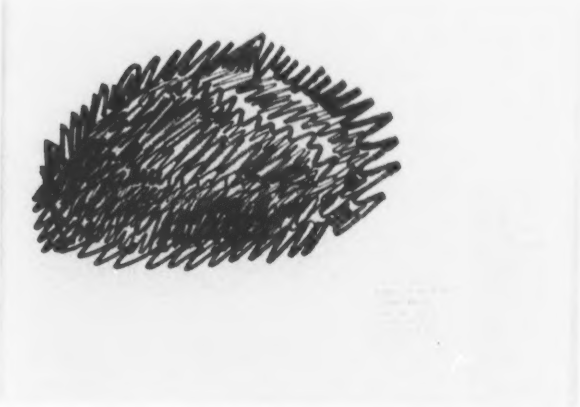


Figure 4. Drawn on 10/31/92 (Saturday - Halloween) 11:00 p.m. Second Day of Period. Pain on and off. Took homeopathic remedies, prescription pain medication, and extra strength Tylenol. Heavy flow. Visiting a friend on route to AATA conference. Friday night (10/30/92) woke up at 3:00 a.m. with bad pain. Took homeopathic remedy for excruciating pain.

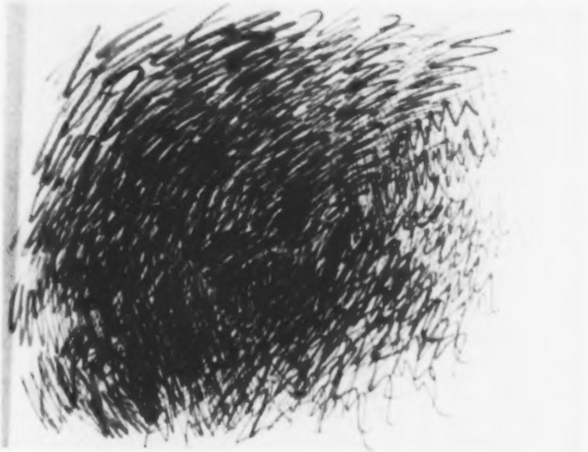


Figure 5. 11/28/92 (Saturday) 12:45 p.m. "The storm hit." Period—flooding. The storm looks like it is moving. I am glued to the chair. Hard to move. Zonked out on drugs due to pain.

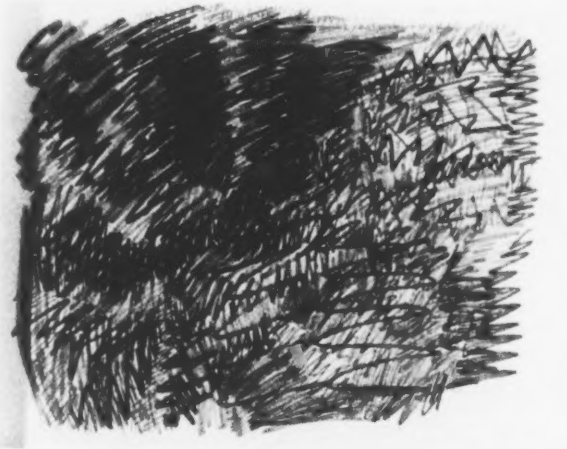


Figure 6. 11/29/92 (Saturday) 5:30 p.m. Wearing TENS Unit. In excruciating pain. Bad cramps. Can't do anything but draw. Took prescription pain medication and extra strength Tylenol. Waiting for some relief. Period—flooding—heavy red flow.

ture during the second day of my period (flooding). It felt like the storm hit. I was "glued to the chair," due to the pain medication and the intensity of the pain; it was hard to move physically. This picture had more colors in it even though it was a pain picture. It was Thanksgiving weekend, and I was at a friend's house. The colors I used for the pictures seemed appropriate for that time of year: lots of orange, red, golden yellow, brown, olivegreen, and black.

Figure 6 was created while I was flooding heavily and in excruciating pain—knifelike pain, which you can see in this picture. Figure 7 was also created while I was in knifelike pain. This is what I consider one of my typical "endo" pictures (endo pain). There are triangular shapes with sharp knifelike lines in black and red only.

Figure 8 was done in the hospital after my second surgery (laparoscopy) in June 1993. I woke up at 4 a.m., the second night after my surgery, with pain and bleeding. The tears rolled from my eyes due to the pain. This picture was different because of its shape. However, it was what I call a typical "endo" picture. The shape reminds me of the feminine pad which I needed to wear due to the bleeding.

Before going on to the next picture, I want to explain a little about my second surgery. I chose to go to an out-of-state endo specialist and had to travel by plane. I brought my sketchbooks and markers to the hospital. I drew up to the time I was taken to pre-op and drew as soon as I could, postoperatively, the day after surgery. I also brought my Walkman with me for surgery. I told the surgeon that I want-

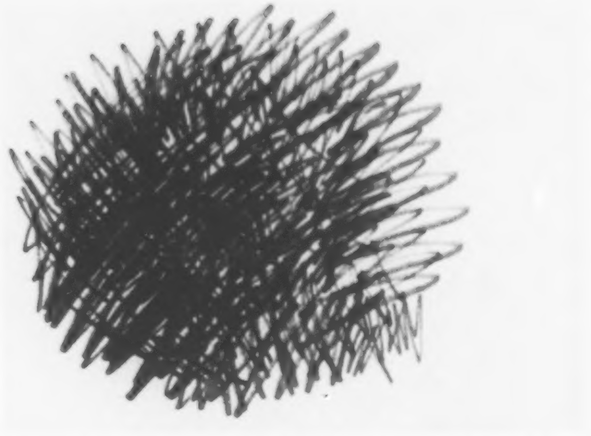


Figure 7. 5/8/93 (Saturday) 8:35 p.m. Second Day of Period. (Endo Pain). G-d it hurts. I took prescription pain medication, extra strength Tylenol, and homeopathic remedy. "The storm hit." I thought this month might be different as I always hope for each month and the same thing happens. I am in excruciating Pain!

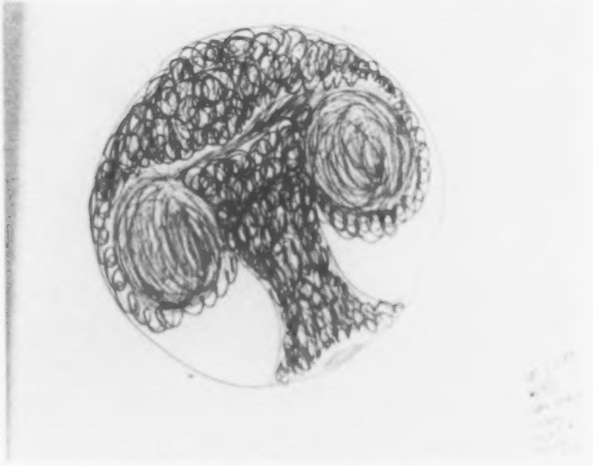


Figure 9. 6/19/93 (Saturday) 11:50 p.m. Drawn after reading surgery report and seeing Doctor's sketch.

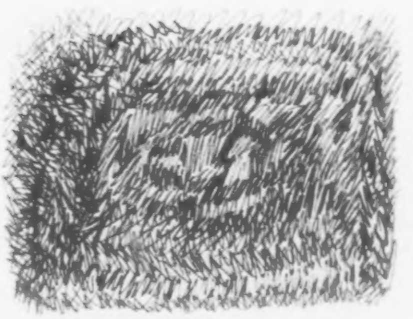


Figure 8. 6/19/93 (Saturday) (In hospital in Oregon, after surgery on 6/17/93). Woke up at 4:00 a.m. in pain. Bleeding. (My period might have started or it is just postsurgery bleeding). Lower back hurts as well as pelvis. Took two Percocet. Waiting for some relief. Tears rolling down from my eyes—sad, due to the pain. Listening to relaxation tapes. The sunrise is beautiful.

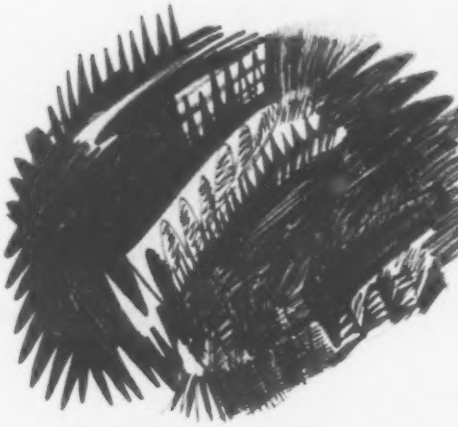


Figure 10. 8/27 - 8/28/93 (Friday - Saturday) 1:30 a.m. Day One-Two of Period. In pain. "The aliens invaded my body" about Wednesday. I took a nose dive. Tuesday I was having a pretty good day minus ear pain. Almost Bubbly Jane, on Tuesday. I have felt awful since. Too many bad days this week. I am tired of being continuously sick.

ed to listen to Louise Hay's Self-Healing tape before surgery; during surgery I wanted to listen to Dr. Bernie Siegel's "Love, Medicine, and Miracles" meditation tape. I was more prepared emotionally for my second surgery. Before my first surgery I was literally in pain every day and wore my TENS Unit into the hospital the day of surgery. After my first surgery, but before my second surgery (approximately 3 years), the pain became progressively worse and it affected my bodily functions, with pain during eating and bowel movements. Before my first surgery, there was so much pain all the time, all over, that I did not differentiate the pain. Figure 9 (June, 1993) was drawn after reading my surgery report and seeing my doctor's sketch of the inside of my pelvis and his explanation of what he did in surgery. Essentially, this portrays the endo all over my pelvic organs. The endo was on my intestines and on the surface of my bowel, which is why I had pain during eating and when using the bathroom.

Another pain picture, Figure 10, was drawn at 1:30 a.m., a few months after surgery. It would take several months to notice a difference after surgery. I was told that the pain could be worse than usual. Well, it was. The week before my period and the week of my period, it seemed an alien force had invaded my body. The line quality is sharp, jagged edges, and the red and black are typical of my pain pictures.

I began to draw circular pictures on and off during the last few years. Figure 11 represents day 14 of my cycle, ovulation time with pelvic pain. I began to add colors to my pain pictures. Here, I used red, black, and blue. During ovulation my ovaries can be quite painful. This circle picture shows what is happening inside my right ovary. During my second surgery, the surgeon removed endo, a cyst from my right ovary, in addition to removing adhesions caused by endo, and two fibroids on my uterus.

Another circle picture (Figure 12) was drawn on the 29th day of my cycle, right before my period. I had a vaginal yeast infection due to being on antibiotics because of chronic ear, nose, and throat infections. Very itchy and in pain. Looking at this picture, I can feel the itchiness.

Figure 13 depicts knifelike pain in a black and red drawing. A dull ache is in the middle of my pelvis and/or knifelike cutting pain is near my hips/ovaries. I am waiting for some relief from the pain. Figure 14, done the third day of my period, shows my intense pain. The flood gates opened. I cannot get enough red and black. This is quite different in that it has a flower shape in the middle with a wavelike shape around it. It is like a light at the end of the tunnel. Figure 15 is another red and black drawing, drawn on the third day of my period when the flow was still heavy. I had a headache and was nauseous from pain medication. I was not able to function or to drive; I was drugged out.

Figure 16 is the most recent pain picture using a circle. I used black, red, brown, and gray.

In this article I focused on the pain pictures. I would have liked to have been able to show more of the pictures

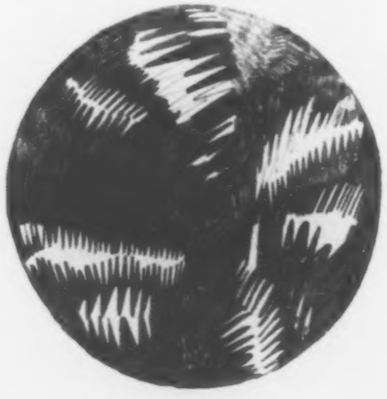


Figure 11. 10/7 - 10/8/93 (Thursday - Friday) 2:15–3:00 a.m. 13th - 14th Day of Cycle. Pelvic pain due to ovulation. Depressed "Pity Party" due to 37th birthday (10/8) because I haven't reached my goals due to medical situation. Feel emotionally better after drawing.

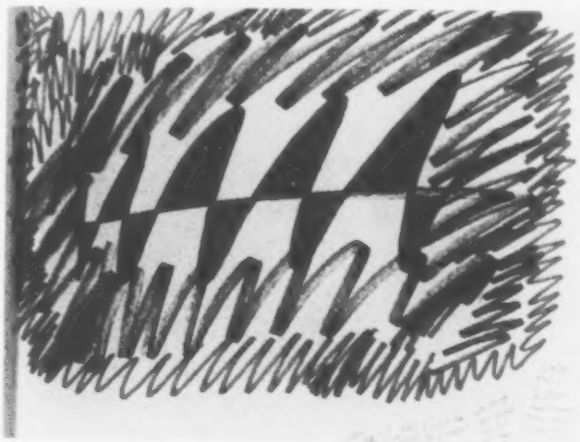


Figure 13. 11/9/93 (Tuesday) 6:15 p.m. Third Day of Period. Took prescription pain medication and extra strength Tylenol. Still flooding. Waiting for some relief from the pain. Knifelike pain near ovaries/hips. Near middle of pelvis, dull ache and/or cutting.

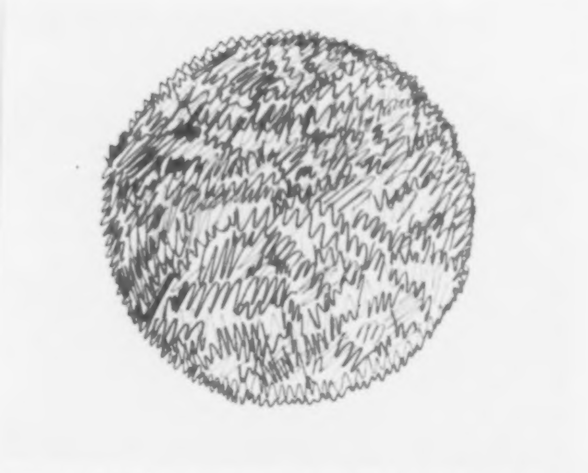


Figure 12. 10/23/93 (Saturday) 6:15 a.m. 29th Day of Cycle. Waiting for period to begin. Physically feel miserable. Very itchy. Vaginal yeast infection. The aliens have invaded—feel very bloated. Pelvis hurts. Hard to move. Fell asleep with lights on.

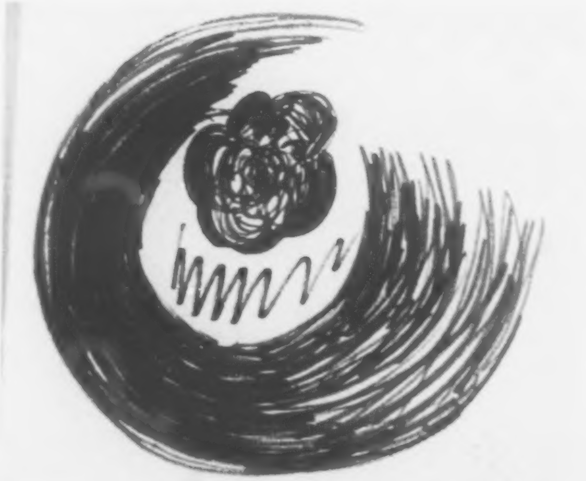


Figure 14. 11/9/93 (Tuesday) 6:25 p.m. Third Day of Period. Flood gates opened. The pain is so intense. I cannot get enough black and red or the colors dark enough. (Markers drying out.)

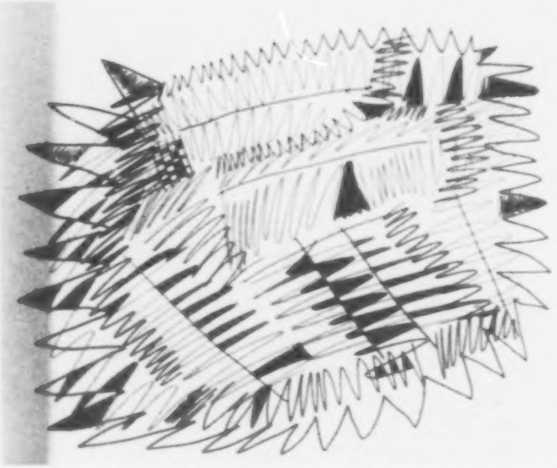


Figure 15. 12/26/93 (Sunday). Third Day of Period. 10:30 a.m. Period came ten days early. Took prescription pain medication and extra strength Tylenol. Bad cramps. Still flowing heavy. Drugged out. Headache, nauseous, and threw up. Went back to sleep. Not able to function or drive.

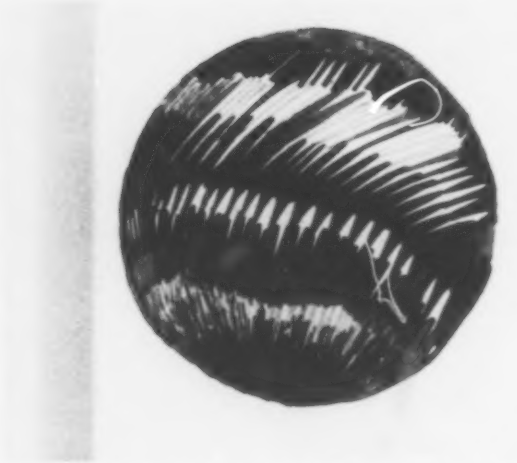


Figure 16. 4/24/94 (Sunday). 9:00 a.m. Fourth Day of Period. Drugged up due to pelvic pain. Took prescription pain medication and antihistamine.

from my sketchbooks, but hope to publish a book with many of my pictures in color and elaborate on different times of the menstrual cycle.

Pain is universal. In showing others my sketchbooks, anyone could pick out the pain pictures from the others. Even though pain is experienced by each person differently, one can relate to another person's pain on some level. In looking at this selection of pictures, most of which focused on pain, some of the common characteristics of the pain pictures were the line quality, jagged sharp triangles, teethlike claws, knifelike cuts, and the colors red and black depicting feelings of anger, fear, depression, and frustration. My pain drawings became more elaborate with levels of colors and the intensity of the texture in the line quality.

This article may shed some light on a growing health issue for women. My reason for sharing my drawings and thoughts and feelings is to help others cope and deal with a chronic debilitating disease, endometriosis. My artwork and my sense of humor helped me to deal with a complex medical condition. I am not aware of anything published in the art therapy literature that pertains to endometriosis. It is a troubling illness because there is no cure; medical science has not figured out the cause. Thus, there is confusion about the best way to treat the illness. I hope this article has opened some minds, eyes, ears, and hearts.

References

International Headquarters Endometriosis Association, Inc. (1987). *Brochure*. Milwaukee, WI: International Endometriosis Association.

Taking Inventory in the Age of AIDS

Emily Piccirillo, MA, A.T.R., Montclair, NJ

Know your path to be the path of all,
That you may safely guide.
Love all beings as members of your own Body,
That you may truly serve.

(Trevino, 1993)

As the AIDS epidemic advances, every practicing art therapist is likely to have PLWAs (persons living with AIDS) as clients, whether we know of this particular diagnosis or not. Despite media emphasis on stereotypes of gay men and IV drug users as those infected, this virus has crossed all barriers—age, gender, culture, socioeconomics, geography. All mainstream and special populations have been touched, urban and rural, directly or indirectly. Therefore, I believe that each discipline has a responsibility to become familiar with basic treatment issues, from the practice of universal precautions to clinical dilemmas.

Based on my 3 years of experience in a large AIDS long-term care facility for adults in New York City, I would like to share some observations and suggestions that I hope will advance the care of these individuals. Many of these ideas may have general appeal and application, but I have chosen to underscore them here because of their specific importance, both intrapersonally and interpersonally, with this deeply complex population.

First and foremost, it is vital to admit that the versatility of this virus is utterly bewildering, even to the medical authorities. Anyone involved with this ambiguous syndrome must realize they are pioneering a strange new frontier, so there is plenty of room for doubts and questions, many controversial. Just when caregivers and clients believe they have seen the full spectrum of potential pathology and have their bearings, new symptoms and conditions surface. There is no such thing as a textbook case. The progression of the disease can fluctuate wildly, even over the course of a single day, often due to sudden stressors or changes in medication. In addition, the virus itself can mutate spontaneously, transforming how it presents itself clinically. Use of the metaphor of a roller coaster is commonplace, it is helpful to keep in mind that if you do not like the unpredictable experience of being on one, you will be especially challenged working with HIV+ individuals.

The complex constellations of thoughts, feelings, and conflicts that accompany this syndrome can place extraordinary demands on linear thought and vebalization, even for highly articulate individuals. Spatial and symbolic expression, with its unique tolerance of ambiguity and contradiction, can better accommodate the overwhelming confusion and uncertainty, without frustrating the client's need to process the profound effects of this experience (Figure 1). The PLWA can begin gradually to give shape and definition to troubling internal and external issues. As with art therapy in general, any latent or vague changes can manifest in the artwork, potentially informing you before the client is consciously aware of them, thereby providing important impressions for differential diagnosis and future treatment.

With variability as central to working with PLWAs, vigilance to shifts in their functioning, whether physical, cognitive, social, creative, or emotional, is essential. If you are working in a setting where you have substantial contact with this clientele, you easily could be the first to notice a new symptom. It might be a faint slurring of speech, the favoring of one leg over the other, minor forgetfulness, or hostility; the possibilities are endless. While one cannot immediately comprehend the full significance of the change, it is important not to hesitate to bring it to the attention of the related disciplines. Swift recognition and appropriate interventions can make a world of difference to the client's quality of life. Fortunately, the changes also may take the form of marked improvements. Since so much is going on, members of the treatment team need to stay in very close touch.

Intrinsic to the virus' unpredictability is a strong sense of one's lack of control, for both you and your client. Now, it is said that a good therapist begins where the client is, but it is hard to imagine easily entering the world of a person living with AIDS when you can tell their suffering is explicit (and when you are struck by the proximity of their birthdate to your own). Establishing a comfortable, well-modulated place for oneself in their chaos is a daily challenge. Just as each client is variously in any one or combination of Kubler-Ross' grief stages (1987), there is an approximate parallel process in the staff. But the unique nature of this grief is defined by the

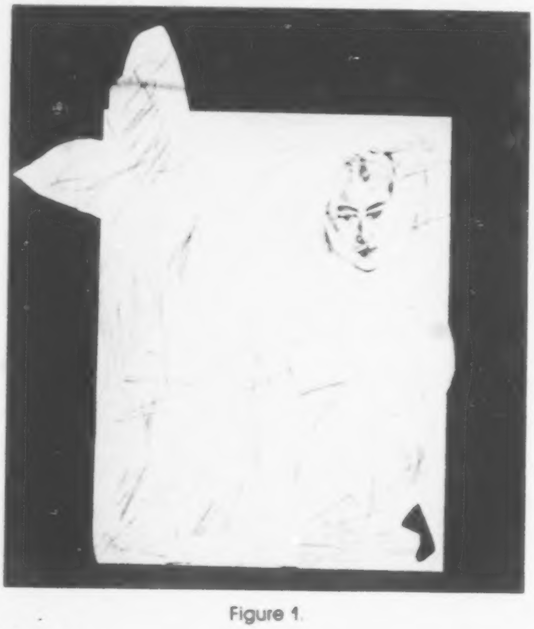


Figure 1.

persistent repetition of loss, creating a strong potential for "survivor guilt," "compassion fatigue," or burn-out. Even at an optimal moment, a trained, seasoned therapist can defensively respond to a PLWA's intense distress with either fight or flight, as more typically characterize our clients. Unfortunately, such reactions in staff usually exacerbate an underlying sense of rejection, futility, and misery in those we serve.

So, at times there is the problem of doing too much—the fight response. Figure 2 shows a client's early depiction of the anger that often drives a healthy wish to combat the illness. The therapist might, however, confront persons who do not get out of bed by taking a "tough love" stance, criticizing their apparent unwillingness to help themselves. Others may try to override signs of decline, urging impaired clients to restore an unrealistic level of functioning while exposing their vulnerable self-esteem to messages of shame, contempt, and ridicule. It is also common for caregivers to try to rescue the clients' sagging spirits, making extreme efforts to insulate them from their graphic reality. Surely there is plenty of room for a well-timed pep talk, distraction, or reassurance, but it is paramount that the prevailing message be that we accept them just the way they are at the moment, with all their attendant chaos. It is when we impose our own agenda, communicating our preferences of how we would like them to change, or change back, that we begin to fail them and wear ourselves out.

Alternately, there is the inclination to do too little—the flight response. Figure 3 shows an "alien'ated" depiction by a client who held an intense wish to escape his condition. For many therapists it seems safer to choose not to establish close bonds with PLWAs, confusing detachment with objectivity. Yet, if you stand back and spectate, you will be held suspect. One client referred to this tendency as "rubber-necking." Inevitably, you will become very attached to some of these persons and will be put through personal changes of your own, some painful and destabilizing, but mostly enhancing. HIV + persons know they are in the midst of a bizarre drama and often describe feeling like they are from another planet; it is up to every person working with them to be as present and open as possible.

While AIDS caregivers rationally grasp that the virus is only transmitted through body fluids, there are still an infinite "what ifs" that can intrude upon the psyche. If these cannot be readily talked about, and quieted with other staff and in support groups, the infectious nature and tragic potential of HIV can override one's best intentions, severely compromising treatment. Since these clients naturally engage in their own life review, it would serve you well to do your own soul-searching about death and dying. Creating your own artwork and completing exercises such as those described in *Mortal Acts: Eighteen Empowering Rituals for Confronting Death* (Feinstein & Mayo, 1993), can be very valuable to this process.

Keep in mind, PLWAs experience devastating losses over the entire course of the disease, in every sphere of their lives. Many are hardened survivors, veterans of chronic trauma, and all too often PLWAs have been abandoned or shunned by their families and friends. Surely this can pose tremendous therapeutic challenges, often reflected in their urgent need to test your sincerity and allegiance as a "real person" in their world. This early socialization can be unwittingly repeated by our first establishing an alliance, only to withdraw attention later as the physical deterioration sets in. Or, it can be corrected through sustained attunement and helpful boundaries. The gravity of the situation, and knowing that each interaction might be your last, makes this second option imperative in order to keep a clear conscience while not becoming thoroughly exhausted.

The experiential nature of art therapy provides PLWAs an immediate opportunity to learn new behaviors and build coping skills since it requires experimenting with change and unknowns. Using the imagination and finding solutions to problems are essential to the active art process, letting them safely practice ways of perceiving and managing the unpredictable. This can have dramatic consequences for PLWAs, empowering them to visualize possibilities as they transform and integrate "mistakes." The art therapy experience serves as a format for dealing with existential dilemmas by reframing them as workable realities; clients literally take their situations into their own hands and do something about them. The active development of inner resources, reasonable goals, and a stable sense of mastery challenges the sense of being a passive victim.

The mural of the volcanic island, shown in Figure 4, was created in a small, open art group. As the small depictions of people were being collaged in at the bottom right, the group's

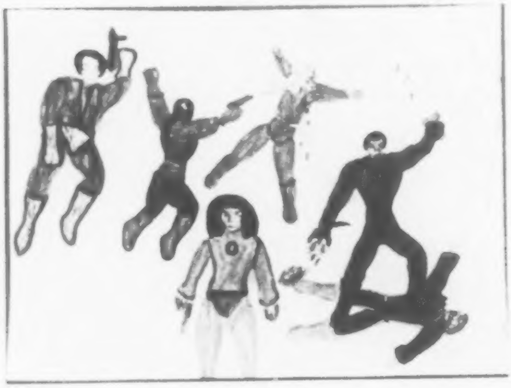


Figure 2.

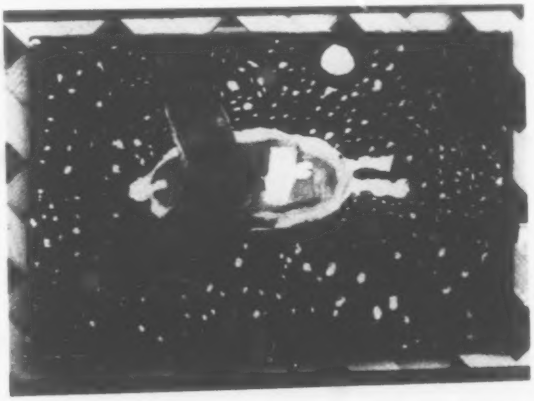


Figure 3.

anxiety over their expressed explosiveness and rage became palpable and the challenging reality of the catastrophe transformed the members' discussion. After acknowledging their satisfaction from the catharsis, they moved swiftly to re-define the situation with the clear intention of helping those caught in the midst of their dangerous erupting scene. Instead of calamity, the final interpretation took a poetic, reparative turn, and the lava became "love rising, flowing freely and spreading its' magic everywhere, purifying rather than burning them." The resulting air of togetherness, relief, and even joy, seemed like quite an achievement. The final additions of the large bumblebee and butterfly at the top seemed to serve as signs of hope and renewal.

Naturally, some PLWAs intuit the possibility of such an intense experience and become ambivalent and frightened of taking such steps. The reasons are manifold and must be carefully explored and respected. Many are reminded of the perils of risktaking. Others believe that by participating they are capitulating to their predicament; there are others who have seldom felt cared for. With such intense unmet dependency needs, they decide that the secondary gains of having the role of patient are too satisfying to forfeit, and refuse to relinquish them. Their only action may be to say "no."

Since many PLWAs have felt marginalized in society since long before their diagnoses, they have an uncanny ability to know your fears, prejudices, and pretenses. Remarkably, having the disease only heightens this sensitivity. This is largely a behavior-based disease—behaviors we are generally taught to judge, and to judge with disdain, creating a good "us" and a bad "them," which reinforces splitting tendencies. This devisive view tends to sacrifice the personal to the political and compounds the suffering; it requires a rigorous struggle to retain one's focus and a sense of togetherness. The damaging internalized messages and habits can then interfere with our capacity to be available to humbly bear witness to another's distinct experience and respond with compassion.

Due to the continued stigma of seropositivity, as well as many of the precipitating high risk activities, clients are often reluctant to own their condition, inhibiting their ability to communicate freely and restore a sense of wholeness. (It is important not to confuse this blocked reaction with the apathy and social withdrawal resulting from dementia, see below.) As HIV+ persons enter the health care system, they often feel stripped of their privacy; ironically this exposure can cause or aggravate a sense of isolation. The small pieces of Figure 5 were made by a resident who presented himself as a very hostile, difficult individual, as he struggled with his need for placement after years of living on the streets. Suddenly, one day he hung these collages as signs on his door, quietly sharing his humanity and humor, parts of himself he had fiercely hidden until that moment. They served him well, providing the staff with a new and positive impression of someone who had been labeled "oppositional" and resistant." His simple, loosely arranged words had a complex effect as they invited staff to reconsider assumptions about him and the strategies being used.

Art therapy grants permission of expression to PLWAs that family and friends sometimes forbid or avoid. Creative languages, from candid to cryptic, allow them to maintain valuable contact with others, while being able to reasonably monitor what they reveal and conceal. Through careful selection of materials and optimal interventions by the therapist, vital defensive maneuvers can be maintained without the threatened loss of interpersonal closeness. In this alternative way, an HIV+ client can purge toxins out of his or her system, a system experienced as acutely contaminated. This can be crucial to gaining relief from the depression that characteristically paralyzes many PLWAs.

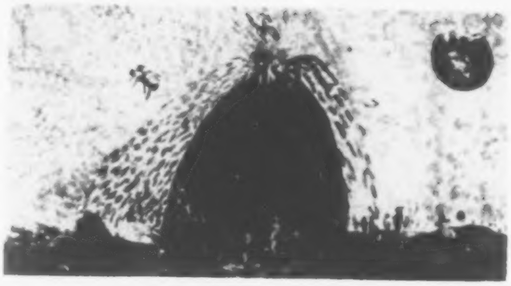


Figure 4.

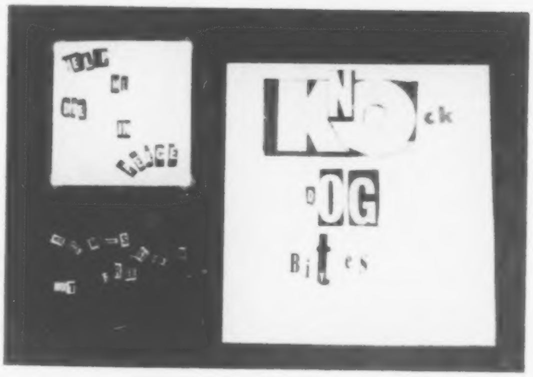


Figure 5.

The content of some art pieces can be very provocative, even raw, and requires finely tuned responses by the therapist. An honest inventory of our deepest beliefs about illness, and this disease in particular, sexual orientation and behaviors, gender relations, chemical dependency, race, culture, religion, capitalism, and criminal justice, will spell out the subliminal influence we will have on discussions as they occur during groups, individual treatment, and as they manifest in the artwork. Figure 6 provides a strong example of such an image, as it captures a male resident's not uncommon preference to focus on his sexual contacts with women, instead of his history of IV drug use, as the source of his HIV infection. It clearly depicts an aggressive, seductive effort to engage the viewer in his fierce conflicts, perhaps to "push buttons." A therapist's caution in such instances can protect the client from the very reactions he might elicit, allowing new and healthier types of exchanges to occur.

Much healing work can occur when clients are supported in their variously desperate and brave efforts to face, sort through, and possibly resolve the turmoil that compromises their well-being and sense of belonging. It is most helpful to be inclusive rather than exclusive, due to the client's often overwhelming urge to blame, menace, persecute, or scapegoat others. Moralizing is all too tempting with such

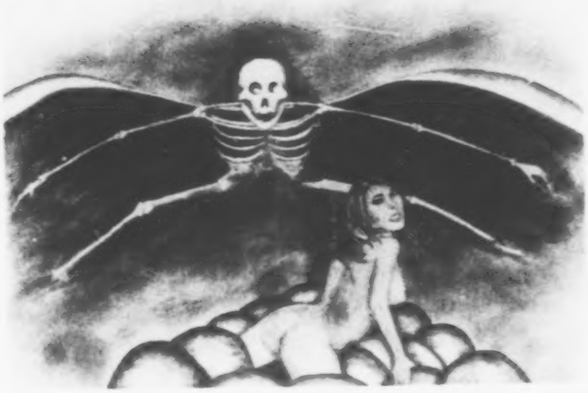


Figure 6.

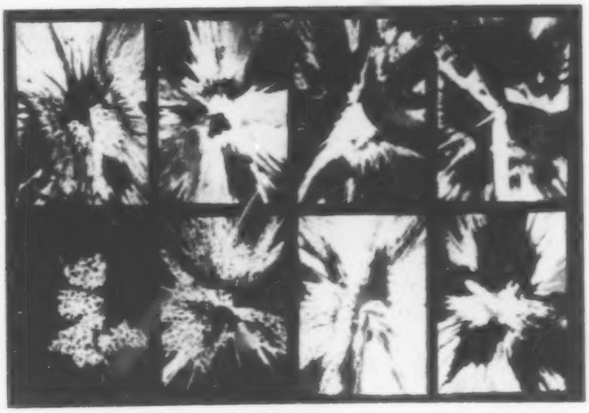


Figure 7.

loaded situations and must be consciously reflected on and processed. I find that it is best to try to practice the kindness, fairness, forgiveness, respect, and patience that are so much easier to preach, and to try to listen as closely as one would to a teacher.

In an inpatient setting, the social nature of art therapy groups cultivates cohesion and builds community. It enlivens and humanizes the often institutional environment. It can reveal astonishing strengths within the population. Wishes, fantasies, and worries can be shared and elaborated and common ground can be discovered. Attention to the "here and now" can be encouraged and appreciated. Some exercises can be interactive and playful, spontaneously providing relief from the sobering reality. Simply having fun is a significant benefit for everyone.

The chance to experience pleasure and ease tension in an enjoyable "cheap thrills" fashion is deeply reparative since familiar and favorite sources of satisfaction frequently have been restricted or eliminated. The "spin arts" in Figure 7 represent a fraction of one resident's remarkable collection of these instant images that evolved from random accidents to cleverly choreographed sequential expressions. Media such as this, that I might have previously overlooked, becomes a surprising resource with this population. No material or process should be taken lightly. Particularly for substance abusers, the art materials can serve as an appropriate, alternative means of stimulating and soothing for affect regulation.

Especially for individual contacts, I recommend studying and cultivating the skills of empathic attunement as described by Rowe, Jr. and Mac Isaac in *Empathic Attunement: The "Technique" of Psychoanalytic Self Psychology* (1991). This book provides ways to assist the client in fleshing out his or her thoughts and feelings without becoming dangerously depleted yourself. In this line of work, you witness a great deal of psychic and physical anguish, rage, and sorrow, often deeply locked within ego deficits and alexithymia (Krystal, 1988). While some individuals are more self aware, having developed effective coping techniques and being able to ask for guidance, space or company as they need it, others are far less competent, even desperately impoverished. This can leave you feeling utterly inadequate, often through projective identification.

It is helpful to try to educate yourself about the most common opportunistic infections and treatments in order to help organize the mind of someone who is struggling to make sense of what is happening. Facts can offer focus and bind anxiety, but be careful not to embellish to create a false sense of security. Any organ can be affected by HIV, for it is carried by the blood to the lungs, liver, brain, uterus, skin, everywhere. As the immune system deteriorates, all the environmental hazards and latent pathogens already in the body can impinge violently. One's medical history can be relived. Some of the symptoms are intermittent, or become chronic, or advance. Others resolve, suddenly or gradually, spontaneously or with treatment.

While I cannot review the multitude of medical problems that can occur with this syndrome, I have selected one HIV-related problem that I seldom see mentioned by the press, but that complicates treatment at every turn. Observation suggests that there is a high incidence of some degree of dementia in AIDS clients. It does not follow a familiar course, as does Alzheimer's disease, and can resemble many other disease processes. It has a bewildering number of medical causes, frequently complicated by pre-HIV factors like head injuries or schizophrenia, and it is common enough that you will find it listed in the DSM-IV. Of those who are too intact for this classification, many more seem to experience some defect in their cognition or short-term recall, even if it is only an occasional lapse of sharpness or quickness.

Significant memory and attention problems are common, requiring substantial reminders and cueing, sometimes on a moment-to-moment basis. Changes can be sudden and surprising, and there can be unnerving instances when you discover you are in the midst of their discovery. A sign might be minor, like needing to write down a previously familiar phone number. Most clients minimize, ignore, or deny it until it advances to the point of embarrassment or marked interference, like forgetting the location of their assigned room. Some experience terrible anxieties with these symptoms and protest loudly that they are neither stupid nor crazy. The deterioration is usually uneven, creating startling discrepancies between areas of functioning. Teaching them small tricks to compensate for the deficits goes a long way.

If the dementia worsens, some clients can become utterly scrambled, babbling nonsense. Still others are so cognitively impaired that they become mute, or forget to chew

Figure 8.

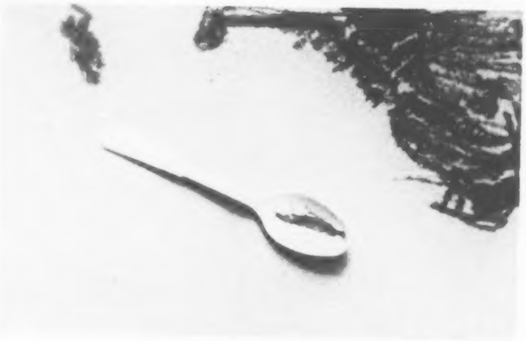


Figure 9.

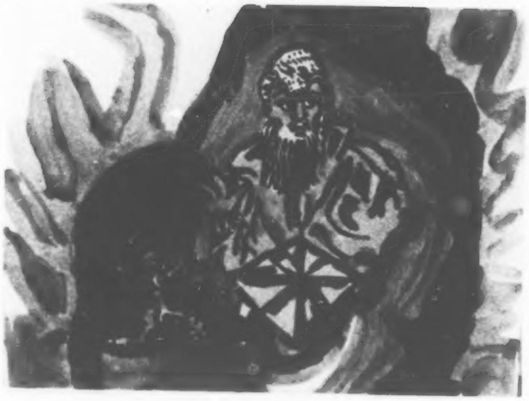


Figure 10.

and swallow, or are unable to follow the simplest one-step directive. Some sit in a dull stupor, impassive to the most lively stimuli. Others become hyperaroused by the slightest external and internal signals and are easily agitated or thrown into a panic. They may have features of organic psychosis, scary hallucinations, or massive delusions. Some perserverate (Figure 8). Many become irritable and suspicious, especially when the dementia is just beginning, accusing others of stealing or lying. Sometimes medications and interventions can help slow or reverse it; sometimes not. In time, it usually progresses.

A more familiar feature can be the tendency to regress, with some PLWAs becoming more like young children, even babies, at times. Social judgment can deteriorate; they can become disinhibited and impulsive. For some, everything goes into the mouth. Figure 9 shows the scribbling tendencies that can occur. The resident who made this picture was unable to differentiate an appropriate drawing surface, moving onto the spoon without interruption. He then tried to lift the drawing from the paper and lick the marks off the spoon. Often the descriptive "pleasantly demented" is applied to those clients who become playful and lighthearted in their efforts to get attention. Usually they need special assistance or individual attention since they are unable to accommodate group demands. Nevertheless, with careful adjustments to the art process, even severely demented clients can continue to gain orientation, gratification, and pride from their creative efforts.

Lastly, by enduring over time, the artistic products prove to affirm the very existence of the creators and often serve as their final mark in the world. This is very helpful as HIV+ persons grapple with their mortality, demonstrating their simultaneous transcience and their permanence. Figure 10 was created by a resident who was exploring his spiritual beliefs and relationship with God. Poignantly, for some, the art is the *only* thing they feel they have to leave behind, granting them a precious taste of immortality. As the pieces accumulate, they can observe their technical and expressive accomplishments and growth, even as their bodies decline. Each completed piece can give fresh meaning to their lives, providing a sense of purpose, peace of mind, and wholeness.

While there are limited treatments for AIDS and no cure in sight, art therapy offers a profound opportunity to heal one's self, one's life, one's soul. This strengthening of identity can help counteract the demoralizing effects of this disease. It can pull HIV+ clients out of their constricting orbits of illness and deliver them back to earth. They are able to gain a sense of fulfillment from the generative nature of art therapy in their often bleak world. They can use their artwork to bring themselves and others closer to understanding, by sharing and displaying it. It can restore laughter to their lives. It can be used as gifts to articulate their gratitude, fondness, and their concern for others. It can even serve as a supplemental livelihood. And, for you, the therapist, it can provide a lasting, resonant, transitional object to ease the ultimate termination.

References

Feinstein , D., & Mayo, P. (1993). *Mortal acts: Eighteen empowering rituals for confronting death.* San Francisco, CA: HarperCollins.

Krystal, H. (1988). *Integration and self-healing: Affect, trauma and alexithymia.* Hillsdale, NJ: The Analytic Press.

Kubler-Ross, E. (1987). *AIDS: The ultimate challenge.* New York: Macmillan.

Mac Isaac, D., & Rowe, Jr., C. (1991). *Empathic attunement: The "technique" of psychoanalytic self psychology.* Northvale, NJ: Jason Aronson.

Trevino, H. (1993). *The Tao of healing: Meditations for body and spirit.* San Rafael, CA: New World Library.

Let Me Wipe My Tears So I Can Help with Yours

Audrey Elkinson-Griff, MA, A.T.R., Birmingham, AL

During the past 6 months I have been moved by the expressiveness of the artwork created by the staff at a nationally recognized research clinic for HIV-infected and AIDS patients in Birmingham, Alabama. Increasingly, walls metamorphose into gallerylike halls, and the benefits of an art therapy program become apparent. The personal touch of aesthetics and emotions seen in artwork on their office walls exposes the need for staff members to minimize personal stress. Amidst a hectic day, when catching a glimpse of his/her own artwork, the creator is reminded of a short respite and period of solace. In this writing, my goal is to highlight multidimensional aspects of nurturing oneself through art therapy, and to reveal its invaluable benefits, in hopes that others may allow time to take care of themselves.

An opportunity for the staff to use art materials was strongly supported by the clinic's director who was sensitive to the needs of her staff and their likelihood for burnout. Following implementation of an art therapy program for patients, a staff art program was begun. Our monthly art groups have provided an expressive outlet for highly stressed workers to rechannel their energy via the creative art process. Staff members have entered sessions noticeably burdened with work-related stress or preoccupied by a particular patient's deteriorating physical condition. Distracted or interrupted by beepers and pages, they attempt to focus on themselves for a short period of time. Upon completion, they leave with insight to their thoughts and feelings, their energy freed up to attend better to the needs of others.

The group time is loosely structured, with the same art materials available that are routinely used for patient groups: pastels, paints, and clay. I usually have some techniques ready in mind to suggest, although, to date those participating have usually entered with ideas of their own. At the start of a session, staff members defuse spontaneously by discussing a particularly difficult event or series of events which occurred over the past few weeks, including the number of recent deaths, varying degrees of illness of patients, and research protocols. Most discussion of artwork takes place on an individual basis which minimizes group process, and simultaneously establishes a safe environment for disclosure. Personal issues, in addition to work-related issues, have emerged in the artwork. With a forum to express concerns that surface, they may be less troublesome on the work front. Here are some examples of what has appeared.

In Figure 1, the immediate stress-reducing benefits of creating art can be seen. It was drawn by a member of the administrative staff, L., who regularly attended staff art. One day, as I set up for a patient group, I was approached by several staff members who asked me if I had seen what L. had done in her office: "It's wonderful!" "It's beautiful!" "She did some great art!" I found this brightly colored, fluid, abstract image drawn on her memo board with display markers. L. commented, "It was one of those days, and I had to do something. After I did this, I was able to get back to work."

Through her artwork, Q., a clinical social worker, highlights some of the issues one frequently expects to face in this clinic setting. Her time and energy is demanded by many, and she is pulled in different directions. Often, her attempts to meet the needs of patients are met with frustration. A strong supporter of art therapy and instrumental in establishing an art therapy program, she has been responsive and sensitive to her own process. In Figure 2, she began with oil pastels to create colorful, energetic, fanlike images. Brightly colored circles were added, with pieces of colored tissue paper randomly placed throughout the picture. Last, lines were added to the curved edge of the fans, as if curtailing their movement. When discussing this drawing, the metaphors of popcorn and fires emerged. Q. related each colored fanlike image to a different patient and her continual need to put out fires and bring things under control as new issues popped up. The green fan in the center depicted today's focus, and the new fires expected to erupt tomorrow were depicted by the solid colored circles. The tissue paper additions were thought to be expressions of her own playfulness and an attempt at maintaining balance in light of daily burdens. From these images, one can only imagine the amount of energy she continuously needs to expend fanning fires, and her continual concern for the health of her patients.

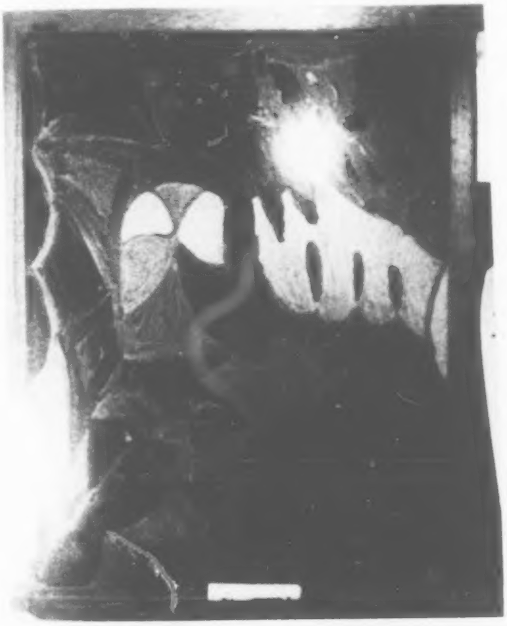


Figure 1. L.'s memo board image

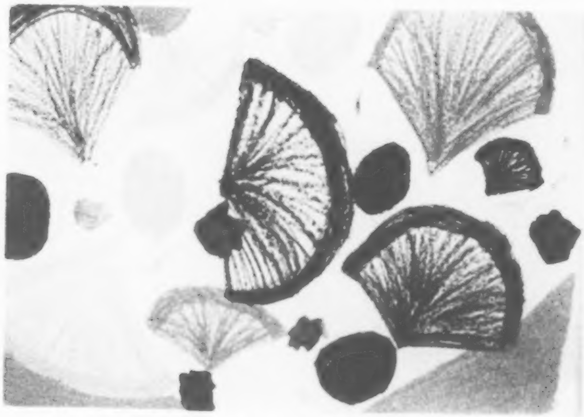


Figure 2. Q.'s "popcorn and fires"

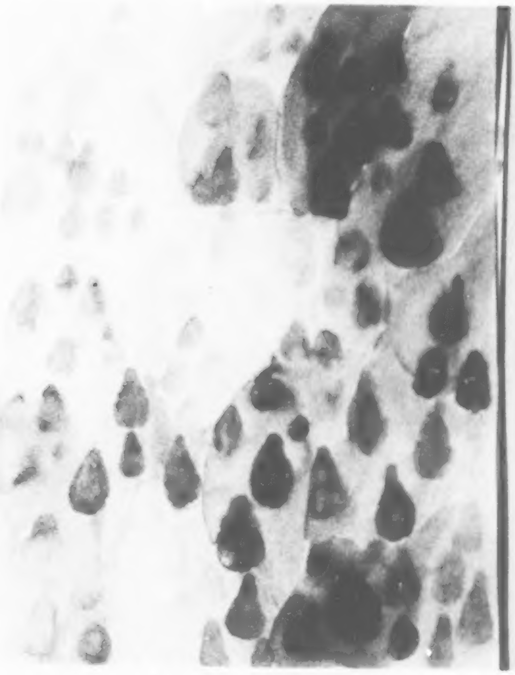


Figure 3. Q.'s teardrops

She produced Figure 3 a few months later. In an effort to contain or minimize her expression, the paper was folded to one-quarter its original size and it seemed she might be making a greeting card. She used watercolors to create small shapes that resembled teardrops, expressing overwhelming feelings of sadness which she related to recent patient deaths and the physical deterioration of other patients. She said that if what she created were a greeting card, she would like to send it to G-d so He would know how she was feeling. She talked about the cathartic value of crying and was thankful she could still release tears, commenting that many staff members who have worked at the clinic for a longer period of time are no longer able to cry.

W., a researcher, was, for many months, a sideline observer of the art therapy program. Although he was gregarious and curious, he never seemed to have the time to participate. As he saw me setting up for a patient group one day, he commented, "If I were to come to art today, I'd make something blue. It's been a blue day today. _____ died over the weekend and I just learned _____, a long time colleague, is HIV positive." A few weeks later, W. attended his first staff art session. He came with specific ideas for artwork, although he felt uncertain whether his artistic skills would allow him to execute his thoughts. A quote by G.K. Chesterton, originally heard in a sermon, had been on his mind: "Death is but a field of flowers." Figure 4 is an illustration of this quote. A field of flowers is dedicated to all the people W. knows who have died of AIDS, currently appromixately 300. After completing his picture, W. said he wanted to add more flowers; the whole field should be covered. However, he would not be able to do it that day: "I can't get past the black today [seen as a dividing line between the hills and meadow]. I'll try to do that next time." Instead, he spent much of his time working on the trees and hill, and added the flowers last.

C., a newly hired clinic chaplain, completed the drawing in Figure 5 during his first participation in staff art therapy. C. was very sensitive and seemed at ease with the art process. He was curious about the meaning of his artwork. His initial comments included discussions about death and references to a family-requested eulogy he recently gave for a patient. He believed there was a bittersweet element to death, that the individual was at peace following death, although survivors were pained by the loss. In his artwork, this belief is illustrated by the contrast between bright rain-

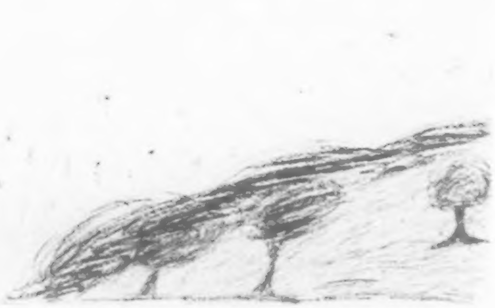


Figure 4. "Death is but a field of flowers."

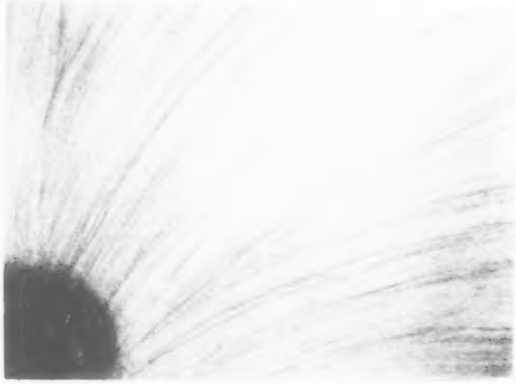


Figure 5. W.'s rainbow and box

bowlike colors and the gray box in the lower, left-hand corner. C. returned to the drawing and blended the pastel colors, minimized the outline of the gray box, and worked it into a circular shape. The red-banded area surrounding the gray became more prominent, and he blurred the rainbowlike colored stripes. Later, he commented that issues related to death are not quite so clear and cannot be easily compartmentalized, while the emotional pain of loss, depicted by the red area, is evident and well-known.

Each week C. had a "Thought for the Week" posted on his door. The week after this experience, the text read: "Approach your life as an artist creating."

Many images of flowers and vacation spots appeared in artwork not discussed here. Beaches and boats were often seen in illustrations of favorite weekend getaways and vacations, with comments about the desire to escape and leave behind daily stresses. Flowers growing in gardens and arranged in vases left the creator feeling good about their inherent beauty. The staff's need to regenerate the depleted and efforts to fight off burnout are illustrated by this type of picture.

Synonymous with concepts of mortality and dying are the words HIV and AIDS. An HIV or AIDS diagnosis suggests an abbreviated finiteness to the infected one's life. There is no escape. Work with this population forces all involved to face the issue of death and to individually find resolution. Several weeks after completing the artwork discussed, Q. commented, "I think I've come to accept death, and believe these patients are truly at peace following death." W. commented, at the end of his first session, that he has always been intrigued by the issue of death and at one time considered becoming a mortician. Although affected by the loss of others, he attempts to embrace death.

If the art process can provide an opportunity for the emergence of thoughts and feelings that lead to resolution of personal issues related to death and dying, it can serve as a vital link in this current medical crisis. If staff members come to terms with their own mortality and reduce personal fears, they are better able to assist others with their needs. Just as images in gray and black give way to brightly colored flowers and other sources of life, the brief cases described here suggest that inital steps toward healing are occurring through art.

Healing Through Art

Darcy Lynn, Brooklyn, NY

Artists have always used their creative talents to deal with life's difficulties. I never found this to be more true than when I was stricken with lymphoma in April 1991. My circumstances were such that I was diagnosed only after life-saving surgery and chemotherapy.

I spent 3 weeks in the hospital, but after 3 weeks out, I was readmitted with an unidentified lung infection. A Hickman catheter was placed in my chest to facilitate the administration of IV antibiotics. During this time I drew and made sketches of my experiences, images I had seen, and images of myself and my doctors. I began to develop these ideas in paint in mid-June after my second stay in the hospital. I painted a few hours each day, depending on my energy level. On days when I was too ill or fatigued, I did not paint at all.

Painting was one thing I could do to be in control of my situation. No one could tell me how or what to paint. I was fortunate to have the encouragement of family, friends, and doctors who all understood the importance of painting.

I developed a body of work which covers the whole of my treatment until I was physically and emotionally recovered in early Spring 1992. Here are a few of the paintings.

Seals I (Figure 1) is from an image I saw while in intensive care, after being taken off the respirator and given oxygen. I was swimming under water with two large protective purple seals. We did not surface but remained below in our underwater heaven.

The painting is about the realization that life is a gift, and the image became such a positive one that I carried the seals motif into other works. I felt the seals were my symbol of survival and hope.

The Hospital Nightmare (Figure 2) was about a specialist who I had seen before my hospital stay. His later visit resulted in this nightmare. He is chasing me on a wheeled platform down a dark hallway of the hospital's basement. On one side of him are dying AIDS patients and on the other, body lockers. In my dream he was threatening to catch me and operate. The nightmare was a warning, a reality almost foretold, because on my second stay in the hospital he did threaten to operate. Luckily it did not happen.

In The Garden (Figure 3) is the image I had just before ending my first hospital stay. My hair was falling out fast. I knew I would soon be bald. I was anxious about what lay ahead, knowing that in the end, it was just me and the lymphoma.

In the painting I am sitting in a garden all misty and grey, full of broken statues. I am in a limbo of loneliness and solitude.

Self-Portrait with Hickman and Scar (Figure 4) was my first nude self-portrait. Using a timer, I photographed myself. The painting was about accepting what had happened to me and the fact that I was still alive and strong in myself.

The image is a female Christ showing all her wounds. The scars under my breast are from the biopsy and other

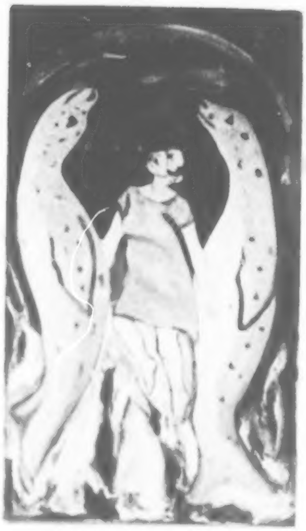


Figure 1. Seals I. Oil on canvas. June 1991. 28" X 16".

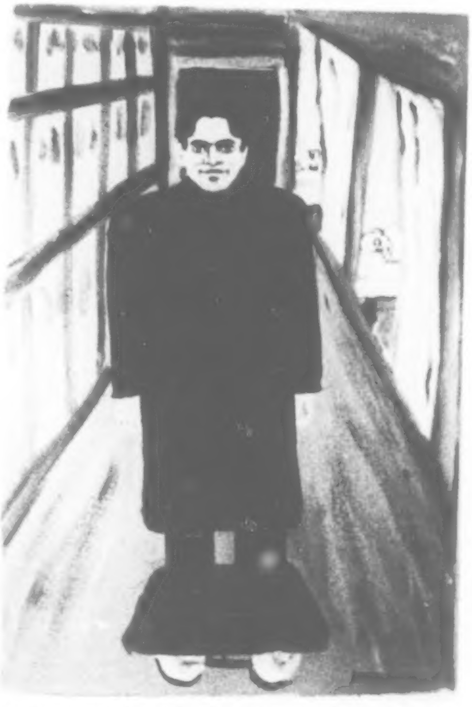


Figure 2. The Hospital Nightmare. Oil on canvas. July 1991. 16" X 24".

minor procedures that were performed, along with the Hickman, which remained in me for 8 months.

Rebirth (Figure 5) is about all the new and positive changes that happened to me as a result of the cancer. I was completely bald, head and body, and felt reborn. A feeling of newness spread through me, and I felt like a child/woman starting over. I had an appreciation of my body and soul and felt blessed for seeing how wonderful life is. The seals swim around like angels flying.

The Three Musketeers (Figure 6) is a comical group portrait of my doctors. The idea came to me after I told my surgeon my plan to paint them. He said, "We'll be The Three Musketeers!" It is also a painting showing the very human side of my doctors, something I always kept in mind.

From the left, in profile, is my surgeon with complacent look on his face, a protective, sweet man. In the middle is my physician, laughing. He supported me throughout with his warmth and wisdom. Behind him is my oncologist, grinning confidently, an intelligent, gentle man with humor similar to mine. As the saying goes, laughter is the best medicine.

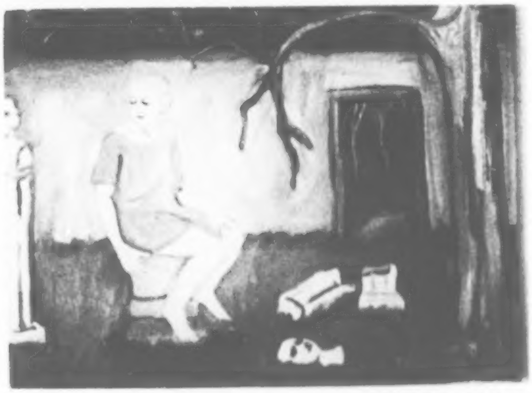


Figure 3. In the Garden. Oil on canvas. June 1991 24" X 18".

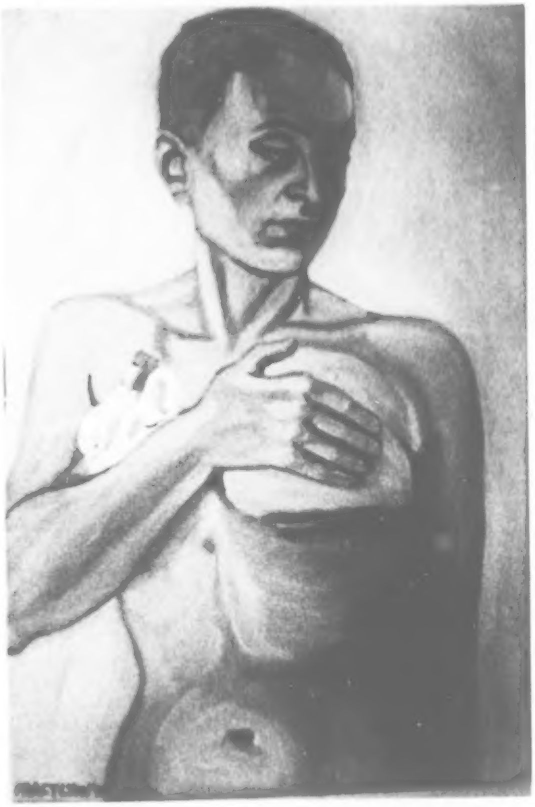


Figure 4. Self-portrait with Hickman and Scar. Oil on canvas. July 1991. 16" X 24".

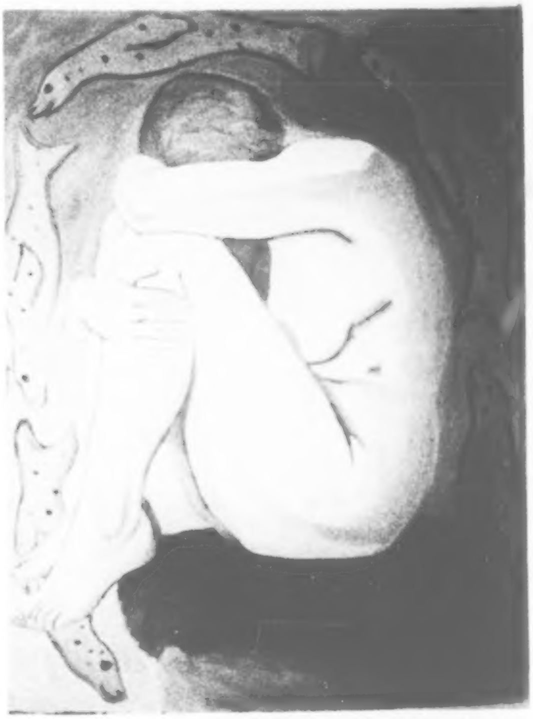


Figure 5. Rebirth. Oil on canvas. August 1991. 18" X 24".

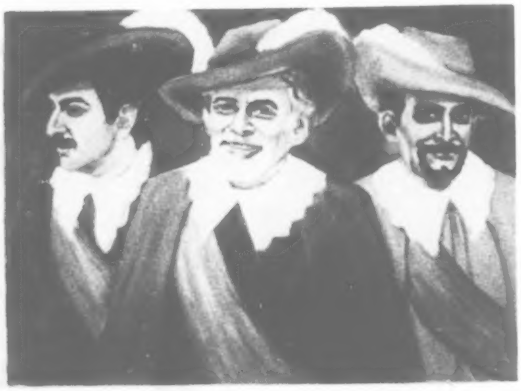


Figure 6. The Three Musketeers. Oil on canvas. September 1991. 24" X 18".

Editor's Note: Darcy Lynn, Brooklyn, NY is the artist and author of a recently published book entitled "Myself Resolved, an Artist's Experience with Lymphoma."

TB, the mask, and me

Susan Conlon, MA, New York, NY

The first time I put on a mask to go into a TB patient's room I felt quivery. The second time I put on a mask to go into a TB patient's room I felt quivery.

Putting on a mask to go into a TB patient's room is not as natural as putting on a hat or buttoning a coat. The reason you put on a mask is not to be pretty or to stay warm. It is to protect yourself from the person you are about to meet, and this is not natural at all.

I think about this as I slip one yellow rubber band over my head, then the other.

I am putting on this mask to protect myself from the person I want very soon, and very much, to trust me. But do I trust him?

I want him to feel safe with me. But do I feel safe with him?

I hold the mask over my face and position the rubber bands, one by one. I pinch the metal nosepiece snug to my face. Nice and tight. Good. No air can get in.

How can a patient feel safe with a person whose face he can't wholly see? Is it reasonable to expect a patient to "express himself" when I myself keep from him that part of my face which expresses so much?

Can a person communicate with only half a face? How will he know if I am smiling? If I am friendly? Will he know that I care?

I open the door.

"Hello," I say to a patient who has no idea who I am or why I'm there or what I really look like. But I am a person. And I did say hello. And I'm not wearing a lab coat.

"Hello," he says back.

When a patient tells of having "feelings of isolation" we may imagine what he is feeling because we ourselves may have had such feelings. And when he says he feels "different" from other people—"an outcast"—we may recall having had a feeling similar to that feeling.

And so we empathize.

But when we enter the room of a patient who is *in fact* isolated, who *has* been cast out, who *is* different from everyone else—so different we must wear a mask when we are with him lest we become "different" too—we are on unfamiliar ground. No longer are we treating *feelings* of isolation, we are treating *real* isolation, and *that* we know nothing about.

So we can't rely on that most useful of tools, empathy. Yes we do have sympathy but this "tool" must be used gingerly if it is to be used at all.

We ask ourselves: "What must it be like to be in this room for weeks, for months? . . . nobody . . . ."

We wonder: "Were I in this room, what would I want?"

Our sympathy may lead us to want to treat our patients as we ourselves would like to be treated. But were we to treat ourselves as we would like to be treated, we might very well put our own health at risk. We could ourselves become TB patients. This fact makes the difference between the "usual" art therapist/patient relationship and the TB patient/art therapist relationship.

And so we wear a mask. And follow very carefully the guidelines set for us by our hospital staffs. And no, putting on a mask isn't as natural as putting on a hat. Nor is it as natural as wearing one.

When you say hello in a hat you hear yourself clearly. A nice warm hello. "Hello." Say hello in a mask and you're not sure what you said; it sounds so garbled. ("How did I sound to the patient?") You wonder if the breath you just used saying hel-low escaped completely, some seems stuck in your mask. You are conscious that you are self-conscious. Aware too that you are slightly panicky about getting your next breath.

But you keep on; yes, aware that the rubber bands are inching up slightly as you continue talking. You feel your hair bunching up. If, at any time, you are unfortunate enough to catch a glimpse of yourself in the patient's mirror, you will wonder who you are. ("Is that what I look like?")

But the wearing of a mask has one beautiful and immediate benefit. It gives you, the art therapist, your first inkling of what it is like to be a patient in real isolation. To be a patient that is different. And what happens is that tool you lost—empathy—now unhides itself.

This means you can begin to relax. You can now be the art therapist you know yourself to be, even with a mask on. And the good news is that because you can now begin to trust you, your patient can too.

And so another good art therapist/patient relationship begins.

Editor's Note: Susan Conlon, MA, is an art therapist at Bellevue Hospital Center in New York, specializing in work with HIV/AIDS patients.

Reviews

Cancer Stories: Creativity and Self-Repair

Esther Dreifuss-Kattan, PhD, A.T.R., Hillsdale, NJ: The Analytic Press, 1990

269 pp., 42 black & white illustrations. $33.95 cloth. ISBN 0-88163-113-2.

Reviewed by **Susan E. Cheyne-King**, MS, A.T.R, LPC, Kent, VA

Few people have been untouched by cancer. In *Cancer Stories: Creativity and Self-Repair*, Esther Dreifuss-Kattan draws us into the inner worlds of cancer patients through their writings and artwork. Dreifuss-Kattan, a psychooncologist and art therapist, emphasizes the need to understand patients' metaphors for cancer. Frequently the metaphor depicts "punishment for a life poorly lived or for suppressed hostility, or else is the culmination of one's hopelessness" (p. 2). Psychooncology is described as an attempt "to deal therapeutically with the psychological realities behind these metaphors and with the defenses that the patient and doctor employ against these overpowering images" (*Ibid.*). It is also a psychological examination of responses to treatment and the threat of death.

The book is divided into two sections: "Psychological Analysis of the Cancer Literature" and "Psychoanalytic Perspectives." In Part I, a literature review provides examples of stages of cancer, the accompanying defenses, and how they are addressed in therapy. The cancer stories are examined "from a psychooncological perspective" (p. 117). I found the first half of this book painful, but gripping, and difficult to put down. It can be appreciated by anyone personally touched by cancer and is especially beneficial to nonphysicians for its description of basic physical and scientific aspects of the disease and treatment. Physicians, however, are given insight and advice into how to deal better with the *patient*, rather than the illness. At the point of initial diagnosis, "distress is determined largely by how patients are told about cancer, not what they are told" (p. 19). An empathic approach is emphasized. Anyone dealing with chronically medically ill and/or terminally ill patients including, but not limited to, those with cancer and HIV, might read the first few chapters to gain a better appreciation of what patients often must endure at the hands of nonempathic clinicians and technicians.

Dreifuss-Kattan points to the importance of openness and honesty with the patient as "the most powerful weapons with which to fight the cancer patient's fear . . . (p. 63). Denial is frequently discussed throughout this section in terms of its adaptive and maladaptive capabilities. The author sees depression (following initial denial), as "a necessary phase of the working-through process in an illness like cancer" (p. 64), and differentiates it from mourning. Other feelings and defenses are explored such as projection, aggression, envy, and guilt.

Dreifuss-Kattan carefully chooses literary examples that eloquently express the terminal phase of cancer. However, most of them "describe the very beginning of this phase, because later the patient typically withdraws into himself and no longer feels the need to communicate his feelings in writing" (p. 98). It is for this reason that she relies on Tolstoy's (1882) short story "The Death of Ivan Ilych" to illustrate emotional aspects of pain and the late terminal phase.

As I read the first half of this book, I found myself wishing it had been available to me when my mother was dying of cancer. I remember searching through *On Death and Dying* (Kubler-Ross, 1969) in an attempt to better understand some of her behaviors and affects. This portion of the book is similar to that classic text, but adds glimpses into the patient's world by way of creative writing and journaling.

The author's goal for Part II is to demonstrate that "there is indeed an intrinsic, if elusive, psychological connection between creativity and loss . . . understanding this connection enables us . . . to respond better to the unique needs of the terminally ill individual" (p. 119). She attempts to do this by first reviewing psychoanalytic theories on creativity and connecting them to separation issues, then interviewing cancer stricken artists. She conveys her hope "that what is at stake in these reports is sufficiently universal to be accessible both to the general reader and to professionals from other disciplines" (than art therapy) (p. 117). Despite this wish, I believe not only will the "general reader" be lost in much of the psychoanalytic interpretations, but the nonanalytic clinician will be mildly annoyed by what may be seen as extremes in interpretation.

Artwork does not appear until the second half of the book. In "Mourning, Loss, and Creativity," Dreifuss-Kattan states "the ability to create new symbols, even threatening ones, plays an important role in the creative response to a life-threatening illness" (p. 130). The artist with cancer "has the ability to give form to life and death and to creativity and mourning" (p. 133). Although only one chapter is specifically devoted to art (psycho) therapy with cancer patients, Dreifuss-Kattan does a nice job of explaining our profession to those unfamiliar with its unique benefits in treating cancer patients. For example, art therapists can recognize split-off feelings such as anger and jealousy in the artwork of the terminally ill. In addition, "art therapy attempts, as one of its principal tasks, to reveal the intact, healthy, creative parts of the self, disclose them to the patient and thus heal the rift" (p. 190). Art is also seen as immortality for the dying patient. Despite these descriptions, the majority of interpretations of art produced in art therapy sessions is focused on the manifestation of transference issues.

In one of the final chapters, Dreifuss-Kattan shows us her own artwork to illustrate countertransference to a dying patient, crystallizing some of the overwhelming feelings (both positive and negative) a therapist might experience when working with terminally ill individuals. She says, "only if the psychotherapist can experience his feelings of hate as well as love can he deal with his grief for the patient he has come to care for so deeply" (p. 226).

One shortcoming of the book is the absence of a discussion about cancer survivors. Each year, more and more individuals are able to survive cancer. Still, they have experienced much of what the less fortunate have experienced, from chemotherapy to types of loss—body image, assault, and fear. Another minor problem is several sloppily edited areas and misspelling the cover artist's name on the dust jacket.

This book is an important contribution to the literature on cancer and creative writing. If the author had devoted more text to art therapy it could have made a significant contribution in this area as well. I found Part I, plus the exploration of artwork in Part II, to be the most effective sections. Except for what some may consider excessive psychoanalysis, the book is basically "user friendly" for clinicians and lay public. It contains an extensive reference section and selected readings and an excellent index.

Cancer Stories is a moving and enlightening book. "To be sure, when we are moved by a cancer story, it is in part because the work embodies a profound, deep experience of the juncture of life with death with which we can identify" (p. 149).

References

Kubler-Ross, E. (1969)., *On death and dying*. New York: Macmillan.

Tolstoy, L. (1960). *Death of Ivan Ilych*. New York: New American Library. (Original work published 1882)

California Art Therapy Trends

Edited by **Evelyn Virshup, PhD, A.T.R.-BC**, Chicago: Magnolia Street Publishers, 1993.

431 pp., 155 black & white illustrations. $29.95 paper. ISBN 0-9613309-3-7.

Reviewed by **Mari M. Fleming, A.T.R.-BC, MFCC**, Berkeley, CA

Intended for a range of readers, from the "complete novice" to those interested in "how *these* California art therapists practice" (p. viii), Dr. Virshup presents a collection of articles by 30 California art therapists. She does not claim these authors are typical, nor is there a specific focus; Virshup emphasizes that California is known for innovation.

The book is loosely organized in five sections with emphasis on "hands on, clinically oriented" art therapy (p. viii). Rather than discuss the material under each section heading, where some articles appear to be arbitrarily assigned, I have chosen to focus on four major themes coalescing the book's major contributions.

The most valuable material in this book describes how art therapists responded not only to budgetary constraints, but to California's increasingly ethnically and culturally diverse population. Formulated following the Rodney King verdict and subsequent Los Angeles riots, articles by Shirley Riley and Anna Hiscox open the book and address the needs of adolescent youth, "the unfortunate fraction of teenagers that have been so damaged that their behaviors have called attention to their plight. These children who come to us are in the greatest need, the sorriest state and with the least resources" (Riley, p. 3). These authors struggle to find ways art theapy settings can address these children's massive needs and provide resources for them.

Riley, an experienced teacher and practitioner with adolescents and families, questions the use of traditional art therapy with a population whose lives allow "for little if any integration or resolution of adolescent tasks" (*Ibid.*). She identifies a basic stance of "not knowing" (p. 5) within "a crisis intervention mode of problem-solving . . . . Not creativity in the art product . . . but creativity in gaining coping skills" (p. 6).

Hiscox, too, emphasizes "the role of worker as learner" (Green, referenced in Hiscox, p. 20). In "Clinical Art Therapy with Adolescents of Color," Hiscox, chair of the Mosaic Committee of the American Art Therapy Association, discusses the intercultural diversity of California's current population. She asserts it is necessary for art therapists in this changing urban environment to "become familiar with cross-cultural and inner-cultural systems and ideology" in order to develop "cultural sensitivity, empathy and genuineness" (p. 17).

The severely traumatized population is also addressed in Thelma Kronreich's article, "Group Art Therapy Intervention with Bereaved Children in the Elementary School." Kornreich describes an innovative program developed to help children use art therapy groups to cope with issues concerning separation and loss. As with each of the authors, Kornreich advocates a use of art that is sensitive to the cultural, ethnic, and socioeconomic needs of youth in today's urban centers.

A second major emphasis in this book, both in case material and chapters on program development, is on families at risk following domestic violence, substance abuse, and sexual abuse. The aftermath of abuse, including posttraumatic stress disorder (PTSD) in children and adults, is also covered in the section titled "Art Therapy with Families and the Abused." They reflect our society's recent awareness and focus on these problems.

Emphasis on treatment within the family system is an important contribution. Thoughtful investigations by Shirley Riley in "Art Therapy with Families Who have Experienced Domestic Violence," and Gayle Callaghan and Mary Rawls in "From Entrapment to Empowerment—Family Therapy with Battered Women and Their Children," present case material that describes the importance of working within the family that has experienced domestic violence. This work spans the shelter experience through postshelter support. Anne Kellogg and Janet McEliece, in "Youth at Risk/Families in Recovery: Multi-Family Group Art Therapy," present a highly structured multifamily group art therapy approach to treatment.

Other authors present casework with children and adults who have experienced abuse, discussing theory and giving examples of casework with individuals. For example, Julia Whitney details the issues and methods used to combine art therapy with psychodrama and sand tray work with a sexually abused homosexual AIDS patient. Seven of the 29 articles center generally on abuse issues, providing an opportunity for the reader to see how theory and practice applies to their particular setting and where they can make a contribution in the cycle of abuse and violence.

California has been seen as a fertile ground for experimentation and integration of methods outside the mainstream of traditional therapies. A third major contribution of this book lies in articles by six art therapists who have integrated their experiences and training in art therapy with that of another discipline or practice. Particularly impressive and valuable in the contributions found in "Art Therapy and —," is the careful elucidation of the necessity for formal study and experience, both in art therapy and another discipline. Together with the articles on family therapy, these writers may offer the most useful information to experienced practitioners as they discuss their training and theoretical stance within the context of descriptions of their work. Selections include Linda Cohn's chapter concerning the integration of art psychotherapy and eye movement desensitization reprocessing (EMD/R), Suzanne Lovell on combining art therapy and authentic movement, Betsy Caprio on using art therapy with sand tray, and Lillian Rhinehart and Paula Engelhorn on art therapy with the art of the sun wheel.

The fourth major contribution of this book lies in articles that describe how these authors have met the challenge of rapidly decreasing health care funding. As experienced practitioners and teachers, they systematically address ways in which California art therapists have developed programs and secured funding, (Unger, Chapman, and Arrington); expanded their practices to work with new populations, (Coufal, Leonard, and Virshup and Virshup), found ways to incorporate art making into training (Howard), and disseminated information about art therapy to other professionals through in-service training (Long and Chapman) and a brochure produced jointly by the Southern California Art Therapy Association and the Los Angeles Cultural Affairs Department (Virshup, Riley, & Shepherd). Chapman's article, "Establishing a Pediatric Art and Play Therapy Program," is particularly inclusive and practical. It provides an important guide to the elements that need to be considered in program development. Each of these are thought-provoking, both for the new professional and experienced therapist.

In my opinion, this book is most useful for the novice art therapist who is in training or beginning to practice. The book appears to be similar to earlier collections of readings, edited by Elinor Ulman (1975, 1980), which survey a range of theory and practice in the field. Of the 30 authors included, 26 are Registered Art Therapists (A.T.R.), 12 or 13 are Licensed Marriage, Family, and Child Counselors (MFCC), and seven are otherwise certified or licensed.

Despite the many contributions of this collection, I do not recommend it without qualification. The book is not well-organized and lacks clear focus. While it represents trends, problems, and solutions in art therapy, it may also represent problems found in art therapy publications. Cathy Malchiodi, Editor of *Art Therapy: Journal of the American Art Therapy Association*, writes:

> First, much of our literature, particularly books, has not had to pass any particularly rigorous standards in order to be published . . . . Often no request is made of the author to submit the final manuscript to objective reviewers in the field for verification and criticism of content, a practice standard in many fields and with many publishers. . . . These types of practices result in publications that often have flaws in factual areas as well as theoretical and methodological areas. (1994, p. 83)

California Art Therapy Trends raises questions for me about the level of scholarship and publication standards in our field. Although these selections vary in quality, I will focus my comments on format and scholarship.

Today, an author may have little control over title page or table of contents. But, when we consider how hard the AATA has fought to insure the validity of the "A.T.R.," it is alarming to see the editor listed on cover and title page as "ATR," and this by a press that prints and distributes art therapy materials.

Certainly, today one rarely sees a book that does not contain typographical errors. However, it is troubling that at least one author's name is misspelled in the table of contents (Anne [sic] for Anna Hiscox). In addition, a figure is apparently printed upside down (p. 352, Figure 1), and incorrectly referred to (p. 353). However, I become alarmed at a completely omitted page! (Page omitted between p. 400 and 401. The publisher is now inserting this page and will mail it on request). This page is critical to an understanding of Howard's thoughtful integration of weekly art making in her graduate program and to understand her framework of "active participation with each art object" (p. 401a, insert).

Other significant problems lie with inconsistencies in format, primarily references that are not held to the APA format. The *Publication Manual of the American Psychological Association* (1984) states, "All citations in the manuscript must appear in the reference list, and all references must be cited in text" (p. 28). Many authors carefully reference every author mentioned in the text, and, as per the APA, do *not* list authors not mentioned. However, other authors fail to follow APA format. For example, one author (p. 119) describes the "Diagnostic Drawing Series created by Barry Cohen and Anne Mills," but *fails to cite* these authors in the references and gives inaccurate wording for the directives. In the same article, as in others, articles not mentioned in the text are listed in the references. On pages 101–102, three authors who write about Multiple Personality Disorder (MPD) in children are cited. While text are provided for projective drawing texts, books on art therapy with children, art with abused chidren, and art therapy with MPD, no art therapist is cited in either literature review, method, or discussion of artwork. No art therapist who has published on evaluation and treatment of abused or MPD children using art is cited (Cohen & Cox, 1990; Jacobson & Mills, 1992).

At a minimum, professional practice and scholarship require that in presenting theory and practice, those who have done "research pertinent to the specific issue" (APA, 1984, p. 25) be cited. Furthermore, it seems to me essential that art therapists cite primary sources and current *art therapy* literature pertinent to the specific topic. This is especially imperative in a field only now developing a significant body of literature, literature rarely referenced by those outside art therapy (Fleming, 1985, pp. 94–95). If we can no longer count on rigorous editing from the publisher, each of us must take responsibility for careful scholarship, particularly in training institutions, by adhering to publication standards, and as individual authors and editors of collections.

As it is, this book does a disservice to the many valuable contributions of the included authors. Art therapists may indeed be innovative, but scholarship requires professonal editing to ensure that art therapy is presented professionally.

References

American Psychological Association (1984). *Publication manual of the American Psychological Association* (3rd ed.). Washington, DC: Author.

Cohen, B.M., & Cox, C.T. (Speakers). (1990). *Comparison of art by severely abused children with adult MPD art.* (Cassette Recording No. IXa). Alexandria, VA: Audio Transcripts.

Fleming, M. (1985). Self-growth in families, kinetic drawings (K-F-D): Research and application [Review]. *Art Therapy: Journal of the American Art Therapy Association, 2* (2), 94–95.

Jacobson, M., & Mills, A. (1992). A survey of art therapy in the identification and treatment of MPD: A time line on art therapy with MPD. Fourth Annual Eastern Regional Conference on Abuse and Multiple Personality. Alexandria, VA.

Malchiodi, C. (1994). Editorial: Sorting out certification. *Art Therapy: Journal of the American Art Therapy Association, 11* (2), 82–83.

Ulman, E., & Dachinger, P. (Eds.) (1975). *Art therapy in theory and practice.* New York: Schocken Books.

Ulman, E., & Levy, C. (Eds.) (1980). *Art therapy: Viewpoints.* New York: Schocken Books.

The Creative Journal for Children: A Guide for Parents, Teachers, and Counselors

by **Lucia Capacchione**, Boston: Shambala Pub., Inc., 1989

120 pp., 29 black & white illustrations. $17.00 paper. ISBN 0-887773-497-6.

Recovery of Your Inner Child: The Highly Acclaimed Method for Liberating Your Inner Self

by **Lucia Capacchione**, New York: Simon & Schuster, 1991.

288 pp., 102 black & white illustrations. $12.95 paper. ISBN 0-671-70135-5

Lighten Up Your Body—Lighten Up Your Life: Beyond Diet and Exercise—the Inner Path to Lasting Change

by **Lucia Capacchione** with **Elizabeth Johnson** & **James Strohecker**, North Hollywood, CA: Newcastle Publishing Co., Inc., 1990.

177 pp., 51 black & white illustrations. $12.95 paper. ISBN 0-87877-150-6

The Picture of Health: Healing Your Life with Art

by **Lucia Capacchione**, Carson, CA: Hay House, Inc., 1990.

165 pp., 83 black & white illustrations. $12.00 paper. ISBN 0-937611-68-9

Reviewed by **Marcia L. Rosal, PhD, A.T.R.-BC,** Louisville, KY

During my first year as an art therapy graduate student, I was introduced to keeping a visual journal. Since that time, I have filled numerous sketch books and bound journals with scribbles, doodles, and images derived from my daily life experiences. Although I cannot conclusively say that journaling has saved my life or changed the course of my existence, the process has enriched my world and expanded awareness of my conflicts and joys. Dr. Capacchione agrees that creating a visual journal can add depth and meaning to human consciousness.

Beginning with *The Creative Journal: The Art of Finding Yourself*, Capacchione (1979) has been a powerful champion of the therapeutic potential of keeping one's own drawing journal. Capacchione believes in the ability of creative journaling to tap one's inner resources and to help people gain inner knowledge and understanding. The four volumes to be reviewed represent only a few of Capacchione's prolific set of books on the self-help journaling methods she espouses.

In this review, these four books will be outlined and described. Two of the four books reviewed here are focused on keeping the "child" (both the young child and the inner child) alive and well. The other two books are creative journaling methods to keep healthy and fit. I will present a general overview of the books before offering comments on each individual book.

General Overview

Capacchione acquired a wide following among the "12 Step" program advocates and the self-help crowd as a result of the journaling method. Her books have mass appeal because of an easy to read writing style and the simple-to-follow methods outlined in each volume. In each book she discusses her personal journey and how journaling has facilitated her growth and development on her path to physical well-being. This intimate touch engages readers and offers them permission to tell their stories through working in their journals.

Capacchione clearly defines what journaling is and delineates the rationate for the methods prescribed. Although the basis for engaging in the journaling process has somewhat different purposes for each population, the main reason for working within the creative journal format is to get to know and understand one's self better.

The parameters for journaling are clearly stated. One vital boundary, even for use with children, is underscored by Capacchione: The journal must be private and confidential: no one must have access to another person's journal without permission. The private and secret nature of the journal is at the heart of its therapeutic value. If this is violated, the method is not useful to many who use it.

Finally, Capacchione discusses the limitations of the diary and urges users of the journaling method to find outside support when needed. Creating a visual record of one's life is not a panacea and the use of the method in addition to other interventions is encouraged. Nor does Capacchione dictate that her journal exercises are to be followed by rote. Instead, she urges readers to use the books as points of reference or as resources and to do the activities which best suit their needs or to develop new, more individually focused exercises.

What Is in Each Book?

Although all four books are about the art of journaling, each book offers a different perspective on the visual journal and the purposes for engaging the process.

The Creative Journal for Children. This book is a guide for adults who work with children. Whether one is a parent, teacher, counselor, or therapist, the book offers assistance to the helping adult for encouraging children to begin and maintain a creative journal. Capacchione outlines 19 goals for the journal method with children. In addition, rationale is given for use in varied settings and under a variety of circumstances.

The journal exercises are divided into six themes ranging from "About Me" to "Dreams and Wishes." Under each theme are 12 journal activities which are designed to assist the child in the self-discovery process. To aid adults in discussing the journal activity with the child, the "how" and "why" and "when" to use the project are outlined. Examples from children's journals illustrate the various exercises and serve to inspire the child.

Recovery of Your Inner Child. Of the four books reviewed here, this book is the most intricate and deviates the most from a general instruction book on the journaling process. The first goal of this book is to help adults from a wide variety of backgrounds to identify and empower the inner child. Therefore, Capacchione discusses the concept of the inner child and her rationale for helping others recover from dysfunctional childhoods. Naturally, her method of healing the child within is through the creative journal process. In this book she recommends that the exercises which accompany each chapter be closely followed. The book begins with learning about the inner child and leads to discovering the spiritual child. Thus, the work somewhat emulates the recovery process of 12 step programs.

Each chapter opens with a narrative about the one particular aspect of inner child work discussed. The author pulls concepts from Jung and archetypal psychology as well as recovery programs to support her ideas and the creative exercises outlined. She asks participants to do a variety of exercises using the nondominant hand. Capacchione states that the inner child is accessed more quickly through the nondominant hand as our dominant hand is closely aligned with our everyday existence. She explains that the written dialogue which occurs between both hands fosters awareness of the conflict between a critical outer world and the needs of our inner consciousness. In sum, the book illuminates the power of experiential creative methods in the healing and recovery process.

Lighten Up Your Body—Lighten Up Your Life. In this book, co-written with Johnson and Strohecker, Capacchione addresses the issue of body image and how it affects our sense of self-esteem. She terms one's sense of ease with the body "feeling at home in your body" (p. 2). The authors claim that well-being with one's body has nothing to do with weight or cultural norms or ideas. The "feeling at home" is experienced from the "inside looking out" (p. 1). After exploring the main concept of the book (to feel better about our bodies), the authors offer creative journaling experiences which correspond with six themes.

The first theme is geared toward getting to know one's body. Secondly, exploring the meaning of food in one's life is advised. Through the exercises, the relationship between feelings and eating is uncovered. Other themes support one's quest for finding alternate avenues of nurturances such as nurturing one's self and cultivating relationships which "feed the soul" (p. 107). The final themes urge readers to find their appropriate body size and type and to discover their unique style and body image. The book ends with a bibliography which serves as a resource for further reading about body image concerns. The authors urge readers to use the exercises in this book as a companion to their health care and exercise programs as prescribed by medical personnel.

The Picture of Health. Capacchione has a broad definition of health. She defines health as "wholeness" (p. 1). Working from this definition, she espouses art as an avenue many of us can use to strive toward wholeness and that she believes our inner artist is a healing entity. The theme of this book as with the others is that working from inside can assist in health and well-being.

Capacchione is clear about her goals for using the workbook. Five goals are stated including finding the mental roots of stress and disease and using the healing power of visual imagery. She discusses the connection between the mind and body and cites the work of psychoneuroimmunologists and oncologists to anchor the concepts.

As this book is for the nonartist public, Capacchione first offers a basic understanding of how to use drawing. She asks us "to play on paper" and the process of doodling and experimenting with drawing materials is artfully explained. As in other Capacchione books, exercises using both the dominant and nondominant hand are presented. Illustrations of scribble journal entries accent the idea that a nonartist can employ the creative journal techniques.

The exercises in the book center around becoming aware of the body and uncovering one's sense of health and well-being. In addition to black and white pictures from journal entries, the book has several full-color prints which add zest to this self-help journaling workbook.

Final Thoughts

Visual journals are not art therapy nor is the use of journaling a substitute for formal therapeutic intervention. Nonetheless the visual journal is therapeutic. These books offer to lay people and to individuals interested in self-help approaches one avenue of exploring their lives. And many people use Capacchione's books for just this purpose. In this sense, Capacchione has spread the good news about the use of art as a means of discovery, as a tool for problem-solving, and as an avenue for healing to a wide audience. I had the opportunity to attend a workshop lead by Capacchione and was heartened to see the positive response of mental health professionals from related disciplines to visual imagery and to the healing power of art. For the professional art therapist, however, little new or advanced material will be garnered from reading these books. Nevertheless, as art therapists we may wish to pass on one of these books to a colleague or friend who wishes to start a journal.

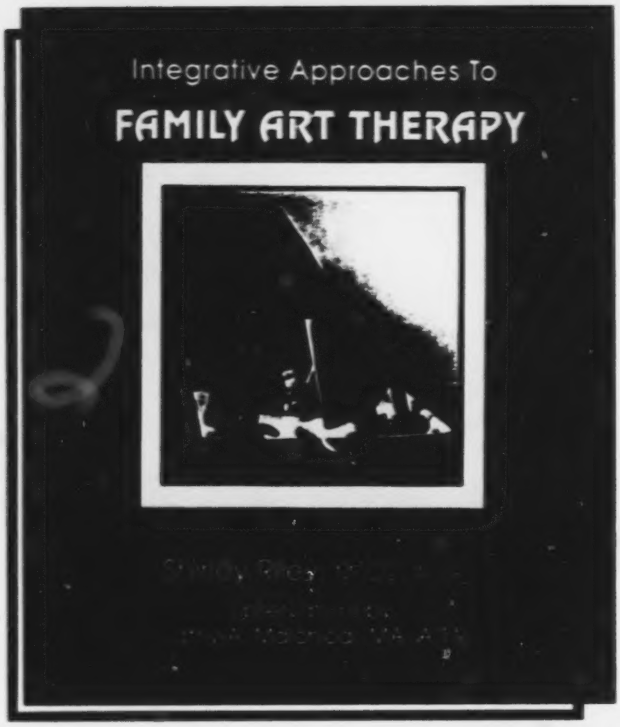
References

Capacchione, L. (1979). *The creative journal: The art of finding yourself.* Athens, OH: Ohio University/Swallow Press.

Echoes Of The Renaissance
SCHOOL OF FINE ARTS
CARROLL N. JONES JR.
A Complete Step By Step Video Guide
To Renaissance Painting:

Tape 1: Theory of Light and Shade
Cast Drawing • Perspective • Proportion • Still Life Drawing
Tape 2: Canvas Stretching • Drawing on Canvas
Fixing and Toning • Under Painting • Egg Emulsion Tempera
Tape 3: Color Theory and Mixing
Application of Color to Still Life
The complete "Echoes Of The Renaissance"
Video series of 3 tapes can be purchased for $179.95
plus $9.00 UPS postage and handling
(For Vermonters add 5% sales tax.)
Individual tapes may be purchased for $69.95
plus $3.00 per tape for UPS postage and handling
Please make checks payable to: Echoes Of The Renaissance
and send your order to:
Carroll N. Jones Jr. PO. Box 1041 Stowe VT., 05672, (802) 253 8080

MAGNOLIA STREET PUBLISHERS


Integrative Approaches To
FAMILY ART THERAPY

Integrative Approaches to

FAMILY ART THERAPY

By Shirley Riley, MFCC, A.T.R.
observations by Cathy A. Malchiodi, MA, A.T.R.

This important new book by noted family art therapist Shirley Riley is designed for both the beginning practitioner as well as the advanced family therapist. An important source of ideas, this text provides not only examples of integrative approaches to family art therapy, but also offers practical ways to utilize art therapy with individuals, families and couples. The volume emphasizes the integration of current thinking in family therapy and the application of art therapy in family treatment. Chapters cover a wide range of theoretical viewpoints, including structural, systemic, narrative, family of origin and social constructionism. Riley brings these theories to life through case examples as well as commentaries on contemporary socio-economic and cultural aspects of family art therapy in the '90s. Cogent introductions to each section by Cathy Malchiodi lend cohesion to the whole.

This is an invaluable resource in both art therapy and family therapy courses. Suggestions for utilizing the material in the classroom as well as in clinical settings are included, making this book a practical guide for students, educators and therapists.

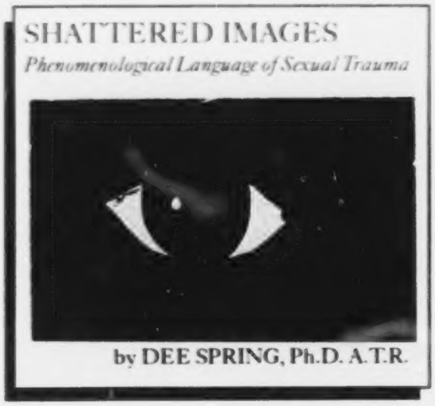
1994, paper $29.95

CALIFORNIA
ART THERAPY
TRENDS
Evelyn Virshup, PhD, ATR

A creative and timely collection of essays and excercises by more than 30 California art therapists. pa. **$29.95**

ART as therapy with children
by Edith Kramer

One of the nost widely read textbooks by a pioneer in the field. Now updated and back in print. pa. **$19.95**


SHATTERED IMAGES
Phenomenological Language of Sexual Trauma
by DEE SPRING, Ph.D. A.T.R.

A unique treatment model for sexual trauma victims incorporating art therapy, testing, imagery and hypnosis. pa. **$36.00**

---

send or fax wholesale/college and retail bookstore orders to:

MAGNOLIA STREET PUBLISHERS
1250 W. Victoria St. ▪ Chicago, IL 60660 ▪ 312-561-2121 ▪ fax 312-477-6096

individual orders to:

STERN'S BOOKS
2004 W. Roscoe St.
Chicago, IL 60618
312-883-5100 or Fax 312-477-6096

All major credit cards and checks accepted. Add $4.00 UPS for first book, .50 @ additional book, USA.

CHARLES C THOMAS • PUBLISHER

☐ Rugel, Robert P.—**DEALING WITH THE PROBLEM OF LOW SELF-ESTEEM: Common Characteristics and Treatment in Individual, Marital/Family and Group Psychotherapy.** '95, 280 pp. (7 × 10), 2 tables. $45.95. *$29.95, paper.*

☐ Makin, Susan R.—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 112 pp. (7 × 10), $29.95. *$15.95, paper.*

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts, Theories and Practices. (2nd Ed.).** '94, 244 pp. (7 × 10), 1 table. cloth—$58.95, paper—$33.95.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $37.95. *$22.95, paper.*

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 × 10), 24 il., $46.95. *$29.95, paper.*

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¾), 34 il., $48.95. *$29.95, paper.*

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $56.95. *$34.95, paper.*

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $92.95. *$49.95, paper.*

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $35.95. *$19.95, paper.*

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $53.95.

☐ Krauss, David A. & Jerry L. Fryrear—**PHOTOTHERAPY IN MENTAL HEALTH.** '83, 260 pp. (6¾ × 9¾), 61 il. (5 in color), 1 table, $46.95. *$29.95, paper.*

☐ Furrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $25.95, spiral (paper).

☐ Benenzon, Rolando O.—**MUSIC THERAPY MANUAL.** '81, 178 pp., 20 il., $29.95. *$14.95, paper.*

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $27.95. *$15.95, paper.*

☐ Singer, Florence—**STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children.** '80, 144 pp., 33 il., $25.95. *$13.95, paper.*

☐ Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 × 10), 12 il. $35.95.

☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 17 il., $47.95. *$29.95, paper.*

☐ Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 186 pp. (7 × 10), 33 il. $41.95. *$26.95, paper.*

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $51.95. *$30.95, paper.*

☐ France, Kenneth—**BASIC PSYCHOLOGICAL SKILLS FOR FRONT-LINE STAFF OF RESIDENTIAL YOUTH FACILITIES.** '93, 212 pp. (7 × 10), 3 il., $45.95. *$29.95, paper.*

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $64.95. *$32.95, paper.*

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¾), 28 il., $38.95. *$24.95, paper.*

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¾), 21 il., $38.95. *$24.95, paper.*

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $48.95. *$29.95, paper.*

☐ Dennison, Susan T.—**ACTIVITIES FOR ADOLESCENTS IN THERAPY: A Handbook of Facilitating Guidelines and Planning Ideas for Group Therapy with Troubled Adolescents.** '88, 236 pp. (7 × 10), 36 il., 26 tables, $46.95. *$29.95, paper.*

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $46.95. *$29.95, paper.*

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $24.95.

☐ Benenzon, Rolando O.—**MUSIC THERAPY IN CHILD PSYCHOSIS.** '82, 112 pp., 34 il., $25.95. *$14.95, paper.*

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $53.95. *$31.95, paper.*

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 260 pp., 54 il., $32.95. *$18.95, paper.*

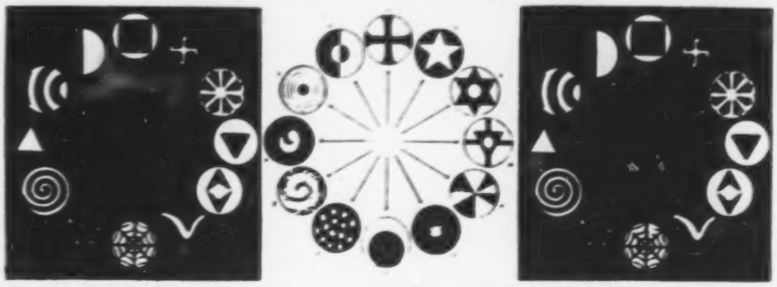
☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $49.95. *$29.95, paper.*

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

MANDALA: THE SACRED CIRCLE

A CONFERENCE HONORING THE LIFE AND WORK OF JOAN KELLOGG



sponsored by the Association of Teachers of Mandala Assessment, Inc.

June 4-6, 1995
Johns Hopkins University
Baltimore, Maryland

This conference is a celebration of 25 years of the work of Joan Kellogg, M.A., A.T.R., one of our most remarkable and innovative thinkers in the area that explores the interface between psychology and the arts. Joan Kellogg is best known for her work in the assessment of drawn Mandalas. Her theoretical model, the Great Round of the Mandala, has enabled hundreds of clinicians and researchers to understand how archetypical images and symbols and colors reflect dynamics of self and psychological development.

For information, call (813)581-0786.

SANDPLAY THERAPISTS OF AMERICA

THIRD NATIONAL CONFERENCE

SANDPLAY THE SILENT VOICE OF THE SOUL

MAY 28-31,1995
SKAMANIA LODGE • STEVENSON, WASHINGTON

Sandplay is a powerful in-depth nonverbal therapy for adults and children. It is rapidly gaining national and international recognition because of its cross-cultural capacities.

- ☐ **Case Presentations**
- ☐ **Workshops and Lectures**
- ☐ **CEU & Sandplay Credits**
- ☐ **Trade Show (books & miniatures)**

Skamania Lodge is a nestled amidst the waterfalls, mountain peaks, forests, and canyons of the Columbia River Gorge. Amenities include an indoor swimming pool, hot tubs, saunas, fitness center, hiking trails, game room, golf courses, horseback riding, and bicycling. Just 45 minutes from Portland and 3$^1/_2$ hours from Seattle, it offers easy access to the Columbia River Gorge's American Indian petroglyphs, windsurfing, the region's wildlife, and nearby Mt. St. Helens.

SANDPLAY THERAPISTS OF AMERICA/STA 95
757 RAMONA STREET, PALO ALTO, CA 94301 • (206) 747-7615

IRIS

"ON THE TRAIL OF BEAUTY"

ANNOUNCING

THE SIXTH JUNGIAN ART THERAPY CONFERENCE

AT THE UNIVERSITY OF NEW MEXICO, ALBUQUERQUE, NEW MEXICO,

FROM JULY 28TH THROUGH JULY 30TH, 1995

MEINRAD CRAIGHEAD
New Mexican Visionary Artist and Writer, will open the conference with a slide presentation of her paintings, some of which appear in her books The Mother's Songs and Litany of the Great River. She will speak of her own spiritual quest "on the trail of Beauty."

DONALD SANDNER
Jungian Analyst and author of Navajo Symbols of Healing, will show slides of the sacred sand paintings used in Navajo Healing Ceremonies. He will give the Keynote Address on BEAUTY WAY CHANT, devoted to Snake Woman's underground journey to the Snake People to obtain their healing power.

VIRGINIA BEANE RUTTER
Jungian Analyst, Art Historian and author of Woman Changing Woman, will give a Closing Presentation WALKING INTO BEAUTY, showing slides of an Apache girl's Sunrise Initiation Ceremony. She will lead a culminating ritual of the conference theme: **The Role of Beauty in Traditional Healing and in our Therapeutic Practice.**

****

TO REGISTER FOR THE CONFERENCE (please use block letters or type) SEND:

Name:________________________________ Phone: (   )   -
Address:____
____

Early Reg. Fee (by June 30th): **$150**, **Students**: **$100**, (After June 30th, $25 extra each).
Enclose check payable to: Jungian Art Therapy Network. Conference details will follow.
MAIL TO: IRIS CONFERENCE, C/O Linney Wix, ATR, Art Therapy Program, Department of Art Education, University of New Mexico, Albuquerque, N.M 87131

Telephone enquiries (NOT FOR REGISTRATION):
East Coast: Ethne Gray, ATR, Conference Chairperson, (617) 332-0383
West Coast: Luanne Lee, ATR, Program Coordinator, (707) 935-9320

The American Art Therapy Association

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), is a non-profit organization founded in 1969, is a national association which represents a membership of approximately 4,750 professionals and students. It is governed and directed by a nine-member Board elected by the membership. AATA has established standards for art therapy education, registration and practice. AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films, and awards.

PURPOSE

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education, and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

CHAPTERS

Affiliated chapters of the AATA have been established throughout the US. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network for people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a chapter member. Information on locating the chapter nearest you is available from the AATA National Office.

MEMBER BENEFITS

All members receive:

Publications

- Art Therapy: Journal of the American Art Therapy Association.
- The Quarterly *AATA Newsletter*
- Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and the membership directory.
- AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability through Maginnis & Associates.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy.

- Governmental affairs activities including Congressional review and monitoring
- State legislative and regulatory activities
- Promotion of recognition and reimbursement of art therapists by third-party payors.
- National liaison with related professional organizations for recognition and promotion of art therapy.

Professional Standards

- Development of model job description and recommendations for licensing standards.
- Development and implementation of national guidelines for approval of Master's Degree and training programs in art therapy
- Development and implementation of nationally recognized Standards of Practice and Code of Ethics of Professional Art Therapists

GENERAL INFORMATION

Membership in the American Art Therapy Association, Inc. (AATA) and Registration (A.T.R.) with the Art Therapy Credentials Board, Inc. (ATCB) **each have separate procedures** for administration and application. Annual A.T.R. Maintenance Fee is billed separately by the ATCB.

For **NEW** Associate, Student, and Contributing members only: please follow the chart below when submitting membership applications:

The Membership year is the calendar year: January 1st, through December 31st.

Applications received between:

Jan. 1st - May 31st: Full dues payment; membership expires Dec. 31st of same year.

June 1st - Sept. 30th: Half year dues plus $5.00 payment; membership expires Dec. 31st of same year.

Oct. 1st - Dec. 31st: Full dues payment; membership for the remainder of the current year and the next full year.

CATEGORIES AND FEES

Professional - By application review process only; approved members may vote, hold office and serve on committees.

- Credentialed Professional Member - Individuals who have been **dually approved** for Professional Membership by AATA and Registration (A.T.R.) by the ATCB; AATA dues are $85/year. ***A.T.R. Maintenance fee is billed separately by the A.T.C.B.***
- Professional Member - Individuals who have completed educational training in art therapy; dues are $85/year.

Associate - Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. Such members may not vote, hold office, or serve on committees. Dues are $85/year.

Student - Individuals who are currently taking full time coursework in art therapy or a related field. Requires a current statement from the institution of learning indicating full time status and coursework content (6 graduate or 12 undergraduate credits.) Student members may not vote or hold office, but may serve on the Student Sub-Committee of Membership. Dues are $35/year.

Contributing - Individual organizations, institutions, or foundations which contribute annually to AATA. Such members may not vote, hold office, or serve on committees. Dues are $120/year.

Retired - Individuals who are at least 65 years of age and who are no longer practicing. Retired members receive publications and reduced fees, but may not vote or hold office. Dues are $35/year. Application provided upon request.

The American Art Therapy Association

Membership Application

Name

Home Address

City State Zip Code

( )
Phone

Business Name

Address

City State Zip Code

( )
Phone

Job Title

Licenses Held & State

Preferred Mailing List Home ☐ Business ☐

Please indicate under which category you are applying:

☐ $85.00 Associate Membership

☐ $35.00 Student Membership (see student membership criterion for necessary documents to accompany this application.)

☐ $120.00 Contributing Membership

Provided upon request:

☐ Professional Application - ***Professional Membership is available by review process only.***

- Credentialed Professional Member - Individuals who have been **dually approved** for Professional Membership by AATA and Registration (A.T.R.) by the ATCB; AATA dues are $85/year. ***A.T.R. Maintenance fee is billed separately by the A.T.C.B.***
- Professional Member - Individuals who have completed educational training in art therapy; dues are $85/year.

☐ A.T.R Application

Please make all checks payable in US dollars and mail to:

American Art Threapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060
(708) 949-6064 Fax: (708) 566-4580

Please complete this survey:

Education (please check highest degree earned):

1 ☐ Doctorate Degree__________
2 ☐ Master's Degree__________
3 ☐ Bachelors Degree__________
4 ☐ Associate Degree__________
5 ☐ Other____________________

(Please indicate exact degree earned, e.g., BA, BS, MA, Etc.)

Work Setting (please check only one):

1 ☐ Hospital
2 ☐ Clinic
3 ☐ Day treatment center
4 ☐ Rehabilitation
5 ☐ Sheltered workshop
6 ☐ Correctional Facility
7 ☐ Residential treatment
8 ☐ Out-patient mental health
9 ☐ School system
10 ☐ Elderly care facility
11 ☐ College/University
12 ☐ Clinical training prog.
13 ☐ Institute Training Prog.
14 ☐ Counseling center
15 ☐ Private practice
16 ☐ Other__________

Area(s) of Specialization (please check up to three):

1 ☐ Addictions
2 ☐ Adolescents, Hospitalized
3 ☐ Adolescents, Psychiatric
4 ☐ Adults, Hospitalized
5 ☐ Adults, Psychiatric
6 ☐ Art History
7 ☐ Art Therapy Education
8 ☐ Art Therapy in Schools
9 ☐ Children, Hospitalized
10 ☐ Children, Psychiatric
11 ☐ Domestic Violence
12 ☐ Eating Disorders
13 ☐ Families
14 ☐ Gerontology
15 ☐ Hospice/Terminally Ill
16 ☐ Learning Disability
17 ☐ Mental Retardation
18 ☐ Neurological Disease
19 ☐ Prisoners
20 ☐ Post Traumatic Stress
21 ☐ Psychotherapy
22 ☐ Rehabilitation
23 ☐ Research
24 ☐ Sexual Abuse
25 ☐ Visual Art
26 ☐ Other__________

Voluntary Information

Age:

1 ☐ 20-24
2 ☐ 25-29
3 ☐ 30-34
4 ☐ 35-39
5 ☐ 40-44
6 ☐ 45-49
7 ☐ 50-54
8 ☐ 55-59
9 ☐ 60+

Salary Range:

1 ☐ Under $10,000
2 ☐ $10-15,000
3 ☐ $15-20,000
4 ☐ $20-25,000
5 ☐ $25-30,000
6 ☐ $30-35,000
7 ☐ $35-40,000
8 ☐ $40-45,000
9 ☐ $45-50,000
10 ☐ $50,000+

Gender:

1 ☐ Female
2 ☐ Male

Hours worked per week:

1 ☐ 0-10
2 ☐ 10-20
3 ☐ 20-30
4 ☐ 30-40
5 ☐ 40+

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Art Therapy, the official journal of the American Art Therapy Association, is a quarterly journal for professionals and students who are interested in the use of art in the fields of mental health, psychotherapy and human development. The purpose of the *Journal* is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. ***Art Therapy*** publishes refereed articles, including illustrations, by art therapists, psychologists, family therapists, and others that reflect the latest advances in theory, research, professional issues, and practice. An emphasis is placed on the use of visual arts in therapy, but articles in related disciplines of interest are considered for publication. *Art Therapy* is an important source for news and summaries of national conferences, book reviews, media, and commentaries.

Recent articles published in ***Art Therapy:***

- ✱An Application of Art Therapy to the Trauma of Rape
- ✱The Art of Art Therapy May Be Toxic
- ✱The Children's Diagnostic Drawing Series
- ✱Art Therapy with Native American Clients: Ethical and Professional Issues
- ✱Diagnosis or Dilemma: Drawings of Sexually Abused Children

---

Art Therapy is available to AATA Members as part of their membership. Non-Members may subscribe at the following annual rates:

Individuals: $40.00 (U.S.) - $60.00 (Foreign)
Institutions: $57.00 (U.S.) - $80.00 (Foreign)

Single Copies are available at:

Members: $10.00 - Non-Members:$18.00

Make checks or money orders payable to AATA and return with this subscription order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois
60060

Please enter my subscription for 1995. Enclosed is a check in the appropriate amount:

Name: ____________________

Address: ____________________

City: ____________ State: ____________ Zip: ____________

AATA REGIONAL SYMPOSIA

DISSOCIATIVE DISORDERS

Presenters: Deborah Good and James Consoli (third presenter to be named at a later date)

Topics include: Dissociation as a part of abuse, assessment and diagnosis, sexual and ritualized abuse issues and concerns, various forms of abuse and their relationships to each other, ethical concerns, legal testimony, and vicarious traumatization/Secondary PTSD.

ADDICTIONS

Presenters: Lynn Jones, Holly Feen and Katie Webb

Participants will receive the latest information on the use of art therapy in the treatment of addiction and dual diagnosis. Art therapists will be able to identify specific non-verbal approaches for working through resistance and denial in the treatment of substance abusers. Counselors will be able to identify specific ways in which to coordinate treatment efforts with art therapists in their facilities.

FAMILY ART THERAPY

Presenters: Mari Fleming, Shirley Riley and James Consoli

The objectives of this symposium is to provide the participants with an overview of how art therapy provides families an enriched vocabulary to assist them in solving family problems. The art therapy gives a "voice" to all age levels and offers a non-threatening vehicle to aid in communication and restructuring the family system. The intensive workshop will offer ways to combine family theories with art expressions and examine assessment methods, short and long term treatment. Participants will engage in experiential opportunities to experience how art therapy is applicable in their own professional setting. Every effort will be made to offer the most current trends in family therapy and art therapy application.

ART THERAPY IN THE SCHOOLS

Presenters: Janet Bush, Sarah Hite and Rebecca Taulbee

The objectives of this symposium will provide the participants with understanding the administrative procedures for implementing an art therapy program in a large, urban school system, become familiar with the uses of art therapy for students in a public school system, become aware of techniques and strategies used in the training and preparation of school personnel; utilize the information they have gained to initiate discussion on approaches and practices of art therapy in public schools; and to be prepared to transfer techniques and strategies for implementing art therapy services to other public school systems.

ART THERAPY WITH THE OLDER ADULT

Presenters: Larry Barnfield, Bernadette Callanan and Judith Wald

The symposium will cover general views on aging, relevant facts and new research, the role of art therapy with elders and settings in which art therapists practice and the special advantages of art therapy with the aging. It will cover the goals of treatment, treatment issues, and consideration of the clinical treatment of three groups of vulnerable aging and case studies.

GOING FOR THE GOLD: GRANTS AND RESEARCH IN ART THERAPY

Presenters: Frances Anderson, Vija Lusebrink and Doris Arrington

Successful grant writing in art therapy is, and will continue to be an important survival strategy in the 90's. Many model art therapy projects funded by grants will be discussed. The entire grant writing and granting process from identification of funding sources (public and private), to proposal development, submission and implementation will be covered. Technical assistance will be available to participants who already have a grant idea or proposal "in process".

ART THERAPY WITH CHILDREN AT RISK

Presenters: Cathy Malchiodi, Julie Epperson and Deborah Good

This symposium proposes to fill the need for advanced art therapy training focusing on theory, interventions, methodology and research with children at risk. "Children at risk" are defined as those who are directly affected by family violence, physical and sexual abuse, neglect, homelessness, and various disabilities such as attention deficit hyperactivity disorder, learning problems, and physical limitation which put them at further risk for abuse and neglect. Emphasis will be on how the clinician can develop both short and long term art therapy interventions, effectively assist the child in crisis and appropriately utilize art expression in assessment of current level of psychological functioning.

ART AND MEDICINE

Presenters: Cathy Malchiodi and Anita Mester (third presenter to be names at later date)

The symposium will focus on the unique dimensions of art therapy within a medical context with people who have experienced life-threatening chronic illness, particularly cancer and HIV. The special role that art expression plays in the assessment and evaluation of both the somatic and psychological status of the individual will be discussed, supported by the current research of both art therapists and clinicians in related fields. Special emphasis will be on paradigms for the use of art therapy within the context of psychoneuroimmunology and mind/body healing. Theories of imagery from current research by Achterburg, Simonton, Bach and others will be covered to assist the participants in integrating the use of art expression with physically ill clients will be presented so that participants acquire an understanding of the practical aspects of adapting art therapy to specific disease conditions. Lastly, emotional and transpersonal issues of grief and loss which are intrinsic to the experience of physical life threatening illness will be addressed.

ADDRESSING DOMESTIC VIOLENCE THROUGH FAMILY ART THERAPY

Presenters: Cathy Malchiodi and Shirley Riley (third presenter to be named at a later date)

This symposium will focus on art intervention and treatment with families who have experienced domestic violence, with the notion that such intervention can be helpful in addressing a larger scope, including social violence. The first half of the symposium will address the use of art expression as intervention for the immediate effects of family violence, with an emphasis on what the art therapist can accomplish in a time-limited setting; focus will be on the unique role of the art therapist in crisis care in shelters, safe houses, and other short term, crisis-oriented facilities. The second half of the symposium will be devoted to how art therapy may be utilized in treatment, focusing on issues of family reconstruction, role adjustments, and post-traumatic separation and loss. The use of art tasks to assist the family in re-thinking gender roles and assigned relationships and to experiment with new modes of interpersonal and intrasocietal communication will be presented.

These Symposia are offered at no charge to the participating chapter

• • • • • • • • • • • • • • • • •

For further information regarding the content or scheduling of these symposia, please contact the AATA National Office at
1202 Allanson Road ❖ Mundelein, Illinois ❖ 60060
(708) 949-6064
Monday through Friday 9:00 a.m. to 5:00 p.m. central time

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to each copy of your manuscript:

Name: ____________________

Degrees/Credentials: ____________________

Address: ____________________

Phone numbers: Home __________ **Work** __________

Type of Submission (check one):

☐ Article

☐ Film/Video Review

☐ Viewpoints

☐ Book Review

☐ Brief Report

Title of Submission: ____________________

____

Checklist:

☐ Five (5) copies, typewritten on 81/2" x 11" paper.

☐ Black and white photos of original artwork plus four (4) photocopies of each.

☐ Paper and references adhere to *Publication Manual of the American Psychological Association* (Fourth Edition).

☐ Abstract of 75-125 words (for articles and brief reports only).

☐ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

☐ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

☐ This Attention Authors form.

Author's Signature ____________________ **Date** __________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060

____

____/____/____

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. Art *Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in Art Therapy, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Editor, Art *Therapy: Journal of the* American Art *Therapy Association,* c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 81/2" x 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication* Manual for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" x 7" and black and white glossy prints, preferably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. **It is the author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 12, NUMBER 2, 1995

2033

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064, FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Resources in Education (ERIC), INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern*.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to **AATA, Inc. Subscribers** should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue; July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Patricia St. John, EdD, A.T.R.-BC
College of New Rochelle, New Rochelle, NY

Book Review Editor
Barbara Sprayregan, PsyD, A.T.R.
Stoney Brook Counseling Center, Chelmsford, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Friends Hospital, Philadelphia, PA

Production Editor
Karen D. Savage

Editorial Board
Pat B. Allen, PhD, A.T.R., LPAT
School of the Art Institute, Chicago, IL
Doris B. Arrington, EdD, A.T.R.-BC
College of Notre Dame, Belmont, CA
Janet Bush, EdS, A.T.R.-BC
Dade County Public Schools, Miami, FL
Julia Byers, MA, A.T.R.
Concordia University, Montreal, Canada
Mariagnese Cattaneo, PhD, A.T.R., LMHC
Lesley College, Cambridge, MA
Susan Cheyne-King MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R., LPAT
George Washington University, Washington, DC
John Goff Jones, PhD, ABPP, A.T.R.-BC
Oklahoma City, OK
Julie Epperson, MA, A.T.R., LPCC
YWCA of Salt Lake City, Salt Lake City, UT
Deborah A. Good, MA, A.T.R., LPAT, LPCC
Family Therapy of Albuquerque, Albuquerque, NM
Anna Hiscox, MA, MFT, A.T.R.
McAuley Neuropsychiatric Institute, San Francisco, CA
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Frances F. Kaplan, DA, A.T.R.
Hofstra University, Hempstead, NY
Carol Lark, MA, A.T.R.
Art Therapy Center of St. Louis, MO
Vija B. Lusebrink, PhD, A.T.R.-BC
University of Louisville, Louisville, KY
Patricia Engle Murphy PhD, A.T.R.
Private Practice, Moscow, ID
Mary Ellen Peacock, MA, A.T.R.
St. Francis of Assisi School, Louisville, KY
Leslie P. Knowles, A.T.R., LMHC
Whitney Academy, East Freetown, MA
Shirley Riley, MA, A.T.R., MFCT
Loyola Marymount University, Los Angeles, CA
Irene Rosner David, MA, A.T.R.-BC
Bellevue Hospital Center, New York, NY
Nancy M. Sidun, PsyD, A.T.R.
The Chicago School of Professional Psychology, Chicago, IL
Susan Spaniol, EdD, A.T.R.
Leslie College, Cambridge, MA
Evelyn Virshup, PhD, A.T.R., MFCC
California State, Los Angeles, CA
Judith Wald, MS, A.T.R.
New York Hospital - Cornell Medical Hospital Center, White Planes, NY

AATA President
Bobbi Stoll, MFCC, A.T.R.-BC

AATA Executive Director
Edward J. Stygar, Jr.

VOLUME 12

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 2, 1995

Editorial

Milestones — Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC 90

Commentaries 92

A Tribute to Janie Rhyne 94

Janie Rhyne, PhD, A.T.R., HLM — Vija B. Lusebrink, PhD, A.T.R.-BC 95

Some Memories of Janie Rhyne — Robert Schoenholtz, A.T.R.-BC 97

A Rhyne Bibliography 98

Articles

Art Therapy Licensure Update — Deborah Good, MA, A.T.R., LPAT, LPCC and Kris Sly-Linton, MA, A.T.R.-BC, LPAT 100

Building Bridges Within the Culture of Pediatric Medicine: The Interface of Art Therapy and Child Life Programming — Diane C. Rode, MPS, A.T.R. 104

Clinical Application of the "Scribble Technique" with Adults in an Acute Inpatient Psychiatric Hospital — Michael J. Hanes, MAT, A.T.R.-BC, LPAT 111

The Diagnostic Drawing Series and the Tree Rating Scale: An Isomorphic Representation of Multiple Personality Disorder, Major Depression, and Schizophrenia Populations — Maureen Batza Morris, MA 118

Brief Reports

The Art of West Indian Clients: Art Therapy as a Nonverbal Modality — Anna Hiscox, MFT, A.T.R. 129

Viewpoints

One Thousand Penises: Working with Adolescent Groups — Elda Unger, MA, A.T.R. 132

Medical Art Therapy: A Window Into History — Irene Rosner David, MA, A.T.R.-BC 135

Grandmother's Clause — Carlene J. Van Sluizer, MA, A.T.R. 136

Reviews

Reverberations: Mothers and Daughters — Erika Cleveland, MA, A.T.R., LMHC 137

Art Therapy with Families in Crisis: Overcoming Resistance Through Nonverbal Expression — James J. Consoli, MA, A.T.R. 137

Video Review: Southern California Art Therapy Association: Art Therapy Today — Harriet Feinstein, MCAT, A.T.R. 139

Video Review: Suicide: A Teenage Dilemma — Nancy Gerber, MS, A.T.R. 141

About the Cover: "Life House," mixed media, 9" × 10½", 1993. Laura Seftel, MPS, A.T.R., LMHC, Northampton, MA, is an adjunct professor at the Graduate Art Therapy at Springfield College in Massachusetts. "This series of house/shrines can simultaneously signify self, family, culture. In the words of a recent reviewer, these pieces express the nexus of intimacy and betrayal in which homes can hold the heart. The ancient symbol of the hand often appears in my work."

Editorial

Milestones

Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC, *Editor*

This issue of *Art Therapy* presents an important update on the New Mexico Counselor and Therapist Practice Act, the first legislation to license art therapists (see Good & Sly-Linton). Although several other states have allowed art therapists to apply for licensure as professional counselors (e.g. in Massachusetts where art therapists with appropriate coursework may apply for a clinical mental health counselor license), the New Mexico law is currently the only one which licenses art therapists by their professional title and according to their particular educational training. As a result of this landmark legislation, art therapists in several other states are currently pursuing the implementation of similar legislation, efforts that would be extremely difficult without this precedent-setting event.

In addition to art therapy licensure the profession has witnessed several other milestones during the last year. The Art Therapy Credentials Board (ATCB) and the Certification Committee recently completed the three-year project to create a national certification program and subsequently conducted a certification examination for art therapists last November. Membership in the AATA continues to rise and the 1994 annual conference was the most well-attended event in many years. There is an increasing level of professionalism throughout the association, including a new ethics document, standards for independent practitioners, educational guidelines, and a continuing education program. This journal continues to see record-breaking numbers of submissions, an indication that interest in the field is high.

There have been other milestones, however, they are ones we would probably like to ignore, but important ones nonetheless. Healthcare professions are currently in precarious battle for turf, leaving many clinicians scrambling for positions, slots in managed care/HMOs, and insurance dollars. As a result, many public agencies are no longer willing to hire unlicensed art therapists and there are reports that private psychiatric hospitals in many parts of the country have laid off unlicensed therapists, including art therapists. Also, it is actually now illegal for unlicensed art therapists to conduct a private practice as a psychotherapist in states where they are not named in licensure legislation or are not specifically excluded (see Webster, 1994, for one example).

Additionally, in some cases art therapists have not been included in counselor and therapist licensure bills or have been denied the opportunity to apply for equivalency under counselor licensure acts. Although some art therapists have been able to apply for licensure as professional counselors, that may not be easy or even possible in the near future. Recently, the National Counselor Certification Board (NCBB) closed the window of opportunity for individuals with related degrees to sit for the counselor examination. This milestone within the field of counseling may have a serious impact on the possibility of art therapists who have a degree other than in counseling sitting for examinations in states where there is a counseling license available.

One other sad milestone for the field of art therapy is the passing of Janie Rhyne, PhD, A.T.R., HLM (a tribute to Dr. Rhyne appears in this issue of the journal). Although I had the privilege of talking with Janie Rhyne many times at annual conferences over the years, I did not really get to know her until the last two years of her life. I unwittingly orchestrated our contact by using a quote by Janie in an editorial I wrote titled "Is There a Crisis in Art Therapy Education?" (1993); in it she stated:

> I've said this to lots of top-notch art therapists and you might as well know it, too; we don't even know that art therapy is a separate field or will it last as a separate field. Quite a few of us are doing other things more than we're doing art therapy. Should it be a separate field? I'm one of the ones who think it probably should not be. Gradually we'll become a part of other fields: psychologists and social workers who use art therapy (in Jordan, 1989, p. 12).

When I first read this quote it raised fundamental issues about art therapy for me, particularly concerning the field's identity as a modality versus discipline. Over the years I have watched art therapists increasingly becoming licensed under other job titles such as counselor, marriage and family therapist, social worker, or psychologist. This trend, along with other problems in areas of training, research, and scholarly writing (Malchiodi, 1993; 1994), has led me to wonder aloud on the pages of this journal whether or not art therapy could ever fully articulate itself as a separate discipline. Janie's candid thoughts on these subjects generated a great many questions for me on these issues and others in our field.

After the editorial was published it was Janie that initiated communication with me. In fact, shortly after the journal was sent out to the readers my telephone rang late one evening; it was Janie calling to let me know that she would be responding to my editorial! It was not a quarrelsome or uncomfortable exchange; she told me she was going to write a rebuttal to what I had written and playfully wanted to know how I was going to respond. Frankly, I did not know how I was going to respond, particularly since I am not as quick of mind as Janie Rhyne. But I became intrigued and delighted that evening with her directness and interest in what I had to say. She did eventually respond in writing in a very thoughtful letter to the editor (see Rhyne, 1994).

That first exchange began a long series of conversations that I will treasure as milestones in my life. Often it was Janie who would initiate the call and I would usually recognize the ring as hers because it generally came late at night. We talked about many fascinating and challenging topics: research paradigms, certification and licensure, healthcare, art, and cybernetics, among others. What impressed me the most was how easy it was to engage in debate with Janie, and how much she enjoyed participating in a good, intellectual argument. But argument is the wrong word: Our conversations were really compassionate discourse, talking out a variety of ideas in a forum of mutual support. While within the AATA people often seem threatened by disagreement and debate, Janie Rhyne was not afraid to look at an issue from all sides and in depth. I will always be impressed by Janie's ability to simultaneously think through ideas on many levels and to stimulate and support others in examining these ideas in new and fresh ways.

Both licensure and certification have been milestones sought after by many in the field of art therapy as necessary to the growth of the profession. However, although we have attained these milestones, there are still more basic ideals to be achieved if we are to grow as a profession. One is our collective ability to encourage the discourse necessary to tackle the tough problems in this difficult healthcare climate and to flourish as a discipline. The second is the intellectual rigor and thoughtfulness that are necessary if we are to continue to expand and define this profession. My conversations with Janie Rhyne remind me that we must attend to both compassionate discourse and the quality of that discourse if we wish to see continued milestones as a profession in the years to come.

References

Jordan, H. (1989). An interview with Janie Rhyne. *American Journal of Art Therapy*, 28, 5–12.

Malchiodi, C. A. (1993). Introduction to special issue on art therapy and professionalism: Is there a crisis in art therapy education? *Art Therapy: Journal of the American Art Therapy Association*, *10*(3), 122–128.

Malchiodi, C. A. (1994). Looking ahead. *Art Therapy: Journal of the American Art Therapy Association*, *11*(4), 257–259.

Rhyne, J. (1994). Letter to the editor. *Art Therapy: Journal of the American Art Therapy Association*, *11*(2), 84.

Webster, M. (1994). Legal and ethical issues impacting unlicensed art therapists and their clients in California. *Art Therapy: Journal of the American Art Therapy Association*, *11*(4), 278–281.

Art Therapy

has extended the deadline for the following special issue:

Art Therapy in the Schools

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to the use of art therapy within schools. Submissions may focus on any aspect of art therapy or population related to this theme; of particular interest are specific applications of art therapy to clients/students in school settings, research, ethical and professional issues, and issues in providing art therapy services within an educational milieu.

New deadline for submissions for "Art Therapy in the Schools" is September 1, 1995. Please see "Guidelines for Authors" in the *Journal* for specific requirements in terms of style and format; submissions which do not follow these requirements will be returned without review. Please send five (5) copies of all submissions to:

Cathy A. Malchiodi, A.T.R., Editor
Art Therapy
c/o AATA, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Commentaries

Letters to the Editor

I have some comments about Dee Spring's article, "Progress or Politics," in the recent issue (Vol. 11, No. 4) of *Art Therapy*. While I agree with a couple of her basic complaints about AATA's history—our stinginess in according honors to our members and a divisiveness that may have stemmed from the Naumburg versus Kramer orientations—I must take issue with her reference to me and quotes from an article I wrote: "The Art Therapist as Exhibiting Artist: Messages from Joseph Beuys, Suzi Gablik, and Donald Kuspit," *Art Therapy, 10*(3), 141–146.

She talks about "an either-or approach to the field," saying that she has "not been able to understand why being a good clinician and a good artist, which includes exhibition, are not compatible . . . and why psychotherapy seems to be tainted in some way that takes away from art expression and vice versa. Yet this argument continues in full force as presented by Lachman-Chapin." She quotes from my opening, questioning about whether the two roles—art therapist and exhibiting artist—*are* fundamentally opposite. This is not an "argument"; it is a profound question which I examine from many points of view. Only someone deeply entrenched in either-or thinking would thus miss the whole thrust of my thinking.

What I am examining is whether, as an exhibiting artist, I can feel the same sense of being an "activist," that is, effecting change, as I do as an art therapist. I examine the concept of activist art, as exhorted by Gablik and Beuys, and compare it to ideas of Kuspit, Marcuse, Becker, etc., who propose that the expression of individual vision through aesthetic means can, in its own way, have profound effects on people. I am not talking about individualism versus community. I am saying that the most important debate in the art work now is whether activist art—art specifically aimed at effecting change—or personal art, where the subversive imagination is at work, can be most useful for changing the way humankind is living its life on this planet. No one has the answer. A recent weekend series of seminars at the Art Institute of Chicago addressed issues concerning the place of the artist in society. Artists from all over the world passionately addressed these questions.

The ideas with which I struggle in my article cannot be boiled down to art therapist versus exhibiting artist as Spring does. Her simplistic categorization of my "argument" stretches the truth of my writing out of focus, out of plumb. It distorts what I have to say so that it becomes, indeed, something else.

I am far from the black-white, either-or thinker that she calls me. Note one of my article's final statements concerning presenting our art therapy identity to the art world:

> I see us as being *both* activist and aesthetic artists. We help, therefore we act. But we also deeply value the aesthetic concerns that make us artists, and which we can impart in our activist role to our clients. . . . We can hope that our clarified identity and our activities both as therapists and exhibiting fine artists—joined with other artists in the art world—will have some power to effect some of the social changes we want.

Note also that I was very involved with the angry debates she refers to around AATA's continued publication of the *American Journal of Art Therapy*. Despite my support of *AJAT*, when members voted to start a new journal, I was at the founding meeting of *Art Therapy*, helping to formulate its focus and becoming the Assistant Editor for the first issue. This is not either-or behavior. It is healing behavior and this too is part of AATA's history.

Lest Ms. Spring and her readers get carried away with simplistic theories, I urge her to reread my complex (and therefore closer-to-the-nature-of truth) article.

Mildred Lachman-Chapin
Sedona, AZ

After reading Dee Spring's article in *Art Therapy* (Vol. 11, No. 4), I feel much more comfortable in the awareness of and saddened by the constant bickering and factions within the AATA. Lack of respect and acceptance for individuals and points of view indicates that our association is more polarized than ever before. We need the courage to face our dark side and ask some basic questions. As healers, we must continue to do all we can to bring these factions together in a working relationship and through creativity bring about lasting solutions, lest we destroy the functional purpose of the AATA.

At 62 this year and feeling too old for such nonsense, I refuse to identify with the defeatist attitudes that rob the innovator of the joy of creating. I take this opportunity to let the *Journal* know of the quite helpful support I have received from Terry Towne, MSW, A.T.R., of the Governmental Affairs committee, and from Deborah Good, A.T.R., and the NM Licensure Board. They were there when I was being threatened by local psychologists with new Wyoming Licensure Law and the new Psychologists Law (which is currently in abeyance).

These two women took the time and made the effort to keep in contact, to follow up and encourage me, sending ample materials, giving leads to others who were helping to make the necessary changes in the laws that will allow us to be meaningfully employed. I am deeply grateful for their encouragement, supportive attitude, and practical resources and recommendations. They represent to me the best of what AATA can be.

Spring's article focused on the need for revamping educational requirements. It is wonderful to have the base of an association that maintains high educational standards, but who is out there creating jobs for our graduated students? If we do not expend as much energy on creating new ways to utilize these graduates, to open doors that are currently closed by prejudice and fear of the "adjunct therapies," where will they find work? Our senior therapists do not seem ready, or willing, to retire, share power or positions, or create new jobs. Who will consider the currently under-employed or unemployed Registered Art Therapists in our midst?

If we are going to survive as a profession, we must provide job opportunities for our own. Why must we fear the new, innovative, or untried? Just because something is new to us does not mean it's unworkable or lacks value; it only means someone must risk trying it. Such risk-taking is the only way we can grow, thus assuring change and development. Not to risk suggests a stifling of creativity that breeds death to any system or organization.

There are quite a few new frontiers yet to conquer, if we can encourage those who see the need to provide alternatives and risk the venture. I returned to Wyoming to fulfill a personal vision of the Arts Ranch that could sustain a minimum of five creative arts therapists full time and 15–45 for the venues within 5 years. I have experienced an excellent working model in Great Britain's program, successful for over 26 years and still going strong. It is easily adaptable to the arts therapies that I have seen and has the power to effect change for children that such venues can create. It is a model that could easily be duplicated, and the program design includes a longitudinal research study to document the results. We are trying to provide exposure, a workable model, a paper trail of what does and does not work, and how effective the design is for employing and opening jobs in the community for arts therapists.

My goal is simple—to pass on my experience, establish a working model that others, younger and more able than I, can continue, duplicate, and recreate in their own creative lights. Few of us work best in a vacuum, without the help, encouragement, support, and counsel of our peers. Without this support it becomes harder and harder to risk rejection, ridicule and belittling snide remarks, and power games to try to establish a new program. This network of support is one of the main purposes of a national association. New ventures and ideas can be nurtured and cherished, even though we didn't think of them ourselves.

Industry seeks the ideas of children because they are not confined by what has been done and are willing to risk exploring possibilities. Wouldn't it be courageous if the AATA would provide resources for development of new job possibilities? Isn't it more productive to encourage new job opportunities that foster our field and organization?

Thank you for the opportunity to express my thoughts. And thank you for the excellent articles that express so well the pain of many of the members while giving some working models to transform the situation.

Lora Diggins, MA, A.T.R., LPAT
Sheriden, WY

I am responding to the letter written by Carol Thayer Cox, A.T.R, LPAT, that appeared in the last issue of *Art Therapy* in which she stated that at the 1993 business meeting the membership approved a resolution by Gladys Agell "that any changes in documents be published in two newsletters preceding a vote." The minutes of the 1993 AATA Annual Business Meeting were printed in the Fall 1993 AATA *Newsletter* (pp. 42–43). No such resolution was presented or approved at that meeting. Resolutions are advisories to the Board and do not set policy.

The Motion No. 11 that she refers to was a motion passed at the November 17–18, 1993 Board of Directors Meeting. The full motion was as follows:

> *That changes in policy documents that are publicly distributed must be published in the* AATA Newsletter *two issues before the proposed changes are voted on by the AATA Board. It is recommended that the ATCB follow the same procedure.*

Such motions become a part of the AATA Policy and Procedure Manual. The manual is used to guide the Board as it carries on the business of the Association. Approved policy and procedure is, and always has been, subject to revision when current Board members decide changes are necessary.

At the Spring 1994 Board Meeting that policy was revised because the Board felt that one publication was sufficient for the membership to respond to, that the Board needed to approve documents before they were published in the *Newsletter* and that ATCB, as an administratively independent corporation, should set its own policy. Policy No. 5.01b Section D. now states:

> *Changes in policy documents that are publicly distributed must be published in the first possible* AATA Newsletter *after the proposed changes are voted on by the AATA Board.*

Unlike The Ten Commandments, no document is cast in stone and the Board welcomes comments, questions and suggestions from the membership on any document that is to be publicly distributed.

At the 1994 business meeting, I stated that I had assumed the revised *Ethical Standards for Art Therapists* would be published in the *Newsletter* prior to the Conference in Chicago. Unfortunately, it was not. However, in April, this document was sent to the professional membership for their vote. It was also published in the Spring *Newsletter*.

Secretary Mary St. Clair's Winter 1995 *Newsletter* report informs the membership that all Board motions that directly affect the membership will be published in the *Newsletter* (pp. 7 & 36). This should help to keep the membership informed of the Board's activity. I sincerely hope that I have addressed the concerns raised in Carol Thayer Cox's letter.

Virginia Minar, A.T.R.
AATA President-Elect

A Tribute to Janie Rhyne, PhD, A.T.R., HLM

1913-1995

Janie Lee Rhyne, 81, of Iowa City died Wednesday, March 1, 1995, in her home after a long illness. Memorial services were held on April 13, Iowa City, IA. Memorial donations may be made to The Institute for Intercultural Studies, Suite B, 165 72nd St., New York, NY 10021.

Ms. Rhyne was born August 14, 1913, in Marianna, Florida, to Martha Jane and Cecil Rhyne. She received her bachelor of arts degree in 1935 and her master of arts in 1956 from Florida State University at Tallahassee. She received her doctoral degree in psychology in 1979 from the University of California at Santa Cruz.

Since 1980 she taught visual language communications to graduate students in the school of social work at the University of Iowa as an adjunct associate professor. From 1979 to 1992 she was visiting faculty in the Vermont College Graduate Art Therapy program. She taught annual courses in the Marylhurst art therapy program and the British Columbia School of Art Therapy. She was an assistant professor at the Institute of the Expressive Therapies, University of Louisville, from 1978 to 1980.

She authored Gestalt Art Experience *and several articles. She was a member of American Art Therapy Association, American Psychology Association, Northern California Art Therapy Association and Iowa Art Therapy Association. She was one of three co-founders of the San Francisco Gestalt Institute. She led several training groups and operated a private practice.*

She married Glenn Middlebrooks in 1936; they divorced in 1955. She married Jack Wise in 1957; they divorced in 1965.

Survivors include one daughter and her husband, Jan and Rock Williams of Iowa City; one son, Jeff Middlebrooks of Baltimore; two brothers and their wives, Cecil and Winifred Rhyne of Tallahassee, Florida, and Jeff and Amy Lou Rhyne of Marianna, Florida; one sister and her husband, Mary Elizabeth and Jack Witherspoon of Knoxville, Tennessee and three grandchildren.—from *Iowa City Press,* March 10, 1995.

Janie Rhyne, PhD, A.T.R., HLM

Vija B. Lusebrink, PhD, A.T.R.-BC

Janie Rhyne was born on August 14, 1913, in Marianna, Florida, and died on March 1, 1995, in her home in Iowa City, Iowa, after a long illness. In the 81 years of her lifetime Janie covered diversity of life styles and education, and lived in many places, including Mexico, Canada, and Europe. In her professional life her interests focused on people as individuals, their life "dramas", their explorations thereof and expressions through art experiences, their perceptions, and their discovery of meaning through visual thinking. Above all, Janie never ceased to be a seeker of intellectual knowledge.

After receiving her B.A. with a double major in art and social sciences from Florida State University, Tallahassee, Florida, in 1935, Janie obtained teacher certification in art, psychology, general science, and English. She taught for a year at a rural consolidated school in Florida, then did graduate research on cultural and psychological implications of State-sponsored art programs and exhibitions in Heidelberg, Germany, in 1937. While raising her family, from 1940 to 1948, Janie was working as an illustrator, mostly for textbooks, for Lippincott's and Winston, Pennsylvania. From 1948-1954 Janie taught children with emotional problems at the Media Friends School in Media, Pennsylvania. She also taught children part time in ghetto areas using art as communication, and worked with paraplegics at the Naval Hospital in Philadelphia.

From 1954–1956 Janie studied art and cultural anthropology at the University of Florida, Tallahassee, Florida, including summer studies in lithography and Middle American Indian culture in Mexico. Upon receiving her Masters degree, Janie moved with her second husband to San Migual Allende, Guanájuato, Mexico, where she was the co-director of VAKI, S. A. from 1956–1960, training Mexican boys in crafts and in producing batik wall hangings. From 1962–1964 Janie lived in an experimental artists community in Fauquier, B. C., Canada.

Janie trained as a Gestalt art therapist with Fritz Perls and various other therapists at the Gestalt Institute of San Francisco, California from 1965 to 1967, and was its Senior Training Therapist from 1966 to 1972. During this time she also maintained a private practice.

Upon finishing her book, *Gestalt Art Therapy*, in 1973, Janie embarked on her doctoral studies in psychology at the University of California, Santa Cruz, and received her PhD in psychology in 1979. During this time Janie presented many workshops on Gestalt art therapy and visual thinking through the Continuing Education program of the University of California, Santa Cruz. In addition, she was also on the field faculty of Goddard College and Union Graduate School, and supervised graduate practicum students from Goddard College, Lone Mountain College, Pratt, and the University of Louisville. From 1978–1980 Janie joined the faculty of the Expressive Therapies program at the University of Louisville, Kentucky, as an Assistant Professor. After moving to Iowa City in 1980, Janie taught visual language communications at the School of Social Work, University of Iowa, as an adjunct associate professor. She was a visiting professor at the art therapy program of Vermont College of Norwich University from 1979–1992, and also taught courses annually at the Marylhurst College Art Therapy program and the British Columbia School of Art Therapy.

Janie was active in the American Art Therapy Association (AATA). She was the chair of the AATA Research Committee from 1981–1985, she served on the Honors Committee and Professionals Standards Committee, and was consultant to the Education and Training Committee.

Personal Recollections

I have known Janie as a teacher, friend, and colleague; she was my model, and she was a wise woman. Janie spanned the past and the future, she was a lady and a rebel, and she was forever young.

My first meeting with Janie was in San Francisco, at the formation meeting of the Northern California Art Therapy Association in the early 1970's. Janie was reserved in her involvement in the discussions and formulations of the organization, but she stood out in the crowd with her presence. Later that year I attended Janie's Gestalt art therapy workshop weekend. Janie lived in Pescadero near the California coast south of San Francisco, in a rambling California ranch style house in a small valley surrounded by a redwood forest. It was a perfect setting for her workshop—a large studio living room, and a deck facing the morning sun overlooking the trees. Janie was always the perfect therapist and hostess, relaxed and casual, open and sensitive to others' needs.

Janie had developed her own style of Gestalt art therapy based on her training at the Gestalt Institute of San Francisco; she had been friends with Fritz and Laura Perls, and had spent time at Esalen. Her workshops offered Gestalt experience in the here and now in the fullest sense of the word. Her presence and depth alone combined with her laid-back acceptance of individuals and their experiences permeated the air during the experiences, discussions, and meals.

As a friend I had the privilege to visit and stay with Janie a number of times in 1973–74 in her Victorian house in Santa Cruz, California. At this time Janie was already working towards her doctorate in psychology, and was friends with intellectual trailblazers like Gregory Bateson and his wife. Janie's house again permeated her essence and hospitality, and reflected her diverse interests. Her office and studio for workshops were in an annex to the house, but her study occupied part of her living room. This was a time of transition for Janie from Gestalt therapy to cognitive psychology incorporating Rudolf Arnheim's insights into Gestalt psychology and art, and Hans and Sulamith Kreitler's research and writings on the psychology of the arts. At this time, though, Janie was searching for her own approaches to scientific investigation dealing with the structure of visual expression. She sought an approach which would honor individuality along with the structural characteristics in the visual expressions of different moods, and she adapted George Kelly's personal construct grid concept to her work with drawings.

Conversations with Janie were challenging, sparkling with ideas and connections produced by her brilliant mind, interspersed with clarifications and questions "You mean that . . . ?" Art, psychology, creativity, are perception were interwoven in these conversations; although Janie insisted on earthbound anchoring and references, her spirit soared and her intellectual energy created a force field—for lack of better definition of the experience—which enveloped and challenged the visitor.

My friendship with Janie expanded into collegiality when Janie joined the faculty of the Expressive Therapies program at the University of Louisville, Kentucky, from 1978–1980. Upon her arrival in Louisville Janie was making her final corrections on her doctoral dissertation. She had persevered in her search for her own approach in investigating the visual language with which individuals' create visual messages about their personal reality. She had analyzed over a thousand black on white mood drawings according to the individuals' own perceptions as reflected in their constructs reported on the Kelly's grid. Janie was pleased with the high number of agreement of the results with her predictions of the structural representations of the different mood states. She presented the results of her research at the 11th Annual AATA Conference, and the "personal dramas of transition" as expressed through the visual language and corresponding constructs at the 12th Annual AATA Conference (Rhyne, 1979a, 1983b). Janie had achieved her goal to prove and show that "art therapists—if they put their minds to it, add a bit of creativity, hard work and stubborn perseverance—can do research that involves art and science in elegant interplay" (Rhyne, 1979a, p. 97). Janie had turned 65 when she received her doctoral degree in academic psychology from the University of California, Santa Cruz.

At the Expressive Therapies program Janie's special class was in Visual Thinking based on her studies and dissertation research (Rhyne, 1979b). She also encouraged the students to test their own ideas through research. Her therapeutic work reflected her change to a cognitive approach in that her focus was "to raise individual levels of cognitive awareness of personal constructs of events" (Rhyne, 1979c, p. 125), whereby the drawings provided possible alternative solutions. Janie's emphasis in her work was on structure and form as content and on figure/ground organization in visual expressions (Rhyne, 1987).

In Louisville, same as in California, Janie's living space and environment were very much a part of her. Janie now lived on the eighth floor of a highrise, in large spacious rooms, with the view from her desk overlooking part of the city. The rooms and furniture were white and cream, highlighted with many shelves with books, and Janie's collection of art and artifacts, and her plants. Janie greeted visitors with her southern hospitality and a glass of wine.

At this time I was working on my dissertation research. I appreciated Janie's supportive presence and questions in what she defined as "heuristic" style of inquiry and teaching: listening and stimulating the person to investigate him or herself further (Rhyne, 1979b). It was a style similar to one she had used in her Gestalt art therapy workshops by asking "I wonder if . . . ?", but this time she supported the unfolding on an intellectual level.

When questioned about it, Janie was willing to share stories of her experiences living in a commune in Canada, as well as her experiences as a therapist living in the Haight/Ashbury area of San Francisco in the late '60s. Nevertheless, her interests were in the here and now, in intellectual challenges. Her comment was: "I am not using so much energy when I am creative, I use much more energy when I am bored" (Rhyne, 1979d).

At the University, Janie, Sandra (Graves), and I used to have discussions about different approaches to art therapy. Janie was interested in the phenomena of seeing and in the two kinds of subjective attributes, namely the formal qualities of the image and the meaning attributed to it, for example, the rectangularity of an image, such as a box or a cigarette case and the individual's constructs for it. Janie acknowledged that she was mostly cognitive in her approach, and that she had some problems with the Gestalt approach in that Gestalt was anti-intellectual, whereas she was not so. Janie was not interested in the hidden meaning of the images or their symbolism: "I am interested in form not dragons!" Janie deplored the lack of clear definitions of terms and vocabulary in art therapy approaches and literature (Rhyne, 1980). Janie was always prepared for such discussions and had done her homework by reviewing the appropriate sources. She was clear and explicit in her statements and kept Sandra and me down to earth.

After leaving Louisville in 1980, Janie moved to Iowa City to be closer to her daughter and her family. My contact from that time on was mainly at the annual AATA conferences.

In the following years Janie made her own next intellectual "drama of transition"—synthesizing different large theoretical frameworks into her own style. In her presentation on the "Psycho-evolutionary approach to expression" at the 12th Annual AATA Conference she drew on Darwin's work on the evolution of emotions, Suzanne K. Langer's philosophies of mind, Gestalt psychology's holistic emphasis, Kurt Goldstein's extension of his view in psychotherapy, Robert Plutchick's psycho-evolutionary perspective of emotion, and contemporary Existential psychotherapy (Rhyne, 1982). Eventually Janie integrated the different views into a systems framework with an emphasis on the individual. She perceived humans as innately systematically functioning and self regulating organisms who use signs, symbols, and other nonverbal languages to give and receive feedback (Rhyne, 1991).

Throughout the years Janie questioned the validity of art therapy as an independent discipline. At the same time she continued to contribute to the field. She was awarded Honorary Life Membership of the AATA in 1980. As the Chair of the AATA Research Committee from 1981–1985 Janie surveyed all the art therapy research up to that date, and wrote the outline "Ten steps in planning good research." She taught at the University of Norwich and other graduate art therapy programs, gave presentations at AATA Conferences, and conducted workshops.

In her work and in her pursuit for new horizons Janie remained true to herself, honest in her comments, and grounded and solid in her being. In her final assessment of art therapy, "The future of art therapy: In what context?" (Rhyne, 1994), she again questioned the diversity in art therapy, and "the vocabularies and descriptions of perceptions and performances in the context of art therapy" (p. 250). She professed that she was still living with questions about art therapy and did not have the answers. Her advice was to reach for "wisdom in deciding which ideas to attend and which not to" (p. 251).

Janie celebrated her 80th birthday with a circle of friends

Figure 1. Janie leaving her 80th birthday party in Atlanta, GA. Photo by Barry Cohen, A.T.R. Courtesy of Anne Mills, A.T.R.

and admirers at the 24th Annual Conference of the American Art Therapy Association in Atlanta, Georgia. Janie had just presented at the Conference her views on new perspectives on art therapy gleaning input from the fields of philosophy, psychology, art history, biology, anthropology, and even paleontology and cybernetics (Rhyne, 1993). At the party Janie was as young in spirit and alive as ever (Figure 1).

Janie touched the lives of many people, and contributed to the field of art therapy in many ways. Her *Gestalt Art Experience* (Rhyne, 1973) is one of the cornerstones of art therapy. Janie's thesis was that "each of us writes our own script for our personal drama of transition, that we do so congruently with our construct systems of the nature of our role in and out of the world of reality" (Rhyne, 1983a, p. 34). In her life Janie lived her own Gestalt fully. She was honest with herself, and she was her own director of the experiential and intellectual dramas she was living.

References

Rhyne, J. (1973). *The gestalt art experience.* Monterey, CA: Brooks/Cole Publishing.

Rhyne, J. (1979a). Expanding our comprehension of visual imagery. In L. Gantt, G. Forrest, D. Silverman, & R.G.H. Shoemaker (Eds.), *Art therapy: Expanding horizons. The proceedings of the 9th Annual Conference of the American Art Therapy Association.* (pp. 95–97).

Rhyne, J. (1979b). Drawings as personal constructs: A study in visual dynamics. *Dissertation Abstracts International, 40*(5), 2411B (University microfilms International No. TX 375-487).

Rhyne, J. (1979c). Gestalt art experience. In L. Gantt, G. Forrest, D. Silverman, & R.G.H. Shoemaker (Eds.), *Art therapy: Expanding horizons. The proceedings of the 9th Annual Conference of the American Art Therapy Association* (pp. 125–126).

Rhyne, J. (1979d). Personal communications.

Rhyne, J. (1980). Personal communications.

Rhyne, J. (1982). Working with what comes naturally: A psychoevolutionary approach to expression. In A. E. DiMaria, E. S. Kramer, I. Rosner (Eds.), *Art therapy: A bridge between worlds. The proceedings of the 12th Annual Conference of the American Art Therapy Association* (p. 68).

Rhyne, J. (1983a). Personal dramas of transition. In L. Gantt, & S. Whitman (Eds.), *The fine art of therapy. The proceedings of the 11th Annual Conference of the American Art Therapy Association* (pp. 31–38).

Rhyne, J. (1983b). Developing art therapy research. In L. Gantt & S. Whitman (Eds.), *The fine art of therapy. The proceedings of the 11th Annual Conference of the American Art Therapy Association* (p. 132).

Rhyne, J. (1987). Gestalt art therapy. In J. A. Rubin (Ed.), *Approaches to art therapy: Theory and technique* (pp. 167–187). New York: Brunner/Mazel.

Rhyne, J. (1991). A systems approach to understanding drawing as visual language. Presentation at the American Art Therapy Association 22nd Annual Conference, Denver, Colorado.

Rhyne, J. (1993). Psychology, art education, anthropology contributions: New perspectives for art therapy. Presentation at the American Art Therapy Association 24th Annual Conference, Atlanta, Georgia.

Rhyne, J. (1994). The future of art therapy: In what context? *Art Therapy, 11*(4), 250.

Some Memories of Janie Rhyne

Robert Schoenholtz, A.T.R.-BC

I met Janie at the AATA conference of 1985 in Chicago where I introduced myself to her at the conclusion of her presentation. A few months earlier I had been driving Heinz von Foerster (the physicist, philosopher, cybernetitian, and consultant to family therapists) to his hotel in Philadelphia, and when we discussed Gregory Bateson and psychotherapy, we eventually began to talk about art therapy. While he did not know much about art therapy, he did ask me if I knew Janie Rhyne, who had been a neighbor of his on Rattlesnake Hill in Pescadero, California. Eventually, each told me that although they had a few conversations over the years, neither had a deep understanding of each other's work. I asked him if it would be all right to use his name as an introduction to Janie, and he approved.

When I attended the panel on research where Janie was presenting, she was discussing her major research influences and included Bateson! I had no idea she knew him or was influenced by him in any way. I anxiously awaited the conclusion of the panel and when I finally was able to approach the presenter's table, she agreed to meet at lunch and seemed to be as interested as I in having a talk. Later, at the lunch table and afterward, I found her to be quite interested in collaborating in developing a way of including Bateson's ideas within an art therapy context.

An interesting anecdote from this time was that there were many hippies in the Bateson classes at Santa Cruz because of his focus on consciousness. This was very stimulating for all and eventuated in Janie's going to work and even moving into the Haight-Ashbury section of San Francisco to help with the drug casualties. This is a good example of the courage and spirit of adventure she exhibited throughout her life.

Eventually Janie shared with me, in increasing detail over time, facts about her relationship with Bateson, which was close and rich. She met Bateson at her PhD program at the University of California at Santa Cruz and, among the many stories she told about this time, she revealed how they had become good friends and how Bateson had sat up all night reading her book when it was first published. He had to read it in the bathroom because it was the only way he could have enough light without disturbing his sleeping wife.

BEST COPY AVAILABLE

Bateson was negative about the idea of psychotherapy but, of course, Janie's book was about art "experience," so it was okay. Their friendship grew to the extent that when Bateson was later diagnosed with cancer, he and his wife, Lois, drove directly from the doctor's office and that initial diagnosis to Janie's apartment so that Gregory could talk with Janie about it.

She pointed out how her work was not based on Bateson in any direct, conscious way but that there is a clear similarity between some of the cybernetic/constructivist ideas of Bateson and the personal construct work of Kelly. We discussed these issues at length and many times in the pursuant years and even presented together at AATA conferences. Two of these presentations stand out as remarkable. The first was when she agreed to let me interview her publicly about Bateson and his ideas regarding art therapy. This was done in a spontaneous, loosely structured format allowing Janie to go on at whatever length she felt appropriate and with the inclusion of comments and questions from the audience throughout the interview. Since we had spoken about these issues at length in the past, it was a joy to participate with her as a rather educated questioner/moderator. It was one of those times when her natural warmth and charm really showed.

At another conference, for the American Society for Cybernetics in Philadelphia in 1993, Janie participated in a panel on art therapy and cybernetics with Maxine Junge and myself. One major presenter at the conference was Mary Catherine Bateson (the well-known daughter of Gregory Bateson and Margaret Mead). In the audience for our panel, sitting directly in front of us, was Lois Bateson, Gregory's wife from the California days who had come specifically to see Janie. Janie's presentation was especially personal: a verbal tapestry, with interweavings of various strands of her life and thoughts eventually culminating in a beautiful statement about art therapy and cybernetics/constructivism. The new introduction to her classic book, *The Gestalt Art Experience*, will address some of the same content as that presentation, its new addendum, on which she was working at the time of her death, was to be more of the same. The former is more about her own life and the latter more about Bateson and cybernetics. At this writing I do not know whether the addendum was finished or close enough to be included in any form.

Janie was a remarkable person—a pioneer in the field of art therapy from over 20 years ago who was not willing to rest on her laurels, but rather always interested in new ideas and new ways of synthesizing ideas. We had many discussions about transpersonal psychology and psychotherapy versus humanistic approaches, and she was always interested in reading, studying, and understanding ideas whether or not she eventually came to accept them.

It was wonderful to see the respect and love with which she was showered at the end of an art therapy presentation; many art therapists were enchanted with her and her ideas. And it didn't seem at all unusual, having known her close up. I met her expecting to find an interesting professional relationship, and instead I found a teacher, colleague, friend, and a vibrantly alive individual for whom I developed a great deal of affection and whom I will never forget. I am very grateful to have known Janie Rhyne.

A Rhyne Bibliography

Rhyne, J. (1968). Humanistic Psychology in teaching. *Association for Humanistic Psychology Newsletter*, Spring issue.

Rhyne, J. (1969). Art therapy. Group leaders workshop. Berkeley, CA: Explorations, 5(2), 34.

Rhyne, J. (1970). Gestalt art experience. In J. Fagen & I. Shepherd (Eds.), *Gestalt therapy now* (pp. 274–284). Palo Alto, CA: Science and Behavior Books.

Rhyne, J. (1972). A la group: Group marriages and extended families. *Association for Humanistic Psychology*, June, 83–84.

Rhyne, J. (1973a). *The Gestalt art experience*. Monterey, CA: Brooks/Cole.

Rhyne, J. (1973b). The Gestalt approach. *American Journal of Art Therapy*, *12*(4), 237–248.

Rhyne, J. (1974). Divergency and growth in art therapy. *American Journal of Art Therapy*, (*14*)1, 14–15.

Rhyne, J. (1976a). Group marriages and extended families. In C. Guion (Ed.), *Satan is left handed* (pp. 83–84). San Francisco, CA: Association for Humanistic Psychology.

Rhyne, J. (1976b). The Gestalt approach to experience, art, and art therapy. In C. Hatcher & P. Himelstein (Eds.), *The handbook of Gestalt therapy* (pp. 237–248). New York: Jacob Aronson.

Rhyne, J. (1977a). Orientations in art therapy. In B. McWaters (Ed.), *Humanistic perspectives: Current trends in psychology* (pp. 79–95). Monterey, CA: Brooks/Cole.

Rhyne, J. (1977b). Review of Z. Zinker *Creative Process in Gestalt Therapy*. *American Journal of Art Therapy*, *16*(4), 157.

Rhyne, J. (1979a). Expanding our comprehension of visual imagery. In L. Gantt, G. Forrest, D. Silverman, & R.G.H. Shoemaker (Eds.), *Art therapy: Expanding horizons. The Proceedings of the 9th Annual Conference of the American Art Therapy Association*, (pp. 95–97).

Rhyne J. (1979b). Drawings as personal constructs: A study in visual dynamics. *Dissertation Abstracts International*, *40*(5), 2411B (University Microfilms International No. TX 375–487).

Rhyne, J. (1979c). Gestalt art experience. In L. Gantt, G. Forrest, D. Silverman, & R.G.H. Shoemaker (Eds.), *Art therapy: Expanding horizons. The Proceedings of the 9th Annual Conference of the American Art Therapy Association* (pp. 125–126).

Rhyne, J. (1979). Gestalt art experience. In L. Gantt, G. Forrest, D. Silverman, & R.J.H. Hastings (Eds.), *Art therapy: Expanding horizons. The Proceedings of the 9th Annual Conference of the American Art Therapy Association* (pp. 125–126).

Rhyne, J. (1979). Review of V. Oaklander, *Windows to our children*. *American Journal of Art Therapy*, *10*(2), 69.

Rhyne, J. (1980). Gestalt psychology/Gestalt therapy: Forms/contents. *The Gestalt Journal*, 3(1), 76–84.

Rhyne, J. (1980). Commentary: Art Therapy research in art education. *The Journal of the National Art Education Association*, 33(4), 34–35.

Rhyne, J. (1981). Transference and countertransference in art therapy. *American Journal of Art Therapy*, *21*(1), 22–23.

Rhyne, J. (1982). Working with what comes naturally: A psychoevolutionary approach to expression. In A. E. DiMaria, E. S. Kramer, I. Rosner (Eds.), *Art therapy: A bridge between worlds. The proceedings of the 12th Annual Conference of the American Art Therapy Association* (p. 68).

Rhyne, J. (1983a). A Gestaltist's avoidance of transference. In L. Gantt & S. Whitman (Eds.), *The fine art of therapy. The Proceedings of the 11th Annual Conference of the American Art Therapy* (pp. 68–69).

Rhyne, J. (1983b). Personal dramas of transition. In L. Gantt, & S. Whitman (Eds.), *The fine art of therapy. The Proceedings of the 11th Annual Conference of the American Art Therapy Association* (pp. 31–38).

Rhyne J. (1983c). Developing art therapy research. In L. Gantt & S. Whitman (Eds.), *The fine art of therapy. The Proceedings of the 11th Annual Conference of the American Art Therapy Association* (p. 132).

Rhyne, J. (1985). Multiple intelligences. *Art Therapy. Journal of the American Art Therapy Association*, 2(2), 84 & 101.

Rhyne, J. (1987). Gestalt art therapy. In J. A. Rubin (Ed.), *Approaches to art therapy. Theory and technique* (pp. 167–187). New York: Brunner/Mazel.

Rhyne, J. (1988). Readers forum. *American Journal of Art Therapy*, 26(3), 70.

Rhyne, J. (1990a). Gestalt psychology/gestalt therapy: Forms/contexts. *The American Journal of Art Therapy*, 29(1), 2–8.

Rhyne, J. (1990b). Review of R. J. Daldrup, L. E. Beretter, D. Engle, L. S. Greenberg, *Focussed expressive psychotherapy: Freeing the over controlled patient. American Journal of Art Therapy*, 29(2), 57–58.

Rhyne, J. (1991). Review of S. McNiff, *Fundamentals of art therapy. The American Journal of Art Therapy*, 30(1), 17–18.

Rhyne, J. (1992). How ideas are generated for research. In H. Wadeson (Ed.), *A Guide to conducting art therapy research* (pp. 15–24). Mundelein, IL: The American Art Therapy Association.

Rhyne, J. (1993). Review of S. Fein. *First drawings: Genesis of visual thinking. The American Journal of Art Therapy*, 33(2), 52–53.

Rhyne, J. (1994). The future of art therapy: In what context? *Journal of the American Art Therapy Association*, 11(4), 250.

Co-authored Articles

Rhyne, J., & Vich, M. (1969). Psychological growth and the use of art materials: Small group experiments with adults. In A. Sutich & M. Vich (Eds.) ***Humanistic Psychology***. New York: Free Press.

Rhyne, J., Williams, F. (1992). Review of T. G. West, *In the mind's eye. The American Journal of Art Therapy*, 31(1), 25–26.

Robbins, D., Lusebrink, V. B., & Rhyne, J. (1979). Personal and general color constructs: A study of color associated with stages of life. In L. Gantt, G. Forrest, D. Silverman, R.G.H. Shoemaker (Eds.), *Art Therapy: Expanding horizons. Proceedings of the 9th Annual Conference of the American Art Therapy Association*, pp. 125–126.

Related Articles

Jordan H. (1989). An interview with Janie Rhyne. *American Journal of Art Therapy*, 28, 5–12.

Editor's note: The Editor would like to acknowledge Dr. Vija Lusebrink for her work in compiling this bibliography and the biographical material on Janie Rhyne.

Contact Art Therapy On-Line!

Get in on the Information Superhighway! If you have a modem you can send e-mail to **ART THERAPY** on-line. Subscribers to the America Online service can send messages to the Editor, Cathy Malchiodi, A.T.R. by contacting the code name "**RdWing**"; those with e-mail can send messages to "**rdwing@aol.com.**" Another onliner, Barbara Levy, A.T.R. can be contacted through America Online "**LEVYB**", through e-mail "**levyb@aol.com.**" or through the Delphi Custom Art Therapy Forum. Barbara hosts this online forum through which art therapists can network and communicate nationwide. To get more information about joining either Delphi or American Online services, please contact **Art Therapy, c/o AATA National Office, 1202 Allanson Road, Mundelein, Illinois 60060.**

Art Therapy: Journal of the American Art Therapy Association, 12(2) pp. 100-103 © AATA, Inc. 1995

Art Therapy Licensure Update

Deborah Good, MA, A.T.R., LPAT, LPCC and **Kris Sly-Linton, MA, A.T.R.-BC, LPAT,**
Albuquerque, NM

Abstract

The New Mexico Therapist and Counselor Practice Act has been in effect for 2 years. This omnibus act includes the first licensure for art therapists in the United States. Two art therapists provide an update on the evolution of that licensure and how these changes have helped other art therapists in their endeavors to create laws to protect themselves as professionals.

Introduction

Five years after the introduction of legislation, the State of New Mexico passed into law the first licensure bill in the United States to govern the practice of art therapists. A previous article (Good, 1993) published in *Art Therapy* explains the original concept development, the process of writing the actual legislation, how the bill was introduced during three legislative sessions, the transformation to an omnibus act, and the factors pertinent to the final passing of this legislation during the 1993 New Mexico Legislative Session.

Deborah Good, MA, A.T.R., LPAT, LPCC

It was difficult to let go of the New Mexico Therapist and Counselor Practice Act once the legislature passed it in 1993. I was tired after the active 5 years in the legislative process. I also was concerned that the art therapist who would eventually be appointed by the Governor to the Counseling and Therapy Practice Act Board must be someone who would continue the work that had been started and who would be diligent, persistent, persuasive, and dedicated. At the request of the New Mexico Regulations and Licensing Department and the Governor the names of three New Mexico art therapists were submitted to be considered for this important position.

By the end of the summer of 1993, all the board members had been selected except for an art therapist. The board began to meet and schedule hearings and the position of art therapist still remained vacant. A public member with an art background influenced the art therapy section of the law, voicing opinions concerning the art therapists governed by the law. I became concerned and contacted the head of the Regulations and Licensing Department to communicate my concerns. I also spoke with the key legislative figures who sponsored the original bill and requested that they communicate my concerns to the Governor and reinforce the appointment of an art therapist to fill the vacancy on the board as soon as possible. Finally, in October 1993, the governor appointed Kris Sly-Linton, MA, A.T.R.-BC, LPAT, to the licensing board.

The time and work that have been donated by Kris since her appointment as the board's art therapy representative are enormous. The writing and passing of legislation is only the first step that begins the legal process of licensing professionals. In her section of this article, Kris outlines the separate process of participating as a state board member once legislation has passed. Since New Mexico law governs three separate but related therapeutic professions, committees appointed by the board continue to accomplish extensive work.

The art therapy section of this legislation was written in a clear, concise framework that left room for the board to create specific and detailed guidelines governing art therapists. To include all of the rules and regulations in the original legislation would have made the bill cumbersome to pass and would have unnecessarily restricted the representation of art therapy as a profession. A licensure bill must be easy to read and clear to a lay person, yet protect the integrity of the profession. When introducing the original legislation I had to inform, educate, and sell art therapy to the New Mexico legislators as a productive, viable means of helping and protecting public consumers. In contrast, the subsequent Counseling and Therapy Practice Act Board had to enforce this legislation once it was passed, following the regulations in the bill and creating additional standards by which professionals must abide.

In the original 1989 Art Therapy Practice Act, a provisional licensure was created for art therapists who had recently graduated and/or not met the requirements for art therapy registration (which are the requirements for licensure). Because the 1993 Counseling and Therapy Practice Act governs separate disciplines individually, a licensure category was created to meet the provisional status of many professionals. This category is the Registered Mental Health Coun-

---

Editor's Note: Deborah Good, MA, A.T.R., LPAT, LPCC, is the author of the first art therapy legislation passed in the US in the State of New Mexico in 1993. She is currently a doctoral candidate in the Counseling Department at the University of New Mexico and she teaches at Southwestern College. Debbie has a private practice which includes contract work with Family Therapy of Albuquerque, Albuquerque Public Schools, and the State of New Mexico.

Kris Sly-Linton, MA, LPAT, A.T.R.-BC, is currently the professional art therapy member on the New Mexico Counseling and Therapies Practice Board. She was the director of the Expressive Arts Department at Desert Hills Center for Families and Youth, Albuquerque. She was recently appointed coordinator for the new AATA Symposium on Adolescents and Art Therapy.

selor (RMHC). Licensure is granted under this title for all professionals working toward the requirements of full licensure as a Licensed Professional Art Therapist (LPAT), Licensed Professional Clinical Counselor (LPCC), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT). Upon application for the RMHC, a plan of intended supervision and contract with the supervisor is required. This allows new professionals to have licensed job opportunities in order to gain the experience they need for licensure within their field.

When the final 1993 omnibus bill was created, a representative from each profession carefully selected the appropriate title for their licensure. The title "Licensed Professional Art Therapist (LPAT)" was chosen for two reasons: (1) having the word professional in the title matched the counselor's title in recognition and status, and (2) most importantly, it came to my attention that in some states activity therapists are licensed as LATs. Many art therapists have had to deal with that title, in one way or another, in order to find employment. The law that New Mexico passed refers to the title Licensed Professional Art Therapist, in order to distinguish it from activity therapists.

Unfortunately, when the licenses were first issued, they read Licensed Art Therapist (LAT). This is an excellent example of the fact that even though a licensing board has to follow the letter of the law that was passed, in executing the licenses mistakes can be made. Fortunately, when Kris Sly-Linton was informed about the reasons for choosing LPAT over LAT, she was able to take this concern to the full licensing board and have the LPAT reinstated. If you have a license in New Mexico, you should be using LPAT after your name, regardless of whether your certificate states Licensed Art Therapist.

An interesting part of this licensure act is that residency in New Mexico is not required in order to be licensed. I am surprised that more art therapists nationally have not taken advantage of the opportunity to become Licensed Professional Art Therapists. However, it is uncertain how other states will view a New Mexico licensed professional art therapist practicing in their state. The rationale for applying for the New Mexico licensure is that it would at least increase your credibility to be a licensed therapist, even if it is in New Mexico. By doing so, you made the effort to obtain art therapy licensure where it is available. Insurance companies will decide individually how they are going to recognize those professionals who do not fit within their state guidelines. Another reason to be licensed in New Mexico is to use your out-of-state license as a rationale for your state to institute art therapy licensure. Why send the money you spend to be state credentialed to another state when your state could be making money by licensing art therapists? This is a rationale that most legislators will listen to. It is a fact that the State of New Mexico has licensed more than twice the number of people expected. Because of this, the state has made over one million dollars to date licensing therapists and counselors.

Lastly, I continually hear arguments within our profession comparing state licensure and national certification. This argument compares apples and oranges. The timeliness of board certification for art therapists through the Art Therapy Credentials Board (ATCB) is remarkable in relationship to the New Mexico Counseling and Therapy Practice Act. Licensure and certification are related; licensure needs the national certification exam in order to maintain a consistency of standards for art therapists throughout the nation. The counselors and marriage and family therapists use their national exam on the state level to qualify and test new professionals for licensure. This unity between state and national insures that the standards we have fought so hard to obtain as art therapists will be maintained.

There are many stages involved in creating laws and standards on the state and national level to enhance our profession and hopefully create new jobs. We can tackle them only one at a time, but the job is never complete. The concept of a working document has become more clear to me through the legislative process. We must stay on top of all laws being created nationally and in our own states so that we can continue to do the work that we have been trained to do. We must maintain awareness of the world in which we live and continue to learn not only how to play by the rules, but also how to create them.

Kris Sly-Linton, MA, A.T.R.-BC, LPAT

When the bill passed, there were five levels of licensure created: Licensed Professional Art Therapist (LPAT), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage and Family Therapist (LMFT); and Licensed Professional Counselor (LPC). Standards Committees, made up of a professional member, a public member, and three other professional members from around the state, were established for each level of licensure to review rules and regulations pertaining to each category and individual license applications.

Although the bill was passed in the winter of 1993, appointments to the Counseling and Therapy Practice Board were not completely filled until the end of October 1993. However, there could be no delay in issuing licenses by July 1, 1994. Although this may seem like ample time to get the job done, due to open meetings acts, legal notice of public hearings, amendments, and so forth, the rules and regulations implementing the new law had to be ready by the end of January 1994, allowing a very short time to prepare such an important document.

In an effort to get as much public input as possible, public Standards Committee meetings were held throughout November and December 1993. The concept was admirable, but many individuals involved in the lobbying process and those who feared they might be excluded from licensing due to educational requirements sometimes turned the meetings into verbal battlegrounds. I was asked by the acting board chair to attend each of the Standards Committee meetings to witness what was occurring and possibly offer some objectivity, since I was the last professional member appointed and had not been overly involved in the lobbying effort.

Prior to my appointment, initial rules had been drafted by the board administrator based on other professions' rules and regulations. These rules had become increasingly more specific, identifying the various professional standards and whenever possible, exact specifications mandated by the bill itself. When I finally attended my first Art Therapy Standards Committee meeting, I found alterations to our portion of the rules had been made, compromising standards regarding su-

BEST COPY AVAILABLE

pervision and post-graduate professional hours. These resulted from advisory input from art therapists not yet able to be registered through AATA and public and professional members not familiar with the field of art therapy. This should come as a word of caution: Don't assume that the process will take care of itself after the bill has passed. Continued vigilence is necessary at all stages of licensing.

I was the last board appointment because the Regulation and Licensing Office's clear preference was that Deborah Good be the professional art therapy member. They seemed to be hesitant to review other recommendations for the position. In retrospect, observing how personal agendas by lobbying professionals have occasionally impaired their judgment in designing standards that may be beneficial to their peers and the public, I now understand Debbie's position that an individual with less personal historical involvement in the legislative process may be able to serve the board's need to a greater advantage.

At this point it is important to stress the purpose of the licensing board and licensure in general. Licensure is not as much to protect the profession as it is to protect the public. It seems that the ultimate outcome of licensing is to maintain professional standards and conduct, and yet it is not the intent to exclude individuals from a given field. We as licensed professionals (and psychologists and psychiatrists have been subjected to this for years!) are often criticized for trying to form exclusive organizations that dominate the healthcare field. I received some of these accusations and was interviewed by a newspaper in New Mexico after having addressed this issue at a special meeting of over 200 paraprofessionals and peer counselors who passionately opposed the licensing bill. They feared losing their jobs and state contracts because they didn't have the educational or supervisory background to be licensed. I was in a difficult position, but the training I had had as a board member in identifying the purpose of the bill helped me to present the case for licensing and public protection.

Regarding art therapy in particular, we were often faced with applications from A.T.R.s who had been awarded their registration under special circumstances. Our law does not permit special circumstances and that became an issue with many A.T.R.s who assumed that licensing was equivalent with possession of registration. This became a recurrent topic at the November AATA conference and was addressed publicly. Throughout the entire licensing effort in New Mexico, AATA has been supportive and helpful. From the AATA staff to the Art Therapy Credentials Board they have always assisted the New Mexico Board with any questions brought to them. As one counselor highly regarded locally and nationally wrote, "From my perspective as a member of the LPCC Standards Committee, I believe that of all of the groups they [the art therapists] have demonstrated the highest level of professionalism and genuine collaborative spirit."

Over 3500 individuals applied for licenses in New Mexico, twice as many as had been anticipated. Of these approximately 10% to 15% were art therapy licenses. A majority of these applications were from outside New Mexico, a strong indicator of how important the licensing issue is. At an international conference I attended last fall, deregulation, standardizations set by the trade, and a trend to consolidate and reduce the number of licensing boards were primary topics of concern. In the near future I do not anticipate any less concern with licensing or professional regulation.

I am currently following up with a Medicaid/Medicare Task Force that is debating whether or not to specify art therapists as providers. The hopes of many art therapists (which were the same for social workers, counselors, and marriage and family therapists) is that licensure will provide more third-party payor reimbursements. Although this can occur (as exemplified by social workers' licensing and certification efforts), it is not a guarantee that we will be identified professional providers. However, it does guarantee that program administrators become more familiar with the professional aspects of art therapists. In our state, which has a reputation for being "artsy", where art as a cultural necessity is not questioned, it did mean an increased awareness—not everyone who packs a paintbrush or has kids draw their feelings should be considered clinically viable. It means that to a certain extent, validity to the profession has substantially been heightened and that qualified art therapists are more likely to be considered for clinical positions than those purporting to be artists-as-therapists. It also means that the public is better protected against individuals who may use art to open up past wounds or trauma and that they won't be abandoned because the therapist doesn't have the training necessary to follow up with an individual.

Although much of the work had occurred when the rules and regulations had been published, applications distributed, and licenses awarded, this was only the beginning. Since July, we have established a Code of Conduct that all licensees must adhere to, and, most recently, a Complaints Committee that includes legal counsel was created to review reports of unethical conduct within the profession.

In the last month, with the advent of a new administration that views licensing and regulation somewhat differently than in the past, we have been involved in evaluating how the board can become more proactive in dealing with future bills that would greatly affect how the board operates. Already this year new legislation has been introduced regarding peer counseling, exemptions and the addition of other types of counseling professions to the board, however, the board had not been consulted about these proposals. After only two years in operation, the board has begun to realize the scope of its responsibilities, and I feel sure there is even more in store for us in the future.

Since we have come so far in licensing art therapists, the singularly most often asked question I receive is, "Should I apply for the New Mexico license?" My reply reflects what we are learning from applicants across the country. We have received applications from individuals in states that do not recognize art therapists in a current counseling or therapy licensing act and ones where there are measures to reduce the scope of professional practice. In states that currently have licensing bills including or referring to art therapy licensing, reciprocity is a reason to apply. And for individuals working with EAPs or agencies that receive professional referrals, a license number is all that is usually required by insurance companies for reimbursement of special services.

The ongoing issue remains: Does licensing standardize a profession that was born out of respecting the uniqueness of the individual? The education I have received as a licensing board member has at least settled this issue in my mind for now. We as therapists have an enormous responsibility to those we treat. Part of this obligation can be met by keeping abreast of the issues and new theories in the field, not just in art therapy, but in the mental health field in general because we do not live and work in a vacuum. Expectations of professionalism do not diminish the creative process that can be enlightening or healing; rather, it asks us only to be more accountable for our actions and recognize our limits. It also serves as a reminder that good business practice reflects, overall, an awareness of good ethical practice. I have not found licensing to be an inhibitor to therapeutic style. If anything, licensing encourages one to grow and find one's own best therapeutic style by expecting the professional to participate in the therapeutic community and to be part of the continuum of that learning process.

Reference

Good, D. (1993). The history of art therapy licensure in New Mexico. *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 136-140.

Echoes Of The Renaissance
SCHOOL OF FINE ARTS
CARROLL N. JONES JR.
A Complete Step By Step Video Guide To Renaissance Painting:

"Alicia"

Tape 1: Theory of Light and Shade
Cast Drawing · Perspective · Proportion · Still Life Drawing
Tape 2: Canvas Stretching · Drawing on Canvas
Fixing and Toning · Under Painting · Egg Emulsion Tempera
Tape 3: Color Theory and Mixing
Application of Color to Still Life
The complete "Echoes Of The Renaissance"
Video series of 3 tapes can be purchased for $179.95
plus $9.00 UPS postage and handling
(For Vermonters add 5% sales tax.)
Individual tapes may be purchased for $69.95
plus $3.00 per tape for UPS postage and handling
Please make checks payable to: Echoes Of The Renaissance
and send your order to:
Carroll N. Jones Jr. PO Box 1041 Stowe ,VT., 05672, (802) 253 8089

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 12(2) pp. 104-110 © AATA, Inc. 1995

Building Bridges Within the Culture of Pediatric Medicine: The Interface of Art Therapy and Child Life Programming

Diane C. Rode, MPS, A.T.R., New York, NY

Abstract

This article discusses the interface between art therapy and the parallel profession of child life. A collaboration between these two disciplines within a pediatric medical setting encourages optimal adjustment for patients and families based on a thorough perception of the individual child's psychosocial reality and illness. Art therapists must acknowledge and build on current literature, national policies, and programming related to the psychosocial needs of children and families during illness and hospitalization. Art therapists practicing in pediatric medical settings are encouraged to broaden their ability to use a wide range of art and play modalities to reach the broadest range of patients and families.

Introduction

Serious illness in childhood and adolescence inevitably requires hospitalization. Life-threatening, chronic illnesses often require multiple, ongoing hospital admissions causing a potential disruption to growth, development, and family and social interactions. Reviews of the literature in 1965 (Vernon, Foley, Sipowicz, & Schulman) and 1985 (Thompson) reveal nearly 500 articles and studies examining children's psychological responses to hospitalization. The literature describes how the experiences of illness and hospitalization can be disruptive and have the potential to negatively influence a child's future psychosocial development. The literature also focuses on the importance of providing developmentally based interventions to prevent or mitigate undue distress (Prugh, Staub, Sands, Kirschbaum, & Lenihan, 1953; Plank, 1971; Hardgrove & Dawson, 1972; Petrillo & Sanger, 1980; Thompson & Sandford, 1981; Bolig & Gnezda, 1984; Goldberger, 1988; Gaynard et al., 1990). Golden (1983) identifies three major sources of stress in children who are ill and require hospitalization. These are related to (a) separation from parents and necessary relocation to a new environment, (b) loss of autonomy and control, and (c) fear of bodily harm and/or death.

Heightened awareness of the psychosocial needs of children and families in the health care setting has had "a profound effect on the shape and function of pediatric units in the hospital. Physical recovery that leaves emotional scars in its wake is now unacceptable in pediatric practice. General hospitals increasingly reflect sensitivity to children's needs for emotional comfort through the provision of accommodations for parents, playrooms, school programs, and carefully planned environmental design" (Wojtasik & Sanborn, 1991). The Association for the Care of Children's Health (ACCH), a multidisciplinary, international organization which promotes the psychosocial well-being of children and families in health care settings has articulated standards for pediatric "family centered care." Founded in 1965 by child health experts, ACCH fosters and promotes the health and well-being of children and families in health care settings through education, multidisciplinary interaction, and research. In its position paper on the care of children and families in health care settings (1977), the Association states: "Threats posed to the emotional security and development of many children and families by serious illness, disability, disfigurement, treatment, interrupted human relations, and nonsupportive human environments have been clearly demonstrated by worldwide research studies. The outcomes can range from temporary but frequently overwhelming anxiety and emotional suffering to longstanding or permanent developmental handicaps. Closer contact with the emotional life of children, increased parent involvement, and communication amongst professionals have contributed to greater understanding as well as to improvements of care." For all pediatric environments ACCH strongly endorses the provision of "readily accessible, well-designed space, equipment and programs for the wide range of play, educational, and social activities which are essential to all children and adolescents."

In its *Handbook of Hospital Care for Children and Youth* (1986), the Academy of Pediatrics recommends that all institutions with 10 or more pediatric beds create programs addressing the emotional and developmental needs of children. The child life profession has developed during the past 25 years in response to the needs of children and families for developmentally specific psychosocial services in the context of hospitalization and illness. The child life specialist joins the pediatrician, the child psychiatrist, the pediatric nurse, and the medical social worker in a multidisciplinary approach to offering comprehensive services within pediatrics. Child life specialists use play to provide developmentally appropriate, normalizing, and educational experiences to children during hospitalization and illness. Child life programs strive to promote optimum development of children, adolescents, and families, to maintain normal living patterns, and to minimize psychological trauma (*Child Life Position Paper*, 1979). Through play, child life staff provide opportunities for mastery, learning, self-expression, family involvement, and peer interaction. The ACCH articulates three essential goals of child life programs in pediatric settings: to minimize stress and anxiety, to provide "essential life experiences"; and to provide opportunities to retain self-esteem and appropriate independence. As elaborated in the *Child Life Position Paper* (1979), each of these goals is related to the provision of "abundant play opportunities." Both arts therapists and child life specialists can share these goals and find dynamic ways to collaborate within the pediatric setting.

Creative Arts Therapy in Pediatrics

What is the role of the art therapist in the multidisciplinary milieu of the pediatric medical/surgical setting? How can the art therapist interact and collaborate with child life programming which focuses on "therapeutic play" as its primary intervention modality?

In the current discourse within the field of art therapy regarding art in pediatric medicine, there has been an absence of reference or relationship to the established psychosocial care practices and literature described above. In our own literature regarding pediatrics and medicine, art therapists have shown an interest in demonstrating the "efficacy of art therapy" (Council, 1993) with specific illness populations or in describing "applications" of art therapy. In a recent special issue of *Art Therapy* (Vol. 10, No. 2) dedicated to art and medicine, the term *medical art therapy* described the "specific use of art therapy with individuals who are physically ill, experiencing trauma to the body, or undergoing aggressive medical treatment such as surgery or chemotherapy" (Malchiodi, 1993). Although it is obviously of some value for art therapists to articulate the applications and efficacy of our specific interventions in specific health care contexts, if we do so in a conceptual, philosophical, and clinical vacuum, we risk participating in what patients often experience as fragmented care. Art therapy interventions in the pediatric setting can be more effective when they are woven into the fabric of the environment, including the patient's relationships with hospital staff, the place of the medical unit, and the illness itself. Art therapists must find ways to develop and build professional identity within the context of the pediatric health care setting, and this development must begin by acknowledging what already exists in the literature, policies, and programming related to the psychosocial needs of children and families during illness and hospitalization.

As an art therapist, child life specialist, and director of the Creative Arts Child Life Program in an urban medical center, I have learned the value of a perspective and approach which embraces multidisciplinary programming in this setting. The interfacing of child life and art therapy in our program reflects a commitment to "family-centered care" (Johnson et al, 1992) and to eclectic creative arts programming designed to address the needs of a variety of children, adolescents, and their families. Through this interface, we have been able to explore a dynamic interrelatedness between professions based on a common philosophy of comprehensive, creative, and developmentally focused family-centered care programming. Child life and the creative arts therapies as interconnected, parallel professions can build bridges within the culture of the medical environment to meet the psychosocial needs of hospitalized children and their families through art and play.

The Culture of the Pediatric Environment

To elaborate art therapy's role in the context of illness and medicine with any population, art therapists should first investigate the culture-creating conditions of illness and the hospital environment itself. The hospital environment, with its specific health care staff and unfamiliar routines and technology, is a unique culture. "A patient admitted to the hospital leaves his/her normal life behind, and enters a state of limbo characterized by a sense of vulnerability and danger. As with other institutions, such as the Army or prison, patients undergo a standardized ritual of entry, by which they are divested of many of the props of their social identity. Their clothing is removed, and replaced by a uniform of bathrobe and slippers. In the ward they are allocated a number, and transformed into a 'case' for diagnosis and treatment" (Helman, 1990, p. 203). In a pediatric medical environment, where many of these events are perceived as threatening and nearly everything is out of the child's control, a physically ill youngster and his or her family may easily feel intimidated or disempowered by the collective "culture" that the hospital represents.

The importance of considering culture and values in the context of art therapy practice was featured in a recent issue of *Art Therapy* (Vol. 11, No. 3). It reminded us of our often neglected responsibility to perceive and respond to the culturally shaped dimensions of our patient's experience. The pediatric medical setting can constellate a "culturally shaped dimension of experience" for patients and families, one which must be addressed to facilitate optimal coping and adjustment. Here, the art therapist is uniquely equipped to encourage imaginal expression regarding the experience of both illness and health within or outside the insitutional health care environment. "Although as art therapists we deal with all the factors that shape an individual personality, our special facility is our fluency in visual expression and communication. Culture is a powerful influence on visual language" (Cattaneo, 1994, p. 184).

Since the medical/surgical setting constitutes the cultural reality in which a child and family are immersed during illness, art therapists must begin to conceptualize their role by recognizing the fundamental effect of the setting in which they encounter the patient. Within that setting, perhaps the interpersonal interactions with health care staff have the greatest potential to impact a patient and family's potential for coping and adjustment. Where interventions are collaborative and comprehensive in multidisciplinary efforts, children and families experience a coherence in care designed to address the developmental, psychological, social, spiritual, and cultural dimensions of their worlds.

The Interface of Child Life and Creative Arts Therapy in Pediatrics

Winnicott (1971) commented about play and creativity: "It is creative apperception more than anything else that makes the individual feel that life is worth living" (p. 41), and "Play is universal; it belongs to health: playing facilitates growth and therefore health; playing leads into group rela-

BEST COPY AVAILABLE

tions; playing can be a form of communication in psychotherapy; playing involves the body; it is in playing, and perhaps only in playing, that the child or the adult is free to be creative" (p. 65). Art therapists and child life specialists share a primary concern: How, through play (and play always involves the creative arts), does the physically ill child experience meaning and a sense of continuity of living? How can both professions join forces to create programming which encourages the child and family to maintain a relationship to their creativity and imagination during the experience of illness and hospitalization?

It is the unique role of the art therapist in the culture of pediatric illness and health care to address this need to engage and preserve imagination for the physically ill child. Hillman's term *arts therapies* (1993) advocates for the use of *all* of the expressive arts: visual arts, music, movement, video, creative writing; "arts therapies" refer to creative acts entered into with the goal of stimulating or engaging imagination. Hillman's idea is that we "engage in *arts* therapy not directly for art, or for the person, or for the emotion, but for the imagination" (1993).

A first step in conceptualizing an interface between creative arts and child life programming in a pediatric medical setting is in understanding the place (or function) of the arts, creativity, and imagination in human life, both practically and psychologically. Art therapists can then begin to appreciate the importance of establishing an environment, a space (imaginally, intellectually, and literally) for patients and families within the hospital setting which allows for a broad range of creative arts expression and play. Within the context of a collaborative approach, art therapists can offer play experiences through a wide variety of creative arts modalities to create a transitional space in which the child, the family, and even the health care staff can experience a sense of "order and connectedness," even in the face of serious illness.

In the hospital setting, art therapists and child life specialists often function as translators of experience. They search, with the patient and family, for play or art modalities that will stimulate imagination and create a transitional space. Then, in the transitional space facilitated by a creative arts experience such as music, drawing, or sculpture, the child can begin to create a dialogue between the inner experiences of illness and hospitalization and the outer world in which he or she lives. Through creative activities a child can access and give form to inner fantasies, concerns, meaning, and even resources related to the experience. Through a collaborative, multidisciplinary approach, art therapists seek to perceive the unique ways in which a patient or family is dealing with the experience of illness and hospitalization and work to translate this information into clarifying communication with health care providers and supportive responses to the patient/family.

The Arts in Action: A Child Life Creative Arts Therapy Program

The primary goal of both creative arts and child life programming in our pediatric medical/surgical setting is to protect and enhance the emotional, social, cognitive, creative, and imaginal integrity of children undergoing the stress of illness and hospitalization. To this end, the program plans and implements diagnostic, supportive, educational, therapeutic, and preventive programs for children and families individually and in specifically designed groups. The Child Life Creative Arts staff endeavors to facilitate and encourage positive coping strategies in children and families as they encounter the wide range of illness-related experiences that occur in the hospital setting.

Children from birth through adolescence are included in the child life program's services on all inpatient units (85 beds) and in two special care units as well as several outpatient programs. The program focuses on the relationship of creativity and imagination to illness and the recuperative experience. The staff is committed to the principles set forth by the Association for the Care of Children's Health and the Child Life Council's philosophy which emphasize family-centered care and psychosocial support via preparation, education, and play opportunities. The staff believe that the dimension of play and our expertise in this sometimes misunderstood domain is the central, most important aspect of our work with children. Play and the related springs of creativity and imagination are the primary realms in which the Child Life Creative Arts staff makes contact with, supports, encourages adjustment, and educates children and families during hospitalization.

The arts play a substantial role in the child life program. Eighty percent of the child life specialists in the program are also Registered Art Therapists (A.T.R.s). The staff is supplemented by artist-in-residence consultants, including video artists, musicians, puppet specialists, a media/computer resource specialist, and a horticulture therapist. There is a formal, intensive training internship and fellowship program for creative arts therapists and child life specialists. This rich tapestry of diverse and talented personnel makes for a dynamic and innovative program which utilizes many creative arts modalities and offers a wide range of programming for patients in both individual and group contexts.

Although the staff seeks to meet the specific learning and therapeutic needs of individual patients and families, the Child Life Creative Arts staff focuses on interventions which attempt to create a sense of community and relationship to the environment. In addition to facilitating open play sessions in three play spaces, they lead daily structured activities including art, performance groups, music, cooking, gardening, puppet play, computer, "hospital bingo," rap, and a weekly "Good Day Show" in which patients function as hosts, audience members, and puppet assistants to create "Ask the Doctor" interviews featuring staff physicians and nurses. Much of this programming seeks to facilitate relationships among patients, families, and health care professionals in the pediatric setting. Nurses and physicians are invited regularly to join specialists and art therapists in playroom activities as "assistants" or "special guests."

Over the years, experimentation between staff specialists and art therapists has resulted in innovative programming with a wide variety of modalities and processes. Video work with patients and families is an example of one such process which has developed into important programming in this setting. Over the years patients have participated in video performance forms from video diaries, to video poems, to more formal efforts in the patient production company, "Through Our Eyes Productions." In this collaborative video production program, patients function as video producers to document their experiences and perspectives on coping with illness and hospitalization. Through this process, patient producers educate and inform fellow patients, families, and health care providers about their coping strategies, concerns, and experiences living with illness.

In these full-feature videos, interested patients work in therapeutic video workshops with a team of child life, art therapists, and video artists. Finished productions range from documentary-style works to short educational videos about specific medical procedures. These are then available for patient education efforts in our own institution and for national distribution. More intimate, interpersonal video programming also exists, for example patients use the video and sand tray modalities to create short, impressionistic "video poems" of their hospital experience for themselves only. Video has become a prominent tool because of its success and popularity with patients and families and also because of the wide range of modalities it can embrace: art, music, movement, and dramatic representation, to name a few.

Creative Arts Processes in Pediatric Settings

I once worked with a mother from Peru whose one-year-old child was dying from bone cancer. She spoke no English and was with her child, alone in this country, for an entire year. In my broken Spanish I tried to communicate with her and find a way to be helpful. We worked together to find soothing physical ways for her to hold her child and to otherwise continue general parenting functions during his illness. We spent long sessions with her son in the rocking chair, quietly rocking and watching him. One day she interrupted the silence of our sessions by saying, "I want to find something to do." She knew I worked in the art room and asked to come and look at the materials. She chose fabric, yarn, and sewing materials and began a year-long project of creating dolls for the parents of children on the unit. Using her sewing skills, she was able to enter what she described as a "meditative state" while sewing and creating many expressive doll figures. Each doll was dressed differently in handmade clothes, and each face was created with a different expression—some joyful, others sad and pensive, some sleeping. She allowed parents to choose a doll from her growing selection. She eventually began a parents' sewing circle in which she taught others to sew dolls. Through her sewing art activity, this mother was able to give her waiting, her many emotions, and her need to experience a sense of community a *form* in the hospital environment. She was also able to experience a sense of purpose and usefulness through her creative arts process.

Lewis Thomas observes, "The thing we are really good at as a species is usefulness. If we paid more attention to this biological attribute, we'd get a satisfaction that cannot be attained through goods or knowledge. Plain usefulness!" (*New York Times*, November 21, 1993) These words remind us of one of the important functions of the arts in our work with pediatric patients and families. The impulse to be of some use, to "make a mark" (as a child with cystic fibrosis once put it), to have a purpose even during illness is an important desire patients often express. Patients realize this desire by hanging artwork, performing music for each other, "decorating" the units, participating in community cooking groups, tending the unit's garden, creating videos for other patients, and working on patient newsletters.

Dissanayake (1992) argues for a view of art-making and creative expression as an "inherent, universal, and biological trait of the human species." She explores the anthropological meaning and function of "the arts" in small scale, premodern societies: "There, while there is no abstract concept of "art," *everyone may be an artist*—decorating their bodies and possessions, dancing, singing, versifying, performing—even when some persons are acknowledged as being more talented or skillful than others. In these technologically simpler societies, the arts are invariably and inseparably part of ritual ceremonies that articulate, express, and reinforce a group's deepest beliefs and concerns. As a vehicle for group meaning and a galvanizer of group one-heartedness, art-conjoined-with-ritual is essential to group survival—quite literally art for life's sake" (1992).

In her "paleoanthropsychobiological" view, Dissanayake understands art as a "behavior of making special," which is a fundamental human proclivity or need. "The arts have always been with us. So have ideas of beauty, sublimity, and transcendence, along with verities of the human condition: love, death, memory, suffering, loss, desire, reprieve, and hope. These have been the subject matter of and occasion for the arts throughout human history . . ." (p. 175). During hospitalization, patients and families often express frustration and a sense of diminishment or disempowerment. In the literal and psychological environment of the hospital, with its high technology and specialist medical staff who are often perceived as not "related," the arts offer the opportunity to create community and re-empower individuals. Creative arts processes offer more than "normalizing" or diversionary experiences during hospitalization; creative arts activities provide patients and families with the means to engage in this "fundamental human proclivity" and dialogue with some of illness's essential themes: loss, mortality, vitality, and transcendence.

In observing the energy and desire that a physically ill child brings to his or her involvement in a creative arts/play process, sometimes despite physical pain, art therapists come to understand something of this impulse, this propensity to "make special," to engage in art and imagination. Broyard (1992) observed, "The sick person's best medicine is desire—the desire to live, to be with other people, to do things. I'd like to suggest, to invent or imagine or recall, ways of keeping one's desire alive as a way of keeping one's self alive" (p. 63). These deceptively simple pursuits of stimulating or facilitating desire and the capacity to "make special" are perhaps the cornerstones of our work with the physically ill child and the creative arts.

Time and time again, those art therapists who work in pediatric medical settings are moved or surprised or inspired by the resilience that children often demonstrate in the face of illness. This capacity for resilience and maintaining a sense of being in the world *and* dealing with the illness at the same time very often is related to the child's relationship to his or her imaginative life. Often intuitively children make use of creative arts experiences to process the problem of their illness and the often restrictive experience of hospitalization. Hillman notes, "We live imagination, not just life, for even 'life' with its problems and troubles is a specifically organized narrative of experience, a way of styling and imagining. . . . We must discover the imagination shaping and informing the problems and then work them out on the level of images" (1989, p. 103). "Working out" problems on the level of images points us again towards an art approach, as images take unlimited varieties of form via materials and modalities.

As facilitators of these processes, creative arts therapists must approach their patients with a familiarity with various modalities, an openness to experience unknown forms (we will not always recognize or be personally comfortable with each patient's form of choice), and a capacity to relate to our own imaginative awareness of the context in which we work.

Case Example

How does a perspective which embraces these philosophical thoughts about imagination, illness, and art assist the art therapist in pediatric practice? How does one "follow the patient's lead" and allow the patient and the illness to determine the modalities and the processes which will invite the child to, as Broyard says, "dance his condition" (1992).? The clinical case described here illustrates how the therapist's capacity to be open to the movements of the patient's imagination is an important and often fruitful beginning. The child life specialist who worked with this child is also a Registered Art Therapist and will be referred to throughout the case as the "therapist."

Valerie was 10 years old when she was brought by her grandmother who had raised her from the West coast of Africa to our busy urban medical center in New York. Ongoing pain in her throat, unable to be diagnosed in her small town, created a fatigue and weakness that concerned Valerie's grandmother. After a reunion with her birth mother whom she had never met, Valerie's throat condition worsened until fever and pain demanded hospitalization. In intensive care following exploratory surgery and diagnostic tests, Valerie was diagnosed with Rhabdo sarcoma. Her prognosis was poor.

Valerie spent the next year primarily living in the pediatric medical/surgical unit and receiving chemotherapy and radiation treatments. In the beginning of her ordeal she was frightened and withdrawn, unable to leave her room because of her lowered immune system. In early art and play therapy sessions at her bedside, Valerie did not relate well and was lethargic and unable to use any materials in expressive activities. She was soon diagnosed with clinical depression which was clearly a result of struggling physically with a sudden catastrophic illness, separation from her country and familiar surroundings, and ongoing isolation in a private hospital room. Her grandmother described her as a very dynamic and creative child who loved art and dance prior to her illness.

For several weeks Valerie remained unable to engage in the arts activities offered by the therapist. It wasn't until the therapist began to talk with Valerie about her country and what her life was like there that she began to relate more actively in conversation. Remembering Valerie's interest in dance, the therapist wondered if she might be interested in doing a small demonstration of dance steps from her African town to teach the therapist during their sessions alone in the room. Surprisingly, Valerie was very interested in demonstrating her dance talents and in instructing the therapist. Despite her weakened state Valerie gave daily "dance lessons" to her therapist, instructing her grandmother and mother to bring special audiotapes for the classes. For the month or so that she remained in isolation, Valerie continued her enthusiasm for the dance classes and for the regular performances she gave to the therapist. During this time, with a newly donated hand-held video camera, the therapist introduced Valerie to video technology. Valerie used the camera in a self-initiated program of recording her dance routines and introduced singing into the productions. She chose songs from her African homeland as well as American songs she was learning from television. She directed the therapist in the assigned job of camera work and in the task of presenting the video outside the room to staff and other patients so that they would "know who I am."

In the year that followed, Valerie remained hospitalized most of the time for chemotherapy treatments and multiple infections. She continued to mobilize her inner resources via her video and performance work. Staff and patients responded to Valerie's videotapes with admiration and enthusiasm, and she was able to establish and cultivate relationships with others from inside her room. When she was finally able to leave isolation and participate in activities, she took a leadership role with her peers and immersed herself in the unit's creative actiities led by child life including art, music, cooking, gardening, and video.

Throughout her hospitalization, which was the better part of a year, Valerie continued her work individually in child life art therapy sessions to create a "video diary" of song and dance performances. She would dress in special outfits and direct the therapist to document the dates and sequences of the pieces. She took particular pride in these video productions and often requested scheduled "screenings" so that other patients, staff, and her family could view her work.

Valerie's condition worsened after 9 months. The tumor in her throat began to grow despite the chemotherapy and radiation treatments. Valerie continued to sing in her productions until she was no longer able to produce sound vocally; she continued to dance her African traditional dances as well as experiment with newer American forms. For Valerie, the combined modalities of dance, song, and performance, which she engaged in throughout her illness, served as "metaphoric hammocks suspended between self and world" (Rose, 1980, pp. 11–12). Her performances for video provided her with a transitional space in which she could live, relate, and be seen even as her illness threatened to annihilate her body and her sense of self. The video modality allowed her to document and preserve her vibrancy, her connection to her lost country and life, and her relationship to her new cultures: her new country, the hospital setting, and the imaginal culture or "the land of the sick," which she now inhabited.

When Valerie was terminally ill and restricted to bed, unable to speak because of the size of the tumor growing now through her mouth, she directed her therapist to set up an ongoing screening of her video performances in her room. Although she did not explain her intention for this, the effect of the videos playing in this dying girl's room seemed to provide her family and those who had cared for her with an indelible impression of her creative, imaginative life in the face of illness. Her positioning of the VCR so that visitors were sitting near her while viewing the videos, but not focusing on her current physical dying condition also allowed her to control and choreograph her death so that it was infused with her life.

Discussion

In her video song and dance performances, as in her enthusiasm for creative activities on the unit, Valerie demonstrated an intimate relationship with both aspects of her existence: the disease which was progressing rapidly and the dynamism and vitality she experienced in her life and wanted others to relate to as well, even in her dying. Valerie employed a creative music and dance mode of expression from her life in her native Africa before illness and combined it with mastery of the previously unknown modality of video to "dance her condition" during her illness until her death. And after her death, she lives on through her video performances. In the words of her mother, "Valerie gave us the gift of her life preserved, so that now, even though I remember how much she suffered, I also see how much she lived."

Winnicott noted a wish as he imagined his own death: "Let me see. What was happening when I died? My prayer had been answered. I was alive when I died. That was all that I had asked and I had got it" (1971). Even when they are not facing an imminent death, children often seem able to spontaneously achieve this state of *living with* their illnesses in their ability to use play and creative arts expression to continue their lives in the face of illness. Hence, the role of creative arts therapists in this setting is to provide a rich and varied creative arts environment in which the children and their families can shape and form their lives and their style and make their own "mark" through their illnesses.

The work with Valerie evolved from her desire to participate in her illness and to make contact with others in the hospital setting. The presence of, and close collaboration with, child life staff and programming made it possible to create opportunities for Valerie to participate as fully as possible in life during her illness. Even in the face of debilitating illness, she was able to maintain a relationship with her life through both the video work and her participation (when physically possible) in daily child life activity groups. Art therapists in pediatric settings are in this way able to collaborate with child life programming and build comprehensive treatment plans to protect the psychological integrity of young patients.

At a recent American Art Therapy Association Conference (1993), James Hillman's keynote address argued for "arts therapies as the therapy of choice." He spoke of "facing the creative act" as fundamentally terrifying because we are facing inhuman forces. Illness, too, can be experienced as terrifying and as belonging to these realms of inhuman forces. "And so," Dr. Hillman said, "the patient needs an ally at his or her side so that he or she can go on imagining; only imagining can cure the damaged (or threatened) capacity to imagine."

In a medical setting with children, with play as the medium or mediating activity, art therapists strive to create opportunities for children and families to enter the experience of their illnesses within the context of their lives. They align with the patient to observe the illness and to devote time and space to allow it to tell its story. They provide tools and materials so that it might, in its own way, describe its condition.

During his difficult illness, Broyard (1992) wrote of the "imaginative life of the sick." He said, "Always in emergencies we invent stories. We describe what is happening as if to confine the catastrophe. The patient's narrative keeps him from falling out of his life and into his illness. Like a great novelist, he gives his anxiety a shape" (p. 19). When children and families interact with creative arts modalities to find and shape images which describe or respond to their illness, they are able to participate in their illnesses without "falling into" them. As art therapists collaborating with child life specialists, we are able to encourage this dialogue, this preservation of imagination, in our *attending* to the imaginative lives of our patients. The original meaning of the Greek word for "therapy" (*therapia*) was "to serve, to foster, to nurture, or to *tend*." Art therapies along with child life programming in pediatric medical settings encourage and foster the imagination that exists in each child.

References

American Academy of Pediatrics Committee on Hospital Care. (1986). *Handbook of hospital care for children and youth*. Evanston, IL: Author.

Association for the Care of Children's Health. (1977). *Position paper on policies for the care of children and families in health care settings*. Washington, DC: Author.

Association for the Care of Children's Health. (1979). *Child life position paper*. Washington, DC: Author.

Boling, R., & Gnezda, M. T. (1984). A cognitive-affective approach to child life programming for young children. *Children's Health Care: Journal of the Association for the Care of Children's Health, 12*, 122–129.

Broyard, A. (1992). *Intoxicated by my illness*. New York: Clarkson Potter.

Cattaneo, M. (1994). Addressing culture and values in the training of art therapists. *American Journal of Art Therapy, 11*(3), 184–186.

Councill, T. (1993). Art therapy with pediatric cancer patients. *American Journal of Art Therapy, 10*, 78–87.

Dissanayake, E. (1992). Art for life's sake. *Art Therapy: Journal of the American Art Therapy Association, 9*(4), 169–175.

Dissanayake, E. (1992). *Homo aestheticus: Where art comes from and why*. New York: The Free Press.

Gaynard, L., Wolfer, J., Thompson, R., Redburn, L., & Laidley, L. (1990). *Psychosocial care of children in hospitals: Clinical practice manual from the ACCH child life research project*. Washington, DC: ACCH.

Goldberger, J. (1988). Issue-specific play with infants and toddlers in hospitals: Rationale and interventions. *Children's Health Care: Journal of the Association for the Care of Children's Health, 16*, 134–141.

Golden, D. B. (1983). Play therapy for hospitalized children. In C. E. Schaefer & K. J. O'Connor (Eds.), *Handbook of Play Therapy* (pp. 213–233). New York: John Wiley & Sons.

Hardgrove, C. B., & Dawson, R. B. (1972). Parents and children in the hospital. Boston: Little, Brown. *Joint Commission on the Accreditation of Healthcare Organizations*. (1989). Accreditation Manuals for Hospitals, 1990. Chicago: Author.

Helman, C. G. (1990). *Culture, health, and illness*. Oxford, England: Butterworth-Heinemon.

Hillman, J. (1989). *A blue fire*. New York: Harper & Row.

Hillman, J. (1993, November). *You can't fix it—And besides it ain't broke*. Keynote Address presented at the American Art Therapy Association 24th Annual Conference, Atlanta.

Johnson, B., Jeppson, E., & Redburn, L. (1992). *Caring for children and families: Guidelines for hospitals*. Bethesda, MD: ACCH.

BEST COPY AVAILABLE

Malchiodi, C. (1993). Introduction to special issue: Art and medicine. *American Journal of Art Therapy, 10*(2), 66–69.

Petrillo, M., & Sanger, S. (1980). *Emotional care of hospitalized children.* Philadelphia: Lippincott.

Piaget, J. (1951). *Play, dreams and imitation in childhood.* New York: W. W. Norton.

Plank, E. N. (1971). *Working with children in hospitals.* Cleveland: Press of Case Western Reserve University.

Prugh, D. G., Staub, E., Sands, H. H., Kirschbaum, R. J., & Lenihan, E. A. (1953). A study of the emotional reactions of children and families to hospitalization and illness. *American Journal of Orthopsychiatry, 23,* 78.

Rose, G. (1980). *The power of form.* New York: International Universities Press.

Rosenblatt, R. (1993, November 21). Lewis Thomas. *New York Times Magazine,* 50–53.

Thompson, R. H. (1985). *Psychosocial research on pediatric hospitalization and health care: A review of the literature.* Springfield, IL: Charles C Thomas.

Thompson, R. H., & Sanford, G. (1981). *Child life in hospitals.* Springfield, IL: Charles C Thomas.

Vernon, D. T. A., Foley, J. M., Sipowicz, R. R., & Schulman, J. L. (1965). The psychological responses of children to hospitalization and illness. Springfield, IL: Charles C Thomas.

Winnicott, D. W. (1971). *Playing and reality.* London: Tavistock.

Wojtasik, S., & Sanborn, S. (1991). In N. Boyd (Ed.), *Play therapy with children in crisis* (pp. 259–309). New York: NY Guilford Press.

Art Therapy: Journal of the American Art Therapy Association, 12(2) pp. 111-117 © AATA, Inc. 1995

Clinical Application of the "Scribble Technique" with Adults in an Acute Inpatient Psychiatric Hospital

Michael J. Hanes, MAT, A.T.R.-BC, LPAT, Oklahoma City, OK

Abstract

The "scribble technique" described in Florence Cane's book, **The Artist in Each of Us,** *(1983) has historically been employed by art therapists as a technique to reduce inhibitions and liberate spontaneous imagery from the unconscious. The author reviews the "scribble technique" procedure and presents examples produced by adult patients in an acute inpatient psychiatric hospital. The examples illustrate how the "scribble technique" can be utilized to empower the client to produce spontaneous imagery from the unconscious and overcome apprehension toward the image-making process.*

Introduction

Cane (1983) used the "scribble technique" as a kinesthetic method to facilitate the creative faculty within children. She alleges the creative capacity is innate and that it can be enticed through reassurance and by providing a favorable combination of circumstances. The "scribble technique" was utilized as a possible means of producing those circumstances conducive to creativity.

Naumburg (1987) later used her sister's technique along with the client's verbal associations as a means of acquiring insight into personal symbolism emerging in graphic content. The open-ended approach of this technique lends itself to projection and the liberation of unplanned and impromptu imagery. Oster and Gould (1987) state the "scribble technique" is "an entertaining, nonthreatening method to help individuals express outwardly those portions of their inner selves that they are reluctant to share" (p. 55). The use of a scribble allows the patient to bypass normal resistances in an attempt to approach and contact less conscious types of imagery (Rubin, 1984). Kwiatkowska (1978) states, "The accidental shapes have a good chance of evoking images from the unconscious, thus bringing into the open material that has been repressed" (p. 40).

The technique is an act of projection comparable to that of the Rorschach blots (Kramer, 1971). Like the inkblots, the scribble is ambiguous, nonthreatening ("anyone can scribble"), and does not elicit learned responses. The individual responds to the stimuli in a personal and unlearned fashion, whereas there are no expected or anticipated responses. Contrary to the inkblots, the "scribble technique" offers the client the opportunity to design his/her own unstructured stimulus upon which to project dormant imagery.

Winnicott (1971) introduced a technique similar to the "scribble technique" which he referred to as the "Squiggle Game." This technique required the child and clinician to alternately draw squiggly lines with the expectation that each would discover and complete an image from the other's squiggly line. Winnicott employed the technique as a method for communicating with a client and asserts the primary objective was not interpretation of the unconscious. Winnicott, who used the "Squiggle Game" as part of the "psychotherapeutic interview," felt the technique provided the individual the opportunity to reveal and communicate his or her current problems or emotional conflicts. Winnicott asserts, "In the therapeutic consultation the material becomes specific and acutely interesting since the client soon begins to feel that understanding may perhaps be available and that communication at a deeper level may become possible" (p. 7).

Materials

Media selection is an important consideration. Naumburg (1987) suggests the art media be simple for easy and quick manipulation, since most of the patients undertaking the art task have limited exposure to the art process. Wadeson (1987) asserts that art media which requires minimal preparation are more conducive to facilitating the emergence of unconscious and spontaneous imagery. Naumburg (1987) also proposes that certain semi-hard art materials are more suitable for releasing spontaneous art expressions. She recommends the use of semihard pastels and acrylic or tempera paints. Case and Dalley (1992) affirm that "paint has more subtle possibilities in aiding the expression of feelings than, for example, felt tip [markers]" (p. 104). Nevertheless, painting by brush may not lend itself efficiently to the production of a continuous and unbroken line. The paint brush may run out of color while in the process of forming the scribble and would impede the production of an uninterrupted line.

Materials that permit modification also allow for psychological insight into areas of difficulty which the patient is presently experiencing (Furth, 1988). I provide the client with a 2B pencil because of its ability to be modified. Pencils may also glide unhindered and consistently across the paper while forming the scribble. Other media such as conté and charcoal sticks do produce a consistent line; however, they do not provide the benefit of being eraseable. Wadeson (1987) generally avoids the use of pencils asserting that they lend themselves

---

Editor's note: Michael J. Hanes, MAT, A.T.R.-BC, LPAT, is Coordinator of Expressive Therapies at CPC Southwind Hospital in Oklahoma City, Oklahoma and an Adjunct Faculty at the University of Oklahoma.

to formality and constriction and attributes this phenomenon to their possible mental connection with writing. However, I have discovered that a series of aerial arm motions prior to completing the scribble reduces this potential association for some clients. On occasion I have observed clients discovering significant names or words "accidentally" drawn in the formation of the scribble. This occurrence may be attributed to the combination of pencil and aerial arm motions, which are associated with formal instruction in handwriting. Some clients have discovered that these significant names or words are messages from the unconscious which have sought expression through the random movements of their own arm and body. Case and Dalley (1992) affirm that words appearing in graphic material may be the client's attempt to draw the therapist's attention to something he/she wishes to address.

Additional factors contributing to media selection include drawing surface and coloration. The paper surface is the receptacle or container for the projected image. A small surface may be seen as constricting and incapable of containing the potential image; a large surface may be experienced as overwhelming, if the client feels compelled to fill the entire space. Therefore 18" × 24" paper seems to be a good size. Wadeson (1987) also advocates these dimensions because paper this size encourages expansiveness rather than constriction. Anything smaller may not be conducive to the production of a sweeping, free-flowing scribble.

Scribble drawings can be created with media such as crayons, cray-pas, and colored pencils, the latter allows for greater detail and shading and permits variance of color intensity. These qualities may yield significant information and draw attention to areas of conflict or importance (Furth, 1988). Dry media also is more controlled than wet or fluid media. Liebmann (1986) asserts that dry media provide safety and security for patients who are apprehensive about employing wet media or "losing control." Some psychiatric patients may find that pencil binds and limits their ability to respond to the scribble technique.

Procedure

The original scribble procedure began with a series of aerial arm motions performed in a sweeping rhythmic fashion. These warm-up rituals are preparation for the drawing of free-flowing lines on the paper. Cane (1983) contended that while expressing an idea through sketching, significant nerves in the shoulder conduct the message from the brain to the hand. Rhythmic arm motions are used to increase blood supply and reduce muscle tension, consequently accelerating the passage of the projected image. Oster and Gould (1987) note that the introduction of rhythmic arm motions is advantageous and contend that the use of aerial arm movements permits individuals to make less constricted scribbles. Some clients may be reluctant to participate in spontaneous arm movements. Cane (1983) employs a sequence of successive exercises which help to liberate spontaneity and build confidence. These elementary exercises consist of simple body movements needed to perform vertical, horizontal, and curved lines.

Steinhardt (1989) alleges the "scribble technique" later declined into a stereotyped procedure which no longer took into consideration the individual's natural body rhythm. The procedure became routine and its application complacent. The technique was "no longer created by free body movement but by random motions of the hand performed without pleasure or conviction" (Kramer, 1977, p. 11). Often the technique is employed without first introducing the rhythmic movements of the arm and body. This divergence from the original procedure may have been brought about by the wish to simplify and accelerate the procedure. The deviation may also be due to the therapist's need to avoid his/her own discomfort and/or the group's uneasiness and resistance to performing the aerial arm movements.

Upon completion of the rhythmic arm motions, the individual is encouraged to draw a continuous and unpremeditated fluid line. During this process the art media (e.g., crayon, chalk, etc.) continuously touches the paper. The resulting scribble may intersect many times forming an irregular and unpredictable pattern or design (Naumburg, 1987).

The person is instructed to stop when he/she feels that the scribble is complete. Ulman (1975) advocates interrupting the scribble at a juncture where the paper is reasonably covered with intersecting shapes, but prior to it becoming an unapproachable entanglement of lines. It is also advantageous not to disturb the person once he/she has engaged in the scribble process. To impede the activity results in the loss of valuable observational data and to interrupt this process would contaminate the client's spontaneous approach to the task.

The scribble may be made with eyes open or closed. Cane (1983) notes that closing the eyes obstructs the mind from consciously directing the hand to represent some customary object. Another variation of this technique encourages the individual to use his/her nondominant hand to assist in making an unconscious rhythmic pattern.

Having created the scribble, the individual is encouraged to review the shapes and forms brought about by the intersecting lines with the expectation of discovering some resemblance or approximation of an image. The individual may survey the scribble as a whole or concentrate on specific shapes and forms within the scribble. The paper can be rotated if the original position of the scribble is not suggestive of an image (Ulman, 1975). In the event the scribble still does not prompt an image, the scribble can be distanced from its creator and once more examined from all angles. This maneuver seems to detach the client from his/her scribble, permitting liberation of the scribble's not yet acknowledged content. Distancing provides separation and may promote a more open-minded point of view.

While developing the projected image, the individual may add as many lines as he/she wishes or obliterate those that obscure the primary image found in the initial scribble. Cane (1983) encouraged her students to emphasize or accentuate the principal lines in an attempt to bring forth the projected image. The completion of the picture may include using colors according to the personal wishes of the individual.

Occasionally no objects are seen by the client, and a design is created from the scribble by randomly filling in shapes with colored media (Figure 1). Kramer (1971) views this as "busy-work" and compares it to the traditional coloring book. It may also be a defensive response to the therapist's request

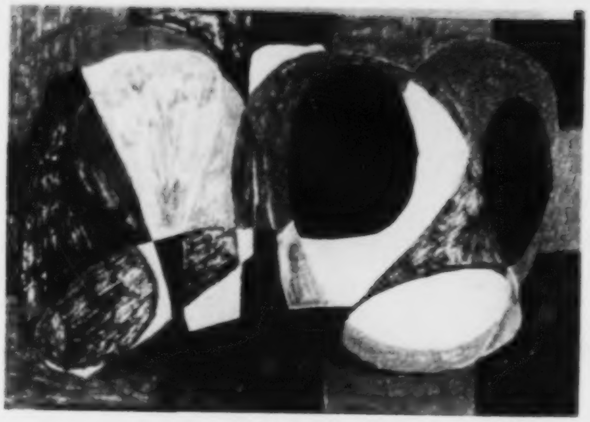


Figure 1.

to discover an image within the scribble. The mindless coloring of shapes allows the individual to remain detached from both thoughts and environment. Case (1990) asserts that "busy-ness does not allow a moment's expression of feeling or unwelcome thought" (p. 141).

At first glimpse the color design may seem meaningless, yet under closer scrutiny one will find several benefits to creating a design of randomly colored shapes. This process can be useful for liberating the individual from initial inhibitions and self-deterrence (Cane, 1983). The color design becomes a springboard from which the client can plunge into his/her creativity. The seemingly purposeless activity may also create an additional stimulus for releasing or projecting images from the unconscious. This is accomplished by encouraging the client to review the colored shapes in an attempt to discover some resemblance of a picture or object. Many times the client discovers that the randomly colored forms are not so "accidental," rather, they combined to form an image from the unconscious.

Sample Scribble Drawings

I obtained the following examples from adult patients participating in group art therapy in an acute inpatient psychiatric hospital. The group structure was what Liebmann (1986) refers to as "semi-open." The clients commit to attending regularly, but membership changed as patients were discharged and new individuals were admitted. A nondirective approach was employed in the sense that participants were provided a variety of art media and encouraged to use these according to their own choices and needs.

In the examples that follow, the clients were hesitant to engage in the art process because of artistic inadequacy, insecurity, and their reluctance to trust their creative faculty. The "scribble technique" was introduced as a means of providing a personal semistructure that would enable the client to bypass his or her feelings of apprehension and begin to approach the image-making process. By stimulating faith in the patient's own creativity, the therapist hoped that in subsequent sessions the patient would be able to employ the art materials without the need for themes or suggestions.

Case Example: Lea

Lea, a 38-year-old female, was admitted to the psychiatric hospital for treatment of a depressive episode coupled with a panic disorder. The client was divorced and had a 15-year-old son who resided with her former husband. Lea had suffered intermittently with battles of depression and anxiety for most of her adult life. The client remained in the hospital for 9 days, during which she attended two art therapy sessions.

In her initial session Lea was extremely hesitant to use the art materials and requested instruction and assistance from the therapist. Since the therapist's time with Lea was going to be limited, the "scribble technique" was utilized because of its minimal structure, artistically nonthreatening properties, and ability to swiftly access images from the unconscious. The scribble drawing also provides the client with the structure needed to develop an image independently from the therapist, hence reducing her reliance.

Lea performed the aerial arm motions in a rigid manner, possibly illustrating her controlled demeanor. Her scribble was completed in the same fashion, demonstrating her hesitancy and reluctance to permit her conscious defenses to abate. Initially she experienced difficulty discovering imagery within the scribble. She was encouraged to rotate the paper and eventually created the image in Figure 2.

Lea described the picture as "a shark searching in the dark ocean, twisting and turning, hunting for food." The shark image is sensual and ladened with sexual symbolism. There is a composite of both male and female elements. The whole shark can be interpreted as an immense penis, conceived as a menacing weapon with teeth. The shark's mouth is central to the picture and may represent vagina dentata (Figure 3), which is devouring the male organ. During the session the client disclosed that she had been involved in a homosexual relationship for the past 13 years; the relationship had recently been terminated by her lover. It is interesting to note there are 13 teeth in the mouth of the shark. Bach (1975) states that numbers of objects found in pictures often signify units of time in a person's life. The imagery may also illustrate her thoughts of castration and ambivalence towards her sexuality. This struggle is echoed in her second scribble drawing.

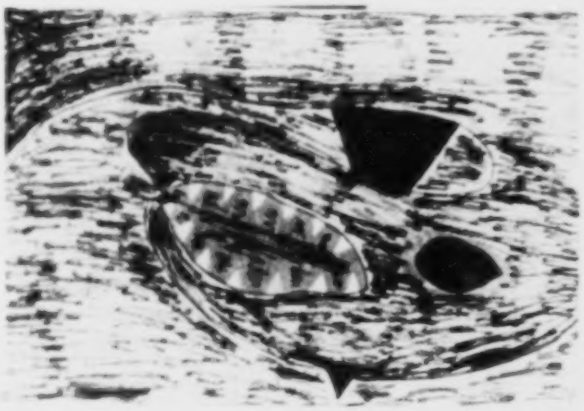


Figure 2.

BEST COPY AVAILABLE

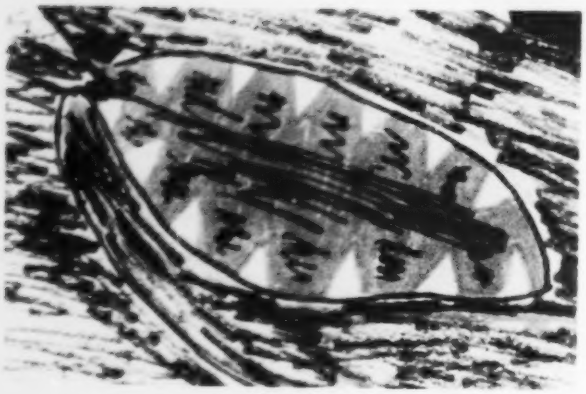


Figure 3.

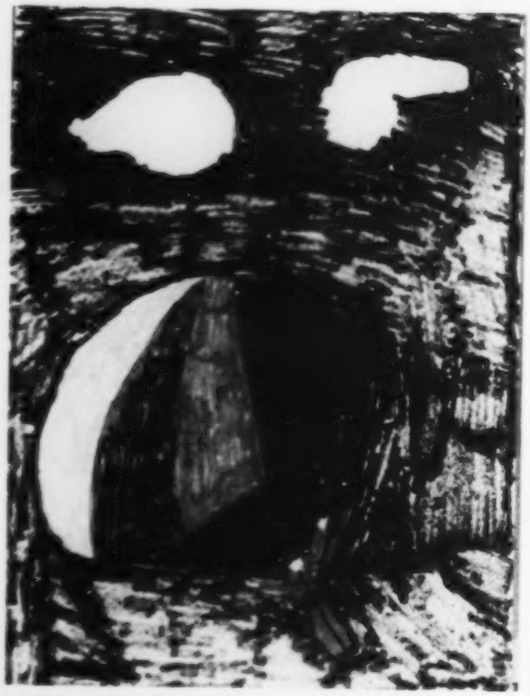


Figure 4.

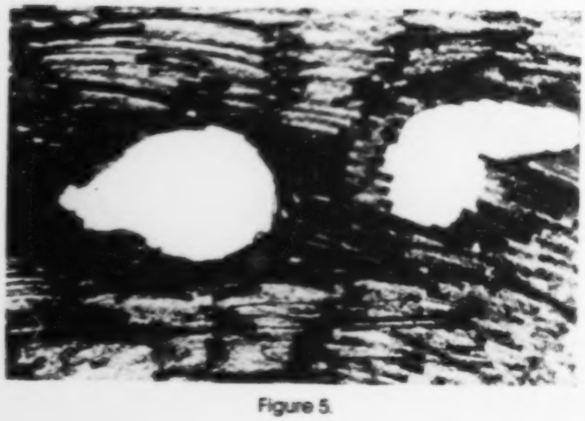


Figure 5.

possibly illustrating the client's transferred feelings onto the therapist for not adequately assisting and joining her therapeutic journey.

In her second art therapy session, Lea used the "scribble technique" to develop the image of a sky diver (Figure 4). On the back side of her paper she wrote, "The sky diver has free-fallen and opened his/her chute, floating freely and calmly toward land. The sky and clouds are beautiful and peaceful." However, the content of sky diving is not congruent with an individual suffering from panic attacks. Figure 5 reveals Lea's thoughts concerning her sexuality. The clouds contain both male and female elements, as did the shark in Figure 2. The clouds form a vagina and penis, and the male organ is facing away from the vaginal opening. This may illustrate her possible rejection of or conflict with heterosexuality. Upon completing the sky, Lea was astonished to discover the sexual significance of her clouds. She disclosed that her marriage and child were an attempt to thrust herself into accepting heterosexuality; however, she stated she felt most at ease with homosexuality.

Although the therapist's time with Lea was limited, the "scribble technique" was useful in helping the client to overcome her inhibitions regarding the art process and to initiate impromptu imagery. Lea was able to overcome her artistic insecurities and develop faith in her creative capacity by utilizing the semistructure of the "scribble technique." The projective qualities of the technique uncloaked feelings and thoughts overwise denied or repressed. The "scribble technique" provided a means of accessing and externalizing internal conflicts, whereupon she could begin to acknowledge and own her intense feelings towards her current and past relationships.

Case Example: John

John, a 42-year-old male, was admitted to the psychiatric hospital for treatment of a depressive episode. The client was divorced and had no children. John had been plagued by excessive feelings of worthlessness and inadequacy for most of his life. He had an extensive history of sexual abuse during his childhood, for which he harbored immense guilt. The client remained in the hospital for only 3 days during which he attended one art therapy session.

John was reluctant to engage the art media and, like Lea, requested instruction and direction from the therapist. He made aerial arm motions in a rigid and taut manner and his scribble was created in the same taut and hesitant fashion. While completing his scribble he asked repeatedly, "Am I doing this right?" further demonstrating his need for reassurance. Upon completing the scribble, John immediately discovered the image in Figure 6.

The client described the image as "a hot air balloon hiding in a valley from the swirling winds." His associations give the impression that John is literally attempting to stay "out of sight" or elude something or someone. The client disclosed to the group that he sought refuge from his problems by placing himself within the confines of the hospital. The menacing sky from which the hot air balloon seeks asylum may actually represent his psychic environment which he perceives as hostile and unpredictable. The viewer can see only the top portion of the hot air balloon, while the remaining part is obscured and protected by the mountains, suggesting John is attempting to keep something or someone concealed. Bertoia (1993) asserts that edging may be an attempt to deny or hide something from consciousness.

The hot air balloon may represent John's wish to ascend or seek a position of dominance or escape (Burns, 1982), yet it appears underinflated and somewhat flaccid or limp. This possibly illustrates his feelings of ineptness and dejection, hence his need to seek a place of refuge.

John terminated his treatment prematurely and discharged himself from the hospital against the recommendation of his psychiatrist and treatment team. John mentioned to the group that he had come to the hospital to seek refuge from his problems, consequently, his expeditious exit from the hospital implies he continues to flee from himself and his internal conflicts. Even though he attended only one art therapy session, the "scribble technique" was beneficial in helping him bypass his intense feelings of artistic inadequacy and create impromptu imagery.

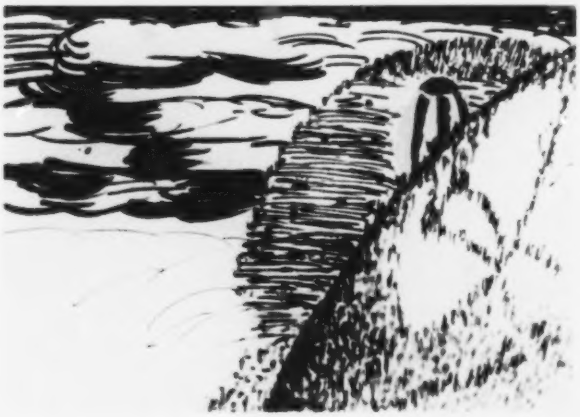


Figure 6.

Case Example: Mary

Mary, a 32-year-old female, admitted herself to the psychiatric facility for treatment of a depressive episode and marital discord. The client had been married approximately 9 years and had two children. She described her marriage as stormy and stated that her husband was both verbally and physically abusive. Over the past year the client had made several unsuccessful attempts to separate from her spouse. Mary was crippled by her low self-esteem and feelings of inferiority. She had no medical insurance; however, she was admitted to the hospital's 5-day charity bed, during which she attended two art therapy sessions.

The client voiced strong inadequacies regarding her artistic abilities and was opposed to engaging the art materials due to her dread of failure and performance anxiety. Her aerial arm motions were performed in a strangled and hesitant manner; however, the warm-up activities enabled her to orchestrate a flowing, unpremeditated scribble. She did not discover an image in the randomly formed shapes and requested to color the various patterns revealed in the scribble.

Upon completion of her design (Figure 1), Mary was encouraged to uncover an image or picture in the colored forms. She immediately discovered an image (Figure 8) which she described as "frightened and shocked." The alarming image

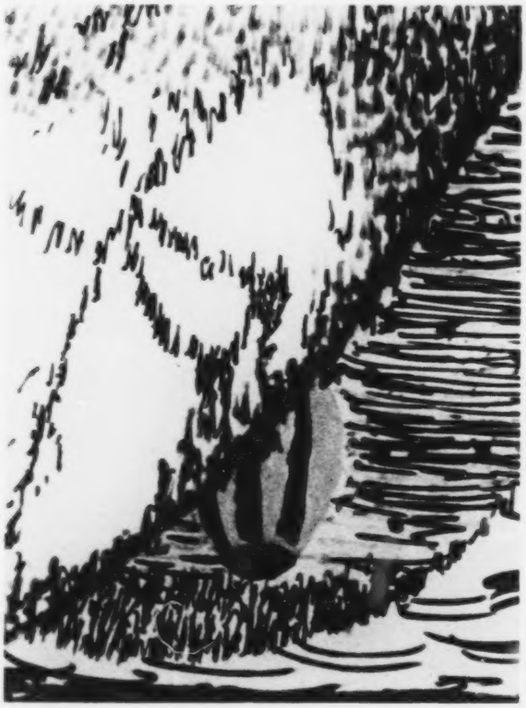


Figure 7.

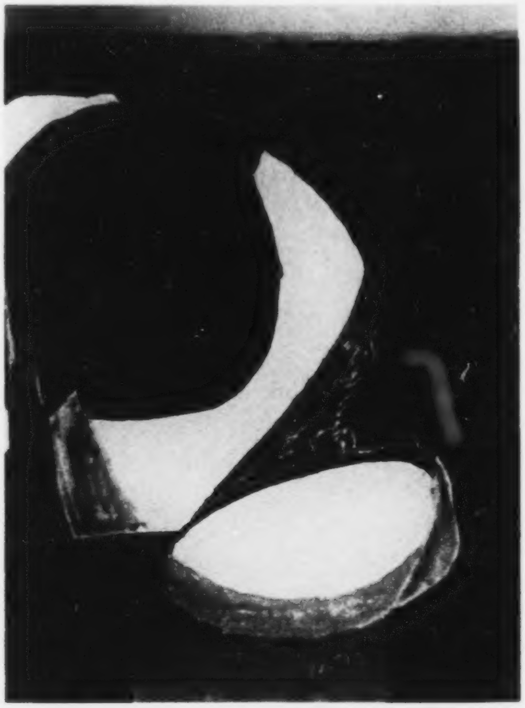


Figure 8.

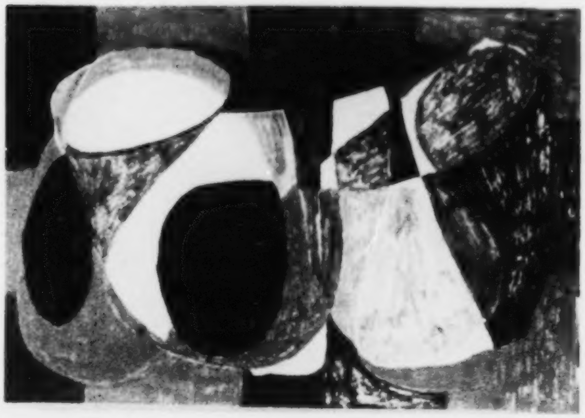


Figure 9.

enabled the client to begin disclosing her fears of being physically abused once again by her husband. The expression also depicts a sense of trauma and helplessness brought about by her husband's relentless physical abuse. When the color design was inverted (Figure 9), the client exposed the image of an erect male organ with testes. The dark circles were viewed as testicles and the softer colors around them as the scrotum. The erect penis protrudes in a penetrating posture. Mary became tearful as she disclosed to the group that her husband habitually compelled her to engage in nonconsenting intercourse.

The scribble technique was useful in helping Mary to overcome her inhibitions towards the art process, which were due to her feelings of failure and artistic inadequacies. The nonthreatening qualities of the technique encourage self-assurance and the production of impromptu imagery. Mary was able to utilize the art process to externalize her fears and pain, at which time she received acknowledgment and support from the group. In a subsequent session, she was less apprehensive about her artistic abilities and able to engage the art materials without the introduction of structure or a liberating theme. She continued to utilize the art process and group setting to explore the horrors of her abuse and find security and support.

Observations and Discussion

In the preceding examples, the "scribble technique" was employed to assist adult clients in overcoming their inhibitions regarding the art process and to elicit impromptu imagery. In each of the examples, the scribble technique was introduced during the client's initial art therapy session due to intense misgivings and apprehension towards the art process. Steinhardt (1989) promotes the use of an open-ended approach at the initial phase of therapy to establish the value of the creative process and the therapist's unconditional acceptance. It is in the initial art therapy session that most clients experience apprehension towards the art process due to their artistic insecurities. Denny (1975) also advocates using the scribble technique as a starting point in therapy with clients who feel intimidated by the art process and who have little conviction in their own creative faculty. The preceding case examples illustrate how the scribble technique can be applied as a means of bypassing performance anxiety and artistic insecurity, while simultaneously promoting the individual's creative capacity.

The open-ended approach of the scribble technique provided the guidance and structure sought by the clients, while at the same time promoting self-assurance and confidence in their own creativity. The scribble's ambiguity permits clients to use the task according to their own needs, rather than imposing excessive and unnecessary emotive themes that may be founded more on the therapist's own needs.

The clients were able to use the scribble technique to create spontaneous images which expressed feelings and thoughts otherwise denied or repressed. The projective properties of the scribble provided swift access to portions of their inner selves which they were reluctant to acknowledge. McNeilly (1983) warns that themes have the tendency to elicit feelings too abruptly, making it difficult for the group and therapist to embrace and comprehend the material; the scribble technique is no exception. In the preceding examples, clients brought forth unconscious material, it is then the therapist's responsibility to help the clients understand this material.

Additionally, the spontaneous images which emerged through the scribble technique enabled the preceding clients to develop faith in their own creativity and image-making process. They became springboards from which the clients were able to engage in the image-making process. The clients became less apprehensive towards the art process and were able to employ the art materials according to their own needs and wishes. Lastly, the scribble technique was useful in bypassing the clients' refusal to participate in the image-making process due to insecurities regarding the art process, discouraging the clients' possible premature termination of art therapy and permitting each individual the opportunity to address unique issues.

References

Bach, S. (1975). Spontaneous pictures of leukemic children as an expression of the total personality, mind, and body. *Acta Psychosomatica, 41*, 1–66.

Bertoia, J. (1993). *Drawings from a dying child. Insights into death from a Jungian perspective*. London: Routledge.

Burns, R. C. (1982). *Kinetic-House-Tree-Person Drawings (K-H-T-P): An interpretative manual*. New York: Brunner/Mazel.

Cane, F. (1983). *The artist in each of us* (rev. ed.). Craftsbury Common, VT: Art Therapy Publications.

Case, C. (1990). Reflections and shadows: An exploration of the world of the rejected girl. In C. Case & T. Dalley (Eds.), *Working with children in art therapy* (pp. 313–160). London: Tavistock/Routledge.

Case, C., & Dalley, T. (1992). *The handbook of art therapy*. New York: Tavistock/Routledge.

Denny, M. D. (1975). Techniques for individual and group art therapy. In E. Ulman & P. Dachinger (Eds.), *Art therapy: In theory and practice* (pp. 132–149). New York: Schocken Books.

Furth, G. M. (1988). *The secret world of drawings: Healing through art*. Boston: Sigo Press.

Hammer, E. F. (1980). *The clinical application of projective drawings* (6th ed.). Springfield, IL: Charles C Thomas.

Kramer, E. (1971). *Art as therapy with children.* New York: Schocken Books.

Kramer, E. (1975). Art and emptiness: New problems in art education and art therapy. In E. Ulman & P. Dachinger (Eds.), *Art therapy: In theory and practice* (pp. 32–42). New York: Schocken Books.

Kwiatkowska, H. Y. (1975). Family art therapy: Experiments with a new technique. In E. Ulman & P. Dachinger (Eds.), *Art therapy: In theory and practice* (pp. 113–125). New York: Schocken Books.

Kwiatkowska, H. Y. (1978). *Family therapy and evaluation through art.* Springfield, IL: Charles C Thomas.

Liebmann, M. (1986). *Art therapy for groups: A handbook of themes, games and exercises.* Cambridge, MA: Brookline Books.

McNeilly, G. (1983). Directive and non-directive approaches in art therapy. *The Arts in Psychotherapy, 10*(4), 211–219.

Naumburg, M. (1966). *Dynamically oriented art therapy: Its principles and practices.* Chicago: Magnolia Street.

Oster, G. D., & Gould, P. (1987). *Using drawings in assessment and therapy.* New York: Brunner/Mazel.

Rubin, J. A. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Rubin, J. A. (1984). *Child art therapy.* (2nd ed.). New York: Van Nostrand Reinhold.

Rubin, J. A. (1987). *Approaches to art therapy: Theory and technique.* New York: Brunner/Mazel.

Schaverien, J. (1990). The scapegoat and the talisman: Transference in art therapy. In T. Dalley, C. Case, J. Schaverien, F. Weir, D. Halliday, P. N. Hall, & D. Waller (Eds.), *Images of art therapy: New developments in theory and practice* (2nd ed.), (pp. 74–108). London: Tavistock/Routledge.

Steinhardt, L. (1989). Six starting points in art therapy with children. In H. Wadeson, J. Durkin, & D. Perach (Eds.), *Advances in art therapy* (pp. 336–356). New York: John Wiley & Sons.

Ulman, E. (1975). A new use of art in psychiatric diagnosis. In E. Ulman, & P. Dachinger (Eds.), *Art therapy: In theory and practice* (pp. 361–386). New York: Schocken Books.

Wadeson, H. (1987). *The dynamics of art psychotherapy.* New York: John Wiley & Sons.

Waller, D. (1993). *Group interactive art therapy: Its use in training and treatment.* London: Tavistock/Routledge.

Winnicott, D. (1971). *Therapeutic consultations in child psychiatry.* New York: Basic Books.

Art Therapy: Journal of the American Art Therapy Association, 12(2) pp. 118-128 © AATA, Inc. 1995

The Diagnostic Drawing Series and the Tree Rating Scale: An Isomorphic Representation of Multiple Personality Disorder, Major Depression, and Schizophrenia Populations

Maureen Batza Morris, MA, Washington, DC

Abstract

This pilot study used the Diagnostic Drawing Series (Cohen, Hammer, & Singer, 1988) and the Tree Rating Scale (Creekmore, 1989) as a means to research isomorphic representations in tree drawings. The tree drawings of 80 subjects, 20 of whom were diagnosed with Multiple Personality Disorder, 20 with Schizophrenia, 20 with Major Depression, and 20 in the Control population, were rated. Patterns which emerged within each diagnostic category were examined, and graphs were used to depict the results. Certain features were found to distinguish each diagnostic category. The descriptive statistical findings were both consistent and inconsistent with earlier Diagnostic Drawing Series research findings (Cohen, Hammer, & Singer, 1988; Creekmore, 1989; Kress, 1991, 1992; Mills, 1989; Mills & Cohen, 1993; Rankin, 1994; Torem, Gilbertson, & Light, 1990).

Introduction

Throughout history, the tree has continued to be one of the most central and consistently used symbols. This universal metaphor depicting human development is used in virtually every religion and in myths, rituals, legends, sacred literature, art, poetry, and dreams. Greek mythological associations include the pine tree with Attis, the cedar tree with Osiris, and the oak tree with Apollo to name but a few. Nordic mythology cites the Cosmic World Tree, Yggdrasil. The Celtic (oak), Scandinavian (ash), and German (lime) heritages specify the use of the tree as a traditional symbol. Within religious realms, Christians refer to the Garden of Eden whose center contains the Tree of Knowledge, while Judaic tradition points to the Tree of Life in the City of New Jerusalem of Apocalypse as a central symbol. More recently, Dante portrays the pattern of celestial sphere as foliage of a tree whose roots spread upwards.

With a greater appreciation and deeper knowledge of the cultural, religious, and mythical implications of the tree metaphor, many authors contend that the tree symbol facilitates the deepest tapping of the psyche (Cohen, Hammer, & Singer, 1988). Hammer (1958) hypothesizes that in the process of drawing the tree, the individual creates a self portrait which is a projection of the self. Others assert that the tree serves as an inanimate object upon which it is easier to attribute a greater amount of less desirable personality traits (Burns, 1987). From a Jungian standpoint, the tree represents the persona. In an attempt to further understand the symbolic meaning of the tree, Jung suggests that "if the mandala may be described as a symbol of self seen in cross section, then the tree would represent a profile view of the self depicted as a process of growth" (Jung, 1954/1967, p. 253). In addition, Plokker (1962) describes the tree as a symbolic representation of one's own personality. Thus, in a variety of ways, the tree can be seen as a graphic representation of the inner self.

While the tree is viewed as a symbol in mythology and religion and a metaphor for one's own personality, the nurturing aspect of the tree is asserted by Koch (1952) as he speaks of the tree as an "embryonal house". The nurturing aspect of the tree is viewed in another context as a representation of the feminine principle (Cooper, 1978), which possesses the nurturing, protecting, and sheltering qualities of the Great Mother. Just as the Great Mother and "embryonal house" are depicted as nurturing, so too might the idealized image of the self-concept be depicted as nurturing.

Although the tree historically has been viewed as a metaphor for development, the use of tree drawings as graphic indicators of self-concept and potential clinical indicators did not emerge until the 20th century. Decades after French and German psychiatrists asserted the use of art as a diagnostic tool, Buck and Hammer introduced the House-Tree-Person (H-T-P) drawings as a means to facilitate freer verbalizations (Buck, 1948; Buck & Hammer, 1969). At the same time, Jucker developed and advanced the projective capabilities of the free drawing of the tree (Hammer, 1958). This projective device was further developed by Koch (1952), a student of Jucker, into a projective instrument to capture the total personality in its deeper layers of being. The clinical applications of the H-T-P were expanded in later research (Burns, 1987; Burns & Kaufman, 1972; Hammer, 1958; Jolles, 1964).

Within the past decades, tree drawings have been examined and analyzed in relation to a variety of diagnostic populations. Read (1931) assessed a series of trees drawn by children to determine the mode of plastic expression. In the study of a young schizophrenic female, Plokker (1962) analyzed the tree drawing in terms of graphic correlations with diagnostic symptoms. Specifically, he cites the lineation, positioning, and relationship of parts as indicators of this particular pathology. Dax (1965) used tree drawings to aid in providing a pictorial representation of depression. In each of these studies, the tree theme was utilized and explored as a diagnostic tool.

According to Arnheim, as the notions of the brain do not deviate from the thoughts to which they are tied, the artwork is indicative of isomorphic representations (Arnheim, 1986). In this manner, the creative processes and products can be viewed as outward expressions and manifestations of internal states. In an effort to understand the meaning of the artwork and the creator of the artwork, individual characteristics of tree drawings have been examined and explained in divergent interpretive studies. Buck (1948) and Hammer (1958) suggest that the trunk depicted within the tree drawing represents the subject's feelings of energy, growth, development, and ego strength. Bollander suggests that the trunk portrays the subject's internal relation to the emotional functions (1977). Numerous investigators specify that a scar, knothole, or broken branch graphically depicted on the tree is reflective of a traumatic event experienced by the subject (Bollander, 1977; Buck, 1948; Hammer, 1958; Rankin, 1994; Torem, Gilbertson, & Light, 1990).

In a similar manner, additional individual characteristics of the tree have been studied. According to Jolles (1964), the existence of falling or fallen apples suggests feelings of rejection or guilt. Jolles further states that broken bark represents a stormy, difficult history, while a heavily drawn bark suggests anxiety (1964). According to Burns, branches drawn in complete symmetry in a detailed manner indicate a compulsive need for control (1987). Branches which are broken or cut off suggest feelings of trauma and/or castration (Hammer, 1968; Jolles, 1964). Branches with large leaves suggest dependency associated with feelings of inadequacy (Burns & Kaufman, 1972; Burns, 1987; Jolles, 1964). According to Jungian psychology, the roots are an expression of the unconscious (Plokker, 1962). In addition, an emphasis upon the roots suggests attention to the past (Burns, 1987).

Although a breakdown of component parts is useful for examining details, an integration of these parts toward a holistic view of the drawing and of the subject is imperative. It is the author's opinion that these parts must be seen as an integral part of a whole, an integral part of the total self.

Existing research using the Diagnostic Drawing Series (DDS) has primarily focused on establishing objective correlations between structural components of artistic expression and psychiatric diagnosis. Normative studies have produced data to establish standards in the following diagnostic groups: Alzheimer's (Knapp, 1994); Borderline Personality Disorder (Mills, 1989); Depression in children and adolescents (Gulbro-Leavitt & Schimmel, 1991); Eating Disorders (Kessler, 1994); Major Depression, Dysthymia, Schizophrenia, and Multiple Personality Disorder (Cohen, Hammer, & Singer, 1988); Multiple Personality Disorder (MPD) (Kress, 1991, 1992, Mills & Cohen, 1993); and Organic Mental Syndrome (Couch, 1992, 1994). Specifically, tree drawings are collected and assessed as the second drawing within the DDS.

Creekmore designed the Tree Rating Scale to provide a more in-depth examination of the detailed aspects of tree drawing, which appeared to be lacking in the DDS Rating Guide (Cohen, 1986; Creekmore, 1989). In doing so, Creekmore rated the tree drawings of the following populations: Control; Depression; Schizophrenia. In 1992, Kress modified the Tree Rating Scale to provide an even closer examination of the formal characteristics and content of the tree drawing.

In view of the historical significance and personal implications of tree drawings, the present pilot study attempted to provide a deeper understanding and validation of tree symbolism, the DDS, and the Tree Rating Scale. It served to augment the perception of the tree as a self-concept depicted within specified psychiatric diagnoses (Multiple Personality Disorder, Schizophrenia, and Major Depression populations) and a Control group. Ultimately, this study provided data used to highlight the possible emergence of an isomorphic pattern.

Through the collection and assessment of this information, the author expected to see patterns of isomorphic representations within each diagnosis. These patterns would be reflected within the graphic content and formal graphic qualities of each tree drawing. Specifically, the tree drawings within each category were expected to reflect the divergent graphic depictions of self-concept for each diagnostic grouping.

Method

Subjects

The sample population was comprised of persons diagnosed with Multiple Personality Disorder, Major Depression, and Schizophrenia, and a Control group. Specifically, the sample population consisted of 80 subjects, 20 in each diagnostic category. The Control group included six males and 14 females, and the average age for this group was 38.6. The Multiple Personality Disorder (MPD) group consisted of one male and 19 females, and the average age was 34.65. Within the Major Depression group, there were eight males and 12 females whose average age was 41.55. Lastly, the Schizophrenia group consisted of 11 males and nine females, whose average age was 28.05. Each of the sample populations was taken from the DDS Archive.

Procedure

The present research served as a continuum for the study of tree drawings. Creekmore (1989) and Kress (1992) examined in great detail the tree drawings of specific diagnostic populations. My decision to use the Tree Rating Scale was based upon the scale's focus on formal as well as content considerations within the drawings. This pilot study incorporated the Tree Rating Scale into the assessment and interpretation of the second drawing of the DDS. The DDS was chosen for its consistent standards and research design.

Eighty drawings were collected from within 80 DDS. Specifically, the drawing represents each subject's response to the following directive: "Draw a picture of a tree." Only the second drawing in the series was rated. Trees depicted in the first and/or third drawing were not considered for this particular study. Each of the 80 second drawings acquired from the DDS Archive was rated according to the Tree Rating Scale. In addition, data on the age and sex of each subject was collected. Lastly, descriptive statistics in the form of percentage data were generated from within each category and each diagnostic group. Graphs were created to depict findings.*

---

*Gratitude is expressed to Michelle Batza Bailey for her assistance in the design of the graphs.

Materials

The present pilot study called for the use of the Tree Rating Scale, modified by Kress, in association with the DDS (see Appendix A). Specifically, the Tree Rating Scale was used to assess and interpret the second drawing of the series which illustrates the directive, "Draw a picture of a tree." This scale examined the following formal characteristics and content within the tree drawing: space usage, page orientation, color usage, idiosyncratic color usage, use of line and/or shape, line quality/pressure, depiction of a landscape, inclusion of flowers, inclusion of animals, tilt, inclusion of writing, integrated tree versus disintegrated tree, ground depiction, leaves, root emphasis, inclusion of knothole, inclusion of swing, unusual placement, inclusion of people, depiction of blood, more than one tree depicted. To properly understand these characteristics, the reader should refer directly to the DDS Rating Guide and the Tree Rating Scale Definitions (see Appendix B).

Results

In an effort to comprehend the results of the research, it is necessary and more effective to view the results in terms of comparative categories between diagnostic and control groupings. As illustrated by the graphs presented, some distinguishing percentage differences emerged among the four populations. Conversely, in many categories the percentages among the populations were too similar to provide a comparison. Caution must be exercised because the percentages provided in this study are descriptive statistics. While these numbers can be compared to other research findings, they are not necessarily statistically significant. While the results of each category will be examined, greater emphasis will be placed on the specific categories which produced distinguishing differences among populations.

The first category examines the use of space (see Figure 1). Within the "space usage" category, the cluster of usage appears to be in the 33% to 66% range. While 55% of the Control, 45% of the Major Depression, 60% of the MPD, and 60% of the Schizophrenia subjects used 33% to 66%, a limited percentage of subjects within some diagnostic groupings used the 0% to 32% or full usage. Specifically, 0% of the Control and Major Depression subjects, 15% of the MPD subjects, and 5% of the Schizophrenia subjects used 0% to 32% of the paper. It can be noted that a low percentage of all of the subjects except Schizophrenia used the full page. At the same time, a similarly low percentage of subjects within each population used 67% to 99% of the paper.

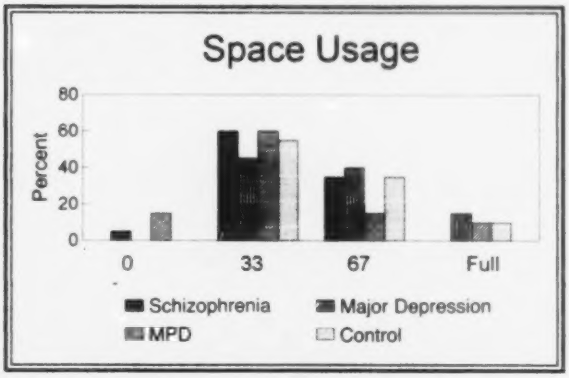


Figure 1. Space Usage Within Tree Drawings

Next, the placement of the paper was examined within the "orientation of paper" category (see Figure 2). Within this category, both the Control and Major Depression groups produced results that indicate little difference in preference for the use of a horizontal or vertical orientation of the paper. At the same time, a high percentage of the Schizophrenia sample (85%) chose a horizontal orientation, while 65% of the MPD sample chose a horizontal orientation.

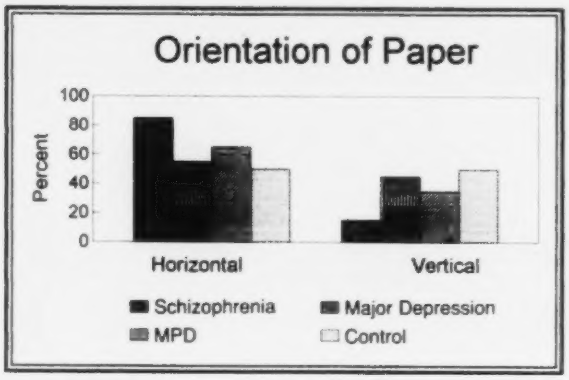


Figure 2. Orientation of Paper Within Tree Drawings

The use of color was explored next (see Figure 3). In terms of the amount of color used within the drawings, a high percentage of the Major Depression (65%), MPD (65%), and Schizophrenia (75%) subjects used two to three colors. Results indicate that 50% of the Control used four or more colors, and 40% used two to three colors. A small percentage of the Control (10%), Major Depression (10%), MPD (20%), and Schizophrenia (15%) samples used only one color.

The use of line and shape was investigated next (see Figure 4). The "line and shape usage" category produced noteworthy results. A large percentage of the Control (80%) and Major Depression (60%) subjects used both line and shape

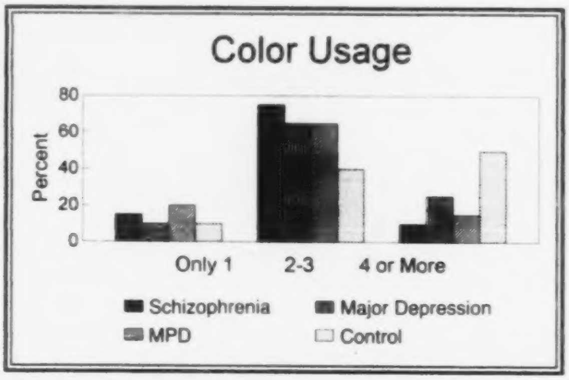


Figure 3. Color Usage Within Tree Drawings

within the drawing. Conversely, 75% of both MPD and Schizophrenia subjects used line only. Interestingly, shape only was used exclusively by 5% of the Major Depression subjects.

The "ground depiction" category provides notable results (see Figure 5). A substantial percentage of the Major Depression sample (55%) used the base of the paper as an implied groundline. The majority of the MPD sample (70%) depicted the tree as floating. The Schizophrenia sample was varied in its results as 30% used a line to represent the ground, and 45% depicted the tree as floating. In addition, the Control sample was varied in its results. The Control group used a line, line/shape, and paper base 20% each, while 30% used a shape only and 10% depicted the tree as floating.

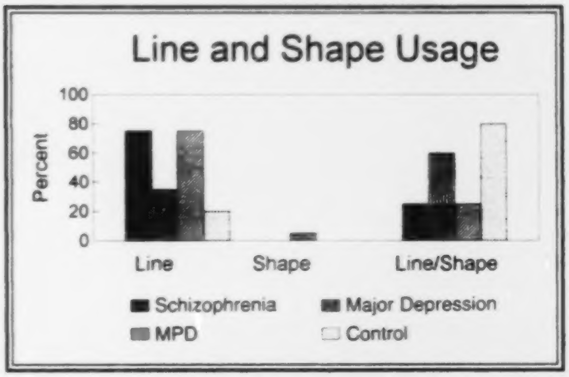


Figure 4. Line and Shape Usage Within Tree Drawings

The use of leaves was examined in the "leaves" category (see Figure 6). The Control and Major Depression group provided similar results in that 70% of the Control and 75% of the Major Depression subjects depicted no leaves on the tree. Similarly, 95% of the Schizophrenia and MPD samples depicted no leaves on the tree. It is worth noting that falling leaves were depicted exclusively by the Major Depression sample (25%). In addition, while leaf emphasis was depicted considerably by the Control sample (30%), only 5% of the MPD sample depicted leaf emphasis.

Next, the "root emphasis" category examined the depiction of the tree's roots (see Figure 7). A large majority of the Control (70%), MPD (90%), and Schizophrenia (100%) subjects did not graphically emphasize the root system of the tree drawing. While 65% of the Major Depression subjects and 70% of the Control did not emphasize the roots, 35% of the Major Depression and 30% of the Control populations did emphasize the roots.

Within the "presence of knothole" category, the Major Depression sample (40%) and Schizophrenia sample (30%) depicted a knothole on the tree (see Figure 8). In contrast, the percentage for a knothole depicted was considerably lower for the Control sample (10%) and MPD sample (15%).

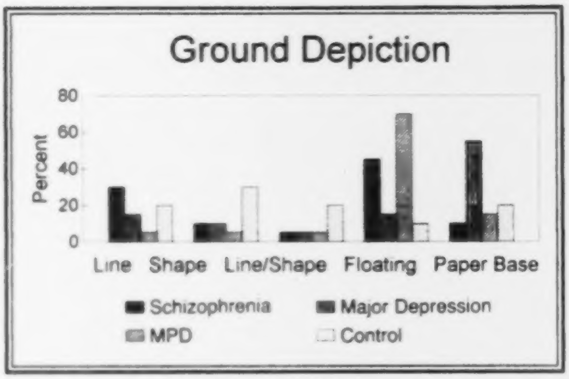


Figure 5. Ground Depiction Within Tree Drawings

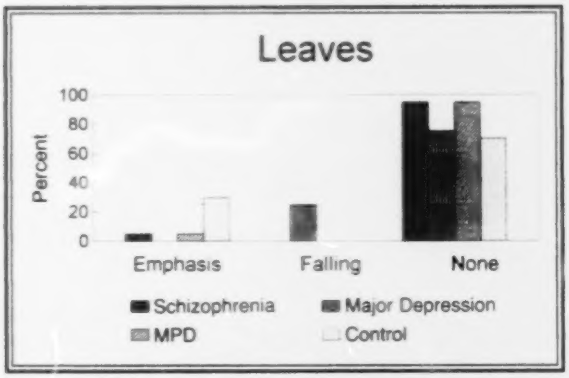


Figure 6. Leaf Depiction Within Tree Drawings

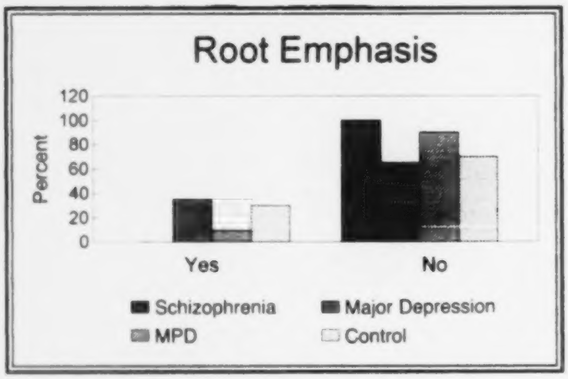


Figure 7. Root Emphasis Within Tree Drawings

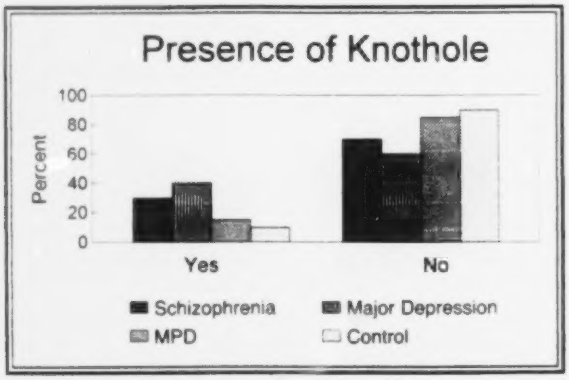


Figure 8. Presence of Knothole Within Tree Drawings

The "unusual placement" category assesses the placement of the tree image on the paper (see Figure 9). The Control sample and Major Depression sample both demonstrated no unusual placement 95% of the opportunities given. Similarly, 85% of the Schizophrenia sample demonstrated no unusual placement. In contrast, 30% of the MPD sample placed their tree to the left of the vertical axis, as well as the 5% of the Major Depression sample who unusually placed trees.

The "integrated versus disintegrated" category classifies each tree as either integrated (fruit, evergreen, palm, willow, or deciduous) or disintegrated (unrecognizable, chaotic branch, without branches, minimal trunk, falling apart, impoverished, broken branches, cut down, or dead). While 85% of the Control sample created an integrated tree, 65% of the Major Depression, 80% of the MPD, and 65% of the Schizophrenia samples created disintegrated trees (see Figure 10).

Specifically within the "disintegrated tree" category, 32% of the MPD subjects created trees classified as "falling apart" and 26% created trees with "chaotic branch systems" (see Figure 11). A majority of the disintegrated trees created by the Major Depression sample (40%) were classified as having "chaotic branch systems" (see Figure 12). A noteworthy percentage (75%) of the Control sample's disintegrated trees were rated as "falling apart" (see Figure 13). Lastly, the Schizophrenia sample created disintegrated trees in which 28% were "impoverished" and 22% had "chaotic branch systems" (see Figure 14).

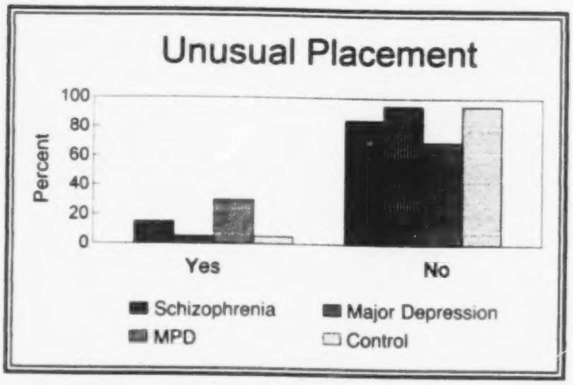


Figure 9. Unusual Placement Within Tree Drawings

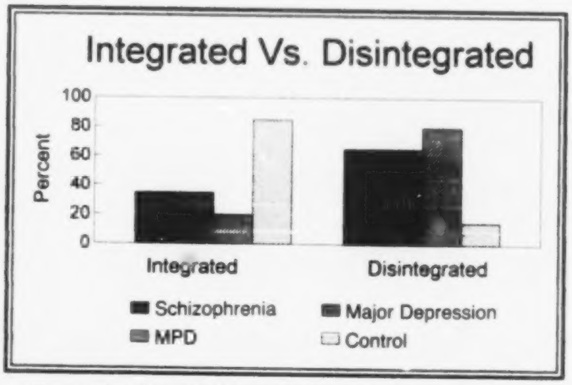


Figure 10. Integrated Versus Disintegrated Tree Depiction

Within the "integrated tree" category, the majority of the Control group created "fruit" (41%) or "willow" (35%) trees (see Figure 15). As 20% of the MPD sample created integrated trees, the majority of these trees were classified as "deciduous" (57%) (see Figure 16). While 35% of both Schizophrenia and Major Depression sample groups depicted integrated trees, 40% of the Major Depression sample depicted "evergreen" trees and 43% of the Schizophrenia sample depicted "fruit" trees (see Figures 17 and 18).

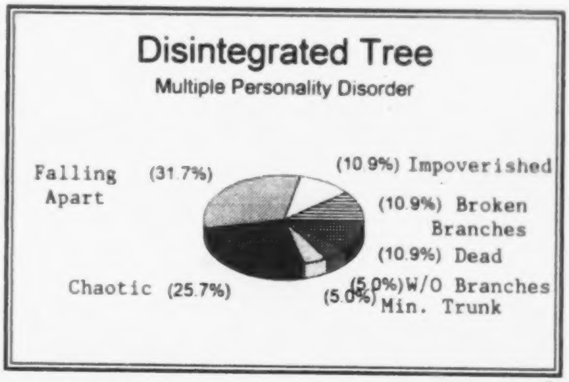


Figure 11. Disintegrated Tree Depiction (Multiple Personality Disorder)

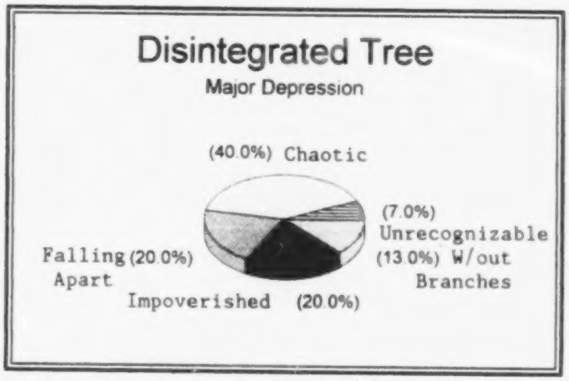


Figure 12. Disintegrated Tree Depiction (Major Depression)

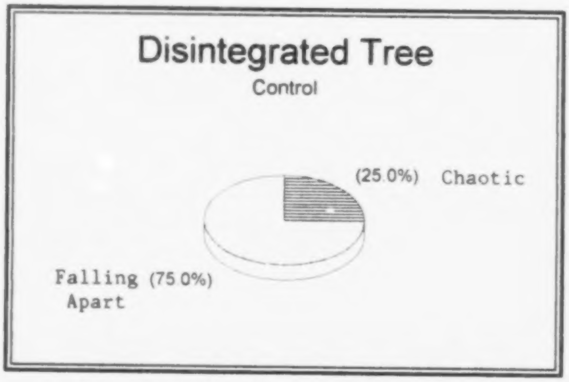


Figure 13. Disintegrated Tree Depiction (Control)

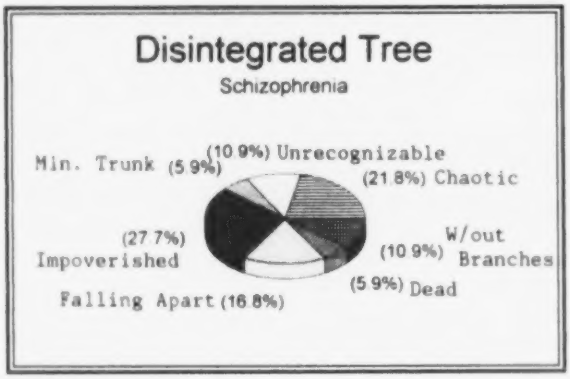


Figure 14. Disintegrated Tree Depiction (Schizophrenia)

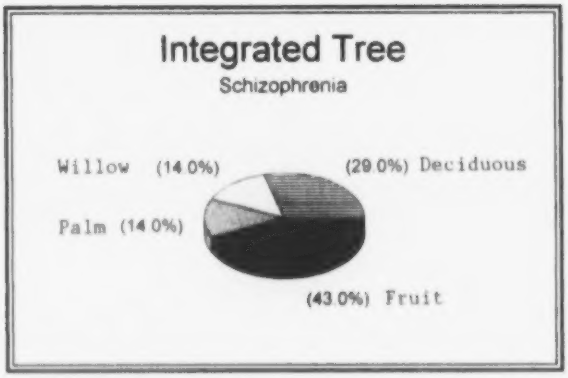


Figure 17. Integrated Tree Depiction (Schizophrenia)

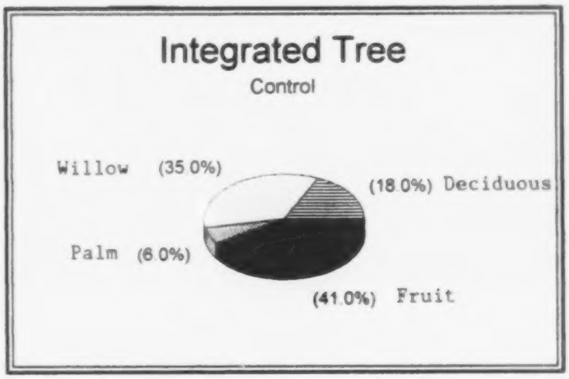


Figure 15. Integrated Tree Depiction (Control)

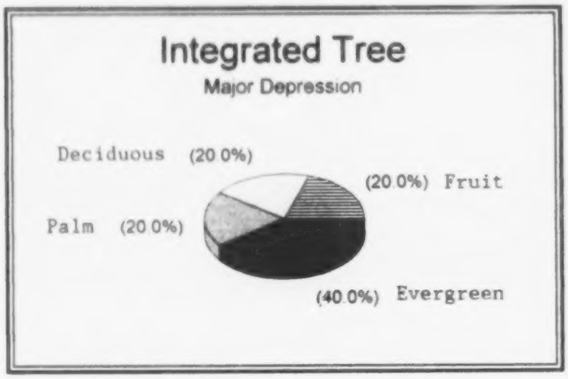


Figure 18. Integrated Tree Depiction (Major Depression)

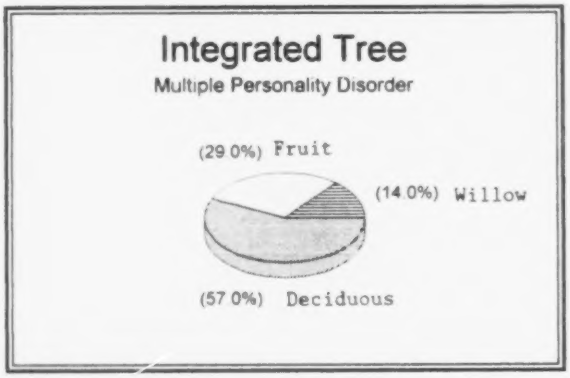


Figure 16. Integrated Tree Depiction (Multiple Personality Disorder)

Finally, the following categories provided data whose results were similar for all of the sample populations: "idiosyncratic color usage," "line quality pressure," "flowers," "animals," "tilt," "writing," "swing," "people," "blood," and "more than one tree." Only one subject, a Schizophrenic subject, used idiosyncratic color. The results indicate that at least 80% of each population used a medium line quality pressure. The only deviation emerged within the MPD sample of which 20% employed heavy line quality pressure. Among all of the sample populations, at least 90% consistently responded by not including flowers, animals, tilt, writing, swing, people, blood, or more than one tree within the 80 drawings.

Discussion

The results of this pilot study can be interpreted in a variety of ways. Several distinguishing patterns emerged among the four sample populations. These patterns can be examined in terms of external manifestations of the internal states of each diagnostic population.

The Control group can be set apart from the other sample populations in several categories. Predominately, the results indicate that the Control group characteristically used four or more colors, a mixture of line and shape, variety in ground depiction, and created the largest percentage of integrated trees. In addition, the Control group did not depict knotholes or emphasize roots. Several elements that appear prominently in the Control group's tree drawings are consistent with previous research results. Mills & Cohen (1993) and Creekmore (1989) reported the tendency for the Control population to include a groundline, use two or more colors, use a mixture of line and shape, and possess a tendency to create integrated trees. Conversely, Creekmore reported a predominant use of 67% to 99% or full space usage, which is inconsistent with this study's findings. Despite these differences, it is helpful to look at these results as a reflection of individuals who present as integrated selves, energetic, untraumatized, and grounded.

The Multiple Personality Disorder sample characteristically used a larger number of colors, a paperbased ground line, root emphasis, and the inclusion of knotholes. These results are consistent with previous research findings (Kress 1991, 1992, Mills & Cohen 1993, Rankin, 1994). In addition, these results coincide with research that relates knotholes to trauma experienced by the subject (Rankin, 1994, Torem, Gilbertson, & Light, 1990). It is necessary to note that the rating scale used in this study did not include a way to score mutation and scarification seen in previous DDS research. The findings of this study, however, imply a damaged tree was often drawn. In this manner, the results of this study and others provide artwork which might generate an image of a damaged, but energetic, individual resting on the outer edges of the paper.

The Major Depression sample characteristically used an average coverage of the paper, two to three colors, line only, unusual placement, and depicted a floating tree image and no disintegrated tree with a chaotic branch system. A preference for the use of line only, two to three colors, and a depiction of a disintegrated tree is consistent with previous research (Creekmore, 1989). In contrast, unusual placement was cited by Cohen, Hammer, and Singer (1988) as a main characteristic of the Major Depression population sample. To analyze this data, it is beneficial to examine the art in terms of conveying intense affect, sadness, isolation, despair, and weak lines. By doing so, a sense of the depressed self emerges.

Lastly, the Schizophrenia sample characteristically used an average amount of space on the page, two to three colors, line only, no unusual placement, and depicted knotholes and disintegrated trees which were impoverished and had chaotic branch systems. The use of one color is consistent with Creekmore's results (Creekmore, 1989). The results fail to support the inclusion of writing and use of idiosyncratic color reported by Cohen, Hammer, and Singer (1988). Nonetheless, the sense of self depicted by this sample population is indicative of a fragmented and impoverished self-concept.

Conclusion

The significance of this preliminary study lies in its implications for expanding the perception of the tree drawing as a manifestation of the inner self. The tree drawings created by the four diagnostic categories appear to offer an indication of the inner state of each individual. A tree that was untraumatized, integrated, colorful, and grounded was characteristic of the Control sample's tree drawings in this study. The tree drawings of the Multiple Personality Disorder sample generated an image of a grounded, usually well-rooted and colorful, but traumatized tree. The tree drawings of the Major Depression sample conveyed an image of a floating, unusually placed, and disintegrated tree drawn in few colors. Lastly, the Schizophrenia sample was characterized by the creation of an impoverished and disintegrated tree, drawn in few colors, and in line only. In this manner, the patterns of isomorphic representations found in this study provide insight into the relationship between pictorial structure and psychiatric diagnosis.

This pilot study has provoked many questions and concerns. Expansion and modification of this preliminary study should be considered by future researchers. The Tree Rating Scale might be modified further to more accurately score observations cited by previous research. Specifically, it would be helpful to score a category relating scarification and mutilation. In addition, it would be beneficial to match the ratio of male to female samples and age averages more closely. Lastly, as the author rated the pictures herself, this must be viewed as a limitation; therefore, an inter-rater reliability test of the Tree Rating Scale is necessary. Despite these limitations, through this pilot study the author hopes to inspire others to become involved in research within the field of art therapy.

Editor's note: I gratefully appreciate the assistance of Anne Mills, MA, A.T.R. and Mary-Michola Barnes, MA, A.T.R. at the Diagnostic Drawing Series Archive, and the collection of DDS by Dorothy A. Anderson, MS, A.T.R.; Leta Hunt, Theresa Kress, MA, Pam Manner, MA, A.T.R., Mike Marshall, MA, A.T.R., Gil Silverman, MA, A.T.R.; and Carol Y. Werne.

References

Arnheim, R. (1986). *New essays on the psychology of art.* Berkeley, CA: University of California Press.

Bollander, K. (1977). *Assessing personalities through tree drawings.* New York: Basic Books.

Buck, J. N. (1948). The H-T-P test. *Journal of Clinical Psychology, 4,* 151–159.

Buck, J. N., & Hammer, J. S. (Eds.). (1969). *Advances in House-Tree-Person techniques: Variations and applications.* Los Angeles, CA: Western Psychological Services.

Burns, R. C. (1987). *Kinetic-House-Tree-Person drawings (K-H-T-P): An interpretive manual.* New York: Brunner/Mazel.

Burns, R. C., & Kaufman, S. H. (1972). *Actions, styles, and symbols in Kinetic Family Drawings (K-F-D): An interpretive manual.* New York: Brunner/Mazel.

Cohen, B., Hammer, J. S., & Singer, S. (1988). The Diagnostic Drawing Series: A systematic approach to art therapy evaluation and research. *The Arts in Psychotherapy, 15,* 11–21.

Cooper, J. C. (1978). *An illustrated encyclopedia of traditional symbols.* London: Thames & Hudson.

Couch, J. B. (1992). *Organic mental syndrome: Diagnostic Drawing Series research with the elderly* (Cassette Recording No. 16). Las Vegas, NV: American Art Therapy Association.

Couch, J. B. (1994). Diagnostic Drawing Series research with older people diagnosed with organic mental syndromes and disorders. *Art Therapy: Journal of the American Art Therapy Association 11*(2), 111–115.

Creekmore, J. (1989). *The Diagnostic Drawing Series tree rating scale.* Unpublished manuscript.

Dax, C. (1953). *Experimental studies in psychiatric art.* Philadelphia: J. B. Lippincott.

Gulbro-Leavitt, C., & Schimmel, B. (1991). Brief report: Assessing depression in children and adolescents using the Diagnostic Drawing Series modified for children (DDS-C). *The Arts in Psychotherapy, 18*(4), 353–356.

Hammer, E. F. (1958). *The clinical application of projective drawings.* Springfield, IL: Charles C Thomas.

Hammer, E. F. (1968). Projective drawings. In A. I. Rabin (Ed.), *Projective techniques in personality assessment.* (pp. 366–396). New York: Springer.

Jolles, I. (1964). *A catalogue for the qualitative interpretation of the H-T-P.* Los Angeles: Western Psychological Services.

Jung, C. G. (1967). The philosophical tree. In H. Read, M. Fordham, G. Adler, W. McGuire & R. F. C. Hull (Eds. and Trans.), *The collected works of C. G. Jung* (Vol. 13, pp. 251–349). Princeton: Princeton University Press. (Original work published 1954).

Kessler, K. (1994). A study of the Diagnostic Drawing Series with eating disordered patients. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 116–118.

Knapp, N. M. (1994). Research with the Diagnostic Drawing Series for normal and Alzheimer subjects. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 131–138.

Kock, C. (1952). *The tree test.* New York: Grune & Stratton.

Kress, T. (1991). *A study of the content of drawings from the Diagnostic Drawing Series of patients with multiple personality disorder.* Unpublished manuscript. The George Washington University, Graduate Program in Art Therapy, Washington, DC.

Kress, T. (Speaker). (1992). *The Diagnostic Drawing Series and multiple personality disorder: A validation study* (Cassette Recording No. 55). Denver, CO: National Audio Video.

Mills, A. (1989). *A statistical study of the formal aspects of the Diagnostic Drawing Series of borderline personality disordered patients, and its context in contemporary art therapy.* Unpublished master's thesis, Concordia University, Montreal.

Mills, A., & Cohen, B. (1993). Facilitating the identification of multiple personality disorder through art: The Diagnostic Drawing Series. In E. S. Kluft (Ed.), *Expressive and functional therapies in the treatment of multiple personality disorder* (pp. 39–66). Springfield, IL: Charles C Thomas.

Plokker, J. H. (1962). *Artistic self-representation in mental disease: The shattered image of schizophrenia.* The Hague: Mouton & Co.

Rankin, A. (1994). Tree drawings and trauma indicators: A comparison of past research with current findings from the Diagnostic Drawing Series. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 119–121.

Read, H. (1931). *Education through art.* New York: Fantheon Books.

Torem, M. S., Gilbertson, A., & Light, V. (1990). Indications of physical, sexual, and verbal victimization in projective tree drawings. *Journal of Clinical Psychology, 46*, 900–906.

APPENDIX A

Diagnostic Drawing Series
Tree Scale

Creekmore, 1989

Pt. ID#: ______________ Age: _____ Sex: _____ Dx: ____________________ Participation #: ____________________

Space Usage	0 33 67 F
Horizontal/Vertical Page	Hp Vp
Color	C1 C3 C4
Idiosyncratic Color	Yes No
Line-Shape	L S L/S
Line Quality/Pressure	Lt M H
Landscape	Yes No
Grass: Line Shape L/S	L S L/S
Vertical Zigzag Horizontal	V Z H
Flowers	Yes No
Animals	Yes No
Tilt	Yes No
Writing	Yes No
Integrated Trees:	
Fruit Evergreen Palm	F E P
Willow Deciduous	W D
Disintegrated Trees:	
Unrecognizable	Un
Chaotic Branch	Ch
Without Branches	3B
Minimal Trunk	Min
Falling Apart	Fall
Impoverished	Im
Broken Branches	Bb
Cut Down	Ct
Dead	D

Ground: Line Shape L/S Floating Paperbase	GL GS GL/S Fl Pb
Leaves: Emphasis Falling None	E Fa N
Root Emphasis	Yes No
Knothole	Yes No
Swing	Yes No
Unusual Placement	Yes No
People	Yes No
Blood	Yes No
More than one tree	Yes No

If there is also a tree in the FIRST picture, what is the difference between it and the tree in the SECOND picture?
The tree in the SECOND picture is:

Size: Bigger Smaller	B Sm
Integration: More Same Less	Mo Sa Le
Species: Same Different	Sa Di
Details: More Same Fewer	Mo Sa F

Please specify any unusual/unclassifiable anomalies:

APPENDIX B
Diagnostic Drawing Series
Tree Rating Scale
Definitions

Jeanne Creekmore, A.T.R. 1989©

Space Usage

Choices are: 0 for 0%–32%
33 for 33%–66%
67 for 67%–99%
F for Full

See page 6 of DDS Revised Rating Guide for definition.

Color

Choices are: C1 for one color used
C3 for 2–3 colors used
C4 for 4 or more colors used

See page 1 of DDS Revised Rating Guide for definition.
Rate colors used in the whole picture.

Idiosyncratic Color

Rate *Tree* only. Acceptable as normal (nonidiosyncratic) colors: black, brown, green (trunk), and autumnal colors (crown) are not considered idiosyncratic use of color. Bluish tones are not considered idiosyncratic in conifers, but idiosyncratic in deciduous trees.

Line/Shape

Choices are: L for Line only
S for Shape only
L/S for Line-Shape mix

See page 2 of DDS Revised Rating Guide.
Rate *just the tree.* Dots do not count as Line or Shape.

Line Quality/Pressure

Choices are: Lt for Light
M for Medium
H for Heavy

See page 5 of DDS Revised Rating Guide.

Landscape

Rate *yes* with inclusion of grass and sky, or grass plus one or more environmental object.

Grass

Must be more than one line on either side of tree (Line only is rated as Ground Line); must include repetitive movement or shape. Also rate for *ground that is not green.*

Subcategories:
Choices are: L for Line only
S for Shape only
L/S for combination of Line and Shape

Also rate direction of grass.
Choices are: V for Vertical
Z for Zigzag—grass is predominantly made up of a mix of vertical and horizontal elements.
H for Horizontal—grass primarily goes in this direction.

Flowers

This category includes flowers on ground or in tree.

Animals

Limited to animals, in, on, or under tree; also includes those on ground.
Does not include birds flying in the sky.
Rate *no* if there is a nest and no birds.

Tilt

Must occur at the trunk of tree and axis must slant 15 degrees or more.

Writing

Incudes titles, nonsense words, labels, name, and date.

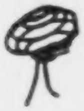
Integrated Trees

Rate only if recognizable—Must be integrated.
Choices are: Fruit
Evergreen—includes many types of pine, Christmas trees.
Palm
Willow—branches must extend below midpoint of tree.
Deciduous—sheds leaves annually

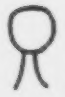
Disintegrated Tree Choices

If tree is not any of these choices below, then it must be considered integrated and rated according to the **Integrated Tree** category.

Unrecognizable—(Un) The image, viewed in context of being the Tree picture, would not be recognized as a gestalt of a tree.

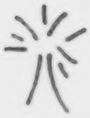


Chaotic Branch System—(Ch) Lack of organization among branches when articulated, or in Crowns drawn by scribbling. Do not confuse with "curlicue" crowns.



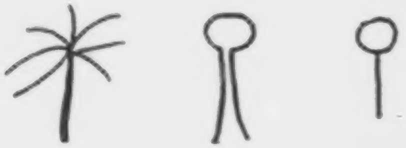
Without Branches—(sB) No branches are drawn; trunk ends without branching out. Includes advanced (not impoverished) lollipop shapes, trees with "curlicue" crowns. Do not rate for palm trees or conifers.

Minimal Trunk—(Min) The trunk extending below the branch system is less than ¼ the length of the tree.

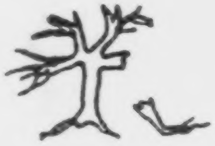


Falling Apart—(Fall) Elements of the tree are primarily disconnected and disjointed. Rater should pay particular attention to the relationship of the trunk to the branches, as well as subsidiary branches to the main branches. Trunk has two sides, at least one of which is not solid or clearly delineated.

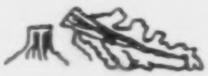
Impoverished—(Im) Line-only trees in monochrome or two colors; particularly when spiderlike, keyhole, or crude lollipop shapes.



Broken Branches—(Bb) Branches that are no longer fully connected to tree; includes branches on ground and cut off or damaged branches.



Cut Down Tree—(Ct) Cut down or broken near trunk.



Dead—(D) Tree appears to be obviously dead.

Ground

Ground Section: Ask yourself "What is the tree resting on?"

Ground Line—(GL) Must be Line Only and extend at least one inch on *both* sides of trunk. A continuous line that spans the base of the trunk must also extend at least one inch on either side of the trunk. Roots do not count as groundline. Grass may count as groundline (if it is line only). Does not include horizon lines in middle of the page. Rate as *Ground Line* if tree is resting on a continuous groundline with shape filled in underneath it.

Ground Shape—(GS) Shape that surrounds tree base; it must extend at least one inch on either side of trunk and be Shape Only.

Ground Line/Shape—(GL/S) Tree rests on combination of both line and shape which extends one inch on either side of trunk. If tree rests totally on line with shape underneath, rate as *Ground Line* (see definition above).

Floating—(Fl) Tree is floating in mid-air, at least three inches from paperbase.

Paperbase—(Pb) Bottom of tree trunk is drawn within one inch from bottom edge of paper. Rate *no* if the highest part of tree base is more than one inch from bottom of paper (even though roots may be within one inch of edge).

Leaves

Choices in this section are:

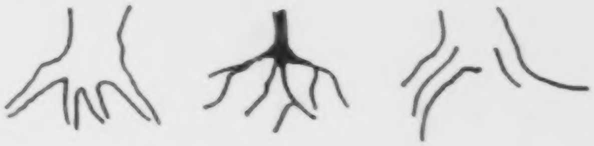
Leaf Emphasis—(E) Some individual leaves are prominent; they are drawn separately and can be identified as leaf shape and counted. Does NOT include lines for pine needles or fronds of palm trees.

Leaves-Falling—(Fa) Leaf/leaves must not be connected to tree; they are either in mid-air or on ground. If Falling is chosen, then Emphasis should be left blank.

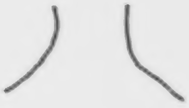
Leaves-None—(N) No leaves on tree; no crown suggested. Includes winter trees and dead trees.

Root Emphasis

Specific roots are clearly delineated with double or single lines; must be more than two lines.
Examples of acceptable choices:

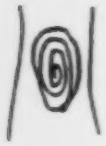


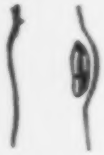
Not acceptable:

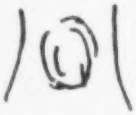


Knothole

Circle enclosed in trunk. May be left empty or filled in; may contain a spiral, be viewed sideways, or suggested with a few lines. Examples:







Swing

Tire swings or swing connected to tree.

Unusual Placement

The image is drawn predominantly above the midline of the page (horizontal axis) OR most of the image is drawn to the right or left of the vertical axis; particularly when the remainder of the page is blank. Trees off center but with other elements in the picture are rated *no*.

People

Includes stick figures or any recognizable human figure image. Figure must be drawn from the head area at least as far as the waist area or below.

Blood

Blood on tree or in any other section of the picture.

More Than One Tree

Rate *yes* if other trees are present in picture; bushes do not count as trees. (Bushes are less than half the size of trees and do not have any predominant trunk.)

Brief Reports

The Art of West Indian Clients: Art Therapy as a Nonverbal Modality

Anna Hiscox, MFT, A.T.R., Albany, CA

Abstract

African Americans in psychotherapy may present complex issues related to ethnicity and culture in addition to their presenting symptoms. Current literature is limited in the area of group identity versus individual cultural differences among African descendants. Historical experiences bind Black people irrespective of geographical location. Being culturally sensitive to clients dictates that therapists understand the bond among Blacks of various social-ecological backgrounds. This paper discusses some of the fundamental distinctions between African Americans and Black West Indian clients.

Introduction

As I thought about writing this article, I reflected on a statement by Nancy Boyd-Franklin in her book, *Black Families in Therapy: A Multi-systems Approach* (1989). She boldly states: "There is no such thing as the black family" (p. 6). This provocative statement intrigued me and also set the tone for this paper. Boyd-Franklin gallantly articulates feelings I have toiled with throughout my childhood.

I am a Black American. However, my heritage and ethnicity could prove to be problematic to the art therapist who conceives African Americans as analogous, closed, and inclusive in behavior and culture. I am especially cognizant of the ethnic and cultural diversity that can exist within families because I grew up in a Black family with both African American and Caribbean roots. I was born in New York City and raised in Manhattan. My paternal family has southern Black roots and moved to New York from South Carolina. My maternal family has its roots in Antigua, Monserrat, and Nassau, Bahamas.

As art therapists, we are just beginning to broaden the scope of our knowledge and practice to encompass a global macrosystem of ethnic diversity. Dana (1993) found that "the 1990 census reported approximately 25 percent of the population of the United States were persons of non-Anglo-American origins, from our four major ethnic/racial groups" (p. 31). This information supports the belief that a contextual understanding of the Black community's intercultural and multicultural differences must be developed prior to working with Black clients.

Frequently, Black people are perceived and classified as a group without the understanding or awareness that there are distinct differences within the culture. Concomitantly, there are historical experiences that must be acknowledged which bind Black people regardless of geographical location. According to Boyd-Franklin (1989):

> While it is necessary to emphasize the heterogeneity of Black families, of equal importance is the consideration of how Black Afro-American families differ from other ethnic groups. The four main areas in which the experience of Black people in this country has been unique from other ethnic groups are the African legacy, the history of slavery, racism and discrimination, and the victim system. (p. 7)

Becoming a culturally sensitive therapist demands an understanding of the bond among Blacks of diverse backgrounds. Brent and Callwood (1993) assert that clinicians must be able to make an accurate assessment of a client, which is unbiased by ethnocentric responses based on their own socioeconomic status and cultural beliefs and practices, if safe and effective treatment planning and implementation is to take place (p. 293). For the Black Caribbean American client, this entails insights into both the common Black experience and the unique experiences of the Caribbean Black heritage.

Many therapists are not aware that Caribbean people are a migrant group. Understanding the inherent reasons for migration contributes to effective therapeutic interventions. Natural resources and advancement opportunities are limited in the islands. Family members frequently relocate to acquire economic stability and/or educational advancement.

According to Brent and Callwood (1993), most families have at least one member who has emigrated to another island or to a major population center of North America or Europe (p. 290). The therapist's understanding of who has the power in the family regardless of the physical proximity to the client increases rapport and trust. For example, my grandfather lived in New York, but he gave advice and reprimanded the inappropriate behavior of relatives residing in the islands.

West Indian families are subject to many traumatic dichotomies. The first dilemma is living in a racist society. The second difficulty is acculturation: the ability to adjust to both Euro-American standards and the mores inherent within the Black community. White and Parham (1990) discuss the di-

BEST COPY AVAILABLE

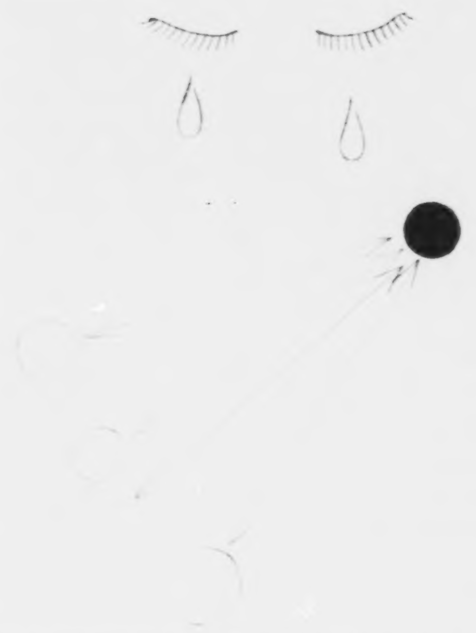


Figure 1. The attached untitled pen-and-ink drawing was illustrated by a 50-year-old female native of Antigua. She stated, "The drawing represents my sadness at leaving my family and friends behind when I left Antigua."

lemma of African American youth interaction. The exosystem in which these children interact also explicitly illustrates the acculturation difficulties of West Indian teens in North America. White and Parham contend:

> Young adults are confronted with a set of dualities defined by being part of, yet apart from, American society, in it but not of it, included at some level and excluded at others. The inclusion-exclusion dilemma is further complicated by their exposure to two different value systems, world view, and historical legacies. (p. 47)

White and Parham unquestionably define the parameters of young Blacks living in America. Viewing ethnicity systematically, there appear to be no differences among African descendants. However, there are major intercultural differences within the Caribbean culture.

West Indian Culture

English is the primary language spoken in the islands. However, misinterpretation and missed nuances by the therapist could initially harm the therapeutic relationship. According to Brent and Callwood (1993), "The linguistic form, depending on the island of origin and the level of education of the speaker, may be any combination—standard British English to a very rapidly spoken rhythmic Creole dialect, which the uninitiated ear may mistake for a foreign language" (p. 293).

West Indians are formal people. Engaging the client(s) during the initial interview can be greatly enhanced by addressing parents and elders by their formal names. Social amenities are required protocols of behavior. Elders as well as all adults demand and expect respect. The accepted behavior of minors is that children should be "seen and not heard." The latency period of childhood is often governed by strict behavior control, with punitive responses by the parent(s) or caretaker. Therefore, therapists should be cognizant of erroneously judging parental control and punishment by imposing Euro-American standards.

Caribbean people are naturally rhythmic and colorful. Bold, bright colors are often reflected in artwork. Also, obtaining the artist's story will reduce the tendency to apply clinical diagnoses to projections that may be based on cultural themes. For example, festive celebrations such as Junkanoo, Christmas, and Three Kings Day can be utilized in art experientials to help mend family conflict by reflecting on happier times.

The Importance of Religion

Dana (1993) described the traditional spiritual beliefs and folkways of African Americans. Similar beliefs are also an integral part of West Indian culture due to the kinship of Black people stemming from African roots. According to Dana, "Spirituality need not be associated with church membership for African Americans but often includes the abiding belief that it is possible to reach out to a superior power for strength and solutions to problems" (1993, p. 42). Spirituality and the belief that God will solve problems may be expressed in several ways, by viewing the problem as punishment from God, by seeing the church as one's personal salvation, and by the occasional practice of witchcraft and voodoo (Knox 1985, cited in Brent & Callwood, 1994).

There are a variety of traditional religious groups and cults, such as Catholics, Lutherans, Moravians, and Rastafarians, on the islands. Although one may belong to a particular religious sect, belief in supernatural phenomena is culturally accepted across denominational groups. However, belief in the supernatural should not be attributed to all Caribbean people and often may become a false stereotype. Therapists must be open to and educated about spiritual beliefs encompassed by Caribbean culture. Misunderstanding alternative belief systems often ends in faulty therapeutic interventions. Teish (1985) contends that voodoo has been mislabeled, misunderstood, and exploited. She asserts, "Voodoo is a science of the oppressed, a repository of woman-knowledge" (p. 171).

Modern Western medicinal technology often is sought in conjunction with folklore medicine. One element of Caribbean spirituality and cultural belief is the Obeah—a shaman man or woman found primarily in Eastern Caribbean culture where folklore medicine is often practiced alongside modern medical technology. The Obeah's practice is based on the belief that illness is the product of unnatural influences. McCartney, a clinical psychologist and native Bahamian, describes Obeah as the phenomenon of the supernatural that renders evil or good makes dreams come true, influences individuals either for their demise or to hold them in one's power. Obeahs can cause either physical or mental illness, or can cure any physical or mental problem (cited in Brent & Callwood, p. 295).

Art therapists working with clients whose frame of reference is strictly from a Euro-American medical model will require assistance in differentiating pathology from traditonal

Figures 2 and 3. "Ros's Dream House" and "Rosalind's First Experience" were illustrated by a 42-year-old native of Barbados. "Rosalind's First Experience" represents her arrival in New York City. She said that it was a cultural shock. One can imagine the trauma of coming from the island of Barbados and arriving in a large city like New York with its large skyscrapers, thousands of people from different ethnic groups, traffic, etc.

folklore ideology and religion. Seeking supervision when necessary and incorporating nontraditional medicine into the therapeutic session decreases resistance, increases motivation, and assists in facilitating appropriate treatment. Research, consultations, and reading outside of our own discipline is a must if we are to provide objective and effectual care to these clients.

Conclusion

Silver (1989) postulates that the expression of feeling in a drawing or painting can provide clues to concepts of self and attitudes towards others, while changes in expressiveness can provide clues to changes in personality before they are evident in other forms of behavior (p. 134). A "free drawing" in the initial therapeutic session is an effective assessment tool for engaging clients whose ethnicity and culture are different from the therapist.

West Indians do not self-disclose easily and typically do not utilize mental health facilities. Brent and Callwood (1993) hypothesize that "the long-standing colonial associations of the Caribbean with Europeans and North Americans have led to an adaptive, self-protective paranoid stance that guards against exploitation" (p. 299). Generally, continentals are treated with respect, but trust is often withheld until there has been a testing period (*Ibid.*). With clients who are skeptical about the benefits of traditional verbal therapy, an awareness of nonverbal communication is paramount.

The therapeutic relationship involves many forms of communication. By observing the client's metacommunication, the clinician may gain insight into the client's affect and thought processes. Sue and Sue discuss the meaning of nonverbal communication and have documented areas of concern in the therapist/client relationship. According to Sue and Sue (1990), "Nonverbals oftentimes occur outside our level of awareness. As a result, it is important that counselors begin the process of recognizing nonverbal communications and their possible cultural meanings" (p. 53).

This article presents only a few considerations when working with West Indian clients. Due to the dynamics of the individual as well as the family, it is wise to remember that not all West Indians are characteristically analogous. However, Brent and Callwood (1993) note, "Integrating cultural and ethnic information into client assessment is necessary to determine what threatens the client's psychosocial security, how the client interprets those threats, and what adaptive strategies the client may have developed to cope with those threats" (p. 301). Art therapists must break through cultural and verbal barriers by showing respect for traditions and customs they are not acquainted with and by utilizing effective techniques for interventions.

The Caribbean culture is rich and vibrant. With the growing change in the U.S. population as indicated by 1990 census, art therapists would be remiss in not examining countertransference issues, persona beliefs, and attitudes when working with people from different backgrounds, such as West Indian people. The importance of cross-cultural art therapy is to provide empathic, safe space where the client can project his/her feelings without worrying about the therapist's stereotypical ideologies. As clinicians, we have a responsibility to paint new avenues of understanding. This can be achieved through the awareness and incorporation of social, cultural, and ethnic traditions in the therapy session.

References

Boyd-Franklin, N. (1989). *Black families in therapy: A multisystems approach*. New York: The Guilford Press.

Brent, J. E., & Callwood, G. B. (1994). Culturally relevant psychiatric care: The West Indian as a client. *Journal of Black Psychology, 19*(2), 290–302.

Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology*. Boston: Allyn & Bacon.

Silver, R. A. (1989). *Developing cognitive and creative skills through art*. New York: Ablin Press.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: theory & practice*. New York: John Wiley & Sons.

Teish, L. (1985). *Jambalaya: The natural woman's book*. San Francisco: Harper Collins.

Virshup, E. (1993). *California art therapy trends*. Chicago: Magnolia Street.

White, J. L., & Parham, T. A. (1990). *The psychology of blacks: An African-American perspective*. New York: Prentice-Hall

BEST COPY AVAILABLE

Viewpoints

One Thousand Penises: Working with Adolescent Groups

Elda Unger, MA, A.T.R., Malibu, CA

One of the benefits I have realized from working with adolescents is that I have become unshockable. Most of my work with these children has been in residential care facilities and in psychiatric hospitals, where they are forever testing you. You need to have the right combination of honesty, genuine interest, caring, firmness, flexibility, and enthusiasm to pass their test.

One of my favorite patients, J, entered my art therapy room at the psychiatric hospital with nine other male and female adolescents. He was about 15 years old, 6 feet, 3 inches, well-built, and energetic—and, a gang member who had been picked up by the police on drug and possession of dangerous weapons charges. For the most part the staff was apprehensive about him and wished him a short stay. Meanwhile, the adolescent group looked up to him as its leader.

J's parents have had some college education and come from middle class families. J was selling and using drugs at an early age, and he was in gun-toting pursuit of a member of another gang when he was picked up by the police. His father, a recovering addict, managed to get J into the hospital instead of jail.

When I guided the group into an exercise dealing with "empowering others," J approached me with a piece of paper and asked me to look at it and tell him what he had drawn. It was a rather good likeness of a penis (Figure 1). "It looks like a penis," I said. "You're right!", he replied. With that exchange, J walked back to his seat and continued drawing. Once again he came to me with the results of his efforts and asked me what I thought it was.

Now there were five penises surrounding the pelvis of a female, complete with pubic hairs (Figure 2). "It looks like five penises," I said. One of the other boys commented that it looked like gang rape. J said, "Absolutely not; it is only a girl who likes a lot of sex." The others in the group agreed that this sounded right.

The next day I asked each person "to draw a scene exhibiting great personal courage." Instead, J continued to draw another penis.

I took a large roll of paper and all the colors of markers, pens, crayons, and oil pastels and firmly told J he was to draw 1,000 penises, using every color in turn, and then repeating every color until he completed 1,000. The group watched this exchange with great interest as J started the assignment. After drawing 53 penises, J stopped drawing them ejaculating. After more time, J stopped and said that he did not want to draw anymore. I insisted that he needed much more work in this area and that he absolutely had to complete the assignment of 1,000.

Somewhat to my relief, J began again, but at the top of the page, he wrote "E's Penis Envy." It was difficult to suppress laughter and surprise at the sophistication of his wit. J

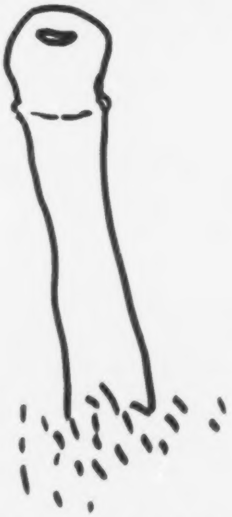


Figure 1. Likeness of J's first penis drawing.

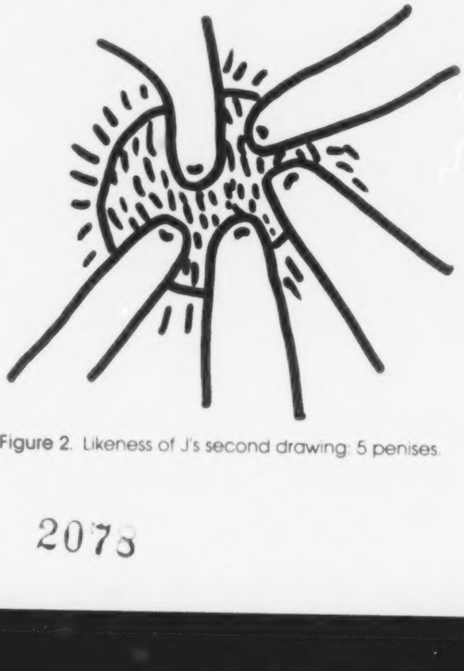


Figure 2. Likeness of J's second drawing: 5 penises.

saw that I was adamant and he continued drawing. By the end of the class period, he was not finished and we neatly put his artwork on the shelf.

When coming upon the adolescents returning from the cafeteria, I heard one of them say to J, "Here comes P.E." (Penis Envy). J said, "Cool it," to the boy who spoke. It was apparent that J had had enough of this subject.

J was very pensive at the next session and quietly confessed to me that he was "intimidated" by having to draw, and that is why he behaved as he did. I was surprised by his word choice and asked him what he would rather be doing. He said he liked to read. Using this information as a way to reach him, I promised to bring him something to read for the next session. But, in the meantime, I asked him to look at a photograph of a painting I had done, to make up a title, and to tell me a story about the figures in the painting. He immediately began writing a story about "The Family," the title he gave the painting. The writing was eloquent and most revealing.

I filled him with praise, so did the members of his group with whom he shared his work. His self-esteem was elevated and he asked if he could do the same with all of my paintings.

When I arrived the next day, J's school teacher informed me that he was ill and did not come to school that day and would probably not come to my art therapy group. To my surprise, he was the first to enter my room. He said, "I was sick all day, but I didn't want to miss art therapy. Did you bring the books?"

I had two books for J. One was an art book with many quotable lines. The other was science fiction, ***Stranger in a Strange Land*** by Robert Heinlein. J. was delighted. He asked me how I knew that his friends called him "Stranger." I explained that I did not know this and we spoke about synchronicity.

J spent the session with our new-found projective therapy in which he wrote about four more paintings. (Examples are Figures 3–7.) Each title and story revealed more of his incredible use of language and his vulnerability. Reflecting J's positive response to our meetings, the nine others in the group became the best behaved and productive adolescent group I ever experienced.

Learning from one of the mental health workers that J was listening to some Mozart on his radio, I asked him about his interest. He explained that he had seen *Amadeus* and recognized the music from the movie. I asked him if he would like a tape of some Mozart music, and he said that he would enjoy that. The other members of his group were then playing their own "rock" tapes.

The next day, I presented him with a tape of Mozart's ***Jupiter Symphony*** and Beethoven's *5th Symphony*. He thanked me affectionately. I went on to my next session and left him to enjoy the tape.

At the end of the day, when I was charting, one of the staff asked me to come and observe a miracle. She said that I wasn't going to believe my eyes. She quietly led me down the hall. As we approached the day room, I could hear the faint echo of Mozart. I looked through the window and saw J and 16 other adolescents sitting silently and listening to Mozart. These were adolescents whose Heavy Metal tapes had been confiscated, but who had all their Rock tapes going full force whenever they were allowed free time.

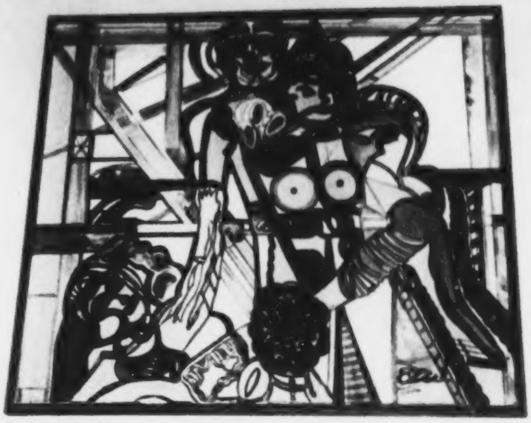


Figure 3. "GREEK GODESS" [*sic*]. This seems to be like a statue of a godess [*sic*] or a godess [*sic*] itself. And her followers or worshipers are admiring her by caressing and giving praise to her.

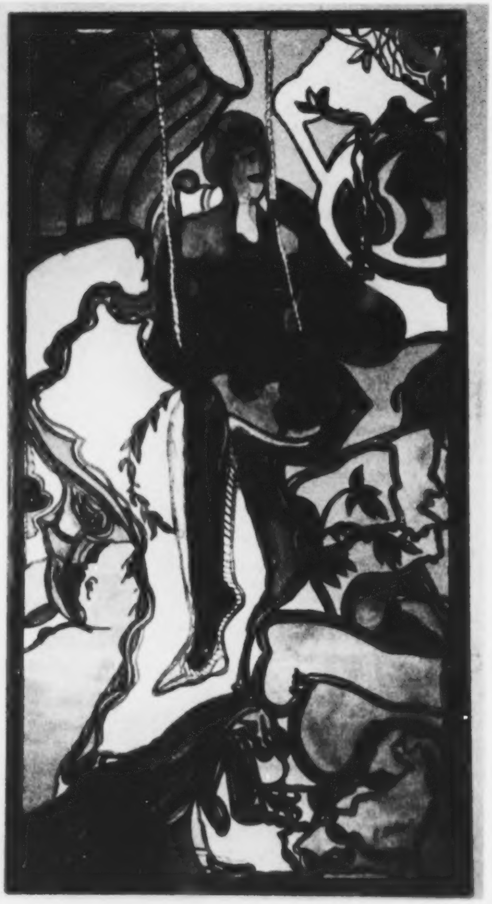


Figure 4. "SWINGING ABOVE THE WORLD". This looks like a woman on a swing. Somehow hanging on while all the art and everything colorful, and everything on earth is falling down. She seems to be without feeling laughing at their demise.

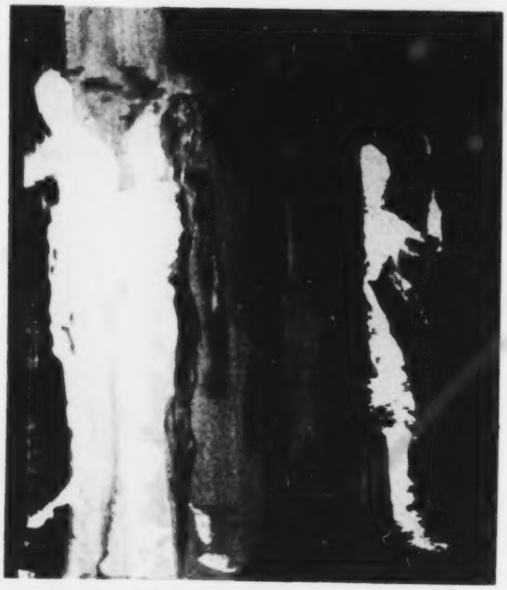


Figure 5. "SPLIT PERSONALITY". On the left seems to be the dark, tutured [tortured] life of this person. On the right seems to be his lighter side. The lighter good side seems to override the tutured [*sic*]. As the light is trying to turn it's [*sic*] back on the dark tutured [*sic*] side. But no matter how hard the light side try's [*sic*] it can't escape it's [*sic*] tutured [*sic*] dark past!

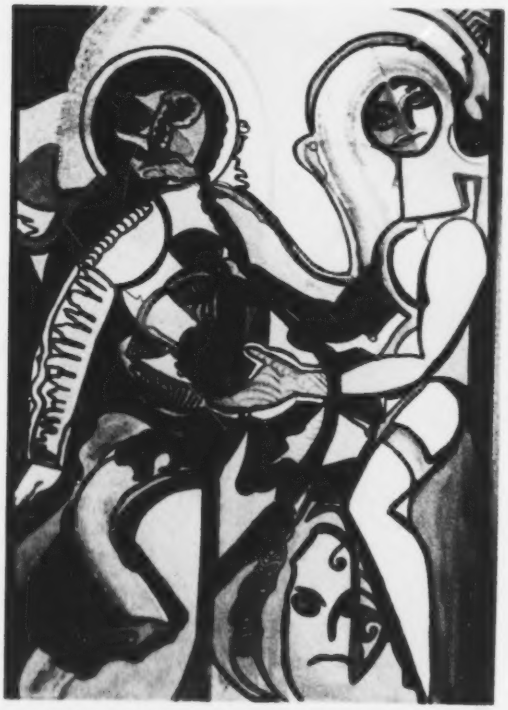


Figure 6. Not to make it sound like all women are like this. But to me, this looks like a woman ripping out a man's heart. Apparently they were once in love. Now being as ruthless as she is, she, without feeling a remorse, rips this loving man's heart out! He seems to be so much in love he doesn't try and get away. Love is truly blind!

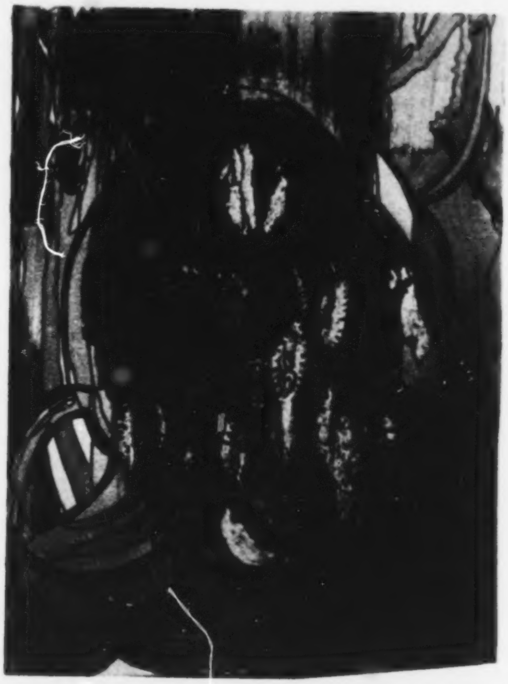


Figure 7. "ACID-TRIP". I hope this interpretation isn't taken as glorifying drugs. Because I'm sober now! But this appears [*sic*] some kind of skull with horns melting. And with all the colors and effects added, it reminds me of, one of my old L.S.D. trips! The skull is melting very colorfully, and exposing the brain and all its matter!

For the next several weeks, almost every one of the adolescents on the unit asked me if I would tape a symphony for them.

Here is an adolescent who was a violent gang member, but a natural leader. By disarming him at the beginning when he was challenging me, but allowing him to win in an area that provided him with much pride and praise for his creativity, I had discovered a talented, responsive individual who was still accessible.

The recent Los Angeles riots have reflected the anger of our disenfranchised youth. Art therapists have an opportunity to reach adolescents who have been alienated by society and give them a chance to succeed at something creative in which they experience pride.

I feel strongly that the most important attitude to bring these adolescents is to make them aware *that they are all artists*. In C. C. Jung's words:

> The creative urge lives and grows in the artist like a tree in the earth from which it gets its nourishment. We would do well, therefore, to think of the creative process as a living thing planted in the human psyche.

We, as art therapists, have this incredible opportunity to do this planting and to awaken the creative urge in the adolescents whose lives we touch.

Associate Editor's note: Captions 3–7 are stories J wrote for Ms. Unger's paintings (pictured). The stories are reproduced as they were written with the original spelling, punctuation, and grammar.

Medical Art Therapy: A Window Into History

Irene Rosner David, MA, A.T.R.-BC, New York, NY

"Spring Flowers"

"It really all started with my pot of flowering cyclamen, which followed me to hospital and stood on my bedside table. . . . We eyed each other like hostile strangers, staring each other out of countenance. I learnt that plant off by heart. . . . It is not a particularly pretty flower, it has no scent, revives no sentimental memories, but grows aloof in chill celibacy and takes an unconscionable time a-dying. . . . Illness, especially a fairly painless one demanding a long convalescence, is a great cleanser of muddled thought and anxious agglomeration. It is a definite anodyne of the mind. . . . Yes, but only for a time. The inexorable revolt against rest is inevitable and this is a most difficult phase."

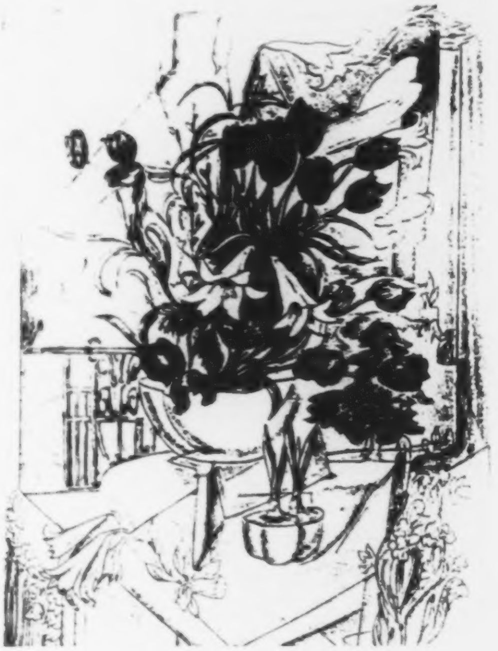


Figure 1. "Spring Flowers"

"I Draw My Room"

"Objects graced my bedside, all of stubborn medical utility. I was increasingly aware that time, which had been 'marking time' for some weeks past, was now definitely halted and stood still—very still! And with this dread realization came the happy discovery of how to set the pendulum in motion again, by the simple act of drawing—drawing the nearest objects to hand. . . . For it is true to say that a bed patient can be described as existing rather than living. It is as an impotent spectator that the patient is forced to view events . . . watching rather than participating in the daily round, like a frustrated witness at his own trial!"

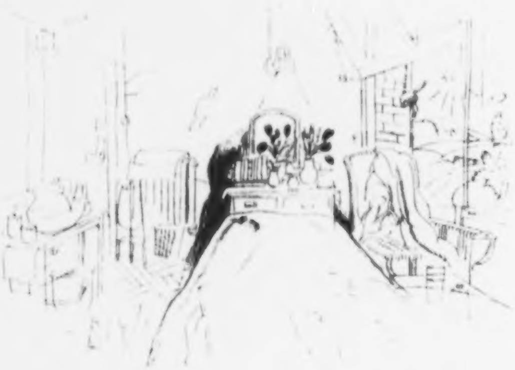


Figure 2. "I Draw My Room"

Commentary: These drawings and quotations are the work of an art therapist who, by his own account, was the first art therapist! They appeared in 1945 in *Art Versus Illness* by the English artist Adrian Hill. While being treated for pulmonary tuberculosis in a sanatorium, Mr. Hill personally discovered the special value of artistic release during his long-term hospitalization. Although many art therapists are aware that he was one of the forerunners in the field, few realize his significance, particularly to medical art therapy. As an art therapist involved in the treatment of TB patients and having researched the history of the profession while in England, I have had the privilege of reading Mr. Hill's original writings. His expressive comments of 50 years ago related to isolation and alienation are again relevant today with the resurgence of TB. His revelation that art making countered inactivity and reinstilled a sense of life seemed to set an eloquent foundation for the profession.

Reference

Hill, A. (1945). *Art versus illness*. London: George Allen & Unwin.

---

*Reprinted with permission from George Allen & Unwin—Harper Collins Publishers Ltd., London

Grandmother's Clause

Corlene J. Van Sluizer, MA, A.T.R., Santa Ana, Costa Rica

Here, read my journals
Contemplate the titles
On my bookshelves
Enjoy the paintings
Decorating the walls
My eyes are clear
I won't flinch
If you look into them

Come in
Make yourself at home
The roses
Are from my garden
And the hot bread is
Fresh out of the oven
Kneaded with time
And the silence
Of its rising
Wisdom is the yeast
Nothing can speed
The process

I share the taste
The particular spices
In this loaf
The nourishment
Is offered
Through my labors
Honor the bread
As you partake
And don't insult me
With a request
For the recipe
To verify
That it is
What it is
The proof is in
Your taste buds
Trust them

(Grandmothers have their
laurels and many full
tummies as testimony)

Come in
Sit down
Let's share some bread
Would you like honey
Or jam on yours?

Call for Papers

9th Art Therapy Association of Florida Conference
Multiple Dimensions of Art Therapy: Art, Client, Therapist
Spring 1996 Conference
May 3, 4, & 5

Attention Art Therapists, Creative Art Therapists, Mental Health Professionals, Allied Professionals and Educators: **ATAF** is seeking papers, presentations, panels, and workshops devoted to understanding and experiencing the process of art therapy in relationship to the art, the client, or the therapist. Submissions may focus on any topic or population related to this theme; of particular interest are: the value of different approaches and paradigms in art therapy, the use of art in the care of the therapist, and how specific psychopathology informs art-making in clinical practice.

Due October 10, 1995

Qualifying materials needed from each presenter includes:

1. Six copies of **Presenter's Resume**
2. Six copies of **Completed Call for Papers Application***
3. Six copies of **Bibliography for Presentation**

After June 12, 1995, For further information and proposal forms, please contact:

Mrs. Peggy Dunn-Snow, A.T.R.-BC, LPAT
165-07 Crenshaw Drive
Tallahassee, Florida 32310

CEU's for art therapists, nurses, social workers, mental health counselors, and marriage and family therapists are being arranged

2032

Reviews

Reverberations: Mothers and Daughters

by **Mildred Lachman-Chapin**, Evanston, IL: Evanston Publishing, Inc., 1994.

47 pp., 15 black & white and 24 color illustrations. $19.95 paper. ISBN 1-879260-32-8.

Reviewed by **Erika Cleveland, MA, A.T.R., LMHC,** Boston, MA

This lovely book reaches me at several levels, as it will surely reach art therapists and others interested in developing a personal relationship to their art and the world around them. The powerful imagery depicted in color and black and white reproductions enhances an accompanying text. This is a book that can be read and viewed repeatedly without losing the impact of its message about the joys and struggles in mother-daughter relationships. I imagine giving it as a gift to my mother or sisters.

As an artist I am inspired by the rich texture of Mildred Lachman-Chapin's artwork which intertwines intimate themes of relationships with broader themes of war and violence. Repetition is used to develop a theme, or, as she describes it, a "pattern." Lachman-Chapin begins with a newspaper clipping of "a screaming Vietnamese boat woman and her husband" (p. 4) and develops this image in a series of screaming faces, each becoming progressively more abstract. This begins an exploration of similar themes on a more universal level.

The body of the book consists of images representing feminine archetypes, accompanied by poems. In "Exposure Conversation," two women confront each other against a black background:

> I bare my breast to you, another woman.
> We are both nurturers. You, like me, are no longer a child.
> You know the pleasures of offering milk, solace.
> You know the tyranny of the hungry mouth, the raging hate of
> the needy one. (p. 28)

This is a haunting image: woman as mysterious, as breast and covered face, dark and deep, rich, evoking an archetypal nurturing power in all women.

Intimate images are contrasted with others that address global issues. "Atomic Prayers" reads:

> Prayers for the dead. For peace.
> We have our ceremonies and rituals
> In memoriam for past horrors.
> Will they cease?
> Hoping for some answer, a sound, a sign, to break the pattern of
> killing, loss and death. . . .
> Together we cover our heads and pray. (p. 41)

In the accompanying painting three women, hands on faces in prayer, are depicted against a black background. Covered faces are repeated, but now they are completely obliterated and breasts are not visible. There is an element of beauty and sense of strength in women who confront the pain and horror of wartime.

Building and echoing through images and poems provide a clear message of the ways women confront pain, anguish, and loss while maintaining hope and connectedness to each other. Touching on cycles of death, birth, and renewal, the book characterizes women's experience throughout the world. For this reason, the book is useful as a meditation tool for women clients who are facing issues of female identity.

Reverberations: Mothers and Daughters is a worthy addition to the tradition of therapeutic texts that reflect on personal experience through artwork and text, such as *Pictures of a Childhood: Sixty-six Watercolors and an Essay* (1986), in which Alice Miller confronts her feelings about her childhood through a series of watercolor drawings.

Lachman-Chapin's book builds on her earlier writing on the trancelike relationship that occurs between art and artist, art therapist and client. Though related to her earlier writings, this book is more personal. It stimulates thought for those who use art in a symbolic manner, but one does not have to be an art therapist to appreciate and enjoy *Reverberations*.

References

Lachman-Chapin, M. (1985). Eriksonian hypnosis and art therapy. *American Journal of Art Therapy, 23*(4), 115–124.

Miller, A. (1986). *Pictures of a childhood: Sixty-six watercolors and an essay* (Hildegarde & Hunter Hannum, Trans.). New York: Farrar, Straus, & Giroux.

Art Therapy with Families in Crisis: Overcoming Resistance Through Nonverbal Expression

Edited by **Debra Linesch, PhD, A.T.R.**, New York: Brunner/Mazel, Inc., 1993.

165 pp., 75 black & white illustrations. $25.00. ISBN 0-87630-638-5.

Reviewed by **James J. Consoli, MA, A.T.R.**, Norfolk, VA

An image continues to be played out in my mind as I consider reviewing this book: A man, traversing the Sahara and close to death by dehydration, is handed a tall glass of water. He immediately and without checking the contents or examining its purity, eagerly swallows it. He is then asked, "Tell me about it; how was it?" He emphatically responds, "It was wonderful!"

I found it difficult to remain completely objective while reviewing and critiquing the contents of a resource that is difficult to find anywhere in the field. Our literature is very light in terms of theory, and heavy with case examples of art therapy success stories. So, please allow me the opportunity to applaud Dr. Linesch's effort at describing family art therapy *theory*; the book truly provides a resource toward understanding theory *with* supportive case material, rather than another compilation offering art therapy cases. Thank you. Now, I believe I can proceed more objectively to review this book.

The title of this long-awaited book may be a bit confusing if one were to assume that ". . . Families in Crisis" describes families that are in need of crisis intervention, (which is addressed in Chapter Two). In fact, the definition of crisis is likened to "a turning point" or "an emotionally significant event" (Mish, 1986, p. 307), which does basically describe the status of the families in this text. Also included in the title is the word *resistance*, defined as "preventing unconscious material from becoming conscious, or *from receiving expression* . . ." (italics added) (Drever, 1979, p. 248). In fact, it is not that the family is resistant to verbal therapy; it is simply that verbal therapy alone does not work as well, nor does it allow for concepts, thoughts, or feelings to be expressed, as does the incorporation of imagery and art within the session. This is obvious when there is a language barrier, as described in the chapter on family art therapy with political refugees. The need for "nonverbal expression" can be less clear to "verbal" therapists who may consider that a child who responds minimally to questions is being "resistant," when, in fact, he or she does not possess the verbal sophistication of adults. However, what is generally true and yet even more subtle is that "The art facilitated intrafamilial dialogue. Communication grew out of self-expression and family members were able to share experiences, feelings, and hopes in ways that were freed of rigid systemic limitations" (p. 157). To visually exaggerate this point, family "verbal" therapy can be analogous to asking a family to, for example, describe their concerns using only their eyes. The individuals can quickly become frustrated and will most likely not return, while the therapist sits back and perceives the family as being "resistant." The client is not resistant; the therapist is resistant (or uninformed) about allowing the client a more direct mechanism for expression than art and imagery allows.

Art Therapy with Families in Crisis was tailor-made for the visually oriented person. I appreciated Dr. Linesch's graphic depictions of varieties of family dysfunction, types of family structures, and art therapy theory regarding how the art process can facilitate a therapeutic intervention to promote positive change and reduce strain on the family system.

Dr. Linesch reports that the intent of this book is to "[go] one step further . . . to focus on the nature of the relationship between the art experience and the curative process as it becomes part of the treatment intervention" (p. vii). She states that other art therapists (Kwiatkowska, 1978; Landgarten, 1987) have described the art process as augmenting and supporting family approaches. Although I agree that Dr. Linesch was successful in explaining family art therapy theory, as opposed to using art in family therapy, the previous art therapists have also written about family therapy as a primary form of treatment as opposed to something that is adjunctive.

Linesch begins the book by describing relevant theory. She provides the reader with some background on family systems thinking and how art can be useful when integrated into the treatment. She then offers case examples written by therapists who describe ways in which art therapy can be helpful with special needs families. Her final chapter, "The Second Look," sums up the answers to questions stated at the outset of the book, considered in relation to the case examples. The questions she presents along with theory and answers in the last chapter are:

1. What are the characteristics of the special needs families discussed in this book that invite the implementation of the art therapy process?
2. What are the characteristics of the art process that seem responsive to these families' special needs?
3. What is unique about the curative relationship between the needs of these families and the art interventions?

Each chapter describing a special population can stand alone as a separate article. What is most impressive is that each author begins with a theoretical model that is applicable to a given special population. For example, in a chapter by Susan Brook, titled "Family Art Therapy with Single-Parent Families," it is averred that one of the most important and most overlooked aspects of working with this family type is providing support for the single parent. Oftentimes we focus on trying to uncover what is wrong with a family and do not emphasize its strengths. By so doing, the therapist can do more harm than good. Susan Brook incorporates examples from the literature, including Riley (1988) and Landgarten (1987), which add to the field of family art therapy theory in this regard. She then provides case examples that begin with her rationale for the interventions based on her hypothesis about that particular family system. Other chapters are written in much the same way and include topics that are unavoidable in treatment, including alcoholism, sexual abuse, and crisis intervention, as well as less prevalent topics such as the aforementioned "Family Art Therapy with Political Refugees." However, what is important about this last inclusion is that the process cannot only be generalized to other populations (specifically the potency of the multifamily art therapy group), but also to the ever important issue of cultural sensitivity and the universality of art and imagery.

It is not clear who the audience is for this book. My assumption is that it can be used for training in family systems theory if presented as part of an art therapy curriculum. Unfortunately, this is not the case in most art therapy training programs. As an instructor I have used it with my students and most of them report that it is a helpful resource that should be placed within the first semester of family art therapy coursework. My fear is that if the non-art therapy training programs were to consider it as a text, they may fool themselves into believing that they, too, can provide the use of art in their family sessions without the appropriate training. However, it appears that the process, as described, may be complex enough to intimidate the would-be art therapy amateurs. I recall a clinical social worker being excited about the news of this book's release and asking me to let her borrow it when I obtained a copy. Her affect was significantly different when she returned it. It appeared she had hoped for the proverbial cookbook of art techniques to use with a family, and, instead, disappointedly returned the text because of its sophistication to non-art therapists.

Dr. Linesch successfully takes chapters written by other authors and sews them together into a quilt. Her thread is easy to see, and the stitching is simple. The reader can see not only the common theme among all of the chapters and the special populations presented, but also the potency of using imagery within family treatment.

My only criticisms are with the format of Dr. Linesch's first and last chapters. These are overly structured and repetitive, resulting in distracting reading. These chapters have the quality of an outline or rough draft rather than the well-integrated fluidness that is more apparent in her other publications. Also, many times prefatory statements are made, like "Again, at the risk of over simplification . . ." (p. 6), or, ". . . and consider the simple models being developed in this chapter in order to theorize about its form" (p. 8). I found myself wanting her to take that extra step and describe the complexity of the concept of process. I question, however if this is an objective reaction, or, am I just thirsty for more (?).

References

Drever, J. (1979). *The Penguin dictionary of psychology* (rev. ed.). New York: Penguin Books.

Kwiatkowska, H. (1978). *Family therapy and evaluation through art*. Springfield, IL: Charles C Thomas.

Landgarten, H. B. (1987). *Family art psychotherapy: A clinical guide and casebook*. New York: Brunner/Mazel.

Mish, F. C. (Ed.). (1986). *Webster's ninth new collegiate dictionary*. Springfield, MA: Merrian-Webster.

Riley, S. (1988). Adolescence and family art therapy: Treating the "adolescent family" with family art therapy. *Art Therapy: Journal of the American Art Therapy Association*, 5(2), 43–51.

Video Review

Southern California Art Therapy Association: Art Therapy Today

Produced and hosted by **Evelyn Virshup, PhD, A.T.R.** Five of nine tapes are reviewed. Interviewees: Bella Schimmel, MD & Thelma Kornreich, MA, A.T.R.; Violet Oaklander, PhD, A.T.R.; Shirley Riley, A.T.R., MFCC; Donna Heider, A.T.R., MFCC; and Rita Coufal, A.T.R., MFCC. Directed by Steve Eng, Santa Monica, CA: Century Cable, Public Access TV.

VHS ½", 25 minutes per tape, color. Purchase: $39.95 for the first tape and $29.95 for each additional tape ordered at the same time from Southern California Art Therapy Association, P.O. Box 4455, Sunland, CA 91041-4455. (California residents add 8% sales tax.)

Reviewed by **Harriet Feinstein, MCAT, A.T.R.**, Centre Hall, PA.

Musing about the video series *Art Therapy Today*, the image of an amoeba surfaced in my mind's eye. An amoeba has the ability to create new appendages to meet the demands of its environment, nourishing and propelling itself at will. This vision of "shape shifting," adaptability, and self-creating seems intrinsic to the practice of art therapy. Likewise, the ability to electively impose boundaries and structure while retaining one's flexibility is a hallmark of the field.

The art therapists interviewed in this series are akin to the amoeba; their malleability supports their ability to rise to the challenges of the populations being addressed. Each therapist has placed her personal stamp on her treatment mode in accordance with her unique life experiences, skills, and professional repertoire. While a conventional format is used throughout the series, a less conventional tone results from the actual interviews. Watching other practitioners in our field demonstrate and discuss their techniques is an inspiring and expanding encounter; their freshness and vitality stimulate the viewer's choices.

Each interview is set in a quietly lighted studio with the participants seated around a table. The introduction and some preliminary questions are initiated by Evelyn Virshup, PhD, A.T.R., who assists in decreasing the awkwardness of the taping process. As the drama evolves, the therapist takes the initiative by providing points of interest. For illustrative purposes artwork is often intertwined with dialogue; the spark is lighted!

Issues of bereavement, including early and later stages of grief, were presented by Bella Schimmel, PhD and Thelma Kornreich, A.T.R., the only team to be interviewed. As colleagues at the Center for the Widowed, they have had a long-standing professional relationship of more than 15 years. Their fluidity and comfort in working together are exhibited throughout the program as they smoothly alternate speaking without discernable cues or rehearsal. Several theoretical stances are mentioned, and their belief in group process and image formation is well-documented though examples displayed by Kornreich. In addition to instituting therapeutic groups for two levels of loss, recent and over a year, Schimmel and Kornreich provide a hotline listing and liaison with the community.

Frequently, the presenting problems of this population include overwhelming sadness, depression, and hopelessness. The slides of artwork exemplify these statements and present some of the ways art therapy groups are used to achieve better functioning. This includes capitalizing on a sense of universality among group members, taking risks with one's feelings and thoughts, and supporting the expression of feelings. Directives are demonstrated as the group leaders ask, "What brings you to the group? What happened this week? What images keep repeating in your mind? What have you not been able to share yet? Is this your first sad loss? What was the holiday like? How are you coping?" Artwork shown here is powerfully expressive and depicts universal themes of loss.

In *Your Art as Language*, Violet Oaklander, PhD, A.T.R., a gestalt therapist, is interviewed to explore her work with children. As part of the introduction, Virshup talks briefly about the integration of play forms and uses of creativity. She states the art, music, dance, and drama help us understand ourselves. Virshup and Oaklander demonstrate the

BEST COPY AVAILABLE

string and ink technique which allegedly coordinates brain functions to create personal revelations. They also demonstrate a minimal processing of the result.

After a brief recommendation of Oaklander's book, *Windows to Our Children*, Virshup and Oaklander discuss uses of her method with puppets. A case study is vividly enacted and, abetted by Virshup, a spontaneous session is created to further display the possibilities of puppet work. This shift felt somewhat stilted and labored, increased by the fact that adults, rather than children, were involved. Throughout the session a slide of a right-left-brain image behind the presenters was distracting and unnecessary.

Subsequently, Oaklander and Virshup touch on parental attitudes and expectations that often present when working with children. Oaklander addresses the "fix-it" expectation often placed on the therapist by parents. She states that she sees herself as helping the client "feel more of who [he/she is] . . . feel good . . . get along with his/her parents." She also attempts to expose "retroflected" feelings to help the children understand the role feelings play in what happens to them. She notes that some children learn this so well that, in their families, they become therapists to their parents.

Oaklander feels that "a changing child changes the family." This is demonstrated in two case studies involving the use of graphic media and Oaklander's processing. She describes a humorous episode about a filmed session for a television station which involved an 11-year-old boy who volunteered to participate. The end result is as clear a description of catharsis via the creative process that I have ever heard, although the term "catharsis" is not specifically used.

In the video with Shirley Riley, A.T.R., MFCC, Riley and Virshup discuss families in crisis and the use of art therapy with this population. Riley is one of the original art therapists trained by Helen Landgarten, who, likewise, focuses on this population. Riley offers the proposition that by using art tasks everyone in the family may be included in the dialogue. Children use art as a natural language and seem to "talk more easily through drawing," particularly when they are at a concrete stage of development. Adults, although more inhibited, initially think more abstractly and are therefore able to process at this level while becoming aware of the children's communication. Adolescents have the opportunity to demonstrate their autonomy through art and may be seen and heard more succinctly in this way.

Riley believes using art tasks allows everybody in the family the ability to explain how he or she sees "the problem." Art permits two levels for messages: the communication and the "meta message." Art also helps move "the toxicity away from feelings." Once a family has successfully worked together on an art effort, the next step is to generalize this ability to problem-solving of family matters. "Art enters their lives," comments Virshup.

Riley and Virshup discuss the value of well-trained art therapists versus other modalities in the use of creative graphic arts. "The reality is that children draw," says Riley. Other professionals recognize this and use artwork in limited ways (i.e., "appreciation of the image"). Both believe that art therapy has an advantage over verbal therapies because "the art therapist has more tools."

Using slides, Riley shows a variety of responses to family directives. Several of the families are involved in abuse issues and the artwork displays elements of beginning stages of the healing process. Riley reminds the viewer of the cardinal rule in many abusive families: "Don't talk, don't tell." Art allows the child to communicate without violating this rule. Riley demonstrates this in an especially vivid pair of drawings on the subject of guilt and how it is passed from parent to child and subsequently internalized. This video demonstrates her sensitivity to the issues at hand and the viewer emerges with a real appreciation of the style and personality of this therapist!

Suncrest Hospital's Donna Heider, A.T.R., MFCC, works with adult women who are incest and ritual abuse survivors. She does not conduct mixed-sex groups because many male survivors "become perpetrators and are actively acting out and not trusted." She describes some of the characteristics of the abuse survivor group, reporting that they are "scanners." Scanners constantly tune into others to discern their needs, are superficial when referring to themselves, tend to disclose information easily with emotionally removed statements, and are overly compliant. A surprising commonalty is that most group members are mature and have passed through their early adulthood almost automatically. They have raised families and held jobs. However, they now want to focus on problems which seem to be intruding into their lives.

Heider discusses the borderline personality makeup of most of her clients. She notes that some are also diagnosed with dissociative identity disorder. These clients test the therapist, waiting for her to fail them. Heider and Virshup also discuss how vital it is to recognize one's own countertransferential feelings, particularly the anger evoked when patients recall horrific events. "Patients need to feel their own anger" in order to trust their affective responses.

Heider is emphatic in her belief that art quickens the pace of the therapeutic relationship because the image is brought forward, fostering an immediate concrete response. Using uncomplicated directives, she focuses on what is happening. "What does it feel like to feel? What was the last thing in group to shake you up? What does disappointment feel like?"

Although examples of dissociative identity disordered patients' artwork are not offered, a discussion of the process is presented. Heider's understanding is that complex dissociation is a frightening experience and a patient with verified alter personalities will usually not advertise this phenomenon. She suggests that the therapist must be wary of someone who too willingly offers this label.

The graphic material shown in this interview is the most disturbing in the series, calling into question one's own reality testing. Heider discusses ritual abuse (i.e., cults), yet it is difficult for the viewer to tolerate; as a result, reality is questioned. A sense of hope is almost nonexistent, the wounds are so profoundly deep.

Once again, we perceive the manner and style of this art therapist and have a sense of what it might be like to work with her. A minor distraction during this video was Ms. Heider's earrings. One may not take jewelry into account when treating clients, however, this video proved it to be a worthwhile consideration.

The last videotape in this review focuses on an unusual speciality, adoptees. Rita Coufal, A.T.R., MFCC, is a former actress and an adoptee. She believes that her acting background was an asset to her training in art therapy. These skills gave her an ease of presence in front of groups, role playing experience, and the quick ability to pick up verbal and movement cues.

What makes this population unusual is that they do not come into treatment as known adoptees. It is through their imagery that the subject emerges. The most frequent presenting problems are depression, suicidality, eating disorders, and powerlessness. Phrases like "sleeping self" and "in a trance" are often used to self-describe. The issue of adoption does not arise or may be mentioned casually, perhaps a denial that adoption is any problem at all. This attitude possibly evokes from those who do not want to appear "ungrateful" or betray the parents who love them.

Among those adoptees who are now wrestling with this, a division may occur which is seen as a split: "good adoptee—bad adoptee." Many tensions arise from this implied state, as in "being sent back" if bad, or the threat of loss of love. There is a great need to find one's real identity, especially when there is a sense that one is "less than" or "was unwanted or given up." The artwork demonstrates the range of these issues affecting both sexes struggling with identity issues.

Coufal says that adoption is an identity which often presents through images as part-versus-whole figures, light and dark divisions, walls, and trust issues.

Coufal has formulated specific tasks to help illuminate the issues surrounding adoption. She asks for pictures about resentments, the empty chair, or a significant person in order to explore the client's realities. She understands the curiosity of adoptees to search for birth parents, not out of disloyalty to adoptive parents but as a way of dispelling myths surrounding their real identity. This lifts the "veil of secrecy" which has had official sanction for over 90 years. As a result of this need, Coufal is part of a network of search organizations and support groups. She recommends Betty Jane Lifton's book *Lost and Found*, an anthology of adoptees' stories.

Reflecting on the video series, I believe there is much to be gleaned from these therapists and their material. Although aesthetically unimpressive, the videos present a survey of art therapists' styles and ways in which therapists use themselves as tools to mediate between the psyche and external world. Their creativity sparks the client, allows for exploration, and gives form and content to expression when words fail.

Using interns, these videos were televised for the public access station; they are not edited. Despite their lack of polish, they are most useful for educating art therapy students and allied professionals. Practicing art therapists will also find them informative since they provoke brainstorming about dealing with various populations, although the experienced art therapist will be screaming for "more artwork!"

Because the tapes are not related to one another, I found it difficult to review the series as a whole. However, each individual tape is worthwhile and moves quickly. I would certainly recommend renting these tapes, were they available for rental purposes. Although the entire set is expensive to purchase, it would be an asset in a medical or teaching library where many could benefit from viewing them.

Video Review

Suicide: A Teenage Dilemma

Produced by **Evelyn Virshup, PhD, A.T.R.**, Los Angeles Suicide Prevention Center, 1987.

VHS, 30 minutes, color. Rental: $80.00. Purchase: $365.00 from Distribution Department, Health Sciences Consortium, 201 Silver Cedar Court, Chapel Hill, NC 27514. (919) 942-8731.

Reviewed by **Nancy Gerber, MS, A.T.R.**, Philadelphia, PA

Teenage suicide is a subject that universally evokes sadness and helplessness. Because teenagers often communicate their despair and hopelessness behaviorally rather than verbally, the suicidal message often is not heard. Increasing rebelliousness, aggressiveness, disrespect, decreasing school performance, promiscuity, and substance abuse can be some of the more drastic signals of depression and suicidal ideation in teens. These behaviors can cause parents, teachers, and other adults to react with anger, punitiveness, or alienation, rather than with understanding. The most persistent and profound statement of this video is a reminder to all adults that drastic changes in the behavior of a teenager should be taken seriously and investigated for the underlying depression and despair that lead to suicide.

This video, which is technically well done, dramatically presents the problems of parents, the expertise of therapists, the poignancy of the teens, and the pain of the survivors in relation to teenage suicide. Its touching, albeit somewhat melodramatic, presentation is appropriate for parents, teachers, and other nonclinically trained adults. Behavioral clues which may suggest suicidal ideation and intent are highlighted to alert the adult audience. Also, conceivably the video can be useful to stimulate discussion among teens, or between teens and their parents, opening doors of communication and understanding.

The video opens with a dramatic enactment. A teenage girl is desperately attempting to talk to her father about her problems. The father is too preoccupied with his televised baseball game to listen to his daughter and simply asks her to get him another beer. The daughter leaves the living room and makes a phone call to an unidentified party with no apparent success. She goes to the bathroom and takes pills and a razor from the medicine cabinet. Finally, in the first allusion to art therapy, she takes lipstick and draws a spiral on the bathroom mirror. End of scene.

This rather cliched and dramatic opening is the weakest part of the video. Although the role-play successfully highlights an apparent detachment that often occurs between parents and their adolescent offspring, the sketch contains too many unclear innuendoes. An analysis of the opening drama would increase the instructional value of this segment. A discussion about the role-play might have reviewed the behaviors of the teenage girl and her father and explained how this behavior and the graphic expression relate to her feelings and potential actions. An explanation of possible parental interventions could contribute to the usefulness of the dramatic portrayal. Instead, the viewer is left to draw his/her own conclusions until the scene is reenacted at the end of the video with a warm, fuzzy resolution.

The remainder of the video contains commentary by knowledgeable therapists, including the producer of the film, art therapist Evelyn Virshup. These segments are interspersed with staged group discussions by teens and interviews with hypothetical parents and survivors of suicide.

During the commentary portions of the video, detailed discussions focus on socioeconomic and cultural factors that contribute to the increase in teenage suicide, the behavioral equivalents of depression in teens, and clues to watch for in adolescents contemplating suicide. The excerpts are succinct, understandable, and educational. They successfully sensitize the audience to these aspects of teenage suicide.

The discussion among teenagers who have made suicide attempts or who have been connected closely to the suicide of a friend or relative is very poignant, but comes dangerously close to melodrama. In these sketches, teens discuss their suicide attempts, share poetry and artwork, and reveal the external or situational precipitators which led to their problems. Teens' descriptions of their internal feelings and behaviors in reaction to these feelings are particularly valuable because they remind adults to look beyond the presenting behavior to indicators of suicidal ideation.

Individual interviews with parents and friends of teens who have successfully committed suicide are a powerful vehicle. These maudlin dramatizations highlight the guilt, anger, and helplessness experienced by survivors of suicide victims. The point is made that teenagers often act impulsively and find "permanent solutions to temporary problems," implying that they have no conception of the finality of the act or the impact their actions might have on others. These monologues by family members and friends underscore the forgotten repercussions of suicide and may be particularly effective in communicating this aspect to a teenage audience.

All of these aspects of the video are quite effective in content and emotional impact. The video is less successful in its treatment of art therapy. Although there is a cursory review of art productions as a valuable form of communication by suicidal teens, the role of art therapy as treatment is never mentioned. A major deficit of this video is the omission of suggested interventions that could be used by parents or teachers who observe graphic clues of suicide. Art therapy content is limited to a brief mention in the excerpts by professionals who remind us that teens often communicate their intentions and despair in their writings and drawings.

In a three to four minute excerpt, Dr. Virshup comments on artwork done by teens who were either contemplating suicide or who had successfully committed suicide. Dr. Virshup discusses some symbols that often appear in the artwork connected to suicidal ideation or intent. Cemeteries, coffins, guns, and blood, she says, should alert parents and teachers to the possibility of suicidality. The spiral, used in the opening dramatic sketch, is never mentioned or explained.

Overall, too much is left to the viewer's imagination and interpretation of the art productions. This vague and dramatic presentation of artwork can, and often does, lead to misinterpretations and misuse of art therapy. More explicit descriptions of art expressions and their connection to human behavior are necessary to teach the audience to be alert for suicidal imagery and to understand and use these messages with teenage charges. Suggestions, such as talking to the teen about his/her artwork or consulting a school counselor or therapist when suicidal imagery surfaces, are practical interventions. Why not use a role-play of a parent who discovers the teenager drawing? How should the parent engage the teen in discussion about the drawings? How should a parent react to symbols which seem particularly alarming or morbid? When should the parent seek professional help?

Every public and professional opportunity must be seized to demystify art therapy. We increase the credibility and impact of our profession when we demonstrate how the drawn image relates to individual concerns and, ultimately, behavior. The lack of such explanations in this video, both in the dramatic and art therapy portions, is disturbing.

This reviewer also felt cheated out of more discussion about both the artwork itself and the process of art therapy with suicidal teenagers. For example, the clinicians repeatedly state that adolescents express their despair in actions, often self-destructive, rather than words or typical symptoms of depression. Art therapy is an ideal intervention that allows the skilled art therapist to evaluate art productions and determine underlying conflicts, defenses, and potential risk of suicide or other acting out behavior. During the evaluation process an opportunity for communication, rather than acting out, is provided. The strength of the art therapy experience with adolescents lies in the creation of empathy between detached and rejecting teens and those who can help them. A depiction of this process should have been provided.

Overall the video clearly accomplishes the following: it emphasizes that extreme behavior in teenagers is often a warning signal to suicidality; it describes the causes and repercussions of suicide, and it implores those who are involved with teenagers to "listen" closely. Conversely, if this video were produced as a public service for parents and teachers who are unfamiliar with therapy or human behavior, it fails as a result of its love affair with melodrama and its neglect of practical interventions and explanations. Commentary and dramatic sketches were often unintegrated, resulting in a patchwork effect. Segments often left interpretation to the viewer; this was disturbing, especially considering the subject matter.

Parents and teachers might benefit from further analysis of intervention techniques and dramatic presentations by experts. Parents or teachers of teenagers often feel completely powerless when attempting to understand or make meaningful connections to the troubled adolescent. It is for this reason that additional practical interventions, rather than innuendoes, would enhance the public service value of this video. By offering some steps to take and some tools to use, the video would provide a greater service to those involved with troubled teens.

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to each copy of your manuscript:

Name: ______________________________

Degrees/Credentials: ______________________________

Address: ______________________________

Phone numbers: Home ______________ **Work** ______________

Type of Submission (check one):

☐ Article

☐ Viewpoints

☐ Brief Report

☐ Film/Video Review

☐ Book Review

Title of Submission: ______________________________

____

Checklist:

☐ Five (5) copies, typewritten on 81/2" x 11" paper.

☐ Black and white photos of original artwork plus four (4) photocopies of each.

☐ Paper and references adhere to *Publication Manual of the American Psychological Association* (Fourth Edition).

☐ Abstract of 75-125 words (for articles and brief reports only).

☐ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

☐ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

☐ This Attention Authors form.

Author's Signature ______________________ **Date** ______________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association,*** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060

____

____/____/____

Guidelines for Submissions

All submissions will be acknowledged upon receipt by the AATA National Office. Art *Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in Art Therapy, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Editor, Art *Therapy: Journal* of *the* American Art *Therapy Association*, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 81/2" x 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication* Manual for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" x 7" and black and white glossy prints, preferably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. **It is the author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Cathy A. Malchiodi, MA, A.T.R., Editor

Art Therapy, the official journal of the American Art Therapy Association, is a quarterly journal for professionals and students who are interested in the use of art in the fields of mental health, psychotherapy and human development. The purpose of the *Journal* is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. ***Art Therapy*** publishes refereed articles, including illustrations, by art therapists, psychologists, family therapists, and others that reflect the latest advances in theory, research, professional issues, and practice. An emphasis is placed on the use of visual arts in therapy, but articles in related disciplines of interest are considered for publication. ***Art Therapy*** is an important source for news and summaries of national conferences, book reviews, media, and commentaries.

Recent articles published in *Art Therapy:*

- ★ Tuberculosis: Art Therapy with Patients in Isolation
- ★ Art Therapy on a Hospital Burn Unit
- ★ The Children's Diagnostic Drawing Series
- ★ Essential Legal Issues for Art Therapists in Private Practice
- ★ Diagnosis or Dilemma: Drawings of Sexually Abused Children

---

Art Therapy is available to AATA Members as part of their membership. Non-Members may subscribe at the following annual rates:

Individuals: $50.00 (U.S.) - $74.00 (Foreign)
Institutions: $77.00 (U.S.) - $100.00 (Foreign)

Single copies are available at:

Members: $12.50 - Non-Members: $23.00

Make checks or money orders payable to AATA and return with this subscription order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my subscription. Enclosed is a check in the appropriate amount:

Name: ____________________

Address: ____________________

City: ____________________ State: ______ Zip: __________

AATA REGIONAL SYMPOSIA

ADDICTIONS

Presenters: Lynn Jones, Holly Feen and Katie Webb

Participants will receive the latest information on the use of art therapy in the treatment of addiction and dual diagnosis. Art therapists will be able to identify specific non-verbal approaches for working through resistance and denial in the treatment of substance abusers. Counselors will be able to identify specific ways in which to coordinate treatment efforts with art therapists in their facilities.

FAMILY ART THERAPY

Presenters: Mari Fleming, Shirley Riley and James Consoli

The objectives of this symposium are to provide the participants with an overview of how art therapy provides families an enriched vocabulary to assist them in solving family problems. The art therapy gives a "voice" to all age levels and offers a non-threatening vehicle to aid in communication restructuring the family system. The intensive workshop will offer ways to combine family theories with art expressions and examine assessment methods, short and long term treatment. Participants will engage in experiential opportunities to experience how art therapy is applicable in their own professional setting. Every effort will be made to offer the most current trends in family therapy and art therapy application.

ART THERAPY IN THE SCHOOLS

Presenters: Janet Bush, Sarah Hite and Rebecca Taulbee

The objectives of this symposium will provide the participants with understanding the administrative procedures for implementing an art program in a large, urban school system, become familiar with the uses of art therapy for students in a public school system, become aware of techniques and strategies used in the training and preparation of school personnel; utilize the information they have gained to initiate discussion on approaches practices of art therapy in public schools; and to be prepared to transfer techniques and strategies for implementing art therapy services to other public school systems.

ART THERAPY WITH THE OLDER ADULT

Presenters: Larry Barnfield, Bernadette Callanan and Judith Wald

The symposium will cover general views on aging, relevant facts and new research, the role of art therapy with elders and settings in which art therapists practice and the special advantages of art therapy with the aging. It will cover the goals of treatment, treatment issues, and consideration of the clinical treatment of three groups of vulnerable aging and case studies.

GOING FOR THE GOLD: GRANTS AND RESEARCH IN ART THERAPY

Presenters: Frances Anderson, Vija Lusebrink and Doris Arrington

Successful grant writing in art therapy is, and will continue to be an important survival strategy in the 90's. Many model art therapy projects funded by grants will be discussed. The entire grant writing and granting process from identification of funding sources (public and private), to proposal development, submission and implementation will be covered. Technical assistance will be available to participants who already have a grant idea or proposal "in process".

ART THERAPY WITH CHILDREN AT RISK

Presenters: Cathy Malchiodi, Julie Epperson and Deborah Good

This symposium proposes to fill the need for advanced art therapy training focusing on theory, interventions, methodology and research with children at risk. "Children at risk" are defined as those who are directly affected by family violence, physical and sexual abuse, neglect homelessness, and various disabilities such as attention deficit hyperactivity disorder, learning problems, and physical limitation which put them at further risk for abuse and neglect. Emphasis will be on how the clinician can develop both short and long term art therapy interventions, effectively assist the child in crisis and appropriately utilize art expression in assessment of current level of psychological functioning.

ART AND MEDICINE

Presenters: Cathy Malchiodi and Anita Mester (third presenter to be named at a later date)

The symposium will focus on the unique dimensions of art therapy within a medical context with people who have experienced life-threatening chronic illness, particularly cancer and HIV. The special role that art expression plays in the assessment and evaluation of both the somatic and psychological status of the individual will be discussed, supported by the current research of both art therapists and clinicians in related fields. Special emphasis will be on paradigms for the use of art therapy within the context of psychoneuroimmunology and mind/body healing. Theories of imagery from current research by Achterburg, Simonton, Bach and others will be covered to assist the participants in integrating the use of art expression with physically ill clients will be presented so that participants acquire an understanding of the practical aspects of adapting art therapy to specific disease conditions. Lastly, emotional and transpersonal issues of grief and loss which are intrinsic to the experience of physical life threatening illness will be addressed.

These Symposia are offered at no charge to the participating Chapter

◆ ◆ ◆

For further information regarding the content or scheduling of these symposia, please contact the AATA National Office at

1202 Allanson Road • Mundelein, Illinois • 60060
(708) 949-6064
Monday through Friday 9:00 a.m. to 5:00 p.m. Central Time

The American Art Therapy Association

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), is a non-profit organization founded in 1969, is a national association which represents a membership of approximately 4,750 professionals and students. It is governed and directed by a nine-member Board elected by the membership. AATA has established standards for art therapy education and practice: AATA committees actively work on governmental affairs, clinical issues and professional development. The AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films, and awards.

PURPOSE

- -The progressive development of the therapeutic use of art.
- -The advancement of standards of practice, ethical standards, education, and research.
- -The provision of professional communication and exchange with colleagues.
- -The provision of legislative efforts to promote and improve the status of professional practice.
- -The promotion of the field of art therapy through the dissemination of public information.

CHAPTERS

Affiliated chapters of the AATA have been established throughout the US. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network for people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a chapter member. Information on locating the chapter nearest you is available from the AATA National Office.

MEMBER BENEFITS

All members receive:

Publications

- -Art Therapy: Journal of the American Art Therapy Association.
- -The Quarterly *AATA Newsletter*
- -Substantial discounts on AATA publications such as Annual Conference Proceedings, other professional journals, films, and the membership directory.
- -AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- -Mailings of professional interest.

Services

- - Insurance, including professional liability, major medical, life and disability through Maginnis & Associates.
- -Access to national experts in art therapy.

AATA Conferences

- -Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- -Governmental affairs activities including Congressional review and monitoring
- -State legislative and regulatory activities
- -Promotion of recognition and reimbursement of art therapists by third-party payors.
- -National liaison with related professional organizations for recognition and promotion of art therapy.

Professional Standards

- -Development of model job description and recommendations for licensing standards.
- -Development and implementation of national Education Standards for approval of graduate level Art Therapy programs
- -Development and implementation of nationally recognized Standards of Practice and Code of Ethics of Professional Art Therapists

GENERAL INFORMATION

The American Art Therapy Association, Inc. (AATA) and the Art Therapy Credentials Board, Inc. (ATCB) are administratively independent. Membership in AATA and registration (A.T.R.) with the ATCB requires separate applications and approval. (A.T.R. registration applications are available from ATCB, 708-566-8910).

For **NEW** Associate, Student, and Contributing members only: please follow the chart below when submitting membership applications:

The Membership year is the calendar year: January 1st, through December 31st.

Applications received between:

Jan. 1st - May 31st: Full dues payment; membership expires Dec. 31st of same year.
June 1st - Sept. 30th: Half year dues plus $5.00 payment; membership expires Dec. 31st of same year.
Oct. 1st - Dec. 31st: Full dues payment; membership for the remainder of the current year and the next full year.

CATEGORIES AND FEES

Professional - By application review process only; approved members may vote, hold office and serve on committees.

- -Credentialed Professional Member - Individuals who have been **dually approved** for Professional Membership by AATA and Registration (A.T.R.) by the ATCB; AATA dues are $85/year. ***A.T.R. Maintenance fee is billed separately by the ATCB***
- -Professional Member - Individuals who have completed educational training in art therapy; dues are $85/year.

Associate - Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. Such members may not vote, hold office, or serve on committees. Dues are $85/year.

Student - Individuals who are currently taking full time coursework in art therapy or a related field. Requires a current statement from the institution of learning indicating full time status and coursework content (6 graduate or 12 undergraduate credits.) Student members may not vote or hold office, but may serve on the Student Sub-Committee of Membership. Dues are $35/year.

Contributing - Individual organizations, institutions, or foundations which contribute annually to AATA. Such members may not vote, hold office, or serve on committees. Dues are $120/year.

Retired - Individuals who are at least 65 years of age and who are no longer practicing. Retired members receive publications and reduced fees, but may not vote or hold office. Dues are $35/year. Application provided upon request.

NON-U.S. - AATA members MUST include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

BEST COPY AVAILABLE

The American Art Therapy Association

MEMBERSHIP APPLICATION

NAME: ______________________________

HOME ADDRESS: ______________________________

____

PHONE: (   ) ______________________________

BUSINESS ADDRESS: ______________________________

____

EMPLOYER: ______________________________

JOB TITLE: ______________________________

LICENSES HELD & STATE: ______________________________

____

PREFERRED MAILING LIST: ☐ HOME ☐ BUSINESS

NON-U.S. AATA members MUST include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

Please indicate under which category you are applying:

☐ $85 Associate Membership

☐ $35 Student Membership **(see student membership criterion for necessary documents to accompany this application)**

☐ $120 Contributing Membership

Credentialed Professional Member - Individuals who have been **dually approved** for Professional Membership by AATA and Registration (A.T.R.) by the ATCB; AATA dues are $85/year. ***A.T.R. maintenance fee is billed separately by the ATCB.***

Professional Member - Individuals who have completed educational training in art therapy; dues are $85/year.

Provided upon request:

☐ Professional Membership Application **(professional membership granted by review approval process only)**

☐ A.T.R. Application - Provided and processed by the ATCB. **(A.T.R. granted by ATCB review approval process only)**

Please make all checks payable in U.S. dollars and mail to:

AATA - American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, IL 60060
(708) 949-6064 Fax: (708) 566-4580

Please complete this survey:

Education (please check highest degree earned)

1 ☐ Doctorate Degree
2 ☐ Master's Degree
3 ☐ Bachelor's Degree
4 ☐ Associate/Certificate
5 ☐ Other ____________

(Please indicate *exact* degree earned, e.g., BA, BS, MA, MS, PhD, etc.)

Work Setting (please check only one)

1 ☐ Hospital
2 ☐ Clinic
3 ☐ Day treatment center
4 ☐ Rehabilitation
5 ☐ Sheltered workshop
6 ☐ Correctional facility
7 ☐ Residential treatment
8 ☐ Out-patient mental health
9 ☐ School system
10 ☐ Elderly care facility
11 ☐ College/University
12 ☐ Clinical training pro.
13 ☐ Institute training pro.
14 ☐ Counseling center
15 ☐ Private practice
16 ☐ Other ____________

Area(s) of Specialization (please check up to three)

1 ☐ Addictions
2 ☐ Adolescents, Hospitalized
3 ☐ Adolescents, Psychiatric
4 ☐ Adults, Hospitalized
5 ☐ Adults, Psychiatric
6 ☐ Art History
7 ☐ Art Therapy Education
8 ☐ Art Therapy in Schools
9 ☐ Children, Hospitalized
10 ☐ Children, Psychiatric
11 ☐ Domestic Violence
12 ☐ Eating Disorders
13 ☐ Families
14 ☐ Gerontology
15 ☐ Hospice/Terminally Ill
16 ☐ Learning Disability
17 ☐ Mental Retardation
18 ☐ Neurological Disease
19 ☐ Prisoners
20 ☐ Post Traumatic Stress
21 ☐ Psychotherapy
22 ☐ Rehabilitation
23 ☐ Research
24 ☐ Sexual Abuse
25 ☐ Visual Art
26 ☐ Other ____________

Voluntary Information

Age:
1 ☐ 20 - 24
2 ☐ 25 - 29
3 ☐ 30 - 34
4 ☐ 35 - 39
5 ☐ 40 - 44
6 ☐ 45 - 49
7 ☐ 50 - 54
8 ☐ 55 - 59
9 ☐ 60 +

Salary Range:
1 ☐ under $10,000
2 ☐ $10,000 - $14,999
3 ☐ $15,000 - $19,999
4 ☐ $20,000 - $24,999
5 ☐ $25,000 - $29,999
6 ☐ $30,000 - $34,999
7 ☐ $35,000 - $39,999
8 ☐ $40,000 - $44,999
9 ☐ $45,000 - $49,999
10 ☐ $50,000 +

Gender:
1 ☐ Female
2 ☐ Male

Hours worked/week:
1 ☐ 0 - 10
2 ☐ 11 - 20
3 ☐ 21 - 30
4 ☐ 31 - 40

RESOURCES

The American Art Therapy Association, Inc.
1202 Allanson Road / Mundelein, Illinois 60060
(708) 949-6064 Fax: (708) 566-4580

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following publications, films, posters and training literature are available from the AATA National Office.

CONFERENCE PROCEEDINGS	MEMBERS	NON-MEMBERS
Creativity and the Art Therapist's Identity (1976) ISBN 1-882147-04-9	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) ISBN 1-882147-05-7	$ 5.00	$ 7.00
The Use of Creative Arts in Therapy (1979 Joint Conference)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) ISBN 1-882147-10-3	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) ISBN 1-882147-12-X	$ 7.00	$10.00
A Bridge Between Two Worlds (1981) ISBN 1-882147-11-1	$ 7.00	$14.00
Art Therapy: Still Growing (1982) ISBN 1-882147-06-5	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) ISBN 1-882147-13-8	$15.00	$20.00
Professionalism in Practice (1988) ISBN 1-882147-08-1	$15.00	$20.00
Painting Portraits: Families/Groups/Systems (1989) ISBN 1-882147-07-3	$15.00	$20.00
Image and Metaphor (1991) ISBN 1-882147-09-X	$15.00	$20.00
The Art Therapist: Artist/Teacher/Clinician/Healer (1992) ISBN 1-882147-14-6	$15.00	$20.00
Common Ground: The Arts, Therapy & Spirituality (1993) ISBN 1-882147-21-9	$15.00	$20.00
Reflecting on the Past, Envisioning the Future (1994) ISBN 1-882147-24-3	$15.00	$20.00

NOTE: Ten or more copies of any single proceeding: 10% discount on total. Set of four proceedings (consecutive years): 20% discount on total. Postage/Handling: $3.00 first item; $.75 each additional.

PUBLICATIONS FROM AATA	MEMBERS	NON-MEMBERS
A History of Art Therapy in the United States (1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual (1994) Howie & Gutierrez ISBN 1-882147-16-2	$25.00	$37.00

OTHER PUBLICATIONS	MEMBERS	NON-MEMBERS
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0 [1]	$24.00	$35.00
Art Therapy in the Schools [3]	$ 6.00	$10.00
National Registry of Masters Theses & Practicum Papers [3]	$15.00	$25.00
Addendum to National Registry [3]	$12.50	$22.50
AATA Chapter Manual [2]	$10.00	N/A
Applying for Funds from Your Area Agency on Aging [3]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance [3]	$ 7.00	$10.00

NOTE: [1] Postage included on all orders for this publication. [2] Ten or more copies - 10% discount. [3] Add $3.00 for postage.

PROFESSIONAL PREPARATION LITERATURE	MEMBERS	NON-MEMBERS
Education Standards	N/C	$ 1.00
Education List (Colleges and Universities offering art therapy programs)	N/C	$ 2.00
◆*ATCB Standards & Procedures for Registration*	N/C	$ 1.00

General Information Packet - $4.00

OTHER LITERATURE	MEMBERS	NON-MEMBERS
Art Therapy Model Job Description	$ .32	$ 1.00
Art Therapy Media List	$ .32	$ 1.00
Bibliography: Books Authored by AATA Members	$ .32	$ 1.00
Ethics Document	$ .32	$ 1.00
Standards of Practice Document	$ .32	$ 1.00

MEMBERSHIP INFORMATION	MEMBERS	NON-MEMBERS
Membership Specialty List	$ 2.62	$ 3.62
Membership Survey	$ .32	$ 2.75
1994 Membership Directory [1]	$ 14.00	$55.00
Criterion for Professional Membership	$ .32	$ 1.00

NOTE: [1] Postage and handling for AATA Directory U.S. - $3.00; Canada/Mexico - $3.25; Foreign - $10.00.

POSTERS	MEMBERS	NON-MEMBERS
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Shipping and handling is included on both posters.

SUBSCRIPTIONS		
ARTherapy: Journal of the American	Individuals = U.S. $50.00	Foreign = U.S. $74.00
Art Therapy Association	Institutions = U.S. $77.00	Foreign = U.S. $100.00
Back Issues	Members = $12.50	Non-Members = $23.00
AATA Newsletter	U.S. $26.00	Foreign $38.00

NOTE: Shipping and handling is included on both subscriptions.

FILMS	TYPE	MEMBERS	NON-MEMBERS
Art Therapy Beginnings	16mm-rental only	$40.00	$50.00
(1977) color/sound/45 min.	1/2" VHS-purchase only	$50.00	$80.00
Michael	16mm-rental only	$30.00	$35.00
(1977) color/sound/12 min.	1/2" VHS-purchase only	$50.00	$80.00
Art Therapy	16mm-rental only	$35.00	$45.00
(1980) color/sound/12 min.	1/2" VHS-purchase only	$50.00	$80.00

NOTE: Postage and handling for VHS - $3.00 each tape; 16mm - $7.00 each film.

ART THERAPY CREDENTIALS BOARD, INC. INFORMATION	MEMBERS	NON-MEMBERS
◆*ATCB/A.T.R. (Registration) Application*	N/C	$ 1.00
◆*ATCB Standards & Procedures for Registration*	N/C	$ 1.00

◆ This information is provided by the American Art Therapy Association, Inc. as a courtesy to the Art Therapy Credentials Board, Inc., an independent certification and registration organization. For further information contact ATCB, Inc. at (708) 566-8910.

---

1. WE DO NOT ACCEPT CREDIT CARDS OR PURCHASE ORDERS. All orders must be made in writing, accompanied by payment in cash, check, or money order in U.S. funds.
2. FOREIGN ORDERS: Shipping will be made per your instructions (surface or air). Please specify shipment method when ordering. Additional postage, if necessary, will be billed separately.
3. RETURNS ARE NOT ACCEPTED for refund on shipped items.

TITLE	QUANTITY	PRICE	TOTAL

SHIPPING INFORMATION

NAME: ______________________________

MEMBER ID#: ______________________________

STREET: ______________________________

CITY/STATE/ZIP: ______________________________

Total: $__________

Postage: $__________

Applicable Discount: $__________

TOTAL ENCLOSED: $__________

Allow 2 - 4 weeks for delivery.
MAKE CHECKS PAYABLE TO AATA

WEAVING NEW VISIONS

26th ANNUAL AATA CONFERENCE 1995

WEAVING NEW VISIONS

Art Therapy in Collaboration with Allied Professions

November 9-12, 1995 • San Diego, California

KEYNOTE SPEAKER

Kay Redfield Jamison, Ph.D.

Author of

Touched with Fire: Manic Depressive Illness and the Artistic Temperament

Dr. Jamison is a Professor of Psychiatry at the Johns Hopkins University School of Medicine and the co-author of the definitive text *Manic-Depressive Illness*. As a clinical psychologist and prominent researcher on mood disorders, she has studied the relation between manic-depressive illness and artistic endeavor, and applied this knowledge to the lives of great artists.

Commentary on *Touched with Fire*

"This enthralling study... enlarges our understanding of the creative process in new and unexpected ways. Professor Jamison combines psychiatric sense with artistic sensibility... "

Dr. Anthony Storr, Author of *Solitude: A Return to the Self* and *Music and the Mind.*

Reprinted with permission from Sterling, Lord Literistic and Free Press — Macmillan, Inc

For further information please contact the AATA National Office at
1202 Allanson Rd., Mundelein, IL 60060 or phone (708) 949-6064

CHARLES C THOMAS • PUBLISHER

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror. (2nd Ed.)** '95, 206 pp. (7 × 10), 21 il.

☐ Makin, Susan R.—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 112 pp. (7 × 10), $29.95. ***$15.95, paper.***

☐ Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 186 pp. (7 × 10), 33 il. $41.95 ***$26.95, paper.***

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts, Theories and Practices. (2nd Ed.).** '94, 244 pp. (7 × 10), 1 table. cloth—$58.95, paper—$33.95.

☐ Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 × 10), 12 il. $35.95.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $37.95. ***$22.95, paper.***

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 × 10), 24 il., $46.95. ***$29.95, paper.***

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¾), 28 il., $38.95. ***$24.95, paper.***

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $48.95. ***$29.95, paper.***

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $56.95. ***$34.95, paper.***

☐ Krauss, David A. & Jerry L. Fryrear—**PHOTOTHERAPY IN MENTAL HEALTH.** '83, 260 pp. (6¾ × 9¾), 61 il. (5 in color), 1 table, $46.95. ***$29.95, paper.***

☐ Benenzon, Rolando O.—**MUSIC THERAPY IN CHILD PSYCHOSIS.** '82, 112 pp., 34 il., $25.95. ***$14.95, paper.***

☐ Furrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $25.95, spiral (paper).

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $53.95. ***$31.95, paper.***

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $49.95. ***$29.95, paper.***

☐ Rugel, Robert P.—**DEALING WITH THE PROBLEM OF LOW SELF-ESTEEM: Common Characteristics and Treatment in Individual, Marital/Family and Group Psychotherapy.** '95, 228 pp. (7 × 10), 2 tables, $45.95, cloth, $29.95, paper.

☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 17 il., $47.95. ***$29.95, paper.***

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $51.95. ***$30.95, paper.***

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $64.95. ***$32.95, paper.***

☐ France, Kenneth—**BASIC PSYCHOLOGICAL SKILLS FOR FRONT-LINE STAFF OF RESIDENTIAL YOUTH FACILITIES.** '93, 212 pp. (7 × 10), 3 il., $45.95. ***$29.95, paper.***

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $92.95. ***$49.95, paper.***

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $35.95. ***$19.95, paper.***

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $46.95. ***$29.95, paper.***

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $24.95.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $53.95, cloth, $33.95, paper.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 260 pp., 54 il., $32.95. ***$18.95, paper.***

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $34.95.

☐ Benenzon, Rolando O.—**MUSIC THERAPY MANUAL.** '81, 178 pp., 20 il., $29.95. ***$14.95, paper.***

☐ Singer, Florence—**STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children.** '80, 144 pp., 33 il., $25.95. ***$13.95, paper.***

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $27.95. ***$15.95, paper.***

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 12, NUMBER 3, 1995

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064; FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Resources in Education (ERIC), INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern.*

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue, July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Patricia St. John, EdD, A.T.R.-BC
College of New Rochelle, New Rochelle, NY

Book Review Editor
Barbara Sprayregan, PsyD, A.T.R.
Stoney Brook Counseling Center, Chelmsford, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Friends Hospital, Philadelphia, PA

Production Editor
Karen D. Savage

Editorial Board
Pat B. Allen, PhD, A.T.R., LPAT
School of the Art Institute, Chicago, IL
Doris B. Arrington, EdD, A.T.R.-BC
College of Notre Dame, Belmont, CA
Janet Bush, EdS, A.T.R.-BC
Dade County Public Schools, Miami, FL
Julia Byers, MA, A.T.R.
Concordia University, Montreal, Canada
Mariagnese Cattaneo, PhD, A.T.R., LMHC
Lesley College, Cambridge, MA
Susan Cheyne-King MS. A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R., LPAT
George Washington University, Washington, DC
John Goff Jones, PhD, ABPP, A.T.R.-BC
Oklahoma City, OK
Julie Epperson, MA, A.T.R., LPCC
YWCA of Salt Lake City, Salt Lake City, UT
Deborah A. Good, MA, A.T.R., LPAT, LPCC
Family Therapy of Albuquerque, Albuquerque, NM
Anna Hiscox, MA, MFT, A.T.R.
McAuley Neuropsychiatric Institute, San Francisco, CA
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Frances F. Kaplan, DA, A.T.R.
Hofstra University, Hempstead, NY
Carol Lark, MA, A.T.R.
Art Therapy Center of St. Louis, MO
Vija B. Lusebrink, PhD, A.T.R.-BC
University of Louisville, Louisville, KY
Patricia Engle Murphy PhD, A.T.R.
Private Practice, Moscow, ID
Mary Ellen Peacock, MA, A.T.R.
St. Francis of Assisi School, Louisville, KY
Leslie P. Knowles, A.T.R., LMHC
Whitney Academy, East Freetown, MA
Shirley Riley, MA, A.T.R., MFCT
Loyola Marymount University, Los Angeles, CA
Irene Rosner David, MA, A.T.R.-BC
Bellevue Hospital Center, New York, NY
Nancy M. Sidun, PsyD, A.T.R.
The Chicago School of Professional Psychology, Chicago, IL
Susan Spaniol, EdD, A.T.R.
Leslie College, Cambridge, MA
Evelyn Virshup, PhD, A.T.R., MFCC
California State, Los Angeles, CA
Judith Wald, MS, A.T.R.
New York Hospital - Cornell Medical Hospital Center,
White Planes, NY

AATA President
Bobbi Stoll, MFCC, A.T.R.-BC

AATA Executive Director
Edward J. Stygar, Jr.

VOLUME 12

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 3,1995

Editorial

Studio Approaches to Art Therapy — Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC 154

Commentaries 157

Special Section on Studio Approaches to Art Therapy

Articles

Coyote Comes in from the Cold: The Evolution of the Open Studio Concept — Pat Allen, PhD, A.T.R., LPAT 161

The Art Studio: A Studio Based Art Therapy Program — Mary McGraw, A.T.R. 167

The Intern Studio: A Pilot Study — Linney Wix, MEd, A.T.R. 175

Keeping the Studio — Shaun McNiff, PhD, A.T.R. 179

Viewpoints

ArtStreet: Joining Community Through Art — Janis Timm-Bottos, MA, PT, RMHC 184

A Consideration of the Studio as Therapeutic Intervention — David Henley, MA, A.T.R. 188

The Base and the Mark: A Primary Dialogue in Artmaking Behavior — Lenore Steinhardt, MA, A.T.R. 191

The Reenchantment of Art Therapy — Jim Young 193

Reviews

Magazine Photo Collage: A Multicultural Assessment and Treatment Technique — Nadia Ferrara, MA, A.T.R. 197

Integrative Approaches to Family Art Therapy — Linda Sibley Seaver, MPS, A.T.R. 198

Photo Therapy Techniques: Exploring the Secrets of Personal Snapshots and Family Albums — Julia Gentleman Byers, MA, A.T.R. 200

Photo Therapy Techniques: Exploring the Secrets of Personal Snapshots and Family Albums — Stephanie Zuperko Dudek 202

Video Review: The Shattered Sugar Bowl: Kids with Diabetes Speak Out / This Flower Comforts You: Girls on Dialysis — Barbara Faith Cooper, MPS, A.T.R. 203

Noteworthy 204

About the Cover: "Upon Leaving Chicago," graphite, 24" × 32", 1994. David Henley, MA, A.T.R., New York, NY, is an associate professor at Long Island University, CW Post Campus. "I know very little about my work. It is not concerned with metaphor or symbolism—I draw precisely what I see and try to think nothing more about it."

2191

Editorial

Studio Approaches to Art Therapy

Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC, *Editor*

In the recent issue of the *AATA Newsletter*, the president's report notes the flurry of activities involving inclusion of art therapists in existing licensures, recognition as independently licensed professionals, and/or acceptance of art therapy certification by state licensure boards (Stoll, 1995). It is no surprise that an urgent need exists within the profession to address issues of managed care, licensure, and provider reimbursement, given the fast-moving, ongoing market reforms in the healthcare arena. The advent of managed care organizations (MCOs) has forced art therapists who are employed in clinical positions or in private and group practices to consider issues such as certification, licensure, and provider status. It has also apparently encouraged the profession to intensify efforts to complete outcome and efficacy studies of art therapy that will convince MCOs of the value of art therapy to clients (also see Stoll, 1995).

While the profession struggles on both the state and national level with these very real battles for livelihood and recognition, there are still philosophical questions within the field of art therapy that remain largely unanswered and often unexplored amidst the bustle over which letters are best to have in back of one's name. This special issue of the journal addresses a theme loosely defined as studio approaches to art therapy and puts forth some aspects about our work that may have been forgotten or at the very least, neglected in our urgency to certify, regulate, and defend our professional turf. Although the articles and viewpoints on these pages may have little to offer to solve the perceived struggles for recognition, provider status, and job security, they do offer some important thoughts that relate to the issue of efficacy of art therapy interventions and how, as art therapists, we can best be of service to our clients.

The concept of art therapy within a studio space is not in and of itself novel, although it has not received much formal attention in our literature. One historic, yet relatively unknown milestone in the development of a studio approach to art therapy is the work of Mary McGraw, A.T.R., at the MetroHealth Medical Center in Cleveland, Ohio (see article in this issue). For over 25 years McGraw has developed and expanded the concept of the art therapy studio through her work with children, adults, groups, and families. A statement in *The Art Studio— Center for Therapy through the Arts: 25th Anniversary catalogue* (1992) describes the essence of the program:

> ...patients' introductions to the Art Studio came by word of mouth, not by referral; they would come in out of curiosity. When they arrived, in cart or chair, they would find inviting things—a bit of current music playing, paintings on the wall, coffee or tea. It might take two weeks of looking on before a patient got up the courage to join those already engaged in creating art. Right away though, surprising things began to happen. People who had never drawn or painted before found themselves unable to stay away, and spending their free time thinking of what they would do next.... (p. 8)

Since its inception, the Art Studio and its satellite programs throughout the Cleveland area have provided creative and therapeutic environments for artmaking for over 16,000 individuals. In addition to McGraw, other art therapists have worked or are currently working in this manner, including Robert Ault at the Ault Art Academy, Topeka, Kansas; Pat Allen, Deborah Gadiel and Dayna Block at The Open Studio, Chicago, Illinois, referred to in this issue; and Irene Ward Brydon at the Creative Growth Center, Oakland, California.

In actuality, what exactly the studio approach to art therapy is remains largely undefined, although there are some identifiable characteristics. One characteristic centers around the idea of space—the environment where the art therapist, the space itself, and people who visit the space come together in what McNiff (see article in this issue) refers to as a "creative ecology of forces." This synergistic effect of therapist, people, and space is rarely discussed, although it is a vital aspect of why artmaking might be helpful to the clients we seek to serve. It has often been observed that art therapy involves both the two important components of product and process; equally crucial to what comprises therapy is how art therapists bring people together within a space.

Time is another important factor in the studio approach; by its very nature, the studio as an environment encourages a more in-depth experience with artmaking. In contrast, clinical approaches often encourage quickly drawn, rudimentary sketches or hastily pasted collages within a 50-minute hour. They also may involve assigning an art task with a specific theme to clients such as draw your anger, draw a person in the rain, etc. After these images are hurriedly completed, a discussion ensues with the person verbally sharing his/her work and the therapist providing feedback. These types of art therapy sessions are particularly common in psychiatric settings where art therapy may be part of an overall treatment program and are prevalent in brief therapy milieus where contact time is limited.

In comparison, studio-based approaches usually involve little or no directives, more time, and therefore, a more in-depth experience with the art process. For example, an individual might, as Timm-Bottos describes in her viewpoint piece on the ArtStreet program, attend the studio as much or as little as s/he wants, working on one ongoing piece or a series of several different works. There are no formal group sessions, although special instructional workshops may be offered from time to time. Working artists/art therapists are generally present and the dynamics of the space are dependent on the ever-changing flux of visitors and participants.

Although both clinical and studio approaches to art therapy may be of value in certain circumstances and within certain frameworks, a comparison of the two approaches does generate many questions about the basic definitions of what is "therapeutic" and what is "artmaking." For example, under what circumstances is it truly helpful or therapeutic for clients to be specifically asked to draw their anger, draw a person in the rain, etc.? When is it more effective for clients to work for more extended periods of time and in unstructured environments such as studio settings? Is it OK for an art therapist to work on his/her own art during a session? Other more general questions come to mind, such as how do we define artmaking? Art? Artists? Do we see our clients as artists or only as clients? Do art therapists see themselves as artists? Is all work that comes from art therapy art? When and if is it important that it be art? Many of these questions have been asked before, but are certainly worth revisiting with respect to the articles and ideas presented on these pages.

As with any methodology, there are some difficulties with the studio approach that must be mentioned. Just as becoming a health care provider and receiving third party payments is difficult for clinically oriented art therapists, working as an art therapist in a studio setting involves similar and perhaps even more intense financial struggles. Since studio programs may be viewed as more art-oriented than clinically based, one of the more difficult aspects of the studio approach is obtaining funding in this time of cuts in grants for art programs and artists in general. The National Endowment for the Arts (NEA) has been threatened with extinction, with proposals to reduce the funding to the arts agency altogether or eliminate at least 40-50% of its available grants (Steis, 1995). Although most artists do not receive grants directly from the NEA, its threatened elimination does impact state art councils who receive funds from the National Endowment and influences the general belief that the arts are not worthy of public funds.

Art therapists interested in funding the types of studio-based programs discussed in this issue may have to seek funding other than public money, focusing on local or corporate foundations, community donations, and receipts from workshop fees and sale of art or related items (see Noteworthy piece on art calendar at the National Jewish Hospital). Strategies for arts-based funding are available (Malchiodi, 1987; Gray, 1995), but art therapists exploring this type of funding are cautioned that their artist identity must be strong in terms of current portfolio and exhibition records (Gray, 1995). In order to be considered, they must demonstrate that they are truly working visual artists with a primary dedication to art and studio work. More often than not, due to lack of time or inclination to do studio work, art therapists may fail to meet these criteria.

Another difficulty those with an interest in the studio approach to art therapy may face is the lack of understanding and acknowledgement within the field of art therapy. The call for papers for this special issue generated surprisingly few respondents; perhaps studio-oriented art therapists want to make art rather than write. But I will also venture that studio approaches to art therapy are seen as a less prestigious career path as opposed to clinical positions. For years art therapists have differentiated themselves from the art-as-therapy approach by calling themselves "art psychotherapists," a term that seems to imply more credibility and clinical expertise than plain old "art therapist." This desire to appear more clinical and psychotherapy-oriented also stems from basic economics; a full-time clinical position offers a higher, hopefully more stable salary (and benefits) than any artist-in-residence position. Having been an artist-in-residence for three different state arts councils, I can unequivocally state that residency money is lean (and does not include health and retirement benefits) and grants for any type of art therapy programming are difficult to obtain, and when obtained, are impossible to live on without other income.

A third dilemma involving studio approaches to art therapy relates to the recent revisions of the AATA ethics document. By its very nature, an art studio sets up a unique set of dynamics among its participants as well as an environment that differs from a clinic or hospital, bringing to question our notions and rules about confidentiality and personal boundaries. As described in both McGraw's and Allen's articles, people can drop in at various times to work in an open studio; space is shared by all participants and privacy is nonexistent; participants freely display their art on walls that, in some cases, the public may look at through windows or by visiting the studio space. There are also undefined aspects of the facilitator's responsibilities and relationship to the participants who attend an open studio. These are not questions easily answered by the profession and are not addressed in the current ethics document which largely focuses on clinical applications of art therapy.

At the start of this editorial a pressing need for efficacy and outcome studies of art therapy was noted. It seems that for the profession of art therapy a crucial question remains: what is it that really makes our work with clients effective? Although there has been considerable research in the area of art-based assessments, these findings are not at the heart of what actually helps our clients to find healing, support, and wholeness through their experience of art therapy. The ability of art therapy to help clients express themselves in ways that words cannot is indeed powerful, but there are deeper aspects of the art process itself and all that it entails which create health and well-being in our clients. In our collective push for clinical recognition by other professionals, organizations, managed care corporations, and state and federal government, we may be neglecting the exploration of aspects of artmaking necessary to justify our uniqueness as a separate discipline.

Like many art therapists, what brought me to this profession is the powerful and personally fulfilling experience of artmaking, of exhibiting and sharing my work with others, and of making art in a studio setting, in groups and individually. Working in my own studio or in others, feeling connectedness to other artists, seeing art in progress, getting lost in hours of artmaking, sharing a cup of tea with a fellow artist, or receiving feedback on my work—these are aspects of artmaking that reinforce my belief about the ability of the art process to effect change, build community, and enhance one's life (Malchiodi, 1994). They are the experiences that led me to consider graduate training in the field, and still inform and inspire my work with clients today.

However, I don't believe that we will come to many favorable conclusions about the efficacy of art therapy until we recognize, investigate, and honor the unique properties of artmaking and how artmaking is best presented in service of our clients. Identifying the efficacy of art therapy will come from our deeper understanding and exploration of media, the art process, and therapeutic space, and how we define these as artists. The answers to our search will not come from our clinical expertise alone, but rather from our knowledge of art and from an intimate, personal connection to our own artmaking.

References

Gray, I. (1995). How grants are awarded: Behind the scenes at a state arts council. *ArtCalendar: The Business Magazine for Visual Artists, 9*(8), 5–6.

Malchiodi, C. A. (1987). Strategies for obtaining art therapy funding from arts-related sources. *American Journal of Art Therapy, 25*(4), 91–94.

Malchiodi, C. A. (1994). *Artists as agents of change: The use of artmaking to build community.* Unpublished paper presented at the 11th Annual Art Therapy Conference, School of Visual Arts, New York, NY, November.

Steis, D. (1995). Art scuttlebutt. *ArtCalendar: The Business Magazine for Visual Artists, 9*(8), 3–4.

Stoll, B. (1995). Report from the president. *AATA Newsletter, XXVIII* (3), 1–2.

The Art Studio. (1992). *The Art Studio—Center for Therapy through the Arts: 25th Anniversary.* Cleveland, OH: Author.

Commentaries

Letters to the Editor

In the last issue of *Art Therapy* (Vol. 12 No. 2), Virginia Minar wrote a letter in response to my letter which appeared in the previous issue. I appreciate Virginia's clarification pertaining to Gladys Agell's Motion No. 11 at the Fall 1993 AATA Board Members Meeting that states that any changes in policy documents be published in two newsletters preceding a vote. I stand corrected that it apparently was not voted on by the membership as a resolution. I remember this motion being presented at the 1993 Annual Business Meeting, and I remember thinking that it would be a positive step towards informing the membership of changes in policy documents that are being considered by the AATA Board well before a vote would be taken.

In Virginia's letter, she stated that Motion No. 11 was passed by the Board at the 1993 Board of Directors Meeting and then revised at the 1994 Spring Board Meeting to read: "Changes in policy documents that are publicly distributed must be published in the first possible *AATA Newsletter* after the proposed changes are voted on by the AATA Board." Virginia wrote that she "assumed the revised *Ethical Standards for Art Therapists* would be published in the *Newsletter* prior to the Conference in Chicago. Unfortunately, it was not." Unfortunate, indeed. It seems unfortunate as well that somehow it did not get published in the Winter 1995 *Newsletter.* But we finally have it published in the Spring 1995 *Newsletter,* which came out AFTER the document was sent to the membership for a vote.

The first time the membership got to see the revised *Ethical Standards for Art Therapists* was when it arrived in the mail in April for a membership vote. Mine was postmarked April 7th, I received it April 10th, and it had to be mailed back to the AATA office by April 17th. That left 1 week to review this document during the time when most people are busy filing taxes and allowed no time for suggestions, comments, and discussion by the membership. Even though this document was approved by the membership, I question its validity. Why have standards of procedure for policymaking if they are not followed? These standards were created so that the membership could have ample time to give feedback to the Board before the final version of a document is offered for a vote.

I continue to be concerned that the membership is not being consulted or heard. I wrote the last letter because there was so much discontent among the members at the 1994 Annual Business Meeting regarding communication between the AATA Board and the members, the way in which the revised ethics document was presented to the members, and an apparent disregard for following policymaking procedures. The *Ethical Standards for Art Therapists* is an important document that affects all art therapists and their work. It requires serious consideration by all of our members. The fact that the last two ethics documents have been copied from other mental health professionals' ethics documents and do not begin to address adequately issues specific to art therapists should be cause for alarm. (Please see Agell, G., Goodman, R., and Williams, K. (1995). The professional relationship: Ethics. *American Journal of Art Therapy,* 3[illegible]), 99–109.) If proper procedure had been followed, each member of AATA would have had time to study and deliberate on these matters.

I appreciate the fact that the Board members are volunteering their time and are dedicated to doing the best job they can. Positions of power, however, can be abused, sometimes unwittingly. When there is an elephant in the living room, someone has to talk about it. If I were a Board member, I would want to know the reactions and responses of the members who elected me to represent them.

One problem seems to be a basic misunderstanding of the relationship between the members of an organization and its Board of Directors. Certainly, between meetings of the members, the affairs of the organization are managed by its Board of Directors, as it is stated in our bylaws. However, it is the membership itself which has the ultimate power to make all decisions as to policy and any other matters which the membership votes on at its meetings. Virginia's statement, "Resolutions are advisories to the Board and do not set policy," is indicative of the present Board's erroneous concept of this relationship. Resolutions of the membership are not "advisories to the Board", they are directives to be followed. In every organization ultimate power lies with its members.

Carol Thayer Cox, A.T.R., LPAT
Fredericksburg, VA

This is a response to Carol Thayer Cox's letter in *Art Therapy* (Vol. 12 No. 1). If, indeed, during the business meeting in Chicago this past November the Board had been engaging in secrecy, defensiveness, "not leveling with its members," and "exercising powers not granted to it" which you say you sensed, I, too, would have "grave concern for what is happening to our association." I'm glad you specifically outlined the cause for your grave concern and hope that by correcting a few of the inaccuracies you relied on, you, too, will recognize this Board's accessibility, industriousness, strong commitment to survival and professional growth, maintenance of open and regular communication with the membership and wide-ranging responsiveness to numerous challenges faced by our profession and its practitioners in today's chaotic marketplace. This Board is proud to be "defenders" of art therapy and proud of the scope of its achievements. As I see this Board continuously striving to keep art therapy positioned as a frontrunner in any reform in health care delivery, my concern is focused on external forces and the potential effect on our association. I am confident that whatever the impact, our association is in good hands.

Throughout many months of research, writing, and review, legal counsel worked with AATA's Committee on Ethics and

Professional Practice (CEPP). Through their struggles to apply AATA's existing ethics to the increasingly serious cases being referred, CEPP recognized the importance of developing more workable and professional standards of ethical practice consistent with those generally accepted among mental health disciplines. With Board Certification in place and art therapists across the country actively seeking licensing, every bid for professional status necessitated an equally professional code of ethical standards. The need, echoed both from within our own CEPP and by our members needing support for their legislative bids for inclusion and legitimacy of practice, was urgent.

The legal ramifications involved to protect consumers with whom art therapists work, to uphold the profession of art therapy by establishing ascertainably high standards of professional conduct consistent with those of other mental health professionals and to protect and insure the integrity of AATA demanded legal review and participation at every juncture, even in the incorporation of members' suggestions. Did the Board have the authority to proceed as it did? Was the Board empowered to update the profession of art therapy? To prepare art therapists for the emerging health care delivery system and its increasingly exacting standards? I believe so.

According to AATA's Bylaws, Article V, Section 2, the duties of the Board of Directors include "... the management of the affairs of the ASSOCIATION and ... to carry out the purposes of the AATA." Article I, Section 2 outlines the purposes which the Board is charged to carry out. These include, but are not limited to, the advancement of "... standards of clinical practice; the maintenance of criteria for training future art therapists in ... therapeutic techniques; the provision of appropriate vehicles for the exchange of information with colleagues and the general public; the coordination of the therapeutic use of art in institutional or private practice settings ...."

You are correct, Carol, in stating that the Board of Directors is elected as an agent of its members. To say that this same elected Board is not empowered to make policy changes without consulting the membership is to tie the hands and feet of those very agents elected to act on behalf of the members. Over the years, AATA's Board members have developed numerous policies and procedures governing the actions of the Board, Committee Chairs and committee members, publications and editorial boards, and even the National Office staff. These are under constant review by the member-workers who follow them in discharging their duties. Committees and Board members are held responsible for annual review of the policies and procedures governing their tasks and are expected to submit motions to the Board to continuously update, upgrade, refine, and clarify obsolete methods and/or policies no longer appropriate or productive in favor of more realistic and workable methods. Thus, motions are regularly submitted to the Board by the Committee Chairs and volunteer workers. Consideration is given to these motions and action taken at every Board meeting which results in changes being made to the Policy & Procedure Manual.

Current policy governed our handling of the revision of the *Ethical Standards for Art Therapists*. If you find this "truly appalling" I can't help but wonder what you (and other members) would say to the Board's failure to take necessary action to remove or revise obstacles or impediments to progress!

I, too, believe the Board owes the members explanations. President-Elect Virginia Minar's response speaks to the specific development and approval of the *Ethical Standards*. I trust my lengthy explanation will provide a more accurate perspective on Board practices and reinstate trust in my very well-chosen, elected Board members. I do not believe the Board owes anyone an apology. In my 9 years of service on AATA Boards and 16 years of service on other Boards of Directors, I have never witnessed more dedicated workers, more intensely committed and goal-directed, nor more cohesive task groups than the 1994 and 1995 AATA Boards. Am I being defensive? You bet I am! I am proud to publicly applaud their organizational and strategic accomplishments to protect art therapy and art therapists in this era of professional crises. The inestimable value of the collective talent and wisdom represented on the Board and the effort they've directed to the professionalization, promotion, and protection of our field deserves applause from all our members. Neither AATA nor I could function or survive without them. I will certainly defend the Board members and their productive efforts against any unfair charges of secrecy or withholding information!

Bobbi Stoll, A.T.R.-BC, MFCC
Los Angeles, CA

I was very pleased to read your editorial, "Milestones," in the most recent Journal (Vol. 12 No. 2). It gave me a wonderful opening to share how we are handling licensing A.T.R.s in Massachusetts. Basically, we have an umbrella, formed by the far-reaching wisdom of Berna Haberman, Emily Mitchell, and Suzanne Canner-Hume. It was not until recently that I have realized how important their formation of the Licensed Mental Health Counselor status actually is. The LMHC in Massachusetts is an umbrella which covers ALL expressive therapists as well as counselors, some PhDs, EdDs, MEds, and probably others of whom I am unaware. Most of the current 4,000 LMHCs in the state were grandmothered/grandfathered into their license. As we reach our second stage, the passage of our vendorship bill, SB 1809, which will guarantee third-party payment to all LMHCs, we have needed to see changes in the educational system. We have been very fortunate in having the schools which give A.T.R.s agree to meet the counseling requirements of the states. In Massachusetts, schools with expressive therapy and counseling programs are attempting to match the social work schools in the number of credit hours. Our parity with social workers will be both financial and educational. Currently, we actually require more hours in clinical work than social workers who require more hours in policy and procedure.

There are disadvantages to the increase in credit hours—the primary one being financial. We are afraid that this will impact people with lower incomes in negative ways and that we may lose some of the brightest and most creative of our people as well as our struggle for diversity.

As a very low-income single mother, I put myself through the Goddard graduate program on loans and hard work. My life is still a difficult financial struggle. I would be the last person to wish to exclude anyone because of finances. However, in order to survive in today's market, we have made compromises and the chief one is the increase in credit hours necessary for licensing.

Meanwhile, the good news in Massachusetts is that we are working together for our licensure and are working in cooperation with social workers as well and hope to improve our relations with psychologists.

I hope that as an art therapist, I can bring a greater sense of working together into the Massachusetts Mental Health Counselor Association and that we have the support of other disciplines. It is certainly nice not to have the divisiveness between art therapists and everyone else in this licensure achievement and in the vendorship attempt.

Mary Pat Palmer, LMHC, A.T.R.
President, MAMHCA
Jamaica Plain, MA

Progress or Politics?: Neither

Taking psychological and clinical theories designed to address individual intrapsychic issues and then applying them to a profession and professional organization issues is an inherently flawed way of addressing the very genuine concerns that are referred to in Dee Spring's recent "Viewpoint" (1994). A similar article recently appeared in *The Arts in Psychotherapy* (1994) in which David Read Johnson characterized creative arts therapists collectively as functioning from a shame-based dynamic which he maintains informs our every personal, professional, and organizational move.

Shame and abuse—buzz words in both the clinical and popular press which have been applied now to our own work and been posited as the source for a myriad of evils. For example, Johnson states that all of the following are related to the shame-based dynamics among creative arts therapists: criticizing each other, inviting nonmember male keynote speakers to our conferences, not joining our organizations into a creative arts therapies larger organization, poor mentoring, and big publicity campaigns ("compensation for feelings of inadequacy") (Johnson, 1994). Similarly, Spring (1994) bears witness to "invisible wounds" that she sees as part of an overall destructive crisis abuse cycle. These "wounds" include her dealings while on the AATA Honors Committee, as an educator dealing with the ETB, "contempt" for her research, and "not being permitted" to present her work at AATA conferences; she then generalizes from her own experience to more global assessments of our profession.

I would like to take issue with the general pathological conceptualization of art therapy as well as the generalizations from personal experience and suggest other avenues toward understanding each other better. I have already mentioned what I see as a major contextual flaw in applying a psychological theory addressing the individual and family to an organizational system or a professional role. However, I realize this is a common method of analysis in the popular literature of our day and, thus, join with others in being interested, indeed titillated, by this sort of *National Enquirer* approach to our professional lives; that is, "who did what to whom" with a general dearth of named sources or even named participants.

What I truly object to is the use of psychological theory as the framework for a personal or even organizational agenda or issue regardless of how valid the issue may be (and I am in no position to dispute the "history" of AATA or Dee Spring's personal experiences). The contradictory messages within the theoretical framework offered are the clue that the theory serves only as a frame and not as a support. For example, Spring refers numerous times to the "ancient leaders" in art therapy with whom she takes issue, describes the members of AATA as "stingy" with awards, and so forth. This language, as well as the labeling offered for every possible involvement one might have with AATA ("secret keepers," "warriors," etc.) and the characterization of "our adolescent crisis-oriented behavior" are all appalling to me as an individual art therapist. I agree with Spring and others that "our response to contemporaries must be respectful rather than destructive if we expect to collect a body of knowledge that includes proof, not just words or case studies" (Spring, 1994). However, I would add that this response is due ALL art therapists, not just our contemporaries, and that the labeling, pathologizing, generalizations, and personal history offered by Spring do little to promote such respectful interchange among us.

Spring is clearly not the only art therapist to ever engage in negative labeling of peers or viewpoints. For example, Bob Ault, in the middle of a very wise and overall balanced article (1994), warns us not to "go off into some hocus pocus of spirituality, or the rigidity of scientific research...." To describe different approaches with terms such as "hocus pocus" or "rigid" is unfairly characterizing positions that have been articulated more clearly and deserve our respect, if not agreement.

Theoretical frameworks and contexts aside, this is not to deny the truth in the importance of knowing our past in order to inform our future. I just take issue with what is offered to me as "the history of AATA" by Spring or others. Am I to listen to the tales of each art therapist as he or she recounts versions of the past 25 years, or am I to look to the publications, conferences, and professional interchange that I have had personal access to? I choose both and seek even more context, information, and history. Junge's (1994) broadening of the history of AATA and art therapy to include the social and political context is a needed correction to the oral history tradition. It is important to deal with our professional history and to address the evolving relationships and roles art therapists will take in the future. In this process, however, we must exert some judgement, discipline, and critical thinking along with respect for our fellow art therapists and our professional organization.

I would like to suggest that there are at least two major contexts, or subtexts, that have not been addressed by either Spring or Johnson among concerns about the future of our profession. One is geographic and the other is generational. Experiences of art therapists vary a great deal depending upon the state or region in which they practice. I write this as one who has always practiced in Oklahoma and as part of a minority within AATA geographically. I have read with genuine concern the issues relative to licensure and practice in California and other areas, but I feel that to generalize about our profession or organization without considering the experiences in other geographical areas is to risk being narrow and provincial. Similarly, generational issues seem to be of growing importance in our organization as we just celebrated our 25th anniversary and are more aware of our "pioneers." I wonder if I am a "new" or "old" art therapist and am content just to be whatever I am. But in reading Spring's article with its references to "ancient leaders" or those "stuck in a 60s mentality" I sense a larger, unspoken issue about leadership, recognition, and the growing generations of art therapists.

Another context for viewing AATA and our profession is one of optimism and strength. Judith Rubin's comments in the special 25th anniversary section of our recent journal attest to this more positive approach: "Art therapy has been a marvelous matrix for me, both personally and professionally, and I feel extremely fortunate" (Rubin, 1994). Our profession is growing: in numbers, in divergent viewpoints, in educational options and focus, in job variety and challenges. I too feel very fortunate to be in this field, to continue to learn and grow as I consider all the embodiments of art and art therapy. To me, it is exciting to see the developments of art therapy in psychotherapy, clinical settings, for personal growth and spiritual discovery, in nonclinical settings, in schools, prisons, rehabilitation centers, and so forth. I feel there is such a need in our society and world for art, expression, and therapy that I hope our organization can embrace all the manifestations of art therapy offered by both licensed and nonlicensed art therapists as long as we all embrace an ideal of a skilled, ethical, and caring art therapist. During my years of membership in AATA, I have benefited from the conferences, preconference courses, *Art Therapy*, AATA *Newsletter*, networking, and stimulation that AATA has provided. No other professional organization speaks so directly to my professional interests. AATA has always been a lifeline of information and has provided a forum for dialogue and for this I am very grateful.

Joan Phillips, MA, MS, LMFT, LPC, A.T.R.-BC
Norman, OK

References

Ault, R. (1994). In search of the wisdom of a vision. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 251–253.

Johnson, D. (1994). Shame dynamics among creative arts therapists. *The Arts in Psychotherapy, 21*(3), 173–178.

Junge, M., & Asawa, P. (1994). *A history of art therapy in the United States*. Mundelein, IL: The American Art Therapy Association.

Rubin, J. (1994). My wishful vision of art therapy in the next 25 years. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 253–254.

Spring, D. (1994). Progress or politics? *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 282–288.

Call for Papers

9th Art Therapy Association of Florida Conference
Multiple Dimensions of Art Therapy: Art, Client, Therapist
Spring 1996 Conference
May 3, 4, & 5

Attention Art Therapists, Creative Art Therapists, Mental Health Professionals, Allied Professionals and Educators: **ATAF** is seeking papers, presentations, panels, and workshops devoted to understanding and experiencing the process of art therapy in relationship to the art, the client, or the therapist. Submissions may focus on any topic or population related to this theme; of particular interest are: the value of different approaches and paradigms in art therapy, the use of art in the care of the therapist, and how specific psychopathology informs art making in clinical practice.

Due October 10, 1995

Qualifying materials needed from each presenter includes:

1. Six copies of **Presenter's Resume**
2. Six copies of **Completed Call for Papers Application***
3. Six copies of **Bibliography for Presentation**

****After June 12, 1995, For further information and proposal forms, please contact:***

Mrs. Peggy Dunn-Snow, A.T.R.-BC, LPAT
165-07 Crenshaw Drive
Tallahassee, Florida 32310

CEU's for art therapists, nurses, social workers, mental health counselors, and marriage and family therapists are being arranged.

Art Therapy: Journal of the American Art Therapy Association, 12(3) pp. 161-166 © AATA, Inc. 1995

Coyote Comes in from the Cold: The Evolution of the Open Studio Concept

Pat B. Allen, PhD, A.T.R., LPAT

Abstract

The Open Studio as a way of working evolved in an effort to maximize the effectiveness of the artmaking process as a means to increase and deepen consciousness. This method differentiates art from psychotherapy and calls into question the validity of marrying these two experiences. Is the open studio within the purview of art therapy? This remains an open question subject to the experimentation of art therapists who apply the method in work situations.

Introduction

I began this paper with an inflated, almost giddy sense of having the answer. Yes, the answer to the malaise of art therapy is to be found in the studio approach. It was shortly after our successful one-month pilot of the Open Studio Project in June of 1993 when I began writing. Yet, somehow, the paper did not get written. The Open Studio Project continued to develop and grow, we found a permanent space and officially opened for business. Still I struggled to write, felt blocked and constricted. I had been sure that the call for papers for a special issue on studio approaches would yield hundreds of papers and Viewpoints, flooding the journal. In fact, finding enough good material for an entire issue was a daunting task (see Editorial).

Finally, while trying to work on the paper on a plane trip to Boston, my pen exploded in my hand. This same pen had functioned quite nicely mere minutes before as I penned a postcard to a friend. As I wiped the ink from my hand and off the airline tray, I felt strongly that I needed some help. I decided to settle down and enter the image process right there on the plane. I asked for help from Coyote, the totem animal of the Open Studio. I asked for an image and this is what I got:

> A bird is flying high over a landscape. From up above there are no divisions. The bird's eye view is dispassionate. Your idea is just a tiny little corner, one sparkplug, a small piece of the overall picture. No need to be grandiose. Remember, Coyote is mangy, a bit dirty and smelly, scratching and such ... and real.

After thanking Coyote for puncturing my balloon of self-importance, I put away the writing for a while. When I returned and reread my beloved opening paragraphs, I realized how intoxicated I had become with the studio idea. I felt comforted in rereading Jolande Jacobi (1977) on inflation:

> ... there is nothing surprising about this sort of hubris; everyone succumbs to it in the course of a deliberately deepened individuation process. But the forces that have been activated in the individual by these insights become really available to him only when he has learned in all humility to distinguish himself from them. (p. 126)

Now doubly grateful to Coyote for my exploding pen that prevented my purple prose from reaching print, I realized I needed to begin the work of distinguishing myself from the ideas.

Background

My initial job in art therapy was a rudimentary variation on the open studio, not by design but through simple ignorance. I didn't know any better than to make art with the people who came to the church basement we called an "after care center." I was an art student, and they all had various psychiatric diagnoses and had been swept back into the community when state hospitals were declared too restrictive an environment in the early seventies. What I remember about my job is that I felt a lot more at home making art with the center's "members," as they were called, than I did in art school with my classmates. As I gradually got an education in art therapy through supervision and further training, I realized we were supposed to have a different sort of relationship—one in which I maintained professional boundaries and kept more distance, one in which roles were clearer. But, looking back, I don't think anyone was worse off for being party to my image making, nor do I think that any more systematic approach would have made a big difference in ameliorating the wounds of the men and women who came to our center.

What was going on in that church basement was simple. Former mental patients had a place to go during the day and an occasional evening, to socialize and add some structure to their lives along with a hot lunch and an ever present coffee pot. Those of us who worked there created ways to pass the time together based on our interests or skills, whether art, yoga, drama, or current events. No big therapeutic outcomes were really expected nor sought beyond trying to provide a supportive community to help people stay out of the hospital. We kept track of who was holding their own and looked for warning signs when members were feeling stress. Often we could avert a crisis or rehospitalization by nothing more sophisticated than knowing people well enough to notice changes in behavior and offering to talk about whatever the problem might be.

We spent 15 to 20 hours a week together in groups, taking

Editor's Note: The author wishes to acknowledge Deborah Gadiel and Dayna Block, cofounders and codirectors of the Open Studio Project, Inc., as collaborators in the process of developing the ideas expressed in this paper and to thank them for their love and support and for meeting the challenge of both friendship and partnership. They welcome visits to the Open Studio Project, Inc. or inquiries about their work addressed to 1739 N. Damen Ave., Chicago, IL 60647.

field trips or just hanging around in the coffee room playing Scrabble. The setting had limitations which precluded a "real" open studio. The church members who donated the space were fastidious folks. No artwork could remain on the walls and our presence had to be cleaned up before Sunday school each week. The images of the kindly Jesus surrounded by children and holiday theme posters were not to be disturbed. But even with such restrictions, members felt free to create, and so did I.

Gradually, as I learned more about therapy, I began to see individuals, families, and groups in the outpatient mental health center of which the after care program was one small part. After some years of practicing art therapy in more conventional ways, I returned to an open studio approach, this time by accident. I was utterly spent trying to apply the principles of therapy I had so painstakingly learned on a short-term psychiatric unit. I was defeated by the limited length of stay and sterility of the setting, and I was bored by listening to shallow discussions of superficial imagery made by patients trying to do what was expected of them. I pretty much gave up and just began to make art during the art therapy time. I stopped cajoling patients out of bed or away from TV. To my surprise, interest in art therapy grew and some patients who had avoided the structured groups showed up and worked intently on self-initiated pieces. The atmosphere shifted and energy grew; for a while, something felt real and right.

In reviewing a paper I wrote about this work (Allen, 1983), where I first used the term "open studio," I was surprised to realize I did not mention the role my own artmaking played in the brief resurgence of a studio atmosphere on the short-term psychiatric unit. In fact, I remember vividly the piece I worked on when participation in my draw-and-talk groups dwindled to nil. It was a fairly large sculpture of a dragon made of newspaper and masking tape, eventually covered with plaster gauze. I would bring it upstairs to the office I shared with the occupational therapy staff and work on it in odd, free moments between groups. After a while, as I entered the locked unit for my nonexistent group, the evolving dragon, now recognizable, sparked interest among patients who began to come in and want to learn how to make sculptures of their own. That was one of my first glimmers that my own artmaking could have a motivating effect and perhaps be a valid part of the art therapy process.

Why didn't I write about the role my art played as a catalyst for patients? Instead, I tell about a goals group I co-led and how that helped me to refocus my energies (p. 94). The goals group was a helpful interlude partly because it was collaborative, partly because it was very clear in structure and format. Also helpful, but not as safe to write about, was my relationship with a patient around that same time. This young man was acutely psychotic when admitted. As his symptoms abated I learned he was also a trained and talented photographer. We spent many hours talking about art and looking at his photographs, though he attended the studio group only once. Gradually I recognized that I had a powerful countertransference response to this man. He mirrored back to me the wounded artist in myself. Once I gained that insight, I experienced a surge of energy in my own artmaking, which I had neglected for quite a while feeling uninspired and having little free time. My relationship to the patient simmered down to collegial friendliness. When he was discharged, I felt the loss; he had taught me a great deal. My belief in the prescribed boundaries of the "patient-therapist" relationship was also shaken. My identification with him help me to restore and reawaken a very important part of myself. He did far more for me than I did for him.

I didn't write about this aspect of the process in 1983 either. I also didn't write about how making art together begins to blur the boundaries between "staff" and "patient." In a studio session, a patient might just as likely have useful feedback for me as I would for him or her. I did realize that I couldn't tolerate the hierarchical roles that are the norm in an institution. It seemed easy for the nurses and doctors; for example, it is very clear who prescribes medication, who hands it out, and who swallows it. For me, blurring the boundaries felt vaguely dangerous, a violation of the cultural norms of the treatment setting. I knew I couldn't continue working in a hospital.

At this same institution, I also worked on an alcoholism treatment program (ATP) where it was necessary to create a very structured approach to art therapy to complement the existing goal-oriented program (Allen, 1985). This was not my favorite way of working. The main goal of the ATP was to break down patients' resistance to recognizing their disease. This confrontational approach was designed to shake the alcoholic patient out of his or her denial of life-threatening behavior. While I saw the value of this approach, I was uncomfortable using art in this way. I felt the time pressure of the brief 3 week length of stay, yet I deeply feel the image has its own time that could not be accommodated in this approach. I fantasized about a studio space on such a unit where, after the confrontational work of group and individual counseling, a patient could come and work at length, painting his or her reactions and putting himself or herself back together. There was no space for such a studio. The room where art therapy was held doubled as dining room, group room, staff meeting room, and leisure space in the evening. Patient images remained up on the walls during all those activities, for better or worse.

To ground myself I created an art talk as part of the lecture series used to educate patients about the disease process. Nurses showed slides of cirrhotic livers in their lecture on physical effects; I showed slides of paintings by well-known artists who grappled with issues of life and death, depression, faith, and relationship. I tried to explain how artists use images to reconcile inner and outer reality and how this process is accessible to anyone. I also showed slides of my own work, which is fairly self-confrontive. I tried to show that I used the process, that I wasn't asking them to do something I wasn't willing to do myself.

Why didn't I write more about these aspects of the art process? I felt I was violating some art therapy taboos. If I am making art during my art therapy job, am I stealing from my employer? If by making art together with patients I am contributing to a breakdown of the tradition of professional distance, am I harming the patient? Is showing slides of my art that are obviously intense, emotional, as well as artistically formed intimidating to the patients and inhibiting their ability to use the process?

These are serious questions. Therapy principles rang in my head: the role of the therapist, the boundaries of the session, appropriate self-disclosure. I certainly knew and had adhered to and respected these rules for some time. I taught these rules to my graduate students. I experienced the validity of the constraints of therapy myself as a client in psychotherapy; yet, as time went on, these rules felt constricting, deadening, in fact harmful to the art therapy process. I began to feel the paradox that much of what makes psychotherapy effective and safe makes art therapy dead and lifeless. I began to seriously doubt this hybrid, this marriage of art and therapy, to which I had been thoroughly dedicated.

Struggling with Art Therapy

The next phase in the development of the studio idea was my doctoral work. I set myself the tasks of looking at art therapy as it had been practiced and documented in the literature and of looking at artmaking as it is done by artists (Allen, 1986). I read artists' accounts of artmaking and carried out a series of interviews using phenomenological methodology which sought to get at the essence of the art-making experience. My research question was, "What is the experience of making art?" I wanted to find out the constituents, the necessary or universal aspects of this experience. By interviewing a range of artists, including some who are also art therapists, I learned that the essence of artmaking—feelings about, even motivations for making art—was indistinguishable from what my goals were in art therapy. Self-expression, communication, feelings of wholeness, suspension of time, entry into a different realm or state of grace: these are some of the constituent parts of involved artmaking, whether the artmaker is a client seeking help for a problem, a professional artist making work to appear in a gallery, or an art therapist fully engaged in his or her own art process. The nature of the final product may distinguish these various artmakers (thought not in all cases), but the process had the same essential elements. McNiff (1977) in a study of artists across disciplines concludes that "all artistic expression emanates from the same human needs" (p. 134). The basic goal of all artmakers seemed to be to know the self, which is also a fundamental goal of art therapy.

The outcome of my doctoral work was the conclusion that artmaking is a process that when practiced in an involved way, in itself promotes health and wholeness. However, such practice can exist side by side with destructive behaviors as well. Human beings are complex. I came to believe that the rules and regulations I had painstakingly learned in order to practice art therapy paradoxically prevented artmaking itself from being fully effective. Consciousness is the crucial element that art therapy added to the equation that is not always present in the practice of artmaking by artists. By adding intention, the clear desire to know something through art, and attention, the honest consideration of meaning in the image, we experience artmaking as creating or deepening consciousness (Allen, 1995). Then, the island of health or wholeness from which the creative impulse springs can be enlarged and strengthened. Psychotherapy can also be a consciousness-creating activity, but its methods function largely on a verbal level. Artmaking, when practiced in an involved way, especially according to some methods developed in art therapy that emphasize allowing the image to create itself (McNiff, 1992), touches a different, preverbal, nonverbal, and even spiritual level. As Florence Cane describes, life situations have parallels in artmaking situations, and understanding the art process can have a carryover into life (1951).

By using the same rules as psychotherapy, art's effectiveness is decreased. The stringent rules of psychotherapy are necessary to safeguard the client as well as the therapist from potent feelings and wishes stirred by the intimacy and intensity of the process that can lead to exploitation and abuse of power in this inherently unequal relationship. In 1988 I wrote:

> Art therapy has the potential to affect the balance of power in the therapeutic relationship in favor of the client if the focus is less on the transference and more on the art. In other words, the client is empowered when his or her primary relationship is to the art rather than to the therapist.... Transformed by the art process, through the discipline of adhering to the limitations and requirements of the medium, the unconscious material can be experienced by the client while he or she maintains an adult's sense of personal dignity. (Allen, 1988, p. 118)

The next phase in the development of the studio concept occurred in collaboration with Deborah Gadiel, presently one of the codirectors of the Open Studio Project, but at that time a graduate art therapy student at The School of the Art Institute of Chicago, where I teach. Having found myself frustrated with the limitations of clinical positions, I was teaching and supervising art therapists and doing a small amount of consulting and private practice. I was uncomfortable in my position as critic of the clinical approach to art therapy without a place to try to develop an alternative; even private practice seemed too restrictive. Deborah wanted to do her thesis on working as an "artist-in-residence" as an aspect of her second year placement. I suggested she try an agency where I supervised the art therapist, Dayna Block, the third founder and director of the Open Studio Project. I felt Dayna would be receptive and supportive of this idea. I have never known another art therapist as grounded and clear in her identity as an artist as Deborah or as knowledgeable and fluent with materials of all kinds. Her idea of artist-in-residence was an operational definition, an alternative role for an art therapist to take that widened the scope of practice to include and validate artmaking within the workplace. At that time she said:

> We as artists can demonstrate problem-solving, risk-taking, and self-fulfillment. We create an atmosphere of involvement. We model a dialogue between ourselves and a piece of art. (quoted in Allen, 1992)

Consulting to this agency and supervising Deborah have helped me to see that the open studio idea can be put into practice in a mental health setting. She continues to perform some of the more traditional tasks of a therapist in her job, though the bulk of her client contact is within the studio.

Presently, the approach Deborah, Dayna, and I have evolved in the Open Studio Project goes even further. We are dropping the therapy paradigm altogether and looking at what the studio process generates as its own paradigm or guiding principles.

What Is the Studio Approach?

Our approach is still evolving, and I have concerns about writing about it at such an early point. Although I can describe what we do and how it seems to work, I can't make many firm conclusions. I can point out concepts in art therapy that this approach challenges and aspects of practice that are called into question. We are defining a little area where the disciplines of art, art therapy, spiritual practice, and service to others intersect. We are at the outskirts where, like Coyote says, things are ragged, mangy, and a little bit rough. That's how we like it. It's not everything nor the only thing. But, it can give some ideas to art therapists, enliven them, maybe be a sparkplug.

The primary attribute to an open studio is energy. Energy is drawn into a place by a variety of factors. The main source of energy is generated by the artists working in the space. It is not enough to put out materials and just let people flounder around with them. It is not enough to solicitously be a monitor and hand out the right brush. It is necessary to be real and active. Over the years there have been more and less successful attempts at having an open studio at the AATA conference. It has seemed to me that not only the space, not only the materials, but the energy of those working in the space is the crucial, yet ineffable ingredient. Discovering how to tap into creative energy is my primary learning goal at the Open Studio. What makes people able to access this in themselves and what prevents it? The arrival of Coyote illustrates something about this.

Our pilot program took place at a downtown gallery run by several young artists who were interested in creating an alternative to the usual gallery scene. Fans of Joseph Beuys, they liked our idea that everyone can create art. They were intrigued with the concept of people from all walks of life coming together in the space. We invited them to come and work alongside participants during workshop and drop-in times. Further discussion revealed a slight discrepancy in our ideas. One artist offered to come in and demonstrate how a "real artist" makes collage. On the only day they actually came to the space to work, about six people were busily working on various pieces. I was painting when one of the artists began a conversation with me about how "… you can't just paint …" and elaborated for me how artists are different and need certain conditions, the right time, the right place, that he was really conceptually beyond this sort of direct image-making. As I listened, I continued painting and Coyote emerged, smoking a cigarette (Figure 1). This trickster figure spoke volumes to me about the trap of taking oneself too seriously, the trap of role, the trap of specialization. The irony of the artist talking away while "ordinary" people "just made art" was a great lesson and remains at the heart of the Open Studio.

All during the pilot month, Coyote showed up in various guises in different people's work, always having a great time (Figures 2, 3, and 4). In Native American tradition, Coyote is seen as a trickster and shape shifter. Another aspect I like about him is that he is a carrion eater, a transformer of dead material (Walker, 1988). He continually and playfully challenges the ego, helping us to be less pompous and self-involved. To work in this way, one must check one's professional persona, be it artist or therapist, at the door. Coyote's energy seems to me less and less welcome in art therapy as the field becomes more regulated, more professional, more self-consciously serious. Nobody wants to get paint on her dress-for-success suit before going into a meeting.

The Open Studio Project

At present, the Open Studio Project, Inc. resides in a storefront space with high ceilings and big windows that looks out onto a busy city street. It is located in a part of the city known for both its ethnic diversity and its indigenous artist community.

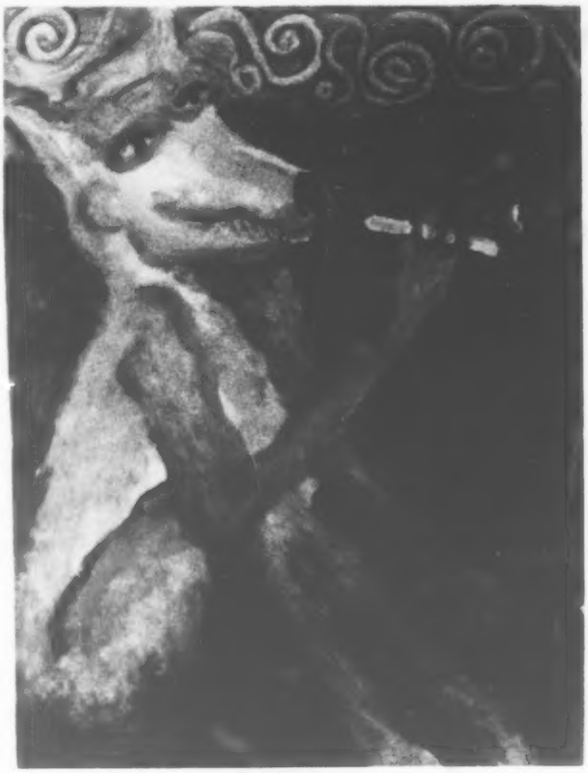


Figure 1.

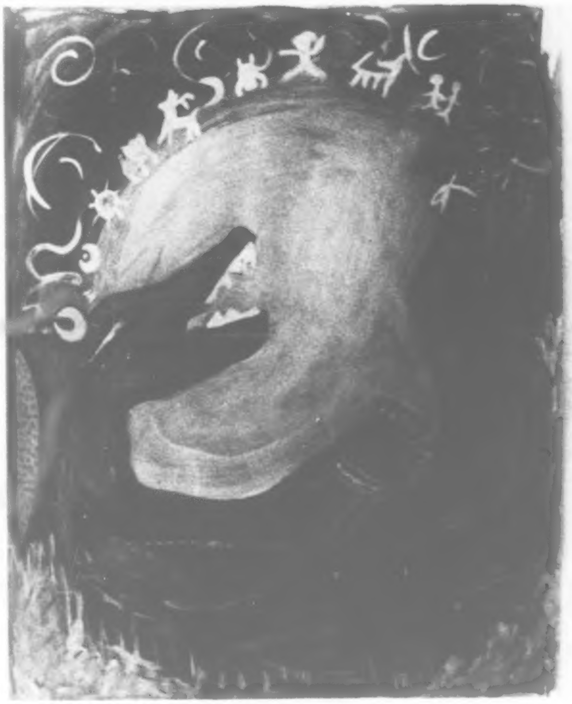


Figure 2.

Synchronistically, this neighborhood has an art event every year when studios and galleries are all open for four straight days, called "Around the Coyote." It is also an area in the throes of gentrification. Who knows how long Coyote will hand around? Old factories are being turned into loft condominiums, and coffee houses and trendy restaurants are springing up. Two blocks away are industrial buildings as well as restored mansions, buildings covered with graffiti, a shelter for the many homeless women in the area, as well as the homes of many poor and middle-class families. Inside the space the walls are paint spattered, and there are shelves piled with supplies and found materials. The "office" is a tiny galley behind the studio space where a computer sits next to piles of artwork and extra supplies.

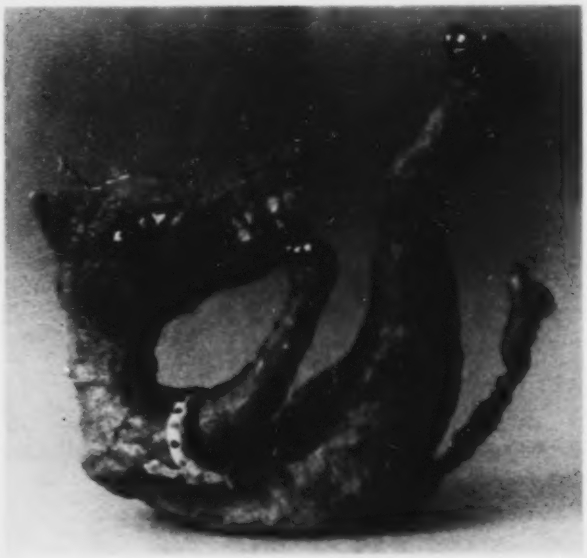


Figure 3.

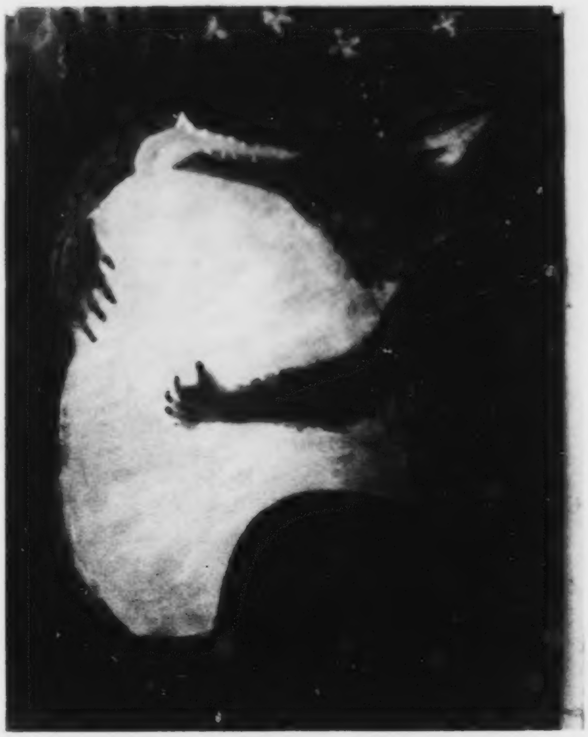


Figure 4.

The Open Studio Project (OSP) came into existence as the answer to a question posed by us in early 1993: "How can we, as artists, be of service to others?" Art therapy, as it has come to be defined and practiced, did not seem to be the answer. At the heart of this question is the wish for Eros, the wish to stay close to the fire, in contact with the life force. We did not ask, "How can we find time to make our own art while working as art therapists?" While that may be a perfectly valid question, it was not ours. Implicit in the phrasing of the question is the belief that our first responsibility is to be aware of and tend to our own needs, our personal fire. We believe that neglecting our own needs diminishes our capacity to be of service. Each of us recognizes a primary drive to know ourselves, others, and the world through our image-making. Each of us works in our art in a way that invites Coyote, constantly challenging concepts of who we are, what we are. Through image-making, we are being created, destroyed, and re-created continually.

After several years of conceptual development and a month-long pilot project in June of 1993, we opened for business at our present location in Chicago in February 1995. Practically speaking, OSP is a not-for-profit 501(c)3 corporation, meaning it is tax-exempt and able to receive donations and contributions which, along with fees for service, support the work, if not yet the workers. All programs are offered on a sliding scale basis. We offer workshops and classes to the public, to groups from social service agencies and schools, and to businesses. We have a core series of workshops which we are evolving that consist of very direct methods of drawing, painting, and sculpture using simple materials. There is a strong focus on developing awareness of one's response to process. Participants are encouraged to allow imagery to develop in its own way and to trust the image to be a guide. The major amount of time in every workshop is spend making art, with a brief time at the end for closure and sharing how the process felt. Content interpretations are not made. In core workshops, comments are restricted to one's own work and process, and quiet witnessing by others is encouraged. Resident artists participate fully in all workshops.

We also have occasional theme-based or materials-based workshops which have a more structured format and more specific goals. For example, a workshop called "Marking Passages" was designed to focus on transitions and changes in life stages with an emphasis on the decisions, events, and struggles that accompany change. "Printmaking" focuses on simple and direct methods of producing multiple images using printing plates constructed of cardboard and found objects as a way to enlarge one's repertoire. We emphasize the physicality of making art by using breathing, relaxation, guided imagery, and music, such as drumming and other percussive sound, to produce entrainment and deepen process. Journaling for self-reflection is suggested for longer term participants. Drop-in time is available for those who wish to take their work further or for anyone wanting to experiment independently.

A Few Things We Have Observed So Far:

- Making art together breaks down barriers and boundaries between people, creating compassion and empathy. This happens most effectively when people are deeply engaged in authentic images. It seems to be true that viewing the struggles of one another through art causes shifts of perception on a deep level. This occurs not so much in insights gained through discussion as in simple witnessing.
- Our practice of making art alongside participants creates an energy that enables all of us to take risks and push further in our explorations as opposed to being an inhibiting factor. This applies to both content and technique.
- Adopting the same simple materials used in art therapy, or in elementary school for that matter, such as tempera and acrylic paints, cray-pas, tape and foil, and found object sculpture renders the image-making process accessible to anyone.
- Bypassing complex techniques, individuals move more easily into the realm of their own images. Remarkable elaboration and embellishments occur as individuals "make special" (Dissanayake, 1995) objects that begin as cast offs and end up speaking for the soul.
- Hanging our images in the space seems to cause people to relax and feel permission to express rather than fear their own content.
- Given the space, materials, time, and example, anyone can use the artmaking process to contact and tap into his or her own inner source of creativity and wisdom.
- The process works especially well if the group is diverse. The energy of too homogeneous a group tends to be less lively, regardless of whether it is a group of all mental patients, all art therapists, all women, all adults, and so forth.

Conclusion

We are at the beginning of a great learning process of experiential research. We are experimenting and watching what happens. We eschew therapy concepts and practices. No records are kept beyond keeping track of attendance. There is no pretense of confidentiality; the public walks by and sometimes stares intently in the window as people work. There are often dual relationships as friends and family members are welcomed to the space. Groups from agencies are mingled with people from the general public. Our responsibility is to create, share our energy, and provide simple instruction; the participant is responsible for his or her own experience. During all workshops we are equal participants. There is no emphasis placed on roles, lengthy introductions, or life stories. In the studio everyone is an artist on his or her own path. No particular emphasis is placed on uniqueness or originality. Referencing the images of others is encouraged: If someone likes an image or technique used by another, borrowing or incorporating is fine.

The studio process cannot be easily communicated in print. To see the fascination in the faces of children who see raw imagery on the walls and then settle down contentedly to make their own with industry and purpose is confirming. A common response when people come into the space is a smile and a sense of physical relaxation. There is a comfort that authentic imagery extends that says it's okay to be yourself in this place. The images themselves, as McNiff says, are medicine. The permission of expression that they grant is enlivening.

During our pilot project in 1993, we were working in a gallery space downtown which we transformed into a studio for a month. The space was located on the first floor of a building that housed several graphic design firms as well as a talent agency. One morning there was a casting call and parades of parents with cute children in tow stood outside our space waiting for the elevator. Some peeked in, including one family who had Grandma along who was afraid of elevators and unable to climb the three flights of stairs. They came in and asked if Grandma could sit with us to pass the time while the mother took her little girl upstairs for the audition. We agreed, and the older woman settled down with her newspaper while we worked alongside a group of adolescent boys from a group home. One was working on a large piece of kraft paper with charcoal, another was creating a pastoral landscape. As our visitor was clearly listening to my conversation with one boy about standing back to really see his 4' x 5' piece, I impulsively asked if she'd like to try, too. With delight, she put down the unread newspaper and an hour later her perplexed daughter found her gray-haired mother happily drawing away alongside a group of inner city boys whom she might have crossed the street to avoid if she'd encountered them elsewhere. This is what we are after, creating a space where the paradox of the uniqueness of the individual and the universality of our humanness can be lightly held, shared, understood, and celebrated, where Coyote can come in from the cold.

> Today, like every other day, we wake up empty and frightened
> Don't open the door to the study and begin reading
> Take down a musical instrument.
>
> Let the beauty we love be what we do.
> There are a hundred ways to kneel
> and kiss the ground.
>
> Rumi

References

Allen, P. (1983). Group art therapy in short-term hospital settings. *American Journal of Art Therapy, 22*(3), 93–97.

Allen, P. (1985). Integrating art therapy into an alcoholism treatment program. *American Journal of Art Therapy, 24*(1), 10–13.

Allen, P. (1987). *The power of the image: A reconsideration of art therapy.* Ann Arbor: UMI.

Allen, P. (1992). Artist-in-residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association, 9*(1), 22–29.

Allen, P. (1995). *Art is a way of knowing.* Boston: Shambhala.

Cane, F. (1980). *The artist in each of us.* Craftsbury Common: Art Therapy Publications.

Dissanayake, E. (1995). Reflecting on the past: Implications of prehistory and infancy or art therapy. *Art Therapy: Journal of the American Art Therapy Association, 12*(1), 17–23.

Jacobi, J. (1973). *The psychology of C. G. Jung.* New Haven: Yale.

McNiff, S. (1977). Motivation in art. *Art Psychotherapy*, 4, 125–137.

McNiff, S. (1992). *Art as medicine.* Boston: Shambhala.

Walker, B. (1988). *The women's dictionary of symbols and sacred objects.* New York: Harpers.

Art Therapy: Journal of the American Art Therapy Association, 12(3) pp. 167-174 © AATA, Inc. 1995

The Art Studio: A Studio-Based Art Therapy Program

Mary K. McGraw, A.T.R.-BC, Cleveland, OH

Abstract

This paper describes the history and development of the Art Studio, a studio-based art therapy program established in Cleveland, Ohio in 1967. It includes the philosophical perspective of its founders who pioneered the use of art therapy with medically ill and physically disabled persons. It provides information about the unique cooperative relationship between a nonprofit organization and county hospital which jointly support the program. Specific patient needs which are uniquely addressed by the Art Studio model are discussed and illustrated by brief case studies and representative artwork.

Introduction

Creativity brings and allows for personal freedom—the freedom to act and to be oneself. The Art Studio at MetroHealth Medical Center in Cleveland, Ohio reflects such freedom. In a creative environment that emphasizes the unique abilities of each individual, the Studio and its staff invite personal expression and growth at a time and in a place where it is not usually expected.

When people enter the Art Studio, they easily forget that they are on the seventh floor of a large metropolitan hospital. Original artwork hangs on the walls. The sounds of a popular radio station fill the air. Someone sips tea while watching another person weave with strips of brightly colored paper. A young man carefully considers his painting before signaling its completion with his signature. Two people in the corner sort through shells and wood bits to be used in the collage on a table nearby.

On closer inspection, however, one realizes that most of the artists are sitting in wheelchairs or lying on carts. The painting is signed with a brush held in the artist's mouth and the weaving is being done with the nondominant hand. Since 1967, more than 16,000 children, adults, and their families have participated in the Art Studio's programs at MetroHealth and in a variety of community settings, such as the Studio's program at Fairhill Center for Aging, which began in 1989.

A Pioneering, Innovative Art Therapy Program

Founded by Dr. George Streeter, Chief of Psychiatry, and Mary McGraw, A.T.R., the Art Studio pioneered the use of art therapy with medically ill and physically disabled persons. It is the oldest art therapy program of its kind in the country. Streeter and McGraw are artists who have been touched by the healing qualities of art in their own lives while coping with long hospitalizations and physical restrictions. They believe that the value of art-centered therapy lies in its nonverbal, image-producing nature, with its inherent ability to symbolically and metaphorically help a person discover, uncover, recover, integrate, and gain insight.

The Art Studio was, and is, innovative in its approach to both funding and the philosophy of its therapeutic arts program. A 1971 article by Elinor Ulman described an "art program in a long-term general hospital":

> In 1967 George Streeter, MD, who heads the hospital's Division of Psychiatry, joined with other amateur artists on the medical staff to make available to patients the rewards they themselves had found in the art process.... It is a place where the emphasis is on a person and his painting, not a patient and his hospitalization.... From the start it has been a separately funded, nonprofit organization.... In both a practical and a symbolic sense, the Studio's financial arrangements make it part of the community, which through art gives the patients something far more valuable than a mere diversion. (p. 145)

The Studio's Board of Trustees works in collaboration with the Hospital's administration to provide the resources necessary to support its programs. The Hospital's commitment is expressed through its funding of two full-time positions and in-kind contribution of space, office supplies, and other logistical support. The five other staff salaries and all other expenses are the responsibility of the Art Studio Board and its administrative director, Darlene Montonaro. Income is raised through contributions from individuals, corporations, and foundations, as well as from fees for services and various self-help programs, such as annual benefits and sales of "WheelArt"—wearable art T-shirts, socks, and aprons created by "painting" with wheelchair tires. (See Figure 1.)

The collaborative relationship between MetroHealth Medical Center and the Art Studio provides a model for other

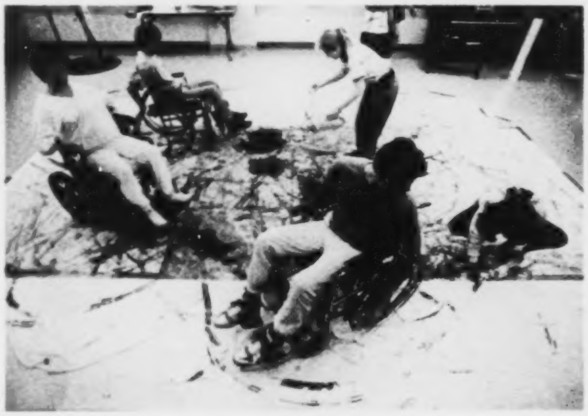


Figure 1.

hospitals and organizations interested in providing arts therapy services, particularly in the current fiscally restrictive health care climate. Though fundraising and financial stability are an ongoing struggle, with support from both private and public sectors and from the arts and human services, the Studio has been able to survive and grow when other valuable programs have been forced to close. In 1967, the Art Studio began with an annual budget of $9,000. In 1994, the budget for its hospital and community programs was over $200,000.

Hospital and community support over the past 28 years has enabled the Studio to creatively develop its services. Art therapy staff can now make an initial contact on an intensive care unit and continue through rehabilitation to a community-based art program. Under McGraw's clinical direction, art therapists see a diverse patient population at MetroHealth and Fairhill, including brain and spinal cord injured, dialysis, oncology, pediatric, stroke, geriatric, chemically dependent, and psychiatric patients. In 1993, approximately 1,000 persons were seen for a total of 10,500 individual and group sessions.

A Broader Spectrum of Opportunities

The Art Studio's administrative structure—independent, collaborative, self-directed, adaptive, creative—has provided the support and continuity for the equally innovative philosophy upon which the Studio's therapeutic arts program has been built. From the beginning, the Art Studio's program was developed around a *studio art* concept. In that safe, creative space intentionally unrelated to pain, loss, or institutionalization, a person is invited, encouraged, nurtured, modeled, and shown how and where to rediscover himself or herself through art. In the studio the emphasis is on the art and artmaking—on the action, not the words. This focus is central to the Art Studio's approach to art therapy, whether the goals are media exploration, skill building, or verbal processing for insight.

According to Streeter (1992), "Art offers uncontaminated opportunity for being yourself; for revealing your identity as a person ... the world of art therapy offers patients a chance to be that utilizes a broader spectrum of opportunities than words alone make available." With the focus on creating art, the art recreates the person with his or her strengths, issues, and solutions. Control is left in the hands of the person, literally and figuratively, while necessary defenses remain intact. The spoken or silent words, evoked by the images and artmaking process, can then increase the potential for change and resolution.

The Studio's founders recognized that physical and emotional illnesses and their treatment can cause pain, anxiety, depression, despair, and withdrawal. People need ways to experience and express these feelings. Clinical practice had demonstrated that traditional psychotherapy was often not appropriate for many of the patients with whom they worked. Words alone did not reduce the pain and confusion. For many, words were not available because of a medical or psychological problem, as in the case of an aphasic or severely traumatized person. And for many others, especially acutely ill or newly disabled patients, words about feelings or fears were often too confrontational or overwhelming (McGraw, 1989).

Many of the patients who participate in the Studio's programs have good support systems and the ego strength necessary to incorporate what has happened. If they are provided with the resources to process and integrate the experience, they can make adjustments and return to optimum psychological and physical health. However, a greater majority of them have preexisting problems, such as personality disorders, dysfunctional families, chemical dependency, and chronic psychiatric histories. These problems have often led to and/or complicated the treatment of the current medical or emotional crisis.

The "broader spectrum" of art-centered therapy has been effective in meeting the needs of these patients at both the hospital- and community-based programs. Over the years, McGraw and her staff have identified specific patient needs which are uniquely addressed by art therapy based in a studio art model:

PATIENT NEED	*ART THERAPY*
1. Direct confrontation is difficult; defenses are necessary. Verbal interaction can be threatening.	1. Used as an indirect method of confrontation to deal with difficult issues; to metaphorically release or transcend, often without words.
2. Must function according to others' schedules in an environment that is often unfamiliar and anxiety-producing.	2. Able to function at own rate within a nonclinical environment that is less threatening.
3. It is urgent for patient to take initiative, have control, decide for self.	3. Puts action in hands, in control of patient, as much as possible. The nonscheduled optional model encourages self initiative in the environment/situation which has taken control away from the patient.
4. There is loss, real and felt. All else in life may be contracting or limited.	4. There is opportunity to expand, to gain. It lasts beyond the moment and has a physical presence outside of the self.
5. With enforced inactivity, verbal contact is either the only form of expression or impossible as an expressive modality.	5. Provides an alternative, self-actualizing, nonverbal expressive modality.
6. Difficulty making new beginnings; not able to adapt.	6. Each session is a new beginning; the adaptive process is taught and learned through association.
7. Feels alone—the only one with these issues/problems.	7. Provides a shared experience among patient, art therapists, and other patients.
8. Out of touch with "self"—how I used to be; how I used to respond.	8. Process and product reflect self; provide a way to see "self."
9. Can't "look" directly at disability or issue; not acceptable.	9. Able to accommodate disability and the accompanying feelings without focusing on them; helps to make more acceptable; can be dealt with more directly in time, as needed.
10. Wary of any reference to psychiatry, even if needed; afraid/angry that people think problem is "in their head"; intuitively seek to protect psyche while body is in crisis.	10. Patient's association to "art" can be less threatening; opens way to the building of a therapeutic relationship, which can lead to trust and ability to accept/seek psychological support.

Art-centered Therapy

The Studio very personally and intentionally responds to needs. According to artist/therapist Kathy Kahn-Denis:

> The silent language of art provides a nonverbal contact and means to relate with the environment.... Through art a person can articulate in paint or clay, feelings and thoughts ordinarily expressed in words. The staff...helps patients gain self-awareness and insight into their life situations through art. They evoke feelings and help open ways to adjust and live with them. (1977)

Thus, the artist as therapist brings his or her own creativity to the relationship and in that way can establish a mutually trusting atmosphere within the shared creative process. Though art therapy staff members chart, attend rounds, receive written referrals, and schedule certain patients, independent use of the open Studio is the goal for all patients. For instance, a brain-injured patient, originally seen on a scheduled basis on the unit by one art therapist because of serious behavior problems, may later choose to attend a media exploration "class" open to all interested patients in the Studio taught by a visiting artist or student intern.

The following guidelines for patient participation in the open studio have been in place since the Art Studio opened: no appointments are necessary; drop-in visits are encouraged during open hours, Monday through Saturday. Families and friends are welcome and invited to participate with patients or on their own if needed and appropriate. There are only two rules: A patient can't hurt himself or herself or someone else or skip a scheduled appointment or therapy. Art skills are taught if a patient asks for help or is attending a "class," if a patient is frustrated or upset with independent efforts, or if a therapist assesses that a new or increased skill would improve ability for creative self-expression. Art skills are not taught to make pretty pictures or to please the therapist, doctor, or family. The artwork belongs to the person who created it to keep, give away, sell, or even destroy. Matting, framing, and exhibiting are important parts of the Art Studio experience. Patient names can be left on artwork, if the patient/artist is mentally competent and wishes to be identified. This recognition is also an integral component of the therapeutic creative process.

Each person's creative process is unique. Thus, artwork reflects the person who created it and serves as an external lasting reminder of his or her accomplishment that helps restore self-worth. Art therapy sessions may focus on *creative arts experiences* that emphasize experimentation, the learning of new information, the development of motor or cognitive skills, and creative thinking. The focus is on the artmaking process. At the other end of the "spectrum" the focus may be *expressive arts experiences* that encourage discussion of feelings and promote adjustment, socialization, and group interaction. An equal emphasis is placed on the process and product, on making art and talking about it.

All Studio-based art therapy utilizes a variety of media and processes to engage patients in creative expression. Materials and equipment are openly displayed and patients are encouraged to "help themselves." The Art Studios at MetroHealth and Fairhill are equipped with pencils, markers, crayons, pastels, tempera, watercolors, acrylics, inks, collage materials, fabric, color paper, clay, wire, wood, yarn, tapes, and an art library. Demonstrations, a picture and slide file, and other resource materials are used for motivation. Individuality and personal expressiveness are encouraged in both the process and the art product.

Patients as Artists

The Studio Art model is best seen through the words and images of the artist patients who have used it. While some patients are discovering new facets of themselves when working with art, others find they can still do something they thought might be lost forever. Frank was a 70-year-old man admitted for rehabilitation following a serious neurological disease that left him with weakness and some loss of feeling in all four extremities, poor balance, and questions about whether he would improve enough to live independently again. Frank "found" the Art Studio at his nurse's suggestion when she discovered he had considered art as a career. Though he showed interest in the environment and was receptive to watching others, Frank was hesitant to try anything himself. His earlier art interest and skills made it more difficult to risk himself since he was afraid he could not even hold a pencil, let alone draw as he had before.

He did come back, showing both his interest and need. McGraw asked if she could do his portrait (Figure 2) to both continue building a therapeutic alliance that was based in art and to demonstrate her willingness to share her creative process. The portrait took two sessions to complete during which time Frank talked about his family, his jobs, and his interests and eventually began to experiment with the drawing materials left on the table near him. Though his first attempts were somewhat shaky and tentative, he had obvious drawing skills, which McGraw acknowledged. He wasn't satisfied with the quality, but expressed surprise at his accomplishment and from that point needed no encouragement to participate.

He drew his room, other patients (Figure 3), and the hospital environment. Though he did not talk very much about his feelings or fears, he gained control of his life as he remastered his

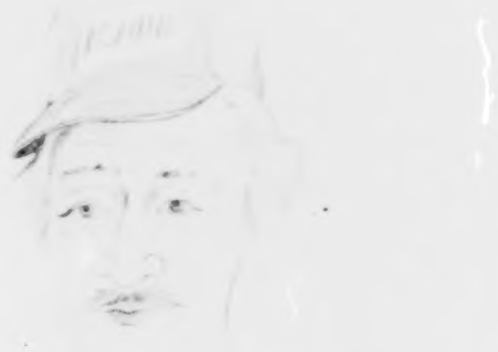


Figure 2.

art skills. He encouraged others in the Art Studio and in therapy, and he gave his work away to those he came to care about. The quality of his artwork improved along with his growing strength and confidence. Figures 4–7 depict the four views Frank saw as he looked out of the hospital's windows, perhaps toward his future. He gave the drawings to the Art Studio for its permanent collection when he went home.

Following his discharge Frank wrote to McGraw about his feelings:

> Your art program recaptured for me a spirit that has been too long dormant and I can never thank you enough for your smiles, your conversation, your encouragement, and your skill in letting me concentrate not on worry, but on those things which might help my recovery.

Kevin was a 22-year-old man who had sustained a fracture of his C5-6 vertebrae in a work-related accident and was now a quadriplegic. Senior art therapist Kathleen Kern-Pilch worked with Kevin throughout his extended hospitalization.

A patient such as Kevin must cope with many losses—control of body functions; sensation of touch, heat, even pain; abili-

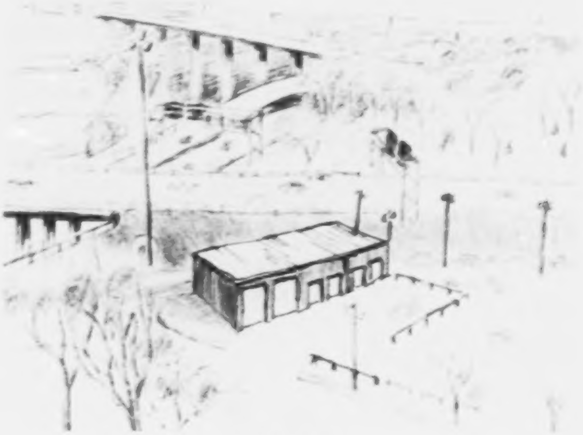


Figure 5.

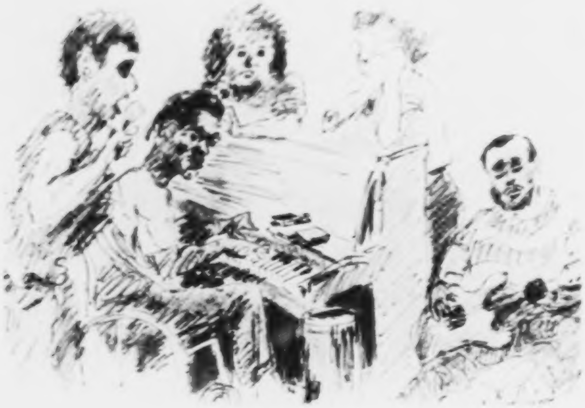


Figure 3.

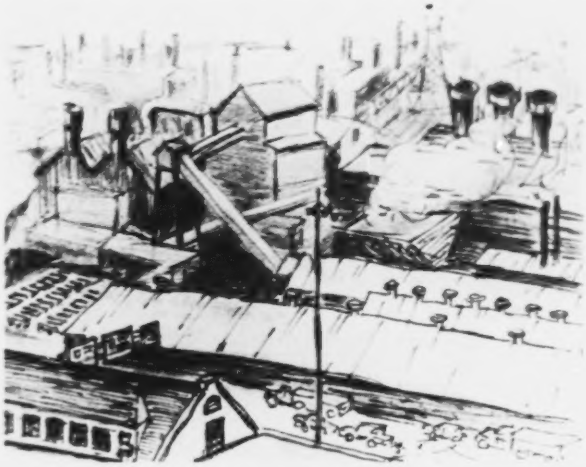


Figure 6.

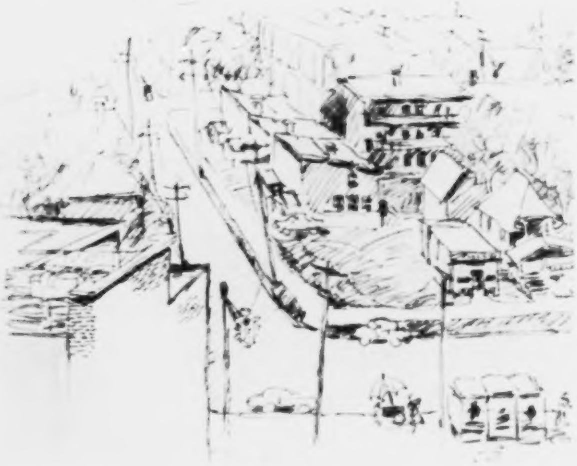


Figure 4.

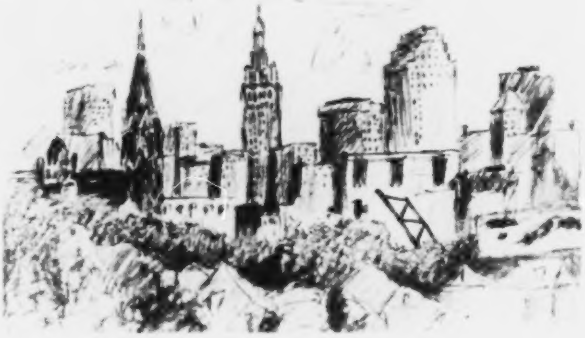


Figure 7.

ty to eat, bathe, dress, live independently; job; and personal relationships. This dramatically altered life style must be addressed within the rehabilitation process, because the newly disabled person is desperately seeking some continuity between who they were and who they have become.

Initially, Kevin explained that he knew nothing about art, but wanted to do something that would help him develop hand strength and coordination. Although he was paralyzed from the neck down, he was learning to write again with the aid of a hand-splint and motion activated through the movement of his upper arm and shoulder muscles. Kern-Pilch responded to his request and provided assistance toward his goal, setting him up to work and adjusting his paint brush and palette. As Kevin's picture developed (Figure 8), it became apparent that he knew more about painting than he had indicated. Over the period of a few weeks, between intensive physical and occupational therapies, a peaceful impressionistic landscape emerged. Only after it was completed, did he talk to Kern-Pilch about the experience when he presented the painting to her. In his own words, "Most everything that I loved to do I can't anymore.... I had to see for myself if I could still paint or if that too was lost.... I'm not sure now what direction my life will take, but I don't need this painting anymore."

Other patients are facing life-threatening medical diagnoses such as cancer or end-stage renal disease. In 1979 the Studio began one of the first art therapy programs for patients undergoing hemodialysis treatment. Art therapist Rich Schultz is currently responsible for this program.

Maria was severely limited, living in a nursing home with little family support. When she began dialysis treatment, Schultz became her "third hand" (Kramer, 1986) since one arm had limited feeling and the other was partially paralyzed. Maria also had limited vision and was legally blind. Applying glue to small bits of colored tissue paper, Maria created wonderfully expressive, bright tissue paper paintings (Figure 9). While working with Schultz on her art, Maria's blood pressure would rise to normal levels helping to medically stabilize her during dialysis treatment. Perhaps just as important, however, was the physical and emotional support that was experienced and felt as Schultz made actual contact during the artmaking process and helped to reduce her sensory deprivation. Maria told Schultz, "I now look forward to coming here only so I can do my art."

Daisy was a 60-year-old female seen in outpatient art therapy by art therapist Dawn Knez. She was referred by her psychologist for "increased activity and opportunity for nonverbal expression." She had recently been diagnosed with spinal stenosis (a narrowing of the spinal canal causing pain and weakness from pressure on the nerve roots), glaucoma, and reactive depression. Physical complaints such as the pain, decreasing mobility, and progressive visual deficit caused her much distress. Although she was aware that surgical intervention could improve her stenosis, she was frightened by the amount of invasion and the risk involved. Daisy attempted to learn all she could about available medical procedures, wanting to have her "eyes wide open." After searching the library for literature and asking questions of physicians, she eventually decided to delay surgery until "absolutely necessary."

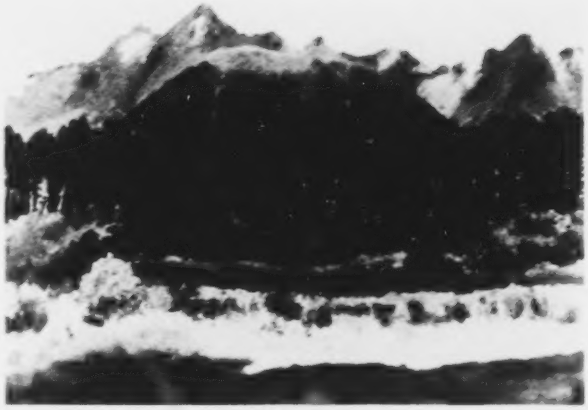


Figure 8.

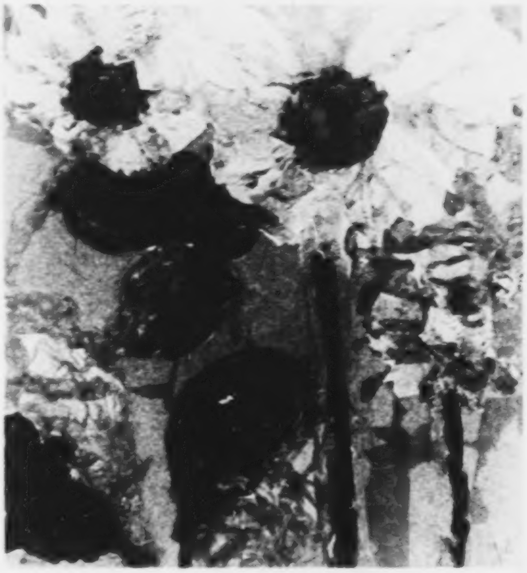


Figure 9.

Daisy responded very positively to involvement in art therapy, particularly learning and working in three-dimensional sculptural media. Daisy's mask (Figure 10), created by applying plaster bandages over her face, strikingly depicts her anxiety and fear regarding her prognosis. Upon seeing its starkness during the painting process, she added hair, earrings, and gold paint (Figure 11). "I used to be glamorous, the life of the party," she said, perhaps expressing her feelings pertaining to multiple levels of loss. When looking at this mask, one recalls her desire to have her "eyes wide open."

The ceramic bird (Figure 12) that Daisy described as "nesting" was completed over three sessions. Significantly, she hollowed out its back, rather than underside, at a time when her own back was causing her so much pain and anxiety about possible surgery. When asked about this by her art therapist, she said, "Now I can put things in it, like tiny flowers; it'll be nice." Though Daisy avoided further discussion about her metaphorical surgical procedure on the bird's back, the process itself was therapeutic. The image is powerful and her verbal response to Knez's question about it is meaningful when one considers it in rela-

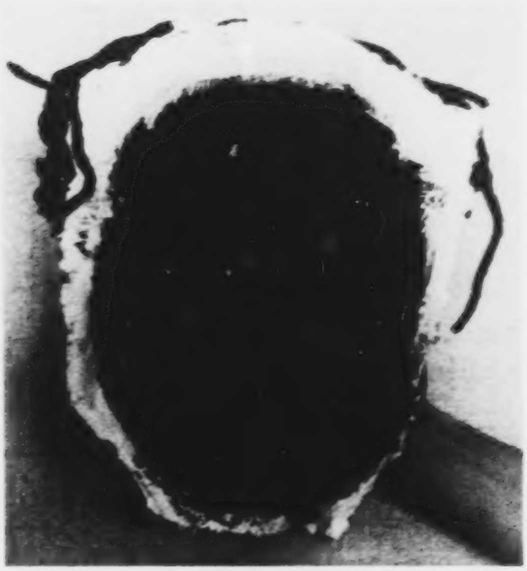


Figure 10.

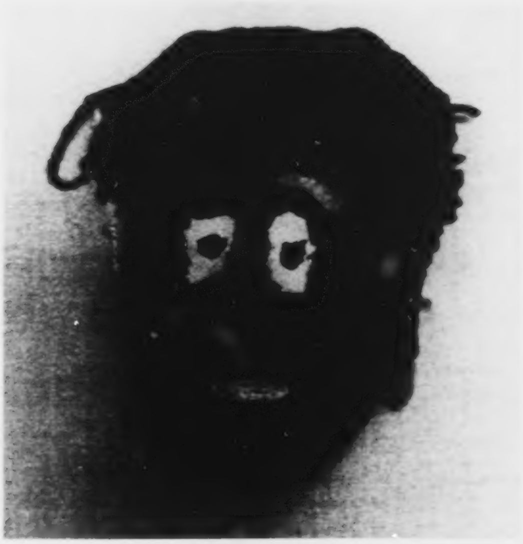


Figure 11.

Figure 12.

tionship to her decision to delay surgery until "absolutely necessary."

Daisy created a textural, boldly colored windchime (Figure 13) at the end of her art therapy treatment program. On the back of each piece she inscribed personally meaningful dates and accomplishments. For example, she included "I started art therapy on February 1." She acknowledged that she had felt hopeless at the start of treatment and explained that "doing things" helped her "feel like somebody" again.

Daisy had benefitted from her creative art therapy sessions and was encouraged by her art therapist and psychologist to continue activities that she enjoyed. She began a swimming class and participating in the Fairhill Art Studio "Discover the Artist" Program.

Eliza came to the outpatient brain injury art therapy program through a referral from the Child Life worker with whom she had faced many hospitalizations as a young woman. A brain stem tumor, diagnosed in infancy, necessitated ongoing medical treatment during her childhood and young adulthood including 60 surgical procedures. Her art therapist, Ky Wilson, had first met Eliza through her poetry when Ky illustrated a book of poems by hospitalized young people. Her well-crafted poems reflecting on life as a person coping with pain and physical limitations introduced Wilson to a powerful self-expressive artist.

Since so much of her life had been focused on illness, Eliza and Wilson decided to focus on her healthy side and strengths in their weekly art therapy sessions. Though the art therapy hour was a time when any problem could be discussed, the focus always leads back to the artmaking and its numerous avenues for positive self-discovery and resolution.

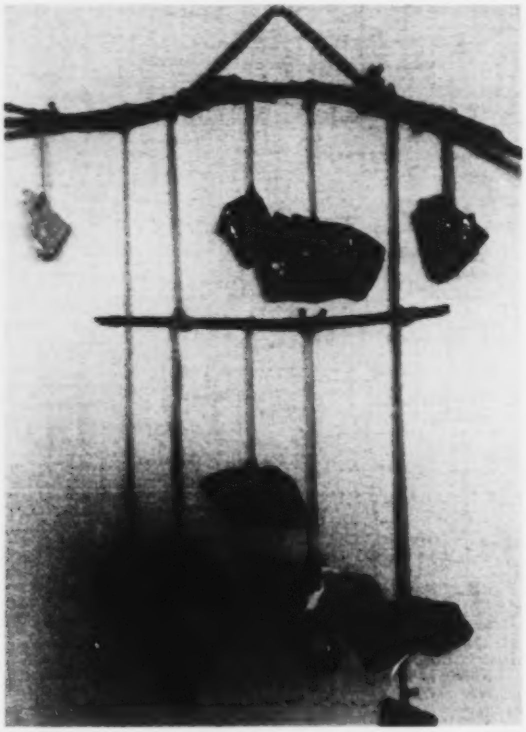


Figure 13.

During the past 2 years, Eliza has used the Studio in a remarkably rich manner, both for developing new relationships with other art therapy staff and patients and for expanding her considerable talent for creative self-expression. She has made use of the "broad spectrum" available in the studio setting for personal reflection on her life situation, to study the history and techniques of art, and to explore new and intriguing media.

Eliza's unique personal expression is seen in the thoughtful and reflective artwork she creates at home and brings into the Studio to process with Wilson. These generally small 8 1/2" x 11" mixed-media works seem to serve as vehicles for expressing, releasing, and sharing past and present pain and the extreme feelings of isolation illness can bring. The terrors of living a life in which dissociation is a main defense against severe physical and emotional trauma and people who don't understand one's feelings are often the subject of these works. When describing her pain, Eliza said, "It's as though I'm an exposed electrical wire, a raw unprotected nerve that vibrates and jumps. The feeling is similar to how glitter affects the eye. I think that's why I like to use glitter so much." Eliza has also developed her ability to use humor to cast a cleverly mocking light on her difficulties. Figure 14, "Doctor At My Bed," exemplifies the distant feeling a patient may have when dealing with a healthcare professional who can't empathize and who creates more distance by not being "real." Through re-creating the masklike smiling face, Eliza gains control of the painful memory by "facing" it and sharing the pain creatively.

Eliza has also used the Studio as a center for the study of art history. Her health no longer permitted Eliza to attend college classes, so she developed a plan to explore each major period of art history, concentrating on 19th and 20th century painting. Each week she and Wilson selected a painting movement to re-create through watercolors or acrylics. Eliza's Impressionism study involved making a study in acrylics of Renoir's "Road at Wargemont." She showed her good humor and self-esteem through her title "Road at Wargemont, Revisited and Improved" (Figure 15). Her study of Renoir shows solid ability to re-create the composition, color, and feeling of Renoir's artistry. This was an affirming, integrating experience.

Eliza also used the Studio setting for extensive media exploration. Since she has such an imaginative mind, the wealth of art materials on hand inspired her to create highly individualistic, mixed-media collages. For example, "Is That All There Is?" (Figure 16) combines balloons, found objects, colored glues, torn

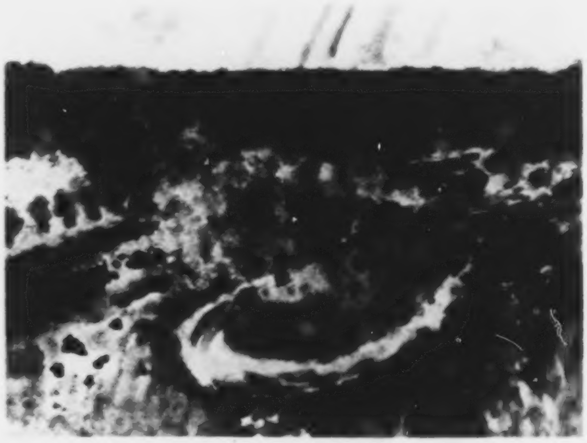


Figure 15.

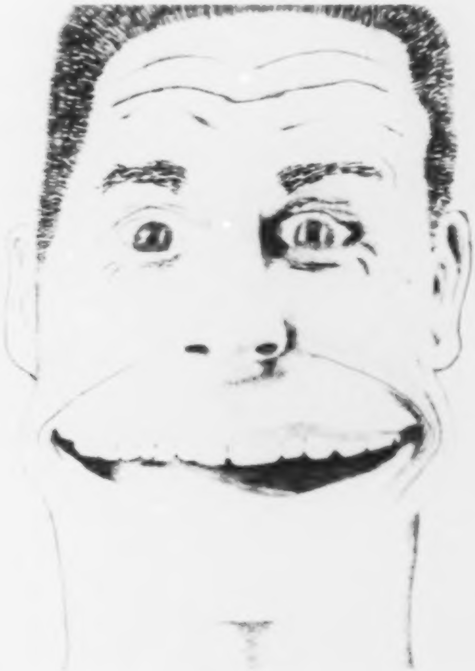


Figure 14.

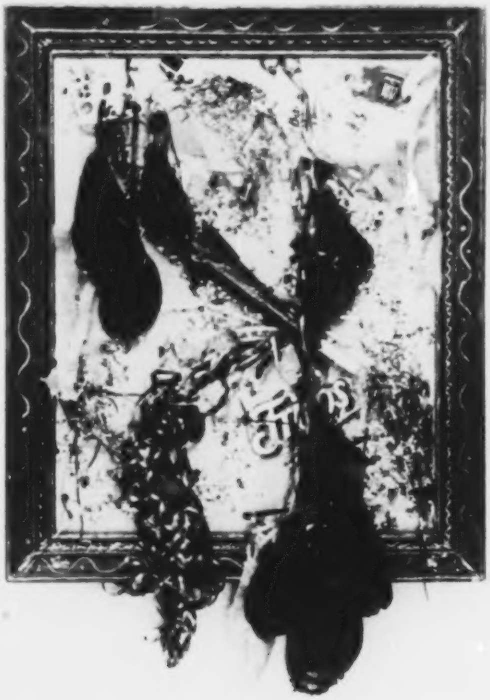


Figure 16.

paper, and glitter to symbolize the leftovers of a party. She decorated the frame with colored glues to incorporate the painting mood in the border. Eliza used the rich media symbolically to ask the question about life: "Is that all there is?"

As her skills in creative artmaking have grown, Eliza has reached out to fellow Studio artists, forming important bonds with volunteers, patients, therapists, and visitors. These bonds with other artists offer her the opportunity to share her gift of creativity, her insights, her love for the healing creative process, and her joy in knowing others through art. In her own words:

> So many tragically traumatic and wonderfully beautiful experiences have occurred in my life that I haven't had much time to assimilate them all into myself. Life "keeps happening." Art helps me bring all this emotion and conflict to the surface (literally!) where I can begin to make sense of most of it and learn how to deal with the utter senselessness of the rest. I really know something important is happening as I create each piece because it feels like what I imagine giving birth feels like: painful, fervent, and all-encompassing but afterwards exhilarating, purposeful, and you want to do it again! It's incredible and eerie how art can bring out so much of my inner world. If God did not give me the ability to create art I would be much like a stomach unable to empty itself—eventually I would burst because life has force-fed me a lot and I tend to bite off more than I can chew as well.

Conclusion

Eliza's words speak eloquently to the healing nature of the creative process for all people and to the Art Studio's purpose for being. Just as Eliza, Frank, and Maria have had their needs met through involvement in the Art Studio's programs, so too have countless others. Though the Studio began its work in a rehabilitation setting with physically disabled and chronically ill patients, it has since expanded to make the arts available and useful to people with other special needs.

The presenting diagnosis may differ greatly, but there is a common need to cope with traumatic events, to make sense of life-threatening, life-altering experiences, and to integrate and make inner and outer worlds congruent. The Art Studio has created specialized programs to make its services more readily accessible to a specific population such as chemically dependent, sexually abused, brain-injured, or elderly persons, both at the hospital and at Fairhill. However, the model for each of these programs has been *studio art* which emphasizes the nonverbal, image-producing qualities of artmaking as central to therapeutic gain. Even when the goal is to increase cognitive skills or encourage discussion of feelings, the art process and its product are integral to the experience. As Eliza said, "Life keeps happening," and art continues to help us bring all the emotion and conflict to the surface where we can begin to make sense of it.

Editor's Note: The author wishes to acknowledge Dr. George Streeter, Kathleen Kern-Pilch, Dawn Knez, Rich Schultz, Ky Wilson, and all past Art Studio staff, trustees, and volunteers for their individual and collective contributions to this paper and the program it describes. The author is pleased to announce that the Art Studio established a Graduate Clinical Training Program in art therapy in April 1995 that incorporates the studio-based model into its education program.

References

Kahn-Denis, K., McGraw, M. K., & Myers, L. (1977). A pioneering art therapy program at Highland View. Cleveland, OH: *Cuyahoga County Hospital Foundation—Quarterly*, Summer, 17–20.

Kramer, E. (1986). The art therapist's third hand: Reflections on art, art therapy, and society at large. *American Journal of Art Therapy, 24*, 71–86.

McGraw, M. K. (1989). Art therapy with brain-injured patients. *American Journal of Art Therapy, 20*, 37–44.

Streeter, G., Downham, T., & Montonaro, M. (1992). The Art Studio—Center for therapy through the arts: A historical review. *25th anniversary historical catalog*, Cleveland, OH.

Ulman, E. (1971). Therapeutic art programs around the world: VIII Highland View Hospital. *American Journal of Art Therapy, 10*(3), 145–152.

Art Therapy: Journal of the American Art Therapy Association, 12(3) pp. 175-178 © AATA, Inc. 1995

The Intern Studio: A Pilot Study

Linney Wix, MEd, A.T.R., Albuquerque, New Mexico

Abstract

This article describes and discusses the Intern Studio Project, a two-semester pilot study. The Intern Studio Project consists of the provision of regular open studio time for art therapy interns in a state university graduate program. The studio enables them to make art in a community setting which enhances personal and professional growth. Psychological and artistic bases for the open studio approach in an academic setting are discussed. These psychological and artistic theories include the relational approach, Hillman's essentialist paradigm, and series and context theories. Students' self-reported experiences in the studio are included.

Introduction

During the academic year 1993–94, I conceived and developed the Intern Studio Project. This became a weekly studio arts experience for student interns in the graduate art therapy program at the University of New Mexico where I teach. After a difficult experience which plunged me into recognizing the necessity of arts-centered research for the field of art therapy education, I understood the importance of recentralizing artmaking in my own professional process. I realized more deeply my belief in art as the structure of an art therapy education, not the icing on the cake, and I began to pursue modes of research based on nonverbal methods of inquiry. One result of this research is the Intern Studio Project, in which the art therapy intern's own art process and product are the focus of the research. Here, visual modes of dissemination, such as art exhibits and video tapes, are as important as the written word.

The Intern Studio Project offers educational and artistic experiences geared toward the prevention of "clinification" (Allen, 1992) of art therapists. It also models and teaches art as "the way" in contrast to art as "the tool" in art therapy education and practice. It provides a forum in which studio participants and facilitator practice the art of maintaining the centrality of artmaking to their own life processes.

In this paper I will discuss the theoretical bases for the Intern Studio and describe the project and the role of artmaking in the development of the art therapy intern. The paper documents what happened during the two-semester pilot study and lays the groundwork for research into the effects of studio participation on intern experience and the effects of the facilitator's participation on the studio structure and on the facilitator's artmaking.

Theoretical Foundation

Allen (1992) discusses what she terms the "clinification syndrome," a process in which art therapists develop clinical skills while art production decreases. This results in a professional art therapist who cannot be differentiated from a social worker or a psychologist. The art therapist loses what has distinguished her or him in the therapy field—her or his art—and looks like any other member of the clinical treatment team.

Although the Intern Studio is not an artist-in-residence situation as described by Allen (1992), it may be another mode of preventing the "clinification" of art therapists. The Intern Studio allows for ongoing studio experience outside of internship and among peers. It provides interns a place to "dwell deeply and fully" (Allen, 1992, p. 23) in the art experience. It is another way for art to stay central to the art therapy experience. The studio can serve as a model for students before they enter the clinical world; furthermore, this experience may partially alleviate the loss of the artist within the therapist who must exist in the clinical or educational setting. Thus, this particular Intern Studio method may contribute to a decrease in the "clinification syndrome."

The writings of Allen (1992) inspired me to determine how I might incorporate the idea of an open art therapy studio into a university environment. However, my larger work both in and out of the Intern Studio has been and is currently influenced by a variety of other writers and artists whose ideas I appreciate as they mesh with ideas of my own. These writers include Gilligan, Rogers, and Tolman (1991), Beittel (1972, 1973), and Hillman (1991, 1992), each of whom has made a significant contribution to my own body of working ideas.

In describing their "relational" paradigm, Gilligan, Rogers, and Tolman (1991) differentiate the development of adolescent girls from the traditional model of developmental theory which posits separation as a goal and is based on the study of males. The relational paradigm suggests that "female" systems have a web-like structure of connectedness in which sustaining relationships is primarily valued. In the Intern Studio, these ideas about relationship are applied to artmaking. In the context of artmaking educationally, therapeutically, or in the community studio setting, the relational paradigm includes, but is not limited to, the person-to-person relationship. In the artmaking process, multiple relationships are constellated. There are the relationships between and with the media—with the chalkiness of pastel put to paper, the squeal of chalk on a board, the thick rubbing of oil pastels, the fluid brush-stroking of tempera onto paper, the pushing of acrylics onto canvas, the rubbing of hands across a paper on a monoprint plate, the textural qualities of paper, canvas, or board, the cool earthiness of the clay felt by the hands. Each of these experiences provokes oral, tactile, visual, and olfactory responses. It is the sensory contact that matters here—the place of sensory connection with the materials. There is also the continuously changing relationship between the maker and her or his creative process, as well as the relationship between the maker and the resultant art image. The act of making sensory contact, central to the hands-on art experience, embodies relationship. Additionally, in this open studio model, there are the relationships among the artists who are working separately, yet together.

The writings of Beittel (1972, 1973), ceramic artist and art educator, have supported my application of relational ideas to artmaking and specifically to the Intern Studio. Two of Beittel's concepts that are especially relevant are those of context and series work. Pepper's "contextualist world view" (as cited in Beittel, 1973), concerns "the event alive in its present … the event in its actuality … when it is going on now, the dynamic dramatic active event … it is an act in and with its setting, an act in its context" (p. 75). In the Intern Studio, the "act" is making art; it is within the context of a weekly studio setting with other students who are interns. This context includes the "dynamic, dramatic" experiences of making art, expressing, feeling, laughing, looking—actually seeing our own work and that of others in process, as well as talking about color, form, technique, and content. By its very nature, the studio context is comprised of a series of art-centered acts involving relationship and the senses. The context also involves the ongoing processes of individuals in a group so that, besides the individual series of week-to-week artwork, a group image is present. Within this contextual framework, series artwork evolves according to each individual's focus:

> It is in the process that we know experientially; it is in the effort to reflect and communicate that we know consciously, cognitively; and it is in the perspective of time, of the series, that we know change and are led to evaluate that change. (Beittel, 1972, p. 211)

Hillman's (1991, 1992) ideas on essential psychology also suggest a "series" approach. Central to the essential psychological view is the idea that from birth we each carry an image, much as an acorn holds an oak, that holds who we will become. What the acorn contains is not available to be seen until we look back at our lives when we are older. Then, the experiences of our lives make sense as they fit into the process of who we are. Thus, life can be conceptualized as a series. Likewise, in a series approach to art, no image stands alone. Each is connected to those that came before and those that are yet to come. Much as Hillman (1992) suggests that we have carried our future selves in the "image in the heart," each art image also emerges from the heart of another image. The Intern Studio functions *in* a relational model, *from* an essentialist model. Participants work relationally *with* one another, with materials and with process and *from* their individual "acorn" experiences.

The essentialist acorn idea, as it applies to the development of the image in series work, follows a relational paradigm. Just as who we are is related to who we were in childhood through the acorn image, art images are related to one another in series work. Each image carries the next image, and when seen in the series context, the inevitability of the emergence of each image becomes visible. Art is a great chronicler of life; reviewing a series of art images helps us see the unfolding of ourselves and our art.

In applying concepts from relational and essential psychological theories to the Intern Studio, I have observed how the imagination and hands-on art experiences feed each other. The word *imagination* is derived from the Latin imago, a "likeness of something" and imaginari, to "form an image in one's mind, to picture to oneself" (Ayto, 1990, p. 294). Hands-on implies a manual act; *manual* derives from *manus*, the Latin word for *hand* (Ayto, 1990, p. 337). Together, imagination and the manual act of making art result in the actual formation of things "never before wholly perceived in reality" (Merriam-Webster, 1994, p. 578). As individuals have engaged in their own acts of forming in the context of the Intern Studio, the studio has taken on its own particular formation as well.

Studio Structure

The Intern Studio met for 3 hours once a week over two semesters. (At this writing, the third semester of Intern Studio is just beginning.) During the first year of the project, five interns participated during the Fall semester; in the Spring semester, nine interns (more than half of the interns in the art therapy program) participated regularly. It has been limited to interns rather than being open to all students because the internship experience can be an especially difficult time for art therapy students. This is the period in their education in which they often neglect their own artmaking as a natural part of the process of becoming an art therapist. Studio participants are in their second and third year of graduate study; thus, they have lost much of the community support that comes with being in first-year courses together. The art space and time provided by the Intern Studio Project serve as a container for interning art therapy students and their artmaking while functioning to prevent the "clinification syndrome" during art therapy training.

I know the "clinification syndrome" intimately. I know it in the clinical setting, where to be a primary therapist one could not also be an art therapist. There were a few years when, in mental health settings, I was caught in the hierarchical dominance of therapy over art. I also know a close relative of this syndrome in the university setting, where to attain academic status, I became more dedicated to the computer and words than to the studio and images. I allowed the terminology of my field to take precedence over the artmaking process. It was a hard lesson to relearn that I am an artist and that what initially brought me to the field of art therapy was my own art experiences, and that it is from the place of experiencing art as healing that I can best work with others. My work must involve an engagement in my own art processes and the art processes of others. The Intern Studio Project provides a context for my artmaking and that of student interns. It also provides the context for research into the effects of artmaking on student interns.

The Intern Studio also has served as a container for the arts focus of my work. For me, the Studio contains the educational, therapeutic, and creative aspects of art. It is designed to instill and maintain, *during* the art therapist's education, the belief in art as "the way," rather than art merely as a therapeutic tool. For example, when art is used as what I call "the way," the art process and product are central to the image of the art therapy process; when art is used as a therapeutic tool, the art is more of a jumping off point for verbal exploration or an illustration for the verbal session. However, neither approach excludes verbal processing. In the former, the art is used as the core and focus of the discussion, with therapist and patient listening for metaphors and stories in and around the image. In the latter, the art leads to a discussion, generally of a problem the patient is encountering;

this leads to a departure from the art image. What I want students to learn from the Intern Studio is the former approach, where the art is central. An essential ingredient here is that the setting is the studio, not the office. The studio setting itself implies the centrality of art.

A focus of the Intern Studio is making art in community. As stated earlier, the idea of contextuality supports the community structure of the studio in that participants make art separately, yet together. One student stated, "I can work by myself here and yet get a feeling of community that gives a lot of support." Another said, "My artwork is affected by working with other people. I like that. I have my studio at home, but this is different." Yet another conveyed this idea when she said, "[In the studio], there's a sharing of creative energy. It's greater than the sum of its parts."

In forming the initial studio, an open invitation was made to interns to join a studio art group designed to explore their ongoing internships through art. A time convenient to the majority of interested interns was chosen to maximize the potential for attendance; the structure of the studio calls for a commitment in attendance and participation in order to reap the benefits of artmaking in tandem with the internship experience. The studio is held in an art therapy studio/classroom. Art materials are supplied by the interns themselves. Students do not receive academic credit for their commitment, but they do receive community support both for their art and for their internship struggles. As Kim Kelly (Figure 1), who completed one semester of internship before becoming a studio participant, said, "Setting aside a time was not a struggle. It was like buying myself ice cream.... Last semester was harder. It was hard to understand the experience of watching other people do art when I wasn't doing my own" (personal communication, 1994).

Internship, although often not discussed, is always present as a component of the lives of the students involved. Internship, then, is a part of the larger image; by this I mean that the image is more than the art product. For these particular students who are immersed in their internship placements and trying to make sense of it through their own art, the internship experience is a part of the image of their lives. Jenny Hubbard, a first-semester intern, observed:

> Psyche meets psyche in therapy. I bring internship into studio whether I'm conscious of it or not. What I do in studio grounds me [in my internship work] and is part of the overall image. From my internship setting to the studio, it's a continuous loop of psychic activity.... When I make these spheres, it's a way to keep all the parts together as a part of a greater image. In making these spheres, a holding happens, and it's a holding that holds the whole internship and me in it. (personal communication, 1994)

In the studio, interns choose the course of their artmaking. In the process of self-directing, the intern is also self-creating. Media, content, and method are self-chosen. Thus, relevance or irrelevance to the "loop of psychic activity" is also self-chosen. These artistic directions are important visual markers along the way to becoming an art therapist. As the interns make their art, their art makes them, and when they look at their art, then they have a new way of seeing their own processes. The acts of making with the hands and seeing with the eyes become central to the current life process, in this case, the process of training to be art therapists.

Art therapy

Figure 1. Kim Kelly with "And Then The Angels Came"

Student Experiences in the Studio

> I came to conclude that the human use of art, wherein art is seen as an ultimate, a discipline, a move toward the expression of feeling through the work of imagination and the resistance of medium, *requires a normative frame in which the "prescription" is self-chosen and self-monitored.* Without centering on his own imagery and intentionality, and the uniqueness of each encounter as process, all aborts for the artist. (Beittel, 1972, p. 206)

Throughout her first semester of internship and studio work, Barbara Falconer prescribed the task of redefining art for herself. During the semester, she struggled with her traditional concepts about art and beauty in contrast to what she was seeing in her psychiatrically based art therapy internship. Her contact with patients and their art so profoundly influenced her ideas about art that she spent many hours in the studio, redefining art at the potter's wheel. She stated that she had once worked for a period of time to create the "perfect" pot and that she had never achieved it. Now, here she was throwing pots and cutting them or deliberately throwing them off-center. She put the trimmings from the outside on the inside; then, what was inside was thrown up and out to emerge as part of the outside. As Falconer reconceived her ideas on perfection in potmaking, she came closer to her current image of the "perfect" pot (Figure 2).

Falconer's understanding of the studio experience was as a meeting ground for "cross-imaging," inside and outside, art therapist and patient. Intrigued by how patients and therapists end up working with similar images, she stated, "It's a re-psyche-ling" (personal communication, 1994). In the relationships between

Figure 2. Barbara Falconer with her "perfect" pot.

art therapist and patient and between internship and the studio experience, the psyche is recycled over and over in different media and different contexts.

The Intern Studio Project provides a container for the enactment of imagination in the hands-on making of art. In the making of ourselves as art therapists, the studio serves a vital function in containing the artist part of that formation. The studio, and perhaps only the studio, has the potential to hold the artist while she or he becomes an art therapist who does not leave her or his artist-self behind.

Third-semester intern Ingrid von Brockdorff stated,

> Studio lets me let go of the business-y parts of internship. The art gives a place for all the stuff you see as an intern to go. When I wasn't doing studio, I had to talk about it all the time. Now I'm wanting to put what I feel into an image around that talk. For me Studio has been a container for what would have been talked about. (personal communication, 1994)

Participants in the Studio Project agree that the studio has added a richness to their internship experiences that previously was missing. Each agrees that her or his own style of artmaking and verbal image work is echoed and heard anew in the studio setting through working together in the student intern community context. The Intern Studio has served as an anchor, allowing an environment for the multiple relationships that occur in the art therapy internship experience to be explored through artmaking in a community studio context.

Conclusion

In its first year, the Intern Studio has helped to keep participants closer to what art therapy just might be about: art. The studio has allowed its participants to remain involved in the image instead of just in words about the image. It has kept interns in a hands-on place rather than being tempted to remain heady about a sensory-rich act that happens through the hands. Studio afternoons have provided art therapy interns an opportunity to maintain what has most often brought them to this profession—their own experiences with art's ability to heal. When the art is made the center of the art therapy education, then the passion of the making is remembered by the maker and imparted to the patient. Studio participants have the opportunity to integrate their experiences into intern work or to use their studio art experiences alongside internship.

Pilot results of the Intern Studio have been encouraging and student feedback has been positive. As a result of the two-semester pilot study, there is an exhibit scheduled for the Fall of 1994 exemplifying the studio process of artmaking in this training program. Grant monies are being sought to support research on the studio method in the training of art therapists and to fund a video documenting the studio process as it unfolds. As a result of the pilot study, a summer course, "Studio for the Art Therapist," was taught in response to pre-intern student requests.

In my own educational and early clinical experiences, I was taught to be a therapist to the exclusion of my artist. Art was my own private matter and responsibility. It still is, of course; yet, the studio has provided me with a different perspective as well. Through the Intern Studio Project, my art and that of participating students have been recentralized in the art therapy training experience as a community matter and responsibility. As studio facilitator, I hope to use the hands-on artmaking experience to help students remember and center their artist-selves as a prerequisite for kindling the therapeutic art experience in others.

References

Allen, P. (1992). Artist in residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association, 9*(1), 22–28.

Ayto, J. (1990). *Dictionary of word origins.* New York: Arcade.

Beittel, K. (1973). *Alternatives for art education research: Inquiry into the making of art.* Dubuque: Wm. C. Brown.

Beittel, K. (1972). *Mind and context in the art of drawing.* New York: Holt, Rinehart, and Winston.

Gilligan, C., Rogers, A., & Tolman, D. (1991). *Women, girls, and psychotherapy: Reframing resistance.* Binghamton, NY: Haworth Press.

Hillman, J. (1991). *Community of men and the Language of desire.* (Cassette Recording) Santa Fe: ARC A/V, 5-63A.

Hillman, J., & Ventura, M. (1992). *We've had a hundred years of psychotherapy and the world's getting worse.* San Francisco: Harper Collins.

Merriam-Webster's Collegiate Dictionary: Tenth Edition. (1994). Springfield, MA: Merriam-Webster.

Art Therapy: Journal of the American Art Therapy Association, 12(3) pp. 179-183 © AATA, Inc. 1995

Keeping the Studio

Shaun McNiff, PhD, A.T.R., Beverly, MA

Abstract

In this paper, the studio is approached as a therapeutic community of images where the therapist functions as "keeper" of the space and atmospheric medicines which act upon the people who visit and participate in its creative ecology of forces. It is not physical suitability which determines the success of the studio. In fact, distractions and imperfections in the space may more accurately mirror the state of psyche and so induce the passionate engagement that calls forth soulful images.

I started my first job as an art therapist at a state hospital in early 1970. Before meeting staff and patients who lived in a huge Victorian brick and granite building constructed in the 1870s, I was introduced to an old wooden building in a field at the east end of the hospital grounds. There was an identical building at the other end, almost a quarter of a mile away. The empty building was to be used exclusively for my art therapy groups. It was called the Art Cottage and its partner at the west end of the hospital was the Music Cottage.

In keeping with the institutional treatment of the time, there was not much happening outside the context of drugs and other restraints, but there was considerable "space" being made available for art. I was untrained and the hospital offered no instruction in the practice of art therapy. The possibilities were as open as the empty rooms of the cottage. In retrospect this was a perfect way to begin. I met the space first, and it told me what to do: It wanted to be filled with images and people making art. The medicines of the process would find their ways through the souls of the people and things involved.

My noninstructions from my supervisors at the hospital were actually quite clear. Their actions said, "Put this place to work." So my career began to take shape around the creation of a workplace, a studio for soul work. Rather than focusing exclusively on the individual problems of patients, I was oriented to a physical space which called for their involvement. We began with the need to fill a space with images and life. I could not do this alone. I needed them to establisn the sense of the place and its function within the hospital.

The cottage had two large rooms with high ceilings, joined by an equally large foyer. It was situated at the crest of a large hill with fields below, the beautiful natural environment always reminding me how the post-Civil War mental hospitals were designed to expose people to the medicines of the physical world. The 1870s advanced the idea of humane treatment for emotional difficulties, and these practices grew from the American Renaissance of the mid-nineteenth century in literature, philosophy, religion, and utopian living. The cottage had windows everywhere, and on its south side an enclosed porch ran along the entire length of the building. The two cottages were probably built for tubercular patients who needed to be housed separately from the main building, and whose treatment was primarily focused on fresh air and light.

To *inspire* means to draw air into the lungs, to breathe, and semantically *spirit* derives from the Latin word for breath, the breath of the gods. The animating principle in both TB treatment and art is inspiration, the inhalation of airs and spirits. It is fascinating to imagine the therapeutic qualities of our art studio being connected in an elemental way to the healing methods practiced in the old TB cottage. Just as the tubercular patients needed good air, the soul benefits from stimulating airs, poetically known as an atmosphere, ambiance, aura. My first art therapy studio was set up according to this natural sense of what the soul needed—creative breezes, breaths, and emanations flowing from a place.

The emptiness of the large space was a stimulus for my work with the patients. As Gaston Bachelard said, "The simpler the image, the vaster the dream" (1994, p. 137). The space invoked freedom and endless possibilities for inhabitation. It pushed me to gather people and images. It served as an alchemical vessel for the transformations of the artistic process. Many things happened within the cottage, and it quietly accepted them all while sheltering everyone involved. It was an asylum within the asylum because of its separation from the main hospital complex. Patients arriving at the cottage literally passed into another world, populated by distinctly different qualities than what they encountered on the wards. Culture and soulful creation radiated from every part of the place.

Twenty-five years later, I see that my art studios are still keeping the rituals initiated by the first weeks in the Art Cottage. We always begin in an empty space which we fill with people and images. The place is transformed and ensouled as soon as the images arrive. Or as Allan Gussow says in *A Sense of Place*, "The catalyst that converts any physical location … into a place, is the process of experiencing deeply. A place is a piece of the whole environment that has been claimed by feelings" (1971, p. 27). The same principle applies to our treatment of artifacts and art made within the studio. Guided by the values of deeply felt experience, we establish a community of creation through the most basic actions of working together and reflecting on one another's expressions.

Participation Mystique

It is the images which carry transformative spirits into our studio groups. Their sensory qualities and energetic auras have a visceral impact on everything they touch. The environment transmits creative forces and becomes a primary agent of transformation. At the age of 23, I intuitively set out to make the space of the cottage into "a place" through creation and the intimate relations it engenders. My lifelong practice within an art therapy studio was constructed in those first days of beginner's mind which atavistically accessed the ancient continuities of a *participation mystique* manifested through the rituals of community. A place presented itself to me, ready to be inhabited with a particular purpose.

My group therapy supervisor at the hospital was a consulting psychiatrist who felt that the most important therapeutic work occurred within communities of all kinds. He was deeply suspicious of the medical model, and we didn't have to look far in the hospital to see its failures. He was open to what was happening in the Art Cottage, and the two of us learned about this new, or very old, therapy through his questions.

We looked at the making of art from the perspective of community interactions, and he introduced me to the ideas of Maxwell Jones. I started a therapeutic community on one of the hospital wards and ran a number of different groups in locked areas of the hospital, but I see now that the most vital and inspirational work we did during those years was in the Art Cottage where the patients, the many volunteers, and my life were being influenced by the creative milieu. We had to get out of the hospital to establish a sanctuary of soul medicine which functioned according to a totally different vision of treatment. Within the hospital, institutional forces swallowed every attempt at change.

As with Jones's experiments with self-help, we discovered that empowering the patient-artists as decision-makers and creators increased their sense of belonging and responsibility. Jones felt that creative transformation was stimulated by a "social ecology" involving flexible and open interaction, listening, the sharing of decisions, learning from mistakes, trust in people, and a pervasive sense that "process was more important than the goal itself" (1982, p. 144).

The therapeutic community "cherished risk-takers" who spontaneously expressed feelings and established a group trust that made it safe for others to open up. It embraced intuition and the way people influence one another through creative contagion.

Ultimately, Maxwell Jones concluded there is "little difference between treatment and training" (p. 104). He said:

> My growing interest in the process of change led me to realize that growth and creativity are, at least in part, a by-product of an open system.... There must be a "destructuring" of what exists. One has to take a risk and become unsecure and vulnerable to reach this stage of transformation.... It is only through this "unknown" that a new order and a new combination or a new identity can be discovered. (pp. 150–151)

Just as Jones, a psychiatrist who began to call himself a social ecologist, pondered whether or not medical science was the proper vehicle for his community practice, I have been increasingly concerned with whether or not the work I do in studios today can be located within the idea of art therapy, which tends to align itself with the clinic rather than the studio, institutions rather than places, "populations" rather than communities, data rather than images. When the discipline is defined in a way that reverberates with the eternal healing functions of art and the participation mystique of community creations, I feel an intense identification.

Unpredictable Inspirations

In recent years I have been encouraged by the writings of Allen (1992) and Moon (1990, 1994) which honor the studio as a vessel of creative transformation. Moon's sense of sanctity for art and Allen's vision of artists-in-residence suggest that the *presence* of the creative process transforms life. If we imagine healing as an energy of creative transformation, then the purpose of art therapy would be cultivation of the salubrious force which finds its way to people in different ways. We never can predict what we are going to receive from a studio, and this quality of the unknown is what most clearly differentiates medicines of the creative spirit from scientific ones. But we go to the studio with a sense of anticipation that we will engage a creative vitality and spirits that will manifest themselves in different ways during each session and in the sequences of a single session.

From the studio we learn that the agents of transformation are more likely to be in the atmosphere, the ambiance or vibes, than within the person. This is why a true therapy of the arts is so closely identified with spiritual traditions where the focus is on the person's relationship to something other than the self.

Within the studio the spirits act upon us. The carefully calculated and replicated procedures of scientific medicine are far removed from the wily and unpredictable movements of creation. A truly artistic therapy is forever breaking down structures in order to make new ones. The creative ecology works in ways that parallel Jones's descriptions of open social systems. Patterns and themes run through a person's and a community's creations, but the effects of a creative process can never be known in advance. Art's medicines are based on surprises, unlikely twists, and the infusion of fresh contents into our lives. My years of working in studios repeatedly show that these contents come upon us *daimonically*, often when we least expect it and frequently against our wills. I can also report to those beginning to work in this way that I never know in advance what a person needs to receive. I want to get people involved in the meditations of the creative process which open to a deep personal dialogue with images and feelings that will present the needs of the soul. It seems that I am forever being surprised by the unexpected results of a person's work in the studio.

So we can say in summary, that the essential medicines of the art therapy studio are conveyed by the environment. They are spirits and forces that impact people in different ways. As a "keeper" of a therapeutic studio, or "caretaker," my primary function is to kindle the soul of the place, to maintain its vitality and its ability to engage people in highly individuated ways. I might carefully plan what materials we are going to use or how our time is structured, but the spirits of the process cannot be predicted, and this is what most thoroughly distinguishes the medicines of the studio from those of positive science. Going into a studio can be likened to visiting the oracle, a temple, or the healing place of Asklepios where the person simply arrives and sleeps in order to dream and receive whatever contents the nocturnal messages deliver. We go into holy places to pray with a similar openness to the movements of the spirit. In using art, like any other spiritual medicine, we never know beforehand what remedies will be delivered and received.

What Places and Materials Do

I recognize that art's medicines are comprised of forces generated by distinct substances and physical spaces which are the most predictable elements within an art therapy studio. Different materials and environments will emit expressions in keeping with their structures. Although they are both involved in constantly changing and uncertain relationships with artists and groups, the materials and studio space have a relative constancy of expression. The free-flowing nature of watercolor evokes distinctly different psychic states than do thick oil paints. Sculpture made from wood and metal will arouse feelings distinct from a clay construction. The materials are carriers of emotions and psychic states that are unique to their beings. The same thing applies to studio spaces. A small, but well-organized workplace full of people will generate a crowded energy that moves creation in a distinctly different way than a large and open space. One is not necessarily better than the other.

For years I have said that research in creative arts therapy should stay closer to the studio where we can experiment with these different material expressions and spirits like physicists or chemists in their labs. Dutch art therapists, in keeping with old European beliefs that cures to internal ills are found in external things, were studying the therapeutic properties of materials well before the formulation of art therapy training in the United States. Because we have valued only what the art object says about the artist, we have overlooked what it presents in itself and how its expression has inherent therapeutic properties.

I don't protest art therapy's humanism, but I feel that a one-sided orientation to the person who makes the object obscures how the material and the artmaking space are the defining qualities of the art therapy profession. The studio and its creations, our object and image-centeredness, are what distinguish us from all of the other person-centered therapies. We need to research materials and environments and what they do to us.

After retiring from her practice of art psychotherapy, Helen Landgarten returned to her studio. I am especially intrigued with the yet-to-be discovered effects of her re-entry into a full-time life of painting. In keeping with what I said about the therapeutic studio, the artist cannot know in advance what she will engage, and she cannot anticipate the impact it will have on her future life or the practice of art therapy. The basic framework of consciousness when entering a studio is an attitude of, "What will arrive today? What will happen over the course of the next year?" The artist may start to work with an image in mind, but in order for the spirits of creation to start cooking, there must be a melting of control and a surrender to the spontaneous movements of expression which will always deliver contents outside our frames of mind.

Landgarten is making a clear statement about priorities. She came to art therapy as a distinguished painter, continued painting throughout her career, and now immerses herself in the life of the studio. I am not as concerned about making direct links between Landgarten's actions in the studio and the clinic, as I am in observing how a life in art therapy has only seemed to deepen her personal commitment to the studio and its spirits. I cannot explain how one place influences the other. My sense, though, is that there is a vital partnership between the two. The studio is the base from which she reaches out to therapy. It is the source of the vision to which Landgarten must maintain a vital connection. This is the model our profession needs to contemplate.

My personal experiences in the studio have always shaped my commitment to art therapy. I feel things in art that I want to bring to others, and as I see others absorbed in the creative process, it recharges my own artistic desires. The studio is an ecology of mutual influences.

I just returned from leading a week-long studio in New Mexico and stayed afterwards for two nights in art therapist/artist Howard McConeghey's studio. The artist was away, but his spirits were strongly present in the art space. Like Landgarten he has retired from the practice of art therapy to paint. I know that many more art therapists are doing the same thing. What unpredictable impact is clinical work with the arts having on a person's desire to be in a studio? What impact will the full cycle of this ecology in the long-term have on the practice and imagination of art therapy?

McConeghey's studio is in a separate building close to his house, apart from the living quarters by a garden. The place is a sanctuary, a temple of sorts. I have the same feeling about Landgarten's studio. Do we live our lives in art therapy as an expression of our longing for the studio? Does service to others give us the freedom to imbibe what Landgarten calls narcissistic self-expression? It is the indirect suggestions, the subtle messages and inspirations, that I feel when visiting both Landgarten's and McConeghey's studios. They want to be in the studio. I sincerely hope this desire sweeps through the soul of the art therapy profession.

I emulate art therapists like Allen, Landgarten, McConeghey, and Moon who maintain a passionate personal commitment to the studio. They keep me attuned to the basis of the work, to the importance of my own expression, to the mainstream of art. Art therapy thinks it is involved in a technical fixing of problems, but the real work has more to do with what the Romantic poets called flying sparks which jump from person to person, image to person, person to image, image to image.

A Therapeutic Community of Images

In my therapeutic studios, art leads the way. The images and movements are always a step ahead of the reflecting mind and its professions. My practice draws heavily from psychotherapy and depth psychology which help us access the medicines of images and groups. What I do today in studios with art therapists, artists, and what we call "healthy people" is not far afield from what I did in the mental hospital 20 years ago. I have stayed with the medicines of the studio, and I have brought them to a broader spectrum of participation.

As I reflect on what we did in the early 70s, I see that a community emerged from the making of images. I am doing the same thing today. Little has changed within my essential studio practice where rituals of community and creation continue to happen spontaneously through our actions in a particular place. For 25 years I have practiced almost exclusively within groups. After the first session of a studio, I am always in awe at the way the space is transformed and the soul is opened as soon as the images arrive.

Every studio repeats the experience of beginning in an empty space, like the Art Cottage at Danvers, which soon becomes populated by creations. I keep telling participants that our group is composed of the many images we make, as well as ourselves. Even in small groups this rich multiplicity takes us into the realm of community. I have stayed with group practice in studios because year after year I see it working deeply on people. I keep saying how the group-mind is more intelligent, creative, and resourceful than any one of us. My therapeutic style involves a careful watching of the group process, in both art and interpersonal interactions, with a faith that soul will treat itself if given the proper environment and support. Like Maxwell Jones and other early group therapists, I work within an emanation model and "trust the process." If we open ourselves, stay committed, and patiently wait, things will happen through the soul's epiphanies.

The group-studio chemistry is based on the process of individual people performing the intimate and isolating rituals of painting within a communal environment. They are drawn together through what I call the "principle of simultaneity" in which the solitary activities of the visual arts are accompanied by the parallel creations of others. In addition to the shared energy of working, participants give attention to each other. We witness and receive the expressions of others and open to what the images have to say. It is this process of making art together and then bearing witness to the arrivals in a sacred way that establishes the healing imagination of the environment.

As a leader my primary functions are protection and inspiration. I "keep" the sanctuary and "maintain" the space for the participants. I set up an ecology in which the process takes people where they need to go. For years I avoided the term *trust the process* because it seemed like the most outrageous cliché, but now I see that it is the fundamental quality of the work. The freedom of the studio environment allows the soul to move according to its purpose.

I try to keep the structures and procedures elemental because I have found that depth and simplicity are bound together. If we overcomplicate the purpose of art, we interfere with the wisdom of the process. I keep returning to the image of the simple, empty space of the Art Cottage as the hypostasis of my work. I prepare an open studio that receives the participants who fill it with their art and souls. Within the studio each person goes on a distinctly personal journey, yet they paradoxically travel together and construct a therapeutic community of images.

Although I have worked alone with many patients in studio settings, my experience of the strongest creative medicine is associated with groups. When we gather to look at images and work with them, the atmosphere changes from that of a conventional art studio to one that conveys qualities of therapy and spiritual community. We look at the pictures through the eyes of soul rather than the more technical perspective of the art school. This way of viewing art does not impair aesthetic quality—to the contrary, it tends to make images more expressive, authentic, free, unusual, and passionate. There is a sacred sense of witnessing rather than an orientation to analytic judgments and labels. People respond to one another, and to the images, from the heart.

One person's artistic expression stimulates an equally soulful response from another. The flow of the group holds an ongoing stream of creative emanations where one artistic expression follows another. Verbal explanations have their place in the studio, but they do not dominate the atmosphere. We find that responding to art with body movement, improvisational sounds, and performances gives everyone a much deeper and clearer sense of how the person is affected by an artwork. We also share dreams that come the night after painting to interpret our works in ways inaccessible to the reasoning mind. The introduction of dreams and other artistic expressions into the studio enhances the psychic environment and expands its resources.

In summary, in a therapeutic studio it is the overall presence, the soul of the place, which grows from the people and images while simultaneously acting upon them. As a keeper of the space my function is to maintain the presence. I do this through example, support, and constant guidance.

Imperfect Environments

Often the places where we work generate very unattractive auras and disturbing environmental forces. I have constructed many hundreds of nomadic studios throughout my 25 years of practice. I feel like a Bedouin traveler who keeps putting up and taking down his tent. In my travels I don't think I have ever worked in an ideal studio. There is always something that could be better organized in the space. I have contemplated constructing an ideal place, but maybe I should not. The perfect studio could establish an unrealizable standard. It may be better for me to keep working with whatever materials I find in the different places I visit. In this way we demonstrate to others how the studio can be set up anywhere.

Groups repeatedly teach me how to maintain a spiritual presence amidst the din of a work area. If the keeper of the process relaxes, this helps everyone else to do the same. The reverse is also painfully true. Everything depends on our concentration and faith in the process.

Although I prefer to work in the best space possible, I have repeatedly discovered that the vitality of a studio has more to do with the creative *presence* generated than the physical features of rooms. Distractions and imperfections may even perversely feed the creative spirit because they are not unlike our often disheveled psyches. There may be a wondrous medicine released by filling an unattractive space with the soul's expressions. We medicine the disquieted places, and this spatial transformation has a corresponding effect on us. The presence of the creative spirit can be felt everywhere when a group is fully committed to its work. A sense of passionate engagement is emitted that cloaks the space.

Where Does Soul's Studio Belong?

I have never taken art therapy for granted, and I often wonder whether it is an appropriate "location" for my practice of soul-making. Years before I heard about art therapy, my interests were focused on the sacred functions of art, the relationship between creation and depth psychology, and multidisciplinary cooperation between all of the arts, the humanities, and sciences. Art therapy appeared in my life in 1970, and our interests merged. To the extent to which art therapy embraces the diverse and unpredictable ways of soulwork, I have felt deeply attached to the profession. Like many people involved in art therapy, I have found that the art education context has a one-sided orientation to technique and cognition which overlooks soulful depths. My studios encourage an active cooperation between the two.

Art therapy has been most useful in providing me with a community of colleagues who serve the same archetypal function. Just as psychotherapy cares for individual souls estranged from religion, art therapy welcomes the expressions of ordinary people alienated from art. But these sanctuaries may be temporary. Soul is inventing new ways of attending to her needs and envisioning a creative future in which the arts once again act as contemplative disciplines in daily life. Even though the mainstream of the art therapy community appears to be increasingly committed to a sacred function of art, the pressures of clinical regulation, written examinations with multiple-choice questions and a general distrust of imagination, may ultimately restrict the free spirits of the studio so that they migrate to other places, more hospitable to the ways of soul.

If we are to keep the soul in art therapy, we must preserve the studio as the practical and spiritual base of our praxis. I would feel much better about the profession if the medicines of the studio were the foundation of a collective vision. But I see that the values of soulwork do not figure prominently in the official persona being constructed today. In place of our former efforts to establish professional standards by looking at the creative portfolios of art therapists and their experience in practice and supervision, they will now be assessed by written tests which have so little to do with praxis.

Art therapy is at an historic point of definition. For over two decades the profession skillfully maintained an inclusion and respect for every conceivable way of imagining what it could be. As the American Art Therapy Association now prescribes and evaluates courses of graduate study, nowhere in all of the regulations is there a requirement that art therapists be involved in an ongoing studio experience during their training and professional practice.

Don't read this criticism as a plea for a new requirement. I prefer a discipline which is perfected through inspiration, like the spirits I describe acting on me as I walk into a colleague's studio. The vitality of the place feeds my desire and encourages me to act in a similar way. In studios we learn through subtle suggestions and influences. The impressions are not always conscious but they work on us nevertheless.

The profession of art therapy cannot avoid benefiting from increased practice within studio environments where the unique medicines of the creative process can be cultivated. My purpose here has been to draw attention to how places influence the soul. Art therapy has overlooked the transferences between people and environments. The idea of therapeutic change has been restricted to what happens between a patient, a therapist, and the artwork with which they interact. My experience indicates that there are so many other forces at work within a milieu, and the notion of a therapeutic studio embraces this diversity of possibilities.

Led by the Space

In this paper I reflect upon the practice of art therapy from the perspective of the physical space, instead of from the more conventional assessment of a patient's problem. When I look back at the beginning of my practice, the space is a formative force. I don't wish to dismiss the treatment of symptoms and complaints; I am only trying to show how they can unconsciously deter the practices of a profession when it tries to accommodate itself to something other than its essential being. Rather than a genesis myth that says, "In the beginning was the symptom," art therapy might try imagining itself from a nonmedical perspective of, "In the beginning was the space," or even, "In the beginning were the art materials and the people who used them."

Symptoms are of course welcomed and they are vital players in the creative process, but they can be engaged from the perspective of art, or within the studio model versus the medical model. What does the space do to us? How does it move us to create an environment that becomes the primary carrier of the therapeutic process? As a therapist or leader, I am one of many agents within a more comprehensive gestalt or presence. The art studio functions like a spa, a watering place for the soul. The elements of the therapeutic studio are never limited to the patient, the artwork, and the therapist. As the therapeutic properties of the spa are discovered, people will come to it with a sense for what they need. Or they will come with an open and flexible mind, knowing only that they are in need, and that the therapeutic environment has many things to offer. The treatment will emerge through the process of a person's interaction with the place.

We reframe the practice of art therapy by focusing on what the studio does, what the materials do, and how artworks created by ourselves and others affect us. When we look at art therapy through the eyes of the soul, we see an ecological field of forces, a total presence of creation, that simply does not fit the linear language and concepts of behavioral science. The mainstream of art's medicine will always flow from the studio.

References

Allen, P. (1992). Artist-in-residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association, 9*(1), 22–29.

Bachelard, G. (1994). *Poetics of space*. Boston: Beacon.

Gussow, A. (1971). *A sense of place*. San Francisco: Friends of the Earth.

Jones, M. (1982). *The process of change*. Boston: Routledge & Kegan Paul.

Jones, M. (1953). *The therapeutic community: A new treatment method in psychiatry*. New York: Basic Books.

Moon, B. (1990). *Existential art therapy: The canvas mirror*. Springfield, IL: Charles C Thomas.

Moon, B. (1994). *Introduction to art therapy: Faith in the product*. Springfield, IL: Charles C Thomas.

Viewpoints

ArtStreet: Joining Community Through Art

Janis Timm-Bottos, MA, PT, RMHC, Albuquerque, NM

> A psychotherapist, and especially an art therapist, should dive deep into the wrecks of psychic disasters, not merely skim the surface to look down from a distance at the barnacled, dismembered vessels on the bottom of the sea. (Wadeson, 1994, p. 153)

Perhaps because I do not swim very well, I was comforted by John Perry's (1993) lecture to our art therapy class several years ago. He said that we work according to how we are made. I was interested in his advice because I had been studying movement therapy for the past 15 years, working as a physical therapist, and through the Feldenkrais® Professional Training Program (Feldenkrais, 1977). I wanted to find new employment and a new way of working that bridged physical therapy and art therapy. I wanted to change the professional/client working climate that came with being an "expert," with the responsibility for fixing what was not working for someone else. I wanted to explore what was working in my own life and in those lives around me, and move, if possible, in that direction. I also wanted to have time to wait, if necessary, to hold and appreciate that which was not moving. Perhaps there are other art therapists who are "made" similarly. We don't swim that well in deep water or feel comfortable wading alone in the darkness of someone else's unconscious.

During winter break before my final semester in graduate school, Louise Kahn and I wrote a grant to combine an open art therapy studio with the teaching of parenting skills at a shelter for homeless families in Albuquerque, NM. Louise, a nurse practitioner for Albuquerque Health Care for the Homeless, had been providing health care at this family shelter for about six months. The proposal was accepted and we began our ten-week parenting/art therapy classes. The course followed the developmental sequence of growing-up, from infancy through taking care of ourselves, as adults. Our weekly discussions of particular phases of childhood were matched with appropriate art materials that served as catalysts to aid discussion. Often we just made art together and talked. The course ended with an unplanned art exhibit, "Roses Aren't Red," at the local library. This small project provided one avenue to the project ArtStreet.

During the period of the parenting/art therapy group, I attended a meeting of the Leadership Albuquerque Group Project as an art therapist who worked with "the homeless." The civic group, made up of leaders chosen from around the community, was interested in a project that promoted economic development within a community of homeless people. This project, chosen to produce a tangible result that would benefit a specific group, invited street people to meetings for relevant input. The consistent members happened to be artists who were homeless.

The group discussed a community-wide art marketing event and a permanent art gallery space, where artists who were homeless could sell their work. One way to explore ideas was to make art together during our meetings. It became my job to provide art materials, a direction in which to move, and witness the emergence of very powerful art-making. The diversity of the group and their visual art contributions enriched the discussions by identifying strengths that were not available through verbal sharing. Eventually, more grants were written by others and "ArtStreet: Joining Community Through Art" was created.

ArtStreet is a group of artists, art therapists, and interested community members who want to use art to build community and increase personal self-esteem, self-sufficiency, and hope among individuals and families who are dealing with homelessness.

ArtStreet found its home with the Albuquerque Health Care for the Homeless. The spacious art studio receives its funding, in part, from Save the Children Foundation. An Albuquerque Community Foundation and a private local foundation grant help to provide abundant materials at each studio session. Although all materials in the studio are available at each studio session (which run about 6 hours, 3 days a week), there is also an area set up to help guide newcomers. Materials change monthly; examples include printmaking, paper making, bee's wax sculpture, felt making, and photography. Artists from the community share their expertise in these speciality areas and everyone is invited to share ideas and skills. I am present to witness the process of artmaking, facilitate the practical workings of the studio, and plan, arrange, and install art exhibits. The directive in the studio is simple: Using the materials in this room, make something.

Within an environment of an open art studio, we can learn to value and respect our diversity. We work, as Perry reminds us, according to how we are made. Spending time, slowing down enough to value how one is physically made, can be as difficult as finding time to do art work. This self-knowledge reaps many rewards. An art therapist can draw rich metaphors from guided movement experiences that teach, for example, how your scapula learns to individuate from your shoulder complex by gradually differentiating from a global, unorganized motion, or how your stiff, stuck neck finds respect in the community of other effort-

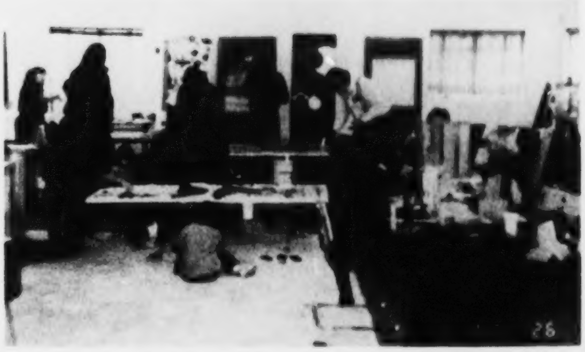


Figure 1. Artists working at ArtStreet open studio.

lessly moving parts. One important lesson from Feldenkrais® Training (Feldenkrais, 1977, 1981) is how my body's movements, with all its habits and pathology, is similar to a diverse community of people who come together with the same intention: to move and make something. Each person, each movement, functioning optimally or not, has a different important contribution.

At this point, our small community consists of about 25 people who have been art making for 8 months, approximately 20 hours a week. Last month, 290 artists signed our ArtStreet Record book. Since ArtStreet opened, a small core of "regulars" have attended all three weekly sessions. Others are in transition between homes, staying at nearby shelters; coming consistently for 6 or 8 weeks, and then not returning. Others come once and return several months later. We invite all ages, especially mothers and children. ArtStreet "regulars" take time from their own work to help new families feel welcome.

Our grant from Albuquerque Community Foundation includes funds to pay artists who are homeless to teach classes and workshops. Mareshah B. Henderson, a skilled multimedia artist and professional photographer was our first mentor artist to teach a public Saturday workshop. The workshop, "Cardboard Sculpture," was enjoyed by all, including a brownie troop. She does not have a home and has had serious health problems, but her art has found a safe haven at ArtStreet (Figure 2).

Miguel came to ArtStreet to finish a drawing. A woman on the street saw how well he drew faces and asked him to draw a portrait of her son who recently died in a gang fight. He sat at the table with the photograph, and told us this story as he added color to the boy's cheeks. The next day he painted a wood sign for ArtStreet (Figure 3). He proudly hung it outside on the fence and received food voucher payments for his work. Miguel hasn't had a home for a long time. He must take medication for a serious blood disorder that makes his body fragile to the elements. He has consistently struggled with his art work, fighting to appreciate the abilities and style he developed without formal training. Recently, Miguel has received support he needs to seek rehabilitation to continue his recovery from life long addictions and threatening life styles.

Sassy, formerly homeless, works for Health Care for the Homeless as a family advocate. She has an endless supply of creative energy which she shares freely with others. One day, she taught us to sculpt using white bread and glue. Her office, near the studio, is decorated with her own artwork. She was a featured artist at "Roses Aren't Red."

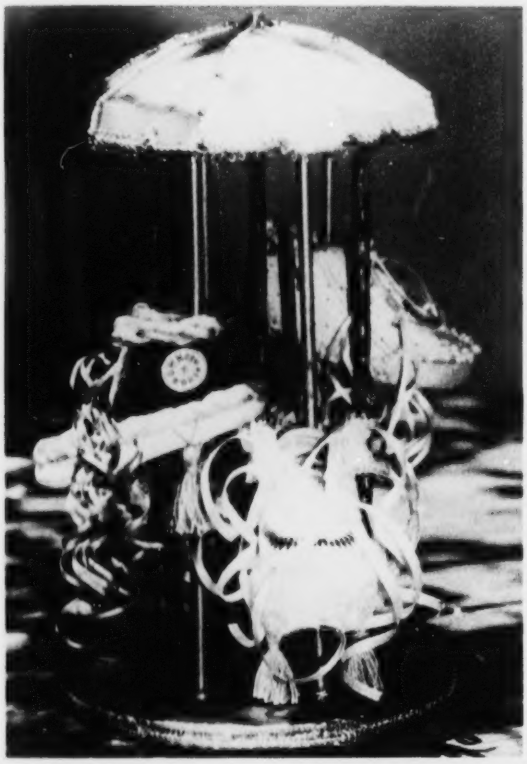


Figure 2. "Faux Dreams" by Mareshah B. Henderson. Shoe art using broken toy, paint, discarded shoes and ribbons. Photograph by Petra Hegger.

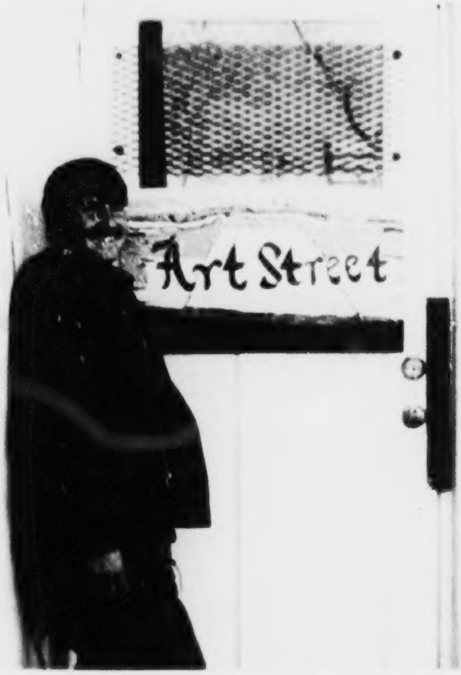


Figure 3. Miguel standing beside his hand-painted ArtStreet sign. Photograph by P. Allen.

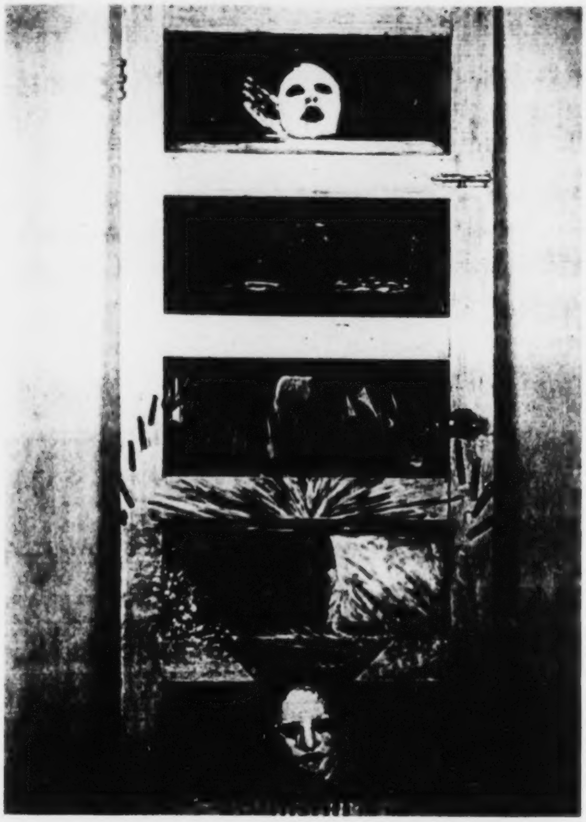


Figure 4. "Isolation...Forgotten" by Steve. Acrylics, collage, plaster masks, discarded door. Exhibited in "The Doors of Albuquerque" at KiMo Theatre Gallery, December 1994. Photograph by Petra Hegger.

Marsha McMurray-Avila worked weekends to finish painting her door in time for the exhibit "Doors of Albuquerque." This collection of 25 painted, decorated doors was exhibited at the KiMo Gallery in downtown Albuquerque (Figure 4). Marsha, an experienced grant writer, is executive director of Albuquerque Health Care for the Homeless and former member of the original Leadership Albuquerque Group. When Marsha works in the studio I help protect the precious time she has with her own art making by reminding others that it is not time for work-related conversations. There are exceptions to this, however. One day our funding agencies arrived with a feast to share and time to make art together. Marsha spoke to the agencies about her experiences at ArtStreet, and, the following week, we were invited to apply for a continuation of funding.

Karen Barnes and her two midschoolers arrived on their own at the studio with help from a social worker. The family attended the original parenting/art therapy class at the shelter in the county where they lived. The children sold their first painting, titling it "Roses Aren't Red." This later became the name of an art exhibit. As a family they worked on a door titled "The Hidden House." The social worker sometimes stayed and worked, played, and ate with us in the studio.

Louise Kahn exhibited and sold her door, "Only You Can Prevent Forest Fires." She is co-creator of "Family Lunch, Art and Play" held at ArtStreet and funded by a grant from a private local foundation. Families who are staying in the shelters are invited to have lunch and make an art project with their children. The nutritious lunches are provided by a day school cook who donates her time and food each Wednesday. For children who are recently traumatized and uprooted, the studio provides a place to unwind and play freely and safely. Ms. Kahn and I frequently combine skills. This collaboration enables Louise to occasionally take time from her schedule to make her own art. She has exhibited in all three ArtStreet exhibits.

Kate Rogers, an art therapist who recently moved to Albuquerque, decorated a tennis shoe for our spring exhibit, "Hats and Shoes: Community Sole Work." Kate brought her adolescent art therapy group, who had decorated their shoes, to see the shoes displayed along with 200 other shoes at the downtown show, ArtsCrawl.

Shirley heard about ArtStreet from other women who were staying at a domestic violence shelter. During her first visits to the studio, she was very quiet. Using old shoes, she began a series of provocative sculptures. While some artists at the studio questioned the violent nature of her art statements, others supported her candid expression. Discussions about "what is beauty?" naturally arose. We agreed to allow everyone's voice to be heard. Sometime later, I suggested to Shirley that, in addition to coming to ArtStreet, she might want to work privately with an art therapist where she could have individual time to talk about her powerful artwork.

Community art making in an open studio environment is a way I have decided to work. The importance of this work is found in the experiences of people who came through the studio doors looking for a community to validate their abilities to make something. This approach is not limited to "art therapy for people who are homeless." We have adapted according to funding sources and dealt with serious issues of homelessness and embraced the "homelessness" lurking in many souls. Most important, this special environment has nurtured creative expression for everyone who has had the courage to make art.

Perhaps there is a biological human necessity satisfied in this act of community art making. Ellen Dissanayake wrote, "Art can be considered as a behavior (a 'need,' fulfillment of which feels good) like play, like food sharing, like howling, that is something humans do because it helps them survive, and to survive better than they would without it" (1992, p. 34).

There have been days at ArtStreet when someone has reminded me to slow down, find space, and make something, because I needed "a little art therapy." Living in a desert landscape and being a lousy swimmer motivates me to find options for working, besides making a living by diving alone toward the bottom of the sea.

Author's Note: I would like to thank my teachers: Pat Allen, Linney Wix, Josie Abbenante, and to Gaby Yaron (who is recently deceased). I would also like to thank the American Association of University Women.

Associate Editor's Note: Ms. Timm-Bottos invites you to respond to her work and the ideas presented in this paper. Correspondence may be sent to: Janis Timm-Bottos, ArtStreet, Health Care for the Homeless—Women and Children's Outreach, 805 Tijeras N.W., Albuquerque, NM 87102.

References

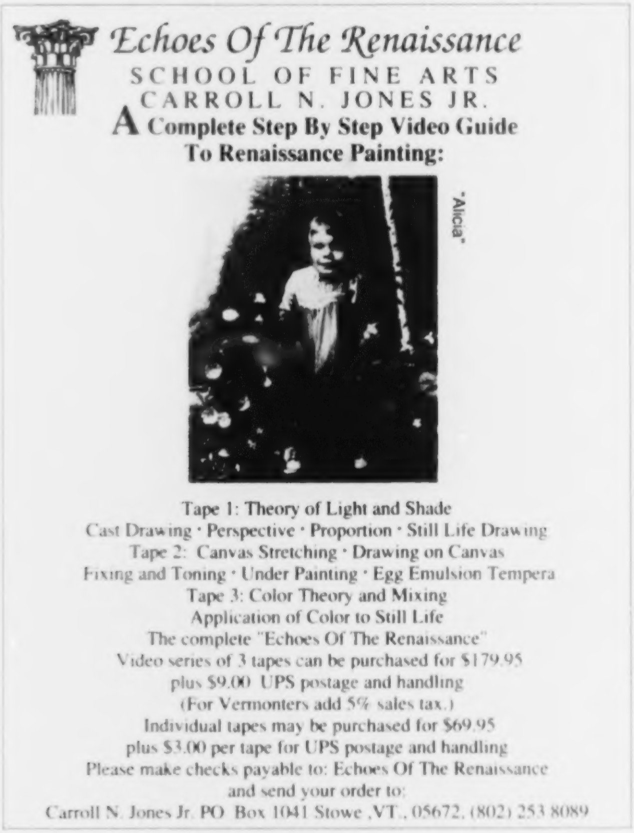
Dissanayake, E. (1992). *Homo aestheticus: Where art comes from and why.* New York: Pantheon.

Feldenkrais, M. (1977). *Awareness through movement.* New York: Harper & Row.

Feldenkrais, M. (1981). *The elusive obvious.* Cupertino, CA: Meta Pub.

Perry, J. (Speaker). (1994). Loss and renewal of our spiritual heritage: Urban culture's secularization and its renewal through archetypes, psyche, and depth work. Lecture series, University of New Mexico, April 1–3.

Wadeson, H. (1994). Diving and snorkeling: The depths and shallows of therapy. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 153–154.



Echoes Of The Renaissance
SCHOOL OF FINE ARTS
CARROLL N. JONES JR.
A Complete Step By Step Video Guide To Renaissance Painting:

"Alicia"

Tape 1: Theory of Light and Shade
Cast Drawing · Perspective · Proportion · Still Life Drawing
Tape 2: Canvas Stretching · Drawing on Canvas
Fixing and Toning · Under Painting · Egg Emulsion Tempera
Tape 3: Color Theory and Mixing
Application of Color to Still Life
The complete "Echoes Of The Renaissance"
Video series of 3 tapes can be purchased for $179.95
plus $9.00 UPS postage and handling
(For Vermonters add 5% sales tax.)
Individual tapes may be purchased for $69.95
plus $3.00 per tape for UPS postage and handling
Please make checks payable to: Echoes Of The Renaissance
and send your order to:
Carroll N. Jones Jr. PO Box 1041 Stowe ,VT., 05672, (802) 253 8089

A Consideration of the Studio as Therapeutic Intervention

David Henley, MA, A.T.R., Hampton, NJ

Introduction

While practicing art therapy at a residential therapeutic school some years ago, I encountered a child who suffered years of parental abuse, leaving him in an autistic-like "feral" state (Candland, 1993). Probably disturbed from early childhood, his parents locked him in the basement during daylight hours, then set him free at night, when he would roam the streets of the city. By dawn he would return to his lair, often with an array of mechanical junk in tow, with which he evidently played and worked during his long hours of solitude. He was eventually rescued and placed in a state psychiatric institution where he remained in solitary because of his wild, uncontrollable state.

When later placed at the therapeutic school, he continued to display extreme shyness toward people. His feral state was akin to any wild animal whose adjustment to captivity was a tortuous ordeal. Biting, spitting, snarling, and defecating were all part of the "fight or flight" reactions against those who approached him intrusively.

In formulating his treatment goals for art therapy, it was obvious that habituation to the studio environment with a minimum of intrusion was paramount. Hence, some form of sheltered, therapeutic space was needed that provided a protective stimulus barrier from the studio-at-large. The first intervention, then, was to create such an environment, one that was reminiscent of his original basement world, where left in silence, he could interact with his familiar objects while also becoming increasingly exposed to the doings of others. We partitioned off a small corner of the studio that was subdued in lighting and traffic yet contained a portal which allowed him to observe the studio community.

After several months of elected confinement, he began to make forays into the surrounding space. These tentative explorations became a ritual for him: Upon entering the studio he would go immediately to his "homebase." Once he inventoried all of his precious found objects he would scope out the scene, then emerge, all the while making visual contact with his corner space. Such "checking back" behavior perhaps insured his space's continued existence or "constancy" (Mahler, 1975), for it was to this cluttered corner that he remained emotionally tied. Its sanctuary enabled him to satisfy his curiosity and "practice" exploration in the Mahlerian sense, all the while remaining libidinally tethered to this powerful psychological and physical territory.

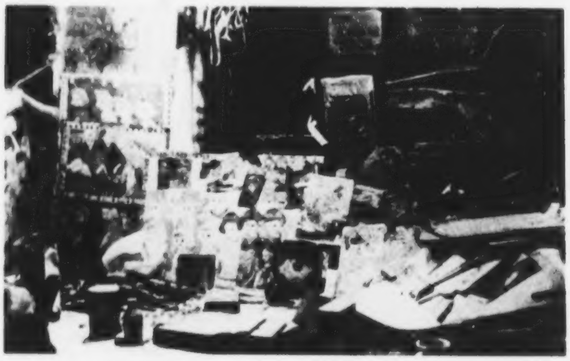


Figure 1. Henry Darger's apartment studio approaches the cluttered space cultivated by my feral client.

This practicing period was facilitated by presenting him with machines and other objects that he could not resist approaching and exploring. While investigating the drill press, the potter's wheel, or the spring-loaded centrifugal casting machine, he reveled within his element. These prized objects became an extension of his territory and, as such, were defended against unsuspecting intruders.

Eventually his need to return to his cloister became less intense and frequent, leaving the space more as a depository for his findings than a dwelling. He began to co-exist, albeit uneasily, with the cohabitants of the studio. Once habituated, he continued to endow the studio space with ritualistic, seemingly magical significance. He began to record his impressions of his space, producing a prolific portfolio of sketches which assumed savant-like qualities (Henley, 1989).

A year after he was successfully weaned from his space, I was asked to help install some of his drawings in his residence hall at the therapeutic school. Upon entering his private room, I was astonished to find a place that was almost identical to the one I had provided him in the studio. This was not just a room, but a veritable middens: Strewn about were piles of broken appliances that were garnished by a string of blinking white lights. A torn poster of Rothko's last show at the Tate Gallery was mounted between two doors which had been wreathed in found bits of cigarette filters, tampon applicators, cotton batting, and so forth, all wired to the moldings as though they sanctified these passages. Broken chairs were stacked upside down in a line which resembled the ramparts of a castle wall. Stacks of discarded albums and other flat material stood around with a presence that suggested that these and other inanimate objects made good company (one recalls the geneticist in "Blade Runner", who engineered his own menagerie of animated characters to relieve his lonely existence).

As an installation, the room seemed like a votive shrine to his original spaces which were reconstructed as though honoring or recalling a dear but now lost love. The extraordinary investment in this re-creation seemed to be accorded with "transitional" significance: To wield its power, nothing less than an exact re-creation would suffice. For this individual, his manipulation of the environment was indeed the "good enough" mother in every sense and, as such, became a most powerful therapeutic and aesthetic force in his treatment (Winnicott, 1965).

The space in which art is made has long been considered a potent force which impacts the form and content of an artist's expression. From the Paleolithic cave painters to modernists such as Pollack and DeKooning to the outsider artist Henry Darger (Figure 1), the studio has provided both inspiration and sanctuary. And, although not every studio is imbued with the significance illustrated in my case example, the studio will more often than not remain central to the arousal of creative fervor.

In other writings I have explored the effect of the studio upon creative motivation, particularly in cases whose artists are of a delicate disposition (Henley, 1992). In this paper, the idea is carried further and asserts that an enriched studio environment is part of a constellation of interventions that are indispensable to art therapy.

The Studio as the "Third Hand"

The studio which facilitates artistic expression in clients may be considered a nonverbally-based therapeutic intervention which has been described by Kramer as a metaphorical "Third Hand" (1986). In practice, the Third Hand may take the form of offering the right size brush to paint delicate facial features, not solely for aesthetic purposes (though these are considered), but mainly to address therapeutic concerns, that is, to maintain better control, minimize unintended distortions, reduce frustration, and evoke subtle facial expressions that reflect different affective states. It may entail performing rescue actions to preserve a clay sculpture, whose impending collapse may be considered a countertherapeutic metaphor for the patient's life situation (though not all artistic failures are countertherapeutic and in need of rescue).

Kramer asserts that such support must be forthcoming in ways that are not overly intrusive—do not distort the client's intentions or impose creative ideas that are inaccessible. By intervening through media and technique, client issues can be broached without confrontation through solely verbal means. The art material functions as a buffering agent, which respects repressed material and its delicate defenses while effectively accessing unconscious or preconscious material pertinent to therapeutic work. And, although Kramer does not identify the environment as a major intervention per se, I am suggesting that the studio space satisfies her criteria as a Third Hand resource that constitutes the very vehicle which sets the stage for further intervention and therapeutic change.

The studio constitutes the initial and perhaps most impressionable experience of the art therapy process. How the space is set up communicates much about the art activity to follow. It conveys to clients, colleagues, administrators, and others something about the values that the art therapist promises to bring to the process. Quality art materials, stimulating visual aides, adequate work spaces, flat files for storage, and tackable surfaces for exhibition all communicate that the client's artistic efforts will be taken seriously. With such basics provided, the stage is set for developing the client's identification with the art process which includes robust playful exploration of media as well as more sophisticated attempts involving thematic and stylistic risktaking. In creating a rich, pro-art ambience, the transition from the everyday and concrete to the sensual, metaphysical abstract is facilitated (Dissanayake, 1989) (Figure 2).

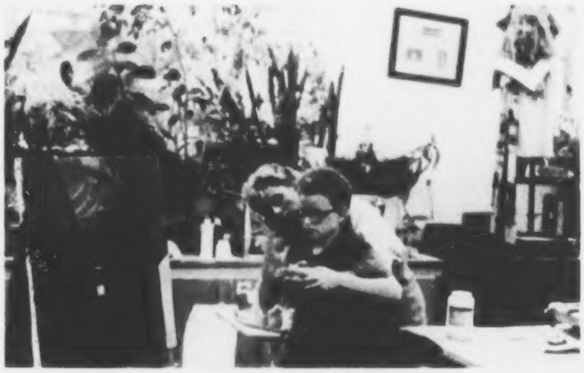


Figure 2. The art therapist cultivates a "pro-art" environment by acting as a role model and supplier of studio props, visual, and other stimulating objects.

For many artists, entering the studio signals an end to preconceptions and judgments over moral, social, or cultural protocols. Self-expression can assume wildly eccentric form, accommodating the artist's idiosyncrasies and pathologies while encouraging a productive work ethic. As a container of potentially overpowering affects, the studio provides the kind of "holding" that Mahler found necessary to facilitate the kind of exploratory behavior described in the opening vignette. With his secure home base, extreme approach-avoidance reactions, which so debilitated the feral boy's capacity to function, eventually gave way to more autonomous, individuated behaviors. As this client expanded his frame of reference (Lowenfeld, 1982) toward more flexible, expansive interactions with his environment, these adaptations became slowly generalized into his everyday environment, as well. Again it was the studio space more than his alliance with the art therapist that assumed the role as the "needs provider."

The Role of the Art Therapist as Environmental Intervention

A critical component of the therapeutic environment involves the way in which the art therapist adapts the space to suit the needs of the client. One such adaptation involves managing stimulation levels to facilitate motivation and in-depth imaginative responses during the art process. Elsewhere, I have explored the critical balance between enriched stimulation levels and those that are a "blank slate" or minimally stimulating (Henley, 1994). For this feral child, this balance oscillated between the need for sheltered space and tantalizing stimuli which lured him beyond his autistic orbit. For many client populations, this dynamic balance is crucial, requiring that the art therapist modulate stimuli as a finely tuned intervention.

Though one cannot generalize, those with attention deficits, sensory impairments, or emotional handicaps might require more subdued or protected settings while those who are environmentally impoverished or suffer from depression may benefit from higher stimulation levels. Hence, the introduction of art room props, visuals, music, light, or other sensory stimuli, can be adjusted according to client need.

The art therapist's very presence constitutes another form of nonverbal, environmental intervention, particularly if he/she actively participates in the artmaking. Creating art alongside the client can further the studio ambience, creating a sense of artistic community, recognizing that a parity exists between every studio member as each person struggles with his or her own creative process. By working in the presence of clients, the art therapist models important artmaking behaviors which clients can begin to identify with and incorporate. Haeseler (1989) points out that such modeling demonstrates how strong affects can be evoked without becoming overwhelmed.

However, it is critical to this concept that the art therapist be acutely aware of how his or her own work impacts the ecology of the studio (Haeseler, 1989). The art therapist must monitor the projection of his or her own unresolved conflicts or other facets of work, which might require repressing disturbing form, content, or style that ordinarily might be taken for granted. Otherwise, the artwork may constitute a countertherapeutic presence which might confuse, disturb, or depress a client who cannot access or use such art expression.

Instead, the art therapist must adopt a benign presence, one that approximates Mahler's ideal of the mother during the separation and rapprochement phases of development. Such benign, yet supportive, presence allows for exploration including those frustrations that naturally accompany the art process. When motivation lags or tolerance for frustration weakens, the art therapist's continued modeling of artistic problem solving may act as Mahler's "refueling" mother who validates, empathizes, and mirrors back to the client an attuned, supportive presence.

Some writers have identified the "art therapist as artist" model as an alternative to traditional clinical models. One such discussion by Pat Allen (1992) views the artist-in-residence model as a means of taking art therapy beyond the institution, into more normative community settings. She describes her involvement with two art therapy students whose internships involved painting in an open-studio environment along with clients who suffered a range of emotional problems (1992). The student artworks which are depicted in Allen's article include an abstract pregnant nude and a nonobjective, expressionistic design, reflecting both interns' sophisticated styles as well as content that could be construed as being issue-laden. It is apparent in one intern's thesis that they worked as most artists do, with a quiet self-absorption and preoccupation that precludes involvement with others. Their markedly art-school styles are probably quite out of reach of the naive capabilities of their clients and thus remain inaccessible to emulate.

It is questionable whether the two interns maintained a conflict-free presence in the environment that would be required if they intended a Third Hand intervention. Given the high-powered, provocative quality of the art, the effort may have proved unsettling or intimidating to others in the group, perhaps diminishing the motivational or therapeutic effectiveness of the atmosphere.

While the artist-in-residence is potentially a useful and needed addition to an inclusive community-based approach to artmaking which may indeed possess therapeutic qualities, this seems quite distinct from art therapy, where each action or nonaction must be supported by a therapeutic assessment which validates the use of interventions.

Conclusions

As a field, it is clear that art therapy is increasingly expected to survive in sterile or impoverished environments. Here I echo Allen's assertion that the art therapist must take a pro-active stance to requisition the proper resources that are conducive to artmaking. This can only occur through energetic means such as inservicing, exhibiting, and politicking in ways that educate mental health professions about the proper conditions that are necessary to ply our craft.

The art therapist too must take the initiative and muster the ingenuity and resourcefulness that transforms a less than perfect space into one that is "pro-art." This may include recycling furniture, scavenging art materials, decorating with props and art world visuals, anything that communicates to the administration that, in addition to our expert clinical and educational skills, we are resourceful scavengers by nature. We are able to create much from very little, and yet, there are basic needs indispensible to our craft that are nonnegotiable.

Such a lesson was driven home in the case of our feral-child who had languished in a state institution because a residential school considered its facility ill-equipped to handle his wildness. Eventually, the school consented to a trial placement, at which time the facility was adapted to meet his unique emotional needs. Upon being visited in his newly arranged "play pen," as the director of support services termed it, all were impressed by this child's adaptation to the space. This was evidenced by an eventual decrease in aggressive reactions and noxious habits. With systematic desensitization, judicious sensory stimulation, and a self-directed pace, this child drew from his environment the nurturance to heal. Eventually he moved on to a community group home where, I suspect, references to his earlier spaces persist both in memory and in his extraordinary art.

References

Allen, P. (1992). Artist in residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association*, 9(1), 22–29.

Candland, K. C. (1993). *Feral children and clever animals*. New York & Oxford: Oxford University Press.

Dissanayake, E. (1989). *What is art for?* Seattle, WA & London: University of Washington Press.

Henley, D. (1989). Artistic giftedness in the multiply handicapped. In H. Wadeson (Ed.) *Advances in art therapy*. New York: John Wiley.

Henley, D. (1992). Exceptional children, exceptional art. Worchester, MA: Davis Publications.

Henley, D. (1994). Transcultural responses to aesthetic and therapeutic experience: An ethical approach. *Art Therapy: Journal of the American Art Therapy Association, 11*(3), 194–199.

Haeseler, M. (1989). Should art therapists create alongside their clients? *American Journal of Art Therapy, 27*(3), 70–86.

Kramer, E. (1986). The art therapist's third hand: Reflections on art, art therapy, and society at large. *American Journal of Art Therapy, 24*(3), 71–86.

Mahler, M., Pine, F., & Bergman, A. (1975). *Psychological birth of the human infant*. New York: Basic Books.

Michael, J. A. (Ed.). (1982). *The Lowenfeld lectures*. University Park, PA: Pennsylvania State University Press.

Winnicott, D. W. (1965). *The maturational process and the facilitating environment*. New York: International Universities Press.

The Base and The Mark: A Primary Dialogue in Artmaking Behavior

Lenore Steinhardt, MA, A.T.R., Ramat HaSharon, Israel

My approach to art therapy is composed of beliefs and principles which I acquired through involvement in the fields of painting, art history, and art therapy. I began as a painter and student of art history and art theory. As a painter, I never asked myself the question, "Where does art come from?" When I became an art teacher, this question became important in helping others contact their personal sources of creativity and experience making art with ease and pleasure and out of an inner need.

The artistic theoretical base proposed by Wassily Kandinsky in his book *Concerning the Spiritual in Art* (1911), provided a good framework for teaching artmaking behavior without specifically teaching art. Kandinsky advocated making art which embodied an expression of the artist's inner spirit and need, rather than reproducing external nature. He drew connections among color, form, movement, sound, the senses, and emotions. Thus, one might paint an abstract image of one's family by expressing in color, form, size, and placement one's intuitive perceptions of each person. This image might be emotionally accurate and achievable, avoiding frustration and disappointment caused by failure to make a visually accurate portrayal.

Later on, as an art therapist, I emphasized the value of spontaneity, play, and fun, and simple curiosity as necessary attitudes if we are to enable art to become a bridge between inner and outer worlds, to allow our images to emerge truthfully. Object Relations theory and D. W. Winnicott, in particular, provided the theoretical base for understanding the need to be creative, to create transitional objects in order to overcome the loss of the original object.

But, in addition to our need to create transitional objects, we also begin our first graphic dialogue with the environment by making marks on the surface of things: on food, dust, vapor, earth, sand, using parts of our body. Creativity alone cannot explain this need. Children make marks, urinate on earth, move objects, and gradually realize their motor movement has made the calligraphy, the mark, which is proof of their existence. Later, when motor control is more developed, we leave permanent marks on trees, benches, stone, and walls, as we scratch our names or our symbols on them with chalk, sticks, stones, and knives. And, we learn to write. Jan Dubowski, an English art therapist, describes the development of mark-making activity in children (1984). Early mark-making is spontaneous and develops in play. Eventually, the child learns to control marks and make comprehensible images which others can understand. The graphic image becomes a nonverbal communication with others.

What is this need to make a mark, to leave a visual image? Many things exist in our lives, but we are not interested in drawing everything. Choosing to draw something specific makes the chosen image special, and we choose to draw what to us is especially interesting.

Ellen Dissanayake, a contemporary art historian, has written about this human need to "make special." In her books, *What Is Art For?* (1988), and *Homo Aestheticus: Where Art Comes From and Why* (1992), she proposes that art must be viewed as an inherent universal or biological trait of the human species, as normal and natural as language, sex, sociability, aggression, or any other characteristics of human nature. She sees art as a behavior that developed in humans as they evolved in order to help them survive. Art has always existed in all of human history, in every human society. It is a psychological or emotional need and has psychological or emotional effects.

In making our art-marks, we invest thought, time, and effort in "making special" the chosen subject. One invests in "making special" in order to differentiate this image from the ordinary. In much the same way, so-called primitive people decorate and prepare themselves for rituals, thus making them special and quite separate from ordinary daily activity. Rituals are special events shared by a group, connecting them in a common meaningful experience (Dissanayake, 1992).

The special image created in art therapy in the presence of a therapist, or therapy group, brings special things to the surface so they can be shared and understood, controlled and resolved. Schavarien (1992) writes about the picture as a scapegoat or talisman. The picture may become our scapegoat onto which we cast all our unwanted parts and drive the picture away. Or, the picture can become a talisman which holds for us our luck. We "make the picture special" so it can serve us therapeutically.

Winnicott (1971) says it is essential for the developing child to spend time playing in order to get in touch with his own life source. Through play he creates his own goals and satisfies his curiosity. The child who cannot play loses contact with the self and is left with a feeling of emptiness, a feeling of not being. The experience of free play builds and strengthens the ego. A sense of differentiation begins with the child learning to know what is his own and what is external. Thus, in this process of ego building, choosing a goal in free play makes the goal special, appropriate, and essential for that moment.

I believe that patients and students of art therapy must experience being in the magic space where transitional objects and creativity meet, where movement and control and mark-making and goals are played with together, enabling us to return to essential processes of self-discovery which may have been damaged by social or environmental influences.

We first make marks out of curiosity and validate our existence. With increasing skill, we control our artmaking. But let us go back to our first "environmental art," marks made in sand, vapor, snow, dust. Do not we still do it? Do we not see a dirty window and write our name, leaving the mark to be discovered by someone unknown? Can we include food, earth, sand, and objects as art therapy starting points leading to clay and paint?

My studio includes a sandplay area where patients use sand and miniatures when it suits their needs to build a picture in an immediate spontaneous way (Kalff, 1980; Weinrib, 1983; Ammann, 1991). This relates to early experiences of sand, earth, and water, and to using objects to construct images. Art materials include gouache, oil pastels, chalk pastels, clay, plastilene, and various sizes of paper. The patient may work on a large table, on an easel, or on the floor.

But, there is an additional aspect to making marks. Making marks connects two things: a surface, or base, on which to make the mark, and the mark itself. This relationship between a surface and marks made on it is a metaphor, a metaphor for ourselves, as a surface, or base upon which life has left marks. Parents, relatives, friends, teachers, society, and the environment have made marks on us of different forms, sizes, and colors. Some marks are pleasant, valued, used for good growth and flow. Some marks are painful and continue to hurt.

Art, as a surface with marks, is the mirror we make of our experiences. Very often, in therapy, our patients use us in subtle ways, as a base to make their marks. They do to us what has been done to them and make us feel as they feel. This is what we do to our art: We make the image feel as we feel.

I replicate this process of life through art. I am the base, I am the sand, the dust, the stone, or the paper, and I make marks as they were made on me. But, then, with more understanding and more control, I begin to make the marks on myself that I want, that I choose, that can change my future.

In my studio, I work with children, adults, couples, and families. Patients may be referred after years of verbal therapy. Sometimes a family is in family therapy while I work with the child. When the art process is dominant, my verbal interventions may be directed only towards the art. If the patient wishes to talk, I may then give verbal interventions.

On a small bulletin board are photos of nature taken on trips to distant places and art postcards from the best museums. On the wall hang two small landscapes that I painted long ago. No patient work is hung. Perhaps I choose pictures which interest me as a quiet way of making my mark on the space without my actually making art during the session.

Editor's Note: A modified version of this paper was given at the Art Therapists Panel, ICET Conference, Haifa, Israel, May 1994.

References

Ammann, R. (1991). *Healing and transformation in sandplay: Creative processes become visible.* La Salle, IL: Open Court.

Dissanayake, E. (1988). *What is art for?* Seattle, WA: University of Washington Press.

Dissanayake, E. (1992a). *Homo aestheticus: Where art comes from and why.* New York: Basic Books.

Dissanayake, E. (1992b). Art for life's sake. *Art Therapy: Journal of the American Art Therapy Association,* 9(4), 169–175.

Dubowski, J. (1984). Alternative models for describing the development of children's graphic work: Some implications for art therapy. In T. Dalley (Ed.), *Art as therapy* (pp. 45–61). London: Tavistock.

Kalff, D. (1980). *Sandplay.* Boston, MA: Sigo.

Kandinsky, W. (1977). *Concerning the spiritual in art.* New York: Dover.

Schavarien, J. (1992). *The revealing image.* London: Routledge.

Weinrib, E. (1983). *Images of the self.* Boston, MA: Sigo.

Winnicott, D. W. (1971). *Playing and reality.* London: Penguin.

INTERNATIONAL CONFERENCE ON STRESS AND HEALTH

The International Stress Management Association will conduct ISMA-6 on October 5-8, 1996 in Sydney, Australia, in cooperation with several other organizations. For information contact:

F. J. McGuigan, Ph.D.
Institute for Stress Management
10455 Pomerado Road
San Diego, CA 92131
(619)635-4698
Fax (619)635-4669
Internet: NOSTRESS@sanac.USIU.edu.

The Reenchantment of Art Therapy

Jim Young, Santa Fe, NM

The first 25 years of the American Art Therapy Association (1969–1994) have been nothing if not exciting. The journal of the American Art Therapy Association (Volume 11, 1994) visited with some of the Association's influential members to glean their retrospectives and their visions of the next quarter century. Their responses reflect the turmoil and excitement of the past as well as the hopes, doubts, and uncertainties of the future.

Janie Rhyne (1994) acknowledges that the ever-increasing diversity of the Association's members could well signal its breakup. Rhyne, at the age of 81, said that we would do well to let go of the past and focus on the era we work in today.

Bob Ault (1994), the AATA's first president-elect and second president, recalls the common vision that united art therapy's founders: "Absolute belief in the value of the importance of using art making and imagery in the treatment of patients" (p. 252). Ault's admonition is that we not lose our understanding of and faith in the art process. We have tended to "psychologize" the art therapy process, Ault claims, in our attempts to make art therapy legitimate while conforming to the demands of higher education. His dream of art therapy's future is that it will find its place in health promotion, thereby serving the general population with new adaptations. The future will find us returning to the "widespread use of the oldest civilizing agent of all, the arts" (p. 253).

Judith Rubin (1994) claims that art therapy will grow in new directions in the next 25 years, with schools in particular. Rubin also sees more collaboration with other expressive modalities. She foresees that art therapy will become less "suspicious or stingy with others" (p. 254), cooperating instead of competing while avoiding the "twin traps of restrictiveness and rigidity" (p. 254). Rubin's most urgent plea is to allow art therapy to enliven us spiritually. To that end she sees "therapeutic art activities" being made available in malls, libraries, churches, and community centers. "We can and should contribute to healing the soul of the community" (p. 254).

Debbie Good (1994), like Ault and Rubin, calls for art therapists to remember that art itself is the wellspring of art therapy's power. When we lose sight of the art, we become "a disconnected community that lives in its head" (p. 257). Good counsels that "intellectualizing our way through life" isn't working anymore and that by "living our lives through our passion we can bring compassion to others" (p. 257).

Cathy Malchiodi (1994) berates art therapists who give lip service to the word "art" while negating the importance of studio art experiences. She points out that art therapists frequently claim, "I just don't have time to make art" or "My creativity is reflected in how I do therapy" (p. 258). Malchiodi laments that "we seem to have come to the convenient conclusion that quick sketches of feelings and badly cut and pasted magazine pictures can approximate art, and that art making is a 50-minute process without much depth" (p. 258). The neglect of our own art as art therapists, she says, is damaging to the profession itself. "Let go of the past," she says, and honor the efforts of the new generation of art therapists who are "blazing new trails and still defining the field of art therapy" (p. 259).

Where Does Art Therapy *Really* Come From?

Before looking into the future of art therapy, it is appropriate to examine the authentic roots of art as a healing force. Joseph Campbell (1988) wrote: "The artist is the one who communicates myth for today" (p. 99). The artist's problem, according to Campbell, is making the inner and outer worlds of today meet.

Ellen Dissanayake (1992) says that art is "species-centric" and therefore a common need for humans. She calls mankind "homo aestheticus" because of our need to "make special" our tools, rituals, and even our play (p. 223).

The arts have been a community-based phenomenon for all but the recent two to four centuries of human existence. Dissanayake (1992) points out that we have recently become consumers of art and no longer participants: "We may forget that formalizations inherent in ritual ceremonies have provided important occasions during which humans throughout their history have experienced the arts, which themselves were emotionally saturated integral reinforcers of important communal beliefs and truths" (p. 139).

Not all the world has lost the significance of art as a community affair. In Bali today (Charle, 1991) the arts are not practiced in a void: "If Bali were a museum, its temples would be dead, its dancers sitting on the sidelines, its musicians silent and its gods forgotten" (p. 11). The Balinese, while embracing modern technology and ways, have not abandoned the arts but have embraced them. The Balinese have no word for art and yet almost all Balinese are artists. Art is worship of life, and life is the realization of a divine order.

In American history, the Shakers believed that God dwelt in the details of their handwork. All work aimed at perfection (Burns, 1987), which prompted Thomas Jefferson, in 1808, to say of them: "If their principles are maintained and sustained by a practical life, it is destined eventually to overthrow all religions" (p. 15).

In Hasidism (Braman, 1994), often compared with Zen Buddhism, there is the notion that the intention or "kavanah" of an artist working with his or her materials could release "God's emanations cast within the material world" (p. 2). The result of such release is a form of uplifting or healing known to all artists.

The intention of the artist is key. Rose Naranjo (Trimble, 1987), a Santa Clara potter, says that a potter with "good intention" can become "one with the clay," and then the pot becomes a shared vision of its own and the potter's spirit (p. 13). The Native American approach to art is similar to that of the Balinese. Art welds and defines the community. While art is sold, it is also used for teaching. Hopi kachina dolls carry religious teachings, especially for the young, and kachina dances are prayers as well as social occasions. Feasts unite communities and bring friends from great distances (Colton, 1949).

Modern psychology corroborates art's spiritual nature with its own languaging of the therapeutic benefits. Csikszentmihalyi (1990) says that the normal state of the mind is chaos and that we create order in relating to life. An artist relates to his or her subject and materials for meaning, and the creative encounter brings about liberation. The creative encounter (May, 1975) is a new event, each time requiring courage. The artist, unlike the psychotics studied by Podvoll (1990), has the ego strength to enter altered states and return safely with inspiration and rejuvenation.

Maslow (1968) was an early proponent of the use of art for self-actualization. He pioneered an existential approach to psychology. Using art as a means to quest for one's identity relies on a phenomenological approach to research in which subjective experience is honored as a foundation for abstract knowledge. The "normal," Maslow claimed, is also worthy of study as a "psychopathology of the average, so undramatic and so widely spread that we don't even notice it ordinarily" (p. 16). He saw existentialism as another branch of psychology, the study of the Self and its ways of being. To Maslow, psychology should consider the full range of human experience from trauma and tragedy through joy and peak experiences.

Maslow (1968), McNiff (1992), and Braman (1994) advocate, respectively, "caring for the object" (p. 75), such as an art piece, with sustained attention as a means of gaining "intra-object richness" (p. 77), "soul-making" (p. 66), or "releasing divine emanations" (p. 2). The "caring minuteness" of the artist, said Maslow, brings about a "many-sided awareness" (1968, p. 76). Thus the artist, the subject, and the materials blend to produce a unique relevance of objects to human concerns that is self-validating and valuable. Even to attempt to justify such experiences, Maslow claimed, takes away value and worth.

In recent heuristic research into the experience of freedom during immersion in a creative process (what Maslow calls "peak experience"), it was acknowledged that freedom as a felt sense could be achieved only by letting go of mental controls (Young, 1995). Maslow noted that self-actualizing people were less controlled and less inhibited and, therefore, less prone to block peak experiences with self-criticism. Carl Rogers (1961) noted that one's ability to access his or her deeper creativity enabled him or her to become fully functioning.

Precisely because peak experiences and freedom as a felt sense are transcendent in nature and personal, they are difficult to quantify and value. The art therapist who assists processes that bring about optimal health must rely on subjective descriptions such as positive feelings, improved outlook on life, renewed optimism, and revitalized creativity as proof of therapeutic results.

The Reenchantment of Art

Suzi Gablik (1991) writes that the

> idea of self-directed professionalism [in the arts] has conditioned, if not totally determined, our way of thinking about art, to the point where we have become incredibly addicted to certain kinds of experience at the expense of others, such as community or ritual. (p. 2)

Today's art, Gablik claims, lacks a cosmic or transpersonal dimension. Modernism has failed us, and we are now becoming aware that things must change: "My sense is that what we will be seeing over the next few decades is art that is social and purposeful" (p. 4). By remaining aloof, art is dying:

> There is a need for new forms [of art] emphasizing our essential interconnectedness—evoking the feeling of belonging to a larger whole—exalted individualism, for example, is hardly a creative response to the needs of the planet at this time—an ecological perspective that connects art to the web of relationships in which it exists [is necessary]. (pp. 5–6)

Morris Berman (1981) urges the recovery of our bodies, our health, our sexuality, our natural environment, our archaic traditions, our unconscious mind, our rootedness in the land, our sense of community, and our connectedness to one another. Berman claims that "participation consciousness" (p. 2), as in the arts, has all but died in the last 400 years with the advent of scientism. The failure of the Cartesian era, he says, should be greeted with excitement as we attempt to build the community of the future in which there is union of heart and head. Berman cites Bali as an example of an "optimizing system" that celebrates art and mystery while flexing with change and modernism.

William Cleveland (1992) claims that we have separated art from action in the work-a-day world. The contemporary art scene appears without direction and without the power to affect our lives. The true task of the artist, Cleveland writes, is "to discover her or his relationship to a community, a community in desperate need of the artist's power to see the world anew" (p. xvi). Cleveland's book, *Art in Other Places*, is about artists who bring "light and hope and the joy of creation to these communities (elderly, prisons, people with disabilities, people with mental illness, hospitals, youth at risk), and they are themselves remade in the process" (p. xvi). Art is created, according to Cleveland, where people come together. Whereas storytelling by the fire or reciting poetry in a pub may have served community art needs of the past, our future communities, with transient life-styles and complex technologies, will need to be creative in the formation and support of community arts programs.

The Reenchantment of Art Therapy

Art therapy today is facing its own "postmodernism." Having grown up over 25 years in the shadow of the medical model, art therapy is struggling to accommodate change and to fulfill its role in society. Art therapy's leaders and founders have thrown down the gauntlet; the challenge has been offered to future generations of art therapists to meet the needs of the community while maintaining faith in the healing power of art.

The medical model, which has largely influenced the brief history of clinical art therapy, serves mainly the pathological needs of the mental health system. It does not yet serve general health maintenance, and it deals mainly with "identified patients" and their family systems. There is a huge population that has mental health needs yet are not "sick" enough to have diagnostic labels. There are also increasing numbers of people interested in self-actualization (Maslow, 1968) and optimal health (Csikszentmihalyi, 1990).

Ault (1989) advocates for the expansion of art therapy to meet the needs of the community at large. Ault runs an art school in Topeka, Kansas. He observes that 25% of art class participants come seeking mental health services in the guise of art classes. "These are not individuals who have been identified as patients or as suffering from mental illness, nor are they the sort of people who generally seek mental health care services from a therapist," Ault says. "They did not identify themselves as patients, yet they exhibited levels of personality and relationship dysfunction that often interfered with or inhibited their lives" (*Ibid*., p. 223).

Ault calls these people "unidentified patients." They come seeking help, though this is unacknowledged, and often experience real changes in their lives without any talk of therapy. Ault found that these people could be served by encouraging "minor changes of attitude and process," maximizing thereby the "therapeutic aspects of the art experience" (*Ibid*.). Acknowledging that while remaining in a generally acceptable norm, "we all range up and down in our daily lives on a scale of healthy to pathological" (*Ibid*., p. 224), Ault poses the question: "What happens to those who are moderately ill or have compensated somehow to cover, deny, or minimize these unresolved conflicted forces within their lives?" (*Ibid*.). He refers to this population as "the great American wasteland" (*Ibid*.).

The parallel between art and art therapy begs attention. Art's original purpose was to serve community healing needs. Later, art, under modernism, served only a small segment of the population. Now there is a movement toward the rebirth of folk art. Art visionaries today (Dissanayake, 1992; Cleveland, 1992; Gablik, 1991) are calling for art to be restored to art for *life's* sake, not art for art's sake. Fox (1988) calls for a general revival of personal arts as necessary for spiritual rebirth and the remaking of a "living cosmology" for today (p. 179).

In art therapy, Ault states, we now need to leave the limited domain of clinical treatment and begin mainstreaming the clinical-based processes into the normal population. This will lead, he predicts, to the further acceptance and understanding of the therapeutic dimension of art on all levels of society. Ault sees this movement taking place as art itself moves out of the commercial vise that is contributing to its removal from the general population.

May (1975) poses an interesting question: "What if imagination and art are not the frosting at all, but the fountainhead of human experience?" (p. 124). McNiff (1992) sees art as the ultimate medicine and calls for the expansion of art as a healing force in the community, "beyond the narrow perspectives of scientism" (p. 43). He claims that it is "art's desire to connect psyche, the dream, the suffering soul, and the daily lives of people" (*Ibid*., p. 53). To do this, art must fully enter the life of the community.

Art Therapy: A Vision of the Future

Art therapists of the future will play a major role in bringing art back to the communities as a healing force. "Therapeutic studios" will become the dominant form of private practice, in which artists will share their art in a therapeutic way with young people, elderly, handicapped, and "normal" people who wish to experience greater harmony between their conscious and unconscious lives. Art therapists will be honored as healers. No longer practicing art mainly in institutional settings, these special artists will contribute to the soul of the community, enhancing life for all who interact with them.

As budgets are cut for school art programs, due to the high cost of administering large scale education, the arts needs of young people will be identified and "made special" by art therapists. It will be generally acknowledged that a dramatically improved mental health picture in the nation has been created by the expansion of art therapy, in its many new applications, helping people return to personal intimacy and making better life decisions.

Art therapy will be called by many names: integrative art, community art, life art, transitional art, educational art, rehabilitative art, and others. The term "therapy" will be unnecessary as the therapeutic uses of art will be assumed and understood by all. No longer will there be therapist/client or therapist/patient hierarchial relationships. Art therapists will be facilitators as well as full participants in community art therapy applications.

Sociologists and historians, sensing the shift in society's values due to the open and widespread practice of therapeutic arts, will be writing about this new paradigm shift. Freedom as a felt sense will be experienced by masses of people, leading to greater understanding of our spiritual nature. Following such experiences, through immersion in creative processes, people will invest more time and energy in their own education toward self-actualization. Jobs and careers will give way to life styles. People will curb their wants and realize true needs. Leisure time will increase, and community will flourish as a result of each person's desire for service and sharing of precious new values.

Art therapy's 50th anniversary celebration (held in Santa Fe, capital of the nation's indigenous arts) will be simulcast to schools, libraries, and community organizations across the country. Gone will be the former days of art therapists' search for identity and resulting arguments about the form and content of art therapy. AATA's speakers will be warmly received as representatives of the rebirth of the healing power of art through its hundreds of new therapeutic forms.

References

Ault, R. E. (1989). *Art therapy with the unidentified patient*. New York: John Wiley & Sons.

Ault, R. E. (1994). In search of the wisdom of a vision. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 251–253.

Braman, S. (1994). *A unified theory of craft*. Goffstown, NH: Studio Potter.

Berman, M. (1981). *The reenchantment of the world*. New York: Bantam Books.

Burns, A, & Burns, K. (1987). *The Shakers*. New York: Aperture.

Campbell, J. (1988). *The power of myth*. New York: Doubleday.

Charle, S. (1991). *Bali, island of grace*. Chicago: Passport.

Cleveland, W. (1992). *Art in other places*. Westport, CT: Praeger.

Colton, H. S. (1949). *Hopi kachina dolls*. Albuquerque, NM: University of New Mexico Press.

BEST COPY AVAILABLE

Csikszentmihalyi, M. (1990). *Flow.* New York: Harper & Row.

Dissanayake, E. (1992). *Homo aestheticus.* New York: Free Press.

Fox, M. (1988). *The coming of the cosmic Christ.* New York: Harper & Row.

Gablik, S. (1991). *The reenchantment of art.* New York: Thames and Hudson.

Good, D. A. (1994). Art therapy and changing times. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 256–257.

Koestler, A. (1964). *The act of creation.* New York: Dell.

Malchiodi, C. A. (1994). Looking ahead. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 257–259.

Maslow, A. (1968). *Toward a psychology of being.* New York: D. Van Nostrand.

May, R. (1975). *The courage to create.* New York: W. W. Norton.

McNiff, S. (1992). *Art as medicine.* Boston: Shambala.

Podvoll, E. M. (1990). *The seduction of madness.* New York: Harper Collins.

Rhyne, J. (1994). The future of art therapy: In what context? *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 250–251.

Rogers, C. (1961). *On becoming a person.* New York: Houghton Mifflin.

Rubin, J. A. (1994). My wishful vision of art therapy in the next 25 years. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 253–254.

Trimble, S. A. (1987). *Talking with clay.* Santa Fe, NM: School of American Research.

Young, J. (1995). *The experience of freedom during immersion in a creative process.* Unpublished manuscript.

Nasco...
Your Palette to
Creativity!

- *SERVICE*
- *QUALITY*
- *SELECTION*

The NASCO Arts & Crafts catalog has everything you need in one source to inspire creativity. For your FREE Arts & Crafts Catalog, write Dept. EAE510 or call toll free.

Free Phone Order Service: 1-800-558-9595
FAX: 1-414-563-8296

Nasco
P.O. Box 901, Fort Atkinson, WI 53538-0901
P.O. Box 3837, Modesto, CA 95352-3837

Reviews

Magazine Photo Collage: A Multicultural Assessment and Treatment Technique

by **Helen Landgarten, MA, A.T.R., HLM**, New York: Brunner/Mazel, Inc., 1993.

224 pp., 96 black & white illus. $29.95, cloth. ISBN 0-87630-706-3.

Reviewed by **Nadia Ferrara, MA, A.T.R.**, Montreal, Quebec, Canada

Art therapy textbooks on assessment are rare and greatly in demand. Helen Landgarten's *Magazine Photo Collage: A Multicultural Assessment and Treatment Technique*, a textbook for students and art therapists, brings evaluation to the foreground and describes how to use a Magazine Photo Collage (MPC) procedure for this purpose. At the same time, it is multiculturally sensitive in its demonstration of uses for the MPC with various populations.

Landgarten recognizes that we live and work in a mosaic society filled with diverse cultures. She presents a nonculturally biased tool, the MPC, and shows how it can be effectively applied to various ethnic and cultural groups, including Asians, African-Americans, and Hispanics. Her method uses pre-cut images from carefully selected, culturally appropriate magazines. These are separated into two boxes and offered to clients. The first box contains pictures of a variety of people from various cultures, and highlights differences in age, sex, and economic condition. The second box offers "miscellaneous items" from a range of photographs that focus on themes related to chemical dependency, physical and/or sexual abuse, eating disorders, and other relevant issues. As a resource for collecting pictures, Landgarten provides a list of "culturally slanted" magazine publications useful for their particular ethnic imagery.

The MPC is a nonstandardized, projective tool. It is described as beneficial for assessment and treatment stages in therapy because "clients can identify with the images and voice their projections onto their self-selected pictures" (p. 1).

In the assessment phase, collage focus is on the manifest content, specifying that the therapist select pictures that reflect the client's ethnicity. Thereafter, in the treatment phase, the clinician may use the MPC to make an intervention or to offer an interpretation, taking into consideration its latent content and, as emphasized by Landgarten, its unique metaphoric language. The clinician gathers the client's free associations in order to understand the symbolism in the collage.

The MPC assessment technique includes four tasks that use the two boxes of magazine pictures. Tasks are presented to the client using specific instructions. In the first task the client selects pictures from the miscellaneous box and writes his or her thoughts about each image. The task is openended and the miscellaneous box of pictures is used because of its nonthreatening nature. No limits are placed on the number of pictures selected. Landgarten carefully outlines what to look for in assessing art-related behaviors (eg., how are the photographs handled, glued, etc.).

In the second task, the client is asked to choose pictures of people and, on a separate paper, writes what the people are thinking and saying. This task "reveals clients' perception about trust, regarding either themselves, someone in their life, or possibly the therapist" (p. 10).

During the third task, either box is used to select pictures that represent something "good" and something "bad." Choices may give clues about the client's idea of positive and negative images.

The fourth task involves choosing one picture from the "people" box, writing what is happening to the person, and how the situation could change. This task may highlight the client's attitude, coping mechanisms, and problem-solving skills.

All four tasks are illustrated with case vignettes that show how to use the MPC during assessment and treatment phases of therapy. In the treatment phase, the MPC can be introduced at any time for any treatment goal. Some MPC objectives are designed to manage cultural differences between client and therapist and encourage development of cultural self-identification and self-awareness.

Certain art behaviors may indicate a client's strengths and problem areas. The manner in which images are looked at, handled, and placed on paper are important to observe. It is also important to observe how the MPC is created, whether in an extremely cautious or regressive fashion. According to Landgarten, "The photos in the MPC are projections of the client's self, symbolic of significant persons in their life, and/or a transference statement" (p. 20). Verbal responses and free associations are also very important and may confirm or contradict the therapist's observations.

Facets of the MPC strongly resemble underlying elements of phototherapy, although there is no reference made by Landgarten to phototherapy literature. Weiser (1993) describes how interacting with personal snapshots and albums as representational objects, symbolic self-constructs, and metaphoric transitional objects can reveal deep forms of awareness. According to Weiser, "Photographs ... have the power to capture and express feelings and ideas in visual-symbolic forms, some of which are intimately personal metaphors" (p. 6).

Landgarten uses clinical vignettes to illustrate her ideas. For instance, one of the goals in a "positive life review" process with an 85-year-old Asian woman was to encourage her to become independently creative. Her collage work became a significant self-object. Both Weiser and Landgarten stress that clinicians should proceed with caution when interpreting the unconscious content of the collages as well as the photographs. The images in both can create bridges to one's inner world in ways that words often cannot fully represent.

Landgarten's inferences about process and artwork do not seem to be founded on acknowledged theoretical approaches, creating, for this writer, a sense of uncertainty and ungrounded speculation. For example, in the case illustration of an 11-year-old Hispanic boy with attention deficit disorder, no attempts are made to relate current clinical concepts about the disorder to interpretations of the artwork. This is not a recommended model for students to follow because a significant aspect ot art therapy training includes learning to base clinical inferences on the client's background, culture, unique interpretations, behavioral observations, and related theory. Linking relevant literature to research is an essential component of the interpretive process.

Collage work clearly can be evocative. The MPC facilitates self-disclosure and helps establish a relationship between overt and latent content. According to Lamy (1986), "The effect of the [collage] process is to increase the emotional involvement since the person is less concentrated on achieving aesthetically pleasing results but rather on the symbolic content ..." (p. 60).

While the MPC is a valuable therapeutic instrument, its limitations, which are important to consider, are not outlined by Landgarten. One potential disadvantage of collage artmaking is that it uses ready-made materials rather than an empty space which can be transformed. Collage work may promote dependency on the available materials and lead to avoiding development of one's creative process (Lamy, 1986). However, collage can be effectively used as a tool to guide the client towards work in drawing, painting, or clay sculpting, gradually developing dependence on one's own creative resources.

Because it is not a standardized tool, the MPC is best when introduced with other standardized assessments. It can also be used as an adjunct to diagnostic art evaluations. This is the first book focusing specifically on magazine collage, and Landgarten has made a valuable contribution to the field by adding a new dimension to art therapy and multicultural assessment. These important contributions warrant further development and research.

References

Lamy, Y. (1986). *A study of collage and assemblage as a therapeutic tool in art therapy.* Montreal, Quebec: Concordia University.

Weiser, J. (1993). *Phototherapy techniques: Exploring the secrets of personal snapshots and family albums.* San Francisco: Jossey-Bass.

Integrative Approaches to Family Art Therapy

by **Shirley Riley, MFCC, A.T.R.**, with observations by **Cathy A. Malchiodi, MA, A.T.R.**, Chicago, IL: Magnolia Street Publishers, 1994.

262 pp., 95 black & white illus., $29.95, paper.
ISBN 0-9613309-5-3

Reviewed by **Linda Sibley Seaver, MPS, A.T.R.**, Bedford Village, NY

This is the chronicle of a weaver and her tapestry of many colors. Shirley Riley achieves the promise of her title by demonstrating clearly the successful integration of art therapy with several distinct approaches to family therapy: structural, systemic, and strategic, and social constructionist/narrative. While affirming the role of both language and visual metaphor in the healing process, Riley places renewed emphasis on the narrative, the family's story of their problem. In an introduction to each section, co-author Cathy Malchiodi, offers observations that place Riley's work in context. She states that it is "[t]he integration of art making into family therapy that yields ... a clearer understanding of family dynamics, roles and rules, ways to reinvent communication and behavior patterns ..." (p. 12). Therapy with Riley, an experienced and gifted clinician, also appears to be a lot of fun.

Riley writes for an audience of professional art therapists and family therapists who are most often psychiatric social workers, but also include psychologists and psychiatrists. Malchiodi's notes in her introductions for teachers and supervisors of graduate art therapy students, offer further points of discussion.

Riley's social constructionist theoretical stance is clearly the latest in an intellectual odyssey. The family and the therapist together will dis-solve the problem by their collaborative efforts. The narrative is central and authority is shared, although the therapist retains responsibility for introducing art tasks that allow the family to illustrate their story.

To her credit, Riley has investigated and mastered the thinking and practice of the strategic, systemic, and structural theories of family therapy. Each of these represents a considerable body of literature and each requires many hours of practice in session to master. The interlacing of art therapy with each of these schools of thinking is Riley's generous contribution to the field. This mastery allows her the flexibility to apply the most useful approach, whatever the presenting problem, whatever the cultural and socioeconomic background of the family. Malchiodi early on refers the reader unfamiliar with family therapy to more comprehensive foundation books in the field. Without this knowledge, one would not fully appreciate Riley's dexterity and skillful interventions.

This book is divided into three sections. In "Family Art Therapy—Integrating Theory with Practice," Riley begins with the significance of the family's illustrations of their story, the reason they came for help. Joseph, an abused 11-year-old, told Riley the story of being forced to kneel on dried beans as a punishment. Through art, she helped the child transform this image by making paper beans, expanding, and playing with their symbolic meaning. At one point, Riley offers Joseph a handful of real dried beans to carry in his pocket as a reminder he now has the power over them and not the other way around. This case vignette shows art therapy at its best. The author investigates the creation of reality and meaning in the therapeutic process.

A basic concept of the social constructionist view is that the therapeutic session is time spent in conversation, co-constructing a new outcome to a problematic situation presented by the client(s). Therefore, "unless the concept of 'languaging,' the dialogue that arises from exploration of the art product, is attended to and understood, the desired outcome of therapy may be at risk" (p. 65). However, in addition:

> The author regards the art product as an illumination of the world view of the client(s). The art product is a visual guideline which informs the therapist in which direction to proceed and encourages new possibilities for resolution of the dilemma under discussion. Therefore, how that art product is discussed is the core of successful therapy (p. 65)

Chapters II and III are ponderous reading. Fortunately, this challenging theoretical or postmodern construct closes with a concise and lucid summary. The case material that follows is excellent with an immediacy that makes engaging reading. Black and white photographs throughout are clearly reproduced and close to the text.

In "Schizophrenia as a Solution to Family Disorders," Riley displays exquisite sensitivity helping a couple solve their marital conflict and deal with their schizophrenic daughter's role in the family. Asked to "take a vacation together" on a large sheet of white paper, the husband drew a black line down the middle. His wife responded with hurt and rage and in tears: "That's what you always do! Keep us apart!" In shock and disbelief, he denied that desire, wishing to change the black line. Riley allows the misery to fill the room before she silently reaches to touch the white oil pastel, gently hinting at a possible solution.

Message received, the husband whited over the black division and expressed his wish "to have this symbolic gesture translate into reality" (p. 75). Further discussion elaborates her integration of the structural theory in order to help this family.

In describing work with a couple concerned with a dying marriage, where the issue of age difference was the presenting problem (she was six years older and always would be), Riley effectively chooses not to be helpful and therefore swallowed up by the double bind. After empathic listening, she assigns homework for the next session: the couple must bring copies of their birth certificates with them. The art task Riley presented at the following session was a collage made of the two copies cut up and rearranged. The couple's work resulted in an attractive, jumbled collage where their separate documents were united. They

> seemed to simultaneously understand what they were destroying and what they were creating. They needed very few words to do this. The couple touched hands, chuckled a lot, encouraged each other's participation in the collage process, and smiled at their completed project. (p. 124)

By taking their presenting problem seriously and responding with an art task that defied logic, Riley frees herself and the clients to move through the impasse and begin work on further treatment issues. She states,

> The metaphoric power that lies in an art task gives the client(s) an opportunity to take charge of creating new possibilities in their problem-solving skills. What deeper level meaning this creative process speaks to in the client may never be fully understood by the therapist. (p. 125)

The case material presented in "Multi Family Group Art Therapy: Families with a Disabled Family Member" displays Riley's versatility and depth of experience. She demonstrates courage, faith, and a sense of adventure in conceiving and leading a multifamily group, "three fathers, three mothers, four boys, three girls, three co-therapists, and myself" (pp. 148-149). The group is observed by eight to ten staff people in the same room while two cameramen and two assistants record the event on video! This description alone makes one smile. Amidst the anxiety, joy, and inevitable confusion, Riley describes a clear and well-planned series of six one-and-one-half hour sessions with three families, each with a member with a disability. Every session has an interpersonal goal, an art task, and a time for processing art, observations, and feelings. She deftly interweaves the third family with the first two by the simple technique of tracing one's hand, cutting it out, and arranging it on a wall mural. The hands of the first two families surround the new members and welcome them to the group.

She increases self-observation by reconfiguring the family groups with the art task of creating an ideal world. This single session

> illuminated the human trait of preference for familiar burdens rather than seeking change and avoiding challenges created by new forms of stress. This realization instilled in families a willingness to work on their own problems, rather than being jealous of other families and what appeared on the surface to be an easier life-style. (p. 152)

Most importantly, the handicapped child, was "rapidly absorbed in this therapeutic approach, reducing differences and enabling parents and the children to focus on problems and feelings in a way that gave permission for change" (p. 157).

Last, but not insignificantly, all three families enjoyed the process of having fun together, a rare occurrence where concern about chronic disabilities can easily eliminate essential pleasure. The use of videotape, common to family therapists, but less so to art therapists, provides evidence to health care administrators, supervisors, and insurers that brief multi-family group art therapy is not only cost-effective but provides a host of therapeutic benefits.

The broad issues Riley addresses in "Family Art Therapy and Postmodern Society" provide the context within which we all work. Family therapy has always taken seriously cultural issues such as feminism, ethnicity, domestic and societal violence, and economic pressures that impinge on family organization. Malchiodi and Riley explore the application of art to families struggling with environmental and interpersonal traumata. Parentified grandparents and grandchildren use art to sustain connections. Both children and adolescents use art to express fear, panic, and anxiety following the Los Angeles riots that marked a community's response to the Rodney King decision of 1992. Photographs of their drawings should be enough to convince the most doubtful health care provider about the value of art to mediate posttraumatic stress. Proper training in child abuse reporting procedures in addition to precautions that insure the therapist's physical safety on the job are essential for professional performance.

Comfortable as a team member, Riley earlier made a psychiatric referral for a young girl in need of medication. Her ethical responsibilities to her patients are not compromised by her need for control. Riley serves us well by reminding us to attend to these topics.

Unfortunately scientific research is a weakness of both fields of family and art therapy. Riley's book offers direction for much needed data. In the introduction the authors refer the reader to Hanna Yaxa Kwiatkowska (1978) who wrote from her experience at the National Institute for Mental Health (NIMH) and offered research protocols and a format for family art evaluations. Helen Landgarten (1987), has also written extensively about family art therapy, but her greatest strength is long term treatment, allowing the reader to follow cases over time.

Managed care has brought enormous changes to the system within which all art therapists and family therapists operate. How we think, how we plan treatment goals, and how we understand the possibilities of care are all affected by the new shape of medical politics where government, insurers, and medicine vie for control. The demand for health care cost containment more than any other single issue begs for research like Riley's multifamily group art therapy.

Generous references and suggested reading listings appear at the end of every chapter. The bibliography is discriminating and useful with a breadth and depth of psychiatry, psychology, art therapy, and family therapy. A glossary of family therapy concepts would have been a useful addition for those new to the field.

Regrets about this volume are few. Originally written as separate articles for journals, such as this one, there are awkward transitions and repetition that a good book editor could have eliminated. The challenge of the concepts within the early chapters on theory is more than overcome by the scope and creativity in the clinical work. The authors chose not to include a discussion of the difficulty inherent in making the shift in thinking from an individual psychodynamically-oriented belief system to a multigenerational family belief system. Art therapy's deep roots in psychoanalysis and art education can make this transition cumbersome, but, as Riley illustrates, the work is more than worth the effort. The directed art task and the use of homework, both common to family therapy, could be seen as intrusive countertransference. Riley's art tasks flow from her understanding of the family's organization, verbal and visual pictures of the circumstances, and mutually agreed-upon goals.

Family art therapy literature is rich, yet sparse; too few of us are writing about what we do. Riley contributes by showing how art therapy applies to many family therapy approaches. Theory and application are successfully interwoven to help many patient populations with various treatment issues. Multifamily art therapy groups are effective for healing, saving time, and money. Videotapes document the creative process for research and training. Through all of this, Riley displays the compassion and wisdom of an experienced clinician who has refined her skills, intuition, and power to listen on many levels. Her tapestry will never be complete because she continues to enjoy this creative process. Offering her clients and readers a golden thread, Riley writes, "There is a lot of looking, seeing, speaking, and hearing left to be done" (p. 5).

References

Kwiatkowska, H. Y. (1978). *Family therapy and evaluation through art.* Springfield, IL: Charles C Thomas.

Landgarten, H. (1987). *Clinical art psychotherapy: A clinical guide and casebook.* New York: Brunner/Mazel.

PhotoTherapy Techniques: Exploring the Secrets of Personal Snapshots and Family Albums

by **Judy Weiser,** San Francisco, CA: Jossey-Bass, 1993.

384 pp., $39.95, cloth, U.S.A.; $52.50, cloth, Canadian. ISBN 1-555-42-552-6

Reviewed by **Julia Gentleman Byers, MA, A.T.R.,** Montreal, Quebec, Canada[1]

"Someone once told me a photo was paper with 'emotion' all over it, of course he meant emulsion, but the malapropism stayed with me (p. 4).

"A photograph, then, has the special quality of being simultaneously a realistic illusion and an illusory reality—a moment captured yet never fully captured. We use film to stop time, which cannot be stopped" (p. 4).

PhotoTherapy Techniques is a long-awaited and much needed text. The author, Judy Weiser, explores how photographs, when analyzed and understood, can reveal people's perceptions of reality. Weiser's book helps readers look at their own and their clients' "perceptive filters." Her book is written for a wide audience: those with a background in mental health psychotherapeutic approaches (including art therapy), as well as people working in special education, English as a second language, clergy, summer camp personnel, and so forth. The author also states that the text may have strong implications for those interested in fields of visual literacy, crosscultural studies, anthropologists, and sociologists, because the book's central thesis—how visual information is coded, represented, and placed in context—has meaning and applications that reach far beyond the fields of art therapy and photography. Weiser also suggests that the book may be used by the general public to enhance self-knowledge and personal growth. However, she wisely cautions against using the exercises on anyone else, other than the self-inquirer, without professional training in therapeutic models.

Weiser begins the book by describing the powers of phototherapy. She reiterates her psychological electicism in her approach to phototherapy, emphasizing that it is both "photo in therapy" and "photo as therapy." She then goes on to define five main approaches to phototherapy which include: (1) photo-projective techniques, (2) self portraits, (3) photos of the client by others, (4) photos taken or collected by the client, and (5) album and photo biographical snapshots. Within each of the chapter sections, Weiser uses anecdotes from her own practice and offers starter exercises. However, she states clearly that the book is not intended as a "how-to" guide to phototherapy but rather a study of the collaborative therapist-client approach. Weiser also states that her book does not [attempt to] provide a comprehensive literature review, but she does make references to other authors and practitioners who have inspired her in the integration of theory and action.

Weiser's ability to describe the camera as a metaphor for the human experience of perception is very creative and insightful. Words like "focal lengths," "space," "perception," and "filters" take on new meanings and tones. In this light, it is surprising that Weiser does not deal with active darkroom techniques.[2] The darkroom experience seems a potential way to explore the shadow side of the personality. The rationale for this omission may be attributed to Weiser's experience using primarily Polaroid pictures and snapshots, the lack of technical facilities, and the resistance of many people to explore the "art" of photography in [a] more in-depth way.

---

[1] From "Book Review" by Julia Gentleman Byers, 1994, *Canadian Art Therapy Association Journal, 8*(2), pp. 37–41. Copyright 1994 by the Canadian Art Therapy Association. Adapted with permission.

After clearly outlining the five principle areas, Weiser then explores more in-depth applications of each technique. In projective phototherapy techniques, emphasis is on

> both the active and passive aspects of projecting, decoding, de-constructing emotional content from stimulus images as the client is assisted in exploring his/her construction and association of meaning and feeling which they believe to be originally residing in the photographic artifact. (p. 61)

Weiser's anecdotes are clinically sound and very moving. She describes a client who noticed "a photo that really caught his eye" hanging on the therapist's wall. The photo was of a white-faced mime. (Weiser promotes photographic images which can be spontaneously chosen by clients to encourage initial projection in the early stages of therapy). This client recounted taking his son to a circus where he had to leave when a white-face[d] clown came out. It was his son's initial disappointment which caused him to explore the incident. At first he thought his reaction was merely claustrophobia. Through this "new" photo he realized that he again "felt panic and the need to flee." His first reaction in therapy was recalling his experiences of sadness and decay in Vietnam during the war. Later, as other similar associations and events occurred in real life, he regained another layer of insight. The client became able to connect powdered Halloween face makeup to powdered lime dust left on children's bodies in a village he helped eradicate as a soldier. Thus, the therapist was able to pursue continued work to resolve repression of thoughts that caused him discomfort in his current life.

Weiser also describes how a therapist can use found photos (magazines, birthday cards, etc.) to evoke responses. This approach appears similar to Landgarten's (1980) use of collage box material in art therapy. However, from Weiser's description, the client doesn't necessarily create new images. Rather, the therapist uses the images to simulate discussion or further phototherapy techniques. For instance, Weiser describes a family who came into therapy having difficulty recognizing their roles and responsibilities in the events leading up to the suicide attempt of their 16-year-old son. The therapist showed the family five photos, asked them to write down their different reactions, and then had the family members share those reactions. The exercise helped show that no one could be wrong in the absolute sense. Subsequently, the family was able to explore their feelings underneath differing perceptions. Weiser appropriately cautions that the layers of defense in each person's capacity to uncover painful material must be executed and lifted slowly. She cites the example of "Mathew" who explored one photo image over 2 1/2 years to resolve undiscovered childhood abuse. At the end of this section, the author provides stimulus exercises in eliciting and questioning techniques to focus on underlying themes and issues.

The next section of the book focuses on working with self-portraits. Weiser tends to design interventions to activate self-esteem, self-confidence, and self-acceptance (not barriers) between clients and others. For instance, she might tell a client, "[P]retend for a moment that you have won a free portrait sitting at the best place in town." The exercise helps the client to use his or her own perception. These types of exercises provide an opportunity to discuss and explore what happens when clients plan and then pose for snapshots of themselves. Further interactive "debriefing" of the experience in actually making that image is created. Weiser also demonstrates how "self-portrait Polaroids made in the therapist's office [might help clients] who are resistant [and] repressing difficult material." "Polarized" Polaroid exercises are used to explore dualities and ambiguities. As Weiser states: "[I]t is not possible to view an image of oneself knowing that it is oneself and see it as if it were a stranger. There is always privileged knowledge that cannot be removed from the perceptual process" (p. 145). However, caution must be used in applying these concepts and ideas to personalities whose self-image is fragile.

The intent in the next part of the book is to explore the connections in "seeing" other perspectives. As Weiser begins, "[T]he key word in speaking of photograph[s] is *take* … and in a sense photographers *take us*, we become partly theirs, at least metaphorically. Their 'having' us is a demonstration that some sort of relationship or interaction between us has occurred" (p. 187).

Weiser says that the camera records everything that its viewfinder "sees," but the implication is that people tend to see selectively, especially when focusing on a person of interest. These implicit metaphorical associations to the "camera" as a pseudo person have been made through[out] the book, attributing photography as a verb as well as a noun. "A camera does not just record, it also mediates" (p. 3). "The camera pointed at her" (p. 54). "My camera has pointed out to me …" (p. 230). "It all depends on the trust of the photographer … the power of the camera …" (p. 197). Although not explicitly stated in the book, from a psychoanalytic perspective one might speculate on the potentialities of the "intrusion" of the camera as having transferential elements in the therapeutic encounter—similar perhaps to the [G]estalt empty chair concept and the Winnicottian concepts of the transitional phenomena and the transitional object. The power of an object which is used to "see" through experience has vast analytical implications for discourse.

Then, from a multilevel framework, Weiser approaches the "debriefing" of photos of the client taken by another. Through the case illustrations of Penny, Eva, Maureen, and Joseph, the therapist describes the importance of the level of actual visual content in the picture. She then probes the meanings of the detail for the client and how original meanings can change over time. She also includes the role of the photographer in relation to the client, whether that relationship is old or new. Finally, with all her clients, she poses the question of what should be done with the images after the therapeutic experience. These anecdotes serve to illustrate secret messages in interpersonal relationships. The author carefully reattributes family system perspectives of family power alignments, triangulation, emotional cutoff, mirroring, and other behaviors.

---

[2] Judy Weiser responds, "Ironically, this was one of the sections addressed in the original manuscript which [the] editor cut due to length-of-book constraints!!"

Subsequently, Weiser also brings in other applications of theory and practice. In the last stages of AIDS-related diseases, Weiser feels very strongly that it is one thing to have photos of special people, places, or things, but it is also different and much better to have photos of oneself. Depending on the therapeutic focus, Weiser states that "taking charge of what is being done to one's body is often the first step in seizing the will to live. Encouraging these types of patients with photographs of their physical and emotional changes is a step towards self-recognition and the ability to react to what is happening."

Finally, the author explores in-depth metaphors of self-construction. She shows how photography assignments can bridge generational, cultural, class, racial, sexual, and even political differences (i.e., shooting pictures instead of guns). Weiser discusses how the control and power over what to frame in the viewfinder increases clients' feelings of empowerment. She also shows how a "collection of photos given to a person [by] another can serve as a very powerful retrospective summation of a person's life, positively reframing unsettling fixed negative experiences. Especially for the geriatric population, [the] collection of photos can be used for life-affirming and memory-evoking purposes."

In her summarizing chapters, Weiser looks at photosystems and personal family systems from a structural perspective. What is noticed in albums is not only the overt content, but selective forgetting, which is really selectively constructed narratives. Weiser "changes the picture" as she demonstrates multigenerational messages and expectations in her own family system. Weiser bravely uses her own narrative to explore and understand the meaning certain photos had for her, to demonstrate her application of the theoretical underpinnings of systems approach, and how photos have made her personal life more insightful. This rare blend of the personal in a text is honest and refreshing. In most psychological books, it is uncommon to find the therapist exposing vulnerability and naivety, but Weiser is fluently able to use herself as an object.

Weiser concludes with reiterating the sense of wonder and awe at the magic inherent in the photographic process. Photographs give the opportunity to witness paradoxes and coexist in mutual contradictions. As the author states in using phototherapy techniques, people can "get a picture" of their lives that is worth more than a thousand words. It seems that through photos as a tool in therapy the client is able to use both the "camera" and the therapist as an auxiliary ego.

Judy Weiser bridges her experience working with First Nation[s] peoples, in family and conjoint therapy, in crisis intervention (divorce, bereavement, and long-term terminally ill, such as AIDS sufferers), in a very sensitive and creative manner. Her book reads as an informative journal full of rich examples of applications. This book is what its title promises: an exploration of the secrets of personal snapshots and family albums. As she reiterates at the end of her book, readers must be comfortable with concepts such as selective perception, situationally-based reality, synchronicity, ego centrism, ethnocentrism, and be fluent enough with one's own theoretical underpinnings to recognize where these things may be affecting communications with clients. The recommended readings are very timely and appropriate. This book affords everybody the opportunity to, as Jung once said, trust that which has meaning.

Reference

Landgarten, H. (1980). *Clinical art therapy*. New York: Brunner/Mazel.

PhotoTherapy Techniques: Exploring the Secrets of Personal Snapshots and Family Albums

by **Judy Weiser**, San Francisco, CA: Jossey-Bass, 1993.

384 pp., $39.95, cloth, U.S.A.; $52.50, cloth, Canadian. ISBN 1-555-42-552-6

Reviewed by **Stephanie Zuperko Dudek**, Montreal, Quebec, Canada*

Weiser is a practicing phototherapist and a professional photographer. Early in her career as a photographer and as a psychotherapist Weiser realized that personal snapshots and personal albums constituted dynamic stimuli that "permitted connections with unconscious and deeply-based memories, thoughts, and feelings which verbal therapy had not been able to reach" (p. XIII). She began using them with her psychotherapy patients and quickly realized the enormous benefits of doing so.

This book is meant to be a guidebook, and it offers a set of techniques for already competent therapists to add to their professional repertoire of counseling skills (p. XV). Chapter Two provides an overview of therapeutic techniques, namely: 1) the projective process, 2) working with self portraits, 3) working with photos of clients taken by other people, 4) working with photos taken or collected by clients, and 5) working with the family album and other autobiographical photos.

The projective process is aimed at exploring client perceptions, values, and expectations. The chapters are amply illustrated with appropriate photos and followed by sample exercises which consist of instructions on how to proceed, what questions to ask, and so on. Weiser also provides examples of actual cases, and her interpretations of the therapeutic process are useful regardless of the therapist's particular theoretical orientation.

The book is well-written, readily accessible to her audience, and potentially useful to therapists of different theoretical persuasions, using different techniques of psychotherapy. The techniques are the result of a caring, involved human being who is obviously passionate about what she is doing and would like to share her skills with as many people as she can reach. This book is a gold mine and is recommended as useful and instructive to persons engaged in the phototherapeutic enterprise. It is, as Weiser says, "a set of flexible tools with which to construct a process tailored to each client's individual needs and goals" (p. 345). Congratulations Judy Weiser, and thank you.

---

*From "Book Review" by Stephanie Zuperko Dudek, 1994, *American Psychological Association, Division 10, Psychology and the Arts, Newsletter*, Summer, unpaged. Copyright 1994 by the American Psychological Association. Adapted with permission.

Video Review

The Shattered Sugar Bowl: Kids with Diabetes Speak Out

Produced and directed by **Diane Rode, A.T.R.**, New York, NY: Through Our Eyes Productions.

VHS 1/2", 30 minutes, color, rental $50, purchase $195.

This Flower Comforts You: Girls On Dialysis

Produced and directed by **Diane Rode, A.T.R.**, New York, NY: Through Our Eyes Productions.

VHS 1/2", 29:21 minutes, color, rental $50, purchase $195. From Through Our Eyes Productions, The Child Life Program, The Mount Sinai Medical Center, Box 1268, One Gustave L. Levy Place, New York, NY 10029-6574, or call 212-241-6797

Reviewed by **Barbara Faith Cooper, MPS, A.T.R.**, South Salem, NY

Diane Rode, Executive Producer of Through Our Eyes Productions, describes this company as

> a patient collaborative video production company where pediatric patients (ages 9–20), who have experienced and mastered aspects of chronic illness and medical interventions, function as video producers to document their experiences. The patient producers work with creative arts consultants to use media and other arts modalities to create their own "living with illness" videos. These videos (five, to date) are used to inform and educate fellow patients, families, health care providers, and the community at large regarding the nature of illness and recuperation as experienced from the point of view of young people living with specific conditions. (Rode, 1994)

The children and adolescents are involved in every aspect of the video-making process, from concept to script, camera work, music, and editing. They are involved in the therapeutic group processes necessary to collaborate in a creative project. More importantly, they process all aspects of their illnesses that come through so beautifully in these films: physical, emotional, and relational.

To review these films, it is necessary to address them from two different points of view. In the Mt. Sinai Child Life Program, video is used as an art medium; these films reflect some of that work. The viewer can appreciate the films as the creative healing process. Second, these films are informative and creative documentaries about their specific subjects. This review discusses two of the five films in this body of work.

In *The Shattered Sugar Bowl*, children with diabetes open the video singing a calypso tune titled "Blood Sugar High, Blood Sugar Low," taking turns singing their own improvised lyrics to the tune. Vignettes of the group of children in creative arts groups demonstrate the use of music, art, sandtray, dance, and drama. The children film each other throughout all of this, and they interview staff and each other about their medical conditions.

They follow each other with their cameras to supermarkets to discuss food choices, to their homes where they discuss their everyday lives living with their condition, and they interview the "person on the street" about diabetes. The children speak about the physical and emotional experiences of their illness from diagnosis to treatment. Their self-treatment, such as taking their own blood sugar counts and giving themselves injections, is shown, described by the children, and demystified.

This Flower Comforts You is made by five girls who are undergoing kidney dialysis treatment, typically three times each week for a number of years. The video is a collage of vignettes of the girls speaking about their experiences through music, poetry, and their artwork. They interview each other, their doctors, nurses, and social workers, and they film each other going through their days which include quantities of time at the dialysis center.

The importance of the creative arts therapies is clearly shown in this film; the film itself is an expressive art piece. Poetry such as "Dear dialysis machine" poignantly explores the girls' ambivalent feelings about treatment. They show collage and poetry titled "How I feel about my kidney failure."

This film very clearly expresses the feeling and lives of the patients and an enormous amount of information about the illness and treatment. As the girls receive treatment, they describe what is happening and how it feels. One girl who had a successful transplant is part of this group. She describes her experience and what her life is like now. Another girl had an unsuccessful transplant and speaks about that as well.

There are poignant, funny, and informative aspects to these films. The children/adolescents become empowered by being able to film and interview the doctors, to be the ones in control in a situation that is, for the most part, uncontrollable.

While these are not "how to use video as a modality" films, they can be quite inspiring to creative arts therapists. (For example, after I showed these films to a graduate art therapy class, one student brought her camera into her field-work setting and made a video with her group.) These films were made primarily as a group process art piece. However, as informative documentary videos they are appropriate for viewing by Child Life departments in medical settings, by educators of doctors, nurses, social workers, and other medically related caregivers, and by anyone interested in using video as a medium.

The films have a professional quality that is enhanced by their homemade aspect. The viewer can genuinely feel the involvement of the children. The music, most of it made by the children, enhances the videos' mood. Clearly, the editing process, which was done by a professional video editor working with the children, keeps the integrity of the project intact.

The "stars" of these videos are the children, who are so open and honest about their feelings and joyful in the creative process. They must feel a good deal of satisfaction in being able to "normalize" an illness for the newly diagnosed children who will watch these films in years to come.

In a sense, these are not films about art therapy. They, as films, are art therapy. The viewer experiences many levels of engagement with these films: as a voyeur into a group's therapeutic process, emotionally experiencing what these children go through, learning all there is to know about diagnosis and treatment from the child's perspective, and as a witness to the creative spirit in all its glory.

Reference

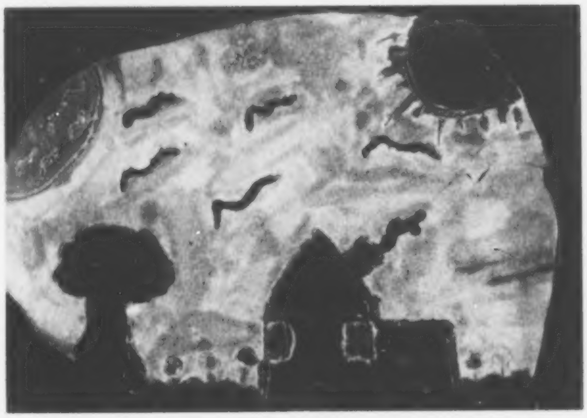
Rode, D. (1994). Informative promotional piece accompanying video.

Noteworthy

1996 Engagement Calendar to Support Pediatric Art Therapy

Robin Gabriels, MA, A.T.R., LPC has announced that a 100-page, full-color desk-top calendar filled with young patients' art is being produced by the National Jewish Center for Immunology and Respiratory Medicine in Denver, Colorado. The proceeds from calendar sales will fund the pediatric art therapy program at the hospital. The art therapy services at the National Jewish Center include individual and family therapy and assessment for patients of all ages. In addition, art therapists offer topic-specific groups such as parent/child interaction, social skills, chronic illness, medical play, body image, self-esteem, single parenting, and multifamily work.

The calendar is an excellent gift idea for family, friends, or business associates. AATA members receive a special rate of $12.00 per calendar plus shipping charges ($2.50); all others may order the calendar for $15.00 plus shipping. Special bulk rates for purchase and shipping are also available. For more information, please write to: National Jewish Center for Immunology and Respiratory Medicine, 1400 Jackson Street, M112 c/o Melissa Bice, Denver, CO 80206, or call 800-423-8891, ext. 1122.



Michelle, age 15: "I did it because I was hoping I could go home some day and go to the pond on a sunny day and watch the animals swim."

The Art of Cay Drachnik

After 20 years of working as a clinician and in governmental affairs on behalf of art therapy, art therapist Cay Drachnik, A.T.R.-BC, HLM, has returned to painting and exhibitions of her work. Her training as an artist has included studies at the Kansas City Art Institute and later work as a fashion illustrator in Washington, D.C. Recently, she has continued her art studies with painters Jerald Silva and Gary Pruner. She currently exhibits her watercolors throughout northern California, in shows, museums, and galleries.

Cay has won numerous awards for her work over the last 3 years, including: the 1993 California Arts League Best in Show; Art of California magazine Bronze Award; the 1993 Northern California Arts League Merit Award; First Place in Watercolor, Lodi Art League; 1995 Best in Show, Lodi Art League; 1995 California State Fair Merit Award; and the 1995 California Art League, 2nd Place in Mixed Media. Cay's work will also be included in a group show at University of California at Davis Faculty Club Show in October 1995. In her spare time, Cay has been conducting art classes for children 7 to 13 years old at the Sacramento Fine Arts Center.

Cay Drachnik with one of her water color paintings at her home in Sacramento, CA.

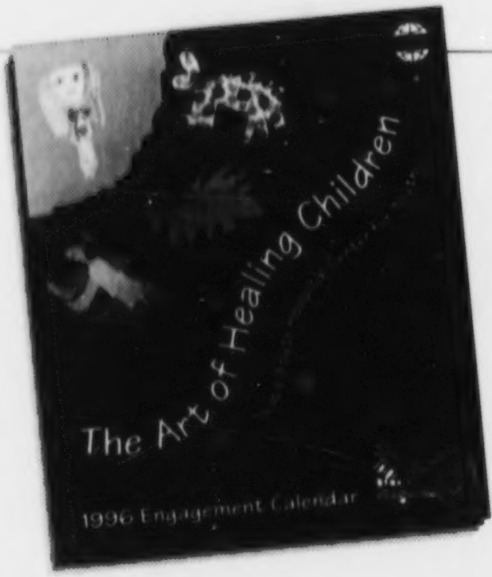
2152

AMERICAN ART THERAPY ASSOCIATION, INC.
26TH ANNUAL CONFERENCE

WEAVING NEW VISIONS
26th ANNUAL AATA CONFERENCE 1995

November 8 - 12, 1995
Town & Country Hotel
San Diego, California

IF YOU HAVE NOT RECEIVED YOUR CONFERENCE PROGRAM
CALL THE AATA NATIONAL OFFICE AT (708)949-6064.



The Art of Healing Children

1996 Engagement Calendar

Forty-eight powerful and poignant full-color artworks and five heartfelt poems by emotionally disturbed children adorn this award winning, critically acclaimed weekly calendar. A perennial bestseller at museum shops and quality bookstores, past editions have sold thousands of copies nationally.

1 WINNER
NATIONAL CALENDAR AWARDS™

WORLD CALENDAR AWARDS™
WINNER

"...a beautiful engagement calendar."
—Jesse Hamlin, S.F. Chronicle

"Their talent tugs at your heart."
—Herb Caen, S.F. Examiner

"Heartbreak, joy on canvas."
—Walt Wiley, Sacramento Bee

"Truth and beauty in art therapy."
—Richard Scheinin, S.J. Mercury News

Make checks payable to:
N.S.H. Children's Arts Program

Send to: Napa State Hospital
Children's Arts Program
P.O. Box 7247
Napa, CA 94558

Please send me ______ calendars @ $14.95 for a total of $ ______

Name ______

Address ______

City ______ State ______ Zip ______

What's New In Ancient Geological Products For Art Therapists

Rock Art Boards

Using the methods of the Ancients who carved heiroglyphics and petroglyphs into stone, this unique form of expression allows the individual to scratch their picture into 5" x 8" sandstone Rock Art Boards—and when they're done, the user has an attractive piece of art. Easy to do, this expressive, tactile method of illustration is appropriate for children, adolescents and adults. Rock Art Boards with the wooden carving styluses are packaged ten for $10.00.

QuickSand Creativity Kit

Make incredible shapes and figures quickly and easily. With the sculpting tools provided and illustrated creativity guide any individual can find expression in three dimensions!

It's an excellent hands-on activity. Mix with water, pack and dry, and you're ready to create fantastic sand sculptures. No additives needed!

QuickSand is *totally reusable:* this all-natural product cleans up quickly and easily. The 8-lb. bucket of QuickSand is $13.00.

All-Natural Jurassic Playsand

Our 200-million year old **pure, dust and dirt free sand** that the dinosaurs walked in is perfect for therapy.

Jurassic Playsand is all-natural, with a warm, cinnamon color, and is smoother, softer, and sticks together better than any man-made sand. Best of all, it's totally safe —there's **no silica dust** to breathe. The cost is $15.00 per 50 lb. bag, which we can ship anywhere in the USA.

Jurassic Sand™
200 MILLION YEAR OLD

Sand Trays

We offer a deluxe sand tray for dry or wet sand therapy use. The tray is 3" deep and a standard 19.5" x 28.5" size. The inside is painted a water-resistant sky blue, and has white melamine sides with durable trim.

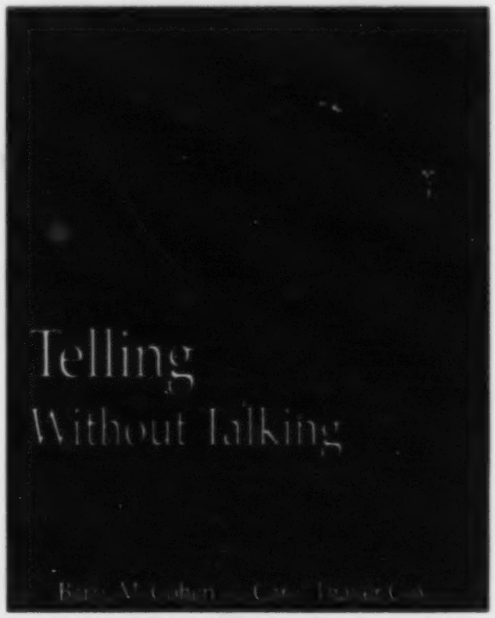
Sand trays cost $75.00 each; add $15.00 for activity top. Our 50 lb. bag of Jurassic PlaySand, for $15.00 extra, will fill your tray to the mid point. Custom trays to fit your space requirements also are available. Shipping on all orders is additional.

These wonderful products and the geologists who discovered them are at:

Salix Corp., where natural products for use in therapy, art and education are brought from the earth to you.

Credit card phone orders accepted; fax or mail your order to: 60 E. 600 South / Salt Lake City, UT 84111 / Phone (801) 531-8600 / Fax 531-8603

"a serious and compelling analysis..."*

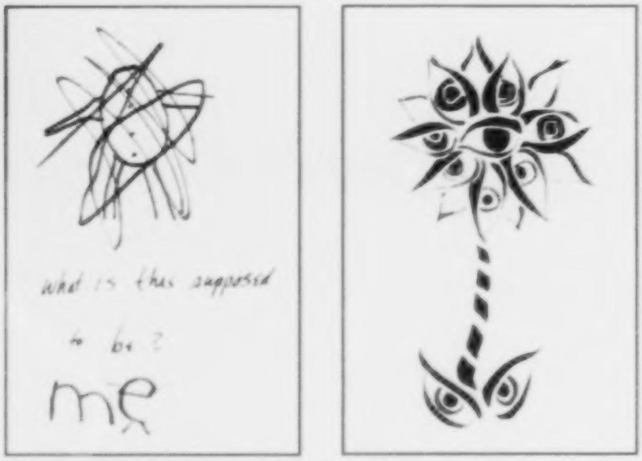


"This book constitutes a leap forward in both the pictorial investigation of dissociative identity disorder and the continuing development of artmaking as therapy... This book, a serious and compelling analysis, is a culmination of years of clinical study that captures the eye, mind, and heart of the reader/viewer"

—Estelle S. Kluft, MCAT, ADTR*

0-393-70196-4 $45.00 314 pages May, 1995

People who have been abused often keep their memories locked in a strongbox of dissociation, hidden even from themselves. Showing how these individuals simultaneously reveal and camouflage dissociated and repressed information in drawings, this ground-breaking book explores the complex messages in art and the graphic communications that are characteristic of those with multiple personality disorder.



Includes analysis of over 180 patient drawings, paintings, and collages. Twenty-one are reproduced in color.

"Essential fare for...those who care about healing and the arts."†

Bridging the Silence:
Nonverbal Modalities in the Treatment of Adult Survivors of Childhood Sexual Abuse
Susan Simonds
70175-1 (1994) $23.00

"Simonds has organized a wealth of practical and theoretical information from more than a decade of hard-to-find publications, conference presentations, and the oral tradition of expressive therapists into a responsible and easy-to-read text."

—Barry Cohen, MA, ATR†

To Order Call Toll Free 1-800-233-4830

W.W. Norton & Company

659

CHARLES C THOMAS • PUBLISHER

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror. (2nd Ed.)** '95, 230 pp. (7 × 10), 21 il., $49.95, cloth, $29.95, paper.

☐ Miller, Susan B.—**WHEN PARENTS HAVE PROBLEMS: A Book for Teens and Older Children with an Abusive, Alcoholic, or Mentally Ill Parent.** '95, 94 pp. (7 × 10), $31.95, cloth, $18.95, paper.

☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 17 il., $47.95. ***$29.95, paper.***

☐ Makin, Susan R.—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 112 pp. (7 × 10), $29.95. ***$15.95, paper.***

☐ Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 × 10), 12 il. $35.95.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 × 10), 24 il., $46.95. ***$29.95, paper.***

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror.** '90, 184 pp. (6¾ × 9¼), 21 il., $38.95. ***$24.95, paper.***

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $56.95. ***$34.95, paper.***

☐ Dennison, Susan T. & Connie K. Glassman—**ACTIVITIES FOR CHILDREN IN THERAPY: A Guide for Planning and Facilitating Therapy with Troubled Children.** '87, 304 pp. (8½ × 11), 203 il., 12 tables, $46.95, spiral (paper).

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $24.95.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $53.95, cloth, $33.95, paper.

☐ Furrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $25.95, spiral (paper).

☐ Benenzon, Rolando O.—**MUSIC THERAPY MANUAL.** '81, 178 pp., 20 il., $29.95. ***$14.95, paper.***

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $27.95. ***$15.95, paper.***

☐ Boy, Angelo V. & Gerald J. Pine—**CHILD-CENTERED COUNSELING AND PSYCHOTHERAPY.** '95, 262 pp. (7 × 10), $59.95, cloth, $34.95, paper.

☐ Giblin, Nan J. & Barbara A. Bales—**FINDING HELP: A Reference Guide for Personal Concerns.** '95, 224 pp. (7 × 10), $49.95, cloth, $29.95, paper.

☐ Nucho, Aino O.—**SPONTANEOUS CREATIVE IMAGERY: Problem Solving and Life Enhancing Skills.** '95, 166 pp. (7 × 10), 15 il.

☐ Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 186 pp. (7 × 10), 33 il. $41.95. ***$26.95, paper.***

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $64.95. ***$32.95, paper.***

☐ France, Kenneth—**BASIC PSYCHOLOGICAL SKILLS FOR FRONT-LINE STAFF OF RESIDENTIAL YOUTH FACILITIES.** '93, 212 pp. (7 × 10), 3 il., $45.95. ***$29.95, paper.***

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $37.95. ***$22.95, paper.***

☐ Breer, William—**DIAGNOSIS AND TREATMENT OF THE YOUNG MALE VICTIM OF SEXUAL ABUSE.** '92, 236 pp. (7 × 10), 5 il., $45.95. ***$28.95, paper.***

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¼), 34 il., $48.95. ***$29.95, paper.***

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $35.95. ***$19.95, paper.***

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $92.95. ***$49.95, paper.***

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $46.95. ***$29.95, paper.***

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $53.95. ***$31.95, paper.***

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 260 pp., 54 il., $32.95. ***$18.95, paper.***

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $34.95.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $49.95. ***$29.95, paper.***

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130

Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

AATA REGIONAL SYMPOSIA

ADDICTIONS

Presenters: Lynn Jones, Holly Feen and Katie Webb

Participants will receive the latest information on the use of art therapy in the treatment of addiction and dual diagnosis. Art therapists will be able to identify specific non-verbal approaches for working through resistance and denial in the treatment of substance abusers. Counselors will be able to identify specific ways in which to coordinate treatment efforts with art therapists in their facilities.

FAMILY ART THERAPY

Presenters: Mari Fleming, Shirley Riley and James Consoli

The objectives of this symposium are to provide the participants with an overview of how art therapy provides families an enriched vocabulary to assist them in solving family problems. The art therapy gives a "voice" to all age levels and offers a non-threatening vehicle to aid in communication restructuring the family system. The intensive workshop will offer ways to combine family theories with art expressions and examine assessment methods, short and long term treatment. Participants will engage in experiential opportunities to experience how art therapy is applicable in their own professional setting. Every effort will be made to offer the most current trends in family therapy and art therapy application.

ART THERAPY IN SCHOOLS

Presenters: Janet Bush and Sarah Hite (third presenter to be announced)

This symposium will provide participants with the administrative procedures for implementing art therapy services and programs in schools. Topics will focus on the uses of art therapy in schools; roles and responsibilities of school art therapists; techniques and strategies for working with students; training and preparation of school personnel; and the funding and marketing procedures required for school art therapy programs. Participants will be prepared to transfer techniques and strategies for implementing art therapy services and programs to school settings.

ART THERAPY WITH THE OLDER ADULT

Presenters: Larry Barnfield, Bernadette Callanan and Judith Wald

The symposium will cover general views on aging, relevant facts and new research, the role of art therapy with elders and settings in which art therapists practice and the special advantages of art therapy with the aging. It will cover the goals of treatment, treatment issues, and consideration of the clinical treatment of three groups of vulnerable aging and case studies.

GOING FOR THE GOLD: GRANTS AND RESEARCH IN ART THERAPY

Presenters: Frances Anderson, Vija Lusebrink and Doris Arrington

Successful grant writing in art therapy is, and will continue to be an important survival strategy in the 90's. Many model art therapy projects funded by grants will be discussed. The entire grant writing and granting process from identification of funding sources (public and private), to proposal development, submission and implementation will be covered. Technical assistance will be available to participants who already have a grant idea or proposal "in process".

ART THERAPY WITH CHILDREN AT RISK

Presenters: Cathy Malchiodi, Julie Epperson and Deborah Good

This symposium proposes to fill the need for advanced art therapy training focusing on theory, interventions, methodology and research with children at risk. "Children at risk" are defined as those who are directly affected by family violence, physical and sexual abuse, neglect homelessness, and various disabilities such as attention deficit hyperactivity disorder, learning problems, and physical limitation which put them at further risk for abuse and neglect. Emphasis will be on how the clinician can develop both short and long term art therapy interventions, effectively assist the child in crisis and appropriately utilize art expression in assessment of current level of psychological functioning.

ART AND MEDICINE

Presenters: Cathy Malchiodi and Anita Mester (third presenter to be announced)

The symposium will focus on the unique dimensions of art therapy within a medical context with people who have experienced life-threatening chronic illness, particularly cancer and HIV. The special role that art expression plays in the assessment and evaluation of both the somatic and psychological status of the individual will be discussed, supported by the current research of both art therapists and clinicians in related fields. Special emphasis will be on paradigms for the use of art therapy within the context of psychoneuroimmunology and mind/body healing. Theories of imagery from current research by Achterburg, Simonton, Bach and others will be covered to assist the participants in integrating the use of art expression with physically ill clients will be presented so that participants acquire an understanding of the practical aspects of adapting art therapy to specific disease conditions. Lastly, emotional and transpersonal issues of grief and loss which are intrinsic to the experience of physical life threatening illness will be addressed.

ADOLESCENT ART THERAPY

Presenters: Kris Sly-Linton (three other presenters to be announced)

The Adolescent Art Therapy Symposium will cover a wide range of topics designed to address a specific focus area requested by the sponsoring organization. This is a somewhat unique approach to the traditional symposia format but considering the multiplicity of problems regarding the treatment of adolescents today, it was felt this would be a way to make each symposium more pertinent to the intended audience. The four person team headed by Kris Sly-Linton, A.T.R.-BC, was coordinated to include professional art therapists that can provide the expertise required to address the following areas: Special Populations of Adolescents, Program Focus, and Teens and Family Systems.

These Symposia are offered at no charge to the participating Chapter.

•••••••••••••••••••

For further information regarding the content or scheduling of these symposia, please contact
AATA National Office • 1202 Allanson Road • Mundelein, Illinois • 60060 • (708)949-6064
Monday through Friday 9:00 a.m. to 5:00 p.m. Central Time

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Cathy A. Malchiodi, MA, A.T.R., Editor

Art Therapy, the official journal of the American Art Therapy Association, is a quarterly journal for professionals and students who are interested in the use of art in the fields of mental health, psychotherapy and human development. The purpose of the *Journal* is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. *Art Therapy* publishes refereed articles, including illustrations, by art therapists, psychologists, family therapists, and others that reflect the latest advances in theory, research, professional issues, and practice. An emphasis is placed on the use of visual arts in therapy, but articles in related disciplines of interest are considered for publication. *Art Therapy* is an important source for news and summaries of national conferences, book reviews, media, and commentaries.

Recent articles published in *Art Therapy:*

- ★ Tuberculosis: Art Therapy with Patients in Isolation
- ★ Art Therapy on a Hospital Burn Unit
- ★ The Children's Diagnostic Drawing Series
- ★ Essential Legal Issues for Art Therapists in Private Practice
- ★ Diagnosis or Dilemma: Drawings of Sexually Abused Children

---

Art Therapy is available to AATA Members as part of their membership. Non-Members may subscribe at the following annual rates:

Individuals: $50.00 (U.S.) - $74.00 (Foreign)
Institutions: $77.00 (U.S.) - $100.00 (Foreign)

Single copies are available at:

Members: $12.50 - Non-Members: $23.00

Make checks or money orders payable to AATA and return with this subscription order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my subscription. Enclosed is a check in the appropriate amount:

Name: ______________________________

Address: ______________________________

City: ____________________ State: ______ Zip: __________

The American Art Therapy Association

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 4,750 professionals and students. It is governed and directed by a nine-member Board elected by the membership. AATA has established standards for art therapy education and practice: AATA committees actively work on governmental affairs, clinical issues and professional development. AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films, and awards.

PURPOSE

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education, and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

CHAPTERS

Affiliated chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network for people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a chapter member. Information on locating the chapter nearest you is available from the AATA National Office.

MEMBER BENEFITS

All members receive:

Publications

- *Art Therapy: Journal of the American Art Therapy Association* (published quarterly).
- *AATA Newsletter* (published quarterly).
- Substantial discounts on AATA publications, such as Annual Conference Proceedings, other professional journals, films, and the membership directory.
- AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability through Maginnis & Associates.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payors.
- National liaison with related professional organizations for recognition and promotion of art therapy.

Professional Standards

- Development of model job description and recommendations for licensing standards.
- Development and implementation of national Education Standards for approval of graduate level Art Therapy programs.
- Development and implementation of nationally recognized Standards of Practice and Code of Ethics of Professional Art Therapists.

GENERAL INFORMATION

The American Art Therapy Association, Inc. (AATA) and the Art Therapy Credentials Board, Inc. (ATCB) are administratively independent. Membership in AATA and registration (A.T.R.) with the ATCB requires separate applications and approval. (A.T.R. registration applications are available from ATCB, 708-566-8910).

For **NEW** Associate, Student, and Contributing members only: please follow the chart below when submitting membership applications:

The membership year is the calendar year:
January 1 - December 31

Applications received between:

Jan. 1 - May 31: Full dues payment; membership expires December 31 of same year.

June 1 - Sept. 30: Half year dues plus $5.00 payment; membership expires December 31 of same year.

Oct. 1 - Dec. 31: Full dues payment; membership for the remainder of the current year and the next full year.

CATEGORIES AND FEES

Professional - By application review process only; approved members may vote, hold office and serve on committees.

- **Professional Member** - Individuals who have completed educational training in art therapy; dues are $85.00/year.
- **Credentialed Professional Member** - Individuals who have been **dually approved** for Professional Membership by AATA and Registration (A.T.R.) by the ATCB; AATA dues are $85.00/year. ***Annual A.T.R. Maintenance fee is billed separately by the ATCB.***

Associate - Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. Such members may not vote, hold office, or serve on committees. Dues are $85.00/year.

Student - Individuals who are currently taking full time course work in art therapy or a related field. Requires a current statement from the institution of learning indicating full time status and course work content (6 graduate or 12 undergraduate credits.) Student members may not vote or hold office, but may serve on the Student Sub-Committee of Membership. Dues are $35.00/year.

Contributing - Individual organizations, institutions, or foundations which contribute annually to AATA. Such members may not vote, hold office, or serve on committees. Dues are $120.00/year.

Retired - Individuals who are at least 65 years of age and who are no longer practicing. Retired members receive publications and reduced fees, but may not vote or hold office. Dues are $35.00/year. Application provided upon request.

Foreign AATA members MUST include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

The American Art Therapy Association

MEMBERSHIP APPLICATION

NAME____________________________

HOME ADDRESS________________________

____

PHONE(___)__________________________

BUSINESS ADDRESS______________________

____

EMPLOYER__________________________

JOB TITLE__________________________

LICENSES HELD & STATE____________________

____

PREFERRED MAILING LIST: ☐ HOME ☐ BUSINESS

Foreign AATA members MUST include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

Please indicate under which category you are applying:

☐ $85 Associate Membership

☐ $35 Student Membership **(see student membership criterion for necessary documents to accompany this application)**

☐ $120 Contributing Membership

Professional Member - Individuals who have completed educational training in art therapy; dues are $85.00/year.

Credentialed Professional Member - Individuals who have been **dually approved** for Professional Membership by AATA and Registration (A.T.R.) by the ATCB; AATA dues are $85.00/year. ***Annual A.T.R. maintenance fee is billed separately by the ATCB.***

Provided upon request:

☐ Professional Membership Application - ***Professional Membership granted by review approval process only.***

☐ A.T.R. Application - ***Provided and processed by the ATCB. A.T.R. granted by ATCB review approval process only. For more information contact the ATCB at (708)566-8910.***

Please make all checks payable in U.S. dollars and mail to:

AATA - American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, IL 60060
(708) 949-6064 Fax: (708) 566-4580

Please complete this survey:

Education (please check highest degree earned)

1 ☐ Doctorate Degree
2 ☐ Master's Degree
3 ☐ Bachelor's Degree
4 ☐ Associate/Certificate
5 ☐ Other ____________

(Please indicate *exact* degree earned, e.g., BA, BS, MA, MS, PhD, etc.)

Work Setting (please check only one)

1 ☐ Hospital
2 ☐ Clinic
3 ☐ Day treatment center
4 ☐ Rehabilitation
5 ☐ Sheltered workshop
6 ☐ Correctional facility
7 ☐ Residential treatment
8 ☐ Out-patient mental health
9 ☐ School system
10 ☐ Elderly care facility
11 ☐ College/University
12 ☐ Clinical training pro.
13 ☐ Institute training pro.
14 ☐ Counseling center
15 ☐ Private practice
16 ☐ Other __________

Area(s) of Specialization (please check up to three)

1 ☐ Addictions
2 ☐ Adolescents, Hospitalized
3 ☐ Adolescents, Psychiatric
4 ☐ Adults, Hospitalized
5 ☐ Adults, Psychiatric
6 ☐ Art History
7 ☐ Art Therapy Education
8 ☐ Art Therapy in Schools
9 ☐ Children, Hospitalized
10 ☐ Children, Psychiatric
11 ☐ Domestic Violence
12 ☐ Eating Disorders
13 ☐ Families
14 ☐ Gerontology
15 ☐ Hospice/Terminally Ill
16 ☐ Learning Disability
17 ☐ Mental Retardation
18 ☐ Neurological Disease
19 ☐ Prisoners
20 ☐ Post Traumatic Stress
21 ☐ Psychotherapy
22 ☐ Rehabilitation
23 ☐ Research
24 ☐ Sexual Abuse
25 ☐ Visual Art
26 ☐ Other __________

Voluntary Information

Age:

1 ☐ 20 - 24
2 ☐ 25 - 29
3 ☐ 30 - 34
4 ☐ 35 - 39
5 ☐ 40 - 44
6 ☐ 45 - 49
7 ☐ 50 - 54
8 ☐ 55 - 59
9 ☐ 60 +

Salary Range:

1 ☐ under $10,000
2 ☐ $10,000 - $14,999
3 ☐ $15,000 - $19,999
4 ☐ $20,000 - $24,999
5 ☐ $25,000 - $29,999
6 ☐ $30,000 - $34,999
7 ☐ $35,000 - $39,999
8 ☐ $40,000 - $44,999
9 ☐ $45,000 - $49,999
10 ☐ $50,000 +

Gender:

1 ☐ Female
2 ☐ Male

Hours worked/week:

1 ☐ 0 - 10
2 ☐ 11 - 20
3 ☐ 21 - 30
4 ☐ 31-40
5 ☐ 41+

RESOURCES

American Art Therapy Association, Inc.
1202 Allanson Road / Mundelein, Illinois 60060
(708) 949-6064 Fax: (708) 566-4580

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following publications, films, posters and training literature are available from the AATA National Office.

CONFERENCE PROCEEDINGS	MEMBERS	NON-MEMBERS
Creativity and the Art Therapist's Identity (1976) ISBN 1-882147-04-9	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) ISBN 1-882147-05-7	$ 5.00	$ 7.00
The Use of Creative Arts in Therapy (1979 Joint Conference)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) ISBN 1-882147-10-3	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) ISBN 1-882147-12-X	$ 7.00	$10.00
A Bridge Between Two Worlds (1981) ISBN 1-882147-11-1	$ 7.00	$14.00
Art Therapy: Still Growing (1982) ISBN 1-882147-06-5	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) ISBN 1-882147-13-8	$15.00	$20.00
Professionalism in Practice (1988) ISBN 1-882147-08-1	$15.00	$20.00
Painting Portraits: Families/Groups/Systems (1989) ISBN 1-882147-07-3	$15.00	$20.00
Image and Metaphor (1991) ISBN 1-882147-09-X	$15.00	$20.00
The Art Therapist: Artist/Teacher/Clinician/Healer (1992) ISBN 1-882147-14-6	$15.00	$20.00
Common Ground: The Arts, Therapy & Spirituality (1993) ISBN 1-882147-21-9	$15.00	$20.00
Reflecting on the Past, Envisioning the Future (1994) ISBN 1-882147-24-3	$15.00	$20.00

NOTE: Ten or more copies of any single proceeding: 10% discount on total. Set of four proceedings (consecutive years): 20% discount on total.
Postage/Handling: $3.00 first item; $.75 each additional.

PUBLICATIONS	MEMBERS	NON-MEMBERS
A History of Art Therapy in the United States [1,2] (1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual [3] (1994) Howie & Gutierrez ISBN 1-882147-16-2	$25.00	$37.00
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0 [1,2]	$24.00	$35.00
Art Therapy in the Schools [3]	$ 6.00	$10.00
National Registry of Masters Theses & Practicum Papers [1]	$15.00	$25.00
Addendum to National Registry of Masters Theses & Practicum Papers [1]	$12.50	$22.50
AATA Chapter Manual [3]	$12.00	N/A
Applying for Funds from Your Area Agency on Aging [1]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance [3]	$ 7.00	$10.00

NOTE: [1] Postage included on all orders for this publication. [2] Ten or more copies - 10% discount. [3] Add $3.00 for postage.

PROFESSIONAL PREPARATION LITERATURE	MEMBERS	NON-MEMBERS
Education Standards	N/C	$ 1.00
Educational Program List (Colleges and Universities offering art therapy programs)	N/C	$ 2.00
◆*ATCB Standards & Procedures for Registration*	N/C	$ 1.00

General Information Packet - $4.00 (includes: Educational Standards, Educational Program List, Standards & Procedures for Registration, and a New Member Application)

OTHER LITERATURE	MEMBERS	NON-MEMBERS
Art Therapy Model Job Description	$ .32	$ 1.00
Art Therapy Media List	$ .32	$ 1.00
Bibliography: Books Authored by AATA Members	$ .32	$ 1.00
Ethical Standards for Art Therapists	$ .32	$ 1.00
Standards of Practice	$ .32	$ 1.00

MEMBERSHIP INFORMATION	**MEMBERS**	**NON-MEMBERS**
Membership Specialty List	$ 2.62	$ 3.62
Membership Survey	$ .32	$ 2.75
1994 Membership Directory [1]	$ 14.00	$55.00
Criteria and Application for Professional Membership	$ .32	$ 1.00

NOTE: [1] Postage and handling for AATA Directory U.S. - $3.00; Canada/Mexico - $3.25; Foreign - $10.00.

POSTERS	**MEMBERS**	**NON-MEMBERS**
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Shipping and handling is included on both posters.

SUBSCRIPTIONS		
Art Therapy: Journal of the American Art Therapy Association	Individuals = U.S. $50.00 Institutions = U.S. $77.00	Foreign = U.S. $74.00 Foreign = U.S. $100.00
Back Issues	Members = $12.50	Non-Members = $23.00
AATA Newsletter	U.S. $26.00	Foreign $38.00

NOTE: Shipping and handling is included on both subscriptions.

FILMS	**TYPE**	**MEMBERS**	**NON-MEMBERS**
Art Therapy Beginnings	16mm-rental only	$40.00	$50.00
(1977) color/sound/45 min.	1/2" VHS-purchase only	$50.00	$80.00
Michael	16mm-rental only	$30.00	$35.00
(1977) color/sound/12 min.	1/2" VHS-purchase only	$50.00	$80.00
Art Therapy	16mm-rental only	$35.00	$45.00
(1980) color/sound/12 min.	1/2" VHS-purchase only	$50.00	$80.00

NOTE: Postage and handling for VHS - $3.00 each tape; 16mm - $7.00 each film.

ART THERAPY CREDENTIALS BOARD, INC. (ATCB) INFORMATION	**MEMBERS**	**NON-MEMBERS**
◆*ATCB/A.T.R. (Registration) Application*	N/C	$ 1.00
◆*ATCB Standards & Procedures for Registration*	N/C	$ 1.00

◆ This information is provided by the American Art Therapy Association, Inc. (AATA) as a courtesy to the Art Therapy Credentials Board, Inc. (ATCB), an independent certification and registration organization. For further information contact ATCB, Inc. at (708)566-8910.

---

1. WE DO NOT ACCEPT CREDIT CARDS OR PURCHASE ORDERS. All orders must be made in writing, accompanied by payment in cash, check, or money order in U.S. funds.
2. FOREIGN ORDERS: Shipping will be made per your instructions (surface or air). Please specify shipment method when ordering. Additional postage, if necessary, will be billed separately.
3. RETURNS ARE NOT ACCEPTED for refund on shipped items.

TITLE	QUANTITY	PRICE	TOTAL

SHIPPING INFORMATION

NAME: __________

MEMBER ID#: __________

STREET: __________

CITY/STATE/ZIP: __________

Total: $__________

Postage: $__________

Applicable Discount: $__________

TOTAL ENCLOSED: $__________

Allow 2 - 4 weeks for delivery.

MAKE CHECKS PAYABLE TO AATA

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to each copy of your manuscript:

Name:______________________________

Degrees/Credentials:______________________________

Address:______________________________

Phone numbers: Home______________________ **Work**______________________

Type of Submission (check one):

☐ Article
☐ Viewpoints
☐ Brief Report
☐ Film/Video Review
☐ Book Review

Title of Submission:______________________________

____

Checklist:

☐ Five (5) copies, typewritten on 8 1/2" x 11" paper.

☐ Black and white photos of original artwork plus four (4) photocopies of each.

☐ Paper and references adhere to *Publication Manual of the American Psychological Association* (Fourth Edition).

☐ Abstract of 75-125 words (for articles and brief reports only).

☐ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

☐ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

☐ This Attention Authors form.

Author's Signature______________________ **Date**______________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

GUIDELINES FOR SUBMISSIONS

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in Art Therapy, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Editor, *Art Therapy: Journal* of the** American Art **Therapy Association, c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8 1/2" x 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication* Manual for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" x 7" and black and white glossy prints, preferably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs, captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. **It is the author's responsibility to secure such permissions**; a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: **Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.**

2164

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 12, NUMBER 4, 1995

2165

BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, U.S.A. 60060. Telephone (708) 949-6064, FAX (708) 566-4580. Non-members may subscribe at the following annual rates: $40 (U.S.) and $64 (Foreign); institutions: $57 (U.S.) and $80 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, IL 60060 (708) 949-6064.

This journal is abstracted in: *Resources in Education (ERIC), INNOVATIONS & RESEARCH, Art Bibliographies Current Titles* and *Art Bibliographies Modern*.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to AATA, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE

American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060
(708) 949-6064

The publication of any advertisement by the AATA, Inc., is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc., is not responsible for any claims made in an advertisement.

ADVERTISING RATES

RATES	1x	2x	3x	4x
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:

January 15 for Spring issue; April 15 for Summer issue. July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The American Art Therapy Association, Inc.
1202 Allanson Road/Mundelein, IL 60060
(708) 949-6064

Editor
Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Patricia St. John, EdD, A.T.R.-BC
College of New Rochelle, New Rochelle, NY

Book Review Editor
Barbara Sprayregan, PsyD, A.T.R.
Stoney Brook Counseling Center, Chelmsford, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Friends Hospital, Philadelphia, PA

Production Editor
Karen D. Savage

Editorial Board
Pat B. Allen, PhD, A.T.R., LPAT
School of the Art Institute, Chicago, IL
Doris B. Arrington, EdD, A.T.R.-BC
College of Notre Dame, Belmont, CA
Janet Bush, EdS, A.T.R.-BC
Dade County Public Schools, Miami, FL
Julia Byers, MA, A.T.R.
Concordia University, Montreal, Canada
Mariagnese Cattaneo, PhD, A.T.R., LMHC
Lesley College, Cambridge, MA
Susan Cheyne-King MS, A.T.R., LPC
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R., LPAT
George Washington University, Washington, DC
John Goff Jones, PhD, ABPP, A.T.R.-BC
Oklahoma City, OK
Julie Epperson, MA, A.T.R., LPCC
YWCA of Salt Lake City, Salt Lake City, UT
Deborah A. Good, MA, A.T.R., LPAT, LPCC
Family Therapy of Albuquerque, Albuquerque, NM
Anna Hiscox, MA, MFT, A.T.R.
McAuley Neuropsychiatric Institute, San Francisco, CA
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Frances F. Kaplan, DA, A.T.R.
Hofstra University, Hempstead, NY
Carol Lark, MA, A.T.R.
Art Therapy Center of St. Louis, MO
Vija B. Lusebrink, PhD, A.T.R.-BC
University of Louisville, Louisville, KY
Patricia Engle Murphy PhD, A.T.R.
Private Practice, Moscow, ID
Mary Ellen Peacock, MA, A.T.R.
St. Francis of Assisi School, Louisville, KY
Leslie P. Knowles, A.T.R., LMHC
Whitney Academy, East Freetown, MA
Shirley Riley, MA, A.T.R., MFCT
Loyola Marymount University, Los Angeles, CA
Irene Rosner David, MA, A.T.R.-BC
Bellevue Hospital Center, New York, NY
Nancy M. Sidun, PsyD, A.T.R.
The Chicago School of Professional Psychology, Chicago, IL
Susan Spaniol, EdD, A.T.R.
Leslie College, Cambridge, MA
Evelyn Virshup, PhD, A.T.R., MFCC
California State, Los Angeles, CA
Judith Wald, MS, A.T.R.
New York Hospital - Cornell Medical Hospital Center,
White Planes, NY

AATA President
Bobbi Stoll, MFCC, A.T.R.-BC

AATA Executive Director
Edward J. Stygar, Jr.

VOLUME 12

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 4, 1995

Editorial

Does a Lack of Art Therapy Research Hold Us Back? — Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC 218

Articles

Art Therapy: Bridging Barriers with Native American Clients — Joy Moody, MEd, A.T.R.-BC, LCPC 220

Art Is All the Feelings Trapped Inside: An Interview with Marilyn McKeon — Susan Spaniol, EdD, A.T.R., LMHC 227

Surviving Elimination of a Graduate Art Therapy Program: Art Education Revisited — Lucy Andrus, MS, A.T.R. .. 231

LA '94 Earthquake in the Eyes of Children: Art Therapy with Elementary School Children Who Were Victims of Disaster — Jasenka Roje, MA 237

Brief Reports

Use of a Drawing Task in the Treatment of Nightmares in Combat-Related PTSD — Charles A. Morgan III, MD and David Read Johnson, PhD, RDT 244

Art Therapists' Employment Experience in a Shifting Economy — Michelle Winkel, MA; Maxine Junge, PhD, LCSW, A.T.R.; Debra Linesch, PhD, MFCC, A.T.R. and Nina Mathews, MA, MFA 248

Outpatient Art Therapy with Multiple Personality Disorder: A Survey of Current Practice — Anne Mills, MA, A.T.R. 253

Viewpoints

Art Therapy at the Crossroads: Arts *and* Science — Terry Tibbetts, PhD, A.T.R. 257
Responses by Harriet Wadeson, PhD, A.T.R.-BC, HLM and Robert Wolf, MPS, A.T.R., NCPsyA 258

Art Therapy Research: Learning from Experience — Debra Linesch, PhD, A.T.R. 261

Photo Essay: Research/Revisiting — Suzanne Calomeris, MA 266

Reviews

Arts Therapies and Clients with Eating Disorders: Fragile Board — Barbara Sprayregen, PsyD, A.T.R. 268

Wet-Into-Wet Watercolor: The Complete Guide to an Essential Watercolor Technique — Tara Marean, MS, A.T.R. 269

Video Review: Courage: Together We Heal! Mural Messages from Incest Survivors — Marcia L. Rosal, PhD, A.T.R.-BC 270

Annual Index, Volume 12 272

About the Cover: "Transition," 38½" × 27½", pastel on paper, by Kate Hartman, MA, A.T.R., Art Therapy Studies/Art Education Program, Buffalo State College, Buffalo, NY. "This piece explores the process in grief of confronting the pain of loss so that one may move to embrace new life attachments and endeavors."

Editorial

Does a Lack of Art Therapy Research Hold Us Back?

Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC, *Editor*

In the Viewpoints section of this issue of *Art Therapy*, Terry Tibbets presents the following provocative idea: a lack of empirical research in the field of art therapy has stymied the growth and recognition of the profession. In his opening statement, he notes that

> art therapy as a clinical intervention continues to be both underutilized and misunderstood by many mental health providers. I suggest that one of the major reasons for this failure to be taken seriously as mental health professionals is because art therapy, as a discipline, has failed to generate empirical data that would support our claims to clinical effectiveness.

It is true that there is a lack of research in the field of art therapy, both quantitative and qualitative. The vast majority of papers submitted to this peer-reviewed publication concentrate on clinical observations, theoretical explorations, and practical applications, not empirical or other types of research. When research articles are submitted, they often focus on surveys of what other art therapists are doing or thinking, rather than on clients' experiences, or focus on the content of art expressions (i.e., art-based assessments). While the latter is important to increasing art therapists' understanding of the meaning of client art, these studies often do not examine the process, efficacy, or outcome of client treatment, issues important to defining how art therapy works and how (and if) it is of value to clients.

Also, the particular type of research (i.e., empirical) that Tibbets cites a lack of, may not be the only path to reliable data on art therapy. Some have noted that the lack of art therapy research may be due, in part, to the lack of methodology compatible to investigation of art processes and art products (Junge & Linesch, 1992; Wadeson, 1992). There may be other methods of research that may be more appropriate to the field of art therapy, including qualitative models such a structured case study research, anthropological, and phenomenological methods.

There are many obvious reasons why there is so little published research available on art therapy. First and foremost, most art therapists train to be master's level clinicians, not researchers; it is unrealistic to expect that most students in art therapy master's programs will be able to generate research of depth and quality. Academic programs generally focus on clinical training (i.e., teaching students to become responsible and effective therapists to the clients they serve), with little time left to dedicate to teaching students the intricacies of research. Art therapy educators have struggled for many years with the need to effectively teach research methodology within two-year graduate training programs and often cannot devote more than a single semester-long course to this topic. The study of research and the completion of research projects competes with other areas of learning (i.e., multiculturalism, professionalism, ethics, legal issues, studio classes) that may be more important to the practical knowledge of art therapy students. Also, with many programs adding coursework to meet counseling licensure laws, there seems to be less and less time for research coursework. As Wadeson says in her response to Tibbets in this issue, "It is one thing to desire research in art therapy. It is quite another to set up conditions to facilitate it."

Since master's level clinicians cannot be expected to contribute significant research, often professions depend on their doctoral level people and educators in higher education to pursue and contribute research data to the field. Art therapists with doctoral degrees or currently in doctoral programs, are often involved in research, although not necessarily research related to art therapy. Since many art therapists undertake doctoral degrees in psychology or fields other than art therapy, they may complete research in areas outside the field, if at all.

In higher education, there is an expectation that professors conduct research and publish that research in peer-reviewed publications. While some art therapy educators are conducting research and writing scholarly papers for publication, the majority are not contributing to the field in this way. Many art therapy educators, particularly those with appointments at small colleges, do not have significant track records in publication and scholarly research. Responsibilities to teach extended courseloads and recruit students to keep enrollments adequate, as well as the desire to do clinical work or studio art, may effect art therapy educators' time and interest in research and writing (Malchiodi, 1993). However, in the near future, art therapy educators' lack of devotion to peer-reviewed publication and research may have powerful ramifications on the growth of the field (and eventually on the continued numbers of applicants to art therapy programs).

In his opening statement, Tibbetts says that "Although art therapy as a professional discipline has been in evidence since the mid-1950s, it has achieved, as we move into the 1990's, only limited acceptance in the larger mental health field." In reading this statement, a related question comes to mind—is it "art therapy" that is not accepted or is it "art therapists" ? There is evidence that art therapy is widely accepted in many sectors of mental health and healthcare in general. For example, the American Counseling Association, a 60,000 member-plus organization, has called for special workshops on the use of arts in therapy at its upcoming international conference, and recently published a text on the use of creative arts therapies (including art therapy) in counseling. When one looks at the fields of mental health, medicine, and the arts, it seems that everyone is doing what might be considered art therapy, whether a registered or board-certified art therapist or not. There are and there will be increasing numbers of those who use art in therapy and /or assessment, underscoring the recognition by others outside the field that art therapy is an effective, viable, and successful treatment.

If art therapy is being embraced and used by other professionals and in a variety of settings, perhaps it is art therapists who are not accepted, rather than art therapy per se. If more art therapy research is generated, will art therapists find more recognition in healthcare and will more art therapists find jobs? That is an experiment that has yet to be run, so we can only speculate on the outcome at this point in time.

Is it just a lack of art therapy research that has held us back? Perhaps it has played a significant part of the woes of art therapy, but there may be more basic problems at the foundation of the profession's dilemmas. Before we can do meaningful art therapy research, we have to be willing to identify and face the real questions about art therapy that need to be answered. Although we probably all believe that artmaking is inherently therapeutic and that the creative process is healing, the investigations necessary to support these simple beliefs have not been completed. We also need to acknowledge and address the question: what does an art therapist contribute to the therapeutic process that another clinician cannot? These are questions that we may take for granted or perhaps wish to ignore, but need to be honestly examined and answered, if only in an effort to serve our clients in the best way possible.

Editor's Note: Special thanks go to LEVYB (Barbara Levy), Larkster (Carol Lark), JWalk212 (James Walker), and SalK212 (Leslie Powell-Knowles), my cyberbuddies, for sharing their ideas on this topic in the Creative Arts Therapies Folder on American Online, and to Linda Gantt, PhD, A.T.R.

References

Junge, M., & Linesch, D. (1992). Art therapists' ways of knowing: Toward creativity and new paradigms for art therapy research. In H. Wadeson (Ed.), *A guide to conducting art therapy research* (pp. 79–83). Mundelein, IL: AATA.

Malchiodi, C. (1993). Introduction to special issue on art therapy and professionalism: Is there a crisis in art therapy education? *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 122–128.

Wadeson, H. (Ed.). (1992). *A guide to conducting art therapy research*. Mundelein, IL: AATA.

Art Therapy: Journal of the American Art Therapy Association is pleased to announce that PsycINFO/American Psychological Association will be resuming coverage of the journal effective November 14, 1995. Readers, researchers, educators, and students will be able to access *Art Therapy* through this database at university and college libraries shortly. The Editor would like to thank the members of the *Art Therapy* Editorial Board and other professionals who took time to write to PsycINFO/APA to encourage the resumption of coverage of the journal in this important database.

Readers may also locate articles published in this journal on two ERIC databases, ERIC Art and ERIC Counseling & Social Sciences, and other databases as listed on the inside front cover.

Art Therapy: Journal of the American Art Therapy Association, 12(4) pp 220-226 © AATA, Inc. 1995

Art Therapy: Bridging Barriers with Native American Clients

Joy Moody, MEd, A.T.R.-BC, LCPC, Hampden, ME

Abstract

This paper describes field observations while working for two years full-time on an Indian reservation. The introduction provides a brief background and sets the scene and impetus for sharing. In the second section, three issues which were found to be central to effective therapeutic relationships are discussed: trust, common ground, and mutual respect and understanding. In the last section, client art is discussed as it relates to Native American spirituality, values, and personal growth.

Introduction

In 1990 I embarked on what was to be a 2-year journey working as an art therapist for the Penobscot Indian Nation. I brought with me a world view which embraced the oneness of all beings, our inseparable link with nature, the universal "language" of art, and the interconnection of mind, body, and spirit. Everything I had read, or been exposed to, which addressed the spiritual perspective of Native Americans led me to believe that my world view was congruent and, therefore, acceptance by clients would be a natural consequence. Nothing I had read or studied prepared me for the hidden challenges of multicultural work: the extensive distrust of non-Indian people, the deep-seated anger, or the way non-Indian employees were treated differently from Indian employees despite their sincere commitment to their helping roles.

My interest in Native Americans had grown over a 3-year period during which I had an increasing number of dreams of Native symbols and power animals, together with indications that I would move to the state of Maine. I did not know why I was to pursue this path, only that I was being led to move 250 miles North to be with Native people. The rest was to unfold. While this background may be judged unnecessary "mysticism" by some, readers are reminded that such judgements arise from specific value systems; value systems which, in my experience, may well be incongruent with Native world views. In fact, in many instances, it was my belief in, and openness to, the importance of messages received through visions and dreams, as well as visual symbols, which allowed therapeutic alliances to be formed.

After my work began, I made attempts to network with other art therapists who were working with, or had interest in working with, Native Americans. However, I found very few art therapists working with Indian people. Moreover, experiences undoubtedly differ from tribe to tribe, the experiences chronicled in this paper involve one Northeastern tribe where participant observation took place in the heart of the community. Working as a full-time staff person on the reservation, in an Indian-run facility, provided a vantage point that was closer to The People (as they refer to themselves) and their ways than would have been possible, for example, in an out-patient hospital within the dominant culture.

The Penobscot Nation is a federally recognized tribe of approximately 2,033 Native people, about 462 of whom reside on the reservation and are eligible for counseling services through the Indian Health Services, a nationwide program for recognized tribes. (Indian Health Services, Public Health Services, and the Alcohol and Substance Abuse Program fall under the U.S. Department of Health and Human Services.) The Penobscot community is close-knit and includes two churches, a community building which houses the tribal government, police and fire departments, a new elementary school, social services center, variety store, and ice arena. The health center is Indian-managed and falls under the authority of the tribal government. There is a racial mix of staff members.

Art therapy was offered through the community health center, a modern out-patient facility which houses medical, dental, nutrition, and counseling services, day care, and meals for the elders. Counseling and art therapy services were supervised by a consulting psychologist and staffed by three Master's level counselors including myself and a substance abuse counselor. The psychologist who conducted initial assessments also diagnosed and assigned clients for counseling and art therapy. A multidisciplinary treatment team met weekly and made recommendations for clients in a process similar to ward rounds in in-patient treatment. The team included the psychologist/clinical supervisor, unit coordinator, counselors, art therapist, doctor, nurse or physician's assistant, pharmacist, nutritionist, social worker, and school liaisons.

Clients were integrally involved in both defining their presenting problems and planning their treatment. Health center clients voluntarily came for services which were free of charge, although occasionally clients were court-ordered into treatment. Language was not a barrier because the Penobscot people use English as their primary language. Efforts are underway, however, to recover the Penobscot language.

The Penobscot people are proud of their community health center and do not appear to hesitate to use the many services offered. While some readers may view those services as Eurocentric, it is an error to assume that all Indian people wish to return to the sole use of traditional medicine and healing. As you read this paper and consider its points, I encourage you to critically identify and examine your assumptions. In my work with Native people, I have found that there are bidirectional assumptions which continue to create feelings of anger and frustration. If we are to overcome discrimination, we must be willing to communicate from a here-and-now stance, setting assumptions aside.

Readers are referred to the many informative texts (American Friends Service Committee, 1989; Freesoul, 1986; McGaa, 1990; Meadows, 1991; Wall & Arden, 1990), written by or in conjunction with Native Americans, that address the Native American's love of and reverence for the earth, nature, and the universe. An understanding of this sacred relationship is important for any art therapist or counselor working with Native peoples. Although Native Americans are not a homogeneous group (having much diversity in geographic location, customs, language, and even their level of comfort with the terms by which they are referred to such as, Indian, Native American, Aboriginal People), their connection with the earth is a shared commonality. In their view all peoples of the earth are inseparably linked through the Earth Mother. To Native Americans spirituality grows from this connection, which is central to their world view.

Central Issues to Therapist Effectiveness

Concordance in the Therapeutic Relationship

"Goodness of fit" between therapist and client is often discussed in art therapist and counselor training (Borden, 1979; Gelso & Carter, 1985; Luborsky, Christ, Mintz, & Auberbach, 1988); the degree of concordance between client and therapist in the therapeutic relationship is integral to therapeutic gains. In may experience goodness of fit is a lofty goal for art therapists or counselors working with Native Americans, but one well worth pursuing. It is lofty due to the hidden challenges of multicultural work, for which one can never be fully prepared, and which cannot be controlled. It is lofty because despite the preparation the art therapist may have made, the experience can never be understood until undertaken.

Goodness of fit or concordant therapeutic alliance is affected by three factors: (1) the close-knit nature of the Native American family and community groups; (2) the counselor's understanding of, and respect for, Native spirituality and values; and (3) bidirectional race hatred which continues in the present generation. These three are central to effective working relationships and present a major challenge for therapists working with Native American clients. Underlying these issues are the accompanying issues of the need for client trust, the need to establish common ground, and the need for mutual respect and understanding. Again, it is important to understand that Indian peoples are not a homogeneous group, and, therefore, the diversity among tribes requires us not to box Native spirituality, customs, or values into a neat package to satisfy our own purposes.

Issues Related to Trust

The concept of the importance of family and community is expressed in the preamble of *Wisdom Keepers* (Wall & Arden, 1990) in prose attributed to The Peace Maker, founder of the Iroquois Confederacy, circa 1000 A.D. "Think not forever of yourselves, O Chiefs, nor of your own generation. Think of continuing generations of our families, think of our grandchildren and those yet unborn, whose faces are coming from beneath the ground" (p. 7). Native Americans honor the voice of the ancestors and hold dear the children and future generations.

Native teachings, which have a long oral tradition, pass down through parents and Elders and are often clutched tightly to keep them safe. The Shinnecock Elder, Starleaf, has said, "So much has been taken, so much has been lost. We hardly know our own language or culture anymore.... In exchange for all he's taken from us, all White Man gives us back is welfare.... That's rape—raping someone's way of life, raping someone's culture and heritage..." (Wall & Arden, 1990, p. 45). The decimation of Native American culture has left its people a legacy of pain which makes sharing difficult and trust even harder. Hallowell (1991) says this pain manifests in feelings of "self-hate, shame, rejection, emotional deprivation, abandonment, and an inability to trust" (p. 5).

To the art therapist, the value placed by The People on family and community can appear as a barrier when coupled with inherited pain and issues of distrust. The art therapist must have more than a sincere desire to know and understand. Expecting an Elder to share the gift of knowledge about the culture is a setup for disappointment. Dufrene (1991) mentions "the secrecy associated with many traditional Indian customs" (p. 20). This secrecy also becomes a barrier to the therapist's learning about and coming to understand the culture and often the family system. At the same time, we are entreated (Dubray, 1985) to become well informed, we are forced to fall back on written accounts of the culture, not all of which are historically or otherwise accurate and many of which are written by non-Indian people or focus on Western tribes and often do not make clear the great diversity among tribes. In my experience a great deal of anger is directed at the therapist for "not understanding," while information is simultaneously held in a closed environment and protected from assumed harm.

Trust develops in the therapeutic relationship when the art therapist is open to, and nonjudgemental of, Native American world views. Without communicating a basic respect for Indian ways, the art therapist cannot hope to have material of any importance shared by clients. Seeking to understand the historical background of the specific tribe from which your client comes is paramount. At the same time, art therapists must recognize that The People's self-hatred, shame, experiences of rejection, emotional deprivation, and abandonment all impact the bond of trust we seek to establish. Indian people question how they can entrust their deepest feelings and experiences to therapists, especially white therapists, whose race caused their pain and took so much away. Their question is an ever-present challenge to the art therapist's skill and stamina.

Issues Related to Establishing Common Ground

Where does the art therapist begin to develop an approach to therapeutic art tasks? Only by seeking to develop an understanding of Native American spirituality and values, can we hope to find a beginning place that is congruent with the client's way-of-being in the world.

To understand Native American spirituality is to know the meaning of the concept of "first cause" (Wall & Arden, 1990). This is what some refer to in the East as "the oneness of all being." To The People, it means that all things are part of the whole: all animals, birds, insects, plants, and trees as well as man.

Indians of Maine and the Atlantic Provinces (Maine Historical Society, 1977) notes that myths were developed to explain Native beliefs, the personality of and relationships among the vegetable and animal kingdoms and man. While it may be perceived that such myths developed in all cultures, it is not true that all cultures consider the oneness of all beings to be a sacred bond. It is difficult at best to attempt to explain the depth that such a sacred bond takes, for it is something felt and fully incorporated into the Native Americans' life. Like the Tao, it cannot be accurately described, only experienced. And, in another sense, though non-Indian people can develop such a sacred bond, it can never be the same unless it is experienced as a Native American.

Myths and folklore "derived from the belief in the unity of man with his natural world" (Maine Historical Society, 1977, p. 21). Native American art was sacred and also derived from this belief. "Their perception of the natural world, the arrangement of the universe, the seasons of cold and warmth, God…the duality of good and evil and life after death governed their concepts of land tenure, their art, their ceremonies, their subsistence and about every conceivable pattern of daily life" (Maine Historical Society, 1977, p. 69). The Indians in Maine and the Maritime provinces were known to have produced rock drawings or petroglyphs, as well as decorative and symbolic art. The artists indwelling spirit was believed to receive strength from the spirit world, when it was called upon for assistance.

The Medicine Wheel or Sacred Hoop is a fundamental symbol of Native American culture and its value system (Doore, 1988). The Medicine Wheel reflects the microcosmic and macrocosmic nature of the circle: the circle and connectedness of the family, the community, ceremony, and all humans; the circle or cycle of the seasons, the constellations, the planets, and life, of which man is only a part, that is, part of the One. The Medicine Wheel reflects the four worlds: mineral, plant, animal, and human. "Sacred" is defined as "A sense of respect and reverence for the larger systems and energies that govern our lives…. (Shamans know that) we are completely surrounded, completely enclosed by that energy" (Doore, 1988, p. 130). Again, art therapists must work to develop both an openness to and understanding of the sacred connection that Native Americans consider in every part of their lives. Today, the Sacred Hoop or Medicine Wheel is often used as a model to teach mental, emotional, physical, and spiritual interrelatedness. Within the model of the circle, well-being can be sought, explored, and embraced.

The circle becomes a starting point—a place of entry, a place of relative comfort to approach art tasks, a place from which a therapeutic alliance may be formed. The circle of the Medicine Wheel is sacred to Native Americans, and those things sacred are regarded as somehow "capable of linking us more closely to a spiritual dimension of life" (Doore, 1988, p. 153). The spiritual dimension can be contacted through art and mandalas as well as song, ceremony, and sacred places.

The Importance of Mutual Respect and Understanding

When Columbus came to the new world, he thought he was in the Indies and so he called The People "Los Indios" (Indians) (Lord & Burke, 1992). I have often heard Native Americans refer to Columbus as "that guy who got lost"; it is clear that they would have preferred for him to stay lost—somewhere else.

The "rape" of the Native culture has been followed by grief, rage, shame, and acculturation, leaving many trapped between two worlds (Dufrene, 1991; Hallowell, 1991; Medicine Eagle, 1991). Discrimination toward Native people continues and is experienced as a deep wound that continually festers. Discrimination coupled with acculturation, which varies in degree from tribe to tribe, adds frustration to the pain. This is manifested in rage, sometimes easily discernible, sometimes subtle and disguised. At times it takes on the appearance and feel of reverse discrimination. This creates a most difficult and often painful environment in which art therapists must work. No matter how attuned, sensitive, or understanding of the origins of inherited rage one may be, discrimination feels the same to all people who experience it.

While writing this article I became aware that discrimination has to do with an imbalance of power and that white society holds the power. However, we have to be cautious about our assumptions. The Penobscots are a federally recognized tribe and a sovereign nation, although tribes differ as to how sovereignty is experienced. The Penobscots have their own school, social services, police and fire departments. They travel on Penobscot nation passports, have their own court, and their own government. The Council circle has been replaced, by agreement, with the governmental structure of Governor and Council who now sit at a rectangular table. The tribal government has full authority over personnel. Indian employees may attend and speak at Tribal Council meetings where major decisions are made that affect all employees. Non-Indian employees, however, are barred from Council meetings.

Moving beyond unconscious behavioral responses (Dufrene, 1991) is a tremendous challenge and, I believe, a slow, evolutionary process. Being caught between two worlds, Native people can't become whites (Deloria, 1983) and are infuriated by the "wannabees," those members of the fictitious tribe who seek to understand and embrace Native ways, often the same people who are moved to try to assist in healing the wounds. Mutual respect and seeking to understand one another are necessary starting points in therapeutic joining, and art media can be used to communicate both feelings and needs.

Art Therapy: Breaking Barriers, Building Self Knowledge

Art therapy is a vehicle for expressing those things that are most important to Native people. In my work with the Penobscots, spiritual/religious and cultural beliefs continually emerged as personal statements which reflected both individual experience and the embracing of the values of the family and community groups. Art therapy can allow the free choice and expression of Native American spirituality and, in doing so, strengthen one's sense of self.

Methodology includes emphasis on the client's interpretation and unconditional positive regard on the part of the art therapist. The therapist must be willing *not* to interpret or judge through his or her own cultural filter and must also be aware that the symbols of one's racial or cultural background may differ from that of Native American clients. The willingness not to interpret and the awareness that some symbols may have different or special meanings to Indian clients provide the safety needed for material to be revealed. The therapist will be constantly challenged by the need to balance his or her own desire for "deeper" material, with a firm understanding that Native American "secrets" are not easily handed over and even broadly expressed concepts of Native American spirituality and values are an honor for the therapist to know.

While expressing, exploring, and clarifying personal beliefs, values, and experiences, clients begin to see how their view relates to their culture and how they fit into it. This is a functional way to recover identity, by seeing one's self as an Indian man, an Indian woman, or an Indian child belonging within the community and living in ways that honor one's heritage. Refinding or remembering one's place in the family/community circle helps to take clients out of isolation and provides a sense of belonging. This belonging and joining with others is important, not because a non-Indian therapist may identify it as such, but because in Native American culture the group and consensus are strongly valued (Wall & Arden, 1990). It is equally important because varying degrees of acculturation, defined as modifications in the culture which have resulted from the influences forced upon it, create conflict for Native American clients that is often presented during a session. Such was the case with the Penobscots who, having lost so much of their culture, are struggling to reestablish Indian traditions and values, while continuing to walk in both worlds.

In the art expressions of the Penobscot people, aspects of Native American spirituality such as the Medicine Wheel, sweat lodge, herbal usage, power animals, and spirit guides appeared and reappeared over the 2 years during which I worked with them. The reader is reminded to consider that entering "Indian Country" and labeling such beliefs as "mysticism" would be a value judgement and would set up an incongruity that would negatively affect the art therapist's ability to establish trust and a therapeutic alliance.

Art therapy was conducted in both individual and group sessions. However, no men expressed interest in group work. One-on-one sessions were based on individualized treatment plans written by the client and therapist and designed to address presenting problems that clients had selected. A women's group was formed and met for 2 hours, once a week, for 8 weeks. At the end of the eighth session, participants completed evaluations which included responses to what was most enjoyed and what was least enjoyed, and suggestions for future groups.

To safeguard against the therapist imposing white society values on group direction, a planning meeting was held to identify art tasks or themes that participants wanted to explore. This was also done in keeping with the value Native Americans place on consensus. As a result, each session included time for introducing the art project, artmaking, processing, and closing segments. Groups started with an opening circle of greeting, followed by relaxation exercises, which were quite popular. Group work included creative journaling, shield making and mandala drawings, beadwork, mask making, guided imagery, and visualization exercises designed to allow maximum room for the client's personal guidance or cultural connection to come forward. Readers may find it of interest that the Penobscots expressed openness to adopting Indian traditions from other tribes. Because so much of their own ways have been lost, they affirm their Indian identity through connection with other tribes and a kind of melding of traditions.

"Creative journaling" (Capacchione, 1979) was introduced to encourage art-making and personal exploration outside of formal group time. Wherever possible, cultural connections to art exercises were provided through the presentation of examples in articles, books, and art photography. The value placed upon the circle in Native American culture was formally discussed prior to the shield making and mandala drawings. Articles and examples of Native American-made shields and the use of the circle were provided. In addition to discussion and information presented about the many Native American tribes who were mask makers, a field trip to an art and antiques shop provided inspiration. The owner, a worldwide traveler, had collected masks from many cultures which gave examples of using a variety of materials in exciting ways. Guided imagery and visualization exercises included discussion about shamanic "journeying." Some of the participants had had this experience, as well as exposure to visions which came through Vision Quest or Sweat Lodge ceremonies.

The works included in this paper were made in both individual and group sessions. The reader is encouraged to study the references listed for in-depth information about the Web of Life, Medicine Wheel, Sweat Lodge ceremony, power animals, herbal medicine, and spirit guides. While some may consider these to be only broad concepts of Native American spirituality, they are integral to the therapist's understanding of the Native world view. Any information shared in session must be treated with due respect; to push for more according to the therapist's need would break the bond of trust and most likely result in the client terminating. In addition, while the reader may desire more details regarding information shared by clients in the following examples, this is not possible. Of the total Penobscot population, only 462 people reside on the reservation, a small island in the Penobscot River. Since everyone knows or is related to everyone else, to reveal more would compromise client confidentiality.

In work that one client titled "Strength of the Women's Circle" (Figure 1), a young mother recovering from alcoholism and a recent separation from her husband expresses a celebration of women. The circle, she said, "is where we as a tribe can draw out our strength." The face "radiates serenity slowly awakening." At the same time she identified with joining the circle, this client was able to "see" that not all of the stars are totally connected, a reflection of her seeking to release self-isolation. The value Native Americans place on the circle and community is illustrated in this oil stick painting.

In Figure 2, titled "The Lodge," the sacred Sweat Lodge is seen in the center of the circle. The client indicated that the cross represents the four directions of the Medicine Wheel (American Friends Service Committee, 1989; Freesoul, 1986; McGaa, 1990). The radiating lines on the top of the drawing, which were executed in glowing, orange tones, represent morning's light. The bottom half of the drawing shows blue Northern lights against a purple sky. The Native woman who drew this piece described its personal meaning: "The stars give one the feeling of being out there, also a deep connection to the universe, a deep reverence of our Great Creator, the Maker of all living things.... We gather together in one sacred prayer, in one small space. Holy grounds, the sweet smell of our medicines...the great relief of letting go of whatever it is we need letting go of.... Thank you Creator for the gift of the Sacred Lodge." In this pastel drawing, the client has clarified her spiritual values, as well as created a means of communicating and sharing them. The Web of Life is beautifully represented as is the Sacred Lodge.

In the "Shield" (Figure 3), the stars express a reflection of the universe and a Native Woman kneels with up-lifted arms. The feeling is one of being centered and reverent. The artist shared that "the shield was made to honor women for their role in providing the structure for cultural continuity." This coming together of circles of women who work diligently toward cultural nurturance and peace is also discussed in *Buffalo Woman Comes Singing* (Medicine Eagle, 1991). The shield was made of cloth stretched over a wooden hoop. Felt was embroidered to the background, and paint was added for accents. Again, this client has found a way to state her personal and cultural values through art therapy and to share them, thereby allowing communication to open.

Figure 4 ("Medicine"), a facsimile of the original art, depicts medicine or herbs and plants considered sacred. This is perhaps an example where a therapist's interpretation, coming through his or her own cultural filter, could go awry. The two curving

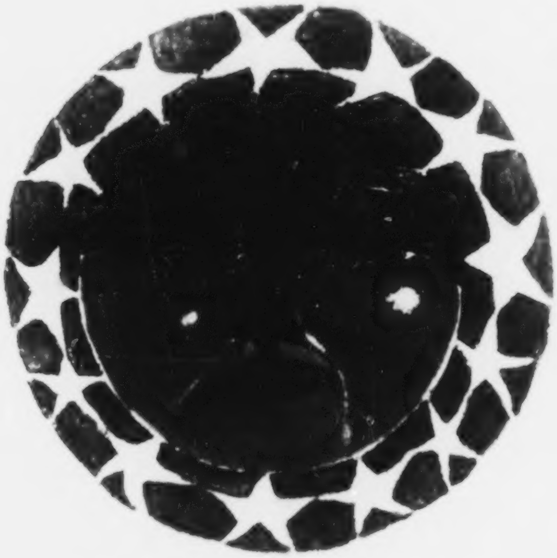


Figure 1 Strength of the Women's Circle

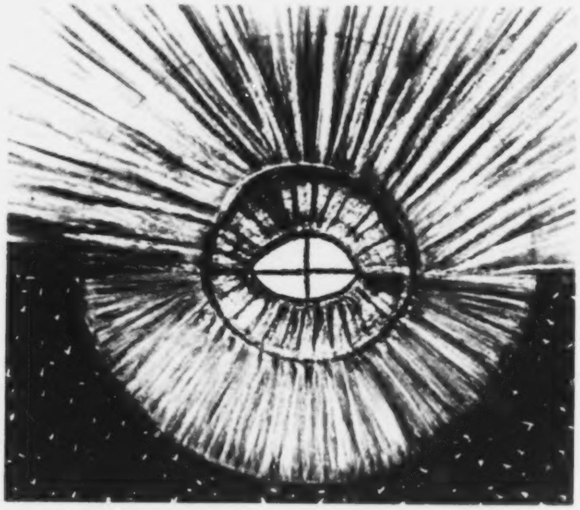


Figure 2 The Lodge

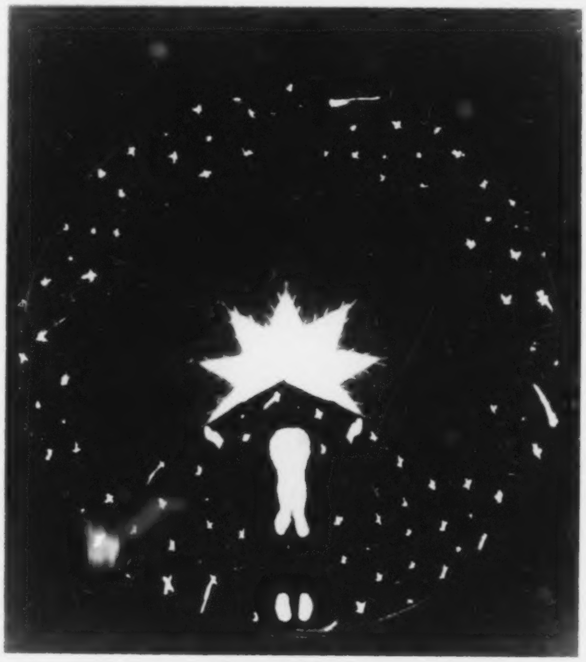


Figure 3 Shield

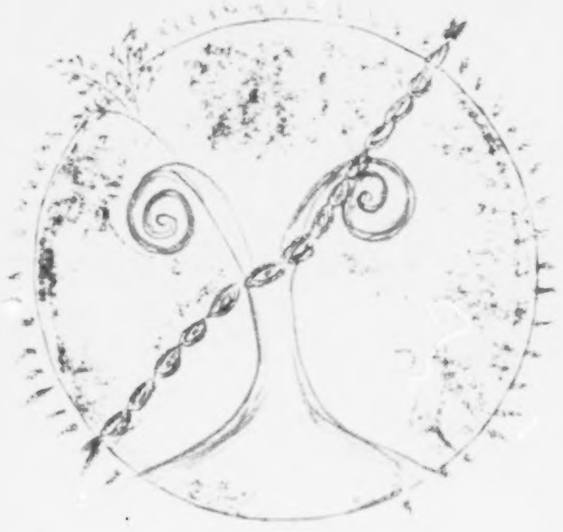


Figure 4 Medicine

forms, which may appear to be a woman's reproductive system or fallopian tubes, are intended to depict the Fiddlehead plant, a popular, edible plant. Its rounded ends are often seen in the curved designs of Penobscot art. The braided line crossing over the Fiddleheads represents Sweetgrass, burned in ceremonies, and in the upper left is a sprig of Cedar (Meadows, 1991, p. 78). This client deeply valued Sweat Lodge ceremonies and community activities which supported the culture.

"Rage" (Figure 5) was formed from clay and natural materials during a series of group mask-making sessions. The client talked about the revelations it brought: "Working on my mask was an experience of acceptance of my anger. I had no idea what my theme was to be, and out came this angry face. My anger has been a part of me I'd rather disown. I was able to look at what I didn't want to before. People who viewed my mask noted that they could easily understand and identify with how that feels, and that helped me not to feel alone with my anger." Created in red clay, brass-tone beads, shells, and bones, the mask has penetrating green eyes which tend to draw in the viewer and requires contemplation. Indeed, this client gained group support and a sense of belonging from verbally processing the art in the session.

In "The Leap" (Figure 6), the circle is once again seen as a holding place for important material. The deer is the client's power animal and guardian (Carson & Sams, 1988). The deer also represent different stages of her growth. The client explained, "The deer on the bottom tells how frightening change can be, how we can become paralyzed by fear. The middle, slightly larger deer is more mature and ready to take the blind leap. The elder deer is looking back toward the direction from which she came." This client was following a path of personal growth which included shamanic journeys (Doore, 1988), Sweat Lodge ceremonies (Freesoul, 1986; McGaa, 1990), meditation, and regular art therapy. The more she "listened," the more messages she received, and the more confident she became in trusting her inner guidance.

Figure 5 Rage

Figure 6 The Leap

Conclusion

The special challenges of multicultural work require art therapists working with Native Americans to develop knowledgeable and well-timed approaches. This happens when the art therapist has prepared, as much as possible, by developing an understanding of the areas of trust, common ground, and mutual respect and understanding affecting their ability to form concordant therapeutic alliances.

Clients develop trust slowly, which is often difficult and frustrating for both the therapist and the client. But those who are willing and ready will make their way to the art therapy room in their own time. Also, bidirectional racial hatred will take a long time to heal at the present rate. Mutual respect and understanding must be sought and exercised by each of us at every opportunity. As therapists, and as individuals, we must continue to seek as many avenues of open communication as we can.

Art therapists can honor the sacred circle and put it to good use as a starting point and safe haven for the unfolding of the client's world view. With as much accurate information about Native American culture as can be gained, we can begin to move forward and formulate art experiences that build on the strengths of Native values. The use of the circle, natural materials, and the acknowledgement of the long history of Native American artmaking encourages expression. Unconditional positive regard and supporting clients to freely interpret their own symbolic speech opens the way for understanding, sharing, and transcending barriers. As clients explore their values and conflicts through art therapy, they begin to put together the fragmented pieces, and they gain a sense of connection, wholeness, and serenity.

References

American Friends Service Committee. (1989). *The Wabanakis of Maine and the Maritimes*. Bath, ME: Maine Indian Program.

Andrews, W., (1989). *Counseling with American Indian clients: A review of the literature*. Unpublished Master's thesis, University of Maine, Orono, Maine.

Borden, E.S. (1979). *Psychotherapy: Theory, Research and Practice, 16*, 256–260.

Campbell, J., & Moyers, B. (1988). *The power of myth*. New York: Doubleday.

Capacchione, L. (1979). *The creative journal*. Athens, OH: Ohio University Press.

Carson, D., & Sams, J. (1988). *Medicine cards*. Santa Fe, NM: Bear.

Claiborn, C., & Robinson, S. (Eds.). (1991). Multiculturalism as a fourth force in counseling [Special Issue]. *Journal of Counseling and Development, 70*(1).

Darou, W.G. (1987). Counseling the northern native. *Canadian Journal of Counseling, 21*, 33–34.

Deloria, V. (1983). *God is red*. New York: Dell.

Doore, G. (1988). *Shaman's path: Healing, personal growth and empowerment*. Boston: Shambala.

Dubray, W.H. (1985). American Indian values: Critical factor in casework. *Social Casework, Jan.*, 30–37.

Dufrene, P. (1991). Comparison of the traditional education of Native American healers with the education of American art therapists. *Art Therapy: Journal of the American Art Therapy Association, Spring*, 17–24.

Feder, N. (1981). *American Indian art*. New York: Harry N. Abrams.

Freesoul, J. (1986). *Breath of the invisible*. Wheaton, IL: The Theosophical Publishing House.

Gelso, V., & Carter, J.A. (1985). The relationship in counseling and psychotherapy: Components, consequences and theoretical antecedents. *The Counseling Psychotherapist, 13*, 155–243.

Hallowell, R. (1991). Studies try to pinpoint the causes of alcoholism. *The U.S. Journal, Feb.*, 5.

Haviland, M., Horswill, R., O'Connell, J., & Dynneson, V. (1983). Native American college students' preference for counselor race and sex and the likelihood of their use of a counseling center. *Journal of Counseling Psychology, 30*, 267–270.

Heinrich, R.K., Corbine, J.L., & Thomas, K.R. (1990). Counseling Native Americans. *Journal of Counseling & Development, 69*, 128–132.

Lord, L., & Burke, S. (1992). Those first Americans. *Readers Digest, Jan.*, 99–102.

Luborsky, L., Christ, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes*. New York: Basic Books.

Luftig, R.L. (1983). Effects of schooling on the self-concept of Native American students. *School Counselor, 30*, 251–260.

Maine Historical Society (1977). *The Indians of Maine and the Atlantic Provinces*. Portland, ME: Author.

McGaa, E. (1990). *Mother earth spirituality*. New York: Harper & Row.

Meadows, K. (1991). *The medicine way*. Rockport, MA: Element.

Medicine Eagle, B. (1991). *Buffalo woman comes singing*. New York: Ballentine.

Silvin, C. (1986). *Maskmaking*. Worcester, MA: Davis.

Stevens, S. (1991). Alcohol and world view: A study of Passamaquoddy alcohol use. *Journal of Studies on Alcohol, 9*, 122–143.

Wall, S., & Arden, H. (1990). *Wisdom keepers: Meeting with Native American spiritual elders*. Hillsboro, OR: Beyond Words Publishing.

Art Therapy: Journal of the American Art Therapy Association, 12(4) pp. 227-230 © AATA, Inc. 1995

"Art Is All the Feelings Trapped Inside": An Interview with Marilyn McKeon

Susan Spaniol, EdD, A.T.R., LMHC, Newton, MA

Abstract

This article is based on an interview with untrained artist Marilyn McKeon about her creative development, motivation, and process. It attempts to relate both her personal understanding of why she makes artwork and her experience of how she makes artwork in her own voice. Ms. McKeon's description of her use of artmaking for self-expression, self-understanding, and self-healing suggests that her creative process is motivated by a natural striving for mental wellness. This conclusion is consonant with the viewpoint of Hans Prinzhorn (1972), who amassed a huge collection of spontaneous artworks by untrained people in European mental hospitals. Prinzhorn theorized that the creative process is based on fundamental esthetic instincts common to all, contradicting the popular association of spontaneous art-making with mental illness. It is also consistent with the phenomenon of so-called "Outsider Art" by people who live or work outside the mainstream of contemporary culture and who produce art in response to "inner necessity" rather than conforming to the changing styles and movements of contemporary culture (MacGregor, 1989).

Introduction

This is not an article about art therapy. Rather, it is an attempt to relate the story of one woman's spontaneous use of art for self-exploration and self-expression in her own words. Because it is possible to discover the general in the particular, I have focused on the experience and meaning of artistic activity to one person to illustrate the integrative and healing power of visual imagery.

When I first met Marilyn McKeon at the opening of the exhibition "Art and Mental Illness: New Images" at Boston University, her three drawings were focal points at the entrance to the gallery. Selected by a jury from over 500 submissions, these works were characterized by a rich luminosity and haunting subject matter that would continue to draw the attention of gallery visitors throughout the exhibition. When I decided to interview artists about their creative processes the following year, I was eager to visit Ms. McKeon to explore her approach to art-making and see more of her drawings.

Located at the end of a dead-end street in a close-knit neighborhood, Ms. McKeon's home is respectable and modest. The front door is adorned with a plaque of a painted wooden duck, a wreath of dried flowers, and a Desert Storm bumper sticker urging Americans to support their troops. We met in the living room, which is decorated with flower pots filled with plastic flowers, a ceramic jar containing a ceramic dog and cat, and two conventional, mass-produced landscapes of the type often sold at roadstands. The home belongs to Ms. McKeon's father. Now in her mid-forties, she moved back with her teen-aged son after her mother's recent death.

Creative Development

Visual art was unimportant to Ms. McKeon as a child. She remembers making "stained glass windows" by drawing meandering black lines on paper and filling them with colors. "I had hardly any talent at all. It was just like doodling to me," she admits. She did not make art again until she was almost 30 and living with an artist, although she describes her work at that time as "just scribbles and colors and things like that." When her first husband left her several years later, she expressed her sense of loss through an outpouring of poems, "about 2,000 of them." But, as a "born-again" Christian, she decided they were "idols" and threw them all away, saying, "Easy come, easy go."

The next year, a close friend saw her doodling and said, "You've got some art talent there. I want you to use it." She told Ms. McKeon never to stop drawing. From that time on, she became a prolific visual artist, and her friend remained her mentor. Ms. McKeon explained, "She's the only one in my life right now. She's like a mother to me and I love her for that."

Although she spends many hours a week making art, Ms. McKeon does not identify herself as an artist. She submits work to group exhibitions only when urged by her friend and does not care whether anyone sees her work. She is uninterested in past art history as well as current art trends, and has no desire to increase her technical skills or range of media. "I don't even want to think of myself as an artist. I don't know anything about art as far as art history goes. I don't want to go to art classes. I just like doing what I'm doing now and that's it."

Creative Motivation

Art-making is a mode of self-exploration that helps Ms. McKeon uncover memories and recover feelings. It is also a process of self-expression that allows her to act out painful emotions, attain a cathartic sense of release, and experience a repertoire of varied emotions.

Ms. McKeon describes her memory as poor for both recent events and more distant memories. She reports that even when she can recall painful experiences, she has difficulty talking about them. "I think art is all the trapped feelings inside," she theorizes. "I suffer from agoraphobia and I think that a lot of my fears come right out on the paper—all kinds of emotions. It's very good therapy for me. Sometimes I just want to sit down and see what I come up with. I'm really questioning what's inside—to experience what's inside when I'm not feeling anything. When I draw and color, I start feeling things."

Through her artwork Ms. McKeon vicariously experiences emotions she cannot feel in her life. Describing her blunted reaction to her mother's recent death, she shows me a picture of "Princess Marilyn" mourning the death of her dog with tear-filled eyes. "I still haven't cried over my mother since about two days before she died, when I wept and wept. It was terrible, but I haven't cried yet. Not at the funeral or the wake—nowhere. But a lot has been coming out in my pictures about mothers and daughters. Since I've started on my art, I've had a lot of losses. And a lot of bad things have happened to me—extremely bad—and a lot of that comes out in my pictures. Anything I'm feeling comes out in the people and objects I draw in my pictures."

Opportunities to experience life and react to life are especially rare for Ms. McKeon because she rarely leaves home. Artwork provides a safe arena in which she can act out strong feelings. "I can be violent and I get violent a lot in my pictures. I feel angry feelings, sad feelings, happy feelings, even fear in my art." It also gives her a vehicle for experiencing a broad spectrum of emotions, from the painful and terrifying to the pleasurable and joyous. And finally, it provides her with a sense of relief and release. "If I didn't have my artwork," she confided, "I'd be very, very messed up."

Creative Process

The process of art-making itself is sometimes more meaningful to Ms. McKeon than its products. Like the Surrealists, she relies on spontaneity to tap her unconscious storehouse of memories and emotional responses. She begins drawing without a deliberate plan or idea about subject matter. "I start with a pencil to let my feelings out, and whatever comes, comes out. It's not like I'm going to draw a picture of you. I couldn't do that if I wanted to. I just draw whatever comes, what feelings come out. Sometimes I don't even know what the picture is until it's finished."

Ms. McKeon's artworks are often outlined with emphatic black lines and filled with strong, vibrant colors, which give them the luminous quality of stained glass windows. The subject is usually human figures in exotic clothing with decorative adornments (Figure 1). Oriented in relation to the overall design of the drawing rather than to a groundline, the figures often seem to merge with the space that surrounds them. The overall design quality is enhanced by rhythmic repetitions of designs that fill all the empty spaces of the drawing, creating the effect of an intricate tapestry woven in rich, glowing threads (Figure 2).

The most frequently drawn figures are exotic maidens (Figure 3); many are veiled; quite a few are pregnant. Describing them, Ms. McKeon says, "It just seems I draw a lot of them with veils over their faces or something, and closed mouths, trapped and frozen and feeling like that. Lately I've been starting with pregnant women, trying to give the impression of being pregnant." While her females are often exotically beautiful, her male figures can be menacing. According to her, "A lot of abuse comes out in my pictures." Although the subjects of some of her pictures are unpleasant, others can be humorous. For instance, she did a drawing called "The Sarcastic Fool" which depicts men who "have their mouths wide open, and they're putting their feet into it." And finally, many of her artworks are religious, with the cross appearing repeatedly as a motif that is both decorative and symbolic.

As an example of her approach, Figure 4 depicts a woman with sharp black lines running through her face. Ms. McKeon explains, "She's so frozen with fear that her face is cracking. It's like ice." Despite the vividness of the verbal metaphor and the drawing, she began drawing without any plan. "I started with her face. Basically I pencil it and then color it in. Sometimes it comes out different because I erase the penciling and do other pencil-

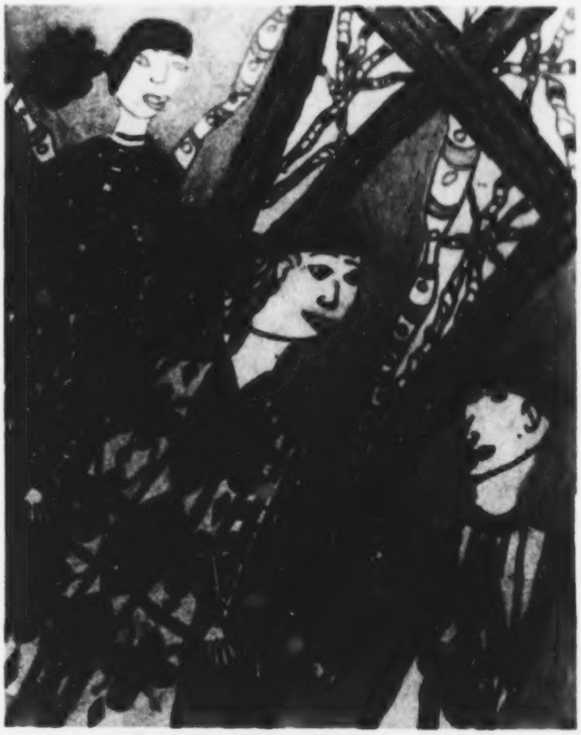


Figure 1 *Oriental Boys,* crayon and pencil, 11" × 14"

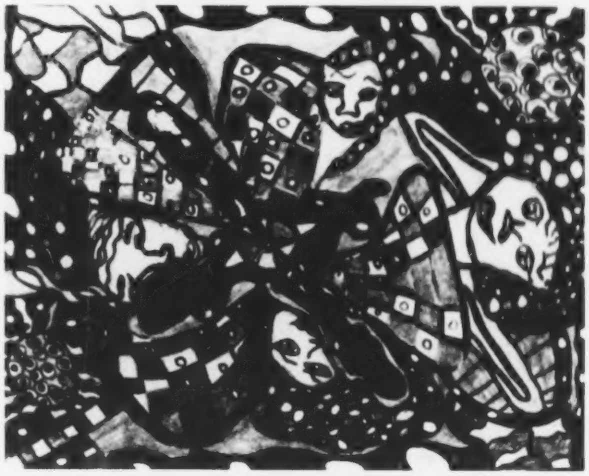


Figure 2 *Masked Pin-Wheel Girls,* prisma color, watercolor, magic marker, and oil pastel, 14" × 15"

ing, but I don't plan all that. I hardly ever plan. It just grows." Yet she has a specific, deliberate goal: to give form to her illusive feeling and thoughts." Even as I'm doing my art I tune in, like to the expression I'm using on the face. I really try to narrow in on the feeling. I try to express something. It takes more time because I want to prove something that I want to express."

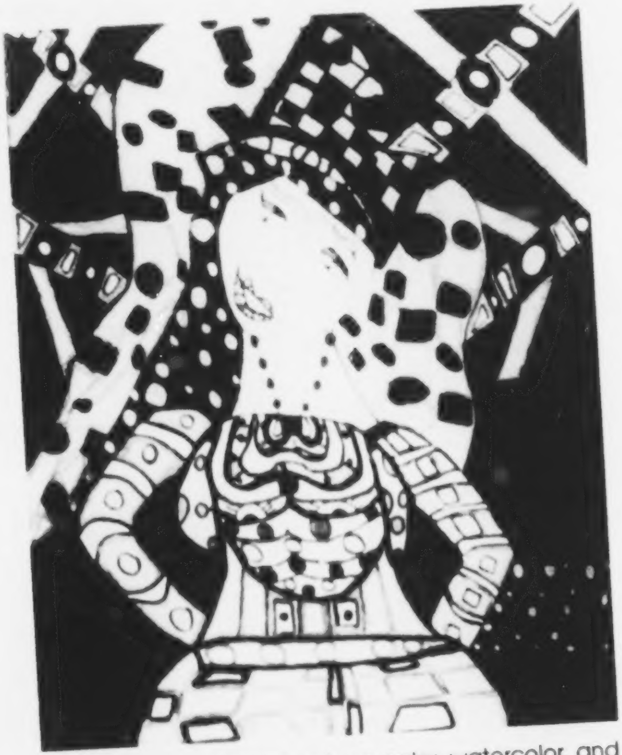


Figure 3 *Indian Princess*, prisma color, watercolor, and magic marker, 11" × 14"

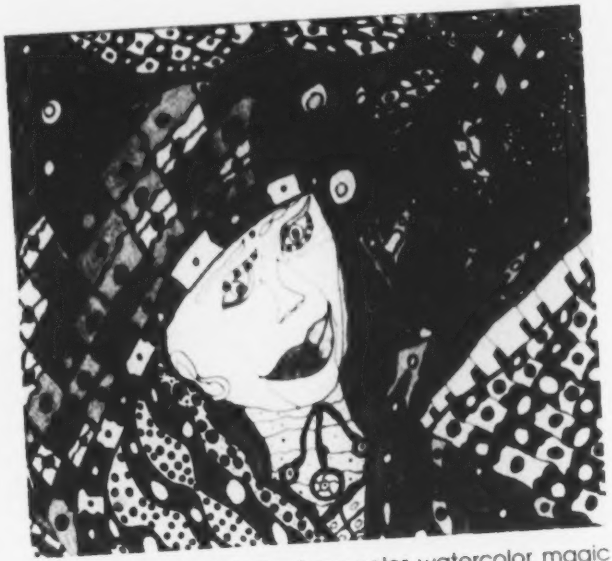


Figure 4 *Stage Fright II*, prisma color, watercolor, magic marker, and oil pastel

Although Ms. McKeon's approach is spontaneous, her handling of formal elements in her drawings is conscious and deliberate. She tries to make her artworks "structured and organized," approaching drawing "like a math problem, especially algebra, because I try to balance shapes and coordinate colors. My thinking is formal." It takes from five to nine hours for her to finish a drawing, and she often makes several a week.

When a drawing is complete, Ms. McKeon feels "pretty good" because she has "accomplished something and gotten [her] feelings out." For her, "getting [her] feelings out" seems to describe a cathartic experience. "Sometimes I hate it [the drawing], and that's all right. I feel a little bit better because I got the feelings out. That's very important. And then I just study it—the picture itself—to see what it means to me. And see what feelings I got out from the past that are trapped inside so I can't remember them on the surface. They're subconscious. I feel relieved after I do a picture. Relieved and clean inside."

Thus, despite long hours of intense labor, innate talent in the visual arts, and creative products of haunting beauty, Ms. McKeon does not consider herself an artist. She is indifferent to sharing her drawings with others, and she has no interest in developing her art in new directions. For her, the process of drawing is primarily a means of self-healing—a way to experience emotion, retrieve memories, and explore the outside world through her imagination.

A So-Called "Outsider Artist"?

The pleasure and fascination I experienced looking through stacks of Ms. McKeon's spontaneous drawings reminded me of my first exposure to artworks from the Prinzhorn Collection almost a decade earlier at a presentation given by Rudolf Arnheim in the Boston Museum of Fine Arts. The Prinzhorn Collection of Art includes 4,000 artworks done spontaneously by untrained patients who lived in isolated European mental asylums at the turn of the century. They were amassed by Hans Prinzhorn (1922), an art historian as well as a physician, who was puzzled and amazed by the prolific artmaking of many patients who seemed to experience a strong need for self-expression. Long before the days of art therapy, it was not uncommon for people to go to great lengths to obtain drawing materials, confiscating paper from wastebaskets, opening old envelopes, and stealing toilet paper to use as drawing surfaces. Many of these untrained artists would draw daily for hours at a time. They are often referred to as Outsider Artists because they lived and created outside the culture of their time. Not only are their artworks similar to one another's in many respects, they also share aspects of Ms. McKeon's drawings.

The subject matter of so-called "Outsider Art" is comparable to Ms. McKeon's. Art works by these artists often seem mysterious due to the private nature of their symbols, which seem to correspond to inner experiences rather than external reality. Their powerful effect often derives from frequent use of religious symbolism, sometimes in combination with visionary or apocalyptic themes. While this subject is meaningful to the artist, it may not be understood by others because of its personal origins and function.

The style of so-called "Outsider Art" is also similar to Ms. McKeon's. It is distinctive in its use of space and color and its overall organization and composition. Chief amongst its distinguishing characteristics is the density of its ornamentation. Surfaces are flat rather than modeled, and empty spaces are filled with various details, giving them an opulent, mosaic-like appearance. Perspective is often rendered form different viewpoints in a single picture or may be lacking completely.

The creative process of Prinzhorn's artists was also similar to Ms. McKeon's. Rather than starting with a mental blueprint, the artists drew people or objects in a form of automatism or stream of consciousness. Styles of artwork remained static instead of evolving in response to explorations and discoveries with the media. Once works were finished, the artists rarely wanted to share them with others. In fact, they often cast their artwork aside or discarded it because they were emotionally invested in the process, but not its products.

Art by people working outside the culture, especially those with mental illness, was often dismissed as mere scribbling until the 20th century. Due largely to the powerful images in Prinzhorn's collection, so-called "Outsider Art" that originates outside the mainstream of the culture is becoming a significant force in the contemporary art scene. During the past decade numerous exhibitions of "Outsider Art" have been held in the United States in well-established museums and galleries, such as the exhibition "Parallel Visions: Modern Artists and Outsider Art" at the Los Angeles County Museum of Art in 1992 and 1993.

The growing popularity of art by people who have experienced mental illness confronts the art world with provocative questions about the nature of art, the nature of mental illness, and the relationship between them. These questions—which probe the fundamental meaning and source of art—were recently addressed by John MacGregor (1989), an art historian trained in psychiatry and psychoanalysis. In his scholarly book, *The Discovery of the Art of the Insane*, MacGregor explores the history of art by people with mental illness. Like Prinzhorn before him, MacGregor's extensive training in art history as well as psychiatry renders him well-qualified to study both esthetic and psychological aspects of spontaneous artworks by untrained people with mental illness. Both scholars demonstrate how private art by these people often reflects the esthetic sensibilities and strong sentiments of their times. Each demonstrates how these artists employ the vocabulary of visual art to create powerful images that express universal human experiences common to all.

The Universality of Artistic Expression

Instead of focusing on the psychopathology of the artists represented, Prinzhorn sought to define the creative process of all people by studying the art in his collection. He analyzed the formal characteristics, or "pictorial configuration," of the works instead of the artists' psyches because he believed "that basic process would be essentially the same in the most sovereign drawing by Rembrandt as in the most miserable daubing by a parapalytic: both would be expressions of the psyche" (Prinzhorn, 1972, p. xviii). He postulated a fundamental drive towards self-expression, composed of urges to play, decorate, organize, symbolize, copy, and communicate. He theorized that the expressive function remains intact despite mental illness, and he concluded that the creative instinct forms the basis of all art and is basic to all people—children and adults, with or without mental illness.

While Prinzhorn's theory was criticized in Freudian circles for failing to analyze underlying unconscious motivations, his emphasis on the universality of the art in his collection was consistent with the Jungian notion of the archetype (MacGregor, 1989) and the collective unconscious. He suggested the possibility that "our patients are in contact, in a totally irrational way, with the most profound truths, and have produced, unconsciously, pictures of transcendence as they perceive it" (Oskar Pfister cited in MacGregor, 1989, p. 203). Like Jung, Prinzhorn accepted the notion of the unconscious, but he emphasized its creative and visionary powers rather than its pathology.

In his discussion of Prinzhorn's remarkable collection, MacGregor places art by people with mental illness within an historic context. He describes how the age-old stereotype of the artist as a mad genius reached its zenith in the 19th century with the Romantics' preoccupation with madness as the supreme source of creative inspiration. He recounts that many artists of the period sought inspiration through altered states of consciousness, heightened emotionality, and eccentric behavior. He reflects how, similarly, 20th century artists often strive to reflect their reactions to their inner worlds rather than depict the appearance of reality.

By supplying a historical context for art by untrained people with mental illness, Prinzhorn rejects the reductive analysis of art as clinical evidence, and passionately promotes it to the ranks of the finest art. He concludes his book with the admonition:

> Whether we call a person an artist or a madman matters little. In this century the two terms have been curiously interchangeable. What is essential is that the creative freedom of both is is maintained and protected, that within our society a way is kept open for those unique and courageous individuals who, shunning the surface and the light, seek, at the bidding of inner necessity, to descend into the darkness in search of themselves. (p. 318)

Conclusion

Prinzhorn's universal view of the origins of creativity and Jung's universal view of the origins of symbols unite Ms. McKeon's creative process with fine art done through the ages and with mainstream artists of our time. Their viewpoints suggest that the drive to make art in people with and without mental illness may be due, in part, to a natural striving for mental wellness. Their perspectives also foster appreciation of the complexity and depth of the human mind in general and link exceptional art to the rich mental heritage of all people.

Editor's Note: The author, Susan Spaniol, EdD, A.T.R., is an Assistant Professor in the Expressive Therapies Program of Lesley College's Graduate School of Arts and Social Sciences, Cambridge, MA. The artist featured in the article, Marilyn McKeon, reviewed it before publication and requested the use of her full name.

References

MacGregor, J. (1989). *The discovery of the art of the insane.* Princeton, NJ: Princeton University Press.

Prinzhorn, H. (1972). *Artistry of the mentally ill.* (Original work published 1922.) New York: Springer-Verlag.

Art Therapy: Journal of the American Art Therapy Association, 12(4) pp. 231-236 © AATA, Inc. 1995

Surviving Elimination of a Graduate Art Therapy Program: Art Education Revisited

Lucy Andrus, MS, A.T.R., Buffalo, NY

Abstract

Art therapy education may be in jeopardy with a number of state schools closing their programs in the past few years (Malchiodi, 1993). This paper examines one such program and the impact of its closing on the art therapy faculty. The discussion focuses on surviving such an event while retaining status as a member of an art education department. In this paper, the author shares reactions concerning the closing of a training program, discusses insights gained from this experience that have meaning for the profession at large, and describes steps taken to retain her academic position that involve a return to art education roots with an art therapy perspective.

Introduction

Until its closing in May 1994, I was the director of an AATA-approved graduate clinical art therapy program housed in the Art Education Department of Buffalo State College. The program was staffed by two full-time, tenure-track A.T.R. faculty and part-time A.T.R. faculty who taught one to two courses each semester. Publicly, "budget constraints" was the reason given for eliminating the program. After 2 years of talk by the administration of phasing out the program, the Art Education Department, consisting of seven art educators and two art therapists, was forced to decide how and where to allocate available departmental resources.

Although the Buffalo State program, with limited resources and faculty, was smaller than some other graduate programs on campus, enrollments were healthy and rising. It enjoyed the long-standing respect and support of the community, to which it provided a high level of service. Buffalo State College was the only school in the State University of New York (SUNY) system to offer graduate art therapy training, and the only school, public or private, within a substantial geographic area to offer affordable training. Furthermore, the demand for art therapy services in this region continued to grow and the trend of employing students upon (and often before) graduation had not abated. Thus, as Malchiodi (1993) pointed out, despite the "robustness" of a program and its contributions to the community, any art therapy training program is vulnerable to similar fate at any time (p. 126).

The intentions in this paper are threefold: (a) to discuss the practical aspects of surviving the elimination of a program, (b) to share what it was like living through the phase-out of a graduate program with a successful track record and a 15-year history, and (c) to focus on the process of returning to art education that may have relevance to the profession at large. In light of the fact that a number of programs have closed their doors and more are threatened with closure, it is important to think about available options for art therapy faculty who have not been eliminated along with their programs, who want to remain in higher education, and who do not wish or are not able to leave their schools for similar positions elsewhere. For many art therapy educators with families and children, relocation is not a viable option.

Having earned continuing appointment (tenure) in 1993, I am somewhat more secure than my untenured colleague. However, program elimination can affect even faculty with continuing appointments. Although I have experience and a Master's degree in art education, I find that I must still prove that I can readily return to my art education roots without the need for an additional degree.

I have not waited for others to decide my fate. From the time I was informed about the phase-out of my program, I considered ideas about what I could do to save my job. The lengthy period from announcement of the intent to phase out our program to its actual closing proved a blessing in disguise, allowing me time to struggle through the grieving process. While renewing ties through the National Art Education Association (NAEA), I began to develop a modified role and identity in art education, while maintaining my status as a clinical art therapist.

Student and Community Adjustment to Program Closing

One thing that helped me accept the program closure was to help others (students, graduates, field supervisors, agencies) adjust to this major change. Students who were partially through the program were assured that they could finish their studies and were given 2 years to do so by the administration. Most of the students who had just been accepted into the program when its phase-out was announced and could not finish in the allotted 2-year period decided to seek training elsewhere. A small handful who did not have the option to relocate or attend other programs were given special advisement and support by the art therapy faculty to remain at the college and complete a Master's degree in a related field; they would eventually obtain postgraduate clinical art therapy training elsewhere.

Most area art therapists had come to rely on our graduate program to fulfill many roles on behalf of the art therapy profession in Western New York State. The program functioned as a center for art therapy education and training, as disseminator of information about the profession at large; as a community liaison, sponsor of professional seminars, workshops, and other continuing education opportunities; and as general supporter and networking agent for area art therapists. Fortunately, the established network of art therapists and allied health professionals did not disappear with the graduate program and formed its own groups for support and promotion of the profession.

The strong reactions of undergraduate students planning on careers in art therapy were unanticipated. These students held meetings, wrote letters to the administration, and protested the closing of the art therapy graduate program. Knowing that the decision was final and that their complaints would essentially fall on unresponsive ears, I was especially attentive to this group, acknowledging their anger and helping them channel this angry energy in a constructive manner. I tried to instill hope that their career aspirations were attainable in ways other than attendance in our graduate program, paticularly for those whose finances and mobility were limited. I spent extra time disseminating practical information on other education and training opportunities. It often felt strange to be promoting other programs as the door shut to our own, but mostly I felt grateful that the profession of art therapy had grown to the point where there were other programs in existence to which I could refer applicants.

A Return to Art Education via Art Therapy

The Art Education Department at Buffalo State College continues to offer an undergraduate minor in art therapy and some graduate art therapy courses as well as the art education major. I now teach both art therapy and art education courses. In assuming this dual role I now find myself trying to keep up with the trends, literature, and conferences of two distinct professions; this is proving to be an engaging challenge. For example, today's focus on diversity and multiculturalism in art education resonates with art therapy's attention to similar issues in clinical practice. Reading the pertinent literature in both art education and art therapy has enriched my perceptions and understanding of each discipline's unique perspective. In turn, my classroom teaching is more amplified and more broadly informed.

Over the years art therapists have noted the relation between art education and art therapy (Anderson, 1980; Drachnik, 1978; Gonick-Barris, 1978; Kramer, 1980; Ulman, 1978). Some art education journals devoted entire issues to exploring this relationship (Mahlmann, 1980; Rogers, 1978). Indeed, the profession of art therapy has strong roots in art education. Most art therapists are familiar with the work of art education leader, Viktor Lowenfeld, who began to build the bridge between these two disciplines back in the forties, particularly through his work and research on the therapeutic aspects of art education for children with disabilities (Lowenfeld, 1975).

While this early exploration of the relationship between art education and art therapy produced valuable ideas and some initial alliances, the relatively young profession of art therapy focused on carving out its own niche in human services. Thus, defining and developing art therapy's own professional identity during the last decade and a half has taken center stage, and investigation of the connections between art education and art therapy has been de-emphasized in the process.

In the meantime, the field of art education experienced its own growing pains resulting in major change during the late seventies and early eighties, as the Lowenfeld-inspired paradigm for art education, which centered on children's creative self-expression through artmaking, shifted to discipline-based art education (DBAE). This new comprehensive approach to teaching art derives instructional content from four basic art disciplines: art production, art history, criticism, and aesthetics (Dobbs, 1992) and has resulted in de-emphasis in the art education domain of Lowenfeld's "art education therapy" ideas, therapeutic art, and the centrality of the psychological importance of art in the lives of children. These efforts to shape professional identities and define methodologies, occurring roughly simultaneously, are yet another similarity between art education and art therapy.

Certainly, my own particular situation forced me to rethink connections between these two related disciplines, both historically as well as for current relevance. Consequently, I began to see evidence suggesting that perhaps the time was right for the professions of art education and art therapy to reexamine their relationship and areas of mutual concern and interest. Rereading the literature from the late seventies and early eighties has been beneficial in many ways, including helping me to maintain a clear boundary between art education and art therapy. In the process of my investigation, I became able to articulate more distinctly the ways in which my department needed me, ways in which I could contribute to its mission and programs.

Common Ground

A number of factors at work today support the need for art educators and art therapists in higher education to again engage in professional dialogue. Three factors emphasize the philosophical and ideological connections between art education and art therapy: (a) the provision of services for children with disabilities, (b) preparation of art educators to teach children with special needs, (c) sensitizing art educators to teach children with unclassified special needs.

Factor 1

Since the implementation of Public Law 94-142 in the late seventies (the Education of All Handicapped Children Act), and the flurry of exchange between art therapy and art education that closely followed, the number of children in the United States requiring special education has grown dramatically. Recent studies reveal that 7.1% of students nationwide are classified as disabled (Ward, 1993). In New York State, the most currently available figure is 10%. Given the growth of special education referrals, coupled with the current inclusion movement in special education where children with disabilities are increasingly integrated into regular education programs, art teachers can expect to be responsible for growing numbers of children with special needs. Thus, as Di Chiara advises, the critical issue is "determining the most expedient way to prepare teachers to meet this challenge" (1994, p. 46). These words recall the prediction of Anderson (1980), who stated that the time was fast approaching when courses in art therapy would be a required component of teacher preparation programs in art education. The implementation of the Individuals with Disabilities Education Act (IDEA), a 1990 reauthorization and updating of the original PL 94-142, which has re-energized the movement to include children with disabilities in regular classrooms, also underscores the need for expedience in teacher preparation.

A great number of art teachers currently employed in schools have little or no background in working with children who have special needs. With the inclusion of special needs children increasing in many public schools, it is incumbent upon higher education to plan and implement appropriate curricula in exceptional education within their teacher preparation programs. A 1993 survey of colleges and universities offering degrees in art education in New York State indicates that only four programs required any coursework in exceptional education (Campbell & Russell, 1993). Evidence indicates that the educational preparation of art teachers for working with children who have special needs is woefully inadequate. Who better to fulfill this crucial training need than art therapists who are members of an art education faculty?

Some educators and administrators may argue that sending their art education majors to another department for a course in exceptional education adequately addresses students' training needs. This may be a good beginning, but it is neither satisfactory nor expedient. My concerns with this approach are twofold: Who interfaces the "art part" with the exceptional education part, and how? and What, if any, preservice experience do students receive that puts them in the field working with or at least observing children with special needs? Most educators will agree that preservice experience for student teachers is critical to their training. Furthermore, if what students learn about teaching exceptional children does not correlate with what they learn about teaching art, then much in that exceptional education class will lose its meaning and quickly fade for want of relevance (Andrus, 1994). A qualified art therapist with background in special needs could be the ideal faculty member to train art education students to work with children who are exceptional. Also, since the art therapist shares common ground with the art educator, he or she will be particularly adept at creating that essential interface. Many art therapists also have an art education background.

At Buffalo State College we urged the requirement of a course on art and special needs for art education majors within our department. Such a course already existed as part of the art therapy minor core and art education majors could take it as an elective. To make it a requirement appropriate for art education majors entailed updating course content, expanding and focusing course material to more purposefully address the needs of art teachers, and augmenting the fieldwork experience. The preexistence of this course was advantageous and timely, and may have lessened potential resistance to making it part of the art education required core.

Having developed the art and special needs course curriculum, I understand the advantages of placing these responsibilities in the hands of an art therapist. For example, through their experiences in this course, students are challenged to examine their stereotypical notions about persons with disabilities. Not surprisingly, most of the students' beliefs prove to be grounded in fear of the unknown, something which can be radically altered through the one-to-one encounters which the fieldwork component of the course provides. Art therapists understand that much of the students' anxiety is based on unconscious fears. Because emotional support is needed in helping people acknowledge and confront these kinds of fears, having a course instructor who is also a therapist is especially beneficial. When the instructor is willing to accept and tolerate diverse opinions, students are more willing to engage in discussion of these sensitive areas; consequently, students are able to work through negative feelings and constructively address personal prejudices. If we don't create this kind of experience for teachers in training, I have great concerns about what fears and stereotypes they may carry with them and how these attitudes and attending behaviors will affect the learning experience for children in the schools.

Also, I am in the process of establishing an on-going relationship with urban public schools in the Buffalo area to enhance the fieldwork experience for students taking the art and special needs course. This encounter, in turn, led me to write a grant proposal which was funded for development of a collaborative fieldwork project to be implemented through my department's art and special needs course.

Another avenue that we have pursued is the inclusion of a concentration in art for special needs within the graduate art education degree program. This concentration will prepare art teachers who will specialize in teaching children who are exceptional, but who do not wish to obtain clinical art therapy training. These "special art educators" will share some of the overlaps with art therapy previously mentioned, such as the ability to integrate art into the Individual Education Programs (IEP) of their students.

Factor 2

Education has yet to seriously consider the growing numbers of students with unclassified special needs in today's classrooms (clientele all too familiar to art therapists). Although these children exhibit very real "special needs" that impede the learning process, they are not recipients of a special education classification by Committees on Special Education and therefore do not receive intervention. This segment of the school population may include children who are abused, children who live with violence on a daily basis, children experiencing depression, or those who are neglected and come to school chronically tired and hungry. Others come from backgrounds where substance abuse, teenage pregnancy, marital strife, or other critical problems dominate family life. Many of these students, often referred to as "at risk," are ill-prepared to profit from teaching. Evidence suggests that the number of such students is on the rise (Vogel, 1994; West & Whitehead, 1993).

The presence of these children together with those having special education classifications clearly indicates that today's classrooms are filled with increased numbers of children who require adapted methods of teaching and learning. Arts teachers, who usually receive a majority of mainstreamed students in their classrooms, need appropriate preparation now more than ever. It will no longer be possible for teachers without some background in special needs to stumble through as was often the case when PL 94-142 and mainstreaming were initiated. As St. John has stated, art teachers "cannot assume expertise merely because an [exceptional] student has been placed in the art class" (1986, p. 15).

Who better in this respect than the art therapy faculty member to develop and teach the appropriate material to art education majors? I began to see important connections between the college's mission statement and ways we could prepare art education majors to work with children who are "at risk." Buffalo State College, located in an urban setting, places great importance on developing ties with the surrounding community, particularly through the inner-city schools. As director of the graduate art therapy program, liaison with the community was an integral part of my activities, and many of our students had worked in settings serving persons with special needs. Tying into the college's urban agenda in terms of the public school setting would be treading familiar ground in many respects; it would also be a shift easily accomplished by the art therapy faculty.

Factor 3

The third factor involves sensitizing art educators to teaching children with unclassified special needs. I teach courses on art for children with special needs, one of which is required for undergraduate art education students; the other is an elective for graduate students. In teaching these courses, I must consider what my art education students are experiencing in their fieldwork and the kinds of material they are bringing into group fieldwork discussion. In these discussions, with both undergraduate students who are doing fieldwork and graduate students who are actually teaching, I spend as much time addressing issues arising from children's struggles with the kinds of problems mentioned previously (violence, homelessness, etc.) and how those issues affect the teaching/learning exchange as I do talking about art education concerns. Almost all these teachers are working with children who manifest behavioral, emotional, or other "special needs" problems that influence the way lessons proceed and that requires teachers to alter their instructional approaches.

How are these unique areas of need in art teacher training being addressed? Who is teaching the art education major how to deal with the chronically sullen teenager in the back of the room, whose withdrawal and isolation are mobilized in response to the family disruption caused by an alcoholic parent and whose low self-esteem and low confidence consistently prevent him/her from engaging meaningfully and spontaneously in the art lesson at hand? Who is helping the art education major to deal with the 8-year-old whose consistent response to every art lesson is some variation of the refrain, "I can't do it. I'm no good at art. Will you do it for me?" Who is teaching the art teacher what to do when she or he receives children's drawings or paintings that consistently show inordinate levels of violence and aggression, images related to death and dying, literal acts of abuse, or any other number of disturbing elements? These examples are drawn from the real experiences of my student teachers.

Due to the nature of nonverbal communication and self-expression through art, art teachers are often the first to see signs of psychological distress in children as revealed in their images. I know of more than one art teacher whose sensitivity and awareness may have literally saved a student's life, or, at the very least, resulted in a much-needed therapeutic intervention.

Because of my art therapy background, I can address many of the needs stated above through supervision of the fieldwork and during class discussions. To help students reflect on their experiences in the field, I employ some of my art therapist skills, using expressive artmaking methods as the jumping off point for students to discuss their concerns and questions. This part of the students' supervision is analogous to the way countertransference is addressed in clinical supervision of students in art therapy programs. The art therapist/instructor, whose training encompasses the study of visual language and the use of metaphor and symbolic meaning in images, has visual as well as verbal information from the students concerning their fieldwork experiences. Such an enhanced view contributes to the accuracy and effectiveness of feedback given in supervision. This aspect of my teaching keeps me close to the "art therapist" part of me and greatly enriches the students' learning as well.

With art therapy faculty more actively involved in art education programs, students are graduating with a greater understanding of issues affecting today's children, issues that surface in the classroom and which cannot always be ignored. Happily, we are also increasing students' awareness about art therapy and art therapists and are planting the seeds for these future professionals to establish mutually beneficial relationships with each other. More than one art education student has sought consultation with an art therapist or recommended the involvement of a qualified art therapist for assessment purposes.

Art therapy educators can bring a unique perspective to the training of art teachers, especially today when more therapeutic teachers are needed in the classroom. This is not to say that teachers without additional training and expertise should make clinical interventions that are the domain of one who is trained to do so. (For more insight into this concern, the reader is referred to St. John's informative article, "Art Education, Therapeutic Art, and Art Therapy: Some Relationships," 1986, published in *Art Education*, the journal of the National Art Education Association.)

Conclusion

Increased awareness and understanding of the issues discussed in this paper on the part of administrators and members of my department have strengthened my position by providing an initial, well-defined agenda for service that is perceived as valuable to the art education programs at Buffalo State College. This has made survival of the elimination of the art therapy program possible as well as productive. My art therapy colleague and I have currently been assigned responsibilities for coordinating and supervising student teaching and general departmental advisement of students entering the art education program. Perhaps the administration recognizes the unique skills we bring to such tasks which require abilities that are second nature to us. Furthermore, although the disciplines involved are distinct from one another, making the transition from supervising clinical art therapy interns to supervising art education student teachers can be accomplished with relative ease. With art as the common ground between these two areas of specialty, I am reminded that by adapting approaches as needed, the ability to be an effective art therapy supervisor has multiple applications to art education.

I am also discovering new opportunities for involvement on a college-wide basis, expanding my connections in the process. During a campus conference on excellence in teaching and learning, I recently presented the results of my preliminary research using expressive artmaking methods to study attitudes of undergraduate students towards student teaching assignments. This presentation led to an invitation by a faculty member in the Fine Arts Department to conduct an expressive artmaking workshop for his painting students. These experiences were not previously possible due to time constraints imposed on me as director of a graduate art therapy program. It seems ironic that in some ways, the work I am doing now may result in greater

Figure 1 "It's Going," tempera paint and gloss medium on paper

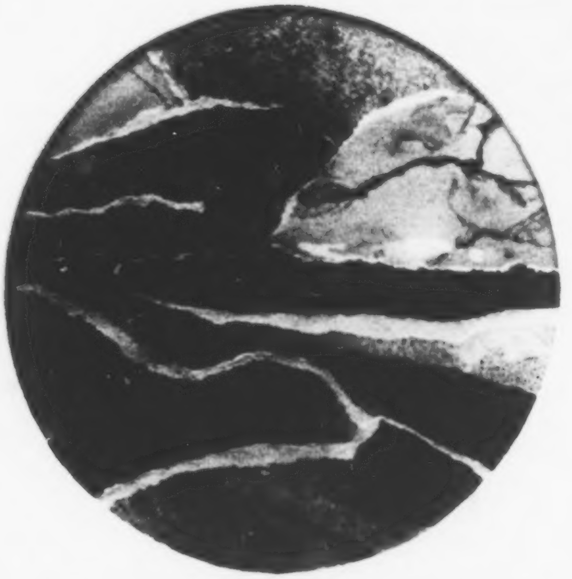


Figure 2 "Interiors 1: Rock, Sky, and Water," collage of torn, marbleized paper

awareness and advocacy of art therapy within my college community.

Some art therapists reading this may be wondering how I preserve my work and identity as an art therapist clinician. In addition to the ways already mentioned, I have maintained a small private art therapy practice which has served several purposes. One, of course, is my own desire to practice art therapy, but other purposes have included the need to keep my skills fresh and relevant in the classroom. Working with clients reaffirms my identity as a clinician, the "art therapist" part of me.

It will be no surprise to many art therapists that it took the crisis of losing my program to get me back into my own personal artmaking. Throughout the phase-out period, I found myself unable to ignore the urge to put color and shape on paper. I sat in my kitchen, with large sheets of paper taped to the refrigerator, moving tempera paints around with brush, fingers, and sticks while my daughter painted happily next to me (Figure 1). During those times when I felt more overwhelmed than usual, I did not paint; I tore and arranged pieces of marbleized paper to form small collages and framed them immediately. These small, intense images felt to me like "interiors," preserved parts of me that I could go into when I needed to fall back and regroup (Figure 2). Now, teaching an art materials course, I am constantly playing with art media and processes, often arriving at new ideas for therapeutic techniques as well as for art education purposes.

As much as I regret the loss of the art therapy graduate program, I am truly beginning to find enjoyment in my new work which, in some very elemental ways, is not so "new" at all. Maybe I am able to embrace these new avenues of work because I am at a time of life when change feels right and even necessary, and I can bring some part of my vision of art therapy and my art-therapist-self to others in new and unique ways. I also am satisfied with these new endeavors because I care about what is happening to the children of our country, seeing possibilities for making a difference through educating future teachers and encouraging them to find better solutions to problems.

It is possible to productively survive the closing of an art therapy program without losing your identity as an art therapist and while continuing to make valuable contributions to your place of employment. It is also possible to expand your own horizons in the process and reap rewards that are not so easily seen when the initial darkness pervades. The path I have chosen is just one possibility. So far, it has been an interesting journey, one whose value becomes clearer with each step.

Editor's Note: Lucy Andrus, MS, A.T.R., is an Assistant Professor in the Art Education Department and was Coordinator of the Art Therapy Studies Graduate Program from 1985–1994 at Buffalo State College, Buffalo, New York.

References

Anderson, F. (1980). Art therapy: Myths and realities. *Art Education*, 33(4), 18–21.

Andrus, L. (1994). Art education: An equalizing force in the inclusion setting. In *Inclusion* (pp. 23–47). [Monograph] New York State Council of Educational Associations.

Barlow, G. (Ed.). (1980). Editorial: Art therapy and art education. *Art Education*, 33(4), 4–5.

Campbell, D., & Russell, K. (1993). *A descriptive research survey to assess the needs of art educators who work with exceptional children in Western New York State.* Unpublished Master's thesis, Buffalo State College, Buffalo, NY.

Di Chiara, E. (1994). Teaching art to students with emotional/behavioral disorders. *School Arts, 93*(6), 46–48.

Dobbs, S. (1992). *The D.B.A.E. handbook, an overview of discipline-based art education.* Santa Monica, CA: The Getty Center for Education in the Arts.

Drachnik, C. (1978). Art therapy: Its relationship to art education. *Bulletin of the New York State Art Teachers Association, 28*(3), 32–33.

Gonick-Barris, S. (1978). Art education and art therapy: Partners in the classroom. *Bulletin of the New York State Art Teachers Association, 28*(3), 14.

Kramer, E. (1980). Art therapy and art education: Overlapping functions. *Art Education, 33*(4), 16–17.

Lowenfeld, V. (1975). *Creative and mental growth (3rd ed.).* New York: MacMillan.

Mahlman, J. (Ed.). (1980). Art therapy and art education: A special issue. *Art Education, 33*(4).

Malchiodi, C. (1993). Is there a crisis in art therapy education? *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 122–128.

Rogers, J. (Ed.). (1978). Art education, art therapy. *Bulletin of the New York State Art Teachers Association, 28*(3).

St. John, P. (1986). Art education, therapeutic art, and art therapy: Some relationships. *Art Education, 39*(1), 14–16.

Ullman, E. (1978). Art education for special groups: The emotionally disturbed. *Bulletin of the New York State Art Teacher Association, 28*(3), 4–6.

Vogel, J. (1994). Throw away the key: Juvenile offenders. *Utne Reader, 66*, 56–57.

Ward, D. (Ed.). (1993). Issues of inclusion. *New York Teacher, 35*(8), 11–15.

West, E., & Whitehead, E. (1993). We got trouble...right here in ...unless.... *NAEA Advisory*, Reston, VA: National Art Education Association.

Echoes Of The Renaissance
SCHOOL OF FINE ARTS
CARROLL N. JONES JR.
A Complete Step By Step Video Guide
To Renaissance Painting:

Tape 1: Theory of Light and Shade
Cast Drawing · Perspective · Proportion · Still Life Drawing
Tape 2: Canvas Stretching · Drawing on Canvas
Fixing and Toning · Under Painting · Egg Emulsion Tempera
Tape 3: Color Theory and Mixing
Application of Color to Still Life
The complete "Echoes Of The Renaissance"
Video series of 3 tapes can be purchased for $179.95
plus $9.00 UPS postage and handling
(For Vermonters add 5% sales tax.)
Individual tapes may be purchased for $69.95
plus $3.00 per tape for UPS postage and handling
Please make checks payable to: Echoes Of The Renaissance
and send your order to:
Carroll N. Jones Jr. PO. Box 1041 Stowe ,VT., 05672, (802) 253 8089

Art Therapy: Journal of the American Art Therapy Association, 12(4) pp. 237-243 © AATA, Inc. 1995

LA '94 Earthquake in the Eyes of Children: Art Therapy with Elementary School Children Who Were Victims of Disaster

Jasenka Roje, MA, Los Angeles, CA

Abstract

This paper discusses art therapy interventions with latency age children who were victims of the Los Angeles earthquake in 1994. The author worked with 25 children at the site of an elementary school in the area hardest hit by the earthquake and offers clinical observations about issues most relevant to the trauma, symptomatology, and defenses exhibited by children during treatment. In the course of therapy children were encouraged to tell their earthquake story in words and in pictures, to explore their current and repetitive thoughts, and to work through their feelings toward the resolution of the trauma. The use of art was instrumental in accessing children's internal processes and helping them return to normal functioning.

Introduction

On January 17, 1994, a powerful earthquake shook the Los Angeles area and left devastation behind: wrecked highways, destroyed buildings, power failure, fires, and thousands of people terrified to go back to their homes. This traumatic event was soon declared a national disaster.

Saylor defines disaster as follows: "destruction of property, injury and/or loss of life; has an identifiable beginning and end; adversely affects a large number of people; is 'public' and shared by members of more than one family, is out of the realm of ordinary experience; and psychologically is traumatic enough to induce distress in almost anyone, regardless of premorbid function or earlier experiences" (1993, p. 2). Disasters have a significant impact on children and 30% to 50% of the children become emotionally affected after disaster. "For them, the disaster feels like an unknown, fearful force which has shaken their world and made them feel less secure" (Farberow & Frederic, 1978, p. 6).

In the aftermath of the earthquake, FEMA (Federal Emergency Management Agency) secured a grant for mental health agencies to do on-site debriefings and crisis intervention with the earthquake victims. Several mental health agencies, including Family Service of Los Angeles, arrived at elementary and junior high schools in the area worst hit by the earthquake and provided counseling for children, faculty, and staff.

In the course of 3 months at Reseda Elementary School, an area in the San Fernando Valley close to the earthquake's epicenter, I worked with about 25 children ages 4 to 11, whom I saw mostly individually, in small groups, and occasionally with their families. To paraphrase Auerbach and Spirito (1986, p. 196), working with schools was potentially an effective way to deal with children's response to disaster, especially because families were disrupted and often living in temporary quarters. It also provided an opportunity to work in close association with teachers who were able to monitor children's behavior and alert the clinicians.

Therapeutic Issues Relevant to Earthquake Trauma

Gillis (1993) mentions several issues which may arise in the event of a natural disaster: immensity of loss, concerns about future safety, seeing adults paralyzed with fear, rescuers who arrive too late, and above all, difficulty in maintaining an inner sense of security under those conditions.

The common issue among the children at Reseda Elementary was the issue of safety, often associated with feelings of loss of control. Almost all of the children reported feeling unsafe in their homes. They were afraid to go to sleep because they feared waking up under the rubble of their bedroom walls. These children drew pictures of their homes with cracks in the walls, broken chimneys, and their family's possessions damaged, broken, and scattered. A 7-year-old, John, took a long time to draw a picture of his house with a large crack in the wall which he feared would collapse in an aftershock (Figure 1). Drawing the house with deliberate precision provided an opportunity for John to restore metaphorically the loss of control he was experiencing before the immensity of this devastation. Four-year-old David persistently drew vertical lines with circles (Figure 2), the

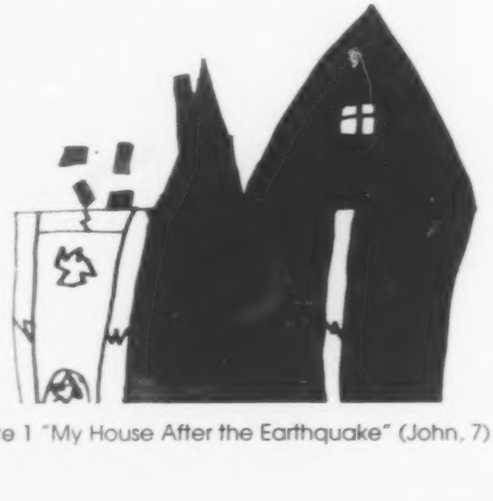


Figure 1 "My House After the Earthquake" (John, 7)

Figure 2 "See What I Can Do" (David, 4)

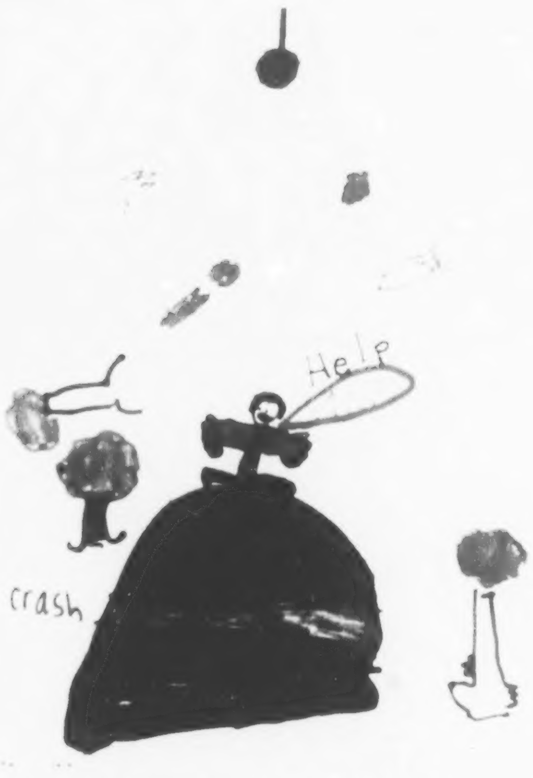


Figure 3 "Help Mom" (Jerry, 8)

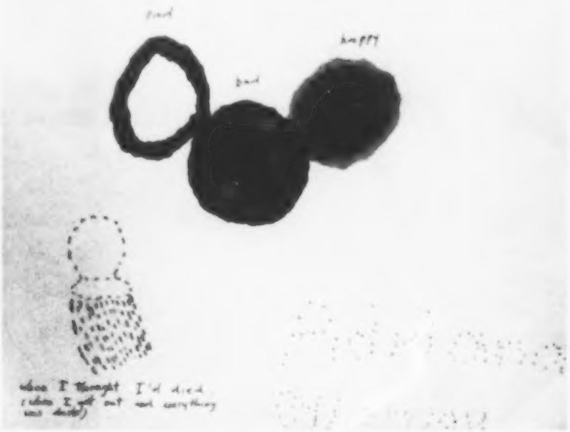

fear
happy
sad
when I thought I'd died (when I got out and everything was dark)

Figure 4 "When I Thought I Was Dead" (Laura, 8)

last skill he acquired before the earthquake. Even when asked to draw a different picture, he still produced the same pattern of lines indicating his need to maintain an inner sense of control.

Another issue related to safety was the issue of abandonment. Due to the great destructive power of the earthquake, which affected both children and adults, trust in the adult world to provide safety and comfort was somewhat shaken. Many children persistently exhibited symptoms of trauma even months after the initial shock, mainly because their parents were symptomatic themselves. Many parents reported feeling lost, confused, and frightened. These parents were unable to attend to the emotional needs of their children and often neglected older children in order to focus on the younger. One of the mothers was so terrified of the earthquake that she failed to empathize with her son, a behavior she had not exhibited before. The more she neglected her son's demands for comfort, the more he clung to her until finally refusing to leave her sight. An 8-year-old boy, Jerry, illustrated his feelings of abandonment in a compelling drawing where he yells HELP MOM, but there is no one to help him (Figure 3).

The children also had thoughts of permanent loss or death. Several children had concerns for the future because they were confronted, perhaps for the first time, with questions of death and dying. Laura, an 8-year-old girl, illustrated how she felt during and after the earthquake (Figure 4). After she identified her feelings as fear of destruction, sadness about losses, and happiness her family was still alive, she drew another shape distinctly different from the rest saying, "When I got out on the street and everything was dark I thought that I was dead. This is my feeling of being dead."

Symptoms of PTSD Exhibited by Child Victims of an Earthquake

The research of Guerin, Junn, and Rushbrook (1990) suggests that, according to parents' and teachers' reports, children who are victims of natural disasters experience increased clinging, difficulty separating form parents, disobedience, difficulty concentrating, and increased activity levels and aggressiveness.

Indeed, as the clinicians arrived on site several weeks after the earthquake, teachers reported increased behavioral and emotional problems with a fairly large number of children. Younger children mostly experienced separation anxiety and somatic ailments, whereas older children exhibited conduct disturbances and difficulty concentrating in class. The disturbances were exacerbated in those children who had premorbid functioning difficulties.

Keppel-Benson and Ollendick (1993) outline symptoms of PTSD in children as follows: (a) recurrent dreams and flashbacks demonstrated in repetitive play reenacting the trauma and/or intrusive memories during quiet time; (b) avoidance of thoughts, feelings, and activities associated with the trauma; and (c) increased arousal symptoms with difficulty sleeping, difficulty concentrating, and hypervigilance. In addition, DSM IV notes a sense of foreshortened future, "omen formation," disorganized behavior, and various somatic complaints.

Commonly reported by the children at Reseda were memories of trauma and nightmares. Since the earthquake hit during the night, the majority of children reported that bedtime was the most difficult time of the day and almost all children avoided sleeping alone. These children found it difficult to settle down because of their recurrent memories of the earthquake. As illustrated by 7-year-old Connie (Figure 5) who re-experienced in her drawing the feeling of being trapped in the darkness, the memory was still very vivid in her mind even several weeks after the earthquake. In contrast to memories of the earthquake, nightmares were more generalized and appeared usually as dreams of monsters, ghosts, or impending doom.

Many children experienced intrusive thoughts during quiet time at school or at home. Teachers reported increased talking or teasing during quiet reading, and many parents complained that their children feared to be by themselves even when going to the bathroom. Several children kept their doors open when using the bathroom or engaged in a conversation behind closed doors fearing to be left alone with their intrusive thoughts.

Avoidance of thoughts and feelings associated with the trauma was also frequently observed, mostly as avoidance of earthquake-related activities. Quite a few children avoided drawing pictures of the earthquake or talking about their earthquake experiences and chose to do other activities instead. Also commonly reported was hypervigilance. Both children and parents often complained that every sudden move or noise made their "heart stop" because it reminded them of the earthquake.

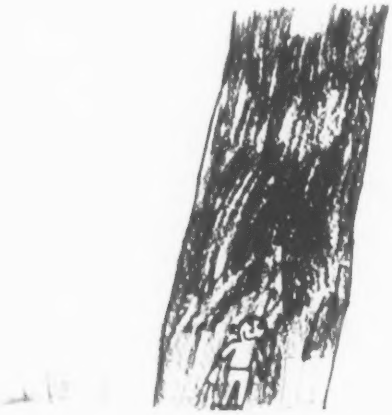


Figure 5 "In the Dark" (Connie, 7)

All of these symptoms occurred frequently at first and in time gradually subsided. Yet, recovery was somewhat prolonged due to an idiosyncratic feature of earthquakes, the continuous occurrence of aftershocks.

Therapeutic Goals and Objectives

The primary goal of therapy was to help the children regain their inner sense of security and trust in the world by letting them express the feelings they were unable to process with their parents or caregivers. Individual or family therapy was indicated to best achieve this objective. Another goal was to help the children resume normal life as soon as possible. By talking about what kind of responses were normal in the event of an earthquake, the children were encouraged to share their feelings with other students. A group setting best achieved this objective. It was the therapists' hope that both individual and group therapy would help the children regain control over their lives and restore trust that could be projected into the future.

Therapeutic Use of Defenses

An initial therapeutic intervention involved letting the children tell about the trauma under controlled conditions. Especially in the beginning, many children re-created circumstances which occurred immediately after the earthquake. Telling their "earthquake story" served to vent the stress feelings with reduced intensity and at the same time created an adaptive defense by allowing children to add a positive aspect to the stories of terror and loss. As children needed to feel happy even in the darkest moments of their lives, they often made comments like, "But I was so happy that my family was not hurt," or "I was happy that my dog (cat, bird, fish) was O.K.," or even "I was really happy that I didn't have to go to school."

However, a few children appeared disinterested or restless when asked to tell their earthquake story and kept looking for other outlets. I interpreted this reluctance to talk about the earthquake as a defense and allowed these children to work through their defenses and to use them adaptively. The following are some examples of the defenses identified during treatment and used therapeutically to promote healing:

Denial—Children sometimes refused to talk about the earthquake or to draw pictures relating to the trauma because they "were not scared." Rather than re-experiencing the trauma in art, these children chose to play their favorite games or draw pictures which related to safer, pretrauma times. One 10-year-old ignored my directives to draw a picture of the earthquake because "it was boring" and asked if I was interested in soccer. Together we created a board game and played board soccer during several sessions without ever mentioning the earthquake. In time he started to regard me as his soccer pal and only then began to talk about his feelings.

Identification—Several children chose to draw dinosaurs or familiar heroes from movies and TV instead of earthquake-related subjects. Their omnipotent heroes who could defeat anything they choose became therapeutically important tools in restoring children's own omnipotent feelings destroyed in the earthquake. One 7-year-old boy persistently drew and modeled in plasticlay his wrestling heroes. One of the wrestlers was particularly powerful and ignored such "stupid things" as the earthquake. He never showed his feelings and was only interested in wrestling, always winning in the end. I commented that his hero didn't look very human by not showing his feelings and he replied, "That's the best part."

Regression—In some instances children were allowed to regress because too much pressure was building up at home or in school. One 6-year-old boy appeared frozen and unable to function in class. His attention and concentration had considerably diminished in comparison to premorbid functioning. After talking to this boy, it appeared that his mother was preoccupied with his younger sister, expecting her son to stay out of the way and thus emotionally abandoning him. Since this child didn't show much interest in drawing or play-acting the trauma, he was allowed to regress by doing scribbles. This activity helped him re-experience an earlier time when he was getting more attention from his mother. With a sparkle in his eye, he would ask the therapist "When are we going to make a mess again?"

Displacement—Sometimes avoidance of earthquake-related subjects had an unusual twist. Several children reported seeing suspicious shadows or hearing strange noises when alone and they attributed these occurrences to burglars or supernatural powers. One 8-year-old girl drew a burglar with a flashlight looking through her bedroom window and reported seeing the burglar every time she went to bed. Another 8-year-old drew a shadow of a hand appearing in his living room and following him around the apartment. It appeared that these children displaced their fear of earthquakes onto something equally frightening, but perhaps more manageable and more familiar.

Escape fantasies—Often, children created corrective experience of the trauma by drawing or modeling figures who were immune to earthquakes because they could fly or move fast from one place to another with specially designed devices. Figure 6, for example, shows a creature named "Rainbow Head" with a propeller on top of its head which helps him leave the land and hop above the rainbow whenever he chooses. This indulgence in fantasy of escape (Herl, 1992) helped restore some control over the immensity and unpredictability of the disaster.

On occasions, escape fantasies were supported by fantasies of revenge. One 7-year-old boy created a house on balloons which could detach in an emergency and fly up in the air. During the earthquake he could thus laugh at the "stupid earthquake" for trying but not succeeding to hurt him anymore.

Safe place fantasies—As part of the healing process children were encouraged to create a safe place for themselves in both drawings and play. This directive provided an opportunity to create an imaginary place where a child could hide in fantasy from intrusive thoughts and feelings. Eight-year-old Megan made a plasticlay bunny who was very scared of earthquakes but found a magic mushroom where she could hide when the earthquake hit (Figure 7) and her friend Rebecca, also 8, created an imaginary island where she would hide with her boyfriend under a nurturing apple tree (Figure 8). Some children, like Laura, included their families in their safe place (Figure 9), but many drew places where they were alone or accompanied by their pets. These images appeared to indicate how supported children felt

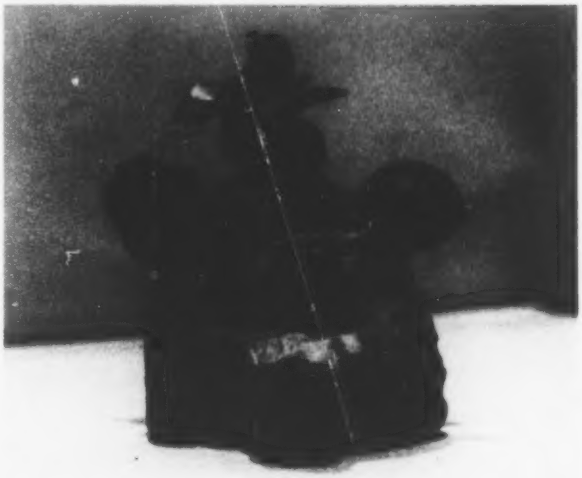


Figure 6 "Rainbow Head" (Jason, 10)

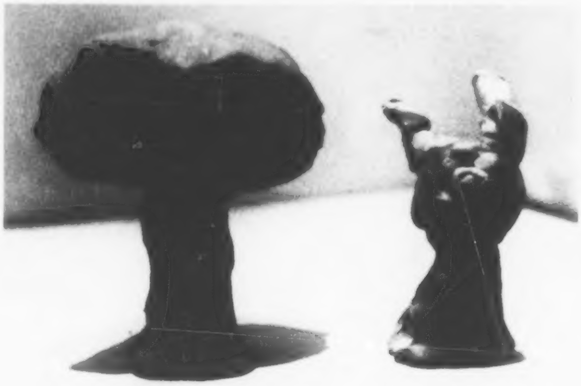


Figure 7 "Magic Mushroom" (Megan, 8)

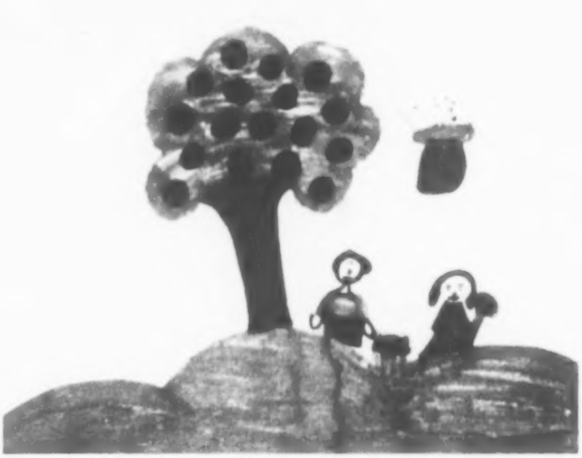


Figure 8 "My Boyfriend and I on Our Island" (Rebecca, 8)

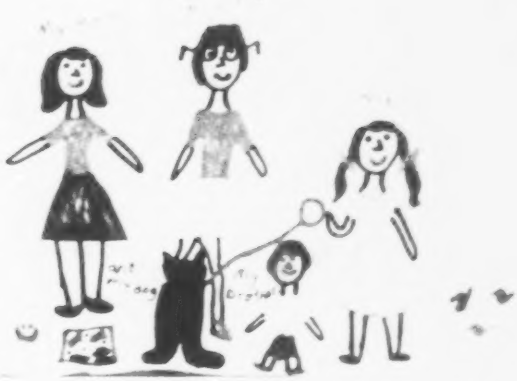


Figure 9 "My Safe Place" (Laura, 8)

by their parents or caregivers. One 9-year-old boy drew a picture of a tree with two street lights as his safe place. Puzzled at first by his choice, I noticed later that the picture was a view form the window where he was sitting. Apparently, the therapy room was the safest place this boy could think of.

Humor—On occasions, humor was introduced as a defense. Children enjoyed producing an earthquake at will by suddenly shaking the table and then laughing at the "frightened" therapist. Or, they were encouraged to tell funny earthquake stories. One 6-year-old told how he couldn't find his shoes in the dark and ended up wearing two different shoes. Another 6-year-old said he didn't realize what was happening when the earthquake hit. He thought his older brother was shaking his bed and kept yelling: "Stop it, stop it."

Intellectualization—Educating about earthquakes prompted some children to intellectualize about the event and become "experts" on the subject. This helped them manage their fear by knowing what to expect and by teaching others. One 10-year-old proudly reported how he impressed his family with his newly acquired knowledge about earthquakes in California, which in consequence made him feel more in control and improved his coping.

Use of Art in the Process of Therapy

Art therapy, combined often with play, was the therapy of choice. This included drawing pictures, creating figures in plasticlay, and telling stories relevant to the trauma. Crayons, markers, color pencils, and color plasticlay were preferred materials. These materials offered more control than some looser materials like watercolors, paint brushes, or clay (Landgarten, 1981). Younger children liked crayons and pencils while older children preferred markers, and almost all of the children enjoyed making figures in plasticlay and then playing with their creations.

The process of therapy followed the basic guidelines of crisis intervention with child victims of disasters. Gillis (1993) points out that early intervention provides the key to successful resolution of trauma and suggests the following: Discuss the facts around the event and clarify misconceptions, explore personalized meanings to the traumatic event, encourage expression of trauma if the child is avoidant, and allow the child to tell and retell the event. The goal is to restore previous functioning and help the child emerge from being a victim to being a survivor.

Initially, the children were allowed to vent through reenactment of the event in pictures followed by talking about what they saw, what they did, and what they heard on TV. The first directive was to "draw a picture of the earthquake the way you remember it." Nine-year-old Annie drew the house shaking while she was yelling for help (Figure 10), 8-year-old Maga drew jumping from the second floor of her apartment house into a mattress held by firemen, and 6-year-old Betty drew the safety of the family truck where her mother put the children after the quake (Figure 11). Five-year-old Eddie made a picture of a round black shape (Figure 12) and his parents commented that, immediately after the earthquake, Eddie drew several pictures identical to this one. This 5-year-old could not verbalize how he felt, but his drawing expressed that his world had disappeared into this black hole. Two weeks later when asked again to draw the picture of the earthquake, Eddie drew his bedroom instead of the black hole (Figure 13). His world had now reappeared and his contact with the environment was reestablished.

As children told about the event, they were encouraged to elaborate and draw more pictures. Pet stories were favored because pets were often in children's care and even more helpless then their young caretakers. Children frequently commented on their pets' acute sense of danger and showed empathy for

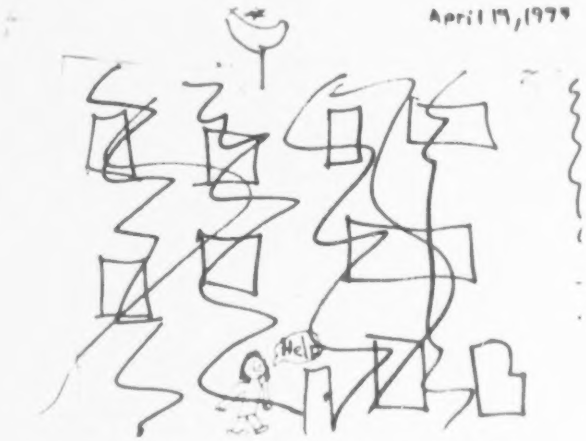


Figure 10 "My House Was Shaking" (Annie, 9)

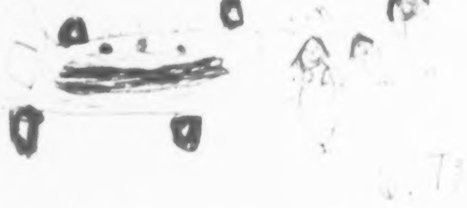


Figure 11 "We Stayed in the Truck" (Betty, 6) their pets' feelings. These stories allowed them to feel useful and competent in face of disaster. Eight-year-old Laura, in her picture of the family, drew her mother holding the baby and herself modeling after the mother by holding her pet bird (Figure 14).

Next, the therapist asked the children about their thoughts during and after the earthquake, how intrusive these thoughts were, and how often they occurred. The directive was to divide the paper in three parts and "draw a picture of what you think most at home, at school, and at night." By extending this directive the children were also asked to draw something which they cannot "shake off" from their mind. This provided an opportunity to explore their obsessive thoughts and also gave room for humor by gluing the picture onto their forehead and trying to shake it off.

When asked what they thought when the earthquake hit, the majority of the children said they knew it was an earthquake, but several of them believed there was a monster, a dinosaur, or even a vampire shaking the house. Some children expressed thoughts that the earthquake was the work of the devil, and these thoughts were often supported by their parents' beliefs and shows on TV foretelling the end of civilization. The therapeutic task was to educate about earthquakes and inquire about thoughts of guilt possibly ensuing from internalizing the trauma. Most of the children acknowledged and accepted the reality of earthquakes, but a few persisted in their beliefs that the earthquake was God's way of punishing them.

Sometimes the earthquake trauma was linked to previous traumas or losses. When asked to draw what she was thinking most when she was alone at home, 8-year-old Maga drew a tree in front of her house from which, she said, the voice of her dead grandfather was calling her. The earthquake triggered an earlier loss, the death of a grandfather who used to take her out and buy her candies.

The following directive was designed to encourage expression of trauma by acknowledging and validating feelings of fear, loss, helplessness, abandonment, and often anger (Landgarten, 1981). The directive was to "draw a picture of being scared, being sad and being mad." After the children had acknowledged their feelings in pictures, they were asked to "draw a picture of how you were feeling in the earthquake." The pictures allowed children to express feelings which were verbally censored. Annie was sad that everything was broken in her house; she was mad at the earthquake and happy when it was over (Figure 15). The picture of anger, however, which she tried to repress verbally, was

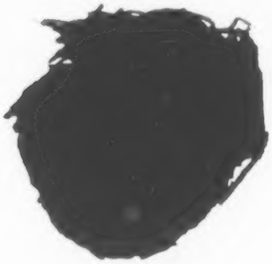


Figure 12 "Picture of the Earthquake" (Eddie, 5)

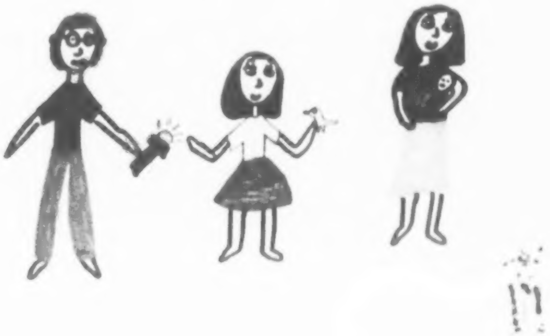


Figure 14 "My Family" (Laura, 8)

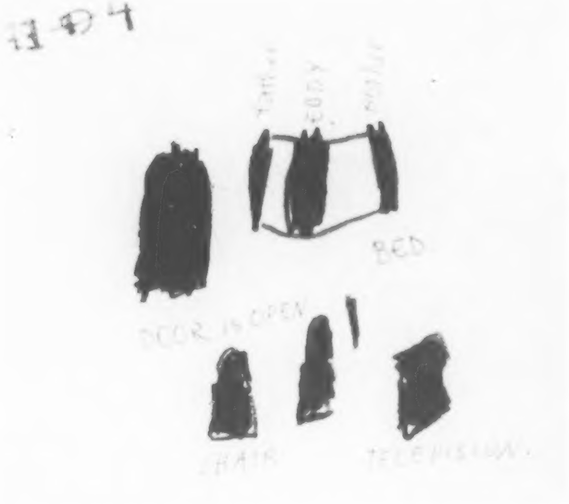


Figure 13 "My Room in the Earthquake" (Eddie, 5)

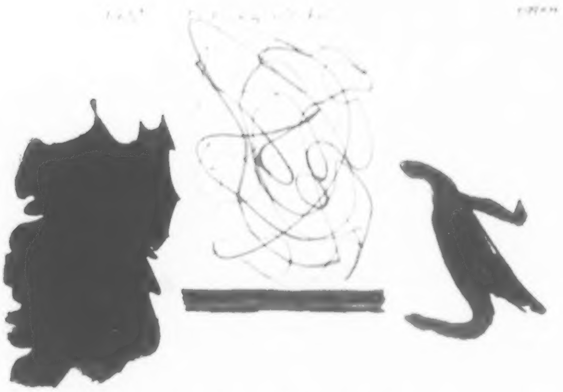


Figure 15 "I Was Mad, Sad, and Happy" (Annie, 9)

quite powerful in the drawing. On the other hand, her expression of happiness, which she was eager to share, was verbally extensive but poor in its visual counterpart.

Those children who were unable to draw a picture of their feelings because the idea was too abstract or because they had a hard time acknowledging their feelings were encouraged to express metaphorically by creating their favorite real or fantastic creature and telling how the creature felt in the earthquake. After completing their pictures (or stories) children were then asked to identify behaviors associated with the feelings. Some said, "I couldn't move, I was so scared" and others "I was yelling," "I was crying," or "I covered myself over the head with my blanket." Some children felt so angry they wanted to "kick that mean old earthquake" and some withdrew into saddening silence when they realized the extent of devastation. Part of this last directive was to help children manage their feelings after they had matched them with the behaviors. Some helpful behavioral and cognitive techniques were then used to reverse the negative thoughts or behaviors into positive: self monitoring, problem solving, and talking positively to oneself (Meichenbaum, 1975).

Conclusion

After three months of our stay at Reseda Elementary most of the trauma related issues had been addressed and processed. However, we realized that there was still a need for continuing support because of long-standing problems which had surfaced during treatment. Many children resisted termination and expressed it by an increased production of "angry looking" sharks, snakes, and guns. One 8-year-old built a plasticlay base into which he inserted several pencils representing a powerful long range cannon. During the last session he kept shooting at the therapist and shouting: "You are dead, dead, dead." These children felt angry, disappointed, and let down because their problems were only skirted and there was a long way yet to go.

Nevertheless, most of the children who were treated were able to resume normal life and return to their premorbid functioning.

Thinking back, several components influenced the recovery process. Since therapists arrived on site three weeks after the original shake, some of the debriefing was already done successfully by the teachers and by the children themselves. Therefore, not all children were symptomatic and quite a few were able to continue with their daily routine. And those children who exhibited symptoms of PTSD because, for various reasons, they were not successfully debriefed early on, in most cases responded fast to therapeutic interventions. However, children with ongoing problems which were unrelated to the earthquake trauma, continued to be symptomatic. Work with these children often uncovered emotional abandonment or neglect by care givers, physical abuse, and in one instance some evidence of sexual abuse was also detected in the drawings. Recovery became increasingly complicated with the emergence of such additional problems.

It appeared that children who responded best to the interventions were those who, according to the teachers, were generally better adjusted in school. These children were more cooperative, listened, and followed directives. After only a few sessions in group therapy, they were able to return to their classrooms relatively symptom free. On the other hand, children with ongoing problems at home or in school responded with more resistance and more behavioral problems. These children were treated for a longer time, mostly in individual and, when possible, also in family therapy. Finally, children who couldn't be helped because they required more intensive long-term therapy were referred out to community mental health clinics.

Art therapy proved to have been a successful treatment modality in the recovery of earthquake trauma. It enabled children to express internal processes which they had no verbal awareness of and it facilitated working through the defenses in order to identify underlying conflicts which hindered recovery.

In conclusion, working with art materials was a fun activity which all children appreciated and which helped disarm their initial resistance, if there was any. Through these children's eyes art became a mighty tool to fight the terrifying experience of the Los Angeles '94 shaker.

References

Auerbach, S.M., & Spirito, A. (1986). Children exposed to natural disasters. In S.M. Auerbach & A.L. Stolberg (Eds.). *Crisis intervention with children and families* (p. 197). Washington D.C.: Hemisphere Publishing.

Farberow, N.C., & Frederic, C.J. (1978). *The media in a disaster* (DHEW Publication No. ADM 78-540). Rockville, MD: National Institute of Mental Health.

Gillis, H.M. (1993). Individual and small group psychotherapy for children involved in trauma and disaster. In C.F. Saylor (Ed.). *Children and disasters* (pp. 165–185). New York: Plenum Press.

Guerin, D.W., Junn, E.N., & Rushbrook, S. (1990). *Children's reactions to earthquake disaster.* Paper presented at the annual convention of the American Psychological Association, Boston, MA.

Herl, T.K. McDougall (1992). Finding light at the end of the funnel: Working with child survivors of the Andover tornado. *Art Therapy: Journal of the American Art Therapy Association*, 9(1), 42–47.

Keppel-Benson, J.M., & Ollendick, T.H. (1993). Posttraumatic stress disorder in children and adolescents. In C.F. Saylor (Ed.). *Children and disasters* (pp. 29–43). New York: Plenum Press.

Landgarten, H. (1981). *Clinical art therapy: A comprehensive guide.* New York: Bruner/Mazel.

Meichenbaum, D. (1975). Toward a cognitive theory of self-control. In G. Schwartz & D. Shapiro (Eds.). *Consciousness and self-regulation: Advances in research* (pp. 223–260). New York: Plenum Press.

Saylor, C.F. (1993) Introduction. In C.F. Saylor (Ed.). *Children and disasters* (pp. 1–9). New York: Plenum Press.

BEST COPY AVAILABLE

Brief Reports

Use of a Drawing Task in the Treatment of Nightmares in Combat-Related Post-Traumatic Stress Disorder

Charles A. Morgan III, MD and David Read Johnson, PhD, RDT,
West Haven, CT

Abstract

Treatment of nightmares in two Vietnam veterans with post-traumatic stress disorder (PTSD) was conducted comparing a drawing task with a writing task. Our hypothesis is that the isomorphism between visual imagery and the visual modality of nightmares may provide a more effective means of transforming and integrating the traumatic material into normal cognitive schemas. In a 12-week intervention in which drawing and writing were alternated, both subjects reported reduction in frequency and intensity of their nightmares in the drawing condition. This study provides support for more extensive study of art therapy methods in post-traumatic stress disorder.

Introduction

Art therapy has been used successfully in the assessment and treatment of post-traumatic stress disorder. Art therapy techniques have increasingly been used to help mental health professionals diagnose and assess the degree of severity of trauma, from child abuse to acute stress (Blain, Bergner, Lewis, & Goldstein, 1981, Manning, 1987; Schornstein & Derr, 1978; Sidun & Rosenthal, 1987; Spring, 1993; Wohl & Kaufman, 1985; Yates & Beutler, 1985). Recently, reports of art therapy in the ongoing treatment of trauma victims have suggested that the acceptance of and working through of the shifts in self-representations resulting from trauma are greatly facilitated by the art process (Johnson, 1987; Kelly, 1984; Malchiodi, 1990; Naitove, 1982; Peake, 1987; Simonds, 1994; Stember, 1977, 1978). The transformation of mental images of traumatic events into visual expression via drawing allows trauma victims to communicate their inner pain nonverbally and less directly than through words. The play of form, color, and style allows metaphoric and partial expressions of trauma, in contrast to the direct representation of the event often called for by linguistic communication. The "canvas" provides a transitional space in which memory and current reality can mix within the perceived control of the subject, so that the ability to integrate previous self-images with the traumatic event is enhanced.

The reported effects of art therapy include improvements in self-esteem, integration, and stress reduction. None of the published reports indicates that art therapy can be a focused treatment for a specific symptom of post-traumatic stress disorder, such as reexperiencing, avoidance, or hyperarousal. Only Golub (1985) has reported on art therapy with Vietnam combat veterans. In that article she mentions one veteran whose recurrent nightmares ceased after rendering them in painting. Similarly, there have been few studies of nightmares among combat veterans with post-traumatic stress disorder (van der Kolk et al., 1984).

This pilot project examines the question whether art therapy, specifically a drawing task, can be targeted to impact on a specific and pervasive symptom of PTSD: nightmares. Due to the visual nature of the symptom of nightmares, it is hypothesized that the victim has recorded the traumatic event in visual form, which during sleep is released into consciousness, waking the subject. If, at the moment of waking, the patient immediately draws the nightmare, the possibility exists that the contents of the event are most available to consciousness and, therefore, can be integrated into the person's overall cognitive schemas.

We became intrigued by informal reports form patients of this effect after initiating an art therapy module in our inpatient PTSD program (Johnson, Feldman, Southwick, & Charney, 1994). Veterans in our program participate in weekly art therapy groups over a 16-week period. Individual art projects as well as a community art show are also important elements in their treatment.

In order to test the effect of drawing on nightmares, we conducted a structured intervention using two conditions on two subjects who were suffering from combat-related nightmares. The first condition consisted of drawing the nightmare immediately after waking. The second condition consisted of writing a nightmare immediately after waking. Both conditions involve the concretizing of the experience. The art task allowed the actual stimulus to be represented in nonverbal form, closer to the manner in which it was originally recorded. We were interested in whether differences in the modality of expression would result in measurable differences in outcome.

Subjects

Both subjects volunteered to participate and were Vietnam combat veterans (ages 42 and 44) who met DSM-III-R criteria for Post-Traumatic Stress Disorder (PTSD), by means of the Structured Clinical Interview for Diagnosis (Spitzer & Williams, 1985). Each was an inpatient in a 16-week PTSD program and reported the presence of combat nightmares that occurred four or more times in a one-month period prior to the trial. These nightmares were of real combat experiences. Both subjects were high school graduates with average intelligence and no prior experience with art therapy or art beyond elementary school. Neither had any learning disability or problem with written or verbal expression.

Description of the Nightmares

Subject #1—"I am flying the chopper down to the LZ (landing zone). It is a hot area, under fire. I have to go down to rescue my men. As I touch down on the zone, more enemy fire breaks out. A woman sniper pops up from a rat tunnel just in front of the cockpit and fires. She kills my co-pilot, then turns on me and fires. It just misses me and I take off. I can see her face clear as day, then I wake up sweating and my heart pounding."

Subject #2—"We are out on patrol and come into this village. We are pretty sure something's up because there are no kids around. All of a sudden one of the guys in my platoon gets hit. Goes down. We open fire. Then they come out. Everybody goes crazy and sets everything on fire, the old men, women, everybody.…I wake up screaming and my bed is torn up. I am covered with sweat."

Method

Subjects were told that they were to participate in an experiment that was to test the effects of both drawing and writing on an individual's ability to go back to sleep after having been awakened by a distressing nightmare. Each was informed that the test involved four 3-week intervals devoted to drawing or writing in an alternating ABAB or BABA format. Every effort was made by the authors to show no bias toward either condition.

During the writing intervals, subjects were instructed, in the event of a nightmare, to write the nightmare "in as much detail as possible," as soon as possible upon awakening. They were provided pens and a notebook for this purpose. Other than the restriction of not drawing the nightmare, subjects were free to stay up or return to bed.

During the drawing intervals both subjects were given a drawing tablet, a set of oil pastels, and a pencil to be kept at the bedside at all times. Subjects were instructed to draw the nightmare "in as much detail as possible" using the oil pastels. A subject could decide to draw the nightmare in its entirety or to draw the traumatic scene that had awakened him. As in the writing intervals, after having completed the drawings, subjects were free to do as they pleased with the exception of writing the nightmare.

Each week throughout the 12 weeks, subjects rated four variables. Frequency of the recurrent nightmare, Intensity of nightmare, and Startle upon awakening from the nightmare were rated on 5-point Likert scales (0 – 4). Difficulty going back to sleep after a nightmare (more than 1 hour) was indicated by a yes/no response. An overall measure of Nightmare Severity was created by multiplying frequency by intensity of nightmares.

Results

Quantitative findings: Table 1 lists the raw data for each subject for each week. Both subjects experienced fewer and less intense nightmares in the drawing condition compared to the writing condition. Difficulty returning to sleep and startle upon awakening were also improved, compared to the writing condition. A two factor ANOVA showed no significant differences between the two subjects, but significant differences in the measure of nightmare frequency, intensity, and severity; sleep difficulty; and startle (see Table 2). In addition, changes within each 3-week period indicate a cumulative effect (positive or negative) of each intervention (see Figures 1 and 2).

Qualitative impressions: Both patients reported a sense of frustration and difficulty during the intervals of writing the

Table 1
Raw Scores on Study Measures for Both Subjects

Week	*Mode*	*Freq.*	*Inten.*	*Overall Severity*	*Sleep Problem*	*Startle*
			Subject 1			
1	drawing	4	3	12	1	3
2	drawing	2	2	4	0	2
3	drawing	1	1	1	0	0
4	writing	1	2	2	1	3
5	writing	3	3	9	1	3
6	writing	3	3	9	1	3
7	drawing	1	2	2	0	1
8	drawing	1	1	1	0	0
9	drawing	0	0	0	0	0
10	writing	2	2	4	1	3
11	writing	3	3	9	1	3
12	writing	-------- patient quit writing ----------				
			Subject 2			
1	writing	3	3	9	1	3
2	writing	3	2	6	0	3
3	writing	3	4	12	1	4
4	drawing	2	2	4	1	3
5	drawing	1	1	1	0	1
6	drawing	1	1	1	0	0
7	writing	2	2	4	1	3
8	writing	3	3	9	1	4
9	writing	-------- patient quit writing ----------				
10	drawing	1	2	2	0	1
11	drawing	1	2	2	0	1
12	drawing	1	1	1	0	0

Table 2
Two Factor ANOVA (Subject × Modality)
of Study Measures

F(1.1.18)

	df	*Nightmare Frequency*	*Nightmare Intensity*	*Nightmare Severity*	*Sleep Problem*	*Startle*
Subjects	1	.01	.09	.01	.40	.26
Modality	1	10.99**	12.85**	11.53**	21.40***	31.26***
Subjects x Modality	1	.92	.09	1.09	.40	.26

** p < .01
*** p < .001

nightmares. In fact, both gave up the writing task in their last week. "I couldn't write fast enough." "It was more annoying to write." "I pushed too hard, the pencil broke...the words just didn't do it right." "I just got more upset inside." Subject #1 reported that during the drawing intervals, "I'm not sweaty and jumpy when I wake up. The nightmare wakes me up, but I'm calmer. More relaxed. I can go back to bed and go to sleep." Subject #2 similarly noted, "It's weird. I don't jump out of the bed anymore." "Writing? Well, I don't seem to be any good at writing. I get too tight inside. I tried it but it doesn't come out. I just get mad. I did it for 10 days but after that—no way! I don't see any difference. I don't know. I still sweat and pace around a lot."

Unexpected findings were the development and increase in aerial perspective in the nightmare and an increased sense of self-awareness while dreaming. "It's not like it happened. I'm seeing it for the first time from the air. I can see it all happening to me just like the situation always was, but I'm up in the air." "It's weird, I know that I'm dreaming while it's happening to me. I never did that before. I say to myself this is a nightmare about Vietnam."

Both subjects also experienced a change in their nightmare's chronological pattern. "The nightmare starts sooner than it used to. Instead of being at the ambush, I start way back at the base-camp. I wake up way before I get to the ambush."

Discussion

This pilot project attempts to explore the specificity of art therapy in the treatment of nightmares in post-traumatic stress disorder. The evidence illustrated by these two subjects is intriguing and raises the question as to the mechanisms involved in the therapeutic effect. Victims of trauma often show difficulties in processing emotional states, usually referred to as alexithymia (Krystal, 1979). Representing emotional states through language may be impaired, thus preventing writing from being an effective means of processing the traumatic material in the nightmare. Consistent with paradigms of cognitive development, however, traumatized individuals may be able to symbolize thoughts and emotions in other ways—specifically through imagistic, iconic, or symbolic modes rather than a lexical one (Werner & Kaplan, 1963). Therefore, we suggest that art therapy provides an isomorphic arena for the expression of the traumatic material.

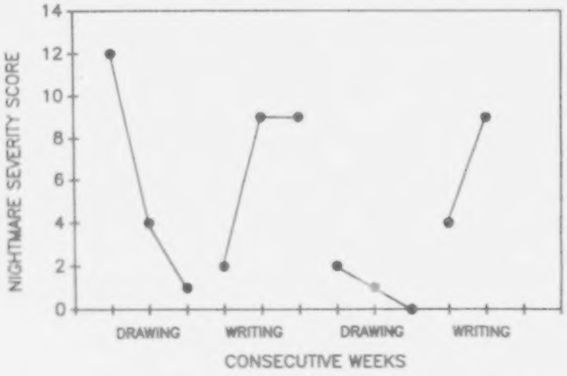


Figure 1 Effects of Drawing and Writing on Nightmare Severity—Subject #1

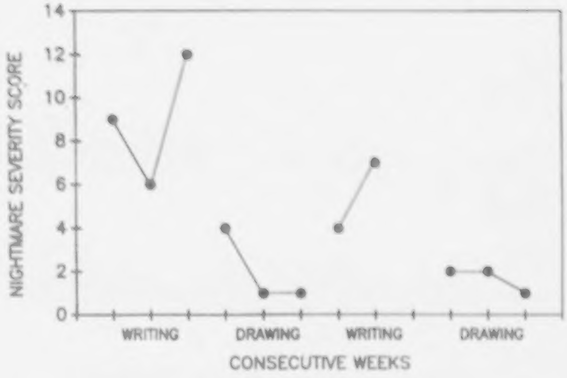


Figure 2 Effects of Drawing and Writing on Nightmare Severity—Subject #2

Nightmares, traumatic or otherwise, are not a new or unknown clinical phenomena. As long as children have had nightmares, mothers have been confronted and challenged with these distressing experiences (Hartmann, 1984). Healthy mothering provides several important things to the distressed child who has suffered a nightmare: a sense of reality testing (that it is only a dream); a sense of mastery (mother can help check under the bed, shut/lock the window, closet, etc.); an opportunity to share (or not be alone with the trauma), and solacing. Art therapy may provide these elements as well. A sense of reality testing is supported by the task of drawing the nightmare, which distances the person from the immediate experience. The mastery element is inherent in the production of the affectively charged drawing—which can be, in concrete fashion, "put away," decreasing the person's sense of helplessness. An opportunity to share the trauma, which is often "beyond words," is present when the subject shows the drawing to the therapist. Solacing (an empathic stance and a containment of the anxiety linked to the imagery) is provided when the therapist is present.

This study suggest that drawing may offer a significant, noninvasive alternative to existing forms of treatment for nightmares. Many questions remain unanswered. First, this study needs to be conducted on a larger sample of patients and among different types of patients with PTSD. Second, the significance of the development of an aerial perspective should be explored. Does this reflect, in a concrete way, the attempt to gain perspective on one's experience, being the visual counterpart of subjective awareness in the nightmare? Finally, other modes of expression (e.g., painting, sculpture, voice, movement) might be studied.

Editor's Note: Dr. Morgan and Dr. Johnson may be contacted at the National Center for PTSD, VA Medical Center, West Haven, CT 06516.

References

Blain, G., Bergner, R., Lewis, M., & Goldstein, M. (1981). The use of objectively scorable House-Tree-Person indicators to establish child abuse. *Journal of Clinical Psychology, 37,* 667–673.

Golub, D. (1985). Symbolic expression in post-traumatic stress disorder: Vietnam combat veterans in art therapy. *The Arts in Psychotherapy, 12,* 285–296.

Johnson, D. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy, 14,* 7–14.

Johnson, D., Feldman, S., Southwick, S., & Charney, D. (1994). The concept of the second generation program in the treatment of post-traumatic stress disorder among Vietnam veterans. *Journal of Traumatic Stress, 7,* 34–41.

Hartmann, E. (1984). *The nightmare: The psychology and biology of terrifying dreams.* New York: Basic.

Kelley, S. (1984). The use of art therapy for sexually abused children. *Journal of Psychosocial Nursing, 22,* 12–18.

Krystal, H. (1979). Alexithymia and psychotherapy. *American Journal of Psychotherapy, 33,* 17–31.

Malchiodi, C. (1990). *Breaking the silence: Art therapy with children from violent homes.* New York: Brunner/Mazel.

Manning, T. (1987). Aggression depicted in abused children's drawings. *The Arts in Psychotherapy, 14,* 15–24.

Naitove, C. (1982). Art therapy with sexually abused children. In S. Sgroi (Ed.) *Handbook of Clinical Interventions in Child Sexual Abuse* (pp. 269–308). Lexington, MA: Lexington Books.

Peake, B. (1987). A child's odyssey toward wholeness through art therapy. *The Arts in Psychotherapy, 14,* 41–58.

Schornstein, H., & Derr, J. (1978). The applications of kinetic family drawings in child abuse. *British Journal of Projective Psychology and Personality Study, 23,* 33–35.

Sidun, N., & Rosenthal, R. (1987). Graphic indicators of sexual abuse in Draw-A-Person Tests of psychiatrically hospitalized adolescents. *The Arts in Psychotherapy, 14,* 25–34.

Simonds, S. (1994). *Bridging the silence: Nonverbal modalities in the treatment of adult survivors of childhood sexual abuse.* New York: Norton.

Spitzer, R., & Williams, J. (1985). *Structured Clinical Interview for DSM-III-R.* New York: Biometric Research Department of New York State Psychiatric Institute.

Spring, D. (1993). *Shattered images: Phenomenological language of sexual trauma.* Chicago: Magnolia Street Press.

Stember, C. (1977). Printmaking with abused children: A first step in art therapy. *American Journal of Art Therapy, 16,* 104–109.

Stember, C. (1978). Change in maladaptive growth of abused girls through art therapy. *Art Psychotherapy, 5,* 99–109.

van der Kolk, B., Blitz, R., Burr, W., Sherry, S., & Hartmann, E. (1984). Nightmares and trauma: A comparison of nightmares after combat with lifelong nightmares in veterans. *American Journal of Psychiatry, 141,* 187–190.

Werner, H., & Kaplan, S. (1963). *Symbol formation.* New York: Wiley & Sons.

Wohl, A., & Kaufman, B. (1985). *Silent Screams and Hidden Cries: An interpretation of artwork by children from violent homes.* New York: Brunner/Mazel.

Yates, A., & Beutler, L. (1985). Drawings by child victims of incest. *Journal of Child Abuse and Neglect, 9,* 183–189.

Art Therapists' Employment Experience in a Shifting Economy

Michelle Winkel, MA; Maxine Junge, PhD, LCSW, A.T.R.; Debra Linesch, PhD, MFCC, A.T.R.; and Nina Mathews, MFA, MA, Los Angeles, CA

Abstract

This paper discusses a study of job search and employment experiences among graduates of a graduate art therapy training program. Results reflect an employment rate of 93.7% with a relatively high level of job satisfaction. Considering the increasing constraints of the mental health system and job market, these results suggest that there is more cause for optimism than seems apparent. The nature of survey participants' job search, employment, employment stability, availability of supervision, and employers' attitudes are described.

Introduction

Like art therapists nationwide, clinical art therapy faculty and students at Loyola Marymount University, Los Angeles, are concerned with the job market in our current changing economic times. To address these concerns, a survey was conducted which covered graduates form 1988 through 1993. The purpose of this study was to investigate the experience of recentgraduates in this job market. The nature of the job search and satisfaction with secured jobs were also addressed. In a field that is still considered relatively new and innovative, art therapy might be one of the first areas adversely affected by recession, downsizing, and funding cuts. Conversely though, the flexibility of the profession may offer other advantages in these changing times.

Since economic recovery arguably began in 1991, there has been only a 2% increase in jobs according to Merrill Lynch economists (*The Wall Street Journal*, 1993). Unemployment in the United States was approximately 7% for 1993. However, the Labor Research Association stated that gross employment figures including the decline in the unemployment rate from 7.6% in June 1992 to 6.8% in October 1993 do not reflect the deteriorating quality of job opportunities (*The Wall Street Journal*, 1993). Although these statistics are based on employment in all fields, they present a basis for understanding the national context for exploration of the clinical art therapy field.

For purposes of this study, Landgarten's *Ten Year Follow-Up Survey of Art Therapy in the Greater Los Angeles Area* (1984) and the previous studies done by Landgarten and her colleagues (Anderson & Landgarten, 1974; Hoseman, 1976; Landgarten, 1974a, 1974b; Siegel, 1979) provide relevant background. To investigate the status of art therapy within the mental health field in the Los Angeles area, Landgarten conducted several surveys beginning in 1972 and culminating in 1982 with her 10-year follow-up study. The surveys included information about current employment for art therapists, the nature of art therapy jobs at mental health institutions, the credentials of those who employed art therapists, and future hiring plans for art therapists at institutions. The 1982 survey—a questionnaire polling 245 mental health institutions in the greater Los Angeles area—concluded that future hiring plans for art therapists were positive. Landgarten's study demonstrated that art therapy, as of 1982, was becoming an accepted mental health modality. Over a decade later, we are still interested in the mental health field's response to art therapy. However, our study focuses strictly on the individual art therapists' employment opportunities and experiences.

Methodology

A questionnaire (Schweigert, 1994) was selected as the most suitable method of data collection. It was designed with 34 closed and open-ended questions. One hundred thirteen alumni graduating in years 1988 to 1993 were mailed the questionnaire, a return-addressed and stamped envelope, and a token pencil to encourage response rate. Results were tallied manually in order to incorporate personal perspectives expressed in the open-ended questions. Numerical figures were averaged and correlated with appropriate variables.

Results

Of the 113 questionnaires sent out, 64 were returned, for a 56.6 response rate. This number included 57 women (89%), four men (6.3%), and three respondents who did not state their gender (4.7%). The majority of participants were White/Anglo/Caucasian (94%), with one African American (1.6%), one Asian or Pacific Islander (1.6%), one Hispanic (1.6%), and one who did not state race. The 30 to 40-years-old age group was the largest with 26 (40.6%). Forty to 50-year-olds comprised 25% (16) of the respondents, and the 20 to 30 and 50 to 60 age categories each accounted for 17.2% (11).

Employment Status

Of the 64 graduates responding to the survey, 60 (93.7%) were employed; four were not (6.3%). Of these four, one woman left her last job by choice to stay home with children, one had been job hunting for 2 weeks after moving out of state, one had been actively job searching for 3 months, and one stated the "pay scale makes it a luxury for me to work in this field now." She

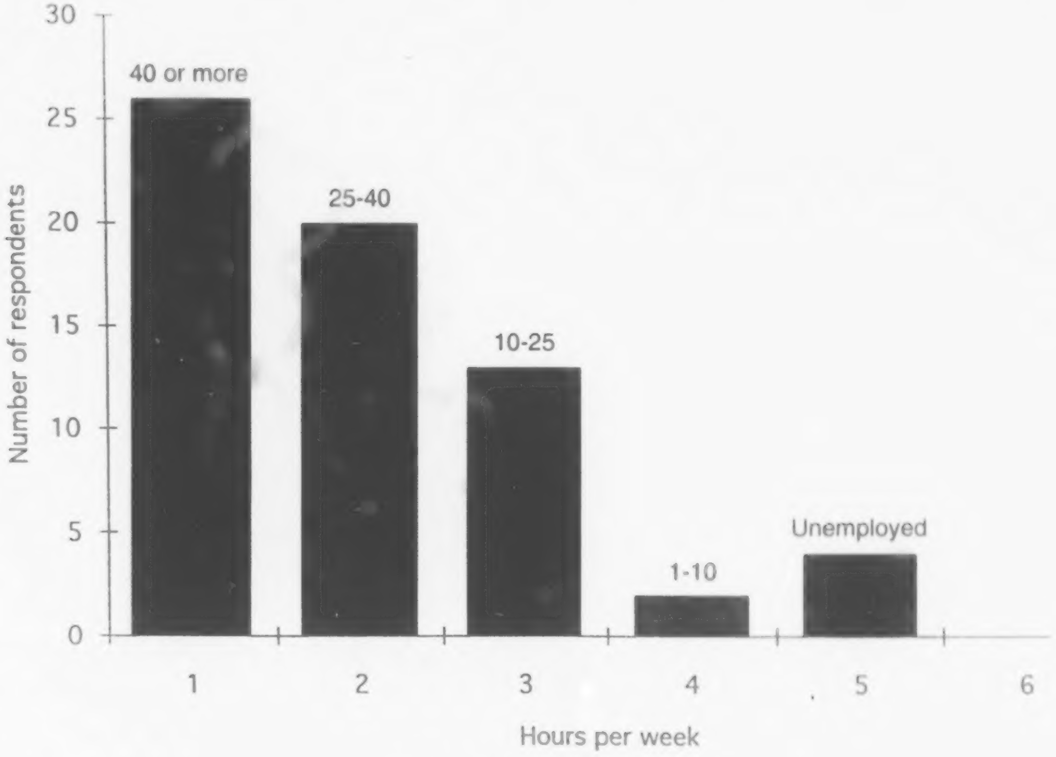


Figure 1 Weekly workload

implied that she was no longer looking for employment in art therapy due to unsatisfactorily low salaries.

Of those employed, workloads varied: 26 respondents (40.6%) worked full-time (40 hours or more per week); 20 (31%) worked 25 to 40 hours per week; 13 worked 10 to 25 hours per week (20.3%); and two alumni worked 10 hours or less per week (3.1%).

Forty-three of the 61 employed respondents (71.7%) were satisfied with their workload whereas 21 (35%) would prefer a change of schedule. Thirteen people said they would like to work more hours, and eight would rather work less. Those who would like to work more hours included three who worked 10 hours or less, six respondents who worked 10 to 25 hours, and four who worked 25 to 40 hours. Five of the eight respondents who preferred a lighter workload worked 40 hours or more per week. Three worked 25 to 40 hours.

Thirty-seven employed alumni had one job, 20 alumni divided their time between two jobs, and three people had three jobs. Monthly income of those who worked 40 hours per week or more average $2,606. Monthly incomes of part-time workers were not calculated due to the variability in the number of hours worked by each person.

Job Responsibilities

Direct individual and direct group therapy were the most common responsibilities on the job. Eighty-three percent of those employed performed these activities (50 respondents). Forty-four art therapists (73.3%) were responsible for case documentation, 34 respondents (56.7%) did direct family therapy, and 19 (31.7%) were involved with administration. These responsibilities were not mutually exclusive; most performed several of these responsibilities. Other job responsibilities included program development, supervision, assessment, public speaking, communication with schools and probation officers, crisis work, marketing, social work, childcare, and teaching art.

Thirty-eight respondents (63%) worked at the same job since graduation. The clients with whom respondents worked covered the spectrum in mental health in terms of age and levels of emotional, physical, and mental functioning. Types of workplaces included schools, residential treatment facilities, inpatient and outpatient hospital services, and multi-ethnic community agencies. The respondents practiced art therapy with individuals, groups, and families. Job satisfaction did not correlate with the client population with which respondents worked. However, several people said they would prefer to work with higher functioning clients and that they were working towards that goal.

Job Satisfaction

Job satisfaction was measured on a seven-point Likert scale, with 7 as "very satisfied" and 1 as "not at all satisfied." For the 60 employed respondents, the average was 5.0; respondents were more satisfied than not with their employment. No correlations were observed between age, salary, or graduating year and job satisfaction.

Employment Stability

Job security was described in terms of estimated longevity. Thirty-five respondents viewed their job(s) as secure (58.3%), 14 suspected their jobs were not secure (23.3%), and 10 did not know (16.7%). Five people did not comment.

Thirty-six received medical benefits, 31 had dental benefits, 13 had pension plans, five received eye care, four got vacation pay, two received life insurance, two had available childcare. The participants were also asked if they were provided with supervision and if so how much. Thirty-three respondents received individual supervision for one hour per week from a licensed clinician, 11 got more than one hour per week individual and/or group supervision, and 7 had group supervision at least one hour per week. Unfortunately, many respondents needed to seek art therapy supervision outside their employment because they were not offered any on site. Eighteen participants responded that they were provided with art therapy supervision. It is possible that some respondents went off site for this supervision, but this was not clarified in the survey. Thirteen were provided with one hour per week individual supervision by a registered art therapist; four people received 2 hours per week; and one person received one hour per month. It may be assumed that the lack of art therapy supervision in the institution indicates the lack of senior art therapists on site. The good news is that art therapists are being newly hired; however, the bad news is they may be the only one without a more senior person as a role model.

Job Search

To assist in their most recent job search, respondents used a wide range of contacts. Newspapers (33 respondents; 21.1%), practicum connections (29 respondents; 45.3%), and friends or family (26 respondents; 40.6%) were the most common. The alumni job bank was utilized by 16 respondents (25%). However, the alumni job bank was also criticized as nonexistent by several respondents. Other sources of contact included publications, talk shows, employment agencies, professors, Southern California Art Therapy Association (SCATA) newsletter, psychologists at sites, supervisors, and the phone book.

Length of job search for those employed varied from 1 week to 6 months, with an average of 3 months. For those graduates unemployed at the time of responding to the questionnaire, they had spent 3.87 months actively job hunting. Types of jobs that alumni applied for included art therapy jobs (48; 75%), counseling (41; 64%), social work (25; 39%), education (6; 9.4%), family therapy, recreational/activities-therapist, program development, psychology, and case management.

Reasons for Not Being Offered Employment

In an open-ended question, participants were asked what reasons were given when they were not offered a position. Some applicants stated they were perceived as not adequately qualified: Several employers wanted social workers (MSWs or LCSWs), and some applicants were rejected because they were not licensed at the time of the interview. Some employers were looking for bilingual (Spanish/English) therapists, salary demands were said to be too high, agency funding was cut, and one employer wanted an arts and crafts director. During the job search, respondents reported sexism (6), ageism (4), bias against art therapy (3), homophobia (2), and preference for ethnic minorities (4). Others felt that employers were biased against MFCTs (Marriage, Family, Child Therapists) and/or interns.

To gain an understanding of employers in our field, respondents were asked about their experiences during interviews. On a seven-point Likert scale, the employers' level of interest in art therapy was rated at 5.5. Most respondents stated that they have educated these employers about art therapy through case presentation, publications, and information about assessment and treatment, for example

In this difficult job market, respondents believed specific personal work experience was most beneficial (43; 67.2%). Credentials in MFCT (39; 60.9%), A.T.R. (36; 56.3%), combination of MFCT and A.T.R. (35; 54.7%), and PhD (22; 34.4%) were also considered important. Publications, specialized training in child abuse and substance abuse, experience with geriatrics, a teaching credential, fluency in Spanish, and determination were also considered important.

Decreasing mental health budgets (30; 46.9%) and the recessive economic climate (28; 43.8%) were faulted for major difficulties in finding employment. Others attributed difficulty to the lack of understanding about art therapy (17; 26.6%) and lack of appreciation for MFCTs (19; 29.7%).

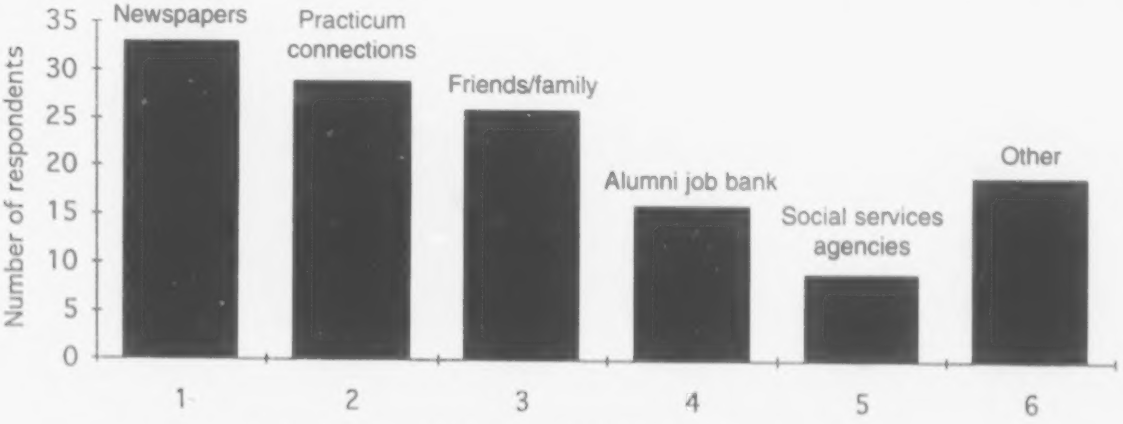


Figure 2 Sources of contact used in most recent job search

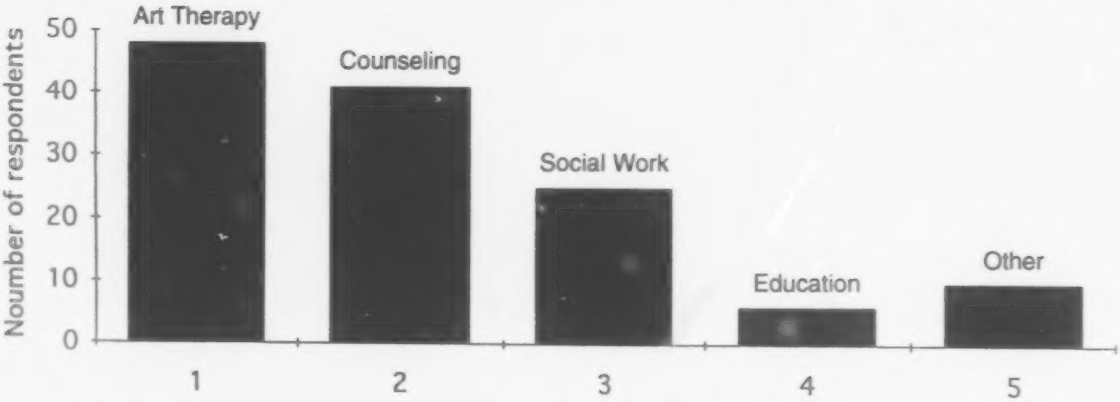


Figure 3 Types of jobs for which respondents have applied

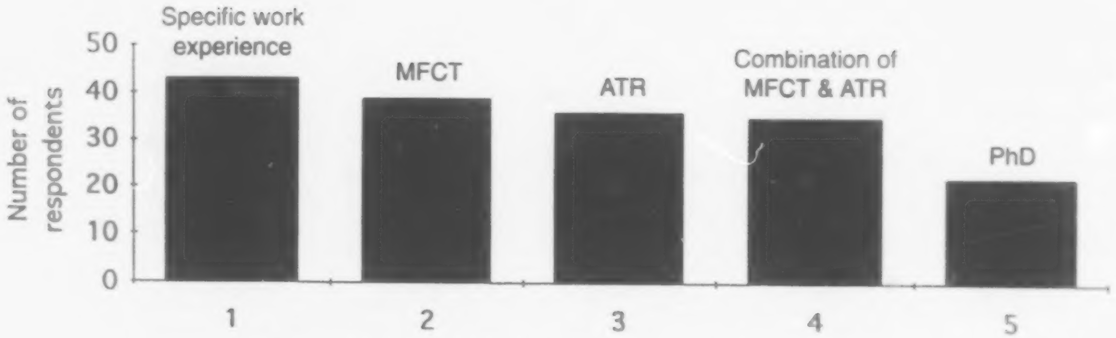


Figure 4 Credentials believed most useful in this job market

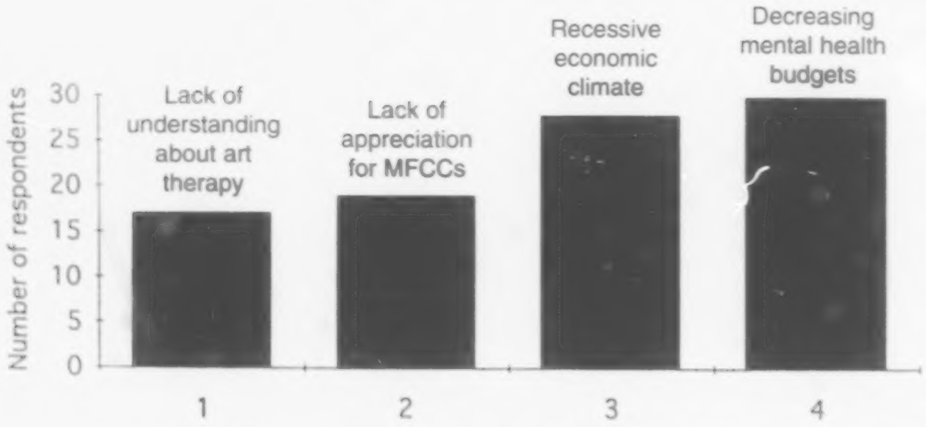


Figure 5 Perceived causes for difficulties in finding employment

Recommendations for Future Clinical Art Therapy Graduates

In another open-ended question, participants were asked what they thought would support future graduates in their job searches. Participants discussed the need for convincing and concise résumés and cover letters, practiced interview skills, and the willingness to "sell" art therapy to employers. Others suggested the importance of gathering short-term work experience, geriatric experience, and administrative and case management skills. Pioneering art therapy in states other than California and in other countries was proposed as an alternative.

Discussion

Despite the difficult economic climate nationwide and particularly in California, respondents to the survey were more satisfied than not with their employment situations. Some respondents were having or had problems finding work, and others were searching for a heavier workload. Clearly the recession has not bypassed the art therapy profession; however, proportionate to unemployment rates nationwide, this group of respondents had not been affected more than the average (6.3% unemployment among respondents compared to 7% nationwide).

The response rate of 56%, although quite high, still suggests that many graduates chose not to return the questionnaire or did not receive it. To gauge reasons for this lack of response, speed of response was compared with job satisfaction. Questionnaires received 3 weeks after mailing were equally as positive as those received within a few days of mailing. This suggests that nonrespondents are not all unemployed, cynical, and unsatisfied. However, this is impossible to measure, given the small sample.

It was anticipated that recent graduates would have more difficulty with the job search for a few reasons: They have less clinical experience, are not licensed or registered, and are struggling with the economic climate of the last few years. Also, there are more art therapists competing for jobs with each graduating year. Hopefully, more jobs are being created as the profession becomes more well-known and respected. This notion is supported by the results. Surprisingly, the rate of employment for more recent graduates was comparable to that of earlier graduates, although their workloads were lighter.

It is fairly common to work at two jobs (33% of those employed), perhaps because of a scarcity of full-time positions. However, there is no correlation between graduating year and number of jobs held by one person. It might be anticipated that 1988 graduates would be more likely to have one full-time position by climbing the ladder of part-time jobs in an agency, but this is not the case. More recent graduates desire to increase their workload (numbers of hours per week) than earlier alumni. This is not to imply that they are harder workers; they simply do not have 40-hour-work weeks like earlier graduates. Conversely, more alumni from earlier graduating classes want to work less hours per week. This factor is unrelated to the respondents' age, and perhaps indicates an understandable level of burnout.

Employment stability and benefits (medical, dental, etc.) are more secure than not for the respondents, although marginally; 58.3% of those employed feel their job is secure. Presumably these figures are partially dependent on the recession and will shift as the economy improves.

The lack of art therapy supervision available to respondents at their places of employment is disconcerting. It is reflective of how few agencies have registered art therapists on staff to provide supervision. It also suggests that employers are not supplying the funds necessary to send graduates off site for supervision. (A more hopeful assumption might be that art therapists often work at sites where previously an art therapist has never been hired.) Several respondents stated that they paid for their own supervision until licensure, which is a considerable cost. Others who did receive supervision (A.T.R. and MFCT) said that due to funding cuts, they were not provided with any supervision as soon as they got licensed (although it is traditional to be supervised only until licensed). Almost one-third of respondents do not receive MFCT supervision. It is probable that most of this fraction are already licensed. No one stated that they needed to pay for their own MFCT supervision.

It would have been beneficial to plot employment and satisfaction rates by geographical location of workplace, but unfortunately this survey did not request respondents to specifically state where they were employed. The sole Canadian respondent expressed great satisfaction about her work situation. Several San Diego residents discussed their difficulties finding work in that region.

In conclusion, while the participants of this survey are experiencing the pressures of an unstable job market, the sentiment among employed graduates is generally positive. Although the results of this survey cannot be generalized to include other art therapists, it is anticipated and hoped that art therapy graduates in other urban centers in the United States and Canada are experiencing similarly positive results in the job search and employment.

One respondent in the study asked that "faculty continue to instill in students the faith in the power of art therapy so they won't confuse a rotten job market with the validity of their call." The largely unanticipated positive experiences of more recent program graduates indicate the possibility that the job picture may hold more potential than common wisdom would dictate, and it may be that the power of the calling of art therapy, instilled by their education, helps many art therapy graduates cross the bridge into a successful professional life even in the most dire of times.

Editor's Note: Graduates of the Loyola Marymount University Department of Marital and Family Therapy (Clinical Art Therapy) receive a degree in Marital and Family Therapy and are eligible to become licensed as Marriage and Family Therapists in the State of California.

References

Anderson, F., & Landgarten, H. (1974). Survey on the status of art therapy in the Midwest and Southern California. *American Journal of Art Therapy, 13*(2), 118–22.

Hoseman, T. (1976). *Status of art therapy in Greater Los Angeles, 1976: A four-year follow-up study.* Unpublished paper. Los Angeles: Immaculate Heart College.

Landgarten, H. (1974a). *Survey of art therapy in 1974: Greater Los Angeles.* Unpublished paper.

Landgarten, H. (1974b). The state of art therapy in Greater Los Angeles, 1974: A two-year follow-up study. *Art Psychotherapy, 5*(4), 227–233.

Landgarten, H. (1984). *Ten-year follow-up survey of art therapy in the Greater Los Angeles Area, 1*(2). Unpublished paper.

Schweigert, W.A. (1994). *Research methods and statistics for psychology.* Pacific Grove, CA: Brooks/Cole.

Siegel, B. (1979). *Status of art therapy in Greater Los Angeles: A seven-year follow-up study.* Unpublished paper. Los Angeles: Immaculate Heart College.

Unemployment. (1993, Second Quarter). *The Wall Street Journal Index,* p. 580.

Outpatient Art Therapy with Multiple Personality Disorder: A Survey of Current Practice

Anne Mills, MA, A.T.R., Alexandria, VA

Abstract

The findings of a 1993 questionnaire completed by 46 North American art therapists are reported. The survey focused on the outpatient treatment of multiple personality disorder by art therapists in private practice. Respondents answered questions regarding their position as primary vs. adjunctive therapist, their role in diagnosing, fees and third-party payment, and activities occurring during art therapy sessions. Treatment issues that respondents indicated were of interest to them included pacing and containment through art and managing the client's chronic suicidality. Other issues of concern to the respondents included self-care of the therapist and enhancing self-efficacy through professional development.

Introduction

Beginning in the summer of 1993, 96 questionnaires and self-addressed, stamped envelopes were sent to art therapists in private practice who were treating clients diagnosed with multiple personality disorder (MPD; now known as Dissociative Identity Disorder).[1] In all, these surveys were distributed to 29 American states and two Canadian provinces.[2] A total of 46 questionnaires were completed and returned.

Clinicians had been placed on the mailing list as a result of having contributed to the literature on dissociative disorders, personal contact with the author (e.g., at conferences and professional meetings in the United States and Canada), listings of art therapists in the membership directory of the International Society for the Study of Multiple Personality and Dissociation, and responses to a notice regarding this survey in the *AATA Newsletter*. The questionnaire also invited respondents to submit names of other art therapists in private practice treating MPD whom they might know. The author believes that this sample is representative as the mailing was broadly distributed and exceeded the number of AATA members who identify MPD/dissociation as one of their top three areas of specialization (n=76, in La Brie & Rosa, 1994).

The survey was designed so that respondents could choose whether or not their submission was anonymous. Some gave up anonymity in order to receive the questionnaire results. Many expressed a strong need to know more about how others do this type of work and wrote about subjects on which they wanted more information or a chance to share their thoughts (see *Issues of Interest* section).

Some respondents did not complete all parts of the survey; this accounts for some totals not adding up to 46.

Characteristics of the Respondents

A large proportion of respondents (25 out of 46) indicated they considered treating the dissociative disorders population to be a clinical specialty. Those who identified themselves as specialists were distinguished by two factors: number of previous clients diagnosed with MPD; and number of persons "to whom I have provided services throughout their completion of integration."

Non-specialists typically had worked with one to five people diagnosed with MPD, while half of the specialists had worked with up to 20 such clients; the remaining specialists reported working with 21 to more than 100 individuals with this disorder. Additionally, those who considered the treatment of dissociative disorders their clinical specialty were twice as likely to report having clients who attained integration. The majority of clinicians, however, had never worked with a client through the integration process.

Both specialists and non-specialists had an average of four-to-five years of experience in the treatment of individuals diagnosed with MPD (both inpatient and outpatient, excluding undiagnosed individuals). A few art therapists in each group had over 10 years of such experience. The number of years of general experience as an art therapist did not seem to predict the likelihood of specializing in this clinical area.

Before beginning a private practice, most respondents appeared to have waited for two years or more after attaining the A.T.R. registration, or to have had clinical degrees beyond art therapy. Of the respondents for whom this is not true (n=18), seven appeared to have begun private practices prior to achieving registration or other clinical degrees.

Characteristics of the Respondents' Practices

Approximately half of all respondents treated persons under the age of 18 who were diagnosed with dissociative disorders. Counting all their present clients (including supervisees, group members, and all age groups), respondents had an average of 18 individuals in their private practices. On average, one-third of these clients were diagnosed with multiple personality disorder, and an additional 20% were diagnosed with another dissociative disorder. Thus, one-half of the respondents' clients typically had severe dissociative disorders. About one-quarter of these clients reported ritual abuse. Respondents indicated that 15% of their clients reported mind control; however, several art therapists indicated that they were not familiar with that term. This finding might have been larger, perhaps, if this concept were more widely known (for definition, see Hassan, 1988).

---

[1] This material was first presented in a preconference course at the 1993 conference of the American Art Therapy Association, by this author (Cohen, et al., 1993).

[2] Specifically: AZ, KY, CA, CO, CT, DC, FL, GA, ID, IA, IL, KS, LA, MD, MO, NH, NJ, NM, NY, OK, PA, SC, TX, UT, VA, VT, WA, WI, WV, Ontario, and Quebec.

To establish if the art therapy practice was geographically isolated—from competition or support—the questionnaire asked if, generally speaking, any other therapist within 50 miles also offered the services the respondent offered. This was deliberately phrased in such a way that respondents could interpret it as related to art therapy and/or dissociative disorders work, and it is clear from the responses that it was interpreted variously. Two-thirds of the respondents responded affirmatively, and many respondents identified themselves with psychotherapists treating MPD rather than with other art therapists. Perhaps this is due to the relatively small number of art therapists who treat MPD.

The challenges of working with this difficult population (about which few art therapists have been educated during their training) in the face of varying types or degrees of isolation provoked a question about professional development. Ways of pursuing continuing education were listed, and respondents endorsed those they had used during the preceding year. "Study through books or audiocassettes" was most frequently chosen, followed by MPD specialist conference, MPD therapist peer supervision, MPD therapist support group, and paid supervision. Consultations with experts on MPD, treatment team meetings in agencies, and research were also reported by respondents. All respondents had availed themselves of some form of professional development.

Contributing to the Diagnosis

For every respondent who denied that he or she "customarily diagnoses, or contributes to the diagnosis of these clients," three indicated they did contribute to diagnosis. Respondents were asked to specify the diagnostic methods they employed. The sole art assessment mentioned by respondents by name was the Diagnostic Drawing Series, which was used by seven clinicians (Mills & Cohen, 1993). The most mentioned non-art assessment was the Dissociative Experiences Scale (Bernstein & Putnam, 1986). Behavioral assessment was informal; several respondents noted watching with heightened attention for changes in the client's personal presentation (specifically, voice, eyes, and movements) and differences in art and handwriting styles.

Primary Versus Adjunctive Therapist

The survey asked if one's status with private practice clients diagnosed with MPD was predominantly as primary therapist, consultant, adjunctive therapist, or some other category. Primary and adjunctive were endorsed equally (n=19). Two respondents described themselves as both primary and adjunctive; perhaps this could be accounted for by different roles on separate cases, or changing roles at various stages in treatment. Respondents attributed moving between primary and adjunctive roles to difficulty finding someone to whom to refer (e.g., with more experience treating MPD than themselves; who accepts Medicaid; who recognizes the diagnosis). One respondent who worked as a primary therapist wrote, "I would happily be an adjunctive therapist in collaboration with a person who does body work. I believe body work is essential to recovery. Often MPDs have had *years* of psychotherapy and [still] need the release provided in art therapy and body work."

Regarding adjunctive work, one person wrote, "I will not accept patients who do not have a primary therapist [who is an] MD or PhD." This may be a way of dealing with not being licensed to provide psychotherapy in areas where this activity is regulated by law. Another said, "I'm not ready to be entirely responsible for such clients." A primary therapist's legal responsibility to his or her client is considerable; if that client has a severe dissociative disorder and is chronically suicidal and the therapist is not licensed to provide psychotherapy, the therapist is imperilled professionally (Webster, 1994; Wirtz, 1994).

The category "other," usually described as a being a cotherapist, was endorsed slightly less than "primary" or "adjunctive." A respondent noted "actively doing [the same] work which psychologist or psychiatrist does" but "concentrating on art psychotherapy.... We cover for each other...and jointly make decisions on hospitalizations." It is notable that the literature on outpatient cotherapy is small; these respondents might be pioneers in a new form of providing care.

No one endorsed the category "consultant." This may suggest that the numerous non-art therapists who appropriate the use of art in treating MPD clients fail to use art therapists for consultation. One respondent wrote, "There are other professionals [who] implement art activities in their sessions and label these interventions 'art therapy.' I know of a local artist who has been hired to provide 'art therapy' in a partial [hospitalization] setting with no training." Some art therapists offer casual, free consultation to colleagues to build rapport, interdependency, and a referral base. This may be an unexplored market for private practitioners but raises ethical issues by seeming to sanction the use of art in therapy by untrained individuals (Mills, Dougherty, Rubin, & Schoenholtz, 1992).

Content of Sessions

The questionnaire asked which activities are "customarily incorporated into your sessions with clients diagnosed with MPD." The first number after an item represents all who endorsed it; the second number, in brackets, represents the number of times the activity was identified as "the single approach that predominates in most sessions with these clients." Categories have been arranged from most to least endorsed: art therapy/art psychotherapy, 44 [31]; verbal psychotherapy, 37 [4]; imagery or storytelling, 28 [2]; psychoeducation, 28 [0]; sand tray/sandplay, 18 [1]; hypnosis, 15 [0]; play therapy, 12 [0].

Several respondents clarified that art psychotherapy, not art therapy, was their predominant form of treatment.

The importance of writing as therapy (journaling, therapeutic letters) was noted by two respondents.

The endorsement of hypnosis seemed quite high, given that much of the instruction in it is open only to licensed Master's level clinicians or those with doctoral degrees, and, therefore, may be difficult for art therapists to pursue. On the other hand, art therapists may be expected to have a special interest in clinical hypnosis and to excel in its practice because of their study of imagery and metaphor. Two respondents added variations of relaxation training, as distinct from hypnosis. One wrote, "Hypnosis NO." At the time of the survey, verbal psychotherapy and hypnosis were the most commonly used treatment modalities for patients with MPD, followed by medication and art therapy (Putnam & Loewenstein, 1993).

Fees and Session Structure

For art therapists in the United States eligibility for third-party payments is not clear-cut. Unlicensed respondents noted they could receive such payments under certain circumstances, including: if the insurance company paid counselors, or if payment was not mandated on being licensed; if the insurance company has registered or contracted with the state; if arrangements were made or endorsed by a psychiatrist or clinical director, or art therapy was provided by doctor's order; if supervision was provided by a psychiatrist or licensed psychologist; or if the provider was considered a specialist in the MPD field.

Most respondents (n=29) indicated they met once a week, on average, with clients who carry this diagnosis. This finding is noteworthy because it differs from the twice-a-week structure common to the verbal psychotherapeutic treatment of those with MPD (Putnam & Loewenstein, 1993). Most of the remainder of the sample averaged two sessions a week, and sometimes more, especially in the early stages of the work. Surprisingly, neither being in the role of primary therapist nor eligibility for at least some third-party payments seemed to necessarily increase the frequency of meetings. On the other hand, a small number of adjunctive art therapists who were not eligible for third-party payments (thus, clients were paying directly for services) reported twice-weekly meetings with clients diagnosed with MPD.

Art therapists who met with clients less often than once a week indicated this was due to either the clients' inconsistency in attendance or financial straits. The survey did not address the adequacy of benefits, such as the not uncommon situation of a client exhausting his/her insurance benefits before treatment is complete.

The length of the art therapy session usually offered clients with MPD was what the survey called "the standard 45- or 50-minute hour." However, one-third of the clinicians offered 60-, 75-, or 90-minute sessions, and some described these lengths as approximate. Respondents noted these longer sessions met objectives that included: planned double sessions for "abreactive work" or the use of hypnosis, sometimes alternating with 50-minute sessions; doing the session with a cotherapist; and allowing sufficient time for verbal preliminaries, artwork, and "brief reorientation."

Licensed respondents (defined as those who have obtained licensure, sometimes with additional degrees) charged an average standard fee of $70 a session. Unlicensed respondents, including those who sometimes received third-party payments, charged an average standard fee of $60. There was a much broader scatter between the fees of the unlicensed art therapists (from $10 to $100, but with most between $45 and $75) than among the licensed ones (distributed fairly evenly from $45 to $95). Fifty dollars and $75 seemed to be nodes at which both licensed and unlicensed art therapists clustered their fees. It is also interesting to note that years of experience in the field, or in private practice, had little correlation with the fees set. On average, the fees of unlicensed art therapists were the same whether they were registered in 1983 and before, or in 1988 and after.

All respondents except four offered sliding scale fees. The average discrepancy between the standard fee and what the survey called "lowest fee negotiated" was $34. However, some respondents indicated they had reduced their fees as much as $60 or more. As a result, some fees were below $20. Other special fees mentioned were pro bono work, $20 for a limited number of indigent clients, $35 for Medicare/Medicaid clients, and $90 for a home visit. Because of the need for a secure treatment frame and MPD clients' potential for violence toward themselves and others (Kluft & Fine, 1993, pp. 26, 169), it is presumed that the home visit service mentioned above would not be offered in the treatment of individuals with dissociative disorders.

About half of the respondents had a different fee structure for initial sessions. Some charge more (on average, $20 more), while others waived the fee if client and therapist decided not to work together.

Numerous art therapists indicated that they offered group as well as individual treatment to dissociative disorder clients, and that clients can be in both at the same time. It has been suggested elsewhere that sharing the therapist with other group members places an intolerable burden on these clients (Comstock, 1990). The reaction of trying to do more or offer more to try to help is a fairly common complication in the treatment of dissociative disorders. Respondents' remarks did show an awareness of the overwhelming unmet needs of these clients, who often report not being able to find adequate care. This may parallel respondents' statements about lacking the support they need in order to do this difficult work.

Issues of Interest to Respondents

The questionnaire asked, "Which issues particularly interest you, at this stage in your work?" The first number after the item represents all who endorsed it; the second number, in brackets, represents the number of times the issue was identified as "the single issue which is currently of most interest to you." Categories have been arranged from most to least endorsed: pacing and containment in art, 22 [8]; avoiding burnout/secondary PTSD, 24 [2]; enhancing efficacy through training/licensure, 22 [3]; spiritual implications of abuse, 22 [2]; keeping the art therapy on track, 18 [6]; managing client's chronic suicidality, 18 [5]; legal/ethical issues in treatment, 22 [1]; ensuring therapist's safety/privacy, 18 [1]; dealing with primary therapist, 17 [1]; incorporation of art in therapy by non-art therapists, 13 [2]; credibility vs. skepticism re: client's allegations, 13 [1]; business matters (records, billing, referrals), 10 [2]; dealing with the issues of therapist as survivor, 10 [0].

Below are additional contributions solicited from respondents that have been paraphrased and clustered in paragraphs, according to theme. The numbers separate comments from different respondents.

How do structured versus unstructured art therapy sessions affect MPD clients? (2) How to use the media for containment. (3) How to keep the focus on the art when one finds oneself doing more psychotherapy. (4) How to incorporate hypnosis and abreaction into the art therapy process. (5) Switching between alters is noted in response to certain media; rapid switches are occurring during the art process. (6) The client's journey via the art process. (7) The concept of MPD is itself metaphorical; it develops out of the human capacity to create and represent. How does this relate to art creation?

What is the process of integration? (2) What art therapy research exists on the diagnosis and treatment of MPD? (3) Am I doing any good? Would further training (e.g., hypnosis) help me do my work better? (4) How can we best help ourselves and our students understand the principles of working with dissociative clients? Could a therapist support and referral system be developed?

What do object relations and attachment theory have to offer as models for working with the MPD experience? (2) How to help the client build a support system, especially when partners or friends are resistant. (3) How separation from the therapist during a planned hiatus can be a positive experience; how this affects timing in my work.

Neurological ramifications of art therapy as primary therapy. (2) Psychobiology of dissociation as it relates to the images, especially those that arise in a fragmented way. (3) MPD being misdiagnosed as learning disability as a stressor for the client. (4) My concerns about the medical model of therapy, especially regarding medication.

The development of the therapeutic relationship. (2) Transference, countertransference, projection, and projective identification.

Especially where allegations of severe ritual abuse are involved: How does the client answer her/his own questions about the meaning of/workings of God? (2) The credibility of both the client and therapist are at risk in this work. (3) There is a range of acceptance of MPD as a viable diagnosis depending on the hospital, or even on the shift.

Perhaps the naming of these important issues will stimulate further discussion in the literature.

Summary

A picture emerges of a profession whose practitioners explore creative ways to provide appropriate services to MPD clients by incorporating cotherapy, group therapy, and longer but less frequent sessions, into the treatment frame; whose proponents readily reduce their already modest fees for clients in financial difficulties; and where the motivation to pursue continuing education is professional responsibility, not better compensation. Art therapy with multiple personality disorder clients in private practice seems to be an embattled subspecialty where the clinician lacks the support of colleagues doing the same work with the same tools, and where knowledge of how to best treat these troubled clients is imprecise.

Nevertheless, many would agree with the respondent who wrote that art therapy "readily speeds [the processing of] information, healing, [and] integration. I do not know how other professions work with MPD without art therapy."

Editor's Note: Correspondence concerning this article should be addressed to Anne Mills, Art Therapy Services of Alexandria, P.O. Box 9853, Alexandria, VA 22304. Electronic mail may be sent to amills@gwis2.circ.gwu.edu

References

Bernstein, E.M., & Putnam, F.W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease, 174*, 727–735.

Cohen, B.M., Cox, C.T., Mills, A., Barnes, M.M., & Des Marais, S. (1993). Practically speaking: Special topics in art therapy with severe dissociative disorder clients. In *Proceedings of the 24th Annual Conference: Common Ground* (p. 26). Mundelein, IL: American Art Therapy Association.

Comstock, C.M. (Speaker). (1990). *When the primary therapist is not a physician* (Cassette Recording No. 20-569-90). Alexandria, VA: Audio Transcripts.

Hassan, S. (1988). *Combatting cult mind control*. Rochester, VT: Park Street Press.

Kluft, R. P., & Fine, C. G. (Eds.). (1993). *Clinical perspectives on multiple personality disorder*. Washington, DC: American Psychiatric Press.

La Brie, G., & Rosa, C. (1994). American Art Therapy Association, Inc. 1992–93 membership survey report. *Art Therapy: Journal of the American Art Therapy Association, 11*(3), 206–213.

Mills, A., & Cohen, B. M. (1993). Facilitating the identification of multiple personality disorder through art: The Diagnostic Drawing Series. In E. S. Kluft (Ed.), *Expressive and functional therapies in the treatment of multiple personality disorder*. Springfield: Charles C Thomas.

Mills, A., Dougherty, M., Rubin, J., & Schoenholtz, R. (Speakers). (1992). *A compassionate discourse: On non-art therapists doing art therapy* (Cassette Recording No. 53). Denver, CO: National Audio Visual.

Putnam, F. W., & Loewenstein, R. J. (1993). Treatment of multiple personality disorder: A survey of current practices. *American Journal of Psychiatry, 150*(7), 1048–1052.

Webster, M. (1994). Legal and ethical issues impacting unlicensed art therapists and their clients in California. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 278–281.

Wirtz, G. (1994). Essential legal issues for art therapists in private practice. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 293–296.

Viewpoints

Art Therapy at the Crossroads: Art *and* Science*

Terry J. Tibbetts, PhD, A.T.R., San Gabriel, CA

Although art therapy as a professional discipline has been in evidence since the mid-1950s, as we move into the 1990s, it has achieved only limited acceptance in the larger mental health field. While some inroads have been made in isolated settings (e.g., alcohol abuse programs in private psychiatric clinics), art therapy as a clinical intervention continues to be both underutilized and misunderstood by many mental health providers. I suggest that one of the major reasons for this failure to be taken seriously as mental health professionals is because art therapy, as a discipline, has failed to generate empirical data that would support our claims to clinical effectiveness.

Such a failure to generate empirical evidence of our effectiveness as a professional discipline appears to reflect two separate but related factors. The first is an overly narrow focus on clinical or artistic issues. Most clinically oriented art therapists tend to view empirical research with the same enthusiasm they reserve for going to the dentist. Instead, they focus on therapeutic work and view themselves as clinicians rather than researchers. This "either/or" dichotomy is highly limiting and, at some level I suspect, reflects our own sense of inferiority as second-class mental health clinicians when comparing ourselves to the "real" mental health professionals (such as social workers or psychologists, who are expected and trained to be both scientists and practitioners).

Contained within this clinical group are the art therapists who view research as simply irrelevant to art therapy, taking the stance that "art is inherently therapeutic." And, since this is so, allowing clients to simply "do art" will invariably result in therapeutic growth. Accordingly, most research efforts are, in the long run, unnecessary. Given such an attitude towards research, it is little wonder that the mode number of professional journal publications by registered art therapists (A.T.R.s) is zero. Nor should it be surprising that one of the few issues that arouses their fanatical frenzy is whether or not studio art courses should be a prerequisite for the A.T.R.

The second factor is that there is almost no institutional or programmatic support for the small minority of art therapists who are interested in systematically examining the efficacy of art therapy in the clinical setting. Very few graduate programs—whether AATA-approved or not—place an emphasis on research. My own A.T.R. program required only one undergraduate-level 10-week course in basic research design, and the quality of the program's completed theses, to be as charitable as possible, was variable.

As a result, most art therapists are either uninterested in or poorly equipped for publishing professional-level empirical studies on the efficacy of art therapy. Without this kind of research support and empirical backing, we run a very real risk as art therapists of being dismissed as "ashtray makers" or "scarf therapists" by our professional colleagues simply because they do not understand what is so special about what we do. Also, because we have no hard data to back up our claims to professional parity, we lack, in sum, any empirically validated ticket of admission. A review of almost any issue reviewed in an art therapy-oriented journal will reveal that the overwhelming majority of articles are theoretical, historical, or case studies. Research data are sadly lacking.

One of the very few empirical studies undertaken in art therapy was published by myself and another A.T.R. (Tibbetts & Stone, 1990). Its emphasis was on evaluating the efficacy of short-term art therapy with adolescents identified by the educational system as having serious emotional disturbances. The results of this study were quite interesting. Among other findings, it appeared that short-term art therapy was most useful for adolescents with depressive disorders, and that its effectiveness appeared primarily related to strengthening the adolescents' sense of identity and increasing their ability to rely on and trust their own feelings and beliefs. Adolescents with anxiety disorders and issues involving emotional rejection by others were also found to benefit significantly from the use of short-term art therapy. By contrast, the use of art therapy was least clinically effective in reducing feelings of anger and aggression. Further, while art therapy resulted in significant affective shifts, only minor changes were noted over the same period of time in overt behaviors monitored in the classroom setting.

These results suggest a number of starting points for further research, some of which appear to challenge assumptions we often make as art therapists. For example, it may well be possible that art therapy is not the intervention of choice for emotionally disturbed adolescents who demonstrate severe behavioral acting-out as a concomitant of their disorder. My point, however, is not whether it is or it is not—rather, my point is that this question will *not* be answered by clinical art therapists who base their responses solely on their "years of clinical experience with this population." It will be answered only by further empirical research that looks more closely at identifying the relevant variables that define successful and unsuccessful art therapy with different populations.

In discussing this published study with other mental health

BEST COPY AVAILABLE

professionals, I have found that invariably the psychologists and social workers (those trained as both practitioners and scientists) ask the empirical questions: Was the fact that the form of art therapy used was Gestalt-oriented a factor in the findings? Would the use of younger students have yielded the same results? What kind of results would have been found if only behaviorally disordered students had been used? Would longer-term art therapy have changed the results? Would the use of a non-A.T.R. professional (e.g., school counselor, school psychologist, or artist) have yielded the same results? Would group art therapy have been more effective in reducing the aggressive responses?

Of more interest to me, however, is the fact that these questions have not been asked by most other art therapists, the ones who should be most interested in the findings and implications of the study. Although the findings of the study were better than I had suspected they might be (and were much worse than my co-author had believed they should be), initial reactions to the study from other A.T.R.s were almost unanimously anecdotal. It quickly became clear that most art therapists were unable to review the study findings in any meaningful way other than by sharing cases from their own practices that either confirmed or negated the study's findings. One A.T.R. (who had not read the study) expressed a typical reaction, "I really don't care what the data show. Art is therapeutic for all populations. If your data don't show that, your data are wrong."

This kind of response is unfortunate and underscores why, as art therapists, we lack that empirical ticket of admission into the world of mental health parity. As art therapists, we are simply not equipped by interest or by training to be scientist-practitioners. Until we are able to collectively recognize the importance of research to the growth and professionalization of our discipline, and to insist that our graduate programs instill a recognition of this importance into the next generation of art therapists, we will continue to be perceived as the ashtray makers of mental health.

Reference

Tibbetts, T.J., & Stone, B. (1990). Short-term art therapy with seriously emotionally disturbed adolescents. *The Arts in Psychotherapy, 17*(2), 139–146.

---

* This article originally appeared in the *Southern California Art Therapy Association Newsletter*, Summer 1990. Reprinted with permission.

Invited Response

Harriet Wadeson, PhD, A.T.R.-BC, HLM, Evanston, IL

I certainly support Terry Tibbetts' plea for the encouragement of research in art therapy. I have tried for a number of years to help enlighten our membership about both the potentials and problems in undertaking art therapy research. Clearly Tibbetts' article emphasizes the need for art therapists to explore our relationship to research, both as a profession and as individual art therapy practitioners. Toward that end I would like to comment on a few of the article's points.

First, the author states that art therapy is not taken seriously because of our failure "to generate empirical data that would support our claims to clinical effectiveness." This claim must be viewed in the context of outcome studies for other kinds of psychotherapy. Until relatively recently there were few such studies, and where they did exist, they indicated that comparable untreated patients recovered as well as those who received psychotherapy. More recently, large scale investigations have been undertaken by the National Institute of Mental Health to investigate the outcome of various treatments for depression.

In any case, although empirical support for positive art therapy outcomes would certainly substantiate art therapy's effectiveness, I do not agree that it is our failure to produce empirical studies that has compromised our position in a field where few such studies exist. Furthermore, it is important to understand the limitations of outcomes studies. Such investigations require definitions of positive outcomes. Some outcome criteria may be measurable—for example, improvement in school performance, decrease in hospitalizations, decrease in substance abuse, and decrease in employment absenteeism. But for the most part, art therapy is often directed toward an improvement in quality of life. That is not usually measurable or even defined. Self reports probably give the clearest indication, but many researchers find such measures too vague and too easily confounded.

In my experience, art therapists have been hired (the bottom line for being taken seriously) not because an administrator has read an article but, more often, because of a personal contact with art therapy. Students get hired because they demonstrate to administrators that they can provide a valuable treatment asset to the facility. An administrator who has valued an art therapist's work will want to hire an art therapist in the future.

Tibbetts states that clinically oriented art therapists "view themselves as clinicians rather than researchers." This does not seem surprising. Tibbetts deplores this "'either/or' dichotomy" and states that we should "insist that our graduate programs instill a recognition of this importance [of research]." As an art therapy educator, I realize how little time we have in a 2-year Master's degree program to train a clinician. I believe that like the other mental health professions to which Tibbetts compares us (psychology, social work), we should expect our doctoral candidates to produce research. Even not considering the missteps that may occur along the way, it requires more than 2 years for students to learn to design and conduct research, to develop a research hypothesis, to identify and establish a client population then conduct a pilot study, and to collect data, then analyze it and draw conclusions. It's one thing to desire research in art therapy. It's quite another to set up to conditions to facilitate it.

As in other disciplines such as psychology and social work, not every clinician is a researcher. The sort of fulfillment that draws one to the work of art therapy is very different from the satisfaction derived from conducting research. It is not surprising to me that some art therapists might eschew undertaking research projects. One might argue, however, that a Master's degree program could teach research methods in such a way as to instill an appreciation of research without requiring students actually to engage in research. I believe this would be a very dry exercise. One learns research by *doing* it.

So, what's the solution? As I mentioned earlier, doctoral programs. The student could gain a sound research foundation, have time to plan and conduct research, and make a contribution to field.

I believe there are many more possibilities than the outcome studies Tibbetts (and many other art therapists) have wanted. In the images our clients produce we have a unique array of data. Unfortunately, we do not know what to do with it. It has much to tell us about the human condition if only we knew how to read it. I have made some primitive suggestions (Wadeson, 1992), but we need much more extensive work in developing methodologies to explore the knowledge images hold. We are more adept in the more clinical realm of encouraging our clients to connect with their images than we are in empirical investigations of them.

My direction in the "crossroads" Tibbetts examines would be to encourage those wishing to pursue art therapy doctorates to blaze a new trail through the uncharted territory of art therapy data. New methodologies could go far beyond identifying and/or counting visual characteristics. We need unique ways to approach our unique art therapy data. If we develop methodologies that are more consonant with the nature of our art therapy work, more art therapists might become impelled toward research.

Reference

Wadeson, H. (Ed). (1992). *A guide to conducting art therapy research*. Mundelein, IL: American Art Therapy Association.

Invited Response

Robert Wolf, MPS, A.T.R., NCPsyA, New York, NY

While it is true that there is a lack of empirical data on art therapy, I found the tone of Tibbetts' article to be quite simplistic and, at times, demeaning in the author's generalized attitude toward art therapists. If it is the author's intention to alert art therapists to the need to publish statistical data, such a judgmental approach, in my opinion, will be ineffective in accomplishing this goal.

Furthermore, the author's assumption that art therapists are second-class citizens simply because we lack this data and are, therefore, not accepted by "scientist-clinicians" seems to be a rather large leap in logic and may not necessarily be correct. The author's thesis that the lack of empirical research has led to our "credibility problem" breaks down if we realize that other psychotherapies, such as contemporary psychoanalysis, do not suffer from the same second-class citizen syndrome, but do also suffer from a paucity of empirical data. Therefore, it cannot simply be the lack of such data that creates this situation.

This raises several larger questions: Is the true value of what we do as art therapists actually measurable through scientific, quantifiable data? Do we want to be absorbed into such a purely scientific community? Or, is what we do very special and different from other "scientific" therapies and, therefore, in need of new and different venues of application as well as tools of measurement?

I believe that these questions begin to speak to the true dilemma for our field. It is not simply that we, as artists, aren't competent to conduct scientific research, but rather that we, as artists, are sensitive to the complexity of these issues and strive to maintain our unique identity. If we try to quantify something that defies such measurement, we may be contributing to the diminution of our credibility.

For many people art therapy is not simply a way to cure illness but rather a vehicle of self-actualization and deep emotional integration. As art therapists in private practice, we often don't see our clients as sick patients, but rather as people who are seeking ways to grow emotionally and spiritually. If we simply follow the existing scientific clinical structures, we have to apply categories of mental illness and dysfunction which often don't really fit our clients. We may even have to choose a "diagnosis" from the DSM-IV to enable our clients to receive reimbursement for our services, which may feel like putting a round peg into a square hole.

These are the deeper issues and Tibbetts' article seems to be lost on the superficial tip of the proverbial iceberg. What we are really describing here is a professional "identity crisis." How do we convey the value of what we do without losing our uniqueness and, therefore, undermining the credibility and effectiveness of our profession? Unfortunately, there is no simple solution to this complex problem. I don't believe that simply producing empirical data will be the miracle cure for our dilemma.

Additionally, the author's tone of frustration cannot possibly serve any productive purpose towards resolving this complex problem. What we need is a slow and thoughtful process of evolution which recognizes and respects the power of art therapy as a specialized field of practice which may very well be better understood as an "artform" rather than as a scientific "cure" for a mental disease.

Associate Editor's Note: Dr. Tibbetts suggested that two art therapists be invited to respond to the paper. Dr. Wadeson and Mr. Wolf were invited to respond in writing. Dr. Tibbetts was also asked to reflect on the article, written 5 years ago. Readers are invited to respond in Letters to the Editor or the Viewpoints section of this journal.

Further Reflections on Art Therapy and Ashtray Making

Terry J. Tibbetts, PhD, A.T.R., San Gabiel, CA, 7/31/95

In reviewing this article before its reprint in *Art Therapy*, I am struck by how little seems to have changed in the 5 years since it was written.

There is an old saying that if you always do what you've always done, you'll always get what you've always gotten. In the past few years, from my perspective, not only has art therapy as a field continued to avoid a focus on empirical validation of its efficacy, but we actually seem to have gone backwards. The single major change in obtaining the A.T.R. is that we now require proof that an applicant has taken studio art courses. This may be an ego-enhancing reminder of how we (as art therapists) believe art therapy is qualitatively different from other therapeutic approaches, but it says little to the larger mental health system about our commitment to clinical excellence—"Well, maybe I did miss that client's suicidal symptoms, but, by golly, take a look at the quality of these ashtrays. Took me five classes to get 'em right, but look at 'em now."

Some of my colleagues point to the establishment of the Art Therapy Certification Exam as an example of the field's increasing professionalization. I *do* view this as a step forward—in creating such an internal quality control mechanism, we are making the statement that we believe ourselves to be a distinct and competent profession. However, it seems to me that this somewhat misses the point. Professionals have a commitment to human change through the systematic application of empirically derived and research-based interventions; artistically oriented art therapists have a commitment to human change through the building of an awareness of and appreciation for the intrinsic meaning of one's own artwork and the healing power of aesthetic creativity. And, while there is a creative tension between the two approaches that can be used in a productive fashion, I am not sure that it is either valid or useful to claim that one can serve both masters equally well.

In fact, *are* we a profession? Or, are we simply a discipline? Or, maybe just a field of specialization? Do we even know, or have we even thought it through? In California, for example, art therapists can easily be licensed as Marriage and Family Therapists. Yet, in the State art therapy organizations this causes much wailing and gnashing of teeth. At the present time, there is a tremendous amount of energy being spent on attempting to get new legislation introduced to allow art therapists to be "registered" (not unlike the process used to register occupational therapists). I am not sure that this is why I went through an art therapy graduate curriculum, fieldwork, and internship, so I could be thought of as the equivalent of an occupational therapist (don't they make ashtrays, too?).

A few years ago, I worked as a coordinator of a quality assurance unit for the State Department of Mental Health. In a review of a local mental health agency, our unit cited the clinic for allowing their clinical psychologist (not an A.T.R.) to write in his notes that he was providing "art therapy" to a client. He was furious and contended that he did not have to be an A.T.R., and, in fact, because he was licensed as a psychologist, "I can provide any type of therapy I feel comfortable with." Perhaps. But did he take those five ceramics courses? More importantly, how would each one of us respond to his assertion? And, on what professional/empirical basis would we justify our responses?

Peterson (1976), in an incisive and well-reasoned article, discussed a similar dilemma in the development of clinical psychology. In his article he identified several conditions which any human service field had to meet to be considered a profession and noted that "the fundamental attitude of the professional practitioner…resembles that of the scientist" (p. 573).

I may be wrong, but I believe that many AATA members would reject that statement. As a field we have never explicitly worked through the issue of whether we are artists first or scientific practitioners first, and I suspect that any dialogue on the issue would be extremely heated (although hopefully productive). Until such an exploration occurs, however, I submit that we will not be asked much by mental health professionals about client dynamics—but we'll sure be asked a lot of questions about ashtrays.

References

Peterson, D. (1976). Is psychology a profession? *American Psychologist, 31*(8), 572–581.

Art Therapy Research: Learning from Experience

Debra Linesch, PhD, A.T.R., Los Angeles, CA

Introduction

This abbreviated description of a research project explores the experiences of five art therapy researchers. Both verbal and artistic descriptions of the art therapists' experiences are used to gain understanding of the specific issues that arise for art therapists engaged in research. The paper demonstrates a research protocol that addresses issues which emerge throughout the exploration. In this way, the content and findings of the project are interconnected with the methods used. The entire project is motivated by my concerns regarding the historic struggles the field of art therapy has had with scholarship.

The approach to research used is qualitative, making use of phenomenological and hermeneutic methods. In-depth, open-ended interviews are used to explore therapists' experiences with research. Four questions define and specify the intention of this research:

1. How do the art therapists' personal backgrounds and training prepare them (or not prepare them) for becoming involved in research?
2. How does the art therapists' clinical work integrate (or not integrate) with their research interests?
3. What obstacles to research involvement are experienced by art therapists?
4. What supports the art therapists' interest and involvement in research?

Review of the Literature

Little discussion has appeared in the field's journals debating the epistemological and methodological approaches to scholarship. Kwiatkowska (1978) is the first art therapy theorist to directly address the issues of research, claiming that even though the clinical judgments art therapists make are impressionistic, these judgments can be systematically organized and can offer solid conclusions. Her cautions regarding inevitable difficulties concerning quantification reflect the attitudes of many art therapy clinicians and would-be researchers who believe the very nature of the art process resists the research process despite their yearning for the validity and respectability that proper research design would offer the field.

Wadeson (1980) focuses more extensively on the issues of research than previous art therapy theorists and recognizes the complex problems in methodology in the field. She acknowledges the need for art therapists to "refine, modify and adapt them traditional science methods to the peculiar problems posed by this field" (p. 138), and goes on to say, "Art therapists may even have to develop new methods" (*Ibid*).

Rubin (1978) acknowledges the field's historic hostility toward research as well as the inherent difficulties in research design that involve artistic productions, but articulates clear and early encouragement for clinicians to openly approach the inquiry process.

In 1984 Rubin, taking another look at the research problem in the field of art therapy, concludes that there is an inherent difficulty in the field's attempt to find reliable and meaningful ways of scoring the products of art therapy. Although she agrees that art therapists need to become capable of doing meaningful research so the stature of the field grows, she acknowledges that options outside the quantitative sphere exist: "We may have gotten caught in the empiricists' numerical web, refusing to recognize the phenomenologically subjective nature of the creative experience" (Rubin, 1984, p. 184).

In his book about the education of creative art therapists, McNiff (1986) takes a strong stand regarding the compatibility between nontraditional, qualitative research methodologies and the inherent approach to knowing that is part of the art therapy process. He exhorts educators to consider research as a post-Master's degree experience and repeatedly emphasizes how traditional behavioral science methods do not always apply to the work of art therapy.

In a published dialogue, Junge (1989) and Rosal (1989) directly address the issues of methodological approach. Rosal encourages the introduction and expansion of single-case research, while Junge articulates her belief that a whole spectrum of research approaches would most likely benefit the scholarly struggles in the field. In 1993, Junge and Linesch discussed the specific compatibility between the scholarship struggles in the field of art therapy and the new potential being made available in the expanding human science methodological spectrum. Also, using a questionnaire (Linesch, 1992) to assess what kinds of approaches to research are being taught in art therapy training programs, I explored my concerns that specific methodologies for art therapy research are not being considered.

Research Approach

The research approach selected for this exploration is qualitative, based on my commitment to make the methodology compatible with the theories and clinical practice of art therapy. It is helpful to define qualitative research more comprehensively than simply a reaction against reductive or quantitative research. Qualitative research is a set of inquiry processes that offer rigorous but open-ended opportunities to explore human experiences in depth. By avoiding the reductive tendencies of quantification, qualitative approaches respect the complexity of human experience and allow for the emergence of meaning and understanding.

Based on the intent to explore the experiences of art therapists who do research, I narrowed the approach of this inquiry to a phenomenological mode. The phenomenological approach (Giorgi, 1985; Ihde, 1986) involves the lived world of experience from which meaning emerges based on description (usually through language) and analysis of that description. Phemenology and its attendant methods support exploring understandings rather than proving or validating existing theory or knowledge. Although I understood my overall approach as qualitative and the scope of my inquiry as phenomenological, it is more specifically within the methods of hermeneutics that I found a methodological home for my exploration. Hermeneutics (Gadamer, 1960; Palmer, 1969; Ricoeur, 1981), a theory that claims all understanding is contextual interpretation, offered my inquiry the opportunity for interpretive engagement in a manner that is similar to the therapeutic engagement I experience in art therapy.

Methods and Procedures

Five practicing art therapists known to be interested and involved in research processes were interviewed for this endeavor. Four of the five were graduates of a West Coast art therapy program and the fifth graduated from an East Coast art therapy program. All five were working as art therapists in the Southern California area and had been involved together in a continuing education workshop to support and facilitate their participation in research endeavors. All four of the West Coast graduates had been engaged in research: one had published prolifically about Jungian theory and was working on an integration of art and sand tray therapy; the second had pursued a detailed examination of 11 years of her paintings as a recovering cancer patient; the third had used a questionnaire to explore professional transitions experienced by art therapists; and the fourth had been involved in an exploration of the imagery of a ritually abused client. The fifth participant had expressed an interest in becoming a researcher and was attending the workshop to support this career goal.

Using Mishler (1986) as a resource for interview style, I developed an interactive interview process, fully embracing my own subjective experiences as support for the development of my understanding of the art therapists' experiences. I listened to the respondents' answers for meaning and paid attention to my own internal stirrings, attempting to allow an overall conceptualization or mapping of the interview to surface and let it resonate with my own personal experiences as a way to come to understand it. I asked the respondents to draw the material we had discussed in an attempt to diagram and come closer to interpretable and shareable metaphors. Indeed, metaphors became integral to the interview process as intersubjective connections that supported the deepening understanding of the meanings within the dialogue.

Once the interviews were complete, they were carefully transcribed, replayed, and rechecked for accuracy. Drawings created by the respondents were appended to the transcripts, and together this became the research data. Interpretive procedures from both phemenology and hermeneutics were used to analyze the art incorporating an iterative use of patterns and metaphors to amplify understanding. The detailed protocol I used for this methodology proceeded through seven steps. Illustrations of each step are included to clarify the procedures.

1. Listing expressions (or horizontalization)

The first step in the process of interpretive data analysis involved careful examination of the verbal description of the experience. Repeated examination allowed identification of expressive units (clusters or groups of words that combined to create discreet meanings). The process of horizontalization gave equal value to each expressive unit, in effect breaking down the data into reusable fragments that could be used in a meaning-making reconstruction. For example, Table 1 lists the first 10 expressive units that were identified in the interview with the first art therapist (B).

Table 1 Listing the Expressive Units

Number	*Speaker*	*Expressive Unit*
1	Debra	earliest experience in research?
2	B	interest in science from childhood
3	B	I had chemistry sets
4	B	I used to dissect things and look at them under the microscope
5	B	I consider that a type of research
6	B	First formal introduction to research was when I was 15 years old
7	B	I was encouraged to enter a science fair
8	B	I developed a real research project
9	B	paper and pencil testing of the other kids
10	B	getting data, raw data

2. Identifying metaphoric structure

The second step involved fundamentally phenomenological analysis made in an attempt to determine the structures that represented the essential components of the respondent's experience. To evolve a structural understanding I diagrammed and rediagrammed my overall understanding of the interview and identified categories (or groupings of the expressive units identified in Step 1) that combined to present a metaphorical framework for the text. For example, in my analysis of the first interview I arrived at a metaphoric structure (based on my understanding of B's words and her imagery) that included 12 categories depicting her development from an early perception of a split between scientist-self and artist-self to maturing integration.

3. Clustering the units of expression

My next step was to sort or cluster the units of expression into the categories I had identified (components of the structural metaphor created in Step 2). The process of clustering the expressions involved formally organizing the categories of meaning and resolving decisions about which expression best fit in each of the categories.

Table 2 illustrates the results of this arduous step with the data from the first interview.

Table 2 Clustering the Expressive Units

Cat. #	*Category Description*	*Number of Expressive Units Identified*		*Example of Expressive Unit*
		B	*D*	
IA	Early experiences — Science Fairs	17	1	#7: I was encouraged to enter a science fair
B	College	23	4	#32: always been intrigued by the scientific method
C	Art Involvement	18	7	#55: and I thought it was very separate
II	Identity Crisis	31	5	#83: I acted out the split
III	First Resolution	5	3	#110: just trying to develop my artistic life
IV	Hodgkin's Disease	16	2	#131: Madame Curie did it, why I can do it
V	Second Resolution	29	8	#149: I wanted to have an influence on the human psyche
VI	Relapse & Recovery	2	1	#172: 3 years of trying to get back on my feet
VII	Discovering Art Therapy	11	0	#181: as soon as I got a taste for the field
VIII	Third Resolution: Part 1	36	21	#226: I was not sure whether or not this was research
IX	Third Resolution: Part 2	13	5	#248: I can't recall having seriously considered doing research
	Insert	25	7	#269: I have a lot of stuff in my drawer
X	Pathways Research Seminar	25	8	#294: that's been a big event in my life
XI	Fourth Resolution	26	4	#326: I'm looking at something very big
XII	Current Integration	47	23	#396: I'm breaking down the barriers and all these things are moving closer together and becoming more unified

4. Structural description

Once the units of expression had all been categorized within the metaphoric structure that illuminated the essential meanings of the described/drawn experience, all the essential categories were linked together and created a reconstructed narrative of the text which I called a structural description of the experience. An excerpt from the beginning of the resulting narrative illustrates the results of this step.

1. Early Experiences

A. Science Fairs

When asked about her earliest experiences in research, B discussed her childhood interest in science and her first formal introduction to research when she was encouraged to enter a science fair in which her project involving paper and pencil testing of other kids won an award. She described how the project taught her about getting data, making correlations, and following the scientific method.

B. College

She proceeded to discuss her psychology major at UCLA, and when asked if her orientation was research or clinical, she described how she learned everything—statistics, experimental psychology, reliability—and although she didn't participate in faculty research, she was intrigued by the scientific world and its methods. She was especially interested in learning about misinterpretations, how statistics don't mean anything without understanding how material was collected and about contamination.

C. Art Involvement

When asked if she was doing artwork at the time, she said yes, but described her creativity as disconnected, diametrically opposed to her interest in science. When the idea of two sides to herself was suggested, she spoke about how she separated her rational self from her intuitive self and how she saw herself as a split person.

5. Textural analysis

The next step was to subjectively and creatively describe my own personal understanding of the interview text. In the methodology my creative process was manifest in the embellishment and rewriting of the above-mentioned structural description, a process by which the textural analysis was created.

An excerpt from the beginning of the resulting narrative illustrates how the description of B's experiences changed as I engaged more creatively with her descriptions. (The words and phrases that are most representative of my own subjective and personally contextual interpretations are italicized.)

B talked nostalgically about her childhood experiences with the scientific method. As she described her early interest in biology her enthusiasm for her life-long curiosity was evident. Her early competitive success in a science fair emerged as a significant life experience that catalyzed an interest in scholarship.

B described her voracious appetite for knowledge as she began UCLA. Her ongoing yearning to know motivated her sustained interest in the scientific world and in particular her curiosity about methodology and its misapplications and limitations.

B defined her early involvement in artwork as separate from her interest in science, in fact representing a facet of herself that was completely split off from her intellectual side. The idea of a large and complicated internal schism emerged.

6. Structural/Textural integration

The next step involved integrating the structural description (that had been carefully extracted from the analysis of the narrative text in Step 4) with the textural description (that had been a result of my creative and subjective responses to the structural analysis of Step 5). The result was a combination of what was said and what was interpreted which seemed to come close to essential understandings of the experiences that were being explored. An excerpt from the beginning of the resulting narrative illustrates this combination of communication and interpretation.

1. Early Experiences

When asked about her earliest experiences in research, B discussed her childhood interest in science and her first formal introduction to research when she was encouraged to enter a science fair. Her voracious appetite for knowledge emerged as the dominant force in her early life.

She discussed her psychology major at UCLA and her sustained interest in the scientific world, particularly the misapplications and limitations of methodologies.

When asked if she was doing artwork at the time, she described her creativity as diametrically opposed to her interest in science and the idea of a large complicated internal schism emerged.

7. Integration of respondents' reactions

In an effort to return to the originators of the description, I submitted all three narrative summaries (structural, textural, and structural/textural) to the respondents and elicited their feedback.

Responding to the interpretive understanding I developed of her statements, B wrote:

> *What I think impresses me the most and what lends such emotion to what you have produced here is how perceptive (for want of a better word) your observations are and how uncanny (there's a better word) your analysis is, in the sense of having gleaned so much that is fundamental to my life struggles, so neatly and so accurately from a rather short exchange of words on one afternoon…and what is especially touching to me is how obviously you were touched by this entire process.*

Results

The five interviews analyzed in this research discuss the experiences of five art therapists participating in research. During the interview process I offered the respondents no definition of research, no parameters for what research involvement meant, nor any specific guidelines about how to interpret my encouragement to simply discuss their experiences. As a result, the research experience was broadly, subjectively, and quite differently defined by each respondent. In some ways this lack of a concise definition for the very phenomenon I was investigating was problematic in the data analysis process. However, since this endeavor was fundamentally about facilitating open-ended discussion to catalyze understanding, I allowed this definitionless state to exist as fertile ground for the emergence of new understandings of the research experience in the field of art therapy.

It is beyond the scope of this paper to present the detailed data analysis supported by the seven-step protocol. Within the meticulous procedure, exhaustive efforts were made to get as close to the meanings of the texts as possible. One quote from the journal I kept throughout the process illustrates the intensity (both emotional and intellectual) of the procedure. Responding to my own weariness and frustration with the painstaking details of qualitative data analysis, I wrote:

> *I am overwhelmed by how intimately connected to (her) language I am. What a privilege to look this deeply into another person's meanings. I am exhausted by this meticulous work but feel so close to new kinds of understanding—not only of (her) words but of my own interpretive context as well.*

From the data analysis emerged five art therapists' stories full of life and meaning that can help inform future scholarship in our field. Rather than tell their stories (contained within the original research project), the remainder of this paper focuses on implications. The study questions introduced earlier are used as a framework for the discussion.

1. How do the art therapists' personal backgrounds and training prepare them (or not prepare them) for becoming involved in research?

The interview data suggest that, as in any other facet of life, research involvement is reflective of one's own history. All five respondents thrive or suffer (sometimes both) as researchers because of their personal backgrounds. This connection between early (often familial) attitudes about inquiry and later success as a researcher is a theme throughout all the dialogues.

One of the participants identified how the conflicts between her family's "male orientation" and her own sense of being process-oriented (i.e., feminine) contribute to her ambivalence about research involvement and, consequently, hinder her whole-hearted participation.

Another who has always seen herself as an artist has always thought that identity prevents her from participating in research of any form. The ambivalence she feels about research involvement hinders her whole-hearted participation. Implicit in these findings is the suggestion that in order to fully engage in the kinds of qualitative research to which art therapists gravitate, the participants must explore and be aware of their own personal history and attitudes about inquiry and epistemology.

2. How does the art therapists' clinical work integrate (or not integrate) with their research interests?

All five respondents in this research process expressed that their interest in scholarly exploration is directly sparked and supported by their contact with clients. Although one respondent initially claimed that her clinical work kept her too busy to consider becoming involved in formal research, as she talked she became aware of many potential exploratory projects that had grown directly out of her work and sparked her interest and enthusiasm.

Another, certainly the most experienced researcher interviewed, clearly articulated the connection between practice and research that all five participants either yearned for or achieved in varying degrees. This sense of scholarship as a natural growth from the art therapists' clinical experiences suggests that research approaches within the field of art therapy must respect and perhaps mirror the ways art therapists come to know their clients.

3. What obstacles to research involvement are experienced by art therapists?

All five respondents originally held the preconceived idea that research in the field needed to be traditional, quantitative, and reductive. This idea seemed to both dominate and discourage the desire to do research and was reinforced by the interconnected idea, also held by all five respondents, that the art process somehow resists the research process.

Thus, this two-pronged belief system appeared to limit all five participants' attitudes and enthusiasm regarding formal research involvement. One expressed her frustration that the art process was too subjective and consequently evaded the legitimacy and validity that "proper" research required. One reflected her ambivalence about trusting the art process as a research method, an issue that was directly related to her difficulty in valuing her own beliefs. Another, who had previously published extensively, described being disarmed and overwhelmed by the male orientation of traditional research and the narrow medical models typically followed by published art therapy research.

4. What supports the art therapists' interest and involvement in research?

The interview data obtained in this research project support the idea, reflected in art therapy literature (Rubin, 1978; Wadeson, 1980), that student and clinician alienation from research could be ameliorated with support, involvement, mentors, and broader definitions of research. All five respondents

BEST COPY AVAILABLE

discussed different kinds of supportive experiences they had in the past that had helped them engage in research. One explained how early relationships with research had facilitated her scholarly interest, and another emphasized the importance of the support she received from other women as well as the opportunity to learn about nontraditional models of research. She also alluded to the importance of integrating art processes with research experience.

Overall, the interviews indicate that involvement with mentors, group support, and awareness of a broader spectrum of research approaches could do much to minimize the kinds of resistance to research seen in these particular art therapists.

Summary of Findings/Understandings and Meanings

The understandings that emerge from this exploration can be simply summarized. For the five art therapists interviewed, scholarship is not an impersonal endeavor disconnected from their personal history. It is an aspiration of significance in their personal and professional development, connected to their values and beliefs as psychotherapists and women. Educationally and professionally these women have experienced intimidation, alienation, and ambivalence regarding participation in research, partly as a result of their own tendencies to understand quantitative empirical research as the methodology of choice and partly as a result of their perceptions that the art process resists methodological rigor. They also perceived, however, that broader definitions of research, involvement with mentors engaged in research endeavors, and ongoing support have impacted and could continue to impact these obstacles to participation. All five expressed enthusiasm for continued development of their identity as researchers.

The findings of this research project open up possibilities for new kinds of understandings about research in the field of art therapy. For the art therapists interviewed, research is an extremely personal, process-oriented endeavor that needs specific kinds of encouragement to overcome deeply rooted resistance. It is my hope that the stories of these five art therapists and the consequent understandings will help the field of art therapy explore and define meaningful connections between its theories, its clinical practice, and its research methodologies.

References

Gadamer, H. (1960). *Truth and method.* New York: The Seabury Press.

Giorgi, A. (1985). *Phenomenology and psychological research.* Pittsburgh, PA: Duquesne University Press.

Ihde, D. (1986). *Experimental phenomenology: An introduction.* Albany, NY: SUNY Press.

Junge, M. (1989). The heart of the matter. *The Arts in Psychotherapy, 16*(2), 77–78.

Junge, M., & Linesch, D. (1993). Art therapists' ways of knowing: Toward new paradigms of research. *The Arts in Psychotherapy, 20*(1), 61–67.

Kwiatkowska, H. (1978). *Family therapy and evaluation through art.* Springfield, IL: Charles C Thomas.

Linesch, D. (1992). Research approaches within master's level art therapy training programs. *Art Therapy: Journal of the American Art Therapy Association, 9*(3), 129–134.

McNiff, S. (1986). *Educating the creative art therapist.* Springfield, IL: Charles C Thomas.

Mishler, E. (1986). *Research interviewing.* Cambridge, MA: Harvard University Press.

Palmer, R. (1969). *Hermeneutics.* Evanston, IL: Northwestern University Press.

Ricoeur, P. (1981). *Hermeneutics and the human sciences.* New York: Cambridge University Press.

Rosal, M. (1989). Master's papers in art therapy: Narrative or research case studies? *The Arts in Psychotherapy, 16*(2), 71–75.

Rosal, M. (1989). Not at odds. *The Arts in Psychotherapy, 16*(2), 79.

Rubin, J. (1978). *Child art therapy.* New York: Van Nostrand Reinhold.

Rubin, J. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Wadeson, H. (1980). *Art psychotherapy.* New York: John Wiley & Sons.

Photo Essay: Revisioning/Revisiting

Suzanne Calomeris, MA,
La Grande, OR

These watercolor and ink images were produced in early 1995. They allude to my move from an Australian coastal metropolis to a tiny, inland, rural town in Oregon. The spirals, ever expanding, can be a symbol for the self. Exchanges that occur in the work result from interfacing with new environments and cultures.

Imagery assists the processing of my personal sense of boundaries—physical, emotional, spiritual, and professional—in relation to everything else that is.

Visual references are made to some Aboriginal ways of depicting landscapes.

The images are 3″ x 5″, using watercolor with ink(s) on paper.

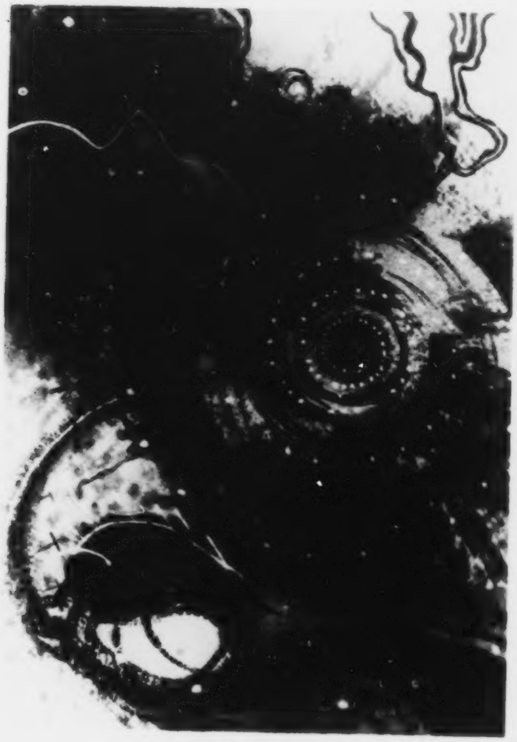


Figure 1 Untitled 1

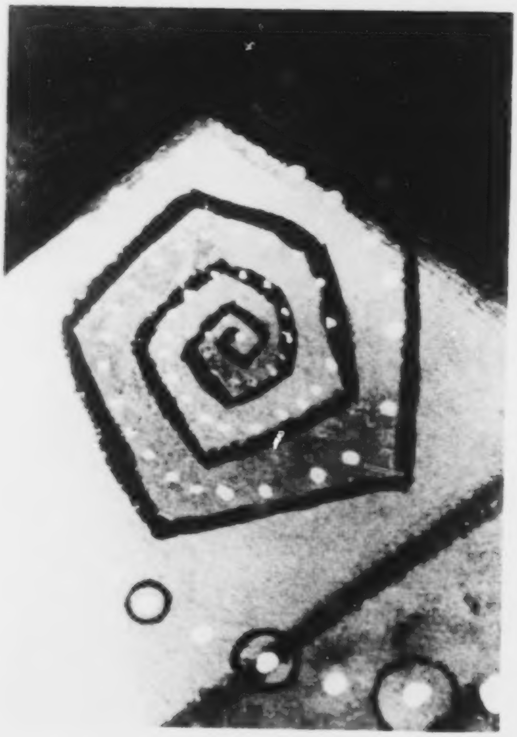


Figure 2 Untitled 2

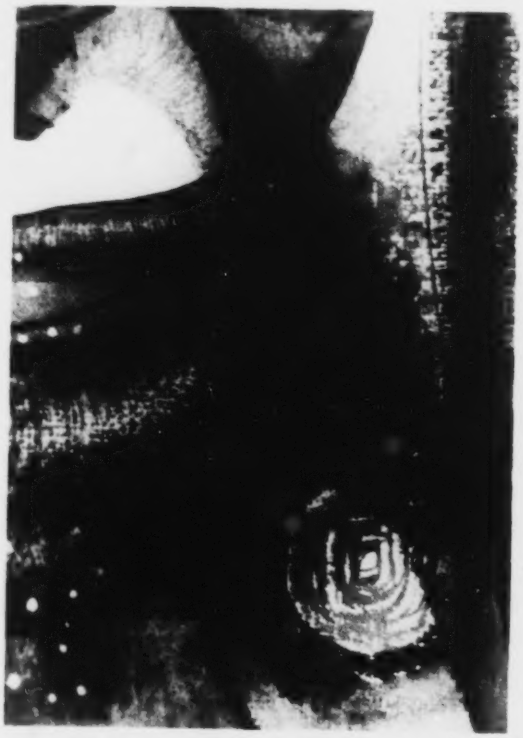


Figure 3 Untitled 3

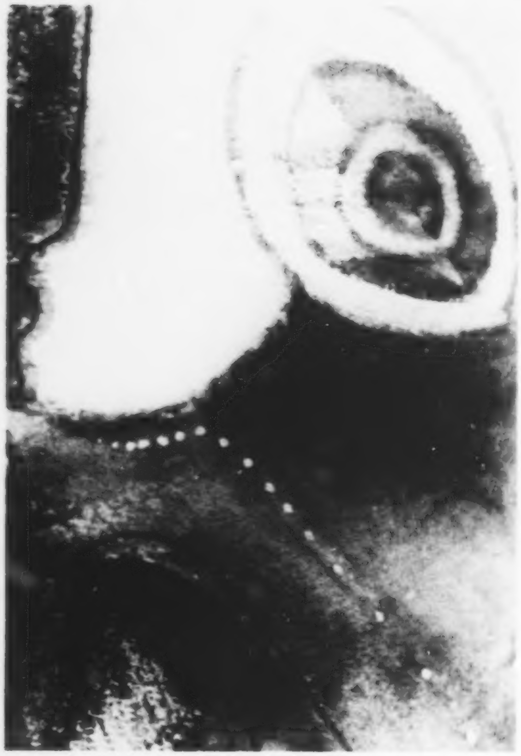


Figure 4 Untitled 4

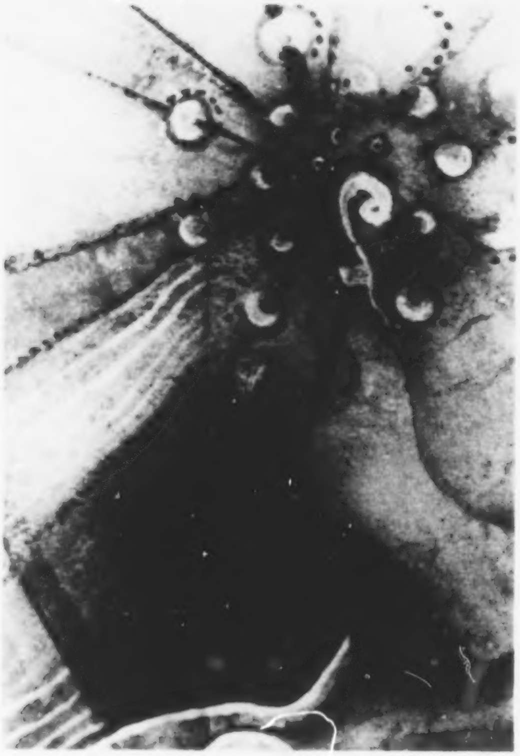


Figure 5 Untitled 5

Reviews

Art Therapies and Clients with Eating Disorders: Fragile Board

Edited by **Ditty Doktor**, London & Bristol, PA:
Jessica Kingsley Publishers, 1994.
309 pp., $29.95, paper. ISBN 1-85302-256-X

Reviewed by **Barbara Sprayregen, PsyD, A.T.R.**,
Arlington, MA

There is, unfortunately, far too little literature on the interface between art therapy and eating disorders. I was, therefore, very excited to learn about the publication of *Arts Therapies and Clients with Eating Disorders: Fragile Board*. This is a good book that makes a substantial contribution to a difficult area of clinical work. Ditty Doktor, editor of the book, is a British dramatherapist who brings together a group of knowledgeable, experienced, talented arts therapists who work and reside primarily in England. The book also includes powerful artwork and writing by a recovered anorexic and working artist.

Arts Therapies and Clients with Eating Disorders: Fragile Board is divided into six sections: Introduction, Art Therapy, Dramatherapy, Psychodrama, Dance and Movement Therapy, and Music Therapy. Doktor begins the introduction by providing a sociocultural, psychological, and biomedical context for the existence of eating disorders. She clearly discusses the complex factors which contribute to the etiology of eating disorders. She goes on to define anorexia and bulimia, according to DSM-III, and to describe the various modalities that comprise the arts therapies. Her discussion then turns to the area of treatment where she advocates a multidisciplinary approach in which medical, cognitive behavioral, and psychodynamic components are all given attention.

Doktor espouses a hypothesis about why the arts therapies are appropriate for treating the population of eating disordered clients. In a section of her chapter "'Acting Out' therapies for 'acting out' clients," she elaborates:

> *The arts therapies practise direct action within their art modality in the therapy. It is important to consider how this acting out can be transformed into a therapeutic form of action, which allows for internal change. This is especially important for acting out client groups such as clients with eating disorders, as they are seen in a psychodynamic framework as acting out through the body their underlying emotional conflicts.* (p. 16)

Like most British arts therapists, she uses an object relationally based, developmental perspective to understand the origins of eating disorders.

Artist Elise Warriner completes the introduction with a moving account of her recovery from anorexia, in which art therapy played an important role. She asserts, "Strange as it may seem anorexia and illustration have at least one thing in common. They are both about expressing oneself without words, yet one is destructive and the other creative" (p. 24).

Part II contains three excellent chapters on art therapy which I will briefly summarize. Joy Schaverien discusses "The Picture as a Transactional Object in the Treatment of Anorexia." Her work refers primarily to individual art therapy with hospitalized patients. She takes an object relational, developmental perspective to understanding anorexia as a presymbolic level of experience or a concretizing of experience. Her theoretical approach is multilevelled and elucidating. Two of her greatest influences in this chapter appear to be D.W. Winnicott and Christopher Bollas. She weaves an illustrative case into her narrative. She writes,

> *The client's relationship to food may be understood to be a means of negotiating, and mediating, between the internal world and the external environment...the art object may temporarily, and unconsciously, become a substitute for the use of food. It may serve a positive function as a transactional object.* (p. 31)

Mary Jane Rust describes her outpatient group art therapy for women who are compulsive eaters. She contrasts three different groups she ran and looks at group members' styles of drawing and interaction in relation to a developmental formulation about the origins of eating disorders. This chapter is useful, among other reasons, for its attention to the interpersonal aspects of the treatment of compulsive eating problems. Rust recognizes the way that imagery in group work becomes a vehicle for sharing and dialoguing about members' inner worlds. She states, "Art therapy is one way of bringing...issues to light, or helping conflicts to move from being locked in the concreteness of the body to a place where they can be imagined, expressed, thought and spoken about" (p. 49).

The final chapter on art therapy was written by Paola Luzzatto. She describes a technique she has developed for creating and using what she refers to as a "Self-World Image" in the treatment of anorexic patients. She hypothesizes that the basic conflict for many anorexic patients involves becoming entrapped within their own defensive processes. She metaphorically labels this the "mental double trap of the anorexic patient." The double trap is composed of three essential elements: a small and helpless self, an enclosure which both protects and imprisons the fragile self, and an indication of persecutory, dangerous forces in the environment or even within the enclosure. She elaborates, "The double trap may be seen as a graphic illustration of what Guntrip (1982, p. 425) calls a 'static closed sado-masochistic system of internal bad-objects'" (p. 64). She describes how she works with the double trap using the symbolic images to help the diminished self gain a sense of empowerment. According to Luzzatto, "The persecutor must lose its power as an internal object...the little self must gain strength. The need for the prison will then decrease" (p. 67). She describes her 16-week treatment of a male anorexic using this therapeutic approach.

Following the section on Art Therapy, the book goes on to cover Dramatherapy, Psychotherapy, Dance Therapy, and Music Therapy. As an art therapist, I found the remaining chapters to be theoretically rich and clinically useful. For example, Linda Winn's chapter discusses how she has successfully integrated art and dramatherapy in developing inservice training programs for staff who work with eating disordered clients. Dance therapist Sally L. Totenbier describes her "Body Image Therapy" technique which uses both image making and body work. Music therapist P.J. Rogers contributes an excellent chapter on "Sexual Abuse and Eating Disorders." While some sections cover techniques of music making or drama that I would not feel competent to use with clients, I found it enlightening to learn more about how expressive therapists work in their chosen modalities.

I found *Arts Therapies and Clients with Eating Disorders* to be a very valuable book. It is probably especially interesting for clinicians who resonate with object relations approaches to treatment and for clinicians who enjoy an emphasis on theory. The book appears to be more theoretically oriented than writings by North American arts therapists. Maybe it seems that way to me because of the various authors' clear and consistent grounding in a similar object relations perspective. This book will probably be less useful for novice therapists, because it is heavy on theory and contains limited illustrations and technical advice.

I have found only one other book that discusses arts therapies with the growing population of eating disordered clients. It is titled *Experiential Therapies for Eating Disorders* (1989). In this very good book, chapters are devoted to art, psychodrama, dance, music, poetry, hypnosis, and other related approaches. Unfortunately it is never cited in *Arts Therapies and Clients with Eating Disorders*. In fact, throughout my reading of the various chapters, I was continually surprised to find only one reference to any American art therapist. It seems a great loss that there is such a lack of dialogue and collaboration between arts therapists on different sides of the Atlantic Ocean.

References

Hornyak, L.M., & Baker, E.K. (Eds.) (1989). *Experiential therapies for eating disorders*. New York: Guilford Press.

Wet-into-Wet Watercolor: The Complete Guide to an Essential Watercolor Technique

Gail Speckmann, BA, New York: Watson-Guptill Publications, 1995.

144 pp., 200 color illustrations. $29.95 cloth. ISBN 0-8230-57715-1

Reviewed by **Tara Marean, MS, A.T.R.,** Croton-on-Hudson, NY

Writing for the beginning to intermediate watercolorist, Gail Speckmann, author of *Wet-into-Wet Watercolor: The Complete Guide to an Essential Watercolor Technique*, provides the reader with an explicit guide to painting with wet-into-wet watercolor techniques. The watercolorist who follows the techniques presented by Speckmann will develop an in-depth understanding of the materials, approaches, techniques, and applications of wet-into-wet watercolor. This book is not meant to address issues art therapists face when using watercolors with patients, nor does it suggest projects specifically for use in art therapy. Using the techniques presented in this book, the art therapist will expand her/his ways of using watercolor with patients.

It is valid to ask why an art therapy journal would publish a review of a book devoted solely to a specific art technique. It is accepted that art therapists must possess a high level of mastery of the materials they use. Wadeson (1980) states

> it is necessary for the art therapist to be familiar with what may be evoked by the different media, what advantages each offers and what limitations each has, so that the media may be selected appropriately. (p. 18)

The ability of watercolor to float and settle and to spread and bloom creates unique opportunities and challenges for art therapy patients.

Robbins (1984) says

> Watercolor, with its unpredictability and transparent nature, is hard to control and necessitates a willingness to be spontaneous, accept change, relinquish omnipotence. Being faced with issues of control and mess can bring to the surface conflicts of disorder and shame associated with internal objects. (p. 193)

Possessing powerful symbolic qualities, watercolor is a staple in most art therapists' supply closets. Therefore, it is imperative that its nature be fully understood. Rubin (1984) explains

> Such an awareness can only be gained through substantial personal experience with medium, tool or process... Only an art therapist who can assist a patient in the use of the medium is legitimately entitled to offer it. (p. 12)

Speckmann's guide provides the reader with a superb account of how to use watercolors. She begins with a 26-page account of materials. Informative descriptions of the behavior of inorganic earth pigments (ochres, siennas, and umbers), inorganic mineral pigments (cadmiums, cobalts, manganeses, and oxides), and organic carbon pigments (sepia and indigo) are carefully presented. She follows this with a description of possible palette choices, including recommended watercolor paint brands. While this brand-specific information is important to the working watercolorist, Speckmann's recommendations may be outside the average art therapist's budget. For example, Speckmann prefers Holbein's Juane Brilliant #1, available in 0.47 oz. tubes ($7.15, A.I. Friedman, NY, 1995), or Holbein's Aureolin ($12.25, A.I. Friedman, NY, 1995). Other recommendations include Grumbacher's Davy Gray, 0.25 oz. ($2.60, Artist's Buying Club, NY, 1995), and Windsor Newton Red in 0.47 oz. tubes ($11.60, Artist's Buying Club, NY, 1995). If the art therapist's budget allows for tube watercolors at all, she or he would be looking for something like Fantasia, a set of 12 .406 oz. tubes ($8.06, Nasco, California, 1995). An even more likely choice is the Crayola® Whole Pan Set of 6 colors ($4.95, Nasco, California, 1995).

Speckmann continues with a full and wonderful description of watercolor brushes and paper. While the brands of products described will not match most art therapists' budgets, understanding the qualities of paper weight and texture, brush quality, and pigment properties may enable art therapists to purchase less expensive substitutes capable of meeting their specific needs. This information also may offer direction for patients who intend to continue painting on their own.

Speckmann offers innovative options for equipping the studio. Art therapists may find useful her suggested uses for surgical gloves, blow dryers, shower heads, and plastic squeeze bottles. She recommends using a food baster to direct a stream of water at the paper, along with spray bottles to keep the paper moist. All items offer new possibilities for the art therapy experience.

The next 38 pages address basic approaches: working on saturated paper, painting by sections, and various approaches. Throughout this section, Speckmann provides highly detailed instructions. For example, in describing one stage of wetness, she says,

> Saturated and shiny; no standing water, but enough wetness on the surface in which the paint can do some very free and exciting things. Keep the paper perfectly horizontal once you have the image you want. You can wick away some moisture by touching the point of a paper towel in places where the paint will not be disturbed. Wipe away excess moisture from the edges. (p. 39)

Of equal clarity is Speckmann's description of paint consistency and the fully loaded paint brush. Speckmann carefully and completely tells how to accomplish each painting process, from the proper angled tip of the supporting board to techniques for lifting paint. Each approach is clearly demonstrated by a color photograph of a completed work followed by many specific exercises designed to explore the technique. Each exercise is clarified by several additional color photographs of examples.

Describing one problem art therapists may face when using watercolors with patients, Robbins states

> Watercolor,…runs all over the wet space that is provided, potentially causing a great deal of anxiety to the person with loose ego boundaries or fear of fusion. (p. 112)

A solution can be drawn from Speckmann's approach to painting by sections. She demonstrates "…a clear example of how painting by sections helps you control the boundaries of color area" (p. 51).

Especially useful to the art therapist is the section on masking. Again, the author's learning techniques to help control the paints' boundaries provide tools to help patients explore watercolors. She offers many innovative ways to control the spread of paints.

Speckmann's techniques of pouring paint, textural effects, and lifting color lend well to the art therapist's knowledge of the use of watercolor.

Gail Speckmann so thoroughly presents her techniques throughout her book that the final chapter, "Applications," seems almost redundant, except perhaps for fine tuning what she has already taught the reader.

As a watercolorist, I commend Speckmann for using words that *paint* descriptions so well that I could *see* them while reading. It was hard for this reviewer to continue reading, because I wanted to paint each exercise as it was presented. As an art therapist, I recommend that all art therapists who use watercolor with their patients read this book.

Resources

A.I. Friedman, 431 Boston Post Road, Portchester, NY 10573

Artist's Buying Club, 1736 Front Street, Yorktown Heights, NY 10598

Sax Arts & Crafts Catalogue, 2405 South Calhoun Road, New Berlin, WI 53151

Nasco Catalogue, 4825 Stoddard Road, Modesto, CA 95356

References

Robbins, A. (1987). *The artist as therapist*. New York: Human Sciences Press.

Rubin, J. (1984). *The art of art therapy*. New York: Brunner/Mazel.

Wadeson, H. (1980). *Art psychotherapy*. New York: John Wiley & Son.

Video Review

Courage: Together We Heal! Mural Messages from Incest Survivors

Written and produced by **Frances E. Anderson, EdD, A.T.R., HLM,** 1992.

30 minutes, color, VHS. Purchase only: $95 (includes a 25-page monograph on the subject). Available from **Frances E. Anderson,** 5620 Art Department, Illinois State University, Normal IL 61761-5620.

Reviewed by **Marcia L. Rosal, PhD, A.T.R.-BC,** Louisville, KY

Courage: Together We Heal! Mural Messages from Incest Survivors begins with vivid images of clay tiles produced by women involved in a 9-week art therapy group. Beautiful, yet haunting images set the tone for this sensitive documentary of a group art therapy program for women survivors of childhood sexual abuse. Clay, as the medium of choice for these abuse survivors, is the focus of the art therapy. A critique of the theoretical discussion, the experiences of the participants, and vignettes from the group experience are the focus of this review.

During the opening sequences of the video, we hear the words of one group member who describes working with the clay as tapping "the true depth of my potential." The use of clay as the primary medium for the group is profound. We learn that clay has specific inherent qualities suited to the therapeutic work of incest survivors. First, the narrator discusses the psychological issues of women who suffer from the lingering effects of sexual abuse. When it is revealed that two goals of therapy for this group are to (a) integrate intellect and affect, and (b) gain a sense of mastery and control, the choice of clay as a primary modality is clear to the art therapist. Nonetheless, the narrator next outlines aspects of working with clay that can help survivors: (a) the tactile aspect of working with clay helps survivors reconnect with their bodies; (b) working with clay can be playful and help survivors experience playful aspects of self; (c) working with clay is a sensory experience and provides an avenue to getting in touch with affect; and (d) clay is a success-oriented medium and as survivors experience success with using clay, a sense of mastery and increased self-esteem are noted.

Finally, the narrator provides an overview of the 9-week treatment plan. Using both still shots of clay products and sequences from the group, the viewer is led through the series of art therapy experiences developed for the group members.

First, the women are introduced to the clay by asking them to make both pinch pots and pots molded on their elbows. The making of pinch pots is a positive, simple means to succeed and a safe way of getting in touch with and expressing anger. To enhance group cohesion, some pinch pots are created by passing around a ball of clay and allowing all members to contribute to the final project. Through the creation of elbow pots, several members tap into physical pain and physical memories. One woman describes her elbow pot as a "torn vagina" and another notes that the "pots looked sexual."

Several sessions are devoted to using clay to create the family of origin and the family of choice. Therapists are careful to explain to group members, ahead of time, that both families will be depicted. Prior knowledge, particularly of the family of choice, helps members through the difficulty of making figures from the family of origin. Creating family members from clay taps into the survivor's anger. However, the group is a safe environment for reexperiencing the anger toward relatives who abused them, or who did not protect them from abuse. Expression of anger within the context of the group and the "working through" stage are vital for the therapeutic process. After confronting the anger associated with the family of origin, constructing a family of choice provides an opportunity for healing. The universality of members' difficult feelings unifies the group. Group members receive first-hand experience about having a choice of who to let into their lives.

During the last two sessions, group members create "message tiles" for other survivors and future group members gives the women a sense of purpose, develops a connection with a network of peers, and provides another avenue for healing. The message tiles are integrated into a mural which is hung in the clinic for all to witness.

In 30 minutes, which is the running time of the video, the viewer is exposed to the issues and needs of incest victims and to one model of media usage in the treatment of sexual abuse. Although the video contains examples of clay as an avenue for process in therapy, the main focus of the art therapy is product-oriented. The goal of the video is achieved by presenting a unique group art therapy approach with specific parameters and limitations. However, the video has three characteristics which preclude in-depth discussion on a multitude of issues associated with conducting an art therapy group for survivors of sexual abuse: (a) the presentation of a specific group art therapy format, (b) the time-limited nature of the group, and (c) the use of one medium to explore sexual abuse issues.

The video contains some explicit language and when group members share their experiences, a great deal of emotion is witnessed. Therefore, the video should be used for educational purposes only. It is also recommended that viewers read the accompanying monograph for further information and as a springboard for discussion and analysis.

In conclusion, the video is a comprehensive overview of one model of group art therapy. Both the issues of sexual abuse and the use of clay in therapy are carefully balanced and competently documented. Finally, the video is professionally produced and chronicles the art therapy process of a sensitive population with great compassion.

Calendar of Events

APRIL 1996

The American Society of Group Psychotherapy and Psychodrama will convene its 1996 Annual Meeting "Seventy-Five Years of Psychodrama: *So Much More to Explore*" April 18-22, 1996 in Houston, Texas. Conference participants will learn new methods and share ideas which place value on empowerment, community building and interdependence. The 1996 Annual Meeting will include a celebration of the diamond jubilee of psychodrama and explore its relationships with creative arts therapies, education, counseling, and the workplace. Individuals interested in receiving registration information should contact the ASGPP National Office: 6728 Old McLean Village Drive, McLean, Virginia 22101, (703)556-9222, fax (703)556-8729, and e-mail: Degnon@AOL.com.

OCTOBER 1996

The International Stress Management Association will conduct ISMA-6 on October 5-8, 1996 in Sydney, Australia in cooperation with several other organizations. For more information call (619)635-4698, fax (619)635-4669, or internet: NOSTRESS@sanac.USIU.edu.

ANNUAL INDEX: VOLUME 12

Index A. ARTICLES

Allen, P. *Coyote Comes in form the Cold: The Evolution of the Open Studio Concept* 161

Andrus, L. *Surviving Elimination of a Graduate Art Therapy Program: Art Education Revisited* 231

David, I.R. & Ilusorio, S. *Tuberculosis: Art Therapy with Patients in Isolation* 24

Feen-Calligan, H. *The Use of Art Therapy in Treatment Programs to Promote Spiritual Recovery from Addiction* 46

Good, D. & Sly-Linton, K. *Art Therapy Licensure Update* 100

Hanes, M.J. *Clinical Application of the "Scribble Technique" with Adults in an Acute Inpatient Psychiatric Hospital* 111

McGraw, M. *The Art Studio: A Studio Based Art Therapy Program* 167

McNiff, S. *Keeping the Studio* 179

Moody, J. *Bridging Barriers with Native American Clients* 220

Morris, M.B. *The Diagnostic Drawing Series and the Tree Rating Scale: An Isomorphic Representation of Multiple Personality Disorder, Major Depression, and Schizophrenia Populations* 118

Prager, A. *Pediatric Art Therapy: Strategies and Applications* 32

Rode, D.C. *Building Bridges within the Culture of Pediatric Medicine: The Interface of Art Therapy and Child Life Programming* 104

Roje, J. *LA '94 Earthquake in the Eyes of Children: Art Therapy with Elementary School Children Victims of Disaster* 237

Russel, J. *Art Therapy on a Hospital Burn Unit: A Step Towards Healing and Recovery* 39

Spaniol, S. *Art Is All the Feelings Trapped Inside: An Interview with Marilyn McKeon* 227

Wix, L. *The Intern Studio: A Pilot Study* 175

Index B. BRIEF REPORTS

Hiscox, A. *The Art of West Indian Clients: Art Therapy as a Nonverbal Modality* 129

Mills, A. *Outpatient Art Therapy with Multiple Personality Disorder: A Survey of Current Practice* 253

Morgan, C.A. & Johnson, R. *Use of a Drawing Task* 244

Teufel, E.S. *Terminal Stage Leukemia: Integrating Art Therapy and Family Process* 51

Winkel, M., Junge, M., Linesch, D. & Mathews, N. *Art Therapists' Employment Experiences in a Shifting Economy* 248

Index C. DEPARTMENTS

Viewpoints

Berstein, J.C. *Art & Endometriosis (From an Artist's Sketchbook)* 56

Calomeris, S. *Photo Essay: Revisioning/Revisiting* 266

Conlon, S. *TB, the Mask, and Me* 72

David, I.R. *Medical Art Therapy: A Window Into History* 135

Elkinson-Griff, A. *Let Me Wipe My Tears So I Can Help with Yours* 67

Henley, D. *A Consideration of the Studio as Therapeutic Intervention* 188

Linesch, D. *Art Therapy Research: Learning from Experience* 261

Lynn, D. *Healing Through Art* 70

Piccirillo, E. *Taking Inventory in the Age of AIDS* 62

Steinhardt, L. *A Base and the Mark: A Primary Dialogue in Artmaking Behavior* 191

Tibbetts, T. *Art Therapy at the Crossroads: Arts and Science* 257

Timm-Bottos, J. *ArtStreet: Joining Community Through Art* 184
Young, J. *The Reenchantment of Art Therapy* 193
Unger, E. *One Thousand Penises: Working with Adolescent Groups* 132
Van Sluizer, C.J. *Grandmother's Clause* 136

Book Reviews

Byers, J.G. *Photo Therapy Techniques: Exploring the Secrets of Personal Snapshots and Family Albums* 200
Cheyne-King, S.E. *Cancer Stories: Creativity and Self Repair* 73
Cleveland, E. *Reverberations: Mothers and Daughters* 137
Consoli, J.J. *Art Therapy with Families in Crisis: Overcoming Resistance Through Nonverbal Expression* 137
Dudek, S.Z. *Photo Therapy Techniques: Exploring the Secrets of Personal Snapshots and Family Albums* 202
Ferrara, N. *Magazine Photo Collage: A Multicultural Assessment and Treatment Technique* 197
Fleming, M.M. *California Art Therapy Trends* 74
Marean, T. *Wet-Into-Wet Watercolor: The Complete Guide to an Essential Watercolor Technique* 269
Rosal, M.L. *The Creative Journal for Children: A Guide for Parents, Teachers and Counselors, Recovery of Your Inner Child: The Highly Acclaimed Method for Liberating Your Inner Self, Lighten Up Your Body—Lighten Up Your Life: Beyond Diet and Exercise—The Inner Path to Lasting Change, The Picture of Health: Healing Your Life with Art* 76
Seaver, L.S. *Integrative Approaches to Family Art Therapy* 198
Sprayregen, B. *Arts Therapies and Clients with Eating Disorders: Fragile Board* 268

Video Reviews

Cooper, B.F. *The Shattered Sugar Bowl: Kids with Diabetes Speak Out/This Flower Comforts You: Girls on Dialysis* 203
Feinstein, H. *Southern California Art Therapy Association: Art Therapy Today* 139
Gerber, N. *Suicide: A Teenage Dilemma* 141
Rosal, M. *Courage: Together We Heal! Mural Messages from Incest Survivors* 270

Editorials

Malchiodi, C.A. *Does a Lack of Art Therapy Hold Us Back?* 218
Malchiodi, C.A. *Milestones* 90
Malchiodi, C.A. *Studio Approaches to Art Therapy* 154
Malchiodi, C.A. *Who Owns the Art?* 2

SPECIAL SECTIONS

25th Annual Conference

25th Annual Conference Program 9
Time Capsule Contributions 12
Gantt, L. *HLM Award Acceptance* 13
Arrington, D. *DS Award Acceptance* 14
Spring, D. *Clinical Award Acceptance* 16
Dissanayake, E. *1994 Keynote Address* 17

A Tribute to Janie Rhyne

Introduction 94
Lusebrink, V.B. *Janie Rhyne* 95
Schoenholtz, R. *Some Memories of Janie Rhyne* 97
A Rhyne Bibliography 98

Every Single Day...

july august september october

365

...the career you've worked so hard to create is at stake.

Whether you're Employed or Self-Employed, you can protect yourself with the AATA-Endorsed Professional Liability Insurance Plan through Maginnis & Associates.

The Plan includes million-dollar limits, court costs and legal fees, affordable premiums and more! That's why the **American Art Therapy Association** endorses this coverage. They want the best, especially when it comes to protecting their members' careers. Call us now for details at:

1-800-621-3008, ext. 105 or ext. 108 if you are Self-Employed.

Maginnis & Associates • A Division of KVI
332 South Michigan Avenue, Chicago, Illinois 60604 • 1-800-621-3008

LESLEY COLLEGE

Master of Arts in Expressive Therapies

A unique program designed for women and men eager to advance professionally and create change in people's lives.

- Integrate the modalities of dance, drama, literature, music, poetry and visual arts with the practice of psychotherapy.
- Combine experiential and creative learning with applied clinical practice and artistic work.
- Specialize in Art Therapy – learn comprehensive skills in the therapeutic use of the visual arts.

Call 617/349-8425 or 800/999-1959 x. 8425 for more information.

LESLEY COLLEGE Office of Graduate Admissions
29 Everett Street, Cambridge, Massachusetts 02138-2790

LESLEY

The following books authored by members of the
American Art Therapy Association
are available for purchase.

	MEMBERS	NON-MEMBERS
A History of Art Therapy in the United States [1,2]		
(1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual [3]		
(1994) Howie & Gutierrez ISBN 1-882147-16-2	$25.00	$37.00
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0 [1,2]	$24.00	$35.00
Art Therapy in the Schools [3]	$ 6.00	$10.00
National Registry of Masters Theses & Practicum Papers [3]	$15.00	$25.00
Addendum to National Registry of Masters Theses & Practicum Papers [3]	$12.50	$22.50
AATA Chapter Manual [3]	$12.00	N/A
Applying for Funds from Your Area Agency on Aging [3]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance [3]	$ 7.00	$10.00

NOTE: [1] Postage included on all orders for this publication. [2] Ten or more copies - 10% discount. [3] Add $3.00 for postage.

Make checks or money orders payable to AATA and return with this order form to:
American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my order. Enclosed is a check/money order in the appropriate amount: $________

Name: ________________

Address: ________________

City: __________ State: _____ Zip: ________

The following posters by members of the
American Art Therapy Association
are available for purchase.

	MEMBERS	NON-MEMBERS
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Shipping and handling is included on both posters.

Make checks or money orders payable to AATA and return with this order form to:
American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my order. Enclosed is a check/money order in the appropriate amount: $________

Name: ________________

Address: ________________

City: __________ State: _____ Zip: ________

CHARLES C THOMAS • PUBLISHER

☐ Nucho, Aino O.—**SPONTANEOUS CREATIVE IMAGERY: Problem Solving and Life Enhancing Skills.** '95, 166 pp. (7 × 10), 15 il.

☐ Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 186 pp. (7 × 10), 33 il. $41.95, cloth, $26.95, paper.

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $64.95, cloth, $32.95, paper.

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $51.95, cloth, $30.95, paper.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $37.95, cloth, $22.95, paper.

☐ Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 288 pp. (6¾ × 9¼), 28 il., $38.95, cloth, $24.95, paper.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¼), 56 il., $48.95, cloth, $29.95, paper.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¼), 34 il., $48.95, cloth, $29.95, paper.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $92.95, cloth, $49.95, paper.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $35.95, cloth, $19.95, paper.

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $24.95.

☐ Benenzon, Rolando O.—**MUSIC THERAPY IN CHILD PSYCHOSIS.** '82, 112 pp., 34 il., $25.95, cloth, $14.95, paper

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $53.95, cloth, $31.95, paper.

☐ Espenak, Liljan—**DANCE THERAPY: Theory and Application.** '81, 210 pp., 33 il., $34.95.

☐ Benenzon, Rolando O.—**MUSIC THERAPY MANUAL.** '81, 178 pp., 20 il., $29.95, cloth, $14.95, paper.

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY.** '80, 90 pp., 4 il., $27.95, cloth, $15.95, paper.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror. (2nd Ed.)** '95, 230 pp. (7 × 10), 21 il, $49.95, cloth, $29.95, paper.

☐ Makin, Susan R.—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 112 pp. (7 × 10), $29.95, cloth, $15.95, paper.

☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 17 il., $47.95, cloth, $29.95, paper.

☐ Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 × 10), 12 il. $35.95.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts, Theories and Practices. (2nd Ed.).** '94, 294 pp. (7 × 10), 1 table. $58.95, cloth, $33.95, paper.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 × 10), 24 il., $46.95, cloth, $29.95, paper.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $56.95, cloth, $34.95, paper.

☐ McNiff, Shaun—**EDUCATING THE CREATIVE ARTS THERAPIST: A Profile of the Profession.** '86, 296 pp. (7 × 10), $46.95, cloth, $29.95, paper.

☐ Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking.** '83, 240 pp., 134 il. (4 in color), 11 tables, $53.95, cloth, $33.95, paper.

☐ Krauss, David A. & Jerry L. Fryrear—**PHOTOTHERAPY IN MENTAL HEALTH.** '83, 260 pp. (6¾ × 9¼), 61 il. (5 in color), 1 table, $46.95, cloth, $29.95, paper.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $25.95, spiral (paper).

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 260 pp., 54 il., $32.95, cloth, $18.95, paper.

☐ Singer, Florence—**STRUCTURING CHILD BEHAVIOR THROUGH VISUAL ART: A Therapeutic, Individualized Art Program to Develop Positive Behavior Attitudes in Children.** '80, 144 pp., 33 il., $25.95, cloth, $13.95, paper.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il (12 in color), 7 tables, $49.95, cloth, $29.95, paper.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

AATA REGIONAL SYMPOSIA

ADDICTIONS

Presenters: Lynn Jones, Holly Feen and Katie Webb

Participants will receive the latest information on the use of art therapy in the treatment of addiction and dual diagnosis. Art therapists will be able to identify specific non-verbal approaches for working through resistance and denial in the treatment of substance abusers. Counselors will be able to identify specific ways in which to coordinate treatment efforts with art therapists in their facilities.

FAMILY ART THERAPY

Presenters: Mari Fleming, Shirley Riley and James Consoli

The objectives of this symposium are to provide the participants with an overview of how art therapy provides families an enriched vocabulary to assist them in solving family problems. The art therapy gives a "voice" to all age levels and offers a non-threatening vehicle to aid in communication restructuring the family system. The intensive workshop will offer ways to combine family theories with art expressions and examine assessment methods, short and long term treatment. Participants will engage in experiential opportunities to experience how art therapy is applicable in their own professional setting. Every effort will be made to offer the most current trends in family therapy and art therapy application.

ART THERAPY IN SCHOOLS

Presenters: Janet Bush and Sarah Hite (third presenter to be announced)

This symposium will provide participants with the administrative procedures for implementing art therapy services and programs in schools. Topics will focus on the uses of art therapy in schools; roles and responsibilities of school art therapists; techniques and strategies for working with students; training and preparation of school personnel; and the funding and marketing procedures required for school art therapy programs. Participants will be prepared to transfer techniques and strategies for implementing art therapy services and programs to school settings.

ART THERAPY WITH THE OLDER ADULT

Presenters: Larry Barnfield, Bernadette Callanan and Judith Wald

The symposium will cover general views on aging, relevant facts and new research, the role of art therapy with elders and settings in which art therapists practice and the special advantages of art therapy with the aging. It will cover the goals of treatment, treatment issues, and consideration of the clinical treatment of three groups of vulnerable aging and case studies.

GOING FOR THE GOLD: GRANTS AND RESEARCH IN ART THERAPY

Presenters: Frances Anderson, Vija Lusebrink and Doris Arrington

Successful grant writing in art therapy is, and will continue to be an important survival strategy in the 90's. Many model art therapy projects funded by grants will be discussed. The entire grant writing and granting process from identification of funding sources (public and private), to proposal development, submission and implementation will be covered. Technical assistance will be available to participants who already have a grant idea or proposal "in process".

ART THERAPY WITH CHILDREN AT RISK

Presenters: Cathy Malchiodi, Julie Epperson and Deborah Good

This symposium proposes to fill the need for advanced art therapy training focusing on theory, interventions, methodology and research with children at risk. "Children at risk" are defined as those who are directly affected by family violence, physical and sexual abuse, neglect homelessness, and various disabilities such as attention deficit hyperactivity disorder, learning problems, and physical limitation which put them at further risk for abuse and neglect. Emphasis will be on how the clinician can develop both short and long term art therapy interventions, effectively assist the child in crisis and appropriately utilize art expression in assessment of current level of psychological functioning.

ART AND MEDICINE

Presenters: Cathy Malchiodi and Anita Mester (third presenter to be announced)

The symposium will focus on the unique dimensions of art therapy within a medical context with people who have experienced life-threatening chronic illness, particularly cancer and HIV. The special role that art expression plays in the assessment and evaluation of both the somatic and psychological status of the individual will be discussed, supported by the current research of both art therapists and clinicians in related fields. Special emphasis will be on paradigms for the use of art therapy within the context of psychoneuroimmunology and mind/body healing. Theories of imagery from current research by Achterburg, Simonton, Bach and others will be covered to assist the participants in integrating the use of art expression with physically ill clients will be presented so that participants acquire an understanding of the practical aspects of adapting art therapy to specific disease conditions. Lastly, emotional and transpersonal issues of grief and loss which are intrinsic to the experience of physical life threatening illness will be addressed.

ADOLESCENT ART THERAPY

Presenters: Kris Sly-Linton (three other presenters to be announced)

The Adolescent Art Therapy Symposium will cover a wide range of topics designed to address a specific focus area requested by the sponsoring organization. This is a somewhat unique approach to the traditional symposia format but considering the multiplicity of problems regarding the treatment of adolescents today, it was felt this would be a way to make each symposium more pertinent to the intended audience. The four person team headed by Kris Sly-Linton, A.T.R.-BC, was coordinated to include professional art therapists that can provide the expertise required to address the following areas: Special Populations of Adolescents, Program Focus, and Teens and Family Systems.

These Symposia are offered at no charge to the participating Chapter.

• • • • • • • • • • • • • • • • •

For further information regarding the content or scheduling of these symposia, please contact
AATA National Office • 1202 Allanson Road • Mundelein, Illinois • 60060 • (708)949-6064
Monday through Friday - 9:00 a.m. to 5:00 p.m. - Central Time

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Cathy A. Malchiodi, MA, A.T.R., Editor

Art Therapy, the official journal of the American Art Therapy Association, is a quarterly journal for professionals and students who are interested in the use of art in the fields of mental health, psychotherapy and human development. The purpose of the *Journal* is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. *Art Therapy* publishes refereed articles, including illustrations, by art therapists, psychologists, family therapists, and others that reflect the latest advances in theory, research, professional issues, and practice. An emphasis is placed on the use of visual arts in therapy, but articles in related disciplines of interest are considered for publication. *Art Therapy* is an important source for news and summaries of national conferences, book reviews, media, and commentaries.

Recent articles published in *Art Therapy:*

- Tuberculosis: Art Therapy with Patients in Isolation
- Art Therapy on a Hospital Burn Unit
- The Children's Diagnostic Drawing Series
- Essential Legal Issues for Art Therapists in Private Practice
- Diagnosis or Dilemma: Drawings of Sexually Abused Children

Art Therapy is available to AATA Members as part of their membership. Non-Members may subscribe at the following annual rates:

Individuals: $50.00 (U.S.) - $74.00 (Foreign)
Institutions: $77.00 (U.S.) - $100.00 (Foreign)

Single copies are available at:

Members: $12.50 - Non-Members: $23.00

Make checks or money orders payable to AATA and return with this subscription order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my subscription. Enclosed is a check in the appropriate amount:

Name: ______________________________

Address: ______________________________

City: ____________________ State: ______ Zip: ________

The American Art Therapy Association

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 4,750 professionals and students. It is governed and directed by a nine-member Board elected by the membership. AATA has established standards for art therapy education and practice: AATA committees actively work on governmental affairs, clinical issues and professional development. AATA's dedication to continuing education and research is demonstrated through annual national and regional conferences, publications, films, and awards.

PURPOSE

- The progressive development of the therapeutic use of art.
- The advancement of standards of practice, ethical standards, education, and research.
- The provision of professional communication and exchange with colleagues.
- The provision of legislative efforts to promote and improve the status of professional practice.
- The promotion of the field of art therapy through the dissemination of public information.

CHAPTERS

Affiliated chapters of the AATA have been established throughout the U.S. Chapters conduct meetings and activities in an effort to promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network for people working toward common goals. Information and support for Chapter members is passed on from the AATA Assembly of Affiliate Chapters to the local level.

You must be a national member to become a chapter member. Information on locating the chapter nearest you is available from the AATA National Office.

MEMBER BENEFITS

All members receive:

Publications

- *Art Therapy: Journal of the American Art Therapy Association* (published quarterly).
- *AATA Newsletter* (published quarterly).
- Substantial discounts on AATA publications, such as Annual Conference Proceedings, other professional journals, films, and the membership directory.
- AATA literature, such as Educational Programs List, Art Therapy Media List, and Standards of Practice.
- Mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life and disability through Maginnis & Associates.
- Access to national experts in art therapy.

AATA Conferences

- Discounts on registration fees to AATA national and regional conferences.

Nationwide Advocacy

- Governmental affairs activities including Congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payors.
- National liaison with related professional organizations for recognition and promotion of art therapy.

Professional Standards

- Development of model job description and recommendations for licensing standards.
- Development and implementation of national Education Standards for approval of graduate level Art Therapy programs.
- Development and implementation of nationally recognized Standards of Practice and Code of Ethics of Professional Art Therapists.

GENERAL INFORMATION

The American Art Therapy Association, Inc. (AATA) and the Art Therapy Credentials Board, Inc. (ATCB) are administratively independent. Membership in AATA and registration (A.T.R.) with the ATCB requires separate applications and approval. (A.T.R. registration applications are available from ATCB, 708-566-8910).

For **NEW** Associate, Student, and Contributing members only: please follow the chart below when submitting membership applications:

The membership year is the calendar year:
January 1 - December 31

Applications received between:

Jan. 1 - May 31: Full dues payment; membership expires December 31 of same year.

June 1 - Sept. 30: Half year dues plus $5.00 payment; membership expires December 31 of same year.

Oct. 1 - Dec. 31: Full dues payment; membership for the remainder of the current year and the next full year.

CATEGORIES AND FEES

Professional - By application review process only; approved members may vote, hold office and serve on committees.

- **Professional Member** - Individuals who have completed educational training in art therapy; dues are $85.00/year.
- **Credentialed Professional Member** - Individuals who have been **dually approved** for Professional Membership by AATA and Registration (A.T.R.) by the ATCB; AATA dues are $85.00/year. ***Annual A.T.R. Maintenance fee is billed separately by the ATCB.***

Associate - Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. Such members may not vote, hold office, or serve on committees. Dues are $85.00/year.

Student - Individuals who are currently taking full time course work in art therapy or a related field. Requires a current statement from the institution of learning indicating full time status and course work content (6 graduate or 12 undergraduate credits.) Student members may not vote or hold office, but may serve on the Student Sub-Committee of Membership. Dues are $35.00/year.

Contributing - Individual organizations, institutions, or foundations which contribute annually to AATA. Such members may not vote, hold office, or serve on committees. Dues are $120.00/year.

Retired - Individuals who are at least 65 years of age and who are no longer practicing. Retired members receive publications and reduced fees, but may not vote or hold office. Dues are $35.00/year. Application provided upon request.

Foreign AATA members MUST include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

The American Art Therapy Association

MEMBERSHIP APPLICATION

NAME ____________________

HOME ADDRESS ____________________

____

PHONE(   ) ____________________

BUSINESS ADDRESS ____________________

____

EMPLOYER ____________________

JOB TITLE ____________________

LICENSES HELD & STATE ____________________

____

PREFERRED MAILING LIST: ☐ HOME ☐ BUSINESS

Foreign AATA members MUST include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

Please indicate under which category you are applying:

☐ $85 Associate Membership

☐ $35 Student Membership **(see student membership criterion for necessary documents to accompany this application)**

☐ $120 Contributing Membership

Professional Member - Individuals who have completed educational training in art therapy; dues are $85.00/year.

Credentialed Professional Member - Individuals who have been **dually approved** for Professional Membership by AATA and Registration (A.T.R.) by the ATCB; AATA dues are $85.00/year. ***Annual A.T.R. maintenance fee is billed separately by the ATCB.***

Provided upon request:

☐ Professional Membership Application - ***Professional Membership granted by review approval process only.***

☐ A.T.R. Application - ***Provided and processed by the ATCB. A.T.R. granted by ATCB review approval process only. For more information contact the ATCB at (708)566-8910.***

Please make all checks payable in U.S. dollars and mail to:

AATA - American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, IL 60060
(708) 949-6064 Fax: (708) 566-4580

Please complete this survey:

Education (please check highest degree earned)

1 ☐ Doctorate Degree
2 ☐ Master's Degree
3 ☐ Bachelor's Degree
4 ☐ Associate/Certificate
5 ☐ Other ____________

(Please indicate *exact* degree earned, e.g., BA, BS, MA, MS, PhD, etc.)

Work Setting (please check only one)

1 ☐ Hospital
2 ☐ Clinic
3 ☐ Day treatment center
4 ☐ Rehabilitation
5 ☐ Sheltered workshop
6 ☐ Correctional facility
7 ☐ Residential treatment
8 ☐ Out-patient mental health
9 ☐ School system
10 ☐ Elderly care facility
11 ☐ College/University
12 ☐ Clinical training program
13 ☐ Institute training program
14 ☐ Counseling center
15 ☐ Private practice
16 ☐ Other ____________

Area(s) of Specialization (please check up to three)

1 ☐ Addictions
2 ☐ Adolescents, Hospitalized
3 ☐ Adolescents, Psychiatric
4 ☐ Adults, Hospitalized
5 ☐ Adults, Psychiatric
6 ☐ Art History
7 ☐ Art Therapy Education
8 ☐ Art Therapy in Schools
9 ☐ Children, Hospitalized
10 ☐ Children, Psychiatric
11 ☐ Domestic Violence
12 ☐ Eating Disorders
13 ☐ Families
14 ☐ Gerontology
15 ☐ Hospice/Terminally Ill
16 ☐ Learning Disability
17 ☐ Mental Retardation
18 ☐ Neurological Disease
19 ☐ Prisoners
20 ☐ Post Traumatic Stress
21 ☐ Psychotherapy
22 ☐ Rehabilitation
23 ☐ Research
24 ☐ Sexual Abuse
25 ☐ Visual Art
26 ☐ Other ____________

Voluntary Information

Age:

1 ☐ 20 - 24
2 ☐ 25 - 29
3 ☐ 30 - 34
4 ☐ 35 - 39
5 ☐ 40 - 44
6 ☐ 45 - 49
7 ☐ 50 - 54
8 ☐ 55 - 59
9 ☐ 60 +

Salary Range:

1 ☐ under $10,000
2 ☐ $10,000 - $14,999
3 ☐ $15,000 - $19,999
4 ☐ $20,000 - $24,999
5 ☐ $25,000 - $29,999
6 ☐ $30,000 - $34,999
7 ☐ $35,000 - $39,999
8 ☐ $40,000 - $44,999
9 ☐ $45,000 - $49,999
10 ☐ $50,000 +

Gender:

1 ☐ Female
2 ☐ Male

Hours worked/week:

1 ☐ 0 - 10
2 ☐ 11 - 20
3 ☐ 21 - 30
4 ☐ 31-40
5 ☐ 41+

RESOURCES

American Art Therapy Association, Inc.
1202 Allanson Road / Mundelein, Illinois 60060
(708) 949-6064 Fax: (708) 566-4580

The American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following publications, films, posters and training literature are available from the AATA National Office.

CONFERENCE PROCEEDINGS	MEMBERS	NON-MEMBERS
Creativity and the Art Therapist's Identity (1976) ISBN 1-882147-04-9	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) ISBN 1-882147-05-7	$ 5.00	$ 7.00
The Use of Creative Arts in Therapy (1979 Joint Conference)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) ISBN 1-882147-10-3	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) ISBN 1-882147-12-X	$ 7.00	$10.00
A Bridge Between Two Worlds (1981) ISBN 1-882147-11-1	$ 7.00	$14.00
Art Therapy: Still Growing (1982) ISBN 1-882147-06-5	$10.00	$14.00
Art Therapy: New Directions in the '80s (1987) ISBN 1-882147-13-8	$15.00	$20.00
Professionalism in Practice (1988) ISBN 1-882147-08-1	$15.00	$20.00
Painting Portraits: Families/Groups/Systems (1989) ISBN 1-882147-07-3	$15.00	$20.00
Image and Metaphor (1991) ISBN 1-882147-09-X	$15.00	$20.00
The Art Therapist: Artist/Teacher/Clinician/Healer (1992) ISBN 1-882147-14-6	$15.00	$20.00
Common Ground: The Arts, Therapy & Spirituality (1993) ISBN 1-882147-21-9	$15.00	$20.00
Reflecting on the Past, Envisioning the Future (1994) ISBN 1-882147-24-3	$15.00	$20.00
Weaving New Visions (1995) ISBN 1-882147-50-2	$15.00	$20.00

NOTE: Ten or more copies of any single proceeding: 10% discount on total. Set of four proceedings (consecutive years): 20% discount on total. Postage/Handling: $3.00 first item; $.75 each additional.

PUBLICATIONS	MEMBERS	NON-MEMBERS
A History of Art Therapy in the United States[1,2] (1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual[3] (1994) Howie & Gutierrez ISBN 1-882147-16-2	$25.00	$37.00
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0[1,2]	$24.00	$35.00
Art Therapy in the Schools[3]	$ 6.00	$10.00
National Registry of Masters Theses & Practicum Papers[3]	$15.00	$25.00
Addendum to National Registry of Masters Theses & Practicum Papers[3]	$12.50	$22.50
AATA Chapter Manual[3]	$12.00	N/A
Applying for Funds from Your Area Agency on Aging[3]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance[3]	$ 7.00	$10.00

NOTE: [1] Postage included on all orders for this publication. [2] Ten or more copies - 10% discount. [3] Add $3.00 for postage.

PROFESSIONAL PREPARATION LITERATURE	MEMBERS	NON-MEMBERS
Education Standards	N/C	$ 1.00
Educational Program List (Colleges and Universities offering art therapy programs)	N/C	$ 2.00
◆*Art Therapy Credentials Board (ATCB) Standards & Procedures for Registration*	N/C	$ 1.00

General Information Packet - $4.00 (includes: Education Standards, Educational Program List, ATCB Standards & Procedures for Registration, and a New Member Application)

OTHER LITERATURE	MEMBERS	NON-MEMBERS
Art Therapy Model Job Description	$ .32	$ 1.00
Art Therapy Media List	$ .32	$ 1.00
Bibliography: Books Authored by AATA Members	$ .32	$ 1.00
Ethical Standards for Art Therapists	$ .32	$ 1.00
Standards of Practice	$ .32	$ 1.00

MEMBERSHIP INFORMATION	MEMBERS	NON-MEMBERS
Membership Specialty List	$ 2.62	$ 3.62
Membership Survey	$ .32	$ 2.75
1994 Membership Directory [1]	$14.00	$55.00
Criteria and Application for Professional Membership	$ .32	$ 1.00

NOTE: [1] Postage and handling for AATA Directory U.S. - $3.00; Canada/Mexico - $3.25; Foreign - $10.00.

POSTERS	MEMBERS	NON-MEMBERS
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Shipping and handling is included on both posters.

SUBSCRIPTIONS		
Art Therapy: Journal of the American Art Therapy Association	Individuals = U.S. $50.00	Foreign = U.S. $74.00
	Institutions = U.S. $77.00	Foreign = U.S. $100.00
Back Issues	Members = $12.50	Non-Members = $23.00
AATA Newsletter	U.S. $26.00	Foreign $38.00

NOTE: Shipping and handling is included on both subscriptions.

FILMS	TYPE	MEMBERS	NON-MEMBERS
Art Therapy Beginnings (1977) color/sound/45 min.	1/2" VHS	$50.00	$80.00
Michael (1977) color/sound/12 min.	1/2" VHS	$50.00	$80.00
Art Therapy (1980) color/sound/12 min.	1/2" VHS	$50.00	$80.00

NOTE: Postage and handling is $3.00 for each VHS tape.

---

1. WE DO NOT ACCEPT CREDIT CARDS OR PURCHASE ORDERS. All orders must be made in writing, accompanied by payment in cash, check, or money order in U.S. funds.
2. FOREIGN ORDERS: Shipping will be made per your instructions (surface or air). Please specify shipment method when ordering. Additional postage, if necessary, will be billed separately.
3. RETURNS ARE NOT ACCEPTED for refund on shipped items.

TITLE	QUANTITY	PRICE	TOTAL

SHIPPING INFORMATION

NAME: ______________________

MEMBER ID#: ______________________

STREET: ______________________

CITY/STATE/ZIP: ______________________

Total: $__________

Postage: $__________

Applicable Discount: $__________

TOTAL ENCLOSED: $__________

Allow 2 - 4 weeks for delivery.

MAKE CHECKS PAYABLE TO AATA

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to each copy of your manuscript:

Name:____

Degrees/Credentials:__________________________________

Address:____

Phone numbers: Home__________________ **Work**__________________

Type of Submission (check one):

☐ Article ☐ Viewpoints ☐ Brief Report

☐ Film/Video Review ☐ Book Review

Title of Submission:__________________________________

____

Checklist:

☐ Five (5) copies, typewritten on 8 1/2" x 11" paper.

☐ Black and white photos of original artwork plus four (4) photocopies of each.

☐ Paper and references adhere to *Publication Manual of the American Psychological Association* (Fourth Edition).

☐ Abstract of 75-125 words (for articles and brief reports only).

☐ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

☐ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

☐ This Attention Authors form.

Author's Signature____________________________ **Date**________________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

GUIDELINES FOR SUBMISSIONS

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Editor, *Art Therapy: Journal* of the American Art *Therapy Association*, c/o American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8 1/2" x 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication* Manual for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" x 7" and black and white glossy prints, preferably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. **It is the author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

ART*herapy*

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 13, NUMBER 1, 1996

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 U.S.A. Telephone (847)949-6064; FAX (847)566-4580. Non-members may subscribe at the following annual rates: $50 (U.S.) and $74 (Foreign); institutions $77 (U.S.) and $100 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 U.S.A. (847)949-6064.

This journal is abstracted in: Resources in Education (ERIC), Art Bibliographies Current Titles, Art Bibliographies Modern, and PsycINFO.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to American Art Therapy Association, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE
American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060 U.S.A.
(847)949-6064 and FAX (847)566-4580

MISSION STATEMENT: The American Art Therapy Association, Inc. (AATA) is an organization of professionals dedicated to the belief that the creative process involved in the making of art is healing and life enhancing. Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy.

ADVERTISING RATES

RATES	1×	2×	3×	4×
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"
Trim Size: 8-1/2" × 11"		

SUBMISSION DEADLINES:
January 15 for Spring issue; April 15 for Summer issue.
July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The publication of any advertisement by this journal is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc. is not responsible for any claims made in an advertisement.

Editor
Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Susan Spaniol, EdD, A.T.R., LMHC
Lesley College, Cambridge, MA

Book Review Editor
Erika Cleveland, MA, A.T.R., LMHC
Lesley College, Cambridge, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Friends Hospital, Philadelphia, PA

Production Editor
Karen D. Savage

Editorial Board
Pat B. Allen, PhD, A.T.R., LPAT
School of the Art Institute, Chicago, IL

Janet Bush, EdS, A.T.R.-BC
Dade County Public Schools, Miami, FL

Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec, Canada

Mariagnese Cattaneo, PhD, A.T.R., LMHC
Lesley College, Cambridge, MA

Susan E. Cheyne-King, MS, A.T.R., LPC, NBCCH
Cumberland Hospital, New Kent, VA

Carol Thayer Cox, MA, A.T.R., LPAT
George Washington University, Washington, DC

Anna R. Hiscox, MA, A.T.R.-BC, MFT
Illinois State University, Normal, IL

Sarah Hite, MS, MSEd, A.T.R.-BC
Eastern Virginia Medical School, Norfolk, VA

John G. Jones, PhD, A.T.R.-BC
Indian Health Service, Wolf Point, MT

Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI

Frances F. Kaplan, DA, A.T.R.-BC
Hofstra University, Hempstead, NY

Leslie Knowles, MA, A.T.R., LMHC
Lesley College, Cambridge, MA

Vija B. Lusebrink, PhD, A.T.R.-BC, HLM
University of Louisville, Louisville, KY

Patricia Engle Murphy, PhD, A.T.R.
Private Practice, Moscow, ID

Mary Ellen Peacock, MA, A.T.R.-BC
St. Francis of Assisi School, Louisville, KY

Trudy Manning Rauch, MS, A.T.R.-BC
Eastern Virginia Medical School, Norfolk, VA

Shirley Riley, MA, A.T.R., MFCT
Loyola Marymount University, Los Angeles, CA

Irene Rosner David, MA, A.T.R.-BC
Bellevue Hospital Center, New York, NY

Patricia St. John, EdD, A.T.R.-BC
College of New Rochelle, New Rochelle, NY

Nancy M. Sidun, PsyD, A.T.R.
The Chicago School of Professional Psychology, Chicago, IL

Evelyn Virshup, PhD, A.T.R., MFCC
California State University, Los Angeles, CA

Judith Wald, MS, A.T.R.
New York Hospital - Cornell Medical Center, White Plains, NY

AATA President
Virginia Minar, MS, A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

VOLUME 13

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 1, 1996

Editorial

Women and Art Therapy — Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC 2

Commentaries 4

Special Conference Section

26th Annual Conference Program 6

HLM Award Acceptance — Vija B. Lusebrink, PhD, A.T.R.-BC 10

Distinguished Service Award Acceptance — Randy M. Vick, MS, A.T.R.-BC 10

Special Award to Nancy Schoebel 11

Articles

Beyond Practice: A Postmodern Feminist Perspective on Art Therapy Research — Helene Burt, DTATI, A.T.R. 12

Becoming Visible: An Art Therapy Support Group for Isolated Low-Income Lesbians — Rachel Brody, MPS, A.T.R. 20

Men's Roles and Their Experience of Depression — Michael Barbee, MDiv, MA 31

In Search of an Accurate Likeness: Art Therapy with Transgender Persons Living with AIDS — Emily Piccirillo, MA, A.T.R. 37

Gender Dysphoria: The Therapist's Dilemma—The Client's Choice — Hannah Sherebrin, RN, A.T.R. 47

Viewpoints

Message of Acceptance: "Gay-Friendly" Art Therapy for Homosexual Clients — Donna Addison, MS 54

Wrestling the Hydra or Can an Art Therapist Find Aesthetic Fulfillment in the Marketplace? — Harriet Wadeson, PhD, A.T.R.-BC, HLM 57

Writers Need Not Be Loners — Patricia B. Allen, PhD, A.T.R., LPAT 60

Summer of Transition: A Visual Essay — Kate B. Hartman, MA, A.T.R. 62

Reviews

Telling Without Talking: Art as a Window into the World of the Multiple Personality — Susan Cheyne-King, MS, A.T.R., LPC, NBCCH 64

Children's Images of Trauma: Terezin, Cambodia, Israel, El Salvador, West Bank and Gaza, South Africa, and Washington, DC — Deborah Golub, EdD, A.T.R., LMHC 64

About the Cover: "Yggdrasill," 30" × 22"; spray enamel, watercolor, charcoal on watercolor paper, by Linda Klein, MA, MFA, A.T.R., LMHC. In Norse mythology, the tree Yggdrasill is the center of the divine world and upholds the universe even as the main pillars uphold the house. When it appears in its full stature, it has already begun to decay. It suffers greater torment than humans can know; and its fate—and image—is bound up with the fate of Odin, the chief Norse god, who, in the most mysterious moment in Norse mythology, hanged himself for nine full nights "on that tree of which none know from what root it rises" in his quest for wisdom.

2237

Editorial

Women and Art Therapy

Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC, *Editor*

Gender, like multiculturalism, greatly impacts the work of art therapists. However, little formal attention has been specifically paid to gender-related topics in art therapy literature. This special issue of the Journal focuses on gender and art therapy, addressing several important subjects, including the following: a feminist perspective on art therapy research (Burt); gay and lesbian issues (Brody, Addison); men's experience of depression (Barbee); and transgender/gender dysphoria issues (Piccirillo, Sherebrin).

Surprisingly, very few submissions were received on the subject of women and art therapy. Women's issues have resurfaced over the years in arts therapies publications (Talbott-Green, 1989; Wadeson, 1989) and at annual art therapy conferences (Abbenante, 1993; Speert, 1994), but seem to continually falter despite the need for attention to these issues. Without a doubt, women's issues pervade art therapists' work: domestic violence (Malchiodi, 1990; Riley, 1993; Riley, 1994a; Riley & Malchiodi, 1994); sexual abuse/assault; single-parent households and reinvented roles for women (Riley, 1994b); and women's health issues (Malchiodi, 1994a), to name a few. The role of art therapy with women is the subject of a forthcoming book (Hogan, 1996), underscoring the continuing importance of this issue in the 90s.

Specific diagnoses such as depression, agoraphobia, anxiety, and dissociative disorders are more often given to women (Figueira-McDonough & Sarri, 1987). The assignment of these diagnoses may involve a degree of gender bias, but it is generally true that women more frequently consult therapists than men. Therefore, it is likely that most art therapists see more female than male clients in their practices.

Although women's issues pervade the profession, art therapy has not come up to speed in including paradigms from women's studies (as well as related gender perspectives) within its framework. Little progress has been made in addressing the problems of utilizing male-dominated approaches with female clients or addressing why art therapists are "spellbound" (Abbenante, 1993) by psychoanalytic theories, rather than incorporating philosophies that might more effectively speak to the needs of women (Malchiodi, 1994b; Malchiodi & Riley, 1995). Art therapy as a profession is largely female (LaBrie & Rosa, 1994) and art therapists' personal struggles as women have affected the robustness of the profession, particularly in the area of education and training (Malchiodi, 1993) and in research (Junge & Linesch, 1992; Burt in this issue). How can it be that among so many women there is so little feminist consciousness and so little attention paid to women's issues?

Art therapy's lack of attention to the inclusion of women's studies in the theory and application of art therapy is strikingly apparent in a sample question listed in the *Certification Examination in Art Therapy Bulletin of Information* (ATCB, 1994). The following example was the very first question presented in the Bulletin:

> The artwork of an adolescent girl reveals several persistent themes, including eagerness to be accepted by peers, concern about her appearance, concern about what other people think of her, and apprehension about her future. According to Erikson, the girl is at what stage of psychosexual* development?
>
> A) Autonomy vs. doubt; B) Identity vs. role confusion; C) Intimacy vs. isolation; D) Industry vs. inferiority. (*The question was flawed in that the term "psychosexual" referred to Freud's theory; "psychosocial" was the term used by Erikson).

The correct answer is "B" (identity vs. role confusion) and by the Erikson schema is the fifth stage in his psychosocial development theory. This question and its choice of subject (an adolescent female) and theory may be a good example of art therapy's neglect of feminist paradigms in education and philosophy. It is fairly common knowledge for more than a decade that the work of Carol Gilligan (1982) and others have brought to question Erikson's developmental stages, particularly in the stage of adolescence. Although Erikson left his sequence of life stages unchanged, even he eventually noted that there was a different sequence for females in his developmental schema, particularly in adolescence.

This observation may be perceived by some as attacking the efforts of the Certification Committee and the test question developers. However, in reality, it is the lack of attention by the larger community of therapists, writers, researchers, and educators that is reflected in the inclusion of this question in the ATCB bulletin. It is also remarkable that neither the bulletin of information nor the *Certification Exam Study Guide* (ATCB, 1994) suggests any references to the works on development such as Gilligan; only Erikson and Freud are listed along with pre-1980 works by Peter Blos on adolescence. If these references were submitted by art therapy educators and art therapists at large, then the profession may need to reexamine its own gender biases, particularly in the areas of human development.

There is another area which art therapists may explore in order to become more gender-sensitive in their clinical work, writing, and research. It is the issue of what artmaking means to female clients, or for that matter, what artmaking means to clients in general, male or female. Again, my thinking about artmaking with female clients was derived from yet another question on the 1995 *Certification Examination Bulletin* (ATCB, 1995) that went like this:

> In an art therapy session, a client uses colored pencils to create a stereotypical image of vase with flowers. Which of the following

media are most appropriate to offer to help the client create more personally expressive images?
A) Charcoal; B) Markers; C) Paint; D) Collage Materials.

The answer according to the bulletin is "C," paint, which is generally accepted by the profession as more personally expressive. Although this may be the logical selection given the choices, is it that easy to say that paint is the solution to personal expressiveness in all such cases? In thinking about women's preferences for materials, a female client came to mind who was very limited in her range of expression with a pencil, and created a great deal of stereotypical imagery as described in the sample question. However, when given the opportunity to express herself through making a quilt, a traditionally female art form and much like collage, she found a personally expressive voice and a freedom in making art not found through other materials, including paint. Gender is not the only factor when helping a client find a material that is most expressive for him/her; attention to cultural background and class or societal status may also affect the choice of art modality and materials.

In order to understand how clients see artmaking, art therapists may have to let go of how we have decided their artmaking should be. What I am suggesting is that instead of simply looking at visual arts as a specific continuum of expressive materials (e.g., paints) to tighter, more controlled material (e.g., pencils), art therapists might want to also take a somewhat different approach: to be receptive to how the individual (according to gender, culture, class, etc.) finds connection and self-expressiveness in art forms themselves, rather than a materials-only approach.

Another way to specifically increase understanding of how women are using art for self-expression is to consider some of the recent exhibits that are bringing women's personal and political issues to attention through visual arts. One is The Clothesline Project (Meyer, Lancaster, & Peck, 1995), a display of shirts made by or in honor of survivors of battering, incest, homophobic violence, assault, and/or rape. Another example is Healing Legacies, a traveling show sponsored by the Breast Cancer Action Group, a national breast cancer awareness and activist organization. This slide registry and traveling exhibition contains a wide variety of visual art and writing by women who have had breast cancer; the show includes works by more well-known artists such as Matuschka and Nancy Fried, as well as women who chose to confront and make public their feelings about breast cancer through the arts. By considering how these two projects successfully use art as therapy and as a voice for women, art therapists may come to redefine their own ways of working with their female clients.

These are a very few modest ideas to reframe and refine art therapy's views of female clients in treatment, and are only a beginning. Women's issues are one of many areas of gender that art therapists need to further explore in their work. Other areas, such as men's issues, lesbian and gay concerns, and other gender topics also need further awareness and consideration within the field. By more closely examining the impact of gender, in addition to culture and class, art therapists will be able to more adequately address the treatment of their client, bringing greater understanding of clients' individual needs and deepening their experience of art therapy.

References

Abbenante, J. (1993). Art therapy, feminism, and archetypal psychology: Something's rumbling in the swamp. In *Common Ground: The Arts, Therapy, Spirituality* (p. 79). Mundelein, IL: AATA.

Art Therapy Credentials Board (ATCB). (1994). *Certification examination in art therapy bulletin of information.* Mundelein, IL: Author.

Art Therapy Credentials Board (ATCB). (1994). *Certification examination study guide.* Mundelein, IL: Author.

Art Therapy Credentials Board (ATCB). (1995). *Certification examination in art therapy bulletin of information.* Mundelein, IL: Author.

Gilligan, C. (1982). *In a different voice.* Cambridge, MA: Harvard University Press.

Figueira-McDonough, J., & Sarri, R. (1987). *The trapped women: Catch 22 in deviance and control.* Newbury Park, CA: Sage.

Hogan, S. (Ed.) (1996). *Women and art therapy.* London: Routledge. In press.

Junge, M., & Linesch, D. (1992). Art therapists ways of knowing: Toward creativity and new paradigms for art therapy research. In H. Wadeson (Ed.), *A Guide to Conducting Art Therapy Research* (pp. 79-83). Mundelein IL: AATA.

La Brie, G., & Rosa, C. (1994). American Art Therapy Association 1992-1993 membership survey report. *Art Therapy: Journal of the American Art Therapy Association, 11*(3), 206-213.

Malchiodi, C.A. (1990). *Breaking the silence: Art therapy with children from violent homes.* New York: Brunner/Mazel.

Malchiodi, C.A. (1993). Is there a crisis in art therapy education? *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 122-128.

Malchiodi, C.A. (1994a). *Invasive art: Art as empowerment with women with breast cancer* (No. 9-149). Denver, CO: National Audio Video.

Malchiodi, C.A. (1994b). Looking ahead. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 257-259.

Malchiodi, C.A., & Riley, S. (1995). *Art therapy in context: Honoring women's voices in our work* (No. 28-154). Denver, CO: National Audio Video.

Malchiodi, C.A. (1996). Art as empowerment for women with breast cancer. In S. Hogan (Ed.), *Women and Art Therapy.* London: Routledge. In press.

Meyer, K., Lancaster, M., & Peck, V. (1995). The clothesline project: Therapy, education, and activism. *Weaving New Visions: Art Therapy in Collaboration with Allied Professions* (p. 148). Mundelein, IL: AATA.

Riley, S. (1993). Art therapy with families who have experienced domestic violence. In E. Virshup (Ed.), *California Art Therapy Trends* (pp. 175-188). Chicago, IL: Magnolia Street Publishers.

Riley, S. (1994a). Art therapy with families who have experienced domestic violence. In S. Riley & C. Malchiodi, *Integrative Approaches to Family Art Therapy* (pp. 179-194). Chicago, IL: Magnolia Street Publishers.

Riley, S. (1994b). Parentified grandparents in family art therapy. In S. Riley & C. Malchiodi, *Integrative Approaches to Family Art Therapy* (pp. 223-232). Chicago, IL: Magnolia Street Publishers.

Riley, S., & Malchiodi, C. (1994). *Integrative approaches to family art therapy.* Chicago, IL: Magnolia Street Publishers.

Speert, E. (1994). Women and art therapy: Moving treatment beyond the patriarchal paradigms. *Reflecting on the Past, Envisioning the Future* (p. 83). Mundelein, IL: AATA.

Talbott-Green, M. (1989). Feminist scholarship: Spitting into the mouth of the gods. *The Arts in Psychotherapy, 16*(4), 253-261.

Wadeson, H. (1989). In a different image: Are "male" pressures shaping the "female" professions? *The Arts in Psychotherapy, 16*(4), 327-330.

Commentaries

Letters to the Editor

I deeply resent being quoted out of context to deliberately distort the meaning of my words as Janis Timm-Bottos has done in the opening sentence of her Viewpoints article, "Artstreet: Joining Community Through Art" (Vol. 12, No. 3, 1995, p. 184). The article opens: "A psychotherapist, especially an art therapist, should dive deep into the wrecks of psychic disasters, not merely skim the surface to look down from a distance at the barnacled, dismembered vessels on the bottom of the sea. (Wadeson, 1994, p. 153)" She sets me up as the strawman to knock down to justify her way of working with the community. In fact, read in context, I had preceded the statement she quoted with: "Surface swimming sometimes makes me feel that I'm not doing my job," and followed it with: "Often, however, I find myself splashing the surface with clients as they wrestle with their daily antagonists—spouses, bosses, co-workers." My article was titled "Diving and Snorkeling: The Depths and Shallows of Therapy." The whole point was to illustrate the movement between depths and shallows.

Timm-Bottos concludes her article by stating, "...being a lousy swimmer motivates me to find options for working, besides making a living by diving alone toward the bottom of the sea" (p. 186). She distorts my metaphor again. The therapist doesn't dive alone; she follows her client. It's Timm-Bottos' clients who must dive alone; she is too "lousy" a swimmer to follow them.

Harriet Wadeson, PhD, A.T.R.-BC, HLM

In David Henley's article in *Art Therapy* (Vol. 12, No. 3) some inaccuracies as well as some misconceptions about the Open Studio Concept and practice need to be addressed. He refers to the Art Therapy Department at Pilsen Little Village Community Health Center. This agency services a variety of populations in the Latino community. Some of these populations include chronically mentally ill, abused children, and dual diagnoses clients. To correct Mr. Henley Dayna Block was not a student or an intern; she was running the Art Therapy Department. Deborah Gadiel was working on her Master's Thesis on the open studio concept. Deborah established the open studio in 1990 and has run the Art Therapy Department since 1992. Clients have benefited from art therapy as well as open studio for six years. To our knowledge Mr. Henley has no first-hand experience with the art therapy program at Pilsen. We are wondering on what he is basing all of his assumptions about our work and its effect on the clients at Pilsen.

Artwork, ours as well as clients', was always visible in the studio. We offered standard art therapy as well as open studio time. We are clear on the value of standard art therapy sessions as well as the different opportunities available in open studio. Obviously during an art therapy session neither of us left the client at a table gaping at us as we furiously worked on our own artwork.

Mr. Henley refers to an image of a pregnant nude in his article. There were several of these paintings, some abstract some more realistic. They were Dayna's self-portraits. She was struggling with her pregnancy and these paintings helped her gain clarity. Teenagers who were often battling hormones, sexuality, and the possibility of pregnancy commented on the series. Adults used these paintings to discuss issues of vulnerability and life choices. This artwork became a springboard for them. Many of these discussions would not have occurred without these paintings. Pregnancy, motherhood, and sexuality are a part of everyone's life. This is how we entered the world. However, it was easier for most people, clients and staff, to refer to a painting, instead of her body. Obviously, it is a bit more removed.

It our experience at Pilsen, viewing us work on our own pieces encouraged clients whether they were walking by the art studio or participating in open studio time. They observed it is worthwhile to make images, and even with years of experience using art materials the point often comes when the artist struggles with her/his piece. This presents an opportunity to discuss metaphoric life struggles. Struggling with an image allows one to explore difficult feelings or prohibitive patterns. This promotes awareness as well as options and resolutions. Clients saw us as human beings with similar emotions modeling a safe outlet for them.

The clients that derive many benefits from an open studio setting are chronically mentally ill (CMI) clients. Instead of applying Third Hand interventions, which are applied in almost every arena of their life, they take responsibility for their own supplies and process. They make their own decisions in the open studio. This includes the most basic decision of whether or not to participate. In an open studio, the artist's/art therapist's energy goes into their own artmaking. The clients do not participate to appease the therapist. However, when the group feels the energy of one or two artists actively engaged in their work, they will get up of their own volition and start painting, drawing, and so forth. The clients who choose to sit are asserting their independence, and their presence is part of the open studio.

Henley comments on the clients' "naive capabilities" as well as their desire to "emulate" our work. In our experience, Pilsen clients are interested in other people's imagery, not intimidated. Deborah annually arranges a field trip for CMI clients to view the MFA Show of the School of The Art Institute of Chicago. This show contains raw imagery, sophisticated conceptual work, and even installations that include body fluids. The CMI clients look forward to this event and can relate as artists because they have a vast repertoire of their own image-making experience to draw from. Provocative artwork is challenging to all who view it. This presents opportunities to relate and share very human responses regardless of one's level of functioning. We react to the experience of viewing the work together, thus creating more empathy among staff and clients. Their familiarity with an open studio setting allows clients to be comfortable with a wide range of imagery, from the MFA Show to the Open Studio Project.

Deborah has also brought the CMI clients to make art at The Open Studio Project. Clients' participation with us in an open studio grounds them in working autonomously in the Open Studio Project as well as other environments. One of the most severe clients was working on a piece and talking to Dayna about G-d, death, hell, and paradise, his major preoccupation. She was painting a piece with skeletons, crosses, cauldrons, cherubs, and a cow. After a while he noticed the painting and asked her about it. She explained that she thinks about some of the same things he thinks about and for her it is more manageable, less overwhelming, to put them on paper. This made sense to him; he worked the rest of the 2-hour session, made two pieces, and participated in the discussion, which is unusual for him. Rather than intimidate these clients, other people's imagery motivates and empowers them.

Everyone has everything inside them including insanity whether one is diagnosed or not. We are as alike as we are different. Art is one of the few ways we can experience that duality together. The open studio allows us to share that experience.

We value the difference between art therapy and open studio. We do not have young children (feral or otherwise), the population with which Henley is most familiar. Their lack of maturity and motor coordination would hinder our participation as artists creating the atmosphere in the open studio. So do not worry David; participants are not expecting a Third Hand to fill water buckets or a therapist to stand encouragingly behind them. They are expecting another human being to be as fully engaged in the creative process as themselves to help create the energy to sustain and support everyone's personal vision.

Dayna B. Block
Deborah Gadiel, A.T.R.

I must applaud you for the Viewpoints contributions of Terry Tibbetts, Harriet Wadeson, and Robert Wolf and for your thoughtful editorial. I find that art therapists are often mired in their own credulity when accountability is demanded and properly expected. It is a difficult exertion, essentially based on self-knowledge. Art therapists, like the common ilk, have amongst us, those who are unwilling to examine their own motives and exclude the basis of analysis. I can not foretell, but know that the struggle for clarity and reason has always been tumultuous, and so the task requires fortitude and stamina…fundamentally because growth is an aggressive act and thus we defend, resist, and retreat.

Thank you for your determination to publish a periodical which is relevant and revealing.

Lee Foster, A.T.R.

ART THERAPY: DEFINITION OF THE PROFESSION

Art therapy is a human service profession that utilizes art media, images, the creative art process, and patient/client responses to the created products as reflections of an individual's development, abilities, personality, interests, concerns, and conflicts. Art therapy practice is based on knowledge of human developmental and psychological theories which are implemented in the full spectrum of models of assessment and treatment including educational, psychodynamic, cognitive, transpersonal, and other therapeutic means of reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, and increasing self-esteem.

Art therapy is an effective treatment for the developmentally, medically, educationally, socially, or psychologically impaired; and is practiced in mental health, rehabilitation, medical, educational, and forensic institutions. Populations of all ages, races, and ethnic backgrounds are served by art therapists in individual, couples, family, and group therapy formats.

Educational, professional, and ethical standards for art therapists are regulated by the American Art Therapy Association, Inc. (AATA). The Art Therapy Credentials Board, Inc. (ATCB), an independent organization, grants post-graduate registration (A.T.R.) after reviewing documentation of completion of graduate education and post-graduate supervised experience. The Registered Art Therapist who successfully completes the written examination administered by the ATCB is qualified as Board Certified (A.T.R.-BC), a credential requiring maintenance through continuing education credits.

The art therapy definition was developed by the American Art Therapy Association, Inc. Board of Directors in November 1995.

THE AMERICAN ART THERAPY ASSOCIATION
26th ANNUAL CONFERENCE

Town & Country Hotel/San Diego, California

NOVEMBER 8-12, 1995

Wednesday, November 8, 1995

Workshops

The Kinetic Circus Character Drawing (K-C-C-D) Procedure: An Art Based Assessment Technique/*Michael J. Hanes*

Psychopuppetry/*Matthew Bernier*

Illuminating Wisdom in Older Adults/*Bernadette Callanan*

Increasing the Range of Self-Expression: Combining Poetry with Art Therapy/*Virginia Minar*

Finding a "Home": Community Artmaking/*Janis Timm-Bottos, Louise Kahn*

Art Therapy and Multiculturalism: Fad or Reality?/*Anna Hiscox, Janise Escobar*

The Healing Link: Music, Imagery, and the Body/Mind Connection/*Stephanie Merritt*

Panels

Outcome Studies for Art and Recreation Therapy: A Collaborative Effort/*Paula Howie, Denise Chatham, Elaine Parks*

School-Based Art Therapy Earthquake Trauma Reduction Program/*Suzanne Silverstein, Mindi Newborn, Carol Palmer, Mirta Siderman, Marcy Stafsky, Joyce Wexler-Ballard*

The Multi Disciplinary Treatment of Attention Deficit (Hyperactivity) Disorder Includes Art Therapy Groups/*Diane S. Safran, Frank M Safran, Susan Finkelstein*

The Future of Our Past/*Michelle Nienkamp, Nancy J. Gray, Kimberly J Wathen*

Thursday, November 9, 1995

Weaving New Visions/*Lori Vance, Karen McCormick, Lynn Kapitan*

Papers

Collaborative Co-Therapy: Art Therapy as Adjunct Within Outpatient Private Practice Team Treatment/*Susan Roller, Kathleen Adams*

The Image-Making Process: Withstanding the Course of Non-Production/*Michael J. Hanes*

Art and Healing: Practitioner, Process, and Audience—A Dialogue/*Mari M. Fleming, Jennifer Colby*

The Power of Language in the Art Therapeutic Relationship/*Susan Spaniol, Mariagnese Cattaneo*

Relying on the Kindness of Strangers' Social Policy: Art Therapy and Poverty/*Nancy Mayer Knapp*

The Crash of US Air Flight 427—Its Impact Upon an Elementary School/*Carole Kunkle-Miller*

Couple Compatibility Assessment Using the Mari® Card Test and Mandala Drawings/*Phyllis Frame*

The Art of Crime/*Paula Howie, Linda Gantt*

Establishing Medical Art Therapy in a New Outpatient Pediatric Pain Management Service/*Janet K. Long*

A Vision Made Reality: Establishing Alliances in a Pediatric Art Therapy Program/*Laura A. Black, Kerith L. Glass*

A Men's Group Using Imagery as a Predominant Way of Knowing/*Robert Schoenholtz*

The Correctional Officer and the Art Therapist: An Unlikely Alliance/*David E. Gussak*

Going for the Gold: Art Therapy Grant Collaborations with Allied Professionals/*Frances E. Anderson, Lisa N. Braun, Patricia Ceresoli*

Art Therapy and Latin America: Answering the Call for New Methodologies/*Mary F. Flanery*

Survival of Aboriginal Culture Through Art: Implications for Cross-Cultural Art Therapy/*Frances F. Kaplan, Michael Campanelli*

Incorporating the Mandala to Center Children Diagnosed as ADD and ADHD/*Valerie Smitheman-Brown*

Mirror Drawings: A Reflection of the Therapeutic Process/*Anne Marie Shopp, Sue Chambers Wallingford*

Student Section/*Helen Landgarten*

Continuing the Search: Expanding a Professional World View Through Multi Cultural Influences/*Michael Franklin*

The Dynamics of Art & Music Therapy in Forensic Settings/*Reid M. Dorwin, Cindy Y. Weyuker*

Art Therapy in Pediatric Rehabilitation/*Julia Andersen*

Searching for the Appropriate Treatment Map: Integrating Object Relations and Family Systems Theories/*James Consoli, Gussie Klorer*

About the Words in Art Therapy/*Karin Dannecker*

Mandala Artwork by DID Clients: A Synthesis of Two Theoretical Models/*Barry M. Cohen, Carol Thayer Cox*

Results of Recent Research Studies Identifying Recurring Visual Symbols and Construct Choices/*Doris Arrington, Pamela Hayes, Estelle Rubinstein*

Amidst Ego, Soul and Art/*Debbie Simms*

Heart Imagery: Multiple Messages and Metaphors/*Lisa Kay*

Posters

The Gorilla Did It! Meeting Art Therapy and Reading Goals Together/*Peggy Dunn-Snow*

Research Findings: Art Therapists' (A.T.R.) Preferences Utilizing Artistic Mediums/*Frank Goryl, Jr., Roz Rutstein*

Behind Bars and Barbed Wire/*Linda Milligan*

Intergenerational Connections: A Collaborative Art Experience Between Nursing Home Residents and Children Residing in Transitional Shelters/*Allison Hurwitz, Linda-Lee Lewis*

Focus Groups

Working with Lesbian/Gay/Bisexual Clients: Issues for Therapists Part 3/*Tih Penfil, William More, Angelique Zeringue*

Mari® Card Test and Mandala Study Group/*Phyllis Frame*

Navigating the Conference: A Student Orientation/*Rebecca A. Wilkinson*

Online Art Therapy Communication/*Barbara Levy, Cathy Malchiodi*

BEST COPY AVAILABLE

Open Forums

Regional Symposia/*Jacquelyn Martin*

Governmental Affairs/*Terry Towne*

Clinical Committee/*Linda Chapman*

Ethics/*Cay Drachnik*

Membership/*Cindy Rosa*

Education/*Bruce Moon*

Workshops

The Art of Healing with the Human Energy Field Using Sound/*Dorothea Hover-Kramer*

Understanding the Spiritual Dimension of a Person Using BATA/*Ellen G. Horovitz-Darby*

Panels

Art and Art Therapy and the Seductive Environment/*Edith Kramer, Lani Gerity, David Henley, Katherine Williams*

The China Connection/*Harriet Wadeson, Delegates*

Art Therapy in Context: Honoring Women's Voices in Our Work/*Cathy Malchiodi, Shirley Riley*

Research in Art Therapy Education - A Dialogue/*Marcia L. Rosal, Debra Linesch, Sarah Hite*

Archetypal Art Therapy Defined/*Josie Abbenante, Ginger Mongiello, Jeanne Wenzke, Linney Wix*

Mexican Fiesta

Friday, November 10, 1995

Master Supervision Groups

Ethics/*Cay Drachnik, Christianne Wilkinson*

Post Traumatic Stress Disorder/*Martha Haeseler*

Deaf/Hearing Impaired/*Ellen G. Horovitz-Darby*

Addictions/*Marie Wilson*

Transferential Dynamics Within the Workplace/*Cam Busch, Lani Gerity*

General Session

Art Therapy Perspectives on Managed Care/*Laura Greenstone, Linda Gantt, Sandra Graves, Ron Hays, Bobbi Stoll, Edward J. Stygar, Jr., Terry Towne*

Papers

Sex Differences in the Fantasies and Self-Images of Delinquent and Non-Delinquent Adolescents/*Rawley Silver*

Art Therapy as Containment in the Stabilization of Dissociative Identity Disorder/*Tammy Nelson*

Will Children's War Images Lead Us to Peace? Professional Collaborations for Unity/*Beth Gonzalez-Dolginko*

Reflecting on Ten Years of Art Therapy for Children Who Are Grieving/*Barbara Betker McIntyre, Julie Adams*

Art Therapist as Member of Medical Multi Disciplinary Burn Team/*Johanna Russell*

Art Therapy Used to Adapt Coping Behaviors of Adult Daughters of Alcoholics/*Carol A. Dikovitsky*

Art Therapy Interventions with Adolescents Who Are Victims of Trauma/*Donna Testa Ochipa*

Art Therapy in Head Start—Preventive Mental Health Services for Disadvantaged Children/*Savneet Talwar, Gussie Klorer*

Imagine/Connect: A Collaborative Approach to Art Therapy in a Clinical Setting/*Carleen Jimenez*

From Hurtful Hands to Healing Hands: Collaborative Treatment of Multiple Personality Disorder/*Tamara McDougall Herl*

Attachment Organization in the Imagery of Addicts and Implications for Treatment/*Elizabeth Holt, Donna Kaiser*

Art Therapy with Laryngectomy Patients/*Susan Ainlay Anand, Vinod K. Anand*

Art Work of Aggressive Organic Geriatric Males, Pre and Post Estrogen Therapy/*Roseann Drew-Leute, Paul N. Bryman*

Holding Onto the Rainbow—Stereotyped Symbols in Patient's Art as Facilitators/*Dafna Mariya*

Student Section/*Shaun McNiff*

Visual and Tactile Interventions in Healing: Sandtray with Mastectomy Patients/*Vija B. Lusebrink, Kristin Seifres*

Through the Viewfinder: Focus on the Ego of Sexually Assaulted Females/*Alexandria Elliot-Prisco*

Coming to Our Senses: The Somatic Roots of Art Therapy/*Suzanne Lovell*

Mutual Benefits: Art Therapy and a Specialized School in a Psychiatric Program/*Dorrie Gussak*

Children Having Children: Art Therapy in a Community Based Early Adolescent Pregnancy Program/*Mary Jo Mermer-Welly, Gloria Stiles*

Integrating Art Therapy and Biofeedback—A New Perspective on Reducing Children's Stress/*Carol DeLue*

Using the Wall Symbol in Art Therapy With Cancer Patients/*Hilde Engelen*

Perspective on Clayworks in Art Therapy/*Frank Goryl, Jr.*

Patient-Focused Care and the Future of Art Therapists in Hospitals/*Susan Cheyne-King*

Special Lecture

Cancer—Creativity and Self-Repair: Theoretical and Clinical Considerations on Art Psychotherapy with Cancer Patients/*Esther Dreifuss-Kattan*

Discussion Groups

Adults with Cancer/*Virginia Minar*

Children with Cancer/*Robin Goodman*

Chronic Disease/*Vija Lusebrink*

AIDS/HIV/*Sandra White*

Posters

Realms of Art Therapy/*Renuka Sundaram*

Opportunities for Children with Disabilities: Artmaking and Assistive Devices/*Carol Kiendl*

Art Therapy with Addictions with an Emphasis on Substance Abuse, Work and Relationship Addictions/*Holly Feen-Calligan*

Focus Groups

Beyond Art Therapy: Creating Effective Continuity of Care Within Mental Health Communities/*Deborah Behnke, Bonnie Bluestein*

Lesbian, Gay and Bisexual Caucus/*Mary Brigid*

Doctoral Programs for Art Therapists/*Linda Gantt*

Student Section—Welcome to AATA/*Bruce Moon, Virginia Minar, Mary St. Clair*

Open Forums

Chapter Affiliates/*Nangee Warner Morrison*

Archives/*Nancy Mayer Knapp*

Public Relations/*Gail Roy*

Mosaic Committee/*Anna Hiscox*

Art Therapy Credentials Board/*Nancy Hall*

Workshop

It's Not Fair! Art Therapy with Bereaved Children and Adolescents/*Patricia Isis*

Panels

Portals and Passages/*Harriet Wadeson, Robert Ault, Maxine Junge, Rose Marano-Geiser*

Finding Meaning in Art: Art Therapists in Collaboration with One Another/*Carol T. Cox, Josie Abbenante, Barry M. Cohen, Paula Engelhorn, Marti Fleming, Wendy Miller, Lillian Rhinehart, Laurie Wilson*

Art-Based Diagnosis: Fact or Fantasy?/*Katherine J. Williams, Gladys Agell, Linda Gantt, Robin Goodman*

Models of School Art Therapy: Three Perspectives/*Sarah Hite, Carmen Drew, Peggy Dunn-Snow*

The Clothesline Project: Therapy, Education and Activism/*Katherine Ann Meyer, Marian K. Lancaster, Elaine Peck, Laura Myer*

Wholistic Art Therapy! An Idea Whose Time Has Come/*Roberta Shoemaker-Beal, Avis Garrett, Sondy Geller, Ellen Horovitz-Darby, Sev Savinch*

Performance Art

Four Lives: A Folk Musical/*Bruce Moon*

Elder Voices/*Laurie Ellen Neustadt, Stuart Stotts*

Saturday, November 11, 1995

Master Supervision Groups

Traumatic Brain Injury/*Patricia St. John*

Issues for the Private Practitioner/*Patricia D. Isis*

Eating Disorders/*Paola Luzzatto*

Homelessness/*Sr. Dorothy McLaughlin, Sr. Marie Larkin*

Abuse and Dissociation/*Deborah Good*

Slide Show Members' Artwork

Keynote

Mood Disorders and Artistic Creativity/*Kay Redfield Jamison*

Papers

Collaborating with Artists: Individual and Communal Healing/*Diane Burdick Gage, Ellen Speert*

Meditation and Art Therapy: Its Many Uses with the Geriatric Patient/*Linda Levine-Madori*

Art as a Way of Knowing: From Therapist to Steward/*Pat B. Allen*

The Myth of Collaboration: The Peace Bridge Project/*Lori Vance, Cindi Clark*

A Practical Review and Integration of All Diagnostic Drawing Series Research Findings/*Anne Mills*

The Cutting Edge: Self-Mutilation Seen in a Larger Context/*Joan Phillips*

Planting the Seed of Art Therapy Awareness: Educating Allied Professionals as Undergraduates/*Barbara Parker-Bell*

Return from Dissociation/*Barbara Sobol*

Development of a Model to Disseminate the Art Scale of Allied Professionals/*Betty Jo Troeger*

Visual Communication—Art Therapy for Interdisciplinary Higher Education Research/*Julia Byers*

The Studio Experience in Art Therapy Training/*Linney Wix*

Mirroring Through Art to Repair the Damaged Self/*Elenore Kanner Weinberg*

Functions of an Art Therapist's Art/*Helen B. Landgarten*

Queenly Maiden: A Case Study in Archetypal Art Therapy/*Barbara A. Falconer*

Moving the Image: Art and Movement Therapy with Older People/*Janet Beaujon Couch, Judith B. Funderburk*

Student Section/*Arthur Robbins*

Posters

The Life Book Group/*Ellie Ehrlich*

Statue of Liberty in Holland: From Artist to Art-Psychotherapist/*Suus M. Scheller-Dikkers*

Awakening the Sleeping Artist: Creative Expression Group for Senior Citizens Ages Seventy-Eight to Ninety/*Linda Lee Goldman*

The Art and Writing of Patients with Tuberculosis, 1945/1995/*Irene Rosner David*

Focus Groups

Inclusion, Exclusion, Intrusion: Can We Accommodate to the Changing World of Mental Health?/*Shirley Riley, Judy Rubin, Laurie Wilson*

Helping HIV+ Clients/Families/Colleagues/*Laura Ellen Neustadt*

Gerontology/*Linda Levine-Madori, Madeline Rugh*

Diagnostic Drawing Series/*Anne Mills*

Open Forums

Journal/*Cathy Malchiodi*

Conference Committee/*Cathy Moon*

Research Committee/*Nancy Sidun*

International Networking/*Pat Grajkowski*

Managed Care Concerns/*Sandra Graves*

Performance Art

Celebrating the Cycle of Life with Art, Dance, Music & Poetry/*Carol T. Cox, Peggy Heller, Carolyn Sonnon, Vicky Wilder*

At the Intersection of Pain and Beauty/*Pat Allen, Randy Vick*

Closing Reception/Dance for Dollars

Sunday, November 12, 1995

Art Therapy Videos

"To Paint the Stars—Vincent Van Gogh"/*Kay Redfield Jamison*

"Eric: Sensory Motor Integration and Art Therapy"/*Arnell Etherington*

"Courage! Together We Heal"/*Frances E. Anderson*

"The Journal TLC"/*Anita Mester*

"Messages: Art Therapy at the Cherrywood Nursing and Living Facility"/*Cyndy Weeks*

"A Portrait of Edith Kramer-Artist/Art Therapist"/*Edith Kramer*

"Individuating Woman: A Transformational and Creative Process"/*Ilse Gilliland*

Legislative Workshop/*Terry Towne*

Papers

Creating a Future: Sandplay with Trauma Survivors/*Terri L. Sweig*

Identifying and Assessing Self-Images in Drawings by Delinquent Adolescents/*Rawley Silver, JoAnne Ellison*

Art Therapy with 3-D Environments/*Bonnie Bluestein*

Paper Dolls: A Therapeutic Technique with Adolescents in Residential Treatment/*Betsy Woodward O'Neal*

The Importance of Being Ernst: How Max Ernst's Art Paralleled His Life/*Evelyn Virshup*

Toward a More Inclusive Use of Imagery and Art in Psychotherapy/*James J. Consoli*

Art in Boxes: An Art Therapist's Exploration of Meanings/*Anna Belle Kaufman*

Workshops

A Collaborative Model: Utilizing Art and Music Therapy with At Risk Adolescents/*Susan D. Loesl, Sheila Feay Shaw*

Weaving Poetry into Art Therapy/*Randy M. Vick*

Panels

Integrating Art Therapy in a Day Treatment Program with Inner City Adolescents/*Eileen P. McGann, Greg Pagano, Harriet Harris*

Shaping Affect and Meaning in Learning to be an Art Therapist/*Arthur Robbins, Laurel Thompson, Elaine Rapp, Pierre Boenig*

Mural Making in the Therapeutic Community: Five Projects and Views/*Leland Peterson, Sondra Goldman, Richard Sorrentino, Jane Cameron, Anne-Marie Levesque*

Conference Courses

Art Making as Complementary Medicine: Art Therapy with Medical Populations/*Cathy Malchiodi*

The Multi-Disciplinary Model for Treatment of Attention Deficit Disorder/*Diane Safran, Frank Safran, Susan Finkelstein*

Women's Narratives and Their Art Therapy Illustrations/*Shirley Riley*

Kinesthetic Imagining: Exploring Body as Therapeutic Vessel and Healing Guide/*Susanne Lovell*

Art Therapy Inquiry: New Research Opportunities/*Debra Linesch*

An Intermodal Approach to Mandala Theory Using Art, Dance, Music, Poetry/*Carol T. Cox, Peggy O. Heller, Carolyn Sonnen, Vicky N. Wilder*

The Ulman Personality Assessment Procedure/*Gladys Agell*

Celebrating Differences: Exploring and Treasuring our Cultures/*Lani A. Gerity, Martha P. Haeseler; Andrea Ramsey*

Incorporating Art-Making in Play Therapy: A Child Centered Approach/*Linda Lea McCarley*

Drawing on Strength: Feminist Art Therapy with Victims of Domestic Violence/*Kathryn A. Webb*

Introduction to the Diagnostic Drawing Series: An Art Therapy Assessment for Adults and Children/*Barry M. Cohen, Anne Mills, Barbara Sobol*

1996 CALENDAR OF EVENTS

APRIL

The American Society of Group Psychotherapy and Psychodrama will convene for its 1996 Annual Meeting "Seventy-Five Years of Psychodrama: So Much More to Explore" April 18-22, 1996 in Houston, Texas. Conference participants will learn new methods and share ideas which place value on empowerment, community building and interdependence. The 1996 Annual Meeting will include a celebration of the diamond jubilee of psychodrama and explore its relationships with creative arts therapies, education, counseling, and the workplace. Individuals interested in receiving registration information should contact the ASGPP National Office, 6728 Old McLean Village Drive, McLean, Virginia 22101, (703)556-9222, fax (703)556-8729, and e-mail: Degnon@AOL.com.

MAY

The 16th Annual Conference of the National Association for Poetry Therapy, "Words For Life" will take place at the Columbia Inn in Columbia, Maryland, May 2-5, 1996. Lucille Clifton and Jack Coulehan, MD, will be the Keynote Speakers. Call (516)944-9791 for more information.

Kaleidoscope® Kids, Inc. will be holding the 3rd Conference and Networking Symposium on Pediatric Hospice-Home Care and Related Inpatient Care at the Omni Charlotte Hotel in Charlotte, North Carolina on May 10-12, 1996. Write for more information to Kaleidoscope Kids, Inc., P.O. Box 1659, Mt. Pleasant, South Carolina 29465.

JUNE

The 31st Annual Conference of the Association for the Care of Children's Health (ACCH) will be held at the Albuquerque Convention Center in Albuquerque, New Mexico, June 9-12, 1996. The theme for the year's conference is "Humanizing Healthcare: Renewing the Spirit of Our Work." Clinicians, administrators, educators, researchers, policy-makers, pediatric facility designers, family members, and others are invited to register. For a preliminary conference program or further information, contact the ACCH Conference Office at (301)593-2487.

OCTOBER

The International Stress Management Association will conduct ISMA-6 on October 5-8, 1996 in Sydney, Australia in cooperation with several other organizations. For more information call (619)635-4698, fax (619)635-4669, or Internet: NOSTRESS@sanac.USIU.edu.

NOVEMBER

The 27th Annual American Art Therapy Association (AATA) 1996 Conference "Many Paths; Multicultural Perspectives in Art Therapy" will be held on November 13-17, 1996 at Adams Mark Hotel in Philadelphia, Pennsylvania.

Acceptance Speech for the Honorary Life Membership Award of the American Art Therapy Association

Vija B. Lusebrink, PhD, A.T.R.-BC

Vija B. Lusebrink, PhD, A.T.R.-BC, Professor Emerita, University of Louisville, Kentucky, has been an art therapy educator for 22 years. She was on the faculty of the Expressive Therapies Program, University of Louisville, from 1974 to 1995, and as a Professor and Director since 1986. She also has been a guest lecturer at the College of Notre Dame, Belmont, California, Florida State University, Tallahassee, Florida, and the University of New Mexico, Albuquerque, New Mexico, among others.

Dr. Lusebrink has published many articles and has written a book, Imagery and Visual Expression in Therapy *(1990). She has given many presentations at the Annual Conferences of the American Art Therapy Association (AATA), the Association for the Study of Mental Imagery, World Conferences on Imagery, as well as at the Annual Meeting of the American Psychiatric Association and the Annual Convention of the American Psychological Association.*

Dr. Lusebrink has been active in AATA as a member of the Standards Committee, 1973–75, Peer Standards Review Board, 1975–77, Program Co-Chair of the 6th Annual Conference of AATA, Member of the Nominating Committee, 1981 and its chair in 1989, Honors Committee, 1982–83, Professional Ethics Board, 1986–87, and Member of the Research Committee, 1990–93 and its chair in 1992. She is a member of the Kentucky Art Therapy Association and a Honorary Life Member of the Northern California Art Therapy Association. She is a member of the Editorial Boards of Art Therapy: Journal of the American Art Therapy Association *and* The Arts in Psychotherapy*.*

I am deeply honored by being chosen to receive the Honorable Life Member Award of the American Art Therapy Association, and I want to thank all who made this come true.

In my work as an art therapist, I have received a number of titles in working with my patients. I have been named by them, depending on the individual and circumstances, a Russian spy (because of my accent); Lady Vija (because one of my patients thought that he was a Lord and that we were married); and Cat Lady (I had a third eye because I could relate to their drawings and paintings). I guess, I also have been known as the tough Dragon Lady among the students of the Expressive Therapies program at the University of Louisville. I never dreamt, though, that I would be named an Honorary Life Member of AATA.

Looking back on my many years as art therapist and art educator, one central aspect stands out for me—my belief in the power of art therapy. Early in my career, as I became aware of many possibilities for the application of art therapy, I realized that I could see more potential for it than I could do myself, and I decided to become an art therapy educator. It has been an exciting and rewarding journey to new awarenesses opened in art therapy by students and colleagues.

In my view art therapy is—like people and art—complex, multidimensional, and multifaceted. Art therapy as a profession needs many individuals with many different gifts, views, and interests. The differentiation and synthesis between the different aspects of and approaches to art therapy make up the weave of its rich tapestry. In my view, at this point we are still at the early stages of exploring the depth of the field, and we merely have scratched the surface of understanding what makes art therapy so effective. Many discoveries are waiting for us in this field—and lots of hard work in addition to the knowledge accumulated and work done.

I am glad that I have been part of the early stages of art therapy development, and that I have been able to contribute some of the strands to the weaving of its tapestry. I am touched by the honor given to me today in recognition of my contributions to the field. Thank you!

1995 Distinguished Service Award Speech

Randy M. Vick, MS, A.T.R.-BC

Randy M. Vick, MS, A.T.R.-BC, graduated from Emporia State University and has practiced art therapy for the past 14 years. His most recent clinical position was as Director of Expressive Therapies in Psychiatry at Michael Reese Hospital, Chicago, where he continues work on an art therapy research project. His current position is Assistant Professor in the Master of Arts in Art Therapy program at The School of the Art Institute of Chicago where his duties include the coordination of internship placements.

He has been President (1985–87), Conference Co-chair (1985), and Program Co-chair (1983–85) for the Illinois Art Therapy Association which awarded him its Distinguished Service Award in 1993.

For the past several years, Randy has worked as part of the team which developed the ATCB certification exam by refining knowledge areas, writing questions, and reviewing the '95 exam in its final stages. Randy also served on the Clinical Committee (1989–93) where he represented both AATA and NCATA at the Mental Health Advisory Committee of the JCAHO. In this capacity he functioned as a member of a rehabilitation therapies coali-

tion which provided input to the Commission as standards relating to these disciplines were developed.

With the 1994 Silver Anniversary conference he completed a five-year term as AATA's Conference Chair, a position he helped to develop. Prior to this he served as Program Chair (1989) and Local Arrangements Chair (1988). Randy is currently on the AATA Board of Directors and has liaison responsibilities to Art Therapy *and the Public Relations and Research committees.*

I'm pleased and proud to accept this Distinguished Service Award, and as an additional act of service to you all I am going to keep my remarks brief. I have absolute empathy for Cathy [Moon] in her role as "time cop" and so will do my part to keep us on schedule.

I want to thank Virginia Minar, Cathy Malchiodi, Marcia Rosal, and Debbie Good who placed my name in nomination for this award as well as the Honors Committee and the AATA Board. It's very gratifying to have your accomplishments recognized by your professional peers.

Eight years ago I was contacted by Linda Gantt who discussed the idea of serving as Local Arrangements Chair for the 1988 conference in Chicago. Things progressed nicely, time passed, and I must have proven myself a worthy pigeon since I was eventually asked to make a long-term commitment to apprentice to the Conference Committee. In this role I was to develop the conference manual and serve as Conference Chair (a role previously seen as part of the duties of the President-Elect) for a multiyear term. The symmetry of beginning and ending my tour of duty in my hometown appealed to me so I signed on through the Chicago conference of 1994. Such are the dangers of aesthetics. That is how I became such a fixture at these little get-togethers, serving in turn the Drachnik, Gantt, Goodman, and Stoll administrations.

During these years I've thought a great deal about our annual meeting and the function it plays in the life of our association and our profession. Comparisons are made to trade conventions and family reunions, but these concepts are insufficient. The metaphor I prefer is that of a village. But not by any means your typical town. Ours is a strange, Brigadoonish sort of place which appears *as if by magic* out of the mists at the appointed time and place. Now, in the play the legendary town is manifest for one day then sleeps for one hundred years until it's next appearance. I must admit that while working on these events the reverse often seemed true; our actual schedule is four days of intense activity followed by a year of relative rest. Different, too, is Brigadoon's pattern of returning to the same Scottish moor each time while we spring up in a new location every year.

Within the bounds of our new town square, we return to our community life with a vigor that would put the singing and dancing inhabitants of that mythical Highland village to shame. Here we greet old friends, buy some books, swap stories, and get a bite to eat, but the primary commerce of our town is in ideas. The trade, barter, and marketing of theories and experiences of art therapy are at the core of these gatherings. When the allotted time is up we disperse, exhausted in body perhaps but reenergized professionally and personally for the work we return to in our "other" homes.

In the play a miracle is given as the reason for the magical appearance of the village, but the work of many hands is what makes this city work. I've been very fortunate to have had the chance over these years to work with many gifted colleagues. Program Chairs Patricia Isis, Cecily Mermann, Rene Bouchard, Cathy Moon, and Barb Fish and dozens of committee members, and Ed Stygar and the AATA National Office staff all have contributed countless hours to these events. If there is magic here it's Mary Buckley whose behind-the-scenes coordination and eye for details make her a true unsung hero.

To this talented mix I brought my creativity, organizational skills, and sense of humor. I put in some long hours, had a good deal of fun, and endured some aggravations—yet by this honor can see it was appreciated. Thank you very much.

Service Award (awarded posthumously)

Nancy Schoebel, 1952-1990

This award was given to honor the dedication and service of Nancy Schoebel to the American Art Therapy Association and to the profession of art therapy. In the 1970's, Nancy represented the AATA in working on legislative issues for the LACAT, the forerunner of the National Creative Arts Therapies Association (NCATA). She was instrumental in the inclusion of art therapy as a service available under Public Law 94-142, and thus paved the way for art therapists in the schools. She served on the AATA's Board as Governmental Affairs Chair from 1981–1985 and was an activist for NCATA's legislative committee. She served as the President of the Potomac Art Therapy Association and at the time of her death was finalizing her work as Co-chair of the Program Committee for NCATA's conference in 1990.

Art Therapy: Journal of the American Art Therapy Association, 13(1) pp. 12-19 © AATA, Inc. 1996

Beyond Practice: A Postmodern Feminist Perspective on Art Therapy Research

Helene Burt, DTATI, A.T.R., Toronto, Ontario

Abstract

The profession of art therapy has failed to integrate gender issues and feminism into the art therapy literature and research. One of the ways gender has had an impact on the profession is through beliefs about research. There has always been a pervasive assumption among art therapists that we need to do more quantitative research in order to further the aims of the profession. This article discusses the relationship between this assumption and the lack of attention to gender. With the hope of generating a dialogue about gender issues in art therapy and art therapy research, this article examines whether there are research methodologies that are less gender biased than others and whether there are research methods which are particularly suited to art therapy.

Introduction: Is Feminism a Four-Letter Word?

In 1988 I presented at the American Art Therapy Association's annual conference, held that year in Chicago. At the time I was employed at a large and innovative adolescent and family treatment center in Calgary, Alberta. I was the only art therapist in Calgary and in the province of Alberta. Therefore, it was quite an inspiration to be surrounded by several hundred fellow art therapists for four days to focus on "Professionalism in Practice," the theme of the conference. My art therapy colleagues were not only professional but also highly educated and committed people, many with extensive clinical experience. They were also primarily female. I remember looking around the huge banquet hall in which we had all gathered to hear the keynote speaker. There were hundreds of women and only a handful of men. I was somewhat perturbed when the keynote speaker turned out to be a well-known male psychoanalyst from Europe who was not an art therapist. I was astounded when he proceeded to give us a lecture on the personal relationship between Gaugin and Van Gogh. I asked myself, "Why had all these bright professional women traveled so far and paid so much money to be delivered an irrelevant talk by a male psychoanalyst?" I felt disrespected, and the conference theme seemed particularly ironic to me given this lack of regard for our own needs as professionals.

In the most recent American Art Therapy Association Membership Survey (La Brie & Rosa, 1994) respondents were asked to identify their gender. Eighty-six percent of the respondents were women, 8% men, and 6% did not respond to the question. In a previous survey (Gordon & Manning, 1991) completed four years earlier, more respondents answered this question with 92.8% being female, 6.8% male, and .4% not responding to the question. It is impossible to say whether the percentage of men entering the field has actually risen by 1.2%. At any rate if this represents the rate of growth of men entering the field, it will be a long time before our profession can be considered anything other than a "woman's profession."

One of the strongest social, political, and philosophical forces of the last century has been feminism. Feminism has strongly influenced the way we conceptualize the therapeutic process. Strangely enough, the art therapy literature maintains a denial and ignorance of feminism quite distinct from other mental health literature. This was evident in a search I conducted on the CD ROM PsycLit (1/87–6/94). I located all catalogued articles and book chapters from 1/87 to 6/94 which had both the words "art therapy" and "feminism" in them. During this 6 1/2 year period, 357 articles had been written which mentioned "art therapy." Out of these 357 articles, two also mentioned "feminism." Out of the 166 book chapters which mentioned "art therapy" none mentioned "feminism." Wondering how this compared to other fields, I did searches in art therapy, psychology, psychiatry, social work, psychotherapy, family therapy, and occupational therapy.

My research indicates art therapy can hold a claim to being the field which has paid the least attention to feminism. Since it has been feminism which has revealed the power differential between men and women in our society as well as the gender bias in psychological theory and practice, the profession of art therapy seems to be operating without an awareness of the sociopolitical structure that oppresses women both who work as helping professionals and who are clients who utilize health care. This presents a major block to our growth as a profession. If we are not aware of the ways in which gender impacts the power or lack of power of women in our society, then we will likely not become aware of the ways gender impacts our work and the growth of our profession. In this way we will remain powerless to effect any change and never obtain the level of recognition we should have.

In 1989 feminism was briefly mentioned in the art therapy literature. This is when both the art therapy articles which had the courage to mention the word *feminism* appeared. Wadeson (1989) challenged art therapists to look at gender issues in her article, "In a different image: Are "male" pressures shaping the "female" art therapy professions?" Wadeson explored the gender bias in clinical theory and research and highlighted the need for research about women to be within the context of women's expe-

BEST COPY AVAILABLE

rience. In the same way, Wadeson maintained, art therapy research methods should develop out of the context of the art therapist's experience rather than out of the context of other professions.

Talbott-Green (1989) also dared use the word *feminist* in her article, "Feminist scholarship: Spitting into the mouth of the gods." Talbott-Green discussed the gender bias in editorial policies and in research which has effectively silenced our voices both as art therapists and as women. She asks,

> As a member of the mental health establishment, as a psychotherapist, do you feel you have representation, control, autonomy, and access to power equal to that which the "real" therapists have? Do you get equal pay for equal work and responsibility for treatment? Is your important knowledge being published and disseminated among a wide audience of mental health professionals? (Talbott-Green, 1989, p. 260)

One of the ways in which our lack of attention to gender has made an impact on our profession is through our beliefs about research. There has always been a pervasive assumption among art therapists that we need to do more quantitative research in order to further the aims of our profession. This article discusses the relationship between this assumption and our lack of attention to gender. With the hope of generating a dialogue about gender issues in art therapy and art therapy research, this article examines whether there are research methods that are less gender biased than others and whether there are research methods which are particularly suited to art therapy.

Postmodernism and Empirical Research Methods

Harding (1991) defines three distinct streams of feminist research: empirical feminist research, feminist standpoint research, and postmodern feminist research. Empirical feminists recognize that there have been gender inequalities in prefeminist research, as for example in Kohlberg's (1958) work which proposed a model of moral development in human beings. Kohlberg's model of moral development is based on a longitudinal study which he conducted with a group of 84 men over a 20-year period, from childhood to adulthood. He drew some interesting conclusions but did not include any women in his study. Therefore, when he generalized his results, women rarely reached as high a moral developmental stage as did men. An empirical feminist research approach, recognizing that these results are biased, might use the same research design but this time include women in the study. An empirical feminist would view the exclusion of women from the study as the problem and view inclusion as the solution.

A feminist standpoint researcher would maintain that inclusion is not enough. In the example of Kohlberg's research, the results are biased not just because women were not included, but also because the theoretical assumptions on which he based his research are gender biased. A feminist standpoint researcher would question and rethink from women's perspective, the traditional models of development, accepted norms of mental health, and other gender-biased theoretical assumptions. Subsequent research would utilize theory based on feminist frameworks such as relational theory (Jordan et al., 1991), a feminist theory of women's development. Bettridge (1994), for example, utilized relational theory to deconstruct traditional theories about adolescent female suicide attempters and to give new meaning, from a feminist perspective, to their behavior. Traditional developmental theory viewed suicide attempts by adolescent females as indicative of a pathologically dependent and manipulative personality structure. Bettridge's research strongly discounts the traditional perspective, finding that adolescent female suicide attempters are no more dependent than adolescent female nonattempters. In Bettridge's research, adolescent female suicide attempts emerge as part of a quest for more supportive interpersonal relationships.

Taking this a step further, a postmodern feminist research perspective would challenge the feminist standpoint perspective by pointing out that it is not enough to conceptualize from a feminine perspective. We also must acknowledge differences among women. A postmodern feminist would address race, ethnicity, culture, sexuality, class, age, and all other sociopolitical aspects of life human beings experience, in the research process. Postmodern feminism continues the examination of how meaning and knowledge are constructed with a focus on who is asking which question about whom. Both feminist standpoint and postmodern feminist researchers understand that it is not so much the search for answers which guides the research process, but more the kinds of questions we ask and how we ask them. There is a recognition that the answers we find will always be defined by the questions we ask.

"Hard" and "Soft" Science and Methodology

Psychology has always been viewed as a "soft" science, while the "hard" sciences, like biology, are based on things you can see. The metaphor of "hard and soft" is humorous at best given that it is obvious which type of science, hard or soft, is considered best. Equally humorous are speculations as to how this metaphor originated. Within psychology, we also have hard research methods (quantitative) and soft research methods (qualitative). Art therapists, like other professionals, have wanted to produce scientific research in order to be taken seriously. As in psychology, the emphasis has been on quantitative research methods. Qualitative methods have not been viewed as very scientific, and many of the current ways of conducting qualitative research do not fit with the assumptions science makes.

It has always been science that defined what was real, knowable, and relevant. Science is based on certain unprovable assumptions which are necessary for conducting scientific discourse. These assumptions are as follows:

1. Nature is orderly.
2. We can know Nature.
3. Knowledge is superior to ignorance.
4. All natural phenomena have natural causes.
5. Nothing is self-evident. Everything must be objectively proven.
6. Knowledge is derived from the acquisition of experience. (Frankfort-Nachmias & Nachmias, 1992)

These assumptions are fine for biology, although they obviously don't explain the phenomena of spirituality or supernaturalism. When it comes to human psychology, these assumptions serve only those who created the assumptions—those in power who, either through gender, class, race, or culture, had the privilege to define science. "All natural phenomenon have natural causes" is an assumption which serves medicine and psychiatry particularly well. If everything has a biological cause, then we should be able to come up with the biological cure and not have to solve problems by dealing with such issues as oppression of certain groups, poverty, violence, and so forth. This particular assumption also serves the economically powerful pharmaceutical companies quite well.

The premise "Nothing is self-evident," or everything must be proven by an objective method, disguises a second implicit and more dangerous assumption—that there is such a thing as objectivity. In fact, everything that can possibly be known or understood changes depending on who is perceiving it and under what circumstances. Therefore, if we are to ask a research question such as, "What does the imagery of women who have been sexually abused look like?" then we need to know what women we are talking about; for example, are we talking about a white middle class Canadian woman or are we talking about a Somalian woman of color who has just emigrated to Canada? We also need to know who the researcher is and what his or her particular set of biases and beliefs are. While science claims to be impartial, the assumptions it is based on serve the dominant group all too well.

Art Therapy and the Research Process

The research process, as defined by scientists, necessitates an experiment which consists of the following elements: theory, problem, hypothesis, research design, measurement, data collection, data analysis, and generalization. Art therapy research has primarily been in the form of clinical case presentations or quantitative studies utilizing art therapy assessment tools such as the Diagnostic Drawing Series (DDS) (Cohen, Mills, & Kijak, 1994) with various different populations. Clinical case presentations are not considered hard research as there is no research design and one cannot generalize from the data. Neither is there any way of measuring validity or reliability, two essential components of measurement. Art therapy studies which utilize measurement tools, such as the DDS, meet the requirements of the scientific research process and work hard to achieve validity and reliability. Validity is concerned with the question, "Is one measuring what one intended to measure?" An art therapy example would be, "Does the image of the eye in a client's artwork indicate paranoia?" The validity would be determined by how strongly the researcher could prove that the image of an eye was a measurement of paranoia rather than of something else. Reliability refers to the extent to which a measuring instrument has variable errors; that is, do its results vary from time to time or from environment to environment? In the above example, if the researcher found that the eye indicted paranoia with a group of participants on a given day but then retested the same group on another day and found that the eye did not indicate paranoia, then the reliability of the measuring instrument would be suspect.

The Viability of the Diagnostic Drawing Series

The DDS is described as "the only assessment tool in art therapy that is supported by extensive diagnostic and procedural research" (Cohen, Mills, & Kijak, 1994, p. 109). While I was able to locate seven published studies (Cohen, Hammer, & Singer, 1988; Couch, 1994; Gulbro-Leavitt, 1989; Kessler, 1994; Leavitt, 1988; Neale, 1994; Rankin, 1994) which have been conducted using the DDS between 1982 and 1994, I do not think these claims are quite substantiated. The first study by Cohen, Hammer, and Singer (1988) concluded, "There appeared to be limited congruence between psychiatric diagnoses and DDS results" (p. 11). Gulbro-Leavitt (1989) investigated the validity of the DDS as a tool to measure depression in children and adolescents. Gulbro-Leavitt observed that the detection of depression in this population had largely relied on self-reporting and on the assessments of clinicians and parents which, according to Gulbro-Leavitt, have only equivocal validity. However, Gulbro-Leavitt's results forced her to conclude that the assessments of clinicians had stronger validity than the DDS.

Although Couch (1994) found differences between her control group of elderly people and her subject group of elderly people with organic mental syndromes and disorders, she acknowledged that her study is limited in that the control group was not representative and the raters were not blind. These two elements usually result in biased results. Kessler's (1994) study of eating disordered patients had no control group, without which her study has no intrinsic validity. In other words, without a comparison group of patients who did not have eating disorders, one cannot determine whether the images Kessler found in the artwork of patients with eating disorders differs from the artwork of patients without eating disorders. Therefore, one cannot even suggest that these images are indicative of eating disorders. Both Neale's (1994) and Rankin's (1994) studies have some interesting and convincing results but so many limitations that, by the standards of empirical research methods, the results do not have much weight.

Gender Bias in Psychiatry and Psychology

The DDS research demonstrates what happens when we try to fit art therapy into patriarchal paradigms like the medical model; we lose the value of the art therapy process and further elevate the medical model's position of power. If art therapists wish to produce research which utilizes the medical model, they should at least be aware of the second-hand oppression our clients experience when we utilize a gender-biased assessment tool such as the DDS. Cohen et al. (1994) described how the test was developed:

> The graphic profiles of the drawings in the Series are correlated with concurring diagnoses assigned by psychiatrists and psychologists at the time of the collection of the pictures; it is from this correlation that the name Diagnostic Drawing Series is derived. (p. 105)

In other words, the researchers chose drawings done by groups of people who represented each diagnostic category and from these drawings concluded that certain characteristics were indicative of certain diagnostic categories. Ironically, the authors claim:

> In addition the DDS is the only published art therapy assessment tool linked to the standards of the DSM III-R (APA, 1980). As it is not predicated on any one particular model of art therapy or verbal

BEST COPY AVAILABLE

> psychotherapy, it can be used by all art therapists as a sort of *lingua franca*. (Cohen et al., 1994, p. 109)

It is precisely because the DDS is based on the DSM III-R that the DDS *is* predicated on a particular model of psychotherapy—psychoanalysis. The characteristics which are pathologized in the DSM III-R and their etiology are based on psychoanalytic beliefs about human development and standards of mental health. The feminist critique of psychoanalytic theory (Jordan et al., 1991; Kaschak, 1992; Sturdivant, 1980) revealed how psychoanalysis legitimized sex-role stereotypes by embedding them in quasiscientific theories of behavior and development like the Oedipal stage of development.

Furthermore, the connection between the DDS and DSM-III-R results in an inherent gender bias in the DDS as a measurement tool. Even though the DSM III-R claims to be an impartial descriptive inventory of symptoms, the fact that certain symptoms are pathologized in the first place is based on a white, middle-class, heterosexual male definition of what is normal. The DSM III-R did not have women or minorities involved in its creation. The DSM-IV (APA, 1994) did, but it's too little too late—the damage has been done. Diagnostic categories are viewed as objective truth rather than as the highly subjective truth of the dominant group in our society which continues to oppress women, other races, cultures, and sexualities. The DSM pathologizes those issues which are problems to those in power in a patriarchal society.

Certain diagnoses are assigned much more frequently to women than men (Rothblum & Franks, 1987). These "women's diagnoses" include Depression, Agoraphobia, Sexual Dysfunction, Simple Phobias, Anxiety States, Somatization Disorder, Multiple Personality Disorder, Psychogenic Pain Disorder, Histrionic Personality Disorder, Borderline Personality Disorder, and Dependent Personality Disorder (Rothblum & Franks, 1987, p. 351). In a 1970 study by Broverman, Clarkson, Rosenkrantz, and Vogel, clinically trained therapists (psychologists, psychiatrists, and social workers) were asked to determine their criteria for healthiness in men, women, and adults in general. The researchers found that the therapists had the same criteria for men and for adults in general but quite different criteria for women. Healthy women differed from healthy men (and therefore healthy adults) by being more submissive, less independent, less adventurous, more easily excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective, and disliking math and science. The same characteristics which define "healthy" women are the hallmarks of the "female" diagnoses. The primary symptoms of these diagnoses—dependency, emotionality, fear of being alone—are all qualities which our society considers essential components of femininity.

A good example of gender bias in the DSM is the diagnostic category of Borderline Personality Disorder (BPD). Of those assigned the diagnosis of BPD, 68% to 78% are women (Ogata, Silk, & Goodrich, 1990). The DSM-IV found that 75% of those assigned this diagnosis are female. The diagnostic criteria for BPD as outlined in the DSM-IV includes some of these same characteristics therapists view as "healthy" in women. Therapists see healthy women as "less independent"; the DSM-IV notes the BPD client suffers from a fear of being alone and a need to have other people with her. The healthy woman is viewed as "more emotional"; the DSM-IV states the BPD client suffers from "affective instability." The healthy woman is viewed as more easily excitable in minor crises and having her feelings more easily hurt; the DSM-IV notes the BPD client is "very sensitive to environmental circumstances." This gender bias creates a link between the personality characteristics of healthy women and the personality characteristics of BPD clients. We must then ask to what degree BPD is an extreme manifestation of the condition of being *feminine* as it is defined by psychiatry and psychology.

"Matricentric" Research

The quality of the mother-child relationship has been viewed as the single, most influential factor in the development of BPD. Much of the accepted, traditional literature concerning the etiology and treatment of BPD clients has its origin in theory developed by Mahler (1971) who noted certain similarities between the psychological makeup of BPD adults and the separation-individuation issues of young children. Mahler hypothesized that derailments in the rapprochement subphase of the separation-individuation process led to the development in adulthood of BPD. This premise was then further expanded by theorists like Kernberg (1975), Adler (1985), and Masterson (1975). A mother who was unable to meet the child's needs for mirroring or who could not tolerate the child's need to separate and individuate was usually the cause. However, BPD etiological theory does not take into account other crucial relationships and life experiences in the BPD client's history.

Birns (1985) questions the prevalent and tenacious belief that the mother-child relationship is the primary contributing factor to either the wellness or pathology of humans. Freud set a precedent with his statement that the mother-infant relationship was "unique, without parallel, laid down unilaterally for a whole lifetime as the first and strongest love object and as prototypic of all later love relations for both sexes" (Birns, 1985, p. 2). Birns points out the lack of evidence to substantiate this and presents current research which challenges this influential belief.

Birns begins by criticizing the ways in which Bowlby arrived at his conclusions. Bowlby observed orphaned children being raised in an institution who were mentally and physically handicapped and concluded that this was due to maternal deprivation. Bowlby also used Harlowe's experiments with monkeys from which he concluded that factors other than food provision were important in child development, particularly, in his view, the mother-infant bond. Subsequent research was designed to further substantiate these initial theories rather than scientifically test them as hypotheses. Bowlby's theory was not based on actual longitudinal studies, the only type of research design which would yield valid information. In fact, Birns reveals, longitudinal studies which have been undertaken to explore the mother-infant relationship as a predictor have shown, as in a study done from 1929 to 1957 at the Fels Research Institute, that maternal-infancy ratings do not correlate with later behavior. The New York Longitudinal Study conducted by Chess and Thomas found that the major predicting risk factor of adult behavior is the temperament of the child and not poor mothering (Birns, 1985).

This focus on the mother-infant relationship naturally resulted in a lack of research into the significance of the father-infant relationship and other relationships in a child's development. Lewis (1986) refers to this as the "legacy of matricentric research" (p. 229). Silverstein (1991) points out the failure of child development researchers to explore the effects of paternal emotional distance on a child's development. The BPD literature on parent-child relationships is a good example of "matricentric research" as it focused on the mother's overinvolvement (Adler, 1985; Masterson, 1975) but failed to explore the effects of paternal underinvolvement. When paternal emotional distance has been noted (Goldberg, 1985), it is viewed as pathological rather than typical. Masterson and Rinsley (1975) were quite unabashed in "mother-blaming":

> This paper describes the role of the mother's faulty libidinal availability in the development of the borderline syndrome. It describes in terms of object relations theory the effects of alternating maternal libidinal availability and withdrawal, at the time of separation-individuation (rapprochement subphase), upon the development of the psychic structure of the borderline patient." (p. 163)

Research as recent as 1991 (Frank & Paris, 1991) continues to utilize Masterson and Rinsley's formulation.

Sexual Abuse

"Matricentric" research also made invisible the childhood trauma many people diagnosed with BPD have experienced. For example, a history of childhood sexual abuse has been consistently found in a large majority of cases. Ogata, Silk, and Goodrich, in their 1990 study, found the incidence of sexual abuse in the BPD population to be as high as 71%, yet the focus was instead on separation-individuation issues in the mother-child relationship. Saunders and Arnold (1991) in reviewing and reframing the core features of the diagnoses—primitive defenses, unstable relationships, identity disturbance, inability to be alone, and self-destructiveness—demonstrates how these features are more easily understood as responses to the trauma of childhood sexual abuse. They give the example of splitting which Kernberg (1975) viewed as a major defense mechanism and indicator of BPD pathology originating in the mother-infant dyad. In a deconstruction of Kernberg's interpretation, Saunders and Arnold point out that splitting is far more likely to be generated from a pathological relationship between the incestuous father or other perpetrator and the child. For example, the child victim of incest is expected to integrate the polarities of the loving parent on the one hand, and the sexually abusive parent on the other. The authors note that, in this light, splitting would seem more a reflection of an internalization of the child's actual experiences of being sexually abused and, therefore, more of a learned response to this trauma than a defense mechanism against rage towards the mother.

Again, it is the questions asked which guide the research, not necessarily the search for answers. If anyone had thought to ask why so many women with BPD were victims of childhood sexual abuse, BPD theory and treatment would look very different today. Given gender bias in psychiatry and psychology, how can art therapy research methods based on the DSM or on patriarchal theories of development yield anything but gender bias results?

Are Qualitative Research Methods the Answer?

Qualitative research methods have appealed to many feminist researchers as a method of choice because the emphasis is on listening rather than quantifying and on learning from the individual participant rather than on generalizing the findings. In qualitative research the data are often the actual words of the participant. This has appealed to feminist researchers because women's voices were silenced in previous research.

The following characteristics of qualitative research are outlined by Bogdan & Biklen (1992). Qualitative research has the natural setting as the direct source of data and the researcher as the primary instrument. Qualitative research is descriptive and the data collected are in the form of words or pictures rather than numbers. Qualitative researchers are concerned with process rather than simply with outcomes or products, for example, understanding how people make meaning and how certain terms and labels come to be applied. Qualitative researchers tend to analyze their data inductively rather than searching out data or evidence to prove or disprove hypotheses before entering the study. Theory emerges from the bottom up, as in the approach developed by Glaser and Strauss (1967) called "Grounded Theory," rather that from the top down. "Meaning" is of primary concern to qualitative researchers who are interested in the ways different people make sense of their lives. This makes room for and stimulates interest in groups other than the dominant one.

If we look at the basic principles of feminism—"the personal is political," choice, and equalization of power—one of the differences between quantitative and qualitative methodology begins to emerge. Quantitative research, because of its emphasis and alignment with the scientific experiment, assumes a stance of objectivity which, as we discussed above, is an illusion. Qualitative research, on the other hand, has stressed the subjectivity of the researcher, "All researchers are affected by observers' bias…Qualitative researchers try to acknowledge and take into account their own biases as a method of dealing with them" (Bogden & Biklen, 1992, pp. 46–47). Most qualitative studies include a section, often titled "Stance of the Researcher," in which are outlined the researcher's biases. Just as feminism held that no one is separate from his or her social context, so does qualitative methodology recognize that no research is separate from the context from which it emerges.

While there is an affinity between feminist research and qualitative methods, can we go so far as to say that there is a feminist methodology? In her feminist research Gilligan (1982) utilized both quantitative and qualitative methodologies. Gilligan observed that there were two distinct ways of talking about the relationship between the other and the self and also in speaking of moral problems. Gilligan looked at Kohlberg's (1958) research noting the gender bias which resulted when Kohlberg, who did not include women in his study, claimed universality for his theory of moral development. Gilligan did three studies, utilizing projectives, surveys, and interviews, and from the data she gathered developed a different way of understanding the moral development of women. Gilligan's work reversed some of the harm done by past research when women's voices were excluded.

Belenky, Clinchy, Goldberger, and Tarule (1986) in their book, *Women's Way of Knowing: The Development of Self, Voice, and Mind*, listened closely to what women had to say about their experience and understood this as distinct from men's experience. Using qualitative methodology they sought to learn from women about their learning processes and how they constructed meaning in their lives. Both Gilligan's and Belenky et al.'s studies proceed from a feminist standpoint and use qualitative methodology. Even so, both have been criticized for their lack of attention to differences between women and for only studying groups of white, middle-class women. Regardless of methodology, by assuming homogeneity among all women, even feminist research can be biased through exclusion.

Conclusion

Feminist research is defined not by the methodology but by the type of questions asked and how they are asked. Neither quantitative nor qualitative methodology is by definition feminist. In the same way neither methodology is more suited to art therapy research than the other. Feminist art therapy research must emerge from an awareness of the power differential between the genders. As I have attempted to argue throughout this paper, art therapists must ask themselves what the goals of our research are and whether our research tools, instruments, and theories are free of bias.

Finally, I leave the reader with the words and images of Isabella, a participant in my doctoral dissertation study. Isabella's account of her healing process speaks to the value of art therapy in helping her make the connection between her symptoms and the childhood trauma she experienced. In her own words, Isabella's story emerges as one of rebirth and triumph rather than one of pathology:

> It's the connection between these three pictures that just blew my mind (Figures 1, 2, and 3).
>
> These ones (Figures 1 and 2) I did maybe 15 years ago. They were just images that were sitting in my head late at night and wouldn't let me go to sleep until I'd painted them. They're totems, to me initially they were these totem poles up North. And I've always had that sunset in my dreams. I used to sit and watch it every night. And I'd been in a book store and just saw the title, *Totem and Taboo*, Freud's book. And I never related any of this to myself except the totems, I kept seeing these totems in my head, one head stuck on a stick. And so I just had to paint it and it had to be up North where that sunset is and, you know at night up North, how even everything that's green is black at night. And I just saw these images of this head, screaming head stuck on a pole.
>
> And then this Spring, just recently I did this one here (Figure 3) of this vulture just about to ram its beak down the mouth of this little bird—it's a combination of a bird and a bat and I'd just had a dream about it a few nights before where there was this little baby bird, it was called a bird-bat, it had the wings of a bat and the body of a bird and it had all this blood running out of its mouth and I kept trying to comfort it but it wouldn't let me hold it. And then I started thinking about when I was first admitted to the hospital because I couldn't eat anymore. I kept feeling there was something stuck in my throat and I'd lost about twenty-five pounds. I just couldn't eat. And I started feeling that there's this penis rammed down my throat, a penis down my throat. And then I remembered these pictures of these heads stuck on a stick and screaming, something caught in their throat. And then I remembered the dreams I'd had about my grandfather and how so many times in my therapy I just felt like there was a cock rammed down my throat. Then I saw this hat in there, the hat in my grandfather's bedroom. This hat looked like Winston Churchill's hat. And I just felt like he was this vulture preying on me, raping me, in all different kinds of ways and the effect that it had on me. It killed me. And I just felt it was the end of me, my grandfather raping me in this incestuous (way)...And these two pictures now are inseparable for me (Figures 2 and 3).
>
> I was thinking about this last night—what would have happened if I hadn't started doing art therapy. I think I probably would have just lived my life on the level of toleration—this is my life. I just have to put up with it. This vague...of not really knowing what had happened to me.

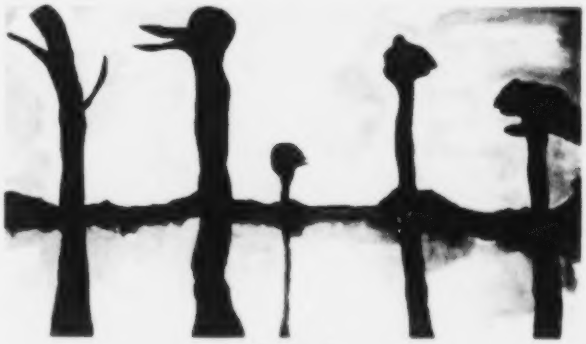


Figure 1

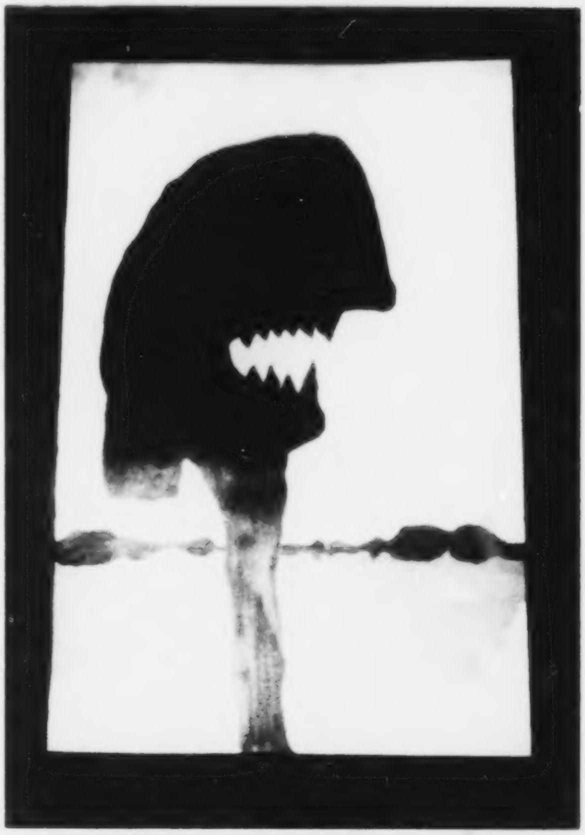


Figure 2

BEST COPY AVAILABLE

I probably would have always been stuck living with not really knowing and just having to live like that. Because what art therapy does for me, it just refines the whole process and makes it so vivid. And I draw because I need to draw—it's not like a hobby. It's something I'm driven to do. Because it satisfies my need to know and to understand what happened to me and to really experience it. I think I would have gone through life living like I was looking through binoculars which were out of focus. And art therapy has helped me focus and see really clearly. I think probably I just would have lived my life out-of-focus.

And it's also a tool that I'll always have—it isn't dependent on other people. And I think people are really interdependent—I think in psychiatry dependency gets a bad name lots of times. But we are really dependent on each other. Without any kind of therapy I would have been dead. I think we should give dependency a good name. It's all right.

I need to show people visually what happened to me. And I have a real need for that. Art therapy allows me to do that, allows me to show myself but…I want that kind of warm support. I think it's healthy to want it. I was brought up thinking it was unhealthy to want it but it's a normal, human need. I guess that's what art therapy has allowed me to do is to really show people visually and very clearly what happened to me and see that I don't have to protect anybody from it. It's kind of like bringing a restricted movie home and being afraid to show it to my parents. Now I feel I can take these restricted pictures out and show them to people—they don't go, "Oh! It's horrible! You're a nasty, dirty person." My art therapist and all these people just look and say, "These are great pictures." And that to me is a shock. 'Cause I really want to be responded to in a positive way even if I'm saying something that isn't pleasant. God! I'd hate to think what my life would be like if I hadn't gotten into this. But I don't see how I could have gone any other way. I feel like the Fates have been guiding me and I feel like I have this guardian angel.

And this whole process to me is sacred. And my writing teacher was saying that, she's really into spirituality, and she says, "The process of making the unconscious conscious is a sacred process." And that's what all this means to me now. (Burt, 1995)

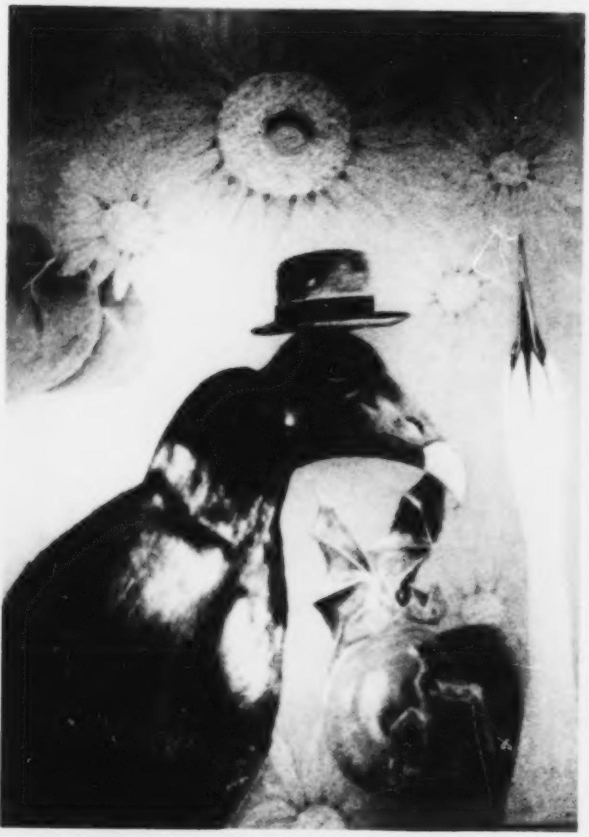


Figure 3

References

Adler, G. (1985). *Borderline psychopathology and its treatment*. New Jersey: Jason Aronson, Inc.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders-IV*. Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders (3rd ed. rev.)*. Washington, DC: Author.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). *Women's ways of knowing*. New York: Basic Books.

Bettridge, B. (1994). *Relational characteristics of female adolescent suicide attempters*. Unpublished doctoral dissertation, University of Montreal, Montreal.

Birns, B. (1985). The mother-infant tie: Fifty years of theory, science, and science fiction. *Working Papers Series* (Tech. Rep. No. 21). Wellesley, MA: Wellesley College, The Stone Center.

Bogdan, R. C., & Biklen, S. K. (1992). *Qualitative research for education: An introduction to theory and methods*. Boston: Allyn and Bacon.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psychoanalysis, 39*, 350–373.

Broverman, I., Broverman, D., Clarkson, F., Rosenkrantz, P., & Vogel, S. (1970). Sex-role stereotypes and clinical judgements of mental health. *Journal of Consulting and Clinical Psychology, 34*(1), 1–7.

Burt, H. (1995). *The experience of self during the recovery process of a small number of women with a history of childhood sexual abuse who are currently in art therapy*. Unpublished paper.

Cohen, B. M., Hammer, J. S., & Singer, S. (1988). The diagnostic drawing series: A systemic approach to art therapy evaluation and research. *The Arts in Psychotherapy, 15*(1), 11–21.

Cohen, B. M., Mills, A., & Kijak, A. K. (1994). An introduction to the Diagnostic Drawing Series: A standardized tool for diagnostic and clinical use. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 105–110.

Couch, J. B. (1994). Diagnostic Drawing Series, research with older people diagnosed with organic mental syndrome and disorders. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 111–115.

Frank, H., & Paris, J. (1991). Parent's emotional neglect and overprotection according to the recollections of patients with borderline personality disorder. *American Journal of Psychiatry, 148*(5), 648–651.

Frankfort-Nachmias, C., & Nachmias, D. (1992). *Research methods in the social sciences*. New York: St. Martin's Press.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Goldberg, R., Mann, L., Wise, T., & Segall, E. (1985). Parental qualities as perceived by borderline personality disorders. *Hillside Journal of Clinical Psychiatry, 7*(2), 134–140.

Gordon, R. A., & Manning, T. (1991). 1990–1991 membership survey report. *Art Therapy: Journal of the American Art Therapy Association, 8*(2), 20–29.

Gulbro-Leavitt, C. (1989). A validity study of the Diagnostic Drawing Series as used for assessing depression in children and adolescents (Doctoral dissertation, California School of Professional Psychology–Los Angeles, 1988). *Dissertation Abstracts International, 49/09*, 4061B.

Harding, S. (1991). *Whose science? Whose knowledge?* Ithaca, New York: Cornell University Press.

Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver, I. P., & Surrey, J. L. (1991). *Women's growth in connection: Writings from the Stone Center*. New York: The Guilford Press.

Kaschak, E. (1992). *Engendered lives*. New York: Basic Books.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York: Jason Aronson.

Kessler, K. (1994). A study of the Diagnostic Drawing Series with eating disordered patients. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 116–118.

Lewis, C. (1986). The role of the father in the human family. In W. Slucken & M. Herbert (Eds.), *Parental Behavior* (pp. 228–258). Oxford, New York: Basil Blackwell.

La Brie, G., & Rosa, C. (1994). American Art Therapy Association, Inc. 1992–93 Membership Survey Report. *Art Therapy: Journal of the American Art Therapy Association, 11*(3), 206–213.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.

Mahler, M. (1971). A study of the separation-individuation process and its possible application to borderline phenomena in the psychoanalytic situation. *Psychoanalytic Study of the Child, 26*, 403–424.

Masterson, J., & Rinsley, D. (1975). The borderline syndrome: The role of the mother in the genesis and psychic structure of the borderline personality. *International Journal of Psychoanalysis, 56*, 163–177.

Neale, E. L. (1994). The children's Diagnostic Drawing Series. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 119–126.

Ogata, S., Silk, K., & Goodrich, S. (1990). The childhood experience of the borderline patient. In P. Links (Ed.), *Family environment and borderline personality disorder* (pp. 85–103). Washington, DC: American Psychiatric Press.

Psychological Abstracts (CD ROM). "1/87–6/94." Washington, DC: American Psychological Association: "Producer." Available: Silver Platter.

Rankin, A. (1994). Tree drawings and trauma indicators: A comparison of past research with current findings from the Diagnostic Drawing Series. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 127–130.

Rothblum, E., & Franks, V. (1987). Custom-fitted straight jackets: Perspectives on women's mental health. In J. Figueira-McDonough & R. Sarri (Eds.), *The trapped woman: Catch-22 in deviance and control* (pp. 348–374). Newbury Park: Sage Publishers.

Saunders, E., & Arnold, F. (1991). Borderline personality disorder and childhood abuse: Revisions in clinical thinking and treatment approach. *Working Papers Series* (Tech. Rep. No. 51). Wellesley, MA: Wellesley College, The Stone Center.

Silverstein, L. (1991). Transforming the debate about child care and maternal employment. *American Psychologist, 46*(10), 1025–1032.

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge, NY: Cambridge University Press.

Sturdivant, S. (1980). *Therapy with women: A feminist philosophy of treatment*. New York: Springer.

Talbott-Green, M. (1989). Feminist scholarship: Spitting into the mouth of the gods. *The Arts in Psychotherapy, 16*, 253–261.

Wadeson, H. (1989). In a different image: Are "male" pressures shaping the "female" arts therapy professions? *The Arts in Psychotherapy, 16*, 327–330.

Art Therapy: Journal of the American Art Therapy Association, 13(1) pp. 20-30 © AATA, Inc. 1996

Becoming Visible: An Art Therapy Support Group for Isolated Low-Income Lesbians

Rachel Brody, MPS, A.T.R., Hudson, NY

Abstract

The special strength of art therapy is that it encourages us to envision, on our own terms, our definitions of self and reality. Since it provides an opportunity to make oneself seen, *art therapy has a special resonance for lesbians because of their historical invisibility and isolation. This paper discusses the imagery and process of an art therapy support group for low-income isolated lesbians, through five related "lenses": (1) women's relational dynamics and the centrality of relationships in lesbians' lives; (2) trauma; (3) socioeconomic class; (4) lesbian identity, visibility, culture, and gender; and (5) transference. An intertwined constellation of themes—safety, danger, gender, aggression, sexuality, power, intimacy, isolation, autonomy, and family—is traced through the progress of the group's interactions and visual productions.*

Introduction

There is a dearth of published material in the creative arts therapies concerning lesbians and gay men. At the time of this writing, only one paper makes lesbian/gay identity and related clinical issues its central focus (Brody, 1994). Although there is extensive lesbian/gay-affirmative literature (Boston Lesbian Psychologies Collective, 1987; Brown, 1989; Burch, 1993; Cass, 1979; de Monteflores & Schultz, 1978; Falco, 1991; Gonsiorek, 1985, 1988; Greene & Herek, 1994; Lenihan, 1985; Silverstein, 1991; Stein & Cohen, 1986), none of it specifically discusses therapeutic groups for lesbians. It is only in the writing of this paper that I was able to appreciate fully the complexity of the Lesbian Support Group's intrapsychic and group dynamics.

Lesbian Support Group (LSG)

The Lesbian Support Group (LSG) was created in response to requests from lesbians living at the YWCA in a small, family-oriented, and conservative Northeastern city where no visible lesbian community or lesbian-affirming services existed. By providing a safe place where lesbians felt they belonged and could be themselves, the LSG was intended to reduce isolation and to build self-esteem, self-awareness, trust, social skills, mutual respect, and a sense of community.

The LSG met once a week for 90 minutes over a period of 12 weeks, after two informational orientation meetings. It was made clear that members were expected to refrain from sexual contact with one another, but because isolation was a primary problem, social contact was not discouraged (Anthony, 1982). Individual interviews, supplemented by a self-administered written questionnaire, were conducted to assess, gather histories, determine goals and expectations, and establish a safe relationship with the leader. All eight of the prospective members were accepted into the group, although three dropped out over the course of the 12 weeks. The remaining five came fairly regularly, although two had ongoing problems with childcare which interfered with attendance. (During four sessions childcare was provided by a YWCA resident, but the YWCA withdrew its permission for on-site childcare because of liability concerns. No fee was charged for the group or for childcare.) Media/techniques included mural, drawing, collage, clay, journaling, and photography. Bibliotherapy was also employed in the form of a lending library of lesbian-affirmative books and periodicals. Members borrowed the readings but rarely referred to them in session.

Group Demographics

Members ranged in age from 18 to 50. Seven were of Anglo-European descent; one was of Puerto Rican descent. Four were mothers, and one member's partner was pregnant. Six were in recovery from drug and/or alcohol abuse, and seven reported histories of physical and/or sexual abuse. Most had little ongoing positive contact with any larger lesbian community or friendship groups and were estranged from family. Five reported knowing as children that they were attracted to females; three discovered their lesbian feelings as adults. Seven were in relationships; four of these relationships were of less than a year's duration. Two did not identify exclusively as lesbians.

All members of the group had had some previous positive experience of group or individual therapy. Seven had graduated high school. Five had had some college education and of these, one had a Bachelor's degree and another had a graduate degree. Five were employed in unskilled low-paying jobs, two had skilled blue-collar jobs, and one was a full-time high school student and was unemployed. All had received, or were currently receiving, some form of public assistance, SSI, Medicaid, disability, or food stamps.

Clinical and Cultural Context

Before presenting the clinical material generated in the LSG, it is helpful to see it in the context of the clinical and cultural factors that shaped its development. Five of these factors will be examined, as if through a series of lenses, each bringing a facet of the LSG's nature into sharper focus. Some of these factors are common, to varying degrees, to many of the clients that art therapists see. The intent is to illustrate the distinct ways in which they are heightened for lesbians, bearing in mind that lesbians are as diverse as any other group of human beings. The LSG was not a random or typical collection of lesbians; what is true of this particular client group will not necessarily be true of all lesbians.

Lens #1: Women's Relational Dynamics

The theoretical perspective that is most relevant to the LSG focuses on the centrality of *relationships* in women's lives, which is further intensified in all-female environments in which women prioritize women. Object relations theory provides a useful starting point to look at these dynamics. Because their primary caretakers are female like themselves, girls develop a sense of self which allows for greater fluidity, mutuality, and empathy than is encouraged in boys (Chodorow, 1978). "Self-in-relation theory" (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) expands on the notion of a linear movement away from merger and toward "separation-individuation" (Mahler, Pine, & Bergman, 1975) by describing a developmental path along which "relationship *and* identity develop in *synchrony*" (Surrey, 1991, p. 63).

Among lesbians, women's general capacity for intense relational intimacy is augmented, as are a tendency toward merger, a softening of boundaries (Burch, 1986), and "conflicts over power, nurturing, and dependence" (Burch, 1987, p. 140). It is critical, however, to measure lesbian relationships against the norms of lesbian culture, which, unlike heterosexual norms, consider the capacity for emotional intensity, and the oscillation between separateness and merger not as a pathology but as a strength. Lesbians place a high value on the "sense of an autonomous self within the assumption of relationship to others" (Vargo, 1987, p. 167).

Self-in-relation theory provides a framework through which to view relationship dynamics among lesbians in general, and the LSG members' patterns of intimacy, autonomy, and isolation, in particular. Group themes continually circled around questions of how to balance one's own needs and wishes with others' and how to develop and maintain a sense of individual identity in the context of intimate relationships. It is in this relational matrix that the group members tested their expectations of themselves and one another, of how much sameness and/or difference they could expect and tolerate without rage or overmerger. Although any therapeutic group will elicit issues of self-in-relation, I cannot overemphasize that this is an especially charged aspect of lesbians' lives. Groups or dyads of heterosexual women may experience the intense intimacy described among lesbian women. However, among lesbians, this intimacy acquires another dimension because of a primary commitment to and sexualization of relationships with women.

The "flip side" of intimacy is power, which was disturbing to the LSG members. Because a feminist concept of equality is generally valued among lesbians, "many lesbians are acutely attuned to inequalities in power" (Burch, 1987, p. 127); real or perceived differences among them can be experienced as a deeply troubling power imbalance. From another angle, Falco (1991) explains that, "because the social power ascribed to men in this culture is absent in the lesbian relationship [or group], many lesbians assume that power struggles will not exist in their relationships, and thus have difficulty recognizing them and dealing with them directly" (p. 114).

Lens #2: Trauma

Lesbians report histories of trauma in the same numbers as heterosexual women (National Institute of Mental Health, 1987, cited in Falco, 1991). However, the LSG was a *de facto* abuse survivors' group, although that was not its intended function. I can only speculate that it attracted lesbians with abuse histories because they were especially in need of support but could not afford long-term therapy. Abuse had damaged and distorted the group members' patterns of self-in-relation, which interlaced the group's potential for lesbian relational intimacy with the emotional sequelae of trauma, including shame, guilt, rage, fear, mistrust, helplessness, flooding, numbing, dissociation, hypervigilance, and low self-esteem (Herman, 1992; van der Kolk, 1987).

The members of the LSG showed an immense hunger and expectation for connection and an inadequate empathy and self-empathy to achieve it comfortably or predictably. Trust in the group was further complicated by three members' revelations that they had been abusive to their children or partners. It is, of course, not uncommon for survivors to perpetuate the cycle of abuse by identifying with the aggressor and re-creating and repeating the original traumatic events in an attempt at mastery or undoing (Krugman, 1987).

Lens #3: Socioeconomic Class

The LSG targeted and primarily attracted women with limited financial resources. For most of the members, their marginal economic status contributed to isolation from the lesbian community and hence to their need for a local group, as they could not afford childcare, transportation, or access to lesbian culture. Their devalued and stigmatized socioeconomic status augmented the group members' feelings of low self-esteem, anger, and powerlessness, as did the control exerted over them by larger social systems. The LSG members, while constrained by the limited educational and economic opportunities for low-income women, were also, of necessity, quite resourceful and self-reliant.

Lens #4: Lesbian Identity, Visibility, Culture, and Gender

Most lesbians form their initial self-concept in families, religions, schools, and communities where only heterosexual feelings and behavior are validated and promoted and where same-sex attractions and relationships are discouraged and denied, sometimes violently. Rich calls this "compulsory heterosexuality" (1980), which makes eroticism between women invisible, limits their awareness of and access to the full range of sexual possibilities, and circumscribes the process of achieving a genuine sense of sexual identity. This results, to varying degrees, in internalizing the dominant culture's homophobia (Margolies, Becker, & Jackson-Brewer, 1987) and its stigmatization of homosexuality (Hetrick & Martin, 1987). To the extent that one has positive contact with the larger lesbian community, the effects of internalized homophobia are mitigated by finding a place among one's own people where one feels valued, included, and accepted. Even for those who are at ease with their lesbianism and who have supportive families, partners, employers, and friends, a wariness and tendency to self-monitor are still necessary survival skills, which can carry over into relationships with other lesbians.

Within the LSG, lesbian pride was embryonic and internalized homophobia had a dominant if subterranean pull on the group dynamics. The group members, while very clear that they had no wish to be heterosexual, had experienced little family or societal support for their lesbian identities, which made the task of valuing and supporting one another especially challenging. Since it is part of the leader's task to "model being genuine" (de Monteflores, 1986, p. 99), I informed the group that I was a lesbian and had begun the LSG out of a desire to foster lesbian pride, visibility, and community. My self-disclosure enabled me to model a defining aspect of my own identity which is also a deep source of my empathy: "Being genuine promotes self-esteem because it requires both acceptance of whoever we are and relating to another within the framework of acceptance of self" (de Monteflores, p. 99).

Establishing one's lesbian identity takes place amidst what is known in the lesbian community as "lesbian invisibility." Just as among heterosexuals, traditionally male values and language define social and sexual norms for both women and men, in the lesbian/gay community a similar pattern has been operative. As a result, the diversity of lesbian lives has been subsumed by the myth of a monolithic "gay" culture. (Gay male culture has also been hidden, but to a lesser extent.) Although lesbian visibility is on the rise, for many lesbians it is dangerous, if not life-threatening, to "come out," and many heterosexuals still believe they do not know any lesbians. Lesbians lives and history have been masked and buried. Many lesbians have limited knowledge of what it means to be a woman who loves women and lack language adequate to express it. The inadequacy of existing language gives added meaning to the group's repeated acknowledgment that their most productive work was done through the art. "Let the talk come from the art, instead of the other way around, the art brings it all up, anyway," said one member. "The art is the good part, the talking is awful," said another.

The expression of gender identity is one area where lesbian culture has made some unique statements. While numerous Native American cultures recognize more than two genders (Williams, 1986), gender identity in mainstream culture is narrowly defined as an either/or, female/male, biologically determined duality. Lesbians employ some more imaginative gender categories for which there are not adequate labels, but which are often described in terms of a butch/femme continuum (Loulan, 1990; Nestle, 1981, 1992). Although these terms elude a simple definition, most lesbians agree on how they apply to individuals (Loulan, 1990). Butch/femme has something to do with conventional and archetypal notions of masculinity and femininity, but in a lesbian context, these concepts become more flexible, more metaphoric, more playful, less tied to biology, and allow for a range of nuance and paradox. Indeed, butch/femme—the idea of gender variations among women—is best conceptualized as a circle formed by bending the poles of the continuum until they meet, allowing for an infinite number of locations on the circumference. One's place on this circle is defined more by external presentation *and* core self-concept than by sexual behavior or power position.

Nestle (1981) describes butch/femme as a "deeply Lesbian *language* of stance, dress, gesture, loving, courage, and autonomy" (p. 100, italics added, capitalization in original). In the LSG these notions of gender informed the members' individual identities and the group dynamics; the fact that they were never explicitly named until the final session was not accidental. Identifying in terms of butch/femme is to let oneself be seen, to take a visibly sexual stance, and to open up discussion of sex and the range of sexuality. The group's reticence maintained the safety and privacy they may have needed, at the expense of appearing somewhat neutered and desexualized to one another. Although the group members did not often assert their gendered/sexualized selves, butch/femme statements emerged in the group dynamics and artwork, which will be seen later on. Art therapy opens up a singularly useful perspective for interpreting butch/femme imagery as an authentic *lesbian visual language*.

Another aspect of lesbian culture that affected the LSG is its distinct social dynamics. On the one hand, group norms in the lesbian community place a high value on introspection, personal growth, and the use of therapy (Morgan & Eliason, 1992). On the other hand, the combination of women's intense relational tendencies, internalized homophobia, and lesbians' need for supportive community in a hostile world can put an inordinate pressure on lesbian groups to provide more than any group is capable of doing (Pearlman, 1987). Expecting both too much and too little from one's much-needed, yet devalued sisters, has been a common tendency in the lesbian community, that leads to an intolerance of diversity and a "demand for sameness" (Pearlman, p. 315).

One way in which this demand for sameness manifested itself in the LSG was in attitudes towards bisexuality. In the context of the group, I considered bisexuality "only in its inherent inclusion of a lesbian orientation" (Weille, 1993, p. 152) and conducted the LSG as a *lesbian* support group. However, the fact that two members were sexually active with men during the course of the group was a source of suspicion and polarization, about which I will say more later.

Lens #5: Transference

Given the power of relationships among lesbians, transferences among group members acquire a special intensity as well. The room may be packed with various transferential layers, as lesbians can be responding to one another simultaneously as reflections of mother, daughter, sibling, lover, rival, friend, and self. There are also particular styles of transference related to male figures, given the broad range of gender identity and self-presentation among lesbians. Relational intensity among lesbians often heightens group responses, both real and transferential, to passion or libido, whether sexual or rageful. Like women in general, the LSG found it difficult and uncomfortable to display and respond to overt expressions of anger and power. The transferential meanings of anger and sexuality as expressed in the LSG were further colored by the members' abuse histories. Sexual trauma blurs the boundaries between sex, anger, and power, amplifying and distorting the sexual charge to anger and the power-related charge to sexuality. These women felt little healthy power of their own, having experienced terrifying powerlessness at the hands of their abusers.

One might expect the sexual charge in a lesbian group to highlight the sexual transferences. However, a self-protective lesbian invisibility kept members shielded from themselves, one another, and myself; the transferences related to parents, children, and siblings were more obvious. Because most of the LSG members had deep concerns regarding parental acceptance, transference to me as parent was probably the most common pattern (Lenihan, 1985).

Group Process

The group intended to offer a consistent structure of time, place, and materials, and to encourage and guide group members in making their own agenda for the content of the sessions. This was not a comfortable process for any of us, but my goal was to provide just enough direction to facilitate expression and interaction, and to allow the members to wrestle with their individual and collective priorities and dynamics (Waller, 1993). During much of the time I was leading the LSG, I felt inadequate, overwhelmed, and frustrated; "it wasn't coming together," as one member observed. Attendance was inconsistent: On no two occasions was the same configuration of members present, which limited group cohesion and made for an unpredictable group culture.

Sessions began with a loosely structured check-in, from which I would try to elicit an underlying theme for the group to develop in the artwork. The group tended to get stuck in the talk, and transitioning to the art was not a predictable process, even when I actively encouraged it. On the whole, however, it was artmaking that facilitated the group process by allowing members to self-soothe and make themselves seen nonverbally. Tension and anxiety were kept to a tolerable level during artmaking and the more art-oriented sessions, and the affective tone became more intimate, relaxed, and playful. When the group worked on individual projects, I did artwork as well, using it to offer feedback regarding the group process.

In addition to written progress notes, I created a visual record of my spontaneous responses to each session and to the group's imagery in particular (Figure 1), which allowed me to view the group process simultaneously as a linear progression and as a gestalt. These drawings were not done in the presence of the group, nor were they shared with the group. This visual progress note (VPN) allows sessions to be compared using several criteria: light/dark, bounded/unbounded, centered/chaotic, loose/tight. Overall, there is a rhythm to the sessions, resulting in a checkerboard pattern which embodies the LSG's push/pull dynamic, as well as what is perhaps an especially lesbian struggle with cycles of joining and separating.

I will now take the reader on a journey through the group's process and artwork. I have grouped the sessions into beginning, middle, and end phases; each phase is named after the most representative image that emerged from it. The first phase, "This Is My Island," was characterized by the isolation and guardedness that made productive interaction almost impossible. The second phase, "Surviving the Black Spot," was shaped by an immersion in shared pain. The third phase, "The Ladder," was characterized by attempts at reaching out and bridging gaps. (All group members are referred to by pseudonyms.)

Sessions #1–4: "This Is My Island"

In the first session members were asked to draw a "full-body self-portrait" in pencil, on 8 1/2" x 11" paper (an evaluative drawing which would be used again in the final session). The drawings revealed distorted and depersonalized body images and a high degree of vulnerability, damage, and defendedness. This, combined with the emergent and highly charged theme of family, set the stage for the group dynamics to follow.

The next week, the words "family values" in Michelle's collage (Figure 2) catalyzed discussion of motherhood childhood, physical abuse, and alcoholism. The lesbian erotic content of Maureen's and Elaine's collages (Figures 3 and 4 respectively) was not addressed by the group, a tendency that would continue. These two collages were provocative and embodied perhaps too nakedly the subterranean group themes: the ambivalently intertwined realities of safety, danger, aggression, tenderness, femaleness, sexuality, and power. As the group progressed, this uneasy mix was acted out more than it was consciously processed.

Maureen's collage shows a lack of integration between words and images, an early sign of the ongoing disparity between the LSG's verbal and visual material. Following the group's lead, I attended to what they found safe to address and did not actively encourage them to "see" the specifically lesbian imagery. I would have had to call the group's attention to it overtly for them to acknowledge it, and even then they might not have pursued it. In the LSG, talking often served the function of the "closet," of defense, the language lesbians use to cover themselves. It was safer to get into arguments than to examine one another's imagery.

Seeing, being seen, and a particular attention to visual statements have been essential parts of lesbian culture. There are visual conventions by which some lesbians identify themselves and recognize one another: styles of hair, clothing, jewelry, and body language. Lesbians look for validation and reality testing in one another's visual cues. But looking has often been surreptitious. It is dangerous for women really to look at one another, or by extension, at their art. In the LSG, as in the larger world, it was easier for women to give themselves permission to look at and recognize the more acceptable, nonlesbian images. The group's muteness in response to the obvious lesbian imagery reveals their discomfort in giving voice to "the love that dare not speak its name."

Regardless of the group's ability to address overtly lesbian imagery, it was important to supply them with lesbian as well as mainstream magazines for collage. By offering a diversity of images from their own culture, I hoped to provide the building blocks for an ego-syntonic visual language. Session #2 ended with a pervasive feeling of sadness, a briefly sustained unifying moment in which the women silently identified and resonated with one another's art and emotions.

In Sessions #3 and #4 "family values" and parenting were again the dominant initial topics. The discussions were somewhat intellectualized, awkward, and detached from the undercurrents of sadness and anger that broke through at times. The group members did not yet have the trust or cohesion to share intimate stories with any comfort and could easily be overwhelmed by one another's pain. There was some acknowledgment when I asked if parenting was safer to talk about than specifically "lesbian issues." I suggested murals in both of these sessions, hoping to nudge the group into closer contact and elicit members' emotional responses to one another and to intimacy. Both the product and process of the first mural, following the directive "what it feels like to be a woman," reflected members' vulnerability and

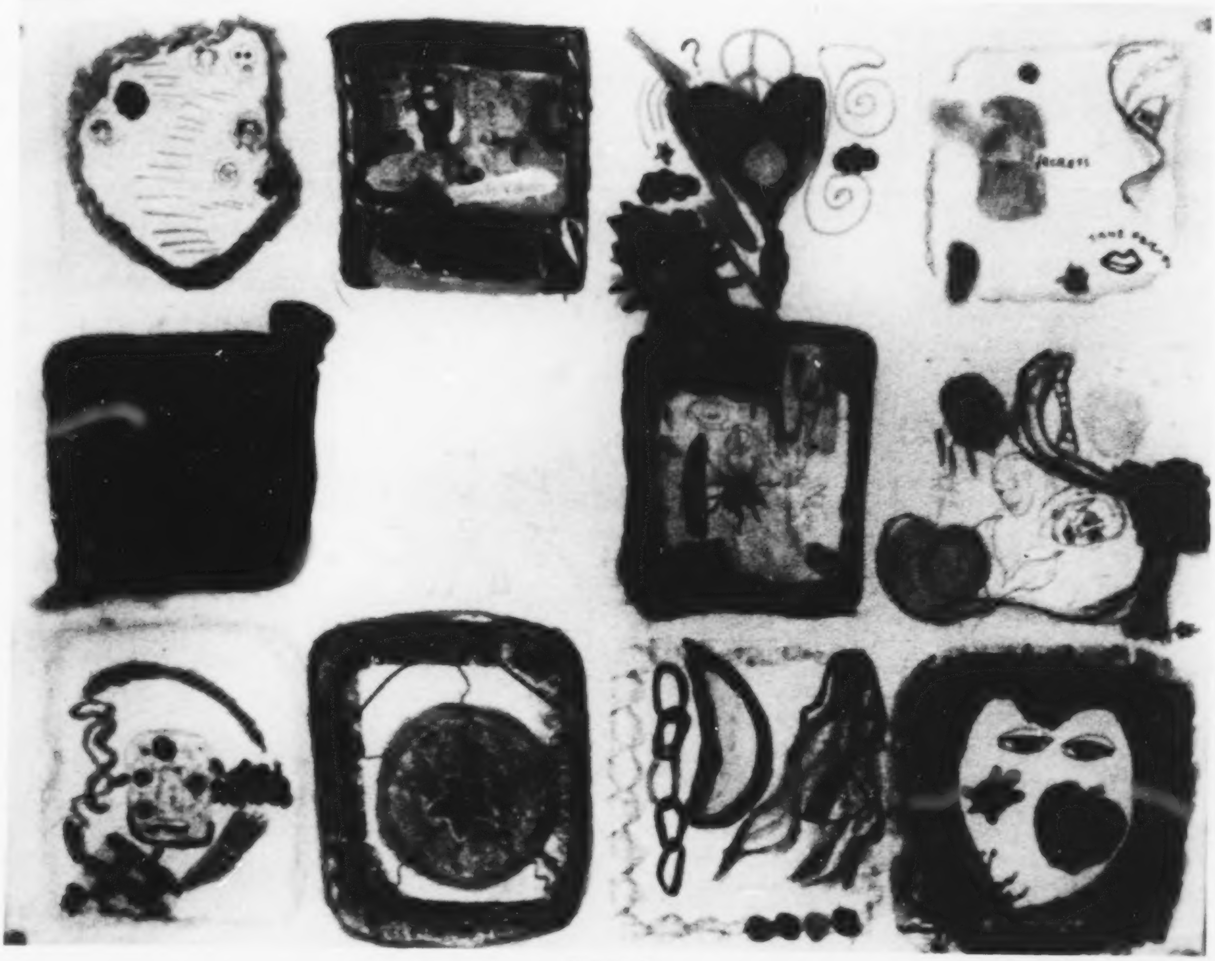


Figure 1

Author's Visual Progress Note (Sequence of drawings reads from left to right, top to bottom)

(1) A ragged holding environment, containing the members' wounded and defended self-portraits.

(2) A selection of their images framed by images from my own collage: a stormy sea, flowers, a bowl of fruit. They are different "fruits" occupying the same bowl, surrounded by tempestuousness and growth. References to my imagery are as dominant as theirs, reflecting my sense of the necessity for a strong leader to hold the group together.

(3) I combined Hannah's drawing of an empty womb with Elaine's glittery heart image into a large red heart with a central hole, perched on Rita's wounded vulva image, surrounded by brittle defenses and separated by a lightning bolt from the fireball of Maureen's rage, a pained and discordant composite picture of womanhood.

(4) Contains the most white space of all my VPNs, suggesting the force of homophobia, creating a guarded distance and reduced visibility.

(5) A deep black smudge, an enlargement of Elaine's from the previous session, containing a few small bits of color, representing the gifts of mutual support the women extended verbally and through art.

(6) My stallion figure, sweating heavily, with the members, represented by their animals, hiding behind sharp fragments. The group was strained to the breaking point. Why did this "support group" seem so bent on self-destruction?

(7) Contains miniatures of the group's images as well as a small blurred outline of Elaine's son who screamed and banged at the door. His form echoes Michelle's crumpled "fetus" and Hannah's fan-shaped reaching-out image, the pain of childhood and parenthood inescapably haunting this group.

(8) This composite of the members' imagery reflects the session's more fluid interaction.

(9) This VPN I find the most aesthetically unappealing and unbalanced. Three members and I are represented by the clay objects we made. Mine, the most detailed and developed, is placed centrally. Theirs are connected more closely to mine than to one another, my presence acting both as a bridge and a barrier. In this session about partners and loneliness, were the transferences to me and fears of one another too strong for them to respond more directly to one another?

(10) A peaceful, warm, and centered image in rose and gold, reflecting a nurturing and balanced session.

(11) Not a balanced or attractive image, but it accurately mirrors the characteristic imagery and dynamics among the three members present. Michelle's crescent moon and Rita's linked chain are turned toward and identified with each other, while Hannah's eye observes.

(12) Images from the final self-portraits contained within my heart: Hannah's direct gaze, Michelle's sturdy turtle, and Rita's life-sustaining fruit.

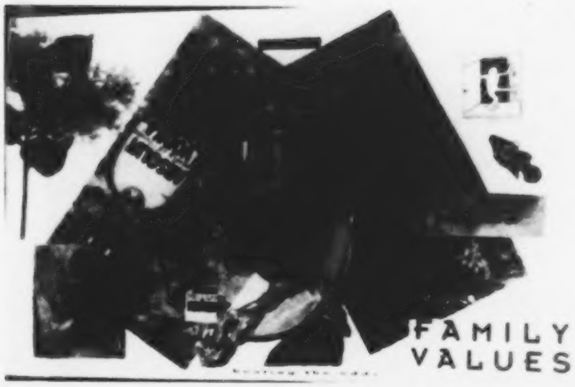


Figure 2

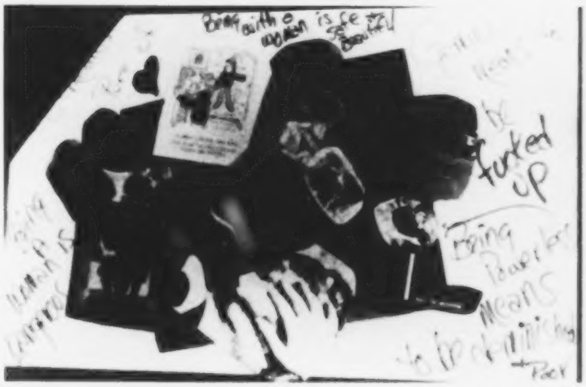


Figure 3

defenses and echoed their initial self-portraits, one woman's image of a tiny woman inside a red and blue vulva (Figure 5) being the smallest and most poignant. Another group member ended this session on an angry note, complaining that the group focused on parenting to the exclusion of lesbian issues.

In the following week's mural on "what it feels like to be a lesbian," most used a small area of the paper with plenty of space between them. Rita's image (Figure 6) represents the rigidity of heterosexual society (black and white lower circle) contrasted with the more variegated lesbian/gay world (upper circle). Her "island" is closer to the latter, but still set apart. Maureen's "island" (Figure 7) suggests some warmth and intimacy, as well as a silencing "shhh"; the others' imagery referred to relationships, isolation, conflict, and the feeling of being judged. Another member said she intended to draw a plant emerging from an underground seed, but ended up with a small black smudge. She became tearful explaining that the "art triggered something that I want to talk about, a lesbian issue, but I'm scared to," and agreed to save it for next time. While I had felt the group move a little closer, my VPN contains the most white space of all my VPNs, suggesting the force of homophobia, both internalized and external, creating a guarded distance and reducing visibility.

Session #5–7: "Surviving the Black Spot"

In the previous sessions there had been a pull toward disclosure of painful secrets. Given the hostility, guardedness, and

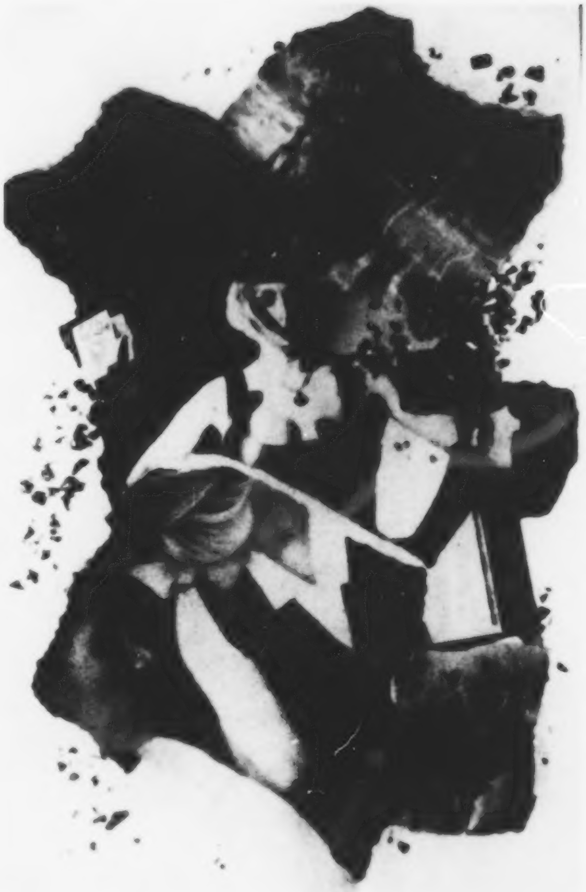


Figure 4

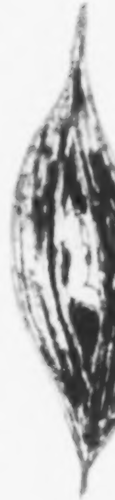


Figure 5

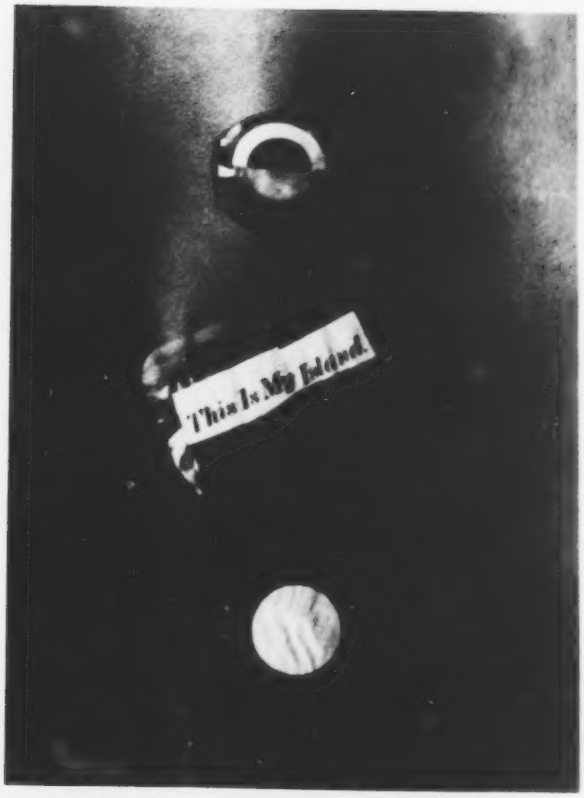

This Is My Island.

Figure 6

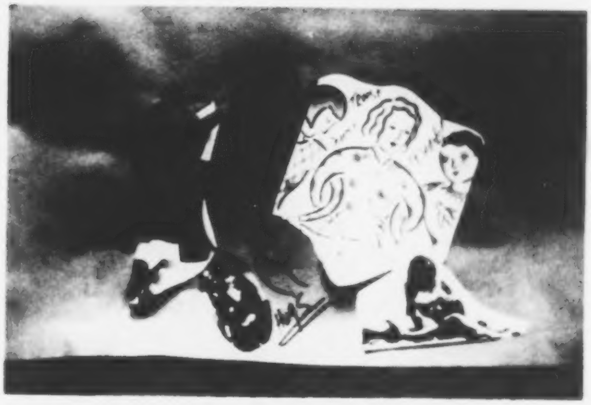


Figure 7

irregular attendance, I had held back from leading the group down these shadowy paths until we had a stronger foundation. Nevertheless, the momentum of the group was carrying us along in this direction. By telling the story she had saved from the previous time, Elaine led us in "moving into the black spot" (Robbins, 1989, p. 125). It was as if we had entered the previous week's mural through her small black smudge, which opened into a frightening landscape familiar to most of the group members.

Elaine told of a recent brief relationship which had turned violent, culminating in her partner's threatening to kill her. She had severed ties with this woman, but still feared for herself and her young child. Others shared their own experiences of having been stalked, abused, or harassed. Other members acknowledged that they had, in Rita's words, "turned it around and became the one on top," becoming abusive to others, and expressed a shared self-hatred for having been victims. The group was putting forth some of its ugliness, daring one another to witness, to tolerate, to accept, or abandon. I validated their courage in admitting that violence exists among women, a fact that the lesbian community has been reluctant to accept. With 15 minutes left to the session, I returned to Hannah's earlier wish to protect Elaine, "to make a tent around her," suggesting that the group make some protective art for Elaine to take with her. A few did, but the session ended without any definitive closure.

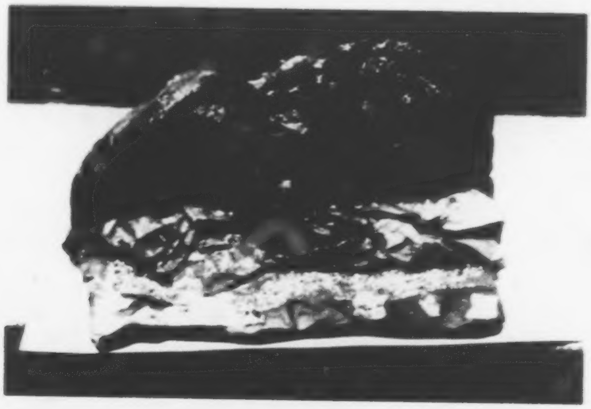


Figure 8

The next week, after this excursion into the black spot of anger, shame, guilt, and fear, I assumed that the group needed to retreat, repair defenses, and self-soothe, so I asked everyone to select an animal figure and create a "safe environment" for it. In Maureen's safe place (Figure 8), a red cat sits in a vulva-shaped "boat" on a river, flanked by deep green foliage: "Being inside a woman's genitals is the only safe place," she said. Interpreted through the lens of lesbian gender, this is very "femme" imagery, as Maureen's imagery often was: a "pussy" in a vaginal boat. It is noteworthy that Hannah and Jessica whose self-presentations, like Maureen's, are within the conventional boundaries of "feminine," also chose cats as animal self-symbols. Rita and Michelle, who in Session #12 would both self-identify as "butch," chose turtles. While it is tempting to speculate how the group might have interpreted these differences, this material remained unexplored. It is obvious, however, that these symbolic identity choices point to the sometimes subtle but significant gender identity differences among women, differences that affected the group dynamics.

As they had in the previous sessions, the group members continued to disregard the specifically lesbian sexual content of Maureen's work. This fueled Maureen's anger and mirrored the group's resistance to intimacy, defending against what they had in common. Although there was some subgrouping and some positive feeling among individuals, the group was not coalescing. While Maureen wanted to focus on "adult lesbian issues," she was most active in provoking discord. As the oldest member, perceived as the angry abusive mother, she became the scapegoat. Toward the end of Session #6 hostility reemerged, as Maureen aggressively lectured Jessica, who feared she was pregnant again, on responsibility, youth, and motherhood. Rita echoed Maureen, angrily voicing dissatisfaction at having bisexuals in the group. This was another source of conflict which was finally being aired openly. These angry outbursts occurred at the end of the session, making closure difficult.

My VPN for this session is so faint as to be invisible. It shows my stallion figure, sweating heavily, with the members, represented by their animals, hiding behind sharp fragments. I left this session feeling that the group was strained to the breaking point and was splintering. I felt angry and inadequate. Why did this "support group" seem so bent on self-destruction?

In preparing for Session #7, I made a drawing of an outer space skyscape: planets, clouds, and comets against a dark red ground, anticipating, as it turned out, the floating, isolated quality of the group's work that evening, as well as its underlying fiery affect. Themes emerging from this session revolved around connection, autonomy, and isolation, embodied in the imagery and in the overtly expressed concerns. Everyone seemed fearful of risk, uncertain about reaching out, and not terribly empathic, but held together by a shared isolation and pain: "Art is the only constant here," remarked Michelle. Jessica's questions about how a teenage lesbian might find a partner led Rita and Michelle to challenge her belief that "having a woman will make it all better." Hannah's art echoed Jessica's concerns, voicing her frequent laments, poignant yet intellectualized, about being "whole" and asking whether a lover is necessary for that. This was expressed, however, in the context of her bisexual boyfriend's leaving her for a man; her active heterosexual side continued to keep others at a distance. Rita's art conveyed her self-protective isolation, comprised of several abstracted linear shapes—suggesting planets, chains, spirals, and a spinning top—carefully built up into a rich surface of glue and glitter floating on black paper. This session gave me the feeling of people peering out from their shelters in the aftermath of a hurricane: Is it OK to show myself? Will I be knocked down? Did anyone else survive?

Sessions #8–12: "The Ladder"

In Session #8, the group acknowledged, and was at least temporarily able to tolerate and process, some of its taboos and hidden agendas. This openness fostered a more fluid, energized, and good-humored exchange than had previously occurred. It began, however, with angry comments from Rita and Maureen about bisexuality. Anticipating such a conflict, I had made no reference to bisexuals in advertising the group, hoping to attract women who identified with the label *lesbian*. Having accepted all of them into the group, on the grounds that Hannah and Jessica, too, needed support for their lesbian side, I was still aware that this was not a satisfactory solution.

Leading this group reminded me afresh that *lesbian*, *heterosexual*, and *bisexual* are concepts, and that real people do not fit neatly into conceptual frameworks. Just as gender is best thought of as a circle with an infinite number of points on its circumference, so is sexual orientation. It is important to keep in mind that sexual identity, behavior, attraction, and fantasy are not always congruent for all women at all stages of their lives (Golden, 1987). It is worth noting that Hannah and Jessica, the least identified as lesbians, felt most comfortable in the group and seemed less pressured by internalized homophobia, since their socially acceptable heterosexual side allowed them to move through and "pass" in the straight world with greater ease. I could not dismiss the others' wariness of them. I could identify with those who were exclusively lesbian and could understand their vulnerability and guardedness about exposing the most private and stigmatized part of themselves to women who at least appeared to benefit from a degree of heterosexual privilege. Hannah talked more freely about her boyfriend and Jessica about her pregnancy scare than the others did about their female partners. But I could not dismiss Hannah's observation that "biphobia" (Ochs & Deihl, 1992) was at least as rampant among gay people as among heterosexuals, nor could I ignore the fact that Jessica now felt like quitting the group, although she desperately wanted to be with women. It is likely, too, that her youthful candor about wanting a female lover may have been experienced by the others as seductive and may have been as disturbing to them as her bisexuality.

Again, the artwork provided some refuge from these polarities, allowing for more lighthearted, respectful, and empathic interaction. I asked the group members to draw individual self-symbols and then pass them around, encouraging each woman to respond visually to the others' artwork, adding what they felt it needed. Maureen's self-symbol (Figure 9) was a two-headed flower, carefully drawn in pencil, to which others added color. Rita explained to Maureen that, "I put sun on the sleeping, gen-

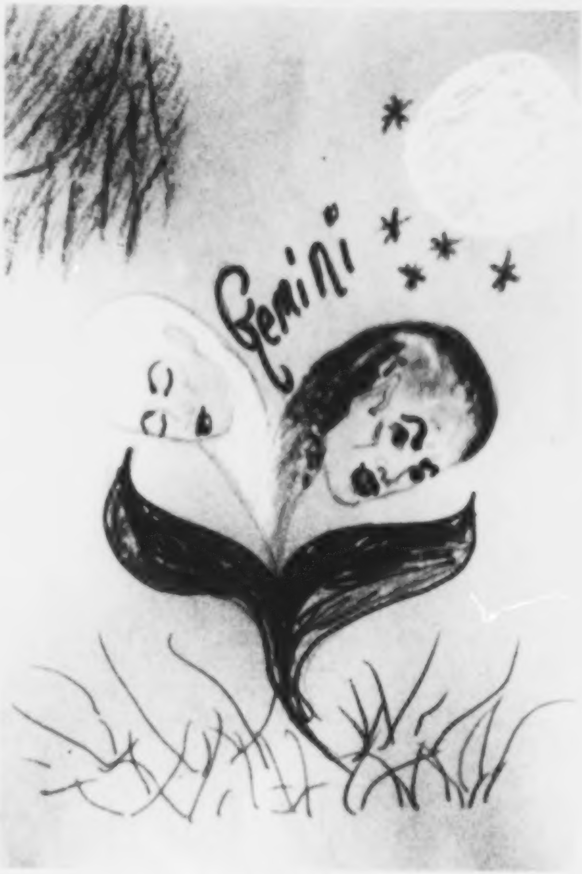


Figure 9

ther side, to wake it up and the moon on the, um, angry side to put it to sleep," feedback which Maureen accepted with some humor. Rita's addition to Hannah's drawing (Figure 10) was similarly affectionate. "Her art is so swirly and abstract, it takes her a long time to get anywhere. I gave her a ladder in black and white, a shortcut." In art therapy terms, I interpret this as Rita balancing Hannah's "round lines" with her own characteristically pragmatic and direct "straight lines." In lesbian terms, this aspect of Rita's contribution to Hannah's drawing can also be understood as a "butch" response to Hannah's "femme" style.

Understanding the LSG's dynamics is enriched by an awareness of the gallantry in Rita's offerings to both Hannah and Maureen that is an expression of her particular gender spirit. Rita, a construction worker, gave Hannah a ladder, a tool, a very butch gift, and literally gave Maureen the sun, the moon, and the stars. In her gifts and in the warmth with which they were received there was a playful, genuine, probably unconscious exchange of lesbian sexualized energy. This validation, however unconscious, may be why the session ended on an unusually positive note and may have allowed the members to tolerate a little more intimacy and difference. Maureen, however, dropped out of the group after this session, with no formal or explicit explanation.

Her departure increased the others' comfort, and Session #10 was perhaps the most satisfying; it is represented as the most peaceful, warm, and centered image in my VPN. Members were considerate and responsive during the initial check-in, which flowed in an unusually organic way. Each woman was dealing with an aspect of self-nurturing and self-assertion: Jessica had "come out" in a poem written for her high school English class, which had been well-received by her teacher; Hannah was trying to make decisions based on her own best interests, without being swayed by pressures from her complicated network of friends, lovers, and ex-lovers; Rita was evolving her own definition of family and had decided not to attend her brother's wedding because her partner had not been invited; and Michelle was coping with flashbacks of childhood abuse by using a variety of supports (12-step meetings, individual therapy, and friends). I suggested they use polaroid photos as a starting point for building images of "taking care of myself." Taking one another's pictures afforded the opportunity for playful and attentive interaction. There was a playpen in the room we were using, which was sometimes used for childcare and two of the women posed themselves in it. Michelle—usually tense, angry, and sad—laughed freely as she posed in black jeans, boots, leather jacket, and spiky hairstyle in the playpen with a tiny blue teddy bear and my "magic wand" toy, appreciating her defenses as she lowered them, enjoying the irony of her butch self-presentation: "I have a lot of armor and portray a tough image, but it's the gentle things that really make me feel safe."

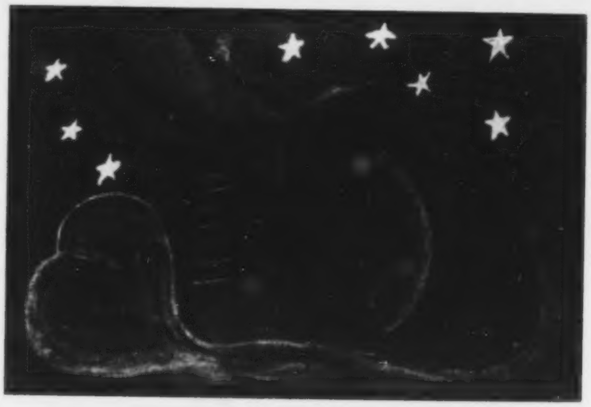


Figure 10

In the final session, in the casual atmosphere as we shared a celebratory pizza, Rita commented on an article that had impressed her in one of the periodicals in the LSG lending library—an interview with Leslie Feinberg, author of *Stone Butch Blues* (1993), who discusses her overlapping identities as a "butch lesbian," a "'passing' woman, a biological female who passes for a man," and "transgendered lesbian" (Brownworth, 1993). This catalyzed a discussion of butch/femme and its relation to the members' gender identities. Although lesbian culture provides more opportunity than the mainstream for a range of gender identity without pathologizing the variations, it does not always afford individuals the opportunity to talk openly about it. Butch/femme is a particularly lesbian topic, of the sort that this group had not ventured to explore before. I asked why this was and Michelle responded that, "We're just bonding now, it took this long to feel comfortable." We moved on to the evening's planned agenda for closure, but I was left wondering if that was the whole answer. This seemed like another "doorknob" revelation, risking intimacy in the safety of impending separation.

I asked each woman to say what the group had meant to her, and they responded with surprising honesty, humor, warmth, and appreciation, ready to separate and able to accept both the positive and negative aspects. I gave each member my impressions of their struggles, growth, and difficulties in the group, and then asked them to draw self-portraits as they had done in Session #1.

When they were finished, I brought out their initial self-portraits and asked them to compare the two. Just as they had softened in relation to one another, there was a softening in their self-portraits as well. Rita commented, "I'm inside a fruit, like when I was talking about Leslie Feinberg having a 'strong core.' I'm a seed, growing. This one is more comforting than the first one. In that one I see my butch stuff, strong and muscular, but there's nothing else on the page. I'm all alone." Similarly, Michelle said, "The first one was just the elements of nature. The second one has a living creature in it, too. And see, the turtle is *gray*. The first one is just black and white lines." Hannah remarked, "It's my face this time, not hiding behind a symbol." For all three, the artwork reflected a significant change: In each pair of self-portraits, the second showed more signs of life, more safety, more relatedness, and healthier defenses.

Observations of the LSG

While this was nominally a support group, it was not an easy or comfortable group to participate in. Again and again, it was the commonalities as much as the differences that made it difficult for the LSG members to coalesce and identify with one another. Their traumatic histories, low socioeconomic status, internalized homophobia, and devaluation as women contributed to an overdetermined sense of stigma, shame, self-hatred, rage, and powerlessness which reduced self-awareness and self-expression and fostered isolation. A limited sense of lesbian identity, as individuals and members of a larger community, equipped them with meager tools for making their authentic selves visible, while the emotional intensity among lesbians was played out with a negative emphasis.

I have perhaps focused excessively on the destructive forces in the LSG and not enough on what made it work, if only intermittently. First, these women are survivors of economic hardship, trauma, isolation, stigma, and addiction. The causes of their pain were sources of strength as well, fueling their resiliency, resourcefulness, and creativity. Being socialized into women's patterns of empathic relatedness, which is intensified among lesbians, reinforced their wish and nascent capacity for intimacy, community, and healing. When the group was formed, most members were on their way up from having "hit bottom," and in the process of recovery in both the narrow and more global senses of the word. They had retained the capacity for love, warmth, humor, and hope despite the many strikes against them, and were able to seek out and use available resources. They persevered in this group because however painful, it nourished them and they recognized it. They also had the strength to be true to themselves, living and loving as lesbian/bisexual women, because this, too, sustained them.

This was a productive and meaningful group for those who stayed with it. More often than not, their pain was witnessed, accepted, and mirrored; risk-taking in the service of intimacy, self-assertion, and self-nurturing was validated, and playful creativity was encouraged. Being in the group may also have supported the women enough to risk becoming more visible in their own worlds, as when Rita came out to a co-worker and also took a stronger stand against her family's homophobia or when Jessica came out in her high school. In the final session, members expressed appreciation for one another and identified how they had changed in the context of the group, a form of growth-in-relation embodied in their final self-portraits.

Conclusion

This paper has examined how a group of isolated low-income lesbian/bisexual women expressed themselves and interacted with one another in an art therapy support group. Lesbian-affirmative, feminist, and trauma theories have been employed to illuminate the cultural and clinical background against which this particular kind of client group must be viewed. I have attempted to define the specifically lesbian aspects of the LSG and the special role of art therapy with this population. It is the area of overlap between what is uniquely lesbian and what is uniquely art therapy that strikes me as especially compelling and worthy of further development.

The concept of *visibility* can be a guide to this exploration. I was surprised by the extent to which lesbian invisibility was operative even in a group whose purpose was to minimize it. It was easier for the group to focus on more general issues and on their differences than to explore, actively and openly, the subjective lesbian experience. In large part, this is because these women did not have an adequate language, grounded in their own experience, to do so. The special strength of art therapy is that it encourages us to envision, on our own terms, our definitions of self and of reality. Artwork was more effective than talk in building group cohesion because it allowed for more immediate, personal imagery and provided a less circumscribed language for making the self genuinely visible. This links the LSG members to their history, to lesbian poets and artists whose goal has been to explore "the dream of a common language" (Rich, 1978) and build "another mother tongue" (Grahn, 1984).

The group's search for an authentic language has been paralleled in the process of writing this paper. In trying to define the lesbian-specific content of the group, I have recognized that my own wariness, my habitual self-monitoring of what to share with a general audience and what to protect, mirrors the group's process and the experience of lesbian/gay people in general. Some of these concerns include: How best to explain a part of my personal world to my professional world? How much to explain? What language will be understood? What may be misunderstood?

I find that this process has resulted in what should be considered a rough map to a previously uncharted territory. I hope that my colleagues will join in filling in this map and in expanding art therapy theory more fully to encompass lesbian/gay/bisexual people. "Normative creativity" (Brown, 1989, p. 451)—the ability to create one's own forms, when the existing forms are not adequate—is a strength of lesbians and gay men, and I would add, of art therapists. As both lesbian/gay culture and art therapy develop and diversify, we can be empowered by one another's public statements to articulate our own, and in doing so, help our clients to do the same.

Editor's Note: The Lesbian Support Group was made possible, in part, by a grant from a local foundation, Holding Our Own, a Fund for Women.

References

Anthony, B. D. (1982). Lesbian client-lesbian therapist: Opportunities and challenges in working together. In J. C. Gonsiorek (Ed.) (1985), *A Guide to Psychotherapy with Gay and Lesbian Clients* (pp. 45–57). New York: Harrington Park Press.

Brody, R. (1994). Ambiguity and integration: A meeting ground for art therapy and lesbian and gay identity development. *Pratt Institute Creative Arts Therapy Review, 15*, 35–44.

Boston Lesbian Psychologies Collective. (1987). *Lesbian Psychologies*. Urbana: University of Illinois.

Brown, L. S. (1989). New voices, new visions: Toward a lesbian/gay paradigm for psychology. *Psychology of Women Quarterly, 13*, 445–458.

Brownworth, V. A. (1993). Stone butch but not blue. *Deneuve, 3*(4), 24–26.

Burch, B. (1986). Psychotherapy and the dynamics of merger in lesbian couples. In T. S. Stein & C. J. Cohen (Eds.), *Contemporary Perspectives on Psychotherapy with Lesbians and Gay Men* (pp. 57–71). New York: Plenum.

Burch, B. (1987). Barriers to intimacy: Conflicts over power, dependency, and nurturing in lesbian relationships. In Boston Lesbian Psychologies Collective (Eds.), *Lesbian Psychologies* (pp. 126–141). Urbana: University of Illinois.

Burch, B. (1993). *On intimate terms: The psychology of difference in lesbian relationships*. Urbana: University of Illinois.

Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4*(3), 219–235.

Chodorow, N. (1979). *The reproduction of mothering.* Berkeley: University of California Press.

de Monteflores, C. (1986). Notes on the management of difference. In T. S. Stein & C. J. Cohen (Eds.), *Contemporary Perspectives on Psychotherapy with Lesbians and Gay Men* (pp. 73–101). New York: Plenum.

de Monteflores, C., & Schultz, S. J. (1978). Coming out: Similarities and differences for lesbians and gay men. *Journal of Social Issues, 34*(3), 59–72.

Falco, K. L. (1991). *Psychotherapy with lesbian clients: Theory into practice.* New York: Brunner/Mazel.

Feinberg, L. (1993). *Stone butch blues.* Ithaca, NY: Firebrand.

Golden, C. (1987). Diversity and variability in women's sexual identities. In Boston Lesbian Psychologies Collective (Eds.), *Lesbian Psychologies* (pp. 19–34). Urbana: University of Illinois.

Gonsiorek, J. C. (Ed.). (1985). *A guide to psychotherapy with gay and lesbian clients.* New York: Harrington Park Press. (Originally published in 1982 under another title.)

Gonsiorek, J. C. (1988). Mental health issues of gay and lesbian adolescents. *Journal of Adolescent Health Care,* 9, 114–122.

Grahn, J. (1984). *Another mother tongue.* Boston: Beacon.

Greene, B., & Herek, G. M. (Eds.). (1994). *Psychological perspectives on lesbian and gay issues: Vol. 1. Lesbian and gay psychology: Theory, research, and clinical applications.* Thousand Oaks, CA: Sage.

Herman, J. L. (1992). *Trauma and recovery.* New York: Basic Books.

Hetrick, E. S., & Martin, A. D. (1987). Developmental issues and their resolution for gay and lesbian adolescents. *Journal of Homosexuality, 14*(1/2), 25–43.

Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver, I. P., & Surrey, J. L. (1991). *Women's growth in connection: Writings from the Stone Center.* New York: Guilford.

Krugman, S. (1987). Trauma in the family: Perspectives on the intergenerational transmission of violence. In B. A. van der Kolk (Ed.), *Psychological Trauma* (pp. 127–151). Washington, DC: American Psychiatric Press.

Lenihan, G. O. (1985). The therapeutic gay support group: A call for professional involvement. *Psychotherapy,* 22, 729–739.

Loulan, J. (1990). *The lesbian erotic dance: Butch, femme, androgyny and other rhythms.* San Francisco: Spinsters.

Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant.* New York: Basic Books.

Margolies, L., Becker, M., & Jackson-Brewer, K. (1987). Internalized homophobia: Identifying and treating the oppressor within. In Boston Lesbian Psychologies Collective (Eds.), *Lesbian Psychologies* (pp. 229–241). Urbana: University of Illinois.

Morgan, K. S., & Eliason, M. J. (1992). The role of psychotherapy in Caucasian lesbians' lives. *Women & Therapy, 13*(4), 27–52.

Nestle, J. (1981). Butch-femme relationships: Sexual courage in the 1950s. In J. Nestle (Ed.) (1987), *A Restricted Country* (pp. 100–109). Ithaca, NY: Firebrand.

Nestle, J. (Ed.). (1992). *The persistent desire: A femme-butch reader.* Boston: Alyson.

Ochs, R., & Deihl, M. (1992). Moving beyond binary thinking. In W. J. Blumenfeld (Ed.), *Homophobia: How We All Pay the Price* (pp. 67–75). Boston: Beacon.

Pearlman, S. F. (1987). The saga of continuing clash in lesbian community, or will an army of ex-lovers fail? In Boston Lesbian Psychologies Collective (Eds.), *Lesbian Psychologies* (pp. 313–326). Urbana: University of Illinois.

Rich, A. (1978). *The dream of a common language.* New York: Norton.

Rich, A. (1980). Compulsory heterosexuality and lesbian experience. In A. Snitow, C. Stansell, & S. Thompson (Eds.) (1983), *Powers of Desire* (pp. 177–205). New York: Monthly Review.

Robbins, A. (1989). *The psychoaesthetic experience: An approach to depth-oriented treatment.* New York: Human Sciences.

Silverstein, C. (Ed.). (1991). *Gays, lesbians, and their therapists: Studies in psychotherapy.* New York: Norton.

Stein, T. S., & Cohen, C. J. (Eds.). (1986). *Contemporary perspectives on psychotherapy with lesbians and gay men.* New York: Plenum.

Surrey, J. L. (1991). The self-in-relation: A theory of women's development. In J. V. Jordan, A. G. Kaplan, J. B. Miller, I. P. Stiver, & J. L. Surrey, *Women's Growth in Connection: Writings from the Stone Center* (pp. 51–66). New York: Guilford. (Original work presented in 1983.)

van der Kolk, B. A. (1987). *Psychological trauma.* Washington, DC: American Psychiatric Press.

Vargo, S. (1987). The effects of women's socialization on lesbian couples. In Boston Lesbian Psychologies Collective (Eds.), *Lesbian Psychologies* (pp. 161–173). Urbana: University of Illinois.

Waller, D. (1993). *Group interactive art therapy: Its use in training and treatment.* London: Routledge.

Weille, K. L. H. (1993). Reworking developmental theory: The case of lesbian identity formation. *Clinical Social Work Journal, 21*(2), 151–159.

Williams, W. L. (1986). *The spirit and the flesh: Sexual diversity in American Indian culture.* Boston: Beacon.

Art Therapy: Journal of the American Art Therapy Association, 13(1) pp. 31-36 © AATA, Inc. 1996

Men's Roles and Their Experience of Depression

Michael Barbee, MDiv, MA, San Francisco, CA

Abstract

Previous research has suggested that a significant source of depression in men is found in conflicts with sex role expectations. These societal expectations are reflected in both men's symptomology and coping mechanisms. A descriptive pilot study was undertaken with five inpatient depressed men using a combination of questionnaires and drawing tasks. Subjects completed the Beck Depression Inventory, Depression Coping Questionnaire, and Bem Sex Role Inventory, as well as four drawings depicting themselves in male roles and two reflecting self-concept. Role drawings were subject-rated on a personal construct grid according to perceived conflict in each role. Support was found for significant sex role conflict being strongly correlated with these subjects' presenting problems at admission for depression. Each man's biographical information and data were analyzed and compared to examine the lives of five individuals in order to gain useful information for working with this population.

Introduction

A theme of the growing body of literature in the area of men's studies is that the present period in our culture causes increasing stress on men due to changing sex role expectations. Although the women's movement has illuminated the rewards of being male in this society, men are learning that these material, social, and political benefits come at a high cost. High rates of ulcers, heart attacks, hypertension, and earlier death for males are attributed to traditional male sex roles in this culture. This increased stress is seen most among men whose view of male sex roles has not changed with the culture (Pleck, 1989).

Pleck (1989) proposes a "sex role strain" paradigm which includes the concepts that sex roles are operationally defined, that they are contradictory and inconsistent, that their violation leads to social condemnation and negative psychological consequences, and that these consequences are greater for males. Attempting to live by the cultural stereotypes which dichotomize behavior and character traits into masculine-feminine results in men's avoidance of all behavior associated with being feminine. Meth (1990) outlined six patterns of gender role conflict resulting from this narrow definition of being masculine: restrictive emotionality, homophobia, power and competition issues, restricted sexual and affectional behaviors, obsession with achievement, and health problems.

It is commonly accepted that almost twice as many women as men suffer from depression (DSM III-R, 1987), and until recently the reasons for this assumption or its accuracy have not been questioned. Most research involving men and depression compares gender differences in depressive symptomology and attributional and coping style differences between the sexes. Studies reviewed on sex differences in depression supported the idea that societal sex role expectations cannot be ignored in studying the experience of depression in men.

In their examination of the "changing faces of masculinity," Connell, Radican, and Martin (1989) noted that although many books about men have been published in recent years, there has been very little research conducted and the books are often limited by their adherence to the theory that men's fulfillment is contingent on living out a particular male sex role. These authors suggest research methods to improve on this approach, including the "life history" method which values the individual experience of particular men. This approach aides in the development of new theory and research with a given population through its openness to all findings which develop rather than to the goal of proving preconceived hypotheses. Neimeyer and Resnikoff (1982) stated that the primary objective of this qualitative research is to uncover private meaning structures and their impact on behavior. "While quantitative methods may be applied usefully to the question, 'How depressed is the client?' they are of less utility in answering, 'What is the experience and functional value of depression?'" Hammond (1989), in an article on alternate research paradigms, emphasized that these interpretive methods place an emphasis on the illumination of meaning. It is an assumption of qualitative research that men's depression can be effectively treated only if its meaning and experience in the lives of individuals are understood.

Published art therapy literature reveals very little regarding theory and treatment of depression and almost nothing about working with adult male clients. Wadeson (1980) described some characteristics of the art of depressed patients in her research at the National Institute of Mental Health as having less color, more empty space, less investment or effort toward completion, more depressive affect or less affect, and an overall feeling of emptiness. She also found a greater resistance to art therapy tasks among depressed patients in general.

Nucho (1982) proposed an equation to guide art therapists in treating depressed clients, which states that the experience of depression is a result of increased demands with decreased supports and resources. Treatment consists of building supports and resources in the four components of the self-system: (1) the body self; (2) the achieving self; (3) the identification self; and (4) the interpersonal self. These components broadly cover the presenting problems in the particular inpatient male population in this study and societal role expectations.

The art therapy component of this research is based partially on the personal construct theory of George Kelly (1955). Kelly emphasized the role of the subject as co-experimenter and active participant in the therapeutic process. Kelly believed that an individual's behavior could be understood only in light of his or her personal constructs and not by external measures imposed by others. Constructive alternativism, the assumption that all individuals are capable of changing or replacing their present interpretation of events, underlies the therapist's ability to assist the client. By understanding these constructs, the therapist can assist the client in adjusting them to fit reality. Shedding light on problems with present role constructs is a major emphasis in therapy with the population in this study, and drawings and other expressive therapy techniques fit well into this approach.

Methodology and Procedures

The researcher worked as an art therapy intern for 9 months with a population which included inpatient men in a private psychiatric hospital. The therapeutic programming emphasized men's issues and their place in mental health. The components of the program included a men's verbal therapy group, a men's expressive therapy group run by the researcher, and a psychoeducational program. The expressive therapy group was held for 1 hour each morning. Basic materials were used within a psychodynamic approach to allow patients to identify and express feelings in a safe and creative way and to give personal shape and meaning to issues which they shared.

Art produced by these men often contains the characteristics mentioned by Wadeson. They also exhibited resistance to art therapy, which stemmed from depression and the patients' belief that art is a child's activity and something with which they are uncomfortable as adult males. Anger was the feeling most readily identified and was almost always viewed as destructive in its expression. Hurt and sadness often lay beneath the cover of anger, anger apparently being a more sex-role-appropriate feeling for men to own and express.

It was also observed that these clients brought a very cognitive approach to treatment, wanting clear answers to their problems (i.e., a "fix it" approach). The art therapy component provided an openness to ambiguity and existential issues as a complement to more cognitive psychoeducational material. Over time, as patients gave up their search for easy answers, they often became more open to the expressive therapy modality.

Hypothesis

It was hypothesized that a correlation would be found between these men's lived sex roles, as reported and as depicted in their drawings, and their presenting problems in depression. The purpose of this study was to establish an information base regarding the personal experiences of depressed men in relation to their sex roles. The study was intended as a descriptive pilot study in a relatively new area of research, that is, depressed men's experiences and their visual depictions. Instruments used to gather this data included three self-report questionnaires and an art exercise designed by the author, comprised of six assigned drawings.

Subjects

The study included a selective sample of men who were admitted to the adult acute psychiatric unit for an episode of major depression as defined by the DSM III-R (1987) over a 2-month period. Those who participated were Caucasian men living near a mid-size Midwestern city and having employment or insurance coverage to allow their stay in a for-profit private facility. Subjects ranged in age from 38 to 61. Patients with diagnoses including psychotic features, personality disorders, organic syndromes, or substance abuse or dependency in combination with depression were not used. Information was gathered during 1- to 2-hour interviews with the researcher, who also served as art therapist on the unit.

These men's depression exhibited itself in some common presenting problems. Most patients complained of some or all of the following: crisis in a marriage or primary relationship, inability to fulfill male role expectations to work and provide for others; somatic complaints; lack of satisfactory relationship with father as a child or currently; blunted affect; isolating behaviors; and little identity apart from instrumental sex roles.

Measures

The methodology was designed to allow both structured responses to standard measurement tools and individual expression of unique life experiences, including self-rating of drawings, to combine both objective measures used in other studies and the subjective art task designed by the author. Subjects completed: (a) the Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961); (b) the Bem Sex Role Inventory (BSRI) (Bem, 1974), developed to measure androgyny and including 60 items divided between personality characteristics commonly considered to be masculine, feminine, or neutral (e.g., independent, sensitive, analytical) rated along a Likert scale; and (c) the Depression Coping Questionnaire (DCQ) (Kleinke, Staneski, & Mason, 1982) which compares strategies of men and women in coping with depression and consists of 29 items rated on a Likert scale, including coping by active and passive, cognitive and affective, and social and isolative strategies. The BDI was chosen as the quantitative scale for depression as it was most used in the literature surveyed; the BSRI and DCQ provided validated measures for identifying males' particular experience of depression.

Subjects were asked to complete six drawings with a Number 2 pencil on 8 1/2" × 11" white paper. These materials were chosen since they are familiar and not specialized "art" tools, and to provide a size which was least threatening since patients were often observed to request a smaller format than the often-used 18" × 24" drawing paper. The drawings included depicting self in four roles: (a) at work, (b) with current family, (c) as a child with family of origin, and (d) with a friend. Two additional drawings relating to self-concept were requested—depiction of self currently and ideal self. The use of the role drawings was derived from current literature on themes of therapy with men—work, intimacy, friendship, and father relationship (Meth & Pasick, 1990). The two self-concept drawings were designed to elicit the subjects' view of themselves in their own terms and to evaluate how present-self and ideal-self relate to roles they fill as men.

Subjects then ranked the four role drawings on four criteria: the role in which they (a) felt most competent, (b) felt the most frustration, (c) felt the most comfortable, and (d) felt they shared the most with others. Ranking was intentionally broad to bring out subjects' individual interpretations. Drawings were ranked

BEST COPY AVAILABLE

Table 1
Personal Construct Grid

BILL	COMFORT	FRUSTRATION	COMPETENCE	SHARING
FAMILY	1	4	2	2
FAMILY/ ORIGIN	4	2	4	4
WORK	3	1	3	3
FRIEND	2	3	1	1

from one to four along these criteria and plotted on a 4 × 4 repertory grid based on Kelly's (1955) work (Table 1).

In addition to the questionnaire and art data, biographical information was gained from subjects' hospital records and from conversations during the interview process. The above material was obtained during 1- to 2-hour interviews with the author, and subjects were informed that they were participating in a study to gain knowledge of their particular experience of depression.

Results

Results of Questionnaires

The BDI responses of the five subjects in this study showed significant scores in the moderate to severe range of 24, 25, 27, and 31, with one subject having a score of only 2. The subjects reported the following symptoms most often: decision-making problems (highest score), sense of failure, lack of satisfaction, fatigue, lack of sexual interest, sadness, hopelessness, social withdrawal, problems with work, and somatic complaints. No subject checked feelings of guilt, self-blame, suicidal ideation, or changes in appetite or weight. These responses, including those of the subject who was reluctant to report symptoms, are supported by Hammen and Peters (1977). Their research found no difference in degree of depression between genders, but did find significant differences in reported symptomology on the BDI. Men were more likely to experience an inability to cry, loss of social interest, a sense of failure, and somatic complaints, suggesting men's suppression of overt depressive symptoms. It is possible that this suppression of symptoms may be correlated with sex role stereotyped expectations regarding depression's acceptability as a man's problem.

DCQ responses revealed significant coping through "ignoring the problem" and "self-blame," followed by "watching TV, meditating or relaxing, cutting down on responsibilities," and "confronting the problem and attempting to find a way out." The reported self-blame conflicts with the subjects' answers on the BDI. However, suppression of symptoms is again highly used, with some subjects referring to their behavior before admission or for the first days of hospitalization as "hiding" or "escaping." Active responses such as confronting the problem emphasize a cognitive approach consistent with these subjects' approach to treatment. Kleinke and Staneski (1982), developers of the DCQ, found that men were more likely to experience lack of appetite, pessimism, lack of satisfaction, irritability, and sleep problems; were more likely to focus on physical problems and use of drugs; and were unlikely to seek help. They found high BDI scores associated with isolation and escape.

On the BSRI, two subjects rated themselves higher on feminine and lowest on masculine characteristics (Table 2), with the remaining three rating themselves somewhat higher on masculine traits. Total scores ranged from 235 to 311. Individual ratings along the Likert scale were either polar (1 or 7) or median (3, 4, 5) on all traits. The two subjects who scored low on masculine traits often made some audible reaction to items such as "leader," "competitive," "forceful," "strong personality," and "makes decisions easily," indicating some lack of self-esteem because of these "deficits." These findings are inconclusive, but may give support to the theory that sex role strain is related to depression and that highly masculine individuals use greater distracting mechanisms. The BSRI was developed from the theory that androgenous persons exhibit more flexible behavior than sex-typed persons. Bem (1974) theorized that individuals with sex-typed behavior would exhibit behavior consistent with stereotypically masculine or feminine roles. Research using this instrument in the study of sex differences in depression (Glazebrook & Munjas, 1986) did not support a higher rate of depression in sex-typed individuals, but did support a high correlation between sex role strain and depression. Conway, Giannopoulos, and Steifenhofer (1990) found high masculinity associated with greater distracting mechanisms.

Table 2
BEM Sex Role Inventory Scores

	MACULINE	FEMININE	NEUTRAL	TOTAL
JOE	58	117	98	273
BILL	90	73	72	235
DOUG	94	81	85	260
RALPH	115	108	88	311
GERRY	58	117	104	279

Results of Drawings

The overall characteristics of the drawings seem to corroborate with Wadeson's (1980) findings regarding the drawing of depressed individuals, both male and female. These subjects' drawings reflect large amounts of empty space, less investment, and very little affective content. Two subjects expressed resistance to the task and were much more comfortable with talking. This resistance was common with this population in the clinical setting in which the research took place. All but one subject used stick figures or nonpersonal symbols.

Drawings of "How I am at work" seemed less difficult for these men, who could easily think of a way to depict themselves in a role in which they had high investment and relied on heavily for self-esteem. Four of the five subjects' drawings were given negative connotations related to performance level, interpersonal factors, or not being appreciated. Rating on subjects' grids for work drawings reflected the factor of this role in their presenting problems or as a role in which they were comfortable because they could see their accomplishments.

Figure 1, a computer disc with a line through it, depicts Ralph's feelings of having his work negated, since the company he worked for had laid him off and was not using his software. At age 38, he had no prior mental health care when he was admitted for depression, anxiety, and abdominal pain. He complained of weight loss, insomnia, and crying spells, and presented with severe stressors directly related to role fulfillment—loss of job and provider role, a six-month marital separation, the ending of a homosexual relationship, and determination fed by guilt to return to his family as father and husband. He had used avoidance to a significant degree by often working as many as three jobs at one time.

Current family drawings were the strongest mirrors of presenting problems in their depiction of marital strife. Two drawings represented confusion, two focused on activities which took attention away from problems, and one showed the relationship's periodic explosions. Men's roles in the family were seen as leading to the subjects' depression and led three of them into extended verbal explanations of their frustration and confusion regarding their role in the family. Grid placement for this role was either most or least on the comfort scale.

Figure 2 is typical of Gerry's drawings, all using the same symbols. It shows this 46-year-old man's relationship with his fourth wife as a series of explosions with intermittent periods of peace. He described this relationship as a constant struggle to fill a role through unsuccessful attempts at compromise and coping. He felt that this pattern was unalterable. Gerry's father had committed suicide and his mother had been chronically depressed. Although he had been unemployed for 2 years and had two mentally handicapped adults to care for, he was unable to identify any source of depression. His drawings reflect his isolation, hopelessness, and suicidality, with his "ideal self" showing a flat line for "peace" but seeming to convey peace which comes through death.

All but one family-of-origin drawing contained human figures, with two families holding hands and three strongly reflecting perceived childhood placement in the family, such as center of attention, caretaker, scapegoat. All drawings dealt with the family in the subjects' preadolescence as instructed. In only one case did family of origin carry significant current emotional energy. This placement in the past made it difficult for some subjects to rank these drawings on the grid and to view the constructs as past or present.

Figure 3 shows Bill as a small child cowering in a corner under the critical gaze of his parents. He described his father as a series of negative male stereotypes, and his parents as not having given him the tools to mature. Bill, 61 and recently separated, had had 9 years of therapy, becoming depressed after two prior divorces. He claimed to have first become depressed after stopping smoking in 1985 and related this to a "chemical imbalance." His strongest self-reported stressor was working in the context of several critical women who surround him in his drawing. This work role seemed to carry an inordinate amount of weight. Bill depicted himself as quite small and impersonal in each drawing, perhaps reflecting his lack of inner locus of control.

Drawings depicting self with a friend seemed to reveal much about relationships outside the family. Two men drew past relationships with a particular friend and stated they had no current friends. Two others depicted male relationships which were acquaintances related to work, with one subject putting a high investment in this relationship. Ranking of friendship drawings on the four constructs reflected whether the relationship was current of not. Current friendships seemed to rate strong in feelings of competence, comfort, and sharing, while friendships which had not been maintained related high in frustration.

Figure 4 depicts Joe, 52-years-old, as a teenager racing his 1956 Mercury against a best friend, his last real friendship. This was Joe's fifth admission in a 9-month period, sparked by marital problems. His sense of failure at marriage and as father of a son on death row was overwhelming. He claimed to have no support and felt abandoned by his wife. His undifferentiated self came through in each drawing, showing himself as a failure in each role and idealizing the past. In self-concept drawings, he could not separate himself from the marriage and depicted current distance in contrast to an idealized past.

Self-concept drawings of present self revealed two subjects who felt good about the progress they had made or need for rest

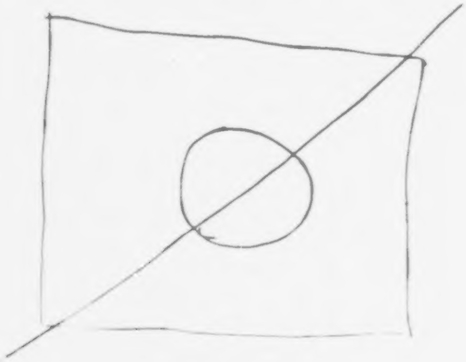


Figure 1 Ralph's work role drawing

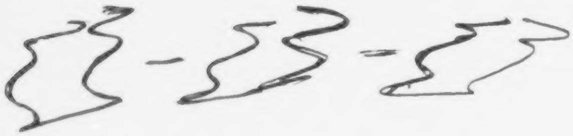
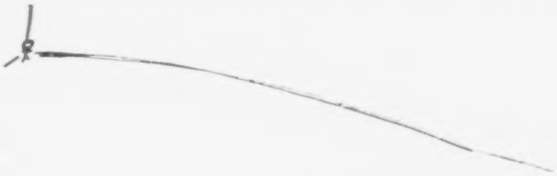


Figure 2 Gerry's current family drawing



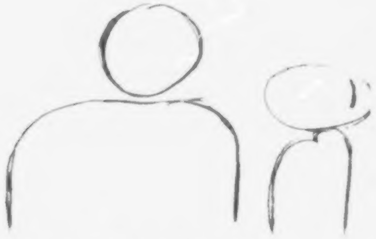


Figure 3 Bill's family of origin drawing

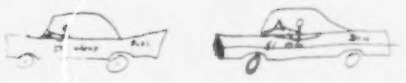


Figure 4 Joe's friendship drawing

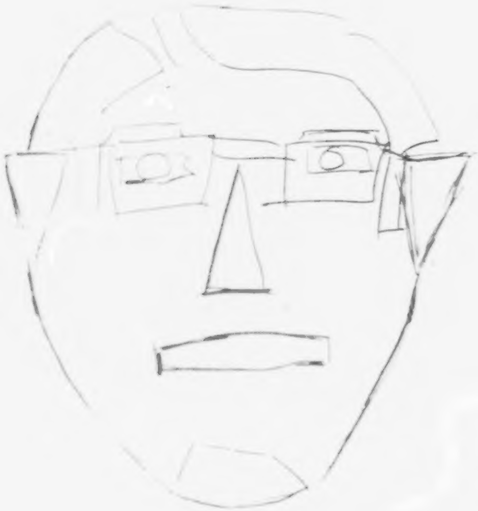


Figure 5 Doug's work drawing

they had achieved in the hospital. Two others showed current states of confusion or rigidness, while a fifth depicted the marital relationship versus the individual. All of the ideal self drawings showed men who had reached a certain level of self-growth and peace, with one finding resolution in marriage. Only one of these did not depict a person. These self drawings seemed to aid the subjects' thinking about the future and how they would like to see themselves. Though each had had suicidal thoughts, all were able to picture a hopeful future.

Figure 5 shows Doug's sense of himself as rigid and hard in geometric lines. He had felt an increasing inability to communicate with others, including his wife. A quiet man of 52, he did not feel very respected as a high school teacher, and his own adolescent daughter did not share his values regarding sexuality. An older daughter had had two children out of wedlock. A child of missionary parents, he felt he was failing in the parental role. His ideal self drawing depicts him in softer lines with a warm, more human face, reflecting his desire to move away from rigidness and to be more accepting and sharing emotionally with others.

In mapping the four role drawings along a personal construct grid, no common themes were revealed. Rather, the grids reflected the individual experience of each subject and corresponded to male role stressors in each of their lives which seemed to have a strong relation to their depression. Table 1 shows Bill's construct grid, reflecting his verbalized presenting concern with his role at work where he experienced great frustration and no positive associations. He finds greatest competence and sharing in a friendship represented by two people over a chessboard, yet this friendship is no longer active. Bill continues to have no positive feelings regarding his family of origin, even after several years of personal work. His emphasis on these roles may be denying the stress in his current family, rated highly on competence, comfort, and sharing, though he had been separated from his third wife for several months. His drawing of them shows two symbols birdwatching—nonpersonal and with attention completely focused away from the relationship.

Discussion

Findings supported the prediction that sex role conflict is related to an individual's experience with depression. It was expected that subjects' responses on the BDI, DCQ, and BSRI would be similar to those of several previous studies. Subjects reported expected findings of suppression of overt symptoms of depression, with mixed findings regarding masculinity/femininity scores. With no subject scoring higher on gender neutral items, there may be indirect support for Bem's theory of sex-typed persons having less flexible coping mechanisms.

Drawings reflected a lack of affective content, a large amount of blank space, and light pressure found in other research by art therapists. Each man in the study was able to use drawings in a unique way to reflect both his roles and their importance and differences between self-concept and ideal self. Grid ratings strongly reflected presenting problems upon admission and emotional content or denial found in role drawings.

Findings cannot be generalized beyond the narrow population used in this study. Research in the literature is also quite limited, most often using college students. Although subjects were excluded who had complicating diagnoses of organic syndromes, personality disorders, or chemical dependency, it may be that a large number of men with depressive symptomology fall into these diagnostic categories, especially chemical dependency.

The purpose of this study was to gain an information base regarding the personal experiences of depressed men in relation to their sex roles. The responses of these five individuals give rich information regarding men's experience with their own depression and how roles are related. In fact, many male patients had never used depression as a term for what they were experiencing, their response being "they tell me I'm depressed." This kind of descriptive data seems crucial in developing informed interventions. Rather than imposing a diagnosis which is not meaningful to some men, we can learn from their personal descriptions and language to present a diagnosis to which they can relate.

The findings of this study and others involving sex role conflict and depression in men seem to have significant implications for clinical practice with men. Clinicians should be aware of men's reluctance to seek professional help, the difficulty of diagnosing depression in many men due to suppression of overt symptoms, and the tendency of males to emphasize somatic concerns and approach their problems in a very cognitive, problem-solving manner. Art therapists may face strong resistance to expressive techniques by men who are depressed.

Roles which men play, such as father/son, spouse, provider, and friend, should be respected for their significance in the lives of individuals who may have little identity apart from them, especially when experiencing severe depression. Assessment should include the degree of investment in and fulfillment of these roles in individual lives. As men often have trouble identifying depression in themselves and are often confused regarding its source, psychoeducational material plays an important role in working with this population.

This pilot study may offer creative ideas for future research with a population about whom little is written. Personal construct theory seems to offer an opening into the experiences of men, and grids might be enlarged in future studies with no assigned categories so that subjects assert their own values and perspectives. These responses could be correlated to current literature to validate findings regarding the importance of gender roles in the lives of men. The repertory grid used with drawings is a natural tool for the expressive therapist, providing a way to integrate art tasks on a cognitive level with which men may be more comfortable. From such information gathered from a larger and more diverse sample, it may be possible to develop a questionnaire which is more specific to the population in rating degree of depression, expression of symptoms, and ways men cope with this illness.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. rev.). Washington, DC: Author.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 53–63.

Bem, S. L. (1974). The measurement of psychological androgyny. *Journal of Consulting and Clinical Psychology, 42*, 155–162.

Connell, B., Radican, N., & Martin, P. (1989). The changing faces of masculinity. In M. S. Kimmell & M. A. Messner (Eds.), *Men's Lives* (pp. 578–585). New York: MacMillan.

Conway, M., Giannopoulos, C., & Stiefenhofer, K. (1990). Response styles to sadness are related to sex and sex role orientation. *Sex Roles, 22*, 579–587.

Glazebrook, C. K., & Munjas, B. A. (1986). Sex roles and depression. *Journal of Psychosocial Nursing, 24*, 9–12.

Hammen, C. L., & Peters, S. D. (1978). Interpersonal consequences of depression: Responses to men and women enacting a depressed role. *Journal of Abnormal Psychology, 87*, 322–332.

Hammond, L. L. S. T. (1989). Alternate research paradigms: A review and teaching proposal. *The Counseling Psychologist, 17*, 3–79.

Kelly, G. A. (1955). *The psychology of personal constructs* (vols. 1-2). New York, NY: Norton.

Kleinke, C. L., Staneski, R. A., & Mason, J. K. (1982). Sex differences in coping with depression. *Sex Roles, 8*, 877–889.

Meth, R. L., & Pasick, R. S. (Eds.), (1990). *Men in therapy: The challenge of change*. New York, NY: Guilford Press.

Neimeyer, G., & Resnikoff, A. (1982). Qualitative strategies in counseling research. *The Counseling Psychologist, 10*, 75–85.

Nucho, A. O. (1982). Art therapy with depressed adults. In A. DiMaria (Ed.), *Proceedings of the 13th Annual Conference of the American Art Therapy Association* (pp. 27–30).

Pleck, J. H. (1989). The contemporary man. In M. S. Kimmell & M. A. Messner (Eds.), *Men's Lives* (pp. 591–597). New York: MacMillan.

Wadeson, H. (1980). *Art psychotherapy*. New York: John Wiley & Sons.

Art Therapy: Journal of the American Art Therapy Association, 13(1) pp. 37-46 © AATA, Inc. 1996

In Search of an Accurate Likeness: Art Therpy with Transgender Persons Living with AIDS

Emily Piccirillo, MA, A.T.R.

Abstract

The purpose of this paper is to introduce art therapists to a "differently gendered" population—transgender males with AIDS—through basic terminology and art expressions. Three cases are discussed, with both art processes and products presented. Special attention is paid to the significant role art played in their relationship with the residential community where they lived, and to the ways it served their efforts to resolve their older (e.g., transgenderism) and newer (e.g., AIDS diagnosis) issues. Distinctive and common themes are considered, along with the special challenges and benefits that come with working with this population.

Introduction

It is important to begin by defining some basic terms that apply to this paper, since their meanings can vary by context:

SEX: being male or female as defined by biology, genetics, and the anatomy, specifically the genitalia.
SEXUAL ORIENTATION: whether one is attracted to male or female partners, both, or neither.
GENDER: presenting with masculine or feminine qualities, largely dependent on cultural associations, ascribed societal roles, and stereotypical mannerisms.
GENDER IDENTITY: one's inner, subjective sense of being male or female, a complex core self-perception. (Spordone, 1994)

It is helpful to clearly distinguish the clients being discussed in this paper as transgender males rather than transvestites, who typically are straight men with male gender identities but who are drawn to dressing as women for well-defined episodes of feminine behavior. Instead, these clients are transgender or preoperative transsexuals, believing themselves to be straight women born into the wrong sex physical body. According to the DSM-IV, they each meet the criteria for the diagnosis of 302.85, Gender Identity Disorder (American Psychiatric Association, 1994). While they prefer male partners, they do not identify themselves as gay since they do not feel they belong to their male bodies. However, using the formal language above, they are male by sex, homosexual by sexual orientation, and of mixed gender, but with female gender identities. Most often, the result of such an intense conflict of differences is difficulty establishing a stable sense of self with persistent cognitive dissonance and "gender dysphoria" fueling efforts to resolve the conflict with reassignment surgery and hormone treatments (Doorn, Poorntinga, & Verschoor, 1994).

All three clients discussed in this paper reported identifying more with females than males as children. As they entered adulthood, they took significant steps to transform themselves from male to female. They spent years routinely cross-dressing as women, publicly adopting female names and images while living in a subculture of prostitution and drugs. They attempted to conceal their genital truth in hopes of appealing to men who identified themselves as straight. All three had begun "corrective" measures focused on their secondary sex characteristics by modifying breasts to varying degrees through implants or hormone supplements, but none had reassignment of the primary sex organs. When they entered treatment for HIV, this process was arrested. When they were admitted to an AIDS long-term care facility, they became involved with art therapy, which presented a new format for their "self-seeking" (Doorn et al., 1994).

These are very complex cases with many layers of treatment issues, but this paper focuses on the role of art therapy in these clients' struggles with their sex, gender identities, HIV seropositivity, and social relations. It is safe to assume that the principal reason these individuals were mainstreamed was their need for medical attention. Still, their sense of being marginalized in society persisted—initially because of their gender/sex issues, as well as being poor men of color and later compounded by the stigma of AIDS.

Treatment of such clients may expose the therapist's elemental prejudices and raise basic questions about conventional assumptions about the self in association with others, especially between the sexes. Without familiar cues to guide us in differentiating men from women, transgenders clash with the dominant culture, unnerving many and tending to provoke apprehension and intense discomfort (Kando, 1973). In fact, they are often held suspect and seen as deviant, since they violate society's codes of conformity and prohibitions, and they raise the specter of sexuality (Docter, 1988). Such clients are very vulnerable to judgement and abuse and pose a tremendous challenge in any setting (Money, 1988).

Stoller (1985) postulates that as a part of maturation and character development, boys are typically taught and encouraged to erect intrapsychic barriers, called symbiosis anxiety, to protect against the feminizing influence of the early maternal bond. In an adult community, transgenders seem to be treated as disturbing reminders of these feminine effects that threaten dissolution; the presence of these individuals activates the defensive shield that prevents these effects from intruding into consciousness. Consequently, "masculine" men are inclined to be the most reactive, warning, "I don't care what he is, as long as he stays away from me." They view the transgender as a failure, unable to resist

2273

the impulse toward the intense primary pleasure that they have renounced. Unfortunately, a transgender's poor boundaries only reinforce and aggravate this alienating trend.

The unique, creative expressions of these individuals directly reflect their personal constellations of issues, beliefs, and losses and solutions. Their art pieces suggest themes and patterns, yet articulate their distinct, richly personal worlds. They serve not only as visible realizations of ambiguous realities, but also serve to advance understanding of them by others, accommodating the need for distance as it arises.

Chris

Upon admission, Chris, a 44-year-old African-American transgender male, instantly demonstrated a need for excessive special attention, making multiple requests and registering complaints. Because of his womanly contours and feminine features, with elaborate make-up, jewelry, and shirts revealing large breast implants, I asked Chris directly if he wanted to be addressed as female or male. As with his neutral name, he convincingly expressed a relaxed indifference, stating, "I'm a chick with a dick, a shemale; I don't care which is used." During placement, staff variably referred to Chris as both "he" and "she," as did most of the other residents. Generally, Chris seemed comfortable with maintaining an androgynous duality, and he allowed his physical appearance to shift with his mood. I found it wise to routinely refer to Chris as a female; this habit served her well during disputes, a preemptive strike against name-calling.

Chris's early personal history was marked by a fragmented, unstable family. She was guarded when asked for details, preferring to limit information to a few fond remarks about her mother. While she kept tenuous ties, she left home in her early teens and seemed quite alone in the world. Still, prior to placement she had lived with her pimp in a loose format resembling a traditional straight relationship. He ended their relationship abruptly when she tested HIV-positive.

Chris had substantial difficulty relating well to others. She introduced herself forcefully, at times trying to make a genuine positive impression, but she usually antagonized others with a manipulative, controlling style. Even with careful intervention, she gradually became more irritable during contacts. Her conversations became more bizarre and confused, with loose associations and a marked tendency to distort and misunderstand what others said. Despite significant episodes of anxiety, hostility, and disruptiveness, she refused psychotropic medications, and finally, after a year's stay, an administrative discharge became necessary.

During Chris's stay at the facility, strong delusional features started to surface, both grandiose and paranoid. She had begun to read about Egyptology; the fact that Egyptian society sanctioned its young men to use cosmetics and look effeminate first attracted her to this subject, seeing this as a kind of formalized gender ambiguity and cross-dressing. As she struggled to transcend her complex predicament and achieve a sense of belonging, she soon decided that many aspects of the ancient Egyptian belief system and mythology had profound personal relevance to her. Her ideas quickly proceeded into magical metaphysical realms. While she knew it was against facility policy, she regularly lit candles and incense in her room, turning her garbage can into an altar. She wore fresh flowers and crystals and selected her clothing by color, believing that certain colors had healing energies. She developed a habit of gluing a decorative plastic gem to the center of her forehead, believing this "solar eye" would infuse her with the power to cure herself. While any of these unusual practices might have complemented her illness well, she was unable to incorporate them reasonably in a balanced manner.

Similarly, her interpretations of Egyptology revealed psychotic thought processes. Adding miscellaneous notions from a host of modern and tribal religions, Chris invented her own comprehensive eclectic spirituality, identity, and view of the cosmos. She incorporated extraterrestrials into her beliefs and made aggressive efforts to convert others to this newly synthesized faith.

She also experimented with new names for herself, all derived from her study of ancient Egypt. She finally composed her own variation, Neithia, based on an identification with Neith, a primeval Egyptian deity of both war and mortuary practices who was neither male nor female but was reported to prefer a female appearance (Lurker, 1980). Believing herself to be an eternal divine being, Chris could then begin to accept and even celebrate her androgynous humanness on this temporary plane. She could reframe her approaching death by claiming passage into the underworld and resurrection as areas of expertise. From this association, she developed a sense of herself as immortal royalty, an heir to a dynasty with many specific gods and goddesses as her direct ancestors. Also, in discovering African-American roots in this noble race, she gained a valuable source of self-esteem and inspiration.

Since ancient Egyptian belief was organized around an endless cycle of existence, with elaborate rituals that marked the intervals of transformation, it fused physical sexuality, death, and the renewal of life. It even claimed that dual-sex supreme gods, like Neith, could be self-engendered. This greatly appealed to Chris, with her expressed desire to become known as a special survivor of HIV, because it suggested she could shape her own destiny and ultimately re-create herself if necessary.

Clearly among Chris' strengths were her imagination and creativity, giving me a special opportunity to play a positive role in her treatment. She actively declined organized art groups but was very motivated to produce spontaneous images on her own. She showed an ease with a range of materials but usually preferred to use colored pencils, with small, selective additions of glitter and dried flowers. Her artwork served as a direct manifestation of her personal process of organizing her chaos. She covered all of her walls from floor to ceiling, her dresser, and both sides of her door with dozens of drawings. In adherence to Egyptian tradition, she even placed on the walls on either side of her bed depictions of jackals ready to escort her into the afterworld in case she died during her sleep.

Most of her art pieces are characterized by a hypersymbolism, in part due to her intelligence and severe distress but also because of the density of meanings in Egyptian iconography. Her artwork testifies to her intense strivings to fight hopeless and helpless feelings, and to transform her experience from passive to active. It expresses her extraordinary efforts to resolve her existential questions and fears of death, to find peace and meaning in her difficult life, and to establish a connection with higher powers as a source of comfort, guidance, salvation, and a homeland. While Chris lacked the ego integrity and interpersonal skills

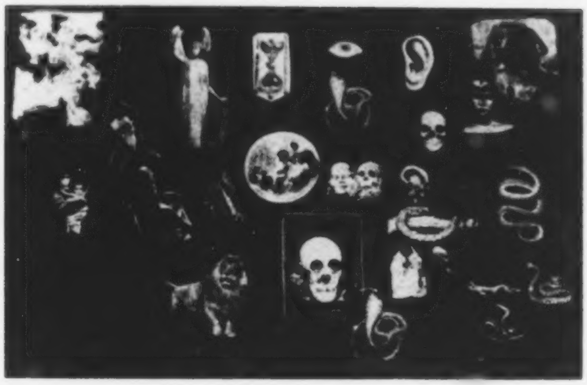


Figure 1

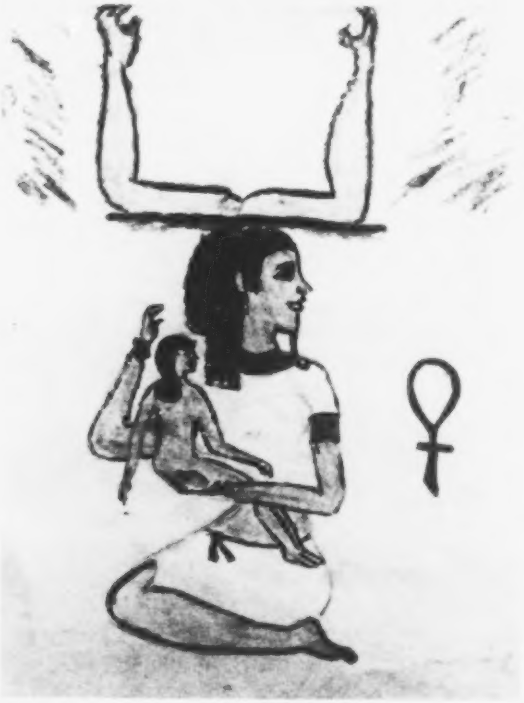


Figure 2

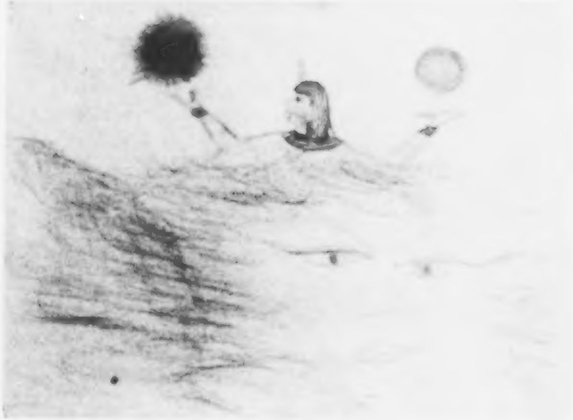


Figure 3

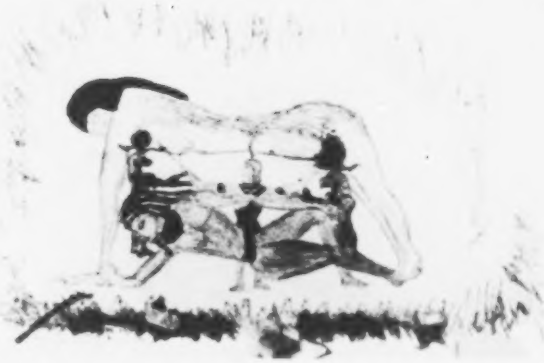


Figure 4

to hold her ground in reality and the structured community, her artwork reflects some success with her core issues.

Her first piece, a collage of xeroxed images from a clip art book (Figure 1), incorporates many themes that were elaborated later in treatment. From the start, Chris clearly stated that her artwork was about "rebirth depicting life, with birth, sex, and death as aspects of the same thing." Note in the upper right corner the sphinx with the face divided vertically, in the center the joined face and skull, the skull with the two young girls doubling as the features (inside square), the madonna, and the mummy. The eye and the ear may represent paranoia. In many subsequent pieces, she used snakes to represent danger and predators.

Figure 2 is a birth image. The central figure is Isis as a mother preparing to suckle the infant Horus (Lurker, 1980). The focus is on "ka"—the creative and preserving power of life symbolized by the upraised arms. It is the energy that lives on after death and is passed on through regeneration, providing two ways to prevail after dying. The ankh on the right is the universal sign of life. Isis was worshiped for her magic and her maternal protection of mortal children from the hazards of the world. Chris's desire for a child and a nurturing childhood of her own became most explicit in this drawing.

Figure 3 depicts the goddess of the heavens, Nut, swimming in the sea/sky. As the mother of the solar god Re and lunar god Osiris, she is shown lifting them up as the sun and the moon, presenting them as sources of renewed life for the deceased (Wilkinson, 1994). The floating face beneath the water is Chris's addition, suggesting her feeling of being engulfed by her situation yet surrounded and accompanied by healing potential, perhaps the blissful uterine condition of the original mother. There are such signs that she did not adequately achieve effective separation/individuation from her mother, resulting in a strong regressive pull towards such a symbiotic fusion (Stoller, 1985). Figure 4 illustrates a legend from the Book of the Dead showing the air god Shu separating his daughter, the sky goddess Nut, from his son, the earth god Geb. Shu is assisted by two ram-headed gods representing souls (Lurker, 1980). As a whole it is believed to symbolize both the cosmos and a coffin. There is a tense sexuality in this piece, with an apparent incestuous component. The struggle taking place seems to reflect Chris's efforts to

BEST COPY AVAILABLE

sort things out, to distinguish the elements of her world so it would be organized and sensible. Again, she has included the united duality of the eternal and the mortal and the female and the male.

These are some of the more coherent images that Chris created, with many others that scrambled the traditional relationships of deities. When we discussed her pieces, it was hard to follow her complicated claims about the content, admittedly due, in part, to my limited knowledge of Egyptology but mostly as a consequence of her shifting use of terms and names. These impulsive, disordered expressions were idiomatic of her desperate ways of coping with her overwhelming life situation.

Kevin

Kevin was 26 when he was admitted and remained a resident until he died nearly a year later. He was of mixed ethnicity, primarily Latino and Polynesian, with a slight, graceful build. His appealing interpersonal style was both gentle and sweet, often shy and marked by a refined elegance. In contrast to Chris, he appeared more masculine and was easy to like. However, he stayed on the periphery of the community, expressing a preference for alliances with staff due to the uncertainty of when his peers might die.

While Kevin had never known his father, he often spoke about his mother, whom he seemed to remember as both loving and neglectful. He was deeply attached to and protective of her. His mother reported that as a pregnant teenager she had resolved to give him up for adoption but then changed her mind when she saw "how beautiful he was." This had established for Kevin a basic sense of being precious and captivating, even though his mother abandoned him for long periods. He and his mother cared intensely for each other despite the blurring of roles and her unreliability.

Kevin was newly blind from CMV retinitis, a common opportunistic infection among persons with AIDS. It robbed him of his vision in just a few months. Still just beginning to come to terms with this tremendous loss, he continued for a long time to entertain unrealistic hopes that surgery would reverse this condition. He was very fashion-conscious, and like many other residents, clothing and accessories, especially nonprescription eyeglasses, helped him feel he was participating in life and articulated his keen sense of individual style.

From the start, Kevin expressed a strong desire to keep his lack of vision from interfering with his functioning, following through with mobility training and selectively requesting assistance from others as he needed it. He joined the available activities, struggling to adapt. It was during this period that he decided to create the life-size doll pictured in Figures 5, 6, and 7. While the doll started casually during an art group as an idea for a hand puppet, it quickly grew beyond that sketchy concept into a lengthy individual project. As it evolved, the doll became the primary locus of Kevin's many existential concerns, serving as an effective medium for life review and resolution.

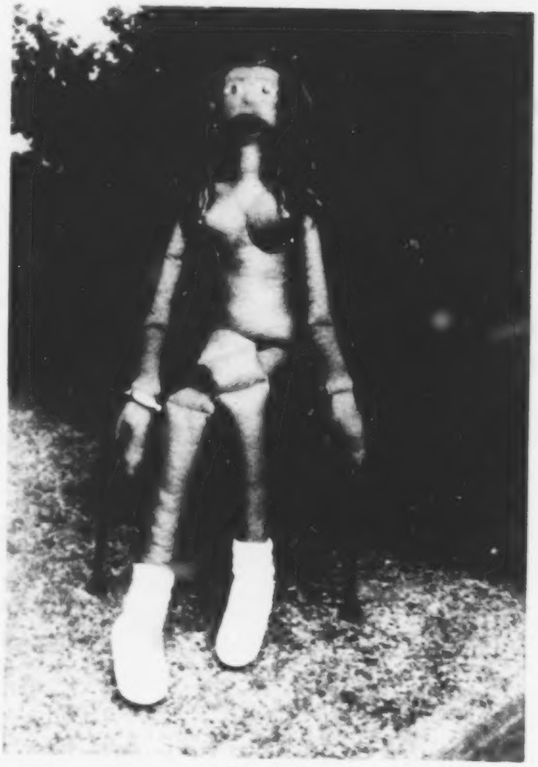


Figure 5

To begin, he selected blue fabric, "like the ocean or the sky." Aside from this poetic reference, this color choice also suggests depersonalization and may indicate an underlying sense of being alien to his world and his body and (forgive the literal cliche) of being "blue" about his life situation. To establish the design and set the basic proportions of the doll, he spontaneously asked me to measure his own limbs, head, and torso. The process involved significant intervals of time because I quickly discovered the therapeutic value of his making every decision about the fine details while I did most of the sewing. I consciously tried to limit my role to functioning as his hands and eyes for practical purposes. He followed each major step of the process with many further adjustments.

The secondary sex characteristics became highly developed, but the genitals remained blank, as if unknown. At one point he considered the addition of pubic hair but never committed to the idea. Instead he focused mostly on the face, breast, and buttocks. The addition of the plastic gemstones began as sequins with the clear intention of attracting attention to "her best features." The mouth was carefully created to meet his requirements of thick sexy lips with pink inside (see Figure 6). Because he insisted on the mouth being able to grasp a cigarette, it seems likely that this orifice functioned as a displaced vagina. He devised the innovation of putting buttonholes on the earlobes in order to be able to easily accessorize various outfits. The holes in Kevin's own ears were torn and frayed, telling evidence of his prior lifestyle.

He wanted the limbs jointed so he could easily bring her into different situations and "so she can pose if she wants." The hands we created by simply tracing his own; by foregoing the articulation of each finger they resembled mittens, reflecting his limited autonomy and dependency needs. He had difficulty choosing how to handle the feet, finally opting to stuff socks and attach them permanently.

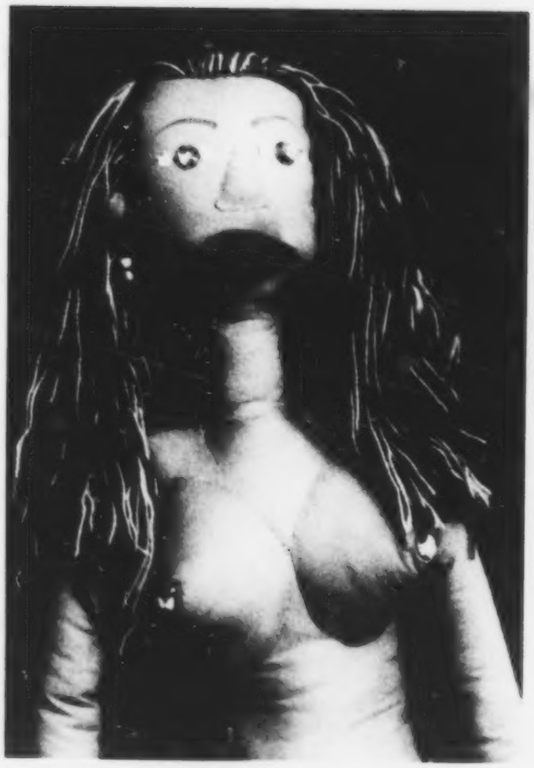


Figure 6

Figure 7

Half in jest, Kevin considered completing the project with the two of us each signing a butt cheek, but he decided instead to create a small birth certificate to mark her official arrival in the world. After much soul-searching he named her "Naomi Vanessa Paula Iman Jackson" because she was "the total babe," with each name taken from a prominent, glamorous black female. He called her "Vanessa" for short. Subsequently, he seldom made public appearances without her, even bringing her with him for routine meals in the dining room and when he traveled throughout the facility. He scheduled his visits to the patio so that he could share her with the children from the facility's developmental disabilities unit and took great satisfaction in hearing their squeals of delight. Otherwise, he kept Vanessa dressed in a sweatsuit in his bed and slept with her nightly. He died with her there at his side, and his mother discussed with me the logistics of transforming the doll into a panel for the Names Project.

Our sessions together also provided Kevin with private opportunities to discuss the various attendant issues, as he illustrated each small step of the creative process with stories from his past. He tended to refer to his female side in the past tense, seeming reluctant to own it, yet reported experiencing his sexuality as female. This discrepancy may have been based on an intense wish for God's acceptance and his renewed Christian faith. His explorations of the scriptures initially produced a crisis as he feared his history placed him "beyond redemption." As with many persons living with AIDS, he was eventually able to focus on divine forgiveness as a source of solace and healing (Winiarski, 1991), supported by a baptism. With his spiritual questions largely answered, he could safely capture and embody his female aspects in a permanent, finite form.

Through all of Kevin's shiftings and soul-searching, Vanessa stayed with him as a constant companion, an unusual kind of consistent, unconditional presence that seemed to give him comfort. She remained neutral as he grappled with all four areas of his sexual self, as defined by this paper's basic terms. One day he would conclude that he was really gay and proud of it, and then the next he longed to "just marry a woman and have a bunch of kids." Sometimes he was a stranger to his body, lamenting that he could never again return to the days of hormones, designer gowns, and drag balls, only later to decide that he was quite content just the way he was.

Perhaps Vanessa also reflected the enduring alliances he established with his many female caregivers, signifying the corrective restitution of his maternal bond. Without a stable, internalized good object, he still found a way to create an externalized surrogate in a reliable compromise solution. Kevin's regrets about not having children of his own were also addressed through Vanessa, as she simulated offspring. She served, additionally, as a novel means of making contact with other actual children. When Kevin took Vanessa to visit the disabled children in the facility, he took on the persona of a father who had thoughtfully arranged a playdate for them to spend time together. Lastly, by having her at his side in his bed day and night, she was always available to address his periodic defensive wish to appear as a straight man with a female lover. This triumverate of child, parent, and partner captured the complexity of his early experiences with his mother.

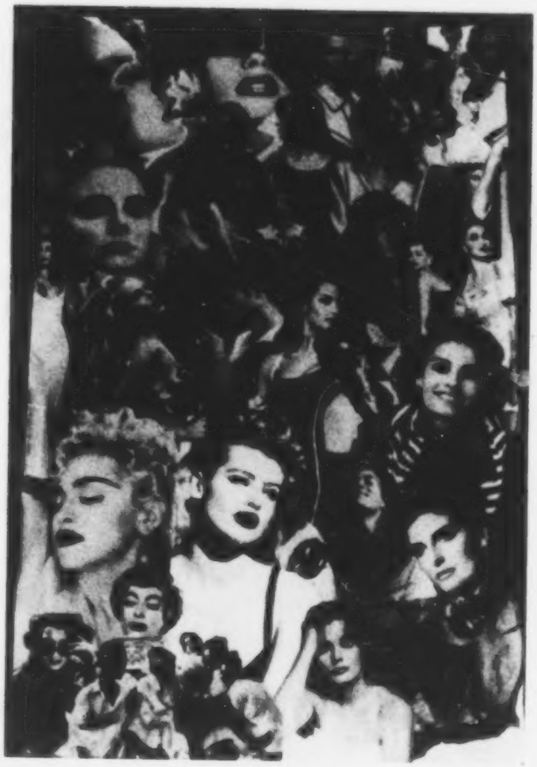


Figure 8

Alternately, in Vanessa Kevin created a physically real version of his ultimate, idealized self—a fantasied body image that transcended both the healthy boy's body he was born with and the infected man's body he was dying with. With needle, thread, and scissors, together we performed a variation of the surgery he never had. Her mature size and "perfect" features pleased his grandiose side. She helped him reclaim the romanticized female lifestyle that he had lost with the onset of his illness. Early in treatment, he brought out scrapbooks he made in prison that were filled with famous women of many races—mostly actresses and supermodels, much like the collage in Figure 8. He knew the sequence of the pages of these books from memory and could describe the composition of each so well that, as I looked at it with him sitting at my side, I had to remind myself that he was no longer sighted. This collection of vivid introjects provided a very rich resource from which his imagination could develop and refine the doll.

By working directly from his basic body type, using fabric, stuffing, and spangles that he modified and enhanced to his own taste, Kevin could again entertain his fondest wish of being a famous star. When we took Vanessa to the patio for a photo shoot at her completion, Kevin continued to make her a self-expression by giving me clear directives about posing her, both clothed and for "tasteful nudes." We even took some playful snapshots of him hamming it up with her for the camera. In the end, by planning to incorporate her into a panel for the AIDS Quilt, he did not want to miss this final opportunity for immortality and fame.

Bobby

Bobby was a 30-year-old African-American male when he was admitted to the facility. He made his presence felt from the moment he first walked onto the unit, joking and chatting with everyone with an easy, loud laugh and robust demeanor. His wildly fluctuating gender identity manifested in sudden marked changes in appearance, voice, and behavior, usually in response to subtle shifts in the social context. One minute he would squeal, whine, and giggle in girlish or infantile tones; the next he would bellow in macho bass tones.

Being hypersexual, Bobby's intrusive behavior included touching, tickling, and pinching both men and women. He tended to wear tight clothes that revealed the residual breasts he had from prior hormone use; a favorite outfit might be hot pants with a T-shirt covered with pairs of pigs explicitly demonstrating a range of sexual positions. (He even eroticized jewelry-making, declaring, "I like anything where things get put into holes.") Such a lack of restraint quickly becomes generalized into the notion of transgenders as immoral (Docter, 1988). Clearly, limits needed to be set on a regular basis to compensate for his poor social judgement and lack of boundaries.

Initially, I was presented with the challenge of integrating Bobby into the activities I provided in the facility. His brazenly unconventional tendencies quickly provoked hostility and fear in his male peers. But as soon as they began to reflexively refer to Bobby as "she" and "her" in the course of conversation, this open acknowledgement seemed to ease tensions. In time, they were able to tolerate, if not accept, his presence, directly setting limits with him in accordance with the modeling done by staff. Since he also could be insulting and demanding, on occasion his inappropriate behavior would escalate to a point where he would need to be ejected from a group.

Bobby was engaged in similar tensions with his family, especially his mother, who communicated a strong desire for Bobby to give up his earlier lifestyle of cross-dressing and behaving as a female. She played on his eagerness to please her as well as his belief in divine judgment, evoking shame and fear of risking rejection by both God and her. In fact, he seemed to have only minimally individuated from his mother, phoning her many times each day to report trivial events in appeals for her approval. His ongoing identity crisis and overall anxiety seemed rooted in his arrested relationship with her and her highly conditional reaction to his gender confusion. In fact, after much initial resistance to consider using art materials, his first breakthrough happened as Mother's Day approached and he decided to make a distinctly masculine picture to give to his mother (Figure 9). Initially, his frequent use of the heart and cross in his work seemed vital to his internal conflicts. Much later, when Figure 10 was created, he had become more spontaneous in his productions and able to reveal his truer transgender self with the inclusion of small breasts.

Unable to relinquish his sense of himself as "a woman born into the wrong body cuz I got a little extra something down there," Bobby carried around a photo of himself as "Janice," his former female street identity. Figure 11 was one of his most prized images, and he related to the face as one in which he could see himself. The conspicuous absence of a similarly well-defined body strongly suggests his lack of readiness regarding his

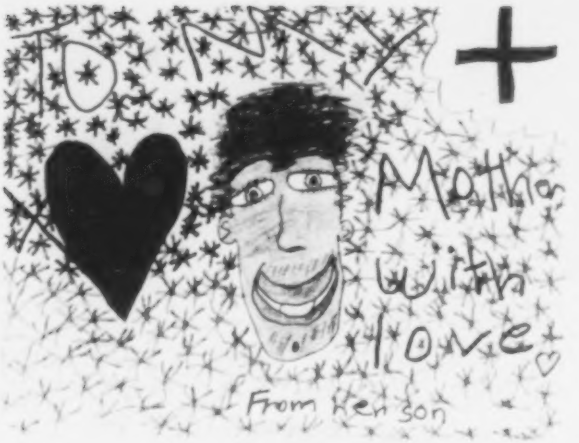


Figure 9

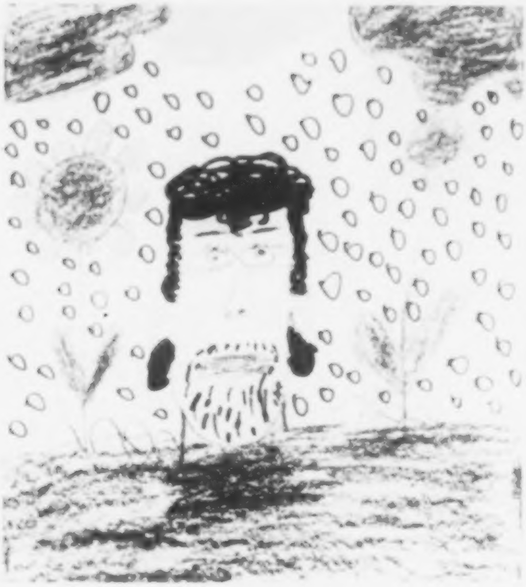


Figure 10

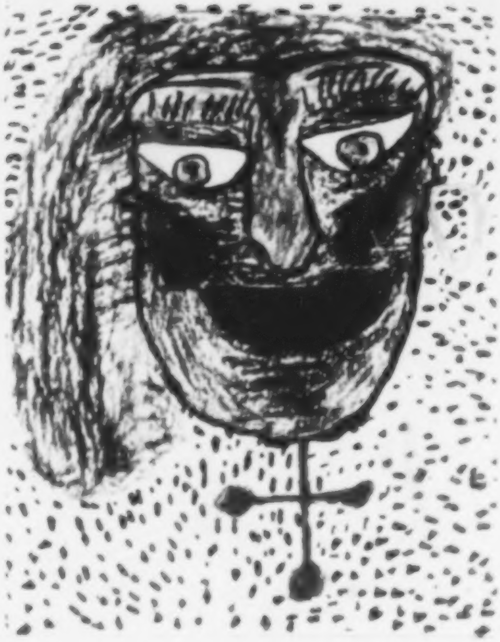


Figure 11

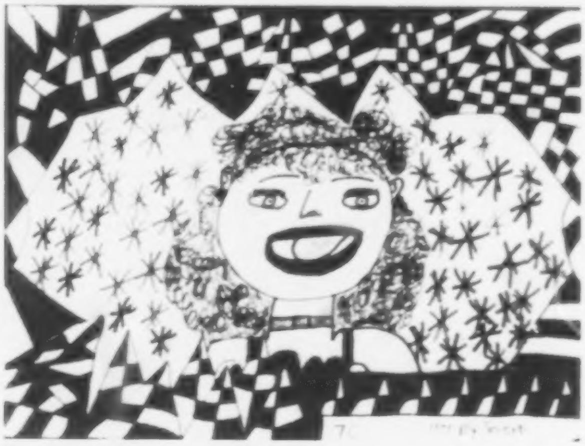


Figure 12

physical condition. He battled with a desire to paint his fingernails and wear lipstick; Halloween was the one time each year he allowed himself to indulge in full make-up and hairstyling, demonstrating expertise by creating a very attractive female appearance. When a volunteer gave him a Barbie doll, he made a wardrobe for her, engaging his repressed inclination to cross-dress. Figure 12 is a typical picture of Bobby's, full of bright colors and shapes and a central female. His humor was often organized around his transgenderism, excusing himself to go to the ladies room and saying "Let your wife do it for you" when offering others his generous assistance. He enjoyed dancing while singing his favorite song "I'm Every Woman."

Bobby maintained that a seizure disorder was the reason for his admission and only occasionally admitted he was HIV-positive, insisting "But it's not the bad kind because I'm not skinny." In fact, he was overweight, carrying most of it in his belly. He would hold his belly as if he were pregnant, joking with other men, both staff and peers, about them being its father. He would speculate about the due date and decided to name the baby Janice. Once, he inflated a rubber glove, stuffed it under his shirt, and began parading around the room. This fantasy could take on delusional proportions, with him stating that he had the internal reproductive organs of a woman and that he could be inseminated through anal sex. He would often refer to his daily medications as birth control pills.

Despite the persistent strains in his life, Bobby could usually find consolation in his Christian beliefs and was very vocal about his gratitude for the positive, pleasing things in his life. He wore a large cross around his neck, taking comfort in his belief that God would "get it right the next time" by reincarnating him as a woman. When he spoke, he often seemed to be testifying to God, commenting on the warmth of sunlight, the colors of an evening sky and especially the support he got from others.

Bobby's artwork usually served him well socially, easing his adjustment to placement and providing a medium for exploring interpersonal distance. His prolific tendencies became controversial, however, since he soon covered the walls of the dining room with nearly 100 drawings. Eventually he was persuaded to transfer most of them to his own room where their number quickly doubled. Due to his profound need to feel liked, Bobby actively strived to accommodate the terms of his new environment. He was still in the facility when I resigned my position, having fully established himself as a vital, central member of the community and creating pictures on a daily basis.

While Bobby easily met the criteria for "full-blown"status for admission, his seropositivity was recent news to him. It was rare to see his denial fluctuate openly, and most of his artwork reflected a highly defended individual. Typically, the main elements of his images are surrounded by a pattern of forms, either fractured geometrics, dots, or asterisks. These alternately seem to protect and impinge. Some figures appear to be boxed in by them. They generally appear to help maintain control and bind anxiety, much as Bobby's staticky chatter filled the air, suggesting a damaged, impulse-disordered self.

Figure 13 is a clear sign of Bobby's internal and external crises. In addition to the customary field of shapes, its unusual content reveals an acute awareness of his situation in the midst of his web of illusion. It communicates his feeling of being trapped in his reality, depicting his self as a solitary, poisonous, black widow spider. The idea of an HIV-positive person's bodily fluids being dangerous is explicit here. Also, according to Cirlot (1971), the spider is a primeval female symbol of destiny as it weaves the thread of each person's life, simultaneously building and destroying it. This image may represent the impinging web of his mother's femininity from which he cannot seem to separate and individuate; he may feel irreparably infected by femininity as well as the virus (Stoller, 1985).

Figure 14 is a very different expression of Bobby's sense of his mortality. He was unable to see the blatant content of the image, yet it quite plainly depicts a baffled looking man apparently alive but buried up to his neck in the earth. Remarkably, he appears to be "pushing up daisies," as the clouds provide rain to nourish this troubling garden. The flowers that accompany him are analogous to his own existence in their transitory bloom and decay. They also seem to represent Bobby's efforts to stay hopeful amidst his circumstances and his intensified drive to enjoy life. Figure 15 was a preliminary sketch that Bobby promptly rejected, most probably due to its frightened expression and skeletal quality, as it graphically captures the gaunt appearance of persons with wasting syndrome in end-stage AIDS. Simply, it was too much for him to bear.

Conclusion

What can be learned from these clients? First, the nature of transgenderism and an AIDS diagnosis are inextricably linked. These two monumental challenges involve pronounced stigma, disapproval and marginalization, multiple losses and dilemmas, and an air of secrecy; both involve radical changes and feeling deeply misunderstood and beyond compassion. They also involve a globally disturbed body image and an overwhelming wish to repair it.

Due to their transgenderism, these clients were already familiar with being at odds with others and themselves, having endured a life-long incompatibility of mind and body (Doorn et

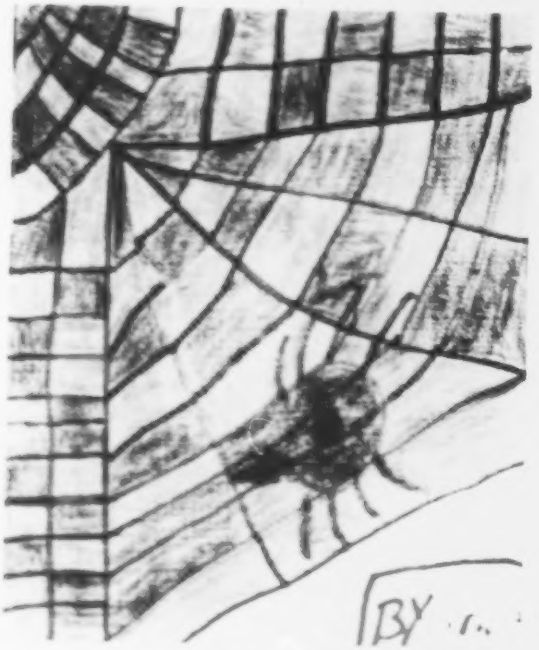


Figure 13

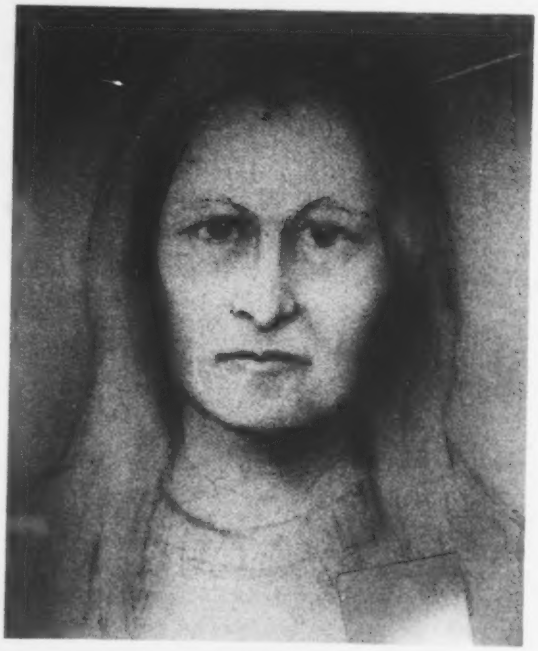


Figure 14

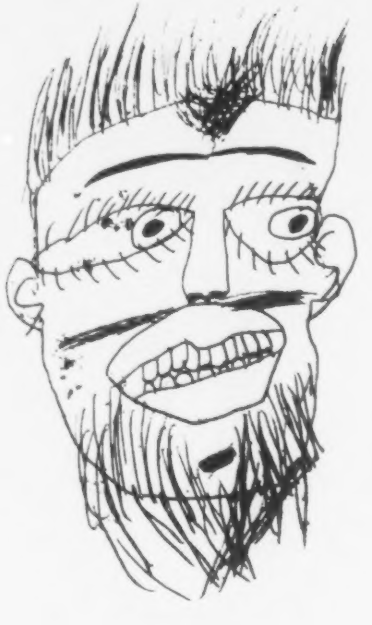


Figure 15

al., 1994). The advancing virus then reinforced this unstable position. In fact, perhaps it was their long-standing gender confusion, albeit pathology, that helped prepare them for the ruptures they were presented with by the AIDS diagnosis. In a sense, they were veterans of the altered self; this uneasy orientation may have fortified them in the face of further uncertainty and adversity. In an often depressing atmosphere, they had a rare capacity for courage and levity. Their history of experimenting with identities and boldly opposing societal beliefs about sex and gender produced a remarkably mercurial sense of the world and strong spiritual faith (Kando, 1994). This uncommon perspective even allowed them to consider ways of transcending mortality and re-creating themselves in harmonious, fantasied forms.

By imposing a terminal dimension, the AIDS diagnosis exacerbated their existing issues with a keen sense of time running out. Awareness of their poor prognosis and the lost chance of "corrective" surgery heightened an already established drive to answer the original and now urgent question—"Who and what am I really?"

Art therapy provided each client with a responsive means to create images in which he could formulate a more accurate self and introduce that self to others. It mobilized and energized these clients by offering an accessible outlet for their troubles, a means of projecting cherished dreams and reclaiming the past, particularly in regard to their physical beings. It accommodated their complicated lives, including all the contradictions, and provided consolation (Piccirillo, 1995). These clients often waxed nostalgic when they discussed their artwork, actively grieving forfeited or otherwise repressed aspects of themselves. In the most essential way, art therapy validated their existence with all its permutations.

Art, like the body, is the self made physical. With its promise of cathected transformation, art took on an especially powerful significance for these individuals who desired so much real change. The use of art materials was conducive to shaping and mastering one's private and public image by experimenting with alternative identities. It is not surprising that a wide assortment of people fill their artwork. Art offered a liberating opportunity to define a distinctive whole self—to say, "This is who I am" while getting support from others.

For these clients, art served their social adjustment. Its visibility spoke to their narcissism, to their grandiose wish for special attention and approval, and to their need to feel insulated. They all found ways to make it attractive, to make it resonate, and to maximize its effect on others. Art allowed them to celebrate and reinforce being different, even flamboyant, yet enabled them to fit in, possibly for the first time in their lives. The prevalence of oral elements describes their need to feel emotionally fed, their receptive sexual appetites, and their preoccupations with procreative potential.

All three used their pieces to communicate with the rest of the community, to articulate themselves, and to create a sense of connection. This triumph over isolation was quite an accomplishment, considering their extensive experience with ostracism and discrimination. With all the other stressors they were facing, placement in a long-term care setting brought with it a certain imperative for them to try to find a way to adapt to mainstream society—outsiders returning to the fold. By emphasizing their strengths and affirming diversity, art therapy supported them in this process toward actualization and integration. Their finished pieces, as convincing demonstrations of mastery, earned them quick respect and favorable feedback.

The content of these clients' art challenged the heterogeneous community of the facility, surprising it with refreshing, spirited expressions through the accessible vocabulary of images. Understanding became an appealing possibility, with even the skeptics discovering familiar elements in the artwork as it provided a safe opportunity to take a moment to get better acquainted. The perplexing, and for some repulsive, ambiguity of being transgender became less threatening as the personal took hold.

Moreover, the clients' artwork facilitated recognition of them as members of humanity, assuring staff and the other residents with AIDS of the universal desire to be known and accepted simply as a person, however unconventional. With the stark proximity of death, they bravely modeled exploration and disclosure. Profiting from their motivation and risks, they sent a vital reminder about survival to many around them—that suffering enables growth when you live fully in the moment, and that even in the tightest trap there is always space to move.

Editor's Note: Emily Piccirillo was the former Director of Activities at Broadway House for Continuing Care in Newark, New Jersey, a 60-bed special care facility for adults living with AIDS. She recently relocated to the Washington, D.C. area.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders IV*. Washington, DC: Author.

Cirlot, J. E. (1971). *A dictionary of symbols*. New York: Philosophical Library.

BEST COPY AVAILABLE

Docter, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior.* New York: Plenum Press.

Doorne, C. D., Poortinga, J., & Verschoor, A. M. (1994). Cross-gender identity in transvestites and male transsexuals. *Archives of Sexual Behavior, 23*(2), 185–201.

Kando, T. (1973). *Sex Change: The achievement of gender identity among feminized transsexuals.* Springfield, IL: Charles C Thomas.

Lurker, M. (1980). *An illustrated dictionary of the gods and symbols of ancient Egypt.* New York: Thames and Hudson.

Money, J. (1988). *Gay, straight, and in-between: The sexology of erotic orientation.* New York: Oxford University Press.

Piccirillo, E. (1995). Taking inventory in the age of AIDS. *Art Therapy: Journal of the American Art Therapy Association, 12*(1), 62–66.

Sbordone, A. (1994). *Transgenderism: Social and psychological issues in the treatment of HIV/AIDS, a case study.* Paper presented at the 16th National Lesbian and Gay Health Conference and 12th Annual HIV/AIDS Forum, New York.

Stoller, R. J. (1985). *Presentations of gender.* New Haven, CT: Yale University Press.

Wilkinson, R. (1994). *Symbol and magic in Egyptian art.* New York: Thames and Hudson.

Winiarski, M. G. (1991). *AIDS-related psychotherapy.* New York: Pergamon Press.

LESLEY COLLEGE

Master of Arts in Expressive Therapies

A unique program designed for women and men eager to advance professionally and create change in people's lives.

- Integrate the modalities of dance, drama, literature, music, poetry and visual arts with the practice of psychotherapy
- Combine experiential and creative learning with applied clinical practice and artistic work.
- Specialize in Art Therapy – learn comprehensive skills in the therapeutic use of the visual arts.

Call 617/349-8425 or 800/999-1959 x. 8425 for more information.

LESLEY COLLEGE Office of Graduate Admissions
29 Everett Street, Cambridge, Massachusetts 02138-2790

LESLEY

Art Therapy: Journal of the American Art Therapy Association, 13(1) pp. 47-53 © AATA, Inc. 1996

Gender Dysphoria: The Therapist's Dilemma—The Client's Choice. Discovery and Resolution Through Art Therapy

Hannah Sherebrin, RN, A.T.R., London, Ontario, Canada

Abstract

The therapist's role and the dilemmas faced in treating a gender dysphoric client are discussed. Ethical and moral issues relating to transsexualism are examined from both a general and Jewish perspective. Art therapy is discussed as an appropriate treatment choice for a transsexual client. Ms. S., the client, describes how the process worked in her particular case. The author aims to shed some light and generate discussion about gender issues faced by both therapist and client.

Introduction

In his comprehensive review article, Pauly (1990) suggests that the term *transsexualism* was coined by Cauldwell (1949), an American sexologist, and popularized by the work of Harry Benjamin (1953, 1966). In the *Standards of Care* manual (Walker et al., 1979, revised and reprinted 1985), which established the standards of care still used today, gender dysphoria is defined as: "That psychological state whereby a person demonstrates dissatisfaction with their sex of birth and the role, as socially defined, which applies to that sex (of birth), and who requests hormonal and surgical sex-reassignment" (p. 79).

The differential diagnosis of Gender Dysphoria or Transsexualism is complicated by the lack of pathognomic laboratory findings or a specialized test. While Gender Dysphoria may exist as part of the pathology of certain psychiatric conditions (Levine & Lothstein, 1981; Lukianowicz, 1959), Transsexualism is no longer accepted as a diagnostic term in the DSM-IV (1994). A male or female who presents "discomfort and inappropriateness about one's assigned sex; and persistent preoccupation for at least two years with getting rid of one's primary and secondary sex characteristics and acquiring the sex characteristics of the other sex" (DSM-III-R, 1987, p. 76), is now diagnosed with Gender Identity Disorder, which is placed in the "Sexual and Gender Identity Disorders" section (pp. 532–538). While the actual criteria for diagnosis did not change much, statements such as "generally there is a moderate to severe coexisting personality disturbance" (p. 74) which tended to stigmatize the condition have been eliminated in the DSM-IV (1994).

While some studies in the past (Murray, 1985; Roberto, 1983; Verschoor & Portriga, 1988) supported the old definition of transsexualism as pathological, others like Fleming, Costos, and MacGowan (1984) found no differences in ego development between nonclinical and transsexual subjects. Lothstein (1984) further questioned the pathological findings, suggesting that the emergence of pathology in transsexual samples is correlated to the type of assessment instrument employed.

Since many of the researchers used "self report" instruments, Brems, Adams, and Skillman (1993) decided to change the testing instrument and used the Draw-A-Person test as a primary assessment tool with 247 subjects. They concluded that "overall, transsexual subjects differ significantly from psychiatric subjects, non-client subjects, men, and women, whereas these groups do not differ significantly from one another" (p. 262). They further state that transsexuals are not clearly identifiable as a psychiatric group. That does not mean, however, that as individuals within the group, they are totally free of any psychopathology. Overall, it was noted that the transsexual group produced higher quality drawings than the psychiatric group or the nonclient, male and female groups. The criteria for judging the "quality" of drawings was not discussed in the paper; therefore, it might not be wise to attach too much significance to this finding. Brems et al. (1993) also observed that the transsexual group, while not being significantly different from other populations with regard to sex-role stereotypes and definitions, "appears to endorse femininity for women to a much larger degree than other individuals." The authors do not clarify what features they consider "feminine," but from looking at examples, it seems that stereotypical depictions of softer features, developed breasts, long hair, hourglass body shape, and so forth, are considered to be more feminine. In Figure 1 you can see how Ms. S. drew the person of "self" even before total identification with being a transsexual as a "feminine" individual according to that definition. She also saw that drawing as feminine in later discussions.

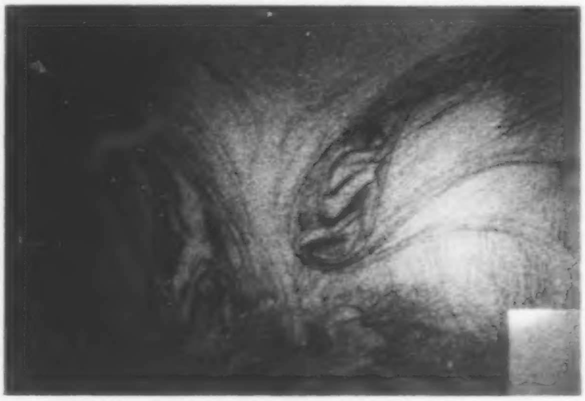


Figure 1

The Therapist's Role

When discussing the role which a therapist should ideally play in the evaluation and treatment of transsexual clients, Pauly (1990) stresses the importance of adopting a neutral position and clarifies this by stating that "the therapist be neither advocate nor detractor. The therapist should offer support, attempt to work through issues, but not be prematurely invested in determining in favor of or against proceeding with SRS (sex reassignment surgery)" (p. 15). It is perhaps this same sentiment that led Ebner (1980) to suggest that the transsexual patient is often avoided in psychotherapy because s/he is perceived as endangering the therapist's own emotional equilibrium by stirring up too much psychic pain in the therapist. Therefore, it is not surprising that once it became clear that Ms. S. wanted to explore transsexual feelings, I had to work through my own feelings and biases before deciding to continue seeing Ms. S. as a client.

Therapists entering into any therapeutic relationship bring with them a system of belief, "*weltanschauung*," consisting of theoretical orientation, concepts of mental health, and personal experiences steeped in cultural background as well as moral and religious values. In addition, Brown (1990) comments that countertransference issues "are noted to be particularly relevant in the care of gender dysphoric individuals" (p. 57).

The theoretical viewpoint I employ is holistic, client-centered, and based on a team approach. The therapist's role is to be the catalyst and facilitator enabling the client to reach a resolution. It is the role of the client, however, to determine the therapeutic goals. My respect for the client as a person and of the artwork as a shared intimacy is the base for my conviction that every client actually knows what s/he needs in order to be at peace within her/his chosen way of life. The therapist's task is to facilitate the client's recognition of her/his own issues through visual communication and to help resolve those issues through building on the individual's strengths.

The formed art is not there for the therapist's benefit or interpretation; rather, it is primarily a means of communication between the client and her/his own self. I see the relationship as a triangular one, between client and therapist, client and art, art and therapist, therapist and client. Theoretically, therefore, a Gender Dysphoric client poses the same challenges as any other client.

Being in touch with one's creativity plays a pivotal role in my concept of wellness and metal health. Creativity expressed in a variety of ways exhibits flexibility and, therefore, an ability to adjust to new situations. Within this view it is not just the *image* itself, but the actual act of creation, the process, and the use of materials within the process which enable change to occur. The product is the object engaging the client and being altered and embellished, simulating life. Thomson (1989) advocates encouraging experimentation and involvement with the process of art-making. "One must put over the point that everything is permissible, everything which the picture calls for. Every instinctive prompting in regard to the work should be followed. This is always a response to the work as it progresses and must not be confused with 'Express your feelings!' which elicits a conscious, one track, and often cramped endeavor. If flexibility is a measure of health, it is just this two way traffic between impulse and consideration (between the primary and secondary process) that is health-giving" (p. 63).

When a person loses touch with creativity, that person's mental health suffers. That person becomes rigid, afraid of change, and uses defense mechanisms which may no longer protect, in fact may indeed be harmful. Yet often that person is afraid to or unable to take chances, make choices, or even see that there are choices available. Art therapy, therefore, can be seen as a suitable modality for working with clients manifesting Gender Dysphoria, allowing exploration and ability to look at a variety of possible solutions. Indeed that was the case of the client described in this paper, who was engaged at one time in producing and teaching art as a livelihood; for this client, art therapy was of particular relevance.

One more obstacle had to be explored: personal experiences steeped in cultural background as well as moral and religious values. My experiences start in war-torn Europe, as a Jewish child surviving the Holocaust. My formative years were spent in Israel, integrating losses and believing in the individual's right to freedom. Personal choices must take into consideration the right of others to the same freedoms. These principles can not be violated. Could I, then, deny Ms. S. a freedom of choice? No, providing I can impart the importance of the principle of responsibility for the consequences of that choice and am willing to facilitate the process of exploration and countertransference.

The religious values are a somewhat more difficult issue. As a practicing Jew, I am bound by *Halakah*, The Way or The Jewish Law, which originates in the statutory Torah of Moses. Orthodox Jews believe that other details were spelled out and transmitted through oral law right down to the present. Moses Maimonides (1135–1204) in his monumental work, *Mishne Torah*, which is still used as a guide in judging current issues in Jewish law, discusses castration in the Book of Holiness.[1] In chapter 16, paragraph 10, it states: "It is forbidden to damage reproductive organs, whether of humans, animals or fowl.... The law that is arrived at thus states: No Jew should do thus whether on his or her own body or on other's body. Any one who castrates is liable to be whipped by *Torah Law* anywhere. Even the one who castrates after a castration was already performed is liable to be whipped" (pp. 104–105).

In the paragraphs which follow this quotation, Maimonides continues to elaborate in detail on various pertinent cases. He concludes that even helping a person to achieve a castration is considered undesirable, though there is not the same stringency of punishment attached as there is for castration itself.

In light of the seriousness of this viewpoint, I have to clarify that Judaism does not impose strictures of *halacha* on non-Jews. A client has the right to a different set of values and religious beliefs, and a therapist should have no problem accepting those. However, in order to adhere to my values for myself, as a supporter, I had to set clear boundaries. I would remain "neutral" in the way Pauly (1990) recommends and have no part in the final decision whether to proceed with the sex reassignment surgery. I would aid Ms. S. in exploring options, refer her to appropriate professionals for assessment and treatment, and remain available to her, offering support and attempting to aid by facilitating working through the issues.

---

[1] The original manuscript was written in Arabic and completed in 1194. The translation in this article is the author's. The version used by the author is a traditional Hebrew language translation published in 1987.

Brief Case History

In the course of therapy, a female client expressed concern and dismay about the behavior of her then husband and father of their three-year-old daughter. She proceeded to describe cross-dressing behaviors, as well as periods of total body hair removal by her spouse. These behaviors, though not totally unfamiliar to her, have become increasingly repulsive, and she was concerned about their effect on their young daughter.

The client expressed a desire to have a family therapy session to explore relationship issues. At this stage there was no clear indication of what the real issues were. As I found out later, there may have been early indicators, but those were suppressed. The manifested purpose of therapy for both the husband and wife was a desire for personal healing and growth in order to facilitate the continuation of a relationship within an intact family unit. Our long-established trust within the therapeutic relationship left the wife confident that she would like to continue in her own individual therapy, while encouraging her husband to pursue his. When the husband (Ms. S.) expressed a desire to work with me as well, we all needed to reconsider our stand. Consulting with colleagues and the parties involved, we arrived at a rather unorthodox decision. I would continue to see both as separate, individual clients, with joint family sessions on a regular basis to assess material that was pertinent to the family unit. The daughter was provided with an art therapist specializing in child development.

In the province of Ontario, Canada, only regulated health professionals are permitted to actually render diagnosis. Since art therapy does not at present fall into this category, *diagnosis* is a forbidden word in the vocabulary of the art therapist. Yet, we all come across situations in which the art and the interpretation of it by the client raise the therapist's suspicion of what the manifested problem entails. The therapist is certainly not qualified to render a diagnosis but is obligated to refer the client to a professional who is qualified to do so. I have followed this route by referring Ms. S. to a medical professional who specializes in sexual and gender disorders. Ms. S. was then referred to an institute in Toronto which is authorized to assess and recommend cases for sex reassignment surgery. When the assessment revealed that indeed the person had Gender Dysphoria, the institute suggested that Ms. S. continue to work with me and the institute as a team. At this point we had to reassess the situation and it became clear that the couple would have to go their separate ways. While Ms. S. started medical treatments with the sexual disorder specialist, I was able to support the wife through a separation process. At this point, the wife was able to terminate her therapy with me, leaving me free to resume therapy with Ms. S. in conjunction with the institute and the medical professional who oversaw the hormonal treatment.

In order to familiarize the reader with Ms. S. and what the process of art therapy meant to her, I have asked that she share her experiences through her own writing.

The Voice of Ms. S.

As I lay in my crib, my mother's youthful, pretty face and beautiful, long, dark hair were one of my earliest memories, together with my happy acceptance that one day I would grow up to be as pretty as she was. Playing "house" with the neighbor girls, skipping, and dolls were enjoyable pursuits during my childhood. As I entered puberty, I anxiously awaited my breasts to develop, but by age 14, I reluctantly realized that damned reflection in the mirror was to be my lot in life: My breasts did not develop; I began growing facial and body hair; my beautiful choir voice disintegrated; and my penis was unlikely to be magically transformed into a vagina. I was stuck in this male body and somehow would have to cope. It wasn't that I didn't realize I appeared physically like a boy—the hateful "brush cut" bore enough evidence for that, but the fact was I didn't feel like a boy, nor did I enjoy doing boy things like playing war, cowboys, sports, and the like. I wanted long hair, makeup, dresses, girlfriends to confide in, and to be asked out on a date by a boy.

My career explorations were revealing: I would become a minister within my religion, but found too many inconsistencies, too much hypocrisy and intolerance to continue. Philosophy had to be a better path for me—surely the pursuit of wisdom should be able to help—yet truth had little relevance amid the carefully constructed arguments and cold, unfeeling reason. What of psychology? Here, the study of the mind and its hidden recesses held great promise and would surely contain some answers to life. Alas, at the time I pursued my studies at university, psychology had a severe inferiority complex towards the "legitimate" sciences. I moved on towards a larger viewpoint: sociology with its overall perspective and comparative cross-cultural analysis would surely.... Floundering through too many statistics and theorizing for my intuitive, emotional self, I began to search for a new discipline.

Art. In art, I found the union of all aspects of human existence: feelings, thoughts, myths and religions, psychology, sociology, philosphy, the sciences. All were amalgamated into a unified conception, and artists were individuals who were free from any particular dogmatic constraints associated with each separate discipline—free to probe into existence, life, and its reasons.

At this time, I had so suppressed being a woman. Thinking I had to live as a male, I did not realize what becoming an artist would reveal, and I remained blind to the obvious messages in the imagery that poured forth from my hands. Willfully blind, for if I admitted the messages how could I change my body into my proper gender? I was, unfortunately, unaware that gender institutes were in fact being set up in Canada around this time.

So, I became a professional sculptor specializing in nude figures. My first major work was an over life-size figure called "The Nightmare" completed as a graduating piece from university. It had two fronts and faces joined together where the backs should have been; one figure was sleeping but the other writhed in a paroxysm of agony. A fitting portrayal of my dilemma.

Countless other sculptures followed dividing themselves into key themes—as though the images would continue to surface and resurface, each time in slightly different form, until at last I grasped what they were saying so eloquently to me: images like "Truth" (Figure 2)—a beautiful woman emerging upwards, yet part of her still caught, immersed in a mire. "Spring and Autumn" (Figure 3) were a pair of bronzes: "Spring" was a woman holding a flowering rose and rising from a crouched position while "Autumn" was a male with eyes closed holding a withered stick and sinking downwards.

I married, changed my career, and we eventually had a child. It wasn't until I went to an art therapist to help support my

Figure 2

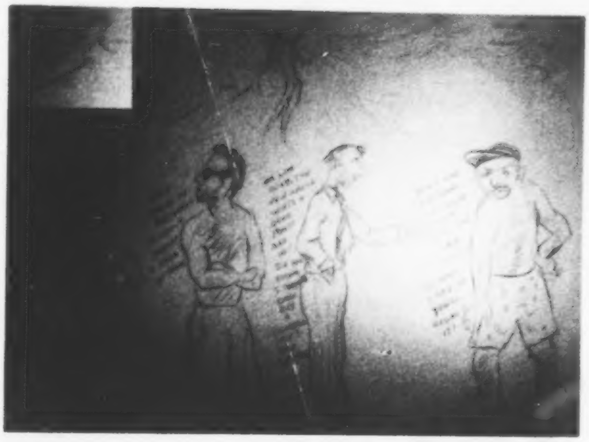


Figure 4

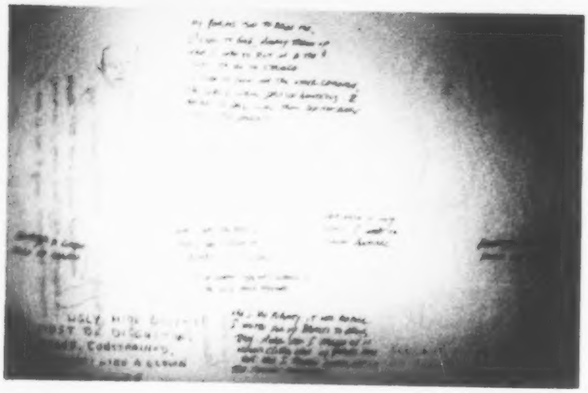


Figure 5

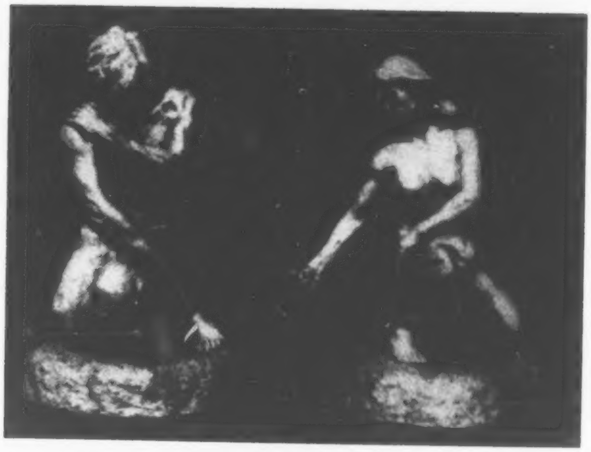


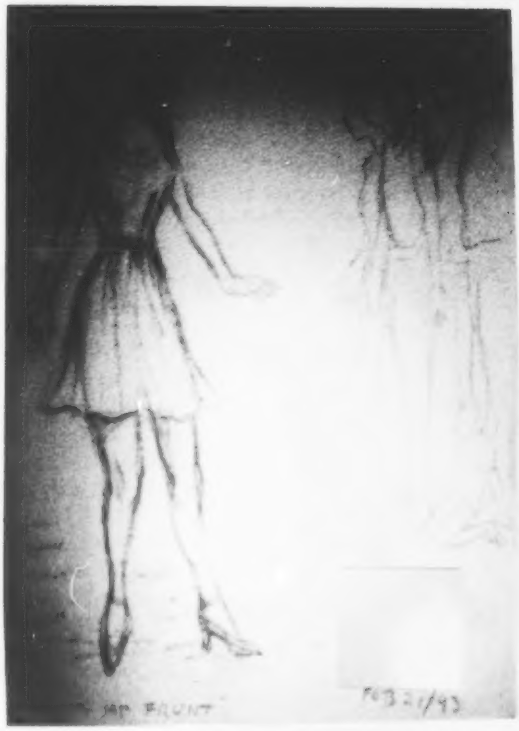
Figure 3

wife during her recovery as an incest survivor that everything came together. I found, like my wife, I had memories, too, but not relating to incest. Mine focused totally on being in the wrong gendered body. The memories and feelings flooded onto the pages during the art therapy sessions—images of the woman I knew I was, still trapped inside this male body and longing to achieve my rightful female form (Figures 4 & 5) and images of my life as a woman finally free to experience the proper social responses to my feminine sex (Figure 6). I moved quickly through the process with my art therapist as an invaluable, objective person—a sort of unrepressible conscience who pointed out unfailingly what my art was trying so courageously all these years to show me, and it showed far more than merely a woman in a male body. It showed a person of great sadness who was frustrated, in anguish, and sinking rapidly into a premature aging and almost lifeless hopelessness as a male.

Inside, I was not that way at all and could no longer condone trying to accept this accident of birth, this hell I was in, nor could I continue trying to live my life for others. I made the decision to embrace my life and vitality and the unknown, and within 5 months I had begun female hormones; within another 3 months I had begun living and working as a woman in accordance with the guidelines for transsexuals from the gender institute.

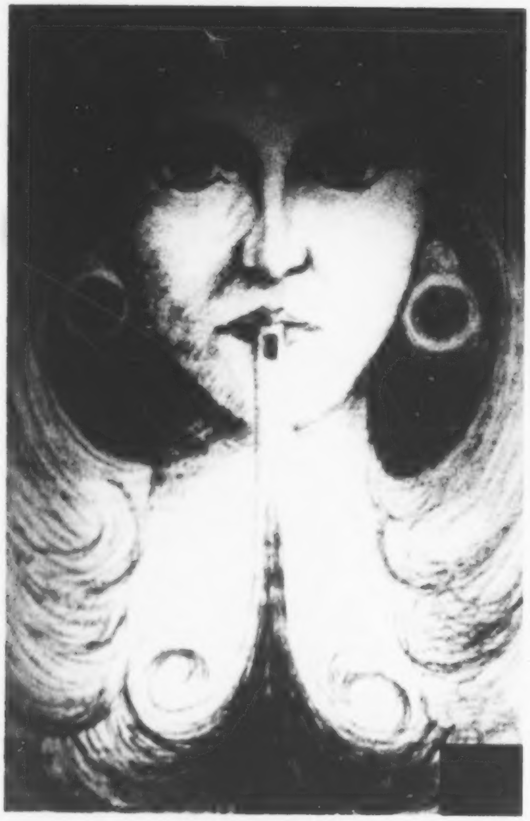
The realization of what I had to do was solved and acted upon. My inner anger and sad feelings were gone, and I experienced a new feeling—a sense of peace for the first time (Figures 7–10). But a host of new feelings and difficulties arose. This process was not over by any means yet, I was beginning to discover!

I had to come to terms with my feelings of regret—of not having acted upon my knowledge much earlier in my life, and the sense of wasted years, wasted decades, now that I knew a sex



[redacted]

Figure 6



[redacted]

Figure 7

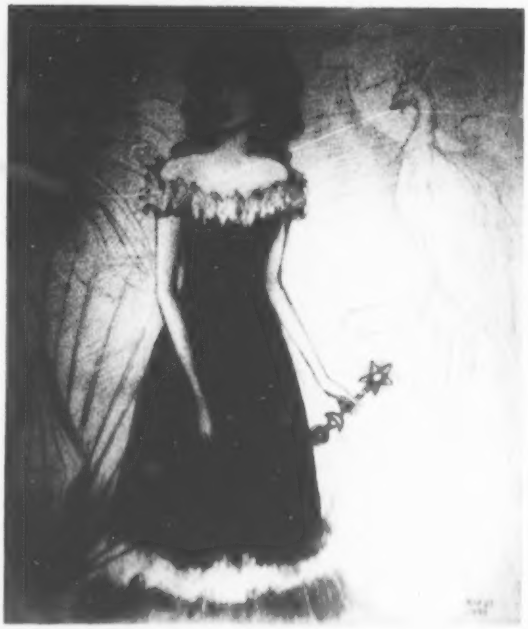


Figure 8

change was indeed possible. A panic arose, a feeling of pressure to move quickly, oh so quickly to recapture those lost years, to make the transition not "yesterday" but much faster than that. Fortunately, everything came beautifully together for me—like being on the right path for the first time: several surgeries, the seemingly endless process of electrolysis, the money to pay for these enormous costs, the support of my employer, the loving support of friends.

Other questions came forward necessitating answers and art therapy provided the means to allow my deep inner self to reassure and answer them to my consciousness. "How to build a whole new life?" "How to make a network of friends, as a person only part way through transition?" "How to cope with those who knew me before? with rejection at times? with family and their diverse reactions ranging from militant disapproval to tentative acceptance?" "How to handle gender discrimination in the workplace from some individuals? or from those involved in the legal process towards resolution of custody and access issues on the way to divorce?" Amazingly, even a scribble would help clarify issues and solutions that were possible, as well as indicate those instances where the problem lay with others and their need to come to terms with it, in themselves. Surprisingly, art therapy could bypass emotional upsets surrounding issues and help put everything in perspective. Despite the emotionalism conceived as being intrinsic to artwork, art can be penetratingly lucid and cooly detached when needed.

One day I leafed through my portfolio of sculptural works and examined my private drawing journals. Every image became crystal clear. I could suddenly understand what had taken 18 years to sink in—and without the use of art therapy, it may well

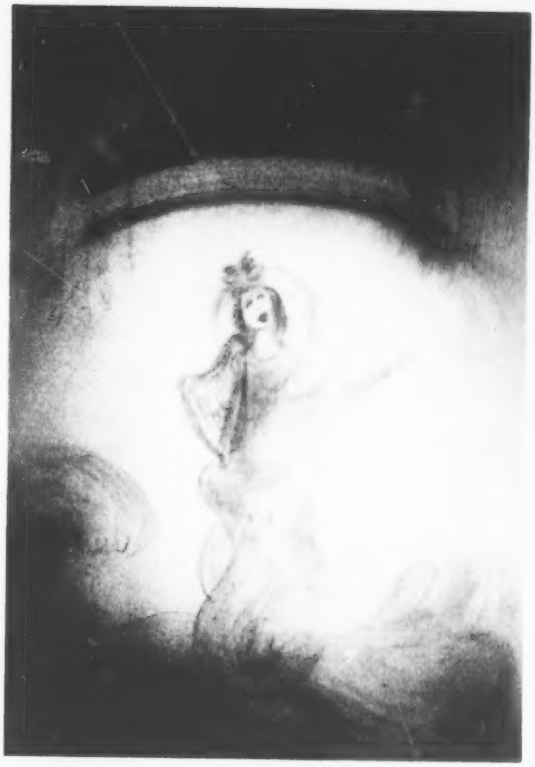


Figure 9

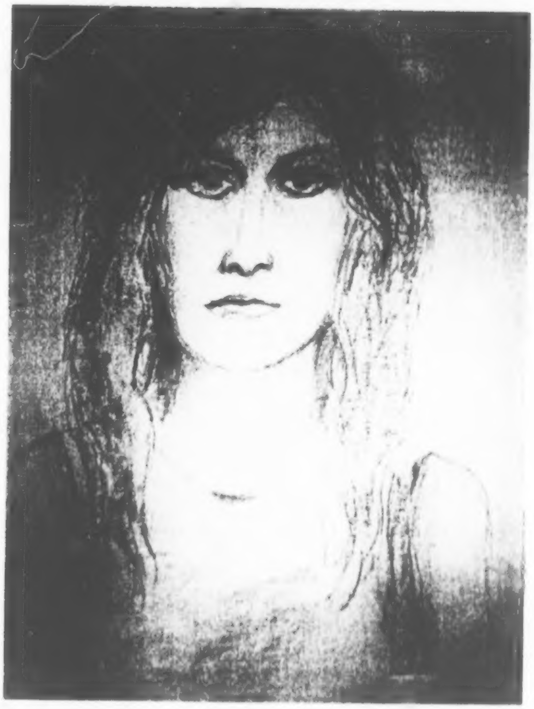


Figure 10

have taken many more! I understood the visual language I had used to communicate with myself. It is true that 18 years of artwork is a long time, yet I do not regret the time taken to explore whether I could in some way live in harmony and at peace with myself in the body I had been born with. I now know beyond a shadow of a doubt what my real gender is, my simple basic need to have a body in harmony with my inner gender (i.e., physical and psychological harmony), and the peace and inner fulfillment that arise from such a state (Figures 9 & 10).

Ironically, despite having been a professional artist and having always created art, even while involved in a different career, I now feel no need whatsoever to do art on my own, and so I don't. Could it be that painting and sculpting was, for me, solely the means of communication between my subconscious and consciousness? Could it be that art was used for years in the manner of self-revelation and now it sits, dormant, waiting to be utilized in a different capacity as a means of communication to others? Be all this as it may, my chisels and pastels lie silent, but there is an incredible music now within my every waking moment.

Epilogue and Conclusions

The divorce is now final. The custody issues are still not resolved. While both parents desperately want the best for their child, they differ in how to achieve this goal. The mother takes the position that she should have sole custody, with limited contact, preferably supervised. Obviously, this is a painful matter for Ms. S., who would like to have an active part in the daughter's life. There are no objective studies to suggest what is least traumatic: loss of contact with a loved and loving parent, or maintaining a close relationship with a parent who changed gender and possible confusion of her own gender identity.

In a recent article about the artwork of a postoperative female Gender Identity Disorder person, Obstfeld (1993), an art therapist working with drug abusers, comments: "Sexual reassignment had not provided as complete an escape from her 'cage' as she had hoped. Emotionally, she still seems trapped" (p. 14). Ross and Need (1989), on the other hand, have assessed the adequacy of gender reassignment surgery on the psychological adjustment of 14 male to female patients. They conclude that aside from the ability to totally pass as a woman, the lack of preexisting psychopathology, the emotional preparedness, and the social supports available are crucial factors in determining the postoperative mental state.

As we continued to work together in preparation for a gender reassignment surgery, which will take place by the fall of 1995, the goal of therapy shifted towards working through issues related to the surgery. By preparing support systems and looking at possible difficulties, Ms. S. hoped to enhance her chances for a successful outcome. The ability to express herself creatively is a pivotal factor in her life and is currently manifesting itself in original flute and harp music performances as well as a limited return to drawing and painting on her own.

Throughout the past 2 years, Ms. S. has lived and worked as a woman. In her writing, she idealizes the process of art therapy, and it may seem from the drawings chosen by her to illustrate the process that she builds an unrealistic view of what being a woman is all about. It appears as if her entire interest revolves around wearing and walking on high heels, playing the harp, dating, and so forth. While indeed those aspects of womanhood are important to her, she attributes this to her need to experience adolescence as a woman, in order to be able to go through stages of maturing in her chosen gender. She is desperate to indulge in romantic liaisons and admits to wanting to make up for lost time. However, she is also engaged in exploring her fears and expectations and realistically looking at what kind of professional life and personal relationships she will be able to build in the future.

Throughout our work together, Ms. S. worked in two-dimensional media exclusively, using primarily chalk and oil pastels as well as pencils. Sculpture was abandoned as a viable art expression, for the time being, in favor of a quicker, more immediate means of expression and exploration of issues. Directive drawings were used to enhance problem-solving techniques, and projective methods were employed with Ms. S.'s own drawings to explore underlying issues of personal difficulties. Ms. S. also writes poetry which helped her in her grief work. The grief issues centered around the loss of the male self, the loss of home and friends, and in particular the realization that the decision to become female will probably result in the loss of the ability to continue parenting the young daughter.

It is reasonable to expect that the extensive preparatory work that Ms. S. accomplished will enhance her chances of emotional stability during and after the period of convalescence. There is no measure, however, which is able to assess the contribution art therapy has played in this process. Tarsh (Snaith, Tarsh, & Reid, 1993) makes the point that in any therapeutic procedure it is important to engage in follow-up studies, but in the case of sex reassignment it becomes even more important. This is because the procedure is irreversible and "may meet with the disapproval of a large part of the population" (p. 682). It may be prudent, therefore, to add compulsory follow-up and continuation of some form of psychotherapy to the requirements which must be followed in order to be eligible for sex reassignment surgery.

Reid (Snaith, Tarsh, & Reid, 1993) comments that in follow-up studies of 141 Dutch transsexuals which measured the subjective well-being of persons who underwent sex reassignment surgery on the basis of gender dysphoria, "subjective well-being was positively correlated with improved psychosocial functioning, having a steady partner, and having completed sex reassignment surgery" (p. 684). Not surprisingly, employment, acceptance by family, and integration of new gender role into day-to-day life were also cited as being directly correlated to the "feel good" factor. It is interesting to note that those who reported continued dysphoric feelings no longer ascribed them to gender problems. Reid concludes by stating, "My impression is that successfully treated transsexuals are mostly self-supporting and are not a drain on society compared with untreated, unhappy people with unresolved gender dysphoria" (p. 684). I hope, therefore, that Ms. S. will continue to engage in a process of active rehabilitation into her new gender role.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd. ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th. ed.). Washington, DC: Author.

Benjamin, H. (1953). Transvestism and transsexualism. *International Journal of Sexology, 7* 12–14.

Benjamin, H. (1966). *The transsexual phenomena.* New York: Julian Press.

Brems, C., Adams, R. L., & Skillman, G. D. (1993). Person drawings by transsexual clients, psychiatric clients, and nonclients compared: Indicators of sex-typing and pathology. *Archives of Sexual Behavior, 22*(3), 256–264.

Brown, G. R. (1990). A review of clinical approaches to gender dysphoria. *Journal of Clinical Psychiatry, 51*(2), 57–63.

Cauldwell, D. O. (1949). Psychopathia transsexualism. *Sexology, 16,* 274–280.

Ebner, M. (1980). Gender identity conflicts in male transsexualism. *Bulletin of the Meninger Clinic, 44,* 31–38.

Fleming, M. Z., Costos, D., & MacGowan, B. R. (1984). Ego development in female-to-male transsexual couples. *Archives of Sexual Behavior, 12,* 505–516.

Levine, S. B., & Lothstein, L. M. (1981). Transsexualism: A clinical approach to gender dysphoria. *Medical Trial Technique Quarterly, 7,* 85–113.

Lothstein, L. M. (1984). Psychological testing with transsexuals. *Journal of Personality Assessment, 48,* 500–507.

Lukianowicz, N. (1959). Transvestism and psychosis. *Psychiatria et Neurologia (Basel), 138,* 67–78.

Maimonides, M. (1987). *Mishne Torah—Safer Kedusha.* Jerusalem, Israel: Mosad Harav Kook.

Murray, J. (1985). Borderline manifestations in the Rorschachs of male transsexuals. *Journal of Personality Assessment; 49,* 454–466.

Obstfeld, R. (1993). Idealization, transformation, and disillusion in the art of a cross-addicted transsexual. *American Journal of Art Therapy, 32,* 12–21.

Pauly, I. B. (1990). Gender identity disorders: Evaluation and treatment. *Journal of Sex Education & Therapy, 16*(1), 2–24.

Roberto, L. G. (1983). Issues in diagnosis and treatment of transsexualism. *Archives of Sexual Behavior, 12,* 445–473.

Ross, M. W., & Need, J. A. (1989). Effects of adequacy of gender reassignment surgery on psychological adjustment: A follow-up of fourteen male-to-female patients. *Archives of Sexual Behavior, 18*(2), 145–153.

Snaith, P., Tarsh, M. J., & Reid, R. (1993). Sex reassignment surgery: A study of 141 Dutch transsexuals. *British Journal of Psychiatry, 162,* 681–685.

Thomson, M. (1989). *On art and therapy—An exploration.* London: Virago Press.

Verschoor, A. M., & Poortinga, J. (1988). Psychosocial differences between Dutch male and female transsexuals. *Archives of Sexual Behavior, 17,* 173–178.

Walker, P. A., Berger, J. C., Green, R., Lamb, R. R., Reynolds, C. L. Junior, & Wollman, L. (1979). *Standards of care: The hormonal and surgical sex reassignment of gender dysphoric persons.* San Francisco: H. Benjamin International Gender Dysphoria Association. (Reprinted (1985) *Archives of Sexual Behavior, 14*(1), 79–90).

Editor's Note: Hannah Sherebrin has a degree in nursing and is a Registered Art Therapist in private practice, an adjunct therapist for the Social Services Department of the London Jewish Community Centre, and a Practicum Supervisor for the Art Therapy Program at the University of Western Ontario, London, Ontario, Canada. Ms. S. is the client and wishes not to use her real name.

Viewpoints

Message of Acceptance: "Gay-Friendly" Art Therapy for Homosexual Clients

Donna Addison, MS, Rockford, IL

A young adult on the psychiatric unit seemed to be having difficulty completing art therapy directives in a manner that was satisfactory to himself. While he had more than adequate artistic ability and appeared eager to participate, he seemed to struggle painfully through the process no matter what we were doing as a group.

He never had much to say about his work or about himself; he remained rather withdrawn from the group, even though he was polite and friendly. By chance, at our next session, I directed the group to make collages from a pile of magazines I had provided. In the pile I had included a variety of magazines, two of which happened to be gay-oriented publications. The patient took the gay magazines and quickly created a wonderfully expressive collage. For the first time in the group he talked of pride, of relationships, and of the struggles he experienced with his family due to his "coming out".

I had not known about his sexual orientation before he created the collage. By "accident" I had given him a message of acceptance when I included the gay-oriented magazines in the pile. Thankfully, the group was supportive, and the patient seemed relieved. Finally, the closet door had opened.

As a professional employed in a clinical setting, I have the luxury of being an openly gay art therapist. Because of my sexual orientation, I am often able to understand what clients are talking about when they describe life "in the closet" or their struggles over losing their family due to disclosure about sexual orientation. Just a few short years ago, as a graduate student, I spent much of my energy editing my conversations with classmates, monitoring artwork created during class, and restricting important information about my long-term relationship and personal life. I remember sweating nervously as I wondered if my artwork would betray me and whether the truth would sneak out! Because I was fortunate to be surrounded by compassionate, understanding classmates and a supportive, open-minded professor, I was eventually able to "come out." Their acceptance led to what I consider profound personal growth and to an increase in my confidence as an openly gay person functioning in society. It also led to an interest in conducting research concerning art therapy programs and the "coming out" process in the classroom (presented in Las Vegas, 1992). Since then, I have found most professionals supportive of my lesbianism, but I have also found that many still subscribe to homosexual stereotypes set forth by society. I have also noticed that the majority of professionals, homosexual professionals included, have varying degrees of homophobia. This is quite understandable given the historical lack of gay-positive research and openly gay role models in society. In fact, until just a few years ago openly gay homosexuals were less visible and most research on homosexuality focused on the "cause" of homosexuality.

"Gay-friendly" research on homosexuality has flourished over the past few years. Falco (1991) notes that there are two specialty journals for health professionals: *The Journal of Homosexuality* and *The Journal of Gay and Lesbian Psychotherapy*. Newspapers include articles on gay-related topics such as the Womyn's Music Festival (Brotman, 1993), gay teens in high school (Lobaco, 1994), and books for children of gay parents (Harlan, 1992). Mainstream publications such as *Time* and *Newsweek* feature articles on gay and lesbian issues (Henry, 1994; Leland, 1994; Mathews, 1992; Pettit, 1994; Turque, 1993). A trip to the local chain bookstore offers a vast array of gay-oriented books on everything from "coming out" information for parents (Fairchild & Hayward, 1989), to homosexual adolescents (Herron, 1983), to legal advice for homosexuals (Curry & Clifford, 1980). Gay magazines are prominently displayed as well. Several presentations related to homosexuality have been made at national art therapy conferences (most recently: Addison, Weiser, Hammond, Barbee, & Thiruvengadam, 1993; Levy, 1992; More & Penfil, 1993; Ombadykow, 1994; Penfil & More, 1992; Treacy, Levy, Addison, & Brewer, 1992; Vetterman & Abbanate, 1994). The AATA Gay, Lesbian, and Bisexual Caucus has been formed and is becoming more visible (Brigid, 1993; Levy, 1993), and articles on gay and lesbian issues are actively sought (AATA, 1994). However, until homophobia is addressed by the majority of mental health professionals and until society ends its discrimination of those who are homosexual or bisexual, we must do more.

As art therapists, we can easily make a few minor changes to create a gay-friendly atmosphere without disrupting our services or offending other clients. The first step is for art therapists to confront their homophobia. Clark (1987) notes that it is essential for therapists to confront their own feelings about homosexuality before working successfully with homosexual clients. This is imperative whether the art therapist is gay or straight. Homophobia is defined as a fear of homosexuality, prejudice

2239

against gays and lesbians (Falco, 1991), avoidance or rejection of anyone suspected of being homosexual (Grace, 1992), belief that homosexual feelings are shameful, loathsome, and disgusting (Clark, 1987), or a cultural mandate to be silent, believing that being gay is "just sort of gross" (Loulan, 1987). Gay art therapists are just as likely to have feelings of homophobia as straight art therapists. Almost everyone is "programmed" from birth to follow a heterosexual "path." Many gays internalize the guilt and shame associated with being a member of a "deviant" minority. If art therapists feel uncomfortable treating homosexuals, or with their own homosexuality, they should examine why they are feeling uncomfortable. Siegel (1985) suggests that homophobia may be resolved through one's own therapy, literature review, contact with homosexual colleagues, and continued contact with homosexual clients. If such actions do not decrease the discomfort, or if the art therapist believes it is necessary to "cure" the patient of homosexuality, the art therapist should refer the client elsewhere.

Undoubtedly, some clients will seek a "cure" for their homosexuality. As a gay therapist and a gay person, I am deeply disturbed by such an idea. It is my convictions that "you can't fix what ain't broke"; homosexuality is not an illness and therefore it cannot be cured. Nevertheless, clients may very well seek a "cure" for homosexuality, and some clients may, as suggested by McDonald and Steinhorn (1990), "decide that although they experience themselves as lesbian or gay, they will choose to live the lifestyle of a heterosexual because the alternative is too painful" (p. 33), cure or no cure. Personally, when I first realized I might be gay, I tried everything I could think of in an effort to "cure" my sexual orientation—therapy, staying inebriated, getting married, avoiding other lesbians, avoiding my parents, workaholism, and denial of anything remotely related to homosexual feelings—so I am able to comprehend this type of thinking. Gratefully, the therapists I have had contact with did not go along with my plans to "cure" my homosexuality. Focusing on internalized homophobia, identity formation, and relationship issues, as suggested by Falco (1991), are productive alternatives to finding the "cure" for those clients struggling with their sexual orientation. Seeking a "cure" for clients is not only a disservice, but in my opinion, it is unethical. Art therapists questioning the harm of complying with the client's wish for a cure as a treatment goal are advised to consult *Stranger at the Gate* (White, 1994), which includes accounts of genital mutilation, psychological torment, and countless suicides and suicide attempts by Christian men while they tried to change or be "cured." Hopefully, the need to find a "cure" will decrease as society, and therapists, are more accepting of homosexuality.

Secondly, acceptance of homosexuality must be conveyed before, during, and after the art therapy takes place. To convey a gay-friendly atmosphere before therapy begins, art therapists in private practice should have gay-oriented publications in the waiting room. Many high-quality magazines being produced by the homosexual community are attractive and informative enough to display in any waiting room and should not offend heterosexual clients. Displaying books on gay and lesbian topics in the office may provide validation and reassurance to new and continuing clients. If music is played in the waiting room or during art therapy sessions, pieces performed by gay-lesbian artists should be considered in the mix of music. First-time patients should be presented with paperwork that employs gay-friendly language—for instance, using the word *partner* in place of *husband* or *wife* on patient history forms. Art therapists monitoring their language during all phases of treatment will convey the message that they do not assume all their clients are heterosexual; words such as *partner* or *significant other* will convey a healthy acceptance of diversity to group members and may encourage homosexual clients to be honest and open. Art therapists make strong statements when they confront patients and staff who make inappropriate jokes and comments about homosexuality in the therapeutic setting. Discussion of alternative lifestyles during verbal processing should be encouraged when appropriate and done in a casual manner. Providing gay-oriented magazines during collage-making sends a subtle message of acceptance to homosexuals in the group, whether or not they choose to use the gay-oriented materials. Attention does not need to be drawn to the gay-oriented magazines; they should be available like any other publication; apologies or excuses should not be offered to heterosexual clients who may come across such magazines. As Clark (1987) notes, being neutral about gayness in an anti-gay environment is not enough to qualify as accepting; art therapists must take an active role in projecting acceptance of homosexuality as a viable option in today's world and as an acceptable topic of discussion during therapy. A lack of response from the therapist can be interpreted as negative to homosexual clients, according to McDonald and Steinhorn (1990), because "silence can imply that the listener is either too uncomfortable or too uninterested to respond" (p. 35). Familiarity with gay-identified symbols (i.e., pink triangles, rainbow flags, and freedom rings) may help art therapists discuss artwork with gay clients.

Finally, art therapists must actively seek information on issues related to homosexuality. Clark (1987) writes that professionals must be familiar with and understand the values, customs, and ceremonies of the people they presume to help. Stereotypes must be addressed and discarded. A myriad of excellent books on homosexuality are available at local mainstream bookstores and libraries. Gay and lesbian bookstores offer an in-depth look at homosexuality that is not available elsewhere. Attendance at pride parades, same-sex dances, and social events is an excellent way to learn more about your own homophobia and about homosexual values, customs, and ceremonies. Members of the AATA Gay, Lesbian, Bisexual Caucus are an excellent resource for direction towards current information and literature.

Of course, no one can "make" art therapists accept alternative lifestyles, and it is unreasonable at this time to assume that all art therapists will be tolerant of homosexuality in their personal or professional lives. As art therapists, we need to convey a message of acceptance to *all* our clients. Sending a message of acceptance does not mean professing one's sexuality when leading a group. It does not mean that a message from a gay art therapist will be more accepting than a message from a heterosexual art therapist. It does not mean art therapists advocate the conversion of clients to or from homosexuality. It does not mean we need to lecture our clients needlessly about homosexual lifestyles. It means that I am free to answer questions about my life and my sexuality honestly. It means that clients are welcome to express their feelings freely. It means we accept our clients as they are, and we accept ourselves for who we are. If we can

BEST COPY AVAILABLE

merely tolerate a client or co-worker, for whatever reason, we must be honest and refer the client elsewhere or seek therapy for ourselves. Our clients deserve the chance to reopen the closet door during art therapy, just as my client needed the opportunity to express himself in a safe environment after receiving subtle reassurance that his feelings were valid and acceptable, just as I needed the support of my peers before I was able to express myself and move toward personal improvement. Homosexuality may have little or nothing to do with our clients' hospitalizations, but homosexuality is never a non-issue. Gay-friendly art therapy acknowledges homosexuality as an acceptable part of life. Such a message of acceptance just might be the catalyst for positive change in ourselves and in our clients.

References

Addison, D., Weiser, J., Hammond, M., Barbee, M., & Thiruvengadam, S. (1992, November). *Coming out: Being lesbian and gay.* (Cassette Recording). Panel presented at the 23rd Annual Conference of the American Art Therapy Association, Las Vegas, NV.

Brotman, B. (1993, August 26). A utopia for women only. *Chicago Tribune*, Section 5, pp. 1, 15.

Clark, D. (1987). *Loving someone gay.* Berkeley, CA: Celestialarts.

Curry, H., & Clifford, D. (1980). *A legal guide for lesbian and gay couples.* Reading, MA: Addison-Weseley.

Fairchild, B., & Hayward, N. (1989). *Now that you know: What every parent should know about homosexuality.* New York: Harcourt, Brace Jovanovich.

Falco, K. (1991). *Psychotherapy with lesbian clients: Theory into practice.* New York: Brunner/Mazel.

Grace, J. (1992). Affirming gay and lesbian adulthood. In N. Woodward (Ed.), *Lesbian and gay lifestyles: A guide for counseling and education.* New York: Irvington.

Harlan, H. (1992, April 5). Books help children of gay parents. *New York Times, 141*, Section 4A, column 5.

Henry, W. (1994, June 27). Pride and prejudice. *Time, 143*, pp. 54–59.

Herron, A. (1983). *One teenager in ten: Writings of gay and lesbian youth.* Boston, MA: Alyson Publications.

Leland, J. (1994, February 14). Homophobia. *Newsweek, 123*, pp. 42–45.

Levy, B. (1992, November). *Gay, lesbian and bisexual caucus: An agenda for the future.* Paper presented at the 23rd Annual Conference of the American Art Therapy Association, Las Vegas, NV.

Lobaco, J. (1994, March 6). For gays, going to school is like entering a lion's den. *The Arizona Republic*, Section B, pp. 1, 8.

Loulan, J. (1987). *Lesbian passion: Loving ourselves and each other.* San Francisco, CA: Spinsters/Aunt Lute.

Mathews, J. (1992, June 1). From closet to mainstream. *Newsweek, 119*, p. 119.

McDonald, H., & Steinhorn, A. (1990). *Homosexuality: A practical guide to counseling lesbian, gay men and their families.* New York: Continuum.

More, W., & Penfil, T. (1993, November). *Working with Lesbian/Gay/Bisexual clients.* Paper presented at the 24th Annual Conference of the American Art Therapy Association, Atlanta, GA.

Ombadykow, S. (1994, November). *Homosexual adolescents: Building a bridge towards autonomy.* Paper presented at the 25th Annual Conference of the American Art Therapy Association, Chicago, IL.

Penfil, T., & More, W. (1992, November). *Working with gay, lesbian, bisexual clients.* Study group presented at the 23rd Annual Conference of the American Art Therapy Association, Las Vegas, NV.

Pettit, S. (1994, August 22). In or out? *Newsweek, 124*, p. 14.

Siegel, R. (1985). Beyond homophobia: Learning to work with lesbian clients. In L. Rosewater and L. Walker (Eds.), *Handbook of Feminist Therapy.* New York: Springer.

Treacy, J., Levy, B., Addison, D., & Brewer, W. (1992). (Speakers). *Coming out: Being lesbian and gay.* Paper presented at the 23rd Annual Conference of the American Art Therapy Association, Las Vegas, NV.

Turque, B. (1993, December 20). Mississippi burning. *Newsweek, 122*, p. 33.

Vetterman, D., & Abbante, J. (1994). *Ethical concerns of lesbian and gay therapists.* (Focus group). Presented at the 25th Annual Conference of the American Art Therapy Association, Chicago, IL.

White, M. (1994). *Stranger at the gate: To be gay and Christian in America.* New York: Simon & Schuster.

Wrestling the Hydra or Can an Art Therapist Find Aesthetic Fulfillment in the Marketplace?*

Harriet Wadeson, PhD, A.T.R.-BC, HLM, Evanston, IL

Part 1—The Question

When invited to present a keynote speech, I asked what subject I should address. Something practical like insurance and licensure or something to do with aesthetics was the reply. That juxtaposition, those two competing topics edging each other out in their claim for art therapists' attention, struck me as the kernel of our dilemma. And indeed, such a choice is one art therapists must often face. There is another competing concern as well, which, for lack of a better term, I will call *humanitarianism*. The competition among these three divergent entities rages at the very core of who we are and what we do.

We are artists with a deep commitment to the significance of meaningful images in our lives. The creativity of those around us—clients, students, peers, supervisors, mentors—weaves an aesthetic connection as mysterious and as powerful as love.

We are therapists who circumscribe our own loneliness by being present in the lonely fortresses erected by our clients. We storm their bastions, not with verbal battering rams, but with the gentleness of acknowledging an image that breathes the sense of "I see you; at last you are understood."

For most of us, the creativity and the caring, the art and the therapy, form a coherent and comfortable union. And if we are asked what we do as art therapists, we probably speak of that union.

But what about the practical concerns, such as licensure? These days, when one art therapist meets another, she or he is likely to ask, "Did you take the certification exam?" In Illinois, where I live and work, art therapists have been lobbying to become part of a new counselor licensing act. Recently, the University of Illinois chancellor announced that we are no longer a "state-supported" university, but rather a "state-assisted" university. Faculty are expected to find external funding. Whereas publications used to be the currency of academia, now grants are. Well, I knew that when I grew up I wanted to be an artist, a therapist, a writer, and an educator. I never wanted to be a fundraiser. But now this is the side of the bread that gets the butter.

In formulating my ideas about the three components of art therapy practice—aesthetics (or art), humanitarianism (or therapy), and the practical (or the marketplace)—ideas and images about art and therapy came readily, and I found I could speak about them fairly easily. But when it came to discussing the marketplace, I found myself wandering thither and yon, from AATA to lobbying efforts, to my university. I don't think I am alone among art therapists in being at home with art and therapy, but feeling confused, resentful, or downright angry in the political arena of the marketplace.

Obviously, I do not speak for all of us. Some of us navigate the treacherous shoals of professional politics with relative ease. Some of us are even good at it. I have been amazed at the strides AATA has made in the marketplace for art therapists during the 25 years since its creation. There are a number of ambitious art therapists who have served AATA well as Board members and committee chairs and who have advanced our profession for the benefit of all of us. The phenomenal growth of art therapy within AATA's 25 years would not have been possible without their efforts. But I believe that most of us are not political animals. We prefer the arena of the studio or consulting room. We are more comfortable dealing with people as individuals or in small groups, rather than in masses. We want to invest ourselves in the creative connections we forge in our work with clients and students, not writing budgets for grant proposals or lobbying legislatures to allow us to do our work.

So what is a poor art therapist, who loves her art and her sister creatures, to do? Can she find aesthetic or even humanitarian fulfillment in the marketplace? How does she wrestle the many-headed hydra of the seemingly dysfunctional bureaucracies that can trap her?

Part 2—The Answer?

I believe our profession has reached a crossroads, a turning point, a brink, a cusp. We have been pushed to this point by the changes in our world, most notably the imminent transformations of the health care delivery system. This system has already mutated into managed care in response to society's economic conditions and is poised to transform precipitously with the establishment of universal health care reform. Art therapists, along with other service deliverers, are lobbying to get a sliver of the health care pie, which is probably all we can hope for in light of current decreased support for mental health benefits.

Since the birth of our profession, we have struggled to define it, and identity conflict seems to be our major diagnosis. We continue to be split at the root of our age-old conflict: Are we artists or therapists? This conflict was acknowledged in our First Great Debate at the AATA Conference of 1982, "Art Psychotherapy vs. Art as Therapy," but it was not laid to rest. These core identity issues continue to determine how we relate to those with whom we interact as well as to ourselves and have surfaced in response to the present licensure panic. Some believe we should become counselors. In some states, for exam-

---

*Associate Editor's Note: This keynote speech (condensed) was given at the Kansas Art Therapy Association Annual Conference, Emporia, KS, in October 1994. As such, some of the conditions described have changed in the past 2 years.

BEST COPY AVAILABLE

ple California and Massachusetts, art therapists are already eligible for the counselors' exam. Some suggest that art therapy should become a division of the American Counseling Association as a part of its current reorganization. In Illinois, we must standardize art therapy curricula and add some counseling courses to art therapy training to become eligible for counseling licensure. California has a similar history.

One of the strengths of our profession, I believe, is our diversity. There are many ways to practice art therapy with many different populations and many different emphases and approaches among our various training programs. Standardization of training could narrow our field. And yet it is understandable that art therapists fear that, in the shrinking mental health job market, unlicensed practitioners will be unemployed. The counselor license could add a measure of security.

Or are we something quite different from counselors? As I ponder this question, I am sitting with my legs spread out before me, the right one encased in a cast. There are crutches by my side. This is my vacation, and I had planned to spend it hiking, biking, canoeing, and swimming. So what do I do with my pain, anger, and frustration at being grounded with a broken foot? Naturally, I make art—strong, active, colorful feet. How can I explain how that helps? Does the broken bone knit faster as a result? Probably not, unless a more positive attitude can aid healing, which is a possibility. In my boredom and restlessness, I find I am happiest while making art. Is it empowerment amidst my feelings of helplessness? Is it the sensuous pleasure of applying beautiful colors to pleasing shapes? Does my picture pull me out of myself and my petty frustrations into a larger sea of universal creativity? Yes, is my response to all these possibilities. If this is a part of what art therapy is about, there is nothing in these experiences that resembles counseling. There is a magic in *making* something of *one's own creation* that distinguishes art therapy from the verbal therapies and even from the other expressive therapies. As we wrestle the hydra of the marketplace, are we in danger of losing the birthmark of our identity that distinguishes us from others, the magic that artmaking can bring?

Hegelian dialectics posit a thesis, then an antithesis, before the two are blended into a synthesis. Perhaps we are seeing such a progression in art therapy today. If the thesis is the pressure toward licensure, then the antithesis is what I will term the "art for art's sake" approach that appears to be a reaction to the licensure panic. This view would have us remain artists who work with people in need, as "artists-in-residence." This antithesis, being artists-in-residence, is fanciful. In these days of shriveling budgets, can we really expect an agency to pay us to come in and do our own art? Such an alternative might be supported temporarily by a grant, but few of us can afford to live solely from grant to grant.

Sometimes in seeking solutions we become mired in either-or thinking: art or therapy, clinicians or artists. And, in fact, the art versus therapy controversy has been a part of our identity embodied by our founding mothers, Naumburg and Kramer, since our birth. I think it is time to recognize that this marriage of art and therapy works, instead of behaving like children of divorce with loyalties to one parent or the other. As we seek further definition of our profession and our work, I feel strongly that the choice is not between art or therapy, or identities as artist or counselor. I believe we must be creative healers and healing creators. The question is not what we are to be, but how.

As I write, I am home two days from a trip to Northern California. Now is not the first time this western frontier has been a leading edge in defining art therapy in the marketplace. Those of us who have been in the field a few years can recall the ease with which California art therapists obtained the Marriage and Family Counseling License (MFCC) and then their extended battles when eligibility requirements were constricted. As a result, they are now required to take considerably more counseling courses, thus those who sit for the California MFCC exam are trained as counselors as well as art therapists.

A vocal group has emerged in Northern California that emphasizes personal growth in art therapy training and spirituality in art therapy practice. They do not want to become counselors, nor do they feel that the MFCC is a meaningful credential for art therapists. They have been successful in lobbying the state to recognize art therapy as an acknowledged profession that is included in California's code of professions. Currently, they are lobbying for the right to practice as art therapists (paradoxically now prohibited) rather than as counselors.

In California, we see articulated the split that prevails but may be less apparent throughout the field: the old art versus therapy, clinical versus spiritual, analytical versus aesthetic, or whatever polarities represent the very different ways art therapy is conceptualized and practiced. So when I said the question is not what we are to be but how, this is what I was asking:

Should art therapists be trained to practice in a number of different ways appropriate to the different venues in which they wish to work and the very different needs of the varieties of populations they might serve? In some respects the diversity of our training programs already offers a broad range of options. But perhaps the need for licensure, which will certainly lead to a standardization of clinical training requirements, will force us to acknowledge that our profession embraces different kinds of art therapists and that there are enough models of art therapy practice for all of us. Training programs could then identify themselves according to their approach to art therapy and the type of work they train their graduates to do.

Personally, I like to practice art therapy in a way that is adaptive to the needs of my clients. Students can be trained in this sort of flexibility by providing a strong clinical *and* creative base. In Illinois, as in California, it is likely that to qualify for a counseling license students will have to take additional counseling courses. Therefore, what I envision for the future is an acknowledgement of what is more or less already in place: some training programs that are clinically based and aimed toward counselor licensure in addition to art therapy certification, or art therapy licensure in states that grant such a license; some less clinical programs that are art-based, personal-growth-based, or spiritually based; and finally, some programs that combine both orientations but make it clear to students what additional training is needed for specific credentialing.

I believe that the advantage of having several training tracts will be the achievement of clarity and definition within the profession. Nevertheless, because both art and therapy are essential in the making of an art therapist, I would not envision training programs neglecting either, but rather preparing students to work with particular populations in the ways appropriate to them. What is needed for this clearer definition to come about is self-evaluation by directors and faculty of training programs directed toward gaining clarity of purpose. Most important is creating the statement of purpose that describes the nature of the particular program's training. AATA, in addition to the programs, should educate applicants about the different forms of art therapy and the appropriate training for each so applicants can make educated choices. Education would also be needed for administrators who hire art therapists and eventually for the public at large.

Beyond the issue of professional identity, there are still questions and concerns, if not panic, regarding opportunities for art therapists under health care reform provisions that might require licensure for providers and limited mental health care for patients. Despite shrinking budgets, I see some very promising directions for our profession. These are not the traditional art therapy sites in the medical/psychiatric areas that will be controlled by health care legislation, insurance companies, or health alliance systems. They are the areas of some of the greatest need in our needy society: drugs, violence, housing, education, employment, health. When we look at social problems, it is difficult to know where to begin because they are all interconnected. We don't know how to untangle the web of suffering that plagues our cities. The challenges are massive as are the efforts needed to meet them. New and innovative interventions are required, directed toward prevention as well as amelioration.

How do we prevent violence? There are no simple answers, but clearly we must begin with the children who are both victims and witnesses of violence so they will not grow up to become violent adults. There must be programs for them in the schools and in the neighborhoods. Although such programs would have many components, central would be opportunities for children to process past and current experiences and to envision their futures. What form would be more natural for this purpose than artmaking?

We already know that art therapy is an effective form of expression for those who suffer from some of the tragic conditions of our current culture. Both child and adult survivors of childhood sexual abuse and/or family violence often find a more powerful and complete expression in the images they create than they can convey in words. Communication becomes possible, but even more important, these survivors are able to grasp and eventually integrate their own tragic histories through their art.

The AIDS epidemic is almost unbelievable in its proportions. The Plague used to conjure images of Medieval cites. Who would have thought it possible in the 20th century? Of course, art therapy does not treat the disease itself, but it does help its sufferers and their families to deal with the grief, rage, and despair accompanying physical ravagement and deterioration, social stigma, and death. Art therapy has a major role in treating other kinds of bereavement as well, including hospice work and helping children deal with deaths of family members.

The need for shelters has proliferated in recent years. The term *shelter* implies protection. Many of our citizens need protection. We have shelters for battered women and children, for people who are homeless, for runaway youths, for prostitutes trying to change careers. Many of these people come from backgrounds of violence and drug abuse. Art therapy is often an important activity in a shelter's daily schedule. I recall a Chicago facility for prostitutes where art therapy is the sole mode of treatment. I also recollect a Chicago day shelter for women who are homeless that has a staff of three and one is an art therapist. Each time I have visited, I have been impressed by the abundance of client art on the walls and the shelves lining them.

Training programs can prepare students for these various populations by hiring art therapists who are expert in work with specific populations. These populations include the people who are experiencing the social ills I have mentioned: patients with AIDS, children who are HIV positive, survivors of childhood sexual abuse, and people who are homeless. Student practicum sites can also serve populations affected by social problems as well as the tried and true psychiatric hospitals and clinics. Students could work with immigrants in centers for refugees, with people who are developmentally delayed, with "lifestyles" groups for gay and lesbian patients, in childlife programs for critically ill children, in residential and day centers for the elderly, in substance abuse programs, in prisons, and in other new types of facilities that are being created each year.

I am enumerating these many settings and the problems they address to stress the extensive need for art therapy services and the varied opportunities for art therapists. I hope it has become evident to you that many of these examples do not fit under the health care umbrella but belong to our social service systems. It is true, of course, that social services are also experiencing budgetary inadequacies. Nevertheless, it is important not to become so blinded by the dazzling array of health care proposals and conflicts that we miss opportunities in other areas of massive need where we can make substantial contributions.

To return to the licensure question, do we go for counseling licensure; do we join with other expressive therapies for licensure; do we try to get licensure for art therapists; do we forget about licensure altogether? It would certainly be easier to make a decision once the new health care system is outlined so we can know how important licensure will be. On the other hand, there is a strong argument for being prepared, that is, licensed, in case it becomes a necessity.

Yet, the argument I have been advancing places art therapy in the social services systems as well, where credentialing requirements are likely to be very different. It behooves us to investigate them. My sense is that there is less licensing panic in that realm because the services I have described are more likely to be funded by social services or educational dollars. There is less likelihood of intrusion from the health care bureaucracy and greater possibilities for the inclusion of specialists to provide specific services. Furthermore, these programs are directed toward long-term societal change so cessation of symptoms does not signal an end to treatment.

Finally, I want to return to my original topic, "Wrestling the Hydra, or Can an Art Therapist Find Aesthetic Fulfillment in the Marketplace?" There is no denying the hydra, the many-mouthed monster of the bureaucratic, political regulatory systems in which each profession fights viciously to protect and maintain its own turf. Each time Hercules chopped off one of the hydra's heads, it grew two more. Cauterization was the only effective decapitation. The fire for the necessary cauterization to make the hydra manageable must come from our own belief in ourselves and our work.

We are indeed fortunate to have at our literal fingertips the magic of transformation that artmaking can create. Yes, I believe we can find aesthetic, professional, humanitarian, and personal fulfillment in the marketplace. I believe we can do so by acknowledging and being faithful to the unique union of art and therapy, not by becoming artists doing therapy or therapists using art. The future of our profession is not to be found in a thrust toward becoming either counselors or artists-in-residence, although some of our members may do so. In the diversity I hope our profession maintains, I would support art therapists' choices. Nevertheless, I believe our central efforts should promote awareness of the many opportunities for art therapy services I have mentioned (and others I have not even envisioned). We must find creative ways to enter new areas and design new programs.

The crossroads created by the revision of health care in the United States forces us to redefine ourselves. If we panic over licensure, we may become counselors. If we react against that possibility by becoming solely artists, we will remove ourselves from the realities of the helping professions. We must achieve a healing synthesis that is neither and both.

Yes, art therapists can find fulfillment in the marketplace. The surest route is synchronous with our personal fulfillment, the healing creativity, the creative healing, that led most of us into this field in the first place. That which we value for ourselves is what others value in us. It was always so, in both the treatment of individuals and the treatment of a profession: if we love ourselves for our own unique gifts, others will love us for them as well. By remaining the creative healers and healing creators that we are, rather than becoming something else, we will ensure that art therapy will have its own unique place among the human service systems.

Writers Need Not Be Loners

Pat B. Allen, PhD, A.T.R., LPAT, Chicago, IL

I have the good fortune of recently publishing my first book after 10 or so years of working toward this goal. In reflecting on this experience, I realize how collaborative the process of writing really is. Family, friends, and colleagues have had a hand in the creation of this work that bears my name. While the bulk of the actual writing was done alone, at different points one individual or another made a crucial contribution that enabled me to move forward. The colleague who read an early halting draft when the work was tender gave encouragement and overlooked the roughness of my expression. Later, when I was further along, my writers' group, talented women who write everything from children's books to essays and poetry, critiqued the form and pushed me to be a better writer. They also listened when I read a letter from an editor and helped me see encouragement where I could only read rejection. There were friends who simply asked how it was all going on a regular basis and the friend who was instrumental in the work getting a careful reading by the publisher. Every one was a welcome and necessary companion on the road to publication.

As a member of the Editorial Board of this Journal, I get to read many papers, most of which are not ready for publication. We have a process of blind review which is meant to ensure that personal prejudice or knowledge about the writer doesn't cloud the reviewer's judgement, and that is a good thing. But I often wish I could talk to the writer face to face. I wish I could provide more than comments on a piece of paper. As a writer, I know that anything less than an unqualified acceptance feels like rejection. I try to offer as much encouragement as possible and suggest revisions that will strengthen a paper. Yet, I know that the author may experience a sense of defeat and, hearing only the "no," may take what Julia Cameron (1992) terms a "creative U-turn" and abandon the work. The risk of not following through is greater if the paper has been written largely in isolation.

It isn't possible for the Editorial Board members to work intensively with each writer; that isn't the job of the Journal. Mentoring exclusively by Board members would risk producing intellectual inbreeding and limit the range of what gets published. The development of one's writing is a professional responsibility accomplished by establishing a network of friends and colleagues within one's own area of interest or geographic area. For all the myth and image of writing as a solitary endeavor, that is not the whole picture. Alternating with the rigorous isolation necessary for crafting good writing is the need for sharing and collaboration.

Different sorts of collaboration are needed at different times. Sharing may be harmful in the earliest stage, when incubation is occurring, when talking about an idea can take away the urgency to write, but it is crucial once you have something down on paper. The following are some ad hoc writer's rules that may have wider application but particularly apply to writing for this Journal.

- A good idea may come quickly, but ideas need to incubate for a long time, to grow and develop and take root. Incidental writing in a journal or notebook is a good beginning. Reviewed periodically, such jottings can yield the germ of a worthy paper. Notice what ideas come up over and over. What ideas excite you when you encounter them again?
- Rough drafts should be read first by someone who loves you unconditionally, someone who will not correct your commas but instead will urge you to elaborate, to keep going. Rough draft readers should be sympathetic to your viewpoint, able to see the gold in the mud and not need to hose away the mud at the same time. Rough drafts

BEST COPY AVAILABLE

need encouragement. Encouragement primes the pump of writing (O'Sullivan, 1996).

- Completed first drafts have a solid idea that has been elaborated with a beginning, middle, and a conclusion. You may have rewritten three or four times by now. Once the paper feels like "your own" and you have some clarity about what you are saying, the paper is asking for a wider reading. A more experienced writer can help you focus your main idea or prune away tangents. Someone who knows more about your subject than you do may suggest some additional references that will strengthen the literature review. This is a time for challenges, testing the strength of what you've written. Give it to someone whose writing you admire, a colleague or a friend who will give you an honest critique.
- Give your work to someone outside of art therapy. No matter what your subject area, your work should be clear enough, free enough from jargon, to make sense to someone in a related field. If it is a research study, let a colleague in psychology or social work with a research background be your reader.
- Consider sending your work to an expert in the subject area, even someone you do not know personally but feel might be helpful. Call that person first and ask if he or she is willing to read and comment on your work. Determine a time frame for yourself and ask if the person can read your work within that frame. If not, ask for suggestions of others whom you can ask. Enclose a self-addressed stamped envelope so your work can be easily returned. Write a thank-you note when your work is returned.
- After you've received some comments from others, go back and reread your work. Do the comments make sense to you? Do they inspire you to action? The mark of good feedback is that it helps you feel clearer about what you want to say. If so, get writing. If not, put the work away and let the voice of the reader fade from your ear. But, make a note to yourself to look at your paper again in a week or two. Mark the date on your calendar. Sometimes it takes a respite from writing to gain clarity.
- When you do go back, read your work aloud. How does it sound? Are there places where you stumble? If so, readers will, too.

Finally, when you think you are as close to finished as you can get, find a copy editor. This person should know grammar and punctuation and need not give a hoot about your subject. Ask the secretaries, former English majors, and school teachers among your acquaintance for help.

Then, after carefully following the "Guidelines for Authors" published in each issue of the Journal, prepare your final copies, proofread one more time, and send them off. Remember that few if any submissions need no revision. Resolve to accept suggestions with good grace. Set a deadline to make revisions and resubmit. Unlike a test in school or a gallery show where if you aren't accepted, that's that, submitting a paper for publication is a process. Don't give up easily.

Are there any dangers in getting help with your writing? Of course. It is possible to have ideas distorted or even stolen, or worst of all, killed by sharing them with the wrong person at the wrong time in your process. You have control over this. Ask for help from people you both trust and respect. Be clear about what you are asking for. In the end, trust your gut feeling about any critique you receive.

Acknowledge any help you receive in an author's note when your paper is published. If someone outside your immediate circle helped you, send him or her a copy of the paper and a note of thanks. Resolve to be a reader for others; it helps them and sharpens your own critical skills.

Am I asking a great deal? Yes. I am asking for excellence, a commitment to do the very best you can. Now that certification, and in some states licensure, is a reality, we have a paramount need to expand and strengthen the base of knowledge in the field of art therapy. Solid writing, based on well-digested experience—clinical, research, and personal—is needed. Writing is about sharing our skills, insights, and experience. Every working art therapist will have something to share along the way. If we strive to write well and participate in cooperative, collegial support of one another, we will all benefit from an increase in cogent, substantive, and lively discourse and perhaps be less lonely by doing so.

Editor's Note: Pat B. Allen, PhD, A.T.R., LPAT, is codirector of The Open Studio Project in Chicago, IL and author of *Art Is a Way of Knowing*, Shambhala Publications, 1995.

References

Cameron, J. (1992) *The artist's way*. New York: Tarcher.

O'Sullivan, W. (1996). Room at the table. *Common Boundary*, Jan./Feb. 1996, pp. 63–64.

Summer of Transition: A Visual Essay

Kate B. Hartman, MA, A.T.R., Buffalo, NY

Summer. The word brings to mind images of long swims in clear ponds, trips to the ocean, unhurried mornings, warm still afternoons, stolen moments of solitude, tending to gardens, but mostly tending to my children, who, during the academic year, share their mother with a full-time faculty position.

During the long winter I would daydream about warm days when I would write and make art and be a serene, loving mother. The summer of 1994 did not allow this flawless vision of creative tranquility; it was a summer of transition. It was a summer of adapting to uninvited changes and a new set of professional expectations brought on by the closing of the graduate art therapy program at the State University College of New York at Buffalo.

In response to these changes, I anticipated sitting down and letting the words and images flow. Instead, I struggled to make my ideas concrete and stared with resignation at unfinished drawings. My feelings bordered on contempt. Why was I so stuck when there was so much to say?

With the closing of the program, a long, anticipated end had come. I felt like someone who had lost a loved one. I knew the closing was coming for years as I watched my director do battle to keep our program alive. Because of our professional contributions to the college and community, we were given a number of reprieves from closing, but in another round of funding cutbacks, what we had feared for so long occurred. I thought I was making a smooth transition to my new role of training art education majors and undergraduate art therapy minors. However, during the time that summer allowed for reflection, I had to confront my loss and engage in the process of grieving. I needed to explore my feelings about not having art therapy graduate students for the first time in 14 years. I took the counsel I had given to students and clients and struggled with this process through image-making.

My first piece reveals my defenses in maintaining distance and control over the changes that were happening in my professional life (Figure 1). On an intellectual level, I explored the fact that change was occurring. The mandala is losing a part of itself, and, as the piece falls away, a new form is revealed in utero, symbolizing the new responsibilities I faced at the College. A conscious attempt is made at acceptance and optimism. The boundaries are shifting and there is no groundline. In spite of my acceptance of the College's decision and my willingness and

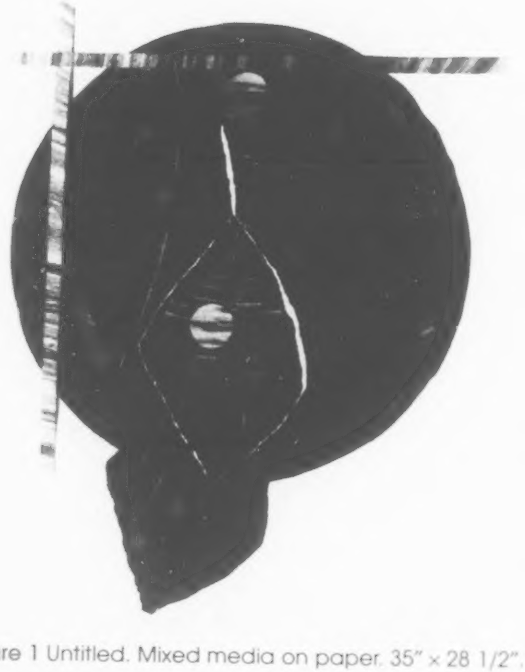


Figure 1 Untitled. Mixed media on paper. 35" × 28 1/2".

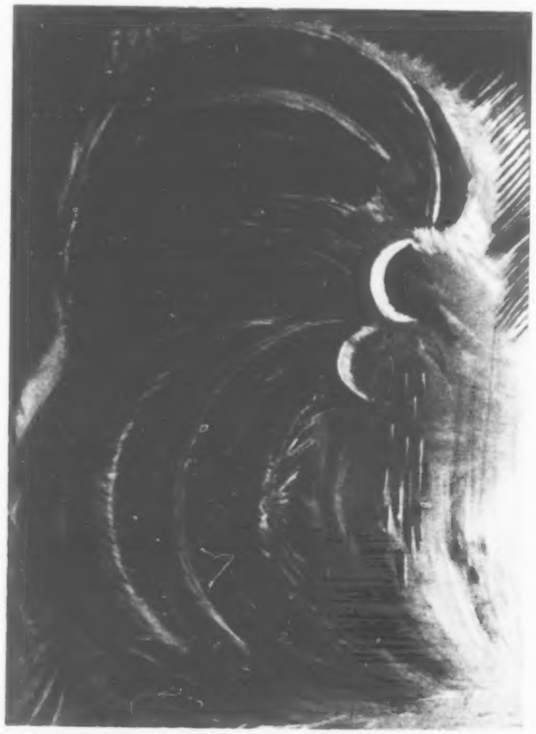


Figure 2 Transition. Pastel on paper. 39" × 28".

interest in assuming a new role, this image suggests that I was not yet feeling stable and secure in my new position. The circle represents my identity as an art therapist, an identity that felt challenged, but one I resolved to rigorously maintain.

A later artwork (Figure 2) indicates movement into the later stages of grieving. I am able to honestly confront my feelings although I feel overwhelmed and powerless in the face of the uninvited changes. Pastels heavily shade the top of this piece as though I am being enveloped in a dark shroud of oppression. Yet, this piece is dichotomous, reflecting the conflicting feelings I felt over my new direction. Duality is expressed in fuchsia and black, reflecting both pain and power. Wavelike lines illustrate sweeping change that felt equally overpowering and exhilarating. Sharply pointed pieces on the right of the image indicate the painful process of letting go, yet they come from a place of dynamic force and fall into an environment filled with rich blue, green, and violet. To me, these colors have always suggested serenity and balance. Despite occasional feelings of being overwhelmed, mid-life has prompted a desire for new challenges and experiences, and the movement in my image reinforces my desire to flow with this unfolding evolution.

Since the fall semester of 1994, I have been the Coordinator of Student Teaching for the Art Education Department, as well as continuing to teach students in the Art Therapy minor. My department colleagues prepare students to teach discipline-based art education. I teach students to know themselves and to examine the personal and professional issues that both promote and hinder their development as they move towards the completion of their undergraduate training. I use my skills as an art therapist to help these prospective teachers understand both themselves and their own students on a more authentic level. In so doing, I have completed my grief work by reinvesting my professional talents and energies in a new direction, with commitment and integrity.

Reviews

Telling Without Talking: Art as a Window into the World of the Multiple Personality

by **Barry M. Cohen, MA, A.T.R.**, and **Carol Thayer Cox, MA, A.T.R.**, New York: W. W. Norton & Co., 1995.

314 pp., 192 black & white illus., 21 color illus., $45.00, hard cover. ISBN 0-393-701-4.

Reviewed by **Susan E. Cheyne-King, MS, A.T.R., LPC, NBCCH**, Providence Forge, VA

Cohen and Cox have again made their mark. Well known in the art therapy community for their work in dissociation and MPD, both separately (Cohen, 1993; Cohen, in press) and together (Cohen & Cox, 1989; Cohen, Cox et al., 1990; Cohen, Cox et al., 1994), they have collaborated on a book for the first time. Noting the role art therapists have played "in differentiating and identifying DID" (dissociative identity disorder) Cohen and Cox "have made our contribution to this process by organizing the art of people with DID into recognizable categories, based on our empirical observations" (p. 291). This contribution is made by delineating their "integrative method," which is "a system for 'reading' pictures in which meaning is derived through the synthesis of process, structure, and content elements" (p. 2). This system is richly illustrated with over 200 pieces of art, which are analyzed according to structure and meaning. This provides the bulk of the text and is broken down into chapters by themes, such as system pictures, threat pictures, and so forth.

Cohen and Cox note that no model of art therapy has addressed a practical method that focuses on structural elements in the artwork, and this book is able to do so successfully. They emphasize the need to look beneath the surface of the artwork, and a crucial element in doing this is their concept of "multileveledness," or the layers of meaning in the art.

From their years of experience in working with clients with MPD/DID, Cohen and Cox are well aware that these individuals often bring their spontaneous artwork to therapists who are not trained art therapists. They state the book is written "to enhance the competency of those therapists" (p. XIX) and warn non-art therapists of the need for education and experience with the art-making process. In addition, their "integrative method" is "designed to give specialists and nonspecialists alike a systematic way of making sense of any art that is produced in the context of therapy" (p. 2).

Although this book deals specifically with the artwork of individuals with MPD, it can be applied to any population. I found virtually no shortcomings of this book, but experienced art therapists may find the number of examples of artwork unnecessary, although interesting. I recommend it for inclusion in standard syllabi for art therapy training, and highly encourage any non-art therapists working with MPD clients to read it thoughtfully.

References

Cohen, B. M. (Speaker). (1993). *Art and MPD: Uncommon realities* (Cassette Recording No. 834-93-13). Alexandria, VA: Audio Transcripts.

Cohen, B. M. (in press). Art and the dissociative paracosm: Uncommon realities. In L. Michaelson & W. Ray (Eds.), *Handbook of Dissociation: Theoretical, Empirical and Clinical Perspectives*. New York: Plenum.

Cohen, B. M., & Cox, C. T. (1989). Breaking the code: Identification of multiplicity through art productions. *Dissociation*, 2(3), 132–137.

Cohen, B. M., Cox, C. T., Mills, A., & Jacobson, M. (Speakers). (1994). *Aspects of artmaking and MPD* (Cassette Recording No. 51-941-94A). Alexandria, VA: Audio Transcripts.

Cohen, B. M., Cox, C. T., Mills, A., & Sobol, B. (Speakers). (1990). *Art by abuse survivors: A lifecycle* (Cassette Recording No. 569-05-90). Alexandria, VA: Audio Transcripts.

Children's Images of Trauma: Terezín, Cambodia, Israel, El Salvador, West Bank and Gaza, South Africa, and Washington, DC

I Never Saw Another Butterfly
edited by **Hana Volavková/U. S., Holocaust Memorial Museum,**
New York: Schocken, 1993. 106 pp., $25.00.

Children of Kampuchea
edited by **The International Rescue Committee,**
Thailand: IRC, 1982. 48 pp.

Childhood Under Fire
edited by **Abba Kovner,**
Tel Aviv: Sifriat Poalim, 1968. 96 pp.

Fire from the Sky
edited by **William Vornberger,**
New York: Writers and Readers, 1986.
64 pp., $9.95.

Faithful Witnesses
edited by **Kamal Boullata,**
Brooklyn, NY: Olive Branch Press, 1990.
120 pp., $19.95.

Two Dogs and Freedom

edited by **The Open School,**
Johannesberg: Raven Press/The Open School.
1986. 55 pp.

Shooting Back

edited by **Jim Hubbard,**
San Francisco: Chronicle Books, 1991.
115 pp., $14.95.

Unforgettable Fire

edited by **Japan Broadcasting Corporation,**
New York: Pantheon, 1981. 111 pp., $11.95.

Reviewed by **Deborah Golub, EdD, A.T.R., LMHC,**
Sunderland, MA

A friend of mine, a German-minority Yugoslav woman born in the Serbian province of Vojvodina, spent 1944 to 1948 in Tito's concentration camps. Images from present-day Bosnia and Herzegovina have revived her own childhood memories, including some unexpected and dreamlike apparitions.

She recalls dusk at the far edge of the flat, frigid plain beyond the camp, where a row of hundreds of strange, exotic birds suddenly appeared and floated soundlessly toward her. Silhouetted against sky, they looked to the 9-year-old like magical storks, skinny-legged, elongated by towering birdcages they carried on their backs. A fellow survivor, an adult at that time, has verified the memory and explained that these actually were women prisoners returning from forced labor with bundles of firewood.

We can marvel at the capacity of children to transform horrible landscapes. We can wonder whether our selective attention to such extraordinary re-creations represents our own need as outsiders to find meaning in the meaningless, imagination in the unimaginable. We adults can look at the art products of children and philosophize, idealize, intellectualize, analyze, categorize, pathologize. Some of us even politicize. What remains fundamental, however, is the child's artistic representation when it is free of adult commentary.

A number of books present the art and writing of children who have lived through diverse catastrophes. Unlike clinical publications about posttraumatic art whose focus tends to be interpretive, the following collections claim no psychological authority. They merely present the images, thereby freeing us to respond directly to their emotion.

I Never Saw Another Butterfly is a classic in this genre. Newly expanded, it contains over 100 drawings and poems made by children at Terezín concentration camp in Czechoslovakia between 1942 and 1944. Many of the compositions were created during classes organized by Friedl Dicker-Brandeis, another prisoner. On the basis of her analysis of the artwork, she formulated ideas about the children's current states of mind, and tried to use the drawing lessons for their psychological rehabilitation as well as art education.

In many cases, assigned and spontaneous work embody aspects of memory. Artists recollect prewar happiness, express nostalgia for lost self, and imprint current horror at Terezín. They memorize and depict SS and beatings, transports, and executions, with the same intensity as they endow past events and future dreams.

Few children of Terezín survived; the majority were transported to Auschwitz in September and October of 1944 and perished soon after. The book gives us the few, poignant biographical facts known about these young painters and writers: their dates and places of birth, barracks number, dates of transport and death. But we also have their echoing voices, their marks on paper, and this book as a memorial.

Primary school children who fled a more recent genocide in Cambodia were asked by staff at Sakaeo refugee camp to describe through drawings and writing their past and present lives, as well as images of the future. What results is the small but memorable publication entitled *Children of Kampuchea*, which contains 20 full-page color plates accompanied by comments in Khmer and English.

While pictures of the genocide often are graphic, their explanations understate the brutality. Readers might speculate about reasons for the verbal restraint and stylistic discrepancy—cultural differences among adults who facilitated the creative expression, cultural proscriptions against distressing a listener, the necessity for children to ingratiate potential sponsors. In any case, the disparity raises questions common to all books reviewed: What are the inherent differences of posttraumatic representation evoked by verbal versus visual modalities? What is the meaning of artmaking to children who witnessed the murder of their country's artists, and whose own emotional expression during the catastrophe surely would have resulted in their own death?

Children living under attack in Israeli border settlements were confined to concrete bomb shelters during the Six Days War. Day and night they heard sounds of shelling and felt the concussion of bombs in the unseen world above them. *Childhood Under Fire*, edited by Abba Kovner, Israeli poet and leader of the partisans of the Vilna Ghetto, presents the drawings, paintings, collages, stories, poems, letters, and diaries of young Israelis during their underground confinement.

Bits of overheard conversation among nursery children provide unsolicited and insightful attempts to understand the experience. Children of all ages express with great tenderness their concern and longing for fathers who are away fighting. A brief preface and afterword echo the artists' own accounts of support provided them by adult caregivers in the shelters; however, the volume is notably free of editorial intrusiveness, allowing the children to speak the anxiety, anger, sadness, confidence, and hope for themselves.

Fire from the Sky in El Salvador was recreated by Salvadoran children between the ages of 8 and 14 while living in Central American refugee camps. "This is what happened." "This is how they killed." "This is how our parents died," begin the narrative reports that accompany pictures. Similarly, drawings appear to be meticulous and exact replications of those remembered events, in which the artists display great control in producing the contours of many small human figures while simultaneously allowing flames to explode from houses and swirl on the page. Although people often are drawn schematically, their weapons are detailed, their actions are specific, and their stories are chilling.

Erasures show through and make the redraws even more meaningful, particularly to the clinically oriented viewer who gains a stronger sense of the psychological impact of trauma on the child's process of remembering and symbolizing. A *campesina* whose earlier version stood erect, now is decapitated—only her pink dress remains intact. A child victim is erased and drawn even smaller; a soldier is enlarged and given more space in the composition. Spontaneous revisions usually further disempower these victims, not an uncommon occurrence in the artwork of survivors generally, in the absence of therapeutic art intervention.

Detailed rendering of traumatic memories, particularly soldiers, guards, police or other individuals whom children perceive as life-threatening, appear across cultures and age groups in the posttraumatic art represented in these books. *Faithful Witnesses* is a trilingual (English, Arabic, French) collection of exquisite drawings and paintings made during the *intifada* by 4- to 14-year-old Palestinian children born and raised in refugee camps. Boullata, a visual artist who initiated the project, wondered how "the small hand that dares to lift a stone [might] attack the paper" when given a crayon or brush and the opportunity to express freely (p. 31).

The children's acuity of vision, vitality of expression, and careful and loving attention to their art are impressive, as are their sophisticated use of media, color, line, and composition. Spontaneous drawings are arranged in the book according to motifs: traditional pastoral landscapes, daily life under occupation, and visions of a peaceful future. Captions offer observations about artistic elements and cultural sources of iconography.

Boullata notes that these young artists often cleave the pictorial composition when depicting scenes with Israelis: soldiers occupy one side of the paper, Palestinians the other. Children of Soweto similarly divide boycotters and police with a simple bisecting line, a barricade, or a space on the page occupied only by bullets, tear gas canisters, or stones.

Two Dogs and Freedom is a modest but powerful book containing achromatic outline drawings and handwritten accounts of violence in the South African townships. All drawings depict violent confrontation—arrests, stone throwing, tear gas, beating, and shooting. Children describe traumatic scenes, the rules and restrictions that control their lives, their distrust and hypervigilance, fears and worries. They also reveal their thoughts about the future, including one 8-year-old's dream from which the book takes its title, for "a wife and two children, a boy and a girl, and a big house and two dogs and freedom" (pp. 54–55).

From a world of poverty, neglect, drugs, and violence come the insistent voices of homeless children in Washington, DC, who have documented their lives with cameras in *Shooting Back*. Because many scenes were shot at eye-level, we see what is central to the child's physical and psychological field of vision; at times, the faces of adults either are out of the frame or seem distant in relation. Children photographing children reveals, instead, the unselfconscious intimacy of a world shared. The black-and-white photos in this recent volume are so unflinching, so full of energy and careful eye, so eloquent and artistically competent as to match the best.

Readers wishing to compare the posttraumatic artwork of children with that of adults who were traumatized at a much younger age should be aware of two final, exceptional references. The first, published in a popular Moscow magazine, is an astonishing collection from among the 700 illustrations drawn by Evfrosinya Kersnovskaya in a diary that she wrote after her release from Stalinist labor camps (*Ogonek*, January 1990, Nos. 3, 4). *Unforgettable Fire* contains the breathtaking testimony of survivors of Hiroshima who felt compelled to paint what they had witnessed 30 years earlier because "Even now I can not erase the scene from my memory. Before my death I wanted to draw it and leave it for others" (p. 105).

The traumatic circumstances of the people represented in these collections are diverse. Their age varies as does the time lapse between the catastrophe and the artistic representation. Unique cultural contexts influence artists' perceptions of the event, as well as the form and content of its rendering. In addition, idiosyncratic characteristics of artists manifest differently in drawings. However, while age, personality, culture, stressor, and number of intervening years influence artistic response in unique ways, there are a number of commonalities in posttrauma art as revealed in these volumes.

First, is the profound relationship between creative impulse, and trauma, memory, and grief. (Indeed, "memory" shares its linguistic root with the words *to mourn*.) The books as a group cause us to consider how memory and symbolization transform each other and how the act of symbolizing mitigates traumatic anxiety, expresses grief, and becomes part of the mourning process. We contemplate how individual and collective memory relate in terms of image-making, and how memory motivates artmaking during or after trauma among children versus adults.

What compels children to create art in moments of catastrophe probably does not relate consciously to sorrow and loss in the same way as it does with adults who often approach creative process in a more conscious way; children's mastery of trauma often takes place at the symbolic level alone. However, neither age nor the amount of time since trauma seems to diminish the survivor's initial need to portray the events as remembered. The content of this portrayal may be repeated and revised as the survivor's memory and his or her relationship to that memory change.

It is clear that the artist's unconscious impulse and the editor's/publisher's conscious intent may vary. Some editors of the books reviewed wish to memorialize, others to educate, still others to persuade. We see few fragmented and meager compositions that might be connected with pathology. The editorial choice to include pictures on the basis of aesthetic considerations, artistic talent, or chromatic reproducibility can lead viewers toward inaccurate generalizations about the posttraumatic imagery of that population, as can the decision to include only representations of horror. Editors' ideological biases about the events themselves expressed either through omission or overt statements in the text probably have little to do with the children's artistic purpose and, unfortunately, distract and detract from the more credible younger voices.

Another recurring feature in the creative process and products of these collections is the tendency to create divisions in the art. Time and space are segmented. Artists use color, elaboration, composition, and style to differentiate between victim and perpetrator, good and bad, helplessness and hope, the nostalgic before and the irrevocable after. These symbolic polarizations may relate to the sudden fragmentation of self-representation connected with the trauma, and the artist's unconscious attempt to integrate the disparate parts of identity.

The ability of children to defend graphically against the painful memory while representing it, seen, for example, in the schematic and stick figures of Salvadoran artists, suggests their attempt at integration and mastery. Artists combine traditional cultural symbols with current circumstances: Palestinian children blend stylized ancient warriors from Islamic miniatures and Assyrian bas-reliefs with their depiction of contemporary Israeli soldiers. Khmer children accommodate traditional Cambodian design and landscape to a catastrophic foreground.

The creative process and products of these child artists reveal their strength, resilience, and hope. It is not just that they make images of a peaceful, benevolent, and just world, or that they find ways to protect themselves from potentially overwhelming feelings evoked by images while embodying the toxic memories. Despite their painful experience, children respond intuitively to the pleasure and joy of interacting with art materials. Without conscious intention to heal polarities, they engage in a process which by its very nature, its demand for both analysis and synthesis, choice and surrender, is unifying and healing. Making art makes whole what has been shattered by trauma.

My psychological curiosity complicates a wholly experienced response to images. I look for particulars about the circumstances of these works of art as a potential source of interpretation and a suggestion to myself that I understand better. Were drawings and poems spontaneous or in response to a directive? Who was present and how did that presence affect imagery? Which materials and colors were available and did the child's selection of them relate to a toxic association with aspects of the trauma? How did artistic traditions of the child's culture influence symbolization? What was the drawing sequence of this composition and its place in a larger series by that artist? How did the child move while working? Were there verbal associations? Chronological age of the artist would give information by which we might assess impact of trauma on artistic development. It is important to know when drawings were made with respect to traumatic events, and what risks were involved in giving form to images and feelings.

Clearly, the finished product, or more precisely, the published reproduction of that original, is only one limited aspect of the child's creative experience; we have not seen the artist in the act of creating. Clearly, no verbal language has been invented to describe adequately the horrors, thus making even more poignant the urgent and assiduous repeated attempts by survivors to clarify to themselves and communicate to others what ultimately can never be understood by outsiders. Nevertheless, it is imperative that we keep looking. Seeing documents of witness, we become witnesses. Moved by works of art, we become artists. Both inform our relationships with survivors of trauma, ultimately teaching us about our collective selves as well.

Note: From *Special Media Review* "Children's Images of Trauma: Terezín, Cambodia, Israel, El Salvador, West Bank and Gaza, South Africa, and Washington, DC" by D. Golub, 1994, *Journal of Traumatic Stress*, 7(2), pp. 327–333. Copyright 1994 by The Plenum Publishing Corporation. Reprinted with adaptations by permission.

THE REMUDA SYSTEM CAN HELP WOMEN AND ADOLESCENTS SUFFERING WITH EATING DISORDERS

CONTINUUM OF CARE
Adult/adolescent inpatient, adult/adolescent residential, partial care and intensive outpatient treatment sites provide tranquil, specialized settings.

◆

LICENSURE
State licensed, JCAHO accreditation with commendation and CHAMPUS provider.

◆

STAFF
Highly skilled professional staff of licensed psychiatrists, internists, psychologists, RN's, master level therapists and registered dietitians providing individualized programs and lengths of stay.

◆

A COMPREHENSIVE PROGRAM
We treat the whole person with individualized programs designed to meet medical, nutritional and psychological needs, blending these components with a non-denominational Christian perspective.

◆

EXPRESSIVE THERAPIES
Provided as a powerful tool to assist individuals in exploring their identities and problems through the use of their own creativity. Activities include art therapy, music, dance/movement and creative writing.

◆

AFTERCARE TRANSITION
Remuda's Aftercare Coordinator will work with the referring professional prior to the patient's discharge to facilitate her transition back into an outpatient setting as she resumes her day-to-day activities.

Most insurance accepted

REMUDA Ranch
Center for Anorexia and Bulimia, Inc.
P.O. Box 2481
Wickenburg, Arizona 85358
1 (800) 445-1900

Eastern Regional Conference on

Abuse, Trauma, and Dissociation

Training in Treatment

May 31 — June 3, 1996

Ritz-Carlton Hotel at Pentagon City • Arlington, Virginia
Barry M. Cohen, A T.R.-BC, Conference Chairman

Our Eighth Annual Event Features These Exceptional Training Opportunities for Art Therapists

OPENING PLENARY ADDRESS
David Spiegel, M.D.
Dissociation, Hypnosis, and Trauma

KEYNOTE ADDRESS
Bessel A. van der Kolk, M.D.
Trauma, Memory, and the Integration of Experience

CLOSING PLENARY ADDRESS
David Calof, RMHC
Notes from a Practice Under Siege

INVITED FACULTY INCLUDES:
James A. Chu, M.D.
Nancy J. Cole, Psy.D.
Christine A. Courtois, Ph.D.
Catherine G. Fine, Ph.D.
Lori D. Galperin, LCSW
Denise J. Gelinas, Ph.D.
James I. Kepner, Ph.D.
Richard P. Kluft, M.D.
Richard J. Loewenstein, M.D.
Nancy J. Napier, M.A., MFCC
Gary Peterson, M.D.
Elizabeth Rice-Smith, Psy.D.
Colin A. Ross, M.D.
Roberta G. Sachs, Ph.D.
Mark F. Schwartz, Sc.D.
Joyanna L. Silberg, Ph.D.
Joan A. Turkus, M.D.
Frances S. Waters, ACSW

INTRODUCTION TO THE DIAGNOSTIC DRAWING SERIES

Sunday, June 2, 1996
Anne Mills, A.T.R.-BC, with opening remarks by
Barry M. Cohen, A.T.R.-BC, founder of The DDS Project

Participants in this day-long course will learn to administer and evaluate the DDS and compile written reports using this clinical art therapy assessment tool. To be held at The Psychiatric Institute of Washington, the site of the DDS Archive, this seminar is a "must" for those who use the DDS regularly in their work. Course content will be based on up-to-the-minute, as yet unpublished, research findings.

ART BY ABUSE SURVIVORS:
DIAGNOSIS AND TREATMENT THROUGH THE LIFECYCLE

Monday, June 3, 1996
Barry M. Cohen, A.T.R.-BC, Carol T. Cox, A.T.R.,
Anne Mills, A.T.R.-BC, and Barbara Sobol, A.T.R.

This full-day training will provide an extraordinary perspective on the effects of early childhood trauma as they manifest in art productions. Research-based diagnosis of post-abuse syndromes using the Diagnostic Drawing Series (for adults and children) will be reviewed and treatment guidelines for the use of art in therapy will be outlined for both specialists and generalists.

ALSO OF INTEREST

TRAUMA, DISSOCIATION, AND THE HOLOCAUST

Thursday, May 30, 1996
James Glass, Ph.D., C. Fred Alford, Ph.D., and Jerrold Post, M.D.

This 3-hour seminar, to be held at the U.S. Holocaust Memorial Museum, will explore the dynamics of hatred, violence, and evil through a psychological analysis of genocide. Attendees will have the afternoon to tour this "must see" facility.

For a complete conference program and registration information, contact:
Eastern Regional Conference, Inc., P.O. Box 9534, Alexandria, VA 22304 • 800/934-3724

Sponsored by

THE CENTER
Post-Traumatic & Dissociative Disorders Program
at The Psychiatric Institute of Washington

CHARLES C THOMAS • PUBLISHER

☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY. (2nd Ed.)** '96, 94 pp. (7 × 10), 4 il.

☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror. (2nd Ed.)** '95, 230 pp. (7 × 10), 21 il, $49.95, cloth, $29.95, paper.

☐ Boy, Angelo V. & Gerald J. Pine—**CHILD-CENTERED COUNSELING AND PSYCHOTHERAPY.** '95, 262 pp. (7 × 10), $59.95, cloth, $34.95, paper.

☐ Makin, Susan R.—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 112 pp. (7 × 10), $29.95, cloth, $15.95, paper.

☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 17 il., $47.95, cloth, $29.95, paper.

☐ Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 186 pp. (7 × 10), 33 il. $41.95, cloth, $26.95, paper.

☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $64.95, cloth, $32.95, paper.

☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $37.95, cloth, $22.95, paper.

☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 x 10), 24 il., $46.95, cloth, $29.95, paper.

☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¼), 34 il., $48.95, cloth, $29.95, paper.

☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $35.95, cloth, $19.95, paper.

☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $53.95, cloth, $31.95, paper.

☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $25.95, spiral (paper).

☐ Benenzon, Rolando O.—**MUSIC THERAPY MANUAL.** '81, 178 pp., 20 il., $29.95, cloth, $14.95, paper.

☐ Machover, Karen—**PERSONALITY PROJECTION IN THE DRAWING OF THE HUMAN FIGURE: A Method of Personality Investigation. (11th Ptg.)** '80, 192 pp. (5½ × 8½), 18 il., $31.95, cloth, $16.95, paper.

☐ Nucho, Aino O.—**SPONTANEOUS CREATIVE IMAGERY: Problem Solving and Life Enhancing Skills.** '95, 174 pp. (7 × 10), 15 il., $41.95, cloth, $25.95, paper.

☐ Cooper, Shawn—**THE CLINICAL USE AND INTERPRETATION OF THE WECHSLER INTELLIGENCE SCALE FOR CHILDREN"—THIRD EDITION.** '95, 466 pp. (7 × 10), 5 il., 20 tables, $74.95, cloth, $39.95, paper.

☐ Miller, Susan B.—**WHEN PARENTS HAVE PROBLEMS: A Book for Teens and Older Children with an Abusive, Alcoholic, or Mentally Ill Parent.** '95, 94 pp. (7 × 10), $31.95, cloth, $18.95, paper.

☐ Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 × 10), 12 il. $35.95.

☐ Landy, Robert J.—**DRAMA THERAPY: Concepts, Theories and Practices. (2nd Ed.).** '94, 294 pp. (7 × 10), 1 table, $58.95, cloth, $33.95, paper.

☐ Sopchak, Andrew L., Andrew M. Sopchak & Robert J. Kohlbrenner— **INTERPERSONAL RELATEDNESS FROM PROJECTIVE DRAWINGS: Applicability in Diagnostic and Therapeutic Practice.** '93, 292 pp. (8½ × 11), 166 il., 46 tables, $61.95, cloth, $34.95, spiral (paper).

☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $51.95, cloth, $30.95, paper.

☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¼), 56 il., $48.95, cloth, $29.95, paper.

☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $56.95, cloth, $34.95, paper.

☐ Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY.** '87, 606 pp. (7 × 10), 11 il., 38 tables, $92.95, cloth, $49.95, paper.

☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $24.95.

☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 260 pp., 54 il., $32.95, cloth, $18.95, paper.

☐ Hammer, Emanuel F.—**THE CLINICAL APPLICATION OF PROJECTIVE DRAWINGS. (6th Ptg.)** '80, 688 pp., 360 il., $55.95, cloth, $33.95, paper.

☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il (12 in color), 7 tables, $49.95, cloth, $29.95, paper.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

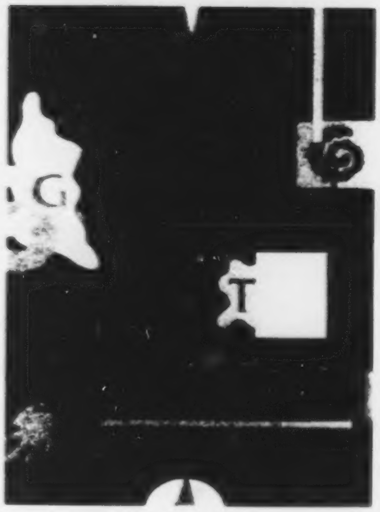
THE GESTALT ART EXPERIENCE
PATTERNS THAT CONNECT

By JANIE RHYNE

REVISED EDITION pa. $24.95

Almost a quarter-century has passed since the first publication of this highly acclaimed book. In this revised edition extensive new sections have been added at the beginning and the end. The new foreword chronicles the authors personal journeying through the 50's and 60's while the afterword speaks of *patterns that connect* and new directions.

> *"Janie Rhyne was one of the truly great original thinkers in the field of Art Therapy. In a genuinely creative act, she synthesized her varied experience with art, people and healing in this eloquently written book. Janie's ability to comprehend, digest and recombine understandings from a wide variety of intellectual disciplines allows her to present us with a way of working which is really her own unique creation."* **Judith Rubin, Ph.D., A.T.R., HLM**



SUPERVISION and Related Issues: A Handbook for Professionals

by Cathy Malchiodi and Shirley Riley

A highly informative and pragmatic guide to the complexities of clinical supervision of art therapists and related mental health professionals. Supervisors, educators, and students will find this text indispensible not only in the supervisory session, but also in the classroom and in work with clients.

Due Spring 1996 PRICE NOT SET

ART THERAPY in Theory & Practice

Ed. by Elinor Ulman and Penny Dachinger

This classic and widely used text is now coming back in print! The book provides a comprehensive introduction to the field of Art Therapy and brings together important thinking, discussion and experience of many major contributors. *Art Therapy in Theory and Practice* provides deep insight into the development of the discipline since its inception some thirty years ago.

Due Spring 1996 PRICE NOT SET

MAGNOLIA STREET PUBLISHERS

1250 West Victoria, Chicago, IL 60660 • 312-561-2121 • fax 312-477-6096

Wholesale and Bookstore orders to above address.

Individual orders to:

Stern's Books
2004 W. Roscoe
Chicago, IL 60618
312-883-5100, fax 312-477-6096

Add $4.00 UPS for first book and .75 for each additional book. Credit cards and checks accepted.

THE GESTALT ART EXPERIENCE, Patterns That Connect, Janie Rhyne	pa. **$24.95**
INTEGRATIVE APPROACHES TO FAMILY ART THERAPY, Shirley Riley & Cathy Malchiodi	pa. **$29.95**
ART AS THERAPY WITH CHILDREN, Edith Kramer	pa. **$19.95**
CALIFORNIA ART THERAPY TRENDS, Ed. Evelyn Virshup	pa. **$29.95**
SHATTERED IMAGES: Phenomenological Language of Sexual Trauma, Dee Spring	pa. **$36.00**
DYNAMICALLY ORIENTED ART THERAPY: It's Principals & Practice, Margaret Naumburg	hd. **$32.95**

IMPORTANT .... ***IMPORTANT*** .... ***IMPORTANT*** .... ***IMPORTANT***

Please note that AATA must receive a change of address notice 6 to 8 weeks in advance to ensure all mailings, including the *Journal* and *Newsletter*, will reach you. AATA is not responsible for misrouted mail as a result of insufficient notification.

CHANGE OF ADDRESS

Name________________________________

Old Address________________________________

Old Phone Number________________________________

NEW ADDRESS________________________________

NEW PHONE NUMBER________________________________

Effective Date________________________________

COLLEGE OF NOTRE DAME

OFFERS:

- Master of Arts in Art Therapy (37 units)
- Master of Arts in Marital & Family Therapy (50 units)
- Post-Graduate Art Therapy Certificate Program (21 units)

- Systems & Jungian oriented art therapy
- AATA-approved Master's Programs
- MA in Marital & Family Therapy meets California state requirements for MFCC licensure
- Afternoons, evenings & weekends
- Summer Program

Art Therapy Program
COLLEGE OF NOTRE DAME
1500 Ralston Avenue
Belmont, CA 94002-1997

For program specifics call
(415) 508-3556

For an application call
(415) 508-3523

LOCATED IN THE BEAUTIFUL SAN FRANCISCO BAY AREA

ORAL HISTORICAL ACCOUNTS OF THE AMERICAN ART THERAPY ASSOCIATION

BY PIONEERS OF THE ASSOCIATION

A VIDEO PROGRAM

The following HLM's, former and current elected presidents have agreed to have their interviews available to the AATA membership. These programs were recorded by volunteers.

☐ 1 Dr. Myra Levick interviewed by Cathy Malchodi
☐ 2 Robert Ault interviewed by Randy Vick
☐ 3 Felice Cohen interviewed by Dr. Irene Corbit
☐ 4 Don Jones interviewed by James Consoli
☐ 5 Dr. Judith Rubin interviewed by Dr. Frances Anderson
☐ 6 Gwen Gibson interviewed by Dr. Jeanne Carrigan
☐ 7 Georgiana Jungels interviewed by Debra Paskind
☐ 8 Dr. Gladys Agell interviewed by Dr. Linda Gantt
☐ 9 Dr. Sandra Graves interviewed by Robert Ault
☐ 10 Cay Drachnik interviewed by Dr. Linda Gantt
☐ 11 Dr. Linda Gantt interviewed by Dr. Doris Arrington
☐ 12 Dr. Robin Goodman interviewed by Cecily Mermann
☐ 13 Bobbi Stoll interviewed by Mari Fleming
☐ 14 Virginia Minar interviewed by Dr. Frances Anderson
☐ 15 Edith Kramer interviewed by Paula Howie
☐ 16 Helen Landgarten interviewed by James Consoli
☐ 17 Dr. Rawley Silver interviewed by Dr. Betty Jo Troeger
☐ 18 Dr. Frances Anderson interviewed by Dr. Valerie Appleton
☐ 19 Dr. Harriet Wadeson interviewed by Dr. Doris Arrington

1-350

PRICE VHS PER TAPE: $19.95 for Members • $24.95 for Non-Members
PRICE PER SET: $322.00 for Members • $403.00 for Non-Members

VIDEO TAPES

NO. OF TAPES ______ x $19.95	$ ______
NO. OF TAPES ______ x $24.95	$ ______
NO. OF SETS ______ x $322.00	$ ______
NO. OF SETS ______ x $403.00	$ ______
DOMESTIC SHIPPING ($3.00 per tape to $30.00 max)	$ ______
FOREIGN SHIPPING ($8.00 per tape to $40.00 max)	$ ______
DENVER RESIDENTS ADD 7.3% SALES TAX	$ ______
CO RESIDENTS ADD 3.8% SALES TAX *IF TAX EXEMPT, INCLUDE CERTIFICATE*	$ ______
NEW YORK RESIDENTS ADD LOCAL SALES TAX *IF TAX EXEMPT, INCLUDE CERTIFICATE*	$ ______
TOTAL OF ORDER	$ ______

MAKE CHECKS PAYABLE AND MAIL YOUR ORDER TO:

NATIONAL AUDIO VIDEO, INC.
4465 WASHINGTON STREET
DENVER, CO 80216
PHONE: (303) 292-2952

QUALITY GUARANTEED - NO REFUNDS - ALLOW 2-4 WEEKS FOR DELIVERY

METHOD OF PAYMENT

Please Note: Foreign customers must pay by credit card or pre-paid Purchase Order and checks must be drawn on US bank in US funds

____ CHECK ____ AMEX ____ MC ____ VISA ____ DISCOVER

CARD# ______________________

EXPIRATION DATE ______________________

SIGNATURE ON CARD ______________________

SHIP TO: (PLEASE PRINT CLEARLY) ☐ Business ☐ Residential

NAME ______________________

INSTITUTION ______________________

ADDRESS ______________________

____

CITY ____________ COUNTY ____________

STATE ________ COUNTRY ________ ZIP ________

DAYTIME PHONE (   ) ______________________

CALL TOLL FREE: 1-800-373-2952 (9-5 MT) • OR FAX YOUR ORDER: (303) 292-5629

American Art Therapy Association, Inc.

November 8-12, 1995
San Diego, California

Audio Cassettes Available

☐ 1. School-Based Art Therapy Earthquake Trauma Reduction Program, *S. Silverstein, MA, ATR; M. Newborn, MA; C. Palmer, MSW; M. Siderman, LCSW; M. Stafsky, MA; J. Wexler-Ballard, LCSW*
☐ 2. The Multi Disciplinary Treatment of Attention Deficit Disorder Includes Art Therapy Groups, *D. Safran, MS, ATR; F. Safran, PhD; S. Finkelstein, MD*
☐ 3. The Future of Our Past, *M. Nienkamp, BA; N. Gray, BS; K. Wathen, BA*
☐ 4. Weaving New Visions, *L. Vance, MS, ATR; K. McCormick, MA, ATR; L. Kapitan, MPS, ATR*
☐ 5. Collaborative Co-Therapy: Art Therapy as Adjunct Within Outpatient Private Practice Team Treatment, *S. Roller, MFA, ATR-BC; K. Adams, PhD*
☐ 6. The Image-Making Process: Withstanding the Course of Non-Production, *M. Hanes, MAT, LAT, ATR-BC*
☐ 7. Art and Healing: Practitioner, Process, and Audience - A Dialogue, *M. Fleming, MAz, MFCC, ATR-BC; J. Colby, MA, MA*
☐ 8. The Power of Language in the Art Therapeutic Relationship, *S. Spaniol, EdD, LMHC, ATR; M. Cattaneo, PhD, LMHC, ATR*
☐ 9. Relying on the Kindness of Strangers' Social Policy: Art Therapy and Poverty, *N. Mayer Knapp, PhD, ATR*
☐ 10. The Crash of US Air Flight 427 - Its Impact Upon an Elementary School, *C. Kunkle-Miller, PhD, ATR*
☐ 11. Couple Compatibility Assessment Using the Mari Card Test and Mandala Drawings, *P. Frame, MA, ATR*
☐ 12. The Art of Crime, *P. Howie, MA, ATR-BC; L. Gantt, PhD, ATR, HLM*
☐ 13. A Vision Made Reality: Establishing Alliances in a Pediatric Art Therapy Program, *L. Black, BA, MCAT, ATR; K. Glass, MA*
☐ 14. A Men's Group Using Imagery as a Predominant Way of Knowing, *R. Schoenholtz, MS, ATR-BC*
☐ 15. The Correctional Officer and the Art Therapist: An Unlikely Alliance, *D. Gussak, MA, ATR*
☐ 17. Survival of Aboriginal Culture Through Art: Implications for Cross-Cultural Art Therapy, *F. Kaplan, DA, ATR; M. Campanelli, EdD, LSW, ATR*
☐ 18. Incorporating the Mandala to Center Children Diagnosed as ADD and ADHD, *V. Smitheman-Brown, MA*
☐ 19. Mirror Drawings: A Reflection of the Therapeutic Process, *A. M. Shopp, LMFT, ATR; S. Chambers Wallingford, MA*
☐ 20. The Dynamics of Art & Music Therapy in Forensic Settings, *R. Dorwin, MA, LAT, ATR; C. Weyuker, BM, RMT*
☐ 21. Art Therapy in Pediatric Rehabilitation, *J. Andersen, BFA, MA*
☐ 22. Searching for the Appropriate Treatment Map: Integrating Object Relations and Family Systems Theories, *J. Consoli, MA, ATR-BC; G. Klorer, MA, ATR*
☐ 23. About the Words in Art Therapy, *K. Dannecker, Dr.phil, ATR*
☐ 24. Results of Recent Research Studies Identifying Recurring Visual Symbols and Construct Choices, *D. Arrington, EdD, ATR-BC; P. Hayes, MA; E. Rubinstein, BA*
☐ 26. Heart Imagery: Multiple Messages and Metaphors, *L. Kay, MA, ATR*
☐ 27. The China Connection, *H. Wadeson, PhD, LCSW, ATR-BC, HLM*
☐ 28. Art Therapy in Context: Honoring Women's Voices in Our Work, *C. Malchiodi, MA, LAT, LPCC, ATR; S. Riley, MFCC, ATR*
☐ 29. Research in Art Therapy Education - A Dialogue, *M. Rosal, PhD, ATR-BC; D. Linesch, PhD, MFCT, ATR; S. Hite, LPC, ATR-BC*
☐ 30. Archetypal Art Therapy Defined, *J. Wenzke, BS; J. Abbenante, MA, LAT, ATR-BC; G. Mongiello, MA, RMHC; L. Wix, MEd, LAT, ATR*
☐ 31. Art Therapy as Containment in the Stabilization of Dissociative Identity Disorder, *T. Nelson, MS*
☐ 32. Reflecting on Ten Years of Art Therapy for Children Who are Grieving, *B. Betker McIntyre, PhD, LPC, ATR; J. Adams, BS, RN*
☐ 33. Art Therapist as Member of Medical Multi Disciplinary Burn Team, *J. Russell, MS, ATR*
☐ 34. Art Therapy Used to Adapt Coping Behaviors of Adult Daughters of Alcoholics, *C. Dikovitsky, SND, MA*
☐ 35. Cancer--Creativity and Self-Repair: Theoretical and Clinical Considerations on Art Psychotherapy with Cancer Patients, *E. Dreifuss-Kattan, PhD, ATR*
☐ 36. Art Therapy Interventions with Adolescents Who Are Victims of Trauma, *D. Testa Ochipa, PhD, ATR*
☐ 37. From Hurtful Hands to Healing Hands: Collaborative Treatment of Multiple Personality Disorder, *T. McDougall Herl, MS, ATR*
☐ 38. Attachment Organization in the Imagery of Addicts and Implications for Treatment, *E. Holt, MS; D. Kaiser, MS*
☐ 39. Art Therapy with Laryngectomy Patients, *S. Ainlay Anand, MA, ATR-BC; V. Anand, MD, FACS*
☐ 40. Art Work of Aggressive Organic Geriatric Males, Pre and Post Estrogen Therapy, *R. Drew-Leute, MA; P. Bryman, DO*
☐ 41. Holding Onto the Rainbow - Stereotyped Symbols in Patient's Art as Facilitators, *D. Moriya, MPS*
☐ 42. Visual and Tactile Interventions in Healing: Sandtray with Mastectomy Patients, *V. Lusebrink, PhD, ATR-BC; K. Scifres, MA, ATR-BC*
☐ 43. Coming to our Senses: The Somatic Roots of Art Therapy, *S. Lovell, PhD, LAT, ATR*
☐ 45. Children Having Children: Art Therapy in a Community Based Early Adolescent Pregnancy Program, *M. J. Mermer-Welly, MA, LSW, ATR; G. Stiles, MA, AT*
☐ 46. Integrating Art Therapy and Biofeedback - A New Perspective on Reducing Children's Stress, *C. DeLue, MA*

☐ 47. Perspective on Clayworks in Art Therapy, *F. Goryl, Jr., MA, ATR*

☐ 48. Patient-Focused Care and the Future of Art Therapists in Hospitals, *S. Cheyne-King, MS, LPC, NBCCH, ATR*

☐ 49. Portals and Passages, *R. Marano-Geiser, ATR; H. Wadeson, PhD, LCSW, ATR-BC, HLM; R. Ault, ATR-BC, HLM; M. Junge, ATR*

☐ 50. Models of School Art Therapy: Three Perspectives, *S. Hite, MS, MSeD, ATR-BC; C. Drew, MEd, ATR; P. Dunn-Snow, MA, MEd, ATR-BC*

☐ 51. The Clothesline Project: Therapy, Education and Activism, *K. A. Meyer, MA; M. Lancaster, MA, ATR-BC; E. Peck, MAET, ATR; L. Myer, MAT, ATR*

☐ 52. Wholistic Art Therapy! An Idea Whose Time has Come, *R. Shoemaker-Beal, MFA, ATR; A. Garrett, PhD, ATR-BC; S. Geller, MA, ATR; E. Horovitz-Darby, MA, ATR; S. Savinch, BS, RN*

☐ 53. Mood Disorders and Artistic Creativity, *K. Redfield Jamison, PhD*

☐ 54. Collaborating with Artists: Individual and Communal Healing, *D. Burdick Gage, BA, MA, PhD; E. Speert, MEd, ATR-BC*

☐ 55. Meditation and Art Therapy: Its Many Uses with the Geriatric Patient, *L. Levine-Madori, MS, CTRS*

☐ 56. Art as a Way of Knowing: From Therapist to Steward, *P. Allen, PhD, LAT, ATR*

☐ 57. The Myth of Collaboration: The Peace Bridge Project, *L. Vance, MS, ATR; C. Clark, MS*

☐ 58. A Practical Review and Integration of All Diagnostic Drawing Series Research Findings, *A. Mills, MA, ATR*

☐ 59. Planting the Seed of Art Therapy Awareness: Educating Allied Professionals as Undergraduates, *B. Parker-Bell, MA, ATR*

☐ 60. Return from Dissociation, *B. Sobol, MA, ATR*

☐ 61. Development of a Model to Disseminate the Art of Scale to Allied Professionals, *B. J. Troeger, PhD, ATR-BC*

☐ 63. The Studio Experience in Art Therapy Training, *L. Wix, MEd, LAT, ATR*

☐ 64. Mirroring Through Art to Repair the Damaged Self, *E. Kanner Weinberg, BA, MA*

☐ 65. Queenly Maiden: A Case Study in Archetypal Art Therapy, *B. Falconer, MA*

☐ 66. Moving the Image: Art and Movement Therapy with Older People, *J. Beaujon Couch, MA, ATR; J. Funderburk, MA, CET*

☐ 67. Art Therapy with 3-D Environments, *B. Bluestein, BFA, MA*

☐ 68. Paper Dolls: A Therapeutic Technique with Adolescents in Residential Treatment, *B. Woodward O'Neal, AB, MS*

☐ 69. The Importance of Being Ernst: How Max Ernst's Art Paralleled His Life, *E. Virshup, PhD, MFCC, ATR*

☐ 70. Toward a More Inclusive Use of Imagery and Art in Psychotherapy, *J. Consoli, MA, ATR-BC*

☐ 71. Integrating Art Therapy in a Day Treatment Program with Inner City Adolescents, *E. McGann, MA, ATR; G. Pagano, MA, MSW; H. Harris, MSW*

☐ 73. Mural Making in the Therapeutic Community: Five Projects and Views, *L. Peterson, MA, ATR; S. Goldman, MA; R. Sorrentino, BFA; J. Cameron, BFA; A. Levesque, BFA*

☐ 74. Finding Meaning in Art: Art Therapists in Collaboration With One Another, C. Cox, MA, ATR; J. Abbenante, MA, ATR-BC; B. Cohen, MA, ATR; P. Engelhorn, MA, ATR; M. Fleming, MA, ATR-BC; W. Miller, PhD, ATR; L. Rhinehart, MFCC, ATR; L. Wilson, PhD, ATR-BC

154-95 A

PRICE PER TAPE: $12.00

MAIL ORDER FORM

NO. OF TAPES ______ x $12.00 $ ________
SHIPPING - DOMESTIC ($1.75 per tape to $12.00 max.) $ ________
FOREIGN ($3.00 per tape to $30.00 max.) $ ________
CO RESIDENTS ADD 3.8% SALES TAX $ ________
DENVER RESIDENTS ADD 7.3% SALES TAX $ ________
IF TAX EXEMPT, INCLUDE COPY OF TAX CERTIFICATE
NEW YORK RESIDENTS ADD LOCAL SALES TAX $ ________
ON TOTAL ORDER. IF EXEMPT, INCLUDE CERTIFICATE
TOTAL OF ORDER $ ________

SHIP TO: (PLEASE PRINT CLEARLY) ☐ Business ☐ Residential

NAME ____________
INSTITUTION ____________
ADDRESS ____________
____
CITY ____________ COUNTY ____________
STATE ____________ COUNTRY ____________ ZIP ____________
DAYTIME PHONE (   ) ____________

METHOD OF PAYMENT
(Foreign customers must pay by credit card or pre-paid Purchase Order)

________ Enclosed is my check (Drawn on US Bank in US Funds)

Charge to ____ AMEX ____ MASTERCARD ____ VISA ____ DISCOVER
CARD# ____________
EXPIRATION DATE ____________
SIGNATURE ON CARD ____________

MAKE CHECKS PAYABLE AND MAIL YOUR ORDER TO:

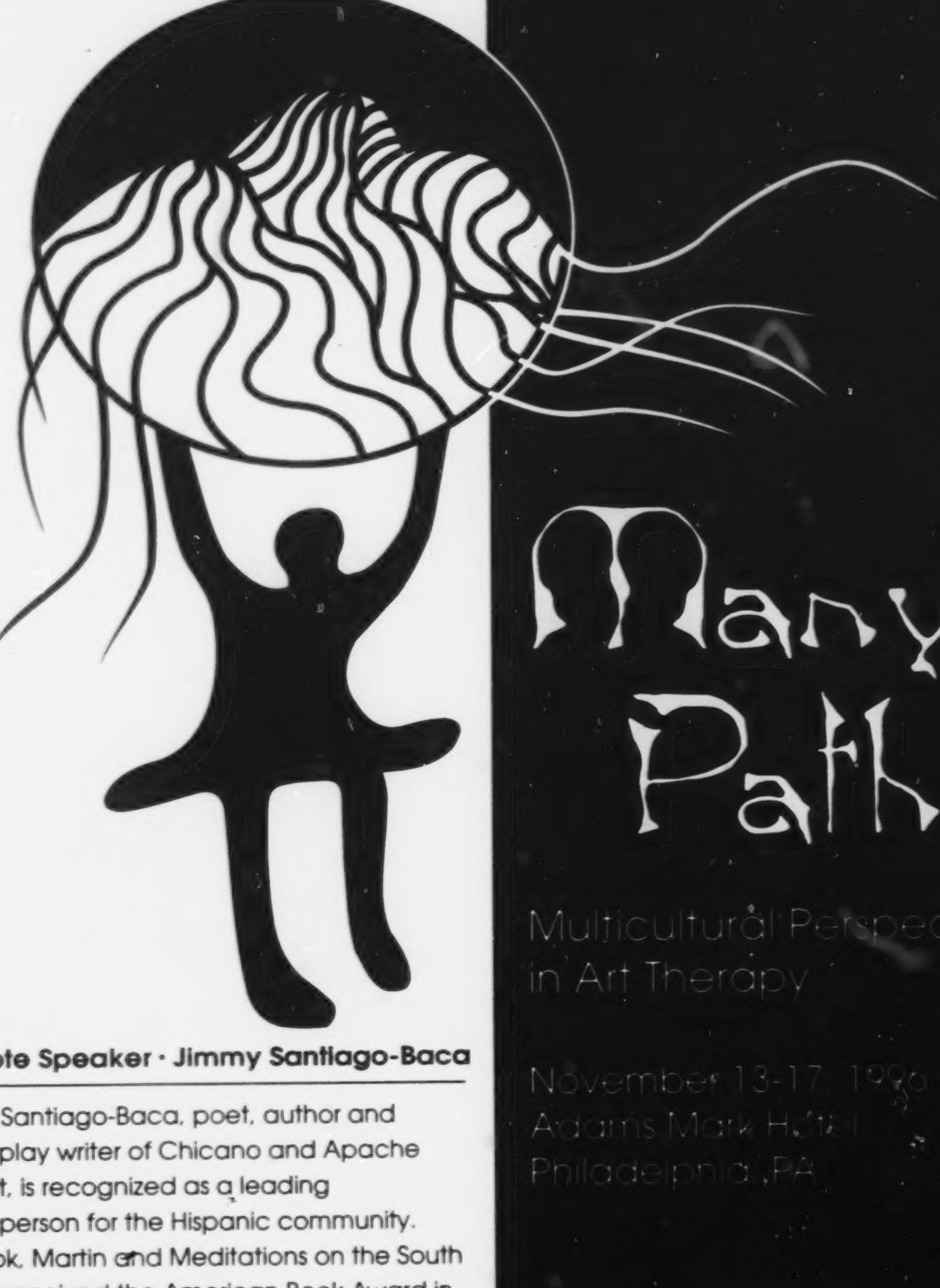
NATIONAL AUDIO VIDEO, INC
4465 WASHINGTON STREET
DENVER, COLORADO 80216
PHONE: (303) 292-2952

QUALITY GUARANTEED - NO REFUNDS - ALLOW 2-4 WEEKS FOR DELIVERY

CALL TOLL FREE: 1-800-373-2952 (9-5 MT) • OR FAX YOUR ORDER: (303) 292-5629

AMERICAN ART THERAPY ASSOCIATION, INC.

27TH ANNUAL CONFERENCE



Many Paths

Multicultural Perspectives in Art Therapy

November 13-17, 1996
Adams Mark Hotel
Philadelphia, PA

Keynote Speaker · Jimmy Santiago-Baca

Jimmy Santiago-Baca, poet, author and screenplay writer of Chicano and Apache decent, is recognized as a leading spokesperson for the Hispanic community. His book, Martin and Meditations on the South Valley, received the American Book Award in 1988. In the summer of 1995, Santiago-Baca was one of the featured poets on the Bill Moyers PBS series, Language of Life. His poetry speakes to a vision of change and community transformation through creative expression.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Cathy A. Malchiodi, MA, A.T.R., Editor

Art Therapy, the official journal of the American Art Therapy Association, is a quarterly journal for professionals and students who are interested in the use of art in the fields of mental health, psychotherapy and human development. The purpose of the *Journal* is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. *Art Therapy* publishes refereed articles, including illustrations, by art therapists, psychologists, family therapists, and others that reflect the latest advances in theory, research, professional issues, and practice. An emphasis is placed on the use of visual arts in therapy, but articles in related disciplines of interest are considered for publication. *Art Therapy* is an important source for news and summaries of national conferences, book reviews, media, and commentaries.

Recent articles published in *Art Therapy:*

- Art Therapy: Building Barriers with Native American Clients
- LA '94 Earthquake in the Eyes of Children: Art Therapy with Elementary School Children Who Were Victims of Disaster
- Use of a Drawing Task in the Treatment of Nightmares in Combat-Related PTSD
- Outpatient Art Therapy with Multiple Personality Disorder: A Survey of Current Practice
- Art Therapy at the Crossroads: Arts *and* Science

Art Therapy is available to AATA Members as part of their membership.

Non-Members may subscribe at the following annual rates:
Individuals: $50.00 (U.S.) - $74.00 (Foreign)
Institutions: $77.00 (U.S.) - $100.00 (Foreign)

Single copies are available at:
Members: $12.50 - Non-Members: $23.00

Make checks or money orders payable to AATA and return with this subscription order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my subscription. Enclosed is a check in the appropriate amount: $ ____________

Name: ______________________________

Address: ______________________________

City: ____________________ State: ________ Zip: ____________

The following books authored by members of the
American Art Therapy Association
are available for purchase.

	MEMBERS	NON-MEMBERS
A History of Art Therapy in the United States [1, 2] (1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual [3] (1994) Howie & Gutierrez ISBN 1-882147-16-2	$20.00	$35.00
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0 [1, 2]	$24.00	$35.00
Art Therapy in the Schools [3]	$ 6.00	$10.00
National Registry of Masters Theses & Practicum Papers [3]	$15.00	$25.00
Addendum to National Registry of Masters Theses & Practicum Papers [3]	$12.50	$22.50
AATA Chapter Manual [3]	$12.00	N/A
Applying for Funds from Your Area Agency on Aging [3]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance [3]	$ 7.00	$10.00

NOTE: [1] Postage included on all orders for this publication. [2] Ten or more copies - 10% discount. [3] Add $3.00 for postage.

Make checks or money orders payable to AATA and return with this order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my order. Enclosed is a check/money order in the appropriate amount: $____________

Name: ____

Address: ____

City: ______________________ State: ______ Zip: ______________

The following posters by members of the
American Art Therapy Association
are available for purchase.

	MEMBERS	NON-MEMBERS
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Shipping and handling is included on both posters.

Make checks or money orders payable to AATA and return with this order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my order. Enclosed is a check/money order in the appropriate amount: $____________

Name: ____

Address: ____

City: ______________________ State: ______ Zip: ______________

AATA REGIONAL SYMPOSIA

ADDICTIONS

Presenters: Lynn Jones, Holly Feen, and Katie Webb

Participants will receive the latest information on the use of art therapy in the treatment of addiction and dual diagnosis. Art therapists will be able to identify specific non-verbal approaches for working through resistance and denial in the treatment of substance abusers. Counselors will be able to identify specific ways in which to coordinate treatment efforts with art therapists in their facilities.

FAMILY ART THERAPY

Presenters: Mari Fleming, Shirley Riley, and James Consoli

The objectives of this symposium are to provide the participants with an overview of how art therapy provides families an enriched vocabulary to assist them in solving family problems. The art therapy gives a "voice" to all age levels and offers a non-threatening vehicle to aid in communication restructuring the family system. The intensive workshop will offer ways to combine family theories with art expressions and examine assessment methods, short and long term treatment. Participants will engage in experiential opportunities to experience how art therapy is applicable in their own professional setting. Every effort will be made to offer the most current trends in family therapy and art therapy application.

ART THERAPY IN SCHOOLS

Presenters: Janet Bush, Sarah Hite, and (third presenter to be announced)

This symposium will provide participants with the administrative procedures for implementing art therapy services and programs in schools. Topics will focus on the uses of art therapy in schools; roles and responsibilities of school art therapists; techniques and strategies for working with students; training and preparation of school personnel; and the funding and marketing procedures required for school art therapy programs. Participants will be prepared to transfer techniques and strategies for implementing art therapy services and programs to school settings.

ART THERAPY WITH THE OLDER ADULT

Presenters: Larry Barnfield, Bernadette Callanan, and Judith Wald

The symposium will cover general views on aging, relevant facts and new research, the role of art therapy with elders and settings in which art therapists practice and the special advantages of art therapy with the aging. It will cover the goals of treatment, treatment issues, and consideration of the clinical treatment of three groups of vulnerable aging and case studies.

GRANTS: GOING FOR THE GOLD

Presenters: Frances Anderson, Vija Lusebrink, and Doris Arrington

Successful grant writing in art therapy is, and will continue to be an important survival strategy in the 90's. Many model art therapy projects funded by grants will be discussed. The entire grant writing and granting process from identification of funding sources (public and private), to proposal development, submission and implementation will be covered. Technical assistance will be available to participants who already have a grant idea or proposal "in process".

ART THERAPY WITH CHILDREN AT RISK

Presenters: Cathy Malchiodi, Julie Epperson, and (third presenter to be announced)

This symposium proposes to fill the need for advanced art therapy training focusing on theory, interventions, methodology and research with children at risk. "Children at risk" are defined as those who are directly affected by family violence, physical and sexual abuse, neglect homelessness, and various disabilities such as attention deficit hyperactivity disorder, learning problems, and physical limitation which put them at further risk for abuse and neglect. Emphasis will be on how the clinician can develop both short and long term art therapy interventions, effectively assist the child in crisis and appropriately utilize art expression in assessment of current level of psychological functioning.

ART AND MEDICINE

Presenters: Cathy Malchiodi, Anita Mester, and (third presenter to be announced)

The symposium will focus on the unique dimensions of art therapy within a medical context with people who have experienced life-threatening chronic illness, particularly cancer and HIV. The special role that art expression plays in the assessment and evaluation of both the somatic and psychological status of the individual will be discussed, supported by the current research of both art therapists and clinicians in related fields. Special emphasis will be on paradigms for the use of art therapy within the context of psychoneuroimmunology and mind/body healing. Theories of imagery from current research by Achterburg, Simonton, Bach and others will be covered to assist the participants in integrating the use of art expression with physically ill clients will be presented so that participants acquire an understanding of the practical aspects of adapting art therapy to specific disease conditions. Lastly, emotional and transpersonal issues of grief and loss which are intrinsic to the experience of physical life threatening illness will be addressed.

ADOLESCENT ART THERAPY

Presenters: Kris Sly-Linton and (three other presenters to be announced)

The Adolescent Art Therapy Symposium will cover a wide range of topics designed to address a specific focus area requested by the sponsoring organization. This is a somewhat unique approach to the traditional symposia format but considering the multiplicity of problems regarding the treatment of adolescents today, it was felt this would be a way to make each symposium more pertinent to the intended audience. The four person team headed by Kris Sly-Linton, A.T.R.-BC, was coordinated to include professional art therapists that can provide the expertise required to address the following areas: Special Populations of Adolescents, Program Focus, and Teens and Family Systems.

These Symposia are offered at no charge to the participating Chapter

• • • • • • • • • • • • • • • • • •

For further information regarding the content or scheduling of these symposia, please contact:

AATA National Office • 1202 Allanson Road • Mundelein, Illinois • 60060 • (847) 949-6064 • (847) 566-4580

Monday through Friday - 9:00 a.m. to 5:00 p.m. - Central Time

The American Art Therapy Association

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 4,750 professionals and students. It is governed and directed by a nine-member Board, elected by the membership. AATA has established standards for art therapy education, ethics, and practice. AATA committees actively work on governmental affairs, clinical issues and professional development. AATA's dedication to continuing education and research is demonstrated through annual national conferences and regional symposia, publications, videos, and awards.

MISSION STATEMENT

The American Art Therapy Association is an organization of professionals dedicated to the belief that the creative process involved in the making of art is healing and life enhancing.

Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy.

ART THERAPY:
DEFINITION OF THE PROFESSION

Art therapy is a human service profession that utilizes art media, images, the creative art process, and patient/client responses to the created products as reflections of an individual's development, abilities, personality, interests, concerns, and conflicts. Art therapy practice is based on knowledge of human developmental and psychological theories which are implemented in the full spectrum of models of assessment and treatment including educational, psychodynamic, cognitive, transpersonal, and other therapeutic means of reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, and increasing self-esteem.

Art therapy is an effective treatment for the developmentally, medically, educationally, socially, or psychologically impaired; and is practiced in mental health, rehabilitation, medical, educational, and forensic institutions. Populations of all ages, races, and ethnic backgrounds are served by art therapists in individual, couples, family, and group therapy formats.

Educational, professional, and ethical standards for art therapists are regulated by the American Art Therapy Association. The Art Therapy Credentials Board, Inc. (ATCB), an independent organization, grants post-graduate registration (A.T.R.) after reviewing documentation of completion of graduate education and post-graduate supervised experience. The Registered Art Therapist who successfully completes the written examination administered by the ATCB is qualified as Board Certified (A.T.R.-BC), a credential requiring maintenance through continuing education credits.

CHAPTERS

Affiliated chapters of the AATA have been established throughout the United States. Chapters conduct meetings and activities which promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network for people working toward common goals. Information and support for chapter members is passed on from the Assembly of Affiliate Chapters to the local level.

You must be a national member to become a chapter member. Information on locating the chapter nearest you is available from the AATA National Office.

MEMBER BENEFITS

All members receive:

Publications

- *Art Therapy: Journal of the American Art Therapy Association* (published quarterly).
- *AATA Newsletter* (published quarterly).
- Substantial discounts on AATA publications, such as Annual Conference Proceedings, other professional journals, videos, and the Membership Directory.
- AATA literature, such as Educational Programs List, Art Therapy Media List, Standards of Practice, and mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life, and disability through Maginnis & Associates.
- Access to national experts in art therapy.

AATA Meetings

- Discounts on registration fees to AATA national conferences and regional symposia.

Nationwide Advocacy

- Governmental Affairs activities including congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payors.
- National liaison with related professional organizations for recognition and promotion of art therapy.

Professional Standards

- Development of Model Job Description and recommendations for licensing standards.
- Development and implementation of national Education Standards for approval of graduate level art therapy programs.
- Development and implementation of nationally recognized Standards of Practice and Ethical Standards for Art Therapists.

GENERAL INFORMATION

AATA and ATCB are administratively independent. Membership in AATA and registration (A.T.R.) with the ATCB require separate application and approval. *A.T.R. registration applications are available from the ATCB at (312)527-6764.*

For **new** associate, student, and contributing members only, please follow the dates below when submitting membership applications. The membership year is the calendar year **1/1 to 12/31**.

Applications received between:

1/1 to 5/31

Full dues payment; membership expires 12/31 of same year.

6/1 to 9/30

Half-year dues plus $5.00 payment; membership expires 12/31 of same year.

10/1 to 12/31

Full dues payment; membership for the remainder of current year and next full year.

CATEGORIES AND FEES

Professional-By application review process only; approved members may vote, hold office, and serve on committees.

- **Professional Member**-Individuals who have completed educational training in art therapy. Dues are $85.00/year.
- **Credentialed Professional Member**-Individuals who have been *dually approved* for Professional Membership by AATA and registration (A.T.R.) by the ATCB. AATA dues are $85.00/year. *Annual A.T.R. maintenance fee is billed separately by the ATCB.*

Associate-Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. This category is not open to master's level art therapy program graduates. Associates may not vote, hold office, or serve on committees. Dues are $85.00/year.

Student-Individuals who are currently taking full-time course work in art therapy or a related field. A current statement from the institution of learning indicating full-time status and course work content (6 graduate or 12 undergraduate credits) is required. Student members may not vote or hold office, but may serve on the Student Subcommittee of the Education Committee. Dues are $35.00/year.

Contributing-Individual organizations, institutions, or foundations which contribute annually to AATA. Such members may not vote, hold office, or serve on committees. Dues are $120.00/year.

Retired-Individuals who are at least 65 years of age and who are no longer practicing. Retired associates receive publications. Retired professionals receive publications and may vote, but may not hold office. Application provided upon request. The maintenance fee is $35.00/year.

The American Art Therapy Association

MEMBERSHIP APPLICATION

NAME ______________________________

HOME ADDRESS ______________________________

____

PHONE (   ) ______________________________

BUSINESS ADDRESS ______________________________

____

EMPLOYER ______________________________

JOB TITLE ______________________________

LICENSES HELD & STATE ______________________________

____

PREFERRED MAILING LIST: ☐ HOME ☐ BUSINESS

Foreign AATA applicants *must* include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

Please indicate under which category you are applying:

☐ $85 Associate Membership

☐ $35 Student Membership *(See student membership criterion for necessary documents to accompany this application.)*

☐ $120 Contributing Membership

Professional Member-Individuals who have completed educational training in art therapy. Dues are $85.00/year.

☐ Professional Membership Application

Credentialed Professional Member-Individuals who have been *dually approved* for professional membership by AATA and registration (A.T.R.) by the Art Therapy Credentials Board, Inc. (ATCB). AATA dues are $85.00/year. *Annual A.T.R. maintenance fee is billed separately by the ATCB.*

A.T.R. Application-Provided and processed by the ATCB. *A.T.R. granted by ATCB review approval process only.* For more information, contact the ATCB at (312)527-6764.

Please make all checks payable in U.S. dollars and mail to:

American Art Therapy Association, Inc. (AATA)
1202 Allanson Road
Mundelein, IL 60060
(847)949-6064 / Fax (847)566-4580

PLEASE COMPLETE THIS SURVEY.

Education (please check highest degree earned)

1 ☐ Doctorate Degree
2 ☐ Master's Degree
3 ☐ Bachelor's Degree
4 ☐ Associate/Certificate
5 ☐ Other ______________

Please indicate *exact* degree earned, e.g., BA, BS, MA, MS, PhD, etc.

Work Setting (please check only one)

1 ☐ Hospital
2 ☐ Clinic
3 ☐ Day Treatment Center
4 ☐ Rehabilitation
5 ☐ Sheltered Workshop
6 ☐ Correctional Facility
7 ☐ Residential Treatment
8 ☐ Out-patient Mental Health
9 ☐ School System
10 ☐ Elderly Care Facility
11 ☐ College/University
12 ☐ Clinical Training Program
13 ☐ Institute Training Program
14 ☐ Counseling Center
15 ☐ Private Practice
16 ☐ Other ______________

Area(s) of Specialization (please check up to three)

1 ☐ Addictions
2 ☐ Adolescents, Hospitalized
3 ☐ Adolescents, Psychiatric
4 ☐ Adults, Hospitalized
5 ☐ Adults, Psychiatric
6 ☐ Art History
7 ☐ Art Therapy Education
8 ☐ Art Therapy in Schools
9 ☐ Children, Hospitalized
10 ☐ Children, Psychiatric
11 ☐ Domestic Violence
12 ☐ Eating Disorders
13 ☐ Families
14 ☐ Gerontology
15 ☐ Hospice/Terminally Ill
16 ☐ Learning Disability
17 ☐ Mental Retardation
18 ☐ Neurological Disease
19 ☐ Prisoners
20 ☐ Post Traumatic Stress
21 ☐ Psychotherapy
22 ☐ Rehabilitation
23 ☐ Research
24 ☐ Sexual Abuse
25 ☐ Visual Art
26 ☐ Other ______________

Voluntary Information

Age

1 ☐ 20-24
2 ☐ 25-29
3 ☐ 30-34
4 ☐ 35-39
5 ☐ 40-44
6 ☐ 45-49
7 ☐ 50-54
8 ☐ 55-59
9 ☐ 60+

Salary Range

1 ☐ under $10,000
2 ☐ $10,000-14,999
3 ☐ $15,000-19,999
4 ☐ $20,000-24,999
5 ☐ $25,000-29,999
6 ☐ $30,000-34,999
7 ☐ $35,000-39,999
8 ☐ $40,000-44,999
9 ☐ $45,000-49,999
10 ☐ $50,000+

Gender

1 ☐ Female
2 ☐ Male

Hours Worked/Week

1 ☐ 0-10
2 ☐ 11-20
3 ☐ 21-30
4 ☐ 31-40
5 ☐ 41+

AMERICAN ART THERAPY ASSOCIATION, INC.

1202 Allanson Road, Mundelein, Illinois 60060 (847) 949-6064 FAX (847) 566-4580

RESOURCES

American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following publications, films, posters and training literature are available from the AATA National Office.

CONFERENCE PROCEEDINGS	MEMBERS	NON-MEMBERS
Creativity and the Art Therapist's Identity (1976) ISBN 1-882147-04-9	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) ISBN 1-882147-05-7	$ 5.00	$ 7.00
The Use of Creative Arts in Therapy (1979 Joint Conference)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) ISBN 1-882147-10-3	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) ISBN 1-882147-12-X	$ 7.00	$10.00
A Bridge Between Two Worlds (1981) ISBN 1-882147-11-1	$ 7.00	$14.00
Art Therapy: Still Growing (1982) ISBN 1-882147-06-5	$10.00	$14.00
Professionalism in Practice (1988) ISBN 1-882147-08-1	$15.00	$20.00
Painting Portraits: Families/Groups/Systems (1989) ISBN 1-882147-07-3	$15.00	$20.00
Image and Metaphor (1991) ISBN 1-882147-09-X	$15.00	$20.00
The Art Therapist: Artist/Teacher/Clinician/Healer (1992) ISBN 1-882147-14-6	$15.00	$20.00
Common Ground: The Arts, Therapy, & Spirituality (1993) ISBN 1-882147-21-9	$15.00	$20.00
Reflecting on the Past, Envisioning the Future (1994) ISBN 1-882147-24-3	$15.00	$20.00
Weaving New Visions (1995) ISBN 1-882147-50-2	$15.00	$20.00

NOTE: Ten or more copies of any single proceeding: 10% discount on total. Set of four proceedings (consecutive years): 20% discount on total. Postage and handling: $3.00 first item: $0.75 each additional.

PUBLICATIONS	MEMBERS	NON-MEMBERS
A History of Art Therapy in the United States [1,2] (1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual [3] (1994) Howie & Gutierrez ISBN 1-882147-16-2	$20.00	$35.00
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0 [1,2]	$24.00	$35.00
Art Therapy in the Schools [3]	$ 6.00	$10.00
National Registry of Masters Theses & Practicum Papers [3]	$15.00	$25.00
Addendum to National Registry of Masters Theses & Practicum Papers [3]	$12.50	$22.50
AATA Chapter Manual [3]	$12.00	N/A
Applying for Funds from Your Area Agency on Aging [3]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance [3]	$ 7.00	$10.00

NOTE: [1] Postage included on all orders for this publication. [2] Ten or more copies - 10% discount. [3] Add $3.00 for postage.

PROFESSIONAL PREPARATION LITERATURE	MEMBERS	NON-MEMBERS
Education Standards	$ .32	$ 1.00
Educational Program List (Colleges and Universities offering art therapy programs)	$ .32	$ 2.00

General Information Packet - $3.00 (includes: Education Standards, Educational Program List, and Information and Membership Application)

OTHER LITERATURE	MEMBERS	NON-MEMBERS
Art Therapy Model Job Description	$ .32	$ 1.00
Art Therapy Media List	$ .32	$ 1.00
Bibliography: Books Authored by AATA Members	$ .32	$ 1.00
Ethical Standards for Art Therapists	$ .32	$ 1.00
Standards of Practice	$ .32	$ 1.00

MEMBERSHIP INFORMATION	**MEMBERS**	**NON-MEMBERS**
Membership Specialty List	$ 2.62	$ 3.62
Membership Survey	$ .32	$ 2.32
Membership Directory [1]	$14.00	$55.00
Criteria and Application for Professional Membership	$ .32	$ 1.00

NOTE: [1] Postage and handling for AATA Directory: U.S. - $3.00; Canada/Mexico - $3.25; Foreign - $10.00.

POSTERS	**MEMBERS**	**NON-MEMBERS**
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Shipping and handling is included on both posters.

SUBSCRIPTIONS		
Art Therapy: Journal of the American Art Therapy Association	Individuals = U.S. $50.00	Foreign = U.S. $74.00
	Institutions = U.S. $77.00	Foreign = U.S. $100.00
Back Issues	Members = $12.50	Non-Members = $23.00
AATA Newsletter	U.S. $26.00	Foreign $38.00

NOTE: Shipping and handling is included on both subscriptions.

VIDEOS	**TYPE**	**MEMBERS**	**NON-MEMBERS**
Art Therapy Beginnings (1977) color/sound/45 min.	1/2" VHS	$50.00	$80.00
Michael (1977) color/sound/12 min.	1/2" VHS	$50.00	$80.00
Art Therapy (1980) color/sound/12 min.	1/2" VHS	$50.00	$80.00

NOTE: [1] Postage and handling for each VHS tape: U.S. - $3.00; Canada/Mexico - $3.25; Foreign - $10.00.

---

1. WE DO NOT ACCEPT CREDIT CARDS OR PURCHASE ORDERS. All orders must be made in writing, accompanied by payment in cash, check, or money order in U.S. funds.
2. FOREIGN ORDERS: Shipping will be made per your instructions (surface or air). Please specify shipment method when ordering. Additional postage, if necessary, will be billed separately.
3. RETURNS ARE NOT ACCEPTED for refund on shipped items.

TITLE	QUANTITY	PRICE	TOTAL

SHIPPING INFORMATION

NAME:

MEMBER ID#:

STREET:

CITY/STATE/ZIP:

Total: $

Postage: $

Applicable Discount: $

TOTAL ENCLOSED: $

Allow 2 - 4 weeks for delivery.
MAKE CHECKS PAYABLE TO AATA

ATTENTION AUTHORS

In order to help us process your submission more quickly, please complete the following information and attach one copy to each copy of your manuscript:

Name: ____________________

Degrees/Credentials: ____________________

Address: ____________________

Phone numbers: **Home** ____________________ **Work** ____________________

Type of Submission (check one):

☐ Article ☐ Viewpoints ☐ Brief Report

☐ Film/Video Review ☐ Book Review

Title of Submission: ____________________

____

Checklist:

☐ Five (5) copies, typewritten on 8 1/2" x 11" paper.

☐ Black and white photos of original artwork plus four (4) photocopies of each.

☐ Paper and references adhere to *Publication Manual of the American Psychological Association* (Fourth Edition).

☐ Abstract of 75-125 words (for articles and brief reports only).

☐ Detachable cover sheet with author(s) name(s), affiliation, degrees and credentials.

☐ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

☐ This Attention Authors form.

Author's Signature ____________________ **Date** ____________________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association*,** c/o AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

GUIDELINES FOR SUBMISSIONS

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy* uses a blind peer review procedure for full-length articles and brief reports; final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor and special section editors.

The following are guidelines for developing and submitting a manuscript. **Manuscripts that do not conform to these guidelines will be returned to the author without review.**

Manuscript Categories

1. **Full-length Articles.** Full-length articles may focus on the theory, practice and research in art therapy or related areas. Manuscripts must include an abstract of approximately 75-125 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Manuscripts should include information on the research design, methodology and results; an abstract of approximately 75-125 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
5. **Film/Video Reviews.** Reviews of media (films or videotapes) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office at the address listed above.
6. **Comments.** Brief comments on articles published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

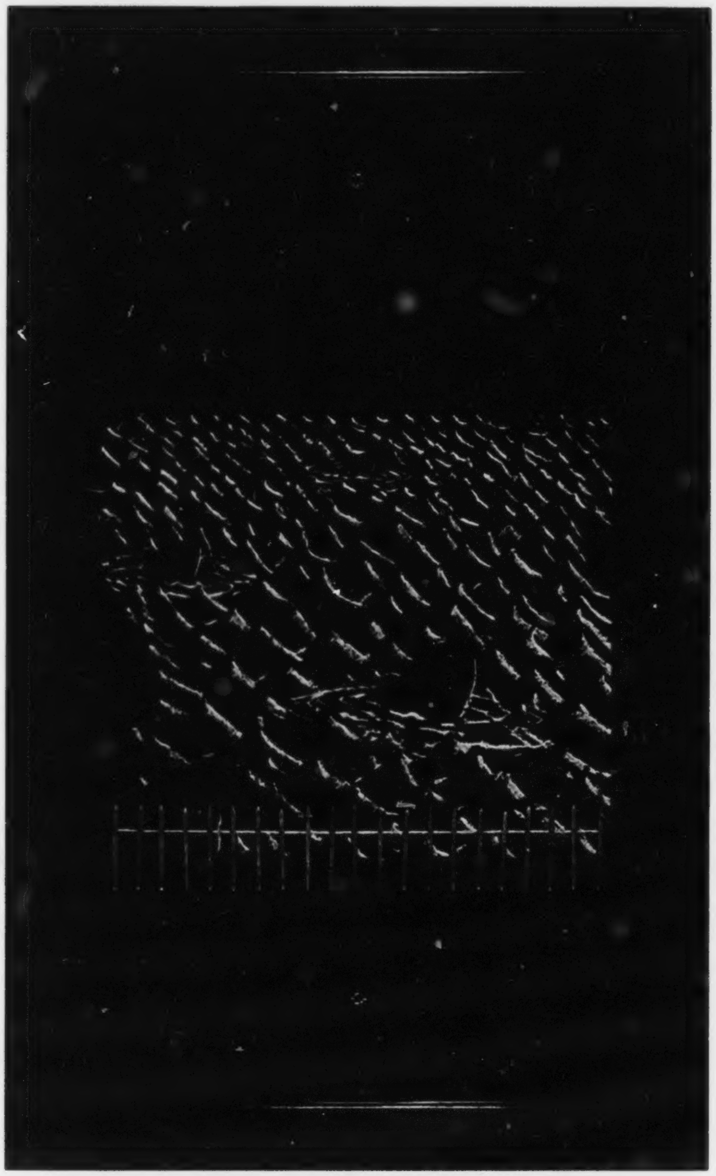
Other Requirements

1. Send **five (5) clear copies** of each manuscript to **Editor, *Art Therapy: Journal* of the American Art *Therapy Association*, c/o American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original articles that are not under consideration by another periodical or publisher are acceptable.
3. Manuscripts must be typewritten on 8 1/2" x 11" white paper with margins of at least an inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Manuscripts must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for more information.
5. An abstract of 75-125 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the APA *Publication* Manual for style of tabular presentations. All tables, charts or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" x 7" and black and white glossy prints, preferably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs; captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions, which is addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. **It is the author's responsibility to secure such permissions;** a copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any manuscript accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their manuscripts on either an IBM, IBM-compatible or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the manuscript to the AATA office. This will help speed processing, editing and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations and materials accompanying their manuscripts.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION



VOLUME 13, NUMBER 2, 1996

2321 **BEST COPY AVAILABLE**

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, 60060 U.S.A. Telephone (847)949-6064; FAX (847)566-4580. Non-members may subscribe at the following annual rates: $50 (U.S.) and $74 (Foreign); institutions $77 (U.S.) and $100 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 U.S.A. (847)949-6064.

This journal is abstracted in: Resources in Education (ERIC), Art Bibliographies Current Titles, Art Bibliographies Modern, and PsycINFO.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to American Art Therapy Association, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE
American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060 U.S.A.
(847)949-6064 and FAX (847)566-4580

MISSION STATEMENT: The American Art Therapy Association, Inc. (AATA) is an organization of professionals dedicated to the belief that the creative process involved in the making of art is healing and life enhancing. Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy.

ADVERTISING RATES

RATES	1×	2×	3×	4×
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"
Trim Size: 8-1/2" × 11"		

SUBMISSION DEADLINES:
January 15 for Spring issue; April 15 for Summer issue.
July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The publication of any advertisement by this journal is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc. is not responsible for any claims made in an advertisement.

Editor
Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Susan Spaniol, EdD, A.T.R., LMHC
Lesley College, Cambridge, MA

Book Review Editor
Erika Cleveland, MA, A.T.R., LMHC
Lesley College, Cambridge, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Friends Hospital, Philadelphia, PA

Production Editor
Karen D. Savage

Editorial Board
Pat B. Allen, PhD, A.T.R., LPAT
School of the Art Institute, Chicago, IL
Janet Bush, EdS, A.T.R.-BC
Dade County Public Schools, Miami, FL
Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec, Canada
Mariagnese Cattaneo, PhD, A.T.R., LMHC
Lesley College, Cambridge, MA
Susan E. Cheyne-King, MS, A.T.R., LPC, NBCCH
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R., LPAT
George Washington University, Washington, DC
Anna R. Hiscox, MA, A.T.R.-BC, MFT
Illinois State University, Normal, IL
Sarah Hite, MS, MSEd, A.T.R.-BC
Eastern Virginia Medical School, Norfolk, VA
John G. Jones, PhD, A.T.R.-BC
Indian Health Service, Wolf Point, MT
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Frances F. Kaplan, DA, A.T.R.-BC
Hofstra University, Hempstead, NY
Leslie Knowles, MA, A.T.R., LMHC
Lesley College, Cambridge, MA
Vija B. Lusebrink, PhD, A.T.R.-BC, HLM
University of Louisville, Louisville, KY
Patricia Engle Murphy, PhD, A.T.R.
Private Practice, Moscow, ID
Mary Ellen Peacock, MA, A.T.R.-BC
St. Francis of Assisi School, Louisville, KY
Trudy Manning Rauch, MS, A.T.R.-BC
Eastern Virginia Medical School, Norfolk, VA
Shirley Riley, MA, A.T.R., MFCT
Loyola Marymount University, Los Angeles, CA
Irene Rosner David, MA, A.T.R.-BC
Bellevue Hospital Center, New York, NY
Patricia St. John, EdD, A.T.R.-BC
College of New Rochelle, New Rochelle, NY
Nancy M. Sidun, PsyD, A.T.R.
The Chicago School of Professional Psychology, Chicago, IL
Evelyn Virshup, PhD, A.T.R., MFCC
California State University, Los Angeles, CA
Judith Wald, MS, A.T.R.
New York Hospital - Cornell Medical Center, White Plains, NY

AATA President
Virginia Minar, MS, A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

2322

VOLUME 13

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 2, 1996

Editorial

Finding Art Therapy on Databases — Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC . . . 86

Commentaries . . . 88

Articles

Contributions to Art Therapy Literature: A Computer Database Survey — Heather Anne Zeigler, MA, A.T.R. and Ronald Hays, MS, A.T.R. . . . 91

The Dimensions of Service: An Elemental Model for the Application of Art Therapy — Randy M. Vick, MS, A.T.R.-BC . . . 96

Dali to Beuys: Incorporating Art History into Art Therapy Treatment Plans — Simone Alter Muri, EdD, A.T.R., LMHC . . . 102

Images of the Heart: Archetypal Imagery in Therapeutic Artwork — Judith Kidd, MA and Linney Wix, MA, MEd, A.T.R., LPAT . . . 108

Brief Reports

Children's Drawings of the Elderly: Young Ideas Abandon Old Age Stereotypes — Joseph A. Weber, PhD; Kathy Cooper, MS, RN; and Jenny L. Hesser . . . 114

Gender Differences and Similarities in the Spatial Ability of Adolescents — Rawley Silver, EdD, A.T.R.-BC, HLM . . . 118

American Art Therapy Association, Inc.: The Results of the 1994-1995 Membership Survey — S. Lorraine Pearson, BA; Kathy K. Walker, BFA; Melinda Martinek-Smith, BFA; Nancy M. Knapp, PhD; and Kenneth A. Weaver, PhD . . . 121

Viewpoints

A Place to Stand: Maori Culture-Tradition in a Contemporary Art Studio — Michael Franklin, MA, A.T.R., LSW . . . 126

Pioneering in Perth: Art Therapy in Western Australia — Michael Campanelli, EdD, A.T.R., LSW . . . 131

Earthquake! — Susan Andruk, MA, A.T.R. . . . 136

Reviews

Existential Art Therapy: The Canvas Mirror (Second Edition) — Patricia Engle Murphy, PhD, A.T.R. . . . 141

Creative Whack Pack: Success Edition — Roz Rutstein, MEd, MAAT, A.T.R.-BC . . . 142

Noteworthy . . . 144

About the Cover: "Domain of the Self II," 18" × 30" by Michael Franklin, MA, A.T.R., LSW, Bowling Green, OH. This assemblage of found and constructed objects reflects a series of associations related to internal spaces accessed through a devoted meditation practice.

23523

Editorial

Finding Art Therapy on Databases

Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC, *Editor*

In "Contributions to Art Therapy Literature: A Computer Database Survey" in this issue of *Art Therapy*, co-authors Ziegler and Hays note in their survey of seven major computer databases that twice as many articles on these databases were authored by individuals who are not art therapists than art therapists. The databases surveyed were: CINAHL (Cumulative Index to Nursing and Allied Health Literature), ERIC (Educational Resources Information Center), HEALTH, MedLine, PSYCH-LIT, SPORT Discus, and Wilson Social Sciences Index. The authors examined material from 1983–1993, tabulating the frequency of articles in which a specific reference was made to art therapy. They also attempted to determine if the authors of articles that appeared in each database were written by individuals with training, professional membership, and/or registration in the field of art therapy.

Although Ziegler and Hays note some problematic aspects in their methodology, their results certainly do underscore the fact that more non-art therapists' published articles are consistently found on databases than articles written by art therapists. They conclude that one of the main reasons for this phenomenon is the lack of inclusion of this and other art therapy journals on major computer databases. *Art Therapy* has only recently been reinstated on PsycINFO and ERIC; it is still impossible for researchers and students to obtain information on many articles appearing in this journal published prior to 1995. MedLine and CINAHL have yet to include *Art Therapy*, which explains why many healthcare professionals have difficulty accessing references to works published in this journal. Art therapy articles written by art therapists are often simply unavailable to those outside the field unless they are able to conduct a hand search of this and other art therapy journals at their local university or college library.

Why *Art Therapy* is Not Included in Some Databases

I am often asked by educators, researchers and students why they cannot locate references to articles in *Art Therapy* on some of the standard databases. First, the field of art therapy is difficult at best to classify and this may be a root cause of its database woes. Because art therapy is essentially a synthesis of the fields of visual art, psychology, and often several other subjects, the challenge for databases is how to categorize it. Does art therapy fit more with art, or is it more aligned with psychology? This is the very question that the profession has asked of itself over the years and is the same question asked by databases which consider including art therapy publications in their listings. For many databases the question of how to classify the subject of art therapy is unanswerable. As a result, art therapy journals may not be included because many databases do not see them as relevant to their specific subject areas and are not willing to take the time to make decisions on an article by article basis to determine if certain papers meet their criteria.

The profession also plays a part in the database problem. Although there is a great deal more literature on art therapy available today than 10 years ago, the available literature often lacks rigor (Malchiodi, 1993), including what is published in journals. The majority of large databases want to see that a journal is committed and dedicated to publishing research data. For some time, the lack of inclusion of art therapy articles in many databases has stemmed directly from the lack of published research. In a recent review of this journal, one large and prominent database specifically noted that most of the articles published in *Art Therapy* were "impressionistic," involving unstructured case material and unsupported observations, rather than using more rigorous standards, including quantitative and qualitative research models, to frame findings.

Lastly, the profession of art therapy expects this journal to wear many hats: to provide theoretical and methodological discourse, to publish scholarly research, to print personal viewpoints and commentaries, to review books and media, and to include visual art and poetry. Most professional journals only provide the first two items—theoretical and methodological discourse and research articles—and publish personal views, comments and reviews in newsletters or other publications. While it is the philosophy of this journal that the inclusion of personal viewpoints, commentaries, reviews, and art are extremely important to art therapy's knowledge base, this philosophy comes at a price when it comes to inclusion on databases. In many cases, databases tend to see this practice as detracting from the strength of the overall publication.

Art Therapy as Its Own Database

An important question emerges from this discussion—what can art therapists do to make the existing, current, and future published work of art therapists accessible to other professionals and students outside the field? Although things are looking up for *Art Therapy* which has been reinstated on PsycINFO and selected articles are included in other databases such as ERIC, many articles will never appear on any databases whatsoever. A hand search is still required to adequately search all issues of *Art Therapy*; since this journal is only carried by a relatively small number of libraries, this cumbersome practice is often difficult at best.

There are a few proactive moves the national association can make to change this situation. First, since many articles in this journal are not included on any database, a simple cumulative index is in order, listing titles of articles and authors. This would be a good first step and a standard one that many other professional journals already offer. Distributing or selling this document to those researchers, educators, and students who contact the association for information and to periodical departments of major university libraries could be, at the very least, a modest beginning and a simple way to promote the published work of art therapists.

A larger and much more difficult project would be to develop a comprehensive database by subject and eventually abstracts; to be even more adventurous, the titles, subjects, and authors of taped presentations given at the annual conference could be included. The goal would be to produce a cross-referenced computer database by subject, title, and author, and annotations such as key words or abstracts. This type of database is similar to PsycINFO or MedLine, where one can find information on a topic through key word, subject, title, or author searches. This is a time-consuming and costly project to undertake, but may be one of the only ways that the profession can make its own voice heard through promoting the written work of its professional members that may remain unknown or unavailable otherwise. If the field of art therapy is truly concerned about its recognition by other allied professions, government and healthcare agencies, this is a proactive step that the association can take to make the work of art therapists more well-known and accessible.

Lastly, at the conclusion of their article, Ziegler and Hays make a plea for art therapists to publish more of their work. Much of art therapy's knowledge base still remains oral history, often communicated at the annual conferences or chapter events, or in some cases, only in the classrooms of certain training programs. It is hard to say why some work presented year after year at annual conferences or in coursework remains largely unpublished. Perhaps art therapists are not inclined to spend the time it takes to write and prepare an article for publication in a journal or may be engaged in clinical or creative work which fills their time instead of writing. Or, perhaps there is a personal need to hold on to findings, ideas, protocols, and other information; seeing them in print means that this material is now available for use, public discussion, scrutiny, criticism, or creative development by others, both inside and outside the profession. In any case, the problem of the recognition of art therapists' published works is one that every one of us in the profession shares and will undoubtedly effect the course, direction, and growth of art therapy in the years to come.

Reference

Malchiodi, C. A. (1993). Introduction to special issue on art therapy and professionalism: Is there a crisis in art therapy education? *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 122–128.

1996 CALENDAR OF EVENTS

AUGUST

The 4th International "Exploration of Creativity" Conference will be held in St. Petersburg, Russia from August 17-20, 1996. The group will also travel to Lithuania and Prague, Czechoslovakia. Contact Maryanne Olsen at (201)262-7544 or fax (201)262-7579 for further information.

SEPTEMBER

"Illuminating the Path: The Art of Art Therapy," a juried exhibition of fine arts and crafts by regional art therapists, will open at the Floyd County Museum on September 17 and run through October 25, 1996 and is presented in conjunction with the Kentucky Art Therapy Association. This unique exhibition will encourage visitors to experience art in a new way, for new reasons. Art works will be displayed with the artists' description and reflection on the process - how the creation of the works has influenced them intellectually, emotionally, and spiritually. For more information pleas contact Roberta Jonkers at (502)429-0240 or Sally Newkirk at (812)944-7336.

The 17th Annual Canadian Art Therapy Association Conference "Vision and Voice—Art Therapy for People with Special Needs" will be held September 27-29, 1996 at the Harbourfront Centre in Toronto, Ontario. The keynote speaker will be Debra Linesch, PhD, A.T.R., MFCC, who will also be conducting a workshop during the conference weekend. For additional information contact Carol Burpee at (905)858-9642.

OCTOBER

The International Stress Management Association will conduct ISMA-6 on October 5-8, 1996 in Sydney, Australia in cooperation with several other organizations. For more information, call (619)635-4698, fax (619)635-4669, or Internet: NOSTRESS@sanac.USIU.edu.

The 1996 Joint National Conference: National Association for Drama Therapy/American Dance Therapy Association announce "Crossing Borders and Expanding Visions: A Conference of Collaboration." The conference will be held from October 17-20, 1996 at the Loews Santa Monica Beach Hotel in Santa Monica, California. Call (203)350-1620 for more information.

NOVEMBER

The 27th Annual American Art Therapy Association (AATA) 1996 Conference "Many Paths; Multicultural Perspectives in Art Therapy" will be held on November 13-17, 1996 at the Adams Mark Hotel in Philadelphia, Pennsylvania. For more information call (847)949-6064.

Commentaries

Letters to the Editor

Thank you for including membership dialogue about the lack of art therapy research in the most recent journal (Vol. 12, Number 4). At this point in the development of the art therapy profession and given the managed health care environment, we need to be grappling with question, "How do we really know art therapy works?" As art therapy professionals, how can we be satisfied with what we have to offer if we do not scientifically know *if* and *how* it is valuable and helpful to patients. We owe it to our profession and patients to validate that art therapy approaches are effective. This can be accomplished only through the active interplay of applied art therapy and sound art therapy research. These two pursuits are not discordant with each other, but rather they can/should dovetail to enhance the art therapy profession.

I believe that art therapy has valuable things to offer the field of mental health, and that we can demonstrate this with well-designed art therapy studies. In doing so, we will be allying with our colleagues in the field of psychology in identifying ourselves as part of a distinct scientific discipline which studies human cognition and behavior. In addition, this will help other mental health professionals, lay people, and managed care companies better understand art therapy and our unique therapeutic skills.

Art therapy could possibly be on the cutting edge in attempting to measure people's introspective experience. Behaviorists, in their attempts to study human behavior in a scientific manner, have avoided trying to measure private events because human behavior is more easily quantifiable. Art therapy provides a concrete, potentially measurable bridge between a person's observable behavior and internal experience. Cognitive psychologists have focused on verbal reports as objective measures of a person's internal experience. However, there are problems in assuming that a person's verbal report will be an accurate measure of his or her private experience. I believe a person's art products are closer to reflecting a person's internal experience than just looking at a person's behavior or considering his or her words. If we can contribute to the field by providing a more accurate means of understanding and explaining human consciousness, then we can improve our ability to predict behavior and influence therapeutic change.

How can we facilitate sound clinical research in the art therapy field? The philosophy of our art therapy programs needs to shift to instill the idea that one needs to routinely ask and scientifically explore questions such as, "Is what I am doing helpful, and how?" Requiring prerequisite courses such as History and Systems in Psychology and Research Methodology will give students a foundation for thinking about our work with people in a scientific manner. In addition, students should be required to work as research assistants as part of their field training and internships. These experiences will introduce students to the trials and tribulations of doing research so that they will be more knowledgeable about what is involved when they attempt research on their own.

Finally, there should be more funding resources available from the AATA for any professional or student member who submits an approved proposal for art-therapy-specific research. There are art therapists, such as myself, in psychology doctoral programs who would like to contribute to the art therapy process by doing art therapy research for a dissertation, but currently the only funding available from AATA is for art therapists wanting to do free-standing research (i.e., not affiliated with a graduate program) or funding after the completion of a project.

In conclusion, we as art therapists have a lot to offer our clients as well as the field of psychology. It is time for us, as a mental health profession, to begin a concerted effort to work not only as excellent clinicians, but also as scientists-practitioners in the search for the best means of understanding and treating others.

Robin Gabriels, MA, A.T.R., LPC

In response to the recent Viewpoints and attendant material addressing art therapy research (*Art Therapy*, Vol. 12, No. 4, 1995), I would like to suggest to Dr. Tibbetts that he stop complaining and make a few ashtrays. If he exercised his creativity to address his frustration with the rest of us, he might come up with some innovative means to catalyze research activity in art therapy.

He clearly has a grasp of the means and methodology to perform art therapy outcome studies that would be of great value to the field. By initiating an online study group, for example, or proposing a focus group or preconference course at the annual conference, he could mentor others in the skills and ideas he values so highly. If he were simply to share the protocol of his outcome study on the Internet and invite other art therapists in similar settings to replicate his work, he would be making a great contribution. This could also provide an exciting possibility to graduate thesis students in programs across the country. Replication is essential to the widespread acceptance of research findings and such a task would be within the abilities of graduate students who might not have the time or knowledge to come up with a research project completely on their own.

It is easy to point the finger at graduate programs, blame the artists, and feel righteous. But, that is precisely the sort of behavior that holds us back, wounding one another rather than seeking common ground. For creative and innovative advances to be made, in research or any other area, acting from the heart, not the spleen is required. Be generous, share your passion, not just your vitriol; spread your knowledge around, Dr. Tibbetts, and you might be surprised at the results.

Pat B. Allen, PhD, A.T.R., LPAT

2326

I wanted first to commend you on the ongoing high quality of *Art Therapy*. I look forward to each new issue and have found the subjects represented stimulating and challenging. I have some concerns, however, with the ongoing "field versus discipline" debate which has been played out increasingly in this journal. I was especially struck by the Viewpoints section in the most recent issue of the journal (Tibbetts, 1995; Wolf, 1995).

In those articles I noted the continuing assumption that (a) art therapy must be either a "field" or a "discipline"—the designation "field" being preferable—and (b) that to gain credibility as a "field" (or "discipline") we must identify exclusively with the clinical/medical model of treatment or the studio/humanistic model of growth enhancement. Considering these arguments and the terms *field* and *discipline*, I observed that these terms are not necessarily exclusive of each other—rather they would seem rather complementary.

A "field," in my vision, is a wide open space where a variety of life can thrive. As the biological reference would imply, a field allows for a diversity of different species, each contributing to and supplementing the life of the whole.

"Discipline" would seem to imply a willingness to follow a belief, drive, or idea with the utmost faithfulness. In this the "discipline" would be willingness to limit attention to anything extraneous to the goal. The mastery and "perfection" of skill or understanding drive the ongoing pursuit.

The life of a "field" (in the biological and theoretical sense) is the product of the "disciplined" pursuit of many different life forms. As noted, activities are mutually supportive and the extinction of one part may be disastrous for the whole.

Tibbetts (1995) and Wolf (1995) both appear to present very *disciplined* views of art therapy. Yet within a view of the larger field of art therapy, there would seem to be room for both to grow along with many more without loss to one or the other.

Perhaps a consideration for the future life of our field is the recognition that within the larger framework of our profession various disciplines are developing. Each new addition offers a challenge to the status quo of our understanding of what art therapy is, and also allows for greater complexity and assurance of our survival.

On a more practical level, recognition of evolving art therapy disciplines presents a challenge in the training of future art therapists. Consideration might be given to acknowledged specialization of training programs to one or another discipline of art therapy (i.e., clinical, studio, medical, etc.). This already exists to some extent, but definition would allow greater clarity for potential students and educators.

Certification (A.T.R.-BC) has been presented as establishing "the most basic level of skill and knowledge required for a professional art therapist." Given the ongoing debate over what is most "basic" to our field, perhaps consideration should be given to developing certification specific to areas of specialization.

These responses may represent an oversimplification of the issues presented—they are meant only to present possibilities for future dialogue. My hope is that as our work continues we will be able to address the life and diversity within our profession with pleasure and excitement, not fear and protectiveness.

James J. Walker, A.T.R.-BC

References

Tibbetts, T. (1995). Art therapy at the crossroads: Arts and science. *Art Therapy: Journal of the American Art Therapy Association, 12*(4), 257–258.

Wolf, R. (1995). Invited response. *Art Therapy: Journal of the American Art Therapy Association, 12*(4), 259.

It is my pleasure to comment upon the authors' (Gadiel & Block) letter for Vol. 13, No. 1, 1996.

I am flattered that the authors have taken the time to respond with such conviction and interest to my article on "the studio as therapeutic intervention." And while their commentary seemed to be harshly critical, even sarcastic towards the end, I welcome the feedback; for, so few readers respond and engage authors such as myself that, indeed, any comment creates a dialogue that is preferred to indifference. I congratulate them on their fine program, yet stand by my observations and informed opinion.

David Henley, A.T.R.

"Who Owns the Artwork?" or "Do the Right Thing!"

This letter reflects the discussions of our Networking Group at the 1995 Coalition of Art Therapy Educators' meeting in San Diego and is also a response to Cathy Malchiodi's (1995) call for more debate on the topic of "Who Owns the Art?" Since the publication of the revised *Ethical Standards for Art Therapists* (1995, 2.6) stating: "Art therapists shall maintain patient treatment records…no less than seven years from completion of treatment," the question has been raised whether the artwork done by clients in art therapy sessions is the property of the artmakers (clients), the art therapists, or the institutions.

Jonathan Braverman, AATA Legal Counsel (1995, p. 24), says that "in many instances artwork may constitute a medical record," and recommends that art therapists photograph the artwork (with prior written consent of the client) for the records so that they can return the original work to the client. Dee Spring (1994) emphasizes the importance of maintaining photographic records and keeping "all the original assessment drawings," (p. 26) particularly because art therapists may be called on to produce artwork in a court of law if they are sued or if they are called to testify for a client.

We think that the artwork done by clients in art therapy sessions belongs to the artmakers. In the debate by art therapists and lawyers about "who owns the artwork," one voice is missing, the client's. Where (and if) the artwork is kept, by whom, during and after treatment, and who outside of the therapy session may see the artwork are all clinical questions to be answered together by the art therapists *and* client in a manner that best suits the client's interests and wishes. Art therapists typically store their clients' artwork so they can review them periodically with clients and sometimes with treatment teams and supervisors. Safekeeping clients' artwork may become a means of safeguarding their "psychic baggage." Helping clients take ownership of the work they are doing is often an important part of the therapy. Clients' desires to destroy, display, or take home artwork may also become grist for the therapeutic mill. Destruction of art can be a cathartic act or a self-abusive gesture; display of art can be ego-enhancing or anger-provoking; taking art home can elicit empathy or misunderstanding from others. It is the art therapist's responsibility to facilitate clients' understanding of their motivations and the consequences of their actions related to their artwork and to encourage decisions and behavior that foster emotional growth.

No one has written that original artwork does *not* belong to the clients (except in the case of assessments, as cited above). However, no one has addressed a central question: What if clients refuse to give us consent to photograph the artwork? If we redefine section 2.6 of our Ethical Standards to say we must photograph clients' artwork, we could be caught between two contradictory mandates in our ethical code—to photograph or not to photograph without consent. The specter of coercing clients is frightening, unthinkable. Our ethical code exists to ensure our clients' rights; staying out of lawsuits should be a byproduct of our ethical behavior. Perhaps it would help us to remember the United Nations Universal Declaration of Human Rights, article 27.2 (brought to our attention by art therapist Karin Dannecker, from Berlin, Germany), which says, "Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author." Keeping in mind that our clients own the artwork *and all rights thereof* will help us find our way through such ethical and moral entanglements.

Even if our clients give us permission to photograph artwork for our records, is it necessary and ethical for us to do so? Spring writes:

> It seems that clinical work done in art therapy sessions...comes under the same rule as other medical records.... Each profession has specific materials that are deemed part of the clinical record (i.e., x-rays, photographs of injuries or damage, test results, etc.). What makes art therapists differ in terms of clinical materials and records of the treatment is primarily based on the art product of the patient. (1994, pp. 26–27)

Equating artwork to x-rays or test results is a little different from comparing artwork to blood, tissue, or urine samples. A more accurate analogy would be comparing art done in art therapy sessions to words exchanged in verbal therapy. Psychotherapists who rely solely on talking are not expected to maintain records in the form of audiotapes; rather, they summarize their sessions as written progress notes and paraphrase significant statements as closely as possible. In cases where art therapists are not able or choose not to photograph clients' artwork, they should be able to describe the art in words (similar to summarizing verbal sessions) and draw facsimiles of the art (analogous to paraphrasing words).

In discussing practical problems with photographing artwork, Malchiodi (1995, p. 2) cites an example of one hyperactive child who goes through a half-ream of computer paper in a session. Although Braverman (1995, p. 15) writes, "Issues of professional responsibility and potential professional liability often outweigh cost considerations," does he realize that many art therapists would have to take hundreds of photos/slides a week? And with so much photographing and filing to do, would art therapists have time left for the other essential part of record keeping—writing about the artmaking process, making assessments, setting goals? In addition to cost, storage, and time considerations, what about the confidentiality issue of all those thousands of labeled photos getting into the wrong hands?

The discussion about "who owns the artwork" has sensitized art therapists to the importance of keeping careful records, but they should have the discretion to interpret "medical records" in a manner that suits their practice. Malchiodi will probably not photograph that half-ream of scribbles, but art therapists working in areas where there is potential for litigation might photograph whatever artwork they have permission to and record to the best of their ability whatever clients say and do.

To find a disinterested legal opinion about the ownership of art, Susan Spaniol telephoned Ira Burnham, Legal Director of the Bazelton Center for Mental Health Law in Washington, DC, a center founded in response to the Americans With Disabilities Rights Act. Burnham (1995) agreed that AATA should take a position on ownership rather than rely on the judgment of individual professionals, and he also advised negotiating photography of artwork at the beginning of treatment. However, he went on to say:

> The possibility of a suit is minimal and the idea that there would be damages awarded is also minimal. If there were a suit, it would be a bizarre law suit, or else a very small part of a larger suit involving something very significant. Photography may not be worth the cost, in addition to its cost in the therapeutic relationship. (1995)

Burnham concluded by declaring, "The law has no asnwer. The profession should do the right thing and decide that the art belongs to the client."

How AATA chooses to respond to the question "Who owns the artwork?" can undermine or reaffirm the moral foundations of our work as art therapists. As the professional organization of art therapists, AATA should do the right thing and declare that artwork belongs to the people who created it. Karin Dannecker forwarded catalogue notes from an art exhibition in Denmark honoring the 40th anniversary of the Declaration of Human Rights. Else Bulow (1988), museum director, writes: "No one can take away the imaginative life of others, not the energy of their images. This is the ultimate human right".

Martha P. Haeseler, MA, A.T.R.-BC
Mari M. Fleming, MA, A.T.R.-BC, MFCC
Leslie Knowles, MA, A.T.R., LMHC
Susan Spaniol, EdD, A.T.R., LMHC

References

American Art Therapy Association. (1995) *Ethical standards for art therapists. Part 1.* Mundelein, IL: Author.

Bulow, E. (1988). *Catalogue notes for an art exhibition honoring the 40th anniversary of the Universal Declaration of Human Rights.* Aalborg, Denmark: Nordjyllands Kunstmuseum.

Burnham, I. (1995). Personal communication.

Braverman, B. (1995). Retention of treatment records under the new AATA Ethics Standards. *AATA Newsletter, XXVIII*(1), 15 & 24.

Malchiodi, C. A. (1995). Who owns the art? *Art Therapy: Journal of the American Art Therapy Association, 12*(1), 2–3.

Spring, D. (1994). Who owns the artwork? *AATA Newsletter, XXVII*(4), 26–28.

United Nations (1948). *Universal declaration of human rights.* New York: Author.

Art Therapy: Journal of the American Art Therapy Association, 13(2) pp. 91-95 © AATA, Inc. 1996

Contributions to Art Therapy Literature: A Computer Database Survey

Heather Anne Zeigler, MA, A.T.R., Harrisburg, PA, and
Ronald Hays, MS, A.T.R., Philadelphia, PA

Abstract

Art therapy literature available on computer databases was surveyed to assess the literary activity of registered art therapists along with other mental health professionals between the years 1983 and 1993. Computer databases were selected as the source of gathering information because they offer a wide and varied audience accessibility to a vast amount of information. Information available from the databases is often the first encounter persons have with professional literature. Seven computer databases were surveyed for the frequency of entries containing the term art therapy. *Findings revealed that twice as many articles authored by individuals other than A.T.R.s were included in these databases. Implications for the field of art therapy and its practitioners and potential compromises in the delivery of services are discussed.*

Introduction

This paper describes a survey of art therapy articles in order to determine the amount, authorship, and source of such articles on computer databases. There were no known precedents for such a survey assessing the availability of published articles concerning art therapy on computer databases such as CINAHL, ERIC, MedLine, and others. Since these databases are widely used by researchers in health-related fields, the inclusion of art therapy articles has an important impact on the understanding and acceptance of the field.

Published research information available on these computer databases includes the title of the published work, authors' names, journal title, page numbers, date of publication, journal issue, key words, and a brief abstract if available. This information represents the initial encounter any researcher would have with an article.

In order to determine who was writing art therapy articles included on computer databases, the investigators considered the authors' credentials and training. An author's qualifications for writing about art therapy may vary depending on his or her education in art therapy as well as years of practice and membership activity in the professional organization. A Registered Art Therapist (A.T.R.) as defined by the American Art Therapy Association is an individual who has completed an acceptable level of education in art therapy, which is approximated with competency. Professional membership in AATA suggests the employment of a code of ethics and certain standards of practice. Given the above issues, assessing the registration status of the author at the time of publication was felt to be significant for several reasons:

- Differences exist in the level of education, clinical supervised training, and experience in art therapy among A.T.R.s, individuals working towards registration (students or graduates), associate members of AATA who may support and recognize the profession (i.e., psychiatrists, psychologists, social workers), and individuals who are not members of AATA and may not recognize the profession of art therapy or acknowledge the education and experience needed to practice art therapy or utilize art therapy techniques.
- It would seem that the knowledge base of the practitioners would suggest varying degrees of understanding of art therapy. Such differences could be reflected in art therapy publications written by these different types of practitioners.
- Ethical questions arise when individuals write about a therapeutic practice in which they may not be qualified, and their writing could have an effect on potential patient care. If information contained in an article is incomplete, misleading, or erroneous, the potential exists for that information to be unknowingly utilized by others who are unaware of errors or misrepresentations of art therapy theory or practice.

Methodology

Initially, the databases were accessed to assess the number of articles pertaining to art therapy. Secondly, it was determined if the authors of the articles were professional members within the field of art therapy, versus other fields. From the outset it was evident that there would be many challenges and potential questions with this methodology. Because no credentials or indicators of education or experience were available from the information on the databases, membership directories from the American Art Therapy Association were utilized. Authors were cross-referenced in AATA membership directories for registration and/or membership.

Seven computer databases were surveyed for the frequency of articles in which an explicit reference was made to art therapy between the years 1983 and 1993. The survey begins in 1983 since this was the first year information regarding registered art therapists was available.

Utilizing the key phrase *art therapy* was viewed as the most direct means of accessing available articles. *Art therapy* was entered into seven computer databases resulting in the location of 543 English language articles and varying definitions and classifications of art therapy within the databases. Readers desiring information on standards and criteria for inclusion of material in databases are referred to the various databases since discussion of their standards was not a focus of this research.

The Survey

1. *CINAHL 1983–1993.* CINAHL is the *Cumulative Index to Nursing and Allied Health Literature*, designed to meet the needs of nurses and allied health professionals. Articles included in the database come from biomedicine, behavioral sciences, education, management, and other popular literatures. A total of 42 articles appeared in the CINAHL database in which an explicit reference was made to art therapy. CINAHL defines art therapy as: "Facilitation of communication through drawings or other art forms" (CINAHL database, 1983). Art therapy is listed under the subheading of "therapeutics."
2. *ERIC 1983–1993.* The ERIC database consists of the *Resources in Education (RIE)* file document citations and the *Current Index to Journals in Education (CIJE)* file of journal article citations from over 750 professional journals. A total of 16 articles in the ERIC database in the years 1983–1993 contained an explicit reference to art therapy. ERIC defines art therapy as: "The therapeutic use of art forms (painting, sculpting, drawing, etc.) in achieving self-expression and emotional release, usually in a context of remediation or rehabilitation" (ERIC database, 1977). Art therapy is listed under the subheading of "therapy" in ERIC.
3. *HEALTH.* The HEALTH computer database is produced by the National Library of Medicine and lists publications concerning health care planning, organization, financing, management, manpower, and related subjects beginning in 1974. One-hundred-fifteen articles were listed in this database pertaining to art therapy. Sixty-seven articles between the years 1983–1993 made an explicit reference to art therapy. No definition of art therapy was listed.
4. *MedLine.* MedLine database covers citations to medical literature from 1966 to the present. A total of 95 articles appeared within the years 1983–1993, with explicit reference to art therapy. No definition of art therapy was listed.
5. *PSYCH-LIT.* The PSYCH-LIT database includes *Psychological Abstracts* and *Psych Books* from 1974 to the present. PSYCH-LIT contains citations and abstracts from journals and books covering the mental health sciences and related disciplines. A total of 766 articles were listed in the PSYCH-LIT database with explicit reference to art therapy. Between 1983 and 1993 a total of 408 articles were listed with an explicit reference to art therapy. PSYCH-LIT defines art therapy as: "Therapy that uses the creative work of clients for emotional expression, sublimation, achievement, and to reveal underlying conflicts" (PSYCH-LIT database, 1973). Art therapy is listed under the subheading "recreational therapy" on the PSYCH-LIT database.
6. *SPORT Discus* 1975–1993. The SPORT computer database is listed as a comprehensive international database containing sports and fitness literature. Subjects included in the database are sports-and fitness-related topics, exercise, medicine, physiology, training, coaching, biomechanics, and psychology. A total of eight articles, published in professional journals, were listed in this database with explicit reference to art therapy. Four articles appeared in the years 1983–1993. No definition of art therapy was listed on SPORT; art therapy was listed under the subheading of "therapy."
7. *Wilson Social Sciences Index 1983–1993.* The Wilson Social Sciences Index contains articles pertaining to social services and social work. Nine articles were listed with explicit reference to art therapy in the years 1983–1993. No definition of art therapy was noted.

Results

The term *art therapy* appeared 639 times in the databases surveyed. Eighty-three articles were repeated across the databases one or more times equaling a total of 96 repetitions. Taking these repetitions into account, the databases surveyed contained a total of 543 articles in which the term *art therapy* was present. Of the 543 articles, a total of 156 were written by or coauthored by registered art therapists. Forty-four articles were written by or coauthored by individuals who gained registration after the article listed was published. Twenty-five articles were written or coauthored by individuals listed as being members of AATA. Three-hundred-eighteen articles were written by individuals not listed as A.T.R.s or as members of AATA. (Please refer to Table 1 and Figures 1, 2, and 3.) Twice as many articles appeared to have been written by nonregistered individuals (see Figure 1).

Several considerations may be made when reviewing the findings.

- Perhaps one of the most important findings is that not every journal pertaining to art therapy and the creative arts therapies was represented on the databases surveyed. Of particular note are the limited entries (21) from *Art Therapy*, the official journal of the American Art Therapy Association, and the decline in entries found after the year 1986 in the *American Journal of Art Therapy*.
- The articles on art therapy found in the databases appeared in a wide variety of journals (see Figure 3). Articles referring to art therapy appeared in 96 different journals in the PSYCH-LIT database, 59 in the MedLine database, 32 in the HEALTH database, 25 in the CINAHL database, 12 in the ERIC database, eight in the Wilson Social Science Index database, and two in the SPORT database.
- Of interest is the distribution of art therapy articles in four art therapy publications: *American Journal of Art Therapy*, *Art Therapy: Journal of the American Art Therapy Association*, *The Arts in Psychotherapy*, and *Pratt Institute Creative Arts Therapy Review*, which lists entries primarily from students in the field of art therapy. Across the databases a strong absence of articles from art therapy journals was apparent. In the CINAHL, MedLine, SPORT, and Wilson Social Science Index databases, no entries were found from the four art therapy publications. Two entries from the *American Journal of Art Therapy* were listed in the ERIC database. Twenty-two entries in the HEALTH database were also from the *American Journal of Art Therapy*. The PSYCH-LIT database held the most entries overall (408) and also had entries from the four art therapy journals. One-hundred-fifty-six articles in the PSYCH-LIT database were entries from *The Arts in Psychotherapy*, 48 articles were listed from the *Pratt Institute*

Table 1
Number of Articles Appearing in Databases Authored by A.T.R.s, A.T.R. Post, AATA Members, and Nonlisted, Nonregistered Individuals

	DATABASE	CINAHL	ERIC	HEALTH	MEDLINE	PSYCH-LIT	SPORT	WILSON S.S.I.
	83-83	1	1	8	4	79	0	0
A.T.R.	88-92	3	3	8	3	57	0	0
	93	0	0	3	1	5	0	0
SUBTOTAL		**4**	**4**	**19**	**8**	**141**	**0**	**0**
	83-87	0	1	4	1	27	0	0
A.T.R. POST	88-92	0	0	0	0	14	0	0
	93	0	0	0	0	0	0	0
SUBTOTAL		**0**	**1**	**4**	**1**	**41**	**0**	**0**
	83-87	0	1	1	0	12	0	0
AATA MEMBER	88-92	0	0	1	1	6	2	0
	93	0	0	1	0	1	0	0
SUBTOTAL		**0**	**1**	**3**	**1**	**19**	**2**	**0**
	83-87	10	3	15	31	117	0	3
NONLISTED	88-92	24	6	18	46	88	2	6
	93	4	1	8	8	2	0	0
SUBTOTAL		**36**	**10**	**41**	**85**	**207**	**2**	**9**
TOTALS		**42**	**16**	**67**	**95**	**408**	**4**	**9**

TOTAL # OF ARTICLES – TOTAL # OF REPEATED ARTICLES

A.T.R. ARTICLES= 176 – 20 = 156
A.T.R. POST ARTICLES = 47 – 3 = 44
AATA MEMBER ARTICLES = 26 – 1 = 25
NONLISTED ARTICLES = 390 – 72 = 318

TOTAL # ARTICLES = **639 – 96 = 543**

Creative Arts Therapy Review; 40 were listed from the *American Journal of Art Therapy*; and 21 entries were listed from *Art Therapy: Journal of the American Art Therapy Association*.

Discussion

Computer databases are vastly becoming the media of choice for researchers, students, professionals, and lay people, offering an enormous amount of information that would by any other means be difficult and time-consuming to compile. The computer databases offer a first "glance" at the literature available on a topic of choice, allowing the researcher to narrow, combine additional variables or areas of interest, or "explode" the topic area to include additional possibilities.

Computer databases may also be valuable to the patient, perhaps indirectly, as a means to gather information on past research and findings, treatment modalities, and related fields that may be applicable to the betterment of a patient's treatment and care. For this reason it is important that what is available on the databases be theoretically correct material, written by authors qualified in the profession about which they are writing. Although the percentage of articles that may contain inaccuracies or erroneous information about art therapy is unknown, "the potential impact can be great if inaccurate information forms the basis for subsequent research or for the treatment of patients" (Kotzin & Schuyler, 1989, p. 337). Articles pertaining to the use of art therapy written by authors lacking in art therapy education or supervised clinical training and experience may be those that contain erroneous or dated information.

Given the findings of this survey, the following questions may be raised: Is there an apparent resistance to research, writing, and publishing within the art therapy field? Do writing and computers threaten the fabric of the field? Rubin (1982) felt that including case illustrations in writings, while aiding visualization, may lead to the feared false generalizations that may and do occur as a result of the inability to justly reduce what has occurred during 20 or more sessions into five pages. What occurs in therapy and in the process of creation during therapy is difficult to translate into words, just as artwork cannot be transformed from a spatial matrix (Wadeson, 1980) into the linear (verbal communication) without losing vital aspects.

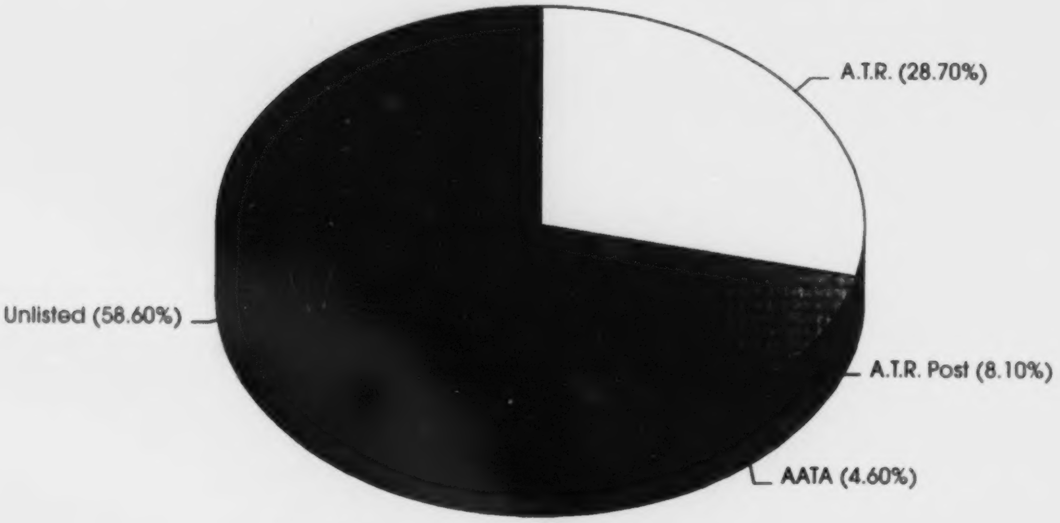


Figure 1 Percentage of Articles By Authorship

A.T.R. = Author was listed as being a Registered Art Therapist (A.T.R.) at the time of publication of the article included in this survey.

A.T.R. POST = Author was listed as being an A.T.R. after the publication year of the article included in this survey.

AATA = Author was listed as being a member, other than A.T.R., of the American Art Therapy Association (AATA) at the time of publication of the article included in this survey.

UNLISTED = Author was NOT Listed as being either an A.T.R. or as holding any other membership within the AATA at the time of publication of the article included in this survey.

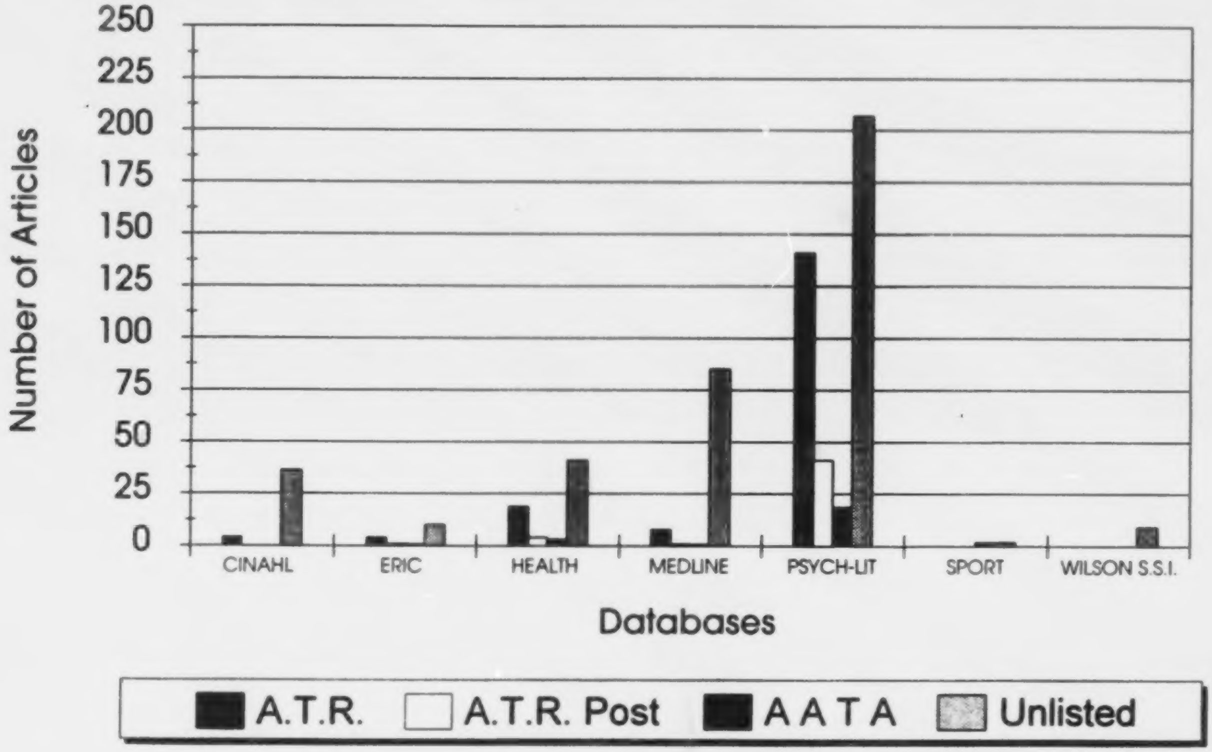


Figure 2 Number of Articles in Databases By Authorship

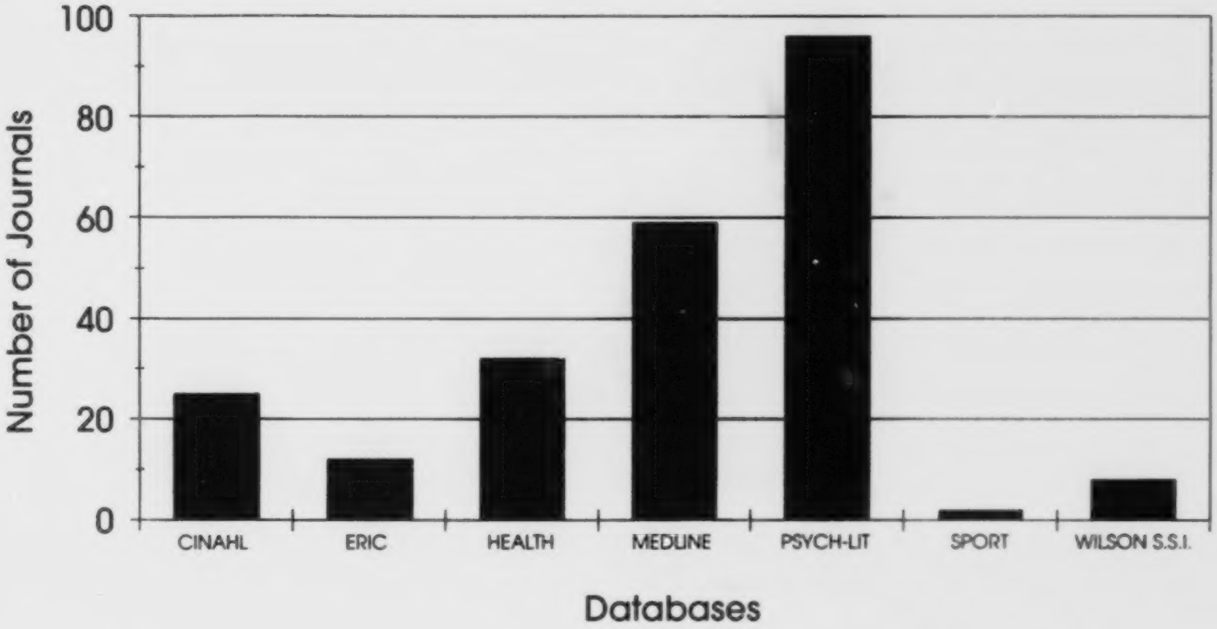


Figure 3 Journals Per Database Containing Art Therapy Entries

This survey has many limitations, including the fact that not every published article about art therapy was accessed, nor was every computer database surveyed. However, the fact remains that the databases surveyed appeared to contain fewer articles written by registered art therapists than by nonart therapists. Also, the limited presence of the journals *Art Therapy: Journal of the American Art Therapy Association* and *American Journal of Art Therapy* in the databases surveyed may have serious repercussions on the visibility, spread of knowledge, and growth of art therapy, as well as on potential patient care and treatment. While contributions in these journals and the other creative arts therapy journals provide information regarding research and practice in the field of art therapy, they certainly do not represent the profession to those who use computer searches for articles on art therapy.

Since what is being written about art therapy in more than half of the articles in this survey may not come from registered art therapists, the situation could be potentially problematic. For example, articles from an art therapy journal found in a database would have been reviewed by the authors' peers, that is "experts" in the field of art therapy. If an article is contained in a nonart therapy journal, then one may question if it has received the same degree of scrutiny regarding its contents and validity.

It is the hope of the authors that the findings and questions raised in this article will serve to increase the awareness and self-questioning not only of those within the field of art therapy, but also of those in related mental health fields, thus encouraging a dialogue which will foster the proliferation of articles that serve to define art therapy and art therapists—who we are and what we can do while keeping the patient's best interests in mind.

Over 20 years ago Hodnett (1973) wrote about professionalizing and defining the field of art therapy. In her conclusions she stated what she felt the field (in 1973) needed to do... "research, research, research!" To accomplish this Hodnett saw the need to borrow "rules" from other fields such as aesthetics and experimental psychology, so that experimental and empirical research could be conducted and translated by means of statistical inference. Hodnett's call in 1973 for more research in the field of art therapy is still relevant today when we might also add the phrase "publish, publish, publish!"

Editor's Note: This article was condensed from a 1994 Master's thesis completed by Heather Anne Zeigler in partial fulfillment of the degree of Master of Arts in Creative Arts Therapy from Hahnemann University, Philadelphia, Pennsylvania. Thesis committee members were Ronald Hays, MS, A.T.R., V. Michael Vaccaro, MD, and Beulah Hall, EdD. Further inquiries regarding the complete unedited thesis may be addressed to the Medical College of Pennsylvania and Hahnemann University Library, Philadelphia, Pennsylvania (215)762-7631. The complete title of the thesis as found in the university library is: "Contributions to Art Therapy Literature by Registered Art Therapists and Other Mental Health Professionals: A Computer Database Survey 1983–1993."

References

Hodnett, M. L. (1973). Toward a professionalization of art therapy: Defining the field. *American Journal of Art Therapy, 12*(2), 107–118.

Kotzin, S., & Schuyler, P. L. (1989). N.L.M.'s practices for handling errata and retractions. *Bulletin Medical Library Association, 77*(4), 337–342.

Rubin, J. A. (1982). Art therapy: What it is and what it is not. *American Journal of Art Therapy, 21*, 57–58.

Wadeson, H. (1980). *Art psychotherapy*. New York: John Wiley & Sons.

Art Therapy: Journal of the American Art Therapy Association, 13(2) pp. 96-101 © AATA, Inc. 1996

The Dimensions of Service: An Elemental Model for the Application of Art Therapy

Randy M. Vick, MS, A.T.R.-BC, Lemont, IL

Abstract

This article presents the "Dimensions of Service" model as a tool for examining where, how, and why art therapists offer their services. Ten aspects central to art therapy practice (context, nomenclature, realm of need, role, conceptual model, purpose, level of function, length of contact, age range, and groupings) are outlined along with reflections on their potential impact on individual practitioners as well as on the profession as a whole. This model was developed out of the author's experience as an art therapy clinician, administrator, and educator and may be useful both to students entering the field and professionals reassessing their current career paths and previously held strategies for the delivery of professional services.

Introduction

In conjunction with the 25th anniversary of the American Art Therapy Association, much has been written, spoken, and indeed even painted (Jones, 1995) about the past, present, and future of the field of art therapy. Recent volumes of this journal featured essays by Honorary Life Members and other award winners sharing their visions of art therapy in the 21st century. Consider for a moment however, if a telescope is the best or only tool for viewing such distant images. What could be seen if a magnifying glass or kaleidoscope were used instead?

Over a decade ago, Johnson (1984) challenged the creative arts therapies to focus on three important tasks: "to articulate our unique contributions...to differentiate a wide range of professional roles...[and] to provide the conditions for mature leadership" (p. 209). While his argument was that these developments will be necessary for the establishment of the expressive therapies as independent professions, these same tasks, particularly the first two, are also pertinent for art therapists exploring their personal career path options.

Robbins (1982), also speaking of professional identity, commented on the "intimate interplay between...personal inner development and...professional growth as an art therapist" (p. 1). To this interplay a third aspect might be added: the maturation of the profession itself within the larger world of human service professions. These three dynamic and concentric layers—the inner person, the individual practitioner, and the profession as a whole—have a combined influence on the career directions of art therapists.

Growth and development of a profession or of individual practitioners can be as effectively stifled by rigid adherence to outmoded concepts as it can by wild, imprudent change. As any profession matures, it must grapple with the task of balancing stasis and chaos. In searching for such a balance, art therapists revisit questions of definition raised in the earliest days of their emerging profession (Ulman, 1961). How far *can* the definition of art therapy be stretched before it is rendered meaningless?

The classic models from our literature with their long-term, intensive, insight-oriented thrust (Kramer, 1971; Naumburg, 1987) have much to offer, yet their strict application in the contemporary human services milieu has limited usefulness. Our work must be shaped by the ongoing and thoughtful incorporation of advances made in art therapy and related fields. Ethical, clinical, and legal considerations demand no less than the maintenance of the highest possible level of current professional standards, yet emotional ties to classic models may slow the adoption of more contemporary treatment paradigms. Clinging to a romantic notion of what art therapy "is" can contribute to a series of disappointing efforts to fit an ossified template to unyielding circumstances, resulting in frustration and ultimately attrition. The wished for ideal is too often in conflict with the practical reality. Increased competition and shrinking funding in health care do not afford art therapists the option of such self-defeating efforts. Nor is the current human services environment quick to embrace innovations without credible support as to their validity. The challenge to the contemporary art therapist is to merge the best of the historical and current practice paradigms. By skillfully bridging the gap between the wish and reality, increases in both job performance and satisfaction may be achieved.

In this essay I offer an alternative model for examining the manner in which art therapy services are delivered. All too often we begin with a fully formed concept of art therapy and search for an opportunity to employ it. For a new graduate entering the job market or a more experienced professional making a career transition, viable employment possibilities may be too quickly dismissed or overlooked entirely if a single, fixed understanding of art therapy is the only model considered. As the former director of an expressive therapies department in a hospital and now as the faculty coordinator of clinical placements in an training program, it is my responsibility to try to assess how good a "fit" there is between a candidate's skills and interests and the demands of any given position. Yet, regardless of level of experience, a congenial pairing of personality attributes to work circumstances is one of the best determinants of career satisfaction. Perhaps much can be gained by reordering this process and considering first the elemental dimensions of art therapy practice in isolation, allowing a fresh, new image to emerge through their eventual recombination.

Dimensions of Service

The "Dimensions of Service" outlined here are those facets of the profession which shape how art therapists apply their skills and training. This model was developed from the author's experience as an art therapy clinician, administrator, and educator and may be useful both to students entering the field as well as professionals reassessing their current career paths and previously held strategies for the delivery of professional services. The dimensions are the parameters which give form to art therapy and have the capacity to simultaneously define and limit the scope of our work. These include context, nomenclature, realm of need, role, conceptual model, purpose, length of contact, level of function, age range, and groupings. While these concepts are intertwined in practice, it is helpful to consider them separately for purposes of discussion.

Context

Context refers to the types of settings where art therapists work and encompasses the location, administrative structures, and kinds of services provided therein. The first broad distinction within this dimension is private versus institutional practice. In the purest form the private practitioner works alone outside the physical and administrative walls of human service organizations. The clinician involved in institutional practice is linked via geographic, administrative, financial, and other ties to a larger pool of professionals who share a common treatment mission. Group practices, consultants, contract therapists, and other modern hybrids represent intermediate variations on these two basic themes. Each model has its advantages and disadvantages which, in turn, have their psychological and fiscal impact on practitioners.

Inpatient or outpatient, another broad contextual distinction among programs which have hospital (medical, psychiatric, or rehabilitative) affiliations, means much more than where the patients sleep at night. Each program may serve completely different clientele or the same individuals in different phases of their treatment. Other important distinctions typically involve funding, length of stay, staff size and mix, level of acuity, types of services offered, and so on. Driven by market pressures, hospitals and medical centers are experimenting with so many variants in this area (day hospital, night hospital, partial hospital, day care, day treatment, clinics, surgicenters, 23-hour units, etc.) as to render the old in/out division nearly obsolete.

Institutional affiliation may not necessarily provide information about the actual location of the program. A church-sponsored elder care program may operate out of that church's basement, while a medical center's hospice may be across town with a wholly separate staff and administration. Schools, long-term and intermediate care facilities, shelters, correctional institutions, residential, and community-based programs offer many opportunities for the provision of art therapy services. The business community (in either the context of staff training and development or Employee Assistance Programs) remains a largely underserved context for our work (Ault, 1986).

Context has the broadest influence on the profession and tends to shape all the other dimensions. The place where art therapists work determines the type of clientele with whom they have contact and most aspects of the services they provide. In addition, it influences who sees art therapists (as well as how they view and provide service to clientele) and creates in the minds of professional peers and the general public an image of who art therapists are and what they do.

Nomenclature

The language used to describe the people with whom we work carries powerful, often hidden messages which can speak volumes about our relationship to them (Spaniol & Cattaneo, 1994). The profession's strong psychiatric legacy is reflected in the use of the term *patient*, which carries with it the echoes of the disease model and of helplessness as well as placing the work within the confines of a hospital. *Client* is considered by many a better, more neutral alternative, but this term too has its detractors. In his 1993 AATA keynote address, James Hillman claimed that in turning to the world of business for this term we stand to sacrifice the implied compassion associated with "patient" care (Hillman, 1993).

Other terms, used directly or left unspoken, typically convey clues about the setting or role of the art therapist. *Student* can refer to a child in a therapeutic school or a graduate trainee but implies that the work features a strong educational component. *Resident* and *inmate/prisoner* both convey a sense of containment but for very different purposes. *Member* (used by day treatment programs) and *guest* (used by some shelters) seem intent upon conveying a warm, cozy sense of belonging while a research *participant* or *subject* is kept at a certain anonymous distance.

An art therapy consultant may view a *program, institution*, or *company* as his or her client, which may contribute to a certain aloofness or might afford a more effective, system-wide focus. In an era of increasing corporate control of health care, the somewhat awkward notion of *customer* and the slightly more digestible *consumer* are often raised accompanied by the concepts of customer satisfaction and profitability. The committee-generated *person being served* was an effort to offend no one (JCAHO, 1995). It is a product of our politically correct times, neutral by design yet perhaps meaningless by accident.

Language subtly shapes our perceptions of the "other." In addition to providing information about the context of our work, our style of interaction, job satisfaction, and therapeutic effectiveness may be indirectly impacted by the terminology we use when referring to those individuals we encounter in the course of our workday.

Realm of Need

The realm of need includes the issues or problems to be addressed in our work and can vary greatly. The primary need being addressed through art therapy has always been (and will probably always be) emotional. This psychological landscape is very broad and rolling and greatly influenced by context and philosophy. While one person's "psychopathology" is another's "spiritual crisis," at the core is the world of feelings and the accompanying thoughts and behaviors. One source organizes the realms of need among individuals seeking mental health services into three broad categories:

> (M)ental illness (as defined primarily in terms of organic and chemical imbalances which require medication maintenance in conjunction with other therapeutic regimens), problems in living (as defined as the need to acquire skills and learning pertinent to various life

> transitions in which they are engaged), and needs of life enhancement (as defined in terms of holistic health and wellness). (Herr & Cramer, 1987, p. 87)

According to a recent AATA membership survey, and true to our historic roots, the majority of art therapists continue to attend to the emotional realms of psychiatric and other mental health populations (LaBrie & Rosa, 1994). With other specialized groups or settings, the emotional concerns can be joined by issues of addiction, family or marital problems, spiritual crisis, business needs, personal growth, or sociocultural pressures. In school settings, educational, developmental, or cognitive goals are emphasized. Rehabilitation programs focus on the physical, psychological, sensory, or developmental limitations and abilities of their clientele. While diagnoses and prognoses vary widely, the physical as well as psychological impact of bodily illness is addressed by art therapists working in medical settings (Malchiodi, 1995).

The concept of realm of need, while related, is not equivalent to population or diagnosis. It transcends these clinical categories to address the human needs behind the labels. As professionals, art therapists must strive to be fully aware of the scope of concerns brought by their clients and to address those which are appropriate to their services. They are ethically bound to refer to other providers those problems which lie beyond the limits of art therapists' training and experience.

Role

Role encompasses how art therapists, their clients, and their colleagues understand art therapy's function in the workplace. Included in this complex notion are official and unofficial job titles, clinical duties, work-week responsibilities, and, most importantly, our sense of professional self. Cashell and Miner (1983), in a review of the literature on professional roles, found that role conflict and role ambiguity are common where "there are unclear job responsibilities, inconsistent expectations, an environment of uncertainty and a lack of communication with co-workers" (pp. 93–94). After surveying staff from 12 area creative arts therapies programs, they concluded that lack of role clarity was an important contributing factor to the feelings of stress, burnout, and career dissatisfaction reported by respondents.

In exploring the idea of how we function on the job, Johnson (1985) posed this question:

> "If a creative arts therapist spends a whole session talking with the client, is he doing creative arts therapy?" The answer is *No* if creative arts therapies are defined by our activity, and *Yes* if they are defined by a more basic principle. (p. 234)

Perhaps the single concept that limits us most is missing the subtle distinction between the tasks art therapists perform and the potential art therapy has. The sensibilities of art therapists are more key to their fully realized roles than are their techniques.

The "artist or therapist" quandary has been an issue of debate for many years in our profession (Ault, 1977). Yet, the realities of the workplace reflect more of a "both/and" rather than an "either/or" stance. The assortment of roles assumed by art therapists can be surprisingly diverse. The functions of artist, teacher, clinician, and healer can coexist harmoniously in the same individual at different points over the course of a career or work week (Lachman-Chapin, Ault, McConeghey, Junge, & Vick, 1992).

Therapeutic role descriptions still remain prominent among our members with 64% of respondents indicating either "Art Therapist" (49%) or "Counselor/Clinician" (15%) as their primary job title in a recent survey. The other categories offered in the survey—"Director" (8%), "Consultant" (2%), "Mental Health" (2%), and "Other" (25%)—may also include individuals for whom the role of therapist is a strong identification (LaBrie & Rosa, 1994). This sample seems to indicate that the tradition of the clinical role (at least in terms of job titles) remains strong. In all likelihood, the identification with the therapist role will and should remain the primary focus of our profession.

The 25% in the "Other" category remains a tantalizing mystery. How many of these members claim among their roles (official and otherwise) "Artist," "Artist-in-residence" (Allen, 1992), "Teacher/Instructor" (Robbins, 1982), "Mentor" (Johnson, 1993), "Healer" (Arnheim, 1990), or "Supervisor" (Calisch, 1989)? In truth, several of these important roles are almost certainly enacted to some degree by most of the respondents to the survey.

Less commonly considered yet significant roles within the art therapy field are "Theoretician" (Rubin, 1984), "Researcher" (Wadeson, 1992), "Administrator" (Sandel, 1987), "Expert Witness" (Levick, Safran & Levine, 1990), and "Social Activist/Advocate" (Junge, Alvarez, Kellogg & Volker, 1993). These and other nontraditional roles may not represent the initial motivations to enter the field (in fact, may be by necessity "grown into") but must be cultivated and supported for the ultimate benefit of the profession as a whole. Such primary roles, while rare in the field, are considered standard and legitimate applications in other human service areas. The growth of elder professional "cousins" has been marked by expansions into areas that are not exclusively clinical in nature. In the field of psychology for instance, the "scientist-practitioner model," where an individual is involved in both research and treatment, can be traced back to the 1940s (Herr & Cramer, 1987, p. 94).

Conceptual Model

What theories or philosophies contribute to the shaping of art therapy training and practice? Of course the work of Freud has left an indelible stamp of our history (Junge, 1994); yet it would seem that today nearly every school of psychological thought has its adherents. Articles illustrating psychoanalytic, Jungian analytic, object relations, self psychology, Adlerian, phenomenology, gestalt, humanism, behaviorism, cognitive, developmental (Rubin, 1987), and existential (Moon, 1990) perspectives appear regularly in the art therapy literature.

Psychological and psychotherapist theories are not the only sources from which art therapists draw conceptual models. Human service fields such as social work, counseling, addictions, education, medicine, neuroscience, cognitive science, nursing, rehabilitation, corrections, holistic healing, therapeutic recreation, occupational therapy, as well as the other creative arts therapies, all have had and can continue to have influence on the profession. Broader reaching areas of study in such disciplines as the arts, sociology, feminism, anthropology, philosophy, ethics, spirituality, and business management all have the potential to inform our theory and practice.

Finally, while sadly still few, there are some conceptual models which, though they build upon existing theories from neighboring fields, can be considered uniquely art therapy models (Lusebrink, 1990). One of the hallmarks of any profession (if it is truly to be called such) is a unique, free-standing body of knowledge which forms the basis of its practice (Herr & Cramer, 1987). Hodnett referred to this substantial base of knowledge as one which "is so vast that no one person could encompass all of it in his lifetime" (1973, p. 108). Art therapy's continued growth depends in large part on the further development of this knowledge base by the thinkers and writers within the discipline and without.

Purpose

The dimension of purpose, which shapes both therapeutic goals and interventions, is at the center of what art therapists do yet remains difficult to concisely define. Embedded in this concept is both the focus to which services are addressed (e.g., illness, personality, behavior, wellness) as well as the intent behind them (e.g., treatment, assessment, support, education, prevention). This dimension explores the question of why we bring art experiences to clients and to what degree these experiences are a means to an end or the end in themselves. Are the processes and products of these experiences to be silently witnessed by the clinician or do they provide material for further discussion and probing? This has been another area of historic debate which has been at times scholarly and, at other times, acrimonious. Yet it is hardly a static issue since each population, group, and individual demands a slightly different approach; and each art therapist must come to a working understanding of the purpose of his or her efforts.

If the classic metaphor of art as "symbolic speech" (Ulman, 1975, p. 4) is to be retained, then it must be remembered that it is a speech which can confess, clarify, and declare as well as distort, confuse, and obfuscate. In a traditional application, the communicative function of art is used to help uncover issues, resolve conflicts, and explore defenses.

An art therapist working in a briefer, more crisis-oriented manner might encourage the client to use the art to illustrate concerns or practice new methods of problem solving. In another context the concrete qualities of art may be useful for diagnostic, assessment, or research purposes. The focus of groups in a rehabilitation setting might be restoring function and supporting strengths.

It would appear that there is no single, "correct" purpose for art therapy, only options with greater or lesser degrees of appropriateness for different circumstances. The greatest gains can be made through the ongoing refinements, by each therapist, of the therapeutic purposes and approaches best suited to his or her unique population coupled with the support of the successful clinical applications by colleagues working in other contexts.

Length of Contact

The time available to work together with a client is dependent on many factors and varies widely. In many inpatient settings today it is not uncommon to have a single session, whereas in some types of academic, residential, or correctional settings, therapeutic relationships may be built over many years.

This dimension implies more than simple length of stay. A client with a history of chronic mental illness may attend only a few sessions in a short-term setting yet can still be a seasoned veteran of many years duration in the larger mental health system. Such a person is, in effect, the recipient of a kind of disjointed, long-term treatment from a series of providers, including, quite possibly, a number of art therapists. Another variation can be found in systems where the art therapist, viewed as a specialist, provides services in a number of programs within the same system. In a situation such as this, the art therapist may follow the client from inpatient unit to day hospital to partial hospital, while other staff members terminate services as the programmatic boundaries are crossed.

The last three dimensions—level of function, age range, and groupings—refer specifically to aspects of the population served. Here too, as with the previous dimensions, a correct fit should be sought between these qualities of client populations and the temperament of the provider.

Level of Function

This dimension can be thought of as a continuum extending from profound disabilities to high abilities. It is a given that *all* clients come to therapy because someone (not necessarily the individual seated before us) has perceived some type of deficit.

The concept of level of function implies a certain orientation toward "improvement," which is often understood as the removal of "problems"; however, the acquisition of new skills, reclamation of old abilities, or the slowing of deteriorative processes all represent improvements in functioning. It would also seem at first that the populations with the greatest limitations would place the greatest demands on the skills and knowledge of the clinician; however, each individual challenges the therapist in different ways.

Age Range

This dimension covers the entire developmental span from very young to very old. At each phase individuals present with certain characteristic patterns of issues and life crises. With emphasis on early childhood intervention as well as the general aging of society, art therapists could very well see a gradual spreading of art therapy services to the outer ends of this continuum.

Groupings

The final aspect of the delivery of art therapy services is the manner in which we group or cluster our clients. The simplest form of this dimension is seeing individuals since, while family, friends, and others may be present in spirit, there is only one person physically in the room with the therapist.

The circumstances quickly become more complex as additional people join sessions. Therapeutic groups can be composed around age, gender, diagnosis, issue, history, or any other circumstance which group members share—even if it is only that they happen to be hospitalized together. Broader interpretations of the concept of group might encompass corporations and the general public. The two most highly specialized types of groups, couples and families, while today much more broadly defined than in the past (Kwiatkowska, 1978), are still shaped by the shared circumstances of their pregroup relationship.

Application

Returning to the three-layered image mentioned earlier, important changes may occur over the course of time. Through life experience, personal growth, perhaps therapy, the inner person has developed. With training, supervision, work experience, continuing education, and so on, the professional self of the practitioner has grown. Simultaneously, as the result of the efforts and contributions of many, the profession itself matures. The individual so described has any number of career options to explore. The Dimensions of Service model can be used as a tool for such explorations by outlining one's current as well as ideal career path along the 10 dimensions defined here.

Conclusion

It is very easy to become overwhelmed when considering the work in a field as complex as art therapy, yet even complex situations can be better understood when examined in manageable portions or looked at with a fresh perspective. The purpose of the Dimensions of Service model is to offer new ways of looking at the profession and to challenge previously held notions.

Just as a magnifying glass allows the viewer a close-up look at the tiny parts of an integrated whole, so too can this model allow us an intimate inspection of the small, perhaps previously unnoticed aspects of our field. Where a kaleidoscope can show the user beautiful and surprising new images with each turn, the structure presented here might allow us to "twist" our previously held notions about the profession and discover an amazing new future we never knew was there.

Amatea, in writing to mental health counselors, outlines five ideas for career development:

> (a) viewing jobs as career bridges rather than career steps, (b) attending to the overall context as well as the content of the field, (c) defining ourselves by personal competencies rather than job titles, (d) focusing on possibilities rather than job positions, and (e) developing a collaborative rather than a competitive support network. (1991, p. 280)

These ideas are very much in harmony with the model presented in this paper and can be of great use to the art therapist considering a career shift. In both models a career is considered to be a dynamic entity which must be viewed within the larger professional landscape. Both recognize the danger inherent in defining a profession based on a single position or job title. And finally, both acknowledge the potential influence the individual practitioner has over the direction his/her career will take.

The systems and strategies for the delivery of human services in this country are undergoing rapid change. With or without art therapists' participation, the circumstances which affect their practice are being altered. We owe it to ourselves, our students, and our clients to be proactive participants in the broadening and deepening of our field. Only through our writing, teaching, workplace experimentation, and collegial support can we together create stronger and perhaps surprising new images of art therapy.

References

Allen, P. B. (1992). Artist-in-residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association*, 9(1), 22–29.

Amatea, E. S. (1991). Developing a career as a mental health counselor: Changing ideas, changing options. *Journal of Mental Health Counseling, 13*(2), 279–290.

Arnheim, R. (1990). The artist as healer. *The Arts in Psychotherapy, 17*, 1–4.

Ault, R. E. (1986). Draw on new lines of communication. *Personnel Journal*, 65(9), 73–77.

Ault, R. E. (1977). Are you an artist or a therapist? A professional dilemma for art therapists. *Creativity and the Art Therapist's Identity: Proceedings of the 1976 Annual AATA Conference* (pp. 53–56). Baltimore: American Art Therapy Association.

Calisch, A. (1989). Eclectic blending of theory in the supervision of art psychotherapists. *The Arts in Psychotherapy, 16*, 37–43.

Cashell, L., & Miner, A. (1983). Role conflict and role ambiguity among creative arts therapists. *The Arts in Psychotherapy, 10*, 93–98.

Herr, E. L., & Cramer, S. H. (1987). *Controversies in the mental health professions.* Muncie, IN: Accelerated Development.

Hillman, J. (1993, November). *You can't fix it—and besides it ain't broke.* Keynote address, 24th Annual American Art Therapy Association Conference, Atlanta, GA.

Hodnett, M. L. (1973). Toward professionalization of art therapy: Defining the field. *American Journal of Art Therapy, 12*(2), 107–118.

Joint Commission on Accreditation of Healthcare Organizations. (1995). *Accreditation manual for hospitals.* Oakbrook, IL: Author.

Johnson, D. R. (1984). Establishing the creative arts therapies as an independent profession. *The Arts in Psychotherapy, 11*, 209–212.

Johnson, D. R. (1985). Envisioning a link among the creative arts therapies. *The Arts in Psychotherapy, 12*, 233–238.

Johnson, D. R. (1993). The challenge of mentoring. *Dramascope: The National Association for Drama Therapy Newsletter, 8*, 15.

Jones, D. (1995). Who, what, where, how?. [Painting & commentary]. *Art Therapy: Journal of the American Art Therapy Association, 12*(1), Cover & 1.

Junge, M. B. (1994). *A history of art therapy in the United States.* Mundelein, IL: American Art Therapy Association.

Junge, M. B., Alvarez, J. F., Kellogg, A., & Volker, C. (1993). The art therapist as social advocate: Reflections and visions. *Art Therapy: Journal of the American Art Therapy Association, 11*(3), 148–155.

Kramer, E. (1971). *Art as therapy with children.* New York: Schocken Books.

Kwiatkowska, H. Y. (1978). *Family therapy and evaluation through art.* Springfield, IL: Charles C Thomas.

La Brie, G., & Rosa, C. (1994). American Art Therapy Association, Inc. 1992–93 membership survey report. *Art Therapy: Journal of the American Art Therapy Association, 11*(3), 206–213.

Lachman-Chapin, M., Ault, R. E., McConeghey, H., Junge, M. B., & Vick, R. M. (Moderator). (1992). *Artist, teacher, clinician, healer: Advancing the dialogue* (Cassette Recording No. 1-144). Denver, CO: National Audio Video.

Levick, M. F., Safran, D., & Levine, A. (1990). Art therapists as expert witness: A judge delivers a precedent-setting decision. *The Arts in Psychotherapy, 17*, 49–53.

Lusebrink, V. B. (1990). *Imagery and visual expression in therapy*. New York: Plenum Press.

Malchiodi, C. (1995). Special issue on art and medicine. *Art Therapy: Journal of the American Art Therapy Association, 12*(1).

Moon, B. (1990). *Existential art therapy: The canvas mirror*. Springfield, IL: Charles C Thomas.

Naumburg, M. (1987). *Dynamically oriented art therapy: Its principles and practice*. Chicago: Magnolia Street.

Robbins, A. (1982). Integrating the personal and theoretical splits in the struggle towards an identity as art therapist. *The Arts in Psychotherapy, 9*, 1–9.

Rubin, J. A. (1987). *Approaches to art therapy: Theory and technique*. New York: Brunner/Mazel.

Rubin, J. A. (1984). Knowing theory. In J. A. Rubin (Ed.), *The art of art therapy* (pp. 189–198). New York: Brunner/Mazel.

Sandel, S. (1987). Moving into management. *The Arts in Psychotherapy, 14*(2), 109–112.

Spaniol, S., & Cattaneo, M. (1994). The power of language in the art therapeutic relationship. *Art Therapy: Journal of the American Art Therapy Association, 11*(4), 266–270.

Ulman, E. (1961). Art therapy: Problems of definition. *Bulletin of Art Therapy, 1*, 10–20.

Wadeson, H. (Ed.). (1992). *A guide to conducting art therapy research*. Mundelein, IL: American Art Therapy Association.

CALL FOR PAPERS

Art Therapy invites submissions to special issues on:

1. Art Therapy with Older Adults

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to art therapy with older adults. Submissions may focus on, but are not limited to, the use of art expression with the broad spectrum of elderly persons in society: institutionalized elderly persons in nursing homes, hospitals, rehabilitation facilities, and hospices; recipients of in-home health services; elderly persons in senior citizen housing and/or attending senior centers; elderly persons involved in intergenerational programs; and family caregivers coping with aging relatives. **The deadline for submission has been extended to *August 1, 1996*.**

2. Art Therapy and Community

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to the broad topic of art therapy and community. Submissions may focus on, but are not limited to, the following: community-based art therapy programs; open studio approaches that involve community participation; art therapy programs designed to achieve social change within a community; art exhibits developed to educate a community on societal issues; art therapy programs for specific cultural communities or groups; or art therapists as a cultural community. **The deadline for submission is *September 6, 1996*.**

3. Art Therapy Research

Art Therapy is seeking full-length articles, brief reports, and viewpoints for a special issue devoted to the topic of art therapy research. Submissions may focus on, but are not limited to, the following: quantitative and qualitative models of art therapy research; research components of art therapy training; critical discussions and explorations of the problems and potentials of art therapy research; art therapy research previously unpublished, particularly outcome studies. **The deadline for submission is *December 31, 1996*.**

Please refer to the "Guidelines for Authors" in the journal for specific requirements regarding style and format. Manuscripts that do not adhere to these guidelines will be returned without review. Send submissions to:

Cathy A. Malchiodi, A.T.R., LPAT, LPCC, Editor, *Art Therapy*
c/o AATA Inc., 1202 Allanson Road, Mundelein, IL 60060

Art Therapy: Journal of the American Art Therapy Association, 13(2) pp. 102-107 © AATA, Inc. 1996

Dali to Beuys: Incorporating Art History in Art Therapy Treatment Plans

Simone Alter Muri, EdD, A.T.R., LMHC, Springfield, MA

Abstract

The important role art history can play when integrated within art therapy treatment plans is explored through individual and group case studies with inpatient and elderly populations. These results illustrate the therapeutic value of art therapy sessions that incorporate museum and gallery visits, slide presentations of modern art, and anecdotal information on artists. Clients were observed to have increased self-esteem, greater self-acceptance, increased social awareness, and enhanced creativity.

Introduction

As an art therapist with chronic patients on an inpatient unit and later as an art therapy consultant working with a variety of populations, I became interested in exhibiting clients' art as part of their treatment plans (Alter Muri, 1994). I began to include slide presentations of art from the modern and postmodern periods in my inpatient art therapy groups and, subsequently, in my private practice to explore the therapeutic benefits of integrating museum and gallery visits into art therapy. I found consistently with all the populations with which I worked (including individuals with developmental delays, learning disabilities, affective and mood disturbances, personality disorders, and the elderly) that art history can be integrated successfully into art therapy treatment and can play a valuable role in enhancing self-esteem, sublimation, socialization skills, introspection, and creativity.

I define the process of discussing artists' works, viewing slides, and visiting museums and galleries as art history, as a part of art history rather than art education. In my approach I do not teach techniques or evaluate art products. This is not a new concept. Buoye-Allen (1985) describes an "art lecture group" that viewed slides and discussed the art of former clients along with art by well-known artists. This approach creates a connection between client art and fine art, promotes group cohesion, and clearly increases the understanding of the many ways art can be a medium of psychological integration. According to Silverman (1981), art can be used to stimulate discussions on sensitive issues. Viewing slides or reproductions facilitates the process of rendering unconscious material more conscious.

The following case demonstrates how the use of art history in art therapy treatment increases self-esteem and encourages formulation of a stronger sense of self.

Case #1

Client W is a 19-year-old male with a history of learning disabilities, periods of psychotic episodes, and bouts of depression. He also has had episodes of substance abuse. Client W attended specialized schools for individuals with learning disabilities and behavioral problems. He has been a client on several psychiatric inpatient units.

I first met Client W in a short-term adolescent day treatment program where I was employed as an art therapist. I worked with Client W in individual and group art therapy sessions for a period of 1 year. After Client W left the adolescent program, he was referred to me in private practice for an additional 2 years. From the first time I saw his art hanging on the wall of the adolescent program, I was intrigued by the outpouring of creative energy in his drawings. The choice of imagery and color was striking. His first pieces of art looked very angry and frightening (see Figure 1).

Figure 1 Totem

Figure 2 Geometric #1

Figure 3 Eyes on time

Client W had not created art beyond his assignments in school. As we worked together and his work started to change (see Figure 2), I encouraged Client W to value and continue his interest in creating art. In individual art therapy sessions, I began to show him slides of artists whose work included similar imagery or elements of art (color, composition, form, texture, line, etc.). These artists were Philip Guston, Keith Haring, and Lucas Samaras. After several months, Client W started to work in what one could describe as a more painterlike style. His perception of himself also changed from someone who had difficulty in succeeding in life to someone who had a gift for creating art.

At this point I began to incorporate the discussion of theories, artistic styles, and selected anecdotal biographical material of modern artists as a source of inspiration in group art therapy sessions that Client W attended. Other adolescents in the group who lacked motivation seemed to be inspired first by the stories and then by viewing slides of the art. The introduction of art history occurred in the beginning or "warm-up" component of the art therapy group. Miller (1993) validated the use of art history as a warm-up tool and also incorporated art history into the art therapy task. Her work with chronic psychiatric clients in a day hospital program demonstrated that clients who participate in art therapy sessions which included art history enrichment became more involved in the art task and spent more time creating art than clients in a control group. Miller claimed that art history enrichment tasks validated art therapy as an appropriate activity for adults (Miller, 1993).

Included in discussions with the adolescent art therapy groups were cubism, futurism, surrealism, and Dada. These movements in art were interesting to adolescents who felt that society and their families did not understand them. One art therapy task inspired by the Dada movement involved randomly cutting words and pictures from magazines and newspapers to create a collage. Group members could then write poems related to the collage. One client expressed a suicide wish as a result of this process and was able to receive additional clinical intervention.

Client W was also interested in these periods of art. He began to go to the library and take out large books on these artists. In individual sessions, we viewed and discussed slides of art from the Dada, pop, and happenings artists, abstract artists of the 1950s, and conceptual and graffiti artists. Many of these images were inspirational to him. For example, after viewing Dali's "Soft Construction with Boiled Beans," he drew (Figure 3) and discussed his issues regarding time and the meaning of life.

Client W's art often expressed strong emotional statements that he wanted to share with others. His anger pictures showed frightening personal issues that he attempted to understand. Haeseler (1987) strongly urges art therapists not to display artwork with violent imagery and instead to encourage clients to redirect their expression of violent imagery through an understanding of the meaning behind the image. I have found that viewing art slides by artists whose images are not overtly violent but contain powerful statements about their attempts to heal traumatic memories can also help clients redirect their own graphic outpouring of violent imagery.

To acknowledge the need to make strong visual statements, I introduced Client W and the adolescent group to two artists, Elizabeth Layton and Joseph Beuys. Both artists created art with strong imagery and were also interested in their messages being heard by society. Anecdotal information regarding Layton stressed her struggle with depression, her ability to use art to work through her own pain, and subsequently, to be able to depict the pain and suffering of others.

Joseph Beuys also used art to come to terms with his experiences. Beuys was a Nazi bomber shot down by the Russians during World War II and rescued by a group of nomadic Tartars who wrapped his body in fat and fur to keep him from freezing (Phillips, 1993). In his art, Beuys utilized honey, fat, and felt to symbolically heal the memory of this traumatic event.

Figure 4 The thermos bottle with its lid off

Figure 4 is an example of Client W's art after being exposed to slides and information on these two artists. This drawing depicted a thermos bottle that was open, the lid suspended in mid-air. Client W described this as his "life recovering from being too hot with a tight cover on in order to offer tea to others." This ability to discuss his art was a significant change; as he began to depict realistic objects, it appeared that he was developing the capacity to verbalize repressed feelings. Previously, he had been able only to sublimate these emotions through artmaking.

I experimented with showing this group of clients "Outsider Art," an inspiration from my trip to the Musee de l'Art Brut in Lausanne, Switzerland, and to several galleries in New York. *Outsider Art* is a term for work created by individuals who have no formal training. Often these individuals create a primitive or naive style of art. Many artists categorized as "outsiders" are artists with psychological problems. The adolescent group, including Client W, was shown reproductions of "Outsider Art." Other adolescents in the group shared Client W's interest in "Outsider Art" but did not identify themselves as artists. Viewing and discussing the art assisted these adolescents to understand that there is no single definition of art. After Client W saw the art, he shared his feeling of hope and inspiration that occurred when viewing the art of individuals who were not trained in art but whose work was currently selling in galleries. In this case, the identification with others who have similar problems can be what Yalom (1975) discussed as universality, a curative factor of group therapy.

During the transitional period in which Client W terminated with the partial hospitalization program and started to see me on an individual basis for art therapy, I recommended that he visit museums and galleries as part of his treatment plan. I also encouraged him to attend current art exhibitions with a friend or family member. Client W was receptive to these ideas and continued to integrate aspects of the art that he viewed into his own work. For example, after observing the work of Kandinsky and Hoffman, Client W's art became more geometrical (see Figure 5). This new ability to work abstractly opened up more avenues of expression and new ways of seeing. At the end of each session, Client W and I put his work up on an easel or wall to view. He discussed the meaning of his art and he titled each piece.

Franklin (1992), Landgarten (1981), and Rubin (1984) all discuss how the process of art therapy can increase self-esteem in adolescents. Museum and gallery trips seemed to have further increased Client W's self-esteem and development of identity. To foster his continued growth, I researched artists who had worked in styles similar to his, one of whom was Jean Michael Basquait. Basquait, originally of Haitian-Hispanic decent, had begun to impact the art world with his graffiti poems on the walls of Soho buildings before he died at age 27 from an overdose of heroin. According to Hunter (1992), Basquait's strongest work is large canvases with rhythmic, improvised slashes of color, abstract signs, and mock-primitive imagery. Through identifying with the struggles of artists, Client W started to view himself as an artist.

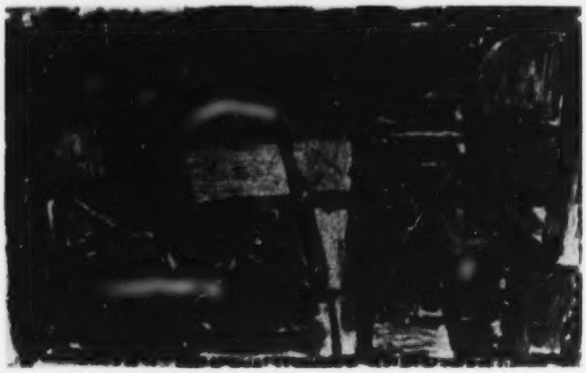


Figure 5 Geometric #8

After working together for 3 years, I contemplated organizing an art exhibit for Client W. With Client W's permission, I showed his art to several artists and art therapists who felt his work was exciting and showed artistic merit. This preview of his art prevented the potential disappointment of an exhibit being poorly attended or reviewed. I shared my colleagues' comments with Client W and together we planned an art exhibit held at a small gallery. The exhibit was well-attended; Client W sold several drawings and paintings. In addition, a curator of another gallery who attended the show scheduled Client W to have a show at his gallery the following year. After several years of creating art, Client W informed me that he now had an identity as an artist; he no longer saw himself as only a person with problems.

To assist the client in identifying himself as an artist is not the usual goal of an art therapist, but it was extremely important to Client W's identity and sense of self. Franklin's (1992) writing on self-esteem discusses art as a haven where the old self can be confronted and the new self rehearsed. Artmaking provides the possibility for clients to explore how they value themselves by observing what they invest of themselves in the artwork and how they respond to it. The continuum of acceptance and rejection becomes an inseparable feature of all art produced, thus creating repercussions for self-esteem issues (Franklin, 1992). Although the process of art therapy has not been a cure for Client W's bouts of depression and psychosis, it is a tool that he uses to assist him in his process towards psychological equilibrium.

Case #2

The case vignette of Mr. H is another example of the effectiveness of including art history and trips to museums and galleries in treatment. Mr. H, a man in his mid-twenties, had developmental delays and behavioral problems and had been diagnosed as emotionally disturbed. After being institutionalized as a child, he resided in several halfway houses. I worked with him once a week for a period of 5 years. During this period he was transferred to several different residences because of both behavioral problems and relocation of clients from various catchment areas. A recurring symbol in Mr. H's art was the image of a house. He drew many pictures of houses, several of which were empty. In some drawings he and I are depicted in the same house (see Figure 6). His stereotypical imagery seemed to be a metaphor for his experience of having to move from one residence to another. Although schematic representation has a place in the normal artistic development of children, often individuals with developmental delays are unable to progress in their artistic development unless some intervention occurs (Henley, 1989; Wilson, 1972). However, once the therapist has succeeded in encouraging a client to take a first step in altering his images, further steps can be gradually promoted. For Mr. H, viewing slides of artwork and going to galleries and museums were a catalyst for changing stereotypical imagery.

Figure 6 The art therapy session

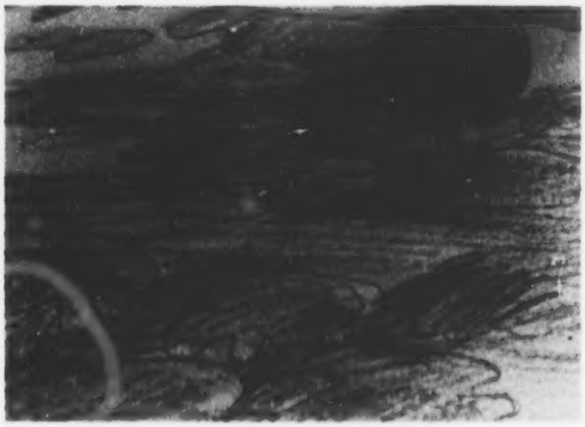


Figure 7 Cape Cod

Figure 8 Ode to Monet

At times, creating art increased Mr. H's frustration and impatience with his stage of artistic development. He wanted his landscape pictures to look realistic, and if they were not rendered to perfection, he became disappointed. To encourage and motivate Mr. H to work from the landscape, I brought in books and slides of various artists who used a more painterly and abstract approach in their portrayal of the landscape (e.g., Wolf Kahn and Joan Mitchell). Viewing art encouraged Mr. H to draw landscapes from his memory. He especially enjoyed drawing scenes from the trips that he had taken with other clients to Cape Cod (see Figure 7).

After 2 years of treatment, he developed a sense of trust and rapport. I began to accompany him to museums and gallery shows which were inspiring to Mr. H. He became interested in doing drawings in a style similar to artists that he enjoyed. After attending a retrospective on Monet, Mr. H drew Figure 8. While viewing an exhibit on artists of the Stieglitz group, Mr. H spent long period of time observing the watercolors of John Marin (see Figure 9). The museum staff, although taken aback at first at Mr. H's appearance, became curious about his love of art. They invited Mr. H to take a stool and create sketches from the artwork that he enjoyed.

Trips to museums and galleries seemed to increase Mr. H's self-esteem, especially when museum guards he once feared as authority figures allowed and encouraged him to draw at the museum. Activities of daily living skills (e.g., learning to take public transportation, handling money, communication, and socialization skills) were also enhanced by his museum and gallery visits. His treatment plan at his residence and at the sheltered workshop where he worked was based on a behavioral model. Staff would not allow Mr. H to go to a museum or gallery unless he attained a certain level of behavior for the week as indicated by the points that he earned on his chart. Going to the museum or gallery became a strong motivation for Mr. H to adopt appropriate social behavior.

Mr. H and I had developed a unique therapeutic relationship. Because I followed him to the different agencies with which he became affiliated, I became one of the few consistent staff members in his life. My sessions with Mr. H emphasized art therapy tasks that focused on decreasing inappropriate displays of anger and increasing verbalization regarding incidents that occurred in his residences. Mr. H was able to direct his anger through the physical quality of the art medium. When Mr. H was beginning to get agitated, he would choose art materials that could produce strong marks, oil pastels and oil bar sticks. On occasion when Mr. H felt that he did not want to create art, we discussed art and artists from books that I brought or books he borrowed from the library. At times I would discuss art from an

Figure 9 Tree in late autumn

Figure 10 My little town

"art education approach," which emphasized viewing the elements of art and allowing Mr. H to validate himself as an artist.

Art History Immersion with Older Adults

My experience with elderly clients demonstrated the effectiveness of using art history to motivate clients to experiment in art and to be less judgmental of their abilities to render objects realistically. Miller (1993) found that art history enrichment groups reduced clients' anxiety. Showing slides to clients can often motivate individuals who are intimidated by the idea of creating art.

A group of highly functional elderly individuals who lived in a housing project, viewed the art of abstract expressionists such as Mark Rothko, Helen Frankenthaler, Franz Kline, and Jackson Pollock and were encourage to take risks, create larger works, and "free up." Their artistic productions began to include exploration with large color masses. Viewing the poured and splattered work of the "color field" artists encouraged clients to paint in new ways. One elderly woman had no money for brushes and painted with Q-tips. I took slides of her work, and we sent them to the Q-tip company. To everyone's surprise they sent her a check for $1,000 to use her creations for an advertisement. Another elderly women, Mrs. G, was inspired by hearing the story of Grandma Moses' transformation from housewife to artist. Mrs. G started to paint local scenes (see Figure 10). This enhanced her self-esteem and gave a sense of meaning to her life. Her new identity as a painter assisted her in dealing with some of her physical problems resulting from aging. Eventually she received recognition from the governor of the state for depicting historic images.

Life review is important for the elderly, and museum visits can often serve as a stimulus for reminiscence. Objects displayed in galleries and museums can play an integral role in stimulating verbal and nonverbal expression (Silverman, 1989). Mrs. M was a very quiet woman in her late 80s. She had immigrated from the former Soviet Union as a young girl. At the museum she surprised staff members with her knowledge of the paintings of Kandinsky and Chagall. The scenes portrayed in Chagall's work brought back memories of her youth. In subsequent art therapy sessions, she began to draw pictures that allowed her to start to process issues from her youth.

In working with women in their 50s, I discovered that including slide presentations of women artists who were dealing with changes in their lives fostered a deeper self-acceptance. One client was dealing with the infidelity of her husband and was rarely able to focus on anything else. I remembered a painting by Frida Kahlo entitled "Diego on my Mind" which may have depicted Kahlo's inability to forget about Diego, even when he was having an affair with her sister (Lowe, 1991). After hearing anecdotal information on Kahlo's life, including how Diego Rivera, Kahlo's husband, was well-known for his infidelity, the client was able to put her images down on paper in an artistic style that was more meaningful and powerful than her usual choice of imagery, which was comprised mostly of flowers and kittens.

Conclusion

Art therapists need to acknowledge the power of art history as a tool in treatment. Unfortunately, many art therapists who refer to art history in sessions do so in a clandestine manner because they are afraid of being labeled art educators by their colleagues. Incorporating art history as a tool in treatment may be inappropriate for art therapists who have a limited knowledge base in art history. Cattaneo (1994) suggested that art is not the universal language that we are often taught to believe. However, in conjunction with a thoughtful and thorough assessment of clients' needs and goals, incorporating art history into art therapy can motivate a wide variety of clients to take greater risks, resulting in art that is often more complete and richer than art produced without the inclusion of art history. The case studies presented offer supporting evidence that art history integrated in art therapy treatment plans can enhance self-esteem, socialization skills, self-awareness, expression of repressed issues, and creativity. It can motivate clients to take risks to put meaningful marks down on paper.

References

Alter Muri, S. (1994). Psychopathology of expression and the therapeutic value of exhibiting chronic client's art: A case study. *Art Therapy: Journal of the American Art Therapy Association, 11*, 219–224.

Buoye-Allen, P. (1985). Integrating art therapy into an alcoholism treatment program. *American Journal of Art Therapy, 24*, 10–12.

Cattaneo, M. (1994). Addressing culture and values in the training of art therapists. *Art Therapy: Journal of the American Therapy Association, 11*(3), 184–186.

Franklin, M. (1992). Art therapy and self-esteem. *Art Therapy: Journal of the American Art Therapy Association, 9*(2), 78–84.

Haeseler, M. (1987). Censorship of intervention: "But you said we could draw whatever we wanted." *American Journal of Art Therapy, 26*, 11–20.

Henley, D. (1993). Stereotypes in children's art: Art therapeutic interventions using Lowenfeld's motivational techniques. *American Journal of Art Therapy, 27*, 116–124.

Hunter, S., & Jacobus, J. (1992). *Modern art.* Englewood Cliffs, New Jersey: Prentice Hall.

Junge, M. (1988). An inquiry into women and creativity including two case studies of the artists Frida Kahlo and Diane Arbus. *American Journal of Art Therapy, 5*, 79–93.

Kramer, E. (1986). The art therapist's third hand: Reflections on art, art therapy, and society at large. *American Journal of Art Therapy, 24*(3), 71–86.

Landgarten, H. (1981). Family art psychotherapy. *International Journal of Family Therapy, 3–4*, 379–395.

Lowe, S. (1991). *Frida Kahlo.* New York: Universe.

Miller, C. (1993). The effects of art history enriched art therapy on anxiety, time on task, and art product quality. *Art Therapy: Journal of the American Art Therapy Association, 10*, 194–200.

Phillips, C. (1993). Back to Beuys. *Art in America*, 89–93.

Rubin, J. (1984). *The art of art therapy.* New York: Brunner/Mazel.

Silverman, L. (1981). Johnny showed us the butterflies. The museum as a family therapy tool. *Marriage and Family Review, 13* (3–4), 131–149.

Wilson, L. (1977). Theory and practice of art therapy with the mentally retarded. *American Journal of Art Therapy, 16*(3), 87–97.

Yalom, I. (1975). *The theory and practice of group psychotherapy.* New York: Basic Books.

ERRATA

Two printer errors occurred in the illustration layout for the article "In Search of an Accurate Likeness: Art Therapy with Transgender Persons Living with AIDS," by Emily Piccirillo, MA, A.T.R., in Volume 13, Number 1, 1996 of *Art Therapy*. A corrected version of this article is now available from AATA. In order to obtain a reprint, please send a request in writing along with a self-addressed, stamped ($0.78) envelope (9 x 12) to the AATA National Office, c/o *Art Therapy*, 1202 Allanson Road, Mundelein, Illinois 60060.

Art Therapy: Journal of the American Art Therapy Association, 13(2) pp. 108-113 © AATA, Inc. 1996

Images of the Heart: Archetypal Imagery in Therapeutic Artwork

Judith Kidd, MA, and Linney Wix, MEd, A.T.R., LPAT, Albuquerque, NM

Abstract

The image of the heart has intrigued philosophers, poets, thinkers, and dreamers across time and cultures. This article explores the image of the heart as it resides in art, myth, literature, and religion. It examines an archetypal art therapy approach to the use of the heart in the artmaking processes of two child clients seen in individual and group art therapy. The historical exploration of the heart is used as a background against which to view personal use of the heart image in art therapy, providing a rich context in which to examine client artwork.

Introduction

When the authors noticed images of the heart becoming prevalent in their own artworks, they were inspired to look closely at the historical and cultural use of the image of the heart. Like other art therapists, both authors are involved in making their own art and in using art to understand personal experiences. The research presented in this paper is a response to hearts occurring initially in both authors' artwork. In seeking a context for these emerging hearts, they undertook the historical research of the heart's appearance in art, myth, literature, and religion. This research in turn has informed their understanding of heart imagery emerging in client artwork.

The Archetypal Heart

Everywhere—in love songs, legends, dreams, and art—the heart beats its insistent voice. The heart has spoken since humankind's earliest abilities to imagine. Eating the heart of the conquered gave power to ancient warriors. Tearing the heart out of a living Aztec hero propelled him into the heavenly realms and left sacred spiritual nourishment to his people. When the heart of the Mayan warrior was ripped from his body, it was placed in a basin held by a stone replica of the demigod, Chac-Mool (May, 1987, p. 27). Mexico City is built on the site of the Aztec capital, Tenochtitlán, which, according to myth, was constructed on the burial site of the heart of the magician and astrologer, Copil. From his heart sprang a sacred *Tenuchtli*, the red prickly pear, upon which stands an eagle clutching in his talons a snake which he cannot succeed in devouring. This occurrence announced that "the glory, the honor, the fame of Mexico Tenuchtitlan" (Debroise, 1988, p. 23) would never be destroyed and thus serves as a symbol of strength and survival.

Estes (1992) views the heart as the psychological and physical center of the human being. "In Hindu *Tantras*, which are instructions from the Gods to humans, the heart is the *Anahata chakra*, the nerve center that encompasses feeling for another human, feeling for oneself, feeling for the earth, and feeling for God. It is the heart that enables us to love as a child loves…" (p. 159). In the story "Skeleton Women," the heart is imagined as a drum which will "call the spirits that are concerned with the human heart" (p. 159). Estes suggests that the heart-as-drum metaphor symbolizes the act of "awakening layers of the psyche not much used or seen" (p. 161) through its insistent beating. The heart of the Tin Man on the journey to Oz was once cut away by the enchanted axe; he was left in a timeless place, rusting away until others came to oil and soothe his joints. Of that lonely period he said, "I had time to think that the greatest loss I had known was the loss of my heart" (Baum, 1958, p. 30). Estes (1992) discusses the heart as one of the few organs whose loss one cannot survive.

> The heart is one of the few essential organs humans (and animals) must have to live. Remove one kidney, the human lives. Additionally, take both legs, the gallbladder, one lung, one arm, and the spleen; the human lives—not well perhaps, but there is life. Take away certain brain functions and the human still lives. Take the heart, the person is gone instantly. (p. 159)

The Tell-Tale Heart (Poe, 1902) speaks metaphorically to the truth-telling nature of the heart, the heart as the central place of truth. In this riveting tale, the continuous beat of the dead man's heart drives the murderer to also be the truth-teller. Here, the soon-to-be murderer approaches his future victim but is frightened by the beat of his heart:

> And now at the dead hour of the night, amid the dreadful silence of that old house, so strange a noise as this excited me to uncontrollable terror. Yet, for some minutes longer I refrained and stood still. But the beating grew louder, louder! I thought the heart must burst. (pp. 110–111)

In both Eastern and Western medicine, the heart is seen as the body's center of life energy. Chinese physicians consider the heart to be the ruler of *Shen*, or Spirit (Kaptchuk, 1988). According to Chinese philosophy, health is a balance of bodily energies, and the individual is seen as a "harmonious landscape," a painting. Through this landscape moves the *Jing*, the essence which underlies all organic life, and *Qi*, the quickening of matter into energy. As the storer of *Shen*, the heart rules the human's desires to live life. "When *Shen* loses harmony the individual's eyes may lack luster and his or her thinking may be riddled" (p. 46). One may lose the essential desire to explore, to create, to live freely, suggesting that perhaps one "has lost heart."

Westerners tend to view the heart as a pump, pushing blood into the lungs to receive essential oxygen, then pushing the refreshed blood into the circulatory system to oxygenate and energize each cell of the body. Alongside this scientific view of the heart is the modernized version of Psyche and Eros as it is presented through Valentine's hearts and Cupid's arrows. The stylized Valentine heart repeats itself in quilting patterns, baking forms, stencils, playing cards, and the hearts of Valentine's Day cards announcing love. The Valentine itself can be traced to German and English derivation that transformed the pierced and bleeding heart of the Baroque period Sacred Heart into a symbol of romance (Debroise, 1988). The romantic connotation, though cleaned up, may link back to the heart exchanges between women and Christ (discussed below).

There seems to be a longing for the repetition of the heart in the human search for center and for belonging. Etymologically, the Welsh word for heart is *craidd* which metaphorically means "centre." The Welsh language distinguishes this center from the bodily organ with "calon, a descendant of Latin caldus 'warm'" (Ayto, 1990, p. 277). No wonder the dispirited soul is drawn to continuously repeat the heart image in its longing for connection with the warmth of the continuously beating human heart.

The Heart of Devotion

In 1988, the Institute of Contemporary Art in Boston organized an exhibition entitled *El Corazon Sangrante/The Bleeding Heart*. This show centered on the image of the bleeding heart specifically as it has appeared in the art of Mexico; heart images portrayed the physicality of the symbolism of the heart as reflecting the archetype of romance and love as well as the heart as the pulse of life. In the exhibition catalogue of the same title, Debroise (1988), a critic living in Mexico and a curator of the exhibition, explains the medieval origins of the sensuality of the heart as it is portrayed in Mexican art forms.

Debroise describes how medieval Catholicism provided fertile ground to nurture visionary heart exchanges between religious women and Christ. These practices, referred to as the "mysticism of the disgusting" (p. 17), are chronicled in the lives of nuns from the 11th to 17th centuries. Catherine of Siena, Lutgarde, and Marguerite-Marie Alacoque, significant women of their times, were empowered by their relationship to the sacred heart of Jesus and the blood flowing from his sacred wound. In these experiences,

> ...the visionary literally penetrates into the interior of Christ's body, where there occurs a complex mystical operation known as the "Interchange of Hearts" in which the young woman takes the vital organ of the Saviour, and gives to Him her heart in exchange. In other cases, Christ offers the organ directly, without requiring the act of penetration itself. (p. 15)

Each of these three women was subsequently canonized as a saint within the Catholic Church, although the Church later attempted to mitigate the sensual, bodily preoccupation within this image. According to Debroise, this "Cult of the Guts" presented issues of sensuality bordering on the obscene, presenting "a serious problem for the Church" (p. 17). The visions of heart exchanges heralded the "growing tendency to separate the carnal from the spiritual, the body from the soul" (p. 17). This is an important period in the history of the heart image because it is of the "Church"; it is "essentially feminine and folk"; and viewing it as holy or perverse, of saints or of witches, depends on the political outlook of the current culture.

In the art of Spain, Mexico, and southern Italy, images of the heart tend toward extreme realism, lacking the Northern purity of simple heart design. In religious paintings, the heart is presented "as a hunk of meat, as a piece of the guts, as a muscle swollen with blood. Removed from the body without losing any of its vitality, it is something more than mere symbol, it is... endowed with enormous emotional potential" (p. 19).

Baroque art shows the heart ambiguously serving both as container and content, as compact and dense yet simultaneously hollow. The contour of the heart appears as a "skin" and holds the blood of life. Though appearing dense, it also floats, suggesting lightness. Though it appears to pulsate, it has been removed from the body. Exposing the heart in this way exteriorizes the interior. Herein, the heart is revealed as a "vessel for the spiritual" (p. 21) and a "symbol for penance and suffering deemed necessary for true religious feeling" (Teitelbaum, 1988, p. 93).

In Figure 1, the traditional image of the Sacred Heart of Jesus is depicted by a 20th-century nun artist who lived within the spirit of the devotional heart and taught it to her students. As can be seen, this heart is pierced delicately, causing five drops of blood to fall downward. Circling the heart is a briar of thorns representing, for believers, the crown endured by Christ in his act of salvation for humankind. Above the heart burns a fire of love, engulfing the cross of humankind's redemption. The rays of light surrounding the heart signify the love of the Savior for the devoted ones.

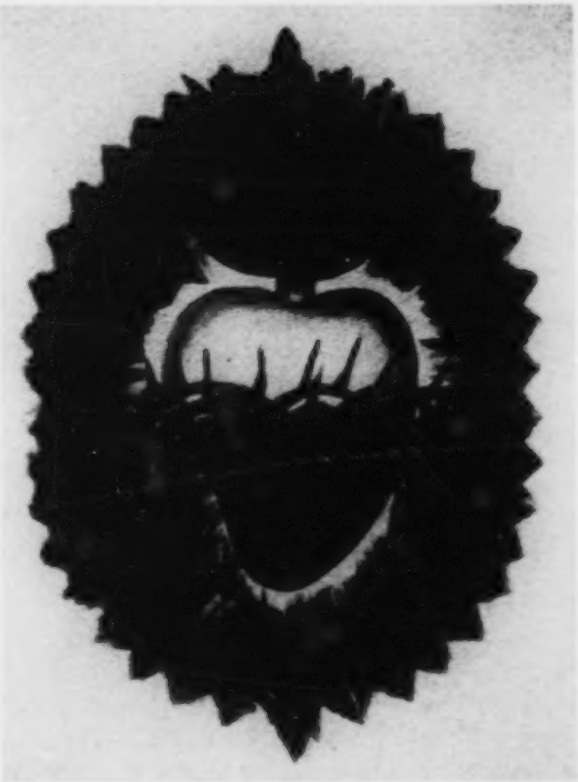


Figure 1 Sacred Heart

Healing the Wounded Heart

A suffering child is perhaps instinctively drawn to the sacrificial heart. The sacrifice of the innocent may be an archetypal memory of children. In ancient times, young children were viewed with deep veneration as sacrificial offerings. Their lives often held greater meaning within the context of ritual and culture than simply as members of a family. Mayan babies born on the equinox were understood to be born especially for sacrifice in early adulthood (Personal communication, Chichen Itza, 1994). Their childhoods prepared them for the honor of sacrifice. During an illness, Emperor Constantine, 3rd-century ruler of all Christendom, "collected a number of children to kill them and bathe in their blood as a healing charm. However, moved by their mothers' tears, the emperor spared the children's lives after all, and the 'saints' restored his health as a reward for this act of mercy" (Walker, 1983, p. 175). Henderson (1968), in Jung's *Man and His Symbols*, discusses the mystery of human sacrifice. "It is precisely because it is a mystery that it is expressed in a ritual act that, in its symbolism, carries us a long way back into man's history.... The ritual has a sorrow about it that is also a kind of joy, an inward acknowledgement that death also leads to a new life" (p. 113).

It is also true that "sacrificing" the heart's natural tendencies is likely to have long-lasting effects on a child's emotions. Florence Cane (1951) observed that if a child avoids painful feelings, her capacity for all feeling may become limited or negated. "The unconscious reaction to these rebuffs is withdrawal. In order to avoid fresh pain, the child avoids all feeling. Thus, the soul retreats, refusing to know or show emotion. The result is a timid or perhaps a closed personality" (p. 93). The fullness of the heart is sacrificed in the avoidance of feeling.

Malchiodi (1990) has documented the frequent appearance of the heart image in the artwork of sexually abused children, especially those who are father-daughter incest victims. She notes that these abused children often show the heart as a stereotypical heart image or that the heart shape is used on clothing. She suggests that the traditional use of the heart in symbolizing love and passion may account for its use in the drawings of sexually abused girls.

We suggest that the heart as depicted in art therapy work be "particularized" (Hillman, 1977) as image rather than generalized as symbol. By this we mean that each heart is specific in its own presentation. It does not represent something else; it presents its own meaning. Working from an archetypal model of art therapy, we facilitate an understanding of that meaning by attending precisely to a client's particular presentation of the heart. This "particularizing" (Hillman, 1977), accomplished partially through the act of precise description of an image, is at the heart of an archetypal, image-focused approach to art therapy.

Case Material S

Heart images dominated the art therapy work of 9-year-old S, who was hospitalized for sexual acting-out, depression, and failing grades in school. She created hearts as she guarded herself from verbally expressing her feelings and as she withdrew from adults.

Reportedly, S's initial sexual abuse was perpetrated by her mother; she had resided in a homeless shelter with her father and brother before being placed in a foster home where she was again reportedly sexually abused, this time by a foster parent. At the time of hospitalization, S was living with her father, brother, stepmother, and stepsiblings. As her treatment progressed, S revealed that her stepmother had also abused her. This revelation raised questions among her therapeutic caretakers. Was this latest account of abuse a figment of the imagination or a fragment of memory that had become confused with person and locale? Should S be put into a group home or returned to her family? At one point her psychiatrist encouraged her to consider the group home as the "best" place, while her psychologist considered a return to the family. Professionals in the clinical system urged S to "tell" her story so that a correct decision as to her placement could be made. However, feeling pressured under the urging and questioning, she withdrew from the array of clinical personnel—the psychiatrist, the psychologist, the group therapist, the art therapist, the nurses, the technical staff, and the teachers. A return to her family attracted her, despite its historical lack of safety. Her feeling of abandonment by the professionals she had come to believe were her trustworthy guardians echoed the loss of faith in her parents and encouraged her to retreat into silence.

S participated in group art therapy and embarked on what seemed to be a promising series of individual art therapy sessions. However, she initiated closure with individual art therapy; in a meeting to explore her desire to terminate, she said, "I don't trust adults anymore. I only trust the other kids." Subsequently, she joined only in group art therapy sessions, surrounding herself with her friends. In the group, she engaged actively with the art materials, painting heart after heart, while sharing little of herself verbally.

In this manner she enacted a theme common to children who have not been nurtured in return for their love. According to Malchiodi (1990), a significant result of sexual abuse trauma in children is their loss of trust in adults: "The person who destroyed that trust was someone who should have been the child's nurturer and protector. The closer the relationship between the child victim and the perpetrator, the greater the likelihood that the child's trust will be severely damaged" (p. 137).

Through her multiple abuses and the subsequent mistrust and withdrawal, the greatest of S's losses may be her heart's ability to feel connection with others. Yet, even in that loss, the heart remains present in her artwork. Her art shows us the journey of her heart. The specific heart images created in group art therapy during this period were unique to S. She made pierced and broken hearts, black hearts, smiling "I love you" hearts, and divided hearts. While these variations on hearts are common to children's drawings, close examination has the potential to reveal a precision and uniqueness to each individual heart. What seems significant in S's case is the timing of her preoccupation with this theme—as she withdrew from adult relationships, her involvement with the image of the heart increased.

In response to S's verbal withdrawal in art therapy group, the authors returned to the literature to facilitate an understanding of her use of this image. There is a striking similarity between S's bleeding heart (Figure 2) and the sacred heart of Figure 1. Both of these hearts have crowns, of a sort, and from both flow a kind of life-blood. In the crowning and the bleeding, both of these

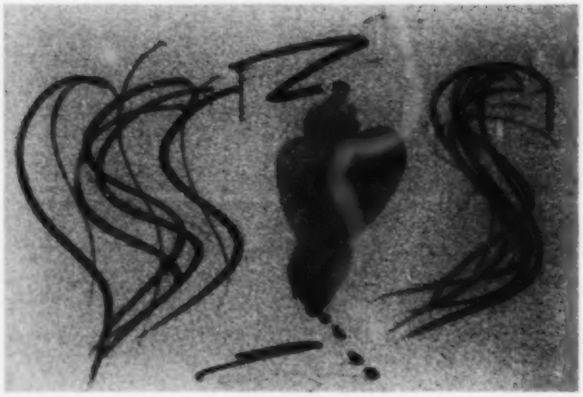


Figure 2

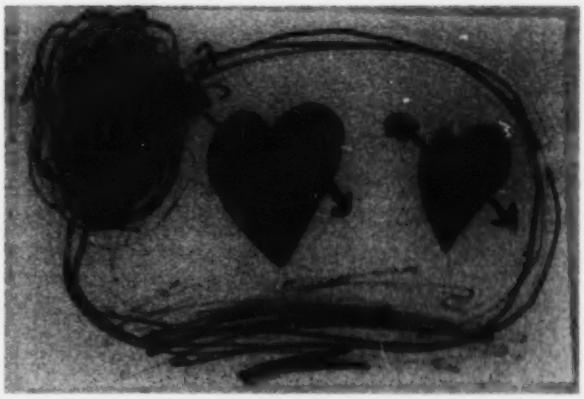


Figure 3

hearts—one a drawing done by a contemporary child and one a traditional symbol painted by a 20th-century nun—symbolically suggest the idea of sacrifice. Without knowledge of the rich cultural meaning of the heart, here specifically the sacrificial heart, we would have a more limited context for understanding S's own depiction of what resembles the traditional sacred heart. S's sacred-heart drawing (Figure 2), includes the protective tangle of color common to her numerous heart drawings; however, more particularly, her image shows an opening in the tangling—there is a space above and below the heart into which may flow a breath of life even as the drops of blood fall.

Experiencing emotion directly seemed threatening to S, as evidenced by her withdrawal from adults and by her unwillingness to tell stories about her hearts. Her actions and drawings demonstrated that a closing off was necessary as she entered a period of waiting with no certainty to her future. It was in this closing off that the emergence of the heart, in its many moods and guises, took place. In working with this child who expressed herself nonverbally, our challenge was to look to the image for clues in the visual qualities of the image—movement of line and color, placement and pattern, and spatial relationships—as echoed through descriptive metaphors. Listening carefully to these metaphors of what is seen in the image can help us hear S's personal rendering of the archetypal image of the heart. Through this "sticking to the image" (Lopez-Pedraza, in Berry, 1982, p. 57), we remain close to S's particular expression, thus preventing a generalized symbol-based interpretation of the work.

Three marker drawings (Figures 3–5) were made very quickly in art therapy during the beginning of S's withdrawal from relationships with adults. In the first drawing (Figure 3), colored lines encircle two pierced hearts, one black, one red. A tangled mass of lines appears to the left of the hearts. The image shows us that when hearts are struck by arrows, what is left is tangled up; one metaphor heard here is that when the heart is struck, what is left is a mess. When the tangling is left, it strings out to encircle the pierced hearts and forms a many-lined floor below. The lining underneath is emphasized by the use of many colors and by the repetition of line. S rapidly drew lines of different colors in this and the two subsequent drawings; her hands flew from one color to the next and the next.

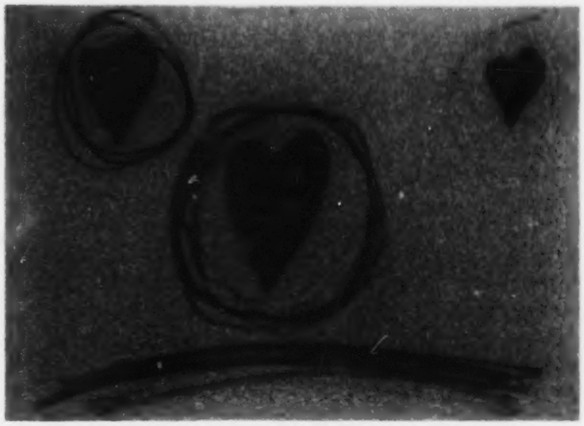


Figure 4

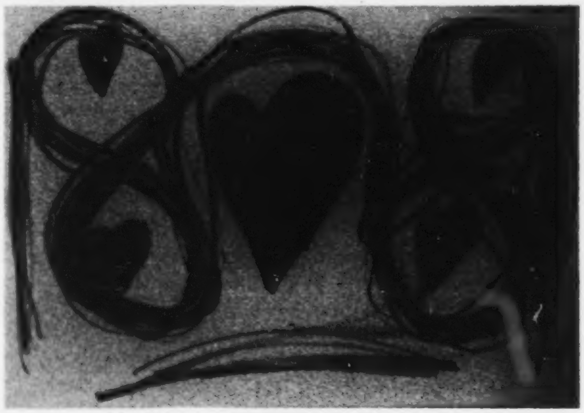


Figure 5

In the second drawing in this series of three (Figure 4), colored lines circle the red and black hearts, encapsulating and separating each heart from the other. The black circled heart is cornered right and is noticeably different and apart from the red hearts; the dark heart is rightly cornered. The multiple, horizontal, curved lines beneath the hearts blend all the colors that are separated above. When hearts are separated, it is in the lining underneath that blending takes place. This bottom edge is repeatedly emphasized. It is in this ground that the blending of all the colors is contained and in which there is potential for support; in the blending there is a grounding.

Figure 5, S's third drawing in this series, shows a change: The lines that encircle and enclose the hearts also connect them. As hearts are encapsulated by a colored lining, that same lining connects the hearts. The large golden heart, central in this drawing, is surrounded by lines and by reflecting pairs of black and red hearts; what is golden is central. To the left and right, colors circle hearts to form figure eights. Hearts are circled and connected by flowing lines; a multiple lining borders left, right, and underneath the hearts; the blended ground-line holds steady. When hearts are separated by lining, there is a connecting by those same lines. As S separates from adults around her, might there be a connecting with herself that happens through the image of the heart? There is a visible progression: First the lines were a tangled mess; then they became a grounding force, separating the hearts; and finally they circled and connected the hearts. "Only [the image] can tell us about itself" (Hillman, 1977, p. 68). In S's images, her heart's story appears to tell us about being left in a mess and about a separating and a subsequent connecting that is made of the same stuff as the mess.

Case Material J

J, age 10, was another child with a history of abandonment and sexual abuse who often used images of the heart in her art therapy work. Though more verbal than S, J expressed herself through her somatic ills. Malchiodi (1990) suggests that children subjected to trauma are likely to have somatic complaints, possibly as a result of stress turned inward. J's existence was continually traumatic as she was moved from foster home to crisis shelter to foster home because of her own family's inability to care for her.

J entered most sessions with a headache or a stomachache. Often she cried from these aches and pains or asked for food to help her feel better. When asked what her aches and pains looked like, J initially produced *The Headake Paine* and *More but Littler Pain*. Both of these drawings place the heart in the context of the body. In *The Headake Paine* (Figure 6), the head is small and pressed against the top of the page; there is little differentiation between the head and the arms and the legs. The body is a large circle with a red-outlined heart in its center. Black markings around and inside the heart emphasize its centrality. Though the picture is titled *The Headake Paine*, the reddened, marked heart is what is central. When there's a "paine" in the head, the heart is central, reddened, embodied, and emphasized by black marker lines within and around it. Perhaps the prevalence of the pain required that it be known only in the head; yet in being particular to the presentation of the image, it is seen that the "headake paine" may actually be a heartache. Logically, the pain is placed in the head; imaginally, it appears to reside in the body and to be of the heart.

More but Littler Pain (Figure 7) shows a small pencil-drawn head and body in the middle of the page, all its sensory contact with the world cut off through lack of limbs and tightly shut eyes and mouth. The only feature of the body is the heart, "…one of the few essential organs humans…must have to live" (Estes, 1992, p. 159), surrounded by eight short lines. When there's "more pain," the heart is in the middle of it; and again, the heart is emphasized by dark markings. Other than within the heart, the pain cannot be seen, tasted, smelled, heard, or touched. Even when there is no other way to make contact, the heart is marked and is all there is to the survival of the body.

Later, while J talked, she filled a page with penciled hearts (Figure 8) right side up, upside down, and diagonal. While some of the hearts are like fish, one heart is upside down and darkened. In the lower, left corner is a brainlike mass with three dark hearts inside. There are hearts all over the page and in the head; when cornered in the head or upside down, there's a darkening of the heart. There seems to be continual confusion for J as to whether to place the feeling function in the head or in the heart. The rhythmic repetition of the hearts drawn on this page is rem-

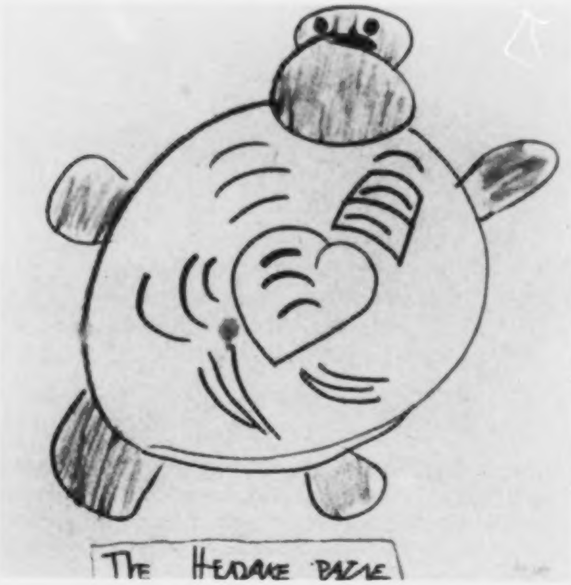


Figure 6 The Headake Pain

Figure 7 More but Littler Pain

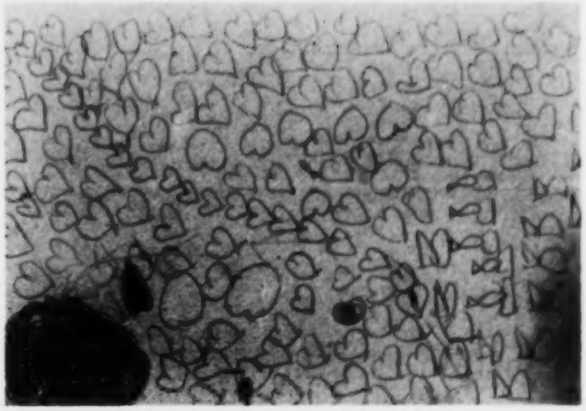


Figure 8

iniscent of the idea of heart-as-drum beating an "awakening [through] layers of the psyche…" (Estes, 1992, p. 161).

Discussion of S and J

The hearts of both of these girls, S and J, required care by the art therapist. As S rushed about, the heart held steady on the page, separated yet connected, tangled yet untangled, changing from one image to the next. As S withdrew from those who wanted her to verbally describe her abuses (in order to determine the best placement possibilities for her), she drew into the sensuous place of her heart, that organ essential to warmth and connection, through artmaking. As those around her struggled to understand her situation, her heart-centered art images continued to emerge at their own pace making their own meaning of messiness, separation, and connection for S.

J's pains were recognizable throughout her body—in her head, stomach, and throat—but in the image, it was the heart that ached and called for attention through its presentation. When things were inexpressible except through somatic ills, then images of the heart appeared in J's artwork. Both Jung and Hillman (Hillman, 1977) discuss the idea of meaning being made clear through image. "As shape emerges, meaning emerges" (p. 75). As art therapists, then, we are in a position to facilitate image-making, thus facilitating the making of personal meaning. We believe that we have the opportunity and the responsibility to do this through an archetypal approach and attitude to art and artmaking because it supports the making of meaning for the client. The meaning emerging from S's work appears to be about the heart's ability to make connections out of the tangled mess even during a period of withdrawal. J's hearts seem to speak to the idea of the heart as central to the survival of her body; her hearts help to locate the pain as a heartache, not just a headache. Both girls, we believe, have used the heart in their imagery to express metaphors of sacrifice, feeling, and connection to a center in times of angst. Clearly, the heart as expressed in their artwork is essential to their survival.

Conclusion

In this exploration of the heart as symbol, image, and metaphor, the authors searched various literature sources. This exploration into art, myth, literature, and religion then provided a contextual framework for particularizing the heart in the artwork of two female child art therapy clients. Repeatedly, the heart's centrality to the expression of pain and disappointment, as well as to survival, emerged. When there was no other source from which to draw, the heart itself became the source and the image. With no other way to be heard, the heart repeatedly asked to be seen and listened to in its presentation in these clients' artwork.

The art therapists responded to these girls' hearts by attending to the heart of the matter—the image itself—inviting the emergence of meaning through the image, believing that the image has the ability to present its own particular metaphorical meaning. Part of the challenge for the art therapist is waiting out the emergence so the image is allowed to present its own meaning. Through this active inviting and awaiting of the images, noticing precisely how the image changes, the artist's process is attended to through an archetypal approach to art therapy. In caring for each of S's hearts as it emerged, noticing and mirroring, her own process of separation and connection was witnessed and given form. Because the therapist followed J through her somatic ills while simultaneously attending to her heart, J became able to focus on her own pain more precisely—the pain in her heart. By attending to each image with the child, the art therapist held the metaphorical meanings of the images in the process of that child. By viewing these personal images in their own particular presentation against a variety of presentations of the heart in the tradition of the imagination, the personal images and meanings were contained by the archetypal forms of the heart as it has portrayed itself through history.

References

Ayto, J. (1990). *Dictionary of word origins*. New York: Arcade.

Baum, L. F. (1958). *The Wizard of Oz*. New York: Scholastic.

Beittel, K. (1972). *Mind and context in the art of drawing*. New York: Holt, Rinehart, and Winston.

Berry, P. (1982). *Echo's subtle body*. Dallas: Spring.

Cane, F. (1983). *The artist in each of us*. Craftsbury Common, VT: Art Therapy.

Debroise, O. (1988). Heart attacks: On a culture of missed encounters and misunderstandings. In *El corazon sangrante/The bleeding heart* (pp. 12–61). Boston: Institute of Contemporary Art.

Estes, C. (1992). *Women who run with the wolves*. New York: Ballantine.

Henderson, J. (1968). Ancient myths and modern man. In Jung, C. (Ed.), *Man and his symbols* (pp. 95–156). New York: Dell.

Hillman, J. (1977). Inquiry into image. *Spring 1977*. Dallas: Spring.

Kaptchuk, T. (1988). *Chinese medicine*. London: Rider.

Malchiodi, C. (1990). *Breaking the silence: Art therapy with children from violent homes*. New York: Brunner/Mazel.

May, A. (1987). *The Yucatan*. San Carlos, CA: Wide World Publishing/Tetra.

Poe, E. A. (1902). *Complete works of Edgar Allen Poe* (Vol. 5). Boston: C. T. Brainard.

Teitelbaum, M. (1988). The devoured heart. In *El corazon sangrante/The bleeding heart* (pp. 90–121). Boston. Institute of Contemporary Art.

Walker, B. (1983). *The woman's encyclopedia of myths and secrets*. San Francisco: Harper.

Brief Reports

Children's Drawings of the Elderly: Young Ideas Abandon Old Age Stereotypes

Joseph A. Weber, PhD, Kathy Cooper, MS, RN, and Jenny L. Hesser,
Stillwater, OK

Abstract

Children's drawings often reveal their attitudes, feelings, and concerns about different issues. Many children have little interaction with the elderly and therefore have a limited conception about old age. A qualitative method of asking children to draw a picture of an old person and then explain or tell a story about the picture is a unique way to unlock the hidden attitudes children may hold. This study concluded that children are abandoning stereotypes related to the attitudes and abilities of older persons. Potential applications for teachers, family therapists, and art therapists are also presented.

Introduction

Bobby, age 9, picked up his crayons and began drawing an active and energetic person who was roller blading with friends in a park. Ten-year-old Sarah spent a lot of time drawing a large face which had a smile from ear-to-ear. Tim, age 8, held up his picture and showed his third-grade class a drawing of a person listening to a "boom box." The interesting thing about these pictures is that each student had drawn a picture of an elderly person.

A combined third- and fourth-grade class was having a group discussion on aging. The enthusiasm of the students was evident as they shared their ideas of aging and the aging process. Nine-year-old Cindy told the class about her grandmother and showed a picture of grandma riding a bicycle. Cindy emphasized, "My grandma is really hip."

What is old? How do children view old age? Do children have a clear understanding of what it means to grow old? In reality, people of all ages, including children, have their own conceptualization of age and what it means to grow old (Fillmer, 1984; Levin & Trost, 1992; Sanders, Montgomery, Pittman, & Balkwell, 1984). Some clues may lay in the children's drawings of the elderly.

When you think of old, what comes to mind? When thinking about an old person, what images do you see? If you drew a picture of old people what would they look like, who would they be with, where would they be, what would they be doing, and how old would they be? These qualitative questions were asked of 104 elementary school students in a Midwestern town. Each student was given a sheet of paper and asked to draw a picture of an old person using a procedure similar to the Draw-A-Person Test (Brown, 1977; Harris, 1963). The children were told to put the age of the person they drew and their own age on the pictures. The students also discussed their pictures with the rest of the class. The pictures were then qualitatively evaluated for the child's concept of age based on content, activity level, and detail. Traditional quantitative experimental design was not applicable in this exploration.

Children's Attitudes Toward Age

Children, like adults, have a unique and different understanding of age and what it means to be old. Children see and interact with older adults, elderly relatives, and grandparents on a regular basis. With increases in life expectancy, the U.S. Bureau of Census (1990) projects that the number of elderly people will more than double to 60 or 70 million people in the next 30 years. The fastest growing segment of the U.S. population are those individuals over the age of 85 years. It is very likely that children will interact with healthy, active, older adults and older family members as multigenerational family networks become common (Naisbitt & Aburdene, 1990).

Many of the myths about the elderly are accepted as fact, and over the years, our society has created an image of the feeble, ill tempered, unfriendly, and mentally slow old person (Braithwaite, 1986; Convey, 1988). Some of the most common stereotypes of aging include aspect of poor health, unproductiveness, senility, and unattractiveness (Dychtwald & Flower, 1989).

Children are likely to have a unique perspective on aging which is not influenced by past experiences or prejudiced views. Many studies have reported the notion that children accept the negative stereotypic images of old people and aging as true (Falchikov, 1990; Seefelt, Jantz, Galper & Serock, 1977; Zandi, Mirle, & Jarvis, 1990). It has been suggested that these negative images may reinforce poor attitudes toward and opinions of the elderly. Teachers, however, can help children build positive views of the elderly that will last a lifetime.

Children's Pictures of Old Age

Children's art is a novel way to gain information on children's thought processes about other people. Children's drawings of people can reveal a considerable amount of information about perceptions, concepts, and human dynamics as viewed through their eyes (Maxim, 1980). Through art children can be creative and imaginative as well as use verbal and problem-solving skills when they discuss their pictures with others (Smart & Smart, 1982).

In this study, children were asked to draw a picture of an old person and discuss the picture's characteristics and features. The discussion and information children shared about their pictures gave new insight into the child's concept of old age. The responses and discussion clearly set a tone of curiosity and excitement among the children, while common negative stereotypes and myths of aging were minimized.

The third- and fourth-grade students in this study ranged in age from 8 to 11 years (mean age = 9.1 years) with the classes being almost equally divided by gender (52.1% boys and 47.9% girls). Drawings were grouped into three categories of artwork. Students were likely to draw a picture of an old person which consisted of the following:

- Face—detailed facial characteristics
- Body figure alone—one old person detailed
- Body figure in scene—an old person interacting with other people, pets, objects, and places

Interestingly, most of the children spent a great deal of time drawing an old person within a scene (50%), almost a third (30.8%) drew a body figure alone, while the remaining (19.2%) sketched a face which often filled the entire piece of paper (see Table 1). Pictures often included older people interacting with other people of all ages. Not only were old people socializing with others, but they were very happy. The sketches showed smiles on 64 faces; 31 expressions were neutral; only nine displayed frowns or unhappy looks.

Table 1 Elementary School Children's Drawings of the Elderly

Demographic Characteristics
N = 104

Age of Artist		**Gender of Artist**	
Mean Age	9.1 years	Boys	52.1%
Range	8–11 years	Girls	47.9%

Picture Characteristics

Gender of Person Drawn	
Males	57
Females	44
Indeterminable	3
	N = 104
Type of Pictures	
Face	30.8%
Body figure alone	19.2%
Body figure in scene	50.0%
Age of Person Drawn	
Mean age	87.5 years
Range	50–199 years
Facial Expressions (all pictures)	
Smiles	64
Neutral expressions	31
Sad/frown	9
	N = 104
Handicap Aids (Some pictures had more than one handicap drawn.)	
Canes	29
Wheelchairs	16
Walkers	3
None	61
	N = 109

Children had a rather realistic view of what age they considered old. In the pictures drawn, the average age of the old person represented was 87.5 years with a mode of 90.0 years. The range was from 50 to 199 years old. Over half (58.6%) of the children showed an old person as healthy and active with no disabilities, while some of the children drew pictures of old people with mobility aids such as canes, wheelchairs, or walkers. Children took a great deal of time to color their pictures. Clothes, faces, scenery, and background objects were often in bright shades of yellow, green, orange, and blue.

David, age 9, drew a picture which incorporated elements of exercise, enthusiasm, happiness, and togetherness. His picture was a scene of four adult figures, ranging in age from 63 to 100 years (see Figure 1), who were walking, jogging, and rolling (in a wheelchair). David illustrated motion and showed his figures (both men and women) outside on the grass on a sunny day.

Nine-year-old Heather also drew a scene, but unlike David, she illustrated a 99-year-old woman dancing (see Figure 2). Her

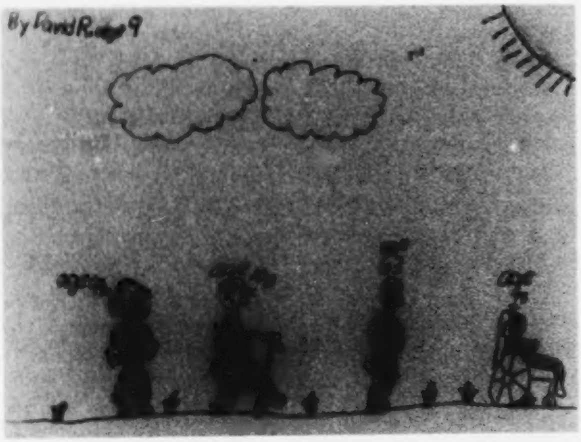


Figure 1 Scene of four adults ranging in age from 63 to 100 years

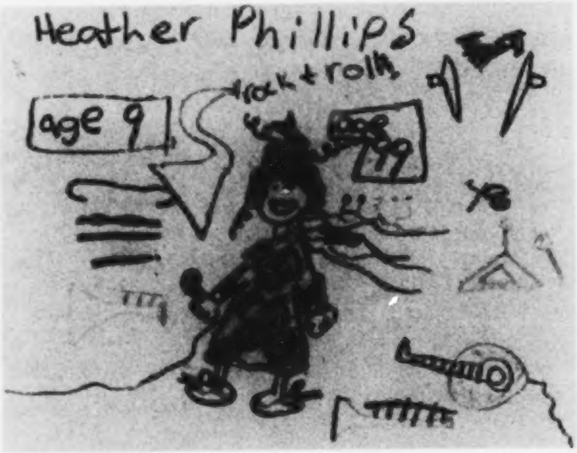


Figure 2 A 99-year-old woman dancing

picture incorporated elements of music, motion, and a variety of musical instruments with the words "rock and roll" coming out of a large horn. In discussing her picture, Heather told the class that this is her grandmother who loves to dance, and, "I'm going to teach her how to skateboard."

All the children who drew figures alone emphasized a front view of the older person. Exactly half of the pictures focused on a mobility aid (a cane or walker), while the other half depicted an old person standing alone. This is illustrated by Travis' (age 9) and Kathy's (age 9) pictures (see Figures 3 and 4). Travis showed a 79-year-old man who was getting ready to go jogging with a 20-pound weight in each hand. In a dialogue with the teacher, Travis mentioned, "I'm going to be this way when I'm old." Kathy drew an 87-year-old woman with a cane. Both of these pictures are representative of all the figures-alone pictures; the figures are standing flat footed, arms stretched outward, and facing forward.

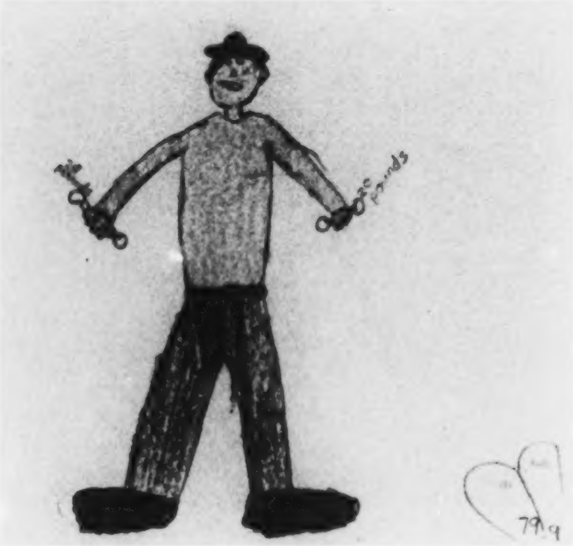


Figure 3 A 79-year-old man jogging and weight-lifting

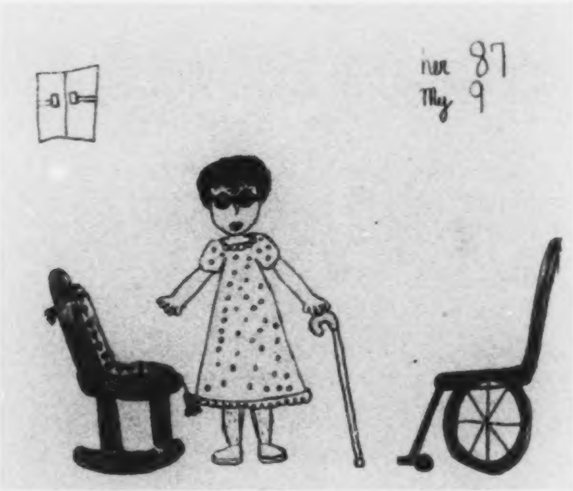


Figure 4 An 87-year-old woman with a cane

Large detailed faces often told a story of emotion and depicted vivid expression. Of the 32 children who drew faces, a majority (45.8%) emphasized happy, smiling faces with large red lips, rosy cheeks, and brightly colored eyes. This was particularly evident in Tessa's (age 9) picture of a 76-year-old-woman (see Figure 5), whom Tessa depicted in a joyful, happy mood. As Tessa held up her picture for the rest of the class to see, she said she gave her older person the name "Clappy Happy." The remaining children who drew face pictures had either a neutral expression (33.3%) or a sad/angry expression (20.8%).

Discussion

In conclusion, we found the results of this study astonishing. The drawings were a simple, interesting, and enjoyable way to obtain children's views on a topic which is sometimes difficult to discuss. The children revealed that they do not hold typical negative beliefs of old people and the aging process, and their drawings were very positive, presenting an energetic look at the elderly. Even when depicting elders with mobility aids, the children used bright colors and full face views, possibly indicating optimism in spite of a minor dependency. This counteracts the typical view that children negatively stereotype old age and infirmity.

There are many uses for children's drawings of the elderly. Classroom teachers and counselors can use the presented technique to open discussion on intergenerational issues pertinent to students and their older kin. Family therapists can identify children's attitudes from their drawings and discussions and target programs and interventions to strengthen family bonds.

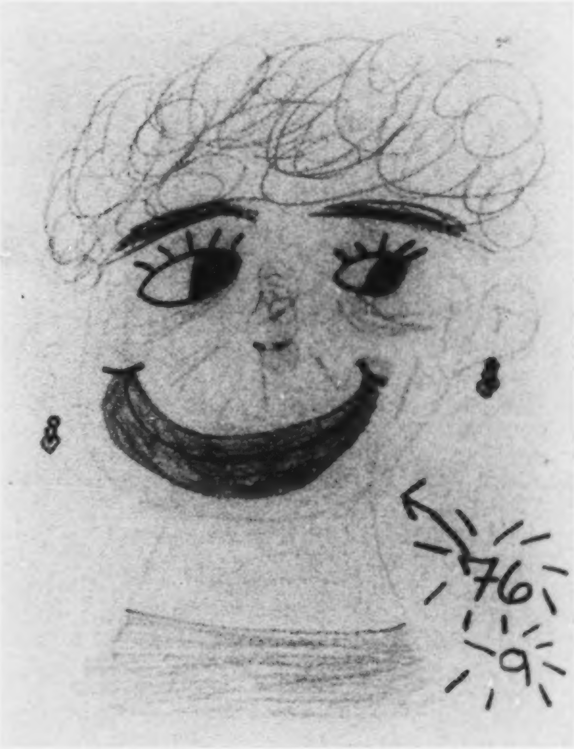


Figure 5 Seventy-six-year-old "Clappy Happy"

Additionally, art therapists can use this technique to explore children's views of older relatives and contacts, facilitate discussions of feelings, and identify coping strategies for troubled families.

Editor's Note: Joseph A. Weber, PhD, is an Associate Professor at the Department of Family Relations and Child Development, College of Human Environmental Sciences, Oklahoma State University, Stillwater, OK 74078-0337. Kathy Cooper, MS, RN, and Jenny L. Hesser were Graduate Research Assistants for this project.

References

Braithwaite, V. (1986). Old age stereotypes: Reconciling contradictions. *Journal of Gerontology, 41*(3), 353–360.

Brown, E. (1977). Reliability of children's drawings in the Goodenough-Harris "Draw-A-Person Test." *Perception and Motor Skills, 44*, 739–742.

Convey, H. (1988). Historical terminology used to represent older people. *The Gerontologist, 28*(3), 291–297.

Dychtwald, K., & Flower, J. (1989). *Age wave.* Los Angeles, CA: Jeremy P. Tarcher.

Falchikov, N. (1990). Youthful ideas about old age: An analysis of children's drawings. *International Journal of Aging and Human Development, 31*(2), 79–99.

Fillmer, H. (1984). Children's descriptions of and attitudes toward the elderly. *Educational Gerontology, 19*(1/2), 99–107.

Harris, D. (1963). *Children's drawings as a measure of intellectual maturity.* New York: Harcourt Brace Jovanovich.

Levin, I., & Trost, J. (1992). Understanding the concept of family. *Family Relations, 41*(3), 348–351.

Maxim, G. (1980). *The very young: Guiding children from infancy through the early years.* Belmont, CA: Wadsworth.

Naisbitt, J., & Aburdene, P. (1990). *Megatrends 2000.* New York: William Morrow and Company.

Sanders, G., Montgomery, J., Pittman, J., & Balkwell, C. (1984). Youth's attitudes toward the elderly. *Journal of Applied Gerontology, 3*(1), 59–70.

Seefelt, C., Jantz, R., Galper, A., & Serock, K. (1977). Using pictures to explore children's attitudes toward the elderly. *The Gerontologist, 17*(6), 506–512.

Smart, M., & Smart, R. (1982). *Children: Development and relations* (4th ed.). New York: Macmillan.

U.S. Bureau of the Census. (1990). *Age, sex, and race for the United States, regions and states.* (STA-1A). Washington, DC: U.S. Government Printing Office.

Zandi, T., Mirle, J., & Jarvis, P. (1990). Children's attitudes toward elderly individuals: A comparison of two ethnic groups. *International Journal of Aging and Human Development, 30*(3), 161–174.

LESLEY COLLEGE

Master of Arts in Expressive Therapies

A unique program designed for women and men eager to advance professionally and create change in people's lives.

- Integrate the modalities of dance, drama, literature, music, poetry and visual arts with the practice of psychotherapy.
- Combine experiential and creative learning with applied clinical practice and artistic work.
- Specialize in Art Therapy – learn comprehensive skills in the therapeutic use of the visual arts.

Call 617/349-8425 or 800/999-1959 x. 8425 for more information.

LESLEY COLLEGE Office of Graduate Admissions
29 Everett Street, Cambridge, Massachusetts 02138-2790

LESLEY

Gender Differences and Similarities in the Spatial Ability of Adolescents

Rawley Silver, EdD, A.T.R.-BC, HLM, Sarasota, FL

Abstract

It is generally accepted that males are superior to females in spacial ability. To test this assumption, the Silver Drawing Test (SDT) was administered to students 12 to 15 years old (N = 33 girls, 33 boys) attending public schools in Nebraska, New York, and Pennsylvania. The test instrument included two spacial subtests: Predictive Drawing (ability to predict and represent sequential order, horizontality, and verticality) and Drawing from Observation (ability to perceive and represent left-right, above-below, and front-back relationships). No significant differences in spatial ability were found.

Introduction

Gender differences have been found in the anatomical structure and organization of the human brain. In the female brain, both hemispheres are involved in verbal and visual-spatial abilities as well as in emotional responses (Moir & Jessel, 1992). According to this research, more information is exchanged between hemispheres in the female brain because the corpus collosum (the bundle of nerve fibers linking the hemispheres) is thicker and has more connections. As a result, women may be better able than men to recognize emotional nuances in voice, gesture, and facial expression. Females may deduce more from such information because they have a greater capacity to integrate and cross-relate visual and verbal information. The emotional nuances may also be manifest in art forms because gender differences in the emotional content of drawings have been found in responses to the Drawing from Imagination subtest of the Silver Drawing Test (Silver, 1990, 1992a, 1992b, 1996).

Gender differences have also been found in spatial ability. According to McGee (1979), psychological testing for more than 50 years has concluded that the most persistent individual differences on multifactor tests of psychological functioning is a sex difference in spatial ability, with males consistently excelling. Gaulin and Fitzgerald (1986), studying the behavior of voles, also found male superiority but hypothesized that male voles evolve superior spatial ability only when they are more mobile and have larger home ranges than females. According to Moir and Jessel (1992), male superiority in spatial ability is not only confirmed but also not even in dispute.

Nevertheless, Hunter (1992) found female college students in Australia superior in spatial ability, as reported in her study on individual differences in problem-solving, information-processing, and other skills. Her subjects included 128 women and 65 men, 15 to 53 years old. The men predominated in engineering and construction courses, the women, in office and education courses. Hunter asked her subjects to respond to five tests. In one of the tests, the Silver Drawing Test of Cognitive Skills and Adjustment (Silver, 1990), women showed higher mean scores on visual-spatial relationships than men, performing better on tasks involving the perception of height, width, depth, and to some extent, sequential order. Hunter concluded that her findings were consistent with Silver's theory that cognitive skills evident in verbal conventions can be evident also in visual conventions.

The present study addresses the question of gender differences in spatial ability as measured by the tests used by Hunter, the Drawing from Observation and Predictive Drawing subtests of the Silver Drawing Test (SDT). Subjects were 66 adolescents attending public schools in Nebraska, Pennsylvania, and New York.

Method

Subjects

Subjects included 33 girls and 33 boys, 12 to 15 years old, attending public schools in Nebraska, Pennsylvania, and New York. The SDT was administered by teachers or art therapists who volunteered to help establish the validity and reliability of the test. In Nebraska a classroom teacher administered the SDT to six boys and nine girls, 13 and 14 years old, who comprised half the number of eighth graders in a rural public school. Since this class had previously been divided for periods of music and art, their teacher decided to test all students during the art period (Silver, 1990). In New York the author administered the test to 15 girls and 23 boys, 12 to 14 years old, all the seventh- and eighth-grade students in a public school in an urban, middle-class neighborhood. In Pennsylvania an art therapist tested nine girls and four boys, 14 and 15 years old, all the 10th grade students. Their responses were scored by both the art therapist and the author as part of a study of scorer reliability. Correlations between the two sets of scores ranged between .71 and .81, significant at the .01 level (Silver, 1986). The responses produced in Nebraska and New York were scored by the author.

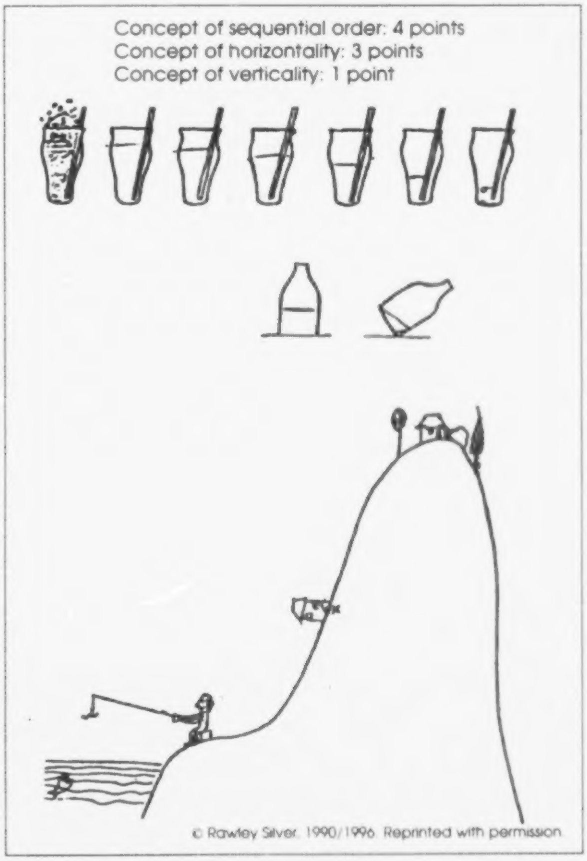
The SDT Observation Subtest

The aim of this drawing task is to assess the ability to perceive and represent proportions, positions, shapes, and three-dimensional relationships of height, width, and depth. Examinees were asked to draw an arrangement of three cylinders which differ in height and width, and a small rock. Responses are scored on a 5-point scale for level of ability to represent horizontal relationships (left-right), vertical relationships (above-below), and relationships in depth (front-back). Accurate and carefully represented responses score 5 points. Approximately correct but not carefully represented responses score 4 points. When the relationships of three objects are represented correctly, responses score 3 points; two objects, 2 points. When only one object appears in the correct position, responses score 1 point. When no object is in the correct position or when there is no representation of height or depth, the score is zero.

The SDT Predictive Drawing Subtest

This subtest includes three drawing tasks (see Figure 1). For the first task, respondents are asked to add lines to a row of glasses, showing how the glasses would appear as their contents are gradually consumed. Drawings which show an evenly spaced series of descending horizontal lines with no corrections score 5 points. Drawings with unevenly spaced increments score 4 points. Those with no sequences, incomplete sequences, two sequences, or sequences with erasures or other corrections score zero to 3 points respectively.

The second task requires respondents to draw a line on a bottle half filled with water, showing how the water would look if the bottle were tilted. The third task requires them to draw the way a house would look if moved to a steep mountain slope. These two tasks are adapted from tasks designed by Piaget and Inhelder (1967) for evaluating concepts of horizontality and verticality. The scoring is based on their observations and rated on the scale of zero to 5 points.


Concept of sequential order: 4 points
Concept of horizontality: 3 points
Concept of verticality: 1 point

© Rawley Silver, 1990/1996. Reprinted with permission.

Figure 1 Responses to the Predictive Drawing task by a boy, age 12.

Procedures

In order to compare responses to the Drawing from Observation and Predictive Drawing subtests by 33 girls and 33 boys, mean scores were analyzed using a computation of T-test scores.

Results

No significant gender differences in spatial ability were found, as shown in Table 1. The overall Manova indicated no overall gender differences on spatial measures. Although the girls' mean scores tended to be stronger in ability to represent depth (front-back relationships), the probability was less than .10 and was not significant. However, it may be significant with a larger number of participants.

Discussion

Although the present study found no significant gender differences in spatial ability, as measured by the Drawing from Observation and Predictive Drawing subtests, Hunter (1992), using the same subtests, found that women excel while other investigators found that males excel. How can these contradictions be explained?

A possible explanation is that some investigators who found male superiority did not use drawing tasks to assess spatial ability. For example, Thomas, Jamison, and Hammer (1973) used a scientific apparatus to present the Piagetian horizontality task. These investigators found that many university women students had not discovered that water remains horizontal regardless of the tilt of its container and did not readily learn the principle through observation. Their report generated much publicity at the time.

In reading the report, I noticed that an illustration of the task seemed to show a subject adjusting the position of bottles mounted on round, rotatable disks below eye level on a machine. Apparently, a critical clue for discovering horizontality was missing: an external horizontal frame of reference. According to Piaget and Inhelder (1967), horizontality is discovered by noticing parallels, so in their teaching experiments, they presented a jar of water on a table at eye level. "Care was taken to have the level of the water at the height of the child's eyes, or a little above, so that he [or she] can see the edge of the surface clearly" (p. 381). The Predictive Drawing task provides an external horizontal frame of reference, a line representing the table surface, but apparently the experiment by Thomas et al. (1973) failed to do so, thus discouraging, rather than encouraging, the discovery of horizontality (Silver, 1978).

Although the present study found no significant differences between genders, Hunter found females superior in representing height, width, and depth, and "to some extent" sequential order. Reasons for the different findings may lie in differing cultural backgrounds, sample numbers, and ages of the two groups of examinees. The 66 American adolescents, 12 to 15 years old, had been compared with Hunter's Australian sample of 65 men and 128 women, 15 to 53 years old.

Table 1 Significant Differences Between Male and Female Adolescents in Spatial Ability Using the Draw A Story (DAS) Instrument (Silver, 1993).

Dependent Measure	***N of Subjects***		***Mean***		***Std. Dev.***		***Degrees of Freedom***	***Value of t***	***Significance***
	Females	***Males***	***Females***	***Males***	***Females***	***Males***			
Sequence	33	33	4.48	4.55	0.83	0.87	64	-0.29	n.s.
Horizontal	33	32	4.12	4.22	0.99	0.97	63	-0.40	n.s.
Vertical	33	33	2.85	2.42	1.64	1.56	64	1.08	n.s.
LR	33	33	4.24	4.18	0.79	1.01	64	0.27	n.s.
AB	33	33	4.18	4.06	0.68	0.75	64	0.69	n.s.
FB	33	33	3.70	3.06	1.10	1.56	64	1.91	$P<10$
Total	33	32	23.58	22.31	3.47	3.57	63	1.45	n.s.

Further study with responses by American adults may clarify the issue. In addition, a more critical examination of Hunter's thesis would be helpful. Although it is clear that female superiority was found in responses to the Drawing from Observation task, it is not clear what was found regarding the horizontal and vertical concepts revealed in responses to the Predictive Drawing task. Additional information about the methodologies used by Hunter, Thomas et al., and other investigators who examine spatial abilities may shed more light on the conflicting results.

The findings reported or summarized here suggest that nonverbal expression through drawing offers unique opportunities to contribute to the growing body of knowledge about age and gender differences and similarities.

Editor's Note: Rawley Silver, EdD, A.T.R., HLM, can be contacted at 700 John Ringling Blvd #1603, Sarasota, FL 34236-1504; home phone (941) 361-7521; work (941) 377-4512 (phone/fax). The author would like to thank Joan Swanson and Robert Vislosky, PhD, A.T.R., who volunteered to administer the Silver Drawing Test to these adolescents, as well as Madeline Altabe, PhD, who performed the statistical analyses reported here. Their assistance is greatly appreciated.

References

Gaulin, S. J. C., & Fitzgerald, R. W. (1986). Sex differences in spatial ability: An evolutionary hypothesis and test. *The American Naturalist, 127*(1), 74.

Hunter, G. (1992). *An examination of some individual differences in information processing, personality, and motivation with respect to some dimensions of spatial thinking or problem solving in TAFE College students.* Unpublished thesis, The University of New England, School of Professional Studies, Faculty of Education, Nursing and Professional Studies, Armidale, 2351 NSW Australia.

McGee, M. G. (1979). Human spatial abilities: Psychometric studies and environmental, genetic, hormonal, and neurological influences. *Psychological Bulletin, 86*(5), 889–918.

Moir, A., & Jessel, D. (1992). *Brain sex.* New York: Dell Publishing.

Piaget, J., & Inhelder, B. (1967). *The child's conception of space.* New York: W. W. Norton.

Silver, R. A. (1978, 1986, 1989). *Developing cognitive and creative skills through art.* Baltimore: University Park Press; New York: Ablin Press.

Silver, R. (1983/1990/1996). *Silver Drawing Test of Cognition and Emotion.* New York: Ablin Press.

Silver, R. A. (1992). Gender differences in drawings: A study of self-images, autonomous subjects, and relationships. *Art Therapy: Journal of the American Art Therapy Association,* 9(2), 85–92.

Silver, R. A. (1993a). Age and gender differences expressed through drawings: A study of attitudes toward self and others. *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 159–168.

Silver, R. A. (1993b). Assessing the emotional content of drawing by older adults: Research findings and implications. *American Journal of Art Therapy,* 32(2), 46–52.

Silver, R. A. (1988/1993). *Draw A Story: Screening for Depression and Age or Gender Differences.* New York: Ablin Press.

Thomas, H., Jamison, W., & Hummel, D. D. (1973). Observation is insufficient for discovering that the surface of still water is invariantly horizontal. *Science, 181,* 173.

American Art Therapy Association, Inc.: The Results of the 1994–1995 Membership Survey

S. Lorraine Pearson, BA, Kathy K. Walker, BFA, Melinda Martinek-Smith, BFA, Nancy M. Knapp, PhD, and Kenneth A. Weaver, PhD, Emporia, KS

Abstract

Every other year for the past 8 years, AATA has surveyed its members to obtain demographics, job and salary information, and areas of specialization. The 1994–1995 membership survey focused additionally on licensure and training issues. In 1994, approximately 4,750 surveys were sent; 2,091 members responded for a 44% return rate. The results of this survey are presented in this article to illuminate the art therapy profession through the responses of its practitioners.

Introduction

"How is AATA going to help art therapists get licensed as art therapists and become covered by insurance companies? This is a primary concern for all art therapists." This comment from the 1995 membership survey echoes the concerns of many art therapists today. One of the purposes of the biennial membership survey is to assess such concerns. By surveying its members, AATA can consolidate information about demographics, job responsibilities, education, and other current licenses. In turn, this information can demonstrate the growing need for licensed art therapists by presenting a clear picture of the art therapy profession.

This most recent membership survey was sent to all AATA members along with the 1995 dues statement. The survey addressed such issues as demographics, education, job titles and tasks, settings and populations, and licensure and further training. Out of approximately 4,750 members surveyed (AATA, 1995), 2,091 responded. The results published in this article reflect only those members who responded to the survey. Results of the three previous surveys appear in Gordon and Manning (1991), La Brie and Rosa (1994), and Malchiodi and Waller (1989).

Personal Characteristics

Ninety-three percent of the respondents were female; 91% were Caucasian (see Figure 1 for ethnicity figures). The highest percentage of respondents had 6 to 10 years of experience in art therapy, although there was a large range, from a few months to over 20 years (Figure 2). The majority of the respondents, 68%, had either a Master of Arts or Master of Science degree (Figure 3). Responses came from all the states except North Dakota and many countries around the world (Figure 4).

The AATA members who responded were most likely to also

Caucasian	91.10%
African American	3.10%
Hispanic	1.90%
Asian American	.80%
Other	2.80%

Figure 1 Ethnicity (by percent)

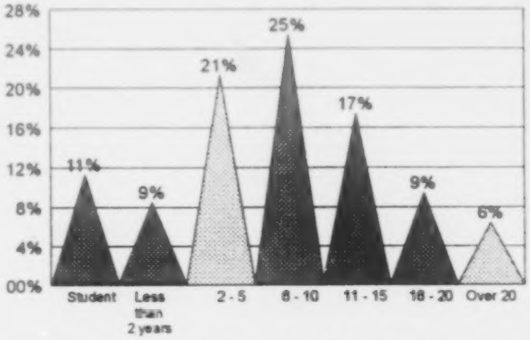


Figure 2 Number of Years Experience (by percent)

BA/BS	7.30%
BFA	1.60%
MS/MA	68.20%
MFA	1.90%
PhD	4.50%
PsyD	.20%
EdD	1.00%
RN	.10%
MDiv	.20%
MEd	3.90%
MPS	3.70%
MSW	1.50%
Other	4.20%

Figure 3 Highest Degree (by percent)

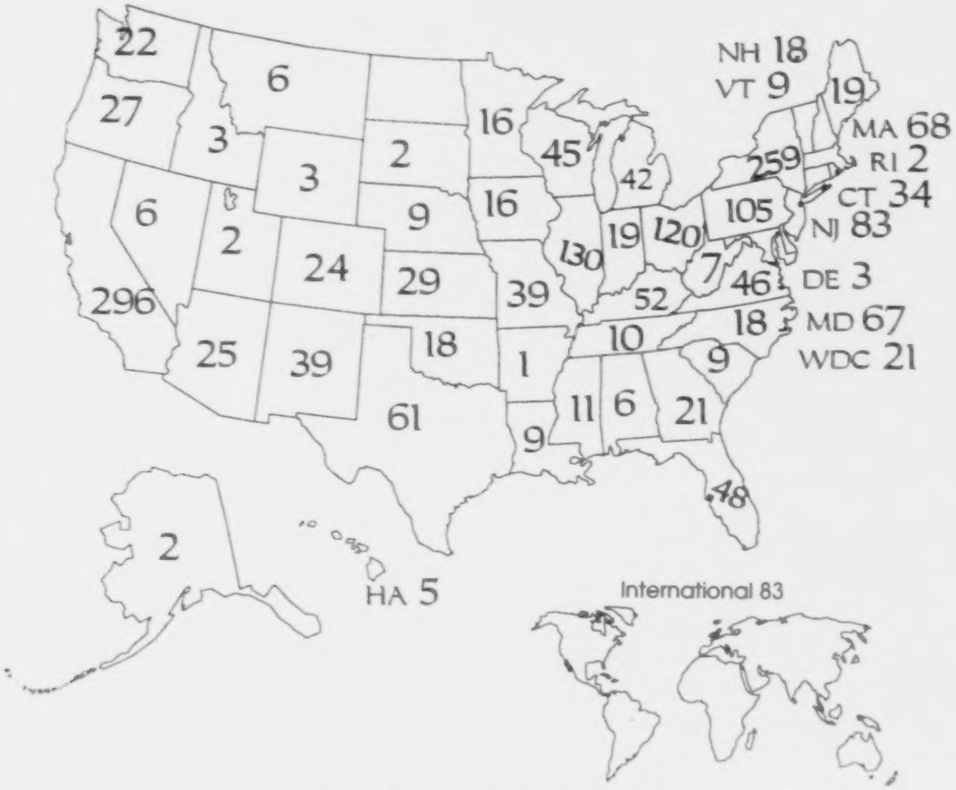

22
27
6
3
3
2
6
2
296
24
9
29
25
39
18
61
16
16
39
1
9
45
42
130
19
120
105
7
46
52
10
18
9
11
6
21
48
259
NH 18
VT 9
19
MA 68
RI 2
CT 34
NJ 83
DE 3
MD 67
WDC 21
2
HA 5
International 83

Figure 4 Number of Responses per State

belong to the American Psychological Association, the American Association of Marriage and Family Therapists, the American Counseling Association, the National Art Education Association, or the National Association of Social Workers. About 20% belonged to a state or regional art therapy association. Interestingly, over 100 respondents reported belonging to the California Association of Marriage and Family Therapy (CAMFT), more than twice as many as those members who belong to the American Association of Marriage and Family Therapy (AAMFT).

Job Information

The most commonly reported job title was art therapist, followed by counselor/clinician and art psychotherapist (Figure 5). Many people also wrote in professor or assistant/adjunctive professor, educator or teacher, coordinator, and social worker. Fifty-two percent of the respondents reported working in a psychiatric or mental health setting. Private practice was reported 29% of the time (Figure 6). Chemical dependency, family and youth services, foster care/adoption agencies, in-home family

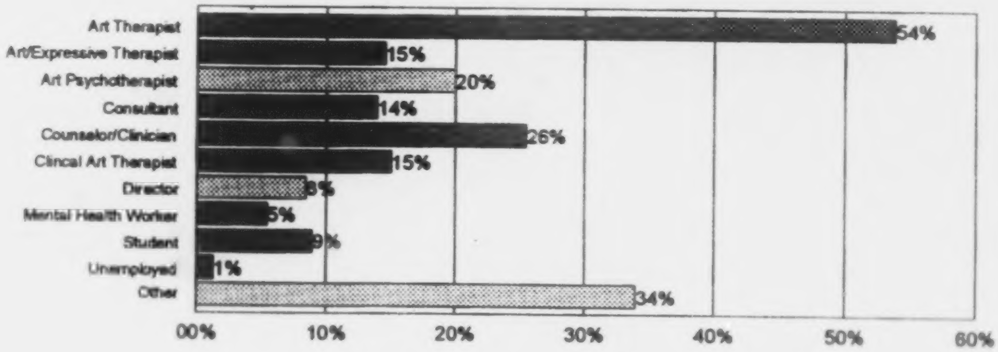


Figure 5 Job Title (by percent)

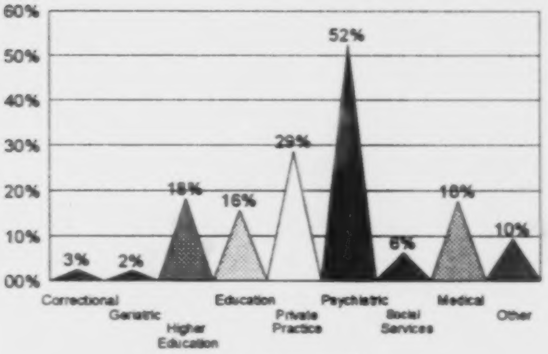


Figure 6 Work Setting

therapy or crisis intervention, and community services were frequently written in.

The specialties and populations reported most frequently were adult psychiatric, abused/neglected children, psychotherapy, adolescent psychiatric, families, and sexual abuse. These were consistently chosen for the first through fifth choices. Grief/loss and creativity were often chosen for the fourth and fifth choice. Other specialties or populations were often written in, including behaviorally or emotionally disturbed clients, women's issues, couples, juvenile delinquents, homeless, and ADD/ADHD.

Individual and group therapy were the modalities most commonly indicated by the respondents. See Figure 7 for the full listing. Assessment or evaluation, case management, program/text development, treatment and discharge planning, and writing were also frequently indicated.

Salary Information

The most commonly reported income was between $26,000 and $30,000 per year, although the range was broad. Pay increased predictably as the number of hours worked per week increased. People working between 31 and 40 hours per week reported earning between $26,000 and $30,000 most often. People working over 40 hours per week typically reported earning between $31,000 and $35,000.

Salaries by setting are listed in Figure 8. AATA members working in private practice or higher education most often reported earnings in the higher ranges. Earnings in the lower ranges were reported by therapists working in geriatric or "other" settings. Again, the range was broad enough to make generalizations difficult.

Figure 9 illustrates salary by degree. Respondents with doctoral degrees reported earning the most money while those with bachelor degrees reported earning the least. The lower range is likely to reflect students who were working at unpaid internships at the time of the survey. Of those with master's level degrees, social workers reported earnings in the highest categories most often; those with MFAs reported earnings in the lowest categories most often.

Salaries appear to increase with the art therapist's years of experience. The most commonly reported salary range for those with less than 2 years experience was between $21,000 and $40,000. The most commonly reported salary range for those with more than 20 years experience was over $40,000. Figure 10 shows the relationship between salary and years of experience.

Male art therapists were twice as likely as female art therapists to hold a doctorate. Yet they were three times as likely as

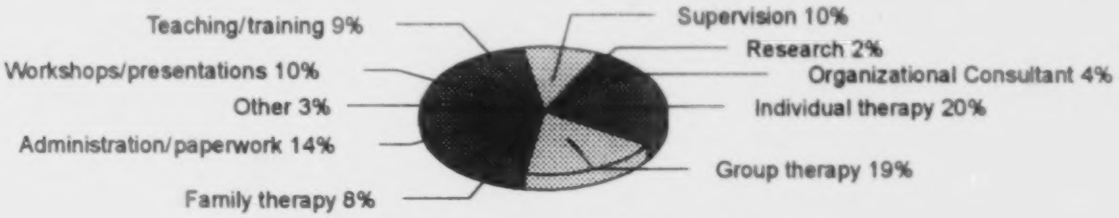


Figure 7 Professional Tasks (by percent)

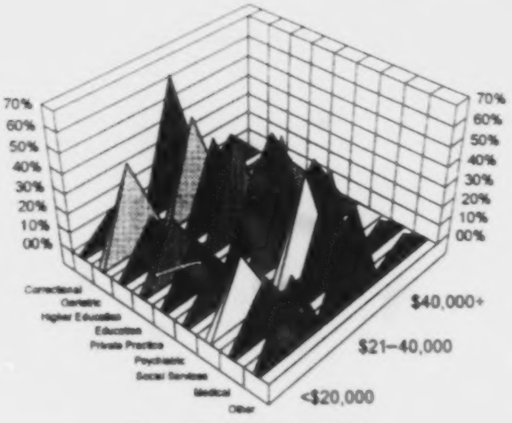


Figure 8 Salary by Setting

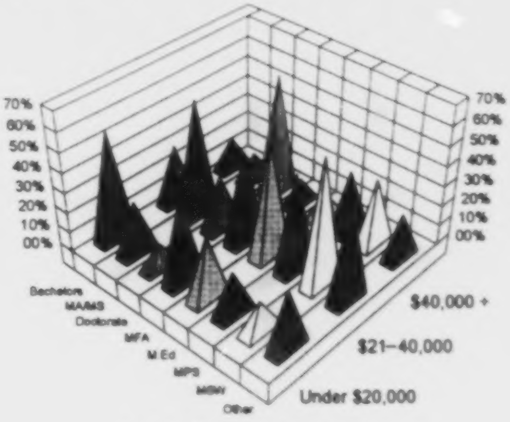


Figure 9 Salary by Degree

female art therapists to earn over $50,000 a year. This disparity in salary is worth further study.

Registrations and Licenses

In addition to an A.T.R., the most commonly reported license or registration was Marriage, Family and Child Counselor (Figure 11). Other therapists also wrote that they were licensed as a social worker, educator, mental health professional or counselor, or marriage and family therapist. The number of responding A.T.R.s per state is shown in Figure 12.

Thirty-seven percent of the respondents stated that they needed training in addition to their art therapy education to obtain their current jobs. Those who most frequently reported this were behavioral scientists, mental health workers, and counselors/clinicians. Those holding doctoral degrees and MSW degrees were also most likely to report additional training. Hawaiians reported the most additional training, followed by

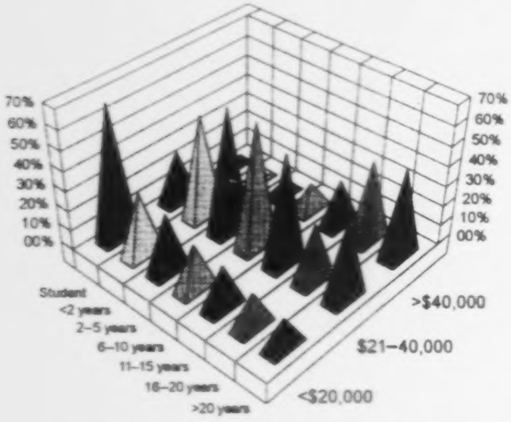


Figure 10 Salary by Years of Experience

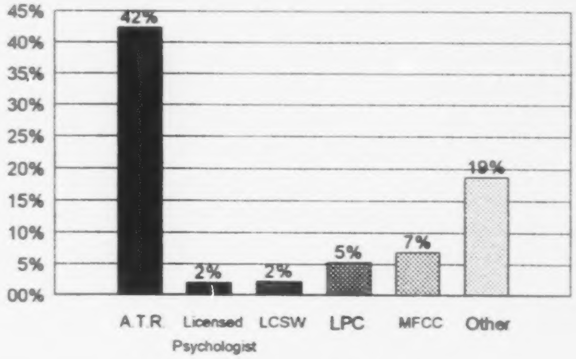


Figure 11 Registration/License

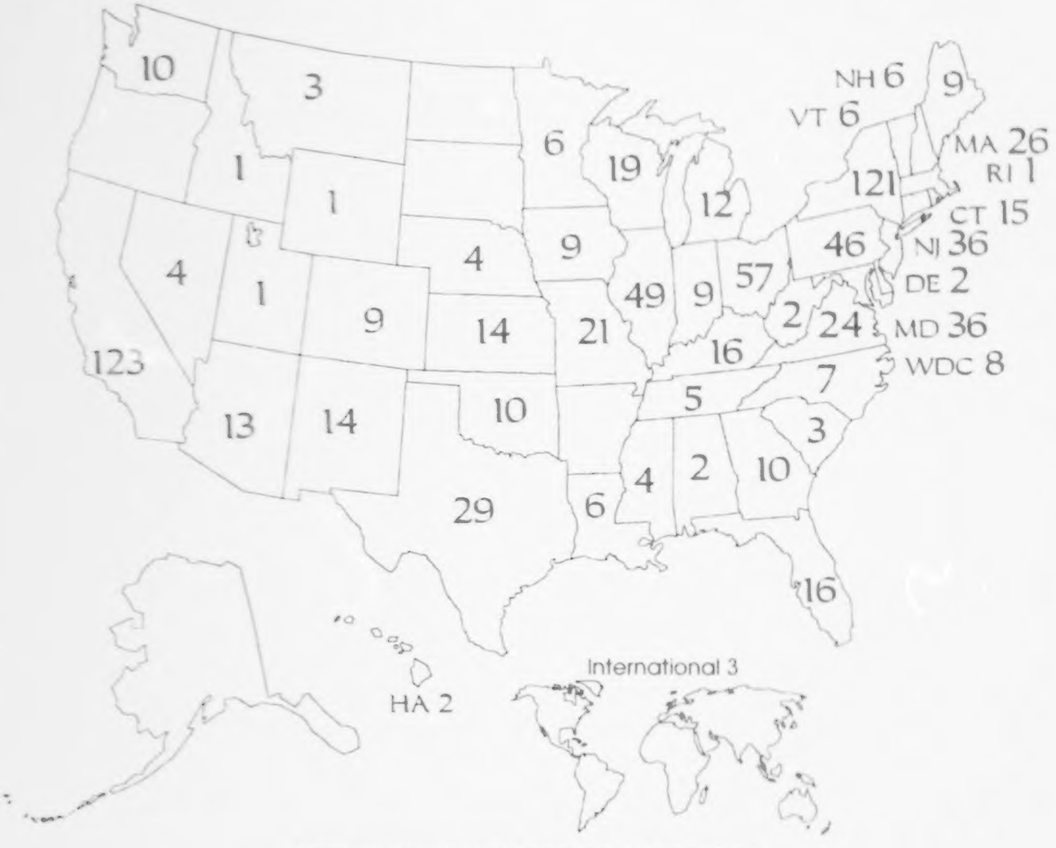

10
3
NH 6
9
VT 6
MA 26
RI 1
6
19
1
121
CT 15
1
12
46
NJ 36
9
4
57
DE 2
4
1
49
9
9
14
21
2
24
MD 36
16
WDC 8
123
7
5
10
13
14
3
2
10
4
29
6
16
International 3
HA 2

Figure 12 Number of Reported ATRs per State

Oklahomans, Minnesotans, and Californias. Those who reported getting additional training for their jobs were over three times as likely to earn more than $50,000 yearly.

Longitudinal Trends

By comparing these results to those obtained from earlier surveys (Gordon & Manning, 1991; La Brie & Rosa, 1994; Malchiodi & Waller, 1989), one can see both growth and consistency in the field of art therapy. AATA membership has grown consistently over the past 8 years. In 1989, Malchiodi and Waller noted a 9% increase in membership over the 1988 statistics. By 1991, membership had grown another 18%. By 1993 and 1995, membership grew 21% and 20%, respectively. Minority membership has grown, as well. African-American membership has increased from 0.6% in 1991 to 1.9% in 1993 to 3.1% in 1995. Hispanic membership has increased from 0.8% in 1991 to 1.4% in 1993 to 1.9% in 1995. Asian-American membership has increased only 0.2% in the past 4 years.

AATA members have remained consistent in their education level, although there has been an increase in doctoral degrees. With a slight decrease, master's degrees continue to be the most commonly reported degree: 86% in 1989, 82% in 1991, 83% in 1993, and 79% in 1995. Members with doctorates rose to 5% in 1993 and 6% in 1995.

Over the years AATA members have consistently reported adult psychiatric, adolescent psychiatric, and psychotherapy as the most common specialties and populations. In 1991, therapists began frequently reporting sexual abuse as a specialty or population. This has continued to be a common response. In 1989, many respondents indicated addictions as a specialty. However, this has not been reported as frequently since then. Child psychiatric was reported frequently as a population in 1989 but has declined in recent surveys. However, sexual abuse and abused and neglected children increased in the number of responses. For the first time in 1995, family was one of the most frequently indicated specialties.

Each of the previous surveys reported salary information in different formats, thus it is difficult to make comparisons. Nevertheless, salaries appear to have increased since 1989. In 1989, the salary mode was between $20,000 and $25,000. In 1991 the highest mean salary was $37,007 for those in private practice. In 1993 and 1995, the mode salary for those working between 31 and 40 hours per week between $26,000 and $30,000.

Future Surveys

The concerns voiced by many AATA members about the 1994–1995 survey, such as lack of clarity and limited ethnicity, have resulted in a changed format for the 1996–1997 survey. Members' suggestions were taken into consideration when the 1996–1997 survey was written. Continuing feedback from AATA members through biennial surveys is extremely important to create a better understanding of the field of art therapy.

References

American Art Therapy Association. (1995). The American Art Therapy Association. *American Art Therapy Association Newsletter, 28*(2), 36.

Gordon, R. A., & Manning, T. (1991). *1990–91 membership survey report.* Mundelein, IL: American Art Therapy Association.

La Brie, G., & Rosa, C. (1994). American Art Therapy Association, Inc. 1992–93 membership survey report. *Art Therapy: Journal of the American Art Therapy Association, 11*(3), 206–213.

Malchiodi, C., & Waller, C. (1989). *1988–89 American Art Therapy Association membership survey.* Mundelein, IL: American Art Therapy Association.

IMPORTANT .... ***IMPORTANT*** .... ***IMPORTANT*** .... ***IMPORTANT***

Please note that AATA must receive a change of address notice 6 to 8 weeks in advance to ensure all mailings, including the *Journal* and *Newsletter*, will reach you. AATA is not responsible for misrouted mail as a result of insufficient notification.

CHANGE OF ADDRESS

Name ____________________

Old Address ____________________

Old Phone Number ____________________

NEW ADDRESS ____________________

NEW PHONE NUMBER ____________________

Effective Date ____________________

Viewpoints

A Place to Stand: Maori Culture-Tradition in a Contemporary Art Studio

Michael Franklin, MA, A.T.R., LSW, Bowling Green, OH

He toi whakairo	Where there is artistic excellence
He mana tangata	There is human dignity

Introduction

During a recent sabbatical, I spent 3 months in New Zealand. (*Aotearoa* is the Maori word for New Zealand, meaning land of the long white cloud.) While there I experienced many events that had an impact on my personal viewpoint of art therapy. The majority of my time was devoted to observing facets of the indigenous Maori culture. Two major settings that allowed these interactions were institutions for higher education (the Polytechnic system) and Vincents, an open art studio in an urban downtown area. Art-as-therapy, for many reasons to be discussed later, flourished in this studio setting. The purpose of this article is to highlight the unique applications of art-as-therapy observed at each site and to show how Maori culture contributes to the unique imagery in this setting. I conclude with some remarks about our profession that were influenced by this experience.

Maori Culture and the Visual Arts

As a culture, the Maori people are deeply spiritual and connected to preserving tradition and community. They believe that everything possesses a *mauri* (life force) and *wairua* (spirit) (Doig, 1989, p. 46). Operating with a profound sense of reverence for the forces of nature, honoring ancestral heritage, and preserving their language and art are just a few of the efforts that have allowed the Maori, through years of struggle, to remain a cohesive people in an amalgamated postcolonial age. Although a wide range of cultures is represented in New Zealand (multiple Polynesian, Eastern, and Western peoples), many from the Maori community feel that multiculturalism will remain a well-intentioned myth until such time that a bicultural attitude prevails that honors and accepts the original culture of the Maori. In essence, it is difficult to accept new, multiple groups until the original group is fully embraced. They have worked hard to preserve the richness of their many traditional customs and beliefs, particularly their artistic heritage. This has not always been easy. The challenge of living in postcolonial New Zealand in the 90s often presents complicated issues.

In the past, non-Maori New Zealanders have often minimized the Maori influence on the arts and looked to Europe and other Western sources to shape their aesthetic directions. Currently the *pakeha* (non-Maori people of fair skin, usually of European, American, or British origin) are strongly considering the indigenous history of the Maori and their profound use of spiritually-invested visual imagery. However, the current age of globalization and the resulting practice of image appropriation have raised many controversial issues. Taking Maori images that have a unique and specific cultural history and using them in one's personal non-Maori art without a true understanding of their purpose is a frequent and disturbing practice. This lack of awareness blatantly demonstrates a trend of cultural insensitivity that flourishes in an atmosphere of image appropriation. The result is believed to be a form of disrespect for what many feel is a matter of intellectual property.

For the Maori, contemporary approaches to art are greeted with a wide range of challenges. Maori elders feared the disintegration of their customs and beliefs as nontraditional influential modes of expression surfaced (Mataira, 1984). Preserving and honoring ancient artistic practices while living and creating art in contemporary society fostered serious questions concerning cultural identity. Noticing these very dynamics, Mead (1984) questioned the assimilation of contemporary art forms as a possible sign of an eroding culture. He observed that:

> Maori artists trained in the schools of the pakeha are spearheading a movement to change the face of Maori art more radically than ever before. One does not know whether they innovate with love and understanding, or whether they are about to ignite new fires of destruction (p. 75).

According to Mataira (1984), contemporary Maori artists:

> did not feel that they transgressed the *mana* (prestige, status, authority, psychic force) of past treasures but looked forward to making their work equal to the revered content they were expressing. With that freedom the Maori aesthetic prevailed and traditional elements still made their presence strongly felt, although the journey was now largely a personal and intuitive one (1984, p. 9).

Maintaining and honoring ancestral connections is a major component of Maoridom. The very core of "the Maori psyche revolves around tribal roots, origins, and identity" (Doig, 1989, p. 25).

An oral tradition prevailed before the arrival of the first Europeans. This contributed, in part, to the wide range of exclusively three-dimensional art objects made during this period. The Maori are highly accomplished in carving (bone, wood, stone) and weaving (flax linen). These art forms were sacred, honored, and cherished professions (Doig, 1989). Art is very much alive since it embodies qualities such as "*ihi* (power), *wehi* (awe, fear), and *wana* (excitement, thrill)" (Ibid., p. 45). For the Maori, the significance and beauty of art are not dependent on the integration of formal properties of art, harmonious design, flawless craftsmanship, or originality. Instead, art is beautiful as a result of its *ihi* or power in the way that it can physically affect the viewer to respond spontaneously (Mead, 1984). An artwork, according to Mead, is treated like a person since it stands for ancestors who occupy a significant place in daily life. The Gods spoke through the vehicle of the artist. This person followed specific protocols and *tapu* (religious or ceremonial restriction) which showed respect for the Gods (Doig, 1989).

Highly accomplished contemporary Maori artists such as Pakariki Harrison are well aware of the constraints or *tapu* in which traditional carvers participated. For example, food and woman were not allowed around certain carvings, and the carvers were not to engage in sexual contact until the project was finished (Mataira, 1984). Since *tapu* no longer permeats all of Maori society, artists question how they can honor the practices of the past and allow art made today to reflect contemporary life issues. It is not easy to integrate ancient practices with current shifts in cultural identity. But it does seem that art, with its profound flexibility to bridge past and present, is a likely way to engage in the challenge to define life for the Maori who live in the latter 20th century.

Admittedly, it is difficult to fully grasp the essential role of the arts in the lives of the Maori. I urge the reader to recognize the severe abbreviation that is offered here and the precious heritage that so easily transcends language. This is an exceedingly brief outline of a large subject that encompasses a complicated history of a people. For an in-depth discussion on this subject, see Mead (1984).

The Marae: A Place to Stand

(Many of the ideas discussed here originate with the work of H. Tauroa and P. Tauroa, 1986.)

The marae is the *wahi rangatira mana* (place of greatest mana), *wahi rangatira wairua* (place of greatest spirituality), *wahi rangatira iwi* (place that heightens people's dignity), and *wahi rangatira tikanga Maori* (place in which Maori customs are given ultimate expression (Tauroa & Tauroa, 1986, p. 17). It is the home of ancestors, family, and the place to stand on mother earth connected to all that a culture could possibly feel. It serves as the central gathering point where tribal affairs can be discussed and experienced (Doig, 1989). For many, the marae offers the urban dweller a sacred place to return, a place of connection where past, present, and future exist simultaneously. The result is an opportunity to reclaim a sense of ancestry, soul, and spirit so easily ignored in 20th century life. These themes are important to understand since Maori culture permeates every remote region of New Zealand society, especially settings where art is created. Realizing that the marae was much more than the physical space it occupied helped me to grasp the quality of transcendence that pervades every aspect of this sacred place to fully "be." A traditional Western sense of place was an inadequate frame of reference by which to try to comprehend the marae.

Arriving at a marae, particularly for pakeha, requires that one be aware of the many protocols for conduct designed to honor the invitation to participate in deeply celebrated customs (Tauroa & Tauroa, 1986). The range of customs are too vast and numerous to describe here in detail. Therefore, a brief description will be offered along with a personal account of what I encountered on one marae.

One of the most revered structures on the marae is the *te whare tipuna* (ancestral house), also referred to as *whare whakairo* (carved house), *whare moe* (sleeping house), or *whare runanga* (council house) (Ibid., p. 90). This magnificent carved structure is truly a symbol, containing an endless range of significant themes that are sacred to a people (Figure 1).

Being welcomed onto a marae and entering the meeting house for the first time are profoundly moving experiences. The *kai karanga* (caller, always a woman) called to us as a form of spiritual welcome, connecting past to present through the first words to be spoken. As I crossed the threshold the penetrating sounds of disarming choral harmonies, for which Polynesian cultures are famous, surrounded and entered me. I felt I was stepping into a holy place, the belly of a people where the spirit of ancestry dwells. Tears came to my eyes as an unknown language and culture embraced me. Access to the spiritual followed as 40 of us pressed noses (*hongi*), sharing one breath, two feeling as one. I felt safe in this house, contained, held, feeling that I had entered a passageway into the hearts of a people that I knew very little about. Later I learned that the song was welcoming both me and my deceased ancestors, that I was to be treated as part of their community as they cried with me for my loved ones who have passed over. Much that is seen and unseen was alive through song, the word, and the great ancestral space of the meeting house.

Customs continued to unfold throughout the morning, and, in fact, for the entire week, which was the length of my stay. I was spending all of this time in the company of polytechnic/college students at their school. The marae was on the school premises, adding a unique dimension to public education. Deeply spiritual themes were embraced throughout the week. All were focused on making art about the Maori creation myth of Papatuanuku (earth mother) and Ranginui (sky father). What was so moving was that the myth was alive in this traditional educational setting. Students were immersed in their own art process to search for the *mauri* (life force) that is present in myth and kept alive

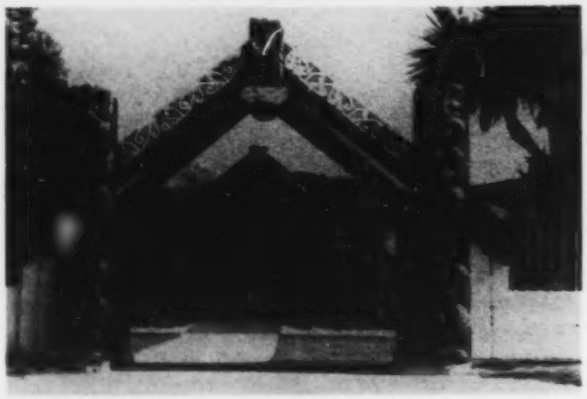


Figure 1

through art. Instructors and students alike formed a community as they entered into a dialogue with sacred themes. I observed how the marae acted as the body or vessel for the people. The art process became a way to articulate the range of student experiences and create a record of what was activated by myth. This was a stunning event to observe, revealing that spirituality and academics were not only existing side-by-side, but were integrated into an exceptional learning environment.

The marae and the art it inspired were responsible for the apparent success of this unique cultural and spiritual experience. The inner sanctuary inspired by this great cultural refuge is recognized by all as a place where centuries of ritual and custom bridge the dualities of life. Within this space the history of Maori culture is retold through the combination of oral traditions, such as storytelling, and arts, such as carving, weaving, and, more recently, two-dimensional work. Because the history of Maori culture evolved, in part, as the result of these traditions, current life on the marae easily embraces the arts as a way to keep the culture accessible and alive. In fact, culture was much more alive than I ever witnessed in a traditional educational setting. Limitations of space and time seemed to be transcended as ancestors were summoned for guidance, myth activated, and art celebrated to affirm the Maori way of being.

Art as Therapy in New Zealand

As far as my research and sources in New Zealand were able to confirm, there is no formal advanced art therapy education in this country. However, this does not mean that art therapy is not alive and developing spontaneously. One reason it has been forming relates to a cultural and social awareness of the benefits inherent in the artistic process. This awareness has been influenced, in part, by the Maori artistic tradition. Just as in the United States and Europe, the genesis of our profession is surfacing in New Zealand out of an art-as-therapy framework. Artists who know well the importance of the creative process, the capacity of paint to wrap itself around emotion, and the stimulation of a studio atmosphere have been hard at work for years in alternative settings in this country.

Arts Access Programs, a term developed by the Queen Elizabeth II Arts Council of New Zealand, have surfaced as a way to introduce people with little or no exposure to the arts. Usually designed for people with specific needs, these programs attempt to facilitate the integration of the arts into communities such as prisons or psychiatric hospitals (Cooke, 1989). Efforts to institute this policy culminated in the development of programs such as the Creative Expression Unit at Cherry Farm Psychiatric Hospital in Dunedin. Believing that art has the capacity to affect and change behavior, additional settings such as Waikeria Prison developed an 8-week inclusive arts program for inmates in 1988 (Ibid.). Selected artists took up residency at the prison and offered their expertise in areas such as music, mural painting, stone carving, psychodrama, and traditional Maori art forms. It was believed that in this setting, as well as others, the emphasis should be placed on wellness rather than illness (Hodges & Norton, 1991). Artists were selected for professional, technical, and aesthetic achievements in their respective fields. The experience enabled inmates to interact within the prison environment with renewed enthusiasm. Mural painting, for example, allowed the prisoners to re-create their predictable environment within the institutional setting (Cooke, 1989).

As far back as 1870, Edward and Ester Seager realized the value of the arts and created a program at what is now known as Sunnyside Psychiatric Hospital. Over 100 years later a multi-activity arts program was developed at the minimum security section of the hospital known as Stewart Villa (Hodges & Norton, 1991). Six artists, along with staff, participated with more than 60 residents. A study evaluating the feasibility, resident participation, and resident well-being (team building, self-esteem, and expanding worldviews) yielded strong support for developing similar programs in facilities around the country.

Vincents

While visiting New Zealand, I was based in Wellington, the capital of the country. This manageable harbor city is surrounded by a hillside. Situated downtown is a wooden, one-story building. Fixed along its exterior is a series of charming plywood paintings, worn like badges of accomplishment. Housed in this structure is a community-based art studio called Vincents. Its green painted frame strongly contrasts with the surrounding vertical office buildings. I could not help but see Vincents as an oasis in the middle of the usual austere urban landscape (Figure 2). The mission statement of Vincents, much like the building's function and physical presence, supports a humanizing environment for "psychiatric survivors":

> Vincents is an arts and crafts workshop committed to building a non-threatening, sharing, and supportive environment in the interest of a healthy community. Vincents responds to the needs of participants, in particular, those who are psychiatric survivors.

Initiated in 1985, founding principles focused on maintaining a "culturally safe" setting strongly grounded in the spirit of the Treaty of Waitangi, the "sacred covenant and social contract" of 1840, established between England and the numerous tribes of New Zealand (Doig, 1989, p. 60). Although this treaty was intended to guarantee Maori people equal rights as British citizens, it was usually ignored by the Crown's legal system. Today, however, the treaty is recognized as the "Magna Carta" of the constitutional rights of the Maori people (Ibid., p. 62). Vincents, like many other agencies, strives to uphold these principles by creating a place of mana for Maori and pakeha alike. Elements of

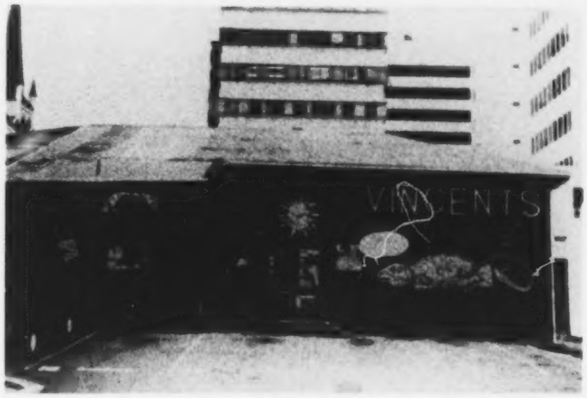


Figure 2

the marae, such as providing a place to stand, and art forms, such as bone carving, are celebrated and encouraged to thrive in this setting. In addition to being culturally sensitive, this open art studio serves those who are usually denied access to the arts due to circumstance or disability. After leaving institutionalized settings, people need community support to make a smooth transition to a previous life style. Vincents tries to welcome everyone, particularly low-income people who are unable to afford similar services elsewhere.

As an art therapist, I was deeply affected by this setting. It was alive, filled with art and creative energy. This thriving studio atmosphere, fully stocked with ceramics equipment and a woodshop, printmaking equipment, painting and drawing facilities, invited endless exploration and dialogue (Figures 3 and 4). It worked because people needed a place to go. It also worked because artmaking, rather than treatment, was pursued. The staff was determined to allow people to focus on their creative interests despite their diagnostic labels.

Professional art tutors were always available to offer personal, cultural, and creative support. When they were not lending technical or emotional guidance, these tutors were encouraged to pursue their own artwork. People attending Vincents rarely appeared intimidated by the artmaking of their tutors. Instead, they seemed to be inspired by watching them manifest the possibilities inherent in a wide range of materials. This studio atmosphere put vision into action. I consider it similar to Edith Kramer's work (1958, 1971) and recent writings in art therapy, such as Pat Allen's advocacy for artist-in-residence programs (Allen, 1992). For example, Kramer's goal of helping young artists create work that "contains and expresses emotionally loaded material" free of direct interpretation from the art therapist closely resembles the intent of the studio atmosphere at Vincents (Kramer, 1971, p. 34). According to Kramer, the working atmosphere should convey that the art therapist "wants neither to impose his ideas nor to elicit any specific information, but that the therapist is there to help him in any way he can to achieve what he wants to do" (Ibid., p. 44).

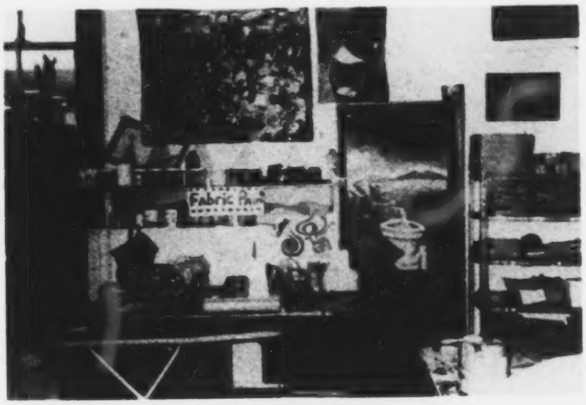


Figure 3

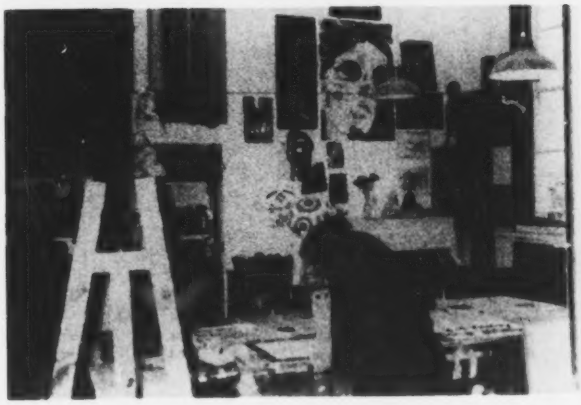


Figure 4

The "clinification syndrome" that Allen describes as using art primarily as a source for diagnosis, discussion, and interpretation was ardently avoided by the tutors at Vincents. However, in several discussions with the director, I affirmed the need for informed knowledge beyond an intuitive understanding of the people who came to Vincents. Many participants struggled with personal issues; they had few places to go and make sense of these challenges. Vincents was their niche or refuge where the personal could merge with the visual. The ideal tutor in this setting would be a psychologically/culturally aware, informed artist with an educated understanding of human behavior, particularly the dynamics of establishing a working alliance, and, most importantly, a deep connection to the visual arts. Such a person would be able to protect the sanctuary of art and understand the care necessary to form a relationship with a person who has a turbulent past. Training would include developing art-based skills (Kramer, 1986), developing one's artist self, and acquiring a wide range of interpersonal skills. Knowledge of psychotherapy would be necessary, although secondary to the goal of helping others receive the benefits of prolonged encounters with creating art.

Being an artist is not always enough. However, approaching artwork with the impulse to *clinify* it may defeat the benefits of the art process. Between these approaches exists a hybrid in which art and therapy support, rather than compromise, each other. This fusion of qualities was typical of many of the tutors at Vincents. "Witnessing this studio in action brought a feeling of mourning within me. I felt as if I was observing the origins of art therapy as it began several decades ago in the United States unfold before me. There was a sense of loss as I wondered what had happened to our art-focused beginnings." Something about Vincents was familiar to me, yet out of reach. Here was a setting where art was therapeutic but for nonclinical reasons. The benefits gained by those attending rested in the flexibility of the art materials, the sanctuary of the art process, celebration of Maori culture, and the opportunity for safe relationships within a working atmosphere. Paradoxically, the tutors were as curious about the way art therapy is practiced overseas as I was about their nonclinical community-based approach. After several hours of discussion we recognized that each had something to offer the other, particularly about ways to integrate art into the lives of people. We recognized that all was not so perfect at Vincents. There were some inherent though understandable problems. Clearly, an art background alone did not offer a sufficient foundation to interact successfully with particular people who attended the studio.

Reflections

Any future development of art therapy in New Zealand will be influenced, in part, by the Maori culture. A bicultural blueprint for living with myth and image is carefully modeled and pursued within contemporary Maori society. Art therapy, in many ways, strives to reintroduce the integrity of these absent connections within the inner world.

My visit to New Zealand allowed me to reconnect with long-held convictions concerning cultural empathy and the richness of an art-as-therapy approach. The studio atmosphere is alive with the benefits reaped from engaging in the creative process. My comments are not calculated to minimize the efforts of those in our field who are doing significant clinical/psychotherapy work and research. As a growing field, it is inevitable that we operate from a variety of ideological viewpoints. However, our challenge has been and is to remain as flexible as the art materials we offer. As art is drained from the graduate curriculum and we expect students to arrive with this training, an imbalance results. We deny ourselves the essence of what we claim to offer for the well-being of others!

I cannot help but wonder about a group of people who often identify themselves as artists and yet feel malnourished in this area. Vincents offers a view of art therapy beginnings and longings. The success of this endeavor highlights what I feel are our mistakes as we move further away from teaching about and working within the art-as-therapy and studio model. The beauty of our work is in the process and materials we offer. The more we provide by way of artmaking, the more we honor our own creative heritage and serve those we encounter.

Author's Note: I wish to thank Rick Lucas, Ross Hemera, Allen Wihongi, Lloyd Harwood, and Ray Thorburn for their generous support during this project.

References

Allen, P. B. (1992). Artist is residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association*, 9(1), 22–29.

Cooke, P. (1989). *Ten artists go to jail: An evaluation of an arts project at Waikeria prison*. Wellington, New Zealand: Queen Elizabeth II Arts Council of New Zealand.

Doig, F. (Ed.). (1989). *Tanoga Maori: A spiritual journey expressed through Maori art*. Sidney, Australia: The Australian Museum.

Hodges, I., & Norton, V. (1991). *Artists at Stewart Villa: The evaluation report*. New Zealand: Department of Health Te Tari Ora Health Research Services.

Kramer, E. (1986). The art therapist's third hand: Reflections on art, art therapy, and society at large. *American Journal of Art Therapy, 24*, 71–86.

Kramer, E. (1971). *Art as therapy with children*. New York: Schocken Books.

Kramer, E. (1958). *Art therapy in a children's community*. New York: Schocken Books.

Mataira, M. (1984). *Maori artists of the South Pacific*. Raglan, New Zealand: New Zealand Artists & Writers Society.

Mead, S. M. (Ed.). (1984). *Te Maori: Maori art from New Zealand*. New York: Harry N. Abrams.

Tauroa, H., & Tauroa, P. (1986). *Te Marae: A guide to customs and protocol*. New Zealand: Reed Books.

AATA and Maginnis & Associates

...your source for Professional Liability Insurance.

Shopping for insurance coverage can be confusing and tedious, especially if you're self-employed. As an AATA member, you are eligible for AATA-endorsed professional liability insurance coverage through Maginnis & Associates. Whether you are **Employed or Self-Employed**—Maginnis offers you affordable, mobile Occurrence Form coverage. For more information, simply complete and mail the form below or call us toll-free at

1-800-621-3008, ext. 105 *or ext. 108 if you're self-employed.*

✂ Detach here

☑**YES!** *Please send me more information about the AATA-endorsed professional liability insurance program. I understand no salesperson will call, and I am under no obligation.*

Name

Address

City State Zip

Please detach and mail to:

Maginnis & Associates
A Division of KVI,
ATTN: LEAD DESK
332 S. Michigan Avenue
Chicago, IL 60604

S.C ___A___

Pioneering in Perth: Art Therapy in Western Australia

Michael Campanelli, EdD, A.T.R., LSW, Perth, Australia

Introduction

Although Western Australia covers a third of the Australian continent and almost a million square miles in land mass, more than half of its inhabitants live in its capital city, Perth (Williams, 1995). Considered the "City of Lights" ever since American astronauts captured its bright sparkle in their photographs from space, Perth is now one of the fastest growing cities in Australia (Kelly, 1995). It is also perhaps one of the most beautiful cities in the world and undoubtedly one of the most isolated. Perth is as far from Sydney as Los Angeles is from Chicago, and the distance between the two cities is covered by vast stretches of uninhabitable desert and scrub land (Mikes, 1968). The city itself, however, is lush, situated on the coast of the Indian Ocean and sprawling around the banks of the Swan River. There are scores of picturesque parks carpeted with unique wild flowers which attract thousands of visitors each year.

It was to this city that I went when I left the United States 3 years ago to teach in the first art therapy training course in Australia at the Academy of Performing Arts at Edith Cowan University. Because art therapy is new to Australia, I was invited to come to Edith Cowan to help develop the art therapy program's curriculum and serve as its clinical director.

The Art Therapy Training Program

The program is based on course recommendations of both the American and British Art Therapy Associations. The content of the lectures, seminars, and workshops resembles training programs overseas in that it combines experiential and didactic coursework. The theoretical orientation of the program is based on an integrated model of psychotherapy which seeks to understand how the major theoretical perspectives (i.e., psychodynamic, developmental, humanistic, and cognitive/behavioral) fit together as a whole. Rather than simply being eclectic or subordinating one theoretical approach to another, the program draws from the collective wisdom of multiple perspectives while searching for complementarity and convergence among them. Value is also placed on multicultural awareness—an understanding of how sociocultural factors influence and regulate the expression of human behavior. Viewing psychological problems within their sociocultural context only serves to enhance the integrity and effectiveness of our art therapy interventions, especially in a city like Perth where there is great diversity of race, ethnicity, and culture.

In addition to equipping students with a working understanding of major theoretical concepts and an awareness of the basic constructs of a multicultural orientation, they are encouraged to generate new ideas by combining and transforming concepts in innovative ways. Encouraging a creative approach to theory is one element of the program's general promotion of a creative attitude in all aspects of professional training. The philosophy of the program is reinforced by its placement within the Academy of Performing Arts. Affiliation with the Academy is a source of great inspiration and an acknowledgment of the importance of creative expression for all people, enhancing quality of life for the general public and restoring the quality of life for clinical populations.

Psychosocial Functions of Aboriginal Art and Healing

Since my arrival in Perth, I have been studying the psychosocial functions of Aboriginal art and its healing potential in Aboriginal communities. The majority of Aboriginal communities suffer from a wide range of physical and psychological problems, and their health concerns are best understood in the context of their history of cultural oppression (Hunter, 1993). Terrible devastation resulted from the colonialization efforts of the dominant white culture which, in the early history of Australia's settlement, included deliberate genocide and brutal assimilation. These cruel policies robbed Aboriginal people of their cultural identity, religion, language, family life, and land (Ward, 1982). Although social changes in recent years have advanced Aboriginal people in social and political spheres, their communities still face the serious obstacles of widespread poverty, racism, unemployment, lack of education, and increased mortality (Reser, 1991). Inextricably linked to the disintegration of their cultural identity are the widespread problems of depression, delinquency, domestic violence, and substance abuse (Reid & Trompf, 1991). These problems have left many Aboriginal people in a desperate state with a devalued sense of their own cultural identity and potential.

Conventional mental health care services have generally proven ineffective in helping Aboriginal people cope with their troubles because they are often established on worldview principles that conflict with Aboriginal culture (Eckermann, 1992). These services often do not take into account cultural differences in value orientation and communication. Many values implicit in mainstream therapy, such as individualism, independence, assertiveness, and direct expression of feelings, conflict with the Aboriginal emphasis on collectivity, interdependence, control of feelings, and cooperation, where the highest good is perceived as contributing to the fulfillment of community needs. Aboriginal people are understandably suspicious of public health services because they are highly institutionalized and viewed as part of the white bureaucratic system which was a source of oppression in the past (Anderson, 1988). Another obstacle to the successful delivery of health services is that they are often administered in isolation, separate from an Aboriginal person's community, and do not make use of the person's cultural affiliation and support system. The fact that there are only a very small number of Aboriginal people trained to staff the various public health agencies and institutions within their communities compounds the challenge of successfully delivering public health treatment with sensitivity to cultural differences (Thompson & Payne, 1992). Although there is a recent trend toward recruiting Aboriginal staff and increasing sensitivity of non-Aboriginal health workers, there is still a paucity of effective and relevant public health services available to Aboriginal people.

In their struggle for survival, more and more Aboriginal people are now speaking out against the inadequacy of conventional mental health services in their communities (Pougher, 1995). They complain about European-style approaches to mental health treatment which emphasize medication. Plus, they consider Eurocentric perspectives on their problems to be another form of oppression. They are calling for an indigenous interpretation of therapy which is holistic and community-based, offered in partnership with Aboriginal people. Rather than restricting therapy to typical clinical settings, Aboriginal communities are requesting outreach efforts where therapeutic services can be offered at the grass roots level, as close as possible to where Aboriginal people live. There is also a request for therapeutic services to include a willingness to acknowledge the reality of social oppression and an effort to empower Aborginal people through fostering cultural awareness and self-esteem. From the Aboriginal point of view, effective therapeutic health care must respect Aboriginal values and strengthen a sense of community and cultural identity to restore Aboriginal dignity.

There is perhaps no better way to meet these aims than by incorporating the arts into the recovery process for Aboriginal people and their communities. Art possesses a power which has proven to be very effective in creating social cohesion and self-respect among Aboriginal people (Caruana, 1993). Being creative has always been an integral part of traditional Aboriginal life, and the arts have played a crucial role in the process of healing (Crumlin & Knight, 1991). Although traditional engagement with art was disrupted through colonization and assimilation in all but the most remote areas of Australia, Aboriginal art continued in less traditional forms, helping many Aboriginal people endure social oppression and reach beyond it by preserving and affirming their creative vitality.

Art holds great promise for opening doors of reconciliation and understanding between Aboriginal and non-Aboriginal people. Although Aboriginal relations with the dominant white culture are strained in practically all areas of contemporary Australian life, the most hopeful signs of mutual respect and equality can be found in the area of art (Sutton, Jones, & Hemming, 1988).

In recent years a greater public recognition of the artistic creativity of Aboriginal people and many Aboriginal artists is evident through exhibits of their work in art galleries of major cities both within and outside of Australia. Aboriginal art is increasingly perceived as an important part of contemporary art practice and considered by some to be Australia's most unique and inspiring art form (Sutton, 1988). The growing awareness and interest in Aboriginal art has strengthened the Aboriginal struggle for survival, especially since many artists receiving public recognition are in the forefront of the national Aboriginal movement for civil rights and cultural renewal.

Given that Aboriginal art has shown great potential for promoting cultural identity and serving as a cross-cultural bridge for reconciliation, it is unfortunate that artmaking has not been integrated into most mainstream mental health strategies for working with indigenous people. It is also unfortunate that there has not been more public support for access to art resources and facilities in Aboriginal communities. However, a small but growing number of unique arts programs are helping to preserve Aboriginal culture and to facilitate the social rehabilitation of Aboriginal people. These programs are set up by Aboriginal and non-Aborginal artists in collaboration with indigenous communities to reintegrate art into Aboriginal life. In addition to providing an opportunity for creative expression and cultural renewal, these programs are proving to be an important and natural part of the individual and community healing process, helping Aboriginal people find the meaning they need to recover a sense of hope and wholeness.

The reincorporation of the arts into the lives of Aboriginal people is supporting therapeutic and social changes for many who have not been reached by conventional mental health services (Sokil, 1993). This confirms the idea that tending the psychological well-being of Aboriginal people can be very effective if offered as part of a holistic approach intricately linked to creative expression. The artists working in these programs use a model of arts facilitation that respects the Aboriginal worldview and responds to the call for social change. These artists are helping to break down barriers between Aboriginal and non-Aboriginal people and improving race relations as trust and reconciliation grow out of sharing the art experience.

Nalda Searles

One artist who is playing an important part in reintegrating art into Aboriginal communities in Western Australia is Nalda Searles, a non-Aboriginal artist and former psychiatric nurse who, in 1992, was invited by an Aboriginal corporation, Warta Kutju, to implement an art-based project for the Wonguntha people who live on the fringes of the remote mining town of Kalgoorlie (Searles, 1994). Most live in conditions of extreme poverty, unemployment, and poor health. A significant number of them are also alcohol and drug dependent, yet are not being cared for or are only marginally cared for by public health agencies. The attitude of local non-Aboriginal people contributes to the distress and alienation of these fringe dwellers since they are considered to be lazy, careless, and irresponsible. Under the influence of oppressive attitudes that question their value and human dignity, many have held a fatalistic view of life that produces a loss of self-respect and a lack of belief in themselves.

It was in this fringe-dweller community that Nalda lived and worked for a 17-month period, funded by a grant to develop an art program that fit the everyday lifestyle of these people, to relieve and soothe their spirits by facilitating pleasurable involvement with art. Her hope was to spark a creative interest and interchange that could promote a positive sense of self-worth and community esteem. Meeting these people on their own terms meant that Nalda needed to be mobile (i.e., working from a vehicle) and available to work in the natural gathering places of Aboriginal people (e.g., street corners and parks). Offering a variety of art materials, Nalda encouraged many fringe dwellers to engage in artmaking, taking her cues from them as she encouraged development of artistic interest.

As they got to know Nalda, their involvement increased over time until some would paint for hours. Although she offered support and responded to occasional requests for advice about choice of themes and use of materials, Nalda's approach was largely nondirective, encouraging each individual to create whatever he/she wished. The most common subject matter to emerge was landscape painting, which is not surprising since a connection to the landscape is so important in Aboriginal culture. They also created designs based on traditional Aboriginal motifs and narrative scenes based on life events or Aboriginal myths and stories. Their artistic ability was remarkable and their motivation was impressive. As Nalda noted, "They rarely said, 'I can't paint'; they just got on with it, learning through the exploration of the media and from each other." Sometimes more than one person worked on the same art piece, adding new features and parts of a story. Similar to the process of creating traditional Aboriginal art, this collaborative way of working promoted social cohesion and a sense of belonging.

The program was successful in achieving its goal of providing a respite from the depression and suffering in these people's lives. The fringe dwellers expressed great appreciation for the program and a desire to have it continue in the future. Their arts involvement became a source of enormous satisfaction that provided a vital focus for many who before the program had wandered aimlessly with little or nothing meaningful to do. It reinforced a sense of community by unearthing images related to aspects of traditional Aboriginal heritage. The program also led to feelings of pride and accomplishment, especially for those whose artwork was admired by others.

One person whose work was especially admired is an Aboriginal elder, Mary McLean, who, with Nalda's encouragement, developed a unique style of painting. Her dynamic and boldly colored art features scenes of Aboriginal bush life with themes of gathering, preparing, and eating food. Mary's participation in the art program led to her first exhibition in Perth and, more recently, to national and international recognition of her work. Her involvement with the program has transformed Mary's life, and she is now a role model of an artist and a bridge-builder for others in her community.

Although not an art therapist, Nalda's approach was similar to an art therapist's approach because she used art to facilitate contact and communication with people who were psychologically distressed and in extreme need. The art became the means by which she established trust and rapport, providing empathic listening, encouragement, and validation of life struggles. Nalda's former training as a psychiatric nurse served her well in fostering dialogue and a shift in attitude which assisted many of the fringe dwellers to clarify their problems and opportunities for change. It was evident that they had a great need to talk about their difficulties which were naturally communicated as part of their arts involvement.

Midland Park Project

Art therapists have much to learn from this community arts approach which has shown great potential as an avenue for healing Aboriginal communities. The program also offers a hopeful alternative model of therapy in which individual healing is not separated from community life. Inspired by Nalda's work, our art therapy department has become involved in a similar community-based art project modeled on the Kalgoorlie program and developed by artist Philippa O'Brien.

I was invited to meet with Nalda, Philippa, and Aboriginal artist Bob Cameron to collaborate on the planning of a suburban art project for Aboriginal people who congregate in the working-class park of Midland. This town is the center of the largest Aboriginal population in the metropolitan area, a junction point for those who have migrated there from all over the state of Western Australia. Its park is a natural gathering place for many Aboriginal people who, like the Kalgoorlie fringe dwellers, are in a state of extreme need.

The park project will become the focus of one of our art therapy internships and will entail providing the Aboriginal people with a variety of art materials as well as some food, since many are often hungry and undernourished. As was the case in Kalgoorlie, they will be invited and gently encouraged to draw and paint. As a relationship develops, we hope to establish art

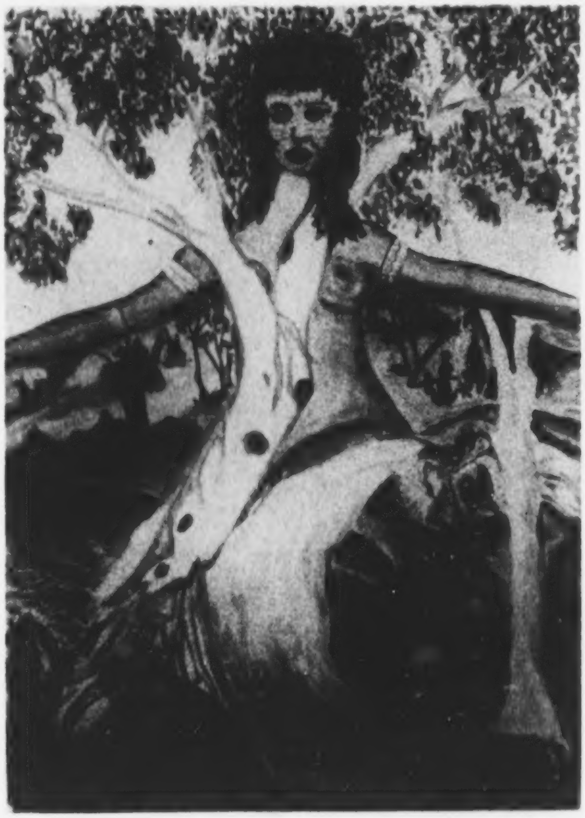


Figure 1 The Aboriginals believe that everything in nature is alive and needs to be cared for and nurtured.

therapy sessions that will expand the art process to address both individual and group problems on a deeper level.

Philippa has already made contact with a few of the people in the park and the responses to the project have been very encouraging. Val Takeo, for example, is an Aboriginal woman whose artwork is quite impressive, considering that she has never painted before. Having lived through the early days of enforced conformity to white ways (perhaps the most dangerous threat to the underpinnings of Aboriginal culture and its continuance), Val realizes the crucial need to preserve aspects of her culture. She uses her art as a form of visual narrative depicting childhood memories, ceremonial activities, and traditional Aboriginal stories. For example, one of her paintings features an image of an Aboriginal creator spirit whose head is painted as part of the earth, indicating his continual presence in the landscape (Figure 1). Above him rises a female earth spirit who is a reminder that everything in nature is alive and needs to be cared for and nurtured by Aboriginal people. In another painting Val depicts an image from an Aboriginal story about Willy Willy, a spirit of a dust storm which travels its angry path carrying the spirits of the dead along with it (Figure 2). Val's art is helping to reclaim her personal past and to revive the collective heritage of her people by visually recording the folklore and life stories that have survived the dark and violent history of Aboriginal oppression. As the park project develops, we hope that Val will continue to recover unknown or forgotten aspects of her culture and through her example inspire others to share experiences that can strengthen Aboriginal identity.

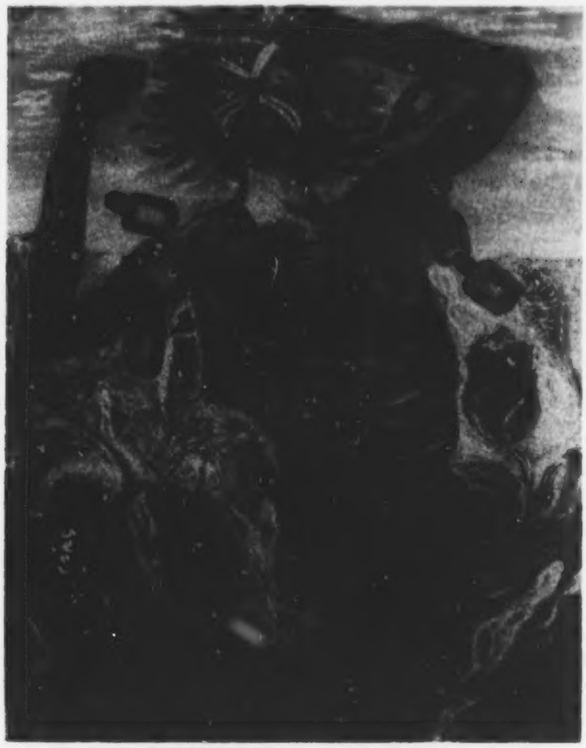


Figure 2 Painting based on an Aboriginal story about the spirit of a dust storm that carries the spirits of the dead.

The Psychosocial Function of Art

My research on the psychosocial function of art and its healing potential in Aboriginal communities has confirmed, over and over again, how interlinked arts involvement is to Aboriginal health and cultural survival. It appears that artistic expression promotes healing through touching an integrative life principle in Aboriginal communities where creative involvement becomes the very source of cultural restoration.

The fact that art is so valuable in helping to restore Aboriginal self-esteem and community identity suggests that art therapy holds tremendous promise as a therapeutic method when working with Aboriginal people. Our proficiency in visual communication and expertise in therapeutic process can foster a new level of reflection and understanding for those Aborginal people with whom we work. To be truly effective in our cross-cultural work with Aboriginal people, however, we must use a broader and more embracing therapeutic approach that affects not only the individual but also the social body of the Aboriginal community as a whole. We must expand the parameters of art therapy practice to support the indigenous values of sharing and affiliation, nourishing the need for connectedness and community bonding. Our Western emphasis on individual and personal achievement must be viewed as culturally relative, and we must not slip into ethnocentric ways of working that diminish the profound importance of interdependency in the social sphere of Aboriginal culture.

Challenging our value assumptions has the additional benefit of encouraging us to consider problems in our own culture from a different vantage point and realize solutions that may be suggested by the Aboriginal way of life. The rootlessness and alienation so characteristic of the Western world are costs that many pay for self-achievement and for conditions that reward competition and independence. In pursuit of that which Western culture has established as the norm, values of generosity and cooperation may be depreciated, leaving us with a restricted sense of our social interdependence. Aboriginal people, with their acute awareness of the interconnectedness of individual human circumstances, remind us that well-being not only means having a healthy mind but a healthy community spirit as well. To cure the ills of our own society may mean finding ways to nurture greater social connectedness and more effective interaction between tending the needs of both the individual and community.

Cross-cultural programs with Aboriginal people also suggest the need for art therapy approaches that are not restricted by conventional therapeutic frameworks and clinical settings. The needs of indigenous people often elude the social welfare system. It is not enough that our work be carried out within the walls of public health agencies. We must form a healing partnership with Aboriginal people through developing art therapy strategies in collaboration with them, reaching out to their communities and making ourselves available to enter their worlds and work among them. This is part of the necessary bridge-building that must exist between indigenous and nonindigenous people if true healing is to occur.

It is my hope that as the Perth art therapy program grows it will attract Aboriginal students who will go on to take a leadership role in developing art therapy in Aboriginal communities. Helping indigenous people help themselves will make art therapy a more efficacious method of treatment; but, until there are

Aboriginal art therapists to care for their own people, we are left with the challenge of the cross-cultural therapy situation.

Providing effective cross-cultural art therapy treatment for Aboriginal people means adopting therapeutic interventions in a holistic manner that is culturally relevant and supports the deepest needs of Aboriginal people: creativity, community, and empowerment.

I am sure that our work with Aboriginal people will have implications for how art therapy will evolve in Western Australia and will challenge us to further develop culturally sensitive interventions that reflect an appreciation for the uniqueness of the Aboriginal culture and the common humanity we all share.

References

Anderson, J. (1988). *Koorie health in Koorie hands*. Melbourne, Victoria: Victorian Department of Health.

Caruana, W. (1993). *Aboriginal art*. London, UK: Thames and Hudson.

Eckermann, A. (1992). *Binan Goonj: Bridging cultures in Aboriginal health*. Armidale, NSW, Australia: Department of Aboriginal and Multi-Cultural Studies.

Hunter E. (1993). *Aboriginal health and history*. New York: Cambridge University Press.

Kelly, P. C. (1995). *The West Australian year book*. Perth, Australia: Australian Bureau of Statistics.

Mikes, G. (1968). *Boomerang: Australia rediscovered*. London, UK: Andre Deutsch.

Pougher, J. (1995). Report presented at the Psychology and Aboriginal Issues Interest Group. Curtin University, Perth, Western Australia.

Reid, J., & Trompf, P. (1991). *The health of Aboriginal Australia*. Sidney, Australia: Harcourt Brace Jovanovich.

Reser, J. (1991). Aboriginal mental health: Conflicting cultural perspectives. In J. Reid and P. Trompf (Eds.), *The Health of Aboriginal Australia*. Sydney, Australia: Harcourt Brace Jovanovich.

Searles, N. (1994). *The Warta Kutju arts project*. Unpublished report. Kalamunda, Western Australia.

Sokil, J. (1993). *Watering the rock hole*. [Video]. Kalgoorlie, Western Australia: Warta Kutju.

Sutton, P. (Ed.). (1988). *Dreamings: The Art of Aboriginal Australia*. London, UK: Viking.

Sutton, P., Jones, P., & Hemming, S. (1988). Survival, regeneration and impact. In P. Sutton (Ed.), *Dreamings: The Art of Aboriginal Australia* (pp. 180–212). London, UK: Viking.

Thompson, J., & Payne, A. (1992). *Working with and for Aboriginal communities*. East Perth, Australia: The Health Department of Western Australia.

Ward, R. (1982). *Australia since the coming of man*. Sydney, Australia: Lansdown.

Williams, J. (1995). *Western Australia: A lonely planet Australia guide*. Victoria, Australia: Lonely Planet Publications.

COLLEGE OF NOTRE DAME

OFFERS:

- Master of Arts in Art Therapy (37 units)
- Master of Arts in Marital & Family Therapy (50 units)
- Post-Graduate Art Therapy Certificate Program (21 units)

- Systems & Jungian oriented art therapy
- AATA-approved Master's Programs
- MA in Marital & Family Therapy meets California state requirements for MFCC licensure
- Afternoons, evenings & weekends
- Summer Program

Art Therapy Program
COLLEGE OF NOTRE DAME
1500 Ralston Avenue
Belmont, CA 94002-1997

For program specifics call
(415) 508-3556

For an application call
(415) 508-3523

LOCATED IN THE BEAUTIFUL SAN FRANCISCO BAY AREA

Earthquake!

Susie Andruk, MA, A.T.R., La Canada, CA

January 17, 1994

At 4:31 on the morning of January 17, in a matter of only 40 seconds, the lives of Southern Californians were changed unexpectedly and abruptly. A 6.8 earthquake rocked the San Fernando Valley. Its effects were felt as far south as San Diego, north to Santa Barbara, and east to Las Vegas, Nevada.

It was an immensely unsettling feeling. My family and I, who live 30 miles from the epicenter, were rattled and rocked in our home. Many things flew through the air, but we did not lose power, and we were able to quickly recover from the initial shock of the quake. However, many others were not so fortunate.

January 18, 1994

I practice art therapy in Northridge, California, the epicenter of the earthquake. I attempted to go to work the day following the earthquake, hoping to find out what had occurred at the hospital. I did not know what to expect, how bad the damage would be, or even if I could get to the hospital by car. I took my usual route but was unable to use the Simi Freeways because of closings due to damage.

I drove the surface streets, attempting to follow the detour, and slowly made my way from the San Gabriel Valley to San Fernando Valley. The drive that usually takes 35 minutes turned out to take well over an hour, as I slowly proceeded from intersection to intersection through detours and signals that were not functioning, allowing only one car at a time to go through an intersection. There were no police to assist in directing traffic. All along the way, streets were buckled, and water gushed out of fire hydrants, down gutters, and into the streets from broken water pipes.

The number of fallen walls increased as I neared the hospital. Concrete block walls in particular appeared to be vulnerable. Piles of bricks and cinderblock were everywhere. The dust filled the air with a strange stickiness; thick and heavy, it created an unusual color in the sky. Stillness and a sense of chaos surrounded me all the way. People wrapped in blankets were in the streets, camping out in make-shift tents. Children in pajamas sat on curbs. Signs hung from trees emploring, "We need food and water." The incredible amount of neediness was extremely overwhelming.

I drove down Roscoe Boulevard through a profusion of traffic. When I caught sight of the hospital, several blocks away, I knew that at least from a distance it was still standing. I hesitated to park on the street because all the curbs and sidewalks were separated and, here too, water was gushing. It seemed that no safe place was available, as I tried to park in a place free of power lines and other dangers such as large trees or block walls that might tumble during the aftershocks.

Crossing the street to the hospital, I found a situation I had never seen. The hospital did not have power or running water, and most of the doors were blocked. Security guards were posted everywhere, directing and cautioning people. The hospital's central driveway had buckled 8 to 10 inches; red tapes marked where people were not allowed to enter. Yellow tapes directed people through areas where they could walk with caution.

Everyone reporting to the hospital was asked to sign in so there would be a record of who was inside in the event that an aftershock caused damage. Before entering the hospital, I looked up at the parking structure, a building reserved for doctors, patients, and high level employees, and saw a vertical crack that went to the top of the five or six story structure.

A row of port-a-potties was outside the hospital in an attempt to maintain sanitation. Signs on all drinking fountains and other areas where once water could be obtained cautioned in English and Spanish not to drink the unsafe water.

Inside the hospital, behind the main entryway, the earthquake had created an 8-inch separation between the floors where two buildings had previously been joined. Plywood was placed over the floor and taped down. The seismic safety inspectors decided that this part of the building, despite this 8-inch separation, was indeed "safe." In the "safe" part of the hospital, light fixtures with squiggling wires dangled from ceilings. Broken glass was strewn beneath each fixture that had burst. People were cleaning up the glass. The hospital CEO had joined them. In blue jeans and holding a dustpan, he swept up while thanking employees for making the effort to come to work.

Great walls were cracked and one hospital building was totally inaccessible. Some lights were powered by the hospital generator, but there was no telephone service, giving a real sense of isolation from the outside world.

Gradually, through seemingly endless hallways on designated walkways, I made my way to the building where I worked. The front door had not been deemed usable for pedestrian traffic. Along the stairwells and walks, chunks of concrete were down, leaving bricks, steel reinforcements, and girders exposed. Was it safe to be walking here? A strange, eerie emptiness and quiet filled the hospital, in contrast to both the usual day-to-day hubbub and the horrendous noise that accompanied all this crunching of concrete. Walkways that had been flat were now twisted and askew, visibly off-center, and no longer at right angles. Pieces of thick, vinyl wallpaper once used to hide the imperfections of commercial construction were buckled and bubbled.

Stairwells were the most frightening because of their hollowness and sense of being impenetrable. Water damage from broken pipes was marked with caution signs.

When I finally reached my office, I found two of my co-workers. It was very comforting to see familiar faces. Our office was in a shambles. Enough light from the windows and a generator light in the hall allowed us to see overturned bookshelves and files, broken glass from lamps, vases, picture frames, and mugs. Nearly everything was on the floor. My office was not in particularly bad shape, but directly across the hall the social worker's office had been flooded and smelled of the dank stench of soaking paper. All her patient files were damaged.

Our first job of the day was to clean up the offices. We three who had arrived first were from the most distant locations. Although we had difficulty driving in, we had suffered the least personal damage to our homes. We could account for only about one-half of our co-workers. No one had heard from either department head. Few people came in that day, but, by day's end, we were able to account for all but three department members.

We shared experiences about how we had each fared, our personal experiences with our families, our lack of preparedness, and our inability to give comfort. Children and their fears of returning to school were big issues. Later, we learned that at least three employees had such severe damage that they could not occupy their homes.

After we superficially cleaned the offices, putting things back on shelves, realigning desks, cleaning up glass, and leaving doors open to air the foul-smelling water-damaged areas, we went elsewhere in the hospital to see what was needed. Since there were no phones, we were unable to contact patients and other staff members. We spent some time tending to the child care unit that had been set up within our department in the occupational therapy area, since the usual child care unit had been damaged too severely to be used and children had been moved down to the first floor. Many children were there. They needed attention and a lot of comforting, particularly during the ongoing aftershocks that were very disruptive. Every time the children were calmed, another aftershock occurred, one time causing an enclosed glass display cabinet to drop many glass shelves and ceramic pieces. The noise was horrible, and there weren't enough adults to comfort all the children. The adults were anxious, too, and several put name tags on the childrens' wrists, for identification, further agitating them.

There was no elevator service. Meals on all five floors needed to be delivered, each carried by hand to very unsettled patients who felt vulnerable because they could not leave the hospital.

January 19, 1994

Two days after the earthquake, telephone service was restored. A crisis intervention team was brought in to debrief mental health workers and help us present crisis intervention to patients, employees, and others who walked in off the streets. When electricity was restored, handouts were prepared and copied.

The crisis intervention team overwhelmed us with information. In 1 hour they tried to soothe our rattled nerves with hugs and tell us that we could evaluate what we could learn from this experience. I, for one, was not feeling in any state to evaluate the earthquake as a learning experience. The aftershocks were loud and frequent, creating a real sense of lack of safety. The most effective comfort came from peers, people I knew. We took the information from the debriefing and did our best to use it when phoning or dealing with patients.

Patients were extremely glad to hear from us. Their reports were chatty; their well-being varied tremendously. Damage suffered and support systems also varied widely. On Wednesday and Thursday after the earthquake, we were able to contact all but three of our 80 day-treatment patients.

January 20 and After

Gradually, some level of normalcy returned to the hospital. Toilets were returned to use, lights worked, telephones were fully restored, food services were gradually restored. The number of large aftershocks diminished, and patients returned to the program.

Patients exhibited varying degrees of stress. Most commented on the tremendous feeling of helplessness that resulted from the darkness and horrendous noise of the earthquake as the earth crunched together and things came crashing down. Patients told stories about bedroom doors blocked by falling dressers, an inability to get out, refrigerators falling, trapping and separating people in different parts of the house, inability to find people in the dark, cut feet from walking on broken glass, flashlights kept by bedsides for just such a disaster found inoperable, inability to get any news or power, lost pets, pools with five-foot waves flooding the first floor of apartment buildings. Some, whose building has been red-tagged, were unable to go back to retrieve property. Some left with only the clothes on their backs. The patients, an already somewhat chaotic population, brought a huge number of issues related to loss.

Some of the most chronic patients were able to deal inventively with loss. An amputee confined to a wheelchair was trapped in her bedroom, unable to go anywhere or do anything. She remained calm and waited for help. Another who is blind and accustomed to the dark eased her way, crawling for 4 hours through rubble and disarray to find her way to a door. Another patient who had been staying for a week at a shelter, identified his needs and arrived at the hospital for help in his pajamas, unshowered and unshaved.

The staff was becoming more and more stressed trying to meet other people's needs. Our own needs and levels of tension increased. We were all making an effort to be supportive of each other, but sometimes this was not enough. We agreed on one thing: We needed to be taken care of, too. A higher level of absenteeism followed the earthquake, with staff reporting colds, flus, allergies, and other symptoms.

To deal with my needs during the 3 weeks after the earthquake, I created a series of small collages. They were useful in dealing with the nervousness and edginess I felt going to work at the epicenter each day, the impact of seeing the damage created, and the seemingly endless road winding through two dust-filled valleys between my home and work (see Figures 1 and 2).

Art therapy was also used in groups with patients. Their art, depicting a variety of problems and experiences and evoking conversations, can be divided into four types based on patients' experiences. First were the disarray issues: the mess, inconvenience, interruption of daily routine. Second were issues of fear, lack of being prepared. Third were safety concerns, and fourth were recuperation and coping techniques related to wanting to leave the area, using FEMA, HUD, and Red Cross services, and other coping experiences.

A 32-year-old man diagnosed with paranoid schizophrenia created a drawing of many overlapping and transparent figures (see Figure 3), representing his highly treasured collection of sculpture that tumbled from a shelf near his bed. The line quality captures the vibration and agitation of the experience and speaks of the escalation of voices he heard after the earthquake. He was able to express his concerns and inability to deal with the mess, the needed cleanup and feelings of immense loss.

A woman patient in her early twenties drew her apartment (see Figure 4). All the chaos and the vibration of the earthquake are shown. She depicts herself under the sofa bed trying to find a safe place. Lines around the outside edge of the paper represent confinement. She shows the disarray she experienced. On her face she draws her fear. The feebleness of her body suggests the helplessness she experienced.

A man in his late forties and a long-term, chronic patient drew a cracked road (see Figures 5 and 6). He depends on routine and repetition to function effectively from day to day and

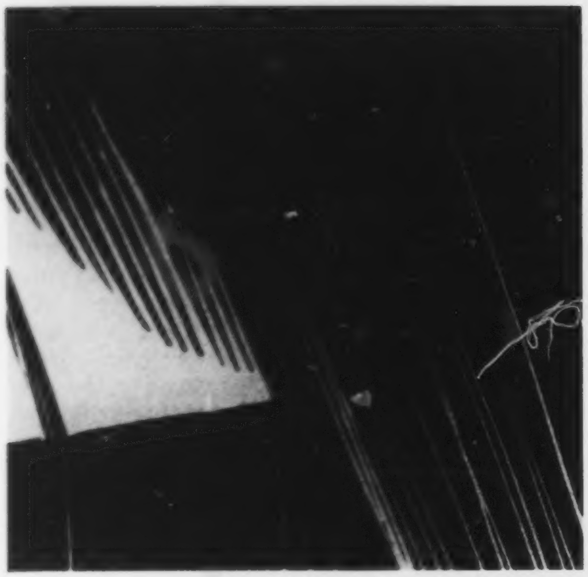


Figure 1 Collage

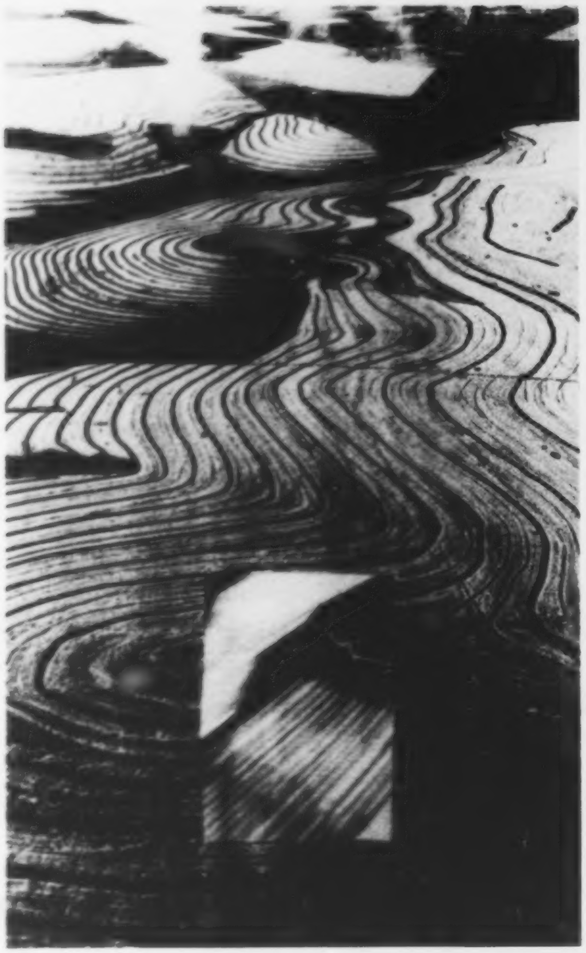


Figure 2 Collage

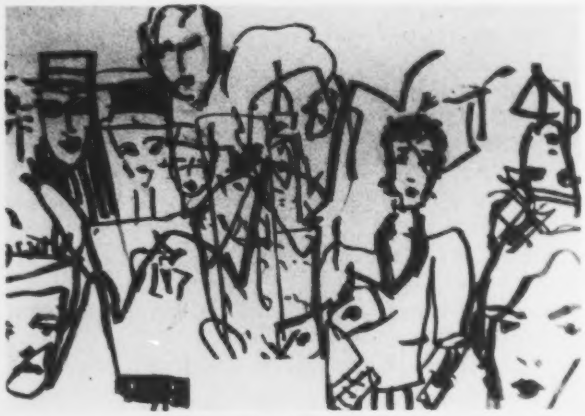


Figure 3 Many figures

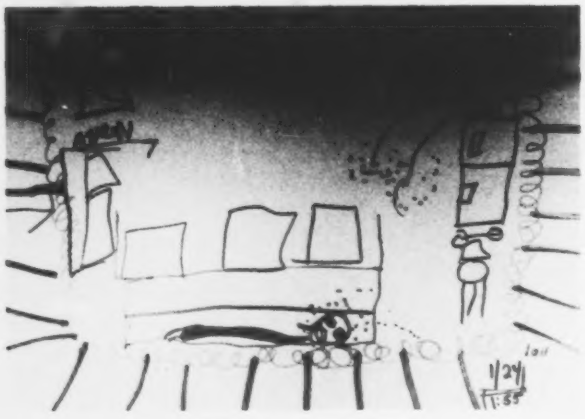


Figure 4 The apartment

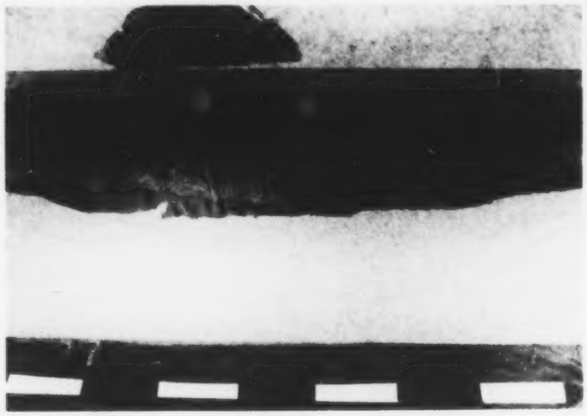


Figure 5 The road

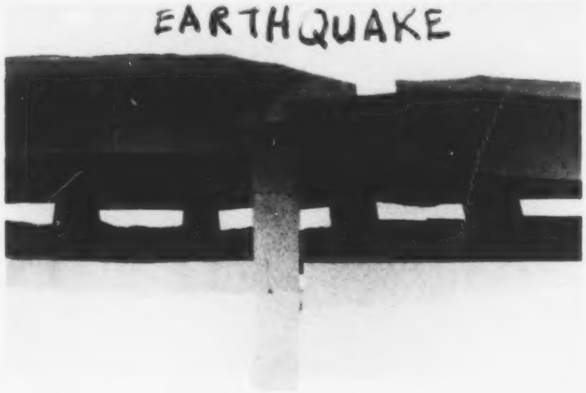


Figure 6 The road

often uses the metaphor of a road in his artwork to show where he is in his journey. After the earthquake, the road had an enormous break representing, he said, road damage and the interruption to his life and the chaos produced by this disruption from his regular routine.

Fear was reflected in many drawings and collages. Two were notable because the two women who did them, a 40-year-old woman and a 75-year-old woman, said they had not been afraid and the earthquake had not bothered them. Each said she had not experienced that much damage and that the earthquake was "no big deal." Both stated they enjoyed having people work together. Although it was true that people were rallying to help each other after the quake, neither woman was able to confront the fear she had felt until she drew what she had experienced. The older woman drew two small children on a grassy field. One child says, "I'm so scared," and the other replies, "So am I." The small size of the figures suggests the immensity of the experience and feelings of vulnerability one feels when small and young (see Figure 7).

The younger woman drew an aerial perspective of a room. Two people face each other at a table. They look up as cracks appear above them, and the building is damaged. The distortion of the building and line work strongly suggest anxiety (see Figure 8).

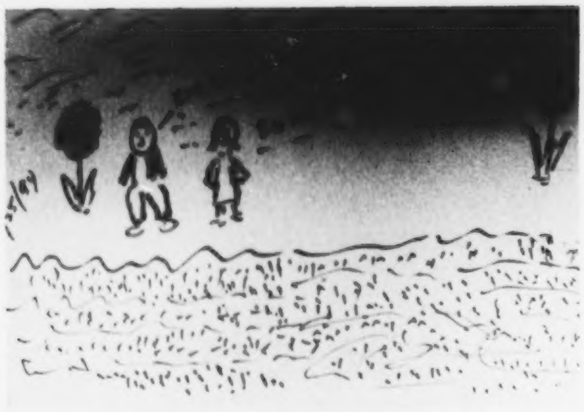


Figure 7 Two children on a grassy field

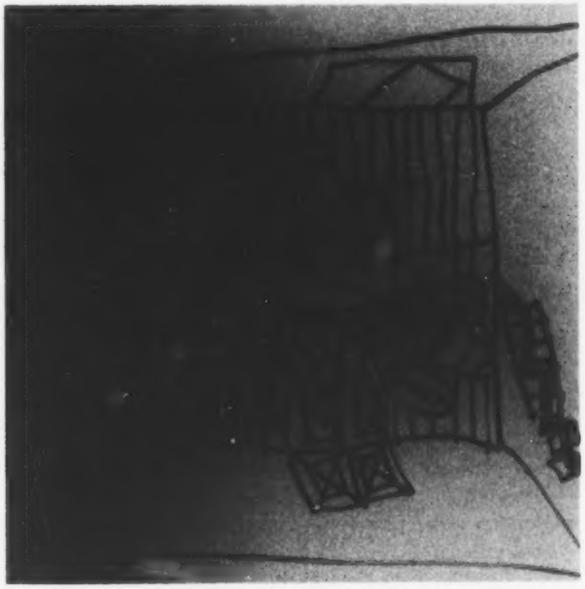


Figure 8 Aerial perspective of a room with two people

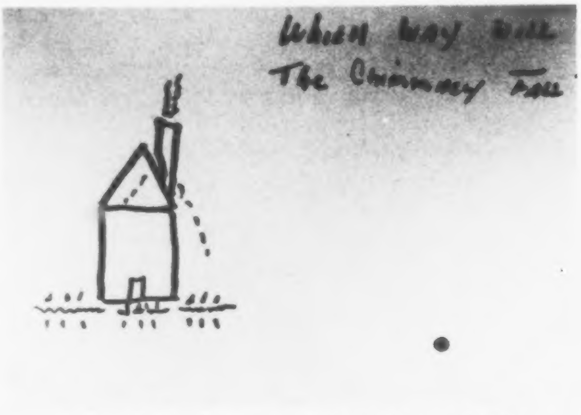


Figure 9 "Which way will the chimney fall?"

Both patients were able to reassess their initial statements about not being afraid when they considered their artwork and acknowledged that they had experienced much anxiety during the quake. Thus, their healing processes began.

Safety concerns were reflected in many drawings. A 60-year-old man who is large in stature and "indestructible" in affect drew a small house with a leaning, cracked chimney. He titled the drawing "Which Way Will the Chimney Fall?" Safety concerns, especially the desire to stay home coupled with the concern about doing so, are captured in this drawing (see Figure 9).

The theme of wanting to leave the area, as a coping mechanism, was seen in many artworks. Many collages made from pictures from a collage box, depicted leaving, going on vacation, or getting away. A 75-year-old man captured the essence of this by selecting a picture not of a car, but of a horse and cart. He titled it "I Am Ready to Leave the Area." This artwork enabled him to discuss his desire to leave the area and how difficult that would be at his age. Issues such as facing the difficulty of selling a home, lowered property values, and the hardship of moving when you are in your mid-seventies, stimulated the entire senior group to discuss their concerns.

On Reflection

The earthquake had an impact on so many, with loss of jobs, loss of homes, disruption in daily living, increase of fear, and loss of control. The surprise of the earthquake made us realize that no matter what we do to prepare, we are really not prepared enough. For our patients, art opened a door for crisis intervention. It facilitated processing of the situation by regular patients, staff, and people coming in for crisis intervention. One woman, the mother of a young child whose school had been condemned, summed up the essence and impact of the earthquake: "Our lives have been changed forever and anyone who doesn't live in the area cannot really understand."

Art helped to capture and process the overwhelming experience of dealing with disasters. It has been a valuable tool for me in dealing with my patients and my own issues.

Master of Arts Degree
in
ART THERAPY
Now Available at
Seton Hill College

- Prepares students for certification and registration.
- Full- and part-time options available.
- Western Pennsylvania's only Master's Program in Art Therapy.

Program begins Fall 1996

Call the Office of Graduate Studies
for more information.

412-838-4255 or 1-800-826-6234

Seton Hill
COLLEGE
Greensburg, PA 15601-1599

Review!

Certification Exam
Review Course

September 14, 1996

Designed to assist practicing art therapists
preparing to take the ATCB Certification
Exam for Art Therapists

Oklahoma Center
for Continuing Education
Norman, Oklahoma

For more information, contact:
The University of Oklahoma
College of Continuing Education
Phone: 1-800-522-0772 ext. 5101
E-mail: smontalvo@uoknor.edu

Reviews

Existential Art Therapy: The Canvas Mirror (Second Edition)

by **Bruce L. Moon, MACE, MDIV, A.T.R.**, Illinois: Charles C Thomas, 1995.

207 pp., 21 black & white illus., $49.95, cloth.
ISBN 0-398-05999-3. $29.95 paperback.
ISBN 0-398-06514-4.

Reviewed by **Patricia Engle Murphy, PhD, A.T.R.**, Moscow, ID

Existential Art Therapy is a 200-page book by Bruce Moon which presents a theoretical view of art therapy from an existential perspective. The question of what makes art therapy different from verbal therapies has always been a difficult one because art therapy is not just the use of art in the therapeutic process. Many psychotherapists use art and play in their work. I thank Bruce Moon for writing a book that helps to articulate, from the broader base of existentialism, a theoretical framework from which to debate a role and orientation for art therapists. It is only by looking through the lens of different viewpoints that we refine the parameters of what we, as art therapists, do.

Moon uses vignettes of former patients in an inpatient setting (Harding Hospital) to highlight and clarify his perspective. Moon's examples are quite useful for the new art therapist or student who needs help to understand his theoretical concepts in the therapeutic context. More importantly, he provides students with a way to think about clients that uses a perspective different from the more traditional medical or psychoanalytic model.

Each art therapist must develop her or his own theoretical construct and way of working that suits that therapist and the setting. To do that, it is essential to review and examine as many perspectives as possible. One might disagree or have a slightly different view, but the review process is an important aspect of developing a technique and philosophy that is unique to one's personal style of dealing with clients and a specific work environment.

Art therapists work in many ways and have many orientations, which help give our profession its richness, depth, and diversity. Moon makes it clear that he is not creating a "how to" book but is providing a thoughtful look at his way of working with clients based on many years of experience. Even if readers don't subscribe to all of his perspectives, this book will help them think about what they do and its theoretical foundation.

Below are some of the features that Moon elucidates, which for me identify how he sees his role as an existential art therapist. However, only some of these seem to be directly related to existential philosophy.

First, his three basic principles include:

1. Moon espouses respect and caring for the client based on common exploration, sharing, and understanding. This approach suggests a shift from a more traditional therapeutic relationship in which the balance is more supplicant to the healer. Thus the art therapist shares or shifts the responsibility for healing to a greater extent to the client. Art serves that function in a variety of ways. Moon, for example, does his own art in the therapeutic setting to reinforce equality and shared purpose. In fact, the 21 illustrations in the book are his artwork. I don't believe he is suggesting that all art therapists should do art with their clients, only that we each find a vehicle for communicating respect and mutual sharing to the client. Building trust becomes an essential element of the caring relationship.
2. Moon discusses using metaphor to help the client gain understanding and self-acceptance. Often he creates the metaphor for the client to enhance that process; other times he works with the client's metaphors. He is fortunate to work in a well-equipped and supportive environment which utilizes a team strategy. Many of us don't have such a range of choices in our professional environment, but we can encourage clients, through art, to create metaphors and work with them in the healing process. Moon proposes that the development of metaphor cannot be done in isolation; it creates a storyline that connects one person to another. The process of doing art becomes important as a way to play out the metaphor or tell a story.
3. Moon puts forth the existential view that each person struggles to find the individual meaning of his or her life, and the role of the therapist is to accompany the person on that journey, providing an environment where it is safe to explore those meanings. He emphasizes client choice and responsibility. He writes that the essential role of the existential art therapist is to walk along as the client journeys toward self-discovery while not imposing individual values or perspectives. This stance is somewhat paradoxical. While Moon suggests that the art therapist's job is to stand out of the way once the therapeutic environment has been created, all therapists know it is difficult to avoid becoming role models on such issues as integrity and dealing with troublesome emotions. In Moon's case, he also becomes a model for doing art. There is nothing wrong with this, but Moon should acknowledge and address the tendency of clients to look to their therapists as role models despite the best efforts of the therapist not to impose his or her values.

My major disagreement with the book is Chapter XII, where Moon discusses the changing nature of mental illness. He does a good job describing the lack of grounding and rootedness that characterizes much of American culture today and how that absence is reflected in the ways emotional disturbances are exhibited. However, he seems to betray his existential orientation when he describes a theoretical construct of borderline personality disorder.

The following are excerpts from Moon's etiology of borderline personality disorder:

> [Until the age of three months the infant is able]...through the primitive ego process of splitting to keep his affective experiences of pleasure and rage entirely separate in his consciousness. . . . It is at this stage of beginning object constancy that there is a defect in the development of the borderline. . . . [In regard to splitting as a defensive mechanism, what is] (b)elieved to be most common is the circumstance where the infant's relationship with mother is constrained by the mother's own pathology. . . . These two basic flaws in the infant's developing ego—(1) the retention of splitting as a defense mechanism and (2) the failure to achieve object constancy—provide the basis for the mass of related symptoms that later characterize the borderline patient. . . . They cannot feel anything like normal grief. (pp. 158–161)

Theoretical models in the therapeutic context are useful to the extent that they provide an understanding of the patient's experience and lead to an effective treatment approach. But they offer only one way to conceptualize a circumstance. Although the constructs put forth by Moon may be useful from one perspective, there are other theoretical models from which to create an understanding of borderline personality disorder that are more consistent with an existential view, are not so harsh in their judgments, and look beyond the mother-child relationship and the notion of a flawed or defective developmental process based on the mother's pathology. For example, the model that Moon describes does not take into account the emerging view of childhood trauma as an important feature of many people with borderline personality disorder. In a recent study of 21 patients with definite borderline personality disorder, 81% gave histories of major childhood trauma, including significant physical abuse (71%), sexual abuse (68%), and witnessing serious domestic violence (62%) (Perry, Herman, van der Kolk, & Hoke, 1990). Other studies support this finding, indicating that 70% to 80% of inpatients with borderline personality disorder have experienced prior child abuse (Goodwin, Cheeves, & Connell, 1990). In today's world, omitting the role of the male parent in the development of the child's personality and attachments, particularly where abuse may be present, is naive and sexist. The main point, however, is that an existentialist is not usually so concerned with "object relations" and "ahistoricity," and focuses instead on a client's inability to experience grief and relationships fully and hence to find meaning in life.

The book has some editing errors such as incomplete sentences (p. 47), duplicated paragraphs (p. 45), and incorrect information (i.e., DSM = the diagnostic service manual, p. 74). Since this is a second edition, these errors may be a reflection of rewriting, using parts of the original text and a hasty rereading. I found it distracting and wish it had been edited and proofread more carefully. We should expect a higher standard for our art therapy literature.

Despite these problems, this is a useful book. It helps the art therapist think about his or her orientation and approach. Using his own struggles and paintings as examples, Moon creates an intimacy with his readers. He has some interesting and novel ideas.

References

Goodwin, J. M., Cheeves, K., & Connell V. (1990). Borderline and other severe symptoms in adult survivors of incestuous abuse. *Psychiatric Annals, 20*(1), 22–32.

Perry, J. P., Herman J. L., van der Kolk, B., & Hoke, L. (1990). Psychotherapy and psychological trauma in borderline personality disorder. *Psychiatric Annals. 20*, 33–43.

Creative Whack Pack: Success Edition, A Whack on the Side of the Head: How You Can Be More Creative, and Creative Whack Pack

by **Roger von Oech**, Menlo Park, CA: Creative Think, 1992.

186 pp., black & white illus. $22.00-Success Edition. ISBN 0-911121-00-5.

Reviewed by **Roz Rutstein, MEd, MAAT, A.T.R.-BC**, Newfoundland, PA

A Whack on the Side of the Head—a title that might put off some clinicians—is a possible resource for art therapists looking for creative problem-solving material with clinical potential.

Art therapists who look forward to reading books that are understandable and informative and who are willing to venture slightly beyond their discipline may consider Roger von Oech's *Creative Whack Pack: Success Edition* worth reading. This 1992 revised edition has two parts, a book and a deck of cards. They can be bought separately or as the *Success Edition*, which includes both.

The back cover informs the reader that the *Creative Whack Pack* was originally used in creativity seminars with Fortune 500 companies and that the author received his doctorate degree from Stanford University focusing on the history of ideas. The book was not written for clinicians; however, it reminds the reader of those characteristics that make creative actions occur. The author provides clear cognitive explanations along with "puzzles, anecdotes, exercise, metaphors, cartoons, questions, and stories" that activate the creative process. All chapters except the first can be read in any order. The nonlinear option offers suggestions about creative blocks while making simple, clear points as reminders to the reader.

On page 10, the author identifies a block by making the following statement: "Many of us have been taught to think that the best ideas are in someone else's head." He shows how negative "self-talk" of long-standing needs to be countered vigilantly. Von Oech's book could become a tool for clinicians working in acute care settings or working with clients experiencing debilitating depression. The quick, easy, and thought-provoking pages are 4 inches by 7 inches and can be transported easily with art materials without adding significant weight or bulk.

Unlike many resources that are written only for clinicians to read, this one can be recommended to clients with minimal reservation. *The Creative Whack Pack* deck of 64 cards could be used in any number of directive or partially directive art therapy sessions. It could also be used as a catalyst for between-session activities. Each card has a key phrase that is defined briefly and illustrated in black line drawings of cartoon images by George

Willet. The images could be catalysts for metaphoric comments by depressed clients and offer potential opportunities for shifts in cognitive frames without significant threat either to fragile self-esteem or to expectations for energy investment.

The cards are divided into four suits—explorer, artist, judge, and warrior—each expanding on the different characteristics of its suit with key phrases such as *Be dissatisfied, Avoid arrogance, Ask a fool, Slay a dragon*, and *Check your timing* to name a few. Opportunity to use either one or a combination of suits provides the clinician with possibilities for various levels of group process and interaction among group members, as well as material for individual art therapy sessions. As with any resource, clinicians working with self-destructive clients will find some cards suggest creative alternatives that, without clearly defined limits, could become catalysts for self-destructive actions.

There is no bibliography or glossary and no credit to sources of information. Von Oech presents the book more as a parlor game and, in fact, it could easily be and probably has been used that way. Clinicians requiring an inexpensive resource that is not explicitly clinical might consider the book and deck of cards worth purchasing. As pointed out earlier, each can be a catalyst for creative expression, either for the clinician who needs a fresh idea or for the client who is stuck in a self-negating place.

BOOKS RECEIVED BUT NOT REVIEWED AS OF, APRIL 15, 1996

Title: *Clinical Supervision: A Systems Approach*
Author: Elizabeth Holloway
Publisher: Sage Publications

Title: *Drama and Healing: The Roots of Drama Therapy*
Author: Roger Grainger
Publisher: Taylor & Francis Publishers

Title: *Dramatherapy: Clinical Studies*
Author: Steve Mitchell
Publisher: Taylor & Francis Publishers

Title: *Art Without Rejection*
Author: Sheila Reid
Publisher: Rush Editions

Title: *Rainbow's End*
Author: Laura Christine Summer

Title: *The Listening Reader: Fiction and Poetry for Counselors and Psychotherapists*
Author: Ben Knights
Publisher: Taylor & Francis Publishers

Title: *Miniature Painting: A Complete Guide to Techniques, Mediums, and Surfaces*
Author: Joan Cornish Willes
Publisher: Watson-Guptill Publications

THE REMUDA SYSTEM CAN HELP WOMEN AND ADOLESCENTS SUFFERING WITH EATING DISORDERS

CONTINUUM OF CARE
Adult/adolescent inpatient, adult/adolescent residential, partial care and intensive outpatient treatment sites provide tranquil, specialized settings.

◆

LICENSURE
State licensed, JCAHO accreditation with commendation and CHAMPUS provider.

◆

STAFF
Highly skilled professional staff of licensed psychiatrists, internists, psychologists, RN's, master level therapists and registered dietitians providing individualized programs and lengths of stay.

◆

A COMPREHENSIVE PROGRAM
We treat the whole person with individualized programs designed to meet medical, nutritional and psychological needs, blending these components with a non-denominational Christian perspective.

◆

EXPRESSIVE THERAPIES
Provided as a powerful tool to assist individuals in exploring their identities and problems through the use of their own creativity. Activities include art therapy, music, dance/movement and creative writing.

◆

AFTERCARE TRANSITION
Remuda's Aftercare Coordinator will work with the referring professional prior to the patient's discharge to facilitate her transition back into an outpatient setting as she resumes her day-to-day activities.

Most insurance accepted

REMUDA Ranch
Center for Anorexia and Bulimia, Inc.
P.O. Box 2481
Wickenburg, Arizona 85358
1 (800) 445-1900

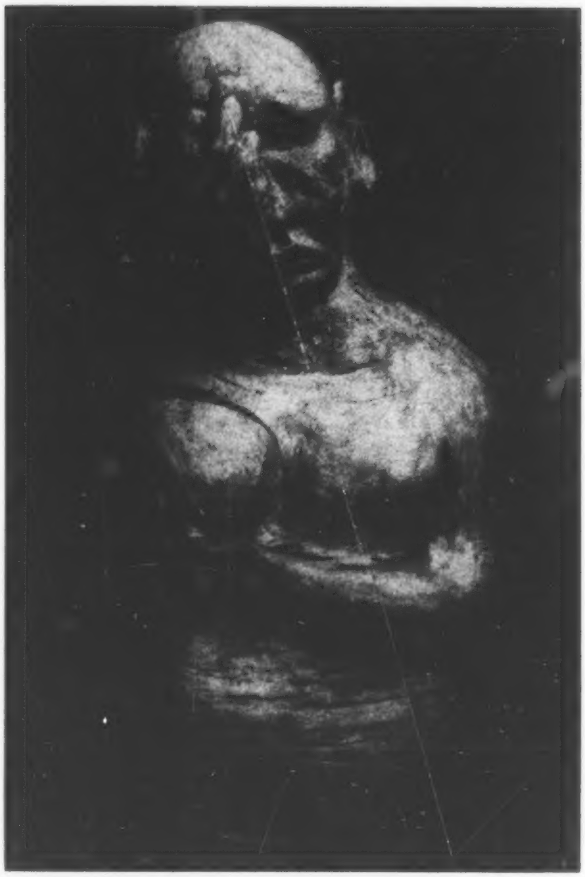
Noteworthy

Art to Demystify Breast Cancer: Healing Legacies

Healing Legacies provides access to the normally private dimensions of breast cancer by surveying the artistic works of women and men who have experienced it. This collection helps to demystify breast cancer, for breast cancer is neither one disease nor one experience. Rather it is an event that requires a collection of voices to reveal its many dimensions—the discovery, the treatment, the recovery process, and the emotions.

The Healing Legacies Arts Registry was created by the Breast Cancer Action Group (BCAG) in 1993. The registry is a growing and living record for this work. Women and men can enter the registry on an ongoing basis since more people are diagnosed each year. This system also allows exhibition sites the greatest amount of flexibility in choosing subject matter, theme, and quantity of work.

The registry consists of painting, photography, poster art, sculpture, fiber and textile art, ceramics, video, hand-made books, poetry, and performance art. *Healing Legacies* made its debut at the U.S. House of Representatives Cannon Building Rotunda. The collection has had a broad appeal. Past exhibits have been mounted in Ohio and Missouri. In 1996 it is scheduled for New Mexico, Vermont and Alberta, Canada. Through *Healing Legacies* the Breast Cancer Action Group seeks to educate the public, patients, and physicians about the varied experiences people have with breast cancer. To receive information about applying to the registry send a SASE to: BCAG: Healing Legacies, P. O. Box 5605, Burlington, VT 05402.



Oh God, Why Me???! Touching the Grief (©1989) Paulette Carr: "When the nightmare confronts you, you want to scream, but can't."

Art Therapist Works with Palestinian Children

Art therapist and educator, Julie Byers, A.T.R., recently traveled to the West Bank and Gaza Strip to help mental health professionals and children. Byers is currently working on a doctorate at the University of Toronto where she stumbled across the assignment. She was asked by a psychiatrist if she would be willing to do some work for the Near East Cultural and Educational Foundation of Canada (NECEF), with which he was affiliated. The program was funded by the children's bureau of Canada's Ministry of Health and Welfare.

During her first trip last summer, Byers visited six clinics, working not only with children who suffer from posttraumatic stress disorder, but also overworked and traumatized healthcare professionals, helping them to handle caseloads through art therapy. She consulted with these professionals on how they could utilize art with children who have endured violence and political upheaval in their short lives.

Counseling Center near Jerusalem; Julia Byers (third from the left) with healthcare professionals at art therapy workshop, July 1995.

AMERICAN ART THERAPY ASSOCIATION, INC.

27TH ANNUAL CONFERENCE

Many Paths

Multicultural Perspectives in Art Therapy

November 13-17, 1996
Adams Mark Hotel
Philadelphia, PA

Keynote Speaker · Jimmy Santiago-Baca

Jimmy Santiago-Baca, poet, author and screenplay writer of Chicano and Apache decent, is recognized as a leading spokesperson for the Hispanic community. His book, Martin and Meditations on the South Valley, received the American Book Award in 1988. In the summer of 1995, Santiago-Baca was one of the featured poets on the Bill Moyers PBS series, Language of Life. His poetry speaks to a vision of change and community transformation through creative expression.

For information contact: American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, IL 60060
(847)949-6064

Magnolia Street Publishers

ART THERAPY
IN THEORY & PRACTICE

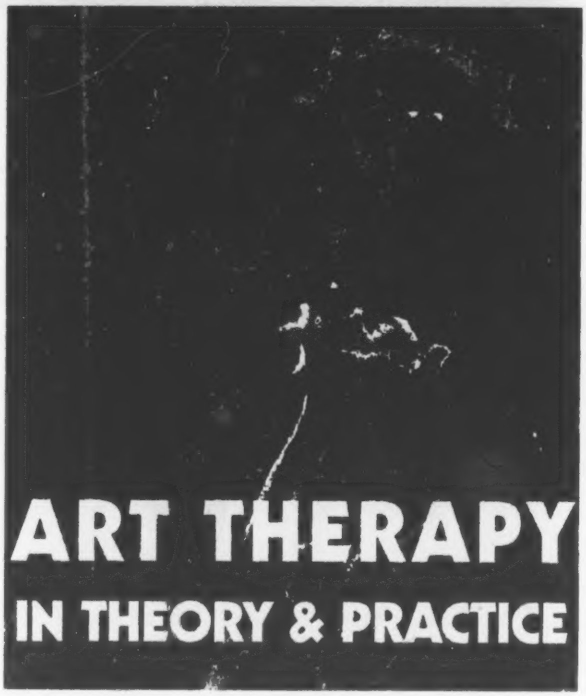
Ed. by Elinor Ulman and Penny Dachinger

"Since its first publication, *Art Therapy in Theory and Practice*, has been used continually as both a textbook and a resource. Many of the chapters have become indispensable classics which continue to define the field of art therapy.

In this reprint, we re-encounter Elinor Ulman's skill as a writer and editor of great perception and eloquence. Her talent was to bring together the seminal writing of a burgeoning professional field and meld them into an organized, comprehensible body. This book, now available to a new generation of readers, stands as a testament to this art."

RANDY M. VICK, MS, A.T.R.-BC
The School of the Art Institute of Chicago

$29.95 404 pages, color illustrations



SUPERVISION and Related Issues: A Handbook for Professionals

by Cathy Malchiodi and Shirley Riley

A long awaited text, this handbook is a highly informative guide to the complexities of supervision in the 90's. Supervisors, educators, and students will find it indispensible not only in the supervisory session, but also in the classroom and in work with clients. An extensive appendix includes ethics and standards of practice, sample forms for use in supervision, laws effecting supervisors and many more references and recources.

Due Spring 1996 **Paper $27.95**

MAGNOLIA STREET PUBLISHERS

5804 N. Magnolia St., Chicago, IL 60660 • 312-561-2121 • fax 312-477-6096

Wholesale and Bookstore orders to above address.

Individual orders to:

Stern's Books
2004 W. Roscoe
Chicago, IL 60618
312-883-5100, fax 312-477-6096

Add $4.00 UPS for first book and .75 for each additional book. Credit cards and checks accepted.

THE GESTALT ART EXPERIENCE, Patterns That Connect, Janie Rhyne	pa. $24.95
INTEGRATIVE APPROACHES TO FAMILY ART THERAPY, Shirley Riley & Cathy Malchiodi	pa. $29.95
ART AS THERAPY WITH CHILDREN, Edith Kramer	pa. $19.95
CALIFORNIA ART THERAPY TRENDS, Ed. Evelyn Virshup	pa. $29.95
SHATTERED IMAGES: Phenomenological Language of Sexual Trauma, Dee Spring	pa. $36.00
DYNAMICALLY ORIENTED ART THERAPY: It's Principals & Practice, Margaret Naumburg	hd. $32.95

CHARLES C THOMAS • PUBLISHER

- ☐ Brooke, Stephanie L.—**A THERAPIST'S GUIDE TO ART THERAPY ASSESSMENTS: Tools of the Trade.** '96, 160 pp. (7 × 10), 7 il.
- ☐ Benenzon, Rolando O.—**MUSIC THERAPY THEORY AND MANUAL: Contributions to the Knowledge of Nonverbal Contexts. (2nd Ed.)** '96, 300 pp. (7 × 10), 44 il.
- ☐ Miller, Susan B.—**WHEN PARENTS HAVE PROBLEMS: A Book for Teens and Older Children with an Abusive, Alcoholic, or Mentally Ill Parent.** '95, 94 pp. (7 × 10), $31.95, cloth, $18.95, paper.
- ☐ Nucho, Aino O.—**SPONTANEOUS CREATIVE IMAGERY: Problem Solving and Life Enhancing Skills.** '95, 174 pp. (7 × 10), 15 il., $41.95, cloth, $25.95, paper.
- ☐ Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror. (2nd Ed.)** '95, 230 pp. (7 × 10), 21 il, $49.95, cloth. $29.95, paper.
- ☐ Makin, Susan R.—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 112 pp. (7 × 10), $29.95, cloth, $15.95, paper.
- ☐ Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 186 pp. (7 × 10), 33 il. $41.95, cloth, $26.95, paper.
- ☐ Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER.** '93, 332 pp. (7 × 10), 32 il., 9 tables, $64.95, cloth, $32.95, paper.
- ☐ Sopchak, Andrew L., Andrew M. Sopchak & Robert J. Kohlbrenner— **INTERPERSONAL RELATEDNESS FROM PROJECTIVE DRAWINGS: Applicability in Diagnostic and Therapeutic Practice.** '93, 292 pp. (8½ × 11), 166 il., 46 tables, $61.95, cloth, $34.95, spiral (paper).
- ☐ Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 × 10), 24 il., $46.95, cloth, $29.95, paper.
- ☐ Fürrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Parents and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8½ × 11), $25.95, spiral (paper).
- ☐ Machover, Karen—**PERSONALITY PROJECTION IN THE DRAWING OF THE HUMAN FIGURE: A Method of Personality Investigation. (11th Ptg.)** '80, 192 pp. (5½ × 8½), 18 il., $31.95, cloth, $16.95, paper.
- ☐ Hammer, Emanuel F.—**THE CLINICAL APPLICATION OF PROJECTIVE DRAWINGS. (6th Ptg.)** '80, 688 pp., 360 il., $55.95, cloth, $33.95, paper.
- ☐ Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY. (2nd Ed.)** '96, 94 pp. (7 × 10), 4 il.
- ☐ Cooper, Shawn—**THE CLINICAL USE AND INTERPRETATION OF THE WECHSLER INTELLIGENCE SCALE FOR CHILDREN®—THIRD EDITION.** '95, 466 pp. (7 × 10), 5 il., 20 tables, $74.95, cloth, $39.95, paper.
- ☐ Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product.** '94, 222 pp. (7 × 10), 17 il., $47.95, cloth, $29.95, paper.
- ☐ Landy, Robert J.—**DRAMA THERAPY: Concepts, Theories and Practices. (2nd Ed.).** '94, 294 pp. (7 × 10), 1 table. $58.95, cloth, $33.95, paper.
- ☐ Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 × 10), 12 il. $35.95.
- ☐ Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency.** '93, 254 pp. (7 × 10), 71 il., $51.95, cloth, $30.95, paper.
- ☐ Moon, Bruce L.—**ESSENTIALS OF ART THERAPY TRAINING AND PRACTICE.** '92, 188 pp. (7 × 10), 21 il., $37.95, cloth, $22.95, paper.
- ☐ McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART.** '89, 258 pp. (6¾ × 9¾), 56 il., $48.95, cloth, $29.95, paper.
- ☐ Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (2nd Ed.)** '88, 386 pp. (7 × 10), 11 il., 3 tables, $56.95, cloth, $34.95, paper.
- ☐ McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY.** '88, 262 pp. (6¾ × 9¾), 34 il., $48.95, cloth, $29.95, paper.
- ☐ Peters, Jacqueline Schmidt—**MUSIC THERAPY: An Introduction.** '87, 186 pp. (7 × 10), 2 tables, $35.95, cloth, $19.95, paper.
- ☐ Michel, Donald E.—**MUSIC THERAPY: An Introduction, Including Music in Special Education. (2nd Ed.)** '85, 152 pp., 2 il., $24.95.
- ☐ Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp., $53.95, cloth, $31.95, paper.
- ☐ McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY.** '81, 260 pp., 54 il., $32.95, cloth, $18.95, paper.
- ☐ Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART.** '78, 304 pp., 125 il. (12 in color), 7 tables, $49.95, cloth, $29.95, paper.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217) 789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street Springfield • Illinois • 62794-9265

ORAL HISTORICAL ACCOUNTS OF THE AMERICAN ART THERAPY ASSOCIATION

BY PIONEERS OF THE ASSOCIATION

A VIDEO PROGRAM

The following HLM's, former and current elected presidents have agreed to have their interviews available to the AATA membership. These programs were recorded by volunteers.

- ☐ 1 Dr. Myra Levick interviewed by Cathy Malchodi
- ☐ 2 Robert Ault interviewed by Randy Vick
- ☐ 3 Felice Cohen interviewed by Dr. Irene Corbit
- ☐ 4 Don Jones interviewed by James Consoli
- ☐ 5 Dr. Judith Rubin interviewed by Dr. Frances Anderson
- ☐ 6 Gwen Gibson interviewed by Dr. Jeanne Carrigan
- ☐ 7 Georgiana Jungels interviewed by Debra Paskind
- ☐ 8 Dr. Gladys Agell interviewed by Dr. Linda Gantt
- ☐ 9 Dr. Sandra Graves interviewed by Robert Ault
- ☐ 10 Cay Drachnik interviewed by Dr. Linda Gantt
- ☐ 11 Dr. Linda Gantt interviewed by Dr. Doris Arrington
- ☐ 12 Dr. Robin Goodman interviewed by Cecily Mermann
- ☐ 13 Bobbi Stoll interviewed by Mari Fleming
- ☐ 14 Virginia Minar interviewed by Dr. Frances Anderson
- ☐ 15 Edith Kramer interviewed by Paula Howie
- ☐ 16 Helen Landgarten interviewed by James Consoli
- ☐ 17 Dr. Rawley Silver interviewed by Dr. Betty Jo Troeger
- ☐ 18 Dr. Frances Anderson interviewed by Dr. Valerie Appleton
- ☐ 19 Dr. Harriet Wadeson interviewed by Dr. Doris Arrington

1-95 0

PRICE VHS PER TAPE: $19.95 for Members • $24.95 for Non-Members

PRICE PER SET: $322.00 for Members • $403.00 for Non-Members

VIDEO TAPES

NO. OF TAPES _______ x $19.95	$ _______
NO. OF TAPES _______ x $24.95	$ _______
NO. OF SETS _______ x $322.00	$ _______
NO. OF SETS _______ x $403.00	$ _______
DOMESTIC SHIPPING ($3.00 per tape to $30.00 max)	$ _______
FOREIGN SHIPPING ($8.00 per tape to $40.00 max)	$ _______
DENVER RESIDENTS ADD 7.3% SALES TAX	$ _______
CO RESIDENTS ADD 3.8% SALES TAX *IF TAX EXEMPT, INCLUDE CERTIFICATE*	$ _______
NEW YORK RESIDENTS ADD LOCAL SALES TAX *IF TAX EXEMPT, INCLUDE CERTIFICATE*	$ _______
TOTAL OF ORDER	$ _______

MAKE CHECKS PAYABLE AND MAIL YOUR ORDER TO:

NATIONAL AUDIO VIDEO, INC.
4465 WASHINGTON STREET
DENVER, CO 80216
PHONE: (303) 292-2952

2386

QUALITY GUARANTEED - NO REFUNDS - ALLOW 2-4 WEEKS FOR DELIVERY

METHOD OF PAYMENT

Please Note: Foreign customers must pay by credit card or pre paid Purchase Order and checks must be drawn on US bank in US funds.

____ CHECK ____ AMEX ____ MC ____ VISA ____ DISCOVER

CARD# ____________________

EXPIRATION DATE ____________________

SIGNATURE ON CARD ____________________

SHIP TO: (PLEASE PRINT CLEARLY) ☐ Business ☐ Residential

NAME ____________________

INSTITUTION ____________________

ADDRESS ____________________

____

CITY ____________ COUNTY ____________

STATE ________ COUNTRY ________ ZIP ________

DAYTIME PHONE (   ) ____________________

CALL TOLL FREE: 1-800-373-2952 (9-5 MT) • OR FAX YOUR ORDER: (303) 292-5629

American Art Therapy Association, Inc.

November 8-12, 1995
San Diego, California

Audio Cassettes Available

☐ 1. School-Based Art Therapy Earthquake Trauma Reduction Program, *S. Silverstein, MA, ATR; M. Newborn, MA; C. Palmer, MSW; M. Siderman, LCSW; M. Stafsky, MA; J. Wexler-Ballard, LCSW*

☐ 2. The Multi Disciplinary Treatment of Attention Deficit Disorder Includes Art Therapy Groups, *D. Safran, MS, ATR; F. Safran, PhD; S. Finkelstein, MD*

☐ 3. The Future of Our Past, *M. Nienkamp, BA; N. Gray, BS; K. Wathen, BA*

☐ 4. Weaving New Visions, *L. Vance, MS, ATR; K. McCormick, MA, ATR; L. Kapitan, MPS, ATR*

☐ 5. Collaborative Co-Therapy: Art Therapy as Adjunct Within Outpatient Private Practice Team Treatment, *S. Roller, MFA, ATR-BC; K. Adams, PhD*

☐ 6. The Image-Making Process: Withstanding the Course of Non-Production, *M. Hanes, MAT, LAT, ATR-BC*

☐ 7. Art and Healing: Practitioner, Process, and Audience - A Dialogue, *M. Fleming, MAz, MFCC, ATR-BC; J. Colby, MA, MA*

☐ 8. The Power of Language in the Art Therapeutic Relationship, *S. Spaniol, EdD, LMHC, ATR; M. Cattaneo, PhD, LMHC, ATR*

☐ 9. Relying on the Kindness of Strangers' Social Policy: Art Therapy and Poverty, *N. Mayer Knapp, PhD, ATR*

☐ 10. The Crash of US Air Flight 427 - Its Impact Upon an Elementary School, *C. Kunkle-Miller, PhD, ATR*

☐ 11. Couple Compatibility Assessment Using the Mari * Card Test and Mandala Drawings, *P. Frame, MA, ATR*

☐ 12. The Art of Crime, *P. Howie, MA, ATR-BC; L. Gantt, PhD, ATR, HLM*

☐ 13. A Vision Made Reality: Establishing Alliances in a Pediatric Art Therapy Program, *L. Black, BA, MCAT, ATR; K. Glass, MA*

☐ 14. A Men's Group Using Imagery as a Predominant Way of Knowing, *R. Schoenholtz, MS, ATR-BC*

☐ 15. The Correctional Officer and the Art Therapist: An Unlikely Alliance, *D. Gussak, MA, ATR*

☐ 17. Survival of Aboriginal Culture Through Art: Implications for Cross-Cultural Art Therapy, *F. Kaplan, DA, ATR; M. Campanelli, EdD, LSW, ATR*

☐ 18. Incorporating the Mandala to Center Children Diagnosed as ADD and ADHD, *V. Smitheman-Brown, MA*

☐ 19. Mirror Drawings: A Reflection of the Therapeutic Process, *A. M. Shopp, LMFT, ATR; S. Chambers Wallingford, MA*

☐ 20. The Dynamics of Art & Music Therapy in Forensic Settings, *R. Dorwin, MA, LAT, ATR; C. Weyuker, BM, RMT*

☐ 21. Art Therapy in Pediatric Rehabilitation, *J. Andersen, BFA, MA*

☐ 22. Searching for the Appropriate Treatment Map: Integrating Óbject Relations and Family Systems Theories, *J. Consoli, MA, ATR-BC; G. Klorer, MA, ATR*

☐ 23. About the Words in Art Therapy, *K. Dannecker, Dr.phil, ATR*

☐ 24. Results of Recent Research Studies Identifying Recurring Visual Symbols and Construct Choices, *D. Arrington, EdD, ATR-BC; P. Hayes, MA; E. Rubinstein, BA*

☐ 26. Heart Imagery: Multiple Messages and Metaphors, *L. Kay, MA, ATR*

☐ 27. The China Connection, *H. Wadeson, PhD, LCSW, ATR-BC, HLM*

☐ 28. Art Therapy in Context: Honoring Women's Voices in Our Work, *C. Malchiodi, MA, LAT, LPCC, ATR; S. Riley, MFCC, ATR*

☐ 29. Research in Art Therapy Education - A Dialogue, *M. Rosal, PhD, ATR-BC; D. Linesch, PhD, MFCT, ATR; S. Hite, LPC, ATR-BC*

☐ 30. Archetypal Art Therapy Defined, *J. Wenzke, BS; J. Abbenante, MA, LAT, ATR-BC; G. Mongiello, MA, RMHC; L. Wix, MEd, LAT, ATR*

☐ 31. Art Therapy as Containment in the Stabilization of Dissociative Identity Disorder, *T. Nelson, MS*

☐ 32. Reflecting on Ten Years of Art Therapy for Children Who are Grieving, *B. Betker McIntyre, PhD, LPC, ATR; J. Adams, BS, RN*

☐ 33. Art Therapist as Member of Medical Multi Disciplinary Burn Team, *J. Russell, MS, ATR*

☐ 34. Art Therapy Used to Adapt Coping Behaviors of Adult Daughters of Alcoholics, *C. Dikovitsky, SND, MA*

☐ 35. Cancer--Creativity and Self-Repair: Theoretical and Clinical Considerations on Art Psychotherapy with Cancer Patients, *E. Dreifuss-Kattan, PhD, ATR*

☐ 36. Art Therapy Interventions with Adolescents Who Are Victims of Trauma, *D. Testa Ochipa, PhD, ATR*

☐ 37. From Hurtful Hands to Healing Hands: Collaborative Treatment of Multiple Personality Disorder, *T. McDougall Herl, MS, ATR*

☐ 38. Attachment Organization in the Imagery of Addicts and Implications for Treatment, *E. Holt, MS; D. Kaiser, MS*

☐ 39. Art Therapy with Laryngectomy Patients, *S. Ainlay Anand, MA, ATR-BC; V. Anand, MD, FACS*

☐ 40. Art Work of Aggressive Organic Geriatric Males, Pre and Post Estrogen Therapy, *R. Drew-Leute, MA; P. Bryman, DO*

☐ 41. Holding Onto the Rainbow - Stereotyped Symbols in Patient's Art as Facilitators, *D. Moriya, MPS*

☐ 42. Visual and Tactile Interventions in Healing: Sandtray with Mastectomy Patients, *V. Lusebrink, PhD, ATR-BC; K. Scifres, MA, ATR-BC*

☐ 43. Coming to our Senses: The Somatic Roots of Art Therapy, *S. Lovell, PhD, LAT, ATR*

☐ 45. Children Having Children: Art Therapy in a Community Based Early Adolescent Pregnancy Program, *M. J. Mermer-Welly, MA, LSW, ATR; G. Stiles, MA, AT*

☐ 46. Integrating Art Therapy and Biofeedback - A New Perspective on Reducing Children's Stress, *C. DeLue, MA*

☐ 47. Perspective on Clayworks in Art Therapy, *F. Goryl, Jr., MA, ATR*

☐ 48. Patient-Focused Care and the Future of Art Therapists in Hospitals, *S. Cheyne-King, MS, LPC, NBCCH, ATR*

☐ 49. Portals and Passages, *R. Marano-Geiser, ATR; H. Wadeson, PhD, LCSW, ATR-BC, HLM; R. Ault, ATR-BC, HLM; M. Junge, ATR*

☐ 50. Models of School Art Therapy: Three Perspectives, *S. Hite, MS, MSeD, ATR-BC; C. Drew, MEd, ATR; P. Dunn-Snow, MA, MEd, ATR-BC*

☐ 51. The Clothesline Project: Therapy, Education and Activism, *K. A. Meyer, MA; M. Lancaster, MA, ATR-BC; E. Peck, MAET, ATR; L. Myer, MAT, ATR*

☐ 52. Wholistic Art Therapy! An Idea Whose Time has Come, *R. Shoemaker-Beal, MFA, ATR; A. Garrett, PhD, ATR-BC; S. Geller, MA, ATR; E. Horovitz-Darby, MA, ATR; S. Savinch, BS, RN*

☐ 53. Mood Disorders and Artistic Creativity, *K. Redfield Jamison, PhD*

☐ 54. Collaborating with Artists: Individual and Communal Healing, *D. Burdick Gage, BA, MA, PhD; E. Speert, MEd, ATR-BC*

☐ 55. Meditation and Art Therapy: Its Many Uses with the Geriatric Patient, *L. Levine-Madori, MS, CTRS*

☐ 56. Art as a Way of Knowing: From Therapist to Steward, *P. Allen, PhD, LAT, ATR*

☐ 57. The Myth of Collaboration: The Peace Bridge Project, *L. Vance, MS, ATR; C. Clark, MS*

☐ 58. A Practical Review and Integration of All Diagnostic Drawing Series Research Findings, *A. Mills, MA, ATR*

☐ 59. Planting the Seed of Art Therapy Awareness: Educating Allied Professionals as Undergraduates, *B. Parker-Bell, MA, ATR*

☐ 60. Return from Dissociation, *B. Sobol, MA, ATR*

☐ 61. Development of a Model to Disseminate the Art of Scale to Allied Professionals, *B. J. Troeger, PhD, ATR-BC*

☐ 63. The Studio Experience in Art Therapy Training, *L. Wix, MEd, LAT, ATR*

☐ 64. Mirroring Through Art to Repair the Damaged Self, *E. Kanner Weinberg, BA, MA*

☐ 65. Queenly Maiden: A Case Study in Archetypal Art Therapy, *B. Falconer, MA*

☐ 66. Moving the Image: Art and Movement Therapy with Older People, *J. Beaujon Couch, MA, ATR; J. Funderburk, MA, CET*

☐ 67. Art Therapy with 3-D Environments, *B. Bluestein, BFA, MA*

☐ 68. Paper Dolls: A Therapeutic Technique with Adolescents in Residential Treatment, *B. Woodward O'Neal, AB, MS*

☐ 69. The Importance of Being Ernst: How Max Ernst's Art Paralleled His Life, *E. Virshup, PhD, MFCC, ATR*

☐ 70. Toward a More Inclusive Use of Imagery and Art in Psychotherapy, *J. Consoli, MA, ATR-BC*

☐ 71. Integrating Art Therapy in a Day Treatment Program with Inner City Adolescents, *E. McGann, MA, ATR; G. Pagano, MA, MSW; H. Harris, MSW*

☐ 73. Mural Making in the Therapeutic Community: Five Projects and Views, *L. Peterson, MA, ATR; S. Goldman, MA; R. Sorrentino, BFA; J. Cameron, BFA; A. Levesque, BFA*

☐ 74. Finding Meaning in Art: Art Therapists in Collaboration With One Another, C. Cox, MA, ATR; J. Abbenante, MA, ATR-BC; B. Cohen, MA, ATR; P. Engelhorn, MA, ATR; M. Fleming, MA, ATR-BC; W. Miller, PhD, ATR; L. Rhinehart, MFCC, ATR; L. Wilson, PhD, ATR-BC

154-95 A

PRICE PER TAPE: $12.00

MAIL ORDER FORM

NO. OF TAPES ________ x $12.00 $ ____________
SHIPPING - DOMESTIC ($1.75 per tape to $12.00 max.) $ ____________
FOREIGN ($3.00 per tape to $30.00 max.) $ ____________
CO RESIDENTS ADD 3.8% SALES TAX $ ____________
DENVER RESIDENTS ADD 7.3% SALES TAX $ ____________
IF TAX EXEMPT, INCLUDE COPY OF TAX CERTIFICATE
NEW YORK RESIDENTS ADD LOCAL SALES TAX $ ____________
ON TOTAL ORDER. IF EXEMPT, INCLUDE CERTIFICATE
TOTAL OF ORDER $ ____________

SHIP TO: (PLEASE PRINT CLEARLY) ☐ Business ☐ Residential

NAME ______________________________
INSTITUTION ______________________________
ADDRESS ______________________________
____
CITY ______________ COUNTY ______________
STATE ________ COUNTRY ________ ZIP ________
DAYTIME PHONE (   ) ______________________________

METHOD OF PAYMENT
(Foreign customers must pay by credit card or pre-paid Purchase Order)

________ Enclosed is my check (Drawn on US Bank in US Funds)

Charge to ____ AMEX ____ MASTERCARD ____ VISA ____ DISCOVER
CARD# ______________________________
EXPIRATION DATE ______________________________
SIGNATURE ON CARD ______________________________

MAKE CHECKS PAYABLE AND MAIL YOUR ORDER TO:

NATIONAL AUDIO VIDEO, INC
4465 WASHINGTON STREET
DENVER, COLORADO 80216
PHONE: (303) 292-2952

QUALITY GUARANTEED - NO REFUNDS - ALLOW 2-4 WEEKS FOR DELIVERY

CALL TOLL FREE: 1-800-373-2952 (9-5 MT) • OR FAX YOUR ORDER: (303) 292-5629

INCREASE YOUR POTENTIAL

Whether it's networking,
training or advertising
—
being a part of our clearinghouse
can be your
BEST MOVE

The *Family Violence & Sexual Assault Bulletin (FVSAB)* is an innovative publication dealing with the issues of family violence and sexual assault. It is produced semiannually by the Family Violence & Sexual Assault Institute, an international resource center and clearinghouse, which maintains a large database of references and unpublished papers and offers many other services to member professionals, organizations and individuals.

FVSAB brings you 60- 80 pages of topics like current classified references, research and treatment articles, networking, conference calendar, book/media reviews, new releases, legislative issues and more all with the goal of increasing networking, education and training.

Call us and make your move to:

Family Violence & Sexual Assault Bulletin

Clearinghouse Subscription Order

Name____________________
Organization____________________
Address____________________
City/State________________ **Zip**_______
Phone(W)____________ **(H)**____________
FAX____________ **Date of order** _________

Method of Payment
☐ **Check (Payable to FVSAI)**
☐ **MasterCard** ☐ **Visa**

Card#________________ **Exp. Date**_______
Signature ____________________

	1 Year	2 Years
U.S. Individuals, Shelters and Crisis Centers	$30.00	$55.00
Institutions, Libraries and Other Agencies	$45.00	$85.00
Canada/Mexico	Add$15.00 to above fee	
Other International	Add $25.00 to above fee	

Call or fax now for your subscription or ask for advertising information
903/595-6600, Fax: 903/595-6799

Family Violence &
Sexual Assault Institute
1310 Clinic Dr., Tyler, TX 75701

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC, Editor

Art Therapy, the official journal of the American Art Therapy Association, is a quarterly journal for professionals and students who are interested in the use of art in the fields of mental health, psychotherapy and human development. The purpose of the ***Art Therapy*** is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. ***Art Therapy*** publishes refereed articles, including illustrations, by art therapists, psychologists, family therapists, and others that reflect the latest advances in theory, research, professional issues, and practice. An emphasis is placed on the use of visual arts in therapy, but articles in related disciplines of interest are considered for publication. ***Art Therapy*** is an important source for news and summaries of national conferences, book reviews, media, and commentaries.

Recent articles published in ***Art Therapy:***

- Art Therapy: Building Barriers with Native American Clients
- LA '94 Earthquake in the Eyes of Children: Art Therapy with Elementary School Children Who Were Victims of Disaster
- Use of a Drawing Task in the Treatment of Nightmares in Combat-Related PTSD
- Outpatient Art Therapy with Multiple Personality Disorder: A Survey of Current Practice
- Art Therapy at the Crossroads: Arts *and* Science

Art Therapy is available to AATA Members as part of their membership.

Non-Members may subscribe at the following annual rates:
Individuals: $50.00 (U.S.) - $74.00 (Foreign)
Institutions: $77.00 (U.S.) - $100.00 (Foreign)

Single copies are available at:
Members: $12.50 - Non-Members: $23.00

Make checks or money orders payable to AATA and return with this subscription order form to:
American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060

Please enter my subscription. Enclosed is a check in the appropriate amount: $ ____________

Name: ____________________

Address: ____________________

City: ____________ State: ______ Zip: ____________

The following books authored by members of the
American Art Therapy Association
are available for purchase.

	MEMBERS	NON-MEMBERS
A History of Art Therapy in the United States [1,2] (1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual [3] (1994) Howie & Gutierrez ISBN 1-882147-16-2	$20.00	$35.00
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0 [1,2]	$24.00	$35.00
Art Therapy in the Schools [3]	$ 6.00	$10.00
National Registry of Masters Theses & Practicum Papers [3]	$15.00	$25.00
Addendum to National Registry of Masters Theses & Practicum Papers [3]	$12.50	$22.50
AATA Chapter Manual [3]	$12.00	N/A
Applying for Funds from Your Area Agency on Aging [3]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance [3]	$ 7.00	$10.00

NOTE: [1] Postage included on all orders for this publication. [2] Ten or more copies - 10% discount. [3] Add $3.00 for postage.

Make checks or money orders payable to AATA and return with this order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my order. Enclosed is a check/money order in the appropriate amount: $____________

Name: ____

Address: ____

City: ______________________ State: ________ Zip: ______________

The following posters by members of the
American Art Therapy Association
are available for purchase.

	MEMBERS	NON-MEMBERS
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Shipping and handling is included on both posters.

Make checks or money orders payable to AATA and return with this order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my order. Enclosed is a check/money order in the appropriate amount: $____________

Name: ____

Address: ____

City: ______________________ State: ________ Zip: ______________

AATA REGIONAL SYMPOSIA

ADDICTIONS

Presenters: Lynn Jones, Holly Feen, and Katie Webb

Participants will receive the latest information on the use of art therapy in the treatment of addiction and dual diagnosis. Art therapists will be able to identify specific non-verbal approaches for working through resistance and denial in the treatment of substance abusers. Counselors will be able to identify specific ways in which to coordinate treatment efforts with art therapists in their facilities.

FAMILY ART THERAPY

Presenters: Mari Fleming, Shirley Riley, and James Consoli

The objectives of this symposium are to provide the participants with an overview of how art therapy provides families an enriched vocabulary to assist them in solving family problems. The art therapy gives a "voice" to all age levels and offers a non-threatening vehicle to aid in communication restructuring the family system. The intensive workshop will offer ways to combine family theories with art expressions and examine assessment methods, short and long term treatment. Participants will engage in experiential opportunities to experience how art therapy is applicable in their own professional setting. Every effort will be made to offer the most current trends in family therapy and art therapy application.

ART THERAPY IN SCHOOLS

Presenters: Janet Bush, Sarah Hite, and (third presenter to be announced)

This symposium will provide participants with the administrative procedures for implementing art therapy services and programs in schools. Topics will focus on the uses of art therapy in schools; roles and responsibilities of school art therapists; techniques and strategies for working with students; training and preparation of school personnel; and the funding and marketing procedures required for school art therapy programs. Participants will be prepared to transfer techniques and strategies for implementing art therapy services and programs to school settings.

ART THERAPY WITH THE OLDER ADULT

Presenters: Larry Barnfield, Bernadette Callanan, and Judith Wald

The symposium will cover general views on aging, relevant facts and new research, the role of art therapy with elders and settings in which art therapists practice and the special advantages of art therapy with the aging. It will cover the goals of treatment, treatment issues, and consideration of the clinical treatment of three groups of vulnerable aging and case studies.

GRANTS: GOING FOR THE GOLD

Presenters: Frances Anderson, Vija Lusebrink, and Doris Arrington

Successful grant writing in art therapy is, and will continue to be an important survival strategy in the 90's. Many model art therapy projects funded by grants will be discussed. The entire grant writing and granting process from identification of funding sources (public and private), to proposal development, submission and implementation will be covered. Technical assistance will be available to participants who already have a grant idea or proposal "in process".

ART THERAPY WITH CHILDREN AT RISK

Presenters: Cathy Malchiodi, Julie Epperson, and (third presenter to be announced)

This symposium proposes to fill the need for advanced art therapy training focusing on theory, interventions, methodology and research with children at risk. "Children at risk" are defined as those who are directly affected by family violence, physical and sexual abuse, neglect homelessness, and various disabilities such as attention deficit hyperactivity disorder, learning problems, and physical limitation which put them at further risk for abuse and neglect. Emphasis will be on how the clinician can develop both short and long term art therapy interventions, effectively assist the child in crisis and appropriately utilize art expression in assessment of current level of psychological functioning.

ART AND MEDICINE

Presenters: Cathy Malchiodi, Anita Mester, and (third presenter to be announced)

The symposium will focus on the unique dimensions of art therapy within a medical context with people who have experienced life-threatening chronic illness, particularly cancer and HIV. The special role that art expression plays in the assessment and evaluation of both the somatic and psychological status of the individual will be discussed, supported by the current research of both art therapists and clinicians in related fields. Special emphasis will be on paradigms for the use of art therapy within the context of psychoneuroimmunology and mind/body healing. Theories of imagery from current research by Achterburg, Simonton, Bach and others will be covered to assist the participants in integrating the use of art expression with physically ill clients will be presented so that participants acquire an understanding of the practical aspects of adapting art therapy to specific disease conditions. Lastly, emotional and transpersonal issues of grief and loss which are intrinsic to the experience of physical life threatening illness will be addressed.

ADOLESCENT ART THERAPY

Presenters: Kris Sly-Linton and (three other presenters to be announced)

The Adolescent Art Therapy Symposium will cover a wide range of topics designed to address a specific focus area requested by the sponsoring organization. This is a somewhat unique approach to the traditional symposia format but considering the multiplicity of problems regarding the treatment of adolescents today, it was felt this would be a way to make each symposium more pertinent to the intended audience. The four person team headed by Kris Sly-Linton, A.T.R.-BC, was coordinated to include professional art therapists that can provide the expertise required to address the following areas: Special Populations of Adolescents, Program Focus, and Teens and Family Systems.

These Symposia are offered at no charge to the participating Chapter.

◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆◆

For further information regarding the content or scheduling of these symposia, please contact
AATA National Office • 1202 Allanson Road • Mundelein, Illinois • 60060 • (847)949-6064 • (847)566-4580
Monday through Friday - 9:00 a.m. to 5:00 p.m. - Central Time

The American Art Therapy Association

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-profit organization founded in 1969, is a national association which represents a membership of approximately 4,750 professionals and students. It is governed and directed by a nine-member Board, elected by the membership. AATA has established standards for art therapy education, ethics, and practice. AATA committees actively work on governmental affairs, clinical issues and professional development. AATA's dedication to continuing education and research is demonstrated through annual national conferences and regional symposia, publications, videos, and awards.

MISSION STATEMENT

The American Art Therapy Association is an organization of professionals dedicated to the belief that the creative process involved in the making of art is healing and life enhancing.

Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy.

ART THERAPY: DEFINITION OF THE PROFESSION

Art therapy is a human service profession that utilizes art media, images, the creative art process, and patient/client responses to the created products as reflections of an individual's development, abilities, personality, interests, concerns, and conflicts. Art therapy practice is based on knowledge of human developmental and psychological theories which are implemented in the full spectrum of models of assessment and treatment including educational, psychodynamic, cognitive, transpersonal, and other therapeutic means of reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, and increasing self-esteem.

Art therapy is an effective treatment for the developmentally, medically, educationally, socially, or psychologically impaired; and is practiced in mental health, rehabilitation, medical, educational, and forensic institutions. Populations of all ages, races, and ethnic backgrounds are served by art therapists in individual, couples, family, and group therapy formats.

Educational, professional, and ethical standards for art therapists are regulated by the American Art Therapy Association. The Art Therapy Credentials Board, Inc. (ATCB), an independent organization, grants post-graduate registration (A.T.R.) after reviewing documentation of completion of graduate education and post-graduate supervised experience. The Registered Art Therapist who successfully completes the written examination administered by the ATCB is qualified as Board Certified (A.T.R.-BC), a credential requiring maintenance through continuing education credits.

CHAPTERS

Affiliated chapters of the AATA have been established throughout the United States. Chapters conduct meetings and activities which promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network for people working toward common goals. Information and support for chapter members is passed on from the Assembly of Affiliate Chapters to the local level.

You must be a national member to become a chapter member. Information on locating the chapter nearest you is available from the AATA National Office.

MEMBER BENEFITS

All members receive:

Publications

- *Art Therapy: Journal of the American Art Therapy Association* (published quarterly).
- *AATA Newsletter* (published quarterly).
- Substantial discounts on AATA publications, such as Annual Conference Proceedings, other professional journals, videos, and the Membership Directory.
- AATA literature, such as Educational Programs List, Art Therapy Media List, Standards of Practice, and mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life, and disability through Maginnis & Associates.
- Access to national experts in art therapy.

AATA Meetings

- Discounts on registration fees to AATA national conferences and regional symposia.

Nationwide Advocacy

- Governmental Affairs activities including congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third-party payors.
- National liaison with related professional organizations for recognition and promotion of art therapy.

Professional Standards

- Development of Model Job Description and recommendations for licensing standards.
- Development and implementation of national Education Standards for approval of graduate level art therapy programs.
- Development and implementation of nationally recognized Standards of Practice and Ethical Standards for Art Therapists.

GENERAL INFORMATION

AATA and ATCB are administratively independent. Membership in AATA and registration (A.T.R.) with the ATCB require separate application and approval. *A.T.R. registration applications are available from the ATCB at (312)527-6764.*

For ***new*** associate, student, and contributing members only, please follow the dates below when submitting membership applications. The membership year is the calendar year **1/1 to 12/31**.

Applications received between:

1/1 to 5/31

Full dues payment; membership expires 12/31 of same year.

6/1 to 9/30

Half-year dues plus $5.00 payment; membership expires 12/31 of same year.

10/1 to 12/31

Full dues payment; membership for the remainder of current year and next full year.

CATEGORIES AND FEES

Professional-By application review process only; approved members may vote, hold office, and serve on committees.

- **Professional Member-**Individuals who have completed educational training in art therapy. Dues are $85.00/year.
- **Credentialed Professional Member-**Individuals who have been *dually approved* for Professional Membership by AATA and registration (A.T.R.) by the ATCB. AATA dues are $85.00/year. *Annual A.T.R. maintenance fee is billed separately by the ATCB.*

Associate-Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. This category is not open to master's level art therapy program graduates. Associates may not vote, hold office, or serve on committees. Dues are $85.00/year.

Student-Individuals who are currently taking full-time course work in art therapy or a related field. A current statement from the institution of learning indicating full-time status and course work content (6 graduate or 12 undergraduate credits) is required. Student members may not vote or hold office, but may serve on the Student Subcommittee of the Education Committee. Dues are $35.00/year.

Contributing-Individual organizations, institutions, or foundations which contribute annually to AATA. Such members may not vote, hold office, or serve on committees. Dues are $120.00/year.

Retired-Individuals who are at least 65 years of age and who are no longer practicing. Retired associates receive publications. Retired professionals receive publications and may vote, but may not hold office. Application provided upon request. The maintenance fee is $35.00/year.

The American Art Therapy Association

MEMBERSHIP APPLICATION

NAME ____________________

HOME ADDRESS ____________________

____

PHONE (______) ____________________

BUSINESS ADDRESS ____________________

____

EMPLOYER ____________________

JOB TITLE ____________________

LICENSES HELD & STATE ____________________

____

PREFERRED MAILING LIST: ☐ HOME ☐ BUSINESS

Foreign AATA applicants *must* include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

Please indicate under which category you are applying:

☐ $85 Associate Membership

☐ $35 Student Membership *(See student membership criterion for necessary documents to accompany this application.)*

☐ $120 Contributing Membership

Professional Member-Individuals who have completed educational training in art therapy. Dues are $85.00/year.

☐ Professional Membership Application

Credentialed Professional Member-Individuals who have been *dually approved* for professional membership by AATA and registration (A.T.R.) by the Art Therapy Credentials Board, Inc. (ATCB). AATA dues are $85.00/year. *Annual A.T.R. maintenance fee is billed separately by the ATCB.*

A.T.R. Application-Provided and processed by the ATCB. *A.T.R. is granted by ATCB review approval process only.* For more information, contact the ATCB at (312)527-6764.

Please make all checks payable in U.S. dollars and mail to:

American Art Therapy Association, Inc. (AATA)
1202 Allanson Road
Mundelein, IL 60060
(847)949-6064 / Fax (847)566-4580

PLEASE COMPLETE THIS SURVEY.

Education (please check highest degree earned)

1 ☐ Doctorate Degree
2 ☐ Master's Degree
3 ☐ Bachelor's Degree
4 ☐ Associate/Certificate
5 ☐ Other ____________

Please indicate *exact* degree earned, e.g., BA, BS, MA, MS, PhD, etc.

Work Setting (please check only one)

1 ☐ Hospital
2 ☐ Clinic
3 ☐ Day Treatment Center
4 ☐ Rehabilitation
5 ☐ Sheltered Workshop
6 ☐ Correctional Facility
7 ☐ Residential Treatment
8 ☐ Out-Patient Mental Health
9 ☐ School System
10 ☐ Elderly Care Facility
11 ☐ College/University
12 ☐ Clinical Training Program
13 ☐ Institute Training Program
14 ☐ Counseling Center
15 ☐ Private Practice
16 ☐ Other ____________

Area(s) of Specialization (please check up to three)

1 ☐ Addictions
2 ☐ Adolescents, Hospitalized
3 ☐ Adolescents, Psychiatric
4 ☐ Adults, Hospitalized
5 ☐ Adults, Psychiatric
6 ☐ Art History
7 ☐ Art Therapy Education
8 ☐ Art Therapy in Schools
9 ☐ Children, Hospitalized
10 ☐ Children, Psychiatric
11 ☐ Domestic Violence
12 ☐ Eating Disorders
13 ☐ Families
14 ☐ Gerontology
15 ☐ Hospice/Terminally Ill
16 ☐ Learning Disability
17 ☐ Mental Retardation
18 ☐ Neurological Disease
19 ☐ Prisoners
20 ☐ Post Traumatic Stress
21 ☐ Psychotherapy
22 ☐ Rehabilitation
23 ☐ Research
24 ☐ Sexual Abuse
25 ☐ Visual Art
26 ☐ Other ____________

Voluntary Information

Age

1 ☐ 20-24
2 ☐ 25-29
3 ☐ 30-34
4 ☐ 35-39
5 ☐ 40-44
6 ☐ 45-49
7 ☐ 50-54
8 ☐ 55-59
9 ☐ 60+

Salary Range

1 ☐ under $10,000
2 ☐ $10,000-14,999
3 ☐ $15,000-19,999
4 ☐ $20,000-24,999
5 ☐ $25,000-29,999
6 ☐ $30,000-34,999
7 ☐ $35,000-39,999
8 ☐ $40,000-44,999
9 ☐ $45,000-49,999
10 ☐ $50,000+

Gender

1 ☐ Female
2 ☐ Male

Hours Worked/Week

1 ☐ 0-10
2 ☐ 11-20
3 ☐ 21-30
4 ☐ 31-40
5 ☐ 41+

AMERICAN ART THERAPY ASSOCIATION, INC.

1202 Allanson Road, Mundelein, Illinois 60060 (847) 949-6064 FAX (847) 566-4580

RESOURCES

American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following publications, films, posters, and training literature are available from the AATA National Office.

CONFERENCE PROCEEDINGS	MEMBERS	NON-MEMBERS
Creativity and the Art Therapist's Identity (1976) ISBN 1-882147-04-9	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) ISBN 1-882147-05-7	$ 5.00	$ 7.00
The Use of Creative Arts in Therapy (1979 Joint Conference)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) ISBN 1-882147-10-3	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) ISBN 1-882147-12-X	$ 7.00	$10.00
A Bridge Between Two Worlds (1981) ISBN 1-882147-11-1	$ 7.00	$14.00
Art Therapy: Still Growing (1982) ISBN 1-882147-06-5	$10.00	$14.00
Professionalism in Practice (1988) ISBN 1-882147-08-1	$15.00	$20.00
Painting Portraits: Families/Groups/Systems (1989) ISBN 1-882147-07-3	$15.00	$20.00
Image and Metaphor (1991) ISBN 1-882147-09-X	$15.00	$20.00
The Art Therapist: Artist/Teacher/Clinician/Healer (1992) ISBN 1-882147-14-6	$15.00	$20.00
Common Ground: The Arts, Therapy, & Spirituality (1993) ISBN 1-882147 -21-9	$15.00	$20.00
Reflecting on the Past, Envisioning the Future (1994) ISBN 1-882147-24-3	$15.00	$20.00
Weaving New Visions (1995) ISBN 1-882147-50-2	$15.00	$20.00

NOTE: Ten or more copies of a single proceeding: 10% discount on total. Set of four proceedings (consecutive years): 20% discount on total. Postage and handling: $3.00 first item and $0.75 each additional.

PUBLICATIONS	MEMBERS	NON-MEMBERS
A History of Art Therapy in the United States [1,2] (1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual [3] (1994) Howie & Gutierrez ISBN 1-882147-16-2	$20.00	$35.00
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0 [1,2]	$24.00	$35.00
Art Therapy in the Schools [3]	$ 6.00	$10.00
National Registry of Master's Theses & Practicum Papers [3]	$15.00	$25.00
Addendum to National Registry of Master's Theses & Practicum Papers [3]	$12.50	$22.50
AATA Chapter Manual [3]	$12.00	N/A
Applying for Funds from Your Area Agency on Aging [3]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance [3]	$ 7.00	$10.00

NOTE: [1] Postage and handling included on all orders for this publication. [2] Ten or more copies—10% discount. [3] Postage and handling: $3.00

PROFESSIONAL PREPARATION LITERATURE	MEMBERS	NON-MEMBERS
Education Standards	$ .32	$ 1.00
Educational Program List (Colleges and Universities offering art therapy programs)	$ .32	$ 2.00

General Information Packet: $3.00 (includes Education Standards, Educational Program List, and Information and Membership Application)

OTHER LITERATURE	MEMBERS	NON-MEMBERS
Art Therapy Model Job Description	$ .32	$ 1.00
Art Therapy Media List	$ .32	$ 1.00
Bibliography: Books Authored by AATA Members	$ .32	$ 1.00
Ethical Standards for Art Therapists	$ .32	$ 1.00
Standards of Practice	$ .32	$ 1.00

MEMBERSHIP INFORMATION	MEMBERS	NON-MEMBERS
Membership Specialty List	$ 2.62	$ 3.62
Membership Survey	$ .32	$ 2.32
Membership Directory [1]	$14.00	$55.00
Criteria and Application for Professional Membership	$ .32	$ 1.00

NOTE: [1] Postage and handling for AATA Directory: U.S.—$3.00, Canada/Mexico—$3.25, and Foreign—$10.00.

POSTERS	MEMBERS	NON-MEMBERS
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Postage and handling is included on both posters.

SUBSCRIPTIONS

Art Therapy: Journal of the American Art Therapy Association	Individuals = U.S. $50.00 Institutions = U.S. $77.00	Foreign = U.S. $74.00 Foreign = U.S. $100.00
Back Issues of *Art Therapy Journal*	Members = $12.50	Non-Members = $23.00
AATA Newsletter	U.S. $26.00	Foreign $38.00

NOTE: Postage and handling is included on both subscriptions.

VIDEOS	TYPE	MEMBERS	NON-MEMBERS
Art Therapy Beginnings (1977) color/sound/45 minutes	1/2" VHS	$50.00	$80.00
Michael (1977) color/sound/12 minutes	1/2" VHS	$50.00	$80.00
Art Therapy (1980) color/sound/12 minutes	1/2" VHS	$50.00	$80.00

NOTE: Postage and handling for each VHS tape: U.S.—$3.00, Canada/Mexico—$3.25, and Foreign—$10.00.

---

1. WE DO NOT ACCEPT CREDIT CARDS OR PURCHASE ORDERS. All orders must be made in writing, accompanied by payment in cash, check, or money order in U.S. funds.
2. FOREIGN ORDERS: Shipping will be made per your instructions (surface or air). Please specify shipment method when ordering. Additional postage, if necessary, will be billed separately.
3. RETURNS ARE NOT ACCEPTED for refund on shipped items.

TITLE	QUANTITY	PRICE	TOTAL

SHIPPING INFORMATION

NAME: ____________________

MEMBER ID#: ____________________

STREET: ____________________

CITY/STATE/ZIP: ____________________

Total: $ __________

Postage: $ __________

Applicable Discount: $ __________

TOTAL ENCLOSED: $ __________

Allow 2 - 4 weeks for delivery.
MAKE CHECKS PAYABLE TO AATA

ATTENTION AUTHORS

Please complete the following information and attach one copy to each copy of your submission:

Name____

Degrees/Credentials________________________________

Address____

____

Phone Numbers **Home**____________________ **Work**____________________

Type of Submission (check one):

☐ Article
☐ Video Review
☐ Viewpoints
☐ Book Review
☐ Brief Report
☐ Commentary

Title of Submission____________________________________

____

Checklist

☐ Five (5) copies, typewritten on 8 1/2" x 11" white paper with margins of at least one inch.

☐ Black and white photographs (at least 5" x 7") of original artwork plus four (4) photocopies of each.

☐ Paper and references adhere to *Publication Manual of the American Psychological Association* (Fourth Edition).

☐ Abstract of 100-150 words (for articles and brief reports only).

☐ Detachable cover sheet with author(s) name(s), affiliation, degrees, and credentials.

☐ Appropriate release forms obtained for use of client art expressions and client information.
(You do not need to send these with your submission, but you must have them on file.)

☐ This Attention Authors form.

Author's Signature______________________________ **Date**________________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association***, c/o American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.

GUIDELINES FOR SUBMISSIONS

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy: Journal of the American Art Therapy Association* uses a blind peer review procedure for articles, brief reports, and viewpoints. Final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor, and special section editors.

The following are guidelines for submissions. **Submissions that do not conform to these guidelines will be returned to the author without review.**

Submission Categories

1. **Articles.** Full-length articles may focus on the theory, practice, and research in art therapy or related areas. Articles must include an abstract of approximately 100-150 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Brief Reports should include information on the research design, methodology, and results. An abstract of approximately 100-150 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry, or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office.
5. **Video Reviews.** Reviews of media (videos) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office.
6. **Commentaries.** Brief comments on submissions published in *Art Therapy*, issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each submission to **Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original submissions that are not under consideration by another periodical or publisher are acceptable.
3. Submissions must be typewritten on 8 1/2" x 11" white paper with margins of at least one inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Submissions must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for more information.
5. An abstract of 100-150 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles, and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for style of tabular presentations. All tables, charts, or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" x 7" and black and white glossy prints, preferably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs. Captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions which are addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. **It is the author's responsibility to secure such permissions.** A copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations, and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any submission accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their submission on either an IBM, IBM-compatible, or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the submission to the AATA National Office. This will help speed processing, editing, and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations, and materials accompanying their submissions.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 13, NUMBER 3 1996

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, 60060 U.S.A. Telephone (847)949-6064; FAX (847)566-4580. Non-members may subscribe at the following annual rates: $50 (U.S.) and $74 (Foreign); institutions $77 (U.S.) and $100 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 U.S.A. (847)949-6064.

This journal is abstracted in: Resources in Education (ERIC), Art Bibliographies Current Titles, Art Bibliographies Modern, and PsycINFO.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to American Art Therapy Association, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE
American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060 U.S.A.
(847)949-6064 and FAX (847)566-4580

MISSION STATEMENT: The American Art Therapy Association, Inc. (AATA) is an organization of professionals dedicated to the belief that the creative process involved in the making of art is healing and life enhancing. Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy.

ADVERTISING RATES

RATES	1×	2×	3×	4×
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:
January 15 for Spring issue; April 15 for Summer issue.
July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The publication of any advertisement by this journal is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc. is not responsible for any claims made in an advertisement.

Editor
Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Susan Spaniol, EdD, A.T.R., LMHC
Lesley College, Cambridge, MA

Book Review Editor
Erika Cleveland, MA, A.T.R., LMHC
Lesley College, Cambridge, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Friends Hospital, Philadelphia, PA

Production Editor
Karen D. Savage

Editorial Board
Pat B. Allen, PhD, A.T.R., LPAT
School of the Art Institute, Chicago, IL

Janet Bush, EdS, A.T.R.-BC
Dade County Public Schools, Miami, FL

Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec, Canada

Mariagnese Cattaneo, PhD, A.T.R., LMHC
Lesley College, Cambridge, MA

Susan E. Cheyne-King, MS, A.T.R., LPC, NBCCH
Cumberland Hospital, New Kent, VA

Carol Thayer Cox, MA, A.T.R., LPAT
George Washington University, Washington, DC

Anna R. Hiscox, MA, A.T.R.-BC, MFT
Illinois State University, Normal, IL

Sarah Hite, MS, MSEd, A.T.R.-BC
Eastern Virginia Medical School, Norfolk, VA

John G. Jones, PhD, A.T.R.-BC
Indian Health Service, Wolf Point, MT

Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI

Frances F. Kaplan, DA, A.T.R.-BC
Hofstra University, Hempstead, NY

Leslie Knowles, MA, A.T.R., LMHC
Lesley College, Cambridge, MA

Vija B. Lusebrink, PhD, A.T.R.-BC, HLM
University of Louisville, Louisville, KY

Patricia Engle Murphy, PhD, A.T.R.
Private Practice, Moscow, ID

Mary Ellen Peacock, MA, A.T.R.-BC
St. Francis of Assisi School, Louisville, KY

Trudy Manning Rauch, MS, A.T.R.-BC
Eastern Virginia Medical School, Norfolk, VA

Shirley Riley, MA, A.T.R., MFCT
Loyola Marymount University, Los Angeles, CA

Irene Rosner David, MA, A.T.R.-BC
Bellevue Hospital Center, New York, NY

Patricia St. John, EdD, A.T.R.-BC
College of New Rochelle, New Rochelle, NY

Nancy M. Sidun, PsyD, A.T.R.
The Chicago School of Professional Psychology, Chicago, IL

Evelyn Virshup, PhD, A.T.R., MFCC
California State University, Los Angeles, CA

Judith Wald, MS, A.T.R.
New York Hospital - Cornell Medical Center, White Plains, NY

AATA President
Virginia Minar, MS, A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

VOLUME 13

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 3, 1996

Editorial

Introduction to the Special Issue on Art Therapy & Education — Cathy A. Malchiodi, MA, ATR, LPAT, LPCC 162

Commentaries 164

Articles

Art Therapy as a Profession: Implications for the Education and Training of Art Therapists — Holly Feen-Calligan, MAT, ATR-BC 166

The Art in Art Therapy Education: Where Is It? — Linney Wix, MA, MEd, ATR, LPAT 174

In the Service of Children: Art and Expressive Therapies in Public Schools — Michele Essex, MA, LMHC; Karen Frostig, MEd, ATR, LMHC; and Julianne Hertz, MA, ATR, LMHC 181

An Interview with Don Seiden — Randy M. Vick, MS, ATR-BC 191

Brief Reports

Are Art Therapy Educators Overworked and Underpaid? — Harriet Wadeson, PhD, ATR-BC, HLM 198

A Reference Library for School Art Therapists — Sarah P. Hite, MS, MSEd, ATR-BC 202

Viewpoints

Art Therapists Exhibiting Children's Art: When, Where, and Why — Leslie P. Knowles, MA, ATR, LMHC 205

When the Edges Bleed... — Harriet Wadeson, PhD, ATR-BC, HLM 208

Reviews

Dreams and Memories — Andrew Yale, MPS 211

Telling Without Talking: Art as a Window into the World of Multiple Personality — Vija B. Lusebrink, PhD, ATR-BC, HLM 211

Soldier's Heart: Survivors' Views of Combat Trauma — Kathleen Lovenbury, MA 213

Dance and Other Expressive Art Therapies: When Words Are Not Enough — Carolyn Johnson, MA, ADTR, LMHC 214

Video Review: Drawing from the Fire — Lizabeth Flanagan, MA, ATR 215

About the Cover: "Kinder Garden," mixed media installation, by Joan E. Bepler, MA, MFA, ATR. "The photograph shows an interior view of the installation, which was part of a recent exhibit at the Vermont College T. W. Wood Gallery. In the work I addressed issues of cultural and personal origins, self and other, memory and consciousness, loss, burial, and renewal. The piece was available for participants to playfully interact with, engaging in the process of change and recreation in a quiet, enclosed space. Research in preparation for the work included readings related to the nature of consciousness, loss, and Jungian sandplay therapy." (photograph: Terence Falk)

Editorial

Introduction to Special Issue on Art Therapy & Education

Cathy A. Malchiodi, MA, ATR, LPAT, LPCC, *Editor*

Recently, *Art Therapy* put out a call for submissions on art therapy and schools, including applications of art therapy within school settings, and research, ethical, and professional concerns in providing art therapy services within educational milieus. In response to this call, the Journal also received many submissions exploring topics related to art therapy education and training. This issue of *Art Therapy* addresses some of the questions and concerns facing art therapy education in the 90s, including the following: the development of art therapy as a professional field and implications for education and training of art therapists (Feen-Calligan); a survey of educators on the inclusion of art in art therapy education (Wix); and a survey of the salaries and workload of art therapy educators (Wadeson). Three articles consider topics salient to the training of art therapists for work in schools: collaboration among training programs, public school systems, and community mental health agencies (Essex, Frostig, & Hertz); publications useful in training school art therapists (Hite); and an examination of ethical dilemmas in the display of children's art in school settings (Knowles). Also included in this issue is an interview with a prominent art therapy educator, artist, and art therapist, Don Seiden (Vick).

Several important and provocative topics directly related to the health and well-being of the field of art therapy are explored in this issue of the Journal. In "Art Therapy as a Profession: Implications for the Education and Training of Art Therapists," Feen-Calligan compares art therapy's development as a profession to three related professions: medicine, social work, and psychology. The author explores how these professions evolved, developed curricula reflective of their fields, established professional standards, and eventually created requirements to practice (requirements for competency through educational standards, certification, and/or licensure), while examining the parallel process of art therapy and its development as a profession.

From her investigation of the fields of medicine, social work, and psychology, Feen-Calligan concludes that art therapists can learn four "lessons" from these fields' professional development. The first lesson she describes may be one of the most difficult for art therapists to embrace: internal consensus, an agreement among the profession on the criteria for belonging to the profession. For example, Feen-Calligan specifically notes that art therapists have had difficulty forming a consensus on issues of certification. This lack of internal consensus is also markedly apparent in the variety of models and definitions of art therapy within the profession. This diversity has created difficulties in agreement on standards of practice, ethics, educational requirements, and certification, and has also made it difficult for the professional association to define art therapy's own unique scope of practice.

Feen-Calligan also notes that legitimacy, demand, and education are three additional issues that art therapy must address in order to progress as a profession. Legitimacy involves defining the service that one provides, as well as doing so with a level of competence. Feen-Calligan cites licensure and research as important to attaining legitimacy, noting with regard to the latter that medicine, social work, and psychology have all had to prove themselves through empirical data. Research may be an area of legitimacy that will continue to be problematic for art therapists because of the inherent difficulties of quantifying art expression and creative process and the profession's resistance and/or lack of inclination to do research within the field.

There also must be a demand for art therapy services. Demand, as noted by Feen-Calligan, is directly related to legitimacy and recognition. She notes that within social work, psychology, and medicine, the numbers of practitioners and status of the profession increased in relation to the market's demand for services. In the case of art therapy, clients may see art therapy as a legitimate service and valuable to their treatment, rehabilitation, or recovery, thus creating a demand; unfortunately, art therapy is not always in great demand (or seen as legitimate) by prospective employers (e.g., hospitals, clinics, and other healthcare agencies). Art therapists often must create demand for their services through educating, volunteering, or marketing their skills through workshops and in-services. The profession of art therapy perhaps, however, can take comfort from Feen-Calligan's observation that the professions of social work, psychology, and medicine were also not in great demand at the beginning of their development and had to demonstrate their worth to both consumers and employers in similar ways.

Lastly, the author notes that education is a factor in the growth of a profession, particularly flexibility of curricula to train practitioners to meet the changing needs of the job market and society. Whether or not art therapy training is evolving to meet the challenges of healthcare in the 90s is hard to determine. Training programs are currently struggling with difficult decisions about what to include in their curricula, ways to educate students for viable employment, and how to address requirements for licensure in their programs. From her study of other professions, Feen-Calligan notes that in order for art therapy to grow as a profession, art therapy education should be broadly based and be inclusive of current trends in the job market, healthcare, and society.

In relation to the question of what to include in art therapy training, in "The Art of Art Therapy Education: Where is It?" Wix asks the perennial question of "Where is the art in art therapy training?", a question that has resurfaced within the profession over the last two decades (Ault, 1977; Malchiodi, 1993; Malchiodi, Allen, & Cattaneo, 1991; Malchiodi, Cattaneo, & Allen, 1988). She emphasizes the consequences of the exclusion of artmaking and studio experiences in art therapy training:

> I have too often observed the artwork of the art therapy intern, the art therapist, and the patient being left behind in service of the well-trusted and well-known "talking cure." This leaving behind of a deep dwelling place in art and the imagination leaves behind what I understand to be central to the profession of art therapy. This particular dwelling place is essential, I believe, to the inner landscape of the art therapist.

To attempt to understand how and if art therapy educators included studio art experiences within their training programs, Wix conducted a survey of art therapy educators to see how many included art studio requirements in their curricula, particularly a studio requirement in conjunction with internship. One interesting trend which emerged from Wix's survey underscored the importance of environment in which art therapy training took place, indicating that training programs housed in art or art-related departments (as opposed to those programs housed in non-arts-related departments such as psychology, education or health, or independent) were more likely to have studio components in their curricula. This implies that the department or place in which training programs are situated may have an important influence on the availability of space for studio work and may play a significant role in whether or not art is a core component of art therapy training. Wix's research also brings to question art therapy educators' responsibilities in providing their students with studio art experiences and the profession's overall commitment to the importance of art in the training of art therapists.

Both Feen-Calligan and Wix raise provocative questions about the field of art therapy in terms of its direction, evolution, and overall vitality. Feen-Calligan underscores what the profession of art therapy may need to consider in order to continue to grow and meet the ever-changing needs of art therapists in training and individuals in the healthcare system art therapists seek to serve. Wix's exploration once again raises an important question about the role of art in art therapy training and the ramifications of excluding or eliminating meaningful involvement with artmaking from art therapy curricula. Both authors bring to light some basic issues that the profession must recognize, explore, confront, debate, and resolve in order to continue to remain dynamic and progressive, and to sustain itself into the next century.

References

Ault, R. (1977). Are you an artist or therapist?—A professional dilemma of art therapists. In R. Shoemaker & S. Gonick-Barris (eds.), *Creativity and the Art Therapist's Identity: Proceedings of the 7th Annual AATA Conference* (pp. 53–56). Baltimore, MD: AATA.

Malchiodi, C. A. (1993). Is there a crisis in art therapy education? *Art Therapy: Journal of the American Art Therapy Association, 10* (3), 122–128.

Malchiodi, C. A., Allen, P. B., & Cattaneo, M. (1991). *Art Therapy: Postmortem.* Plenary presentation at the 22nd Annual Conference of the American Art Therapy Association, Denver, CO.

Malchiodi, C. A., Cattaneo, M., & Allen, P. (1988). *Where is the Art in Art Therapy? (or are we our own worst enemy?).* Panel presentation at the 19th Annual Conference of the American Art Therapy Association, Los Angeles, CA.

Editor's Note: A special issue focusing specifically on art therapy in schools will follow in the coming months.

Art Therapy is pleased to announce that we are now indexed in CINAHL (Cumulative Index of Nursing & Allied Health Literature), a nursing and allied health database which indexes over 900 medical, nursing, and allied health journals and is utilized as resource for medical literature throughout the world. Researchers can now locate information on articles published in *Art Therapy* on CD/ROM, magnetic tape, and in print form at libraries and online through the Internet.

Commentaries

Letters to the Editor

As a 34-year-old graduate student in art therapy, with strong roots in the feminist community, I was proud to have the Journal pay attention to these values. I was especially interested in Helene Burt's article, "Beyond Practice: A Postmodern Perspective on Art Therapy Research" (*Art Therapy*, Vol. 13, No. 1, 1996, pp. 12–19). I would like to further Burt's important message by bringing to light an important contribution to art therapy research informed by feminist theory overlooked by Burt: Maxine Borowsky Junge and Debra Linesch's article "Our Own Voices: New Paradigms for Art Therapy Research" in *The Arts in Psychotherapy* (Vol. 20, No. 1, 1993, pp. 61–68).

Burt's ability to integrate the dichotomy among hard and soft research pays credence to the feminist value of supporting differences without "either/or" thinking, moving art therapy away from this lineage in our history. I feel fortunate for the graduate training I receive in which dichotomous thinking is discouraged and where we are supported for integrating a variety of approaches in our identity as art therapists. Research is not separate from our clinical identity, and artmaking is integrated into every clinical class we have.

I went on to read with sadness a letter in the commentaries from a distinguished art therapist who was harsh in her way of correcting another art therapist. It was ironic to me that in this issue exploring feminism, I observed a continuation of the age-old battle of the division of support among women by means of critical name-calling in the face of error. This is what has kept women from achieving power together through the ages. I agree with Burt and Malchiodi that, indeed, we are a profession which has a naivety of feminist consciousness.

However, giving credence to the feminist motto of "the personal is political," my hope is that feminist values will integrate their way into our profession at the base first—how we treat each other as a members of the same group—before we begin to apply them at an academic and theoretical level.

Laura Miera
Los Angeles, CA

I applaud Helene Burt for her outstanding article "Beyond Practice: A Postmodern Feminist Perspective on Art Therapy Research" (*Art Therapy*, Vol. 13, No. 1, 1996, p. 12). It is courageous for any art therapist to reveal the biases in our field, and Ms. Burt's thorough research and witty writing accomplish this superbly.

A few points had strong resonance for me: Ms. Burt's debunking of the objectivity myth, her analysis of relational theory, and her reminder of "the basic principles of feminism—'the personal is political,' choice, and equalization of power" (p. 16). I find that these three principles are teachings for women and men as well. As a man who understands "the political nature of the personal," I realize that my role as an art therapist is to know who I am and be true to myself. I also realize that the way I practice art therapy is my *choice*, and that it is all right for some to disagree with me. Finally, I cultivate the attitude that I am not better than my clients, in order to "equalize power" during art therapy.

I am deeply moved by the words and images of Isabella. They show art therapy at a level that honors the sacredness of relationship between artwork, client, and therapist. I admire the level of refinement reached by Isabella and her art therapist, but I am not surprised by it because that is what happens when one takes the time, the care, and the attention to do image work.

This article, and others like it, are very significant because they create a more inclusive definition of professionalism in art therapy. Thank you, Isabella, for perseverating in bearing witness to the story in your artwork for 15 years, and thank you, Ms. Burt, for sharing your work with your peers.

Martin Perdoux, ATR
Chicago, IL

This is a comment on "Wrestling the Hydra or Can an Art Therapist Find Aesthetic Fulfillment in the Marketplace?" by Harriet Wadeson (Vol. 13, No. 1, 1996, pp. 57–60).

I was impressed by this article, considering the depth of problems, solutions, and choices put forth by the author. However, I was struck by her chagrin at the thought of art therapists becoming "counselors," or "something else."

It seems to me that this is a mute point, since I believe what art therapists do for their clients is indeed counseling. The AATA clearly takes the stand, as expressed in the definition of the profession published in the same issue of *Art Therapy: Journal of the American Art Therapy Association* as Ms. Wadeson's article, that art therapists will use their professional skills as a means of "reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, and increasing self-esteem." I insist that this is counseling!

According to my dictionary, the definition of *counselor* is "adviser." Art therapists do give advice! *Counseling* is defined as "professional guidance of the individual by using psychological methods." We do that also. *Counsel* (noun) is defined as "advice given as a result of consultation." Surely the art therapist's method of utilizing "patient/client responses to the created products," another part of the official definition of our profession, would have to be termed consultation.

I see no problem with considering an art therapist a counselor—I merely see another example of bickering about professional terminology. "Art therapy vs. art as therapy" is the first example I encountered when I entered this field 10 years ago; and it still does not make sense to me to argue about terms. We do what we do because we know art works therapeutically in many ways. We are skilled in using created art products to effect change and improve the quality of life for our clients.

These goals are important to many mental health professionals, no matter what their titles may be. If a small group of art therapists cannot get licensing in their state because they cannot afford a lobbyist, but can get licensing under the title of Family and Marriage Counselor, Mental Health Counselor, and so forth, then I believe that is the way to go. After they are licensed, they may continue to do the work we all know has value for so many troubled people—people for whom verbal therapy alone does not work.

Why not add other titles to "art therapist"? We know what we are, as Ms. Wadeson said, and we can always make that clear in any work environment.

It would lighten my heart to see the seasoned professionals in the art therapy field become less involved in semantics and more involved in the practical ways of getting on with our jobs.

Sheila Pite, ATR
Orange, CT

COLLEGE OF NOTRE DAME

OFFERS:

- Master of Arts in Art Therapy (37 units)
- Master of Arts in Marital & Family Therapy (50 units)
- Post-Graduate Art Therapy Certificate Program (21 units)

- Systems & Jungian oriented art therapy
- AATA-approved Master's Programs
- MA in Marital & Family Therapy meets California state requirements for MFCC licensure
- Afternoons, evenings & weekends
- Summer Program

Art Therapy Program
COLLEGE OF NOTRE DAME
1500 Ralston Avenue
Belmont, CA 94002-1997

For program specifics call
(415) 508-3556

For an application call
(415) 508-3523

LOCATED IN THE BEAUTIFUL SAN FRANCISCO BAY AREA

Art Therapy: Journal of the American Art Therapy Association, 13(3) pp. 166-173 © AATA, Inc. 1996

Art Therapy as a Profession: Implications for the Education and Training of Art Therapists

Holly Feen-Calligan, MAT, ATR-BC, Detroit, MI

Abstract

The reciprocal relationship between art therapy practice and education has been addressed by Wadeson (1989). Recently, others have speculated about the future of art therapy and art therapy education in light of today's social, political, and economic climate (see *Art Therapy: Journal of the American Art Therapy Association*, Vols. 1, 2, 3, 4). This article explores the question, "What should art therapy education comprise in order for our profession to remain vital?" The question is addressed by observing patterns in the development of related professions and professional education. Three professions—medicine, social work, and psychology—are examined. Four lessons for the art therapy profession that seem apparent upon analysis of these professions are outlined. This article attempts to contribute to the discussion of the direction necessary for art therapy education.

Introduction

The 25th anniversary of the American Art Therapy Association (AATA) in 1994 stimulated reflection about the history of our profession and speculation about what the future holds. Junge and Asawa (1994) write that attention to the past can provide important messages for the future, and they note similarities between the development of the professions of art therapy and social work. This article extends the examination of the social work profession by also examining other professions to identify certain patterns of growth occurring whenever new occupational groups form. Attention is given to the development of three professions—social work, medicine, and psychology—because of their similarities to art therapy. Because education is critical to the viability of new professions, the influence of societal changes on art therapy education is elucidated. The article concludes with some thoughts about how art therapy might learn from the experiences of other professions in terms of establishing professional legitimacy and preparing new practitioners.

The Development of Professions

Professions are a phenomenon of the modern world, developing from changing conditions in the larger society (Elliott, 1972; Haskell, 1977; Metzger, 1987). A profession is defined as having a body of knowledge, a degree of autonomy in practice, a service ethic, a procedure to admit new members, self-regulatory power, and frequently a state-supported licensing system (Freidson, 1970; Metzger, 1987). Occupations seeking to establish themselves as professions claim the service they offer is valuable and vital to society (Elliott, 1972). Frequently, there is a sense of calling to a particular profession (Moore, 1970).

Elliott (1972) identified the process through which a profession is born. First, an occupational group is engaged in full-time work on a particular set of problems. A profession emerges as knowledge in a field increases and specialization develops (Ben-David & Collins, 1966; Elliott, 1972). The new professional group outlines its own position and for a time may face competition from overlapping occupations and professions (Ben-David, 1965; Elliott, 1972). A period follows in which the profession attempts to stabilize itself and to maintain a position in society (Wilensky, cited in Elliott, 1972). Training and selection procedures are later formulated, as well as a professional association.

The profession lobbies for public recognition and legal support for its control over entry and modes of practice. The profession then elaborates a formal code of ethics (Wilensky, cited in Elliott, 1972). Elliott (1972) notes that professions having a substantial body of knowledge are better able to convince society of their value. The profession's responsibility for interpreting that body of knowledge is an important aspect of its autonomy.

Ben-David and Collins (1966) write that the growth of the scientific disciplines can be represented by an S-shaped curve. The ideas necessary for the creation of a new discipline are usually available over a relatively long period of time, in several places, but only a few of the potential beginnings lead to growth. Growth occurs when there is interest in the new idea, when conditions exist for a new role to develop—usually an opportunity for a new occupation—and with the existence of networks making new ideas into cumulative processes. "Ideas beget ideas until the time is ripe for a new and coherent system of thought and research to arise" (p. 451). There follows a spurt of activity until a plateau is actually reached.

The Rise of the Professions of Social Work, Medicine, and Psychology

Professional Social Work

Early social work evolved from charity organizations in the 19th century whose work involved friendly visiting and character reformation of the poor (Lubove, 1965). In the 20th century, problems of social control and economic deprivation intensified due to urbanization and industrialization. The magnitude of the charity workers' task began to call for greater organization and technical skill than they were able to provide. Charity workers, or caseworkers, as they began to call themselves, believed they had the beginnings of a scientific knowledge base, as well as specialized skill acquired by experience and formal education (Lubove, 1965).

Dr. Richard Cabot introduced one of the first casework specialties, medical social work, to Massachusetts General Hospital in 1905. As an outpatient physician, Dr. Cabot had no time to deal with anything but the patient's physical symptoms. He observed that patients could be cured physically but once they returned to poverty, poor food, and filth, illness recurred. Cabot hired social workers to overcome the hospital's isolation from the social roots of the disease and to ensure a full and accurate diagnosis, taking into account the patient's social and environmental situation (Lubove, 1965).

Many of the first social workers were female nurses who were very familiar with hospital routine, physicians, and sickness. These nurses set about to emphasize casework as their special function, which had as its aim to "release the energies of the individual in the best direction possible" (Lubove, 1965, p. 31). The new casework profession was elevated in status from nursing, for caseworkers or social workers worked in tandem with physicians, not subordinate to them. In the first two decades, medical social work ". . . depended on the prestige and power of sympathetic physicians and administrators" (Lubove, 1965, p. 30).

In the early days, social workers were confused with occupational therapists, nurses, mental testers, and "neighborliness." Psychiatry strengthened social work's position in the 1920s and more clearly defined its role. Stressing the probability of multiple causation in delinquency and dependency and the need for comprehensive physical, mental, and social examination, psychiatry paralleled social work in the evolution toward differential casework. Psychiatry and social work were developing a theory of the individual as being a product of his or her environment. Medical social work practiced in the hospital provided the proper environment and resources with which to do research. A crucial development between 1880 and 1930 was the emergence of the belief that social work was heading toward a scientific understanding and control of behavior and at the same time clarifying its distinctive social function (Lubove, 1965).

In the early 1900s, the first psychiatric hospitals and psychiatric units in general hospitals were established. Of interest to art therapists was an experiment undertaken at Massachusetts General Hospital in 1907. A teacher of clay modeling, Katherine Burrage, was added to the staff. Her salary was paid by the chief of neurosurgery who hoped her methods would arouse new interests and improve concentration and social consciousness among mental patients (Lubove, 1965).

Training to do medical social work initially consisted of apprenticeship programs in hospitals. The lack of standards in these programs, however, meant that an employer could not assume a minimum competence when hiring a medical social worker. In response, Dr. Cabot initiated a 10-month program at the Boston School of Social Work, which included supervised work at Massachusetts General, school lectures, and conferences. In time, any person desiring to enter hospital social work needed to meet specific educational requirements, as the education of social workers progressed from specialized apprenticeships to professional education in universities.

In 1918 the American Association of Hospital Social Workers (AAHSW) was founded. The purpose of the organization was to insure a minimum standard of competence, to establish a code of conduct, and to avoid unreasonable exclusiveness. In the absence of any state licensing system, the AAHSW could only indirectly control standards of technical competence and inculcate professional norms through its own membership requirements. In 1918 this was difficult given the shortage of social workers and wide variation in hiring practices. Thus, the association was fairly powerless to exclude anyone from doing social work. As time went on, however, the membership requirements were raised. The AAHSW restricted membership to paid workers and encouraged professional education in schools of social work with internships or through approved alternate educational careers. Later, other specialized factions formed their own professional associations, such as the Association of Visiting Teachers and the Psychiatric Social Workers. The American Association of Social Work (AASW) was born in 1921, the first national organization encompassing all the various social work associations (Lubove, 1965).

The emergence of professional organizations paralleled the establishment of professional social work schools. The leadership of one school—The Chicago School of Civics and Philanthropy (later part of the University of Chicago)—seemed to have particular significance to the growth of social work. Professors Edith Abbott and Sophonisba Breckenridge, experts in child welfare and labor legislation, believed social work's future as a profession depended on the school's ability to produce administrators equipped to handle broad problems of legislation and community welfare. Prior to this the emphasis in social work education had been on casework, technique, and field work. Abbott and Breckenridge argued that such training produced technicians but not scientific persons and that an understanding of public welfare administration, social research, law, and social insurance should also be part of the curriculum. In 1932 the Association of Social Workers adopted standards for education. The standards required courses in casework, community organization, group work, social work, public welfare administration, child welfare, problems of labor and industry, social statistics, research, legislation, and the legal aspects of social work (Lubove, 1965).

Medicine

Prior to the 19th century the medical profession was a weak and economically minor profession (Starr, 1982). Advancements in science legitimized medicine so that physicians could increasingly deliver what they said they could, thereby strengthening their authority. The power the profession enjoys today originated in the dependence of others on the knowledge, competence, and authority of physicians whose skills were valued and needed by society (Starr, 1982). The development of medicine into a full-fledged profession was not a smooth progression, however. It involved the interaction of a number of variables including changes in society, medical schools, medical societies, licensure, and protective medical legislation (Freidson, 1970; Starr, 1982).

Societal changes in the 19th century created a market for medicine that had not been in existence previously. At that time the care of the family was left to women who relied on relatives, neighbors, and lay practitioners for remedies and cures in the case of illness. Physicians were called on only in emergencies. With the rise of industry, the increase in employment outside the home, and the decrease in family size, people were not as available as they once were to care for their sick family members.

Industrial society also indirectly cut the cost of medicine. In the past, it was not uncommon for a whole day's work to be lost in search of a physician. When families were able to produce less of what they needed to live and when paved roads were built making travel more feasible, the use of physicians increased. The growth of general hospitals and mental hospitals also served to bolster business for physicians (Starr, 1982).

During the colonial period apprenticeship served as the principal source for training. Although a certificate of proficiency could be earned by apprenticing, a degree granted authority. The first medical school was chartered in Philadelphia in 1765. After the War of 1812, medical schools quickly grew in number. Typically, the initiative for the medical schools came when a group of doctors approached a local college to offer a medical degree. Physicians felt colleges would lend legitimacy to their enterprise and provide the legal authority to grant degrees. From the college's perspective, the medical school meant added prestige without any investment, since the schools were all self-financed by students' tuition (Starr, 1982).

Despite these efforts many problems existed in medical education. Originally medical colleges granted bachelor's and doctoral degrees in medicine. However, since the bachelor's degree was sufficient for practice, many students who received the bachelor's degree never returned to complete the doctoral degree. As a result, the bachelor's degree was dropped with only one course for that degree retained as a prerequisite for the doctoral program. Thus, as the degree was elevated, the requirements for entering a medical doctorate program were reduced. Another problem of medical education was that physicians could start their own schools, and many did so, without regard for established medical education standards (Starr, 1982).

Licensure laws calling for the examination of doctors had been in existence since 1760, but for a long time these were ineffective. There were no penalties imposed for practicing without a license. "The collective interest of practicing physicians was to keep entry into the profession restricted, but the particular interests of the doctors involved in medical education and licensing conspired to keep the field open" (Starr, 1982, p. 45). At this time one could enter the medical profession either through a medical society by virtue of a license, or through a university once having been awarded a diploma. Therefore, neither medical societies nor university medical programs held definite authority. The medical societies had a fundamental problem: If they maintained high standards, their membership would be small; if they opened themselves up to large numbers of practitioners, they would need to sacrifice high standards. Eventually licensing would be granted only to those graduating with a medical doctorate degree, but this was still decades away (Starr, 1982).

In 1846 the American Medical Association was founded to raise and standardize the requirements for the medical degree and to keep unqualified physicians from practicing. Still, sectarian groups in existence advocated nontraditional education and had no interest in standardizing medical education. One strong sectarian group were the homeopathic physicians led by Samuel Hahnemann (1755–1843). Because the philosophical and experimental nature of homeopathy was embraced by much of the public, traditional medical degree programs began adding homeopathic specializations to their curriculum. With time, however, the nontraditional groups lost their strength and, in fact, were strongest when they were needed by the traditionally educated physicians to promote the medical profession as a whole (Starr, 1982).

By the 1880s a licensing movement existed nationwide, reflecting the circumstances of society at that time. The movement applied not only to physicians, but also to any group wishing to seek licensing protection. There was little opposition to licensing, since anyone in a respectable business could qualify to be licensed under the statutes. The primary opposition to licensure in medicine came from within the ranks (Starr, 1982). Much of the opposition had to do with the fear that licensing would impede freedom of research. For example, William James, a respected Harvard physician and professor, argued that Christian Science "mind curers" had the right to experiment with their new modes of therapy (Starr, 1982).

While licensing had the desired effect of limiting the numbers of doctors, the supply still outweighed the demand, and the AMA was unable to effect much change in the area of its original mission, medical education. Therefore, the Council on Medical Education was initiated by the AMA to establish minimum requirements. In time two schools, Harvard and Johns Hopkins, significantly raised their requirements (and their tuition). Other schools followed this lead. Ultimately, an emphasis on research and internship training and higher standards for medical practice stabilized medical education (Starr, 1982).

Psychology

In what will sound familiar to art therapists, the earliest beginnings of psychology are said to reach back to prehistory (Ben-David & Collins, 1966). Explanations of human thought and behavior can be found in every language. In the case of psychology, originally there were two types: speculative philosophy and physiology. During the late 18th and early 19th centuries, Darwin and other evolutionary theorists influenced consideration of the evolution of the mind and the relationship between the mind and the body (Stern, 1965).

A new group among the psychologists emerged primarily in Germany with the work of Wilhelm Wundt and Carl Stumpf. Conditions in Germany allowed for the effective network for communication of new ideas and a commitment to the new field and new roles (Ben-David & Collins, 1966; Stern, 1965). Psychology did not exist as a separate discipline in the United States until after 1870 (Stern, 1965). In this country, the study of the mind remained within a small realm of metaphysics (Stern, 1965).

The growth of psychology in the United States can be largely attributed to its being part of the curriculum at the prestigious educational institution of Harvard. William James was the first to teach psychology at Harvard beginning in 1875, first under the auspices of anatomy and physiology, then under philosophy. As a medical student, William James had spent a year in Germany in 1867, where he had become interested in approaching psychology in a scientific rather than a speculative manner (Stern, 1965). The opportunity to teach psychology came following a Board of Overseers report that Harvard's curriculum did not reflect the new views espoused in Europe at that time.

A highlight of James' tenure at Harvard was his origination of a laboratory in which students could engage in hands-on empirical research. "By the fall of 1875 James realized that experimentation; removal of religious, metaphysical, and logical terminology; and the need for specialists as instructors were the primary requisites for the success of psychology as an independent science" (Stern, 1965, p. 185). In 1878 the first PhD was awarded at Harvard in philosophy and psychology. The years between 1886 and 1890 were tremendous growth years for psychology at Harvard in which many new specialists were added to the faculty, presenting different views on the same subject.

Higher Education and the Professions

As is evident in the previous examples, a critical aspect of the stabilization of a profession is the education of new professionals. Generally, professional education evolved as requirements were added to apprenticeships. During American colonial years, doctors, lawyers, clergymen, and others began accepting several students to train as a group, and eventually the groups became proprietary or professional schools (Brubacker & Rudy, 1958). At first neither the apprenticeship nor the new "professional school" was able to provide all that was required in the way of professional preparation. What seemed lacking was a combination of academic study and practical application. Eventually professional education became the responsibility of higher education. It was felt that preparation through a degree program ensured a level of competence (Brubacker & Rudy, 1958).

Yet the inclusion of professional education in higher education raised another question: What is the purpose of higher education? Should the aim of higher education be the pursuit of truth, as Aristotle, John Henry Newman, and others advocating classical or liberal education would have us think? Or, should higher education be concerned with the preparation of students for their life's work, as those championing vocational education would assert? (Brubacher & Rudy, 1958; Pelikan, 1992). This long-debated philosophical dilemma may shed some light on the question, "What should art therapy education entail?"

Others argue that good professional education is comprised of both theory and practice (Sandalow, 1988; Zuber-Skerritt, 1992). The evolution of psychology, social work, and medicine would seem to support the inclusion of research in the professional curriculum, as well. Moreover, the viability and growth of a profession require not only skilled technicians and researchers, but also an understanding of the larger picture, the interface of the profession with society, as evidenced by social work's eventual need for schools to train administrators equipped to handle broad problems of legislation and community welfare.

Sandalow (1988) explains, "The proper object of a graduate education . . .is not merely to equip students for the 8 or 10 or 12 hours a day in which they will be performing in professional roles, but to assist them in developing character traits, intellectual skills, and an understanding of the world that will enrich their lives and enhance their capacity to act as moral beings" (p. 14). Graduate education is disciplinary education. Understanding a discipline entails not only the ability to work with its components but to work independently of them. Intellectual skills and other education are not necessarily brought into graduate study as courses but instead develop as study proceeds. They are developed through a process that is intrinsic to acquiring an understanding of a discipline. Specialized education does not need to be narrow. It depends on the types of questions asked—whether the questions are those of a discipline that has turned inward upon itself or whether they reach outward toward an understanding of the world (Sandalow, 1988).

Levi (cited in Pelikan, 1992) agrees that the professional school must be concerned in a most basic way with the world of learning and the interaction between this world and the world of problems to be solved. For example, Levi states a law school needs to be a part of a university so as not to lose connection with people. Pelikan (1992) added that to qualify as a profession an occupation must involve some tradition of critical philosophical reflection. There also must exist a body of scholarly literature in which such reflection has been developed and debated. The university is possibly the only place in which reflection and debate such as this can be cultivated (Pelikan, 1992).

Art Therapy: The Profession and Education

Early Education

The Morrill Act of 1862 provided federal assistance to the states for education in agriculture and the mechanics arts (Brubacher & Rudy, 1958). Although not specifically mentioning fine arts, it opened many possibilities for experimentation and helped to shift the concept of higher education toward the preparation of professionals. Many "land grant" colleges were founded with departments of music and art and the emphasis on the practice of art (Ackerman, 1973).

The training that was considered appropriate for women in the early 19th century was centered in the arts (Ackerman, 1973). At Oberlin College, for example, women were admitted to a ladies' course in which classes in the arts replaced many of the ancient language requirements. The first art school affiliated with a university was founded at Yale in 1866. Although the art school remained independent from the college and did not offer degrees, it was open to women who comprised the majority of its students. By 1873 coeducational Syracuse awarded degrees in architecture, painting, photography, and engraving. Wellesley established a college of music in 1880, and Newcomb College (New Orleans) founded in 1886 offered a strong arts and crafts curriculum (Ackerman, 1973).

Until the later part of the 19th century the arts were excluded from higher education for men, since they were thought of as being merely ornamental (Ackerman, 1973). The exception was drawing, a subject typically included in engineering and agricultural curricula (Ackerman, 1973). It was not until the Victorian era that the arts in higher education were considered useful or professional (Ackerman, 1973). Junge and Asawa (1994) note that art therapy has been developed almost exclusively by women and view art therapy as a women's movement.

Art education studies in the early 1900s were concerned with the fundamental nature of the art experience, the relationship between art and life, and the impact of art on emotional well-being (McNiff, 1986). These ideas are closely allied with art therapy. However, when art education moved toward standard methods and away from the individual, this propelled the establishment of the art therapy profession (McNiff, 1986).

One view of the history and evolution of art therapy can be found in Junge and Asawa's *History of Art Therapy in the United*

States (1994). The authors note the emergence of group therapies, the advent of psychoanalysis, the human potential movement, trends in treating mentally ill persons in the community, and the ideas of progressive education and art education as contributing to the development of art therapy.

The first training opportunities in art therapy were offered through apprenticeships (McNiff, 1986). Those who desired to do the work of art therapists aligned themselves with a pioneer in the field. At the beginning of the formation of the American Art Therapy Association (AATA), there were a variety of educational approaches, such as apprenticeships and in-service hospital training that would lead to registration. When the AATA began to require art therapy education for registration, a number of clinical, institute, and academic programs were initiated (Junge & Asawa, 1994).

In 1967, Hahnemann Medical College and Hospital (now Hahnemann University) in Pennsylvania initiated a graduate training program in art therapy leading to a master's of science degree. The requirements consisted of completion of a 1-year didactic course, a supervised clinical internship, and a thesis project (Levick, Goldman, & Fink, 1967). An earlier graduate program in art therapy was initiated by Dr. Roger White at the University of Louisville; however, that program remained inactive until 1969 (Junge & Asawa, 1994).

At the time of the initiation of the program at Hahnemann, mostly artists were entering the field of art therapy. Myra Levick (1989), founder and director, argued that these artist-students should have a background in psychological theory prior to classes in art therapy techniques. At Hahnemann the psychoanalytic orientation was the basic theoretical construct of the program. Because art therapy was expected to become an integral part of mental health services, Levick felt it was important to think of art therapists as professionals "having the same moral obligations to the people we treat as any professional in the field of mental health" (1978, p. 138).

By the 1970s the AATA had developed guidelines for the education of art therapists that included both didactic courses and practicum experiences and recommended undergraduate work in art and psychology. The master's degree was the desired entry level into the field, though the AATA did not make this a requirement until much later (Junge & Asawa, 1994). The AATA grants "Approval" or endorses those graduate programs meeting the educational standards outlined by the Association (AATA, 1994). By 1992, 29 Approved master's degree programs were in place across the country, as well as numerous undergraduate and graduate courses (Baker, 1994).

Issues in the Training of Art Therapists

As a "hybrid profession" (Wadeson, 1989, p. 103) art therapy is impacted by changes in both the art and therapy fields. Changes in society and economics have changed the world of mental health care providers (Wadeson, 1989). Budget reductions are common in health care, insurance plans, and art departments in schools. Services are determined by what insurance companies will pay and often preclude art therapy (Riley, 1989).

Baker (1994) interviewed art therapists about the field's "growing pains." Pat Allen (cited in Baker, 1994) notes that due to the jobs that have become available in health care facilities, art therapists have focused on developing clinical skills while their art lags behind. Many art therapists are concerned that the more art therapy looks to the medical model, the further the field strays from the unique qualities art has to offer (Malchiodi, 1994). Miller (cited in Baker, 1994) agrees with the concern that rigid adherence to professionalization may undercut the focus on the artistic, creative side.

Art therapy positions in health care facilities frequently require a license in order for the facility to receive third-party payment for the art therapy service (Baker, 1994). Because there is no license for art therapy in most states, many art therapists have become social workers, licensed professional counselors, or psychologists in order to viably practice art therapy. At the same time, a growing tendency is for such professionals to incorporate art into their work, creating greater tension within art therapy. Many art therapists want to make sure they are known as artists who understand the process patients go through when creating a work and who make interventions via the art that nonartist psychologists couldn't possibly make (Baker, 1994).

The situation in California exemplifies what is happening in many states today (Wadeson, 1989). Until recently California art therapists could be licensed under the Marriage and Family Counseling Certification (MFCC). After the requirements were tightened a couple of years ago, art therapists could sit for the MFCC exam provided they had taken these classes: Human Growth and Development, Human Sexuality, Psychopathology, Cross Cultural Mores and Values, Theories of MFC counseling, Professional Ethics and Law, Human Communication, Applied Psychotherapeutic Techniques, Research Methodology, and Psychological Testing (Wadeson, 1989). Although art therapists can practice art therapy without the MFCC, they are not able to find jobs without that credential (Junge, personal communication, November 20, 1994).

Circumstances are similar in Michigan. One graduate art therapy program exists in the state and was founded in 1982. The program at Wayne State University applied for Approval by the American Art Therapy Association in 1993 and was awarded AATA Approval in 1994. In preparation for the AATA Approval process the curriculum was reorganized and revised. This process was rather lengthy, involving obtaining approval from the University's College of Education, Teacher Education Division, and Curriculum Committee.

Despite the new art therapy curriculum, pressures to change the curriculum again are coming from Michigan art therapists seeking positions in counseling and educational facilities (personal communication, Michigan Association of Art Therapy Executive Board, February 29, 1992). Prior to October 1993, art therapists were eligible to apply for the Licensed Professional Counselor Credential (LPCC), a credential presently recognized by insurance companies for reimbursement of counseling services. Since this date the requirements for the LPCC have been upgraded, requiring equivalent coursework to a master's degree in counseling. This change prohibits most art therapists from applying for the license if their only graduate coursework has been in art therapy (Michigan Board of Counseling, 4-23-91).

When the art therapy faculty was polled in the summer of 1995 about whether to offer a 60-credit interdisciplinary master's degree in counseling with an art therapy specialization (including all counseling courses needed for the LPCC), the majority responded, "Yes!" Reasons cited were the availability of jobs, third-party reimbursement, and strengthening the program's clinical component. Should this plan be carried out, the 41-credit art therapy master's degree program (MEd in Art Education, Art Therapy Variant) that presently exists would remain in place; however, continued interest in this program, if the proposed interdisciplinary program is initiated, remains to be seen.

Training shapes a profession, but influences upon the profession shape the type of training that is demanded by the market (Wadeson, 1989). Art therapy education today is struggling with the same questions faced earlier in our history. Should there be a "classical" education in the pursuit of "truth"? Should the education of art therapists consist of courses, regardless of whether they are related to art therapy as it was first practiced, that enable graduates to get jobs? Will the art therapy profession become a subspecialty of counseling or some other mental health profession?

Nancy Hall, past AATA Government Committee Chair, believes that for art therapy to be reimbursable, art therapy training will probably need a curriculum that is in line with that of counseling programs (cited in Baker, 1994). Wadeson (1989) believes the issue of third party payment is likely to encourage training of art therapists as specialists within other health care professions.

The AATA membership voted to initiate a national certification examination which was offered for the first time in November 1994. A certification exam is believed by many to be the next logical step to gain professional recognition, and eventually licensure and third party payment (Baker, 1994). In New Mexico, for example, the Counselor and Therapist Practice Act was signed into law in 1993, establishing the first independent license for art therapists (Baker, 1994). In order to practice art therapy in New Mexico, art therapists will now need to pass the national certification exam. "Reality states that those who are certified and licensed are going to get jobs, and most of us need jobs" (Good cited in Baker, 1994, p. 46). Certification is also thought to protect the public against incompetence.

Lessons from Other Professions

Art therapists may take comfort in the knowledge that as members of a developing profession, they are not alone in their concerns. Social workers likewise felt their profession had become dehumanized and had lost its compassion and enthusiasm (Lubove, 1965). Eduard Lindeman, a social work educator, feared that bureaucratization and professionalization had transformed the social worker from the "embodiment of sentiment" into the "symbol of technique" (cited in Lubove, 1965, p. 85). Although held in fairly high esteem by the public, social workers themselves "envied the lawyers, doctors, and engineers whose professional associations enforced standards of practice and codes of ethics, resulting in 'images of something definite in the public eye'" (Lubove, 1965, p. 128). Like art therapists, social workers felt their salaries weren't high enough, and that talent was being lost to other professions (Lubove, 1965).

Internal Consensus

The art therapy profession can learn at least four lessons from social work, psychology, and medicine. The first lesson concerns the internal problem of consensus (Starr, 1982). Members in the profession must agree on the criteria for belonging to the profession. Starr (1982) wrote that perhaps the greatest problem with establishing the collective authority of the medical profession in the 19th century arose within the ranks. "Internally divided, it was incapable of mobilizing its members for collective action or of winning over public opinion" (p. 80). Evidence of this discussion in terms of art therapy has arisen with questions concerning what should be on the board certification exam or even questions over the necessity of the exam itself.

Legitimacy

Second, the profession must establish itself as a legitimate one. Art therapists must be able to define the service they provide and to perform the service with competence. That is why research demonstrating the effectiveness of art therapy is so important. Both physicians and social workers had to demonstrate their skills in order for their professions to become recognized and grow. Advances in science contributed to the legitimacy of social work, medicine, and psychology. Social work advanced when it was perceived that the profession was heading toward a scientific understanding and control of behavior (Lubove, 1965). Traditionally educated physicians were respected as authorities, given the new expertise science provided them (Starr, 1982). Psychology developed when the study of the mind was empirically investigated (Stern, 1965). Licensure, once it was finally enacted by the medical profession, contributed to the legitimacy of that profession. To be licensed meant to be competent or legitimate. Medical licensure also strengthened the AMA by requiring participation in the organization (Starr, 1982).

Demand

Related to legitimacy is a third lesson: There must be a demand for the service the profession provides. As Starr (1982) explained, not until there was a market for medical services did the medical profession increase in numbers and status.

Education

The fourth lesson involves education. There is a reciprocal relationship between training and practice (Wadeson, 1989). Training shapes the way the profession will develop. In the United States, the profession of psychology developed in large measure because of the coursework in psychology at Harvard during the middle 1800s. The reformation of social work education to include courses in administration equipped social workers to handle broad problems of legislation and community welfare (Lubove, 1965). Although at present most creative arts therapists identify with clinicians, Johnson (1985) believes they should diversify to be administrators, researchers, lobbyists, and the like, minimizing dependence on other professions for their existence. Sandalow (1988) reminds us that specialized education need not be narrow and should inspire the asking of questions that reach outward toward an understanding of the world.

Art Therapy: The Future

Art therapy pioneers recently responded to the question, "Where will art therapy be as a profession in the next 25 years?"

Many of the pioneers interviewed predict there will a market for art therapy services, although the market may primarily be in nonmedical settings. Halfway houses and group homes, shelters, AIDS units, and programs for the elderly may be some settings in which a need for art therapy will exist (Kramer, 1994). The impact of changes in health care are difficult to predict, but art therapists will need to be prepared for changes in the pay-for-service by insurance provider system that is now in place (Wadeson, 1994).

To survive in the future art therapy will have to be known by others in health care and education as an essential service (McNiff, 1986; Wadeson, 1994). "Professions that survive with strength and purpose are those that address themselves to the needs of society rather than the more specialized interests of professionals" (McNiff, 1986, p. 42). If art therapists perceive themselves in adjunctive or secondary roles, they will have this destiny for their profession (McNiff, 1986).

Creative arts therapists need to identify their unique contributions and to articulate the new information art therapy can add to education or health care (Johnson, 1985). What is needed, therefore, is research demonstrating the authority and essential nature of art therapy.

In 1989 Wadeson predicted greater divergence in art therapy training programs. She recommended art therapy educators plan training for the kind of art therapist they will prepare. Training programs may identify themselves along a continuum of clinical, research, or administrative routes. Applicants would be able to acquaint themselves with the different orientations of each and there would be a common ground on which all can maintain balance. McNiff (1987) predicted the next growth area in the profession will be research and scholarship, serving both clinical practice and higher education. "Interdependence among the three is essential" (McNiff, 1987, p. 285).

This writer agrees with the sentiments of Johnson (1984) who feels the creative arts therapies have not developed in the 20th century by accident. They are the result of an historical process and serve some function for our culture now. Art therapists must grasp that function and find ways to realize it.

Conclusion

The emergence of the professions in the 19th century corresponded to societal changes. The development of the profession of art therapy followed a pattern of growth similar to other scientific disciplines. The struggles facing art therapy today are not unlike those faced by other professions. Art therapy may learn from several related professions as it strives to establish its legitimacy. In order for art therapy to survive, the profession will need to define its parameters and the service it provides. The service provided by art therapists must be perceived as essential to the needs of society and be rendered with competence. Higher education plays a role in the development of a profession, as professions seek to standardize the preparation of members. Art therapy might be wise to diversify its educational programs to train researchers, administrators, and lobbyists in addition to clinicians.

Editor's Note: Requests for reprints should be sent to: Holly Feen-Calligan, Wayne State University, 163 Community Arts Building, Detroit, MI 48202.

References

American Art Therapy Association (n.d.). *Education standards for programs providing art therapy education.* Mundelein, IL: Author.

Ackerman, J. S. (1973). The arts in higher education. In C. Kaysen (Ed.), *Content and context: Essays on college education* (pp. 219-266). New York: McGraw-Hill.

Baker, B. (1994, July-August). Art therapy's growing pains. *Common Boundary.*

Ben-David, J., & Collins, R. (1966). Social factors in the origin of a new science: The case of psychology. *American Sociological Review, 31,* 451-465.

Brubacher, J., & Rudy, W. (1958). *Higher education in transition: An American history: 1636-1956.* New York: Harper & Brothers.

Elliot, P. (1972). *The sociology of the professions.* Great Britain: Herder and Herder.

Freidson, E. (1970). *Profession of medicine.* New York: Dodd, Mead.

Haskell, T. (1977). *The emergence of professional social science: The American social science association and the nineteenth-century crisis of authority.* Chicago: University of Illinois Press.

Johnson, D. R. (1984). Establishing creative arts therapies as independent professions. *The Arts in Psychotherapy, 11,* 209-212.

Johnson, D. R. (1985). Envisioning the link among the creative arts therapies. *The Arts in Psychotherapy, 12,* 233-238.

Junge, M. B., & Asawa P. P. (1994). *A history of art therapy in the United States.* Mundelein, IL: American Association of Art Therapy.

Kramer, E. (1994). We cannot look into the future, without considering the past and present. *Art Therapy: Journal of the American Art Therapy Association, 11,* 91-101.

Levick, M., Goldman, M., & Fink, P. (1967). Training for art therapists: Community mental health center and college of art join forces. *Bulletin of Art Therapy, 6,* 121-124.

Levick, M. (1978). Quality in training. In L. Gantt, G. Forrest, D. Silverman, & R. Shoemaker (Eds.), Art therapy: Expanding horizons. *The proceedings of the ninth annual conference of the American Art Therapy Association* (p. 138). Baltimore: American Art Therapy Association.

Levick, M. (1989). Reflections: On the road to educating the creative arts therapists. *The Arts in Psychotherapy, 16,* 57-60.

Lubove, R. (1965). *The professional altruist: The emergence of social work as a career 1880-1930.* Cambridge, MA: Harvard University Press.

Malchiodi, C. (1994). Certification: In search of accountability. *Art Therapy: Journal of the American Art Therapy Association, 11,* 170-173.

McNiff, S. (1986). *Educating the creative arts therapist.* Springfield, IL: Charles C Thomas.

McNiff, S. (1987). Research and scholarship in the creative arts therapies. *The Arts in Psychotherapy, 14,* 285-292.

Metzger, W. (1987). A spectre is haunting American scholars: The spectre of professionalism. *Educational Researcher, 16,* 10-19.

Michigan Board of Counseling. (1991). *Administratic rules (#64-01-01).* Lansing, MI: Author.

Moore, W. (1970). *The professions: Roles and rules.* USA: Russell Sage Foundation.

Pelikan, J. (1992). *The idea of a university: A reexamination.* New Haven, CT: Yale University Press.

Riley, S. (1989). Change: The reality of the mental health provider's world in the 1990s. *Art Therapy: Journal of the American Art Therapy Association, 6,* 99-102.

Sandalow, T. (1988). The university and the aims of professional education. *Rackham Notes: Intellectual History and Academic Culture at the University of Michigan: Fresh Explorations.* (Available from Horace A. Rackham School of Graduate Studies, 915 East Washington, Ann Arbor, MI 48109-1070.)

Starr, P. (1982). *The social transformation of American medicine.* New York: Basic Books.

Stern, S. (1965). William James and the new psychology. In P. Buck (Ed.), *Social Sciences at Harvard 1860-1920* (pp. 175-222). Cambridge, MA: Harvard University Press.

Wadeson, H. (1989). Art therapy education at the crossroads. *Art Therapy: Journal of the American Art Therapy Association, 6,* 103-105.

Wadeson, H. (1994). Question: Will art therapy survive universal health coverage reform? *Art Therapy: Journal of the American Art Therapy Association, 11,* 26-32.

Zuber-Skerritt, O. (1992). *Professional development in higher education: A theoretical framework for action research.* London: Kogan Page.

CALENDAR OF EVENTS

1996

OCTOBER

The International Stress Management Association will conduct ISMA-6 on October 5-8, 1996 in Sydney, Australia in cooperation with several other organizations. For more information, call (619)635-4698, fax (619)635-4669, or e-mail: NOSTRESS@sanac.USIU.edu.

The 1996 Joint National Conference: National Association for Drama Therapy/American Dance Therapy Association announce "Crossing Borders and Expanding Visions: A Conference of Collaboration." The conference will be held from October 17-20, 1996 at the Loews Santa Monica Beach Hotel in Santa Monica, California. Call (203)350-1620 for more information.

NOVEMBER

The Society for Alternative/Complementary Medicine and Wellness in Health Care was created from the powerful and positive experience had by all that attended the National Conference on Alternative/Complementary Medicine in Allied Health Conference last year. This conference will be combined with the National Wellness and Health Promotion Conference to form the 4th National Conference on Alternative/Complementary Medicine and Wellness will be held in the Metro DC area in this Fall. Call (301)236-4614 or fax (301)236-4609 for more information.

The 27th Annual American Art Therapy Association (AATA) 1996 Conference "Many Paths; Multicultural Perspectives in Art Therapy" will be held on November 13-17, 1996 at Adams Mark Hotel in Philadelphia, Pennsylvania For more information call (847)949-6064.

The National Association for Music Therapy (NAMT) and the American Association for Music Therapy (AAMT) will hold a Joint Conference "Music Therapy: A Tapestry of Many Voices," on November 16-19, 1996 at the Opryland Hotel in Nashville, Tennessee. Call NAMT at (301)589-3300 for more information.

1997

FEBRUARY

The 6th Annual "Emerging Artists Competition" will be held in New York City at Slowinski Gallery's Mulberry Street exhibition space. The first prize is $1,000.00 and the deadline for submissions is October 30, 1996. Send a SASE for prospectus to Slowinski Gallery, 215 Mulberry Street, New York, New York 10012 or e-mail: slowart@aol.com. For more information call (212)431-1190.

Art Therapy: Journal of the American Art Therapy Association, 13(3) pp 174-180 © AATA, Inc. 1996

The Art in Art Therapy Education: Where Is It?

Linney Wix, MEd, ATR, LPAT, Albuquerque, NM

Abstract

The meaning and placement of studio components within art therapy education programs are explored in this article. The results of a survey of art therapy educators regarding the inclusion of art studio requirements in conjunction with internship in their educational curricula and the effects of including art in educational programs are discussed. Central to the discussion is the idea of place *for artmaking. Supporting the idea of place, a model studio component for interns in an AATA-approved art therapy education program is discussed with a focus on student responses to participation. The studio as a container for artmaking and art's potential to heal is examined in the context of nonsupportive educational, organizational, and practical settings.*

> *"It is art which makes life, makes interest, makes importance . . . and I know of no substitute whatever for the force and beauty of its process" (Henry James cited in Stevens, 1951, p. 169).*

Introduction

From the documentation of the first year of the Intern Studio Project (Wix, 1995) at the University of New Mexico (UNM) has evolved a second-year study that focuses on a developing body of research designed to study the effects of studio work on the education of art therapy graduate-student interns. The research is based in UNM's ongoing studio for interns.

Although I understand the meaning of research to include the idea of thorough investigation through systematic questioning, I cannot dismiss the etymological connection that " . . . *search* denotes 'going round in a circle'—for its ultimate source is Latin *circus* 'circle' . . ." (Ayto, 1990, pp. 464-465). By the time *circare*, "go round" reached Old French as *cerchier*, it had come to mean "'examining' or 'exploring'" (Ayto, 1990, p. 465). My use and understanding of research includes a "going round" in order to gain multiple viewpoints toward an experience, defined by Ayto (1990) as a "condition of having undergone or been affected by a particular event . . . " (p. 213). Hillman's (1975) writings discuss this process of event-deepening-to-experience as a quality essential to soul-making. Studio research requires multiple perspectives in its very nature of exploring the sensory-laden experience of giving precise form to feeling through the working of art materials with the hands. The studio process is naturally cyclical in its inclusive patterns of making and viewing, immersing and stepping back to see what has been made.

The word *study* comes from Old French *estudie*, from Latin *studium*, "eagerness, intense application," hence "application to learning." *Studio* derives from the same source via Italian and is also connected to *hit* (Latin *tundere*), the "application of extreme effort" (Ayto, 1990, p. 507). Based on these etymological roots, I understand the studio to be the home of "application of extreme effort" in artwork. Art derives from "an Indo-European root *ar-*, which meant 'put things together, join.' Putting things together implies some skill: hence Latin *ars* 'skill.'" (Ayto, 1990, p. 37). Thus it makes sense to me that the studio is the place for working with effort and skill to make an image that precisely depicts an emotion, an idea, or a state of mind. When studio serves as the place that houses image-making and when one believes, as Jung did, that image is psyche, then the studio has the potential to house soul-making through the "application of extreme effort" in artmaking.

Background

The Intern Studio (Wix, 1995) at UNM was developed out of the concern that students become too involved with the clinical aspects of art therapy relationships, resulting in art therapy practice that is more of a verbal-psychological model than an arts model. Allen, discussing the pressure to develop a clinical identity, states, " . . . knowing that clinical therapeutic skills may aid their stature in the work place and facing a dearth of genuine art therapy theory, educators usually fall back on trying to convey clinical expertise gleaned from established areas of psychology . . . " (1992, p. 24).

The Intern Studio provides a place in which multiple imaginations spawn in fertile ground. McConeghy (1995) states, "When an emotion is not held aesthetically within its image, the image is reduced in quality." Studio is where artists work in the eager, intense application of art skills to form that image which holds the emotion or idea. When the place, physical and psychological, for forming the work is missing, the image, left unformed, "is reduced in quality" (*Ibid*). Is it possible that the scarcity of art studio requirements amidst the dearth of genuine art therapy theory (Allen, 1992, p. 24) in art therapy education perhaps reduces the quality of the education? If knowing intimately about emotional holding through artmaking is basic to the practice of art therapy, then the educational setting seems an apt place to hone that skill. When studios therein are missing, the emotional holding through artmaking is difficult to realize in academia. McConeghy (1995) continues, stating, "Paying attention requires passion". It seems that the roots of passionate attention-paying to artmaking are naturally found working in the studio. To pay passionate attention to the artwork of clients we first must passionately pay attention to our own artwork.

As an educator, I am concerned about the lack of attention paid to studio as the place to house the "application of extreme effort" required in the making of art in art therapy education programs. I have too often observed the artwork of the art therapy intern, the art therapist, and the patient being left behind in service of the well-trusted and well-known "talking cure." This leaving-behind of a deep dwelling place in art and the imagination leaves behind what I understand to be central to the profession of art therapy. This particular dwelling place is essential, I believe, to the inner landscape of the art therapist.

Leaving behind art and imagination as mere residue for a somehow more important verbal model of therapy serves the fantasy of the superiority of the Euro-American medical model. An art therapy model that keeps art as its heartbeat, and the studio as container of that heartbeat, has the potential to serve the needs of patients, art therapy students, and art therapists in healing the imagination through both image-making and the images themselves. I maintain that an art-centered art therapy model is the only model that can adequately hold image and the imagination—and the studio is its natural home.

How is it that as art therapists we either lose, or are taught to lose, our inner, direct knowledge of the significance of art? Is it perhaps partially from the lack of available art therapy studio requirements and options in our educational programs? If artwork is not central to the education of the art therapist, then it will not likely be central to the intern's art therapy sessions. Further, if artwork is missing from art therapy sessions, then what marks us as *art* therapists? Placing art at the center of art therapy education is a matter of trust which comes from the awareness that the practice of art is the heartbeat of art therapy. This *placement* of art is an essential issue in the field of art therapy. Sticking with this metaphor of "field," is art what we graze on, the very food of art therapy? Is art the fence line, that which contains and forms boundary lines? In fact, art has the potential to be both of these things to art therapy. Art as field and as fence line in art therapy suggests the holding and digestion of "stuff" through image-making and images. "When going into the imagination, it seems one should keep close to the images . . ." (Hillman, 1975, p. 93). Likewise, when going into art therapy, it seems one should keep close to art.

Literature

Robertson (1963/1982) suggests that in being invited into " . . . imaginative participation" through the drawing or making of an object, " . . . an experience is transformed because we have made it part of ourselves. So, art is a way of coming to terms with experience. Here we are brought face to face with the mystery of the self, which is shaped in the act of shaping material things and created anew in the act of creating" (p. 107). She continues, "We must have faith in our own experience that art does re-create; and we can only have our faith renewed by making recurring opportunities for our personal re-experience of this" (*Ibid*).

Hillman (1975) speaks eloquently about what is pivotal to an art-centered art therapy attitude:

> Ideas remain impractical when we have not grasped or been grasped by them. When we do not get an idea, we ask "how" to put it in practice, thereby trying to turn insights of the soul into actions of the ego. But when an insight or idea has sunk in, practice invisibly changes. The idea has opened the eye of the soul. By seeing differently, we do differently. Then "how" is implicitly taken care of. "How?" disappears as the idea sinks in—as one reflects upon *it* rather than on how to do something with it. This movement of grasping ideas is vertical or inward rather than horizontal or outward into the realm of doing something. The only legitimate "How?" in regard to these psychological insights is: "How can I grasp an idea?" (p. 122)

The sinking in, the grasping of the idea of art's ability to re-create and to heal, happens through the art therapist's own "recurring opportunities for . . . personal reexperience" (Robertson, 1963/1982, p. 107) in artmaking. That is, the "how" in doing art therapy has the potential to be handled largely by art therapy interns' and practitioners' immersion in studio art experiences. Of course, this working-on-one's-own-art part of the "how" is only one portion of the art therapist's full education; currently, however, it is the part that is left behind in favor of imparting a particular psychological theory which is rarely image-focused and is often a "hodgepodge of clinical concepts" (Allen, 1992, p. 24).

Residing in the place of artmaking provides insights that can be learned in no way other than the direct experience of making art. How else can one grasp or be grasped by art insights than to set up residence in the place of making? In order to dwell in the place of art insight, more than an experiential exercise designed for use in art therapy coursework is needed. In coursework, the brevity, the boundary issues inherent in sharing psychic material in class, and the subsequent grade upon that work all contribute to the prevention of a deep dwelling. The "effort" is misplaced in experiential exercises; the intent in coursework is usually to learn how to use an exercise either to determine or further a patient's state of mind or health. In a studio context, the "effort" is on one's own artwork—always working toward precise communication of an emotion or idea through image. Thus, the studio component is necessary in art therapy education—to know through one's own experience with making and image, to know through one's own precise communication, in the studio, the place for "extreme application" in artmaking.

Kramer (1994) urges art therapists to seek part-time (rather than full-time) art therapy positions in order to maintain their own art practices. She insists that as art therapists we must "not lose our identity" and that we "uphold the laws inherent in making art" (pp. 91-92). She states,

> . . . when it comes to mobilizing this specific creative fervor, this passion, this energy that's in art, I can do an awful lot because it's in me and I can communicate it. I'm very interested in anything a person does that begins to look like art, that begins to look like it's taking shape, taking form, and communicating something, that it's not superficial and it's done with very profound involvement. It's done with passion. That passion has to be in you so that you can stimulate it in others. (McMahan, 1989, p. 112)

Art and image as deep dwelling place seems to be an attitude not held by the American Art Therapy Association (AATA). The AATA *Guidelines for Academic, Institute and Clinical Art Therapy Training* (1993) state, "Normally studio art courses are regarded as undergraduate prerequisites rather than as sources of graduate credit" (p. 5). In the revised *Education Standards* (1995) this statement is eliminated, and it is stated that art therapy education programs "must have regular access to . . . studio for working with art materials . . . [and to] studio art equipment and special supplies" (p. 6). This is the first evidence of the AATA's support for the inclusion of studio opportunities in art therapy education and may be a sign that AATA's attitude is changing. Evidence of art involvement in the form of slides is required neither for professional registration (ATR) nor for Board Certification.

Part I: Educator Survey

The research in process springs from a lesson I learned in my own work as an art therapy educator about the importance of maintaining a nonclassroom studio for the artmaking of art therapy students during their internships. Due to time and energy commitments for internship placements, as well as the clinical expectations of the agency, the intern's own artwork often receives little attention. Additionally, internship is a lonely time for art therapy interns; they tend to struggle with whether or not they must give up that which initially brought them to the field—art—in order to become art therapists. Working alone, in a private studio, often exacerbates the loneliness experienced at the internship site.

Method

To determine studio opportunities available to interns in educational programs, I surveyed art therapy educators. Because the research originated at UNM, its studio is not included in the research responses. The questionnaire used in this survey asked whether the program is graduate or undergraduate, what degrees are offered, and where the art therapy program is housed in the college or university. Topics covered in the questionnaire included whether or not the program has a studio component for interns and, if so, whether studio is required or elective, and if not, if there is a need for studio. Respondents were then asked for a description of the nature and purpose of their program's studio component and its effects on interns.

Results

The 59 questionnaires sent out generated a total of 32 responses (Table 1). Of the 24 responding graduate programs, eight indicated that they have a studio requirement in conjunction with internship, while 16 indicated no studio requirement in conjunction with internship (Table 2 is based on 24 graduate program responses). Four of the eight graduate programs responding in the affirmative are AATA-approved, four are not. Of the 16 graduate program questionnaires returned stating that they do not have a studio component, 10 are AATA-approved programs and six are not approved. While four of these 16 respondents stated a need for a studio component for interns, six stated that there is no need for studio in conjunction with internship in their programs. Two of these six discussed the inclusion of experiential exercises in coursework precluding the need for a studio component per se. Four respondents stating that their programs do not offer an intern-related studio stated that their students are required to take from 3 to 12 studio credits not necessarily related to internship during their graduate studies. One respondent in this category discussed her program's stocked studio which is available for students to use.

Table 3 (based on 24 graduate program responses) looks at where the studio is located in the art therapy education program. Six of the eight programs requiring studio involvement during internship are housed in art or art-related departments. Only three responding graduate programs that are housed in art or art-related departments do not contain a studio requirement. The only AATA-approved programs requiring studio involvement

Table 1
Type of Program by AATA Approval
(Based on 32 Total Responses—24 Graduate; 8 Undergraduate)

Program Type	AATA Approved		Not AATA Approved		Number & % of Respondents	
	Number	%	Number	%	Total Number	%
Graduate Program	13	40.62%	9	28.12%	22	68.75%
Undergraduate Program	0	0.00%	8	25.00%	8	25.00%
Graduate & Undergraduate Program	1	3.12%	1	3.12%	2	6.25%
TOTAL	**14**	**43.75%**	**18**	**56.25%**	**32**	**100.00%**

Table 2
Studio Component Requirement / AATA Approval
(Based on 24 Responding Graduate Programs)

Studio Component	AATA Approved		Not AATA Approved		TOTAL	
	Number	%	Number	%	Number	%
Required	4	16.67%	4	16.67%	8	33.33%
Not Required	10	41.67%	6	25.00%	16	66.67%
TOTAL	**14**	**58.34%**	**10**	**41.67%**	**24**	**100.00%**

Table 3
Program Placement / Studio Requirement for Internship
(Based on 24 Responding Graduate Programs)

Department	Studio Required		Studio Not Required		Total Programs	
	Number	%	Number	%	Number	%
Art/Art Ed/Art-related	6	25.00%	3	12.50%	9	37.50%
Independent	1	4.17%	4	16.67%	5	20.83%
Psychology	0	0.00%	3	12.50%	3	12.50%
Health/Medicine	0	0.00%	2	8.33%	2	8.33%
Graduate School/Education/ Continuing Education	0	0.00%	4	16.67%	4	16.67%
Other	1	4.17%	0	0.00%	1	4.17%
TOTAL	**8**	**33.33%**	**16**	**66.67%**	**24**	**100.00%**

with internship are housed in art or art-related departments. A total of 75% of the responding graduate programs with an intern studio requirement are housed in art or art-related departments. Only one independently housed graduate program indicated a studio component in conjunction with internship; that program is not AATA-approved. Interestingly, of the four responding AATA-approved, independently housed art therapy programs, none contains a studio requirement.

Three art therapy education programs responding in the affirmative described their required studio component as a 1-hour studio built into the internship/field experience courses; one of these studio hours consists of projects, themes, and methods to be utilized with clients, while another consists of artmaking periods in which interns respond to patient art with a focus on the interns' abilities to use their own art responses to understand patient art and countertransference issues. A studio component described by another responding program includes a materials and methods course focusing on "materials discovery and development" and results in a portfolio presentation at semester's end. One respondent stated, "Students say they feel more confident in their practicums as a consequence of practicing these techniques [in studio]." Another AATA-approved program offers two art therapy studio courses with a minimum of one required; these courses are designed to develop a repertoire of techniques to be used with patients. This particular program states, "Studio is a vital part of the program." Two respondents who work in programs offering studio in conjunction with internship also discussed studio requirements not connected with internship.

Only one program requires a studio that is devoted to the art therapy intern's own artmaking process. This particular studio distinguishes itself by the intern's self-determined artistic involvement in contrast to an intern's response to a patient's artwork or completion of a project. This mandatory course is required in conjunction with internship. It is described as an opportunity for "students [to] engage in self-directed study within a group studio environment" in which "an in-depth relationship with his or her artmaking is begun." This program with the self-determined studio component requires a portfolio as part of the candidacy review for upper-level coursework in art therapy. Comments on this studio requirement include this from an onsite supervisor—"The students understand art as the vehicle for change"—and this from an instructional supervisor—"The students' capacity to explore their art and the creative process as a vehicle for demonstrating mastery is one of the most valued outcomes [of studio involvement] . . . . Fluency in articulating the place of art in [the students'] work is evident in practicum, comprehensive exams and thesis."

Eight of the 32 total responses were from undergraduate programs, three of which described strong studio components requiring from 24 credit hours of art to "one-third of required coursework in studio." Six of those eight undergraduate programs are housed in art or art-related departments. One respondent stated that the studio component of the art therapy major at her college "serves to ensure that students have a thorough understanding of artistic principles . . . and the technical skills necessary to produce art. The studio experience will make the therapist more effective as she will have an in-depth understanding of the methods and materials of the artistic process."

Discussion

Clearly, the "home" of an art therapy program makes a difference in the program's attitude toward the inclusion of art studio requirements in the curriculum. This is most clearly indicated by programs where there is no studio component; only three (of 16) responding programs without an intern studio component are housed in art or art-related departments (Table 3). This may imply that programs housed in nonarts-related departments do not have studio space available to students; thus, there is no place for "intense application" when it comes to art. Studios are commonly found in art or art-related departments.

One of the interesting results of the responses from art therapy educators is the variety of definitions of "studio," ranging from its use in discussing countertransference toward clients and their artwork, to interns' responses to clients' work, to development of techniques to be used with clients, to self-directed personal artmaking. This varied definition of *studio* in art therapy education results in a variety of ways to include studio experiences in the education of art therapists; these range from required studio courses, to elective studio courses, to time set aside for artistic responses to patients' art, to encouraging students to make art at home. When no intern studio was offered, there were additional studio components, not connected with internship, required and elective, within programs.

Simply stated, there are neither guidelines nor requirements for the inclusion of art in art therapy education. Art's inclusion or exclusion appears to be determined by where a program is housed and by the attitude and approach of the educators. The high rate of exclusion of studio opportunities from art therapy education in general (and for interns specifically) indicates a certain lack of commitment on the part of educators to art as the heartbeat of art therapy. Just as an image is diminished in quality when it does not hold the emotion or idea aesthetically, perhaps art therapy education is diminished in quality when it does not hold art at its center. When art is not the heartbeat of art therapy education, it is not the heartbeat of art therapy—possibly indicating a lack of trust in art's ability to heal.

Part II: Intern Studio

UNM's Intern Studio Project (Wix, 1995) is grounded in a participant/observer research model (Beittel, 1972, 1973) where the participants and the facilitator/observer are all subjects in the process of being formed through the particular act of making art. Thus, as facilitator, I also participate in the studio. I find it difficult at times to be responsible for the functioning of the studio and also to be deeply involved in making my own art. I continue to struggle with this dual role, seeking to navigate the ground of facilitator while simultaneously finding ways to facilitate my full use of the term *studio* through my own artmaking efforts. Metaphorically, I hold the tension of dual placement, being in the field and standing at the edge as the fence.

Method

The Intern Studio is a studio option for graduate students in art therapy at UNM. Participating students do not receive academic credit for their involvement. They voluntarily attend a regularly scheduled studio that meets for 3 hours weekly on an academic semester schedule. The Intern Studio is designed particularly as a place for art therapy graduate students who are interning to pay attention to their own artmaking.

Interns choosing not to participate in the Intern Studio were surveyed to determine reasons for nonparticipation. Interns choosing to participate were surveyed at the beginning and at the end of a semester's participation to determine the desired effects of studio participation (prestudio) and the actual effects of studio participation (poststudio) on personal artmaking and on attitudes toward and performance in internship.

Results

Of six nonparticipating interns, three stated a time conflict or no available time as the reason for nonparticipation; two stated they work in their own studios; one stated "other" reasons.

Ten Intern Studio participants completed prestudio and poststudio questionnaires (described above) as well as a questionnaire to determine reasons for participation. Figure 1 depicts interns' stated reasons for Intern Studio participation.

Preparticipation. The first question on the preparticipation questionnaire was, "How do you expect Intern Studio participation to affect your own artmaking?" The following quotations are representative responses: "I hope to be inspired by artmaking of others . . . and look forward to the community influence on my artmaking; I want to develop painting skills; I hope to develop a

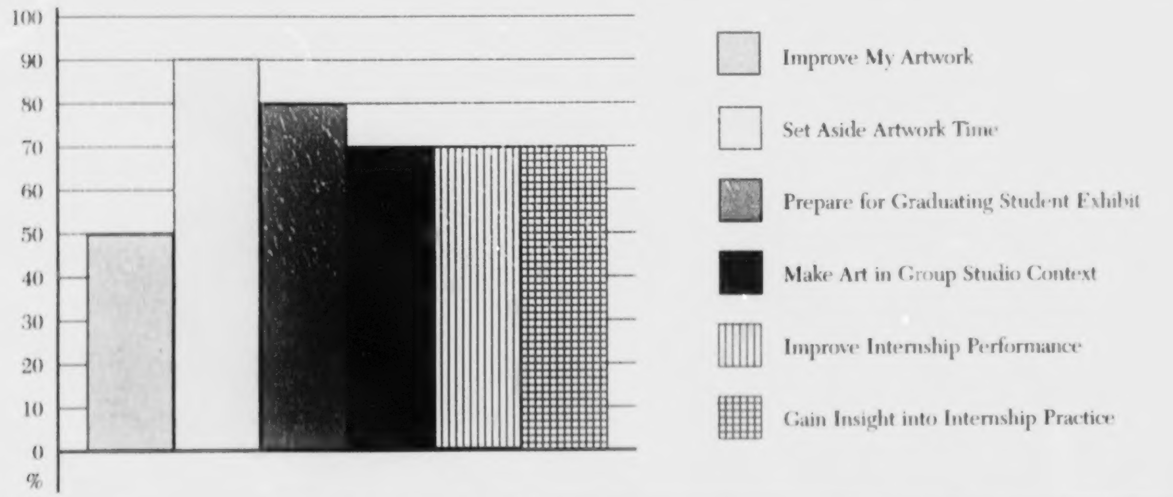


Figure 1 Intern Studio Participants: Reasons for Participating

deeper relationship with my inner self through my artmaking." "I'm looking forward to making art in a soul-supporting environment." "I want to participate to concentrate on *my* art . . . to make artmaking a more regular activity . . . to expand my definition of art."

The second question on the preparticipation questionnaire was, "How do you expect Intern Studio to affect your attitudes toward internship and performance in internship?" Again, a summary of intern responses follows: "I expect my work in studio to deepen my connection with clients through connecting more deeply with myself." "I count on studio to provide a place to reflect on internship experience." "I hope to understand through my own art process what I am asking of clients in their artmaking." "I want the studio to provide relaxation and an expressive outlet for internship stresses."

Postparticipation. Postparticipation responses were much more lengthy than preparticipation ones. Having experienced the studio, interns were able to speak at greater length and in greater depth regarding their experiences. On postparticipation questionnaires, all studio participants indicated positive effects of studio participation on their artmaking and on their attitudes toward and performance in internship. A summary of statements made by participating interns regarding the effect of Intern Studio participation on artmaking and internship attitudes and performance follows.

Regarding studio effects on personal artmaking, interns said: "Studio kept me connected to my own art and provided a stronger connection to my clients' processes." "Studio grounded me in my own art life in a way that grounded me in internship." "I recognized that art is the basic ingredient in art therapy." "Studio extended and strengthened ideas that the availability of a wide range of materials can stimulate and deepen art expression." "I was inspired by the work of others and felt supported in artmaking in this soul paradigm." "Studio reaffirms what art therapy is about—art." "Studio helped me encourage clients to stay with artmaking through learning to trust my own art process—even when it is difficult." "Without my own ongoing artmaking it was harder to engage clients in their artmaking and easier to slip into verbal processes."

Regarding the effect of studio participation on attitudes toward and performance in internship, interns made the following statements. "Studio strengthened my commitment to *art* being central to internship. It helped me make internship an artful experience." "Studio gave me time to set aside to do my own art, a great relief, when as an intern, you watch so many others making art and you are helping them." "Being involved in studio facilitated the integration of my artist and therapist selves." "Studio provided an outlet for stresses associated with internship through personal artmaking . . . renewed my strength to continue interning each week . . . increased empathy and compassion for patient processes . . . increased knowledge of materials and methods and my ability to structure intern sessions authentically . . . increased my enthusiasm for my process, group process, and patient process." "Studio enlivened artmaking for me and in turn for my patients." "It made a big difference in trusting art for myself and for clients . . . and improved my ability to focus on patient art process by staying with my own art even when it got hard." "Studio helped me encourage clients to stay with artmaking through learning to trust my own art process." "It improved my ability to facilitate client process through my own first-hand knowing that soul expresses itself through art." "There was a distinct change in my degree of ease with engaging clients in *art* therapy . . . this is partially due to my firmer stance on centrality of art and imagination made possible by my personal recommitment (through studio)."

Discussion

From student comments, overall trust in one's artmaking appears to be an issue that is central to facilitating patients' artmaking processes. Intern comments evidence that trust is learned most profoundly through an engagement with one's own artmaking processes. When interns are regularly and deeply involved in making their own art, it appears that they are more likely to trust artmaking for patients and to trust their own ability to facilitate art relationships.

It appears that Intern Studio participation realizes the potential of art in art therapy education. Results imply that the interns' commitment to their own art processes is vital to their commitment to art in internship practice. A further implication is that art is pivotal to art therapy education, to the art therapy intern's well-being, and to the art therapy intern's attitude and performance. An essential ingredient in these implications is the provision of *place*, physical and psychological, to dwell deeply in artmaking.

Over six semesters the Intern Studio has become very important to interns in UNM's art therapy program. The studio offers participants the first-hand opportunity to learn to trust art through their own involvement in self-directed artmaking.

Conclusion

I believe that the real work of art therapy education is missing when, in the context of art therapy programs, students have not experienced their own commitment to making art in programmatic studios designed for art therapy students. As indicated by student responses to their Intern Studio participation, this type of studio experience tends to deepen both the intern's art and internship experiences, to strengthen connections made with patients and patients' artmaking, to increase empathy toward the patient experience, to provide additional support to students in their internships, and to decrease isolation during internship and artmaking. Perhaps most important, for the individual and for the field of art therapy, the Intern Studio supports and encourages the centralization of art and imagination in the education and practice of the art therapy intern. Art at the center of art therapy education can only make us better art therapists through our intimate experiences with art and the imagination. Studio naturally provides the place for practicing the intense application of artmaking, leading to faith in art and imagination as container and contained, as fence and field in art therapy.

According to educator responses, art is outside the fence in many art therapy programs. While the number of programs providing studio support for students is discouraging, the results from students participating in UNM's Intern Studio are encouraging. Written notes from art therapy educators in programs that offer a studio component suggest similar findings—that their students also thrive and develop "artistic fluency" through studio participation and that studio requirements are "vital" to their art therapy programs. UNM interns report that their own studio involvement strengthened and supported their relationships in art therapy sessions as well as their abilities to facilitate patient art involvement; they report that the studio "fed" them and that art has been the "silent witness of Self" through studio involvement during their art therapy education.

Through their own "extreme application of effort" in the studio context, participants in the Intern Studio know the joys and the hazards inherent in the territory of artmaking. They know first-hand how artwork reveals the "soul's desperate concerns" (McConeghy, 1995). There is a chance that these revelations of the soul through art may prove to be of equal importance to acquiring clinical skills in art therapy education; it may prove that this intimate, first-hand knowledge—gained through direct experience with making art in the studio—is what ultimately provides students with the skills and insights to care for patients as *art* therapists.

The question continues to loom in my mind: As educators, what is our responsibility for providing students the place, psychologically and physically, for deeply meaningful involvements with artmaking in art therapy education? If educators fail here, they may be destroying their own field by not providing students and themselves with that nourishment found only in making art which is so central to the care they offer others.

Editor's Note: The author wishes to thank participants in the Intern Studio Project who have attended and participated with the fullest of hearts and minds and in so doing have taught me much about the inestimable value of artmaking for the field of art therapy: Shirley Barnes, Joelle Baum, Katherine Bokinskie, Brenda Bunker, Kim Carter, Virginia Coupe, Trish del Baugh, Joe Dvorak, Barbara Falconer, Diana Fosse, Lonni Ann Fredman, Alison Green, Sue Hermes, Maria Hinojos, Jenny Hubbard, Kat Humphrey, Kim Kelly, Threima Leech, Pam Matsuda, Susan McCamey, Gayle Mecca, Lindy Merry, Sandra Mueller, Merle Pokempner, Sarbat Ramos, Ransom, Deb Rogers, Tristen Spears, Deb Steele, Janis Timm-Bottos, Ingrid von Brockdorff, Heidi Wolne, and Yoko Yoshioka.

References

American Art Therapy Association. (1995). *Education standards.* Mundelein, IL: AATA.

American Art Therapy Association. (1989). *Guidelines for academic institute and clinical art therapy training.* Mundelein, IL: AATA.

Allen, P. (1992). Artist in residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association,* 9(1), 22-29.

Ayto, J. (1990). *Dictionary of word origins.* New York: Arcade.

Beittel, K. (1972). *Mind and context in the art of drawing.* New York: Rinehart and Winston.

Beittel, K. (1973). *Alternatives for art education research.* Dubuque, IA: Wm. C. Brown.

Hillman, J. (1975). *Re-visioning psychology.* New York: Harper Colophon.

Kramer, E. (1994). We cannot look into the future, without considering the past and present. *Art Therapy: Journal of the American Art Therapy Association, 11*(2), 91-92.

McConeghy, H. (1995). Lecture, IRIS, Jungian Art Therapy Conference, Albuquerque, NM.

McMahan, J. (1989). An interview with Edith Kramer. *American Journal of Art Therapy* 27(4), 107-114.

Robertson, S. (1963/1982). *Rosegarden and labyrinth: A study in art education.* Dallas: Spring Publications.

Stevens, W. (1951). *The necessary angel.* New York: Vintage Books.

Wix, L. (1995). The intern studio project: A pilot study. *Art Therapy: Journal of the American Art Therapy Association, 12*(3), 175-178.

IMPORTANT**........................**IMPORTANT**........................**IMPORTANT**....................**IMPORTANT

Please note that AATA must receive a change of address notice 6 to 8 weeks in advance to ensure all mailings, including the *Journal* and *Newsletter*, will reach you. AATA is not responsible for misrouted mail as a result of insufficient notification.

CHANGE OF ADDRESS

Name______________________________

Old Address______________________________

Old Phone Number______________________________

NEW ADDRESS______________________________

NEW PHONE NUMBER______________________________

Effective Date______________________________

Art Therapy: Journal of the American Art Therapy Association, 13(2) pp. 181-190 © AATA, Inc. 1996

In the Service of Children: Art and Expressive Therapies in Public Schools

Michele Essex, MA, LMHC, Karen Frostig, MED, ATR, LMHC; and Julianne Hertz, MA, ATR, LMHC, Cambridge, MA

Abstract

This article describes an intraprofessional collaboration between a graduate program in art therapy and expressive therapies, an urban public school system, and a community mental health agency. It addresses the relationship between the state of society, the state of schools, and the need for community involvement within the schools. The authors examine the important role of art and expressive therapies in providing services to underserved, "at-risk" children in public school settings. It also describes the role of off-site art and expressive therapies' supervisors in educational settings and the development of a handbook to guide therapist trainees in the supervision process. The final section consists of case vignettes which illustrate the use of art and expressive therapies in public schools.

Introduction

Although there is a significant body of literature on art and expressive therapies within schools, much of it represents work that takes place in specialized settings. There is little in the literature that addresses the development of the role of expressive therapies in the public schools, the integration of the expressive arts into the main school program, and the collaboration among members of an interdisciplinary staff. Many articles explore the benefits of using art and expressive therapies with children with physical handicaps (Herrmann, 1995; Kunkle-Miller, 1990). Other literature examines the similarities and differences between art therapy and therapeutic art education when working with violent imagery drawn by emotionally disturbed adolescents (Graham, 1993).

Some articles address the use of art and expressive therapies with children who, as a result of emotional difficulties, have been referred through the school system to a separate treatment setting for individual or group therapy (Steinhardt, 1993; Zeiger, 1994). In the current climate of dwindling social service resources, referral to inpatient treatment, residential facilities, and mental health agencies has become increasingly difficult. Only those children in the most acute distress can, usually after a prolonged time period, receive time-limited services at these facilities. The result is that greater numbers of more disturbed children remain in the classrooms of the public schools. The art and expressive therapist must explore how these factors shape and define the clinical expressive work to be accomplished in the schools.

The therapist trainees in schools are confronted with the socioeconomic environments in which the children live and are challenged to examine and frame treatment within this larger political context. Literature supports the importance of understanding the social and environmental contexts of school and home for children referred for treatment and also addresses how these factors influence the therapist's and client's conceptualization of therapeutic issues and how these perceptions affect the course and outcome of treatment (Case & Dalley, 1990; Franklin, 1990; Gersie, 1995). Gersie, who works in "therapeutic settings located in deprived urban environments" (1995, p. 207), states that when working in this kind of environment, it is the responsibility of the art and expressive therapist not only to help the client express and contain, but also to facilitate the client's ability to implement change. She also addresses various challenges that can affect the work of art and expressive therapists working in these environments. These include threats of physical violence, confrontation with one's own and others' racial prejudice, and "a feeling of impotence generated by the apparent multiplicity of problems . . . awareness of the limits to one's own capacity to facilitate change" (p. 212).

Dalley (Case & Dalley, 1990) makes similar observations related to school settings and focuses on the necessity to account for social and environmental contexts when treating children. She believes that the therapist should be a collaborative member of the staff, sharing objectives, goals, and problems inherent in working within a school system. She also describes how to define the role of art therapist within the school system and examines how professionals work within a system, although their different disciplines are not governed by the same code of ethics. For example, a frustrated teacher may want information about a child that the therapist trainee considers confidential. It is important to identify how that information can be shared in a way that satisfies the teacher yet protects the integrity of the therapeutic relationship.

Dalley discusses the importance of consistent scheduling and how to facilitate a child's reintegration into the classroom after therapy sessions and describes how to avoid possible stigmatization by the peers of those children being seen outside of the classroom. She also addresses the potential benefits of removing a disruptive child so as to help diffuse a potentially difficult classroom situation. The change resulting in new group dynamics often enables other students to participate more fully than if the disruptive child had remained the group focus.

Many articles speak to the natural tendencies of children to move between different forms of expression and the use of art therapy to stimulate this transfer. As children learn and develop through the action of play, intermodal work can be most beneficial. Art therapy easily leads into storytelling. Dramatic play can become spontaneous psychodrama which can be expanded by creating art to illustrate the story being enacted (Cattanach, 1995; Kunkle-Miller, 1990; Steinhardt, 1993).

Art and Expressive Therapies in Public Schools: A Collaboration

The collaboration between Lesley College's Expressive Therapies Program in Cambridge, Massachusetts, Cambridge Public Schools, and Cambridge Youth Guidance Center began in the fall of 1993. The Expressive Therapies Program has a 20-year history of successful training collaborations within private school settings. However, there were very few examples of art and expressive therapies within public school settings. Although collaborations between graduate schools, school systems, and community mental health agencies had been rare in the past, current societal and world changes have precipitated their collaboration.

The severity of problems that children bring into school settings is rising dramatically. Violence, sexual abuse, suicide, substance abuse, poverty, and the decay of family and community structures are just some of the numerous issues affecting children today. While historically the function of schools was solely to educate children, more and more schools are becoming havens for children in distress. Schools are often the only safe, stable, and structured part of a child's life.

Some school systems have recognized children's increasing emotional needs and have adapted their programs to include school-based counseling, family work, psychoeducational groups and activities, and teen health clinics. Other school systems reject the notion that schools should address such a wide range of emotional and social needs and firmly maintain their focus on education alone. The fact remains, however, that schools *are* being expected to handle students who face very serious, complicated, challenging issues from home and social environments that make it difficult for them to focus and learn in the classroom setting. Depression, truancy, and acting-out behaviors are but a few of the symptoms present in the student who is having difficulty in school. Schools and school professionals are being expected to do more with less money and less resources available to them.

In 1990 a decision by the New Jersey Supreme Court emphasized the critical need for public school support and services for poor students and declared New Jersey's Public School Act of 1990 unconstitutional as it applied to poor urban school districts (*Abbott v. Burke*, 1990).

> The fact is that a large part of our society is disintegrating, so large a part that it cannot help but affect the rest. Everyone's future is at stake, and not just the poor's. The educational needs of students in poorer urban districts vastly exceed those of others, especially those from richer districts. Those needs go beyond educational needs; they include food, clothing and shelter, and extend to lack of close family and community ties and support, and lack of helpful role models. They include the needs that arise from a life led in an environment of violence, poverty, and despair. Urban youth are often isolated from the mainstream of society . . . . The goal is to motivate them, to wipe out their disadvantage as much as a school district can, and to give them an educational opportunity that will enable them to use their innate ability. (*Abbott v. Burke* as cited in Forsyth and Tallerico, 1993, p. 400)

It is precisely these "at-risk" urban youth who are most in need of counseling services to support their ability to learn in a classroom setting. The inclusion of art and expressive therapies in the Cambridge Public Schools arose out of a need to provide specialized therapeutic services to children who were unlikely to receive them within their communities. Until recently many public schools in Massachusetts were reluctant to house clinical services, preferring to refer students to community mental health agencies for treatment. When students exhibited serious emotional or behavioral problems, they were sent to private therapeutic day schools or residential schools funded by their school district. With the decline of state and federal funds for education and the emphasis on an inclusion model of education (a philosophy advocating all children should be in "regular" classroom settings regardless of their disability), Cambridge, as well as other public schools, has begun to incorporate more school-based services, including expressive therapies.

History and Development of the Training Collaboration

In the first year of the collaboration between Lesley College, Cambridge Public Schools, and Cambridge Youth Guidance Center, eight therapist trainees were placed in the five elementary schools and one comprehensive high school. In 1994 and 1995, 10 therapist trainees were placed in the school system with five additional schools joining the collaboration.

Cambridge is a city of 98,000 people representing a wide range of diverse ethnic and socioeconomic backgrounds. The School Department consists of 14 elementary schools and one comprehensive high school, serving over 8,000 students who speak over 46 languages. This diversity offers a rich training environment for therapist trainees. As the training program with Cambridge Public Schools evolved, it became evident that art and expressive therapies helped to reach students who did not easily respond to traditional talk therapy.

Working with Children in Art Therapy (Case & Dalley, 1990), describes the integration of art therapy into a multicultural school similar in diversity to the Cambridge Public Schools. Explaining the benefits that art therapy can bring to school settings the author writes:

> Using the art materials, their [the students'] feelings are expressed and contained in the session in a safe and nonthreatening way—which for some of the more disturbed children provides an enormous relief. For some of them, the classroom situation sets up the worst areas of conflict and they end up behaving badly because of the attention that they crave and have to compete for. The knowledge that at some time in the week they will have an attentive adult to themselves in itself gives a sense of security for that particular child as there is no competition for that time or space . . . . This is one main advantage of building into the school day a space in which children can creatively explore their imagination, fantasies, and fears and can be seen as part of their overall learning experience rather than being separate from it (p. 169).

Administration and Structure of the Training Collaboration

The Coordinator of Field Training has administrative responsibility for overseeing the training collaboration with

Cambridge Public Schools. She serves as a liaison between all individuals involved in the collaboration including therapist trainees, site supervisors (mediation specialists), clinical supervisors (Cambridge Youth Guidance Center), off-site art and expressive therapies supervisors, Lesley College faculty, and Cambridge Public School administrators. She is an advocate for the therapist trainees ensuring that they receive quality training and ongoing supervision within the schools to develop their clinical and expressive therapies skills. With on-site and off-site supervisors, she serves as a contact person and mediator to address any issues, problems, or concerns related to training. Twice each year, the Coordinator of Field Training makes site visits to each school to meet with the therapist trainees and their supervisors to assess the collaboration and discuss recommendations for continued improvement.

At the end of the training year, all supervisors are invited to an evaluation meeting at Lesley College which is facilitated by the Coordinator of Field Training. At this meeting a "year in review" is conducted. All participants are involved in an evaluation process to determine the strengths and weaknesses of the year and to develop new goals and strategies for the next year.

The training model with Cambridge Public Schools includes the following criteria.

Training Responsibilities (weekly)

- 2-5 hours individual counseling; 3-4 hours group counseling
- 3 hours milieu work
- 2 hours case management, 1 hours administrative work
- 1 hour consultation with teachers, parents, school staff
- 1 hour meeting on "Students at Risk" and Chapter 766, referred students with special needs
- 1 hour (weekly) individual supervision with mediation specialist
- 4 hours (per month) supervision with art or expressive therapist
- 10 hours (per year) supervision with Cambridge Youth Guidance Clinician (for practicum)
- 15 hours (per year) supervision with Cambridge Youth Guidance Clinician (for internship)

Learning Objectives

- Develop a multicultural perspective in utilizing arts and expressive therapies with children
- Develop ability to work with children and/or adolescents in individual and group counseling
- Learn to listen and respond appropriately to racial, sexual, social, and ethnic differences
- Develop an understanding of how to effectively utilize the intraprofessional supervision model
- Strengthen ability to set clear, supportive limits and follow through on limit setting
- Learn interview and assessment techniques
- Learn how to write and implement treatment plans geared for the academic setting
- Use process recording notes
- Develop a working relationship with staff members, parents, and outside professionals
- Gain an understanding of how expressive therapies may enhance a child's school experience
- Develop an awareness of transference and countertransference issues
- Establish a professional identity as an expressive therapist working within a school setting

Intraprofessional Collaborative Supervision Model

The overall collaboration is administered by the Coordinator of Field Training. Currently there are no art or expressive therapists employed by Cambridge Public Schools. Therefore, an intraprofessional model of supervision was developed to meet the professional state licensing and registration requirements for therapist trainees (Figure 1). In addition to preparing to become registered as art, dance, or music therapists, art and expressive therapists are eligible to become licensed mental health counselors in the state of Massachusetts.

The therapist trainee receives on-site supervision by a mediation specialist (individuals who are certified school counselors, social workers, or psychologists); consultative supervision by a licensed psychologist or social worker from Cambridge Youth Guidance Center (contracted by Cambridge Public Schools); and off-site art, dance, music, or expressive therapies supervision from a registered art or expressive therapist (contracted by Lesley College).

The roles of these professionals are described below.

Mediation Specialist On-Site Supervisor. Each therapist trainee is assigned a mediation specialist who is based in the school and is designated as his or her primary on-site supervisor. The primary supervisor provides direction for the therapist trainee's work (assigns cases and groups, helps with scheduling of space, supplies, etc.). The role of the mediation specialist in the school is to create a supportive environment with resources for problem-solving and conflict resolution that are accessible to all.

The mediation specialist provides a minimum of 1 hour of weekly supervision. She or he also co-lead groups with therapist trainees. The mediation specialist is responsible for guiding, mentoring, supporting, and advocating therapist trainees to enable them to function skillfully as school-based therapists within the system.

Cambridge Youth Guidance Center Supervisor. The Cambridge Youth Guidance Center (CYGC) provides consultative supervision for therapist trainees in the schools. This supervision by licensed psychologists and social workers enables therapist trainees to meet state licensing requirements. This supervision also explores systems issues, such as how to work in a school setting and how to negotiate school work with teachers and counselors. CYGC supervisors also co-lead groups with therapist trainees and address professional development issues and the ethics and standards of practice of their profession. Building a therapeutic relationship, diagnostic work, framing problems and goals, and supporting fragile children and families are common themes in CYGC supervision.

Art and Expressive Therapies Supervisor. The art and expressive therapies off-site supervisor is responsible for providing art and expressive therapies supervision for therapist trainees for a total of 4 hours per month. She or he models, mentors, and instructs therapist trainees on art and expressive therapies assessment tools, techniques, and modalities appropriate for working

Expressive Therapies in Cambridge Public Schools
An Intraprofessional Training Model

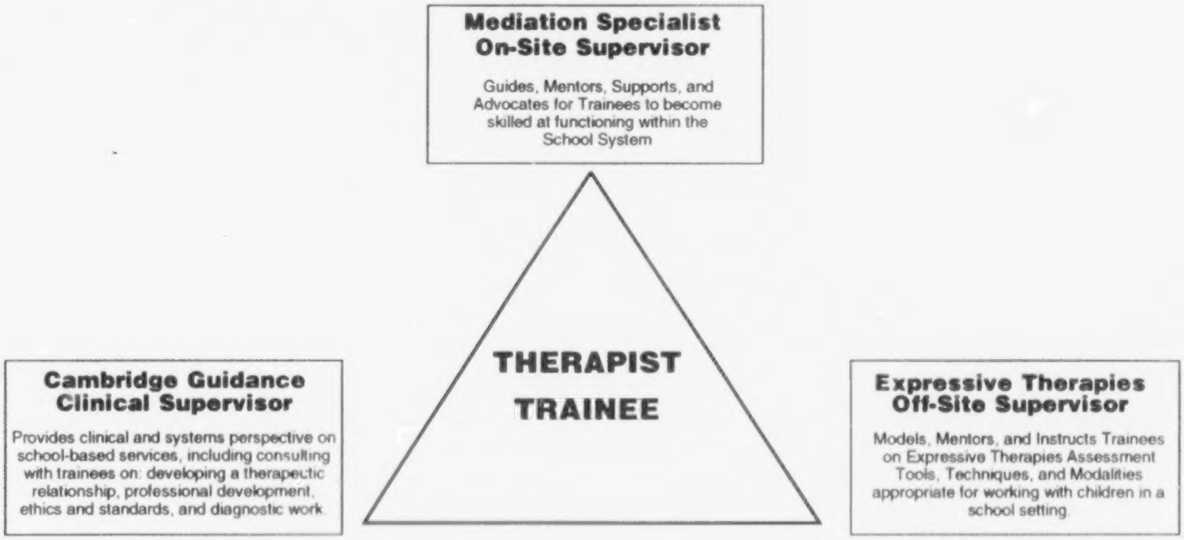

Mediation Specialist
On-Site Supervisor
Guides, Mentors, Supports, and Advocates for Trainees to become skilled at functioning within the School System
THERAPIST TRAINEE
Cambridge Guidance
Clinical Supervisor
Provides clinical and systems perspective on school-based services, including consulting with trainees on: developing a therapeutic relationship, professional development, ethics and standards, and diagnostic work
Expressive Therapies
Off-Site Supervisor
Models, Mentors, and Instructs Trainees on Expressive Therapies Assessment Tools, Techniques, and Modalities appropriate for working with children in a school setting

Figure 1 An Intraprofessional Training Model

with children in a school setting. The art and expressive therapies supervisor makes site visits each semester to observe therapist trainees utilizing art and expressive therapies with children. Whenever possible, supervisors enable their supervisees to observe them at their place of employment.

The Role of Off-site Art and Expressive Therapies Supervision

In the collaboration between Lesley College and the Cambridge Public Schools, art and expressive therapies supervisors oversee two or three therapist trainees each year at various sites throughout the Cambridge Public School system. One of the most important supervisory responsibilities is bridging the gap between the detached, focused, expressive atmosphere of the college setting and the highly charged, chaotic, and confrontational atmosphere of the large, urban, inner-city public school system. At the same time, off-site art and expressive therapies supervisors and their therapist trainees are challenged to navigate through a system in which the supervisor is an outsider and where art and expressive therapies are an unknown, viewed by some with enthusiasm and by others with suspicion.

The Supervisory Relationship

Off-site art and expressive therapies supervision in the school setting is a complex process for both supervisor and therapist trainee. The clarification of art and expressive therapies in the larger sense illuminates the unique set of issues specific to the off-site supervisory relationship in this setting. Edwards (1993) describes the content of supervision as follows: "As applied to therapeutic work, including the training of art therapists, the word *supervision* is generally used to describe the process by which therapists receive support and guidance in order to ensure that they are addressing the needs of the client. This encompasses a number of functions concerned with monitoring, developing, and supporting individuals in their therapeutic role" (pp. 216-217).

Supervision is a responsibility and commitment to supporting the growth of another person. Ideally, supersvision unfolds at its own pace, paralleling a nondirective treatment model. Two people sit together and discover the content of the work between them. The provision of support and direction occurs within the context of developing a clinical understanding of issues and goals. The off-site art and expressive therapies supervisor must pay special attention to sustaining the relationship even when they are away from the site. "Without an effective and open dialogue with a supervisor, a student will be missing a most enriching part of his or her entire learning process" (Robbins, 1994, p. 20).

An important aspect of supervision is organizing a clear holding environment from which therapist trainees can clarify expectations, as well as define the parameters of their work. The development of a supervision handbook, which spells out responsibilities and maps out the system, has helped to create the necessary structure. The handbook does not replace the evolving and responsive relationship; rather it is a tool that frees up the supervision hour so that time can be spent examining the more emotionally based issues that arise in the training process. Edwards (1993) cautions that "the training of art therapists should not be approached in a purely academic manner and will, therefore, by its very nature involve students learning about feelings, that is, their own feelings as well as those of their clients"

(p. 221). Supervision must include structured guidance in the therapeutic artistry of the modality and a more nondirective approach that includes exploration of feelings which leads to greater self-awareness. Mollon (as cited in Edwards, 1993) states:

> The aim of supervision . . . should not be to teach a technique directly and didactically, but rather to facilitate the therapist trainee's capacity to think about the process of therapy—on the assumption that technique grows out of this understanding. But what kind of thinking is involved here? It is not an active problem-solving kind of activity, not a critical evaluative activity such as is involved in reading a research paper for example, but rather it is best described as a state of mind which is receptive and reflective, one which is open to impressions, perhaps somewhat akin to dreaming. (p. 219)

Supervision in the Educational Setting

The off-site art and expressive therapies supervisor is often viewed by school personnel as infusing a depleted school system with new energy, bringing innovative solutions to old problems, and maintaining optimism in the face of limited budgets and bureaucratic constraints. However, limited availability restricts the off-site supervisor's ability to assist the therapist trainee in his or her journey through a stressed system compromised by overwhelming societal needs and issues. These tensions are at the core of the pioneering effort to establish viable art and expressive therapies programs in the schools.

In the absence of on-site art and expressive therapies supervision and mentoring, therapist trainees must look to the educational milieu for mentoring possibilities in related areas such as conflict resolution groups or, more recently, emotional literacy programs (Goleman, 1995). While these programs open up new directions for the role of art and expressive therapies within the schools, they also rekindle the struggle for the art and expressive therapist to define his or her expertise within the educational setting. The challenge for art and expressive therapists is to join other educators in their efforts to promote children's self-awareness, improvement of peer relations, reduction of self-defeating behaviors, and support of academic performance, while maintaining a therapeutic allegiance to the image and the development of artistic processes. Having an off-site supervisor may actually be an advantage. Located outside of the system, the supervisor is not involved in system politics that often compromise system effectiveness. She or he can retain a clear voice and sense of purpose in envisioning an art and expressive therapies program within the schools. For example, she or he can react effectively when therapist trainees report that teachers view leaving the classroom for art and expressive therapies as a "reward" contingent upon good behavior or assign school work to the therapy hour as part of a behavioral plan. The off-site supervisor can empower the therapist trainee to establish a program that speaks the language of creative arts therapies and holds true to the principles of the trade.

The School Calendar

The school setting, unlike the clinical setting, has a particular calendar that helps to shape certain patterns within a 9-month timeframe. Part of the task of supervision is to help the therapist trainee anticipate the ebbs and flows of the school year according to the school calendar.

September marks the end of summer and the return to academic life, structure, classroom routines and expectations, and focused peer interactions. "Holiday fever" begins by mid-October and continues through January. Anxiety is heightened around the December holidays. December vacation is riddled with hopes and dreams, real-life limitations, and harsh disappointments. Late winter to early spring marks a period of stabilization, work, and growth. April vacation begins the termination process which unfolds over the final 2 months of school. Accomplishments, increased sunshine, heartfelt yearnings, and sadness can describe this period of time as children prepare to say good-bye to a network of caring and attentive adults.

Patterns in supervision echo the school calendar. Beginnings, middles, and ends occur simultaneously for children, teachers, and support staff, including therapist trainees. The uniqueness of the academic calendar can help a therapist trainee prepare for predictable stressful periods.

The Art and Expressive Therapies Supervision Handbook

A supervision handbook was developed as an instructive tool to help clarify the purpose of art and expressive therapies within the school environment. It supplies therapist trainees with a list of topics to help focus the supervision hour, maximizing the therapist trainee's learning through structure and organization. The handbook contains forms which help therapist trainees conceptualize treatment. It provides strategies and potential solutions to deep-seated systems problems. The handbook includes various steps for independent program development between weekly supervision meetings and serves as a means to measure and mark weekly accomplishments. The educational nature of the handbook helps to lower therapist trainees' anxiety levels, thereby allowing them greater freedom to explore and investigate areas of vulnerability in their own process of professional development. The handbook is divided into four parts.

1. Expectations of Therapist Trainees

Art and expressive therapist trainees are expected to work with school personnel in developing a responsive art and expressive therapies program to service the school's population of "at-risk" youth as well as make individual referrals of special needs children. Therapist trainees are expected to join educators in a unified commitment toward the cognitive, emotional, social, and creative development of children by establishing clear art and expressive therapies objectives that interact with educational goals. Ethical standards of confidentiality, release forms, maintenance of student portfolios, treatment documentation, and reporting suspected abuse all protect the children in treatment and provide a context for the work.

2. Structural Guidelines

- *Weekly Log*—The weekly log provides on-site and off-site supervisors with a quick overview of the therapist trainee's weekly schedule. The log informs supervisors of scheduling issues, the therapist trainee's weekly caseload, overall program delivery and documentation, and patterns of communication and collaboration with teachers and co-leaders.
- *Referral Form*—The referral form provides therapist trainees with background information about the children

referred for treatment. Before this form was created, information was often delivered to the therapist trainees in anecdotal fragments. The referral form specifies clinical information upon which a treatment plan may be built, including presenting problems, reason for referral to art or expressive therapies, an overview of the child's personal and family history, description of school performance and peer relationships and recommended treatment goals. The form also helps therapist trainees by identifying a contact person for a quick exchange of pertinent information.

- *Process Notes*—Process notes help therapist trainees conceptualize treatment. The notes encourage them to practice organized and thoughtful reporting and to officially document sessions. They contain behavioral observations such as attendance, attitude, level of involvement, task skills, and transitions to and from group or individual sessions. They also provide a forum to describe the content of each session, the use of imagery, group sociometry, interactions with the therapist trainee, and transference and countertransference issues.
- *Group Protocol*—The group protocol provides a standardized format to describe a range of art therapy services. It indicates the group title, group description, goals, and referral criteria. It forms the basis for the group contract. The group protocol quickly informs teachers about the content of the group, the requirements for membership, and the procedure for referral.
- *Mini-case Presentation Format*—The mini-case presentation format combines the referral form with the process notes, creating an organized context from which to view the students' art. The outline format helps the therapist trainee organize a presentation of the artwork. It stimulates discussion, as therapist trainee and supervisor explore the layers of meaning implicit in the image and the process of its creation.

3. The Importance of Collaboration and Communication

Art and expressive therapists are trained to collaborate with professionals from other disciplines as a member of a treatment team. They learn to approach treatment with an understanding that communication is the basis of good treatment. In a school setting, teachers often work in isolation, creating autonomous classroom experiences for their students. Typically, therapist trainees enter the school setting searching for existing channels of communication only to find themselves in the position of having to create them. Without an on-site art and expressive therapies supervisor to guide them in this process, therapist trainees can feel discouraged and overwhelmed.

The supervision handbook places great emphasis on the therapist trainee's responsibility to maintain ongoing contact with referring teachers. It encourages therapist trainees to seek as well as create opportunities for team involvement.

4. Shared Art and Expressive Therapies and Educational Goals

The viability of placing therapist trainees in the school setting is based on a premise of shared goals. Art and expressive therapies, as practiced in the school setting, further a child's cognitive, emotional, social, and creative development through a unique integration of experience. Educational goals include improving communication and interpersonal skills, increasing awareness through self-expression, increasing self-esteem through mastery, and achieving containment through sublimation. Art and expressive therapies utilize spontaneous experimentation to facilitate a range of task competencies, for example, facility with materials, sequencing skills, concentration. The creative process engages the child with a sense of discovery, risk-taking, and a heightened appreciation of aesthetic sensibilities, while promoting problem-solving strategies. Art and expressive therapies illicit a student's spirit and capacity for self-motivation, provide an outlet leading to tension reduction, and improve group cooperation through collaboration of ideas.

Case Vignettes

In the public school, referral for treatment often results from maladaptive behaviors in the classroom or in the society of the school rather than from knowledge of a child's diagnosed emotional problems. As Dalley (Case & Dalley, 1990) explains, "Where art therapy is established in the schools, it can be seen to benefit those children who have particular emotional or behavioral difficulties and whose special needs cannot be met in the classroom" (p. 161). The child often comes for treatment with no known specific history of pathology or indication of the sources of underlying problems. The treatment goals set by school personnel revolve around improving the child's behaviors in order to improve learning. Dalley states, " . . . the role of art therapy as a central means of working with the child's emotional needs to help the achievement of learning potential is stressed" (p. 161). The challenge for the therapist trainee is to maintain therapeutic integrity within this system and still help meet these goals.

The ultimate goal of the therapeutic encounter in the public schools is to help children improve their educational performance. Edgcumbe states the rationale for referring a child to therapy: " . . . that where a child's ability to profit from educational experience is being interfered with by internalized conflicts, or by distortions in ways of relating . . . then individual therapy is required" (as cited in Case & Dalley, 1990, p. 166).

It can be frustrating for both the therapist trainee and off-site art or expressive therapies supervisor to begin to work with a child with little or no clinical history. However, this deficit can provide a powerful training opportunity by allowing the therapist trainee to assess the child through the art and expressive modalities. The following condensed vignettes were chosen to illustrate the work of two therapist trainees who began treatment with varying amounts of background information about their clients. Each vignette is designed to show how art and expressive therapies treatment within a public school setting can address the goals of personal catharsis, behavioral containment, growth of the imagination, and identification of underlying problems within a therapeutic setting, as well as the goals necessary for the child's improved performance within the school setting.

The two cases were chosen to exemplify situations which included a range of identifying information, interventions used, and types of responses. The first case includes substantial background information that informed the therapist trainee's work. After an art assessment, treatment interventions were developed in supervision. Through the expressive metaphors, the child was able to express underlying problems which were affecting his

BEST COPY AVAILABLE

school performance. The second case describes how the therapist trainee, with no historical data, helped a child use art to verbalize his perception of his interpersonal difficulties with peers. This self-awareness led to improved behavior in all aspects of his school life including the development of improved peer relationships.

Kevin

Kevin is a 6-and-a-half-year-old Haitian male. He is an only child who lives with his parents in a low-income housing project. It is unclear whether his parents are married and how much time the father actually lives with the family. Both parents, who are Haitian, have a high school education. This is a bilingual home in which both Creole and English are spoken. Kevin has been diagnosed with verbal, auditory, language, and motor skill developmental delays. Tests also indicate mild hyperactivity and attention deficits. Kevin was referred for expressive therapy because of difficulties with social interactions with peers and poor physical boundaries; he was either overly affectionate or physically aggressive with classmates. Kevin is currently repeating kindergarten. The goals of the referring classroom teacher were for Kevin to develop better social skills and to receive consistent, positive attention from an adult. When asked by the therapist trainee, during an initial interview, if he knew why he had been referred, Kevin stated he did not know and appeared to be unaware of his academic and social deficiencies.

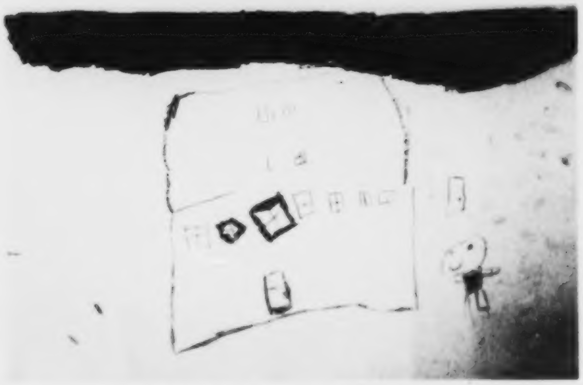


Figure 2 Kevin (6.5 years old)

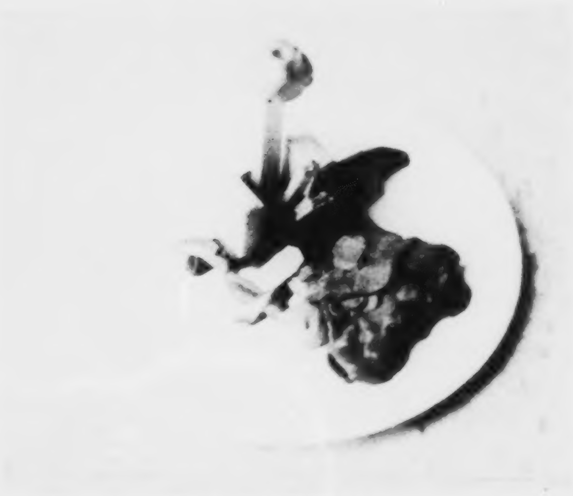


Figure 3 Kevin

In the first session, the therapist trainee provided Kevin with paper and craypas and told him he could draw whatever he wished. Kevin drew a picture of what he described as himself standing outside of his house at night (Figure 2). When she presented the drawing in supervision, the therapist trainee described Kevin's difficulty manipulating the craypas. Assessing the artwork she noted the floating quality of the figure and house, the inaccessibility of the house, and the foreboding black sky above the house. The therapist trainee said that Kevin was unable to give her any more information or tell a story about the drawing, stating that her questions were making him tired.

At the beginning of the second session, Kevin described the drawing: "I am going to the park to play. (What are you going to do at the park?) Slide. I can go all by myself. I am not afraid of nothing. (How long do you stay?) Six minutes. Other people want to slide. I go back home to eat dinner, chicken and rice. I am not afraid when it's dark."

Kevin drew again with craypas in the second session. When discussing the process in supervision, the therapist trainee repeated her concern with his difficulty in handling the materials. In assessing the similar elements and content of the drawings, the therapist trainee suggested that the inaccessibility of the house and the huge black sky could indicate family problems.

The possibility of giving Kevin materials that were easier to manipulate and might help expand his metaphoric expression was suggested by the supervisor. For the next session the therapist trainee decided to offer Kevin colored plasticene which he used to make multicolored coils that he called "snakes." He chatted with his therapist trainee while he repeatedly formed these figures and then cut them into pieces. In his own way, Kevin used this session to explore the possibilities of the material and exert control over it.

During ensuing weeks Kevin began to construct elaborate clay and balsa houses (Figure 3). As he developed his constructions, he told evocative stories that seemed to communicate fears about his home environment. He described the house as a vampire's house flanked by snakes. In the front of the house, Kevin put out clay pizza for the vampire to eat. When the therapist trainee asked Kevin about entering the house, he replied that when he was inside the house he would "turn into a ball to be safe from the vampire."

Through art and storytelling Kevin was able to share emotional concerns that probably interfered with his behaviors and performance in school. As treatment continued Kevin began to bring peers to sessions. The treatment goals, appropriate expression of feelings, better peer relations, and improved self-esteem were developed at the beginning of the year and maintained for the duration of the expressive therapy treatment. Behavioral improvements in the classroom were noted throughout the year.

Brent

Brent was a fourth grader referred by his teacher for individual counseling due to low self-esteem, difficulties with social and organizational skills, and poor attention in the classroom. His history was unknown to the therapist trainee when she began treatment. Most notable to the therapist trainee in the initial stages of treatment was Brent's difficulty in focusing and his tendency to move around the room quickly and frequently. She also noticed that he was quite comfortable using art materials.

An early drawing by Brent (Figure 4) was titled, "Man Hit by Lightning." The therapist trainee and supervisor discussed the emotional content evoked by the few, simple lines drawn by the child. They seemed to reflect the terror felt by this figure. The supervisor encouraged the therapist trainee to explore the lightning metaphor in order to deepen her understanding of Brent's affective experience. For example, the supervisor asked what it might feel like to be struck by lightning? What would a child this age have experienced as a lightning strike? As the relationship between the therapist trainee and Brent developed, he was more willing to discuss his artwork and to respond to encouragement for further exploration of his images. She noticed an improvement in his ability to relax, focus, and concentrate.

Brent began to develop an ability to address emotional issues through his images and discussions about them. Figure 5 is a folded, two-part picture titled, "What Happens When No One Else Is Around." The outside drawing is a contained, precise, pencil sketch of a male face. The inside drawing (Figure 6) shows two figures lightly outlined in pencil. The stomach area of the figure on the right is colored in with orange and red marker. The figure on the left has these same colors spewing toward the other figure from its mouth. Brent described this as a scene of two people getting angry with one another. He said the anger was represented by the colors and noted that the figure holding his anger inside was like him.

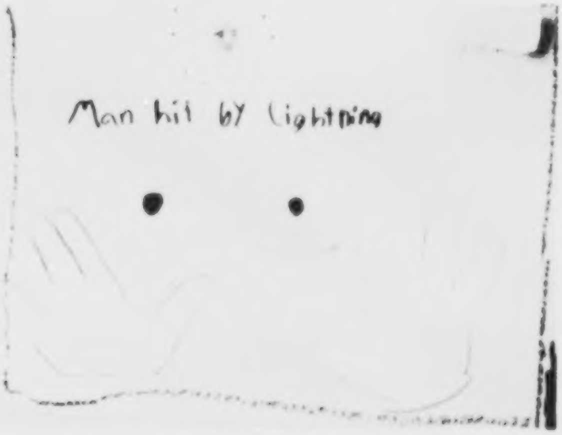


Figure 4 Brent, "Man Hit by Lightning"

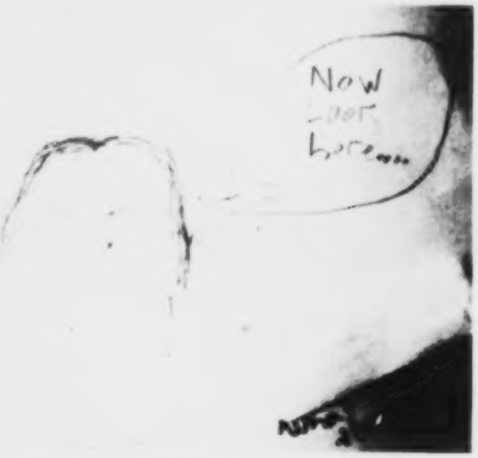

Now not here...

Figure 5 Brent, "What Happens When No One Else Is Around" (outside)

This admission led to a discussion about fights in which Brent had been involved and his perception that other children were unwilling to befriend him because of his aggressiveness. He was then able to verbalize his feelings of anger and loneliness because other children teased him. The therapist trainee was able to use this clear disclosure to guide Brent in further exploration of ways to improve his peer relationships.

Although it was a difficult challenge, Brent was able to invite a classmate to a number of counseling sessions after the 10th session. The therapist trainee reported that their interactions were friendly, and Brent demonstrated improved social skills during these sessions. Throughout the year Brent's interactions with others, his organizational and social skills, self-esteem, and overall mood improved notably. He became able to verbalize his strengths and identify areas in need of further examination, including conflict resolution with peers.

Evaluation of the 1994-1995 Training Year

At the end of the 1994-1995 training year, an evaluation was completed including feedback from all participants in the training collaboration. The evaluation highlighted the strengths, weaknesses, and continuing challenges facing the program. What follows are excerpts from the evaluations of therapist trainees, mediation specialists, Cambridge Youth Guidance Center supervisors, and art and expressive therapies supervisors.

Strengths of the Training Program

- The diversity of children (e.g., socioeconomic, ethnic background, and clinical issues)

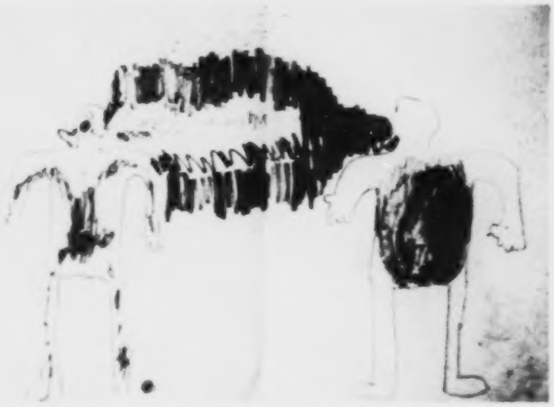


Figure 6 Brent, "What Happens When No One Else is Around" (inside)

- Utilization of expressive therapies modalities with individuals, groups, dyads
- Co-leading groups with a variety of professionals
- Opportunity to learn about the public education system and the role of art and expressive therapies within the schools
- Learning how to set clear limits and goals for individual and group work
- Quality supervision. Exposure to experienced mental health professionals with varying backgrounds contributed to a positive learning experience.

Weaknesses of the Training Program

- Need for adequate office space to see children
- Need for adequate assortment of art and expressive therapies media
- Difficulty obtaining information from files regarding past psychological information
- Periodic inconsistent on-site supervision as a result of the necessity for mediation specialists to attend to crisis management
- Need for adequate communication between teachers and therapist trainees
- Need for a comprehensive orientation at the beginning of the school year to cover such issues as mandated reporting in the school system, the role of therapy in schools, release of information procedures, and the intraprofessional supervision model
- Need for inservice training on art and expressive therapies in the schools to better inform school personnel about the field of art and expressive therapies

Strengths and Weaknesses of the Intraprofessional Supervision Model

The following are some direct quotes that represent therapist trainees' supervision experience.

Student A: *The three supervisor model worked well for me. I was able to gain three viewpoints: social work/systems, clinical and expressive therapies. They never worked against each other, but all this supervision can be very time-consuming. I was lucky in the sense that all three supervisors were professional, communicative, and very knowledgeable. Having this as a practicum student was essential for learning how to use supervision.*

Student B: *It was very helpful. I found certain issues I could take to only one of the supervisors because the other two might not know about one particular area. Initially, I had some problems in my understanding of how to work with all three, but eventually I found it very rich because each of the supervisors had a different way of viewing a child. I was able to take all the help and hopefully able to synthesize it.*

Continuing Challenges Facing the Cambridge Public Schools Collaborative

Lack of operating funds is the biggest obstacle that the training program faces. The cost of supplies, supervision, and overall administration required to run this program successfully must be addressed within the next year if it is to continue. The professionals involved do not want this program to become one of the many projects founded on good intentions, only to fall victim to burnout, unmet goals, and inadequate resources. It is essential that funding sources be secured from grants, corporations, and/or private contributions to adequately oversee this program. Currently the program is being run on the goodwill and strong commitment of the professionals involved.

Why would a group of already overworked professionals be so dedicated to a collaboration where they receive little to no remuneration? (Supervisors are either paid with graduate school course vouchers from Lesley College or a small nominal hourly rate for supervision.) The common thread and commitment which unites the professionals of this collaboration is that each was at one time a school-based counselor or an art and expressive therapist within a school setting. They know firsthand the power, the challenges, and the rewards of the therapeutic relationship developed within a school setting as compared to that of a private practice setting.

It is clear that school-based counseling, including art and expressive therapies, should be available in more schools across the nation. Many children never make it through the door of a private practice office or mental health agency. Lack of money, resistance, fear, or general disorganization may prevent a child from making an office visit at a particular time each week. But the development of a trusting therapeutic relationship, particularly for disenfranchised children or those with histories of trauma, requires more than offering a "safe space" to talk and the assurance of confidentiality. Children need to get a sense of what kind of people their therapists are before they learn to trust them. As a result of visibility and accessibility within schools, these therapeutic alliances are frequently more successful than those in private practice therapy where a child usually sees a therapist only once a week.

Facing Reality, Offering Vision: The Future of Art and Expressive Therapies in the Schools

The authors believe that art and expressive therapies in public schools contribute significantly to meeting the needs of children, communities, and therapist trainees. Now more than any other time in history the severity of the problems that children present in schools clearly demonstrates their overwhelming needs and the community's responsibility to serve them. It is anticipated that in the future, long-term treatment for children is more likely to occur in schools than in any other setting. The literary and clinical evidence that is presented in this article points to art and expressive therapies as preferred treatment modalities which effectively meet the therapeutic needs of public school children. Until the role of the art and expressive therapist within public schools becomes more clearly defined, it is necessary to provide therapist trainees with tools that help structure their learning experience. These include an intraprofessional model of supervision and handbook that represents the tenants of the profession as adapted to educational settings. The work of the children, as illustrated by the case vignettes, is a powerful testament to each one's ability to use various expressive modalities to address intrapsychic issues that lead to better school performance and improved learning.

The necessity of a conscious and informed collaboration between art and expressive therapists, educators, and the community is imperative to better meet the needs of school children. The time has come for everyone to take a more active role in the efforts to improve the quality of schools so they can truly educate and nurture children. It is the responsibility of all members of society to prepare children to become whole, healthy, productive, and loving human beings. They will be, after all, the leaders of the 21st century.

References

Case, C. & Dalley, T. (1990). Images and integration: Art therapy in a multi-cultural school. *Working with children in art therapy*. London: Tavistock/Routledge.

Cattanach, A. (1995). Drama and play therapy with young children. *The Arts in Psychotherapy*, *22*, 223-228.

Edwards, D. (1993). Learning about feelings: The role of supervision in art therapy training. *The Arts in Psychotherapy*, *20*, 213-222.

Forsyth, P. & Tallerico, M. (1993). Understanding the urban context and condition of practice of school administration. *City schools*. California: Corwin Press.

Franklin, M. (1990). The esthetic attitude and empathy: A point of convergence. *American Journal of Art Therapy*, *29*, 42-47.

Gersie, A. (1995). Arts therapies practice in inner-city slums: Beyond the installation of hope. *The Arts in Psychotherapy*, *22*, 207-215.

Goleman, D. (1995). *Emotional intelligence*. New York: Bantam Books.

Graham, J. (1994). The art of emotionally disturbed adolescents: Designing a drawing program to address violent imagery. *American Journal of Art Therapy*, *32*, 115-121.

Herrmann, U. (1995). Trojan house of clay: Art therapy in a residential school for the blind. *The Arts in Psychotherapy*, *22*, 229-234.

Kunkle-Miller, Ç. (1990). Potentials and problems in establishing an art therapy program in a residential school for children who are deaf. *American Journal of Art Therapy*, *29*, 34-41.

Robbins, A. (1994). *A multi-modal approach to creative art therapy*. London: Jessica Kingsley Publishers.

Steinhardt, L. (1993). Children in art therapy as abstract expressionist painters. *American Journal of Art Therapy*, *31*, 113-120.

Zeiger, R. (1994). Use of the journal in treatment of the seriously disturbed adolescent: A case study. *The Arts in Psychotherapy*, *21*, 197-204.

LESLEY COLLEGE
Master of Arts in Expressive Therapies

A unique program designed for women and men eager to advance professionally and create change in people's lives.

- Integrate the modalities of dance, drama, literature, music, poetry and visual arts with the practice of psychotherapy.
- Combine experiential and creative learning with applied clinical practice and artistic work.
- Specialize in Art Therapy – learn comprehensive skills in the therapeutic use of the visual arts.

Call 617/349-8425 or 800/999-1959 x. 8425 for more information.

LESLEY COLLEGE Office of Graduate Admissions
29 Everett Street, Cambridge, Massachusetts 02138-2790

LESLEY

Art Therapy: Journal of the American Art Therapy Association, 13(2) pp. 191-197 © AATA, Inc. 1996

An Interview with Don Seiden

Randy M. Vick, MS, ATR-BC, Lemont, IL

Abstract

This article is based on an interview with Don Seiden—artist, educator, and regional pioneer in the field of art therapy practice and training in the Midwest. A personal account of his career path features ground-breaking work with two very different institutions and the training program which grew out of his connections to both. Reflections on historical developments in the field are followed by thoughts on future trends in the profession. Central to the conversation is the theme of the unique perspective artists can bring to the fields of mental health and science by their ability to sort and combine information and bring order out of chaos.

Introduction

Don Seiden is an artist, educator, lecturer, and for the past 32 years has been a quiet pioneer in the field of art therapy in the Chicago area. His primary contributions to the profession have been as the founder of the Illinois Art Therapy Association and Chicago's first graduate art therapy program (at the School of the Art Institute) as well as the first art therapy program at Rush Presbyterian St. Luke's Medical Center. Through his dynamic teaching style, his warm, genuine manner, and above all, his unwavering trust in the power of the creative process in healing, he has served as mentor, role model, and inspiration for a generation of art therapists. Reluctant to travel outside the Midwest, his influence is felt indirectly through graduates practicing across the United States and elsewhere.

The "new" model of the art therapist as artist turning primarily to the studio for conceptual inspiration instead of the clinic has been embraced by Don throughout his career. His one-man exhibit of recent work at Chicago's Enid Oklahoma Gallery in the summer of 1995 provided an opportunity for this discussion of his professional history and thoughts on the future of the field.

Artist's Statement

In the summer of 1994, I began a series of wall sculptures which were boxes that encased heads. The faces were pressed up against plexiglass. A mixture of the horror of asphyxiation and the humor of distortion collided. About 6 months later I was hospitalized with a severe asthma attack. It was the first occurrence since I was a very young man.

Earlier the same year I had also been working on my altered photographs. The process involved taking 35mm pictures of ordinary images. I would then paint or draw imaginary forms on the prints, a kind of surreal experience. Following this, I rephotographed the finished picture which united the original photo with the additional painting. It was a way for me to comment on my suspicion that the invisibility of air may hide events and experiences which our normal senses are unable to perceive. I realized that both these art experiences were dealing with the mystery of air—invisible, necessary for life, without which we die.

As an art therapist I have always been fascinated with the human psyche and its complexity. As an art teacher I have respected the need for art in the lives of people. As an artist, my life, my work, my play have all been compressed into the process of making things which describe the adventure of self-exploration. The experience of living for me is described adequately only through my art.

Interview

Q: It's really a nice opportunity to be here at this wonderful show with you and to have the time not only to talk about both this show and your work as an artist but also to reflect and look at some of your pioneering work in the field of art therapy and how it all ties together. Why don't you start out by telling me a little bit about the show.

A: Well, the show is essentially a major change in my life as an artist, I think. Particularly, and certainly, it has ramifications in terms of my role as an art therapist and an art educator. But, as an artist, what has happened here, I think, is that my work has moved away from the materiality of my sculpture. In the past I've worked with materials that were very physical—carving, metal work, and so on—and this show has moved off into another direction entirely. It's more like mind stuff, you know, more conceptual, maybe even more spiritual in terms of my own life. I think that's an important fact.

Q: Is that because of a transition as a person or are you consciously looking to make some changes in your work?

A: Well, I'm rarely conscious (laughter) of myself as a person. I'm less conscious of myself as an artist, but, by that I mean, I think that the work just sort of takes over and becomes what it becomes. But at my age I think that there is another viewpoint that I'm beginning to take in terms of how I view my experience and how I view the world. And that has to do with seeing in places where I've never seen before. Noticing things I've never noticed before. So, I think that what becomes important has not been very important before, and it seems as if some of the ideas around the concept of air represented in this show—airlessness and infinite space—those ideas are new. I'm not sure where they are going to take me in terms of the other aspects of my life, but as an artist that comes first.

Q: One of the key things that strikes me about the show and the work in it is the idea of being confined or compressed into a small space. That's something that you've dealt with a lot in

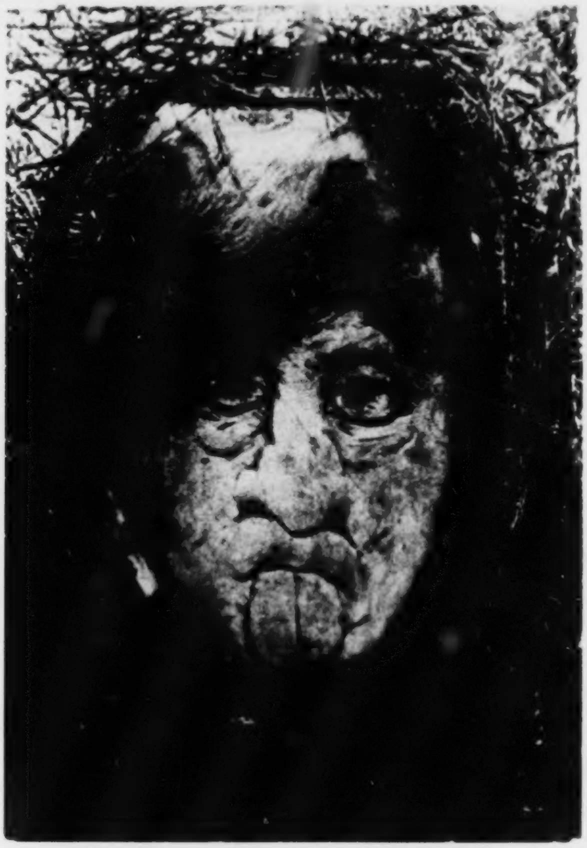


Figure 1 "Airless," mixed media 8" x 11"

the show. But when I think back about what I know of your career in the field of art therapy, that hasn't seemed to have been a problem for you—feeling hemmed in or compressed. It seems like you have expanded into a field and you cross so many boundaries easily. You introduced yourself just a second ago with talking about yourself as an artist and as an art therapist and as an art educator, so those boundaries don't seem to worry you too much. Were those divisions more or less clearly defined for you, or did you always ignore them early on when you first found yourself in the field?

A: Well, the boundaries were always there in terms of how one achieves a certain kind of recognition or status. I mean, I got a certificate to become an art teacher. I never had to connect that with being an artist. I just made art, and when I became an art therapist, there was no such thing as art therapy; therefore, I invented something that worked for me and later turned into something that now requires that people have certification. So, I think that ultimately the aspect of this that you're questioning—the lack of boundaries—was there for me. I would do what I felt I wanted to do in the work that I chose. I crossed boundaries that were never there and I created boundaries; that is, I put up fences between things so that other people would know what I was doing.

Q: So you kind of defined your own space. . . .

A: Exactly. I would have to define my own space, and I would have to define it clearly enough for other people to understand it. But basically I'm washed over with art. I mean, art itself is a thing that entered my life and never left, and these other things arose from it.

Q: When you say you got into the field of art therapy or you found yourself in the field, was there a point where you sort of began to use the term or you heard the term and said, "Oh, that seems to be what I'm doing"? How did that come together for you? Do your recall?

A: At the very beginning, when I was interested in art as a way of perceiving and expressing and communicating, the term *art therapy* was not really something that I thought about. It came into being a little later on, after I'd already begun to work in mental health. I worked in a mental health setting, a number of them as a matter-of-fact, in the area of psychiatry, and I wound up at Rush Presbyterian St. Luke's Hospital beginning its program in art therapy. But this took a long time. It just sort of developed over years. My entry really was partly because I was interested in where my images were coming from. I wondered about my own art and my own being, and, like most artists, I think I began to wonder where do these things come from? Why would I make this instead of that? So that's when I got into working with other people through art, and I chose to work with people who are emotionally disturbed—people who are unstable mentally, functioning in very poor ways in their lives, and who wind up in hospitals being treated for various psychiatric disorders—because I felt that that was where these images were most powerful.

Q: That was the origin of images for yourself and where you felt there was a parallel for those people. It's a kind of a leap to go from a personal exploration about "Where does this come from for me?" to the realization that it could be helpful for someone else.

A: I learned very early how helpful it was for me. I knew that my art was extremely important in keeping me stabilized. My life was not as stable as my art. Art was there all the time when I needed it, and I knew, even though I couldn't describe it exactly, that making art was a kind of healing process. Understanding my art, trying to understand what it meant in terms of my whole being, that was another part. But it was another part that I was trying to understand through other people's work as well because I knew somehow that the process of making art was very helpful to my psychic well-being. I assumed it would be the same for other people, and what the work meant in terms of mental health or in terms of one's emotional stability was something that interested me. So an institution was the best setting for me to work with other people. It became therapy. I started working as an art teacher in an institution, but, you know, the word *therapy* was a difficult word. It got more difficult when I wanted to start a program at the School of the Art Institute [of Chicago] because the word *therapy* was, you know, dangerous.

Q: And it's still a bit frightening in that context. So the hospital brought you in to teach. And at that time, had you been teaching at the School yet? At the Art Institute?

A: Yes, I had started teaching at the Art Institute approximately the same time. It's hard to say just when, but the Art

Institute came first and then came the Rush experience. I believe it was 1963 or 1964.

Q: So people at the hospital saw that you had these credentials, let's say, as a teacher of art.

A: Right.

Q: So it became easy for them to bring you in. There must have been some people there who functioned as support or mentors or teachers since there was no training program for you, obviously, since you started your own later.

A: It was so exciting in those days. Number one, the medical establishment had more time to devote to teaching than it seems to do today and more time to work with people. At that time there were a number of people on the staff who were very psychoanalytically oriented, and of course their connection to art was very pure in the sense that psychoanalysis was interested in dreams and art, so we had great conversations, great seminars. It opened up a world for all of us, and I was just reveling in that whole thing. It was beautiful. The psychiatrists, of course, were working on medication at that time too, so there was a lot going on in terms of advances, in terms of how people were treated.

Q: It really was a revolutionary time in mental health from a lot of angles, and it seems like around that time other people, seemingly simultaneously in different parts of the country, were stumbling into this notion of art therapy as well. How do you see yourself in that larger context? It seems so extraordinary that everyone seemed to be coming down that same path or at least similar paths.

A: What seemed to happen here in Chicago was that there were a few scattered people who were working in other institutions, and I had heard about what was happening on the East Coast and little-by-little word would get back to me in the midlands here. I felt like Daniel Boone in the prairies during the time when the American Art Therapy Association was developing. I don't remember what year it was, but somewhere around 1973 or 1974, I got in contact with AATA and began to get my credentials through them. At that time art therapy was beginning to develop. Also, a few people here in Chicago got together and formed the Illinois Art Therapy Association. I was the charter president of that group, and we were just sort of comparing notes on what we did. We never had much connection to the national organization beyond the letters (ATR) and in a sense trying to get credentialed. But it was all happening and it was happening without my knowing it until word spread across the country.

Q: But that didn't seem to hinder you. You didn't feel like you needed that backing. It sounds like you plowed right in. When you heard about others, it was helpful to kind of put things together, but if they didn't exist it wouldn't have stopped you.

A: Oh, no, no because I was very much into what I was doing, totally. As a matter of fact, I felt that some of it was a little hindering because I had to accumulate a lot of my work in order to present to AATA, so at that time it was interruption in some respects. But obviously I knew that this thing was going to grow. I just wanted to be in it at the time it was growing. So it was good. It was good.

Q: And was it around that time too when the program at the School, the training program, began to be discussed?

A: Yes, I was in the sculpture department. I chaired the sculpture department for a few years, and during that time I was getting more and more invested in art therapy and more and more interested in what it was doing for other clients and people with whom I was working. So I opened a connection with the art education department at that time to teach a class called "Art in Psychology." In that class I brought in people who were in the mental health world—psychiatrists, psychologists, and analysts—alongside artists whom I knew in Chicago. Some of the best artists would come and be paired off with a psychiatrist, and they would just discuss art and what it meant to the artist, and so on. That was a wonderful class and that led me to another class along the same lines and ultimately to the beginning of an art therapy program. It was safe, at that time, to do one class as an experimental class, but as soon as I began to think about a program that would offer some sort of certificate or ultimately a degree, a master's degree, that was when the trouble started. The school was interested in the program. Art therapy was just beginning to become known and the faculty was, for the most part, very hostile. The administration saw some possibilities, probably in terms of future students. The faculty was a little scared because the word *therapy* was an invasion of sorts, in terms of what art meant to a lot of people. There was this whole romantic notion about art and artists where you, in a sense, gave up your life to art. Even though that might involve problems and neuroses, artists used to say, "Don't take my neuroses away. I'll lose my art." But we got started and a year later we had a review and that review was devastating. They brought in people from all over the place to talk about it because it was starting to grab a hold. But we got through the review, and it's a whole story that I'm not going to go into now, but it was wonderfully stimulating for everybody in the School. I think it was an educational process for all of us. Everybody learned a lot more about the relationship of art to the psyche to the human experience. Whether or not art therapy or making art was a healthy, creative, good thing for people was the subject that was being discussed and probably still is being discussed in some cases. It's just that it's a huge thing to talk about.

Q: So what point in time is this? When was the first graduating class?

A: The program began as a graduate level certificate program. Students completed 36 credit hours and received a certificate in art therapy at the graduate level. That was 1979, and in 1981 the master's program came into being and from then on it was a 2-year program, 60 semester hours of work. Two years produced a student who received a master's degree, and from then on they would get credentials through the American Art Therapy Association, the ultimate credential being Registered Art Therapist.

Q: And that's still pretty much the model?

A: Yes.

Q: And then somewhere along the line you went back to your connections at Rush and pulled them into the training pro-

program. How was that finessed because that seems like quite a coup?

A: That was really wonderful. Because the Chair of the Department of Psychiatry at Rush (Jan Fawcett) was a person who was very interested in what I was doing. He would watch what I was doing and I guess he thought of me as a motivator. I mean, I could get depressed people running around and wrapping furniture like Cristo would do. He found this process very interesting and unusual. So we had a very good relationship, and when it came time to develop a program at the school at the time of our review, I was very firm about trying to get people connected to the program who had relevancy in the world of psychiatry because I didn't have those kinds of credentials. I was an artist who was doing this, you know. And so I needed to get the Rush connection fixed in order for the School of the Art Institute to be happy and comfortable with what we had. So, I talked to the doctor who was in charge, the department chair there, and we got it going in a way that was so crazy. I mean, I met him in the corridor one day and I said, "We need these courses. What are we going to do?" So we sat there and in about 10 minutes we worked out the whole program and Rush's relationship to it. But it happened 1-2-3. It was just amazing how big things happen.

Q: Well, it must have been percolating at some depth.

A: Oh, yeah, we had started talking about it and, you know, I had talked about it with people at the School. It was all beginning slowly, but when it was finalized, it was done just so incredibly fast. And, then the work started.

Q: So you continued to work at Rush during that time as well?

A: Oh, yeah.

Q: And what other kinds of populations or places have you worked with clinically? You've taught all along? There hasn't been a break in the teaching?

A: No, the teaching was ongoing and the work with other populations was continuing. I mean, I worked with the developmentally disabled, depressed people, and with adults and children. I worked with community problems in various places. Every diagnostic category probably was at one time or another in my life, so it was all ongoing, all intermixed, always me just working—hopefully, bringing art into people's lives in a new way.

Q: And people were receptive, obviously, because you continued to do that. Now, during that time, did you notice any shifts? I mean, you worked as an educator all along, you worked as a clinician all along in various contexts. And, obviously, you continued your work as an artist all along. Did you notice any shifts in that work over time or the impact of your evolving work as artist in terms of the clinical work? How did you see them interplaying?

A: Well, the artmaking was always at the core of everything I did. Art itself, my experience making art as an artist, was always the kind of furnace that generated the heat for everything else. It was the beginning of the whole thing. But then when I taught and watched how art entered the lives of my students or when I did therapy with people and watched how art was entering into their lives, it would affect my art. It would help to change me, so that it was always a kind of interaction of experience with people and interaction of experience with material and experience with ideas that were constantly being generated from here and from there and from everywhere. My whole life has been a problem of keeping it all together, making sense out of the whole thing because I didn't have any specific kinds of guidelines for what I did. And I think I have it more together today than probably ever before, but I should hope to by this time—it's been over 30 years.

Q: Well, when you look at the work in this exhibit, it's really about combining and sorting various materials and putting them together in an interesting way. It's really a parallel to your life in so far as not having a rigid boundary or a rigid frame to work within but having a rich environment and sorting out is really central to it all.

A: Absolutely. *Sorting it out* is probably the phrase to understand how things link up with one another. Something I had heard once, "For people who believe in magic, *analogy* is the first word," means that everything is related, everything is next to another, everything is connected. And if you can plug into that powerful source of energy at the right place and the right time, magic will happen. But science, which is what I had always been interested in reading about, and certainly ideas that were present in the world of psychology indicated to me that analogy would be the *last* word. Things are not analogous until *proven* to be analogous.

Q: So analogy is the last conclusion?

A: It's the last conclusion that says, "Oh, yes, this is like that." So art came somewhere in the middle because I always believed somehow that everything is analogous and I didn't have any fear about trying to prove this through my art. But whenever I talk to myself about meaning, I always trusted science to be based on a kind of factual truth and so I would have the idea that the analogous situation that I have put forth may not be the real answer for anything but it certainly made art, you know. So I guess sorting it out and working with art—the science, left and right brain, call it what you wish—it was always a fact of trying to bring things together in a way that is comfortable for me.

Q: When you say you trusted science, in terms of what? In terms of a scientific method to later back up or prove what you arrived at more intuitively?

A: Yeah. I think that says it pretty well. I think that art for me has been intuitive. I trust my intuition more and more in terms of making life decisions as I get older and it becomes more important for me to believe in my intuition. But I don't trust it for everybody else, and I don't trust it for the world, and I don't trust it for giving me factual information on what experience is all about. Science gives me that other side that I can sort of look to at least. So I put it together and this business of putting things together is where the sorting out process takes place.

Q: And wonderful things, as we see here, sort of come out of that sorting process. That process could appear a bit unpredictable, but it doesn't sound like it has been for you.

A: It hasn't really been unpredictable because it's a process that sort of flows. You know, in other words, I guess that my process is so important in terms of what kinds of solutions, what kinds of answers, what sorts of products I come up with. So I do trust the process because it's inclusive. It includes ideas from physics, and from biology, and from psychology certainly, and it helped me to come to some answers.

Q: So, those principles from the sciences are always in play anyway and they are more of the things that you kind of sort through.

A: Yes.

Q: That's interesting. You know, we talked about the development of the program and development of your art. What do you see in terms of larger trends in the sciences, art therapy, education, or art that have had an impact on your work? You talked about psychoanalysis a little earlier. Any other major schools of thought from other areas that have impacted your career?

A: Well, I think that the interest that I have in reading about science and art and how they interact has had an influence. The people who have influenced me in terms of my readings have been John Dewey and Arthur Koestler. People who have a very broad vision of life and put things together from various sources have always been interesting to me in terms of reading. I see that the movement of science and the movement of art and the movement of education have all been gradually expanding, expanding, expanding to be more or less able to accept within the realm of life experience other ideas, newer ideas, that come from different sources.

Multiculturalism, for example, is nothing more than an expansion of our ability to take in and accept. And, you know, as I understand it, evolution itself has to do with growing from the simple to the complex, and we are constantly moving more and more into complexity. Now that requires a different kind of understanding. I mean, if you deal with things on a one-to-one basis, it's pretty simple. You know, this causes that, but you don't have that today. You have cocktail mixtures of medications. You have hundreds of thousands of people congregating in hundreds of thousands of little groups. I mean, the communities that we have to deal with today believe: "I am a person who takes a certain kind of medication. . . . I belong to a group of people who do this. . . .We all buy Chevrolets," or whatever. Not to mention, all the ethnic and cultural groups that we have to deal with. At any rate, how do you grapple with this kind of complexity? That's what's happening. You deal with it like artists deal with it. You have to understand the true nature of diversity and how you bring it back into unity. How do you take more and more and more and make it simpler, more understandable. Technology helps, certainly, and of course, the thing that I think is much more important is that fact that if you understand something about patterns and groupings and relationships, you will be able to deal with it. But I absolutely believe that that's what the trend is. It's towards more and more diversity.

Q: So really forcing us, again, to select and to sort from a richer field and then once those selections and that sorting have been done to really begin to distill ideas down to a usable form.

A: Yes, yes. In order to make things functional, they have to come within the framework of the individual person and that's what's so difficult, you know, because most people can't handle too many ideas at one time. I don't know, maybe it's five or something, but we have to have ways of being able to plug into that kind of immensity. At the same time, the earth is getting smaller and smaller and smaller and there's more and more communication. That's what is happening and how big it's getting. That's how much we have to learn. That's how much is out there waiting to be put into our information carriers.

Figure 2 Don Seiden in his Chicago studio

Q: And so art therapy is like any other field, and the people working in it are faced with that immensity of information, that overwhelming tidal wave of information, and how to sort it out. Do you see for the field any particular trends in growth or danger as we go forward?

A: Looking at the field of art therapy, I see the need for us to begin to think more like artists, not less. To begin to understand that making art is exactly what is required to take all sorts of unconnected things, things that don't look as if they're necessarily related, to have a belief that they are connected and bring them together into some sort of unity and wholeness. Other people don't do that. Science tends to take things apart and find out what makes them tick. But artists are the only people who really take everything and pack it up and put it into this simple form. That's very important because artists are so used to seeing on a grand scale you know, to looking at the world with all of its stimulation. Think of growing up when your fantasy life was just so vibrant you had to find ways to take all the information and put it into some simple form to be able to understand. That's what artists do best. That's what they're here for, and I think if we as art therapists begin to think that way more and more, we're going to understand why art could be helpful to people. It can simplify life. It could make life more functional, you know, go back to the drawing board and see what it's like and then go out and do it.

Q: But there's that very murky and complex stage when you're sorting through all of the extremes, the bits and pieces first, I think, that can be exciting but also confusing and scary, and I wonder how it is that we can help people with that transition.

A: Well, during the time when people are attempting to sort out their lives, that's when chaos fades and that's why science is so helpful in this. You can utilize a lot of help to simplify the pieces and the parts and understand how they fit into the whole structure in terms of diagnosis and treatment options. So you get an opportunity to observe what science has done already and will continue to do, to sort out those facts. However, in order to help people pull them together into a functional unit, science cannot help very well. Science can help people understand the nature of the problem, but it takes the other side of the person to pull it all together and re-create—so the word *creativity* is extremely important in mental health. I mean, you don't have healing processes without creativity occurring. Even if it's a cut, you're going to get scar tissue. Something new has been added.

Q: So it's that synthesis that we can provide versus a more analytic, scientific approach?

A: I believe that's very, very important.

Q: What about the kinds of places that we'll work? I mean, you started out in a classic kind of context: long-term, inpatient, psychiatric, primarily adult, in a psychodynamic, psychoanalytic, medical model.

A: That's changing dramatically. I don't see the art therapists leaving that setting totally; however, certainly as the years went on I saw patients who would have been in the hospital for years sometimes come out in 6 weeks. I think time limits have been getting smaller and smaller so that the whole world has speeded up to such a degree that we have to work in much more difficult ways, not only time-wise but also by moving out into the community. Art therapy people are expanding; they're getting more complicated in their own lives. Art is necessary in life now, much more so than ever before. It's not so much a commodity. It's far more of a living vehicle for people to utilize in their lives. I don't know if I answered that question.

Q: You're really addressing the idea of moving out of your confined contexts to more integrated contexts within the community.

A: Yes.

Q: And it sounds like, at least, it was hinted that art needs to do that as well, the field of art, to move out of the galleries and into people's lives in some new ways.

A: Yes, and it is happening in so many interesting ways. I mean, the artist was always on the fringes of society, critiquing it from various points of view. Today, I think that there is a movement that allows the artist to become more a part of things, and art therapists, as people, are smack in the middle of things. I mean, like teachers, they are out there in the trenches working with people directly, using art, and it's been very helpful. It works beautifully well, and I think all that means is that more and more art therapists will be needed as time goes on, but in different capacities.

Q: And in the capacity not as commentator and not necessarily as the person who dissects and analyzes as scientists have done. So it's going to be, I would imagine, in that integrating and synthesizing kind of function.

A: I think that's the main function. I think art tends to bring things together, and I think that will always be the case. There is room and this is something that I personally feel very happy about. There is a space. There is room for an understanding of life experience by looking at the products of art as well as the process being something that helps people to function better. And by that I mean that even many of the great artists who suffered from mental and emotional disorders and some who "died in the line of beauty," as I like to say, left behind great art which in some respects was the solution to the order out of chaos problem. Art has a history of doing, looking, and understanding how to bring things together and can help people understand how to pull together parts of our life and make them part of something bigger, whole, and significant, and I think that's an area that we need to understand more fully. It is not interpretation of art, it is more like an understanding of art that helps us to understand how it was accomplished.

Q: So, you're really talking about an interesting, and I think, underutilized aspect in the therapeutic potential of art. Not a view exclusively to the "making" of art, which is what art therapists traditionally try to get their clients to do in some way, but in terms of a certain therapeutic "viewing" of art in a way that is different than museums do and different from an art historical perspective.

A: Yeah, that to me is an exciting new world that we haven't done a whole lot with yet. But it's there waiting for us. Can you imagine how one could enter the formal world of art, the horizontals, the verticals, the circles and the squares, and through that entry understand the dynamics of life experience? That is, can we know what it's like to be walking that horizontal plane? And having sudden intersections occur? Can you really understand what that might say about life? Can we walk that wavy line and understand what it means to meander as opposed to going from here to there, straight line, goal-orientation? And, how do you mix it up and make it beautiful? It's done everyday. Artists do it all the time, but we don't look at art that way very often. We tend to segregate everything.

Q: Even that language is not particularly the language of the therapeutic encounter.

A: No, it isn't. But I think that we're missing some language here. I think science needs it. Everything is way too sequential. It's "follow this after that." There needs to be, in communicating with clients, much more of the interaction between image and word that allows for some new way of perceiving.

Q: It's the kind of analogies you mentioned earlier when you talked about magic—the world of magic versus the world of science. I mean, that's much closer to the world of magic there because you're dealing with analogy in a more direct way.

A: Yeah. I've always thought that I'm on this continuum with magic over here and science over there and art sort of goes like this (back and forth gesture), but I always have felt more comfortable with magic. Except today, there's a reaching out and I've seen it in my contacts with people in the sciences and on a few occasions when I've attended and been part of symposia where science and art have come together. There's a need for one another.

Q: In the cases that I know that you've been involved with, it seems like a reaching out on the part of science versus art reaching to science.

A: It definitely has been that way. Art needs science to give credence to intuition. Science needs art to give life to fact. Something like that.

Q: And you're standing between them?

A: Smack in the middle.

Q: Shuttling back and forth between the two?

A: Right.

Q: What haven't we touched on? What do you see for yourself? What kind of synthesis are you ready to make now?

A: Well, it seems for me that it is, in many respects, an evolution of sorts. I did a series of paintings here at the show called an evolution series. It went from Monday through Sunday. Each one was a different day, and they sort of connected back to the evolution of mankind if you will. But, I realized that I cannot really predict what is going to happen to me, in the sense of more and more integration, except that my world is in some ways becoming more and more boundaryless than ever before. And so, what seems to be happening is that I'm becoming more and more Don Seiden, whoever that is, which is, I think, as it should be as I get older. I mean, I was born into the world and given this name. I'm gonna die and walk out of this world with that name and that's about it, but. . . .

Q: But, you're refining it and polishing it.

A: But I'm polishing it all the time like Brancusi would polish his sculpture.

Q: Which is, I imagine, looking at them, a polishing that is being done in a very loving way. I mean, gently, to find the most appealing aspects in them.

A: I think so.

Q: And it seems like a process that you're working on yourself.

A: Yes.

Q: Well, I've enjoyed this talk.

A: Thank you, I have too.

Epilogue

I have known Don since my earliest involvement with the Chicago art therapy community after returning from graduate school. This, of course, would come as no surprise to anyone familiar with the Illinois Art Therapy Association, since he is considered locally to be the undisputed godfather of the profession. I have recently come to enjoy a rarer pleasure as a colleague at "The School." Working and teaching with him have provided me with the opportunity to see a true master at his craft. This experience is both joyful and humbling since the standard he has set is not easily approached. I have already caught myself when faced with a teaching dilemma (and probably will many times again) silently asking myself, "What would Don do now?" He has become, for me, a benchmark of quiet wisdom, creative thinking, soothing sensitivity, and above all, excellence in teaching.

John Dewey (1958), the educator, psychologist, and philosopher, said:

> The remaking of the material of experience in the act of expression is not an isolated event confined to the artist and to a person here and there who happens to enjoy the work. In the degree in which art exercises its office, it is also a remaking of the experience of the community in the direction of greater order and unity. (p. 81)

This philosophy is strongly reflected in Don's work. These acts of expression, the ordering and making sense of experience, are vital contributions that the arts make to society. Viewing art therapy from its broadest vantage point, we can recognize our role in helping to facilitate this process on the individual as well as the societal level. This perspective is the gift Don gives to the field.

Reference

Dewey, J. (1958). *Art as experience.* New York: Capricorn Books.

Call for Papers for the 10th Art Therapy Association of Florida Conference
"Art Therapy and the At Risk Population" Spring Conference from May 2-4, 1997

Attention Art Therapists, Creative Art Therapists, Mental Health Professionals, Allied Professionals and Educators: ATAF is seeking papers, presentations, panels, and workshops devoted to understanding the professional issues and guidelines that all art therapists follow. Submissions may focus on any topic or population related to this theme; of particular interest are: issues of confidentiality, issues regarding artwork (i.e.: ownership, permanent records, exhibitions), issues of certification and licensure, and issues of graduate and post graduate training and educational standards. Due October 1, 1996 Qualifying materials needed from each presenter includes: 1) Six copies of Presenter's Resume 2) Six copies of Completed Call for Papers Application* 3) Six copies of Bibliography for Presentation

******For further information and proposal forms, please write to:* Mrs. Peggy Dunn-Snow, ATR-BC, LPAT, 2401 SW 50th Street, Ft. Lauderdale, Florida 33312. Continuing Education Credits for art therapists, nurses, social workers, mental health counselors, and marriage and family therapists are being arranged.

Brief Reports

Are Art Therapy Educators Overworked and Underpaid?

Harriet Wadeson, PhD, ATR-BC, HLM, Evanston, IL

Abstract

Questionnaires were sent to the 22 AATA-approved graduate programs to survey the working conditions of art therapy educators. With few exceptions, the data from the 16 respondents indicate that art therapy educators' salaries are lower than national university faculty salary averages, that few are tenured, and that course loads are high. It appears that few educational institutions have made strong commitments to their art therapy graduate programs.

Introduction

As I have struggled to increase the funding for the art therapy master's degree program I direct, amidst shrinking budgets for higher education, I have often felt overworked and underpaid. My annual salary increases have seemed miniscule. Frequently, I have complained to other art therapy educators and have heard their tales of woe. In this frame of mind, I decided to investigate the working conditions of other art therapy educators. Are we really as beleaguered as we seem? Although we frequently discussed course load, administrative responsibilities, rank, and tenure, we were usually too delicate to mention salary. In order to gather that very important information as well, I developed a brief one-page questionnaire that would be filled out anonymously. I sent it to the 22 AATA-approved MA programs. I reasoned that these are established programs, rather than brief experiments, and would therefore give an accurate picture of art therapy in academia. There were 16 responses, approximately a 73% return.

From the information collected, the factors most relevant were the following: (a) number of full-time faculty, (b) course load, (c) salaries, and (d) tenure. These factors seemed the significant determinants of the institutional support given an art therapy educator. (Although faculty rank has symbolic significance, it was not included because salary and tenure are the basics of remuneration and job security.)

Two earlier surveys also collected information on art therapy faculty salaries. Lusebrink (1993) received responses from 10 approved art therapy graduate programs. Gordon and Manning (1991) surveyed individual art therapists. Of 1,022 who answered a salary question, 121 were faculty. Nevertheless, it was difficult to interpret the results of these studies because neither study indicated whether salaries were for 9-month or 12-month contracts.

Table 1 shows the responses obtained from each institution in this current study. A monthly salary rate has been added in order to compare 9-, 10-, and 12-month contracts. Information not supplied is signified by "?."

Public vs. Private Institutions

Respondents were queried as to whether their institution was public or private since private institutions tend to pay higher salaries than public colleges and universities. This surmise was borne out in a 1994-1995 faculty salary survey by the American Association of University Professors (AAUP) (Silverman, 1995). AAUP questionnaires were mailed to administrators at approximately 3,000 colleges and universities; responses were received from 2,200, accounting for more than 90% of all U.S. faculty. Although my questionnaire distinguished public and private institutions, it did not specify those that are church-related, where salaries are lower than at public institutions, according to the AAUP survey.

Table 1 indicates that most program director respondents from public institutions are on 9-month contracts, whereas most at private colleges and universities are on 12-month contracts. Contract length is more variable among other art therapy faculty.

Number of Full-Time Faculty

Lusebrink (1993) found among 10 approved graduate programs that one had four full-time faculty; three had three full-time faculty; two had two full-time faculty; and four had one full-time faculty. These results are consistent with the results obtained from the 16 programs included in this study: one program has four full-time faculty; four programs have three full-time faculty; five programs have two full-time faculty; and six programs have one full-time faculty.

Anyone who has taught in an art therapy graduate program recognizes that the number of full-time faculty available to handle the many needs of students, programming, practicum sites, AATA approval, and intrauniversity relations makes a significant difference. Among responding institutions, the average number of full-time faculty is a little less than two (1.93), with six of the 16 programs managing with only one full-time faculty. Although courses may be taught by part-time instructors, for these six the burden of the entire program, including its administration, rests on the shoulders of only one person.

Course Load

Not surprisingly, course load is related to number of full-time faculty. In fact, Table 1 shows that at those six institutions with only one full-time faculty, the program director teaches four to six courses per year. Therefore, in addition to all the administrative responsibilities, these art therapy educators carry full teaching loads. At schools with more than one faculty, the program director is given release time for administrative duties by carrying a smaller course load than other faculty. (Institution K is the exception; here the program director teaches one more course, but he or she is on a 12-month contract and the other faculty are on a 9-month contract.)

Colleges and universities vary in the expected full-time faculty course load, usually ranging from four to eight courses per year as can be seen in the spread among art therapy educators. Further, some respondents cited additional contracts to teach extra courses (Institution N), supervision added to course load rather than being a part of it (Institution A), and coteaching (three out of four courses for the program director of Institution G). Among the respondents, average annual course load is five courses for program directors and almost seven (6.66) for other art therapy faculty (see Table 1).

Salary

Lusebrink (1993) cites salary ranges by rank, but there is no indication of the number of faculty at each rank. Gordon and Manning (1991) break down salary range by percentages, showing a preponderance of low salaries: 20% below $20,000, 27% between $20,000 and $30,000, 22% between $30,000 and $40,000, 16% between $40,000 and 50,000, 3% between $50,000 and 60,000, and 6% over $60,000. As mentioned above, no distinction is made between 9-month and 12-month contracts.

It's difficult to compare salaries of those with 9-month and 12-month contracts. On the one hand, it is assumed that those with full-year responsibilities have an opportunity to make more money than those with a standard 9-month contract. On the other hand, educators who have the summer off may take much needed rest and relaxation and/or have the opportunity to earn

Table 1
Art Therapy Educators' Survey

		Program Director				Other Full-time Faculty					
Institution	**No. of Full-time Faculty**	Annual Course Load	Annual Salary	Contract Months	Monthly Salary	Annual Course Load	Annual Salary	Contract Months	Monthly Salary	**Tenured**	**Tenure Track**
Public											
A	3	5	$55-60,000	12	$4,583-5,000	?	$45-55,000	12	$3,750-4,583	3	N/A
B	1	6	45,500	9	5,055	N/A	N/A	N/A	N/A	1	N/A
C	2	4	33,600	9	3,733	6	32,000	9	3,555	0	2
D	1	6	33,600	9	3,733	N/A	N/A	N/A	N/A	0	0
E	2	6	32,000	9	3,555	?	?	?	?	0	1
Private											
F	3	6	75,000	12	6,250	8	40,000	9	4,444	1	2
G	4	4	58,522	12	4,879	?	32-45,000	12	2,667-3,750	0	0
H	1	3-4	48,000	12	4,000	N/A	N/A	N/A	N/A	0	1
I	1	4	45,000	12	3,750	N/A	N/A	N/A	N/A	1	N/A
J	2	5	40-50,000	9	4,444-5,555	8	40-50,000	9	4,444-5,555	1	1
K	2	6	42,000	12	3,500	5	35,000	9	3,889	1	1
L	2	7	42,000	10	4,200	6	?	?	?	N/A	N/A
M	1	5	40,000	12	3,333	N/A	N/A	N/A	N/A	N/A	1
N	3	4-5	34,000	12	2,833	6-7	30-45,000	12	2,500-3,750	1	2
O	1	5*	34,500	12	2,875	N/A	N/A	N/A	N/A	N/A	N/A
P	3	2	?	9	?	7	?	9	?	N/A	N/A
Average	2	5	$43,400		$4,393	7	$40,800		$3,991		
9-Month Equivalent			39,533				35,918				

? information not supplied
N/A not applicable
0 tenure/tenure track available but none on it
* quarter system

money elsewhere, perhaps teaching in a desirable location for all or part of the summer. The monthly amount entered in Table 1 indicates earnings for the actual time at the institution. Two respondents noted that they earned extra summer salaries (Institution B, $11,000 for administration and teaching one course and Institution D, $9,000 for advising and teaching one course in the summer). Another (Institution G) stated that salary is based on clinical work as well as teaching, so it is difficult to compare salaries from that school with the others. Table 1 shows that at all but one school (Institution K) the program director's salary is higher than that of other art therapy faculty. (Institution J gives the same range for both, so it is not possible to tell.)

The average monthly salary for program directors is $4,393, or the equivalent of $39,533 annually for a 9-month contract. (For those respondents that give a range, the midpoint is used in computing an average. Institution G is not included since salary there is based on clinical work as well.) The average monthly salary for other faculty is $3,991 or $35,915 for 9 months. (For other faculty salaries that show a range, the midpoint is used in averaging if there is only one other faculty; where there are two, the top of the range is used for one and the bottom for the other. Once again Institution G is excluded since salary is based partially on clinical work.)

It is evident from the AAUP survey (Table 2) that the average art therapy program director salary of $39,533 is comparable to an average assistant professor salary at a public institution. When comparing the individual salaries in Table 1 to those in the AAUP survey, it is evident that many program directors and all tenured faculty (nine) are associate and full professors. Nevertheless, all program director salaries at public universities are below the AAUP public university associate professor average of $46,990, based on 9-month contracts. (Institution A's 9-month equivalent is $41,250–$45,000.) At the private institutions excluding Institution G (salary includes clinical work), only Institution F's program director earns more than the AAUP private institution associate professor average of $49,990. Removing Institutions F, G, and possibly J, the 9-month equivalent salaries of program directors at private institutions do not even meet the average of $43,630 for associate professors at church-related schools. (The 9-month equivalent for Institution H is $36,000 and for I is $33,750.) Other full-time faculty earn less than program directors, but since only three institutions give a definite figure, it is not possible to generalize. The data show clearly that with the exception of Institution F, salaries of art therapy educators fall below national averages.

Tenure

At three of the 16 institutions responding, with six faculty among them, tenure is not available. Of the remaining 28 full-time art therapy faculty among the respondents, only nine are tenured. Eleven are on tenure track. For the remaining six, tenure is available at their institutions, but not for them:

- No Tenure system: 6 faculty
- Tenured: 9 faculty
- Tenure track: 11 faculty
- Nontenure track: 6 faculty

Of the three institutions with no tenure system, one stated that multiple-year contracts are available (Institution P). Although tenure is available at Institution G, the respondent stated that one must be a full professor and that it is very difficult to obtain. One might question the security of the nine art therapy programs with no tenured faculty, five of which also do not have any faculty on tenure track.

Discussion

In addressing each of the four factors described, the general picture emerges as follows: Of the 16 programs for which there are data, seven operate with only one full-time faculty; 10 program directors carry a full course load of five courses or more annually; all other faculty teach at least five courses annually and some as many as eight; salaries are considerably lower than national averages; and tenure is not available to 12 out of 32 full-time faculty.

It might be postulated that an established, professionally approved clinical training program should have at least the following:

- a minimum of two full-time faculty;
- a program director who is tenured at the rank of associate professor and earning at least the AAUP lowest average of $43,630 for that rank;
- other faculty on tenure track at the assistant professor rank and earning at least the AAUP lowest average for that rank of $35,900;
- release time for the program director to handle administrative responsibilities;
- a maximum annual course load for the program director of no more than four courses; and
- other full-time faculty who each carries an annual course load of no more than six.

Table 2
Average Faculty Salaries from AAUP Survey, 1994-1995

	All-combined	**Public**	**Private/ Independent**	**Church-related**
Professor	$63,450	$62,000	$73,160	$55,940
Associate professor	$47,040	$46,990	$49,990	$43,630
Assistant professor	$39,050	$39,210	$41,230	$35,900
Instructor	$29,680	$29,600	$31,660	$28,380
Lecturer	$32,600	$31,890	$36,400	$31,520

Source: American Association of University Professors

When we look at Table 1, it is evident that only Institutions A and F meet these rather minimal standards. Both program directors' course loads are higher than the suggested amount, but they are spread out over 12 months.

The overwhelming conclusion from the data is that art therapy graduate programs are hardly the jewels in the crown of their respective institutions. Looking at the figures for the individual schools in Table 1, most are characterized by either one faculty, no tenure, or low salary. It appears as though most institutions have made only the minimum commitment to their art therapy master's degree programs.

In trying to understand the meaning of these conditions, it is unclear whether this is the price to be paid for being an educator in a not-yet-well-established field or if the implications are more complex. In recent years, at least five graduate programs have closed. Art therapy training programs seem to be expendable. Although a few of the training programs are over 20 years old, the overall picture of art therapy education has a temporary feel, as though the institutions that house them are unsure about giving their continuing support.

Art therapy educators ask a lot of themselves. They are leaders and models. They join the struggle for licensure, in some states just to allow art therapists to practice. They try to embody the best art therapy can be. They inspire their students, fight for training programs, often as a sort of stepchild in the academic family, and do all this while overworked and underpaid.

References

Gordon, R., & Manning, T. (1991). The 1990-91 membership survey report. *Art Therapy: Journal of the American At Therapy Association*, 8(2), 20–29.

Lusebrink, V. (1993). Art therapy faculty survey. *Art Therapy: Journal of the American Art Therapy Association*, *10*(3), 156–158.

Silverman, E. R. (1995/June). Two separate surveys find salaries for faculty increasing at all levels. *The Scientist*, 12.

AATA and Maginnis & Associates

...your source for Professional Liability Insurance.

Shopping for insurance coverage can be confusing and tedious, especially if you're self-employed. As an AATA member, you are eligible for AATA-endorsed professional liability insurance coverage through Maginnis & Associates. Whether you are **Employed or Self-Employed**—Maginnis offers you affordable, mobile Occurrence Form coverage. For more information, simply complete and mail the form below or call us toll-free at

1-800-621-3008, ext. 105 *or ext. 108 if you're self-employed.*

Detach here

☑ **YES!** *Please send me more information about the AATA-endorsed professional liability insurance program. I understand no salesperson will call, and I am under no obligation.*

Name

Address

City State Zip

Please detach and mail to:

Maginnis & Associates
A Division of KVI,
ATTN: LEAD DESK
332 S. Michigan Avenue
Chicago, IL 60604

S.C.__A__

A Reference Library for School Art Therapists

Sarah P. Hite, MS, MSEd, ATR-BC, Norfolk, VA

Abstract

Although school art therapists have more clinical training than similar master's level professionals working in schools, art therapists often are not trained in a number of areas essential to success in the educational setting. This paper reviews areas of competence essential to comprehensive school art therapy service delivery and suggests books, journals, and journal articles for use by school art therapists as a resource library. The author suggests art therapy texts as well as references in the areas of assessment in special education, intervention in the school setting, program planning and evaluation, consultation, and research. Utilizing these resources will enhance the effectiveness of those seeking to meet the challenges and urgent needs represented by increasing numbers of students with special education needs.

Introduction

Opportunities for school art therapists are growing because the numbers of children in need of specialized services in school are increasing rapidly. As a result of today's health care crisis, we are seeing more and more disturbed youngsters in schools, who previously might have been seen in clinical settings. Increasing numbers of students are deemed eligible for special education services, and the population of at-risk, behavior-disordered students who do not qualify for special education services is growing daily (Capuzzi & Gross, 1989).

Art therapy offers a unique answer to the challenge of these students with special needs because art-based interventions can address all spheres of a child's functioning: cognitive, emotional, social, and physical (Anderson, 1994; Fowler, 1994). Although they have more clinical training than teachers and most school counselors, art therapists are not often trained in a number of areas essential to success in a school setting. Special education settings and alternative schools may be utilized as practicum placements in graduate art therapy training, but few programs offer specific coursework to prepare the graduate for work in schools (J. Bush, personal communication, March 6, 1995). The purpose of this paper is to review areas of competence essential to comprehensive school art therapy service delivery and to suggest books, journals, and journal articles to which the art therapist working in a school setting might refer. This list of reference materials is meant to augment the art therapist's clinical and practice library containing volumes on psychopathology, assessment and diagnosis, ethics and standards of practice, supervision, cross-cultural issues, and safety in the art room.

Art therapists work in school settings under various auspices. They are providers of related services to special education students. They are consultants to school counseling, psychology, or social work departments; child study teams; and curriculum development committees. They are therapeutic art teachers in schools for students with special needs, or they are art teachers whose classrooms are filled with students at risk of dropping out of the educational system. Sometimes art therapists working for community agencies deliver services in school buildings.

Since there are so many models of school art therapy service delivery, no text is sufficiently comprehensive to cover all aspects of the field. Therefore, in addition to select art therapy texts, we can utilize a small collection of reference materials addressing areas of competence school art therapy requires of its practitioners. These areas include assessment, intervention, program planning and evaluation, consultation, and research.

Recommended Art Therapy Texts

The core of the school art therapist's library consists of three books devoted exclusively to art-based interventions in schools. *Art for All the Children: Approaches to Art Therapy for Children with Disabilities* (Anderson, 1992) covers most aspects of delivering direct art therapy services in special education settings. In addition to a clear overview of the theoretical bases of art therapy and children's art development, the book includes art therapy approaches specific to each category of special education. Excellent chapters covering Individualized Educational Program (IEP) development, adapting the art experience for students with disabilities, and self-concept development through art make this book the theoretical and practical foundation of the school art therapist's library. Anderson's 1994 *Art-Centered Education and Therapy for Children with Disabilities*, a text intended for undergraduate art, art therapy, and special education students, is also invaluable to the practicing school art therapist. In addition to similar but abbreviated versions of material covered in her earlier book, Anderson includes several chapters about utilizing art to facilitate learning in specific content areas, through integration of art into the special education curriculum.

Henley's *Exceptional Children Exceptional Art: Teaching Art to Special Needs* (1992) is the third core school art therapy text. Henley bases his theoretical approach on Lowenfeld's and Kramer's works, and defines the role of the art specialist who works with students with special needs as a therapeutic art educator, placing emphasis on the capacity of the art specialist to function as both teacher and support staff in the special education setting. While this is a book about teaching art, chapters on setting up the art room, adaptions, IEP development, and especially media choice and art tasks for exceptional students make this text essential.

Assessment in Special Education

Hallahan and Kauffman's 1994 *Exceptional Children: Introduction to Special Education* is an excellent resource for understanding categories of exceptionality and the characteristics of students in various categories, as well as history and current trends in special education. A chapter on multicultural and bilingual aspects of educating students with special needs makes this special education text up-to-date. Included in each chapter on exceptionality is a section about transition to adulthood and independent living, which is particularly useful to the school art therapist working with adolescents. The book is illustrated with paintings rendered by artists with impairments, making it uniquely appealing to art therapists. The world of special education moves so swiftly that textbooks often cannot stay entirely current. Even though *Exceptional Children: Introduction to Special Education* is among the newest texts on the market, issues related to inclusion as well as to students who are "Other Health Impaired" are not addressed in this book.

Exceptional Lives: Special Education in Today's Schools (Turnbull, Turnbull, Shank, & Leal, 1995) fills in these gaps. This book includes a comprehensive chapter on inclusion and collaboration. These two models of educational reform, inclusion and collaboration, are of relevance to art therapists because art therapists may function as related services providers under either model. This text also includes the most current information on special education public policy and laws and has chapters on the newest categories of exceptionality, Traumatic Brain Injury and Autism.

Intervention

To supplement the school art therapist's clinical skills and ground the treatment approach in an educational setting, two books and three journals are particularly helpful. Capuzzi and Gross' *Youth at Risk: A Resource for Counselors, Teachers and Parents* (1996) introduces the art therapist to concepts and definitions related to the rapidly increasing population of students at risk, those youngsters who do not meet criteria for special education but who are clearly in need of specialized interventions and services. Of particular use to art therapists are the chapters on topics not typically included in most clinical texts: adolescent pregnancy, gang membership, and preventing school dropout. Additionally, information about successful programs that address the educational needs of youth at risk might be useful in planning art therapy interventions with this challenging student population.

The Mentally Ill Child Grows Up (Black, 1994) addresses the critical problem of disturbed adolescents' transition from the special education setting to the world of work. Treatment approaches, legal aspects of work related to handicapping conditions, and elements of successful programming are discussed.

The Council for Exceptional Children, an organization devoted to improving the educational outcomes of individuals with exceptionalities, publishes two journals which are useful resources for school art therapists. *Exceptional Children* includes results of rigorous special education research, and *Teaching Exceptional Children*, directed at professionals who work with students with exceptionalities, contains information about classroom strategies that work with exceptional students. The National Dropout Prevention Network is an organization whose mission is to address the educational needs of students at risk; this group's new publication, *The Journal of At-Risk Issues*, explores a range of topics related to alternative education, dropout prevention strategies, and programs that work to improve the educational outlook of students at risk.

Program Planning and Evaluation

Any school art therapy program must include a mechanism for accountability so that consumers such as parents will know that the services they are paying for through tax dollars or tuition are yielding positive results. Individualized Educational Programs for students in special education have evaluation measures built into them, but not all students served by art therapists are special education students. Furthermore, a program of services requires comprehensive accountability and evaluation because documented positive outcomes can provide the rationale for continuing services. As part of public education, school counselors have long been involved in evaluation for this purpose and to ensure that high-quality services which meet specific needs continue. The school counseling text, *Developmental Guidance and Counseling: A Practical Approach* (Myrick, 1987), has a good chapter on accountability which is easily adapted for use in school art therapy programming.

Dade County Public Schools' *Handbook for Therapists* (1994) is the program guide for the Clinical Art Therapy Program in Miami, Florida, which employs more art therapists than any other school system. This manual contains details of every aspect of the Dade County program, including job descriptions, procedures for every job activity from ordering supplies to writing assessments, guidelines for meetings with parents of students, and forms for documentation and recordkeeping. Although specific to Dade County, this is an excellent example of a thoroughly planned, comprehensive program manual and can serve as a model for school art therapy program planning and evaluation in other school systems.

Consultation

Consultation: School Mental Health Professionals as Consultants (Dinkmeyer, Carlson, & Dinkmeyer, 1994) states that consultation in schools involves adults sharing information and ideas, coordinating services, and strategizing about solutions to problems. Usually the problems requiring consultation relate to the adults' inability to meet the educational needs of students. This text, written for school counselors but easily adapted to school art therapy, asserts that consultation offers a "powerful tool to change the school environment and community" (p. 14). Thus, consultation skills are essential for art therapists engaged in persuading school systems about the value of art therapy services and programs. These authors utilize an Adlerian approach to consultation, an approach widely used and understood in schools. The authors define the consultant's role in the school setting and suggest practical techniques and strategies for working with teachers and parents.

Sherman, Shumsky, and Rountree's 1994 *Enlarging the Therapeutic Circle: The Therapist's Guide to Collaborative Therapy with Families and Schools* describes models of consultation and therapeutic collaboration. Although not all school art therapists will be utilizing the family systems model offered here, several chapters prove useful for school art therapists regardless of their theoretical approach. Chapters on the organization of schools and school systems, consultation models, school-based intervention models, and case examples might all be useful for the art therapist working in a school setting.

Art therapy consultation may involve offering education and training to teachers, staff, and administrators regarding an art therapy approach with students with special needs. Lyons and Tropea's 1987 article, "Creative Arts Therapists as Consultants: Methods and Approaches to Inservice Training in the Special Education Forum," relates the authors' experiences as arts consultants to the Arts in Special Education Project in Pennsylvania. Practical suggestions for format, content, and approach to inservice training for special education teachers are provided.

Research

References to guide the school art therapist in research efforts are the final component of the school art therapist's resource library. Like evaluation measures which show the success of school art therapy programming, research results indicating that art therapy yields significant positive change in students with special needs can justify funding for more services. To augment *A Guide to Conducting Art Therapy Research* (Wadeson, 1992), a text aimed specifically at research in education is useful. Isaac and Michael's *Handbook in Research and Evaluation* (1995) succinctly covers all dimensions of educational research, including a section on organizing, classifying, and operationalizing cognitive and affective objectives for research. This section is especially useful for art therapists who must translate more familiar, clinically oriented treatment goals into research objectives stated in educational language.

A Guide to Conducting Art Therapy Research (Wadeson, 1992) contains information about seeking grant funding for research. An additional reference specific to schools is *Grants for Special Education and Rehabilitation: How to Find and Win Funds for Research, Training and Services* (Ferguson, 1993). This handbook provides detailed, step-by-step guidelines for writing grants, glossaries of funding sources for special education, handy charts and outlines, and federal application forms. For school art therapists working with at-risk rather than special education populations, the same author and publisher (Capitol Publications, Inc.) have produced numerous similar sourcebooks.

These are some suggested volumes, articles, and journals which, coupled with basic art therapy resources, constitute the knowledge base and address competency areas of school art therapy. Utilizing these resources will enhance the effectiveness of those seeking to meet the challenges and urgent needs represented by increasing numbers of students with special education needs.

References

Anderson, F. E. (1992). *Art for all the children: Approaches to art therapy for children with disabilities* (2nd ed.). Springfield, IL: Charles C Thomas.

Anderson, F. E. (1994). *Art-centered education and therapy for children with disabilities*. Springfield, IL: Charles C Thomas.

Black, B. (1994). *The mentally ill child grows up*. New York: Brunner/Mazel.

Capuzzi, D., & Gross, D. (1996). *Youth at risk: A prevention resource for counselors, teachers, and parents* (2nd ed.). Alexandria, VA: American Counseling Association.

Council for Exceptional Children. *Exceptional children*. Reston, VA: Author.

Council for Exceptional Children. *Teaching exceptional children*. Reston, VA: Author.

Dade County Public Schools Office of Exceptional Student Education. (1994) *Handbook for art therapists*. (Available from the Clinical Art Therapy Program, Dade County Public Schools, Art Therapy Office, 1500 Biscayne Boulevard, Miami, FL 33132)

Dinkmeyer, D., Carlson, J., & Dinkmeyer, D. (1994). *Consultation: School mental health professionals as consultants*. Muncie, IN: Accelerated Development.

Ferguson, J. (1993). *Grants for special education and rehabilitation: How to find and win funds for research, training and services*. Alexandria, VA: Capitol Publications.

Fowler, C. (1994, November). Strong arts, strong schools. *Educational Leadership*, 4-9.

Hallahan, D. P., & Kauffman, J. M. (1994). *Exceptional children: Introduction to special education*. Boston: Allyn and Bacon.

Henley, D. (1992). *Exceptional children exceptional art: Teaching art to special needs*. Worcester, MA: Davis.

Isaac, S., & Michael, W. (1995). *Handbook in research and evaluation* (3rd ed.). San Diego, CA: EdITS.

Lyons, S., & Tropea, E. (1987). Creative art therapists as consultants: Methods and approaches to inservice training in the special education forum. *The Arts in Psychotherapy*, *14*, 243–247.

Myrick, R. D. (1987). *Developmental guidance and counseling: A practical approach*. Minneapolis, MN: Educational Media.

National Dropout Prevention Network. *The Journal of At-Risk Issues*. Clemson, SC: Author.

Sherman, R., Shumsky, A., & Rountree, Y. (1994). *Enlarging the therapeutic circle: The therapist's guide to collaborative therapy with families and schools*. New York: Brunner/Mazel.

Turnbull, A., Turnbull, H., Shank, M., & Leal, D. (1995). *Exceptional lives: Special education in today's schools*. Englewood Cliffs, NJ: Merrill.

Wadeson, H. (Ed.) (1992). *A guide to conducting art therapy research*. Mundelein, IL: American Art Therapy Association.

BEST COPY AVAILABLE

Viewpoints

Art Therapists Exhibiting Children's Art: When, Where, and Why

Leslie P. Knowles, MA, ATR, LMHC, South Dartmouth, MA

As a member of the Editorial Board of *Art Therapy*, I became increasingly concerned as I reviewed articles for this issue and realized that displaying artwork created by children in art therapy in school settings has become a common practice. Every article I reviewed stated that client artwork was being exhibited in the school and, in a few cases, artwork was hung in school hallways for public viewing. For example, one author wrote about an exhibition of art created by a group of adolescent girls who were in treatment to deal with peer and school difficulties. All the girls had emotional problems and came from a variety of dysfunctional situations. Many had histories of trauma and abuse. The therapist decided to hang body tracings made by these girls during art therapy sessions in the school corridors for students, teachers, and staff to view. The author never mentioned how these emotionally disturbed girls were protected from possible ridicule or overwhelming feelings that can accompany viewing one's artwork on public display.

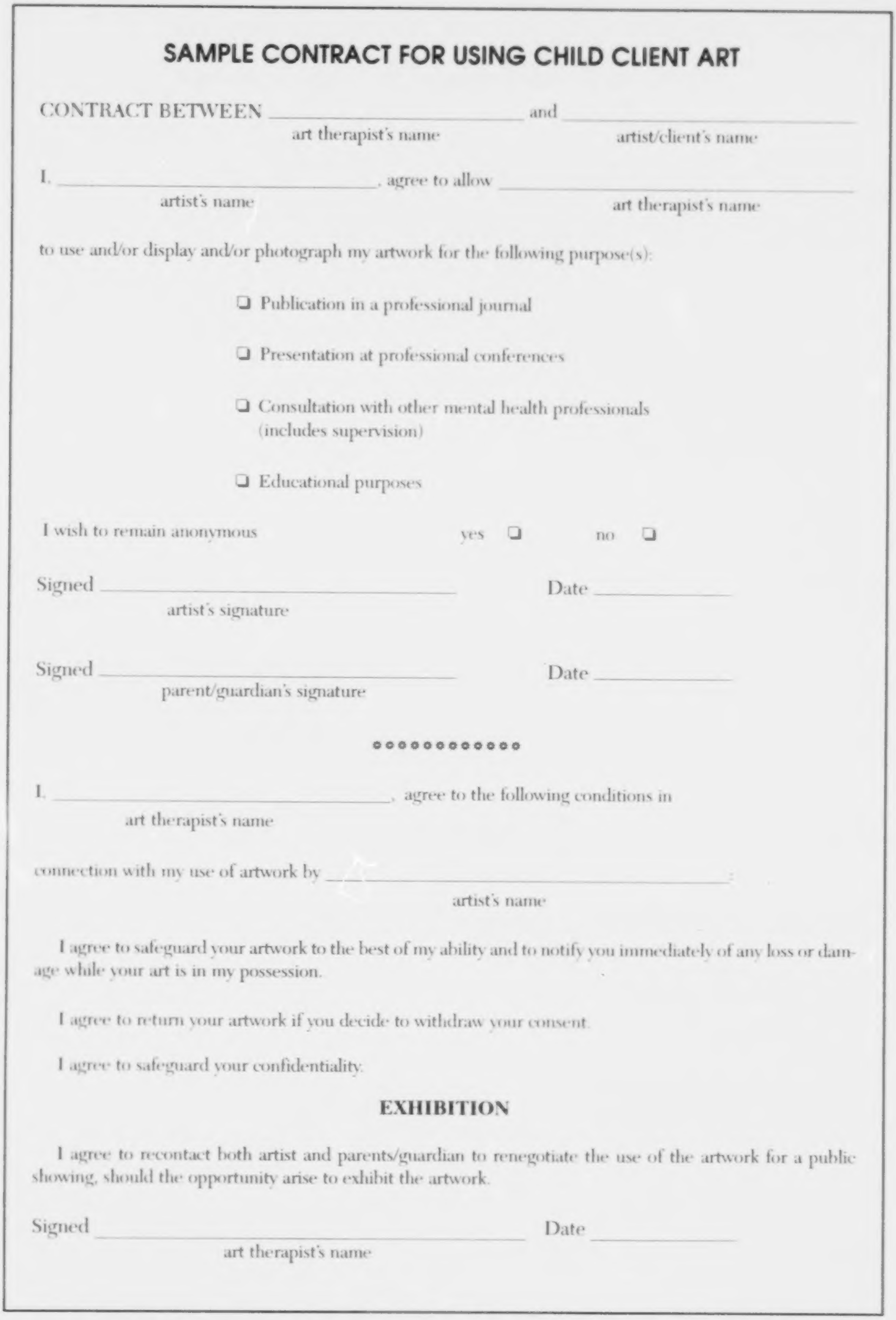
After reading these accounts, I experienced a growing tension in the pit of my stomach that seemed to be a signal that something was amiss. I decided to write some of my thoughts to begin a dialogue with other art therapists about children's rights to confidentiality and the ethics of displaying the artwork they create in art therapy treatment. As a result of my reflections, I question if the American Art Therapy Association has given adequate attention to the potential long-term and damaging effects on a child of exhibiting art done in art therapy for all to see.

Section 3 of the "Ethical Standards for Art Therapists," published by AATA in 1994 addresses the issue of "Public Use and Reproduction of Patient Art Expression and Therapy Sessions." All subsections contain a phrase requiring written informed consent from the patient when art therapists display clients' artwork. For children, informed consent has always involved permission from a parent or guardian. Art therapists are required to obtain written consent to provide treatment. Consent forms for art therapy must include a statement allowing the art therapist to use or display artwork created in a professional setting for the purpose of supervision or education (see Figure 1). Confidentiality is insured and the client is granted the right to revoke his or her consent. When I have presented this form at the onset of treatment, parents and guardians have never failed to provide the requested signatures. By the end of intake, caretakers have entrusted me not only with their child's mental health treatment, but also with the protection of any artwork created by the child while in my care.

When the artwork leaves the realm of traditional therapeutic parameters, confusion about the child's rights may blur sound judgment. The motivation to display clients' art can be strong. Art exhibitions have long provided art therapists with a way to inform the public about their work. Art shows can educate teachers, staff, and parents and can provide evidence of the value of art therapy. Children's imagery is often exciting and provocative, and it frequently cries out to be hung on the wall for others to enjoy. For the child artist, viewing one's own work on a "gallery" wall is thrilling and may help build positive self-esteem. When art therapists use clients' art for case presentations, supervision, and education, the boundaries may also become unclear. There is no doubt that viewing and reflecting on children's art with colleagues and supervisors can be both beneficial and enlightening and can also play a role in safeguarding a child's rights. However, continued care must be taken in these instances to protect confidentiality as the artwork leaves the therapy room.

In her article, "Confidentiality Reexamined: Negotiating Use of Art by Clients," Spaniol (1994) carefully examines the idea of negotiating the conditions under which art therapists may utilize their client's art. She offers a sample release form which "distinguishes between using art for exhibition, publication, presentation, consultation, and/or education" (p. 71). The guidelines for how clients may allow their art to be used are precise and clear. Although her article is geared toward work with adult clients who have the right to make their own informed decisions about use of their art, I believe that a similar form could be used when negotiating a treatment contract with parents and guardians of children. I would attach a clause to Spaniol's prototype consent form requiring the art therapist to renegotiate with the client and his or her parent or guardian if she or he decides to display the child's artwork (see Figure 1). The art therapist must carefully consider the emotional consequences to the child when selecting art for exhibition and should interview the child to explore his/her feelings about having the work shown publicly. The parent or guardian needs information about the negative reactions that their child might have when viewing the artwork on display outside of the therapy session.

Another issue concerns the authenticity of client art and the censorship that may come into play when making art for an exhi-



SAMPLE CONTRACT FOR USING CHILD CLIENT ART

CONTRACT BETWEEN ____________________ and ____________________
art therapist's name artist/client's name

I, ____________________, agree to allow ____________________
artist's name art therapist's name

to use and/or display and/or photograph my artwork for the following purpose(s):

☐ Publication in a professional journal

☐ Presentation at professional conferences

☐ Consultation with other mental health professionals (includes supervision)

☐ Educational purposes

I wish to remain anonymous yes ☐ no ☐

Signed ____________________ Date __________
artist's signature

Signed ____________________ Date __________
parent/guardian's signature

○○○○○○○○○○○○

I, ____________________, agree to the following conditions in
art therapist's name

connection with my use of artwork by ____________________:
artist's name

I agree to safeguard your artwork to the best of my ability and to notify you immediately of any loss or damage while your art is in my possession.

I agree to return your artwork if you decide to withdraw your consent.

I agree to safeguard your confidentiality.

EXHIBITION

I agree to recontact both artist and parents/guardian to renegotiate the use of the artwork for a public showing, should the opportunity arise to exhibit the artwork.

Signed ____________________ Date __________
art therapist's name

Figure 1 Susan Spaniol has given the author permission to reprint Figure 2 from "Confidentiality Reexamined: Negotiating Use of Art by Clients" with adaptations for use with children.

bition. The two approaches to gathering a client's art for exhibition are selecting existing images for inclusion or creating new images after the client is informed that a show will take place. Our goal as art therapists is to encourage our clients to use art materials to explore their feelings with spontaneity and authenticity. However, once aesthetics enters the art therapy room, the probability that censorship will take over for both child and therapist increases dramatically. The hope or expectation that the child's art will become the focus of public attention alters the relationship between the client and the artmaking process as well as the relationship between the client and the art therapist, who acquires the additional role of art critic.

In her article, "Censorship or Intervention: But You Said We Could Draw What We Wanted," Haeseler (1987) describes an incident that occurred when adolescents in an inpatient art therapy group created a mural in which they vented their anger at staff. The art therapy intern displayed this piece in the unit lounge. The staff removed the mural because of its "insulting" content, which upset the adolescents because they felt betrayed. The art therapist had told them that they could express their feelings openly and without restraint. Apparently not! How can we expect children to receive the benefits of art therapy if they do not feel free to express themselves spontaneously and authentically without fear of criticism or censorship? Perhaps an alternative solution to displaying the mural would have been hanging it in a more private setting to initiate a dialogue between clients and staff.

An essential component of both individual and group treatment in art therapy is the processing, searching, and storytelling that evolve after image-making. Within the boundaries of an art therapy session, the child is free to talk about the image, explore its meaning with the art therapist, and make changes that feel appropriate. Moving the artwork into school hallways or inviting others into the art therapy room to view the images exposes the child to a wider circle of commentary. Teacher, staff, parents, or peers may discuss the child's art in ways that foster great pride in the child. However, the child may also hear commentary that she or he perceives as negative, hurtful, or offensive. Art hung in school halls is subject to scrutiny by all; the child's protection and confidentiality cannot be insured.

As a therapeutic discipline, art therapists cannot assume that it's "OK" to hang a child's picture on a wall just because it's art. The display of art created in a therapy session for the purpose of furthering a child's progress in treatment—whether in a clinic, school, or hospital—should be handled by the art therapist as she or he would handle treatment notes. Would we transcribe treatment notes from a session and then hang them in public? Of course not! We must answer the question, "Whose needs are being served by showing clients' art?" Most children have alternative opportunities to display their artwork in school settings if they choose to do so. Child clients who display artistic interest, talent, and enjoyment can be encouraged to participate in artmaking in and out of school and outside of therapy. For instance, they may be given opportunities to make art at home or to take art classes in the community. With the child's consent, this artwork would be appropriate for public display.

My supervision of art therapy graduate interns working in schools leads me to suspect that administrators and teachers often exert pressure on art therapists to show art made in their sessions with children. AATA should consider adopting guidelines aimed at protecting the confidentiality of child clients that supplement those written to protect consenting adult clients. These standards would relieve the intern, as well as the seasoned therapist, from making difficult ethical decisions when they are pressured by administrators.

Art therapy programs need to arm their students with a protocol that will be respected and followed and that spells out the organization's regulations on showing child/client art. In addition, it is imperative that all of us who practice art therapy assess our personal attitudes and policies regarding the display of clients' art. The more time I spend working with children who depend on me to protect their feelings, their confidentiality, and their images, the fewer reasons I find to support showing art made in clinical therapy sessions.

My goal in presenting these ideas is to begin an exchange with other art therapists about the rights of children and the need to protect their feelings, confidentiality, and privacy in treatment. Clearly, there is a lack of consensus within the field on the issue of displaying artwork done in art therapy sessions, and children are most at risk for suffering from our lack of clarity. Perhaps reexamining and reevaluating our thoughts about this issue will ensure that we are working from current ideals and principles rather than past premise.

References

American Art Therapy Association. (1994). *Ethical standards for art therapists*. Mundelein, IL: Author.

Haeseler, M. (1987). Censorship or intervention: "But you said we could draw whatever we wanted!" *American Journal of Art Therapy*, 26, 11–20.

Spaniol, S. (1994). Confidentiality reexamined: Negotiating use of art by clients. *American Journal of Art Therapy*, 32, 69–74.

When the Edges Bleed . . .

Harriet Wadeson, PhD, ATR-BC, HLM, Evanston, IL

What is art therapy? This question appears atavistic for a field with a professional association a quarter century old and practitioners with a history that extends even longer. Although in various stages of art therapy's development, we have continued to define ourselves as a profession with greater or lesser intensity, our present self-reflection appears to be of a different order.

Through most of our development, we have conceptualized art therapy as a discipline of considerable breadth that could encompass many approaches. We have prided ourselves on our inclusiveness. We have had our Freudians, our Jungians, our gestaltists', our art educationists, to name a few (Rubin, 1987). We have had humanists, faith healers, disciples of Native American healing, Buddhists, existentialists, phenomenologists, archetypal psychologists, feminist therapists, and more. And, of course, we have had our very own "art psychotherapists" and "art as therapy-ists." We have recognized that art therapists work with very diverse populations in various kinds of settings and that ways of working that are appropriate for some might not be for others.

So why ask now, "What is art therapy?" Haven't we been refining answers to that question throughout the quarter century of our organized history?

External Pressures

I do not believe the question is atavistic. Something has shifted. What we are negotiating now is not a refinement. We are facing a much clearer polarization where those who are moving to the extremes are themselves asking whether their work is something other than art therapy.

Elsewhere I have written of the current external pressures that are forcing changes in art therapy (Wadeson, 1994). Shrinking health care budgeting that has spawned managed care has further necessitated licensure. Most often it is the counseling license art therapists seek (for example, in California, Massachusetts, and Illinois). For most state licenses, requirements include specifically identified counseling courses. In Illinois, art therapists wishing to sit for the counselor exam after 1998 will have to have graduated from an art therapy master's degree program that identifies itself in the school catalog as training counselors. Parallel to this development are art therapists whose clinical positions have evolved to case management and other responsibilities or who may serve as administrators in sectors other than art or expressive therapy; in other words, art therapists who do little or no art therapy.

Studio Approaches

Against the background of this changing scene, and in some instances because of it, have emerged increasingly vocal art therapists forming a counter valence of studio-based art therapy. In fact, it was the recent issue of *Art Therapy: Journal of the American Art Therapy Association* devoted to "Studio Approaches to Art Therapy" (Malchiodi, 1995) that prompted the reflections presented here. In it Allen (1995) asks, "Is the open studio within the purview of art therapy? This remains an open question . . ." (p. 161) and in describing her approach, "We eschew therapy concepts and practices" (p. 166). In the same issue McNiff (1995) poses a similar question, ". . . I often wonder whether it (art therapy) is an appropriate 'location' for my practice of soul making" (p. 182) and "Even though the mainstream of the art therapy community appears to be increasingly committed to the sacred function of art, the pressures of clinical regulation . . . and general mistrust of the imagination may ultimately restrict the free spirits of the studio so that they migrate to other places (than art therapy), more hospitable to the ways of soul" (p. 183).

Borders

Where are the borders, then, that distinguish art therapy at one pole from art and at the other from therapy? What is it about our work that is uniquely art therapy? Certainly art therapists do not hold a patent on the invention of art. As stated over and over in the issue of *Art Therapy* previously cited (Vol. 12, No. 3), art is for everyone. In his visions of the future, Young (1995) states, "Therapeutic studios will become the dominant form of private practice, in which artists will share their art in a therapeutic way with young people, elderly, handicapped, and 'normal' people . . ." (p. 195). It follows, therefore, that this "ultimate medicine" (Young, 1995, quoting McNiff, 1992) is not the province of art therapists alone. People who call themselves psychiatrists, psychologists, social workers, or whatever are as entitled to use this "ultimate medicine" in their work as readily as we do. Some of them may even be artists.

Where is the boundary between art therapists and other therapists? Especially if art therapists are trained and licensed as counselors and may hold positions that entail work that does not include art, the focus becomes even more blurred. At the other pole, the distinction between art therapy and studio artmaking is even fuzzier. Most of us became art therapists because we found that our own artmaking was "therapeutic." I cannot number the many graduate school applicants who have responded to my question, "Why do you want to become an art therapist?" with responses about wanting to bring to others the healing their own art has brought to them.

Evolution of Art and Therapy Vectors

The answer appears to me to encompass evolvement. As I reflect on my own art therapy career, it seems to parallel art therapy's development in some respects. I entered art therapy because I loved artmaking but knew I did not want to be an artist. I wanted to be a therapist. I believe early art therapists were art people who wanted to work with others in a more personally meaningful way than as art educators. As I began my work at the National Institute of Mental Health, I was entranced. I was fascinated by all I learned, intrigued by psychopathology, amazed by the windows to the inner worlds of my psychotic patients their art opened to me, gratified by the connections I felt with them. They were not "other." In time the feet of clay of the medical model in which I worked began to emerge from beneath its stately robes. I experimented with alternative modes. I began teaching and found that I enjoyed making art with my students, and new learnings came from working in this way. I loved the creative projects students made in art assignments developed outside class. I inaugurated an Annual Art Therapy Summer Institute at Lake Geneva, Wisconsin. There the learning community I had developed at the university deepened to a sustained learning/artmaking community in a beautiful natural setting away from the demands of other responsibilities.

Similarly, I see art therapy as having moved from an art base to intoxication with the clinical and back to the love of artmaking in the community. A swinging pendulum. But I believe our evolvement is more spiral than circular. We will not return to the place where we began. We have come too far.

Definition

The therapy pole seems easier to define. Art therapy is based in art. An art therapist who is not using art in work with clients or is not directing or developing programs utilizing art for therapy is not practicing art therapy. Other mental health professionals who utilize artmaking in work with clients may be practicing art therapy. They are irrelevant to our definition at the present time; future art therapy licensure may restrict art therapy practice to those with art therapy credentials.

Distinctions are more difficult to draw at the art pole. Are quilting bees art therapy? People making art together in some beneficial manner is too loose, too general, too unneeding of an art therapist to characterize our work. This is not to say that the projects described in *Art Therapy: Journal of the American Art Therapy Association* are not of significant benefit to their participants. Nor is it to say that art therapists should not continue to work in this way. But I do not believe this work should be called art therapy. Art therapists might be especially adept at this kind of work, but so might artists who work well with others. And, in fact, such is the case in many instances. For example, Art Encounters, an Evanston, Illinois, organization, in addition to sponsoring visits to artists' studios and other art activities, has formed an artmaking group for blind individuals. The group leader does not claim to be an art therapist. I have been part of a drumming/chanting/dancing group led by a Native American medicine man. The experience is not labeled "expressive therapy."

Art therapy should be therapy, not just therapeutic. Anything can be therapeutic—taking a walk, listening to music, watching the sunset. If I write a poem, paint a picture, talk over a problem with a friend, I may achieve greater therapeutic benefit than from attending a session with a therapist. I may experience catharsis, insight, resolution, transformation, growth. Nevertheless, when we speak of a profession, we must include the professional. An art therapist is one who introduces artmaking for therapy "professionally."

It is not the setting in which we work or the needs of the client with whom we work that determine whether the artmaking opportunities we provide constitute art therapy. It is a question of role. Artists can establish an open studio on a psych ward. Artists can work with drop-ins at a shelter for the homeless. Artists can organize art projects for disadvantaged youth. It is our focus on and commitment to the growth of the individual or the group that distinguishes art therapists from artists working with those in need. It is our knowledge base in human dynamics and art's possibilities for enhancing personal growth that distinguishes us. This differentiation comes clear in an observation made by Henley (1995). He draws attention to the role of the art therapist. He states that the art therapist's "each action or non-action must be supported by a therapeutic assessment which validates the use of interventions" (p. 190). He continues by drawing a distinction between the art therapist and the artist-in-residence in this criticism of Allen's description (1992) of the latter:

> . . . the high-powered, provocative quality of the art (of the art therapy intern/artist-in-residence), . . . may have proved unsettling or intimidating to others in the group, perhaps diminishing the motivational or therapeutic effectiveness of the atmosphere." (p. 190)

It would seem then that the art therapy intern was being an artist and, according to Henley, not necessarily being mindful of her responsibilities as an art therapist.

Because art therapists are also artists, some of us may work as artists with an extra sensitivity and understanding of the needs of our clients. Nevertheless, the reality of our own development toward greater professionalism in combination with the external realities of tightening human provider systems (managed care, licensure) mandate definitions of what we provide and how we are qualified to do so. In a service-oriented profession, the bottom line of definition is what is the service and who is qualified to provide it.

In her unique manner of expressing wisdom forthrightly, Janie Rhyne (1995) began to address this issue:

> How far can diversity expand within any association before the organization comes apart at the seams? . . . Twenty-five years ago art therapists differed and disagreed but there was an accepted vocabulary for discussion of most of our issues. Can we go back and establish that vocabulary? I think not. Can we instead, construct and accept a definition of the art therapists' roles whose boundaries include each of us, from psychoanalysts to shamans? I don't see how. (pp. 250-251)

She went on to discuss her own rejection of shamanism and the stance of its practitioners. Although I do not find the same problem in encompassing various theoretical approaches, I do agree with Rhyne that our overinclusivity is no longer viable. Working with others in ways in which we discard the role of therapists is internally inconsistent. We may call ourselves artists, spiritual facilitators, community organizers, art educators, art resource agents, or whatever, and although these roles may combine with art therapy, if they replace it, we are not working as art therapists.

Conclusion

In sum, the tightening net of accountability and our own increased professionalism mandate a clearer definition of art therapy, especially at the extremes where it borders on being therapy without art or art without therapy. Although some of us may practice in these ways, we should not consider such work art therapy. What we call art therapy must be based in art, and its practitioners must be conducting therapy. I have not, in this discussion, ventured far into the murky realm of just what constitutes therapy and what doesn't, but, clearly, for a beginning we should not include in art therapy the work of those who themselves describe it as other than therapy. As we continue to evolve what we are now calling "studio approaches to art therapy," we need to notice our edges in defining ourselves to ourselves, to others, and to those who become students of our practice.

There are dangers if we do not do so. As our edges bleed into being counselors on one side and artists-in-residence on the other, we are in peril that this combination may form a vise in which art therapy as a distinct profession could be squeezed into nothing in the middle. Art therapy may become a subspecialty of counseling. Art as therapy may become a subspecialty of studio art or art education.

Finally, as I struggle to keep my balance on the shifting sands of art therapy today, as I try to make sense of the push-me-pull-you art therapy has become, what appear to be the opposing vectors of art and therapy eventually point me in the same direction. It is clear that we need definition. Lest we become so overinclusive that art therapy holds meaningless distinctions, we need to define what we are not, in order to know more clearly who we are.

References

Allen, P. (1992). Artist in residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association*, 9(1), 22-29.

Allen, P. (1995). Coyote comes in from the cold: The evolution of the open studio concept. *Art Therapy: Journal of the American Art Therapy Association*, *12*(3), 161-166.

Henley, D. (1995). A consideration of the studio as therapeutic intervention, *Art Therapy: Journal of the American Art Therapy Association*, *12*(3), 188-190.

Malchiodi, C. (Ed.). (1995). Studio approaches to art therapy. *Art Therapy: Journal of the American Art Therapy Association*, *12*(3), 154-156.

McNiff, S. (1995). Keeping the studio. *Art Therapy: Journal of the American Art Therapy Association*, *12*(3), 179-183.

McNiff, S. (1992). *Art as medicine*. Boston: Shambala.

Rhyne, J. (1995). The future of art therapy: In what context? *Art Therapy: Journal of the American Art Therapy Association*, *11*(4), 250-251.

Rubin, J. (1987). *Approaches to art therapy*. New York: Brunner/Mazel.

Wadeson, H. (1994). Question: Will art therapy survive universal health coverage reform? *Art Therapy: Journal of the American Art Therapy Association*, *11*(1)26-28.

Young, J. (1995). The reenchantment of art therapy. *Art Therapy: Journal of the American Art Therapy Association*, *12*(3), 193-196.

THE REMUDA SYSTEM CAN HELP WOMEN AND ADOLESCENTS SUFFERING WITH EATING DISORDERS

CONTINUUM OF CARE

Adult/adolescent inpatient, adult/adolescent residential, partial care and intensive outpatient treatment sites provide tranquil, specialized settings.

◆

LICENSURE

State licensed, JCAHO accreditation with commendation and CHAMPUS provider.

◆

STAFF

Highly skilled professional staff of licensed psychiatrists, internists, psychologists, RN's, master level therapists and registered dietitians providing individualized programs and lengths of stay.

◆

A COMPREHENSIVE PROGRAM

We treat the whole person with individualized programs designed to meet medical, nutritional and psychological needs, blending these components with a non-denominational Christian perspective.

◆

EXPRESSIVE THERAPIES

Provided as a powerful tool to assist individuals in exploring their identities and problems through the use of their own creativity. Activities include art therapy, music, dance/movement and creative writing.

◆

AFTERCARE TRANSITION

Remuda's Aftercare Coordinator will work with the referring professional prior to the patient's discharge to facilitate her transition back into an outpatient setting as she resumes her day-to-day activities.

Most insurance accepted

REMUDA Ranch

Center for Anorexia and Bulimia, Inc.
P.O. Box 2481
Wickenburg, Arizona 85358

1 (800) 445-1900

Reviews

Dreams and Memories

by **Joan Sherman**, Madison, NH: Heart's Desire Press, 1993.

67 pp., 16 color illus., $24.95, paper
ISBN 0-9642 424-0

Reviewed by **Andrew Yale, MPS**, Lewisburg, WV

The last few years have not been the best of times for psychotherapists. Struggling to survive the onslaught of managed care, we look glumly to looming budget cuts and respond naturally enough by focusing increasingly on our professional survival. In such an atmosphere, it's easy to forget the values that led us to enter the mental health professions. Yet there are moments that remind us. It may be a sudden connection with a patient to whom no connection existed before, or a particular richness that enters the silence to announce that healing is taking place. Or it may be a slim volume of paintings and words that appears unbidden to remind us that the power of the image to heal remains undiminished, no matter how dark the times.

Such a volume is *Dreams and Memories* in which Joan Sherman, now a successful businesswoman in her sixties, recounts a small portion of her odyssey through 40 years of virulent depression to the psychic integration she now enjoys. That this integration was achieved through art therapy makes the account of particular interest to those engaged in that practice. It also confirms our belief in the inherent healing capacity of aesthetics; for Sherman, over the course of her lifetime, had experienced a variety of modalities with minimal response. Here we have a strong personal testimony to the exceptional efficacy of art, which although perhaps indefinable, can certainly be experienced.

Sherman's story is told in a series of paintings which she began in 1991 with the encouragement of her therapist. The paintings apparently follow the psyche in its nonlinear, transequential approach to conflict. Thus, before commenting on the artwork, it may be useful to examine a brief chronological account of the events Sherman considers pivotal in her life and illness.

Raised in a cultured middle-class home, Sherman was 19, happily married, and 5 months pregnant when she fell into a severe depression. In a locked ward at Baltimore's Phipps Clinic, she was subjected to a regimen of barbiturates and physical restraints. Somehow she learned of her physician's plan for a "therapeutic abortion" should she not respond quickly to treatment. Desperate to save her unborn child, Sherman successfully forced herself to "play sane." She was released, gave birth to a daughter, began to paint, and struggled intermittently with depression. The birth of her second child triggered a postpartum psychosis which was treated with 21 episodes of electroshock. Then began an ongoing search for a "kind doctor," which led Sherman through a long series of chemotherapists and social workers. It wasn't until she met Dr. Paul Lidstrom that she experienced herself responding to therapy. Dr. Lidstrom encouraged her to paint, and with one exception, the paintings in *Dreams and Memories* were done over a 2-year span while in treatment with him.

The series of paintings begins with the threatening imagery and dull colors of "The Crab Thing" and progresses through a reshaping of the major traumas and triumphs of Sherman's life. In "Phipps Clinic," she confronts the feelings left from her first hospitalization which, 40 years after the fact, still evoked recurring nightmares. In "Death of My Mother," one of the most striking pieces in the book, Sherman melds multiple layers of time and experience into a single, spare, and powerfully composed image which invokes the transtemporal qualities of the psyche. "Just Above Water," one of the last paintings in the series, suggests an evolution in Sherman's psychoaesthetics. The composition is loose and simpler than the more densely worked earlier paintings, and the free bold use of line is less constricted. Nonetheless, the work is strongly connected. It projects a new sense of life, with broadening space in the psyche for growth to occur.

Sherman acknowledges her debt to Frieda Kahlo, but to my eye she owes more to such primitives as Ralph Fassanella and Howard Finster. One senses that her personal aesthetic will continue to evolve and become more distinctive. The last paintings in the book give hints of that process beginning.

Dreams and Memories is doubly valuable. As a survivor's account of an often unfeeling health care system, it reinforces our belief in the need for kindness and the healing potentials of art. Completely free of jargon, it is easily understood by people for whom art therapy may also be a lifeline. I have used this book with excellent success to encourage patients to engage in the creative process. By its directness and lack of pretension, this simple account of one woman's experience inspires an excitement and an engagement with creating that are the healthiest antidotes to the time we are all living through.

Telling Without Talking: Art as a Window into the World of Multiple Personality

by **Barry M. Cohen** and **Carol Thayer Cox**, New York: W.W. Norton & Co, 1995.

314 pp., 173 black & white illus., 21 color illus., $45.00, hard cover. ISBN 0-393-70196-4

Reviewed by **Vija B. Lusebrink, PhD, ATR-BC, HLM**, Palo Alto, CA

Therapists who have worked with patients with Dissociative Identity Disorder (DID) are often exposed to visual expressions which are remarkably similar in structure and content, such as presentation of multiples within one symbolic image, fragmentation, or changes in style within the same picture. The therapists may also become aware of the repetition or fixed nature of these images in the individual's expression until some breakthrough is achieved in the communication among the alter personalities.

Cohen's and Cox's *Telling Without Talking* focuses on the structure of the visual communications and expressions of DID patients, a specific population which can benefit especially from the therapist's understanding of the structural aspects of the visual language. Often these patients do not have a parallel consciousness among their different personalities, whereas their visual expressions contain messages in structure and content that can benefit the process of therapy and the communication among various dissociated parts of the self. In *Telling Without Talking*, the authors combine in-depth knowledge of how to deal with DID patients, with keen observations of the structure and meaning of the patients' visual expressions.

The main body of the book is based on Cohen's and Cox's conceptualization and classification of the spontaneous visual expressions of DID patients into 10 categories. In this illustrated book, they describe how to create meaning by synthesizing patients' artistic strategies and styles with the content of their visual expression. Therapists working with this difficult population will be pleased to see this wealth of visual information available in book form.

Telling Without Talking consists of 13 chapters. The first two cover the major components of visual literacy and briefly introduce the 10 categories. The three levels of determining meaning in artwork—namely the process level, structural level, and content level—are presented schematically. The authors define the parameters of their approach in that their 10-category model addresses meaning derived from the structure of the spontaneous expressions only. In two additional tables they elaborate on the styles and artmaking strategies seen most frequently in each category. The authors also are careful to warn readers about the possible effect on the therapist of the traumatic-content of a number of the pictures. The latter warning is well warranted.

The following 10 chapters briefly introduce general concepts related to each category and discuss the structure and meaning of 10 to 12 illustrations in each category. The sequence of categories is: chaos, fragmentation, threat, induction of self-hypnotic process, trance, abreaction, switching, and alert pictures. The authors are careful to point out that the visual expressions of DID patients do not necessarily follow this sequence. Twenty-one color illustrations provide a better appreciation of the richness and complexity of the symbolic expression than the black and white pictures in the book. The final chapter is a case study of a DID patient, illustrated with 66 pictures.

"System" pictures represent the different parts of the self and their interrelation. The images illustrate repetitions of forms or multiples of the same object. The main structural elements of system pictures are juxtaposition, sequentiality, and dimensionality. The "chaos" pictures represent the system in disorder, which may be associated with cognitive confusion and physiological arousal. The structure of these pictures reflects movement and force isomorphic to the internal strife among the personalities. Scribbles and portrayals of explosions are the main characteristics of chaos pictures. "Fragmentation" pictures mirror the fractured sense of self as represented through shattered surfaces and disembodied limbs, indicative of the psychological effect of chronic dissociation. These pictures are characterized by the simplicity and boldness of the forms used to communicate the experience. "Barrier" pictures provide dividing lines between the conscious and dissociated components of the self. Naturalistic and expressionistic styles and juxtaposition are most often seen in barrier pictures. "Threat" pictures portray danger from the destructive parts of the self. These pictures are more likely to contain writing than the pictures in other categories, and they are characterized by expressionistic style, juxtaposition, and strong black and red color. "Induction" pictures reflect the self-hypnotic process of creating features such as dots, meandering lines, and spirals in a perseverative manner. These pictures are predominantly monochromatic. "Trance" pictures represent disorienting internal realities through juxtaposition of ostensibly unrelated images, differences in scale, and surrealistic style. "Abreaction" pictures revisit the traumatic experiences. According to the authors, these pictures are the most disquieting; due to their portrayals of violent, sexual, and sadistic acts; they are used "to tell without talking." "Switching" pictures are representations of the serial self, whereby the executive control is shifted among the different personalities within the same picture. These expressions can provide the patient with graphic clues about the existence of the alter personalities; for example, they may reflect developmentally different graphic expressions and styles. Switching pictures often display randomness of placement and obliteration of some of the forms. "Alert" pictures tell without talking, thus circumventing the prohibition against talking about the abuse.

The final chapter of the book presents a case study of the DID patient who inspired the professional collaboration between the two authors. The pictures selected from her prolific visual expressions amply illustrate the presence of the 10 categories in one individual's work. The book concludes with a glossary and extensive bibliography on DID. Cross-references to the various artists and their works help the reader observe continuities and discontinuities in the structure of the visual expressions of the 29 patients whose artwork illustrates the 10 categories.

Cohen's and Cox's focus on reading the structural elements of visual expression and their integration with the content "as a pathway into the pictorial communication" (p. 13) define an important aspect of art therapy. The meaning thus arrived at represents a valid dimension in considering any visual and art expression, but, as the authors have shown, especially important with DID patients. The multileveledness of art and symbolic expression allows the patient "to reveal information in a drawing while simultaneously camouflaging it from the viewer or herself" (p. xviii). At the same time, the authors are careful to point out that the multileveledness of symbolism defies a single definition of the meaning of a symbolic image and that an ongoing discussion with the patient about the art process and product is essential to its understanding.

Cohen and Cox explicitly state that their approach does not address therapy with DID patients. As a consequence of its focus on the element of structure, the book does not emphasize the feelings associated with or expressed through the images. It is interesting to note that attention to the structural and formal elements of visual expression helps distance the viewer from the emotions associated with the image (Lusebrink, 1990). In the case of DID patients, the structural and formal approach may provide a double service for the therapist: first, it may enhance understanding of the expression and the internal state or states of the patient; and second, it may alleviate some of the emotional stress of relating to distressing visual expressions. The emotional distance thus created allows the therapist to be more objective and may prevent some of the countertransference often created by highly charged material.

Telling Without Talking is not an easy book to read because of the emotional impact of the images. The descriptive material also challenges the reader to synthesize concepts and detailed observation, which requires more focused attention than perceiving images globally and listening to a story. The reader will be rewarded, though, with appreciation for the interrelationships of the structure and for revealing details which easily might have escaped the viewer's casual glance. As Cohen and Cox have shown, in working with DID patients the details are often important in integrating the meaning of the images. The authors state that this book is offered "to enhance the competency of those therapists whose client brings spontaneous art into treatment" (p. xix). It is my guess that only a few dedicated therapists without art background will have the patience to read the objective descriptions of the images; as matter of fact, it is also my guess that only a small number of art therapists will take the time to fully benefit from the discussion of the structure and meaning of the images. This does not decrease the value and importance of the information offered because even a cursory survey of the text will help the reader relate to the patient's experience and to the often obscure visual material he or she may create to conceal as well as reveal. However, the synthesis of structure and style with the content provides a translucency to the visual expression which may be overlooked by considering process and content alone.

Regarding the integrative approach to the visual expressions, the authors could have elaborated more on the two tables. Table 2-1 reviews styles seen in each category, and Table 2-2 reviews artmaking strategies most frequently seen in each category. After studying the images in the 10 categories, such a discussion would have been useful to reinforce the differences and interrelations among the different categories. Consistent use of the term *Dissociative Identity Disorder* throughout the text also would be recommended.

Cohen's and Cox's *Telling Without Talking* is a major contribution to art therapy literature. It reflects excellent scholarship, observational skills, and ability to conceptualize and generalize from complex and diverse visual material. The approach and concepts presented in this book should benefit clinicians and researchers in the field of therapy, especially art therapy.

Reference

Lusebrink, V. B. (1990). *Imagery and visual expression in therapy.* New York: Plenum Press.

Soldier's Heart: Survivors' Views of Combat Trauma

Edited by **Sarah Hansel, PhD; Ann Steidle, RN; Grace Zaczek, MPH; and Ron Zaczek, USMC,** Lutherville, MD: The Sidran Press, 1995.

242 pp., 16 black & white illus., $19.95, paper.
ISBN 0-9629164-6-3

Reviewed by **Kathleen Lovenbury, MA,** Hardwick, MA

"The soul remembers what the heart disavows: being mortally wounded by each soldier who died" (p. 15).

Combat changes the person who fights. Wherever fighting goes, death—actual or threatened—and serious injury are witnessed and experienced. Young men and women, many striving to find themselves and determine their own destinies, have found themselves in a world filled with terror, powerlessness, and revulsion. Soldiers from every civilization have returned from war haunted by fear, pain, and death through nightmares, obsessive review of war experiences, and feelings of anger and depression. This syndrome has gone by many names. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III and DSM-IV) published by the American Psychiatric Association has labeled this condition Post-Traumatic Stress Disorder (PTSD). At various times in history, Combat Fatigue, Shell Shock, and Soldier's Heart were some of the labels assigned to the physical and emotional changes experienced by people returning from war. Hansel (a psychologist and a trauma recovery specialist), Steidle (a psychiatric and mental health nurse and trauma recovery specialist), R. Zaczek (a Marine Vietnam veteran), and G. Zaczek (a community mental health coordinator and volunteer in the Vet Outreach program) formed The National Trauma Institute in Baltimore to "advocate for those experiencing stress-related traumas, their families, and clinicians working with these individuals" (p. 7). *Soldier's Heart*, a collection of pieces addressing combat-induced stress disorder, is the Institute's first project.

Giving form to the unspeakable, expressing feelings and experiences is a basic human need. However, many people who survive traumatic events attempt to deny or forget about these disturbing experiences. Anguish, despair, and fear may continue to affect the survivor's life despite all attempts at denial of the events. The submission process for *Soldier's Heart* provided ". . . a means for letting veterans and their families step back from the stress with which they live, take stock of where they are, and articulate their feelings" (p. 7). It is the hope of the Institute that combat trauma survivors and their families ". . . will benefit from the sense of brotherhood and community they find—that they will see they are not alone and can prevail, and that the wisdom in this collective work will help them find peace" (p. 11).

Trauma undermines the survivors' ability to trust, feel strong emotions, and contain intense memories. Healing can take place with the acceptance, concern, and respect of another person. Relationships are not limited to therapy but can be any relationship "where the veteran feels in charge of the process and can trust the other person enough to risk looking at the traumatic experience, remembering what happened, putting it into context, and filling in any gaps (p. 4). Hanzel et al. clearly indicate that the ". . . survivor must be able to tolerate arousal and strong distressing emotions" (p. 5). Harmful and helpful responses from those who form healing relationships with the survivor are also presented. Hanzel et al. discuss the ". . . importance of support for the veteran and family surviving combat trauma" (p. 146). They dispel the illusion that a loving, supportive, and understanding family will heal all veterans and their families.

Soldier's Heart is not a clinical manual for the treatment of PTSD experienced by combat veterans. The book is written for veterans, clinicians, and veteran's spouses, families, and friends. The chapters were selected and organized based on the 200 pieces of work submitted by 70 authors. Some of the work has been edited to provide greater clarity, and only work that reflects the "impact of combat on the veteran's life" (p. 9) is included. Art therapists, however, will find that the editors do not convey the full complexity and richness of using art and poetry as an expression of traumatic experience.

This is a straightforward and readable book. Each chapter begins with a general overview of a symptom or experiences related to PTSD, followed by a collection of powerful poetry, essays, and art. The book concludes with Theater Maps, Military Units, Resources, and a Glossary. A number of excellent books focusing on PTSD, accounts of combat, and treatment are included in the Resource section.

Veteran's essays, poetry, and visual images make it possible for the reader to take part in the ordeals depicted and to experience the horror, the sorrow, the pity, and the unimaginable atrocities that most human beings never encounter. The body of the book is divided into eight themes: Something's Wrong; Isolation; Seeking Help; Despair; Loss, Mourning, and Grieving; Escape; Family and Other Perspectives; and Making Sense of It All. The images, poems, and essays bear witness to the pain, anguish, and loss veterans endure and also the hope they try to maintain. Personal images and writing are interspersed with pieces that express more universal issues. The contributions by veterans of World War II, Korea, and Desert Storm illuminate and characterize the veterans's experiences of healing from PTSD. For this reason this book is useful as a tool for survivors to "find comfort" despite isolation, "recognize their healing journey in the words of others," "find words" for their experiences, "be inspired to use positive coping skills," and to "take hope" (p. 6). It is also a valuable resource for clinicians and the veteran's spouse, family, and friends because it provides a clear understanding of the collective experience of veterans through the eyes of the combat trauma survivors themselves.

This powerful book affected me at multiple levels, as it will surely affect art therapists and others interested in understanding the emotional legacy of trauma and its impact on combat survivors and their families. The potent imagery, poetry, and essays shared by veterans provide an insider's view of the many dimensions of Post Traumatic Stress Disorder, from emerging consciousness, through sorrow and anguish, to acceptance and hope. This is a book that can be read repeatedly without losing its impact.

Dance and Other Expressive Art Therapies: When Words Are Not Enough

Edited by **Fran J. Levy, EdD, BCD, CSW, ADTR,** with **Judith Pines Fried,** and **Fern Leventhal,** New York & London: Routledge, 1995.

268 pp., 6 black & white illus., $18.95, paper
ISBN 0415-91229-6 (pbk.)

Reviewed by **Carolyn Johnson, MA, ADTR, LMHC,** Worcester, MA

Fran Levy has conceived, edited, and contributed to a volume of extraordinary clinical case studies utilizing dance and movement therapy as well as art, music, and drama therapies. The contributors are all experienced dance-movement and/or expressive arts therapists who offer the reader stimulating, articulate, reflective, and moving descriptions and discussions of complex human dilemmas, theories for understanding these dilemmas, and unique methods of interventions. Central to the book's meaningfulness is its emphasis on utilizing multimodal approaches—including dance, drawing, mask-making, costuming, singing, and verbalization—to address the unique needs, strengths, and aesthetic and sensory preferences of the clients. Though primarily a compilation of dance therapy studies, three chapters include art therapy interventions: Levy's own chapter describing long-term multimodal therapy with a woman struggling with a unique form of "multiplicity"; Lawlor's presentation (among other cases) of a woman working to overcome codependency; and Harvey's description of the multimodal therapy of an adopted, sexually abused child. The book is divided into two sections, the first dealing with adults and the second with children. Chapters in the first part include work with multiple personality disorder (MPD) clients, battered women, borderline patients, chemical addiction, codependency, anxiety, and geriatrics. In the second part, chapters focus on work with children who are blind from birth, sexually abused, at risk for attachment disorders, autistic, and learning-disabled.

Levy's book provides example after example of the saliency of the arts to therapy, especially when joined with the empathy and openness shared by so many of the book's contributors. Each author presents case material—background information, theory, and case progress notes—as well as the author's reflections on his or her own work. It is these reflections which, for me, provide the most compelling reading. The therapists share the struggles of their own creative process—their doubts, vulnerabilities, and "mistakes" while doing therapy. In Duggan's report of her work with learning-disabled inner-city adolescents, for example, she describes her difficulty finding the right "structure" to contain the exuberant and often unchanneled energy of the adolescents. She writes openly about her failed attempts to impose some containing order (and the kids and her own subsequent frustration) until the moment when she recognized, quite surprisingly, the need for the very simplest of dynamic structures. Her description of her own creative process as a therapist parallels many of the dynamics of a successful therapeutic process—conflict, the search for meaning and order, struggle, and eventually, understanding. This relationship between creativity and healing is understood by most creative arts therapists to be the central basis for our work. But the chapters in Levy's book provide, for non-creative arts therapists as well, powerfully convincing examples of the potency of including the arts in the therapeutic process.

In the introduction Levy identifies three themes that are woven into the fabric of the case presentations: 1) trust and empathy as the key ingredient for establishing a working therapeutic alliance, 2) the integration of art forms to address specific needs and developmental issues, and 3) the primacy of symbol and metaphor in the expressive arts therapies. The first theme, that of establishing a safe, therapeutic container which inevitably includes the therapist's emphatic response to the client, is central to all psychotherapies. But the other two themes are particularly characteristic of the expressive arts therapies and are well described in the book's chapters. In Lawlor's chapter, "Confronting Co-Dependency," she relates these two themes by noting that the ". . . multimodal approach sets the stage for symbolic confrontation between different aspects of the individual's self and between the self and others" (p. 111). The use of symbolic action, images, sound, and play provides the metaphorical equivalents of feelings and for many clients offers opportunities for the safe expression and communication of difficult feelings and experiences. In her introduction, Levy reiterates Robert Landy's contention that "through projective techniques creative arts therapists allow for an aesthetic distance from core emotions while still encouraging genuine self-expression" (p. 3). Each author, regardless of whether he or she uses multiple modalities, discusses the importance of introducing clinical interventions that are responsive to the developmental needs and aesthetic and sensory preferences of the clients. The rationale for the use of directed versus nondirected interventions, the use of props, materials, and choice of music, for example, are sensitively described.

Art therapy interventions are utilized in the above-mentioned three chapters as part of thoughtfully directed therapeutic processes. In Levy's chapter "Nameless: A Case of Multiplicity," the use of body movement and verbalization were perceived by both the client and the therapist as much too threatening in the initial stages of treatment. Levy recognized the usefulness of drawing as an intermediary modality (all six black and white figures in the volume are included in this chapter) and provides detailed descriptions of the process in which the drawings emerged, and of the theoretical framework for understanding them. Levy utilizes the work of, and is mentored by, Dr. Sidney Levy, a psychologist, psychoanalyst, and Professor Emeritus from New York University who developed the Levy Animal Drawing Story test (LADS) in the 1940s.

Lawlor's chapter, "Confronting Co-Dependency: A Psychodramatic Movement Therapy Approach," includes a study of a woman client, an author and illustrator of children's books, who was encouraged by the therapist to construct a series of masks representing her feelings. The masks became the focal point and inspiration for a sequence of powerful, metaphorical dances which included the rage and intense sadness the woman was struggling with at the time. Utilizing the more familiar visual medium helped her to deepen her understanding of her feelings and made possible the further, less familiar exploration of her experience through movement and drama.

Harvey, in "Sandra: The Case of an Adopted Sexually Abused Child," introduced drawing into early sessions with Sandra and her adopted mother in an attempt to identify dysfunctional patterns of nonverbal communication between the two and to increase his understanding of Sandra's self-concept. Drawing became a regular component of ongoing family therapy in this fascinating case.

There is much in this volume relevant to art therapists, despite the fact that only three of the 16 chapters specifically include art therapy interventions. As expressive arts therapists, we are trained to attune to the relationship between the dynamics of feelings and expression and the dynamics of artistic form. It is this relationship between feeling and form that distinguishes creative arts therapies from verbal approaches and lends potency and integrity to our work. It is this relationship that transcends the boundaries of specific art forms. Space, time, texture, color, line, and rhythm are the common denominators of all the arts. As a creative arts therapist, I find the multimodal approach to be both familiar and challenging and, perhaps most importantly, particularly attuned to the uniqueness of each of our clients. Levy's book lends credence to this approach and adds richness to the expressive therapy literature.

Video Review

Drawing from the Fire

Produced and directed by **Chris Holmes**,
Stanford University, Department of
Communication, 1993.

VHS ½", 23 minutes, color. Purchase only: $39.95
from Chris Holmes Productions, 310 Esplanade,
#65, Pacifica, CA 94044, E-mail: mycroft@svpal.org

Reviewed by **Lizabeth Flanagan, MA, ATR,**
Ardmore, PA

All at once we are drawn in and horrified by this videos initial scenes borrowed from a local news broadcast. The subject is the 1991 wildfire which spread, resisted containment, and finally destroyed much of Oakland Hills, a community in the hills of Oakland, California. Statistics reveal the horrible aftermath: 10,000 people evacuated, 3,800 homes burned, 150 people injured, and 25 killed.

But as much as the opening scenes of "Drawing from the Fire" depict trauma and devastation, it is also clear by the film's end that it is even more about hope. We are introduced to school personnel, therapists, children, and their parents who turn our attention to the growth that takes place when individuals are challenged by disastrous circumstances.

The video profiles the work of Pediatricare, a nonprofit organization offered as an outside service because of the widely felt devastation. Kristen Mendenhall is the featured art therapist who works with the children and parents of Hillcrest as part of this service. She describes the benefits of the school-based art therapy groups that provided the children with a way to express thoughts and feelings related to the trauma. Creative drawing was used to "deepen into their feelings," which allowed for safe exploration. She also presents the programs as both a time- and cost-effective measure. The parents did not have time to seek out other professionals and its availability within the school as part of a daily program made treatment more accessible.

Next we see Mendenhall conduct a group session in which the children are encouraged to process their physical as well as emotional reactions. The shots of the children eagerly sharing their experiences underscore her previously-stated rationale that a child may not possess the verbal acuity needed to process aspects of his or her world and so may find art expression much more comfortable and suited to the immediate need of working through trauma. Even for those unwilling to verbalize, creating a drawing still assures that they are participating members who benefit and ultimately internalize success.

One boy comments on his physiological reaction to the fire: "My knees are registering 10 on the Richter scale and I felt like someone was riding a bicycle in my stomach." Questions are raised by children who wonder why their house burned down while across the street others did not. There are misconceptions and anger expressed by a girl who thinks her friend's house was saved because "she knows all these firemen" and therefore was given priority over her neighbors. A school staff member comments later in the film that some children internalized guilt, believing the fire was a direct result of their misbehavior.

Following the group, Mendelhall goes on to relate how she noted progress in the artwork of a 6-year-old boy. Her comments are not too technical nor do they gloss over the intent and result of the therapeutic art process. She shows us changes from a chaotic and helpless evacuation scene to a drawing in which the boy is able to isolate the intensity of his anxiety and terror inside the outline of certain rescue figures. Her final comments sound somewhat trite and fail to recognize the underlying dynamic implications. In referring to the boy's ability to graphically contain and finally master his fear she states, "I thought it was cute," and "his crying stopped and he felt a lot better." Nevertheless, Mendenhall's direct approach coupled with the visual aid of the drawings make it possible for even an untrained eye to grasp her interpretive information. The images can speak to a large audience because the video is not as concerned with detailed clinical discussion as it is with providing a service to a community in need. Mendenhall also comments on how important it was for the school staff to understand how the intervention was helping. A discussion between teachers, social workers, and therapists allows us to see the unity and common goals of the various professionals. They are also given an opportunity to discuss their feelings and concerns as well as their observations of the children.

Two segments deal more directly with parents and individual families. We are told about a support group specifically for families. One family is filmed walking through the ruins of what was once their home. A boy kicks a soccer ball against an exposed concrete wall while his baby sister climbs a leveled stairway. The mother talks about finances and insurance issues and asks, "Can it be home again?"

The Oakland Museum of Children's Art became involved in the program by sponsoring a tile project in the school. Museum staff worked with the children to create individual tiles to be mounted together on a wall. Mendenhall speaks of the symbolic role of the fiery kiln and how it imparts strength and permanence to each tile. The tiles are used as a backdrop to the closing credits, strengthening a sense of hope.

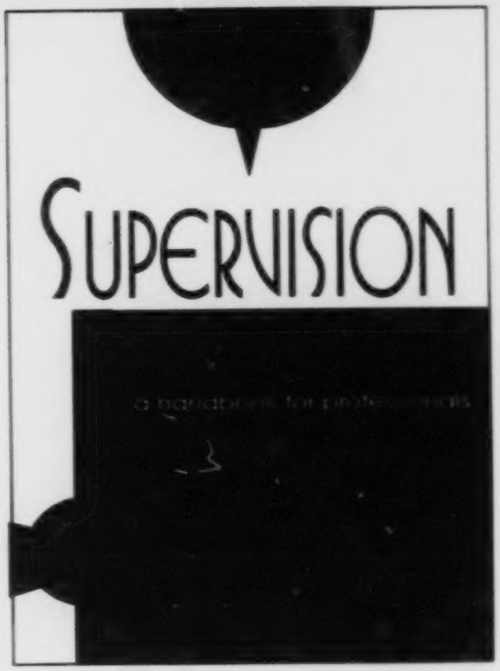
At the end of the video, we are left with the image of a mother and son, the primary bond, as they talk about their struggle. The image solidified a sense of commitment. The boy talks with a certain maturity about how this experience has changed him: "You learn from what's happened to you." He is the same boy who had shared first in the art therapy group.

The film does not offer an original viewpoint to the profession of art therapy due to the nature of the topic explored: an extreme and catastrophic situation that demands visceral rather than cerebral exploration. There is little time for delineation of theoretical theses and schools of thought. In this respect the video's function as a teaching tool within art therapy study and practice seems limited.

For those interested in school and community-based programs, clinicians, and the larger community, this video is certainly a good inservice to the field. As proposed in the accompanying notes, it intends to be helpful to other communities that may require the services of trained professionals in the aftermath of tragedy or natural disasters by relating the story of one such community. It presents one powerful rationale for using outside services: They are not directly affected by the tragedy and are better able to function by objectively focusing on the immediate needs of the community.

Despite its subject, the video maintains a fresh, immediate quality. The editing and direction result in a fluid offering of evocative imagery. We are challenged as viewers to work together—just as this Oakland community did—to feel, think, and process the devastation on different levels. The music, credits, and sound contribute to the high quality of this film, telling a compelling story that will be inspiring for any viewer.

What this film definitely can do for the art therapist is renew his or her convictions about the healing power of creativity and just how versatile our skills are, whether in the context of the conventional health care setting or in response to disasters of greater proportion.



MAGNOLIA STREET PUBLISHERS

SUPERVISION
and Related Issues:
A Handbook for Professionals
by Cathy Malchiodi and Shirley Riley

A long awaited text, this handbook is a highly informative guide to the complexities of supervision in the 90's. Supervisors, educators, and students will find it indispensable not only in the supervisory session, but also in the classroom and in work with clients. An extensive appendix includes ethics and standards of practice, sample forms for use in supervision, laws effecting supervisors and many more references and resources.

Paper $27.95

ART THERAPY
IN THEORY & PRACTICE
Ed. by Elinor Ulman and'Penny Dachinger

"Since its first publication, *Art Therapy in Theory and Practice*, has been used continually as both a textbook and a resource. Many of the chapters have become indispensable classics which continue to define the field of art therapy.

In this reprint, we re-encounter Elinor Ulman's skill as a writer and editor of great perception and eloquence. Her talent was to bring together the seminal writing of a burgeoning professional field and meld them into an organized, comprehensible body. This book, now available to a new generation of readers, stands as a testament to this art." RANDY M. VICK, MS, A.T.R.-BC **Paper 29.95**

MAGNOLIA STREET PUBLISHERS
5804 N. Magnolia St., Chicago, IL 60660 • 312-561-2121 • fax 312-477-6096

Wholesale and Bookstore orders to above address.

Individual orders to:
Stern's Books
2004 W. Roscoe
Chicago, IL 60618
312-883-5100, fax 312-477-6096

Add $4.00 UPS for first book and .75 for each additional book. Credit cards and checks accepted.

THE GESTALT ART EXPERIENCE, Patterns That Connect, Janie Rhyne	pa. $24.95
INTEGRATIVE APPROACHES TO FAMILY ART THERAPY, Shirley Riley & Cathy Malchiodi	pa. $29.95
ART AS THERAPY WITH CHILDREN, Edith Kramer	pa. $19.95
CALIFORNIA ART THERAPY TRENDS, Ed. Evelyn Virshup	pa. $29.95
SHATTERED IMAGES: Phenomenological Language of Sexual Trauma, Dee Spring	pa. $36.00
DYNAMICALLY ORIENTED ART THERAPY: It's Principals & Practice, Margaret Naumburg	hd. $32.95

CHARLES C THOMAS • PUBLISHER, LTD.

- Cohen, Jane G. & Marilyn Wannamaker—**EXPRESSIVE ARTS FOR THE VERY DISABLED AND HANDICAPPED FOR ALL AGES. (2nd Ed.)** '96, 250 pp. (8 1/2 x 11), 135 il., spiral (paper).
- Moon, Bruce L.—**ART AND SOUL: Reflections on an Artistic Psychology.** '96, 168 pp. (7 x 10), 15 il..
- Benenzon, Rolando O.—**MUSIC THERAPY THEORY AND MANUAL: Contributions to the Knowledge of Nonverbal Contexts. (2nd Ed.)** '96, 300 pp. (7 x 10), 44 il.
- Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY. (2nd Ed.)** '96, 84 pp. (7 x 10), $29.95, cloth, $19.95 paper.
- Nucho, Aino O.—**SPONTANEOUS CREATIVE IMAGERY: Problem Solving and Life Enhancing Skills**. '95, 174 pp. (7 x 10), 15 il., $41.95, cloth, $25.95, paper.
- Cooper, Shawn—**THE CLINICAL USE AND INTERPRETATION OF THE WECHSLER INTELLIGENCE SCALE FOR CHILDREN—THIRD EDITION**. '95, 466 pp. (7 x 10), 5 il., 20 tables, $74.95, cloth, $44.95, paper.
- Makin, Susan R—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 112 pp. (7 x 10), $29.95, cloth, $17.95, paper.
- Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 186 pp. (7 x 10), 33 il., $41.95, cloth, $29.95, paper.
- Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER**. '93, 332 pp. (7 x 10), 32 il., 9 tables, $64.95, cloth, $37.95, paper.
- Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 280 pp. (6 3/4 x 9 3/4), 28 il., $38.95, cloth, $26.95, paper.
- McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY**. '88, 262 pp. (6 3/4 x 9 3/4), 34 il., $48.95, cloth, $33.95, paper.
- Nucho, Aina O. —**THE PSYCHOCYBERNETIC MODEL OF ART THERAPY**. '87, 248 pp. (6 3/4 x 9 3/4), 50 il., 4 tables, $48.95, cloth, $33.95, paper.
- Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking**. '83, 240 pp. 134 il. (4 in color), 11 tables, $53.95, cloth, $38.95, paper.
- McNiff, Shaun—**THE ARTS AND PSYCHOTHERAPY**. '81, 260 pp., 54 il., $32.95, cloth, $18.95, paper.
- Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (3rd Ed.)** '96, 400 pp. (7 x 10), 9 il., 3 tables.
- Love, Harold D.—**CHARACTERISTICS OF THE MILDLY HANDICAPPED: Assisting Teachers, Counselors, Psychologists, and Families to Prepare for Their Roles in Meeting the Needs of the Mildly Handicapped in a Changing Society.** '96, 240 pp. (7 x 10), 13 il., 22 tables.
- Brooke, Stephanie L.—**A THERAPIST'S GUIDE TO ART THERAPY ASSESSMENTS: Tools of the Trade.** '96, 164 pp. (7 x 10), 7 il., $32.95, cloth, $22.95, paper.
- Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror. (2nd Ed.)** '95, 230 pp. (7 x 10), 21 il,$49.95, cloth, $33.95, paper.
- Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 x 10), 12 il. $35.95.
- Landy, Robert J.—**DRAMA THERAPY: Concepts, Theories and Practices. (2nd Ed.)**. '94, 294 pp. (7 x 10), 1 table, $58.95, cloth, $39.95, paper.
- Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product**. '94, 222 pp. (7 x 10), 17 il., $47.95, cloth, $29.95, paper.
- Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency**. '93, 254 pp. (7 x 10), 71 il., $51.95, cloth, $35.95, paper.
- McNiff, Shaun—**DEPTH PSYCHOLOGY OF ART**. '89, 258 pp. (6 3/4 x 9 3/4), 56 il., $48.95, cloth, $33.95, paper.
- Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY**. '87, 606 pp. (7 x 10), 11 il., 38 tables, $92.95, cloth, $54.95, paper.
- Furrer, P. J.—**ART THERAPY ACTIVITIES AND LESSON PLANS FOR INDIVIDUALS AND GROUPS: A Practical Guide for Teachers, Therapists, Patients and Those Interested in Promoting Personal Growth in Themselves and Others.** '82, 144 pp. (8 1/2 x 11), $25.95, paper (spiral).
- Espenak, Liljan—**DANCE THERAPY: Theory and Application**. '81, 210 pp., 33 il., $34.95.
- Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART**. '78, 304 pp., 125 il. (12 in color), 7 tables, $49.95, cloth, $34.95, paper.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217)789-9130
Books sent on approval • Complete catalog sent on request • Prices subject to change without notice

2600 South First Street • Springfield • Illinois • 62794-9265

ALLEGHENY
UNIVERSITY
OF THE HEALTH SCIENCES

We've Changed Our Name, But Not Our Program.

The Art Therapy Program

at Allegheny University of the Health Sciences, formerly Medical College of Pennsylvania and Hahnemann University, is part of the unique and world-renowned Creative Arts in Therapy Graduate Program at home in an academic health center. The didactic, clinical and supervisory aspects of the program are balanced and integrated to provide a foundation of theoretical knowledge and practical application. To learn more, visit us; talk to our students and faculty.

Call (215) 762-6924 or visit us at www.allegheny.edu.

Allegheny University of the Health Sciences
Department of Mental Health Sciences
Mail Stop 905, Broad & Vine • Philadelphia, PA 19102-1192

The following posters by members of the
American Art Therapy Association
are available for purchase.

	MEMBERS	NON-MEMBERS
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Shipping and handling is included on both posters.

Make checks or money orders payable to AATA in U.S. funds and return with this order form to:
American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my order. Enclosed is a check/money order for the appropriate amount: $__________

Name: ______________________________

Address: ______________________________

City: ________________ State: ______ Zip: __________

AATA REGIONAL SYMPOSIA

ADDICTIONS

Presenters: Lynn Jones, Holly Feen-Calligan, and Katie Webb

Participants will receive the latest information on the use of art therapy in the treatment of addiction and dual diagnosis. Art therapists will be able to identify specific non-verbal approaches for working through resistance and denial in the treatment of substance abusers. Counselors will be able to identify specific ways in which to coordinate treatment efforts with art therapists in their facilities.

FAMILY ART THERAPY

Presenters: Mari Fleming, Shirley Riley, and James Consoli

The objectives of this symposium are to provide the participants with an overview of how art therapy provides families an enriched vocabulary to assist them in solving family problems. The art therapy gives a "voice" to all age levels and offers a non-threatening vehicle to aid in communication restructuring the family system. The intensive workshop will offer ways to combine family theories with art expressions and examine assessment methods, and short- and long-term treatment. Participants will engage in experiential opportunities to experience how art therapy is applicable in their own professional setting. Every effort will be made to offer the most current trends in family therapy and art therapy application.

ART THERAPY IN SCHOOLS

Presenters: Janet Bush, Sarah Hite, and (third presenter to be announced)

This symposium will provide participants with the administrative procedures for implementing art therapy services and programs in schools. Topics will focus on the uses of art therapy in schools; roles and responsibilities of school art therapists; techniques and strategies for working with students; training and preparation of school personnel; and the funding and marketing procedures required for school art therapy programs. Participants will be prepared to transfer techniques and strategies for implementing art therapy services and programs to school settings.

ART THERAPY WITH THE OLDER ADULT

Presenters: Larry Barnfield, Bernadette Callanan, and Judith Wald

The symposium will cover general views on aging, relevant facts and new research, the role of art therapy with elders, and settings in which art therapists practice and the special advantages of art therapy with the aging. It will cover the goals of treatment, treatment issues, and consideration of the clinical treatment of three groups of vulnerable aging and case studies.

GRANTS: GOING FOR THE GOLD

Presenters: Frances Anderson, Vija Lusebrink, and Doris Arrington

Successful grant writing in art therapy is, and will continue to be, an important survival strategy in the 90's. Many model art therapy projects funded by grants will be discussed. The entire grant writing and granting process from identification of funding sources (public and private), to proposal development, submission, and implementation will be covered. Technical assistance will be available to participants who already have a grant idea or proposal "in process."

ART THERAPY WITH CHILDREN AT RISK

Presenters: Cathy Malchiodi, Julie Epperson, and (third presenter to be announced)

This symposium proposes to fill the need for advanced art therapy training focusing on theory, interventions, methodology, and research with children at risk. "Children at risk" are defined as those who are directly affected by family violence, physical and sexual abuse, neglect, homelessness, and various disabilities such as attention deficit hyperactivity disorder, learning problems, and physical limitation which put them at further risk for abuse and neglect. Emphasis will be on how the clinician can develop both short- and long-term art therapy interventions, effectively assist the child in crisis, and appropriately utilize art expression in assessment of current levels of psychological functioning.

ART AND MEDICINE

Presenters: Cathy Malchiodi, Anita Mester, and (third presenter to be announced)

The symposium will focus on the unique dimensions of art therapy within a medical context with people who have experienced life-threatening chronic illness, particularly cancer and HIV. The special role that art expression plays in the assessment and evaluation of both the somatic and psychological status of the individual will be discussed, supported by the current research of both art therapists and clinicians in related fields. Special emphasis will be on paradigms for the use of art therapy within the context of psychoneuroimmunology and mind/body healing. Theories of imagery from current research by Achterburg, Simonton, Bach, and others will be covered to assist the participants in integrating the use of art expression with physically ill clients, and will be presented so that participants acquire an understanding of the practical aspects of adapting art therapy to specific disease conditions. Lastly, emotional and transpersonal issues of grief and loss which are intrinsic to the experience of physical life-threatening illness will be addressed.

ADOLESCENT ART THERAPY

Presenters: Kris Sly-Linton, Patty Isis, and (two other presenters to be announced)

The Adolescent Art Therapy Symposium will cover a wide range of topics designed to address a specific focus area requested by the sponsoring organization. This is a somewhat unique approach to the traditional symposia format but considering the multiplicity of problems regarding the treatment of adolescents today, it was felt this would be a way to make each symposium more pertinent to the intended audience. The four person team, headed by Kris Sly-Linton, was coordinated to include professional art therapists that can provide the expertise required to address the following areas: Special Populations of Adolescents, Program Focus, and Teens and Family Systems.

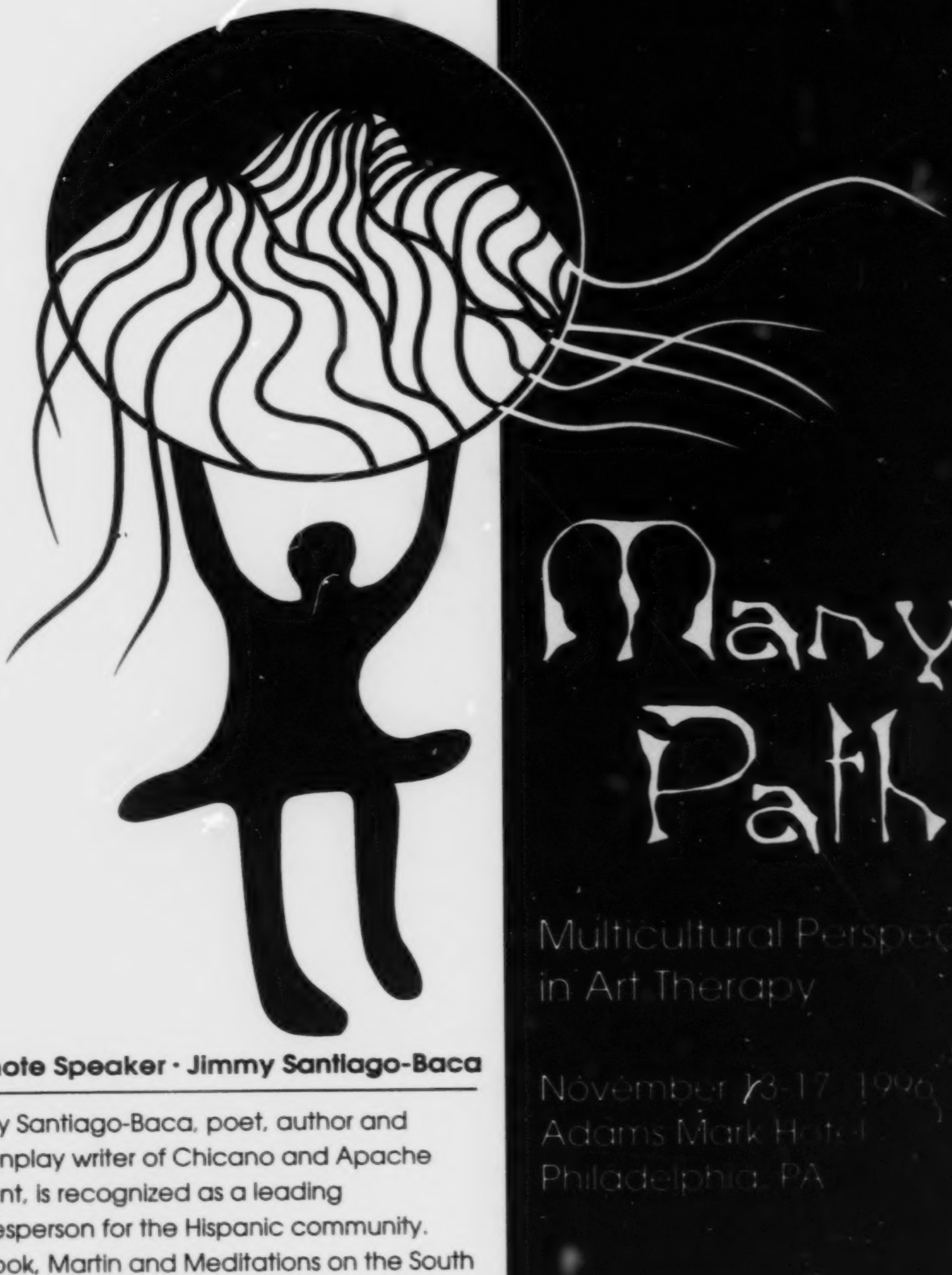
These Symposia are offered at no charge to the participating Chapter.

• • • • • • • • • • • • • • • • • •

For further information regarding the content or scheduling of these symposia, please contact
AATA National Office • 1202 Allanson Road • Mundelein, Illinois • 60060 • (847)949-6064 • (847)566-4580
Monday through Friday - 9:00 a.m. to 5:00 p.m. - Central Standard Time

AMERICAN ART THERAPY ASSOCIATION, INC.

27TH ANNUAL CONFERENCE



Many Paths

Multicultural Perspectives in Art Therapy

November 13-17, 1996
Adams Mark Hotel
Philadelphia, PA

Keynote Speaker · Jimmy Santiago-Baca

Jimmy Santiago-Baca, poet, author and screenplay writer of Chicano and Apache decent, is recognized as a leading spokesperson for the Hispanic community. His book, Martin and Meditations on the South Valley, received the American Book Award in 1988. In the summer of 1995, Santiago-Baca was one of the featured poets on the Bill Moyers PBS series, Language of Life. His poetry speaks to a vision of change and community transformation through creative expression.

For information contact:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, IL 60060
(847)949-6064

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

Cathy A. Malchiodi, MA, ATR, LPAT, LPCC, Editor

Art Therapy, the official journal of the American Art Therapy Association, is a quarterly journal for professionals and students who are interested in the use of art in the fields of mental health, psychotherapy and human development. The purpose of ***Art Therapy*** is to advance the understanding of how visual art functions in the treatment, education, development, and enrichment of people. ***Art Therapy*** publishes refereed articles, including illustrations, by art therapists, psychologists, family therapists, and others that reflect the latest advances in theory, research, professional issues, and practice. An emphasis is placed on the use of visual arts in therapy, but articles in related disciplines of interest are considered for publication. ***Art Therapy*** is an important source for news and summaries of national conferences, book reviews, media, and commentaries.

Recent articles published in ***Art Therapy:***

- Art Therapy: Bridging Barriers with Native American Clients
- LA '94 Earthquake in the Eyes of Children: Art Therapy with Elementary School Children Who Were Victims of Disaster
- Use of a Drawing Task in the Treatment of Nightmares in Combat-Related PTSD
- Outpatient Art Therapy with Multiple Personality Disorder: A Survey of Current Practice
- Art Therapy at the Crossroads: Arts *and* Science

Art Therapy is available to AATA members as part of their membership.

Non-members may subscribe at the following annual rates:
Individuals: $50.00 (U.S.) - $74.00 (Foreign)
Institutions: $77.00 (U.S.) - $100.00 (Foreign)

Single copies are available at:
Members: $12.50 - Non-Members: $23.00

Make checks or money orders payable to AATA in U.S. funds and return with this order form to:
American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060

Please enter my subscription. Enclosed is a check/money order for the appropriate amount: $ ____________

Name: ____

Address: ____

City: ______________________ State: ________ Zip: ____________

The American Art Therapy Association

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-for-profit organization founded in 1969, is a national association which represents a membership of approximately 4,750 professionals and students. It is governed and directed by a nine-member Board, elected by the membership. AATA has established standards for art therapy education, ethics, and practice: AATA committees actively work on governmental affairs, clinical issues, and professional development. AATA's dedication to continuing education and research is demonstrated through annual national conferences and regional symposia, publications, videos, and awards.

MISSION STATEMENT

The American Art Therapy Association is an organization of professionals dedicated to the belief that the creative process involved in the making of art is healing and life enhancing.

Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy.

ART THERAPY:
DEFINITION OF THE PROFESSION

Art therapy is a human service profession that utilizes art media, images, the creative art process, and patient/client responses to the created products as reflections of an individual's development, abilities, personality, interests, concerns, and conflicts. Art therapy practice is based on knowledge of human developmental and psychological theories which are implemented in the full spectrum of models of assessment and treatment including educational, psychodynamic, cognitive, transpersonal, and other therapeutic means of reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, and increasing self-esteem.

Art therapy is an effective treatment for the developmentally, medically, educationally, socially, or psychologically impaired; and is practiced in mental health, rehabilitation, medical, educational, and forensic institutions. Populations of all ages, races, and ethnic backgrounds are served by art therapists in individual, couples, family, and group therapy formats.

Educational, professional, and ethical standards for art therapists are regulated by the American Art Therapy Association. The Art Therapy Credentials Board, Inc. (ATCB), an independent organization, grants post graduate Registration (ATR) after reviewing documentation of completion of graduate education and post graduate supervised experience. The Registered Art Therapist who successfully completes the written examination administered by the ATCB is qualified as Board Certified (ATR-BC), a credential requiring maintenance through continuing education credits.

CHAPTERS

Affiliated chapters of the AATA have been established throughout the United States. Chapters conduct meetings and activities which promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network for people working toward common goals. Information and support for chapter members is passed on from the Assembly of Affiliate Chapters to the local level.

You must be a national member to become a chapter member. Information on locating the chapter nearest you is available from the AATA National Office.

MEMBER BENEFITS

All members receive:

Publications

- *Art Therapy: Journal of the American Art Therapy Association* (published quarterly).
- *AATA Newsletter* (published quarterly).
- Substantial discounts on AATA publications, such as Annual Conference Proceedings, other professional journals, videos, and the Membership Directory.
- AATA literature, such as Educational Program List, Art Therapy Media List, Standards of Practice, and mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life, and disability through Maginnis & Associates.
- Access to national experts in art therapy.

AATA Meetings

- Discounts on registration fees to AATA national conferences and regional symposia.

Nationwide Advocacy

- Governmental affairs activities including congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third party payers.
- National liaison with related professional organizations for recognition and promotion of art therapy.

Professional Standards

- Development of Model Job Description and recommendations for licensing standards.
- Development and implementation of national Education Standards for approval of graduate level art therapy programs.
- Development and implementation of nationally recognized Standards of Practice and Ethical Standards for Art Therapists.

GENERAL INFORMATION

AATA and ATCB are administratively independent. Membership in AATA and Registration (ATR) with the ATCB require separate application and approval. *ATR registration applications are available from the ATCB at (312)527-6764.*

For ***new*** Associate, Student, and Contributing members only, please follow the dates below when submitting membership applications. The membership year is the calendar year **1/1 to 12/31**.

Applications received between:

1/1 to 5/31

Full dues payment; membership expires 12/31 of same year.

6/1 to 9/30

Half-year dues plus $5.00 payment; membership expires 12/31 of same year.

10/1 to 12/31

Full dues payment; membership for the remainder of current year and next full year.

CATEGORIES AND FEES

Professional-By application review process only; approved members may vote, hold office, and serve on committees.

- **Professional Member-**Individuals who have completed graduate level educational training in art therapy. Dues are $85.00/year.
- **Credentialed Professional Member-**Individuals who have been *dually approved* for Professional membership by AATA and Registration (ATR) by the ATCB. AATA dues are $85.00/year. *Annual ATR maintenance fee is billed separately by the ATCB.*

Associate-Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. This category is not open to Master's level art therapy program graduates. Associates may not vote, hold office, or serve on committees. Dues are $85.00/year.

Student-Individuals who are currently taking full-time course work in art therapy or a related field. A current statement from the institution of learning indicating full-time status and course work content (6 graduate or 12 undergraduate credits) is required. Student members may not vote or hold office, but may serve on the Student Subcommittee of the Education Committee. Dues are $35.00/year.

Contributing-Individual organizations, institutions, or foundations which contribute annually to AATA. Such members may not vote, hold office, or serve on committees. Dues are $120.00/year.

Retired-Individuals who are at least 65 years of age and who are no longer practicing. Retired Associates receive publications. Retired Professionals receive publications and may vote, but may not hold office. Application provided upon request. The service fee is $35.00/year.

The American Art Therapy Association

MEMBERSHIP APPLICATION

NAME____

HOME ADDRESS_______________________________________

____

PHONE(______)______________________________________

BUSINESS ADDRESS___________________________________

____

EMPLOYER____

JOB TITLE____

LICENSES HELD & STATE______________________________

____

PREFERRED MAILING LIST: ☐ HOME ☐ BUSINESS

Foreign AATA applicants *must* include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

Please indicate under which category you are applying:

☐ $85 Associate Membership

☐ $35 Student Membership *(See Student membership criterion for necessary documents to accompany this application.)*

☐ $120 Contributing Membership

Professional Member-Individuals who have completed graduate level educational training in art therapy. Dues are $85.00/year.

☐ Professional Membership Application

Credentialed Professional Member-Individuals who have been *dually approved* for Professional membership by AATA and Registration (ATR) by the Art Therapy Credentials Board, Inc. (ATCB). AATA dues are $85.00/year. *Annual ATR maintenance fee is billed separately by the ATCB.*

ATR Application-Provided and processed by the ATCB. *ATR is granted by ATCB review approval process only.* For more information, contact the ATCB at (312)527-6764.

Please make all checks payable in U.S. dollars and mail to:

American Art Therapy Association, Inc. (AATA)
1202 Allanson Road
Mundelein, IL 60060 USA
(847)949-6064 / Fax (847)566-4580

PLEASE COMPLETE THIS SURVEY.

Education (please check highest degree earned)

1 ☐ Doctorate Degree
2 ☐ Master's Degree
3 ☐ Bachelor's Degree
4 ☐ Associate/Certificate
5 ☐ Other ____________________

Please indicate *exact* degree earned, e.g., BA, BS, MA, MS, PhD, etc.

Work Setting (please check only one)

1 ☐ Hospital
2 ☐ Clinic
3 ☐ Day Treatment Center
4 ☐ Rehabilitation
5 ☐ Sheltered Workshop
6 ☐ Correctional Facility
7 ☐ Residential Treatment
8 ☐ Outpatient Mental Health
9 ☐ School System
10 ☐ Elderly Care Facility
11 ☐ College/University
12 ☐ Clinical Training Program
13 ☐ Institute Training Program
14 ☐ Counseling Center
15 ☐ Private Practice
16 ☐ Other ______________

Area(s) of Specialization (please check up to three)

1 ☐ Addictions
2 ☐ Adolescents, Hospitalized
3 ☐ Adolescents, Psychiatric
4 ☐ Adults, Hospitalized
5 ☐ Adults, Psychiatric
6 ☐ Art History
7 ☐ Art Therapy Education
8 ☐ Art Therapy in Schools
9 ☐ Children, Hospitalized
10 ☐ Children, Psychiatric
11 ☐ Domestic Violence
12 ☐ Eating Disorders
13 ☐ Families
14 ☐ Gerontology
15 ☐ Hospice/Terminally Ill
16 ☐ Learning Disability
17 ☐ Mental Retardation
18 ☐ Neurological Disease
19 ☐ Prisoners
20 ☐ Post Traumatic Stress
21 ☐ Psychotherapy
22 ☐ Rehabilitation
23 ☐ Research
24 ☐ Sexual Abuse
25 ☐ Visual Art
26 ☐ Other ______________

Voluntary Information

Age

1 ☐ 20-24
2 ☐ 25-29
3 ☐ 30-34
4 ☐ 35-39
5 ☐ 40-44
6 ☐ 45-49
7 ☐ 50-54
8 ☐ 55-59
9 ☐ 60+

Salary Range

1 ☐ under $10,000
2 ☐ $10,000-14,999
3 ☐ $15,000-19,999
4 ☐ $20,000-24,999
5 ☐ $25,000-29,999
6 ☐ $30,000-34,999
7 ☐ $35,000-39,999
8 ☐ $40,000-44,999
9 ☐ $45,000-49,999
10 ☐ $50,000+

Gender

1 ☐ Female
2 ☐ Male

2464

Hours Worked/Week

1 ☐ 0-10
2 ☐ 11-20
3 ☐ 21-30
4 ☐ 31-40
5 ☐ 41+

AMERICAN ART THERAPY ASSOCIATION, INC.

1202 Allanson Road, Mundelein, Illinois 60060 (847) 949-6064 FAX: (847) 566-4580

RESOURCES

American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following publications, films, posters, and training literature are available from the AATA National Office.

CONFERENCE PROCEEDINGS	**MEMBERS**	**NON-MEMBERS**
Creativity and the Art Therapist's Identity (1976) ISBN 1-882147-04-9	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) ISBN 1-882147-05-7	$ 5.00	$ 7.00
The Use of Creative Arts in Therapy (1979 Joint Conference)	$ 5.00	$ 7.00
Focus on the Future: The Next Ten Years (1979) ISBN 1-882147-10-3	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) ISBN 1-882147-12-X	$ 7.00	$10.00
A Bridge Between Two Worlds (1981) ISBN 1-882147-11-1	$ 7.00	$14.00
Art Therapy: Still Growing (1982) ISBN 1-882147-06-5	$10.00	$14.00
Professionalism in Practice (1988) ISBN 1-882147-08-1	$15.00	$20.00
Painting Portraits: Families/Groups/Systems (1989) ISBN 1-882147-07-3	$15.00	$20.00
Image and Metaphor (1991) ISBN 1-882147-09-X	$15.00	$20.00
The Art Therapist: Artist/Teacher/Clinician/Healer (1992) ISBN 1-882147-14-6	$15.00	$20.00
Common Ground: The Arts, Therapy, & Spirituality (1993) ISBN 1-882147-21-9	$15.00	$20.00
Reflecting on the Past, Envisioning the Future (1994) ISBN 1-882147-24-3	$15.00	$20.00
Weaving New Visions (1995) ISBN 1-882147-50-2	$15.00	$20.00

NOTE: Ten or more copies of a single proceeding: 10% discount on total.
Set of four proceedings (consecutive years): 20% discount on total.
Postage and handling: $3.00 first item and $0.75 each additional.

PUBLICATIONS	**MEMBERS**	**NON-MEMBERS**
A History of Art Therapy in the United States [1,2] (1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual [3] (1994) Howie & Gutierrez ISBN 1-882147-16-2	$20.00	$35.00
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0 [1,2]	$24.00	$35.00
Art Therapy in the Schools [3]	$ 6.00	$10.00
National Registry of Master's Theses & Practicum Papers [3]	$15.00	$25.00
Addendum to National Registry of Master's Theses & Practicum Papers [3]	$12.50	$22.50
AATA Chapter Manual [3]	$12.00	N/A
Applying for Funds from Your Area Agency on Aging [3]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance [3]	$ 7.00	$10.00

NOTE: [1] Postage and handling included on all orders for this publication. [2] Ten or more copies—10% discount. [3] Postage and handling: $3.00.

PROFESSIONAL PREPARATION LITERATURE	**MEMBERS**	**NON-MEMBERS**
Education Standards	$ .32	$ 1.00
Educational Program List (Colleges and Universities offering art therapy programs)	$ .32	$ 2.00

General Information Packet: $3.00 (includes Education Standards, Educational Program List, and Information and Membership Application)

OTHER LITERATURE	**MEMBERS**	**NON-MEMBERS**
Art Therapy Model Job Description	$ .32	$ 1.00
Art Therapy Media List	$ .32	$ 1.00
Bibliography: Books Authored by AATA Members	$ .32	$ 1.00
Ethical Standards for Art Therapists	$ .32	$ 1.00
Standards of Practice	$ .32	$ 1.00

MEMBERSHIP INFORMATION	**MEMBERS**	**NON-MEMBERS**
Membership Specialty List	$ 2.62	$ 3.62
Membership Survey	$ .32	$ 2.32
Membership Directory [1]	$14.00	$55.00
Criteria and Application for Professional Membership	$ .32	$ 1.00

NOTE: [1] Postage and handling for AATA Directory: U.S.—$3.00, Canada/Mexico—$3.25, and Foreign—$10.00.

POSTERS	**MEMBERS**	**NON-MEMBERS**
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$25.00	$35.00
"Three Art Therapists" (Edith Kramer)	$25.00	$35.00

NOTE: Postage and handling is included on both posters.

SUBSCRIPTIONS		
Art Therapy: Journal of the American Art Therapy Association	Individuals - U.S. $50.00 Institutions - U.S. $77.00	Foreign - U.S. $74.00 Foreign - U.S. $100.00
Back Issues of *Art Therapy: Journal of the American Art Therapy Association*	Members - $12.50	Non-Members - $23.00
AATA Newsletter	U.S. $26.00	Foreign $38.00

NOTE: Postage and handling is included on both subscriptions.

VIDEOS	**TYPE**	**MEMBERS**	**NON-MEMBERS**
Art Therapy Beginnings (1977) color/sound/45 minutes	1/2" VHS	$50.00	$80.00
Michael (1977) color/sound/12 minutes	1/2" VHS	$50.00	$80.00
Art Therapy (1980) color/sound/12 minutes	1/2" VHS	$50.00	$80.00

NOTE: Postage and handling for each VHS tape: U.S.—$3.00, Canada/Mexico—$3.25, and Foreign—$10.00.

- WE DO NOT ACCEPT CREDIT CARDS OR PURCHASE ORDERS. All orders must be made in writing, accompanied by payment in cash, check, or money order in U.S. funds.
- FOREIGN ORDERS: Shipping will be made per your instructions (surface or air). Please specify shipment method when ordering. Additional postage, if necessary, will be billed separately.
- RETURNS ARE NOT ACCEPTED for refund on shipped items.

TITLE	**QUANTITY**	**PRICE**	**TOTAL**

SHIPPING INFORMATION

NAME: ____________________

MEMBER ID #: ____________________

STREET: ____________________

CITY/STATE/ZIP: ____________________

Total: $__________

Postage: $__________

Applicable Discount: $__________

TOTAL ENCLOSED: $__________

Allow 2 - 4 weeks for delivery.
MAKE CHECKS PAYABLE TO AATA

ATTENTION AUTHORS

Please complete the following information and attach one copy to each copy of your submission:

Name ______________________________

Degrees/Credentials ______________________________

Address ______________________________

____

Phone Numbers **Home** ______________ **Work** ______________

Type of Submission (check one):

☐ Article
☐ Video Review
☐ Viewpoints
☐ Book Review
☐ Brief Report
☐ Commentary

Title of Submission ______________________________

____

Checklist

☐ Five (5) copies, typewritten on 8 1/2" x 11" white paper with margins of at least one inch.

☐ Black and white photographs (at least 5" x 7") of original artwork plus four (4) photocopies of each.

☐ Paper and references adhere to *Publication Manual of the American Psychological Association* (Fourth Edition).

☐ Abstract of 100-150 words (for articles and brief reports only).

☐ Detachable cover sheet with author(s) name(s), affiliation, degrees, and credentials.

☐ Appropriate release forms obtained for use of client art expressions and client information.
(You do not need to send these with your submission, but you must have them on file.)

☐ This Attention Authors form.

Author's Signature ______________________ **Date** ______________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association***, c/o American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 USA.

GUIDELINES FOR SUBMISSIONS

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy: Journal of the American Art Therapy Association* uses a blind peer review procedure for articles, brief reports, and viewpoints. Final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor, and special section editors.

The following are guidelines for submissions. **Submissions that do not conform to these guidelines will be returned to the author without review.**

Submission Categories

1. **Articles.** Full-length articles may focus on the theory, practice, and research in art therapy or related areas. Articles must include an abstract of approximately 100-150 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Brief Reports should include information on the research design, methodology, and results. An abstract of approximately 100-150 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry, or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office.
5. **Video Reviews.** Reviews of media (videos) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office.
6. **Commentaries.** Brief comments on submissions published in *Art Therapy;* issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each submission to **Editor, *Art Therapy: Journal of the American Art Therapy Association*, c/o American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original submissions that are not under consideration by another periodical or publisher are acceptable.
3. Submissions must be typewritten on 8 1/2" x 11" white paper with margins of at least one inch. The body of the paper, references, tables and quotations must be double-spaced.
4. Submissions must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for more information.
5. An abstract of 100-150 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles, and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for style of tabular presentations. All tables, charts, or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" x 7" and black and white glossy prints, preferably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs. Captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions which are addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. **It is the author's responsibility to secure such permissions.** A copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations, and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any submission accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their submission on either an IBM, IBM-compatible, or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the submission to the AATA National Office. This will help speed processing, editing, and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations, and materials accompanying their submissions.

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

VOLUME 13, NUMBER 4, 1996

2469 BEST COPY AVAILABLE

STATEMENT OF PURPOSE: *Art Therapy: Journal of the American Art Therapy Association* is the official journal of the AATA, Inc. The purpose of the journal is to advance the understanding of how visual art functions in the treatment, education, development and enrichment of people. The journal provides a scholarly forum for divergent points of view on art therapy and strives to present a broad spectrum of ideas in therapy, practice, professional issues and research. An emphasis is placed on the use of the visual arts in therapy, but articles in related disciplines of interest to art therapists will be considered for publication.

ART THERAPY: JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION (ISSN 0742-1656) is published quarterly by the AATA, Inc., 1202 Allanson Road, Mundelein, Illinois, 60060 U.S.A. Telephone (847)949-6064; FAX (847)566-4580. Non-members may subscribe at the following annual rates: $50 (U.S.) and $74 (Foreign); institutions $77 (U.S.) and $100 (Foreign). AATA members receive the journal as a benefit of membership.

Single Issues: For price and ordering information, call or write to AATA, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 U.S.A. (847)949-6064.

This journal is abstracted in: Resources in Education (ERIC), Art Bibliographies Current Titles, Art Bibliographies Modern, and PsycINFO.

Authorization to copy: No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, photocopying, recording or otherwise, without permission in writing from the copyright holder.

Change of Address: Notices should be sent at least six weeks in advance to American Art Therapy Association, Inc. Subscribers should notify the post office that they will guarantee forwarding postage. Undelivered copies resulting from address changes will not be replaced, but single issues may be purchased at the single issue price.

AATA NATIONAL OFFICE
American Art Therapy Association, Inc.
1202 Allanson Road, Mundelein, Illinois 60060 U.S.A.
(847)949-6064 and FAX (847)566-4580

MISSION STATEMENT: The American Art Therapy Association, Inc. (AATA) is an organization of professionals dedicated to the belief that the creative process involved in the making of art is healing and life enhancing. Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy.

ADVERTISING RATES

RATES	1×	2×	3×	4×
Full Page	$300	$275	$240	$195
One-half Page	275	250	215	165
One-fourth Page	200	175	140	95

MECHANICAL REQUIREMENTS	Width	Depth
Full Page	7"	10"
Half-Page Horizontal	7"	4-7/8"
Half-Page Vertical	3-3/8"	10"
One-fourth Page	3-7/8"	4-7/8"

Trim Size: 8-1/2" × 11"

SUBMISSION DEADLINES:
January 15 for Spring issue; April 15 for Summer issue; July 15 for Fall issue; October 15 for Winter issue.

15% Agency Discount.

The publication of any advertisement by this journal is not an endorsement of the advertiser or of the products or services advertised. The AATA, Inc. is not responsible for any claims made in an advertisement.

Editor
Cathy A. Malchiodi, MA, A.T.R., LPAT, LPCC
Institute for the Arts & Health, Salt Lake City, UT

Associate Editor
Susan Spaniol, EdD, A.T.R., LMHC
Lesley College, Cambridge, MA

Book Review Editor
Erika Cleveland, MA, A.T.R., LMHC
Lesley College, Cambridge, MA

Film/Video Review Editor
Mindy Jacobson, MCAT, A.T.R.
Friends Hospital, Philadelphia, PA

Production Editor
Karen D. Savage

Editorial Board
Pat B. Allen, PhD, A.T.R., LPAT
School of the Art Institute, Chicago, IL
Janet Bush, EdS, A.T.R.,-BC
Dade County Public Schools, Miami, FL
Julia G. Byers, MA, A.T.R.
Concordia University, Montreal, Quebec, Canada
Mariagnese Cattaneo, PhD, A.T.R., LMHC
Lesley College, Cambridge, MA
Susan E. Cheyne-King, MS, A.T.R., LPC, NBCCH
Cumberland Hospital, New Kent, VA
Carol Thayer Cox, MA, A.T.R., LPAT
George Washington University, Washington, DC
Anna R. Hiscox, MA, A.T.R.-BC, MFT
Illinois State University, Normal, IL
Sarah Hite, MS, MSEd, A.T.R.-BC
Eastern Virginia Medical School, Norfolk, VA
John G. Jones, PhD, A.T.R.-BC
Indian Health Service, Wolf Point, MT
Lynn Kapitan, MPS, A.T.R.
Mount Mary College, Milwaukee, WI
Frances F. Kaplan, DA, A.T.R.-BC
Hofstra University, Hempstead, NY
Leslie Knowles, MA, A.T.R., LMHC
Lesley College, Cambridge, MA
Vija B. Lusebrink, PhD, A.T.R.-BC, HLM
University of Louisville, Louisville, KY
Patricia Engle Murphy, PhD, A.T.R.
Private Practice, Moscow, ID
Mary Ellen Peacock, MA, A.T.R.-BC
St. Francis of Assisi School, Louisville, KY
Trudy Manning Rauch, MS, A.T.R.-BC
Eastern Virginia Medical School, Norfolk, VA
Shirley Riley, MA, A.T.R., MFCT
Loyola Marymount University, Los Angeles, CA
Irene Rosner David, MA, A.T.R.-BC
Bellevue Hospital Center, New York, NY
Patricia St. John, EdD, A.T.R.-BC
College of New Rochelle, New Rochelle, NY
Nancy M. Sidun, PsyD, A.T.R.
The Chicago School of Professional Psychology, Chicago, IL
Evelyn Virshup, PhD, A.T.R., MFCC
California State University, Los Angeles, CA
Judith Wald, MS, A.T.R.
New York Hospital - Cornell Medical Center, White Plains, NY

AATA President
Virginia Minar, MS, A.T.R.

AATA Executive Director
Edward J. Stygar, Jr.

2470

BEST COPY AVAILABLE

VOLUME 13

ARTherapy

JOURNAL OF THE AMERICAN ART THERAPY ASSOCIATION

NUMBER 4, 1996

Editorial

Art Therapists in Cyberspace — Cathy A. Malchiodi, MA, ATR, LPAT, LPCC 230

Articles

The Use of Art Therapy as a Predictor of Relapse in Chemical Dependency Treatment — Sara Brizdle Dickman, MS, ATR; Jonathan E. Dunn, MD, PhD; and Abraham W. Wolf, PhD 232

Children of the Stones: Art Therapy Interventions in the West Bank — Julia Gentleman Byers, EdD, ATR 238

Observer, Process, and Product — Noa Schwartz, MA, ATR 244

Mandala Drawing: Facilitating Creative Growth in Children with A.D.D. or A.D.H.D. — Valerie Smitheman-Brown, MA, ATR-BC, and Robin P. Church, EdD 252

Brief Reports

The Amusement Park Technique in the Treatment of Dually Diagnosed, Psychiatric Inpatients — Kathy D. Hrenko, MCAT, ATR, and Robert Willis, LSW, CAC 261

Painting as Language for a Stroke Patient — Shulamit Carmi, BA, and Tonni Mashiah, MD 265

Viewpoints

Considerations for the Treatment of Childhood Gender Identity Disorder — Audrey E. Bergin, MA, ATR, and Mary Ann Niclas, LCSW-C 270

The Absent Father: Gender Identity Considerations for Art Therapists Working with Adolescent Boys — Martha P. Haeseler, MA, ATR-BC 275

A Mother's Journey of Healing: When a Child Changes Gender — Linda Milligan, MPS, ATR 282

Art Beyond Humanism: Non-Western Influences on an Art Therapist's Practice — Martin Perdoux, MAAT, ATR 286

Reauthoring the Dominant Narrative of Our Profession — Shirley Riley, ATR, MFCT 289

Artistic Production as a Diagnostic Approach to Illness — Yvonne Pepin-Wakefield, PhD 293

Dreaming and Waking in Russia — Sally Brucker, MSW, ATR 297

Reviews

Creativity and Madness: Psychological Studies of Art and Artists — Martha P. Haeseler, MA, ATR-BC 300

Literacy Through the Book Arts — Leslie P. Knowles, MA, ATR, LMHC 301

About the Cover: "Kachina-Spirit Guide," 9" × 12", is a one-of-a-kind print (monoprint) by Sally Brucker, MSW, ATR, Takoma Park, MD. It is part of a series called "Kachinas." The image of the guide came in a dream and, for Brucker, symbolizes the presence of the "third eye" or "spirit" present in the therapeutic space when what has been heretofore hidden, emerges. The figure of Kachina is borrowed from Native American culture which honors the power of the spirit to heal and guide others. At the end of therapy, Sally often gives her clients a small reproduction of this print as a way to honor their spirit and continuing journey.

Editorial

Art Therapists in Cyberspace

Cathy A. Malchiodi, MA, ATR, LPAT, LPCC, *Editor*

Cyberspace is a familiar catch-all phrase for the infinite world of computer networks that include the Internet and the World Wide Web. The Internet or "the Net" is the mother of all computer networks and was originally developed for communications purposes by the US Department of Defense in the 1960s. Eventually, businesses, institutions, and the general public connected to the Internet, with the number of people using the Net skyrocketing in the 90s.

The World Wide Web (a.k.a. WWW or the Web) is generally considered to be the most popular spot of the Internet, an area in which individuals, organizations, institutions, and businesses have developed sites commonly known as Web pages. It is commonplace these days to hear someone speaking about his or her personal Web page, to notice more "www" addresses appearing on business cards and advertisements, and to encounter numerous Web sites during cyberspace travel. Currently, the AATA, several chapters, creative arts therapies associations, the National Creative Arts Therapies Association (NCATA), and a few enterprising art therapists have developed Web pages. The AATA Web page (www.arttherapy.org) has been up for more than a year and is currently devoted to governmental affairs and to providing the names of Board and Committee Chairs. Since mostly students travel the Internet, hopefully the AATA will include additional resources, more detailed information on membership, professional opportunities, education, and publications on its Web site in the near future.

Although the Internet and the Web have become popular ways to communicate, cyberspace may not be the most frequently used form of communication between art therapists. However, given its popularity and versatility, it is still one that every art therapist ought to experience at least once. Some believe that cyberspace is the ultimate form of networking with other art therapists. For example, Danny Sofer's Web page (http://www.sofer.com/art-therapy/) notes the following:

> The Web offers many things that existing forms of communication (newsletters, magazines, conferences, meetings) offer, but it also offers many advantages: it is cheap; it is global; it is collaborative; it is democratic; it creates fast feedback loops; and it's becoming increasingly ubiquitous.

While the Internet and the WWW offer many opportunities for art therapists wishing to communicate with others both within and outside of the field, it is not always clear what the actual advantages are. For instance, it is difficult to say that online communications are "cheap"; in reality, the cost of using the Internet or online services that are necessary to surf the Net or browse the Web is quite variable. For students and educators at universities, luckily there is generally no cost or a very nominal fee for access to the Internet and the Web. But for the average art therapist, access through a home computer is the most likely way to get to the Internet or browse the Web. This requires a considerable amount of capital, including a computer with adequate capacity to use an online program, and a way to get online (e.g., a service such as America Online, Compuserve, or other company for a monthly fee of anywhere from $10/per month and up). Getting online also requires a modem and may require a separate phone line if you want to keep your main home or office line free to receive calls while online. If one really wants to fully experience cyberspace, manuals and magazine subscriptions to publications such as *NetGuide* may also be necessary.

Going online also requires that you have considerable free time to spend staring at your computer screen. Unfortunately, most online users have slow access speeds—in other words, they have modems that transmit data at 9600 bits per second or less. There are modems that transmit information at 14,400 bps (bits per second) and 28,800 bps, and some people at universities have direct cable access which can transmit data at very high speeds. Most art therapists who have a modem are likely to have one with a slower access speed which often means that online travel is sluggish and visiting Web pages which have many graphics to download can be extremely frustrating.

One clear advantage of online communication is the ability to be interactive with other art therapists and professionals, even around the world. Once one is online there are a variety of ways to communicate with other individuals and groups. The most popular way is probably e-mail (electronic mail). This is a direct form of communication similar to leaving a message on someone's phone answering machine, except that e-mail messages are sent as text and deposited at the address or mail box of the recipient. An amusing part of electronic mail is the use of online monikers; in most cases you are able to choose your online name and some art therapists have been quite inventive with their choices. I have interacted with a MrCrayon, Larkster, Cyanotype, BlueHer674, GO LIVE IT, CrowMother, Mystickona, PLAYMIKE, and PurpleArt, to name a few. There are some people I only remember by their cyberspace names, forgetting or, in some cases, never knowing their "Earth" names at all.

In the area of speed and convenience, communication via cyberspace, versus phone communication or snail mail, has many advantages. I now take for granted that I will receive e-mails each week from throughout the US, will regularly find notes from colleagues in Europe, Asia, and South America, and will be able to send a communication to someone on the other side of the world in seconds. For example, cyberspace has made it possible and easy to work on a manuscript with another art therapist in Scotland, to get information on what Asian art therapists are doing, and talk with a publisher in Brazil, all from my home computer.

There are also possibilities for public communication online through bulletin boards (places where you can post messages for everyone who visits the site to read) and live online chats (areas where many people can meet online at a given time and type in responses on screen, a kind of "text" conversation). My initial response to online chats and bulletin boards was positive, imagining them as places for discussion and possibly even peer supervision (Malchiodi, 1996). However, after three years of observing both chats and bulletin boards, it seems that they are more useful as support groups for art therapists rather than ways to debate or discuss professional issues. The majority of entries on bulletin boards and folders are questions about where to obtain training, where to find work, and what to do with various client populations. Perhaps this is the nature of cyberspace itself: since one cannot see who one is talking to in online forums and bulletin boards, body language and facial cues are not available as visual references. Misunderstandings and misinterpretations of messages frequently occur, often resulting in ruffled feathers and hurt feelings. Also, since what is entered onto a bulletin board or chat forum is permanent, many art therapists may be reluctant to submit an opinion that others will be able to read.

Both bulletin boards and online chats seem to go through phases where people are very active in the discussions to times when no one seems to be interested. For example, in 1994 and 1995, the Creative Arts Therapies folder in the Better Health & Medical Network of America Online (AOL) was very active, while currently it rarely receives new entries. Similarly, the Creative Arts Therapist's online chats on AOL were once well-attended, while the current chats attract little participation. Perhaps that will change as more art therapists come online.

On the other hand, an Internet forum created by Barbara Levy, ATR-BC, called CATCHAT ™ (http://plaza.interport.net/cats) is a very active bulletin board for creative arts therapists, professional colleagues, and those interested in art, music, dance, and drama therapy. I visited the art therapy section while writing this editorial and at that time it had daily entries, although those entries are generally questions about training programs (where should I go to school?) or job opportunities (where do I find a job?). For the seasoned professional there is little advanced material; however, these cyber-forums for art therapists are helpful for students or novice therapists who are asking basic questions and looking for information on how and where art therapists practice.

When participating in either bulletin boards or live chat sessions there are some important factors to consider. For example, the chat host or discussion leader is not necessarily a qualified professional in the field or topic. I have attended quite a few chat sessions on America Online (AOL) in various health-care sections and have found the qualifications of the chat hosts to be uneven at best. AOL does not necessarily pick the most qualified people for the job; according to Elin Silveous, co-coordinator of the Better Health & Medical Network/AOL, qualifications seem to have little to do with selection of discussion leaders:

> The qualifications for facilitating group meetings in the Better Health & Medical Network are not based on clinical expertise, board certification, nor any other medical credentials. Although a facilitator may have a clinical background, their clinical profession is not a qualification for facilitating a group meeting in the Better Health & Medical Network. As you know, our group meetings are not intended for the provision of diagnostic nor therapeutic recommendation. Our selection of facilitators for start-up group meetings in the Better Health & Medical Network is based on numerous factors, but health care background is not one of them. (online communication)

This lack of quality control is not limited to live online chats. Web pages are generally not subject to any critical review; whoever creates them may use them to present select information, generate business, or promote oneself or one's services, just as one would create an advertisement for a newspaper or a highway billboard. What you may read on a Web page is not necessarily the truth or the best information, and is only as accurate as the person who wrote or compiled it.

There is indeed a democracy involved in the Internet as Sofer noted; no one controls or owns the Net or what goes onto it. The downside of the situation is no one controls what information is placed in cyberspace, thus quality control is almost nonexistent. However, the upside is cyberspace does allow for free expression of thoughts and ideas, a welcome concept in this day and age.

There are numerous pros and cons of venturing into cyberspace and it certainly may not be for every art therapist. Cybertravel is intriguing, but it does take patience and a lot of time, even with the fastest modem or direct cable access. Like many individuals, I was initially excited about the Net and the Web, but I eventually found that I did not have the time to devote to wading through it. E-mail—like snail mail, phone messages, and faxes—has been become one more item that I have to attend and respond to on a regular basis. Live online chats, which interested me at the outset, now seem to be a tedious way of communicating with others and have the missing element of hearing a voice or seeing a face. Bulletin boards are great for those who are exploring the field of art therapy, but for the advanced professional offer little new in the way of helpful information. Also, there is currently so much information on the Net and the Web that one would need to be either retired from active practice or unemployed to pursue reading even a fraction of it.

However, would I give up traveling cyberspace? No, I would not. I enjoy the ability to quickly communicate with people around the world, an impossible notion only a few years ago. I also have come to take for granted that I can search the Web for research data in areas such as Medline and ERIC from the comfort of my home office. Most of all, I like the idea of being able to travel through "space" that is still largely undefined and often uncharted, somewhat like the field of art therapy. Perhaps this is one characteristic that makes cyberspace attractive to those art therapists who want to boldly go where few have gone before.

Reference

Malchiodi, C. A. (1996). Peer supervision. In C. Malchiodi & S. Riley, *Supervision & related issues: A handbook for professionals* (pp. 116-123). Chicago, IL: Magnolia Street Publishers.

Editor's Note: Another interesting art therapy Web page is one constructed by Petrea Hansen, Art Therapy in Canada (http://www.io.org/~phansen/index.html). Hansen has compiled a series of bibliographies that are well worth a visit if you are conducting a literature search or simply browsing the Web for information on art therapy.

Art Therapy: Journal of the American Art Therapy Association, 13(4) pp. 232-237 © AATA, Inc. 1996

The Use of Art Therapy as a Predictor of Relapse in Chemical Dependency Treatment

Sara Brizdle Dickman, MS, ATR, Jonathan E. Dunn, MD, PhD, and
Abraham W. Wolf, PhD, Cleveland, OH

Abstract

This pilot study evaluated the hypothesis that relapse in patients treated for chemical dependency could be predicted by evaluating artwork completed during the active treatment phase. A retrospective study, based on 5 years' observation, was carried out at a large county hospital. A rating manual was developed identifying 11 items as potential indicators of relapse. Two independent art therapists rated 50 sets of four assigned drawings. Three of the 11 items were found more likely to be present in the drawings of patients who relapsed within 3 months after treatment. These included (1) the presence in a drawing of psychoactive substances or drug paraphernalia, (2) the lack of either a figure representing the self or any articulated or detailed figure in a drawing, and (3) the use of an abstract or geometric drawing style on at least 66% of the picture.

Introduction

Chemical dependency continues to be a major problem in healthcare today. According to estimates, it costs the United States as much as $165.5 billion annually (Hogan, 1993). This cost includes not only treatment but also "the productivity losses caused by premature death and inability to perform usual activities, and costs related to crime, destruction of property and other losses" (Hogan, 1993, p. 14). Relapse rates tend to fall within the range of 45% to 60% (Hoffman & Miller, 1994). Predictors to identify patients at high risk for relapse could be very useful in the formulation and/or execution of an individual's treatment plan.

This study sought to determine if items drawn in therapist-directed art therapy tasks could be used as effective predictors of relapse during treatment for chemical dependency. Previous work using art therapy with chemically dependent individuals has focused on assessment and the use of a variety of different treatment approaches. Allen (1985) described the integration and application of art therapy into a hospital inpatient alcoholism treatment program. She noted that patients seemed to gain insight through artmaking and that many patients found their defenses challenged, which was the overall goal of the program. Foulke and Keller (1976) wrote about the art experience in addict rehabilitation where the goal was to facilitate tolerance and integration of affective experience under conditions of full ego control. Spring (1985) identified a symbolic language in the art of chemically dependent, sexually abused women. For some of these women, drawing provided authentic relief from pain during the session, and for others it provided a model for achieving a sense of control. Albert-Puleo (1980) used an analytical approach when she encouraged narcissistic transference and used it as a focus for treatment. Cox and Price (1990) used incident drawings to help adolescents translate inner experiences into art expressions and break through to feelings of self that had been lost through substance use. Julliard (1994) used art therapy, combined with role-playing, to increase chemically dependent patients' belief in Step 1 of the 12-step program. Each of these authors anecdotally found art therapy beneficial during the treatment and recovery from chemical use.

The retrospective study described in this article used art therapy in the treatment of substance abuse in a different way. In this study, art was looked at as a possible predictor of future behavior, particularly relapse. The treatment team at the county hospital, including a psychiatrist, a psychologist, counselors, residents, medical students, and the art therapist, hypothesized that patients' drawings might contain predictors of those patients at high risk for relapse. Based on 7 years of providing art therapy services to this population, the art therapist and the psychiatrist decided to retrospectively examine patient artwork to see if they could identify items predictive of relapse.

History

The research site, a 742-bed, nationally recognized county hospital located in Cleveland, Ohio, provides a full range of both inpatient and outpatient, general and tertiary healthcare. In 1976 a Center for Alcohol and Chemical Dependency was established. Under the aegis of the Department of Psychiatry, this program treats adult patients ranging between 20 and 45 years of age. After an initial evaluation, treatment consists of a 3-week outpatient program. The program utilizes a comprehensive therapeutic approach to help resolve the physical, social, and emotional needs that accompany chemical dependency. Individual and group counseling, Alcoholics and Narcotics Anonymous, family care, and an aftercare program are included.

Art therapy was added to this treatment plan approximately 10 years ago. At the outset the goal of the program was to provide patients with an avenue for personal expression beyond the traditional verbal one, with a focus on encouraging expression of feelings about their addiction, treatment, and recovery. This approach was implemented successfully for several years. However, in 1991, after consultation with the medical director, there was a decision to shift the direction of the art therapy program so that art expressions began to be used to assess and evaluate patient progress in the recovery program. New patients as well as readmissions were required to attend four twice-weekly

BEST COPY AVAILABLE

art therapy group sessions which lasted up to 2 hours each. At these sessions, after an initial warm-up exercise, they were given one of the following four sequential drawing tasks: (1) How do you feel about being in recovery? (2) What makes you angry? (3) What is the most difficult part of recovery for you? (4) How do you plan to continue your recovery after you leave this hospital treatment program? These questions were developed specifically to evaluate patient compliance and attitude toward treatment and became part of the standardized data for evaluation as this current study evolved. Drawing materials consisted of 12″ × 18″ paper (white or colored) and markers or oil pastels.

Methodology

After observing and processing the artwork of chemically dependent patients for several years, the treatment team realized that certain items were appearing frequently in the drawings. The presence of these items was noted not only by the art therapist, but also by the psychiatrist and counselors working in the program. Discussion about these recurring themes, styles, and symbols generated the research efforts of this study.

Eleven items were identified as potential predictors of relapse. A rating manual was developed by the authors to define and give examples of those 11 items (Table 1). Two art therapists not currently working with a chemically dependent population were trained to identify the 11 items. They scored each item positive (if present), negative (if not present), and/or not applicable. Each drawing was rated on a separate score sheet and each rater scored 50 sets of the sequential drawing tasks described previously.

Table 1
Rating Manual Items

The rating manual defined and gave examples of the following 11 items for scoring. Raters were instructed to rate either positive (+) if present, negative (−) if not present, or not applicable (±) for each item.

Items rated included:

Item 1: Stereotypical Drawing—an oversimplified drawing lacking originality and *not* including personal information about the patient
Item 2: Presence of Psychoactive Substances/Paraphernalia of Use
Item 3: Placement of Psychoactive Substances Near (within 4 inches) a Human Figure
Item 4: Enlarged Scale of Psychoactive Substances—substances proportionally large, or covering 1/6 of the page
Item 5: Lack of Self/Lack of Any Articulated Figure—lack of self representation or lack of any figure or face articulation
Item 6: Steps—stairs inaccessible or nonfunctional relative to the drawing
Item 7: Spacial Progression Toward the Left (viewer's left) Side of the Page—roads, footprints, or stairways progressing clearly toward the left
Item 8: Dichotomous Thinking—representation of opposites, or picture divided into two halves
Item 9: Presence of Water—body of water (not including rain or clouds)
Item 10: Abstract or Geometric Drawing Style—picture is predominately (at least 66%) abstract
Item 11: Despair/Helplessness—with no help present

Fifty sets of drawings by 50 patients who finished the program in 1992 or 1993 and for whom follow-up data were available were selected. The sample population had the following characteristics: the mean age was 35.8 years (10.5 SD); 47% were female; 69% were Caucasian; 43% were single, 37% were divorced or separated, and 20% were married or cohabitating; the mean level of education was 11.6 years (2.1 SD); 55% had a high school degree or greater, but less than 5% had obtained a 4-year college degree; 62% had previously participated in some form of chemical dependency treatment. Of this group of patients, 23 had relapsed and 27 had abstained from chemicals for 3 months after leaving the program. The posttreatment follow-up data were collected by telephone interview as part of the program's regular quality assurance work.

Subjects who relapsed were compared to abstainers on each of the 11 addiction indicators. A positive score on each addiction indicator was scored and summed for drawings 1 through 4 for that indicator. Therefore, scores for each indicator ranged from 0 to 4. Because of their restricted range, the summed scores for cases who relapsed were compared to those who abstained using the Chi-Square statistic. Results of the Chi-Square analyses for each indicator are reported at the .10 and .05 level of probability. All data were analyzed and reported separately for Rater 1 and Rater 2.

Results

Table 2 reports the comparison of subjects who relapsed and who abstained after 3 months for each of the 11 items. Values in this table represent the proportion of subjects who received a positive score on any of the four drawings. For both Rater 1 and Rater 2, subjects who relapsed were scored as having a greater proportion of positive items on all four drawings with one exception (Item 7, Progression to Left). Chi-Square analyses of the proportion of cumulative items indicated suggestive ($p < .10$) and significant ($p < .05$) results for both raters on Item 2 (Presence), Item 5 (Lack of Self), and Item 10 (Abstract). The interrater reliability (IRR) average was 96.4% (Table 3). Forty-five percent of the sample (23/50) relapsed 3 months after treatment.

Discussion

Statistical outcomes bore out the hypothesis because three of the items (2, 5, and 10) appeared to be indicators of future relapse. Nevertheless, each of the 11 items offers the following interesting data.

Item 1: Stereotypical Drawing (Figure 1). This item was included in the study because it was theorized that nonidiosyncratic, highly idealized drawing responses such as rainbows, hearts, and flowers, and smiling/frowning faces represented either a lack of personal investment in or a resistance to the recovery process. This was a difficult item to document, and it did not prove to be statistically significant. The raters had problems identifying and agreeing on this item, as the stereotype concept appears to be a highly individualized one. The rating manual definition and examples were unable to clarify this, and it was

Table 2
Association of Addiction Indicators on One or More Drawings by Relapse/Recovery for Rater 1 and Rater 2

	Rater 1		Rater 2	
	Relapse	Abstained	Relapse	Abstained
N	23	27	23	27
Item 1 Stereotype	17.4%	7.4%	17.4%	7.4%
Item 2 Presence	82.6%	48.2%**	82.6%	48.2%**
Item 3 Placement	52.2%	37.0%	52.2%	37.0%
Item 4 Scale	73.9%	44.4%	69.6%	48.2%
Item 5 Lack of Self	100.0%	92.6%*	95.7%	88.9%**
Item 6 Steps	30.0%	29.6%	30.0%	40.7%
Item 7 Progression to Left	22.0%	22.0%	22.0%	29.6%
Item 8 Dichotomy	52.0%	37.0%	52.0%	37.0%
Item 9 Water	21.7%	14.8%	21.7%	14.8%
Item 10 Abstract	47.8%	33.3%*	60.9%	29.6%**
Item 11 Despair	21.7%	30.7%	30.4%	22.2%

* $p < 0.10$
** $p < 0.05$

Table 3
Interrater Reliability Drawings

	A*	B	C	D	MEAN
1. Stereotype	100%	100%	100%	100%	100%
2. Presence	100%	98%	100%	100%	100%
3. Placement	100%	98%	100%	98%	99%
4. Scale	98%	96%	100%	98%	98%
5. Lack of Self	94%	84%	84%	84%	87%
6. Steps	100%	92%	100%	96%	97%
7. Progression to Left	100%	94%	92%	98%	96%
8. Dichotomy	100%	100%	100%	98%	100%
9. Water	98%	98%	98%	98%	98%
10. Abstract Style	82%	98%	96%	98%	94%
11. Despair	98%	84%	94%	98%	94%
Average Mean 96.45					

* A = all drawings #1
B = all drawings #2
C = all drawings #3
D = all drawings #4

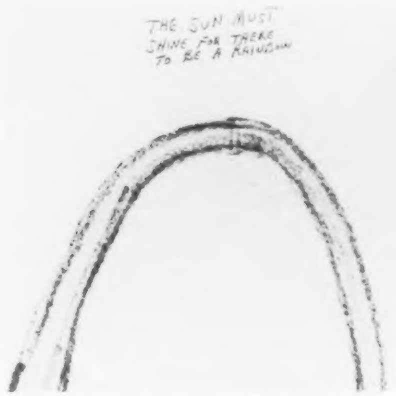

THE SUN MUST SHINE FOR THERE TO BE A RAINBOW

Figure 1

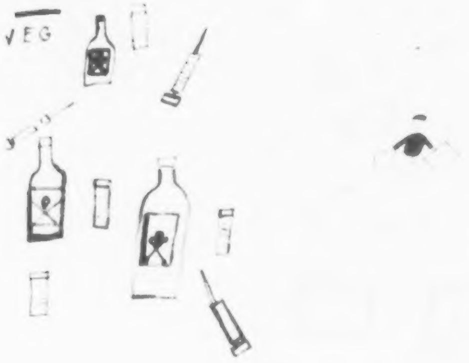


Figure 2

decided to review each of the drawings where there was a question regarding stereotype. This review accounts for the 100% IRR score on this item.

Item 2: Presence of Psychoactive Substances or Paraphernalia of Use (Figure 2). This item appeared to be most significantly related to relapse with a probability rate less than .05. Subjects who relapsed within 3 months drew substances almost twice as often as those who did not. As Table 2 indicates, 83% of relapsing patients included some substances in their work, compared with 48% of recovering patients. It appears that patients fixated on alcohol and chemicals drew them more often and were more likely to relapse than those who did not include them in the four assigned drawing tasks. This item, therefore, may provide a valuable visual clue in the assessment of patient treatment. Counselors and art therapists who recognize this chemical presence in the artwork as a red flag indicating relapse might factor this into their patient evaluation and treatment planning, using the drawings in discussions with patients.

Item 3: Placement of Substances Near a Human Figure (Figure 3) and **Item 4: Enlarged Scale of Psychoactive Substances** (Figure 4). The data for Item 3 and Item 4 reflect a wide numerical range between recoverers and those who relapsed, with the higher score belonging to those who relapsed (Table 2). Item 4 had an average range of approximately 25 points between those who relapsed and those who did not, a good indication that when a substance is drawn proportionally

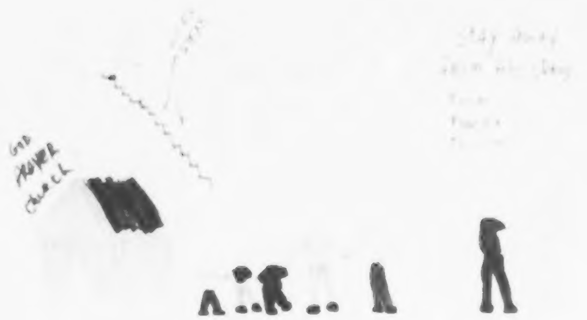


Figure 3

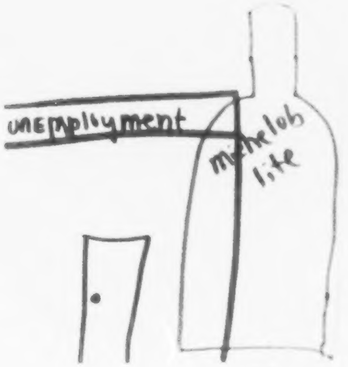


Figure 4

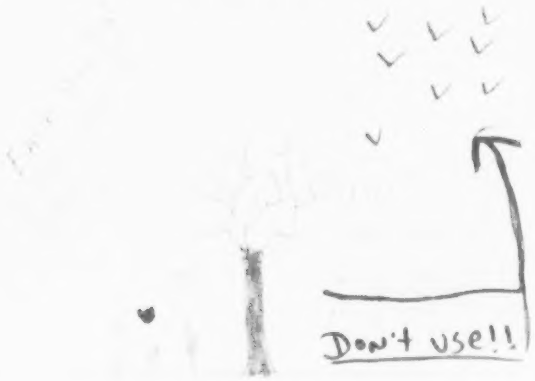


Figure 5

Figure 6

large (that is, large in proportion to the rest of the items in the drawing or to the paper itself), the patient is at risk for relapse.

Item 5: Lack of Inclusion of a Human Figure Representing or Identifying the Patient (Figure 5) or **Lack of Any Articulated Figure** (Figure 6). This item received a statistically significant rater *p* score of approximately .05 for one rater and a near significant *p* score of .10 for the other rater. Table 2 documents the importance of this item, with the highest percentage of relapsing patients, 100% in the case of one rater, drawing pictures devoid of human figures. Although abstainers also scored high on this item, relapsing patients all scored higher. The importance of the human figure has been well documented in the field of art therapy and psychology (Machover, 1949; Hammer, 1958). Conversely, the lack of the human figure or an unarticulated stick figure may make a statement also. It might reflect denial, which is an important stage of recovery, or a lack of personal commitment to or investment in the recovery process. This absence of a human figure or lack of detail on a figure might also reflect a resistance to participation in the art therapy process, which often translates into a resistance to treatment itself. This item was difficult to rate and, after much discussion, the definition was refined to say that *any* detail on the figure (more than a dot for the eyes, nose, and mouth) was counted as an articulated or detailed figure (e.g., hair, a hand, or foot, etc.).

Item 6: Steps (Figure 7).Recovery usually includes a 12-step program. Item 6 was an attempt to identify stairs with steps from that program and to look for stairs that did not appear to be integrated into the drawing (inaccessible or nonfunctional) as predictors of relapse. Individuals who relapsed often drew stairs that appeared to be floating or were too large/unreachable for a figure to climb.

Item 7: Spatial Progression Towards the Left (Figure 8). This item was an attempt to apply the theory that the left side of the page represents an individual's past (Ogden, 1977). Therefore, a progression in this direction might indicate a behavioral return to past use, that is, relapse. However, the data on both Items 6 and 7 were unable to sustain this hypothesis, and, for these two items, patients who relapsed did not score higher than nonrelapsed patients (Table 2).

Item 8: Dichotomous Thinking (Figure 9). Initially, this dichotomous drawing appeared to reflect statistical significance between relapsing cases and nonrelapsing cases, with a *p* of .02 based on an initial N of 38. Dichotomized, "black and white" thinking is often found in addicted individuals, who may have an inability to see the middle range of "grays." This would translate into a behavioral inability to moderate chemical use. When the N was expanded to 50, however, the *p* value changed to 3.5. Nevertheless, those who relapsed scored higher on this item, with a point difference of 15 from those who did not relapse (Table 2). This item was also difficult for the raters to score.

BEST COPY AVAILABLE

requiring frequent review, and this accounts for the higher IRR (Table 3).

Item 9: Presence of Water (Figure 10). This item did not prove to be statistically significant in this study, appearing only 20 times (10%) and equally divided between relapses and abstainers. This does not appear to support the findings of Devine (1970) in her investigation of the paintings of alcoholic men where 27% included water in their paintings. In this study both drug users and women were included. This composition of the study sample, along with the directed nature of the task and the use of dry media rather than paint, may have contributed to the results. Flowing paint itself may be more conducive to images of water. In her study, Devine also found boats were "the most popular theme of all." However, in this group of 200 assigned drawings, only one boat was drawn. Albert-Puleo (1976) found water to be a prevalent theme: "Water is commonly regarded as a sym-

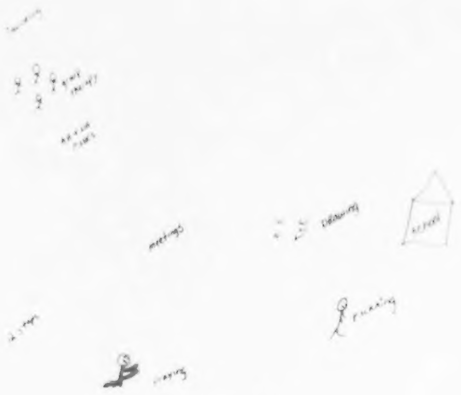

meetings
drawing
running
playing

Figure 7

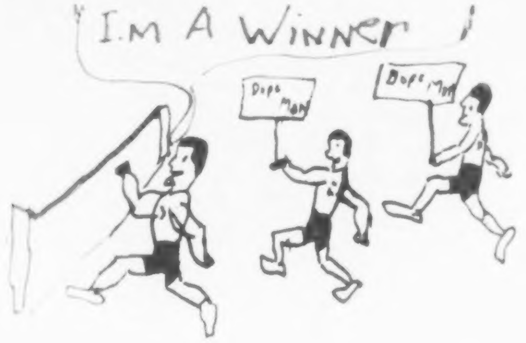

I.M A Winner !
Dope Man
Dope Man

Figure 8

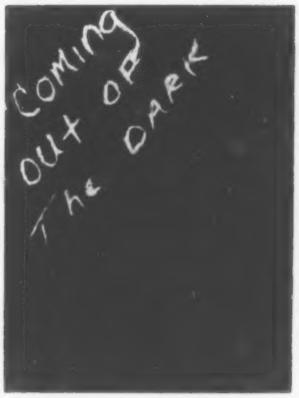

Coming out of The DARK

Figure 9

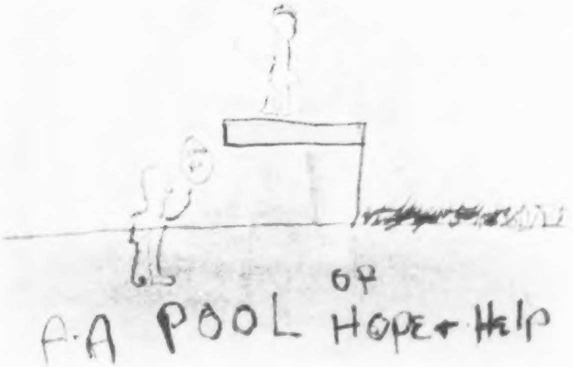

A.A POOL of HOPE + Help

Figure 10

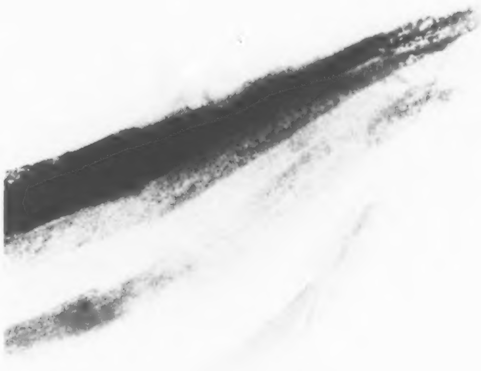


Figure 11

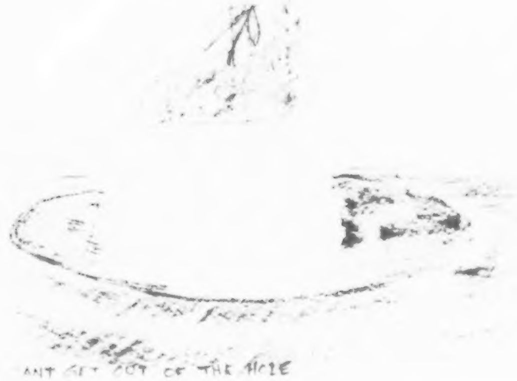

ANT GET OUT OF THE HOLE

Figure 12

bol of regression. Alcoholism is traditionally seen as a similar regression, the need to dissolve one's consciousness in the comfort of liquid escape" (p. 49). Perhaps the directed nature of drawing tasks such as those in this study may have influenced the choice of symbols.

Item 10: Abstract or Geometric Style (Figure 11). This item using an abstract or geometric style over at least 66% of the picture approached statistical significance for Rater 1 and was statistically significant for Rater 2 with a *p* value just at the .05 mark. These drawings appeared to be exactly what their name implies, that is, abstractions. When patients elect an abstract drawing style, they may be avoiding the difficult realities of treatment, preferring the amorphous lack of realistic detail found in abstract designs. This also may indicate that they are unable or unused to dealing with boundaries or to making clear statements and/or are afraid to take the risk of exposing themselves on paper. The use of abstraction may be a visual expression of the paranoia often associated with chemical dependency ("Will this be used against me?"). Until a patient is able to get beyond this fear of honest expression, either on paper or verbally, relapse is likely.

Item 11: Despair or Helplessness (Figure 12). This item was found by one rater more often in the drawings of relapsed patients (Table 2). This rater scored those who relapsed 18% more likely to draw despair than those who did not relapse. Conversely, the second rater found a higher percentage of abstainers for this item. Where despair was depicted with dark colors, clouds, or rain, but some help was present as a potential end to the despair, the drawing was not rated positive for despair.

Conclusions

Art therapy has been used in the treatment of chemical dependency for over 25 years. Its application varies according to the philosophy and staff of the specific treatment program. Emphasis on visual expression, whether for insight, assessment, or evaluation, utilizes the special qualities art therapy offers a population mainly familiar with verbal therapy and expression.

This retrospective study hypothesized that art therapy might be used as a predictor of future behavior regarding relapse. It consisted of a four-part structured drawing exercise carried out as part of the treatment and evaluation process in an outpatient chemical dependency program at a large county hospital. Eleven specific indicators were selected for analysis from an assigned drawing experience. Statistical outcomes substantiated the hypothesis because three of the 11 items rated appeared to be indicators of future relapse. Those items were the presence of psychoactive substances or paraphernalia of use in a drawing, the lack of a figure representing the patient or of any articulated or detailed human figure, and a picture drawn entirely or predominantly (66%) in an abstract or geometric style. These three items were noted more often in the drawings of patients who relapsed within 3 months after treatment.

A rating manual was developed for this study which is available for use by other investigators. Initial testing indicated the manual was relatively easy to use and assisted in rater objectivity. The hypothesis generated by this retrospective study should be tested prospectively both in the research setting and in other settings. The authors suggest that results should be compared with follow-up data after 1 year. Further analyses of the drawings of patients who dropped out of the program before completing treatment may offer additional data in the prediction of relapse.

In this study, the outcome was defined as a dichotomous, unidimensional indicator; that is, the individual either remained abstinent or relapsed. Clearly this approach misses individuals who may have used chemical substances on only one or two occasions, learned from their relapse, and changed their behavior. In this study, the single outcome indicator was used for practical reasons since the data were already being collected for other purposes. Further studies might allow for such behaviors, as well as look at data 6 months or a year after treatment, to compare the results.

References

Albert-Puleo, N. (1980). Modern psychoanalytic art therapy and its application to drug abuse. *The Arts in Psychotherapy, 7,* 43-52.

Allen, P. (1985). Integrating art therapy into an alcoholism treatment program. *American Journal of Art Therapy, 24,* 10-12.

Cox, K., & Price, K. (1990). Breaking through: Incident drawings with adolescent substance abusers. *The Arts in Psychotherapy, 17,* 333-337.

Devine, D. (1970). A preliminary investigation of paintings by alcoholic men. *American Journal of Art Therapy, 9,* 115-128.

Foulke, W., & Keller, T. (1976). The art experience in addict rehabilitation. *American Journal of Art Therapy, 15,* 75-82.

Hoffmann, N.G. (1994). Assessing treatment effectiveness. In N. S. Miller (Ed.), *Principles of addiction medicine,* (p. 8). Chevy Chase, MD: American Society of Addiction Medicine.

Hoffmann, N. G., Halikas, J. A., David, M. L., & Weedman, R. D. (1991). *Patient placement criteria for the treatment of psychoactive substance use disorders.* Washington, DC: American Society of Addiction Medicine.

Horgan, C. (1993). *Substance abuse: the nation's number one health problem: key indicators for policy.* Princeton, NJ: Institute for Health Policy, Brandeis University for The Robert Wood Johnson Foundation.

Julliard, K. (1994). Increasing chemically dependent patients' belief in Step One through expressive therapy. *American Journal of Art Therapy, 33,* 110-119.

Ogdon, D. P. (1997). *Psychodiagnostics and personality assessment: A handbook* (2nd ed). Los Angeles: Western Psychological Services.

Spring, D. (1985). Sexually abused, chemically dependent women. *American Journal of Art Therapy, 24,* 13-21.

Art Therapy: Journal of the American Art Therapy Association, 13(4) pp 238-243 © AATA, Inc. 1996

Children of the Stones: Art Therapy Interventions in the West Bank

Julia Gentleman Byers, EdD, ATR, Montreal, Canada

Abstract

This article reports on art therapy interventions with children, families, and mental health workers, who were experiencing Post Traumatic Stress Disorder syndrome as a result of the military conflicts in the West Bank and Gaza. Through references to mental health literature regarding art therapy with individuals in war zones, the psychological effects of war and violence on children and their families are identified. The author describes art therapy in six mental health clinics. The artwork from participants in group workshops helped to open lines of communication among people enduring attempts at reconstruction and rehabilitation of their society. The article ends by describing follow-up plans to promote empathic dialogue among mental health workers in the different cultures.

Introduction

In March 1995 I was invited to participate in the Partnership for Children project which was funded by the Children's Bureau of the Ministry of Health of Canada. Dr. Farid Ohan, Associate Principal of Seneca-at-York College and Associate President of the Near East Cultural and Educational Foundation of Canada (NECEF), and Dr. Jim Graff, philosophy professor at the University of Toronto and President of NECEF, provided this opportunity to facilitate art therapy training and interventions in the West Bank and Gaza. This unique project allowed a Canadian mental health team to interact with children, families, and mental health workers experiencing post traumatic stress disorders.

The NECEF's aim was to introduce a new approach for reconstruction and rehabilitation in war-ravaged societies by addressing the psychological and emotional trauma of children and their families affected by the combat. Before the Intifada conflict and violence, there were no community mental health services available in the area. During the past 7 years, mental health clinics and special services have been established, partly by international relief organizations, in the occupied territories.

Review of the Literature

The psychoanalytic exploration of children in traumatic situations such as war and separation began with the pioneering work of Anna Freud during World War II (1973) and Bowlby (1951). As identified by Apfel and Simon (1993), "The value of psychoanalytic/psychodynamic perspectives in research on children in war necessitates a design of research protocols which includes questionnaires, semistructured interviews, open-ended interviews, or expressive therapies, such as drawing and drama" (p. 176).

The connections between a subject's past and present experiences become clearer when the affective states are explored through art. At this point the art therapist can guide the individual toward appropriate integration and improved functioning by helping bear the pain of decoding and re-experiencing affective distress. As Johnson (1987) comments, "Unique aspects of nonverbal media are applicable at each stage of post traumatic stress disorder treatment: initially gaining access to traumatic memories, working-through and integrating the split-off parts of the self, and finally in re-joining the world of others" (p. 12).

Through the sensory quality of art materials, a child depicts how he or she experiences the world, giving meaning to the confusion of the external environment. Conveyed by sights, sounds, textures, smells, colors, forms, and bodily responses that comprise memory and recollection, the art media provide a portrait of significant relationships that help the child through difficult situations. As Apfel and Simon (1993) note, "War is not the only stress and distress in children's lives. War exacerbates children's concerns about their humanness" (p. 177).

Since excited affect is exacerbated through war, the excitement itself may be one major means of coping with fear, depression, and isolation. The war situation stimulates powerful projections and fantasies. These may be real or unreal, but the opportunity to express one's experiences may be gratifying and provide some relief from some of the anxiety and angst.

Colon (1984) emphasizes the multiple stresses and frequent crises endured by low- or no-income families. A by-product of war-torn areas is severe unemployment, which results in massive social and psychological problems for families with large numbers of children. "Maltreating" families are described as disorganized with blurred boundaries between the parental and child subsystems (Boszormeny-Nagy & Spark, 1973). Family art therapy is useful in dealing with the fears and disturbances within the family system. Through symbolic and metaphoric communication, family members are able to develop an empathic understanding of how each member's strengths and weaknesses contribute to the family unit and structure. For example, when fathers in a patriarchal culture are imprisoned, tortured, or humiliated through loss of employment, other family members often experience extreme stress and disorganization. Art therapy can serve a critical role in the development of independence and the dependency issues of self-evaluation and regulation. As an example, legitimate concerns about child safety in an unpredictable environment may result in overprotection and discouragement of increased independence. As Hobfoll (1991) suggests, at this time the role of significant adults as supporters is even more important than normal parenting skills, promoting nonjudgmental listening to children's fears. Often adults are ill-equipped or temporarily deny the importance of validating the children's struggles because their own hardships are too extreme.

Cicchetti and Rizley (1981) found that these human factors can be either transient or enduring. Vulnerability, challenges, and protective issues recur in multiple dimensions of family life and need constant monitoring. Because art materials are nonthreatening, families can be encouraged to express their dilemmas for the sake of the children's welfare. Ellingson (1991) notes that many clients treated with conventional therapies are likely to suffer from existential conditions rooted in life experiences, rather than from psychological conditions. So that children do not become developmentally delayed, preventive, secondary, or tertiary symptoms need to be treated as soon as possible. The art process fosters the experience of struggling to establish equilibrium between polarities of emotions. People gain a sense of freedom in their choice to express colors and art media. As Ellingson (1991) emphasizes, "Choice is the key word—choosing is freedom in action" (p. 8).

Whether the individual is a child, an adolescent, a parent, or an adult mental health worker suffering from burnout, expressing the existential dilemma of war or violence can be extremely empowering when life events leave the impoverished community feeling helpless. The anxiety of nihilism is redirected by developing self-identity, concern for one's fellow beings, and national pride, while respecting other cultures. Art as communication, therapy, or psychotherapy offers a recontextualized role of validating traumatized people's experiences in a meaningful and healing way.

Emotional Effects

The children referred to in the title of this article represent those who have experienced the multidimensional aspects of surviving war and living in an occupied territory. Although adults use guns and other sophisticated weaponry to fight the ongoing religious and political conflicts in the Near East, it has been observed and documented that children have expressed their frustration and discontent by throwing stones. In ancient times, wars were fought with stones and clubs; this archaic return may represent the "rawness" of historic years of conflict and primitive emotional responses. In attempting to master and control their hostile environment, the children's actions have received reinforcement from their peers and indirectly from family members.

Even though the trauma of an active war has passed since the Intifada and the Gulf War, the Palestinian and Israeli people live in an environment of constant potential danger. For example, on July 3, 1995, while I was working in the West Bank, activists in the street of Ramallah demonstrated their rage at the Israeli authorities who had kept their friends and family members imprisoned for lengthy periods of time because of alleged war-related crimes.

People on the West Bank and Gaza are enduring another aspect of the reconstitution and reconstruction of their war-ravaged society—not only the traumas of death, torture, and physical and mental damage that is apparent in the faces seen in mental health clinics, but also the "sleeper" or dormant effects similar to those of children of divorced parents (Wallerstein & Blakeslee, 1989). Symptoms such as night terrors, withdrawal, or acting-out behavior appear 5, 10, or more years after the traumas are actually experienced. Secondary symptoms, seemingly not related to the initial trauma, such as domestic violence, learning disabilities, and psychologically delayed child development, begin to surface during this same time frame. Children with adolescent siblings witness unrest in their families. Children born subsequent to the Intifada years experience the loss of significant family members through death and imprisonment. As Garbarino and Kostelny (1993) note:

> Danger is a judgment about the social meaning of risk and an authorization for effective and moral response. Subjective danger is the phenomenological construction of liability to injury or evil consequences while objective danger is an empirical determination regarding the probability of liability being translated into injury (p. 23).

As previously documented, during the Intifada, Palestinian children developed a "bravery" when combating Israeli soldiers and showed a reckless disregard for their own safety. During the author's brief encounter with the people of the West Bank and Gaza, the confusion regarding objective and subjective dangers people experienced was noted. The people felt safe when they should have been afraid, or felt endangered when in fact there was negligible risk. Of particular developmental interest is whether or not the expression of danger results in psychological disruption.

Between acute and chronic danger, one might classify the atmosphere in the clinics as one of ongoing traumatic stress. The mental health workers are in a constant state of insecurity, with frequent threats of being laid off and having extremely low remuneration for their services. The curfew restrictions, check points, and armed border crossings are constant reminders to everyone of the highly volatile environment. Taxis and private cars are licensed in orange, blue, or green representing the degree of restriction of passage between the demographic areas of the clinics.

The multilevel effects of chronic danger are felt by everyone in the West Bank. As articulated by Dr. V. Hasbourn of the Child and Family Clinic in Bethlehem, everyone has been affected by Post Traumatic Stress Disorder relative to his or her direct and indirect experience (personal communication, 1995). Palestinian children are at risk of emotional withdrawal that may be socially adaptive in the short term but a source of danger to the next generation (Losel & Bliesener, 1990). When political ideology reflects communal violent conflict, the ability for empathy is decreased, which can lead to identification with the aggressor. As Erickson (1976, p. 238) describes: "The major problem for adults and children alike is that the fears haunting them are prompted not only by the memory of past terrors but by a wholly realistic assessment of present dangers." Studies show that after World War II, the level of emotional upset displayed by the adults in a child's life, not the war situation itself, was the most important factor in predicting the child's prognosis.

Studies of Palestinian children after the start of the Intifada reported an increase in children's complaints of sleep disturbance and depression (Baker, 1990). Dr. Shafiq Masalha (1993), Acting Director of the Palestinian Counseling Center, documented the reactions of Palestinian children to the Gulf War. He observed a variety of manifestations of the children's anxieties, including the fear of sirens, with panic attacks when the sirens were on; enuresis, especially when the sirens were on; fear of wearing gas masks; rumors of mass graves prepared by the Israelis for the Palestinians; and rumors of mass expulsion of the Palestinians by the Israelis. He also noted correlated concerns of the Palestinian men bothered by feelings of helplessness, being unable to protect the children. Through researching the dreams of these children, Masalha concluded that sociopolitical conditions which existed prior to the outbreak of the war increased the children's anxiety. The children became passive after having been active participants in the struggles for the 3 years prior to the war. Since little or no mental health services were available at the time of the Intifada, the population was not equipped to deal with the psychological traumas associated with tortures, deaths, and the loss of basic needs.

Mental health workers in this area needed to learn to be cognizant of monitoring their own emotional states in response to Post Traumatic Stress Disorder and the psychological effects of danger. Their current caseloads represent a diversity of symptomatic complaints that reflect the "sleeper" effects of children's traumas. As Johnson (1987) observed, diagnosis of post traumatic stress responses from childhood physical war trauma has been problematic due to the profound denial and dissociation at the time of the trauma. Fortunately, or unfortunately, in times of occupations the degree to which adults acknowledge and handle the stresses tends to impact the long-term ability of children to integrate the experience constructively.

The following observations from the different clinics are presented as examples of brief art therapy interventions with follow-up recommendations.

The Near East Cultural and Educational Foundation (NECEF)

As identified in the NECEF project's funding proposal, reconstruction and rehabilitation demand a multifaceted, multitiered mental health program. The project emphasizes establishing empathic bridges among children of different backgrounds "so that they may come to see that, despite variations in living conditions, children everywhere have common fears, hopes and aspirations."

The project proposed that paraprofessionals (i.e., art therapists) give seminars to mental health professionals in the West Bank and Gaza on techniques and issues in counseling. The content was to focus on the relevant needs of children who had been traumatized by violence and the effects of violence on their families, interpersonal relationships, and social/community structures. As an art therapist, I was also expected to consult with teachers and community workers involved with groups of children participating in an Art Exchange/Kids-to-Kids Program. This subsidiary program provided an opportunity for Palestinian and Canadian children to express and exchange their concepts of "self" and "community." Canadian children were chosen from a variety of backgrounds, including children from two native communities in the Northwest Territories, two schools in British Columbia, and schools in Edmonton, Windsor, Hamilton, and Toronto with an Arabic-language program. Rima Said, an Arabic-speaking art therapist, and others helped establish the pairing of Canadian children with peers in the West Bank and Gaza.

Between June 24th and July 8th, 1995, I conducted art therapy training and crisis intervention sessions at six clinics in the West Bank and Gaza: the Palestinian Counseling Center in Ramallah, the Gaza Community Mental Health Program, the Khan Younis Clinic in Gaza, the Child and Family Clinic in Bethlehem, the Médècins sans Frontieres' Child and Family Clinic in Jenin, and the Child and Family Guidance Training for Mental Health Clinic in Bethlehem. In this article my work at four of the six clinics is described.

Initially, I facilitated a 4-day workshop at the Palestinian Counseling Center on using art therapy to treat people experiencing post traumatic stress disorders. In Gaza I worked with Dr. Sameh Hassan, a child and family psychiatrist, facilitating teamwork through art therapy in organizations in the Gaza Community Mental Health Program. In Jenin, through the Medicins sans Frontieres Association, I was asked to emphasize art therapy with adolescent populations. In Bethlehem, at the Child and Family Guidance Training Clinic, I focused on direct interventions with 30 children, ages 4 to 15, whose symptomatology included: autism, elective mutism, hyperactivity, withdrawn behavior, and overt post traumatic stress disorder symptoms. Together with the clinical psychologist, the director of the clinic (a psychiatrist), the social worker, and special education therapist, I provided the children with therapeutic art materials, a new experience for many.

Ramallah

Understandably, mental health workers in the West Bank and Gaza were displaying symptoms of professional burn-out and stress. Due to travel restrictions, consultations between professionals were rare. Many clinicians felt isolated and relied on international training groups to provide ongoing supervision and training. Many of the workers had families struggling to survive with the uncertainty of employment.

The initial goal of the art therapy workshop at the Palestinian Counseling Center was to provide the workers with an increased awareness of the process of utilizing art materials. By becoming sensitive to their own symbolic use of art media and decoding approaches, participants were able to observe each others' perspectives. Through processing their own individual responses to the art workshop experience, they could readily apply theoretical and practical concepts of therapeutic intervention with the children in their caseloads. Many psychologists who had problematic case issues of resistance or hopelessness were interested in better understanding and interpreting the art productions. They also needed validation for the extremely demanding role of being a parental figure in the therapeutic community as well as in the larger community struggling to rebuild.

The workshop began with the aid of translators (although many spoke English) by encouraging the participants to introduce themselves by making spontaneous symbols that represented either parts of their experiences or personalities. The initial directive was to address the issue of identity in the self and others. Since participants came from five different agencies, the importance of establishing meaningful contact with each other was facilitated.

One psychologist depicted his identity by drawing the Palestinian flag. Beneath the flag, he placed the name of the clinic that employed him and talked about the tensions he felt at the

BEST COPY AVAILABLE

clinic. On the side he drew his family with a border around them and two trees, a pointed-tipped tree in the center and a quickly drawn red tree below. He reflected that the poverty of his human figures revealed his recent struggles trying to obtain advanced degrees while caring for his young children. He drew a sun above, which expressed his hope for a better future.

During the afternoon session, I encouraged participants to build empathic responses to each other through imagery. First, I asked all participants to paint spontaneously. After completing their free pictures, they exchanged their images and I instructed them to share with each other nonverbally. Then, I asked them to make another painting representing what they thought the original picture needed or was missing. Next, these two images were discussed.

One participant added a frame around the painting because the image looked as if it needed containment. The river spilling over and the turbulent atmosphere of the landscape seemed to need a protective boundary. This participant was able to recognize that what she gave the other person was indeed what she herself needed to structure her own overwhelming environment. She also depicted her clients as birds, a symbol of freedom. Through this experience she was able to express her crisis, receive support, and develop coping skills.

Another group member chose to partially frame the other's abstract forms, not to impose another structure but to work with the flexibility of the lines. Symbolically, this person also acknowledged a desire not to invade others. Although to a critic adding a background or frame to the picture might be the easiest solution in empathically complementing an image, it was striking how these two participants used the notions of borders in a symbolic and productive way.

On the second day I introduced plasticine, with its elastic and dimensional qualities, as a communication tool. Through processing the joint productions, discussions focused on reviewing the timing and pacing of the therapeutic process, decoding the metaphors, and recognizing the multiple levels of interpretation. Participants in one of the small groups were able to work through a very conflictual miscommunication with their art. One mental health worker had created a physically disabled child in green plasticine sitting in a white wheelchair. She felt frustrated and angry about her client's disability, which was caused by the war. It was hard for her to separate her feelings about her client from her feelings about the civil unrest. The other participant thought the plasticine figure was lonely, so she provided a large companion. In response, the first mental health worker felt misunderstood. She felt intimidated by the size and shape of the "helper." The interaction allowed the participants to acknowledge how easy it is to assume each other's needs in the service of goodwill.

At the end of the day, participants requested consultation on specific cases. I chose to supervise these through role-playing actual therapist/client sessions which included countertransferential responses. A special education counselor requested role-playing a situation in which an early adolescent child was resistant to therapy. The presenting problem included an overprotective mother who complained that her daughter was too shy. This revealed a common Palestinian theme in the undifferentiated mother/daughter relationship. The therapist role-played the client who was desperately attempting to define her own space in the separation/individuation process. What became evident to the observing participants was the need to constantly lead the client. All reflected on their own tendencies to want to control the session in the countertransferential response of similarly protecting the child from the unpredictably dangerous environment in which they live.

On the third day, I focused on crisis intervention tools for the therapists. Through the spontaneous use of multimedia and found objects, participants explored the use of directive and nondirective activities to evoke the projected client's associations and expressions. Wire was repeatedly chosen for images which drew associations to the barbed wire fences that surrounded many of the refugee camps, prisons, and checkpoint borders between Israel and Palestinian territory. Participants explored the versatility of the medium by building lines of communication. Feelings of pain, frustration, and hope were expressed.

A group mural brought closure to the workshop. What was remarkable in the collective image was that one of the quieter participants showed leadership in choosing the underlying structural form for the picture. The notion of understanding group dynamic processes was still a new concept for these workers. In a fleshlike tone, this new leader drew a pointed hill-like base on which others spontaneously elaborated. This gesture tended to divide the picture. Some people coped by defining their contributed space in a hidden way, or in a gesture to combine common elements as one image. The group observed the two competing suns that were drawn in the top corners. They concluded that the different textures of the painted suns expressed the paradoxes of danger and warmth they felt in relation to local authority figures. They identified different chaotically drawn parts of the image as corresponding to different defenses used to cope with their clients.

Bethlehem

Many children in Bethlehem could not go to school for years due to the occupation. In 1995, Dr. Hasbourn, a psychiatrist at the Bethlehem Clinic, observed that of the 500 children experiencing Post Traumatic Stress Disorder, many lacked any therapeutic or positive community opportunities over the summer months. No movies, theaters, or parks were available to the children. For children in abusive homes, or homes broken by the loss of family members, providing a summer camp served as an "illusion" of normalcy.

Although the director expected 15 children to come to the clinic for the summer camp, 30 arrived, ranging in age from 4 to 15. The children were divided into two groups, 8 years old and younger, and older than 8 years. The clinic's facilities were very small, so we spontaneously converted individual interview rooms into activity rooms. Since art materials were very new to the children (some had never held a paintbrush or had the opportunity to create in plasticine), they were eager to use the supplies. Surprisingly, there was very little acting-out behavior. The children appeared eager and focused on the new experience.

The younger children were very reluctant to be spontaneous with the range of supplies they were offered. The older children were quicker to use the materials and share their ideas. By placing four mural papers on the wall, the children from both groups were given about 15 minutes to illustrate what was important to them in the collective image. A 14-year-old began by painting his fantasy of being on a boat, even though there are no lakes in Jerusalem and the nearest water area is either the Dead Sea or the Mediterranean Sea. Another child drew a line creating a space between the water and the land. On the land, there were many sparse trees and many suns. The children's depiction of birds as symbols of freedom was most prominent. The chaotic nature of the birds in flight seemed to represent the symbolic constriction of not being able to fly away because others were in the way.

Post Traumatic Stress Disorder in children frequently manifests itself as hyperalertness, constricted affect, and sleep disturbances. The "sleeper" onset seems to develop when news of a recent uprising occurs in local areas. As previously stated, it is how the adults respond to the events or carry on with daily activities that determines adaptive or maladaptive responses in children. Again, through depicting fences, borders, and barriers, these children express a need for safety as containment rather than confinement.

Jenin

Médècins sans Frontieres (MSF), a French team of doctors and paraprofessionals, was sent to Jenin to assist in creating a mental health clinic. Their purpose was to assist, supervise, and train local health workers to develop an ongoing clinic to meet the needs of the population of Jenin. The most recent influx to the clinic were children entering the turbulent phase of adolescence. With no community services (sports, arts, or music facilities), the team worried how the adolescents would make use of their free time. The propensity for males to identify with the aggressor and utilize violence was becoming an increasing social problem, especially for adolescents from dysfunctional family systems. Night curfews were still frequent when outbursts arose. The team created a "greenhouse" space within the clinic as a place where adolescents would feel safe and free from the unstable environment. The team actively sought multimedia suggestions on how to "transform" the space. Bolstered by adolescent psychological theories, they looked for the opportunity to exchange creative therapeutic strategies in dealing with the onslaught of the impending social crisis.

With an emphasis on adolescent group art therapy, I facilitated a 1-day workshop with the psychiatrist, two social workers, a special education counselor, a psychometrist, two psychologists, a translator, and the driver of the team's car. Themes focused on the recollections of the trials and tribulations of their own adolescence and how these related to their clients' issues and concerns. Several creative artworks were shared in promoting awareness of the therapeutic strengths with the complementary team approach. Participants were able to acknowledge an awareness of their own experiences with adolescents and how they were countertransferentially responding to their clients.

Bethlehem Child and Family Guidance Training Clinic

Dr. V. Hasbourn, director of the Bethlehem Clinic, had recently begun a 6-month training program for mental health workers. Since art therapy was a new modality, she requested a seminar on the application of art therapy with family therapy. Following a seminar on general systems theory by Dr. S. Hassan, I facilitated a hands-on experience of family dynamics. As in systems theory, the basic assumption is that the "identified patient" is part of a larger biological system that interacts with the whole. A ball of string was passed to different participants so that eventually all were linked together like lines of communications within a family. By pulling tight, releasing tension, and letting go, participants experienced a hands-on experience illustrating that families are always in the process of change.

The group was then divided into two families, with four observers and one therapist, to role-play imagined family dynamics through art therapy. As developed by Landgarten (1980), the directive was to draw two murals. The first drawing was nonverbal, followed by another with verbal interaction. The families were instructed to title the artwork. One mural depicted issues of estrangement that surfaced during the discussion of the family dynamics. This drawing revealed the dominance of the father figure in the family, who had been imprisoned for 7 years for war-related activities. His face was maimed from the torture he endured in prison. To reintegrate into the family, he attempted to control his family members by defining the theme of the picture. The quiet son drew red people in prison next to the hot sun. The mother also used red, creating a fence and attempting to add some flowers to an imagined house. The daughter drew the gray areas of the home, soldiers fighting, and prison bars within the prison in attempts to support her father's cause.

The father completed the picture by adding the gun which was supposed to break the hand-cuffs of the Israeli soldiers. He then took the red pen and wrote the title: "The Palestinian Present Situation." The daughter took on the role of attempting to show the father how he was overbearing and hurting the family members. The mother aligned with her quiet son, almost afraid to risk confrontation with her emotionally labile husband. As observed in similar family dynamics, when a discordant marital relationship exists, parents develop a fusion with a child for needed support and comfort. Although this pseudo-family presents an organized system through the orderliness of the image, the content reveals barriers to communication. Continued discussions focused on strategic interventions to help the family members realign and reintegrate into an effective family system.

Summary

Dr. Eyad El Sarraj, psychiatrist and director of the Gaza Community Mental Health Program, argues that children of the stones are not made of stone, and psychological problems are born from their seemingly hopeless situation (personal communication, 1995). In 1993, a survey of 2,779 children found that 92.5% were exposed to tear gas, 42% were beaten, 55% witnessed beatings, 4.5% had bones broken, 85% were exposed to night raids, and 19% were detained for short periods of time. Through international aid and intervention, the statistics of traumatized children are decreasing, although the "sleeper" effect of the traumatic events and the multiple stresses on the families is being identified in increasing numbers.

To continue to support the efforts of the mental health workers and to encourage empathic bridges between international children, the Kids-to-Kids Program is currently being brought together in a book and exhibition. A further development is the inclusion of an interactive CD-ROM produced by

Lila Pine, an independent artist. Drawings from native and immigrant Canadians will be available for bicultural exchange through a WEB site. The children, utilizing the new technology, will be able to interact by reaching to each other's symbolic messages and empathizing with each other's life situations. As a source of empowerment for the children, their families, and the mental health teams, this interactive technology promotes the therapeutic use of moral, cultural, and family development. The emphasis of the CD-ROM is to develop a greater understanding of global peace through acknowledging, validating, and celebrating cultural differences while emphasizing the similarities within all humanity.

I returned to the West Bank and Gaza in June 1996. Currently negotiations are being planned to facilitate exchanges between Israeli and Palestinian mental health workers to develop additional treatment strategies. Israeli and Palestinian children need assistance to make sense of the violence they have experienced. All children fear separation, loss, death, pain, and abandonment. Supportive significant relationships, open communication, and a sense of hope and confidence are human rights for all people. It is the global efforts of many which will offer hope for the next generation. As Wadeson (1980) stated, "Life. Meaning. Creativity. Art. In the largest sense, they are all one" (p. 3).

Editor's Note: The author would like to take this opportunity to acknowledge Bob Ault, ATR, HLM for his encouragement and assistance in editing this article. Much appreciation is given to Human Sakhnini who voluntarily and spontaneously served as translator for the NECEF team for some of the art therapy workshops. The opportunity to work with Dr. Graff and Dr. Hassan on the NECEF team was invaluable. The human encounter and privilege of meeting all participants and colleagues on the trip will long be remembered.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Apfel, R., & Simon, B. (1993). On the value of a psychoanalytic perspective in research on children in war: Group interviews of Israeli and Palestinian children during the Gulf War and one year later. In L. A. Leavitt & N. A. Fox (Eds.), *The Psychological Effects of War and Violence on Children*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Baker, A. (1990). The psychological impact of the Intifada on Palestinian children in the occupied West Bank and Gaza: An exploratory study. *American Journal of Orthopsychiatry, 60*, 496-505.

Boszormenyi-Nagy, I., & Spark, G. (1973). *Invisible loyalties: Reciprocity in intergenerational family therapy*. New York: Harper & Row.

Bowlby, J. (1982). *Attachment and loss* (Vol. 1). New York: Basic Books.

Bronfenbrenner, U., & Crociter, A. C. (1983). The evolution of environmental models in developmental research. In P. Mussen (Ed.), *Handbook of Child Psychology* (pp. 357-414). New York: Wiley.

Cicchetti, D., Rizley, R. (1981). Developmental perspectives on the etiology, intergenerational transmission and sequelae of child maltreatment. *New Directions for Child Development*, 11, 31-56.

Colon, F. (1981). The family life cycle of the multi-problem poor family. In E. Carter & M. McGoldrick (Eds.), *The Family Life Cycle: A Framework for Family Therapy* (pp. 432-448). New York: Gardner.

Ellingson, M. (1991). A philosophy for clinical art therapy. In H. Landgarten & D. Lubbers (Eds.), *Adult Psychotherapy*. New York: Brunner Mazel.

Erikson, K. (1976). *Everything in its path: Destruction of community in the Buffalo Creek flood*. New York: Simon & Schuster.

Freud, A. (1973). Report on the Hampstead nurseries 1939-45. In A. Freud (Ed.), *The Writings of Anna Freud*. Vol. III. (pp. 453-540). New York: International U. Press.

Garbarino, J., & Kostelny, K. (1993). Children's response to war: What do we know? In L. A. Leavitt, & N. A. Fox (Eds.), *The Psychological Effects of War and Violence on Children*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Garbarino, J., Kostelny, K., & Dubrow, N. (1991). *No place to be a child: Growing up in a war zone*. New York: Lexington.

Graff, J. (1991). *Palestinian children and Israeli state violence*. Toronto: University of Toronto Press.

Hobfoll, S., et al. (1991). War related stress: Addressing the stress of war and other traumatic events. *American Psychologist, 46*, 848-855.

Janis, I. (1951). *Air war and emotional stress*. New York: McGraw-Hill.

Johnson, D. R. (1987). The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy, 14*, 7-13.

Landgarten, H. (1980). *Clinical art therapy*. New York: Brunner Mazel.

Losel, F., & Bliesener, T. (1990). Resilience in adolescence: A study of the generalizability of protective factors. In K. Hurrelmann & F. Losel (Eds.), *Health Hazards in Adolescence* (pp. 299-320). New York: Walter deGruyter.

Masalha, S. (1993). Conditions on the psychological reactions of Palestinian children to the Gulf War. In L. A. Leavitt & N. A. Fox (Eds.), *The Psychological Effects of War and Violence on Children*. Hillsdale, NJ: Lawrence Erlbaum Associates.

NECEF. (1994). Partnership for Children Project. 106 Duplex Avenue, Toronto, Ontario, Canada M5P 2A7.

Wadeson, H. (1980). *Art psychotherapy*. New York: John Wiley & Sons.

Wallerstein, J., & Blakeslee, S. (1989). *Second chances: Men, women and children in a decade after divorce*. San Francisco: Ticknor & Fields.

Art Therapy: Journal of the American Art Therapy Association, 13(4) pp. 244-251 © AATA, Inc. 1996

Observer, Process, and Product

Noa Schwartz, MA, ATR, Regina, Saskatchewan, Canada

Abstract

The structure of art as a symbol system is composed of three dimensions: observer, process, and product. In this paper, each dimension is described, discussed and its application to art therapy illustrated through presentation of a case study of a 12-year-old boy suffering from a progressive neurological disorder. It is argued that the structural aspects of art are integral to art therapy and facilitate the discussion and understanding of the function and method of art therapy.

Introduction

"Every art form involves communication on the part of one person (or subject) to another by means of a symbolic object that the first subject has created, and that the second is able in some way to understand, react to, or appreciate" (Gardner, 1973, p. 30). This article is concerned with the structural and functional aspects of art as a symbol system. It is argued that these structural aspects of art are integral to art therapy and facilitate the discussion and understanding of the principles involved in art therapy.

To understand how art functions, it is necessary to distinguish among the three dimensions that are inherent to its structure: the *observer* who perceives the artwork, the *process* by which the artwork comes into existence, and the *product* which is the work of art itself (Weber, 1958). This conceptual framework establishes an external reference for what is involved in viewing, understanding, and responding to art in general and to clients' artwork in particular. These concepts also facilitate the discussion and understanding of the functions and methods of art therapy.

A brief description of process, product, and observer follows in order to provide a theoretical framework for the discussion of these dimensions in art therapy. A case study of a 12-year-old boy with tubular sclerosis, a progressive neurological disorder, is used to present these theoretical dimensions in the clinical practice of art therapy.

The Observer—It's All in the Eye of the Beholder

An artwork, functioning as a symbol designed to communicate, can only fulfill its function when viewed and experienced by another person. The observer's response is a result of what is experienced while viewing the drawing (Dewey, 1934). "It's all in the eye of the beholder" means that different people have different experiences and responses to what they see when they view and experience works of art. Through past experience, accumulated knowledge, expectation based on context cues, current state of mind, and projection, the observer supplements the sensory information received in looking at works of art (Arnheim, 1974; Dewey, 1934; Gombrich, 1960; Winner, 1982).

"Not only how but what it (the eye) sees is regulated by need and prejudice" (Goodman, 1968, p. 7). Just as the art object is created by a unique individual at a particular point in time from a background of experiences that define who that person is (Shahn, 1957), so too the viewer of the object is a unique individual at a specific time with a personal background that comes to bear on the experience of the moment (Dewey, 1934). According to Gombrich (1960), the more abstract the picture, the richer the inferences the observer must make in order to complete the viewing process.

When art is produced in a therapeutic situation, the therapist responds as both a facilitator of the artwork as well as an observer as described above. However, the response to the product must be therapeutically motivated, involving awareness of one's reaction to what one sees and perceives, and using that self-awareness to relate to the needs of the client and the work at hand. The response fosters the therapeutic relationship and forms the basis on which the therapeutic interaction is built.

The Process—Actions Speak Louder Than Words

Artwork is motivated and determined by certain forces in the artist as well as by external stimuli that affect his/her world view (Kivnich & Erikson, 1983; Weber, 1958). The artistic process requires simultaneous physical, emotional, and intellectual involvement in order to balance the internal and external forces that impinge on the artist. In choosing to draw and constrained by the medium, the artist embarks on a process, on a course of action over time to achieve a self-determined goal.

When we speak of process in art therapy we speak of the client's activity, the involvement in a creative pursuit. The therapist's perception and response to the client's activity (as well as the response to the final product of this activity as described above) is also an aspect of this process. Process also refers to the interaction between the client and therapist as they perform their respective roles in the relationship, often referred to as the therapeutic process.

In outlining his notion of the psychology of creation, Weber (1958) relies on introspective and unconscious processes suggested in psychoanalytic accounts of the creative process. With regard to professional and successful artists, Weber (1958) writes that to create is to approximate a memory or situation from childhood that is usually forgotten. A childhood situation or event manifests itself, in general, unconsciously in a work or group of works of art as a "theme."

Weber (1958) distinguishes between two types of themes, which he calls *personal* and *transpersonal*. Personal themes are derived from the artist's individual experience based on the earliest discovery of the world. Transpersonal themes relate to the common aspects of experience, which relate to many people.

In art therapy the client is encouraged to create personal themes that are formulated out of the client's own, individual, unique experience in order to give that experience concrete form. In making it concrete, the experience becomes accessible to both client and therapist. These personal themes have significance only to oneself unlike, using Weber's terminology, *great art*, which features transpersonal themes that have meaning to many people. The opportunity for clients to create personal themes in art therapy allows them to organize their own unique experience and awareness through art, just as transpersonal themes in the most powerful of symbolic objects serve to organize cultures.

Process also relates to the therapist's observing the individual in action as opposed to relying solely on verbal descriptions regarding the client's behavior, psychodynamics, strengths, and weaknesses. How does the client deal with success, failure, solving problems encountered along the process of creation, and finding problems to solve which engage one in the creative process? In opposition to the psychoanalytic perspective, some writers view the creative process as the urge to solve problems (Arnheim, 1962; Dewey, 1934) while others view it as the urge to find problems (Getzels & Csikszentmihalyi, 1976).

Arnheim (1962) writes that visual thinking—a conscious, rational, intellectual process—is central to the artist's way of working where constant decisions have to be made as problems arise in the creation of a work of art. The creative process, he writes, is a series of deliberate, conscious, logical choices made on the basis of the need to communicate a particular meaning and organizing its presentation through a specific medium requiring formal considerations. Getzels and Csikszentmihalyi (1976) agree that artists continually confront problems which must be solved in order for their work to progress. They extend this argument by proposing that creativity involves not only the ability to solve problems but also the motivation to discover challenging problems.

Csikszentmihalyi (1993) outlines how the evolutionary process has built a preference for complexity into the human nervous system. He writes that just as we experience pleasure when we do things that are necessary for survival, like eating and procreating, we also experience enjoyment when we are occupied in projects that stretch our skills and allow us to recognize and master new challenges. The feelings that are generated from the experience of mastering difficult challenges, that require using one's personal skills to their limits are called *flow* (Csikszentmihalyi, 1993). Some of the characteristics of flow are concentration, absorption, deep involvement, joy, and a sense of accomplishment.

Flow is an experience that can occur only when one is actively involved in doing something. Csikszentmihalyi (1993) mentions that activities like mountain climbing, writing poetry, painting a picture, even developing and implementing a program to feed and educate poor children can cause flow to occur. Neither talking nor thinking about flow can cause its occurrence; the activity is essential, in the pursuit and experience of the process of creativity.

In art therapy an attempt is made to provide the client with flowlike experiences. Flowlike experiences rely on doing, not solely on talking. Experiences are "flow" when they foster well-being, self-expression, self-understanding, and even motivation to find and solve more challenging problems. Art therapy also provides the client with the ability to provide these experiences for himself/herself outside of the therapeutic session (Ulman, 1961).

The Product—A Picture Is Worth a Thousand Words

The product exists and stands between the observer and the artist (Gardner, 1973; Langer, 1942; Weber, 1958). Like a novel with its linguistic structure, a drawing through its visual structure contains information and knowledge within itself. Through its physical existence—the product—the art object embodies meaning and knowledge in its own right.

The object's concrete form is determined by the message that the artist is attempting to convey, by the materials the artist chooses to use, and by the artist's skill in making his idea, thought, and/or feeling visible. As the artist Ben Shahn (1957) writes in describing the "biography" of a painting, "It is the wholeness of thinking and feeling within an individual; it is partly his time and place; it is partly his childhood or even his adult fears and pleasures, and it is very greatly his thinking" (p. 51). The recombination and new formulation of these ingredients in the art object embody a separate, independent, and unique existence from the work's production as well as from its producer.

As discussed earlier, the work of art, the symbolic object designed to communicate, functions only when it is seen and responded to by another. The work of art can only convey knowledge, meaning, and understanding when it is perceived. As the adage indicates, it would take a thousand words to describe the totality of: the artist's intention, the meaning embodied in the work of art, the experience generated in viewing the work of art, as well as understanding the meaning of the viewer's experience in consciousness. Yet, still, all these words would not describe the picture adequately. The work of art speaks for and of itself in its own unique way.

Summary

As an observer the therapist perceives the client, the therapeutic process in progress, the client's artwork as well as the client's work of art. The process of art therapy is documented by, and reflected in, the client's art and the transformations of form and content within it, over time, due to the influence of the therapeutic relationship. The product of art therapy, generally considered the client's art, is broadened in this theoretical framework to include the accumulated work from all the sessions, both the works of art and the work of healing that go hand in hand in art therapy.

Observer, process, and product are interconnected and interrelated dimensions of the total art experience. Their conceptual delineation facilitates a discussion of processes and experiences that are continuous. These three integral and integrated aspects of art provide a theoretical framework which leads to greater understanding of art therapy issues and practice. The remainder of this article presents a case study of art thera-

BEST COPY AVAILABLE

py with a 12-year-old boy suffering from a progressive neurological disorder in order to demonstrate the application of this theoretical framework to clinical work.

Case Study

The Therapist as Observer

Jon suffered from tubular sclerosis, a congenital disease characterized by benign slow-growing tumors of glandular origin which cause lesions in major body organs, such as the heart, kidney, liver, spleen, lungs, and nervous system, resulting in progressive mental retardation and sometimes epilepsy (Adams, 1989). Tubular sclerosis is typified by a slow deterioration of mental functioning causing intellectual deficiency. It may be accompanied by behavioral and affective derangements resulting in what may be loosely classified as a primary type of psychosis (Adams, 1989). Jon had the characteristic reddish butterfly pattern of spots on his cheeks and over the bridge of his nose that is a typical symptom associated with this disease. He did not exhibit any seizure activity, which often accompanies this disorder, and he was not receiving any anticonvulsive medication.

In Grade 1, when the effects of Jon's disease were still minimal, his teacher wrote in a report that he appeared to be a very frightened boy who desperately wanted help. She wrote that he could not read and that he was most apprehensive when he was learning to read. At the age of 7 years and 8 months he did not know his birthday or his address.

Progressive deterioration from the disease affected Jon's behavior and thinking. Six years later, at the age of 12, Jon repeatedly attacked younger children in the schoolyard. When reprimanded by the principal, he attacked the principal and was transferred from the adapted Educable Mentally Handicapped Program to a special learning class where his behavior could be monitored and controlled.

Jon's parents were angry at his teachers for their lack of understanding while the teachers thought Jon's parents did not properly control his aggressive behavior. In the meantime Jon continued to be in class, as he had for 6 years, displaying remarkable stamina in facing academic work for which he was progressively more and more unsuited (over the 6 years, his IQ had dropped more than 30 points to an approximate IQ of 75 at the time of referral).

Jon presented himself as a wary, defensive, and withdrawn preadolescent. He was sensitive to his environment and responded intuitively and impulsively rather than critically. For example, in response to the principal's attempt to confront and control his wild behavior, Jon lashed out aggressively, punching and kicking as well as cursing and yelling. He seemed insecure and threatened when being criticized or when feeling defensive. During a meeting with his father, teachers, principal, and therapist, Jon could not answer questions asked of him; he looked confused, scared, and belligerent. He could not tolerate all the questions nor reflect on situations that occurred and in which his impulsive and violent actions were inappropriate. At the meeting Jon responded nonverbally, his face frozen in a scowl as if to "say" the questions were stupid.

Jon used environmental clues to help him orient to his surroundings. When asked what day of the week it was, Jon could give the correct answer by looking at the name listed on the blackboard for lunch duty as a different person was assigned on different days of the week. He fabricated alternative scenarios or denied situations in which he acted impulsively and aggressively. Jon denied breaking things when he became angry, saying he "goes to his room and listens to music."

Jon was aware of his limitations and expended a great deal of energy covering up his inadequacies and trying to seem "normal." He swaggered when he walked, he talked tough and "cool" but could not continue the pretense beyond these superficial mannerisms. In the privacy and security of the art therapy sessions, he was willing to learn the name of his illness as well as to answer whether he felt physically good or bad at that particular time. He stated repeatedly that he did not like the "work" at school and that there was "too much." He said that he enjoyed putting things together with his hands and had successfully held a newspaper route for 2 months (with support from his father). Jon's father reported that Jon was able to make and serve breakfast as well as take care of all his physical needs.

Jon was referred for art therapy to assess his psychological condition and to provide him with an educational experience that did not rely exclusively on verbal communication. This assessment would provide input into the development of realistic educational goals and into the determination of effective future treatment.

The role of the art therapist as an observer began with the description of the client and the formulation of the goals of therapy based on the compiled information. Writing a case study from the art therapist's perspective is in itself the observer's point of view. In the role of observer, the art therapist's response to the client and his art (both the activity and the final product) is based on educated sense perceptions at a particular point in time supplemented by knowledge gained from personal and professional experience.

Process of Therapy as Documented by Jon's Drawings

Jon attended 12 1-hour art therapy sessions conducted twice weekly for 6 weeks. The sessions were held in the special learning center in an inner-city school. Each picture, each symbolic object made up of combined symbols, represents Jon's ongoing communication with the art therapist. Unable to put his thoughts, feelings, or ideas into words, Jon made use of the time and place provided him to convey meaning through concrete realization. The therapist's availability and response to Jon's changing images formed the dialogue that is embodied in the sequence of pictures.

Jon was silent and apprehensive during the first few sessions. Over time as he became accustomed to the therapist, the format of the sessions, and the expectations of drawing pictures and reflecting on them, he relaxed and worked in a focused and involved manner. Jon completed over 30 pictures (all pencil drawings on white paper, except for one crayon drawing) over the course of therapy.

Jon was always polite, allowing the therapist to enter the room first. He brought chairs to the table in preparation for work. He was compliant and agreeable, working very hard to be liked and accepted. Jon rarely initiated conversation and did not verbally volunteer information about himself. He answered most questions with, "I don't know," "It depends," and "It does not

BEST COPY AVAILABLE

matter." In general, Jon's affect was reserved and withdrawn, occasionally responding to humor with a sideways smile.

Jon drew in a slow, methodical, and purposeful manner. He presented concrete objects and environments which he differentiated and organized on the page as they came to his mind, one object leading to the next. Jon's drawings and responses to them were reminiscent of drawings and responses made by children younger than his chronological age.

The major repetitive themes of Jon's drawings centered around life in the wilderness, wild animals, explosions, the threat of fire, and human figure drawings of a boy in various situations. "The Boy" was drawn in the first session depicting a front view of a smallish male figure listening to his boom box and standing next to a basketball and hoop. The pierced earring with its cross, the three peace signs on the figure's necklace and pants, the above-mentioned props, and the muscles on the boy's arms relate an attempt to portray a good image. The startled expression on the figure's face and the upraised arms create a contrasting mood of surprise and/or fear in the drawing (Figure 1).

Two of the many drawings with the human figure in them find the 'Boy' in front of a burning building (Figure 2) and scoring a goal in hockey (Figure 3).

These pictures were given titles by Jon. They are "Put It Out" (Figure 2) and "The Breakaway Boy" (Figure 3). They indi-

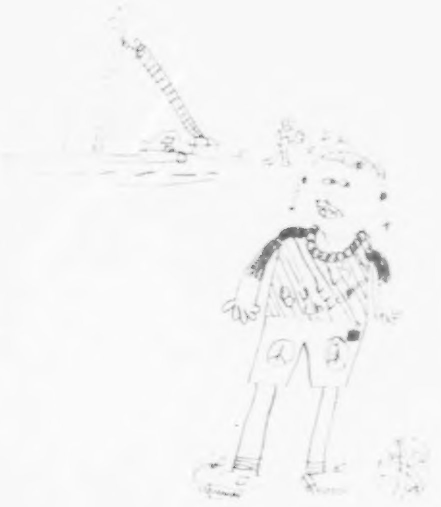


Figure 2 "Put It Out"

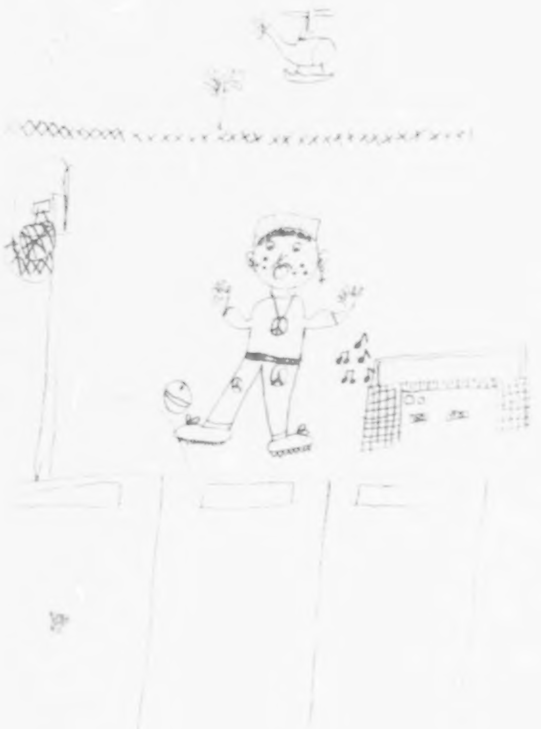


Figure 1 The boy with a facial expression that conveys fear and/or surprise combined with features such as muscles and objects portraying images of adolescence

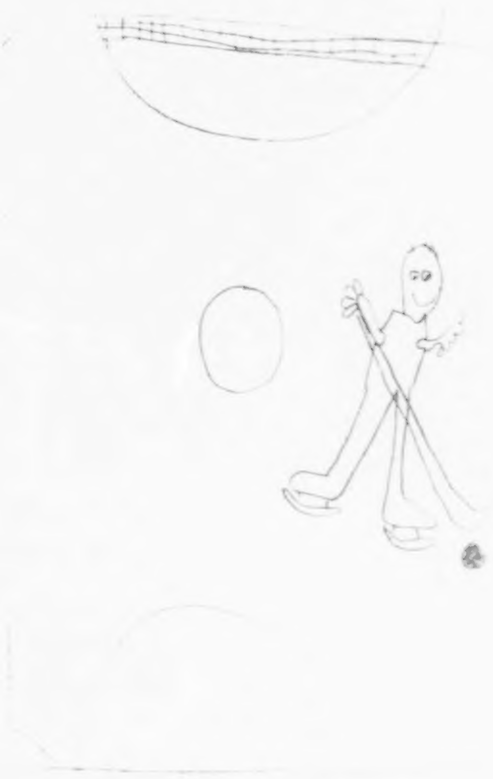


Figure 3 "The Breakaway Boy"

cate a progressive change in content from a preoccupation with external danger to positive images of internal control and wishful aspirations of success. These drawings also show a progressive change in form. There is variation in detail, complexity, integration, realism, and involvement in terms of time spent on producing the drawing. Both content and form were determined by how Jon felt, what he was thinking about, as well as what was going on in the session at the time that he drew the picture.

"The Great Adventure" (Figure 4), one of Jon's first expressive pictures (titled by him), depicted a bear hiding in a mountain cave looking scared, "weird," and somewhat ugly. A helicopter with a net and a search light projecting out from the bottom were drawn hovering in the air above and to the left of the mountain.

Jon said that the net under the helicopter was to capture the fierce bear. When asked what was his favorite part of the picture, Jon indicated the mountain climbers, seen as tiny stick figures in the bottom, left-hand corner. He said his least favorite part was that the bear might be harmed in the pilot's attempt to save him. In describing the part that he liked best in his pictures, he would often describe the situation being depicted (the representational content) rather than the way it was drawn (stylistic form), as in this case or in Figure 2, in which he said that his favorite part was that "they are putting out the fire."

"The Great Adventure" (Figure 4), "The Runaway Bear" (Figure 5), and "The Hiding Bear" (Figure 6) form a series that show the transformations of the bear image in Jon's drawings. From a primitive shape with four straight lines for legs in "The Great Adventure" (Figure 4), the bear figure becomes differentiated, with paws, claws, teeth, and fur in the "Runaway Bear" (Figure 5).

The bear in "Runaway Bear" (Figure 5) is active. Unlike its depiction in the other two drawings (Figure 4 and Figure 6), here the bear is stealing honey from the house drawn in the upper, left-hand corner of the page just under the sun. Finally, "The Hiding Bear" (Figure 6) depicts a cub, looking directly out at the viewer, with a fallen tree behind him. The fallen tree is depicted as two long horizontal lines with short crooked lines radiating off them at a 90 degree angle. These lines come out of the bear's ears and look as if they go through the bear cub's head, rather than behind it.

"The Bomber" (Figure 7) and "The Unstoppable Fire" (Figure 8) depict two of Jon's many openly hostile and aggressive themes. "The Bomber," flying right and staying straight, has two bombs on the wings, a pilot with a machine gun shooting down an enemy plane as well as a gunner under the plane. Another gun is drawn on the side of the plane with "NASA" on the tail and identification marks drawn near the nose at the front of the aircraft.

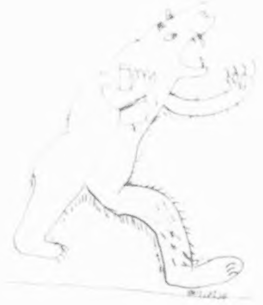


Figure 5 "The Runaway Bear"

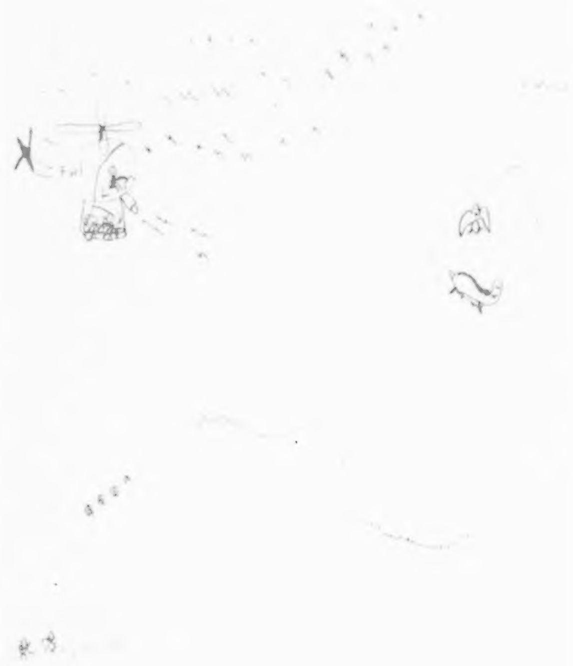


Figure 4 "The Great Adventure"

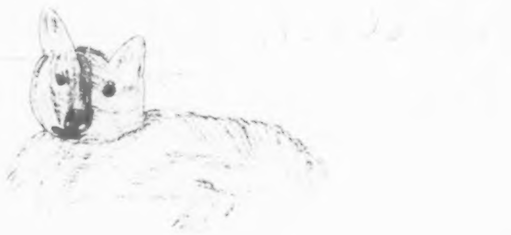


Figure 6 "The Hiding Bear"

"The Unstoppable Fire" was a crayon drawing which depicts two mountains, a lake, a sun, a rabbit burrow in the bottom, left-hand corner of the page with two rabbit ears sticking out, and arrow-shaped trees dotted on the mountainside and in the valley. The fire surrounds the house drawn near the mountain peak on the right side of the page. Black smoke covers the house, the black chimney, and the top, right-hand corner of the page. There are a great number of details in the image: raindrops, birds and one bat litter the sky above the trees; a river flows in the valley between the two mountains, leading to a lake covering the bottom half of the page; in the lake there is an octopus, a sunken ship, and a clam.

Figure 9, "Owl, Fish, Bear, Zebra, Skunk, Pig, Leopard," and "Leave the Wild Alone!" (Figure 10), produced near the end of the art therapy sessions, indicate the interaction and result of the therapeutic relationship that had been established during the previous sessions. In allowing Jon to freely express himself in his artwork, accepting him unconditionally and nonjudgmentally, supporting and gently guiding his drawing development, a feeling of trust, mutual respect, and collaboration had been developed, mostly nonverbally.

These two pictures represent the struggle and successful structuring of Jon's images to create an integrated, coherent, and meaningful whole. Both Figures 9 and 10 required great effort in terms of motivation, cooperation, and concentration on Jon's part. "Owl, Fish, Bear, Zebra, Skunk, Pig, Leopard" (Figure 9) shows three concentric circles delineating areas for fish in the inner circle, trees in the middle circle, and different animals in the outer circle. Each animal is identified by distinguishing marks and is drawn in a simple, primitive manner that is sensitive, integrated, and delicate.

Jon found the circle too complex a form within which to structure his symbols on the page and took the suggestion that he use the rectangular page boundaries to help him to organize and frame his next drawing. "Leave the Wild Alone!" (Figure 10) was drawn in response. It shows seven deliberately delineated rectangular components, representing trees overloaded with acorns on the bottom to his ever-present sun with jagged rays, stereotyped birds, and puffy clouds at the very top of the page. There is a row of tents with a campfire protectively enclosed by rocks above the tree section; drawn in the next row is an underwater scene with a school of fish; then repeated images of an owl and a rabbit occupy center page as representations of wildlife. Next are four snowcapped mountains, each with a little circle on it depicting a cave (similar in form to the cave drawn in Figure 4), and at the top a city scene with repeated images of a building (similar in form to the burning building depicted in Figure 2), traffic lights, and a car. Jon was pleased and proud of this picture. He gave the title in the form of the imperative, "Leave the Wild Alone!," directing the viewer and conveying a clear meaning, as opposed to describing the content of the picture as he had previously done.

Finally, in comparing Jon's drawings of a house, there is a visible difference between "The New House" (Figure 11, drawn at the first session) and "Jump Up" (Figure 12, drawn at the last session). In "The New House," a bird's-eye view is used to depict different rooms incorporating top and side views for objects in each room. Prominently displayed is a center rug with a boat floating on concentric circles. The sun is placed incongruously at

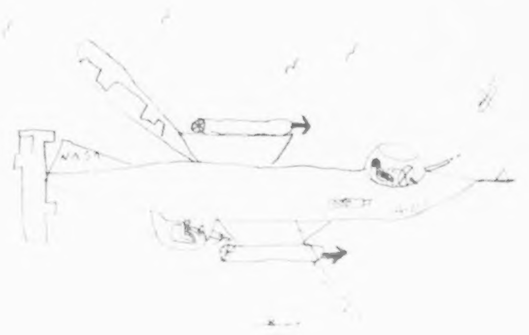


Figure 7 "The Bomber"

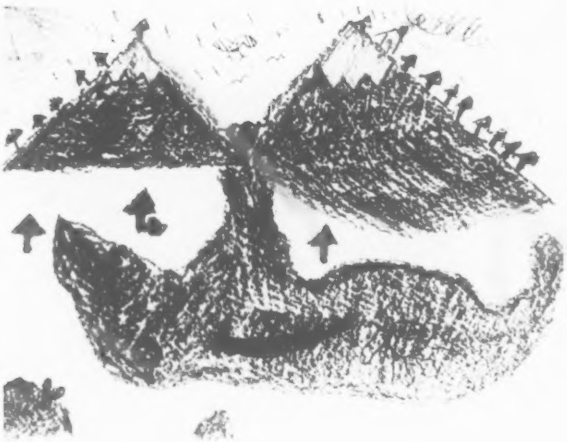


Figure 8 "The Unstoppable Fire"

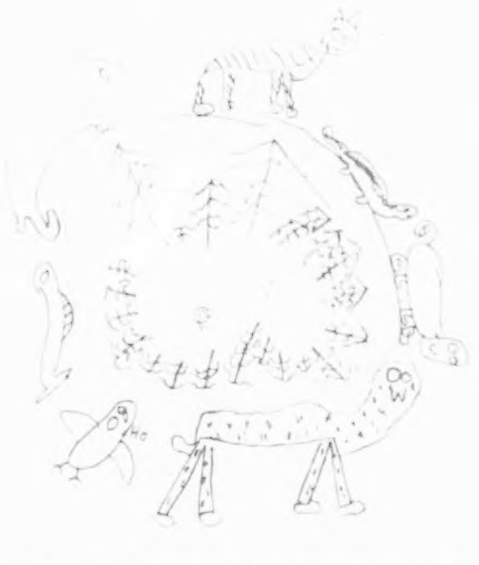


Figure 9 "Owl, Fish, Bear, Zebra, Skunk, Pig, Leopard"

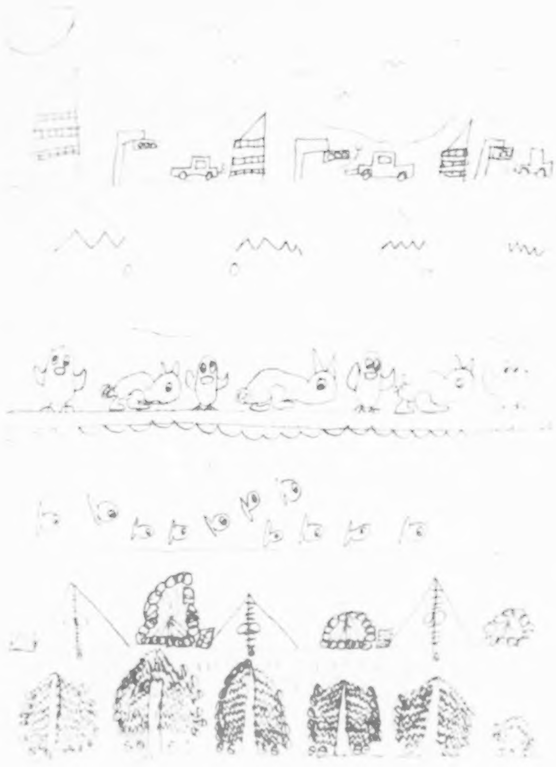


Figure 10 "Leave the Wild Alone!"

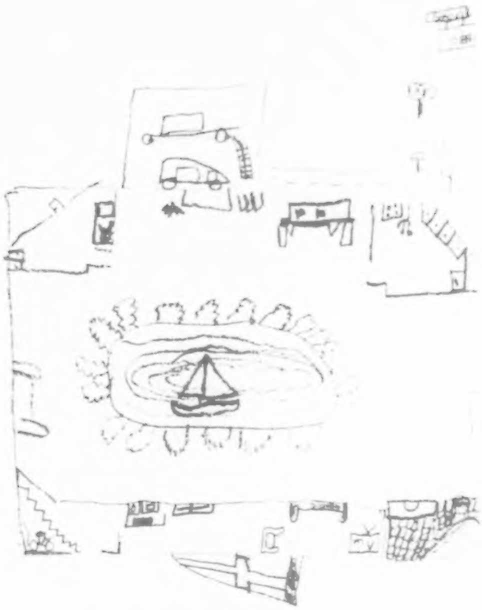


Figure 11 "The New House"

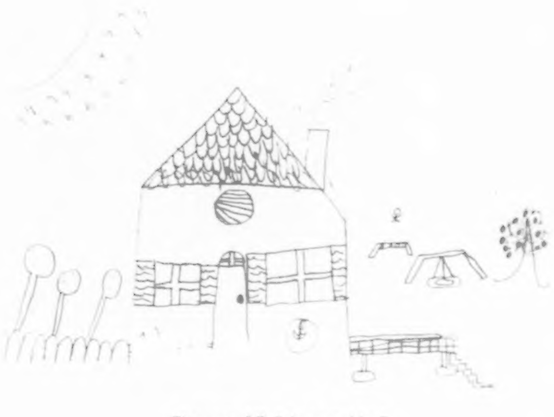


Figure 12 "Jump Up"

the bottom, right-hand corner of the page possibly indicating disorientation caused by anxiety felt at the first meeting.

In "Jump Up," his last picture, Jon used a more conventional view of a house with flowers, deck, tire swing, tree, and trampoline in the yard with a small stick figure floating above the trampoline. As he became relaxed during the sessions, he was able to use more space on the page and placed the sun, more appropriately, in the top, left-hand corner of the page. The reworking of the roof area and deteriorating pattern of shingles have been thought to indicate organic disorder (Jolles, 1971) and could, in those terms, indicate Jon's valiant effort to overcome his limitations.

The transformation in the form and content of Jon's artwork during the course of therapy embodies and represents the therapeutic process. Each picture stands between Jon and the art therapist and captures at a particular point in time a communication which prompts a response, resulting in the next picture, another communication from Jon to the therapist and a response, thereby embodying the dialogue, the ongoing interaction between client and therapist. The art activity provided Jon with the opportunity and the tools to organize his thoughts, feelings, and ideas in concrete terms by drawing what he wanted in his own way. Once drawn, the picture could present him with those very thoughts, feelings, and ideas as well as enable him to share them with the therapist and, subsequently, his parents and teachers. Jon's artwork changed from day to day and from picture to picture depending on what was going on around him, how he was feeling physically that day, and what he wanted to convey about himself to the therapist.

Jon portrayed many outdoor and camping activities in his artwork. Camping was a family activity that Jon enjoyed and through which he developed many strengths. By these drawings he was able to communicate to his parents that their guidance and support were essential to him. These drawings also revealed another side of his personality. In class Jon was belligerent, aggressive, and uncooperative while attempting to cover up his inability to do assignments in reading, writing, and arithmetic. In his artwork he portrayed a sensitive, gentle, and intuitive side of his character, specifically in relation to wild animals and preserving the wilderness, an aspect of his personality which had not been apparent to his teachers previously.

Jon was productive, competent, self-directed, and self-controlled during the art sessions. During the 6-week period that he was involved in the artwork, he had no violent outbursts. The school personnel and his parents began to collaborate at this time, which prevented Jon's manipulative antics. Jon experienced success in that he was pleased with the results and progress of his efforts; Jon experienced acceptance as he was allowed to function at his own level and was supported by the therapist for all aspects of his work and involvement; Jon experienced relatedness with another person as he was given undivided attention, respect, and honest feedback; Jon experienced growth as he saw the change and development in his drawn forms and was proud of the final result.

Product—The Art Book and the Outcome of Therapy

All of Jon's drawings were dated and mounted on colored paper with printed titles and the pages numbered and compiled into an art book for him. On the last day of the art therapy sessions, Jon created the front cover of his art book by drawing the letters of his name on a background of flamboyant lines and colors. He also pasted a Certificate of Merit, given to him at the last session, into his art book.

He turned the pages of his art book and looked over the 30 pictures he had drawn. Flipping through the pages, at times Jon stared intently at a drawing, and at times he passed by one quickly. He went back and forth, in no particular order looking first here and then there. The work of art captured and documented, like a visual diary, the time spent and served as a reminder of the progress made in art therapy. The art book portrayed his mountains, helicopters, planes, human figure drawings of a boy listening to music, a boy playing at sports, a bear at one time wild, another time a hiding cub, a sunken ship, a great adventure; the art book portrayed his ideas and his work. The art book also portrayed his development and his involvement. The concrete expression of thought and feeling, of time and meaning enabled Jon to reveal and revisit past experience at his leisure and convenience.

Conclusion of Case Study

The goal of therapy to help the client change behaviors that were maladaptive and destructive within the limits of his physical illness and emotional disabilities was achieved by providing Jon with the opportunity to discover and experience adaptive and creative behaviors available to him. The art activity engaged in a time and place removed from the everyday with an objective outsider, not parent, teacher, or peer, allowed Jon (since he was in a new situation) an observer, a process, and a product with which to discover and experience new behaviors and responses within himself.

Jon's drawings were constructions of perceptions of his environment integrated with internal sensations that were communicated to the therapist in the form of pictorial responses. He was proud of the result of his efforts which became visible and tangible to him through the art product. Jon experienced success, relatedness, and self-control. These experiences as well as the self-awareness gained from these experiences were embodied in his art book.

The unique usefulness of art therapy rests in the synthesis of art with the treatment of psychological disorder. Art therapy makes the art experience available to all individuals; inherent in the art experience is observing art, producing art, and keeping objects of art in one's possession. As illustrated in the case study, understanding these dimensions within the theoretical framework of observer, process, and product, their interrelationships and their distinct and combined functions, enables the art therapist to better discuss, describe, and, in turn, understand the work of art therapy.

References

Adams, R. D. (1989). *Principles of neurology.* News York: McGraw Hill.

Arnheim, R. (1974). *Art and visual perception.* Berkeley: University of California Press.

Arnheim, R. (1962). *The genesis of a painting: Picasso's Guernica.* Berkeley: University of California Press.

Csikszentmihalyi, M. (1993). *The evolving self.* New York: Harper Collins.

Dewey, J. (1934). *Art as experience.* New York: Minton, Balch.

Erikson, J. M. (1979). The arts and healing. *American Journal of Art Therapy, 18*(3), 75-80.

Gardner, H. (1973). *The arts and human development.* New York: John Wiley & Sons.

Getzels, J., & Csikszentmihalyi, M. (1976). *The creative vision: A longitudinal study of problem finding in art.* New York: John Wiley & Sons.

Gombrich, E. (1960). *Art and illusion: A study in the psychology of pictorial representation.* Princeton, NJ: Princeton University Press.

Goodman, N. (1968). *Languages of art.* New York: Bobbs-Merrill.

Jolles, I. (1971). *A catalog for the qualitative interpretation of the House-Tree-Person (H-T-P).* Los Angeles, CA: Western Psychological Services.

Kivnick, H. Q., & Erikson, J. M. (1983). The arts as healing. *American Journal of Orthopsychiatry, 53*(4), 602-618.

Langer, S. K. (1942). *Philosophy in a new key.* Cambridge, MA: Harvard University Press.

Oster, G. D., & Gould, P. (1987). *Using drawings in assessment and therapy.* New York: Brunner/Mazel.

Shahn, B. (1957). *The shape of content.* Cambridge, MA: Harvard University Press.

Ulman, E. (1961). Art therapy: Problems of definition. *Bulletin of Art Therapy, 1*(2), 10-20.

Weber, J. P. (1958). *The psychology of art.* (J. A. Elias, Trans.). New York: Delacort Press.

Winner, E. (1982). *Invented worlds.* Cambridge, MA: Harvard University Press.

BEST COPY AVAILABLE

Art Therapy: Journal of the American Art Therapy Association, 13(4) pp. 252-262 © AATA, Inc. 1996

Mandala Drawing: Facilitating Creative Growth in Children with ADD or ADHD

Valerie Smitheman-Brown, MA, ATR-BC, Lutherville, MD, and
Robin P. Church, EdD, Baltimore, MD

Abstract

Using a single-subject, multiple-baseline research design, this study investigates the creative growth and behavioral changes precipitated by the work done in art therapy through the employment of the mandala as an active centering device with children who have been diagnosed with Attention-Deficit Disorder (ADD) or Attention-Deficit Hyperactivity Disorder (ADHD) accompanied by a history of impulsivity. During specified intervals of treatment, a drawing was requested, "Draw a person picking an apple from a tree," and rated according to the guidelines of the Formal Elements Art Therapy Scale (FEATS). Through examination of the drawings and objective findings of this scale, it appears that a visual measurement of creative growth was achieved. Preliminary findings indicate that the mandala exercise has the effect of increasing attentional abilities and decreasing impulsive behaviors over time, allowing for better decision making, completion of task, general growth in developmental level, and an interest in personal aesthetics.*

Introduction

Children who have a history of Attention-Deficit Disorder (ADD) or Attention-Deficit Hyperactivity Disorder (ADHD) accompanied by impulsivity exhibit those behaviors in most situations, including art therapy sessions. By introducing the drawing of a mandala at the beginning of each session as an active centering device, it is expected that there will be evidence of an increase in attention span and a decrease in impulsive behaviors. Along with this behavioral adjustment, an improvement in the individual creative developmental level according to Lowenfeld's criteria is anticipated.

The choice of the mandala is related to the work of Jung (1972), R. Kellogg (1969), and J. Kellogg (1978, 1984). All concur that the use of the mandala is an experience that often creates a calming and relaxing effect on the artist. Jung began painting mandalas in 1916 and regarded the form as "corresponding to the microcosmic nature of the psyche" (1965, p. 196).

Rhoda Kellogg's work describes the mandala as the first emergent form in creative expression after the scribble stage. The ability to draw a circle appears to be crucial to pictorial development (Kellogg, 1969). According to the extensive work of Joan Kellogg, mandalas offer a channel for creativity and provide maps of inner growth. The mandala form presents a structural device on which to concentrate and can be approached as a drawing of ongoing process (Kellogg, 1978, 1984).

Literature Review

A literature review reveals that ADD and ADHD appear to be the most researched areas of childhood behavior. In these common disorders of childhood, an individual exhibits significant problems with attention span, impulse control, and motor activity level relative to similar-age peers. In tracing the history of this disorder, Barkley states, "The prevailing view of ADHD at the close of the decade of the 1970s concluded that hyperactivity was not the only or the most important behavioral deficit seen in hyperactive children; poor attention span and impulse control were seen as equally if not more important in explaining their problem" (1990, p. 20). The diagnostic criteria in the DSM II (1968) emphasized distractibility and impulsivity as defining factors and the Diagnostic Statistical Manual III (DSM III) (1980) created subtypes based on the absence or presence of hyperactivity. It was diagnostically important to differentiate between the behavioral traits characteristic of hyperactivity versus aggression in order to prescribe efficient treatment. The DSM IIIR (1987) made two important revisions: (1) the need to establish the symptoms as being developmentally inappropriate for the child's mental age, and (2) the coexistence of an affective disorder no longer excluded the diagnosis. The most recent diagnostic criteria cited in DSM IV (1994) divide symptoms into two major categories—inattention and hyperactivity-impulsivity. When evaluating symptomology criteria regarding the degree to which it is maladaptive and inconsistent with developmental level should be considered.

Barkley states that "the decade of the 1980s closed with most professionals viewing ADD or ADHD as developmentally handicapping conditions that are generally chronic in nature, have a strong biological or hereditary predisposition, and have a significant negative impact on academic and social outcomes for many children" (1990, p. 36). It has long been accepted that children with ADHD are more likely to have specific cognitive processing deficits than other children. School underachievement is rampant in this population. Behaviors associated with ADD and ADHD prevent a child from achieving his/her potential, resulting in a lack of ability to cue themselves internally, critical to the control and organization of behavior.

***Editor's Note:** Excerpted with permission of the authors from the *Rating Manual for the Formal Elements Art Therapy Scale* © by Linda Gantt and Carmello Tabone (in press). Researchers wishing to use this instrument in their studies must obtain written permission from the authors. For inquiries about permission and for copies of the rating manual please contact: Gargoyle Press, 314 Scott Avenue, Morgantown, West Virginia 26505, telephone (304) 291-2915, fax (304) 291-2918.

Research done on the impulsive behaviors of children diagnosed with ADD or ADHD points to the need to facilitate relaxation and centering in order to offer them the opportunity to attend to task and achieve growth potential. Barkley notes that ADHD children display fewer behavioral problems with tasks that are novel or unfamiliar (1990, p. 214). In quoting research done by Zentall, Barkley supports the fact that ADHD children are more likely to pay attention to colorful or highly individually stimulating materials compared to "normal children." Tasks requiring an active, motoric response as opposed to a passive response may also help hyperactive children channel their behaviors.

A recent study by Epperson and Valum (1992) points to the value of art therapy with ADHD children due to the unique nature of the artmaking process. Expressive qualities evident in art products are thought to serve as a record of behaviors at the time the child was involved in the process. Motor movement, attention, and degree of impulsivity are thought to be reflected in line quality, use of material, degree of organization, integration, and completeness evident in the resulting artwork. The creative process provides a record of the child's emotional/behavioral status with the creation of a permanent product. While Epperson and Valum's study primarily investigated children's art to examine if changes in imagery were evident and could be explained by variation in medication dosages, it also considered how changes in the art might correspond with overt behavioral changes. The investigation indicated that stimulant medication can have a significant influence on expressive qualities. In addition, the data from art products corresponded in a positive manner to data obtained from a behavioral assessment measure (Epperson & Valum, 1992).

Methodology

The multiple baseline across individuals' designs following a model described by Kazdin (1982) was chosen for this research project for the following reasons: It allows for continuous assessment of effects of the intervention on performance over time; the descriptive function of the baseline phase can act as a basis of predicting the level of performance if the intervention is not provided; it has the ability to incorporate a larger sampling; and there is no need to use reversal or experimental techniques to demonstrate the effects of the intervention.

This study assessed the functional relationship between treatment strategy and behavior change by introducing the intervention to different baselines at different points in time. The baseline targeted attention span and impulsivity across eight students and four control subjects. Once the intervention was introduced to attempt to alter the particular behaviors, it was not withdrawn as in the standard single-subject ABAB designs which will temporarily withdraw the intervention to prove the hypothesis. After behavioral baseline was established, two students and one control were introduced to the intervention immediately. Two additional students and one control were added each 30 days thereafter.

As a practical and visual measurement of change, this study used a drawing task, "Draw a person picking an apple from a tree," suggested in Lowenfeld (1947, 1956) and developed more completely as a diagnostic tool by Gantt (1990, 1993) using the Formal Elements Art Therapy Scale (FEATS). The FEATS was developed to describe global variables in the artwork of adult psychiatric patients. This scale was chosen because it is both objective and consistent. The FEATS rates the following pictorial variables: prominence of color, color fit, energy, use of space, integration, logic, realism, problem-solving, developmental level, details of objects and environment, line quality, depiction of person, perseveration, and rotation. Each variable is measured on an ordinal scale with five defined points (Gantt & Tabone, in press).

The FEATS was originally designed for adults. To use this study with children, it was determined that four elements of the scale applied: integration, problem-solving, developmental level, and details of objects and environment. As the FEATS may not be familiar to readers, the exact wording of the rating manual and a copy of the ordinal scale for the four elements chosen are noted in Appendix I and II.

Subjects

The population chosen for this study consisted of eight student subjects and four control subjects, ages 10-13, attending an Intensity V school. Intensity V is a level of education designed to meet the needs of children with severe emotional and developmental issues and maintain the least restrictive environment for learning. Each student and control subject had carried a diagnosis of ADD or ADHD for more than 1 year and had a documented, ongoing history of impulsive behaviors.

Procedure

Baseline data were gathered from historical and observable patterns of behavior, use of the Child Behavioral Checklist (Achenbach, 1979), general artwork produced before the intervention, and the repeated drawing task, "Draw a person picking an apple from a tree," also produced prior to the introduction of the intervention. Ongoing behavioral data were charted through direct observation. The intervention was considered to begin during the art therapy session in which the mandala drawing was first introduced.

The student was presented with a piece of 12" × 18" white paper, on which a circle 10½" in diameter had been drawn in pencil and a box of 48 Holbein oil pastels. The student was informed that beginning with the present session, he/she will be creating a free-choice circular drawing for the first 5 minutes as a means of relaxing before beginning other artwork. The student was instructed to begin in the center of the circle and draw whatever he/she wished. At the conclusion of the mandala exercise, the student was given free choice of artwork and art medium for the remainder of the session. The 5-minute time was a minimum; the mandala could, of course, be continued as long as the student wished to work. This method of organizing the beginning of each art therapy session was consistent over the research period once the intervention was introduced.

Throughout the course of the research, the control group had access to nondirective art therapy techniques and were not introduced to the mandala exercise. Every 2 months all the students were requested to repeat the task, "Draw a person picking

BEST COPY AVAILABLE

an apple from a tree." For this drawing the student was offered 12″ × 18″ white drawing paper and a set of 12 "Mr. Sketch" ™, washable, nontoxic markers. All repeatable drawings were rated according to the Formal Elements Art Therapy Scale (FEATS) by three independent raters. The author obtained a prepublicaton copy of the FEATS rating manual, and each rater was trained in the areas of the scale considered applicable to children prior to viewing the artwork. The raters were blind to the subjects and the hypothesis. Two studies are presented in this article as an illustration of the changes observed in developmental level and the behavioral adjustments indicated by the use of the mandala.

Case Study #001

Student #001 is a 13-year-old female with a DSM IIIR diagnosis of Attention-Deficit Hyperactivity Disorder, Elective Mutism, and Mild Mental Retardation, r/o Post Traumatic Stress Disorder. Her history shows significant attentional difficulties and impulsive behaviors from birth, intensified after 8 years of age and coinciding with the commencement of elective mutism. This student completed 20 mandala drawings and five repeatable drawings administered in 2-month intervals, during the course of the intervention. In comparing these drawings, it should be noted that this student was not previously known to have drawn a full human figure.

Figure 1 shows the preintervention drawing. The drawing was executed in less than a minute. The student drew only a face and impulsively used all the colors available for each part of the hair. The apple and tree are designated by words. While it might be possible to recognize the apple, the tree is severely rotated and was considered unrecognizable. Although the images are in close proximity, there is no apparent interaction.

In Figure 2 drawn 2 months later, the student exhibits a full body schema. The arms appear to be single lines drawn in red reaching towards the apple. Again, the apple is recognizable. The tree drawing now has what appears to be a square trunk. Of note is the attempt at integration between the images. The most striking difference in Figure 3 is the tree drawing. Although this tree is still somewhat chaotic, it contains fruit, leaves, and a sticklike trunk or branch system which are all recognizable and colored appropriately. The image of the person displays some possible distinction between body parts noted by the use of red for the head and yellow for the balance of the body. Interaction and energy are suggested in the arms reaching up towards the tree. The student normally chose to communicate by writing, and the words seen in the drawing describe the change in hairstyle.

Figure 4 includes the addition of a groundline and sun, perhaps indicating a recognition of the environment. The tree is grounded, and the leaves and apples are in proper position. The person may be jumping up to get the apple, indicative of energy. The arm is bent and drawn along the trunk line of the tree touching the apple. The postintervention drawing, Figure 5, is a scene that could be said to be both integrated and environmental. Color is appropriate throughout the drawing, and images are filled in to indicate volume. The body schema differentiates among head, body, and facial features by the use of color. Energy is depicted in the person jumping and reaching for the apple.

The cognition of this student has been described by educators and psychologists as scattered, indicating widely variable

Figure 1

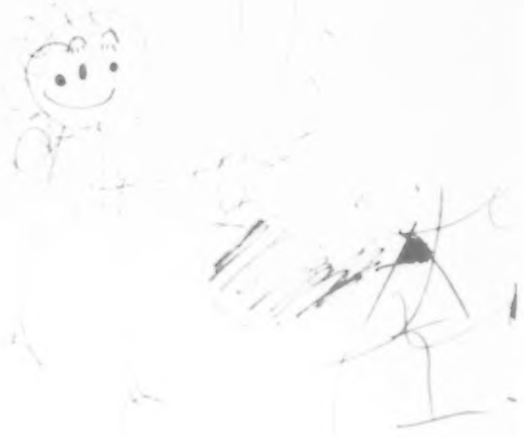


Figure 2

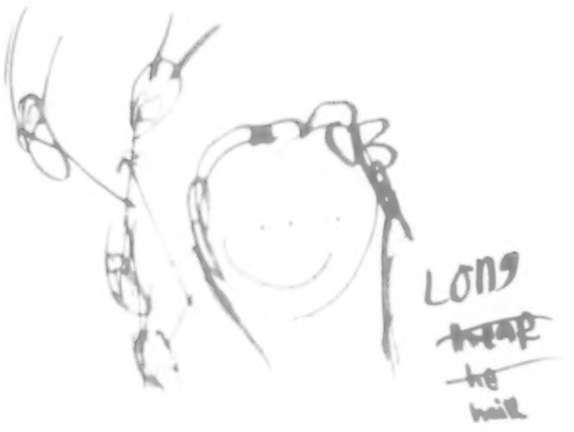


Figure 3

Figure 4

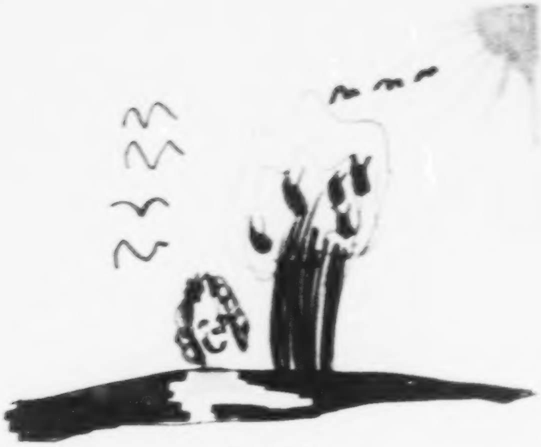


Figure 5

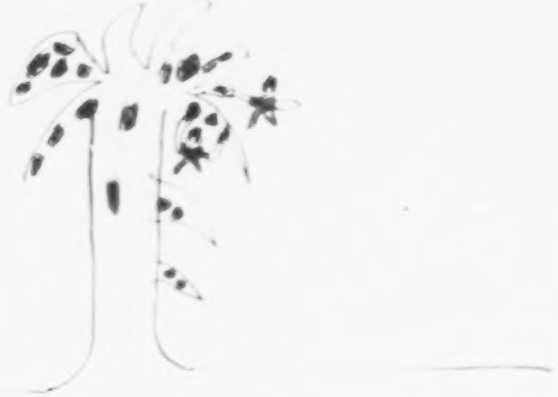


Figure 6

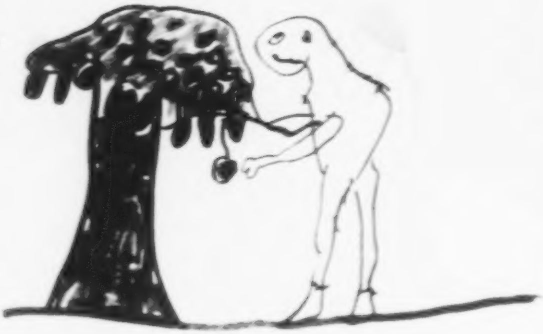


Figure 7

abilities. This can be seen particularly in the developmental level of her figure drawings. Using Lowenfeld's criteria, steady progress in developmental level can be noted in the five repeatable drawings. Comparison of the pre- and postintervention drawings exhibits her ability to attend to detail and produce a more integrated drawing and include more environmental details in her work as she gained strength in her ability to focus and control impulsive behaviors.

Case Study #002

Student #002 is a 10-year-old boy diagnosed with Attention-Deficit Hyperactivity Disorder, Separation Anxiety Disorder, and Post-Traumatic Stress Disorder. There was a history of attentional difficulties and impulsivity apparent since the age of 4 when abandoned by his primary caregiver. The student completed 16 mandala drawings and four repeatable drawings administered every 2 months.

The preintervention repeatable drawing, Figure 6, can be said to exhibit impulsivity in line quality and branch connections. The apples appear to be drawn without regard to their actual placement on the tree. Color prominence and problem-solving are minimal. The content of the image is fantasy based with the depiction of what are described as elves flying in the tree to pick apples.

Described by the student as a "dinosaur picking an apple from a tree," the image in Figure 7 continues the fantasy element. The tree is filled in with color giving a sense of volume, the apples are more organized, and the work is color appropriate. The student displays possible anxiety in the line quality of the dinosaur and impulsivity in the overlay of the sun on the back of the animal. While still not totally reality-oriented in the depiction of a giant picking an apple from a tree seen in Figure 8, the figure appears to be progressively more humanoid. The balance of the drawing shows an integrated environment, including sun, skyline, clouds, and groundline. The tree, leaves, and apples are organized and object-color appropriate. All of the images shown depict volume and solidity.

In the postintervention repeatable drawing, Figure 9, the most dramatic change noted is the departure from fantasy seen in the images of two human figures: one climbing a ladder to pick the apple and one holding a basket of apples. The figures are not well defined, but can be identified as human and are sized appropriately compared to the tree. The student displayed his problem-solving capability by adding the ladder, thus imaging an appropriate response to the challenge of the task. Groundline

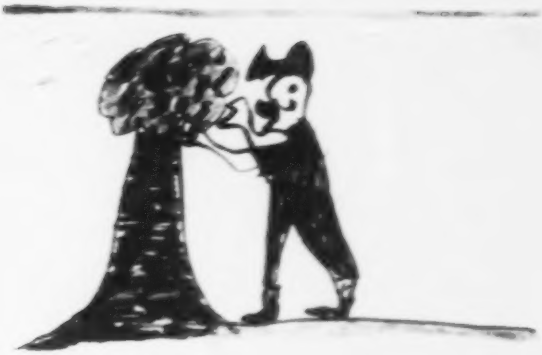


Figure 8

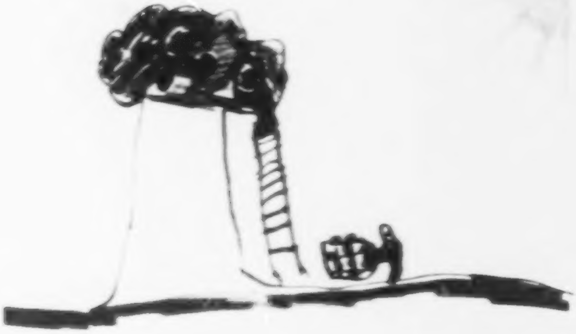


Figure 9

and sun complete the picture. A review of the drawings shows a steady improvement in the developmental level from the preschematic stage in the emotional use of color and relationship to reality towards the schematic level in the student's depiction of human figures, relationship in color/object, and environmental awareness.

Conclusions

This study investigated the development and behavioral changes precipitated by the work done in art therapy through employment of the mandala as a centering exercise with children who have been diagnosed with ADD or ADHD accompanied by a history or impulsivity. It was hypothesized that incorporation of an active centering technique in the form of a mandala drawing at the start of each art therapy session would foster increased attentional capabilities and effectively decrease impulsive tendencies during the session. The overall creative expression of the child was used as an additional support for the hypothesis. By examination of the repeatable drawing task, "Draw a person picking an apple from a tree," rated on four scales following the guidelines of the FEATS, a visual measurement of change was recorded.

The findings indicate that the mandala exercise had the effect of increasing attentional abilities and decreasing impulsive behaviors over time, allowing for better decision making, completion of task, expression of growth in developmental level, and an interest in personal aesthetics. Four areas of the FEATS ratings deemed particularly applicable to the population were chosen for investigation: integration, problem-solving, developmental level, and details of objects and environment. These categories were chosen to emphasize the concrete nature of the visual expression and assist other professionals to explore the use of the formal elements of art as a tool for understanding change and growth on other levels.

Analysis of the ratings in these four areas examined in the preintervention and postintervention drawings by the subject group reveals an average increase of 35% in integration, a 38% increase in problem-solving attempts, a 37% increase in awareness of details of objects and environment, and a 22% increase in the ratings of the developmental level (Figure 10A-D). Within the control group, three of the four subjects made no perceivable advance in the categories tested. One student made significant progress throughout the research, perhaps due to the introduction of art therapy in general (Figure 11A-D).

The Baseline/Performance Data Over Time for the two cases presented in this study chart the targeted behaviors of attention span and impulsivity (Figure 12). This was accomplished through prechecklists/postchecklists completed by the teachers and direct observation throughout the course of the intervention. Each student shows a gradual improvement in attention capability and decrease in impulsive behaviors that correlate to the visual improvement in creative developmental level over time. This appears to indicate that the use of the mandala drawing to facilitate active focusing allows the student to exhibit a more age-appropriate developmental level.

A comparison of the Baseline/Performance Data Over Time between student and control subject groups showed an increase in attention span and a decrease of impulsive behaviors in all subjects. The student group, however, improved attention span after introduction of the intervention by an average of 23% while the increase in attentional span observed in the control group averaged a bit less than 10%. A decrease in impulsivity of 24% was observed in the student group and a decrease of 12% within the control group.

The diagnosis of ADD or ADHD accompanied by a history of impulsivity was the only criteria for choosing subjects for this research. According to the outcome of this research, it appears that a wide range of additional Axis I and Axis II issues are not a factor in the application of this intervention. Inherent differences in the cognitive strength of each student appear to have no adverse effect on the work, although it may take a bit longer to observe change for the lower functioning student. Some variables which may have influenced the student's progress during the research should be considered. The students involved had been in this placement for a year or more, the length of exposure to the structured setting should be considered. All of the students were medicated to address their handicapping conditions. Medications and dosages were not a controllable variable for this research. Art therapy was a new modality, and the individual

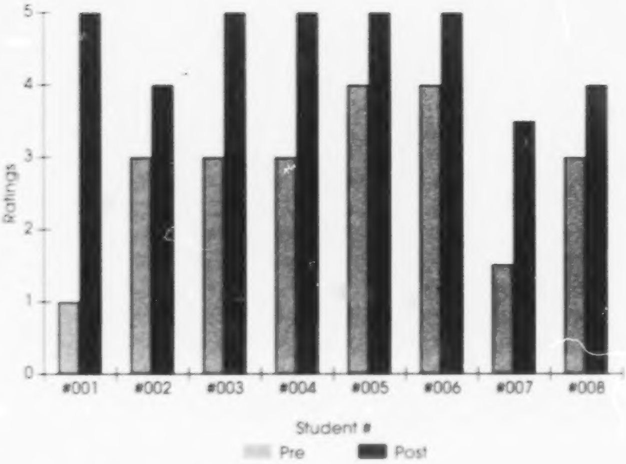


Figure 10A Pre & Post Intervention Comparisons
PPAT Rating 5 - Integration

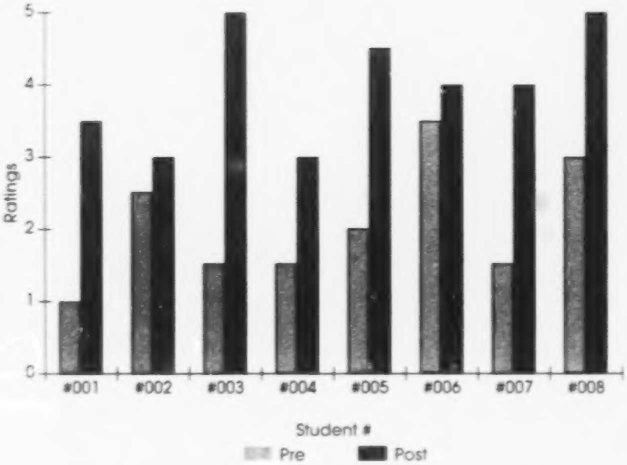


Figure 10B Pre & Post Intervention Comparisons
PPAT Rating 8 - Problem Solving

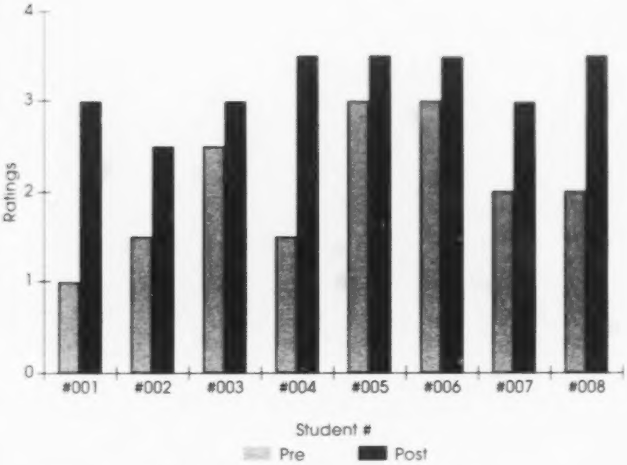


Figure 10C Pre & Post Intervention Comparisions
PPAT Rating 9 - Developmental

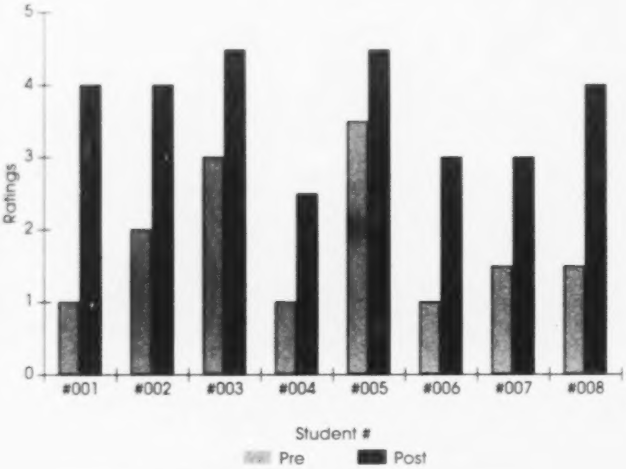


Figure 10D Pre & Post Intervention Comparisions
PPAT Rating 10 - Details of Objects & Environment

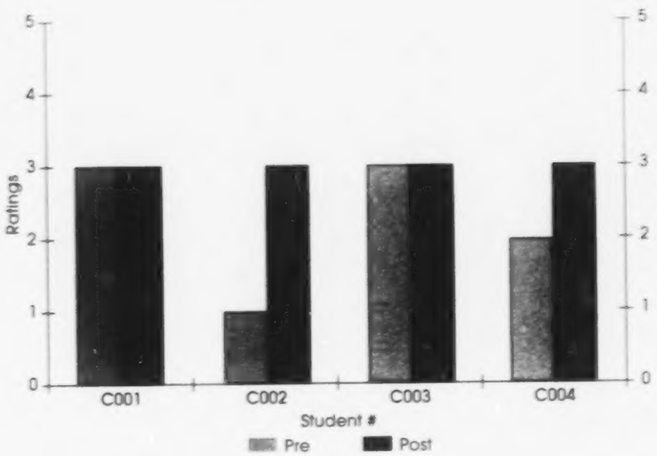


Figure 11A Pre & Post Intervention Comparisions
PPAT Rating 5 - Integration

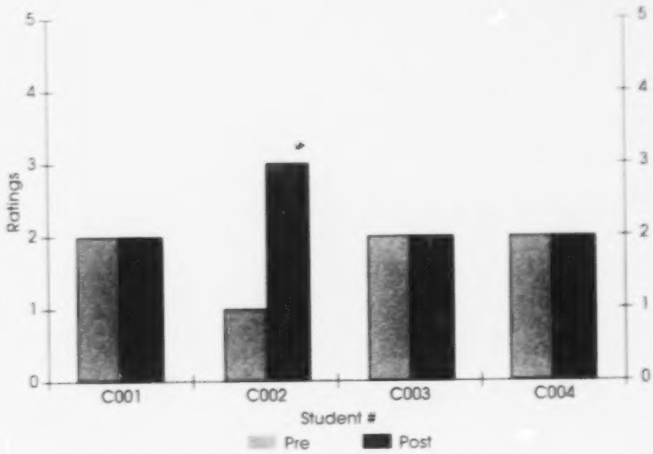


Figure 11B Pre & Post Intervention Comparisions
PPAT Rating 8 - Problem Solving

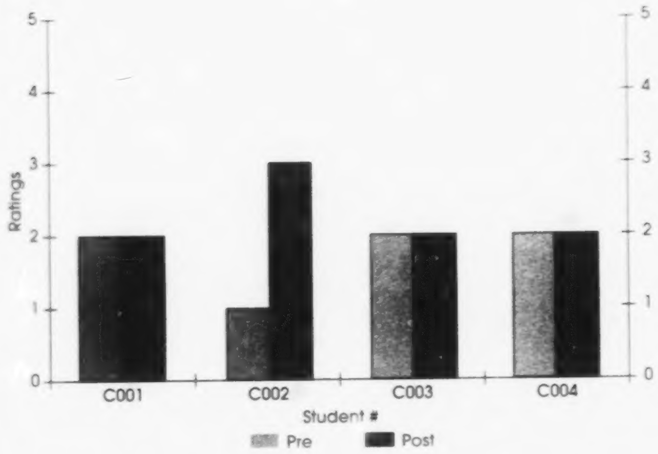


Figure 11C Pre & Post Intervention Comparisions
PPAT Rating 9 - Developmental

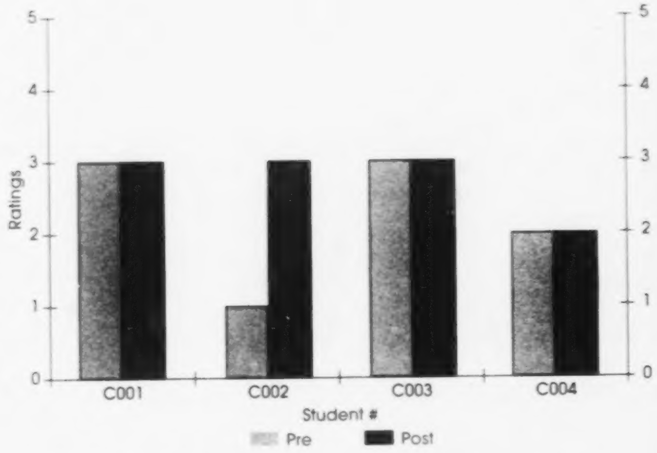


Figure 11D Pre & Post Intervention Comparisions
PPAT Rating 10 - Details of Objects &
Environment

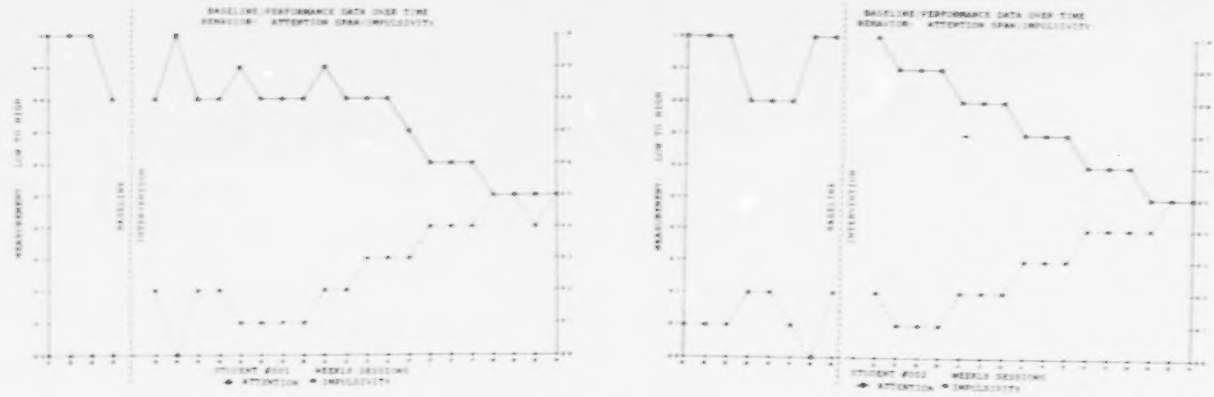


Figure 12

attention could have encouraged the possibility of an increase in expression of developmental level.

The results of this study indicate that the intervention has some promising results. The project, begun during the 1994-1995 school year, is being researched on a continuing and expanded basis at this facility. The use of mandala drawings as an active focusing tool is being piloted during the 1995-1996 school year in a classroom setting prior to several different academic subjects and several different age groups. The goal of the research is to observe the effects of the intervention in a demand situation such as the classroom. Investigation will focus on the translation of the increase in attentional capabilities and the decrease in impulsivity as it relates to academic performance. A matching study conducted in another facility and additional research using this technique are encouraged.

References

Achenbach, T. M. (1979). The Child Behavior Profile. *Journal of Consulting and Clinical Psychology, 46,* 478–488.

American Psychological Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychological Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychological Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychological Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Barkley, R. (1990). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment.* New York: Guilford Press.

Carter, J. (1979). Art therapy and learning disabled children. *Art Psychotherapy, 6,* 51-56.

Epperson, J., & Valum, J. (1992). The effects of stimulant medications on the art products of ADHD children. *Art Therapy: Journal of the American Art Therapy Association, 9*(1), 36-41.

Gantt, L. (1990). *The validity study of the Formal Elements Art Therapy Scale (FEATS) for measuring diagnostic information through assessing formal variable in patients' drawings.* Unpublished dissertation, University of Pittsburgh, Pittsburgh, PA.

Gantt, L. (1993). Correlation of psychiatric diagnosis and formal elements in art work. In F. Bejjani (Ed.), *Current research in arts medicine* (pp. 69-74). Pennington, NJ: Acapella Books.

Gantt, L., & Tabone, C. (in press). *Rating manual for the Formal Elements of Art Therapy Scale (FEATS).*

Giddan, J. (1991). Communication issues in attention-deficit hyperactivity disorder. *Child Psychiatry and Human Development, 22,* 45-51.

Jung, C. (1972). *Mandala symbolism.* Princeton, NJ: Princeton University Press.

Kazdin, A. (1982). *Single case research designs.* New York: Oxford Press.

Kellogg, J. (1978, 1984). *Mandala: Path of beauty.* Lightfoot, VA: MARI.

Kellogg, R. (1969). *Analyzing children's art.* Palo Alto: Mayfield Publishing.

Lowenfeld, V. (1947, 1956). *Creative and mental growth* (8th ed.). New York: Macmillan.

APPENDIX I

Excerpts from Rating Manual for the Formal Elements Art Therapy Scales

by Linda Gantt, PhD, ATR-BC, HLM

Scale #5 — Integration

Look at the overall balance and relationship of the elements to each other. If the picture is not at all integrated and seems to have no overall composition, mark 1. If there is some attempt at making a relationship between two or more of the elements, mark 3. If the composition is well-integrated and well-balanced, mark 5.

Scale #8 — Problem-Solving

How effective is the solution for getting the apple out of the tree? If the person cannot get the apple, the picture would be rated 1. If the person has the apple in hand but it is not apparent how he/she got it, rate the picture 2. If the person is on a rock, box, or ladder (or on some other reasonable type of support) but is not reaching for the apple, mark 3. Rate the picture 4 if the person is on a ladder or rock or other reasonable type of support, or on the ground reaching for the apple but not able to grasp it. Solutions which rate a 5 would be showing the person on a ladder or rock (or on some other reasonable type of support) or standing on the ground with the apple actually in hand (that is, in the process of picking the apple as the directions for the picture state).

If the person seems to have picked the apple but the solution is not reasonable (such as a small branch with the apple on it coming straight out of the middle of the trunk), mark it 3.

Scale #9 — Developmental Level

Keep in mind Lowenfeld's developmental levels. Scribbles would be rated 1. Those with circular or rectangluar shapes for the person's body and no attempt to portray realistic proportions or relationships of objects would be marked between 1 and 2. Drawings like those of 4 to 6-year-olds would be rated 2. Latency age drawings (with a baseline and objects lined up on it) would be rated 3. Adolescent drawings (with overlapping of objects and with realistic sizes for each object in relation to the others) would be rated 4. "Adult" drawings (those which show some artistic sophistication) would be rated 5.

Scale #10 — Details of Objects and Environment

How many extra items are there in the drawings? If there is nothing but a person, a tree and/or an apple and these items are drawn simply with little detail (e.g., a single line for the tree trunk and a rounded form for the top), rate the drawing 1. If a horizon line is added or there is some suggestion of grass, rate it 2. If there is a horizon line and one or two additional details, mark 3. If there are many additional details such as flowers, clouds, a sun, or other trees, rate it a 4. If there are abundant and inventive details such as fences, other trees, and special clothing details (e.g., a pattern on a shirt), rate the picture 5.

Revised October 1993

APPENDIX II

Excerpts from Formal Elements Art Therapy Scale (FEATS) Rating Sheet

by Linda Gantt, PhD, ATR-BC, HLM

#5 — Integration

Not at all integrated	1 2 3 4 5	Fully integrated

#8 — Problem-solving

No evidence of problem-solving	1 2 3 4 5	Reasonable solution to picking apple

#9 — Developmental Level

Two-year-old level	1 2 3 4 5	Adult level

#10 — Details of Objects and Environment

No details or environment	1 2 3 4 5	Full environment, abundant details

Revised October 1993

Brief Reports

The Amusement Park Technique in the Treatment of Dually Diagnosed, Psychiatric Inpatients

Kathy D. Hrenko, MCAT, ATR, and Robert Willis, LSW, CAC, Warminster, PA

Abstract

This article examines a specific art therapy task in the treatment of dually diagnosed, psychiatric inpatients. The amusement park technique is a nonthreatening, unique way to engage patients in the therapeutic process. It provides important diagnostic and prognostic information to the art therapist. This article identifies common imagery created and demonstrates how the artwork serves to identify the psychodynamic concerns of the mentally ill substance abuser. Connections are examined relating patients' choice of image, psychiatric diagnosis, and drug of choice.

Introduction

Amidst the current atmosphere of managed healthcare systems and proposed reforms, the impact on inpatient treatment has led to shorter and shorter lengths of stay. The challenge for healthcare professionals is then to rapidly evaluate and stabilize patients. Collins and Uhlman (1995) report, "What's emerging under managed care is a new mental health model: short-term treatment of immediate problems that emerge at different points in a person's life cycle, rather than long-term treatment for underlying problems that aren't readily apparent" (p. A13). Therapists must search for techniques and interventions which will quickly engage the patient and reveal important diagnostic information.

This article explores the use of the amusement park technique in group art psychotherapy with dually diagnosed inpatients. This particular technique has been utilized for the past 5 years as part of an art therapy program in a 40-bed inpatient psychiatric center, which functions within a milieu therapy model that includes individual sessions with a psychiatrist, traditional group therapy, art therapy, recreation therapy, substance abuse groups, and a variety of psychoeducational sessions. Patients immediately begin a busy schedule of back-to-back therapy sessions. What a relief it must be for patients who are in crisis to enter a group where they are asked to represent their lives in the form of an amusement park ride or event.

The amusement park technique had frequently been used with the center's adolescent population as a way to understand their interests. When faced with a particularly resistant, young adult community, this technique was used in an effort to engage the patients. The results were quite interesting and very different from the responses of the adolescents. While the adolescents tended to approach the task in a more concrete manner drawing rides they enjoyed, the adults were able to make selections that demonstrated their life struggles. This paper will explore some of the reasons why this technique may be appealing and therapeutic for dually diagnosed patients in general.

The Attraction of the Amusement Park Technique

The amusement park theme has been used most effectively with a higher functioning population. These patients are generally not overtly psychotic and have undergone at least a partial detoxification process. The art therapy session runs for approximately 1 hour and often contains 10 to 15 patients ages 18 and above. The patients sit around tables covered with white mural paper and can choose from a variety of drawing materials. They are instructed to draw an amusement park ride, booth, or event which represents their life. Following the completion of the task, patients are given an opportunity to talk about their artwork and share with the group how the image they created relates to their lives.

Research into the dynamics of drug dependence and dual diagnosis shed further light on the possible conscious and unconscious attractions to the amusement park theme. Richards (1993) notes several commonly accepted theories on dual diagnosis. Among those are the "escape hypothesis of addiction (that individuals use psychoactive substances to avoid certain feelings and thoughts) and the self-medication hypothesis of drug use (that individuals use drugs because of their positive effects on the symptoms of psychopathology) . . ." (p. 38). He also discusses the "stimulus control hypothesis of addiction (that individuals use drugs to increase, decrease, and modulate the level of impinging environmental and internal stimulation) . . ." (p. 38). Richards indicates that each of these theories is relevant in dual diagnosis treatment.

The amusement park theme may provide similar functions to the self-medication phenomenon or the escape hypothesis. Albert-Puleo (1980) states, "Drug abuse can be viewed as a maladaptive way of handling feelings by retreat into euphoric states" (p. 43). A carnival ride or trip to the amusement park for depressed patients may be a perfect opportunity for relief from their overwhelming unhappiness. A similar relief also may come from substances as Fieve (1975) notes. "One of the most common indicators of depression is a growing dependence on alcohol, sleeping medications, and other drugs that may promote momentary relief, at least from the surface anxiety and lack of energy associated with the underlying depression" (p. 98). Schoenborn and Horm's (1993) study on negative moods (defined as depression, loneliness, restlessness, boredom, and upset) found that men who experienced these affective states were three times as likely to be heavy drinkers than those who reported no negative moods (p. 1). The amusement park and its rides may produce effects of relief similar to those brought about by drug or alcohol use.

Through an analysis of dreams, Whitmont (1969) provides another point of view regarding substance use which seems directly relevant to the superficial, thrilling aspects of an amusement park.

> One might assume that most drug addicts and alcoholics are misguided "seekers of the spirit" (alcohol has been called spiritus vini). They are compelled to seek a form of the spirit to be found in the world of Dionysus, the god of renewal through the light from below, from the earth rather than from the heavens, and who signifies necessity to find life and meaning in the ecstasies and terrors, in the beauties and agonies of this concrete world, not merely in the remote, abstract spirit realm as it is commonly understood. (p. 227)

Patients often comment on the attraction to certain rides despite their fears. Similarly, addictive patients will discuss their continual use of substances despite negative consequences or feelings experienced.

Krystal and Raskin (1970) explore "altered states of consciousness," which was originally defined by Ludwig (1966). They correlate these altered states to personality functioning and the need for drugs. Characteristics such as sensory deprivation, overstimulation, as well as ecstatic, hypnotic, and toxic states may serve to defend against unpleasant or undesirable affect. Amusement park rides produce similar effects of overstimulation (by light, speed, sound), sensory deprivation (by darkness), and even hypnotic-like states on repetitive rides. Rides may also provide disorientation that is brief and controlled. Krystal and Raskin (1970) state, "Being freed from the task of orientation to reality is especially likely to be exhilarating when disorientation is temporary and controlled. Disorientation may be used defensively as a block against confrontation or for carrying out a dangerous impulse" (p. 79). The feelings and sensations the amusement park provides are what mentally ill addicts are looking for in their drugs to respond to the symptoms of their mental illness.

Ride Selections as They Relate to Diagnosis and Drugs of Choice

The relationship of the subject to his or her choice of ride seems to be similar to the relationship of the symptoms and the drug(s) of choice. Upon closer examination of particular ride selections, patients were able to describe the way in which their drawings represented their lives. This often included the intimate connections between their psychiatric symptoms and their drugs of choice. While every mural contains a variety of rides, booths, and events, common symbols emerged. Although quantitative data have not yet been researched, this technique has been used for several years with approximately 200 patients. The common symbols were striking, thus prompting this exploration of the relationships between this technique and the dynamics of the mentally ill substance abuser.

For example, patients who draw merry-go-rounds or ferris wheels often state that this image visually represents their cycles of depression and drinking. Sternberg (1980) studied the relationship between addiction and affective disorders, finding statistical correlation between depression and alcohol use.

Many of the patients with Bipolar Disorder who were also addicted drew roller coasters which reflected their status. The ups and downs of the ride also served to represent the highs and lows of the cocaine addict. As one 33-year-old female patient described her manic episodes to the group (Figure 1), she explained that the high points on her roller coaster showed when she used cocaine "to go even higher" to enhance her mania.

Another frequent image as previously mentioned is the ferris wheel. Once again the idea of height comes into play for depressive patients. They reported that the downward movement symbolizes the onset and progress of depression. Dually diagnosed patients will often indicate where they were located on the ride when they began feeling psychiatric symptoms or began using substances. The motion, direction, and speed of the rides play important parts in the personal meaning of each symbol. Patients describe life as speeding out of control, going around and around, or constantly filled with ups and downs. Figure 2 was drawn by a 36-year-old female suffering from Major Depression, Obsessive Compulsive Disorder, and Alcohol Abuse. She described her life as "the ride from hell, speeding out

Figure 1 My life is a roller coaster!

Figure 2 The ride from hell, speeding out of control, without a seatbelt

BEST COPY AVAILABLE

of control, without a seatbelt." She further explained that the lack of a seatbelt represented the loss of family support she experienced due to her alcohol abuse. The patient drew herself moving backwards on the ride, which may be indicative of her lack of engagement in treatment. She was discharged at her own request soon after she drew this picture. The patient returned to the hospital in less than a week following an alcoholic binge.

The Therapeutic Value of the Amusement Park Technique

Patients find common connections to their peers in the amusement park mural. The symbology may serve to connect people with different diagnoses, but similar life paths. Fieve (1975) writes, "Researchers are aware of the resemblance of acute alcoholic episodes to manic-depressive moodswings" (p. 114). When both patients draw roller coasters (Figures 1 and 2), they begin to see that although their problems may be individual, they feel support in knowing they are not alone in their struggle. Patients find a variety of amusement park events which lend themselves to self-expression. These have included the above-mentioned rides as well as clowns, water slides, hot-air balloons, food stands, games of chance, and even "freak shows." Further examination of these images suggests similar relationships between the patients' substance abuse and their psychiatric illness. One thing remains clear: Each selection seems to have very relevant and personal meaning to the patient.

When verbally processing the mural, patients appear to easily relate to one another's drawings and life situations especially when several roller coasters, ferris wheels, and merry-go-rounds have been drawn. Patients find common bonds when discussing this ride called life. Yalom (1975) in his study of curative factors in group therapy discusses this concept of universality:

> In the therapy group, especially in the early stages, the disconfirmation of their feelings of uniqueness is a powerful source of relief. After hearing other members disclose concerns similar to their own, patients report feeling more in touch with the world and describe the process as a "welcome to the human race" experience. Simply put, the phenomenon finds experience in the cliche "we're all in the same boat . . ." (p. 8).

The amusement park technique appears to offer a nonthreatening avenue for patients to express their feelings. This is especially helpful to the mentally ill addict. Albert-Puleo (1980) writes, "Drug addicts unaccustomed to tolerating emotions, let alone talking about them, are initially threatened at the prospect of verbalizing feelings. Art expression thus provides a safe step toward the eventual goal of verbal discharge" (p. 48). The artwork also serves as a concrete way for substance abusers to connect their drug use with affect. Patients use their artwork as a means of self-expression of pain, at the same time patients receive support from fellow group members. Figure 3 represents a roller coaster on fire. It was drawn by a 32-year-old man diagnosed with Major Depression and Alcohol and Drug Dependence. The patient explained to the group that he had not felt anything for 20 years because whenever any feelings arose, he would use substances. When the group confronted the patient on the possible anger expressed by the fire, he agreed that it represented years of "rage." He also explained that the higher he gets the more he gets burned but he just keeps getting high. He told the group that although the ride (which symbolized his alcohol and drug use) was extremely dangerous, that was part of the appeal or "thrill" for him.

Patients often share their feelings of being overwhelmed, frustrated, or hopeless about not being able to get off the ride. For some patients stopping the ride or reaching the end of the line may indicate suicidality. Figure 4 was drawn by a 35-year-old male suffering from Major Depression and Alcohol Dependence. He related his life of depression, drinking, and bouts with suicidal feelings to the ferris wheel. He explained to the group that he just wanted to get off the ride and go to another part of the park where he could live happily with his children. The patient represented himself at the bottom of the ferris wheel with little hope of ever getting off the ride. However, the patient explained to the group that when he began feeling suicidal, he had voluntarily admitted himself to the hospital hoping to develop some new coping skills.

This technique frequently elicits discussions about feelings of powerlessness—that someone or something is controlling the ride. For those involved in 12-step programs such as Narcotics Anonymous (1982), this experience provides a visual way of looking at the first step which states, "We admitted we were power-

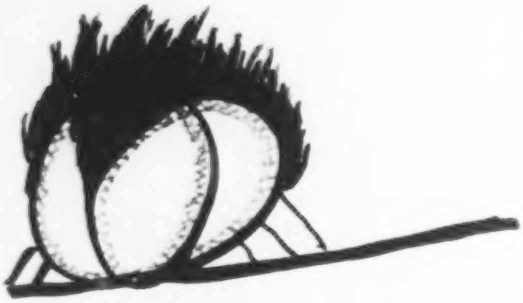


Figure 3 A roller coaster on fire

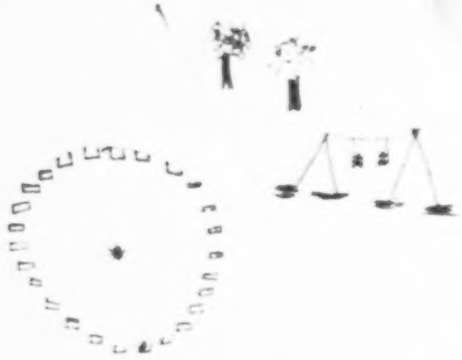


Figure 4 No way to get off the ride

less over our addiction, that our lives had become unmanageable" (p. 19). This idea is supported by Potocek and Nichols-Wilder (1989) who write, "Art and movement interventions are one way of interpreting the Twelve Steps and practicing their applications" (p. 103).

Another therapeutic aspect of the amusement park theme evolves from the patients' perceptions and verbalizations about where they are located on the ride. As previously shown by Figure 2, the location or direction in which the patient is moving can have prognostic value. For example in Figure 5, a 37-year-old male with Major Depression and Alcohol Abuse (not active) reported being at one point (at the bottom of the ferris wheel) at the time of admission, but during group several days later, he was feeling hopeful. The patient shared his aftercare plans with the group including continuing therapy for his depression and active participation in Alcoholics Anonymous meetings to maintain his sobriety. The patient now saw himself as moving uphill.

Patients perceiving themselves at different points on the ride may be valuable in the treatment process. Yalom (1975) writes about "instillation of hope," which occurs when patients have contact with others who have improved and are able to share how they have successfully coped with their problems. The artwork serves as visual reinforcement that patients can see themselves at better points in their lives. Yalom's theory on altruism or the importance of giving in therapy also is reflected in this task. One alternative technique which can be utilized to promote instillation of hope and altruism is for patients to be instructed to provide suggestions for how peers can get off their rides or deal with their problems by relating their past successes. In a group where the patients are cohesive and comfortable with one another, patients can even draw solutions (for themselves or others), finding ways to deal with their rides and symbolically ending the negative cycles. Interesting discussions can also be stimulated by asking questions about which rides or booths group members would like to visit and why.

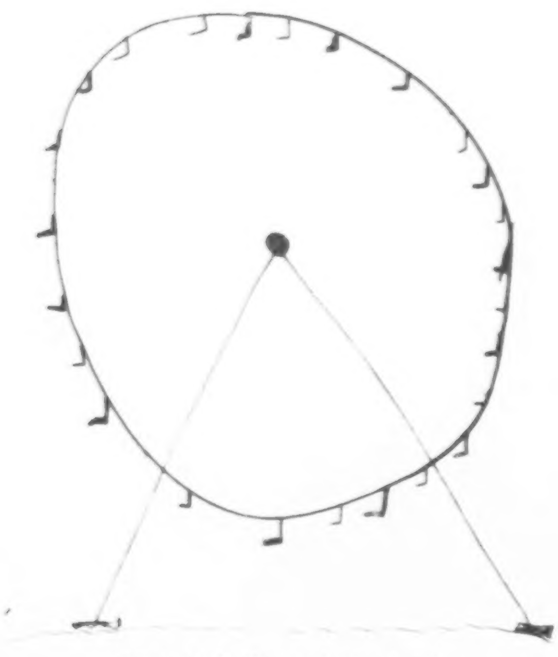


Figure 5 My life is a ferris wheel

Conclusion

The amusement park technique has proven to be a valuable and creative intervention in the treatment of psychiatric patients, especially those struggling with addictions. As Farrelly and Joseph (1991) warn, "Preparing to manage continuing increases in utilization of psychiatric emergency services, particularly in a climate of increasing fiscal constraint, will demand the most creative use of all potential resources at our disposal" (p. 137). Potentially, this technique can provide valuable diagnostic and prognostic information. It seems to quickly engage patients, even those demonstrating resistance to therapy. The group mural also provides therapeutic value both in the process and in the imagery created. Although this article focused on an inpatient, adult psychiatric population, the same technique has been utilized successfully with detoxification and adolescent psychiatry units. The amusement park technique, though simple in presentation, offers promise and versatility in its applications to individual, group, and family art psychotherapy.

References

Albert-Puleo, N. (1980). Modern psychoanalytic art therapy and its application to drug abuse. *The Arts in Psychotherapy, 7,* 43-52.

Collins, H., & Uhlman, M. (1995, February 5). The new world of mental health. *The Philadelphia Inquirer*, A1, A12, A13.

Farrelly, J., & Joseph, A. (1991). Expressive therapies in a crisis intervention service. *The Arts in Psychotherapy, 18*(2), 131-137.

Fieve, R. R., (1975). *Moodswing, the third revolution in psychiatry.* New York: William Morrow and Company.

Krystal, H., & Raskin, H. (1970). *Drug dependence: The disturbances in personality functioning that create the need for drugs.* Northvale, NJ: Jason Aronson.

Ludwig, A. (1966). Altered states of consciousness. *Archives of General Psychiatry, 15,* 225-234.

Narcotics anonymous (5th ed.). (1982). Van Nuys, CA: World Service Office.

Potocek, J., & Nichols-Wilder, V. (1989). Art/movement psychotherapy in the treatment of the chemically dependent patient. *The Arts in Psychotherapy, 16*(2), 99-103.

Richards, H. J. (1993). *Therapy of the substance abuse syndromes.* Northvale, NJ: Jason Aronson.

Schoenborn, C. A., & Horm, J. (1993). Negative moods as correlates of smoking and heavier drinking: Implications for health promotion. *Advance Data, 236,* 1-13. Vital and Health Statistics of the Center for Disease Control and Prevention/National Center for Health Statistics.

Sternberg, D. E. (1989). Dual diagnosis: Addiction and affective disorders. *The Psychiatric Hospital, 20*(2), 71-77.

Whitmont, E. C. (1969). *The symbolic quest.* New Jersey: Princeton University Press.

Yalom, I. D. (1975). *Curative factors in the theory and practice of group psychotherapy.* New York: Basic Books.

Painting as Language for a Stroke Patient

Shulamit Carmi, BA, and Tonni Mashiah, MD, Gedera, Israel

Abstract

Stroke patients experience physical, emotional, and social difficulties during various stages of the rehabilitation process. Use of painting as a means of self-expression can help by providing an outlet for the release of emotions that the patient can no longer hold inside. A series of paintings by N., a stroke patient, offers a clear demonstration of the artistic process as a vehicle for airing feelings of anger, yearning, loneliness, and the desire to make contact. As the only Arab patient in a Jewish hospital, N. used symbols that developed out of his experiences of a culture that was foreign to him. His paintings offer a striking example of the integrative role that art can play in the recognition and organization of the internal conflicts experienced by the patient.

Introduction

Stroke patients, especially those who become hemiplegic, suffer from a disturbed sense of body image, which in turn can threaten their emotional stability. This is often aggravated by stroke-produced speech impairment affecting communication at times when self-reliance is lost and the patient is dependent on others. Therefore, the treatment of the psychological and social needs of the elderly stroke patient poses a great challenge to the rehabilitation team and requires cooperation between its members and the patient. It is surprising to find that art therapy has rarely been applied to the rehabilitative treatment of stroke patients, as evidenced by the scant literature on the subject (Adsit & Lee, 1986; Weinberg, 1985). This is especially odd since in patients with chronic, disabling, or even terminal diseases, art is a valuable tool both diagnostically and therapeutically (Rosin, Matz, & Carmi, 1977).

The diagnostic, emotional, and rehabilitative value of art therapy with stroke patients was stressed by Field (1976), who also discussed the recovery of physically impaired limbs and bodies. The focus of treatment is on helping the individual gain maximum autonomy within the boundaries of his or her disability. Furthermore, the artwork itself helps to reveal the patient's manipulative abilities as well as his or her emotional state and self-image. These factors can be indicative of the patient's diagnosis and prognosis.

The Patient

N., male, age 57, divorced father of four, carpenter by profession, had a stoke with a right hemiplegia and with a slight motor impairment of speech (dysarthria). His cognitive state was good; however, in addition to the stroke, his emotional state was confounded by several factors. A dominant issue was his national and religious identity. He was born and had lived in Akko, an enclosed fishing port on the Mediterranean famous for its Crusader fortifications and buildings, with a mixed Jewish and Arabic population. N.'s mother was Jewish and his father was Arabic. Since Jewish religion is matrilineal and Moslem religion is patrilineal, N. is considered Jewish by Jews, whereas by Islamic laws, he is a Moslem. N. was raised and educated as an Arab, his wife and children were Arabs, and he had spent most of his life in Arab society. Suddenly he found himself in this hospital as the only Arab patient among Jewish patients and staff.

Another problem was his family life. Several years ago, he divorced his wife, quarreled with his children, and was forced to leave Akko. He relocated to Jaffa, another picturesque biblical port (from here Jonah escaped to meet the whale) near Tel-Aviv, also with a large, mixed Jewish-Arab population. In his new home he suffered the stroke. During his stay no family member ever visited him. A third issue that added to his confusion was his eviction, a consequence of failure to pay his rent, so that during hospitalization he became homeless.

The Paintings

During his hospitalization and rehabilitation, N. was a prolific painter. Through his paintings he confronted his memories and feelings and thus provided him with a way to rehabilitate his hurt self.

When he first came to the therapy room in his wheelchair and saw the painting materials on the table, he informed us that he was a painter and had painted in his childhood. For this reason we suggested he return to painting and he agreed immediately. Since that day N. came daily, on his own initiative, to the therapy room and spent many hours painting with his nondominant left hand. Having considered himself a painter, his self-perception had now changed. He always had subjects to paint; therefore, it was decided not to intervene in his work. He was reluctant to answer questions and spoke very sparingly.

N.'s paintings can be divided into four main groups, each reflecting his experiences during one particular stage of his hospital stay. They relate the issues and emotions with which he was grappling: his background and national identity, loneliness and the desire to make contact, anger and conflicts, and yearning for home and independence. These topics are discussed in the chronological order in which they affected N.

Background and the Issue of National Identity

N.'s first paintings were disorganized—stains of paint separated by empty white spaces, which attested to the difficulty he experienced in controlling the paintbrush in his left hand. His

BEST COPY AVAILABLE

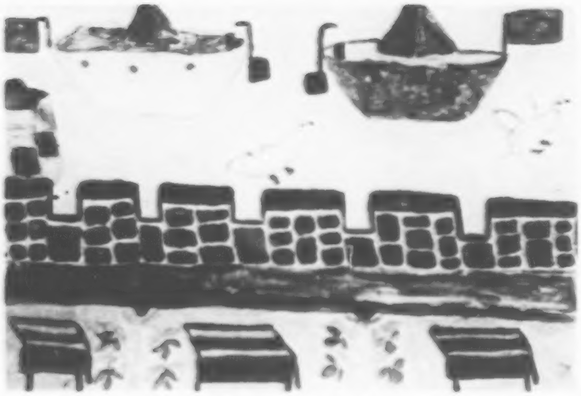


Figure 1 Akko, the city of N.'s birth

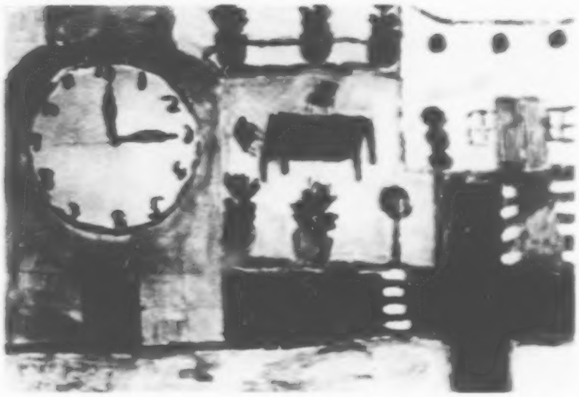


Figure 2 Jaffa

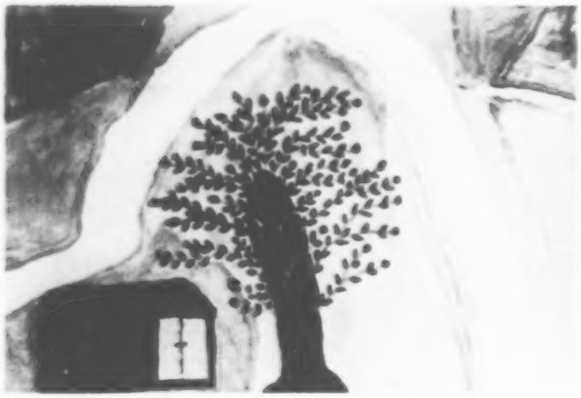


Figure 3 Phallic Tree

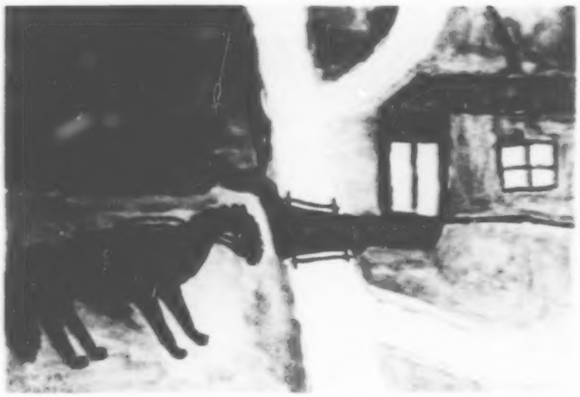


Figure 4 Loneliness

control of the brush improved quickly, and through his paintings, N. began to tell the story of his life.

In Figure 1, he painted Akko, the city where he was born—the city wall, a public garden, boats with Israeli flags, and, in his words, doves of peace. In figure 2, we see his present place of residence, Jaffa, with the clock tower that is the symbol of the city. The clock is always painted in yellow, the color of hope according to N., as time carries a promise. In this picture we see the first allusion to the issue of "home," an issue that was to occupy him a great deal during the long months of creativity ahead. There is a traffic light and a crosswalk in the background, and a table and chairs set up in the middle of the street. The inference is clear—he has no home. In another picture he paints a table under the sky, set for the Passover Seder.

As the only Arab in the hospital, N. felt that he was different and perhaps felt somewhat discriminated against. To be "different" may mean simply to be different from others in some way. Sometimes both sides recognize the difference, and this recognition can affect the way they relate to each other. Now that he was hospitalized, he was completely dependent on Jews. He adopted Jewish religious phrases such as *Baruch Hashem* (Bless God) and *Be-ezrat Hashem* (So help me God) and tried very hard to win the favor of his benefactors.

One of his paintings shows a patient wearing a black skullcap, as worn by observant Jews. The logo of *Kupat Holim*, the Israeli Sick Fund, is visible on the blanket. There is a nurse standing at the head of the bed, her posture lordly and masterful. This is the first hint of the conflicts that have developed between N. and the nurses during his hospitalization and of arguments that have infuriated him, which he mentioned in the therapy room. These were clearly expressed in his paintings.

Loneliness and the Desire to Make Contact

As N.'s physical state improved, he asked the social worker whether he could marry again. Figure 3 is an example of his paintings during this stage, characterized by the presence of a phallic shaped tree surrounded by a river which flowed in a breastlike curve. In Figure 4, we can see that loneliness preoccupied his thoughts. The painting shows a lonely horse, without a rider, retreating from the hurdle that prevents him from reaching home. As a symbol, the horse ranks high in terms of closeness to man (Cooper, 1992, p. 130). The horse serves as a mount for kings, noblemen, and warriors. N.'s horse, however, with its terrified, startled, somewhat withdrawn expression, is not the proud mount of a king. This horse may represent the fear of shriveling manhood and N.'s lack of confidence in his sexual function.

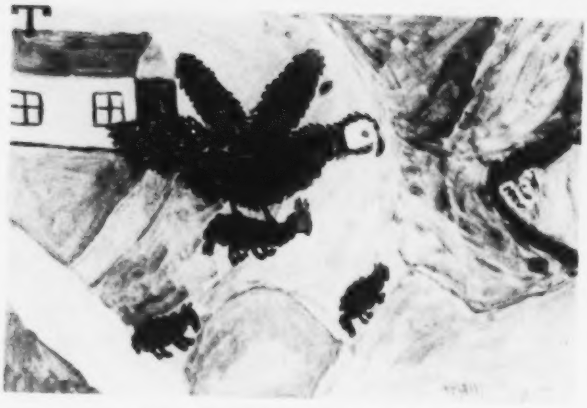


Figure 5 Eagle preying on a hare

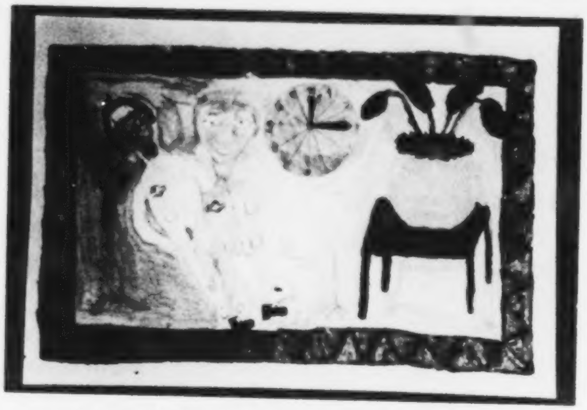


Figure 6 Progress toward independence

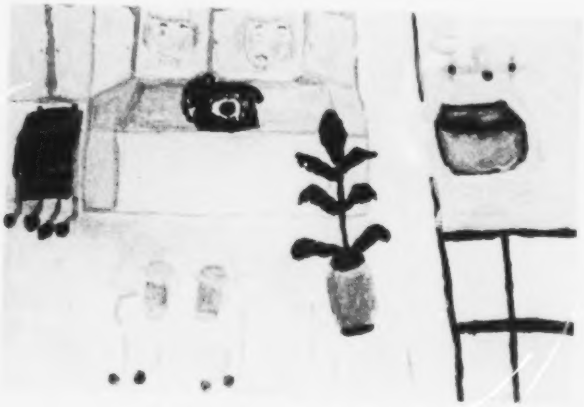


Figure 7 The nurses' station

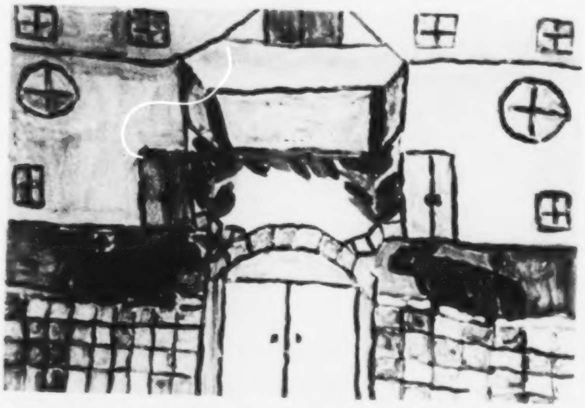


Figure 8 "House belonging to rich people"

Another painting shows a yard with a swing and a little swimming pool. We noted the absence of people in the picture and asked him about it. His irritated response was, "They aren't necessary!"

During this stage N. dealt with feelings of loneliness and abandonment. Although he spoke negatively about his family, his separation from them during the period of his hospitalization contributed to his loneliness. Grappling with these traumas made the integration of the damaged self possible.

Anger and Conflicts

N.'s condition continued to improve; he progressed from using a wheelchair to walking supported with a tripod cane. He walked around the ward and listened in on conversations among the nurses, a pastime that led to a number of misunderstandings. He painted Figure 5 following an argument he had with a member of the staff. When asked what the painting portrayed, N. answered, "It is an eagle preying on a hare. A strong, powerful animal attacks a small and weak one."

Figure 6 shows his progress toward independence. . . . In the picture we see him walking, supported by a cane, on the arm of a pale and ugly nurse. The nurse, who is supposed to be supporting him, falls down—she is unreliable. A clock is painted in the center of the painting—sign of passing time (see also Figure 2). The images are surrounded by a sawtooth frame.

The process for "working through" trauma includes eliminating the sense of denial, ventilation of fear, release of rage against the bodily assault, and mourning where loss is involved (Landgarten, 1981, p. 335). N. was dealing with the changes in his body image, namely his restricted mobility and impaired speech. Following an argument N. said, "A nurse should be like an angel to the patient." Figure 7 portrays the nurses' station. The ward is painted in pale, gray colors, in contrast to the bright colors that characterize most of his paintings. (It is noteworthy that he uses these pale colors every time he painted the ward.) The nurses, again portrayed as ugly and pale, are fading in the background. The most conspicuous object in the painting is the telephone—a tool of communication and the link with the outside world, and a plant in a pot. N. paints plants and flowers, which are sometimes symbols of death and resurrection and of the force of life (Cooper, 1978). Another painting depicts the ward's dining room and the nurse's aide who serves the food. The attendant has been painted with great care—she is wearing a yellow smock and her expression is friendly. Although she stands next to the trolley, she serves no food; the wagon is closed. There are no patients in the dining room.

BEST COPY AVAILABLE

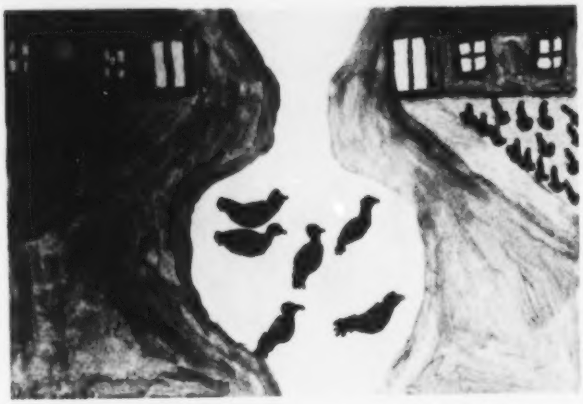


Figure 9 Small, pleasant, colorful homes

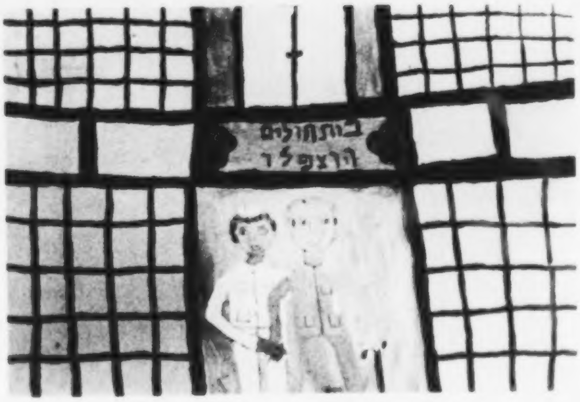


Figure 10 Leaving the hospital

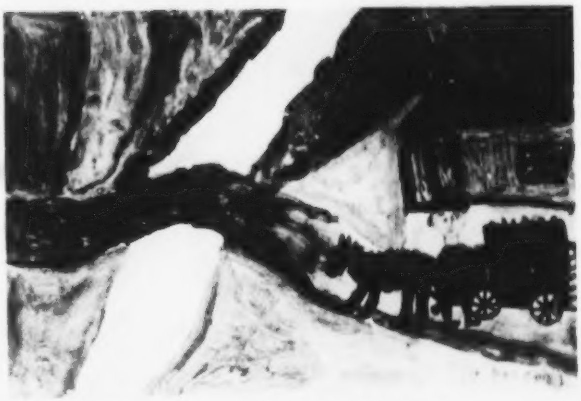


Figure 11 "Someone in the village"

Yearning for Home and Independence

As his condition continued to improve, his yearnings for home and for independence grew stronger. At this stage N. painted pictures of "beautiful houses." Discussing Figure 8 he said, "This is not my house. It belongs to rich people. I will not have a house like this." The houses are large and fenced in, the gates are locked shut, and sometimes there are large animals standing guard. These houses are reminiscent of villas of wealthy Arabs, with the courtyards enclosed by high walls. Everything is locked and sealed; there is no way for N. to enter.

In mythological paintings, two imaginary beasts are sometimes depicted guarding the Tree of Life or other riches (Cooper, 1978). N.'s treasure is the house, but it is inaccessible to him, being protected by the monsters. Following the series of large villas come rows of small, pleasant colorful houses in a variety of settings, including gardens and fields (Figure 9). N. has acknowledged that he would like living in one of these homes, but these houses are also closed. There is a wonderful light shining through the closed windows. The passage to these houses is convoluted and fraught with obstacles; in most cases there is no path leading to the door. Despite these apparently negative aspects, the paintings are optimistic. Vegetation and birds abound, and there are ducks and boats in the water.

As the time of N.'s discharge neared, difficulties arose which delayed his leaving the hospital. He painted three very poignant paintings in which he showed his home moving off into the distance until it disappeared, until finally there was no house at all. After these paintings came a series of pictures of strange, unreal houses set among stones and tree trunks.

On the day N. happily reported that his discharge was imminent, he painted himself leaving the hospital, leaning on a tripod cane. A nurse, standing erect, is embracing him. The hospital, with barred windows like a jail, is painted in yellow, the color that symbolized hope for N. He and the nurse step out of the building and step out of the painting as well (Figure 10). The next painting (Figure 11) was painted after some time had passed. N. was still in the hospital, but informed me that he would be leaving soon. The painting shows a man loading suitcases onto a wagon harnessed to a horse. "Who is the man?" I asked. N. replied, "Someone in the village." The horse is about to pass a bridge to a new life. The river is an obstacle but at the same time a source of life and appears in many of N.'s paintings.

After his discharge from the hospital, N. moved to an Arab neighborhood in Jaffa and returned to the Arab community. His house was decorated with Arabic verse, and he lived in harmony with his new neighbors. The first picture he painted in his new home was of a large boat. There was an important new detail added to the picture—a bridge from the boat to the shore. The wandering boat traveler is now safely upon land. In the foreground, on the shore, there is a house. It is the same house that appeared in his earlier paintings, with the light shining through the windows.

Conclusion

During his stay in the hospital, N. painted approximately 50 pictures. While his paintings dealt with a variety of different issues, the "home" motif was the thread that ran through all of his work, from his earliest creations to the last picture he painted before leaving the hospital. Yaretzky, Lif-Kimchi, and Levinson (1994) describe group work in art therapy with "The Home" as the central theme in the life of hospitalized persons. This is especially true if "home" is not necessarily the place to which the patient will return.

BEST COPY AVAILABLE

The emotional state of the stroke patient, whose motor speech impediment hampers communication, can be deduced from analyzing the elements in the paintings. The motifs in N.'s pictures are characteristic of paintings by other patients in a similar physical condition. What made N. unique was the continuity in his paintings. This progression turned painting into a language that replaced speech to serve as a means for spontaneous expression. The painting became an integral part of the process of his rehabilitation and return to the community.

References

Adsit, P. A., & Lee, J. (1986). The use of art in stroke group therapy. *Rehabilitation Nursing, 11*(6), 18-9.

Cooper, J. C. (1978). *An illustrated encyclopedia of traditional symbols.* London: Thames and Hudson.

Cooper, J. C. (1992). *Symbolic and mythological animals.* London: Aquarian-Thorsons.

Field, J. (1976). Art therapy in a neurological hospital in London. *American Journal of Art Therapy, 15*(4), 99-103.

Landgarten, H. (1981). *Clinical art therapy: A comprehensive guide.* New York: Brunner-Mazel.

Rosin, A., Matz, E., & Carmi S. (1977). How painting can be used as a clinical tool. *Geriatrics, 32*(1), 41-46.

Weinberg, D. J. (1985). The potential of rehabilitative computer art therapy for the quadriplegic, cerebral vascular accident and brain trauma patient. *Art Therapy: Journal of the American Art Therapy Association, 2,* 66-72.

Yaretzky, A., Lif-Kimchi, O., & Levinson, M. (1994). Group processing with clay and its role in geriatric rehabilitation. *Therapy Through the Arts: The Journal of the Israeli Association of Creative and Expressive Therapies, 1*(3), 59-68. [In Hebrew. Abstract in English]

Art Therapy: Journal of the American Art Therapy Association invites submissions to a special issue on:

ART THERAPY WITH PEOPLE WITH SEVERE MENTAL ILLNESS

Art Therapy is seeking full-length articles, brief reports, viewpoints, book reviews, and video reviews for a special issue devoted to art therapy with people with serious psychiatric disabilities, including schizophrenia and the mood disorders of manic depression and major depression. Submissions may focus on, but are not limited to, the use of art expression in settings such as psychiatric hospitals, day treatment, community programs, club houses, and client-run organizations. In addition to art therapeutic applications, articles may address related issues such as the relationship between creativity and mental illness, and the relevance of art therapy to disability culture, advocacy, and the concept of recovery.

Deadline for submission is August 1, 1997. Please refer to the "Guidelines for Submissions" at the end of this journal for specific requirements regarding style and format. Submissions that do not adhere to these guidelines will be returned to authors without review. Please send submissions to: AATA Journal, Attn: Susan Spaniol/ Associate Editor, 1202 Allanson Road, Mundelein, Illinois 60060.

Viewpoints

Considerations for the Treatment of Children with Gender Identity Disorder

Audrey E. Bergin, MA, ATR, and **Mary Ann Niclas, LCSW-C,** Timonium, MD

Introduction

The treatment of children with Gender Identity Disorder is laden with extremely important ethical and moral considerations. As therapists, we understand that any treatment of behavior outside the bounds of a culture's expectations must be approached with caution and with a thorough understanding of the culture in which it occurs. However, this diagnosis, because it is additionally burdened by society's gender expectations and by our own gender and resultant expectations, requires even more care. It is of paramount importance that we clarify our own biases and expectations of gender-based behavior before attempting treatment of children with Gender Identity Disorder. The children deserve no less.

Cultural Considerations of Gender

Gender-typed behavior, as all behavior deemed appropriate or inappropriate, is defined by culture. Therefore, it cannot be universally described and attempts to do so have failed (Luria & Jacklin, 1993). Since norms are set by each culture, they grow and evolve with their culture. Our culture's approach to gender-based behavior has evolved to the point of a question rather than an answer: "What is gender-appropriate or gender-normal behavior?" And, so far, we have been unable to quantify an answer.

Work by Luria and Jacklin (1993) showed that only a minority of the grade school children studied were behaving the way our society expects, based on their gender. This clearly illustrates that our expectations of appropriate behavior of boys versus that of girls is based on stereotypes and not on reality. However, it must be noted that stereotypes create cultural expectations—they put pressure on children to conform and they put pressure on adults to define divergent behaviors not as harmlessly different but as potentially harmfully aberrant.

A rather extreme example of cultural gender-based differences is described in Herdt's (1987) study of the semen-eating cultures of New Guinea, such as Sambia. In these cultures, prepubescent boys are housed with older men. The boys' male partners repeatedly feed them semen through the act of fellatio. They believe that the semen has growth-giving powers necessary for a boy to become a man. Once fully grown, the young man leaves the house ready for a heterosexual marriage. "These cultures lack any word for homosexuality . . ." (Luria & Jacklin, 1993, p. 547).

This ritual is considered a normal, healthy, and necessary route to manhood within its culture. In our culture it would be considered deviant and abusive. This clearly illustrates that normal sexual and gendered behavior is defined by culture, not by biology. So too is the diagnosis of Gender Identity Disorder.

However, it is not just culture which defines, as well as impedes, this diagnosis and treatment. It is our individual gender and expectations as well. Unlike other aspects of a client's personal therapeutic issues, such as a history of abuse, socioeconomic status, marital status, race, and religion, gender cannot be filtered out of a pool of available therapists. There are no androgynous therapists who could truly treat gender-related issues objectively.

In addition, in our culture male traits have dictated what is considered the norm, and it is on this foundation that the diagnostic criteria of Gender Identity Disorder is based. Travis (1992) discusses research in the field of psychology which describes differences between men and women. She describes the literary point of view that men value their work efforts more than women, implying that there is something wrong with women. Travis asks why it is not stated that men overvalue their work compared to women. According to Luria and Jacklin (1993), Western philosophies tend to polarize differences, giving one side positive value and the other side negative value. There is an unspoken message which accompanies our culture that categorizes differences into polarities of good and bad, superior and inferior, normal and abnormal, and when we make a diagnosis we go through the same process. Rather than accept deviations from the norm, we tend to classify them as unhealthy. Due to the combination of cultural expectations and individual biases, the diagnosis and treatment of Gender Identity Disorder is fraught with pitfalls.

The Question of Treatment

> Imagine that you, as a small boy, find yourself day dreaming not about sexual haisons with girls, but about the opportunity to cuddle with another boy. Pretend that you have no real interest in the opposite gender but find members of your own fascinating. Then try to imagine what would happen were you to communicate this interest to your peers. Their disgust and aversion would create in you a pro-

BEST COPY AVAILABLE

> found shame in the immediate situation because of the sudden impediment to mutuality and shame at yourself for being wrong, defective, disgusting. (Nathanson, 1992, p. 298)

This scenario illuminates the high price society extracts from individuals who deviate from gender expectations. As therapists, it is our job not to add to that price unwittingly. That is why a careful and thorough evaluation of our biases is critical to successfully deal with gender issues. Our individual comfort level with our own sexuality and the clarity we bring to our own definitions of maleness and femaleness ultimately determine how that child is viewed and assessed. That, in turn, drives how the child is diagnosed,which, in turn, drives the treatment plan.

Even the diagnostic criteria can work against our best efforts for objectivity. They are heavily reliant on individual interpretation (e. g., ". . .strong and persistent preferences. . ." ". . .intense desire. . ." ". . .[p]ersistent discomfort. . ." etc.). There are simply no quantifiable measurements for children with Gender Identity Disorder. Therefore, careful consideration needs to be given to the diagnostic criteria. In addition, clinicians' biases will also determine the degree of masculinity or femininity associated with the identified behavior. Since objective measures appear to be lacking, and cultural and individual factors will influence how one defines normal or abnormal, it is particularly important for the therapist to assess the source and nature of the behavior defined as problematic.

The hurdles to an appropriate diagnosis are awesome. Objective, quantifiable measurements are unavailable. Cultural and individual factors greatly influence our ideas of normal and abnormal. But there are practices that can help the therapist overcome those barriers. A thorough assessment of the source, nature, and the context of the behavior helps us better approach and design appropriate treatment.

The following considerations help map out the scope of the behavior, its possible stimuli, and its larger context (Rotheram-Borus & Gwadz, 1993):

- Evaluate the number and types of current and prior sexual behaviors of the child.
- Take a thorough history of any sexual behavior problems.
- Consider possible motivations for the sexual behaviors. Are other children involved? If so, what is the client's relationship to the other child(ren)? Is bribery, trickery, or any type of coercion used? How do(es) the other child(ren) feel regarding the sexual behavior of the child being assessed?
- Review the developmental history of the child. Is there emotional or physical abuse or neglect? Is there sexual abuse?
- Assess the child's school behavior, peer relations, behavior at home and out-of-home activities (day care, recreational programs, and so forth).
- Focus on the collective family history as well as individual history. Specific areas to explore are emotional, physical, or sexual abuse, psychiatric disorders, divorces, incarcerations, and spousal battering.
- Evaluate the emotional and sexual climate in the home.

In addition, it is imperative to assess the child's perception of gender differences and the meaning he or she associates with those differences. For example, does a girl really want to be a

Table 1
Diagnostic Criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

1. repeatedly stated desire to be, or insistence that he or she is, the other sex
2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing
3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex
4. intense desire to participate in the stereotypical games and pastimes of the other sex
5. strong preference of playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as the stated desire to be the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbances manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection or urinating in a sitting position, assertion that she has of will grow a penis, or assertion that she does not want to grow breasts or menstruate, remarked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:

302.6 Gender Identity Disorder in Children
302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):

Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both
Sexually Attracted to Neither

American Psychiatric Association. (1994). Diagnostic & Statistical Manual of Mental Disorders (4th ed.). Washington, DC: Author. pp. 537-538.

boy, or does she desire the societal or familial privileges associated with being a boy?

The therapist must carefully consider the goals of treatment. Clearly one would like to alleviate underlying pschopathology and reduce the child's social ostracism. Examination of one's biases and prejudices is most important at this juncture. If the function of therapy is to help others listen and respond to their true selves, then working to suppress a genuine sexual orientation is not ethical, moral, or therapeutic. How can one be "wrong, defective (or) disgusting" for being honest with oneself?

When treatment begins, we suggest it take place on two different levels: family therapy to address marital conflict or parental psychopathology, and psychotherapy for the child. Meyer and Sohmer (1983) state that children who present with Gender Identity Disorder symptomatology "... very often serve as the vehicle through which parents express their own problems with self-image or sexuality" (p. 161). In fact, Stoller (1972) offers the idea that Gender Identity Disorder is a disturbance that rests not with the individual child but with interpersonal, family dynamics.

The second part of treatment is psychotherapy for the child. This process is difficult to quantify; however, case studies written in a qualitative or descriptive fashion give the impression that children benefit from the therapy ("Gender Identity Disorder and Early Object Loss"). Art therapy and play therapy are recommended modes of treatment because of their symbolic, metaphorical, and nonthreatening nature. Using these modalities, children are able to work through possible issues of abuse or family tension and conflict, all of which may be the underlying dynamics behind Gender Identity Disorder. The following case studies illustrate these concepts.

Case Study 1: Clyde

Clyde is a 10-year-old boy being treated in a residential treatment center for children who are severely emotionally disturbed and dangerous to themselves and others. He is the youngest child of Ms. Morrison. His only brother, Fred, is 16. Clyde was referred for treatment after numerous hospitalizations for aggressive and sexualized behavior as well as suicidal ideation and gestures. Clyde was 1-year-old when his parents separated; both he and his brother continued to live with their mother. According to Clyde's mother, Mr. Morrison was a violent alcoholic and drug abuser. During their years together, Mr. Morrison was reportedly physically, emotionally, and sexually abusive to his wife. Ms. Morrison alluded to being sexually abused as a child by a family member. Her anger at this and at her husband was still fresh; she openly stated that she hated men and feared her sons would grow up to be like their father. Clyde had limited contact with his father. The treatment team suspected that Ms. Morrison used Clyde's numerous hospitalizations in part to hide him from his father since she believed her husband had sexually abused him. In the past, when Mr. Morrison visited Clyde in the hospital, Ms. Morrison removed him from treatment immediately. She also moved her home and refused to provide her new address to staff since she did not want Clyde's father to know where they were living. Ms. Morrison told the staff that if Mr. Morrison exercised his legal rights to visit Clyde, she would remove Clyde from the facility.

Clyde's treatment consisted of individual art therapy and milieu, group, and family therapies. His working diagnosis was Major Depressive Episode with features of Gender Identity Disorder also noted. During the initial family therapy session, Clyde curled up in a fetal position on his mother's lap and babbled baby talk. This was acceptable to Ms. Morrison and even welcomed by her. Fred did not participate in the family sessions. As therapy proceeded, Ms. Morrison revealed that Clyde was dressing in feminine clothing, talking in a girlish voice, and saying that he wanted to be a girl. Although staff never observed any of this behavior, Clyde did admit that he "... would do anything to get [his] mother's attention." The treatment team suspected that Ms. Morrison's active hatred of men, coupled with Clyde's strong desire for her attention, encouraged Clyde's feminine behavior. In addition, his behavior was reinforced by Ms. Morrison's videotaping him when he behaved like a girl. Ms. Morrison said the videotaping was to prove to mental health professionals that Clyde was gender identity disordered. It was the treatment team's opinion that Clyde's need for his mother's attention at almost any cost and the resulting enmeshment of the two, were the source of Clyde's feminine behavior.

Clyde and Ms. Morrison attended weekly family therapy. Initially, the therapist worked to assist Ms. Morrison in encouraging Clyde's age-appropriate behavior, in setting limits on unacceptable behavior, and in developing her own outside interests and friendships as a way of decreasing enmeshment between the two. With support from the family therapist, Ms. Morrison was able to set limits on Clyde's infantile and aggressive behaviors. Also, with that support, she joined a local church group. Soon after, Clyde's baby talk decreased, as did his destructive and sexualized behaviors.

Clyde began individual art therapy concurrent with his family therapy. (The art therapist and the family therapist were different clinicians.) Early in his individual treatment, Clyde drew several family pictures (Figure 1). In these pictures he depicted himself and his mother wearing similar clothing, which appears to be a dress. His older brother is clearly differentiated by his clothes; he is wearing a T-shirt and shorts. A quick analysis of the picture would possibly indicate features of Gender Identity Disorder. However, given the family history and the dynamics of their interactions, it seems to be reflective of Clyde's enmeshment with his mother. It may also suggest Ms. Morrison's projective identification on Clyde due to her past experiences, which only deepened Clyde's sense of enmeshment.

During spontaneous sand tray play, Clyde repeatedly expressed a sense of conflict which seemed symbolic of his family's conflict. For example, Clyde placed a large dragon in the center of the sand tray, dividing it into two sides. The animals that lived on either side were unable to move from one side of the tray to the other because the dragon would attack them if they tried. Similar themes of conflict were seen in his artwork as well.

Since conflict related to family seemed to be a repetitive theme, Clyde was prompted to create a story with pictures about a family of birds. He was given the scenario of a mother bird and two baby birds who were young and could not fly well. The mother bird was worried about the babies and did not want them to fly far because of all the terrible things that could happen to them.

What follows is Clyde's completion of the scenario:

Once upon a time, there was a tree with three little birds in it (Figure 2). One bird was the mother and she had two baby birds. As the babies got older, they began to explore the rest of the tree (Figure 3). The mother bird used to worry about them because she knew there were cats around. The mother bird had a way to protect the babies from cats. She knew of a nearby bush where she could move the babies in order to hide from the cat. Every day the mother bird sees the cat, and knows it is coming. The mother bird tells the babies, and they all fly to the bush (Figure 4). The baby birds are scared. Eventually, the cat quietly climbs up the tree, then suddenly jumps out and grabs one of the baby birds. The baby bird starts flapping its wings as fast as it could. It got free from the cat and flew away. When the cat has the baby bird, the mother comes out and starts pecking at the cat (Figure 5). They all get safely back to their nest. The three birds get together and build a watchtower (Figure 6). The watchtower had everything they need. Overhead a bird patrol flies. The family can call anytime there is a cat nearby. Then the bird patrol takes the cat away. Sometimes the cat comes back, but the family can always call the bird patrol again. Eventually, the cat learns to stay away from the tree. And the bird family lives happily ever after.

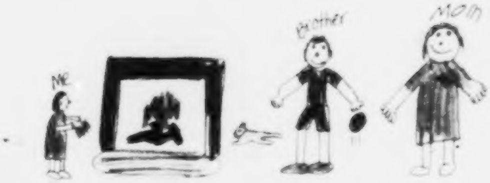


Figure 1 Example of family portrait

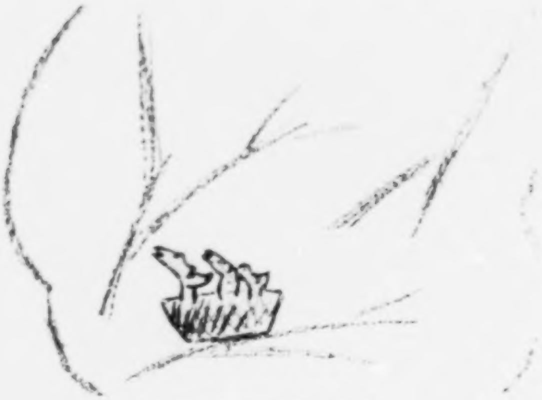


Figure 2 The bird family

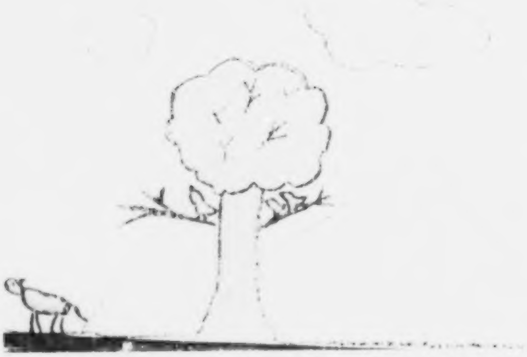


Figure 3 The baby birds explore the tree

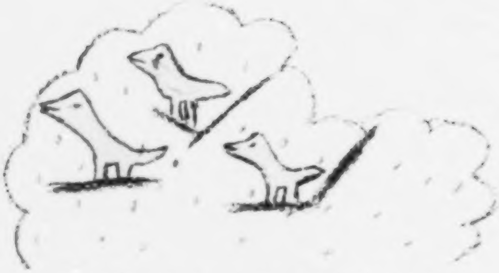


Figure 4 The bush where the family hides

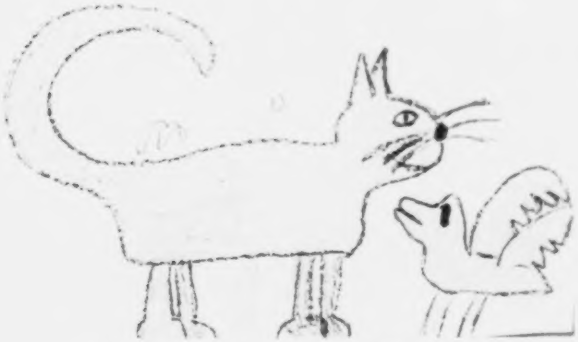


Figure 5 The confrontation with the cat

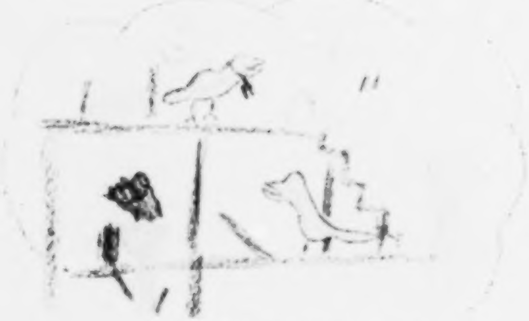


Figure 6 The bird's watchtower

Clyde's story gives a clear picture of his perception of the family dynamics. One could interpret the mother bird's behavior as a metaphor for his own mother's behavior, and her fears concerning Clyde's father. The artwork allowed Clyde to begin experiencing his feelings about his family situation. As a result, his presenting behavior problems decreased significantly over his 3-month stay, and he was discharged home, continuing treatment in outpatient therapy.

Case Study 2: Joe

Joe is a 12-year-old boy being treated in the same residential facility as Clyde. Joe has one younger sister, age 7. Joe's sister lived with a family friend. The children were not able to live with their parents due to the parents' own difficulties. Joe was referred for suicidal ideation, running away, making false abuse allegations, and fighting. In addition, Joe exhibited sexualized behavior such as voyeurism, cross-dressing, and what is typically defined as "feminine behaviors and body language."

Many of Joe's behaviors quickly stabilized upon entering the facility. During his 9-month stay, no suicidal ideation was observed, and there were no episodes of running away or severe aggression. His behaviors were mainly manipulative and characteristic of a boy struggling with gender issues. For example, Joe borrowed a female friend's lipstick and used it secretly. He was also intrigued by a popular female vocalist and had a shrine to her in his room (Figure 7). He emulated her movements and make-up style and desired her wealth and popularity. He attempted to do this privately. He formed a Gay Club with some of the younger boys on his unit and tried to keep it hidden from staff. Lastly, Joe fantasized that a male staff member had a crush on him; Joe stated that he wished the staff person would kiss him on the cheek.

Joe participated in weekly individual and group therapy and monthly family therapy meetings with his mother. In his individual therapy, he was initially very guarded and tried to keep conversations on a superficial level. When this failed, Joe attempted to shift the focus onto the therapist. As Joe began to trust the therapist, he started questioning the changes in his body. Joe and the therapist reviewed books to answer his questions. The books presented the material with a heterosexual orientation. Joe was told that although the book presented boys liking girls and vice versa, some boys like boys and some girls like girls, and that was acceptable. At first Joe questioned the normality of boys liking boys. Given time and reassurance, he was able to accept this possibility. A few weeks later he decided to tell his mother that he was gay. After this, Joe seemed very comfortable with his homosexuality, and the focus of his therapy shifted to helping him cope with society's reactions. The manipulativeness around the behaviors described earlier gradually subsided. Joe's mannerisms became more overt. This was seen as a healthy sign because less energy was going into deception and was instead channeled into self-acceptance.

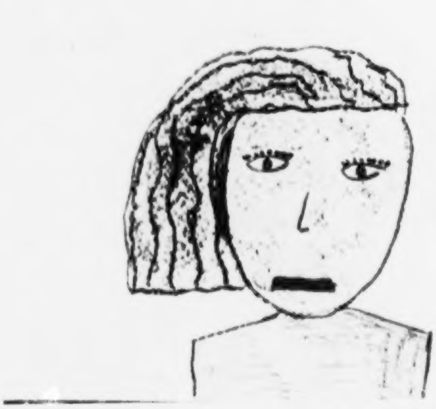


Figure 7 Female vocalist emulated by Joe

Conclusion

There has been much controversy surrounding the diagnosis of children with Gender Identity Disorder. Perhaps this diagnosis has become a replacement diagnosis for that of homosexuality, which was removed from the *Diagnostic and Statistical Manual* in the 1980s. Indeed, even within the homosexual community there is disagreement about "whether this is a problem of sociology or biology or even if it is a problem" (Luria & Jacklin, 1993, p. 552). This debate is on-going in the mental health arena as well.

We have presented a critique of childhood gender-typed behavior and the diagnosis of Gender Identity Disorder itself. Given this, it is our opinion that responsible clinical behavior requires assessing and treating possible underlying causes, such as sexual abuse or family dynamics, when presented with a child who shows possible signs of Gender Identity Disorder. Not to do so could be a violation of one of the basic tenants of ethical treatment—client self-determination. If, on the other hand, the long-term goal of treatment is to prevent homosexuality, the morality of the treatment must be called into question.

References

American Psychiatric Association. (1994). *Diagnostic & statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Gender Identity Disorder and early object loss. Author unknown.

Herdt, G. (1987). *The Sambia: Ritual and gender in New Guinea.* New York: Holt, Rinehart & Winston.

Luria, Z., & Jacklin, C. (1993). Sexuality and gender. *Child and Adolescent Psychiatric Clinics of North America, 2*(3), 543-558.

Meyer, J., & Sohmer, B. (1983). Gender problems in children. *Drug Therapy, 13*, 159-173.

Nathanson, D. (1992). *Shame and pride: Affect, sex, and the birth of the self.* New York: Norton & Company.

Rotheram-Borus, M. J., & Gwadz, M. (1993). Sexuality among youths at high risk. *Child and Adolescent Psychiatric Clinics of North America, 2*(3), 415-449.

Stoller, R. (1972). The bedrock of masculinity and femininity: Bisexuality. *Archives of General Psychiatry, 26*(1), 207-212.

Travis, C. (1992). *The measure of women.* New York: Simon & Schuster.

The Absent Father: Gender Identity Considerations for Art Therapists Working with Adolescent Boys

Martha P. Haeseler, MA, ATR-BC, Guilford, CT

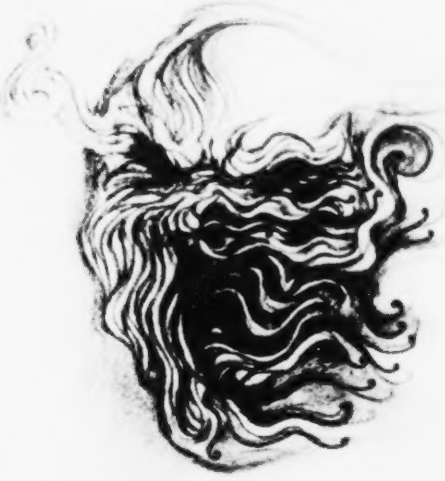


Figure 1 Max: "When women, even women with the best intentions, bring up a boy alone, he may in some way have no male face, or he may have no face at all" (Robert Bly, 1990, p. 17).

Introduction

When 16-year-old Max was admitted to a psychiatric inpatient unit following an overdose of his mother's antidepressant pills, he let me know he was very interested in art and had his mother bring in drawings done since he was 12-years-old. A few of these drawings and works done during his hospitalization are interspersed throughout this article, along with those of other adolescent boys. These drawings illustrate the discussion. Interpretation of the artwork is minimal; salient history helps to illuminate its relevance.

Max

Max, an only child, had not seen or heard from his father since infancy, although he knew his father was remarried and had a daughter. When Max was 5 years old his mother began a 7-year relationship with a young man who had emotional and alcohol problems. Max was deeply attached to him and his family. The psychiatrist's admitting note included, "It seems Max can no longer be the sole support for his mother."

Discussion

The poet Robert Bly (1990) writes, "Twenty to thirty percent of boys now live in houses with no adult male present" (p. 186). For art therapists who work with inner city adolescent boys, this statistic often reaches 100%. Bly says that in contemporary society the image of the male, and the father, is debased and that in the absence of male mentorship boys grow up "soft" (*Ibid.*, p. 4), emotionally numb, and ashamed. Bly says boys need to get in touch with the "Wild Man. . . the positive side of male sexuality" (*Ibid.*, p. 223), to develop their resolve, spontaneity, Kingly and Warrior qualities, and their ability to grieve. According to the psychoanalyst Peter Blos (1962), masculine gender identity formation depends on an identification with the same-sex parent. "Nothing can be accomplished without. . . [the boy's] having come to terms with the father, or rather, with his image or object representation" (*Ibid.*, pp. 156-157). It is interesting that both poet and psychoanalyst, writing 28 years apart, emphasize the importance of the father or male mentor in a boy's life. Additionally, current research has identified that boys from father-absent homes show greater feminine role identification (Kodandaram, 1991), delinquency, mental disorders, poor academic performance (Lewis, 1991), reduction in cognitive and linguistic abilities (Tarantino & Lorichini, 1989), and poor self-esteem (Harper & Ryder, 1986).

What is masculinity? Some define it as "any quality that is felt by its possessor to be masculine" (Stoller, 1985, p. 11). To one teenage boy, long hair is masculine; to another, no hair is masculine. Others (Blos, 1989, pp. 5-6) define masculinity as culturally, more than individually, determined. Rakoff (1989) writes that given the variations in child-rearing in our culture, "a variety of male human sexual behavior . . . [should be considered] normative" (p. 28). Masculinity is associated with gender identity, but separate from sexual preference; a male homosexual may be conventionally masculine.

Are there masculine and feminine characteristics in art? In 1963, Erikson noticed that young boys built towers out of blocks while girls built containers and houses, thereby recapitulating their anatomy (p. 106). Despite subsequent feminist influences on child-rearing practices, and despite the changing roles of men and women since 1963, some gender differences are still easily observable in child art (Silver, 1992; Silver, 1993) and play (Gilligan, 1983, pp. 9-11) (Figure 2). Is the creative process in men partly propelled by a wish to give birth to a baby? (Blos, 1962, p. 63). Can we see the art process itself as embodying both feminine and masculine characteristics—empathy and expressivity combined with forceful action? Do we not all contain the masculine and feminine within us, the animus and anima?

BEST COPY AVAILABLE

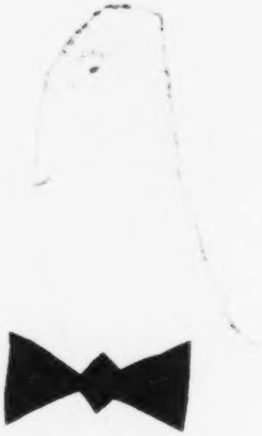


Figure 2 Adolescent boys often draw thinly disguised phalluses: "My Thumb."

How is masculinity developed? Biologically, "the 'resting state' of tissue is female" (Stoller, 1985, p. 74) unless given a hormonal push in utero by androgens to differentiate into maleness. In the psychoanalytic model, the boy baby, when in symbiosis with the mother, identifies with her. Stoller (1985) writes that "for masculinity to develop, each infant must erect intrapsychic barriers that ward off the desire to maintain the blissful sense of being one with mother" (p. 182). These protective barriers contain "fear of female anatomy; envy and resultant derision of women; fear of entering their bodies; fear of intimacy. . .fear of manifesting. . .feminine attributes. . ." (p. 182), all characteristics of what we have come to know as homophobia. Many writers emphasize the importance of the father as "a vital part of the separation-individuation process" (Blos, 1989, p. 10). Stoller (1985) writes that the pre-oedipal father "serves as a shield to protect the child against impulses mother might have to prolong the mother-infant symbiosis. . .serves as mother's main support. . . later directly modifies behavior by reward and punishment; . . [and] is a model. . .for identification" (p. 44). Mahler, Pine and Bergman (1975) write that "identification with the father or possibly with an older brother facilitates a rather early beginning of the boy's gender identity" (p. 215). The child's relationship with the father is more in accordance with reality because it is not overladen with a history of symbiotic attachment, as is the relationship with the mother. Bouchard (1985) stresses the importance of the pre-oedipal father in helping the child develop autonomous ego functioning.

In classical psychoanalytic thinking, when the boy enters the oedipal stage he still identifies with the active/phallic mother and turns his libido toward father, wishing to have a baby by him (Blos, 1962, p. 26). This is called the negative oedipal stage (Figure 3). The positive oedipal stage begins when he turns his libido towards mother and competes with father. He then represses these desires, partly due to castration anxiety, accepts the reality principle, forms the superego, and begins an identification with father that is the basis of the ego ideal and helps consolidate the masculine identity. Blos (*Ibid.*) writes that if the oedipal stage is not resolved in this way the boy remains in submission to the phallic mother, who is both desired and feared. The absence of the father during the oedipal stage can hamper the boy's ability to gain a foothold in the reality principle as well as in masculinity. (Max's chief complaint on admission was "reality frightens me.")

Gender identity is thought to be established in most cases in early childhood (Rakoff, 1989). However, as the boy enters adolescence these conflicts around attachment, identification, and sexuality (Figures 4 and 16) are revived, offering him another chance to rework them in a way that results in a gender identity and sexuality that is congruent with sense of self. Rakoff (1989)

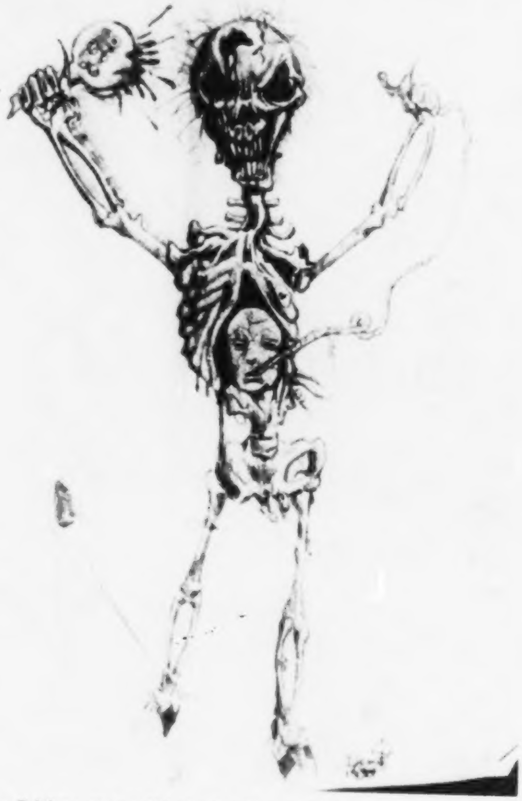


Figure 3 Max drew this just after mother's lover left the family. Max pointed out that the skeleton giving "stillborn" birth is itself a baby holding a rattle. Note the fetuses in the corners. "My mother didn't like this picture."

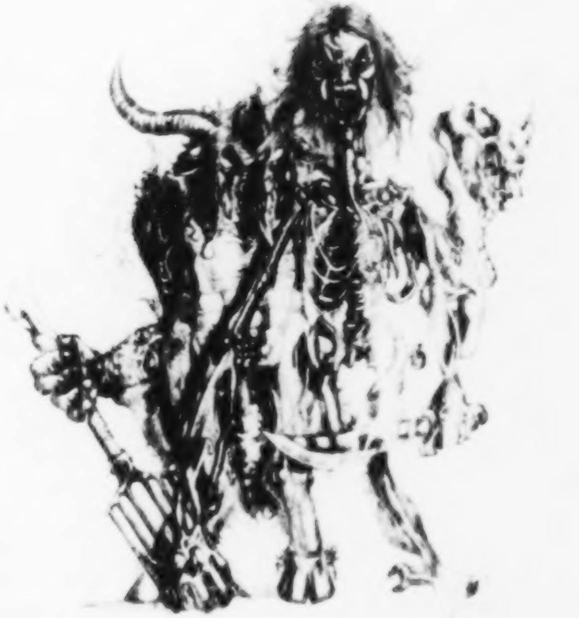


Figure 4 Max: Note that the female half of the merged skeletal figure points a knife at the phallus of the male half.

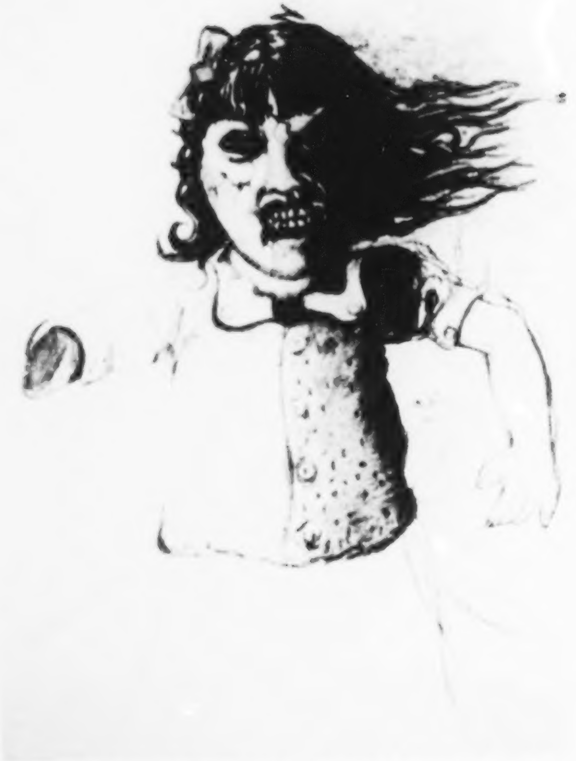


Figure 5 Max: "I have always been afraid of dolls."

writes, "The father in most societies is the bridge from the domain of intimacy, emotional bonding, sexuality—the locus of our 'clothed' experience—to the public culture of duty, the performance principle, the life of political mankind—our clothed experiences" (p. 30). Bly writes that boys must first bond with women, then separate, then bond with men and separate: "... boys need a second birth, this time a birth from men" (p. 16). Blos writes of object hunger for the same-sex parent in adolescence (p. 91); Bly writes of "father-hunger" (p. 94) which women cannot feed.

What if there is no man in the boy's life? Esmen (1989) writes, "It is the intensification of the oedipal and pre-oedipal tie to the mother that makes adolescence so turbulent in father-absent situations—the need aggressively to break away from both the sexual and the dependent attachments that have not been adequately mitigated by a close connection with the father, one that might prepare the boy adequately for his masculine role" (p. 24). (Max said, before discharge, "I guess I'm tied to my mother's apron strings. That's why I've always liked to take off to fantasy-places in my mind.") Blos writes that the central theme of male preadolescence is "castration anxiety in relation to the phallic mother" (p. 64) (Figures 4 and 5). The image of the witch, the vengeful woman warrior, the fearsome goddess Kali, is ubiquitous in mythology, literature, and the artwork of adolescent boys (Figures 6, 7, and 8). Bly writes that "the possessive side of the Great Mother will start its imprisonment" (1990, p. 187) (Figure 9) unless men call the boy's away. The oedipal victor is a Pyrrhic victor; he wins, but he loses. The adolescent boy alone with women must erect massive defenses against their fearfulness (A. Freud, 1966).

Bly writes of the importance of a male mentor for boys, even in father-present families. In many father-absent families, a male relative will emerge who aids in the separation from mother and the development of a masculine identification (Forsyth & Gramling, 1990). Many boys find themselves a mentor outside of

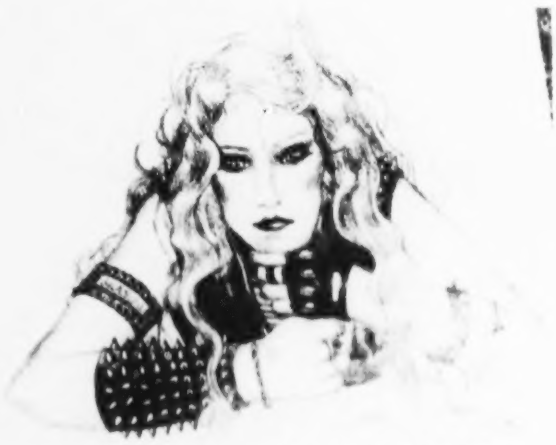


Figure 6 Max: Her armband says "Slayer."

the home, a teacher or even a gang leader. For father-absent boys, a same-sex therapist is often recommended (Moberly, 1986).

Can a female art therapist help these father-absent boys? Is she a second-choice therapist, less effective than a man? Not necessarily. I think a woman can be effective in treating these clients if she is aware of their special needs.

Most importantly, she can be sensitive to the boy's need to establish clear boundaries in the therapeutic alliance. She is careful lest her caretaking instiacts feed the fear of merging. Much has been written about the need for the art therapist to provide a nurturing holding environment, a maternal matrix within which the client can begin to separate/individuate (Lachman-Chapin, 1987; Robbins, 1987). However, as Gilligan writes, "Since masculinity is defined through separation while femininity is defined through attachment, male gender identity is threatened by intimacy . . ." (1982, p. 8), and these boys easily become lost in that empathic sea. Figures 10 and 11, portraits of an art therapy intern drawn only partly in fun, suggest how frightening the artist perceived his attachment to her. (See also Figure 12.) Blos (1962) writes that "the therapist's aim is to replace infantile sharing and merging by identification, or . . . to replace the search for external sources of self-esteem . . . by the discovery of one's own resourcefulness" (p. 228). Transference becomes quickly evident in working with these clients, manifesting itself either as a yearning to return to the symbiotic union, or, more commonly, as

[redacted]

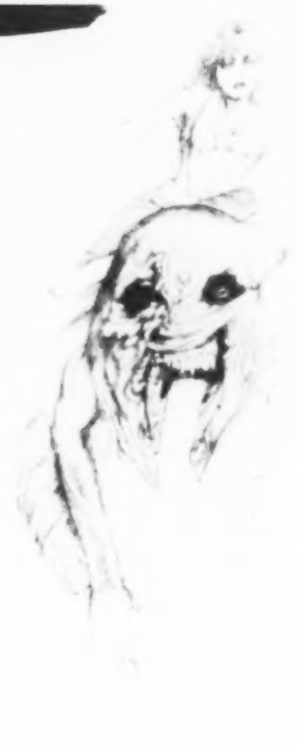


Figure 7 Max: She has no weapons but "the horned monster protects her."

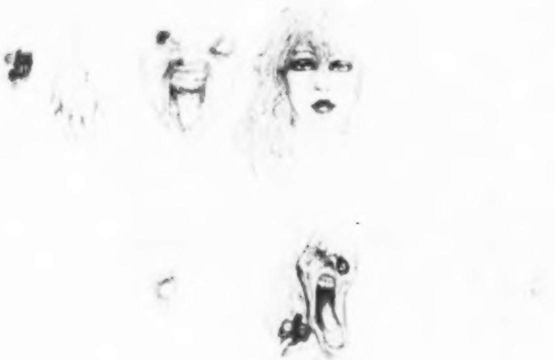


Figure 8 As Max works on drawing a realistic female face and body, the monster/male face seems to be fading away. However, the woman in the bottom becomes masked and then a monster face emerges from her.

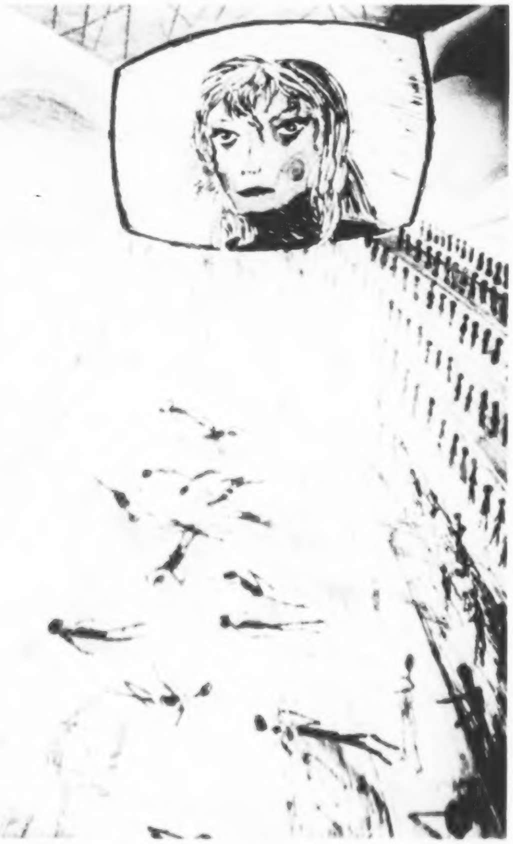


Figure 9 The 16-year-old artist said, "This is a fantasy pleasure chamber. The woman on the huge video is inciting the people to dance faster and faster and they are having so much fun they don't notice that they are beginning to bleed and die."

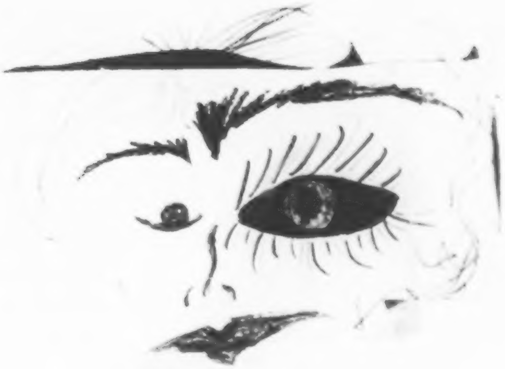


Figure 10 By a 14-year-old. Portrait of the art therapy intern.

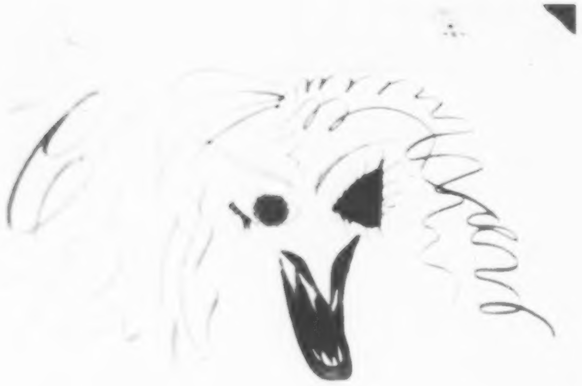


Figure 11 By a 14-year-old. Portrait of the art therapy intern.

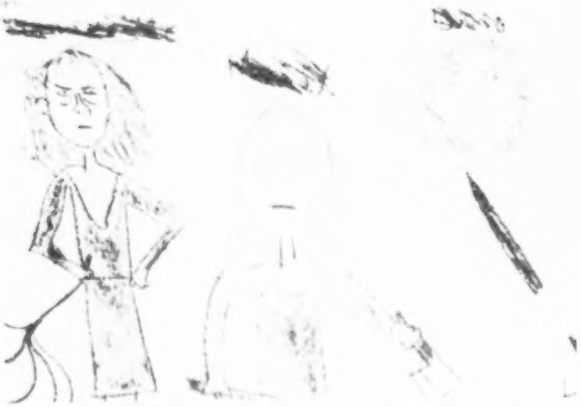


Figure 12 By a 14-year-old. "The nurses are out to get me with their hatchets."

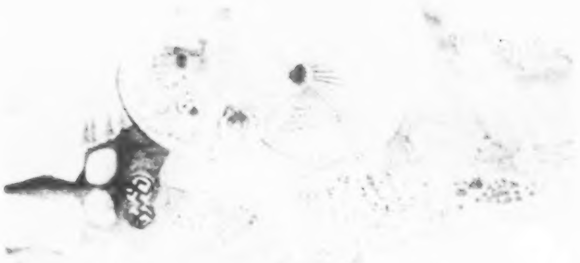


Figure 13 Max: The central portion of this last work reads, "Long ago I wandered through my mind in the land of fairy tales and stories, lost in happyness (sic). I knew no fears. Innocence and love was all I knew. Was an illusion." The sun is coming up over the sleeping village as Max makes a turn from fantasy to reality.

fierce defenses against such regression. The relationship with the art therapist may also be perceived as sexually stimulating. Rather than encouraging or interpreting transference, the art therapist can more fruitfully support adolescent boys in her role as artist, mentor, or teacher, thereby reducing transference and sexual anxiety. It is often useful to see these adolescents in group versus individual sessions. The group can allow distance from the art therapist as needed and provide opportunities to identify with, learn from, and be supported by peers. The art therapist's skill with these boys lies not in interpretation or aiding in the acquisition of insight, but in providing them with the opportunity to experience their own resourcefulness as potent artmakers and experience the sense of mastery and deep assertion of the self and identity that artmaking affords.

What about identification? The adolescent boy can identify with the female art therapist as a practicing artist with no threat to his self-image. Allen (1992) writes that "The opportunity for clients to observe involved art making is in itself therapeutic" (p. 26). In a previous article, I wrote:

> Insofar as I can make my strengths and talents known to adolescents, they can identify with the attributes I possess while clearly seeing me as separate from themselves. They can become comfortable in the mentor/apprentice relationship and, once the roles are clearly defined and psychological distance is established, can make healthy use of the nurturance provided by the therapeutic alliance (Haeseler, 1989, pp. 72-73).

The growing ability to see the art therapist as a real other, separate from himself, introduces into the symbiotic dyad what Ogden (1986) calls "threeness" and helps the boy individuate. He can then identify with the considerable resourcefulness and risk-taking that artmaking requires and with the public role of the artist. The artmaking itself can represent a move from the unclothed intimate world to the clothed public world of action, "the performance principle," and reality (Figure 13).

Chasseguet-Smirgel writes that "the mother's responsibility ... is to bring the child to project his Ego Ideal onto successive and ever more advanced models" (1984, p. 28), encouraging him to admire this father rather than devalue him. The art therapist, alert to these issues, can help the boy celebrate his maleness, This may mean providing materials for large constructions, or stone carving, for example. However, Rakoff (1989) writes, "Should the therapist share the implicit assumption that a valid masculinity is to be expressed only as a fully heterosexual sexual orientation, then the uncertain, troubled adolescent will undoubtedly be given invalidating messages rather than the support and education he requires" (p. 29).

Art therapists who empower these clients as artists can help them gain a foothold in their preferred style of masculine identity and provide the means with which they can express dynamic issues such as father-hunger and fear of the phallic woman, get in touch with grief and anger, search for gender identity and the "male face," discover the Warrior's resolve and spontaneity, and create the Wild Man.

Tim

Fifteen-year-old Tim, hospitalized for a suicide attempt, had come to a standstill, giving up his usual love of sports to sit on his bed and stare into space. Although his parents divorced when he was 5 and his father moved out, Tim had maintained a close relationship with him until 2 years ago when Tim and his mother moved to the United States from their native Caribbean island. Tim had not seen his father since. In Tim's first art therapy group he drew himself as "a half a person; that's how I feel" (Figure 14).

Other artwork illustrates issues of father hunger (Figure 15), gender identity and sexuality (Figures 16 and 17), and fear of and anger at women (Figure 18). When his father arrived to

Figure 14 Tim: "I feel like half a person."

Figure 15 Tim: "Dreaming of my father."

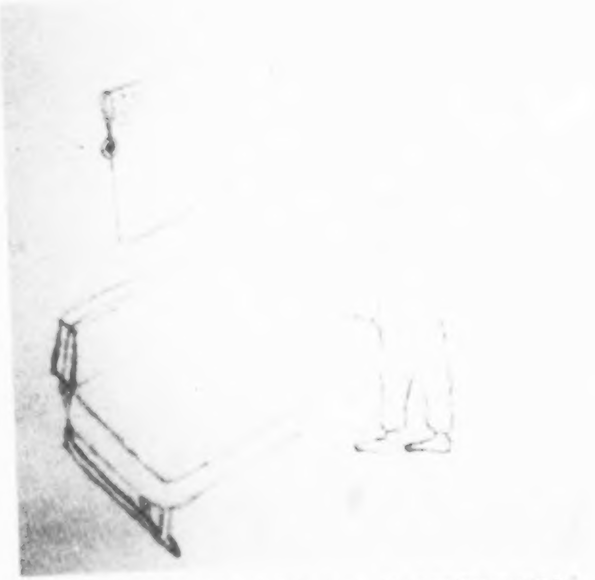


Figure 16 Tim: "I feel like someone's peeing on me."

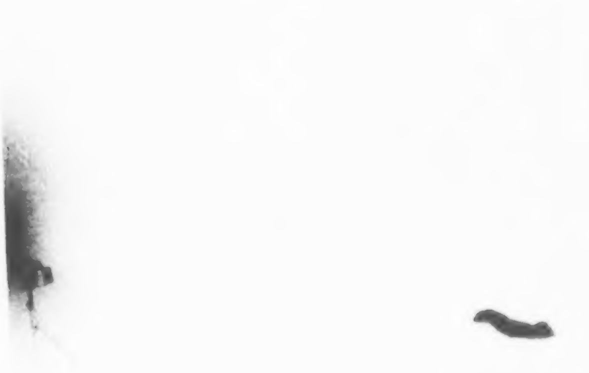


Figure 17 Tim: "It's a he/she that doesn't know if it's a he or a she."

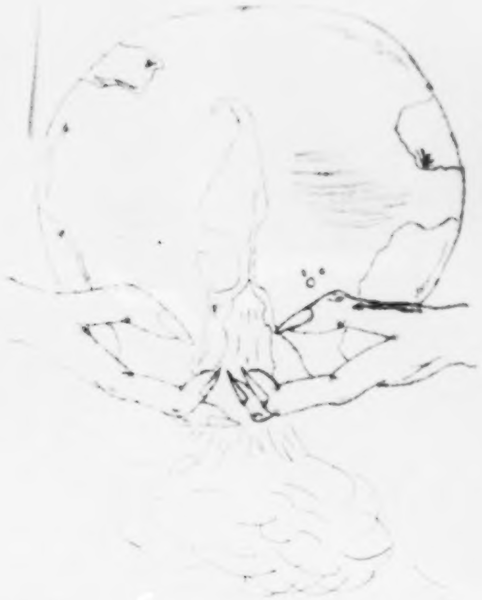


Figure 18 Tim: "Those are my mother's hands tearing my world apart."

take him back to his island home,. Tim drew Figure 19, his first picture in color.

References

Allen, P. B. (1992). Artist-in residence: An alternative to "clinification" for art therapists. *Art Therapy: Journal of the American Art Therapy Association, 9*(1), 22-29.

Blos, P. (1962). *On adolescence: A psychoanalytic interpretation*. New York: The Free Press (Macmillan).

Blos, P. (1989). Masculinity: Developmental aspects of adolescence. *Adolescent Psychiatry, 16*, 5-15.

Bly, R. (1990). *Iron John: A book about men*. New York: Addison-Wesley.

Bouchard, R. (1985). *Separation from the mother in early adolescence: A study in art therapy*. Unpublished manuscript.

Chasseguet-Smirgel, J. (1984). *Creativity and perversion*. New York: W. W. Norton.

Erikson, E. (1963). *Childhood and society* (2nd ed.). New York: W. W. Norton.

Esmen, E. (1989). Discussion of Peter Blos's chapter. *Adolescent Psychiatry, 16*, 21-25.

Forsyth, C. J., & Gramling, R. (1990). Adaptive familial strategies among merchant seamen. *Lifestyles, 11*(2), 183-198.

Freud, A. (1966). *The ego and the mechanisms of defense*. New York: International Universities Press.

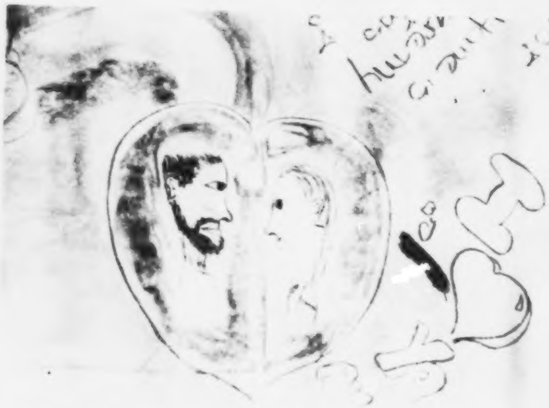


Figure 19 Tim: "My father and I together at last."

Gilligan, C. (1982). *In a different voice*. Cambridge, MA: Harvard University Press.

Haeseler, M. P. (1989). Should art therapists create artwork alongside their clients? *American Journal of Art Therapy, 27*, 70-79.

Harper, J., & Ryder, J. (1986). Parental bonding, self-esteem and peer acceptance in father-absent male adolescents. *Australian Journal of Sex, Marriage and Family, 7*(1), 17-26.

Kodandaram, P. (1991). Sex role identification in father-absent juvenile delinquents. *Journal of Personality and Clinical Studies, 7*(1), 63-65.

Lachman-Chapin, M. (1987). A self psychology approach to art therapy. In J. Rubin (Ed.), *Approaches to art therapy theory and technique* (pp. 75-91). New York: Brunner/Mazel.

Lewis, O. (1991). Paternal absence: Psychotherapeutic considerations in boys. *Contemporary Psychoanalysis, 27*(2), 265-287.

Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant*. New York: Basic Books.

Moberly, E. R. (1986). Attachment and separation: The implications for gender identity and for the structuralization of the self: A theoretical model for transsexualism and homosexuality. *Psychiatric Journal of the University of Ottawa, 11*(4), 205-209.

Ogden, T. H. (1986). *The matrix of the mind: Object relations and the psychoanalytic dialogue*. New York: Jason Aronson.

Rakoff, V. M. (1989). Discussion of Peter Blos's chapter. *Adolescent Psychiatry, 16*, 26-30.

Robbins, A. (1987). An object relations approach to art therapy. In J. Rubin (Ed.), *Approaches to art therapy, theory and technique* (pp. 63-74). New York: Brunner/Mazel.

Silver, R. A. (1992). Gender differences in drawings: A study of self-images, autonomous subjects, and relationships. *Art Therapy: Journal of the American Art Therapy Association, 10*(3), 159-168.

Stoller, R. J. (1985). *Presentations of gender*. New Haven, CT: Yale University Press.

Tarantino, S. J., & Lorichini, D. F. (1989). Field dependence, language ability, and self-concept as a function of father's absence. *Perceptual and Motor Skills, 69*(2), 20-27.

BEST COPY AVAILABLE

A Mother's Journey of Healing: When a Child Changes Gender

Linda Milligan, MPS, ATR, Voorhees, NJ

As an art therapist working in a juvenile prison, I often find myself reflecting on imprisonment and its many forms: physical, emotional, and/or spiritual. After some contemplation, I found myself working on a very detailed drawing in dots with pen and ink. This was a very soothing process and, as the image took shape, I discovered I was creating a fable. The artwork, "Martin's Fable" (Figure 1), is a picture of a woodland nymph trapped inside a bubble. Although she has many fine woodland treasures that could make her happy and healthy, she longed to be outside her bubble. One day a magpie came, gently wrapping his wing around her. They flew away; she went from darkness to light.

As I studied the finished picture I was struck by the similarity between the fable and my son's life. Although "Martin's Fable" is a recent picture, it stirred a desire to reexamine art that I created years ago as I struggled to understand an extraordinary event in my child's life and to heal my pain from loss. Like the recent message of "Martin's Fable," this brief article is a reflection of my earlier journey from darkness to light.

Eight years ago my oldest child, at the age of 20, began the exploration of deep feelings later diagnosed as Gender Identity Disorder (DSM IV, 1994). This resulted in a female-to-male gender change. It is not in the scope of this article to explore the cause or ramifications of transgender disorders. Rather, it is to look at how a body of art helped a mother integrate this change. Looking back, I remember that my own feelings closely followed a pattern described by Kubler-Ross in *On Death and Dying* (1969): denial and isolation, anger, bargaining, depression, and acceptance. However, as I look over my art, I see three primary stages: stage I, consisting of denial, isolation, and bargaining; stage II, anger and depression; and stage III, acceptance and hope.

The first stage began when I learned of my daughter's deep feelings and her need to explore the possibility of gender dysphoria. My thoughts and reactions were vague and very intellectual. I hoped the situation would resolve itself so I chose not to deal with it, talking little about it to family and friends. I did a good deal of denying, isolating, and bargaining with God, hoping that another reason would be found to explain her profound feelings. I did not make art during this period, as my denial led me to believe I had no pain to express.

The second stage began when changes in my daughter became obvious, dressing as a male and using a new name, Martin. It was at this point that I turned to my art to express my feelings, which were mostly pain and anger (Figure 2). I created a collage to express what I knew and didn't know. I knew I had lost my daughter, but did not know what it meant to have a son. I felt that my memories of my child would fade away and that she had been torn from the very center of my being. For the next year or so I struggled with sadness over this change (Figure 3) and anger, because I had no say in this event (Figure 4). I feared that I and others would not understand, and harm could come to my child (Figure 5).

I struggled with a great deal of confusion as I sifted through my understanding of gender, sexual orientation, and their impact on happy, healthy relationships (Figures 6 to 10). My sadness and anger were also based on my feelings of failure and rejection: failure that I did not accept this change instantly, and feeling that my attempts to comfort my child were being rejected. I believe my anguish was my self-imposed prison of expectations. At the core of those expectations was the belief that if I could be more than the "good enough" mother (Winnicott, 1971), I would not lose my child.

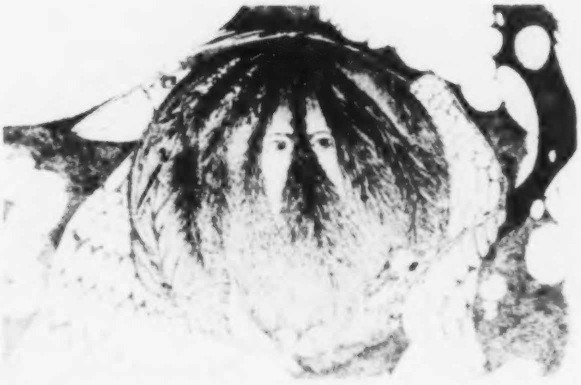


Figure 1 Martin's Fable, pen and ink, 18" × 12"

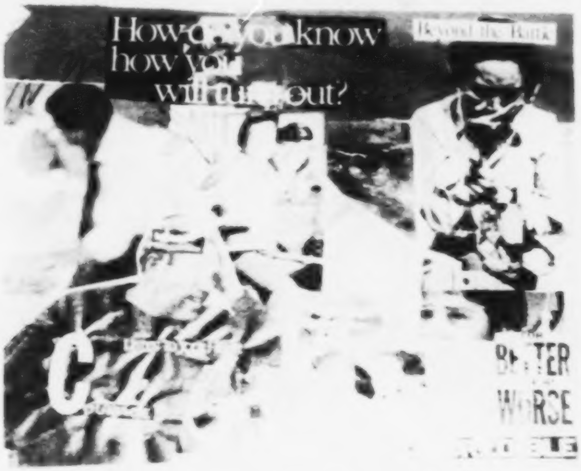


Figure 2 Untitled, collage, 18" × 12"

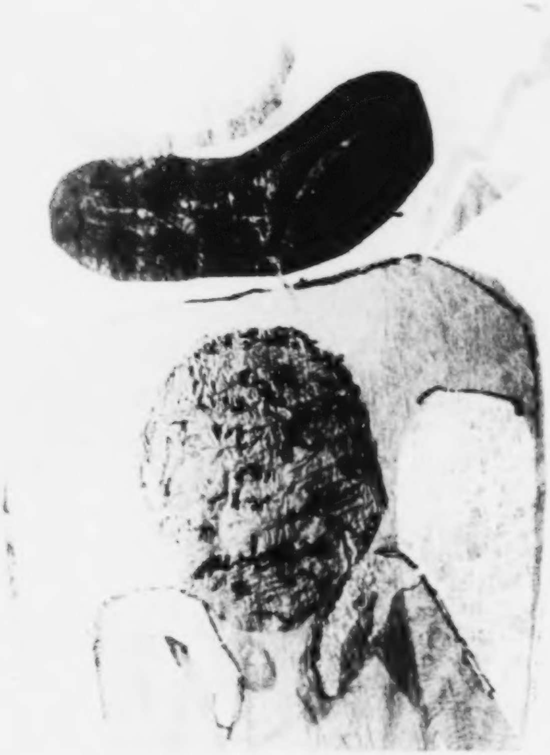


Figure 3 Untitled, tissue collage, 18" × 24"

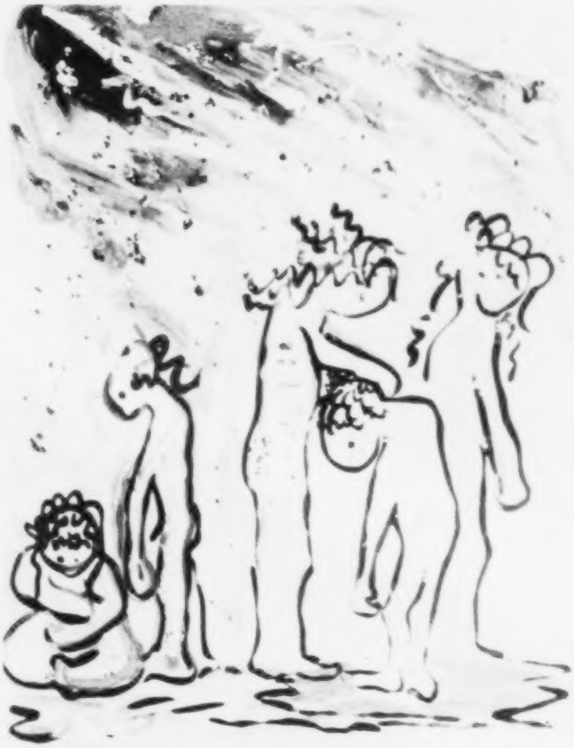


Figure 5 Untitled, tempera with glitter, 18" × 24"

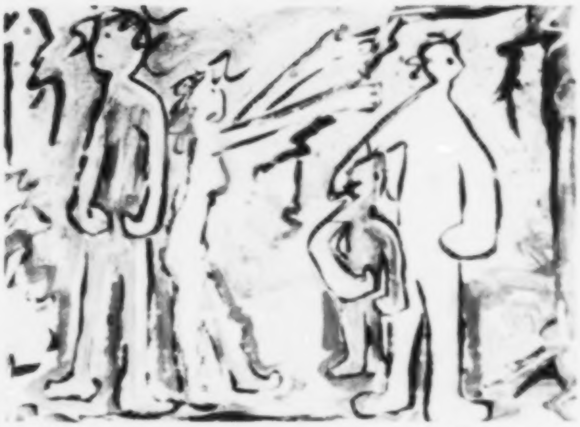


Figure 4 Untitled, tempera with glitter, 18" × 24"

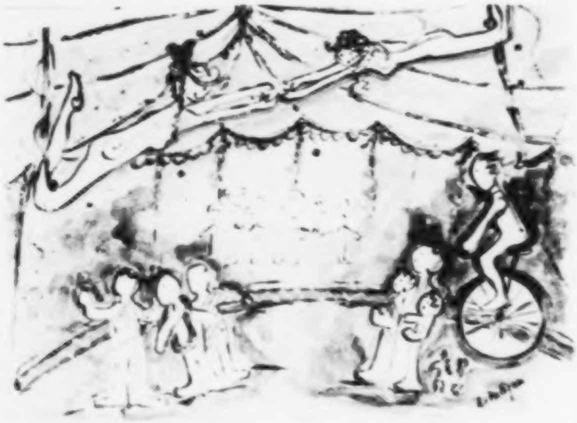


Figure 6 Feats of Daring, tempera with glitter, 18" × 24"

Over time, anger, depression, fear, and confusion developed into a patchwork quilt. My artwork was done on 18" × 24" paper with tempera paint. The paint was thick, with lots of movement and many deep colors. I found myself exploring the feel of the paint, pushing it about as I pushed about my new and old beliefs about people and things I loved. My images contained people, sometimes naked, and at other times color and design were imposed on the bodies to express conflict. The conflict centered on these questions: Are we what we see or are we what we feel? Is our "being" visible or invisible? Can our bodies be our prisons?

The concept of imprisonment is expressed throughout my art with thick borders or blocks of color around the people, and lines of color separating sections. At times, the content is circus themes, playful, and humorous (Figure 6). This paralleled how I sometimes spoke to friends about this change. I often found myself mixing male and female names and pronouns as I reflected on past and present events. I found humor a saving grace as it eased my pain and helped to put others at ease. The playfulness of the images helped me feel safe as I looked at the intense feelings expressed. The playful subjects minimized the sense of being imprisoned in time and place.

The flying trapeze artists symbolize the courage of change.

BEST COPY AVAILABLE

physical or emotional, and the need for those feelings to be seen and acknowledged. Change is the process of traveling from pain and darkness, through fear, to a new understanding and light.

My art brought release and much comfort. Sometimes the paintings were done quickly, like sketches—tension and energy pouring out. At other times I painted colorful dots over and over, creating pleasing patterns which helped me to feel connected to my daughter. Later, instead of dots, I used glitter to soften the strong feelings. The glitter had a way of falling off the painting and turning up in unexpected places, reminding me of my son. Those small pieces of glitter, and the brief moments when found, helped to integrate the larger event into my life.

I did not always understand the images, or why I needed to create so many, but they poured out rapidly and with little planning. The images presented in this brief article are just a small portion of the dozens painted.

I believe that acceptance (stage III) began in my art and in my heart before I realized it intellectually. I remember an uneasiness while I painted "The Spell" (Figure 8), yet I felt a deep connection with each figure, male, female, old, and young. We all have many aspects of ourselves, and the journey of life is to understand how they fit together. The egg and tree of life are symbols of a new life, my son. This was followed by a very pregnant form, sharing of news (Figure 9) and the appearance of hearts on the mother and child (Figure 10).

Acceptance is a dance of gains and losses. As I got closer to a fuller acceptance I began using soft pastels. The sadness I felt was softer, more manageable, and inside me (Figure 11). It no longer felt overwhelming. I also felt a soft connectedness with my child (Figure 12). I began exploring the relationship of being a mother to a son.

Acceptance is further expressed in Figure 13, done in tissue collage. It is a soft impressionistic landscape with myself off to the right side. I am peacefully watching. What is out in front is not clear but is workable. This was the last image in a series begun 2 years ear-

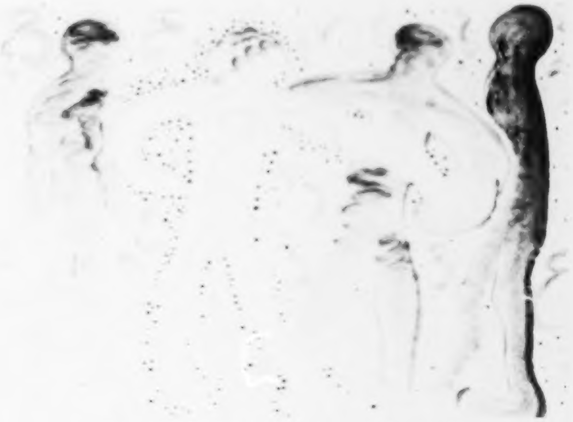


Figure 7 Untitled, tempera, 18″ × 24″

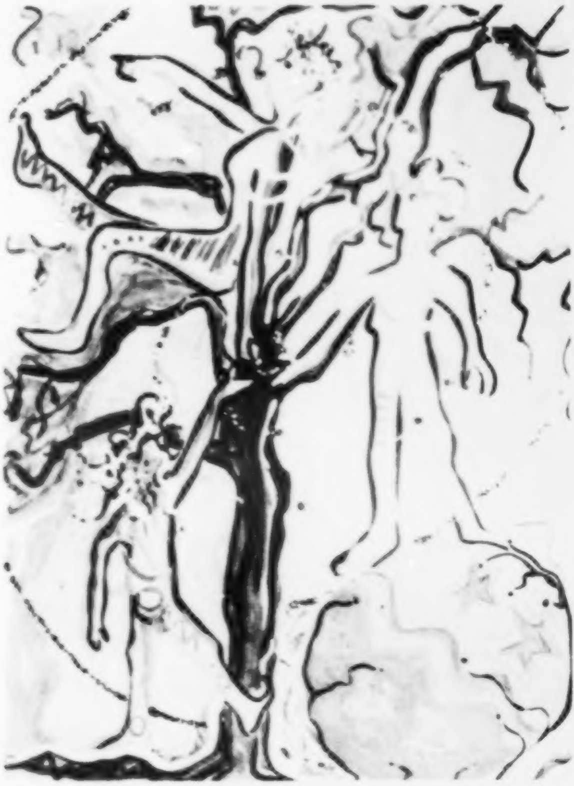


Figure 8 The Spell, tempera with glitter, 18″ × 24″

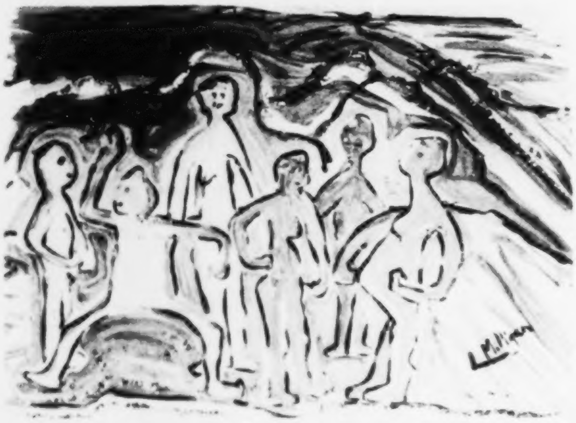


Figure 9 Untitled, tempera with glitter, 18″ × 24″

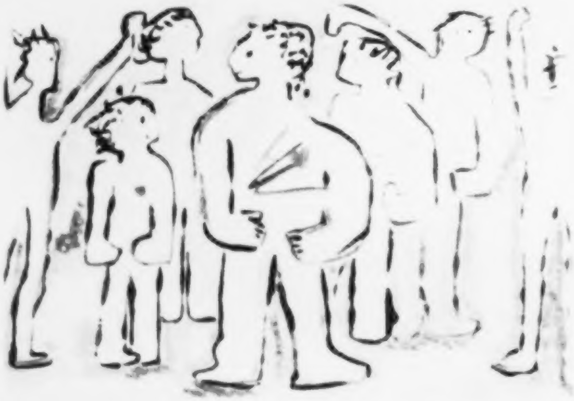


Figure 10 Untitled, tempera, 18″ × 24″

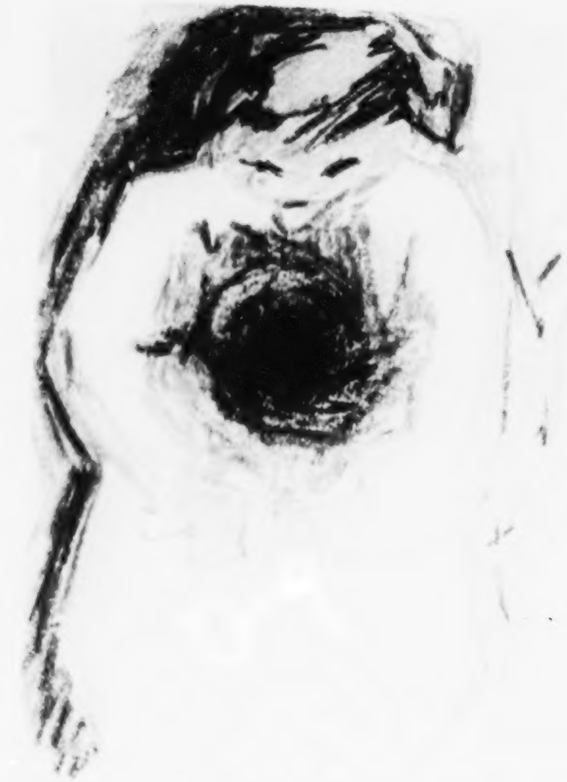


Figure 11 Untitled, pastel, 18″ × 24″

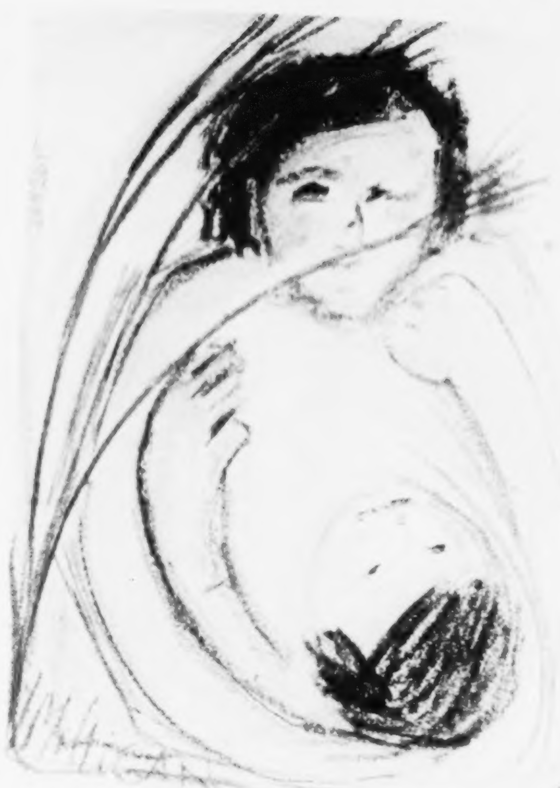


Figure 12 Holding My Child, pastel, 18″ × 24″

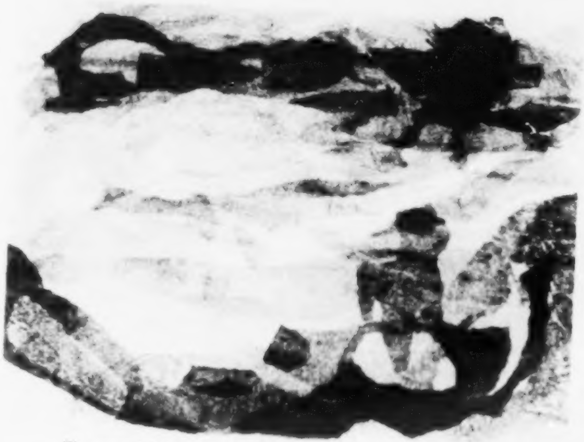


Figure 13 Untitled, tissue collage, 18″ × 24″

lier. At that point I had come full circle, a mother watching her child go from childhood to manhood, and I knew I embraced this new person . . . my son.

In the picture, "Martin's Fable," the magpie helps the woodland nymph escape from the bubble by traveling with her from darkness to light. My child traveled a similar path, changing the physical outer self to match the spiritual inner self. Likewise, my art helped me travel through the grief process. I escaped the spiritual prison of isolation, anger, judgmentalism, and self-imposed expectations, and moved towards an acceptance of the process of growth and self-fulfillment.

My journey of acceptance was much like a spiral staircase, slowly taking me upward from darkness to light. Each time I reexamined a question, my understanding moved to a higher level—a level that was clearer and softer. Art allowed creativity to solve my inner struggles by adding distance without denying pain It permitted an exploration of outcomes, preventing me from getting locked into one view during the process of change. It gave voice when I had no words to explain the questions I was trying to understand and answer.

My healing took time. At first I believed my grief related to the loss of my daughter. I came to understand it as my fear of losing a relationship due to a belief system which prevented me from seeing my child as a whole being. Artmaking helped me to safely explore the importance of gender, body shape, and sexual orientation to our relationship. These are complex issues not given to quick, easy answers. I have come to accept this change and embrace my son with all my heart. I know Martin is a much happier, more fulfilled person as a male, and our relationship continues to be unique, as it was before the change.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorder* (4th ed.). Washington, DC: Author.

Kubler-Ross, E. (1969). *On death and dying.* New York: McMillan.

Winnicott, D. W. (1971). *Playing and reality.* New York: Routhledge.

BEST COPY AVAILABLE

Art Beyond Humanism: Non-Western Influences on an Art Therapist's Practice

Martin Perdoux, MAAT, ATR, Chicago, IL

In this article, I present the viewpoint that the doctrine of humanism limits my practice of art therapy. In *Merriam Webster's Collegiate Dictionary* (10th ed.), the traditional Western definition of *humanism* is "a doctrine, attitude, or way of life centered on human interests or values; especially: a philosophy that usually rejects supernaturalism and stresses an individual's dignity and worth and capacity for self-realization through reason" (1993, p. 564). Whether we recognize it or not, most of us art therapists were born and raised in a Western Eurocentric culture, and our thoughts and actions are shaped by the philosophy of humanism. It is, as the dictionary reminds us, our "way of life" (1993, p. 564), and it is a matter of responsibility to be aware of it. Please note that I am not writing about humanistic therapy, but the all-encompassing attitude of humanism that underlies *all* forms of therapy, including art therapy, and all forms of Western thought and action. Making art on my own or alongside other people reminds me that humanism, the way of life within which art therapy developed, has limitations that are worth examining.

It is very hard to see something so vast when you are standing in the middle of it, and the only reason I saw the influence of humanism is that I stepped outside it when I had the good fortune to live for 10 years among the Kumeyaay, a southern California Indian tribe. The Kumeyaay language does not separate the world into the natural and supernatural, as English does, and thus has encouraged its users to resist European humanism. The Kumeyaay find no "magic" in what European descendants would perceive as "supernatural"; for the Kumeyaay, *anything* that exists is necessarily alive, intelligent, and self-aware. Paula Gunn Allen explains that "many non-Indians believe that human beings possess the only intelligence in phenomenal existence (often in any form of existence)" (1992, p. 60). By contrast, "The Indian assumes that this awareness is a natural by-product of existence itself" (*Ibid.*).

Historically, the movement of humanism is "associated with the Renaissance, with its emphasis on secular studies (the humanities), a conscious return to classical ideals and forms, and a rejection of medieval religious authority"; modern usage often indicates a "respect for scientific knowledge" (*The Concise Columbia Encyclopedia*, 1983, p. 393). In order to understand how humanism brought about this kind of thought, we must look back to the beginning of Western civilization, to the fall of Adam. Ken Wilber retraces the evolution of scientific knowledge from the initial drawing of boundaries by Adam, which "merely classified, and were useful only in description, definition, naming, and so on" (1979, p. 32). "As a matter of fact," Wilber remarks, "Hebrew tradition has it that the fruit of the Tree of Knowledge actually harbored knowledge not of good and evil but of the useful and the useless—that is, technological knowledge" (pp. 31, 32). The descendants of Adam continued drawing metaboundaries to count, and then to measure, what Adam had named. Algebra allowed 17th century scientists "to search out abstract relations between those measurements, which could be expressed in theories, laws, and principles," laws that "seemed, in some sense, to 'govern' or 'control' all the things and events marked off with the very first type of boundaries. . . . Adam could name the planets; Pythagoras could count them; but Newton could tell you how much they weighed" (pp. 34, 35). With each new boundary came "more generalized knowledge, and hence more power" (*Ibid.*).

This world of classical boundaries was shattered around 1925 when quantum physics established that the ultimate reality of subatomic particles did not fit the old physical laws and could not even be located. The Heisenberg uncertainty principle established that subatomic particles could not be located because they had no boundaries; therefore, all knowledge based on the laws of physics became null and void. As Wilber states, "The crucial item is that the physicists now *know* that these boundaries are pretend and make-believe, and that the basic constituents themselves remain no-boundary" (p. 37). Unfortunately for the world, the rest of the Western technocracy did not recognize the full significance of the quantum physics revolution, either because they were not aware of advances in physics or more likely because they did not want to relinquish the sense of control over nature that came with the old classical system of physical laws. "This is difficult for most of us to grasp, for we are still very much under the spell of Adam's original sin, and so we cling to boundaries as to life itself" (p. 41). This comment from Wilber also explains the difficulty in understanding and letting go of humanism.

If quantum physics has succeeded in forming a worldview that is essentially identical to the Kumeyaay's, why does the rest of the scientific community continue to grasp at the straws of old classical physics, clinging to outdated scientific knowledge, and living a life principally ruled by the ideals of humanism? This question is particularly pressing when one understands that the sense of alienation, fragmentation, and conflict many people experience is due to the act of drawing a boundary itself: "Because when you establish a boundary so as to gain control over something, at the same time you separate and alienate yourself from that which you attempt to control" (p. 32). The quantum physics revolution is also important for art therapy because the realization that all things are connected in "a richly textured field" (p. 42) changed the scientist's role from observer to participant (p. 40). If art therapy wants to be part of scientific knowledge, it might as well be a part of the most current scientific knowledge. For example, it follows that the art therapist should be a full participant in the artistic process, rather than an observer.

In this article, I use the term *self* as the answer to the question, Who am I? Wilber explains the process of answering that question:

> What you are actually doing, whether you know it or not, is drawing a mental line or boundary across the whole field of your experience, and everything on the *inside* of that boundary you are feeling or calling your "self," while everything *outside* that boundary you feel to be "not-self." (1979, p. 4)

I also mention the phrase *flexible self*, which according to Wilber's definition of *self* is derived from the ability to redraw the boundary line between self and not-self, thereby including more or less of the universe within that boundary. The ability to empathically identify with other humans and other species is proportional to how inclusive the boundary is. Once again, humanism can limit the flexibility of the boundaries we draw because it centers on human interests, and because it does not believe in nonhuman intelligence and self-awareness. In other words, humanism can be said to stiffen the self, and its emphasis on reason dictates that we ought not to waste time learning to relate to the "inanimate" world. This means quite literally that the most intelligent, dynamic, and interesting part of the world is absent from our perception of it.

The doctrine of humanism may be followed with well-meaning intentions, but it often results in anthropocentrism, or an psychotherapist Ralph Metzner (1992) refers to it, "Human chauvinism, or speciesism" (p. 4). Humanism does indeed invite humans to relate to each other, but that capacity is greatly reduced by the inability to relate to the rest of the universe. Most art therapists would agree that the increased capacity to put themselves in their clients' shoes is crucial to their successful practice. Some have even written books showing that it is in their best interest to acknowledge the intelligence that manifests itself through images (Allen, 1995; McNiff, 1992). I believe that the limits of the humanist attitude are an underlying cause of our relational problems, and that they must be transcended.

Throughout my art therapy practice, I have not only become aware of the importance of having a well-defined and flexible self, but I have also realized that art therapy requires strength and flexibility in an area that is related to the self: the artist-self. This realization has led me to distinguish the terms *role* and *style*, which I use as follows: Whereas I favor the nondirective *style* of the open studio, I assert my *role* as a leader. The strength and flexibility of my artist-self is of paramount importance in asserting my role as a leader since I prefer to create my own artwork alongside clients in order to be a full participant. I have never felt that my own artistic process permanently intimidates clients. In fact, I find that my participation gradually encourages people to create within the noncompetitive arena of the art studio. This requires that I maintain a certain level of genuine creative activity. This also requires awareness of personal issues addressed by my own art so I can differentiate them from my clients' concerns.

This approach leads me to define my role as helping clients develop their artist-self by "pulling them in my wake," so to speak. The terms *artist-in-residence* or *artist-as-therapist* may define my role most accurately, although they are not usually used for someone who works in an institution for people with chronic or acute mental illness. I have so far succeeded in cultivating the *artist-in-residence* role through slide presentations of my own artwork. This casual group format has been tremendously helpful, especially when the facilities were short of what I call an art studio. Still, the most helpful factor in my ability to cultivate my role as a leader in groups or individual art therapy has been the attitude I refined while I lived for 10 years in a community where thoughts were not shaped by humanism. There, I learned to respect and to relate; I began to understand my place in the world and among fellow human beings in a new way. In other words, my self became more flexible.

A flexible self can benefit any human being, provided he or she has a defined self in the first place. Individuals who suffer from mental illness can be characterized as people who did not have the chance to define themselves, or people who lost the self they knew. It is my experience that the definition of an artist-self among people whose self is not well-defined is not only helpful but it may fill a vacuum. It may be that the artist-self provides a self-definition that people with mental illness may lack.

Should this formulation seem disconcertingly simple or even simplistic, understand that it is not ordinary in terms of its value. Outpatient clients kept coming back for more when they were not required to do so. Many demonstrated a level of practice and devotion in their art that would shame most art students. Their motives were certainly not financial; rather, it was simply that they defined themselves in terms of their art. Their art was a controllable field of experience (perhaps the only one in their life) through which they could draw a boundary, finally creating an answer to the question, Who am I?

The subjective experience of mental illness, of not knowing where one's self starts and ends, is undoubtedly terrifying, but it does allow one a noticeable capacity to empathically identify with other lifeforms. That ability was demonstrated to me by many clients I saw at The Thresholds, a psychosocial clubhouse for adults with chronic mental illness.

During a weekly group that led to the biannual publication of *The Musing Place*, the literary and arts magazine of Chicago's mental health community for which I was the Editor-in-Chief, a 30-year-old man I will call Mike empathically identified with another species. Imagining he was a cheetah, he painted its running silhouette and attached it to a poem about the wild animal. The humor and wit of the poem suggest the pleasure Mike must have felt while writing and painting:

> I yawn. I blink. I stretch.
> I roll and shake the leaves off my back.
> I meander through the bush.
> I freeze; I catch a gazelle in my eyes.
> I stalk silently.
> With a burst of lightning speed, I race toward the gazelle.
> I leap and dig my blunt front claws into its eyeballs.
> It falls.
> It pants under me and I rest on it for twenty minutes until I have the strength to bite it to death.

Traces of Mike's restless personality and bipolar disorder peer through the wide-eyed portrait of the animal; he even called it "a psychotic cheetah." The caption Mike wrote under the cheetah's portrait also reads like an autobiography: "An endangered specie [sic], the cheetah is the fastest land mammal alive in the African bush." The man has merged with the animal, creating a hybrid. Mike has chosen an animal that is restless and explosive by nature. When he so completely identified with the cheetah, Mike's explosive temper and manic restlessness suddenly became adaptive traits. For the few minutes when Mike drew and wrote, all of his symptoms became useful qualities.

This case vignette illustrates that although an undefined self is not to be wished on anyone, it may allow a similar quality of empathy that a well-defined and flexible self would allow. This client was able to empathically identify with an animal in a way that could be said to be therapeutic in two ways. First, Mike safely explored a new temporary identity as a cheetah in his artwork, and he experienced empathy with the animal, giving it qualities usually reserved for humans. Mike's exercise, however transitory, seemed to dissolve the boundary between man and animal, moving him away from the alienation of humanism. Second, for the first time since the onset of his illness, Mike was able to see his symptoms in a positive light. For someone whose symptoms are a tremendous source of frustration and anger, this reframing is nothing short of a revelation. This therapeutic identification with another lifeform could not have happened if Mike had not been encouraged to define his artist-self through years of artmaking at The Thresholds.

Beyond its practical applications in art therapy treatment, this relationship between the artist-self and the self also helps explain the romantic conception of art, the creative process, and its fascination with psychopathology. This view of the artist-self indicates that the romantic concept of art may in fact hold some truth: that an undefined self begs for a boundary that can be explored and defined appropriately during the gradual emergence of an artist-self. The romantic view of the artistic process points to important coping possibilities, which so many case studies illustrate; however, romanticism also alienates art and artists from everyday life. John MacGregor (1989) points out that "extreme individuality is an essential component of the Romantic artist and his work," and that such an artist is "the visionary who alone could see realities invisible to others" (pp. 71, 72).

Everything in Western culture, even art school, teaches us that the creative process should be reserved for a few gifted or diseased ones. Hermetic boundaries have been drawn to isolate artlike behaviors into well-guarded bastions. "Art remains an elitist activity, made and, more important, consecrated by the few" (Dissanayake, 1988, p. 183). Contrast this idea of art "separated from primary lived experience" and the quality of life I experienced among the Kumeyaay, where "virtually everyone was a participant in and appreciator of art" (*Ibid.*), and you understand the value of art beyond humanism. Until the artist-self is validated by a culture that would integrate it into the commonplace of everyday life, the status quo will remain.

I believe in a definition of art therapy as a field that can integrate art into day-to-day life and dissolve the boundary between art, life, and consciousness. With this definition, therapy becomes the qualifier, and art therapy is really the "therapy of art." Art therapy is a definition inside of another, inside of another, inside of another. The most inclusive one, the therapy of art, may be the most important one to defend. When art is integrated in everyday life, everything becomes an art (thus the phrase "the art of . . ."), everyone can be an artist, and everyday life becomes a practice. Life becomes a work of art. The benefits of the creative process, including therapeutic ones, are distributed throughout everyday life and available to all who participate.

At present, art therapists have the opportunity to play an important part in the reintegration of art into everyday life. Art therapists can encourage people to define their artist-self. In the case of persons with mental illness, it could be the first stable sense of self they have experienced. In the case of the world at large, especially the Western world, it can help in a more subtle but no less essential way: Art therapists can, against all reason, offer a way to learn to perceive the world as a whole, intelligent, and dynamic place, a way to taste life beyond humanism.

References

Allen, P. B. (1995). *Art is a way of knowing.* Boston: Shambhala.

Allen, P. G. (1992). *The sacred hoop: Recovering the feminine in American Indian traditions.* Boston: Beacon Press.

Concise Columbia Encyclopedia (1983). New York: Columbia University Press.

Dissanayake, E. (1988). *What is art for?* Seattle: University of Washington Press.

MacGregor, J. M. (1989). *The discovery of the art of the insane.* Princeton, NJ: Princeton University Press.

McNiff, S. (1992). *Art as medicine.* Boston: Shambhala.

Merriam-Webster's Collegiate Dictionary, Tenth edition. (1993). Springfield, MA: Merriam-Webster.

Metzner, R. (1992, June). *The Split Between Spirit and Nature in European Consciousness.* Paper presented at the Twelfth International Conference of the International Transpersonal Association, Prague.

Wilber, K. (1981). *No boundary: Eastern and Western approaches to personal growth.* Boulder: Shambhala.

Call for Papers for the 10th Art Therapy Association of Florida Conference
"Art Therapy and the At Risk Population" Spring Conference from May 2-4, 1997

Attention Art Therapists, Creative Art Therapists, Mental Health Professionals, Allied Professionals and Educators: ATAF is seeking papers, presentations, panels, and workshops devoted to understanding the professional issues and guidelines that all art therapists follow. Submissions may focus on any topic or population related to this theme; of particular interest are: issues of confidentiality, issues regarding artwork (i.e.: ownership, permanent records, exhibitions), issues of certification and licensure, and issues of graduate and post graduate training and educational standards. Due October 1, 1996. Qualifying materials needed from each presenter include: 1) six copies of Presenter's Resume; 2) six copies of Completed Call for Papers Application*; 3) six copies of Bibliography for Presentation.

**For further information and proposal forms, please write to:* Mrs. Peggy Dunn-Snow, ATR-BC, LPAT, 2401 SW 50th Street, Ft. Lauderdale, Florida 33312. Continuing Education Credits for art therapists, nurses, social workers, mental health counselors, and marriage and family therapists are being arranged.

Reauthoring the Dominant Narrative of our Profession

Shirley Riley, ATR, MFCT, Los Angeles, CA

Introduction

This is the appropriate time in the evolution of the profession of art therapy to re-create our image and explore a new model of our profession responsive to the postmodern mental health climate. To that end, I would like to take the reader on a fantasy trip and hypothesize what it would be like to move the birth of our occupation forward in time, from the 1950s to the present. After looking at art therapy from this visionary viewpoint, I will offer the reader a sobering look at today's mental health concerns and how they seem to be influencing our clinical practice. The conclusion will incorporate both vision and reality, suggesting how we can move beyond our current concepts of art therapy to re-create a psychotherapeutic service that is both aesthetic and pragmatic. We can enter the postmodern society of mental health providers.

The Time Capsule

If art therapy was conceived in the 1990s, do you think it would be born burdened by the paradoxical question: is art therapy "art as therapy or therapeutic art"? Or is that familiar struggle just an outworn expression of the age of the Fifties, when the traditional analytical view of therapy was "either this way or nothing," rather than, "this way and many more"? I would like to think that this issue, which has been conflictual in the past, would seem pointless, limiting, and diverting attention away from the quality of therapy that we have to offer.

In the postmodern climate of competition that dominates our world of mental health services, I suspect there would be room for all our philosophies under the master umbrella of creativity. We would focus our talents on presenting art therapy as a method of treatment that most successfully gives access to the silent, visual knowing part of our intellect that is often neglected in the process of verbal therapy (Tinnin, 1990). We would assume that creativity is not limited solely to a relationship with the art, and accept a broader definition of creativity that includes how we and our clients can find more successful ways to live in today's social system. I think that the founders of the art therapy profession of the postmodern world would be seen as pragmatically aesthetic or, if you prefer, aesthetically pragmatic, offering the best of all possible worlds.

Our imaginary "founding parents" would be able to explain to other professionals that we conduct therapy in many ways and we follow many theoretical schema. In addition, we are also aware that with the introduction of a visible vocabulary created by the clients, the art therapy will modify theory to make it more personally responsive to each client. The aesthetics of choosing the right theory to "fit" the client's needs turns the therapy into a co-constructed search for a new aspect of the problem-saturated situation. When the client is involved in re-creating his or her view of life, through artwork and reflections on art, the client embraces actions which lead to a "unique outcome" (White & Epston, 1990).

The well-trained art therapist, born in today's world, has a broad knowledge of psychological theories but is not totally committed to any singular belief system. The art of the therapy comes by watching and encouraging the client to find images behind images, uncovering meta messages that surface through the image. Clients may discover how they were taught to accept their discomforting world view as an immutable "truth," their only alternative. It takes no stretch of the imagination to remember the terrible "truths" that some clients have endured. Through their graphic illustrations, clients can develop a new understanding of their trauma and how their hard-fought-for defenses were necessary to make living tolerable in a painful world.

In this postmodern art therapy world I am proposing, art therapists would agree that within every setting offering psychological help, and with every population served, it is necessary for the therapist to wear specialized lenses when viewing clients' needs. For example, it is obvious that we cannot wear inpatient lenses for viewing outpatient treatment (Hoffman, 1990). With each clinical situation only an individualized, unique treatment approach is the "right" way to conduct art therapy. This would eliminate the unnecessary struggle over whether there is greater benefit from a studio art experience, contrasted to a more structured clinical art therapy treatment plan, or conflict over behavioral art therapy treatment (the structure limits creativity) versus the spontaneous use of art in adult growth groups. There would be acceptance that the same art therapist may become a "different" therapist at different times, in response to different needs of the client. That is to say, the therapist changes his or her approach to conform to the therapeutic needs of the person in treatment. It is not "difference" that is in question; it is rigidity that should be censured.

Consideration of the overwhelming social pressure of our time in history would be built into our system of therapy. There would be no division between case management and "real" therapy. No one would question that the client is a whole person and what is needed in one aspect of his or her life cannot be divided from the rest. The therapist would move quickly to alleviate, within the scope of his or her powers, physical traumas from the client's world, such as abuse, and to provide needed social services and health care information. After these issues are attended to, the client would be less troubled and better able to deal with relationships and intrapsychic problems. It would never occur to our newly invented postmodern art therapist that she or he was in danger of losing her or his identity because social work services were needed immediately, rather than art therapy. It is basic good sense to acknowledge that in extreme crisis the client is focused on survival rather than therapy. Art therapists have no reason to feel threatened; they know art therapy exists because, all through time, people have made art and learned through the experience. There are many clinicians who are so visually oriented that they cannot "not" be art therapists; for these counselors it is impossible not to "see" therapy as well as hear and speak it.

In harmony with the ever-changing circumstances of the postmodern world, art therapists would continue to bring their viewpoint to the public—a synthesis of theory and imagination, of silent and verbal communication. As we embrace the challenge of explaining our profession, we would make it clear to allied professionals that we are not solely an adjunctive methodology. We can equally achieve therapeutic goals and provide complete mental health services as primary therapists, restricted only by the limitations imposed by state licensing laws.

Reality and the Impact of Social Concerns

With this model of the newly created art therapist in mind, let us come back to the here-and-now and see if we are willing to re-create ourselves to fit today's challenges.

For example, it has been documented that children reveal their troubles through the concrete language of art (Malchiodi, 1990; Rubin, 1978). However, if a child's artwork leads to information regarding discrimination at school, the art therapist is obligated to lay aside the art materials and investigate the school system that may be unaware of a traumatic situation that should be addressed. A second example might be a family unable to problem-solve their interpsychic difficulties. When five or six people are living in one room and rotating the use of the bed and floor space, drawing the pressures of cramped quarters and lack of privacy is not enough to reduce their stress. The art therapist may need to accompany the family to a social agency to reinforce and support the coping strengths they have worked on in therapy. She may also need to assist clients as they follow through and encounter the social service worker and housing authorities. Therapy no longer fits the 50-minute format within the confines of the therapist's office. Even the rigid format of California's Medi-cal system allows coverage for the therapist to engage in some external mental health activities that will lead to higher functioning for the client. In private practice these undertakings would probably be covered by the client; however, in my experience, these extra services are more often required for clients that are in a clinic setting.

There are countless other similar crisis situations that could be mentioned, if there was space to do so. Who of us likes to do these managerial things? I venture to say very few. Like it or not, we should take heed that if we choose *not* to enter the fray of social services and managed care systems, we will lose the position of primary therapist to other clinicians who are less aesthetic and more pragmatic. Calling oneself a therapist indicates that we have accepted the role of advocate for our clients and must do what we can in that role.

Not every clinical setting asks the art therapist for social agency involvement in combination with the art therapy, but many do. I worked in an outpatient agency for many years practicing art therapy and I was expected to be the therapist in charge of the family's complete treatment plan. This included therapy, case management, referrals for psychiatric consultations and testing, and school follow-ups. I wrote Medi-cal progress notes with DSM diagnoses, which require that one member of the family be identified as the I.P. I did this, although it was against my beliefs about family systems. My cooperation was needed to help the clinic keep its doors open; my paperwork produced state revenue. However, when the door to my room closed, I conducted "my" therapy without external restrictions. My treatment team knew my approach and were consulted clinically, as needed. Privately, I think it made me a little crazy to record in one manner and practice therapy in another, but I never noticed that it had an effect on the families. I found a way to focus on the family's need for treatment and translate it into language that satisfied stipulations but still gave me the freedom to provide the therapeutic services that my clients required.

In contrast to the long-term, purely psychological treatment plan approach, I have come to believe that we must assist clients on many levels whenever there is a risk of losing vital support systems that give their life dignity. In addition, we must realize that therapy is moving away from the individual session dealing only with intrapsychic difficulties. Most therapists are faced with dealing with the complications of real world challenges: the pregnant teen-ager; the client ill with cancer or AIDS; the homeless, with their multiple problems; the drug-abusing youth or adult. We cannot limit our services to just the hospital, clinic, or therapeutic school. Outpatient clients go home, hospitalized patients need aftercare; children have to deal with their peers, gangs, and their parents when school is over. The clients have to accept the advantages and disadvantages of short-term therapy, and so do we.

There are many forms of short-term therapies that are widely used by HMO providers, clinics, hospitals, and persons in private practice. To name a few of these theories we can point to the following: solution-focused therapy (de Shazer, 1988; Friedman, 1993; O'Hanlon & Weiner-Davis, 1988); problem-solving therapy (Haley, 1976); and the MRI brief therapy group in Palo Alto (Fisch, Weakland, & Segal, 1982). The proponents of these approaches feel that the success of therapy has little to do with the time involved in treatment, and clients are generally happy to achieve their goals as promptly as possible. Some clinicians feel that the populations that are not benefiting from these brief therapies are those professionals who deal with more severely damaged clients, such as clients with schizophrenic disorders, severely abused clients, those with dissociate disorders or borderline personality disorder, and other chronically distressed persons. Their care has often been shifted to day treatment centers where the objectives and goals are developed to fit their needs. These patients receive medical therapy through the use of prescribed drugs and complementary psychotherapy to evaluate the changes sought through medication. The psychiatrist handles the medication and sets the treatment goals but often does not spend much time with the patient. As we look at the changing mental health scene, it becomes apparent that along with the people we serve, we are not only art therapists, we are also members of a society in transition and must develop our skills to meet the prevailing demands of the times.

BEST COPY AVAILABLE

Where are we going?

I am confident that a large majority of our graduate programs are offering an adequate background in psychological theory, practice, and principles of art therapy. My questions are: "Are they educating students to join the mainstream of today's mental health care system? Are our students being taught how to join managed care (or whatever will replace health insurance in the future) in order to survive?" If the next generation of art therapists does not endure, neither will the profession. If there is no place in the job market for art therapy, how can we ply our trade? I do not particularly like this limiting change, but I feel that our first responsibility is to our students and their future. We can teach our students and trainees the pragmatics of providing treatment, as well as the aesthetics of conducting therapy. I am sure that the dominantly creative character of the persons in our field will make them better "problem solvers." It takes imagination and visualization to find new ways "to beat the system" and not compromise on the quality of treatment that brings comfort to our clients! What is often overlooked is that creativity also brings satisfaction to the creator, no matter from where it springs. There are many ways to be artful and therapeutic in the world of managed care. We have a broad palette of approaches in the art therapy room; we must not be afraid to step outside that room into the hassle of our mental health environment. It is not as though we have a choice.

Theories and Treatment

In the current literature and personal reflections of many of the foremost thinkers in the field of family therapy (the field with which I am most acquainted), there is a major shift in the focus of theories and personal involvement of the therapist. There is a thrust to bring the many approaches to treatment under a broad encompassing theory, not discarding but including the variety of belief systems that have developed in this field (Breulin, Schwartz, Kune-Karrer, 1992). Perhaps we should do the same.

Theorists are offering more comprehensive approaches to treatment; many of these theories emphasize language and restorying histories (Anderson & Goolishian, 1988); co-creating therapy with clients (Hoffman, 1993); using a reflecting team to demystify the sessions (Thomm, 1985); and externalizing the problem, viewing it as an entity separate from the individual (White & Epston, 1990). All these approaches are ways of conducting therapy that share the goal of depathologizing the client or family. This attitude takes a wide perspective of the problem, admits the involvement of the therapist, and offers relief in an effective and shorter time frame. These changes may have come about partially in response to the economic pressures from society, but they are theoretically sound and operate from a base of respected systemic thinking.

I think we have to make similar shifts in our thinking. Why not go past the issue of how we do art therapy? There are many roads to success, and there is no question that what we do is useful. We do not have to contrive an entirely new formula for art therapy; we only have to work together to find an aesthetic/pragmatic explanation of our expertise for those who question it. We can preserve the skills we have and add others that we know we need to survive. We can remain the same and be different simultaneously; we loose nothing!

A recent issue of the journal *Networker* (1995) devoted attention to the necessity of bringing a variety of skills to the field of mental health that we might ordinarily avoid. A practice consultant is quoted:

> Many therapists are great clinicians, but terrible business people, temperamental artists in a profession that is changing from being an art to an industry. These changes create a lot of cognitive dissonance. Some clinicians can make the change and learn to explain themselves to the business community but for others, altering themselves to fit the pattern of consumer capitalism cuts too close to the marrow of their personal identity. Some even leave the field rather than make these compromises. (Lawless, 1995, p. 24)

Turning Theory into Political Practice

Over my 20 years of practice and supervising, I have seen many students and colleagues establish their own identities in the mental health field. Their successes went further than substantiating their skills as therapists and demonstrating how the addition of art made for improved treatment. They demonstrated that they could write excellent case progress notes (consistent with state standards), support a child in a school I.E.P. (individual education plan), fight the county worker for justice for a client, argue with a divorce lawyer in defense of a naive woman client, work with a family in denial of the demise of their son with AIDS, and accept the role of activist for the good of the clients. The hands-on willingness of these men and women art therapists to encounter the mental health system, in every aspect, has radically reeducated the local community in Southern California. Both consumers and providers have a new understanding of the capabilities of the art therapist which has transcended the sometimes stereotyped and misunderstood view of our place in the mental health system.

What has caused me distress and left me puzzled is that these very persons were not always embraced and accepted by our own art therapy community. There appears to be a notion that they are degraded because they are not "really" doing art therapy. I think we should adopt some of the wisdom of social workers. They have no problem with their identity; they just stay together and gain more power every year. If they lack expertise in an area of service, they invent another subspecialty of social work! I think we should do the same. In truth, we are doing that very thing and should take pride in all the workplaces infiltrated by art therapists and remade to meet their own creative standards.

In the same vein of enhancing our survival skills, another question can be posed. Why not get some some sort of allied license until our own comes along? Why not boast that we can expand our educational programs to include information demanded by the state licensing boards and still not dilute the art therapy core of every course? Why not be comfortable with who we are, and know that we can use the current available licenses, such as MFCT or counseling, to keep ourselves alive? There are many good reasons why art therapists should continue to work together both clinically and politically with allied professions without the fear of danger or compromise.

BEST COPY AVAILABLE

There is a theoretical concept that may be very useful to further the move toward an altered vision of art therapy. This way of thinking is called social constructionism, which has been incorporated into modern-day individual and family psychotherapy, both by psychiatrists and psychotherapists (Anderson & Goolishian, 1988). A fundamental concept they propose is that we all have invented a basic reality of the events of our life based on the prevailing myths and belief systems we have been taught. However, in dialogue with another we can learn to see aspects of our history that have been disregarded. This dialogue opens the possibility for a new interpretation of our story and creates the potential for a new and more positive ending to the dominant narrative. This concept has been called "re-authoring a life script" (White, 1990).

This concept could be used to reauthor the current invented reality of what an art therapist is and what she or he can and cannot do. A fresh dialogue could free us to move on and embrace and enhance all aspects of our work with clients and ultimately with ourselves. What we believe in becomes our truth, and since truth has many facets, we can invent a reality that takes advantage of the challenge presented by today's society. The historical "founding parents" of our profession established our identity in the face of disbelief from many professionals. However, they took the encouragement they received from others and held on to their own convictions. They believed in the positive qualities that art therapy could bring to treatment. We face a different challenge in the preservation of our identity. We can do it best by recognizing that although change is threatening, it also offers new opportunities to redefine our profession and continue to offer our unique talents to clients and the profession of mental health.

References

Anderson, H., & Goolishian, H. A. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 27*(4), 371-393.

Breulin, D. C., Schwartz, R. C., & Kune-Karrer, B. M. (1992). *Metaframeworks: Transcending the models of family therapy.* San Francisco: Jossey-Bass.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy.* New York: Norton.

Fisch, R., Weakland, J. H., & Segal, L. (1982). *The tactics of change.* San Francisco: Jossey-Bass.

Friedman, S. (Ed). (1993). *The new language of change.* New York: The Guilford Press.

Haley, J. (1976). *Problem-solving therapy.* San Francisco: Jossey Bass.

Hoffman, L. (1990). Constructing realities: An art of lens. *Family Process, 29,* 1-29.

Hoffman, L. (1993). *Exchanging voices: Collaborative approach to family therapy.* London: Karnack Books.

Malchiodi, C. (1990). *Breaking the silence.* New York: Brunner/Mazel.

O'Hanlon, W. H., & Weiner-Davis, M. (1988). *In search of solutions: A new direction in psychotherapy.* New York: Norton.

Rubin, J. (1978). *Child art therapy.* New York: Van Nostrand Reinhold.

Timmin, L. ((1990). Biological processes in non-verbal communication and their role in the making and interpretations of art. *American Journal of Art Therapy, 29,* 9-13.

Thomm, K. (1987). Interventive interviewing: Part II, Reflexive questioning as a means to enable self healing. *Family Process, 26,* 167-184.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* Adelaide, South Australia: Dulwich Center.

Wylie, M. S. (1995). The new visionaries. *The Family Therapy Networker, 19*(5), 24-25.

---

[*] **Editor's Note:** This manuscript was first offered in a slightly altered form as the keynote address at the Buckeye Art Therapy Conference, 1995, Columbus, Ohio.

IMPORTANT* .... *IMPORTANT* .... *IMPORTANT* .... *IMPORTANT

A change of address notice should be sent at least six weeks in advance to the AATA National Office to ensure that all mailings, including the *Journal* and *Newsletter*, will reach you. AATA is not responsible for misrouted mail as a result of insufficient notification of an address change. Undelivered copies resulting from an insufficient address change notification will not be replaced, but single issues may be purchased at the single issue price.

CHANGE OF ADDRESS FORM

Name____

Old Address____________________________________

Old Phone Number_______________________________

NEW ADDRESS__________________________________

CITY____________________**STATE**______**ZIP +4**____________

NEW PHONE NUMBER_____________________________

E-MAIL ADDRESS_______________________________

Effective Date_________________________________

Artistic Production as a Diagnostic Approach to Illness

Yvonne, Pepin-Wakefield, PhD, Port Townsend, WA

The idea that art can be used as a diagnostic tool and may also aid the diagnostic work of medical practitioners is based on my personal experiences and on themes that emerged in my doctoral research. These themes are:

1. Drawing enhances cognition, enabling people to focus more intensely on an object and that object's relation to relevant situations.
2. Combined visual and abstract modes of thinking permit people to see imminent, but intellectually unrealized structure in a problem-solving situation (Pepin-Wakefield, 1993).

These themes suggest the following:

1. Anatomically based drawings may be useful in the diagnosis of certain physical pathologies.
2. A combination of abstract and visual modes of thinking may aid a client's cognitive understanding and verbal description of physiological processes, which may in turn aid diagnosis.

My original foray into the therapeutic nature of spontaneous drawings began during my adolescence. At age 13, drawing became a way for me to identify and alleviate conscious and unconscious feelings related to the deaths of my parents. Over the years, I drew hundreds of drawings of "Little People," characters that became containers for the transmission of a plethora of emotions (Figure 1).

Years later, just as I used spontaneous drawings to identify and release psychic pain, I used similar creative processes to express and identify physical pathologies. Viewed retrospectively, I believe some of the early drawings which abstractly portray psychological distress may also indicate the origins of physical disease manifested later in adulthood. The following visual examples, I believe, support my contention that artistic production can be an effective diagnostic tool which may give the primary care provider a direct link to uncensored nonverbal messages involved in artmaking and provide direct access to emotional and physical memory associated with illness.

A simple line drawing reflects the origins of my foray into using art to express and diagnose physical pathologies (Figure 2). Drawn in 1977, the image depicts severe pain in my bronchial area. Doctors treated the symptoms with antibiotics, but the discomfort persisted. One night, when the pain was unusually intense, I used a black felt-tipped marker to make a line drawing of the distressed area. The next night the pain was rendered more distinctively through a pencil drawing (Figure 3). As the pain persisted, my drawings of it evolved to include color. In Figure 4, I enclosed abstract versions of lungs, trachea, and bronchial tubes within circles. Then, using a red crayon, I shaded in the portions which felt afflicted. Intuitively sensing that the color green was soothing, I used that color crayon to shade in and around the areas of pain.

Over subsequent weeks I made a series of drawings which represented the afflicted bronchial region, each time discovering through the process of drawing, and later by incorporating some form of a green media, that the pain would subside. I frequently referred to anatomy and physiology books to pinpoint the location and strengthen the accuracy of the drawings. Eventually, I would discover that the discomfort in my upper respiratory tract was caused by an allergy to a form of vegetation growing around my studio. By then I discovered I was able to control the pain by "drawing it out," identifying the afflicted regions by imagining them in abstract but anatomically referenced drawings and adding healing color.

What began as an unconscious expression evolved into a conscious inquiry into the range of ways color is used in healing practices. My informal research led me to publications (Anderson, 1975; Clark, 1975; Ouseley, 1949) chronicaling the historical uses of color in healing. My discoveries were supported by studies that indicated the color green has been used to lower blood pressure and dilate capillaries. Additional research suggested that each color has a definite wavelength, carries a dif-

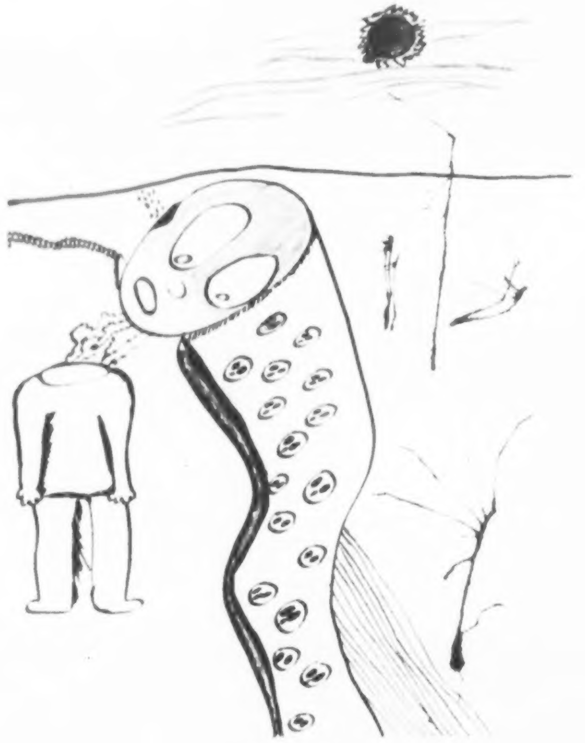


Figure 1

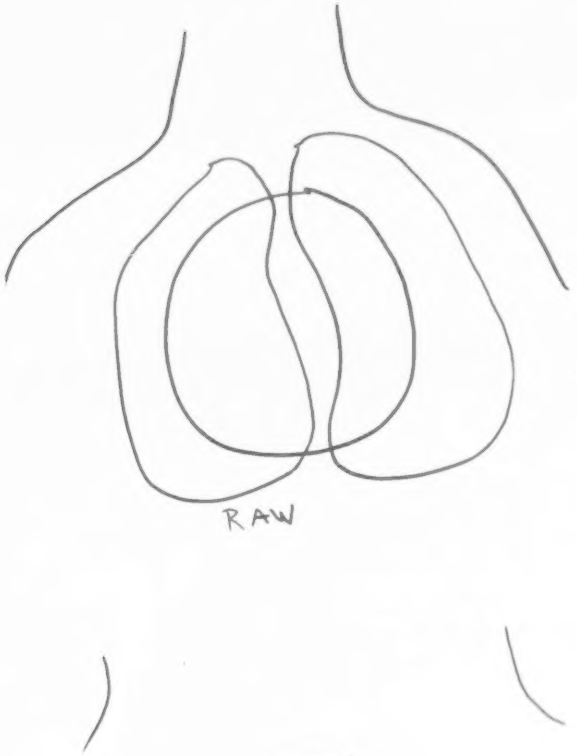


Figure 2

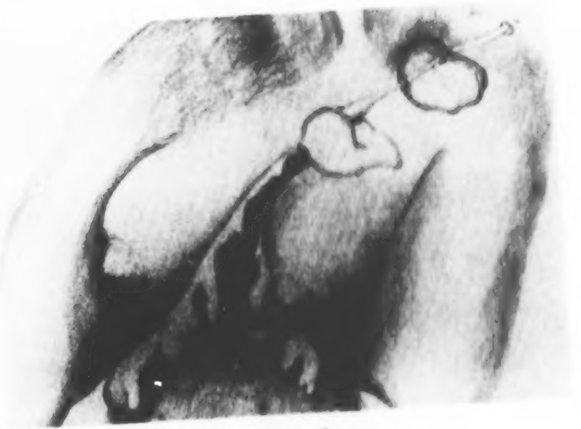


Figure 3

ferent frequency and impact force, and can affect muscular, mental, and nervous activity. Increasingly I began to cross-reference my intuitional drawings with the study of anatomy and physiology to describe other physical symptoms.

The following examples illustrate how I have used a range of media to heighten my abilities to visually express and identify physical ills. This methodology of using artwork to understand physical pathologies represents a phenomenological approach by examining the multiple realities of underlying forms and patterns to describe the phenomena of human consciousness. Unlike other methodologies, phenomenology cannot be reduced to hard and fast rules, yet the reduction of phenomena can be bracketed and studied.

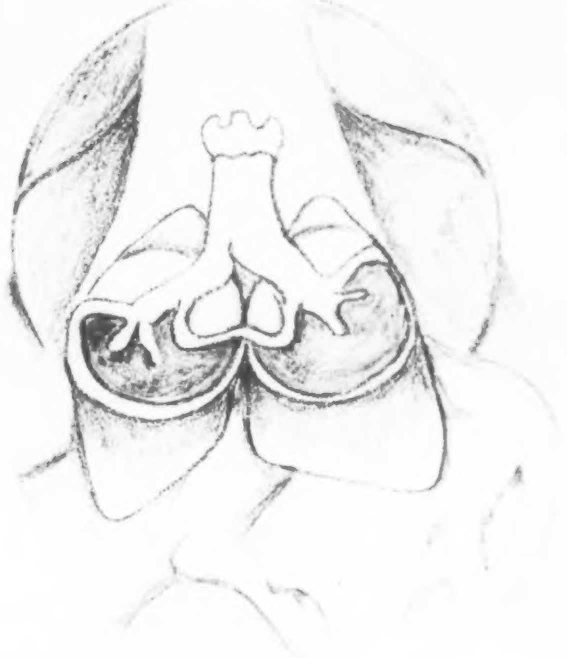


Figure 4

Based on my success in "drawing out" discomfort, I again used art to reconcile persistent pain in my upper left temporal region, intuitively expressing it as the color red and bringing in the color green to sooth the area (Figure 5). Throughout the next 10 years, cranial imagery would spontaneously crop up in my drawings, especially during times I was working through emotional issues and junctures.

Nearly 20 years after these first drawings were made, I would discover their hermeneutical associations when I was diagnosed as having temporomandibular joint disorder (TMJ): a group of conditions involving injury or dysfunction occurring in the temporomandibular joints, jaw, tissues, muscles, tendons, and ligaments involved in jaw movement.

A major theme occurring throughout the "Little People" drawings, the first drawings I used to represent psychological pain, depicted trauma to the head, which was continually being pierced by objects or severed from the body (Figure 1). Over the years, this suffering became more anatomically rendered, indicating perhaps the development of TMJ (Figure 6).

If it is accepted that long-term physical pain produces secondary psychological suffering, can long-term psychological pain produce secondary physical pain? Could it be that my TMJ was the result of continuing emotional distress, maintaining a "stiff upper lip," "gritting my teeth" to bear my adolescent years of isolation and disassociation (Figures 6 and 7)? Is it possible that these early drawings reflected the origins of a physical condition that only decades later would be diagnosed?

Another example of my personal use of art and its potential use as a medical diagnostic tool is found in a body of my early paintings and drawings, numbering in the hundreds, which increasingly reflected abstracted intrauterine imagery (Figure 8). As with the other drawings, these works of art were created spontaneously.

Many of these intrauterine images were recorded in Japanese accordion books which I used as visual diaries. In a Japanese accordion book, all the pages are attached to the others and fold in or out between two covers. The books range from 6 to 11 inches in size, and fold out in lengths from 4 to 15 feet long, allowing imagery and compositions to merge. The books' format, like human physiology, a continuous web of organic interplay, depicts interconnected imagery flowing from one point into another.

From 1975 to 1981, I used a range of media in the Japanese accordion books and my paintings to create surreal, abstract, realistic, and metaphorical images and symbols of intrauterine forms. During this time I consulted doctors about pain in my left abdominal region, only to be left with a bill for an undiagnosed

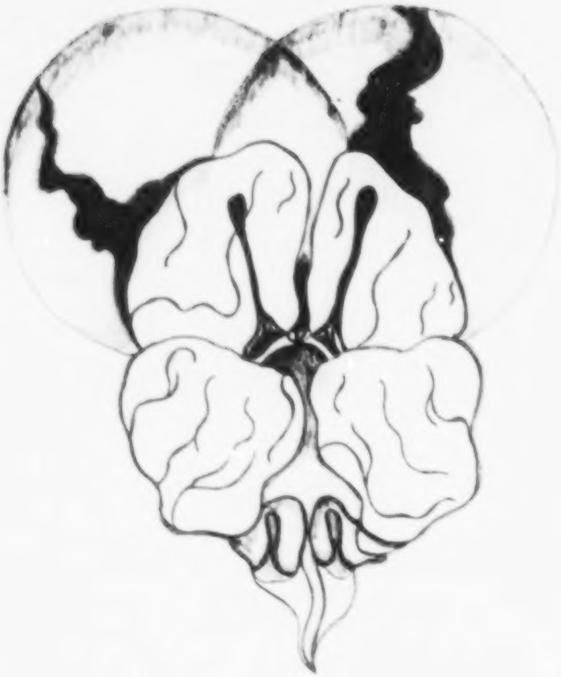


Figure 5

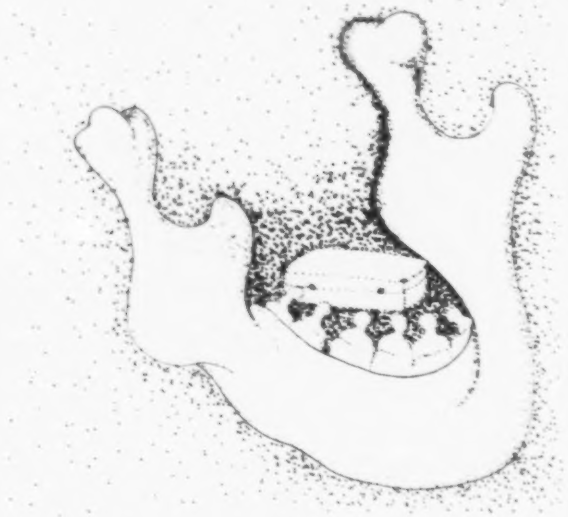


Figure 7

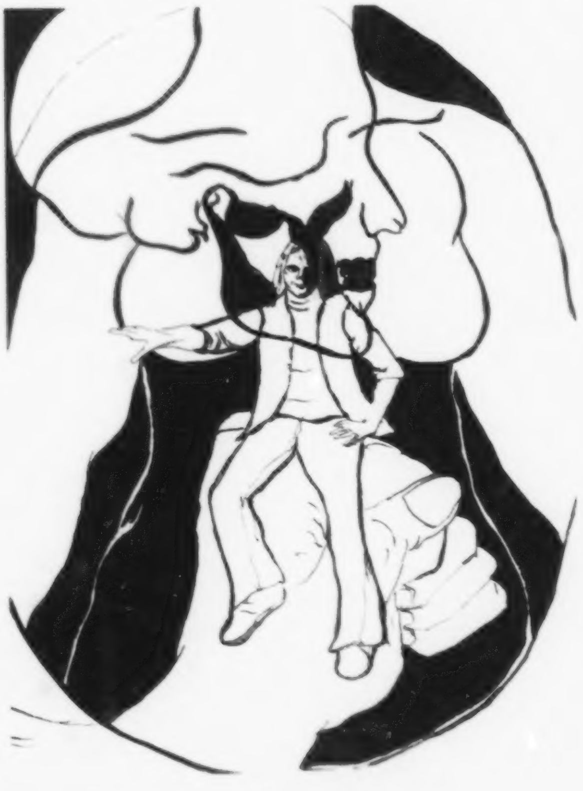


Figure 6

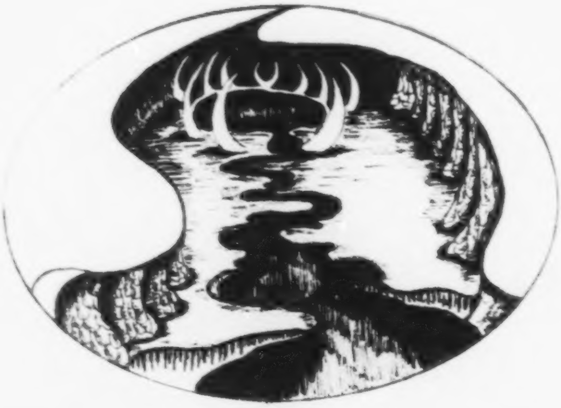


Figure 8

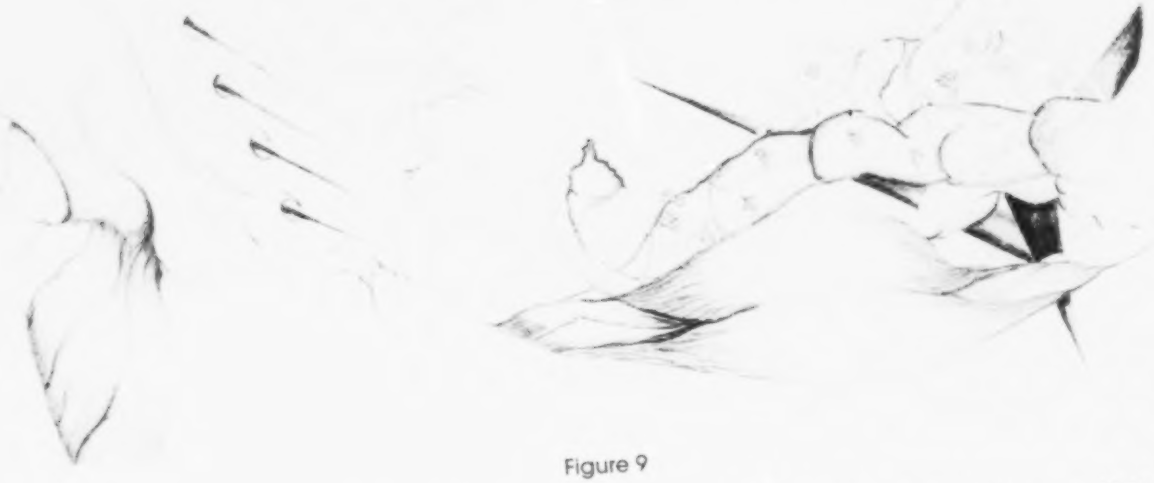


Figure 9

and often debilitating discomfort. One time I took some of these drawings to a doctor who looked at them, asked a few questions, and speculated that I had endometriosis, a condition characterized by the abnormal occurrence of functional endometrial tissue outside the uterus (Figure 9). The next day I underwent a laparoscopy and the doctor's conjecture was verified. Since first experiencing symptoms of endometriosis and beginning a series of abstract womblike artwork, the disease had spread and created numerous internal adhesions. Had I shown these drawings to a receptive doctor earlier, I may have been spared years of suffering and subsequent major surgery.

The Swiss physician and chemist Paracelsus generally believed the spirit can prevail over matter and subsequently manifest disease or health in the physical body. He also believed that the spirit is the master, imagination is the tool, and the body is a plastic material. In my case, imagination was the tool I used to document a visual history of pain and to help control both psychological and physical pain.

In a longitudinal study of artwork it could be possible to discover recurring themes, colors, and images that could help identify a disease or a particular stage in the development of a disease. Artwork used in the context of health care could, I believe, expedite diagnostic work. In addition, such a tool could be useful in working with children, people who are mentally and verbally impaired, and non-English speaking patients. This method of visual diagnosis could provide people with a sense of responsibility and ownership of their bodies and at the same time provide medical practitioners with a simple and cost-effective diagnostic tool.

References

Anderson, M. (1975). *Color healing*. New York: Samuel Weiser.

Clark, C. (1975). *The ancient art of color therapy*. New York: Simon & Shuster.

Goodrick-Clark, N. (1990). *Paracelsus: essential readings*. Wellingborough: Crucible.

Ouseley, S. (1949). *Colour meditations*. Essex: L.N. Fowler.

Pepin-Wakefield, Y. (1993). *Are nonverbal interventions that use drawing tasks more effective than verbal interventions in group problem-solving?* (Unpublished Doctoral dissertation, Fielding Institute, 72-73). University Microfilms International, 9403377.

Dreaming and Waking in Russia

Sally Brucker, MSW, ATR, Washington, DC

Introduction

Last winter I had a dream that literally took me places I had never dreamed of going. Like a foreign traveler, I allowed myself to go to unfamiliar places, trusting that if I ceased looking for "something," I would find what I was seeking. And it reminded me once again that when we are mindful of the connection between our waking and dreaming selves, we can experience moments of understanding and self-awareness not otherwise possible. While there are many theories and schools of thought pertaining to dreamwork, within the context of this article I will refer to Gestalt (Perls, 1969), Lucid Dreaming (LaBerge, 1983), and the "If this were my dream" technique (Ullman, 1979). The following is the story of my dreaming process and, as such, it moves between dreaming and waking states. I will begin with the dreaming state where, when my eyes were closed, it all began.

Dream of My Grandmother

While preparing for an art exhibition called "Dream Maps," I decided to keep a dream journal. I recorded the following dream in January, 1995:

> I am in an unknown country. Almost immediately, I see the tiny figure of my maternal grandmother, Jenny, standing in the center of a hall in a large, ornate, and somewhat gaudy art museum. She is dressed like a poor Russian peasant (which she once was) and is looking slightly forlorn. Although she has been dead for over 20 years, I sense that I am standing in her old-age home. I look around and notice a group of young troubadours rehearsing a play. They consist of men and women dressed in lavish period costumes, laughing merrily and drinking from enormous gold goblets. I realize it is *they* who are responsible for caring for my granny, and since they are clearly neglecting her, I become incensed. I stomp over to them demanding, "Why aren't you taking better care of my granny?" They laugh, pour me a glass of wine, and say, "Relax, Sally. Your granny is fine."

Since, in my work as a psychotherapist, I am accustomed to working regularly with dreams, my initial inclination was to delve into my own. But since I am also aware of the internal havoc dreamwork can wreak, in that moment I opted for avoidance.

Waking

In March, 1995, my exhibit, "Dream Maps," was shown in a gallery in Washington, DC. It consisted of abstract monoprints and handmade dream journals relating to the process of dreaming. The "dream maps" were intended, like dreams, to give the observer/dreamer the experience of traveling through an unknown landscape. They were also concerned with how light and image emerge in dreams and then become fragmented when the dreamer awakens. From the fragments, the dreamer, like the traveler, holds a map containing residues of form and feeling from which meaning must be deciphered. A woman from the Association for the Study of Dreams (ASD) attended the show and invited me to New York to take part in an art exhibit in conjunction with the ASD annual conference. I eagerly accepted and signed up for several sessions on dream interpretation including "Lucid Dreaming."

Lucid dreaming has been defined as the phenomenon of dreaming while being fully conscious that you are dreaming (LaBerge, 1985). During a lucid dreaming session, we were asked to go back into a dream that needed further work and, in a semidream state, to continue or to change aspects of the dream. I went back into my granny dream, but this time I approached my grandmother and asked her if she was indeed all right. She, in turn, smiled an angelic, ethereal smile and responded, "My dear, I am fine. Stop worrying so much about me, about the young people. Take time to visit this beautiful museum."

On awakening from our lucid dreams, we were asked to help create a "dream play" from one lucid dream so the group could help the dreamer elucidate further meaning. To my amazement, my dream was chosen! The actors volunteered and, as their director, I chose the cast and staged each scene. After an enthusiastic 10-minute rehearsal, the dream play began. The audience utilized the technique developed by Montague Ullman (1979) called "If this were my dream." Instead of offering a direct interpretation, their role was to help me (the dreamer) understand the dream by imagining that the dream was theirs. The statement "If this were my dream" was utilized as a way of doing this. I was then free to accept or reject any such statements. Through observing this process of my dream coming to life and through hearing the nonjudgmental comments made by others, I came to realize that my grandmother was telling me to stop worrying so much. Instead of focusing on the caretaking responsibilities of my now elderly mother and family, I should instead focus on myself. "Go to Russia and visit the Hermitage!" she suddenly seemed to be saying. I was both grateful and perplexed.

When I returned home, I opened my mail and found an announcement of a conference on Creativity and Psychotherapy in, of all places, St. Petersburg, Russia! By now, fully captivated by the call of my dream, I submitted a proposal for a workshop called "Drawing Your Dream Map." It was accepted and, with no hesitation, I decided to attend. What in the world, I wondered, are they dreaming about over there?

The Conference in St. Petersburg

This city of 5 million that stretches along the Neva River has often been called the Venice of Russia. Ornate former palaces and stately buildings painted in bright hues of ochre, azure, peach, and lime evoked a mood of nostalgia and delight. The

BEST COPY AVAILABLE

newly painted Hermitage stretched endlessly and beckoned brightly. Would I find my granny there? I wondered. We were there at the time of the white nights, which creates a mystical, dreamlike atmosphere in the evening. We strolled and watched the towers, statues, and buildings gleam against the river and canals. In stark contrast, by daylight, we saw the city's grime, the poor conditions of many people, the former prison for those who opposed Stalin's policies, and the unforgettable memorial for those who died in the horrific siege of Leningrad in 1942 and 1943.

The official title of the conference was "Exploration of Creativity, Third International Conference on The Creative Arts in Psychotherapy, Education, and Medicine, Nursing, and Human Relations." It extended for a period of 9 days, 6 days in St. Petersburg and 3 days in Vilnius, Lithuania. Cosponsors were Cross-Cultural Consultants of Milford, New Jersey and the Harmony Institute of St. Petersburg, Russia.

The Harmony Institute for psychotherapy and counseling was established in 1988 as the first comprehensive treatment and (more recently) training center in humanistically oriented psychotherapy. Its relatively small staff of 40 runs a crisis hotline for the city and provides crisis intervention and ongoing treatment, including expressive arts therapy, to individuals and families.

Participants in the conference included over 40 persons from the U.S. and Europe, representing a cross-section of disciplines. Over 120 Russian professionals and students attended the 4-day conference in St. Petersburg. More than 40 presentations of papers and workshops were made including, "Creative Confrontation in Psychotherapy," "The Effective Role of Expressive Communication in Work with School Age Children," and "Life Story: Art Therapy Analysis."

Drawing Your Dream Map

My presentation, "Drawing Your Dream Map," was a day-long workshop combining art therapy, dream enactment, and didactic presentations of theoretical and practical material related to dreaming. In the workshop, I presented the major theoretical foundations of dream analysis, including Freud, Jung, and Gestalt; described the inception and execution of my monoprints; and guided participants in art and drama activities designed to help them expand their creativity, self-expression, and understanding of their dreams. I had no idea who would attend, what their level of clinical experience and knowledge would be, or how receptive they would be to the methods presented. Would they be ideologically bent, fearful, rigid, incredulous, skeptical, analytically-oriented, bored, or unable to understand me? After all, it was only in the past few years that psychologists from western Europe and the United States have even been allowed to teach and freely exchange clinical data and vignettes with their Russian counterparts. I wondered also if the social problems so manifest at this time would supersede the seeming luxury of interpreting dreams.

I was both amazed and delighted to see 25 eager and curious men and women squeeze into the tiny room I had been given to conduct my workshop. They were teachers, music therapists, dance therapists, and art therapists from St. Petersburg, Moscow, Georgia, and Belarus. There was a Turkish psychiatrist and an American woman who had brought her own Russian interpreter—a delightful young woman who actively participated in the session. To my surprise, they were all eager to learn practical elements of expressive art therapy. When asked about their familiarity with major psychological theorists (Freud, Jung, Erikson, Gestalt, Systems, Object Relations Theory, etc.), they responded almost impatiently, "Don't you know that we Russians are considered to be the best informed people in the world? We have studied all the theories. Now let us practice." So much for my preconceptions of the poor, uninformed Russians! As it turns out, with the greater access to European and American resources (since Perestroika), they have devoured and digested a tremendous amount of theoretical material. Not as interested in orthodox theorists as much as active, dynamic processes, they were expressive therapists in the truest sense. For the next 8 hours, they listened, questioned, and eagerly threw themselves into the experiential work of drawing their dreams in handmade books, discussing them, and finally enacting them. I was curious about how comfortable they would be acting their dreams. When they protested my suggestion that they act out only two dreams due to time constraints and pushed for more, all barriers vanished. So, what *were* these Russians dreaming?

The Open Window—Natasha's Dream

Natasha, a 29-year-old music therapist from Moscow, had the following dream while on a pleasurable vacation:

> **Scene One**—I am in a beautiful place inside a lovely cottage. The sun is shining and the grass is green. There is not a cloud in the sky. The window is open and I can see clearly outside. I feel relaxed and comfortable.
>
> **Scene Two**—The day turns cloudy and the window appears, but now there is a curtain flapping madly in the wind. The sun disappears. There is no grass. I am frightened.

Disturbed and puzzled by her dream, Natasha asked, "Why would I dream this?" She then made a brief sketch of her dream and, using the gestalt therapy technique of identifying with each element of the dream in the first person, stated, "I am a window. I am open, receiving warm sun and light. I am a curtain flapping, covering the window." As she went deeper into this image, Natasha was struck by her fascination with the curtain, seeing it as the central element of her dream. Working further with this image and watching others enact her dream, Natasha realized how much she protected herself from acknowledging and expressing deeply felt pain and fear. The sunny house with no curtain was seen as mirroring her outer self. The curtained window, she thought, represented her defense against looking more deeply at her "clouds, storms, or shadow self."

I was amazed at the similarity between Natasha's dream and those of many of the women I see in my practice in Washington, DC. These defenses usually surface as they are about to enter the deeper work of therapy, where they must confront their fears, impulses, and deeper unconscious concerns. This dream poignantly conveyed the ambivalence of that moment. The vacation setting became a metaphor for Natasha's wish to delay the hard work ahead of her. A statement by one of the three men in the workshop, "I would hate to depend on the wind to determine which way I would go," and the women's sighs and laughter echo the different gender perceptions I hear quite often during the couples therapy sessions I lead. At this point, *I* began to daydream. Does Natasha's dream reflect the "dark side" of the Russian soul that appears in so many Russian novels I have read, or still yet, the ephemeral hold the Russian people feel they have on the sunny promise of Perestroika? As for Natasha, she appeared both exhilarated and exhausted.

The Coffee Cup and The Flower—Dmitri's Dream

In this seemingly simple, short dream, there appears a cup of black coffee with a flower sitting next to it. In relaying his dream, Dmitri, a young man of 30, posed Plato's eternal question to the group, "Is the glass half empty or half full?" The group responded with more questions: "Stirred or unstirred?" "Asleep or awake?" Those who enacted this dream felt frustrated. They longed to stir the coffee, to drink it, to smell the flower, to create a romance from the image. For, unlike Dmitri, they were well past their adolescence! As for him, the image would remain as it appeared in his dream, a philosophical question, poised on the brink of change. It is evident that Dmitri could not take this image any further and that for him, it was enough. I could not help wondering though, *will* the cup be half empty or half full for him? Just that morning, Marina, my language interpreter, had commented to me that she was worried about the immediate future of her 19-year-old daughter who has just returned after a year in a university in the United States. "She was better off there," she confessed. "Here she will be marginalized. She must decide on a profession. There will be no room for the youthful explorations she experienced last year." What *will* happen to Dmitri's dreams?" I wondered.

Waking Thoughts

Both Natasha's and Dmitri's dreams touch upon the risks of life changes and choices. To enter the eye of the storm for Natasha meant that she would not feel safe, although she already knew that the flimsy curtain in her dream would not adequately protect her. The tension between the universal wish for childlike innocence and safety, and the drive towards self-knowledge was clearly one message contained in her dream.

In Dmitri's dream one might view the cup of coffee as a kind of wake-up call to adulthood, romance, sexuality, or action—a call away from childhood which, understandably, he approaches with uncertainty. My "granny" dream can be seen as another call to action, to look at my past and to move forward. In order to do so, I must make choices for myself not always based on what is good for others. The human urge to delay or defend loss, a necessary precursor to change, is a recurrent and universal theme in psychotherapy as well as political and social change.

Dream Catcher

I know so little about the daily lives of the men and women in the workshop, yet for one day, we shared the intimate space of our dreams. Their humanity, humor, and spirit touched me deeply. Even more than that, it reassured me. One poignant moment I will never forget occurred on a day I decided to go off on my own. Due to the paucity of cabs near our hotel, I dashed off with what little time I had and literally jumped on a trolley car. Initially feeling quite proud of myself and, not worried that I spoke no Russian, I sat enjoying the sights, reassuring myself that all the trolleys eventually headed towards central St. Petersburg. This trolley, however, began making several turns away from the center of town and soon I found myself in an unknown, exceedingly dreary, and increasingly frightening part of town. Encountering a steady stream of somber and unfriendly faces, I began to panic! By now, at least 40 pairs of unfriendly eyes were upon me and the center of town seemed impossibly far away. This was beginning to feel like one of those endless and frustrating really *bad* dreams saved only by the realization that it *is* "only a dream" Just when it seemed I would be riding around St. Petersburg forever, the trolley finally turned and a friendly pair of eyes met mine, inquiring if she could help. Irina, a beautiful young architect who spoke fluent English, got off the trolley with me, helped me onto another, and rode with me to my destination. When she left me, I told her she was my "angel" and that I would like to give her a gift. I reached into my briefcase and there it was—not something I usually carry with me. I handed Irina my small Native American dream catcher that I had brought to show my workshop participants. "Please take this," I said. She smiled as I told her the story of the dream catcher and of my own dream of coming to Russia. We embraced, parted, and I turned to enter another dreamlike space, the enchanting "Summer Garden."

In 1908, my grandfather Sam, AWOL from the Russia army jumped a ship, dreaming of America. Soon after he was settled, he sent for my Grandmother Jenny. In 1995, I hopped a plane with my backpack and briefcase in tote, dreaming of Jenny. When I finally made it to the Hermitage, I could have sworn I saw her there, smiling her ethereal smile and teaching me more about dreaming than I could have ever learned elsewhere.

References

La Berge, B. (1983). *Lucid dreaming*. New York: Ballantine.

Perls, F. (1969). *Gestalt therapy verbatim* Lafayette, CA: Real People Press.

Ulmann, M. (1979). *Working with dreams*. Boston: Houghton Mifflin.

Reviews

Creativity and Madness: Psychological Studies of Art and Artists

Edited by **Barry M. Panter, MD, PhD, Mary Lou Panter, RN, Evelyn Virshup, PhD, ATR,** and **Bernard Virshup, MD**
California: AIMED Press, 1995.

299 pp., 65 black & white illus., $24.95, hard cover. ISBN 0-9641185-1-3

Reviewed by **Martha P. Haeseler, MA, ATR-BC,**
Guilford, CT

People are always interested in the lives of famous artists, musicians, and writers and curious about what makes them tick: what psychological, physical, and societal forces have influenced them to create and have inspired the nature of their work. This book, written by mental health professionals, addresses such speculations in a series of psychoanalytically oriented essays.

My main criticism of this book is that the title, *Creativity and Madness*, implies a link between artmaking and psychological/mental instability and distress. This link is supported by the following quotes from the preface and introduction: "The material artists use for their art comes from the primitive levels of their inner lives. . . . To remain so in touch with that primitive self is to be on the fine line between sanity and madness. . . . [Artists] use the conflicts and torments as elements of the creative process" (Panter et al., 1995, p. xi). "We think that emotional suffering, and the struggle against it, is found in most great artists" (Panter et al., 1995, p. xvii). Some authors emphasize that the psychological problems of artists fuel their work. Edvard Munch is quoted as saying, "I want to keep these sufferings—being without them would ruin my art" (Panter et al., 1995, p. 81). Marcel Proust said, "Everything great in the world is created by neurotics" (Panter et al., 1995, p. 189). And indeed, this book describes many tormented lives, descents into madness, suicides.

Ever since Cesare Lombroso wrote that "geniuses should be diagnosed as suffering from a degenerative psychosis" (MacGregor, 1989, p. 94), questions have been raised such as those in this book: "Are creative artists mad?" (Panter et al., 1995, p. xvi) and "Must the artist suffer?" (Panter et al., 1995, p. xvii). These questions are worth asking. However, emphasizing a connection between art and madness only serves to perpetuate the stereotype that one has to be crazy to make art, which contrasts with a basic tenet of art therapy, that creativity lies within all people. I fully subscribe to psychological theories that attribute part of the impulse toward artmaking to efforts to repair early traumas, to restore losses, and to repair early narcissistic injuries. However, these experiences are universal to humankind and do not necessarily produce mental illness or great artists. And use of the word *defect* in the following quote, "Many creative persons suffer a structural defect, often related to early object loss, which may be temporarily healed by the artistic productions" (Garber, *citing* Klingerman, in Panter et al., p. 204) may be psychoanalytically applicable but nevertheless implies that there is something wrong with creative people. "Madness"—psychosis, schizophrenia, or bipolar disorder—can certainly be related to stress and trauma, but it is also a malfunction of brain chemistry, a physical illness with biological and genetic antecedents. Some people with psychotic illness can sustain a high level of functioning and quality of life, as does Kay Redfield Jamison (1995), whereas others become overwhelmed by the struggle to stay connected to reality and other people.

How do we explain the relatively high incidence of psychotic illness among famous artists, writers, and musicians? Perhaps their drive to create is nature's response to the incipient illness as it is experienced by these talented people. In the face of loss of self and reality they turn to artmaking to marshall all their resources to heal themselves, to order the disordered, to express their pain, and to reestablish their selves. Art therapists often see this drive to create in their psychotic clients. If there is a connection between creativity and madness, I would argue that it is because many people who are "mad" make art to maintain a connection to the world and themselves, not because people who are creative are "mad." Furthermore, there are many sane artists (some of whom are art therapists) and many psychotic people who are not artists.

If this were a book about psychotic artists the title would fit. However, the book also describes the wonderfully resilient lives of Michelangelo, Elizabeth Layton, and Pieter Breugel the Elder, and some authors describe the "reparative, and even lifesaving" (Berman, in Panter, et al., p. 60) function of artmaking, especially for people in distress. All of the authors are respectful to the artists and some provide a thorough overview of the work of leading theorists who have written about the psychology of artists. Many of the authors provide a complete picture of the artist's social, political, and artistic milieu and discuss how the artwork relates to both inner and outer necessities. Some briefly mention possible genetic factors contributing to the artists' psychological distress. The authors who state that they themselves are artists, writers, and musicians seem to have the most sensitive understanding of the artistic process. For example, Mallin (Panter, et al.) points out that the poverty and rejection often experienced by artists, "with swings between depression and elation, can predispose a person to being cast by society as mentally ill" (p. 112).

In a psychological study of art and artists, I would wish to see more discussion of the ideas of Dissanayake (1994) about the importance of art and ritual in meeting fundamental needs of societies and individuals, the ideas of Prinzhorn (1922) about

BEST COPY AVAILABLE

humankind's innate impulses to make art, and the ideas of Kramer (1971)—that in the sublimation process people attain their highest level of functioning.

In the preface, Panter writes that the book "is intended for both the lay person interested in psychology, art, and the creative process, as well as the mental health professional" (p. xii). As a result, there is an admirable attempt to explain complex psychological theories in simple language, including a glossary defining art and psychology terms that may be unfamiliar to a lay reader. However, in some articles this simplification seems to have inclined the authors to emphasize a single explanation for artists' distress, which seems reductionistic in the light of the complexity of the subject. For example, Bond (Panter et al., 1995), writing of Virginia Woolf, includes much interesting detail about her upbringing and discusses her development in terms of Phyllis Greenacre's seminal thoughts about the development of genius. The author reviews Margaret Mahler's stages of separation and individuation, argues that Woolf never attained psychological separation from her mother, and correlates the rapprochement subphase with bipolar disorder: "The manic condition, then, is a desperate compromise between the attempt to avoid further regression to the symbiotic state of dissolution of self, and the frantic urge to ward off a painful reality" (p. 238). The arguments are compelling and well-illustrated with excerpts from Woolf's writing. However, discussion of Woolf's psychological development should at least acknowledge her strongly ambivalent relationship with her father, with whom she identified (Panken, 1987), and who himself often collapsed in "fits of the horrors" (Bell, 1972, p. 39). Mention should also be made of her sexual molestation by her half brother, George Duckworth, when she was 6, and again after her mother's death when she was 13, a few months preceding her first psychotic episode (Bell, 1972). These violations may well have contributed to the development of her symptoms of anxiety, anorexia, and dissociative states.

Attention to a few technical details would have improved the professional presentation of the book. For example, there is no illustration list giving sources of the art reproductions, there are many quotations given without reference, and there are also many typos and errors, for example, Kavanah, in Panter et al. (1995) gives Picasso's birth date as 1881, then writes "in 1931, when Picasso was 40…" (p. 226).

In sum, the book transcends its name. It is evident in reading this book that art is not only about torment and madness. The motivations for and products of the artmaking process are as wide-ranging and deep as life itself and include light as well as dark, joy as well as pain, sanity as well as madness, love as well as death.

References

Bell, Q. (1972). *Virginia Woolf: a biography*. New York: Harcourt Brace Jovanovich.

Dissanayake, E. (1994). *Reflecting on the past: Implications of prehistory and infancy for art therapy's future*. Keynote speech presented at the 25th Annual Conference of the American Art Therapy Association, Chicago, IL.

Jamison, K. R. (1995). *An unquiet mind: A memoir of moods and madness*. New York: Alfred A. Knopf.

Kramer, E. (1971). *Art as therapy with children*. New York: Schocken Books.

Lombroso, C. (1864). *Genio e follia*. Milan.

MacGregor, J. M. (1989). *The discovery of the art of the insane*. Princeton, NJ: Princeton University Press.

Panken, S. (1987). *Virginia Woolf and the "Lust of Creation." A psychoanalytic exploration*. Albany: State University of New York Press.

Prinzhorn, H. (1922, English translation 1972). *Artistry of the mentally ill*. New York: Springer-Verlag.

Literacy Through the Book Arts

by **Paul Johnson**, Portsmouth, NH: Heinemann, 1993.

155 pp., 39 black & white illus., 52 figures, 87 diagrams, $18.95 cloth. ISBN 0-435-08766-5

Reviewed by **Leslie P. Knowles, MA, ATR, LMHC**, South Dartmouth, MA

Literacy Through the Book Arts is the second in a series of books by author Paul Johnson (*A Book of One's Own* is the first) in which he examines the multiple possibilities found in the form of book art. Although teachers and parents are the intended audience for the book's message of what children are capable of achieving using words, illustration, and design, art therapists will find the book useful in their clinical practices and personal art expression.

The book is divided into four parts with an introduction, conclusion, and an appendix that includes suppliers of book art materials and equipment in both the U.S. and the U.K. Johnson uses simple, easy-to-follow instructions, supported throughout the book with diagrams and examples of children's work. He clearly illustrates how many of the book forms can be made from a single sheet of paper.

Part 1 of the book is a rather lengthy, historic overview of book art and a discussion of language in its written and visual form. Chapter 3, titled "The Psychology of the Fold," peaked my interest as Johnson begins to examine the appeal of the book format both historically and today. The folding of a single piece of paper can create a three-dimensional environment that is able to change its shape while remaining the same form. "The fold is an invitation into something tantalizingly magical. We enter a book through a fold; without it there is no way in, and once in, no way out without it" (p. 35). He discusses the "image-making plasticity" of the folded piece of paper and the three-dimensional appeal of the format, which "begs to be energized with communicating symbols" (p. 35).

In this chapter, Johnson begins his discussion of the two basic approaches to book art that he details in Parts Two and Three: the concertina (or accordion) book and the origami book. By the time I finished this section, which includes wonderful illustrations and diagrams, I was ready to start folding.

Part Two has three chapters that detail the potentials of the concertina format. In its simplest form, the concertina is a rectangular piece of paper folded four times to create a free-standing horizontal book that has eight possible pages. Johnson describes numerous approaches to creating a concertina book and illustrates his discussion with books written by children.

Conversations about the book are included, both in this chapter and in other sections of the book, in a question/answer format. The children are encouraged to talk about source material, writing style, and illustrations. The author shares work done by both individual children and small group collaborations, discussing the benefits of both approaches.

I was intrigued by the enormous range of books that are introduced and illustrated, from the simple four-fold, eight-page book, to the imaginative "top-cut" book, to the detailed, intricate "pop-up" book, to the extended form that includes the work of multiple artists. The variations appear to be endless.

Part Three explores the "origami continuum." As explained by Johnson, "The only structural difference between a concertina book and an origami book is a cut across the central panels of the landscape horizontal" (p. 105). While the pages of the concertina book can be turned in the conventional reading manner, it is without a central, pivotal spine. Johnson explains that the absence of a spine is contrary to our traditional expectations of how a book should appear. The origami book looks like a real book with a spine and a front and back cover, all clearly defined. The author discusses the potential this book form has to influence cognition and creative action.

The final section of the book discusses in detail the materials needed for book art. This section may be redundant for most art therapists who have a prior understanding of art materials. There is also a section on displaying books and evaluating finished work that is applicable to educational but not clinical settings.

As stated earlier, this book is intended for use by teachers and parents whose children are exposed to this holistic approach to learning in school. Although the teachers are instructed to incorporate bookmaking into their classroom curriculums, much of the work is continued, expanded, or completed at home where parents are encouraged to both assist and participate with their children in the process. As an art form that has both creative and therapeutic potentials, bookmaking for use in a clinical practice has possibility and merit. As I read the book, I imagined numerous clients and groups that would benefit from the structure that book art can provide. The idea of personal storytelling through the book form has value, as does metaphorical storytelling. The relative simplicity or complexity of bookmaking can be adapted to the needs of each population. While reading Johnson's descriptions of his work with 4-year-olds, I could imagine applying the same structure to a geriatric group involved in life review.

Books can bring up the notion of the "happy ending." For clients who have difficulty envisioning a new way of life, the process of creating a book with a positive outcome could assist them in visualizing change and growth. In my work with children who are victims of abuse and adolescent sex offenders, I see many ways to utilize the book format—from the keeping and sharing of secrets, to the development of pragmatic ways to keep self and others safe. As part of a group session, bookmaking could be used in a variety of ways to create trust, cooperation, and group identity.

Used as a part of any therapy session, this format would require an active role by the therapist. Many clients would need help planning, cutting, and writing, but the process could be both productive and healing. Johnson includes illustrations of books that are precut along the top edge by the teacher into forms that stimulate the children, as well as books that are cut as part of the story developed by the child.

This form of artmaking is also quite inexpensive and requires a minimum of effort lugging materials. The author's recommended paper, cutting utensils, and art materials are basic and easy to acquire. All can be adapted for use with a variety of client populations. Johnson encourages the children, whenever possible, to be allowed to cut the book forms themselves. Obviously, the sharp craft cutters recommended for much of this work would be inappropriate for many clients, but scissors would be an adequate replacement.

Literacy in the Book Arts is a book that art therapists will appreciate, especially those interested in a holistic approach that enables clients to benefit from the combined use of the word and the image. Johnson encourages his readers to become book artists themselves, a notion that I would endorse. Since reading the book, I have become a novice bookmaker and have found it to be an enjoyable variation on the journals I have kept for years. Johnson concludes his book a bit dramatically, but in the same spirit of enthusiasm found throughout the book:

> For those who have come to know the magic and renewing power of the book form and felt its magnetic attraction, life can never be the same again. May all of us, through our own books, seek out a form of expression that is more purely and essentially our own. (p. 153)

CALENDAR OF EVENTS

1997

FEBRUARY

The 6th Annual "Emerging Artists Competition" will be held in New York City at Slowinski Gallery's Mulberry Street exhibition space. The first prize is $1,000.00 and the deadline for submissions is October 30, 1996. Send a SASE for prospectus to Slowinski Gallery, 215 Mulberry Street, New York, New York 10012 or e-mail: slowart@aol.com. For more information call (212)431-1190.

ANNUAL INDEX: VOLUME 13

Index A. ARTICLES

Barbee, M. *Men's Roles and Their Experience of Depression* . . . 31

Brody, R. *Becoming Visible: An Art Therapy Support Group for Isolated Low-Income Lesbians* . . . 20

Burt, H. *Beyond Practice: A Post Modern Feminist Perspective on Art Therapy Research* . . . 12

Byers, J. G. *Children of the Stones: Art Therapy Interventions in the West Bank* . . . 238

Dickman, S. B.; Dunn, J. E.; & Wolf, A. W. *The Use of Art Therapy as a Predictor of Relapse in Chemical Dependency Treatment* . . . 232

Essex, M.; Frostig, K.; & Hertz, J. *In the Service of Children: Art and Expressive Therapies in Public Schools* . . . 181

Feen-Calligan, H. *Art Therapy as a Profession: Implications for the Education and Training of Art Therapists* . . . 166

Kidd, J. & Wix, L. *Images of the Heart: Archetypal Imagery in Therapeutic Artwork* . . . 108

Muri, S. A. *Dali to Beuys: Integrating Art History into Art Therapy Treatment Plans* . . . 102

Piccirillo, E. *In Search of an Accurate Likeness: Art Therapy with Transgender Persons Living with AIDS* . . . 37

Schwartz, N. *Observer, Process, and Product* . . . 244

Sherebrin, H. *Gender Dysphoria: The Therapist's Dilemma—The Client's Choice* . . . 47

Smitheman-Brown, V. & Church, R. P. *Mandala Drawing: Facilitating Creative Growth in Children with A.D.D. and A.D.H.D.* . . . 252

Vick, R. M. *An Interview with Don Seiden* . . . 191

Vick, R. M. *The Dimensions of Service: An Elemental Model for the Application of Art Therapy* . . . 96

Wix, L. The Art in Art Therapy Education: Where Is It? . . . 174

Zeigler, H. A. & Hays, R. *Contributions to Art Therapy Literature: A Computer Database Survey* . . . 91

Index B. BRIEF REPORTS

Carmi, S. & Mashiah, T. *Painting as Language for a Stroke Patient* . . . 265

Hite, S. P. *A Reference Library for School Art Therapists* . . . 202

Hrenko, K. D. & Willis, R. *The Amusement Park Technique in the Treatment of Dually Diagnosed, Psychiatric Inpatients* . . . 261

Pearson, S. L.; Walker, K. K.; Martinek-Smith, M.; Knapp, N. M.; & Weaver, K. A. *American Art Therapy Association, Inc.: The Results of the 1994-1995 Membership Survey* . . . 121

Silver, R. *Gender Differences and Similarities in the Spatial Ability of Adolescents* . . . 118

Wadeson, H. *Are Art Therapy Educators Overworked and Underpaid?* . . . 198

Weber, J. A.; Cooper, K.; & Hesser, J. L. *Children's Drawings of the Elderly: Young Ideas Abandon Old Age Stereotypes* . . . 114

Index C. DEPARTMENTS

Viewpoints

Addison, D. *Message of Acceptance: "Gay-Friendly" Art Therapy for Homosexual Clients* . . . 54

Allen, P. B. *Writers Need Not Be Loners* . . . 60

Andruk, S. *Earthquake!* . . . 136

Bergin, A. E. & Niclas, M. A. *Considerations for the Treatment of Childhood Gender Identity Disorder* 270

Brucker, S. *Dreaming and Waking in Russia* . . 297

Campanelli, M. *Pioneering in Perth: Art Therapy in Western Australia* 131

Franklin, M. *A Place to Stand: Maori Culture—Tradition in a Contemporary Art Studio* 126

Haeseler, M. P. *The Absent Father: Gender Identity Considerations for Art Therapists Working with Adolescent Boys* 275

Hartman, K. B. *Summer of Transition: A Visual Essay* 62

Knowles, L. P. *Art Therapists Exhibiting Children's Art: When, Where, and Why* 205

Milligan, L. *A Mother's Journey of Healing: When a Child Changes Gender* 282

Pepin-Wakefield, Y. *Artistic Production as a Diagnostic Approach to Illness* 293

Perdoux, M. *Art Beyond Humanism: Non-Western Influences on an Art Therapist's Practice* 286

Riley, S. *Reauthoring the Dominant Narrative of Our Profession* 289

Wadeson, H. *When the Edges Bleed...* 208

Wadeson, H. *Wrestling the Hydra or Can an Art Therapist Find Aesthetic Fulfillment in the Marketplace?* 57

Book Reviews

Cheyne-King, S. *Telling Without Talking: Art as a Window into the World of Multiple Personality* 64

Golub, D. *Children's Images of Trauma: Terezin, Cambodia, Israel, El Salvador, West Bank and Gaza, South Africa, and Washington, DC* . . . 64

Haeseler, M. P. *Creativity and Madness: Psychological Studies of Art and Artists* 300

Johnson, C. *Dance and Other Expressive Art Therapies: When Words Are Not Enough* 214

Knowles, L. P. *Literacy Through the Book Arts* 301

Lovenbury, K. *Soldier's Heart: Survivors' Views of Combat Trauma* 213

Lusebrink, V. B. *Telling Without Talking: Art as a Window into the World of Multiple Personality* 211

Murphy, P. E. *Existential Art Therapy: The Canvas Mirror (Second Edition)* 141

Rutstein, R. *Creative Whack Pack: Success Edition* 142

Yale, A. *Dreams and Memories* 211

Video Review

Flanagan, L. *Drawing from the Fire* 215

Editorials

Malchiodi, C. A. *Art Therapists in Cyberspace* 230

Malchiodi, C. A. *Finding Art Therapy on Databases* 86

Malchiodi, C. A. *Introduction to the Special Issue on Art Therapy & Education* 162

Malchiodi, C. A. *Women and Art Therapy* . . . 2

SPECIAL SECTIONS

26th Annual Conference

26th Annual Conference Program 6

Lusebrink, V. B. *HLM Award Acceptance* . . . 10

Vick, R. M. DS Award Acceptance 10

Special Award to Nancy Schoebel 11

2546

ALLEGHENY
UNIVERSITY
OF THE HEALTH SCIENCES

We've Changed Our Name, But Not Our Program.

The Art Therapy Program

at Allegheny University of the Health Sciences, formerly Medical College of Pennsylvania and Hahnemann University, is part of the unique and world-renowned Creative Arts in Therapy Graduate Program at home in an academic health center. The didactic, clinical and supervisory aspects of the program are balanced and integrated to provide a foundation of theoretical knowledge and practical application. To learn more, visit us; talk to our students and faculty.

Call (215) 762-6924 or visit us at www.allegheny.edu.

Allegheny University of the Health Sciences
Department of Mental Health Sciences
Mail Stop 905, Broad & Vine • Philadelphia, PA 19102-1192

The following posters by members of the
American Art Therapy Association
are available for purchase.

	MEMBERS	NON-MEMBERS
"I'm Into Art Therapy" (Elizabeth "Grandma" Layton)	$20.00	$30.00
"Three Art Therapists" (Edith Kramer)	$20.00	$30.00

NOTE: Shipping and handling is included on both posters.

Make checks or money orders payable to AATA in U.S. funds and return with this order form to:

American Art Therapy Association, Inc.
1202 Allanson Road
Mundelein, Illinois 60060

Please enter my order. Enclosed is a check/money order for the appropriate amount: $__________

Name: ____________________

Address: ____________________

City: __________ State: _____ Zip: _______

THE REMUDA SYSTEM CAN HELP WOMEN AND ADOLESCENTS SUFFERING WITH EATING DISORDERS

CONTINUUM OF CARE

Adult/adolescent inpatient, adult/adolescent residential, partial care and intensive outpatient treatment sites provide tranquil, specialized settings.

◆

LICENSURE

State licensed, JCAHO accreditation with commendation and CHAMPUS provider.

◆

STAFF

Highly skilled professional staff of licensed psychiatrists, internists, psychologists, RN's, master level therapists and registered dietitians providing individualized programs and lengths of stay.

◆

A COMPREHENSIVE PROGRAM

We treat the whole person with individualized programs designed to meet medical, nutritional and psychological needs, blending these components with a non-denominational Christian perspective.

◆

EXPRESSIVE THERAPIES

Provided as a powerful tool to assist individuals in exploring their identities and problems through the use of their own creativity. Activities include art therapy, music, dance/movement and creative writing.

◆

AFTERCARE TRANSITION

Remuda's Aftercare Coordinator will work with the referring professional prior to the patient's discharge to facilitate her transition back into an outpatient setting as she resumes her day-to-day activities.

Most insurance accepted

REMUDA
Ranch
Center for Anorexia and Bulimia, Inc.
P.O. Box 2481
Wickenburg, Arizona 85358
1 (800) 445-1900

INNOVATIONS

Puts New Research to Work for You

Community-Based Instructional Support
by David W. Test and Fred Spooner
Reveals a wealth of research and literature on instructional strategies designed to teach chained tasks in community settings.
34 pp., ISBN 0-940898-43-8
$21.95
($19.95 - AAMR members)

Teaching Practical Communication Skills
by Kathleen Dyer and Stephen C. Luce
Provides practitioners with field-tested strategies for instructing students who communicate in various modes, including gestural, verbal, sign language, and communication boards.
30 pp., ISBN 0-940898-42-X
$21.95
($19.95 - AAMR members)

Opportunities for Daily Choice Making
by Linda M. Bambara and Freya Koger
Describes basic principles of choice making, presents how to teach choice making to the passive learner, describes how to build in daily choice making, and addresses common questions about choice making.
52 pp., ISBN 0-940898-44-6
$21.95
($19.95 - AAMR members)

To order by phone or fax using your credit card, Call 301/604-1340 or Fax 301/206-9789

AAMR
AAMR Publication Center • P.O. Box 25, Annapolis Junction, MD 20701-0025

Volume II of "Quality of Life" Released by AAMR

Quality of Life: Volume II
Application to Persons with Disabilities
Edited by Robert L. Schalock

Compliments "Quality of Life: Volume I, Conceptualization and Measurement"

This second volume discusses quality of life applications in the areas of service delivery, organizational change, and public policy. Volume II identifies key future issues necessary to improve the lives of people with disabilities, and the importance of ethnicity in understanding and applying the quality of life concept. These topics are discussed within the framework of ten core quality of life principles by 27 respected authors. Don't miss this comprehensive two-volume set! **Buy both volumes today and get a 10% discount!**

ISBN 0-940898-41-1; $35 ($29.75 AAMR Members)

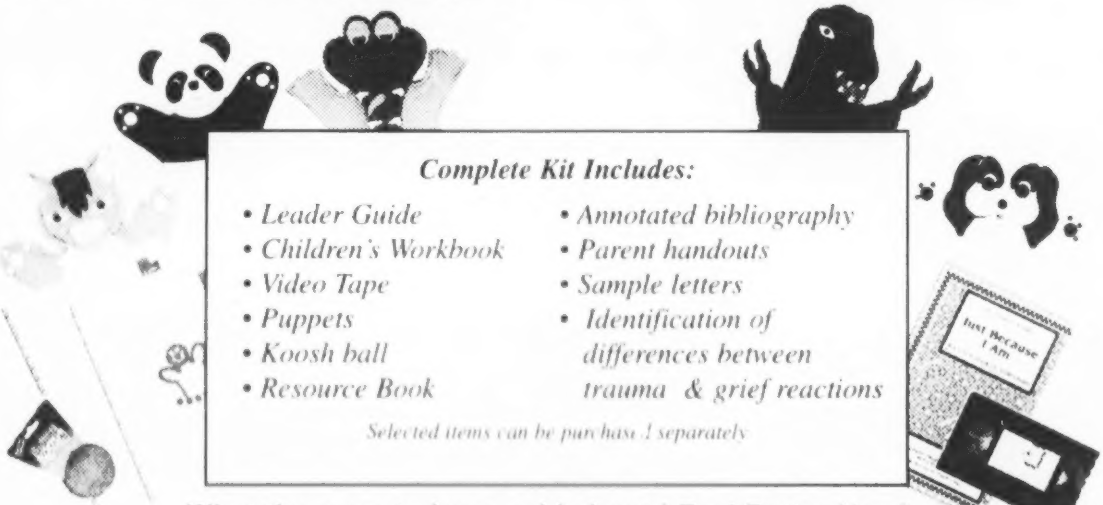
Order by phone or fax. Call 301/604-1340 or Fax 301/206-9789

AAMR
AAMR Publication Center • P.O. Box 25, Annapolis Junction, MD 20701-0025

Helping Traumatized Children
Find Relief
From the Terror of their Trauma

I Feel Better Now! is . . .

- An eight session group program for children 6 - 12 years old.
- Deals with violent and non-violent trauma including incidents including murder, suicide, witness to violent or non-violent yet traumatic incidents, death by fire, drowning, car crashes, other unexpected losses, environmental traumas, forced separation from parents, divorce.
- Field tested in schools and agencies with150 traumatized children.
- The group process is based upon an educational model of teaching, exploring, guiding, normalizing, and the reframing of experiences. Feelings are addressed in order to be normalized, not analyzed.



Complete Kit Includes:

- *Leader Guide*
- *Children's Workbook*
- *Video Tape*
- *Puppets*
- *Koosh ball*
- *Resource Book*
- *Annotated bibliography*
- *Parent handouts*
- *Sample letters*
- *Identification of differences between trauma & grief reactions*

Selected items can be purchased separately

What the experts have said about I Feel Better Now! ...

"I will be using this program again and again!" Lynn Hunt, Clinical Social Worker

"...most beneficial and needed program for traumatized children." Jan Hinton, MA, LPC, Psychologist

"...invaluable in helping children verbalize their painful losses." Donna Groth, MSW, School Social Worker

"Well organized, easy to follow, easy to implement, wonderful materials." Audrey Bauze, M.Ed, Elementary Counselor

"...definitely helps traumatized children in a concrete and supportive way." Peggy Schneider, MA, Elementary Counselor

"Extremely versatile and adaptable to the different kinds of trauma that children experience." Lynne Krajenke, ASCW, Clinical Therapist

"...wonderful opportunity for children to resolve issues they have had to bury within themselves." Dorris Paille, M.Ed, Elementary Counselor

TLC

To order: Call or FAX TLC with credit card informational
TEL (313) 885-0390, FAX (313) 885-1816.
To order by mail, send check for $95 plus $6.95 S & H to:
TLC, 900 Cook Road, Grosse Pointe Woods, MI 48236.

Developed by the Institute for Trauma and Loss in Children (TLC), a program of the Children's Home of Detroit, Michigan's oldest non-profit children's residential agency
Written by William Steele, MA, MSW, Director TLC Institute; Pamela Lemerand, PhD, Director Instructional Studies; Deanne Ginns-Gruenberg BSN, LLP

SOUTHWESTERN COLLEGE

A graduate institution offering adult learners a holistic, experiential and person-centered educational experience.

M.A. in Art Therapy

◆

M.A. in Counseling

◆

Art Therapy Certificate

SOUTHWESTERN COLLEGE
P. O. Box 4788
Santa Fe, NM 87502-4788
(505) 471-5756
e-mail: swclib@sfol.com

Deborah Good, Ph.D., ATR, LPAT, LPCC
Art Therapy Program Chair

Southwestern College is accredited by the Commission on Institutions of Higher Education of the North Central Association of Colleges and Schools. Southwestern College maintains a nondiscrimination policy.

COLLEGE OF NOTRE DAME

OFFERS:

- Master of Arts in Art Therapy (37 units)
- Master of Arts in Marital & Family Therapy (50 units)
- Post-Graduate Art Therapy Certificate Program (21 units)

- Systems & Jungian oriented art therapy
- AATA-approved Master's Programs
- MA in Marital & Family Therapy meets California state requirements for MFCC licensure
- Afternoons, evenings & weekends
- Summer Program

Art Therapy Program
COLLEGE OF NOTRE DAME
1500 Ralston Avenue
Belmont, CA 94002-1997

For program specifics call
(415) 508-3556

For an application call
(415) 508-3523

LOCATED IN THE BEAUTIFUL SAN FRANCISCO BAY AREA

ASGPP
55TH ANNUAL

PSYCHODRAMA CONFERENCE

February 20th - 24th, 1997
New York City

Where The Action Is:

Psychodrama, Expressive Arts, Group Psychotherapy

The **American Society of Group Psychotherapy and Psychodrama** invites you to join us at the **Holiday Inn Crowne Plaza in NYC** for our 55th Annual Psychodrama Conference: **"Where the Action Is"** February 20th - 24th, 1997. We will be exploring the widespread use of action methods in various disciplines. Included in the program will be:

- **Pre and Post Conference Training Institutes** in Psychodrama, Sociometry and Group Psychotherapy
- **Experiential Workshops** in Psychodrama, Playback Theater, Drama, Dance/Movement, Music, Art and Poetry Therapyet
- **Presentations and Post Conference Training Institute** on Psychodrama and Psychoanalysis
- **Workshops Using Action Methods** with Families, Couples, Adolescents, Eating Disorders, Past Life Regression, Trauma, Diversity, Education, etc.
- **KEYNOTE SPEAKER: BESSEL A. VAN DER KOLK M.D.** Associate Professor of Psychiatry at Harvard University; Chief, Eric Lindeman Trauma Center, Mass General Hospital, Author of PSYCHOLOGICAL TRAUMA

Join us in the **Heart of the New York City Theater District** for an exciting, spontaneous and creative event!

FOR FURTHER INFORMATION CONTACT:
Louise Lipman, CSW, TEP
Nan Nally-Seit, ACSW, PAT

ASGPP
19 West 34th Street
Penthouse Floor
NYC, NY 10001

(212) 947-7111 x 239, x 267
FAX (212) 239-0948
Email: LipmanNYC1@aol.com

BEST COPY AVAILABLE

CHARLES C THOMAS • PUBLISHER, LTD.

- Moon, Bruce L.—**ART AND SOUL: Reflections on an Artistic Psychology.** '96, 168 pp. (7 x 10), 15 il..
- Cohen, Jane G. & Marilyn Wannamaker—**EXPRESSIVE ARTS FOR THE VERY DISABLED AND HANDICAPPED FOR ALL AGES. (2nd Ed.)** '96, 236 pp. (8 1/2 x 11), 135 il., $40.95, spiral (paper).
- Benenzon, Rolando O.—**MUSIC THERAPY THEORY AND MANUAL: Contributions to the Knowledge of Nonverbal Contexts. (2nd Ed.)** '96, 300 pp. (7 x 10), 44 il.
- Plach, Tom—**THE CREATIVE USE OF MUSIC IN GROUP THERAPY. (2nd Ed.)** '96, 84 pp. (7 x 10), $29.95, cloth, $19.95 paper.
- Nucho, Aino O.—**SPONTANEOUS CREATIVE IMAGERY: Problem Solving and Life Enhancing Skills**. '95, 174 pp. (7 x 10), 15 il., $41.95, cloth, $25.95, paper.
- •Makin, Susan R—**A CONSUMER'S GUIDE TO ART THERAPY—For Prospective Employers, Clients and Students.** '94, 112 pp. (7 x 10), $29.95, cloth, $17.95, paper.
- Horovitz-Darby, Ellen G.—**SPIRITUAL ART THERAPY: An Alternate Path.** '94, 186 pp. (7 x 10), 33 il., $41.95, cloth, $29.95, paper.
- Kluft, Estelle S.—**EXPRESSIVE AND FUNCTIONAL THERAPIES IN THE TREATMENT OF MULTIPLE PERSONALITY DISORDER**. '93, 332 pp. (7 x 10), 32 il., 9 tables, $64.95, cloth, $37.95, paper.
- Fryrear, Jerry L. & Irene E. Corbit—**PHOTO ART THERAPY: A Jungian Perspective.** '92, 220 pp. (7 x 10), 24 il., $46.95, cloth, $32.95, paper.
- Gold, Muriel—**THE FICTIONAL FAMILY: In Drama, Education and Groupwork.** '91, 280 pp. (6 3/4 x 9 3/4), 28 il., $38.95, cloth, $26.95, paper.
- Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR.(2nd Ed.)** '88, 386 pp. (7 x 10), 11 il., 3 tables, $56.95, cloth, $39.95, paper.
- Levick, Myra F.—**THEY COULD NOT TALK AND SO THEY DREW: Children's Styles of Coping and Thinking**. '83, 240 pp. 134 il. (4 in color), 11 tables, $53.95, cloth, $38.95, paper.
- Krauss, David A. & Jerry L. Fryrear—**PHOTOTHERAPY IN MENTAL HEALTH**. '83, 260 pp. (6 3/4 x 9 3/4), 61 il. (5 in color), 1 table, $46.95, cloth, $32.95, paper.
- Benenzon, Rolando O.—**MUSIC THERAPY IN CHILD PSYCHOSIS.** '82, 112 pp., 34 il., $25.95, cloth, $16.95, paper.
- Spencer, Linda Bushell—**HEAL ABUSE AND TRAUMA THROUGH ART: Increasing Self-Worth, Healing of Initial Wounds, and Creating a Sense of Connectivity**. '97, 210 pp. (7 x 10), 10 il.
- Radocy, Rudolf E. & J. David Boyle—**PSYCHOLOGICAL FOUNDATIONS OF MUSICAL BEHAVIOR. (3rd Ed.)** '96, 400 pp. (7 x 10), 9 il., 3 tables.
- Love, Harold D.—**CHARACTERISTICS OF THE MILDLY HANDICAPPED: Assisting Teachers, Counselors, Psychologists, and Families to Prepare for Their Roles in Meeting the Needs of the Mildly Handicapped in a Changing Society.** '96, 240 pp. (7 x 10), 13 il., 22 tables.
- Brooke, Stephanie L.—**A THERAPIST'S GUIDE TO ART THERAPY ASSESSMENTS: Tools of the Trade.** '96, 164 pp. (7 x 10), 7 il., $32.95, cloth, $22.95, paper.
- Moon, Bruce L.—**EXISTENTIAL ART THERAPY: The Canvas Mirror. (2nd Ed.)** '95, 230 pp. (7 x 10), 21 il,$49.95, cloth, $33.95, paper.
- Exiner, Johanna & Denis Kelynack—**DANCE THERAPY REDEFINED: A Body Approach to Therapeutic Dance.** '94, 130 pp. (7 x 10), 12 il. $35.95
- Landy, Robert J.—**DRAMA THERAPY: Concepts, Theories and Practices. (2nd Ed.).** '94, 294 pp. (7 x 10), 1 table, $58.95, cloth, $39.95, paper.
- Moon, Bruce L.—**INTRODUCTION TO ART THERAPY: Faith in the Product**. '94, 222 pp. (7 x 10), 17 il., $47.95, cloth, $29.95, paper.
- Chickerneo, Nancy Barrett—**PORTRAITS OF SPIRITUALITY IN RECOVERY: The Use of Art in Recovery from Co-Dependency and/or Chemical Dependency**. '93, 254 pp. (7 x 10), 71 il., $51.95, cloth, $35.95, paper.
- McNiff, Shaun—**FUNDAMENTALS OF ART THERAPY**. '88, 262 pp. (6 3/4 x 9 3/4), 34 il., $48.95, cloth, $33.95, paper.
- Bruscia, Kenneth E.—**IMPROVISATIONAL MODELS OF MUSIC THERAPY**. '87, 606 pp. (7 x 10), 11 il., 38 tables, $92.95, cloth, $54.95, paper.
- Landreth, Garry L.—**PLAY THERAPY: Dynamics of the Process of Counseling with Children.** '82, 380 pp. $53.95, cloth, $36.95, paper.
- Espenak, Liljan—**DANCE THERAPY: Theory and Application**. '81, 210 pp., 33 il., $34.95.
- Kwiatkowska, Hanna Yaxa—**FAMILY THERAPY AND EVALUATION THROUGH ART**. '78, 304 pp., 125 il. (12 in color), 7 tables, $49.95, cloth, $34.95, paper.

Write, call (for Visa or MasterCard) 1-800-258-8980 or 1-217-789-8980 or FAX (217)789-9130

Books sent on approval • $5.50 - Shipping / $6.50 - Canada • Prices subject to change without notice

2600 South First Street • Springfield • Illinois • 62794-9265

MAGNOLIA STREET PUBLISHERS

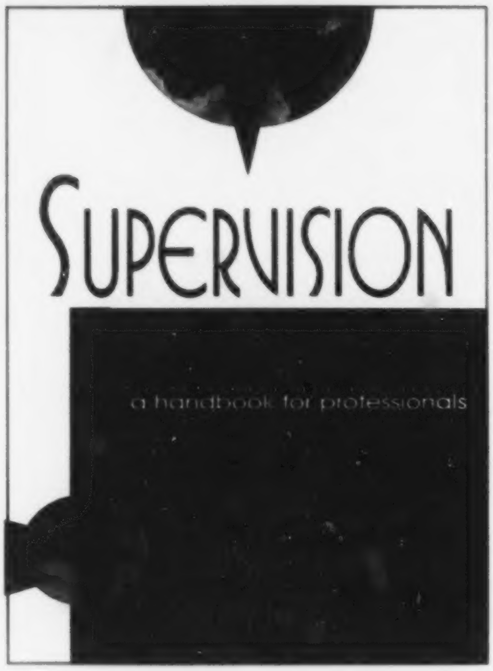
SUPERVISION and Related Issues:

A Handbook for Professionals

by Cathy Malchiodi and Shirley Riley

A long awaited text, this handbook is a highly informative guide to the complexities of supervision in the 90's. Supervisors, educators, and students will find it indispensable not only in the supervisory session, but also in the classroom and in work with clients. An extensive appendix includes ethics and standards of practice, sample forms for use in supervision, laws effecting supervisors and many more references and resources.

Paper $27.95



ART THERAPY IN THEORY & PRACTICE

Ed. by Elinor Ulman and Penny Dachinger

"Since its first publication, *Art Therapy in Theory and Practice*, has been used continually as both a textbook and a resource. Many of the chapters have become indispensable classics which continue to define the field of art therapy.

In this reprint, we re-encounter Elinor Ulman's skill as a writer and editor of great perception and eloquence. Her talent was to bring together the seminal writing of a burgeoning professional field and meld them into an organized, comprehensible body. This book, now available to a new generation of readers, stands as a testament to this art." RANDY M. VICK, MS, A.T.R.-BC **Paper 29.95**

MAGNOLIA STREET PUBLISHERS

5804 N. Magnolia St., Chicago, IL 60660 • 312-561-2121 • fax 312-477-6096

Wholesale and Bookstore orders to above address.

Individual orders to:
Stern's Books
2004 W. Roscoe
Chicago, IL 60618
312-883-5100, fax 312-477-6096

Add $4.00 UPS for first book and .75 for each additional book. Credit cards and checks accepted.

THE GESTALT ART EXPERIENCE, Patterns That Connect, Janie Rhyne	pa. **$24.95**
INTEGRATIVE APPROACHES TO FAMILY ART THERAPY, Shirley Riley & Cathy Malchiodi	pa. **$29.95**
ART AS THERAPY WITH CHILDREN, Edith Kramer	pa. **$19.95**
CALIFORNIA ART THERAPY TRENDS, Ed. Evelyn Virshup	pa. **$29.95**
SHATTERED IMAGES: Phenomenological Language of Sexual Trauma, Dee Spring	pa. **$36.00**
DYNAMICALLY ORIENTED ART THERAPY: It's Principals & Practice, Margaret Naumburg	hd. **$32.95**

AMERICAN ART THERAPY ASSOCIATION, INC.

1202 Allanson Road, Mundelein, Illinois 60060 (847) 949-6064 FAX: (847) 566-4580

RESOURCES

American Art Therapy Association, Inc. serves as a clearinghouse for information about the field of art therapy. The following publications, films, posters, and training literature are available from the AATA National Office.

CONFERENCE PROCEEDINGS	**MEMBERS**	**NON-MEMBERS**
Creativity and the Art Therapist's Identity (1976) ISBN 1-882147-04-9	$ 5.00	$ 7.00
Art Therapy: Expanding Horizons (1978) ISBN 1-882147-05-7	$ 5.00	$ 7.00
The Use of Creative Arts in Therapy (1979 Joint Conference)	$ 5.00	$ 7.00
Focus on the Future - The Next Ten Years (1979) ISBN 1-882147-10-3	$ 6.00	$ 8.00
The Fine Art of Therapy (1980) ISBN 1-882147-12-X	$ 7.00	$10.00
Art Therapy: A Bridge Between Worlds (1981) ISBN 1-882147-11-1	$ 7.00	$14.00
Art Therapy: Still Growing (1982) ISBN 1-882147-06-5	$10.00	$14.00
Professionalism in Practice (1988) ISBN 1-882147-08-1	$15.00	$20.00
Painting Portraits: Families, Groups and Systems (1989) ISBN 1-882147-07-3	$15.00	$20.00
Image & Metaphor: The Practice & Profession of Art Therapy (1991) ISBN 1-882147-09-X	$15.00	$20.00
The Art Therapist: Artist, Teacher, Clinician, Healer (1992) ISBN 1-882147-14-6	$15.00	$20.00
Common Ground: The Arts, Therapy, Spirituality (1993) ISBN 1-882147-21-9	$15.00	$20.00
Reflecting on the Past, Envisioning the Future (1994) ISBN 1-882147-24-3	$15.00	$20.00
Weaving New Visions (1995) ISBN 1-882147-50-2	$15.00	$20.00
Many Paths; Multicultural Perspectives in Art Therapy (1996) ISBN 1-882147-51-0 (available after 11/13/96)	$20.00	$25.00

NOTE: Ten (10) or more copies of a single proceeding—10% discount on total. Set of four (4) proceedings (consecutive years)—20% discount on total. Postage/handling—$3.00 first item; $0.75 each additional item.

PUBLICATIONS	**MEMBERS**	**NON-MEMBERS**
A History of Art Therapy in the United States[1,2] (1994) Junge & Asawa ISBN 1-882147-23-5	$35.00	$50.00
Continuous Quality Improvement Manual[3] (1994) Howie & Gutierrez ISBN 1-882147-16-2	$20.00	$35.00
A Guide to Conducting Art Therapy Research ISBN 1-882147-03-0[1,2]	$24.00	$35.00
Art Therapy in the Schools[3]	$ 6.00	$10.00
National Registry of Master's Theses & Practicum Papers[3]	$15.00	$25.00
Addendum to National Registry of Master's Theses & Practicum Papers[3]	$12.50	$22.50
Applying for Funds from Your Area Agency on Aging[3]	$ 7.00	$10.00
Aging Artfully: Health Benefits of Art & Dance[3]	$ 7.00	$10.00

NOTE: [1] Postage/handling included on all orders for this publication. [2] Ten (10) or more copies—10% discount. [3] Postage/handling—$3.00.

LITERATURE	**MEMBERS**	**NON-MEMBERS**
Art Therapy Model Job Description	$ .32	$ 1.00
Media List	$ .32	$ 1.00
Bibliography: Books Authored by AATA Members	$ .32	$ 1.00
Ethical Standards for Art Therapists	$ .32	$ 1.00
Standards of Practice	$ .32	$ 1.00
Art Therapy: Journal of the American Art Therapy Association Index	$ 4.00	$ 6.00
AATA Legislative Handbook[1,2]	$37.50	$55.00
AATA Chapter Manual[3]	$12.00	N/A

NOTE: [1] Postage/handling included on all orders for this publication. [2] Ten (10) or more copies—10% discount. [3] Postage/handling—$3.00.

PROFESSIONAL PREPARATION LITERATURE	MEMBERS	NON-MEMBERS
Education Standards	$ .32	$ 1.00
Educational Program List (Colleges and Universities offering art therapy programs)	$ .32	$ 2.00

NOTE: General Information Packet—$3.00 (includes: Education Standards, Educational Program List, Information and Membership Application, Professional Membership Criteria, and Resources List).

MEMBERSHIP INFORMATION	MEMBERS	NON-MEMBERS
Professional Membership Application	$ .32	$ 1.00
Membership Survey	$ .32	$ 2.32
Membership Specialty List	$ 2.62	$ 3.62
Membership Directory [1]	$19.00	$65.00

NOTE: [1] Additional postage/handling—Canada/Mexico add $2.20; Foreign add $7.00.

SUBSCRIPTIONS		
AATA Newsletter	U.S.—$26.00	Foreign—$38.00
Art Therapy: Journal of the American Art Therapy Association	Individuals—U.S. $50.00 Institutions—U.S. $77.00	Foreign—U.S. $74.00 Foreign—U.S. $100.00
Back Issues of *Art Therapy: Journal of the American Art Therapy Association*	Members—$12.50	Non-Members—$23.00

NOTE: Postage/handling is included on both subscriptions.

POSTERS	MEMBERS	NON-MEMBERS
"I'm Into Art Therapy" by Elizabeth "Grandma" Layton	$20.00	$30.00
"Three Art Therapists" by Edith Kramer	$20.00	$30.00

NOTE: Postage/handling is included on both posters.

VIDEOS	TYPE	MEMBERS	NON-MEMBERS
Art Therapy Beginnings (1977) color/sound/45 minutes	1/2" VHS	$50.00	$80.00
Michael (1977) color/sound/12 minutes	1/2" VHS	$50.00	$80.00
Art Therapy (1980) color/sound/12 minutes	1/2" VHS	$50.00	$80.00

NOTE: Postage/handling for each VHS tape—U.S. add $3.00; Canada/Mexico add $3.25; Foreign add $10.00.

- WE DO NOT ACCEPT CREDIT CARDS OR PURCHASE ORDERS. All orders must be made in writing, accompanied by payment in cash, check, or money order in U.S. funds.
- FOREIGN ORDERS: Shipping will be made per your instructions (surface or air). Please specify shipment method when ordering. Additional postage, if necessary, will be billed separately.
- RETURNS ARE NOT ACCEPTED for refund on shipped items.

TITLE	QUANTITY	PRICE	TOTAL

SHIPPING INFORMATION

NAME ______________________________

MEMBER ID# ______________________________

STREET ______________________________

CITY/STATE/ZIP ______________________________

2554

Total: $____________

Postage: $____________

Applicable Discount: $____________

TOTAL ENCLOSED: $____________

Allow 2 to 4 weeks for delivery.
MAKE CHECKS PAYABLE TO AATA.

The American Art Therapy Association

THE ORGANIZATION

The American Art Therapy Association, Inc. (AATA), a non-for-profit organization founded in 1969, is a national association which represents a membership of approximately 4,750 professionals and students. It is governed and directed by a nine-member Board, elected by the membership. AATA has established standards for art therapy education, ethics, and practice. AATA committees actively work on governmental affairs, clinical issues, and professional development. AATA's dedication to continuing education and research is demonstrated through annual national conferences and regional symposia, publications, videos, and awards.

MISSION STATEMENT

The American Art Therapy Association is an organization of professionals dedicated to the belief that the creative process involved in the making of art is healing and life enhancing.

Its mission is to serve its members and the general public by providing standards of professional competence, and developing and promoting knowledge in, and of, the field of art therapy.

ART THERAPY:
DEFINITION OF THE PROFESSION

Art therapy is a human service profession that utilizes art media, images, the creative art process, and patient/client responses to the created products as reflections of an individual's development, abilities, personality, interests, concerns, and conflicts. Art therapy practice is based on knowledge of human developmental and psychological theories which are implemented in the full spectrum of models of assessment and treatment including educational, psychodynamic, cognitive, transpersonal, and other therapeutic means of reconciling emotional conflicts, fostering self-awareness, developing social skills, managing behavior, solving problems, reducing anxiety, aiding reality orientation, and increasing self-esteem.

Art therapy is an effective treatment for the developmentally, medically, educationally, socially, or psychologically impaired; and is practiced in mental health, rehabilitation, medical, educational, and forensic institutions. Populations of all ages, races, and ethnic backgrounds are served by art therapists in individual, couples, family, and group therapy formats.

Educational, professional, and ethical standards for art therapists are regulated by the American Art Therapy Association. The Art Therapy Credentials Board, Inc. (ATCB), an independent organization, grants post graduate Registration (ATR) after reviewing documentation of completion of graduate education and post graduate supervised experience. The Registered Art Therapist who successfully completes the written examination administered by the ATCB is qualified as Board Certified (ATR-BC), a credential requiring maintenance through continuing education credits.

CHAPTERS

Affiliated chapters of the AATA have been established throughout the United States. Chapters conduct meetings and activities which promote the field of art therapy on a local level. Chapters provide a forum for addressing professional issues as well as a network for people working toward common goals. Information and support for chapter members is passed on from the Assembly of Affiliate Chapters to the local level.

You must be a national member to become a chapter member. Information on locating the chapter nearest you is available from the AATA National Office.

MEMBER BENEFITS

All members receive:

Publications

- *Art Therapy: Journal of the American Art Therapy Association* (published quarterly).
- *AATA Newsletter* (published quarterly).
- Substantial discounts on AATA publications, such as Annual Conference Proceedings, other professional journals, videos, and the Membership Directory.
- AATA literature, such as Educational Program List, Art Therapy Media List, Standards of Practice, and mailings of professional interest.

Services

- Insurance, including professional liability, major medical, life, and disability through Maginnis & Associates.
- Access to national experts in art therapy.

AATA Meetings

- Discounts on registration fees to AATA national conferences and regional symposia.

Nationwide Advocacy

- Governmental affairs activities including congressional review and monitoring.
- State legislative and regulatory activities.
- Promotion of recognition and reimbursement of art therapists by third party payers.
- National liaison with related professional organizations for recognition and promotion of art therapy.

Professional Standards

- Development of Model Job Description and recommendations for licensing standards.
- Development and implementation of national Education Standards for approval of graduate level art therapy programs.
- Development and implementation of nationally recognized Standards of Practice and Ethical Standards for Art Therapists.

GENERAL INFORMATION

AATA and ATCB are administratively independent. Membership in AATA and Registration (ATR) with the ATCB require separate application and approval. *ATR registration applications are available from the ATCB at (312)527-6764.*

For ***new*** Associate, Student, and Contributing members only, please follow the dates below when submitting membership applications. The membership year is the calendar year **1/1 to 12/31**.

Applications received between:

1/1 to 5/31

Full dues payment; membership expires 12/31 of same year.

6/1 to 9/30

Half-year dues plus $5.00 payment; membership expires 12/31 of same year.

10/1 to 12/31

Full dues payment; membership for the remainder of current year and next full year.

CATEGORIES AND FEES

Professional-By application review process only; approved members may vote, hold office, and serve on committees.

- **Professional Member**-Individuals who have completed graduate level educational training in art therapy. Dues are $100.00/year.
- **Credentialed Professional Member**-Individuals who have been *dually approved* for Professional membership by AATA and Registration (ATR) by the ATCB. AATA dues are $100.00/year. *Annual ATR maintenance fee is billed separately by the ATCB.*

Associate-Individuals interested in the therapeutic use of art who support the purposes and objectives of AATA. This category is not open to Master's level art therapy program graduates. Associates may not vote, hold office, or serve on committees. Dues are $100.00/year.

Student-Individuals who are currently taking full-time course work in art therapy or a related field. A current statement from the institution of learning indicating full-time status and course work content (6 graduate or 12 undergraduate credits) is required. Student members may not vote or hold office, but may serve on the Student Subcommittee of the Education Committee. Dues are $45.00/year.

Contributing-Individual organizations, institutions, or foundations which contribute annually to AATA. Such members may not vote, hold office, or serve on committees. Dues are $150.00/year.

Retired-Individuals who are at least 65 years of age and who are no longer practicing. Retired Associates receive publications. Retired Professionals receive publications and may vote, but may not hold office. Application provided upon request. The service fee is $50.00/year.

The American Art Therapy Association

MEMBERSHIP APPLICATION

NAME________________________________

HOME ADDRESS____________________________

____

PHONE(_____)_________________________

BUSINESS ADDRESS________________________

____

EMPLOYER______________________________

JOB TITLE______________________________

LICENSES HELD & STATE_____________________

____

PREFERRED MAILING LIST: ☐ HOME ☐ BUSINESS

Foreign AATA applicants *must* include an additional $17.50 above required dues when submitting payment to cover the cost of foreign postage.

Please indicate under which category you are applying:

☐ $100 Associate Membership

☐ $45 Student Membership *(See Student membership criterion for necessary documents to accompany this application.)*

☐ $150 Contributing Membership

Professional Member-Individuals who have completed graduate level educational training in art therapy. Dues are $100.00/year.

☐ Professional Membership Application

Credentialed Professional Member-Individuals who have been *dually approved* for Professional membership by AATA and Registration (ATR) by the Art Therapy Credentials Board, Inc. (ATCB). AATA dues are $100.00/year. *Annual ATR maintenance fee is billed separately by the ATCB.*

ATR Application-Provided and processed by the ATCB. *ATR is granted by ATCB review approval process only.* For more information, contact the ATCB at (312)527-6764.

Please make all checks payable in U.S. dollars and mail to:

American Art Therapy Association, Inc. (AATA)
1202 Allanson Road
Mundelein, IL 60060 U.S.A.
(847)949-6064 / Fax (847)566-4580

PLEASE COMPLETE THIS SURVEY.

Education (please check highest degree earned)

1 ☐ Doctorate Degree
2 ☐ Master's Degree
3 ☐ Bachelor's Degree
4 ☐ Associate/Certificate
5 ☐ Other ______________

Please indicate *exact* degree earned, e.g., BA, BS, MA, MS, PhD, etc.

Work Setting (please check only one)

1 ☐ Hospital
2 ☐ Clinic
3 ☐ Day Treatment Center
4 ☐ Rehabilitation
5 ☐ Sheltered Workshop
6 ☐ Correctional Facility
7 ☐ Residential Treatment
8 ☐ Outpatient Mental Health
9 ☐ School System
10 ☐ Elderly Care Facility
11 ☐ College/University
12 ☐ Clinical Training Program
13 ☐ Institute Training Program
14 ☐ Counseling Center
15 ☐ Private Practice
16 ☐ Other __________

Area(s) of Specialization (please check up to three)

1 ☐ Addictions
2 ☐ Adolescents, Hospitalized
3 ☐ Adolescents, Psychiatric
4 ☐ Adults, Hospitalized
5 ☐ Adults, Psychiatric
6 ☐ Art History
7 ☐ Art Therapy Education
8 ☐ Art Therapy in Schools
9 ☐ Children, Hospitalized
10 ☐ Children, Psychiatric
11 ☐ Domestic Violence
12 ☐ Eating Disorders
13 ☐ Families
14 ☐ Gerontology
15 ☐ Hospice/Terminally Ill
16 ☐ Learning Disability
17 ☐ Mental Retardation
18 ☐ Neurological Disease
19 ☐ Prisoners
20 ☐ Post Traumatic Stress
21 ☐ Psychotherapy
22 ☐ Rehabilitation
23 ☐ Research
24 ☐ Sexual Abuse
25 ☐ Visual Art
26 ☐ Other __________

Voluntary Information

Age

1 ☐ 20-24
2 ☐ 25-29
3 ☐ 30-34
4 ☐ 35-39
5 ☐ 40-44
6 ☐ 45-49
7 ☐ 50-54
8 ☐ 55-59
9 ☐ 60+

Salary Range

1 ☐ under $10,000
2 ☐ $10,000-14,999
3 ☐ $15,000-19,999
4 ☐ $20,000-24,999
5 ☐ $25,000-29,999
6 ☐ $30,000-34,999
7 ☐ $35,000-39,999
8 ☐ $40,000-44,999
9 ☐ $45,000-49,999
10 ☐ $50,000+

Gender

1 ☐ Female
2 ☐ Male

2556

Hours Worked/Week

1 ☐ 0-10
2 ☐ 11-20
3 ☐ 21-30
4 ☐ 31-40
5 ☐ 41+

ATTENTION AUTHORS

Please complete the following information and attach one copy to each copy of your submission:

Name______________________________

Degrees/Credentials______________________________

Address______________________________

____

Phone Numbers **Home**________________ **Work**________________

Type of Submission (check one):

☐ Article
☐ Viewpoints
☐ Brief Report
☐ Video Review
☐ Book Review
☐ Commentary

Title of Submission______________________________

____

Checklist

☐ Five (5) copies, typewritten on 8 1/2" x 11" white paper with margins of at least one inch.

☐ Black and white photographs (at least 5" x 7") of original artwork plus four (4) photocopies of each.

☐ Paper and references adhere to *Publication Manual of the American Psychological Association* (Fourth Edition).

☐ Abstract of 100-150 words (for articles and brief reports only).

☐ Detachable cover sheet with author(s) name(s), affiliation, degrees, and credentials.

☐ Appropriate release forms obtained for use of client art expressions and client information. (You do not need to send these with your submission, but you must have them on file.)

☐ This Attention Authors form.

Author's Signature________________________ **Date**____________

Please send completed form with submission to: **Editor, *Art Therapy: Journal of the American Art Therapy Association***, c/o American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060 USA.

GUIDELINES FOR SUBMISSIONS

All submissions will be acknowledged upon receipt by the AATA National Office. *Art Therapy: Journal of the American Art Therapy Association* uses a blind peer review procedure for articles, brief reports, and viewpoints. Final decisions regarding publication are made by the reviewers and the Editor. Decisions regarding submissions to other sections are made by the Editor, Associate Editor, and special section editors.

The following are guidelines for submissions. **Submissions that do not conform to these guidelines will be returned to the author without review.**

Submission Categories

1. **Articles.** Full-length articles may focus on the theory, practice, and research in art therapy or related areas. Articles must include an abstract of approximately 100-150 words summarizing the major point of the article.
2. **Brief Reports.** Short articles which focus on the results of research are appropriate for this section. Brief Reports should include information on the research design, methodology, and results. An abstract of approximately 100-150 words should also be included.
3. **Viewpoints.** Short articles focusing on personal experiences, poetry, or original art may be submitted to this section.
4. **Book Reviews.** Reviews of books of interest to art therapists may be submitted at any time. Books which authors wish to have considered for review may be sent directly to the AATA National Office.
5. **Video Reviews.** Reviews of media (videos) may be submitted at any time. Media which producers wish to have considered for review may be sent directly to the AATA National Office.
6. **Commentaries.** Brief comments on submissions published in *Art Therapy;* issues critical to the profession and practice of art therapy, or letters to the Editor may be submitted to this section and should conform to the style of all other submissions.

Other Requirements

1. Send **five (5) clear copies** of each submission to **Editor, *Art Therapy: Journal of the American Art Therapy Association,* c/o American Art Therapy Association, Inc., 1202 Allanson Road, Mundelein, Illinois 60060.** Neither AATA nor the Editor can be responsible for submissions sent to any other address.
2. Only original submissions that are not under consideration by another periodical or publisher are acceptable.
3. Submissions must be typewritten on 8 1/2" x 11" white paper with margins of at least one inch. The body of the paper, references, tables, and quotations must be double-spaced.
4. Submissions must be prepared in APA style. Please refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for more information.
5. An abstract of 100-150 words must be included with full-length articles and brief reports.
6. Please avoid footnotes wherever possible.
7. A cover sheet should be prepared to include the full name(s) and degree(s) of the author(s), professional affiliations, and the return mailing address of the author to whom correspondence can be sent. Authors' names, positions, titles, and places of employment should not appear in the body of the paper to assure anonymity and to facilitate blind review.
8. Use tables sparingly and type them on separate pages. Refer to the *Publication Manual of the American Psychological Association* (Fourth Edition) for style of tabular presentations. All tables, charts, or diagrams must be legible and able to withstand reduction. Include originals and four (4) photocopies.
9. Photographs must be at least 5" x 7" and black and white glossy prints, preferably with high contrast. Photocopies of illustrations or art expressions are not acceptable for publication. Figure numbers and captions should be noted on the back of photographs. Captions must be typed and submitted on a separate sheet of paper. Please refer to figures in the text as Figure 1, Figure 2, etc. Include four (4) sets of photocopies of original photographs.
10. Lengthy quotations (300 words or more from one source) or reproduction of works of art (this does not include client art expressions which are addressed below) require written permission from the copyright holder for reproduction. Adaptation of tables or figures from copyrighted sources also requires approval. **It is the author's responsibility to secure such permissions**. A copy of the copyright holder's written permission must be provided to the Editor immediately upon acceptance of the article for publication.
11. Client/patient confidentiality must be protected in the title, abstract, text, photos, illustrations, and other accompanying material. Proper releases for use of client art expressions and other client information must be obtained and kept on file by the author.
12. It is expected that any submission accepted for publication in *Art Therapy* will go through at least one revision before publication. If authors have prepared their submission on either an IBM, IBM-compatible, or Macintosh computer, upon acceptance, they can send a 3.5" diskette containing an electronic copy of the submission to the AATA National Office. This will help speed processing, editing, and publication.

Note: Authors bear full responsibility for the accuracy of all references, quotations, and materials accompanying their submissions.

ART THERAPY
1202 Allanson Rd.
Mundelein, IL 60060

Address Correction Requested

Non-Profit
Bulk Rate
U.S. Postage Paid
Champaign, IL
Permit 16